Washington State Health Care Authority

School Employees Benefits Board Meeting

November 6, 2017

Washington State Health Care Authority

School Employees Benefits Board

November 6, 2017
1:00 p.m. – 5:00 p.m.

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

Table of Contents

TAB 1

Washington State Health Care Authority

AGENDA

School Employees Benefits Board
November 6, 2017
1:00 p.m. – 5:00 p.m.

Health Care Authority
Cherry Street Plaza
Sue Crystal Rooms A & B
626 8th Avenue SE
Olympia, WA 98501

TVW is planning to live webcast the meeting at www.tvw.org
Call-in Number: 1-888-407-5039 Participant PIN Code: 60995706

1:00 p.m.*	**Welcome and Introductions**		Lou McDermott, Chair	
1:10 p.m.	**Meeting Overview**		David Iseminger, Acting Director Employees & Retirees Benefits (ERB) Division	Information
1:15 p.m.	**SEBB By-Laws**	TAB 2	David Iseminger, ERB Acting Director	Information
2:15 p.m.	**Health Care Today and Tomorrow**	TAB 3	Dan Lessler, M.D., Chief Medical Officer Clinical Quality and Care Transformation Division	Information
3:15 p.m.	**Break**			
3:30 p.m.	**Setting the Stage: Health Benefits and Insurance Overview**	TAB 4	Marcia Peterson, Manager ERB Benefit Strategy & Design Section Kim Wallace, Financial Services Division	Information
4:30 p.m.	**Public Comment**			
5:00 p.m.	**Adjourn**			

***All Times Approximate**

The School Employees Benefits Board will meet Monday, November 6, 2017, 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.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

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 November 3, 2017.

Washington State Health Care Authority

SEB Board Members

Name	Representing
Lou McDermott, Acting 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@siginsures.com	Employee Health Benefits Policy and Administration
Pete Cutler 7605 Ostrich DR SE Olympia WA 98513 C 360-789-2787 p.cutler@comcast.net	Employee Health Benefits Policy and Administration
Patty Estes Eatonville School District PO Box 1364 Eatonville WA 98328 C 360-621-9610 p.estes.sebb@gmail.com	Classified Employees
Dan Gossett 603 Veralene Way SW Everett WA 98203 C 425-737-2983 dan.gossett@comcast.net	Certificated Employees

SEB Board Members, *(cont.)*

Name	Representing
Katy Henry Spokane Public Schools 200 North Bernard Spokane WA 99201 V 509-325-4503 khenry@washingtonea.org	Certificated Employees
Terri House Marysville School District 4220 80th ST NE Marysville WA 98270 V 360-965-1610 Terri_house@msd25.org	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@mead354.org	Employee Health Benefits Policy and Administration (WASBO)
Alison Carl White 12515 South Hangman Valley RD Valleyford WA 99036 C 509-499-0482 alison.carlwhite@gmail.com	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

11/2/17

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

2017-18 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. The meetings begin at 1:00 p.m., unless otherwise noted below.

October 23, 2017

November 6, 2017

December 11, 2017

January 17, 2018

January 29, 2018

March 15, 2018 - 9:00 a.m.

April 30, 2018

May 30, 2018

June 13, 2018

July 30, 2018

August 30, 2018 - 9:00 a.m.

October 4, 2018 - 9:00 a.m.

November 8, 2018 - 9:00 a.m.

December 13, 2018 - 9:00 a.m.

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: August 30, 2017
TIME: 1:26 PM

WSR 17-18-043

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

8/28/17

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

Health Care Today & Tomorrow

Dr. Dan Lessler
Chief Medical Officer
Clinical Quality and Care Transformation
November 6, 2017

Washington State Health Care Authority

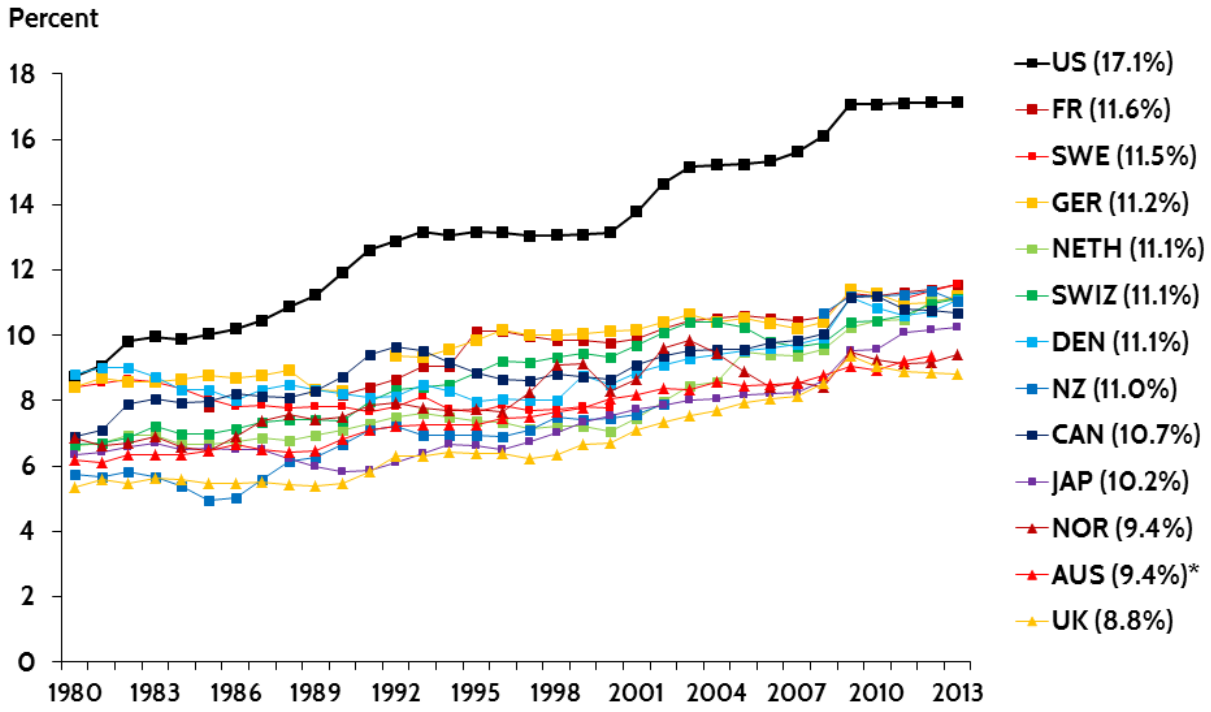
Objectives

- Describe the current state of health care.
- Explain the imperative for change.
- Explain changing from volume to value.

Washington State Health Care Authority

Health care spending

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

"Medical costs are the tapeworm of American economic competitiveness."

Warren Buffett

Cost = price x utilization

Prices

Exhibit 7. Prices for Hospital and Physician Services, Pharmaceuticals, and Diagnostic Imaging

	Total hospital and physician costs, 2013[a]		Diagnostic imaging prices, 2013[a]		Price comparison for in-patent pharmaceuticals, 2010 (U.S. set to 100)[b]
	Bypass surgery	Appendectomy	MRI	CT scan (abdomen)	
Australia	$42,130	$5,177	$350	$500	49
Canada	–	–	–	$97	50
France	–	–	–	–	61
Germany	–	–	–	–	95
Netherlands	$15,742	$4,995	$461	$279	–
New Zealand	$40,368	$6,645	$1,005	$731	–
Switzerland	$36,509	$9,845	$138	$432	88
United Kingdom	–	–	–	–	46
United States	$75,345	$13,910	$1,145	$896	100

[a] Source: International Federation of Health Plans, 2013 Comparative Price Report.
[b] Numbers show price indices for a basket of in-patent pharmaceuticals in each country; lower numbers indicate lower prices.
Source: P. Kanavos, A. Ferrario, S. Vandoros et al., "Higher U.S. Branded Drug Prices and Spending Compared to Other Countries May Stem Partly from Quick Uptake of New Drugs," *Health Affairs*, April 2013 32(4):753–61.

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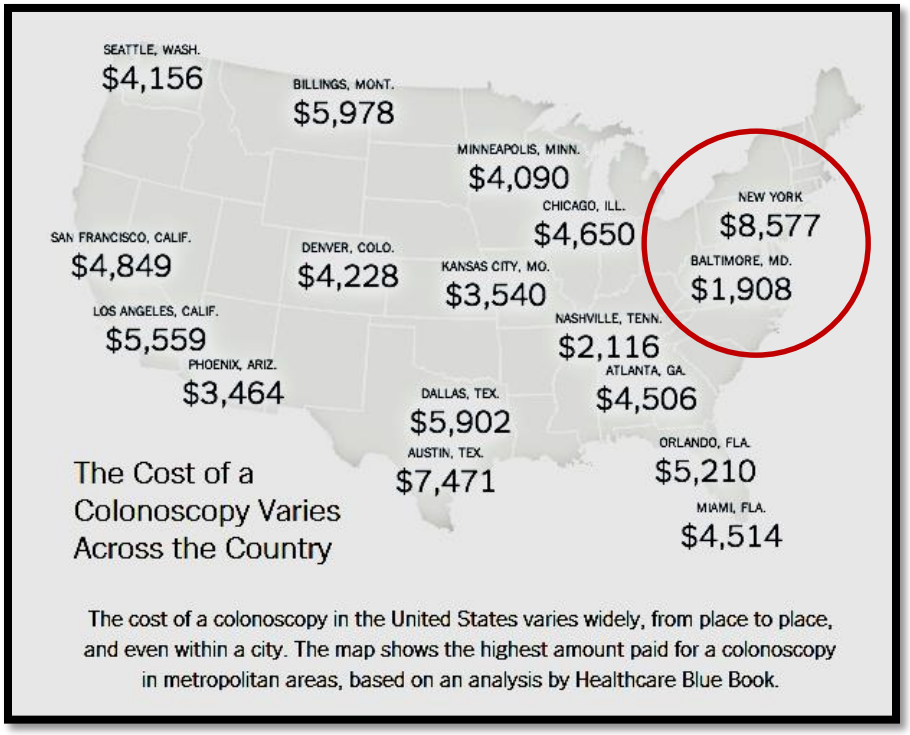
Price variation



Unexplained variation across commodity services.

Washington State Health Care Authority

Utilization

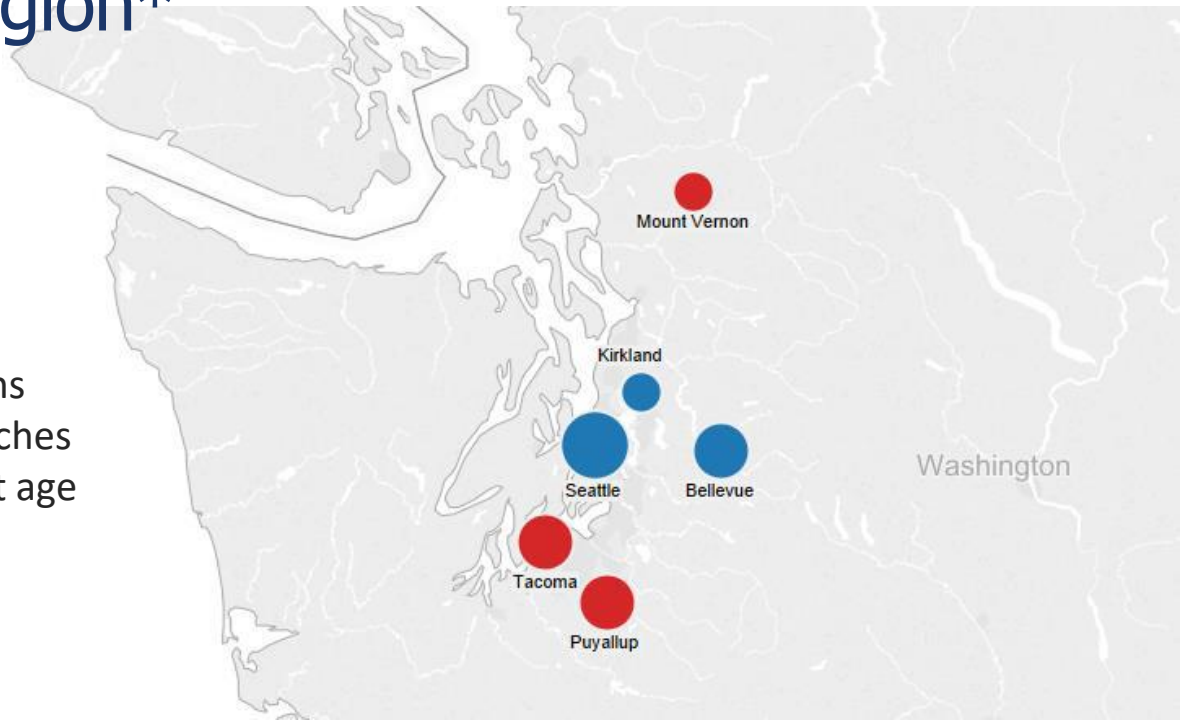
Exhibit 5. Diagnostic Imaging Supply and Use, 2013

	Magnetic resonance imaging		Computed tomography		Positron emission tomography	
	MRI machines per million pop.	MRI exams per 1,000 pop.	CT scanners per million pop.	CT exams per 1,000 pop.	PET scanners per million pop.	PET exams per 1,000 pop.
Australia	13.4	27.6	53.7	110	2.0	2.0
Canada	8.8	52.8	14.7	132	1.2[a]	2.0
Denmark	–	60.3	37.8	142	6.1	6.3
France	9.4	90.9	14.5	193	1.4	–
Japan	46.9[b]	–	101.3[b]	–	3.7[b]	–
Netherlands	11.5	50.0[b]	11.5	71[b]	3.2	2.5[a]
New Zealand	11.2	–	16.6	–	1.1	–
Switzerland	–	–	36.6	–	3.5	–
United Kingdom	6.1	–	7.9	–	–	–
United States	35.5	106.9	43.5	240	5.0[a]	5.0
OECD median	11.4	50.6	17.6	136	1.5	–

[a] 2012. [b] 2011. [c] 2010.
Source: OECD Health Data 2015.

Hysterectomy: Utilization variation in the Puget Sound Region*

(Larger circles means the use pattern reaches across more patient age and gender types)



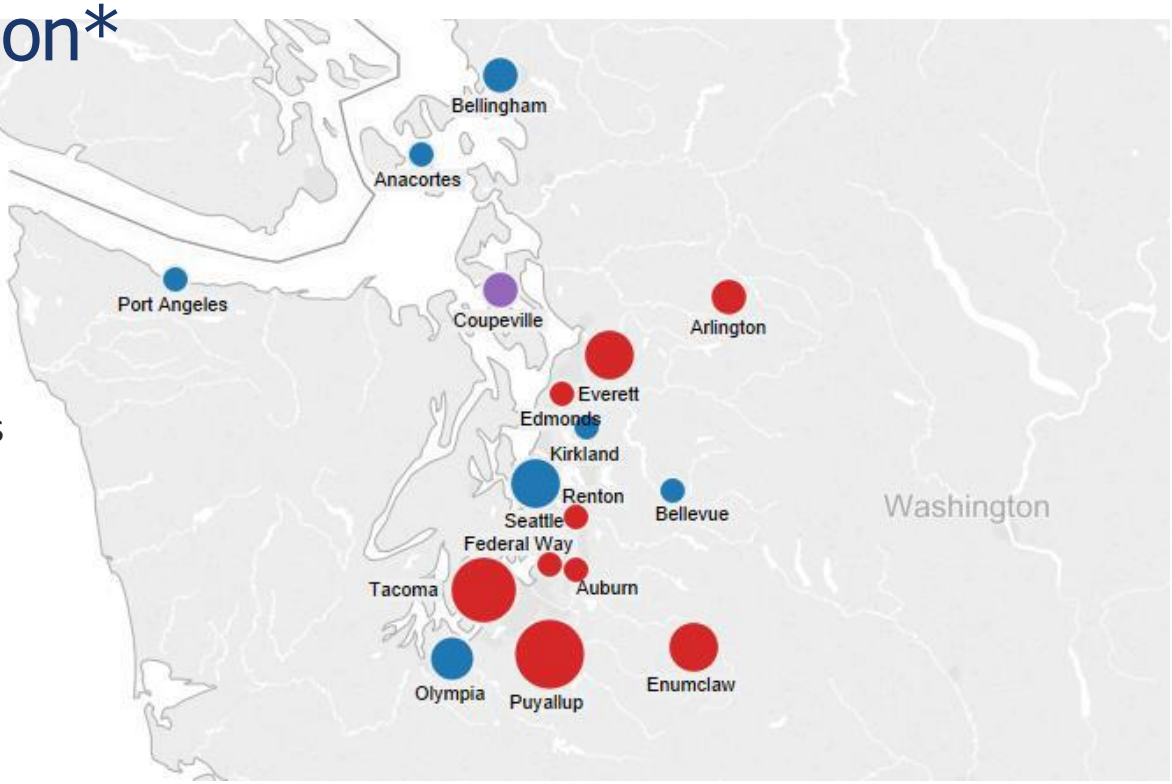
Higher rate than region

Lower rate than region

*2012 Data, Commercially Insured Washington Health Alliance: http://wahealthalliance.org/alliance-reports

Upper endoscopy: Utilization variation in the Puget Sound Region*

(Larger circles means the use pattern reaches across more patient age and gender types)



Higher rate than region

Lower rate than region

*2012 Data, Commercially Insured, Washington Health Alliance: http://wahealthalliance.org/alliance-reports

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What are we purchasing? The Washington Health Alliance Community Check-Up Report*

Measure	State Rate: Commercially Insured	National Committee for Quality Assurance National 90th Percentile: Commercial All Lines of Business
Blood Pressure control - hypertension	57%**	75%
Diabetes – Blood Pressure control	63%**	76%
Diabetes – Poor Blood Glucose control	37%**	21%
Cervical CA screening	75%	82%

*www.WACommunityCheckup.org

**State rate for this measure based upon NCQA Quality Compass

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Estimates of annual US health care waste*

• Failures of care delivery	$128 billion
• Failures of care coordination	$ 35 billion
• Overtreatment	$192 billion
• Administrative complexity	$248 billion
• Pricing failures	$131 billion
• Fraud and abuse	$177 billion
TOTAL	**$910 billion**

*Berwick and Hackbarth. JAMA. 2012;307(14)

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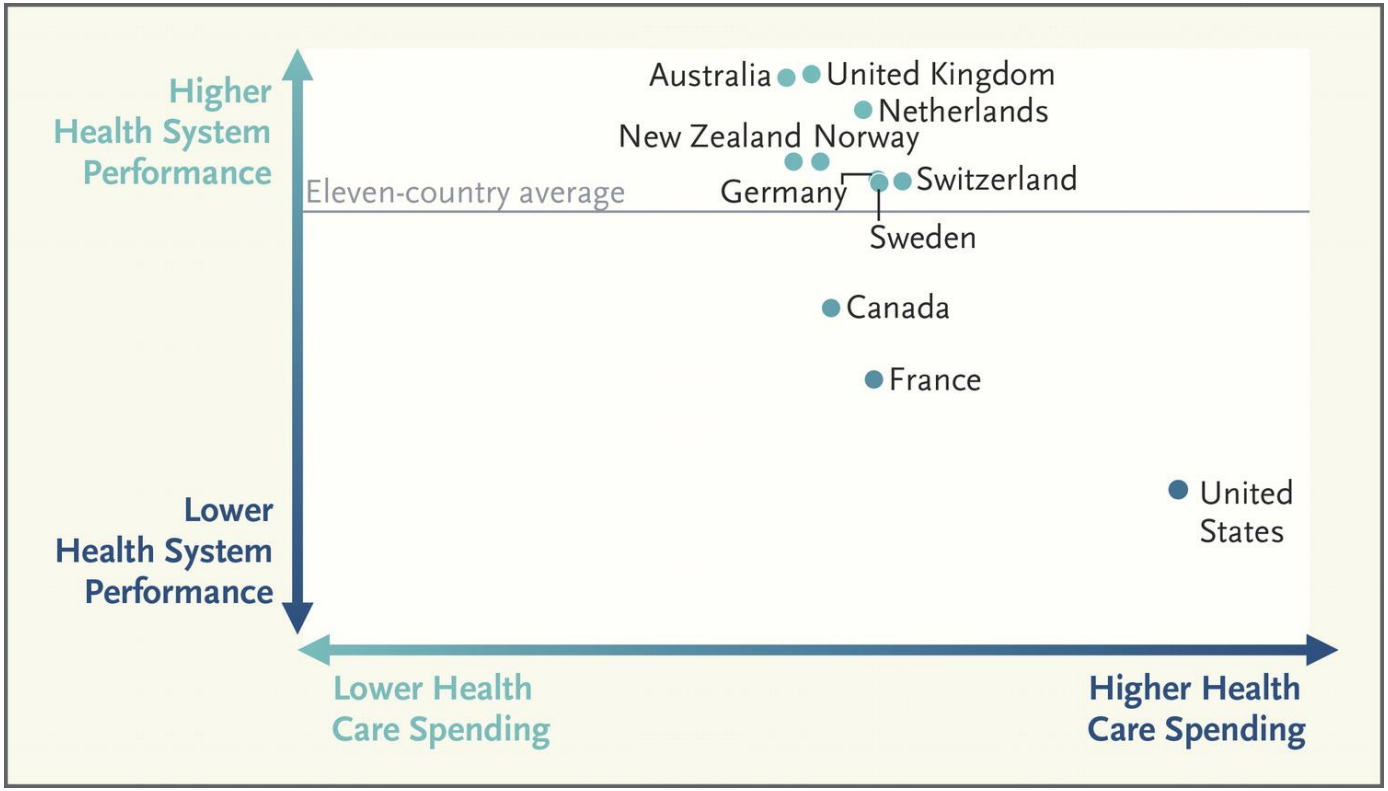
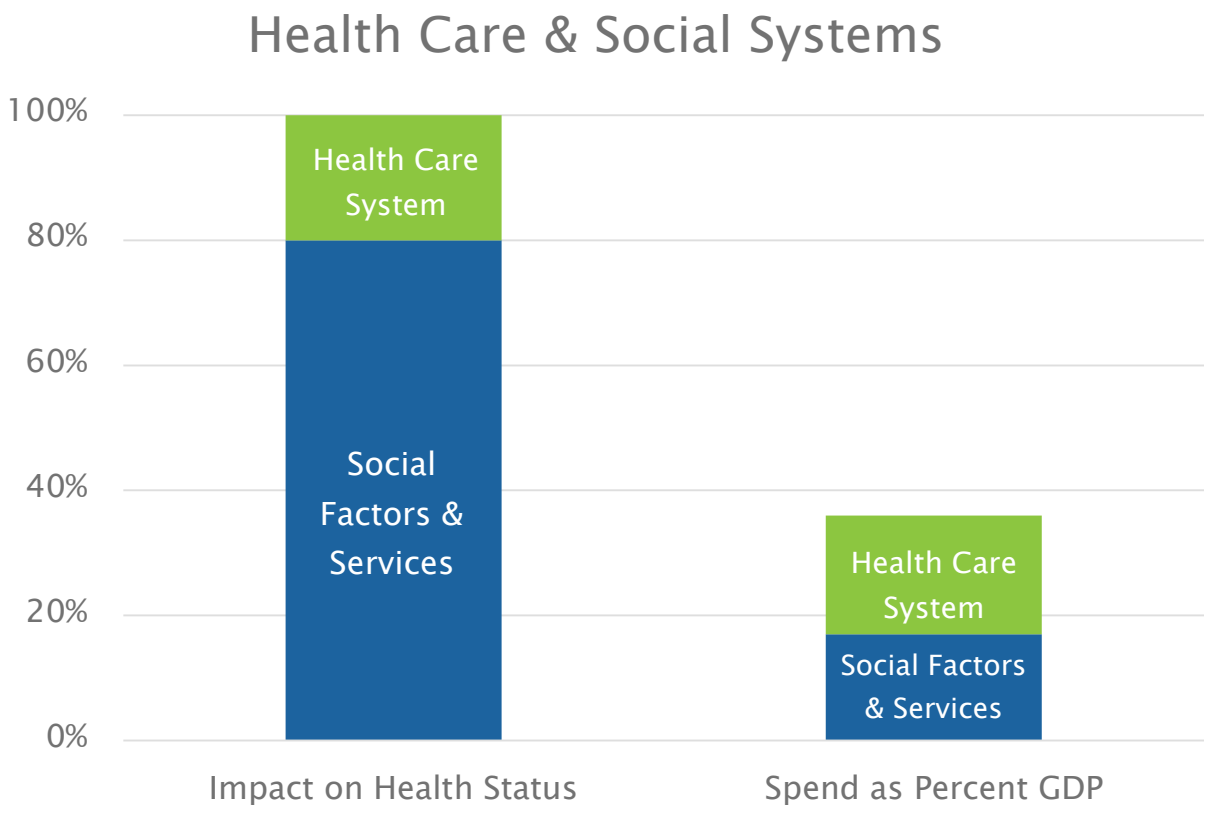
U.S. health system underperformance



Source: Schneider and Squires, http://www.nejm.org/doi/full/10.1056/NEJMp1708704

80/20 rule & resource allocation



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System failures

- Lack of communication and coordination across the continuum of care
- Lack of shared accountability
- Lack of data and transparency
  - Price
  - Process
  - Outcome

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The desired outcome: the "Quadruple Aim"

- Better care
- Improved population health
- Lower cost
- Professionally satisfied and stable clinician community

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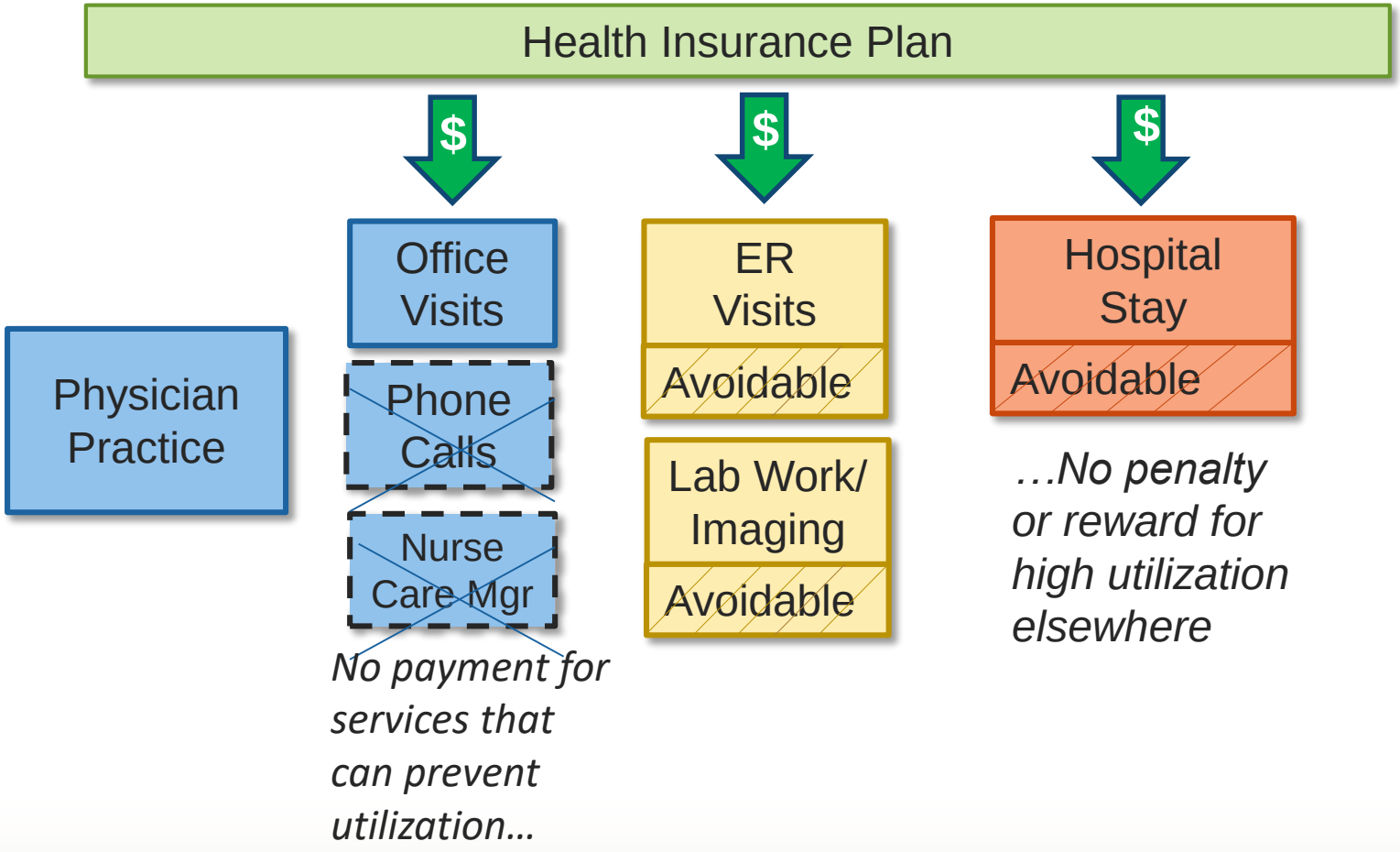
Current (fee-for-service) payment methods



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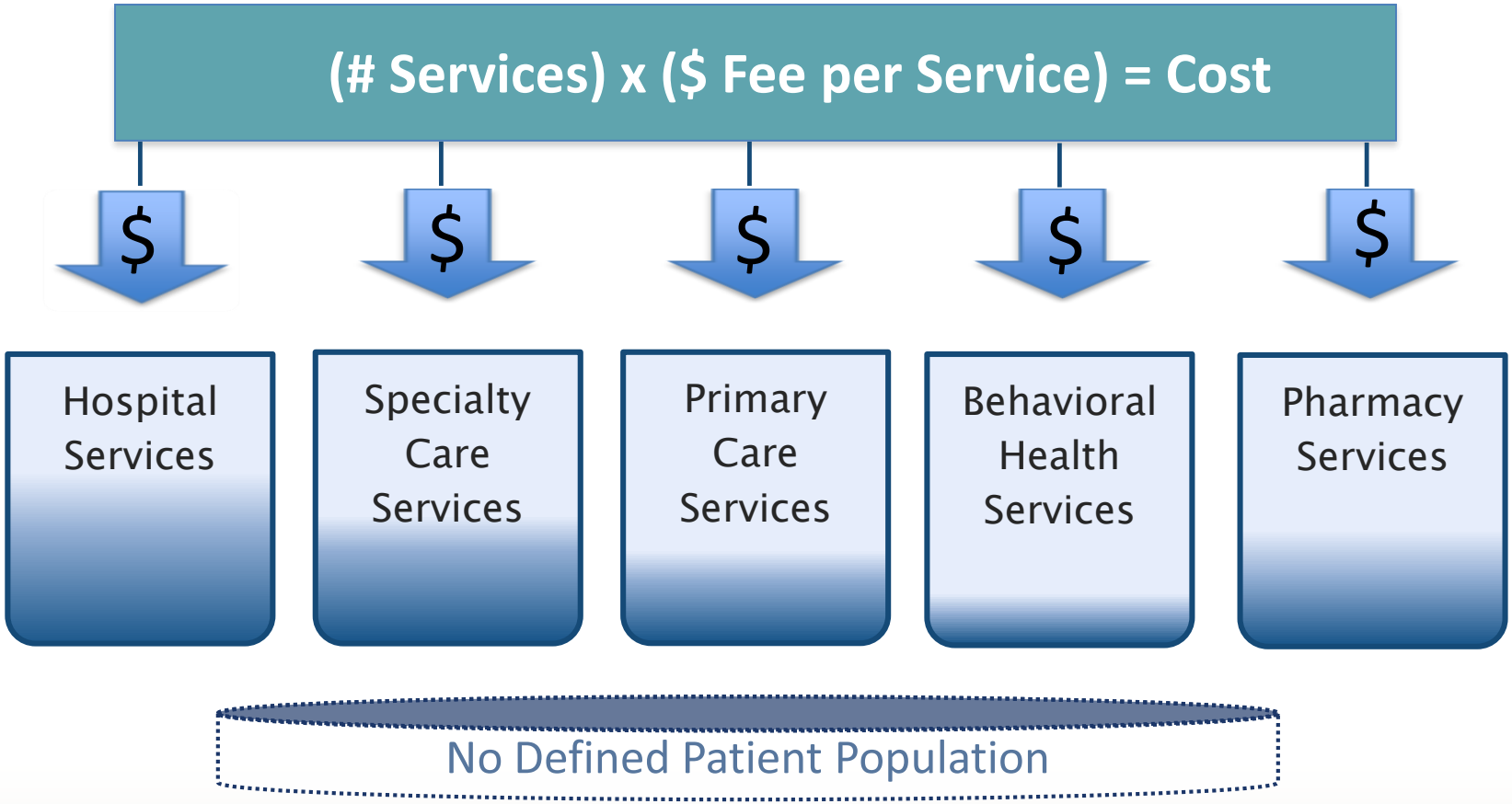
Volume-based payments



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Systems and insanity (or insane systems…)

- "Every system is perfectly designed to achieve exactly the results it gets."
  - Donald Berwick

- Insanity: "Doing the same thing over and over again and expecting different results."
  - Albert Einstein


ROWING HARDER DOESN'T HELP IF THE BOAT IS HEADED IN THE WRONG DIRECTION
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Rational system design: "whole person care"

- Health reform must address accountability for cost and outcomes
- This imperative is driving system design that:
  - Focuses on social, physical, and behavioral health needs
  - Emphasizes coordination of care across sectors
  - Requires financial flexibility, shared data, and collaborative leadership

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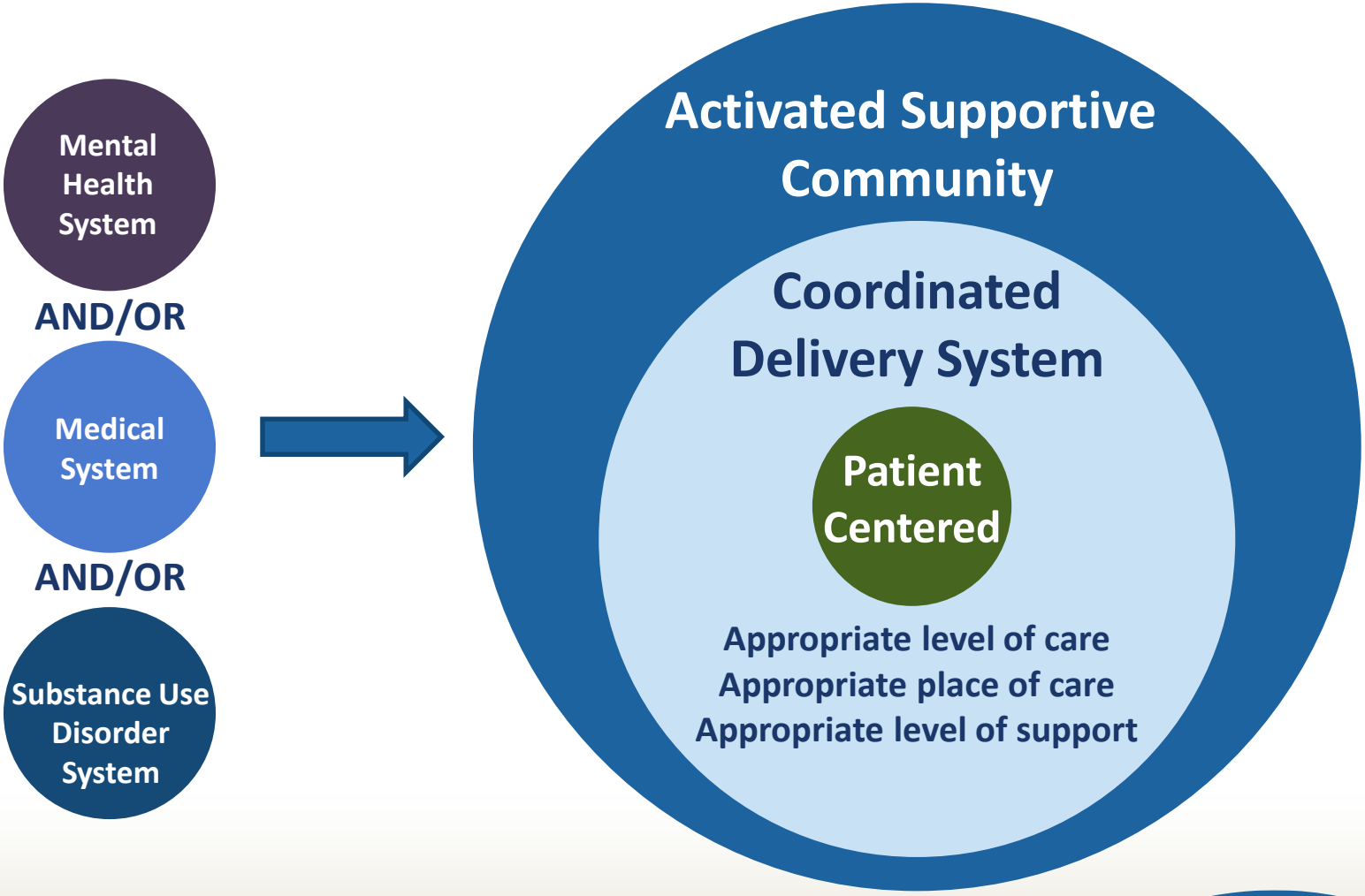
Rational system design: a shift in focus



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Payment Drives System Transformation

Status Quo (Volume-based) System	Transformed (Value-based) System
Fragmented clinical and financial approaches to care delivery	Integrated systems that pay for and deliver whole person care
Uncoordinated care and transitions	Coordinated care and transitions
Unengaged members left out of their own health care decisions	Engaged and activated members who are connected to the care they need and empowered to take a greater role in their health
Variation in delivery system performance (cost and quality) with no ties to clinical or financial accountability and transparency	Standardized performance measurement with clinical and financial accountability and transparency for improved health outcomes

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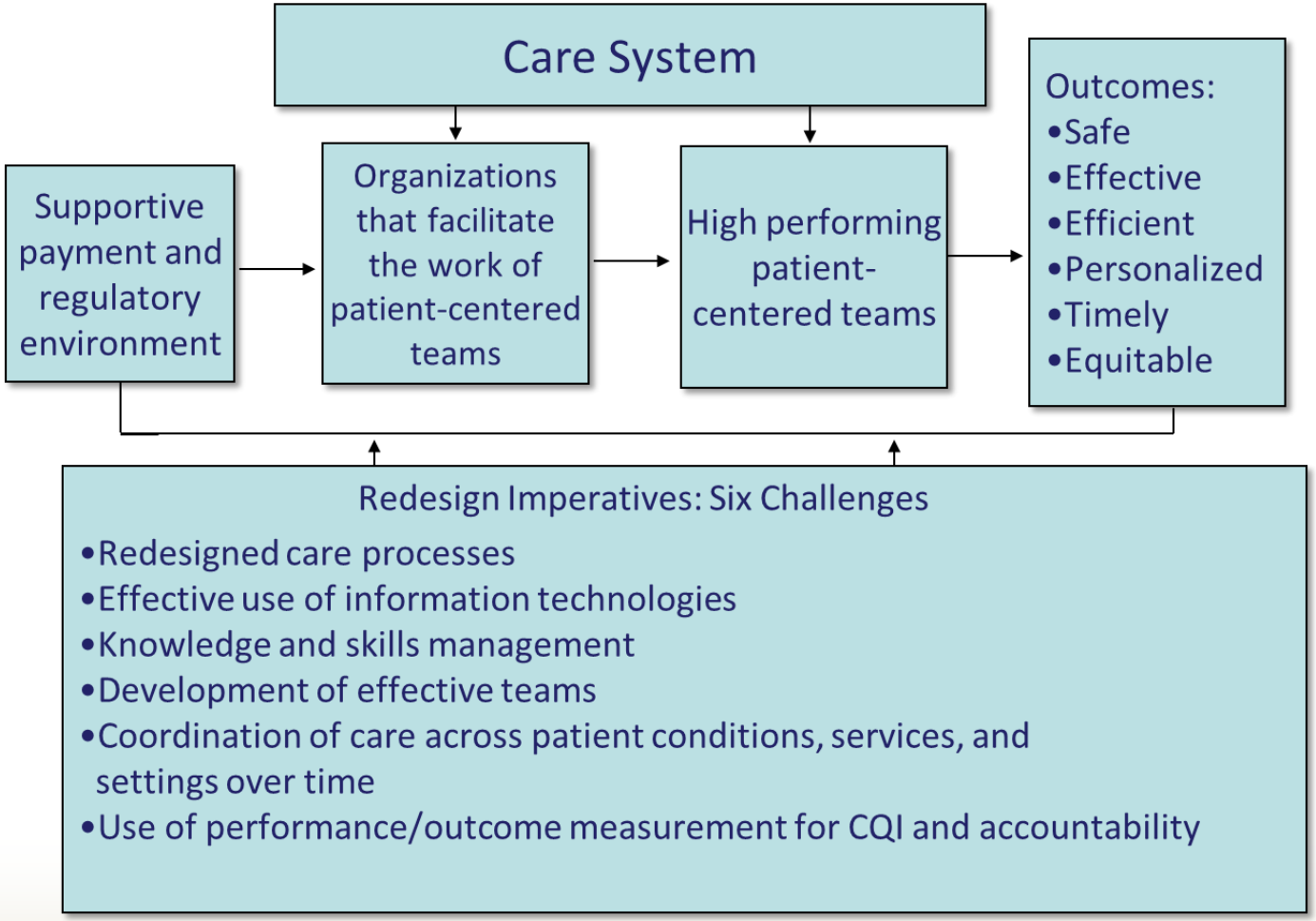
Challenges for Practice Transformation



Value-based purchasing (VBP) and incentives

- Incentive = Something that motivates or rewards an individual to perform an action
- In health care, that desired action is to provide coordinated, integrated, high-value care
- Value-based payments = reward/incentivize providers to provide coordinated care, high-value care

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Examples of HCA Value-based purchasing initiatives

Public Employee Benefits Board – State Employees	Apple Health – Medicaid
• Accountable Care Program – clinically integrated network model with up and downside risk to incentivize clinical and quality accountability • Total Joint Replacement Bundle and Center of Excellence • Third Party Administrator – Request For Proposals requires bidders to offer value-based products to book of business to spread value in the marketplace	• 1% Managed Care Organization premium withhold based on quality and provider value-based payment arrangements • Behavioral and physical health integration (financial) statewide by 2020 • New Medicaid value-based reimbursement model for rural health clinics and hospitals • Medicaid Demonstration regional value-based payment goals tied to incentive payments

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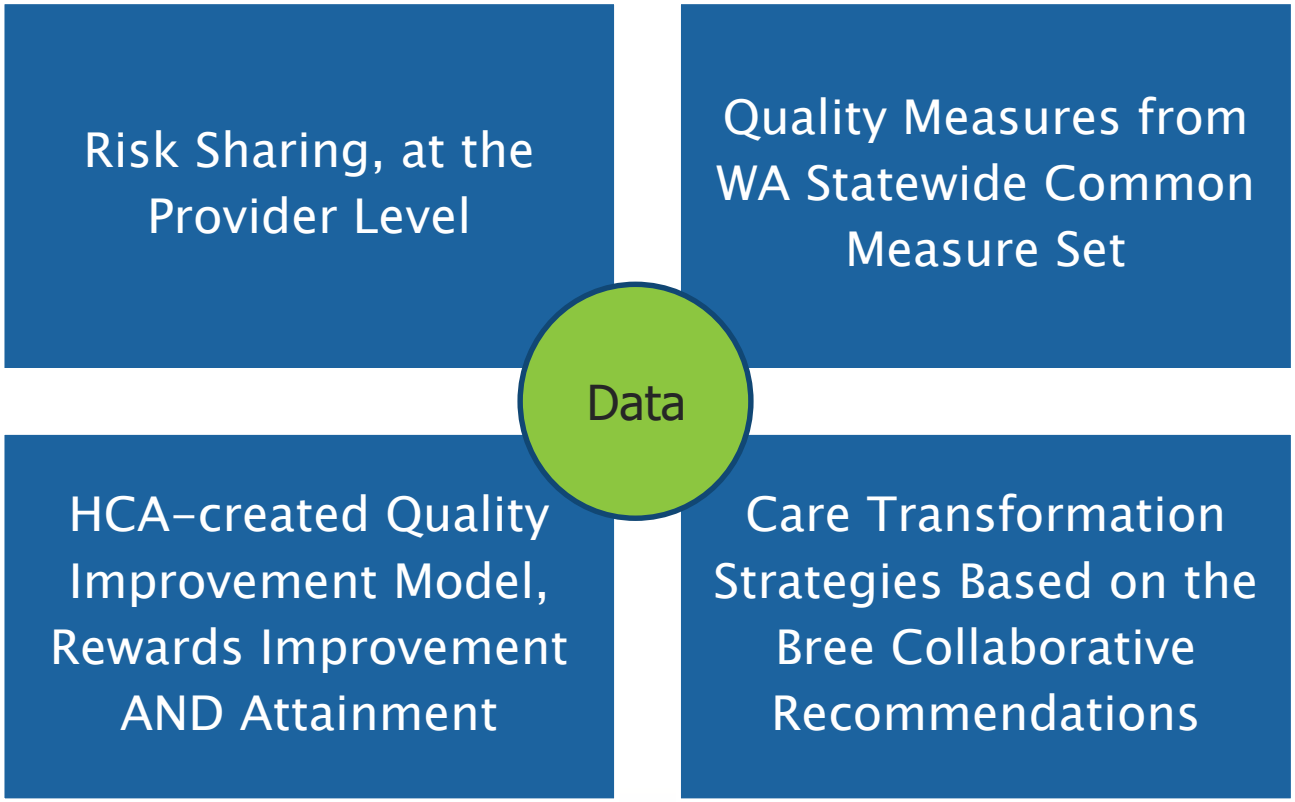
Driving common elements in all HCA new models of care



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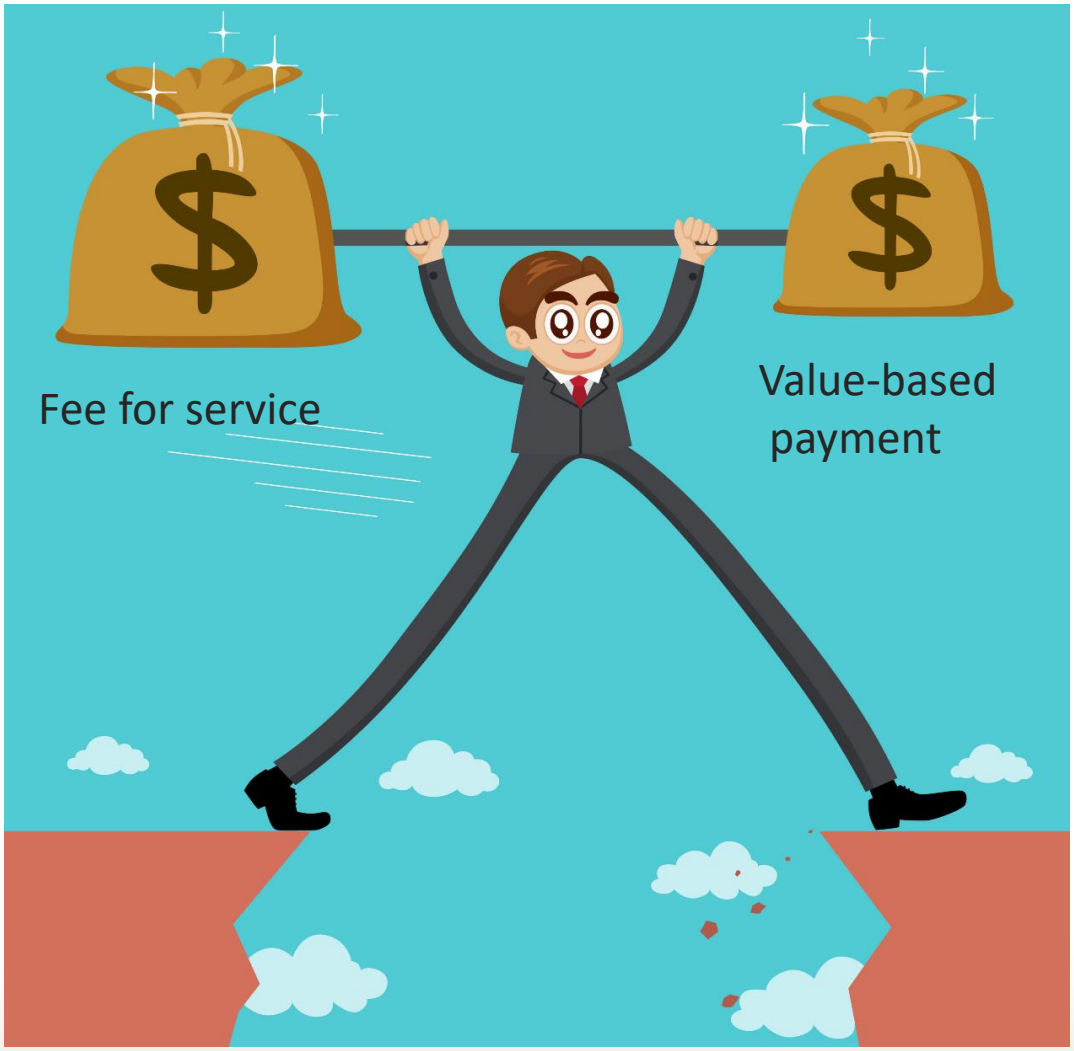
Crossing the quality chasm



Prevailing against brutal facts: providing stability

- Transitioning from fee for service to value-based payments
  - An imposing challenge, but…
  - "Hopelessness does not make for renewal" (quoting John Gardner, "Self-Renewal," 1963)
- Upfront systems thinking before committing resources and taking risks can provide stability during a time of turbulent change

Accountable Care Program Performance Comparted to Targets

Measure
Adult BMI
AMM Acute
AMM Continuation
CAD Statin Prescribed
CAD Statin Adherence
Combo 10
Chlamydia Screening in Women
Colorectal Cancer Screening
Hemoglobin A1c Poor Control (>9.0%)
Blood Pressure Control (<140/90 mm)
Retinal Eye Examination
Controlling High Blood Pressure
**NTSV C-section

In 2016, our networks either met our high standards or made significant improvements toward meeting our high standards.

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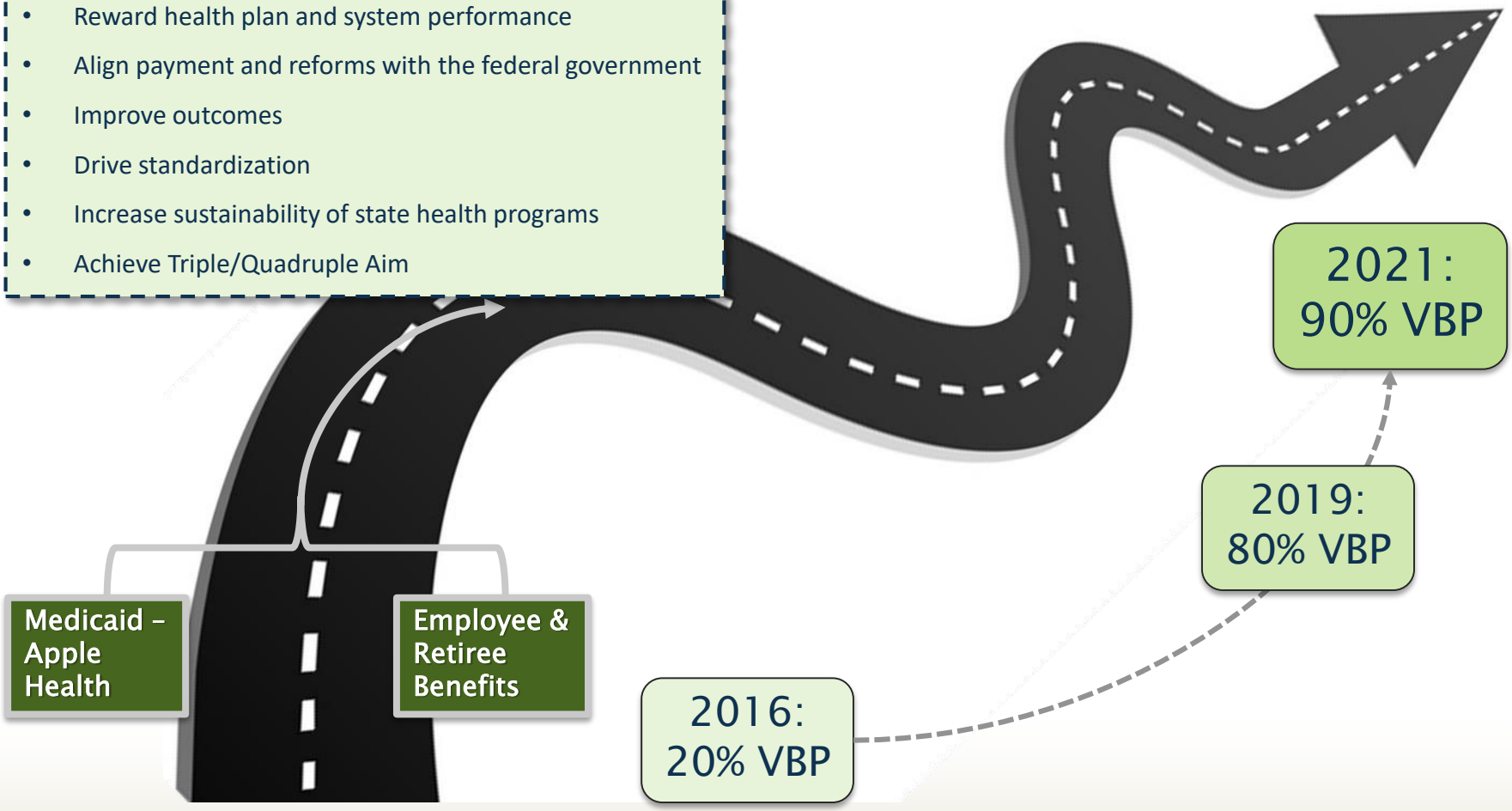
HCA Value-based Roadmap

- Reward patient-centered, high quality care
- Reward health plan and system performance
- Align payment and reforms with the federal government
- Improve outcomes
- Drive standardization
- Increase sustainability of state health programs
- Achieve Triple/Quadruple Aim



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Questions?

More Information:

https://www.hca.wa.gov/about-hca/healthier-washington

Dr. Dan Lessler, Chief Medical Officer

Daniel.Lessler@hca.wa.gov

360-725-1612

TAB 4

Washington State Health Care Authority

Setting the Stage: Health Benefits and Insurance Overview

Marcia Peterson, Employees and Retirees Benefits Division
Benefit Strategy and Design Section

Kim Wallace, Financial Services Division
PEBB and SEBB Programs
November 6, 2017

Washington State Health Care Authority

Outline for Today

- Regulatory environment
- Insurance risk
- Types of health plans
- Benefits program design
- Medical benefits
  - Provider network structure
  - Covered services
  - Risk for high claims costs
- Dental benefits

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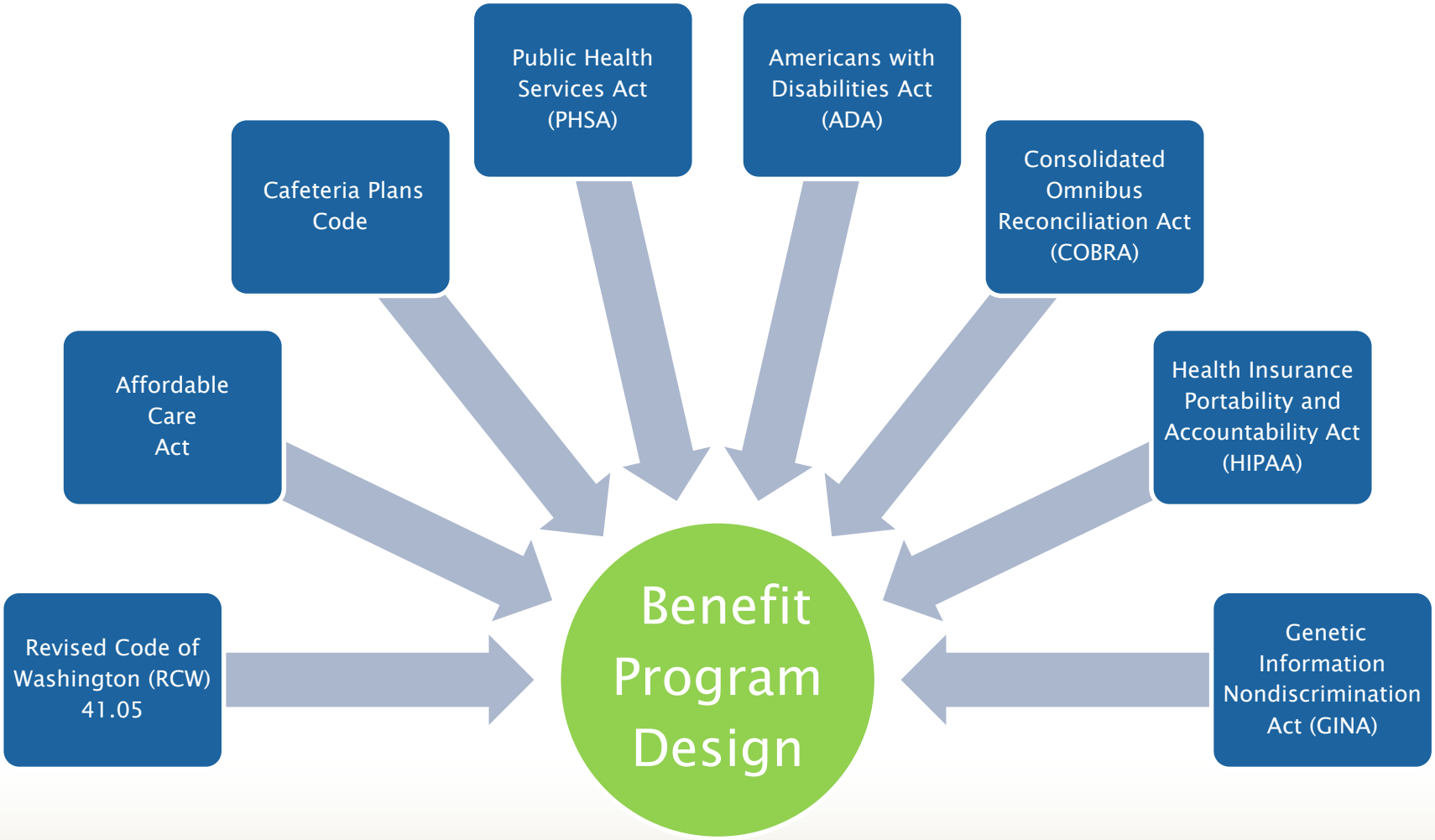
Regulatory Environment



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Insurance Risk

The likelihood that an insured event will occur, requiring the insurer to pay a claim.

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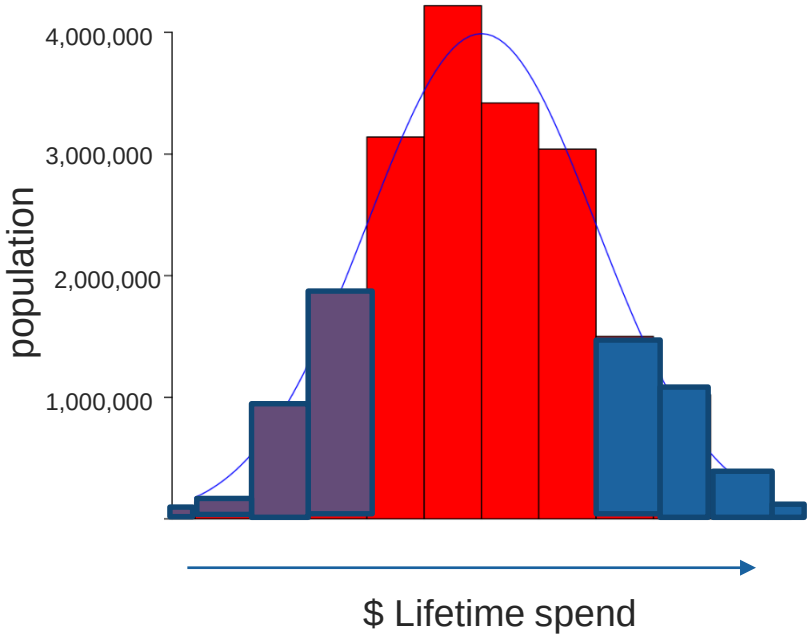
Distribution of Health Risk within a Population



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Employer-Sponsored Health Plan Funding Arrangements

- Fully-Insured Health Plans
  - Employers contract with a health plan to provide insurance coverage for its employees.
  - Premiums based on employer size, population characteristics, and health care use.
  - Health plan bears the risk.
  - Smaller employers tend to offer fully-insured plans.
  - Known annual premium cost, employer does not have to pay for claims that are higher than premium payments.

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Employer-Sponsored Health Plan Funding Arrangements, (*cont.*)

- Self-Insured Health Plans
  - Employer acts as own insurer, pays the claims costs directly.
  - Employer will sometimes use third party administrator to process the claims.
  - Employer bears the risk and must pay all claims even if they are much higher than predicted.
  - Large employers tend to offer self-insured plans.

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Types of Plans

- Preferred Provider Organizations (PPO)
  - Health plan contracts with providers to create a network of participating providers.
  - You pay less if you use providers that belong to the network.
- Health Maintenance Organizations (HMO)
  - Have their own network of providers who tend to have incentives for preventive care, wellness.
- Consumer Directed Health Plans (CDHP)
  - A high–deductible plan must be paired with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA).

Member Cost Sharing

- Copayments are collected at the provider visit; typically a flat fee per visit.
- Coinsurance is a percentage of cost to be paid by the member after the claim is adjudicated.
- Deductible is the $ amount that the member must pay for care in a plan year before coinsurance applies.
- Out-of-Pocket Maximum is the $ amount paid by the member for care in a plan year beyond which the member pays no more out of pocket, i.e., the plan pays 100%.

Washington State Health Care Authority

Overall Benefits Program

- Basic Benefits
  - Benefits provided and largely paid for by the employer.
- Optional Benefits
  - Other benefits offered through the employer that employees can choose to pay for.
- Example
  - Basic life insurance – State pays for certain $ amount of coverage for the employee.
  - Optional life insurance – Employee can choose to pay premiums to obtain more coverage, e.g., wants $100,000 more life insurance than what Basic provides.

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Funding Approaches

- Set $ Amount, like current state allocation for school benefits.
- Set Benefits/Coverage, like current PEBB Program benefits.

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Risk Pool

- Single Risk Pool
  - The legislation creates a new single risk pool for all employees and dependents from K-12 school districts, ESDs, and charter schools across the state.
- The Effect
  - People who use a lot of health services, aka “high cost” enrollees, are in the same risk pool as people who use few or no health services, aka “low cost” enrollees.
  - When rates and premiums are set, funds must cover the expected costs of all people in the entire risk pool.

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Risk Pool, (*cont.)*

- Employees will choose different health plans (for example PPO plans vs. HMO plans), which will affect the premiums and cost sharing they pay during the year.
- Even when employees choose different health plans, they are still all in the same Risk Pool, so they affect one another's rates and premiums.

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Medical Benefit Plan Design

- Types of services covered
- Provider network structure

Types of Services Covered

- The government regulates many services that are covered by medical plans. HCA will help clarify and keep the Board updated regarding these requirements.
  - Example: United States Preventive Services Task Force (USPSTF) recommendations; the Affordable Care Act requires coverage of screenings and counseling services rated “A” or “B” by the USPSTF as well as selected immunizations and preventive services specific to children and to women with no member cost share.
- Additional services can be added to a medical plan, such as prescription drugs and vision care.

Provider Network Structure

- Preferred Provider Organization (PPO) networks
  - Broad based and typically include negotiated discounted rates in contracts with most providers. Member usually pays more to go "out of network."
- Health Maintenance Organization (HMO) networks
  - Typically include fewer providers than PPO networks. The providers may be employed by the Carrier/Plan or they may be contracted. Often, emergency care is the only care covered outside the HMO network.

Provider Network Structure, (*cont.)*

- Accountable Care Networks
  - Select network of providers that offer integrated care management with responsibility for improving quality of care and effectively managing the total cost of care for the plan.

Dental Plans

- Networks
  - Preferred Provider Organization (PPO) networks are broad based and typically include agreements with most providers. Member usually pays more to go "out of network."
  - Dental Maintenance Organization (DMO) networks typically include fewer providers than PPO networks. The providers may be employed by the Carrier/Plan or they may be contracted.

Dental Plans, (*cont.*)

- Insurance Risk
  - Fully-Insured: Plan sponsor pays premiums to the carrier. The carrier is at risk for gains and losses on the cost to provide services.
  - Self-Insured: Plan sponsor pays claims costs. The plan sponsor is at risk for gains and losses on the cost to provide services.

Questions

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