Washington State Health Care Authority

School Employees Benefits Board
Meeting Minutes

May 16, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 p.m. – 4:00 p.m.

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

SEB Board Counsel
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 9:04 a.m. Sufficient members present to allow a quorum. Board self-introductions followed.

Agenda Overview
Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda. TVW was present to record the Board Meeting.

April 10, 2019 Board Meeting Follow Up
Dave Iseminger, Director, ERB Division. The Board had questions on eligibility enrollment policies and the value-based formulary. Rob Parkman and Marcia Peterson have embedded answers to those questions in their presentations.

I want to respond to public comment from Troy Andrews of Local Laborers 252 in Tacoma. He presented the Board with an interpretation that he and others had about statutory authority. They believe this Board has authority to carve out or waive entire groups or subsets of SEBB Organizations. We provided a written response to Mr. Andrews, in addition to meeting with him in person, since the last Board meeting. I told him HCA's understanding and interpretation of the statutes is the Board has the ability to allow and establish terms and conditions for individual school employees to waive

individually, and the Board has already established those criteria. The Board does not have authority to carve out an entire sub-component of a SEBB Organization or an entire SEBB Organization. Mr. Andrews presented his questions about individuals being able to waive, but a lot of it was language talking about exempting an entire subset of the population. I want to remind the Board and the public that even if an individual waives, the way the funding structure is set up, an employer still pays because the funding rate represents an average of funds that are needed for the entire Program.

As our communications team says, "waiving isn't saving." It doesn't save money at an individual district on the employer contribution for an individual who waives. There were some underpinnings of the questions about there being savings in the system. The funding rate is an average that has a projected number of people who will waive benefits. So waiving isn't saving and an exemption or allowing an entire group to not be part of the SEBB Program wouldn't save money in the system per se. We continued those conversations. I just wanted to give the Board the discussion and update because there were assertions about this Board's authority.

Lou McDermott: Dave, can you dumb it down a tick and tell us whether or not it still has a negative impact on him? If his individual members waive, does it fix his problem?

Megan Atkinson: Dave, do you want to phone a friend?

Dave Iseminger: I would love to phone a friend who's going to come up here next anyway.

Megan Atkinson, Chief Financial Officer Health Care Authority. When you talk about waiving isn't saving, the funding rate has been set for both budgeting purposes and invoicing purposes for a district. Having members waive does not save. It doesn't help an individual district. Now, when you take a step back up to the 35,000 foot or 50,000 foot level, if in our funding rate assumptions, we have an assumption about what percentage of the population will waive, we currently are using 8%. If we end up post-open enrollment with a larger number of employees waiving coverage, that does impact the modeling of the global funding rate. Likewise, if we have a lower number of members who choose to waive, that also would impact the global funding rate.

So your question, Chair McDermott, about what's the takeaway? When we're in a year and a funding rate has been established, having a larger or lesser number of the employees at a district level waive doesn't impact that district's invoice. When we are doing modeling for a subsequent year, having an open enrollment behavior of waiving does impact the assumptions we will use in subsequent funding rates.

Lou McDermott: So if I recall, the individuals in his group are concerned because by going into SEBB benefits, they'll no longer be in their insurance, accumulating hours and time. That was going to translate into a sort of retirement. They were going to have a very low premium when they retired. Are they no longer able to go into that benefit or can they waive their medical through the district, continue to do what they're doing, and then reap that benefit at retirement? Or would that be up to the district to fund both?

Dave Iseminger: I can't speak to the exact benefit structure. What Mr. Andrews was definitely wanting was clear information so the employees in his bargaining unit would understand the rules of the road that they were about to go into. They would be able to make decisions related to either retiring before the SEBB Program is in place and be able to access the benefits they currently understand, versus continuing employment. He was looking to make sure that if there was not an ability to be exempt or fully waived out of the program, at least his members would know the information up front to be able to make decisions over the next few months. I believe they have the information they need to make decisions. But I can't speak to the exact benefit structure and choices that each of them have.

Alison Poulsen: I want to make sure I understand what Megan is saying - in the first biennium, it's not going to matter if we ended up with 14% of people waiving to an individual school district. They're going to be on the hook for the amount. Where it could potentially have cost savings to a district would be the next time you're calculating eligibility, you might see less of a financial cost?

Megan Atkinson: There are key points in time when funding rates are set. The percentage of employees who waive is a key assumption in building the funding rate. We'll talk about it more in my presentation.

SEBB Finance 2019-2021 State Operating Budget

Megan Atkinson, Chief Financial Officer. I have a late addition to this presentation which is in the pocket of your binder.

As Dave indicated, the Legislature adjourned on time, no special session. A budget was passed, but we're still awaiting the Governor's action on the budget. We'll walk through the budget as it was passed. If there are vetoes that impact the program, of course we'll update you at a subsequent Board Meeting.

We will walk through the legislative update on the operating budget, key funding rate assumptions, budget language about the flow of funding rate dollars, decision package action impacting the Program, and different budget language. There is SEBB language in section 200 of the HCA budget, language in section 500 of the K-12 sections, and language in section 900 of the Collective Bargaining Section. You have to piece it all together. This is what we've found so far. There is always the caveat that possibly we've missed something; but if any member wants a packet of the language, let us know and we'll get it for you.

Slide 3 – Monthly Funding Rate Comparison. This is a very high-level look. We are comparing Fiscal Year 2020 and Fiscal Year 2021 on this slide. The green line is the funding rate we provided in early March, feeding that into the legislative budget deliberations. The yellow line is the funding rate in the final budget.

Dave Iseminger: Some of you may remember in the April Board Meeting, Megan explained a number that's $1,114 instead of the $1,096 you see on Slide 3. Those numbers are functionally equivalent. It was how the administrative loan was accounted for.

Megan Atkinson: There is the funding rate and then there's the net funding rate. The funding rate is typically what ends up in an enacted budget. Not always. The net funding rate is the actual amount needed to cover the projected expenditures of the plan. We often have surplus spend, especially on the PEBB Program side. I would anticipate that happening, also, on the SEBB Program side once we're more mature as a program. Either surplus spend from previous years where we have overestimated the funding rate, or if we end up in a situation where we're projecting to have a deficit, that can also impact the funding rate.

Let's look at the two-sided handout the front of your binder. Side 1 has "SEBB Funding Rate" in large print at the top of the page and a column entitled "Conference Budget (Funding Rate)."

Side 2 has no header and a column "HCA Update – 3/1/19." The total in the HCA Update column is $1,096. The list on Page 2 is all the funding rate components that totaled $1,096. That was the funding rate discussed in a previous Board meeting.

The Conference Budget Funding Rate on side one totals $994. The differences are on the K-12 remittance. We previously modeled $67 for the K-12 remittance. It is now at $70. It's a modeling change referenced in the budget. Per the Collective Bargaining Agreement, as well as budget language, paying for the K-12 remittance is an employer responsibility that goes into the funding rate. The funding rate is used for driving funding out to the district for state funded staff and by HCA for invoicing districts for all eligible staff, including those who waive.

There are three differences listed at the bottom of the chart on side 1. The K-12 remittance is different. It was $67, now it's $70. Administration and other costs was $32, now it's $26. The surplus and deficit spend was $18, now is $116. That increase in the deficit is the impact of the Legislature choosing a funding rate of $994 versus the funding rate we provided of $1,096. The $994 is the current net funding rate for the PEBB Program. Essentially, that represents an adequate funding rate currently modeled to be an adequate funding rate for a similar benefit program, for a similar set of public employees for a mature program.

The net PEBB funding rate doesn't take into consideration the startup cost on the SEBB side, like the loans we have to repay to the General Fund. The other significant startup is going from zero reserves to a 7% medical and 4% percent dental. That's a fairly large component of our initial projected funding rate on the SEBB side. Whereas on the PEBB side, you're just funding the marginal increase or decrease each year of those reserves based on enrollment and claims fluctuation on the self-insured population.

What the Legislature has done, if you take everything we put together - the benefit offering and the funding rate specified in the budget, budget language directing the agency, and the SEB Board, as well as the lack of any change in the statutory authority for the benefit program and eligibility - in Section 938 of the budget it says "funding to provide provisions of the 2019-21 Collective Bargaining Agreement and for procurement of a benefit package that is materially similar to benefits provided by the Public Employee Benefits Board Program as outlined in policies adopted by the School Employees Benefits Board." The Legislature is essentially saying to keep doing what

you're doing. Keep implementing the program that you're implementing. They only put forward a $994 funding rate and we will go forward if needed, with a supplemental budget package.

We want to take away from this that the Legislature funding the $994 funding rate in fiscal year 2020, and $1,056 in fiscal year 2021, it doesn't change the modeling HCA is doing on the program now. Our modeling will be wrong, 100% guaranteed. Will it be off to this degree? That's unlikely but the next big updates in modeling will be later this summer when we update for final bid rates, and then after open enrollment in the fall when we update for enrollment.

The enrollment update is important because it gives us actual information for two large assumptions. One assumption is the percent of employees who waive. Remember we collect the funding rate for a waived employee, but we have no expenditures for them. If a larger percentage of employees waived than what we are currently modeling, that puts a downward pressure on the funding rate. If a larger number of employees enroll, that's upward pressure on the funding rate. We'll lock down that assumption after open enrollment.

The second significant assumption that we will lock down after open enrollment is how employees enroll across the tiers, and their plan selection. Do they enroll in a managed care plan where we just pay premiums every month? Do they enroll in a self-insured plan where we have claims risk? We currently have them spread similar to the PEBB Program population for waiver assumptions and enrollment assumptions across the tiers. We'll get actual information post-open enrollment that will feed into modeling that we do for the Governor's supplemental budget. That will feed into an update on what our funding rates should be, based on enrollment information. That's when we'll have the first solid funding rate for the program.

If I were in a school district and being conservative, I would budget a number larger than the $994 we were funded because it is not what we're modeling or what we believe will be the cost. If we continue to model a funding rate in excess of $994, the agency will go to the Legislature with a supplemental budget package. I don't know what action the Legislature will take or how that action will play out in funding the program. I think it's reasonable to assume the action in the next legislative session would most likely be focused on state funded staff only. If you're trying to budget at the school district level, the most conservative approach would be budgeting a funding rate in excess of $994.

Dave Iseminger: Megan, just to clarify, for the months related to fiscal year 2020, HCA will invoice at $994 and the Legislature is unlikely to retroactively raise the $994? If they need to increase, they would increase the fiscal year 2021 funding rate to be more than $1,056 to account for the deficit that needs to be filled. Is that correct?

Megan Atkinson: I'm going to say with certainty, we will invoice districts for the funding rate that's specified in the budget, the $994. I'm less certain the Legislature won't change that funding rate mid-year in the 2020 supplemental budget. I didn't anticipate being in this situation, but I don't know what remedy the Legislature will choose. A mid-year adjustment to a funding rate would be highly unusual. If they did adjust that, would it be the same funds flow with the money going from OSPI through apportionment to the districts, back to the HCA through our monthly invoicing? An additional complication is

the Legislature did not address our cash flow needs. We're starting the fund with just a few million dollars in balance. We don't have sufficient cash in the fund to manage our month-to-month cash flows. The agency will be working with the State Treasurer on how to manage the benefits fund going negative every month as we pay bills and then wait for the districts to pay their invoice. The benefit fund sort of has two pressures on it. One is a month-to-month cash flow pressure and one is an overall funding for the program pressure. It's an unusual situation and I don't fully know how it will be addressed next year by the Legislature. They could leave fiscal year 2020 funding rate untouched and make it all up in the fiscal year 2021 funding rate. To my knowledge, there's not a parallel in the PEBB Program that we can go back and look to see how that was addressed.

Alison Poulsen: I don't logistically understand the difference between what it's going to cost, what is allocated, and who's going to make up that gap, whether districts have to make it up in an interim period until it gets fixed? I understand they're not going to change things midway, but if we think it's going to cost this, there's a deficit. Who holds the deficit in the short term?

Megan Atkinson: Great question. The agency and the benefit funds hold the deficit in the short term. The state manages that across the state treasury in cash flowing a state fund that's going to go negative. Our benefit fund is in the state treasury and it will go negative every month as we pay bills, and spending from that fund will be at a rate to drive the fund into a negative by the end of the fiscal year. We will work that cash flow mechanism out with OFM and the State Treasurer because the State Treasurer manages all state funds held in the treasury. How the Legislature will address that negative in the benefit fund next session is unknown.

Pete Cutler: I have three questions. Dealing with this most recent issue, it seems to me that the budgeting risk to the school districts most likely is for their staff that are not state funded --

Megan Atkinson: I agree.

Pete Cutler: -- and that's where it would be prudent to budget, or expect a higher funding rate than the $994 for beginning either mid fiscal year, or no later than the beginning of fiscal year 2021. Because of the McCleary Decision, it seems very likely they will fund. They will not leave the school districts having to backfill or they won't increase rates without providing the money for the state funded positions along with that funding increase. For all other positions, the districts are going to have to plan accordingly.

On the $994, I think you used a term, the "current PEBB rate." Is that a reference to current fiscal year PEBB Program rate? Is that what is built in the budget for PEBB Program beginning July 1?

Megan Atkinson: Yes. Again, the net funding rate. It doesn't benefit from any expenditure of surplus. The budgeted PEBB Program funding rate is less because we're spending some surplus. The net fund rate, the funding rate necessary to cover the current projected expenditures for the PEBB Program, is $994.

Pete Cutler: If we go to the budget watch, we'll see a lower number but the net funding rate after adjusting for the use of surplus would be the $994. I guess it had to do with the waivers and I wanted to clarify. If you have a bunch of people waive more than what's expected, that actually reduces a fiscal pressure on the state because the employer's been sending in money for those employees but they're not actually incurring the expense. Thank you.

Wayne Leonard: Megan, the preferred outcome from what I'm hearing is the Legislature would have a supplemental budget item next year to take care of the deficit in the Program. What if they don't? This Program obviously can't continue to run in a deficit position. It seems like the only alternative is either to require the employer or the employee, or both, to contribute more to the Program.

Megan Atkinson: There are a couple of things, and in the Legislature's defense, the modeling we're doing has many assumptions. A couple of things could materially change our modeling and the expenditures for the Program. Some of them are within the Legislature's authority, and for some, we need to see what actually happens. A portion of the funding rate assumes we will repay the General Fund-State loans. The Legislature could take that off and forgive it by saying it was a grant of startup money to the Program and it doesn't need to be repaid. That would permanently change and lower the expenditures for the program.

The other assumption is the employee behavior could break our way. We could have a higher percentage of employees waive. We could have a larger percentage of employees enroll on the single subscriber tier. We could have better than anticipated claims experience on our self-insured program. We will know the number of waivers and how employees enroll across the tiers before the Legislature is back in town. They will have the benefit of actual information and the financial impact. We won't have significant claims experience, however.

There are things the Legislature could do. For the loan experience, once we update our modeling, it could change the amount of funding needed to fully fund the SEBB Program and not have the program modeled to be in a deficit situation.

If the Legislature doesn't take action, there are a couple of things we could do. Again, unless the Legislature changes eligibility, we also have for this upcoming fiscal biennium a Collective Bargaining Agreement the Legislature took action to fund. It's funded in the budget. There's language around it being funded and approved. That also puts structure around this. In the years that I've been in state government, I've seen the Legislature defer funding action until they have solid known information. That's one of the purposes of a supplemental budget in our two-year budgeting cycle. I've never seen the Legislature run programs into deficit at the end of a fiscal biennium. I'm not a budget law expert, but I think it would be difficult and perhaps even unprecedented, for the Legislature not to take action to fund a program it authorized and has left in place statutorily. I expect a supplemental budget solution. I just don't know exactly what it'll look like. Does that answer your question?

Wayne Leonard: Yes and no. I know it's probably an unanswerable question in terms of what if they don't. But, part of the difficulty in the school district budgeting world is

we're all trying to adjust to a new model of the new financial structure now. You'll probably see around the state there are school districts making fairly large budget cuts. Part of the difficulty is the SEBB Program and trying to get a handle on what this is really going to cost at the local level. It's a bit beyond just the non-state funded employees because there are policy decisions in terms of the number of hours worked, including subs as eligible. All of the things that add to an unknown. Just as we, at the SEB Board level, won't know what this Program actually costs until people enroll at the local level, it's the same problem.

The State Treasurer has a backstop to fund a deficit. By saying we're going to budget a higher level than the $994 means we're going to lay more people off or cut more programs. That's not going to fly with most of our school boards. It's difficult not knowing. If next year additional costs could be pushed out to the employer, when I had some discussions earlier in the year with legislative staffers, their suggestion at the end of our conversation is that we would just have to allow school districts to raise their levy to help pay for this. They did do that, allowed districts to try to go out and raise levies. But in our world, those levies aren't to pay for legislative policy.

Megan Atkinson: Not all districts have the same levy ability. I have been thinking about what information, as the HCA CFO, share to help provide clarity to the degree that I can. I can provide clarity around when our modeling gets updated. I can share the legislatively authorized funding rate for state-funded staff, the revenue for the school district, and the invoicing we'll do. The state model will pick up $994 and drive $994 times the benefits allocation factors (BAF) out to school districts. We will invoice for the $994 per eligible employee. Those will be aligned. But we know that based on the current modeling we have for health care, the $994 seems low.

If a school district budget officer is wondering when they will have updated information, I would watch for the model and funding rate that we model this summer after we lock down bid rates. That will give an indication of how good our procurement is. That's the next significant known that will go into our model and we'll bring those funding rates to you. Then I would look at what the modeling is that we do for the Governor's budget post-open enrollment, which is a significant model update. If those two funding rates continue to be higher than the $994, and more like the $1,096, then the only logical conclusion I think a school district business officer could make is that they're going to have to pick up additional cost for their locally funded staff, whether that would be in fiscal year 2020 or fiscal year 2021. That's still unknown until the Legislature takes action. If all of our modeling updates continue to show a needed funding rate more to the $1,000 and less to the $994, then I think the school district's only reasonable budget assumption would be there's going to be a bill due. On the state-funded staff, I'm less certain because the Legislature has an obligation to fund those staff.

Wayne Leonard: When you say this summer, are those the meetings scheduled at the end of July and the first part of August? I understand the schedule for state timing. But as a point of reference, many school districts adopt their budget in July. Even that's pretty late in the game to be making budget adjustments for most K-12 school districts.

Dave Iseminger: The rate setting process we'll bring to the Board will be to present the resolutions and rates at the July 17 meeting for voting at the July 25 meeting, or present them on July 25 for voting at the August 1 meeting.

Megan Atkinson: Slide 4 – Funding Rate Assumptions as of April 27, 2019 shows the different assumptions in terms of how the Legislature chose to fund. We submitted a model with a large number of assumptions, all detailed and modeled out for legislative staff to use in briefing members. Some of those key assumptions are on this slide in the column on the left. The column on the right is what we know was included in the budget. We didn't receive a model back from the Legislature so we have no direction from them to change any assumptions. As I said earlier, we have language in the budget bill essentially telling us to stay the course. The only key assumption that we're changing with legislative direction is our loan repayment schedule. The column on the right goes into detail about the fact the Legislature uses the PEBB net funding rate.

Slide 5 – Flow of Funding Rate, which provides additional directions around the flow of dollars. Again, in the SEBB world, it's different than what we've been doing in the PEBB world. The K-12 health benefit funding will be allocated through OSPI through the apportionment process. It goes out to the districts and then the districts will send the payments back to the Health Care Authority. When you're thinking about how the districts are pulling together the money, the state funding is the state employer funding for state-funded staff. The districts still have to pull from employee pay the employee contributions. And then, of course, the districts have to provide the employer contribution for locally funded staff. Those three buckets of money get combined and sent to the Health Care Authority for the monthly invoice we send out.

There was conversation during the legislative session about the cash flow for the SEBB Program benefit fund. The only action taken was language in the budget directing the districts to provide payment to Health Care Authority within three business days of receiving the January 2020 allocation. In addition, HCA is directed to provide a Late Payment Report per Section 213 of the budget which says, "by February 5, 2020, the Health Care Authority shall report…for school districts, ESDs, and charter schools that have not remitted payment for January coverage as of January 31, 2020."

In anticipation of this presentation, I was pulling together different pieces of information to try to thread together budget direction the districts paying within three business days of receiving the 2020 allocation, which I interpret to be the January 2020 apportionment. The OSPI apportionment schedule for 2020 is not available yet.

Wayne Leonard: Last business day of the month?

Megan Atkinson: If the last business day of the month ends up being January 29, January 30, or January 31, the school districts won't receive their apportionment until that last business day. They then have three business days to remit to the HCA, which could put us into February. We're directed to provide a report if we haven't received the coverage payment as of January 31. A district could meet the direction to provide the payment within three business days but still be called out as a late payer in our late payment report. Obviously, what HCA will do is put the right verbiage around this depending on how the apportionment schedule, the three subsequent business days, the receipt of the payment, all works so we aren't using a legislative report to shame a district when they followed the directions they received.

Dave Iseminger: Megan, if you look at the calendar, the last business day of January 2020 is Friday, January 31, which means three business days is February 5, the day the report is due. So you could have a district that perfectly pays within three business days, didn't have the money until the day that it was owed.

Megan Atkinson: We want to meet the intent of the legislation, be responsive to the Legislature, and be good partners. We'll figure out a way to verbalize that.

Pete Cutler: I'm picking up the impression that the only thing the Legislature asked you to look at is that deadline for the first month of 2020. They're not asking you to track timeliness of payments throughout the year?

Dave Iseminger: I think it's fair to say, Pete, they only asked us to report on that first payment, but we will track invoicing on a monthly basis.

Pete Cutler: It seems to me that would be more relevant, in addition to making the technical change. Obviously, it's ridiculous if your allocation is getting to the districts on the last business day of a month to expect payment turnaround within three business days.

Megan Atkinson: Pete, that was a lot of the conversation we had with OSPI and with legislative staff, a better understanding of the apportionment flow, the invoicing, etc. It's my guess the cash flow varies by district and how much a district uses apportionment that comes at the end of January for January bills versus for February bills. There are different cash flow considerations that go into operating a district.

Slide 6 – Decision Packages. The decision packages we submitted, all but two were picked up and there are reasons why two others were not. I'll let Dave explain the online decision tool.

Dave Iseminger: We put forward an agency decision package to have a perpetual tool to help employees navigate the number of plans they have and make suggestions on plans they may want to enroll in. When the decision package wasn't picked up in the various budgets, we proceeded with creating a pilot program. We used variance that existed in the start-up funds for the current fiscal year in our administrative budget to buy the licensure for the fall 2019 open enrollment. The experience we get from the pilot project will help us determine whether this is something we ask for perpetual funding in the future. Knowing there will be a large number of plans that new school employees will have, there will be a decision support tool this fall, despite the systemic ongoing request not being funded. We will have a pilot for this open enrollment.

Megan Atkinson: The only other decision package is the Pay1 replacement. We had a request for funding to do additional research around a system replacement project. It wasn't picked up by the Legislature on either side, not for the PEBB or the SEBB Programs.

Dave Iseminger: Pay1 is our backend accounting, invoicing structure system. Our overhaul of SEBB My Account, the frontend enrollment piece is going full steam ahead. We'll have an update and a new demo at the next Board Meeting. Think of the Pay1

replacement as the backend accounting side. Everything that matters to Megan and the districts. It's from 1977.

I have two pieces of clean up. I said the July 17 and July 25 meeting. It's July 18 and July 25 meetings. And there was a piece Megan mentioned earlier about eligibility. Nothing changed in the statute. I'm going to revise that to nothing materially changed in the statute. There is a piece Cade will talk about in a few minutes. There was a delay of non-represented ESD employees passed by the Legislature. As we had been modeling that, we didn't have any material changes to the financial projections because of the number of employees that were attributable to that population. So there's that change, but not a material one.

2019 Legislative Session Debrief

Cade Walker, Executive Special Assistant, ERB Division. If I could take a small point of personal privilege to say hello to Mrs. Walker's elementary school class who's tuned in as they've been learning about state government. They're watching us via TVW to learn how our process works.

I'm here to give the last update on legislation from the 2019 session. We ended up doing a grand total of 336 bill analyses within the ERB Division. That's accounting for thousands of hours by our analysts looking through 336 bills, and providing important information for us to help the legislative process move forward this session. This is an increase of about 115 bills from last year.

House Bill 2140 did not make it into our materials today, but it's the bill Dave just referenced. This bill passed, and the primary policy behind HB 2140 was about the local levies. It also carved out the non-represented Educational Service District (ESD) employees from participation in the SEBB Program until January 1, 2024. That does leave in all the represented employees from the ESDs, which we know there's approximately 300 employees who will be coming into the SEBB Program starting 2020 and approximately 3,000 or so employees who will be entering in from ESDs in 2024. HB 2140 also has a requirement that HCA produce a report on ESDs that goes through some of the funding aspects of benefits for their employees, as well as the different funding sources for the ESDs. We are responsible for producing the report to the Legislature by November of next year.

Slides 3 – 5 – Passed Legislation. All of the bills I'll review passed and have been signed by the Governor, except 2SHB 1065 is waiting to be signed. HB 2140 has yet to be signed by the Governor, but he has until Tuesday of next week to act.

2SHB 1065 passed. This legislation has been circulating around the Legislature for the last five or six years. It's to protect consumers from out-of-network health charges, specifically when have an emergency procedure at a hospital, your hospital bills are covered, but you may receive a surprise bill from the anesthesiologist that is out-of-network and you owe them a substantial dollar amount for the out-of-network charges. This bill helps protect against that and allows the consumer to pay the in-network rate for those services that occur in those emergency type settings, including anesthesiology, laboratory, pathology, etc., that were unavoidable. We were in support of this legislation.

EHB 1074. This bill raised the purchasing age for tobacco products from 18 years of age to 21 years of age. This bill may have implications to some degree on the tobacco surcharge that's assessed. The bill included language on vaping products being included in that age range that adjusts upwards. In the tobacco surcharge we will be assessing for the SEBB Program population, it does not include vaping products in the tobacco definition. That may be a consideration in the future. Do we change to align with this legislation?

Dave Iseminger: We're not anticipating bringing anything to the Board this season for changing or evaluating the surcharge for 2020. How the regulatory environment continues to change with regards to vaping products is something the agency has been monitoring since the tobacco surcharge was implemented 2014 in the PEBB Program. At some point there will be a fulcrum tipping point in the regulatory environment where we may come to both Boards asking you to consider evaluating and changing your tobacco product definition to include vaping products. This is another piece of the puzzle of the regulatory environment and seeing how things are changing. We will continue to monitor.

Cade Walker: House Bill 1099 provides additional protections to adult children on their parent's health insurance plans who are over the age of 18. They're defaulted to the same communication and privacy other adults are regardless of whether or not they are a dependent on a plan or they're the primary subscriber. We supported this legislation.

Pete Cutler: On Engrossed Substitute House Bill 1099 dealing with requiring carriers to provide network information for mental health providers, I presume it applied to our insured plans with Kaiser. Does it apply to Uniform Medical Plan as well, or for the SEBB Program?

Cade Walker: Engrossed Substitute House Bill 1099, I conflated that with SSB 5889. I apologize. ESHB 1099 is the legislation requiring expanded notification for network adequacy and provider availability, specifically related to mental health services. A constituent testified before the Board about this bill. It has passed and been signed by the Governor's Office. Because it is within ESHB 1099 and it's an OIC regulation, our analysis is the Uniform Medical Plans are exempt from that requirement although they already display that type of information on their website. The provider search for Regence does have the availability of mental health providers, if they're accepting new patients, and providing a listing of those providers within the service area.

Dave Iseminger: Voluntary compliance, Pete. It doesn't squarely hit the self-insured plans, but typically, we try to implement the same --

Pete Cutler: It's great to know that Regence administration of the UMP already includes the ability to verify whether a given provider is accepting new patients. And that's great. Thank you.

Cade Walker: Engrossed Substitute Senate Bill 5526 is the Cascade Care/Public Option. You may have seen this on national news. The agency was tasked with certain responsibilities in the procurement efforts for the public option that will be

provided on the exchange. We're still looking at where that will be landing and the Employees and Retirees Benefits Division's involvement. We will provide technical assistance for the public health option.

Dave Iseminger: This doesn't have a direct impact on either the SEBB Program or PEBB Program, but as your program has significant influence on the commercial market, so does your sister program, and so will this. We wanted to keep the Board apprised of other activities in the commercial market that are also influenced by this agency.

Cade Walker: 2SSB 5602 related to preventive services and women's reproductive services. It provides protections for gender and gender expression. It expands some of the service requirements that health carriers and student health plans are supposed to offer. It expands coverage under certain reproductive treatment and services for all populations. Our plans will be in compliance.

Dave Iseminger: ESSB 5526 and 2SSB 5602 have been signed by the Governor.

Cade Walker: SSB 5889 is the bill I confused with ESHB 1099. This is expanded protections for adult children on their parents' coverage, ensuring they have the privacy they're otherwise afforded. It also allows children over the age of 13 to request to have all their health information from the health carrier and provider sent to them upon written request. For over 18, the expectation is the carriers communicate directly with the member regardless of their status of the subscriber on a plan.

Slide 6 – Passed Rx Legislation. Two pieces of pharmacy legislation passed. Engrossed 2 Substitute House Bill (E2SHB) 1224 and ESHB 1879. In E2SHB 1224, health carriers and pharmacy benefit managers (PBM) must report to the Health Care Authority prescription pricing data and advanced notice before increasing prices of certain drugs. The Health Care Authority must analyze the data and provide an annual report to the Legislature on pharmacy pricing. It's a transparency bill related to the cost of prescription drugs.

ESHB 1879 requires clinical review criteria that's used to establish a pharmacy utilization management protocol. It must be evidence-based. If a health carrier or pharmacy benefit manager uses restrictions, they must provide clear, readily accessible and convenient processes to request an exception. This bill establishes requirements and timelines for step-therapy exception requests.

Pete Cutler: On ESHB 1879, it says they have to use evidence-based prescription drug utilization management criteria. Does it require them to disclose what criteria they used, both to the consumer and to the Health Care Authority?

Cade Walker: I don't have the answer and will follow up with you.

Pete Cutler: That would be good because I know when I was working with that issue, there was quite a bit of push-back from carriers claiming they were prohibited, the different entities they used as organizations to provide them with criteria, made it a condition they couldn't disclose what the criteria was. I'd be very curious to hear whether that transparency issue was addressed.

On E2SHB 1224, were there any questions or issue about legal challenges based on this was something that states can't require organizations to do? There again, that was something that was claimed in the past. I'm not sure if that legal context, in terms of requiring PBMs or health carriers to provide cost data, whether there's greater clarity now than there used to be about what a state could do. Do you have any idea about that?

Dave Iseminger: Pete, E2SHB 1224 limits the disclosure of the transparency information to purchasers and the Legislature. I don't believe the final version has a forum by which any member of the public can go and find the information. The disclosure is more limited in the final bill than the original versions of the bill. My understanding was part of that balance may have related to the very things you're bringing up.

Pete Cutler: So subject to same exceptions from public disclosure as the actuarial analysis and that kind of stuff.

Dave Iseminger: Yes. It's a somewhat soft spotlight. It's not as bright a spotlight as maybe for the entire public.

Pete Cutler: It's only a select few have access to the spotlight.

Dave Iseminger: Purchasers and the Legislature.

Cade Walker: Slide 7 – Newly Required Reports for ERB. I wanted to give a brief overview of the new reports required of the agency or our program this session. We have six reports we're responsible for, four of which I've listed.

November 1, 2019 we are required to report in a more formalized manner to the Legislature addressing the Medicare eligible retirees, the rising cost of prescription drugs, and member premiums. The ERB Division has been working with the Legislature and providing that information this last session. Now we're required to have a more formal report provided to them in November 2019.

As Megan mentioned, by February 5, 2020 we need to tell the Legislature if districts were timely in paying us.

November 15, 2020 there is a report due to the Legislature about the feasibility of a consolidation of the SEBB Program into the PEBB Program by January 1, 2022.

Dave Iseminger: The Legislature gave us a timing assumption to use in the report. The report will describe challenges and benefits, the pros and cons of a consolidation, and a target date was given as a framework for that report. I don't know if legislative action will be needed during a subsequent legislative session to authorize the actual consolidation of programs. It is a timeline established for the agency to put together the report and give guardrails for assumptions included in the budget provision. It is clear, however, that there are two pieces in the budget provision – it's not the PEBB Program and the SEBB Program into something new. It's not the PEBB Program into the SEBB Program. The framework is the SEBB Program into the PEBB Program. The

Legislature gave us that assumption and a starting date assumption. I don't want people assuming something is definitely happening in 2022.

Sean Corry: Will this Board be part of the discussion? How will we be informed about that work?

Dave Iseminger: This report was added in the late aspects of the budget process. We are thinking how we're going to create the report and timeline. There will be intense interest from many parts of the public, stakeholders, and both Boards. I can't answer exactly how it will happen yet because we've only known this report existed for two and a half weeks. We will be working through the process of how that report will get completed and delivered. I have no details yet. For a decision of this magnitude, we will make sure there are ways for people to be included in the stakeholdering process.

Cade Walker: The last report, which is due December 31, 2020 is on the current costs and health plans offered by ESDs, comparison on those costs, and the benefits offered currently by ESDs. Of those who were to participate in the SEBB Program and the revenue sources for ESDs.

One point I did want to mention about House Bill 2140 and the ESDs, the ESD non-represented employees are eligible to participate voluntarily in the PEBB Program. We made sure that option was available to them. We currently have three ESDs accessing PEBB Program benefits, I believe.

Dave Iseminger: Five.

Cade Walker: Five ESDs currently participating in the PEBB Program and they'll be allowed to voluntarily remain in the PEBB Program until 2024 when they're compelled to migrate to the SEBB Program.

Pete Cutler: On the November report, it says benefit options available, Medicare eligible retirees. Do I understand that correctly to mean what are some options the Legislature could enact to create new options for Medicare retirees? I guess it's all offered through the PEBB Program. In terms of the PEBB Program retirees, is it to remind us what you currently offer as options in the PEBB Program or is it a give us more options? What are our different opportunities?

Dave Iseminger: It's about a reminder of what the entire Medicare portfolio looks like in the PEBB Program, as well as options for changing that portfolio - likely adding to that portfolio, additional plan options for the future.

Lou McDermott: What class does Mrs. Walker teach?

Cade Walker: She's in first grade at McLean Elementary School.

Lou McDermott: First grade! Thank you for all your work, Mrs. Walker.

[break]

Policy Resolutions
Rob Parkman, Policy and Rules Coordinator, Employees and Retirees Benefits Division. There are two policy resolutions for action today. SEBB 2019-09 – Error Correction Recourse and SEBB 2019-10 – Error Correction Premium Responsibilities. Slide 3 is language from RCW 41.05.740 which connects the policy decisions today to the Board's authority.

Slide 4 – Policy Resolution SEBB 2019-09 – Error Correction Recourse. Changes made since the last review are: a period was added after "identified" in the third row from the bottom. We added "Health Care Authority approves all error correction actions," second and third row from the bottom. The resolution you saw at the April meeting is in the Appendix for your reference. Stakeholder feedback: one stakeholder commented they support this resolution with concerns. The concerns included issues around retroactive coverage and the process and interaction required between the SEBB Organization and the Program. There were no other comments.

Vote on Policy Resolutions
Lou McDermott: **Policy Resolution SEBB 2019-09 - Error Correction Recourse**

Resolved that, if a SEBB Organization fails to provide notice of benefits eligibility or accurately enroll a school employee or their dependents in benefits, the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified. The Health Care Authority approves all error correction actions and determines if additional recourse is warranted.

Pete Cutler moved and Alison Poulsen seconded a motion to adopt.

Sean Corry: In my firm's experience working with the carriers and school districts, it's very common to retroactively correct errors that occur in enrollment. Was there discussion about liability for the districts due to less flexibility? The carriers have always been kind to fix eligibility, at least in our experience, missed eligibility dates, retroactively enrolling. This is apparently not going to occur if this passes. Was there a discussion at the Board level or among people here representing school districts about the shift or increased risk of liability for claims that might have been paid by carriers had enrollment occurred properly? I'm wondering if that discussion occurred and what the result of that discussion, what effectively is a transfer of risk to the districts with this going forward.

Dave Iseminger: This resolution states that at least the error is corrected prospectively. It does not prohibit a retroactive enrollment. In fact, in the PEBB Program, additional recourse - this last sentence where the Health Care Authority approves all additional recourse - often the additional recourse warranted is a retroactive enrollment that is necessary under the circumstances. There are many instances where that action is ultimately part of a recourse. We want to be very clear because there have been instances as in the PEBB Program about prioritizing immediately getting the prospective piece fixed and then everybody getting together and deciding exactly what the correct retroactive additional recourse might be. In some instances, an employee might have had insurance elsewhere and so they're not interested in that coverage. They are not asking for that recourse. We didn't want to set up mandatory retroactive enrollment. The next Resolution SEBB 2019-10 talks

about where some of the liability might be based on mistakes that happen. That would be incorporated either prospectively or retrospectively, as well. This language doesn't prohibit retrospective enrollment. It prioritizes, gets prospective enrollment sorted out first, and then additional error correction that's warranted would be approved by HCA. Sometimes the agencies in the PEBB Program proactively ask for that and other times HCA says, "you need to look at this recourse." We approve the type of recourse needed. We maintain that authority at HCA to ensure consistency across all employers and for the integrity of the program. Did that help, Sean?

Sean Corry: Somewhat.

Dave Iseminger: Why just somewhat? I don't like just being somewhat helpful.

Sean Corry: I said somewhat because what you explained is much more than what is in this last sentence.

Pete Cutler: I'll just weigh in. For one, I'm highly fixated on trying to promote administrative simplification. I'm generally in favor of having administrative changes take place prospectively. But what Sean has said about carriers being willing to extend enrollment retroactively also sounds vaguely familiar from my past career. Because that's actually much simpler in terms of tracking than if you try and retroactively take away coverage. I was wondering if there'd be any problem with just saying on that last sentence after the word "additional recourse," if it would be any problem with adding "which can include retroactive enrollment." Insert something like that to make it explicit that is an option the HCA could take.

Dave Iseminger: I think it's fine if somebody wants to make a motion to amend and add, as you said, Pete, something similar to, if it would read "if additional recourse, which may include retroactive enrollment, is warranted." I would just use the word "may" instead of "could." We tend not to use "could," or "would," or "should." We use "may," or "must," or "shall," or "will."

Pete Cutler: I move that the resolution be amended to add after the word "recourse" on last sentence at the very bottom of the page, insert ", which may include retroactive enrollment,."

Pete Cutler moved and Sean Corry seconded a motion to adopt the amendment.

Voting to Approve: 9
Voting No: 0

Lou McDermott: Proposal to amend Policy Resolution SEBB 2019-09 passes.

Amended Policy Resolution SEBB 2019-09 – Error Correction Recourse

Resolved that, if a SEBB Organization fails to provide notice of benefits eligibility or accurately enroll a school employee or their dependents in benefits, the error will be corrected prospectively with the enrollment in benefits effective the first day of the month following the date the error is identified. The Health Care Authority approves all

error correction actions and determines if additional recourse is warranted, which may include retroactive enrollment.

Katy Hatfield: So the clause is actually supposed to be inserted between "recourse" and "is warranted," technically. Does everybody understand it? (The Health Care Authority approves all error correction actions and determines if additional recourse, which may include retroactive enrollment, is warranted.)

Dave Iseminger: We'll let the record reflect that the chair said it as needed instead of the other way when we finalize the minutes, Connie.

Voting to Approve Amended Resolution: 9
Voting No on Amended Resolution: 0

Lou McDermott: Amended Policy Resolution SEBB 2019-09 passes.

Rob Parkman: Slide 5 - Policy Resolution SEBB 2019-10 – Error Correction Premium Responsibilities. Changes since last introduced: The last part of the resolution was changed from "without rescinding the insurance coverage" to "the error will be corrected prospectively with termination of benefits effective the first day of the month following the date the error is identified." This was added at the request of the Board at the last meeting. You can see the actual resolution presented at the April meeting in the Appendix. Stakeholder feedback: One stakeholder supported with concerns. Their concerns included the negative impact on the staff that made the mistake.

Lou McDermott: **Policy Resolution SEBB 2019-10 – Error Correction Premium Responsibilities.**

Resolved that, if a SEBB Organization errs and enrolls a school employee or their dependents in SEBB insurance coverage when they are not eligible and there was no fraud or intentional misrepresentation by the school employee involved, premiums and any applicable premium surcharges already paid by the school employee will be refunded by the SEBB Organization to the school employee. The error will be corrected prospectively with termination of benefits effective the first day of the month following the date the error is identified.

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2019-10 passes.

Annual Rule Making 2019

Rob Parkman, Policy and Rules Coordinator, ERB Division. I'm going to provide a high level briefing on this year's rule making. I will highlight the most significant changes in rule making activities. No action needed from the Board.

Slide 2 – Rule Making Timeline. Next week we will file our CR-102 and conduct a public meeting for that CR-102 on June 25. We will file the CR-103, our final rules, if all goes well. Those rules will be effective October 1 in support of open enrollment.

Slide 3 – Focus of Rule Making. We are on a two-year rulemaking plan. This year's focus is to add the rules generated during this phase. Last year, we generated about 85% of our rules. This year we're generating the other 15%. We found a couple additional rules we thought we needed to support Go Live. We'll look at the administration and benefits management, regulatory alignment, amendments within HCA's authority, and the implementation of the Board resolutions from last November through today.

Slide 4 – New Sections Added This Year Within the WACs we created, this reflects a little more than an inch of rules, about 212 pages, double sided. That's what the Board accomplished in the last year and a half. I wanted to show you we actually have a product. A lot of work has gone into this over the last two years.

Within the Enrollment Chapter WAC 182-30, there are currently 16 sections. Six sections were added this year. One of those sections is a new one we didn't anticipate, but it was for this first open enrollment because it won't be like our normal open enrollment. We had to have a special rule because it will be an active open enrollment, not our normal anticipated passive open enrollment.

Within the Eligibility Chapter, WAC 182-31, we currently have 19 sections seven of which were added this year. We added one we didn't originally plan for and that was based off those more generous eligibilities the Board passed for Go Live. You passed a resolution in January and a couple in March that caused us to create a new section.

Then we have the Appeals Chapter, WAC 182-32, which has 44 sections. We only added one section this year based on the wellness resolution you passed.

We have a total of 79 sections.

Slide 5 – Administration and Benefits Management. From the administrative and benefits management point of view, we amended and created new definitions. We defined what a "week" is. When the Board passed the more generous eligibility with that kind of mid to late-year hire, we talked about six of the last eight weeks. We needed to define what a week is so that we can do the counting correctly. We've made a number of other readability changes to other definitions. We've changed some sections to remain in alignment and consistent with the other program rules. These would include changes made to COBRA, salary reduction, and when subscribers enroll or remove eligible dependents.

Slide 6 – Regulatory Alignment. The state has a Paid Family and Medical Leave that starts January 1 so we have updated the rules to include that state law. We've made amendments due to the passage of Engrossed Substitute House Bill 2140. That will be ready to file next week.

Pete Cutler: Rob, can you remind me what ESHB 2140 is?

Dave Iseminger: ESHB 2140 is the bill referenced a couple times that has the delayed implementation of non-represented ESD employees until 2024.

Rob Parkman: Slide 76 - Amendments within HCA's Authority. We amended some special open enrollment (SOE) rules. These included clarifying that newly hired school employees get 31 days to make an election, not 60 days based on an SOE. We also amended the continuity of care rule to add clarity to this special open enrollment rule to allow plan changes based on continuity of care issues. We amended the dependent moves in and out of these United States of America provision and added "and that change in residency results in the dependent losing their health insurance." So we've added another requirement onto that SOE.

Dave Iseminger: These are things that help align or clarify pieces under IRS regulations. For example, that last one, if there isn't a loss of the health insurance, if you picked a plan that has international coverage, for example, the Uniform Medical Plan, your change in residency doesn't change your ability to access the plan you're in, then it's not really an authorized IRS event.

I also saw a couple of puzzled looks with the first one. We'll have somewhere around 600,000 to 700,000 members between the two programs. There are often creative arguments that come up during appeal. This one was something generated because it's not expressly stated anywhere in IRS rules. We had an individual who missed their 31-day period and questioned why she didn't get another 29 days because, technically, she had a new job and changed enrollment and under the IRS rules, because she had a change in job, she argued she got 60 days. We told her not when you're *starting* your job. We talked with our tax advisors about this particular rule and they said it's inherently obvious but nobody stated it. We added it so we don't have any more creative arguments. We learn all the time in our appeals processes of creative arguments and where we can eliminate risk.

Pete Cutler: Can you at least steer me to the chapter that has the continuity of care rule?

Rob Parkman: We have it in a couple places. The first place would be WAC 182-30-090.

Slide 8 – Implement SEB Board Policy Resolution. We have implemented 17 SEB Board resolutions that are already in rule. They are in the Appendix if you want to see the full list. It also shows which rules support those Board resolutions.

Affordable Care Act (ACA) Reporting

James Koch, Management Analyst, Benefits Accounts Section, ERB Division. I'm here to provide information about the Affordable Care Act (ACA) reporting requirements and penalties, and to describe how the Employees and Retirees Benefits Division helps support school district ACA reporting.

Slide 3 – ACA Background. In 2010, Congress passed the Patient Protection and Affordable Care Act, which was intended to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and address rising healthcare costs.

Slides 4 – 5 - ACA Provisions Include: Some of the well-publicized provisions you're likely familiar with include coverage for children up to age 26, the tax treatment of children under age 27, no pre-existing condition exclusions, no lifetime limits, and no rescissions of coverage. Health plans now have to provide standardized summaries of benefits and coverage, and W-2s must report the full cost of employer coverage.

The ACA also created health benefit exchanges or health insurance marketplaces in every state. They can offer reduced premiums to qualifying subscribers who meet household income criteria and who don't have disqualifying offers of coverage. It established the individual mandate, which requires or required most individuals to have health insurance or pay a penalty. It established the employer shared responsibility requirements, which require large employers to provide certain employees with medical coverage or pay a penalty.

These three provisions significantly impact employers to enable enforcement of the individual mandate and employer shared responsibility provisions. Regulations require certain medical insurance coverage data be reported to the federal government to prove compliance, and penalties were established to incentivize compliance. It's really complicated so I'll provide a high level, systems level overview of the ACA coverage reporting requirements.

Dave Iseminger: I want to make sure it's clear to people, obviously the individual mandate has changed since the original legislation was passed by congress, but the reporting requirements that underlie the enforcement ability were unchanged. Even if the individual mandate to individual consumers and individual citizens isn't being enforced or doesn't have an actual dollar amount penalty, the reporting behind all of it is unchanged and there's still reporting obligations.

James Koch: Slides 6 – 12 - ACA Medical Coverage Reporting, shows the requirements that currently exist for these different systems. In red is the health benefit exchanges (HBEs). Slide 6 - HBEs report enrollment across the big curvy line. Enrollment and premium subsidy information of taxpayers, in this case, it's the subscribers, specifically. They report enrollment and premium subsidy information to the IRS and they report premium subsidy information to employers. HBE reporting requirements are important because enrollment of certain employees at a health benefit exchange is what actually triggers employer shared responsibility penalties.

Slide 8. In purple, we have two groups: health insurance issuers of fully insured coverage and government sponsored programs like Medicaid, Medicare, and Tricare. Each of these groups report medical enrollment to both the IRS and taxpayers, again, specifically to subscribers on the taxpayer side.

Slide 9. In green, we have employers. Large employers, those with 50 or more full-time equivalent employees must report information about offers of coverage to both full-time employees and the IRS. All employers, regardless of size must report self-insured medical enrollment to employees, subscribers, and the IRS.

Slide 10. Finally, in blue, we have taxpayers. All of us around the table, we have to report medical enrollment of all family members to the IRS. This is what we do annually

on our tax returns. And as Dave mentioned, even though that penalty has been zeroed out through the most recent legislation, the reporting requirement does remain. Whether it will remain next year or not remains to be seen.

Slide 11. Together, these reporting requirements give the IRS and taxpayers a complete picture of medical coverage offers to full-time employees and enrollment for all covered individuals. Basically, taxpayers get a full picture of enrollment and the IRS gets a full picture of enrollment and offers of coverage.

Slide 12. With all this data, the IRS can then assess shared responsibility penalties if applicable. For taxpayers, these are the individual mandate penalties we've discussed. And for employers, these are employer shared responsibility penalties. I'll discuss employer penalties in the next couple slides. As Dave mentioned, the individual mandate is currently zeroed. That didn't affect employer shared responsibility penalties.

Slides 13 – 20 - ACA Reporting. These next few slides we'll look at the regulations behind the reporting requirements. We'll review reporting regulations for fully insured health plans and employers who offer self-insured coverage and reporting regulations for employer offers of coverage and the related penalties. I'll show you a few 1095 report samples.

Slide 14. Health insurance coverage reporting is required under Internal Revenue Code Section 6055. It directs that health plans and employers with self-insured health plans must report health plan enrollment to covered individuals on forms 1095-C or 1095-B, and report the same information to the IRS. Under this requirement, school districts report self-insured Uniform Medical Plan enrollment, speaking of the future SEBB Program benefits.

Dave Iseminger: Remember the Uniform Medical Plan is statewide so it is possible there could be at least one person in every district enrolled in the Uniform Medical Plan; and therefore, all school districts are likely to have at least some self-insured reporting they need to do if they're not already doing it today.

James Koch: Fully insured plans will report their plan enrollment. It really is a straightforward reporting requirement. It's a monthly enrollment summary done once a year.

Slide 15. The employer shared responsibility reporting is required under Code Section 6056. Under this regulation, large employers must report offers of coverage to full-time employees on a form 1095-C and report the same information to the IRS.

Slide 16 – Code Section 4980H establishes the penalty structure for employers who fail to offer medical coverage to certain employees. This regulation establishes that small and large employer penalties may apply if a large employer fails to offer full-time employees medical coverage that is affordable and provides minimum value. As described on this slide, the underlying words are terms of art. They're specifically defined by the regulation. Large means 50 or more full-time employees or full-time employee equivalents. If you had 100 half-time employees, that would meet the standard of 50 full-time employees. Full time generally means an employee who

averages 30 hours a week or 130 hours a month. Affordable means the lowest cost of self-only coverage available to the employee. It doesn't exceed 9.5% of the employee's household income. The 9.5% is an annually adjusted measure. Minimum value means the plan share of the total allowed cost of benefits is 60% or greater. Under this framework, regulations further established the small and large penalties, which are influenced in part by that second criteria, the degree to which the employer offers full-time employees medical coverage.

Dave Iseminger: To be clear, it's not about whether an individual employee, at this point, elects the coverage. It's whether there's actual coverage that meets these criteria *offered* to the individual.

Pete Cutler: On the beginning of the Internal Revenue Code Section 4980H, I want to clarify that the adjectives small or large are intended to modify the penalties, right? Not the word employer?

James Koch: Correct. Exactly.

Pete Cutler: It's not like we have different penalties for that. There are employer penalties that may be large penalties or smaller penalties.

James Koch: Exactly.

Dave Iseminger: Pete, that's actually James' next set of slides, walking through what a small penalty is and what a large penalty is.

James Koch: Thank you for that distinction. Slide 17. Under this regulation, a small penalty is assessed when the employer offers coverage to 95% or more full-time employees. The employer does not offer coverage to a particular full-time employee from the remaining 5% or less of the employees. The employee not offered coverage enrolls in a health benefit exchange or marketplace coverage, and that employee receives a premium tax credit for the coverage they enrolled in. If all four of those conditions occur, the employer is assessed s per employee per month penalty. The small penalty rate is adjusted annually. It began in tax year 2014 as a $250 per month penalty. And in 2019 it's been annually adjusted to $312.50.

Slide 18 – Small Penalty Example. We all work for the same large employer. Our company had 100 full-time employees. 95 employees are represented by green faces and were offered qualifying coverage. Five employees, represented by red faces, were not offered qualifying coverage. If one of those employees not offered coverage enrolled in coverage through the Washington Health Benefit Exchange for the entire tax year and qualified for a premium subsidy for every month of the tax year, then the small penalty would be $312.50 times 12 offending months for a total of $3,750.

James Koch: Slide 19 is an example of a large penalty. The large penalty would be assessed when the employer offers qualifying coverage to less than 95% of full-time employees and one full-time employee not offered coverage enrolls in an HBE or marketplace coverage, and that employee receives a premium tax credit for coverage. In this case, because the employer failed to offer at least 95% of full-time employees an

offer of coverage, the penalty rate is the monthly penalty rate multiplied by the count of all full-time employees for each month that the criteria is met. This large penalty rate began at $166.67 in tax year 2014. It's been annually adjusted up to $208.33 a month in tax year 2019.

Slide 20. The same graphic is used here as we did for the small penalty. The penalty is dramatically larger than the small penalty. If all employees work for the same large employer and the company still had 100 full-time employees but only 94 full-time employees were offered qualifying coverage that leaves six full-time employees who were not offered coverage. Only one employee was enrolled in the HBE and received the premium subsidy each month. The large penalty is $208.33 times the 12 offending months times the 100 full-time employees in the organization, or about $250,000 for that employer.

Alison Poulsen: If there were two employees, does that have an exponential impact or is it a maxed out --

James Koch: No, because the calculation is just on one or more. It's a threshold of one or more if you're under 95%. But, if in the small penalty example there were two employees who enrolled in the HBE, the small penalty would have been doubled.

Slide 21 is an example of 1095-C. It's used by large employers to meet one or both of the ACA reporting criteria applied to large employers. Slide 22 - Large employers have to issue the form to employees or former employees who meet one of two criteria: Criteria 1 - employees determined full time for one or more months of the year; and/or Criteria 2 - employees or former employees enrolled in self-insured coverage for one or more months of the year. Slide 23 - if you're receiving form 1095-C because you met the Criteria 1, you were determined full time for one or more months, then Part II is completed. It basically reports information to IRS about the employer's offer of coverage to the employee using specific codes described by IRS.

Dave Iseminger: James is showing you examples of the 1095-C that was created by the Health Care Authority for use in the PEBB Program. The coding used is explained on the back of the form.

James Koch: If you're involved in this, you appreciate the directions on the back of the form are very limited. You'll get all kinds of questions from employees because it is a complicated code set.

Pete Cutler: The Board doesn't really get a flavor for the complexity here unless you do look at those code sets and realize how granular the different distinctions between different situations have been split up. But for our sake, I'm glad you didn't.

Dave Iseminger: If you want to think about the complexity and I always think of the 1095 as your health W2. We all know our W2s are complicated, have a lot of different coding. It's the same exact thing. This is your health insurance enrollment and offer of coverage W2.

James Koch: Slide 24 is an expanded view of Part III of the 1095-C. If you're receiving a 1095-C because you meet Criteria 2, you were enrolled in self-insured coverage for one or more months of the year, Part III will be competed as well. Any employee who's enrolled in self-insured coverage for SEBB, that would be Uniform Medical Plan coverage, will have Part III filled out. If an employee waived coverage or they elected non-self-insured coverage, that section will be empty.

Slide 25. An IRS 1095-B looks very similar. Part IV of the form is used to report covered individual enrollment. Slide 26 - Fully insured plans report covered individual enrollment on a 1095-B. Small employers with less than 50 full-time equivalent employees, like some school districts, report self-insured enrollment of employees and former employees. Former employees would be like retirees who continue to remain enrolled in self-insured coverage. I would say that in 2018, we had 88 school districts that had 50 or fewer employees. We've had a fair number that would likely use a 1095-B because they're not required to use a 1095-C. They're not a large employer. You don't want to be filling that form out if you're not required to. They would use the 1095-B to report only those employees who enrolled in Uniform Medical Plan coverage. Some large employers choose to report former employees' self-insured coverage enrollment using a 1095-B. They may choose to report their full-time employees on the 1095-C and then report their former employees enrollment only on a 1095-B. That is allowed under regulations. Government sponsored programs, Medicaid, Medicare, Tricare, should be using this form to report enrollment as well.

Slide 27. The Employees and Retirees Benefits Division has an important role in supporting school districts' ACA reporting. It's been going on since 2015. Since then, we've provided PEBB Program enrollment data to all school districts except those with no Uniform Medical Plan enrollment. In 2018, we only had nine school districts who didn't receive an enrollment data file from us. We distributed 302 data files to school districts who had one or more employees enrolled in the Uniform Medical Plan.

Dave Iseminger: If you're wondering why everyone got this information, it's because there are retirees who have always had eligibility under the PEBB Program, and the bulk of enrollment in the PEBB Medicare portfolio is UMP Classic. The bulk of retirees from the K-12 system, of which there's roughly 50,000, have been enrolling primarily in the Uniform Medical Plan. As a result, we have been giving that data back to the school districts so they can do their employer responsibility reporting for those retirees. The state did not pick up and complete the reporting requirement on behalf of school districts. We provided the data necessary for them to complete the report. The data flow has been in existence for four to five years and that's what we'll be leveraging to continue to give the data that we've already given for retirees, and in the future for the SEBB Program enrollment as well.

James Koch: There are two categories of districts we've worked with. Participating districts are those who contract with the PEBB Program for their employees. They receive the employee enrollment information and former employee enrollment information for their retirees and COBRA enrollees. Nonparticipating districts are those who don't contract with the PEBB Program and only receive the retiree enrollment information Dave described, specifically for Uniform Medical Plan enrollment. Beginning in 2020 under the SEBB Program, every school district will be in our participating district category and receive data.

Slide 28. To prepare a school district for our annual data distribution, we verify the data distribution contacts for every school district in writing. We make sure to validate who we're communicating with is still valid about a month before we start to produce those data files. We provide sample enrollment data files and guidance documents so they can take a look at examples before they have the actual data files. And we provide group and individual trainings for school district staff on how to use and apply our data.

Slide 29. We securely distribute enrollment data. It's an ongoing process. Prior year enrollment data is distributed every year in early January. January 7 of this year we distributed 2018 enrollment data files. Rapid data distribution is important because employer reporting requirements by regulation are January 31 of every year. Every year since the beginning, the reporting requirement has either been completely relieved for 2014 or delayed beyond that January 31 date. But we've always distributed data in January because some employer groups who we distribute data to choose to do their reporting sooner than that extended deadline.

Dave Iseminger: Typically, that extension is a last minute extension. We never want to rely or put a district in a position where they don't have the data and the IRS doesn't grant an extension.

James Koch: After the January distribution where we've distributed the prior year's data, monthly thereafter, we distribute any corrections. These include additions due to retroactive enrollment, changes due to corrections, or deletions due to retroactive terminations. Of course, more files change near the front of the year and very few files near the end of the year.

Slide 30. After they receive their data, the school districts are responsible for ACA reporting. They will use the SEBB Program and the PEBB Program enrollment data provided by the ERB Division, along with their own district payroll data and their own district's established method under the federal rules for determining full-time status of employees to complete their ACA reporting. That includes forms 1095-C to employees or former employees and copies or data transmissions to the IRS.

Anecdotally, districts have some supports in this process just by my experience talking with them. We provide a lot of guidance in terms of the data that we provide. We help point them to the right places in the regulation where their questions can be answered. The educational service districts do a great job with helping school districts both understand the data and how to do data reporting requirements. WSIPC plays a role in helping districts understand how to use that data and provide reporting guidance. Many districts use a third party to actually perform the reporting requirements.

Pete Cutler: My recollection, at least from three or four years ago, was the IRS rules for determining who is a full-time employee were really complex and had specific additional complexities related to people who worked on a school year, academic year type basis. My recollection then was there was concern that if you guessed wrong about whether your employees were full time, you could end up missing that 5% standard and be at risk of huge penalties because you thought certain people really weren't full time and the IRS could determine they were. Has there been additional guidance? Has that been a problem for school districts or state agencies in terms of getting clarity on which employees are full time?

James Koch: I can't speak to whether it's been a challenge for individual districts. It is a complicated system for determining full-time employees. There are special provisions that apply to educational organizations like the school districts whereby, essentially, the regulations are neutralizing the effect of not working over summer months. The termination of full-time status is based on the calculation of the hours of service relative to the full-time standard of 130 hours a month. Those protections were in place so school districts weren't caused to disproportionally determine employees as not full time.

The regulations themselves haven't changed since they were initiated. There was a surge of conversation and education that occurred in 2014 in the lead up to the regulation. Since then I think there's been a calming because there haven't been any changes. As an employer, you really had to make the right steps on the front end to be able to set yourself up for ongoing measurement of full-time status for those employees. I'm not aware that people have changed their measurements after that first year. I know for the state we haven't.

Dave Iseminger: There is so much complexity on the third bullet it could be it's own hour presentation. Even you and I who are interested in this, are barely interested in that level of detail. We know there are multiple ways to determine full-time status and the districts have chosen different ways. There's no uniformity in how districts are determining full-time status. They've chosen different subsets of that regulation. We see all of this data on the PEBB Program side with state agencies to monitor proper eligibility determinations. It's one of the tools in our toolbox to indicate an agency is bordering on the 95% threshold and could be going about to triggering a large employer penalty. What's going on in that setting? Is there something about the types of employees that prompts us to look and bring to the PEB Board a recommended change on eligibility? Or it gives us insight as to where we prioritize our Outreach and Training Unit with that home HR department to make sure they understand how eligibility requirements work and to ensure determinations are being done correctly.

The third piece is an area James and his team spent a lot of time looking at to determine if there is something wrong in how the data actually flows. Are there mix ups in the data and how are people coding things? We use it in an auditory function to determine how rules are being implemented. I imagine we will do the same with districts. That will give us insight to determine if we need to bring back to the Board possible changes in eligibility to help people be in more compliance, or do we need to assist individual school districts that are the furthest away from the 95 percentile? We want to help them avoid penalties as best we can.

James Koch: I would just clarify that 95 percentile is determined by the specific districts. It's not a function of the Health Care Authority. Through conversation with them, we can help and engage in that conversation the same we way we do for state agencies.

Pete Cutler: That is useful to know there is an active monitoring process now taking advantage of this data that's required to be reported and collected. As a SEB Board Member, I'm not that worried about it because with our eligibility criteria, 630 hours in a year, I think there's very little risk you'll have a district having somebody work 130 hours a month over nine months, or however long it is the feds require, who hasn't met the

630 hour requirement. I think given our eligibility criteria in the SEBB Program, it's probably going to be low-risk for the districts. It had the potential, at least, if the IRS had wanted to be vigorous on auditing and enforcement of causing a risk of high penalties in certain situations. I'm glad to hear about the monitoring, so thank you.

Dave Iseminger: On the monitoring standpoint, it's very hard. We're talking about the SEBB Program on 2020 being reported in 2021. In 2019 we gave 2018 data and the IRS just sent their 2016 letters. You're talking about six to eight year spans at the same time. I think we've only had one full cycle of penalty letter discussions on the PEBB Program side and we haven't identified something that systemically needs to be brought either to the Legislature or the PEB Board about eligibility. Offers of coverage has shown there are various training opportunities but not something systemic to change. It's going to be several years down the road because of the lags that it takes for the IRS to decide when they're going to send enforcement letters.

Lou McDermott: The Board will meet in Executive Session during the lunch period pursuant to RCW 42.30.(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 non-published information related to the development, acquisition, implementation of state purchased healthcare services as provided in RCW 41.05.026. The Executive Session will conclude no later than 1:00 p.m. The public portion of the meeting will resume no earlier than 1:00 p.m.

[break]

<u>Procurement Benefits Refinement Update</u>
Lauren Johnston, Senior Account Manager, Employees and Retirees Benefits (ERB) Division. Slide 3 – Procurement Update. The table on this slide shows the contracts that have been signed in the left-hand column, and ongoing contract negotiations in the right-hand column. The signed contracts include: three self-insured medical contracts, which include the UMP Achieve 1, UMP Achieve 2, and UMP High Deductible; all Centers of Excellence contracts; all dental contracts; two vision contracts (Davis and iMed); the Long-term Disability contract; Life and AD&D; the plan selection tool contract; and a contract for dependent verification to be used in the initial launch.

Ongoing contract negotiations include the UMP Plus networks, all fully insured medical, the medical Flexible Spending Arrangement and Dependent Care Assistance Program (DCAP), and the MetLife vision contract. Officially, Aetna has withdrawn as a potential carrier after confirming they cannot participate in the state-based exchange for individual market coverage.

Dave Iseminger: The carriers we are still under negotiations with are Kaiser Permanent Northwest; Kaiser Permanente Washington, their HMO product lines; Kaiser Permanente Washington Options, their PPO products; Premera; and Providence. We have the Uniform Medical Plan, administered by Regence, for the medical side and MODA for the pharmacy side.

Lauren Johnston: Slide 4 – Future Board Actions. On June 12, the Board will need to finalize plan designs based on direction provided today. Either at the July 25 or August 1 meetings, the Board will need to approve final plan offerings, service areas, and the monthly employee premium.

Slide 5 – Finalizing Fully Insured Medical Benefit Design. To finalize the fully insured medical benefit design, we need final guidance from the Board today in order to make modifications to the plan designs by all of the carriers, which needs to occur before the June 12 meeting. The Not to Exceed (NTE) rates on the plan designs endorsed at the November 18 Meeting may limit those changes. Any potential changes must be within the current NTE rates.

Dave Iseminger: I've said the long standing analogy is 90% of your work was done before the legislative session, 10% of your work after legislative session. This is that time for any refinement. Any changes within any part of the benefit design must be locked in by June 12 because from June 12 until July, we'll be in the final rate setting process. Any benefit changes would impact that rate development process. We are not anticipating at this point that you have specific requests.

Lauren Johnston: Kaiser Washington Options submitted a change yesterday to their plan design. The comparison sheet was updated to reflect this change. It is included in their NTE rates. Under Kaiser Washington Options Plan One, the diagnostic tests, labs, and X-Rays, currently it says 20%. It's really 20% over $500. That means the member would have a $500 allowance and then they would pay 20% of anything over the $500. So just an update on that one.

Dave Iseminger: Lauren, that means the box on the comparison chart would look exactly like it looks for plan two?

Lauren Johnston: Exactly.

Dave Iseminger: Every time we release the latest version of the comparison chart, somebody finds something. It never fails. We're assuming the Board doesn't have concerns with accepting that change because it's not a takeaway. It advances things and was already built into the rate. We're just planning to auto-incorporate that in future documents.

Lauren Johnston: Slide 6 – Default Considerations. In setting the statewide default plans, HCA will consider: the monthly employee premium - or planned rates for benefits that are 100% employer paid, like vision - and the actuarial value of the medical plans; the extent of the service areas; and the provider network and access. We will set a statewide default plan to ensure equity and administrative simplification.

Dave Iseminger: I want to remind the Board, you took action at a previous meeting to say that when people don't interact during the open enrollment process, they will be defaulted into employee-only coverage for medical, dental, vision. They would have the basic life insurance and basic long-term disability plan and be defaulted as a tobacco user. There was a question of which plans for medical, dental, and vision. We described there would be a process where the agency identifies those plans. I

committed to the Board that although we are taking the steps as an agency to set those plans, we would engage with you and have a discussion on those. This presentation is highlighting the considerations we plan to use in selecting different plans. Lauren will go through the timeline process, but in that good faith, I said we would talk about what the process would be with you, bring you the types of things we plan to focus on, and see if there are things you want us to take into consideration.

Lou McDermott: How's HCA looking at the actuarial value? I get the monthly employee premium. You want to try and put them in something they can afford. I understand that, but when you're looking at actual value, what's your initial thinking?

Dave Iseminger: For example, and I'll use UMP as the examples because those are the plans that have the most discussion and the most robust information on all three of these points. You might get to a point where you believe UMP Achieve is the most appropriate default plan. Should it be 1 or 2? Should it be the 82% AV plan or the 88% AV plan? If you were to set the default plan as UMP Achieve 1, it comes with a lower premium, but it also comes with a lower AV, meaning lower claims cost paid by the plan in the long run. That's why it's listed as a single bullet point because they are intimately related. We wanted to acknowledge the amount the plan pays on the backend is something to focus on as well. Anything else you think we should focus on?

Pete Cutler: I just remembered that this is something the agency believes is an agency decision as opposed to a Board decision. Now I've taken more interest in what you were just talking about, that interplay between presumably wanting a low employee premium, but also wanting to balance that against the level of out-of-cost sharing. The higher the AV number, the lower deductible, the lower out-of-pocket cost at point of service. But the trade-off then is it's going to have a higher employee premium. I would be curious to know whether the agency is going to look for a balance between those two or whether it thinks it should prioritize one or the other as being more important. And you can answer this next month if you want.

Dave Iseminger: Probably won't answer that today.

Katy Henry: I was going to add to what Pete said. One of the things I hope is considered is the maximum out-of-pocket costs. I think it's aligned to what he's saying but it's one of the biggest considerations people make when they select a plan on their own.

Dave Iseminger: I'd be curious of the Board's insight. If the choices come down to UMP Achieve 1 versus UMP Achieve 2, with the information we have now, that's a difference of a $34 a month premium or a $101 a month premium. The $34 a month premium comes with a deductible at the single subscriber level of $750, and a $3,500 maximum out of pocket. The $101 a month premium has a $250 deductible and a $2,000 maximum out of pocket. How would the Board weigh that difference? I think there are equally valid reasons for balancing either of those.

Lou McDermott: Dave, if someone is defaulted, can they get out of the plan?

Dave Iseminger: It is important to realize that once an individual is defaulted into a plan, they'd be able to change it at a subsequent open enrollment or if they had an

appropriate special open enrollment event. But they would be locked in until either the next annual open enrollment or that special open enrollment event.

Lou McDermott: What if the reason they didn't enroll was because they're getting insurance through their spouse and they believe this doesn't apply to them. All of a sudden, they're getting defaulted and now they're in two plans?

Dave Iseminger: They would have the advantage of dual coverage in that type of situation, but we're working to help people understand the implications of not acting. One thing we have learned over time is that, to some extent, people have not really understood what would happen if they didn't engage. They know what the default plans are. Some people just hate giving the government information and they'll just default because it's exactly what they wanted.

We make sure the communication is as robust as possible about what the implications are of not engaging in the system. But, ultimately, if they filed an appeal, we would figure out what the circumstances were. It's all individual circumstances. At the very least, even in the PEBB Program when someone is defaulted, we make sure to highlight to them when the next opportunity to either waive coverage or select a different plan will occur. We would continue that engagement with school employees.

Lou McDermott: Did the Board have any other considerations the agency should look at as it makes the decision? I would want to have better coverage even though it would cost me more per month because I don't want to get the big bill. But that's me.

Dave Iseminger: But we have a wide range of economic circumstances.

Lou McDermott: Exactly.

Dave Iseminger: I don't know how people would feel about being defaulted into a $101 per month policy when they could've been defaulted into a $34 a month policy.

Lou McDermott: Or if they didn't want the policy at all. They thought that by not engaging nothing was going to happen. Now they're paying $100 a month.

Dave Iseminger: I would encourage you, if there's anything you want to share today, great. But also be thinking about this because this will probably be the most robust part of the conversation we need to have as we come forward with what the agency plans to do and ask for your thoughts on what we intend to set as the default plans.

Patty Estes: Can we refresh on what we decided earlier on how we are going to default someone?

Katy Hatfield: Yes. I didn't find the tobacco surcharge resolution, but I did find SEBB 2018-54. The resolution is: "Resolve that, the default election for an eligible school employee who fails to timely elect coverage will be as follows: enrollment in employee-only medical coverage, enrollment in employee-only dental coverage, enrollment in employee-only vision coverage, enrollment in basic life insurance, and enrollment in basic long-term disability insurance." The only one of those that has an employee premium is the medical.

Dave Iseminger: The question to the Board was do you want people defaulted into coverage or not defaulted into coverage?

Patty Estes: And did we, in any discussion, define timely manner?

Dave Iseminger: Timely manner is set by, I believe it's resolution SEBB 2018-12, a 31-day enrollment period for newly eligible folks. For the initial program launch, it would be during the annual open enrollment.

Lou McDermott: Katy, was he right? Is it number 12?

Katy Hatfield: Maybe. . .it's not 12.

[laughter]

Dave Iseminger: 12 is a key one, though! Tobacco's somewhere around 14 or 15 then.

Patty Estes: My only concern is we have this brand new program. We have open enrollment. We have school districts that are overwhelmed with things that are happening, budgetary things. People get lost in that shuffle and miss the communication that they need to enroll and end up getting defaulted because they missed a timeline. I have concern with some of our lower paid, right on that cusp, 630 hour employees that maybe $100 is a pretty significant portion of their paycheck that we're defaulting them into for a year, or however many months until the next open enrollment. For me, that 82% AV is looking a little better because it's an average. It's something that's very manageable for any of our subscribers, I would think. But I'm definitely going to look at it a little further. That's where my concerns lie with going any higher than that.

Lou McDermott: Dave, with the initial rollout program, we're expecting an unusually high default rate from a standard year in the future? It would be higher than it would be in the future because it's year one? Is there any chance that we could change it from year to year? The first year, you default into the cheaper plan to take care of the initial wave, and for the next year default into the higher plan.

Dave Iseminger: We'll definitely look at that. There will be lots of different system issues we'll have to think about plus the communication challenges. That's partly why we bring this process about setting the default plans to the Board now because we're not actually setting them today. We still have a 45-60 day period to go through. We'll definitely bring back insight if we think it's a permanent setting versus something that can be revisited.

Pete Cuter: My recollection from my prior employment with Health Care Authority was that the UMP was selected as the default for the PEBB Program because it had the most enrollment. It's the one most people like. It seemed like a logical reason to say, on average, people would like to be defaulted into this rather than some other option. That option could be kept open for a second or third year. Obviously, going in, we don't know where people are going to go. But that might be something we can look at as an optional refinement in the future.

Dan Gossett: You also default with the $50 tobacco surcharge. Is that correct?

Dave Iseminger: $25 tobacco surcharge. There are two surcharges. Tobacco is $25 per month and the spousal surcharge is $50. Since you'd be defaulted into employee-only status, there's no way for you to get the $50 spousal surcharge because we can't default you in enrollment with dependents that we don't know.

Dan Gossett: So the do not exceed rate would be not $101, it would be $126, correct?

Dave Iseminger: That would be the real experience. We don't say that it is part of the medical premium. It's an addition to the premium, but the real-life experience would be a deduction of $101 plus $25, so $126.

Lou McDermott: The theory is the person would see that on their stub, the medical and the surcharge, and they would be able to at least do something about the surcharge if they didn't smoke.

Dave Iseminger: Unlike medical plan changes, you can prospectively change, first of the next month, your tobacco status. That does not require a special open enrollment event.

Katy, you're flipping. Do you have more?

Katy Hatfield: Yes. I have to talk numbers. So it's 2018-13 not 2018-12. [laughter] That is, "Resolved that, all school employees enrollment elections including an election to waive, if allowed, must be received no later than 31 days after the date that the school employee becomes eligible for the employer contribution." And that is driven in part due to IRS regulations.

And then, 2018-18 is, "Resolved that, the subscriber's account will incur $25 monthly premium surcharge if he or she fails to attest that any member 13 or older does not engage in tobacco use."

Wayne Leonard: What does the default look like to the subscriber since enrollment will be through the SEBB My account. Do those default things automatically populate when they set up their account or are all the selection options blank?

Dave Iseminger: That's a great question. I think I know the answer but I'm going to wait for Jerry Britcher, our CIO, to answer that question when he presents the SEBB My Account demo next month. Wayne, I think your question is when somebody signs into SEBB My Account, is it going to auto populate the default positions so somebody has to affirmatively change, or are all the radio buttons going to be blank and then on the backend after November 15 anybody who's blank, our system fills it in. I'll make sure that we're able to answer that question from a technical perspective next month.

Patty Estes: I think, too, when looking at the funding rates, it was a funding based on the 82% or 88% AV?

Dave Iseminger: Under the Collective Bargaining Agreement, the benchmark is the 88% UMP Achieve 2 plan.

Patty Estes: That might be something to consider when we're looking at school districts who are getting less funding, or defaulting somebody into a plan. What does that look like from the school district's perspective on having to pay for those locally funded versus the state funded versus all the other stuff.

Dave Iseminger: I'll just clarify that the $994 will be invoiced for all people regardless of what an individual actually enrolls in or waives. Whether the default is set, the invoicing to districts will be $994. We will charge eligible employees based on the funding rate.

Patty Estes: Okay, now I get it.

Dave Iseminger: It could influence the future enrollment mix evaluations that result in changes to the model for future funding rates, but it would not, in the short term, immediately impact the employer amount a district pays for either the state-funded or locally funded FTEs for staff.

Wayne Leonard: I have a follow-up to my last question. What does it look like in terms of the default, but what it also looks like if someone is not eligible because they may try to enroll and they may not be eligible. Is that something the school district has to affirm? Would they go in and say these employees are not eligible or how is that going to work? Jerry could answer that next month as well.

Dave Iseminger: I can give a little bit more insight to that one in advance, but we can do some follow-up as well. This fall, the districts will send a file that is uploaded into SEBB My Account for people that are eligible. If somebody tries to log into SEBB My Account and they can't log in, the first question that will be evaluated is, are they in the upload file or not? If they're not in the upload file, then the question is, why did the district determine they aren't benefits eligible. And then the next question is, does the employee believe that was an erroneous eligibility termination and want to file an appeal of that process? If they are in the uploaded file, it's an IT problem of what's mixed up in the login process that the individual isn't actually able to access their account. Only people who are eligible for benefits will be able to log into SEBB My Account. But just because you aren't in the upload file doesn't mean you might not appeal why you were determined as not eligible.

Wayne Leonard: Are those upload files then transmitted monthly as we hire new employees throughout the year?

Dave Iseminger: Now we're getting too far out in my swim lane and I will make sure we can answer that type of question next month with the SEBB My Account demo.

Lauren Johnston: Slide 7 – Default Setting Timeline. During the final rate setting, between the June 12 and July Board meetings, the HCA will identify a default plan for medical, dental, and vision benefits and will present the intended default plans, along with final rate information, to the Board at the July meeting for discussion. HCA will finalize the default plans once the Board endorses the medical plan monthly employee premiums.

Dave Iseminger: When we come back in July with the resolutions on the employee premium contributions, that's when we'll show you the intended default plans. You have 60 days to think about the debate we were just talking about a few minutes ago, the mix between the AV and the employee monthly premium, to gather thoughts if there are constituents or stakeholders you want to talk with. That would be the best time for that guidance.

Lou McDermott: Sean Corry, one of our Board Members had to leave after the Executive Session. He had to get back to Seattle. He's going to call in for this next discussion.

Dave Iseminger: He may or may not join.

UMP Pharmay Benefit
Molly Christie for Marcia Peterson. I am bringing the UMP Pharmacy Resolution to the Board for action. The PEB Board approved the UMP Value Formulary at their April 24, 2019 meeting. Both Boards need to approve this resolution in order for it to be implemented in January 2020.

Slide 2 – Follow Up from Last Meeting. There were questions we wanted to address most of which relate to understanding the impact of the value formulary on SEBB Program members.

There was a question about the different formularies available to school employees. We've provided a comparison at the high level pharmacy benefits structure for some formularies under Kaiser Northwest, Kaiser Washington, Premera, and Providence with the UMP Value Formulary. We addressed evidentiary standards and required documentation for those who have gone through an exception process in the past. We provided additional information on how the transition period will work, and information on HCA's website regarding the exception process for the current Tier 3. And how many preferred drugs a member must try under that existing process.

Slide 3 – Pharmacy Benefit Comparisons. We selected these carriers for the analysis because school employees are likely to have had experience with them. However, these are not necessarily the formularies we'll be using in the SEBB Program. There is a lot of variation in formularies. This is an illustrative example. The formularies go by different names. We're using Value. Today we'll look at the Essentials Formulary, Drug Formulary, and Formulary B or F.

Slide 4 – Tiered Pricing and Copays. You'll see they have a lot in common. They all have some form of benefit design that uses tiered pricing to encourage use of preferred or high value drugs and to discourage the use of non-preferred or low value drugs. Each tier has a member cost share designed to steer members to the lower tiers before trying something like a Tier 3 drug that might not provide an added benefit.

Slide 5 – Pharmacy and Therapeutics (P&T) Committees. They all use a Pharmacy and Therapeutics Committee, made up of physicians and pharmacists, to establish what drugs are included on the formulary and how to place new drugs according to safety, efficacy, and other rigorous evidentiary standards.

Dave Iseminger: Although they all have P&T Committees, they're all different. Reasonable minds might come to different conclusions about what tier an individual drug is, but the process is all similar.

Molly Christie: Our preferred drug list under UMP has a Pharmacy and Therapeutics Committee that oversees the list, as well as MODA's Pharmacy and Therapeutics Committee, which oversees drugs not covered or not reviewed by the preferred drug list Pharmacy and Therapeutics Committee. Experts review this for us.

Slide 6 – Drug Exclusions and Exceptions. All of these plans have drugs not included on their formulary. They are usually very high cost, low value drugs. For non-covered prescription drugs, they all have an exception process like what we've been talking about where the prescribing provider works with the plan to establish whether there's a medical necessity that merits the use of a non-covered or non-formulary drug.

Slide 7 – Pharmacy Benefit Comparisons. All of these plans appear to be using a similar approach. They're using an evidence-based formulary to encourage the use of high-value drugs to address out-of-control pricing for some new drugs and existing brand drugs, and to retain access to non-formulary drugs for members who have a medical necessity.

Ryan Pistoresi will walk through the next few slides of specific examples. This group of drugs treats diabetes and we want to show you how different plans manage their formularies. We've chosen diabetes because it tends to be the highest spending class for employer plans. There are a lot of drugs that treat a lot of things. Just for diabetes alone, there are 60 drugs within four drug classes. There's a lot of variation in what plans cover; and even if they're not covering certain drugs, they're still treating a condition their members have effectively. We've talked about pharmacy trend in specialty drugs. We are seeing this trend where plans are transitioning to more formulary management to try and control volatility in spending and to drive better value. Again, for all of the plans we looked at, there is an exception process that allows members to access non-formulary drugs if there's a medical necessity.

Dave Iseminger: Pete, you asked a question last meeting about trying to compare all the formularies of all the plans. We started down that path and quickly realized because of the variability and complexity and the extent of drugs for even a single disease state, trying to do something that was totally comprehensive was going to become extremely unmanageable. In an attempt to answer your question, Pete, we identified a high-cost drug area and did a deep dive on one example. Instead of trying to do a mile-wide and inch-deep, we went a mile-deep on one-inch wide. This is our attempt to answer that question knowing it was getting unmanageable to try to do it for the entire formularies.

Pete Cutler: I appreciate that Dave. I understand trying to cover every drug class and all the details was not something that was going to be realistic within the scope of our decision-making timeline. Having said that, I also believe that it'll be important to get to that detailed level with actual school employees before you hit January 1 to know for those, that are covered, say, under Premera now, are covered under whatever other plan, I guess Kaiser would be another one. If covered by Kaiser or Premera, they'll have the option of staying with those drugs. Aetna would be a better example. They're

not going to be on the Aetna formulary. How many of them will be forced off of the drug they're using now unless they use an appeal process and engage with they can start discussions with their doctor to figure out what they can do before they are facing a big price increase as part of the overall move into the SEBB Program on January 1. I think it'd be worthwhile to spend time trying to identify those situations as much as possible in advance so you can proactively initiate communications to help people avoid a last minute surprise. But for policy making briefing, I think this is great.

Ryan Pistoresi. Slide 8 – Formulary Comparisons. I'm here to walk through a detailed example on one of the many different drug classes. We chose the diabetes drug class because there are a number of different drugs and management styles. It also happens to be the number one drug spend for the commercial world. On the left of the chart are the different formularies we reviewed for this example. Across the top are the number of drugs in the drug classes and the bars with the different colors represent the number of individual drugs within these subclasses. At the bottom of the chart you see the four different subclasses we reviewed. There were a total of 60 drugs that could be covered within these drug classes. Two of the plans, the Premera K-12 and the UMP 2019, have all 60.

I want to draw your attention to the Premera essentials and the UMP Value Formulary. From doing this research, we were able to hear from Premera that they are planning on moving what would be the K-12 population from the 2019 formulary to Premera Essentials. They're also looking at moving towards a value formulary for 2020. Premera Essentials, Providence, UMP Value Formulary, Kaiser Tier 3, and Kaiser Tier 2 are the ones we would anticipate the K-12 employees would see at 2020 or beyond.

If you look at the different colors, you'll notice the bars are all different sizes between the different plans. That's because within these drug classes are multiple options that work in the same way. They target the same receptors, but may have slightly different characteristics and different prices. The P&T Committee evaluates the drugs and helps make recommendations. They may say for these drug classes, we'll have two or three options. For the other ones, we may have all 20 but we'll want to manage that through preferred and non-preferred status, which is the key on Slide 9.

Slide 9. We have it broken out by the total number of excluded drugs, the total number of non-preferred drugs, and the total number of preferred, generic, or value drugs. They are split between the two Kaisers at the top, the two Premeras in the middle, and the two UMP formularies at the bottom. For each set, the number of preferred generic, or value drugs are the same within each of those carriers. But they have different managing strategies. For example, with the Premera K-12 to the Premera Essentials, some non-preferred drugs are now excluded, which helps direct members towards the higher-value drugs. Same thing with UMP. We do this not only to direct members to higher-value drugs for a lower out-of-pocket cost, but to help members who are paying more for drugs when they don't necessarily know there is an alternative. There are exception processes for all of these plans in case they do try some of these preferred medications, they aren't appropriate, and they need to step into those drugs. The key takeaway from these slides is to show that all of the different plans have some strategy in place that is to manage the different drugs given there is so much variation.

On Slide 8, there were about 20 different insulin drugs. All of those insulin drugs work on the same mechanism of action in the body. They have slightly different properties with how fast they work, but as you'll see, all plans offer the availability for those drugs, and then the exception process in case they need to step into what would be an excluded drug. This would be similar to what you would expect in other drug classes with a lot of brand products, or a lot of high spend.

Dave Iseminger: I want to assure the Board, when you see the word "exclusion," I'm sure that invokes some concerns. The exception process we described before is the way in which an individual would access something in the purple bar under the UMP formulary. It's much easier for you to get something that's in the brown, a drug designated by the brown bar. You have to go through the exception process to get something excluded. If you have medical necessity reasons and go through that exception process, you would still be able to access that drug covered at an in network rate.

Molly Christie: Slide 10 – Evidentiary Standards. Regarding the process for new members to get an exception for a non-formulary drug, prior to the January 1, 2020 benefit start date, new UMP members will receive an initial communication about their prescription drug coverage that describes what happens if your drug is not part of the UMP Value Formulary, and what options are available to you. We have a link in this presentation (Slide 12) to the preferred drug list that will be updated to include all drugs on the Value Formulary. You can look by drug class to see what drugs are in an entire drug class. You can look by the drug you're on and it'll tell you what tier it's in. It'll tell you if there are lower cost alternatives. It's really useful and is a great tool for us to communicate to members about how they can manage and select a plan that's going to work for them.

If a new UMP member tries to fill a non-formulary medication, MODA will work with their provider to see if it's appropriate to switch them to a formulary alternative. If the member's provider determines it's not appropriate to switch, that's when they'll submit an exception request to MODA that includes rationale for why the formulary alternatives are not appropriate, as well as the names of the drugs the member tried.

Dave Iseminger: Molly, I think Patty had a question last time about whether or not they need to submit the negative complications. Does there need to be chart notes indicating what drugs the member tried that caused a reaction to where the drug was changed? Will the member be forced to try that drug again? No. Essentially the doctor's note suffices and it doesn't have to come with a deep chart review of the implications and impacts of negative consequences of trying a drug. We're going to rely and trust the provider based on what they submit, but it needs to come from the provider.

Molly Christie: Slide 11 – Transition Period. There was a question about the transition period for non-formulary drugs. We currently have a transition process in place for drugs on the formulary. We are working with MODA to create a transition plan to accommodate new members taking non-formulary drugs. The 90-day transition period that we've talked about applies to non-specialty drugs on the formulary but that have prior authorization or step therapy requirements. For members taking non-formulary drugs again, we're working with MODA to develop that transition plan.

Slide 12 – Exception Process Clarification. At the last SEB Board Meeting, a question was asked during public comment about information on the HCA website related to how many drugs a member must try before being approved for an exception under a current Tier 3 exception process. The information suggested there was a threshold of maybe two preferred drugs per drug class before getting the exception. We suspect the confusion was caused by looking at the Apple Health section of the HCA website. Apple Health is our Medicaid Program. That part of the website does discuss that for those plans, there is a two preferred drug threshold before any exception will be approved.

On the UMP web pages, we don't maintain a list of preferred drugs that a member must take before being approved for a Tier 3 exception. However, we do have the UMP preferred drug list so there's a link to that and members can review how their drug is covered, whether or not there are lower cost alternatives, and find other information about what's covered.

Pete Cutler: Do you have to be a member to sign onto that or is it available to the public?

Molly Christie: It's available to the public. It's a useful tool. Slides 13-14 – Proposed Change. This underscores the importance of having a single formulary for both the PEBB Program and the SEBB Program. We are proposing that you adopt a resolution where UMP would use a value formulary for the drug benefit. We're proposing this change because it's simpler and more consistent with other plans the SEBB Program members will be familiar with. It offers better value. It addresses an equity issue in the current UMP pharmacy benefit by allowing members approved for an exception based on medical necessity to pay a lower cost share. It could save members money at the pharmacy when a less expensive alternative exists. It could help protect UMP from extreme volatility in drug pricing. It allows members already taking drugs in refill protected drug classes to remain on their drugs. It could help stabilize the pharmacy trend in premiums. This is the best time to make this change to avoid member disruption a year from now. It also provides continuity for K-12 employees who will or may transition to PEBB Program benefits when they retire. This provides continuity between the PEB Board and the SEB Board in making sure we have a single UMP formulary consistent across those populations.

Dave Iseminger: The fourth bullet – protect plan from extreme volatility in drug pricing was discussed at length at the PEB Board Meeting when they passed this resolution. It passed with a vote of four-three. The most significant concern that resulted in no votes was concern about people who are already on drugs that aren't in a refill-protected class and the transition they will go through. Your Chair was Chair Pro Tem of that particular meeting, so he might have additional insights about the PEB Board Meeting from his perspective. If you pass this now and it's implemented at the same time as the start of the SEBB Program, you actually sidestep over that issue because you won't have people who jump into UMP for the first time, get used to a formulary in 2020, and then in the future, potentially change formularies. You wrap this transition into their overall transition into UMP if they select it as part of the Program.

Lou McDermott: When I was thinking about our discussion on this, I wanted to bring up the fact that the PEB Board grappled with this for three years. I think, fundamentally,

there's a bit of distrust in the agency that the agency is trying to do right by its members and that there isn't this behind the scenes, we're trying to save money. And so we're trying to pass a benefit which we're going to put a bunch of nice words on but what we're really trying to do is save money.

I think what's true is there are likely dollar savings associated with it, but there's also the member considerations. In the real world, there is a cat and mouse game going on between pharmaceutical companies and employers who are self-insured and control their benefits, and carriers and Pharmacy Benefit Managers (PBMs) because the pharmaceutical companies discovered a while back there are benefit designs that allow you to get the more expensive drug if you pay a higher cost share. So what they started doing is handing out coupons. You could be paying $300 a month for your medication, and if you call the pharmaceutical company, they'll send you a coupon for $300 so you pay zero. But your employer's paying $5,000. While you don't see that on your monthly tab as you go to the pharmacy, you pay your $300, and then you get your $300 back, you experience it in your premium inflation.

On the PEBB Program side, premium inflation is most acutely felt by retirees. Most of their retiree premium is based on pharmacy expenses. Retirees were getting hit with double digit increases year over year. As this benefit design was brought to the PEB Board, it was difficult to see that it wasn't a takeaway, that what we were trying to do is make sure people have the appropriate medication.

There's a fine line on how you implement. What I'd like to assure the Board is that our group of folks is trying to do everything they can to give people an opportunity to explain why they had a bad reaction in college to a certain medication, making sure I know further in the presentation I assume we're going to talk about the exclusions. There are medications we're excluding from being impacted by the formulary change, from having to try different medications. We're trying to have a thoughtful benefit which plays into that cat and mouse game but also make sure people get the right drug and premium balance. It was a tough, tough conversation. I started the conversation when I was the PEBB Program Director and Dave got it across the finish line three years later. But it was a long conversation. I know this Board isn't having the advantage of talking about this year after year. But there has been a lot of activity, and a lot of concerns with implementation especially.

Dave Iseminger: I want to make sure people don't latch onto when you said there would be exclusions. What you meant was there are refill-protected classes we're not touching. That doesn't mean drugs are excluded from coverage. We meant there are parts of the formulary that wouldn't be impacted by the value formulary implementation.

Terri House: That's what we reviewed last month, correct?

Dave Iseminger: Correct. The refill-protected classes, things like anti-psychotics, anti-epileptics. I believe there were a variety of others actually listed in the resolution.

Molly Christie: Slide 15 is the timeline we're looking at. If we want to implement the UMP Value Formulary by January 1, 2020, this Board will need to approve the resolution no later than June 12, 2019. The PEB Board did approve the resolution on

April 24, 2019. The resolution you saw in the last SEB Board Meeting has not changed. It hasn't changed from the resolution the PEB Board voted on and approved. This is the resolution language you are familiar with.

Lou McDermott: I'm interested in the Board's perspective on voting on the resolution today. I'll give my two cents before you give me your nickel. [laughter] I want staff to get started on this as soon as possible because both the PEB Board and the SEB Board will be going through it. It gives us more time to stakeholder, to vet, to really work through the issues. The sooner we hit the go button, I know we could hit it now but you never quite hit it until the resolution passes unfortunately. I want them to get started on this to make sure we uncover every stone and make sure we protect our members. It takes time to vet all those possibilities because stuff comes out of the woodwork during the process. That's my preference. But I am very interested in the Board's opinion.

Pete Cutler: I support all the comments that the Chair has made about this. I support both the importance of this issue and the hard work that's been put into it, the careful analysis and the need to go to value-based purchasing. Dysfunction in the market in terms of how pharmaceutical companies can distort market dynamics to their benefit in terms of profits at the loss to both members and employers or taxpayers that pay for their benefits. I think it's very important. And frankly, I'm ready to vote to support it now. My questions have been answered. I think the communications, the implementation roll-out, and the communications are very important. I don't know that there's anything that we can do to address that through the motion. But we will have to count on the Health Care Authority and the SEBB Program to really put the resources into that kind of communication and analysis to make sure the transition is explained as well as possible. I'm ready to act.

Terri House: I agree with Pete and Lou. I think we've talked about pharmacy several times over the last six, seven months and I think we're ready to move on this.

Alison Poulsen: I agree. I think we should move forward.

Lou McDermott: Sean, are you on the line?

Dave Iseminger: He texted me and he's worried about talking and stopping in traffic. He did not intend to call back in.

Dan Gossett: We've had a really high level look at this and to try to get in the weeds, I hate to admit this, but I've been reading PEB Board minutes. [laughter] And realized that it seemed like how much more detail, questions like how many members would be impacted by this. That was given to the PEB Board. How much they anticipated savings were going to be in the next year and the next year after that. That was given. And then the impact of what that would be on rates. With the school employee population and all the different plans, it is incredibly difficult to gather that information. I looked at what that information was for the PEBB Program. I know how much was going to be saved and the impact on premiums. I don't know if the impact on trend was there.

Dave Iseminger: Very lightly. Keep going.

Dan Gossett: But that information, I've looked at it but I don't know if that would make any difference with anybody else's opinion.

Lou McDermott: Dan, I think one of the issues within the PEBB Program is the UMP makes up two-thirds of the entire population. We are estimating that it'll be a much smaller percent here. I think the issue with the PEBB Program versus the SEBB Program is that there is the policy discussion as to what you're going to do and how it's going to impact people and why you want to do it. That discussion is the same at the PEB Board or the SEB Board. I hope when you read the materials, you saw the same analysis that was given. What's different is the PEBB Program has actual experience so the natural question for the Board Members is how many people does this affect? What are the dollar amounts? Is the juice worth the squeeze? And within the SEBB Program, unfortunately, most of our discussions are theoretical based on the PEBB Program experience. In theory, you could probably take the PEBB Program population with the estimated population that is going to be in UMP in the SEBB Program and you could downsize the numbers to come to that. But they're coming from different plans that already have formularies. It's really hard to tell.

Dave Iseminger: The other piece I was going to add is remember that on the PEBB Program side, as has been mentioned, for retirees, the Uniform Medical Plan is the primary payer for pharmacy benefits. This will have more potential impact on the trend in premium implications of the Medicare portfolio. The PEB Board, at one point, I think that was two seasons ago, was debating whether this should apply to both the non-Medicare and the Medicare piece. At that time, we were primarily focused on describing what the impacts would be to the Medicare population because that's where the brunt of the financial burden of drug cost is. That is a factor not present in your Program as a fully active employee program. That would be the other reason, in addition to the difficulties already described, the pieces that you see that we presented to the PEB Board also have a big lens of Medicare over it that is different and not present here.

Lou McDermott: One thing that's interesting is your decision here today is going to affect those retirees, a significant portion of which are schoolteachers, school employees. It's an indirect benefit. But the decision to go with the formulary today allows the PEBB Program to go with the formulary, which allows relief to those retirees. There is a ripple effect from this decision beyond the people we're modeling that are going to go into UMP from the SEBB Program. There is a ripple effect that will affect many people.

Wayne Leonard: I'm willing to move forward with this. I think it's consistent with other actions we've taken to try to have some cost containment in our health insurance premiums and keeping our premiums at a rate that's affordable to people.

Lou McDermott: We're going to proceed to a vote.

Policy Resolution SEBB 2019-11 – Self-Insured Value Formulary

Resolved that, beginning January 1, 2020, contingent upon approval of a value formulary resolution by both the PEB Board and SEB Board, all UMP plans require the use of a value-based formulary and:

- Non-formulary drugs are covered only when medically necessary and all formulary drugs were ineffective or are not clinically appropriate for that member, and
- Multi-source brand-name drugs including those in refill-protected classes, are covered only when medically necessary and all formulary drugs have been ineffective or are clinically inappropriate for that member, and
- Members who have been taking a non-formulary drug are required to switch to the formulary drug, unless:
  - they receive or have already gone through the exception process and been approved, or
  - their drug is within one of the refill protected drug classes which include: antipsychotics, antidepressants, antiepileptics, chemotherapy, antiretrovirals, immunosuppressives, and immunomodulatory/antiviral treatment for Hepatitis C.

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

Fred Yancey, Washington State School Retirees. We're indeed in support of this sort of change. We see the benefit for retirees. My only concern, and I've raised them before, is when you've got 20 generic drugs that treat diabetes. For making somebody try all 20 before they're allowed to move to a brand-name drug is problematic I guess. And whether they would have to is another issue. The only other issue I have, and I've raised this before, too, and so maybe I'm just inept and someone could argue that point. You use the term "exception." The website uses a different term. I mean, I can't find an easy explanation for me trying to find an exception. I think the website calls it prior authorization. That's my guess because it's as close as I can come to trying to find how I, as a consumer, could get an exception to the process. And I've said that before. It should be so easy, and it isn't, at least to me. So again, very supportive of the idea because we, meaning retirees, are being strangled as you well know by a disproportionate amount of prescription use with tremendous cost to us. So thank you very much for considering.

Dave Iseminger: Chair McDermott, I'll add additional context. The PEB Board asked for a follow-up response even after the resolution passed for a clear written explanation of the exception process. That is in the works that we'll be presenting back to them. We can bring that back to this Board for additional information as well, or context as follow-up. Also, House Bill 1879 discussed earlier this morning. One of the pieces of that is as of plan year 2021, formularies have to be evidence-based and you must have clear written exception processes. That dovetails with the work we'll be doing. We are committed to working on creating clear communications and making sure it is a robust and easy to follow step-by-step process which will then also allow us to comply in advance of plan year 2021 with House Bill 1879's requirements.

Like all other resolutions, SEBB 2019-11 went through the stakeholder process. We received one comment back that was in support of the resolution.

Pete Cutler: Since the communications around the exception process specifically, and around this change are so important for its success, will we have a chance to see what's being proposed for those materials or at least some kind of current draft before the end of our meetings scheduled this year? Or is it likely to not be ready until later?

Dave Iseminger: I'm not going to promise a specific date, but I understand the piece which both Boards and stakeholders in both populations are heavily interested in how this will be communicated. We will do our best to bring back at least the general nature of that process. Once it is in its final stages, we can get it out so people can see how we're going to be communicating it, even if it is outside of the Board season, possibly a follow-up email to the Board.

Pete Cutler: Please don't call a Board Meeting just for this. I'd be quite happy to go with the email distribution.

Before the vote, I think it's already clear, but want to make sure. We're talking about one single value-based formulary for all the Uniform Medical Plans, right?

Dave Iseminger: Yes.

Voting to Approve: 8
Voting No: 0
Absent: Sean Corry

Lou McDermott: Policy Resolution SEBB 2019-11 passes.

2020 Benefit Refinements Policy Development
Dave Iseminger. This is the culmination of the 10% homework after the Legislature has completed its work.

Slide 2 – Preliminary Considerations. This first piece is something Megan Atkinson discussed at the beginning. The funding assumptions in the final operating budget passed by the Legislature confirmed the longstanding assumption that the agency had been presenting to you; use the PEBB dollars as the proxy for what is going to be spent on this Program. In fact, as Megan highlighted in Section 938 of the budget bill, it expressly talks about the funds are to be used to purchase materially similar benefits to the PEB Board as already adopted by the SEB Board. This is why it was so important for this Board to act in advance of the legislative session because as I had foreshadowed, the Legislature needed to have a sense as to what could be bought. We kept legislative staff up to date on the workings and progress of the Board.

Outside of the legislative session, I know that many of those staff members listen in to these meetings, follow-up on them, or sometimes watch them when they are recorded by TVW. They had actual knowledge of the work you have done. Many times in budgetary documents, they don't give you the type of direction that was given here. This was a clear affirmation of the work that had already been done and a reassurance that because the funding rate of $944 came in, which is different than the modeled number from the Health Care Authority, there was not a direction to this Board that you needed to cut benefits to fit that funding level. That is an important piece.

There's not a requirement to decrease benefits. But on the flipside of that, there's also a definitive answer to one of a longstanding question from several Board Members: is there more money to spend to increase and enrich elsewhere? The answer to that is equally no. You are down to horse trading as I've described it over the last several

months. Any final changes you want to make in the portfolio would need to be done by the June 12 Board Meeting. They would have to essentially be budget neutral within the framework we described to the Board over the last year.

Slide 3 – Timeline for Decision Making on SEBB Program LTD Benefit. At the last Board Meeting, we described the Long-Term Disability Benegit (LTD) benefit because of all the areas within the benefit portfolio, that is something the Board expressed concerns and misgivings about. In fact, in recent weeks, I've had a variety of questions, one I thought I would share with the Board because it finally dawned on me why so many people struggle with this benefit. Many people have asked why the state isn't getting a good deal on LTD. What people see is it's going to be a $400 benefit. If I, in my own school district, am able to procure a better benefit, why isn't the state able to leverage its purchasing power across the entire state in a single pool to be able to get a better benefit? The answer is we do have a very competitive rate. But if you go back to the handout that was in your folder for Megan's presentation that broke down the funding rate, you'll see that only two dollars of that $994 is going towards LTD. When you're only spending two dollars per member per month, you're getting a $400 benefit because you're spending two dollars per month. Obviously, if you spend more than two dollars a month, you can have a better benefit. So it's not that the purchasing power isn't able to get a good competitive rate. It's the allocation is within the funding rate that's being attributed and spent on this particular benefit. That's where we've gotten to describing to you previously, a horse trade if you change the orthodontia benefit this way, it results in this amount of claims freeing up, which then converts to a dollar PSPM on LTD, which then increases the LTD benefit.

I think that was an aha moment when I described it to people. Two dollars of the $994 is going towards LTD. The bulk of that $994 is going towards medical. It's not that the state isn't getting a good rate. It's how much is being allocated towards that particular benefit.

Slide 3 is the discussion from last meeting about the long-term strategy on working on the basic LTD benefit. We are obviously right around that 2019 line that says Board decision point for plan year 2020. We're past the legislative session. We're towards the tail end of this SEB Board season. If there's anything the Board wants to change with regards to the program launch, it would need to be done by the June 12 meeting. I have slides in this presentation you've seen before about options that have not seemed appealing to a majority of the Board, yet, other options are, in some people's words, more draconian than these ideas. We have not found that magic benefit swap that seems to increase the LTD benefit with an appealing or palatable decrease. We wanted to continue to provide that context and say if there's something in this list that you want to proceed with, now is the time.

We aren't ending the conversation there. I said at the WASBO Conference last week that the elephant in the room is the basic LTD benefit. The districts don't like it. The employees don't like it. The agency doesn't like it. Everyone agrees that we don't like the benefit as it is now. It is something I am committed in my leadership role as the ERB Director to try and improve for both programs because it is a benefit we need to put some eyes on and be addressing. One of the pieces is the agency working on a decision package to make sure the Legislature and Governor's Office have information

about what it would cost to increase the benefit level for both programs. We're going to be working over the summer and in the fall to be able to submit a decision package that describes a range of options for potential funding mechanisms to see if there's a desire to increase the allocation from two dollars on LTD to another amount. There's no guarantees that anything will happen, but we would submit it and it would go through the legislative process. You would know this time next year whether that option was taken. If it wasn't, then you could further engage in benefit swaps for the 2021 plan year.

Lou McDermott: Isn't another opportunity making sure we express to our members what the optional LTD benefit is and what it isn't? Mostly pushing the optional LTD as I know we've already had a dry run at that through the PEBB Program.

Dave Iseminger: That's actually an excellent transition. Slide 4 – Strategies Relate to Long-Term Disability (LTD) Benefit. This is actually a new slide that we haven't presented to you before. We finished our negotiations with The Standard Insurance Company that during the fall open enrollment next year in 2020, school employees will have a second medical underwriting free bite at the apple in enrolling in optional LTD insurance. So everybody this fall gets a fresh bite of the apple. If you've been denied before, doesn't matter. You can get benefits. We know with the extent of changes happening this fall, many people are going to focus on medical and dental. We know because of the structural concerns about the quality of the basic benefit that people might be so focused on medical/dental they miss out on disability.

We worked with The Standard and it would not impact rates to do this one-time second bite at the apple. I am a bit concerned that school employees may think this would be available every year, which it won't be, so we're going to have to be careful about the messaging. It was another tactic to try to mitigate and prompt the ability to leverage that optional benefit. Again, that optional benefit is employee paid but it is a valuable opportunity to not have to go through medical underwriting. We were able to negotiate in a way that if somebody between fall of 2019 and fall of 2020 goes forward and submits medical underwriting and fails, they still get the enrollment opportunity in fall 2020. This is truly a second bite at the apple for anybody, even if they get denied sometime in the intervening year. I wanted to bring that to the Board because we thought it was a valuable component to bring as an opportunity for school employees to fit in with this LTD puzzle. Alongside of that, we're going to go through the decision package process.

We recently went through a one-time first time in 40 years, special open enrollment, no medical underwriting in the month of March, for PEBB Program employees because in that model right now, it's a paper-based enrollment system. We are still waiting out the keying period to get final numbers. But we had a large increase in an uptake of optional enrollment. We're somewhere around 33% to 34% participation, whereas we had been at 25% participation. We had somewhere between 6,000 and 7,000 employees sign up for optional LTD for the first time. We know that if we take time to emphasize this benefit in a special opportunity, we are able to educate people about it and get them to understand the importance of this benefit. We really did want to work with The Standard and we're glad we could partner with them to bring this second opportunity. This is another mitigation piece. We are leveraging the optional piece that Lou was just highlighting.

The rest of the slides are all things you've seen before. Slide 5 is this chart that describes adding a dollar, two dollars, etc. in dollar increments if you were able to find money in a benefit swap what you would approximately be able to increase the monthly maximum benefit from. The far left, the $400 is what is spent using that two dollar allocation in the funding rate and then the subsequent amount.

Slide 6 is about the income distribution of school employees. There are a lot of caveats to this. This is based on 2016-2017 data from the S275. It's before this past summer's infusion of funds into salary negotiations. This number doesn't reflect any of those recent developments, but it does give a proxy. We thought this was important just to be able to overlay and think about what salaries people have that they could be insuring and the maximum benefit level.

Slide 7 highlights the four different benefit pieces we evaluated last fall and continue to evaluate as options that were among the potentially more palatable benefit swaps the Board might want or be willing to consider. I'm interested in any further Board discussion. I'm reminded of that Einstein quote, "Don't expect different results if you keep doing the same thing." It's what we have for you to think about for benefit swaps because we've tried to have discussions here about other ideas, some of which were generated by Board Members. No other ideas have been generated by the agency, the Board, or others at the state. There's no silver bullet here on a potential benefit swap. That doesn't mean next year we won't find additional pieces. But for the 2020 launch, these are the things we've evaluated so far.

Slides 8-12 go into the detail of each of these different benefit swaps. I think the only one that had some discussion from Board Members was the basic life insurance, but it didn't seem that a majority of the Board was interested. You could decrease the basic life insurance from 35,000 to 25,000 and in exchange you'd essentially be able to raise the LTD basic benefit from $400 to $600. We highlighted how you could fundamentally change the dental benefits. When we went through those presentations in November, I saw grimaces just now, so I'm going to move on. But it was something that we presented to you and the implications.

There had been a question about capping fully insured orthodontia because the prominent enrollment is going to be in UDP, which is already capped. There's no juice to squeeze there. It wouldn't make any difference. That one, even if it was palatable, wouldn't change anything.

There was a discussion and we evaluated eliminating orthodontia, which could have a profound impact. It could raise the basic LTD benefit to $1,000; but at the same time, many of the Board Members were excited about having an embedded orthodontia in dental. We know some of the dental benefit impacts are that there are many plans in the K-12 world which have a way, that if you engage in your preventive care, you are able to get a lower out-of-member cost share and that is a structural difference that won't exist in the SEBB Program. I think many people saw incorporation of an orthodontia benefit as a helpful offset to the fact that you couldn't get to a lower cost share for those class one and class two covered benefits.

Those were the pieces evaluated before. The question before you is if there's anything you are interested in us bringing to you because your final opportunity for the program

launch 2020 benefit design changes is the June 12 meeting. If you think of something after that, we will evaluate it for 2021. We're coming up on the finish line for the 2020 program launch and my favorite word, iterative, we will continue to have an iterative process on rules and benefits from now until the end of time.

Lou McDermott: Very inspiring, Dave. End of time? Board Members, thoughts about engaging in the horse trading, or are we feeling comfortable with where the benefit has wound itself to?

Pete Cutler: First of all, I wasn't sure whether that comment about the iterative process going on for ever and ever was a threat or a promise. [laughter]

Dave Iseminger: It was both. Yes.

Pete Cutler: As everybody on the Board knows, I feel strongly about the long-term disability benefit and its important place. And just in case anybody had questions, I'm not looking for any tradeoff now. It's not like I think we have overly generous benefit provisions in any of the benefits we've approved so far. I think the issue is important enough that it should be addressed head-on by the employee organizations and state discussions going forward, and presumably in collective bargaining come next summer. It is not something I would want to do a little nibble at the edge here or there when in fact, it's something that deserves a good, hard look with all the players. I appreciate all the work that's been done by Health Care Authority staff and the information we've been provided. But for what it's worth, I'm not looking for any tradeoffs to enhance the benefit now.

Alison Poulsen: I would concur with Pete's comments and just thank the staff for the very diligent analysis and creative thinking. I would agree that the strategy around a decision package in a future legislative session is really the smart way to go and that I think we have had a very thoughtful process to get there. I am appreciative and looking forward to the future part.

Dave Iseminger: I guess what I would say is it doesn't look like we'll have much on the agenda about a final benefit refinement because there's not a specific request to bring something for potential action at the same time as you're hearing it. Essentially, your 10% homework looks like it's done as of today. I'm looking around and seeing head nods. So now begins the iterative process for 2021. A pat on everyone's back. Think about where you were as you were appointed back in September 2017 to now. You have finalized and the Legislature has funded a benefit package structure for the launch of a program that has been debated for three decades. Just take that in for a moment.

Pete Cutler: And I was there from almost the beginning. [laughter]

Dave Iseminger: And so was Barb Scott!

Lou McDermott: And I think we know why it took three decades then. [laughter]

Pete Cutler: I apologize.

Lou McDermott: Congratulations, Dave.

Dave Iseminger: No, thank you to the Board for all of the work that went into last November and the appreciation of the guardrails that are in place that lead you to the decision to not have any further refinements for 2020.

Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP)

Marty Thies, Account Manager, Portfolio Management and Monitoring Section, ERB Division. The Board received an initial overview of the Medical FSA and DCAP programs in January of last year. My purpose this afternoon is to update the Board regarding the Medical Flexible Spending Arrangement (FSA) and the Dependent Care Assistance Program (DCAP) and describe for the Board what these benefits will look like in the SEBB Program.

These two supplemental benefits are often referred to as 125 plans as they are outlined in Section 125 of the Internal Revenue Code. This may be new terminology for SEBB Organizations and we're trying to navigate that and make it translate for them as they make the change. Today, I'll be summarizing what these two benefits look like, how they work, what our experience in the PEBB Program looks like since 2013, and a little bit about our implementation of this program within the SEBB Program. These benefits are administered by the Health Care Authority and do not require a Board vote.

Dave Iseminger: The authority, as Marty said for the salary reduction plan, which includes Medical FSA and DCAP, is agency authority. That's why we haven't done lots of presentations for you. We wanted to keep you apprised. The benefit design and decision making authority is with the agency and that's why there's no Board action.

Marty Thies: Our Cafeteria Plan includes a salary reduction plan, which will allow school employees to participate in Medical FSA and DCAP by reducing their taxable salary so they can spend pre-tax dollars through a Medical FSA or DCAP account for out-of-pocket medical expenses or eligible dependent care expenses.

Slide 4 – How a Medical FSA Works. During this upcoming and every annual open enrollment afterwards, school employees can elect a pre-tax amount to defer from their pay. The limit is set by the plan sponsor, Health Care Authority, but cannot exceed an annually designated IRS maximum. On day one of the plan year, January 1, January 2, whatever the first Monday is, the entire annual deferral is available to employees, though they haven't deferred anything yet. That's a great benefit. For instance, they could have a surgery on January 2 and use the entire year's deferrals. To claim, the employee uses a Medical FSA debit card or submits after purchase claims to the Medical FSA vendor using paper, email, fax, or a mobile app, after which the employee is reimbursed for those expenses. Annually, unclaimed funds are forfeited.

Dave Iseminger: That forfeiture is required under IRS rules. Sometimes there are employees upset that the money is forfeited to the plan sponsor or the employer. But that is a key component regulated by the IRS. It is required. What this agency has done with those forfeitures on an annual basis is use it to offset the administrative expenses for running the program.

Lou McDermott: Another benefit is people don't have to pay back, if they have that surgery on January 2, they use their entire Medical FSA, and they leave employment, that's also a benefit to them that they do not have to repay. Is that correct?

Marty Thies: That is built into the program. You could defer for the entire year and be gone in a month.

Dave Iseminger: Right. That is another key aspect to the forfeiture requirement under the IRS. Forfeitures also help mitigate the risks of somebody who has claimed all funds before they made all of their deferrals, left employment, and no longer have paychecks from which to defer. The forfeiture is used to offset those expenses in that instance, as well as administrative expenses.

Marty Thies: Slide 5 – Examples of Eligible/Ineligible Expenses. The column on the left lists examples of eligible expenses. These are common medical out-of-pocket expenses, dental, orthodontia, pharmacy. The first item, bandages and sunscreen, can't be purchased in large amounts to stockpile. There can be limits to what you can purchase at on time.

On the ineligible list is health insurance premiums. Also included as ineligible are maternity clothes, sunglasses, maybe special food. These cannot be reimbursed through a Medical FSA.

Slide 6 – Pros and Cons. Why do we offer a Medical FSA to employees? The primary benefit for employees is they can reduce their income taxes by deferring pre-tax dollars. For example, if an employee deferred the maximum of $2,700 and they paid taxes at a 12% rate, they'd save over $300. Already mentioned is the entire amount is available day one. You can essentially pay out of pocket against future deferrals. However, if the employee does not end up with enough eligible out-of-pocket expenses to claim, or they had those but didn't claim them on time, the possibility exists they will forfeit those funds. Also, reducing your taxable income along the way will impact the calculations for your social security checks, retirement, and otherwise. For SEBB Organizations, they are not liable to pay FICA on deferred earnings. Let's say you had that same employee defer $2,700 over a year. The SEBB Organization would save $207 if you multiply that by 7.65%.

Pete Cutler: That would be true for the employee as well. Both those contributions would not have to be paid on that deferred amount.

Marty Thies: That's correct and that's why it would impact social security calculations. End of year forfeitures go to the plan's sponsor, which helps reduce the per participant per member administrative fee.

Dave Iseminger: I want to be very transparent about a piece because I know many school districts have asked me personally and my staff. SEBB Organizations currently get all of this administrative stuff for "free" and now there's going to be a per participant per month (PPPM) administrative fee that's owed. That seems counterintuitive. What I've tried to highlight for people is those expenses exist somewhere in the system. You may not be writing a check for them but they are born somewhere in the system. As we

go forward with this centralized Cafeteria Plan at the state, those administrative pieces will be much more transparent. It's a cost in the system somewhere and now it will be very clear where and what they are.

Marty Thies: Slide 7 – Key Dates. These are key dates in the evolution of the Medical FSA benefit because by far, the greatest potential disadvantage of a Medical FSA account is the danger of forfeiting a portion of your income. It's been called the "use it or lose it" rule. In 2005, recognizing this, the IRS adopted the grace period, which gives up to two and a half months into the next plan year to both incur and claim additional eligible out-of-pocket expenses. In 2013, the carryover was implemented whereby a maximum of $500 can be carried over to the next plan year and it will be available to the employee for the entire next plan year. Now if that employee has $600 they haven't spent at the end of the plan year, they can still move $500 to the next plan year but they will forfeit that $100 over the $500 limit.

Dave Iseminger: With the grace period, it doesn't matter what the amount is that you're able to claim. If you hadn't spent $600, there's nothing forfeited on the first day of the next plan year. You have the ability to incur or claim the full expenses until the grace period is up. Another opportunity that people utilize the grace period for is you could deliberately not spend your money, save it up, and then double dip into your last year's grace period Medical FSA dollars and your next year's grace period dollars and immediately have access to a larger dollar amount to reimburse you for a major medical expense in January or February. You can utilize the grace period to be very thoughtful about when you're going to have services that are extraordinarily expensive with out-of-pocket costs and use it as a short-term bank account, essentially.

Marty Thies: A sponsor can offer a grace period or a carryover or neither, but not both. In the SEBB Program benefit, we'll have a grace period of two and a half months.

Dave Iseminger: As we move into implementation, it comes as no shock that roughly one half of the school districts do one way, half the school districts do the other way. There are a few that don't do either and so we know there have been concerns as we've moved forward in this implementation about people who are on carryover that have to go to grace. If we had done the other way, we would have had the other half of the room upset. We are aware there are many ways the districts have administered this benefit. Part of this is to get everybody onto the same page. Half of the room was going to be upset no matter what we did.

Marty Thies: We are doing our utmost to encourage people to spend their accounts.

Slide 8 – Medical FSA/HSA Incompatibility. An employee cannot have both. In other words, those enrolled in high deductible plans who thereby have an HSA cannot enroll in a Medical FSA. Each annual open enrollment, there are two to three dozen people who end up enrolled in a high deductible plan for the next year and they also try to open a Medical FSA. We flag those and alert employers so they can talk to the employees so they can make a choice. If we don't hear from people, they're disenrolled from the Medical FSA. We try to mitigate against that.

For the SEBB Program Medical FSA benefit, there will be a $2,700 maximum deferral for 2020, which is the maximum allowed by the IRS. The IRS usually announces

increases to the maximum in December, which is too late for all our communications. There will be a $240 minimum deferral that will likely remain constant. As I noted before, we'll have a grace period rather than carryover.

Slide 9 – Dependent Care Assistance Program (DCAP). The DCAP has the same basic structure as a Medical FSA, however, the maximum deferral is $5,000 and the employee has access only to funds that have been deferred. In February, they can utilize what they've deferred in January. There's no rollover or grace period for the DCAP account. Employees must incur and claim in the plan year. And like a Medical FSA, annually unclaimed funds are forfeited.

Slide 10 – Examples of Eligible/Ineligible Expenses. These expenses are work related. Work means being at work, looking for work, or engaged in work-related educational activities. Examples of eligible expenses are after school programs, child care, dependent or elder care, etc. Examples of ineligible expenses are dance or piano lessons, a babysitter when you're not at work, tutoring, etc. A caregiver cannot be a relative.

Slide 11 - Medical FSA/DCAP Vendor. Navia Benefit Solutions has been the vendor for HCA since 2014. They have national accounts but they're based in Bellevue. They serve several other states and between 30 and 35 school districts already, large and small, east and west of the mountains, accounting for more than 6,000 school employees.

Slide 12 – Medical FSA/DCAP Logistics. Employees sign up for an account with Navia during open enrollment. Deductions are set up by the SEBB Organization. Each pay period, the deferrals come to the Health Care Authority. As employees submit their claims to Navia, Navia reimburses them and then bills the Health Care Authority for funds used. Monthly, the Health Care Authority pays Navia a per participant per month administrative fee. Fees paid by SEBB Organizations will be offset by forfeitures.

Dave Iseminger: The enrollment that will happen this fall is a separate portal than SEBB My Account. SEBB My Account will have a directional link to provide information about the benefit. It will have a link to how to enroll. There is a separate employee portal for Navia to make the enrollment. There's also a paper-based option but there is a robust online enrollment process that people will be linked to through SEBB My Account.

Marty Thies: Slides 13-14 – Benefit Utilization. As far as utilization under the PEBB Program, you can see there's been a steady growth in the years that Navia has been our administrator, 6.7% annually. It fluctuates every year as people retire and new employees come on. Tens of millions of employers nationwide offer Medical FSAs to their employees. In the last five years, PEBB Program employees have reduced their taxes by approximately $18 million and agencies have saved in FICA expenses over $11 million.

Slide 15 – SEBB Program Medical FSA/DCAP: Implementation. We're now working with Navia to bring 300 plus SEBB Organizations into the fold. They're coming from programs that have different design features, plan years that don't coincide with the

calendar year as ours does, carryovers rather than grace periods. ERB Division communications, in collaboration with Navia, is creating communications for bringing the SEBB Organizations and employees into this benefit smoothly. We're increasingly engaging the SEBB Organization staff to prepare for data sharing and payroll deductions.

Dave Iseminger: I was just going to add the transition to a calendar year plan took me by surprise. I'm sure many of you are aware the general medical plan enrollment is different for districts, but they tend to fall in November to October or October to September. Yet, the Medical FSA/DCAP has more variability. We were made aware recently that there is a May to April Medical FSA non-calendar plan year. It turns out that virtually every permutation of a 12-month cycle exists for Medical FSA/DCAP. So the conversion and transition to a calendar year plan is even more complex in Medical FSA/DCAP than it is in medical. I was rather surprised that one might have a non-calendar year plan that is a different non-calendar year plan from your medical plan. It has proved to be yet another kind of interesting little nugget within consolidation efforts.

Wayne Leonard: Is Navia also a TPA for the HSAs?

Dave Iseminger: The state does not have a direct contract relationship with an HSA account manager. They're subcontractors of the medical plans. For example, on the PEBB Program side, it is fortuitous that for the UMP (through Regence), KPWA, and KP Northwest the subcontractor is HealthEquity so it is the same administrator for all the PEBB Program members. On the SEBB Program side, the proposal before you, UMP, again, HealthEquity would be the subcontractor for UMP. Providence is the only other carrier who suggested having an HSA plan and I believe their subcontractor also happens to be HealthEquity. It looks like that would be uniform within the portfolio but it is not a direct contract relationship for the state.

Marty Thies: Navia does provide that service. A lot of the Medical FSA/DCAP administrators, that's part of their inventory of services. But we don't do that with them.

Wayne Leonard: A lot of school district employees have HRAs also. I know there's restrictions with their HRAs with coverage of spouses that may be on Medicare. Is there similar restrictions for HSAs and FSAs?

Dave Iseminger: We'll follow up with this at a future meeting, Wayne. But I do know that there are implications of HSA enrollment if you have a split account that includes one individual who is Medicare eligible. That's not the case for Medical FSA as far as I'm aware. But there are some nuances for a married couple where one is Medicare and the other not Medicare when it comes to HSA. We'll do a little bit of follow-up on that.

Wayne Leonard: I'm thinking primarily of our bus driver pool. A lot of retirees that drive bus either have Medicare or Tricare coverage so that question will probably come up.

Patty Estes: Wayne, I have an HSA and I have my daughter who is also covered. I had my daughter on my coverage who is also covered under her father's coverage. In

order to use my HSA to cover anything for her, they wouldn't allow it. I would've had to reimburse HealthEquity for any of those expenses. I ended up taking her off of my HSA because her coverage was better with her dad. I know they can't be doubly covered with an HSA plan.

Wayne Leonard: Right. I think with the HRAs, if someone's on Medicare, you have to put it in limited status.

Dave Iseminger: I know just enough to be dangerous. So we'll do some follow-up on the kind of Medicare split account situation and its implications for Cafeteria Plan benefits.

Public Comment

Julie Salvi, Washington Education Association. I will try and be brief today. I know the road is calling but I wanted to touch on two things. One was from early in the day when Megan was talking about the rates and when they might be adjusted. For those who don't know me well, I have a ten-plus year history of being legislative staff and OFM staff on K-12 budgets. There is a tried and true tradition in K-12 of not adjusting health care or other rates on school districts during an open school year. I would fully expect that it would hit in the 2020-21 school year any adjustment would be made, not during next school year. When this has come up before and the Legislature has thought about trying to make an adjustment mid-year, it is quickly brought up to them by their many staff who will remind them districts cannot lay off staff during a school year. Every May 15 is essentially the deadline. If they have contracts that won't be renewed for a full year, they need to notify staff by that time. So during the year, they cannot make reductions in their certificated staff. By the time legislative budgets are approved, the school year's essentially over and the Legislature also recognizes that to either push on the cost or take some other reduction that impacts school districts' bottom line, there's not room for the school districts to adjust within that school year window. That is why, based on that long history of how they have done things over the years, for pension changes, health benefits, and others. I would not expect it to hit until the second year.

And the other thing I wanted to touch on was Pete's comments related to getting information out about the value formulary. I think that is very important and I would emphasize that I wouldn't focus just on UMP. Knowing that some of these other plans will also have value formularies, it would be helpful to find some way to have information go out that would give people information on where they can go to look for the various formularies as they're considering plans in open enrollment, and as they're looking to transition to a new plan. Making that transparent because that will be new to many people in K-12. Thanks for your time.

Lou McDermott: Thanks for your insight and I appreciate the feedback.

Dave Iseminger: I had written a note to myself for things like the virtual benefits fair to ask carriers to be very explicit about where the members will be able to get information about the formulary. So similar minds thinking. I have one public comment I need to respond to that was submitted in writing.

In the front pocket of your binders is written testimony submitted to the SEB Board Correspondence and specifically noted to be presented as part of public comment at the

next Board Meeting. We've never had that before on the PEB Board or SEB Board side. So the process that we're planning to go through is that we will give you a copy of it, we will have it put verbatim in the minutes, but I'm not going to read it for you because if we get suddenly 6,000 of them, I don't want to read 6,000 word-for-word emails to you.

I would say about this one from Krista Hurling at the Wenatchee School District, the heart of her public comment is a question and assertion about, she is a substitute teacher and how substitute teachers are treated in the SEBB Program population. The underlying assertion is that individuals who meet the hour requirement aren't eligible for benefits. There's a couple of things that I want to make sure the Board's aware of. There were opportunities or ideas at the end of the legislative session in bills that would have exempted, or otherwise changed, the eligibility for substitutes. That did not pass so nothing changed with regard to eligibility of substitutes. If they are anticipated to work, or actually work, 630 hours, they are benefits eligible in the SEBB Program. This comment may have come up in the context of hearing about those legislative changes.

At the same time, we'll take the opportunity to ensure the Wenatchee School District is aware of how to apply eligibility requirements for substitute teachers and any school districts that have similar confusions about how this applies to substitute teachers.

From: Krista Herling <teacherkrista@gmail.com>
Sent: Monday, May 6, 2019 9:52 PM
To: HCA SEB Board <SEBBoard@hca.wa.gov>
Subject: Re: Public comment

Hello, I would like to submit this comment please!

To the Board of SEBB:
My name is Krista Herling and I am a substitute teacher in the Wenatchee School District. This is my first year back subbing after having my 4 children, who are now in school full time. Because it is my first year back I got a slow start in subbing this year, but I will almost reach the half-time mark with jobs currently scheduled through June and expect to easily reach it next year.

I recently learned that SEBB benefits will not be offered to subs because we "aren't guaranteed hours," even if we reach the threshold for part time employees. This feels patently unfair to me when we have the same credentials as the teachers and many of us work at least part time every month. Other part time employees are offered benefits when they reach the half time threshold (per your current guidelines), yet substitutes will be shut out of ever receiving any benefits. Many of us are unable to work as full time teachers either due to life circumstances or unavailability of jobs. There was one (1) full time position open to me in this area this year.

I understand it involves more paperwork, but it seems like we should be offered the same benefits as other part time employees and those should continue as long as we maintain the average of half time work. There has to be some way to make it work rather than just say we are shut out completely. School districts couldn't function

without substitute teachers, some days I work all my classes plus the prep period because there aren't enough subs as it is.

Thank you for taking the time to consider that we are valuable employees as well and deserve the same rates of benefits.

Krista Herling

Pete Cutler: Dave, I want to be absolutely painfully clear. So this does mean if somebody in a school year -- is it based on a school year? Let's say they sub worked a bit in September through December. They hit 635 hours of being a substitute. As soon as it becomes clear that they're going to hit 635 hours, the coverage kicks in and it's good for the rest of that school year.

Dave Iseminger: That is true. There is at least one caveat. I don't remember the resolution number. They do not have to work but as long as their employment relationship is maintained, for example, a substitute teacher reached 630 hours by December and then didn't put forward any other hours, until the employment relationship is terminated, they remain benefits eligible until August 31. If for some reason a district or the employee severs that employment relationship, then the other Board resolutions that kick in for the termination of benefits, the first of the next month would apply. If a district decided come February they were not going to bring that substitute back and then severed the employee relationship, that might serve as a basis for ending benefits prospectively. But without any change to the employment relationship, the individual remains benefits eligible through the end of the school year, which is statutorily August 31.

Pete Cutler: So that's even better than the PEBB Program rule about requiring eight hours or whatever that standard was for continuing coverage. As long as the employment relationship, however that's determined continues --

Dave Iseminger: I think, Pete, a core difference between the PEBB and SEBB Programs is that maintenance rule. In the PEBB Program, there's a maintenance rule for eligibility. In the SEBB Program, eligibility is determined anew every school year, every September. There's a reboot of eligibility every year in the SEBB Program that doesn't happen in the PEBB Program; and conversely, there's a maintenance rule in the PEBB Program where there's no maintenance rule in the SEBB Program.

Pete Cutler: Great. Thank you very much.

Wayne Leonard: At the WASBO conference recently, there were questions and I just want to clarify. The next school year, the SEBB Program doesn't start until January 1. When does the 630 hours of eligibility start? Does it start January 1 or does it start September 1?

Dave Iseminger: It starts September 1, 2019. An important piece for districts this summer, in August or September, will be uploading into SEBB My Account the eligibility file of those individuals who meet the requirements for benefits as of January 2020. That will be based on the hours in the 2019-2020 school year, which is September 1

through August 31. The hours anticipated to be worked or actually worked in September will be part of the consideration of the eligibility determinations for the benefits that become effective in January.

Wayne Leonard: Okay. And severing the employment relationship with a substitute employee, one of the difficulties, I guess for the business offices is that if a substitute becomes eligible and then they no longer accept open days where they could sub, there's no paycheck to deduct their portion of the health insurance premium. My understanding is that the employer is still responsible for making that payment. Whereas if a person is on COBRA and they don't make their payment, their insurance is canceled. Is that correct?

Dave Iseminger: Wayne, everything you said is correct.

Wayne Leonard: Then you can imagine there's some frustration if people are receiving benefits and not accepting substitute positions. There was some discussion about can the employer sever the relationship if they refuse to take substitute assignments?

Dave Iseminger: Katy, you were starting to find the termination resolution. Did you find it?

Wayne Leonard: Substitutes haven't typically been eligible for benefits, that issue has never come up. But if we're paying for medical benefits for someone then there's going to be more of that employer/employee relationship, more skin in the game, so to speak. There are a lot of questions about how much are we, as a school district, going to be on the hook for in terms of medical premiums. A lot of times there's substitute shortages and we can't get subs. There's a lot of questions I'm getting around that and I'll be honest, I don't know the answers to all of those things because I haven't delved into the details like some of the other WASBO members have. That's where the questions are evolving from. If they're benefits eligible, and particularly if their benefits go in July and August, then there's no work. We don't typically want to be the Health Care Authority's collection agency if these people move away and we don't know where they are and we're still paying their benefits.

Dave Iseminger: What I'm going to do, Wayne, because you've eluded that you have a variety of questions that have come your way, I'm going to make sure that Barb Scott and Rob Parkman reach out to you to make sure we know which questions, in case they are ones they haven't received yet through their various channels --

Wayne Leonard: They may have received them already. I don't know.

Dave Iseminger: We'll at least confirm that piece so we can make sure we're answering those different questions. I know there is certainly a lot of concern from districts about the fact that HCA will send our invoicing on a monthly basis that uses the $994 funding rate times the benefits eligible individuals and expect payment for them, both the employer and employee contribution, regardless of state and local funded status. Ultimately, the requirement to collect the employee premium will be on the districts to recoup from the employees. So definitely aware of that piece, understanding that it has even more intricacies when it comes to substitute teachers. I know we've

answered a fair amount of questions about substitute teachers. I'm positive we haven't answered all of them but I'll make sure the team gets to you to make sure we at least have all the questions so we can be working through them. There'll be more iterative process with work on the Board on rules probably around substitute teachers as we move forward.

Wayne Leonard: And it's not just substitute teachers. It's all substitutes, right?

Dave Iseminger: Yes. I often say substitute teachers but I do mean generally substitutes.

Dave Iseminger shared potential agenda topics for the June 12, 2019 SEB Board Meeting.

Lou McDermott: Thank you, Dave, to you and your staff. Thank you Board Members. Thank you TVW and Mrs. Walker and her first grade class.

Next Meeting
June 12, 2019
10:00 a.m. – 2:00 p.m.

Meeting adjourned at 3:11 p.m.