School Employees Benefits Board Meeting

March 7, 2019

Washington State Health Care Authority

School Employees Benefits Board

March 7, 2019
9:00 a.m. – 3:30 p.m.

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

Table of Contents

Meeting Agenda 1-1

Member List 1-2

Meeting Schedule 2019 1-3

SEB Board By-Laws 2-1

Approval of July 30, 2018 Meeting Minutes
Approval of August 30, 2018 Meeting Minutes
Approval of September 17, 2018 Meeting Minutes
Approval of September 17, 2018 Combined PEBB / SEBB Meeting Minutes 3-1

January 24, 2019 Board Meeting Follow up 4-1

SEBB Finance Update 5-1

Policy Resolutions 6-1

COBRA Continuation Coverage Overview 7-1

Eligibility and Enrollment Policy Development 8-1

Legislative Update 9-1

SEBB Organization Readiness: HCA Support 10-1

Member Communications 11-1

Pharmacy 101: Policy Levers to Manage Drug Trend 12-1

Benefits Update 13-1

TAB 1

Washington State Health Care Authority

AGENDA

School Employees Benefits Board
March 7, 2019
9:00 a.m. – 3:30 p.m.
Sue Crystal Rooms A & B

Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98501

Call-in Number: 1-888-407-5039 Participant PIN Code: 60995706

9:00 a.m.*	**Welcome and Introductions**		Lou McDermott, Chair	
9:05 a.m.	**Meeting Overview**		David Iseminger, Director Employees & Retirees Benefits (ERE Division	Information
9:10 a.m.	**Approval of Meeting Minutes:** • **July 30, 2018 Minutes** • **August 30, 2018 Minutes** • **September 17, 2018 Minutes** • **September 17, 2018 PEBB / SEBB Combined Minutes**	TAB 3	Lou McDermott, Chair	Action
9:15 a.m.	**January 24, 2019 Board Meeting Follow-up**	TAB 4	David Iseminger, Director ERB Division	Information/ Discussion
9:30 a.m.	**SEBB Finance Update**	TAB 5	Kim Wallace, SEBB Finance Manager, Financial Services Division	Information/ Discussion
10:00 a.m.	**Policy Resolutions**	TAB 6	Rob Parkman, Policy and Rules Coordinator, ERB Division	Action
10:45 a.m.	**COBRA Continuation Coverage Overview**	TAB 7	Barb Scott, Manager Policy, Rules, and Compliance Section, ERB Division	Information/ Discussion
10:55 a.m.	**Eligibility & Enrollment Policy Development**	TAB 8	Rob Parkman, Policy and Rules Coordinator, ERB Division	Information/ Discussion
11:25 a.m.	**Legislative Update**	TAB 9	Cade Walker, Special Assistant to ERB Division Director	Information/ Discussion
11:45 a.m.	**Executive Session and Lunch**			

1:15 p.m.	**SEBB Organization Readiness: HCA Support**	TAB 10	Jesse Paulsboe, Outreach & Training Unit Manager, ERB Division Alisa Richards, Customer Service Operations Manager, ERB Division Jerry Britcher, Chief Information Officer	Information/ Discussion
1:45 p.m.	**Member Communications**	TAB 11	Rochelle Andrake, Communications Consultant, ERB Division	Information/ Discussion
2:15 p.m.	**Pharmacy 101: Policy Levers to Manage Drug Trend**	TAB 12	Molly Christie, Project Manager Benefit Strategy & Design Section, ERB Division	Information/ Discussion
2:40 p.m.	**Benefits Update**	TAB 13	Lauren Johnston, Contract Manager, ERB Division	Information/ Discussion
3:10 p.m.	**Public Comment**			
3:30 p.m.	**Adjourn**			

***All Times Approximate**

The School Employees Benefits Board will meet Thursday, March 7, 2019, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8th AVE SE, Olympia, WA. The Board will consider all matters on the agenda plus any items that may normally come before them.

The Board will meet in Executive Session, pursuant to RCW 42.30.110(1)(d), to review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs; and pursuant to RCW 42.30.110(1)(l), to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session will begin at 11:45 a.m. on March 7, 2019 and conclude no later 1:15 p.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.

Direct e-mail to: SEBboard@hca.wa.gov. Materials posted at: https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program by close of business on March 5, 2019.

Washington State Health Care Authority

SEB Board Members

Name	Representing
Lou McDermott, Deputy Director Health Care Authority 626 8th Ave SE PO Box 42720 Olympia WA 98504-2720 V 360-725-0891 louis.mcdermott@hca.wa.gov	Chair
Sean Corry Sprague Israel Giles, Inc. 1501 4th Ave, Suite 730 Seattle WA 98101 V 206-617-6998 seanpcorry@gmail.com	Employee Health Benefits Policy and Administration
Pete Cutler 7605 Ostrich DR SE Olympia WA 98513 C 360-789-2787 p.cutler@comcast.net	Employee Health Benefits Policy and Administration
Patty Estes 7904 155th Street CT E Puyallup WA 98375 C 360-621-9610 p.estes.sebb@gmail.com	Classified Employees
Dan Gossett 603 Veralene Way SW Everett WA 98203 C 425-737-2983 dan.gossett@comcast.net	Certificated Employees

SEB Board Members

Name	Representing
Katy Henry Spokane Public Schools 200 North Bernard Spokane WA 99201 V 509-325-4503 khenry@washingtonea.org	Certificated Employees
Terri House Marysville School District 4220 80th ST NE Marysville WA 98270 V 360-965-1610 Terri_house@msd25.org	Classified Employees
Wayne Leonard Assistant Superintendent of Business Services Mead School District 608 E 19th Ave Spokane WA 99203 V 509-465-6017 wayne.leonard@mead354.org	Employee Health Benefits Policy and Administration (WASBO)
Alison Poulsen 12515 South Hangman Valley RD Valleyford WA 99036 C 509-499-0482 alison@betterhealthtogether.org	Employee Health Benefits Policy and Administration

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3/1/19

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue SE • P.O. Box 45502 • Olympia, Washington 98504-5502

UPDATED SEBB MEETING SCHEDULE

2019 School Employees Benefits Board (SEBB) 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 24, 2019 - 9:00 a.m. – 5:00 p.m.

March 7, 2019 - 9:00 a.m. – 5:00 p.m.

April 10, 2019 - 1:00 p.m. – 5:00 – p.m.

May 16, 2019 - 9:00 a.m. – 5:00 p.m.

June 12, 2019 - 9:00 a.m. – 5:00 p.m.

July 18, 2019 - 9:00 a.m. – 5:00 p.m.

July 25, 2019 - 9:00 a.m. – 5:00 p.m.

August 1, 2019 - 9:00 a.m. – 5:00 p.m.

August 29, 2019 - 9:00 a.m. – 5:00 p.m.

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

Updated 11/27/18

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: November 27, 2018
TIME: 3:36 PM

WSR 18-24-024

TAB 2

Washington State Health Care Authority

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

School Employees Benefits Board
Meeting Minutes

DRAFT

July 30, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:00 p.m. – 5:00 p.m.

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

SEB Board Counsel:
Katy Hatfield

Members Absent:
Alison Poulsen

Call to Order
Lou McDermott, Chair, called the meeting to order at 1:03 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

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

Approval of January 29, 2018 SEB Board Meeting Minutes
Lou McDermott: Pete Cutler moved, and Terri House seconded the motion to approve the January 29, 2018 SEB Board Meeting minutes as written. Minutes approved by unanimous vote.

June 13, 2018 Meeting Follow Up

Dave Iseminger: Pete Cutler asked for claim information comparing international claims versus domestic claims. I will prepare a slide for the next Board Meeting. Then the entire Board will have the information in writing.

During the vision presentation, there was a request to get both self-insured plan information and fully insured plan information on the upcoming procurement. We did modify the procurement in a way that allowed us to get information for both of those options.

There were several requests for the fiscal impacts of different benefit modifications, as well as insight on the Per Subscriber Per Month (PSPM). We use the word "subscriber," which you may think of as the employee (PEPM). We made sure that information is addressed in Kim Wallace's presentation today.

I also want to provide a pharmacy update. In the May meeting, we presented the current Uniform Medical Plan Pharmacy benefit design, as well as changes we're going to take before the PEB Board for a possible change to the pharmacy benefit for calendar year 2019. We did not ask you to take action on Proposed Resolution SEBB 2018-24 because we thought it would be appropriate for you to know what the PEB Board did with that information because they've had a long, multi-year discussion about pharmacy benefit design. At the June 20 PEB Board meeting, the Board split on their vote on whether to implement a change for 2019. The vote was 3 to 3. We will go back, make some changes to the proposal, and bring it back to both Boards for discussion at future meetings. We will work on educating this Board by building the framework and understanding of overall drug cost impacts in the US and to SEBB Program members. We will modify the proposed PEB Board resolution and bring it to both Boards for evaluation. Proposed Resolution SEBB 2018-24 is in a holding pattern.

The 2019 SEB Board Meeting schedule is at the end of TAB 1. There are several meetings in the months of July and August. Once the Legislature finishes with the operating budget, we work with the Board to set the premiums. We have a limited amount of time to complete the process in order to get communications out before the beginning of open enrollment. This information comes from various sources, including the Collective Bargaining Agreement and the operating budget. You're here in rapid succession next summer in order to complete the process. Although this is the first time this Board has met since June 13, we've had three meetings with the PEB Board since our last meeting here with you. This is actually our eighth meeting in ten weeks, between the two Boards. This time of year is very heavy with Board meetings.

Regarding the K-12 Retiree Report due to the Legislature, statute requires that the agency work and consult with both the PEB and SEB Boards about the final report. We will call a special joint meeting of both Boards on September 17 to ensure we provide the same information. That will give us an opportunity for a discussion on the information we're sharing, provide time to finish the draft, and get it through our review process in order to submit it to the Legislature on time.

Agenda Item: Life and AD&D Insurance

Scott Palafox, Deputy Director, ERB Division: Slide 2 – Resolution SEBB 2018-10 was approved on March 15, 2018. It allows the Board to leverage the offerings under the Public Employees Benefits Board Program Life and AD&D Benefit.

Slide 3 – Current PEBB Program Life and AD&D Benefit. I provided some background information on our current Life and AD&D benefit in December. HCA did a procurement in 2016, and the MetLife Insurance Company became our vendor, effective January 1, 2017. We have a group term life policy, which is typically what an employer offers its employees and it's usually issued for one year, and renewable annually. Group life coverage remains in place until the employment terminates, or until the specific coverage terms end. You may have the option to convert your coverage to an individual policy if you leave employment.

Pete Cutler: For employee term life, is that a voluntary or employer paid?

Scott Palafox: Optional coverage is employee paid. Basic coverage is employer paid.

Slide 4 – Why do we Need Life Insurance? Purchasing insurance is a financial protection when we experience a financial loss. There are different kinds of insurance products that protect our assets and our families, like homeowners and automobile insurance. We have short-term and long-term disability insurance to replace income if we become disabled.

Life and AD&D insurance products are purchased to: replace or substitute lost income, especially if the person that dies is the primary wage earner, or the sole source of wage earnings for the family; asset protection; funeral costs - a funeral averages between $8,000 - $10,000; financial protection - for outstanding debts; and, simply, peace of mind.

Slide 5 – Facts. According to Life Insurance Statistics and Facts, a report by the life insurance industry, 43% of the population does not own a life insurance policy in any amount. In 2018, of the people who already have a life insurance policy, one in five admit that they don't carry enough. 50% of the people admit they would likely buy life insurance if they could do it without a medical exam. Approximately 40% of millennials would feel more comfortable if their partner or spouse carried more coverage. For the older generation, this is not the case. They more than likely have paid off student loans, paid their mortgages down or even off, so the need is less for them as it is for those still acquiring assets. One in three families admit it would be in a financial disaster within a single month should the household's breadwinner suddenly pass. 46% don't have cash to cover a hypothetical $400 emergency.

Beth Heston, PEBB Procurement Manager, ERB Division. Slide 6 – Life Insurance 101. We take life insurance for granted. We have it or we don't. Life insurance is to protect the people that depend on you. Life insurance products usually fall into two categories - term life and accidental death and dismemberment.

Term life insurance is based on group coverage. The whole group is insured and it is one of the least expensive. It lasts for a certain amount of time with renewals available. The largest term is the period of your employment. As long as you're state employed and benefits-eligible, you receive this benefit. Some plans offer portability, which allows you to take it with you when you leave employment and some have age restrictions.

Accidental death and dismemberment is inexpensive. It's unlikely you're going to die in an accident. The most recent statistics from 2015, from the Centers for Disease Control, indicate only 5.4% of deaths occur in accidents.

Slide 7. There are two methods of paying premiums: basic, which the employer pays, and supplemental, which the employee chooses and pays.

Pete, you mentioned “early voluntary.” Some people call supplemental life insurance voluntary, or optional. HCA uses the word "supplemental" across all benefits.

The term "life insurance" is a pure life insurance. The policyholder pays the premiums and if he or she is killed or dies while it's in effect, the beneficiary or beneficiaries get the death benefit. It's straightforward and easy to understand. It's also the most affordable life insurance. You can cancel the term policy before it expires and you don't lose anything because it has no money value.

There are two methods of determining rates. There is: 1) a blended rate or 2) the traditional tobacco user or non-tobacco user. The blended rate puts everyone in the same pool and tends to be more expensive because the safer members and less safe members are paying the same rate. The traditional rate is divided by tobacco users and non-tobacco users.

HCA’s rates are currently the traditional-tobacco users and non-tobacco users. We have a strong push with our health plans to incentivize people to stop using tobacco. This method of rating encourages people to stop. It also rewards those who have already stopped or never smoked at all.

Evidence of Insurability (EOI) and Guaranteed Issue (GI). Medical underwriting is usually required for life insurance. When an employer has a large group, they can negotiate a guaranteed issue amount that allows the member to avoid any medical exam.

Pete Cutler: On the negotiated guaranteed issue, is that usually just for a window period? Like when you first come on employment?

Beth Heston: Yes. Normally, on initial hiring, you can get 31 days to choose an amount of life insurance without having to undergo underwriting, which extends to whomever is being insured. There are special open enrollment circumstances, but it is normally upon hire.

Pete Cutler: It's just a window, okay, thank you.

Lou McDermott: And also when you're switching from one vendor to another vendor.

Beth Heston: Yes. In the PEBB Program, it was a new open enrollment with a new guaranteed issue amount for all PEBB Program subscribers when the new plan went into effect January 1, 2017.

Dave Iseminger: This highlights how different Board decisions come together. There is a prior resolution that this Board has passed that set the election period for new employees. As we negotiated with the carrier about this plan, we talked about guaranteed issue for the same period the Board established as the initial new employee election period, which was the 31-day period. This shows how different things come together.

Patty Estes: How is that going to work with open enrollment for the SEBB Program? Does everybody have that guarantee?

Beth Heston: During open enrollment, everyone will be joining a new group and allowed to sign up for the new guaranteed issue amount.

Slide 8 – Decision Point #1. Does the Board want to authorize a basic term life and a basic AD&D benefit paid by the state?

Dave Iseminger: Just to be clear, there are still funding questions. This is the perennial question of “how do we make a decision about what to offer when we don't know what the answer to the funding question is?” There are many different moving parts. I've asked the Board to do 90% of the homework now, and when the funding questions are answered next July, we'll talk about how the funding matches the benefit design. If more funds are available than that benefit design supported, we'll give you ideas and options for how you could spend the rest of the allocated money. If there's less money, we would present information on the different options you have for meeting the funding that was allocated by the Legislature. That's one piece.

I also think of the Board in a relay race as both the first and the anchor. You're lead and anchor because you're going first in describing generally what you think is the way forward for the benefit design, but then you're also the anchor because you have that refinement that’s necessary on the back end once the funding question is answered.

That will be a theme. That’s the approach we will take to create a general framework of benefits. Complete 90% of your homework now and refine when funding is clear.

Beth Heston: Slide 9 – Employee Basic Term Life and AD&D. Because you agreed in the earlier resolution to leverage the existing contract that HCA has with MetLife, negotiations have begun. We shared the data about the SEBB Program population with MetLife and worked with them to design a basic life benefit that also included basic

AD&D. We negotiated $35,000 for basic term life and $5,000 for basic employee AD&D. These terms are valid as long as an employee is benefits eligible and could be ported when leaving employment. The basic premium is employer-paid.

Pete Cutler: Just to be real clear, this is what was negotiated for the PEBB Program and is what is offered currently, or provided actually, to a state employee currently. Did that contract also include explicitly any commitment by MetLife to extend similar rates or anything for the SEBB Program population?

Dave Iseminger: When we negotiated that contract, we foreshadowed that if there was another large group of 20,000 lives or more that came in, we would enter negotiations and leverage that procurement and contract for a future discussion. There was not a guarantee.

Pete Cutler: It was subject to negotiations, great.

Dave Iseminger: We actually had our carrier, MetLife, do a census review. They obviously found some differences in the census review of the SEBB population from the PEBB population. There was a different average age and gender mix. They actually came back to us, and our actuaries reviewed their assumptions, that those two differences offset each other. They canceled each other out in the two programs. They felt they could give us the same rate and benefit design.

When we moved to MetLife on the PEBB Program, there were premium reserves built up under the prior carrier that we were able to use to stabilize the rates. For the SEBB Program, there are no reserves. That was another factor in working on benefit design, building a system with no influx of reserves to stabilize premiums. It is great that, even though the demographics canceled each other out and there were no premium stabilization reserve (PSR), they were able to offer the same rates and benefits. It is the same on a Per Subscriber Per Month (PSPM) basis. We're still finalizing the rates, but it's looking like we can have a comparable PSPM for the basic benefits that would be employer paid that exists in the PEBB Program.

Pete Cutler: How long has the state offered the AD&D as a basic benefit?

Beth Heston: Since 1977.

Pete Cutler: I don't remember AD&D being a basic benefit before, but okay, I'll go back and check. Thank you.

Beth Heston: Slide 10 – Concierge Services with Basic Life. Our life insurance offers concierge services that would also be available in the SEBB benefit. Those include access to legal services with WillsCenter.com, Portability, Funeral Assistance, Grief Counseling, Accelerated Benefit Option, and Travel Assistance.

I want to talk about our accelerated benefit option. If someone receives a terminal diagnosis, and been told you will not live more than 24 months, you can take out up to 80% of your life insurance to use for expenses. You can pay your house off, pay medical bills, travel, whatever you wish. The benefit becomes immediately accessible. The other 20% is available for post-death expenses.

Pete Cutler: On the accelerated benefit option, if you're married, does your spouse have to agree to that if they're going to be the beneficiary?

Beth Heston: No. And if your spouse is insured, they can also take a portion of their benefit as well.

Pete Cutler: I was going to say if it were a retirement benefit and you were going to draw a lump sum payment, then the federal tax code requires there be a spousal consent. This is not treated like a retirement benefit. Okay, great.

Beth Heston: No, it’s not. All the benefits are taken post-tax. There's no tax taken out of the benefit amount when it's paid. There are no tax implications to the beneficiaries.

Slide 11 – Value Added AD&D Features. With AD&D, we have other value-added features, which include amounts that are given to either the surviving person who was in the accident who was dismembered in some way, or the beneficiaries. Those include a seat belt benefit. If someone is injured, killed in a car accident, there's an extra payment if an airbag deployed or if they were wearing their seatbelt at the time. There is also a spouse or state-registered domestic partner education benefit available. If that person needs to be retrained or was in the process of doing something educationally, they will get additional money towards their tuition. There's a child care benefit to care for children while you, your spouse, or state-registered domestic partner are finishing that education. There's also a child education benefit. If you're paying tuition for your kids, this will assist with that. And lastly, a rather new addition to AD&D, if you are permanently or irreversibly brain damaged in the accident and you survive, there's a payment to cover that irreversible brain injury.

Dave Iseminger: Beth, just to be clear, from your prior slide, it was described as a $5,000 basic benefit. Then, depending on if you were wearing your seatbelt and whether you had kids in child care or in school, it'd be on top of that $5,000. There's a bonus, a couple thousand dollars for this or a couple thousand dollars for that. It's on top of the underlying $5,000.

Beth Heston: Exactly. So much around life insurance is based on how the death certificate is filled out, and your circumstances, which you will have if you enrolled for this insurance, will be in the system and it will tell the insurance vendor what to pay. They will investigate and pay the appropriate extra amounts.

Slide 12 – Decision #1 – Considerations. Under RCW 41.05.740, the Board is authorized to offer life and accidental death and dismemberment insurance. The key to

these basic coverages is that all employees are covered the moment they start working for the state. This gets the most vulnerable employees, those who cannot afford or choose not to enroll in any other kind of coverage.

When the PEBB Program changed vendors in 2017, we had an astounding re-enrollment because this life insurance product had been closed for so long and had been very rigid, since 1977. We went from 32% of our population participating in the benefit to 51% of our population. That's a huge jump. It even surprised MetLife. However, 49% of the population still only has basic coverage. We gave them the opportunity to sign up for a supplemental benefit and they chose not to or they couldn't afford to. The basic benefit covers everyone.

Dave Iseminger: I do want to highlight one other nuance with the first bullet. Not only does the Board have the authority, but it has exclusive authority with regards to Life and AD&D benefits. If the Board doesn't exercise its authority to authorize a benefit, the way the law is written, the local school district cannot step in and offer a benefit. If you did not create a life insurance benefit, there would be no life insurance benefit in the K-12 system because local districts do not have the authority to create a benefit.

Beth Heston: Slide 13 – Decision #1 – Recommendation. The staff recommendation for employee basic life is that you authorize $35,000 in term life and $5,000 in employee basic AD&D.

Dave Iseminger: I want to provide context to the Board. One is the incremental cost of different changes within these benefits. We feel it's best to put forward a single recommendation, but, I do want to describe what the different costs would be if you were to exercise and create a different benefit design. Although we are still in negotiations with MetLife, I want to give you a general snapshot of what the rates could look like and use this as an example of how you can alter different benefit designs across your portfolio.

For example, the employee basic life insurance, essentially $10,000 worth of life insurance, equates to roughly $1 in per subscriber per month (PSPM) costs. Later in Kim's presentation, that is also an example of $1 in PSPM to increase chiropractic, acupuncture, and massage limits to 24. It's an example of how a dollar given here could be used to give a dollar there across the portfolio.

On accidental death and dismemberment, the entire cost for the SEBB population, using PEBB as a proxy, the entire annual premium would only be somewhere around $100,000 - $125,000, which equates to about a nickel PSPM.

I'm not revealing specific rates, again we're not completely done, but I'm talking in general.

We're starting chapter three with the Board across all benefit design. We don't know what the Legislature is going to fund, but, we do know from Senate Bill 6241, there was

an expressed intent to have the same, or more funding, put into the system as exists in the PEBB population. We have been using that intent as a grounding point as we bring forward benefit designs to you. This recommendation is a representation of that. We will use the core structure of PEBB benefits and recommend changes along the way. For example, when we bring forward the disability benefit, it will be a different benefit than exists in PEBB. First, there's no short-term disability in PEBB to be able to stack and dovetail with the long-term disability. We also know that the PEBB long-term disability basic benefit was not something the SEB Board was interested in pursuing as a possible benefit design for the SEBB Program.

There is more information to come and ways for you to alter different parts of the benefit design. Our recommendation at this point is that you have the $35,000 benefit as basic life and a $5,000 AD&D. As we go forward and learn more about the funding, you can then consider how to make different changes.

Sean Corry: Thanks for that, Dave. We've already discussed, and are working on, the pricing of various medical tweaks to the plans. And, similarly by implication just now, you framed it as "there's a dollar here that could be maybe paid for by this dollar over here," as if it's currently a fixed dollar amount that we have to play with. But, it's actually not yet. I just like to make that observation. But, I do appreciate the opportunity to have within each benefit perhaps a spectrum of choices that we've asked for. Not only for us to consider, but to see the pricing and what that dollar is. It will be very helpful, to me at least, to get clear information about not only here, but to raise the disability benefit to something that's closer to what school districts now offer their employees. I would like to see that kind of thing, so we can see, for me to pretend that it's a zero sum game, but, also knowing that maybe we can choose as a Board to request effectively more cash, more money for this, because we want to have better benefits for the school district population as a whole. With all of that, I really look forward to getting good information on paper about what these costs would be to enhance life insurance coverage so that we can put that in the spectrum of choices that we can consider. And, maybe we'll reject all of the enhancements that I can imagine as possibilities in my mind. But, I'd love to be able to reject them, as opposed to not be able to at all. Which then brings me to a couple of other things.

One of the things I personally would like to see regarding the take up rate of the voluntary life, I'd love to see that stratified by income levels for state employees. My guess is that it is not a straight-line comparison there. That might help me understand how much I should be concerned about that aspect of it.

And, lastly, more broadly, we have a proposed resolution that, by its words, would lock us in. I mean, we could change it later, but I do have concern about the proposed resolution as it's written now because I'm not there yet. I think it's premature to lock into a benefit design without seeing what the alternatives are and what the pricing would be. So, however that plays out over the constricted time that we have, I think it's important for us to be able to see that information and be able to evaluate it. I have trouble with endorsing a resolution that, in effect, locks us into something, when at the same time,

we're asking for alternatives to that very same level of benefits. I'd like us to somehow figure out how to avoid voting on something that maybe shortly thereafter, we as a Board, might want to modify. I don't know how to go about doing that, but it's difficult for me to see that path.

Dave Iseminger: Sean, I'd just respond quickly that I can appreciate how the Board might feel that every time you vote on a resolution you're at this precipice, and it's the last time you'll talk about it. I try to reassure you that this is an iterative process. The agency is asking you, because of where we are in the process, to put together a range for the benefits, and then refine after the next legislative session.

We'll talk this afternoon about treatment limitations because the Board had questions. You took a step forward at the last meeting and passed resolutions. We can bring language to refine those. The process of amending a resolution is certainly fine with us. We can make sure we tee up the things you want to amend in those resolutions. I think giving more structure along the way to bring some pieces of the puzzle together, even if you are refining them later, is something that can only help give clarity to this program as it is launched.

Sean Corry: One last follow-up question then. If amending is a possibility, why is it that we would be asked to vote for locking in that it will be essentially the PEBB benefit for SEBB enrollees, when we could look at choices first, come up with a recommendation, and then have a resolution based on that work after the fact?

Lou McDermott: From my perspective and where I sit in the agency, and as I've watched the SEBB Program unfold, I think one of the difficulties is you have to start somewhere. Where there's give and take between the different benefits, as Dave said, you could have a little bit more of this and a little bit less of that, it almost creates a situation of the chicken and the egg. Do you wait until the very end when every single program has been vetted to its full extent? You could have this level of benefit, or this, or this, etc., and then at the end, do a juggling act and take a little here and add there.

Conceptually it's possible. But, from a programmatic standpoint, and the number of staff we have working on the Program, it becomes extremely difficult to juggle multiple procurements and negotiations at the same time. What I believe Dave is trying to do is nail down one thing at a time; and at the end, review what’s been done and how the Board feels about it in its totality. Are there things we want to change?

I don't know how to create that assurance that that's what we're trying to do. It is partly a workload issue of not being able to put it all on the table at once. I think that's where the Board, through its relationship with the agency and the process we're going through, will need to trust that if we're saying there's flexibility, there will be flexibility. It's difficult to present it all today and say here it all is!

Sean Corry: Thank you for that, Lou. What popped into my head now is not a resolution that we shall have this benefit that we might amend later, but perhaps the

resolution should be, and the previous one should have been, we shall use these as benchmarks. We'll use these as our targets for pricing and discussion, locking in later. I don't know how that practically would be any different, but it doesn't effectively compel us to say this is the benefit we are going to have, the benefit we are targeting. There is a subtle difference, but I think gives us some room and some comfort to look at alternatives without having to reverse ourselves in the future.

Dave Iseminger: We're always looking for feedback on the wording of the resolutions and you're giving us some feedback, Sean. I'd be interested in other Board members' feedback, as well. As a reminder, we put forward this resolution in its initial proposed state in order to discuss what the resolution is like. We'll take it to stakeholdering as Barb does with the eligibility resolutions, and bring back something in the future for action. Do other Board members have thoughts about this particular resolution?

Pete Cutler: I actually share Sean's preference that if the resolutions really are intended to say for now as a baseline we are considering, or assuming we will proceed with whatever the benefit is at this level, subject to review and confirmation at some point in the future. If that's really the intent, I would like that to actually be in the resolution. It's a little bit awkward to have a resolution that says flat out, we are making a decision; and then say, “well, but verbally, you're not really making a decision now. You have the ability to adjust it later.” I would feel more comfortable with something that more clearly stated that this is tentatively the decision, the policy approach. And subject to such refinement or adjustment as the Board may find desirable.

Even on that, you could have some kind of deadline. I earlier heard that November for some of the benefits we were dealing was considered a drop dead date. Personally, I would like to wait on making, locking in decisions until after October 1 because the statute says, “in theory, by October 1,” we will know what the collective bargaining agreement, what the two sides, both the state governor's office and the employer organizations, have agreed upon as a funding level. That would bring a certain, at least if not the final number, because obviously the Legislature could change it, but it's very, very, very hard to change what's been included in the budget as part of implementing the Collective Bargaining Agreement. I think that would be a time when we would have key information, and the questions of tradeoffs would be more real, in terms of, if we go on that this is the size of the box we're operating within, assuming the Collective Bargaining Agreements are ratified. I definitely would like to have financial information at least weeks before being asked to lock into a decision, although that may be months down the road, if that's really what the intent is. But, I do not want to get something a couple days before a Board meeting and be asked to lock in a policy decision. Thank you.

Katy Henry: I would support what both Sean and Pete have said. I don't think I have anything else to add, but I did want to voice my support.

Beth Heston: Slide 15 – Proposed Resolution SEBB 2018-30 - Basic Term Life Insurance and Accidental Death and Dismemberment Insurance. I think our discussion has wrapped that up.

Slide 16 – Decision Point #2. The Board could authorize a supplemental term life insurance for eligible employees and a supplemental AD&D insurance. Supplemental means employee paid. The state would pay nothing, but we would use the group buying power to negotiate low rates and keep those rates stable.

Slide 18 – Agency Recommended Employee Supplemental Plan Design. We have negotiated with MetLife and come up with a supplemental term life and a supplemental AD&D. As with basic, they last as long as you are benefits eligible and can be ported if you leave employment. Negotiated rates are in $10,000 increments. A guaranteed issue, no medical underwriting, up to $500,000. If you want more than $500,000, you would get that in $10,000 increments with evidence of insurability. It is usually brief evidence of insurability, not a complex one. If the person passed medical underwriting, they would be able to have up to a million dollars of insurance. For the supplemental AD&D, it would start at $30,000, again in $10,000 increments, up to $250,000. This would all be guaranteed issue.

Dave Iseminger: AD&D is all guaranteed issue because you can't underwrite for an accident. It took a long time for that to stick in my head. The lower end of coverage is $30,000 instead of $10,000 because when you get to such a small dollar amount, at some point it becomes such a fractionated penny that it's challenging to quantify.

Beth Heston: Slide 19 – Decision Point 3. Does the Board want to authorize supplemental term life and supplemental AD&D insurance for spouses or state-registered domestic partners and dependent children? Dependent children could be covered from ages 2 weeks to 26 years.

A supplemental term life insurance plan for spouses/state-registered domestic partners would allow a subscriber to also insure his or her spouse/state-registered domestic partners' income. If the employee is the second breadwinner in the family, they have the ability to protect themselves against loss of their partner and the greater breadwinner. The employee must have supplemental life insurance on themself, and then the spouse/state-registered domestic partner can have 50% of what the employee has. It's tied to the subscriber's amount. AD&D does not have the same requirement.

Dave Iseminger: I want to clarify for the record. You mentioned your spouse’s employment. There is not an employment requirement in order to have spouse coverage. I want to make sure that’s clear. The subscriber is the one who owns the policy. If I took out an insurance policy on my state-registered domestic partner, it doesn't matter whether he's working or not and he doesn't have any control over the coverage level because I'm the one owning it and paying the premium out of my paycheck. It's all controlled by the subscriber and there is no work requirement for the individual you're insuring.

Beth Heston: The same with the children.

Lou McDermott: One quick point. As we get into this discussion about benefit design and why is it $500,000 and not $480,000? Why is it a million, why isn't it $600,000? One of the things that's hard to articulate to the Board is when we negotiate with a vendor, we are looking at what we have and gathering information from our consultants and others on what's out in the world. Then we're trying to get the best deal for our members, to get the highest numbers possible. That guaranteed issue of $500,000, if we could have gotten our way, it would have been unlimited. But, remember, you're sitting across the table from someone else who doesn't want to give you that. What you're seeing in these designs, when you ask why we landed on $30,000, it's all one big negotiation.

We go into negotiations with a list of things we really want. Many employees and their spouses/state-registered domestic partners unable to get insurance due to health conditions that have developed over time. We heard that message over and over again, anecdotally, and people coming up to us inside this building saying, "we hear you're negotiating for life insurance; please try and get as high a guaranteed issue as you can because my spouse has X. Or I have Y. And we're unable to get insurance." A few people in the building had spouses with terminal illnesses. That resonates with us as we go through the negotiating process. We try to get the best value we can while holding down the cost. Trying to get the guaranteed issue. This life insurance procurement was the best deal we could secure on that day with that company.

Dave Iseminger: You are using a lot of analogies from the state employee experience, but we have every reason to believe that the same thing would happen with school employees. When I started with state employment, I have my original enrollment packet and I wrote on my life and LTD packet "look at this later" because I was focused on my $1,000 a month student loan payments, not whether I was going to have a diagnosis in ten years and not be able to pass underwriting. It's the human nature of life cycles and where you are when you're starting employment and what you're able to take advantage of with your salaries at different points in your life and your employment career and your aversion to risk for insurance purposes in general.

Lou McDermott: Dave, do you remember the total amount of optional coverage we had insured among the population?

Dave Iseminger: Our total coverage for state PEBB Program employees, before our open enrollment and switch to MetLife, was just under $9 billion in total coverage. After open enrollment, it was over $18 billion. The entire population, in addition to the roughly 20% increase uptake in optional, also doubled the volume of insurance they had between themselves and the spouses and children they were covering.

Lou, earlier you made a point of saying the best deal we can get on this day. I wanted to remind the Board that in this context, 'that day' wasn't that long ago. This benefit design that was described to you today was launched on the PEBB side about two

years ago. This is partly why we brought the request to proceed with contract negotiations with the vendor to you because we didn't anticipate that we would learn much from the market by going back out again.

Pete Cutler: I'm quite sympathetic to insurance companies for their concerns about adverse selection dynamics and whether it's in life insurance as in situations that Lou mentioned, or health insurance, or disability insurance. The more you open up and say, "you can wait until your house is on fire and then apply for your fire insurance," the higher the premiums will be for fire insurance. That goes for life insurance, disability, whatever. So, I'm quite sympathetic for that concern of the idea to provide the opportunity for protection, but also have it in a way that does not cause the decision making of a few to raise the cost of coverage a lot for others. From what I've seen in terms of the supplemental options, they all seem perfectly reasonable to me. Thank you.

Beth Heston: Slide 21 – Agency Recommended Supplemental is a visual look at this recommendation.

Slide 22 – Dependent Child Term Life. When I first took over the life insurance plan for the PEBB Program, there was a $2,500 child life insurance option. We worked hard to expand the child life and AD&D benefit. Slide 23 is a result of that effort. It is the Health Care Authority's recommended plan design. The supplemental dependent child term life benefit is in $5,000 increments starting at $10,000 up to $20,000. The supplemental dependent child AD&D benefit is also in $5,000 increments starting at $10,000 up to $25,000.

Slides 24 and 25 – Decisions 2 and 3 – Considerations. We've talked about employee supplemental, spouse/state-registered domestic partner supplemental, and child supplemental. These plans are optional for the employee and employee paid. They are the property of the employee.

Dave Iseminger: If an employee wants coverage for a spouse/state-registered domestic partner that required medical underwriting, obviously they need their spouse's permission in consultation. But, up to the guaranteed issued amount, technically the subscriber can just enroll them and get the coverage.

Patty Estes: I grabbed a copy of the benefit plan from the hallway display and it actually says that the basic AD&D is not portability eligible.

Beth Heston: That's for the PEBB Program.

Patty Estes: So, this is something negotiated differently for SEBB?

Beth Heston: Yes, under SEBB it would be portable. And I wanted to mention that all these deductions from payroll will be taken post-tax. The claim benefits to survivors is not taxable. Again, supplemental coverage is optional.

Individual life insurance can be more expensive than group term. Offering this group supplement for spouses might be the only source available to them. And as Lou mentioned, not everyone can pass underwriting. When the SEBB Program goes live, employees would get a new open enrollment and the chance to insure those that might not otherwise be insurable.

During our recent re-enrollment for calendar year 2017, there was an increase of spousal coverage of almost 50%. We went from 19,900 spouses insured to 37,000 spouses insured. Children's insurance is very inexpensive, but often overlooked, so, we wanted to make that available as well.

Slides 26 and 27 – Decisions 2 and 3 – Recommendations. The Health Care Authority's recommendations are to authorize:

- Employee supplemental term life benefit from $10,000 up to $500,000 with a guaranteed issue, and up to a maximum of $1,000,000 in $10,000 increments. Evidence of Insurability (EOI) would be required for increments over $500,000.
- Supplemental accidental death and dismemberment benefit starting at $30,000 up to $250,000.

Under the employee supplemental life benefit, authorize:

- Supplemental term life and AD&D insurance benefit to a spouse/state-registered domestic partner.
- Child term life and AD&D insurance benefit.

Slide 28 – Proposed Resolution SEBB 2018-31 – Supplemental Term Life Insurance Plans.

Dave Iseminger: Does the Board have similar sentiments about locking in a benefit design on supplemental employee paid, as was expressed for the employer paid? They're fundamentally different.

Pete Cutler: I can only speak for myself, but, they are different for me. I am comfortable, since there's no trade-off involved in terms of offering the supplemental, i.e., employee-paid benefits. I'm comfortable moving ahead with locking in something. I'm comfortable with the amount of information I have now that I could make a decision and vote next month, but I would also be open to hearing whether other Board Members have concerns or questions.

Sean Corry: I do see a connection, in that if we were to agree to approve a more robust basic life benefit, that would inform our numbers here. If we were to go to – I'll make something up - a quarter million dollars of basic life, which I suspect we would not do, but, using that number as an example, I think that would affect our decisions about the supplemental. I personally would tie them together and treat them similarly, which is not to commit yet, except for maybe as a target for the purposes of our conversation for discussion, but, have a wording that somehow does not require us to rescind a previous resolution. That's basically where I am.

Lou McDermott: So, are you saying if the basic were to be much larger, then we could bring the optional downward to relieve the rate pressure?

Sean Corry: I would think that as a natural decision point, something to consider. Because, in this employee supplemental death line, coverage is for the employee - the employee purchases it. But, if we have a more robust basic life and there's some consideration from the company on the rate for that bringing down this, perhaps then there would be a reason to change these numbers. I don't know that they would be changeable. I got nods here when I suggested that these numbers might be something we would reconsider if we had a more robust plan. But, if that's certainly not the case, I'd like to hear why that wouldn't certainly not be the case.

Dave Iseminger: I want to make the Board aware of a couple of things. First, there's no cross-subsidization between employee-paid and employer-paid benefits. Any premiums, reserves that build up on either side, would be separate. There isn't necessarily that interchange between the two benefits, especially because they are tracked as separate funding pots. This is highly germane to the conversation here. Just because there would be a benefit increase on a basic side doesn't mean the financial underpinnings of the optional would change.

Second is a reminder. Let’s say I am in the PEBB Program and I have $500,000 life insurance on myself. If I die, my partner gets $535,000. I want to make sure that it's clear it's the basic plus the optional that's the payout. It's not $500,000 with $35,000 coming from basic and $465,000. It is an additive effect.

Sean Corry: I do appreciate that. Maybe I want to restate my cloudy thinking here. If MetLife can confirm that costs associated with these opportunities for employees would not be affected by different levels of basic life, I have no problem with it.

Dave Iseminger: I think we can confirm that at the next meeting.

Lou McDermott: Let's say, for example, the basic is $35,000. And, we have a guaranteed issue of $500,000. So the total amount would be $535,000. But, let's say we negotiate a basic of $135,000. To achieve the $535,000 you would only need $400,000 as the guaranteed issue. If we drop the guaranteed issue, it could provide some rate relief. So, there is a loose connection between the two.

Dave Iseminger: I think that's Sean's question. We can talk with the carrier about that and bring information back to the Board. I try to answer your questions in real time, but, I think I’ve set an unreal expectation of myself.

Beth Heston: Slide 29 – Agency Recommended Life Insurance Plan, is a visual slide of the options in stair step fashion.

There is a correction on the bottom of this slide. In the second bullet from the bottom, for AD&D, the supplemental spousal AD&D is in $5,000 increments for the

spouse/state-registered domestic partner. The employee is in increments of $10,000, which makes it easier to split since it's based on the 50% rule.

Slide 30 – Supplemental Life Rates is very vague because we are currently in rate negotiations with the contracted carrier and we wanted your input. It's assumed the rates will be similar to those in the PEBB Program because the demographic variation, as Dave explained, results in slightly different costs. They almost cancel each other out. We will have the specific rate information available for you, hopefully before the August 30 meeting.

Dave Iseminger: We will make sure to provide examples of what the math looks like to give you a sense of what an employee would actually be paying on a monthly basis with those rates. Behind the goldenrod sheet in your Briefing Book are the comparator slides previously presented to the Board at December's meeting. They show the benefit structure back when we were originally doing comparisons of benefits across the K-12 system with the WEA select plans, Lynden School District, and the Seattle Public Schools. You can see the comparison points of what is being proposed versus what existed in that example.

Retired and Disabled School Employees Risk Pool Analysis Legislative Report

Kayla Hammer, Fiscal Information and Data Analyst, Financial Services. In this presentation, we will discuss what is the legislative report; the current retired and disabled school employee risk pools; an overview of PEBB retirees; their benefits and subsidies; legislative requirements for the report; proposed approach to the analysis; and timeline.

What is the legislative report? RCW 41.05.022(4) requires the Health Care Authority, in consultation with the PEB and SEB Boards, complete and submit analysis of the most appropriate risk pool for retired and disabled school employees. This analysis is due to the Legislature on December 15. Currently, when an eligible school employee retires, they have the option to join the PEBB Program and utilize the employee benefit offerings. They would become part of one of the two legislatively mandated risk pools managed by the Health Care Authority, the non-Medicare risk pool, or the PEBB Medicare risk pool.

Slide 7 – Current PEB Board Risk Pools, is a diagram to help illustrate the risk pools under the PEBB Program. The non-Medicare risk pool is a community-rated risk pool of state employees, employee groups in school districts that voluntarily purchase PEBB benefits, eligible retired and disabled school employees, and state retirees not yet enrolled in Medicare Parts A & B. The blue bars are the state employees and the state retirees that are non-Medicare. It also has the employer groups, or the political subdivision groups, that opt into PEBB Program benefits. The purple bar is the school Medicare or non-Medicare retirees.

School and state retirees that utilize PEBB benefits are offered the same benefits at the same rates. The non-Medicare retirees can purchase the PEBB non-Medicare plans,

and Medicare retirees can purchase the PEBB Medicare plans. Both school and state retirees receive the same subsidies to help offset the cost of those benefits. Per the RCW I mentioned earlier, the report will include the size of the non-Medicare and Medicare retiree enrollment pools, the impact on costs for both state and school retirees for any proposed risk pool changes, the need for and the amount of an ongoing retiree subsidy allocation, and the timing and approach for any risk pool changes.

Slide 7 – Legislative Report Requirements. Slide 8 – Retiree Enrollment Pools. The first requirement is the size of the enrollment pools. The report will include total retirees enrolled in PEBB, the number in school versus state retirees; how many are Medicare versus non-Medicare.

Slide 9 – Enrollment Data, is an enrollment data table of the current PEBB Program as of June 2018. It is approximate enrollment counts by group. The blue bars are state employees, or the non-Medicare or Medicare retirees. The purple rows are the schools and the green rows are the political subdivision groups.

Sean Corry: Can you tell us the percentage of retiree enrollees as a percent of total employees? There's a dramatic difference in the numbers between schools and state employees and I know that the population of employees is different, but is it proportionate? We've got about 380,000 in the blue enrollment and about 60,000 in the purple. Is that about the same percentage of the active employees for these two populations? Or, is it substantially different? I don't know how many employees are school district employees and how many employees are state employees.

Kayla Hammer: In the current PEBB pools? I want to make sure I'm understanding your question.

Sean Corry: What I'm thinking about is how school district retiree programs have worked over the years, and whether it's been somehow different, so much different that the actual uptake of retirement coverage through the PEBB is substantially different with school district employees as it has been with state employees. And, if you could tell me how many employees are in the school district population and how many are in the state active employees right now, I can do the math.

Dave Iseminger: We'll follow up with the specific number. What you see on the top blue line is actually subscribers and their dependents, and you're asking for just the subscriber/employee count. Correct?

Sean Corry: What I'm really asking for is how many employees were in each of the two groups because I can do the math.

Pete Cutler: I can see Sean's point. It's just a data point that wouldn't be in your data so far because it's just the number of school employees. Just to get a sense of how many school employees are there compared to school retirees. That's all. And, it's not something you would have had in the PEBB numbers.

Lou McDermott: Didn't we have that in the previous presentation?

Kayla Hammer: We have estimated numbers for what we think will be eligible under the SEBB program.

Dave Iseminger: There are numbers we could throw out that may not be accurate, so we'll follow up with the correct numbers. I think we understand the question you're asking.

Sean Corry: Just a curiosity, if it's not any trouble.

Dave Iseminger: It's no trouble.

Kim Wallace: I think you're making the point, Sean, that K-12 retirees currently have the option of coming into PEBB, but they don't have to, as a retiree. I think you're asking for not just the number of K-12 retirees that have come into PEBB, but, those others that, as of these counts, are not represented.

Sean Corry: That's essentially right. It just gets to what percentage of the school district's employees are actually taking advantage of this program and if it's a substantially different percentage than with state employees. It may lead to the question, why is that?

Kim Wallace: Exactly. Coming into the PEBB Program and choosing PEBB retiree benefits.

Pete Cutler: Since we're on the topic of numbers, for a future meeting, can we get the average claims cost for the different groups, for the different categories that you have here? I no longer remember what the average claim cost is for the Medicare retirees and how that compared with the non-Medicare retirees. For the Medicare retirees, the state pays secondary, whereas we're primary for the non-Medicare retirees. If we could get average claims I would appreciate that.

Kayla Hammer: Absolutely. We do have some information on cost relativity for each group that I plan to share with everybody, but not today.

Slide 10 – State and School Retiree Impacts. The second requirement is to address the possible impacts on costs for both the state and school retirees should any risk pool changes occur. There are several options that will be considered for the school retirees which are listed on this slide.

Slide 11 – Create SEBB Program Non-Medicare Risk Pool. In this scenario, we would create a SEBB Program non-Medicare risk pool. You would remove the non-Medicare school retirees from the PEBB Program under the SEBB Program and merge what is the employee pool that will exist in 2020, with the non-Medicare retirees into one risk

pool under the SEBB Program. All Medicare retirees would stay in PEBB, in this particular scenario.

Slide 12 – Create SEBB Program Non-Medicare and Medicare Retirees Risk Pools. In this scenario, we would create the non-Medicare risk pool and a SEBB Program Medicare risk pool under the SEBB Program. We would remove the school non-Medicare retirees and Medicare retirees from the PEBB Program entirely. For this scenario, with the addition of the Medicare enrollees, we would need to procure Medicare plans and design new benefit offerings. That would require SEB Board approval of plans.

Slide 13 – Create Two Additional SEBB Program Risk Pools. In this scenario, three risk pools are created under the SEBB Program: Employee Risk Pool, Non-Medicare Risk Pool, and Medicare Retiree Risk Pool. This also requires an additional procurement activity and SEB Board approval of plans.

Slide 14 – One SEBB Program Risk Pool. This scenario creates one risk pool under the SEBB Program. It would combine the employees, Non-Medicare school retirees, and the Medicare school retirees.

Each scenario requires an analysis of the impacts on costs and the legality. The current risk pools are legislatively mandated. Any changes to what currently exists and what will exist in 2020 would require legislative action. Furthermore, outside of Washington State law, there are federal regulations with Medicare and the IRS when it comes to employee and retiree benefits. These issues would all need to be considered.

Slide 15 – Other State Examples. As of 2017, I found 19 states that allow the pooling of public employees and school employees. Each program varies across the country. Most programs appear to offer continued coverage to early retirees, much like we do in the PEBB Program. There would be no employer premium contribution after they had retired. The Medicare risk pools are usually handled separately from those pools.

Pete Cutler: On that comment where the programs allow the non-Medicare retirees to continue accessing benefits available to employees, is it clear from the data you have, in addition to having the same benefits, which is what we have in the PEBB Program, is it clear whether the rates are based on the total experience of that total pool? Or, do they sometimes allow the same benefits, but have two different premium rates, one that reflects the higher claims experience of higher retirees versus active employees?

Kayla Hammer: Based on my research, I don't want to say yes to either of those scenarios for sure. It seemed like not a ton of data or deep research was done, but there were some that had the blended premium like they do in the PEBB Program now. Some of them seemed like it might be slightly different rates. I would need to do further research to answer that.

Pete Cutler: Okay, thank you.

Kayla Hammer: I can provide examples today. I used Oregon and New Jersey. In Oregon, they have the Oregon Educators Benefits Board (OEBB) and the Oregon Public Employees Benefits Board (OPEBB). In Oregon, the state purchases the health benefits for both programs. The non-Medicare retirees in both OEBB and OPEBB have the option to continue coverage within the same pool from which they retired, but they also have the option to purchase retiree benefits through the Oregon PERS health insurance program. The Medicare risk pool is managed separately from the OEBB or OPEBB. They're managed by the Oregon PERS program and are no longer part of either of those programs, after they become Medicare eligible.

In New Jersey, the state offers self-insured medical plans only. They also have two separate programs for education versus state employees. Early retirees can continue coverage with no employer contribution, much like Washington and Oregon. The Medicare retirees are separately pooled and offered Medicare advantage plans, also through the self-insured products. I also briefly looked through different financial analyses of alternative risk pool options that other states have, and it does seem that most of them didn't find significant financial impacts by either separating out or further combining different risk pools. It seemed that most states were embracing more value-based purchasing strategies, or switching to more self-funded options as a way to deal with growing health care costs.

Slide 16 – Retiree Subsidy. Another legislative requirement of the analysis will include consideration of possible impacts to the retiree subsidy allocation, the need for an ongoing subsidy allocation, and the amount of that allocation.

Slide 17 - Timing and Approach. Each possible change to the current scenarios has a different set of challenges that can affect the amount of time needed and the approach. Factors such as required changes to legislation as the risk pools are legislatively mandated. Any change will require legislative action. There are implementation and administrative considerations. Many work streams go into the management of risk pools. Each work stream has its own set of regulations and timelines, all of which can affect the timing and implementation. Some examples are benefit design and procurement. Any changes to risk pools would potentially require us to procure new benefit options and go through the Board approval process. Contract management goes hand in hand with procurement activities. Each contract has its own set of guidelines. Rate development is needed if we purchase new plans. Member communication is key to success.

Slide 18 – Timeline is the current timeline for completing the report.

Pete Cutler: Something that has been a source of confusion and somewhat controversy over the years has been what I was taught to refer to as the employee carve-out, which has to do with the structure by which the state currently drives dollars out to districts for funding for employee insurance benefits. A portion of those dollars then gets sent back to the Health Care Authority to cover the cost of the subsidies provided to school retirees. That framework has befuddled many a person working in this field. I'm at least

curious about how, under the current legislation, if there is no agreement on a statutory change, what would go forward in terms of those mechanics? Is there any change in the bill that passed? What kind of changes would come to that process under these different pooling arrangements? Off the top of my head, it's not clear to me how the different pooling arrangements would affect how much should be sent back by the school districts or mechanically how that would be handled. So that, just that area, generally of the carve-out, would be something I would be interested in having more information about, either in a Board Meeting or as a separate briefing paper that's available to Board Members.

Kayla Hammer: Absolutely. I can say that for 2020 there won't be any changes. But, mechanically, I imagine there will be some changes to the way it's collected.

Kim Wallace: When you say employee carve-out, I think you're referring to the K-12 remittance?

Pete Cutler: Yes, otherwise known as the K-12 remittance.

Kim Wallace: In addition to what Kayla said about the status quo plan for 2020, ie., no switching of risk pools for 2020, we're not looking at a change there. But, certainly as early as 2021, or whenever a change would become effective, then our analysis is going to be looking at the impacts to that process. Especially impacts to the actual amounts as they're derived currently in the PEBB model. That's absolutely a part of the definition and the plan for the content of the report.

Pete Cutler: Great. As long as it's really in the report, I think, obviously that's a key place for policy makers to be able to see that discussion. Thank you.

Dave Iseminger: This slide shows the special meeting on September 17 that I previewed at the beginning. Today was level setting as to what the report is about. We're anticipating by mid-September that we'll be bringing information back to both Boards at the same time. Kayla, tell them what we think we'll have in September?

Kayla Hammer: We're going to be sharing more defined enrollment counts; relative risk scores for each group; cost relativity showing how different the costs are between different groups and how that could potentially impact the overall cost for each grouping; and if there are impacts to the K-12 remittance.

Dave Iseminger: I do want to be clear that the Board doesn't need to take a position on the report. Statutorily, the agency is supposed to make a recommendation and get consultation from both Boards. I'm sure that there are many different opinions. We're going to capture your feedback and your sister Board's feedback and find a way to wrap that up into the report, providing your insights collectively. We wanted to level set for now this core information and then bring back detailed information to you in September as we finalize the report.

Kayla Hammer: Slide 19 – Discussion. HCA is interested in your opinions regarding the retiree risk pool analysis, this report, risk pools, subsidies, the implementation and administrative considerations mentioned earlier, or anything else you want to share.

Policy Resolutions

Barb Scott, Policy, Rules, and Compliance Section Manager, Employees and Retirees Benefits Division. Today there are four policy resolutions for action. These resolutions were introduced at the May SEB Board Meeting. We've been working with stakeholders on them since. Proposed Policy Resolution SEBB 2018-28 is missing off of the slide. It was also introduced at the May meeting, but we're continuing to work with stakeholders on that policy, and will bring it back to you in August.

Pete Cutler: What was it about? What is the general topic?

Dave Iseminger: The stacking of hours is the topic of SEBB 2018-28.

Barb Scott: I'm going to cover SEBB 2018-25 and SEBB 2018-26 out of order. It will be easier for you to follow. In addition, staff have examples available to you; and in at least one instance, we added a new example. We've also changed a few.

Slide 3 - RCW 41.05.740(6)(c) & (d). We've included this RCW so you have it available to you during our discussion today. The electronic RCW has been updated by the Code Reviser's Office, and the amendments made to it from Engrossed Substitute Senate Bill 6241 have been incorporated.

Slide 4 – Policy Resolution SEBB 2018-26 addresses when eligibility is established for an employee whose anticipated work pattern is changed during the school year. We did receive stakeholder feedback regarding this policy. One stakeholder recommended that eligibility align to when the change in the work pattern actually occurs rather than when anticipated to occur. RCW 41.05.740(6)(d)(ii) limits the Board to establishing eligibility criteria that is no more restrictive than requiring that a school employee be anticipated to work at least 630 hours per school year to be eligible. To align the eligibility to when the change in work pattern actually occurs, rather than when it's anticipated to occur, would delay an employee from receiving benefits. That would be considered more restrictive.

As introduced, Policy Resolutions SEBB 2018-26 and SEBB 2018-25 were logically aligned. Both resolutions had a change occurring based on the anticipation rather than when it actually occurs. Our policy recommendation on SEBB 2018-25 has been revised. That's why I'm putting them in this order so you'll be able to see how, although there was a logic originally, what we're actually bringing to you today breaks that logic. We did not make changes to Policy Resolution 2018-26.

Slide 7 - Policy Resolution 2018-25 would address under what circumstances eligibility for the employer contribution toward SEBB benefits ends. We have three different times when that would end. One would be an employer-initiated termination notice,

when that is effective; when an employee's resignation is effective; and the employee's work pattern is changed such that they are no longer anticipated to work 630 hours during the school year. We received a lot of feedback on this particular policy proposal. Generally, stakeholders were concerned with this third bullet. They were concerned with the idea that eligibility would end when the employer anticipates a change, rather than when it actually occurs. Based on stakeholder feedback, the policy we're recommending is revised. The revision is to the last sentence of the third bullet. The policy shift is to align eligibility for the employer contribution toward SEBB benefits to end with the change in work pattern, when it actually occurs, rather than when it's anticipated to occur. Examples three and four will reflect this shift.

Slide 10 – Example #3 is revised to reflect that the change in eligibility for the employer contribution toward SEBB benefits occurs in the same month, October, that the employee's change in work pattern occurs.

Dave Iseminger: The change on Slide 10 is the words in bold towards the bottom that says "effective immediately." That's the clarity added to this slide. What Barb has described is by changing the employer contribution end date to align with when the change is effective, conveying the work pattern is effective immediately, gets you to benefits ending in October, which is going to contrast with the next slide.

Barb Scott: Correct. Slide 11 – Example #4 is revised to reflect that the change in eligibility for the employer contribution toward SEBB benefits occurs in the same month the employee's change in work pattern occurs. In this example, the employee's change in work pattern occurred on January 4, so benefits will end January 31.

Dave Iseminger: My understanding is part of what drove stakeholders to provide feedback resulting in this change is, in this example, although the employer might anticipate on October 13 the para-educator was going to lose Johnny Student in January and won't be providing services to them anymore, Suzie Student might enter the picture between October and January creating no change in the work pattern. This would allow some of that flexibility for those circumstances that overcome and override the original anticipation. If that never came to fruition, there's no loss of benefits. Is that a good understanding?

Barb Scott: I think that's a good understanding. The example we heard was the bus driver example where additional routes are added and they end up having the right number of hours anyway. To wait until the change actually occurs allows them to not lose benefits when often times additional work is added anyway. The policy we're bringing to you reflects a change occurring when the actual change in work pattern occurs. The eligibility would align to that. That is a disconnect from the earlier policy where we're saying, "it's aligned to when it's anticipated to occur" in order to gain benefits. For your benefit, we have included the original policy resolution introduced in May.

Lou McDermott: **Policy Resolution SEBB 2018-26 – SEBB Eligibility for the Employer Contribution Based on a Revision to the School Employee's Anticipated Work Pattern.**

Resolved that, if a school employee's work pattern is or will be revised such that he or she is now anticipated to work 630 hours for the school year, the school employee establishes eligibility for the employer contribution toward SEBB benefits as of the date the school employee is anticipated to work 630 hours for the school year.

Terri House moved and Pete Cutler seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-26 passes.

Policy Resolution SEBB 2018-25 - When the Employer Contribution for SEBB Benefits End

Resolved that, the employer contribution toward SEBB benefits ends the last day of the month in which the school year ends. The employer contribution toward SEBB benefits will end earlier than the end of the school year if one of the following occurs:

- The SEBB Organization terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the employer-initiated termination notice is effective;
- The school employee terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the school employee's resignation is effective; or
- The school employee's work pattern is revised such that the school employee is no longer anticipated to work 630 hours during 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 effective.

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

Brian Sims, Washington State School Directors Association. I think this is difficult. We largely support this, but there may be one additional consideration you might want to make, considering what you are putting in front of the Board. I think it's 2018-32, which we are also supporting, but the point is that, I think eligibility should be symmetrical to whatever makes someone eligible. The reverse of that would make them ineligible. In 2018-32, you're going to make someone eligible who is hired full time mid-year, let's say April, and even though they're not going to be working for 630 hours, the test is, are they working essentially full time during the months? And, next school year, they will be

working sufficient hours. With respect to 2018-25, if you have, let's say a full-time employee, a teacher who changes the employee relationship from a full-time person to a substitute, for example, and school districts have challenges with respect to recruiting qualified substitutes, under this policy that change would not affect their SEBB eligibility. Even though on a monthly basis, and if they continued that way for the next school year, they wouldn't be eligible for SEBB. That's asymmetrical with respect to 2018-32.

Lou McDermott: I want to make sure I understand. If you have a school teacher who is full-time employed during the school year and they decide to become a substitute teacher and work a certain number of hours a month, doesn't the last bullet cover if they say, "I'm only going to work 10 hours a month, or one shift, or whatever?"

Brian Sims: Let's say that happens in March and they have already met the 630.

Barb Scott: Policy Resolution SEBB 2018-32 is a policy resolution that the Board is not taking action on today. It is a policy resolution being introduced and is yet to be worked through with stakeholders. I am trying to follow Brian's example. On the fly, it sounds to me like a termination of the employment relationship would have occurred and then they would have started as a substitute teacher. But, I think that on this one I would want to walk through the details before I answered the question on the record.

Lou McDermott: I haven’t seen this policy resolution. Is Policy Resolution SEBB 2018-32 a refinement of SEBB 2018-25? Does it add some nuance to SEBB 2018-25 or is it completely separate?

Barb Scott: I would say that Brian is right in that, to some degree, they all work together. All of these are pieces of a bigger puzzle, but, if there is a direct connection, I'm not seeing it yet.

Brian Sims: Let me try another example. A classroom teacher, I'm not sure the actual transaction, whether that teacher would quit, terminate, and then get hired as a substitute, or whether it's just a change in the employment relationship from full-time classroom teacher to substitute part time. If it's the latter, they would continue to be eligible here, under Policy Number 25.

Lou McDermott: That part confuses me. When you said the latter, if the relationship isn't contract terminating and a new contract starting, you're saying if it is the same contract but they're working from this many hours to this many hours, you're saying they would continue to be eligible?

Brian Sims: Yes, I'm raising that as a possible concern. First, we don't want to make it easier for a regular classroom teacher to quit midyear. That's a really challenging thing. If they believe they can carry their health insurance clear until the end of August, that makes that decision a little easier. I think it's an open question about what the nature of that change would look like. Your advisors in WASBO could help inform that. I'm just raising it as a concern. It may be something you want to revisit at another time. So, I'm

not saying hold up the adoption of this policy, but it is a concern and it's part of that symmetry nature that I've mentioned. If it's okay to consider that kind of a thing to make someone eligible, then it ought to work on the other side and make them ineligible.

Barb Scott: I have a presentation later today that will include the policies we're introducing, which will be sent to stakeholders. Typically, we try to send them out within a day or so of your meeting, and then we begin to work through those with stakeholders. My team is learning a lot through this process. We are trying to form policy resolutions based on conversations we've had. Policy Resolution 2018-32, when I get to that later this afternoon, I believe was a policy brought forward based on some hiring needs that WASBO identified. SEBB 2018-32 is trying to resolve that. If it creates another issue, I suspect stakeholders will help us to understand that. If it needs to be refined, typically we're bringing those back to you. I'm trying to call out those refinements. SEBB 2018-32 hasn't been broadly stakeholdered yet. It will be, post today. I'll work with Brian and others to determine if it needs to be refined prior to bringing it back to the Board. Part of what it will be trying to deal with is some of these difficult hiring situations identified by WASBO.

Dave Iseminger: I know we're jumping into what is 2018-32, and trying not to talk about 2018-32 until we get to 2018-32, but that policy is about gaining eligibility, whereas this is talking about the backend. That's where it's not directly related, but the symmetry piece or the internal logic is what I think Brian's raising. As we've learned in a lot of these resolutions as we stakeholder, it generates the next one that comes two months later, which then generates the next one two months later. We keep building the eligibility framework together with you.

Wayne Leonard: I do think that Mr. Sims is correct though, with a scenario if a teacher retires at semester, they've already reached their 630 hours. Then, because of a substitute teacher shortage, they continue to sub and continue to get medical benefits. It would go to the stacking resolution, too. If you start including hours from both positions they've had, they would continue to remain eligible for medical benefits for the remainder of the school year, just from substituting occasionally in the second half of the school year.

Lou McDermott: As we make our rules, I would imagine the system is going to respond by making changes within its own structure. If there is an issue for the school districts that differs from their historic practice, I would imagine there would be some practice changes if they want to work within the eligibility structure that's set. I'm not suggesting they're gaming it, I'm suggesting they're going to change their business practices.

Pete Cutler: I think the key issue here is that with the language put in the statute last session, it says the eligibility standard can be no less than providing coverage for persons who work 630 hours in a school year. In effect it's interpreted by the agency as once you've hit that 630 hours, as long as you maintain an employment relationship of any type with that employer at any level of hours, your eligibility for the health benefits continues. That is consistent with the retirement systems. There are provisions that

provide once you hit a certain amount of hours, you're eligible for a year of service credit. It doesn't matter, as long as you maintained an employment relationship, whether you continue to work at a high enough level that would have normally been associated with earning a month of retirement credit for every month.

And it's also the Affordable Care Act. There's something about if you use this approach and the person's eligible, the employer's got to make them eligible for the whole year regardless, as long as they're still an employee, regardless of how much they work. That is what we have to deal with. We apparently have a statutory provision that says once they've hit 630 hours of work, and they continue in employment, they continue to be eligible for the health coverage. I would also say though, if they retire in the sense of applying for a retirement benefit, they have severed the employment relationship because the IRS will not allow a person to collect benefits from a qualified retirement plan unless they have severed the employment relationship. That would be a limit there.

In terms of changing from "I want to" and the employer saying "yes, I'll let you work two days a month instead of full time," as I understand the statute and the agency's interpretation, once they worked 630 hours in the year, that two days of employment would come with health benefit coverage until the end of the school year.

Brian Sims: Thank you very much.

Patty Estes: As far as the first bullet, with the employer terminating the employment relationship, I want to point out layoffs that are effective as of the next school year. As an example, if a classified employee gets a letter in June saying they're laid off as of September 1, the wording says they're eligible for that benefit until the end of September, with that effective date of September 1. On Lou's point, it's probably going to change some business practices when these all become effective. I just wanted to point out that is something that can happen as well.

Barb Scott: So are you asking for a change to the slide?

Patty Estes: No, I was just pointing out that's another example.

Wayne Leonard: I have a question on the last one. We've had situations where a teacher may work the first semester and be above the 630 hours, and then the second semester they request a leave, parenting leave or some other kind of leave, where they don't continue to work the rest of the school year. I'm assuming that, at some point, the benefits would end. We would hire a new employee to teach the second semester, and that new employee would also be covered by medical benefits and the employee that is on leave – at some point would their benefits end?

Barb Scott: We are working on some leave-related policy resolutions. I will admit that I am struggling with them, which is why they're not in front of you yet. We'll see if they make it by September. Part of the difficulty is there is no hours requirement for

maintenance under SEBB in the legislation that I've found. At this point, if they're still your employee and they have satisfied the 630 hours, I don't know if I could bring a policy resolution to the Board that would be more restrictive. I legally may not be able to do that. That would require a legislative change rather than something this Board could address. We're working on them with WASBO and others in trying to understand the different things that actually occur as they're trying to do business I have had your exact issue explained to me as well. If the employee satisfied the 630 hours, it would be very difficult to say they hadn't already earned their benefits for the school year based on not having an hours requirement for maintenance, without a change in the employment status.

Wayne Leonard: The request for an approved leave wouldn't change the employment status?

Barb Scott: I'm still looking at that piece. Are there certain leaves that would make a difference? If so, what does the leave have to look like? WASBO has given us a list of the different types of leave they're used to, maternity being one of those. We're still working through those to see if there's any effect on the eligibility based on leave, or if it's a certain duration of leave.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-25 passes.

Barb Scott: Policy Resolution SEBB 2018-27 addresses eligibility being established when an employee is not anticipated to work 630 hours in the school year actually works 630 hours. It will create an expectation that eligibility be re-evaluated for those employees not anticipated to work 630 hours in the school year. Stakeholder comments received on this resolution supported it as written. There is no change to the resolution as it is written from the way it was introduced to you. However, we added an additional example based on stakeholder request, example #2. The stakeholder wanted it to be clear that once eligibility is earned, the employee maintains that eligibility unless the employment relationship ends. Staff took example #1 where an employee not anticipated to work 630 hours in the school year actually worked 630 hours as of February 9, resulting in SEBB coverage beginning effective March 1. They then added that the employee's hours are reduced on April 5 and addressed the question the stakeholder wanted us to address, whether or not this would have an effect on the employee's eligibility. They added the last bullet, does the employee keep SEBB coverage? The answer is yes, through August 31, 2021, the end of the school year.

Dave Iseminger: That's actually a really good example of the entire discussion we just had with the Board.

Wayne Leonard: Did we ever answer the question about dual enrollment? If there's a retired teacher that's enrolled in PEBB, whether they would become eligible under SEBB?

Barb Scott: We did not address any prohibition on dual enrollment. That resolution hasn't been brought back to this Board. We have not broached the subject of dual enrollment under both SEBB and PEBB. If an employee were eligible under SEBB, then they would need to receive benefits. As far as the employer contribution toward benefits, they would have been eligible for it and it would need to be paid to the Health Care Authority.

Dave Iseminger: That's as it currently stands, but that's an area we've described that we need to evaluate and have conversations with the Board. Maybe that will be Resolution SEBB 2018-40.

Lou McDermott: **Policy Resolution SEBB 2018-27 - SEBB Eligibility for the Employer Contribution Based on Actual Hours Worked.**

Resolved that, a school employee who is not anticipated to work 630 hours in the school year, but actually does work 630 hours, establishes eligibility for the employer contribution toward SEBB benefits as of the date the school employee worked 630 hours.

Pete Cutler moved and Patty Estes seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-27 passes.

Barb Scott: Policy Resolution SEBB 2018-29 would require employees to provide evidence of a dependent's eligibility in order to enroll the dependent in SEBB coverage. We did receive stakeholder feedback on this policy proposal. One stakeholder supported it fully. Another stakeholder wanted transition rules in order to help with the wave of dependent verification documents that we expect when SEBB goes live. We are currently looking at options to address transition rules. We also had a stakeholder who was concerned about the workload for payroll and we're also looking at ways that we might be able address some of the impact to payrolls. There is no change to the resolution from it's introduction in May. The only other note I had on stakeholder feedback was we did answer the question for those employees currently in bargaining units purchasing benefits through the PEBB Program. Because we did the dependent verification on those dependents, they would not have to be re-verified and would transition over.

Pete Cutler: Am I correct that with this resolution the SEBB Program or PEBB Program or whatever, PEBB, or HCA, would be able to provide a timeline of when documents are due? This doesn't lock it in to what date the documents need to be provided. It would be within the administration of the benefit or of the enrollment and up to HCA in terms of how quickly the documentation has to be provided?

Barb Scott: We haven't come up with transition rules for the initial go live. When we did the PEBB Program dependent verification, it was significant. We had special transition rules for the initial push where we were more generous. We also made sure that our communication plan was tailored in order to help employees through that. As far as dependent verification post-go live, this policy would help to shape those rules that will be used after that. We could come back with some grace period for transition, things like that. But, typically, with a special open enrollment event, for example, marriage, there's a special open enrollment window that is dictated somewhat because we do run benefits under a cafeteria plan. Dependent verification would need to come in with that, adding the spouse or adding the state-registered domestic partner. For go live transition, we can look at some grace period or other things like we have with PEBB.

Pete Cutler: You could do that even if we adopt this resolution exactly as it is?

Barb Scott: Yes, absolutely.

Pete Cutler: This would not lock you in to or block you from go live transition period? Great, thank you.

Lou McDermott: When we do these activities that affect someone's eligibility or affect them fiscally, such as the smoking surcharge, we're always trying to make sure that we give the member the benefit of the doubt, give them as much time as we can, communicate as many times as we can, give them that opportunity. It can have a very negative impact on their families if a person were to be kicked off insurance and not able to get back on. There'll be a lot more to come on that topic.

Pete Cutler: I'm fully supportive of that. I'm also supportive of the concerns for the school districts, with all the changes going on, it would be better not to have this documentation requirement be jammed into a short period. It would be better if some flexibility for the initial transition was provided understanding that once the SEBB Program is up and running, you would want prompt, shorter time periods for new individuals. I wanted to make sure we aren't accidentally locking you into a tighter framework than you might want six months from now.

Patty Estes: Can I ask what the current time frame is for a school district that is enrolling in PEBB?

Barb Scott: I could not answer that question. I don't do the employer group work. I don't know if they're using a transition today for bargaining units joining us under the

current process. Are you talking about if school district A chose to start purchasing benefits through PEBB, if there's a transition? I don't know if one exists today.

Dave Iseminger: Generally, Patty, the dependent verification process that exists is somewhere between 30 and 60 days after the original enrollment. When somebody sends in documentation that isn't adequate, it's communicated back to them that wasn't quite enough support, here's another bite at the apple, because here's what was missing. There's a little bit of a rolling example for them, or period for them to fulfill or correct inadequacies in the dependent verification process. But, there is a starting timeline that's either 30 or 60 days, and then extra if they've made an attempt but didn't quite provide the proper documentation.

Patty Estes: I think I remember it was 60. We just went through that as a school district a couple of years ago. I was just trying to get at what there was currently, because it does say the HCA's required time frame, not our required time frame.

Lou McDermott: **Policy Resolution SEBB 2018-29 - School Employees are Required to Provide Evidence of a Dependent's Eligibility to Enroll the Dependent.**

Resolved that, the school employee who wants to enroll his or her dependent is required to provide evidence of the dependent's eligibility. If the school employee does not submit the required evidence to verify his or her dependent's eligibility within the HCA's required timeframe, the dependent will not be enrolled.

The school employee's next opportunity to enroll the dependent, if eligible, would be the next eligible open enrollment.

Terri House moved and Pete Cutler seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-29 passes.

Barb Scott: Our next steps will be to incorporate your policy decisions into program rules.

SEBB Program Self-insured Medical Plans Treatment Limits and Benefit Costs

Kim Wallace, SEBB Finance Manager. I am going to share information in follow-up to requests made at the May meeting. Specifically, information with regard to potential cost impacts of different treatment limits for chiropractic services, acupuncture, massage, and the therapies. I will also share broader cost information putting the

treatment limit cost impacts in context of the overall cost that the SEBB Program medical plan is likely to experience.

Slide 3 – Illustration – Changes in Visit Limits. With regard to treatment limits, this illustration is based on 2017 PEBB UMP Classic state employees. It's important to consider the numbers listed in this context are an historical estimate of what would have been true for this particular PEBB UMP Classic population of employees in 2017 had the treatment limits been different. I want to emphasize that, because it's important not to see these numbers as a prediction or projection of what the costs in the SEBB Program will be. But, they do provide clarity regarding an order of magnitude impact for the different treatment limits listed here.

We have prepared four options. We have the current state in UMP Classic which is the 10, 16, 16, and 60. As you move to the right in the table, the number of treatments goes up. For comparison purposes, if this particular population of covered UMP PEBB employees had option one treatment limits, our actuaries estimated there would have been an approximate 60 cents per subscriber per month (PSPM) increase in cost paid. That means plan-paid cost. As you move to the right, as the visit limits go up, there is an increase from up to $1.00 PSPM, an increase of $1.30 PSPM, and then $2.30 for option four, with the highest treatment limits. I will note that this increase in plan-paid PSPM is an increase on top of an approximate $40 plan-paid PSPM for these services. In 2017, the plan paid for these services, approximately $40 PSPM. Had the limits increased, the $40 would have gone up by the 60 cents, the $1.00, the $1.30, and the $2.30.

Slide 4 – Data and Methodology. You requested clarification regarding the data and the methodology behind these numbers. I want to make some very important points. First, these figures are based on the 2017 experience, and that 2016 and 2015 did show similar results. Again, for the PEBB UMP Classic state active employees, a stable situation. The second bullet, a small percentage of UMP members actually use those chiropractic, acupuncture, and massage services. Of those who did use those services, most did not reach the existing limits. In fact, for chiropractic services, 75% of those who did use the service didn't reach the limit. For acupuncture, it's 90% and for massage, 93%. People stepped into the benefit, started using the services, but for this population, did not reach the existing maximum number of treatments. However, the estimated increases in the plan-paid amounts in the table did assume both increased utilization by members who had hit the existing limits and new claimants due to the increased limits, which we refer to as benefit-induced utilization. The modeling included that "welcome mat" kind of dynamic. It's not terribly significant in terms of the dollar values. If we strip out the benefit-induced utilization, you see a very small decrease in those numbers. We believe in benefit-induced utilization, so we are showing you the numbers that included that.

Last on this slide are a couple of really important notes. The amounts shown are really a view to order of magnitude. We can't emphasize enough that these numbers do not represent an estimate of the costs under the SEBB Program. The amounts shown are

well within the margin of error that is in our SEBB Program modeling currently. That's a fancy way of saying you can get a sense of the cost impact that treatment limit changes would likely have under the SEBB self-insured medical plan. But, quoting numbers or assuming that $2.00 means $2.00, or $11.00 means $11.00, etc., is a dangerous business. There are many unknowns in our SEBB financial modeling currently, and it's not clear that we will see behavior and cost, etc., in SEBB just like we see in PEBB.

Slide 6 – Breakdown of Total Allowed Costs. This slide shows the bigger picture. Not just chiropractic, acupuncture, massage and the therapies. It looks at all the costs. It is a breakdown of total allowed costs in the medical plan. On the left are the major categories of costs - inpatient, outpatient, other professional, physician core, and prescription drugs, all totaling $488.36 per member per month (PMPM). That actually translates to about $855 per subscriber per month. The main point on this slide is that therapy and chiropractic, acupuncture, and massage (CAM) services represent less than 5% of the total allowed costs. In the tan bar labeled "hospital outpatient," of the $133.11, $2.49 of that was for therapy services. You add that together with 4.1% or $20.09 of the light purple, other professional cost - $2.49 and $20.09 is the $22.58, or 4.6%. The breakout of that 4.6%, or the $22.58, is on the right in the shades of orange.

Lou McDermott: Kim, just a clarifying question. The $22 turns into $40 when you get to a subscriber. That's where the $40 came from.

Kim Wallace: Correct. You're connecting all those dots. Yes, the $22.58 per member per month is $40 per subscriber per month. We realized we needed a crosswalk between the treatment limit table and the overall cost breakdown. You'll notice the shaded stacked orange bar on the right is a total value of $22.58 compared to the one on the left, which is $488.36. If we were doing this completely proportionately, the stacked orange bar would be much shorter. We wanted to make it readable so it really is only a value of $22.58, or 4.6% of the total allowed. Again, this is actual costs for PEBB 2017 UMP non-Medicare active employees.

Slide 7 – Overall Cost Drivers and SEB Board Considerations. When we think about total overall costs and the decisions you're making, this slide is a review. We'll go through the overall big picture cost drivers, how they relate to the Board decisions you're making, and the policies you're considering. Number one, of course, is eligibility and enrollment. Who is eligible and who enrolls drives costs. A medical plan with 500,000 people costs more than a medical plan with 100 people. Thinking in total costs, not cost per person.

Number two on the list is the utilization of services. Utilization is affected by a number of things. A leading benefits design decision that affects utilization of services is the levels of member cost sharing. What people are facing when they choose to use the services. We have talked a great deal about the levels of member cost sharing in the self-insured medical plans that you are designing. Treatment limits do affect utilization as well. You're trying to make decisions about that. Accountable care strategies affect how much health care is received. We have made a strong commitment to value-based

purchasing strategies and accountable care because the focus is not just on less care to save money, but on the most appropriate care at the most appropriate time.

I don't have a lot of comments for number three and number four. I want to acknowledge that the unit cost, the amount of money you're paying for a service or for a day in the hospital, affects cost significantly. We've talked about the contracted provider rates and fees we have in place, by leveraging the contract that PEBB UMP uses. Covered services and exclusions also have an affect. It's number four on the list, however, because with the Accountable Care Act, much is defined, dictated, and mandated in terms of what covered services must be. There are decisions that can be made, but the essential health benefits are defined and required.

Slide 9 – Amount of SEBB Program Funding is Unknown. What does all this mean going forward? As the SEB Board, you are developing eligibility policy and determining medical plan designs prior to knowing the amount of employer funding. Richer plan designs and benefits are likely to result in higher costs, but specifically in higher monthly employee premium contributions as well. I know we are all keeping an eye on affordability. The SEB Board is making tradeoffs in an effort to spend all of those monies and the contributions from the employer and the employees wisely. Refining the eligibility or benefits next year in the spring or summer in response to legislative budget decisions could occur, and there could be some difficult choices to make at that time.

Slide 10 – Considerations. Eligibility, member cost sharing, and treatment limits are going to impact costs. Those total costs will be borne in part by employees and, of course, there's a balancing act between strong benefits and total cost.

Slide 11 – Recommendation – Align with Current State for 2020. Our recommendation is that the benefits be aligned with the current state for plan year 2020. That's the green column. We do acknowledge that there may be a desire to increase the limits. If so, we would suggest that you consider options #1 or #2. Mainly, because of the likely cost impact. Again, I'm not saying it's 60 cents and I'm not saying it's a dollar, but the order of magnitude cost impact increases as the limits go up.

Lou McDermott: Kim, has there been analysis of the SEBB data to look and see how their actual utilization looks compared to the various options?

Kim Wallace: Not of the CAM and the therapy services specifically. One of the challenges, of course, is that the current K-12 employees have many different benefit design options and have different family members enrolled in those plans than is likely to occur under the SEBB Program.

Katy Henry: Is that possible to look at?

Kim Wallace: We can look at the data we do have available. We would share whatever we could, with as much clarity as we could. And then, qualify, or caveat, as needed.

Lou McDermott: I think it's always helpful to know what's happening today if you're trying to set this amount. If people are, on average, using less than the current state, or on average, using more than the current state, that would be important to know. Then you know what kind of impact it's going to have on people. People are going to discover they have less available to them than they did previously, and that may be an issue. I understand with benefit design there are different plans, but it'd be nice to know on average.

Kim Wallace: We will need to be careful when we compile and share the K-12 claims data, when we project/predict, what that would mean under these benefit designs. I'm not sure how confident we can be in that prediction. But, we can certainly report what we see in the data, and then any reasonable guesstimates about what could happen with the different limits. Is that what you're asking for?

Lou McDermott: Yes, just trying to understand where people who are receiving chiropractic services, what's the spectrum of utilization? Are there people getting 20 visits during a year? Are there five of those and the rest of them getting no more than eight? Or, are there tons of people getting 12 or 14? Understanding the population and what they're doing today. I understand there's the caveat of benefit design and different things going on, but there's got to be some underlying numbers that let us know in general where they are.

Kim Wallace: We use the 2017 PEBB UMP Classic PPO employee data because it's very recent and that population's very large with relatively similar demographics. It's not likely that the utilization would be drastically different with similar benefit design.

Lou McDermott: I've wondered about that because when you're dealing with your average state employee, you're looking at a 12-month cycle. You have time off for holidays. You have sick leave and vacation leave. But, with school teachers, I've always wondered if utilization is different. If they hit it hard during the summer months when they're off. I don't know. I have wondered if the populations are different in nature.

Kim Wallace: And it would show up in benefits utilization.

Lou McDermott: It would show up in the benefits, right? Just a thought.

Sean Corry: Kim, a couple of minutes ago you said something that I want to ask about. It was sort of casual going past this thought. It was something about how there will be fewer people who will be in the PEBB - SEBB Program than are currently enrolled in districts. It seemed like there is going to be fewer people enrolled than are currently enrolled in school district coverage. Did I hear that correctly? What did you mean by that?

Kim Wallace: I think you are referring to a comment about members. It was the opposite, or what I meant to say is that we are anticipating that there will be more dependents actually enrolled under the SEBB plans than are currently enrolled in the K-12 medical plans. That's what I meant to say. That's what I have in my head about the number of people enrolled.

Pete Cutler: I don't think any of us disagree. What I'm curious about is having been involved with the collection of data, the K-12 tried to collect the claims data from insurance companies back in 2012 or whenever this began, that there were great challenges in getting data reported at a granular level and in a consistent manner. I have no idea what's going on, but that would be useful at least for me, and hopefully the other Board Members, to understand just maybe a summary of how consistently is the data reported for all the different school districts and different carriers that cover school employees. I certainly know back in 2012 you would not have been able to answer questions at all about how many visits in a year did employees of district one have compared to district two. I don't know whether the way data is being collected now, whether that gives you the ability to provide answers with confidence, or whether it still varies depending on which carriers' data you're looking at, or which data set you look at. Any kind of background explanation for future meeting just to give us a sense of how reasonable is it for us to ask what happens in the K-12 world now related to this versus what kind of data do you not have access to?

Dave Iseminger: That's on the list, Pete. We're not going to conjecture to describe it now. We'll bring that back.

Dan Gossett: The recommendation that you're making here is that for self-insured plans and fully insured plans? Or, is it going to be different?

Kim Wallace: This is specifically with respect to the self-insured medical plans that you are designing for SEBB.

Dave Iseminger: Dan, we'll wait to talk about fully insured. Procurement responses are due this Thursday. We'll be in evaluations scoring mode, and that will be a significant portion of the conversation for the October and November meetings.

Lou McDermott: The reality, though, is that a lot of the fully insured plans try and have comparable benefits to the self-insured. A lot of them mirror those. Not 100%, but close.

Dave Iseminger: I will say that our procurement, at least the non-scoring part of the procurement, asked for proposed benefit design variances from UMP Classic and covered services. I pledged at the last meeting that whenever they came, if a fully insured carrier comes back with something that is covered, they would recommend covering that's on the exclusion list of UMP, that we would evaluate, bring it to the Board, and talk about those variances. You eventually have to make that decision

about allowing benefit variance across the pool or maintaining benefit similarities across all of the products. That will be up for discussion eventually with the Board.

I do want to make sure that I'm clear. We brought this recommendation without a proposed resolution. We have language that if the Board wants to proceed with some sort of modifications to the resolutions they passed in June to make changes, we can certainly bring that information and those slides to the Board. That might make sense because we are talking about different trades that the Board could make between benefits. We'll see if there's other information we can bring, from claims information, continue this dialogue, and then have the Board convey to us what you want to see in resolutions later this fall. I did want to make sure that we were being responsive to the Board's request to see this type of information at the very next meeting. Just know that this is still part of that ongoing discussion as we march towards November.

Eligibility and Enrollment Policy Development

Barb Scott, Policy, Rules, and Compliance Section Manager, ERB Division. I am introducing three proposed policy resolutions.

Slide 4 – Proposed Policy Resolution SEBB 2018-32 – Mid-year Hires for Positions that are Anticipated to Work 630 Hours in the Next School Year. This policy would create eligibility that is more generous than the requirement for an employee anticipated to work 630 hours in the school year. It's our understanding that a number of positions, superintendents for example, are hired by districts effective July 1 and expected to work full time. The more generous eligibility standard is within this Board's authority, and the resolution that is in front of you is one that folks are telling us they will need in order to secure these positions that they're used to providing benefits to, and that are typically hired around July 1 each year. It's my understanding that today, these employees would have benefits. Because this is a difficult one to work through, we ended up with school employees who are not anticipated to work the 630 hours within the current school year because of the time of year that they are hired, would establish eligibility for the employer contribution if they meet two conditions. The first condition is anticipated to work at least 52.5 hours per month in the remaining months of the current school year. We arrived at 52.5 by taking the 630 hours and dividing it by 12.

The second condition is anticipated to work at least 630 hours in the upcoming school year. We did apply two conditions in order to make sure it resolved the problem that was brought forward to us without creating new ones. Im looking for your thoughts on these resolutions. I'll incorporate those prior to sending them out to stakeholders.

The example is of a new school employee hired toward the end of the school year. The employee is not anticipated to work 630 hours during the current year because of the time of the year they're hired. They are anticipated to work at least 630 hours during the upcoming school year. Their first day will be on July 1, 2020, and they're anticipated to work at least 52.5 hours in the months of July and August. In this case, SEBB coverage would begin August 1, 2020, first of the month following, based on paragraph number two of SEBB Policy Resolution 2018-12, which you already adopted.

We recognize the employee will have a one-month gap in coverage. Coverage begins August 1. The first of the month following the employee's first working day, leaving a gap of one month based on when we apply SEBB Resolution 2018-12. In this example, staff specifically noted that it's a new employee, and that's how that is being applied. Proposed Policy Resolution SEBB 2018-34 would resolve this for an employee who is moving between SEBB Organizations by requiring the new SEBB Organization to begin coverage effective the first day of the calendar month in which an employee transfers. We recognize that for a new employee, coverage would begin August 1, 2020. Very different from a transfer employee, which I have a resolution I'll introduce to you to address that.

Proposed Policy Resolution SEBB 2018-33 – Returning School Employees with Uninterrupted Eligibility Get Uninterrupted Coverage. This resolution allows a school employee who has already established eligibility for the employer contribution toward SEBB benefits to have uninterrupted benefits if the employee is returning to the same SEBB Organization and is anticipated to work at least 630 hours. Without this policy, an employee would have a gap if they return on September 5, the first day of school for their SEBB Organization, based on paragraph number one of SEBB 2018-12 as adopted. The example for this resolution is of a school employee who works for a SEBB Organization for the 2020-2021 school year and was receiving the employer contribution on August 2021. The school employee will continue to work for the SEBB Organization in 21-22 school year in a position anticipated to work at least 630 hours.

Dave Iseminger: Barb, just to be clear, this resolution is trying to address that situation where a school district's first working day is not September 1, and you have a returning employee year over year. It's to avoid that couple of days of lack of coverage.

Barb Scott: It is. The clarity I would add is this policy resolution, the uninterrupted, really is taking care of employees who go from year to year. The next one that I'm going to share is taking care of employees who transfer. Policy Resolution SEBB 2018-12 was how we treat employees who are new and when does coverage begin? In introducing that, we've talked through a lot of questions that different folks have, and I'm bringing those to you now as resolutions so that we can be clear as to how we're applying it. In this case, an employee who goes from year to year, we don't want them to have a gap. I don't believe you would have intended for them to have a gap of four or five days, if they're coming back every single year to the same district. This policy will make it clear to everyone that's not how it works for an employee who is returning. In the same way, I knew we would need to deal with transfers, and so we're bringing forward a policy that clearly addresses if I were an employee who transferred from one SEBB Organization to another. I would also not end up with a gap in benefits. But, recognizing that if I'm brand new, coming from Oregon or California to work here, benefits for a new employee starts based on Policy Resolution SEBB 2018-12.

Proposed Policy Resolution SEBB 2018-34 – School Employee's Eligibility When Transferring SEBB Organization is intended to resolve the issue described earlier when I covered the example related to proposed Policy SEBB 2018-32. It would remove the

gap that would otherwise occur for an employee who transfers from one SEBB Organization to another, provided the employee is eligible for the employer contribution toward SEBB benefits in the position they are leaving, and is anticipated to be eligible for the employer contribution toward SEBB benefits in the position they're moving to. Based on our conversations with stakeholders, these employees would be eligible today. For employees who currently have PEBB benefits, there is a transfer rule in place that allows for this.

Example 1 is an employee who works for SEBB Organization A as a teacher, and is eligible for the employer contribution toward SEBB benefits. She takes a position with SEBB Organization B as a teacher, where she is anticipated to work 630 hours in the upcoming school year. The school employee's last day with employer A is August 31, and the school employee's first working day with B is the first day of school, September 7. She is eligible for the employer contribution September 1 and coverage for SEBB would begin September 1 based on the application of proposed Policy Resolution SEBB 2018-34.

Example 2 is the school employee works for organization A and is eligible for the employer contribution toward SEBB benefits. He takes a position with SEBB Organization B as a principal where he is anticipated to work 52.5 hours a month in the months of July and August. He is also anticipated to work at least 630 hours in the upcoming school year. His last day with employer A is June 30. His first day with employer B is July 1. He is eligible for the employer contribution July 1. His SEBB benefits coverage would begin on July 1. The example shows how proposed Policy Resolution SEBB 2018-34 will eliminate a gap in eligibility for employees who transfer from one SEBB Organization to another mid-year.

Patty Estes: For the examples, if that was July 3 and not July 1, that would be the gap that's needed for them to be a new employee? Or, how does that work?

Barb Scott: Are we on example 2?

Patty Estes: Any of them. Because all of them have been literally his last day is this day, his first day is the very next day. What if it was two or three days later?

Dave Iseminger: Patty, go back to example 1. I think that example might better describe what you're talking about , where the last work day is at the end of August but the first day for the next organization is - there's that little bit of a -

Patty Estes: But that would be their first day of school. Correct?

Barb Scott: Even if I took a different example, and it wasn't a teacher but someone working in nutrition, their first day literally was on September 7, and they were transferring from one to the other, they would get benefits effective September 1 in order to alleviate no gap because they are transferring from one SEBB Organization to another.

Patty Estes: I'm having trouble working that through with the word "transfer." I saw a lot of confusion back behind you with that "transfer because it's from one school district to another school district. Say I work in nutrition and my last day is August 31 regardless of what organization I'm going to. A lot of the “welcome back” things you will actually get paid for so it's a first day of work, but it’s before August 31 for a different school district.

Katy Henry: That's my exact same question.

Terri House: They're called days one and two for us.

Katy Henry: Your first day of work, well, I was going to say, too, that even in our school district, we start before the kids come. So, whether you're a teacher or a classified employee, your first day of work is in the same month that you've left your previous district and started in your new district. So, then who is providing coverage for that month?

Dave Iseminger: I don't know that I'm going to have Barb answer that question on the fly right now. This is exactly what we're asking the Board to do as we're bringing proposed resolutions to you. As you highlight things, we’ll see if there's anything that we can accommodate with it before we release it out to stakeholders. That also gives us the heads up to be working on that piece. That's exactly what this is designed to do.

Barb Scott: Katy, we have a rule today that we apply for the PEBB population. For state agencies, transfers and employments occur on the first of the month or sixteenth of the month. There's this issue of partial eligibility in one organization, and then partial eligibility in another. We have a policy in place that requires payment from the organizations based on if you're leaving an organization and I was employed by them even the first day of the month. That organization is responsible for payment for the entire month. Because, we only deal in full month's payments. The organization I'm moving to would be responsible for the payment for me for the next month of coverage. Rob has been working with me to determine whether or not we'll need a similar policy proposal for you to take action on in order to resolve the same type of issue within the SEBB environment.

Dave Iseminger: To be clear, Barb wasn't announcing that was what she thought she was going to be bringing forward. She was giving an illustrative example of how it could be solved and it's on the radar for resolution.

Barb Scott: Our next step will be to get them out to stakeholders and bring policy recommendations back to you.

Public Comment

Julie Salvi, Washington Education Association. I want to touch a little bit on the discussion around the treatment limits and encourage the Board to keep discussing this over time. My reading of this is without any Board action, then it is by default the

agency recommendation because that is what you adopted previously. So, to make any change, you will need to keep discussing this. I appreciate the discussion at the end where there's interestingly more data on utilization. I think that will be very helpful to the Board going forward.

The presentation itself was very heavy on the fiscal impact and the fiscal consideration, and I didn't hear much discussion about the change management and the changes that educators in the field are facing in systems that they have been used to for years on end, which have had broader treatment limits. And, when I look at the fiscal impact, while yes, there is some fiscal impact within a margin of error, that fiscal impact is relatively small in the scheme of your total health benefit expenditures. I think the expectations in the field are very high and people historically over time in a system that has been run by educators has placed value on higher limits. And, I encourage you to continue that discussion.

And then, I just had one brief comment on number 33 that was just discussed. We have appreciated these continuation, the effort at looking at continuation. We would like to see more of a default on continuation. If someone has been eligible in one school year, and they are continuing essentially in that same position, their hours are unchanged, we'd like to see it worded more as a default rather than having to go back to the anticipated to work 630 hours. If they are essentially doing the same thing year in, year out, if we could just get more to a default of continuation unless and until their schedule changes, I think that will be helpful probably for all involved. Thank you.

Dave Iseminger: We actually were trying hard to have a resolution similar to what Julie was just describing in the packet for today. We just couldn't get over the finish line for today, because as we start, we find a lot of things in our own wording as we're trying to vet it. I just wanted the Board to know that something in that vein is on the horizon for bringing to the Board for consideration. We just couldn't get it there today.

Next Board Meeting
August 20, 2018
12:00 p.m. – 5:00 p.m.

Preview of August 30, 2018 SEB Board Meeting
Dave Iseminger: Potential agenda items for the August meeting are: Policy resolutions for action and introduction; begin discussion about dental benefit designs; recommendation on vision as a standalone benefit versus an embedded benefit within medical; a presentation about the Centers of Excellence bundled payment program; an ethics presentation; data about treatment limitations; and information related to the dual enrollment resolution.

Going forward we may have longer Board Meetings. It will be a busy fall. Our meetings will transition from the Monday meetings to later in the week. We'll also be planning to get you the Board materials on the same schedule that we have been getting them to you, so you'll have more time for review.

I also want to acknowledge the things staff are doing with the SEBB Program. I know it's been five weeks since we saw the Board, and I wanted to give you a snapshot as to a lot of work that staff have been doing behind the scenes. It’s been a busy five weeks. We received, evaluated, and announced a disability vendor through the procurement process for long- and short-term disability, and that was The Standard Insurance. Since the last meeting, we released the vision RFP, which has responses due today. We held a bidder conference and answered 60 questions from vendors in two rounds of questioning.

On the fully insured medical procurement that was released, we held a bidder conference and answered 87 questions from the carriers as part of that procurement. We have ongoing and kicked off negotiations with MetLife on life insurance and AD&D, which resulted in the presentation today, and with dental benefits, which will result in a presentation in August.

There has been a significant amount of work done on rules based on resolutions the Board has passed. We will soon be releasing them for external stakeholder review as we move into the formal rulemaking process. Collective bargaining kicked off and we had our first collective bargaining session. On top of that, the same staff were supporting the PEB Board, which had three meetings and set rates for 2019.

It's been a really heavy amount of work and there's a lot of pieces that are going into launching the program beyond the presentation of two inches of materials to go over in four hours with the Board. I just wanted to take a moment to highlight the hard work the staff is doing on behalf of the Board and on behalf of the agency.

Meeting adjourned 4:45 p.m.

School Employees Benefits Board
Meeting Minutes
D R A F T

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

Members Present:
Lou McDermott
Patty Estes
Dan Gossett
Terri House
Pete Cutler
Wayne Leonard
Alison Poulsen
Sean Corry (Arrived late)

Member Absent:
Katy Henry

SEB Board Legal 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.

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

Approval of March 15, 2018 Meeting Minutes
Lou McDermott: Pete Cutler found a typo on page 5 in his first comment, last sentence. PEBB should be SEBB. The correction was made in the Briefing Book you have in front of you, but not on the version sent electronically.

Terri House moved and Pete Cutler seconded a motion to approve the March 15, 2018 minutes as amended. Minutes approved by unanimous vote.

Approval of April 30, 2018 Meeting Minutes
Alison Poulsen moved and Patty Estes seconded a motion to approve the April 30, 2018 minutes as written. Minutes approved by unanimous vote.

July 30, 2018 Board Meeting Follow-up

Dave Iseminger, Director, Employees and Retirees Benefits Division. At the June Board Meeting, Pete asked for information about the PEBB Program Uniform Medical Plan (UMP) cost internationally versus domestic.

Slide 2 is a chart that provides a visual of the numbers regarding international and domestic claims.

Pete Cutler: Thank you very much.

Dave Iseminger: The Health Care Authority (HCA) completed both procurements it was undergoing since the last meeting. We completed the separate vision benefit plan and announced three separate apparently successful bidders. They were Davis, EyeMed, and MetLife. We are proceeding to contract negotiations. Lauren will provide more information about that procurement at the end of the meeting.

HCA also completed the fully insured medical procurement. On Monday, we announced six apparently successful bidders. In alphabetical order, they are: Aetna, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of Washington Options (their PPO product line), Kaiser Foundation Health Plan of the Northwest, Premera, and Providence. We are proceeding with negotiations on those contracts. We'll discuss the ongoing contract negotiations in Executive Session.

We have gone through the branding exercise for the self-insured plan names. The name selected for the plan that correlates to Policy Resolution SEBB 2018-21 is UMP Achieve One, which was roughly 82% actuarial value (AV) plan. UMP Achieve Two correlates to Policy Resolution SEBB 2018-20, which was the approximate 88% AV plan.

Policy Resolution SEBB 2018-22 is the high deductible plan, which we are naming UMP High Deductible. It will contrast with, on the PEBB side, the UMP Consumer Directed Health Plan (CDHP).

Policy Resolution 2018-23 is UMP Plus. We brought information back about the different treatment limitations. We talked to the networks and this is a multi-contract situation. There are different parties which makes it more complicated than the other UMP Plans. We've come to the conclusion that, if the Board wants to make changes on different benefit designs, there would be the ability to do that within UMP Achieve One, UMP Achieve Two, and UMP High Deductible. For UMP Plus, because of the multi-plan contracts, it would be much more complicated and challenging to make revisions within the benefit design. Therefore, that plan name can continue to be called UMP Plus. Those are the plan names for the self-insured portfolio.

K-12 Data Support for Decision Making

John Bowden, Manager, School Employees Benefits Section**,** and **Kayla Hammer**, Fiscal Information and Data Analyst, SEBB Finance. We are presenting information on data available to HCA to assist in answering questions in preparation for creating the School Employees Benefits Board Program.

Slide 3 – Five K-12 Data Sources. These data sources, or sets, describe what types of data elements are contained within those data sets. They were not necessarily collected for the purposes we're using them for now. They are data around school employees and the benefits they currently receive. They are rich with data, but the original intent was not for starting this program. We have K-12 staffing data, Office of the Insurance Commissioner data collection results, K-12 groups currently in the PEBB Program, HCA legislated data request, and fully insured medical data received from a Request for Information (RFI).

Slide 12 - K-12 Staffing Report. The Office of the Superintendent of Public Instruction collects this data twice a year from school districts, ESDs, and charter schools. Data is collected early in the school year and again later in the year because there are changes in staffing that occur. There is a preliminary report and a final report.

This data set, the S-275 Personnel Report, contains information about most employees, but not all of them. Substitute teachers for the most part are not included. A few are included when they reach a certain number of days that they sub. The most recent report is from the 2016-17 school year. The data includes: employee name, demographic information, gender, race, ethnicity, age, job title, job duties, and FTE worked. It does not contain hours worked. It has a percentage of FTE. It also contains compensation information, their salary or wages. For each employee, there are typically multiple lines for each type of compensation they receive.

Slide 5 lists some of the sample questions used in this data set: how many employees are potentially eligible; what types of jobs do these employees have, comparing certificated and classified, part-time and full-time employees. I showed you a report showing school employees are predominately female, some of the urban/rural divisions, and east/west. This was important because we had employees asking us not to forget them. On the east side, we don't have the same kind of access. We can use some of the demographics in the K-12 workforce to compare to other populations, such as the state employees in PEBB.

As I mentioned, there are limitations with the S-275 report. There isn’t really information about substitute teachers. When we talk about substitute teachers being eligible, if they work 630 hours or more, this is a large segment with no information. It also does not include information about independents. We don't know how many children, spouse, or state-registered domestic partners there might be. A very important piece on the FTE is it’s a percentage. An employee, a teacher, for instance, who works 80% in one district may not work the same number of hours as a teacher in another district who is also listed as working 80%. For teachers, that's not a big problem, but for classified, some of those differences become a little bigger.

Slide 6 – OIC K-12 Data. This slide is the Office of the Insurance Commissioner data collected over a five-year period, school years 2012-13 through 2016-17. It was collected to look at whether school employees should be consolidated into a single benefit program. That was very relevant for what you are doing here. It contains employee, district, and carrier data. It has information about the planned benefits, the medical and dental premiums paid, and in some places, information about vision. But, the emphasis is medical.

There is some employee demographic information about what plans or tier levels the employees have selected and about dependents. Most of what we know about dependents from these data sets is by the tier. About half of the districts were able to supply information about dependents, but not in all cases so it's incomplete. There is also information about what the employees' contribution is to the medical plans they selected. There are some large claims by diagnostic categories. These are employees that have claims over $100,000 in total.

Slide 7 has sample questions providing answers to what types of plans and benefits employees selected, and what the individual employee contribution is. A limitation is that it is only the school districts and no information about the educational service districts or the charter schools. In many cases, particularly in the claims area, it's aggregated data, not individual and focused on the medical coverage. The data is about three years old.

Kayla Hammer: Slide 8 – K-12 Groups in PEBB Program, is another data source. It comes from HCA's vendors and contractors. HCA provides the eligibility and enrollment data, and the carriers provide the claims data. It is then aggregated, matched up, and blinded for use by our contractors. The data contains enrollment and claims data over multiple years, including partial 2018. It contains data on both health and dental plans, and data for approximately 3,600 employees from 71 school districts, 5 ESDs, and approximately 4,700 dependents. Slide 9 has sample questions like: how does K-12 enrollment within the PEBB Program compare to the broader PEBB Program enrollment, and what areas of the state are current K-12 groups participating in the PEBB Program? I think the major limitation with this data source is that it's not a large enough sample for standalone estimates or projections. As I said on the previous slide, 3,600 compared to the total population that will exist in SEBB is not a lot.

Slide 10 – HCA Legislated Data Request. Data was collected from current K-12 carriers in March and April 2018 and aggregated by HCA contractors. This data was authorized in HB2242 in 2017. ESSB6241 adjusted the timeline slightly in 2018. It contains data from all different types of benefit offerings currently offered to K-12. It includes profiles and benefit package information, claims of limited demographics, diagnosis and procedure codes, total cost and employee cost-sharing, and information.

Slide 11 has examples of questions, like how does the cost per service vary by region and compare between carriers, and what is the relative morbidity of the population? Limitations with this data is that it's difficult to standardize. Each carrier submitted data that wasn't necessarily comparable. Some provided different plan year information, varying plan designs between carriers, and highly variable descriptions of benefits and features. It wasn't representative of future eligibility. Those enrolled previously are not the same that will enroll in the future. As we know, eligibility is different now as it will be under the SEBB Program. Another example of that is we estimate there is a 20% waiver rate that currently exists in K-12. We don't anticipate that being the same under the SEBB Program. There's limited dependent information.

Dave Iseminger: There's one other piece that was brought to my attention. I've talked before about this data set because this is the April carrier data that was received. I described it as being 85%-90% of the data. What I've learned is that it's very heavy on

medical and dental. It has a fair amount of life and LTD but it is not as robust a set on life and LTD benefits. As we try to do some comparison to give information from this data set, it has limited predictive aspects with regards to life insurance and disability. It is much more robust for medical and dental.

Kayla Hammer: Slide 12 – Request for Information Data. In April 2017, we sent out a request for information to the K-12 fully insured medical carriers. This data contains fully insured medical plan data. We only received data from carriers that were potentially interested in responding to a future RFP. It had demographics and distribution data, possible plan design information, and non-binding rates.

Slide 13 has examples of questions like what are possible plan designs that would be offered? What counties are carriers proposing to cover? What is the range of potential bid rates for the program? Some limitations to this data are the ability for the comparison of the non-binding rates. The rates that we received were based on population variable and we only received age and gender, and area information. We're missing some bits that would make it a clearer picture.

We also asked them to build the non-binding rates, based on what they projected the entire population to look like. Not all K-12 carriers responded, so we are missing some bits of information. The rates are non-binding and not representative of the K-12 population that will exist under the SEBB Program.

John Bowden: Slide 14 – Takeaways on Using Data. None of these data sets were collected with the express purpose of consolidation, although the OIC data was collected with that possible use. In many cases we're trying to answer questions for you that go beyond the original intent of the data set. Not all the data sets are complete, pointing out substitute teachers in particular. We don't know about their needs. We don't even know how many substitute teachers would be eligible. We can't tie data sets together. There isn't a unique identifier in these five that we can tie one employee's demographic information in the S-275 to any claims data that might be for that particular individual. The claims data are services that employees have received.

It's important to remember it's based on what was offered to them, and what they selected in terms of a medical plan. With SEBB Program changes, the plans offered and what they might be able to select could be very different than what they have selected and used in the past. Within those plans, there would be differences, potentially, in their design. The types of services covered and the treatment limits, for instance, could be changed. What we have in terms of claims data is representative of what the member pays and what was available to them. If you make changes in copays, deductibles, or the coinsurance, their share of the payment, the patterns of usage may change as well.

I think it goes without saying that the available data are historical, so when you do future what-if's, you have to keep in mind things do change. We don't have anything to project what possibly might come in the future. But, keep in mind that there are changes. Some changes for consideration are the 630-hour threshold to be fully eligible. That's a lower eligibility than exists for many of the districts now. Although it is different in many places, an important piece is that for the employees' share there's no more prorating.

The 630 hours is fully eligible. All employees will be paying the same for the same plan in the same tier, across the state. We won't see differences in the employees' contribution, other than by the plan and tier selected.

The employees' premium share depends on the number of people they have included. A big piece is the three to one ratio that now exists, so that employees that have a spouse, state-registered domestic partner, and children will pay no more than three times as much as an individual would pay. We'll find employees that have previously waived, the 20% Kayla mentioned, that's a big part of the reason we expect lower waive rates. We'll have employees that haven't been there before. A few other things may change, such as employees or dependents currently Medicaid-eligible where they might receive benefits. There's a number of factors we can't predict right now that will influence the utilization.

Patty Estes: You keep saying substitute teachers are not included in the data. What about substitute classified employees? Are they not included as well?

John Bowden: My guess is they would not be. I haven't seen anything in the S-275 that suggests they are substitutes. In the job classification, there is substitute teachers specifically listed as one of the groups. I haven't seen substitute classification.

Patty Estes: It would be varied, like bus drivers, food service, all of that...

John Bowden: If they are in there, and I don't believe they are, we wouldn't be able to tell that they are substitutes.

Patty Estes: Okay. Thank you.

Wayne Leonard: I think you are referring to the S-275 report where that data is, and based on my knowledge, that report would not include classified subs. The only certificated subs I think it contains is certificated subs in a long-term sub position. It doesn't include very much information on the day-to-day substitutes.

John Bowden: I think the last time I looked , I seem to recall about 60 substitute teachers in any given school year that are in the S-275 statewide, and we know there are considerably more than sixty.

Dave Iseminger: That is an example of the limitation of the data set.

Pete Cutler: Has HCA prepared, or are they going to prepare, something that provides a more detailed written description of the data elements of each of these written sources? This is useful for giving a general idea, but I'd be very curious to know at a much more granular level, what the elements are that are collected by the different reports.

Dave Iseminger: Certainly, Pete, we can work to make that available to the Board. We didn't want to go through that granular level here, but we can certainly put together the data elements and a brief description of them.

John Bowden: I started preparing that as an appendices to this presentation, and I think I got up to about 22 pages It'll be rather large.

Pete Cutler: I understand.

Dave Iseminger: It’s in the works already and we'll complete it and make it available.

Kayla Hammer. I had a follow-up, not an agenda item. As a follow up to this presentation, in regard to the discussion that's been taking place with possible impacts on increasing the benefit limit for the CAM and therapies, (chiropractic, acupuncture, and massage). As I'm sure you remember, Kim Wallace in previous presentations has presented a table and it looked at UMP Classic active employees, non-Medicare. Looking at possible magnitude of the different levels, increments of increasing the limit, and what the possible paid per subscriber per month (PSPM) impact would be. We were asked if we could do the same thing with the K-12 data that we have.

It turns out that, based on the differences in underlying the population that we have for the K-12 and what was used in the analysis of the UMP Classic, we are unable to populate that table with K-12 information. We did some other analysis and I think I have information that would be beneficial to share with you today.

Our review of historical experience suggests that the amount spent in calendar year 2017 per subscriber on CAM and therapies for the currently covered K-12 population is 40% lower than that for UMP Classic non-Medicare state active in 2017.

Lou McDermott: Dollars, utilization, or both?

Kayla Hammer: Dollars. The PSPM paid on CAM and therapies. There are three components needed to estimate the cost of benefits or benefits change. Percentage of members who are claimants, average visits per claimant, and the average cost per service. In looking at the experience data, we found that the percentage of members who are claimants, and the average visit per claimant, were both lower in the current K-12 population than the UMP Classic. Just a note that the average visit per claimant for both of the populations does not meet the current PEBB UMP Classic visit limitation.

Sean Corry: Excuse me. What you just said meant that in general the benefits available in school districts plans have lower limits than what's available in the state plan that you were using as a comparator?

Kayla Hammer: No. That's not what I was saying. I was saying the average visit per claimant that happens for everybody. In K-12, on average, the claimant doesn't use the benefit limit. They use much less than that, like five days. Five visits, I believe. I have to look at my numbers again, I just have notes.

Sean Corry: So, you're suggesting it's not a function of lower limits themselves?

Kayla Hammer: Yes, it's just the benefits utilization behavior.

Lou McDermott: Let me understand this. Is the behavior of the K-12 system less than PEBB's current limits?

Kayla Hammer: Yes, that's what we've seen.

Lou McDermott: So, they're less than their limits and it's also less than our limits?

Kayla Hammer: They have varying benefit limit offerings.

Lou McDermott: In general.

Kayla Hammer: In general, yes. But most of them on average used lower than the 16 visit limit in PEBB UMP Classic.

Terri House: Kayla, is it possible that we get a paper copy of what you just said?

Kayla Hammer: Yes. And, lastly, the average cost per service actually varied quite a bit by service type between UMP and K-12. One wasn't necessarily higher than the other as far as the average cost per service. The average cost per service for acupuncture might have been somewhat more expensive and there was variability between those. The first two items really can impact overall cost. The percent of members who were actually claimants and the average visit per claimant was lower in the current K-12 covered population.

Pete Cutler: Not to beat a dead horse, but by average, you mean the average number of visits in a year by the claimant?

Kayla Hammer: Yes.

Pete Cutler: Great. And in terms of the average cost paid for whether it was acupuncture –

Kayla Hammer: Service.

Pete Cutler: Service that varied sometimes higher, sometimes lower, so, no distinct pattern.

Kayla Hammer: Yes. And, there's some regional variability, I imagine. There's a lot of variables that come into play with the cost per visit.

Sean Corry: I have a question, because what you've been telling us makes me think of the presentation that Kim did for us last time, which, by the way, I followed up with a question and we had some correspondence back and forth about whether the pricing, as you go into more and more visits, makes sense. The pricing provided by Milliman, apparently. There was follow-up from Kim that effectively argued that this is the reason those numbers make sense. As an aside, her answer didn't make sense to me. But, in any case, what I'm really getting to is that now that we have an understanding that the actual utilization among school districts generally is lower, or considerably lower, how

does that tie into what seemed to be a rather large prediction of utilization and cost for those therapies that Kim was talking about?

Kayla Hammer: Are you asking about increased benefit limit and increased utilization as a result of that?

Sean Corry: My vague memory of this was it was increased utilization that came at a cost. There was pricing associated with it. There was a fairly large jump in pricing at the last increase of benefit availability. It was a downward slope and then at the end a big jump. In my words, it's just that once it became a free-for-all, everybody would jump in. Putting aside my continued disagreement with that pricing, what you're telling me now is new information, which is that at Seattle Public Schools, school districts generally, and I think at Seattle, too, utilization of those benefits is relatively low. Having available benefits currently that are not being used makes me think that there won't be a rush to take up additional services, and therefore, it doesn't help me understand the big jump in pricing that Kim talked about.

Megan Atkinson HCA Chief Financial Officer. I'm going to interrupt here. On the phone is Ben Diederich, one of our actuaries from Milliman. Ben, as always, if I start describing things incorrectly, jump in and help correct us.

Sean, I want to help tie these things together. For the Board Members, you'll recall Kim presented some analysis on the CAM and the therapies around this discussion of benefit limits. Benefit limits differing across the different K-12 plans, generally having benefit limits different than what we have seen in our PEBB UMP plan, and then trying to understand if you have benefit limits that are higher or lower and how that either drives or doesn't drive over all plan cost. Kim started the conversation. We had follow-up questions and in the follow-up questions, Milliman undertook the analysis that Kayla was describing. I want to put a bow on what Kayla was describing first.

I think the urban myth around a utilization difference that, again, the mythology was in the K-12 population, a higher utilization of CAM and therapies. We have been told anecdotally as we were setting up the SEBB Program, the K-12 population really uses these benefits. They're important to the population and they are high users of the benefit. The analysis Kayla was describing as comparing the utilization from the data we have available to us, the utilization we see in the K-12 population wasn’t comparing the utilization in K-12 to the K-12 current limits because those limits vary across the different K-12 plans. We have the entire UMP population in one plan with one set of limits. In the analysis, we did see that the K-12 population had lower utilization than compared to the PEBB UMP population. That's what Kayla was describing. Lower utilization and, I believe, lower cost per service?

Kayla Hammer: Varying costs per service.

Megan Atkinson: Varying cost per service. I want to put a bow on that because that's different than, again, the urban myth that we had around the K-12 population of these limits.

I want to pivot over, Sean, to your questions. Yes, we have an ongoing conversation around the cost estimates we were presenting and showing you if you set these CAM and therapy limits at a higher level versus a lower level. Milliman costed out two sets of behaviors when they did the analysis. They were costing out the current users increasing their use of these benefits. So, somebody getting a massage every other month, and then scheduling and getting a massage every month. Someone getting a chiropractic adjustment? I've had these instances in my own health where I schedule, one every other month or one every two months. Those current users using more.

There was a second behavior of people who aren't currently coming in and using. I believe in the last response, Kim and Milliman were trying to pull those behaviors apart because you were raising good questions about what would we expect in the behavior. I want to also provide the caveat that there's not a set algorithm to use. There's not a body of research you can point to and say, “this definitively is how people respond when you have” (when you change benefit limit”). It's essentially knowledgeable, informed experts getting together and asking what we think would happen. That is what was in the analysis we were presenting. With that sort of preface, I believe the question you are asking today is: does the information we've seen now that we've gone in and pulled apart the K-12 utilization, see that they actually use less than UMP? I'm speaking for you, so, correct me if I'm wrong. Essentially, would that change or adjust the information we had presented previously? Is that where you are now?

Sean Corry: That's just fine.

Megan Atkinson: Ben, I'm going to send it over to you and see if you want to weigh in to help Sean and the Board understand, as we're looking at costing out differences in these benefit limits, how to think about this and how to move forward in looking at this analysis.

Lou McDermott: Is there one more variable in that mix? The two variables were new people coming in and how behavior changes in the existing population. Does provider behavior change? The providers are usually familiar with your benefit levels, what plan you're at, and how much you can do. I'm wondering if there's any thought of whether or not the providers actually change their behaviors. If they know you only have twelve, one a month sounds great because it's a plan year. If it's 24, twice a month might seem reasonable. I don't know if that's true. Is that part of the calculus?

Kayla Hammer: I believe it is. I will go back and re-read what I read, but I do believe that was taken into consideration because, you're right. People know their benefit limits. If they have fifty, they can go every other week and it would be better for you to go every other week.

Sean Corry: To interject, I want to first agree that would be a variable worth considering. But, given the behavior that you've told us is occurring within school districts, I would guess the impact of that variable would be very small, since very few people are reaching maximums now, relatively speaking in the K-12 population.

Megan Atkinson: Ben, can you weigh in and help us with this conversation now?

Ben Diederich, Milliman. Everything that's been said up to this point, I agree with. Especially, Kayla, your last point about the discussion that provider behavior definitely comes into the calculus. The biggest piece that I don't know if enough emphasis was placed in the discussion, is that the population currently covered under K-12 is very different than the population that's likely to be covered under SEBB because of the change in the employee contributions. We're going to get a great deal more of dependent spouses covered under the population. When we presented the analysis originally, we were presenting PEBB results. That was making the grand assumption that the eventual SEBB Program population will look more like the PEBB Program population than what it looks like currently today. We're circling back with the results of what the current K-12 utilization is looking like. That utilization is different. It is lower, like Kayla was talking about. But, that's going to change when we get to 2020 and implement the SEBB Program. I think the big unknown is modeling what the future benefits are going to cost under the future program. That's the piece that we're trained to give estimates around on the initial presentation.

Megan Atkinson: I think what we're struggling with, and the reason we hadn't brought this up on the tail end of John and Kayla's presentation today, is these data limitations and trying to predict and model future behavior with a population that could be significantly different. We're expecting significantly different than the population we have right now. I understand this is a hard conversation because we're asking you, in a separate work stream, to decide on benefit limits. I'm not certain we're going to be able to get data and definitive costing in a way that we can do anything more than give you a different costing and say we're still uncertain. This is one of those areas where we look at the benefit design and the overall benefit package, rather than think we're getting overly precise, think of it in terms of magnitude of the total benefit package. In all honesty, possibly just a comfort level that you individually or collectively have with knowing what the K-12 employees are experiencing now, the options that they have now in their benefit packages, information that we can give you about how much they truly are utilizing based on the information we have. Again, a comfort level with a decision around a benefit limit. We're not going to be able to get you definitive costing on that.

Sean Corry: Thank you for that. Two things. One, it was a good email conversation I had with Kim about this and if any Board Members individually want to see that, I'd be happy to pass it on. But, what I'm hearing here is, “this is our best guess,” and not hearing that you have a high probability of being right. Which, for me, puts money on the table if for conversations about other tweaks to benefits. Maximums in other areas, copay changes, changes in the cost of the life insurance, for example, which we're going to start talking about today. I see that as all in the mix.

Megan Atkinson: Sean, as we move forward on looking at life insurance, other benefit limits, and everything, the best kind of metaphor/parallel I can give you all is, if you go on your weekly grocery shopping and you have a list. You have a general idea of how much you spend each week as you go. But, as you move through the grocery store, you routinely select the more expensive bottle of wine, the more expensive cut of meat, the more expensive, the more expensive. Then, overall, you're going to get to the checkout and you’ve driven the cost higher than what you thought you were going to when you walked in the store doors. This is an area where we put together the benefit

package and provide you options regarding disability, life, and other benefits. Even if we can't definitively cost each and every one of those for you, what we will be coming back and trying to help you keep track of is, "you went high here, you went high here, you went low here." You know, that. We can't definitively cost the total benefit package for you and what it's going to cost in 2020, but we can keep track of and help you understand the decisions you're making consistently pushing cost. Or, are they staying around neutral, are they coming in a little frugal?

Sean Corry: And lastly, I appreciate that because that is the way I have been thinking about it. The only other comment I want to make is that when we have this discussion about benefit changes here or there within a medical plan or across a range of benefits, there is uncertain money on the table here and there. But, what also is not fixed yet is the dollar amount that will be funded by the Legislature. If we knew that number, it would be much easier for us because we would have certain pennies on the table. Now, we don't. I'm saying that not to say that we should be cautious. What I'm saying is that gives us an opportunity, as a Board, to make decisions about the benefits we would recommend for the population of school districts. If it causes costs to go up somewhat and I'm putting a reasonableness aspect into it, that would be the ask from the Legislature. It's not a fixed dollar amount yet.

With that in mind, I think these kinds of conversations are very helpful to us as we drill into these different benefits, and the level of benefits that will change for school district members and whether it's okay from our point of view, on whether it's different from what PEBB has now. I'm looking forward to those conversations.

Dave Iseminger: I want to say one piece related to this concept. Although the Legislature has not set a fixed dollar amount, we do know, and Megan's described before to the Board, that just getting over the FTE to head count piece is going to be a significant amount of money that has to be addressed in the system. There are multiple places where there is already a significant amount of money that needs to be addressed by the Legislature related to launching this program. There is a cautionary tale, there are already major components to bring the SEBB Program into alignment with how the state has addressed state employees. There are significant areas where hurdles need to be crossed. The more that is requested on other parts will continue to raise the entire cost of the program.

Wayne Leonard: I had a follow-up question to some of Sean's questions. This assumption that the population is going to change significantly, is that based on an actuarial guess, or is that based on the limited data of the K-12 groups that have moved to PEBB?

Megan Atkinson: It's both, but, the data behind it is what we've seen as K-12s move into the PEBB Program. They add dependents, spouses, and children and look like our PEBB population.

Ben Diederich: We're also modeling the employee base that’s within the current K-12 system, who’s eligible for benefits, and what their associated dependents would be if all of them have the PEBB broad demographics. These are two large populations within the -- [audio cut off]

Lou McDermott: We lost you, Ben.

Ben Diederich: All right. There's static on the line. I don't think I can get through it.

Megan Atkinson: Okay.

Pete Cutler: First of all, I want to reinforce your point that I think there is going to be some significant sticker shock on the cost of providing full funding on a head count basis of the K-12 employees.

Another point I want to make is that I assume as we go forward, for every cost estimate given for any of the different options in front of the Board, it'll be based on the agency's best analysis, which will be heavily contributed to by the actuaries and their data access sources. It seems to me that this latest information is just one more piece to fine tune when we get down to actually making decisions. Maybe it'll tweak that estimate we got. I'm not sure. But, at least they'll be able, if it doesn't, indicate why they don't think it should.

And, last but not least, as I understand it, collective bargaining statutes say that before our Board Meeting in October, we should have a collective bargaining agreement (CBA) that includes an exact number that all employee organizations that are part of that coalition, and the Governor's office are going to say, "This is the funding level that is appropriate. We support going forward for the next biennium." In my mind, at that point we'll know the size of the box that we're working within and that's when I'm looking forward to where the rubber meets the road in terms of what are the tradeoffs.

Dave Iseminger: To that point, assuming there is a ratified tentative agreement of a CBA. We'll plan to talk about it at the October meeting.

Alison Poulsen: I think I wanted to add on to what Pete said about appetite in the Legislature to move this when there are a number of other health related things that I think are going to be in front of the Legislature and we should be aware in general of that type of spending.

Dave Iseminger: The other piece I wanted to add is, as you think about the head count FTE piece, that's unique to SEBB in bringing up the SEBB Program. When you start to talk about potential increases on other benefits, life insurance, disability, there will be a natural question for the sister program of, if there's money to pay for SEBB to push a benefit up, do we have double the amount of money for that request to bring both programs up? There is an extra layer of consideration in the legislative process for the implications of what this Board thinks about and what your sister Board would think. That is another factor for consideration.

Centers of Excellence

Marty Thies, Account Manager for the Centers of Excellence Program. Today's purpose is to inform the Board about the Centers of Excellence Program (COE). This is currently a benefit option available to UMP Classic and Consumer Directed Health Plan (CDHP) members. Three things. For serious procedures members might need, they

can opt to use the Centers of Excellence Program for that procedure, or they can use their existing benefits with UMP. Secondly, the program is about quality. We incentivize members to use the Centers of Excellence. Cost savings are a secondary consideration and quality is first. And third, the SEB Board can choose to adopt this COE Program to overlay on selected SEBB self-insured plans.

Slide 3 – Centers of Excellence Program. There's a national movement toward a focus on quality rather than quantity of care. This is true especially for procedures and services that have a wide variation in cost and outcomes. Slide 4 – Washington State. Washington has been a leader in this area. In 2014, the Legislature gave HCA the directive to increase value-based purchasing and increase access to high quality, high value care. Two years later, the PEB Board approved a resolution to establish the Centers of Excellence Program. There are three main components to the Program. First, there's procurement, issuing a Request for Proposal (RFP) requesting the potential Centers of Excellence abide by the Bree criteria. We incentivize members to use the Centers of Excellence. All this is to improve access to health care quality. Regarding cost, the idea is to bundle together a standard set of services associated with a procedure, and then pay an agreed-upon contractual price for that episode of care.

Dave Iseminger: This is a prospective case rate; an episodic case rate that's determined. It is not a look back at claims and a retroactive bundling of services and then saying we're only reimbursing you for this. This is actually a prospective payment model.

Marty Thies: Yes, what we pay is a matter of contract. Slide 5 – Standards and Best Practices. I believe you’ve heard about the Bree Collaborative and the Bree Criteria from our former Chief Medical Officer, Dr. Dan Lessler. The next few slides provide a brief update of the Bree Collaborative, established in 2011 by the Legislature to address issues of variation in cost and outcomes, and working toward better health trends in Washington State. The deliverables of the collaborative were to identify best practices to establish methods to collect, report, use, and improve access to health data, and increase the use of evidence-based practices.

Slide 6 – Bree Collaborative. This slide is procedures and health conditions the Bree Collaborative has addressed over the years. Total knee and hip replacement is where the Health Care Authority started with its Centers of Excellence Program because of high utilization in the PEBB Program self-insured plans. Slide 7 – Total Joint Replacement. Utilization for 2014, 2015, and 2016 was approximately 650 total hip and knee joint replacements each year. We saw high variability in cost in the data. It could be as low as $20,000; a replacement with complications could approach $100,000. We wanted to address that.

Bree also focuses on specific standards for total joint replacement: appropriateness, fitness, surgeons who have performed fifty plus surgeries a year and begin surgery before 5 p.m., and recovery.

Slide 8 – Total Joint Replacement: Design. The design of the total joint replacement bundle is voluntary participation. Members do not have to use the Centers of

Excellence available to Classic and CDHP members. The primary incentive is low to no out-of-pocket cost to members. The bundle includes the surgery, their inpatient stay, the implant itself, any durable medical equipment post-op, case management from the time they call to the time they leave with their new hip or knee, and even transportation and accommodations for both the patient and a care companion that joins the patient during the procedure. This is a prospective payment. There is no reconciliation after the fact, and we have a 90-day warranty with our Centers of Excellence for certain complications. Seven, 30, 90 days out, if there is an issue, the Center of Excellence will cover it.

Dave Iseminger: We are describing the design as it relates to how the PEB Board has implemented it in their self-insured plans, and highlighting UMP Classic and CDHP. That means the question before this Board will be if you want to adopt this program, do you want to adopt it in UMP Achieve One, UMP Achieve Two, and UMP High Deductible? It does not currently overlay within the UMP Plus plan on the PEBB side. We are still working on if there are ways to integrate those payment models represented in that plan. But, the question before the Board at a subsequent point will be whether you want to adopt this type of program for the UMP Achieve One, Two, and High Deductible plans.

Lou McDermott: I was involved in the procurement of this plan. We were looking to have something that was statewide and not centrally located on the west side because we knew traveling was going to be difficult. When we went through the responses to the RFP, I couldn't believe some of the numbers we saw on readmissions. A facility in the local area applied and they had a 15% readmission rate out of every hundred people. Fifteen people wound up back in the hospital for infections or secondary issues. The successful bidder had a readmission rate of 0.2 - two out of a thousand. When we say the price difference and the quality difference was variable, we mean incredibly variable. I like to point that out because I thought we were going to see some variation, but not that much variation! These numbers they reported to us, it wasn't us trying to glean it together from the data. They thought they were doing a great job. That was the other part. When we were doing orals and the site visits, they were very proud of their numbers and statistics, and had no idea where they were on the scale.

Marty Thies: Perfect segue, Lou. Slide 9 - The Centers of Excellence Total Joint Replacement Team is Virginia Mason Medical Center. Lou just described their complication rate. They have been involved with the Bree Collaborative, I believe, since its inception and have certainly adopted Bree criteria in their clinical practice. The third-party administrator is Premera Blue Cross. They do an enormous amount of work starting the moment the member calls to ask about the benefit to the survey 30 days after surgery. We call it concierge case management, holding hands, pulling medical records together, preparing referral to the Center of Excellence, handing off the member, and the surveys at the end.

Slide 10 – Calendar 2017 COE-TJR. This slide is a snapshot of our experience with the total joint replacement bundle in the first year. Premera prepared and sent 122 referrals to the Center of Excellence. In 2017, 95 of those referrals had surgery. Another sixteen of the 122 were in the pipeline toward a surgery. Eleven did not result in surgery for

various reasons. The Center of Excellence is in Seattle. People are coming from all over the state to take advantage of this program.

Slide 11 – Summary: Quality and Costs. There have been zero readmissions for members undergoing a joint replacement at the Center of Excellence and no complications reported resulting from these surgeries. There has been great savings to participating members, unless they have a CDHP and they, by IRS rules, must use their deductible. They are not paying out-of-pocket. (Data shows the average out-of-pocket cost, depending on the facility you select, is about $900-1,000.) For the UMP population, these surgeries at the Centers of Excellence, with this high quality, were less expensive than the surgeries outside of the Centers of Excellence.

Pete Cutler: Just to confirm that less expensive is to the Uniform Medical Plan, as opposed to the prior bullet being for the participants.

Dave Iseminger: There is both savings to the member and savings to the plan.

Pete Cutler: First bullet point seemed to hit the one, just wanted to make sure the second one was not just stating that first bullet a second way, but was in fact dealing with the overall plan cost.

Lou McDermott: I think one of the intangibles was readmissions. Readmissions aren't cheap, and even if there were to be a readmission, it would be under warranty and neither the state or member would be charged.

Marty Thies: Correct, within the warranty timeframe. There is a seven-day warranty, a 30-day warranty, and a 90-day warranty for complications. What we've done is use those codes to look at Regence data to see if people have been going elsewhere to address complications and did not find anything in their data.

Emily Transue, Associate Medical Director, HCA. Those conditions and timelines essentially match a consequence of a surgery. If you have pneumonia within seven days, it had to do with a surgery. If you have pneumonia two and a half months later, it's probably independent.

Marty Thies: Slide 12 – Comments from Members. Premera sends out surveys to those who undergo surgery at the Center of Excellence. There is an opportunity for participants to give narrative comments about their experience. Slide 12 highlights some of their comments, all favorable.

There have been other comments, too. Someone didn’t like the hotel. It took longer than they anticipated to gather medical records to prepare the referral. Others said the opposite. "Boy, we just zipped right in there." Sometimes, there were issues with care companions and not having someone available to accompany them for several days.

Slide 13 – PEBB Program Participant Surveys. We try to address issues we can to make the program better. We have quantitative data that reflects this. There are sixteen survey questions. Six questions highlighted on this slide and scored one

through ten. Of the 16 questions, five were between eight and nine. The other eleven were nine and above. The lowest was eight and there was one of those.

Dave Iseminger: I think it was actually 8.3. It's not even eight.

Lou McDermott: What was the question?

Marty Thies: "After I sent my information, I received my recommendation in the expected time frame." I mentioned that we got an 8.3. The highest were: "If I have another joint replacement, I'll use the COE again" -- 9.7; "I'd recommend the program to family and friends" -- 9.7. Extremely strong member response and a response rate of 69%.

Dave Iseminger: One other piece is the travel benefit applies for anybody who is outside of 60 miles of the Center of Excellence. If you're outside of 60 miles of Virginia Mason, you're eligible for the travel benefit.

Marty Thies: Slide 15 – Benefit Design. That was the first bundle of the Centers of Excellence Program. We are implementing a second bundle for spinal fusion. Over-utilization is an issue when it comes to spinal fusion. If a member is found to be a fit or appropriate candidate for spinal fusion, there is a comprehensive evaluation that is provided. We hope that, in itself, will decrease utilization appropriately. The benefit design for the spinal fusion bundle is much the same as the joint replacement; Bree criteria, little to no out-of-pocket, travel expenses, etc.

Slide 16 – Spinal Fusion Centers of Excellence Procurement Timeline. The timeframe for implementing this bundle is quite aggressive. The RFP was released in February and two apparently successful bidders were selected in July. Virginia Mason will be one of the Centers of Excellence, and Capital Medical Center, with a relationship with Olympia Orthopedics, is the second Centers of Excellence for the Spinal Fusion Program. We will implement the program on January 1, 2019.

Slide 17 – Next Steps. There will be a follow-up presentation to the Board at the October 4 Board Meeting. I will bring a resolution for your consideration to include the Centers of Excellence Program benefit in the SEBB Program. The anticipation is the Board would take action at the November Board Meeting.

Alison Poulsen: Are there other COE proposals on the table for the future for either the SEB Board or the PEB Board that we might see coming forward? I think this is really exciting when you actually talk about the triple aim. I'm going to imagine even the quadruple aim, you might see some improved job satisfaction from providers in that way. I'm just curious if we would imagine more of this happening as we try and meet those needs.

Emily Transue: I think someday, yes. We don't currently have a pipeline on what that would look like.

Dave Iseminger: The best marker for things that could potentially be part of a Centers of Excellence Program would be some of the other topics rooted in Bree criteria. That is the starting point. If you look around nationally, other areas some employers have gone forward with are things like bariatric surgery and coronary artery bypass graft (CABG). There are Bree criteria related to those, so they might be logical next areas for review, but we're in the very early stages of a potential third bundle.

Alison Poulsen: I was specifically interested in the maternity side.

Dave Iseminger: That is an area we're also in the early stages of pursuing.

Policy Resolutions

Barb Scott, Manager, Policy, Rules, and Compliance Section, ERB Division. There are three policy resolutions for action today. Policy Resolution SEBB 2018-28 was introduced in May; Policy Resolutions SEBB 2018-33 and SEBB 2018-34 were introduced in July. We continue to work on Policy Resolution SEBB 2018-32, mid-year hires for positions anticipated to work 630 hours in the next school year, and plan to bring it back to you for action at a future meeting. Changes have been made to the resolution titles and language, so we've included the original language as they were introduced in the appendix.

Slide 4 – Policy Resolution SEBB 2018-28 Eligibility for the Employer Contribution Based on Stacking of Hours. This resolution ensures all hours worked by a school employee are counted towards determining eligibility. It will address cases where a school employee fills more than one position. We are recommending the Board authorize stacking within a single SEBB Organization. This resolution would not prohibit the Board from expanding this policy in the future. As far as stakeholder feedback, most stakeholders supported the policy as written. However, one stakeholder suggested we allow stacking across SEBB Organizations with premiums prorated across SEBB Organizations. They are looking at the PEBB eligibility for faculty within the higher education institutions, where stacking is allowed across organizations, and where there is a proration of premiums across those higher education institutions. This is very specific to just faculty and faculty hours. We will continue to evaluate cross-district employment situations and bring information to the Board at a future meeting.

On the slide before you, we removed the word "only" from the end of the sentence where it says, "within one SEBB Organization." The original resolution said, "within only one SEBB Organization." Passing this resolution will reassure school employees who are working multiple positions within a single SEBB Organization today.

Lou McDermott: **Policy Resolution SEBB 2018-28. Eligibility for the Employer Contribution Based on Stacking of Hours.**

Resolved that, a school employee may establish eligibility for the employer contribution toward SEBB benefits based on stacking of hours within one SEBB Organization.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-28 passes

Barb Scott: Policy Resolution SEBB 2018-33 would allow a school employee who has already established eligibility for the employer contribution towards SEBB benefits to have uninterrupted coverage if the employee is returning to the same SEBB Organization, and is anticipated to work at least 630 hours. Without this policy, a returning employee would have a gap if they return on September 5, the first day of school for their SEBB Organization based on paragraph number one of SEBB 2018-12 as adopted, which identifies when coverage begins. School year ends August 31, and for some employees, their first day the next year is going to be September 5. What we're trying to accomplish is to have uninterrupted coverage for that employee who is going from one year to the next. This policy is intended to prevent that gap.

Most of the stakeholders supported the resolution with some minor edits. We've incorporated those into this version. One stakeholder would like us to put forward a policy that would presume eligibility rather than coverage. We will be introducing a separate policy to support presumed eligibility later in this meeting. There were some changes to the body of the resolution. We removed the word "eligibility" from this policy because we wanted to focus on removing that gap in coverage that could exist for some employees.

Lou McDermott: **Policy Resolution SEBB 2018-33. Returning School Employees with Uninterrupted Coverage.**

Resolved that, a school employee returning to the same SEBB Organization who is anticipated to work at least 630 hours in the coming school year, and who was receiving the employer contribution in August of the prior school year, will receive uninterrupted coverage from one school year to the next.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-33 passes.

Barb Scott: Policy Resolution SEBB 2018-34 – Eligibility When Moving Between SEBB Organizations. This resolution is intended to remove the eligibility and coverage gap that would otherwise occur for an employee who moves from one SEBB Organization to another within the same month or a consecutive month. The employee must be eligible for the employer contribution toward SEBB benefits in the position that they're leaving, and anticipated to be eligible for the employer contribution toward SEBB benefits in the position they are moving to.

Most stakeholders supported the policy resolution with one edit replacing the word "transferring" to "moving." The introductory clause was also rewritten in order to address a question where an employee had a gap of many months, or maybe went a year between employment. We addressed that by including, "within the same month or a consecutive month," so you could see they're moving from one spot to the next.

Dave Iseminger: That change also aligns with all the examples provided to the Board at the prior meeting. The examples all conveyed same or consecutive month examples. When the question came up we knew it needed to be made clearer.

Lou McDermott: **Policy Resolution SEBB 2018-34. Eligibility When Moving Between SEBB Organizations.**

Resolved that, a school employee will have uninterrupted coverage when moving from one SEBB Organization to another within the same month or a consecutive month if the following conditions are satisfied:

- The employee was eligible for the employer contribution toward SEBB benefits in the position they are leaving; and
- The employee is anticipated to be eligible for the employer contribution toward SEBB benefits in their new position.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-34 passes.

Barb Scott: The next steps will be to incorporate these resolutions into SEBB Program rules.

Ethics Training

Kate Reynolds, Executive Director, Executive Ethics Board. This presentation today is more of an introduction and it may create more questions. Contact information is on the last slide in your materials.

The Ethics Act is a 1995 Act largely driven by the need to bring various pieces of ethics into one statute that would cover all state employees. The Ethics in Public Service Act covers all state employees. It covers the Executive branch employees, Judicial, and Legislative branch. Each one has their own ethics board that governs the Act for that particular branch. It's to hold us accountable to the public.

First consideration is access to confidential information and protecting state employees. Then there is the use of public equipment and the use of technology. Everything that you use is the property of the state, and we need to be good stewards of that. We also

need to be accountable for how we use our time when we're in our role as state employees. We need to make sure we are using our time for the good of the people of the state.

Who is the Executive Ethics Board? It's a five member Board appointed by the Governor for a five-year term. Two are state employees, one classified employee and one exempt employee, which is important to ensure you have the state employee perspective. They cannot take personnel actions, but they can issue a civil penalty of up to $5,000 per violation to an individual state employee. The Board has a few statutory missions. One is to interpret the law, and they do that through enforcement actions and through publishing Advisory Opinions.

Advisory Opinions are when someone writes into the Board with a particular set of facts asking if it would be a violation, not a violation, or how do I avoid violating the Act with this particular set of facts? The response is published. All of those are on our web page. You can search on topic, year, agency. There's numerous search provisions. It's a great place to start if you have a question.

The Ethics Board also adjudicates complaints. The Board’s jurisdiction is roughly over 60,000 state employees and the Executive Branch.

Complaints come to us from the public, agencies, boards, commissions, colleges, etc. They can refer matters to us for investigation. Sometimes, they do that before a personnel action. We also work closely with the State Auditor's Office with whistleblower investigations. They do the investigations and if there's an Ethics Act component, they forward it to us for further proceedings under the Act.

Most of our complaints come from co-workers. If there is a violation under the Ethics Act, we open an investigation. Our investigators take charge at that point. There is an opportunity for the respondent to reply, provide evidence to the investigators, and be part of the process. It comes to me for review to see if it's eligible for an Executive Director dismissal. If it's not, it's passed to the Board for a finding of either a reasonable cause or for a dismissal, as well. At that point, if they find reasonable cause it goes through a normal administrative process. The respondent can request a hearing before the Board and would have an opportunity to present witnesses and evidence. The Board would make a determination on whether there is a violation. If the respondent is not happy with the outcome, which does happen, they can appeal to Superior Court.

The first section of the Act people come into problems with are conflicts of interest. It's about 20% of our cases. We get calls with potential conflicts of interest or actual conflicts of interest and they want to know how they can mitigate the issues that are going on, or even avoid the conflicts of interest. It has to do with the concepts of benefit and bias. How you deal with those because you wear two hats. You wear your state employee hat when you're sitting on the Board and you wear your private hat. What we're looking for is the intersection of when your private interests and your interests with your official duties are not going to align. When they start to butt heads, that's where the conflict of interest comes in.

There are a couple different places where we see this a lot. One of them is you own a private business. As an example, you own a private business, and you supervise individuals in your state job that may need some extra money and you decide to hire them during the summer to help with your painting business or whatever it may be. That would be a conflict of interest because your official duties as a supervisor and your private interest as a business owner are not aligning.

Another example is you work at an agency that does permitting processes and you're in charge of the permitting process. You send out all the RFPs, you review all the RFPs that come in, you decide who gets the grant money, and you administer that grant money. Let's say you go out and you start a non-profit in this area of work and you apply for that grant money. You review your own application for your non-profit's application. You decide to grant the money to your non-profit. You administer the money of your nonprofit. There is a conflict of interest there and that's a problem.

What we see a lot with board and commission work is that you volunteer on a board or commission and because a lot of them are volunteer, you get a small stipend. But then, in your personal life, you also run a business or have other interests that may not align at some point with your official duties on the board or commission. This is where we do a lot of our advice pieces. People call us and ask for advice. They may have accepted a position on a board and they own a business where people come before the board that might be competitors or they might have a personal interest in contracts that they review. The Ethics Board will look at a few things.

There are two gold standard advisory opinions on this, 9609 and 9609A. They're on our web page. They lay out what the Board expects when you come into a conflict of interest situation. 9609A are model rules the Board has proposed could be used by boards and commissions. For example, you have a written procedure for conflicts of interest issues that board members may come across. The first thing that the Board is going to expect you to do is abstain. They're always going to expect you to just remove yourself from the situation, abstain from putting yourself in a situation where there may be a conflict of interest. We realize that's not always the most practical way to go. What are you expected to do? The second thing is disclose. Start the conversation with both sides. Start the conversation with the boards or commission, with your employer, if you think there might be a problem. Then, look for those written procedures. Some agencies have written procedures in terms of what happens with conflicts of interest. Or, they have forms that you need to fill out that will help the agency identify conflicts of interest. Look to see if there are already written procedures in place.

Lastly, I think this is an underutilized tool, largely because it's more of a legal concept, is a screening memo. It basically identifies a potential conflict of interest, or even an active conflict of interest and addresses how it will be solved. It helps so people don’t panic when the situation comes up. You have a plan and a process in place. Also, if there is a complaint, you can send that into the Ethics Board and let them know the potential issue was already identified and this is how we dealt with it. Everyone understood what was expected, we have this memo. It's very helpful for both sides, to get out in front of it.

The second section of the Act that we have a lot of questions on and not a lot of cases is actually the gift section. Gifts are broadly defined under the Act. It can be anything of economical value. It can be a gift, a gratuity, or a favor. And, basically, the baseline in the Act is that you can't accept anything if it's reasonably expected to influence the performance or nonperformance of your duties. I call this the Lamborghini rule. If someone drops the keys on your desk to a Lamborghini, they wink at you and they say, "You know what you're supposed to do, right?" Obviously, they're trying to influence you. So, don't take the keys to the Lamborghini. That's the baseline to the rule.

Now we chip away from that baseline because not everything is meant to influence your performance. It's not always that obvious. Before you accept a gift, ask yourself two questions. Depending on the answers to those questions, you may or may not be able to accept the gift. The first question is what is the gift worth? The second question is who is giving me the gift?

What is the gift worth? The Act says a state officer may accept a gift with a value of less than $50 from a single source, or from multiple sources with a cumulative value of $50 per year. There are certain things under the Act that are excluded from that $50 gift rule. It's either by a definitional section or by the other more involved section of the gift act. Basically, it's items from your family members. We don't get involved with what you got for your birthday from your mom. Gifts between co-workers are excluded from the definition of gift. For example, when you have a shower of some sort or you have a retirement party, those are they type of things contemplated under there. Also, promotional items. If it comes in a box of 300, you can have it. So, all of those pillow mints, those pens that break when you click them the first time, those post-it notes, like those visors, you can keep those types of things. Also tokens of appreciation. Those acrylic stars that say, "You're a rock star 2018!" You can keep all of those, as well. Food at a hosted reception, which we'll talk about, what a hosted reception is.

For the second question, you need to determine whether or not you're a Section 4 employee. That is really about who is giving you the gift. Section 4 refers to the section of the act. That's important because Section 4 employees are limited on what gifts they can accept. The $50 gift rule does not apply for them and they can only accept things delineated in Section 4 of the Act. There are three questions for determining Section 4 employees. Each time someone tries to give you a gift, you need to go through this analysis to determine whether it's permissible or not. Question 1, are you employed by a regulatory agency or an agency that seeks to acquire goods or services? The word "agency" can be replaced with board, commission, whichever kind of body you sit on. This would also drill down to the divisional level. It's not necessarily your agency. If you work in the contracting section of your particular agency then you would have to answer "yes."

Question 2, does your agency regulate or contract with the person giving you the gift? This is also future. If you know in the future they're going to be seeking a contract or some other type of agreement with you, then you would have to answer "yes."

Question 3, did you participate in the regulatory or contractual matters with that person? If you're going to be reviewing their proposal, application, or permit whatever it may be, then you need to answer "yes."

If you answer yes to all of those questions, then you are a Section 4 employee. As I mentioned, the $50 gift rule goes out the window. Stricter restrictions apply to the types of gifts you may accept. You cannot accept flowers or plants, travel expenses. If you get into that situation, feel free to give us a call. It's based on the facts and where you're sitting in relation to that particular entity and whether you're in Section 4.

Food and beverage could be an issue. You're allowed to go to a hosted reception, which the Ethics Board has defined as: You walk into a room and there's approximately 300 people. You know some of them and don't know some of them. They may be state employees, maybe not. Some may be from an industry. There are tables on either side with food. That's the general rule. If you're sitting down, there's silverware, salt and pepper, linens, and people are bringing you your food, it's no longer a hosted reception.

There's a limited exception in the Act for meals in the course of your ordinary business that are infrequent. Let's say you're invited to a working lunch, where lunch is going to be provided, but it's part of a working lunch. You're there in your official duties and it happens maybe once a year. It may fall under Section 5. Section 4 employees can still accept all those promotional items, the pillow mints and all that stuff.

Slide 10 – Use of State Resources. 33% of our cases come under this section. You cannot use state resources for your private benefit or gain. The resources are given to you by the state to do your job. We're able to see what Facebook pages you've been on, what you commented on, what you posted, which bills you paid, where all your banking institutions are, what you printed, how long you took editing things, what printer you printed things to. We get a comprehensive snapshot of how you've been using the resources that were given to you.

Pete Cutler: Just to be clear, that's only for state supplied computers. It's not your home computer.

Kate Reynolds: Correct. There is a de minimis use rule. It has to meet all the following criteria: occurs infrequently, use is brief, little or no cost to the state, no interference with official duties not done to support an outside organization, does not support a private business, does not compromise the security or integrity of state property, information, or software. If any of the above are knocked out, it's no longer considered de minimis use under the rule.

De minimis use is brief and infrequent. It could be making a medical appointment, sending a brief email to a significant other or your child because maybe they got out early and you just want to make sure they got home safely. Or, if you don't have a fancy smart phone and you're going someplace after work that you don't know how to get there, go ahead and MapQuest it and get there safely. Those are some examples of brief and infrequent.

Lou McDermott: If somebody from the Board has a question, are they to ask Dave? Are they to ask Katy Hatfield? Are they to ask you?

Kate Reynolds: You could ask anybody. We're considered the subject matter experts so if it's easier, come directly to us. We are more than happy to do that. It also depends on how things are set up, because there are some agencies that have a chain of command for questions. You're not prohibited from coming directly to us.

Lou McDermott: Dave, some guidance on that for the Board Members. For me, we have an agency ethics advisor, and I would go and talk to that person. But, for others on the Board, if there's multiple paths for them, what are their options?

Dave Iseminger: Board Members can go directly to Katy Hatfield. It could be to me. We can provide insight from our experiences in the agency. I'd be interested, if there's something Kate's giving advice on, if it's something that the agency can learn from as well. But, Kate said you're not prohibited, and you can certainly go directly to Kate. If there are things you're comfortable sharing, I can be part of the conversation so that the agency can also learn. I think that there's value to that, too.

Kate Reynolds: Sometimes we get emails where the ethics advisor or the AAG are copied on, as well, because they want everyone in on the conversation. That's always an option. Every agency is required under the Act to have an ethics advisor. They are a great resource because they are our first line of defense in terms of asking questions. They know the agency players and the specifics that we might not. If they don't know the answer, they will come to us.

Katy Hatfield: I was hoping that you could explain for the Board a little bit about how Section 4 might interact with their specific roles in terms of that they are not in the contracts unit at HCA, they are not sending out the RFPs, they're not reviewing the actual bids that Kaiser, Regence, and Premera are sending back. But, yet they still have a role in voting on final products that will be provided, and they also provide feedback during the contracting process. Can you talk about how that works in real life?

Kate Reynolds: Any time you're in that relationship where you're approving, disapproving, providing feedback, can make discretionary decisions - any of those things -- you're most likely in a Section 4 relationship with that entity/individual who is coming before you. In an abundance of caution, depending on what they're approving, too. We would need facts like where are you in the process? What is your role in the process? In an abundance of caution, I would say, safely, if someone's coming before you to seek approval on something, then you're most likely in a Section 4 relationship with them, and you should not be accepting gifts from them. That's a good baseline to start from. If you have specific questions, because the relationship with the individuals coming before you is a little murky, whether it would fit under that, then call us and we can start asking questions to see which line you're on.

Dave Iseminger: I can provide more clarity. We will often, in the contracts, the agency will bring forward the plan designs, although there are obviously carriers behind that. We're presenting the recommendations around the plan designs for your approval. All the contracts have clauses that are subject to Board approval, which means if the Board doesn't approve that plan, we would terminate the contract. That is a direct relationship

that is probably a key factor that might help people feel more comfortable, that the assumption should be that they're Section 4 employees.

Kate Reynolds: I would totally agree with that. The other thing, too, I should note, is that sometimes people will come and drop a plate of cookies for the Board Members as a thank you for all the hard work you do. With those guidelines sometimes I say, you know, it's best to just put that out in a general area where everyone can eat the cookies, and not put them all in your pocket and go home with them.

Dave Iseminger: Everyone's looking at the food HCA put out because we had them here since 9 a.m. for eight hours.

Kate Reynolds: The agency is not in a Section 4 relationship with the Board. It's okay to eat the muffin.

You cannot use state resources for political campaigns. There's no de minimis use under this. It doesn't mean you can't be politically active. You just have to do it on your own time, with your own resources. You have to do it as a private citizen. You're passionate about environmental issues and believe everyone must get involved. You bring a copy of the environmental ballot initiative petition to the Board Meeting and ask all of the Board Members to sign it. That's a violation.

Sean Corry: On Slide 17, it's a violation if that petition or ballot measure is brought to work and time is spent soliciting signatures. But, it's not a violation if I were to do it with my neighbor who happens to work with me at the same agency.

Kate Reynolds: As long as you do it after hours and not on facilities. If you say to your coworker, "Meet me in this neighborhood and we'll go doorbelling for an hour after work," and take off your HCA sweatshirt, you'd be fine.

If you're asked by a local politician for your support in their upcoming campaign and they want to use your name and commission title, they come to the commission headquarters, take a picture of you standing in front of the commission, use it in their flyers and on Facebook, you need to be really careful with this. There's actually an advisory opinion on this that you can use your title, but you have to use a disclaimer. You have to say, "I'm not speaking on behalf of my agency, board, or commission. I'm speaking as an individual." I would be very careful with that because it looks like you or the agency itself is endorsing, or commission itself, and not just you. You need to be mindful of that.

What this boils down to is public trust. The public is trusting you with all the resources and the time to do the job that you've been appointed to do, you have to keep that in mind, it's about that public trust and being good stewards of the trust that they've put in you.

We have a 90-minute online training. We also have tons of materials online, our enforcement and final orders or stipulations, the advisory opinions, and FAQs.

Dave Iseminger: Kate, if they email you a question with a lot of sensitive information, how does your advice interact with the Public Records Act?

Kate Reynolds: You do not have attorney-client privilege with me. I am not anyone's attorney. I don't give privileged advice. Anything you send to me would be subject to the Public Records Act. We get a lot of phone calls. There are a few things I prefer to do in writing. Just because it's so factually intensive and it really depends on one fact or another. That's post-state employment advice. I will always push it on to email. And some conflicts of interest. If they're really complicated and there are a lot of different players and a lot of different roles, then I will ask you also to put that in writing so I can really take a look at it. Other than that, you can call us.

Lou McDermott: Thanks, Kate. The Board will meet in Executive Session during the lunch period, pursuant to RCW 42.30.110(1)(d), to review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs; and pursuant to RCW 43.30.110(1)(l), to consider proprietary or confidential non-published information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session will conclude no later than 1:30 p.m. The public portion of the meeting will resume no earlier than 1:30 p.m.

Group Vision Plan(s) Procurement Update

Lauren Johnston, SEBB Procurement Manager. Slide 2 – Status. Eight proposals were received in response to the group vision plan procurement. Three apparently successful bidders (ASB) will move to the next phase. They are Davis Vision, EyeMed, and MetLife. MetLife will negotiate to offer only a fully insured plan as they did not submit a bid for a self-insured plan. We will be asking the Board to take action on Policy Resolution 2018-35, which will establish a separate group vision plan. We will also be going into contract negotiations with all three ASBs, as well as working on plan designs and rates.

Slide 3 – ASB Response Highlights. Based on their responses, the ASBs cover the comprehensive eye exam, as well as prescription lenses, frames, contact lenses, and other lens options (ultraviolet coating, transition lenses, tinting, anti-scratch, etc.). There will also be the option to have online or in-person purchasing of hardware. All three ASBs offer a one-year warranty for prescription lenses and/or frames and customer service seven days a week.

Slide 4 – ASB Network Key Takeaways. Some of the ASB's takeaways have to do with geographical coverage, which include the potential for vision provider coverage in 37 Washington counties. Garfield and Columbia Counties have no optometrists or ophthalmologists located in those counties. There are none to contract with.

Provider coverage is available in the other 49 states, as well as Washington, D.C., Guam, Puerto Rico, and the U.S. Virgin Islands. Out-of-network coverage is accessible outside of the United States. If a member receives services while traveling abroad, they could receive services and submit a form for reimbursement. On the provider contracting side, these are credentialed providers. Some of the credentialing is done

based on their work experience, things like member complaints, criminal history, litigation, etc. We are also increasing rural access for members through provider contracting and the option to purchase hardware online. Some optical retailers that are potentially included are Costco, Pearl Vision, America's Best, and Lens Crafters.

Slide 5 - ASB Proposed Provider Locations. This map provides you with the number of providers in each county. It combines the three ASBs. It's a local overview of what it would look like in Washington, and the border counties in Idaho and Oregon.

Sean Corry: I have a question on the "combined." Picking on King County with 1,043 providers, is that 1,043 providers that are in common with all three of the vendors, or is it in every single one, whether that provider's contracted with one or three?

Lauren Johnston: It's combined. One might have 500 of the 1,043, another might have 200, another might have 300.

Sean Corry: So, if we had all three plans in place, we'd have that number of providers?

Lauren Johnston: Yes.

Pete Cutler: Does that mean you have accounted for duplication so that, if the same provider signed up for all three they are not showing up as three providers, they're just showing up as one?

Lauren Johnston: That is my understanding, yes.

Dave Iseminger: I do want to be clear that we're entering the contract negotiation stage. None of this is final in any way, shape, or form. Obviously, nothing's finalized until contracts are signed and the Board has approved benefit design.

Lauren Johnston: Slide 6 – Considerations. I wanted to provide you some considerations to assist you in making your decision of whether or not to approve a separate group vision plan. Considerations on the left are for a separate group vision plan. Carriers who specialize in providing group vision benefits, as well as the option to purchase hardware online using in-network benefits, possible set copays or co-insurance for benefit options after the allowance is met. Instead of paying 100% after an allowance is met, there might be some copays or coinsurances that are set for the member that they would be aware of. Many school employees are already familiar with separate vision plans. There are more purchasing options without the member having to submit a reimbursement form. If I purchase hardware online and I use an in-network provider, I wouldn't have to submit a reimbursement form to my vision carrier. If it's an in-network provider, the claim would go through to the network carrier and they would pay the claim on my behalf instead of me having to submit a reimbursement form. There's also higher visibility into plan costs and utilization, so more transparency for the member. It could potentially mitigate the future Cadillac tax responsibilities under existing federal law.

Dave Iseminger: And, for that last one, just as a reminder, the current iteration of the Cadillac tax is supposed to hit starting in 2022. It's been pushed out by Congress several times, but it is still on the books and could hit. There are very few ways in which an employer with a high-value plan can mitigate their Cadillac tax liability. One of the interesting quirks of the IRS regulations in the law is that vision benefits count if they're embedded, but they don't enter the calculation if they're outside. That's, I believe, a 40% excise tax above a certain threshold. It is a significant tax.

Lauren Johnston: Considerations to continue to keep the vision benefits embedded within the medical plans is that regardless of the type of service that a member were to receive, the provider bills one carrier for all services. That would be their hardware, exams, any other kind of eye medical services they would receive. It would all go to the medical carrier. There is the potential for more contracted providers, based on the carrier that might end up being the final contracted group vision plans. Eye health services are more likely to be integrated and managed with medical services. Right now, there might be a disconnect between providers talking to one another, or the medical plan talking to the primary care provider or the eye doctor if there were to be some sort of an eye health problem that the member was facing.

Slide 7 – Proposed Policy Resolution SEBB 2018-35. Group Vision Plan(s). The proposal is to offer a group vision plan(s) beginning January 1, 2020 that is separate from the medical plans. By passing this resolution, the Board's intent would be no vision benefit coverage under the medical plans, except when required by law. Or in other certain situations, if a child was receiving a well child visit, the pediatrician was doing part of their well child exam, and the visual acuity exam work to be done in that visit. That's just one example.

Dave Iseminger: For clarity, this is the proposed resolution we're teeing up this time. We will push it into stakeholder review, but we are going to ask the Board to take action on this at the September 17 special meeting to help eliminate some of the variables as we move into the fully insured medical plan proposals that we'll bring to you in October.

Life and AD&D Insurance

Beth Heston, PEBB Procurement Manager. Our objectives today are to provide additional information about the proposed basic and accidental death and dismemberment insurance benefits and to take action on Policy Resolution 2018-31. We received a lot of stakeholder feedback.

On July 30, we talked about the basic life and AD&D insurance. We recommended a $35,000 basic life insurance plan, with a $5,000 basic AD&D. The Health Care Authority recommended benefit levels align with the current funding assumptions. The Board asked about pricing and increasing the basic benefit.

Dave Iseminger: The last bullet, “an increase or decrease of $10,000 in basic life insurance is estimated as ~$1 per subscriber per month (PSPM). I verbally committed to putting it in writing for your slides. That approximate, what does $10,000 or $1 in PSPM equal? We'll continue to provide this type of metric as we're providing recommendations on other benefits so you can see the types of relationship you could do to trade between different benefits. We'll try to put it in the context of a dollar PSPM.

Sean Corry: I don't mean this facetiously, but it's in this case about a buck per subscriber, but what are the parameters. Is it within ten cents? Or is it within fifty cents? What I'm saying, you've rounded it to the nearest dollar.

Dave Iseminger: Sean, when I say a dollar, I'm talking within a penny or so. We've asked the carriers to identify what a dollar equals? It happened to be $10,000. If it was $6,975, then it would be $6,975 as $1 PSPM. We're trying to benchmark it to a dollar.

Beth Heston: Slide 4 – Stakeholder Feedback and Responses. The first item of stakeholder feedback had to do with the increased coverage amounts. We wanted to put on the record and make everyone aware that amounts of basic life insurance over $50,000 have tax implications for employees under the IRS code. It's perceived as taxable income. Taxes have to be paid on those amounts. It's an imputed salary and it's based on an IRS table that we've included in the appendix of this presentation. It becomes a calculation of what it's aligned with.

Dave Iseminger: The important thing here is we're highlighting that there's extra impact on employees of having an amount that's imputed into their tax returns as an amount that they then owe federal income tax on. It's just for the education of the Board that once you hit that $50,000 threshold, there's imputed income for the value above $50,000. We put one illustrative example, to give you a sense as to what that imputed taxable income is. It's not something the Health Care Authority has done at this point. We do have an understanding from WASBO officials that some payroll processes in school districts currently have the ability to handle this. We haven't been able to confirm that as widespread, but, there is this assertion that there is this ability and some employees currently do this imputed income. We want the Board to be aware of that implication on an employee's taxable income.

Sean Corry: I was about to say, essentially, that you just said, that is routinely done by many school districts already. It's a payroll function that's in their system that's fairly easy to do and being done.

Beth Heston: We also wanted to talk about benchmarking insights. We looked at 2018 carrier data. We asked for the employer and employee paid data be separated. What we got was mainly combined funding sources. Despite these limitations, looking at the overall limited data, the suggestion is that employer-paid life insurance benefits do not currently exceed the $50,000 cap for the majority of school districts.

Dave Iseminger: Let me paraphrase a bit. Earlier today I talked about the April carrier data the agency got and there are some limitations, particularly when it comes to life insurance and disability. That was my breadcrumb to pick up and reinforce that there are a lot of limitations when it comes to life insurance because we had roughly about half of the school district data that was provided as part of that carrier request. When we talked to our actuaries at Milliman, there were a lot of concerns about being able to draw specific conclusions. What they could tell in a general brushstroke from what they received is it seemed that, generally speaking, most school districts had a benefit that was under $50,000 as a basic employer paid. We know there are definitely examples against that. What we saw in the carrier data provided, again acknowledging that it has

some limitations, was that of roughly half of the school districts represented in that claims pool, it was suggested that it was below $50,000.

Sean Corry: That's a different measure than counting heads who are enjoying that higher level of benefit. I think the larger districts generally have a higher benefit than $50,000. Which means, I think the majority of employees have the better benefit.

Dave Iseminger: We're providing the examples of data that we do have, acknowledging its limitations. Back in December, we did a comparator in Seattle, Spokane, Lynden, and WEA. We know there are instances where they are higher, and it's not on a head count basis that we're providing this. We're giving you the information we do have.

Beth Heston: There are ten school districts currently insured by our carrier, MetLife. They're non-PEBB participants. In that group, the average benefit for employer paid is $14,200. One district has $50,000 and the most common benefit is $10,000 employer paid. We can also compare that to the federal employees' group life insurance.

Lou McDermott: Beth. Total lives?

Beth Heston: I don't have that number.

Dave Iseminger: Total lives in the $10,000? We can follow up with that.

Lou McDermott: I was curious if it's 100 people or 1,000.

Beth Heston: The federal life insurance benefit is 1/3 paid by the government, the other 2/3 paid by the employee. That benefit is one times salary, rounded up to the next $1,000 - plus $2,000 on top of that. The average benefit for federal employees is about $83,000. But, again, they're paying 2/3 of that themselves.

We also looked at the public sector of other states. In nine states, there is no employer-paid life insurance. Five states have $10,000 or less. Five states are in the $15,000-$25,000 range. Two states have $25,000 - $50,000. And then, six states have one times salary. No states that we reviewed, in the total of 27 states, included spouse or child life coverage in employer-paid benefit.

Dave Iseminger: With that piece, we were trying to find additional benchmarks to provide you. The public sector, it's very hard to determine exactly when school teachers are included, or if it's other public sector pieces. We're trying to give you a sense in the public sector from what we can see, different pieces of information about different ways there is employer-paid life insurance coverage.

Lou McDermott: Sean, do you have experience with whether or not dependents are covered with basic? Or, is it usually just the employee?

Sean Corry: Both. It is usually just the employee. But in some cases, there is a small amount of dependent life that comes with the basic package.

Beth Heston: I'm going to talk about that now because one of the other pieces of feedback we got was that some school districts' medical plans have embedded life coverage for the employee, spouse, and dependents. Our comment on that would be under PEBB. Under SEBB, we believe the employee medical premium contributions will be taken as pre-tax deductions. When the benefit is paid, the beneficiaries have the tax burden. If you choose $50,000 of coverage and you pay with pre-tax dollars, when the $50,000 is paid, it won't be $50,000. The tax burden is subtracted from that. It makes the true value of the death claim a little less definite. As I said, depending on the given tax situation, the amount could be different.

Dave Iseminger: The other pieces harken back to the conversation about the cafeteria plan that Tristin Leppa-Sullivan provided last April. We were envisioning under the plan that medical would be taken pre-tax and save those payroll tax deductions, or lower taxable income on that piece. Life insurance would be on a post-tax basis. That way, an individual would have assurances that whatever amount they elected truly was free and clear under IRS rules at the time the benefit was taken. We wanted to make sure that, although there was the stakeholder feedback about this, there wasn't a specific request to have life insurance embedded, but, we wanted to make sure we explained to the Board what the assumption was about how those premiums would be paid and the reason for that recommendation.

Beth Heston: The other thing about including dependents, whether they're spouse or children, in the risk pool is that the employees seem to be relatively healthy because they're actively at work. When they subscribe, when spouses, state-registered domestic partners, and other dependents are included, there's no assumptions to be made about their health. That causes us to get higher risk scores because they don't know who they're getting. Higher risk scores generally mean higher rates. That's another drawback of having it embedded.

We had questions about whether employees' current insurance amount above the new proposed plan's guaranteed issue could be grandfathered. We are discussing the possible transition opportunity related to honoring some existing coverage amounts. It's still under discussion; and of course, our goal is to minimize disruption to the members as they come over. The next point brought up was that some school districts use a higher employer-paid life insurance coverage as a recruitment tool. We want to emphasize that, under the statewide risk pool, we can't offer varying amounts to different employees. That speaks directly to the equity of benefits. There was talk about that putting a district at a recruiting disadvantage, but when everyone's getting the same amount, no one has any advantage or disadvantage.

Dave Iseminger: Remember that this Board has the exclusive jurisdiction with regards to this benefit. The local school districts, ESDs, and charter schools don't have the ability to offer competing or additional supplemental plans beyond what this Board authorizes.

Slide 8 – Proposed Resolution SEBB 2018-30. Basic Term Life Insurance and Accidental Death and Dismemberment Insurance. We're not asking the Board to take action on this proposed resolution today. I want to highlight one small change that was

made to this resolution based on the discussion the Board had at the last meeting. At the end there is an extra clause that says, "unless modified in a subsequent resolution by the Board." This is true of all resolutions. I've tried to describe the iterative process that the Board can revisit different pieces, then some resolutions don't need to be amended. The policy idea is a separate stand-alone resolution. I felt the Board wanted extra assurances in this particular instance, so I did want to say that it would be true, regardless of whether those words were there, but I felt that the Board really wanted those words written in. We've added them in the current proposed version. We will ask the Board to take action on Policy Resolution SEBB 2018-30 at the October 4 meeting. We believe there will be even more context about the entire benefits package at that point.

Pete Cutler: As I wrestle with this, I think I mentioned prior in a Board Meeting, I'm a big fan of the life insurance benefit and the basic life insurance term benefit. In my mind, the accidental death and dismemberment insurance is roughly equivalent to having employer funds pay for lottery tickets. It's a benefit with no real basis in policy. I was wondering, would it be possible to split this into two separate resolutions, so when it comes time to vote, I can robustly endorse one and not have to go on record as endorsing the other?

Dave Iseminger: We'll take that under advisement; but, you can always put on the record, if there is any subset of a resolution that you're uncomfortable with, ultimately say yes or no, and describe all aspects of a resolution and your concerns about any part of any resolution. I will say that when the resolutions went out for stakeholder feedback, there was not a request to eliminate the AD&D benefit. The request was to increase the AD&D basic employer benefit. Apparently people want more lottery tickets. I'll remind you that, when you look at the total premium that's paid, for example, on the PEBB side, we spent somewhere between $6,500,000 per year on the basic benefit to the carrier. For the AD&D, the $5,000 benefit on the PEBB side, it's about $100,000. The cost of that, if you wanted to horse trade the money related to AD&D, it's such a small amount that there really wouldn't be much you could trade that for. That's another related factor.

Pete Cutler: I thought it couldn't hurt to ask. Secondly, if they are split, I will not feel bad at all if it's an eight to one vote; however, we have many members on the Board. I understand it's not particularly material in terms of the overall package of benefits, but there's just some part of me, my past life as a budget analyst, what I consider a rational benefit policy for an employer-paid benefit of this type, I prefer not to be on record in support of it. So, thank you. Whatever the Board or the agency decides, I'm fine with. Thank you.

Dave Iseminger: I think this record may be adequate enough to describe your lack of appreciation and support of that benefit. I think it will also be in the July minutes. So it can be in July, August, and October's, if you'd like.

Beth Heston: Slide 9 – Basic Benefit – Next Steps. We'll ask the Board to take action on the policy resolution at the October 4 meeting. If the basic life benefit exceeds $45,000, rates for both the basic and the optional coverage will be re-evaluated. But,

the optional benefit design would not need to be reconsidered because if we raise the amount of the basic benefit, we could have what we generally call "adverse selection."

Dave Iseminger: At the last Board Meeting, there were some questions. Could you take action on the supplemental benefit, because, if you ended up changing the basic benefit, what's the relationship there? That's the transition point to the rest of the presentation, which is asking for action on the supplemental life insurance benefit because the benefit design would not need to be revisited. We will go through the rates that go with the supplemental benefit design in the slide deck. If the Board were to consider a different benefit design, we would also try to describe to you the potential impact on the supplemental rates at the same time. But, they are sufficiently divorced from each other. We felt the Board could proceed with the benefit design on the supplemental benefit.

Beth Heston: Slide 10 – Recommended Supplemental Life Insurance Plan. This is the layout of the supplemental life insurance design, up to a guaranteed issue, with no evidence of insurability, no need to take a health test. The amounts over $500,000 would require evidence of insurability. That's for employees. And then, up to 50% of the employee's supplemental, with $100,000 for the spouse or state-registered domestic partner. A supplemental dependent term life of $10,000 - $20,000 in $5,000 increments. That is all guaranteed issue. And, lastly, the supplemental spouse, employee, and child AD&D, those are guaranteed issue, no need for -- can't medically underwrite an accident.

I spoke to MetLife just before the meeting to make sure I had the most recent statistics. When people sign up for the supplemental life insurance, if they choose to do EOI, they are asked to fill out the evidence of insurability questions online. Statistics are that 60% of people pass immediately and are approved for higher amounts. The evidence of insurability is not elaborate in that case.

Slide 11 – Supplemental Employee and Spouse Rates The rates listed are per $1,000 of insurance. You take the amount of life insurance in thousands, multiply it by these rates, and that will give you the monthly payment. All rates are guaranteed for five years.

Slide 12 – Supplemental Child and AD&D Rates. These rates are guaranteed through 2024.

Dave Iseminger: I want to talk about subsidization. I want to remind the Board that there are no premium reserves that can be used to subsidize any rates. If you take these rates and compare them to the PEBB population, you'll see that the PEBB Program population is paying less right now. As the PEBB Program transitions to MetLife, there are some premium reserves that needed to be spent down so there's a subsidy on some of those rates. Yours are comparable rates, when you take out the subsidization on the PEBB side. I did want to make sure that you were aware of that. Here, there are no subsidies or no premium reserves to use to lower these rates, even in a short-term period.

Beth Heston: The reason for that is it will be a non-participating plan.

Dave Iseminger: It's also because we're starting a plan and there's no money when you start a plan.

Beth Heston: The next few slides are examples of supplemental premium calculations. Slide 13 is for a smoker, 35 years old with $200,000 on himself and $100,000 on their spouse. They'll be paying $18 a month for their employee coverage and $9 a month for their spouse coverage. The example of the 50-year old non-smoker who chooses a $150,000 supplemental employee coverage, and $75,000 for the spouse, which is 50% of the employee's coverage. The rate is $28.50 per month. And $14.25 for the spouse. Slide 14 is child life with $20,000 of supplemental child life at $2.48 per month. Supplemental employee and spouse AD&D for $250,000 in coverage would be $4.75. $25,000 in supplemental child AD&D would be $0.40.

Slide 15 – Policy Resolution SEBB 2018-31. Supplemental Term Life Insurance Plans.

Dave Iseminger: When we went through stakeholder feedback earlier in the presentation, the stakeholder feedback was all about basic life insurance. There were no specific concerns related to the supplemental benefit we provided. There was one question, I believe sub-bullets 2, 4, 5, and 6 didn't have a reference to guaranteed issue. A few people thought there would be clarity at the resolution itself on guaranteed issue. The only change made was one piece of feedback clarifying guaranteed issue. GI was added to the end of all of the bullets, to provide clarity to the stakeholder response.

Katy Henry: Beth, can you confirm for me that it doesn't matter what the age or the smoking status of the spouse is?

Beth Heston: It's all dependent on the enrollee, the subscriber owns the account. So, it would be the employee themselves.

Lou McDermott: They're going to pay the smoking rate for the spouse, even though the spouse is a nonsmoker for the insurance? That's what we're saying, it all keys off the subscriber? If the subscriber is a non-smoker and the spouse is a smoker, we're paying the non-smoker rate for supplemental insurance for the spouse?

Beth Heston: Yes, because the way our plans work, the plan actually belongs to the employee, so, their status is what's most important.

Lou McDermott: For rates.

Beth Heston: For rates. Also, the age is based on the last day of the tax year.

Lou McDermott: **Policy Resolution SEBB 2018-31. Supplemental Term Life Insurance.**

Resolved that, beginning January 1, 2020, the voluntary employee paid supplemental life benefit will include:

- An employee supplemental death from any cause life insurance benefit of $500,000 guaranteed issue (GI), up to a maximum of $1,000,000 with medical underwriting for amounts over $500,000;
- An employee supplemental AD&D benefit of $30,000 up to $250,000 GI;
- A spouse or state-registered domestic partner death from any cause life insurance benefit of up to 50% of the employee supplemental elected amount with $100,000 GI and amounts over $100,000 with medical underwriting;
- A spouse or state-registered domestic partner AD&D benefit of $30,000 up to $250,000 GI;
- A child death from any cause life insurance benefit of $10,000 up to $20,000 GI; and
- a child AD&D benefit of $10,000 up to $25,000 GI.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-31 passes.

Dental Benefits

Beth Heston: Slide 2 Policy Resolution SEBB 2018-06 – Fully Insured Dental and Slide 3 – Policy Resolution SEBB 2018-07 – Self-Insured Dental, both passed by the Board on March 15, 2018. These resolutions will leverage features of the Uniform Dental Plan.

Slide 5 – Overview of ERB Dental. The Employees and Retirees Benefits Division has three dental offerings: DeltaCare Dental Plan, which is a managed care restricted network plan with 27,652 members enrolled; Uniform Dental Plan, a wide-ranging preferred dental provider organization administered for HCA by Delta Dental of Washington with ~226,000 members; and Willamette Dental Plan, another managed care plan with roughly 32,000 members. In the managed care plans, you have to see a dentist that belongs to the managed care plan. In a PPO, you can choose the dentist if they accept Uniform Dental. About 96% of dentists in Washington accept Uniform Dental. The majority of PEBB Program members have selected the Uniform Dental (PPO) Plan.

The proposed SEBB Program self-insured dental plan would be administered by Delta Dental of Washington. It would have the advantage of reaching that wide number of contracted providers. It would be like the Uniform Dental Plan, but with claims paid from SEBB funds, subject to financing decisions. The subscribers can see any provider that accepts Uniform Dental Plan. It is the preferred provider organization. It currently covers every county in Washington and some counties in Oregon and Idaho where it's accepted.

Slide 8 – Proposed SEBB Self-Insured PPO Option. We've shown you annual maximums for medical plans. An annual maximum for a medical plan is how much the subscriber has to pay per year. With a dental plan, an annual maximum is how much

the plan must pay during the year. So, they're not equivalent. The current deductible in the Uniform Dental Plan would be $50 for an individual and $150 for a family. I'm told it's a comparable deductible to the WEA plans.

Dave Iseminger: As a reminder for the Board, in the appendix is another recurring theme. We will always include the comparator slides presented at the Board for the various benefits at the December and January meetings. If you want to review the deductible pieces, it's Slide 2 in the Appendix. Any other parts of this benefit design, the other comparator parts, are in the rest of the slides and the Appendix.

Beth Heston: The general office visit, diagnostic, and preventative services are covered at 100%. Fillings and restorative dentistry, including porcelain crowns, is covered at 80%. Implants are not covered at 80%. We are discussing crowns that fit onto dental implants. Those are covered at 50%, but crowns that go on your live tooth are covered at 80%. Root canals are covered at 80%, and routine or surgical extractions are covered at 80%. Local anesthesia is covered at 80%. Dental implants and orthodontia are covered at 50% until the $1,750 maximum is reached.

Dave Iseminger: There's not a lot of orthodontia embedded within a dental plan in the current K-12 system. Where it exists, it exists as a stand-alone. This proposal would include that piece. We are aware there are a variety of different dental benefit designs that exist in the current K-12 world. There's the incentive plan design where, as you access preventive care in successive years, the cost share goes up over time. Part of what we're describing here is putting forward a self-insured option. I know as you read the resolution, you're going to see a lot of the words that say the same. One thing, as you look at a self-insured plan, thinking about the comfort level of taking on that risk, this is a plan design that many people in the state are familiar with the financing and costs associated with it. It will help make people comfortable with taking on that liability, as we've talked about, with the financing decisions that have to be made as this process goes forward. We will bring fully insured dental designs at the October meeting for consideration, and action at the November meeting. We are looking for the best ways to balance the different ideas of plan designs that exist, and see if there is a way to offer a variety of different benefit designs across the portfolio. Today's discussion is just with the self-insured plan.

Beth Heston: Slide 9 – Considerations. One consideration is to have statewide coverage with comparable rates to the PEBB Program self-insured plan. People in the state are used to the way the funding works. Orthodontia coverage is included. And, we believe that, compared to the other plans included in your appendix, we have a competitive benefit structure.

Slide 10 – Proposed Resolution SEBB 2018-37. So, the proposed resolution is SEBB 2018-37. Beginning January 1, 2020, and subject to financing decisions, the SEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks, and same clinical policies as the Uniform Dental Plan (UDP) in place for plan year 2020 under the PEBB Program. The cost shares (deductible, out-of-pocket maximums, coinsurance for services, etc.) will be the same as the UDP benefit under the PEBB Program.

Dave Iseminger: This syntax should look very familiar to you. It's the same syntax used for Resolutions SEBB 2018-20 through 2018-33 about the comparability piece. It's akin to Resolution 2018-20. It is that exact same structure and language. At the beginning, Beth provided copies of Resolutions 2018-06 and 2018-07. For purposes of proceeding with launch, directly leveraging existing contracts and not doing a procurement was a good way to go, considering all of the work on the table. There is a request and commitment through that original resolution to engage in further discussions about dental benefit design in 2020.

Beth Heston. Slide 11 – Next Steps – October. The goal is for the Board to take action on the Policy Resolution 2018-37 in October. There will also be a presentation of the fully insured dental options in October.

Eligibility and Enrollment Policy Development

Barb Scott, Manager, Policy, Rules, and Compliance Section. There is one draft Policy Resolution to discuss today. SEBB 2018-36 - Eligibility Presumed Based on Hours Worked the Previous School Year. This Proposed Policy Resolution would ensure that if a pattern is established, it would be presumed that the employee is anticipated to continue working 630 hours in the current school year if they are returning to the same position or combination of positions with the same SEBB Organization. In order to be clear, we have included examples of position types which is different from what we've done before. If the employee is not anticipated to work 630 hours in the current school year, the SEBB Organization would need to inform the employee in writing and provide the employee with their appeal rights or how to appeal an eligibility decision.

In RCW, the SEBB Organizations will be required to notify employees of their eligibility, which clarifies if this presumption isn't true, then the organization would rebut by putting in writing as to why the employee isn't anticipated to work 630 in the current school year. Employees are always required, based on RCW, to be given the right to an appeal. That information would be included in the notice.

Dave Iseminger: We put in that parenthetical teacher, para-educator, food service worker, etc., to make sure it was clear to the Board and employers that we didn't mean 4th grade teacher of social studies couldn't become a 5th grade teacher of language arts. It was not that granular of a position. It was more at a macro level. We felt that would be an assurance to both the Board, as well as the stakeholder community employers, about what level of position was really met.

Barb Scott: Slide 5 is an example of a part-time custodian not anticipated to work 630 hours or more during the 2020-2021 school year. But, in March of 2021, he actually worked 630 hours and earned eligibility for the remainder of the school year. The question posed is, is the employee eligible for the employer contribution toward SEBB benefits when he returns to work in the same custodian position for 2021-2022 school year? The answer, based on the proposed policy, is yes.

Wayne Leonard: I think for a lot of these positions, to make an estimate or a determination if you think they're going to work 630 hours in a year, is difficult for the certificate in classified substitutes that might become eligible. If they continue, because

the need for substitutes can vary greatly from year to year, depending on illnesses or depending on the amount of training that you put on. That's one area I would have concerns about, not necessarily presuming a substitute would be eligible if they attained eligibility in one year. Not necessarily presuming they would be eligible in the following year.

Barb Scott: In the notice that would go to employees, would you see that being communicated in the notice so it says, "based on what we anticipate in this upcoming school year, we don't anticipate that we'll have need for you in the same capacity as the prior year?" It being communicated to the employee, based on their eligibility change, is required by RCW today. The employee would have the right to an appeal of that decision. We included that language at the bottom part of the resolution to make sure it was clear that, if it isn't anticipated to be the same, if there are differences, then that would be articulated in writing to the employee and they would have that right to appeal.

Wayne Leonard: It's not that we don't anticipate the need for substitutes. We don't necessarily have a good way to anticipate the number of hours they will work.

Dave Iseminger: Wayne, are you expressing that you'd have concerns about how an employer would give specific reasons of not anticipating 630 because that's what this would require in the substitute setting. You're saying as this applies to substitutes, as Barb's describing it, the employer would have to describe in writing why Katy Hatfield, who was a substitute teacher in year one, isn't anticipated to have 630 hours this year and you're concerned about the ability to describe that lack of 630 hours in year two?

Wayne Leonard: Part of it is the way we fill substitutes. It's not necessarily by calling and scheduling them. They can actively go online to most of our online systems and seek positions. They may not want to work as much as they did the prior year. Or, there may not be the same level of opportunities from one year to the next, depending on flu outbreaks or the number of professional development trainings. I don't have any way to anticipate the number of hours they would work in any given year because they're not scheduled. Most of our other employees have a schedule for 180 days, X number of hours a day where substitutes do not.

Dave Iseminger: Wayne, you're expressing concern with the application of the presumption in the first place, in the substitute setting.

Terri House: Just to piggyback on what Wayne said, I read the resolution as employees, so, that's contracted employees within the school district. That would be the teachers, the para-educators, food service workers, custodians, bus drivers, etc. Subs are at-will employees. They can work when they want, like Wayne said. I think there needs to be some delineation between actual school district employees and subs, in that resolution.

Barb Scott: This will show my lack of understanding to some degree, but it has been my understanding that some districts actually have substitutes that would be considered employees of the district where others may not.

Terri House: I can speak a little bit to that. Our district employees, in certain job classifications, are considered "rovers." That's an actual paid contractual job. They may be a roving custodian so they don't have a home base, per se, every day. They may report to a different school. But, they have a job every day. They're expected to be there every single day.

Barb Scott: In some districts?

Wayne Leonard: I would add on to that. They actually have a contract for a certain number of days, whether it's 180 days, whether it's 260 days. They just don't know where they'll be working. They are employees, as opposed to a substitute that, you know, may come once a week, four times a month, or whenever you call them. They may fill in on an at-will basis.

Barb Scott: Are these substitute teachers? Or bus drivers? When we use the word "substitute" are we encompassing many different job classes?

Wayne Leonard: It could be multiple. It could be both classified and certificated staff.

Barb Scott: Was there a specific change to the resolution that you were wanting us to look at making before we send this out to stakeholders?

Terri House: I think the delineation between what is a substitute employee and a contracted employee, an actual employee, is by district.

Patty Estes: I think the issue is the presumption that they're going to work 630 hours because they worked 630 hours the year before. If we put another bullet point in justifying substitutes, there could be something we're getting into whether they're under contract or not, they're still school employees and they're under our umbrella for benefits if they hit 630. We're putting the responsibility of eligibility for those employees on the school district, or on the employers. The employers would have to do some kind of letter because they're not anticipated to work 630 hours in a given school year until they hit that, then they wouldn't be eligible, because there's no way to anticipate whether a substitute classified employee is going to work 630 hours in any given year or not. I think Wayne and Terri both have good points from my perspective. There's really no way to know, from year to year, how many hours a substitute will work, whether it's classified or certificated.

Barb Scott: Am I hearing you want us to include an exception for substitutes that actually presumes they would not be eligible until they actually hit the number of hours?

Patty Estes: I would say something along those lines. My school district gives letters to contracted employees, classified or certificated, at the end of every school year. It's a letter of reassurance for the next school year. Substitutes don't get anything like that. Our substitute classified employees, I speak from experience because I was one before I became a permanent employee, it depends on whether you get that phone call and can go in for that day. Or, you don't get that phone call. There's not a set amount of hours. It goes on a year-by-year basis.

Barb Scott: We will take this away and work with stakeholders.

Wayne Leonard: When I went back and looked back at my certificated substitute roster, for example, we have somewhere between 250 and 300 certificated substitutes on our list at various grade levels and various subject matters they're qualified to substitute in. When I looked at how many hours they've actually worked in the year, I came up with an estimate that probably 70 of them would become eligible in that year. But, whether in the following year, the same 70 would become eligible, or a different group would become eligible, I would not have any way to know. Some may become eligible again. Some probably wouldn't. I wouldn't necessarily know at the beginning of the year.

Lou McDermott: Do we have any parallels in PEBB?

Barb Scott: We have two categories of eligibility within the PEBB population that come to mind.

PEBB has eligibility for seasonal employees. If you have a season of three months or more, you are eligible for benefits during your season. If you work a season that is nine months or more, you also get off-season benefits. (You're eligible for the employer contribution during your off-season.) That language in the PEBB eligibility stems from work done when school districts were mandated to purchase coverage for their active employees through the PEBB Program, back in the early '90s. We have been looking at the seasonal employee eligibility. In the PEBB world, there's a presumption that if a seasonal employee is brought back for the second season, they're presumed eligible.

In addition to that, PEBB has some complicated language that is very unique to part-time academic employees, specifically related to faculty hours. Their eligibility stays in place until it is not mathematically possible for them to attain the hours.

Pete Cutler: I think Barb, from a policy and overall perspective, a key differentiator here is that with the substitutes, they're not planning on coming to work every day. With seasonal, you may only work a couple months, but you are going to work almost always. It's full time, but even if it's part-time, you have a position and you will be showing up for work. Whereas, with this unique situation with school districts, it’s the employee.

My father was one, he decided once he retired, he was working as a sub when he wanted to work and not when he didn't, which is a very different dynamic. I share the feeling that it would be good to have a third bullet that carves out positions, or people employed in positions that are that substitute. Now, you have to be careful with the use of "substitute" because in the world of a pension policy that some districts call people "substitutes," in reality they are in for covering a full semester or almost a full year. Anything short of a full school year, some districts would call them a "substitute." It's not that the employee doesn't have the option of, "do I want to go to work this day or week?" I wouldn't want the label "substitute" to have them not be included by the general policy. I think an additional qualifier should be included.

Barb Scott: I've shared the concern about a label. There is some litigation history related to that, especially with higher education institutions. Applying a label, just saying that a substitute would not be eligible, reminds me of some of our history with PEBB. We’ve been trying to figure out the true differences. What makes one position unique, compared to another is really where we want to be. We'll work with stakeholders. If you have specific ideas you want us to consider, I want to capture those, too.

Terri House: Instead of saying "substitutes," taking into consideration no labels, we're considered “continuing employees.” If we have a contract year to year, we're considered “continuing.” Substitutes, on the other hand would be non-continuing employees and have to achieve those hours in order to be benefits-eligible. Could you use language like that in the resolution?

Barb Scott: That may be very helpful. The reason PEBB has the presumption for seasonal employees is because, through litigation and other work related to that, we found there was somewhat of a practice for employers to bring back employees that they described as temporary or intermittent employees. They worked them similar to how they would a seasonal employee. They would bring the same employee, the same firefighter, back year after year and not give them benefits.

Working to put PEBB eligibility into RCW, where it lives today, was complicated. Working with a number of different stakeholders in order to get that legislation, we came up with the need for a presumption for seasonal employees. That's why we're exploring it here, to figure out if SEBB needs something similar to make sure the eligibility groundwork is laid, and employees know when they're eligible for the employer contribution and when they're not. If there is an appeal, we need to have sound eligibility to support us in that.

Sean Corry: There wouldn't be a problem with districts dealing with this presumption issue to take their time in presuming, leaving it to maybe having a 600-hour threshold, for example, before they're in the queue for the presumption of working 630. 600 sort of pushes it. That's only three days, four days off of 630, but, if you were to set up some sort of watch so you get a pop-up at some point, that might be helpful. Just a practical thought that I wanted to put out there.

Lou McDermott: Barb, in the PEBB world, I know the presumption is a little bit in the eye of the beholder, right? Different agencies apply that differently. Not that we would want them to, we would love it all to be uniform. But, different agencies have different books of business. I’m speaking to Sean's comment, that presumption of 630, many districts could come up with that in a different way.

Some districts could look at the previous years' experience. I know that may not be the best way based on your comments about sickness and turnover and things like that. But some districts, maybe large districts who have the law of numbers, say, "Everyone who got over 630 last year, and if they're on the rolls this year, we assume they're going to get over 630." Then, maybe having a break somewhere that says once you hit this certain amount, we look at how much time's left in a year and we give it to you. Would districts have flexibility to decide what that presumption is going to be?

Barb Scott: I guess that's how we set it up to some degree. In the PEBB world, you're right, not every employer administers it exactly the same, based on their own business needs. For example, I know in working with some of them that we pretty much know there's going to be a certain number of fires and a certain need for a core set of firefighters every single year in Washington State.

The Department of Natural Resources is going to know that they're probably going to need a certain number of pilots and a certain number of firefighters. They know there is going to be a core season. The season may run long on either end of it, or the season may run short. The season may be a horrific season and they have to bring in an additional 20 firefighters they weren't expecting.

In some of those agencies, they've said there are 70 seasonal positions. If it happens that Scott is brought back each time into one of these 70 positions, then we're anticipating for him to work the full season every year and we bring him back every year. But, if we bring Joe into one of the 20 slots that we need because we're having a really bad year, we don't anticipate we're going to bring Joe back the next year. He's going to get the letter saying, "We don't anticipate you're going to be back next year, so your eligibility ends on a specific date." You're right, Lou. They do it differently depending on what their business needs are within the different agencies. I would expect that we could do something similar to that for SEBB, but I haven't thought it through or worked it with stakeholders.

Dave Iseminger: I think, Lou, in your description you might have implied that there is a 630-hour presumption in the PEBB requirements. While there is a presumption, I don't want it to be implied that it's exactly the same one in here. There is a presumption, I don't think it's 630, and I don't think it matters what the number is.

I think you're brainstorming in a couple of different ways. This is a very difficult process for finding the exact words to use. We'll certainly look at if there a way to reference continuing employees, not using labels. We'll go back and look at the definition of school employee in statute and reconcile things there. Maybe there's a way to do a presumption, a threshold before the presumption kicks in. We appreciate the different ideas. We will do some work on this and still hit that two-business day promise to stakeholders of getting things out. We will definitely take back some of these ideas.

Katy Hatfield: One thing about seasonal workers that's a little bit different in the PEBB world than in the SEBB world that I think is important to keep in mind is that, for PEBB, with seasonal employees, it's not just about working the season that makes them benefits eligible. It's also a secondary requirement that they're expected to be a repeated seasonal employee. If you get hired for one blueberry season and you're only going to work for one blueberry season, you don't get benefits. It's only upon the employer thinking that they're going to come back the next year as well. The presumption in PEBB is about presuming the person is coming back again once they've established a pattern of coming back every year, and you don't have that kind of overlay in SEBB where there's going to be a situation where somebody needs to be presumed to be working the next year to be benefits-eligible. Keep that in mind when you're thinking about brainstorming how to do that, because the seasonal employees for

PEBB, while it is interesting, and I think it's important to look at, it really is quite different than SEBB.

Barb Scott: That's true. They aren't even apples and oranges. In the PEBB world, there is language that says the employee is going to work a season of three months or greater, so it's between three and 11 and the employee is going to work the half-time threshold, which is 80 hours a month for the PEBB Program. Also, they are anticipated to return the following season. It's that "anticipated to return the following season" provision that exists in the PEBB eligibility, which does not exist for SEBB. Part of the difficulty here is that PEBB, through evolution, litigation, and years of work, has substantial eligibility in RCW. SEBB does not yet. We're working off very minimal language in the RCW.

The next step will be to send this out to stakeholders, and bring something back to the Board on October 4. I won't see you, other than in the audience, maybe, on September 17.

SEBB Program Rule Development Plan and Process

Rob Parkman, Policy, Rules, and Compliance Section. Today we'll take a look at our high-level plan, which is our two-year plan we started about ten months ago.

Slide 3 – High-Level Rule-making Timeline. We started our timeline on November 3, 2017. When the program was starting up, we started to work on rules planning. We actually started the development for what we're calling the first cycle, or first phase, which we're in right now. We started that in February 2018 through the end of the year. February was work groups trying to figure out the RCW and figure out a path. Since then, we have actually developed rules and sent them out for stakeholdering.

We'll rapidly transition into the second year, almost the next day. We'll start the second phase or cycle. Within that, we're going to start in early January and be done by October, which is open enrollment. And then, we go live January 1, 2020.
From a rule-making perspective, we need to be done by July 2019. Rules are the starting point for other products that support open enrollment and Go Live. If we wait too long, the other teams will not have time to do their work. We are on a fast pace to baseline rules that can be used to run the program.

The goal for year two is to make additional tweaks to rules from the first cycle and add other rules as needed. We won't be able to get all the rules done in the first cycle. We have already identified rules for the second cycle.

Slide 4 – 2018 SEBB Program Rule-making Plan. This graph is the HCA rule-making plan sheet. The legend on the bottom left has a triangle that's actually statutory requirements we will follow. The oval identifies HCA requirements. Starting at the top left corner, we start with the CR101, which is one of the formal rule-making products we need to produce. We started working that in May and turned it into our rules coordinator on June 1. She filed it with the code reviser on June 6 and our CR101 was published in the Washington State Register on June 20.

Dave Iseminger: Rob, a CR101 is trying to describe the scope of the forthcoming rule-making. It's a very high-level description of the work that's about to be done under The Administrative Procedures Act rule-making process. It's very high level.

Rob Parkman: Correct. For this one, since they're all new rules, we opened three new chapters and we will be conducting eligibility, enrollment, and appeals within these chapters. Then, on the left side coming down vertically, you can see where we've actually done a lot of the drafting and stakeholdering. That began on February 1 and went through July 20. That's where we developed the first set of rules and sent them out on July 21 through the first part of August for internal review. The internal review is the inside HCA review with a little legal help outside of HCA. That produces multiple comments, which shapes the future product. That shaping happened in mid-August this year. The blue box is the external review, and that's where we stand now. That was sent on August 20 and it should be concluded by tomorrow. We already have multiple comments and have started to work.

Dave Iseminger: Rob, can you tell the Board how many stakeholders currently receive the rule-making products?

Rob Parkman: We send to the same group of stakeholders we sent all of the proposed resolutions to, which is a group of about 10 or 15. We sent it out through GovDelivery, which is about 450 email addresses. It was the first time we used GovDelivery for rule writing. It was a very broad reach.

Dave Iseminger: Anyone can sign up for the rule making on the Health Care Authority's website.

Rob Parkman: I want to talk about the external review document that was sent out on August 20. Today's Board meeting had a number of resolutions, three of which you passed. Those are in that document. We were trying to get as much into it as we could because external stakeholdering is a key piece of the process. We don't want to add too much after we get through external stakeholdering. One thing I did add that I will soon be taking out is Policy Resolution SEBB 2018-32. It was withdrawn today so it will come out of this external review. We will not be moving forward with that at this time.

Dave Iseminger: Rob, similarly, if the Board had delayed action on one of the other resolutions today, or had not taken action on it as had been anticipated, those pieces would have been removed as well. We don’t presume to know what the actions of the Board will be, but it's easier to pull than it is to add. That's how the annual rule-making process works.

Rob Parkman: We’re trying to get as much as we can in the first cycle. Once we complete the external review tomorrow, next week and through the middle of September we will be reviewing those comments and probably using them to shape the next document, which is the CR-102 document. This is our last review before the CR-102 cycle. After we get done in mid-September with external review, we go to the typing service. Mid- to early October we will be sending to the typist who put it in exactly the right form the Code Reviser needs. Across the bottom now is the CR-102 on the left, and then the CR-103 on the right. We will file the CR-102 through the HCA

rules coordinator on October 19, file October 24 with the Code Reviser, publish on November 7, and hold a public meeting right after Thanksgiving, which is an open public meeting for anyone to provide comments on the rules.

We will file the CR-103 on November 30 with the HCA rules coordinator. She will file those on the December 5 and they become effective January 10. That will be our first year of rule making.

Dave Iseminger: Your takeaway from Rob's presentation is that this is a very complex process, which the agency has a lot of experience with.

Rob Parkman: Slide 5 is the 2019 SEBB Program Rule Making Plan. We start the next drafting of rules on January 11. Very similar slide. Just the next year. I'm going to start with the upper left blue box. The last plan ended on January 10 and this plan starts on January 11. We will start rule writing in the fall and winter, so we can roll right into it. It's a much shorter rule writing this time, with internal review in March, and then out for external review. The goals is to get the rules in place so our Communications Team can start to produce necessary documents and our Outreach and Training Unit can start to produce the documents they need to support open enrollment and Go Live on January 1, 2020.

Slide 6 – SEBB Program Rules High-Level Authority. The green box in the middle of the slide is the Washington Administrative Code (WAC). That is what we are producing. We have authority to produce those rules from multiple places. At the 12 o'clock position is this Board. The power for this Board comes from RCW 41.05.740. A vast majority of the resolutions that Barb Scott has been bringing to you over the last few months directly flow into the rules. At two o'clock position, you see the Revised Code of Washington. There are other RCWs that influence the rules, for example, the other parts of 41.05 and Title 48, which is the insurance code. At about the 4 or 5 o'clock position, you see the state budget. Besides the money that comes out of the state budget, which is very important, but, not so much of a rules impact. A rules impact is a budget proviso that requires us to do surcharges. From that, we get the spousal surcharge, spousal/state-registered domestic partner surcharge, and the tobacco surcharge. Those are included in rules.

Dave Iseminger: The budget proviso, if you want to go find it, is in Section 504 of the budget. It's in the 500 series.

Rob Parkman: Correct.

Dave Iseminger: I believe it was also included in your Board packets in either April or May as the authority for some of the resolutions this Board passed related to setting tobacco use and tobacco product definitions.

Rob Parkman: At about the 7 o'clock position, is the Health Care Authority. The power for the Health Care Authority comes out of 41.05 RCW and, in particular, the major impacts is the appeals. The authority for appeals is with the Health Care Authority. We also have the cafeteria plans, and run the programs. Around the ten or eleven o'clock position, you have federal laws. They certainly do impact. The rules that are out now

are a section on COBRA and a section on the Family Medical Leave Act, or FMLA, which, again, are related to federal legislation.

Slide 7 – SEBB Resolution Tracking. This slide is a tracker of what we currently have going on. All the resolution numbers that come before the Board are tracked on this spreadsheet. We track them not only for where we are right now, but for historical purposes. I have done a little filtering and you can see that we have 2018-12, 2018-26, and 2018-27. We also track the description. We show these are currently active, they were passed by the Board, and the date they were passed by the Board. The box on the right shows the WAC in which the resolutions were incorporated.

This is a living document. At some point, you could change any of these resolutions. I will make the resolution inactive and indicate it was superseded by another resolution. Then, I would track that other resolution to where it's actually used in rules. Over time, this will help us keep track of how we make changes.

Slide 8 – Draft SEBB Program Rule. This slide is an extract out of the current WACs currently out for external review. This particular one is WAC 182.31.040, establishing eligibility. The first big block says, "Sub 3 school employees eligibility criteria." It's the actual resolution you passed, SEBB 2018-12, and now it has been incorporated into rule. The smaller box on the right is SEBB 2018-27 and the bottom box is SEBB 2018-26. This slide is the flow down from your approved resolutions into rules.

Pete Cutler: On Slide 7, where you make the references to its use within WAC 182.32.040, or whatever. I'm 99% sure you're talking about these are proposed rules or proposed drafts? We really don't have any rules just yet, but we have drafts.

Rob Parkman: By January 10, 2019, we would hope to actually have effective rules.

Pete Cutler: And then they will be the actual rules? Great. Thank you.

Rob Parkman: Slide 9 – SEBB Program Rules Structure. This is a living document. As of August 10, the asterisk at the bottom indicates changes can be made. Actions of the Board influences that change. There are three chapters: 182-30 – Enrollment Chapter, with 12 sections; 182-31 – Eligibility Chapter, with 18 sections; and 182-32 – Appeals Chapter, with 45 sections. At this moment, we have 75 sections, 64 of which are currently out in external review and we are processing in this phase of rulemaking.

Next SEB Board Meeting
September 17, 2018
1:00 p.m. – 2:30 p.m.

Combined SEBB & PEBB Meeting
September 17, 2018
2:45 p.m. – 4:45 p.m.

Potental Agenda Items for September 17, 2018 Board Meeting

Dave Iseminger: At the September 17 meeting, we'll discuss the vision benefit stand-alone resolution along with reviewing stakeholder comments received; disability benefit designs and propose resolutions for action in November.

We'll have a joint meeting with the PEB Board for further discussion of the K-12 Retiree Report that's due from the agency at the end of the year.

I have one item to correct in the record. I forgot to do it while Beth was here. Under Tab 11, in your Appendix, Slide 3. We realized we switched the framework as we were moving from left to right over the columns. On Slide 3, on one of the dental comparison charts under the Health Care Authority PEBB benefits, it says preventive screening -- zero dollars. That framework was from the members' perspective. But, the entire rest of the chart is from the plans' perspective. If you look at preventive screenings for the Health Care Authority column, it says zero dollars, but then in the other columns it says, 100% paid. It should be corrected in the Health Care Authority column that the preventive screenings are 100% plan paid. As we prepare these comparisons for the fully insured at the October Meeting, we will make that correction as well, but I did want to make that correction on the record.

Lou McDermott: Thank you, Dave. Again, I want to thank you and your staff for all the work and I want to thank the Board members. These are long days and the topics are complex and there's lots of questions. Answers aren't always readily available and there are delays on getting answers, so, I appreciate all the work you're putting in.

Meeting Adjourned at 3:40 p.m.

School Employees Benefits Board
Meeting Minutes

DRAFT

September 17, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:00 p.m. – 2:30 p.m.

Members Present:
Lou McDermott
Wayne Leonard
Katy Henry
Dan Gossett
Terri House
Patty Estes
Sean Corry
Pete Cutler (Late)

Member Present by Phone:
Alison Poulsen

SEB Board Counsel:
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 1:00 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Agenda Overview
Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda. Today's meeting is a special meeting under the Open Public Meetings Act and limited to the items on the agenda. At 2:45 p.m. we will go into a combined meeting with the Public Employees Benefits Board for staff to brief both Boards on the Retired and Disabled School Employees Risk Pool Analysis.

Vision Benefit
Lauren Johnston, SEBB Procurement Manager. Slide 2 – Apparently Successful Bidders Proposed Provider Locations – Updated. There was a question at our last meeting of whether or not the providers listed were unique providers. Although I thought they were, they were not. This is an updated slide of proposed unique provider count per county.

Slide 3 – Considerations. The table on the left is the group vision plan. These are carriers who specialize in providing vision benefits such as routine eye exams and any eyewear like contact lenses, eyeglasses, etc. School employees are already familiar with separate vision benefits. There are more purchasing options without the member submitting a reimbursement form. There is higher visibility into plan costs and utilization. This mitigates the future Cadillac tax responsibilities under federal law.

The table on the right is the embedded vision benefits. Regardless of service type, the provider bills one carrier for all services. This could include the routine eye exam and eyewear, as well as any medical services provided during the visit. There are potentially more contracted providers, depending on the carrier within a medical carrier's network. Eye health services are more likely to be integrated and managed with medical services for an embedded carrier.

Stakeholder feedback on Policy Resolution SEBB 2018-35 was generally positive to having separate vision plans.

Dave Iseminger: If I remember correctly, there was a funding question where stakeholders were curious whether it was going to be employer-funded or have employee premium contributions. We're not able to answer that question at this time.

Sean Corry: I have a question about the map showing the providers by county. Could you repeat the process given that we're looking at a likely candidate for contracting with, and I know that's a long process. Some of the counties have very few providers identified in a rather large geographical area. Could you tell us the process of working with the likely contractor, and increasing the numbers so it's not geographically difficult to see a provider?

Lauren Johnston: I can tell you based off conversations we've had so far that the carriers not currently in every county, or those counties that don't have much provider access, were already aware that this was likely going to be an ask of them. They've already started doing recruitment with providers in those counties trying to increase their provider network. They will also receive a file with zip codes and census data so they can determine how many providers they might need in an area. Something to consider is there might not be more providers to contract in certain areas.

Terri House: Do you have a timeline on how long it takes from recruitment to signing as a provider?

Lauren Johnston: My understanding is the average is about 60 days.

Pete Cutler: Right now, we have school districts across the state that have various carve out plans for vision benefits that include a certain number of providers between all of their plans. Do you have a sense of whether that's a much larger number of providers that school employees currently have access to for the vision benefits

compared to what we have here? Or, is there not a huge difference? Is the small number of providers shown in the rural areas more a function of a lack of providers in those areas?

Lauren Johnston: I have not done that analysis. If I were to take into consideration Garfield and Columbia Counties, which have none within the medical carriers, it shows the same on the vision carriers' side as well. If it were to follow that trend, I would say they are likely close.

Dave Iseminger: Lauren, for the record, could you describe again the relationship between the stand-alone vision and what benefits, if any, would remain in the medical plans? I want to make sure the record's clear and the Board's clear about that.

Lauren Johnston: Based on a vision provider's licensure, some are able to provide medical services, like an ophthalmologist. There are services that you would receive for your eyes that have to do with a medical diagnosis. This is not elective, like eyewear for daily use. These are medical vision services received for eye surgery, that sort of thing. Those would stay within the medical carriers. This stand-alone benefit is specifically for your routine eye exam, contact lenses, glasses.

Lou McDermott: **Policy Resolution SEBB 2018-35 – Vision Benefit**

Resolved that, the SEBB Program will offer a group vision plan(s) beginning January 1, 2020 that is separate from the medical plans.

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-35 passes.

<u>Disability Insurance</u>

Betsy Cottle, Contract Manager, Employees and Retirees Benefits Division. Slide 2 – Decision for the SEB Board. You have decisions to consider based on information we're providing today. One decision is whether or not to offer a short-term disability product. You will also need to consider long-term disability plan design components, like how long is the waiting period, whether or not employees have a choice to use sick leave or elect their pension, and whether or not we are going to ask them to opt in for supplemental disability insurance or opt out. Opt in means you affirmatively choose supplemental insurance. Opt out means you have it until you say no thank you.

Slide 3 – What is Disability Insurance? Disability insurance is used to replace a portion of a person's income when they are not able to do their job as a result of a disability. It

covers a portion of your income to give you an incentive to go back to work. If it were unlimited income replacement, no one would want to return to work.

The benefit is paid on a tax-free basis for the supplemental portion. Basic, or employer paid, benefits gets taxed before it is delivered to the person.

Pete Cutler: Am I right that in terms of whether it's a taxable benefit, it really hinges, not on the label of supplemental, but if the employer pays for it, it's taxable income when received? If funded solely by the employee, it is not taxable?

Cade Walker, Executive Assistant to the ERB Division Director: That's correct with one slight add on. If the premium is paid by the employee on a post-tax basis, the benefit is received to the employee post-tax when they get the benefit itself. Again, premiums for medical are paid pre-tax and this benefit is paid post-tax.

Pete Cutler: So, under a cafeteria-type plan, if the premium is made and it's not paid from after-tax income, like our health is done with pre-tax income, and if the disability benefit premium were paid by the employee also with pre-tax income, then later if they collected disability benefits, at that point it would be taxable income? It's kind of you tax at one end or you tax at the other?

Betsy Cottle: That is the basic principle. I'm sure we are swirling the two concepts and we're going to get confused. Why don't we come back with exactly which tax goes where?

Pete Cutler: Great, I appreciate that.

Dave Iseminger: To summarize quickly, Pete, one of your questions was it's not the name of the benefit "supplemental" versus "basic." It's really a function of how the premium was paid. Was the premium paid with pre- or post-tax dollars. That's the key piece.

Betsy Cottle: Slide 4 – What is the definition on disability? We use the word "disability" a lot. The insurance standard definition of a disability means being unable to perform with reasonable continuity the duties of your job as a result of sickness, injury, pregnancy. The other place where we use the word disability is in connection with Social Security Disability Administration. When you get to Social Security disability, it generally means you have exhausted your long-term disability program and have reached permanent disability. Long-term disability is for a period of time during which you could go back to work. If you become permanently disabled while you are on a disability product, the insurance company who administers that product will assist you in getting to Social Security at the appropriate time. That's why the definitions are different.

Dave Iseminger: Another key piece is when you look at the first definition, it says, "the duties of your job." It's really the top disability definition is rooted in the job you were

performing and whether your disability makes you unable to perform that job or those job duties. Whereas, Social Security Administration is more of a permanent disability, and the second line of the definition says, "any substantial, gainful activity by reason of any medically determinable, physical, or mental impairment." That's really any employment. So, the top one for this benefit that we're describing, the employer-sponsored benefit, or SEBB Program benefit, is about your specific job versus permanent disability under Social Security.

Pete Cutler: When I worked with the Insurance Commissioner's office, there were actually different definitions that different companies used, and it was a source of huge headaches because people really didn't understand until they had a problem, everybody wasn't using the same standard. Is this the definition that's used with whatever carrier provides the disability benefit for the PEBB Program right now?

Betsy Cottle: It is. And, it happens to be the same vendor we're going to use for the SEBB Program, so it is definitely their definition.

Pete Cutler: Great. We lock in on that, so, it definitely applies to what we'd be taking advantage of. Thank you.

Betsy Cottle: Exactly. Slide 5 – Washington School Districts – Income, is an illustration of the current income levels experienced by the SEBB population. Cade will talk about how this is going to change in the next couple years.

Cade Walker: While the data on this chart is from the 2016-2017 S-275 data collected by the Office of the Superintendent of Public Instruction (OSPI), we have some expectations with the recent legislation relationship to *McCleary*. The subsequent funding adjustments, or increases, have been made that we will see some fairly substantial shifting within these bands of salary. We anticipate seeing a migration towards more of the center two bands from the lower bands. We would expect to see adjustments in this, but we wanted to use this for illustrative purposes to articulate and show where current salary levels are, generally speaking, for the K-12 population.

Betsy Cottle: Slide 7 – Washington Paid Family and Medical Leave Program. We thought we would be proposing a short-term disability program for the SEBB population. As a result of the Washington Paid Family and Medical Leave Program that was passed last year, there are other things to consider. Beginning next year, employers, regardless of size, are required to collect and remit premiums to the Employment Security Department, the administrator for this program.

There are two parts to this new program, family leave and medical leave. Family leave covers events like the birth of a baby, adoption, placement of a child, care for a family member, and some military connected events. Medical leave covers self-care for the employee after a qualifying event. Medical leave is sometimes called short-term or temporary disability. Almost all employees in Washington State will begin contributing 0.4% of their income for this benefit starting January 1, 2019 for use starting January 1,

2020. The program pays benefits weekly, which is common with short-term disability products, as well. The maximum benefit payment is up to $1,000 a week and reached if an employee makes $1,405 per week or more. To qualify for the program, employees must have worked 820 hours during the past five quarters, or 15 months. There are 12 weeks of coverage available and up to 18 weeks under very specific circumstances. An example of the 18 weeks of coverage would be a complicated pregnancy. Employees are eligible for this benefit once every 52 weeks.

Lou McDermott: Are we saying a new employee starting their job on January 1, 2020 would have to accumulate 820 hours before they would be eligible for the program, if they didn't have a job before?

Betsy Cottle: That is correct. We will be talking about the groups of people who may be in those gaps in a couple of slides.

Slide 9 – Washington PFML and Group Short-Term Disability Insurance. This slide talks about the breakdown between employee and employer. And, as we said on the previous slide, the PFML Program will provide up to $1,000 a week of an employee's income. Almost all employees of the state will begin to contribute January 1, 2019. Employees pay 63% of the premium and employers pay 37%. Short-term disability insurance generally replaces up to 60% of an employee's salary while they are unable to perform the duties of their job. Premiums for this benefit are generally paid by the employee. Any benefit received from the Washington Paid Family and Medical Leave Program will be deducted from any short-term disability benefit.

Slide 10 – Washington’s Paid Family and Medical Leave Program Premium Example. This is an example equation showing how a premium will be paid. If you make $2,500 in a pay period, you would pay a $10 premium. The employer's premium share would be $3.70, or 37% of $10. The employee’s share would be $6.30, or 63% of the $10 premium.

Slide 11 – Washington PFML and Group Short-Term Disability Insurance Benefit Payment Examples. Slide 11 shows a variety of annual incomes and compares what you would get from the Paid Family and Medical Leave Program and a traditional short-term disability benefit. Only those people making $100,000 or more would get a better benefit from a short-term disability product.

Sean Corry: Could you tell me, again, how you're defining the short-term disability product? You're showing the short-term disability weekly benefit. How is that structured?

Dave Iseminger: The short-term disability benefit in this slide is if the Board created a short-term benefit that perfectly mirrored the Paid Family and Medical Leave Program. So, a 12-week benefit, a similar waiting period, and a 60% benefit, you would be able to see the income point at which the benefit under your short-term disability benefit would

be better than the Paid Family and Medical Leave benefit. But, this is showing, for most incomes, that the Paid Family and Medical Leave would be a richer benefit.

I think the other key piece to hone in on is from two slides earlier. The Paid Family and Medical Leave Program payment would be deducted from a short-term disability benefit, there are income disregards in disability benefits so that there aren't double payouts. At some point, you get to a scenario where there's no incentive for you to work. In this type of scenario, what it's showing is the Paid Family and Medical Leave for an employee at $30,000, $50,000, or even $80,000, would have a complete income disregard. They would essentially be paying a premium for a SEBB short-term disability benefit with the carrier and then get no real benefit from it, because the Paid Family and Medical Leave benefit, if they pursued that, would be an income disregard against this product.

Betsy Cottle: Slide 12 – Short-term Disability Insurance Considerations. There are potential coverage gaps between the Paid Family and Medical Leave Program and a typical short-term disability benefit. The person that Lou described is exactly the person who would most likely not have a short-term benefit that very first year.

Cade Walker: Or, until they reach the 820 hours worked threshold.

Betsy Cottle: Another detail we discovered when thinking about this program is the initial open enrollment for the SEBB Program is projected to start October 1. If you are a person walking into your very first job, you would potentially be eligible for the Paid Family and Medical Leave Program by March of the following year.

Dave Iseminger: The other piece for a lot of these people is it's their first job. They might be younger, healthier, and invincible and prioritizing other benefits over short-term disability insurance. Most people aren't entering the workforce for the first time. You can stack hours across employers under the new Paid Family and Medical Leave Program. Even if you had entered the workforce prior to 2020, stacking hours, and moving jobs every month, you could add those hours together. It really is the very first time you're entering the work force.

Sean Corry: There's one other category that came to mind and that is people who had been in the work force and are coming back into the work force, with a gap in time. In school districts, that's maybe more common than in other industries, or even with state employees, I'm not sure. But, I know that it's really common in school districts for this to occur.

Betsy Cottle: Another gap that we've identified is coverage for employees making above $1,405 a week. That's the point at which the Paid Family and Medical Leave actually quits giving an equivalent benefit to short-term disability.

This last one is the most complex. Eligibility for Paid Family and Medical Leave requires an employee to work 820 hours in the previous five quarters. Eligibility for

SEBB benefits is anticipated to work 630 hours, or having actually worked 630 hours. As such, an employee who does not work the required 820 hours for PFML would still be eligible for a short-term disability benefit if one were offered in the SEBB Program.

Dave Iseminger: Slide 13 – Short-term Disability Insurance Recommendation. Essentially, one of the things we considered when making a recommendation to not offer a short-term disability benefit, was creating a product tailored for a subset of the population would be difficult to communicate clearly the eligibility for that benefit and how people would swing in and out of eligibility as they hit that 820 hours. We felt there would be complexity in the system and difficult to explain that benefit and which subset of school employees would have access to it. Instead, we are encouraging the Board to rely on the Paid Family and Medical Leave Program as the primary short-term disability benefit.

Pete Cutler: Has the Health Care Authority talked with the insurance company or their actuaries regarding whether a company would even be willing to offer a plan for which enrollment was available to persons who had, at that point, very limited connection to the workforce, historically? I know from working there, again, employee benefits in the past that insurance companies generally, both with health insurance and disability, tend to see much higher claims experience with people who have very limited work connections and histories compared to an average work force. It would be interesting to find out, if there is interest by other Board members, on pursuing a private short-term disability separate from the state, what kind of cost limitations may be involved.

Dave Iseminger: Pete, in fact we did have robust conversations with The Standard, who is the carrier that we've had under contract for the PEBB Program and was the apparently successful bidder. Both their sales and actuaries teams agreed that if the long-term disability benefit were to perfectly dovetail and pick up right where the Paid Family and Medical Leave Program goes off, it wouldn't make sense to put forth and cultivate a short-term product like you've described. You actually described it really well, encapsulated the discussion that we've had with Standard. But, essentially, there wouldn't be a viable product. If employers move in the direction that we're recommending to this Board, that essentially, the short-term disability market in this state will fundamentally change because of the Paid Family and Medical Leave bill.

Betsy Cottle: Historic enrollment numbers in the school employees' arena has been low. One of our vendors has reported 1% to 2% uptake. Another one talked about the possibility of a 10% uptake for supplemental short-term disability.

Sean Corry: If you had talked with the administration for Seattle Public Schools or somebody at Seattle Public Schools, you would know the uptake on the voluntary short-term disability program has historically hovered around 20%.

Betsy Cottle: They were definitely the outlier in the groups that I was able to identify. But, yes, that is correct. Our recommendation is on Slide 13. The Health Care Authority recommends that the SEBB Program does not offer a short-term disability

benefit. Offering a short-term disability benefit would likely lead to confusion and redundancy. Employees will already be paying for the Paid Family and Medical Leave Program. Offering short-term disability insurance would largely be duplicative and result in paying for a benefit rendered almost nominal by the Paid Family and Medical Leave Program. There will be minimal gaps in coverage, as discussed previously, for employees who are either just starting employment or exceed the maximum weekly salary. As a result of the Paid Family and Medical Leave Program, it is assumed that the commercial short-term disability market is going to constrict significantly.

Patty Estes: If I'm doing my math correctly, our 630 minimum hour employees eligible for benefits will not hit that minimum for the Paid Family and Medical Leave Act. Yet, they actually have to work four hours more per month to hit that because, typically, our 630 is a 3½ hour, nine-month employee.

Betsy Cottle: Remember, your 630-hour employees will begin paying for the new PMFL Program in January 2019.

Patty Estes: But, they're not eligible to take it because they will not hit that in 15 months so, they would be paying for something that they're not eligible to receive.

Dave Iseminger: Patty, I want to make sure we understand the question. You're talking about all employees in the state will be paying 0.4% of their income regardless of whether they're eligible for the benefit, is that your question and point?

Patty Estes: Yes. These people that are not eligible to take advantage of this, we're going to leave them in the lurch. They're not going to have anything if we decide not to offer short-term disability?

Dave Iseminger: Patty, if you look at the projected salary of an individual who is working 630 hours, there are different benefit choices they'll have to make. Assuming they're going to focus on medical, dental, or other benefits in the suite, they'll also have this 0.4% income contribution they'll have for the Paid Family and Medical Leave whether they qualify for that benefit or not. Those individuals will likely not prioritize electing a short-term disability with the other choices they'll need to make with their paychecks.

Patty Estes: Do we have any research saying that is the case?

Dave Iseminger: We brought up the short-term disability historically low volumes at least another indicator. Although it's not broken down by classified or certificated staff, it was an indicator, generally in the K-12 market, this is not a benefit with a significant uptake. With the Paid Family and Medical Leave coming, based on the legislative act to fill in and fundamentally change the short-term disability market, it didn't seem the most prudent course forward to recommend a short-term disability benefit.

Patty Estes: I think my biggest concern is that we are going to have all these new employees that weren't eligible for benefits before, that we have no data historically on, and, if we decide not to offer this, they are literally left with nothing. That's my concern.

Pete Cutler: Two things. In terms of my math, as I understand it, if we have somebody, Patty's representation, you have somebody working just 630 hours in a school year, it wouldn't really matter if it's over twelve months or over nine months. But, over that 12-month period, if they continue to work at a 630 hour rate, that would be on average 70 hours a month, which would be another 210 hours in the first three months of the next school year. In the 15-month period, it would be over 820 hours. In theory, somebody at the 630 threshold, if that was the only job they had -- the only hours --

Lou McDermott: Actually, Pete, I think she is correct. If you take the 630 hours, and amortize it over 12 months, it's 52 hours a month. If you were to go 15 months of that, that's 787.

Pete Cutler: I guess if it were somebody working 52½ hours a month, 12 months, that would be a different issue. But, as Patty said, most of what you have are the folks who work part-time over a nine-month period. That correlates to the retirement eligibility standard, as well. The assumption of 70 hours a month being an eligibility standard and generating 630 hours in a year. It is true somebody working 53 hours a month, 12 months a year, then the math would not work out.

Lou McDermott: Do they normally work nine months?

Patty Estes: Yes.

Pete Cutler: Then the other issue, as David pointed out, is the larger problem for all employees who want to work on a part-time basis, and really just won't be getting 820 hours of employment in a 15-month period, the private market sounds like it's going to dry up. There is the risk of trying to cover folks that have that low attachment to the work force doesn't make them an attractive group to even offer an insurance product. That's maybe a larger problem. It certainly wouldn't hurt for the HCA to check if there are other carriers who want to do it. But, there again, from my work with the Insurance Commissioner's Office, my guess is that the whole sector is likely to back out and just say that the remaining population is not a commercially feasible population to try and provide a short-term disability benefit for.

Sean Corry: In response to my friend Pete on that point, my firm, which is an insurance brokerage firm, is actually talking with carriers, including The Standard, about whether effectively a carve-out short-term disability program is constructible, and, whether it's going to be viable.

Secondly, I didn't really hear a resolution of Patty's concern about employees who are going to be paying premiums while they're employees, but it'd be difficult for them to become eligible for this benefit. I know there are other school district people here in the

room, of course, and they may have a sense of what percent of employees that is, but it's ill-defined for me at the moment. So, I leave that concern open.

And, finally, with respect to Seattle Public School's voluntary short-term disability program, where the uptake is essentially about 20% on average over the past dozen years or so, which happens also to be with The Standard, it is an "if-then" kind of program in that, only eligible people may apply. The eligibility is limited to those who don't have enough sick leave to take them to their long-term disability benefit. They would have a gap in income. It's a construction we did with The Standard that frankly, in our view, is not that complicated. The one thing that is, the complication is that we look at the employees' number of accumulated sick leave days in the past. And, if they have, at the point of picture, more than enough sick leave days, or hours, to take them to their long-term disability benefit, they're not eligible for the short-term program. So, we're targeting employees who do have that gap. We help them understand that they have the gap. A letter that's easy to send out. It's one piece of paper, which also includes their cost. We have a rather substantial uptake for that.

And, lastly, I think, we haven't talked about in the description of the state program, the possibility of an employer, and I don't know how this fits in this context, being able to create a program that can be used as an opt-out plan from the state program. That's also a possibility. I think it would be much more complicated for the SEBB Program, of course, because I'm sure the employer is defined as the school district. But, maybe not. I just point out the omission is, I think, maybe something worth noting, that, for our minds, the possibility of an opt-out should at least be discussed and considered. And, maybe considered for rejection, but it hasn't been discussed.

Betsy Cottle: I can address a couple of the comments that you've made in that there is no opt-out for any employer. They are able to apply for a self-administered plan, but it must meet or exceed the Paid Family and Medical Leave Program.

Sean Corry: My apologies. That's what I meant to say.

Dave Iseminger: A couple of other things, just to level set for the Board. The Paid Family and Medical Leave insurance that we're describing isn't administered by this agency. I want to make sure that's clear. We're describing another program like yours, that's being built. We're all learning about it. We know more about Paid Family and Medical Leave than when we released the procurement, which was more than we knew when we asked you to take action on going forward with the procurement last March. We are learning about that new product.

As Betsy was just describing, lack of opt-out mechanisms for the most part, are part of the underlying legislation. The legislature would be the ones that changes eligibility requirements related to that. So, Patty, when you asked the question about the individuals who pay into the system and who may never meet the eligibility, we can report that's what we see under legislation and being administered by a separate agency. I know that's probably not a satisfying response, but we're trying to describe

this program that's being built by a sister agency, its implications for the insurance market, and the product you're charged with considering.

I think a second piece to keep in mind is, remember that this Board has the jurisdiction over disability benefits. Whether they decide to administer or not administer a benefit, school districts can't fill in the gaps. If this Board didn't pass a disability benefit, short- or long-term disability, there would be no short- or long-term disability benefit available within the K-12 system. Remember that's a feature of how the legislation was clarified in Senate Bill 6241. I just want to remind people about different overlapping authorities and jurisdictions. It gets complicated quickly.

Terri House: I have one quick question. On the eligibility, it says, "to have worked the 820 hours in the previous five quarters." Does that set your eligibility, and then you're eligible from then on, or is that every 820 hours you work in a school year?

Betsy Cottle: I hadn't asked that question, but from what I have read of the law and the rules, it is an ongoing eligibility requirement. If you have not worked 820 hours in the past 15 months, I don't think you're eligible. I can certainly ask and confirm.

Terri House: That would be helpful. Thank you.

Patty Estes: And, with that wording “worked,” what about the school employees who only work nine months a year? Then they have those three months, or however long, that they do not work, how is that taken into consideration for the 15 months?

Betsy Cottle: Those are both really good questions and we'll find out.

Dave Iseminger: We'll do our best to find out if the sister agency has answers to those questions. Can't promise that another agency knows the answer to the question.

Lou McDermott: I'd be interested to know. I'd also be interested to know what hours they're counting as part of that 820. If somebody goes on short-term disability for a period of time, and then they come off, but then they go back on does that count as zero time?

Dave Iseminger: I do think that all of these are great questions to ask about the Paid Family and Medical Leave Program. I'll again draw you back to the bottom of Slide 9 where whomever is eligible for the Paid Family and Medical Leave benefit, receives it, and has paid into it, that any benefit they receive would be deducted from the hypothetical short-term disability benefit that they could also sign up through the SEBB Program. Since there's that fundamental tenant that everybody who is over 820 hours would be eligible for this benefit, they will have paid into this benefit up until somewhere between $80,000 - $100,000 annual salary. It's a better benefit, and a SEBB benefit becomes a duplicative benefit. We're worried about people inadvertently double paying for a benefit. That's a part of the concern.

Katy Henry: Is it possible that someone from the other agency could come and answer questions here? Or, does it have to be filtered through you?

Dave Iseminger: We can see what we can do about inviting them and having questions answered.

Patty Estes: I'd like to see more information on school employees who are taking the short-term disability. What are their incomes? What are their hours? I know we have a very small window with the PEBB population, so, maybe we can see what's going on there.

Sean Cutler: In response to Patty's request, I know that the school districts my firm works with, through our office, probably can get that information very easily. We would be happy to work with you to get it.

Dave Iseminger: Great. Thank you for that, Sean. At this point, we're not intending to bring forward a resolution to this Board. We won't bring forward a negative resolution. It was strange enough to have a presentation built that says don't do something. But, in this context, that's where we are. We'll continue to answer questions about this product. At this point, there won't be a "thou shalt not offer short-term disability" resolution for you to take action on.

Betsy Cottle: Slide 15 – Disability Plan Design Components. We will now talk about long-term disability. The big difference with long-term disability is that it’s a monthly benefit. Disability insurance has several standard plan design components. One standard component is the base waiting period. This is the length of time between the beginning of your disability claim and the first payment received. In general, the waiting periods can be anything from 30 days to 365 days. Another standard is the value of the maximum monthly payment. Other components are choice or no choice options for both pension and sick leave. The choice option means that a member chooses to receive payment from either sick leave and/or pension. If a member chooses to receive it, that value is deducted from their disability payment. The no choice option deducts either sick leave or pension from the disability payment whether or not the member receives that benefit payment. In other words, if I have sick leave, under the no choice option I can choose to use it or I can keep it. But, they're going to deduct the value of my sick leave.

Slide 16 – Employer-paid Basic LTD Plan Design. This is an employer paid basic long-term disability plan design. The table shows the waiting period would be the latter of 90 days or the end of the Paid Family and Medical Leave. For pension, you would have a choice to take it or not. That is important to those people who become disabled at a very young age. If we require a young disabled person to receive their pension earlier than is the standard period for that program, it would likely be discounted. In other words, a 30-year old person who is required to take their pension may see $.50 on their dollar, or less. Sick leave, we say no choice because we believe you should use your sick leave before you take a long-term disability benefit. And then, we have

representations of what is available to us the same as PEBB, and if we increase the per subscriber per month contribution by the employer by a dollar, how much more we can get per dollar of increased contribution. So the first one is $400, which is 60% of $667.

Cade Walker: One point I'd like to make regarding the very first column that is assuming the per subscriber per month (PSPM), or rate, the dollar amount that is comparable to what is offered in PEBB. What I wanted to highlight is that the maximum monthly benefit of $400 is a 67% increase in the benefit that's available to the PEBB population for the same dollar amount. The primary reason for this is something called the "occupational load." The occupational load is an industry term used to describe the factors about the risk of an industry's potential for becoming disabled and the return to work quickness, of that same industry. We have learned that the occupation load for the SEBB population for the K-12 industry is different enough from the PEBB occupational load that would allow us to have an increase benefit of 67%, or the $400 maximum monthly amount for this population.

Dave Iseminger: I've just tried to describe that we would bring to the Board that dollar incremental PSPM difference, so that eventually, as you start to make choices about where you want to shift or, for example, we described in the life insurance benefit that a swing of $10,000 in basic life is a dollar PSPM. If the Board wants to make the basic life insurance benefit $25,000, take that dollar and put it here, you would see what the long-term disability basic employer-paid benefit could be. We've described to you a range of options, this being the benefit that may be the most enticing to the Board for trying to improve. We wanted to give you a wide range as to the examples of the PSPM increases. If you are able to trade $2, then you can have an $835 benefit. We wanted to make sure we gave you as robust a description as possible, of the incremental increase on a per subscriber per month basis in this benefit, anticipating that you'd have concerns about a $400 benefit being the final benefit offering from the Board.

Pete Cutler: I think you've been completely clear, but I want you to verify that I'm understanding correctly. This basically says that if we wanted to offer a base benefit, a maximum monthly benefit of about $1,000 a month, take the $1,060 example, that whatever amount the PEBB Program currently pays for the long-term disability, if we add $3 per subscriber per month to that dollar amount, it would be roughly enough to pay for a $1,000 maximum benefit.

Dave Iseminger: Correct, Pete.

Sean Corry: I pulled the trigger and I pushed the button. Frankly, I can't remember whether this Board has voted on what the base LTD plan will look like. Have we not?

Dave Iseminger: Did you say "base LTD?"

Sean Corry: That base long-term disability program. Have we?

Dave Iseminger: No. This is the first presentation about the disability benefit, both short- and long-term. Subsequently there will be proposed resolutions for future action. I know it's hard to track all the different moving parts.

Sean Corry: Understood. I personally, on behalf of the employees of school districts, the vast majority of whom I think have a substantially better long-term disability benefit than is offered to state employees through the PEBB Program, to have that costed out on a district by district basis, of course, would not nearly be as economical as it would be if it were a statewide purchase of an incremental $1,000 benefit, for example, if it were done by the state. I know that I speak for others who are not in this room, and also especially the beneficiaries of a more robust long-term disability program, to ask that when we move forward in our discussions with this that we hear from you folks some clear and accurate analysis of what the incremental cost is to have a robust 60%, 66 2/3%, plan for school district employees so that we have that number in mind when we're talking about whether -- and I know that we talked a bit about this last meeting. I heard clearly the interest in making sure that we have reasonable costs for employees on the medical plan. But without knowing what that trade-off is, without having a clear picture, we don't know what we're rejecting or what we're choosing. I personally make that request of you, to bring that information to the Board for us to have a clear conversation about the trade-offs.

Dave Iseminger: Sean, can I clarify? You'd be interested basically in another column on the chart that showed what the value of an employer-paid benefit would cost for a full 60% of salary?

Sean Corry: The value -- define what you mean by value.

Dave Iseminger: The PSPM or annual cost.

Sean Corry: The cost. That would be helpful.

Dave Iseminger: Okay. But at a 60% of salary?

Sean Corry: I threw that out because that's pretty common for the level of benefit that we have so I think that would be a good starting point.

Dave Iseminger: Okay.

Betsy Cottle: Slide 17 – Employee-paid Supplemental LTD Plan Design, represents a supplemental or employee-paid long-term disability plan design. It has the same sets of criteria for waiting periods, and whether or not there's a choice or no choice. We have listed an opt-in version of the plan. You are welcome to consider an opt-out plan, but that would often come with a lot of people who are surprised by a benefit that they didn't expect. We'd have to communicate about that.

Dave Iseminger: If you had an opt-out benefit, this Board would be saying "X number of dollars are coming out of school employees' paychecks to pay for a benefit until an employee says don't do that." Right?

Betsy Cottle: Right.

Dave Iseminger: But opt-in is an affirmative choice and the employee makes an affirmative knowledgeable choice about what's being deducted out of their paycheck.

Betsy Cottle: Exactly. We previously talked about pension choice and sick leave no choice previously. Here we have a range of premiums and estimated monthly benefits if we were to offer a supplemental employee-paid long-term disability product that gives you 60% of $10,000 a month. The left side of the table shows the range for a monthly premium for someone making $30,000, between $9 and $15 a month. Their estimated monthly benefit would be $1,500. The chart describes the rising premium based on income and what an approximate 60% benefit would be at those annual income levels.

Dave Iseminger: For the Board's knowledge, the reason there are ranges here is it depends on what the basic benefit is. That represents the full range of a $400 to a $2,048 monthly benefit. Then the range of estimated monthly premium is directly related to what the basic plan is that's paid. That's why those ranges are there. The $30K, $50K, $80K, and 100K came from the earlier income slide. That was the high point of each of the main breaks on the initial income slide in the presentation.

Patty Estes: Just to point out, I know that it might be a redundant point, but $30,000 a year is about twice what a 630-hour employee actually makes. That bottom line is probably about half of that.

Betsy Cottle: We understood that most of the people in that category were less than full-time when we pulled the numbers.

Slide 18 – Long-term Disability Considerations. The proposed SEBB employer-paid long-term benefit design mirrors the PEBB benefit waiting period pension and sick leave design features, but offers a larger monthly benefit of $400, a 67% increase from the PEBB benefit. The Health Care Authority will continue presenting options in October for the Board to consider benefit trade-offs to potentially increase the basic long-term disability benefit.

Dave Iseminger: A little more about that last piece. For example, your decision to have a stand-alone group vision benefit, as we engage in the conversations with carriers, there may be the potential for some cost savings. If there are, on a PSPM basis or on a claims basis, we'll bring you that information; and say in that specific area we're going to assume you're probably interested investing it. We'll provide you the value of the decision and how much more you can put towards long-term disability. We anticipate bringing that back in October.

Sean Corry: Just to make sure, on Slide 18, that it's 67% increase, which is $400. It's a really big percentage. It makes it sound like it's quite grand. What is the SEBB level now?

Dave Iseminger: The PEBB level?

Sean Corry: The PEBB level now?

Betsy Cottle: $240.

Pete Cutler: Is it reasonable to infer that the underlying proposed policy is to have the SEBB long-term disability benefit funded at the same rate as the PEBB benefit. And one outcome of that is that it is the $400 versus the $240, but in reality the policy driving that $400 has nothing to do with that $400 as a good number. It has to do with that's how much you can buy, if you use the same amount of premium dollars that are currently used in the PEBB Program.

Dave Iseminger: Pete, the Policy Resolution SEBB 2018-38 that's before you describes the benefit, because this Board has the choices to make between the benefit trade-offs. Over the past several months I've described what we believe is a zero sum game that, over the course, and I'm making up this number just for illustrative examples, let's say there's $100 per subscriber per month that's paid for everything that's not medical. And PEBB spends it, divides it evenly across the benefits. This Board does not have to use the same distribution across the benefits, but the same sum total of $100 couldn't be exceeded. If you want to take a dollar that's spent on PEBB on life insurance and instead put it on LTD, you're still spending $100. You're putting a dollar somewhere differently than PEBB is.

We've described along the benefits portfolio, so far, life insurance, now disability, what the benefit would be for this population in SEBB if you spent the same PSPM. We've also given you incremental differences so you could make the decision to trade off benefits as you reach the decision-making point in October and November. It's not that we're trying to just frame up all of the pieces so you can see what the same distribution will buy, knowing that the population is different. The demographics are different. The carriers will say that one is riskier or less risky relative to the others. What the same PSPM would buy. Ultimately, your choice as to how you're going to distribute that is up to you.

Pete Cutler: I fully agree. Frankly, coming from a budget background, there will be what I call a box and a dollar amount that will be collectively bargained between the school employee organizations and the Governor for how much will be proposed to the Legislature as funding for the insurance benefits. I personally believe that we are dealing within that dollar amount, if you spend more on something you're going to have less to spend on something else. But having said that, I think it would be more helpful for the record for this recommendation to be clearer, that it is tied to providing the benefit at the same funding level that is currently used for the Public Employees

Benefits Board. Otherwise, it looks like the $400 is being proposed as some great enhancement. When in reality, it's still a very small amount and I would say still a token amount compared to the need. I think somehow adding that other concept would be in my view helpful.

Dave Iseminger: Pete, for clarity, in the resolution or in the record?

Pete Cutler: I don't have a strong feeling for that. As long as the record is the same as the slide so people going through the briefing materials online or whatever, it stands out clearly. This is tied to a funding benchmark, not to a policy decision or recommendation that this is somehow a desirable target.

Dave Iseminger: I think you're correct, Pete. That will be in the record. Again, the reason we put up the resolution the way we did, we're not going to ask the Board to take action on this resolution until the November meeting. If you want to trade something along the way we would just strike the last part and change $400 to a different number and 60% to a different number. That would be the resolution you pass because you've traded off something somewhere else in the resolution. We've just teed up what we believe is the box of money that you have to spend. We're trying to show each of the benefits with the same PSPM and then again, what your incremental differences could be so that you can make a decision. I think everything you said is correct and on the record.

Sean Corry: I'll say again, which I've said, I think, in this arena, but also privately to you, Dave, that the amount of money that we'll have to spend is not yet set. It will eventually become a fixed dollar amount. It's subject to negotiations, not only as going on what I think that was contemplated in the last mention, but it will be subject to negotiations every day of the session until the last day of the session. I think it's important to realize that, yes, we will have a fixed dollar amount at some point in time. But we don't know what that number is now.

Secondly, with respect to making benefit choices for school district employees, especially where we have more discretion about whether to, and also looking at, what in the areas of coverage are in the five basic benefits, for example, dramatically different between what happens at school districts and what happens for state employees. I think it's much more important from my view to have incremental costs available so that we can see what that actual tradeoff dollar amount might be, for life and disability coverage. It may be worth it to us, as representatives of school districts across the state, to do something different than what is being proposed and discussed here. But we won't be able to do that unless we have clear information about the benefit choices and their costs, anything that any employer here would expect when they're working on their own employees' benefits. They want to know what the tradeoffs are, what the numbers are, to make a good informed decision. I don't think that we are getting that kind of information, in order to make that informed decision. I would strongly ask that we get that kind of information before we have to make a decision on what kind of plans we're going to be offering to state employees.

Dave Iseminger: Sean, maybe we can follow up offline afterwards if you'd like. Can you describe for me more the level of incremental information you want because my staff has put forward a $10,000 swing in life insurance is a dollar PSPM. $20,000.00 is $2 PSPM, $30,000 is $3 PSPM. This chart on Slide 9 shows the incremental dollar increase for $7. We didn't give you 60% of the benefit because looking at the entire suite of benefits it seems challenging to find even $7 PSPM. We can certainly provide what the legislative price tag, essentially, would be for a 60% benefit. What other information can we describe for you for the tradeoff pieces? I think my staff and I would appreciate any clarity about the additional context you're looking for.

Sean Corry: I'd be happy to provide that once I talk with my staff about what's most common, or uniform, across the school districts we work with. I think it would be perhaps helpful to hear from other members of this committee about what they would like to see as well. It could be a very simple thing. It could be just one or two other possibilities within the benefit plan structure. So perhaps we can work on that together.

Dave Iseminger: And that's a perfect segue. I was going to open it up and see if there are things others wanted to ask.

Wayne Leonard: I do recognize that when we offer a package of benefits there is going to be a balance in terms of cost and what can be provided. I was wondering if you have data about the frequency of long-term disability claims. In my 25 years, maybe it's just I haven't heard about them because of HIPAA or something, but I don't know if I recall any of my employees ever out on a long-term disability claim.

Betsy Cottle: I can tell you that there was some research done by the Massachusetts Institute of Technology. I don't remember the citation, but I can certainly provide it to the Board, that one in four people, in their employed life, will be disabled.

Wayne Leonard: Long-term?

Betsy Cottle: With an average claim of three years.

Wayne Leonard: Okay. Thanks.

Dave Iseminger: We'll take that as a to-do, to see if there's something we can bring back to the Board, Wayne, what our data shows about the frequency of claims.

Wayne Leonard: And for the record, I guess, too, is even though if school districts couldn't offer another benefit that doesn't preclude employees who don't think this benefit is sufficient to get a private disability insurance policy, correct?

Dave Iseminger: I think that's correct.

Sean Corry: I wanted to respond to Wayne. From my experience, a privately purchased disability policy that has any robust features would be medically underwritten and difficult to purchase. Costly. And in the market today, not many people buy them.

Dave Iseminger: I was going to add to that, Sean. I think when you look at life insurance, disability in particular, there's a much more robust individual market for life insurance than there is disability for the reasons Sean was just describing.

Betsy Cottle: Draft Policy Resolution SEBB 2018-38 – Employer-paid Basic Long-term Disability. The SEBB Program will offer the following employer-paid long-term disability plan to subscribers beginning 1/1/2020:

- Waiting period - later of 90 days or end of Family and Medical Leave.
- No choice sick leave
- Choice pension
- Maximum monthly benefit $400 (60% of $667)

Dave Iseminger: Again, we've already described the proposal and why we put the dollar amount that we have. As the Board goes through its subsequent conversations and we present the rest of the benefits suite at the October 4 meeting, if the Board wants to do some trading, it will be very simple to strike the bottom part and change it to a different amount, as you're exchanging different benefit pieces across the portfolio.

Dan Gossett: And the earliest we'll vote on this is the November meeting?

Dave Iseminger: Correct.

Sean Corry: In response to you saying in effect, if we vote for this, the majority says yes to this in the November meeting, we can change it in the future? We will be able to? I appreciate that opportunity but in our communication, know that we're going to be changing, or at least not tying into a number we know we can change later. I'm trying to get to what the process is. If we choose to not approve this resolution as it's written, what's the process for bringing it back in a way that would be more compatible with the interests of flexibility or different levels of benefits that we just talked about for the past 20 minutes. Tell me again what the process would be if we reject this resolution in November, as it's written.

Dave Iseminger: If the Board, after we present in October, comes in November and in their discussion there's a motion and a second on this resolution and you come to a general consensus that you want to raise the last line to $1,060 because you believe you have $3 PSPM, and as a group you're thinking when we go to the life insurance benefit, we are going to make sure it’s $25,000 so there's a dollar. The staff described, that in the vision there's a $1.50 and we have another $.50. You'll change it right then at the moment and pass a resolution as you would amend the resolution on the floor to say "maximum monthly benefit of $1060. We wouldn't reintroduce the whole concept of the resolution and then bring it back at a subsequent meeting. The horse trading that

I've described, the tradeoff between benefits, would happen during that November meeting.

Sean Corry: One other question. The way we will get that information about these benefit choices, the alternatives, I think the routine would be in the packet which would come to us a few days before the meeting itself? Is that how you would anticipate that we would get that additional information?

Dave Iseminger: The core of that information will be presented at the October 4 meeting. So 34 days before the November 8 vote. Then follow-up questions. It depends on the granularity of the follow-up questions. But the PSPM incremental increase on disability is here today on September 17, compared to November 8. The $1 PSPM and life insurance was presented in August 30 for November 8. The core rest of the information will be at October 4.

Pete Cutler: I was going to ask if The Standard can provide information about the utilization of the long-term disability benefit by state employees, or by PEBB Program members. I'm not sure if they consider that proprietary information but it would provide a baseline in understanding that the occupational risk is considered higher for state employees than school employees. If it's available, that's part of what I'd like to have by October, if possible.

Betsy Cottle: I have that available.

Dave Iseminger: The other thing I just want to remind the Board is I've described this as a relay race, and you're both lead and anchor. I've also said it with the analogy of do 90% of your homework by November and there's 10% left to do after legislative session. We're not going to hit it right on the dot without the final legislative answer to the funding question. We'll have to revisit once the funding comes in. That will be the tail-end refinement next summer as you're setting final rates on the medical plans.

Sean Corry: But that dollar here or dollar there question is really -- you also have to include not only the cost to the benefits but what the impact is on the employee payroll deduction, right?

Dave Iseminger: Correct.

Sean Corry: So that's effectively where it gets to. I want to make sure that we all understand that the net is always paid by the employee.

Dave Iseminger: I just wanted to reinforce to the Board that even after November there's still some refinement to go. November is not the last time, but it is a core piece for setting up the macro structure of the benefit so it can further inform the legislative process about what they're funding.

Betsy Cottle: Slide 20 – Draft Policy Resolution SEBB 2018-39 – Employee-paid Supplemental Long-term Disability. The SEBB Program will offer the following employee-paid supplemental long-term disability plan design:

- Waiting period - Later of 90 days or end of Paid Family and Medical Leave Act
- No choice sick leave
- Choice pension
- Maximum monthly benefit $10,000 (60% of $16,667)

The Appendix has handouts from the Employment Security Department's Paid Family and Medical Leave Program.

Next Meeting

October 4, 2018
9 a.m. – 5:00 p.m.

Preview of October 4, 2018 SEB Board Meeting

Dave Iseminger provided a preview of the October meeting. The core of the meeting will be to present benefit design proposals and resolutions on vision, fully insured dental, fully insured medical, and then the revisiting of the self-insured plan treatment limitations.

We'll provide additional information about the Centers of Excellence Program and a resolution related to creating that program in the SEBB Program; dual enrollment; asking for action on basic life and self-insured dental; and discuss eligibility proposals.

Wayne Leonard: I think you said maybe at the last meeting that you might have information on results of the state collective bargaining process at the October 4 meeting?

Dave Iseminger: It depends. I believe a tentative agreement is out for ratification. In no way are we influencing that, but we're hoping that we'll be able to describe something about a potentially ratified TA at the next Board meeting. For any ratified TA, there's a submittal that goes through the OFM process on October 1. We're anticipating if there's that transmittal, then we'll be able to talk about it on October 4. If not, we won't be able to talk about it on October 4.

Meeting adjourned at 2:31 p.m.

Combined Public Employees Benefits Board and School Employees Benefits Board Meeting Minutes

DRAFT

September 17, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
2:45 p.m. – 4:45 p.m.

PEB Board Members Present:
Sue Birch
Tim Barclay
Carol Dotlich
Myra Johnson
Tom MacRobert

PEB Board Members Present by Phone:
Yvonne Tate
Harry Bossi
Greg Devereux

SEB Board Members Present:
Lou McDermott
Pete Cutler
Sean Corry
Patty Estes
Katy Henry
Dan Gossett
Terri House
Wayne Leonard

SEB Board Member Present by Phone:
Alison Poulsen

PEB Board and SEB Board Counsel:
Katy Hatfield

Call to Order
Sue Birch, Chair, called the meeting to order at 2:47 p.m. Sufficient members were present of both the PEB Board and SEB Board to allow a quorum. Board introductions followed.

Agenda Overview

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda. Today's meeting is a special joint meeting of both Boards to discuss one topic, the Retired and Disabled School Employees Risk Pool Analysis. Under legislation, this agency is to consult with both Boards. The ultimate decision that the Legislature may or may not make based on the report that the Health Care Authority produces could impact either or both programs. This is not the first step on a journey of consolidating the programs. This is a discussion because of a specific legislative report about where K-12 retirees should be housed within the various programs and risk pools created under current state law. This is a special meeting under the Open Public Meetings Act. I make this point because we need to stick to the topic on the agenda.

Retired and Disabled School Employees Risk Pool Analysis

Kayla Hammer, Fiscal Information and Data Analyst, Financial Services Division, HCA. Today we'll talk about the legislative reports. We'll discuss background, what is the report and its purpose, the anticipated 2020 risk pools, 2018 PEBB Program enrollment, PEBB Program non-Medicare risk pool data and information, PEBB Program Medicare risk pool data and information, and the retired and disabled school employees risk pool scenarios and their implications.

Slide 3 - What is the Report? RCW 41.05.022(4) requires the Healthcare Authority, in consultation with the PEB and SEB Boards, to complete and submit an analysis of the most appropriate risk pool for the retired and disabled school employees. This is our second round of consultation with both Boards. This report is due to the Legislature on December 15, 2018. Comments and feedback from this Board consultation and the previous consultation will be documented. It's my intent to share it as an appendix to the report in regards to the most appropriate risk pool, cost impacts, member experience, state and federal laws and regulations, implementation, and administrative complexity.

Dave Iseminger: The legislation did not outline the criteria. What Kayla just described is what we see as high-level categories for potential impacts. It is not described in statute.

Tom MacRobert: I'm curious. Could you give me a little more explanation on what you mean by member experience? I'm assuming you're referring to people who have gone through some type of situation comparable to this.

Kayla Hammer: What I mean by member experience is if we were to make changes to the current risk pools that exist, how would they be affected? Would that result in having to choose new plans? Would it impact their cost personally or as a group? Those are examples of what I mean by member impact.

Tom MacRobert: Then also, implementation and administrative complexity. Are you anticipating that if you make changes, there will be overarching concerns in making those changes?

Kayla Hammer: Yes, that's correct. We will go into more detail in this presentation. But, yes, there are some overarching things that would change should risk pool changes be suggested.

Dave Iseminger: Tom, an example would be if the K-12 retirees were moved into the SEBB risk pools, there are currently no procurements or Medicare products that have been procured. There would need to be additional procurements. The SEB Board would have before it the task of authorizing similar or different product offerings. That would be an example of administrative complexity. We might have Medicare plans for PEBB and different Medicare plans for SEBB, as an example.

Kayla Hammer: Slide 5 – Insurance Risk is the likelihood that an insured event will occur requiring the insurer to pay a claim. In health insurance risk, it's viewed on more of an aggregate level instead of the singular example seen on this slide. The amount of risk would be measured by the likelihood that the total claims cost would exceed what was expected.

Slide 6 – What is a Risk Pool? A risk pool is a group of individuals whose medical costs are combined and evaluated to calculate premiums. It's also a means to organize legislative funding for the different pools. Regardless of personal circumstances, if you are part of a risk pool, you will pay the same rates for the same plans as everyone in your pool. Pooling risks allows costs of the less healthy to be offset by the relatively lower costs of the healthy. The amount of risk has impact on the premiums.

Slide 7 – Risk Pool Dynamics. Although the risk within a pool impacts the rates, risk pool changes would not result in aggregate cost savings as the risk pools are not the primary driver for rate setting. There will be individual impacts that can vary dependent upon the changes proposed because when you are moving risk around, you would be reducing or increasing subsidization between individuals. Combining people with different levels of health risk into a single pool increases the level of subsidization from the relatively healthy to the relatively unhealthy. Currently, in the PEBB non-Medicare risk pool, the employee population is subsidizing the non-Medicare retirees, as an example. If you were to combine people with a similar health risk, there would be the opposite effect. There would be little to no subsidization.

Dave Iseminger: The Board will see examples of what Kayla just described in later slides with numbers. We'll be coming back to this concept with tangible examples. I think the first bullet on Slide 7 is a profound piece that changing risk pools doesn't change the aggregate cost to the system. Let's say a billion dollars is being spent right now. If you mix up the population into different pools, you're still spending a billion dollars. It’s what individual people are paying. I think some people believe that changing around the risk pools could create money in the system, but the reality is that it's still the same total amount of money. It's how different people are pooled. The system isn't creating, losing, saving, or generating money with the idea of changing risk pool arrangements.

Kayla Hammer: Correct. Slide 8 – Anticipated 2020 Medical Risk Pools, is an example of anticipated risk pools for 2020. Each one of these pools is legislatively mandated and the way the Legislature funds each pool is different. There is the non-Medicare community-rated risk pool under PEBB. It consists of state and other employees, non-Medicare state retirees, and non-Medicare school retirees. The PEBB Program Medicare risk pool consists of Medicare-enrolled state and school retirees. The SEBB risk pool is solely a school employee pool under the SEBB Program, which is separate from the PEBB Program.

Slide 9 – Anticipated 2020 Risk Pool Considerations. Assuming no changes in 2020, this slide lists considerations about the scenario that currently exists. In the PEBB non-Medicare risk pool, it combines the employees with the retirees. The risk pool is community-rated across plans. Rates are based on the level of risk within the entire pool. State active premium contributions are a portion of the community rate. The non-Medicare retirees pay the community rate. In the PEBB Medicare risk pool, it combines the state and school retirees that are eligible and enrolled in Medicare. The plans offered to that pool are not the same as the non-Medicare pool. The plans are rated separately based on member experience, and the state premium contributions are a portion of the plan rate up to a monthly limit.

Lou McDermott: I noticed you said member experience. I want to make sure what you're referring to is claims experience. Two different ways to interpret member experience.

Kayla Hammer: Yes, that's correct. Now we'll look at and discuss data. The next few slides show PEBB Program enrollment data. Slide 11 – PEBB Program Member Enrollment. This data is enrollment by group as of August 2018. The member count is accountable subscribers and dependents. There's an asterisk next to state employees and state retirees with notes below. On this table, state employees also includes others. It includes political subdivision or employer groups. There's also the K-12 current people that are in the PEBB Program in this count, COBRA, and others. The state retiree asterisks includes state retirees and those employer group or political subdivision members.

Dave Iseminger: When a political subdivision joins and contracts with the Health Care Authority for PEBB benefits, not all of them bring retirees with them. It's a subset of political subdivisions. I want to be clear that not everyone who joins the PEBB Program includes retirees. As a reminder, there are about 72 K-12 school districts with some or all of their bargaining units in PEBB benefits. But, come 2020, they get moved out of PEBB risk pools and put into the SEBB risk pool.

Kayla Hammer: There is a significant difference between these populations. If you look at the state employee count, for example, that's a lot of employees versus the non-Medicare retirees that are within that pool.

Dave Iseminger: Employees and dependents.

Kayla Hammer: Yes. Slide 12 – Subscriber Enrollment is member count. The dependents accounted for on the last slide are not on this slide.

Slide 13 – 2017 PEBB Program Non-Medicare Risk Pool Data. Now we will discuss data specific to the PEBB Program Non-Medicare risk pool. This is 2017 claims data. We'll talk about relative risk scores, average monthly paid claims, and total annual paid claims separated by group.

Dave Iseminger: This discussion is about the first box on the left side of Slide 8.

Kayla Hammer: Yes. Slide 14 – What is a Risk Score? A risk score is a calculated number reflective of the risk within a population or morbidity. Morbidity is the rate of disease in a population, or how unhealthy is that population, and a measure of that. Risk is calculated based on demographic information, diagnosis codes, drug codes, and utilization. Population groupings with higher average risk as expected to have higher claims cost due to that high morbidity.

Slide 15 – Non-Medicare Relative Risk Scores. This data is based on 2017 claims data.

Pete Cutler: On the risk score, is this used for risk adjustment within the PEBB Program or is this risk analysis being used just for purely analytical reasons? I'm curious how it connects to the rate setting process.

Kayla Hammer: The risk scores that I'm sharing today were a separate analysis and not necessarily what we use for rate adjustment. I would have to double-check that to be completely sure.

Pete Cutler: But the PEBB Program still does use some type of risk adjustment process for the populations?

Kayla Hammer: Yes. That is correct.

Carol Dotlich: You're talking very quickly for me to keep up. My question is back on the other two slides where you had program member enrollment and subscriber enrollment. The totals are quite different. Can you define what the difference is between the two total numbers?

Kayla Hammer: Yes, I can. Slide 11 is member enrollment. It has the subscribers and any dependents on their account. It's a significantly higher number. Slide 12 is looking at subscribers, which is just the employee or retiree, who are eligible and able to enroll in the medical benefits. No dependents.

Slide 15 shows risk scores relative to the statewide PEBB non-Medicare average of 1.0. Any amount above or below 1.0 is the percent of utilization expected compared to the average. An example would be, if you look at the table and see the school retiree non-

Medicare at 1.682, their expected utilization is 68% higher than the statewide average of 1.0.

Sue Birch: Average in this pool?

Kayla Hammer: Yes, average to this pool. Slide 16 – Average Monthly Non-Medicare Paid Claims per group. This is also 2017 PEBB Program claims data. The dollar amount shown is per adult unit per month (PAUPM) and is relative to the statewide average of $535. The monthly average paid claims is based on utilization and is impacted on plan selection. If a specific group was prone to selecting a specific plan that paid at a higher level than other plans, that can have an impact on what is shown here in the average paid claims. If you think about the last slide with the risk scores and connect those to what you're seeing here in average monthly paid claims, the groups that had the higher relative risk score tend to have, on average, a higher paid claims amount per month. The enrollment slide you saw earlier had over 100,000 subscribers in the state employee group. The numbers are much smaller, only a couple thousand, in the high utilizing groups. That helps create balance across the pool as far as overall cost.

Pete Cutler: On the paid claims, is that affected by whether somebody's seeing a consumer directed or a high deductible plan versus one of the other plans?

Kayla Hammer: Yes, the plan selection does impact that. Without having it in front of me, I couldn't say which group chooses certain plans more often than others. But that definitely does impact the cost of what's paid.

Pete Cutler: Am I right that the risk adjustment would not be impacted by that because it would look at how many tendency of what drugs you use, what kind of diseases you had, whatever factors that are not keyed by what your point of service cost share is?

Kim Wallace: Correct. The risk adjustment that we do as a regular matter of course in the PEBB Program to establish the ultimate premiums and rates does not adjust for differences in plan design.

Pete Cutler: Okay. That would make sense because the factors mentioned on Slide 14 were diagnosis codes, demographic information, drug codes, those kind of things, which really are not tied to what kind of out of pocket cost you have in your plan. Thank you.

Kayla Hammer: Slide 17 – Annual Non-Medicare Risk Pool Paid Claims. This slide also based on 2017 claims data. This is looking at all members. You may notice the percent of enrollment does not equal 100% because there are other groups in the non-Medicare pool, the employer groups. They are not part of this state employee line in this particular table, which is strictly state employees. There are other people within this particular risk pool and they account for about 12% of the enrollment.

Now we will talk about the middle column on Slide 8, the PEBB Program Medicare Risk Pool. Slide 19 – Medicare Risk Pool. Medicare data is shared separately from the non-Medicare data because the risk pools are separated in statute and funded differently by the Legislature. The insurance plans offered to the different groups are different. The Centers for Medicare and Medicaid Services (CMS) regulates the kind of insurance plans that can be purchased by people enrolled in Medicare. And then because of the differences in the insurance types, the reimbursement is different between the two populations.

Dave Iseminger: As an example, on the Medicare pool for pharmacy benefits, the UMP benefit in the PEBB Medicare pool pays primary for pharmacy but it pays secondary for medical. In the non-Medicare risk pool, the UMP pays primary for everything. That's an example of the reimbursement model being different.

Kayla Hammer: The PEBB Medicare plans are either secondary to Medicare or they are Medicare advantage plans. This results in the two populations cost data not being comparable since Medicare is picking up the bulk of the allowed costs for the Medicare pool on medical.

Slide 20 – Medicare Risk Scores. Based on our research, the K-12 retirees currently enrolled in the PEBB Program are slightly more healthy compared to the PEBB Medicare risk pool as a whole. However, K-12 retirees have significantly higher morbidity than active employees and early retirees. There are challenges and complexities with comparing the risk scores and associated costs of the Medicare and non-Medicare risk pools due to some of those things I mentioned on the previous slide, primarily, the way in which the plans reimburse based on the different types of plans offered to those two populations.

Lou McDermott: On your second bullet, could you say the PEBB Medicare retirees also?

Kayla Hammer: That's correct. Both or all the populations in the Medicare pool have higher morbidity than the active.

Lou McDermott: I just wanted to make sure we weren't calling it out because it wasn't similar in the other pool.

Dave Iseminger: As a reminder, the context of this report is what to do with K-12 retirees. The information, if it's silent for other parts of the retiree population, it's because the question being answered is what to do with K-12 retirees. The absence of information about other parts of the pools doesn't mean that it's similar, different. It’s because we're trying to focus on the simple and straightforward K-12 retiree piece. We’re trying not to introduce even more complexity within the description.

Kayla Hammer: Slide 21 – Annual Medicare Risk Pool Medical Benefit Costs by group. It's important to point out that the benefit cost amount is a combination of things. It is

self-insured claims cost, administrative fees, and fully insured medical premiums. This is not strictly claims costs as it was on the previous slide when we were talking about the other risk pool within PEBB. The total medical benefit costs between the groups is similar. There is some increased cost in the school retiree group within that risk pool, but they also have a higher percentage of member enrollment.

Dave Iseminger: Again, we tried to spend a lot of time with the titles of these slides because I know as you flip back and forth between medical benefits cost and claims cost, you'll start to think that they're the same thing but they really aren't. Claims cost is just claims cost. This is titled medical benefit cost and that description at the bottom indicates it's more than just claims. I just want to remind you about that difference.

Sue Birch: Could you share a little more information about administrative fees, if that is a blended rate? And could you give us a little more context about administrative fees?

Kayla Hammer: We pay a fee to Regence for managing this for us. It’s related to having a self-insured program.

Sue Birch: Thank you.

Kayla Hammer: Slide 22 – Scenarios: Implications and Considerations. I want to discuss the scenarios that we presented previously and talk about implications and considerations. Slide 23 – Create SEBB Program Non-Medicare Risk Pool, is a slide you’ve seen before. This is a scenario that would create a non-Medicare risk pool under the SEBB Program and we would remove the non-Medicare school retirees currently in the PEBB Program and move them into a community pool with the school employees under the SEBB Program. The school Medicare retirees would remain in the PEBB Program Medicare risk pool.

Kim Wallace: Kayla, I think what this is showing is that on the left-hand side in the green is the current PEBB Program non-Medicare risk pool without the non-Medicare school retirees. We move them over to the far right and essentially create the same type of non-Medicare risk pool for SEBB as there would be for PEBB.

Kayla Hammer: That is correct, Kim. Slide 24 - Considerations. Any risk pool changes that we discussed today will require changes to state legislation and likely changes in the way the Legislature funds each of those risk pools. The non-Medicare school retirees could have the same plan options they use prior to retirement in this particular scenario, which would result in a positive member experience for many. This could also lead to a negative member experience for the PEBB participating school non-Medicare retirees currently in the PEBB Program having to move over and to potentially having to switch insurance again. There are impacts on the employee populations as well. By removing some of the higher utilizing population currently in the PEBB non-Medicare community-rated pool, there could be a slight reduction in premiums for employees, assuming they were having a high impact on the current pool. By adding higher utilizing

population to the SEBB employee pool, there could also be an increase to premiums for school employees. These are potential impacts.

Dave Iseminger: Just a couple of additional examples of what this would really feel like to a member. The second bullet, for example, non-Medicare school retirees could have the same plan options they used prior to retirement. Let's go forward in our time machines, and it's now April of 2020. The plans that the SEB Board is currently talking about creating and are now in place in January 2020, at the end of that school year, Katy Henry retires from her teaching job. Now she can continue to have the same plans versus right now what would happen is she would come over and be in the PEBB plans. She would pick up on PEBB plans that are similar to those that state employees have. The example we're trying here is Katy gets to have the same plans she had as a school employee. She would have to probably pick up more of the premium, but the plans that she's already begun experiencing as a K-12 employee in SEBB, she would be able to maintain that experience and wouldn't switch plans until the point she reached Medicare age.

The third bullet is really describing, on Slide 11, the number of people that are non-Medicare school retirees currently in PEBB, about 4,000 members. Those are the members that, if the pool switched and you move that purple box to the far right, if this were the scenario the Legislature picked, those 4,000 people would have an affirmative plan switch that would have to happen.

Wayne Leonard: The K-12 remittance that we currently pay, does that subsidize both the non-Medicare retirees and the Medicare retirees? Or is it primarily one group?

Kayla Hammer: It's both.

Tom MacRobert: I want to make sure I understand this. So on the one hand, non-Medicare school retirees could have the same plan options, meaning if you have Kaiser Permanente, Uniform Medical, those remain the same, correct?

Kayla Hammer: What I meant by having the same is actually speaking as of 2020. Let's say you are in SEBB in 2020. You enrolled, you're working. You sign up for X plan. Then next year, 2021, you retiree. You would potentially be able to keep whatever you signed up for in 2020. In 2021, you could have that same plan. But for people that are already retired and under the PEBB Program right now, they may not have access to the plans that they've become accustomed to over the last two years of their retirement.

Tom MacRobert: So, that's the third bullet then that you were referring to. They might have to switch in that scenario.

Kayla Hammer: Yes.

Tom MacRobert: Okay, thank you.

Kayla Hammer: Slide 25 – Create SEBB Program Non-Medicare and Medicare Retirees Risk Pools. In this scenario, there would be the non-Medicare risk pool created under SEBB, like on the previous scenario. But in this, we would also create a Medicare pool under the SEBB Program. That would remove the Medicare school retirees from the PEBB Program into their own pool that would be managed by SEBB. The same considerations would exist as on the previous scenarios slide, as for the non-Medicare risk pool under SEBB. In this scenario, though, the HCA may need to procure a Medicare portfolio for the SEBB Program. Current PEBB Medicare school retirees would then maybe have to select new plans. This could impact up to 34,000 subscribers. It also could lead to a divergence of rates, plan offerings, member costs, and subsidy amounts.

If the pools were separate, there's no guarantee the Legislature would award the same Medicare explicit subsidy for both populations. We talked before that the K-12s currently in PEBB Medicare were slightly healthier than the Medicare pool as a whole. There would be assumed savings if you were to move them into their own pool. But it's not guaranteed that they would receive the same subsidy amount they were awarded previously under PEBB. There could be savings, there could not be. It depends on what the Legislature would decide to do. There's also additional administrative and program costs associated with this scenario. The implications for the Medicare retirees is that reducing the population can impact the risk of the pool, which would then impact the rates. The school Medicare retirees could end up with some savings, potentially. And then there is also the potential for the state Medicare retirees who were slightly less healthy to have an increase in their premiums.

Dave Iseminger: There's a lot to unpack on this slide. I'll share a couple of examples. I want to level set for each of the Boards. I want to make sure the SEB Board realizes when the agency goes to the PEB Board, we present both non-Medicare plans and Medicare plans. We talk about both risk pools and both plan options and premium setting at the same time for both of those risk pools. In this scenario, that would be done at the SEB Board, as well. Because right now, the agency is presenting the SEB Board with plans on, if I were wearing my PEBB hat, we'd be talking about the non-Medicare risk pool. We would have to very likely go forward and do procurements and bring other plan designs forward to the SEB Board for this second risk pool the Board would manage, the fourth risk pool for the agency, but the second risk pool for the SEB Board. It's not a given that we'd be able to procure the same carriers, the same plan design we've seen as we've presented different benefit options to the SEB Board that your demographics are different. There could be a different rating if the pool is split apart. That would be a whole other function and work stream that would be generated under this scenario to the SEB Board is procurements for Medicare plans, authorizing of Medicare plans, rate setting for Medicare plans. We would be doing everything just like we do for the PEB Board twice. HCA would be doing it twice for the SEB Board.

The third bullet means that if you have separate Boards, separate plans, and separate risk pools, things could diverge in a variety of different ways. It's no guarantee that any of those divergences would happen, but it's certainly possible, given that the

populations would be rated and assessed differently by the carriers. You very well may get somebody who says they used to pay less with them, or, now they are paying more. There's going to be that comparison between two separate Medicare risk pools that are described here in a way that doesn't exist today.

Kayla highlighted the subsidy amount and how the Legislature could handle that differently. I'm not as confident that the SEB Board understands the funding mechanism that happens for retirees and how it differs from employees. For employees, there's a state contribution where the employee pays the difference between what is the total cost from the carrier minus the state contribution. There's an amount the carrier agreed to that is the total plan payment rate to carriers. You subtract the state contribution and the difference is what the employee pays.

On the retiree side, there's the payment rate for the carrier and then the state Legislature has set for next year, the state will contribute $168. There's a flat amount put in the state budget that is paid. The difference is then paid by the employee. Of course, I'm oversimplifying because it's not really $168. It's $168 or 50% of the premium, whichever is less. But in effect, there's a flat dollar amount put directly into the budget. On the employee side, it is negotiated. There's Collective Bargaining Agreements. On the retiree side, it's a flat amount the Legislature puts in the budget.

Kayla Hammer: That's specifically for Medicare retirees.

Pete Cutler: My understanding is in the HCA statutes, there's a provision that, in essence, requires the premiums for non-Medicare retirees to be based on the average claims experience of those non-Medicare retirees plus active employees. Is there a similar type provision in the language dealing with setting premiums in the SEBB Program?

Kayla Hammer: There's no language now because at this time, the SEBB Program is strictly an active pool of school employees.

Pete Cutler: Okay, that would make sense now that you mention it. And there's nothing about that in the future if there is a change, it's just silent?

Kayla Hammer: This report is the next step for the Legislature to evaluate if they were going to make any changes.

Pete Cutler: Great, thank you.

Carol Dotlich: I would like to explore a little bit the impact of the Medicare explicit subsidy if the two groups, the Medicare eligible were separated.

Kayla Hammer: As of right now, for the PEBB Medicare risk pool, which has the school retirees in it now, there is a set amount for the explicit subsidy. I believe it's going to be $168 in 2019 or 50% of the premium, whichever is less. If they were to separate, there

is nothing in statute about what the subsidy amount would be for the SEBB Medicare risk pool. That would be up to the Legislature to decide and reevaluate. I can't speak for what they would do or if they would make any changes to the PEBB pool with it being sliced pretty much in half. We do know that there is nothing written for the SEBB, if there was a SEBB Medicare pool.

Patty Estes: When we talk about procurements, I know we've talked a lot about our timeline for SEBB and launch. What's the timeline if we were to try to procure Medicare plans?

Dave Iseminger: I'll answer this two different ways. This is all hypothetical as to when any changes would go into effect. If scenario two were selected by the Legislature, the earliest they could make any changes would be during the 2019 Legislative session. It would be very challenging and I'm pretty sure the agency would explain why implementing for plan year 2020 would be particularly challenging. It would be on a 2021 timeframe or later. It would depend on what the Legislature set as the timeline.

For doing the actual procurement process, we actually haven't done a full evaluation as to the Medicare procurement options. I'll give an example. When we did our life insurance procurement on the PEBB side and rebooted that product from beginning to end, procurement all the way through implementation was just under a year. When we are working on the SEBB procurement currently, the SEB Board in the March meeting authorized and directed the agency to go forward with a disability procurement, as an example. We've gone through that procurement and today brought you some preliminary benefit design pieces, asking you to take action soon. We're in contract negotiations and then the plan would go into effect in 2020. It really depends. I would say anywhere from a year and a half to two years is average. The more complicated the procurement, like our third party administrator for Regence, that took three and a half years plus two years of implementation. The less complex procurements can be under a year from beginning to end. But it's typical that it's somewhere between a year to two years.

Sue Birch: I think it's important to note, you referred to it as scenario number two. I believe you're referring to Slide 25 and now you're referring to scenario one on Slide 23. Is that correct?

Dave Iseminger: I was trying not to number them. And now you're saying I'm numbering them in voice.

Sue Birch: You numbered them. I just wanted to clarify for everybody.

Dave Iseminger: Yes.

Kim Wallace: I wanted to add also that when we're thinking about a procurement related to Medicare plans, that also introduces CMS and Medicare. The overarching

environment in regulations, etc. One of the things that HCA is researching and is aware of is that there's an added set of deadlines and considerations when entertaining the idea of offering new or different Medicare plan options. That would be another factor that comes into play as we would be planning a Medicare related procurement.

Wayne Leonard: A quick question to clarify my understanding. I think you just said when the Legislature makes this decision. Is this just informational for us or are we going to make a recommendation to the Legislature?

Dave Iseminger: You could use "when" or "if." There were 20 years of legislative reports about K-12 benefits consolidation and then the official recommendation wasn't what was passed in the House Bill 2242. When and if, let me correct that part on the record. The second piece is, we're here consulting with you, describing the scenarios and what pieces we're seeing as considerations. The agency is charged with making a recommendation on the most appropriate risk pool. The Boards separately or together are not dictated to take a vote. We're asking for your insight so that we can add it into the report. The agency will make a recommendation. Whether the Legislature puts this on a shelf and it collects dust; or they, for ten years, two years, one year, or they act on it in 2019, there are a lot of different factors in the legislative arena as to whether something will be specifically acted on our not. It's the agency making a recommendation and the Legislature taking action one way or the other, or leaving things how they are.

Tom MacRobert: Kim, if I'm understanding what you just said correctly, though, if you were to transfer a large pool like the Medicare retirees from one group to the other group, you could have the potentiality of having to go out and do a whole new procurement of benefits for that group because you've made such a substantial change?

Kim Wallace: I was commenting on the plan offerings that the HCA would be entertaining and wanting to offer across all retirees, both the K-12 and the state retirees. The act of separating them into two different pools suggests that there is a reason to do that. It's part of the analysis that we're doing, looking at that question. Are there compelling reasons to do that? It may be that there are not. HCA is interested in your feedback and views on the desirability of actually splitting the Medicare retirees to separate pools. From our vantage point, we want to highlight that is serious work and it comes at a cost. What we're thinking hard about and inviting you to comment on, is the benefits, what's really achieved by such a separation? What goal would be achieved by separating the Medicare retirees because of the administrative complexity, cost, and timing? We would want to be really clear as to what is being achieved.

Kayla Hammer: Slide 27 – Create Two Additional SEBB Program Risk Pools. In this scenario, the non-Medicare school retirees would be removed from the PEBB Program under the non-Medicare risk pool into their own pool under the SEBB Program. The Medicare school retirees would be removed from the PEBB Program and in their own risk pool under the SEBB Program.

Slide 28 – Consideration. There are similar considerations as previous slides for the non-Medicare and Medicare pools, particularly the PEBB non-Medicare pool. There's likely a small impact to employees in the PEBB Program and SEBB Program based on the risk pool in which the non-Medicare or school retirees are assigned. PEBB Program employees may save by removing the higher utilizing, the small utilizing population, as mentioned previously.

There is the possibility that SEBB Program employees, if Slide 23 scenario was enacted, could have slightly higher rates. But in this scenario, school non-Medicare retirees would be in their own pool. There would be no subsidization situation happening in the SEBB employee pool. However, the small risk pool for non-Medicare retirees would result in increased cost for those early retirees because we would be removing that subsidization talked about previously, the value of a community-rated pool. It's estimated that the premium increase could be as much as 58% to 60% for that small pool of people. That's assuming no legislative subsidy was in place for the non-Medicare retirees.

Dave Iseminger: A big piece of this Kayla is trying to highlight is a lot of these implications and considerations are rooted in the fact that it's such a small number relative to the big picture. Again, if you go back to the earlier slides, we're talking about 2,600 subscribers or 4,000 members compared to hundreds of thousands of individuals in a risk pool. When you get to that small of a pool, it has a lot more volatility.

Sue Birch: Dave, are we worried with these smaller entities, of the plan design and/or the offerings that would be available?

Dave Iseminger: Sue, I do think that's another implication of the scenario on Slide 27. The SEB Board would have to decide, are you going to rate the pools separately for employees and non-Medicare retirees but give them the same plan offerings, or do we do another set of procurements with a different set of plans and have something that's a middle ground between employee plans and full Medicare retiree plans. It would open up the door to that further question in a way that is not present in either of the prior two scenarios, where the non-Medicare school retirees are with the school employees. It doesn't necessarily inherently introduce that. It just means that they would be community-rated separately. The SEB Board could decide to offer the same plans from the employee risk pool or a different set of plans. It would at least create that option.

Kayla Hammer: Slide 29 – One SEBB Program Risk Pool. This scenario illustrates one risk pool under the SEBB Program that contains employees, non-Medicare and Medicare retirees, removing both groups of retirees, the non-Medicare and Medicare from the PEBB Program, all under SEBB.

Slide 30 – Considerations. Further verification is needed on the legality of this scenario. We know it requires changes to Washington State legislation, as this is fundamentally different from the way risk pools are currently funded and managed under statute. Federal law needs further review. The illustration does look like a community-rated pool

but it would not function that way because one thing we do know is that under federal law, no issuer can sell a major medical policy to a Medicare enrollee. That means, regardless of the risk pool, the Medicare retirees will still be purchasing specific plans, which is not the same as people that are not enrolled in Medicare.

Dave Iseminger: If you stay on Slide 29, it looks like everybody's together and being treated the same exact way. But it functionally would not be that way because the bottom purple box would have completely separate plan offerings than either or both of the prior two boxes. The reality is if you were trying to community rate them in a single pool as shown on Slide 29, you would end up immediately having some sort of adjustment factor based on the different plan designs. You would immediately see a different rating structure within what looks like one pool. It would create this plan adjustment factor for lack of a better description that is inherent to the fact that Medicare retirees will have fundamentally different options than non-Medicare retirees. It may look like one pool but it wouldn't function like one pool, which would beg the question, why make it look like one pool.

Kim Wallace: I want to circle back to the comment I made a few minutes ago. We're looking at these different options. I think it's important to consider what would be achieved by moving away from what is currently anticipated so that we can be really clear. That's what HCA is seeking in our report. HCA wants to be really clear on the rationale and underpinnings of our analysis of the most appropriate risk pool for the K-12 retirees. We're keeping in mind what would be accomplished. Why? What would be the better outcome from a recommended change? We invite you to share your views on the opportunities to change and why. What are you envisioning accomplishing?

Tom MacRobert: I'll jump in. After you have gone through and given us a really good descriptor of all of these different plans, I can see no benefit to switching. Maybe you could enlighten me as to why that perception is incorrect. I would love to hear it. But as it stands right now, I can't see any benefit.

Dave Iseminger: Several of us around this table went to law school so we can always play devil's advocate. I don't want anyone to think that me saying one way or the other is supporting an option. It's just me being a lawyer. One of the examples would be the member experience of being able to maintain the same plans, especially that non-Medicare retiree. If you were to move them in the way that's described on Slide 23, where you move non-Medicare retirees, school retirees into the school employee risk pool, then those recently retired young retirees or not Medicare eligible retirees, they get to maintain that plan relationship that they've experienced. At least the future new retirees, not the current ones that are in the PEBB pool. That would have a disruption. But future new retirees would be able to have similar plans they experienced as school employees. They only have one switch to the Medicare retirees plans in the PEBB Medicare risk pool when they enroll in Medicare. If you kept the exact system that was in place today that's envisioned for 2020, you'd have a K-12 employee who has SEBB plans, they're an early retiree, they move to the PEBB non-Medicare risk pool plans,

then they become Medicare eligible and have another shift into a completely different Medicare plan. You could eliminate one of those shifts by a future state where the K-12 non-Medicare retirees are able to maintain the same plans they enjoyed as active school employees. That's one advantage to one of the scenarios.

Tom MacRobert: But that would be the smallest group we're talking about, the least number of people that would be impacted.

Dave Iseminger: Correct. That is a small group. It's about 4,000 members and I think it was 2,600 subscribers.

Tom MacRobert: Okay, thank you.

Katy Henry: But it would affect all future SEBB retirees.

Dave Iseminger: Correct.

Dave Iseminger: Katy, another point, for the record, to keep in mind is that with the consolidation of SEBB, as I always say, the bridge to PEBB will become more apparent. There are many school teachers who learn about PEBB very close to retirement and that's the first time they ever hear of the PEBB Program. With one agency administering both programs, that bridge will be clear and that number may get higher as time goes by.

Patty Estes: I just want to make sure I'm understanding the cost to a school employee if we put the non-Medicare retirees into the same risk pool with the school employees, that would increase their cost.

Kayla Hammer: It could impact the cost because you are moving a small group of people that are typically utilizing into --

Patty Estes: With a smaller funding mechanism with a subsidy. Am I understanding that correctly?

Kayla Hammer: With the non-Medicare risk pool scenario, it is assumed there would be no legislatively mandated subsidy for the non-Medicare retirees. They benefit from a blended premium rate by being in a pool with active employees. Does that make sense?

Patty Estes: No, it's okay, though.

Kayla Hammer: It's a lot to take in on one day.

Pete Cutler: Following up on that, in fact on Wayne's questions, the payment that school districts who don't have employees in PEBB currently, which is a great majority of districts, there is a monthly payment, which I think is referred to as a carve out. It

represents the Health Care Authority's estimate of the cost that the PEBB Program plans incur for all the school retirees that's calculated and updated every year. In theory, on Slide 24 where it talks about the impact of moving the non-Medicare school retirees into a single pool with actives, there could be an increased premium for school employees. My understanding and theory, if you're calculating that carve out accurately, it would not have a premium impact because the dollars would now be pulled out and no longer available to school districts - because they're going to HCA to pay for those costs and would no longer be transferred to HCA and they would remain with the school district.

Kayla Hammer: Let me clarify. You're saying that in that scenario, there would essentially be a wash?

Pete Cutler: Right. I think on making a decision on what to recommend here, for me, it's influenced by trying to understand how that carve out funding mechanism would offset premium impacts that would otherwise be expected to occur. I don't need a discussion right now. But it would be useful before we go too much farther.

Kim Wallace: What some people refer to as the carve out, others refer to as the K-12 remittance. One thing I wanted to clarify for the group is the amount of money you're referring to that the school districts pay in the K-12 remittance covers the value of the retiree costs and comes in two flavors: the implicit subsidy and the explicit subsidy for retirees. That amount is financially modeled and calculated by HCA. They are suggested values. I want to make the point that the Legislature does pick a number and they don't have to pick the suggested value.

Pete Cutler: Thank you for that clarification. In my prior role, often reviewing those numbers, that's an important part for the record. It's actually a legislative decision based on analysis provided by the Health Care Authority.

Kim Wallace: Right. The reason that's important is how much of a wash would occur. It's a funding decision about that retiree subsidy amount. I think none of us know what exactly would come of that calculation of that implicit subsidy.

Dave Iseminger: As we're moving on, I want to say even though this presentation didn't really get into the inner workings of the K-12 remittance or carve out, they'll certainly be described in the report about the implications. There were too many variables, especially with how Kim just described it for it to be as fruitful of an add-on to this presentation. It certainly will be discussed in the final report.

Pete Cutler: Dave, I think it would be useful to have something written up available to Board Members. Maybe just post it on the web. I think providing feedback on different options for pooling, unless you understand the mechanism for the remittance, it really is hard to make an informed point of view. I hope we can get something in writing before December. Thank you.

Carol Dotlich: I wanted to clarify, under this scenario on Slide 23, can you foresee the impact on the PEBB non-Medicare risk pool costs?

Kayla Hammer: Potentially. We talked about relative risk scores previously. And we talked about how in the Medicare pool under PEBB, currently, the K-12 retirees are healthier than the pool as a total. So there is the potential that by removing a, maybe slightly healthier -- they are mostly comparable. But there could be a negative impact, I suppose, on the PEBB Medicare pool. It would depend on the number of people removed and the overall effect on the rating of the plans that happened after the fact. I could say yes, there could be. But it's hard to say.

Kim Wallace: I think your comments just now seem to be focused on a change in Medicare retirees and splitting them up. I think Carol's asking about on Slide 23, the movement that's happening is the non-Medicare school retirees leaving PEBB and coming over and joining --

Kayla Hammer: I was looking at the wrong scenario. You were curious about the impact on the PEBB Program non-Medicare risk pool by removing. The non-Medicare school retirees who were slightly healthier, had a slightly better risk score than the non-Medicare state retirees. So you're removing a small amount of people that are still high utilizing but less high utilizing than the other non-Medicare retirees. There is a possibility that the ratio of healthy to less healthy could be disrupted. So potentially, that could result in some increase to that PEBB non-Medicare pool.

Dave Iseminger: Carol, in the non-Medicare risk pool, there's 275,000 state employees. There are 5,300 non-Medicare state retirees and 4,000 school non-Medicare retirees. So a very small portion of when you compare on Slide 15 the relative risk score that's in the middle of those three populations. It's probably going to be fairly small but it could happen. And that would be a slight increase overall because you're taking out some subset of the piece that is on the healthier side of the equation but not the healthiest or largest.

Carol Dotlich: Do you have any sense of percentage or dollar amount that change could be?

Kayla Hammer: I do not have that information. And it wouldn't be something that could easily be measured until you went through the procurement process and looked at the new pool and had conversations with carriers to get a real idea about what that would be.

Patty Estes: Am I correct in remembering that the current K-12 employee population enrolled in PEBB is around 30-35,000?

Dave Iseminger: No, it's 3,500.

Patty Estes: Okay. Taking that into effect, too, there could potentially be about 7,000 that move out.

Tim Barclay: I think you asked for our thoughts and comments on these various options. I'll give that to you. Remember, you asked for it. So just quickly on the four different options, my thought is the fourth one makes no sense. You're bundling people together to bundle them together only to do all the work to separate them to make it sort of functional for others. I don't think the fourth option is really worth a whole lot of conversation.

Sue Birch: Tim, to clarify, you're referring to the one on Slide 29?

Tim Barclay: Yes. The single risk pool of all the different people. I won't spend a lot of time on that.

I think the interesting question is if we start with the first scenario on Slide 23, which I think makes a lot of sense. I agree with Pete's comments earlier that throwing the non-Medicare school retirees in with the school employees doesn't have to have a big impact depending on how the K-12 remittance funding is transferred with it, and how it's administered in the calculation of the premiums. It's a small number of people. You've got some sense of potential for offset, in terms of how they decide to do the K-12 remittance. The administrative simplifications of not making people switch into the PEBB Program, I think this scenario makes a lot of sense.

The second one on Slide 25, I'm struggling to see the value. We're going through some work now in PEBB to restructure the Medicare benefit portfolio. To ask the Health Care Authority to do that twice, present it, and potentially deviate between different boards doesn't make a lot of sense to me. People, no matter what pool they come from, when they become Medicare eligible have to make a choice, have to make a change of plans. It's not going to make life easier for them to go to one versus the other. Furthermore, I think it's a little inconsistent with the whole context of how SEBB was created in the first place, which was to create more consistency between how folks are funded and managed. I think it would be a little bit counter to where the Legislature's trying to go to then take a population that has already combined into a single Medicare benefit package and split it into two and create more administration and more differences. I don't think it makes a lot of sense to split that pool out.

The third one I already commented on. I just don't think those people are big enough or different enough with the K-12 [indecipherable] to justify splitting them into a separate pool. That’s my take on it, when it's all said and done, the only scenario that really makes any sense to pursue is the first one.

Wayne Leonard: I would concur with Tim's summary. If there are going to be any changes, it appears that the pooling on Slide 23 would probably be the only one that makes sense. And even with that, I would hope that we would look at minimizing the

administrative costs of administering all these different pools or plans. If it was going to result in higher administrative costs, I'd probably rather just keep it the same.

Tom MacRobert: You have to submit this to the Office of Financial Management in November? Is that correct?

Dave Iseminger: Yes. All the legislative reports this agency does, this is one of 41 that we're doing this calendar year, or between last session to this session. All of our reports, we do a review through OFM. It's a standard part of the legislative report-making process for this agency.

Tom MacRobert: It's my understanding, unless there's something that comes completely out of whack, that's something they just say it looks good. The numbers look good. The numbers match. It's not an analysis of what you're trying to do but rather it's an analysis of the numbers you're using, right?

Dave Iseminger: I think it varies based on the reports. I've seen reports that the agency's worked on that's had a lot of substantive feedback that has said this needs further clarification. You need more data to represent this piece. Or there's this other part of the equation. That's why it is a multi-week process to really give the best report possible to the Legislature with a critical eye from OFM, outside of the agency to inform that process. I would definitely not describe it as a rubber stamp. It is a substantive process.

Tom MacRobert: At the time you send the report, you're going to have to make a recommendation. You're going to have gone through these different scenarios and come to a conclusion as to which one you think represents the interests of everybody and make that recommendation. Hopefully OFM says yes and it goes to the Legislature.

Sue Birch: Tom, I don't think it's fair to represent that HCA would make the recommendation that represents everyone’s opinion. I don't believe HCA would suggest we represent either the PEB or SEB Board in that recommendation.

Tom MacRobert: No, I wasn't asking that. What I was saying is that you are going to have to come to a recommendation.

Sue Birch: That is correct.

Myra Johnson: First, I want to say thank you. You've clarified the mud just perfectly. Thank you and I appreciate that. I, too, am liking the scenario on Slide 23 with the explanation on Slide 24. My one concern, and I know the answer's probably going to be, "We're trying, we're trying." That last line, “Possible increase premium for school employees." I would like that to be miniscule if even non-existent, which I understand with all the scenarios in play and I understand it is a possibility. If this is the one that you move forward, reiterate that any increase is not a positive.

Yvonne Tate: What I was thinking about is between the option on Slide 25 or Slide 23, I guess the question really is, if you have a [indecipherable] . . .

Sue Birch: Thank you for that, Yvonne. Anybody else on the line? Harry, Allison, or Greg, if you've gotten off your flight?

Harry Bossi: I'm okay, thank you.

Alison Poulsen: I don't have any further questions. I really appreciate the thoughtful discussion. This is a complicated and important decision.

Sue Birch: Thank you, Alison. I have a question I'd like to ask for a little clarification. On scenario one, Slide 23. Is the thought process that by moving the non-Medicare school retirees, even though we might have more uniformity with the types of plans that they're moving onto when they're not an active employee, it's likely that the plans are going to be more similar and so that's the dominant health care motive. Is the thought that the Medicare plans offered to both are state employees PEBB and SEBB members are going to be more uniform throughout the state? Was that some of the thought process you had about the Medicare plan designs that would be available in that middle column?

Dave Iseminger: In this scenario on Slide 23, essentially nothing would change but this wouldn't be something that prompts a specific change in the Medicare risk pool. There are plenty of other pieces the PEB Board's been evaluating as to implications for the Medicare risk pool. But right now, state and school retirees have the same option to the same plans in that Medicare risk pool. If there were any changes to the plan offerings, they would remain equally accessible by both parts of the risk pool because they are in a single risk pool. I think that's what you might be asking.

Sue Birch: It seems to me that the carriers would be able to offer more uniformity based off Medicare.

Dave Iseminger: That's what they do now. There is no distinguishing in the Medicare risk pool based on what kind of retiree you are. You're a Medicare retiree in the Medicare risk pool. The only reason they're different is we were just highlighting K-12 versus state. But from a carrier standpoint, that Medicare risk pool in the middle column, there's no differentiation based on who your employer was when you were an active employee.

Kim Wallace: I want to ask a follow-up question to Sue. I think you're asking a question about the kind of continuity or alignment that people experience when they become a retiree. I think it's a matter of Health Care Authority making a policy decision that gets implemented in terms of managing the Medicare portfolio. There has been historically, care taken to create a logical path for employees covered under the PEBB Program to have benefits or at least carriers that they are comfortable with, familiar with,

etc. when they retire. Currently, in the PEBB Program, the carriers offering Medicare plans to retirees are carriers that are familiar to our offering plans to employees. I think one of the questions with the new SEBB employee program, the question would be then, how is it that there is this logical, reasonable flow and path for them to go from being a K-12 employee with SEBB coverage to being a K-12 retiree with Medicare coverage in PEBB. I think it's a good point. I think it's part of designing and maintaining the full Medicare portfolio that we now, the HCA has an evolving responsibility to consider designing a Medicare portfolio of offerings that makes sense for all the folks that are retiring into Medicare in a new way. We've cared about that for a long time but I think it's part of the review and the new look at the full Medicare portfolio being offered is taking into consideration what do all of the people experience as they come in to Medicare coverage as a retiree. Is that what you were asking about?

Sue Birch: Thank you. That's exactly what I was looking at here. I'm trying to understand how we're stair stepping folks.

Carol Dotlich: I agree with Tim. I think this plan makes the most sense of all the scenarios provided.

Public Comment

Fred Yancey, on behalf of the School Retirees Association. Thank you very much for your attention to this issue. The life of a retiree living on a fixed income, as you know, is a challenge. And our concern really is your perspective of what scenario you pick. Our concern is what we have to pay for insurance. It's a very simple sort of concern. So we want the best scenario that gives a retiree the best insurance at the lowest cost. It was suggested, and I think Ms. Wallace suggested it as well, but I won't put words in her mouth and I may have misunderstood her. But if you look at the number of subscribers and we talk to our seniors that have retired, you only have a fraction of retirees that elect to go into the PEBB Program to begin with. I think it's because there aren't enough offerings to attract enough retirees. I mean, the real question is, you know, should you be out there getting some more options for retirees. The ones I talk to, our own membership, probably, we're guessing only about 40%, you know, belong to the PEBB Program. When I looked at the Medicare offerings because I'm Medicare eligible, you know, I was kind of dismayed at the few choices I had. I'm happy with the choice I made but I talk to my friends that are not even school related and they tell me their Medicare plans. And I'm going, "Boy, there's a wide variety of choices that I didn't see reflected in the PEBB." So again, thank you very much. Our concern and I didn't hear anything about that today other than general comments and it's too bad. I really would like to know what sort of rates we're looking at for retirees. I don't know how -- I understand how hard that can be to find out. Thank you.

Julie Salvi, with the Washington Education Association. Sorry I didn't sign up earlier. So our interest is ensuring that the retirees stay in a robust enough pool, to have the best deal available for them. And I look at the current state of affairs and the first options where a number of your Board Members were also recommending as really being kind of the two options before you that would check off a number of those boxes

for us. The other -- I didn't hear a lot of interest in the other plans and I just wanted to offer an idea, which is I would like to see some entertainment of how a transition plan could be made because I think what we're going to run into is current non-Medicare retirees who are in PEBB who are not going to be interested in moving to SEBB only to move back to PEBB in a few years when they're Medicare eligible. And then once K-12 employees are in SEBB, many of those people who are early retirees, non-Medicare retirees would like to stay in SEBB. And that may be an option. There could be a way to transition between the two and not have current non-Medicare retirees bouncing between PEBB and SEBB. And that may be a more interesting option to consider if you're ruling out some of these other options going forward. So kind of an option of how you might transition with the carve out or remittance that is out there. I think there's a mechanism, financially, to make that work. And that would be a new scenario that would keep the employees in mind for how many changes they're having to go through.

Doug Nelson: Yes. Doug Nelson from Public School Employees of Washington. So on the record, we support Slide 23. I think we're talking about the non-Medicare retirees. And you have to realize, in the K-12 system, we have developed an organically developed insurance industry over 30, 40 years. I think what this whole SEBB Program is about is providing something similar for everybody across the state. And so I recognize that the PEBB or the SEBB non-Medicare retirees will have to change. Join the club. There's about 160,000 K-12 employees who are going to be changing too. So I agree with Julie. If we can figure out an easy transition way, that would be great. But if not, it might be just a bullet that has to be bitten on like everybody else is. Thank you.

Dave Iseminger: I do appreciate the historic nature of bringing both Boards together for a conversation that could impact both. I just appreciate everybody coming together for a special meeting. I appreciate the comments from both Boards in July and particularly today as we were able to get more information to you for your consideration. We'll wrap up all of your comments and insight as an appendix, or as some part of the report, and appreciate your willingness to engage on such an important topic. I was glad we were able to give you about 45 days' notice for this meeting and that everybody could come here to the Health Care Authority. So thank you all.

Sue Birch: Dave, thank you, as usual to you and your team for preparing all of this and getting us all together.

Meeting adjourned at 4:25.

TAB 4

Washington State Health Care Authority

January 24, 2019 Board Meeting Follow Up

Dave Iseminger, Director
Employees and Retirees Benefits Division
March 7, 2019

January 24 Meeting Follow Up

The following are the respondents to the Virtual Benefits Fair RFI*:

- Jellyvision
- Conduent
- Business Solver
- Resources Online
- Eboro
- KAI

* Request for Information

January 24 Meeting Follow Up (*cont.*)

UMP Provider Search:

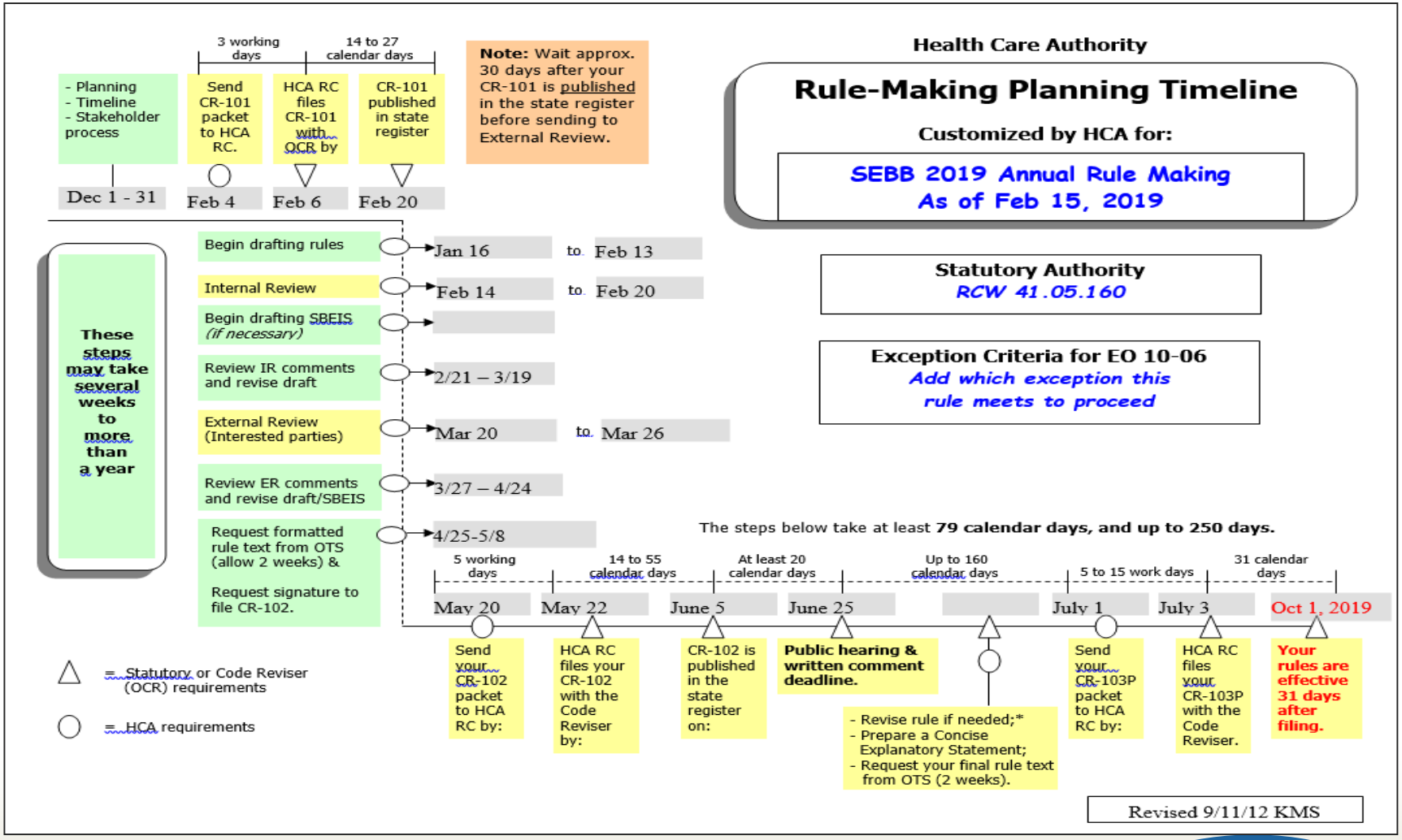
https://web.healthsparq.com/healthsparq/public/#/one/insurerCode=RG_I&brandCode=RG_UMP&productCode=N484590599&postalCode=&state=WA

January 24 Meeting Follow Up (*cont.*)

- Who are dependents? Dependents for the SEBB Program were established by the approval SEBB 2018-01, SEBB 2018-02, and SEBB 2018-03. This link will take you to WAC 182-31-140 where this information was captured in rules.
- What are SEBB Organizations?
  - Per RCW 41.05.011(22) "School employees benefits board organization" means a public school district, or 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.
  - Per WAC 182-30-020 "School employees benefits board organization" or "SEBB organization" means a public school district, or 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.

Washington State Health Care Authority

January 24 Meeting Follow Up (*cont.*)



January 24 Meeting Follow Up (*cont.*) Tobacco Cessation UMP

- *Members must be ages 18 years and older to participate*
  - **Quit For Life Program** provides print and online tools to help members live tobacco-free
    - Use the Quit Guide workbook to stay strong between coaching calls
    - Connect with other people trying to quit and track your progress on the members-only Web Coach® site
  - **Smokefree Teen Program** is for teens 17 years and younger and is part of the National Cancer Institutes Smokefree.gov Initiative (Not offered through UMP)
    - Offers free tools and online services with easy accessibility from their cellphone

January 24 Meeting Follow Up (*cont.*) Tobacco Cessation - Kaiser WA

- *Members must be 18 years and older to participate*
- **Breathe** is a self-guided online module
  - A member answers questions
  - Offers skills and action steps to help through the quit process

January 24 Meeting Follow Up (*cont.*) Tobacco Cessation - Kaiser WA

- **Quit For Life Program** provides print and online tools to help members live tobacco-free
  - Use the Quit Guide workbook to stay strong between coaching calls
- Connect with other people trying to quit and track your progress on the members-only Web Coach® site

January 24 Meeting Follow Up (*cont.*) Tobacco Cessation - Kaiser NW

- **Breathe.** This online program can help you design a personalized action plan to stop using tobacco
  - *Ages 18 and older*
  - Program is free to members
- **"Freedom from Tobacco" one or six sessions classes available at KP medical offices**
  - *Ages 18 and older*
  - Program is free to members

Washington State Health Care Authority

January 24 Meeting Follow Up (*cont.*) Tobacco Cessation - Kaiser NW

- **Telephone coaching.** Sessions with a coach will help you create a plan for quitting and provide ongoing support
  - *Ages 14 and older*
  - Program is free to members
- **Cultivating Health *Freedom from Tobacco Kit.*** This interactive, self-paced kit is sold through the Health Engagement & Wellness Services department
  - *Ages are not limited* and costs $15
- **Coverage for medication therapy** may be available

January 24 Meeting Follow Up (*cont.*)

Below is the link to Dave Iseminger's testimony before the Senate Ways and Means Committee:

https://www.tvw.org/watch/?eventID=2019011217

Washington State Health Care Authority

Questions?

Dave Iseminger, Director

Employees and Retirees Benefits Division

Dave.Iseminger@hca.wa.gov

TAB 5

Washington State Health Care Authority

SEBB Finance Update

Megan Atkinson, Chief Financial Officer
Kim Wallace, SEBB Finance Manager
Financial Services Division
March 7, 2019

Overview

- Update on HCA-suggested SEBB Funding Rate as of March 1
  - Based on 2020 Final Not-to-Exceed (NTE) Rates for medical, dental, and vision
- 2020 Medical Final NTE Rates (Fully insured still confidential)
  - Employer Medical Contribution (EMC) and Uniform Medical Plan (UMP) Employee Premiums
- What the employer will pay: EMC vs. Funding Rate
- Budget impact of updated rates to SEBB Funding Rate

Washington State Health Care Authority

SEBB Funding Rate

Projection from Summer/Fall 2018 vs. HCA modeling as of 3/1/2019

SEBB Funding Rate Components	FY 2020	
	Collective Bargaining - 8/7/18	HCA Update - 3/1/2019
EMC (PAUPM) [1]	$616	$578
Ratio of Adult Units to Subscribers	1.586 [2]	1.573 [3]
Medical Premium Contribution (PSPM) [4]	$977	$907
100% Dental Premium (PSPM)	$80	$91
100% Vision Premium (PSPM)	$18	$10
100% Basic Life Premium (PSPM)	$4	$4
100% Basic LTD Premium (PSPM)	$2	$2
K-12 Remittance (PSPM)	$77	$67
Admin and other costs (PSPM) [5]	$16	$32
Total Cost (PSPM) [6]	**$1,174**	**$1,114**

Source:
Coalition bargaining session materials - 8/7/18
Legislative Budget Funding Rate Scenario - 3/1/19

Notes:
1. PAUPM - Per Adult Unit Per Month
2. 1.586 adult unit factor is a modeled assumption for the SEBB eligible employee population, including enrollment of dependents, which was used for the Collective Bargaining Scenario.
3. 1.573 adult unit factor is an updated modeled assumption for the SEBB eligible employee population, including enrollment of dependents.
4. PSPM - Per Subscriber Per Month
5. Admin and other costs includes GF-S loan repayment
6. Values are rounded within modeling.

Washington State Health Care Authority

2020 Employer Medical Contribution (EMC) and UMP Employee Premiums

Based on Final Not-to-Exceed Rates

Plan	Actuarial Value (AV)		Employee Only	Employee & Spouse/SRDP [1]	Employee & Child(ren)	Employee, Spouse/SRDP & Child(ren)	Employee Contribution as Percent of Total Premium
		X = Cost at First Tier	Tier 1: 1:00x	Tier 2: 2:00x	Tier 3: 1:75x	Tier 4: 3:00x	
SEBB UMP Plus	89%	Total Premium	$649	$1,298	$1,136	$1,947	11%
		Employer Contribution (EMC)	$578	$1,156	$1,012	$1,734	
		Employee Contribution	**$71**	**$142**	**$124**	**$213**	
SEBB UMP Achieve 2	88%	Total Premium	$679	$1,358	$1,188	$2,037	15%
		Employer Contribution (EMC)	$578	$1,156	$1,012	$1,734	
		Employee Contribution	**$101**	**$202**	**$177**	**$303**	
SEBB UMP Achieve 1	82%	Total Premium	$612	$1,224	$1,071	$1,836	6%
		Employer Contribution (EMC)	$578	$1,156	$1,012	$1,734	
		Employee Contribution	**$34**	**$68**	**$60**	**$102**	
SEBB UMP High Deductible	83%	Total Premium [2]	$603	$1,206	$1,055	$1,809	4%
		Employer Contribution (EMC)	$578	$1,156	$1,012	$1,734	
		Employee Contribution	**$25**	**$50**	**$44**	**$75**	

Notes:

The 2020 EMC of $578 is 85% of the Total Premium (Final NTE Bid Rate) of the SEBB UMP Achieve 2 (88% AV plan).

All values in the table above are on a PAUPM basis.

1. SRDP - State Registered Domestic Partner
2. Total Premium for the SEBB UMP High Deductible Health Plan includes an employer HSA contribution of $375 per year for Tier 1 and $750 per year for all other tiers

Washington State Health Care Authority

What the Employer will pay: EMC* vs. Funding Rate

- The Funding Rate includes several components (as shown on Slide 3)
  - Let's focus in on the EMC and the Medical Premium Contribution component – the first three rows of the Funding Rate table

*Employer Medical Contribution

Washington State Health Care Authority

What the Employer will pay: EMC vs. Funding Rate

EMC (PAUPM)	**$578**
Ratio of Adult Units to Subscribers	**x 1.573**
Medical Premium Contribution (PSPM)	**$907**
100% Dental Premium (PSPM)	91
100% Vision Premium (PSPM)	10
100% Basic Life & Basic AD&D Premium (PSPM)	4
100% Basic LTD Premium (PSPM)	2
K-12 Remittance (PSPM)	67
Admin and other costs (PSPM)	+ 32
Total Funding Rate (PSPM)	**$1,114**

*Values are rounded within modeling.

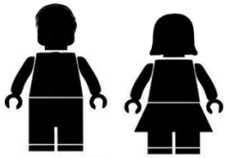
Washington State Health Care Authority

What the Employer will Pay: EMC vs. Funding Rate

Tier 1 **1**

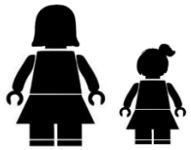
EMC = $578
Funding Rate = $1,114

Tier 2 **2**



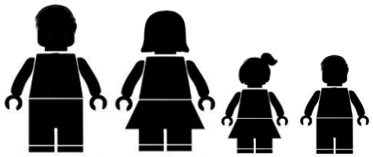
EMC = $1,156
Funding Rate = $1,114

Tier 3 **1.75**



EMC = $1,012
Funding Rate = $1,114

Tier 4 **3**

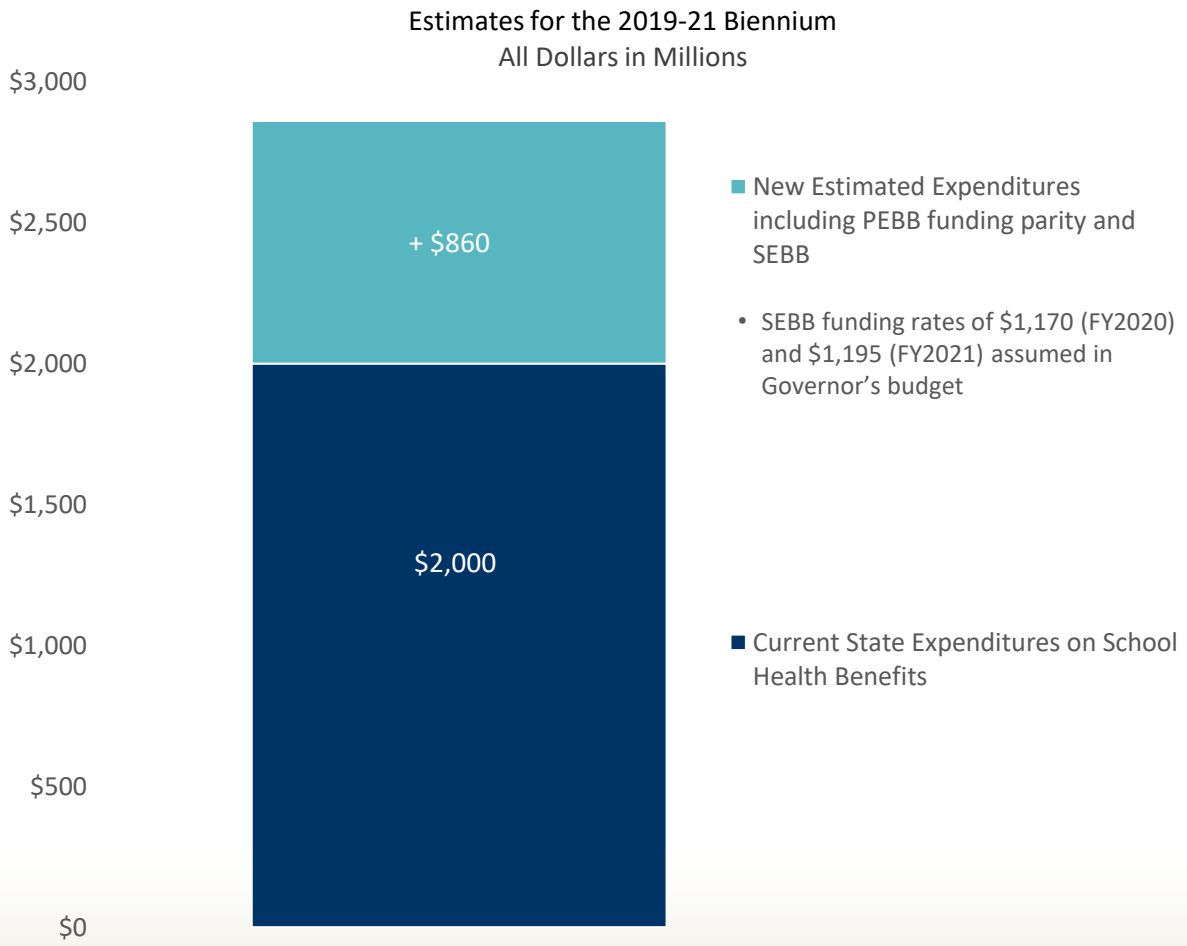


EMC = $1,734
Funding Rate = $1,114

*Employer will also pay the Funding Rate for employees who waive medical

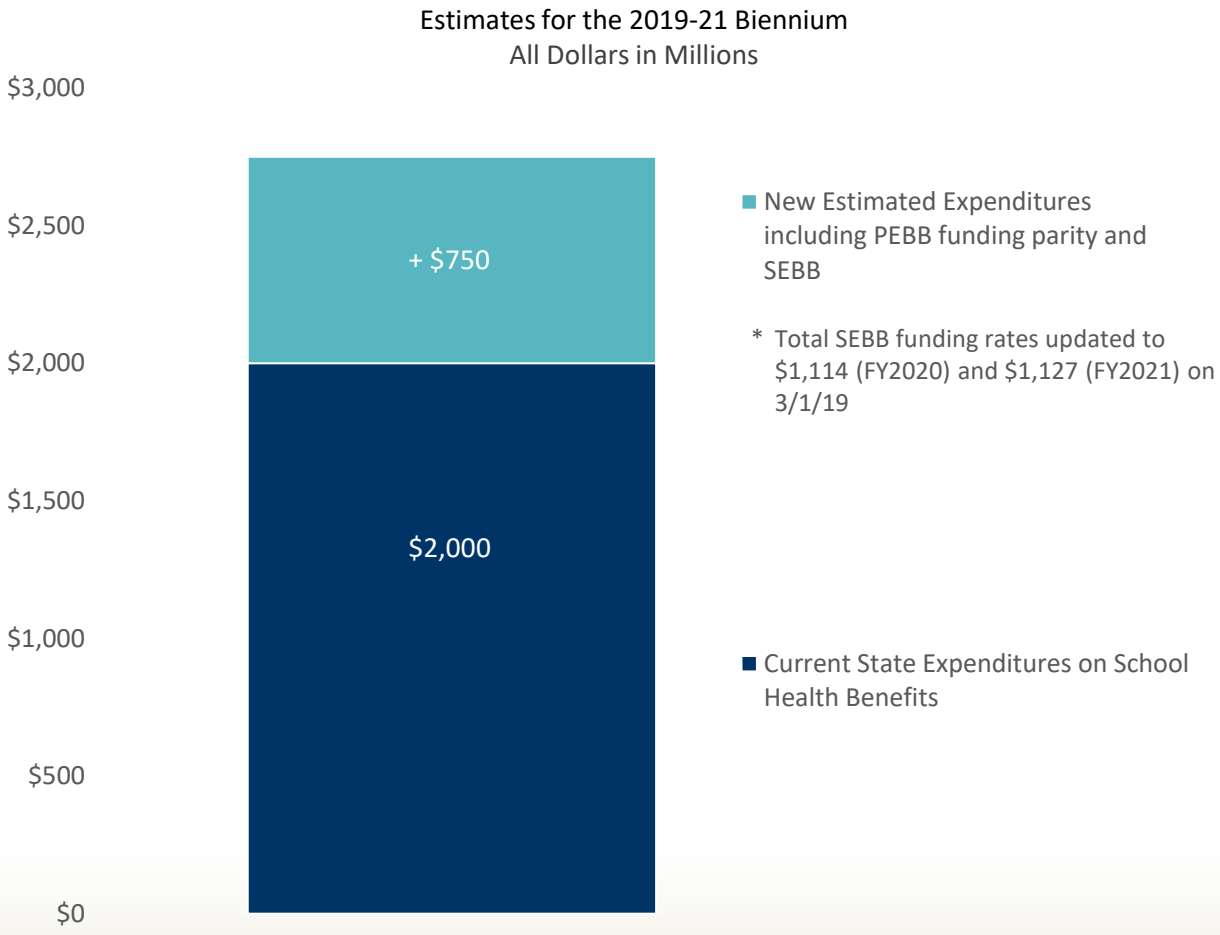
Washington State Health Care Authority

Fiscal Impact of SEBB Program to the State (Governor's Budget)



Washington State Health Care Authority

Fiscal Impact of SEBB Program to the State (March Updated Rates)



Next Steps

- House of Representatives will release proposed budget bill with SEBB Funding Rates for FY2020 and FY2021.
- Senate will release proposed budget bill with SEBB Funding Rates for FY2020 and FY2021.
- Important note:
  - If SEBB Funding Rate amounts in the House and/or Senate budget bills are lower than $1,114, don't necessarily mean SEBB is being underfunded.
  - HCA will analyze both budgets and assess impacts.

Washington State Health Care Authority

Questions

Megan Atkinson, HCA Chief Financial Officer

Megan.Atkinson@hca.wa.gov

Kim Wallace, SEBB Finance Manager

Financial Services Division

Kim.Wallace@hca.wa.gov

TAB 6

Washington State Health Care Authority

Policy Resolutions

Rob Parkman, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
March 7, 2019

Washington State Health Care Authority

SEB Board Policy Resolutions

- SEBB 2019-01 Requirement to negotiate by group under RCW 41.05.740(6)(e)
- SEBB 2019-02 Anticipated work hours eligibility range under RCW 41.05.740(6)(e)
- SEBB 2019-03 SEBB benefits authorized under RCW 41.05.740(6)(e)
- SEBB 2019-04 SEBB tier categories and premium tier ratios authorized under RCW 41.05.740(6)(e)
- SEBB 2019-05 Employer share requirement under RCW 41.05.740(6)(e)
- SEBB 2019-06 SEBB continuation coverage eligibility for school employees not eligible for benefits under the SEBB Program
- SEBB 2019-07 SEBB continuation coverage eligibility for dependents already on a SEBB Organization's continuation coverage

Washington State Health Care Authority

RCW 41.05.740(6)(e)

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

(e) Establish terms and conditions for a school employees' benefits board organization to have the ability to locally negotiate eligibility criteria for a school employee who is anticipated to work less than six hundred thirty hours in a school year. A school employees' benefits board organization that elects to use a lower threshold of hours for benefits eligibility must use benefits authorized by the school employees' benefits board and shall do so as an enrichment to the state's definition of basic education;

Washington State Health Care Authority

RCW 41.05.740(6)(e)

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

(e) Establish terms and conditions for a school employees' benefits board organization to have the ability to locally negotiate eligibility criteria for a school employee who is anticipated to work less than six hundred thirty hours in a school year. A school employees' benefits board organization that elects to use a lower threshold of hours for benefits eligibility must use benefits authorized by the school employees' benefits board and shall do so as an enrichment to the state's definition of basic education;

2 resolutions on the terms and conditions:
- Employer share of premium contribution; and
- Tier categories and ratios.

2 resolutions on eligibility criteria:
- Groups that can participate; and
- Range of anticipated hours that can be negotiated within.

1 resolution on SEBB authorized benefits.

Washington State Health Care Authority

Policy Resolution SEBB 2019-01
Requirement to negotiate by group under RCW 41.05.740(6)(e)

Resolved that, a SEBB Organization engaging in local negotiations regarding eligibility for school employees under RCW 41.05.740(6)(e) may only negotiate by group as described below:

- The entire SEBB Organization; or
- An entire collective bargaining unit; and/or
- A group containing all non-represented school employees.

Washington State Health Care Authority

Policy Resolution SEBB 2019-02
Anticipated work hours eligibility range under RCW 41.05.740(6)(e)

Resolved that, a SEBB Organization engaging in local negotiations regarding eligibility for school employees under RCW 41.05.740(6)(e) shall negotiate within the range of anticipated to work hours described below:

- No less than 180 hours per school year; and
- No more than the threshold to meet the SEB Board's eligibility established pursuant to RCW 41.05.740(6)(d).

Washington State Health Care Authority

Policy Resolution SEBB 2019-03

SEBB benefits authorized under RCW 41.05.740(6)(e)

Resolved that, a SEBB Organization engaging in local negotiations regarding eligibility for school employees under RCW 41.05.740(6)(e) must offer all of, and only, the following SEBB benefits to school employees and their dependents:

- Medical (includes the wellness incentive program);
- Dental;
- Vision; and
- Basic Life and Basic AD&D.

Washington State Health Care Authority

Policy Resolution SEBB 2019-04

SEBB tier categories and premium tier ratios authorized under RCW 41.05.740(6)(e)

Resolved that, a SEBB Organization engaging in local negotiations regarding eligibility for school employees under RCW 41.05.740(6)(e) must offer the same tier categories and premium tier ratios as adopted in SEBB 2018-14.

Washington State Health Care Authority

Policy Resolution SEBB 2019-05
Employer share requirement under RCW 41.05.740(6)(e)

Resolved that, a SEBB Organization must contribute:

- The employer medical contribution (EMC) used for a RCW 41.05.740(6)(d) school employee multiplied by the applicable tier;
- 100% of the monthly premium, for all tiers, for the dental and vision plans as selected by the school employee;
- 100% of the monthly premium for the basic life and basic AD&D benefits;
- 100% of the monthly administration fee as charged by HCA; and
- 100% of the monthly K-12 remittance fee.

Washington State Health Care Authority

Employer Medical Contribution (EMC) and UMP Employee Premiums

Based on Final Not-to-Exceed Rates

SEBB UMP Plus	**89%**	Total Premium	$649	$1,298	$1,136	$1,947	11%
		Employer Contribution (EMC)	$578	$1,156	$1,012	$1,734	
		Employee Contribution	**$71**	**$142**	**$124**	**$213**	
SEBB UMP Achieve 2	**88%**	Total Premium	$679	$1,358	$1,188	$2,037	15%
		Employer Contribution (EMC)	$578	$1,156	$1,012	$1,734	
		Employee Contribution	**$101**	**$202**	**$177**	**$303**	
SEBB UMP Achieve 1	**82%**	Total Premium	$612	$1,224	$1,071	$1,836	6%
		Employer Contribution (EMC)	$578	$1,156	$1,012	$1,734	
		Employee Contribution	**$34**	**$68**	**$60**	**$102**	
SEBB UMP High Deductible	**83%**	Total Premium [2]	$603	$1,206	$1,055	$1,809	4%
		Employer Contribution (EMC)	$578	$1,156	$1,012	$1,734	
		Employee Contribution	**$25**	**$50**	**$44**	**$75**	

Notes:

The 2020 EMC of $578 is 85% of the Total Premium (Final NTE Bid Rate) of the SEBB UMP Achieve 2 (88% AV plan).

All values in the table above are on a PAUPM basis.

1. SRDP - State Registered Domestic Partner
2. Total Premium for the SEBB UMP High Deductible Health Plan includes an employer HSA contribution of $375 per year for Tier 1 and $750 per year for all other tiers

Washington State Health Care Authority

Dental Tiers

Plan		Employee Only	Employee & Spouse/SRDP [1]	Employee & Child(ren)	Employee, Spouse/SRDP & Child(ren)
	X = Cost at First Tier	**Tier 1: 1:00x**	**Tier 2: 2:00x**	**Tier 3: 2:00x**	**Tier 4: 3:00x**
SEBB UDP	Total Premium	$48.67	$97.34	$97.34	$146.01
	Employer Contribution	**$48.67**	**$97.34**	**$97.34**	**$146.01**

Notes:
All values in the table above are on a PAUPM basis.
1. SRDP - State-Registered Domestic Partner

*Figures shown are for the Uniform Dental Plan (UDP). There will be additional dental plans offered, but the associated NTE rates are confidential as of 3/7/19; and therefore, not shown.

Washington State Health Care Authority

Vision Tiers

Plan		Employee Only	Employee & Spouse/SRDP [1]	Employee & Child(ren)	Employee, Spouse/SRDP & Child(ren)
	X = Cost at First Tier	**Tier 1: 1:00x**	**Tier 2: 2:00x**	**Tier 3: 1.75x**	**Tier 4: 3:00x**
SEBB Vision Plan	Total Premium	$5	$10	$9	$15
	Employer Contribution	**$5**	**$10**	**$9**	**$15**

Notes:

All values in the table above are on a PAUPM basis.

1. SRDP - State Registered Domestic Partner

*Figures shown are for illustrative purposes only. NTE rates for vision are confidential as of 3/7/19; and therefore, not shown.

Washington State Health Care Authority

SEBB Funding Rate

As of 3/1/2019

SEBB Funding Rate Components	FY 2020
EMC (PAUPM) [1]	$578
Ratio of Adult Units to Subscribers	1.573 [2]
Medical Premium Contribution (PSPM) [3]	$907
100% Dental Premium (PSPM)	$91
100% Vision Premium (PSPM)	$10
100% Basic Life & Basic AD&D Premium (PSPM)	$4
100% Basic LTD Premium (PSPM)	$2
K-12 Remittance (PSPM)	$67
Admin and other costs (PSPM) [4]	$32
Total Cost (PSPM) [5]	**$1,114**

Source:
Legislative Budget Funding Rate Scenario - 3/1/19

Notes:
1. PAUPM - Per Adult Unit Per Month
2. 1.573 adult unit factor is an updated modeled assumption for the SEBB eligible employee population, including enrollment of dependents.
3. PSPM - Per Subscriber Per Month
4. Admin and other costs includes GF-S loan repayment
5. Values are rounded within modeling

Washington State Health Care Authority

School employee and SEBB Organization share requirements under SEBB 2019-05 Example #1

Example: Classified Employee (part-time bus driver)

A part-time bus driver, who works about 400 hours each school year, is offered benefits by her SEBB Organization. She elects coverage in UDP and vision for herself, her spouse, and 3 children. She waives medical.

Question	Cost for 6e eligible	Cost if 6d eligible
How much is the school employee's medical premium per month?	$0	$0
How much will the SEBB Organization have to pay HCA for this school employee per month?	$265	$1,114

Washington State Health Care Authority

School employee and SEBB Organization share requirements under SEBB 2019-05 Example #2

Example: Classified Employee (part-time bus driver)

A part-time bus driver, who works about 400 hours each school year, is offered benefits by her SEBB Organization. She elects subscriber-only UDP, vision, and UMP Achieve 2.

Question	Cost for 6e eligible	Cost if 6d eligible
How much is the school employee's medical premium per month?	$101	$101
How much will the SEBB Organization have to pay HCA for this school employee per month?	$735	$1,114

Washington State Health Care Authority

School employee and SEBB Organization share requirements under SEBB 2019-05 Example #3

Example: Classified Employee (part-time bus driver)

A part-time bus driver, who works about 400 hours each school year, is offered benefits by her SEBB Organization. She elects coverage in UDP, vision, and UMP Achieve 2 for herself, her spouse, and 3 children.

Question	Cost for 6e eligible	Cost if 6d eligible
How much is the school employee's medical premium per month?	$303	$303
How much will the SEBB Organization have to pay HCA for this school employee per month?	$1,999	$1,114

Washington State Health Care Authority

Policy Resolution SEBB 2019-06

SEBB continuation coverage eligibility for school employees not eligible for benefits under the SEBB Program

Resolved that, a school employee and their dependents who are enrolled in medical, dental, or vision under a group plan offered by a SEBB Organization on December 31, 2019, who lose eligibility because the school employee is not eligible under the SEBB Program, may elect to enroll in one or more of the following SEBB benefits: medical, dental, or vision coverage. These benefits will be provided for a maximum of 18 months on a self-pay basis.

Washington State Health Care Authority

SEBB continuation coverage eligibility for school employees not eligible for benefits under the SEBB Program Example

A bus driver, who has himself and his spouse enrolled in district benefits (medical, dental, or vision), is not anticipated to be eligible under the SEBB Program effective January 1, 2020.

- Is there a COBRA qualifying event? No, change in eligibility is not a qualifying event.
- Is this school employee and his spouse eligible for SEBB continuation coverage? Yes, based on adoption of SEBB 2019-06.
- What SEBB benefits are they eligible for? Medical, dental, or vision coverage.
- How long may this coverage continue? 18 months (similar to reduction of hours).

Washington State Health Care Authority

Policy Resolution SEBB 2019-07
SEBB continuation coverage eligibility for dependents already on a SEBB Organization's continuation coverage

Resolved that, a dependent of a school employee who is continuing medical, dental, or vision coverage through a SEBB Organization on December 31, 2019 may elect to finish out their remaining months, up to the maximum number of months authorized by COBRA for a similar event, by enrolling in a medical, dental, or vision plan offered through the SEBB Program on a self-pay basis.

Washington State Health Care Authority

SEBB continuation coverage eligibility for dependents already on a SEBB Organization's continuation coverage Example

A bus driver terminates his relationship with his domestic partner on June 22, 2019. The domestic partner elects continuation coverage under the terms of the school district's group health plan effective July 1, 2019, and is still enrolled in continuation coverage as of December 31, 2019. Are they eligible for SEBB continuation coverage?

- Is the domestic partner a COBRA qualified beneficiary? No.
- Is this domestic partner eligible for SEBB continuation coverage? Yes, based on adoption of SEBB 2019-07.
- What SEBB benefits are they eligible for? Medical, dental, or vision coverage.
- How long may this coverage continue? 36 months (similar to divorce).

Next Step

Incorporate policy resolutions into SEBB Program rules.

Washington State Health Care Authority

Questions?

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Washington State Health Care Authority

APPENDIX

Washington State Health Care Authority

Proposed Policy Resolution SEBB 2019-01
Requirement to negotiate by group under RCW 41.05.740(6)(e)
(as presented January 24, 2019)

A SEBB Organization that elects to locally negotiate eligibility for school employees under RCW 41.05.740(6)(e) may only negotiate by group as described below:

- The entire SEBB Organization; or
- An entire collective bargaining unit; and/or
- A group containing all non-represented school employees.

Washington State Health Care Authority

Proposed Policy Resolution SEBB 2019-02
Anticipated work hours eligibility range under RCW 41.05.740(6)(e)
(as presented January 24, 2019)

A SEBB Organization that elects to locally negotiate eligibility for school employees under RCW 41.05.740(6)(e) shall negotiate within the range of anticipated to work hours described below:

- No less than 180 hours per school year; and
- No more than the threshold to meet the SEB Board's eligibility established pursuant to RCW 41.05.740(6)(d).

Washington State Health Care Authority

Proposed Policy Resolution SEBB 2019-03

SEBB benefits authorized under RCW 41.05.740(6)(e) (as presented January 24, 2019)

A SEBB Organization that elects to locally negotiate eligibility for school employees under RCW 41.05.740(6)(e) must offer all of, and only, the following SEBB benefits to school employees and their dependents:

- Medical;
- Dental;
- Vision; and
- Basic Life and Basic AD&D.

Washington State Health Care Authority

Proposed Policy Resolution SEBB 2019-04

SEBB tier categories and premium tier ratios authorized under RCW 41.05.740(6)(e)

(as presented January 24, 2019)

A SEBB Organization that elects to locally negotiate eligibility for school employees under RCW 41.05.740(6)(e) must offer the same tier categories and premium tier ratios as adopted in SEBB 2018-14.

Washington State Health Care Authority

Proposed Policy Resolution SEBB 2019-05
Employer share requirement under RCW 41.05.740(6)(e)
(as presented January 24, 2019)

A SEBB Organization must contribute:

- The same employer medical contribution (EMC), for all tiers, as if the school employee were eligible under RCW 41.05.740(6)(d);
- 100% of the monthly premium, for all tiers, for the dental and vision plans as selected by the school employee;
- 100% of the monthly premium for the basic life and basic AD&D benefits;
- 100% of the monthly administration fee as charged by HCA; and
- 100% of the monthly K-12 remittance fee.

Washington State Health Care Authority

Proposed Policy Resolution SEBB 2019-06

SEBB continuation coverage eligibility for school employees not eligible for benefits under the SEBB Program

(as presented January 24, 2019)

A school employee who is enrolled in medical, dental, or vision under a group plan offered by a SEBB Organization on December 31, 2019, who loses eligibility because they are not eligible under the SEBB Program, may elect to enroll in one or more of the following SEBB benefits: medical; dental; or vision coverage. These benefits will be provided for a maximum of 18 months on a self-pay basis.

Washington State Health Care Authority

Policy Resolution SEBB 2018-14
The SEBB Program Premium Structure
As approved at April 30, 2018 Board Meeting

Resolved that, within the premium structure for the SEBB benefits where there is both an employer and employee premium contribution, there will be four tier categories. The premium tier ratio and employee premium contribution for each tier category will be:

Tier Category	Premium Tier Ratio
Subscriber Only	1.00
Subscriber and any Child(ren)	1.75
Subscriber and Spouse/State-Registered Domestic Partner	2.00
Subscriber and Spouse/State-Registered Domestic Partner and any Child(ren)	3.00

TAB 7

COBRA Continuation Coverage Overview

Barbara Scott, Manager
Policy, Rules, & Compliance Section
Employees & Retirees Benefits Division
March 7, 2019

Washington State Health Care Authority

Goal

Provide the SEB Board with information regarding COBRA continuation coverage

- The federal requirement
- Who are Qualified Beneficiaries
- What are Qualifying Events
- How long must coverage be continued
- COBRA's successor plan requirement

COBRA – Federal Requirement

State and local governmental group health plans must provide COBRA continuation coverage to certain individuals.

Washington State Health Care Authority

General Requirement

The group health plan must provide that each **qualified beneficiary** who loses group health plan coverage as a result of a **qualifying event** is entitled to elect to continue group health plan coverage for **a limited time** on a self-pay basis.

Who are COBRA Qualified Beneficiaries

- The following individuals who are covered under the plan on the day before a qualifying event:
  - Covered employee;
  - The federally recognized spouse and dependent child of the covered employee; and
  - children born to, or adopted by, a covered employee during a period of COBRA continuation coverage.

Washington State Health Care Authority

What are Qualifying Events?

- Voluntary or involuntary termination of the covered employee's employment other than by reason of gross misconduct;
- Reduction of hours of the covered employee's employment;
- Divorce or legal separation of the covered employee from the employee's spouse;
- Death of the covered employee; and
- A dependent child ceases to be a dependent under the generally applicable requirements of the plan.

Washington State Health Care Authority

How Long Must Coverage be Continued?

- 18 months for **termination** or **reduction of hours**. May be extended to:
  - 29 months with disability determination
  - 36 months (for the covered dependent of an employee) if a second qualifying event occurs during the initial 18 month period
- 36 months for **the covered dependent of the covered employee for loss due to** the following qualifying events:
  - Divorce or legal separation;
  - Death of the covered employee; or
  - A dependent child ceases to be a dependent under the requirements of the group plan.

COBRA Successor Plan Requirement

The SEBB Program must allow a SEBB Organization's **COBRA qualified beneficiaries,** who are enrolled in group health plan coverage on December 31, 2019, to run out the time they have remaining under the COBRA limit by enrolling in SEBB medical, dental, and vision plans.

COBRA Continuation Coverage Example #1

A bus driver, who has himself and his spouse enrolled in SEBB benefits (medical, dental, and vision), resigns effective June 18, 2020.

- Who are the Qualified Beneficiaries? The covered employee and his covered spouse
- What is the Qualifying Event? Termination of employment
- How long must the group health plan allow each of the qualified beneficiaries to continue coverage under COBRA? 18 months

Washington State Health Care Authority

COBRA Continuation Coverage Example #2

A janitor, who has herself and her spouse enrolled in SEBB benefits (medical, dental, and vision), divorces her spouse effective January 31, 2020.

- Who is the Qualified Beneficiary? The covered spouse
- What is the Qualifying Event? Divorce of the covered employee's federally recognized spouse
- How long must the group health plan allow ex-spouse to continue coverage under COBRA? 36 months

Washington State Health Care Authority

COBRA Continuation Coverage (Successor Plan) Example #3

A bus driver divorces his spouse on June 22, 2019. The spouse elects COBRA under the terms of the school district's group health plan effective July 1, 2019, and is enrolled in COBRA as of December 31, 2019.

- Are they a the Qualified Beneficiary? Yes
- What is the Qualifying Event? Divorce
- How long must the SEBB Program allow the ex-spouse to continue coverage? 30 months (36-6=30)

Washington State Health Care Authority

COBRA Continuation Coverage Example #4

A teacher, who has himself and his spouse enrolled in SEBB benefits (medical, dental, and vision), reduces his hours from 40 hours per week to 10 hours per week effective November 30, 2021.

- Who are the Qualified Beneficiaries? The covered employee and his covered spouse
- What is the Qualifying Event? Reduction of hours
- How long must the group health plan allow each of the qualified beneficiaries to continue coverage under COBRA? 18 months

Washington State Health Care Authority

Questions?

Barbara Scott

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TAB 8

Washington State Health Care Authority

Eligibility & Enrollment Policy Development

Rob Parkman, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
March 7, 2019

Washington State Health Care Authority

Introduction of Policy Resolutions

- SEBB 2019-08 Terms and Conditions for RCW 41.05.740(6)(e)

Washington State Health Care Authority

RCW 41.05.740(6)(e)

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

(e) Establish terms and conditions for a school employees' benefits board organization to have the ability to locally negotiate eligibility criteria for a school employee who is anticipated to work less than six hundred thirty hours in a school year. A school employees' benefits board organization that elects to use a lower threshold of hours for benefits eligibility must use benefits authorized by the school employees' benefits board and shall do so as an enrichment to the state's definition of basic education;

Washington State Health Care Authority

Proposed Policy Resolution SEBB 08 Terms and Conditions for RCW 41.05.740(6)(e)

For school employees whose eligibility is established under RCW 41.05.0740(6)(e), all SEBB Program rules within chapters 182-30, 182-31, and 182-32 WAC apply except for provisions within those rules governing benefits that are not authorized in SEBB 2019-03 to be offered to RCW 41.05.740(6)(e) employees.

Washington State Health Care Authority

Next Steps

- Incorporate Board feedback in the proposed policy
- Send the proposed policy to stakeholders *(after today's meeting)*
- Bring recommended policy resolution to the Board to take action on at the April 10, 2019 Board Meeting

Washington State Health Care Authority

Questions?

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TAB 9

Washington State Health Care Authority

Legislative Update

Cade Walker, Executive Special Assistant
Employees & Retirees Benefits (ERB) Division
March 7, 2019

Washington State Health Care Authority

Number* of Bills Analyzed by ERB Division

	ERB Lead	ERB Support	
High Impact	32	23	55
Low Impact	67	104	171
	99	127	226

*As of 3/1/19

Washington State Health Care Authority

Legislative Update – ERB high lead bills

2/22	Origin Chamber – Policy	32 bills
3/1	Origin Chamber – Fiscal	17 bills
3/13	Origin Chamber – Rules/Floor	5 bills
4/3	Opposite Chamber – Policy	bills
4/9	Opposite Chamber – Fiscal	bills
4/17	Opposite Chamber – Rules/Floor	bills
	Governor	bills

Cut-offs

Last day of the regular session: **4/28**

Washington State Health Care Authority

SEBB Program Impact Bills

- HB 1547 - Concerning basic education funding (levy lid)
- HB 2096 - Concerning educational service district health benefits

Washington State Health Care Authority

PEBB Program Impact Bills

- HB 1085 - Concerning premium reduction for medicare-eligible retiree participants in the public employees' benefits board program
- HB 1414/SB 5335 - Paying state retirement benefits until the end of the month in which the retiree or beneficiary dies
- *HB 1220/SB 5275* - Adding a non-voting representative from the Office of the Insurance Commissioner to the PEB Board

Washington State Health Care Authority

ERB Impact Bills

- *HB 1065*/SB 5031 - Protecting consumers from charges for out-of-network health care services
- *HB 1074*/SB 5057 - Protecting youth from tobacco products and vapor products by increasing the minimum legal age of sale of tobacco and vapor products
- *HB 1523/SB 5526* - Increasing the availability of quality, affordable health coverage in the individual market
- *SB 5889* - Concerning insurance communications confidentiality

Washington State Health Care Authority

ERB Topical Bills

- Reproductive health:
  - *SB 5602* - Eliminating barriers to reproductive health for all

- Pharmacy:
  - *HB 1224* - Concerning prescription drug transparency
  - *HB 1879* - Regulating and reporting of utilization management in prescription drug benefits
  - *SSB 5184* - Concerning prescription coverage and the use of mail order services
  - *2SSB 5292* - Concerning prescription drug cost transparency

Washington State Health Care Authority

Questions?

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TAB 10

Washington State Health Care Authority

SEBB Organization Readiness: HCA Support

Washington State Health Care Authority

ERB Division Outreach & Training
SEBB Initial Enrollment Training Plan

Jesse Paulsboe, Manager
Outreach & Training Unit
Employees & Retirees Benefits (ERB) Division
March 7, 2019

Washington State Health Care Authority

ERB Support

ERB Outreach & Training

- Supports employers and agency personnel, payroll, and benefits offices' staff through phone, secure online correspondence, open enrollment benefits fairs, presentations, dedicated employer websites, eligibility and enrollment training materials, and guidance
- This ensures that employers achieve accurate eligibility and enrollment decisions for their employees' accounts

ERB Customer Service

- Provides eligibility review and determination for members' enrollment in PEB Board insurance coverage in alignment with federal laws, rules, new initiatives, or legislative mandates
- Provides account enrollment, in-person lobby services, and customer service support via a toll-free line **for retirees, COBRA, and continuation coverage members**

ERB Communications

- Creates member print materials, emails, web content, and social media
- Supports Outreach and Training with FAQs, messaging, and benefits fairs materials
- Provides expertise in developing communications strategies, plans, tactics, and messaging

Washington State Health Care Authority

Who are the trainers?

The ERB Outreach & Training (O&T) Team ensures that employers achieve accurate eligibility and enrollment decisions for their employees' accounts.

ERB O&T assists employer personnel, payroll, and benefits offices' staff (Perspay) through a 1-800 phone line, secure email correspondence, open enrollment benefits fairs, presentations, dedicated employer resource websites, eligibility and enrollment training materials, and guidance.

Who will we train?

- **Approximately 1,000 SEBB Organizations:**
  - Payroll Staff
  - Personnel Staff
  - Benefits Administrators

  Serving:

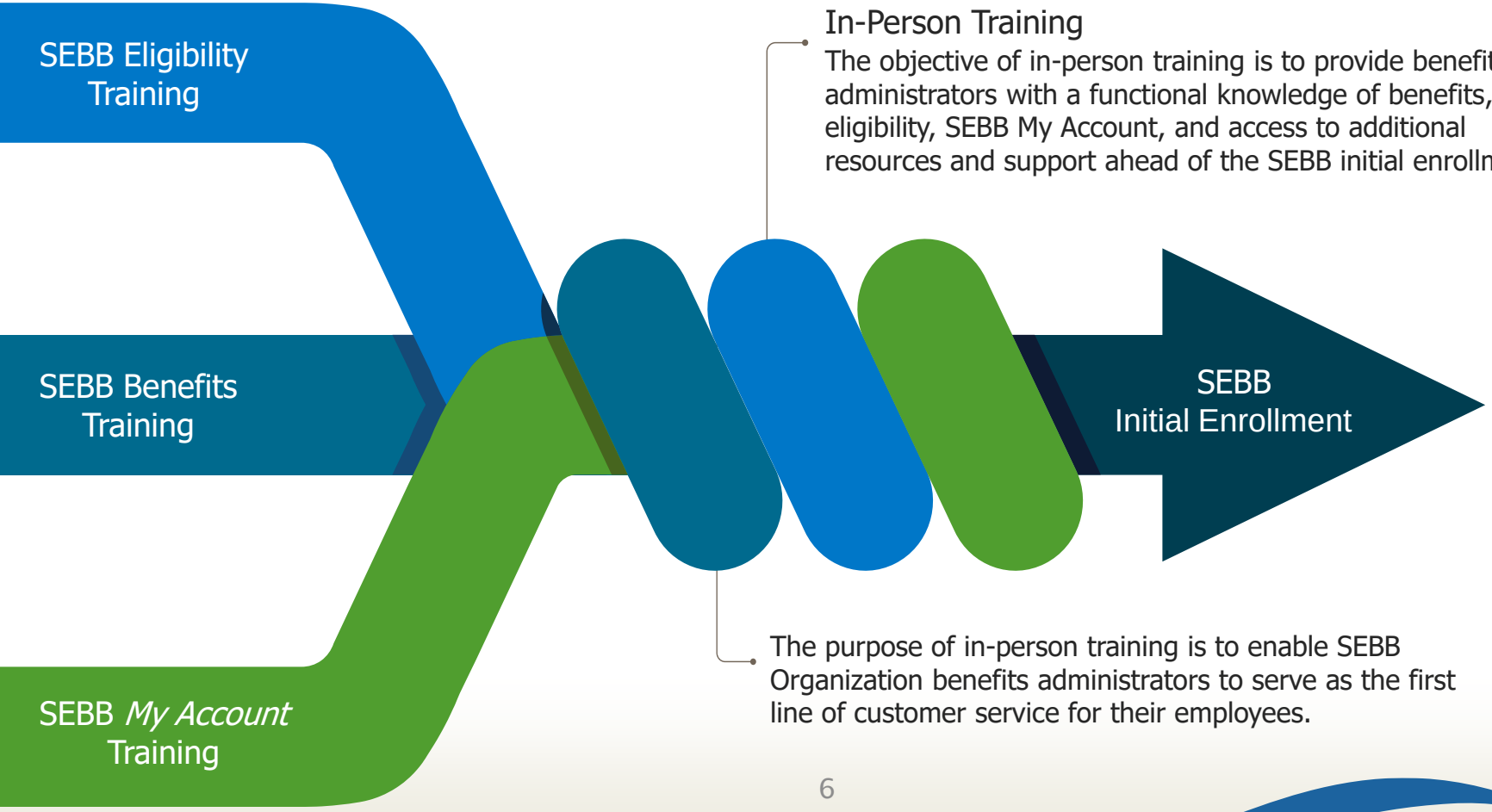
  - 295 School Districts
  - 9 Educational Service Districts
  - 12 publicly-funded Charter Schools

x 100

- **Union staff representing school employees**

Washington State Health Care Authority

SEBB Training Objectives: What will we train?



In-Person Training

The objective of in-person training is to provide benefits administrators with a functional knowledge of benefits, eligibility, SEBB My Account, and access to additional resources and support ahead of the SEBB initial enrollment.

The purpose of in-person training is to enable SEBB Organization benefits administrators to serve as the first line of customer service for their employees.

Train the Trainer Strategy

1) ERB O&T Educates Perspay Staff on benefits, eligibility, and SEBB *My Account.*

2) Perspay Staff educate their school employees on benefits, eligibility, and SEBB *My Account.*

3) School employees reach out to their Organization's Perspay staff as the first line of customer service.

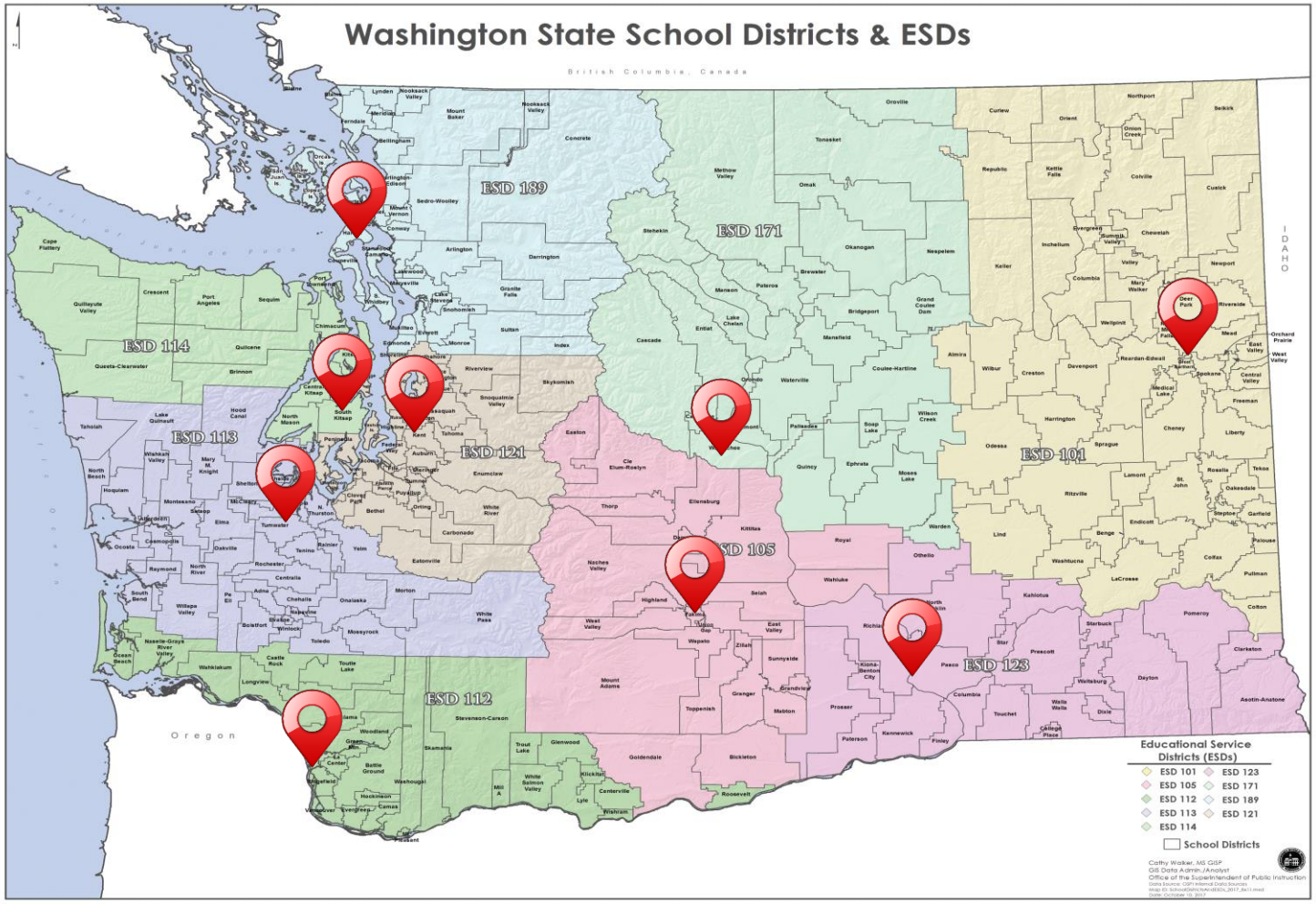
4) Perspay staff reach out to ERB O&T when they need assistance serving school employees.

Washington State Health Care Authority

Training Schedule: When, where, how long?

In-Person training:

- August – September
- Exact dates TBA
- Currently coordinating to host training at the nine ESD locations across the state.
  - 9 events in Aug.
  - 9 events in Sept.
- Webinar training last week of September.
- Two-Day Class (16 hrs) Covering Benefits, Eligibility, and SEBB My Account.



Washington State Health Care Authority

Additional Resources for Employers/Employees

Employers

Phone Support

Over-the-phone assistance for Perspay Staff during regular business hours.

Secure Email Correspondence

Secure online email correspondence with ERB Division subject-matter-experts.

PERSPAY Website

A dedicated website for Employers with resources, materials, worksheets to assist employers.

In addition to in-person Perspay training, HCA plans to provide the following resources to benefits administrators and employees:

SEBB *My Account*

A proprietary online enrollment application that makes enrollment and benefits administration streamlined and user friendly.

Employees

Online Decision Support Tool

A program that helps employees make informed benefits decisions.

In-Person Benefits Fairs

ERB O&T will conduct nine in-person benefits fairs at the nine ESD locations across the state.

Virtual Benefits Fair

An online benefits-education portal designed to assist employees during Initial Enrollment. Accessible 24/7.

Washington State Health Care Authority

Questions?

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Washington State Health Care Authority

Customer Service Unit

Alisa Richards
Customer Services Operations Manager
Employees and Retirees Benefits Division
March 7, 2019

Customer Service Unit

Currently serves:

- Public Employee Retirees
- COBRA and other Continuation Coverage enrollees
- Retiring employees
- K-12 retirees

Customer Service Unit (*cont.*)

- 16 FTEs
- Assists over 100,000 retirees, retiring employees, and PEBB Continuation Coverage enrollees
- Is available through a toll-free phone line or in-person lobby services
- Keys retiree subscribers' account enrollment
- Employees are served by their employer's personnel, payroll, or benefits office

Customer Service Unit (*cont.*)

Will serve:

- SEBB Organization COBRA and other Continuation Coverage enrollments
- SEBB Organization retiring employees

HCA will work on the Successor Plan of current SEBB COBRA and other Continuation Coverage enrollments to be administered by the Health Care Authority effective January 2020.

Customer Service Unit (*cont.*)

For the SEBB Program implementation, we will:

- Hire additional FTEs
- Update the 1-800 phone line with FAQs and messaging to help refer SEBB Program employees to the right resources
- Refer callers to their health plan for questions regarding covered services
- Answer calls from SEBB Program enrollees with questions about continuing their coverage after retirement

Washington State Health Care Authority

Questions?

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Washington State Health Care Authority

IT Organizational Readiness

Jerry Britcher
Chief Information Officer
March 7, 2019

Information Technology Supports

Personnel-Payroll (Perspay) Staff

Training and Practice

- As noted, 16 hours of training
- A SEBB *My Account* "Sandbox" will be available to Perspay staff for practicing and extended learning
  - Web accessible, practice environment for Perspay staff that does not impact operational or "live" data

Information Technology Supports (*cont.*)

Classified, Certified, and Administrative Staff

Training

- A series of instructional videos
- Videos will cover typical processes for benefits selection
- Materials will also be available to print

Washington State Health Care Authority

Questions?

More Information:

https://www.hca.wa.gov/employee-retiree-benefits/school-employees

Jerry Britcher, CIO

Enterprise Technology Services

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TAB 11

Washington State Health Care Authority

Member Communications

Rochelle Andrake
Communications Consultant
Employees and Retirees Benefits Division
March 7, 2019

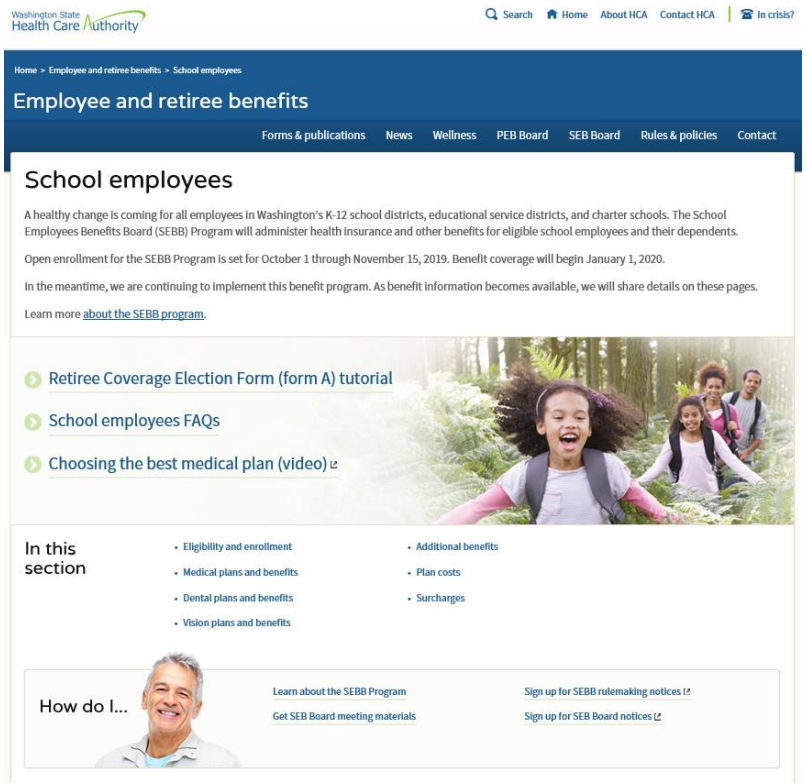
SEBB Communication Strategy

- HCA website
  - FAQs
- GovDelivery email subscription service
- Member toolkits
- Direct mailings
- Social and news media

Washington State Health Care Authority

HCA Website

- hca.wa.gov/sebb-employee
- Contains the latest news and updates
  - Printable materials
  - FAQs for members and school administrators
- Updated as SEB Board decisions are made
- Initial enrollment information available 9/1/19



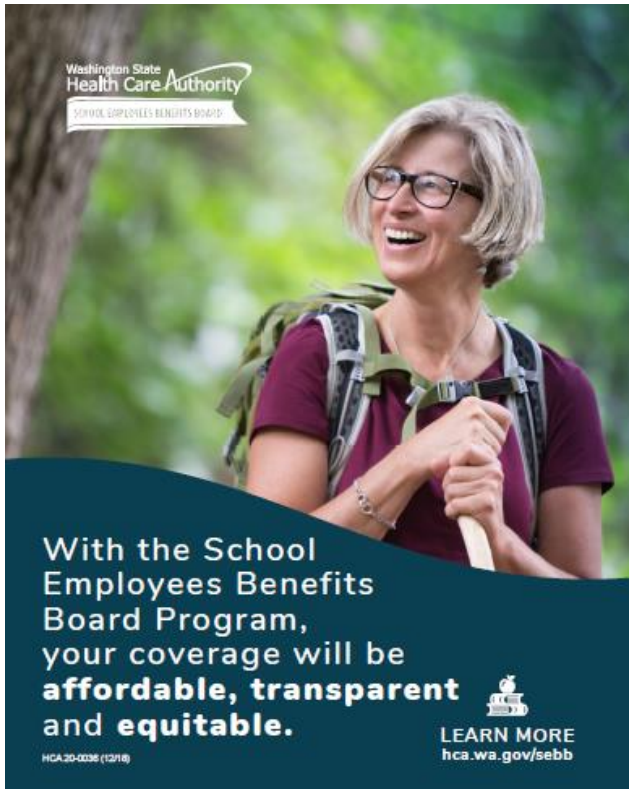
GovDelivery Emails

- Sign up for alerts
  - Board meeting notices
  - Rule making notices
- Members will be able to opt in and go paperless through SEBB *My* Account
- Delivers important messages to school administrators and other stakeholders to distribute to members

Washington State Health Care Authority

Member Toolkits

- Began November 2018
- Contains fact sheets, infographics, posters, and articles
- Sent monthly to benefit administrators, labor unions, and WASBO for distribution to employees



Available online at hca.wa.gov/sebb-fact-sheets

Direct Mailings

- Recently received member contact information
- Plan to send several direct mailings leading up to initial enrollment:
  - Introductory letter (mid-March)
  - Newsletter (early June)
  - Postcard (mid-August)
  - Initial enrollment packet (mid-September)
    - Will include benefit fair information, plan comparisons, monthly premiums, service areas, how to check provider networks, and how to enroll beginning October 1, 2019

Media Plan

- Op-ed article from HCA Director Sue Birch
- Regular posts and ads on Facebook and Twitter
- Media kit posted in HCA Press Room and sent to local media statewide
- News releases to advertise initial enrollment information

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Questions?

More Information:

http://hca.wa.gov/sebb-factsheets

Rochelle Andrake, ERB Communications

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TAB 12

Washington State Health Care Authority

Pharmacy 101

Policy Levers to Manage Drug Trend

Molly Christie
Strategic Plan Project Manager
Employees & Retirees Benefits
March 7, 2019

Recap

- **At the last SEB Board meeting we looked at UMP (PEBB) and K-12 trends in pharmacy and discussed how:**
  - Pharmacy is a major driver of UMP (PEBB) health plan spending and impacts member premiums;
  - Our current K-12 pharmacy data is very limited, but a snapshot suggests similarities in trends for utilization and top drug classes with UMP (PEBB); and
  - Benefit tiers and prescription drug formularies ensure appropriate access to medically necessary, cost-effective medications while holding down costs.

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Follow-up

UMP (PEBB) Top Therapeutic Classes by Utilization, 2018

Drug Type	Drug Class	Rx per 1,000 members
Traditional	Antidepressants	1,126.1

- ***Why does the prescription rate for antidepressants appear so high?***
  - In 2018, 80,680 UMP members, or 34% of the total ~275,000 UMP members, filled at least one prescription for an antidepressant
  - The prescription rate includes refills, which may be for 30 days, 90 days, or another supply period
  - Antidepressants may be used to treat a variety of conditions including anxiety, neuropathy, migraine, chronic pain, and more

Preview

- Today's presentation will cover policy levers for the federal government, states, and health plans to manage the prescription drug trend.

Federal Policy Strategies

- **The federal government has exclusive authority to pass laws related to drug pricing and generics approval. Specific strategies that have been proposed in these areas include:**
  - Expanding federal purchasing power – allowing the federal government to use its purchasing power through Medicare to negotiate lower drug prices
  - Eliminating "middleman" drug rebates – phasing-out drug rebates negotiated between manufacturers and Pharmacy Benefit Managers, Medicare Part D plans, and Medicaid MCOs
  - Speeding generics to market – altering brand patents and market exclusivity to allow generics to reach the market faster

Many of the federal policies under discussion could have major impacts—positive or negative—on employer-sponsored plans.

State Policy Strategies

- **Some strategies that have been implemented or are being explored at the state level include:**
  - Combined (volume) purchasing – Leveraging purchasing power of states, agencies, or private entities to negotiate lower drug costs
  - Price transparency – Enforcing price transparency on drug manufacturers and pharmacy benefit managers, usually through public reporting on drug price setting for new drugs and price increases for existing drugs
  - Rate setting – Establishing a reimbursement ceiling or range for medications; often combined with price transparency proposals
  - Importation – Importing lower-priced drugs from another country (usually Canada) to reduce spending and drive competitive pricing

Combined Purchasing: NW Prescription Drug Consortium

- **State-backed combined purchasing pharmacy program to negotiate better drug rates:**
  - Formed via an Interstate Agreement between Washington and Oregon – includes major Washington State agencies that pay for or purchase prescription drugs directly
    - **Uniform Medical Plan (HCA)**
    - Labor & Industries
    - Department of Corrections
  - Over 1 million people receive prescriptions purchased through the Consortium
  - Administered by Moda Health – based in Portland, Oregon

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NW Prescription Drug Consortium – *Value*

- *What value does the Consortium offer to members?*
  - **Competitive Price**
    - Guaranteed minimum contract rates for brand and generic drugs that improve over time
    - Fixed administration fees (flat fee per paid transaction)
    - Annual market checks and rate adjustments for market competitiveness
  - **First-of-its-kind Transparency**
    - 100% transparent contract—participants pay exactly what the pharmacy is paid for a medication and receive 100% of manufacturer rebates
  - **Focus on Member Experience & Outcomes**
    - High-touch clinical programs designed to enhance the level of care and outcomes for members
    - 24/7 customer service

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NW Prescription Drug Consortium – *Performance*

- ***Recent achievements for UMP:***
  - In 2018 the Consortium's administrator Moda Health readjusted their per-claim administrative fee to match market price competitiveness, saving UMP an estimated $3.57M
  - In 2018 Moda was able to outperform their financial guarantee to UMP by $10M
  - A complete claims audit (1.73M claims for UMP) revealed 100% claims processing accuracy

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Combined Purchasing: Hepatitis C

- Governor Inslee's statewide Directive 18-13 on eliminating Hepatitis C (HCV) by 2030 directs HCA to collaborate with other state agencies, including the Department of Social & Health Services, the Department of Corrections, and the Department of Labor & Industries to "initiate an innovative strategy to purchase curative HCV medications"

- To achieve this, HCA issued a single RFP* to pharmaceutical manufacturers on 1/22/19

*RFP – Request for Proposal

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State Policy Strategies: Other Examples

- Price transparency
  - In 2018, 6 states, including Oregon (HB 4005), passed prescription drug pricing transparency laws that require drug makers to report reasons behind dramatic price increases
  - In 2019 there are 23 bills pending in 12 states, including Washington (HB 1224/SB 5292) and Oregon
- Rate setting
  - The National Academy for State Health Policy (NASHP) developed model legislation for states to establish price ceilings for high-cost drugs
  - In 2018, 7 states considered some form of rate-setting for prescription drugs, but none of the bills passed; Maryland, Minnesota, and New Jersey introduced bills based on NASHP model legislation
- Importation
  - In May 2018, Vermont became 1st in nation to pass importation law for less-costly pharmaceuticals from Canada but awaits federal approval for implementation
  - In 2019, there are 20 bills pending in 12 states, including Oregon

Plan Strategies

- **Strategies that plans may use to manage pharmacy spending:**
  - Benefit design (tiers)
  - Value Formulary
  - Utilization management tools
  - Value-based payment

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Uniform Medical Plan Proposed Value Formulary

Establish a value formulary, or a list of covered drugs, to manage UMP pharmacy spend

Where does the "value" come from?

- Medicines that are equally effective but more costly than available alternatives are not covered

What does this mean for members?

- Access to medicines in every therapeutic class
- Possibility for lower out-of-pocket costs at the pharmacy
- An exception process for non-formulary (non-covered) drugs when medically necessary

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Prescription Drug Utilization Management

- **Preauthorization**
  Prescribing clinicians must submit documentation of medical necessity for a drug before the plan will cover it.
- **Step Therapy**
  Patients must "step through" or try certain drugs before another drug (such as a brand alternative) will be covered.
- **Quantity Limits**
  A limit on how many or how much of a certain drug you can get.
- **Substitutions**
  Substituting a generic equivalent or a therapeutic alternative* drug for a non-preferred brand drug or biologic
- **Medication Management Programs**
  Usually targeted programs to improve adherence or reduce inappropriate use of certain drugs.

* Therapeutic alternatives are drugs that are chemically different from your prescribed drug but provide the same therapeutic benefit

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Drug Utilization Management Examples: Uniform Medical Plan

- **Preauthorization**
  - Specialty drugs
- **Step Therapy**
  - Metformin for Type 2 Diabetes
- **Quantity Limits**
  - Opioid pain medication
- **Substitutions**
  - Generic Substitution under Washington State Law
  - Therapeutic Interchange Program
- **Medication Management Programs**
  - Rheumatoid Arthritis Dose Optimization Pilot Program

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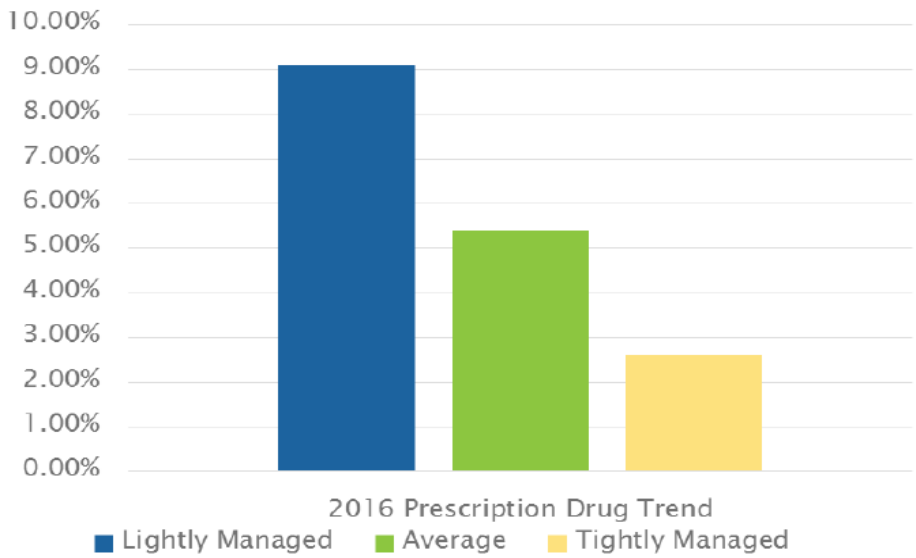
Why do health plans use these tools?

- **Managing how members use their pharmacy benefit helps control drug spend**



Total drug spend for tightly managed plans at Express Scripts had a significantly lower trend than lesser managed plans

Source: Express Scripts. 2016 Drug Trend Report. Express Scripts Holding Company. Feb 2017.

Value-based Payment - Examples

- **CVS Health**

Rate-setting according to value

Insurance carrier CVS Health offers a new benefit design option to purchasers that would exclude certain drugs from coverage if their cost after negotiation is above cost-effectiveness threshold

- **AstraZeneca**

Paying for outcomes

Drug maker AstraZeneca has agreed to adjust discounts to Medicare Part D for a brand-name blood thinner based on patient outcomes

* Therapeutic alternatives are drugs that are chemically different from your prescribed drug but provide the same therapeutic benefit

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Key Takeaways

Proposed federal policies to manage prescription spending have largely focused on Medicare & Medicaid but could have significant impacts on employer-sponsored plans.

Many states are attempting to pass legislation aimed at lowering drug spending. Proposed policies include volume purchasing, importation, transparency, and rate-setting. UMP participates in a combined/volume purchasing arrangement through the NW Prescription Drug Consortium.

Health plans may use a combination of benefit design, formularies, utilization management, and value-based payment to manage pharmacy spending. UMP relies on many of these tools and supports implementation of a value formulary.

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Up Next

Pharmacy 101 Wraps Up!

Additional pharmacy topics can be covered on request (with advanced notice)

Later this SEB Board season…

Value-Formulary Discussion

Washington State Health Care Authority

Questions?

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TAB 13

Washington State Health Care Authority

Benefits Update

Lauren Johnston
Senior Account Manager
Employees and Retirees Benefits Division
March 7, 2019

Objectives

Provide updates on:

- Vision carrier network expansion
- Updates to fully insured medical plan designs
- Updates to medical benefits comparison chart

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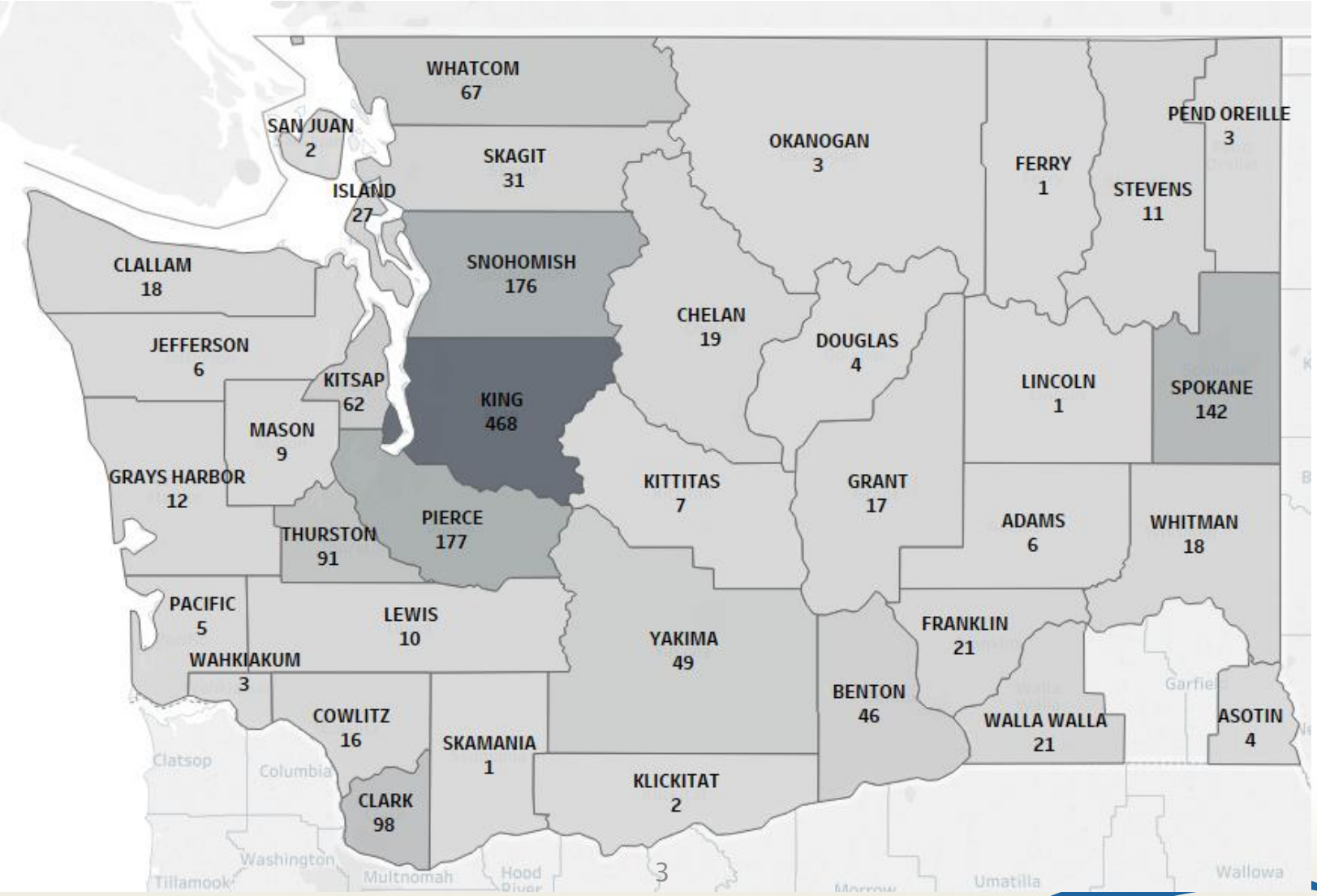
Combined total number of vision providers



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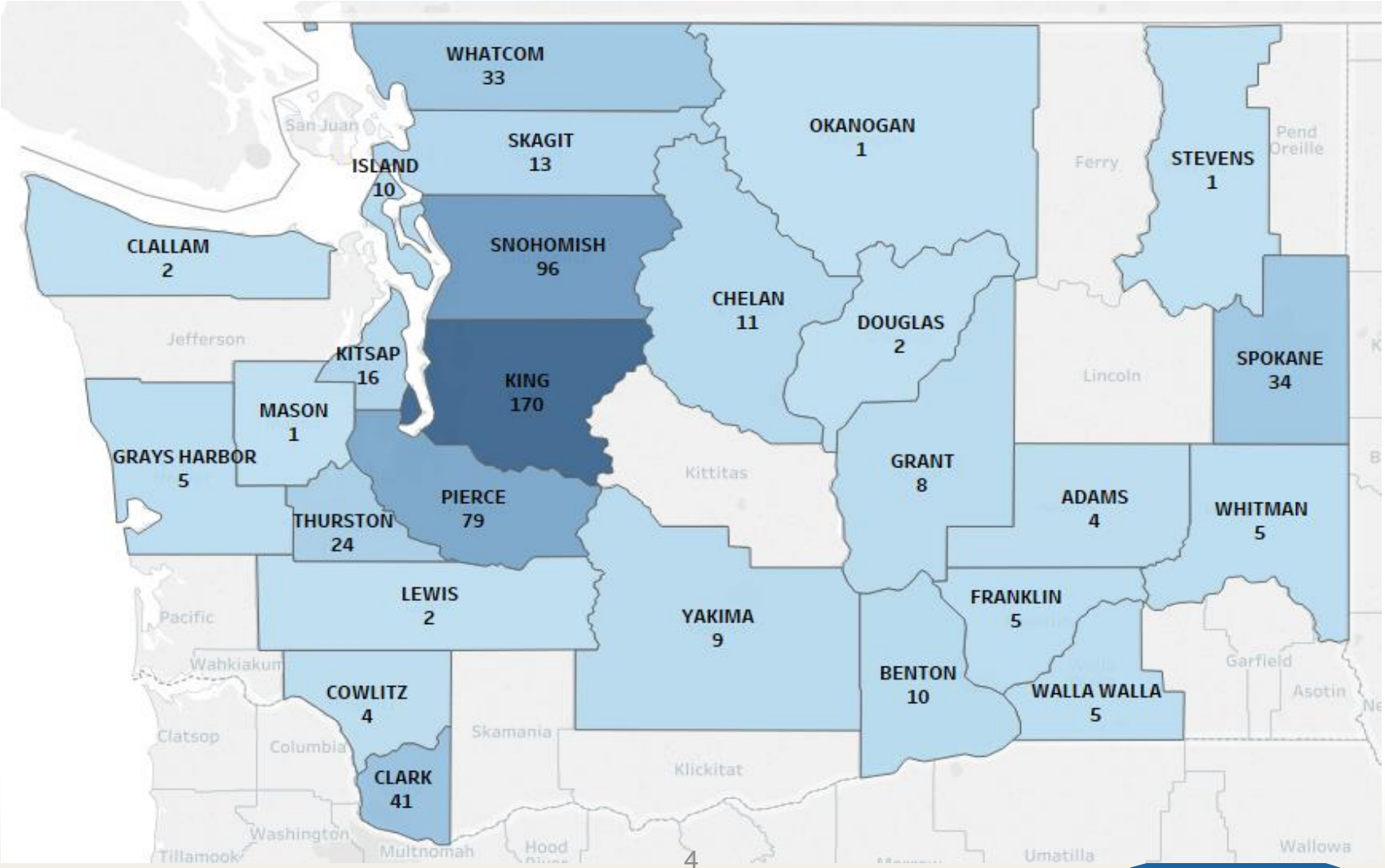
Total number of Davis providers



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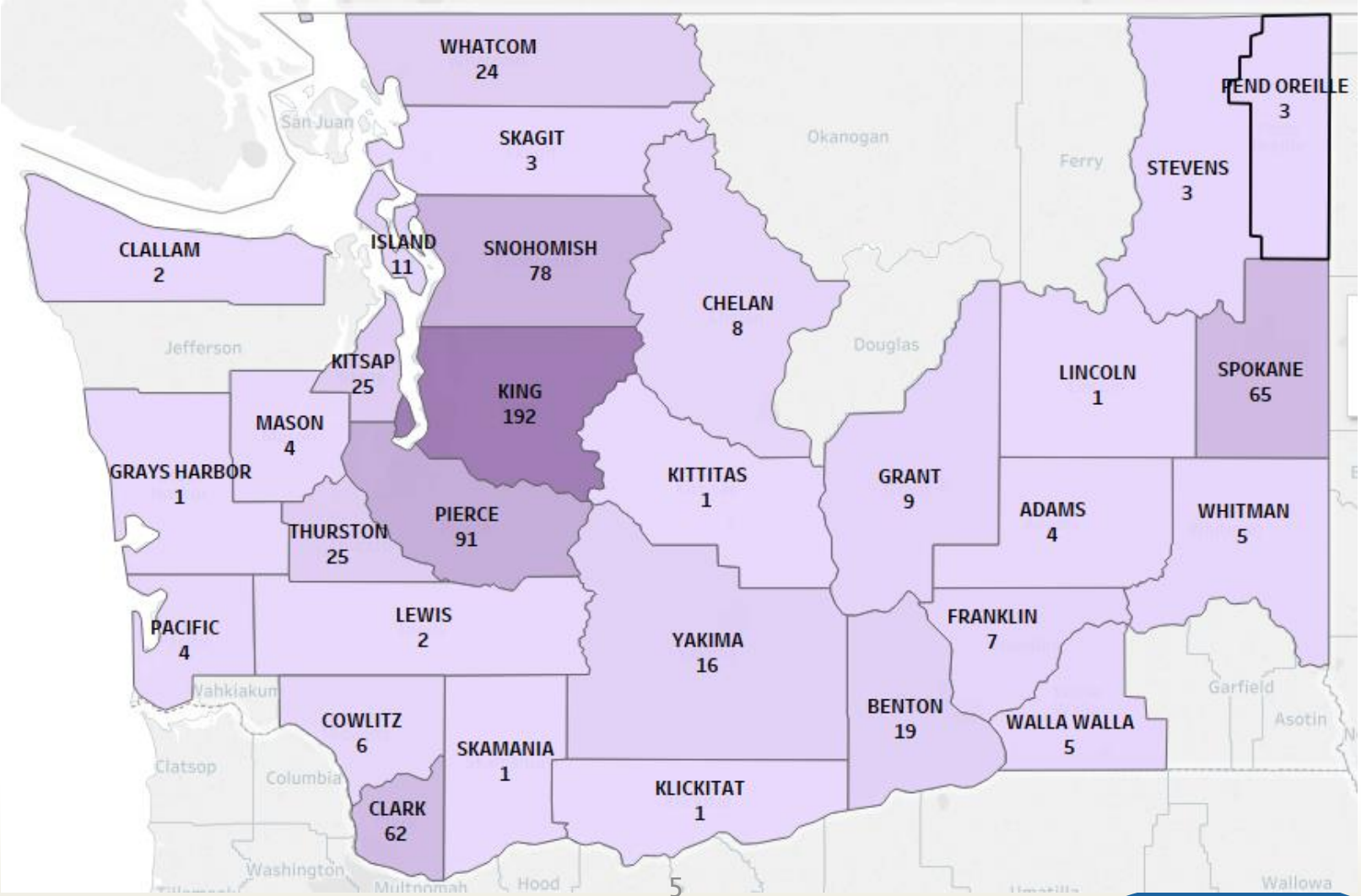
Total number of EyeMed providers



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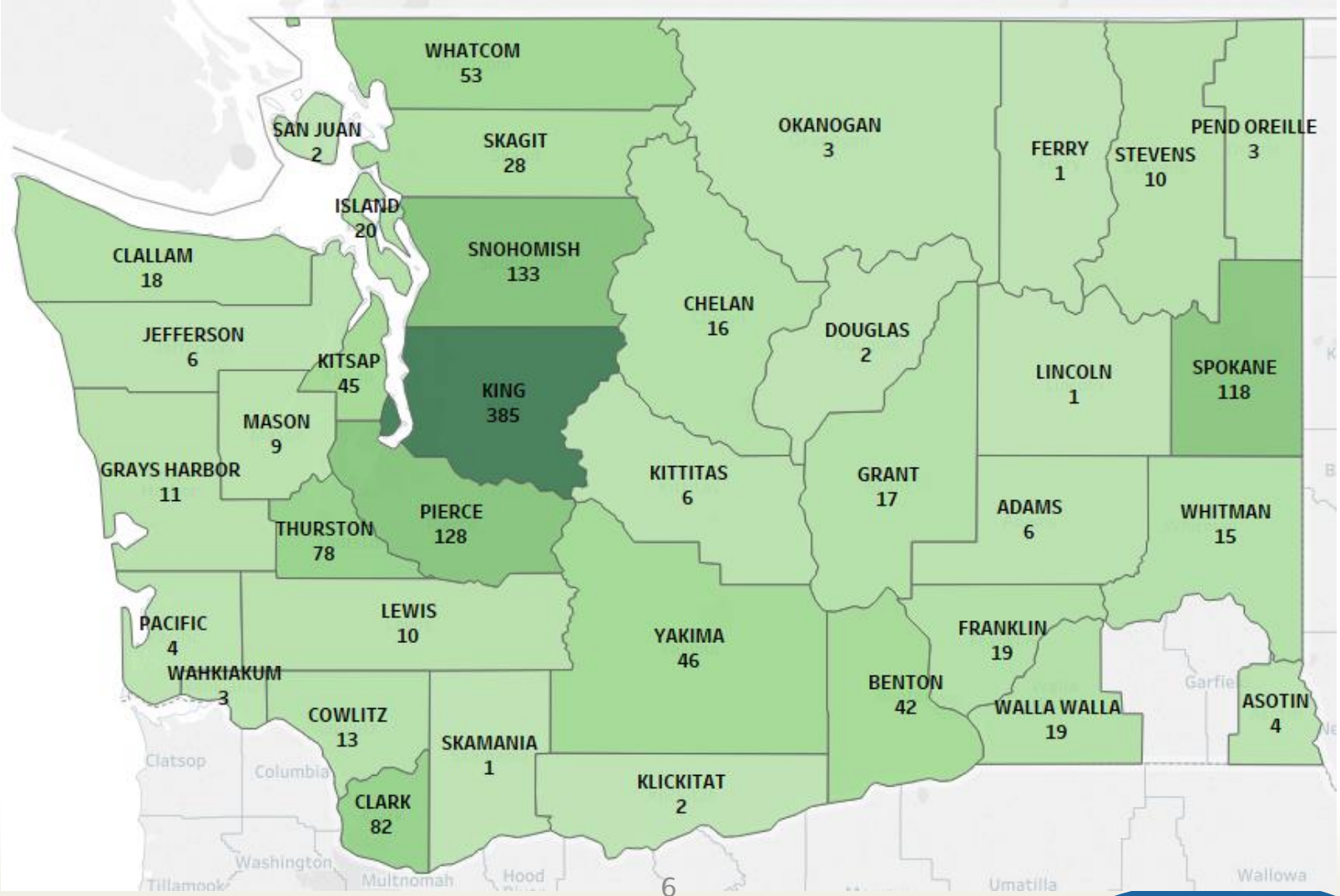
Total number of MetLife providers



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Fully Insured Medical Updated Plan Designs

Summary of fully insured plan changes

1. New Premera plan per your request to align the prescription deductible with the UMP Achieve 1 plan.
2. Technical changes to Kaiser's primary care age band copays; 18 is now considered an adult instead of a child.
3. Providence need to update their HSA plan specialty Rx cost share to meet Medicare Part D Creditable Coverage criteria.
4. Aetna Plan 1 – emergency room deductible is waived
5. Slight refinements to actuarial values (AV).
6. Benefit comparison document updated.

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Actuarial Value (AV) changes

Plan Name	Previous	Current
Premera Plan 1	80.8%	79.2%
Premera Plan 3 (NEW)	NA	79.6%
KPWAO Plan 1	81.5%	81.9%
KPNW Plan 1	81.3%	82.5%
Aetna Plan 1	81.4%	82.5%
KPWA Plan 1	82.8%	83%
Providence Plan 2	84.6%	83.4%
Premera Plan 2	83.7%	83.9%

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AV changes (*cont.*)

Plan Name	Previous	Current
KPNW Plan 2	84.1%	84.9%
KPWAO Plan 2	84.6%	85%
KPWA Plan 2	85.9%	86%
Aetna Plan 2	83.0%	86.5%
KPWAO Plan 3	88.5%	88.8%
KPWA Plan 3	89.8%	89.9%
KPNW Plan 3	89.8%	90.1%
KPWA Plan 4	91.4%	91.5%

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Summary Benefits Chart Changes

Plan Name	Benefit	Previous	Proposed
Aetna Plan 2 ($750 deductible)	Mental Health (outpatient)	$20 copay	$15 copay
Premera Plan 2 ($750 deductible)	Rx Deductible	$250/$625	$125/$312
Premera Plan 3 (NEW PLAN – $1250 deductible)	All listed	NA	See Benefits Comparison Chart

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Providence HSA Plan – AV TBD*

PPO

	Medical			
Deductible (single/family)	$1,750/$3,500			
Coinsurance	20% INN*** / 50% OON***			
Max OOP** (single/family)	$5,000/$10,000			
	Pharmacy			
Deductible (single/family)	Combined with Medical Deductible			
Coinsurance	**Generic:** 20%	**Preferred:** 20%	**Non-Preferred:** 50%	**Specialty:** 50% up to $200
Max OOP** (single/family)	Accumulates to medical max OOP**			
	Copay	**Coinsurance**	**Subject to Deductible?**	
Emergency Room		20%	Yes	
Hospital: Inpatient		20%	Yes	
Hospital: Outpatient		20%	Yes	
Office Visits: Primary Care		20%	Yes	
Office Visits: Specialist		20%	Yes	
Urgent Care		20%	Yes	

*AV = Actuarial Value will be finalized once employer HSA contribution is known.
**OOP = Out-of-Pocket
***INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

Premera Plan 1 – 79.2% AV

PPO

	Medical			
Deductible (single/family)	$1,250/$3,125			
Coinsurance	20% INN** / 50% OON**			
Max OOP* (single/family)	$5,000/$10,000			
	Pharmacy			
Deductible (single/family)	$500/$1,250 (waived for preferred generic)			
Coinsurance	**Generic:** $7	**Preferred:** 30%	**Non-Preferred:** 50%	**Specialty:** 40%
Max OOP* (single/family)	Accumulates to medical max OOP*			

	Copay	Coinsurance	Subject to Deductible?
Emergency Room	$150	20%	Yes
Hospital: Inpatient		20%	Yes
Hospital: Outpatient		20%	Yes
Office Visits: Primary Care	$20		No
Office Visits: Specialist	$40		No
Urgent Care		20%	Yes

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

Premera Plan 3 – 79.6% AV

PPO

	Medical		
Deductible (single/family)	$1,250/$3,125		
Coinsurance	20% INN** / 50% OON**		
Max OOP* (single/family)	$5,000/$10,000		
	Pharmacy		
Deductible (single/family)	$250/$750 (waived for preferred generic)		
Coinsurance	**Generic:** $7	**Preferred:** 30%	**Non-Preferred:** 50% **Specialty:** 40%
Max OOP* (single/family)	Accumulates to medical max OOP*		
	Copay	**Coinsurance**	**Subject to Deductible?**
Emergency Room	$150	20%	Yes
Hospital: Inpatient		20%	Yes
Hospital: Outpatient		20%	Yes
Office Visits: Primary Care	$20		No
Office Visits: Specialist	$40		No
Urgent Care		20%	Yes

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

KPWAO Plan 1 – 81.9% AV

PPO

	Medical		
Deductible (single/family)	$1,250/$3,750 Split 2X OON***		
Coinsurance	20% INN / 50% OON***		
Max OOP* (single/family)	$4,500/$9,000 Split 2X OON***		
	Pharmacy		
Deductible (single/family)	No pharmacy deductible		
Coinsurance	**Generic:** $10 ($5 E**) **Preferred:** $50 ($40 E**) **Non-Preferred:** 50% to $125 **Specialty:** 50% to $150		
Max OOP* (single/family)	Accumulates to medical max OOP*		
	Copay	**Coinsurance**	**Subject to Deductible?**
Emergency Room	$150	20%	Yes
Hospital: Inpatient		20%	Yes
Hospital: Outpatient		20%	Yes
Office Visits: Primary Care	age 0-17: $0 age 18+: $30 ($20 E**)		No
Office Visits: Specialist	$40 ($30 E**)		No
Urgent Care	Primary care: $30 ($20 E**) Specialty care: $40 ($30 E**)	Inpatient/outpatient: 20%	Office: No Inpatient: Yes Outpatient: Yes

*OOP = Out-of-Pocket
**E = Enhanced benefit. Applies if member uses a KP Medical Center and providers or other designated providers
***INN and OON = In-Network and Out-of-network

Washington State Health Care Authority

KPNW Plan 1 – 82.5% AV

HMO

	Medical			
Deductible (single/family)	$1,250/$2,500			
Coinsurance	20% INN** / 100% OON**			
Max OOP* (single/family)	$4,000/$8,000			
	Pharmacy			
Deductible (single/family)	No pharmacy deductible			
Coinsurance	**Generic:** $20	**Preferred:** $40	**Non-Preferred:** 50% to $100	**Specialty:** 50% to $100
Max OOP* (single/family)	Accumulates to medical max OOP*			
	Copay	**Coinsurance**	**Subject to Deductible?**	
Emergency Room		20%	Yes	
Hospital: Inpatient		20%	Yes	
Hospital: Outpatient		20%	Yes	
Office Visits: Primary Care	age 0-17: $0 age 18+: $30		No	
Office Visits: Specialist	$40		No	
Urgent Care	$50		No	

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

Aetna Plan 1 – 82.5% AV

PPO

	Medical			
Deductible (single/family)	$1,250/$2,500 INN** $2,000/$4,000 OON**			
Coinsurance	20% INN** / 50% OON**			
Max OOP* (single/family)	$5,000/$10,000 In-network $8,000/$16,000 Out-of-network			
	Pharmacy			
Deductible (single/family)	No pharmacy deductible			
Coinsurance	**Generic:** $10	**Preferred:** $35	**Non-Preferred:** $50	**Specialty:** $150
Max OOP* (single/family)	Accumulates to medical max OOP*			
	Copay	**Coinsurance**	**Subject to Deductible?**	
Emergency Room	$150 (waived if admitted)		No	
Hospital: Inpatient		20%	Yes	
Hospital: Outpatient		20%	Yes	
Office Visits: Primary Care	$30		No	
Office Visits: Specialist	$40		No	
Urgent Care	$30		No	

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

KPWA Plan 1 – 83% AV

HMO

	Medical			
Deductible (single/family)	$1,250/$3,750			
Coinsurance	20% INN** / 100% OON**			
Max OOP* (single/family)	$4,000/$8,000			
	Pharmacy			
Deductible (single/family)	No pharmacy deductible			
Coinsurance	**Generic:** $10	**Preferred:** $25	**Non-Preferred:** $50	**Specialty:** 50% to $150
Max OOP* (single/family)	Accumulates to medical max OOP*			
	Copay	**Coinsurance**	**Subject to Deductible?**	
Emergency Room	$150	20%	Yes	
Hospital: Inpatient		20%	Yes	
Hospital: Outpatient		20%	Yes	
Office Visits: Primary Care	age 0-17: $0 age 18+: $30		No	
Office Visits: Specialist	$40		No	
Urgent Care	Primary care: $30 Specialty care: $40	Inpatient/outpatient: 20%	Inpatient: Yes Outpatient: No	

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

Providence Plan 2 – 83.4% AV

PPO

	Medical		
Deductible (single/family)	$750/$1,500		
Coinsurance	20% INN** / 40% OON**		
Max OOP* (single/family)	$2,500/$5,000		
	Pharmacy		
Deductible (single/family)	Combined with Medical Deductible		
Coinsurance	**Generic:** $10 **Preferred:** $45 **Non-Preferred:** $75 **Specialty:** 50% with $150 cap		
Max OOP* (single/family)	Accumulates to medical max OOP*		
	Copay	**Coinsurance**	**Subject to Deductible?**
Emergency Room	$75	None	Yes
Hospital: Inpatient		20%	Yes
Hospital: Outpatient		20%	Yes
Office Visits: Primary Care		20%	INN**: No OON**: Yes
Office Visits: Specialist		20%	INN**: No OON**: Yes
Urgent Care		20%	INN**: No OON**: Yes

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

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Premera Plan 2 – 83.9% AV

PPO

	Medical			
Deductible (single/family)	$750/$1,875			
Coinsurance	25% INN** / 50% OON**			
Max OOP* (single/family)	$3,500/$7,000			
	Pharmacy			
Deductible (single/family)	$125/$312 (waived for preferred generic)			
Coinsurance	**Generic:** $7	**Preferred:** $30	**Non-Preferred:** 30%	**Specialty:** $50
Max OOP* (single/family)	Accumulates to medical max OOP*			
	Copay	**Coinsurance**	**Subject to Deductible?**	
Emergency Room	$150	25%	Yes	
Hospital: Inpatient		25%	Yes	
Hospital: Outpatient		25%	Yes	
Office Visits: Primary Care	$20		No	
Office Visits: Specialist	$40		No	
Urgent Care		25%	Yes	

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

KPNW Plan 2 – 84.9% AV

HMO

	Medical			
Deductible (single/family)	$750/$1,500			
Coinsurance	20% INN**/ 100% OON**			
Max OOP* (single/family)	$3,500/$7,000			
	Pharmacy			
Deductible (single/family)	No pharmacy deductible			
Coinsurance	**Generic:** $15	**Preferred:** $30	**Non-Preferred:** 50% to $100	**Specialty:** 50% to $150
Max OOP* (single/family)	Accumulates to medical max OOP*			
	Copay	**Coinsurance**	**Subject to Deductible?**	
Emergency Room		20%	Yes	
Hospital: Inpatient		20%	Yes	
Hospital: Outpatient		20%	Yes	
Office Visits: Primary Care	age 0-17: $0 age 18+: $25		No	
Office Visits: Specialist	$35		No	
Urgent Care	$45		No	

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

KPWAO Plan 2 – 85% AV

PPO

	Medical		
Deductible (single/family)	$750/$2,250 Split 2X OON***		
Coinsurance	20% INN***/ 50% OON***		
Max OOP* (single/family)	$3,500/$7,000 Split 2X OON***		
	Pharmacy		
Deductible (single/family)	No pharmacy deductible		
Coinsurance	**Generic:** $10 ($5 E**) **Preferred:** $50 ($40 E**) **Non-Preferred:** 50% to $125 **Specialty:** 50% to $150		
Max OOP* (single/family)	Accumulates to medical max OOP*		
	Copay	**Coinsurance**	**Subject to Deductible?**
Emergency Room	$150	20%	Yes
Hospital: Inpatient		20%	Yes
Hospital: Outpatient		20%	Yes
Office Visits: Primary Care	age 0-17: $0 age 18+: $25 ($15 E**)		No
Office Visits: Specialist	$35 ($25 E**)		No
Urgent Care	Primary care: $25 ($15 E**) Specialty care: $35 ($25 E**)	Inpatient/outpatient: 20%	Inpatient: Yes Outpatient: No

*OOP = Out-of-Pocket

**E = Enhanced benefit. Applies if member uses a KP Medical Center and providers or other designated providers.

***INN and OON = In-Network and Out-of-Network

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KPWA Plan 2 – 86% AV

HMO

	Medical		
Deductible (single/family)	$750/$2,250		
Coinsurance	20% INN** / 100% OON**		
Max OOP* (single/family)	$3,000/$6,000		
	Pharmacy		
Deductible (single/family)	No pharmacy deductible		
Coinsurance	**Generic:** $10 **Preferred:** $25 **Non-Preferred:** $50 **Specialty:** 50% to $150		
Max OOP* (single/family)	Accumulates to medical max OOP*		
	Copay	**Coinsurance**	**Subject to Deductible?**
Emergency Room	$150	20%	Yes
Hospital: Inpatient		20%	Yes
Hospital: Outpatient		20%	Yes
Office Visits: Primary Care	age 0-17: $0 age 18+: $25		No
Office Visits: Specialist	$35		No
Urgent Care	Primary care: $25 Specialty care: $35	Inpatient/outpatient: 20%	Inpatient: Yes Outpatient: No

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

Aetna Plan 2 – 86.5% AV

PPO

	Medical		
Deductible (single/family)	$750/$1,500		
Coinsurance	20% INN** / 40% OON**		
Max OOP* (single/family)	$3,000/$6,000 In-Network $6,000/$12,000 Out-of-Network		
	Pharmacy		
Deductible (single/family)	No pharmacy deductible		
Coinsurance	**Generic:** $15	**Preferred:** $25	**Non-Preferred:** $40 **Specialty:** $60
Max OOP* (single/family)	Accumulates to medical max OOP*		
	Copay	**Coinsurance**	**Subject to Deductible?**
Emergency Room	$150 (waived if admitted)	20%	Yes
Hospital: Inpatient	$300/admission	20%	Yes
Hospital: Outpatient		20%	Yes
Office Visits: Primary Care	$15		No
Office Visits: Specialist	$20		No
Urgent Care	$15		No

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

KPWAO Plan 3 – 88.8% AV

PPO

	Medical		
Deductible (single/family)	$250/$750 Split 2X OON		
Coinsurance	20% INN / 50% OON		
Max OOP (single/family)	$2,500/$5,000 Split 2X OON		
	Pharmacy		
Deductible (single/family)	No pharmacy deductible		
Coinsurance	**Generic:** $10 ($5 E*) **Preferred:** $50 ($40 E*) **Non-Preferred:** 50% to $125 **Specialty:** 50% to $150		
Max OOP (single/family)	Accumulates to medical max OOP		
	Copay	**Coinsurance**	**Subject to Deductible?**
Emergency Room	$150	20%	Yes
Hospital: Inpatient		20%	Yes
Hospital: Outpatient		20%	Yes
Office Visits: Primary Care	age 0-17: $0 age 18+: $20 ($10 E*)		No
Office Visits: Specialist	$30 ($20 E*)		No
Urgent Care	Primary care: $20 ($10 E*) Specialty care: $30 ($20 E*)	Inpatient/outpatient: 20%	Inpatient: Yes Outpatient: No

*OOP = Out-of-Pocket
**E = Enhanced benefit. Applies if member uses a KP Medical Center and providers or other designated providers.
***INN and OON = In-Network and Out-of-network

Washington State Health Care Authority

KPWA Plan 3 – 89.9% AV

HMO

	Medical		
Deductible (single/family)	$250/$750		
Coinsurance	20% INN** / 100% OON**		
Max OOP* (single/family)	$2,000/$4,000		
	Pharmacy		
Deductible (single/family)	No pharmacy deductible		
Coinsurance	**Generic:** $10 **Preferred:** $25 **Non-Preferred:** $50 **Specialty:** 50% to $150		
Max OOP* (single/family)	Accumulates to medical max OOP*		
	Copay	**Coinsurance**	**Subject to Deductible?**
Emergency Room	$150	20%	Yes
Hospital: Inpatient		20%	Yes
Hospital: Outpatient		20%	Yes
Office Visits: Primary Care	age 0-17: $0 age 18+: $20		No
Office Visits: Specialist	$30		No
Urgent Care	Primary care: $20 Specialty care: $30	Inpatient/outpatient: 20%	Inpatient: Yes Outpatient: No

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

KPNW Plan 3 – 90.1% AV

HMO

	Medical		
Deductible (single/family)	$125/$250		
Coinsurance	20% INN** / 100% OON**		
Max OOP* (single/family)	$2,000/$4,000		
	Pharmacy		
Deductible (single/family)	No pharmacy deductible		
Coinsurance	**Generic:** $10 **Preferred:** $20 **Non-Preferred:** 50% to $100 **Specialty:** 50% to $150		
Max OOP* (single/family)	Accumulates to medical max OOP*		
	Copay	**Coinsurance**	**Subject to Deductible?**
Emergency Room		20%	Yes
Hospital: Inpatient		20%	Yes
Hospital: Outpatient		20%	Yes
Office Visits: Primary Care	age 0-17: $0 age 18+: $20		No
Office Visits: Specialist	$30		No
Urgent Care	$40		No

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

KPWA Plan 4 – 91.5% AV

Core-HMO Network (Limited network)

	Medical		
Deductible (single/family)	$125/$375		
Coinsurance	15% INN** / 100% OON**		
Max OOP* (single/family)	$2,000/$4,000		
	Pharmacy		
Deductible (single/family)	No pharmacy deductible		
Coinsurance	**Generic:** $10 **Preferred:** $25 **Non-Preferred:** $50 **Specialty:** 50% to $150		
Max OOP* (single/family)	Accumulates to medical max OOP*		
	Copay	**Coinsurance**	**Subject to Deductible?**
Emergency Room	$150	15%	Yes
Hospital: Inpatient		15%	Yes
Hospital: Outpatient		15%	Yes
Office Visits: Primary Care	$0		No
Office Visits: Specialist	$30		No
Urgent Care	Primary care: $0 Specialty care: $30	Inpatient/outpatient: 15%	Inpatient: Yes Outpatient: No

*OOP = Out-of-Pocket
**INN and OON = In-Network and Out-of-Network

Washington State Health Care Authority

Questions?

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SEBB Program Medical Benefits Comparison Chart

Note: Subject to legislative funding and final decisions by the SEB Board

Last revised 3/1/2019

Recent updates in red

	Aetna		Kaiser NW			Kaiser WA				Kaiser WA Options			Premera			Providence		UMP			
Annual Costs/ Benefits ^	***Plan 1***	***Plan 2***	***Plan 1***	***Plan 2***	***Plan 3***	***Plan 1***	***Plan 2***	***Plan 3***	***Plan 4***	***Plan 1***	***Plan 2***	***Plan 3***	***Plan 1***	***Plan 2***	***Plan 3***	***HSA***	***Plan 2***	**UMP Achieve 1 (82% AV)**	**UMP Achieve 2 (88% AV)**	**UMP High Deductible**	**UMP Plus**
Deductible (single/ family)	$1,250/ $2,500	$750/ $1,500	$1,250/ $2,500	$750/ $1,500	$125/ $250	$1,250/ $3,750	$750/ $2,250	$250/ $750	$125/ $375	$1,250/ $3,750	$750/ $2,250	$250/ $750	$1,250/ $3,125	$750/ $1,875	$1,250/ $3,125	$1,750/ $3,500	$750/ $1,500	$750/ $2,250	$250/ $750	$1,400/ $2,800	$125/ $375
Max out-of-pocket limit	$5,000/ $10,000	$3,000/ $6,000	$4,000/ $8,000	$3,500/ $7,000	$2,000/ $4,000	$4,000/ $8,000	$3,000/ $6,000	$2,000/ $4,000	$2,000/ $4,000	$4,500/ $9,000	$3,500/ $7,000	$2,500/ $5,000	$5,000/ $10,000	$3,500/ $7,000	$5,000/ $10,000	$5,000/ $10,000	$2,500/ $5,000	$3,500/ $7,000	$2,000/ $4,000	$4,200/ $8,400**	$2,000/ $4,000
Coinsurance	20%	20%	20%	20%	20%	20%	20%	20%	15%	20%	20%	20%	20%	25%	20%	20%	20%	20%	15%	15%	15%
Ambulance (air/ground, per trip)	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	25%	20%	20%	20%	20%	20%	20%	20%
Diagnostic tests, lab, and x-rays	20%	20%	$30	$25	$25	20% over $500	20% over $500	20%	15%	20%	20% over $500	20%	20%	25%	20%	20%	20%	20%	15%	15%	15%
Emergency room	$150	$150 + 20%	20%	20%	20%	$150 + 20%	$150 + 20%	$150 + 20%	$150 + 15%	$150 + 20%	$150 + 20%	$150 + 20%	$150 + 20%	$150 + 25%	$150 + 20%	20%	$75	$75 + 20%	$75 + 15%	15%	$75 + 15%
Inpatient services	20%	$300 + 20%	20%	20%	20%	20%	20%	20%	15%	20%	20%	20%	20%	25%	20%	20%	20%	$200/day up to $600 + 20%	$200/day up to $600 + 15%	15%	$200/day up to $600 + 15%
Outpatient services	20%	20%	20%	20%	20%	20%	20%	20%	15%	20%	20%	20%	20%	25%	20%	20%	20%	20%	15%	15%	15%
Preventive care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Spinal manipulations	$30	$15	$40	$35	$30	$30	$25	$20	$0	$30	$25	$20	20%	25%	20%	20%	20%	20%	15%	15%	15%
Primary care	$30	$15	$30	$25	$20	$30	$25	$20	$0	$30	$25	$20	$20	$20	$20	20%	20%	20%	15%	15%	$0
Specialist	$40	$20	$40	$35	$30	$40	$35	$30	$30	$40	$35	$30	$40	$40	$40	20%	20%	20%	15%	15%	15%
Urgent care	$30	$15	$50	$45	$40	$30	$25	$20	$0	$30	$25	$20	20%	25%	20%	20%	20%	20%	15%	15%	15%
Mental health (outpatient)	$30	$15	$30	$25	$20	$30	$25	$20	$0	$30	$25	$20	$20	$20	$20	20%	20%	20%	15%	15%	15%
Physical, occupational, and speech therapy	$40	$20	$40	$35	$30	$40	$35	$30	$30	$40	$35	$30	$40	$40	$40	20%	20%	20%	15%	15%	15%

^ In-network

** Out of pocket expenses for a single member under a family account are not to exceed $6,850.

SEBB Program Medical Benefits Comparison Chart

Note: Subject to legislative funding and final decisions by the SEB Board

	Aetna		Kaiser NW			Kaiser WA				Kaiser WA Options			Premera			Providence		UMP			
Annual Costs/ Benefits ^	***Plan 1***	***Plan 2***	***Plan 1***	***Plan 2***	***Plan 3***	***Plan 1***	***Plan 2***	***Plan 3***	***Plan 4***	***Plan 1***	***Plan 2***	***Plan 3***	***Plan 1***	***Plan 2***	***Plan 3***	***HSA***	***Plan 2***	**UMP Achieve 1 (82% AV)**	**UMP Achieve 2 (88% AV)**	**UMP High Deductible**	**UMP Plus**
Rx deductible	None	None	None	None	None	None	None	None	None	None	None	None	$500/ $1,250*	$250/ $625*‡	$250/ $750*	Combine with medical deductibles	Combine with medical deductibles	$250/ $750	Tiers 2-4 $100/ $300	Applied to medical deductible	None
Rx out-of-pocket limit	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	$2,000/ person	$2,000/ person	$2,000/ person	$2,000/ person
Retail: Value tier																		5% up to $10	5% up to $10	15%	5% up to $10
Retail: Tier 1 (Generics)	$10	$15	$20	$15	$10	$5	$10	$10	$10	$10	$10	$10	$7	$7	$7	20%	$10-$15	10% up to $25	10% up to $25	15%	10% up to $25
Retail: Tier 2 (Preferred Brand)	$35	$25	$40	$30	$20	$25	$25	$25	$25	$50	$50	$50	30%	$30	30%	20%	$45	30% up to $75	30% up to $75	15%	30% up to $75
Retail: Tier 3 (Non-preferred)	$50	$40	50% up to $100	50% up to $100	50% up to $100	$50	$50	$50	$50	50% up to $125	50% up to $125	50% up to $125	50%	30%	50%	50%	$75	10-50%	10-50%	15% (non-specialty)	50% up to $150
(Most Specialty)	$150	$60	50% up to $150	50% up to $150	50% up to $150	50% up to 150	50% up to $150	50% up to $150	50% up to $150	50% up to $150	50% up to $150	50% up to $150	40%	$50	40%	50% up to $200	50% up to $150	50% up To $150	50% up to $150	15%	50% up to $150

^ In-network

*Waived for preferred generic prescription drugs.

‡ Rx deductible for Premera Plan 2 shows the SEB Board-approved deductible at the November 2018 Board meeting; Premera has proposed changing this figure to $125 / $312.

Note: The retail pharmacy benefit member costs are based on a 30-day supply.

02/22/2019

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

School Employees Benefits Board (SEBB) Program benefits: A high-level overview

This is a summary, and is not inclusive of all covered services. Figures, plans, and carriers shown are subject to legislative funding and final decisions by the SEB Board, which will occur in late July 2019 and will include monthly employee premiums and the service area for each plan.

Medical benefits

	Aetna		Kaiser NW			Kaiser WA			
Annual Costs/Benefits	**Plan 1**	**Plan 2**	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**
Deductible (single / family)	$1,250 / $2,500	$750 / $1,500	$1,250 / $2,500	$750 / $1,500	$125 / $250	$1,250 / $3,750	$750 / $2,250	$250 / $750	$125 / $375
Out-of-pocket max	$5,000 / $10,000	$3,000 / $6,000	$4,000 / $8,000	$3,500 / $7,000	$2,000 / $4,000	$4,000 / $8,000	$3,000 / $6,000	$2,000 / $4,000	$2,000 / $4,000
Coinsurance	20%	20%	20%	20%	20%	20%	20%	20%	15%
Rx deductible	None	None	None	None	None	None	None	None	None
Rx out-of-pocket limit	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max

	Kaiser WA Options			Premera			Providence		UMP			
Annual Costs/Benefits	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 1**	**Plan 2**	**Plan 3**	**HSA**	**Plan 2**	**UMP Achieve 1**	**UMP Achieve 2**	**UMP High Deductible**	**UMP Plus**
Deductible (single / family)	$1,250 / $3,750	$750 / $2,250	$250 / $750	$1,250 / $3,125	$750 / $1,875	$1,250 / $3,125	$1,750 / $3,500	$750 / $1,500	$750 / $2,250	$250 / $750	$1,400 / $2,800	$125 / $375
Out-of-pocket max	$4,500 / $9,000	$3,500 / $7,000	$2,500 / $5,000	$5,000 / $10,000	$3,500 / $7,000	$5,000 / $10,000	$5,000 / $10,000	$2,500 / $5,000	$3,500 / $7,000	$2,000 / $4,000	$4,200 / $8,400**	$2,000 / $4,000
Coinsurance	20%	20%	20%	20%	25%	20%	20%	20%	20%	15%	15%	15%
Rx deductible	None	None	None	$500 / $1,250*	$250 / $625*‡	$250 / $750*	Applied to medical deductible	Applied to medical deductible	$250 / $750	Tiers 2-4: $100 / $300	Applied to medical deductible	None
Rx out-of-pocket limit	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	$2,000 per person	$2,000 per person	$2,000 per person	$2,000 per person

*Waived for preferred generic prescription drugs.

‡Rx deductible for Premera Plan 2 shows the SEB Board-approved deductible at the November 2018 Board meeting; Premera has proposed changing this figure to $125 / $312.

**Out of pocket expenses for a single member under a family account are not to exceed $6,850.

2/25/2019

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

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Medical benefits (continued)

	Aetna		Kaiser NW			Kaiser WA			
Annual Costs/Benefits	Plan 1	Plan 2	Plan 1	Plan 2	Plan 3	Plan 1	Plan 2	Plan 3	Plan 4
Ambulance	20%	20%	20%	20%	20%	20%	20%	20%	20%
Emergency room	$150	$150 + 20%	20%	20%	20%	$150 + 20%	$150 + 20%	$150 + 20%	$150 + 15%
Inpatient services	20%	$300+20%	20%	20%	20%	20%	20%	20%	15%
Outpatient services	20%	20%	20%	20%	20%	20%	20%	20%	15%
Primary care	$30	$15	$30	$25	$20	$30	$25	$20	$0
Specialist	$40	$20	$40	$35	$30	$40	$35	$30	$30
Urgent care	$30	$15	$50	$45	$40	$30	$25	$20	$0

	Kaiser WA Options			Premera			Providence		UMP			
Annual Costs/Benefits	Plan 1	Plan 2	Plan 3	Plan 1	Plan 2	Plan 3	HSA	Plan 2	UMP Achieve 1	UMP Achieve 2	UMP High Deductible	UMP Plus
Ambulance	20%	20%	20%	20%	25%	20%	20%	20%	20%	20%	20%	20%
Emergency room	$150 + 20%	$150 + 20%	$150 + 20%	$150 + 20%	$150 + 25%	$150 + 20%	20%	$75	$75 + 20%	$75 + 15%	15%	$75 + 15%
Inpatient services	20%	20%	20%	20%	25%	20%	20%	20%	$200/day, up to $600 + 20%	$200/day, up to $600 + 15%	15%	$200/day, up to $600 + 15%
Outpatient services	20%	20%	20%	20%	25%	20%	20%	20%	20%	15%	15%	15%
Primary care	$30	$25	$20	$20	$20	$20	20%	20%	20%	15%	15%	$0
Specialist	$40	$35	$30	$40	$40	$40	20%	20%	20%	15%	15%	15%
Urgent care	$30	$25	$20	20%	25%	20%	20%	20%	20%	15%	15%	15%

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

School Employees Benefits Board (SEBB) Program benefits: A high-level overview

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Dental benefits

	DeltaCare	Uniform Dental	Willamette
	Managed care	PPO	Managed care
Annual maximum	No max	$1,750	No max
Deductible	$0	$50 (individual) / $150 (family)	$0
General office visit (after deductible)	$0	100%	$0
Routine/emergency exams	100%	100%	100%
Fillings / crowns	$10 – $50 / $100 – $175	80%	$10 – $50 / $100 – $175
Root canal	$100 – $150	80%	$100 – $150
Orthodontia	$1,500 per case	50% until plan has paid $1,750; then any amount over $1,750	$1,500 per case

Vision Benefits

	Davis Vision	EyeMed	MetLife
Routine exam (every 12 mos.)	$0	$0	$0
Frames (every 24 mos.)	$0 up to $150, then 80%	$0 up to $150, then 80%	$0 up to $150, then 80%
Lenses	$0	$0	$10
Progressive lenses	$50 – $140	$55 – $175	$0 – $175
Conventional* contact lenses	$0 up to $150, then 85% (or 4 boxes from collection lenses)	$0 up to $150, then 85%	$0 up to $150, then 100%
Disposable* contact lenses		$0 up to $150, then 100%	

*Disposable contact lenses are single-use lenses and are removed and discarded after a determined period of time, typically at the end of each day or week. Conventional lenses, with proper care and cleaning, can be used for longer periods of time, from one month to up to one year.

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

School Employees Benefits Board (SEBB) Program benefits: A high-level overview

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Life and accidental death & dismemberment (AD&D) insurance

Employer paid	
Insurance type	**Basic**
Employee basic life	$35,000
Employee basic (AD&D)	$5,000
Employee paid	
Insurance type	**Supplemental**
Employee supplemental life	• Guaranteed issue (GI)* up to $500,000 in $10,000 increments, up to a maximum of $1,000,000 • Evidence of insurability (EOI)* required for amounts over $500,000
Supplemental spousal term life (tied to employee coverage amount)	• Up to 50% of employee's supplemental • GI up to $100,000 in $5,000 increments • EOI required over $100,000
Supplemental dependent child term life	• GI up to $20,000 in $5,000 increments • For dependents age 2 weeks to 26 years
Supplemental employee, spousal, and child AD&D	• Employee: GI up to $250,000 in $10,000 increments • Spouse: GI up to $250,000 in $10,000 increments • Child: GI up to $25,000 in $5,000 increments

*Guaranteed issue benefits are available to any eligible employee, with no evidence of insurability. Evidence of insurability (or proof of good health), for these plans, is provided through an online questionnaire. Eligibility is approved or denied upon completion of the questionnaire.

Supplemental employee and spouse life insurance monthly premiums (per $1,000 of coverage)		
Age	**Non-smoker**	**Smoker**
<25	$0.038	$0.050
25-29	$0.042	$0.060
30-34	$0.046	$0.080
35-39	$0.058	$0.090
40-44	$0.088	$0.100
45-49	$0.128	$0.150
50-54	$0.188	$0.230
55-59	$0.346	$0.400
60-64	$0.534	$0.630
65-69	$0.962	$1.220
70+	$1.438	$1.988

Supplemental insurance: Premium examples

35-year-old smoker

- $200,000 supplemental life for employee: $18/month
- $100,000 supplemental life for spouse: $9/month

50-year-old non-smoker

- $150,000 supplemental life for employee: $28.50/month
- $75,000 supplemental life for spouse: $14.25/month

Any eligible employee (guaranteed issue)

- $20,000 supplemental life for child: $2.48/month
- $250,000 supplemental AD&D for employee or spouse: $4.75/month
- $25,000 supplemental AD&D for child: $0.40/month

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

School Employees Benefits Board (SEBB) Program benefits: A high-level overview

This is a summary, and is not inclusive of all covered services. Figures shown are subject to legislative funding and final decisions by the SEB Board.

Long term disability (LTD) insurance

Employer-paid basic LTD plan design	
Insurance type	**Basic**
Benefit waiting period*	90 days or the end of family / medical paid leave, whichever is longer
Pension	Choice (The member can choose to be paid from their pension; if they do, it is deducted from their disability benefit.)
Sick leave	No choice (The benefit will not begin paying until the end of the member's existing sick leave, whether or not the employee uses and receives payment for the sick leave.)
Maximum monthly benefit	$400

Employee-paid supplemental LTD plan design	
Insurance type	**Supplemental**
Benefit waiting period*	90 days or the end of family / medical paid leave, whichever is longer
Enrollment type	Opt in (The member must actively enroll in this benefit.)
Pension	Choice (The member can choose to be paid from their pension; if they do, it is deducted from their disability benefit.)
Sick leave	No choice (The benefit will not begin paying until the end of the member's sick leave, whether or not the employee uses and receives payment for the sick leave.)
Maximum monthly benefit	$10,000

*Benefit waiting period: The length of time between the beginning of a member's disability claim and the first payment the member would receive.

Supplemental LTD cost examples		
Annual income	**Estimated monthly premiums**	**Estimated monthly benefit (includes basic benefit)**
$30,000	$9 – $15	$1,500
$50,000	$15 – $25	$2,500
$80,000	$25 – $40	$4,000
$100,000	$31 – $51	$5,000

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

School Employees Benefits Board (SEBB) Program benefits: A high-level overview

This is a summary, and is not inclusive of all covered services. Figures shown are subject to legislative funding and, for the FSA and DCAP benefit, final plan design decisions by the Health Care Authority.

Additional benefits

Additional benefit maximum contributions	
Medical flexible spending arrangement (FSA)	
Maximum contribution	$2,700 (anticipated amount for 2020)
Dependent care assistance program (DCAP)	
Maximum contribution	$5,000 for a join income tax return / $2,500 each for separate income tax returns