Washington State Health Care Authority

**School Employees Benefits Board**
**Meeting Minutes**

July 25, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 p.m. – 12:00 p.m.

**Members Present**
Sean Corry
Alison Poulsen
Katy Henry
Pete Cutler
Dan Gossett
Lou McDermott

**Member via Phone**
Wayne Leonard
Patty Estes
Terri House

**SEB Board Counsel**
Angela Coats McCarthy

**Call to Order**
**Lou McDermott, Chair**, called the meeting to order at 9:00 a.m. Sufficient members were present to allow a quorum. Board self-introductions followed. TV Washington (TVW) was in attendance live webcasting the meeting (www.tvw.org).

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

**Approval of March 7, 2019 Meeting Minutes**
Alison Poulsen moved and Pete Cutler seconded a motion to approve. Minutes approved as written by unanimous vote.

**July 18, 2019 Board Meeting Follow Up,**
**Dave Iseminger**, Director, ERB Division. Many of the questions asked were answered contemporaneously last week or were broader, long-term policy questions for discussion regarding the program launch. Today is an historic meeting. This is the Board's 21st meeting with two significant pieces of legislation and a funding bill enacted

and signed by the Governor. The Board, HCA staff, and many stakeholders have been working very hard for two years. Some stakeholders have been working for decades, or most of their careers, to bring about state consolidated, high quality, affordable benefits for school employees. I'm very proud of all the hard collaborative work you and so many other stakeholders have gone through that have brought us to this monumental point.

As you know from reviewing the Board materials for this meeting, Megan will be presenting additional updated rate information to you, specifically revised rates from Premera, when she presents shortly. I want to give the Board and public additional context about the last few days, Premera's newly proposed rates, and the resulting employee premium contributions.

Starting with the Board materials produced for the July 18 Board Meeting, they were published on HCA's website on Monday, July 15. As Board Members, you already had received an email copy before they were posted. Unsolicited, Premera emailed the agency and submitted revised, lower rates to the Health Care Authority on the afternoon of Wednesday, July 17. When Megan comes up, she'll be able to talk with you more about the rate setting process that occurred over the past several months.

At the Thursday, July 18 Board Meeting, HCA presented to the Board the rate information and employee premium contributions from the already publicly available Board materials. As is clear in the record, the Board did meet in Executive Session last Thursday. Although I cannot comment about the discussion that occurred during that Executive Session, I want the record to be clear about who attended the Executive Session because the agency has heard concerns about who was present during that Executive Session. The attendees included only SEB Board Members, HCA staff, and Assistant Attorney General Katy Hatfield from the AG's Office.

Between last Wednesday and last Friday, our HCA finance team had conversations with Premera and discussed the basis for their rate change. Again, when Megan comes up, she can provide more information during or after her presentation. Last Friday afternoon, we informed all potential SEBB Program fully insured medical carriers about Premera's recently submitted revised rates. Remember, until the Board takes action, no one is a carrier in the portfolio.

The agency stated an intent to present the revised Premera rates to you at this July 25 Board Meeting, and we initially gave Kaiser Northwest, Kaiser Washington, and Kaiser Washington Options until this past Monday morning to submit revised rates. The Board received, in your materials this week, a copy of a letter sent by Kaiser Washington and Kaiser Washington Options to the Health Care Authority. And after receiving that letter, HCA responded by offering additional time to provide updated rates and the ability to delay a vote on their premium resolutions until August 1. We did not receive updated rates or a request to delay action on the resolutions.

The agency had an obligation to present the Board with Premera's revised rates because only the Board has the authority to authorize employee premium contributions. Therefore, rates and premium contributions are not final until this Board acts. The additional rate information you received could have a significant impact, and as Megan will describe, millions of dollars each month on the monthly employee premium

contributions. For clarity, the materials you have before you today have all the rate information as it was presented last week and a version with Premera's revised rates. The Board has the authority to accept either of the proposed rates. I want to be clear the order of the resolutions before you is in alphabetical order. You've heard me say many times over the last two years that we try to alphabetize things here at the Health Care Authority. Again, the Board has the authority and the rates are not final until the Board has acted. Megan and I will answer your questions to the best of our abilities during the next part of the meeting during her presentation.

**2020 Premium Resolutions**

**Megan Atkinson**, Chief Financial Officer. Slide 2 – Overview. I have one follow-up item and then the voting on the premium resolutions. There's a bullet missing between the two bullets listed. I will be walking you through the latest rates.

Slide 3 – SEBB Funding Rate. We've walked through this slide several times. This is the conference budget funding rate updated with our procurement information. Starting at the top of the table is the $555 employer medical contribution (EMC) that is on a per adult unit per month (PAUPM) basis. That pivots off of our self-insured UMP Achieve 2 plan. We multiply that by an assumed ratio of adult units per employee. That ratio is calculated to take into account the enrollment of dependents, as well as an assumed amount of eligible subscribers who will waive their coverage.

We then get to the $869 medical premium contribution that is now on a per subscriber per month (PSPM) basis. Moving down the chart is the dental premium, vision, basic life, basic LTD, all of which are paid by the employer. There is a K-12 remittance also paid by the employer. The K-12 remittance is specified in the funding act, the budget bill. The administrative and other costs are next. And we end up with a surplus or deficit spend.

As you see in this scenario, we balance to the bottom line, which is the total cost of the funding rate that is assumed in the biennial appropriations act, which is per subscriber per month (PSPM). That funding rate for fiscal year 2020 is $994. We balance to that, which puts us projecting to be in a deficit situation of $81, again, on a per member per month basis. That's the update on how we look balanced against the funding rate.

Slide 4 – Employee Premium Contributions: Medical. Slide 5 – Employee / Employer Premium Contributions. This information is presented the same way as last week. It's helpful to look at Slide 5 and Slide 6 together because it takes the physical space of two slides to walk you through all the plan offerings. Slide 5 is the employee contributions for Kaiser Northwest, Kaiser WA, and Kaiser WA Options offerings. This slide is read from right to left. On the far right is the proposed 2020 total composite rate. The middle column is the employer medical contribution, which is the same number for all the offerings because it's based off of HCA's own self-insured UMP Achieve 2 plan. The green highlighted column is the proposed 2020 employee contribution at the single subscriber tier. Those get multiplied by the tier ratios. The breakdown isn't included in today's presentation but it is in the Appendix, which are the slides from last week.

Slide 6 has numbers that changed from last week. Slide 6 shows the other two offerings in the portfolio, the Premera and UMP offerings. The first three rows are the

three Premera offerings. You'll see an asterisk and a footnote. These values have been updated since the July 18 Board meeting. Dave was explaining in his introductory remarks, last week we received, unsolicited from Premera, an inquiry about their ability to submit revised rates. While we were through the phase of the process that is rate negotiation with the carriers, we were not through the rate development cycle. The rate development cycle comes to conclusion when the Board votes affirmatively on employee contributions. That authority for setting employee contributions and accepting rates rests with the Board. We could even today be sent back to the negotiating table based on your actions.

While rate negotiation with the carriers was complete, the rate development was not complete. Premera notified the agency and asked about submitting new rates. We communicated to them that while we would make no commitment about taking those rates forward, we were willing to accept their information so we could at least have a conversation with them. The subsequent rates that Premera submitted resulted, in our opinion, in significant reductions to the employee contributions. Therefore, we brought those rates forward to you for action today. Those rates are on Slide 6 in the first three rows. You can see the employee contribution. For comparison purposes, the prior Premera rates are in the Appendix and shown on Slide 21.

So everyone can have an understanding of the relative change, the lowered rates, updated rates showing here are: employee contributions of $70 for the Premera Blue Cross High PPO, $31 for the Peak Care EPO, and $22 for the Standard PPO. The prior rates resulted in employee contributions of $98, $80, and $48 respectively for reductions from $98 to $70, $80 to $31, $48 to $22.

Because of this significant change in the Premera rates and the significant impact on employee contributions, we felt an obligation from the agency's standpoint to bring those forward to you for consideration. I want to reiterate that the ultimate authority for improving the employee contributions rests with the Board. We have brought both sets of Premera rates forward for you and obviously we'll respect the decision and the action of the Board.

**Pete Cutler**: Megan, my first question is, in a 24-hour period, we had Premera come forward with significantly reduced rates. Those new rates presumably were based on new changes in their actuarial assumptions in terms of estimating their costs going forward. Did they explain the details of each element that went into the change of assumptions? Did they explain why they waited until after they had submitted their final bids before they suddenly came up with new assumptions and a new bid?

**Megan Atkinson**: Yes. We did enter into conversations with Premera about that because we had those same questions. Those are the obvious questions. In subsequent conversations that the Health Care Authority had with Premera, Premera indicated a couple of things. They indicated they had a misunderstanding of the process and thought there was one more round of rate negotiations still to occur, indicated they had those lower rates already prepared for a final round of rate negotiations. They indicated the rates still had space in them to be lowered because they made changes in their margin assumptions, as well as changes in their out-year trend assumptions.

**Pete Cutler**: Do we have this in writing? As a Board Member, I'm really uncomfortable relying on verbal assurances.

**Megan Atkinson**: The explanation about the lowered margin and lowered trend assumptions was in verbal conversation with them. The misunderstanding about the process was, I believe, included in one of their emails. I would need to double check, but that's my recollection.

**Lou McDermott**: Megan, what do you think the annual impact would be based on our modeling of how many people are going to go into those plans? What do you think that number would be from a member perspective?

**Megan Atkinson**: Obviously we've talked a lot about the enrollment modeling we've done to date and how that's come into play in various points along the process. While we don't have any type of stochastic decision modeling happening where we're trying to model actual employee decision making, we do have enrollment modeling both at the population level and then enrollment modeling where we've spread the population across the offered plans in the portfolio. Based on how we have the population spread currently, over a 12-month period, these reduced rates would result in member reduction and member cost for premiums cost of around $35 million a year. And again, I think for us, that underscores the significance of this rate change and the obligation we felt on the agency side of being able to bring those forward to you.

**Pete Cutler**: Megan, I'm really uncomfortable with that number without knowing the assumptions because clearly there are other plans that school employees could go to that would not require higher contributions. There are key assumptions, would people stay in and pay the higher premium or would they move to another plan offering that would allow them either same or lower premiums. Understanding more details about the assumptions that go into that, would be important. From my point of view, the integrity of the process is more critical anyway. But in addition to that, I'm really uncomfortable relying on a single number without knowing the details of the assumptions. Where would these people who you think would have gone into Premera, where would they have gone, and the basis behind that. I assume that's something the actuaries put together?

**Megan Atkinson**: No, we do not. Again, I want to emphasize, we do not have any type of stochastic decision model underlying our enrollment assumptions. The enrollment assumptions we have relied on our actuaries for have been at the population level. We have spread the population across the plans in the portfolio offerings for purposes other than rate setting like when we needed to have communication or conversations with the legislative staff during the state budget negotiations, when we have needed information to build into our admin assumptions, for example.

I understand the point you are making, Pete, that all of our modeling is based on a series of assumptions. For some of the modeling, we utilize our actuaries to support us in that. Other modeling, we do internally in HCA. The spreading of the population across the plans in the portfolio is modeling we did within the agency and you are correct. We could be, and in fact, I guarantee you we will be, wrong in how we have predicted people could spread or enroll across the plans. I don't share that $35 million

figure with you to in any way try to encourage you to use that as a single data point in your decision making. What we are trying to do from the agency perspective is bring forward to you the information we have, any contextual data points that we think might be helpful to you in making your decision.

**Lou McDermott**: Megan, I want to be clear on something. We had the internal modeling, which spread the population out among the plans that were available. Then this wrinkle comes into play where there is a significant rate reduction. You made no further adjustments to those models based on how people would respond to that rate reduction. You said this is where we think they're going to land and that $35 million is just a straight calculation off that from one rate to another with no additional populations moving around towards or away from the plan?

**Megan Atkinson**: That is exactly correct.

**Pete Cutler**: I appreciate that this was done under a tight timeframe. I have to admit, having worked with actuaries and knowing how important pricing is to predicting where people will move, I'm frankly uncomfortable being asked to make a decision without that kind of analysis. Based on actuarial analysis and what actuarial science says about how people move based on pricing options, this is our estimate of where we really think we'd end up, which I understand is a different kind of calculation than what you were able to pull together based on the data you have. I guess that's really not a question. I feel like that's a bit of data that would've been better for the Board to have.

**Megan Atkinson**: I want to remind everyone that the way we manage the bidding for the population is we ask all the plans to bid the entirety of the population. Then we use additional risk adjustment, as well as regional adjustment factors, to get to the plan's payment rate. The plans bid as if they receive the entire population. And then we use risk adjustment with the actuaries based on how people actually enroll to get to a payment rate for the plans.

**Sean Corry**: Megan, could you tell us please, what we know about the actuarial work that's been done on either Kaiser Permanente's reduced rates and Premera's reduced rates? Are these reductions fully supported by the actuaries who vet these kinds of things for us?

**Megan Atkinson**: I want to draw a couple of distinctions for some of us who are familiar and have worked in the Medicaid business. We have very strict guidelines from the federal government, from CMMS at the federal level, on having actuarial certification of our Medicaid rates. We don't have those same requirements for our employer sponsored offerings. The process that the carriers go through is they submit information on our bid rate forms. Those go to our actuaries. We also receive them here at the Health Care Authority. We do a review to make certain formulas are correct. It's not a cursory review, but a first tier review, making sure the forms are completed correctly, there are no formula errors, there are no omissions of the data.

In addition to that, we rely on our actuaries to go in and see the way the carriers built up their rates to see if the actuaries see anything that appears alarming, inconsistent, or unsupportable. We do not ask our Milliman actuaries to certify the carriers' rates. We

have our actuaries certify our UMP rates because they are responsible for building our UMP rates and they have to adhere to their standards of practice for that. Each carrier has their own actuary team and I assume each carrier is utilizing their internal actuaries to build up their rates and certify to the carrier's comfort level the rates they submitted to us. We do not have any way to validate or invalidate the different business decisions that each carrier is making about how they are trying to position their plans or their offerings across the portfolio.

When we get in conversations, and we've been in conversations with both of the carriers because both carriers had reductions to their rates late in the game. The Kaiser reductions to the rates occurred before the materials were submitted for the July 18 meeting. The Premera reductions occurred after. And that is what makes it unusual. Both carriers, though, lowered their rates late in the rate development process and we had similar conversations with both of them around how sustainable their rates are, why the late change, what has changed in your view of the data. Remember, we use the same data book they have. We had all of those conversations but there's not a step in the process, Sean, like we have in the Medicaid side where we actually get a firm certification of the rates. Does that help at all?

**Sean Corry**: It does. Thank you. It makes me wonder about the extremes though. If carriers have cut their rates in half and propose those, which, on its face, would be too low? Let's just presume. What's the mechanism for you then? What triggers would you have to declare that this is just over the line?

**Lou McDermott**: Can I get a point of clarification? When Sean said cutting the rates in half, they did not cut their bid rate in half. They cut the premium portion, which is a small -- I just want to make sure folks --

**Megan Atkinson**: The bid rate reduced such that --

**Sean Corry**: I understand. Thank you for that clarification.

**Megan Atkinson**: -- but the employee contributions went down, some of them by half, not all of them, yes.

**Sean Corry**: But back to my question. There seems to be an implied point at which you would step in and say these are unreal. Tell me, if you don't have a rigorous actuarial vetting of the proponent's numbers and the new numbers, how do we handle the smell test?

**Megan Atkinson**: I want to clarify, while we don't require an actuarial certification on our SEBB Program rates like CMMS requires on the Medicaid side, we do rely on our actuaries to do a vetting, a review of the rates. We have conversations with our actuaries about do we think these rates are too low? Do we think these rates are sustainable? Do we agree with the carrier's analysis of the trend assumptions? We have those conversations. If the rates were so low that we felt strongly they were dangerous in some way, jeopardizing the program, jeopardizing the offerings, that's information we would communicate with you now while you're getting ready to vote on the rate resolutions. Instead of just presenting the rates to you, we would have

additional commentary. I will say, when we had the conversations with Premera and they indicated they had lowered their margin and trend assumptions they conveyed to us, the trend assumptions they're carrying in their rate development are in line with the trend assumptions we're carrying in our own UMP rate development. They didn't seem out of line with what we're carrying ourselves.

**Dave Iseminger**: I want to make sure Board Members on the phone know that we had some background noise so we keep muting and unmuting. If you're trying to talk, we'll turn it back on for you periodically to get your talking points. Also, we described late in the process rates coming in. I wanted to be very clear that our documentation described a rate process that spanned multiple months, an April-June-ish range was anticipated for that rate negotiation process. June was when we received the most recent round of rates from KP Washington, KP Washington Options, and KP Northwest. Premera provided them on July 17. When we were describing things as coming in late in the process, I wanted to be very clear on the record that there is a difference between June and July and who was received in June and Premera's receipt in July. I did not want them to be lumped together in people's minds incorrectly.

**Wayne Leonard**: Pete mentioned the integrity of the rate negotiation process. I'm a little confused on that too. My experiences with these kinds of processes is that once that timeline is spelled out fairly clearly in the request for proposal or a bid document, at a certain point in time, no new information would be accepted. Hearing that Premera was confused about that timeline is a little concerning. But not having been involved in a rate negotiation process, or a rate development cycle, and not having seen the RFP, my question to the HCA staff, is this normal in this kind of process that information would come in this late from both carriers, especially when the Health Care Authority hasn't adjusted their rates this late in the process? They're sticking with their original rates. Is it normal to see this kind of activity this late in this process?

**Megan Atkinson**: I want to walk through the process for everyone. Last year the RFP was released and carriers responded. As part of that, we communicated with the carriers in the RFP that we would do a second phase, a request for completion (RFC), which is underneath that umbrella, when we finalize rates. Within the RFC is where we spelled out the timeline for rate negotiation and finalizing the rates with action from the Board. Because rate negotiations can be difficult to predict how many times you need to go back and forth, and because this was a new offering, we didn't spell out to the day or even the week the timeline. Instead, we had broad categories of months as Dave was explaining earlier. We spelled out, I think it was April to June would be rate negotiations between HCA and the carriers, and July through August would be finalization of the rates with action taken by the Board.

I want to clarify again because I might be creating the confusion. Dave clarified it, but I want to clarify it again. The final rates that we have from Kaiser came in June before we prepared and released the Board materials for the July meeting. It was in the last round of rate negotiations with Kaiser that they lowered their rates and then we had conversations with them of what caused this? This is after we've given you all the data. We had that conversation with Kaiser. Again, that was in June.

We had the notification from Premera in July, after we prepared and released the Board materials, and after we communicated the rates to both carriers. We asked if these

were their final rates for us to submit to the Board. I want to be clear we did communicate to the carriers these are your final rates to be submitted to the Board. Emphasizing again, the rate development process does not end until the Board takes action. Does that help at all, Wayne?

**Wayne Leonard**: But then they weren't final. Is that what I'm hearing? After you told them these were the final rates you submitted to the Board, they submitted lower rates?

**Megan Atkinson**: Yes. The electronic communication from us goes out to the carriers. In the message we includes their rates and ask them to validate those rates. These are your final rates for us to submit to the Board on July 18.

**Katy Henry**: Did they validate the rates at that time?

**Megan Atkinson**: Yes. Then Premera responded indicating they misunderstood the process, and upon further reflection, were able to lower their rates more. They asked if we would accept a late offering. We told them we couldn't promise that we would take the new rates to the Board, but they could submit in order for us to have a conversation about them. They submitted the lower rates, we had the conversation with them about what caused this change, what are you seeing in the data, how are you able to lower your rates at this point. And now we've brought them forward to you.

**Terri House**: If we were to move forward with accepting Premera's reduced rates, is Premera offering any greater coverage in the state of Washington, in areas they hadn't covered before?

**Dave Iseminger**: Terri, when we received the revised rates last week, there was nothing changed, or proposed as changes, to the service areas that were in the Board's materials last Thursday and publicly released. The revising downward of the rates did not impact positively or negatively service areas already locked in with a carrier.

**Lou McDermott**: Or benefit design? No changes to benefit design?

**Dave Iseminger**: Correct. There were no changes to benefit design. It was purely numbers.

**Alison Poulsen**: Going on a different line of thinking, can you talk through next year's rates and how this ties into future rate development and expectations members would have around, if I select a plan like this, do we cap how much growth there could be? Can you talk through that process for us?

**Megan Atkinson**: Definitely. Before I do that, I want to clarify one thing because I'm looking at the email chain now. On Thursday July 11, we communicated to 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." The next communication we had from Premera was the communication asking to lower their rates. I mentioned a moment ago that Premera said, "Yes. These are our final rates." That is not what happened. We communicated, "Are these final?" It was a few days later that they communicated, "We'd like to revise our rates." I want to clarify that for the record.

Now I'll answer your question, Alison. One of the things we do immediately after this process is done is to start thinking about next year. We've already started strategizing. One is what data will we request back from the carriers as we enter into 2021 rate negotiations. What type of information will we want to be looking at? What type of analyses will we want the actuaries to undertake? For example, some of you are probably aware there's been some really interesting national research done around hospital prices, and especially around regionalization or regional differences in hospital prices. That's going on my list of what type of information will we want on that and what type of analyses will we want the actuaries to do. We do have the regionalization factors we've calculated for the SEBB Program, and we see differences across the state in cost. We have assumptions about how that is indicative or isn't indicative of provider and contract efficiency. We'll probably want to look at that.

How are the carriers' costs happening across the regions? As you also may recall, when we walked you through the PEBB Program contracts that we're leveraging for the SEBB Program, we have certain performance guarantees on our UMP side. Those performance guarantees are pegged in some instances off of a certain percent of Medicare. That is also a pricing mechanism you're seeing a lot of research around, a lot of focus on nationally, of using the Medicare pricing, which already includes some regionalization as a base when you compare your plan offerings to try to judge the cost effectiveness and efficiency of your plan.

Those types of things are what's already going on the drawing board as we think about the 2021 negotiations. For timing purposes, we will probably have the first communication with carriers for 2021 in November or December 2019. It's not that far into the future. In addition, I think it's fair to say we anticipate clarifying with more detail the rate development process and the timelines for rate negotiations. Does that help?

**Alison Poulsen**: I guess part of what I was curious about is rates that are set this year and how that would affect what a member would expect to see in increases next year. I understand the data analysis. I don't think I have enough context for where there are protections for members, or it's just a market force that if your rate went up that much, I might be looking at a different kind of plan.

**Megan Atkinson**: We don't have rate guarantees on any of our rates. We asked both carriers for rate guarantees. Kaiser did offer a rate guarantee that we ultimately did not accept because we felt it was too high. Accepting a rate guarantee signaled our willingness to negotiate up to that level. Premera did not offer a rate guarantee. There are a couple data points we look at for rate negotiations for subsequent years. A lot of focus ends up, especially when we're communicating, what percent increase are future rates? Your rate that you set, especially here at year one, is pretty important because we judge the "acceptableness" of future rates off of what percent increase are they from where you are right now. We benchmark against national data, which also will have percent increase information in it.

We will heavily leverage the information we have about our own self-insured offerings. Depending on how much population we get, it's very likely we could have enough of the population where it's statistically significant when we look at the experience of the carriers. What is their claims experience? We want a relationship with carriers where

they stay in business and want to be in this space, but not so much that we're overpaying. We also have the ability to leverage the federal calculations around medical loss ratio and administrative ratios. We will leverage that information as we work the carriers.

I can't say we will only allow 2% on in-patient and 3% on professional services, and, 7.5% on prescription drugs. I can't give you those types of firm benchmarks. I can describe the totality of the information we bring in. If we get into the 2021 rate negotiations with carriers and some of our partners come forward with rates we feel are not acceptable, the agency will communicate that to you and why we feel they're unacceptable. Does that help?

**Alison Poulsen**: That does. Thank you very much.

**Pete Cutler**: Two questions. In terms of the trend assumption, margin assumption changes, and whatever other actuarial assumption changes Premera made, would it be possible for HCA to do a comparison chart of what the Kaiser Permanente proposed rates, what their assumptions were for those factors versus Premera versus UMP?

**Megan Atkinson**: We definitely can pull together a comparison chart for you of the specific data points that we have for all of the carriers, of the crucial ones. The rate book is large. We'll distill some of those down. I'm not sitting here today without looking at it. I'm not confident that margin is a data point in the rate book. The trend information and those types of things, we can pull out.

**Pete Cutler**: What you're saying is somewhere Premera laid out that they reduced their margin, presumably they'd tell you how much. But you may not be able to compare that with Kaiser.

**Megan Atkinson**: I'm not certain that margin is a data point that we have across all plans.

**Dave Iseminger**: And Pete, we'd have to think carefully about whether this is proprietary and confidential information.

**Pete Cutler**: That's what I was trying to get at.

**Dave Iseminger**: Distinguish between the public and what the Board would have access to, so if that's something the Board wants to review, we'd have to think about that overlay as well, to lay that out for the record, too.

**Pete Cutler**: That was part of my question, whether this was even something you could share and it sounds from your comment, David, that it may be something you can share with the Board but not the public.

**Dave Iseminger**: Possibly. I just wanted to raise the yellow flag that this could be something considered to be proprietary. We would have to walk through that analysis. I'm not saying I know the answer to that question. We'd have to talk with the Attorney General's Office and the carriers because they also have a right to protect proprietary information.

**Pete Cutler**: Sure. I'm not asking to violate any contract terms, especially regarding proprietary things. There is an underlying question for the Board of this last minute change, which Premera claims they had been working on and had been planning to propose before. It's a red flag for me as a Board Member that a significant change would be made so late in the game, and especially knowing that they made that change after they knew what the Kaiser rates were. They obviously knew the UMP rates before that. I think part of my due diligence in terms of fiduciary duties is I want to know are those assumptions similar so that it seems reasonable? I've worked with actuaries for a long time. I know when you predict the future, there could be a wide range of assumptions that are considered professionally acceptable, albeit, not all equally strongly defensible. I would like that information if possible.

The second thing I just want a confirmation. Kaiser said an email went out May 11 saying send us your final rates and they did use the term final rates by a certain date. Then as you indicated, either a letter or an email was sent on July 11 was sent saying, "We have your final rates. We're sending them in." I guess what I don't understand is how could Premera possibly think after those two communications they had another opportunity to propose different rates. I guess that's really a question for Premera rather than for you. Thank you.

**Lou McDermott**: Megan, while you were talking, you did indicate when you reviewed the Premera out years, you reviewed their trend assumptions. They were in line with UMP. Is that correct? You did say that? Okay.

**Sean Corry**: Megan, I want to follow up with basically the same question Pete just asked. What I'm hearing from you folks, the Health Care Authority, is that this language about final rates was written in pencil and not in pen. Final doesn't really mean final. Give me please a clearer understanding of that term and how it's been used in the past as compared to how it's being used today.

**Megan Atkinson**: I appreciate that question, Sean, and that distinction because it is the crux of the conversations we've had internally and obviously the crux for a lot of you. I think it really rests on the understanding of the rate development process and the authority of the Board to approve employee contributions, and de facto approved bids. We consider the rate negotiations with the carriers to be a component of the rate development process. It's not the entirety of the rate development process.

When we use the term "final" with the carriers, we had been meaning we're through negotiating with you. It's final. The reason we felt the Premera rates needed to come before you is because you haven't taken action on the employee contributions. Therefore, we aren't finished with rate development until that action occurs. We can't presume the action you're going to take on the resolutions. All of the resolutions could fail and we would need to get information from you and go completely back to the table. Because of our clarity that final action from the Board has yet to occur, we felt these rates could come back to you. If, and at the point in time when that action has been taken by the Board, we wouldn't bring anything back. A carrier could come in after that asking to revise and we would say it's too late. Board has taken action and we're finished with 2020. Does distinguishing final in that context help?

**Sean Corry**: It helps a little. Thank you for that. The use of the word "final" is still bugging me because it's clearly not final. What we're hearing is there was a discussion and a decision at the Health Care Authority, that in this case, final is up until this hour. We could hear from Kaiser or Premera right now. Somebody could pop up and say they have better rates. Given that context, has this circumstance occurred in your many years of negotiations with the carriers now only one, I think, for the PEBB population where final didn't really mean final? Or is it more likely if you look back that when you said this is the final date, these are your final rates, you've rejected submissions after that in other circumstances like this? Is this unique? Have you never faced this circumstance? And if you have faced this circumstance, how did you handle it?

**Megan Atkinson**: I have not gone back and looked at all of the timelines for every PEBB rate development that's occurred over however many decades we've had the PEBB Program in place. It is somewhat of a different situation in this regard because the years that I have been involved on the PEBB side, we've only had a self-insured product and one plan offering, one carrier offering.

**Dave Iseminger**: Megan, just to correct, we've had two but they haven't had overlapping service areas.

**Megan Atkinson**: Correct. I think of them as one. They haven't had overlap in service areas. Again, I haven't gone back and looked at all the PEBB timelines to see if this has happened. I will say for the ones that I have been involved in, we haven't had this happen. Again, the communication from Premera was unsolicited by the agency and unexpected. But given the timing of where we were in the rate development process, we felt strongly that it needed to come forward to the Board.

Our understanding of the rate development process is an additional factor and the rates aren't final. The employee contributions have not had Board action yet. In addition, we look at the entirety of it. If we sat on this information and not brought it to the Board for your deliberation, that equally feels like we're holding information from the Board that you should have access to in your deliberations. It's trying to find the right balance in those situations. Yes, it is unusual and I feel strongly that this wasn't information for us to keep from you.

**Sean Corry**: Thank you. I appreciate that. But there's an in between. The in between would have been these came in late after the date we declared it final; and therefore, rejected. This seems unique unless there are other people from the Health Care Authority who can remember times before you were in your position where this has occurred where final did not mean final. Or it was squishier than what I would have expected. Is this a unique circumstance, Dave? Lou?

**Lou McDermott**: In 2012 when I ran the PEBB Program, there was one year in particular where there was significant rate increases by Kaiser Permanente, which was Group Health at the time. So Group Health had a significant increase. We worked back and forth, again, looking at their assumptions, the actuaries stating their cases. We got to a point where they were not willing to move any further. It was done. We looked at those rates. There was a lot going on with employees not getting raises, different things were going on. It was going to have a negative impact on our members. I went to

Group Health headquarters and made the plea that they help us out, that they help out our state employees, that they reduce their rates. They came back with lower rates.

So the negotiations were done. I made one last plea. It was very out of the ordinary and they did reduce their rates. I think one of the reasons why rate development isn't as prescripted in rules is because it's a very unusual process. You're trying to weigh many different variables that come into play: market share, location, where are the service areas, what is the other plan doing, what is the UMP or self-insured experience showing. If we are showing a dip in in-patient across the board and we're being told by the carrier they're seeing a massive increase in in-patient across the board, we have those discussions to understand why. What's going on with your contracting? Why is this happening? Every year is a different flavor. I haven't been in direct negotiations with the carriers in many years now. My experience showed that every year had its own flavor, its own cadence.

**Sean Corry**: Thank you, Lou. So one summary statement that's in my head is that this is the year in which it becomes clear to everyone that final really doesn't mean final. I haven't seen the language in the documents referred to in Kaiser Permanente's letter that Board Members at least received. It wasn't in the public packet. And I don't know why, but in any case, we're setting a precedent, I think, very clearly based on this conversation mostly, that final doesn't mean final, that the use of the word is squishy. It's really not final until we take the vote. So let's go at it until the last moment.

**Dave Iseminger**: Sean, I would say we have an opportunity in the next year to redefine words, be even clearer. And so whatever action is taken by the Board today can also be refined by how the agency communicates with carriers in the future.

**Katy Henry**: Have both of these carriers worked with the HCA in the PEBB Program and gone through those timelines with the PEBB Program in the past?

**Dave Iseminger**: KP Washington, and in its prior iteration Group Health, has been a longstanding, partner with the PEBB Program for many, many years. I'm trying to think, Premera has a supplemental Medicare plan in the Medicare population for the PEBB Program and has for as far back as I can remember reading the various enrollment documents. I'm not sure how far back, but at least not in the last roughly decade, they've not been on the employee side of the equation. They've only been on the retiree side of the equation. If you go back far enough in the early days of the PEBB Program, maybe 15 years ago, there were 10, 12, 15 carriers and Premera was among them at that time. They are a TPA for the Centers of Excellence Program, the bundled payment program. That's a very different kind of rate negotiation contract piece but I wanted to be clear about the other contractual relationship they have with the PEBB and SEBB Programs through the Centers of Excellence as the TPA, third party administrator.

**Katy Henry**: Two other questions. I'm going to get them in while I can before Sean and Pete have more questions. One relates to what Alison said earlier based on going into the next year and looking at rates and plans. Going into next year, the Board still has the authority to decide plans and rates in the following year. So just because we may vote on a plan this year, or carrier, does not mean that would still apply next year? We would still go through the voting process, correct?

**Dave Iseminger**: That's correct. We would talk with you during the rate development process about how it's going. If you are concerned about a plan, we would negotiate with the carrier a rate that would exclude or include a plan so you would have that option available to you to cut a plan out of the portfolio.

**Katy Henry**: Okay.

**Lou McDermott**: This may be jumping ahead, but we have other tools available to us. If we felt the rate changes that come in for next year were having a negative impact on our members, and with the nature of sticky insurance, a lot of times once people have insurance, they stay with it. There are opportunities to take other actions such as active enrollment. We could have an active enrollment every single year. That's not what we do in the PEBB Program. We haven't had the conversations on the SEBB Program side as to whether we're going to do that, but that is a conversation we could have to combat some of these forces at play. There are some things we can do on our side. Obviously, most of our attention has been around finalizing the negotiations, the SEB Board meetings, getting the rates in, communication, and updating the IT systems, doing all those things. But those conversations will kick in as we begin rate development for the next year.

**Katy Henry**: If the Board does not take action today, what is the drop dead date by which something has to happen in order to have plans ready for 2020?

**Dave Iseminger**: Katy, that would be next Thursday's August 1 Board Meeting. When we set the original Board timetable schedule and released it sometime in mid-2018, we had no foresight as to how long the legislative process would take during the 2019 legislative session. We prepared timetables as if the Legislature completed its work on June 30 of this year. As we all know, the Legislature got out earlier than June 30 but we had built and accommodated a system in which we could proceed with open enrollment with all the information locked in on August 1. Since the legislature adjourned in late April, we saw an opportunity to expedite getting more information out to school employees. We have a very tight timetable. Six business days is a long time when you're talking less than 50 business days to go. There is a real positive aspect if the Board were comfortable and took action today. But if you're asking what the drop dead date is, it is next Thursday. As we've gone through this past week, we've been very clear with the options that we presented to the letters that we received from carriers. If a carrier needed more time they could ask for a delay from their end for us to bring and host an August 1 meeting for you to act on them. Does that answer your question?

**Katy Henry**: Yes, thank you.

**Sean Corry**: The letter from Kaiser Permanente identifies specific parts of the RFP or other documents which we have not seen. And the argument that they make and we probably will hear them make is that the language referred to is clear enough that final should mean final. That's the essence of their argument, I think. It makes me wonder if a delay of a week might be important enough to do so we Board Members can see what the language is to get a sense of what we think was truly communicated to the carriers as opposed to what we're hearing now, which is final doesn't really mean final. Final isn't until the vote. I'm essentially asking this question of other Board Members whether

we think there's value to delaying a week on this particular vote so we can get clarity about what we have actually communicated in the RFP process.

**Dave Iseminger**: We can make the documentation available to the Board. There are extra things that we add onto your Board emails, like we always batch the stakeholder feedback. There was a request in January as we were going through the eligibility resolutions to see the raw feedback HCA receives in addition to the presentation that happens at the Board meeting. We've always added supplemental materials. We did provide you copies of the various letters we received from Kaiser Washington/Washington Options and Kaiser Northwest. There are those references to the RFP document and a contract provision. We haven't included them but we can certainly provide them to you.

I will say the RFP itself has been on the HCA website since last August and is still there to this day. We've known that's a very active, high interest, RFP and it sat there along with the disability procurement. Basically, every procurement we've done in the PEBB and SEBB Programs in the last year and a half has been maintained on that website, partly because we anticipated we would get multiple public records requests. The answer when we receive such requests is to go to the website. That's not trying to say the Board should go look. I'm just saying that piece has been publicly available.

Megan and I both described the nature of the description in the RFP and the contract had very broad anticipated phases. It described the legislature will do this in these months and then we'll all get together and work on these activities in this range of months. It did not get to a granular level of a week by week, hour by hour, five pm close of business on this day deadline. The contract RFP provisions cited, the RFC, which is a subset of documents within the RFP, they do not get into that granular level. We'll certainly provide them to the Board if you want them.

**Lou McDermott**: Angela, I'm correct in assuming that the protest component for the RFP has already been adjudicated.

**Angela Coats McCarthy**: Yes, it was dismissed as untimely.

**Sean Corry**: Can you explain that because I didn't understand.

**Dave Iseminger**: The letter you received invoked two potentially different processes. One was a protest of the procurement and the other was invoking the dispute resolution process under the contract. The agency has already communicated back in writing that a protest of the procurement is untimely. Under procurement rules of the state, a bidder during a procurement has five business days after the protest period after they've received a debriefing to submit a protest. That debriefing has to occur within a set number of days of the announcement of the apparently successful bidders, which as I'm sure you remember occurred last fall, approximately in September. So after we announced ASBs, there's a period in which a debriefing can happen for any carrier. From that debriefing opportunity, there's a timetable to submit a protest. Under those rules, a protest of the procurement itself is approximately ten months late at this point.

**Sean Corry**: Thank you, Dave. So in this case, final means final?

**Dave Iseminger**: I'm not sure I understand your question, Sean.

**Sean Corry**: Well, they have a particular number of days to act and they did not act within that period of time. There's a final date on that.

**Dave Iseminger**: Sean, if you're looking for how these are reconcilable, both of them are how the law is described. The procurement laws describe a specific period for a protest period and the laws of the state of Washington give this Board the authority for the final rate setting in employee premium contributions. So the law speaks as to where the various authorities are and that's how, if you're struggling with how to reconcile final may mean or appear to mean different things in different settings, it's the legal framework from which each is presented.

**Pete Cutler**: Dave, if I understand correctly, the essence of the situation as the HCA looks at it is to the extent Kaiser Permanente wanted to challenge or protest the RFP that the assumption is the law provides when the RFP goes out and the apparently successful bidders are selected, there's a very short period. That's for challenges of the very basis of the RFP, just the structure, whatever is wrong, it somehow doesn't comply with law. Whereas there's a separate question of when you have a challenge of is RFP being followed. Is the contract, the initiation of a contract, I'm not sure what the status is. And that seems to me is really what KP is getting at, not that the underlying RFP was fundamentally flawed from a legal point of view. From their point of view, they don't think the RFP provisions are being followed. And that kind of challenge, I assume, can be made by them now. It's not challenging the RFP per se. It's challenging whether the Health Care Authority is following the RFP.

**Dave Iseminger**: Pete, I'll tread lightly here. I discussed how we have communicated the untimeliness of a protest of the RFP. We have engaged in the contract dispute resolution process. There are timetables within the contract for the dispute resolution process and we have not issued, under that timetable, our next stage in that process. So we are engaged in the contract dispute resolution process but the challenge to the underlying RFP and the process that it is invoking a protest as it's defined for procurement purposes, has been denied as untimely.

**Pete Cutler**: I appreciate the clarification because I think that was the important difference. Thank you.

**Lou McDermott**: And Sean, I have a follow-up question for you. When you talked about delaying the vote, are you talking about delaying the specific vote for the Premera rates? Is that what you're interested in?

**Sean Corry**: You're making me commit. The answer is when I was speaking before, that's what I was talking about. That's what I meant. That's what I did not articulate.

**Lou McDermott**: Understand. And I think we have, as we go through our procedure, an opportunity as the resolution is introduced to move the date of the resolution, to move it to next meeting.

**Megan Atkinson**: If there are no other questions on the slides, the next thing in the slide deck are the resolutions. Slides 6-8 show how the single subscriber employee

contributions multiply across the tiers. We spent a lot of time on that last week. I think you are familiar with how that multiplication works.

**Dave Iseminger**: There are five separate resolutions before you. With one exception that I'll speak to in a moment, they are the same as presented last Thursday. The structure of them is carrier by carrier. The question before you is about the acceptance of the suite of plans and the employee premiums associated with those plans. I want to remind you as I did last week that the passing of an employee resolution inherently ratifies the underlying benefit design, as well as the service areas as we presented them at the last meeting. Your authority is related to setting the employee premiums. That's why these are structured this way. It's an up or down vote on the entire suite for that carrier.

The difference you will see is in Slide 12 – SEBB 2019-15 Premera Medical Premiums, because we have presented you numbers for rates that are different for that carrier on two different dates. We wanted a resolution that was very clear. I believe when we get to that resolution, Chair McDermott will specifically ask if there's an amendment to strike and put a different date in the resolution, if the Board wants to, for example, insert July 18, 2019 and adopt the rates that were presented last Thursday instead of this Thursday. We wanted to at least present the syntax of it and the parliamentary process will exist to be able to go through amendments, motions, and changes.

**Sean Corry**: Dave, thank you for that. A question for clarification. At that point, I'm asking for a suggestion, actually if we were to agree to wait for one week on the particular issue we've been talking at great length about, the Premera submission, would it be at that point that we would move, second, and vote on the delay of that particular item?

**Lou McDermott**: Yes. I will read the resolution, ask for a motion to adopt, and a second. I'll ask for public comment, comments from the Board until we're prepared to vote, and then we'll vote.

**Premium Resolution SEBB 2019-12 - KPNW Medical Premiums**

**Resolved that,** the SEB Board endorses the Kaiser Foundation Health Plan of the Northwest employee premiums.

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

**Susan Mullaney**: Mr. McDermott, I respectfully request to be recognized by the Chair to address the Board on the 2020 premium resolutions and process. Thank you. Mr. McDermott and members of the School Employees Benefit Board, I'm Susan Mullaney. I serve as President of Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Incorporated. That's a mouthful. Both carriers are honored to provide care and coverage for over 62,000 teachers, administrators, and staff, as well as their families in public schools around Washington State. And we are committed to continuing to serve as their trusted provider and partner for many, many more years to come in the SEBB Program.

Why I'm here today, I wanted to be here personally, it's a simple one. I'm here to express Kaiser Permanente Washington's deep and significant concern with and objection to an eleventh hour radical departure from the established process to which all bidders were obligated to follow. That process aberration allowed Premera to submit rates after the deadline established by the Health Care Authority procedures. I can tell by now, I think everybody's read the letter that I submitted so thank you very much for taking the time to do that.

Briefly, in extensive materials, I want to talk about process. In extensive materials and communications from the Health Care Authority, each bidder was directed to submit the most favorable terms it was capable of providing for the benefit of school employees and their families. The HCA and the successful bidders -- so we submitted our final rates June 19. Not July 17, June 19. And bidders entered into contracts on or by July 3. Final rates were confirmed on July 11 by the Health Care Authority to Kaiser Permanente Washington, and to the best of our knowledge, and I think it's been confirmed here this morning, to the other successful bidder. That was July 11. We submitted our final rates June 19.

In the SEBB Briefing Book published on Monday, July 15, those previously private rates were made public in preparation for the July 18 SEB Board meeting. That was proper procedure as it gave the public, including teachers and other school employees via the SEBB website, the fully vetted and HCA analyzed rates and enabling public awareness and comment. Presenting the rates to the public on July 15 also informed the contracting plans for the very first time of other plans' best and final rates. So this is the first time that any health plan saw another health plan's rates. And if we understand it correctly, only after Kaiser Permanente's rates were made public, did Premera then quietly communicate to the Health Care Authority on Wednesday, July 17 that it wished to revise its final rates. Nevertheless, at the July 18 SEB Board meeting, we were all told that the rates that were presented in the July 15 SEBB Briefing Book would be voted upon by the SEB Board at today's Board meeting.

Unfortunately, in what we believe is a plain violation of contract and the basic notions of fairness and integrity in the public contracting process. Outside of public view, Premera's late altered rates were presented to this Board behind closed doors. As you might imagine, when we learned about this after the fact, we objected to this subversion of the contracting and public review process. Let me paint this in simple terms: despite clear protocols that guarantee that all bidders would have equal opportunity to develop and submit their best and final offers without knowledge of their competitors' bids, Premera was permitted to see our rates and then submit changes that would be to its advantage. I think it's curious that their rates came down so much and they are within a dollar, if you look closely, they are within a dollar of our rates. I've heard an assertion that the late submitted Premera rates would also provide savings to the state and school employees that would've been unavailable had Premera not been permitted to submit late rates.

So the process is one thing and I've covered that. But then there's also, it sounds like, the question of, "wow, this is worth so much money. How can we not look at it?" There are no savings to the state. I want to be really clear about that. Why is that? The state is using a defined contribution approach that was walked through earlier this morning

based on the UMP benchmark plans. The defined contribution means that the state is fixing what it will pay at a maximum dollar amount on the basis of a formula. Prior to Premera's amended rates, that defined contribution was $555 for a single employee per month for all plans. With Premera's amended late rates, none of their rates come in low enough to affect that $555 contribution on the state's part. So therefore, the state would still pay the same amount per employee, that $555 rate, regardless of the amended rates. That's true for all employee coverage tiers. So I want to be crystal clear, the state does not save any money.

As for school employees, real people who need access to affordable, high-quality health care, the bidding process already produced a number of affordable health care options available to school employees and their families at similar benefits. Here's an example: if I'm a single school employee, the original rate submissions included seven plan options for me priced at $50 or less a month. Of those seven, three plan options are actually priced at $25 or less. If I'm married with a family, there are also seven health care options priced at $150 or less per month. None of Premera's proposed new rates would offer a less expensive choice to me than what's already available in a UMP or Kaiser Permanente plan. And because the large provider networks offered under the states in Kaiser Permanente's PPO plans, with most of those options, it's very unlikely an employee would need to change providers, which I think is also another important consideration when selecting a lower cost plan other than Premera's.

These are massively important technical details. That's why I'm taking the time today to walk you through this. But I'll take a step back, though. What matters as much, so there's the money issue, all right? So the state doesn't save money. A real person already has really good options. Premera's new rates don't change that and they are also enough options out there with a broad enough network that a real person wouldn't have to change providers to gain access to those lower rated plans. But what matters as much as that is the integrity of the process and you've all discussed that at great length this morning. So you, this Board of directors and the Health Care Authority are leading a brand new process. You know, it is a momentous occasion. And with that, you carry such a significant burden and responsibility to make sure that this process is airtight. And I agree with the comment said earlier that you're setting a precedent. You are setting a really important precedent with following a process that from our perspective was really well laid out. We know that a lack of process integrity could undermine the trust in the entire program, in this entire new program. Process matters.

If the SEB Board were to endorse this radical departure from the established process, I'm really concerned that future bidders would be deterred from entering the process, diminishing competition, and driving up costs. You know, to some of the points made earlier, where does the process begin and end? Is it actuarially sound? Could I show up today and say, "Hey, I've got a lower rate." You know, we put our best foot forward. We submitted rates in mid-June. We did a lot of work on that. And that will stand up to actuarial test for sure. Me, personally, I don't think I'd feel comfortable with a 24-hour turn cycle changing rates so dramatically. So that process really matters. Does final mean final? In our eyes, final meant final when we were notified these were final rates. And now they're coming to you.

Public scrutiny of the bids and rates will diminish if the process is not adhered to. Undermining the benefit of a largely transparent process, I think that matters a lot. A

transparent process where members of the public and affected employees can have a meaningful say in its outcome, meaningful access to transparent, vetted rates, and a meaningful say in its outcome. Kaiser Permanente, we have served school employees as our valued customers, patients, and partners in this state over many years and in Oregon, over many, many years. We would not engage in -- I want to be really clear about this -- we would not engage in or ask SEBB to countenance or support this kind of gamesmanship, which ultimately hurts a thoughtful and deliberate process designed to get the best and most effective health care services for school employees. We would not ask that of you.

The good news is that there is a way to correct the procedural problems and reestablish fairness into this process. The SEB Board, you as this Board, have the ability to approve the rates originally and timely submitted with the July 15 SEB Board Briefing Book. Those were the rates that followed the prescribed process that was really well laid out by this very hardworking HCA team. You guys have worked night and day to bring this to life. That was really well laid out. Those rates have been reviewed for actuarial soundness and they offer to the employees of our schools a wide variety of affordable options for excellent care and coverage. So we respectfully request that this Board take that action today clearly and decisively. My team has prepared, and I will now provide you with a motion to accomplish that outcome. I'll give this to you David since you're running the show here. So there you go.

I trust, especially after hearing this really thoughtful discussion, and after seeing the incredible hard work that was put in by this great HCA team, this Board will take the necessary actions to guarantee that procedural integrity is assured in the SEBB Program so teachers, administrators, and staff of our public schools can have confidence and trust in the system that provides their health care and coverage.

Mr. McDermott, I really want to thank you for you giving me this opportunity today and for the thoughtful discussions that we've had. I really appreciate that and for all the work that your team has put into this process. It's been a lot. And I want to thank this entire Board for all the work you've put into this process and for setting up SEBB. That's huge. And I really want to thank you for listening to me this morning and thoughtfully hearing Kaiser Permanente's point of view. And I'll conclude there.

**Lou McDermott**: Thank you, Susan. Are there more comments from the public?

**Doug Nelson**: On behalf of Public School Employees of Washington and our 30,000 members, several thousand of who are on Premera currently and will be on Premera, we're looking for the lowest premiums possible for quality health insurance. It is absurd to me that process issues are getting in the way of providing the lowest cost insurance to my members. I urge you to approve the Premera updated rate. If Kaiser needs more time to come up with another competitive offer, they should. I have negotiated with school districts for decades who told me this is their last, best, and final offer and I think that's interesting, but we think you can do better. All that is happening here is a very competitive market with a strong interest in providing quality health care at the lowest cost. I urge you to approve updated Premera rates. Thank you.

**Lou McDermott**: Any comments from the Board?

**Pete Cutler**: I just want to confirm, we're on Premium Resolution 2019-12. Will we have a chance to make comments specifically on the Premera resolution later?

**Lou McDermott**: We are going to follow the same exact procedure for each resolution: public, Board, opportunities to amend or modify the resolution.

**Pete Cutler**: Okay, because I will have comments at that point but I have no comments related to the Kaiser Permanente Northwest medical premium motion.

Voting to Approve: 9
Voting No: 0

**Lou McDermott**: **Premium Resolution SEBB 2019-12 passes.**

**Dave Iseminger**: I just want to pause for this historic moment. You now have medical plans in your SEBB Program!

**Lou McDermott**: **Premium Resolution SEBB 2019-13 - KPWA Medical Premiums.**

**Resolved that,** the SEB Board endorses the Kaiser Foundation Health Plan of Washington employee premiums. Is there a motion to adopt?

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

Voting to Approve: 9
Voting No: 0

**Lou McDermott**: **Premium Resolution SEBB 2019-13 passes.**

**Premium Resolution SEBB 2019-14 – KPWAO Medical Premiums**

**Resolved that,** the SEB Board endorses the Kaiser Foundation Health Plan of Washington Options, Inc. employee premiums.

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

Voting to Approve: 9
Voting No: 0

**Lou McDermott**: **Premium Resolution SEBB 2019-14 passes.**

**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.

We're at the Premera resolution. Do any Board Members want to make a motion? I think the options before us are we can vote on the former premiums, we can vote on the new premiums, we can vote to delay the vote until August 1. I think those are the three permutations.

**Sean Corry**: I would like to propose a motion that on this particular resolution SEBB 2019-15 we delay consideration and voting on this resolution until next week's meeting.

**Lou McDermott**: There's a motion to move the vote not specifically to which rate set but to move the vote to next Thursday.

**Sean Corry**: Yes, thank you.

Pete Cutler moved and Terri House seconded a motion to delay the vote on Premium Resolution SEBB 2019-15 until the August 1, 2019 SEB Board Meeting.

**Julie Salvi**: Good morning. This is Julie Salvi with the Washington Education Association and I was holding my comments until you got to Premera. I want to start by recognizing the work of the Board that you've done over these many months and clearly you are taking your jobs very seriously and I appreciate the due diligence that you have. I don't have an objection to delaying the vote but I did want to share our perspective on some of the things we've heard today, and the rate considerations going forward.

I certainly recognize why Kaiser Permanente would feel the way they do. In the end, I represent members who work in K-12 education and who are going to want to see the best deal possible on every plan. We have members who are loyal to Premera. We have members who are loyal to Kaiser. This is a new system for them. There is a lot of skepticism out there among many members that this may not be the best deal for them. And to see a Board pass on an ability to get lower rates would not be well received by my membership and would add to that skepticism.

Things that I heard today include, this was within the scope of a fluid process. Maybe it is not the norm. It is highly unusual. It is unfortunate that it happened that way but that it was within the bounds of what could happen because you had not formally adopted rates yet. I also heard from HCA -- or I did not hear -- any alarm bells being raised. I heard that they asked questions about the rates. They did their investigation. They are not bringing forward to you any major concerns at this point. It was not an ideal process point but it is something within the scope of what can be done, and within the bounds of what might be considered reasonable in terms of rates.

You are standing up a new and very large system. It's gone pretty flawlessly over time. This is the first bump in the road. I appreciate that you've asked serious questions and taken time to consider this; but in the end, I would recommend that you accept the rates that Premera has put in for the July 25 Board Meeting. Thank you.

**Wayne Leonard**: I just want to understand, or be clear what we hope to find out in the next week by August 1, if we delay the vote.

**Lou McDermott**: Well, Wayne, I think you're asking a good question. I wondered myself the same thing. I do not believe the dispute portion of the contract, which is being invoked, will be resolved and remedied by August 1. We have already adjudicated the protest. That has been denied so additional information would be, if the Board Members want additional information that they want to study and evaluate and review to make their decision by next week, or further contemplation from the agency's perspective. I don't know what other work we're going to do between now and then.

We would not have brought the rates from a finance perspective until those conversations with the carriers happened, questions were asked. It was pressure tested. So I don't know the answer to your question. I believe others do though. Others have feelings about that.

**Dave Iseminger**: I always struggle with whether I should say something in public or Board comment, but it's a point of clarification inquiry. If the Board feels it wants to see the contract, the phrases, parts of the contract in RFP, we could recess, pull that together, give it to you, put copies on the table outside. I can move the member experience presentation to your August 29 meeting. I am presenting that as an opportunity, if you wanted to exercise it and felt that would give you the information you're looking for. I'm not positive it would or wouldn't, but we could push that item to the next agenda and give you space within the confines of this meeting as well, to review it and we could put copies on the table for the public as well, and email it to the Board Members on the phone. So just a point of clarification inquiry.

**Lou McDermott**: We were finishing up the public. Wayne chimed in. So now we're on Board discussion. Unless there was somebody from the public on the phone who didn't have an opportunity to speak up, feel free to do that. But we're now at Board discussion. So folks are free to make comments or ask questions.

**Doug Nelson**: This is Doug Nelson from Public School Employees. So we just want to go on the record of opposing a delay for the very reason that Wayne was bringing up. What is it you need to make the final decision? I agree it's a tough decision for you. However, you're talking about $35 million in premium decreases that you're possibly going to turn down. If you're going to possibly turn that down, you better have a very good reason. And if you don't have a strong direction why you don't vote for it today, I'd like to know what it is. What is it you need to make that tough, final decision? Your Attorney General has said it is approved for you to make this decision today on the updated Premera rates. Your Attorney General says it's okay. So we urge you to do it today, get it done so we can build SEBB for 2020. Thank you.

**Terri House**: Okay. So my seconding Sean's motion, I'm wondering if giving the additional time, would that allow Kaiser to revise rates?

**Lou McDermott**: It is my understanding, we have given Kaiser the opportunity to take this additional time to revise the rates and Kaiser is standing on their current rates. They did not invoke that request and ask for additional time. So I don't know if the answer would change if we didn't vote today and we went back to Kaiser and asked if they were really sure. I don't think it would change.

**Terri House**: Can I piggyback onto my question? If we vote no on the motion that's on the floor right now, then we just turn around and vote on the resolution today, correct?

**Lou McDermott**: That is correct. And there would be another opportunity, just to be clear, to vote on either rate set. We could vote on the old rate set or the new set. That's a change that can be made as well. So this vote right now, we're at the Board discussion component. The next will be a roll call vote. If you vote yes and we have five votes then we will delay the Premera vote until August 1. If we have less than five then we will not.

**Terri House**: Thank you.

**Pete Cutler**: In terms of what information would be useful, as I pointed out earlier, we do not have specific information about the actuarial assumptions that Premera changed and I come back to the fact they made those changes under very short notice. They've given a verbal representation that had to do with plans that they had all along. But frankly, we've also had nothing that explains why they twice got written communication saying these are your final rates or once saying send us your final rates and then after they did saying these are your final rates. Why they believe the process allows that basically to be thrown out as immaterial.

It's looking at the contract language, I mean, I believe that actually, either the Health Care Authority or Premera should bring the contract language to the Board and the RFP process and show how much flexibility it provides. Therefore, it's Kaiser that's unreasonable in assuming that those rates were final when they were called final rates.

Frankly, based on information I have so far, and based on the information that's been provided by Kaiser in their letter, all the facts they laid out, all the specific representations and the fact that there's been nothing in writing from Health Care Authority, or anybody else that refutes those facts or those representations, like I said, nothing in writing, as a Board member, I can't see how I could come to accept the revised Premera rates for the two basic reasons laid out in the Kaiser Permanente letter back from July 22.

One, I don't have enough information to be confident that those revised rates are based on sound actuarial assumptions. And secondly, accepting rate changes after carriers have submitted their final rates and after those rates have been made public would undermine the integrity of the whole contracting and rate-setting process. While that would be very politically popular, it doesn't make it right and it's not fair to, in this case, the other carriers involved. And I think that, with all due respect to the others who have spoken, I think the integrity of the rate-setting process is very important to building stable long-term relationships with carriers. And I think going for a short-term financial gain at the sacrifice of integrity in your process would be a bad decision.

I'm happy to give support to the motion for giving another week to collect more information, and Lord knows, maybe I will see things I haven't seen so far and change my mind. But at this point, I have to admit, that integrity issue is so important, I don't really see that it would make much of a difference. Thank you.

**Sean Corry**: I'd like to second what was just said. In my view, seeing the words that have been referred to in the letter and in our discussion is important to me to judge how clear or unclear final really means. It's that information that I'm particularly interested in seeing. I think considering this and considering what Pete just, I'm definitely in favor of a one-week delay for this little extra task to make sure that we're acting properly as a Board in a responsible way. Thank you.

**Katy Henry**: I don't know that we're going to get information that will change my mind but in trying to be collaborative in working with the Board. I'd be willing to support delaying it so that you can have more information in helping you determine what your

final decision would be. I will have to state that representing the voices of almost 90,000 school employees who are very fearful about this transition, it would not be in their best interest, I think, for me to say no to lower rates because that will help them. They don't have all this background. Many of them won't look deeper to know what has been going on at the Board and to see how we arrived at this. They will just see how much plans are going to cost and what the plan benefits are. And while I share and I think the questions that you have all asked today bring up a lot of wonderings in my mind, that still holds as my top priority. That's where I am. But I can support waiting so that there's more information for the Board to look at.

**Alison Poulsen**: I think as Dave has done a great job of explaining the journey that we were going to be on, it's pretty incredible how smoothly things have gone. At this point, the integrity with which Kaiser has put forth their information is to be commended. I think anytime you have some level of interpretation, others could interpret differently, and I feel confident that a better price point for members to have a choice is in the best interest of what is going to make our state healthier. There is no more information that would be provided to me that would change how I'm ready to vote. So while I would appreciate the thoughts that Katy had about being collaborative, I think we are delaying a vote that is maybe not necessary.

**Wayne Leonard**: I would echo some of Katy's comments. At this point, I've probably heard enough to vote, but I would be willing to defer to other members if they would feel more comfortable waiting a week. As you all are probably aware, I've had, over the last year or so, a lot of concerns about the cost of the SEBB Program to the employer, to the state, and how school districts would be able to afford it. I'm concerned about the integrity of the process the last, the eleventh hour submission of this. Essentially, I agree with pretty much everything that the KP representative said about the process. But I'm really having trouble with saying that we would not accept lower rates that would benefit school employees. Having said that, I will probably vote for the motion to delay a week.

**Lou McDermott**: So, my two cents. I think we're coming down to an issue of do we have some technical issues. Is it actuarially sound? Is it viable? Are we going to have increases next year? I think those discussions by our finance team, by Megan, she did a good job articulating that. When KP came back and reduced their rates, we had the same exact questions to the point where we asked them for a rate guarantee, trying to insulate ourselves from big increases. I don't think it's hard to extrapolate out that in this moment in time, folks are trying to acquire as much market share as they can. Insurance is sticky. Once you have it, once you have your provider, it's sticky.

This is the moment in time when people have the opportunity to get their insurance, and barring any plans not being offered next year, the switching assumptions that are made by the actuaries are fairly minimal. So then we jump into trying to cost contain, trying to control those rates. Again, we asked for a rate guarantee. Premera said no way and KP came back with a number that's unreasonable. So now you get into the fairness issue. There's a technical side and then there's the fairness issue. Overlaying all this, there's a legal component, which I've been told by my AGs to stay away from. So I'm not going to dive into that. But there is the legal component that's hidden in the background.

On the forefront, we have a fairness issue and we also have a sustainability issue. And are these real rates? They're real for today. That's what we have today. They're real. That other stuff, the fairness issue, I understand that. And I understand we all, as Board Members, have our own calculous, and I understand that the vote I cast today, I am a part of the Health Care Authority, and when I spoke with our AGs and asked if I am voting for me or am I voting for HCA? She said I am voting for me. Do what you think is right. And so each of us has to do that and I love that we're all talking about it. I love that we have strong feelings about it because this is hairy. Those are my two cents and I think we're ready to vote unless anybody wants a last comment.

Voting to Approve: 5
Katy Henry
Wayne Leonard
Sean Corry
Dan Gossett
Pete Cutler

Voting No: 3
Patty Estes
Terri House
Alison Poulsen

**Lou McDermott**: My vote, actually, is unimportant. We have enough votes to carry the motion. **The motion to delay the vote on Premium Resolution SEBB 2019-15 – Premera Medical Premiums to August 1, 2019 passes.**

**Premium Resolution SEBB 2019-16 - UMP Medical Premiums**

**Resolved that,** the SEB Board endorses the Uniform Medical Plan employee premiums.

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

Voting to Approve: 9
Voting No: 0

**Lou McDermott**: **Premium Resolution SEBB 2019-16 passes.**

[break]

**Member Experience**
**Rochelle Andrake**, SEBB Program Communications Supervisor. Jesse Paulsboe, Michelle George, and I are here to walk you through the member experience for school employees as they prepare for their first annual open enrollment.

Slide 2 – Information Pathways. We recognize there are different circumstances and preferences that affect the member experience so we've created multiple paths for school employees to learn, decide, and enroll in SEBB benefits. The main information pathways school employees will use are online, paper, and in person. Most employees will use a combination of these methods to prepare for open enrollment.

Our online communications provide access to a variety of information on demand. The information is searchable and updated frequently as more details become available. We also provide paper communications so employees have tangible resources accessible without a computer. Even some who have frequent access to computers or mobile devices prefer to hold paper documents in their hands when given the choice. Since paper documents are physically present, they may be more noticeable to some than email. Finally, in person communications can come from anyone who knows about the SEBB Program, whether it be a benefits administrator, union representative, fellow employee, or even a neighbor or family member. These opportunities for two-way in-person communication allow employees to get customized information specific to their situation. It can also help influence decision making based on experience.

Slide 3 – Communications to date. The first communication about the SEBB Program was our toolkits. These were emails monthly to benefits administrators, unions, and associations from November 2018 through June 2019. The toolkit materials include fact sheets, infographics, articles, and posters. This allows for online or print communications to employees and provides a resource for benefits administrators to be able to address employees' questions in person. Organizations can use the toolkit materials in whatever format is effective for their employee population. We understand that some organizations began using the toolkits earlier than others; however, we've learned that the number of organizations using the toolkits continues to grow.

In March we sent an introductory letter directly to employees' homes using data we collected from SEBB Organizations back in February. For some, this mailing may have been the first time employees learned about the SEBB Program.

The *Intercom* newsletter mailed in June provided information about eligibility, the enrollment process, and what benefits will be available. It also had helpful resources about how to prepare for the transition to SEBB Program benefits. For your reference, this newsletter was handed out at the last Board Meeting.

I also wanted to mention that all communications include information about how to access our materials online and everything that we send to an employee's home or distribute as a toolkit is also available on our website. If you ever want to see anything, that's where to go.

Slides 4-5 – Upcoming Communications. In just a few weeks, we'll send a reminder postcard, which directs employees to our Preparing for Enrollment webpage and gives them information about gathering dependent verification documents. It will go out to employees' homes.

The SEBB Program webpages will be updated with final premiums, benefit offerings, and benefits fairs details no later than September 3.

In mid-September, we will mail the *School Employee Initial Enrollment Guide* to employee's homes. We will also provide SEBB Organizations with an additional supply of printed enrollment guides and forms packets, enough for approximately 20% of their eligible employee population. This will account for new employees, those who need paper enrollment forms since they won't be included in the guides, and anyone who may not have received an enrollment guide in the mail.

The in-person benefits fairs begin on September 30 and will occur throughout the state during open enrollment.

The first annual open enrollment begins October 1. On that day, employees will have access to enroll online using SEBB My Account and learn more about their benefits through the virtual benefits fairs and ALEX, the online benefits advisor.

Slides 6-9 - Member Experience Examples. We recognize people have different ways of learning and comfort levels with technology. We've created multiple pathways to get information about the SEBB Program. These are examples of how our communications can be used by school employees to help them learn, decide, and enroll in SEBB Program benefits.

Slide 7 – Online Path Example. Dave has a job with regular access to email. He receives frequent communications from his benefits administrator, including links to toolkit materials. He is curious about the SEBB Program so he visits the SEBB webpages regularly to get the latest updates. He's able to access the site from his computer, tablet, or smartphone. Dave likes self-service and convenience. He uses the virtual benefits fair and ALEX to get advice and compare benefits. Once he's researched his options and picked his plans, he uses SEBB My Account to enroll and upload his dependent verification documents.

Slide 8 – Paper Path Example. John does not have access to a computer at his job. He does see some of the printed toolkit materials and resources like posters and fact sheets shared by his benefits office. He receives mailings from the SEBB Program to his home like the *School Employee Initial Enrollment Guide*, which allows him to learn about his plan options. As he receives information from the SEBB Program, he's encouraged to use the online options available. In the *Guide*, he learns about the in-person benefits fairs. At the benefits fairs, John sees information about how to use SEBB My Account but John likes his paper. So he chooses to go through his benefits administrator to get paper forms and submit his enrollment and dependent verification materials.

Slide 9 – In-Person Path Example. Margot is a new employee hired in September. She receives her *School Employee Initial Enrollment Guide* from her benefits administrator. She's invited to attend a benefits fair with her co-workers. At the benefits fair, she sees a demonstration of SEBB My Account. Through conversations with her colleagues who informed her of how quick and easy it was to enroll online, she decides to use SEBB My Account to enroll. In addition, friends and family discuss with her about posts they've seen on social media and in the news about SEBB.

Regardless of an employee's engagement level, there are opportunities to learn about the SEBB Program through the media, which will increase as open enrollment grows closer. We've recently started boosting our Facebook posts and advertisements and we're continuing to engage with the media through media alerts, press releases, and an op-ed article that we're working on to raise awareness of the open enrollment opportunity and the equitable and affordable benefits the SEBB Program will provide.

**SEBB Benefits Fairs**

**Jesse Paulsboe**, Outreach and Training Manager. I'm going to talk about SEBB benefits fairs and how they contribute to member experience. Slide 11 – SEBB In-Person Benefits Fairs. On September 29, 2019, two teams from our Outreach and Training Unit will begin traveling across the state to conduct 20 SEBB benefits fairs between September 30 and November 7. The fairs will take place in venues located in most of the major population centers across the state. Additionally, the SEBB benefits fairs are coordinated with the following considerations in mind: the fairs will be in the evening with extended hours to accommodate SEBB Organization employees unable to attend fairs during the day due to busy work schedules.

Vendor representatives will be onsite to answer questions directly from employees regarding specific plans and benefits. HCA representatives will be onsite to assist with general questions about the SEBB Program, guidance on online enrollment, and to provide SEBB enrollment materials. SEBB Organizations may continue to host their own benefits fairs at the district and school level. While HCA will not oversee or attend the district level events, we'll continue to assist the Organizations by providing vendor points of contact upon request should they wish to invite the vendors to the district events.

Slide 12 – SEBB Benefits Fair Schedule. For reference, this is a list of benefits fairs.

**Pete Cutler**: I am a little taken aback. We have a lot of population in King County and it seems like only a smattering of benefits fairs relative to the population. But now that I think of it, surely what's relevant is the number of school employees. But still, I have to imagine there are a lot of school employees in Seattle and right around Seattle. Are you going to have more HCA staff there assuming that more employees will show up at those locations? Or how will you deal with that?

**Jesse Paulsboe**: We have the ability to adjust. We have staff on standby to attend if it is too crowded. We will get into different ways to mitigate the crowds. The school districts have a culture of hosting their own benefits fairs. And with 20 benefits fairs being offered by HCA, we didn't want to tell them they couldn't host their own. We've offered to provide them the information to go ahead and make that coordination, to supplement the 20 we have in the state.

**Pete Cutler**: It sounds like a great strategy. I would not want to hear that, in some major population center, Tacoma, Seattle, whatever, where the lines were so long that people didn't get to talk to anybody. I'd like to hear that maybe through school district sponsored fairs or whatever that everybody who wanted a chance for a one-on-one conversation in that kind of a venue has the chance to do it. That would be my only concern.

**Dave Iseminger**: And Pete, as we begin the benefits fairs we will get a better gauge as to the attendance of those. We are not exactly sure what to anticipate, but as we get real time feedback from the first couple of benefits fairs, we'll be able to adjust.

**Jesse Paulsboe**: Slides 13-14 – Virtual Benefits Fair. In addition to the in-person benefits fairs, we're in the process of developing the SEBB virtual benefits fair (VBF). The virtual benefits fair is an interactive online website created with the same goal in

mind as the in-person benefits fairs: to make learning about benefits and plans available to subscribers and their families easy and user friendly. The VBF, as we refer to it, offers 24/7 access to SEBB Program benefits' information from the convenience of the subscriber's home or desk.

Slide 13 is a very early prototype of the site. It's designed to emulate the appearance of an in-person benefits fair. The visitor first enters a central lobby where they are presented with an introductory video that orients them with the virtual benefits fair environment. From the lobby, the visitors navigate into a virtual benefits exhibition hall where each vendor has their own booth to display plan options and other helpful resources. Each vendor booth contains videos, digital brochures, marketing materials, the summaries of benefits and coverage and the certificates of coverage for the subscribers to peruse. Additionally, each booth has the ability to hyperlink out to the vendors' microsites should the subscriber desire to see more specific offerings in greater detail.

Slide 14. If visitors seek additional assistance, the virtual benefits fair offers single click access to ALEX, the online benefits advisor. In addition to your computer or laptop, the virtual benefits fair will be optimized for mobile devices. The entire SEBB Program initial enrollment experience, from learning about benefit options to enrollment in SEBB My Account, can be completed on a smartphone or tablet. The virtual benefits fair will go live October 1, 2019.

**Sean Corry**: In looking at Slide 14, will this be available to anybody? Do you have to sign in as an employee?

**Jesse Paulsboe**: Anybody can access the site.

**Pete Cutler**: My guess is that you are engaging in significant user testing so when on October 1 it won't be the first time it's been stress tested in terms of what if everybody shows up at the same time.

**Jesse Paulsboe**: That's correct. Our IT department is involved in the development process and load testing for the virtual benefits fair site. It is in accordance with the same standards we're doing for the SEBB My Account site.

**Dave Iseminger**: I do want to highlight one thing because it's come to my attention in a couple of different venues. The second bullet, Optimized for mobile devices. That is also true for SEBB My Account. I've heard that there are instances where a school employee might have an experience where the interaction they have with their district starts in electronic form but then ultimately, they have to sit at a desktop because they can access it electronically, but they can't complete a process unless they're at a desktop. People will be able to use SEBB My Account on the virtual benefits fair on as big or small a phone as they have, as big or small a tablet they have. They could be at a desktop. It is optimized that way.

I've heard there are a lot of school districts appreciating that optimization for mobile devices. They are starting to think creatively about how they can help facilitate open enrollment. Like going to a bus depot station during a break period or that time,

between shift one and shift two routes and sitting with people and walking through and having a mini benefits fair and enrollment experience with staff right there. I wanted to highlight for the Board, and for the record, that everyone will be able to use SEBB My Account and the virtual benefits fair on their own devices. And it won't have the scalability issues that sometimes happens on websites. It is optimized for that use. We're really proud of that.

**ALEX Online Benefits Advisor**

**Michelle George**, Communications Manager, ERB Division. Slide 16 – Background. I am going to talk about the ALEX online benefits advisor. The Health Care Authority procured for an online decision support tool to help school employees learn about their SEBB Program benefits and advise them about their health coverage. HCA selected Jellyvision, which provides an interactive state-of-the art benefits communication software. Their ALEX online benefits advisor does two things: it educates users on the different benefits offered and how they work. It also recommends plans based on the user's preferences on cost and how they use health care. By responding to ALEX's questions, employees can make informed choices so they know how their plans and benefits work before they choose to enroll.

Slide 17 – Purpose of online benefits advisor. The purpose of the online benefits advisor is twofold. First, we want to provide an experience that could help our new members and their families learn about SEBB Program benefits 24/7 at their own pace in an easy to learn, fun way. We also wanted to avoid placing an undue burden on the payroll and benefits offices in helping their employees learn about SEBB Program benefits at the same time that they were learning about them.

Slide 18 – Who can use Alex? School employees enrolling for the first time during the SEBB Program's first annual open enrollment, as well as newly eligible during the school year who need to enroll in benefits within 31 days. Another benefit is other family members can use ALEX to make or influence the enrollment decisions in the SEBB Program. ALEX will be available starting October 1.

Slide 19 – What can ALEX do for employees? Say I'm a school employee who doesn't have time to read all the information about my SEBB Program benefits. I can go online and use ALEX to help me understand both the benefits and the plan choices available to me. ALEX can provide me with plan choices available to me as well as a comparison tool to help me understand how the plans work and the differences among the plans as well as make recommendations about which plans may be best for me based on my preferences. Using ALEX has been described as sitting down with a really friendly guy who knows a lot about benefits and can pretty much answer all of your questions and help you make a selection.

**Dave Iseminger**: I know when we presented the service areas last week, it can get complicated fast when you're looking at those various charts. ALEX will only show you what plans are available for you just like SEBB My Account. When you go into SEBB My Account, the logic populates only those plans that meet those various criteria we talked about last week.

**Michelle George**: Slide 20 – How SEBB Program will use ALEX. ALEX will be a 24/7, easy to use interactive tool. HCA will use ALEX and its member communications to

promote it. HCA will also link to ALEX from SEBB My Account and the virtual benefits fair that Jesse talked about, as well as other SEBB Program webpages to make sure it's very easily accessible. People will see "Ask ALEX" throughout our website, including SEBB My Account and the virtual benefits fair.

Slide 21 - How does ALEX work? A simplified demonstration of ALEX shared with the Board for illustrative purposes. The SEBB Program's ALEX tool will determine specific plan recommendations based on how the SEBB Program plans work, the actual cost, such as premiums and copays, and access to providers. The SEBB Program can also tailor the questions used in ALEX to add questions not shown in this demonstration or to remove other questions to better advise users on how to select a plan available to them.

[ALEX Demonstration]

**Sean Corry**: I'm easily confused and so I might be different than others. In some parts of the demo the first few choices were about you, what do you want, and in small print it says something about family. I'm guessing that some people are going to think that you're talking just about me and not about the dependents? It was confusing to me.

**Michelle George**: The text might need to be more prominent.

**Sean Corry**: Just to make sure you know who ALEX is actually speaking about. It says, "You're looking for you and your family." It didn't say that before.

**Pete Cutler**: Did your attorneys sign off on having a software program where you actually recommend which health plan they should go into? In the past, that was considered high risk to get to the point of actually recommending.

**Michelle George**: One of the benefits of ALEX is it doesn't usually recommend one plan specifically. It will suggest a few plans. It will help you, when it comes to the benefits comparison and the cost comparison, showing you those different costs among the plans to help you, based on your preferences.

**Pete Cutler**: Does it also come with a disclaimer early in the process of whatever decisions you make really are yours?

**Michelle George**: I believe that's in the acceptance agreement at the very beginning.

**Pete Cutler**: Okay, thank you.

**Lou McDermott**: Pete's referring to the fact that the PEBB Program, for many years, was very agnostic towards plans that it was very dry and technical. Here are the copays, here's this, here's that. In recent years, we have expanded that to try and help employees understand based on their life circumstances what plan may be more favorable for them. If you have kids in college and they're on your plan, having them in the Uniform Medical Plan Classic, which we have a global presence, is better for you. So, yes, that is something, Pete, we have tried in more recent years to not push plans but guide members to plans that, based on their life circumstances, would be better for them. It's something that's been explored with our attorneys.

**Pete Cutler**: I want to be clear. I think it is very helpful to the members. I think it is a very complex area. I know there are certain legal risks, depending on whether there's disclaimers or whatever. But as long as you've worked it out with the AG's office or whomever helps you with that analysis, I'm sure it's fine.

**Michelle George**: Slide 22. ALEX also asks members about their experience using it. Jellyvision offers a data analytics tool that provides the Health Care Authority with real time snapshots of employee engagement with ALEX, including which plans are being explained and highlighted the most. It also compiles employee feedback that lets us know how they feel about their experience with ALEX. Users who choose to answer a survey after using the ALEX tool will have their answers retained anonymously and made available to be used in aggregate form to report on the user experience.

In addition to the survey results, ALEX collects information about things like total visits to the site, the duration of the sessions, what type of device or browser is being used, the plans being discussed and the plans recommended to be able to report on how users are engaging the ALEX tool. All of this data is stored anonymously so it cannot be associated with any one individual.

Slide 23 – How ALEX handles users' privacy. ALEX ensures that the collected answers are limited and do not directly identify any one individual. It does not store or share any personally identifiable information or any protected health information. The data shared with HCA will only be anonymous and in an aggregate form. Any aggregate data collected and stored by ALEX is encrypted both in the transmission and storage.

Slide 24 – Other employers use ALEX. There are other large employers who have used ALEX with great success such as the Oregon Health Authority, Teacher Retirement System of Texas, the Commonwealth of Virginia, the state of Rhode Island, and Princeton and Harvard Universities.

**Pete Cutler**: With Oregon Health Authority, do you know do they use it with their Public Employees Benefit Board?

**Michelle George**: Yes.

**Pete Cutler**: -- Oregon educators?

**Michelle George**: I don't know about educators. They do use it with their public employees.

**Pete Cutler**: Definitely with PEBB. Okay, great.

**Public Comment**

**Brian Simms**, Washington School Directors Association (WASDA). I was watching the meeting from home thinking this is going to be boring. It certainly wasn't. [laughter] I threw a jacket on and came down because I want to make one comment about the rates. Are the revised Premera rates legally and contractually appropriate in front of you? If they are, I believe you really have to adopt them. And the reason for that is I think, just as we saw the last part of this meeting, the open enrollment process, if we

end up in court over this, that's going to be what gets jammed and you'll have hair on fire for the HR people in the school districts. Families will be worried about continuing coverage for critical care, all that kind of stuff. I think it's really a legal question for you and you may have to get briefed on that next week in Executive Session. The rates aren't so far out of line that there'd be an actuarial issue. They're really in sync with a lot of the other ones. Are those revised rates legally and contractually and according to rules in front of you? I don't think fairness is the issue. I think it's a legal matter. And I just hope that gets resolved clearly so we don't end up in court and we don't end up jamming the implementation of SEBB. Up until late December, WASDA has advocated for this for over a decade and we're looking forward a smooth transition. Thank you.

**Lou McDermott**: Thank you. The next Board Meeting is August 1. On a personal note, I will be in Central Oregon next week on vacation with my family so I'm trying to figure out if I'm coming back the night before, the day of, how that's going to work. There's no way I'm going to let you cross across the finish line without me. So I'll be here. I've got to negotiate with my spouse [laughter] as to when I depart. If I come back the night before, I'll probably ask Dave to make the meeting earlier. If I come the day of, probably a little later. We won't know that until I get home tonight. [laughter] So we'll keep everyone informed.

The last part is, I want to make sure all the Board Members have the documentation or information they need so they are prepared to vote next Thursday. Dave, I don't know if we want to collect that here publicly, if you want people to ping you and you send it all out? I don't know how you want to handle that today.

**Dave Iseminger**: Well, the interesting thing, Chair McDermott, is we will be trying to get you a Briefing Book as fast as we can. We have historically tried to get the Briefing Book to the Board the Friday before. That has not always been the circumstances. As we sit here at noon on Thursday, I'm not sure exactly if you'll get your Briefing Book tomorrow or Monday. I know of a few things the Board has specifically asked for. I can outline a few things that I know you're probably interested in and we'll evaluate what can be shared with you and whether or not there's pieces that need to be in Executive Session or not, so stay tuned.

This isn't a complete commitment of a list of things, but these are things I think you're interested in and they're on the evaluation list, so to speak. I think you're interested in having the parts of the RFP contract, RFC that were cited in KP Washington's letter. You are interested in whatever information we may or may not be able to share about actuarial comparisons or trend comparisons among the different parts of the portfolio. I'm curious if people want to populate this list a little bit more now. I'm sure you'll walk away and think of something as soon as you enter your cars. You can always drop me an email and say please add this to the list.

**Pete Cutler**: What occurs to me, I'd like to see what letters or emails were actually sent to the carriers saying, "Submit your final rates," or whatever that was.

**Next Meeting**
**August 1, 2019**
**9:00 a.m. – 11:00 a.m.**

**Preview of August 1, 2019 Meeting**

**Dave Iseminger**: Usually I do a preview of the next meeting but I think everybody knows the agenda will have one agenda item, action on Premium Resolution SEBB 2019-15.

Meeting adjourned at 12:07 p.m.