Washington State Health Care Authority

School Employees Benefits Board
Meeting Minutes

March 7, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 p.m. – 3:30 p.m.

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

Member Via Phone
Alison Poulsen

SEB Board Counsel
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 9:01 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 July 30, 2018 Meeting Minutes
Katy Henry moved and Patty Estes seconded a motion to approve the July 30, 2018 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

Approval of August 30, 2018 Meeting Minutes
Terri House moved and Wayne Leonard seconded a motion to approve the August 30, 2018 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

Approval of September 17, 2018 Meeting Minutes

Dan Gossett moved and Wayne Leonard seconded a motion to approve the September 17, 2018 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

Approval of Combined SEBB/PEBB September 17, 2018 Meeting Minutes

Terri House moved and Katy Henry seconded a motion to approve the September 17, 2018 minutes from the combined SEBB/PEBB Meeting. Minutes approved as written by unanimous vote.

January 24, 2019 Board Meeting Follow Up

Dave Iseminger, Director, ERB Division. At the January meeting, I had about nine questions asked. One response is not in your slides. During the IT update, there was a request from the Board that school employees receive confirmation of elections they just made. That was not in the original IT build, but it is now. That development has already occurred. Thank you for that suggestion. There will now be a way in the SEBB My Account system for employees to print a confirmation after they have completed their open enrollment elections this fall.

Slide 2. The agency completed a Request for Information (RFI) to help with a virtual benefits fair or an online selection tool. There was a request to have a list of the individual entities that responded to the RFI. The six respondents are: Jellyvision, Conduent, Business Solver, Resources Online, Eboro, and KAI. We have since moved on to a Request for Proposal (RFP) and are in the middle of scoring, so I can't describe too much more detail about that RFP.

Slide 3. At the last meeting, I provided general links about how an individual would access the provider directories with each of the potential fully insured carriers. That slide did not have the UMP provider search. This slide has that link, related to the provider search tool. When we get to the open enrollment packet that we send school employees this fall, we'll make sure we're highlighting ways for individuals to check provider directories. But for your materials, this is how you would check it right now to get a sense of the UMP provider network.

Slide 4. We have received a lot of questions about how to find information about who are eligible dependents, and what the phrase "SEBB Organization" means. We've used that phrase a lot. It means all of the entities, school districts, charter schools, and educational service districts. That's the umbrella term within the rules that were codified. I wanted to put those in a slide so the Board had that information since those are key terms, and where you would find them in the codified rules in the Washington Administrative Code (WAC).

Slide 5. There was a request for the timeline for rulemaking. The agency completed its first rulemaking and those rules are codified. The next day we opened the same rule chapters to start rulemaking exercise two. This is the timeline related to completing the second rulemaking. In general, we have started drafting different parts of those rules, and begun the official notice process under the Administrative Procedures Act for rulemaking. After the Board finishes making its decisions this month and next, we'll be able finalize rules that go out for public comment. We'll be on the journey identified by

this timeline to ensure all the rules from the second rulemaking are codified in time for open enrollment.

Even though the rules won't be effective until later in the year, we want to get the rules locked down early enough that our training unit can rely on them for helping SEBB Organizations understand how the eligibility rules work. That's one of the big pushes for the second rulemaking.

Slide 6. There was a question about the age requirements for tobacco cessation, although I can't remember the context in which it came up. This slide is fairly self-explanatory. It's generally around 17 or 18 years of age when you're able to participate in the tobacco cessation programs embedded within the various medical plans. Slides 6 through 9 provide specific information by carrier.

To dovetail this with decisions we've teed up and the Board made last summer, the tobacco surcharge must have a reasonable accommodation for individuals to pursue cessation opportunities. The benefit package within the medical plans includes the primary way by which someone could pursue that accommodation and be relieved of having to pay the surcharge. For those below age 17 or 18 who are trying to quit tobacco, there is an accommodation made in the Board's prior resolutions for ages 13 until 17 or 18 years of age. There is access to an online tobacco cessation program for them. The tobacco surcharge isn't applied to individuals under age 13. Each of the age bands has a way to avoid the surcharge by pursuing tobacco cessation for 17 and 18 years or older, through the medical plan itself. Otherwise, it's an online portal that is part of a Department of Health program.

Slide 11 is the link to the Senate Ways and Means Committee presentation I made. I also have copies for you of a Labor Coalition letter that was sent to various legislators.

The last question was some requested legal advice related to (6)(e) local bargaining that Katy Hatfield followed up with in an email directly to the Board, with attorney-client privilege. I'm not going to outline what that insight was, but remind you that question was answered in the interim.

Pete Cutler: Am I correct that if we have questions or want some clarification of what was in Katy's memo, the appropriate place to discuss that would be Executive Session?

Katy Hatfield: I don't think it qualifies for Executive Session, but you can come talk to me directly.

SEBB Finance Update

Megan Atkinson, Chief Financial Officer, Financial Services Division. We previously showed you slices of the data using modeling from last summer for the collective bargaining cycle. We were getting ready to kick off a bid rate workstream with the carriers and rate development for the self-insured plans with our actuary, Milliman. This is highly important because of the way we structured the employer medical contribution for the SEBB Program.

When the not-to-exceed bid rate information came in, it was run through all the models, and then results in updates. That was necessary to complete so we could feed an update into the legislative budget cycle, because both the House and the Senate are furiously wrapping up their budget development. We expect to see the first round of legislative budget proposals later in March. That will indicate whether or not they are using our recommendations or making their own modeling assumptions. It will be an indicator of how the Legislature is viewing our SEBB funding request.

Slide 3 – SEBB Funding Rate. The table on this slide you have seen before. It shows the different funding rate components, the Collective Bargaining funding rate development used last summer for collective bargaining, and the HCA update for March 1. Some of these numbers have moved around, most notably, the employer medical contribution, which is a result of our UMP self-insured rate development.

The employer medical contribution (EMC) is benchmarked off the UMP Achieve 2, 88% AV Plan. That number went down. Last summer, we were modeling the EMC at $616 and it's down to $578, which is a result of additional information and our bid rate development. There was a small adjustment of the ratio of adult units to subscribers. Then you see the math that results in the medical premium contribution. As you move down the table, you see dental, vision, Basic Life, Basic LTD, K-12 remittance, and administration and other costs.

I want to discuss why the administration and other costs essentially doubled. We currently have a loan from the State General Fund Account for SEBB operating expenses. As we were feeding information into OFM for development of the Governor's budget, we realized we need a second General Fund-State loan for the first six months of next fiscal year, because we will not have received revenue from the school districts until January 2020. We obviously need to keep operating July through December. In addition, because of the way some of our contracts are written with our plan administrators, we will pay claims. Some claims are paid weekly, some are paid a couple times a month. We fund the Flexible Spending Arrangement (FSA) vendors very quickly in the month. We will have claims to pay in January when we won't have school district revenue right away. We did a cash flow analysis that informed an additional General Fund-State loan. The administration costs went up because of the assumptions around repaying that second General Fund loan.

Slide 4 – 2020 Employer Medical Contribution (EMC) and UMP Employee Premiums. You've seen this table before and the structure remains the same. The only difference is the update on UMP Achieve 2 premiums and employer medical contribution. All premiums have been updated since the self-insured rate build. They are both crucial, but the benchmarking is based on the 85% employer contribution on Achieve 2.

Sean Corry: When I saw the actuarial values for the UMP Plus and the UMP Achieve 2, they're very close. The Plus is 89%, but the premium difference is odd for me because the UMP Achieve 2 rates are higher. The employee contribution is higher on UMP Achieve 2. I don't understand why those would be true if the actuarial value of UMP Achieve 2 is less than UMP Plus.

Megan Atkinson: I'm going to ask Ben Diederich from Milliman to come up because he leads the team at Milliman that does all of our self-insured rate development.

Ben Diederich: Sean, that's a great, astute observation. I think the biggest driver of that differential is the narrow network on UMP Plus. UMP Plus is a product where we have two contracted networks under the PEBB Program and those networks provide more integrated care services. Those integrated care services yield savings that lower that premium contribution. The service area is not quite as broad. UMP Achieve 2 is going to have a statewide offering, so there's also some cost differentials. The UMP Plus is more concentrated around the five counties around Seattle. It's since been expanded, but that's what's able to create that lower premium contribution relative to UMP Achieve 2.

Sean Corry: Understood and thank you.

Wayne Leonard: I wanted to check my understanding here, and I don't know if this is for you or for Megan, on how the rates are set. It seems like the total rate is very sensitive to what is determined to be the employee medical contribution, and then the ratio. Over the last few months, when we've been talking about this, as I recall, there's been a lot of discussion that we expect more dependents to be coming on these plans as we move to the SEBB Program. If the ratio of adult humans to subscriber went down from 1.586 to 1.573, maybe it's just my plans in eastern Washington, but on the Premera pool that I'm in in my district now, I think it has a ratio of about 1.7. I think the Kaiser Permanente Plan is even higher, in terms of dependents on the plan. Maybe there's more singles in the Puget Sound area, or whatever, but when I look at the four tiers, three of the tiers are in excess of 1.5. It seems like for most they're expecting single subscribers to bring this weighted average out at 1.5. Is that correct? Or am I misreading this.

Ben Diederich: You're not misreading the chart. We're assuming about 40% of the population will be in the employee only tier, at the 1.0 ratio. But it's also important to clarify a little bit about what you're asking for in terms of the member to employee ratio. I think that is what you're quoting is 1.7 for some of your groups.

Wayne Leonard: It could be. Maybe they're not comparable numbers. But I'm trying to logically check my understanding, because my understanding is there's no reserves set up for SEBB. That part of the rate includes building reserves. If we're anticipating a lot more dependents coming on the plan, I'm wondering if these rates are too low, or if they come in higher than this, what's the plan in terms of the reserves? Then next year, do we see a spike in rates to repay those? I'm concerned. What I think I understand and what I hear from my current plans, is this rate going to be enough?

Dave Iseminger: Ben, maybe you can answer questions similar to something that I struggled with, that the adult unit ratio on Slide 2 isn't the same thing as the dependent assumptions. Can you help explain that to the Board? I know I struggled with that for a long time and I think it's not intuitive that the tier ratio isn't the number to compare to Wayne's 1.7.

Wayne Leonard: That might help me understand this.

Ben Diederich: The member to subscriber assumption that we're assuming is 2.06 for medical. That's probably more comparable to Wayne's 1.7 that you're seeing for some of your eastern Washington groups.

Dave Iseminger: Will you describe what the adult unit ratio is designed to do?

Ben Diederich: The adult unit ratio really falls out of the fact that our funding structure is per subscriber. The Legislature is giving us an average amount per subscriber in the funding rate. We want employee premium contributions to be the same percentage across all tiers. That's what you're looking at in this chart. If you were to go through and calculate the percentage of employee contribution for a family tier, and the percentage of an employee contribution for an employee only, they will all be the same percentage for each of the individual plans. For UMP Achieve 2, they'll actually be the 15% target because that's how we set the $578 EMC.

When we want a structure where all the employees pay the same percentage, regardless of what tier they enroll in, we set up the employer contribution on a per adult unit basis. We set up the premiums to also be on a per adult unit basis. Now we've got the carriers setting rates and the employer contributing costs in a manner that all varies by the same ratios. Those tier ratios have been established to be consistent with how the carriers are going to set rates, and how we are going to charge employee contributions.

Wayne Leonard: Okay.

Ben Diederich: The 1.573 used in the funding rate is translating what we project the population to be as a whole, across all of the SEBB Program, how the people are going to fall within the four tiers. Also, how many people are going to waive because a critical assumption is, if a person waives their medical coverage, we will be charging a funding rate for that person. We will not have any expenditures of an EMC. The waive percentage is going to also impact that 1.573.

Pete Cutler: At the risk of causing more confusion, or maybe going from clarity to creating confusion, if you're looking at a subscriber to member ratio, then every child that's covered as a dependent is another subscriber?

Ben Diederich: Member, yes.

Pete Cutler: I'm sorry, another member, not a subscriber. But when you're calculating adult units, each child does not count as one adult unit.

Ben Diederich: Exactly.

Pete Cutler: That's why you have a different ratio of subscribers to members, versus subscribers to adult units.

Ben Diederich: Correct.

Pete Cutler: Great, thank you.

Dave Iseminger: Ben, will you confirm what unit a child is?

Ben Diederich: A child in this instance is 0.75. You'll see that in the employee and child/children tier. All children, regardless of if you have one, two, three, or more, are all valued at a 0.75 adult unit. This whole structure is put into place, always motivated by having employee premium contributions that are the same percentage across tiers. It really doesn't matter what we were to pick as tier factors. All different tier rations would have done is skewed how much percentage a premium the people in the higher tiers would have to pay relative to the cost of the average. The carriers are all looking at per member per month prices. They're evaluating their population for all members that participate. They're going to convert that per member per month price into what premium they want to charge, under the assumption of how many premium units they're going to collect based on the tier ratios that we've set, and the percentage of people that are going to participate by tier ratio. Some carriers may get all families. If those carriers get all families, they may have more children. Those more children may be less expensive than adults. So, their per member per month price is going to go down. But then, they're going to have more members relative to the adult units, because we're only going to give them three premium units to cover however many children they've signed up. The hope is that it tilts it back into the relative cost structure that we can compare across all plans. We can make sure that we're charging premium contributions that are equitable for all tiers within whatever plan they choose to participate.

Wayne Leonard: Thank you.

Kim Wallace: Wayne, you mentioned about the potential that the funding rate is too low. I wanted to address that. Both the authorizing environment and the funding environment is keenly aware of the possibility. There's certainly discussion about what would be done in that event. One good thing to remember is that the FY20 funding rate is going to be received by HCA for that six months of 2020, January through June, essentially one year from now. In one year from now, we will know actual enrollment. We will see the dependent load coming in and will know more about that ratio than we do now. We will have the opportunity to assess the funding rate for 2021. We can make changes if needed.

Dave Iseminger: The Board has heard Megan Atkinson and Kim Wallace say many times that no matter what we do, we're definitely going to be wrong. We're not going to hit the bullseye. We'll either be a little high or a little low. We are making reasonable assumptions. We've had conversations with legislative staff and at OFM about different pieces. They understand the recommendation that HCA makes and they can pull different funding assumptions and levers.

Wayne Leonard: This is probably not a question for Ben, but I've been getting questions from WASBO members about how much the employee has to pay, especially around the K-12 remittance piece because right now that's different all over the state. A lot of employers pay it. Some have cost share arrangements with their employees; and in some districts, the employee actually pays. What I've been telling them is the only thing they can charge employees is the employee contribution. That's what comes out of pocket.

Dave Iseminger: To put a finer point, the medical employee premium. And that is because one of the terms of the Collective Bargaining Agreement clarified that the employer has to pay the K-12 remittance.

Wayne Leonard: Correct.

Dave Iseminger: The only thing they can be charged is the employee member premium; and then if the school employee makes an election for an FSA benefit, a DCAP, or an HSA contribution, those can be deducted as well. But when it comes to premiums for the suite of benefits, it's the employee medical contribution.

Wayne Leonard: So, I'm telling them the correct information.

Dave Iseminger: It sounds like you are, yes.

Wayne Leonard: Good. I don't want to be telling them the wrong information.

Dave Iseminger: While we're still on this slide, we've highlighted that we've been trying to give you fairly accurate numbers along the way. We are now at a point where these are not-to-exceed rates. When you look at this chart and the four various employee contribution rows, the largest number you see is in Tier 4 of $303. You are understanding this chart correctly that within the suite of self-insured plans that could be on the table, the most a school employee would pay for full family coverage is $303 per month. I know that contrasts with experiences Board Members have described before. I want confirm that you are reading this chart correctly. This is just the self-insured part of the benefits portfolio. We felt we could show you and the public our cards now, so to speak, while the rest of the not-to exceed rates are still under negotiation. These could inch down, but it's not likely that they will change significantly. They won't increase.

Megan Atkinson: Wayne, I want to add context. For the school districts, there are benefits under the Collective Bargaining Agreement that are 100% paid by the employer -- all of those assumptions are built into the funding rate the school districts will receive for their state-recognized staff. But then, of course, there's still the locally funded staff.

We've already discussed Slide 5 – What the Employer will pay: EMC vs. Funding Rate.

Slide 6 is a continuation of Slide 5 and walks through the math. The employer medical contribution is benchmarked off the self-insured 88% AV plan. 85% of that was the $578. We multiply that by the ratio of adult units to subscribers. We get the medical premium contribution on a subscriber basis, the conversion Ben was speaking to, for the dental premium, vision, etc., moving down, also on a per subscriber per month basis (PSPM). That gets to the total funding rate of $1,114. It went down from what we modeled last summer. That results in a lower gross state funding need for K-12 health benefits.

Sean Corry: We heard earlier that we're looking at a family size of close to two, on average, with Regence -- excuse me, wrong company -- Premera or Kaiser is running about 1.7, 1.8. And we're expecting, I think just generally speaking, additional enrollment of dependents maybe getting to two or higher. So, that 1.53, which is the

ratio of adult units to subscribers somehow is translated from that expectation of enrollment of family size of on average, say, two?

Megan Atkinson: Correct. The weighting that Pete brought up for the adult units to subscribers, a child is not a 1.0. But comparing the member to subscribers, the child is a 1.0.

Sean Corry: I thank you for saying that because that raises another question I had when that was said. A child is counted as a 0.75, is that what I heard?

Megan Atkinson: Yes.

Sean Corry: That, I tried to think of the math, a child is 0.75 -- how? That brings us down to 1.573. I'm not asking for you to do the math at this moment. But I just haven't gotten it yet, that somehow it's translated into this lower number.

Megan Atkinson: Okay, would you like to walk through it now?

Wayne Leonard: It's an average of all the enrollment?

Megan Atkinson: It's all the variables going through the entire equation. We can have Ben come up and walk through it.

Sean Corry: Which, by the way, I've learned explains why $578 x 1.53 is actually $909.

Kim Wallace: We've had that conversation as well. There are many places in the financial model that involve rounding. There's quite a dynamic effect watching the EMC run through the model. I can assure you that the critical numbers in the model are the $578, the 1.573, and the $1,114. Thank you for noticing that, Sean. A number of us noticed that as well.

Ben Diederich: It's difficult to go through this easily without rounding things off, but let me try to take reality and give you a simplified illustration of how we get to the 1.573. Because we don't have a table prepared for this, we'll need pencils or good mental imagery. There are four tiers. Let's assume there's 40% in a single tier, 15% in the employee/spouse tier, 15% in the employee plus children tier, and 15% in the employee plus family tier. And those don't add up to 100 because we still have the waives.

Sean Corry: What's the percentage for the waive, to make it to 100?

Ben Diederich: We'll make it 15% in this example, or we can make the family tier 20% and make the waives 10%.

Sean Corry: So it's a game. Okay.

Ben Diederich: It's 100% of the population. They're either going to waive or enroll in one of the four tiers. Let's make the family tier 20%, which makes waives 10%. That should add up to 100%. The number of adult units associated with each tier for employee only is 1.0; employee plus spouse is 2.0; employee plus children is 1.75;

family is 3.0. Waives are now zero. Zero adult units are paid out in the EMC when a person elects to waive their coverage.

We can do the same process and say how many members per subscriber we think each contract is going to have. Employee only is going to be 1.0. Employee plus spouse is going to be a 2.0. Employee plus children. How many children do we think on average there are going to be within the SEBB Program population for every subscriber that elects coverage? I would say maybe 1½. For simplicity of math we choose 2 kids. That's going to be 3.0 members compared to subscribers. So right there, you've got a member to subscriber for 15% of the population that's a 3.0., but the premium adult units that we're going to be charging are 1.75. That's going to be the biggest spot that pushes down the adult unit to subscriber ratio.

Dave Iseminger: Plus the waivers are at zero.

Ben Diederich: Plus the waivers at zero. Let's use the same 2 kids for member per subscriber for a family. That now goes up to 4.0. Then, waivers again are not going to have any covered members per subscriber, so that's another zero. It is 40 (40% x 1.0 adult unit), 30 (15% x 2.0 adult units), and then 15% x 1.75 adult units is 26.25. I'll get you a table later, Connie, for the notes. 20% family x 3.0 adult units is 60. We have 40 plus 30 plus 26.25 plus 60 equals 156, divided by 90, and it's a 1.736 adult unit ratio.

Now, we'll do the math for members. That's 40, 30, 45, 80. That's 195 divided by 90 and 2.166. In our simplified illustration, the member per subscriber is going to be a 2.166 ratio. That's covered members per eligible subscribers. The covered adult units per eligible subscriber is going to be 1.736.

In reality, the number for employee-only coverage is 42%. We have more singles. The employee plus spouse is 15%. The employee plus child (children) is 15%. The full family is 19%. And waives are 8%. That's going to be the tougher math underlying our calculation of the 1.573. That distribution, when we apply it to the 1, 2, 1.75, and 3.0, those are the premium tier ratios, and we assume waives are going to be zero, that math is going to come out to the 1.573.

The rounding Kim was talking about are the reasons why the $578 times 1.573 doesn't equal the $907. That's because we want to charge employee premium contributions at a whole dollar. We have a couple rounding places where we want to make things simple to communicate. The employee premium contribution is one of those. The funding rate is another place. The starting point and the ending point are both whole dollar numbers. We keep the $1,114 at whole dollars. The $578 we also keep at whole dollars, so we can say whole dollar $578 is the employer contribution versus a premium that's charged out to the penny. We also round the employee premium contribution so we can make the percentage test signed in collective bargaining.

Sean Corry: I followed most of that. Thank you very much.

Lou McDermott: Ben, when you get that chart for Connie, Connie can get it out to the Board, as well as put it in the Board materials.

Megan Atkinson: Because we walked through so many things around the tier ratios in detail, I'm going to flip through these slides because I don't know that they add much more at this stage of the game.

Slide 7 is the employer contributions by tier. The funding rate remains the same. The employer contributions vary by tier.

Slide 8 – Fiscal Impact of SEBB Program to the State. I want to make one last point in terms of contrasting the modeling from summer to the updated modeling of March 1. The simple stacked bar shows the current amount of funding contributed for state expenditures on school health care, about $2 billion. Last summer we were modeling a need for an additional $860 million. OFM does the modeling for us.

Slide 9 shows the reduction in the funding rate that goes down to a need for an additional $750 million. The update was given to legislative staff supporting the members and writing the budget. That's a savings of around $100 million. It's significant and why they needed the updated information.

Pete Cutler: Is this General Fund-State funding only?

Megan Atkinson: Yes, but state funds in K-12 education.

Pete Cutler: This is not overall system funding, which would include the local and federal dollars. This is purely at the state side, thank you.

Megan Atkinson: This is state budget impact. I talked about this a little at the beginning.

Slide 10 – Next Steps. Next we will see legislative budget proposals. When the budget proposals come out, if they use a funding rate that differs from the $1,114 we're currently modeling, it doesn't necessarily mean that the program is underfunded. It means they've made different assumptions. Assumptions that would not impact our program the way we have it structured is a longer payback on the General Fund-State loans, for example. Our bids are currently set with an assumption around how quickly we build up reserves. They could have a different assumption and spread out our buildup of reserves, as long as they gave us a safety net, with an ability to come in for emergency funding if necessary. I wouldn't be concerned about that. Those are two examples of changes and assumptions they could make that wouldn't indicate directing you to change the program as it's structured. The vast majority of levers for the SEBB Program, and especially the SEBB Program funding, are in the Collective Bargaining Agreements. We will watch and see if the Legislature funds those.

Pete Cutler: Do you know when the updated revenue forecast comes in? That’s what, in theory, will trigger very rapid release of Senate and House budgets thereafter.

Megan Atkinson: No.

Dave Iseminger: Chair McDermott, I propose we take a break and see if any Board Member had any follow-up questions for Katy regarding her legal advice. Otherwise,

there wouldn't be time for those conversations before we moved into the related part of the agenda asking for Board action.

Lou McDermott: Okay. Let's take a break. And I think the revenue forecast comes out March 20, Pete.

[break]

Lou McDermott: Alison, did you join us by phone?

Alison Poulsen: I did.

Lou McDermott: Okay. Welcome. We're going to switch the next two agenda items so Barb can provide the Board information on COBRA continuation coverage before action is requested on the two continuation coverage resolutions.

COBRA Continuation Coverage Overview

Barb Scott, Policy, Rules, and Compliance Section Manager. I will provide a general overview of COBRA, and some specific requirements under COBRA, in hopes of providing context for the next presentation and answering questions from the last meeting.

COBRA is the acronym for Consolidated Omnibus Budget Reconciliation Act, passed in 1985. The Act has regulations in three different areas of federal regulation: the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, and the Public Health Services Act (PHSA). For governmental plans like those of states and political subdivisions, we pay attention to what's in the Public Health Services Act. ERISA doesn't apply. Because of that, sometimes what you see that comes out of Department of Labor isn't necessarily exactly what we have to follow, because typically ERISA plans have to follow that. We pay more attention to and follow the Public Health Services Act, regulations and guidance that comes out of Health and Human Services and the Internal Revenue Service.

The Employees and Retirees Benefits (ERB) Division is set up to administer COBRA coverage. It's been administered fully in-house since 2003 or 2004. The Division administers COBRA for the PEBB Program. Notices are sent by our systems in-house. We have staff that are very familiar with COBRA requirements and are prepared to administer COBRA for the SEBB Program.

Because COBRA comes from federal regulation, we're not going to bring policy proposals to the Board that the federal regulation requires us to act on as a governmental plan. What you are seeing instead are policy resolutions that fill the gap for situations that COBRA doesn't cover, and COBRA doesn't require. That's where the Board's authority comes in.

Slide 4 – General Requirement. The regulation requires that a group health plan maintained by a state or a political subdivision of a state, must provide each qualified beneficiary who loses group health plan coverage due to a qualifying event the ability to elect to continue group health plan coverage for a limited time on a self-pay basis.

Slide 5 – COBRA qualified beneficiaries include the covered employee, the covered federally-recognized spouse and dependent child of the covered employee, and children born to or adopted by a covered employee during a period of COBRA continuation coverage. COBRA is limited in scope. There are a number of individuals not on this list. Policy resolutions are being introduced to the Board to address some of the exclusions, such as SEBB Policy Resolution 2018-58, which was adopted by the Board in January. That policy extended continuation coverage to dependents not federally recognized as a spouse or dependent child of an employee, for example, domestic partners.

Slide 6 – What are Qualifying Events? The term "qualifying event" means any of the following events which result in a loss of coverage for a qualified beneficiary. They are voluntary or involuntary termination of the covered employee's employment, other than the exception for gross misconduct; reduction of hours; divorce or legal separation of the covered employee from the employee's spouse; death of the covered employee or a dependent child ceasing to be a dependent under the requirements of the group health plan.

Not all events that cause a loss of coverage are qualifying events. For example, an employee who is eligible and covered under a district's plan on December 31, 2019, but not eligible under SEBB eligibility, will experience a loss of coverage; but they won't experience a qualifying event. Because of that, Policy Resolution SEBB 2019-06 will be introduced to you later today.

Slide 7 – How Long Must Coverage be Continued? The length of coverage allowed corresponds to the qualifying event. For termination of employment of reduction of hours, the length of coverage is 18 months. That 18 months can be extended to 29 months if the qualified beneficiary is determined to have been disabled under Social Security Administration at a time during the first 60-day period of continuation coverage. Eighteen months may also be extended for a spouse or a child if there's a second qualifying event during the initial 18-month period. For example, if there's a divorce or a child ages out during that first 18-month period. For divorce, legal separation, death of the covered employee, or dependent child ceasing to meet the age limits under the plan, the coverage will go for a total of 36 months. If there's a divorce during the 18 months, then the 18 months will be extended so that the maximum number of months from the first qualifying event is 36 months. There will never be more than the 36 months.

SEBB Organizations will have qualified beneficiaries who are currently enrolled in COBRA coverage when those organizations transfer to SEBB coverage in January 2020. We know there will be divorces that will happen during the summer. There will be children who will age out under the district plans during the summer. We will look to successor plan requirements under COBRA in order to figure out how to handle those situations. The SEBB Program must allow individuals who are COBRA-qualified beneficiaries enrolled in COBRA as of December 31, 2019 to run out the time they have remaining by enrolling in plans offered by the SEBB Program. So, 18 months or 36 months, based on their original qualifying event, is what they would run out under the SEBB Program because all district health plan contracts will end December 31, 2019. SEBB Organizations will continue to provide group health plan coverage through the

SEBB Program; therefore, qualified beneficiaries will have continuing rights through successor plans that SEBB Organizations have through the SEBB Program.

Dave Iseminger: HCA will be providing the direct administration of COBRA on behalf of the school districts going forward, just as HCA does COBRA administration for the PEBB Program population. That responsibility will be taken on by HCA on behalf of the districts.

Pete Cutler: Am I correct that currently the school districts are individually, either by themselves or by third party administrators, handling COBRA administration for their employees?

Dave Iseminger: Yes.

Pete Cutler: I wish we had thought about that in advance as something to advertise in favor of this legislation, because I imagine a lot of districts will be very happy to hand that off.

Barb Scott: Some of them may have their plans doing it for them. But it is a task.

Pete Cutler: COBRA is pretty complicated.

Dave Iseminger: These days, we try to highlight some of the benefits that are shifting or burdens that are shifting from the districts to the Health Care Authority whenever we can. This is one of them that we are highlighting more and more.

Barb Scott: Not all individuals currently enrolled under a SEBB Organization's group health plan will be considered qualified beneficiaries. For example, an ex-domestic partner who was eligible under the district's plan where the partnership is dissolved this summer so is no longer eligible may be offered coverage under the district plan that is COBRA-like. But they are not a qualified beneficiary. There was no requirement for the district plan to offer them COBRA-like coverage. Some of the policy resolutions we're bringing to you will deal with this type of situation.

Wayne Leonard: On the COBRA administration part, I thank you for taking that over because it's not fun. This is all on a self-paid basis, so, if someone's out on COBRA and they cannot make their payment, what does the Health Care Authority do? Currently, people end up in my office and want the district to make some kind of arrangements when they can't pay. I end up being the schmuck that has to say "no."

Barb Scott: Rules are being written that will detail everything from the initial payment process, which under COBRA is under 45 days from the date of election to the delinquency process and the grace period provided for late payment of premiums. In addition, Rob's team is drafting a number of administrative policies to address things like requests for payment plans.

Wayne Leonard: I think that's great, but in terms of the communication to school district administration, I know school districts make side deals with employees, for lack of a better word. If those things are going to be frowned upon and you take

administration of it, I think school district business offices are going to be very grateful and thankful. It may also reduce the flexibility they've had over the year to make separate arrangements for people.

Barb Scott: That could be.

Wayne Leonard: If that's going to be the case, I think that should be communicated to business officials, because typically, it starts at the superintendent and then we're told to do it.

Barb Scott: That's good to know.

Lou McDermott: I think, too, it may actually increase some of the flexibility because some school districts may not be as flexible as yours. There will be a policy around how much flexibility there is in the system. Nobody wants to kick anybody off health insurance. I think that is true.

Barb Scott: That is a truth.

Sean Corry: Sometimes exceptions are made to the strict COBRA rules. It's actually said and implied. In those circumstances, for people who are currently continuing coverage, or will be on the transition date continuing coverage, under those looser rules, the Health Care Authority was going to be the administrator. You're not farming this out to another party, are you?

Barb Scott: No, we are not.

Sean Corry: Would you continue the COBRA enrollees as they are without question?

Barb Scott: We would not continue it without question. In order for them to be able to move from the district COBRA coverage to the SEB Board COBRA coverage, we will have to make sure each one qualifies either within the federal regulation (COBRA-qualified beneficiary who had a qualifying event) or the Board's policy resolutions. In order for them to participate, eligibility will have to be met.

If there are payment plans under the district plans, they will be going away. Those accounts will be cleaned up prior to them coming to SEBB Program coverage. We'll look at the original qualifying event, the date of the original qualifying event, their name and address, and then calculate how many months remain. We'll communicate with them so they can provide a completed election form and which plans they're electing under the SEBB Program.

Lou McDermott: Barb, it's theoretically possible that somebody who didn't have a qualifying event but was allowed to have COBRA, in the change-over, would not be eligible for COBRA in the SEBB Program? That is a scenario?

Barb Scott: That is a scenario.

Lou McDermott: Do they have appeal rights?

Barb Scott: I would have to think that through instead of answering that now. But currently if we deny someone something, we always give them an appeal right.

Dave Iseminger: Probably, Lou. That's what Barb just said. Probably.

Lou McDermott: Most likely.

Dave Iseminger: Yes. The important piece is that HCA will communicate directly with the members if they fall behind on a payment, for example. There are times within our self-pay options that we work on payment plans. We would negotiate what is applicable on a specific case-by-case scenario.

Sean Corry: I know that for administrators, superintendents, etc., it's not uncommon to have separation or contractual agreements where continuation of coverage for some period of time is part of the deal. This falls into that snag, too, when you clean up COBRA. It's either going to be COBRA-eligible or not. Is that correct?

Barb Scott: Yes. I think you're talking severance package type deals.

Sean Corry: As an example, yes.

Barb Scott: I don't know how the different districts have addressed these. If they are keeping them on employee benefits for, say six months. Or whether the district is saying you're no longer an employee as of June 30, but we will pay your COBRA benefits for the next six months. I have tried to imagine the scenarios with the team. That's why you're seeing policy proposals come forward.

If it's somebody who is on COBRA and their contract hasn't been renewed but you've given them a severance of six months, HCA would take them on for the run out for their COBRA period because they were terminated. They've obviously had a qualifying event. We're not concerned about who is making the payment to us, necessarily. If they're making the payment to us, or if you're giving them a bulk of money and they're making the payment out of that, it's set aside just for that. As long as it isn't something that's been given to them where they're not eligible under COBRA, or not eligible under one of the Board resolutions.

Dave Iseminger: I'm sensing a theme that the Board wants to hear more about implementation of COBRA by the Health Care Authority. We can put together a presentation about that as we continue to work through some of the details. This presentation was to give context as to why certain resolutions are coming to fill in gaps. We will work on how we're implementing different things and present that to the Board at a future meeting.

Barb Scott: I did include examples on Slides 9 through 12. I hope they are helpful as you go through Rob's presentation later. The first example is of a bus driver, who himself and his spouse are enrolled in SEBB benefits. The bus driver resigns effective June 18, 2020. The covered employee and his spouse would be qualified beneficiaries. The qualifying event would be termination of employment. The duration of coverage for

COBRA would be 18 months, based on the qualifying event of termination of employment.

The second example is a janitor who has herself and her spouse enrolled in SEBB benefits. She divorces her spouse effective January 31, 2020. Qualified beneficiary is the covered spouse. Qualifying event is divorce of the covered employee's federally recognized spouse. The length of coverage would be 36 months, based on divorce.

Example three is a bus driver who divorces his spouse on June 22, 2019. Spouse elects COBRA coverage under the school district's group health plan, effective July 1, and is enrolled in COBRA as of December 31, 2019. They are a qualified beneficiary and the qualifying event is divorce. The length of time the spouse is eligible to continue coverage under the SEBB Program would be 30 months. They've already had six months under the district plan, so the run out would be 30 months.

Example four is a teacher who has himself and a spouse enrolled in SEBB benefits. He reduces his hours from 40 hours per week to 10 hours per week, effective November 30, 2021. The qualified beneficiary in this case would be the covered employee and the covered spouse. The qualifying event is reduction of hours, and the length of time would be 18 months. This scenario assumes the employee didn't already meet the 630 hours for the school year.

Sean Corry: I have a question related to Wayne's comments with COBRA-like agreements. School districts commonly have self-pay arrangements that are not COBRA. I'm raising this now so it is raised and not forgotten. There is a significant number of employees at districts on a leave of absence, or some way in which they are not funded for their benefits, and they're allowed to continue staying on the plan for periods of time, as has been the practice of school districts across the state. Self-pay is another category of disruption. I can't tell you how many there really are. But it's an important one to think about as we go into this transition.

Barb Scott: The Board did adopt a resolution, SEBB 2018-57, that accounted for an employee who is on an approved leave of absence being able to self-pay for coverage for a maximum of 29 months. The 29 months would be inclusive of the 18 months of COBRA. That policy resolution will be included in the rulemaking that Rob and his team are working on right now.

Sean Corry: Thank you, Barb. The caution that I have now is that self-pay is not universally defined. There are lots of practices out there that may not fit the box. I'm worried that we'll go into this without having given it thought.

Barb Scott: If there are scenarios that you can think of that don't fit within the resolution the Board already passed, send those to us so we can look into them.

Dave Iseminger: Barb and her team have monthly meetings with WASBO officials to ferret out other examples of self-pay. Thank you for raising the concern. We will definitely make sure that we've covered different scenarios.

Policy Resolutions

Rob Parkman, Policy and Rules Coordinator, Employees and Retirees Benefits Division. There are seven policy resolutions for action today.

Slide 4 is the same slide from the initial briefing. The language from RCW 41.05.740 (6)(e) is further broken down to show the relationship of the (6)(e) RCW with the resolutions I'll present today for action. The first box on the right shows there are two resolutions on terms and conditions, which will include the employer share, tier categories, and ratios. A resolution will be introduced today that deals with additional terms and conditions for the (6)(e) area of the RCW. The second box shows two resolutions on eligibility criteria SEBB Organizations can use when engaging in local negotiations regarding eligibility. It includes what groups can participate and a range of anticipated work hours that can be negotiated within. The third green box shows one resolution on approved benefits for this population. Remember, the SEBB Program must create multiple new processes and procedures to administer this part of the SEB Board's authority. There is no similar requirement within the PEBB Program for this idea.

Dave Iseminger: A question was asked at the last meeting about permissive versus mandatory bargaining. That question exists regardless of whether you take action on these resolutions. Your authority doesn't extend into answering that question. My analogy is to think of a light switch. Whether that light switch exists, the permissive versus mandatory question isn't something you have authority over in statute. But how that light switch works, if it is used, is your authority. The part of the resolutions on the benefits side would establish the benefits allowed and the cost to employees and a cost to employers. The dimmer switch on the light is the eligibility requirements.

If you passed Resolutions 1 and 2, it would indicate the range of groups to which a SEBB Organization could apply these benefits and hours. If the light switch exists and it turns on, here are the benefits and the authority for local bargaining related to eligibility. It can only be within that range. Complicated analogy, but I think it encapsulates the theme. I hope this provides a framework as you take action on these five resolutions.

Wayne Leonard: In preparation for the meeting, we had a conversation about these next five resolutions. I still have concerns about them. You asked at that time if I could think about them and bring information back that would be helpful in adjusting or improving the resolutions. I don't have any suggestions now because I haven't been able to contact many members in my group that know more than I do about this. But I listened to a WASBO group that Barb and John were at, and there were a lot of questions about it.

You indicated it might be possible to delay these votes to the April meeting, at the latest. Some of my concerns, just from talking to a few people, for example, in your analogy when we were discussing the first two resolutions being somewhat of a dimmer switch, and then an on/off switch, school districts right now have provided benefits to certain people, but it would be medical only. Or it would be a different cost share. They've had some flexibility. And now it's either on or off. I don't think that information is out to people. All the information I've seen that has been distributed to people only talks about (6)(d) employees who have 630 hours or more.

This part of the bill has been in there for a year but it hasn't garnered much attention. Potentially, if we pass these resolutions now, I understand information can come out and groups could be bargaining this summer for these benefits. At the school district business office level, we don't currently know what the SEBB Program is going to cost at the local level. We don't know how many additional employees might become eligible at this lower level of eligibility. We don't know how many employees, like substitute employees, may reach that 630-hour cap. And many people aren't even aware that isn't on the radar. I worry about schools ending up bargaining this when they don't even know what the cost of the (6)(d) employees are going to be, let alone the (6)(e) employees.

I can see a situation where, at least in terms of the (6)(e) employees, people of the school districts that may bargain this are probably typically going to be the ones with more resources to be able to afford to offer these benefits. The part with the state changing this whole financing system was to try to eliminate the haves and have-nots. Now there's legislation to try and change the levies again. I worry about that because this will create another situation where there's haves and have-nots. Some districts will be able to offer these benefits. Some districts won't.

Dave Iseminger: Just to clarify, Wayne. That very topic exists under the law, regardless of what the Board does. There is statutory authority. That question exists because of existing state law. The authority for the Board is about setting guardrails.

Wayne Leonard: Correct. When we had our discussion, I brought up some examples like can we do medical only. Your response was, no. That would be too difficult for the HCA to administer. I don't want to put words in your mouth.

Dave Iseminger: If that's what you heard, I can describe a bit more and clarify. With these five resolutions, they are all five different levers. The authority for the Board is to pull those levers in any combination it wants, within some constraints. For example, in the first resolution about by group, if the Board wanted to go even more granular than a bargaining unit, we would advise the Board of risks associated with that. What we put forward for the Board on that particular resolution is the maximum flexibility. But, if you wanted to raise it and say districts can't do it by bargaining unit, they've got to come all in for the entire organization or not at all, you'd have that authority.

Let's look at the second resolution on hours eligibility. When we presented it last month, we described a 180-hours floor as helping mitigate risk by ensuring that there was definitely an employment relationship. There was a concern that if you would go lower than 180, you would start to have concerns about whether there is that employee/employer relationship. Now, you can change that number 180 hours and be anything up to the (6)(d) threshold. There's complete flexibility within that range in that proposed resolution.

When you switch to the benefits resolution, you could say medical only, a combination of the four benefits, or all of the benefits, as the agency put forward in its recommendation. There are at least two main reasons that colored the three Benefit Resolutions. First, the most likely individuals, if the light switch exists and is turned on, to be covered in these situations are people who could bounce in and out of (6)(d) and

(6)(e) eligibility because they are so close to the 630 hours threshold. It would seem strange to me if there was a situation where an individual district bargained to cover 180 to 250 hours, but not 250 to 630 hours. You would think the first group of people who might be covered are those individuals who are on the edge of (6)(d) eligibility. As people bounce in and out of that eligibility, because their hours could change, recommending that the benefits' piece is the same in both of those categories would smooth out the experience for those school employees.

The second reason is administrative simplification. Right now there is so much variability in the system. That was part of the reasons for the SEBB Program consolidation. When we look at that framework for why this Program was created and putting forward proposals related to (6)(e) benefits, it seemed logical to create little variability; the point of the SEBB consolidation is to eliminate a fair amount of variability. For the Board to provide a set of benefits that also would be the same if you bounced in and out of (6)(d) would smooth that transition, reduce the variability, and help with administrative aspects.

Lou McDermott: Wayne, we've had these discussions internally. I handle a lot of the operational aspects of the Health Care Authority. From my position, one of the things I like to do is know what the guardrails are because I understand how long it takes our internal processes. We have approximately 1,400 employees. When we make a change, it takes a long time to execute the change, put the policies in place, and let the older policies go by the wayside. There's always a transition. From my perspective, the sooner we can identify the guardrails for the school districts, the sooner they can start adjusting their business practices. And then, understanding it all the way, because even if we tell them today, they're not going to fully get it for a while because they're going to have to look at their own internal processes. They're going to have to make some adjustments. They're going to have questions. It's going to be back and forth to really establish what those guardrails are. That's my thoughts on getting to something that is more definitive so they can begin to make the adjustments they need to make.

Wayne Leonard: I agree with that. I guess my concern is I don't even know what the guardrails are as a Board Member. I just know what's been presented as a possible resolution. When I brought up that situation, are there other things that is a potential guardrail that I don't know about? It feels like, and this isn't to be critical, because I think we're operating with different levels of knowledge, but, like last spring when we were first starting to feel our way through the medical plans. It was you get to set the terms and conditions as long as the plans look like PEBB, sort of.

Dave Iseminger: Taking into account the two Program's funding similarities, is how I would say it.

Wayne Leonard: And trying to leverage the PEBB plans to get the plans moving on time. This feels the same way, where I don't necessarily know, and I haven't had a lot of time to get input from my members about, if you don't like these, what would we like to see? I know we got some feedback from WASBO members. But, even as a Board Member, I don't necessarily know what different items there could be. Some of the comments were that this is expected to cover a very small number of people. I'm not sure we know that, once it's subject to collective bargaining. Obviously, financial resources are finite and limited, so that will be one guardrail. It doesn't say in the bill

that this is expected to be a limited number of people or clear legislative intent. Those were comments made by other groups. I'm queasy about voting on them because I feel like I don't know the stuff I need to know. And one month from now, I may not know that

much either. I may try to solicit information from other people. And everybody's so busy, I may not be able to get any response. That's where I'm at. I just want to let you know. I've been thinking about this and I haven't come up with any good answers in my head.

Lou McDermott: One of the issues that always comes up when we're creating a new program is that unexpected, "is it really that way?" We think it's that way. We look at the rules. We look at the bill. We implement a program. We think it's that way, and then we get a challenge. The challenge can come through the administrative process, the courts, or just a direct challenge where an advocacy group or an attorney contacts us and says, "We see the way you're doing the program. We see the bill. We don't agree with how you did it."

Over time, programs develop as case law takes place, as administrative hearings take place, as re-examination takes place. To be honest with you, I don't think there's any way to hit anything perfectly because you just don't know until someone challenges it. You don't know there might be a weakness in the way the bill, the statute, was created, and even the policies created behind it. There is always fear. And we experience it, too, because sometimes a bill will have a wide-open center to it and we have to interpret what we think it meant. Then, when someone challenges it we discover that's not exactly what they meant. And then, we're having to change the program.

I totally agree with you that we're not going to know it all the way. There probably will be challenges. There will be different school districts that could be negatively impacted by the guardrail or not able to do what they've historically done because of that guardrail. We encourage them to challenge us and to explore those possibilities. We work with our Assistant Attorney General (AAG) as new legal arguments come in. Many times we meet with the AAGs and get their perspective. We make adjustments, if necessary. I do understand. There's a need for informing the world so they can make the appropriate changes. There's a need for completely understanding what the ramifications are. I don't think either one is completely overriding that we are deep in the game. I'm becoming concerned to the point of wanting to vote and see how people feel about it and let the chips fall where they may.

Dave Iseminger: I want to give one more context to something Wayne said, which was, we deliberately brought these five resolutions as a packet because we think these are the fundamental guardrails and concepts the Board would need to chime in on. Unfortunately, we realized between last month and this month that there was a sixth one that, essentially, Rob will present later, that basically says a lot of the decisions you've already made apply in the (6)(e) setting. For example, the 31-day enrollment period, when benefits begin, when they end, etc.

Our goal was not to have a twelve-month dissertation on (6)(e) eligibility, but have you build the bare minimum foundation. It was deliberate to present them all together. Which type of employees, what type of benefits, how much different people can pay,

and what the hours are. These are levers we think you need to chime in on about this area, as a set.

Sean Corry: I have two questions. One is whether there was any substantial, substantive effort to get feedback from administrators and bargaining groups about the limits that are in these resolutions that we're asked to consider. And, secondly, a question for Wayne, whether we could expect, if we delayed it a month, for example, that we would get information and opinions and asks within the next month that would change the resolutions in any way. If we were to delay, whether you could handle a delay for a month.

Dave Iseminger: I won't answer the question directed to Wayne, but I'll answer the other two. With all policy developments, we have a monthly meeting set up with WASBO to talk through different issues with each of the resolutions. This set of resolutions went through that same process. WASBO feedback is typically among the stakeholder feedback Rob presents that we've always anonymized. There were conversations with WASBO that did describe concerns. Rob will go through those as we go through the resolutions later. Primarily, it was could the hours' threshold not be 180, could it be a higher number? Could it be medical only instead of the four benefits? Could the employer split not be tied to the EMC of the state Collective Bargaining Agreement? Could you make it something like a range? I don't believe that we actually got a proposal for a specific range. But the resolution, in theory, could read as "no less than 50%, but no more than 75%," and create a range. Those were the three core concepts that came from the WASBO meetings.

There was one piece of written feedback from Julie Salvi and the Washington Education Association (WEA). We also have a monthly meeting with the Super Coalition members who were part of the collective bargaining process, and we talk through upcoming resolutions and upcoming communications. It's a workflow group to be able to get feedback. I think Julie's feedback that you received in her email embodied that insight.

We will provide you that feedback, but we are actually making the same recommendations on the resolutions HCA put forward in January. The one exception was to change the nuance of "electing to locally negotiate" to "who engages in local negotiations." The thought was to not have the Board step into anything about whether a light switch exists or not, that permissive versus mandatory debate. That was the only change as a result of the stakeholder conversations. We are describing the feedback that came in both of those deliberative processes.

Your last question was the timing piece. There is the ability to have the Board vote on these resolutions in April, if necessary. I think the question I kept coming back to is, what information can we provide that can help change that perspective to make something different about your understanding in April versus March? There are risks, but not insurmountable. The agency can lean into that process. We're getting very close to the end of the decision making process that can make it into rules for development, and be codified in the WAC in time for the end of the year. The other challenge, though, is we do need to begin communicating to districts what those guardrails are because that question of what authority is under that statute exists today. It could rear its head as early as this summer, as Wayne has pointed out. There is the concern that delaying defining these guardrails takes away another month of being able

to get people to understand what the guardrails are. There are issues with delay, but I don't think they are insurmountable. I do think there is benefit to proceeding if at all possible.

Wayne Leonard: Your question to me was if a month would help and if we would get additional information. My honest answer is I don't know. Put together information,

send it out via email to a group, and some people respond and some people don't. The user group that Barb went to had comments in here already. I don't know if we would get just the same comments, that we agree with those comments, if we would get additional comments. I think my biggest concern is there are a lot of estimates from school districts about what they think this is going to cost. There's ESDs doing estimates, and there's people telling their legislators this is going to be a huge cost. But nobody really knows. Like Megan said, next March we'll know, because people will have enrolled. It's the same thing from our end. A year from now, we'll know what it's costing. But we don't know right now.

Then, to have this other option, you can bargain additional stuff, and we don't even know what it's going to cost makes me real queasy. I don't know if we would get additional information. I really honestly don't. And we may not because in another few weeks it's going to be Spring Break and people will be off or taking vacation. They're all paying attention to legislative stuff now. I don't know if by the time this crosses their desk they may not. I guess if the guardrails are what we have in here, I think people need to just understand them, if they're going to bargain this. Typically, under our current program, if we say "medical only" and you get funded by your FTE, then it's primarily giving employees access to medical insurance. They pay the majority of the cost. This is giving them access and the employer pays the majority of the cost. It's a big change in the mindset of when we start talking about bargaining with our employee groups. I don't know if people realize that.

Dave Iseminger: I hear that if the Board were to pass the five resolutions, focusing clear communications on Resolution 5 might be a key point, because that's the employer split you're describing that may not be as appreciated.

Wayne Leonard: Right, all or none, too. Right now a lot of districts don't do all or none. They might bargain with a group that is medical only and then we have to deal with the administrative complexities with Premera, Kaiser, or whomever. That's my biggest concern. I don't know how widespread the knowledge is. The group that Barb meets with is relatively small.

Barb Scott: I took two things away from the work we did with the WASBO work group. There was a reaction to the knowledge this language exists within RCW, and it is the responsibility of this Board to set the terms and conditions as far as how this will function. There was pure reaction to begin with. Once we got into talking about it, now there is knowledge it exists and there was greater feedback around how they might see this functioning. They shifted from the idea that this would just provide access, which is their current world, to this is extending eligibility for employer-paid coverage to this group. Once they caught that concept, they paid greater attention to the hour threshold and to the number of different benefits that would be available. They provided us with

the specific feedback that, providing access and an employer contribution for medical might be a better starting position for districts.

Also, the hours' threshold we threw out was maybe lower than what they would think about now because of the difference in the way this plays out compared to their current world. Those were the things I took away from that conversation. Now that they are more aware of this provision in RCW, they are thinking about it. We came away with some really good feedback from them. I think that was what Rob included in the notes you were provided.

Wayne Leonard: That pretty well sums it up.

Patty Estes: I have a question for Katy Hatfield in private before we move forward on this one, if that's okay.

Lou McDermott: Okay, let's take a quick break.

[break]

Lou McDermott: Patty, are you good?

Patty Estes: Yes!

Rob Parkman: Slide 5 – Policy Resolution SEBB 2019-01: Requirement to negotiate by group under RCW 41.05.740(6)(e). The policy considerations for this resolution must ensure that all similarly situated school employees are treated the same when provided benefits, and that the determination of who would qualify for these benefits would be the responsibility of the SEBB Organization.

There is a global change on Policy Resolutions SEBB 2019-01 through SEBB 2019-04. Based on stakeholder feedback, we replaced "that elects to locally negotiate" with "engaging in local negotiations regarding eligibility." I won't repeat it when discussing the other three resolutions. The resolutions presented at the January meeting are located in the Appendix.

Stakeholder feedback. There was one stakeholder who supports the groups allowed to participate as presented in the resolution.

Lou McDermott: **Policy Resolution SEBB 2019-01: Requirement to negotiate by group under RCW 41.05.740(6)(e).**

Resolved that, a SEBB Organization engaging in local negotiations regarding eligibility for school employees under RCW 41.05.740(6)(e) may only negotiate by group as described below.

- The entire SEBB Organization; or
- An entire collective bargaining unit; and/or

- A group containing all non-represented school employees.

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

Doug Nelson, representing Public School Employees of Washington. We have 32,000 classified employees that we are preparing for negotiations for this year. I am in charge of all of our negotiations. We have 227 bargaining units. 150 of them are focusing with open contracts and re-openers. We are developing contract negotiation language as we speak. We have gone along with all five of these resolutions that you're going to be dealing with. We support them. Even though they're guardrails and rules that we're going to have to follow that we currently don't have to follow, because, if we only follow the law, it's wide open. We have decided to go along with these resolutions as a midpoint. From our organization perspective, on all five of these resolutions, we've looked at them, they've put guardrails around what we can do, and we're comfortable with them. So, I would urge support. Thank you.

Voting to Approve: 9
Voting No: 0

Lou McDermott: **Policy Resolution SEBB 2019-01 passes.**

Rob Parkman: Policy Resolution SEBB 2019-02: Anticipated work hours eligibility range under RCW 41.05.740(6)(e). Considerations in the development of this resolution was the 180 hours equals one hour a day for the required number of school days within one year. Also, one hour a day shows some employment relationship given that these are employer-sponsored health benefits. This policy provides a maximum flexibility and access that seems reasonable for the local negotiations process. The only change to this resolution was the global change mentioned earlier.

Stakeholder feedback. One stakeholder wants the widest range possible for negotiation purposes. Another stakeholder wants the floor moved to 450 hours. This would equal about 2.5 hours per day for a nine to ten month employee. We have not made any changes to the floor of hours within the resolution. This policy as presented presents the maximum flexibility and access that seemed reasonable for the local negotiations process.

Lou McDermott: **Policy Resolution SEBB 2019-02: Anticipated work hours eligibility range under RCW 41.05.740(6)(e)**

Wayne Leonard: Is there a way to make a motion to amend the current policy?

Katy Hatfield, SEB Board Counsel. Yes. If there's a motion and a second, you can make a subsidiary motion. At that point, you move to amend or you move to postpone to a certain time. That then becomes the motion that we would debate and vote on first. Then, seeing the answer on that, go back to the original motion if needed. Or vote on the motion to amend if that was implemented.

Lou McDermott: **Policy Resolution SEBB 2019-02: Anticipated work hours eligibility range under RCW 41.05.740(6)(e)**

Resolved that, a SEBB Organization engaging in local negotiations regarding eligibility for school employees under RCW 41.05.740(6)(e) shall negotiate within the range of anticipated to work hours described below:

- No less than 180 hours per school year; and
- No more than the threshold to meet the SEB Board's eligibility establishment pursuant to RCW 41.05.740(6)(d).

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

Wayne Leonard: I would like to make a motion to amend. I would like to amend 2019-02 to have the hours be no less than 450 hours. I'm concerned that, if someone only works 180 hours, all of their wages may not have enough. If they're selecting a plan for full family coverage, they may not have enough in wages to cover the premium for that plan is my concern.

Katy Hatfield: Now you ask if there's a second to Wayne's motion to amend.

Pete Cutler seconded the motion to amend.

Doug Nelson, representing Public School Employees of Washington. Part of the review that we had of this over the last two months was in recognition we needed to negotiate in good faith. We came up with 180. We agreed with it. We thought it was a reasonable number. After all, it's voluntary whether the school districts agree to 180, 300, or 600. It's up to them. This gives maximum flexibility but also puts a bar in place. We think it's a reasonable bar. So, we oppose the amendment.

Fred Yancey, on behalf of Washington Association of School Administrators. We would be actually in support of postponing the main idea. It would be our preferred option. But we'd certainly be in support of the suggested amendment. Even though it's going to be mandatory bargaining. However you word it. Groups are going to get together and demand their share of the pie. I would like to see districts at least analyze how many employees are we potentially looking at, at 180 hours. How many are we looking at, at 450? And without that data, you're arbitrarily setting a benchmark telling people you can start bargaining. I would be very much in support of that secondary to want to delay.

Patty Estes: I think this range gives the school district a range and they can choose to engage in that or not. It also gives some flexibility to both sides when negotiating to set that bar, that this is just the floor level, and as I understand it, this is establishing the work relationship. If we raise that to 450, then we're saying that work relationship starts at 450 versus the 180. As a classified employee, I know several that are at 180 that would like the chance to engage. I think that's where I stand on that. I would like the 180. I think that's the best one.

Terri House: I agree with Patty, in the respect that this is a guardrail. As a Board, we're laying out the lanes right now. I think if we went any further than this we would be

interfering with the collective bargaining process and I don't think as a Board we want to do that. I would support going back to the original.

Pete Cutler: I have to admit, to begin with, my preferred action would have been to postpone action, because I am concerned that I don't really understand enough of the dynamics and implications of setting the limit as low as 180 hours, in terms of the ability to provide the coverage with employer paying the full rate toward the normal full employer share. But I did want to second because I wanted some discussion. I did not want to go straight to a vote.

My concern as a former budget guy is, I look at this and, if you had somebody working at $20/hour over 180 days, that would be about $3,600. And for $3,600 in compensation, you might be asking an employer to engage in bargaining to provide over $14,000 a year in insurance benefits. That's a huge disparity that most people in the public would not begin to understand. It would be like this group is in better shape than any of us. I hesitate, in terms of having taken action that might make it look like the program provided to school employees statewide is more generous than average workers and employees in this state can hope to have the opportunity to enjoy themselves. But, having said that, I also understand it's not providing benefits at that level. It's just a question of which group of employees would employers and collective bargaining groups be able to begin negotiations. I am actually wishy-washy myself on the particular number. But I at least wanted to get a budget perspective and a policy perspective into the discussion before we vote.

Wayne Leonard: I don't think the 180 hours is necessarily a level that establishes an employment/employee relationship. I think that we're talking about establishing eligibility guardrails or eligibility criteria. I think, as David mentioned, if the major concern was people falling in and out of coverage depending on the number of hours, I think that the 450-hour guardrail seems reasonable.

Lou McDermott: We will do a roll call vote on Wayne's suggested amendment.

Voting to Approve: 2
Pete Cutler
Wayne Leonard

Voting No: 7
Patty Estes
Alison Poulsen
Dan Gossett
Katy Henry
Sean Corry
Terri House
Lou McDermott

Lou McDermott: The motion to amend fails.
I'll now go back to the original Policy Resolution.

Lou McDermott: **Policy Resolution SEBB 2019-02: Anticipated work hours eligibility range under RCW 41.05.740(6)(e)**

Resolved that, a SEBB Organization engaging in local negotiations regarding eligibility for school employees under RCW 41.05.740(6)(e) shall negotiate within the range of anticipated to work hours described below:

- No less than 180 hours per school year; and
- No more than the threshold to meet the SEB Board's eligibility establishment pursuant to RCW 41.05.740(6)(d).

Voting to Approve: 8
Voting No: 1
Wayne Leonard

Lou McDermott: **Policy Resolution SEBB 2019-02 passes**.

Rob Parkman: Slide 7 – Policy Resolution SEBB 2019-03: SEBB benefits authorized under RCW 4105.740(6)(e) The policy considerations for this resolution are for benefits offered, to have the same benefit design as (6)(d) school employees. For example, no Collective Bargaining Agreement can change the number of chiropractic visits or the value of the wellness incentive. Also, remember that SEBB Organizations must use SEBB benefits and can't offer competing coverage as described in RCW 28A.400.280.

There was the global change made to this resolution, and for clarity, added “includes the wellness incentive program” within the first bullet.

Stakeholder feedback. One stakeholder wants the same benefits as (6)(d) eligible employees receive. Another stakeholder wants medical only for this group. No changes were made to the benefit package as presented today, to ensure that alignment with the (6)(d) is as close as possible.

Dave Iseminger: With the piece of stakeholder feedback about having the exact same benefits as (6)(d), a work relationship under 630 hours couldn’t support a long-term disability benefit. That is why it is not in the list and you only see four of the five major benefits.

Pete Cutler: Did the agency consider giving two options, either medical only or the full package, as presented here? And if it did, why was the decision made to require the full package as the only option?

Dave Iseminger: The answer to your question is yes, that was a consideration as we were bringing forward a recommendation. There are at least two reasons that I recall we didn’t propose flexibility here. The first was, again, smoothing out that transition between (6)(d) and (6)(e). (6)(d) employees have all of the benefits. You would lose access to some other benefits, especially if you were on the fringe of the eligibility requirements between the two employee types. A second piece that was a consideration is right now, when a school district joins the PEBB Program, they have to

join full benefits. The experience the districts have had if they've engaged with the state program has included accessing the full suite of benefits. That was another piece of the puzzle. That is par for the course for how the agency and districts have interacted with the state program to date. At least the 70-ish districts that currently engage with the PEBB Program benefits.

Pete Cutler: Dave, do I understand, in terms of administrative processes, that right now, at least with how the PEBB Program interacts with school districts, that it is an all-in or you don't come in at all? Therefore, in terms of administrative processes and structures, is it safe to say that would be the simplest and smoothest framework to have for the new SEBB employers as well?

Dave Iseminger: Yes.

Pete Cutler: Okay. For what it's worth, my observation would be that one could make a case that the need for continuity of benefits and the importance of providing access to benefits is much more important for health benefits than the other categories of insurance benefits. I could see someone making a case for bifurcating the options that way. Although, here again, it's a new enough area for me, I'm not sure myself where I would land at the moment. But, I would like to at least have a sense of whether that would be considered a feasible option, to provide at least from the Health Care Authority's perspective, a choice of either medical or the whole package.

Dave Iseminger: Pete, ss you were talking, I remembered a third reason. Remember that as with the (6)(d) population, districts don't have any authority with any of these benefits. If “medical only” was how the resolution read, no district could add on. The Board would be setting that lever to the point where there is no ability below (6)(d) eligibility to have access to any of the non-medical benefits. That was another part of the consideration. It’s the only way there would be employer group coverage access for the other benefits. That was another tipping point for having the opportunity to have these benefits.

Pete Cutler: Okay. Thank you.

Wayne Leonard: Following up on Pete's question. It's almost like we have two different groups of employees. Maybe with what you had indicated of people right around that 630 hours falling in and out of coverage, it makes total sense to offer them the full suite of benefits. People that are maybe down at the lower level of hours that aren't falling in and out of benefits are the ones, I think, that districts historically have maybe bargained medical only for. Those are kind of two distinct groups of people. In terms of the first resolution, we talked about maximum flexibility. But in this resolution, it's all or none, right?

Dave Iseminger: That goes back to what I described as the agency put together a package. The theme of Resolution SEBB 2019-01 and SEBB 2019-02 is eligibility. The theme of Resolution SEBB 2019-03, SEBB 2019-04, and SEBB 2019-05 is benefits and cost of those benefits. You could have flexibility in either of those domains. But having flexibility in both of those domains, you're much more into the very system that exists today with variability by bargaining unit, by cost, by benefit. The ability to have a more

prescriptive, uniform experience, even in the (6)(e) world, was what led the agency to recommend the benefits portion be more prescriptive, and the eligibility provisions have more flexibility.

Wayne Leonard: I guess it's a dilemma, in terms of the bargaining of these, what we can do for our employees is going to depend a lot on the cost. It makes sense to me if we want maximum flexibility, and we want to give people with very few hours access to medical benefits, to have a bifurcated situation. If you're talking about people with higher hours and close to eligibility, and not falling in and out of coverage, when we talk about those lower hour employees, it is going to be more and more expensive to say yes at the bargaining table. Or to make -- if it's all or none -- most districts will have trouble affording the all portion of it, is my concern.

Patty Estes: I think for me, Wayne, when I think about this, it's this Board allowing the bargaining units and the school districts to engage in those bargainings with those hours as the flexibility, but not outside of the Board's purview as to what those benefits will be.

Wayne Leonard: I understand that. But that's what we're deciding here, what those guardrails will be, whether it will be the full suite of benefits or whether it would be something different. Correct?

Dave Iseminger: Yes. And I think what you're describing and why we brought all five resolutions at the same time is there is tension between each of them. Balancing that tension and the different interests is what you're describing. I think you're accurate, Wayne, to describe that a district would know the rules of the game if the Board passed SEBB 2019-03, SEBB 2019-04, and SEBB 2019-05. They would know that turning the light switch on comes with this, this, and this. I assume as a business official, that would factor into my decision whether to turn the light switch on or leave it off.

Wayne Leonard: Right. If you're looking at trying to help the employees with a lower level of hours, you would want a lower cost option, which would be medical only, is all I'm saying.

Lou McDermott: One of the things that's going to happen, like Megan stated previously, is we're going to guess wrong on the tiers. We're going to guess wrong on how many people come in, on which tier they're going to be in. We're also going to have intended and unintended consequences. As the PEBB eligibility has evolved over the past 30 years, and I don't know how many pages long it is, but it's long, as we pass these resolutions and implement the rules, there will be issues that come up. They will become very apparent to us, instead of the theoretical, what if this happens? Know that the program will be making adjustments, as any program does, as it goes forward.

Dave Iseminger: And bringing them to the Board when it's in your authority.

Lou McDermott: I saw it in the PEBB Program all the time. As we implemented new policies, there were unintended consequences that we didn't fully appreciate, or at least the magnitude. Wayne, I think you're bringing up a good point. It's difficult to know how big of a deal it's going to be.

Patty Estes: I do have a question as far as eligibility goes. I'll propose a scenario. Say we do pass this. A (6)(e) employee from some district, they negotiated that 180 hour employee is eligible for benefits. Do our eligibility rules still apply to that (6)(e) employee, as far as who is eligible for benefits as far as dependents and spouses go?

Dave Iseminger: That is the hallmark of why we have a sixth resolution on (6)(e). That is Resolution SEBB 2019-08 that Rob will present later. It addresses that very scenario that we realized the dependent eligibility, the enrollment period, and other things weren't accounted for in these five resolutions.

Patty Estes: Secondly, we were talking earlier about the waives and which plans people would enroll, those same values and financial aspects would apply here as well, yes?

Dave Iseminger: That's Resolution SEBB 2019-04, essentially. If the Board passes Resolutions SEBB 2019-04 and SEBB 2019-05, the same financial mechanisms apply.

Patty Estes: Okay, just making sure.

Lou McDermott: **Policy Resolution SEBB 2019-03: SEBB benefits authorized under RCW 41.05.740(6)(e)**

Resolved that, a SEBB Organization engaging in local negotiations regarding eligibility for school employees under RCW 41.05.740(6)(e) must offer all of, and only, the SEBB benefits to school employees and their dependents:

- Medical (includes the wellness incentive program);
- Dental;
- Vision; and
- Basic Life and Basic AD&D.

Pete Cutler: Chair, I'm not sure how this works, but if I want to make a motion that we postpone consideration of this resolution.

Lou McDermott: That happens after there is a motion and a second.

Katy Hatfield: Yes. Wayne has the book open to the right page on that. The process is that we would have the motion on the floor and seconded, and then if someone wants to make a motion to postpone to a certain time, we would treat that as a subsidiary motion. We would vote on that and then depending on the outcome of that it would either be tabled to a certain time or we'd go back and vote on the original motion.

Sean Corry: Asking you, Katy, a question about what you just said. We are this moment considering a motion to adopt and it hasn't happened yet. Pete's interjecting before this is actually on the table.

Katy Hatfield: My understanding is he was just asking a question about how to do it.

Pete Cutler: I just asked a question. I haven't made a motion yet.

Sean Corry: So if you were to make the motion now -- I'm not encouraging -- .

Katy Hatfield: He can't make the motion now. A motion to table has to be a motion related to one under consideration, technically.

Patty Estes moved and Katy Henry seconded a motion to adopt.

Pete Cutler: I move that we postpone consideration, or a vote, on Policy Resolution SEBB 2019-03 until the April meeting.

Sean Corry seconded the motion.

Doug Nelson, representing Public School Employees of Washington. We oppose the amendment. Quite frankly, as I said, things are moving along whether you like it or not. And we're looking for direction and postponing when this has been out there, we've known this is coming, is not going to make it any easier on April 10. It's actually going to make it harder for us, as we prepare for negotiations.

Pete Cutler: I would feel better having a little bit more analysis behind the administrative implications and process implications if the Board policy was to give school districts the option of either providing, when they negotiate, for just medical coverage, or the full package, or the benefit package that's proposed in the underlying resolution. I don't even really know what I would favor, but I would like to have more background on that before making a vote. Thank you.

Voting to Approve: 3
Pete Cutler
Wayne Leonard
Sean Corry

Voting No: 6
Patty Estes
Alison Poulsen
Dan Gossett
Katy Henry
Terri House
Lou McDermott

Lou McDermott: The motion to postpone fails. I'll now go back to the original Policy Resolution.

Lou McDermott: **Policy Resolution SEBB 2019-03: SEBB benefits authorized under RCW 41.05.740(6)(e)**

Doug Nelson, representing Public School Employees of Washington. First, I have to testify on behalf of Julie Salvi, who is sick today at home and listening avidly on the phone. She asked me to say the following regarding the resolution. And that is if school districts don't want to do it, they say "no" at the bargaining table. It is not a mandate that they do it. It's an option. From our organization's perspective, when we worked in the Legislature drafting and supporting this language, we intended that employees would be treated the same. That was the issue. It was the level, how many hours they were going to work in order to get the same benefits everybody else was getting. So to answer Wayne's comment, yes. We went into it with our eyes open. That meant that some employees probably would be excluded because the school districts couldn't afford it. We knew that. But that's the price of the bargain. Thank you.

Voting to Approve: 9
Voting No: 0

Lou McDermott: **Policy Resolution SEBB 2019-03 passes**.

Rob Parkman: Policy Resolution SEBB 2019-04: SEBB tier categories and premium tier ratios authorized under RCW 41.05.740(6)(e). The global change was made to this resolution.

Stakeholder feedback. One stakeholder wants this to be the same as (6)(d), composite, not a tiered rate. They are okay for now but may have additional comments once the rates are presented. Another stakeholder is okay with the resolution but believes this will cause administrative complexity and issues in the future.

Lou McDermott: **Policy Resolution SEBB 2019-04: SEBB tier categories and premium tier ratios authorized under RCW 41.05.740(6)(e)**.

Resolved that, a SEBB Organization engaging in local negotiations regarding eligibility for school employees under RCW 41.05.740(6)(e) must offer the same tier categories and premium tier ratios as adopted in SEBB 2018-14.

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: **Policy Resolution SEBB 2019-04 passes.**

Rob Parkman: Policy Resolution SEBB 2019-05: Employer share requirement under RCW 51.05.740 (6)(e). The intent of this resolution is to have similarly situated school employees and school SEBB Organization payment breakdown as (6)(d). This will be based on a tier selected, not an average or composite cost. Premiums for school employees, as you will see in some examples, will be very similar for (6)(e) and (6)(d).

There have been a number of changes to this resolution. Changes to the first bullet. It used to say, “the same employee medical contribution (EMC)” for all tiers as if the school employee were eligible under RCW 41.05.740(6)(d). That has been changed to,

“the employer medical contribution (EMC) used for a RCW 41.05.740(6)(d) school employee multiplied by the applicable tier.”

Stakeholder feedback. One stakeholder wants medical only for this group. Another stakeholder wants this to be the same as (6)(d), a composite rate, not a tiered rate.

Examples have been included to show the different breakdown costs for the (6)(e) population. When you see the employee premium cost, these examples do not show any possible additional surcharges that may be added. These could be added dealing with the tobacco use surcharge or the spousal/state-registered domestic partner surcharge.

Dave Iseminger: Does the Board want to go through the math in the same way we did earlier with Ben? We've provided it here so you can go through each chart and see how you get the numbers. The main theme and point of the examples, if you go to Slide 14, is the bottom mark. Many people were asking what it would look like from the employee and the employer standpoint, (6)(e) versus (6)(d). The bottom was the point of the examples. Stakeholders were asking for examples so people can track and easily see how it would be different for (6)(e) versus (6)(d). That's why these examples were created. If you go through these examples, you have to pick the right column and add the numbers from each of the tables between Slide 10 and Slide 13 to get to the numbers. We wanted to give the information to the Board and the public and school business officials about how you would add the math, and then show the examples. We could walk through them if the Board wants.

Lou McDermott: **Policy Resolution SEBB 2019-05: Employment share requirement under RCW 41.05.740(6)(e)**

Resolved that, a SEBB Organization must contribute:

- The employer medical contribution (EMC) used for an RCW 41.05.740(6)(d) school employee multiplied by the applicable tier
- 100% of the monthly premium, for all tiers, for the dental and the vision plans as selected by the school employee;
- 100% of the monthly premium for the basic life and basic AD&D benefits;
- 100% of the monthly administration fee as charged by HCA; and
- 100% of the monthly K-12 remittance fee.

Terri House moved and Patty Estes seconded a motion to adopt.

Fred Yancey, on behalf of Washington Association of School Administrators. I wish David would have worked through an example, because I look at the cost figures and I couldn't quite understand.

Dave Iseminger: We'll follow up with you afterwards and go through all the examples you want.

Fred Yancey: I don't need all of them. Just one would have been a help. If I understand this correctly, if I worked 180 hours and it was negotiated, the district chose to negotiate with my unit, and if I qualify, then my district would pay 100% of my premium for medical? Is that my understanding of what this resolution says? Because the math didn't work out in the examples. That's why I'm asking the question.

Dave Iseminger: The short answer is "no." It would not be 100% of medical. Essentially, tying this as closely as possible, the EMC for (6)(e) employees for that which exists under (6)(d). The challenge is, if you remember Megan's presentation after the Lego people slide, it showed that the funding rate was the same by tier for (6)(d) employees.

Kim Wallace: Fred, the important thing to remember about the medical contribution under the (6)(e) portion of the program is that the employer is going to contribute. What this resolution says is that the employer will contribute the amount of money that is defined by the EMC by tier. If a (6)(e) employee enrolls as employee only, the employer will contribute $578 towards the medical plan that individual employee chose. If the employee enrolls their spouse along with them, the employer will contribute two times the EMC. If the employee enrolls their spouse and their children, the employer will contribute three times the EMC. That's the important distinction between a (6)(d) employee, where the employer is contributing the funding rate. But for (6)(e) employees, the employer is actually contributing by tier of enrollment. Person by person, under medical.

Fred Yancey: So it's the 500+ figure times --

Kim Wallace: $578 times the tier ratio, exactly. So it's a direct relationship based on the actual enrollment of the (6)(e) employee and their dependents.

Fred Yancey: Thank you. I understand. My position would still be the same. It just helps me understand that school districts would be opposed to this resolution. And for obvious reasons. First of all, for the Board to think that they're not meddling in the collective bargaining process, that's a fallacy on your part. You're basically setting a structure and a design for collective bargaining process, and forcing districts into a position. Of course, the law does this, forces them into a position of either saying "yea" or "nay" to bargaining itself. But for you not to think you are not involved in bargaining, you are.

We are opposed to this, and the question is cost. And, again, if you projected a potential cost to this, and was it Pete that made the statement about you could earn a very small amount in a given school year but in terms of benefits it might be 10 or 12 times the value of what you're paying. Well, that's the issue of humanity is to whether or not to offer health insurance aside. It's a very absurd sort of ratio. Great benefit, no question, but unaffordable, and districts would be opposed. Thank you.

Pete Cutler: Kim helped clarify, but my understanding is really when we're dealing with the employees who meet the minimum number of hours eligibility threshold, who presumably are being funded through the state, what the employer chips in is the funding rate. It really doesn't matter if every single one of those employees has a family. Or if none of them do. The employer, because the goal is to get the total amount of funds that are going to be needed for the PEBB population, or in this case, SEBB Program, across the state. Whereas with this situation, the cost will vary depending on whether a given school district's employees are covering families, or just an individual employee. I could infer that may have something to do with the idea that because we're dealing with costs that can't project an overall total cost that you could somehow then come up with an average for all the districts. You're trying to get something that will more closely track the added cost from just those employees coming from a given district. Anyway, Kim's comments were helpful because before she spoke I was trying to figure out why the numbers looked different than I expected. So, thank you.

Dave Iseminger: Confirmed on all fronts. Everything you said was correct.

Wayne Leonard: Just a quick question. So, if I understood Kim's comments, for these employees, we could be paying much more than the composite rate. Okay. That's a "yes."

Dave Iseminger: Or much less. It depends on the tier and the amount of dependents enrolled.

Voting to Approve: 7
Voting No: 1
Wayne Leonard

*Alison Paulsen had another meeting and needed to leave at noon. No vote.

Lou McDermott: Policy Resolution SEBB 2019-05 passes.

Rob Parkman: Policy Resolution SEBB 2019-06: SEBB continuation coverage eligibility for school employees not eligible for benefits under the SEBB Program. This resolution provides eligibility to school employees and their dependents who will not meet the SEB Board eligibility criteria as of January 1, 2020. Tying into the COBRA presentation Barb made earlier, a change in eligibility is not a COBRA-qualifying event. This is more generous eligibility than is required by statute.

Changes made since last presented. In the first row, we added, "and their dependents." In the second row, we changed "is" to "are." In the fourth row, we changed "losses" to "loss" and removed "they are" and changed it to "the school employee."

Stakeholder feedback. Two stakeholders provided comments and they both supported it as written.

Slide 18. We added an example to help clarify the intent of this resolution. I tweaked some of Barb's earlier examples to where they are not a qualified beneficiary or a

qualifying event. The bus driver, who has himself and his spouse enrolled in district benefits, medical, dental, or vision, is not anticipated to be eligible under the SEBB Program effective January 1, 2020. Is there a COBRA-qualifying event? No. Change in eligibility is not a qualifying event. Is this school employee and his spouse eligible for SEBB continuation coverage? Yes, if this resolution passes the Board. For what SEBB benefits are they eligible? Medical, dental, or vision coverage. How long may this coverage continue? Eighteen months. This is similar to the COBRA-qualifying event of reduction in hours.

Pete Cutler: I want to confirm that by its implications, the longest this policy would have operational impact would be mid-2021. It's not like new people would be rolling into it. It's a snapshot at that point, if you lose it?

Rob Parkman: Correct. That transition into Go Live would start on January 1, and the 18 months would start at that point.

Patty Estes: Based on the previous resolutions we just adopted, should we consider a change to the very last sentence? Should we add “or otherwise bargained for,” after "these benefits will be provided for a maximum of 18 months on a self-pay basis," because if they lost eligibility with a SEBB Organization, they could still enroll in SEBB if negotiations and new contracts were negotiated over the summer.

Dave Iseminger: Patty, the hook, and I think the key part of this resolution, is what does the world look like on December 31, 2019, and then the 18-month run out.

Katy Hatfield: Patty, it's somebody who is losing eligibility for the SEBB Program under either (6)(d) or (6)(e). They're not eligible for benefits, period.

Patty Estes: Okay. Thank you.

Sean Corry: I picked up what I think is an ambiguity and I want to ask about it in case it actually is one. We've got somebody who is going to be falling off coverage who is enrolled in medical, dental, or vision, which implies a choice that sometimes that occurs, that some people get medical and not others, for example. So it goes on to say "eligible to continue” is to medical, dental, or vision, implying in one sense they can continue the same benefits they had. It's a continuation of benefits. But it doesn't say that it's not an election time to choose one of those three, which might be different than what they've had as an employee eligible under the old regime. Am I parsing that too finely?

Pete Cutler: I would agree. Reading it more carefully, the title refers to continuation coverage. As I read it, somebody could be an employee covered just in dental or vision. They could lose eligibility for that because they don't meet eligibility under the SEBB Program. But after that it appears to allow you to elect to enroll, not just to continue coverage, which is the COBRA concept, but to actually enroll in your choice of medical, dental, or vision coverage. I don't know it's a huge issue, but it is a little strange that it would seem to trigger an eligibility for medical coverage for somebody who had not even been in under medical coverage, or any one of the others.

Barb Scott: The language was intended to capture that an employee could be enrolled under any one, or a combination of medical, dental, or vision. An employee who was only enrolled under vision, and who lost eligibility for vision, wouldn't necessarily be able to then pick up medical as an election on January 1. I will say that once they are enrolled in coverage, because they are part of the population, they do get the benefit of annual enrollment or special open enrollment. If I were to walk that out with you, if Barbara lost eligibility under her school district and she enrolled in medical coverage on January 1, during the next annual open enrollment for 2021, Barbara would be presented with the benefits available to employees and she would get to select from them. (medical, dental, or vision)

Does that answer your question, Sean? Or does that cause you concern with the words on the resolution?

Sean Corry: It doesn't cause me any more concern about the words. I'm not sure your circumstance answers the question that at open enrollment any one of those is an option for an employee no longer eligible. The "or" then works, medical, dental, or vision. I believe you've answered my question.

Lou McDermott: **Policy Resolution SEBB 2019-06: SEBB continuation coverage eligibility for school employees not eligible for benefits under the SEBB Program**

Resolved that, a school employee and their dependents who are enrolled in medical, dental, or vision under a group plan offered by a SEBB Organization on December 31, 2019, who lose eligibility because the school employee is not eligible under the SEBB Program, may elect to enroll in one or more of the following SEBB benefits: medical, dental, or vision coverage. These benefits will be provided for a maximum of 18 months on a self-pay basis.

Katy Henry moved and Patty Estes seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2019-06 passes.

Rob Parkman: Policy Resolution SEBB 2019-07: SEBB continuation coverage eligibility for dependents already on a SEBB Organization's continuation coverage. This policy is brought to the Board because COBRA defines qualified beneficiary as the covered employee, a federally recognized spouse of a covered employee, or the federally recognized dependent child of a covered employee. Federal law does not recognize domestic partners. This policy provides eligibility to a dependent of a school employee who is already on continuation coverage as of December 31, 2019. Again, this is more generous eligibility than is required. It is similar to SEBB 2018-58, which was approved at the January Board Meeting. The exception is these dependents are already on some type of continuation coverage as of December 31, 2019.

No changes were made to this resolution. We did receive stakeholder feedback from two stakeholders. They both support as written.

An example was added to help clarify the intent on Slide 20. A bus driver who terminates his relationship with his domestic partner on June 22, 2019, a few months into the future. The domestic partner elects continuation coverage under the terms of the school district's group health plan, effective July 1, 2019, and is still enrolled in that continuation coverage as of December 31, 2019. Are they eligible for SEBB continuation coverage? Is the domestic partner a COBRA-qualified beneficiary? The answer is "no." Is this domestic partner eligible for SEBB continuation coverage? The answer is "yes," based on the adoption of this resolution. What benefits are they eligible for? Medical, dental, and/or vision. How long may this coverage continue? Here I need to make a clarifying comment. We have 36 months, which is similar to divorce. But this employee already started their 36-month clock six months ago. It was started in July, so when they transition to SEBB, they would have already used up six months. We would provide an additional 30 months. So 36 is the total number. The first six months actually count.

Lou McDermott: **Policy Resolution SEBB 2019-07: SEBB continuation coverage eligibility for dependents already on a SEBB Organization's continuation coverage**

Resolved that, a dependent of a school employee who is continuing medical, dental, or vision coverage through a SEBB Organization on December 31, 2019 may elect to finish out their remaining months, up to the maximum number of months authorized by COBRA for a similar event, by enrolling in a medical, dental, or a vision plan offered through the SEBB Program on a self-pay basis.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2019-07 passes.

Lunch Break and Executive Session

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

[break]

Lou McDermott: We are going to adjust the agenda. We will have Rob back up next and then move into the legislative update.

Eligibility and Enrollment Policy Development

Rob Parkman, Policy and Rules Coordinator, ERB Division. There is one policy resolution being introduced today, SEBB 2019-08, which deals with terms and conditions for RCW 41.05.740(6)(e).

Slide 4. I will start off with admitting a typo in the second row. The RCW reference has an additional zero that will be removed at the next meeting. Proposed Policy Resolution SEBB 2019-08: For school employees whose eligibility is established under RCW 41.05.740(6)(e), all SEBB Program rules within chapters 182-30, 182-31, and 182-32 WAC apply except provisions within those rules governing benefits that are not authorized in SEBB 2019-03 to be offered to RCW 41.05.740(6)(e) employees.

The current proposal is to have as many SEBB Board resolutions that already passed effective for the (6)(e) population for ease of administration. Many policies have already passed over the last year. For example, I know earlier this morning there were questions on this. You want to have the same dependents' eligibility as approved in SEBB 2018-01, SEBB 2018-02, and SEBB 2018-03 over a year ago by the Board. These are already contained within WAC 182-31-140. This policy would say those same (6)(d) eligible dependents would be the same eligible dependents for (6)(e), have the same dependent verification as approved in SEBB 2018-29 and currently contained within WAC 182-31-140. The same dependent verification resolution that already passed would be the same requirement for (6)(e) people.

Another example is the new hire election period, within 31 days of becoming eligible for the employer contribution, as approved in SEBB 2018-13, and as currently contained within WAC 182-30-080. That same resolution that talked about as a new employee you would have 31 days to make an election, that same process would apply to the (6)(e) employees.

The intent is to have as many of the policies that have already passed to apply to the (6)(e) population, and as already codified within the WACs that have already been generated, or soon will be generated.

Dave Iseminger: I know we talk about administrative simplification quite a bit. That's also the district's ability to do administration as well, to say for (6)(e) the enrollment period is 60 days, but for (6)(d) the enrollment period is 31 days. For (6)(d) benefits begin on one timeline, but they are on a different timeline for (6)(e). The administrative function is not just for the Health Care Authority. It is also a significant aspect of districts' administration of the eligibility in this decentralized system. I know this language is a little bit convoluted. We don't have a rule on long-term disability (LTD) or life insurance. We have a rule on premium that has a subset about each of the benefits. That's why it had to be worded in a way that says all of the rules, except for those that reference LTD, for example, because in Resolution SEBB 2019-03, LTD wasn't listed. It’s the nature of how the rules are codified. They're not benefit by benefit. They're more subject by subject.

Rob Parkman: The intent is to make the administration as similar to (6)(d) wherever it made sense.

We would be happy to receive feedback from the Board. We will incorporate your feedback and send the resolutions out for stakeholdering. I will bring this resolution to the Board for action at the April 10, 2019 Board Meeting. And you will see those stakeholdering results at the next Board meeting.

SEBB Organization Readiness: HCA Support

Jesse Paulsboe, Employees and Retirees Benefits (ERB) Division, Outreach and Training Unit Manager. I'm one of three presenters you will hear from this afternoon representing units within the ERB Division that provide outward support and assistance to the various audiences within the PEBB and SEBB communities.

Slide 3 – ERB Support. My unit provides PEBB and SEBB Organizations support at the employer level by providing training, guidance, and resources to Organization benefits administrators who, in turn, provide guidance and support to their benefits-eligible employees. **Alisa Richards** will talk to you about the customer service team, which provides enrollment assistance, in-person lobby services, and toll-free phone support to members who do not have employer benefits administrators, such as retirees, COBRA, and continuation coverage populations. Additionally, you'll hear from **Rochelle Andrake**, with the ERB Communications Team, which is responsible for creating member print materials, email, web content, and social media. **Jerry Britcher**, our Chief Information Officer will talk about IT organizational readiness.

Slide 5 – Who are the trainers? The Outreach and Training team consists of 13 full-time employees. While the team spends much of its time in a training capacity, the ultimate goal is to assist employers in achieving accurate eligibility and enrollment decisions for their employees' accounts. In addition to in-person training, we provide assistance to personnel, payroll, and benefit staff. We also have a dedicated 1-800 line for employers, secure email correspondence, open enrollment benefits fairs, informative presentations, and dedicated employer resources, and enrollment training materials and guidance. The term "Pers/Pay" is a word commonly used in the PEBB Program and basically an abbreviated combination of personnel and payroll. It's interchangeable with Benefits Administrator.

Pete Cutler: You're talking about the current division, which right now is dealing 90% I'm guessing with the Public Employees Benefits Board Program. I was looking, thinking we were dealing only with the SEBB Program. As I got farther into it, I thought this sounds a little bit like the PEBB Program, and I realized this is the foundation you already have operating, supporting the PEBB Program.

Jesse Paulsboe: Yes, sir.

Pete Cutler: That will then be the home for initiatives and activities for the SEBB Program?

Jesse Paulsboe: Yes, sir.

Pete Cutler: Great, thank you.

Dave Iseminger: I think I've described before some of the staffing model that we have in the Health Care Authority. The ERB Division supports both programs. We don't have a PEBB wing and a SEBB wing. We have an integrated model for the two programs, to provide support as much as possible where there is alignment. There are specialists in some different areas because the programs aren't completely synonymous with one another. When it comes to outreach and training, we've expanded the staffing model to account for supporting SEBB Organizations. What Jesse is providing and describing is a model built off PEBB employers. Some of the team will support PEBB employers and some will support SEBB employers.

Jesse Paulsboe: Slide 5 – Who will we train? While the slide indicates we will have trained approximately 1,000 SEBB Organizations, we're actually going to train 1,000 personnel and payroll benefits staff who serve the 295 school districts, the 9 ESDs, and the 12 charter schools. In addition, we're extending the training to union staff representing school employees as well.

Dave Iseminger: If a district contracts out third party administrative services, we would consider that part of the training. Whatever the model is that the district is using for its administrative services and customer service, those are the people included. Whomever is making the determination to providing support on behalf of the district, that's who we'll train, in addition to the unions because members will often come to them with questions. They asked if they could participate in the trainings as well, and we said the more the merrier to help people during the process.

Jesse Paulsboe: Slide 6 – SEBB Training Objectives: What will we train? The left side of the slide shows the three training components. They are eligibility, which is knowing which employees qualify for SEBB benefits; benefits training, which is knowing what benefits are available to eligible employees; and SEBB My Account training, knowing how the eligible employees can enroll into SEBB benefits using the online enrollment program and how to manage their Organization's benefits using the administrative functionality of SEBB My Account.

When we conduct in-person training, our primary focus will be on these three areas. Our objective for the initial training period is not to make Pers/Pay staff subject matter experts on all nuances of the SEBB Program, but to make them knowledgeable and comfortable with the task required to make SEBB initial enrollment a success at their respective Organizations. Additional training and resources will be provided to Pers/Pay staff as the SEBB Program transitions out of this initial enrollment phase.

Slide 7 – Train the Trainer Strategy. Our training strategy is to conduct training for all Pers/Pay staff on benefits eligibility in SEBB My Account. In turn, Pers/Pay staff will educate the school employees on benefits eligibility. So you have your 13 HCA staff training your roughly 1,000 SEBB Organization staff, who then assist the approximate 150,000 SEBB-eligible employee population.

That training model converts into the customer service model. School employees reach out to their Organizations' Pers/Pay staff as the first line of customer service. The Pers/Pay staff, if there are questions or issues they can't resolve at their level, can reach out to our staff, who will assist them. We use this same model in the PEBB

Program. The main difference is the SEBB Organizations are all joining at the same time.

Slide 8 – Training Schedule. There are approximately 317 Organizations across the state in need of training. This slide shows the training schedule. To make in-person training as accessible as possible within the timing and resource constraints, we've developed a two-day curriculum that will take place at the 9 Educational Service Districts (ESDs) across the state. The Pers/Pay staff would attend the training at their ESD. The primary training window is the month of August, with O&T staff traveling to the ESDs to conduct the training.

The first training will kick off at ESD 121 in Renton on August 1 and 2. We just confirmed the schedule with the ESDs. Because this is such a busy time for everyone, we're also offering the same two-day training at each of the ESDs in September. In some locations like Spokane where there is a large number of schools affiliated with the ESD, there will be three and four trainings.

Dave Iseminger: They'll say can't you do training before August? One of the challenges is there is no good time. We've talked about the time crunch over the last 18 months. There is a lot of information we can't convey yet. We can't train on the benefits until you've finalized your homework on the benefits, which can't happen until the Legislature has left town. Unfortunately, the only time to do the training has to be after the Board's final decisions in July, but before open enrollment begins in October. There's only that two-month period, which unfortunately also is the beginning of school. We will do recorded webinars so there will be 24/7 access for individuals who can't leave their district on the time that's in their regional ESD area, either in the primary training in August or the makeup sessions in September. We made a model that accommodates that entire time, and we'll talk with districts about webinars being an additional option.

Jesse Paulsboe: Slide 9 – Additional Resources for Employers/Employees. For employers we'll have phone support; secure email correspondence; and a dedicated Pers/Pay website, featuring worksheets, resources, and materials to assist them. It's a resource specifically for them, which we update whenever there are changes.

For employees, there will be an online decision support tool, which will take input from the employee based on their specific life circumstances and needs; it will provide information and help them make informed decisions about benefit selection. Additionally, we'll conduct nine in-person benefits fairs at the ESDs in the month of October. The virtual benefits fair employees can attend 24/7 on their own terms. It provides the same experience, where they would get the information. It will be designed almost like a benefits fair where you have booths and they can click on it and get the same information they would get at the benefits fairs. SEBB My Account is another feature that will help both populations, giving employees the opportunity for a user-friendly, online enrollment experience; and providing the employers with an online administrative portal to manage those benefits.

Dave Iseminger: A lot of people think of the support design tool as a health literacy tool. It would be something that helps people understand a little bit more, what is a

PPO, an HMO, the HSA? The acronym suite that comes with insurance. You can also think of it as a health literacy tool. We actually are in the midst of procurements for both the decision support tool and support for the virtual benefits fair. These are non-benefits procurements the agency's been doing and that's an example of two of them.

Pete Cutler: Are the decision support tool and the virtual benefits fair functionality and services that are going to be provided in the PEBB Program as well as the SEBB Program?

Dave Iseminger: Not at this point. This is something that will be unique for the SEBB open enrollment launch. We are going to use it in the SEBB Program as a test pilot for how well the state might want to support something like that for both programs ongoing. We think it's extremely important to have for this initial open enrollment launch at a bare minimum.

On the employer side, we completed another procurement to have support to the districts for dependent verification during this initial open enrollment. We are in the midst of contract negotiations with a vendor to provide additional support to employers for the bubble that will happen with dependent verification this fall.

Alisa Richards, Customer Service Operations Manager. Slide 2 – Customer Service Unit. Currently the Customer Service Unit serves public employee retirees, COBRA and continuation coverage enrollees, retiring employees, and the K-12 retirees.

Slide 3. We have 16 FTEs in our unit. Staff assists over 100,000 retirees, half of which are the K-12 population, retiring employees, and PEBB continuation coverage enrollees, through phone calls to a toll free line, or in-person lobby services.

Lou McDermott: Can you talk about why we help retirees versus actives?

Dave Iseminger: The trainer model that Jesse just went through, the first line of defense is the home employer. When you retire, you don't have an employer. So the Health Care Authority becomes your home agency for non-pension benefit purposes. And that means Alisa's team is now your home employer.

Pete Cutler: Can I state for the record, it's a very good model.

Alisa Richards: In addition, the Customer Service Unit keys subscriber retiree enrollment forms. Employees are served by the employer's personnel payroll and benefits office.

Dave Iseminger: I'm sure you're aware we've talked quite a bit how the PEBB Program is a very paper-based model. We're entering the 21 century with the SEBB Program and working on a front-end initial enrollment electronic option. That will yet again be another opportunity for the state to try and advance things away from a paper-based model in the PEBB Program, once the SEBB Program has launched. We're not going to reboot both programs at the same time.

Alisa Richards: Slide 4. With the SEBB Program implementation, the Customer Service Unit will serve SEBB Organization COBRA and other continuation coverage enrollees, as adopted by the Board. Currently, the districts administer this coverage. That will transition to the Health Care Authority. HCA will be working on a successor plan for the current SEBB COBRA and other continuation coverage enrollees and their qualified dependents, which was also referenced earlier in Barb's presentation.

Slide 5. We expect the SEBB Program implementation in January will increase our phone calls, our document processing, and lobby visits from the K-12 retirees, as well as an increase in our COBRA and other continuation coverage enrollment forms for the K-12 population. We will hire additional FTEs to help with that additional workload. For the 1-800 line, we'll make sure to update that with FAQs and phone messaging, to help refer the SEBB Program employees to the right resources. If we see a pattern in the type of calls on the 800 line from the SEBB employees, we will work with the ERB Division Outreach and Training staff, and they, in turn, will work with the appropriate SEBB Organization benefits offices on providing more guidance to help their employees.

Lou McDermott: As a reminder to the Board, the consolidation between the retirees has already taken place. The retirees are together and we already serve the K-12 retirees.

Alisa Richards: For questions about services covered under their plan, we will refer them back to their health plan as we do today. As SEBB Program employees have questions about their coverage after retirement, we'll continue to assist and answer those questions, for a smooth transition of benefits. The Customer Service Unit is excited about the employees coming on to having their benefits administered through the Health Care Authority. This will help build that awareness of those retiree benefits once they're ready to retire.

Patty Estes: Have you already started getting phone calls?

Alisa Richards: We have had a few phone calls asking about the program. We don't have a lot of information, so we refer them to the HCA website, where it has all the current information.

Jerry Britcher, Chief Information Officer for the Health Care Authority. Slide 2 – Information Technology Supports. Pers/Pay staff will be getting 16 hours of in-person training. We will supplement that with what we will refer to as a "sandbox environment." They will have an environment they can practice in that will not impact the production environment. They won't be modifying any employee's data live. They will only have access to this practice environment. We can technically extend that past the point of Go Live, but the intent is this is during the August-September time frame. After they receive their training, they can go in and practice to their heart's content. It is web-accessible and can be accessed from home or work. We're designing SEBB My Account so it will auto-adjust to the form factor that you're using. If you're using a tablet, a phone, or computer, it will adjust to your screen size. Obviously, the greater the density of the content the harder the view is on the smaller screen. You will still be able to access it, regardless of form factor.

Slide 3. For the classified, certified, and administrator staff, we're going to be developing a series of instructional videos that will follow something like "creating a secure access Washington account," and walk you through that process. We will have that for all of the basic aspects of going in and doing your benefit selection so the average employee will have a set of instructional videos that will walk them through each step that they can go through and view that. We can't do the in-person training for all the employees of the school districts, so this was our way of addressing that. We will also have the video available through the virtual benefits fair so they can access it in that context. The materials will also be available for print. They will have that ability to make a hard copy of those videos.

Terri House: When we're doing our forms online, if we're filling everything out, when I do my name and address and things like that one time, will it populate it all the way through?

Jerry Britcher: As a matter fact, what will happen is when you go in, the name will actually already be populated, as will the address. The system may give you the ability to change your address if it's necessary. But we will populate based on the data received from each of the individual school districts. You don't have to re-enter the data when you go into the system.

Member Communications

Rochelle Andrake, SEBB Program Communications Supervisor. I'm going to provide you with information about how we're communicating with future SEBB Program members to prepare them for initial enrollment. We're using a variety of methods to reach out to school employees and other interested stakeholders. I'll walk you through our strategy and explain how we're working to engage future SEBB Program members and educate them about their new benefits.

Slide 3 – HCA Website. We launched the first SEBB Program webpage in October 2017, before the first SEBB Board Meeting. Since then, the site has grown to contain all of the latest news and updates about the program, including printable materials and frequently asked questions. The website's updated often, as Board decisions are made. Our team has built pages to include more information about eligibility and what benefits will be offered. Specific information related to initial enrollment, like service areas, premiums, and how to enroll, will be available no later than September 1. Of course, if we get information earlier we may be able to post it sometime in August.

Dave Iseminger: Some of you have sent me questions or you catch me between meetings and tell me what you are hearing when you go to meetings. All of that falls downhill to Rochelle and her team. That helps expand our FAQ section. The last time I checked, I think I counted FAQs somewhere in the 70 to 90 range. I think I've given her four this week and I have about 15 more possible ideas. I appreciate the Board's input. If it's a trend, we can draft an FAQ so the next time the question is asked, we can provide the answer or they can find it themselves on the website.

Rochelle Andrake: Staff meet weekly with subject matter experts to keep them updated and fresh. As decisions are made, they take some of the FAQs and actually populate the webpage data so you can find the information in multiple areas. With the

FAQs, we have ones that are general, related to school employees and other populations; but we also have ones specific to school administrators and the questions they are asking, because we understand the subject matter is different for those two populations.

Slide 4 – GovDelivery Emails. GovDelivery is the platform we use to send messages to our stakeholders. Anyone interested in learning more about the Board or the SEBB Program can sign up for alerts to receive messages about Board meetings or rulemaking. Once the SEBB My Account system is live, school employees will be able to use this system to opt in to receive GovDelivery email messages from the SEBB Program. They can opt in to having their communications delivered in a paperless format. In the meantime, we use GovDelivery to send important notices to school administrators and other school business officials to share information with members.

Dave Iseminger: It's been a long journey getting districts to identify the right people to be on those list serves. We still run into scenarios. I had one just yesterday asking who the information went to and those questions go to Rochelle and the list serve team. They can tell them where we sent it and the district can identify the correct person. We update the list and tell them where to get all the information they missed. We are constantly cleaning up that information to make sure those list serves are as robust as possible. When we talk about things going via GovDelivery, we're talking about program communications. We're not talking about explanations of benefits or other documents that come directly from a health care or insurance provider. Some communications will be mailed directly from the carriers. We're talking about the things generated by the Health Care Authority.

Rochelle Andrake: Slide 5 – Member Toolkits. The Toolkit is one of the first methods we used to reach out to school employees. You heard in Jesse's presentation that he plans to train the benefit administrators to be the first point of contact for school employees about their benefits. We created these toolkits to support direct member communication to employees through their benefit administrators, and other trusted resources, such as their unions and associations. We published our first toolkit in November 2018. The toolkits contain fact sheets, infographics, posters, informational articles, and we encourage schools to share this information in whatever fashion works best for their organization. Whether it's printed or online materials, we want to make sure there's a component in the toolkit that works for them. We send the toolkits monthly, and we'll continue through June.

We started talking about high-level information. We'll continue to update as we get more information, like eligibility rules, medical, vision, and dental. In February/March, we're talking about additional benefits, like life insurance and the medical flexible spending account. All toolkits are available at HCA.WA.gov/factsheets.

Dave Iseminger: Like we do for PEBB employers, where we have roughly 500 employers that access PEBB benefits, we have 317 School Organizations that are going to be accessing SEBB benefits. We know those resources our vast 800 employers have is very different. Some have a lot of resources and some have resources to be able to contract out for services. Others have a part-time benefits officer that helps their ten district employees. We try to make it so if an employer wanted to, they could take the information we provide, forward it on, or print it.

We create the floor so if a district wants to go on autopilot, take our information, and use it, they can. We know that among 317 school employers, there's a wide range of resourcing that's available.

Rochelle Andrake: Slide 6 – Direct Mailings. I'm happy to report that we now have member contact information for the majority of school employees. We sent our first direct communication to school employees yesterday, approximately 158,000 potentially eligible school employees. The letter introduced the SEBB Program to those who may be hearing about it for the first time. It's high level, and contains links to SEBB Program factsheets and the website, for further information. And that letter is online if you need it. I think it's also in the back of your Board materials as well.

Dave Iseminger: It's in the front pocket. That's the mailing that went to about 158,000 people.

Lou McDermott: Are members going to have the ability to sign up for a list serve and receive newsletters electronically? When does that kick in?

Rochelle Andrake: It will not kick in until they enroll, because it's an opt-in feature and it's set up through SEBB My Account.

Lou McDermott: They'll have the opportunity to enter their email address? Is that a requirement or is it optional?

Rochelle Andrake: It's optional. They can opt into it.

Wayne Leonard: A lot of our business office staff are already on GovDelivery and getting those notices. I got mine the other day.

Dave Iseminger: That's right, Wayne. We send a notice to the business officials on our list serve when something is about to go out. We always give the employers the heads up when the Health Care Authority is mailing something, either via GovDelivery or a physical mailing to employees. In our trainer model, somebody's going to walk up with their flyer and say "What does this mean?" We make sure as it's going out the door we give a heads up to all employers, "This is the exact document your employees are about to receive and you may get questions." We send that out in advance.

Rochelle Andrake: We also put an announcement on the website since it was the first one. We make every attempt that whenever we send in a communication to our members that we inform stakeholders and the school business officials to make sure everybody knows it's coming.

Our next planned communication is a newsletter. We'll send it in early June and it will contain brief articles to inform employees about the benefits that will be available to them. Articles will be "How to Know How Much Life Insurance You Need," "Things to Think About When Choosing a Medical Plan," and how to prepare for the initial enroll enrollment, such as ensuring you have paperwork ready to verify your dependents. We know school employees will be hard to reach during the summer, so we're planning on sending a large colorful postcard in mid-August to say hello and remind them that our

website will be open with final open enrollment information on September 1, and we'll send their initial enrollment materials in the mail around mid-September.

The August postcard will be very brief and will let them know more information is coming. Their initial enrollment packet being sent in mid-September will contain the final benefit information. It will include information about benefits fairs, final plan comparisons, monthly benefit premiums, service areas, and information about how to enroll using SEBB My Account or a paper form.

Dave Iseminger: As an example, there are PEBB Program enrollment packets on the wall in the hallway outside the rooms where staff assist subscribers when they come to HCA for assistance. It's a 50-page booklet with a table of contents and information to assist you in making your decisions. Rochelle describes plan comparisons later in the materials like what you saw in Lauren's presentation. In the Appendix, there's an example of Lauren's presentation that draws off of the plan comparison we showed the Board in November that lined up all the plans with the various cost shares and pieces, so there's a way for people to compare. That's what we mean by plan comparisons.

Rochelle Andrake: Slide 7 – Media Plan. Another communication strategy is a media plan. We recognize this is a huge change for school employees, and one that affects a large population. In order to raise awareness and help ease anxiety and concern about the change in benefit structure, we will proactively reach out to the media to provide information. We've already done one op-ed piece in the Seattle Times in late January. Our goal is to produce more op-eds in other large papers that reach different regions in the state, like Spokane and Vancouver.

In addition, we've been using social media to target messages to school employees about SEBB. This includes sharing links to our toolkits, and using our information graphics as visual elements. Going forward, we want to collect testimonials to share. We've created a media kit and posted it to the HCA Press Room. There are about four fact sheets in the Press Room. We're working on creating a media alert to let the media know those are available, if they want to get information. These kits provide more robust fact sheets and data about SEBB, to help inform articles that reporters may write. As initial enrollment approaches, we will produce news releases to advertise initial enrollment information. And I believe the op-ed. Did you include that?

Dave Iseminger: No. We'll follow up. We had intended to put in the packet a copy of the op-ed that Director Birch pitched, and was published in the Seattle Times. It didn't quite make it in the packet, but we'll follow up with a copy of that.

Lou McDermott: Rochelle, can you also underscore the work that's being done with the union to get the word out?

Rochelle Andrake: We have monthly meetings making sure they are aware. They're included in all toolkit messaging that goes out, in all of the heads up messaging, and we're working with them to ensure they are another level of information to the member. They have direct contact with them in different ways, and we're trying to leverage that connection.

Dave Iseminger: We're essentially including designated union communication folks as additional Pers/Pay staff. Anytime something's sent to the district business officials that says "this mailing is going out to members," they're on the same list serve, so that the unions have the same awareness as to what their membership might be asking them. We're basically treating them as another personnel payroll officer function. They get the same level of information that business officials are getting.

Rochelle Andrake: And the associations as well. We've had direct contact with people from the Association of Washington School Principals, and they've published information from the newsletters and linked to our toolkits.

Sean Corry: It gets me to guessing that the answer is "yes," but when you started talking about unions, it sounded like you're talking about the Washington Education Association. But there are many other unions involved. And you've been communicating with all of the other unions that are at various school districts across the state?

Dave Iseminger: When working with the unions, we contact the spokesperson for the Super Coalition that was the representative for bargaining. Information flows out from that communication to the various components of the Super Coalition. We primarily speak to the spokesperson for the Coalition. We have monthly meetings to be able to keep information up to date with our union partners, and most of the core representatives who were present during the summer bargaining process are there. Not just the spokesperson. We don't just mean to say Washington Education Association (WEA) or Public School Employee. It is the full smorgasbord of the Super Coalition, but we primarily speak and give information to the spokesperson.

Rochelle Andrake: Similar to the way we collected contact information to ensure we're targeting the correct people on the school business side, we've done the same thing with unions and associations. Members of the Coalition have provided lists of other people who should receive the information regarding the toolkits, like their communications representatives.

Dave Iseminger: We intend, at this point, to include an enrollment form in the enrollment packet going out in September, because we know that not all school employees have access to the preferred, easy to use, SEBB My Account online enrollment system. For those who can't access that website, we want to make sure they have a way to enroll in benefits using a paper form.

Wayne Leonard: I did see the op-ed article in the Seattle Times. It makes more sense it was written by Sue Birch. I think when I initially saw it, there was no author that I remember seeing. It was on the left hand side of the paper, so I was under the impression it was the Seattle Times Editorial Board that wrote it.

Dave Iseminger: Wayne, within two weeks there were two op-eds. One was by the Seattle Times, and a separate one by Sue. We'll get the Board copies of all op-eds that happened in that two-week period.

Patty Estes: There was an article submitted by a reporter, and one was an op-ed.

Dave Iseminger: There was an article, a Times op-ed, and then Sue's op-ed. So there were really three things that happened in the same time period.

Wayne Leonard: Slide 7, third bullet, the media kit posted in the HCA Press Room. Is that on the website?

Rochelle Andrake: Yes.

Dave Iseminger: We can provide that link to the Board, as well, along the our op-ed extravaganza.

Rochelle Andrake: Speaking of links, the link on Slide 5 – Member Toolkits is incorrect. The link on the contact page, Slide 8, is correct. There is no hyphen between "fact sheets." Factsheets should be one word in the link. hca.wa.gov/sebb-factsheets

Pharmacy 101: Policy Levers to Manage Drug Trend

Molly Christie, Strategic Plan Project Manager, Benefit Strategy and Design Section, ERB Division. This is the final presentation in the Pharmacy 101 series, and will cover policy levers to manage the drug trend.

Slide 2 - Recap. At the last SEBB Board meeting, I reported on PEBB UMP pharmacy trends. We looked at K-12 pharmacy use data, too. We discussed how pharmacy is a growing component and driver of UMP spending, how K-12 data is very limited, but it doesn't indicate any major differences compared to PEBB UMP. We also covered how pharmacy benefit tiers and formularies work, and provided examples specific to UMP.

Slide 3 – Follow Up. Last meeting we looked at the top drug classes for UMP by utilization, and there were questions. There was a discussion around high utilization rates for anti-depressants, in particular. It's Slide 11 if you want to refer back to those slides. What we're seeing is over 1,000 prescriptions per 1,000 members. This rate seemed confusing, but there are a few reasons why we're seeing this result. The rate of prescriptions per 1,000 members represents prescriptions filled by over 80,000 UMP members. All together that's about 34% of the UMP population, so not everyone has a prescription for an antidepressant. Each prescription is counted individually, so that includes refills for different day supplies, 30, 60, 90. Overall this amounted to 285,000 prescriptions. We have about 275,000 members. That's why you're seeing this rate. In addition, not all antidepressants are necessarily prescribed to treat depression. Some can be used to treat things like neuropathy, chronic pain, anxiety, etc.

Slide 4 – Preview. Today's presentation will cover federal policy levers to manage drug trend, and we'll spend a bit more time on state and health plan strategies.

Slide 5 – Federal Policy Strategies. When we talk about bending the cost curve for pharmaceuticals, it's important to level set and recognize who has power to do what, because there are a lot of different players. I know for myself, I've asked why can't we, as a state, decide what prices manufacturers can set, or why can't we do something about how fast generics reach market. It's because those are really the authority of the federal government. If they choose to pass laws related to those issues, that's within their sphere of influence.

I've pulled together a short list of federal policy areas that have gotten national attention recently. One of these is allowing the federal government to negotiate prices for Medicare Part D. These are the private Medicare prescription drug plans. The Trump Administration also recently proposed a rule that would eliminate drug rebates negotiated between drug manufacturers and pharmacy benefit managers, specifically on behalf of Medicare Part D and Medicaid managed care. Many people personally credit increases in drug prices to these back door rebates where you have a list price that's set and a rebate is a percentage of that list price. Pharmacy benefit managers tend to keep a portion of that rebate and pass on another portion to whomever the payer is. If the list price goes up, that rebate dollar amount goes up, and the pharmacy benefit manager can keep a bit more of that. It's not that simple, but people will point to that as one of the factors that drives up list prices. This policy would get rid of that component. It would encourage drug manufacturers to give discounts directly to patients. There are implications for that. It's a potentially impactful piece of policy we should be aware of moving forward.

Allowing generics to reach markets quicker through alterations to brand patents and market exclusivity may also limit drug spending. Experience has shown when there are four to five generics on the market, the price of the original brand medication can drop between 50% and 80%. Federal legislation would be required to make this change.

As a large employer group purchaser, many federal policies under consideration could have a trickle-down effect. Some could be direct. A lot of what we're seeing now would potentially impact a program like SEBB indirectly.

Slide 6 – State Policy Strategies. At the state level, there are a number of strategies that have already been implemented, or are currently being explored. Some of these include combined purchasing, which involves leveraging the purchasing power of groups to negotiate lower drug costs; price transparency laws that usually require public reporting on how drug prices are set for new drugs, and then justification for any major price increases on existing drugs; and rate setting, which is different from price setting. Rate setting is setting a ceiling or a range for how much a payer will pay for a drug. It's not how much the manufacturer can charge for it. And then importation of certain drugs from other countries, like Canada or Europe.

Slide 7 – Combined Purchasing: NW Prescription Drug Consortium. In Washington, agencies began pooling for prescription drugs in 2005, and joined with Oregon in 2006, to create the Northwest Prescription Drug Consortium. This is a state-backed purchasing program that negotiates better rates for over one million people, including members in UMP. The Consortium is administered by Moda Health which is based in Portland, Oregon.

Slide 8 – NW Prescription Drug Consortium – Value. There are many benefits to being part of the Consortium. They include competitive price discounts for prescription drugs that are designed to improve over time, as well as fixed administration fees per pharmacy transaction. Each year the Consortium contracts with an independent third party to perform a market price check of network rates, including for specialty medications. If Consortium pricing is outside a defined range, we negotiate a new price.

Another guiding principle of the Consortium is to ensure that purchasing programs pay exactly what pharmacies are paid for a medication. As I mentioned earlier, the spread that pharmacy benefit managers can keep. This can happen in a few ways. Payers are billed more than pharmacies are paid. The billing party, which is usually the pharmacy benefit manager, keeps a portion of that, also considered the spread. Another way you can have spread is through rebates. With the Consortium, none of that is kept by the pharmacy benefit manager, it's transparent and passed through to the participating programs. This is really a first of its kind program among states. It was when it was created, and remains so today.

Finally, specialty drugs play an increasing role in managing complex conditions. Consortium specialty pharmacy services offered through Ardon ensure high touch care through clinical pharmacists who provide a range of services, including proactive monitoring of therapy to counseling on effectively managing side effects, which can be serious with specialty medications. These services are supported by 24/7 access to a customer service representative.

Dave Iseminger: Before we go on, I want to tie this together. In your establishing of self-insured plans last June, any members who join UMP, their numbers will add to the purchasing power of the Consortium. When we talk about the state purchasing that is through the self-insured plans, these are benefits of having UMP within the SEBB benefits portfolio.

Molly Christie: At present, no school districts are a part of the Consortium. School districts that are a part of the PEBB Program have the opportunity to be, but they are not, at this point.

Slide 9 – Performance. What does this mean for UMP? Some recent achievements include adjustments to Moda's administrative fee last year, to match market price competitiveness. This reduced UMP spending by an estimated $3.5 million. Moda also outperformed on their 2018 price discount guarantee to UMP by $10 million. Overall, they beat their price guarantees by $20 million and half of that was for UMP, specifically. A claims audit revealed 100% of claims processing accuracy from a complete claims audit of 1.73 million pharmacy claims for UMP in the first half of 2017. Moda looked at all claims.

Lou McDermott: I want to clarify. I thought I heard you say school districts who are participating in PEBB are not in the Consortium. But they are in the Consortium for purchasing through Moda. Correct?

Dave Iseminger: All PEBB Program UMP members can benefit from the Consortium. If a district opts to join PEBB, and its employees are in UMP, same thing would have applied to them as it applies to everybody else in UMP.

Lou McDermott: Benefit from the Consortium. I just want to make sure.

Molly Christie: Yes. Thank you.

Dave Iseminger: I want to underscore that the six-month claims audit had zero errors. That is the second report in a row. The last non-zero error rate was .00017. I think it was three claims out of 1.7 million. There is a very consistent high accuracy rate found in the complete claims audits.

Molly Christie: Slide 10 – Combined Purchasing: Hepatitis C. Washington State is also using principles of combined purchasing in an innovative initiative to eliminate Hepatitis C in this state. At the end of January, HCA issued a request for proposals to purchase curative Hepatitis C medications in collaboration with other state agencies, notably the Department of Social and Health Services, the Department of Corrections, and the Department of Labor and Industries. A key objective is to work with a single drug manufacturer to bring down the cost of Hepatitis C medications to enable the state, and ultimately other purchasers, to eliminate Hepatitis C without exceeding current expenditures.

Dave Iseminger: We're currently in the midst of that procurement and can't talk about the details.

Molly Christie: Slide 11 – State Policy Strategies: Other Examples. As I mentioned earlier, numerous states have implemented or explored policies related to price transparency, rate setting, or importation. Six states have passed transparency laws that require drug makers to report reasons behind dramatic price increases. In 2019, there are 23 similar bills pending in 12 states, including two bills in Washington. There's a bill in the House and a bill in the Senate. Seven states considered rate setting in 2018. None of those bills passed. In May 2018, Vermont became the first state to pass a law to import high cost drugs wholesale from Canada. The program does require federal approval from the Secretary of the U.S. Department of Health and Human Services (HHS). Vermont will submit a proposal to HHS by July 1, 2019. There are 20 importation bills that are pending this year in 12 states, including Oregon.

Slide 12 – Plan Strategies. Plan-level strategies to manage drug trend include some of what we talked about in the last presentation. They include modifications to benefit design and formulary development, as well as tools to manage how enrollees use their benefit and how plans pay for better value. While we've discussed these strategies in the context of self-insured plans, a lot of the examples have been UMP, which is a self-insured plan, they are also commonly used in fully insured plans. These strategies aren't unique to self-insured plans.

Slide 13 – Uniform Medical Plan Proposed Value Formulary. UMP has an open formulary under which all drugs, including low value, high cost drugs, are covered at different cost shares. HCA has proposed a value formulary for UMP under which certain low value drugs, or drugs that are more costly but not more effective than available alternatives, would not be covered unless members are approved for an exception. For members, a value formulary would mean access to medicines in every therapeutic class that are currently covered by UMP, possibility for lower out-of-pocket costs at the pharmacy, and an exception process for non-formulary drugs when medically necessary. Most private insurance plans use some sort of formulary to limit coverage for drugs that may not provide enough additional value over alternatives to justify greater costs.

Dave Iseminger: I'm going to take us back to last summer. Resolution SEBB 2018-24 was in a holding pattern, for lack of a better discussion. We brought it to this Board at the same time a simultaneous resolution went to the PEB Board, about potential changes to the UMP formulary for the current plan year 2019. There was a lot of discussion and a desire to find out what the PEB Board was going to do, because they have been talking about this issue for a couple of years. The PEB Board split in a vote, 3-3. We did not ask this Board to proceed with any further consideration until we talked about that formulary idea. We have a modified version building off last year's work with the PEB Board that we're taking back to the PEB Board this calendar season. We're similarly going to be bringing information about the conversation that's happening in the PEB Board to this Board. It's not the same as SEBB 2018-24, but it is in that concept. Nothing changes unless you act and decide to make a change. But that is another part of the pharmacy conversation over the next couple of months that we'll be having with both Boards.

Molly Christie: Slide 14 – Prescription Drug Utilization Management. Utilization Management refers to ways plans manage how people use their pharmacy benefit. Most plans, including fully insured and self-insured, use all, or a combination of the following: pre-authorization, which requires prescribers to submit documentation of medical necessity for a drug before the plan will cover it; step therapy, whereby patients have to step through, or try lower cost drugs before a higher cost alternative will be covered; limits on how many, or how much of a certain drug members can get over a period of time, or per prescription; substitutions, or replacing a non-preferred drug with a preferred drug that is a therapeutic alternative or equivalent; and medication management programs, which are usually targeted to specific drugs or specific conditions, to improve adherence to a medication regimen, or to reduce inappropriate use.

Slide 15 – Drug Utilization Management Examples: Uniform Medical Plan. A few examples of Utilization Management tools that UMP uses to track usage, safety, and cost are: step therapy, which can be used for clinical or cost purposes, or both. An example of this is Metformin, for Type 2 diabetes. Clinical guidelines recommend Metformin as the first line of therapy for Type 2 diabetes prior to any other medications prescribed. Metformin also tends to be a less expensive alternative. If the member's disease can be well managed on the drug, that's the first step. If not, the member moves into other medications.

Ryan Pistoresi: The nice thing about Metformin is there's a lot of clinical data to show that it is a very effective and safe medication. Since it's been around for a while, it's one of the cheapest medications there is. A lot of different clinical guidelines recommend the use of this first. It's typically the one that you think of when you think of step therapy for pharmacy management.

Molly Christie: Generic substitution under Washington State law. Generic substitution is a policy that helps Washington manage drug cost. Pharmacies must post a sign that references the law that says if there's a generic alternative for your drug, that's going to be prescribed to you unless your doctor has written that you need to have the brand drug they prescribed, or unless you have an issue with having a generic alternative.

There is also the Washington State Therapeutic Interchange Program. It's a similar concept, but allows a pharmacist to substitute a therapeutic alternative drug. If the therapeutic alternative is not a generic per se, it's chemically different, but it provides the same therapeutic benefit, they can substitute this for a non-preferred brand name drug in certain cases. The value formulary also helps support this practice.

Moda Health, the Consortium's pharmacy benefit manager, runs medication management programs to ensure appropriate use of certain medications, optimum health outcomes, and adherence. One of these is the Rheumatoid Arthritis Dose Optimization Pilot program. This is to minimize the likelihood of long-term side effects from biologic treatment. Treatment for rheumatoid arthritis, like Humera, is a biologic. There can be severe side effects. The idea is: What is the lowest amount of medication you can prescribe, and still make sure this person's disease state is controlled? Moda runs this pilot program for us, and we're reviewing the results.

Ryan Pistoresi: I'd like to go back to the therapeutic interchange. That is part of the Washington Pharmacy and Therapeutics Committee Process. We do have a Board of different practicing physicians, pharmacists, an ARNP, and a physician's assistant who reviews the clinical data around these drugs. They review the safety and the efficacy information. They're the ones that make the decision whether therapeutic interchange applies to different drug classes. It's not HCA that makes that decision. It's a Board of practicing providers around the state that make that decision. We follow their recommendations when we have a preferred product. The providers this applies to are endorsing providers. They have reviewed and approved the list. They know when they write for a drug that therapeutic interchange could occur. They get notified from the pharmacy when that occurs. It's a great program in Washington where we're able to find these medications and switch to the most cost effective alternative.

For the Medication Management Programs, we have some other ones and we're continuing to work with Moda about new ideas and potentially being pilots on these. This one is the most recent one we've initiated. They also do different mailing campaigns where they identify potential adverse events or other safety concerns, and then send out letters to providers to make sure they are aware.

Molly Christie: Slide 16 – Why do health plans use these tools? The plan level strategies we're talking about today can have an impact on overall trends. They impact costs. In 2016, the largest pharmacy benefit management company, Express Scripts, showed that plans that aren't very strict in their use of these strategies exhibited the highest drug trend, whereas tightly managed plans have the lowest.

Slide 17 – Value-based Payment – examples. A few payers and manufacturers have also started to experiment with ways to drive lower cost and better outcomes through alternative payment approaches. For instance, health insurer CVS Health offers a new benefit design option to its clients that would exclude certain drugs from coverage if their cost after negotiation with manufacturers is above a specific threshold. The threshold would be established by an independent research organization who evaluates new drugs that enter the market for effectiveness and value, and calculates a fair market price range.

Another example is drug maker AstraZeneca. If you watched the recent congressional hearing, they actually referenced this. They're very proud of it. AstraZeneca has agreed to adjust discounts to Medicare Part D for a brand name blood thinner called Brilinta, based on patient outcomes. Brilinta is used for patients who have had a heart attack. The way this program works is patients who are on it, if they don't suffer another heart attack over 12 months, the plan gets lower discounts. If the patient does have a heart attack, the payer gets greater discounts. They're essentially paying for that patient's outcome, how well that drug works.

Slide 18 – Key Takeaways. Major takeaways: proposed federal policies could have significant impacts on employer-sponsored plans. Unfortunately, the most we can do is stay informed, and try to plan for what's next. Recent years have seen an influx of state legislation to lower drug spending, including policies on volume purchasing, importation, transparency, and rate setting. UMP participates in combined purchasing arrangement through the Northwest Prescription Drug Consortium. Health plans use a variety of tools to manage pharmacy spending, including benefit design, formularies, utilization management, and value-based payment arrangements. UMP relies on many of these tools, and supports implementation of the value formulary.

Pete Cutler: On the last point, we're going to have a discussion about value-based formularies? Is that with the idea of benefit design changes for 2020? Or 2021?

Dave Iseminger: Moda has indicated they would be able to implement something if the Board wants to act, for January 1, 2020. After discussion, if this Board wants to take action and have something changed for 2020, we'd be able to administer that. If the Board doesn't want to take action for 2020, nothing has to change.

Pete Cutler: That assumes we make a decision by when?

Dave Iseminger: Before June because it would impact the rate setting process and giving you premiums in July.

Benefits Update

Lauren Johnston, Senior Account Manager, ERB Division. Slide 3 – Combined total number of vision providers. This slide looks at the combined total number of non-duplicated vision providers in every county in Washington. If a member lived in King County, for instance, they would have access to 468 providers, based on the three carriers currently in the portfolio. That's Davis Vision, EyeMed, and MetLife.

Slide 4 – Davis Vision providers. This slide has been updated. Provider networks are fluid. They're constantly changing, based on what's happening with the providers. What you saw in the fall might be different from I'm presenting today. For the most part, the county coverage is the same.

Dave Iseminger: Lauren, can you give the Board a sense as to how much the number increased from the last time they saw these charts, in September.

Lauren Johnston: I don't have the exact number off the top of my head. I can give you an approximation. Davis has been working with approximately 52 providers. To date, four of them are in the process of negotiating a contract.

Slide 5 – EyeMed Providers. EyeMed had around 90 new providers they're adding. I got an update today that they've contracted with three additional providers not included on this chart.

Slide 6 - MetLife Providers. MetLife has provider coverage in every county throughout the state, except for Columbia and Garfield Counties. There are no providers in those counties.

Slide 8 – Summary of fully insured plan changes. Premera added a new plan per your request that has a prescription drug deductible that aligns with the UMP Achieve Plan 1. Kaiser made technical changes to their primary care age band copays. Originally it was ages zero to 18 and zero dollars. Eighteen is considered an adult, so the age range is now zero to 17, and 18 and older.

Dave Iseminger: These are things that came up since the November Board vote that were identified during the rate negotiation process. These are plans asking to be on the table. We're not asking you to take any action on these, but we are providing updates to the various documents that we've given you over time, to reflect what those changes would be. At the end of the day, you can say yes or no to the overall plan design, you can guide their plans designs. But at some point we will know what they are offiering and you will vote yes or no.

Lauren Johnston: The only exception to that is Aetna Plan 1, for the emergency room deductible waived. It was like that on their originally submitted plan design template, it was not something we caught. Their Plan 2 has the deductible waived but their Plan 1 does not.

Providence updated their HSA plan specialty drug cost share in order to meet the Medicare Part D creditable coverage criteria. I'm not sure if that's something the Board could say yea or nay to. If the plan is going to be in place and they're going to have drug coverage, it has to meet certain requirements, that being one of them. Because of the changes, there are slight refinements to the actuarial values. They are not much, but we have made note of those as well.

Slide 9 – Actuarial Value (AV) changes. This slide is in order of those plans that have changes to the actuarial values, from lowest to highest. It's not the same within the previous because some that had changes are now in a different order than what they were before. If you want to look at where the plans currently stand with their actuarial value, you are going to want to look at the far right column.

Dave Iseminger: For actuarial values, try to focus on the general piece of it. Don't focus on the .2 of 79.2%. It's a general proxy that has a lot of nuances to it. It's a general guiding point. If one of these shifted by .1% or .2%, we're not going to come back to the Board and show a new chart.

Lauren Johnston: Slide 11 – Summary Benefits Chart Changes. Aetna Plan 2, the $750 deductible, Aetna is requesting to change the mental health outpatient visit copay from $20 to $15. Premera Plan 2, $750 deductible plan, they are requesting to change their direct deductible from the $250 and $625, single subscriber family, to $125 for a single subscriber and $312 for the family. When the Board asked them to go back and look at their prescription drug deductible on the higher deductible plan, they took a look overall at their prescription drug deductibles and decided to make a request to change that one as well. They cut it in half.

Dave Iseminger: Premera Plan 2 is what led to your amendment to ask for a third Premera plan. That drug deductible caused you to ask for another plan. The summary benefits chart Lauren referred to is the 11 x 17 chart we showed in November that has 17 columns. That is what we're talking about.

Lauren Johnston: Providence Plan HSA. The specialty drug is now 50% up to $200. It used to be $50. Premera Plan 1 changed the AV to 79.2. The new Premera Plan 3 is a new plan based on the prescription drug deductible requested to match UMP Achieve 1. Everything on the chart, except for the deductible, matches Premera Plan One.

KPWAO Plan 1. The age band says 0-17 has a $0 copay for primary care office visits. Ages 18 and over are now at the $30 copay.

Dave Iseminger: The shift there is instead of being 0-18 and 19+, it's 0-17, and 18+. As you look at the other KP plans, all of the subsequent KP plans show similar age band changes.

Lauren Johnston: Aetna Plan 1. Their emergency room deductible originally said it was waived, but it is not. That change is in red. KPWA Plan 1, change to age band. Providence Plan 2 has an updated AV. It's now 83.4%. Premera Plan 2 has an update to the prescription drug deductible, $125 and $312.

The next three plans are KP plans, all the same changes within the age bands. Aetna Plan 2 is an update on the AV. The remainder of the slides are KP plans, with the age band changed. The KPWA Plan 4 does not have an age band change because there is no age band for the primary care. There is a change in the AV level to 91.5%.

SEBB Program Medical Benefits Comparison Chart. All changes are in red. Aetna Plan 2 has the change for the mental health outpatient copay visit from $20 to $15. Premera Plan 3 is all in red because it's considered a new plan.

Dave Iseminger: We did clarify and added that asterisk related to the UMP high deductible plan, but there is an embedded individual maximum out-of-pocket piece. We described that to the Board, but realized this chart didn't have a annotation for that so we added it as context. As a reminder, no individual has to meet the, for example, $8,400 deductible. If you have two people on the plan, there is an embedded individual maximum out of pocket.

Lauren Johnston: The Providence HSA Plan, changing it to 50% up to $200 for the specialty drugs, for the member out of pocket costs.

Dave Iseminger: When you look at this chart, it reflects the changes as if you've accepted them. I know you have not accepted them. The general theme was mostly to the favor of the member and we began documenting those. The one that we weren't sure exactly how to deal with was on the prescription drug piece, the lowering of the Plan 2 deductible. We left on the chart what you had approved in that context, because that was the most substantive change that was identified as possible during the rate build process. We noted in an asterisk that they have proposed lowering that. We had to make a decision on that one way or the other, and we thought that we would show what you had approved in that instance because it was the most substantive change. We also wanted it to align with other communications produced and had started passing out.

The last piece of Lauren's presentation is a six page primarily blue and orange colored document that goes benefit by benefit on a high level. It's gives you a snapshot of the entire portfolio of benefits based on the decisions the Board made in November. These pages synthesize the materials scattered throughout July, August, September, October, and November in one comprehensive document.

We won't ask the Board to take action on any of these refinements until after the legislative budget comes in.

Legislative Update

Cade Walker. Total bills analyzed to date is 239. That's comprised of 99 bills where we are lead division, meaning we take the primary responsibility for the agency in performing the bill analyses, incorporating the other analyses from other divisions and spearheading the analysis.

We had 127 bills that we've been a support on. We do an analysis of impacts on particular legislation for our division and pass it along to the lead analyst for them to incorporate into their analysis for the agency. I am the ERB Division Coordinator and I act as the go-between with our agency, the Division, and all our analysts, and help coordinate that input.

Lou McDermott: When Cade says that he means we respond with thorough in depth advice on what the possible impact of that bill would be. The good thing is the legislative process is a fairly long process, and as we do these analyses, we continue to work on them even after we've submitted our information.

Dave Iseminger: It's a lengthy process. But it's often a fast process at the same time, as Cade was alluding to. One of the key features is this bill analysis is done on all bills so that for any bill that is decided there needs to be fiscal note, there is pre-work already done that can help drive that fiscal note information process. The key part of this is the fiscal notes and the assumptions the agency has about what is meant by the words on the page. The words on the page aren't always the clearest. We try to inform the Legislature about what the potential fiscal impacts are, of their ideas.

Cade Walker: Slide 3. As of today, we've reached over the halfway mark of the anticipated session. It's a 105-day session and we're on day 53. Our next big cutoff date is March 13, which is the date when a bill that started in one particular body,

whether the House or Senate, goes to the next chamber to be considered by the other chamber.

Pete Cutler: Do I read this correctly? You say that 32 bills came out of either the House or Senate policy committees that dealt with ERB-related issues? By the time of the cutoff for fiscal committees, which happened on the first, the count was down to 17 bills that in theory were still alive, because they had passed that threshold?

Cade Walker: I apologize for the confusion on this. As of March 1, 32 bills started in the Policy Committee originating chamber that were ERB high impact bills. As of March 1, 17 bills made it to the Fiscal Committee. There were only five high impact ERB-related bills on the originating chamber's floor.

Pete Cutler: At this point, you only have five high impact bills to keep track of?

Cade Walker: That is correct.

Pete Cutler: That sounds like the fiscal committees did their job.

Dave Iseminger: As a gentle reminder, House Bill 2242, which establishes the SEBB Program, was generated and passed on the same day of the last day of the third special session. There's always opportunities for new bills to make it through the process.

As you look through this, if you see a bill number that's in italics, that means it made it through the various hurdles so far that the Legislature has imposed on itself. If it's not in italics that means it did not make it past a particular cut-off.

Cade Walker: Slide 4 – SEBB Program Impact Bills. The two bills we have been tracking closely for the SEBB Program are House Bill 1547, and its correlative Senate Bill 5465, which is concerning basic education funding that was OSPI requested legislation. It has stalled in appropriation committees, and House Bill 2096, which was concerning the educational service district's health benefits. That also has no movement currently out of its appropriation committee. That bill was allowing the non-represented employees of educational service districts to be exempt from participation in the SEBB Program until 2024. It carved out the non-represented and had only the represented employees from ESDs, of which there is approximately 250 or so, included in SEBB. It was a partial carve-out, or partial exemption from participation for the time being. That bill has since stalled with no action taken.

Slide 5 – PEBB Program Impact Bills. We are currently tracking three bills. HB 1085 concerns premium reduction for Medicare eligible retiree participants in the PEBB Program. It would raise the amount of premium covered by the state.

Dave Iseminger: To clarify, there's language in the statute that says the state will subsidize up to a certain amount and this would flip it on its head and make it “no less than.” We tell each Board about the respective program impact bills to the other Board, because these are illustrative of things that the Legislature could do to you one day. Maybe not in this exact context, with retirees being squarely in the PEBB Program as of today. But it illustrates ideas that come up in Olympia on employee benefit programs.

Pete Cutler: For the record, it would affect the retiree remittance. It would affect employers in districts.

Cade Walker: Then we have House Bill 1414/Senate Bill 1535. We support this because it extends the payment to the end of the month in which a retiree or beneficiary dies. It would help us administratively in that we would not have to go back or request from the estate premiums for benefits during the month of death. There is no movement on this currently.

Dave Iseminger: More importantly, it's a challenging time in people's lives. There are a lot of challenges with the current system where, unfortunately the way the pension is set up is the money is clawed back in the month of death. And this was something that the LEOFF 2 Board and the Department of Retirement Systems were advocating for. We certainly felt that it would be in consumers' best interest and former state employees' best customer service to those individuals, to not have to be talking about whether the estate's going to cover medical expenses or other expenses during that challenging time.

Cade Walker: HB 1220 and its companion Senate Bill 5275 would be adding a non-voting representative from the Office of the Insurance Commissioner to the PEB Board. It's listed here because it could be something we see for the SEB Board in the future.

Dave Iseminger: Cade means changing the composition of a Board is a topic that the Legislature could achieve. There's not been any discussion about adding someone from the Insurance Commissioner specifically to the SEB Board.

Cade Walker: Slide 6 – ERB Impact Bills. This slide is looking at general bills for our division that have potential impacts on both programs. House Bill 1065/Senate Bill 5331 is what we refer to as the zombie bill that keeps coming up. This is protecting consumers from balance billing, or out of network health care service charges. It's a high priority topic area.

House Bill 1074/Senate 5057 protects youth from tobacco products and vapor products by increasing the minimum legal age of tobacco/vapor products. This has two parts to it. One is raising the age for purchasing tobacco products from 18 to 21. The other part is including vapor products with the sale of tobacco-type products. We don't see it as having a direct impact in either PEBB or SEBB Program. Given that there is a tobacco surcharge, we do see there being some potential implications down the line by raising the minimum age to purchase tobacco products and the inclusion of vapor products in that same category of tobacco-like products.

House Bill 1523/Senate Bill 5526 increases the availability of quality affordable health coverage in the individual market. This is the state public option bill that you may have heard about. Cascadia Health is the other name that's been applied to it, creating the public option for the state. There would be implications for the ERB Division, most likely in the arena of procurement. I believe the Legislature's intent is to rely on ERB's expertise in procuring of commercial health plans, and leveraging that experience to the formation of the public option.

Senate Bill 5889 concerns insurance communications confidentiality. This increases access for a class of protected individuals. As children are on their parents' plans for longer, they need the autonomy and discretion to seek care from providers without necessarily having to have their parents' involvement, given they are on their parents' plan. It allows them to have their own addresses listed, their own chains of communication that don't need to go through the policyholder which they receive their insurance on. It's protecting the privacy of those individuals over the age of 13.

Dave Iseminger: Cade described one of the protected populations although I think another part of the bill is domestic violence situations. It sets up a classification of certain individuals where there's an extra layer of thoughtfulness around where the communications go, what the autonomy is of individuals to get care.

Cade Walker: ERB Division Topical Bills. We also track bills in those areas that we know are of high importance to both our members and our division for administrative purposes. This year, Senate Bill 5602 – Eliminating barriers to reproductive health for all, has a litany of different service requirements within it. We are tracking it closely.

House Bill 1224, House Bill 1879, Senate Bill 5184, and 2SSB 5292 are several bills relating to pharmacy services, transparency, and utilization management

Public Comment

Troy Andrews, Business Agent and President of Laborers Local 252. I'm going to keep it brief. Mine are in the form of questions, so I hope you'll indulge me because I'm trying to find some information out for my members who work in the Tacoma School District. I have some fact sheets that you guys put out on the internet. Can I pass them out? That way we're all looking at the same thing.

Essentially, what I do is I represent the maintenance people that work in the Tacoma School District. At the Tacoma School District we have about 55 people between the laborers, the operating engineers, and the different building trades crafts. We can't get our arms around, and no one seems to be able to tell us, if this affects us who are under multi-bargaining unit trusts for our medical coverage. This first part, it essentially says, "benefits available through the SEBB Program will replace the health and insurance benefits currently provided by school districts, ESDs, charter schools, SEB Organizations." Does that include me? We're like zenith administrators. I'm self-insured. So the guys that work for me are on the laborer's medical plan. Some are in the sound partnership. But a lot of us are in our own union organization. So the guys that work at the district are in the same medical as I am in the outside construction. And we don't know yet if this affects us or not. And that's kind of the question I have on the table for today.

Lou McDermott: So, I would imagine we're not going to give you a quick response. There are a lot of entities that fall into a strange category. We have an evaluation we do to figure out where you fit. It sounds to me like this is one of those cases.

Dave Iseminger: You are correct, Lou, I'm not going to be able to sit here and answer directly now. What I will say, the gist of the legislation is any school employee, so there's an employment relationship with the school district where the individual is

anticipated to work 630 hours, that is a broad-sweeping eligibility proclamation within the statute, by the Legislature. I have your contact information. We'll get into the specifics of your organization, where it fits, get clarity beyond the general, broad-sweeping base.

Troy Andrews: And I respect that. Because I mean, it's a deep question. The immensity of what you folks are dealing with here is overwhelming. No offense, it's all I could do to stay awake and I was only here an hour.

My concern is where this impacts the most, and I'll cut to the chase and let you guys go home to your families. Right now, I'm a member of the Laborers and I have 55,000 hours as a working member of the Laborers Union. When I retire, my medical will be $142 a month, as long as I have medical coverage the day preceding my effective retirement date. If I have a break in that service, so if I have a member that's at 30,000, 40,000, 50,000, it's on a rolling scale, if they roll into this they've gone from paying $142 a month for insurance to maybe a thousand, or whatever it costs for retiree medical. So it's a huge economic impact. You've set your life, you say, "I'm going to make $5,000 at retirement. Now all of a sudden I say I need $1,000 of it back for your medical care that I budgeted $142 for. So, it's huge impact. Again, I won't go into any more. Please, if there's anything I can do to help, contact me. Again, my intentions here, all of the trades in Tacoma are in the same situation. We're talking a small, out of 300,000 people you're dealing with maybe 1,000 across the state that are in this situation. Like I say, school district for Tacoma, we have a threshold of 55 people that must be there all the time, so I know we have a minimum of 55 in this category.

And the second question was asked by one of the administrators. How does this affect people that have opportunity to have retiree military benefits? So, again, if that's something we can sidebar on I won't waste your time on that today.

Dave Iseminger: That's actually a concept that has come up a couple of times in the last two to three weeks. We've actually been working on some FAQs so that we have standard responses to what coverage qualifies for being able to waive SEBB coverage. There have been specific questions related to military health plans. That is something we're in the works of being able to answer more directly for everyone.

Lou McDermott: Dave, at the April 10 meeting, it would be nice for the Board to hear the dissection of this process, understand what was thought of, and the information that was provided back.

Troy Andrews: You're saying April 10?

Lou McDermott: Yes, but you will be working directly with someone. We want to make sure it gets revealed here, because I'm sure people are going to be curious as to how this turns out.

Troy Andrews: Right. And, again, there's such a structure to this. The only people I've reached out to, I talked to Steve Hobbs. They say when they think past, they didn't envision the intent of it being people losing retirement coverage as much as a way to bring down cost where you guys control cost control for the states and we know what

our budget's going to go to and how much it's going to be. So we respect what you're doing. This would immensely help my people if there's a way that we can let them stay in their medical plan. I respectfully thank you for your time.

Dave Iseminger: We will definitely work with you, Mr. Andrews. We will also give an update to the Board in April as to how this all went. But we'll talk with you long before then. Probably not today.

Troy Andrews: I appreciate your time. Again, I really respect what you guys are doing here. Like I say, I represent 2,500 members just in my local in nine counties of the state, so I thought my job was hectic enough. I'm just keeping up from getting fired and going home and coming home safe every day so thank you for what you're doing for our people. Have a great day.

Preview of April 10, 2019 SEB Board Meeting

Dave Iseminger. Hopefully there are two more budget proposals released in the Legislature, one from the House and one from the Senate. The finance team will do a comparison of the Governor's budget, House budget, and Senate budget.

We'll have a legislative update. There will be a resolution for action. Depending on where we are in the cycle, we may bring back some of the initial discussions related to a possible value formulary proposal for the Board to consider.

Next Meeting

April 10, 2019
1:00 p.m. to 5:00 p.m.

Meeting adjourned at 3:21 p.m.