Washington State Health Care Authority

School Employees Benefits Board
Meeting Minutes

August 1, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 11:00 a.m.

Members Present
Pete Cutler
Terri House
Patty Estes
Wayne Leonard
Lou McDermott

Member on the Phone
Katy Henry
Sean Corry
Dan Gossett
Alison Poulsen

SEB Board Counsel
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 9:00 a.m. Sufficient members were present to allow a quorum. Board self-introductions followed.

TV Washington (TVW) is livestreaming our meeting today. You can watch at WWW.TVW.org.

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

Approval of April 10, 2019 Meeting Minutes
Terri House moved and Pete Cutler seconded a motion to approve the April 10, 2019 SEB Board Meeting minutes as written. Minutes approved by unanimous vote.

July 25, 2019 Board Meeting Follow Up
Dave Iseminger, Director, ERB Division. There are more and more people viewing the SEBB Program website pages. I wanted them to see the suite of benefits worked on by

this Board and the Health Care Authority, through the procurements for the last two years, and anything that could continue to get this information out. Slides 2-9 are an overview. These documents were provided multiple times. I want to keep repeating it to make sure you have access to it. I also wanted to make sure you had it handy today in case there was any need to refer to benefit design. All other questions will be handled in the next presentation.

2020 Premium Resolutions Continued

Megan Atkinson, Chief Financial Officer, Financial Services Division. I've asked Ben Diederich, with Milliman to join me today. Ben's the lead on our actuarial team. There was quite a bit of conversation last week, some of which got into areas around the actuarial underpinnings of the rates, our rate calculation, and our rate development conversations that occur. I've asked Ben to be here to walk you through some documents and then possibly answer questions you might have that go outside my scope of understanding.

Slide 2 – Employee Premium Contributions – Medical. We will walk through the employee premium contributions still awaiting action. You took action last week on the full suite of the Kaiser Permanente offerings, as well as the Uniform Medical Plan. We still have the outstanding Premera resolution. You know where we are in the story, we have two different rate offerings from Premera, those presented to you on July 25, shown on Slide 3, and those presented on July 18, shown on Slide 4.

Slides 3 and 4 are formatted the same. The only changes are the rates from Premera. Slide 3 are the rates presented on July 25. Slide 3 are the lowered bids they presented. The first table is set up to show the Single Subscriber Tier Employee Contribution; the Employer Medical Contribution (EMC), which benchmarks off of our UMP Achieve 2 Plan; and the Proposed 2020 Total Composite Rate. We've been through these tables many times. I think you are familiar with how the math works, so I won't belabor the point. On the lower half of Slide 3 is focusing on Premera's offerings, how the employee contributions vary by tier. Slide 4 are the rates presented on July 18.

The only difference between Slide 3 and Slide 4 is the total composite rate, which impacts the employee contribution. The employee contribution goes down as the total composite rate goes down.

Slide 5 – Rate Comparison. This slide is transitioning to bring forward information to address the concerns from our conversations last week and questions we received. We have spent quite a bit of time over the last week going back into the data we have available. Looking at the entire suite of data points we have, pulling from that data and trying to come up with visual representations of the data, to both help you understand more about the rate development process, as well as understand the plans relative to each other, and were there significant diversions that occurred.

When we do rate development, we ask the plans for quite a bit of information. The vast majority of that information is proprietary and confidential to the plans. While we receive that information, and it is information that Ben and his team can use in assessing the rates and assessing the carriers' offerings, it's not information we can share. What we do per the statute is we allow the carriers the opportunity to designate things as proprietary and confidential and we respect that designation.

As we were looking at the information we have, and preparing things to bring forward to you today, we went back to each of the carriers and asked them to redact what they did not want shared publicly.

The table on Slide 5 was an attempt to show how the rates change from the point in time, I believe it was back in February, that we received the Not-to-Exceed (NTE) rate, and then the ending point of negotiations with the total composite rate, as we presented on July 25, showing the rates changed over time. We had several rounds of negotiations that occurred. We have information on this slide blacked out because the carrier asked us to redact that information.

Looking at the bottom half of the table to Premera and UMP, from the point in time we got the total, Not-to-Exceed rate, and the ending point, the rates went down. I don't know if that's really that revolutionary. We would expect that. It's a rate negotiation and the starting point was Not-to-Exceed rates. You would hope they had gone down.

Pete Cutler: Megan, I'm curious how, for Premera, the Not-to-Exceed rate compared. Is it identical to the rates they were sent as their final proposed rates back in June? Or was there a difference between, so it's like a staircase, or I don't know which way it's going, but there were other changes.

Megan Atkinson: The Not-to-Exceed rates you see from Premera, if you compare those with the rates we presented on July 18, you will see they went down. It's just they went down again, to the rates presented on July 25. Does that answer your question?

Pete Cutler: Yes. I guess it answers my question. What I was most curious about was how much their rate had dropped between the rates they proposed in June and then what they proposed on July the 25, just to get a sense of what magnitude of actuarial adjustments were made in that period of time, as opposed to anything that happened before June.

Megan Atkinson: You can see in the data points here on Slide 5. Let's take one as an example. Premera Blue Cross High PPO, their Not-to-Exceed rate was $680. If you go to Slide 4, that same plan, the rates presented on July 18 went from $680 to $653. If you look at the rates on July 25, it went down to $625.

Pete Cutler: So that $680 represents what their proposed rate was as of June?

Megan Atkinson: No. The $680 is the Not-to-Exceed rate received in February. We had several rounds of rate negotiations that got us to the June rate. Then Premera submitted one more round of rates in July.

Pete Cutler: This is useful. But I also, as I indicated, the question came up, was there rigorous review of the actuarial assumptions that went into the new rates that were proposed on July 17 by Premera? And that point of analysis would have had to do with what had they proposed, what assumptions did they have underlying the rates they submitted in June versus what rates they were proposing on July 17. That's the gap I was most interested in as a Board Member, to get a sense was that 1% or 2%? Was it 4%? Was it 11%? I didn't have a sense of the magnitude.

Megan Atkinson: I think it's comparing the rates presented on July 18, which were the June rates, and the rates presented on July 25, the July rates.

Pete Cutler: Now that you mention it, that seems very logical, thank you.

Wayne Leonard: In rate negotiations or the development process, there are other things being discussed besides just the rates, correct? We've talked about the expansion of the geographic coverage area.

Megan Atkinson: Right. Wayne, I'm going to hold on that comment a little bit because it's one of the things Ben's here to walk you through. We have a rate development sheet the plans prepare and provide us. Ben and his team prepare it for UMP on each round. Those submissions come in from the plans along with an actuarial memo. The plans have their own in-house actuaries. As they submit additional bid rates in each round of the negotiations, that also comes with a memo from their actuary certifying the bids are in compliance with actuarial standards of practice. Those memos are marked confidential and proprietary. I can't share those with you, but we do receive them with a full bid sheet. Ben is going to walk you through a blank sheet in a bit so you can see the information we receive. Because you're absolutely right, we don't just get the per member per month (PMPM). We get more than that.

Lou McDermott: Ben, I think the bottom line is that as we go through rate negotiation, there's a lot of twists and turns. Things go up and down, service area, plan design, bid. On the final rates that came in, is there anything from an actuarial perspective that was alarming to you? Was there anything that was extra concerning?

Ben Diederich: No. For the first year of this program, we have a lot of uncertainty. That amount of uncertainty is going to create a range, especially within the rate development process, and that last final step that Premera took is well within the reasonable range of what that uncertainty is worth.

Megan Atkinson: Slide 6. My team has spent a lot of time this last week pulling data together and using the chart wizard in Excel trying to come up with tabular representations of the data to help you with this decision you have. Slide 6 shows a graphical representation of how the rates change from the point in time we have the Not-to-Exceed rate to the final. These are blinded out of respect for the Not-to-Exceed being marked as proprietary and confidential. What you can see, though, is the rates went down during the course of negotiations. I don't know if that's very insightful. We started with the Not-to-Exceed rate so they wouldn't have gone up. You would hope they would go down. In addition, I'll remind everyone even our UMP rates went down because as we were moving through rate development, we got an additional year of claims data. That claims data drove a reduction in our own UMP rates. It was a more favorable experience than what I think a lot of us had been carrying in our initial assumptions.

Dave Iseminger: Megan, I want to make sure it's clear on the record that although these are blinded, the scale in the underlying images is the same. They're all scaled the same. You just made five different blocks for each carrier because 19 lines on a single chart got cumbersome, correct?

Megan Atkinson: Yes. Slides 7-8 – Rate Comparison, are our attempt to distill key statistics we believe are informative when looking across the portfolio of offerings. Last week we discussed how the lower Premera rates compare to the other offerings in the portfolio. We tried several different ways to see if we could get anything informative to help answer the question Pete struggled with earlier, are these rates reasonable. Are these rates responsible if you vote to accept them? One thing we learned, when you think at the high level, all of the decision points and the information feeding into a rate development, it's a ton of things. It is the carrier's individual business model. It is the carrier's efficiency contracting with their providers and their networks. It is the carrier's own utilization statistics, their own unit cost information. Then, it's their read of the riskiness of the population. All of those things feed into the rate development. When you get into the rate development for a specific plan, you have things that vary across the plans. The benefit offerings, the deductibles, the out-of-pocket maximums. All of those things feed into the actuarial valuation of the plan, which is the fourth column on the chart, the AV column.

We didn't find any one thing that we could pull and display for you to help you assess across the portfolio of offerings how the rates are falling. The cream settling up to the top is when you look at the deductible of the plan. Remember you took action and gave us direction to standardize the deductibles on the single tier. Slide 7 is the single tier. The deductibles, combined with the out-of-pocket maximum, are statistics people can understand even if they don't have a high degree of health insurance literacy. Those impact the value of the plan to them, their own pocketbook. You can see how the employee contribution goes in those groupings. We've shaded the groupings by deductible. At the top of the table is UMP High Deductible. It's in a class by itself, with a high deductible. We've given you the out-of-pocket maximum and the AV. Those numbers are from the 2019 federal AV calculator. It has an employee contribution on the single tier of $25.

I'll walk through how the table is set up. The green shaded blocks are the plans across the portfolio that have a $1,250 deductible on the single tier. The out-of-pocket maximum varies from $4,000 to $5,000. The actuarial value also varies. It's clustered starting at 79.6% up to 83%. The employee contributions range from $13 to $39 and the last column is the bid rates. There are other key statistics about this plan design like the amount of the copay, etc. We didn't do additional statistics on variability from the low employee contribution of $13 to the high contribution of $39.

Looking at the yellow rows, the $750 deductible plans, the out-of-pocket maximum is tightly grouped. There is only one with $3,000. Everything else is at $3,500. And the actuarial values are tightly grouped, from 84% to 86%. Again you can see the variability on the employee contribution, from $19 to $70. That's a bit bigger spread.

The salmon colored rows are the $250 plans and the purple rows at the bottom are the $125 plans. Because the deductible and the out-of-pocket maximums don't scale mathematically with our tier ratios the way that employee contributions and bid rates do, we prepared this same table for you at Tier 4.

Slide 8 – Rate Comparison. The groupings aren't as clean because the deductibles don't scale in the same way. We didn't require the same deductible groupings in Tier 4.

The plans at the top of the chart have the highest deductible ranging from $3,100 to $3,700. The out-of-pocket maximums increase. The actuarial values are tightly grouped because the AVs of the plans don't change. And then there is a bit more variability on the employee contribution. You can see the math impact of the variability on Tier 1 because all of these employee contributions multiplied by the same tier ratio.

The groupings are shaded to group deductibles in the same general area, but it's not the same pure breakage by group on the deductible. These tables pull enough statistics together to help get a sense of how the plans positioned. It's not clean, however because there are many things going into the rate development. It doesn't break cleanly across the plans.

Dave Iseminger: I've noticed some confusion about the actuarial values. I want to remind the Board we presented AVs early on that had one AV number, and then there was a refresh. The AVs on these slides are the most recent. There are citations with old AVs in various documents, but I want to be very clear these are the most recent since the last time Lauren presented to you.

Megan Atkinson: Ben's going to walk you through one of our bid rate proposal templates so you can get a sense of the information we receive for each round of bids, and give you a sense of the entirety of the information.

Dave Iseminger: We will post a copy of it later with the other Board materials already on the website.

Megan Atkinson: This Excel spreadsheet is what we receive back from the carriers. There is a limitation sheet and a description about the general inputs.

Ben Diederich: This template is used for bid development and the carriers are responsible for the values they input and making their determination of how they're going to price this product. We've generally structured this worksheet combination in a manner similar to how the federal government developed the Uniform Rate Review Template, known as the URRT, that's used for the individual and small group markets.

What we're representing on worksheet one is the base period of experience and we're projecting that forward through a whole slew of factor adjustments that, at the end, gets to the final claims projection on an allowed basis for 2020 plan year. Allowed claims are the amount of claims the health plan expects the population to utilize before application of benefit design provisions. We've started with a representation of what the base period experience is going to be and we've provided a few different data points for them to consider when they're developing that base period experience. Those come from the data book we've collected of various carrier data submissions, and we've summarized, aggregated, and reported back to them as, "Here's the overall statewide data book average from an allowed cost perspective repriced to Medicare, and here is what your individual slice of that experience looks like repriced to Medicare." If they want to take and use that to represent their base period experience, they're more than welcome to or they can interject their own outlook on what they think a historical period would be.

These first set of factors take that base period experience they've entered, if it's different than the data book, and we normalize to a statewide average. These bid rates are

functioning on a statewide average basis for calculating employee premium contributions. When we get actual enrollment calculated in the spring, we will apply a series of adjustment factors to these bid rates to determine how much revenue the individual plans will receive. We're at a high level starting point of what the individual carriers are projecting the entire SEBB Program population to look like under their statewide program.

Megan Atkinson: I want to focus for a moment on column A, on the far right, the Service Category. That's breaking out the bid. The first grouping is inpatient (IP), inpatient medical/surgical, inpatient psych, AD&D, inpatient maternity. SNF is skilled nursing. The next category is outpatient. On line 23 ER; that's typically a high cost area. Down rows 30 to 32 are professional fees. Rows 30 through 37 are pharmacy. This gives you an idea of the information we get that is broken out in a more granular fashion, not just a gross per member per month (PMPM).

Dave Iseminger: I want to make sure it’s clear that when a carrier submits their bid, they're bidding as if they're getting the entire population. There's not an enrollment assumption of a subset of the slice of the population. They're bidding as if they get everyone. Correct?

Ben Diederich: Correct. That’s what the normalization section of worksheet one is doing. It's taking whatever population they chose to input into the base period experience and normalizing it so it represents the entire statewide population of SEBB Program. Since we're still in the base period of time, we now have the two trend assumptions to move that forward to now be the 2017-18 statewide base period experience. We're still at 100% of Medicare. One of the processes we introduced for this bid rate development was to have all the carriers submitting their data and we are repricing that data to represent what a Medicare reimbursement level would be. At this point of rate development, we can make comparisons across all bidders where everyone has the same level of unit cost reimbursement. Now we're at a base period.

Sean Corry: Megan said something before in terms of serving categories that confused me. You said AD&D, what is that?

Ben Diederich: I think there was a misquote. It's alcohol and drugs, substance abuse treatment that's bundled with psych, Sean.

Sean Corry: I see. Thank you very much.

Ben Diederich: Now we're progressing to project the 2017-2018 period into what we believe the 2020 plan year will be. We have another period of trend factors and some additional management, if they think the management of their program is going to change relative to what they reported in their base period experience. We have some seasonality that was a function of the initial data book, where we had some different periods of run out that we were trying to give them the opportunity for adjustment.

We have the reimbursement column, which is the percent of Medicare base period experience converted over to represent what they anticipate their reimbursement levels are going to be in 2020. Finally, we have morbidity shift adjustments. When they

represented their statewide population for 2017-2018, if they think the new enrollees in 2020 are going to have a different morbidity, they would make that adjustment here.

They're going to apply any area or charge adjustment they're anticipating relative to the area factors for all the rating areas we will be making adjustments for in 2020. The carriers have presumably reviewed those. If they think their own area factors are different than how we're going to be reimbursing them, they would make an adjustment to their overall bid rate so their revenue would be whole. And then we have the last sort of catch all and we ask them to itemize it.

Pete Cutler: Ben, I love getting into actuarial detail. This is great, by my standard, even if a lot of it is going over my head. Am I correct that the carriers, Premera, Kaiser Permanente, whatever, for each of their plans they submitted this Excel sheet with the data filled in and that would have been a worksheet like this underlying each of the rates that were their "final" rates that were submitted? Am I correct that when Premera submitted new rates with whatever changes?

Ben Diederich: Yes.

Pete Cutler: Okay. Was it relatively easy for Milliman to identify where those changes were and review?

Ben Diederich: Yes.

Pete Cutler: Great. Thank you.

Ben Diederich: We could see where the changes were in each of these factors listed. What we've now projected and maybe I'll clarify a little bit, Pete, worksheet one is submitted at the carrier level. This represents the aggregate average across all plans that the carrier is submitting. We've illustrated here $210 PMPM is the allowed composite across all benefit plans that they're expecting. The last few columns we gave them an opportunity in case there was something different from an experience projection they wanted to represent. They could simply blend in a manual claims cost estimate, and then credibility weight the two. The overall experience period average the $210 of projection then flows to start the starting point of worksheet two.

Worksheet two represents what the plan's specific projections are going to be. We no longer have the category of service detail on worksheet two. Worksheet two is now done in the aggregate. All of our reviews of category, service, reasonableness, and their projection of individual categories, that's done on worksheet one at the aggregate level across all plans.

Now we have plan-specific adjustments they can incorporate. There's a benefit design induced utilization factor, which is to say that one plan, for example, may have a richer benefit design relative to the portfolio at large. That plan's allowed cost is going to have benefit-induced utilization increases represented in the overall average that was short of what the dollars they anticipate needing for this individual plan. Or in excess, depending on the induced utilization factor.

The other is if they're making adjustments to covered services. If covered services are different between plans, if they're excluding some sort of specific service, they would make that adjustment here. And then the third on an allowed basis is any sort of network impact. If they're proposing a different network, they would incorporate that network adjustment within this row of factors. Then we have two other adjustments they can incorporate so the product of all these factors and the overall carrier allowed equals the plan specific allowed PMPM projection.

Now we get into the consideration of benefit design. We had a little bit of benefit design introduced in these first two factors, induced utilization and covered services, but this is the lion's share of the benefit design impact, which is the pricing actuarial value, which represents the ratio of paid to allowed for each individual plan.

Megan Atkinson: For the people following along on the telephone, Ben's moved over to worksheet two in the Excel file. He's in column D down to rows 22 to 26.

Ben Diederich: Yes, I forget we're navigating on the phone as well. Sorry about that. The plan specific pricing actuarial value is going to be slightly different than the federal actuarial value that was on the table Megan presented earlier. This is the carrier specific evaluation of what they think their particular benefit plan performance is going to be, based on their own internal modeling, not based upon what the federal government modeling is indicating off of the federal AV. We expect the pricing AV to be somewhat in line with the federal AV, but certain carriers could have an outlook on their benefit design that's different from the federal AV calculator considerations. The product of plan specific allowed PMPM in row 20, with the total plan paid adjustments in row 26, gets you to the plan specific paid PMPM in row 28.

Lastly, we have the input of the retention PMPM, which is going to get added to the plan specific paid PMPM to become the standardized premium equivalent PMPM. For those on the phone, we're still on the retention PMPM components, or the administrative costs, on row 32, taxes and fees on row 33, and the margin, or contribution to surplus, in row 34. Those total retention items then get added together to create the standardized premium equivalent PMPM.

Now we're still at a per member per month level and so the next step is to convert that PMPM premium equivalent into the per adult unit per month premium that's going to be included on the bid rate. We do that by representing what they anticipate their member months to be across their entire portfolio because we don't know how the enrollment is going to break differently across the individual plans. They estimate their total number of member months, as well as their total number of subscriber months by tier, and then the product of their enrollment by tier, with the tier factors develops the number of adult unit months. The adult unit months is going to be the same for each individual plan. We haven't allowed them to vary any sort of rate relativity at the plan level for enrollment mix. And then that conversion factor of member months to adult units then gets multiplied by the PMPM so that it converts it from a PMPM to a per adult unit per month value. This per adult unit per month value then is input into the bid rate template as the single employee rate.

Megan Atkinson: Thanks, Ben, for walking us through that. That is the rate sheet we get. As Ben clarified, we get it on every round as we move through rate negotiations. I

am hopeful that having some insight into the type of information we're gathering, as well as some of the summary statistics we pulled forward and the representation of those statistics, is helpful to you.

Dave Iseminger: Although we hadn't planned to go through the entirety of the appendix, I just want to overview for the Board and the public what is in the Appendix. Megan tackled the actuarial soundness questions that the Board had and the appendices to Megan's presentation are the various documentation referenced and requested at the Board meeting last week. Included is the premium resolution as it was presented to the Board last week and there is one word change that was recommended. If you go to Slide 10, the word “revised” was added before "Premera." We always show you wording changes from one meeting to another.

Slide 10 is the resolution we have for your consideration today. The word "revised" has been added solely because, if you look through the materials form the July 25 meeting, you see both versions of the rate and the recommendation to add “revised” would make it as clear as possible. The version presented last week is in your appendices.

The second part of your appendices are rate tables, both of the single subscriber and all the tiered levels, of all the employee premium contributions you took action on last week. As you continue through the appendices, it begins with a packet of seven letters that were exchanged between the Health Care Authority and the Kaisers, back and forth between July 22 and July 29.

The next piece of the packet is a copy of the letter I believe each Board Member received directly from Kaiser Permanente Washington and Washington Options sometime yesterday. We did go through and look at the official SEBB Correspondence email account and did not identify any other kind of advocacy or comments from the public. We have always batched those together for you when we send you the Board Briefing Book.

The rest of the appendices for the most part are the components cited in the original July 22 letter from Kaiser to the Health Care Authority. There's the Request For Proposal 2.20, as well as any questions that were asked during the procurement process related to Section 2.20.

Then the next part of the appendices is the Request For Completion (RFC). You'll note it's labeled as a "non-ASB" or Apparently Successful Bidder version. When sent to carriers, they were carrier specific, so we put in your packet the document just before making it specific to each carrier. Included is the template used to make the carrier-specific documents as we went through the RFC process. Also, there are each of the amendments to that RFC just like we have amendments during any procurement process.

Next in the appendices are email chains between the carriers. I believe Pete asked for those. We did present those to the carriers for them to make any asserted proprietary or confidential redactions. The redacted marks are requests from each of the carriers. There's a chain for KP Washington and Washington Options, a second chain for KP Northwest, and a third chain for Premera.

At the end of the packet is Exhibit 3 from the contracts that were executed. The reason you have four versions are some slight additional wordings in some of the amendments versus others. We wanted to give you complete copies. Those are the versions of everything we believe the Board asked for last week.

Lou McDermott: Thank you, Dave. The next item is the vote. We're going to go through discussion but if a member of the Board wants to make a motion to amend, it would probably be good to do it in the beginning, as the resolution is on the screen. It is for the July 25 revised rates.

Vote - Premium Resolution SEBB 2019-15 – Premera Medical Premiums

Lou McDermott: **Premium Resolution SEBB 2019-15 – Premera Medical Premiums**

Resolved that, the SEB Board endorses the revised Premera employee premiums as presented at the July 25, 2019 Board Meeting.

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

Pete Cutler: I propose amending the motion to read that the SEB Board endorses the Premera employee premiums from July 18 as shown on the wall.

Dave Iseminger: I'll clarify for those on the phone. The motion is to strike the word "revised" and replace it with "initial," and strike the date "July 25, 2019" and replace it with "July 18, 2019."

Lou McDermott: The proposed amended resolution reads: "Resolved that, the SEB Board endorses the initial Premera Employee Premiums as presented at the July 18, 2019 Board meeting.

Sean Corry seconded the motion to approve the amended resolution.

Doug Nelson, Public School Employees of Washington: Good morning, Chair McDermott, Members of the Board. I think this is your 19 meeting, right?

Dave Iseminger: This is the 22nd meeting of the Board.

Doug Nelson: Wow. Congratulations. I would urge you to oppose the amendment and it really goes to why I'm actually going to ask you to support the actual motion that was made. I'll get started. The process issue that's being raised is an interesting process issue. I refer to your Attorney General's opinion on what to do in this issue. I think your advice has been to go ahead. You can do this. And I urge you to approve the updated Premera rates. Kaiser has made a point of "this is unfair." Well, actually, it is fair because they were given the same opportunity as Premera took. So there isn't a fairness principle that's been violated. They were given the same opportunity but chose not to adjust their rates.

Having drafted the SEBB legislation, competition was one of the major features of the SEBB Program in first place. What you're seeing is competition, robust competition.

Robust competition for the first time that this is being offered. I'm not surprised that there were some machinations going on. These are businesses that are out to make money. I am not surprised and I urge you to acknowledge that a part of SEBB is competition.

I have to say that to deny rate reductions is contrary to your charge to develop affordable insurance plans. To deny substantial rate reductions is unconscionable. Don't take $35 million from employee pocketbooks and give it to Premera, when Premera has said they don't need it. We urge you to support the motion to approve the updated rates, and deny the amendment. Thank you.

Julie Salvi, Washington Education Association. I won't repeat everything Doug just said and everything I said last week, but thank you for the work you've done over the years of developing this. You are so close to being done and launching the first year. We appreciate all of that. We also support the underlying amendment and oppose the revised amendment because we have looked at the HCA provided materials and the communications that point to the broad timeline in the underlying contract. We think you have the authority to go forward. To not accept a lower rate on behalf of our members, and to ask them to pay more than they otherwise would have to - we just cannot agree with that.

We understand the concerns on both sides, and we do hope the Board will continue these discussions so that none of you are in this position next year. I don't think anyone wants to land in that place again. But given where we are today, and the underlying contract language, we encourage you to accept the revised rates, and going forward, have conversations about how we don't all end up here again next year. Thank you.

Melissa Putman: I'm with Kaiser Permanente. I think the Board is well aware of our concerns, as it goes to the integrity of this process. We all know relationships matter, and we want to be the best partner that we can be to Health Care Authority. I think we want to see this process followed, and understand the position you're all in today. So we just want to say thank you, and would urge you to support the amendment.

Pete Cutler: First of all I want to acknowledge that this is, I imagine, an issue that especially those who don't have a lot of experience with dealing with health care contracting, to them it looks very simple. Here's an opportunity to get lower rates. Why not do it? And I have to admit that I think it's reasonable, especially for members of the Board, to count on generally the Health Care Authority's recommendations or advice, whether a situation is acceptable under principled rate setting processes.

Having said that, to me the facts of the situation are simple. First, in June the carriers submitted their final supposed rates for 2020 to the Health Care Authority for the SEBB Program. The Health Care Authority told them the rates would be submitted to the Board at the July 18 meeting. On July 15 those proposed carrier rates were posted on the web, became public knowledge, and of course I would assume came to the attention of Premera. Two days later, Premera asked the Health Care Authority if it could submit lower rates than the final rates it had submitted in June. From its letter it was clear it did not believe it had a right to insist on that. It did not even indicate that it thought the rate setting process was open to changes. But it asked.

On that day, Health Care Authority did permit Premera to submit proposed changes to its rates, and on July 22 we have Kaiser Permanente Northwest and Kaiser Permanente Washington who both sent letters protesting the Health Care Authority's decision to allow Premera to change its proposed rates. Those letters explain that they believe the Health Care Authority's actions undermine the integrity of the negotiation rate setting process, and also were not permitted under certain provisions of the Request For Proposals and contracts.

The response from the Health Care Authority to date has been to not discuss at all the integrity of the rate negotiation process -- to just set that aside and not even acknowledge that is an issue. In effect, it is saying that since the contract doesn't explicitly prohibit the Health Care Authority from accepting changes to the final rates that carriers submit, it is free to do so. It doesn't point to any contract language that would affirmatively provide or even hint that there is discretion to the Health Care Authority to wait until the last minute before a Board Meeting, to allow changes up to the very last minute before a Board Meeting, which it appears to believe.

So as you might guess, I am disappointed in the Health Care Authority's responses and how it's handled this situation. I know this is something where reasonable people can disagree, but for me, conducting one's affairs with integrity involves enacting ways where your actions are consistent with what assurances you've given to others and what you say your stated values are. In my view, that's a higher standard of conduct than merely not violating explicit contract requirements. I was also raised to believe that acting with integrity is important, and good things happen over the long term to persons and organizations that act with integrity and bad things happen to those who don't. So I'm disappointed in the Health Care Authority's handling of the situation.

Like I said, I understand why Board Members would reasonably be inclined to accept the rates, but at the end of the day, HCA represented to all the carriers that the rates they submitted in June would be their final proposed rates, to be submitted to the Board. It did not mention any opportunity for later changes. And then later decided to act inconsistent with that representation. And obviously the attraction of lower rates for members is a very powerful attraction. But in my view, the fact that it believes that it's not prohibited from accepting those revised rates, it's not prohibited by any explicit contract provision does not mean it's acting with integrity. And for that reason I urge this Board to adopt the rates that Premera originally proposed as its final rates. Period.

Sean Corry: Thank you, Pete. You said everything that I would have wanted to say but much more eloquently than I would have. I'm going to support this motion largely because of the things that Pete laid out for us with respect to the integrity of the process, which has been essentially my concerns throughout the last week, week and a half, however long it’s been since we’ve seen these documents. I do want to add one point of a personal nature. In conversations in the past few weeks, it's been implied to me that my position on this, that my questioning, sometimes harsh questioning about the process, was a function of my favoritism towards Kaiser Permanente. And I want to assure you all, and for the record, that if the companies actions were reversed, they had been reversed in Kaiser Permanente's offer to lower their rates same as it did with Premera, I would be against adopting those new rates because of the process that was implied if not explicitly in the associated documents. I think the integrity of the process

has been violated here and that's the reason I am going to be voting to support this motion.

Alison Poulsen: I really appreciate the comments from Pete and Sean about the integrity of the process and I think there's a lot of learning that we will carry forward in this process. But at the end of the day, I think the opportunity for us to get as many competitive products to our enrollees is really at the top of my priority list. So I will be voting to oppose the amendment and support the revised rates.

Wayne Leonard: Last week we asked for the staff to provide some additional information including some actuarial data. Thank you for going through the rate development sheet. I will admit that this is not the kind of bidding I'm normally used to. We don't really have rate negotiations and rate development processes. I do hope in the future this process can go a little bit more smoothly, because I do agree that doesn't feel right. But I'm satisfied with the information I saw that there's just a lot of vagueness or whatever in this whole process. And so I am going to vote to oppose the amended resolution as well.

Lou McDermott: Just some thoughts from me. You know, the agency has been put in a difficult position. The staff have been dealing with our AGOs, with our actuaries, with each other. We've had leadership communication. It's been difficult. The position we're in today is a result of a process that is, in my opinion, intentionally vague to allow the back and forth to occur. And I think everyone is aware of that. The Board is the final vote. And to be honest with you, one of my old friends, our previous CMO, used to say, "is the juice worth the squeeze?" In this case, if those Premera revised rates would have been insignificant, we probably would not have brought them to the Board. But it was significant. And we felt it was out of our domain to make that final call, because it did fit within the parameters of the rules. It is legal. And so that's why we're letting the Board make that final decision.

Voting on the request to amend SEBB 2019-15

Voting to Approve: 2
Pete Cutler
Sean Corry

Voting No: 6
Terri House
Dan Gossett
Wayne Leonard
Alison Poulsen
Patty Estes
Katy Henry

Lou McDermott: My vote is not necessary. The request to amend Policy Resolution SEBB 2019-15 Fails.

Premium Resolution SEBB 2019-15 - Premera Medical Premiums

Resolved that, the SEB Board endorses the revised Premera employee premiums as presented at the July 25, 2019 Board Meeting.

Voting to Approve: 6
Terri House
Dan Gossett
Wayne Leonard
Alison Poulsen
Patty Estes
Katy Henry

Voting No: 2
Pete Cutler
Sean Corry

Lou McDermott: My vote, again, is not necessary. Premium Resolution SEBB 2019-15 passes.

I want to thank everybody, thank the staff, the Legislature who passed this. It's a historic day. The Board Members who have stuck this out, 22 meetings, a lot of work going from ground zero. It's been a heck of a journey. I'm really thankful for Sue Birch, our Director, for letting me chair this meeting. It's really been an honor. It's a big deal, and I really appreciate everybody who has worked on this.

Next Meeting

August 29, 2019
9:00 a.m. – 12:30 p.m.

Preview of July 25, 2019 SEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the August 29, 2019 Board Meeting.

I also want to echo Chair McDermott's comments. I had a moment yesterday. I was looking through video that the team is producing about how open enrollment will go. There was this moment as I got to around minute 10, where it said here is the online enrollment portal where you check your plan selection box. Here's the plan names, the premiums, the icon to go to Alex and say "help me navigate these plans." And just the embodiment of what it took to get to this two-minute segment of a video, and the work that has been done by staff, by the Board, by the Legislature. It really was a very humbling moment to realize this has been a 30-year debate in the state and we're now 61 days from employees choosing their plans. It really struck me. We didn't bring tissues, Patty or Alison. Alison, you've told me you've had some tissue needs in this last month. But I just wanted to say that it's really incredible when you step back and think about all the work staff have done, the Board has done, the agency has done, the

Legislature has done, the Governor's Office support, stakeholders -- it really has been quite a two-year journey.

Lou McDermott: On that note, congratulations. We have a SEBB Program! Let's go do it.

[applause]

Meeting adjourned at 10:15 a.m.