

School Employees Benefits Board
Meeting Minutes

December 13, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
8:30 p.m. – 12:45 p.m.

Members Present:

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

Member on Phone:

Alison Poulsen (In Transit)

SEB Board Counsel:

Katy Hatfield

Call to Order

Lou McDermott, Chair, called the meeting to order at 8:30 a.m. Sufficient members were 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.

Approval of May 30, 2018 Meeting Minutes

Lou McDermott: Pete Cutler moved and Katy Henry seconded a motion to approve the May 30, 2018 minutes. Minutes approved as written by unanimous vote.

November 8 Board Meeting Follow Up

Dave Iseminger, Director, ERB Division. I'm going to turn it over to Lauren because these are much more technical than I usually handle at this part.

Lauren Johnston, SEBB contract manager. Slide 1 – Fully Insured Medical Follow Up. A question asked was whether there are limits on mental or behavioral health visits for

all of the vendors. There are no limits to behavioral and mental health visits within the proposed plans.

Slide 2 - Fully Insured Medical Follow Up. The Board wanted us to ask the plans to provide information on utilization management for mental health that included pharmacy. I'll go through the carriers one at a time and address mental health utilization management (UM) and pharmacy. For Aetna, they responded that they have an integrated approach that uses evidence-based medicine and is a holistic model. Around their pharmacy UM, they review misuse, waste, and abuse. They review every claim before a drug is dispensed to ensure there are no issues prior to them receiving that drug.

For Kaiser Permanente Northwest (KPNW), Kaiser Permanente Washington (KPWA), and KPWA Options, they basically have the same policies. For mental health UM, providers do not need prior authorization to prescribe, only to determine coverage for a patient. A provider could prescribe a service, but in order to determine if the service is going to be covered, there might be utilization management once they get to the coverage point. For pharmacy UM, they use a Pharmacy in Therapeutics Committee to regularly review new and existing medications.

Slide 4. For Premera mental health utilization management, they do a concurrent review that focuses on member acuity and facility utilization patterns using nationally recognized criteria. Their pharmacy UM does a concurrent drug utilization review and a prior authorization review.

Providence uses an integrated utilization management program that is contracted with Optum. Optum is a vendor that does utilization management like prior authorizations, etc. For pharmacy UM, they have UM edits that require approval from the Pharmacy and Therapeutics Committee.

Pete Cutler: Thank you very much, Lauren. This is a good, very high-level summary. But I have to admit, if I were an employee, I would not be satisfied with such a generic overview. The question would be is it possible to get detailed information for what these plans do because as the saying goes, "the devil is in the details." And that would be in this area. It would be very helpful if we had, at least, access to that.

Lauren Johnston: We do have that. It was not my understanding that you would want that kind of detail. How would you like it provided?

Pete Cutler: Well, if it could be either available sent as a PDF document in response to email, or posted where we could get it on the web. Either would be fine.

Dave Iseminger: Pete, we did get a fair amount of detail. It started to become unwieldy as we tried to put it in presentation format, so we presented at a high level. We can make sure more detail is available.

Pete Cutler: That's great. I would agree that I don't think going through the detail would've been helpful in this context. Thank you.

Lauren Johnston: Slide 5. The next question we asked carriers is if their pharmacy policies included step therapy for certain classifications of drugs and specific diagnosis codes. Aetna, for the step therapy for drugs question, their formulary does include step therapy as a standard component of pharmacy benefits. However, it does not apply to specific diagnosis codes. All of the Kaisers had the same response, which is that some drugs on the formulary are subject to step therapy, and step therapy is based on prerequisite drug therapy only, not diagnosis code.

Dave Iseminger: Just to level set, can you describe, generally, what step therapy is? I want to make sure everybody knows what we're talking about.

Lauren Johnston: I will try. I'm not a clinician.

Lou McDermott: Let's have Ryan come up.

Ryan Pistorosi, Assistant Chief Pharmacy Officer, Health Care Authority. Step therapy is a preferred medication used as the frontline medication. Once someone uses that medication, they may step into another medication if the medication doesn't work, or if there's an adverse event.

Lauren Johnston: Slide 4 – For Premera, they also use step therapy for drugs, and their policy does include step therapy for certain classifications for drugs. They use the drug utilization review to ensure cost effectiveness and safety of the member's prescription therapy. Their policy does include step therapy for specific diagnosis codes. And lastly, Providence said they have step therapy edits placed on select antidepressants and antipsychotics. They do not utilize diagnosis code step therapy edits at this time.

2019 Open Enrollment: The Vision for School Employees

Dave Iseminger, Director, ERB Division. I want to talk about where you've been and where we're going. I often describe the Board's work as a multi-chapter book. Chapter One was the orientation phase, and ultimately culminated in procurement resolutions. From October 2017 through March 2018, we were setting a foundation. The agency explained what we learned about the new school employee population that was going to be in the SEBB Program and level setting insurance concepts in the employer benefit world. Then the Board took action on procurement resolutions. That ultimately triggered three procurements by this agency that were performed over the summer.

While the agency was working on the procurements, the Board was in Chapter Two of its journey, which was developing the self-insured medical plan. That was a multi-month conversation about the values of having a self-insured plan within the portfolio. We talked in Executive Session about the financial advantages of the state's Uniform Medical Plan. That culminated in the Board passing four resolutions that set the stage for the Uniform Medical Plan offerings within the SEBB portfolio.

In Chapter Three, you refined benefits within the self-insured plans, specifically related to treatment limitations last month. This chapter really began in July and culminated last month with the multiple benefit design resolutions for medical, dental, vision, disability, life insurance, and AD&D.

Now that the Board has turned the corner of the November Meeting and has a preliminary benefit suite that we will give context to the upcoming legislative debate, we are into Chapter Four. The Board's work in this chapter will be focused on refining the final core eligibility requirements. Barb Scott talked about the detail that needs to be fleshed out on the eligibility framework.

The Board has already passed 8 resolutions related to eligibility in enrollment policies. You passed 36 resolutions between the procurement and benefit design world. But there are still ongoing topics that need to happen with eligibility. As Barb and I have described over and over, it is an iterative process when it comes to eligibility. The PEB Board is still working with esoteric aspects of the eligibility framework within its 30- to 40-page rule set. This Board, future members of this Board, and future directors of this program will continue talking about eligibility until the end of time. We're building off of the statutory framework the Legislature passed in 2017. We'll continue refining that with some key topics that really need to be in place as a foundational setting for the program launch.

The other piece that's in eligibility in this next chapter is the authority that the Board has to put some terms and conditions around the below 630 hours or the requirements for individuals who don't meet SEBB eligibility. In Senate Bill 6241 last session, the Legislature gave districts the authority to offer optional benefits that don't overlap with this Board's jurisdiction and are below the eligibility framework this Board sets up. There are foundational terms and conditions that Barb will be bring to the Board next month for action to give terms, conditions, and framework to that setting. This Board will be working on more eligibility pieces in the next couple of months while the Legislature does its work. We've described many times in the SEBB Program launch that there's a lot of chicken and the egg issues that have happened in the last year and a half. Fortunately, this Board has been able to take action in the last year to give more context for the next stages of the program launch.

For implementation, the decisions you have made are driving IT decisions and IT work that is being done at HCA in order to prepare for open enrollment. We are hoping that open enrollment will have a significant IT online experience, but not exclusively that. We know not everyone has robust access to a computer for all jobs. There will be paper options, as well. But, we are making sure there will be a robust online opportunity.

The Legislature will be in town next month and they will answer the funding question. Later today, the Governor's budget will come out, and I'm hoping by the end of the meeting I can give you a little insight. We'll have a broader discussion next month about what that proposal is. The Legislature will make its decisions during the regular session, which ends April 28. Once we know the Legislature funding, whether that's April, May, or June, the Board will enter the final chapter of refining the benefits. Once we know the final fiscal target, the agency will bring you recommendations and resolutions about refining the benefits. Then, it will be the final push on communications for open enrollment.

We wanted to talk about when school employees walk into open enrollment, next October, what it will look like and how that differs from the world they're in today. Slide 3 – Simple, Transparent, and Equitable. These are the three core concepts the agency

is using to describe the SEBB Program. We know the current system has a lot of complexities, a lot of variance. School employees can't necessarily turn to their brother and sister school employees who are in other districts and compare notes. Everybody's allocation could be different. The funding coming in from local districts that's supplementing what's coming from the state can vary. Benefit packages vary. This consolidation includes that consolidation of purchasing so there will be the similar access to plans for all school employee. Now there is an overlay of service areas, so not every plan will be available to every employee. But, there will be more consistency across the state about what plans are available to school employees.

The transparency in benefit cost is another key part. The Legislature has funded school employee benefits at \$2 billion a biennium. That was disseminated to school districts for use on benefits. By consolidating purchasing, the agency will be the one-stop for the Legislature to have accountability for how those funds are used.

The other piece that's important for transparency is what school employees will actually experience. Many of you know that there are allocation worksheets that school districts have throughout the state. You basically have to go through a form writing down the multiplier of your FTE, shopping off a list of a la cart, and eventually find out at the end if you are going to pay the district or is the district going to pay you. There'll be a lot more transparency for school employees about what exactly their costs are and the consistency of those costs over the year. Because, in the current system, a lot of changes to premiums happen either on a monthly or quarterly basis, depending on which district you're in. Through this new system, once premiums are set for January, they will stay the same for the entire calendar year.

The equity piece is in the eye of the beholder. What's equitable to one person may not be equitable to another person. When we say "equity" from the state's standpoint, it's about once individuals meet the eligibility threshold for benefits that they should have access to high quality, full benefits. Because of the way the eligibility framework is set by the Legislature, once an individual reaches 630 hours, they will not have prorated benefits. They will have full access to the benefits the state believes they should have. Those are the pieces we're focusing on to ensure there is a healthy workforce. If you have a healthy workforce, all of that's off of the table, and educators and school employees can focus on producing a quality education for children.

We are anticipating a six-week open enrollment from October 1, 2019 through November 15, 2019. For anyone who's been an administrator, November 15 is a Friday. It's much easier to end things on a weekday than a weekend, because inevitably there will be something that happens with an IT server on the last day. It's easier to have things end in the middle of the week. You also have customer service centers open for people to get their questions answered.

The agency is building an online open enrollment system. We plan to do a demonstration at the January Board Meeting. It's still in the development phase. Our IT team has been working on it for about ten weeks. What has already been built is quite impressive. Individuals will be able to enroll directly through this platform on the Health Care Authority's website with their own credentials and be able to make their plan selections and their attestations for tobacco and spousal surcharges.

The primary portal people will use is the online platform hosted at the Health Care Authority. Between now and then, we will send out communications about the benefits. We will send newsletters, mailers, and emails. We will share the communication plan at the next Board Meeting. Your Briefing Books have copies of some of the core materials produced in the last few weeks. A one-page sheet is included that shows the preliminary suite of benefits. We are going to collaborate with business officials and unions that were part of the super coalition bargaining sessions this summer. We had a meeting yesterday to talk about a communication strategy that would involve them and communicating directly with school employees. We're collaborating with WSIPC to have direct member contact information so that the agency can communicate directly with the new members. There'll be a very robust rollout of communications over the next couple of months, especially once we get past the legislative session, once funding questions are answered and employee premiums are set by the Board in approximately July.

We are also working on tools to provide a self-service option for this portal and we will be doing a lot of training. We are collaborating with the ESDs to be able to host bigger training events for business officials, and we will collaborate with the unions because they have a strong history of working with their members and helping explain benefits. They're also going to be part of these trainings so that they can help the school employees who typically turn to them. We are trying to take a holistic approach about providing support because HCA is based in Olympia and there are 295 school districts across the state. We won't have the staff to do 295 separate presentations in each of the school districts.

Slide 5 – Choices: Medical Benefits. When they are in this platform, they'll have a lot of choices. I know that's something this Board has highlighted as an important goal and strategy for the portfolio of benefits. We're anticipating there'll be anywhere from two to six carriers in counties. That includes the Uniform Medical Plan, which technically isn't a carrier. That means there'll be a range of five to 16 plan choices. If the service areas the carriers were proposing held true through next July, we would anticipate that most counties and most school employees would have access to somewhere between four and seven plan choices. On the high end, there would be 16 if the Board authorizes all of the proposed plans.

Because of the wide range of carriers in the mix, we're anticipating that approximately 90% of all physicians will be in at least one of the networks. At open enrollment, individuals can do a provider search to ensure their provider is part of the benefit they select.

Another key piece is that there will be a range of plan choices and monthly premiums. We've talked about, and the Board has coalesced around, four separate deductibles. Those separate deductibles and other out-of-pocket maximums will be part of the decision making process as subscribers select their plans.

Pete Cutler: Regarding the network coverage, do you have a sense of how soon employees will be able to check the availability of their own physician? Do you think it's not going to happen until open enrollment, which would strike me as being very late in the process given how many employees there are and how many people may be making inquiries. I'm not sure what the process or timeline is for getting that data in.

Dave Iseminger: I don't have that with me today, Pete. I agree with you that waiting until open enrollment would be too late. I know we are having conversations with the carriers and they're interested in being able to start communicating to school employees. We've said it's a little premature until the Board authorizes your plans and you have some sense of the premiums. They are asking what can they do. I told them a provider search is going to be key for people to be able to make their selections. And, whatever you can do to make your provider search engine as robust as possible, as intuitive as possible, as accurate as possible, that's going to be something that's key. But I'll bring back to the Board at the next meeting what we think is the actual timeline for when provider information will be out. I agree it should be before October.

With medical plans, I'd appreciate any feedback you have about the things that we anticipate school employees will be focusing on. They're obviously going to focus on provider network and how much their monthly premium will be. That won't be set until June or July after we go through the final carrier negotiations and bring that information to the Board. And then, what their out-of-pocket costs could be.

The last one, is the 11x17 chart from the last meeting. I've received a lot of feedback and it's been a good tool for people to describe what the benefits could look like. I think some people were hesitant to distribute it because it is not a final product. You endorsed those for purposes of rate setting. It does give a snapshot into what the general accumulators could be for the plans.

Through the Uniform Medical Plan and the Board's actions last month, there is the Centers of Excellence Program. Anybody who needs a total joint replacement will have access to essentially a free knee or hip if they choose to go to the vendor contracted with the agency. We'll be working more on this, but the financial incentives with wellness that were agreed to during the collective bargaining process and then this Board has some additional eligibility requirements.

Pete Cutler: You might anticipate this, but for the record, I continue to believe the collective bargaining statutes do not permit the agreement to go into requirements regarding reducing cost sharing or anything in terms of design of a Wellness Program, and that is actually a matter under the jurisdiction of this Board. I personally have nothing against it, assuming the Board wants to go forward with that. But, from my point of view, when I read this, there are two things you can absolutely say are going to be there, and there's a third thing that is queued up to be there. But, from my point of view, it's not a done deal until this Board votes. So, just for the record.

Dave Iseminger: So noted for the record, Pete.

Slide 7 – Affordable Medical Benefits for Dependents. During open enrollment, school employees will experience changes in the system related to the three-to-one ratio. There's been this mythical three-to-one ratio unicorn that many people have been chasing for decades. It is clear in the statute the SEBB Program cannot exceed the three-to-one ratio. This Board passed a resolution that set up the three-to-one ratio and the tiered ratio between four tiers and did not further compress and shock the system. But, from the school employees' perspective, they're going to see an overly simplified chart with four tiers that does the multiplication for them and simply says, "if you want a plan, this is what it costs for that plan. If you want to add a dependent, this is what it will

cost.” They're going to see the variance between the single subscriber tier and the full dependent tier as much more compressed than a lot of school employees have experienced in the past.

I do recognize that some school districts made strides and achieved that three-to-one ratio, but many other school districts had not. There'll be a significant number of school employees, when they see these premium charts for their monthly out-of-pocket premiums, that will have a very different experience around the affordability for those dependents. Two or three years ago when I sat in the Legislature audience on one of the bills, there were several individuals who were pouring their hearts out because of their inability to cover their family members. There was one testimony that sticks out in my mind about a woman who was pleading with the Legislature to do something about dependent affordability for school employees, because her daughter couldn't get married to her long-term partner because of their financial situation. They would have lost eligibility for other programs. They couldn't get married because they couldn't afford adding him to her school-based benefits. I'm hoping that we start to hear less and less of those stories as this program is launched and that three-to-one ratio really makes dependent affordability real.

Lou McDermott: Dave, to your point of the shock in the system, there also will be employees who have an experience of no premiums who will now be experiencing premiums. There is that side of the tale.

Dave Iseminger: Yes. I have not been in rooms where that conversation has come up from the new members. But I do understand that a lot of times, in school employee meetings when an individual paying nothing now learns they will pay something in the future, other people in the room will speak up and talk about how much they're paying out of their paychecks. I know we've heard a lot of stories from Patty and Terri about people who write checks to their school district or that benefits are 90% of their paycheck, and that has tempered some people's concerns when they realize how much some of their colleagues are paying. It is shock in the system for sure on both ends.

Slide 8 – Choices: Dental Benefits. There will be three plan choices based on actions by the Board. We're not anticipating any significant provider disruption. We're anticipating 94% to 96% percent of all dentists will be in one of the plans. We'll make sure we're clear about what the provider search engines will look like and their availability when I bring that back to the Board.

Sean Corry: Dave, I should've asked this before when you used that type of percentage. 94% to 96% of all dentists are in one of the plans. But, for a particular plan, it's quite possible that the percentage is actually much smaller than that.

Dave Iseminger: That's correct. Especially in the medical setting. On the dental setting, the Uniform Dental Plan, Delta Dental is the third party administrator. There's a fairly significant overlap between existing plans and the Uniform Dental Plan, which has statewide coverage. Would you like me to bring that breakdown back?

Sean Corry: Do we want to see that?

Pete Cutler: I think maybe we should. I have to admit, I'm somebody who's under Uniform Dental Plan now and I decided to give a hard look to the Delta Dental Care Plan and Willamette. I would, with all due respect, my choices were much more limited. As I would portray it, it's like, yes, Uniform Dental Plan gives you an extremely broad network. The other two are managed care plans. You trade off that you have a much more limited panel of providers you can go to, and in the case of Willamette, a much, much smaller number in exchange for more generous coverage. I have to admit, as a consumer, I was frustrated by the difficulty in determining -- because of course, every dental practice believes they all do wonderful work and only wonderful work and all their patients are happy. I ran out of time in terms of trying to track down some objective source of information about quality of care, patient satisfaction. And I'm not sure whether that's something that the Health Care Authority tracks, in terms of contract compliance, or whether it's something that no one's really been able to fill that gap. But anyway, it would be helpful to get a sense, because in Seattle, you'd want to have a sense of how broad is the network for Delta Care, especially in that area versus the access in the Uniform Dental Plan.

Sean Corry: And finally, Dave, even within the Uniform Dental Plan, the percentage of available dentists varies significantly by county.

Dave Iseminger: Correct.

Sean Corry: So, that 94% to 96% is one way to tell the truth, but it doesn't give me a good picture of real access.

Dave Iseminger: For vision, we brought provider maps every possible way. We'll go back and see if there's a way to bring similar things for dental like we separated it apart for vision to give more insight.

Lou McDermott: I think that speaks to making sure we have the tools available for the member to find which plan is right for them, which one covers their provider, so they can make that choice. That's really going to be a key element to success.

Dave Iseminger: All very good points. We'll work on being able to describe that for the Board, but more importantly, in anticipation for describing it to the members.

Another feature of the dental plans is that there is no employee premium that will be paid. In the allocation worksheets that school employees experience now, it's a mandatory benefit. But they actually go through the math of subtracting out the premium from their allocation. All of that will be behind the scenes now. Instead, they'll just see, I'm going to pay zero per month. These are my three plans. Pick a plan after researching the plans.

Slide 9 – Choices: Vision Benefits. Because of the Board's actions at the last meeting, we're on the road for three different plans for school employees. We have provided some very robust provider maps up to this point, but we've also challenged each of the three vendors to work on expanding their provider networks. They have an obligation to us to report back their efforts on that by the beginning of February. We'll be bringing some updated information to the Board then, We'll have a better sense as to what the fuller network looks like. They have been given the rallying cry to expand their networks

as much as possible between October through February. There are going to be a variety of retail options, online option for purchasing hardware, in addition to brick and mortar stores people can visit. Similar to dental, the member experience will be a zero dollar premium and instead focus on plan features. They won't have to do a subtraction on their allocation worksheet. That allocation worksheet will no longer exist.

The other benefits, life and long-term disability (LTD) - they won't have to take specific action on unless they want supplemental coverage. I know the Board may be revisiting the level of the LTD benefit as we go further into 2019 after the Legislature gives us the final financial target. But, essentially, they will be described what their benefit is and they won't have to take a particular action to enroll in a basic LTD benefit. Same for the basic life and basic AD&D benefits. They will have opportunities for electing supplemental insurance without medical underwriting during the open enrollment period.

They will also have the opportunity to enroll in an FSA or DCAP, as long as they don't enroll in a high deductible plan. Inevitably, we take care of all the administration on the back end. It's one of the reasons open enrollment will end in the middle of November and the plan doesn't begin until January. We go through a reconciliation to make sure employers are not facilitating violations of IRS codes. There are certain enrollment limitations. During open enrollment, they'll make their elections and we'll do clean up on the back end during the six weeks after open enrollment.

Slide 11 – School Employee Decision Making Pre-SEBB. This slide embodies what my team understands is an experience that's happening to school employees today. There is a lot of information flowing around them that stems from the local Collective Bargaining Agreement. Their eligibility may be different. They can't compare it with another bargaining unit within the same school district, let alone across school districts. The pooling arrangement can be extremely different. Their plan options are different based on bargaining and by school district. There's variability. From that flows out this allocation, there's funding from a couple of different sources. From the employee's perspective, they're basically told what this number is they can spend on a shopping menu. They go through and try to figure out what applies to them. Which things to elect? What things not to elect? What can they afford?

Premiums will even be different after their selections are made. In some instances, either the month or two months after they make their election, the variance in the pooling arrangement will result in some sort of shift in their premiums. They don't know exactly what they're going to pay. They have an estimate as to what they're going to pay when they're making their elections. On top of that, they have to take into account if their allocation is prorated or not.

Lou McDermott: Could somebody familiar with this explain to me how the premium changes during the year?

Sean Corry: I'll do it. With some of our firm's clients, there's a reallocation once or twice over a year's time. Generally, that's the limit for our clients at least. The intent, generally, in my firm's experience, is to help the districts use all of the money intended for benefits without overspending. We target for the end of the fiscal year, or with respect to the payment to the health plans, an endpoint. So we target that and make adjustments once or twice to get close enough to be able to spend all of the money

allocated for benefits without dipping into funds from the school district that weren't intended for that purpose.

Lou McDermott: So, there's no mechanism for a premium stabilization fund where you have a certain percent that's held back so you can continue to keep premiums level? You try and get to zero each year?

Sean Corry: I was trying to explain what I thought was your question, which is what the mechanism is or what the purpose of that is. I think there are some school districts that do have stabilization funds that carry over. But, it's not universal for sure.

Lou McDermott: I see. And is it small adjustments or is it significant adjustments?

Sean Corry: With our clients, they're small adjustments because the first prediction is generally good. But sometimes it's off because the exigent forces where we can't predict the elimination of a health plan, for example, and what those people will be choosing when they're leaving a health plan and choosing among others. That prediction's a little hard to do, for example.

Lou McDermott: I see. Thank you.

Dave Iseminger: There's all this complex information and decision making and this web of determining whether an employee has the adequate funding and their ability to afford different parts of the benefits package. Employees all have unique questions that the employer and the employee have to track. They have to know who is in what bargaining unit and what's their FTE. There are so many different questions that employees legitimately have because of the complexity of the system, as well as the business officials. They have to navigate all of these different financial mechanisms to understand what it is that they can afford and buy.

As we go forward, a lot of the collective bargaining pieces are out of the way. The Collective Bargaining Agreement is the same for all. It's the same financial measure. All of the pooling is done behind the scenes at the state.

Slide 12 – School Employee Decision Making Post SEBB Program Go-Live. From the employee perspective, they'll see the monthly premium they will owe. There won't be this premium stabilization or variance that exists that changes the premiums after their election. Once the Board sets the employee contribution in July, everyone will know exactly what they're going to pay starting in January for the entirety of that next calendar year. As employees go into open enrollment, they'll know exactly what their defined employee premium contribution will be. They'll be focused on those core questions without the clutter and complexity of what they can afford or how much money they have to spend on benefits. It really comes down to, "what does my paycheck look like and what can I afford for different plan options?"

They're going to be much more focused on those provider questions on what the cost shares will be. And, hopefully, getting a little bit more into those accumulators and focusing a little bit more on some of the high level aspects of design rather than having to get over the hurdle of understanding their allocation before they can even get into the benefit design. That simplification, hopefully, will make this a better experience.

Patty Estes: I can tell you, as someone that has gone through the chaos of not having anything before moving into the PEBB Program, which I'm guessing that transition's going to be a little similar for a lot of people. It was so simple that it was confusing [laughter] because we were so used to having to figure all of these other aspects out before we could actually look at just simply, what plan do we need?

Because we were, "wait, don't I have to worry about pooling?" No, you don't have to worry about that anymore. We were expecting to have to worry about things that were not even remotely on the table anymore. I know I went back and forth with the PEBB Program people quite often, trying to figure out what I was going to do.

Dave Iseminger: You were looking for where the other shoe was going to drop because you thought you were missing something.

Patty Estes: Yeah. That's from a member standpoint, it's going to be a big shock to not have to worry about any of that.

Dave Iseminger: But hopefully a welcome shock.

Patty Estes: Yes. And now that I've been through it, it's way easier to explain and help other people with picking plans and figuring out, "well, this is how we're going to do this." Even comparing plans from the options we have now to the options we had before, that transition was easy but eerily easy.

Lou McDermott: What I'm hearing though is that, in our communication plan, we have to be ready for people who are going from a very complex system to a very simplistic system. We need to make sure to articulate in such a way they don't look for the hidden machinery that doesn't exist.

Patty Estes: "Where's the fine print?"

Lou McDermott: Okay.

Pete Cutler: When some pension changes were put through, I know there was a strong undercurrent of, I don't know if paranoia's the right word, but just concern of, "what are you not telling us? What are you hiding from us?" "What's your real motive?" And so, trying to keep communications as transparent as possible would be helpful.

Katy Henry: I also think that most districts have a streamlined process that most employees are used to having gone through for years and years. We will be butting up against that known entity. I think ensuring districts have all the tools they need, and their employees, who are typically running them, are well informed, will help it go much smoother.

Dave Iseminger: On the dental and vision side, there isn't even that question about affordability. They won't even have to subtract from the allocation worksheet. It'll just be, "what benefit do I want?" because it's fully paid for by the employer.

Slide 13 – Allocation vs. Contribution. On the left-hand side, it's an illustrative example of an allocation worksheet that staff found from this past open enrollment. It takes you

through this math formula: what's your FTE status times a specific allocation? That's what your contribution is. Put that in line A, subtract line B, leave line C. Go over to this page, put this in here, subtract C to get to D. And, at the end, you go down to the bottom and is it a positive or a negative number? "Do I write a check or does something come out of my paycheck?" And then, at the end, there's that kind of asterisk for medical premiums. After open enrollment, local pooling funds could change and your monthly premiums might differ from what was used in your decision making tool.

In the future state, you'll have one 8 ½" by 11" page. I just showed Tier 1 and Tier 4. You'll have your medical plans and a chart that explains what your monthly premium will be based on who you're enrolling. You will dive into, just like in the current system, into other plan information to go, "what is the differences between A, B, and C?" And we'll have comparator charts like we brought to the Board last time for different benefits. From a financial framework, you're not going to have to do all that math. Instead, you're going to go to this chart and determine what you want and whether you can afford it. That's the number I'm going to pay. Can I add my kids? I can afford 1.75, that's the plan I'm picking.

It doesn't involve as much math, so to speak. What that leads to then is, in addition to folks on that premium chart, there's the original two questions that were on a prior slide. They're going to focus on the provider search engine and making sure their provider is in their network, and then some of those high-level accumulators, the deductible and the out-of-pocket expenses. I understand one of the challenges some school employees have at this point is, they have to do that allocation worksheet multiple times. They have to do it for themselves as an employee only, and then they do it for their dependents. And so, they're really going through that math multiple times.

Whereas in the future state, they'll see the monthly premium, see it multiplied out on the chart and go, "Okay, \$25 or \$37.50. Can I afford \$37.50? That's the plan I want and they enroll themselves and their dependents. Looking only at the employee contribution really is a seismic shift for the member experience.

That's what we're anticipating for open enrollment, focused on an online experience but knowing that we have to have a paper-based backup system for employees who don't have as much access to computers in their day-to-day work or at home. And then, making sure we're describing differences in the financial aspects in making it simple to understand. Addressing those issues and really having employees focus on those provider searches and those key features of the benefit plan.

Slide 14 – Milestones. How do we get there in the next nine to twelve months. Today the Governor's budget comes out. We have kicked off the formal not-to-exceed rate negotiation process with the carriers. We've had some conversations with the six of them over the last month. Their access to data to be able to start working on rates begins today. We will be going back and forth with the carriers over the next two to three months. We're to deliver refreshed financial modeling to the Legislature at the beginning of March, along with some other information that the agency provides for budgetary purposes as they get the March revenue forecast, so that can be the most up-to-date information as the various chamber budgets come out, as they march towards the end of session and passing an operating budget.

The real key part was this Board in November endorsed moving forward different plan designs for rate development. We'll work on rate development and bring that to the Board and to the Legislature during the legislative session. Once the Legislature makes it's final decisions, we'll bring back information to the Board in May, June, or July for working on refining benefits and setting the final employee premiums. That work should end in late July and we should have about 60 days to finish the end of the communication push into open enrollment.

Open enrollment will begin on October 1. We'll do some cleanup and move into the administrative launch. We think of this program launch at the agency in two phases. There's the October 1 open enrollment member-facing phase, and the go live for the administrative services that begin January 1, 2020. Between now and then, we'll do the final execution of contracts with all of the carriers. We will be completing the IT build for that front-end enrollment system that we'll be offering for school employees. We're anticipating that that will be completed in the late-April, early-May, and that will be when we are able to kick off the formal training with ESDs, business officials, and unions so they are able to go out and support school employees once open enrollment happens. After the budget is enacted, but before premiums are set, we'll have the refinement discussion of benefits with the Board.

Sean Corry: I have a question that I think can't be answered now. I was in a meeting yesterday where the general budget was discussed. The context was that basically the ask among people around the state and organizations was well over a billion more than what the budget's going to be able to afford. So, the discussion yesterday was we're going to have to be careful about what we ask for and keep our expectations reasonable with respect to a limited sum of money. So, that in context, we'll see the Governor's budgets, which is not, of course, the final budget. I don't remember having a conversation here about the possibility, maybe not the likelihood, but the possibility that the funding to K-12 benefits as determined as hoped for by the bargaining numbers that occurred a couple months ago is actually going to be the number. What are we going to have to think about? And this could be a question for an answer on another day. But what are we going to have to think about if the funding is not what was originally proposed through the bargaining agreement?

Megan Atkinson, Chief Financial Officer. Sean, I was going to mention this at the beginning of my presentation, so, great lead-in. The process in collective bargaining is obviously this last summer the state had negotiations with the labor union coalition. That tentative agreement was submitted to the Office of Financial Management (OFM). The next step in the process is for the Director of OFM to certify the Collective Bargaining Agreements as financially feasible. That was done earlier this week. There is a letter from the OFM Director, actually for all the bargaining agreements, but including the SEBB bargaining agreement that they are deemed financially feasible.

Since that determination has been made, the Governor will include funding for the bargaining agreement in his budget, which we'll see later today. The Legislature has a binary question in front of them. They can approve funding the collection of bargaining agreements, or they cannot fund and turn the bargaining agreement down. They cannot tweak the bargaining agreement. If they turn it down, we end up going back to the table. In the past, there have been times when the Legislature has turned down an agreement and offered a certain amount of money and sent everyone back to the

bargaining table, or they've provided other direction. There are questions about the legality of that, but it has happened in the past.

There is a provision in the bargaining agreement to get the state and the unions through the first year, even if we're renegotiating the bargaining agreement. I don't have the agreement in front of me and I can't remember the exact language.

Dave Iseminger: Essentially, the part of the Collective Bargaining Agreement says that, if the bargaining agreement is funded but yet there are still some other things that are changed that could be potentially impacting the bargaining agreement, the launch of the program can go forward. And then, we would go back to the table to negotiate the impacts of those changes that the Legislature made, while simultaneously negotiating potent impacts to the second year of the bargaining agreement. There's this clause that allows the status quo that was agreed to for the launch. Then we're back at the bargaining table to talk about the impacts of any legislative changes next summer rather than waiting two full years until the next cycle of bargaining.

Pete Cutler: I just wanted to confirm that is specific to the K-12 health benefit contract.

Megan Atkinson: Yes.

SEBB Program Financial Terms

Megan Atkinson, Chief Financial Officer, Financial Services Division. Before getting into the sides, I want to make a couple of notes. With the bargaining agreements being financially feasible and the Governor's budget out today, if we're able to have any materials pulled and available, I'll disseminate stuff back to you. But again, with the OFM Director deeming the bargaining agreement financially feasible, we expect it to be funded in the Governor's budget.

Dave Iseminger: We will make a presentation on the Governor's budget in January.

Megan Atkinson: I also wanted to do a some financial staff housekeeping. Unfortunately, Kayla Hammer, who you've met and worked with before, accepted a really great opportunity with the Senate Ways and Means Committee. I always hate to lose staff, but it is a great opportunity for her and we wish Kayla well in her work with the Legislature. We have already added to our staff. We recently hired a great fiscal analyst from Florida, Grace Fletcher. I don't think you all have had a chance to work with her yet. But she and Kim are a really great team and I know we'll be fine, even with Kayla's departure. In addition, we are teaming across the PEBB finance people and the SEBB finance staff, because there's a lot of intersection of the two programs. Don't be surprised if sometimes we end up with a slightly larger team at the Board table.

Slide 2 – Purpose. We will define and describe financial terms. The five terms we'll discuss are: the funding rate, K-12 benefit allocation, K-12 benefit allocation factor (BAF), the Employer Medical Contribution (EMC), and the employee premium contributions.

Slide 3 – SEBB Program Funding Rate. This is a critical number and we'll be using it a lot. It'll be important to the K-12 districts and employers. It's the per subscriber amount we will invoice and the employers will pay for each SEBB benefits-eligible employee.

That includes those who waive medical benefits. As a reminder, the reason that we collect a funding rate, even when an employee waives, is because the funding rate calculation has already taken into account an assumption about a certain percentage of benefits eligible employees waiving their coverage. Even if we didn't do it with this methodology, even if we used a methodology where we only collected for people who elect coverage, we would still need the same amount of money. The reason we do it this way is so we collect a slightly lower amount of money across a larger pool of people so we don't inadvertently create an incentive for an employer to withhold benefits from someone who actually is eligible. This is what we do in PEBB and the way we'll do it here.

Currently, the K-12 benefit allocation we're used to seeing in the budget bill is calculated on a different base and with different methodology than the funding rate we will use for the SEBB Program. We really encourage that we not try to do a comparison of the two statistics. Currently, I think the K-12 benefit allocation is in the \$800s. I think it's \$850 or something like that. The numbers we've been using throughout the summer are a SEBB funding rate of about \$1,100. So, very different, but the statistics, again, different eligibility, different benefit package. They're very different statistics and you really can't compare the two.

Slide 4 – K-12 State Insurance Benefits Funding. In aggregate, this is the funding the state will send to school districts for health care. These will be in the budgets in the K-12 section, the education section. It's based on a prototypical school funding model. It largely uses enrollment projections to produce a number of state funded FTEs. In addition, we take the benefit allocation factors, the BAFs, and apply those to convert this FTE base to a headcount base. We calculate those at the state level. Those are specified in the Collective Bargaining Agreement.

For state funded classified staff, we have a factor of 1.43. For state funded certificated staff, a factor of 1.02. You may be remembering some of the conversations we had this summer. OFM has done these calculations and the insight that we got and then we all, went, "Of course it's that way," is that big difference between the factor used for classified staff versus the factor used to certificated staff. What you're seeing in classified staff, where districts have a little bit more flexibility around the educational model because they're not tied to classroom size requirements, that factor is larger. You're seeing the district hiring practices of using more than one person on what otherwise would be a single FTE slot. The resulting staffing values are multiplied by the funding rate. We typed out the formula here. It's really very simple. It's the number of generated FTE times the BAF times the funding rate. In aggregate, that results in hundreds of millions of dollars being driven out to school districts for health care benefits.

Pete Cutler: First of all, I mean, in terms of the difference in the ratio, I assume part of the factor is that there are a lot of classified functions, bus driving, for example, that don't logically involve a six- or seven-hour day. It makes sense, efficiency-wise, to have them part time. The other thing is, if I understand correctly, the result of this is every school district, their allocation will be based on the same 1.43, let's say, for the classified employees. It doesn't matter whether from past practice they have hired a whole lot of part time people or only a few. It's an average number. So, therefore, in a way, you'd have winners if you have districts that got by with more part-time positions

where there's less gap between the FTE and a headcount than districts that have a higher than average ratio of part-time people. They're going to have to figure out how to work with that. It'll be their issue to manage rather than something that's considered a basic education responsibility by the state. Thank you.

Megan Atkinson: Pete, you do raise a good point, and one that we wanted to clarify on the slide in one of our various edits as we got ready for the Board meeting. Those two factors are calculated at the statewide level. It wasn't calculated and we don't have a breakdown by district. I can't tell you what the variability is across the districts in the state. Obviously, we all know that each district does their educational program a little bit different. I would expect some variability. To Pete's point, some districts could win with these factors and some districts could lose with these factors.

Wayne Leonard: I probably have a bit more knowledge than most of the Board Members about some of this prototypical school funding model. But, like a lot of my members, a lot of the business officials are still estimating that going in the SEBB Program is going to cost their districts a significant amount of money above and beyond what the Legislature will fund. Some of it is related to other factors. For example, in many, many school districts, maybe 20% to 25% of their funding is categorical funding through federal grants or whatever. There's no additional funding for SEBB in those programs. That's correct?

Megan Atkinson: Correct.

Wayne Leonard: A lot of those programs are there to serve students in poverty or special needs students. This increase in costs on those programs will have a significant impact. I'm not sure the Legislature's aware of that. Because, if the costs aren't funded, there will be fewer people working in those programs.

The other thing that I don't think this is going to fund is potentially all the new employees that would become eligible under SEBB. We've talked about that a little bit before. My concern, for example, is certificated and classified substitutes that have historically not been covered by medical insurance. When I looked at my data in Mead School District, potentially, I could have another 100 people qualify for medical benefits, which would be an additional \$1.4 million that I would have to find. When it's presented like, "well, you're going to have these great benefits and the employer's just going to pay the full employer allocation," that's true. But the employer may not have money to pay for this. That's going to potentially result in a lot of layoffs and other program adjustments around the state, which I'm not sure is being fully appreciated by the Legislature.

Megan Atkinson: I'm not a K-12 funding expert. I don't want to get myself into an area where my ignorance quickly becomes apparent. When we go into the legislative session this year, these granular issues around how the state's education funding covers or doesn't cover the staff districts have on the ground, I think will definitely rise up. From our perspective at the Health Care Authority, we're focused on the funding we need to run the benefit program. One of the things we have talked about, what is the total universe of the staff, the substitute issue, part time coaches, all of that. I think it will be very interesting. That sounds sort of a weak word, but sort of very interesting to see as we end up going through our enrollment period, as school districts apply the eligibility criteria, really how many people come in under the umbrella of the SEBB

Program and how that compares to what is recognized in the state funding. Again, I want to emphasize what I'm walking you through now is the state funding, so the state recognized staff.

Lou McDermott: Wayne, I'm curious on your modeling you did. Did you take into consideration the BAF going to 1.43?

Wayne Leonard: Yes. That benefit allocation factor jumping up is helpful. It's a lot higher than I thought it was going to be. But, since that only applies to the state prototypical school funding model, the generated staffing units, it doesn't --

Lou McDermott: It had some dampening effect, but not --

Wayne Leonard: Yes, it had some dampening effect, and typically, districts that have operated with full levies have more staff and impacted negatively under the new school financing model.

Districts that got more federal grants based on high poverty or based on students with special needs, could raise their levies even more. Typically they hire more people to work with that population of students. None of those programs are receiving additional funds. They're going to be impacted more negatively than other districts. It's not an equal impact across the state, from district to district.

Lou McDermott: And from your perspective, the higher negative impact will occur in areas that have larger issues with poverty and special needs students because they're receiving more dollars and that's not taken into consideration?

Wayne Leonard: Potentially. And those programs aren't receiving additional funding for employees' health insurance. They typically have more employees to work with those children, too.

Lou McDermott: Okay, thank you.

Megan Atkinson: I should point out that the current staff multiplier is 1.15. This is a significant increase for the classified staff side. But Wayne's point is well taken.

Slide 5 – SEBB Program Employer and Employee Contributions. Per the Collective Bargaining Agreement, the employer and employee medical premium shares will be calculated using an employer medical contribution or an EMC. This is a difference in the SEBB Program calculations than how we do it in the PEBB Program. For those used to the PEBB Program world, this is a different way of calculating the employer and employee medical premiums. So, the EMC is set to be equal to 85% of the monthly premium for the UMP Achieve 2 plan, or our self-insured plan, with an estimated 88% actuarial value. The employee will pay the difference between the EMC and the monthly premium, but they will pay no less than 2% of the EMC.

We're doing a benchmarking methodology where we're benchmarking off of one of our self-insured plans, the 88% AV plan. Doing the employer/employee split at an 85%/15% split. This methodology is called out in the Collective Bargaining Agreement. We do have some modeling we've been using this summer and some numbers, again,

that I'll walk you through in a little bit. We don't have final bid rates. These numbers will change a bit, but the methodology and the percent split won't change.

The other point that I want to make on Slide 6 is that our premium tier ratios you approved will be used and applied for the premium contributions. Both the employer contributions and the employee contributions will benefit from the tiering ratios. I think that's a departure from what some school districts and some school employees have experienced. So, that employer contribution set on the employee-only tier is then multiplied by the tiering factor so as an employee enrolls more family members and the premium goes up, the employer contribution increases and the employee contribution increases. That 85%/15% split remains, and then the benchmarking off of the 88% AV plan remains as well as you move across the tiers.

Dave touched on this already, but dental, vision, basic life and basic long-term disability, the employee will pay zero. Or said differently, the employer will pay 100% of the monthly premiums.

Slide 7 – SEBB Program Funding Rate Dates. This table shows how we build up the funding rate. These numbers are based on modeling used during the summer. They do not reflect final bids because we don't have final bids. They also do not reflect a legislative action. Don't fall in love with these numbers, they illustrate the way the math works. The employer medical contribution at the first row in the blue, the modeling that we used this summer showed it's \$616 per month. We multiple that by a ratio of adult units to subscribers. That's estimated currently to be 1.586. What all is in that number? It's a kind of important ratio. It is our assumptions around family mix. It's our assumptions around the percentage of the population who waive their coverage and the dependent mix, which we'll use family mix. But all of that is in that number.

Pete Cutler: Do you know how that compares with the mix in PEBB?

Megan Atkinson: We're using PEBB to inform this. I don't know if that's exactly the same ratio.

Pete Cutler: But some were similar. Thank you.

Megan Atkinson: Literally, if you multiply this \$616 times the 1.586, you'd go down and get the \$977. From there on, everything is on a PSPM or a per subscriber per month basis. We change the base there a bit as we go through the math and then get to a number that's used in budgeting. The medical premium contribution ends up being \$977. You see here the employer fully funding dental, vision, basic life, and basic LTD. We have an assumption around the K-12 remittance, which we have to continue because we still have K-12 retirees in a PEBB risk pool versus having the SEBB actives in the SEBB risk pool. We still need that K-12 remittance for a little bit longer. We have admin and other costs. In that last line, we've got another footnote there on that \$16. This modeling assumes repayment of the general fund state loan. That's the loan we're using for operating funds right now. Depending on what level of admin funding we have in the Governor's budget, that number could change. This is the modeling and the numbers used this summer. We will have updated numbers once we see the Governor's budget and once we get through final bids. Then further updated numbers possibly with a final legislative budget.

Pete Cutler: Two questions. On paying back the general fund state loan, do you know off the top of your head roughly how much the \$16 is associated with that and how long? Is that a two-year period, four-year period, six-year?

Megan Atkinson: I don't know how much of the \$16 is the loan repayment. I know that we have about \$30 million to repay. I think it was about \$26-\$28 million. We assume that we get it repaid in that first biennium.

Pete Cutler: Oh, just a one biennium.

Megan Atkinson: It's a one biennium repayment. As we were building up and assisting OFM with building up the Governor's budget, we had one of these "that's funny in hindsight" moments where we realized that we wouldn't have K-12 district employer contributions coming in until January 2020. But we would need to operate the program July 2019 through December of 2019; and thus, we needed a second general fund state loan to cover those six months. Again, that \$26-\$28 million that we have for the current biennium, we do have a request into OFM that we needed a second general fund state loan to cover those first six months of the next biennium. I know that \$16 doesn't currently reflect reality.

Pete Cutler: We can hope that maybe somehow the cost will be forgiven or spread over a longer period of time and that might free up some dollars for better long-term disability benefit or something similar.

Megan Atkinson: I think your point, Pete, is that it is important as we're comparing our SEBB numbers to the current K-12 allocation as well as if we end up comparing SEBB to PEBB. In the initial biennium, we will have a fairly substantial general fund state loan to repay. That will impact the SEBB funding rate. It's important to keep that in mind.

Pete Cutler: A second topic area, the K-12 remittance, dealing with the cost of retiree coverage. Am I correct that HCA's going to be sending a report to the Legislature sometime this month about the funding?

Dave Iseminger: Literally, we're supposed to send it tomorrow. We plan to discuss this report at the January meeting.

Pete Cutler: If it's official delivery to the Legislature, I assume that makes it public and can we get a link to it or something?

Dave Iseminger: A number of people are interested in that report. We post all of our legislative reports on the HCA website. We'll send something out to the Board that has a link to that report in particular.

Pete Cutler: Great, thank you.

Megan Atkinson: Slide 8 – Illustrative Example: Employer Medical Contribution (EMC) and Employee Premiums. Don't fall in love with these numbers on this chart. They are for illustrative purposes. Look at the columns left to right. This is a hypothetical suite of plans. It shows you how the employer medical contribution, which is the green

highlighted row of \$616. The \$616 is the number we were using in modeling this summer in bargaining. But, again, we don't have bid rates so these are estimates. You can see how, as you move across the tiers, then let's just take this first one because it's the easiest one to go across, the employer contribution. In the employee only tier, you see the \$616. You move across to the employee and spouse or partner tier. Then it becomes \$1,232. Again, it's just the math. So, it's just the \$616 times the tier ratio. And up at the top, we've got these tier ratios in the shaded gray area. So, the \$616 times the two. That gives you \$1,232. And then, as you just keep moving across, the times the 1.75, times the 3.0. So, you can see the employer contribution is growing as you move across the tiers. The math is really straightforward. With the example at the employee only tier, the plan A with a 90% AV. If they have a premium of \$775, the employer's contribution is the \$616. You just do the math and you end up with the employee contribution of \$159. And then again, of course, if you move across the tiers the total premium, the employer contribution, the employee contribution, those all grow because you're multiplying all of them by the tiering factor.

We did highlight the SEBB UMP Achieve 2 showing the benchmark plan to where the math should work out to where the employer contribution, the \$616 is 85% of the \$725, that illustrative premium rate there. So, again, this is just to illustrate how the math will work. Should I mention these aren't the real numbers? But hopefully they are close.

[break]

Pharmacy 101

Molly Christie, Strategic Plan Project Manager, Benefit Strategy and Design Section. Today's presentation is a brief series we're doing in the 2019 Board season discussing the pharmaceutical industry and prescription benefits.

Slide 2 – Preview. In today's presentation, we will examine national prescription utilization and spending focusing on the specialty drug trend. I'll also touch on strategies drug manufacturers use to promote costly brand drugs.

Slide 3 – Prescription Drugs Are on Everyone's Agenda. In 2018, at least 45 states considered more than 1,140 measures on prescription drugs. I plan to cover some of those strategies in a future presentation, as well measures our state has been looking at. There were 160 new laws signed just last year in 44 states. Drug policy is likely to be a major federal issue. In the upcoming Congress, health care was one of the biggest concerns among voters in the recent midterm election.

Slide 4 – About 6/10 Americans Report Currently Taking at Least One Prescription. A lot of people take prescription drugs. In the most recent Kaiser Family Foundation health tracking poll, six out of ten respondents reported currently taking one prescription, and 25% of Americans say they take four or more. This is not a bad thing. This is helping keep us healthier longer. For instance, prescription drugs help many Americans with chronic conditions live healthy lives. More than half of the growth in prescription volume in the last five years has gone to treating common chronic diseases including hypertension, mental health, and diabetes.

Lou McDermott: I'm sorry, that number's pretty staggering. Does the data take into consideration kids because a lot of kids don't take medication. Is the number even worse or are kids excluded from that?

Molly Christie: I will look into the methodology. I remember seeing that it was American adult, but I'll confirm that and get back to you.

Lou McDermott: Okay. That makes me feel a little better.

Molly Christie: Slide 5 – Keeping Us Healthier Longer. The world's population has a longer life expectancy than ever before in history. This can be attributed to breakthroughs in modern medicine. In fact, 2035 will be the first time in US history that Americans over 65 as an age group are expected to outnumber children under 18. It's a huge shift in our population demographics. This aging population was the primary driver of prescription utilization between 2012 and 2017, people aging into that 65 and over group.

Slide 6 – The US Spends a Lot on Prescription Drugs. Most good things are not free. I'll caveat this slide and say it's to provide an illustration for some big numbers and to provide context. It's not a value statement. I'll let you decide your own value and opinion. Our country does spend a lot of money on prescription drugs. In 2017, our prescription spending outspent the Gross Domestic Product (GDP) of Norway by more than \$60 billion. That same year, gross prescription spending was about half of what we spent nationally on Social Security. The trends in prescription spending are expected to continue to outpace growth in total health spending through 2026.

Slide 7 – Particularly Compared to Other Health Services. Furthermore, prescription spending is surprisingly high compared to other health services. For a typical commercial health plan, almost 25% of a member's premium dollar goes to prescription drugs. That's more than any other category measured in this study, including hospital stays, doctor services, in-patient, and out-patient visits. This spending is high and it's rising, largely because of extremely expensive specialty drugs. For example, ten years ago, specialty medicines accounted for about a quarter of total pharmacy spending nationally. Today, they contribute about 47%. At the same time, specialty drugs represent only 2% of prescriptions dispensed.

Slide 9 – Specialty Drugs Bring Exciting Innovation. What are specialty drugs? They are breakthrough therapies that treat, and sometimes even cure, life-threatening or debilitating diseases. A specific example you may have seen on the news is about hemophilia and a potential cure on the horizon. Hemophilia is a genetic disorder that prevents proper blood clotting. For people with this disorder, it can be extremely painful and even minor injuries can cause life-threatening bleeding. Most people require constant injections to replenish blood clotting factors. On average, these medications cost \$270,000 annually. There are about 20,000 people in the US on these drugs. But the good news is that recent research has demonstrated in mice that hemophilia could potentially be treated for life with a single injection. This new specialty treatment could be available in the next few years. That's an example of a specialty drug.

There is no common definition. Health plans come up with their own definitions based on different characteristics. But there are some very common characteristics that most

specialty drugs have. They're more likely to treat complex or rare diseases. So, for instance, many specialty medicines are considered orphan drugs by the FDA, meaning they treat a condition that affects fewer than 200,000 people nationally. Furthermore, specialty drugs often require one-on-one patient education and counseling, as well as special oversight by your doctor. They're often developed from living cells. These are called biologic medications, which require special handling and administration, oftentimes that's in the hospital through an injection or infusion. Specialty drugs are extremely costly compared to traditional drugs. They can average ten times the cost of traditional medications.

Part of this high expense is because most specialty drugs don't have generic equivalents. The FDA grants patents to drug manufacturers when they create a new drug. They have exclusive marketing and manufacturing rights. But oftentimes, those patents on average last 20 years. There are mechanisms that drug manufacturers can use to extend the life of those patents. Generics, on the other hand, are comparable to brand-name drugs in quality, strength, route of administration, intended use, all the things pharmacists look at when deciding what type of drug is appropriate for treating certain diseases.

Lou McDermott: Ryan, is it fair to say they have the same sort of active ingredients but there may be some differences in how it's put together with other compounds?

Ryan Pistori, Assistant Chief Pharmacy Officer. You are correct. Generics have the same active ingredients and approved by the FDA. They are the same in terms of their variability, so when you take a medication and the medication starts to work in your body, that generic works the exact same way. All the pharmacodynamics, all the pharmacokinetics need to be similar enough that they would produce the same effect. They are interchangeable.

Molly Christie: Thank you, Ryan. That's exactly what I was going to say. [laughter]

Slide 10 - ... And Enormous Price Tags. In the past 12 years, average spending for specialty claims in employer health plans has grown four-fold. Pricing for these specialty drugs is based on what manufacturers think the market will bear. There is no complex process to pricing drugs. For example, the drug manufacturer Novartis has hinted that it might charge \$4 to \$5 million for a new gene therapy that treats type one spinal muscular atrophy. This is a rare genetic disease, oftentimes fatal, that affects about one in 20,000 toddlers. A single dose of this new medication could potentially prevent the disease if given shortly after birth. It would also be the most expensive and would set the record for the most expensive drug in history.

Slide 11 – The Specialty Drug Pipeline Shows No Sign of Slowing. Drug manufacturers are allowed to do this. They can set whatever price they choose for new drugs they develop. There's no limit for how much they can increase the price of a brand-name drug that they have a patent on. For example, the price of EpiPen rose from \$100 in 2007 to \$600 in 2016. There's no sign that we can see the specialty pipeline is slowing any time soon. Over the past 12 years, the number of specialty drugs approved by the FDA has almost tripled. Breakthrough specialty drugs may be available by 2022 that treat certain types of cancer, blindness, hemophilia, Alzheimer's disease, and certain neurologic diseases. This list is not comprehensive. There are more.

In 2017, there were over 35 specialty drugs approved by the FDA. Included were, the first medicine to treat all forms of Hepatitis C and CAR-T treatments, which engineer a patient's own immune system to fight cancer. In 2018, we're continuing to see new specialty drugs, such as a new class of drugs to prevent migraines and multi-drug resistant HIV.

Slide 12 – Manufacturers Spend Billions to Advertise Brand Drugs. Generics are usually substantially less expensive than brand-name drugs. For this reason, drug companies spend a lot of money on advertising and promotion to encourage brand loyalty by patients and prescribers before their drugs go off patent. These lower cost generics become available. In 2015, drug companies in the US spent \$5.2 billion on direct-to-consumer advertising, which is up more than 60% since 2011. The United States and New Zealand are the only countries in the world that allow direct-to-consumer advertising for pharmaceuticals. In the US, these types of drug ads are one of the largest growing categories of advertising on TV. Drug manufacturers also target physicians to help sell their products. They use gifts, samples, and other forms of direct payment. In 2015, physicians received \$7.33 billion in payments as gifts or for speaking on behalf of specific brand-name drugs. Globally, nine out of ten of the biggest pharmacy companies spend more on advertising than they do on research and development for new medications.

Slide 13 – All of This Advertising Encourages Brand Use. These marketing tactics are effective. That's why they use them. Studies have found substantial effects of advertising on brand-name drug utilization. You may have talked to your doctor after you saw an ad or you know someone who has. In the Kaiser Family Foundation poll that I mentioned earlier, 14% of people admitted to talking with their doctors after seeing or hearing a prescription ad on TV. In over half of those interactions, doctors prescribed that brand-name drug.

Lou McDermott: The thing that's interesting, when I watch those commercials, some of them don't even tell you what the drug treats. They're getting to the point where they say, "this drug's amazing," and leave it at that. They don't tell you what condition it treats. They tell you that little thing at the end about all the side effects, death being the top one. So interesting.

Dave Iseminger: And don't take it if you're allergic to it. That's my favorite part of the commercials.

Molly Christie: Interestingly, there have been studies showing that the long list of side effects actually helps improve the credibility of the drug because people think if all of those things could happen, it must be really effective. Nothing good comes for free. That's an interesting phenomenon.

To your point, Lou, drug advertisements can be very overwhelming and misleading to consumers. Drug companies don't have to spell out exactly how the drug works. They don't have to mention the cost, or note if there's a generic or another drug in a similar class with less risk. Drug ads can also encourage people to request high-cost brand-name medications when lower cost generics are available. Doctors often don't know

whether there's a generic medication available or what the price difference would be if there is a generic available. They want to treat your illness.

Drug advertising does impact physician prescribing practices. There have been medical centers across the country that have restricted promotional activities by drug manufacturers. They've found that doctors who are not exposed to these promotions actually prescribe less of those promoted drugs. Health plans, in response to this, encourage their members to select lower price drugs by requiring greater member cost share for the higher priced drugs. Manufacturers in response, provide copay coupons and waive the cost share or a large part of the cost share when you go to the pharmacy. You can get copay coupons online. Sometimes you might get them directly from your doctor.

You give the coupon to your pharmacist and your copay that's been set by your health plan is either reduced to, say, \$25, or it's reduced to zero. The drug company is picking up the cost that you would normally pay. However, at the same time, the health plan is still paying their percentage of the cost of that drug. The health plan can't see on their end that you've paid zero of your cost share. You get the drug you need at a lower out-of-pocket cost, and it counts toward your deductible. However, your health plan is still paying more than they would be paying if you chose a generic version. This can lead to increased premiums for all members on that plan because the total cost to the health care system is higher than it would otherwise be if you had chosen the generic.

Estimates suggest that at least half of drugs with copay coupons have generic equivalents, or close generic substitutes, at a lower price. Copay coupons are also used in 42% of all specialty prescriptions. Most specialty drugs don't have generic equivalents. These are helping people that don't have any other option. However, 18% of all brand-name prescriptions with generic equivalents are filled through commercial medical plans.

Lou McDermott: Molly, as we go through subsequent presentations, are we going to talk about strategy plans used to combat that?

Molly Christie: Absolutely we are, yes. Slide 15 - ... And the Impact Can be Significant. This does lead to a lot of additional spending. There was a study in 2016 that looked nationally at 23 drugs that had copay coupons, which led to \$700 million to \$2.7 billion in additional spending over a five-year period.

Slide 16 – Key Takeaways. A rapidly aging population and a high prevalent of chronic conditions means prescription utilization is not expected to decrease. It will probably continue to increase.

Specialty medicines are bringing promising breakthroughs but also extremely high prices. The specialty drug trend is the primary driver of prescription spending, both nationally and for employer plans.

Drug companies spend a lot of money on promotion and advertising to ensure brand-name loyalty over generics. This is not always at a benefit to patients or to the health system.

As I mentioned earlier, this is the start of a series of presentations on pharmacy. In January, we're going to talk about UMP pharmacy trends specifically so you get a better sense of what it looks like for large employer plans in Washington. In March, we're going to discuss strategies that employers can use to manage pharmacy spending to address some of these issues that are presented in this presentation.

Pete Cutler: Can I guess that the PEB Board is also having briefings and going into background on these topics?

Molly Christie: Yes. We are going to be covering similar topics in the PEB Board Retreat in January and during the next PEB Board season as well.

Pete Cutler: Prescription drugs are addressing chronic conditions tend to be used more by folks who are over 60, most of whom are retirees in the PEBB Program. That's what seemed to me a place where you'd be feeling a lot of pressure in terms of cost trends. But, since the question of how that retiree's coverage would be funded long term, it would be very helpful for this Board to stay on top of it for that group.

On a second point, it seems like we have two distinctly different types of drugs that are significant cost drivers. One of them is the specialty drugs. In a nutshell, the drugs are generally agreed to be addressing some of major medical condition, so adding value. But, for whatever reason, are extremely expensive in part because the cost of developing or marketing the drug can only be spread over a relatively small number of patients.

The other group are brand-name drugs where companies are doing their darnedest to insulate the patient from having to pay for choosing a much more expensive brand-name drug when they have a generic option that's presumably just as effective. The only entity that benefits from them picking the brand-name drug is the company that sells the brand-name drug. It seems like both issues need to be looked at, but the strategies in dealing with them are going to be different.

Molly Christie: Absolutely. I think that's spot on. The strategies around the specialty drug trend is getting into volatility and what we saw in 2015 with Hepatitis C. It just spiked. Those strategies are probably going to be on a federal level. There is less that states or large employers can do to manage that. What we're seeing them do is take more control of their plan to try and make sure they're getting the best value where they have the control to do that within their sphere of influence. We're doing interesting things in Washington, so I'm excited to talk about some of those things.

Pete Cutler: I'll be looking forward to hearing more.

Dave Iseminger: We wanted to start this series with the SEB Board because we're on at least year four of ongoing pharmacy discussions with the PEB Board. This is the first presentation in a longer journey. We've been talking about pharmacy issues, because of the retiree population that the PEB Board has to manage, for several years and different approaches they can take.

Pete Cutler: Since we're on the topic, I think Molly did an excellent job. It was really, really good information.

Paid Family and Medical Leave

Nick Streuli, Director, Legislative and Operations, Employment Security Department. Thanks for having me here today. Slide 2 – The Path to Paid Family & Medical Leave. This slide gives a brief overview of the journey the state of Washington had with the concept of Paid Family and Medical Leave. In 2007, the state actually passed a Paid Family and Medical Leave Program. However, they did not include a funding mechanism with it. The law sat on the books for years and years. In 2015, the Governor was able to secure some grant funding from the Department of Labor to do a study on how we could fund a Paid Family and Medical Leave Program. In 2017, the Legislature took up that concept and passed the Paid Family and Medical Leave Act. The bill that passed in 2017 was quite different than the program that was originally passed in 2007, and it tacked on quite a few additional benefits beyond what was in 2007.

It's 2018 and we're in the middle of implementing this Program. The Legislature gave us a very aggressive timeline. By January 1, 2019, employers begin deducting premiums from employees' wages. By 2020, benefits will become available for employees.

Slide 3 – Why Paid Family and Medical Leave? I like to remind people that almost every single person is going to experience, in their lifetime, some type of event this Program will cover. It's not just that birth, placement, or adoption of a child, but perhaps you have a sick loved one, perhaps your parents get ill, a sister, a brother, anything like that you will be able to take leave under this Program to take time off work and support them during that time. It's an essential benefit supporting folks when they need it most.

It's also a benefit to employers. It gives them a mechanism so people can take leave, take that time off work, and have an easier pathway to returning to work. One of the things you hear about quite often in today's world is, when one of these life events happen, the employee needs to take a break from work. It can sometimes be challenging for them to re-enter the workforce or return to that job. It can be challenging for the employer to find someone to replace them. With this Program, we think we're going to see a much higher percentage of people returning to the workforce after these life events occur. Of course, it's important because it also creates a shared cost mechanism between the employee and the employer to fund the Program.

Slide 4 – Who Does This Apply To? Every worker in the state of Washington is covered by this Program. There are two exceptions. We're not allowed to impose taxes on the federal government or their employees, so federal employees are not covered. The other group not covered would be tribal employers. Everyone else is covered by the Program.

Lou McDermott: Obviously, we have a large military personnel. So, all military personnel are not covered?

Nick Streuli: Correct. There may be some, depending on if they're contractors or how that works, but generally speaking, yes.

Slide 5 – Rollout Timeline. 2019 and 2020 are the are the two really big dates. Starting on January 1, 2019, all of the wages earned are going to be subject to the Paid Family

and Medical Leave premiums. We'll collect those premiums for all of 2019, and then, on January 1, 2020, benefits will become available. It was interesting to hear about your loan repayment. We similarly received a loan to start this Program and that is due at the end of the biennium. We also, out of those premium collections for the first quarter of 2019, have to pay back a loan. We have some commonalities.

Slide 5 – Paid Family and Medical Leave. There are two buckets of benefits. There is the family leave and there is medical leave. Family leave covers things like caring for your family members, birth or placement of a child, or certain military-related events. I say, "military-related events," we call military exigency leave. Let's say you are a military spouse and your spouse is going to be deployed. You would be able to take leave through this Program to help get everything set up and get ready for your household as your person is getting ready to deploy. Also, to spend some time with them before they actually deploy. That's one of the things that counts under the family leave side of the house.

On the medical leave side, it's really straightforward. It's just your own medical conditions. So, if you have some type of a qualifying condition that you are struck ill with that would count, you would be able to take leave.

Slide 7 – Benefits. It's a weekly wage replacement and I like to describe it as a sliding scale. A low wage worker is going to receive a higher percentage of their wages replaced. The benefits in the early days will range anywhere from a weekly minimum of \$100 all the way up to \$1,000. That \$1,000 is set to be readjusted, I believe in 2021 or 2022 to be 90% of whatever the state average weekly wage is at that time. That \$1,000 weekly benefit amount cap will continually be readjusted based off of what the state average weekly wage is doing.

On the weeks of leave, typically you're allowed up to 12 weeks of leave. To get into the details on that, there are 12 weeks of leave allowed for family and 12 weeks of leave allowed for medical side. Let's say you have a qualifying condition for family leave and a qualifying condition for medical leave in the same year. You would be allowed to take up to 16 weeks, so only a combined total of 16, if you have a qualifying condition that counts on both sides within the same year. In certain circumstances, you would be allowed up to a cap of 18 weeks, but that's only if you experienced a period of incapacity related to pregnancy.

Slide 8 – Benefit Examples. This chart shows four examples of weekly benefit amounts. The first one, if an employee has an average weekly wage of \$400, their weekly benefit amount would be \$360. That is 90% of their wages replaced through this Program. The bottom one, if the employee's weekly wage is \$1,800, they're going to receive the maximum benefit of \$1,000. That's only 56% of their wages replaced. That gives an example of how that sliding scale works.

Slide 9 – Eligible for Care in Family Leave? Here is a list of who is eligible and who is not. Covered includes children, step-children, foster children, adopted children, grandchildren, spouses, siblings, parents, grandparents. For those of you familiar with FMLA, the state's Paid Family and Medical Leave Act, coverage is slightly broader in terms of the eligible family members. There are one or two of these that are not covered for the federal FMLA that are covered for the state Paid Family and Medical

Leave Act. On the other side of the equation, folks who wouldn't be covered: godparents, aunts and uncles, cousins, distant relatives, pets. Oddly enough, there was a discussion of whether or not pets counted.

Slide 10 – Begin. Here is the leave life cycle as we call it. The first thing we have to figure out, if you're going to be using this leave, is whether you meet the 820 hours of eligibility to qualify. Once you've met the 820 hours to qualify, you then must have a covered event. Your eligibility would be determined based on your type of event. If either your family member or yourself have a serious health condition, that would deem you eligible for the Program. This is where there starts to become dual tracks. Let's say the eligible event is an unplanned life situation, which I think is probably going to be the majority of folks taking this leave. The life event would happen and you would file your claim. If this is a planned event, you know you're going to have a child in several months, you could file your claim before that life event actually happens so everything is set up and ready to go when that event happens. Once the event happens and you start filing your weekly certifications, you would start to receive those weekly benefit payments.

Slide 11 – Eligibility. The Paid Family Medical Leave Act establishes that, in order to qualify for the Program, you must have worked at least 820 hours in what they call your qualifying period. Qualifying period is the first four of the last five completed calendar quarters. If you don't have the required 820 hours in the first four of the last five completed calendar quarters, we can look at the last four completed calendar quarters to determine if you have the 820 hours. But that's only if you didn't have them in the first side of that equation. What we look at in that qualifying period is all of your employment. Regardless of whether you worked for the Health Care Authority, or the Employment Security Department, or Starbucks, we take all of the employment that you had in that qualifying period and add up all of those hours to determine if you have 820 hours. It's not tied to a specific employer. In that way, a lot of folks are using the terminology that it's portable. There's a couple of examples on the slide. If you worked at least an average of 20 hours a week for 41 weeks, you would have the required 820 hours.

Lou McDermott: Is that for Washington employers or if you came from another state?

Nick Streuli: Hours worked in another state would not count. It's only for employment in the state of Washington.

The second example on Slide 11 is if you worked 40 hours a week, by 20 and a half weeks, you would have the required 820 hours. The lowest you could go, if you averaged 16 hours a week for the full 52 weeks within a year, you would be able to meet the 820 hour qualifying.

Sean Corry: Nick and Senator Fain made a presentation to our clients several months ago. The question I have relates to what you just talked about, the accumulated hours that might occur across employers. At the moment of claim, my question has to do with what that particular employer is responsible for doing in assisting and informing an employee who might have hours at other employers.

Nick Streuli: It's a really good question and I want to caveat everything I'm about to say with we are really focused as an agency right now in what is required for January 1, 2019, which has to do with the employer premium payments. There is some rule and process development to be done about the employee benefits.

Sean Corry: I need to interrupt because the first question I wrote down was what's the rulemaking progress?

Nick Streuli: The rulemaking process is going along really well and I'm going to cover that in a later slide that shows where we're at in the different phases of rulemaking.

Related to your first question, we're still working through some of that process but it's likely that, if the employee is currently employed, the employer that they're employed with is going to receive some type of a notice that says, an employee of yours has filed for Paid Family and Medical Leave. There are some requirements in the law that an employee give 30-days notice in certain circumstances prior to taking leave. We would likely ask the employer, if that applied, to let us know if that had been done. It's often in the employer's best interest to reply and let us know whatever information they do have. But, if an employer doesn't reply, there's no penalty on the employer. An employee doesn't have to be attached to an employer to apply for Paid Family and Medical Leave benefits. As long as they have the 820 hours in their qualifying period, they could be unemployed and receive this benefit.

Dave Iseminger: Nick, before you move on, will you describe why the number 820 was selected by the state?

Nick Streuli: During the legislative negotiations, this certainly was a contentious topic. The numbers discussed during the negotiations were related to the federal FMLA, which is, of course, 1,250 hours in order to qualify. And in order to qualify for unemployment eligibility, which is another program we administer at the Employment Security Department, it's 680 hours. I believe that 820 lands right in the middle of those two numbers. That seemed like a reasonable number.

Sean Corry: When filing a claim, will employees be required to use up existing sick or vacation time before getting the benefit?

Nick Streuli: No. In fact, an employer cannot require an employee to do that.

Patty Estes: With the eligibility, I know in previous conversations you've probably been briefed on, we talked about school employees not working for two months and how this plays into being able to meet the requirements. How would that work for the average classified school employee that does not work 20 hours a week?

Nick Streuli: It's difficult to say. If they worked an average of 16 hours throughout the 52-week period, they're going to meet the 820 hours. To give some background on how the hourly reporting requirement will work, if the employee is a full-time salaried employee, the employer is directed by law to report 40 hours on their quarterly wage reports. 40 hours per week. If the employee is a part-time employee or otherwise an hourly employee, they have to report the hours actually worked. In some cases, and I'm

not as familiar with the classified school employee, whether or not they would be considered full time or part time.

Patty Estes: Most of the time they're part time.

Nick Streuli: Most of the time considered part time. Then they would be actually reporting the hours worked.

Patty Estes: My only concern is, from mid-June to beginning of September, they literally do not work anything. There's a lot of employees that do that. That would leave pretty much the majority of that population without being able to use this benefit because that's almost an entire quarter they would not be working.

Nick Streuli: That would be unfortunate. But because we're looking at four quarters, I think it's possible, since we're taking all of the hours from that four-quarter period, there might be 820 hours in there. If they have other employment somewhere, let's say they're working at a Starbucks or somewhere else, those hours are going to get added into the calculation as well.

Patty Estes: Okay. Thank you.

Lou McDermott: And back to that example, I would imagine it's really dependent on what portion of the year they're asking for the leave. If it's near the end of the school year, they've got all those hours behind them. If it's at the beginning of the school year, more problematic.

Nick Streuli: I think because we're looking at a four-quarter period of time, it should be capturing all four of those quarters. It'll have the time where they weren't working, but it'll also have all of the time they were.

Dave Iseminger: I think we're all struggling with the ramp up. Once you reach 820 hours then there's your steady state. That's where the rolling average will end up happening if you have a cycle where you're not working in the summer or you're working in a different employment and it's stacking, you're always looking four quarters back. Lou, what you were just describing is in the start-up. There's not a start-up each year that you have to reach 820 hours. It's when your event happens, you do the four-quarter look back and that's how you determine the eligibility. Right?

Nick Streuli: Exactly right. Good discussion.

Patty Estes: What about employees that aren't necessarily tracked by hours but they are stipend employees? How is that being reported or is it required to be reported?

Nick Streuli: We thought we knew how we wanted to handle stipend employees. And then we learned nearly every employer has a different definition of "stipend" and they're all different than the dictionary definition of "stipend." So, we're looking at that. At a high level, we know in a general sense how to handle per diem. So for example, per diem is a reimbursement of costs incurred as you're discharging your duties. Those wages would not be subject to the premium in most cases. I want to qualify myself. In

terms of stipend, we really are still trying to sort that out. We will have some guidance coming out relatively shortly.

Pete Cutler: Am I correct that, for the unemployment insurance program, that stipends for coaching or whatever would be hours, the hours associated with that income should be reported for the unemployment insurance program?

Nick Streuli: It's going to depend on their definition of stipend. I believe you're correct, but I can follow up.

Pete Cutler: Okay. Because my sense is if you already have an insurance program that requires employers, for better or worse, to attribute a certain number of hours to a certain compensation, then presumably that could be what you use to piggyback off of. It does seem like policy-wise, the federal government for the Affordable Care Act when determining if somebody's working an average of 130 hours a month for a year, they went down the path of attributing hours to school employees for summer break periods. But that sounds like that would have to be something the Legislature might have to do rather than something being within the purview of the Department, given the statute the way it's written now.

Nick Streuli: Correct.

Pete Cutler: Do I understand, when you say it's four of the last five quarters, if somebody has worked for a full school year on a part-time basis, and it happens that when they're applying, that one quarter would be the summer months, they would have the option of picking the four quarters that did not include the summer months?

Nick Streuli: Since it's a four quarters, which is the full duration of the year, either way it's going to include the summer.

Pete Cutler: It's a four of five.

Nick Streuli: Well, it's which four are we using? Are we using the first four of the last five quarters, or are we using the last four completed? Either way, we're looking at four quarters.

Pete Cutler: And that's a good point. If it's all four quarters then, by definition, it included the quarters that were the employment period.

Nick Streuli: Exactly. But if, in that example, in the first four of the last five quarters they did not have the required 820 hours, we would then have the ability by law to look at the last four completed calendar quarters. Let's say for some reason last quarter they happened to work more or their hours got ramped up, then that would be a situation where we could pick up those hours.

Dave Iseminger: I think the word we're all missing is it has to be four consecutive quarters. It's either the first four consecutive of the last five or the last four consecutive of the last five.

Nick Streuli: Correct.

Dave Iseminger: It's not pick and choose four out of five.

Nick Streuli: And that concept is identical to the Unemployment Insurance (UI) Program. That concept was from UI. I do want to specifically call out the UI Program is a federal program that states administer. We tried to pick a number of similarities for ease of administration. There are places where the Legislature chose to deviate from the way the insurance program for unemployment insurance works and the way the Paid Family and Medical Leave Act will work.

Slide 12 – Premiums. The premium calculation is set in statute for the first two years of the Program. It is 0.4% of gross wages. That is split between the two different buckets of leave. One-third of that 0.4% is attributed to the family leave bucket. Two-thirds of that 0.4% is attributed to the medical leave bucket. The reason we did this break out is, in an analysis of the other states that have Paid Family and Medical Leave, they found about one-third of their claims were attributable to what we call family leave and two-thirds of their claims were attributed to medical leave. From there, the employee is responsible for 100% of the premium rate attributed to the family leave bucket.

On the medical leave side, the employee is responsible for a minimum of 45%. The employer is responsible for 55%. The employee being responsible for 63% of the Paid Family and Medical Leave premium and the employer responsible for 37% of the Paid Family and Medical Leave premium. From our perspective, when the employer does their quarterly reporting, we're looking to see if that split took effect. An employer is absolutely able to pay any portion of the employee's premium amount that they so choose. They can't deduct more than 63% from the employee's wages, but they can choose to deduct less and pay more of that premium amount themselves.

On the bottom of Slide 12 is an example of what that breakout would be for an employee who had \$50,000 per year in wages. The employee that year would be responsible for \$126.67. The employer would be responsible for \$73.33. At the end of the day, the employer does act as the employee's agent, so the employer is responsible for transmitting the whole premium amount to the Department on that quarterly reporting basis. The Legislature also included in the law that small businesses with fewer than 50 employees are not responsible for paying that employer share of the Program. They are only responsible for deducting the premium amount from the employee and transmitting that to the Department.

Dave Iseminger: In that small business scenario, the employee doesn't have to pick up the employer's share. They just pay their 63%.

Nick Streuli: That's correct. They pay their 63% percent and the employer deducts that from them, but the employee does not pick up the employer share.

Slide 13 – Reporting. Since we also administer the Unemployment Insurance System, we tried to marry the two programs for ease on the employer. Employers will be required to report on a quarterly basis. Their reports and premium payments are due by the last day of the month following the close of the quarter. They're required to report to us the name, SSI or TIN of the employee, any of the wages earned, hours worked, and the total premium amount deducted from that employee. This is very similar to what they do currently for unemployment insurance purposes. The only difference being, in

unemployment insurance, the employee doesn't pay any portion of the taxes owed for unemployment insurance. They obviously don't have to report what they deducted from the employee because it better be zero.

Dave Iseminger: Nick, is there any requirement that the employer report to the agency on a quarterly basis, but they're collecting premiums out of each paycheck? Or can an employer have the discretion to take a lump sum out at the end of the quarter?

Nick Streuli: Very good question. That's something we addressed in rulemaking. An employer has to deduct on a pay period basis no less than monthly. If for some reason their pay periods are every six weeks, they would need to deduct at least monthly. But, if their pay periods are shorter than that, they have to deduct on a pay period basis. If they don't deduct, the employer then becomes responsible for that premium amount. They can't go back and take it from the employee.

Slide 14 – Paid Sick Leave and FMLA. Paid Sick Leave, Paid Family and Medical Leave, and FMLA are three programs that operate in a similar sphere. We've definitely been answering a lot of questions as we've been implementing about what the differences are between the new Paid Sick Leave law that came into effect with Initiative 1433, our Paid Family and Medical Leave Act, and the federal FMLA. At a high level, Paid Family and Medical Leave and Paid Sick Leave cannot be used at the same time. You can't be on leave and receiving Paid Family and Medical Leave benefits, and at the same time, collecting paid sick leave from your employer and using those paid sick leave hours. They can't be done together.

To Sean's question earlier, an employee may choose which of those two they would like to use. But an employer cannot require them to use all of their sick leave or all of their vacation leave prior to taking Paid Family and Medical Leave. And that is a difference between the federal FMLA and our Paid Family and Medical Leave Act. In the federal FMLA, an employer can require an employee to exhaust their leave balances prior to going on FMLA or while they are using FMLA. That cannot happen with the Paid Family and Medical Leave Act.

In most cases, the Paid Family and Medical Leave Act is going to run concurrently with FMLA. We are grappling with this section of the law. We want to make sure we get guidance because that term "concurrently" can mean different things. It's the only time in the law that requirement is mentioned. We are trying to get clarity.

Slide 15 - Outreach. We've been doing a lot of outreach across the state. Hopefully, you've heard some of our commercials, received our mailers, seen us on Facebook or other social media. But, specific to the education sector, we have been working with OSPI, we have done presentations for the educational service districts, and we have been working directly with WSIPC. That way they are ready when this comes into effect in just a couple of weeks.

Pete Cutler: I assume it's obvious this is not just for school employers and employees?

Nick Streuli: Tons of other outreach all over the place.

Pete Cutler: When I first saw this, I thought you were doing everything through ESDs.

Nick Streuli: No, we have done hundreds and hundreds of presentations to lots of associations and various other groups. You're going to see a big ramp up in our marketing right now. I think every week for the last several weeks, either KING 5, KOMO, or any of the other news outlets have run stories. We're really trying to get out there to make sure that everybody knows this is coming.

Slide 16 – Implementation in Phases. This slide helps answer Sean's question, which was how is the rulemaking going. Because this Program had to be implemented quickly, we needed to break down into small sizeable chunks what needed to be done when, so we could have those things done when they needed to be done. If we attempted to do all of the rulemaking for premiums and benefits in one large lump, we would likely not be finished with that today because it takes a lot of back and forth and negotiating. People would not be ready and we would not have information out there for folks to know what they need to do on January 1, 2019.

The rulemaking is broken into six phases. We are currently in the middle of an overlap period where we're wrapping up Phase 3 and ramping up Phase 4. So far in rulemaking, we've covered things like voluntary plans, Collective Bargaining Agreements, and premium liability. We're just now getting to some of the benefit application, and benefit eligibility stuff. We're also just beginning the continuation of benefits and fraud. All of that is happening simultaneously. Phase 5 of the rules is going to cover things like job protection, benefit overpayments, and some miscellaneous provisions. Those are some of the things that really aren't going to come into effect until deep into 2020 once these benefits are available, people are needing that job protection, on perhaps a benefit overpayment has occurred.

Finally, late 2019, we're going to do Phase 6 of rulemaking, which is appeals. Appeals are the last stop in the process. We felt like that was an appropriate one to tack onto the end.

We have achieved an important milestone already and I want to call it out because it was no shortage of work to achieve. The law allows employers to apply for "voluntary plans." If an employer feels like they can provide these benefits that are as good or better than the state plan, through their own private company or through an insurance product provided that's on the market, they are allowed to apply for a voluntary plan. They would be exempt from the Program and they would provide those benefits to the employees in their voluntary plan program. In order to have a voluntary plan in place by January 1, 2019, we had to start accepting, processing, and approving or denying applications over the summer. In September, we actually turned on functionality in our IT system to allow those voluntary plan applications to be turned in. We had staff available to process them and work with employers to approve or deny them, so they can be in place come January 1. That was a big milestone.

Sean Corry: With respect to that, opting out, essentially?

Nick Streuli: Effectively.

Sean Corry: There's no exception for school districts, for example, public entities. It's available for school districts as well.

Nick Streuli: Correct. It's available for anyone.

Sean Corry: Thank you. I have a related question. A lot of school districts have some form of short-term disability or voluntary short-term disability programs available for purchase by individual employees. In those circumstances, can there be layering of benefits? Would you permit somebody to get up to 100% of pay from two different programs, for example?

Nick Streuli: So, you're saying, let's say they did a voluntary plan, provided the benefits one way, but then covered the delta in the wages from what the plan covered and what 100% of their wages were? Is that kind of the example you're throwing out?

Depending on the way, yes, it is an option. There are conversations happening about how that could even be broadened a little bit to allow employers greater flexibility to replace up to 100% of an employee's wages.

Pete Cutler: If an employer opts out, approved for a voluntary plan, does that mean the hours for those employees don't count towards the Program, don't count towards 820-hour standard?

Nick Streuli: They could not require more than 820 hours for eligibility in their voluntary plan program. They would have that same criteria or less. They could say, for our voluntary plan, we think 600 hours is right. And, because that's a more generous benefit than what we're offering in the state plan, that would likely be acceptable.

Now, if, let's say, an employee moves from a voluntary plan employer to a state plan employer, those hours are immediately portable and we consider them in the eligibility criteria for the state plan. Let's say they left that employer, there's no gap in coverage. Great questions.

Slide 17 – Employer Toolkit. This toolkit is on our website and we've sent to every employer in the state. It attempts to get them ready for January 1. We want to make sure all employers and, by extension, their employees, are ready. Employees are going to see something coming out of their paycheck, starting with that first paycheck in January. We wanted to make sure we were able to equip employers with the information they needed to communicate to their employees about what it is, why it's there, what it's going towards, and what benefits will be available in the future. The toolkit is very comprehensive. It includes a paystub insert, which is available on our website for download as well if an employer wants to put something in the employee's paycheck. It gives information about the Program. It also helps fill them in on what their responsibilities are, how the premiums work, reporting, and everything else. It has a readiness checklist. If you complete all these steps, you're ready to go

Slide 18 – More to Come. There's a lot more to come. We're working furiously to get the IT system ready to accept these reports from employers. We're trying to get that same IT system ready to accept benefit applications in 2020. The rulemaking, as I mentioned, is ongoing. We have customer care teams available if you have questions or want to call. Anyone in the public, that number is broadly published. Call, ask your questions, we're here to help.

Lou McDermott: Back a couple slides, if the employer is choosing to provide their own product, are there limitations in how much they can charge their employees? Can they transfer the full cost of the product to alleviate themselves from having to pay the employer premium?

Nick Streuli: They cannot. They could not deduct more from the employee than the employee would have had deducted had they been in the state plan.

Dave Iseminger: If I could summarize, essentially, a voluntary plan has to be at least as generous, if not more generous than what they would get through ESD's program?

Nick Streuli: At least as good or better. Exactly right.

Dave Iseminger: Nick, correct me if I'm wrong, does Washington's implementation of this program have a different flavor than many of the other states? Most other states that have implemented this, roughly five states, have a broad short-term disability benefit statewide that they could piggyback off and expand. Whereas, there was not a similar situation here. I think that's an important part of the conversation to realize. There was already a statewide benefit and it was transformed into this, versus the wholesale creation here in our state.

Nick Streuli: Yes. That's absolutely correct. We're the first state to take on both of these at the same time. Every other state, and there were some states that had a temporary disability program dating back to the 40s, of the states that have Paid Family and Medical Leave, of which we're the fifth, we're the first one to do both at the same time. We're certainly getting calls. I think we've had visits from more than a dozen other states or in some way interacted with them as they are exploring this same concept.

Dave Iseminger: We brought this conversation to the Board and asked the Employee Security Department to present because of the disability benefit conversation that we had back in September.

There was a question from the Board about could the HCA try to scope what the school employee population looks like that would be between the 630 hours that existed in the SEBB Program versus the 820 hours that exists under the PMFL. Our best estimates at this point, are there are about 3,600 school employees that would fall within that range. Important pieces to remember are there's no way from our data to account for people who have other employment outside of the school district. There may be people seeking part time employment, not for the purposes of getting benefits, but maybe a supplemental retirement income. They may not be interested in this type of benefit or in benefits in general. With the amount of salary individuals are making, they may be prioritizing other benefits and are not interested in a short-term disability benefit. The other big piece is that if they definitely aren't reaching 820 hours, isn't there a waiver process by which an employee can opt out of the PFML Program.

Nick Streuli: Only for out of state. There is a provision in the law. It's called a conditional premium waiver. If you are, for some reason, working in this state but centralized normally in some other state and you're working in this state temporarily,

there is a conditional premium waiver if it's believed that you're not going to work the 820 hours. But that's only if you're from another state.

Dave Iseminger: Could you clarify for the Board, if an employee is definitely only working 630 hours they would pay their portion of the 0.4%.

Nick Streuli: They would.

Dave Iseminger: Even though they cannot possibly qualify for the Program. They have that premium obligation regardless of whether they meet the eligibility requirements.

Nick Streuli: Correct. It's that insurance system concept.

Policy Resolutions

Barb Scott, Manager, Policy, Rules, and Compliance Section. We have two policy resolutions for you to take action on today. Other than fixing a couple of typos on the slides from November and adding the word "eligible" to the title of Policy Resolution SEBB 2018-54, as well as hyphenating the words "employee-only," the policy proposals are the same as those introduced in November.

Examples have been included related to Policy Resolution SEBB 2018-53 – School Employees May Waive Enrollment in Medical. In providing two examples, we're hoping to answer questions received from stakeholders. As was mentioned on one of Megan Atkinson's slides, the funding rate calculation assumes a certain percentage of eligible employees will waive, which reduces the average amount of employer funding per employee. The proposed policy would only allow employees enrolled in other employer-based group medical to waive their enrollment in medical where there is an employee contribution. It would not allow employees to waive enrollment in benefits that are 100% paid by the employer. The term "employer-based group medical" would be defined and is intended to mean group medical related to a current employment relationship. It would not include medical coverage available to retired employees, and it would not allow employees to waive their enrollment in order to enroll in Medicaid.

In addition, not mentioned in this policy resolution because it is a federal requirement, employees are allowed to waive SEBB medical in order to have Medicare or Tricare be their primary coverage, including Tricare as a retiree. We received stakeholder feedback on this policy. One stakeholder expressed concern that the proposal does not support employees waiving enrollment in medical if they're enrolled in medical for a spouse's retiree medical plan. The same stakeholder suggested that the program could alternatively allow employees to waive enrollment if they're enrolled in other coverage that is equivalent to the coverage offered by the SEBB Program. We did not modify the resolution that's before you today because this particular policy is consistent with one the agency already has in place for the PEBB Program. In addition, it is intended to minimize the risk of adverse selection and not create administrative burden to evaluate whether the plan they're waiving for is equivalent to a plan offered through the SEBB Program. There would be a decent amount of administration required. This proposal doesn't include that idea.

Another stakeholder expressed concern that the policy doesn't allow employees to waive in order to be enrolled in Medicaid coverage, which is not an employer-based group medical plan. We didn't modify the proposal to allow for waiving for employees eligible under the Medicaid Program. At this point, I don't really have a complete idea of what that would look like. We did address this question with the stakeholder by letting them know that, if an employee and their family does meet Medicaid eligibility, they could continue to be enrolled in Medicaid. This proposal wouldn't prevent them from doing that. Medicaid would then be secondary payer on claims. But, without really understanding how this would function, I didn't include it in this particular policy proposal. We do have a meeting on the books with our agency partners in Medicaid to have a conversation about what that might look like and having conversations about the work they do specifically with school districts and how their determinations might be affected in the future. We'll bring that information back to the Board if you have any interest in that.

Dave Iseminger: You hear me say that rulemaking is an iterative process. This is the start. There are areas we can work on for the future, but this is a foundational start to build upon.

Barb Scott: Example #1 is of a school employee, a bus driver, who's eligible for the employer contribution. They're currently enrolled in medical coverage through their spouse, who is a Boeing employee. The school employee wants to waive his enrollment in SEBB medical and the question is whether this would be allowable under the policy resolution being presented today. The answer is yes. The Boeing coverage he's enrolled in qualifies as employer-based group medical. It's based on current employment of their spouse with Boeing.

Example #2 is an example of a school employee eligible for the employer contribution. She is currently enrolled in medical coverage through her spouse's Boeing retiree medical coverage. The school employee wishes to waive her enrollment in SEBB medical. The question, again, is this allowable under the resolution in front of you today? And the answer would be no based on coverage that's available to her spouse as a retiree from Boeing, not a current employment relationship.

Pete Cutler: Thanks, Barb. I do want to stress that I strongly support the general policy priority of keeping the administration simple. One of the problems or concerns we had as policy makers with the K-12 context before, there were hundreds of different plans. Trying to figure out how something compared to another thing got into a lot of details and was very time consuming. I fully support the idea of trying to keep it standard. It's very easy to administer in terms of deciding if somebody has robust enough coverage, in this case employer-plan coverage to permit them to waive coverage. Clearly, the policy goal is to make sure people have health insurance coverage and don't somehow, for whatever reason, take themselves out of that.

It's a policy of the state that we want people to have health insurance coverage if they're full-time employees, in this case of a K-12 district. The one question I do have is how does this standard compare in the context of the ability of somebody who retires and is eligible for PEBB retiree coverage? I know they have the ability to waive or put on hold. I'm not sure of the technical term.

Barb Scott: Defer.

Pete Cutler: Defer coverage if they have other coverage. I know, in that case, there is a focus on is it actuarially equivalent or robust enough because you don't want somebody going to a cheap plan that has minimal coverage, then waiting until they have an expensive condition, and then coming back into the PEBB Program. I'm curious how that standard which is applied to PEBB retirees compares to the standard that's being proposed here.

Barb Scott: The PEBB Program for active employees has a policy that looks like this. Part of the reason is they want to make certain the coverage that employees waive, if they're going to waive enrollment in the benefits that are offered by the state, the other coverage they're enrolled in is comprehensive enough in nature that there isn't an adverse selection, a risk of that within the PEBB Program. Same concept here with SEBB. You wouldn't want to create a situation where the other coverage that folks are enrolled in may not be comprehensive and then, when employees move back into SEBB coverage, have adverse selection occurring within the SEBB pool.

At the same time, the question really, as far as the retiree coverage goes within PEBB, the PEB Board put in place provisions for retirees to be able to defer enrollment when they're enrolled in employer-based group medical coverage. If an employee is eligible under the SEBB Program and also eligible as a retiree under the PEBB Program, there's a provision that the PEB Board has in place so they could defer that enrollment in the PEBB retiree coverage in order to enroll in their SEBB employee coverage. It's going to be cheaper, likely, to be enrolled in coverage where there's an employer contribution toward it than to be enrolled in coverage as a retiree under the PEBB Program.

We see that often even today with school district coverage. Folks will go back to work and defer their enrollment in PEBB retiree coverage. They come back to us later when they decide they really are going to quit working. The PEB Board has a number of different provisions even beyond employer coverage as an option for deferring. You can defer for Tricare enrollment. You can defer if you are eligible, under the most recent rulemaking for the PEB Board, if you are eligible for coverage under CHAMP VA as well.

Dave Iseminger: Pete, the one thing that I would add is under the deferral rule, it's comprehensive employer-sponsored coverage. There is no actuarial value test or evaluation of that. The only place there's any concept of a plan comparison is in the spousal surcharge, because the Legislature set that up as a comparison to the benchmark plan in the PEBB Program. To be able to explain how to do a plan comparison and the calculator is a challenge. To have to replicate that for all possible employer plans would be an administrative challenge.

Earlier, in my first presentation, it may have sounded like I was bashing the allocation worksheet. Actually, I think that allocation worksheet, much like our employer surcharge calculator, explains a very complex situation easily for people. I think the point is if we didn't have to do the calculator for the spousal surcharge or the allocation worksheet, it would make the whole process even simpler.

Pete Cutler: I want to assure you that I definitely do not want the Health Care Authority to replicate that actuarial equivalent standard in any other context, much less, particularly in this SEBB situation.

Dave Iseminger: One more thing I wanted to highlight for the Board and for the public is these examples are key pieces for helping train benefits officers who will be doing eligibility determinations. We had a suggestion since the last meeting to find a way to make it more user friendly on the website. I want to make sure you all knew that on the meetings and materials page, at the bottom, we have a dynamic chart that shows all the resolutions that have passed. For all of them that have examples, there are hyperlinks that go directly to the examples within the briefing books so that anybody who's trying to understand what the resolution really means has these illustrative examples on hand. I wanted to take an opportunity to highlight that and thank, I believe it was Fred Yancey who made that suggestion. Those types of suggestions are really helpful in getting the word out about what the Board means in its resolutions.

Lou McDermott: Policy Resolution SEBB 2018-53 – School Employees May Waive Enrollment in Medical

Resolved that, a school employee who is eligible for the employer contribution toward School Employees Benefits Board (SEBB) benefits may waive their enrollment in a medical plan if they are enrolled in other employer-based group medical.

Allison Poulsen moved and Katy Henry seconded a motion to adopt.

Voting to Approve: 9

Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-53 passes.

Barb Scott: Policy Resolution SEBB 2018-54 would default employees into coverage that includes an employer contribution. It would not default the employee into any supplemental coverages. We received stakeholder feedback related to this policy. One stakeholder suggested that employees should be defaulted into a waived status rather than into coverage for medical specifically. We did not modify the proposed policy based on this feedback because of the potential that the employee would be uninsured. There was no other feedback from the stakeholders on that particular policy.

Sean Corry: Sorry for missing this in November if it came up. But which plans are chosen for these people who need to be slotted into coverage?

Dave Iseminger: The question for the Board is the foundation of into coverage or out of coverage. Until the Board sets premium contributions and we know the full service areas and exactly what plans are available, we can't answer that question. We will engage in the discussion with the Board when that information is available. This is to get the Board to set the foundation and rules that it will be into coverage, and then we'll work on the specific plans in a couple of months.

Sean Corry: Do we intend to change the language of this particular resolution once that is determined? Because the resolution itself doesn't indicate any selection process. It's just that there'll be coverage.

Dave Iseminger: Correct. If there is something for the Board to take action on, we would bring a subsequent resolution related to that. If it's within the agency's authority, we would convey in our communications what the final plan is. We believe it's within the agency's authority, but we will certainly be discussing with the Board all of the implications of different plans, both in public and sometimes in Executive Session for the more proprietary things. This is to set the foundation. The reality is, as we get into the rulemaking process, we're about to finish rulemaking one and will have a short rulemaking two. There won't be time to codify things in rules after a certain period. We won't have the information to get into the specific plans until after that rulemaking has been essentially completed. The plan names won't exist in rule 2020. It will instead exist in the communications and be informed by Board discussion. Today is about being clear there will be coverage. Which coverage, specifically, will be in subsequent discussions.

At this time, we don't anticipate this resolution would have to be changed or revisited. Do you have a particular concern?

Sean Corry: Thank you. When there's a determination how this is going to work, the resolution itself isn't clear to say that this is going to happen. There's no indication in the resolution what the process is. It's this open, "you're going to get some coverage" language that's just confined to that. It's figured out someplace else and it's not addressed here. It doesn't direct one to that process or that decision making.

Dave Iseminger: I'll go back to my "I" word: iterative. This is the first step in the journey of defaulting into coverage. I know what plan people would go into is an important concept. We haven't laid all the breadcrumbs for all the iterative process of future ones. I guess I'm just struggling with what your suggestion is.

Sean Corry: So, this is simply a placeholder?

Dave Iseminger: Not a placeholder. It's just the first step in the journey.

Barb Scott: What this does is let employees know, and it especially lets employers know, there is a process this Board will put in place that determines what's going to happen as far as the enrollment actions they'll have to take if an employee fails to make an election of coverage. The action will be taken to enroll the employee in coverage and will not leave them uninsured. It specifically states they will be enrolled in medical coverage, dental coverage, vision coverage, and the basic life and basic long-term disability coverage. What we don't have information on today is which medical plan, which dental plan, and which vision plan. That's the piece Dave is explaining we will know later. At this point, we want to at least be able to assure folks that employees will be enrolled in coverages.

Lou McDermott: What we're saying is, this falls under agency purview. The agency believes it has the authority to decide which plan is defaulted into. The agency will discuss that with the Board, but it's the agency's belief that HCA can select a plan.

Whether or not there is a default concept, we believe falls within the Board's purview. We will discuss the methodology with the Board. I do believe in PEBB, the methodology is you will be defaulted in the largest plan that is available, who has the largest membership, or something like that, which is the Uniform Medical Plan. Barb, what's the exact language?

Barb Scott: The PEB Board uses the Uniform Medical Plan as the default plan because the plan is available nationwide. It wasn't defaulting an employee into a product that wouldn't be usable for them based on where they're geographically located. The other options, even on the dental side, the default is the Uniform Dental Plan, which has the largest provider network and is available, again, across the state. They didn't have to look at what's available in each geographic area in order to select which plan. We didn't choose other plans because they aren't available statewide or nationwide for every employee. Especially with higher education, we have folks who are out of country. Using the Uniform Medical Plan allows for coverage even for those employees.

Dave Iseminger: The way Barb used the word "Board," "we," and "they," we're all stumbling over. I don't believe we've ever identified Board resolutions where the PEB Board made a resolution that said enrollment shall be in UMP and we're not bringing that to this Board. We're trying to do the same process with both Boards. There will definitely be robust conversation with this Board. I can't stress that enough because I don't want people to be worried the agency is going to do something without Board input. When we have information available about exact service areas and what the premiums are looking like, we'll engage in conversation with the Board and get the Board's insight about the appropriateness of the default plans. Then, the agency will make the decision and proceed with implementation.

Pete Cutler: I like the idea of having that discussion down the road. Off the top of my head, my initial reaction is I would support the general same approach in terms of looking for the plans that have the broadest network, that have the most enrollment, and trying to parallel that.

Having said that, I'm not sure I agree. With all due respect, I think that is a policy decision and I think, by inference, it is something that would be a logical thing to have the Board make. I'm not going to worry about it because it's very clear to me we'll have the discussion. If it's decided that a resolution would be appropriate, I can envision very easily how that could be a separate resolution tied into this one that we have in front of us today. I'm quite happy to go ahead with this one today.

Lou McDermott: Policy Resolution SEBB 2018-54 - Default Enrollment for an Eligible School Employee Who Fails to Meet a Timely Election

Resolved 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.

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

Voting to Approve: 9

Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-54 passes.

Wellness Program

Justin Hahn, Program Manager, Washington Wellness, Benefits Strategy and Design Section, ERB Division. At the October Board Meeting, we presented an overview of worksite Wellness Programs and provided a demonstration of the online portal that we used to track, monitor, and reward participation. Today, we're going to walk through the approach we are planning to use for the SEBB Wellness Program and tee up some important decisions that the Board will need to make.

Slide 2 is the language from the Collective Bargaining Agreement on wellness. It says, "The SEBB Program will offer a Wellness Program to eligible employees who enroll as a subscriber in a SEBB medical program in 2019 for plan year 2020..."

Slide 3 – Implementation Plan. We are currently planning internally. The plan is to use the existing HCA wellness vendor, Limeade, to implement the SEBB Wellness Program and be ready for open enrollment in October 2019.

Slide 4 – SmartHealth Demonstration. In October, we provided a three-minute demonstration on the SmartHealth portal. I want to describe more about the background approach, strategy, and details of the program.

Slide 5 – SmartHealth Overview. SmartHealth is our online health and wellness portal. It's mobile-friendly. It's a population focused health and wellness behavior change tool. We see it as our biggest tool for wellness that we have within the PEBB Program, where it exists now. It's an intuitive engagement experience personalized through the well-being assessment, which is the 200 questions that individuals who utilize the platform answer based on four different focus areas: physical health, emotional health, financial health, and work-life balance. Based on your well-being assessment responses, you get a tailored experience on this platform. Through the activity rating, for each activity, you can do a thumbs up, thumbs down. That indicates things you're interested in, things you're not interested in, and weighs those against the things your interests. It puts it into a formula.

The well-being assessment is National Committee for Quality Assurance (NCQA) accredited. There are points-based health activities incentivized by extrinsic and intrinsic incentives. They use a gamification methodology to incentivize people to participate. There's also an extrinsic \$50/\$125 incentive that's been described before. Those are just some of the things that get you over the hump and interested in the Program.

There are intrinsic incentives. We currently have a year-long campaign about what's your "why." We are evolving that into calling it "pursue your purpose" for this coming

year. It's to identify what your "why" is, what your purpose is, and then use SmartHealth to support that purpose.

It also offers alternatives for those with a disability or who don't have internet access. There are things in place to address that. It's an opportunity to bring all health and wellness management programs under one umbrella where health plan benefits like flu shots and dental visits can be promoted. It's very flexible. The goal is to make changes for life and not just once a year.

Pete Cutler: Can you remind me, on the very first slide about population-focused health and wellness. I'm embarrassed to admit, I'm not quite sure what "population-focused" means in this context.

Justin Hahn: In this context, we work with individuals, but we're using this tool for the whole population and tailored to working with individual by individual with something constructed from the ground up for that individual.

Pete Cutler: Is it fair to say that the population would be all the covered PEBB Program lives and now going forward it would include the SEBB Program lives? It's not the whole state of Washington or anything, it's just the folks that are actually within the Program.

Justin Hahn: Correct. The population is those that have access to the portal.

Pete Cutler: What is a pulse survey?

Justin Hahn: A pulse survey is a pop-up box. I think they want to correlate it in that way because they do come up pretty often. It's just a little survey. It's similar to when you're navigating through the internet with your browser and a little right-hand corner thing pops up and says, "How are you liking this experience?" One to five stars.

Pete Cutler: In terms of the bringing the health and wellness management programs under one umbrella, I'm a Kaiser now member. I filled out a health assessment for them, plus I did the assessment for SmartHealth. I like SmartHealth, that it covers a variety of different aspects. But it did seem it would be ideal somehow if they were coordinated or connected because maybe my doctor would benefit from knowing the things that I have on my SmartHealth assessment and vice versa. There's hard data. There's actual blood pressure readings, etc. on the Kaiser one. I'm curious, is there any hope of having greater coordination or connection between those two? Not just Kaiser, but any of the other health plans that we might be dealing with?

Justin Hahn: That's a good point and an ongoing issue we're continuing to talk about. At this point, they're not correlated. With three different health plans, there are some challenges to it.

Pete Cutler: I'd imagine, with looking at possibly six or seven plans, it would be all the more complicated with school employees. It's something to think about as a potential goal.

Dave Iseminger: On population-focused health, although individuals are interacting with the system, the data staff are analyzing is on the entire population. We can't see how individuals answer questions, but we can look at agency trends. There can be a focus within that agency or in that sub-part of the population. We have the ability to do that. That gets back to this data, we're collecting it under an employer hat versus the health assessments that the plans are doing. They're doing it under the provider hat. There are some legal intersections there with being able to coordinate. That is something we're always trying to be cognizant of.

Alison Poulsen: A lot of folks don't want their wellness assessments being in the hands of their insurance carrier. It creates a high level of anxiety when our intent is to help get to healthier behaviors.

Justin Hahn: Thank you. Slide 6 – SmartHealth Activity Categories. Our wellness focus is to improve population health by looking at the population that we serve that has access to this online portal by keeping healthy people healthy, reducing health risks, and managing ongoing or chronic conditions. These three buckets include all people wherever they happen to be on their life path. As you drill down, it gets more specific and relevant to the individual experience.

Slide 7 – Activity Examples. This slide shows activities in those three categories. There are some individual activities, team activities, and some cross over from one column to the next. Under keeping healthy people healthy, drafting a gratitude list is one activity. I participate in this daily, waking in the morning, writing down or at least thinking about those things that I'm grateful for. Under the same heading is stepping it up together, two million steps, which is a steps challenge with groups. It's a team challenge. SmartHealth is smart enough to have individuals group together and it tends to be between five and ten folks per group. Through positive peer pressure and encouragement, we divide the two million steps for this month and that means 10,000 steps per day per person, whatever you want to talk about or maybe it's 5,000 steps. More doable for a lot of people. And the people encourage each other. It's not just an interaction with yourself and the platform, but you have the opportunity to include more people.

Under reducing health risks is preventive dental exams. That encourages you to go see the dentist, get a preventive check-up, and see what's going on. That's a verified activity that has been confidentially reported back from the provider to Limeade, which is the provider of the portal. You get the points after the billing happens and the reporting goes back to Limeade.

Lou McDermott: Pete, back to the population health comment, when we look at our plan and where we're like other books of business, where we're less, where we're more, one thing we noticed is we had a lot of people not going for annual dental visits. What was unfortunate, folks with children were also not bringing their kids in. If you don't go in for your annual, there's a tendency not to bring in your kids for their annual. When we noticed that, we asked the wellness folks to go ahead and see if they could incorporate some sort of carrot in the benefit so you would go in for your annual. We did see the overall numbers of dental visits go up. It wasn't isolated to Pete. We noticed the trend didn't seem good, we threw in an incentive, saw the number go up, positive things happening.

Pete Cutler: Thanks. That is actually a very good example because I could see here something was identified on a population basis as beneficial to try and figure out some way to incentivize something on a population basis rather than individual. Thanks for that example.

Justin Hahn: Under the “manage chronic conditions” column, there is a focus on tobacco cessation. Depending on your coverage, you get a message about benefits under your plan that are available to you. On the PEBB side, we've actually turned this on for everybody because it's not just you that may be using tobacco products, but it may be somebody in your family who's covered under the medical plan. The same with the Diabetes Prevention Program. That's an evidence-based program through the CDC that we're able to promote. We're actually rolling out, the beginning of January, a virtual Diabetes Prevention Program, which we're very excited about that we're going to be advertising and promoting on the platform.

Slide 8 is a mockup of activities a SEBB SmartHealth participant could see and could join on their way to earning the incentive. There is World Diabetes Day, stick to a bedtime routine, join the SmartHealth community, which is a place to go and post pictures and talk about your experience with SmartHealth.

Lou McDermott: One other thing about the experience that's nice that we've discovered in the PEBB Program is that, with different medical plans, there are different benefits available. They might use different smoking cessation company to provide their benefit. Because we give an eligibility feed to Limeade, we tell them which plan you're in. You don't see stuff that's not applicable to you. It makes the experience much easier to show you stuff that's applicable to you. That's tough sometimes to figure out.

Justin Hahn: Slide 9 is an example of a fictional SEBB Program member who is active in SmartHealth. She's 55 years old, a 25-year school employee, lives in King County, and recently diagnosed with diabetes. She loves to cook and is interested in becoming more active. She takes her well-being assessment, she sees a program that's being promoted to her for chronic condition management, and she clicks on that, learns more information, and gets involved with that. Under reducing health risk, she participates in the local farmer's market recipe exchange activity. She knows that activity is important for management of her diabetes. It's also important for anybody. And so, she joins the Washington Walks activity.

Slide 10 – Earning Points. Points are assigned based on the duration of the activity and the intensity. Difficult activities are worth more points. They're tracked in multiple ways, including claims, and importing data from tracking apps such as FitBits and things like that for walking and self-reporting. SEBB Program subscribers will need to earn the required number of points to qualify for the incentive. Activities will start and be completed within the activity timeline. There are distinct activity timelines within the incentive deadline.

Slide 11 – Decisions and Considerations Eligibility. There are two key decisions that the SEB Board will need to make. First is eligibility. SEBB Program subscribers eligible for medical benefits will be eligible to participate. Within the PEBB Program, where we offer SmartHealth currently, the PEB Board made the decision to allow use of only the

portal for spouses and state-registered domestic partners. That portal-only means you have access to the program, but you are not eligible for the extrinsic incentives. There is some value in encouraging families in wellness behaviors. We've seen, anecdotally, one spouse is doing something, the other spouse deciding to do it as well. There is positive peer pressure and encouragement. But there is a cost associated with anybody who is eligible for the program. We estimate that for a calendar year, its approximately \$800,000. Does the Board want to allow spouses and state-registered domestic partners to participate in the online portal?

Pete Cutler: I want to confirm, was that \$800,000?

Justin Hahn: Yes, approximately per year for access.

Sean Corry: I have a question about that. From what pool of money does that \$800,000 or whatever these expenses, the rewards come from? Is it coming from the premium pool that everyone therefore pays in their little share?

Lou McDermott: Yes, as well as the employer, correct? If it's an 85%/15% split of the \$800,000, the employer's picking up 85% of that.

Dave Iseminger: Remember the various pools that go into the big pot of money is the funding rate that's funneled through the prototypical model of the districts, the amount of money forwarded to the Health Care Authority from that prototypical model, in addition to the amount the school districts will pay for the locally funded position, and all employee contributions. The vast majority of that is obviously an employer pot of money. That comes into the large fund for the SEBB Program, just like there's a separate large fund for the PEBB Program. There are different allocations for different funds. The administrative account is used by HCA to administer the program. There's one for the TPA funds for the Uniform Medical Plan, one for the TPA funds for the Uniform Dental Plan. All of that is baked into that one slide where it was \$16 administration. All of the admin fees from everybody is the admin line. The admin line involves not just admin for this agency but admin in general.

Patty Estes: Do we have any kind of utilization from the PEBB Program on the spousal or state-registered domestic partner? Do we have any numbers?

Justin Hahn: Yes, we do. It's considerably lower. In regards to the PEBB Program and thinking about registered, we have approximately 46% of eligible PEBB Program subscribers currently registered and 5% are for spouse/state-registered domestic partners. That's approximately 66,000 on the subscriber side and about 3,000 on the spouse/state-registered domestic partner side.

Wayne Leonard: I've been somewhat skeptical of Wellness Programs that we've instituted in our district because it seems like the healthy people all participate and the ones that probably need it the most don't participate. But, if we were going to allow spouses to access this, do you have data that suggests we would save more than \$800,000 in medical claims?

Justin Hahn: I do not have information about that. We can look into that but it's a difficult equation to make from participation in the program to return on investment

savings or 'x' amount of dollars. That is the perennial, golden question. We have lots of data and interesting things in between those two markers that we can share. I can provide that information and additional research as necessary. Whatever the Board would like.

Pete Cutler: While you're preparing the background fiscal analysis, a question would be that \$800,000, is that based on the assumption that everybody who is a SEBB Program member that has a spouse or state-registered domestic partner, this program would pay an administrative fee to Limeade for all those spouses? Or would they only pay the administrative cost for those who actually registered with the SmartHealth Program?

Justin Hahn: It is for people that are eligible to access the portal, those would be eligible subscribers in the PEBB context, as well as spouses/state-registered domestic partners. It's a per subscriber per month for eligible.

Dave Iseminger: It's based on eligibility, not actual access and utilization of the program.

Justin Hahn: Exactly. Proposed Policy Resolution SBBB 2018-55 – Eligibility for Participation in the SEBB Wellness Program. The spouse or state-registered domestic partner of an eligible school employee may participate in the SEBB Wellness Program activities, but is not eligible to receive an incentive payment.

Dave Iseminger: As always, we'll bring back more information based on the questions you've asked. Is there anything else on this particular resolution that anyone wants us to bring back? It will go out in the normal stakeholdering process that all the other resolutions do.

Justin Hahn: Slide 13 – Decisions and Considerations Deadline. This slide talks about 2020 and beyond. I want to distinguish the difference between those two. We recognize the SEB Board is different from PEB Board. We have considered SEBB Program employee needs with regards to the incentive deadline. The second consideration for the Board to consider is how long subscribers will have to earn the incentive, what we call the incentive deadline for the calendar year. We recommend that the program launch each year in January, and that SEBB Program members have until the end of November to earn enough points to be eligible for the \$125 incentive in the following year.

Lou McDermott: I know when we first launched the program in the PEBB Program, we cut it off June 30 because of concerns with modeling and trying to guess how many people were going to get the incentive. Are actuaries saying because of the PEBB experience, we're feeling confident enough in the modeling that it won't have a substantive impact on rates or anything?

Dave Iseminger: In the PEBB Program, originally, the deadline was set at June 30 because of actuarial concerns and trying to estimate. In conversations with OFM and the Legislature making sure there could be as robust a model as possible, after a year or two of experience was under the belt, those concerns were lessened. The PEB

Board moved the deadline to September 30, and that's where the PEBB Program's deadline is now.

When we looked at the September 30 deadline, it's the first 30 days of school. It's probably not the best timeline. When we recommended to the PEB Board moving from June to September, we had conversations with carriers about how well it would work to be able to describe what incentive people had earned during open enrollment for the next plan year, and working with carriers to make sure the data was integrated. That's where we landed on the September deadline. That was about three years ago.

Because we were worried about September 30 for your population, we went back to the carriers and asked what else we could do. We tried to push as far into the calendar year as possible to be as far from the start of the school year as possible. Administratively, a period for all of the data to catch up, so when somebody shows up in the emergency room on January 1, the data is there and they're not asked to put down a credit card to pay for the deductible that's actually reduced because of what they did in SmartHealth. That's where that gap comes up in December. There's been an iterative process of learning about the program. Here, based on the four to five years of experience with the PEBB Program, we are saying, "We think with all the players in the sandbox, we can recommend a deadline of November 30."

Slide 14 – Proposed Policy Resolution SEBB 2018-56 – Deadline for Completing Wellness Activities. The important piece on this slide is the November 30 deadline would be rooted in when your medical benefits began. It's a sliding scale because, under the federal wellness rules, we're also trying to balance having equal access to the program. At some point, you have to have a deadline. For those people who, in this scenario, begin benefits after the month of September, they have a truncated period in which they can work on access to the benefits. They still have to earn points. But we work with Limeade to identify a way for people to participate in a robust way and have a quality experience, but also still have the ability to earn the incentive.

The reason we can have a deadline of December 31, in the second clause, is the vast majority of people are taken care of by the November 30 deadline date. You get 95% of the people who have benefit effective dates prior to October, and all that data works through the system. There is a small number of people where a catch up can happen with the data closer to January. We couldn't work with carriers to have everybody have a deadline on December 31 and still have everything work on January 1.

Lou McDermott: What I'm hearing is no, it's not a problem.

Dave Iseminger: Correct.

Pete Cutler: I certainly support having the period of time that persons can engage in activities in order to qualify for the incentive, having that run as late into the year as is administratively feasible. The fact that the carriers and the agency feel like they could take it through November, I think is excellent. Can I, as PEBB Program member retiree, can I hope for a similar extension, although, actually, it's not going to be very important because I'm going to be on the Medicare Program next year?

Dave Iseminger: Obviously, both programs are going to learn from each other. Now that we know carriers are less concerned with the November 30 date because of the work here, we'll be having similar conversations with the PEB Board if they want to extend the deadline. We knew that September 30 would be a challenge here and so we engaged in those conversations.

Pete Cutler: Great, thank you. I feel very strongly that the only way a reduction in deductible can be implemented through a Wellness Program is through a vote of this Board. I do not believe collective bargaining statutes allow for a Collective Bargaining Agreement to make that happen unilaterally. I have nothing against that if that's the will of the folks, especially those who actually are in the school districts. But I think the resolutions should be worded to provide that the Board approves that there be this incentive payment in the form of a reduced deductible and then have the timeline language. I just want you know that's a personal concern.

Eligibility & Enrollment Policy Development

Barb Scott: This presentation comes with some explaining because we have errors within it. I hope to navigate you through it.

I'm introducing two policy resolutions today. Slide 4 - Proposed Policy Resolution SEBB 2018-57 – Maximum Number of Months that Self-Pay Coverage is Allowed. This resolution allows employees to continue enrollment in SEBB benefits on a self-pay basis for a maximum of 29 months during an approved leave of absence. The 29 months would include the number of months allowed under COBRA. It's our understanding that many districts currently allow staff who are off on an approved leave of absence to self-pay for their coverage for a period of time in addition to the maximum number of months that are required to be offered under COBRA coverage. Typically, for an employee who loses eligibility, the number of months that they would be eligible for based on that event is 18 months under COBRA. The agency, in our administration, we plan to offer 18 months of COBRA coverage. What this would do is allow something that is beyond the minimum requirement under the federal regulation.

The PEBB Program has a 29-month provision in place today. This slide reflects the same 29 months. We did have some earlier conversations with the WASBO workgroup in trying to understand what exists out there today and what they're used to administering. They said it really varies by district as to how many months is allowed within contracts for employees to self-pay for the coverage. The 29 months that you see here is what is used under the PEBB Program. The PEBB Program's policy related to this predates COBRA. It goes all the way back into the 70s. That 29 months does happen to align to the maximum number of months that an employee could possibly get under the federal regulation based on a disability determination under a specific title.

Dave Iseminger: The federal requirement is 18 months. The Board could be more generous to allow self-pay longer and it would be easy to plug into the system what the agency already has to have the Board take that discretion and move it to 29 months.

Barb Scott: Yes. If we haven't already said it, we have been allotted enough staff that we will administer COBRA here in house at the agency. Our systems are set up to be able to handle this.

Pete Cutler: From an actuarial point of view, in terms of the PEBB Program, does the program track the claims history of individuals who go on COBRA or on similar continuation coverage, and how that compares with the claim history of active employees of the same age group?

Barb Scott: I would expect that we do have some data around that. I know that generally, those folks who continue coverage, especially under COBRA now, employees who are continuing it during an approved leave, the data may look different than it does for actual COBRA coverage. But most group health plans will say that those folks who enroll in coverage under COBRA are a little bit more expensive.

Dave Iseminger: We'll clarify at the next meeting when we bring this resolution back for action, the slice and dice data abilities of the agency. I believe we do have those abilities, but we'll go into more detail in follow up.

Pete Cutler: It may be that the numbers are so small that even if it's a higher average claims cost, it's still de minimis in terms of the overall funding.

Dave Iseminger: I can tell you, Pete, that in the PEBB Program, across the entire population, it's about 382,000 lives. The self-pay population is around 1,000.

Pete Cutler: Yes, but it would be good to -- as my budget analyst kicks in and says, "I just want to see numbers. I just want to be sure." Thank you.

Barb Scott: Slide 5 – Proposed Policy Resolution SEBB 2018-58 – Continuation Coverage for Dependents Not Eligible Under the SEBB Program. On this policy, the words "a spouse/state-registered domestic partner or child" all those words should be stricken, and instead add, "The dependent." The Proposed Resolution should read:

The dependent of a SEBB eligible school employee who is enrolled in medical, dental, or vision under a school employee's account on December 31, 2019 who loses eligibility because they are not an eligible dependent under the SEBB Program may continue enrollment for a maximum of 36 months on a self-pay basis.

Barb Scott: We are bringing this to you because staff are starting to work on the rules. The first phase of rulemaking is complete. We've been through public comment, the public hearing process, awaiting a formal filing of the adoption notice by our agency. Staff have finished your phase one rules for this program. They're working on phase two rules and thinking through the transition of employees from school district eligibility in existence today to those who are moving to SEBB coverage and also to populations that will not be eligible under SEBB. This policy is addressing a very specific population that we had conversations about when we talked about dependent eligibility for the SEBB Program. The dependent eligibility includes spouse and state-registered domestic partners. That leaves a group of dependents, those domestic partners who are not state-registered and their children, for us to consider how we're going to communicate with them and what the transition is going to look like for those families.

With that said, COBRA at the federal level requires continuation coverage for federally recognized spouses and federally recognized children. Domestic partners aren't federally recognized spouses and their children wouldn't necessarily always be federally

recognized either. Because of that, they're not deemed qualified beneficiaries under COBRA. When they lose eligibility under school district plans, they don't have to be offered COBRA coverage. Different than a spouse or a child of an employee who loses coverage that's federally recognized. This policy proposal would extend eligibility for COBRA-like coverage, a maximum of 36 months on a self-pay basis, for those dependents who are currently covered under a school employee as of December 31, 2019 and who loses eligibility because they are not an eligible dependent under the SEBB Program.

The 36 months we're suggesting on the slide is equivalent to the number of months that is required to be offered to a spouse who loses eligibility under an employee under a group health plan based on COBRA or a dependent child who ages out. The wording on the slide is very specific that it wouldn't go beyond the maximum of 36 months. We may have folks already being provided continuation coverage under the district programs based on those contracts that is equivalent to a spouse who loses coverage. It could be a dissolution of a partnership, or if there is a child who wasn't a federally recognized child under COBRA that aged out based on the limiting age, which is typically age 26 for all group plans.

Dave Iseminger: I wanted to bookend this and tie it up even a little more. When the team was looking at the impacts and transitions for school employees and dependents, we went back and thought about the feedback from the very first resolution. Resolution 2018-01 was about setting the eligibility to spouses and state-registered domestic partners and there were concerns that various Board Members raised about that loss of coverage based on the current, more liberal domestic partner policies in some school districts. The genesis of this resolution was the concern you raised. It provided an opportunity to bring to the Board another way to allow an option for coverage for those people who don't meet the new SEBB eligibility requirements.

Sean Corry: Thank you, Dave. To clarify, for those districts which offer COBRA, say with air quotes, to dependents "who might not qualify," when the switch is made in January 2020, the point being that, for those who lose eligibility at that moment from their group plan at the school district, they would be offered COBRA coverage through the Health Care Authority system for 36 months.

Dave Iseminger: COBRA-like coverage. I don't know that you can call it COBRA.

Sean Corry: I used air quotes again.

Dave Iseminger: Yes. By passing in this resolution, it would authorize that scenario. For a maximum length of some people, if their first month is January 2020, they could make it all the way to December 2023. If they already are an existing COBRA subscriber, it would be less than that. But the maximum length of the breadbox would be 12/31/23.

Lou McDermott: But for the more liberal eligibility criteria to the more conservative, it would be three years starting on 1/1/2020.

Dave Iseminger: Yes.

Pete Cutler: Just to be real picky, it really wouldn't technically be continuing enrollment because actually, they'd be going off the school district plan into the SEBB Program. So, just for what that's worth.

Lou McDermott: From their perspective, yes.

Dave Iseminger: We'll take a look at the word "continue" on the next to last line.

Wayne Leonard: Barb, did you say they would not be eligible for COBRA coverage under our old plans?

Barb Scott: That's correct. Under the current district plans, if there is a provision that is currently offering them COBRA-like coverage, if that's what they're current experience is with those plans, there's no federal requirement for them to do that. It does not exist because they are not COBRA-qualified beneficiaries under the federal regulation. When those plans go away, when they terminate, there really is no plan to offer them.

Dave Iseminger: There's the difference between the federal recognition and requirement that gives an employee COBRA protections versus the ability a district could do what we're recommending here, which is to be more liberal and offer the opportunity for self-pay coverage. But the difference between requirement and individual discretion to offer that self-pay is a distinction to keep in mind.

Barb Scott: I'm going to add one more thing to it to help add a bit of clarity. A group health plan is required under COBRA. A governmental plan, like SEBB, is under the Public Health Services Act, but it functions in the same way. You have to offer COBRA coverage to those deemed qualified beneficiaries. The group health plan, those rules require that COBRA coverage be offered for a specific number of months based on a loss of coverage, a qualifying event that causes a loss of eligibility under the group health plan. Typically, those are 18 months and 36 months.

There is a set of events that can occur that would cause COBRA coverage to terminate earlier than the 18 months that must be offered, typically, to an employee who loses eligibility under the plan or the 36 months that would have to be offered to a federally recognized dependent who loses coverage under the plan. One of those early termination events is that the group health plan itself is terminated. For school districts, there won't be a group health plan left come December 31, 2019. If they have no other participants in their plan, I don't know that they would want to continue to cover just COBRA members. I don't know what the district plans are thinking about that. But, if there's no plan left, then that's the question.

Dave Iseminger: We'll have more about COBRA administration and other aspects. This resolution is about offering an additional opportunity for those people who won't meet SEBB eligibility requirements. We can go into a large rabbit hole about COBRA administration. We have many more months to do that.

I want to say two things to wrap up. First, the Governor's budget has come out. Although the devil's in the details and, we'll talk about it at the next meeting, the Collective Bargaining Agreement is fully funded. That's good news for everybody.

Preview of January 24, 2019 SEB Board Meeting

Dave Iseminger: We'll talk about the Governor's budget in more detail, what's happened in the first ten days of the legislative session, and the K-12 retiree report. We're planning a demo of the front end IT system in its current development state. We'll be talking more about our communications plan and roll out for members. Barb will bring the four resolutions introduced today for action and will present additional resolutions.

Lou McDermott: I really want to thank the Board for all the work they've done this year. I wish you a happy holiday, safe travels, and we'll see you next year.

Next Meeting

January 24 2019
9:00 a.m. to 5:00 p.m.

Meeting adjourned at 12:44 p.m.