Washington State Health Care Authority

School Employees Benefits Board Meeting

Updated 7/31/19

August 1, 2019

Washington State Health Care Authority

School Employees Benefits Board

August 1, 2019
9:00 a.m. – 11:00 a.m.

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

Table of Contents

TAB 1

Washington State Health Care Authority

AGENDA

School Employees Benefits Board
August 1, 2019
9:00 a.m. – 11:00 a.m.
Sue Crystal Rooms A & B

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

TVW is planning to livestream this meeting at www.tvw.org

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

9:00 a.m.*	**Welcome and Introductions**		Lou McDermott, Chair	
9:05 a.m.	**Meeting Overview**		David Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information
9:10 a.m.	**Approval and April 10, 2019 Meeting Minutes**	TAB 3	Lou McDermott, Chair	Action
9:15 a.m.	**July 25, 2019 Board Meeting Follow up**	TAB 4	David Iseminger, Director ERB Division	Information/ Discussion
9: 20 a.m.	**2020 Premium Resolution Continued**	TAB 5	Megan Atkinson, Chief Financial Officer, Financial Services Division	Action
10:30 a.m.	**Public Comment**			
11:00 a.m.	**Adjourn**			

***All Times Approximate**

The School Employees Benefits Board will meet Thursday, August 1, 2019, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8th AVE SE, Olympia, WA. The Board will consider all matters on the agenda plus any items that may normally come before them.

Direct e-mail to: SEBboard@hca.wa.gov. Materials posted at: https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program by close of business on July 30, 2019.

Washington State Health Care Authority

SEB Board Members

Name	Representing
Lou McDermott, Deputy Director Health Care Authority 626 8th Ave SE PO Box 42720 Olympia WA 98504-2720 V 360-725-0891 louis.mcdermott@hca.wa.gov	Chair
Sean Corry Sprague Israel Giles, Inc. 1501 4th Ave, Suite 730 Seattle WA 98101 V 206-623-7035 sean.corry@hca.wa.gov	Employee Health Benefits Policy and Administration
Pete Cutler 7605 Ostrich DR SE Olympia WA 98513 C 360-789-2787 pete.cutler@hca.wa.gov	Employee Health Benefits Policy and Administration
Patty Estes PO Box 76 Eatonville WA 98328 C 360-621-9610 patty.estes@hca.wa.gov	Classified Employees
Dan Gossett 603 Veralene Way SW Everett WA 98203 C 425-737-2983 dan.gossett@hca.wa.gov	Certificated Employees

SEB Board Members

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

Legal Counsel
Katy Hatfield, Assistant Attorney General
7141 Cleanwater Dr SW
PO Box 40124
Olympia WA 98504-0124
V 360-586-6561
KatyK1@atg.wa.gov

5/17/19

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

UPDATED SEBB MEETING SCHEDULE

2019 School Employees Benefits Board (SEBB) Meeting Schedule

The SEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501.

January 24, 2019 - 9:00 a.m. – 5:00 p.m.

March 7, 2019 - 9:00 a.m. – 5:00 p.m.

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

May 16, 2019 - 9:00 a.m. – 5:00 p.m.

June 12, 2019 - 9:00 a.m. – 5:00 p.m.

July 18, 2019 - 9:00 a.m. – 5:00 p.m.

July 25, 2019 - 9:00 a.m. – 5:00 p.m.

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

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

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

Updated 11/27/18

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

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

WSR 18-24-024

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

SEBB MEETING SCHEDULE

2020 School Employees Benefits Board (SEBB) Meeting Schedule

The SEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501.

January 27, 2020 - 9:00 a.m. – 3:30 p.m.

March 5, 2020 - 9:00 a.m. – 3:30 p.m.

April 2, 2020 - 9:00 p.m. – 3:30 – p.m.

May 7, 2020 - 9:00 a.m. – 3:30 p.m.

June 4, 2020 - 9:00 a.m. – 3:30 p.m.

June 24, 2020 - 9:00 a.m. – 3:30 p.m.

July 16, 2020 - 9:00 a.m. – 3:30 p.m.

July 23, 2020 - 9:00 a.m. – 3:30 p.m.

July 30, 2020 - 9:00 a.m. – 3:30 p.m.

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

7/2/19

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 09, 2019
TIME: 1:24 PM

WSR 19-15-021

TAB 2

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD BY-LAWS

ARTICLE I
The Board and Its Members

1. Board Function—The School Employees Benefits Board (hereinafter "the SEBB" or "Board") is created pursuant to RCW 41.05.740 within the Health Care Authority; the SEBB's function is to design and approve insurance benefit plans for school district, educational service district, and charter school employees, and to establish eligibility criteria for participation in insurance benefit plans.

2. Staff—Health Care Authority staff shall serve as staff to the Board.

3. Appointment—The members of the Board shall be appointed by the Governor in accordance with RCW 41.05.740. A Board member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.

4. Board Composition —The composition of the nine-member Board shall be in accordance with RCW 41.05.740. All nine members may participate in discussions, make and second motions, and vote on motions.

5. Board Compensation—Members of the Board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

ARTICLE II
Board Officers and Duties

1. Chair of the Board—The Health Care Authority Director or his or her designee shall serve as Chair of the Board and shall conduct meetings of the Board. The Chair shall have all powers and duties conferred by law and the Board's By-laws. If the regular Chair cannot attend a regular or special meeting, the Health Care Authority Director may designate another person to serve as temporary Chair for that meeting. A temporary Chair designated for a single meeting has all of the rights and responsibilities of the regular Chair.

2. Vice Chair of the Board—In December 2017, and each January beginning in 2019, the Board shall select from among its members a Vice Chair. If the Vice Chair position becomes vacant for any reason, the Board shall select a new Vice Chair for the remainder of the year. The Vice Chair shall preside at any regular or special meeting of the Board in the absence of a regular or temporary Chair.

ARTICLE III
Board Committees
(***RESERVED***)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW, but the Board may enter into an executive session as permitted by the Open Public Meetings Act.

2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.

3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.

4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.

5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 24 hours prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. An audio recording (or other generally-accepted electronic recording) shall be made of each meeting. HCA staff will provide minutes summarizing each meeting from the audio recording. Summary minutes shall be provided to the Board for review and adoption at a subsequent Board meeting.

6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board members in the minutes.

ARTICLE V
Meeting Procedures

1. Quorum—Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.

2. Order of Business—The order of business shall be determined by the agenda.

3. Teleconference Permitted—A Board member may attend a meeting in person or, by special arrangement and advance notice to the Chair, by telephone conference call or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the SEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at Board meetings may also occur in conjunction with a public hearing or during the Board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Board members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .

6. Representing the Board's Position on an Issue—No Board member may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.

7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the Chair, or upon request of a Board member, a roll call vote may be conducted. Proxy votes are not permitted, but the prohibition of proxy votes does not prevent a temporary Chair designated by the Health Care Authority Director from voting.

8. State Ethics Law and Recusal—Board members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW. A Board member shall recuse himself or herself from casting a vote as necessary to comply with the Ethics in Public Service Act.

9. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order Newly Revised. Board staff shall ensure a copy of *Robert's Rules* is available at all Board meetings.

10. Civility—While engaged in Board duties, Board members conduct shall demonstrate civility, respect, and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

ARTICLE VI
Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The SEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.

2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety, and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

TAB 3

Washington State Health Care Authority

D R A F T

School Employees Benefits Board
Meeting Minutes

April 10, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:00 p.m. – 5:00 p.m.

Members Present
Pete Cutler
Patty Estes
Dan Gossett
Alison Poulsen
Terri House
Lou McDermott

Members on the Phone
Katy Henry
Wayne Leonard

Members Absent
Sean Corry

SEB Board Counsel
Katy Hatfield

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

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

Approval of October 4, 2018 Meeting Minutes
Patty Estes moved and Terri House seconded a motion to approve the October 4, 2018 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

Approval of November 8, 2018 Meeting Minutes
Pete Cutler moved and Dan Gossett seconded a motion to approve the November 8, 2018 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

Approval of December 13, 2018 Meeting Minutes

Terri House moved and Patty Estes seconded a motion to approve the December 13, 2018 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

March 7, 2019 Board Meeting Follow Up

Dave Iseminger, Director, ERB Division. Slide 2. There was a request for links to the news articles that reference the SEBB Program. I can already tell you this slide is out of date because there were three this week in various newspapers. The links are from various Seattle Times articles, many of which were picked up by other regional newspapers and run through the Associated Press process.

Slide 3 is a link to all the core communications we are conveying out to the districts, educational service districts, and charter schools. Every month our communication team produces a packet of roughly three or four materials. These toolkits usually consist of a one-pager, an infograph, a poster, and a news article that could be put in either an email digest or anything else the districts are using to convey information. These toolkits have been produced monthly since November and are available on the HCA website, as well as the other fact sheets the agency has produced over the last year. A lot of people are accessing the 11x17 preliminary medical benefit design from November's meeting and a six-page document we created of a high level overview of the entire suite of SEBB Program benefits.

Slides 4 through 9 - SEBB Finance Follow up. Ben Diederich from Milliman talked about the adult unit ratio and how it's different from the dependent load, and to do the math. He did an illustrative example and then the real example. We committed all of that to writing so you have that in your packets. I won't go through it again, but this is the promised written format.

At the end of Mr. Troy Andrews public comment, there were questions as to whether the union employees that he represents are part of the SEBB consolidation. We reached out to Tacoma Public Schools, and understand those members of that bargaining unit are considered full-time employees of the Tacoma School District. That means, as the law exists today, they would be subject to consolidation. We have conveyed that information to Mr. Andrews.

SEBB Finance 2019-2021 Budget Update

Megan Atkinson, Chief Financial Officer. Slide 3 – Net Funding Rate versus Funding Rate. The net funding rate is a concept we started driving home on the PEBB side a few years ago. We found it helpful because frequently on the PEBB side, we end the year with a surplus. That surplus buys down the next year's funding rate. The net funding rate is the funding rate needed in its totality without the benefit of any surplus or paying back any deficit. The net funding rate for the SEBB Program, under the modeling we have been using and that we provided to the Legislature at the beginning of March, is the middle column, the $1,114. After I presented that at the last meeting, there were questions.

In the legislative conversations, there was discussion around the number in the last column, the $1,096. The conversation of, "is the $1,096 underfunding SEBB, what is the difference between the two," etc. The $1,096 amount is the sum of those rows

above. We've reviewed this chart with you many times. I think you're familiar with the format of it. The $1,096 benefits from an assumed surplus spend on a per subscriber per month basis -- $18. We've titled that surplus spend. That's the benefit of the starting loans from the General Fund-State. If you model using the scenario that we have right now with the initial $28 million loan, and the additional $10 million loan, we are currently projecting to underspend this year's administrative money, the $28 million. We don't think we'll fully spend it by June 30. There'll be a little bit left in the fund.

The additional $10 million that the Governor had in his budget, which was also picked up in the legislative budgets, would start with a surplus, a little bit of money already in the account. That money used would essentially buy down the funding rate. But again, the net funding rate is the funding rate regardless of any surplus spend or deficit payback. That's the true amount needed to fund the program operations. That is the $1,114 in the first year.

That's the difference between those two numbers. Is one underfunding or not? They both fund the program, just with a slightly different look at the funding needs.

Slide 4 – Monthly Funding Rate Comparison. The table on this slide shows the comparison between the House budget and the Senate budget. The green rows are the funding rates we modeled out using our assumptions we provided to the Legislature at the beginning of March. The $1,096 amount is for fiscal year 2020. We haven't talked much about fiscal year 2021, but we had a funding rate modeled for fiscal year 2021, which was $1,127. Comparing the green row with the tan row, you see the House has lower funding rates in both years, and the Senate has larger differences. Larger, lower funding rates.

Slide 5 – Funding Rate Assumptions. We need to understand the assumptions being used to drive the funding rates. One is higher than the other. I'll walk through the House budget and then the Senate budget.

The big differences are the House went through and made some detailed assumption changes in the model. They made different assumptions about our loan repayment, our premium stabilization reserve build (PSR), and our medical trend. The loan repayment and PSR build are straight math. If you assume we repay the loan differently, and the House pushed it out, then we don't have those expenditures to repay the loan immediately. We don't need the funding rate to cover that expenditure. It's essentially lowering the expenditures, which means you can have a lower funding rate because you need less revenue. It's the same thing on the premium stabilization reserve. We had initially modeled an immediate build-up to 7% of the PSR. The House budget pushes that out as a more gradual build. Still getting to the 7%, but into the next couple biennium out. We wouldn't need as much revenue to build a reserve more quickly, so we can have a lower funding rate.

For the inflation assumption, the House is essentially saying the state is going to bear more risk, take on a lower trend assumption, and by lowering the trend assumption from our best estimate, they're essentially having a higher probability that they're going to miss on trend. They're bearing more risk, but they're not directing a change in the program structure. It doesn't appear to be in any way tied to approval or disapproval of

the Collective Bargaining Agreement. I don't think it's anything we necessarily have to be worried about. There is the potential that if we end up with a higher trend a year from now, when we're coming into next legislative session and our financial performance appears to be poor and the conversation doesn't include the fact that they lowered our trend assumptions, there's a possibility the conversation can be why isn't the SEBB Program better managing trend. We will just have to remind them that we are managing our trend and they underfunded our trend. Those are the House assumptions.

The Senate budget does something different. They took our funding assumptions on the PEBB Program and carried them over to the SEBB Program. It's a very different approach and drives a considerable difference in the funding rates. If you want to try to discern what the logic is on the Senate budget, you could draw the conclusion that they're essentially saying, "you have one large body of public employees, state employees, and here's what our experiences are with them. We're going to assume the second large body of public employees, school district employees, are going to have the exact same financial needs." We all know there are some differences between the populations. We believe there will be considerable differences in our enrollment across self-insured and managed care. There will be differences across the plan offerings. It's a unique approach to the modeling. Unless the Legislature takes action to change the collective bargaining, the structure of the program, the eligibility requirements, the Senate is driving more risk into subsequent budget periods.

Let's say the final conference budget ends up with the Senate funding rates and our experience ends up closer to what we're actually modeling. So the funding rate we have in the first year is $100 and some less, on a per-member-per-month basis, than what we need. That would drive the fund into a deficit situation and we would be coming to the Legislature for a supplemental budget fix. It would be really rare for that supplemental budget fix to drive out different employer and employee contributions in an active year. There are different permutations, but it would look something like the fund would get a loan to get us through fiscal year 2020. We would then have higher funding rates in fiscal year 2021 to pay that back. That's one example of how it could look. It wouldn't be a scenario where employer and employee contributions would change mid-year for a plan year.

Pete Cutler: On the inflation assumption in the House budget, apparently the model they used has a 5% trend assumption for both years?

Megan Atkinson: Yes.

Pete Cutler: Given the very small dollar impact, I would guess the model used a number not much bigger.

Megan Atkinson: It went down one point.

Pete Cutler: Apparently, the Senate just decided we like, or we choose to believe the assumptions used in the model forecasting cost in PEBB Program, we think that's what's going to unfold. Even though the Health Care Authority thinks that other numbers are more appropriate, they're going to take a roll of the dice and hope the school employee experience mirrors the PEBB experience closely.

Megan Atkinson: I think that's one interpretation. There's not intent language with it, so I'm guessing. I think what I know for certain is they did take the model as we proposed it on the PEBB side for the PEBB Program, and then they just carried those numbers over for the SEBB Program.

Dave Iseminger: They then used the net funding rate for the PEBB Program. They didn't use the operational budget number. They used the net funding rate from that model. So it's not a number you would see in the current operating budget for PEBB, because the operating budget doesn't include the net funding rate.

Megan Atkinson: For the PEBB Program, rolling back to the prior slide about the difference between net funding rate and the budgeted funding rate, on the PEBB side, the budgeted funding rate is benefiting from spending down surplus. To Dave's point, they did take the net funding rate for the PEBB Program, which is the funding rate for the true program cost, and rolled that over for the SEBB Program.

Lou McDermott: Megan, I would assume our concerns have been expressed to the Legislature about the various funding rates and impacts from our perspective?

Megan Atkinson: Yes. When the budgets are proposed by the chair of each committee and move through the process, the initial introduction of the chair's proposal, as it passes out of the fiscal committee and passes off the floor, we have a process by which we communicate agency concerns to the Office of Financial Management. They roll those up for concerns that are communicated by the Director of Financial Management, David Schumacher, to the fiscal chairs on behalf of the Governor. We did communicate our concerns.

Alison Poulsen: I want to make sure I understand what the implications are in terms of the decisions we have in front of us. If we were to assume that there will be some sort of compromise between the House and the Senate budgets, does that change any of our design work we have done? Or are you saying, generally, we think we're still in the sweet spot and the gap is more in the risk that would have to be cleaned up in 2020 or 2021?

Megan Atkinson: I would say more of the latter. I think, for where we are in development of this program, without the Legislature giving you direction to change the path that we're on in setting up the program, and without a change in the structure of the program, the eligibility, etc., then we stay the course. The Legislature is making decisions as the appropriating body of how to fund that program. And again, this may feel like it's really specific and personal to the SEBB Program, but they're doing this across the entire suite of state agencies. All state programs. There are times when the Legislature, as the appropriating body, disagrees and gives us the amount of money they think we need.

Lou McDermott: To Megan's point, she said it's based on the assumptions we have for the program already. If they were to see one of our assumptions, like our average deductible rate, and they think it should be $1,000, then they will change the funding rate to X. That would be a clear signal we need to change something. But right now they're saying we think this is the number. They are pushing out the loan and the PSR,

and looking at a different trend. We don't have any indication they want us to make programmatic changes.

Dave Iseminger: The very levers that you see on Slide 5 are assumptions within the modeling provided to the Legislature. They decided to crank those levers differently. That modeling, although very complex, has an underpinning to it of similar financial expenditures as the PEBB Program but with a different enrollment number. Where we have come to you as an agency and explained that zero sum game, the starting assumption is the same pot of money, yet a different enrollment number is embedded. Neither the House nor the Senate budgets cranked those levers differently. That's why we don't have any belief that this Board has any obligations, as it stands right now, to make any benefit design changes to drive a lower number.

Megan Atkinson: Typically, based on our experience on the PEBB Program side, if they were trying to communicate that intent to us, either to the Board or to the agency, they would have given us a model with those differing assumptions. For example, on the Senate side, we didn't get a model back. On the House side, we did get a model back with those discreet assumptions. We don't have any additional direction.

Pete Cutler: My understanding is that both budgets assume and fund the Collective Bargaining Agreements dealing with health care benefits. And that within itself basically creates a concept of an entitlement, which means that if there's a budget shortfall, unlike some areas like Parks, you can just say, well it costs more than we thought so we're going to have to cut back Parks. In this case, we have contractual agreement commitments that the Board and the level of benefits and premium share have to meet. Certainly, from my past experience, be treated more as it's a mandatory hole we have to fill if it comes in costing more than you thought. In my mind, I think this is really a subject for the budget committees and OFM. They'll have a lot of areas in which they're going to be asking themselves how much risk do we want to take for next biennium, or for next year? It wouldn't even be a biennium thing.

Megan Atkinson: That's a good reminder, Pete. I didn't mention that. In the back of the budget sections, there is language in both the House and the Senate budget explicitly funding the Collective Bargaining Agreements.

Slide 6 – Flow of Funding Rate. I mentioned there was a proviso difference between the two budgets. There was a little difference in the flow of the funding rate. Currently, in the current K-12 world, the employee health benefit funding is appropriated to the Office of the Superintendent of Public Instruction (OSPI). It goes through their apportionment process and distributed to the school districts once a month. That schedule is in statute. The House budget doesn't change that. The money for state-funded staff is appropriated to OSPI, goes through the apportionment process where it is allocated out to school districts, and then we would invoice the districts and collect employer and employee contributions for both the state and the locally funded staff.

The Senate budget has a different direction where the money is appropriated to OSPI. But, rather than it flowing through the apportionment process out to the districts, OSPI would transfer that money directly into the HCA benefit account. That is on the basic education funded staff. It is not for the health care benefits associated with the special

education program and the transportation program. The language isn't in every portion of the budget and we have not started conversations with OSPI yet on how that would work. We are waiting to get through the conference budget process and see how it would work. I'm clearly not an apportionment expert. This is different language in the Senate budget.

Slide 7 – Decision Packages. This slide is a comparison. It compares all three budgets, the Governor's, the House's, and the Senate's, and shows the decision packages we requested, specific funding requested, and the differences between what the Governor funded in his budget versus what's in the House and Senate budgets. They are largely the same. There are two items highlighted in yellow indicating one was not in the House budget and one was not in the Senate budget. One is the online decision tool and the other was an additional study looking at the Pay1 replacement project.

Dave Iseminger: For the online decision tool, the original decision package we put forward was for about $800,000-$900,000 to create a selection tool that would exist in perpetuity for the program. We knew of the possibility of 16-20 plans in some parts of the state. If there were upwards of a dozen or more plans, we wanted to make sure there was something available to help people navigate plans.

In starting this program, we didn't always hire staff on the exact day we expected. We built a variance within the program. We were able to secure, with our existing funding, a one-year licensure to do this for this initial open enrollment. We will use this as a pilot project to make a pitch for more sustainable funding in the future. I want to assure the Board that we are proceeding with this pilot, if you will, for this fall's open enrollment to achieve that goal and help school employees navigate all of their new choices. So not a super big concern with the status of that decision package.

The Pay1 replacement. We have talked a lot about the front-end SEBB My Account enrollment system. It is the front-end user experience enrollment process. On the back end are the accounting functions that we call Pay1. Pay1 at this agency has been around since the late seventies. There's been perpetual conversations about replacing Pay1. We are leveraging Pay1 as the back-end accounting functionality for the SEBB Program. We are using both of those, that original coding refined for both the PEBB Program and the SEBB Program. This is funding to continue the discussion about the ways to replace that component of our IT system. If not picked up, that means Pay1 will probably turn 45 or 46 years old, at least.

Lou McDermott: That's COBOL, right?

Dave Iseminger: Yes. It's one of the state run programs that's still around. Our CIO was surprised it was still here when he joined the agency. Gerald Ford was president when Pay1 was created! The individual Apple computer was not yet on the market.

I want to highlight the second line item, employee retirees benefit staff. That is a decision package split between the programs. This isn't funding attributed solely to you.

Megan Atkinson: I also need to correct myself. A moment ago when I was discussing the language difference, I said the Senate language was only in the basic education

portion, it wasn't in special education or the transportation. That's not correct. It's in all the necessary different sections of the K-12 part of the budget. There were some conversations going around on how to peel that piece of apportionment off for the different pieces of staff, basic education staff versus the special education and the transportation sections. But the language is in all the sections of the budget. Sorry about that.

Pete Cutler: Megan, curiosity on that particular proposal from the Senate to have the K-12 benefit funding be allocated by OSPI directly into the SEBB fund. It would seem to me it would require that you have school districts clearly being able to identify which of their employees are the state-funded positions that correlate to whatever dollar amount was associated with that school district versus which positions are funded from other sources.

Megan Atkinson: Thanks Pete, that's a good question. We've had a lot of conversations about this. Depending on the conversation and who is around the table, we go down various rabbit holes trying to think this through. There are several complicating factors. I'll set aside whether the OSPI systems can do this or not because it's outside of my purview. From the Health Care Authority perspective, one thing we really don't want to be doing is having to reconcile with districts the color of money associated with each individual person. Our invoicing process is such that we will provide on a monthly basis, as we do now for the PEBB K-12s, a full membership enrollment file detailed by employee, plan, and tier. That is given prior to the month of coverage for the school district payroll office to essentially reconcile to make sure they made the right benefit changes, employment changes, or eligibility changes for their employees. That is used in calculating the total amount due.

From our perspective at the Health Care Authority, it's easiest and most straightforward for us if we can treat the amount due to the school districts as a total sum. You have x amount that you owe us for these employees' coverage. If we end up in the situation where a portion of the funding, and again it would only be the employer contribution for the state funded staff, comes directly to our benefit fund, then we would end up in a situation of some type of reconciliation. Obviously, a school district is going to want their membership file, and as an example, what the total amount due is, say $10,000. But how much did the OSPI already pay you? The school district would only want to pay HCA the net difference. While those conversations could occur still at an aggregate level, I do fear that it would set up the situation where the school district says OSPI was supposed to pay you $7,500 not $5,000. It would be difficult to ever have those conversations without all three players involved, the school district, HCA, and OSPI because we each would have a piece of the story. I am concerned about that reconciliation workload and I've elevated that as a concern of how it changes our role, and then the need for a reconciliation.

Legislative Update

Cade Walker, Executive Special Assistant, Employees and Retirees Benefits Division (ERB). A lot of the bills we've been tracking have not substantially changed since our last meeting. I will highlight what bills have passed and what new bills have come out since our last meeting.

Slide 2 – Number of Bills Analyzed by ERB Division. As of today, the Division has done 287 bill analyses. The ERB Division had 32 high impact bills that we were lead on and 32 high impact bills that we were support. ERB was lead on 77 low impact bills and support on 120. Slide 3 shows where the bill have landed in the process. As of today, there are two bills that have made it to the Governor's desk for signature.

Slide 4 – SEBB Program Impact Bills. Specific to the SEBB Program, House Bill 1547 concerns basic education funding and House Bill 2096 concerns educational service districts health benefits. Both stalled in committee. We will continue to track them. There has been no additional action since our last meeting.

We are also following recently introduced House Bill 2140 relating to K-12 education funding. It has potential impacts on the SEBB Program even though it is directly related to K-12 funding, not to SEBB funding. Similar to HB 1547, it addresses levies.

Dave Iseminger: House Bill 2096. A flavor of that did get generated within the Senate budget. That's an example of how topics can get breathed into life in different areas. This bill would have delayed implementation of non-represented educational service district (ESD) employees into the SEBB Program to 2024. The Senate, in its committee as it was passing amendments to the budget, included a back of the budget provision that would similarly delay implementation of non-represented ESD employees until July 1, 2021. Not exactly the same time frame, but the same concept, that same population.

The Senate budget also made a reduction of funding of a couple hundred thousand dollars that was associated with that change. That exists within the Senate budget. It doesn't exist within the House budget. There are questions about if that's a change that really needs to go through a statutory vehicle, or if that is eligible for back of the budget provisions. I want you to know the Senate did include that within their budget modeling of a shorter term delay of non-represented ESD employees.

Alison Poulsen: A question on that. Do you have a sense of how many employees that would be potentially covering? And is it just how ESDs generate revenue to pay for employees that wouldn't be part of the initial funding package?

Dave Iseminger: When we did the analysis on 2096, and this is the same population, I believe we estimated it was somewhere between 2,000 and 3,000 employees that could fit in that model. That wasn't enough for us to change our underlying modeling assumptions. It was well within the confidence intervals, if you will. It didn't require any sort of refresh to the March model that Megan has previously presented. That is the kind of scope it looks like it could impact.

Alison Poulsen: Is there concern that they don't have a levy structure in the way a school district would? I don't know if I'm saying that quite right.

Dave Iseminger: Alison, that is the crux of the question because the ESDs are funded as a service model from the districts, and then they have Early Childhood Assistance Program (ECAP) funding for some of their positions. They do have a fundamentally different funding structure. That is part of what prompted this very topic from the ESDs to the Legislature.

Alison Poulsen: The ESDs would need to cover those employees whether they feel like they have the money or not? Is that a fair statement?

Dave Iseminger: Alison, let me make sure I understand. I think you're saying if they are delayed, it's not that they don't have coverage, it's just that they don't have coverage through the SEBB Program. They otherwise would have coverage --

Alison Poulsen: Yes, that would be another way. Or that if they have to meet the timeline, they've just got to figure out how to fund that. There isn't a way for them to be exempted from receiving their health insurance through the SEBB Program as a school employee.

Dave Iseminger: I think the way you just said it is what it's doing. It's delaying their mandatory participation in the SEBB Program until July 1, 2021. It would carve out and exempt from the mandatory participation. If an ESD wanted to voluntarily join earlier than that, they could. But their mandatory participation date would be July 1, 2021. Whereas everyone else under the whole SEBB Program consolidation, mandatory participation is January 1, 2020.

Alison Poulsen: And so an ESD would have to continue to have an insurance relationship in addition to…

Dave Iseminger: They would maintain the authority and have the responsibilities for benefit offerings to non-represented ESD employees.

Alison Poulsen: Excellent. Thank you.

Cade Walker: Slide 5 – PEBB Program Impact Bills. Bill numbers not in bold or not italicized are still in their current committee. They haven't moved past the cut-offs. For the bills related to Medicare eligible retirees in the PEBB Program, those have stalled in committee. The paying state retirement benefits until the end of the month in which a beneficiary dies stalled as well. House Bill 1220, adding a member from the Office of the Insurance Commissioner to the PEB Board, is still moving through the process, meeting all its cut-off deadlines. We are tracking that closely for the PEB Board.

Slide 6 – ERB Impact Bills. House Bill 1065, regarding balanced billing and out-of-network billing had a second reading. We have been following this very closely for the last five years. It is a good consumer protection bill that we support.

House Bill 1074 raises the tobacco purchasing age and vapor product purchasing age from 18 to 21. This bill passed and went across the Governor's desk for signature. We will continue to assess what that means for our programs, given we do have tobacco surcharges and this may have some implications that the Board will need to take future action on related to tobacco surcharges.

Dave Iseminger: We'll continue monitoring exactly the implications. As a reminder, the tobacco surcharge, you did have some resolutions you voted on about the definition of tobacco product and what the duration of the look back period is for use of tobacco products. We have to overlay if there are any changes that might be necessary

because of this legislation. The current tobacco surcharge does not include vapor products. That would be the implementation for 2020. If there's future changes that we would bring to the Board for 2021, we would bring similar recommendations to both the PEB and SEB Boards. There will be some housekeeping things that need to be done. But the Board doesn't need to chime in on those. A lot of the language that's in our rules references that 18-year old date, so those will all be shifted to 21. But we don't bring things to the Board that are mandatory requirements under either federal or state law. We only bring you things where there's discretion in policy choices for you to make.

Cade Walker: House Bill 1099 provides notice about network adequacy to consumers. It passed and was signed by the Governor's office. This bill requires that a health carrier must prominently post the following information on its website: whether the health carrier classifies mental health treatment or substance abuse treatment as primary care or specialty care; the number of business days an enrollee must have access to covered mental health treatment or substance abuse treatment services under the network standards; and information or action an enrollee must take if they are unable to access covered mental health treatment or substance abuse treatment. This is another good consumer bill that we were support.

Senate Bill 5889, which also passed, relates to the disclosure of information to protected individuals. This requires health carriers to recognize that you may have adult dependents on your coverage over the age of 14, I think, and are considered a protected individual. When requested, the health carrier must communicate solely with the adult dependent and must respect their request for non-disclosure unless they receive written authorization otherwise to disclose that information to the subscriber on the plan.

Both of these bills have had input from our health carriers -- both ones HCA is working to contract with and our current contracted carriers. None of the carriers that we heard back from expressed any concerns about either of these bills. We assume the passage of them will be a smooth update to their processes and procedures, as required by these two bills.

House Bill 1523 and Senate Bill 5526 are the “Cascade Care” bills. They are both still moving, with a lot of different action taken on them.

Pete Cutler: How would the last bill you mentioned, 1523, impact the ERB Programs? It deals with the individual market, which does not, on the face of it, deal with us.

Dave Iseminger: Pete, this agency, the public option bill has had consultation with both the Insurance Commissioner's office, the Health Benefit Exchange, and the Health Care Authority. The Health Care Authority is the primary purchaser of health care for the state, and the ERB Division in particular with expertise in the commercial market. That's the tie that has been drawn for this agency. As a health care purchaser having a significant role in a commercial market, there would be expertise here to also be leveraged and help purchase a public option that could be offered on the exchange. It's not necessarily ERB, it's really HCA. But as the ERB Division is the primary engine that has commercial impacts here in the agency, it often gets defaulted to saying there is an ERB Division impact.

Pete Cutler: Just to be real clear, it does not actually call for changes in the PEBB Program or the SEBB Program, but it does involve taking advantage of expertise, resources in this division or agency?

Dave Iseminger: That is correct.

Cade Walker: Slide 7 – ERB Topical Bills. A new bill came out, House Bill 2154 abolishing abortion. As it stands now, no action taken. It falls within our topics we follow, along with Senate bill 5602, which is still currently in play.

On the pharmacy side, we still have a number of bills that are still being considered and having action taken on them. We are tracking those, along with our Clinical Quality and Care Transformation (CQCT) Division.

[break]

Policy Resolution

Rob Parkman, Policy and Rules Coordinator, ERB Division. We have one policy resolution for you to take action on today, Policy Resolution SEBB 2019-08 – Terms and Conditions for RCW 41.05.740(6)(e).

This Policy Resolution establishes terms and conditions to satisfy the requirements within RCW 41.05.740(6)(e). From a policy perspective, to have as many SEB Board approved resolutions as possible be effective for this population, this resolution would allow as many resolutions as possible to be effective for this population. It would also make the administration of this part of the program easier. Changes made since introduction. The resolution number was updated from SEBB 08 to SEBB 2019-08. This reflects our current numbering process. We removed the typo, the extra "0" that was in the second line for the RCW reference. The resolution presented at the March meeting is located in the Appendix.

Stakeholder feedback. Two stakeholders provided feedback. One supported the resolution because it would ensure consistent program rules for employees granted SEBB Program eligibility under the (6)(d) and the (6)(e) eligibility rules. The other stakeholder supported it because it would make it easier for the program to be administered overall.

Lou McDermott: **Policy Resolution SEBB 2019-08 - Terms and Conditions for RCW 41.05.740(6)(e)**

Resolved that, 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 for provisions within those rules governing benefits that are not authorized in SEBB 2019-03 to be offered to RCW 41.05.740(6)(e) employees.

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

Voting to Approve: 6
Voting No: 0

Absent from Vote: 3
Katy Henry
Wayne Leonard
Sean Corry

Lou McDermott: Policy Resolution SEBB 2019-08 passes.

Eligibility and Enrollment Policy Development

Rob Parkman, Policy and Rules Coordinator, ERB Division. I'm introducing two policy resolutions today. First, Policy Resolution SEBB 2019-09 - Error Correction Recourse, and Policy Resolution SEBB 2019-10 - Error Correction Premium Responsibilities. Both resolutions deal with SEBB Organization errors. We will run a decentralized system. With all the new SEBB Organization school employees joining the SEBB Program on January 1, 2020, there may be some employer errors that need correcting. These resolutions provide direction on how to handle those errors.

Slide 4 – Proposed Policy Resolution SEBB 2019-09 – Error Correction Recourse. If a SEBB Organization fails to provide notice of benefits eligibility, or accurately enroll a school employee or the dependents in benefits, the error will be corrected prospectively with enrollment and benefits effective the first day of the month following the date the error is identified unless the Health Care Authority determines additional recourse is warranted.

Policy considerations: SEBB Organizations must correct eligibility and enrollment errors they caused; SEBB Organizations will correct these eligibility and enrollment errors prospectively, unless the Health Care Authority determines additional recourse is warranted. Recourse may include reimbursement of dollars paid for claims, or dollars paid for other coverage by the school employee while the error was in effect. This may also include retroactive enrollment, based on the Health Care Authority's power in this resolution.

Pete Cutler: The language where you gave the examples of what might be included recourse, is that intended to be part of the policy resolution, or is that just comments?

Rob Parkman: Those are additional comments.

Proposed Policy Resolution SEBB 2019-10 - Error Correction Premium Responsibilities. If a SEBB Organization errors and enrolls a school employee or their dependents in SEBB insurance coverage when they are not eligible, and it is clear there was no fraud or intentional misrepresentation by the school employee involved, premiums and any applicable premium surcharges paid by the school employee will be refunded by the SEBB Organization to the school employee without rescinding the insurance coverage.

Policy considerations: SEBB Organizations must correct eligibility and enrollment errors. This policy addresses when a school employee or their dependents were found eligible and enrolled in coverage when not actually eligible for SEBB benefits. It requires the SEBB Organization to bear the cost of this mistake by refunding all premiums and applicable premium surcharges paid by the school employee for the coverage. The SEBB benefit coverage will not be terminated retroactively but will be terminated prospectively.

Dave Iseminger: That bottom piece, about not rescinding coverage, is because federal law prohibits the retroactive rescission of insurance coverage. This resolution is saying if there was a mistake, the person who bears that mistake is the employer, not the employee. I do think that we've received some feedback already and if the Board's amenable to it, it will be considered Board feedback. It would add the word "retroactively" in "without retroactively rescinding the insurance coverage." To be very clear about no retroactive rescission. In our world we often think of rescission as being retroactive, but we can be very clear that it's retroactive rescission. We'll add the word "retroactive" in the last clause.

Pete Cutler: I definitely approve that and I would suggest it also would be helpful to be very clear that it is permissible, however, to cancel the insurance on a prospective basis going forward if the person is not eligible. Just no doubt at all if somebody reads it. Thank you.

Rob Parkman: So you want that added to the resolution?

Pete Cutler: That's what I would suggest.

Dave Iseminger: I'm curious other people's thoughts about adding that to be clear that it's retroactive rescission that is prohibited, but also prospective cancellation is allowed.

Terri House: Could I get an example of that? Of what Pete means? Could you provide me an example of that clause?

Pete Cutler: I think it is actually the concept. It is generally understood that if you are discovered to not be eligible for some kind of benefit that you've been signed up for by your employer, once that mistake is discovered, this policy wants to make it clear that there will be no risk that you will have that eligibility retroactively taken away, and therefore, be subject to the cost of claims you may have incurred while you thought you were eligible. But the same time, I know from having worked with Collective Bargaining Agreements in other situations in the past, there have been some that said, "well if it's not clear, then perhaps we have a right to just continue on coverage once the employer has made a mistake. They can never basically correct it." And the idea is to say, "no, it can be corrected going forward. It just can't be corrected in any kind of retroactive manner."

Terri House: Thank you, Pete.

Rob Parkman: I will incorporate the Board feedback received. We will send that out to stakeholders. We'll conduct the same stakeholdering we have over the last 18 months. We'll bring a recommended policy resolution back to the Board to take action on at the May 16 Board meeting.

UMP Pharmacy Benefit Proposal

Marcia Peterson., Benefit Strategy and Design Section, ERB Division. **Ryan Pistoresi**, Assistant Chief Pharmacy Officer. Dr. Emily Transue, Associate Medical Director.

Dave Iseminger: I want to remind the Board about this journey. Last May, we had a proposal, Resolution 2018-24, about possibly changing the self-insured plan's formulary. The Board did not take action on this resolution in 2018. A similar topic has been debated by the PEB Board about changes to the pharmacy formulary components the last two or three years.

Last year, this Board wanted to know what the PEB Board did since they have spent a lot of time talking about this topic. The PEB Board had six voting members at that meeting, and split the vote 3-3. Nothing changed and we have gone back to the PEB Board with something different in 2019. There were plenty of other topics to discuss with you for the SEBB Program launch so we tabled the discussion here.

We spent time in the intervening months working on a revision to the pharmacy proposal and presented this resolution to the PEB Board at their March meeting. They had fewer questions than ever before! We are asking them to take action on the resolution in the next couple of meetings.

We will bring a similar concept to you. If there's going to be a benefit change for 2020, it would have to occur for both programs at the same time. Both Boards have to agree to it. That's where we are now. So Marcia's going to present on this topic today. It's part of the reason we had Molly Christie before you the last three meetings talking about different components of pharmacy, and now we're leading into this discussion. We won't ask you to take action on this at the next Board meeting, but we will ask you to take action after the PEB Board takes action.

Marcia Peterson: I want to point out there is an appendix. In this appendix are definitions I'll be using throughout. You may want to pull that out and look at it while I'm talking.

Slide 2 – Considerations. If the Board wants to make this change to the UMP pharmacy benefit, it would be best if the change is made now for it to go into effect January 2020. The PEB Board is also considering this change. Moda is our pharmacy benefit manager for UMP and they are unable to administer two benefit designs for the same plan, at least in time for implementation in 2020. Both Boards would need to approve the resolution in order for the change to occur for plan year 2020. If you were to wait to make this change next year, it would be more disruptive to members because all SEBB Program members will experience a change in their benefits in 2020. It would be less disruptive to those members who choose UMP, get used to the new formulary, and then have it change in 2021 or 2022 if you were to make the change later. Also, K-12 retirees who move from UMP plans in the SEBB Program and then retiree and move to the UMP plans in the PEBB Program coverage would have continuity in their formularies, if they're both the same.

The more consistent the UMP benefit is for both populations, the less likelihood of confusion when members are looking for information on our website around cost shares, etc. You have some time to think about this and ask questions before we bring it to you for a vote. It will need to be approved by June 12 for it to be effective 2020.

Slide 3 – Proposed Policy Resolution SEBB 2019-11 – Self-insured Value Formulary. This resolution has the exact same language the PEB Board is considering. Unlike the fully insured plans, the self-insured plan we're talking about today currently has an open formulary. The main change is that it would operate more like other health plans, for instance the fully insured, with some drugs that are on a formulary and covered, and some that aren't.

SEBB 2019-11. Beginning January 1, 2020, contingent upon approval of a value formulary resolution by both the PEB Board and SEB Board, all UMP plans require the use of a value-based formulary, and:

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

Slide 5 – A high-level look at the current UMP pharmacy benefit tiers. I'm going to take you through an explanation of how it's going to work. The UMP pharmacy benefit was established in 2014. It has five tiers and an open formulary. For every covered drug class, there are drugs in one of the above tiers. In general, all drugs are covered in some way, shape, or form. The copays, which are the costs the member pays, are designed to steer members toward the lower-cost drugs. You can think of Tier 3 drugs as having similar effectiveness as those in the other tiers, but they cost more both for the plan and the member.

The Preventive Tier reflects the United States Preventive Services Task Force (USPSTF) recommendations and includes largely vaccines and contraceptives that were made a requirement for coverage within the Affordable Care Act (ACA). Those have no coinsurance or deductible in order to reduce financial barriers to their use. Value Tier has a small coinsurance amount so as not to discourage the use of these drugs and to keep them affordable for members who need them. Tier 1 includes select generic drugs at a slightly higher cost. Tier 2 includes preferred drugs that tend to be brand name drugs. Tier 3 has the highest out-of-pocket costs and includes non-preferred drugs. From the member's perspective, the drugs in these tiers might be largely interchangeable in terms of effectiveness. It's best for the member's pocketbook and for the plan's ability to hold down premium costs if the member does choose a lower cost drug.

The problem we've run into in this plan is there's a lot of volatility in drug pricing. There are some really high-priced drugs in Tier 3 non-preferred drugs where the members are responsible for paying up to 50% of the costs. Although the tiers are designed to

encourage members to choose something that may be just as effective but at a lower cost share, we found members and providers may not be aware that those less expensive drugs are available and will work for them. They get the expensive drug that was prescribed. Drug companies have introduced copay coupons, which effectively negate these member incentives. The plan still pays the cost.

Slide 6 shows the actual member costs as they currently exist for the UMP pharmacy benefit. Column one names the tiers. Column two shows the coinsurance or deductible the member pays for their drug depending on the tier it's in. Column three shows the maximum out-of-pocket costs for a member for a 30-day supply. Their annual maximum out-of-pocket is $2,000.

Dave Iseminger: The only thing I'm going to add is the context of this is a 30-day supply because it could be 30-day or 90-day supply. This example is a 30-day supply.

Marcia Peterson: Every health plan struggles to keep their drug costs down by using some sort of coinsurance mechanism. By and large it seems to work a little. Within the PEBB Program population, the use of generics is really high, about 90%. So it's working to some extent. Sometimes there's no generic available and the price of the Tier 3 drugs can be extremely high. For example, if my doctor prescribes a Tier 3 drug for me that's not a specialty drug that costs $2,000 for 30-day supply, my out-of-pocket cost is $1,000. Faced with that, it is in my best interest to try something equally as effective that costs less.

Drug manufacturers have found a work-around by offering copay coupons. In my example, if I'm able to apply my copay coupon, I might pay only $20 for that same $2,000 drug which is great for me, but the plan is still paying $1,000 to the drug company. To protect the plan, and ultimately the member premiums, from drug price increases, we would like you to consider establishing a value formulary for the Uniform Medical Plan.

Slide 7 is an illustration of copay coupons and how they contribute to increasing premium costs. The costs shown are just examples. Copay coupons may be available from your physician or found online. As a patient, you give the card to your pharmacist when you get a prescription filled. The amount of the copay may be reduced or covered entirely. The pharmaceutical company that makes the drug covers the cost of reducing your copay when you use the card. However, the health plan still pays the price of the most expensive drug, as only the consumer gets the benefit of the coupon. This is illustrated by the third column in the table, which shows that for the brand name drug costing $3,800, a copay coupon could lower the member cost from $1,900 to $0, but the plan still pays 50% of the price of the drug despite the coupon. This can lead to increased premiums for everyone because the total cost to the health system is much higher, in this case, more than 12 times higher than the generic option. While on the one hand, copay coupons can be really helpful to patients trying to afford expensive drugs. They ultimately serve to mask the true cost of the brand drug.

Slide 8 – Copay Coupons are easy to find. As I was doing research for this presentation, I was amazed to realize how easy it is to find copay coupons online. I could save hundreds of dollars by using the coupons if I really wanted to get the drug

Concerta, which is a brand name, versus the alternative. While this is great from the individual member's perspective, and we would never try to discourage anyone from trying to save money, when you multiply that by thousands of members, the plan as a whole just got more expensive for everyone. That's one of the reasons why we're proposing the formulary, to protect against that.

Slide 9 – Proposal: Pharmacy Benefit Tiers – UMP. The value formulary would essentially eliminate Tier 3, or nonpreferred drugs, from coverage. For every covered drug class, there is at least one drug in the other tiers. In the light blue box on the right, it indicates members would pay 100% for the cost of these drugs not on the formulary, or they would go through an exception process. If they can show medical necessity, those drugs would be covered.

Dave Iseminger: I want to highlight what Marcia said because it's such a critical piece and it can get lost in it. "For every covered drug class, there is at least one drug in the other tiers." It's not like there's a disease state or a drug class where there wouldn't be a coverage option within the pharmacy benefit. It's saying you need to try those lower cost possibly/probably equally effective drug first, before going to the one that will increase the cost for the overall plan and could impact member premiums.

Ryan Pistoresi: Just to kind of reiterate, we're not looking at excluding any types of drugs for certain disease states. Everyone currently taking a Tier 3 drug will have an alternative available for them, or a system in place to ensure there is access for these members to get the medically appropriate drugs.

Pete Cutler: Is there some analysis done of the efficacy of the options that are provided in Tiers 1 or 2, or the value because I could see somebody saying “for whatever class of drugs I'm taking, you give me an option, but it's not nearly as effective as what you're preventing me from getting in Tier 3.”

Ryan Pistoresi: Every drug on the UMP formulary does go through a review process through the pharmacy and therapeutics committee. There are certain drug classes that go through the Washington State Pharmacy and Therapeutics Committee, which meets every two months. They review the most current safety and efficacy data and comparative effectiveness data so they can make that comparison. Then we go through a cost analysis process at HCA and select a lot of the drugs that way. For all the other drugs not on the Washington preferred drug list, they go through Moda's P&T Committee. They have a Board of physicians and pharmacists that review the safety and efficacy of those drugs. They provide us the recommendation so that we have a chance to review and either approve them, which mostly we do, or if they're a Washington P&T drug class, then we'll look at some reconciliation that we can do for those drugs. Every drug does have a P&T review to ensure there is comparable safety and efficacy. Moda does provide the recommendations of how these drugs should be structured on our preferred drug list.

Emily Transue, Associate Medical Director. The one thing I would add is if for an individual one drug was more effective, if the drug on Tier 2 didn't work, they would be able to go through the exception process. As a rule, there should be comparable efficacy, but individual circumstances do vary.

Pete Cutler: So it's both. Once something's considered equally effective available in the higher tier, or lower tier number, but for a given individual, there is a process if for that individual the doctor or whomever doesn't believe that option is effective, then they can seek access to a drug that's not in the formulary. Thank you.

Marcia Peterson: Those are good questions and we have struggled to understand those as well. It's important to shift our mindsets. I had to do this myself. As a layperson, I watch tv and see advertisements. I'm excited about these drugs that are advertised and it's embedded in my mind that "this is the best drug." I've had to learn to think about this, in this process as a member, I begin my medications for a medical condition with a most-preferred drug therapy. I only go to those other therapies if necessary. Most fully insured plans usually have formularies. We are proposing one as well. Why would you pay more for a drug that's no more effective than a lower cost drug?

Slide 10 is an example of why that's actually a better option for our members. I'll use the drug Lyrica as an example. Lyrica treats nerve pain and commonly used to treat fibromyalgia. It's a Tier 3 drug and costs the member $214 for a 30-day supply. We chose Lyrica because it's one of the most requested exceptions in the PEBB Program. Gabapentin is a generic alternative, also used to treat nerve pain and fibromyalgia. It's a Tier 1 drug and costs the member $1.78 for a 30-day supply.

Slide 11 is an example of what we're worried about happening and we want to avoid by setting up this value formulary. The example shows two members, Don and Dave, who are both prescribed Lyrica for fibromyalgia. They both try gabapentin, but as can happen for a few people, it doesn't work for either of them. Don is aware of the exception process and his doctor and plan determine there's medical necessity for him to take Lyrica. He pays the Tier 2 price and gets Lyrica at that price. Dave is not aware of the exception process and goes through the whole thing, ends up paying the Tier 3 price. He has not gone through the exception process. He can still get Lyrica, but he's paying $214 for a 30-day supply.

We asked ourselves if we could address this issue with better education, but with 150,000 subscribers and all of their dependents, there are going to be people who fall through the cracks. That's what's happening now. It creates inequity for people. By eliminating Tier 3, it basically requires people to go through the exception process so they don't get stuck paying those higher prices.

Ryan Pistoresi: We put the exception process in place because there were people that needed to progress to Tier 3 drugs because they did try the lower cost alternatives, but because there were no lower cost alternatives, we didn't want there to be a barrier in terms of the costs. We wanted to make sure they're taking the medication that is medically appropriate for them, and the one that works. Not everyone in the plan knows about this process. There are a lot of people who could benefit from this, take their drug currently and they do meet this process, but they're not paying the Tier 2 cost share. We believe this would benefit the members.

Dave Iseminger: I saw a puzzled look for a minute. I will say it again in a slightly different way. When we described the current UMP formulary earlier in the

presentation, we drove home that point that every drug and drug class has something within all the formulas. It ties to Pete's question that for most people, the lower cost drug is effective for them and for some, they didn't win the genetic lottery. They got the bad lottery ticket and the drug that works for most people doesn't work for them. In that instance, they have a drug in Tier 3 and are paying that higher rate. We came up with the exception process. Just because I got the bad genetic lottery ticket, I'm not penalized for that. I tried all the things that work for everybody but didn't work for me. Now we would eliminate the Tier 3 category. Instead, everybody goes through the exception process. You won't go through the exception process if you're part of the majority who the drug works for. Everyone starts with the preferred drug.

Patty Estes: The question that keeps rattling through my mind is how is this going to work for open enrollment and that giant switch that's going to be flipped.

Ryan Pistoresi: We are working on a transition plan. Regardless of the action on this resolution, we are working on a transition plan for all new members that would be going through open enrollment and potentially joining the UMP Plan for 2020. We are looking at how we can identify what medications the members are currently using so they can continue to use it, especially around specialty medications. We are working on a transition process that could incorporate the value formulary should both Boards approve it.

Patty Estes: I have several friends on medication. They've been on that same medication for years. Having them go through the exception process where they have to try another drug could be potentially dangerous medically. That would be a concern of mine, of someone not informed on the process. Hearing that they have to now go through this process might scare people a bit.

Dave Iseminger: There are a couple of safeguards in place. Even if the Board doesn't pass this resolution, we would always be very sensitive with those categories of anti-psychotics and the list of seven refill drug-protected class.

Patty Estes: Refill-protected classes?

Dave Iseminger: Whether or not the resolution passes both Boards, there will be a lot of careful sensitivity with those particular disease states. There are a lot of delicate medication transitions that have happened. That is one piece that has a special bubble around it to protect it. The second piece, when someone is getting to the drug that is now working for them and had previously tried different drugs along the way, they would get credit for that. They wouldn't have to retry a drug they had already tried in a previous step therapy under another insurance plan. I want to make sure there is an acknowledgement of that piece. You don't have to repeat your homework if you've already done it.

Patty Estes: With that, the question would be how do they prove they've already tried that. Do they have to provide medical records? What does that process look like?

Ryan Pistoresi: There is going to be a transition period and process for the Uniform Medical Plan. When people first join the plan, they'll be able to fill the medications.

Moda will be able to gather data and better understand what medications members are on. We will also be able to provide information on open enrollment. If your friends know what medications they're on and they're asking questions, they could be able to reach out to Moda or to the other SEBB plans and ask how are these medications covered? Is there anything else I should know about? What is my potential cost share for a 30-day supply? There will be information available. Hopefully we can answer a lot of these questions during open enrollment for a smooth transition for January 1, 2020, and have a system in place to allow PEBB Program members to fill their medications and not be interrupted, even for drugs that have prior authorization or step therapy, etc.

Emily Transue: One of the important points that you raised is what if it's dangerous for them to change. There's a real distinction between when it's dangerous to change, and when it's really what someone is used to. If someone has been taking the blood pressure medication Lisinopril, even if it's been for 20 years and it's working for them, and there's another one called Benazepril that's basically the same and works the same for 95-99% of people, there would be an expectation that there would be a change since that's a low risk situation. There's no reason to think they'd do poorly on Benazepril.

The creation of those protected classes really was specifically around those areas where there can be a danger to changing. There also would be an awareness in other situations if the clinician explained that this patient has a set of conditions and it's not safe for them to change, that would be taken into account in the exception process, in addition to the other standard components.

The question of the evidence standard for showing if you are on something before. I think we'll probably have to go back and look that up. I know different Pharmacy Benefit Managers (PBMs) handle that differently and I'm just not sure about Moda.

Dave Iseminger: We'll follow up on that at our next meeting.

Ryan Pistoresi: Typically that information is between the provider and the PBM. There will be a lot of communication. It's not really on the member to be able to generate pharmacy records or pharmacy claims to show what drug they took on what date. It'll mainly be between the provider and the PBM, and potentially the pharmacy in case they need to have some communication there to ensure the patient is able to get the right medication.

Patty Estes: I think that answered almost everything. So, follow up. Thank you.

Dan Gossett: I'm trying to think about how to word these questions. I guess in a pre-SEBB world, that's what we've been talking about. You tried the generic, there's been a problem with it. The way the language here says you've done all formulary drugs under it. Maybe with your provider at that point you hadn't tried all of them. Are you going to have to go back and work with other generics that you hadn't tried?

Ryan Pistoresi: Is this for a new start?

Dan Gossett: Already been on something.

Ryan Pistoresi: I think we have examples of that in future slides.

Dan Gossett: Okay.

Marcia Peterson: Slide 12 is a summary of the issues we've talked about for the current design that we want to fix with a value formulary. The current design is open, has tiered pricing, and has an exception process, if you know about it.

The challenges are that the members might or might not be aware of the less expensive alternatives that they could actually use. Tiered pricing doesn't always work to steer members to lower cost alternatives that are just as effective. Copay coupons negate the impact of that shared pricing and cost the plan. Members who are prescribed Tier 3 drugs might not be aware that the exception process exists.

Slide 13 – Uniform Medical Plan Proposed Value Formulary. When we use the term value, we're referring to the fact the drugs have the same level of effectiveness as lower cost drugs, but are higher cost and not included in the formulary. The medications can change all the time. There are always new drugs coming on that are being evaluated.

Pete Cutler: I have a comment about where does value come from? My understanding is if these medicines are, for a given drug class, expected to be of equal efficacy and safety, that understates it, should be that but are not expected to work better than. This makes it sound like you may get lucky. What we're offering may be worse, where in fact, it's the assumption I've done research and it's expected that the ones that drop more will probably not work better than the option they do have.

Getting to the point you made about how the formularies could change. If I were a member, I'd be concerned about how much risk is there that something that I've been approved for that's, say, in Tier 1 or 2, or whatever, would get dropped. I'd find myself mid-plan year, when I can't make a change, finding that I no longer can take that drug. How much turnover, and how much notice, is there for turnover on the formulary?

Emily Transue: Drugs typically jump to being less expensive rather than more expensive, although there are some exceptions. Most of the changes that are happening to the formulary are things shifting to lower on the tier structure and being added in as a lower cost drug. There are rare occasions where there is a frame shift. You've probably read in the papers about a few older, generic drugs who were picked up by a new manufacturer and the price was increased 200 - 300 fold. There would be the potential in that kind of situation if there was an equivalent, much cheaper drug, that someone would be asked to change. But that would be a relatively rare situation.

Pete Cutler: Thank you.

Marcia Peterson: Slide 14 has examples of how the value formulary will work from a member's perspective. In this first example, a member who's notified that the drug that she was previously taking, Lyrica, that was previously covered, is no longer on the formulary and is now not covered. Unless she has already gone through the exception process, or if she's using a drug from one of the refill-protected drug classes, which Lyrica is not as far as I know, she has three choices. She can continue using Lyrica,

but would have to pay the full cost in order to continue using it. Or she could try Gabapentin. In this case, that's on the formulary, and she could pay the applicable copay. Or she can request an exception for medical necessity, and go through the process with her physician and the plan. If she's approved, she can continue using Lyrica. Maybe there's some reason why that's the only thing that will work for her. And pay the applicable copay, at the Tier 2 level in this case. If she's not approved, she can go ahead and pay the full cost, or she can use the covered drug and pay the lower copay. In talking with our clinicians, it's very likely other health plans have a similar process that your members are going to go through.

Slide 15 is the example of somebody newly prescribed a non-formulary drug. Again, we're going to use Lyrica. We have a member who goes to see his doctor. He's newly prescribed Lyrica, a Tier 3 drug not on the formulary. He goes through a similar process. He can use Lyrica and pay the full cost. He can use Gabapentin. He needs to try that and pay the applicable copay. Or, in using that, and requesting the exception he can go through that process. Again, his physician and plan work together to determine if there's medical necessity for him to use Lyrica. He has similar choices. If he's approved, he goes ahead and gets Lyrica at the Tier 2 copay. If he's not approved, he can still use Lyrica if he really wants to but he's paying 100%. Or he can go ahead and use Gabapentin, or whatever the formulary drug is. So that's how the exception process would work.

Slide 16 shows the refill protected drug classes. If the formulary changed to exclude a drug in one of these classes, the member would not be required to switch to the formulary drug. I think that addresses your comment, Patty. That is a concern we've all heard from friends, family members with chronic conditions, and life threatening diseases. They've spent years trying to find exactly the right drug that works for them. In these cases, you can see antipsychotics, antidepressants, and so on. They would not be asked to switch.

Ryan Pistoresi: Going back to the last slide where we went through the example. A lot of members who are going towards these non-formulary drugs usually do try the lower cost alternatives first. But this is a way for us, if someone is stepping into some of these higher-cost drugs, to tell them about this formulary version that is safe, effective, and a much lower cost to the member and would you be able to try that instead? If they have already done that, there is the exception process. It's not very frequent that a member will start with one of these non-formulary drugs without having tried some of the other alternatives. They may already have tried two or three of them. If they still want to continue, there's still a few other formulary alternatives that are not only lower cost to the member but lower cost to the plan.

Alison Poulsen: On that point, I'm curious about the process from my doctor prescribing me Lyrica. I assume the pharmacy and the pharmacist is now saying, "gosh, it's going to cost you this amount based on the tier. But you could try this." And so, if I agree, I want to try the lower cost one because it's better for my pocketbook, how does that information then get back to the provider? Or does the pharmacist have to consult with the provider, and has the provider made a decision to prescribe Lyrica because of it being Lyrica versus the type of medicine? Could you just talk about the process part of that?

Emily Transue: Yeah, I can talk about it from the physician side and then Ryan can talk about it from the pharmacy side. Typically, that's a phone call while you're in the pharmacy. Or it could be a fax if you get there at seven o'clock on a Saturday. And there would always be a check with the doctor. I shouldn't say "always." There would typically be a check with the doctor to make sure. “There’s something that's much cheaper. Is this something that you think would be appropriate for your patient?” And the doctor would say yes or no.

There are rare exceptions to that. There's a substitution process for some things that are very nearly equivalent where if the doctor signs up to say, “it's okay for you to substitute within these groups unless I sign on a different line, to say it's got to be what I said exactly.” But typically that would be a communication cycle back and forth. That's really normal.

One thing that I would really want to express in all of this. I graduated from medical school in 1996, and back then, we were not that concerned about prices and you just wrote whatever you wrote. If someone came in and said, “I want this one -- we write for that one.” Over the last 10 or 15 years, it has become very much the norm of what we all do to try to figure out how to get people what they need within a set of cost constraints that are going to be reasonable. People really try to pick the lower cost and formulary things in general, when they can. People have the expectation that there will be times when you're going to be having that back and forth with the pharmacy. For me, the horrifying thing is when you don't have it and someone comes back holding an inhaler saying, “I spent three hundred dollars on this because they said there was a different one, but I figured you probably gave me the best one.” And I'm thinking, “the $40 one is exactly the same, but I didn't know that your insurance company was going to view them differently.” Those discussions are part of the world that we expect to live in as docs and having that happen as seamlessly at the pharmacy as possible is certainly what you expect to try to do as a doc.

Lou McDermott: When we have the discussions internally, it's always about trying to steer folks to the most cost-effective medication that work for them. There's always exceptions, and those are always built into the framework. But what happens is the world sort of changes their practice. So, originally, when the tiering system was built, the use of coupons for members wasn't widely used. And so the Tier 3 was a disincentive to use that medication. There was a little known exception process, that you could get the Tier 2 pricing for the Tier 3, but you'd have to know that. There's a portion of the population who was disadvantaged because of that. They didn't know, they didn't have the information. But at the end of the day, you know when the drug companies started realizing, “hey, if we just waive the employee's copay then we're still going to get the big hit on the employer.” It has become less and less effective as a tool.

The theme you heard around the old system and the new system is still getting medication that works to the patient, and making sure it's the most cost effective way -- and always allowing an exception, because we're dealing with people. And people are all different. And there are unique circumstances. Anytime we transition, like we're transitioning from what folks are in today to what they're going to be in tomorrow, lots of thought goes into how to make that transition. So on the PEBB Program side, the

thought is, how do we implement this new program the best way possible? Is it going to be like the cold shower and everyone's going to right on January 1, or is it going to be the, we grandfather people in to the medications they're already in and then there's lots of discussion on how to do that.

In this program, there is the same discussion but a little bit different because we're picking people up from all different kinds of insurance and now trying to incorporate them in ours with that bottom line of making sure that they get the medication they need, that it is as seamless as possible. But that's sort of the theme. It's not a tactic to try and take medications away from people. It's to try and get them to the right medication. The format we used before, the pharmaceutical company has outsmarted us. That's why they get paid billions of dollars. They found a way around our structure. So this is now to combat that. And in a few years, we'll be back with, “oh, guess what now.” So, just some thoughts.

Patty Estes: I actually did work in a pharmacy for a few years, so I understand that process where we would call, “is this one okay? Does it interact?” So I get that process. My question is more about the exception process. How long does that typically take? Is it back and forth? I know you guys said the member typically doesn't have a lot to do with that. It's more in between the providers and the insurance companies. So how does that process work, and what does that look like for a new member switching over to a UMP that wasn't on a UMP before?

Ryan Pistoresi: The current process usually will take a couple of days. Usually what happens is you get the exchange between the pharmacy, they bill it, it comes back with a reject message, and says “must try the formulary alternative” or like a typical prior authorization wherein the pharmacy contacts the provider's office and says this is now a prior authorization. The physician will then call the plan and say, “what information do you need, and how do I submit it?” Once they get the information that they're able to get from the chart notes or from the pharmacy records, they will submit that to Moda. And there is a clinician at Moda that will then be able to review that and determine if the information is sufficient to grant the exception, if there is more information that's needed, if they need to make a call, or if there is not enough information, if they don't meet the criteria, then that denial. And then that gets communicated back to the pharmacy and they are either able to adjudicate the claim and get the medication to the patient, or they'll be able to provide an alternative that's based off of the formulary exception. If someone is denied, they can point them towards an appropriate alternative that would be approved.

For new members, though, that point would be similar but it may be a bit more of a challenge since they will be new to the plan. They won't necessarily have a lot of that claims history and so there may be more information that needs to come from the provider's office. But it should only take a couple of days to get the information into the Pharmacy Benefit Manager (PBM) for them to review, and then make a determination.

Dan Gossett: It's difficult to have data for the SEBB population, because we're dealing with all these different groups. But we should have data for the PEBB population and so the question -- a couple questions is what's the percentage of the people in the PEBB Program that this would impact? Right now, under the PEBB Program, what's the percentage of medications that are generic that are taken?

Marcia Peterson: I think that's 90% within the PEBB population.

Emily Transue: And there are also brand name medications in Tier 2, so the number would be less than 10% who would be in the exception process.

Patty Estes: Another number that I would be curious to get is the percentage of denials in the exception process, and maybe why.

Ryan Pistoresi: The denial number for the most recent quarter that we got a report from Moda is about 70%. And the reason it is about 70% is that a lot of patients that are trying to go through this process usually go after trying maybe one alternative or none. People try to see if they are able to go through that process. So most of the time when we get these medication requests for the exception process, it's denied because there are still other alternatives. We're able to provide that list and say, “here are one or two other alternatives that you would need to try first before getting this exception.” If you look at the case, then the member has the decision to try those or they can continue to pay at the Tier 3 cost share or try the alternatives.

Pete Cutler: Am I correct that the Health Care Authority would have access to which drugs are covered in the formularies for at least several of the larger carriers that are currently covering school employees, such as Kaiser, Premera, or Aetna? Is that publicly available or accessible information for the Health Care Authority?

Ryan Pistoresi: If I can clarify your question. So you're looking for a few high-profile disease states like diabetes, hypertension -- and seeing how the different formularies compare?

Pete Cutler: Actually, just which drugs they will cover under which tiers. My daughter just signed up for a large group employer plan in Florida. We were able to print off an amazing number of pages of details. They were in various tiers and had various footnotes. Some were more complicated to access than others. But if that information is available, it would seem one place we could start where it would be helpful if there are resources available, would be to look at what these other carriers do because in the school area, last I checked, a huge amount of the coverage is with insured plans. It's not self-insured. If you have access for those carriers and what they include in their formulary, it should be possible, hopefully, to do a check off, to see where don't we align if we eliminate Tier 3. That would, without getting into an individual person-by-person SEBB Program member interaction, be a way to try to predict how many different drugs would we expect to have some kind of discrepancy in terms of what they could access under the value-based formulary versus what they're currently getting access to.

Dave Iseminger: We won’t answer that question off the fly right here, but we'll take a look at that request for basically formulary-by-formulary comparison with the proposed UMP formulary to elucidate the types of drugs that would be the most likely candidates for people to be navigating, or impacted by this.

Pete Cutler: Thank you.

Dave Iseminger: There are two pieces I want to add. The Health Care Authority keeps talking about these as real issues that are happening in the PEBB Program. And by you taking the opportunity to switch to this formulary at the same time the SEBB Program is launched, you avoid creating these problems in your population. While we're using very active verbs now, it's because we have a population that has these issues and I wanted to acknowledge that verb tense. In reality, by passing this at the same time as the PEB Board, you would avoid some of the very problems that exist, that are prompting the agency to recommend this to the PEB Board.

The second piece is Slide 16. It is an important piece about these refill protected classes and why the generic therapeutic definitions are on it. It is true that under existing state law that if there is a generic drug created that covers one of the drugs in one of these disease states, there is already a requirement to switch to that generic drug because, by definition, a generic is same dose, same form, same safety, same strength, etc. It is essentially identical. State law requires that switch to generic drug. That is not the case if it's a therapeutic drug. It's got something just a little different so it's not a generic. Where there is a true generic, there would be a requirement to switch to a refill protected class, even in a refill protected setting because of existing state law.

Marcia Peterson: Slide 17 – Proposed Changes. This slide summarizes what we've already talked about. Why are we proposing this? We feel it's simpler and more consistent with other plans that our SEBB Program members will encounter. It offers more value, addresses equity issues by allowing for that lower copay if the member goes through the exception process. It could save members money at the pharmacy when there's a less expensive alternative and could protect the plan from some of the extreme volatility in drug pricing that we've seen the last few years. It allows members already taking drugs in refill protected drug classes to remain on their drugs. It could help control the trend in premium prices, keep the drug spend at a manageable level for our SEBB population. We feel this is the best time for this change to avoid member disruption a year from now. It addresses the continuity issue for K-12 employees who then move into the PEBB Program when they retire.

Lou McDermott: Are we going to talk about the significance of the impact to the retirees? It will have a positive impact on the retirees and their premiums? Because of the way the retirees' premiums are established, the significant increase in pharmaceutical cost is picked up by them. They're feeling the entirety of that increase. While on SEBB and PEBB, with the 85% - 15% split, we're feeling a portion of that increase, but the retirees feel most of it. They have been impacted significantly. When we have an increase in premium, let's say by $10, maybe $7 or $8 of it is pharmacy, $2 or $3 is medical and other, whereas, the retirees are experiencing the whole $10. It's really been hard on them and they've had some double digit increases.

Dave Iseminger: That is why we've been on a multi-year journey with the PEB Board about this issue. It stems from the fact that once you're in Medicare, Medicare pays primary for medical. But under the UMP, Medicare pays secondary on pharmacy. And so, when you're the primary payer for pharmacy under UMP, your pharmacy costs heavily drive the ultimate premiums that are paid. That's fundamentally the structure that exists on the PEBB retiree portfolio. With UMP as primary payer for drugs, those costs do get borne more on the member. That's why we've been on this journey.

Although retirees aren't in your risk pool, at least for today and probably not tomorrow, but maybe one day.

Marcia Peterson: Slide 19 – Proposed Policy Resolution SEBB 2019-11- Self-Insured Value Formulary.

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

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

Marcia Peterson: Slide 21. What will happen if either Board chooses not to adopt the value formulary this year? If that happens, the existing tier benefit design will remain unchanged for both programs. It could result in inequities, exposes the plan to more risk from some of the pricing volatility, and it would be harder to implement in following years because of changes for members two years in a row.

Lou McDermott: Marcia, who is voting first? Just out of curiosity.

Dave Iseminger: The PEB Board will vote first. As I said, we recognized last year there was intent interest as to what the PEB Board would do since they've had many more years focused on this issue. That is why we presented this resolution to the PEB Board at the end of March. Because we started that way, the cadence is always that there is a PEB Board Meeting before a SEB Board Meeting. There will always be an opportunity to have the SEB Board vote after the PEB Board. The drop dead date for each Board to make its decision is June 5 for the PEB Board and June 12 for the SEB Board. By design, the calendar and how we have scheduled it with the meetings, there would absolutely be an answer to whether the PEB Board said yes or no before the drop dead date for this Board.

Lou McDermott: So the PEBB resolution, is it contingent on SEBB saying yes? Is that how that works?

Dave Iseminger: It's the literal same resolution, though I do think the title's different. I think we added the word "self-insured" in this title. But the words of the entire resolution are identical.

Pete Cutler: First of all, I will admit there's been some question about what if this body for some reason wanted to move on this and adopt this resolution today? Is there anything from a legal point of view that would prevent us from acting before the PEB Board?

Lou McDermott: I don't think there would be. It would be contingent upon the PEB Board saying "yes" as well.

Pete Cutler: I understand that.

Lou McDermott: But I don't think there's a reason, although our historic practice is to introduce the resolution and then take action at the next Board meeting.

Pete Cutler: And, generally, that is my preference as well, just to have time to think about it and stew on it. A second question, on the resolution. On the second bullet on Slide 19 it says, "multi-source brand-name drugs are covered only when medically necessary and all formulary drugs have been ineffective," which implies you can't be a multi-source brand-name drug and also be a formulary drug. I guess I don't understand, what falls in the class of a multi-source brand -ame drug that excludes it from being a formulary drug?

Ryan Pistoresi: Multi-source brand-name drugs are like originator drugs that have generic alternatives. As we talked about earlier in today's presentation, the generic alternatives are available at lower tiers and state law directs the members to the lower cost alternatives. If they tried the generic and the generic doesn't work, there are still multi-source brands. If there is some clinical rationale, and this is very few and far between, but we've seen experience with it, that a multi-source brand works when a generic doesn't, that's talking about that. Really the multi-source brands and why that's a separate bullet point from the non-formulary drugs is that these are non-formulary drugs with generic alternatives that are on the formulary.

Dave Iseminger: Pete, if you go to Slide 25 in your definitions, that might also help. A multi-source brand by definition is a brand name drug that is no longer under patent protection, and has one or more generics available. For example, back in the day Allegra was the primary allergy seasonal medication that many people took. It was on patent for 20 years. In the last four or five years, it went off patent and they made Allegra-D, which was slightly different so they could get another patent. The point being, then you started seeing in your grocery stores the grocery store version of an antihistamine. It was exactly the same chemical active ingredients and same percentages as if you picked up the Allegra box. And so Allegra, the multi-source brand, would not be covered unless everything else wasn't effective.

Pete Cutler: So by definition, if you have a multi-source brand-name drug, that drug has a generic alternative, and by definition the generic alternative would presumably be in the formulary somewhere and 100% of those cases where it is a generic in the formulary, then the brand name drug is excluded from the formulary? So it is a subset of nonformulary.

Dave Iseminger: It's almost like reading statutes. You have to go back to the definitions to understand.

Pete Cutler: And that's a good reminder. But it was not self-evident to me that if a drug had a generic, then automatically that meant any brand-name version of that would be excluded from the formulary. That was implied in the definition.

Ryan Pistoresi: Currently, for UMP and what we've been doing since 2014 is whenever a brand-name drug has a generic in the market, that brand-name drug automatically moves to Tier 3. If it's a Tier 2 drug, it automatically will move to Tier 3 and then the generic will be covered at a lower tier.

Pete Cutler: That was a piece of information I needed. Thank you.

Marcia Peterson: Slide 22 is when the UMP value formulary will go into effect for the SEBB Program population, by January 1, 2020. The SEB Board needs to vote no later than June 12. We can vote earlier and the PEB Board has to vote, too.

Dave Iseminger: So for purposes of this presentation, we know there are a couple of questions that we need to follow up on. I want to make sure I've captured those. We will bring this back in May to talk about the follow ups of what's the evidentiary standard that's used, which was Patty's question, and the percent of PEBB Program people we believe will be impacted, which was Dan's question, and then whatever we can do with the publicly available formulary comparison that Pete brought up. We'll bring back those questions, as well as any insights that are new from the PEB Board Meeting in two weeks and if they vote in two weeks, the results of any vote.

Lou McDermott: On the "how many people are impacted," if I remember right, from the original PEB Board presentation, the answer is "it depends" on how you implement it.

Dave Iseminger: We're going to figure out how to best answer the Board's question, Chair McDermott, without committing right now what that's going to be. We'll bring back stakeholder feedback, of course. We could always, in anticipation, schedule that you take action on it.

Pete Cutler: I think the underlying policy has been carefully thought out and I think it really would be hard for me to imagine what new information would come up that would lead me to not support adopting it. But at the same time, I would also, if it wouldn't be too much work, appreciate a confirmation of what we know about how many of the plans the school district employers are coming from, do in fact have closed formularies, because that's a big thing. If in fact 90% are moving from one closed formulary to another, then I think that's a different messaging situation than if many of them are coming from some variation on an open formula, for whom this will be perceived as a takeaway. So that would be helpful, if it's possible to get that information.

Dave Iseminger: We'll do our best.

2020 Final Benefits Design Refinements

Dave Iseminger and **Marcia Peterson**. I've talked a lot about your work being a novel broken into various chapters. We're about to enter the last major chapter of the Board's work before the Program launch. I told the Board, depending on how closely you read the October/November/December minutes, that 90% of your work was before the

legislative session and setting a preliminary suite of benefit designs. That was really the culmination of, I believe, 18 votes in the November meeting.

After the Legislature answers the final funding question, there would be the opportunity for refining the benefits in any way you wanted to. We are about to enter that stage. It is, unfortunately, a chapter with a relatively narrow timeline. It has to begin after the Legislature has done its operating budget, but before we can go into the final rate-setting piece, to be able to have the benefit design locked in enough to create and bring you employee premium contributions.

The window we're looking at is discussion and ideas at this meeting, information that we can present and have you vote on in the May meeting, and then action taken by the June 12 meeting. So aligned with the pharmacy deadline of June 12, any benefit for refinement for the 2020 program launch would need to be locked in at that June 12 meeting. After the June 12 meeting, we'll go back to the fully insured carriers and do the final rate negotiations and bring you employee premiums in the month of July. You can't make a benefit change and expect the same premium contributions to come out in the same meeting. That sets the timeline for this refinement period being the June 12 meeting.

We want to talk with you and get a sense if there are things you are interested in us preparing for May. You can also think about this between now and May, and ask us in May. But if you do ask us for specific ideas in May, we would be bringing that analysis and any potential resolutions without stakeholder review at the June 12 meeting. That would go against the principle that we've had of trying to present things, go through a month's stakeholder process, and bring them back to you. So if there are things that you want, we could prepare accompanying resolutions that could go through stakeholder review between the May and June meetings, it would be informative for the agency to know what type of things you want us to review.

I want remind you of some things we've presented in the past and will bring back in May. There was a lot of concern around the basic Long-Term Disability Benefit (LTD). The $400 employer-sponsored benefit. We previously presented a couple of potential horse trades, as I've always called them. One of them being the life insurance benefit. You could reduce that basic benefit from $35,000 to $25,000 in order to have an uptick on the basic LTD benefit. Some Board members asked that we present information about capping the dental orthodontia benefit in the fully insured plans. We presented information if you eliminated the orthodontia benefit from being in the dental plans.

Those are, I believe, the three primary pieces of information shown to the Board. We also presented information about the chiropractic, acupuncture, massage benefits, and the combined physical therapy/occupational therapy/speech therapy/neurodevelopmental therapy (PT/OT/ST/NDT) limits, and you took action to refine those upward in the November meeting.
If there are other areas you are looking to that are on par with that or equally important to try to improve, any guidance on that would be appreciated because right now our lens has been what are things that we can present to you to horse trade up the LTD basic benefit.

Our first question is are there things you're interested in refining other than the LTD basic benefit in an improvement direction. The second question is, are there other parts of the portfolio, upon further reflection, that you can identify that would generate enough claims projection savings to alter the LTD benefit?

I want to set up the timeline. We will bring back information we provided before for LTD benefits. And then, if there's other things you're interested in us preparing over the next month for May, we would love to hear your ideas. Otherwise, November 2018 votes are the current status quo. No further action leaves those prior actions in place.

When we bring information in May about those prior horse trades that we've highlighted about LTD, we'll also talk about the long-term strategy of putting forward a decision package in the next supplemental budget process to possibly have the Legislature take an incremental step. That's the “ask for more money” option, which doesn't exist for 2020, but it could exist for plan year 2021. We will talk about that long-term strategy if there is no trade that a majority of the Board is willing to make in the short term. We'll talk about some of the strategy the agency was going to pursue for the long term.

Pete Cutler: Not to further beat a dead horse that I've been beating for quite a while, but I feel very strongly that the state should offer both for public employees/state employees, and for school employees a more robust long-term disability coverage plan. At this point, given how far we are and how tight the funding levels are, already below what the Health Care Authority has indicated it believes necessary to fund what we have already adopted, I personally am a fan of the "ask for more money.” Provide all the analysis and presumably tie that to the collective bargaining cycle and process since it's really ultimately up to the employee organizations to discuss with the state what that priority should be given to that benefit. I personally won't be coming in asking for ways to shoehorn in some incremental change before we go live with the program next year.

Dave Iseminger: Thanks for those comments, Pete. And I will say that we already know that you couldn't eliminate the basic AD&D benefit to be able to increase the LTD. I know, you don't like the basic AD&D benefit. But we already know the analysis that the AD&D claims don’t provide enough to improve the Basic LTD benefit at all. That is not something that would help. I just wanted to throw that out in a tongue in cheek moment.

Public Comment

Fred Yancey, Washington Association of School Administrators. Again, I thank you for all your work and expertise. It's way beyond mine, but I'm trying to play catch up. I'm going to go backwards in terms of most current to what you discussed earlier. First of all, I'm concerned, as I think Patty is, the issue of drug use and the fact that you have to try all possible generics before you can move to something that might be more effective. I'm just concerned at a humane level. I went on your health care site to see how easy it was to find the waiver process and it's not easy. Which, you know, so that would be my one suggestion along that line. Although I did find a statement, I didn't bring my phone, that says you only have to try two generics in order to qualify for your other. And that's different than “all,” which is what you're discussing here today. So I'm just not sure. I could show you that site, I just didn't bring my phone up. But it says very clearly, "two." I think I'm clearer now, but it would be nice to see it, just a nice little one-two-three, this

is how the exception process works. Terms like "PBM" don't mean a lot to me. They may mean a lot to you, but I hear it a lot. I would just like to see that.

And then of course the data that has been suggested, in terms of formulary, I think what I heard Pete ask, and I think it would be my concern, is do the health plans currently in use in this state by K-12 employees use the tier system? And are the drugs that they place in the tiers similar to what UMP drugs are? Or do you suddenly have a common Tier 2 drug that's in my current plan that suddenly would be a three in UMP Plan? I think that's what I heard you ask, and I think that would be good information to have.

Now going to what you said earlier, and I think, Patty again, and I would call you Mrs. Whatever but I don't , Mrs. Estes, okay, I see the last name here, to not presume familiarity. And correct me if I'm wrong. But earlier on the discussion it seems like the SEB Board believes that their mission is to operate by legislative directive. And so, which is certainly true, no question on that. But here's my question. Let's assume the Legislature concludes by the May 10 meeting, and I'll take bets on that, but that's a separate issue, okay? And let's assume they only allocate $1,000 or $900. Let's assume they choose a figure less than what the Senate chooses. Then I think, in my opinion, it's incumbent on the Board to look at the designs of the plan to bring the premium rates down to meet that $900. To sit there and design a plan and you don't know the premiums, all of these unknowns in this. But if you end up with a host of plans you have to offer and the cost is $1,200, then look at the difference you're inflicting on districts, in addition to their already burdened to cover unformulated appropriated funded staff. So I think it's incumbent upon you to consider that. That's not a legislative directive. But if you're met with two sets of figures, then I think it's incumbent on you to alter the designs to bring the cost under the figure that's funded. That's my two cents. Thank you for your time.

Rachel Smith: Good afternoon. I am Rachel Smith and I am an educator. And I am a grieving parent who is coming before you because I was a citizen sponsor of a bill that was recently signed Wednesday of last week by Governor Inslee. Engrossed Senate Bill House Bill 1099, which is about network adequacy and transparency. I come before you because this document was given to me by OEBB when I was an educator in Oregon, for the one year that I took off to go take care of my son when he disclosed to me that he was struggling with depression and a possible addiction to cocaine. I was able to get renters into my home here in Federal Way, transfer my job as an assistant principal down to Portland, Oregon, land a job as an assistant principal, find a home to stay in, all within three weeks' time. No parent is able to do that. I've pulled it off, and told my spouse, "Don't work, just stay with Brennen. We're going to get him the help he needs."

So I'm used to moving mountains for my students. I needed to move it for my own child. I did it. When I signed up through OEBB, the Oregon version of you, I was given this document. And emblazoned across the top is "The care you need when you need it." Never has there been more false advertising than this document. In this document, which I am sure you are creating one for my fellow educators and state employees here, it lists out-of-pocket premiums, copays, maximum out-of-pocket for individual, what you pay for your generic versus your name brand prescriptions, and it also specifies here "mental health inpatient and residential services, chemical dependency,

inpatient and outpatient residential mental health office visits." And I actually sat there with my son and went through this document and highlighted it. I said, "Don't worry, son," when he said, "Mom, rehab is so expensive and I don't want to break the bank on the family." I said, "Don't worry. I have bought the Cadillac of insurance policies that were offered to me as an educator. I've got you. The other options were 80% coverage. I've got 100% coverage. The other ones had high copays, I've got a zero copay. All we have to do is activate this care."

And my kid had hope. My kid believed. I believed. I was a Kaiser Permanente baby. I had all my children there. I was born there. My cousin's an ER doctor for Kaiser. Never had any issues. I've always received timely appropriate care. Why would this be different? Especially since I bought the Cadillac version as a school administrator. My son did a 20-, no, I'm sorry, a 51-minute intake that day with Kaiser over the phone. He was, unbeknownst to us, mis-triaged as routine care. There was nothing routine about what my son disclosed. I heard it through the door. I'm a nosy mom. Made sure he wasn't hiding the ball. He said, “I need a mental health care appointment. I'm struggling. I need chemical dependency inpatient. I'm struggling. And I've never been on antidepressants or antianxiety, but right now I need something.” That's three different kinds of appointments my son was asking for very specifically. And they said you can have an appointment in 29 days. 29 days. So he comes out. And my son who moved mountains, and testified before congress, and was a page, and was keynote speaker for his high school, who is my kid, who speaks like I do, all right? Came out and said “29 days,” and I said, “well, you did your job, kid but now it's time for some parental freak out -- because 29 days when you're suffering is too long.”

So I got his permission for his dad and I to call. And so we called and they said, nope he's 20 years old, you need to get a release. No problem, next day, opening of business, the doors open, there was my family, signing the release. And so we started calling and advocating for Brennen every single day. I had somebody with him. Every. Single. Day. We were told, “have a go bag, we're going to have a cancellation, we're going to get him in.” Every. Single. Day. When I was told, “well, can't we go anywhere else? I was told, no, it's a closed network. You won't have any coverage. Don't worry, we're going to get you in.” Every. Single. Day. Four days before my son's appointment, he was struggling, he had his hopes dashed, he had relapsed, and within five minutes my son legally purchased a 12-gauge shotgun in a pawnshop. He walked across the street and for $5.99, the cost of a Happy Meal nowadays, my son bought the ammunition and within an hour, my son lay dead.

My fierce, low-hanging fruit, ready to receive help, begging for help kid isn't here today because I didn't know something. And that is the network adequacy number for Kaiser Permanente was 43%. 43% of the time did you get the timely access to care -- urgent, emergent, or routine. Less than a 50-50 shot. So every time I called in, they were lying to me. There was no doctor for my kid. Didn't matter what kind of coverage. Didn't matter that I paid top dollar for it. There were no doctors. There was no network adequacy. My kid didn't get seen. He had no hope of it. I should have known that as a consumer. It doesn't say "network adequacy" anywhere. House Bill 1099, which is now law of the land as of last week, says that you must convey that to me as a consumer on documents like these.

So I'm here today to help with that process. To share my story, and to help you make sure that these documents have the transparency, the accountability, and so that my para-educators in my school who can't choose anything but the cheapest plan, and probably are dealing with low network adequacy, at least they know that. So that when their kid needs help, they can go use social services. They can call on their church. They can do what they need to do. Because they'll at least know they've got a crappy plan. So that's what House bill, now Engrossed Senate Bill 1099, that the Governor just signed, did. So that no one else doesn't know the way that I didn't know. So I'll share with you, this is the plaque that is up in Kaiser Permanente's corporate office now, and it says, "Timely access to quality mental health care and addiction services is just as important as timely access to quality physical health care." Kaiser Permanent must never forget this, just as we will never forget our son, brother, and friend Brennen, who left us too soon at the tender age of 20. And you'll note the date on here. My kid was supposed to turn 24 tomorrow.

So please help us, as consumers, as educators, as state employees who are going to be reading this document, know what we are getting. Please hold the insurers accountable to delivering on the promise because if I only paid 43% of my premium they'd drop me in a heartbeat. If this were a car that you were selling, and the airbags only deployed 43% of the time in an accident, that car would be recalled and the industry wouldn't be allowed to sell it. This is about truth in advertising, transparency, accountability, and frankly it's the same thing I had OEBB do, which is I said, have anyone who wants to have you to peddle their product show you the network adequacy numbers up front and convey that to us so you aren't holding a deadly secret, and that information is clearly communicated to us as the consumer, so that when we need to access the care when you need it, it actually is the truth. Thank you for listening to me.

Lou McDermott: Thank you very much.

Pete Cutler: Thank you for coming and testifying. My heart goes out to you for your loss. I have not had nearly the extreme situation you did, but I can say I have had personal experience within my family, almost identical dynamics. Incredibly frustrating to have the illusion of access to behavioral health support services and behavior addiction support services and to instead find that the organization's idea of prompt care is four weeks, six weeks, something that's totally unrealistic. So anyway, I'm very glad to hear the bill's been signed and I hope it applies to the state plans.

Rachel Smith: It does.

Dave Iseminger: It does.

Pete Cutler: And I look forward to seeing what the Health Care Authority -- I think we should have very robust focus on providing information about network adequacy, and especially in behavioral health. I think it is a particularly problem area. But that has long been a problem of whether, like you say, you always know what your benefit is for going to the doctor for a regular visit, or a specialist, or whatever. But this has been an area in which trying to get information has been very difficult for patients and for potential persons when they're looking to sign up for a plan. I think it's great that you helped move this along and I'm looking forward to hearing what the Health Care Authority will be doing to implement it with the SEBB Program. So thank you.

Lou McDermott: Other comments from the Board? Ms. Smith, could you stay after for a few minutes?

Rachel Smith: Yes.

Troy Andrews, President of Laborers 252 in Tacoma. I was here before and we spoke about this change in medical, and how it affects my members' medical when they retire. Again, I represent the members of Laborers Union 252. They are employed at Tacoma School District. My members are currently covered by a Collective Bargaining Agreement that clearly shows the responsibility of the school district to pay into my union trust funds for health care. This puts us in an expensive situation to the taxpayers of Washington State because of the definition of what an employee is. The definition of an employee is a person who works 630 hours per year and is employed by the Tacoma School District. This has been verified by Mr. Rob Parkman of the Washington Health Care Authority, to apply to my members. The extra cost to the taxpayers, due to the fact that the district is contractually obligated through the Collective Bargaining Agreement to make union trust payments and provide medical coverage to these employees based on the new SEBB requirements, which would in effect cost taxpayer for coverage and it cannot be exempted from without action taken by the Board. I've got some handouts I'd like to hand out to go with this, if I may. Thank you very much. These are RCWs that are essentially in the SEBB law, I guess I'll call it. Once everybody gets them, I'll move on.

Under RCW 41.05.740, School Employees Benefits Board, it states the following in section one: “The School Employees Benefits Board is created within the authority. The function of the School Employees Benefits Board is to design and approve insurance benefit plans for school employees and to establish eligibility criteria for participation in insurance benefits plans.” This essentially outlines the responsibility and scope of the Board. Section two, number two -- section seven, if you look on this handout, which is on the second page at the bottom, I highlighted it -- it states the following: “School employees shall choose participation in one of the health care benefit plans developed by the School Employees Benefits Board. Individual school employees eligible for benefits under subsection (6)(d),” which again is highlighted on the first page, it says School Employees Benefits Board and on the second page (d) is highlighted and states the following: this section may be permitted to waive coverage under terms and conditions established by the School Employees Benefit Board.”

Article Six states, “the School Employees Benefits Board shall,” subject indeed “determine the terms and conditions of school employee and dependent eligibility criteria, enrollment policies, and scope of coverage.”

When I came before, I asked if there is a waiver, a process to where my people covered by a Collective Bargaining Agreement, which my people feel is clearly covered regardless of whether you implement this one or not, is still going to have to be paid in due to a trust agreement that I have through the school district through a Collective Bargaining Agreement. We're going to be paying for two sets of insurance, one that is obligated by contract and one that's obligated by this new law that's being passed.

While my people meet the definition of 630 hours, which is an employee, and work for a state agency or a school district, it doesn't relieve the process of them having to pay into my trust agreement, because they have a trust agreement with our health trust.

Mr. McDermott and the Board, it appears that the Board has the authority to grant a waiver by definition in RCW 41.05.740. I feel it also appears, due to the burden it will add to taxpayers of Washington State, you have an obligation to be the steward of the taxes paying for this medical plan to make sure a waiver is created so funds are not being paid on benefits that are already provided by the Laborers Union. While these authorities are written in law, the obligation to make a person's life better is written in morality. If no action is taken to fulfill the responsibility, hardworking men and women of the Laborers Union in the state of Washington will be adversely affected due to the loss of access to their union-provided retiree medical.

I just want to say, will you please examine this? I feel from what I'm being told, and my legal teams have looked at things, you have the authority to set waivers in place based on this language. My members are going to go from, again, being able to get retiree medical as low as $150 a month, like I will have when I retire. If they're pulled out of that and don't have effective coverage the day before they retire and they're in the new medical plan, the cost could be $600 - $1,200, accordingly. Myself, I have 57,000 hours as a laborer. I joined the Laborers in 1982. That 57,000 hours has been paid into a retirement fund so when I retire we have access to that retirement to buy down this. Now I'm a worker, maybe I'm going to walk away three, four, five thousand dollars and all of a sudden my medical goes to twelve, fourteen hundred because of a change in a law and a waiver that's not allowed to keep me on my medical plan. That worker can't afford to retire any more. That's just reality. I mean, it's expensive to live. And that's what's going to eliminate this for them.

I have 15 people at the school district. From what I understand, this affects people at the Seattle School District as well because they're having trouble with retention due to the temporary employees up there. As soon as they no longer become temporary and no longer needed, they go back to the union hall and their medical drops off and they have no way of carrying it back with them, to carry it on to their next employer, so they will have a break in coverage. So, again, you guys are very professional, very diligent, this is your 16 meeting from what I understand. And from looking at the packets, this is not a small undertaking. I get it. But these are human lives whose lives are going to be affected by this so I really, really request that you look at this, if you have the authority -- which I feel this law says you do. Please work with me to make the adjustments we need to, to look out for these working men and women. And thank you for your time. Happy to answer any questions if you have any.

Lou McDermott: We will look into it.

Troy Andrews: Thank you, I appreciate it.

Next Meeting

May 16, 2019
9:00 a.m. – 4:00 p.m.

Preview of May 16, 2019 SEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the May 16, 2019 Board Meeting.

Lou McDermott: Dave, thank you and thank you to your staff. I appreciate the public comments. Mrs. Smith, I appreciate your story. When we sit here and do this function, we're talking a lot about numbers. And we talk about the cost and we talk about eligibility, who's in and who's out. And away from this Board, as we administer the PEBB Program, we have the other side, which is the members, the people. And this Board has been insulated from that because you don't have any members yet. You will. You'll have members in January and stories like this and others will come before the Board. They are very emotional, but they do guide our actions and they are important to hear. And I hear them all the time regarding a variety of topics. And so I appreciate you coming today and sharing your story. I hope everybody has a good evening.

Meeting adjourned at 4:15 p.m.

TAB 4

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

July 25, 2019 Board Meeting Follow Up

Dave Iseminger, Director
Employees and Retirees Benefits Division
August 1, 2019

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

School Employees Benefits Board (SEBB) Program benefits: A high-level overview

This is a summary, and is not inclusive of all covered services. Figures, plans, and carriers shown are subject to legislative funding and final decisions by the SEB Board.

Medical benefits

	Kaiser NW			Kaiser WA				Kaiser WA Options		
Previous Name	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**	**Plan 1**	**Plan 2**	**Plan 3**
Annual Costs/Benefits	**KPNW 1**	**KPNW 2**	**KPNW 3**	**KPWA Core 1**	**KPWA Core 2**	**KPWA Core 3**	**KPWA Sound Choice**	**KPWAO Access PPO 1**	**KPWAO Access PPO 2**	**KPWAO Access PPO 3**
Deductible (single / family)	$1,250 / $2,500	$750 / $1,500	$125 / $250	$1,250 / $3,750	$750 / $2,250	$250 / $750	$125 / $375	$1,250 / $3,750	$750 / $2,250	$250 / $750
Out-of-pocket max	$4,000 / $8,000	$3,500 / $7,000	$2,000 / $4,000	$4,000 / $8,000	$3,000 / $6,000	$2,000 / $4,000	$2,000 / $4,000	$4,500 / $9,000	$3,500 / $7,000	$2,500 / $5,000
Coinsurance	20%	20%	20%	20%	20%	20%	15%	20%	20%	20%
Rx deductible	None	None	None	None	None	None	None	None	None	None
Rx out-of-pocket limit	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max

	Premera			Uniform Medical Plan (UMP)			
Previous Name	**Plan 2**		**Plan 3**				
Annual Costs/Benefits	**High PPO**	**Peak Care EPO**	**Standard PPO**	**UMP Achieve 1**	**UMP Achieve 2**	**UMP High Deductible**	**UMP Plus**
Deductible (single / family)	$750 / $1,875		$1,250 / $3,125	$750 / $2,250	$250 / $750	$1,400 / $2,800 (Combined Med/Rx)	$125 / $375
Out-of-pocket max	$3,500 / $7,000		$5,000 / $10,000	$3,500 / $7,000	$2,000 / $4,000	$4,200 / $8,400**	$2,000 / $4,000
Coinsurance	25%		20%	20%	15%	15%	15%
Rx deductible	$125/$312*		$250 / $750*	Tier 2 and specialty; $250 / $750	Tier 2 and specialty; $100 / $300	Applied to medical deductible	None
Rx out-of-pocket limit	Applies to max		Applies to max	$2,000 per member with a family maximum of $4,000	$2,000 per member with a family maximum of $4,000	Applies to max	$2,000 per member with a family maximum of $4,000

*Waived for preferred generic prescription drugs.

**Out of pocket expenses for a single member under a family account are not to exceed $6,850.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

School Employees Benefits Board (SEBB) Program benefits: A high-level overview

This is a summary, and is not inclusive of all covered services. Figures, plans, and carriers shown are subject to legislative funding and final decisions by the SEB Board.

Medical benefits (continued)

	Kaiser NW			Kaiser WA				Kaiser WA Options		
Previous Name	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 2**	**Plan 2**	**Plan 3**	**Plan 4**	**Plan 1**	**Plan 2**	**Plan 3**
Annual Costs/Benefits	**KPNW 1**	**KPNW 2**	**KPNW 3**	**KPWA Core 1**	**KPWA Core 2**	**KPWA Core 3**	**KPWA Sound Choice**	**KPWAO Access PPO 1**	**KPWAO Access PPO 2**	**KPWAO Access PPO 3**
Ambulance	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Emergency room	20%	20%	20%	$150 + 20%	$150 + 20%	$150 + 20%	$150 + 15%	$150 + 20%	$150 + 20%	$150 + 20%
Inpatient services	20%	20%	20%	20%	20%	20%	15%	20%	20%	20%
Outpatient services	20%	20%	20%	20%	20%	20%	15%	20%	20%	20%
Primary care	$30	$25	$20	$30	$25	$20	$0	$30	$25	$20
Specialist	$40	$35	$30	$40	$35	$30	$30	$40	$35	$30
Urgent care	$50	$45	$40	$30	$25	$20	$0	$30	$25	$20

	Premera			Uniform Medical Plan (UMP)			
Previous Name	**Plan 2**		**Plan 3**	**UMP Achieve 1**	**UMP Achieve 2**	**UMP High Deductible**	**UMP Plus**
Annual Costs/Benefits	**High PPO**	**Peak Care EPO**	**Standard PPO**				
Ambulance	25%		20%	20%	20%	20%	20%
Emergency room	$150 + 25%		$150 + 20%	$75 + 20%	$75 + 15%	15%	$75 + 15%
Inpatient services	25%		20%	$200/day, up to $600 + 20%	$200/day, up to $600 + 15%	15%	$200/day, up to $600 + 15%
Outpatient services	25%		20%	20%	15%	15%	15%
Primary care	$20		$20	20%	15%	15%	$0
Specialist	$40		$40	20%	15%	15%	15%
Urgent care	25%		20%	20%	15%	15%	15%

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

School Employees Benefits Board (SEBB) Program benefits: A high-level overview

This is a summary, and is not inclusive of all covered services. Figures shown are subject to legislative funding and final decisions by the SEB Board.

Dental benefits

	DeltaCare	Uniform Dental Plan (UDP)	Willamette
What you pay:	Managed care	PPO	Managed care
Annual maximum	No max	$1,750	No max
Deductible	$0	$50 (individual) / $150 (family)	$0
General office visit (after deductible)	$0	$0	$0
Routine/emergency exams	$0	$0	$0
Fillings	$10 – $50	20%	$10 – $50
Crowns	$100 – $175	50%	$100 – $175
Root canal	$100 – $150	20%	$100 – $150
Orthodontia	$1,500 per case	50% until plan has paid $1,750; then any amount over $1,750	$1,500 per case

Vision Benefits

What you pay:	Davis Vision	EyeMed	MetLife
Routine exam (renews January 1)	$0	$0	$0
Frames (renews January 1 in even years)	$0 up to $150, then 80%	$0 up to $150, then 80%	$0 up to $150, then 80%
Lenses	$0	$0	$10
Progressive lenses	$50 – $140	$55 – $175	$0 – $175
Conventional* contact lenses	$0 up to $150, then 85% (or 4 boxes from collection lenses)	$0 up to $150, then 85%	$0 up to $150, then 100%
Disposable* contact lenses		$0 up to $150, then 100%	

*Disposable contact lenses are single-use lenses and are removed and discarded after a determined period of time, typically at the end of each day or week. Conventional lenses, with proper care and cleaning, can be used for longer periods of time, from one month to up to one year.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

School Employees Benefits Board (SEBB) Program benefits: A high-level overview

This is a summary, and is not inclusive of all covered services. Figures shown are subject to legislative funding and final decisions by the SEB Board.

Life and accidental death & dismemberment (AD&D) insurance

Employer paid	
Insurance type	**Basic**
Employee basic life	$35,000
Employee basic (AD&D)	$5,000
Employee paid	
Insurance type	**Supplemental**
Employee supplemental life	• Guaranteed issue (GI)* up to $500,000 in $10,000 increments, up to a maximum of $1,000,000 • Evidence of insurability (EOI)* required for amounts over $500,000
Supplemental spousal term life (tied to employee coverage amount)	• Up to 50% of employee's supplemental • GI up to $100,000 in $5,000 increments • EOI required over $100,000
Supplemental dependent child term life	• GI up to $20,000 in $5,000 increments • For dependents age 2 weeks to 26 years
Supplemental employee, spousal, and child AD&D	• Employee: GI up to $250,000 in $10,000 increments • Spouse: GI up to $250,000 in $10,000 increments • Child: GI up to $25,000 in $5,000 increments

*Guaranteed issue benefits are available to any eligible employee, with no evidence of insurability. Evidence of insurability (or proof of good health), for these plans, is provided through an online questionnaire. Eligibility is approved or denied upon completion of the questionnaire.

Supplemental employee and spouse life insurance monthly premiums (per $1,000 of coverage)		
Age	**Non-smoker**	**Smoker**
<25	$0.038	$0.050
25-29	$0.042	$0.060
30-34	$0.046	$0.080
35-39	$0.058	$0.090
40-44	$0.088	$0.100
45-49	$0.128	$0.150
50-54	$0.188	$0.230
55-59	$0.346	$0.400
60-64	$0.534	$0.630
65-69	$0.962	$1.220
70+	$1.438	$1.988

Supplemental insurance: Premium examples

35-year-old smoker

- $200,000 supplemental life for employee: $18/month
- $100,000 supplemental life for spouse: $9/month

50-year-old non-smoker

- $150,000 supplemental life for employee: $28.50/month
- $75,000 supplemental life for spouse: $14.25/month

Any eligible employee (guaranteed issue)

- $20,000 supplemental life for child: $2.48/month
- $250,000 supplemental AD&D for employee or spouse: $4.75/month
- $25,000 supplemental AD&D for child: $0.40/month

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

School Employees Benefits Board (SEBB) Program benefits: A high-level overview

This is a summary, and is not inclusive of all covered services. Figures shown are subject to legislative funding and final decisions by the SEB Board.

Long term disability (LTD) insurance

Employer-paid basic LTD plan design	
Insurance type	**Basic**
Benefit waiting period*	90 days or the end of family / medical paid leave, whichever is longer
Pension	Choice (The member can choose to be paid from their pension; if they do, it is deducted from their disability benefit.)
Sick leave	No choice (The benefit will not begin paying until the end of the member's existing sick leave, whether or not the employee uses and receives payment for the sick leave.)
Maximum monthly benefit	$400

Employee-paid supplemental LTD plan design	
Insurance type	**Supplemental**
Benefit waiting period*	90 days or the end of family / medical paid leave, whichever is longer
Enrollment type	Opt in (The member must actively enroll in this benefit.)
Pension	Choice (The member can choose to be paid from their pension; if they do, it is deducted from their disability benefit.)
Sick leave	No choice (The benefit will not begin paying until the end of the member's sick leave, whether or not the employee uses and receives payment for the sick leave.)
Maximum monthly benefit	$10,000

*Benefit waiting period: The length of time between the beginning of a member's disability claim and the first payment the member would receive.

Supplemental LTD cost examples		
Annual income	**Estimated monthly premiums**	**Estimated monthly benefit (includes basic benefit)**
$30,000	$9 – $15	$1,500
$50,000	$15 – $25	$2,500
$80,000	$25 – $40	$4,000
$100,000	$31 – $51	$5,000

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

School Employees Benefits Board (SEBB) Program benefits: A high-level overview

This is a summary, and is not inclusive of all covered services. Figures shown are subject to legislative funding and final decisions by the SEB Board.

Additional benefits

Additional benefit maximum contributions	
Medical flexible spending arrangement (FSA)	
Maximum contribution	$2,700 (anticipated amount for 2020)
Dependent care assistance program (DCAP)	
Maximum contribution	$5,000 for a joint income tax return / $2,500 each for separate income tax returns

SEBB Program Medical Benefits Comparison Chart

Note: Subject to legislative funding and final decisions by the SEB Board

	Kaiser NW			Kaiser WA				Kaiser WA Options			Premera			Uniform Medical Plan (UMP)			
Annual Costs/ Benefits ^	***KPNW 1***	***KPNW 2***	***KPNW 3***	***KPWA Core 1***	***KPWA Core 2***	***KPWA Core 3***	***KPWA Sound Choice***	***Access PPO 1***	***Access PPO 2***	***Access PPO 3***	***High PPO***	***Peak Care EPO***	***Standard PPO***	**UMP Achieve 1 (82% AV)**	**UMP Achieve 2 (88% AV)**	**UMP High Deductible**	**UMP Plus**
Deductible (single/ family)	$1,250/ $2,500	$750/ $1,500	$125/ $250	$1,250/ $3,750	$750/ $2,250	$250/ $750	$125/ $375	$1,250/ $3,750	$750/ $2,250	$250/ $750	$750/$1,875		$1,250/ $3,125	$750/ $2,250	$250/ $750	$1,400/ $2,800*	$125/ $375
Max out-of-pocket limit	$4,000/ $8,000	$3,500/ $7,000	$2,000/$ 4,000	$4,000/ $8,000	$3,000/ $6,000	$2,000/ $4,000	$2,000/ $4,000	$4,500/ $9,000	$3,500/ $7,000	$2,500/ $5,000	$3,500/$7,000		$5,000/ $10,000	$3,500/ $7,000	$2,000/ $4,000	$4,200/ $8,400**	$2,000/ $4,000
Coinsurance	20%	20%	20%	20%	20%	20%	15%	20%	20%	20%	25%		20%	20%	15%	15%	15%
Ambulance (air/ground, per trip)	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	25%		20%	20%	20%	20%	20%
Diagnostic tests, lab, and x-rays	$30	$25	$20	20% over $500	20% over $500	20%	15%	20% over $500	20% over $500	20%	25%		20%	20%	15%	15%	15%
Emergency room	20%	20%	20%	$150 + 20%	$150 + 20%	$150 + 20%	$150 + 15%	$150 + 20%	$150 + 20%	$150 + 20%	$150 + 25%		$150 + 20%	$75 + 20%	$75 + 15%	15%	$75 + 15%
Inpatient services	20%	20%	20%	20%	20%	20%	15%	20%	20%	20%	25%		20%	$200/day up to $600 + 20%	$200/day up to $600 + 15%	15%	$200/day up to $600 + 15%
Outpatient services	20%	20%	20%	20%	20%	20%	15%	20%	20%	20%	25%		20%	20%	15%	15%	15%
Preventive care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%		Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Spinal manipulations	$40	$35	$30	$30	$25	$20	$0	$30	$25	$20	25%		20%	20%	15%	15%	15%
Primary care	$30	$25	$20	$30	$25	$20	$0	$30	$25	$20	$20		$20	20%	15%	15%	$0
Specialist	$40	$35	$30	$40	$35	$30	$30	$40	$35	$30	$40		$40	20%	15%	15%	15%
Urgent care	$50	$45	$40	$30	$25	$20	$0	$30	$25	$20	25%		20%	20%	15%	15%	15%
Mental health (outpatient)	$30	$25	$20	$30	$25	$20	$0	$30	$25	$20	$20		$20	20%	15%	15%	15%
Physical, occupational, and speech therapy	$40	$35	$30	$40	$35	$30	$30	$40	$35	$30	$40		$40	20%	15%	15%	15%

^ In-network

* UMP High Deductible has a combined medical and prescription drug deductible.

** Out of pocket expenses for a single member under a family account are not to exceed $6,850.

SEBB Program Medical Benefits Comparison Chart

Note: Subject to legislative funding and final decisions by the SEB Board

	Kaiser NW			Kaiser WA				Kaiser WA Options			Premera			Uniform Medical Plan (UMP)			
Annual Costs/ Benefits (in network)	***KPNW 1***	***KPNW 2***	***KPNW 3***	***KPWA Core 1***	***KPWA Core 2***	***KPWA Core 3***	***KPWA Sound Choice***	***Access PPO 1***	***Access PPO 2***	***Access PPO 3***	***High PPO***	***Peak Care PPO***	***Standard PPO***	**UMP Achieve 1 (82% AV)**	**UMP Achieve 2 (88% AV)**	**UMP High Deductible**	**UMP Plus**
Rx deductible (single/family)	None	None	None	None	None	None	None	None	None	None	$125/$312*		$250/ $750*	Tier 2 and specialty; $250/ $750	Tier 2 and specialty; $100/ $300	Combined with medical deductible	None
Rx out-of-pocket limit	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max	Applies to max		Applies to max	$2,000 per member; $4,000 family maximum	$2,000 per member; $4,000 family maximum	Applies to max	$2,000 per member; $4,000 family maximum
Retail: Value tier														5% up to $10	5% up to $10	15%**	5% up to $10
Retail: Tier 1 (Generics)	$20	$15	$10	$5	$10	$10	$10	$10	$10	$10	$7		$7	10% up to $25	10% up to $25	15%**	10% up to $25
Retail: Tier 2 (Preferred Brand)	$40	$30	$20	$25	$25	$25	$25	$50	$50	$50	$30		30%	30% up to $75	30% up to $75	15%**	30% up to $75
Retail: Tier 3 (Non-preferred)	50% up to $100	50% up to $100	50% up to $100	$50	$50	$50	$50	50% up to $125	50% up to $125	50% up to $125	30%		50%				
(Most Specialty)	50% up to $150	50% up to $150	50% up to $150	50% up to 150	50% up to $150	50% up to $150	50% up to $150	50% up to $150	50% up to $150	50% up to $150	$50		40%	30% up To $75	30% up To $75	15%**	30% up To $75

Note: All plans cover legally-required preventive prescription drugs at 100 percent, with no deductible.

*Waived for preferred generic prescription drugs.

**After deductible met.

Note: The retail pharmacy benefit member costs are based on a 30-day supply.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Questions?

Dave Iseminger, Director
Employees and Retirees Benefits Division
Dave.iseminger@hca.wa.gov

TAB 5

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

2020 Premium Resolution (Continued)

Megan Atkinson, Chief Financial Officer
Financial Services Division
August 1, 2019

Employee Premium Contributions

Medical

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Employee / Employer Premium Contributions – 7/25

	Proposed 2020 Employee Contribution (Single Subscriber)	EMC (Employer Medical Contribution)	Proposed 2020 Total Composite Rate
* Premera Blue Cross High PPO	$70	$555	$625
* Premera Blue Cross Peak Care EPO	$31	$555	$586
* Premera Blue Cross Standard PPO	$22	$555	$577

Employee Contribution by Tier

	Subscriber	Subscriber & Spouse/SRDP*	Subscriber & Child(ren)	Subscriber, Spouse/SRDP*, and Child(ren)
* Premera Blue Cross High PPO	$70	$140	$123	$210
* Premera Blue Cross Peak Care EPO	$31	$62	$54	$93
* Premera Blue Cross Standard PPO	$22	$44	$39	$66
Subscribers may be subject to the following surcharges				
Tobacco Surcharge	$25	$25	$25	$25
Spousal Surcharge	N/A	$50	N/A	$50

- EMC is on a Per Adult Unit Per Month (PAUPM) basis
- Rounded to the nearest dollar

* Updated values since the July 18, 2019 Board Meeting

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Employee / Employer Premium Contributions – 7/18

	Proposed 2020 Employee Contribution (Single Subscriber)	EMC (Employer Medical Contribution)	Proposed 2020 Total Composite Rate
Premera Blue Cross High PPO	$98	$555	$653
Premera Blue Cross Peak Care EPO	$80	$555	$635
Premera Blue Cross Standard PPO	$48	$555	$603

Employee Contribution by Tier

	Subscriber	Subscriber & Spouse/SRDP*	Subscriber & Child(ren)	Subscriber, Spouse/SRDP*, and Child(ren)
Premera Blue Cross High PPO	$98	$196	$172	$294
Premera Blue Cross Peak Care EPO	$80	$160	$140	$240
Premera Blue Cross Standard PPO	$48	$96	$84	$144
Subscribers may be subject to the following surcharges				
Tobacco Surcharge	$25	$25	$25	$25
Spousal Surcharge	N/A	$50	N/A	$50

- EMC is on a Per Adult Unit Per Month (PAUPM) basis
- Rounded to the nearest dollar

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Rate Comparison

	Total Composite Rate (NTE)	Total Composite Rate (as presented 7/25)	Percent Change
Kaiser Permanente NW 1		$583	
Kaiser Permanente NW 2		$596	
Kaiser Permanente NW 3		$661	
Kaiser Permanente WA Core 1		$568	
Kaiser Permanente WA Core 2		$574	
Kaiser Permanente WA Core 3		$644	
Kaiser Permanente WA SoundChoice		$604	
Kaiser Permanente WA Options Access PPO 1		$594	
Kaiser Permanente WA Options Access PPO 2		$624	
Kaiser Permanente WA Options Access PPO 3		$671	
* Premera Blue Cross High PPO	$680	$625	-8%
* Premera Blue Cross Peak Care EPO	$661	$586	-11%
* Premera Blue Cross Standard PPO	$648	$577	-11%
Uniform Medical Plan (UMP) Achieve 1	$612	$588	-4%
UMP Achieve 2	$680	$653	-4%
UMP High Deductible (with a health savings account)	$603	$580	-4%
UMP Plus	$649	$623	-4%

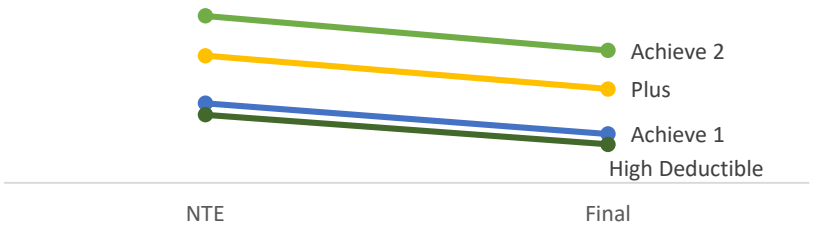
- Total Composite Rate for the SEBB UMP High Deductible includes an employer HSA contribution of $375 per year for Tier 1 and $750 per year for all other tiers
- Rounded to the nearest dollar

* Revised Premera Total Composite Rate as presented on 7/25/19

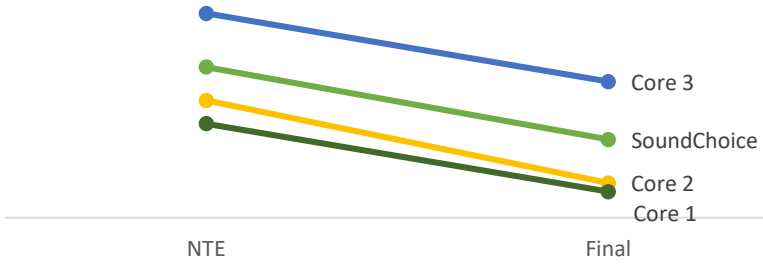
Note: With carrier asserted proprietary and confidential information redacted.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

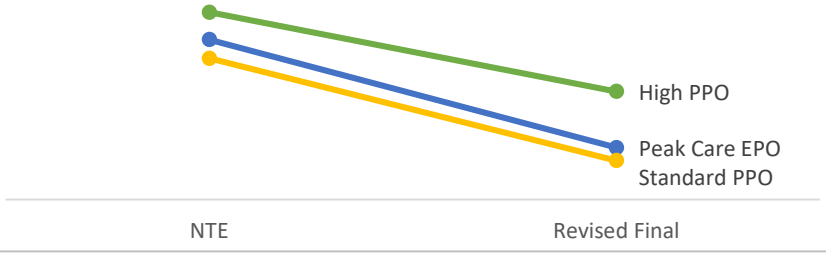
UMP



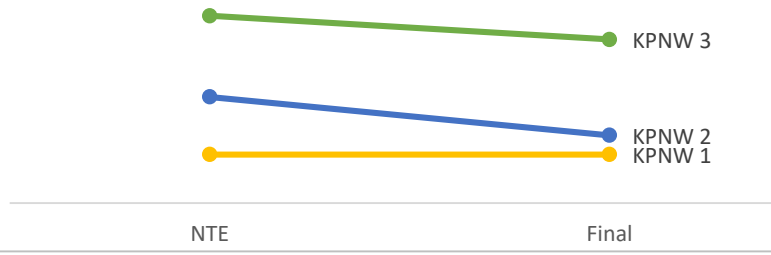
KPWA



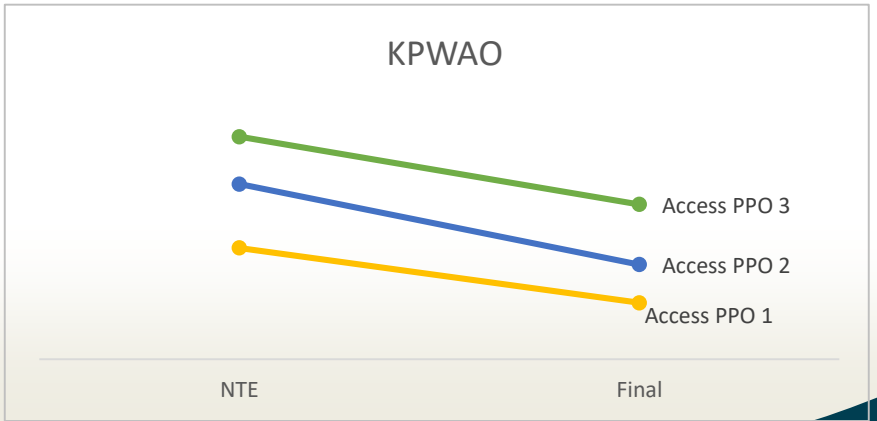
Premera



KPNW



KPWAO



Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Rate Comparison

Carrier	Deductible (Single)	Single Out-of-Pocket Maximum	AV	Plan Name	Tier 1 Employee Contribution	Total Composite Rate*
UMP	**$ 1,400**	**$ 4,200**	84.0%	UMP High Deductible	$25	$ 580
KPWA	**$ 1,250**	**$ 4,000**	83.0%	KPWA Core 1	$13	$ 568
Premera	**$ 1,250**	**$ 5,000**	79.6%	Premera Standard PPO	$22	$ 577
KPNW	**$ 1,250**	**$ 4,000**	82.5%	KPNW 1	$28	$ 583
KPWAO	**$ 1,250**	**$ 4,500**	81.9%	KPWAO Access PPO 1	$39	$ 594
KPWA	**$ 750**	**$ 3,000**	86.0%	KPWA Core 2	$19	$ 574
Premera	**$ 750**	**$ 3,500**	83.9%	Premera Peak Care EPO	$31	$ 586
UMP	**$ 750**	**$ 3,500**	84.0%	UMP Achieve 1	$33	$ 588
KPNW	**$ 750**	**$ 3,500**	84.9%	KPNW 2	$41	$ 596
KPWAO	**$ 750**	**$ 3,500**	85.0%	KPWAO Access PPO 2	$69	$ 624
Premera	**$ 750**	**$ 3,500**	83.9%	Premera High PPO	$70	$ 625
KPWA	**$ 250**	**$ 2,000**	89.9%	KPWA Core 3	$89	$ 644
UMP	**$ 250**	**$ 2,000**	88.0%	UMP Achieve 2	$98	$ 653
KPWAO	**$ 250**	**$ 2,500**	88.8%	KPWAO Access PPO 3	$116	$ 671
KPWA	**$ 125**	**$ 2,000**	91.5%	KPWA SoundChoice	$49	$ 604
UMP	**$ 125**	**$ 2,000**	90.0%	UMP Plus	$68	$ 623
KPNW	**$ 125**	**$ 2,000**	90.1%	KPNW 3	$106	$ 661

- Total Composite Rate for the SEBB UMP High Deductible includes an employer HSA contribution of $375 per year for Tier 1 and $750 per year for all other tiers
- Rounded to the nearest dollar

* Total Composite Rates as presented on 7/25/19

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Rate Comparison

Carrier	Deductible (Family)	Family Out-of-Pocket Maximum	AV	Plan Name	Tier 4 Employee Contribution	Total Composite Rate*
KPWA	$ 3,750	$ 8,000	83.0%	KPWA Core 1	$39	$ 568
KPWAO	$ 3,750	$ 9,000	81.9%	KPWAO Access PPO 1	$117	$ 594
Premera	$ 3,125	$ 10,000	79.6%	Premera Standard PPO	$66	$ 577
UMP	$ 2,800	$ 8,400	84.0%	UMP High Deductible	$75	$ 580
KPNW	$ 2,500	$ 8,000	82.5%	KPNW 1	$84	$ 583
KPWA	$ 2,250	$ 6,000	86.0%	KPWA Core 2	$57	$ 574
UMP	$ 2,250	$ 7,000	84.0%	UMP Achieve 1	$99	$ 588
KPWAO	$ 2,250	$ 7,000	85.0%	KPWAO Access PPO 2	$207	$ 624
Premera	$ 1,875	$ 7,000	83.9%	Premera Peak Care EPO	$93	$ 586
Premera	$ 1,875	$ 7,000	83.9%	Premera High PPO	$210	$ 625
KPNW	$ 1,500	$ 7,000	84.9%	KPNW 2	$123	$ 596
KPWA	$ 750	$ 4,000	89.9%	KPWA Core 3	$267	$ 644
UMP	$ 750	$ 4,000	88.0%	UMP Achieve 2	$294	$ 653
KPWAO	$ 750	$ 5,000	88.8%	KPWAO Access PPO 3	$348	$ 671
KPWA	$ 375	$ 4,000	91.5%	KPWA SoundChoice	$147	$ 604
UMP	$ 375	$ 4,000	90.0%	UMP Plus	$204	$ 623
KPNW	$ 250	$ 4,000	90.1%	KPNW 3	$318	$ 661

- Total Composite Rate for the SEBB UMP High Deductible includes an employer HSA contribution of $375 per year for Tier 1 and $750 per year for all other tiers
- Rounded to the nearest dollar

* Total Composite Rates as presented on 7/25/19

Bid Rate Proposal Template Walk-through

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.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Questions?

Megan Atkinson
Chief Financial Officer
Megan.Atkinson@hca.wa.gov

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Appendix

Premium Resolution SEBB 2019-15 Premera Medical Premiums

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

Employee Premium Contributions

as adopted on July 25, 2019

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Employee / Employer Premium Contributions

	Proposed 2020 Employee Contribution (Single Subscriber)	EMC (Employer Medical Contribution)	Proposed 2020 Total Composite Rate
Kaiser Permanente NW 1	$28	$555	$583
Kaiser Permanente NW 2	$41	$555	$596
Kaiser Permanente NW 3	$106	$555	$661
Kaiser Permanente WA Core 1	$13	$555	$568
Kaiser Permanente WA Core 2	$19	$555	$574
Kaiser Permanente WA Core 3	$89	$555	$644
Kaiser Permanente WA SoundChoice	$49	$555	$604
Kaiser Permanente WA Options Access PPO 1	$39	$555	$594
Kaiser Permanente WA Options Access PPO 2	$69	$555	$624
Kaiser Permanente WA Options Access PPO 3	$116	$555	$671
Uniform Medical Plan (UMP) Achieve 1	$33	$555	$588
UMP Achieve 2	$98	$555	$653
UMP High Deductible (with a health savings account)	$25	$555	$580
UMP Plus	$68	$555	$623

- EMC is on a Per Adult Unit Per Month (PAUPM) basis
- Total Composite Rate for the SEBB UMP High Deductible includes an employer HSA contribution of $375 per year for Tier 1 and $750 per year for all other tiers
- Rounded to the nearest dollar

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Employee Contribution by Tier

	Subscriber	Subscriber & Spouse/SRDP*	Subscriber & Child(ren)	Subscriber, Spouse/SRDP*, and Child(ren)
Kaiser Permanente NW 1	$28	$56	$49	$84
Kaiser Permanente NW 2	$41	$82	$72	$123
Kaiser Permanente NW 3	$106	$212	$186	$318
Kaiser Permanente WA Core 1	$13	$26	$23	$39
Kaiser Permanente WA Core 2	$19	$38	$33	$57
Kaiser Permanente WA Core 3	$89	$178	$156	$267
Kaiser Permanente WA SoundChoice	$49	$98	$86	$147
Kaiser Permanente WA Options Access PPO 1	$39	$78	$68	$117
Kaiser Permanente WA Options Access PPO 2	$69	$138	$121	$207
Kaiser Permanente WA Options Access PPO 3	$116	$232	$203	$348
Uniform Medical Plan (UMP) Achieve 1	$33	$66	$58	$99
UMP Achieve 2	$98	$196	$172	$294
UMP High Deductible (with a health savings account)	$25	$50	$44	$75
UMP Plus	$68	$136	$119	$204
Subscribers may be subject to the following surcharges				
Tobacco Surcharge	$25	$25	$25	$25
Spousal Surcharge	N/A	$50	N/A	$50

- State-Registered Domestic Partner (SRDP)
- Total Composite Rate for the SEBB UMP High Deductible includes an employer HSA contribution of $375 per year for Tier 1 and $750 per year for all other tiers
- Rounded to the nearest dollar

July 23, 2019 - July 29, 2019

Letters Between
KPWA, KPWAO, KPNW & HCA

KAISER PERMANENTE®

July 22, 2019

Transmitted via US Mail and electronic mail
Sue Birch, Director
Louis McDermott, Deputy Director
Lesley Houghton, Primary RFP Coordinator
Beth Heston, Contract Manager
Washington State Health Care Authority
Email: contracts@hca.wa.gov
Mailing Address: PO Box 42702, Olympia, WA 98501

Re: Kaiser Plan Year Final SEBB 2020 Rates; Dispute Notice and Protest regarding HCA Procedure

Dear Ms. Birch, Mr. McDermott, Ms. Houghton and Ms. Heston:

Consistent with Section 4.5 of the Request for Proposals No. 2716 ("RFP 2716"), and sections 7.15 of resulting HCA contracts K3022 and K3023, we are writing to dispute and register a formal objection and protest on behalf of Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (collectively "KP Washington") to the possible acceptance of late employee premium rate changes from Premera Blue Cross ("Premera"), as inconsistent with RFP 2716 and other procedural guidance published by the Health Care Authority ("HCA"), the requirement for rate development transparency as memorialized in, among other places, paragraph 3.5.2 of the Request for Completion ("RFC"), and the final rates set by HCA for approval by the HCA after consultation with the successful bidders as memorialized in HCA correspondence dated July 11, 2019 from Grace Fletcher to Natalie Bell.

HCA's late solicitation to KP Washington on July 19, inviting KP Washington to submit new final employee medical premium rates with only **five business hours to respond**, does not resolve the procedural violations or harm caused by entertaining rate submissions from Premera that violate the processes in place and postdate the deadline of June 2019 to finalize the rates. This process deviation, to which Kaiser has not been fully informed or privy, raises the specter of bias in the procurement process and demonstrates material non-compliance with the procedures described in RFP 2716, the contracts and other HCA communications.

Typically, a bidder has sufficient time to gather relevant facts in support of a protest. Here, however, the unprecedented, five-hour deadline for KP Washington's response has limited the bidders' ability to research the details of this process aberration. For example, we do not know what actions the SEB Board may have taken to allow Premera to proceed to submit premium rates that were revised after final rates were submitted and evaluated for actuarial soundness, and well after the deadline for such submission as identified by the RFP, RFC and the resulting contracts.

The following describes parts of the relevant chronology:

- Consistent with RFP 2716, the HCA engaged in a closed bid process, such that no private bidders would have access to the bids of competing, private bidders;
- June 17, 2019: Private bidders are notified by May 21, 2019 email from HCA's Grace Fletcher that they must submit final bids by June 17th, according each bidder eighteen (18) business days to develop and submit appropriate and actuarially sound rates. An extension is granted for KP Washington to submit final bid rates for two days by June 19, 2019, but still consistent with the timeline June 2019 deadline identified in paragraph 2.20(3) of RFP 2716 and Exhibit 3 of Contracts K3022 and K3023;
- July 3,2019: In response to HCA's specific timing request in order to provide sufficient time for the HCA to present executed contracts to the SEB Board on July 18, 2019, KP Washington transmitted fully executed SEBB 2020 contracts to HCA, inclusive of final NTE rates;
- July 11, 2019: HCA confirms in writing that rates submitted are considered final and will be presented to SEB Board on July 18, 2019;
- July 15, 2019: HCA publishes SEBB Briefing Book with final bid rates on website.
- July 18, 2019: Public SEB Board Meeting where HCA presents all final rates to the SEB Board;
- July 18, 2019: Non-public SEB Board meeting following the public meeting takes place where Premera's revised rate proposal is presented;
- Friday, July 19, 2019: HCA emails KP Washington at 3:19 pm, communicating "late changes to the Premera rates," and extending "one final chance to review and/or revise" KP Washington's final rates for the SEBB portfolio. KP Washington is given approximately five business hours to review, revise and submit new rates by 11:00 am Monday July 22, 2019.

The procedures established by RFP 2716 and memorialized in the resulting contracts K3022 and K3023 were designed to ensure a fair and deliberate process where all private bidders were afforded the same process and opportunity to prepare and submit bids, including rates with measured assessments of actuarial soundness. The bidders all had notice and a fair opportunity to finalize these rates and meet with SEBB's actuaries and staff by the June 2019 deadline. The process's care, ensuring rates are supported by thorough actuarial support, assures market stability and program sustainability. The late filing by Premera and eleventh-hour solicitation of KP Washington to submit *new* rates (after both the June rate submission deadline *and* after SEB contracts had already been executed between applicable bidders and the HCA) seriously calls into question the integrity of the process and the soundness of the Premera filings and how seriously the SEB takes the actuarial underpinnings of the bids of all parties. The process deviation in favor of one private bidder also raises questions of inappropriate, and potentially unlawful, bias.

For relief, KP Washington respectfully requests that the SEB Board treat the rates submitted to it by HCA on July 15 as final and that the late-revised final bid rates proposed by Premera on July 18, 2019 be rejected as untimely and SEB Board consider the final bid rates of all parties submitted by the June 2019 deadline HCA imposed by RFP, RFC and contract.

KP Washington reserves the right to amend its protest and dispute notice to supplement the record as further facts come to KP Washington's attention.

KAISER PERMANENTE®

We ask that you provide this dispute notice, objection and protest to the full SEB Board and that KP Washington be provided an opportunity to engage the SEB Board in public proceedings consistent with the Public Meetings Act.

Sincerely,

KAISER FOUNDATION HEALTH PLAN OF WASHINGTON

KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS, INC.

Susan E. Mullaney, President

Joseph Smith, Vice President, Sales and Business Development

cc: David Iseminger, Director, Employees and Retirees Benefits Division, Washington State Health Care Authority

Natalie C. Bell, Senior Account Consultant, KP Washington

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

July 23, 2019

Transmitted via US Mail and electronic mail
Sue Birch, Director
Louis McDermott, Deputy Director
Lesley Houghton, Primary RFP Coordinator
Beth Heston, Contract Manager
Washington State Health Care Authority
Email: contracts@hca.wa.gov
Mailing Address: PO Box 42702, Olympia, WA 98501

Re: Kaiser Plan Year Final SEBB 2020 Rates; Dispute Notice and Protest regarding HCA Procedure

Dear Ms. Birch, Mr. McDermott, Ms. Houghton and Ms. Heston:

On behalf of Kaiser Foundation Health Plan of the Northwest ("KFHPNW"), we are writing to join in support of the letter Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (collectively "KP Washington") sent to the HCA on July 22, 2019, with the subject "Re: Kaiser Plan Year Final SEBB 2020 Rates; Dispute Notice and Protest regarding HCA Procedure."

Consistent with what is set forth in KP Washington's aforementioned letter, procedures established by RFP 2716 and memorialized in KFHPNW's resulting contract (K3024) were designed to ensure a fair and deliberate process where all private bidders were afforded the same process and opportunity to prepare and submit bids, including rates with measured assessments of actuarial soundness. As such, KFHPNW joins KP Washington in respectfully requesting that the SEB Board treat the rates submitted to it by HCA on July 15 as final and that the late-revised final bid rates proposed by Premera on July 18, 2019 be rejected as untimely. We also ask that the SEB Board consider the final bid rates of all parties submitted by the June 2019 deadline HCA imposed by RFP, RFC and contract.

We appreciate the opportunity to offer group health plan coverage for Washington school employees and their dependents. We look forward to finding a mutually acceptable resolution of this matter.

Sincerely,

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

Ruth Williams-Brinkley

Ruth Williams-Brinkley, President

Kaiser Permanente Building
500 NE Multnomah Street, Suite 100
Portland, OR 97232-2099

Keith Forester, Vice President, Marketing, Sales & Business Development

cc: David Iseminger, Director, Employees and Retirees Benefits Division, Washington State Health Care Authority

Hilary Getz, Executive Account Manager, Kaiser Foundation Health Plan of the Northwest

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

Email Delivery

July 23, 2019

Susan E. Mullaney, President
Joseph Smith, Vice President, Sales and Business Development
Kaiser Foundation Health Plan of Washington
601 Union Street, Suite 300
Seattle, WA 98101

Dear Ms. Mullaney and Mr. Smith:

SUBJECT: Response to Letter Dated July 22, 2019 and Other Important Information

Thank you for your letter dated July 22, 2019, in which Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (collectively, "KP Washington") registered an objection and protest regarding Request for Proposals No. 2716 ("RFP") from the Health Care Authority ("HCA"). After receiving the letter, HCA Deputy Director Lou McDermott had phone calls yesterday afternoon and today with Ms. Mullaney.

This letter responds to the objection and protest, memorializes the calls between Mr. McDermott and Ms. Mullaney, and provides other important information that necessitates a prompt reply from KP Washington.

Background

KP Washington was an Apparently Successful Bidder ("ASB") under the RFP, leading to contracts between HCA and KP Washington denoted as K3022 and K3023. In the July 22 letter, KP Washington appears to lodge a bid protest pursuant to Section 4.5 of the RFP. The letter also invoked the dispute resolution provision (Section 7.15) of the contracts.

Bid Protest

During today's call, Mr. McDermott advised Ms. Mullaney that HCA would bifurcate the bid protest from the contract dispute and that HCA would deny the bid protest as untimely. This letter confirms HCA's position that the bid protest is untimely and therefore is denied.

Section 4.5 of the RFP provides as follows:

> A bid protest may be made only by Bidders who submitted a response to this RFP and who have participated in a debriefing conference. Upon completing the debriefing conference, the Bidder is allowed five Business Days to file a protest with the RFP Coordinator. Protests must be received by the RFP Coordinator no later than 4:30 p.m., Pacific Time on the fifth Business Day following the debriefing.

The HCA RFP Coordinator announced the ASBs on August 27, 2018. Bidders had until August 30, 2018, to request a debrief conference. Any bidder who participated in a debrief conference would have had a protest deadline in early September 2018. KP Washington did not request a debrief conference (which in itself precludes the filing of a bid protest). In any event, KP Washington's letter of yesterday's date is more than 10 months after any potential deadline for filing a bid protest and therefore is untimely.

Contract Disputes

With respect to the contract disputes, Section 7.15 requires HCA to issue a response within five business days of the July 22 letter. HCA will issue a written response by 5:00 p.m. on Monday, July 29, 2019.

Potential Action by SEB Board – KP Washington Response Required

As you know, KP Washington's final rates for the School Employees Benefits Board program were presented to the School Employees Benefits Board ("SEB Board") on Thursday, July 18, 2019. The SEB Board plans to vote on the rates for the relevant programs on Thursday morning, July 25, 2019. At that meeting, HCA currently intends to advance KP Washington's final rates to the SEB Board for vote. However, KP Washington has the following options:

First, KP Washington can take no further action, which will mean that the rates for KP Washington that were presented to the SEB Board on July 18 will be presented to the SEB Board on July 25 for possible action and adoption by the Board.

Second, if KP Washington would like to delay the vote, and does not want the SEB Board to consider or vote on the KP Washington rates at the July 25 meeting, then KP Washington must notify HCA in the manner described below by **5:00 p.m. on Wednesday, July 24, 2019**. During the July 22 phone call with Mr. McDermott, Ms. Mullaney seemed to indicate that a rate adjustment is not something KP Washington would like to pursue; however, given the fact that you raised the issue of potentially needing more time to adjust rates in your letter, we wanted to give you this option.

If HCA receives timely notice from KP Washington to delay the vote on the KP Washington plans, then KP Washington will have until **5:00 p.m. on Monday, July 29, 2019**, to provide HCA with updated rates. If that occurs, then the updated rates will be presented at the SEB Board on Thursday, August 1, 2019. If KP responds by **5:00 p.m. on Monday, July 29, 2019** requesting that the SEB Board not vote on the KP Washington rates at the August 1st meeting then the meeting will be canceled and those plans will not be offered in SEBB for the 2020 plan year. The August 1st meeting will be the last opportunity for the SEB Board to consider and ratify KP Washington's rates.

To request a delay of the SEB Board vote on your rates, you must email your request to both of the following:

- David Iseminger, david.iseminger@hca.wa.gov
- Louis McDermott, lou.mcdermott@hca.wa.gov

As mentioned above, if Mr. Iseminger and Mr. McDermott do not receive an email from you by 5:00 p.m. on Wednesday, July 24, 2019, with any contrary instruction, then KP Washington's current rates will be presented to the SEB Board on Thursday morning, July 25, 2019.

Sincerely,

Annette Schuffenhauer
Chief Legal Officer
Division of Legal Services

cc: Sue E. Birch, Director, Health Care Authority (HCA)
Louis McDermott, Deputy Director, HCA
Dave Iseminger, ERB Director, Employees and Retirees Benefits Division, HCA
Andria Howerton, Contracts Specialist, Division of Legal Services, HCA

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

Email Delivery

July 24, 2019

Ruth Williams-Brinkley, President
Kaiser Foundation Health Plan of the Northwest
500 NE Mulnomah Street, Suite 100
Portland, OR 97232

Dear Ms. Williams-Brinkley:

SUBJECT: Response to Letter Dated July 23, 2019 - Contract #K3024

Thank you for your letter dated July 23, 2019, in which Kaiser Foundation Health Plan of the Northwest ("KFHPNW") registered an objection and protest regarding Request for Proposals No. 2716 ("RFP") from the Health Care Authority ("HCA") and requested dispute resolution in accordance with 7.15 of contract #K3024.

Background

KFHPNW was an Apparently Successful Bidder ("ASB") under the RFP, leading to a contract between HCA and KFHPNW denoted as #K3024. In the July 23 letter, KFHPNW appears to lodge a bid protest pursuant to Section 4.5 of the RFP. The letter also invoked the dispute resolution provision (Section 7.15) of the contract.

This letter only addresses the RFP protest. With respect to the contract disputes, Section 7.15 requires HCA to issue a response within five business days of the July 23 letter. HCA will issue a written response by 5:00 p.m. on Tuesday, July 30, 2019.

Bid Protest

Section 4.5 of the RFP provides as follows:

> A bid protest may be made only by Bidders who submitted a response to this RFP and who have participated in a debriefing conference. Upon completing the debriefing conference, the Bidder is allowed five Business Days to file a protest with the RFP Coordinator. Protests must be received by the RFP Coordinator no

later than 4:30 p.m., Pacific Time on the fifth Business Day following the debriefing.

The HCA RFP Coordinator announced the ASBs on August 27, 2018. Bidders had until August 30, 2018, to request a debrief conference. Any bidder who participated in a debrief conference would have had a protest deadline in early September 2018. KFHPNW did not request a debrief conference (which in itself precludes the filing of a bid protest). In any event, KFHPNW's letter of yesterday's date is more than 10 months after any potential deadline for filing a bid protest and therefore is untimely.

Sincerely,

Annette Schuffenhauer
Chief Legal Officer
Division of Legal Services

By email

cc: Sue E. Birch, Director, HCA
Louis McDermott, Deputy Director, HCA
Dave Iseminger, ERB Director, Employees and Retirees Benefits Division, HCA
Andria Howerton, Contracts Specialist, Division of Legal Services, HCA

KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington
Sally Barian Yates
Vice President & Regional Counsel
Office: 206-448-6157
Email: sarah.b.yates@kp.org

VIA EMAIL

July 24, 2019

Annette Schuffenhauer, Esq.
Chief Legal Officer
Division of Legal Services
State of Washington Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, WA 98504-5502

Email: annette.schuffenhauer@hca.wa.gov

Re: Kaiser Dispute Notice and Ensuing Procedure

Dear Ms. Schuffenhauer:

Thank you for your July 23rd letter. This letter will respond on behalf of Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (collectively, "KP Washington").

Without conceding or waiving objections to the procedural or contractual propriety of the deadlines and options that are set forth in your letter, KP Washington's position is as follows:

1) We believe that, at its July 25 meeting, the SEB Board should consider and resolve to ratify the rates for all contracting plans that (a) were finalized in early July 2018 (HCA confirmed that KP Washington's rates were final on July 11), (b) published on the SEB Board website and provided to the SEB Board on July 15, and (c) presented to the SEB Board on July 18 in open session. This would be consistent with our expectations and those of the public following the open session of the July 18 Board meeting. Per our July 22 dispute notice, the revised Premera submission (which we've since learned was provided to the HCA on July 17, days *after* KP Washington's rates were made public) is contractually and legally improper, has not been properly published, and should not be considered at the July 25 Board meeting.

2) During his July 23 phone call with Ms. Mullaney, Mr. McDermott committed to Ms. Mullaney that she would have an opportunity to address the SEB Board in the public session on July 25 before any vote is taken relative to a resolution endorsing the rates of KP Washington or Premera plans.

In reliance on that commitment, this letter confirms that Ms. Mullaney intends to speak to the Board before any vote is taken.

Please advise of any questions or concerns. Thank you.

Very truly yours,

Sally Barian Yates
Vice President & Regional Counsel
Kaiser Foundation Health Plan of Washington
On behalf of
Kaiser Foundation Health Plan of Washington and
Kaiser Foundation Health Plan of Washington Options, Inc.

cc: Susan Mullaney, President, KP Washington
Joseph Smith, Vice President, Sales & Business Development, KP Washington
David B. Robbins, Esq., Perkins Coie, LLP
Todd Hesse, Sr. Director, KP Washington
Shawna Sweeney, Esq., KP Washington
John Quirk, Esq., KP Washington

SBY:dr

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

Email Delivery

July 29, 2019

Susan E. Mullaney, President;
Joseph Smith, Vice President, Sales and Business Development
Kaiser Foundation Health Plan of Washington
601 Union Street, Suite 300
Seattle, WA 98101

Dear Ms. Mullaney and Mr. Smith:

SUBJECT: Contract Dispute Resolution – HCA Contracts #K3022 and #K3023

Thank you for your letter dated July 22, 2019, in which Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., requested dispute resolution in accordance with Section 7.15 of contract #K3022 and #K3023 (the "Contracts") and also submitted a protest of the underlying Request For Proposals No. 2716 ("RFP"). In a letter dated July 23, 2019, the Health Care Authority ("HCA") responded to the bid protest. In this letter, HCA responds to the request for dispute resolution under both Contracts.

Background

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., (collectively, "KP Washington"), were successful bidders under the RFP. HCA executed the Contracts on July 3, 2019 with KP Washington. According to Section 1.2, the purpose of the Contract(s) is as follows:

> The purpose of this Contract is to establish Contractor as a provider of SEBB Medical Plan(s), as described in this agreement, for the School Employees Benefits Board (SEBB) Program, in which the Contractor will assume financial responsibility for their Members' medical Claims and for all incurred administrative costs. The following categories of services that Contractor will provide to HCA, all as more fully described in this Contract and all exhibits and attachments hereto are:
>
> A. Benefits Services - This includes, but is not limited to: providing benefits in accordance with the Certificate of Coverage in effect during the Contract year, Clinical Management, Utilization Management, Chronic Condition Management, and Case Management.

B. Administrative Services - This includes, but is not limited to: implementation, Claims administration, customer service provided via toll-free line and fax lines, Member communications including mailing of members' materials and identification cards, online services, and processing Appeals and Complaints.

C. Health Transformation Services - This includes, but is not limited to: rewarding patient-centered, high value care; improving quality outcomes and patient experience; driving standardization based on evidence and best-practice.

HCA values its relationship with KP Washington and shares the desire for a prompt resolution of this dispute. HCA, through David Iseminger, Director of the HCA Employee and Retirees Benefits Division, and Lou McDermott, Deputy Director of HCA, have been in frequent communication with leadership of KP Washington to ensure shared understanding of the actions related to the School Employee Benefits Board ("SEB Board") finalization of premiums for this product offering. This letter will reiterate the authority that HCA does and does not possess related to finalization of the premiums associated with the Contract(s).

In the July 22 letter, KP Washington contends that HCA violated the Contract(s) by presenting information to the SEB Board regarding newly submitted rates of another successful bidder (Premera) after HCA had completed its review of proposed premiums. I conclude that KP Washington has not cited a provision of the Contract(s) to support that proposition.

Upon review of the Contract(s), it is clear that there was no "cut-off" date to submit the final premiums for consideration to the SEB Board, nor was there a contractual obligation of HCA to KP Washington to reject (or refuse to consider) Premera's adjusted premiums.

Exhibit 3 of the Contract(s) (entitled "Rate Development Process"), at pages 85 and 86, outlines the timeframe in which the SEB Board would consider and vote on the final premiums for plan year 2020. The exhibit notes on page 85 that the SEB Board process would take place from June to August 2019. And that is what has been happening.

Decision

Based on a review of the Contract(s), including Exhibit 3, HCA respectfully disagrees that it violated the Contract(s) by providing the SEB Board with information regarding Premera's updated premiums. The SEB Board was entitled to receive the information to help fulfill its statutory duties related to developing plans and encouraging cost saving. The SEB Board must "design and approve insurance benefit plans for school employees[.]" RCW 41.05.740(1). Those plans must include "[m]ethods of maximizing cost containment while ensuring access to quality health care" and the Board must "[a]uthorize premium contributions for a school employee and the employee's dependents in a manner that encourages the use of cost-efficient health care systems." RCW 41.05.740(6)(b)(i); RCW 41.05.740(6)(c). The updated Premera information advances these statutory obligations.

Because the SEB Board has the authority to review and approve the adjusted Premera premiums at issue in this dispute, HCA had an obligation to provide them to the SEB Board for consideration. Therefore, HCA did not violate Contracts.

Dispute Resolution Process

If you disagree with this response and wish to engage in future dispute resolution, you will have five calendar days from the date of this letter to notify me of that request by following the instructions below. Section 7.15 of the Contract(s) states in pertinent part:

> If the initiating party is not satisfied with the response of the responding party, then the initiating party may request that the HCA Director and a representative of Contractor as selected in Contractor's sole discretion ("Contractor Representative") mutually review the dispute. Any such request from the initiating party must be submitted in writing to the HCA Director and the Contractor's Representative within five (5) Business Days after receiving the response of the responding party. The HCA Director and the Contractor Representative will mutually determine the procedural manner in which they will mutually review the dispute. A party's request for a dispute resolution must:
>
> I. Be in writing;
> I. Include a written description of the dispute;
> II. State the relative positions of the parties and the remedy sought;
> III. State the Contract Number and the names and contact information for the parties;
>
> B. This dispute resolution process constitutes the sole administrative remedy available under this Contract. The parties agree that this resolution process will precede prior to either party any action in a judicial or quasi-judicial tribunal.

As noted above, to engage in continued dispute resolution, you must notify the HCA Director within five business days after receiving this letter by emailing your request to sue.birch@hca.wa.gov and copying me at annette.schuffenhauer@hca.wa.gov to ensure appropriately processing of your request.

Sincerely,

Annette Schuffenhauer
Chief Legal Officer
Division of Legal Services

cc: Sue E. Birch, Director, Health Care Authority (HCA)
Louis McDermott, Deputy Director, HCA
Dave Iseminger, ERB Director, Employees and Retirees Benefits Division, HCA
Andria Howerton, Contracts Manager, Division of Legal Services, HCA

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

Email Delivery

July 29, 2019

Ruth Williams-Brinkley, President
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, OR 97232

Dear Ms. Williams-Brinkley:

SUBJECT: Contract Dispute Resolution – HCA Contract #K3024

Thank you for your letter dated July 23, 2019, in which Kaiser Foundation Health Plan of the Northwest ("KFHPNW") requested dispute resolution in accordance with Section 7.15 of contract #K3024 (the "Contract") and also submitted a protest of the underlying Request For Proposals No. 2716 ("RFP"). In a letter dated July 24, 2019, the Health Care Authority ("HCA") responded to the bid protest. In this letter, HCA responds to the request for dispute resolution under the Contract.

Background

KFHPNW was a successful bidder under the RFP. HCA and KFHPNW then executed the Contract on July 3, 2019. According to Section 1.2, the purpose of the Contract is as follows:

> The purpose of this Contract is to establish Contractor [KFHPNW] as a provider of SEBB Medical Plan(s), as described in this agreement, for the School Employees Benefits Board (SEBB) Program, in which the Contractor will assume financial responsibility for their Members' medical Claims and for all incurred administrative costs. The following categories of services that Contractor will provide to HCA, all as more fully described in this Contract and all exhibits and attachments hereto are:
>
> A. Benefits Services - This includes, but is not limited to: providing benefits in accordance with the Certificate of Coverage in effect during the Contract year, Clinical Management, Utilization Management, Chronic Condition Management, and Case Management.
>
> B. Administrative Services - This includes, but is not limited to: implementation, Claims administration, customer service provided via toll-free line and fax lines,

Member communications including mailing of members' materials and identification cards, online services, and processing Appeals and Complaints.

C. Health Transformation Services - This includes, but is not limited to: rewarding patient-centered, high value care; improving quality outcomes and patient experience; driving standardization based on evidence and best-practice.

HCA values its relationship with KFHPNW and shares the desire for a prompt resolution of this dispute. HCA, through David Iseminger, Director of the HCA Employee and Retirees Benefits Division, and Lou McDermott, Deputy Director of HCA, have been in frequent communication with leadership of KFHPNW to ensure shared understanding of the actions related to the School Employee Benefits Board ("SEB Board") finalization of premiums for this product offering. This letter will reiterate the authority that HCA does and does not possess related to finalization of the premiums associated with the Contract.

In the July 23 letter, KFHPNW contends that HCA violated the Contract by presenting information to the SEB Board regarding newly submitted rates of another successful bidder (Premera) after HCA had completed its review of proposed premiums. I conclude that KFHPNW has not cited a provision of the Contract to support that proposition.

Upon review of the Contract, it is clear that there was no "cut-off" date to submit the final premiums for consideration to the SEB Board, nor was there a contractual obligation of HCA to KFHPNW to reject (or refuse to consider) Premera's adjusted premiums.

Exhibit 3 of the Contract (entitled "Rate Development Process"), at pages 85 and 86, outlines the timeframe in which the SEB Board would consider and vote on the final premiums for plan year 2020. The exhibit notes on page 85 that the SEB Board process would take place from June to August 2019. And that is what has been happening.

Decision

Based on a review of the Contract, including Exhibit 3, HCA respectfully disagrees that it violated the Contract by providing the SEB Board with information regarding Premera's updated premiums. The SEB Board was entitled to receive the information to help fulfill its statutory duties related to developing plans and encouraging cost saving. The SEB Board must "design and approve insurance benefit plans for school employees[.]" RCW 41.05.740(1). Those plans must include "[m]ethods of maximizing cost containment while ensuring access to quality health care[,]" and the Board must "[a]uthorize premium contributions for a school employee and the employee's dependents in a manner that encourages the use of cost-efficient health care systems." RCW 41.05.740(6)(b)(i); RCW 41.05.740(6)(c). The updated Premera information advances these statutory obligations.

Because the SEB Board has the authority to review and approve the adjusted Premera premiums at issue in this dispute, HCA had an obligation to provide them to the SEB Board for consideration. Therefore, HCA did not violate the Contract.

Dispute Resolution Process

If you disagree with this response and wish to engage in future dispute resolution, you will have five calendar days from the date of this letter to notify me of that request by following the instructions below. Section 7.15 of the Contract states in pertinent part:

> If the initiating party is not satisfied with the response of the responding party, then the initiating party may request that the HCA Director and a representative of Contractor as selected in Contractor's sole discretion ("Contractor Representative") mutually review the dispute. Any such request from the initiating party must be submitted in writing to the HCA Director and the Contractor's Representative within five (5) Business Days after receiving the response of the responding party. The HCA Director and the Contractor Representative will mutually determine the procedural manner in which they will mutually review the dispute. A party's request for a dispute resolution must:
>
> I. Be in writing;
> II. Include a written description of the dispute;
> III. State the relative positions of the parties and the remedy sought;
> IV. State the Contract Number and the names and contact information for the parties;
>
> B. This dispute resolution process constitutes the sole administrative remedy available under this Contract. The parties agree that this resolution process will precede prior to either party any action in a judicial or quasi-judicial tribunal.

As noted above, to engage in continued dispute resolution, you must notify the HCA Director within five business days after receiving this letter by emailing your request to sue.birch@hca.wa.gov and copying me at annette.schuffenhauer@hca.wa.gov to ensure appropriate processing of your request.

Sincerely,

Annette Schuffenhauer
Chief Legal Officer
Division of Legal Services

cc: Sue E. Birch, Director, Health Care Authority (HCA)
Louis McDermott, Deputy Director, HCA
Dave Iseminger, ERB Director, Employees and Retirees Benefits Division, HCA
Andria Howerton, Contracts Manager, Division of Legal Services, HCA

July 30, 2019

KPWA & KPWAO Letter to Board Members (Chair Example)

KAISER PERMANENTE

July 30, 2019

VIA U.S. MAIL AND ELECTRONIC MAIL

School Employees Benefits Board
ATTN: Louis McDermott, Chair
Email: louis.mcdermott@hca.wa.gov
Mailing Address: P.O. Box 42720, Olympia, WA 98504-2720

Re: Response to July 25th SEB Board Meeting and Request for Action at August 1st SEB Board Meeting

Dear Mr. McDermott:

On behalf of Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (collectively "KP Washington"), KP Washington is honored to currently provide care and coverage for over 62,000 teachers, administrators, staff and their families in public schools across Washington state. We are committed to continuing to serve as their trusted partner through offering affordable care and coverage to SEBB program subscribers for years to come.

As part of KP Washington's strong commitment to and investment in the success of this new program and as a follow-up to my testimony at the July 25th SEB Board Meeting, I am writing directly to each SEB Board Member to both:

- Provide additional context and information relevant to the significant program integrity issues raised by Premera's submission of late-revised rates after the HCA's June 2019 deadline, and

- Request that the late-revised Premera bid rates that were presented to the SEB Board on July 18, 2019, be rejected as untimely and improper and that the SEB Board instead votes on the rates submitted by Premera by the June 2019 deadline HCA imposed by RFP, RFC, and contract.

As outlined in the attached July 22, 2019, letter, HCA engaged in a closed 2020 SEBB bid process, such that no private bidders would have access to the bids of competing private bidders. Nevertheless, Premera's late-revised rate proposal was considered by the SEB Board in a non-public meeting on July 18, 2019. This non-public meeting took place after bidders were required to submit final bid rates (June 2019) and after the SEBB Briefing Book with final bid rates was made available to the public (on July 15, 2019). This effectively transformed a "closed bid" procedure, in which all bidders were required to submit rates and other material benefit terms on the "most favorable terms bidder can propose,"[1] to an auction. KP Washington trusted that the procedures proposed in the RFP documents would be followed. Importantly, the failure to follow the procedures established by RFP, RFC, and contract, also directly undermines the benefit of a process that was intended to allow members of the public and affected school employees to have transparency and a meaningful and timely voice in the ultimate outcome of the process.

It is our understanding that the SEB Board will vote on Premera's rates for the 2020 calendar year during the August 1st SEB Board Meeting. Below is some important information and context that we respectfully request you to consider, as you prepare to make your determination at the meeting.

[1] RFP § 2.15.

First, during the July 25th SEB Board Meeting, an HCA official suggested that there was no inequity because "both [Premera and KP Washington] had reductions late in the game."[2] Such equivalence is inaccurate. KP Washington's rates were negotiated during the rate negotiation period as provided in the bid materials and contracts and significantly before KP Washington was privy to other bidders' rates.[3] Premera's late-revised bid rates were provided only after it had already submitted its final rates with HCA (June 2019) and after it had public access to KP Washington's final rates (on July 15, 2019). As further outlined in KP Washington's July 22nd letter to the HCA (attached), the RFP, RFC, and entered contracts clearly do not permit this late and auction-like rate submission by Premera.

Second, HCA processes require that rates presented to the SEB Board are supported by thorough and appropriate review for actuarial soundness. By HCA's own admission, such processes were not followed relative to the late-revised Premera rate submission. At the July 25th SEB Board meeting, HCA acknowledged that it did not submit Premera's revisions for actuarial review, did not undertake any dynamic or stochastic modeling, and did not vet the assumptions behind these new rates. One SEB Board Member noted that it was the board's "fiduciary duty" to know whether the assumptions underlying the revisions were actually similar to those of KP Washington or even Premera's prior assumptions.[4] The SEB Board identified at multiple points in the hearing that the late-submitted changes to the Premera plans were purely numbers. There were no changes to service area. There were no changes to benefit design.[5] While KP Washington understands that an actuarial review may now have been initiated in advance of the upcoming August 1st SEB Board Meeting, such a last-minute review does not resolve the procedural violations or harm that would result (to the public, KP Washington, and to the integrity of the SEBB program's processes) if the SEB Board were to endorse Premera's late-revised rates.

Third, the unsubstantiated estimated savings to school employees mentioned in the July 25th SEB Board meeting should not be relied upon by the SEB Board. Notably, the HCA undertook no dynamic modeling. Instead, HCA simply multiplied the proposed decrease in school employee contributions for Premera's late-revised rates across the estimated population. Doing so fails to account for the fact that both KP Washington and UMP will offer SEBB subscribers 2020 plans with benefits and/or subscriber contributions that are either better than or similar to what is offered within similar Premera plans. Additionally, through focusing solely on subscriber contributions to premium, HCA's calculations fail to account for other important financial factors facing SEBB subscribers. Specifically, HCA's projection of financial savings for SEBB subscribers does not factor in differences in actuarial value or the plans' respective benefit designs. For example, the chart presented below shows that Premera's PPO plan offerings have both lower calculated actuarial values (requiring more cost for Premera subscribers to access certain benefits) and higher out-of-pocket maximums than comparable PPO plans offered by KP Washington. Premera is also the only private bidder to impose pharmacy deductibles in its plans.[6] As illustrated through the chart below, the portions of the bidding process

[2] Hearing at minute 28:00 and at minute 32:25. Given that a final transcript of the July 25th hearing is not yet available, citations here are to approximate times in the hearing video as recorded and publicly available at TVW.
[3] See: RFP 2716, ¶2.20(3) and K3022, Ex. 3.
[4] Hearing at minute 51:00-06.
[5] Hearing at minute 40:40.
[6] See: https://www.hca.wa.gov/assets/pebb/sebb-meeting-briefing-book-071819.pdf (beginning on page 115 of 159) and https://www.hca.wa.gov/assets/pebb/sebb-meeting-briefing-book-072519.pdf (beginning on page 84 of 136). Actuarial value calculations were performed using the 2019 Federal AV calculator as provided by the U.S. Department of Health and Human Services and the plan benefits in the July 18, 2019, SEB Board Meeting Briefing Book linked above.

KAISER PERMANENTE®

that were appropriately conducted already produced a number of affordable plan options, with robust benefits and networks, that are already available to school employees and their families. As such, the late-revised Premera rates are not necessary in order to deliver the desired financial and plan benefit value to SEBB subscribers.

SEBB PPO PLANS	KPWAO Access PPO		Premera PPO		UMP PPO
	KPWAO Access PPO 2	KPWAO Access PPO 1	Premera High PPO	Premera Standard PPO	UMP Achieve 1
Deductible (single)	$750	$1,250	$750	$1,250	$750
Out-of-pocket max (single)	$3,500	$4,500	$3,500	$5,000	$3,500
Actuarial Value	85%	82%	81.33%	78.54%	
Coinsurance	20%	20%	25%	20%	20%
RX deductible (single)	$0	$0	$125	$250	$250 Tier 2
Primary Care copay	$25	$30	$20	$20	20%
Specialist copay	$35	$40	$40	$40	20%
Inpatient	20%	20%	25%	20%	$200 per day, up to $600 +20%
Outpatient	20%	20%	25%	20%	20%

In conclusion, in direct conflict with clear procedures established by RFP, RFC, and contract to ensure a fair and deliberate process where all private bidders were afforded the opportunity to submit final bid rates by no later than June 2019, Premera was permitted to submit late-revised rates to its own advantage after HCA had made KP Washington's rates public on July 15, 2019. If the SEB Board (particularly in this initial bidding process) is viewed as endorsing this type of departure from firm processes and program integrity, it may deter full participation in the bidding process going forward - at a cost that may result in higher premiums and fewer plan and provider choices for school employees and their families in the future. This form of procedural non-compliance would also directly undermine the benefit of a procurement process that was intended to allow members of the public and affected school employees to have full confidence in the new SEBB program and its processes.

As highlighted above, there is a simple path through which the SEB Board can restore integrity to the SEBB program's processes while also ensuring the critical availability of a number of affordable health plan options (with robust benefits and networks) for school employees and their families. In order to ensure that all necessary actions are taken to guarantee the integrity of the SEBB program, so that teachers, administrators, and staff of our public schools have confidence and trust in the system that provides their health care and coverage, we respectfully request the following:

- As the late-revised Premera bid rates are untimely and improper, we request that the SEB Board reject the Premera rates that were presented in closed session on July 18, 2019, and vote on the Premera rates as submitted by the June 2019 deadline HCA imposed by RFP, RFC, and contract.

Thank you for your attention to this important matter and for your review of this letter as you consider how you will vote on Premera's SEBB plan rates during the upcoming August 1st SEB Board Meeting. Our team looks forward to continuing to work collaboratively with the SEB Board and HCA to advance of our shared

KAISER PERMANENTE®

commitment to providing the high level of service and quality that Washington's school teachers, administrators, staff, and their families deserve. I would be pleased to discuss further with you at your convenience in advance of the August 1st SEB Board Meeting. Please feel free to reach out to me directly at (206) 448-5792.

Sincerely,

KAISER FOUNDATION HEALTH PLAN OF WASHINGTON

KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS, INC.

Susan E. Mullaney, President

CC: Sue Birch, Director, HCA
Joseph E. Smith, Vice President, Marketing, Sales & Business Development

ATTACHMENTS (1):

(1) Letter, dated July 22, 2019, from KP Washington to HCA with Subject "Re: Kaiser Plan Year Final SEBB 2020 Rates; Dispute Notice and Protest regarding HCA Procedure"

Request For Proposal
(RFP) #2716

Section 2.20 and All Section 2.20 Q&As during procurement process

STATE OF WASHINGTON
HEALTH CARE AUTHORITY

REQUEST FOR PROPOSALS (RFP)

RFP NO. 2716

NOTE: *If you download this RFP from the Health Care Authority website, you are responsible for sending your name, address, e-mail address, and telephone number to the RFP Coordinator in order for your organization to receive RFP amendments or bidder questions/agency answers directly from the RFP Coordinator. HCA is not responsible for any failure of your organization to review any amendments or agency answers to questions, or for any repercussions that may result to your organization because of any such failure.*

PROJECT TITLE: SEBB Program Fully Insured Medical Plans

PROPOSAL DUE DATE: August 2, 2018 by 4:00 p.m. *Pacific Time*

Only hard copy/physical Proposals and e-mailed Proposals will be accepted. Faxed Proposals will not.

ESTIMATED TIME PERIOD FOR CONTRACT: The Washington State Health Care Authority (HCA) estimates the Contract(s) will be signed in November 2018. Benefit plans and Member services will not begin until January 1, 2020, but an extended period of Implementation is expected. Implementation will begin immediately following Contract execution. The initial term of the Contract(s) will extend through December 31, 2023. Thereafter, Contract(s) may be extended for up to an additional eight (8) years in increments of not less than one (1) year, at the sole discretion of the HCA.

BIDDER ELIGIBILITY: This procurement is only open to those Bidders that: (1) responded to all mandatory elements of the HCA's Request for Information (RFI) 2646; and (2) satisfy the minimum qualifications stated herein. Failure to meet either of these requirements will result in the rejection of such bid prior to evaluation and scoring.

an objection to any particular term or condition, the term or condition will be deemed agreed to by the Bidder. HCA reserves the right to discuss any Bidder proposed change to terms or conditions and to clarify and supplement such proposal.

Bidders are reminded that this is a competitive solicitation for a public contract and that HCA cannot accept a Proposal, or enter into a contract, that substantially changes the material terms and specifications published in this RFP. Proposed changes to any particular term or condition of the Draft Contract will be used to determine the responsiveness of the Proposal. Proposals that are contingent upon HCA making substantial changes to the material terms and specifications published in the RFP may be disqualified.

If, by December 3, 2018, an ASB and HCA cannot reach agreement on acceptable terms for the Contract, HCA may cancel the selection and award the Contract to the next most qualified Bidder.

The services to be performed by an ASB will involve the use of information that is protected by HIPAA. As such, the ASB must agree, as a component of the final Contract, to abide by the Data Share Agreement (DSA) included as part of the Contract.

2.18. Contract Delay Contingency

In the event the Benefits Start Date under a Contract is delayed until a later year for any reason, HCA reserves the right to terminate the Contract at its sole discretion. It may also choose to make a good faith effort to maintain the contractual relationship and to amend the Contract as necessary to address the delay.

2.19. Implementation / Timeframe

It is anticipated that contracted services will be implemented in two (2) phases.

Phase One - Implementation and Planning: This phase includes coordination with the HCA staff, consultants, and other contractors to build the infrastructure necessary to support the plan(s) and make sure the ASB is prepared to provide services. This will include such items as the eligibility files and group structure for Members. This phase will begin once the Contract is signed (which HCA estimates to be early November 2018), and will continue at least through October 1, 2019. Implementation will begin based on a number of assumptions, which are subject to change.

Phase Two – Delivery of Health Plan Services: This phase is the delivery of the plan(s) the ASB is contracted to provide. Specific services described in the Contract will begin on January 1, 2020, or thereafter, as specified in the Contract and continue for the term of the Contract.

HCA will work with the ASB(s) to further define the contents of each phase in the implementation plan and Contract. The HCA reserves the right, in its sole discretion, to alter the timing of the implementation timeframe at any time.

2.20. Request for Completion Process (RFC Process)

The HCA anticipates completing the process of obtaining and negotiating rates from apparently successful bidders and determining final payment rates to Contractor(s) in four (4) phases.

1. **September – November 2018**
   Orientation to rates approach and methodology, including risk adjustment and area adjustment using geographic rating regions similar to OIC's rating regions.

2. **December 2018 – February 2019**
   Release of Request for Completion (RFC), submission of initial rates by Contractors, and negotiation of not-to-exceed (NTE) rates. This process will allow Contractors to receive an updated data book that contains summarized School Employee data to assist in the development

of proposed rates for the plan designs approved by the SEB Board. HCA anticipates that Contractors will use School Employee enrollment data they have to develop rates and will use the statewide data as a reasonableness check. Prior to receiving this data, Contractors may be required to sign a non-disclosure agreement (NDA) or a data share agreement (DSA). The RFC will request rates and final plan designs, and any other information that may be required to include in a Contract for providing health care services. The RFC will also include instructions regarding how to access the claims data, and a specific due date by which a Contractor must provide their RFC Response. At this time, HCA anticipates that the RFC will go out in early December 2018. If HCA and a Contractor are unable to agree on NTE rates, HCA has sole discretion to terminate the Contract resulting from this RFP.

3. **March - June 2019**
   Negotiation of final rates and plan designs as needed to align with 2019-2021 biennial budget development. Final rates and plan designs will be added to the Contract(s) as amendment(s). It is anticipated that any such amendments will be executed by September 2019.

4. **January - June 2020**
   Develop and apply risk and area adjustments to produce final payment rates for plan year 2020. Final payment rates will be incorporated into Contract(s) via contract amendment(s).

2.21. Costs to Propose

HCA will not be liable for any costs incurred by the Bidder in preparation of a Proposal, in conducting a presentation, or any other activities related in any way to this RFP.

2.22. Receipt of Insufficient Number of Proposals

If HCA receives only one responsive Proposal as a result of this RFP, HCA reserves the right to either: 1) directly negotiate and contract with the Bidder; or 2) not award any contract at all. HCA may continue to have the Bidder complete the entire RFP process. HCA is under no obligation to tell the Bidder if it is the only Bidder.

2.23. Cancellations, Acceptance, Administrative Irregularities, and Discussions

This RFP does not obligate the State of Washington or the HCA to contract for services specified herein in full or in part. The HCA reserves the right to:

1. Cancel all or part of this RFP at any time for any reason.

2. Accept or reject any and all Proposals, in whole or in part.

3. Reject any part of any or all Proposals and continue to evaluate the modified version of the Proposals.

4. To waive, or permit cure of, administrative irregularities (however, waiver or permitting cure of such an irregularity does not imply the HCA will waive or permit cure of other or subsequent irregularity(-ies)).

5. To modify the RFP at any time.

6. To conduct discussions with all qualified or potentially qualified Bidders in any manner necessary to serve the best interests of the HCA and the people of the State of Washington.

Washington State Health Care Authority

Solicitation Amendment

SEBB Program Fully Insured Medical Plans

RFP No. 2716

Amendment No. 3

Date Issued: June 28, 2018

Purpose: Round 1 Questions and Answers

Amendment need not be submitted with Proposal. All other Terms, Conditions, and Specifications remain unchanged. The above referenced solicitation is amended as follows:

The following are the questions and answers from the *Round 1 Questions* period and the *Pre-Proposal Conference*.

The rest of this page is intentionally left blank.

11	1.7 Minimum Qualification #8	Our organization has adopted S & P, Moody's and Fitch to monitor and measure our financial health organization-wide. As it relates to the carrier minimum qualifications, will one these financial rating institutions suffice?	The Health Care Authority will amend Minimum Qualification #8 to allow bidders an opportunity to provide all of the most recent documentation they have from the several major companies that rate the financial strength and credit worthiness (e.g., Standard & Poor's, A.M. Best Company, Weis Research, Fitch, Moody's, Kroll). This amendment will give bidders who do not participate in A.M. Best, an opportunity to respond to Minimum Qualification #8 with other comparable information they have. HCA anticipates posting the amendment that will update this Minimum Qualification early next week.
12	2.20	Following rate development and financial modeling, what opportunities will the SEB Board and Carriers have to revisit plan design ahead of open enrollment?	After a Carrier is announced as an ASB, and Contract negotiations start, there will be an opportunity for HCA and the Carrier to alter the submitted plan designs. The plan designs finalized between HCA and the Carrier will be presented to the SEB Board for approval. The SEB Board could ask for some things to change about the plan designs, at which time HCA and the Carrier would revisit the plan designs to update them based on SEB Board input. There will likely be no changes prior to the Annual Open Enrollment for Plan Year 2020. However, each year thereafter, there is the opportunity to revisit plan design through the Request of Renewal process.
13	2.20	How, if at all, will the geographic rating regions be different than OIC's rating regions?	At this time, it is HCA's intent to use the OIC rating areas.
14	2.20	What are SEBB's financial goals around rates over this initial 3 year contract term?	Stability, sustainability, and value-based purchasing.
15	2.20	What kind of data will be included in the "*data book that contains summarized school employee data*" that is to be released in December?	Summarized cost models representing the allowed patient pay and paid claim amounts by category of service, additional summaries relating to the level of unit cost performance, and risk relativity of geographic areas.

Washington State Health Care Authority

Solicitation Amendment

SEBB Program Fully Insured Medical Plans

RFP No. 2716

Amendment No. 5

Date Issued: July 19, 2018

Purpose: Round 2 Questions and Answers

Amendment need not be submitted with Proposal. All other Terms, Conditions, and Specifications remain unchanged. The above referenced solicitation is amended as follows:

The following are the questions and answers from the *Round 2 Questions* period.

The rest of this page is intentionally left blank.

18	Section 2.20	If the rate and benefit confirmation is not complete in early Q2 would HCA consider moving the due date of system readiness?	Yes; HCA would consider moving some aspects of system readiness to December 3, 2019. HCA's hope is to have all system readiness completed prior to the SEBB Annual Open Enrollment to ensure the work is complete and focus is on open enrollment activities for both the Carriers and HCA, but HCA understands that select dates may need to be adjusted depending on finalizing Contract details. The Plan Year start date will remain at 1/1/2020. Therefore, it is important Contractors are prepared to partner with HCA on this and complete what is needed on time.
19	Section 2.20 Item 4	Section 2.20 #4 states: *(HCA will) develop and apply risk and area adjustments to produce final payment rates for plan year 2020. Final payment rates will be incorporated into Contract(s) via contract amendment(s).* What data will HCA use to determine risk differences between SEBB health plans? Specifically, will HCA use diagnoses pulled from claims data; age/sex demographic data; or a combination of both or some other method?	HCA will use diagnosis and drug codes from claims data as well as the age/gender/demographic data after open enrollment to determine the adjustments for risk.
20	Section 2.26	Please confirm whether bidder may satisfy these insurance obligations using self-insurance or combination of self-insurance and commercial insurance.	Yes, self-insurance or a combination of self-insurance and commercial insurance would be fine.
21	Section 3.2.1	As far as the RFP formatting requirements are concerned, are Bidders permitted to include header text outside of the 1 inch margin requirement for each response exhibit?	Yes, that is fine. The requirement is that margins are no less than 1 inch.

Request For Completion (RFC)

Non-Specific Apparently Successful Bidder (ASB) Version

Washington State Health Care Authority

School Employees Benefits Board (SEBB) Program Request for Completion (RFC)

Project Title	Request for Completion (RFC) for Carrier Contract #KXXXX
RFC Response Due Date	RFC Response due: January 15, 2019 by 5:00 p.m. PDT
Submit RFC Response To	Contracts@hca.wa.gov

December 13, 2018

Time Sensitive Material

Contents

Commented [HLE(1]: Update in ASB-specific versions once plan designs are added in.

SECTION 1: DEFINITIONS

"Apparent Successful Bidder" or "ASB" means the entity this RFC is addressed to that was selected as an entity to perform the anticipated services under RFP 2716, subject to contract negotiations and execution of a written contract.

"Bid Rate" means a rate by plan that reflects the statewide profile with an average relative risk score of 1.0.

"Carrier" means insurance company.

"Contract" means the contract referred to on the cover page of this RFC document which is currently being negotiated between HCA and the ASB. This includes all schedules, exhibits, attachments, incorporated documents and amendments.

"Data Book" means one or more electronic files of historical membership and claims experience data provided to carriers for the purposes of assisting them in the development of Not-to-exceed (NTE) Rates. There is a statewide version and a carrier-specific version of the Data Book.

"Employer Medical Contribution (EMC)" means the amount, per collective bargaining, that the employer will contribute per month towards medical premiums for SEBB-eligible employees. The amount is defined to be 85 percent of the monthly premium for the self-insured SEBB UMP Achieve 2 plan, regardless of which plan the employee chooses. The EMC rate is multiplied by SEBB-approved tier ratios to derive the amount the employer will contribute by tier.

"Final NTE Rate" means the rate by plan and by tier negotiated between HCA and the Carrier. This rate will be used to calculate monthly employee premiums by plan and by tier. The 2020 rate by plan and by tier, before any adjustment for risk or area factors, cannot exceed this dollar amount.

"NTE Rate" means the rate by plan and by tier a carrier proposes to HCA in their response to this RFC. This rate may or may not be equal to the Final NTE Rate.

"SEBB Funding Rate" means the amount per SEBB-eligible employee that employers will remit to HCA for SEBB benefits on a monthly basis.

All capitalized terms not otherwise defined herein have the meaning ascribed to them in the Contract.

SECTION 2: GENERAL INFORMATION

2.1 Purpose

The purpose of this RFC document is to obtain binding not-to-exceed (NTE) rates based on the final plan design options from the Carrier that were approved by the SEB Board on November 8, 2018. HCA anticipates completing the process of obtaining, negotiating, and finalizing rates in the following phases:

December 2018 - February 2019	Release of RFC, submission of initial rates by ASBs, and negotiation of NTE Rates.
March - June 2019	Negotiation of changes if needed to align with 2019-2021 biennial budget development.
June - August 2019	SEB Board vote on 2020 employee premiums by plan; Contract amendment for negotiated rates signed for Plan Year 2020.

The ASB is expected to meet all requirements described in the RFC.

2.2 Funding

It is expected that funding rates for the SEBB Program will be included in the 2019-21 Omnibus Appropriations Act that will be enacted in the summer of 2019.

Continuation of the Contract beyond the RFC Process is contingent upon the agreement to rates such that HCA can manage the overall SEBB Program expenditures to remain within the budget approved in the final omnibus appropriations act passed by the Washington Legislature and enacted by the governor.

The NTE Rates established during the RFC Process will be relied upon by the agency to advise the Washington Governor's Office and Washington Legislature on the development of the SEBB Funding Rate during the 2019 legislative session(s).

2.3 RFC Coordinator

The RFC Coordinator is the sole point of contact in HCA for this RFC. All communication between the ASB and HCA upon release of this RFC must be with the RFC Coordinator, as follows:

Primary RFC Coordinator	Lesley Houghton
Alternate RFC Coordinator	Laura Shayder
E-Mail Address	contracts@hca.wa.gov

2.4 RFC Amendments

HCA reserves the right to amend this RFC at any time. In the event it becomes necessary to revise any part of this RFC, addenda will be provided via email to HCA's ASB contact(s).

If a conflict exists between amendments, between an amendment and the RFC, or between multiple amendments, the document last in time controls.

2.5 RFC Schedule

Following is the planned RFC schedule including key milestones and dates:

RFC ACTIVITY SCHEDULE		
Item	**Action/Activity**	**Date**
1	HCA releases RFC and Data Book containing 2016-2017 school year data	By December 13, 2018
2	HCA releases updated Data Book that adds 2015-2016 school year data	December 14, 2018
3	HCA releases final Data Book that adds 2017-2018 school year data	December 21, 2018
4	HCA/Carrier conference calls for Q&A; may include Carriers as a group and/or one on one with HCA	December 17, 2018 – January 10, 2019
5	RFC Responses due	January 15, 2019 by 5:00 pm PDT
6	HCA provides feedback and requests second round of NTE Rates, if needed	Week of January 14, 2019
7	HCA provides estimated Employer Medical Contribution (EMC) and associated employee premium contributions by plan	January 31, 2019
8	ASB submits Final NTE Rates	February 8, 2019 by 5:00 PDT
9	NTE Rate negotiations complete	February 15, 2019
10	HCA provides updated SEBB Funding Rate to the Legislature	March 1, 2019
11	HCA responds to requests and questions from the legislature	January – TBD
12	Legislature enacts 2019-2021 Biennial Budget, which includes SEBB Funding Rate	TBD (approximately April 28, 2019 – June 30, 2019)

12	SEB Board approves employee premiums for Plan Year 2020	July 2019 (estimated)
13	Execution of Contract amendment	July – August 2019 (estimated)

2.6 Proprietary Information and Public Disclosure

Materials submitted as part of the RFC Response will become the property of HCA. All such materials will be deemed public records as defined in Chapter 42.56 of the Revised Code of Washington (RCW).

Any information in the RFC Response that the ASB desires to claim as proprietary and exempt from disclosure under Chapter 42.56 RCW, or other state or federal law that provides for the nondisclosure of a document, must be clearly designated. The information claimed to be exempt must be clearly identified as proprietary or confidential on the bottom of each page. Marking the entire RFC Response exempt from disclosure or as proprietary information **will not be honored.**

If a public records request is made for the information that the ASB has marked as proprietary or confidential, HCA will notify the ASB of the request and of the date that the records will be released to the requester unless the ASB obtains a court order enjoining that disclosure. If the ASB fails to obtain the court order enjoining disclosure, HCA will release the requested information on the date specified. If an ASB obtains a court order from a court of competent jurisdiction enjoining disclosure pursuant to Chapter 42.56 RCW, or other state or federal law that provides for nondisclosure, HCA will maintain the confidentiality of the ASB's information per the court order.

2.7 Notification of Terms

HCA will document the final negotiated results of the RFC Process and obtain Carrier signature, after which ASB cannot make changes to SEBB Program plans or Service Area(s) without the written consent of HCA. The NTE Rate Form, Exhibit A, will become part of the 2020 Contract.

2.8 Format of RFC Response

ASB must review and respond to all forms included in the RFC. RFC forms are included as exhibits and listed below. Please format your RFC Response as follows:

1. *EXHIBIT A - NTE Rate Form* and *EXHIBIT A-1 - SEBB Rate Proposal Template Instructions* - Complete NTE Rate Form using the SEBB Rate Proposal Template Instructions (must include plan names).

2. *EXHIBIT B – 2020 Plan Design Templates* - Review and verify (must include plan name).

3. *EXHIBIT C - 2019 Federal Actuarial Value Calculator Output* and *EXHIBIT C-1 – Federal AV Input Questionnaire* - Provide copy of Federal AV Output and complete corresponding Input Questionnaire Form for each plan.

4. *EXHIBIT D – Certifications and Assurances Form* - Complete the form per the instructions included in the form, and sign and date it.

5. *EXHIBIT E – Carrier Questionnaire v2019* - Respond to each question following the instructions included in the questionnaire.

6. *EXHIBIT F - 2020 Eligibility and Enrollment Language (as of 12/13/18)* - See *Exhibit E – Carrier Questionnaire #2* for instructions.

7. *EXHIBIT G – Short Names and Contact Information* - See *Exhibit E – Carrier Questionnaire* #3 for instructions.

8. *EXHIBIT H – Service Area* - See *Exhibit E – Carrier Questionnaire* #4 for instructions.

9. *EXHIBIT I – RFC Checklist* - Check off each item as completed, sign, and submit as part of the RFC Response.

2.9 Submission of RFC Response

ASB must submit the RFC Response to the RFC Coordinator electronically, to the email address listed in section *2.3, RFC Coordinator*. ASB must follow the instructions listed in section *2.8, Format of RFC Response* and submit the RFC Response by the due date and time listed in section *2.5, RFC Schedule*.

SECTION 3: PREPARING YOUR BENEFIT DESIGN AND NTE RATE PROPOSAL

3.1 Benefit Design and NTE Rate Analysis

Milliman, Inc. is authorized to conduct the benefit design and NTE Rate analysis and to negotiate on behalf of HCA. As HCA's consultant, Milliman may conduct one-on-one carrier discussions regarding clarification or negotiation of ASB's RFC Response from which specific recommendations to HCA can be made. Information exchanged or discussed in the one-on-one carrier discussions may be considered proprietary in accordance with RCW 41.05.026.

3.2 Demographic Assumptions

Consolidated Statewide Data Book and ASB-specific Data Book are anticipated to be sent to the ASB in accordance with the dates listed in Section 1.5, RFC Schedule.

3.3 Rule Assumptions

The ERB Division is in the process of establishing SEBB Program and Washington Administrative Code (WAC) rules. Once established, the ERB Division will review SEBB Program and the Washington Administrative Code (WAC) rules annually and may amend rules after the review. SEBB Program administrative policies will be published for public comment before adoption and will be posted on the HCA's website.

Initial SEBB Program rules will be enacted in the Washington Administrative Code in January 2019. HCA will perform a second rule-making process throughout 2019 to supplement the initially enacted rules. Due to timing and requirements of rule-making, some policies enacted in 2019 by the School Employees Benefit Board that must be followed during the 2020 plan year may not be codified in rules prior to 2020. Carrier must follow all policy resolutions enacted by the Board even if they are not codified in a WAC rule.

3.4 Benefits Design and Programs

3.4.1 Number of Proposals

As part of the RFC Response, ASB must submit a proposal for the 2020 SEBB Plan benefit designs approved by the SEB Board, updated to ensure compliance with benefit mandates under the Affordable Care Act (ACA) and all changes requested by HCA in this RFC. Complete *EXHIBIT A - NTE Rate Form*, using the instructions in *EXHIBIT A-1 - SEBB Rate Proposal Template Instructions*, and ensure the accuracy of the benefit design components provided in the *EXHIBIT B – 2020 Plan Design Templates*, for each proposed design. HCA requests for the submitted NTE Rates for each proposed plan to reflect a rate with a "carve out" for vision benefits.

3.4.2 High Deductible Health Plan (HDHP) Assumptions (if applicable)

ASB should assume the following:

- A HDHP deductible per carrier plan design;
- HSA contribution limit for self-only and family TBD Spring 2019
- An employer HSA contribution, if any, will be determined in 2019;
- Cost-share contribution for contraceptives in accordance with SB6219;

ASB should ensure that plan design meets Medicare Part D Creditable Coverage criteria.

3.4.3 Preventive Services – USPSTF A and B Recommendations

Proposed plan designs must comply with all preventive services requirements in accordance with the ACA, including USPSTF A & B recommendations.

3.4.4 Vision Benefits

Carrier must "carve out" benefits for vision for each proposed plan. In accordance with a decision by the School Employees Benefit Board, HCA intends to offer stand-alone group vision benefits to SEBB Program Members starting January 1, 2020. See *EXHIBIT A - NTE Rate Form*.

For the purposes of the NTE Rates, vision benefits include an annual comprehensive eye exam provided by an optometrist or ophthalmologist, eye glass frames and lenses, and contact lenses.

3.4.5 SEBB Plan or Service Area Changes

Carrier cannot make changes to SEBB Program plans or Service Area(s) after Final NTE Rates are approved by HCA without the written consent of HCA.

3.5 Rate Instructions: Employees

The proposed NTE Rates should be developed only for active School Employees within the SEBB Program risk pool. The rate tier structure is shown, below in Table 1 – SEBB Program Rate Tier Structure. ASBs need to provide a single blended rate by plan, i.e. for both enrollees who qualify for the wellness incentive of a Subscriber annual deductible level and family deductible level each reduced by $50, and enrollees who do not qualify for this wellness incentive.

Rates should not include benefits for routine/annual vision exam(s) and hardware.

Table 1 – SEBB Program Rate Tier Structure

Tier Structure	Tier Level	Tier Ratio
Employee Only	1	1
Employee + Spouse/SRDP	2	2
Employee + Child(ren)	3	1.75
Employee, Spouse/SRDP, + Child(ren)	4	3

Notes:
SRDP = State Registered Domestic Partner

3.5.1 NTE Rate Forms

NTE Rate Form (Exhibit A) and SEBB Rate Proposal Template Instructions (Exhibit A-1) are included in this RFC.

3.5.2 Rate Development Transparency

HCA requires detailed Carrier information and transparency with respect to the rate development process. Please include your actual calculations and work papers used to develop your rates. In addition, please ensure your detailed supporting documentation includes the following:

- A summary description of your actual rating methodology – at a conceptual (not mathematical) level;
- Description of the ASB's enrollment assumptions between plans;
- On a per Member per month (PMPM) basis, the amount you have included for administration. Show all subcategories used in your company's internal modeling, including but not limited to the following:
    - Premium tax
    - Margin
    - Fees or taxes required in 2020 under the Affordable Care Act, e.g. PCOR;
- Show in detail how you applied fees required under the Affordable Care Act, e.g. PCOR.

3.5.3 Premium and Area Adjustments

The proposed School Employee NTE Rates should reflect your Plans' expected cost based on the entire SEBB School Employee risk pool, as provided in the Data Book, accounting for expected differences in morbidity and geographic membership distributions between the Data Book and 2020.

Payment rates, for months during calendar year 2020, may vary based on Carrier risk and area factors. The final SEBB-approved Bid Rates will be multiplied by risk and area adjustment factors to determine payment rates by plan (amount paid to the Carrier) for plan year 2020. HCA anticipates adopting the following rate adjustment schedule:

A. Bid Rates

Reflects statewide profile with an average relative risk score of 1.0.

B. Interim Payment Rate(s)

TBD

C. Final Payment Rate

Will be determined in April 2021 and will reflect the complete concurrent risk for Plan Year 2020.

The employer medical contribution (EMC) is collectively bargained to be 85 percent of the monthly premium for the self-insured SEBB UMP Achieve 2 plan—with an estimated actuarial value of 88 percent. The EMC will be applied uniformly across all medical plan offerings within the SEBB portfolio. The employee contribution will be the difference between the Bid Rate for the plan selected and the EMC. The EMC rate and employee contribution are multiplied by the tier ratios shown in Table 1 – SEBB Program Tier Rate Structure. The minimum employee premium contribution across all plans and all tiers is collectively bargained to be set at no less than 2 percent of the EMC. HCA may need to provide a final balancing of the proposed rates to ensure the collective bargaining result is achieved and risk adjustment is revenue neutral across all fully insured SEBB Medical Plan carriers and UMP, the State's self-insured plan.

EXHIBIT A - NTE Rate Form

This exhibit will be provided to ASB as a separate excel document.

EXHIBIT A-1 - SEBB Rate Proposal Template Instructions

This exhibit will be provided to ASB as a separate PDF document.

EXHIBIT B – 2020 Plan Design Templates

This exhibit will be provided to ASB as a separate PDF document.

EXHIBIT C - 2019 Federal Actuarial Value Calculator Output

This exhibit will be provided to ASB as a separate excel document.

EXHIBIT C-1 – Federal AV Input Questionnaire

This exhibit will be provided to ASB as a separate word document.

EXHIBIT D – Certifications and Assurances Form

Health Care Authority Procurement for SEBB Fully Insured Medical Benefits

Completion of this Information form is a **mandatory requirement** for contracting with the Washington State Health Care Authority (HCA). The certifications and assurances contained herein are a required element of the RFC Response.

Contact Person for Carrier's Benefit Design and Rate Proposals **Include Name, telephone number, and e-mail address**	
Contact Person for Certificates of Coverage, Contract Terms, and Carrier's Questionnaire **Include Name, telephone number, and e-mail address**	

1. We declare that all answers and statements made in the RFC Response are true and correct.
2. Our RFC Response is a firm offer until December 31, 2019 and may be accepted by HCA without further negotiation (except where obviously required by lack of certainty in key terms).
3. We have not been assisted in preparing this RFC Response by any current or former HCA employee acting in other than his or her official, public capacity. If there are any exceptions to these assurances or we have been assisted, we will identify and include the following information on a separate page attached to this document for each such individual: (a) name, (b) current address and telephone number, (c) current or former position with HCA, (d) dates of employment with HCA, and (e) detailed description of the assistance provided by the individual.
4. We acknowledge that HCA will not reimburse us for any costs incurred in the preparation of our RFC Response. Materials submitted as part of the RFC Response will become the property of HCA and we claim no proprietary right to the ideas, writings, items or samples.

The undersigned is authorized to bind the ASB to a contract. Under the penalties of perjury of the State of Washington, the undersigned affirms the truthfulness of the statements made herein. The undersigned certifies that the ASB is now, and shall remain, in compliance with the certifications and assurances contained herein, and agrees that such compliance is a condition precedent to the award and continuation of any related contracts. The undersigned acknowledges the ASB's obligation to notify HCA of any changes in the statements, certifications and assurances made herein.

Signature

Title

Organization

Date

EXHIBIT E – Carrier Questionnaire

1. **General**
   Confirm in the space provided below that your NTE Rates are based on the plan designs provided to you in the RFC, which have been approved by the SEB Board for rate development.

2. **Exhibit F- 2020 Enrollment and Eligibility Language (as of 12/13/18)**
   Are any changes required to Exhibit F to be compliant with federal regulations or Title 48? If yes, please note the changes as a tracked change in the word version of Exhibit F that was provided and return as part of your RFC Response. Provide sufficient detail to ensure HCA understands the implications, including applicable federal or state regulatory/statutory references. If no changes are needed, please state in the space provided below.

3. **Complete Exhibit G – Short Names and Contact Information.**

   a. **Legal and Short Name**
      Complete Exhibit G to reflect both the legal name registered with the Office of Insurance Commissioner and the preferred "short name" used by the HCA. Information needs to be compliant with Title 48.

   b. **Enrollee Contact Information**
      Complete Exhibit G to reflect the 2020 Enrollee contact information

4. **Exhibit H – Service Area**
   Complete Exhibit H to identify what counties your plans will be offered in for Plan Year 2020.

EXHIBIT F - 2020 Eligibility and Enrollment Language (as of 12/13/18)

This exhibit will be provided to ASB as a separate word document.

EXHIBIT G – Short Names and Contact Information

Commented [HLE(2]: Make ASB specific

SEBB Medical Plans – Legal/Long Names	Short Names	Enrollee Contact
Kaiser Foundation Health Plan of Washington		Phone number: TTY: Address: Website (if available yet): Claims Reimbursements Address/Fax: Appeals & Grievances Address/Fax:
Kaiser Foundation Health Plan of Washington Options, Inc.		Phone number: TTY: Address: Website (if available yet): Claims Reimbursements Address/Fax: Appeals & Grievances Address/Fax:

SEBB Medical Plans – Legal/Long Names	Short Names	Enrollee Contact
Kaiser Foundation Health Plan of the Northwest		Phone number: TTY: Address: Website (if available yet): Claims Reimbursements Address/Fax: Appeals & Grievances Address/Fax:
Aetna		1 Phone number: TTY: Address: Website (if available yet): Claims Reimbursements Address/Fax: Appeals & Grievances Address/Fax:
Premera Blue Cross		1 Phone number: TTY:

SEBB Medical Plans – Legal/Long Names	Short Names	Enrollee Contact
		Address: Website (if available yet): Claims Reimbursements Address/Fax: Appeals & Grievances Address/Fax:
Providence Health Plan		1 Phone number: TTY: Address: Website (if available yet): Claims Reimbursements Address/Fax: Appeals & Grievances Address/Fax:

EXHIBIT H – Service Areas

Commented [HLE(3]: Make ASB specific

This Exhibit will be provided to ASB as a separate excel document.

EXHIBIT I – RFC Checklist

☐ NTE Rate Form (Exhibit A)

☐ Acknowledge accuracy of 2020 Plan Design Templates (Exhibit B) for each plan

☐ 2019 Federal Actuarial Value Calculator Output (Exhibit C) for each plan

☐ Federal AV Input Questionnaire (Exhibit C1) for each plan

☐ Certifications and Assurances Form (Exhibit D)

☐ Carrier Questionnaire (Exhibit E)

☐ Edits and comments on prospective 2020 Eligibility and Enrollment information, as of December 13, 2018 (Exhibit F)

☐ Short names and contact information (Exhibit G)

☐ Service areas offered for Plan Year 2020 (Exhibit H)

Mark checklist as each component is completed. When all are completed, please sign and include with the RFC Response.

_____ _____

Authorized Signature Date

Washington State Health Care Authority

Request for Completion (RFC) Amendment

Amendment No. 1

[Insert Carrier Name] Contract #[Insert Contract #]

Date Issued: January 4, 2019

Purpose: Revise definitions and add a new one, update the RFC Schedule, include information regarding the Hepatitis-C Medication Carve-out, and attach an updated Exhibit D.

Amendment need not be submitted with RFC Response. All other terms, conditions, and specifications remain unchanged. The above referenced RFC is amended as follows:

1. Section 1, *Definitions* is hereby amended to include the following definition for *Final Bid Rate*:

"Final Bid Rate" means a rate by plan that reflects the statewide profile with an average relative risk score of 1.0. This is a rate negotiated between HCA and the Carrier. This rate will be added to the Contract via an amendment as the agreed upon Bid Rate for Plan Year 2020. Risk and area adjustment factors will be applied to the Final Bid Rate to derive the payment rate.

2. Section 1, *Definitions* is hereby amended to delete the definitions for *Bid Rate*, *Final NTE Rate* and *NTE Rate* in their entirety with the following updated definitions:

"Bid Rate" means a rate by plan that reflects the statewide profile with an average relative risk score of 1.0. HCA may require Carrier to submit a Bid Rate by plan that is lower than the Final NTE Bid Rate, in response to 2019-2021 Legislative Budget development, and negotiate a Final Bid Rate for Plan Year 2020.

"Final NTE Rate" or **"Final NTE Bid Rate"** means a rate by plan that reflects the statewide profile with an average relative risk score of 1.0. This is the final not-to-exceed rate by plan negotiated between HCA and the Carrier. This rate will be used to calculate monthly employee premiums by plan on or about March 1, 2019. The Bid Rate and Final Bid Rate by plan, before any adjustment for risk or area factors, cannot exceed this dollar amount for Plan Year 2020. This rate will be added to the Contract via an amendment. This rate may or may not be equal to the Final Bid Rate.

"NTE Rate" or **"NTE Bid Rate"** means a rate by plan that reflects the statewide profile with an average relative risk score of 1.0. This is a not-to-exceed rate by plan a Carrier proposes to HCA in their RFC Response. This rate may or may not be equal to the Final NTE Rate or Final NTE Bid Rate.

3. Section 2.1, *Purpose*, the table is hereby deleted in its entirety and replaced with the following updated table:

December 2018 - February 2019	Release of RFC; Submission of NTE Rates by ASBs; Negotiation of NTE Rates; Negotiation of, and agreement on, Final NTE Rates; and Contract amendment for Final NTE Rates signed for Plan Year 2020
March - June 2019	Negotiation of changes if needed to align with 2019-2021 biennial budget development.
June - August 2019	SEB Board vote on 2020 employee premiums by plan; Submission of Bid Rates by ASBs; Negotiation of, and agreement on, Final Bid Rates; and Contract amendment for Final Bid Rates signed for Plan Year 2020.

4. Section 2.5, *RFC Schedule*, the *RFC Activity Schedule* is hereby deleted in its entirety and replaced with the following updated *RFC Activity Schedule*:

RFC ACTIVITY SCHEDULE		
Item	**Action/Activity**	**Date**
1	HCA releases RFC and Data Book containing 2016-2017 school year data	By December 13, 2018
2	HCA releases updated Data Book that adds 2015-2016 school year data	December 14, 2018
3	HCA releases final Data Book that adds 2017-2018 school year data	December 21, 2018
4	HCA/Carrier conference calls for Q&A; may include Carriers as a group and/or one on one with HCA	December 17, 2018 – January 10, 2019
5	RFC Responses due	January 15, 2019 by 5:00 pm PDT
6	HCA provides feedback and requests second round of NTE Rates, if needed	Week of January 14, 2019
7	HCA provides estimated Employer Medical Contribution (EMC) and associated employee premium contributions by plan	January 31, 2019
8	ASB submits Final NTE Rates	February 8, 2019 by 5:00 PDT
9	NTE Rate negotiations complete	February 15, 2019
10	Execution of Contract amendment to include Final NTE Rates	February 2019 (estimated)
11	HCA provides updated SEBB Funding Rate to the Legislature	March 1, 2019

12	HCA responds to requests and questions from the legislature	January – TBD
13	Legislature enacts 2019-2021 Biennial Budget, which includes SEBB Funding Rate	TBD (approximately April 28, 2019 – June 30, 2019)
14	SEB Board approves employee premiums for Plan Year 2020	July 2019 (estimated)
15	Execution of Contract amendment to include Final Bid Rates	July – August 2019 (estimated)

5. Section 2.7, *Notification of Terms* is hereby deleted in its entirety and replaced by the following updated language:

HCA will document the Final NTE Rates and Final Bid Rates via Contract amendments, as described in Section 2.5, *RFC Schedule*. Once the amendment for the Final Bid Rates has been executed, the ASB cannot make changes to SEBB Program plans or Service Area(s) without the written consent of HCA.

6. The following new section 3.4.5, *Hepatitis C Medication Carve-out* is hereby incorporated:

Carrier must include NTE Rates by plan, both with and without Hepatitis C medication costs. The "without Hepatitis C medications" scenario is referred to as "the carve-out". For the purposes of developing these Bid Rates, Carrier should assume the following:

- HCA will reimburse Carrier for their actual costs of Hepatitis C drugs prescribed per approved coverage criteria, i.e., criteria that are substantially similar as those applied under the Uniform Medical Plan. Actual costs means the actual amount that Carrier paid to pharmacies or to a specialty pharmacy vendor(s), minus any rebates, point of service cost sharing, or discounts Carrier received from or negotiated with manufacturers for Hepatitis C drugs prescribed for the treatment of Carrier's members/patients with Hepatitis C.
- Management of patients and distribution of the medications will remain the responsibility of the Carrier.
- Carrier must include an estimated net cost per patient for a standard course of treatment (such as Mavyret 8-weeks or Epclusa 12-weeks) and estimated annual patient count.

Carriers must include a Hepatitis C medications rate component, e.g., dollar amount, in the appropriate section of the NTE Rate Form (Exhibit A) to indicate how much has been included in the total Bid Rates by plan to cover Hepatitis C medications. Payment rates would be derived from the "without Hepatitis C medications". As set forth above, HCA will reimburse Carrier for their actual costs of these drugs. See Section 3.5.1, *NTE Rate Forms*, for further instructions.

HCA reserves the right to change the approach to the Hepatitis C medication carve-out. In the event of a change, HCA will notify Carrier and may allow Carrier to change Bid Rates, if applicable.

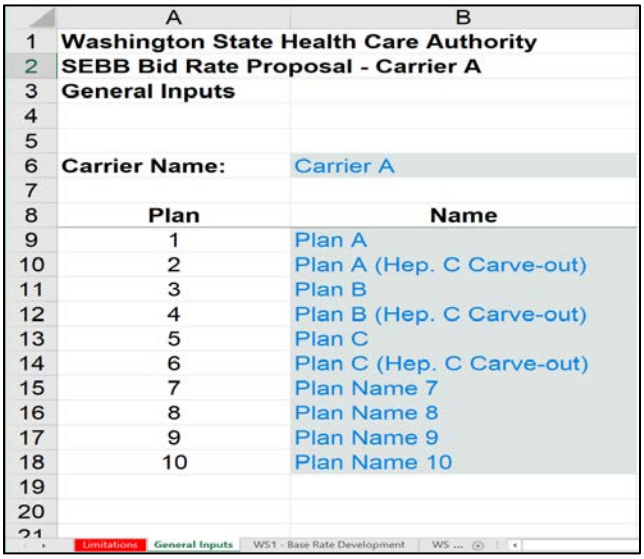
7. The original section 3.4.5 *SEBB Plan or Service Area Changes* has been renumbered to section 3.4.6.

8. Section 3.5.1, *NTE Rate Forms* is hereby deleted in its entirety and replaced with the following updated language:

NTE Rate Form (Exhibit A) and SEBB Rate Proposal Template Instructions (Exhibit A-1) are included in this RFC.

Hepatitis C Medication Carve-out Input Instructions into *EXHIBIT A - NTE Rate Form*:

- "General Inputs" tab
    - Carrier must submit two versions for each plan: 1) with Hepatitis C medication included, and 2) with Hepatitis C medication carved-out.
    - Carrier must input two versions for each plan as a separate cell in Column B – specifically, cells B9:B18.
    - Carrier must include the regular plan name for plan versions that include Hepatitis C medication coverage. For plan versions that do not include Hepatitis C medication coverage, Carrier must add the following tag to the end of the regular plan name: "(Hep. C Carve-out)".
    - Carrier must group the two versions of their plans next to one another, with the version that includes Hepatitis C medication coverage first and the version with Hepatitis C medication carved-out second.
        - *Example:*



	A	B
1	**Washington State Health Care Authority**	
2	**SEBB Bid Rate Proposal - Carrier A**	
3	**General Inputs**	
4		
5		
6	**Carrier Name:**	Carrier A
7		
8	**Plan**	**Name**
9	1	Plan A
10	2	Plan A (Hep. C Carve-out)
11	3	Plan B
12	4	Plan B (Hep. C Carve-out)
13	5	Plan C
14	6	Plan C (Hep. C Carve-out)
15	7	Plan Name 7
16	8	Plan Name 8
17	9	Plan Name 9
18	10	Plan Name 10
19		
20		
21		

Limitations | General Inputs | WS1 - Base Rate Development | WS ...

- "WS2- Plan Rate Development" tab
    - Carrier must enter pricing differentials for Hepatitis C medication benefits into "Other – 1" section on rows 16 and 24.
    - Row 16: In the corresponding cell for the "(Hep. C Carve-out)" plans, Carrier must input the difference in the total cost of the benefit package (i.e., "allowed cost") once Hepatitis C medication benefits are removed.
    - Row 24: In the corresponding cells for the "(Hep. C Carve-out)" plans, Carrier must input any impact to the paid-to-allowed ratio resulting from the removal of Hepatitis C medication benefits.
    - The combination of rows 16 and 24 should result in the total difference in cost to the plan (i.e., "paid claims") from carving out Hepatitis C medication benefits.

9. Section 3.5.3, *Premium and Area Adjustments* is hereby deleted in its entirety and replaced by the following updated language:

The proposed School Employee NTE Rates should reflect your Plans' expected cost based on the entire SEBB School Employee risk pool, as provided in the Data Book, accounting for expected differences in morbidity and geographic membership distributions between the Data Book and 2020.

Payment rates, for months during calendar year 2020, may vary based on Carrier risk and area factors. The SEBB-approved Final Bid Rates will be multiplied by risk and area adjustment factors to determine payment rates by plan (amount paid to the Carrier) for plan year 2020. HCA anticipates adopting the following rate adjustment schedule:

A. Bid Rates

Reflects statewide profile with an average relative risk score of 1.0.

B. Interim Payment Rate(s)

TBD

C. Final Payment Rate

Estimated to be determined in June 2021 and will reflect the complete concurrent risk for Plan Year 2020.

The Employer Medical Contribution (EMC) is collectively bargained to be 85 percent of the monthly premium for the self-insured SEBB UMP Achieve 2 plan—with an estimated actuarial value of 88 percent. The EMC will be applied uniformly across all medical plan offerings within the SEBB portfolio. The employee contribution will be the difference between the Final Bid Rate for the plan selected and the EMC. The EMC rate and employee contribution are multiplied by the tier ratios shown in Table 1 – SEBB Program Tier Rate Structure. The minimum employee premium contribution across all plans and all tiers is collectively bargained to be set at no less than 2 percent of the EMC. HCA may need to provide a final balancing of the proposed rates to ensure the collective bargaining result is achieved and risk adjustment is revenue neutral across all fully insured SEBB Medical Plan carriers and UMP, the State's self-insured plan.

10. Exhibit D, *Certifications and Assurances Form* is hereby deleted in its entirety and replaced by the updated Exhibit D included with this amendment.

The rest of this page has been intentionally left blank.

EXHIBIT D – Certifications and Assurances Form

Health Care Authority Procurement for SEBB Fully Insured Medical Benefits

Completion of this Information form is a **mandatory requirement** for contracting with the Washington State Health Care Authority (HCA). The certifications and assurances contained herein are a required element of the RFC Response.

Contact Person for Carrier's Benefit Design and Rate Proposals **Include Name, telephone number, and e-mail address**	
Contact Person for Certificates of Coverage, Contract Terms, and Carrier's Questionnaire **Include Name, telephone number, and e-mail address**	

1. We declare that all answers and statements made in the RFC Response are true and correct.
2. Our RFC Response is a firm offer until December 31, 2019 and may be accepted by HCA without further negotiation (except where obviously required by lack of certainty in key terms).
3. We have not been assisted in preparing this RFC Response by any current or former HCA employee acting in other than his or her official, public capacity. If there are any exceptions to these assurances or we have been assisted, we will identify and include the following information on a separate page attached to this document for each such individual: (a) name, (b) current address and telephone number, (c) current or former position with HCA, (d) dates of employment with HCA, and (e) detailed description of the assistance provided by the individual.
4. We acknowledge that HCA will not reimburse us for any costs incurred in the preparation of our RFC Response. Materials submitted as part of the RFC Response will become the property of HCA and we claim no proprietary right to the ideas, writings, items or samples.

The undersigned is authorized to bind the ASB to a contract. Under the penalties of perjury of the State of Washington, the undersigned affirms the truthfulness of the statements made herein. The undersigned certifies that the ASB is now, and shall remain, in compliance with the certifications and assurances contained herein, and agrees that such compliance is a condition precedent to the award and continuation of any related contracts. The undersigned acknowledges the ASB's obligation to notify HCA of any changes in the statements, certifications and assurances made herein.

_____

Signature

_____

Title

_____

Organization

_____

Date

Request for Completion (RFC) Amendment

Amendment No. 2

[Insert Carrier Name] Contract #[Insert Contract #]

Date Issued: January 11, 2019

Purpose: Revise section 3.5.3, *Premium and Area Adjustments*.

Amendment need not be submitted with RFC Response. All other terms, conditions, and specifications remain unchanged. The above referenced RFC is amended as follows:

1. Section 3.5.3, *Premium and Area Adjustments*, is hereby deleted and replaced in its entirety with the following:

3.5.3 Premium and Area Adjustments

The proposed School Employee NTE Rates should reflect your Plans' expected cost based on the entire SEBB School Employee risk pool, as provided in the Data Book, accounting for expected differences in morbidity and geographic membership distributions between the Data Book and 2020.

HCA does not know the number of working hours for individuals whose claims are included in the Data Book. Some individuals with claims included in the Data Book may have worked fewer than six hundred thirty (630) hours in the reported school year. Carriers my use their own discretion when deciding whether and how to account for this. RCW 41.05.740(6)(e) requires the SEB Board to, "establish terms and conditions for a school employees' benefits board organization to have the ability to locally negotiate eligibility criteria for a school employee who is anticipated to work less than six hundred thirty hours in a school year. A school employees' benefits board organization that elects to use a lower threshold of hours for benefits eligibility must use benefits authorized by the school employees' benefits board and shall do so as an enrichment to the state's definition of basic education."

As stated in the Request for Proposal 2716, there are approximately 10,500 School Employees who work fewer than 630 hours in a school year. Per the statute, each individual school organization may locally negotiate eligibility for their employees who do not meet SEBB eligibility criteria. The Final Bid Rates will be extended to individuals whose eligibility has been locally negotiated.

Payment rates, for months during calendar year 2020, may vary based on Carrier risk and area factors. The final SEBB-approved Bid Rates will be multiplied by risk and area adjustment factors to determine payment rates by plan (amount paid to the Carrier) for plan year 2020. HCA anticipates adopting the following rate adjustment schedule:

A. Bid Rates

Reflects statewide profile with an average relative risk score of 1.0.

B. Interim Payment Rate(s)

TBD

C. Final Payment Rate

Will be determined in April 2021 and will reflect the complete concurrent risk for Plan Year 2020.

The employer medical contribution (EMC) is collectively bargained to be 85 percent of the monthly premium for the self-insured SEBB UMP Achieve 2 plan—with an estimated actuarial value of 88 percent. The EMC will be applied uniformly across all medical plan offerings within the SEBB portfolio. The employee contribution will be the difference between the Bid Rate for the plan selected and the EMC. The EMC rate and employee contribution are multiplied by the tier ratios shown in Table 1 – SEBB Program Tier Rate Structure. The minimum employee premium contribution across all plans and all tiers is collectively bargained to be set at no less than 2 percent of the EMC. HCA may need to provide a final balancing of the proposed rates to ensure the collective bargaining result is achieved and risk adjustment is revenue neutral across all fully insured SEBB Medical Plan carriers and UMP, the State's self-insured plan.

KPWA/KPWAO & HCA

2020 Rate Negotiation Emails

(with carrier asserted proprietary or confidential information redactions)

From: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>
Sent: Friday, July 19, 2019 3:19 PM
To: Natalie.C.Bell@kp.org; David.S.Holt@kp.org; Bryce.R.Rindahl@kp.org; Todd.A.Hesse@kp.org; John.Lamb@kp.org; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; Getz, Hilary (KP) <Hilary.K.Getz@kp.org>
Cc: Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>; McDermott, Louis (HCA) <lou.mcdermott@hca.wa.gov>; Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Diederich, Ben (Milliman) <Ben.Diederich@milliman.com>; Aaron Gates <aaron.gates@milliman.com>
Subject: Kaiser Plan Year 2020 SEBB Final Rates
Importance: High

Good afternoon,

We are sending this message to inform you of some late changes to the Premera rates. In the interest of full transparency and fairness, HCA is extending you one final chance to review and/or revise your final rates for the SEBB portfolio (see updated rates below).

With the SEB Board scheduled to vote on final rates next Thursday, we require a quick turnaround on your final rate confirmation and would need a response no later than 11:00AM, Monday, July 22nd.

	Proposed 2020 Employee Contribution (Single Subscriber)	EMC (Employer Medical Contribution)	Proposed 2020 Total Composite Rate
Kaiser Permanente NW 1	$28	$555	$583
Kaiser Permanente NW 2	$41	$555	$596
Kaiser Permanente NW 3	$106	$555	$661
Kaiser Permanente WA Core 1	$13	$555	$568
Kaiser Permanente WA Core 2	$19	$555	$574
Kaiser Permanente WA Core 3	$89	$555	$644
Kaiser Permanente WA SoundChoice	$49	$555	$604
Kaiser Permanente WA Options Access PPO 1	$39	$555	$594
Kaiser Permanente WA Options Access PPO 2	$69	$555	$624
Kaiser Permanente WA Options Access PPO 3	$116	$555	$671
Premera Blue Cross High PPO	$70	$555	$625
Premera Blue Cross Peak Care EPO	$31	$555	$586
Premera Blue Cross Standard PPO	$22	$555	$577
Uniform Medical Plan (UMP) Achieve 1	$33	$555	$588
UMP Achieve 2	$98	$555	$653
UMP High Deductible (with a health savings account)	$25	$555	$580
UMP Plus	$68	$555	$623

Tanya Deuel
ERB Finance Manager
Financial Services Division
office: 360.725.0908
cell: 360.764.0149

From: Natalie C. Bell <Natalie.C.Bell@kp.org>
Sent: Thursday, July 11, 2019 3:05 PM
To: Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>
Cc: David S Holt <David.S.Holt@kp.org>; Bryce R. Rindahl <Bryce.R.Rindahl@kp.org>; Todd A Hesse <Todd.A.Hesse@kp.org>; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; John Lamb <John.Lamb@kp.org>; Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Natalie C. Bell <Natalie.C.Bell@kp.org>
Subject: RE: Final PY20 SEBB Rates - KPWA/KPWAO

Thank you Grace. Have a wonderful afternoon.

Kind Regards, Natalie

Natalie C. Bell
Senior Account Consultant, Sales Department
Kaiser Permanente
Office 253-383-7867
Cell 253-212-7120
E-mail Natalie.C.Bell@kp.org

From: Fletcher, Grace (HCA)
Sent: Thursday, July 11, 2019 2:38 PM
To: 'Natalie C. Bell' <Natalie.C.Bell@kp.org>
Cc: David S Holt <David.S.Holt@kp.org>; Bryce R. Rindahl <Bryce.R.Rindahl@kp.org>; 'Todd.A.Hesse@kp.org' <Todd.A.Hesse@kp.org>; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; John Lamb <John.Lamb@kp.org>; Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>
Subject: Final PY20 SEBB Rates - KPWA/KPWAO

Good afternoon,
Thank you for your most recent round of bids. We are considering these final, and will be presenting the information below to the Board on July 18.

Employer Medical Contribution (EMC) = $555

Employee Contributions
(Single Subscriber):

KPWA
Core 1 - $13
Core 2 - $19
Core 3 - $89
SoundChoice - $49

KPWAO
Access PPO 1 - $39
Access PPO 2 - $69
Access PPO 3 - $116

UMP
UMP Achieve 1 - $33
UMP Achieve 2 - $98
UMP High Deductible - $25
UMP Plus - $68

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
ERB Finance
Cell: 360-791-7489

Upcoming Out of Office: 7/12/19

From: Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>
Sent: Tuesday, July 2, 2019 12:29 PM
To: Natalie C. Bell <Natalie.C.Bell@kp.org>
Cc: Diederich, Ben (Milliman) <Ben.Diederich@milliman.com>; Aaron Gates <aaron.gates@milliman.com>; Mike Hamachek <Mike.Hamachek@milliman.com>; David S Holt <David.S.Holt@kp.org>; Bryce R. Rindahl <Bryce.R.Rindahl@kp.org>; Todd A Hesse <Todd.A.Hesse@kp.org>; John Lamb <John.Lamb@kp.org>; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>
Subject: RE: School Employees (SEBB) Rates / Final / Sustainable Rates

Thank you, Natalie and the entire KP team, for the conversations we have had over the past few days so we can finalize the SEBB KPWA rates. I appreciate the effort to come together for these conversations on short notice and during a holiday week.

HCA has had an opportunity to discuss the 2020 rates and the rate guarantee you provided. I want to express how much HCA is looking forward to collaborating with your organization to the benefit of the SEBB members. However, I am declining the offered [redacted] rate cap for all KP plans. Our concern is that accepting that level of rate cap would mistakenly communicate our willingness to find that level of rate increase acceptable. Instead, we will finalize the most recent rates you submitted.

We have recently discussed the HCA's renewed focus on looking at our portfolio and plan offerings so we maximize the value to the member. To that end, we are looking forward to talking with you more this summer and fall about the initiatives detailed in your reply below and how those initiatives can be fully leveraged for our PEBB population.

Thanks so much and Grace will be in touch to finalize rates.

--Megan

Megan Atkinson
Chief Financial Officer
Financial Services Division
office: 360-725-1222
megan.atkinson@hca.wa.gov

Washington State Health Care Authority
www.hca.wa.gov

From: Natalie C. Bell <Natalie.C.Bell@kp.org>
Sent: Monday, July 1, 2019 3:45 PM
To: Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>
Cc: Diederich, Ben (Milliman) <Ben.Diederich@milliman.com>; Aaron Gates <aaron.gates@milliman.com>; Mike Hamachek <Mike.Hamachek@milliman.com>; David S Holt <David.S.Holt@kp.org>; Bryce R. Rindahl <Bryce.R.Rindahl@kp.org>; Todd A Hesse <Todd.A.Hesse@kp.org>; Natalie C. Bell <Natalie.C.Bell@kp.org>; John Lamb <John.Lamb@kp.org>; Molly T. Mchugh <Molly.T.Mchugh@kp.org>
Subject: School Employees (SEBB) Rates / Final / Sustainable Rates

Thank you again for your time on Friday and again today. [redacted]

[redacted]

[redacted]

[redacted]

Please let us know if you have any additional questions.

Kind Regards, Natalie

Natalie C. Bell
Senior Account Consultant, Sales Department
Kaiser Permanente
950 Pacific Avenue, Suite 900
Tacoma, WA 98402
Office 253-383-7867
Cell 253-212-7120
E-mail Natalie.C.Bell@kp.org

From: Natalie C. Bell <Natalie.C.Bell@kp.org>
Sent: Wednesday, June 19, 2019 4:33 PM
To: Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>
Cc: Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Heston, Beth (HCA) <beth.heston@hca.wa.gov>; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; Natalie C. Bell <Natalie.C.Bell@kp.org>
Subject: SEBB Final Rates Submission KPWA & KPWAO

It's the little things. Labeling subject line correctly for submission.

From: Natalie C. Bell
Sent: Wednesday, June 19, 2019 4:27 PM
To: Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Heston, Beth (HCA) <beth.heston@hca.wa.gov>; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; Natalie C. Bell <Natalie.C.Bell@kp.org>
Subject: RE: SEBB Final Rates Submission KPNW

Good afternoon. [redacted]

Attached are the final SEBB 2020 bid rates and underwriting notes for Kaiser Permanente of Washington and Kaiser Permanente of Washington Options, Inc.

The following are updates/changes specific to this submission:

- **Trend Util & Charge (columns Y & Z, WS #1) –** [redacted]
- **Network Impact (row 15, WS #2) –** [redacted]
- **New Entrant Adverse Selection (row 17, WS #2, HMO only) –** [redacted]

Please let us know if you have any questions. We look forward to the following months and the years to follow.

Kind Regards, Natalie

Natalie C. Bell
Senior Account Consultant, Sales Department
Kaiser Permanente
Office 253-383-7867
Cell 253-212-7120
E-mail Natalie.C.Bell@kp.org

[redacted]

[redacted]

From: Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>
Sent: Wednesday, June 12, 2019 4:16 PM
To: Natalie C. Bell <Natalie.C.Bell@kp.org>; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; Hilary K Getz <Hilary.K.Getz@kp.org>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Heston, Beth (HCA) <beth.heston@hca.wa.gov>
Subject: SEBB EMC Update
Importance: High

Good afternoon,

Below is the information, as requested, to assist in your preparation for tomorrow's conference call.

EMC (PAUPM):

- $555

Employee Contributions (Tier 1 – Employee Only):

- UMP Achieve 2 - $98
- UMP Achieve 1 - $33
- UMP Plus - $68
- UMP High Deductible - $25

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
ERB Finance
Cell: 360-791-7489

From: Fletcher, Grace (HCA)
Sent: Wednesday, June 5, 2019 10:09 AM
Subject: SEBB EMC Update
Importance: High

Good morning,

Milliman has evaluated the experience from the latest databook and determined that it will support lower UMP rates than those provided during the NTE phase of the bid rate development process. Accordingly, trend assumptions in the UMP rate development have been updated to reflect the most recent experience available; these trends support lower UMP rates. At this time, we anticipate that the EMC will ultimately fall within the $550 - $565 range—an EMC within this range would be a reduction from the previously shared EMC. Milliman and HCA are working to finalize a number of additional assumptions and will distribute a finalized EMC later in the procurement process. Below is an updated final bid rate development timeline.

Updated Timeline (Tentative):

- **Release Final Area Factors** – last week of May (completed)
- **Release Preliminary EMC Range** – 6/5/19 (completed)
- **Preliminary Round of Final Bid Rates (and updated actuarial memorandum)** – due to HCA 6/7/19
- **Release Final EMC** – ~~on 6/4/19~~ during the week of 6/10/19
- **Release Final UMP Bid Rates** – ~~on or after 6/7/19~~ during the week of 6/10/19
- **One-on-one carrier calls to walk-through Preliminary Final Bid Rate Submission** – 6/13/19 or 6/14/19
- **Final Round of Final Bid Rates** – due to HCA 6/17/19

Please feel free to reach out with any questions.

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
SEBB Finance
Cell: 360-791-7489

From: HCA Contracts <Contracts@HCA.WA.GOV>
Sent: Wednesday, May 29, 2019 2:35 PM
Subject: HCA Request for Completion (RFC) for SEBB Fully Insured Medical Contracts [DO NOT ENCRYPT]

Good afternoon,

HCA is providing the attached updated SEBB area factors to include data from School Year (SY) 2017-18. This version of the area factors uses three years of data (SY15-16 through SY17-18) and updates the prior version, provided 1/9/2019.

Please let me know if you have any questions or concerns. Thank you.

Lesley Houghton
Contracts Specialist
Division of Legal Services
Office of Contracting and Procurement (OCP)
Phone: 360-725-1353
Email: lesley.houghton@hca.wa.gov

From: Fletcher, Grace (HCA)
Sent: Wednesday, May 22, 2019 10:06 AM
To: Molly T. Mchugh <Molly.T.Mchugh@kp.org>
Cc: Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>
Subject: RE: SEBB Data Book V2019.1 - KPWA/KPWAO

Hi Molly,

Attached is an updated version of the SEBB Bid Proposal Template. This version of the template replaces the prior version that was attached to my email from yesterday evening. Please take note of the following minor changes to the "WS 1 – Base Rate Development" worksheet:

- Inputs are re-labeled to use a default experience period of November 2017 – October 2018, or School Year (SY) 2017-18.

- The two columns that were previously used to isolate a single year of trend between SY2016-17 and SY2017-18 have been deleted, since the template assumes an SY2017-18 starting point and the extra year of trend is no longer needed.

Please feel free to let me know if you have any questions.

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
SEBB Finance
Cell: 360-791-7489

Washington State Health Care Authority
www.hca.wa.gov

From: Fletcher, Grace (HCA)
Sent: Tuesday, May 21, 2019 6:37 PM
To: Molly T. Mchugh <Molly.T.Mchugh@kp.org>
Cc: Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>
Subject: SEBB Data Book V2019.1 - KPWA/KPWAO

Hi Molly,

V2019.1 of the SEBB Data Book has been posted to the Milliman FTP site. You can access the SEBB V2019.1 Data Book using the login information provided below.

The due date for submission of the preliminary round of Final Bid Rates will be **June 7, 2019**. HCA and Milliman will review the preliminary submission and will schedule one-on-one calls with each carrier to walk-through/provide feedback on the preliminary submission. Carriers will then have an opportunity to make any adjustments to their bid rates, based on feedback provided by HCA and Milliman, and will submit their official Final Bid Rates to HCA by **June 17, 2019** (COB). Please use the attached Bid Rate Template for submitting your Final Bid Rates.

If you have any questions or would like to schedule a call to discuss the process, please let me know.

Tentative Timeline:

- **Release Final Area Factors** – last week of May
- **Release Final EMC** – on 6/4/19
- **Release Final UMP Bid Rates** – on or after 6/7/19
- **Preliminary Round of Final Bid Rates** – due to HCA 6/7/19
- **Final Round of Final Bid Rates** – due to HCA 6/17/19

Instructions for Final Bid Rate Submission:

- Final Bid Rates should be submitted using the same bid rate template (Exhibit A) that was used for the Final NTE Bid Rates from the RFC (attached).
- Final Bid Rates must be submitted for each plan, including two versions for each plan: 1) with Hepatitis C medication included, and 2) with Hepatitis C medication carved-out.
    - Refer to Hepatitis C Medication Carve-out Input Instructions provided in Section 3.5.1 of RFC Amendment 1 (released on January 4, 2019)
- **As a reminder, the Final Bid Rates cannot exceed the Final Not-to-Exceed (NTE) Bid Rates submitted during the RFC on February 8, 2019.**

How to access the Data Books:

- Go to the following website - https://ftp.milliman.com/EFTClient/Account/Login.htm
- [redacted]
- Password – updated password will be provided in a separate email from Milliman

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
SEBB Finance
Cell: 360-791-7489

Washington State Health Care Authority
www.hca.wa.gov

KPNW & HCA

2020 Rate Negotiation Emails

(with carrier asserted proprietary or confidential information redactions)

From: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>
Sent: Friday, July 19, 2019 3:19 PM
To: Natalie.C.Bell@kp.org; David.S.Holt@kp.org; Bryce.R.Rindahl@kp.org; Todd.A.Hesse@kp.org; John.Lamb@kp.org; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; Getz, Hilary (KP) <Hilary.K.Getz@kp.org>
Cc: Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>; McDermott, Louis (HCA) <lou.mcdermott@hca.wa.gov>; Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Diederich, Ben (Milliman) <Ben.Diederich@milliman.com>; Aaron Gates <aaron.gates@milliman.com>
Subject: Kaiser Plan Year 2020 SEBB Final Rates
Importance: High

Good afternoon,

We are sending this message to inform you of some late changes to the Premera rates. In the interest of full transparency and fairness, HCA is extending you one final chance to review and/or revise your final rates for the SEBB portfolio (see updated rates below).

With the SEB Board scheduled to vote on final rates next Thursday, we require a quick turnaround on your final rate confirmation and would need a response no later than 11:00AM, Monday, July 22nd.

	Proposed 2020 Employee Contribution (Single Subscriber)	EMC (Employer Medical Contribution)	Proposed 2020 Total Composite Rate
Kaiser Permanente NW 1	$28	$555	$583
Kaiser Permanente NW 2	$41	$555	$596
Kaiser Permanente NW 3	$106	$555	$661
Kaiser Permanente WA Core 1	$13	$555	$568
Kaiser Permanente WA Core 2	$19	$555	$574
Kaiser Permanente WA Core 3	$89	$555	$644
Kaiser Permanente WA SoundChoice	$49	$555	$604
Kaiser Permanente WA Options Access PPO 1	$39	$555	$594
Kaiser Permanente WA Options Access PPO 2	$69	$555	$624
Kaiser Permanente WA Options Access PPO 3	$116	$555	$671
Premera Blue Cross High PPO	$70	$555	$625
Premera Blue Cross Peak Care EPO	$31	$555	$586
Premera Blue Cross Standard PPO	$22	$555	$577
Uniform Medical Plan (UMP) Achieve 1	$33	$555	$588
UMP Achieve 2	$98	$555	$653
UMP High Deductible (with a health savings account)	$25	$555	$580
UMP Plus	$68	$555	$623

Tanya Deuel
ERB Finance Manager
Financial Services Division
office: 360.725.0908
cell: 360.764.0149

From: Hilary K Getz <Hilary.K.Getz@kp.org>
Sent: Thursday, July 11, 2019 2:57 PM
To: Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; Natalie C. Bell <Natalie.C.Bell@kp.org>
Subject: RE: Final PY20 SEBB Rates - KPNW

Received – thank you!

Hilary K. Getz
Executive Account Manager
500 NE Multnomah, Ste. 100
Portland, OR 97232
(503) 813-4616
(503) 407-7967 cell
Hilary.K.Getz@kp.org

Brigette Pache, Sr. Associate Account Manager
(503) 813-3692
Brigette.X.Pache@kp.org

Shelly Taylor, Associate Account Manager
(503) 813-3068
Shelly.Taylor@kp.org

From: Fletcher, Grace (HCA)
Sent: Thursday, July 11, 2019 2:37 PM
To: Getz, Hilary (KP) <Hilary.K.Getz@kp.org>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; 'Natalie C. Bell' <Natalie.C.Bell@kp.org>
Subject: Final PY20 SEBB Rates - KPNW

Good afternoon,
Thank you for your most recent round of bids. We are considering these final, and will be presenting the information below to the Board on July 18.

Employer Medical Contribution (EMC) = $555

Employee Contributions
(Single Subscriber):

KPNW
KPNW 1 - $28
KPNW 2 - $41
KPNW 3 - $106

UMP
UMP Achieve 1 - $33
UMP Achieve 2 - $98
UMP High Deductible - $25
UMP Plus - $68

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
ERB Finance
Cell: 360-791-7489
Upcoming Out of Office: 7/12/19

[redacted]

[redacted]

[redacted]

Washington State Health Care Authority
www.hca.wa.gov

[redacted]

[redacted]

From: Hilary K Getz <Hilary.K.Getz@kp.org>
Sent: Monday, June 17, 2019 4:29 PM
To: Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Heston, Beth (HCA) <beth.heston@hca.wa.gov>; Natalie C. Bell <Natalie.C.Bell@kp.org>; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; Jennifer E. Stacy <Jennifer.E.Stacy@kp.org>; TROY E MARCOE <Troy.E.Marcoe@kp.org>
Subject: SEBB Final Rates Submission KPNW

Good afternoon, we are pleased to provide our final KPNW SEBB 2020 bid rates and accompanying actuarial memorandum. As always, we welcome any questions you may have. We look forward to the next steps in this process. Thank you!

- Hilary

Hilary K. Getz
Executive Account Manager
500 NE Multnomah, Ste. 100
Portland, OR 97232

(503) 813-4616
(503) 407-7967 cell
Hilary.K.Getz@kp.org

Brigette Pache, Sr. Associate Account Manager
(503) 813-3692
Brigette.X.Pache@kp.org

Shelly Taylor, Associate Account Manager
(503) 813-3068
Shelly.Taylor@kp.org

From: Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>
Sent: Wednesday, June 12, 2019 4:16 PM
To: Natalie C. Bell <Natalie.C.Bell@kp.org>; Molly T. Mchugh <Molly.T.Mchugh@kp.org>; Hilary K Getz <Hilary.K.Getz@kp.org>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Heston, Beth (HCA) <beth.heston@hca.wa.gov>
Subject: SEBB EMC Update
Importance: High

Good afternoon,

Below is the information, as requested, to assist in your preparation for tomorrow's conference call.

EMC (PAUPM):

- $555

Employee Contributions (Tier 1 – Employee Only):

- UMP Achieve 2 - $98
- UMP Achieve 1 - $33
- UMP Plus - $68
- UMP High Deductible - $25

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
ERB Finance
Cell: 360-791-7489

From: Fletcher, Grace (HCA)
Sent: Wednesday, June 5, 2019 10:09 AM
Subject: SEBB EMC Update
Importance: High

Good morning,

Milliman has evaluated the experience from the latest databook and determined that it will support lower UMP rates than those provided during the NTE phase of the bid rate development process. Accordingly, trend assumptions in the UMP rate development have been updated to reflect the most recent experience available; these trends support lower UMP rates. At this time, we anticipate that the EMC will ultimately fall within the $550 - $565 range—an EMC within this range would be a reduction from the previously shared EMC. Milliman and HCA are working to finalize a number of additional assumptions and will distribute a finalized EMC later in the procurement process. Below is an updated final bid rate development timeline.

Updated Timeline (Tentative):

- **Release Final Area Factors** – last week of May (completed)
- **Release Preliminary EMC Range** – 6/5/19 (completed)
- **Preliminary Round of Final Bid Rates (and updated actuarial memorandum)** – due to HCA 6/7/19

- **Release Final EMC** – ~~on 6/4/19~~ during the week of 6/10/19
- **Release Final UMP Bid Rates** – ~~on or after 6/7/19~~ during the week of 6/10/19
- **One-on-one carrier calls to walk-through Preliminary Final Bid Rate Submission** – 6/13/19 or 6/14/19
- **Final Round of Final Bid Rates** – due to HCA 6/17/19

Please feel free to reach out with any questions.

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
SEBB Finance
Cell: 360-791-7489

From: HCA Contracts <Contracts@HCA.WA.GOV>
Sent: Wednesday, May 29, 2019 2:35 PM
Subject: HCA Request for Completion (RFC) for SEBB Fully Insured Medical Contracts [DO NOT ENCRYPT]

Good afternoon,

HCA is providing the attached updated SEBB area factors to include data from School Year (SY) 2017-18. This version of the area factors uses three years of data (SY15-16 through SY17-18) and updates the prior version, provided 1/9/2019.

Please let me know if you have any questions or concerns. Thank you.

Lesley Houghton
Contracts Specialist
Division of Legal Services
Office of Contracting and Procurement (OCP)
Phone: 360-725-1353
Email: lesley.houghton@hca.wa.gov

From: Fletcher, Grace (HCA)
Sent: Wednesday, May 22, 2019 10:06 AM
To: Getz, Hilary (KP) <Hilary.K.Getz@kp.org>
Cc: Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>
Subject: RE: SEBB Data Book V2019.1 - KPNW

Hi Hilary,

Attached is an updated version of the SEBB Bid Proposal Template. This version of the template replaces the prior version that was attached to my email from yesterday evening. Please take note of the following minor changes to the "WS 1 – Base Rate Development" worksheet:

- Inputs are re-labeled to use a default experience period of November 2017 – October 2018, or School Year (SY) 2017-18.
- The two columns that were previously used to isolate a single year of trend between SY2016-17 and SY2017-18 have been deleted, since the template assumes an SY2017-18 starting point and the extra year of trend is no longer needed.

Please feel free to let me know if you have any questions.

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
SEBB Finance
Cell: 360-791-7489

Washington State Health Care Authority

www.hca.wa.gov

From: Fletcher, Grace (HCA)
Sent: Tuesday, May 21, 2019 6:36 PM
To: Getz, Hilary (KP)
Cc: Johnston, Lauren (HCA) ; Deuel, Tanya (HCA)
Subject: SEBB Data Book V2019.1 - KPNW

Hi Hilary,

V2019.1 of the SEBB Data Book has been posted to the Milliman FTP site. You can access the SEBB V2019.1 Data Book using the login information provided below.

The due date for submission of the preliminary round of Final Bid Rates will be **June 7, 2019**. HCA and Milliman will review the preliminary submission and will schedule one-on-one calls with each carrier to walk-through/provide feedback on the preliminary submission. Carriers will then have an opportunity to make any adjustments to their bid rates, based on feedback provided by HCA and Milliman, and will submit their official Final Bid Rates to HCA by **June 17, 2019** (COB). Please use the attached Bid Rate Template for submitting your Final Bid Rates.

If you have any questions or would like to schedule a call to discuss the process, please let me know.

Tentative Timeline:

- **Release Final Area Factors** – last week of May
- **Release Final EMC** – on 6/4/19
- **Release Final UMP Bid Rates –** on or after 6/7/19
- **Preliminary Round of Final Bid Rates** – due to HCA 6/7/19
- **Final Round of Final Bid Rates** – due to HCA 6/17/19

Instructions for Final Bid Rate Submission:

- Final Bid Rates should be submitted using the same bid rate template (Exhibit A) that was used for the Final NTE Bid Rates from the RFC (attached).
- Final Bid Rates must be submitted for each plan, including two versions for each plan: 1) with Hepatitis C medication included, and 2) with Hepatitis C medication carved-out.
    - Refer to Hepatitis C Medication Carve-out Input Instructions provided in Section 3.5.1 of RFC Amendment 1 (released on January 4, 2019).
- **As a reminder, the Final Bid Rates cannot exceed the Final Not-to-Exceed (NTE) Bid Rates submitted during the RFC on February 8, 2019.**

How to access the Data Books:

- Go to the following website - https://ftp.milliman.com/EFTClient/Account/Login.htm
[redacted] Login User Name – [redacted]
- Password – updated password will be provided in a separate email from Milliman

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
SEBB Finance
Cell: 360-791-7489

Premera & HCA

2020 Rate Negotiation Emails

(with carrier asserted proprietary or confidential information redactions)

From: Ken Chandler <Ken.Chandler@PREMERA.com>
Sent: Friday, July 19, 2019 3:30 PM
To: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Randy Christensen <Randy.Christensen@PREMERA.com>; Hiu-wan Ko <Hiu-Wan.Ko@PREMERA.com>; Thomas Bonin <Thomas.Bonin@PREMERA.com>; Rebecca Peterson <Rebecca.Peterson@PREMERA.com>
Cc: Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>; McDermott, Louis (HCA) <lou.mcdermott@hca.wa.gov>; Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Diederich, Ben (Milliman) <Ben.Diederich@milliman.com>; Aaron Gates <aaron.gates@milliman.com>
Subject: RE: Updated Premera Proposed Rates for SEBB 2020.1.1

Thank you Tanya (and HCA Team). We appreciate the ability to adjust rates this late in the game. Have a great weekend.

Ken Chandler
425-918-4731
ken.chandler@premera.com

From: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>
Sent: Friday, July 19, 2019 3:22 PM
To: Randy.Christensen@PREMERA.com; Ken.Chandler@PREMERA.com; Hiu-Wan.Ko@PREMERA.com; Thomas.Bonin@PREMERA.com; Rebecca.Peterson@PREMERA.com
Cc: Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>; McDermott, Louis (HCA) <lou.mcdermott@hca.wa.gov>; Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Diederich, Ben (Milliman) <Ben.Diederich@milliman.com>; Aaron Gates <aaron.gates@milliman.com>
Subject: RE: Updated Premera Proposed Rates for SEBB 2020.1.1
Importance: High

Good afternoon,

Thank you for your updated rates, we are considering these your final rates and will present these to the SEB Board next week, July 25th for a vote.

In the interest of full transparency and partnership, we wanted to inform you that HCA is extending an opportunity for Kaiser to have one final chance to adjust their rates in response to these recent developments.

Below are your updated rates that we will be including in the board materials for next week.

	Proposed 2020 Employee Contribution (Single Subscriber)	EMC (Employer Medical Contribution)	Proposed 2020 Total Composite Rate
Premera Blue Cross High PPO	$70	$555	$625
Premera Blue Cross Peak Care EPO	$31	$555	$586
Premera Blue Cross Standard PPO	$22	$555	$577

Tanya Deuel
ERB Finance Manager
Financial Services Division
office: 360.725.0908
cell: 360.764.0149

From: Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>
Sent: Friday, July 19, 2019 1:03 PM
To: Ken Chandler <Ken.Chandler@PREMERA.com>; Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>; Randy Christensen <Randy.Christensen@PREMERA.com>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Hiu-wan Ko <Hiu-Wan.Ko@PREMERA.com>
Subject: RE: Premera proposed rates

Thank you, Ken. I appreciate the response. We'll be in touch later today.

--Megan

Megan Atkinson
Chief Financial Officer
Financial Services Division
office: 360-725-1222
megan.atkinson@hca.wa.gov

Washington State Health Care Authority
www.hca.wa.gov

From: Ken Chandler <Ken.Chandler@PREMERA.com>
Sent: Friday, July 19, 2019 12:59 PM
To: Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>; Randy Christensen <Randy.Christensen@PREMERA.com>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Hiu-wan Ko <Hiu-Wan.Ko@PREMERA.com>
Subject: RE: Premera proposed rates

Hi Megan,

This does help clarify and our team didn't catch the expectation about a response, and we apologize. Randy and Hiu-wan did discuss the notion of a guarantee with others at Premera. Our conclusion is that we are unable to give a guarantee on this fully insured product at either rate level (our initial or the new rates sent), that we land on for year one. Premera clearly understands the long-term play involved in exchange business (and at this time have managed over eight million member months through exchange business), Premera wants to be involved with the K-12 employees and their families for the next 50 years, and is planning to be your partner for SEB for years to come.

Ken Chandler
425-918-4731
ken.chandler@premera.com

From: Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>
Sent: Friday, July 19, 2019 12:08 PM
To: Ken Chandler <Ken.Chandler@PREMERA.com>; Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>; Randy Christensen <Randy.Christensen@PREMERA.com>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Hiu-wan Ko <Hiu-Wan.Ko@PREMERA.com>
Subject: [EXTERNAL] RE: Premera proposed rates

HI Ken,

Thanks for the reply.

In the conversation we had earlier this week regarding the proposed lower Premera rates HCA discussed, at length, our concerns about aggressiveness in the Premera rates and how the margin and trend assumption changes that Premera made might not be sustainable past the first year of the program. That potential situation could result in a negative member experience. We are not requiring a rate guarantee. We asked that Premera discuss the ability of the organization to provide a rate guarantee. We also discussed some options for how a guarantee could possibly be structured.

Dave and I thought that conversation was happening within Premera and expected to hear back yesterday.

Does this help clarify?

--Megan

Megan Atkinson
Chief Financial Officer
Financial Services Division
office: 360-725-1222
megan.atkinson@hca.wa.gov

From: Ken Chandler <Ken.Chandler@PREMERA.com>
Sent: Friday, July 19, 2019 11:29 AM
To: Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>; Randy Christensen <Randy.Christensen@PREMERA.com>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Hiu-wan Ko <Hiu-Wan.Ko@PREMERA.com>
Subject: RE: Premera proposed rates

HI Dave,

I'm sorry I missed the call on Wednesday. I'm unclear what Premera is being asked to guarantee? Under the fully insured exchange model that SEB is, year to year to year, carriers will need to adjust rates based on membership capture and performance of that membership. If a carrier increases too much from one year to another, members have the ability to decide and select another carrier. Our initial rates didn't require a guarantee, and because we are asking if we can lowering our current rates using the new June trend data (and I agree we are very late in this request, but it does benefit the SEB membership), we now need a guarantee, I'm struggling with the ask. If the concern is that we will increase in year two, given how an exchange works, that same concern should always exist. If the new lower rates cannot be accepted without a guarantee we fully understand.

I can jump on a call to discuss further if I'm missing something else about this request.

Ken Chandler
425-918-4731
ken.chandler@premera.com

From: Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>
Sent: Friday, July 19, 2019 9:14 AM
To: Randy Christensen <Randy.Christensen@PREMERA.com>; Ken Chandler <Ken.Chandler@PREMERA.com>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>
Subject: [EXTERNAL] Re: Premera proposed rates

Ken and Randy,

Megan and I just spoke and based on the call Wednesday, we left off expecting insight from premera on a rate guarantee related to the new rates.

We need your response to our rate guarantee request by 1pm today.

Dave
Sent from my iPhone

On Jul 19, 2019, at 8:41 AM, Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov> wrote:

HI Randy and Ken,

I just want to follow-up from our conversations earlier this week regarding updated Premera rates. As you know, we left off with HCA requesting a rate guarantee. I believe you will be responding yesterday. I don't believe we received a response. To ensure your response to our request doesn't get lost, please include Tanya Deuel and Grace Fletcher on your reply. They will be monitoring email. I have included Tanya and Grace on this message so you will have their email addresses.

Thanks,
Megan

Megan Atkinson
Chief Financial Officer
Financial Services Division
office: 360-725-1222
megan.atkinson@hca.wa.gov

From: Hiu-wan Ko <Hiu-Wan.Ko@PREMERA.com>
Sent: Wednesday, July 17, 2019 2:07 PM
To: Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>; Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>
Cc: Randy Christensen <Randy.Christensen@PREMERA.com>; Ken Chandler <Ken.Chandler@PREMERA.com>
Subject: Updated Premera Proposed Rates for SEBB 2020.1.1

Hello Grace and Lauren,

Attached is the updated SEBB rate proposal for PBC.

Also, my understanding is that the Rx deductible for the $750 High PPO and $750 Peak Care EPO have been updated to $125 waived for preferred generic. If this is different than your understanding, please let us know.

Thanks,

Hiu-Wan Ko, FSA, MAAA
Director, Actuarial Services
Premera Blue Cross

425-918-4917

From: Atkinson, Megan M. (HCA)
Sent: Wednesday, July 17, 2019 12:30 PM
To: 'Ken Chandler' <Ken.Chandler@PREMERA.com>; Randy Christensen <Randy.Christensen@PREMERA.com>
Cc: Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>
Subject: RE: Premera proposed rates

Hi Ken and Randy,

Thank you for contacting us with the possibility for updated Premera rates. Due to the timing of a new rate submission, I want to confirm your process for a new submission.

Please submit updated rate sheets to Lauren Johnston and Grace Fletcher at their HCA email addresses. We want to be able to receive this information and process this quickly.

--Megan

Megan Atkinson
Chief Financial Officer
Financial Services Division
office: 360-725-1222
megan.atkinson@hca.wa.gov

From: Ken Chandler <Ken.Chandler@PREMERA.com>
Sent: Wednesday, July 17, 2019 11:23 AM
To: Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>; Randy Christensen <Randy.Christensen@PREMERA.com>
Cc: Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>
Subject: Re: Premera proposed rates

Hi Dave,
Thank you. We have our actuaries assessing right now and will submit adjustments through the tool. Aiming at 2:00, and I'll keep you posted.
[redacted]
More to come.

Ken Chandler

425-918-4731

ken.chandler@premera.com

From: Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>
Sent: Wednesday, July 17, 2019 11:12:26 AM
To: Randy Christensen <Randy.Christensen@PREMERA.com>
Cc: Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Ken Chandler <Ken.Chandler@PREMERA.com>
Subject: [EXTERNAL] Re: Premera proposed rates

Randy,

We cannot make any promises given the timing of your request, but we would review any submission that you make that could possibly lower rates.

If you submit additional lower rates for review - via the same process and to the same people you have submitted in the process - we will review that and get back to you as quickly as possible.

We need you to submit anything you want us to review as quickly as possible. Preferably by 2:00 today if at all possible.

Dave

Sent from my iPhone

From: Randy Christensen <Randy.Christensen@PREMERA.com>
Sent: Wednesday, July 17, 2019 9:05 AM
To: Iseminger, David M. (HCA) <dave.iseminger@hca.wa.gov>
Subject: Premera proposed rates

Dave,

As we continue to analyze our pricing, we believe that we could offer lower pricing than our initially submitted rates. We respect the entire process of submitting programs and pricing and are not attempting to circumvent the process. But, if there is a process to provide an even better cost structure, we would like to provide it.

Thanks for in advance for your thoughts, Dave.

Best regards,

Randy

RANDY CHRISTENSEN | DIRECTOR, LABOR ACCOUNTS & PUBLIC PLANS | PREMERA BLUE CROSS | 425.918.3692

Assistant: Michelle.Primc@Premera.com | 425.918.8202

From: Fletcher, Grace (HCA)
Sent: Thursday, July 11, 2019 2:39 PM
To: 'Thomas Bonin' <Thomas.Bonin@PREMERA.com>; 'Randy Christensen' <Randy.Christensen@PREMERA.com>
Cc: Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Atkinson, Megan M. (HCA) <megan.atkinson@hca.wa.gov>; Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>
Subject: Final PY20 SEBB Rates - Premera

Good afternoon,

Thank you for your most recent round of bids. We are considering these final, and will be presenting the information below to the Board on July 18.

Employer Medical Contribution (EMC) = $555

Employee Contributions
(Single Subscriber):

Premera
High PPO - $98
Peak Care EPO - $80
Standard PPO - $48

UMP
UMP Achieve 1 - $33
UMP Achieve 2 - $98
UMP High Deductible - $25
UMP Plus - $68

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
ERB Finance
Cell: 360-791-7489
Upcoming Out of Office: 7/12/19

From: Thomas Bonin <Thomas.Bonin@PREMERA.com>
Sent: Monday, June 17, 2019 4:46 PM
To: Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>
Cc: Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>; Randy Christensen <Randy.Christensen@PREMERA.com>; Proposal Development <PropDev@PREMERA.com>; Rebecca Peterson <Rebecca.Peterson@PREMERA.com>
Subject: RE: SEBB Data Book V2019.1 - Premera
Importance: High

Good afternoon,

This email is to confirm that Premera will not be submitting a final round of bid rates as our rates have not changed. Considering our recent decision to expand into Snohomish County with the $1250/$250 plan, is there any additional documentation you need from us at this point?

Regards,

Thomas Bonin
Sr. RFP Specialist
Premera Blue Cross

From: Thomas Bonin
Sent: Friday, June 7, 2019 3:12 PM
To: Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>
Cc: Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Deuel, Tanya (HCA <tanya.deuel@hca.wa.gov>; Randy Christensen <Randy.Christensen@PREMERA.com>; Proposal Development <PropDev@PREMERA.com>; Rebecca Peterson <Rebecca.Peterson@PREMERA.com>

Subject: FW: SEBB Data Book V2019.1 - Premera
Importance: High

Good afternoon,

Please find attached Premera's updated bid rate template and actuarial memorandum.

We look forward to the next steps in the process.

Best regards,

Thomas Bonin
Sr. RFP Specialist
Premera Blue Cross

From: Fletcher, Grace (HCA)
Sent: Wednesday, June 5, 2019 10:09 AM
Subject: SEBB EMC Update
Importance: High

Good morning,

Milliman has evaluated the experience from the latest databook and determined that it will support lower UMP rates than those provided during the NTE phase of the bid rate development process. Accordingly, trend assumptions in the UMP rate development have been updated to reflect the most recent experience available; these trends support lower UMP rates. At this time, we anticipate that the EMC will ultimately fall within the $550 - $565 range—an EMC within this range would be a reduction from the previously shared EMC. Milliman and HCA are working to finalize a number of additional assumptions and will distribute a finalized EMC later in the procurement process. Below is an updated final bid rate development timeline.

Updated Timeline (Tentative):

- **Release Final Area Factors** – last week of May (completed)
- **Release Preliminary EMC Range** – 6/5/19 (completed)
- **Preliminary Round of Final Bid Rates (and updated actuarial memorandum)** – due to HCA 6/7/19
- **Release Final EMC** – ~~on 6/4/19~~ during the week of 6/10/19
- **Release Final UMP Bid Rates** – ~~on or after 6/7/19~~ during the week of 6/10/19
- **One-on-one carrier calls to walk-through Preliminary Final Bid Rate Submission** – 6/13/19 or 6/14/19
- **Final Round of Final Bid Rates** – due to HCA 6/17/19

Please feel free to reach out with any questions.

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
SEBB Finance
Cell: 360-791-7489

From: HCA Contracts <Contracts@HCA.WA.GOV>
Sent: Wednesday, May 29, 2019 2:35 PM
Subject: HCA Request for Completion (RFC) for SEBB Fully Insured Medical Contracts [DO NOT ENCRYPT]

Good afternoon,

HCA is providing the attached updated SEBB area factors to include data from School Year (SY) 2017-18. This version of the area factors uses three years of data (SY15-16 through SY17-18) and updates the prior version, provided 1/9/2019.

Please let me know if you have any questions or concerns. Thank you.

Lesley Houghton
Contracts Specialist
Division of Legal Services
Office of Contracting and Procurement (OCP)
Phone: 360-725-1353
Email: lesley.houghton@hca.wa.gov

From: Fletcher, Grace (HCA)
Sent: Wednesday, May 22, 2019 10:05 AM
To: randy.christensen@premera.com
Cc: Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>
Subject: RE: SEBB Data Book V2019.1 - Premera

Hi Randy,

Attached is an updated version of the SEBB Bid Proposal Template. This version of the template replaces the prior version that was attached to my email from yesterday evening. Please take note of the following minor changes to the "WS 1 – Base Rate Development" worksheet:

- Inputs are re-labeled to use a default experience period of November 2017 – October 2018, or School Year (SY) 2017-18.
- The two columns that were previously used to isolate a single year of trend between SY2016-17 and SY2017-18 have been deleted, since the template assumes an SY2017-18 starting point and the extra year of trend is no longer needed.

Please feel free to let me know if you have any questions.

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
SEBB Finance
Cell: 360-791-7489

From: Fletcher, Grace (HCA) <grace.fletcher@hca.wa.gov>
Sent: Tuesday, May 21, 2019 6:35 PM
To: randy.christensen@premera.com
Cc: Johnston, Lauren (HCA) <lauren.johnston@hca.wa.gov>; Deuel, Tanya (HCA) <tanya.deuel@hca.wa.gov>
Subject: SEBB Data Book V2019.1 - Premera

Hi Randy,

V2019.1 of the SEBB Data Book has been posted to the Milliman FTP site. You can access the SEBB V2019.1 Data Book using the login information provided below.

The due date for submission of the preliminary round of Final Bid Rates will be **June 7, 2019**. HCA and Milliman will review the preliminary submission and will schedule one-on-one calls with each carrier to walk-through/provide feedback on the preliminary submission. Carriers will then have an opportunity to make any adjustments to their bid rates, based on feedback provided by HCA and Milliman, and will submit their official Final Bid Rates to HCA by **June 17, 2019** (COB). Please use the attached Bid Rate Template for submitting your Final Bid Rates.

If you have any questions or would like to schedule a call to discuss the process, please let me know.

Tentative Timeline:

- **Release Final Area Factors** – last week of May
- **Release Final EMC** – on 6/4/19
- **Release Final UMP Bid Rates** – on or after 6/7/19
- **Preliminary Round of Final Bid Rates** – due to HCA 6/7/19
- **Final Round of Final Bid Rates** – due to HCA 6/17/19

Instructions for Final Bid Rate Submission:

- Final Bid Rates should be submitted using the same bid rate template (Exhibit A) that was used for the Final NTE Bid Rates from the RFC (attached).
- Final Bid Rates must be submitted for each plan, including two versions for each plan: 1) with Hepatitis C medication included, and 2) with Hepatitis C medication carved-out.
    - Refer to Hepatitis C Medication Carve-out Input Instructions provided in Section 3.5.1 of RFC Amendment 1 (released on January 4, 2019)
- **As a reminder, the Final Bid Rates cannot exceed the Final Not-to-Exceed (NTE) Bid Rates submitted during the RFC on February 8, 2019.**

How to access the Data Books:

- Go to the following website - https://ftp.milliman.com/EFTClient/Account/Login.htm
[redacted]

Regards,

Grace A. Fletcher
Fiscal Information & Data Analyst
SEBB Finance
Cell: 360-791-7489

Washington State Health Care Authority
www.hca.wa.gov

Carrier & HCA Signed Contracts

Exhibit 3

Washington State Health Care Authority	**PROFESSIONAL SERVICES CONTRACT** **for Fully Insured Group Medical Plan**	HCA Contract Number: K3022 Resulting from Solicitation Number: RFP2716

THIS CONTRACT is made by and between Washington State Health Care Authority, (HCA) and Kaiser Foundation Health Plan of Washington, (Contractor).

CONTRACTOR NAME		CONTRACTOR DOING BUSINESS AS (DBA)		
Kaiser Foundation Health Plan of Washington				
CONTRACTOR ADDRESS | Street		City	State	Zip Code
601 Union Street, Suite 3100		Seattle	WA	98101
CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR E-MAIL ADDRESS		
Natalie C. Bell	(253) 383-7867	Natalie.C.Bell@kp.org		
Is Contractor a Subrecipient under this Contract?	CFDA NUMBER(S):	FFATA Form Required		
☐YES ☒NO		☐YES ☒NO		

HCA PROGRAM	HCA DIVISION/SECTION
School Employees Benefits Board (SEBB) Program	Employees and Retirees Benefits (ERB) Division
HCA CONTACT NAME AND TITLE Beth Heston, HCA Contract Manager	HCA CONTACT ADDRESS Health Care Authority PO Box 42684 Olympia, WA 98504
HCA CONTACT TELEPHONE (360) 725-0865	HCA CONTACT E-MAIL ADDRESS Beth.Heston@hca.wa.gov

CONTRACT START DATE	CONTRACT END DATE	TOTAL MAXIMUM CONTRACT AMOUNT
Implementation Start Date: DOE Plan Year Start Date: January 1, 2020	December 31, 2023	PSPM

PURPOSE OF CONTRACT:

Contractor agrees to provide all contracted insurance plans and administrative services, as herein specified, for Members enrolled in the School Employees Benefits Board (SEBB) Program.

The parties signing below warrant that they have read and understand this Contract, and have authority to execute this Contract. This Contract will be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
Joseph E. Smith	Joseph E. Smith, Vice President	7/3/19
HCA SIGNATURE DocuSigned by: Annette Schuffenhauer 4F259FCAF7C2450...	**PRINTED NAME AND TITLE** Annette Schuffenhauer Chief Legal Officer	**DATE SIGNED** 7/3/2019

EXHIBIT 3 – RATE DEVELOPMENT PROCESS

Request for Completion (RFC)

HCA released a one-time RFC on December 13, 2018 to obtain binding not-to-exceed (NTE) Rates. Contractor NTE Rates will be based on the final plan design options that were approved by the SEB Board on November 8, 2018. To develop rates, Contractors will use their current School Employee enrollment data in combination with the Data Book of summarized historical School Employee data provided by HCA. The Final NTE Rates established during the RFC will be relied upon by HCA to advise the Washington State Legislature during the 2019 legislative session(s). HCA anticipates completing the process of obtaining, negotiating, and agreeing to Final NTE Rates and Final Bid Rates in the following phases:

Rate Development Phases

December 2018 - February 2019	Release of RFC, submission of NTE Rates by Contractor, and negotiation of Final NTE Rates.
March - June 2019	Negotiation of changes if needed to align with 2019-2021 biennial budget development.
June - August 2019	SEB Board vote on 2020 employee premiums by plan and Contract amendment for Final Bid Rates signed for Plan Year 2020.

Employer Medical Contribution and Final Bid Rates

The Employer Medical Contribution (EMC) is collectively bargained to be 85 percent of the monthly premium for the self-insured SEBB UMP Achieve 2 plan—with an estimated actuarial value of 88 percent. The EMC will be applied uniformly across all medical plan offerings within the SEBB portfolio. The employee contribution will be the difference between the Final Bid Rate for the plan selected and the EMC. The EMC rate is multiplied by the SEBB-approved tier ratios to derive the amounts that the employee and employer will contribute by tier. The minimum employee premium contribution across all plans and all tiers is collectively bargained to be set at no less than 2 percent of the EMC.

Rate Adjustment Process

Rate adjustments will include the application of risk and area factors to the Final Bid Rates for Plan Year 2020. Rate adjustment(s) will be revenue neutral across all SEBB medical plans, and will be calculated and shared with the Contractor periodically. Rate adjustments may or may not change actual amounts paid to Contractor during Plan Year 2020. Amounts paid to Contractor may be equal to the Final Bid Rates until there is a “true up” that implements the Interim and Final Payment Rates, outlined in the below rate adjustment schedule.

HCA anticipates determining Final Payment Rates and adjusting amounts paid to Carrier for Plan Year 2020 by June 30, 2021. HCA anticipates adopting the following rate adjustment schedule:

Rate Adjustment Schedule

Final Bid Rates	Reflects statewide profile with an average relative risk score of 1.0. The rates are used to calculate employee premium contribution.
Interim Payment Rates	Area factors will be applied to the Contractor's Final Bid Rates on or around April 2020. Amounts paid to Contractor, prior to the application of the area factors, will also be retroactively adjusted for the actual number of Subscribers covered and the original invoice the actual number of premium units paid to Contractor.
Final Payment Rates	It is anticipated that Final Payment Rates will be determined by June 30, 2021 and will reflect the complete concurrent risk score and application of area factors for Plan Year 2020. Final rates paid to Contractor will be retroactively adjusted.

The rate adjustment process described above may also be applied to Plan Year 2021.

Washington State Health Care Authority	**PROFESSIONAL SERVICES CONTRACT** **for Fully Insured Group Medical Plan**	HCA Contract Number: K3023 Resulting from Solicitation Number: RFP2716

THIS CONTRACT is made by and between Washington State Health Care Authority, (HCA) and Kaiser Foundation Health Plan of Washington Options, Inc., (Contractor).

CONTRACTOR NAME		CONTRACTOR DOING BUSINESS AS (DBA)		
Kaiser Foundation Health Plan of Washington Options, Inc.				
CONTRACTOR ADDRESS | Street		City	State	Zip Code
601 Union Street, Suite 3100		Seattle	WA	98101
CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR E-MAIL ADDRESS		
Natalie C. Bell	(253) 383-7867	Natalie.C.Bell@kp.org		
Is Contractor a Subrecipient under this Contract?	CFDA NUMBER(S):	FFATA Form Required		
☐YES ☒NO		☐YES ☒NO		

HCA PROGRAM	HCA DIVISION/SECTION
School Employees Benefits Board (SEBB) Program	Employees and Retirees Benefits (ERB) Division
HCA CONTACT NAME AND TITLE Beth Heston, HCA Contract Manager	HCA CONTACT ADDRESS Health Care Authority PO Box 42684 Olympia, WA 98504
HCA CONTACT TELEPHONE (360) 725-0865	HCA CONTACT E-MAIL ADDRESS Beth.Heston@hca.wa.gov

CONTRACT START DATE	CONTRACT END DATE	TOTAL MAXIMUM CONTRACT AMOUNT
Implementation Start Date: DOE Plan Year Start Date: January 1, 2020	December 31, 2023	PSPM

PURPOSE OF CONTRACT:

Contractor agrees to provide all contracted insurance plans and administrative services, as herein specified, for Members enrolled in the School Employees Benefits Board (SEBB) Program.

The parties signing below warrant that they have read and understand this Contract, and have authority to execute this Contract. This Contract will be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
Joseph E. Smith	Joseph E. Smith, Vice President	7/3/19
HCA SIGNATURE DocuSigned by: Annette Schuffenhauer 4F259FCAF7C2450...	**PRINTED NAME AND TITLE** Annette Schuffenhauer Chief Legal Officer	**DATE SIGNED** 7/3/2019

EXHIBIT 3 – RATE DEVELOPMENT PROCESS

Request for Completion (RFC)

HCA released a one-time RFC on December 13, 2018 to obtain binding not-to-exceed (NTE) Rates. Contractor NTE Rates will be based on the final plan design options that were approved by the SEB Board on November 8, 2018. To develop rates, Contractors will use their current School Employee enrollment data in combination with the Data Book of summarized historical School Employee data provided by HCA. The Final NTE Rates established during the RFC will be relied upon by HCA to advise the Washington State Legislature during the 2019 legislative session(s). HCA anticipates completing the process of obtaining, negotiating, and agreeing to Final NTE Rates and Final Bid Rates in the following phases:

Rate Development Phases

December 2018 - February 2019	Release of RFC, submission of NTE Rates by Contractor, and negotiation of Final NTE Rates.
March - June 2019	Negotiation of changes if needed to align with 2019-2021 biennial budget development.
June - August 2019	SEB Board vote on 2020 employee premiums by plan and Contract amendment for Final Bid Rates signed for Plan Year 2020.

Employer Medical Contribution and Final Bid Rates

The Employer Medical Contribution (EMC) is collectively bargained to be 85 percent of the monthly premium for the self-insured SEBB UMP Achieve 2 plan—with an estimated actuarial value of 88 percent. The EMC will be applied uniformly across all medical plan offerings within the SEBB portfolio. The employee contribution will be the difference between the Final Bid Rate for the plan selected and the EMC. The EMC rate is multiplied by the SEBB-approved tier ratios to derive the amounts that the employee and employer will contribute by tier. The minimum employee premium contribution across all plans and all tiers is collectively bargained to be set at no less than 2 percent of the EMC.

Rate Adjustment Process

Rate adjustments will include the application of risk and area factors to the Final Bid Rates for Plan Year 2020. Rate adjustment(s) will be revenue neutral across all SEBB medical plans, and will be calculated and shared with the Contractor periodically. Rate adjustments may or may not change actual amounts paid to Contractor during Plan Year 2020. Amounts paid to Contractor may be equal to the Final Bid Rates until there is a “true up” that implements the Interim and Final Payment Rates, outlined in the below rate adjustment schedule.

HCA anticipates determining Final Payment Rates and adjusting amounts paid to Carrier for Plan Year 2020 by June 30, 2021. HCA anticipates adopting the following rate adjustment schedule:

Rate Adjustment Schedule

Final Bid Rates	Reflects statewide profile with an average relative risk score of 1.0. The rates are used to calculate employee premium contribution.
Interim Payment Rates	Area factors will be applied to the Contractor's Final Bid Rates on or around April 2020. Amounts paid to Contractor, prior to the application of the area factors, will also be retroactively adjusted for the actual number of Subscribers covered and the original invoice the actual number of premium units paid to Contractor.
Final Payment Rates	It is anticipated that Final Payment Rates will be determined by June 30, 2021 and will reflect the complete concurrent risk score and application of area factors for Plan Year 2020. Final rates paid to Contractor will be retroactively adjusted.

The rate adjustment process described above may also be applied to Plan Year 2021.

Washington State Health Care Authority	**PROFESSIONAL SERVICES CONTRACT** **for Fully Insured Group Medical Plan**	HCA Contract Number: K3024 Resulting from Solicitation Number: RFP2716

THIS CONTRACT is made by and between Washington State Health Care Authority, (HCA) and Kaiser Foundation Health Plan of the Northwest, (Contractor).

CONTRACTOR NAME		CONTRACTOR DOING BUSINESS AS (DBA)		
Kaiser Foundation Health Plan of the Northwest				
CONTRACTOR ADDRESS Street		City	State	Zip Code
500 NE Multnomah St.		Portland	OR	97232
CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR E-MAIL ADDRESS		
Hilary K. Getz	(503) 813-4616	Hilary.K.Getz@kp.org		
Is Contractor a Subrecipient under this Contract?	CFDA NUMBER(S):	FFATA Form Required		
☐YES ☒NO		☐YES ☒NO		

HCA PROGRAM	HCA DIVISION/SECTION
School Employees Benefits Board (SEBB) Program	Employees and Retirees Benefits (ERB) Division
HCA CONTACT NAME AND TITLE Beth Heston, HCA Contract Manager	HCA CONTACT ADDRESS Health Care Authority PO Box 42684 Olympia, WA 98504
HCA CONTACT TELEPHONE (360) 725-0865	HCA CONTACT E-MAIL ADDRESS Beth.Heston@hca.wa.gov

CONTRACT START DATE	CONTRACT END DATE	TOTAL MAXIMUM CONTRACT AMOUNT
Implementation Start Date: DOE Plan Year Start Date: January 1, 2020	December 31, 2023	PSPM

PURPOSE OF CONTRACT:

Contractor agrees to provide all contracted insurance plans and administrative services, as herein specified, for Members enrolled in the School Employees Benefits Board (SEBB) Program.

The parties signing below warrant that they have read and understand this Contract, and have authority to execute this Contract. This Contract will be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE
(X)	KEITH A. FORRESTER, VP MSBD	7/3/19
HCA SIGNATURE DocuSigned by: Annette Schuffenhauer 4F259FCAF7C2450...	**PRINTED NAME AND TITLE** Annette Schuffenhauer Chief Legal Officer	**DATE** 7/3/2019

EXHIBIT 3 – RATE DEVELOPMENT PROCESS

Request for Completion (RFC)

HCA released a one-time RFC on December 13, 2018 to obtain binding not-to-exceed (NTE) Rates. Contractor NTE Rates will be based on the final plan design options that were approved by the SEB Board on November 8, 2018. To develop rates, Contractors will use their current School Employee enrollment data in combination with the Data Book of summarized historical School Employee data provided by HCA. The Final NTE Rates established during the RFC will be relied upon by HCA to advise the Washington State Legislature during the 2019 legislative session(s). HCA anticipates completing the process of obtaining, negotiating, and agreeing to Final NTE Rates and Final Bid Rates in the following phases:

Rate Development Phases

December 2018 - February 2019	Release of RFC, submission of NTE Rates by Contractor, and negotiation of Final NTE Rates.
March - June 2019	Negotiation of changes if needed to align with 2019-2021 biennial budget development.
June - August 2019	SEB Board vote on 2020 employee premiums by plan and Contract amendment for Final Bid Rates signed for Plan Year 2020.

Employer Medical Contribution and Final Bid Rates

The Employer Medical Contribution (EMC) is collectively bargained to be 85 percent of the monthly premium for the self-insured SEBB UMP Achieve 2 plan—with an estimated actuarial value of 88 percent. The EMC will be applied uniformly across all medical plan offerings within the SEBB portfolio. The employee contribution will be the difference between the Final Bid Rate for the plan selected and the EMC. The EMC rate is multiplied by the SEBB-approved tier ratios to derive the amounts that the employee and employer will contribute by tier. The minimum employee premium contribution across all plans and all tiers is collectively bargained to be set at no less than 2 percent of the EMC.

Rate Adjustment Process

Rate adjustments will include the application of risk and area factors to the Final Bid Rates for Plan Year 2020. Rate adjustment(s) will be revenue neutral across all SEBB medical plans, and will be calculated and shared with the Contractor periodically. Rate adjustments may or may not change actual amounts paid to Contractor during Plan Year 2020. Amounts paid to Contractor may be equal to the Final Bid Rates until there is a “true up” that implements the Interim and Final Payment Rates, outlined in the below rate adjustment schedule.

HCA anticipates determining Final Payment Rates and adjusting amounts paid to Carrier for Plan Year 2020 by June 30, 2021. HCA anticipates adopting the following rate adjustment schedule:

Rate Adjustment Schedule

Final Bid Rates	Reflects statewide profile with an average relative risk score of 1.0. These rates are used to calculate employee premium contribution.
Interim Payment Rates	Area factors will be applied to the Contractor's Final Bid Rates on or around April 2020. Amounts paid to Contractor, prior to the application of the area factors, will also be retroactively adjusted for the actual number of Subscribers covered and the original invoice the actual number of premium units paid to Contractor.
Final Payment Rates	It is anticipated that Final Payment Rates will be determined by June 30, 2021 and will reflect the complete concurrent risk score and application of area factors for Plan Year 2020. Final rates paid to Contractor will be retroactively adjusted.

The rate adjustment process described above may also be applied to Plan Year 2021.

Washington State Health Care Authority	**PROFESSIONAL SERVICES CONTRACT** **for Fully Insured Group Medical Plan**	HCA Contract Number: K3025 Resulting from Solicitation Number (If applicable: 2716

THIS CONTRACT is made by and between Washington State Health Care Authority, (HCA) and Premera Blue Cross, (Contractor).

CONTRACTOR NAME		CONTRACTOR DOING BUSINESS AS (DBA)		
Premera Blue Cross				
CONTRACTOR ADDRESS | Street		City	State	Zip Code
7001 200th Street SW, MS 102		Mountlake Terrace	WA	98043
CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR E-MAIL ADDRESS		
Ken Chandler	(425) 918-4731	ken.chandler@premera.com		
Is Contractor a Subrecipient under this Contract?		CFDA NUMBER(S):	FFATA Form Required	
☐YES ☒NO		N/A	☐YES	☒NO

HCA PROGRAM	HCA DIVISION/SECTION
School Employees Benefits Board (SEBB) Program	Employees and Retirees Benefits (ERB) Division
HCA CONTACT NAME AND TITLE Lauren Johnston, SEBB Procurement and Senior Account Manager	HCA CONTACT ADDRESS Health Care Authority PO Box 42684 Olympia, WA 98504-2684
HCA CONTACT TELEPHONE (360) 725-1117	HCA CONTACT E-MAIL ADDRESS Lauren.johnston@hca.wa.gov

CONTRACT START DATE	CONTRACT END DATE	TOTAL MAXIMUM CONTRACT AMOUNT
Implementation: Date of Execution Plan Year Start Date: January 1, 2020	December 31, 2023	PSPM

PURPOSE OF CONTRACT:

Contractor agrees to provide all contracted insurance plans and administrative services, as herein specified, for Members enrolled in the School Employees Benefits Board (SEBB) Program.

The parties signing below warrant that they have read and understand this Contract, and have authority to execute this Contract. This Contract will be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
Jeffrey Roe	Jeffrey Roe, President + CEO	6/12/19
HCA SIGNATURE DocuSigned by: Annette Schuffenhauer 4F239FCAF7C2450...	PRINTED NAME AND TITLE Annette Schuffenhauer Chief Legal Officer	DATE SIGNED 6/13/2019

EXHIBIT 3 – RATE DEVELOPMENT PROCESS

Request for Completion (RFC)

HCA released a one-time RFC on December 13, 2018 to obtain binding not-to-exceed (NTE) Rates. Contractor NTE Rates will be based on the final plan design options that were approved by the SEB Board on November 8, 2018. To develop rates, Contractors will use their current School Employee enrollment data in combination with the Data Book of summarized historical School Employee data provided by HCA. The Final NTE Rates established during the RFC will be relied upon by HCA to advise the Washington State Legislature during the 2019 legislative session(s). HCA anticipates completing the process of obtaining, negotiating, and agreeing to Final NTE Rates and Final Bid Rates in the following phases:

Rate Development Phases

December 2018 - February 2019	Release of RFC, submission of NTE Rates by Contractor, and negotiation of Final NTE Rates.
March - June 2019	Negotiation of changes if needed to align with 2019-2021 biennial budget development.
June - August 2019	SEB Board vote on 2020 employee premiums by plan and Contract amendment for Final Bid Rates signed for Plan Year 2020.

Employer Medical Contribution and Final Bid Rates

The Employer Medical Contribution (EMC) is collectively bargained to be 85 percent of the monthly premium for the self-insured SEBB UMP Achieve 2 plan—with an estimated actuarial value of 88 percent. The EMC will be applied uniformly across all medical plan offerings within the SEBB portfolio. The employee contribution will be the difference between the Final Bid Rate for the plan selected and the EMC. The EMC rate is multiplied by the SEBB-approved tier ratios to derive the amounts that the employee and employer will contribute by tier. The minimum employee premium contribution across all plans and all tiers is collectively bargained to be set at no less than 2 percent of the EMC

Rate Adjustment Process

Rate adjustment will include the application of risk and area factors to the Final Bid Rates for Plan Year 2020. Rate adjustment(s) will be revenue neutral across all SEBB medical plans, and will be calculated and shared with the Contractor periodically. Rate adjustments may or may not change actual amounts paid to Contractor during Plan Year 2020. Amounts paid to Contractor may be equal to the Final Bid Rates until there is a "true up" that implements the Interim and Final Payment Rates, outlined in the below rate adjustment schedule.

HCA anticipates determining Final Payment Rates and adjusting amounts paid to Carrier for Plan Year 2020 by June 30, 2021. HCA anticipates adopting the following rate adjustment schedule:

Rate Adjustment Schedule

Final Bid Rates	Reflects statewide profile with an average relative risk score of 1.0.
Interim Payment Rates	Area factors will be applied to the Contractor's Final Bid Rates on or around April 2020. Amounts paid to Contractor, prior to the application of the area factors, will also be retroactively adjusted for the actual number of Subscribers covered and the original invoice for the actual number of premium units paid to Contractor.
Final Payment Rates	It is anticipated that Final Payment Rates will be determined by June 30, 2021 and will reflect the complete concurrent risk score for Plan Year 2020.

The rate adjustment process described above may also be applied to Plan Year 2021.