

School Employees Benefits Board
Meeting Minutes

November 6, 2017
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:00 p.m. – 5:00 p.m.

Members Present:

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

Members on the Phone:

Sean Corry

SEB Board Legal Counsel:

Katy Hatfield

Call to Order

Lou McDermott, Chair, called the meeting to order. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

TVW, the Washington Public Affairs Network provided a live web cast and taped the meeting.

Agenda Overview

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

SEBB By-Laws

Dave Iseminger, ERB Division Director: Several things went into creating these proposed By-Laws. First, we reviewed a core document from the Public Employees Benefits Board, which HCA helps administer, and then reviewed it against the State Board of Education By-Laws to see if there were obvious areas that might be supplemented for the SEBB Program. From those two documents, staff created this core document of By-Laws for your review.

I will go through each article one at a time and see if there are questions, thoughts, ways that you might want to revise them. We'll bring back a more final version for you to consider at our next meeting. If there are things you want to amend at the next meeting, then we would go through the formal amendment process for the final version. Once final, you will vote on them at the December 11, 2017 meeting.

Article I: The Board and Its Members. This article provides the structure of the Board. Some of it is reiterating items that are in state law. The core act for creating the SEB Board has been codified from the Code Reviser's Office and can be found in RCW 41.05.740. Chapter 41.05 RCW is the Health Care Authority's primary chapter of state laws. This article describes how individuals get appointed to this Board; who makes up the Board; that you have equal rights with regards to discussing, making, and seconding motions; as well as voting on motions. It describes the current compensation rules that exist under the House Bill 2242 that were passed.

Katy Henry: Under Article 1, Number 5 - Board Compensation, is it possible for school districts to be reimbursed for substitute days for classified or certificated employees that serve on the Board?

Dave Iseminger: That question has been asked of us. The authority for the Office of the Superintendent of Public Instruction (OSPI) to reimburse school districts for substitutes in the manner that you've described has not been provided to the Health Care Authority in statute, so that couldn't be created in these By-Laws. We are aware that this is an area of interest. There is an upcoming legislative session and I'm sure there are individuals that may try to address this question then. Unfortunately that can't be rectified via the By-Laws because the authority has to come in statute.

Katy Henry: Thank you.

Dave Iseminger: **Article II: Board Officers and Duties.** This essentially describes a Chair and a Vice Chair. This article outlines that the Chair of the Board, under state law, is the Health Care Authority (HCA) Director or the Director's designee, and describes the powers to call meetings; and indicates that on a meeting-by-meeting basis, the Health Care Authority Director, if they can't serve, could designate an individual and delegate the authority they have under state law to serve as a temporary Chair for the meeting. The Vice Chair responsibilities pick up where statute describes a Vice Chair serving if the Board Chair, or the Director's designee, can't serve for an

individual meeting. The primary responsibility under statute is for the Vice Chair to serve in the absence of a regular or temporary Chair. We hope the Board would elect a Vice Chair amongst yourselves at the December meeting. If anyone is interested in serving as Vice Chair, send an email to Connie. That way we can prepare for that part of the December meeting.

Lou McDermott: Dave, would the Vice Chair have their vote and the Chair's vote? So basically, have two votes? Or are they just one?

Dave Iseminger: They would have one vote. If the regular or the temporary Chair delegated by the Director wasn't there, it would be an eight member voting body for that meeting, assuming all of the other Board members were present.

Article III: Board Committee. We're not sure if there are ad hoc committees or more standing committees that the Board might want to make, but we reserved that as an article for future By-Laws.

Article IV: Board Meetings. This Article talks about the structure of Board meetings. It reiterates the training Katy Hatfield, your AAG, provided two weeks ago about the Open Public Meetings Act. It describes the responsibilities of the agency for convening and providing necessary notice under the Open Public Meetings Act for regular and special meetings. It describes that there is no condition for attendance. Lou asks at the beginning of meetings that if anyone is interested in giving public testimony, to please sign in. That's not a requirement, but it does help orchestrate the end of the meeting.

We'll also be describing the public accessibility for these meetings that are here in the Sue Crystal room at the Health Care Authority and we have a teleconference option. We'll continue to use facilities that are accessible to the public. We will also give members as much notice as possible for them to attend the meetings.

Pete Cutler: I'm curious. If a special meeting is called, it says that the notice will be consistent with the Open Public Meetings Act, but I'm just curious what does that require? 24 hours?

Dave Iseminger: The notice requirements for special meetings are 24 hours in advance and the agency would have to give notification to publications of record that have indicated that they want notice of such special meetings. A posting of the agenda is also required on the front of the Health Care Authority and any place where a special meeting is held. If for some reason the meeting couldn't be held here and we needed a special meeting located at the Sea-Tac Airport, we would post at the front of the Sea-Tac Airport, as well as here. We would send a notification to the necessary publications on record, as well as our normal process on the internet.

Lou McDermott: I think it's fair to say we wouldn't try to schedule a special meeting in 24 hours. I don't think there's anything we're doing that requires that sort of urgency.

We have had times where either the Legislature has gone long and we don't have a final budget or things have happened where we've had to schedule a couple weeks out; but I would be shocked if we ran into a situation where we must meet tomorrow and discuss something. I'm not sure that's going to happen.

Pete Cutler: Glad to hear that.

Dave Iseminger: Special meetings would have teleconference options and you would be able to access remotely if indeed there was something urgent of that nature.

Article V: Meeting Procedures. This Article is describing quorum.

Lou McDermott: Dave? Is Katy Hatfield available to Board Members for questions regarding what something may mean or not mean from a technical perspective?

Katy Hatfield: Sure.

Lou McDermott: I just want to make sure the Board knows they can deal with the AGO on a specific issue. They have the freedom to do that.

Dave Iseminger: Per Article V, a quorum is five of the nine Board Members. Five Members are required for a transaction of business; but if only four of you are here, there could be informational discussion about topics but a vote could not occur. If there isn't a quorum present and the Chair doesn't think it is necessary to meet, then the Chair can adjourn the meeting.

Article V indicates that we will follow an agenda and have accessibility via teleconference. It also describes how we handle public testimony during Board meetings. Specifically that there will be time reserved at the end of every regular meeting. The Chair will always ask for public comment during the Board discussion, before a vote is going to happen, for any testimony that is relevant for that vote to ensure the Board hears all of the insight from the public before the vote is taken. Generally, the Chair has the ability to limit public testimony in the event there is a large number of people who sign up and want to give testimony during the designated block of time. Members of the public are also welcome to provide written testimony or information via the SEB Board mailing address that is printed on every agenda.

For motions and resolutions, agency staff will prepare a resolution for your consideration that could be amended during the meetings if necessary, but generally serve as a starting point – very much in the same vein as the By-Laws process. Except for changes to the By-Laws, it will be majority rules. For the By-Laws, two-thirds, or six of you, would need to vote in favor of a By-Law change after this initial ratification of the By-Laws.

Article V – 6. Representing the Board's Position on an Issue: previews the training that's coming. In December, Katy is going to do a presentation about the Executive

Ethics Act and a few of your obligations. This Article hits on possibly one of the areas in the training - that you are not allowed to purport to represent the Board unless the Board as a whole has said you have the power to represent a view of the Board. Just make sure that you are speaking on behalf of yourselves rather than on behalf of the Board, unless you have all agreed that you have a joint talking point.

Katy Henry: Article V – 6, representing the Board’s positions, you could speak on a personal level, but you couldn’t state that you are representing the Board. Is that what you are clarifying?

Dave Iseminger: Correct.

Katy Henry: Okay.

Dave Iseminger: Article V – 7 describes the manner of voting. Generally the Chair will decide whether it will be a voice vote or a roll call vote where the Chair will ask each person individually to announce their vote, yes or no. Proxy votes are not permitted, but that the proxy vote prohibition doesn’t apply to the Director of the Health Care Authority when they’ve delegated their responsibilities of Chair to a temporary Chair. That is, in part, because under the State law, the powers of the Health Care Authority Director can be delegated; and so the By-Laws wouldn’t be able to usurp the statutory authority that’s vested in the directorship.

Article V – 8 is a preview of Katy’s December meeting training, that Board members are subject to the requirements of the Ethics in Public Service Act; and that as we get to voting on matters, it will be up to you to identify and recuse yourself from any vote that’s necessary for your compliance with the Ethics in Public Service Act. Katy will be doing a presentation to the Board about that before your first vote on the By-Laws.

Article V – 9, Parliamentary Procedure. We’ve put in a provision that Robert’s Rules will be the governance structure for the meetings.

Article V – 10 is just asking that you be civil, as well as the attendees be civil, during meetings.

Article VI - Amendments to the By-Laws and Rules of Construction. Article VI is how to amend your By-Laws. It would take six of the nine Board Members to amend them and we’ll just have a liberal construction to make sure that everything works out well and purports and complies with State laws and regulations.

Katy Henry: I want to make sure I understand. Regarding Board compensation, is it prohibited to provide substitute costs to the school districts for those employees?

Dave Iseminger: I would say the agency doesn’t have statutory authority. It’s not that it’s prohibited, it’s just not authorized.

Katy Henry: So the only way to make that change is through the legislative session you spoke about earlier?

Dave Iseminger: Not necessarily just this session, but via the legislative process.

Health Care Today and Tomorrow

Dan Lessler, MD, MHP Chief Medical Officer, HCA: My objectives today are to provide a high level overview of the current state of health care in this country, to convince you of the imperative need for changing how we deliver health care in this country, and to provide a road map of how we can go from volume to value.

Slide 3. No presentation about health care in this country can begin without this slide on the cost of health care. Slide 3 shows that as a percentage of gross domestic product, the United States spends more on health care than any other industrialized country – approximately 18% or about 1/6 of the US economy. This translates to about 1 in 6 people in this country are employed in some way in health care. As we move to try and improve how health care is delivered, we have to be cognizant of the potential impact it is going to have on the US economy. Warren Buffett said at his annual shareholders meeting of Berkshire Hathaway, “Medical costs are the tapeworm of American economic competitiveness.” If you talk to any business leader who is covering the cost of health care for their employees, they would likely endorse his point of view.

Slide 5. It really comes down to a very simple equation: $Cost = Price \times Utilization$.

The table on Slide 6 compares prices for some common procedures across a number of different countries. The US, generally speaking, has much higher prices for relatively common procedures like bypass surgery and an appendectomy relative to other countries. If you read health care economist’s analyses of what drives costs in the United States, many believe the primary driver is price, although utilization is a problem as well. In addition to the very high prices in the US, there is also a tremendous variation in pricing across the United States. That is the current state of health care in the United States today.

Slide 7 is meant to underscore the extent of price variation. For a very common procedure like a colonoscopy screening, you can see that by traveling from New York to Baltimore, the prices come down from \$8,500 to \$1,900. That’s approximately 25% of the cost for the same procedure in Baltimore as in New York. This wide variation in cost is typical for this procedure across the country as Slide 7 indicates.

Slide 8. What about utilization? This slide is a snapshot showing utilization of some common radiologic procedures. Again, the rate of usage for these diagnostic imaging studies is much higher in the United States than in other countries.

Going back to Slide 5, $\text{Cost} = \text{Price} \times \text{Utilization}$, you can understand that both price and utilization contribute to the fact that we spend more on health care than any industrialized society in the world. What are we getting for this? I will delve a little into observations around outcome, and one of the most remarkable observations around practice variation.

The Washington Health Alliance (WHA) maintains a voluntary database of many commercial plans, self-insured PEBB Program data, and Medicaid data, and is able to do certain analyses that look at underlying rates of use. Slide 9 is an analysis the WHA did a few years back of hysterectomy rates across the Puget Sound Region. Looking at the slide, red is high and blue is low. The bigger the red circle, or the bigger the blue circle, then the bigger the affected population. The smaller the circle, the smaller the population. What you can see if you just look at Seattle versus Tacoma, or Puyallup, a woman is much more likely to have a hysterectomy if they live in Tacoma or Puyallup than if they live in Seattle or Bellevue. There's no obvious underlying reason for this. If you look at the demographics of these areas, you can't explain why more women have a clear indication for having this procedure in one place than the other. Quite frankly, it is an unexplained variation that is worrisome in terms of what it says about the performance of our health care system.

Slide 10. The same is true for upper endoscopy. This is where a gastroenterologist takes a tube with a camera on the end and looks into your stomach or small intestine. This is an example of how an ulcer diagnosis is made. On Slide 10 you see the same wide variation across the region in terms of rates and this unexplained variation.

We have the highest costs – price and utilization. We have incredible variation in utilization of procedures across the country, but also and specifically here in the Puget Sound Region.

Lou McDermott: When you say higher rate, you're referring to utilization rate and not cost rate?

Dan Lessler: Yes, utilization.

What about clinical outcomes? How are we doing? Slide 11 is statewide data from the Washington Health Alliance amongst commercially insured. There are four different measures: Blood Pressure Control – Hypertension, Blood Pressure Control – Diabetes, Poor Blood Glucose Control – Diabetes, and Cervical Cancer Screening.

You can see amongst the commercially insured in this state what our rates are and then compare that to the National Committee for Quality Assurance (NCQA), which accredits health plans in terms of their 90th percentile. This is what the best performers are doing now. The percentages for Washington State have considerable room for improvement.

There is evidence in Washington State that we have a lot of practice variation, which is unexplained. In terms of outcomes for common disorders or preventative measures, we at best, do so-so compared to a benchmark that is admittedly a high benchmark, but I think we'd all aspire to such a benchmark.

Slide 12 shows other reasons why health care costs so much beyond just merely price and utilization. An article by Don Berwick, and a colleague of his who founded the Institute for Health Care Improvement and is a renowned expert on health care and health care quality in the country, did the analysis of waste in health care that you see on this slide. They looked at six different areas: failures of care delivery, failures of care coordination, overtreatment, administrative complexity, pricing failures, and fraud and abuse. Some of these, like pricing failures, are along the lines of what I've already mentioned. But failures of care delivery, failures of care coordination, overtreatment, which speaks to the practice variation, add up to almost a trillion dollars. That data is probably seven years old now. So you've got price, utilization, practice variation, fair to midland outcomes, and a lot of waste.

Slide 13 captures our spending versus our performance. On the x-axis to the right is higher spending, to the left is lower spending. On the y-axis, up top is higher health system performance and down below is lower health system performance. The best place to be is in that far left upper corner where you have a higher system performance and lower health care spending. The United States is completely opposite to that desired state with the highest health care spending and the lowest health system performance. By health system performance, we are talking about population health indicators: for example, longevity and infant mortality. These are all things that are actually worse in the United States than in any of the others listed here.

Slide 14. Those outcomes aren't just the result of the medical care system. When you look at population health, people particularly in public health are quick to point out that roughly 20% is driven by medical care and the rest is driven by social determinates of health, such as issues around housing and education, etc.

Another interesting observation about the United States in terms of explaining its overall poor performance relative to other industrialized societies may have to do with the amount of dollars we spend on health care versus other kinds of social services. In other countries, a much greater proportion of Gross Domestic Product (GDP) is spent on other kinds of social services and a relatively lower amount is spent on medical care. The net outcome of that appears to be better population health status than in the United States.

Lou McDermott: Dan, has anyone ever looked at their total spend and if they're spending more money on the social determinates of health and less money on actual health care? Is their overall spend still comparable with our overall spend?

Dan Lessler: That's a good question. I don't know the answer to that. Generally speaking, I think it's more how the money is spent. I'd have to confirm this, but I think it

has more to do with how those resources are expended as opposed to the total amount that is expended.

Pete Cutler: Dr. Lessler, on the column that says spend as percent GDP, can you remind me what the source of this data is?

Dan Lessler: This is taken from a Health Affairs article. I can get the reference for you.

Pete Cutler: I would be curious.

Dan Lessler: We can get the reference. I think it is a distillation of the other slide.

Slide 15. I want to come back to the issues with the health care system in terms of explaining where are the system failures? Generally there's a recognition that there is a lack of communication and coordination across the continuum of care. That in some sense, often times the right hand doesn't know what the left hand is doing. Part of what drives that is a lack of shared accountabilities. In a moment I'll show you a slide with multiple silos that a colleague of mine refers to as cylinders of excellence, but the idea being that there isn't a single point of accountability in terms of delivering care. And then there is a lack of data and a lack of transparency. There's a lack of price transparency, a lack of transparency in terms of process measures of care, and in terms of outcomes of care. What we desire, and let me caveat that by saying clearly it's sort of in the best of times, worst of times, clearly there are some amazing outcomes and things that happen within our health care system. But what I'm describing is overall at a population level when you add it up, this is what it looks like. I don't want to underplay the fact that there are some things that the health system does well. That is important to recognize. So where do we want to go?

Slide 16. People used to talk in terms of the Triple Aim. We now talk about the Quadruple Aim, which is better care, improved population health, lower costs, and a professionally satisfied and stable clinician community. A colleague of mine refers to this as clinician joy. For my colleagues who are actively practicing medicine, the system is not working ultimately for many patients; but it's not working for them as well. It really is broken for all participants in some sense; and restoring that professional satisfaction, obviously, is important to maintaining a strong provider community. I know when I retire, I want somebody to be there who is willing and ready to take care of me as I age. So one could ask with that being the picture, what drives that kind of picture?

Slide 17. I think fundamental to the cost question it has to do, in part, with how we pay for services. As the saying goes, you get what you pay for. In that fee-for-service environment, if there's no way to bill for it, then typically people won't provide it. On this slide, you can see three arrows with dollars in them. So office visits, our current system is encounter based. Most of the time you need to physically be in front of a provider in order for that provider to get compensated. If they try to manage your care with phone calls or emails, and so forth; or if they hire a nurse care manager if you are somebody with a chronic disease, to help you better self-manage that chronic disease, in most cases they can't get paid for it and that's problematic. At the same time we pay for

emergency room visits, some of which may be avoidable if there were alternatives like telemedicine and so forth. We could avoid some of those costs, but of course those who run emergency rooms or lab facilities, etc., as long as they're getting more volume, they're getting more business and more revenue. From their perspective, they don't see the pressure to drive any kind of innovation or change. And likewise from a hospital standpoint.

Slide 18. The other way of looking at this, and these are my cylinders of excellence, is each area may be optimizing what it's doing from its standpoint; but when you roll it up, it doesn't add up for us as a community, as a society. I think the big picture problem is the lack of a single point of accountability, and that accountability really goes to accountability for a defined population. For us sitting around this table, that defined population is our public employees and their dependents. It's on their behalf, I would argue, that driving toward a single point of accountability is going to work best in terms of the outcomes and the clinical care that they receive.

Slide 19. I use this slide in a lot of presentations and it is one of my favorite slides. I mentioned Don Berwick earlier. He founded the Institute of Health Care Improvement and he's fond of saying, "Every system is perfectly designed to achieve exactly the results it gets."

People might have heard of Albert Einstein's definition of insanity in that it popped into my head in the "Doing the same thing over and over again and expecting different results." If you have a system perfectly designed to get the results it gets, which is the system we have now, and if we keep doing the same thing, we are not going to get different results, so I titled this slide "Systems and insanity (or insane systems...)." Slide 20 really captures this well in terms of folks rowing harder towards the waterfall. And rowing harder is certainly not the answer as in the case here. Row in a different direction. So, what is that direction and what should we be aspiring to?

Slide 21. We talk about whole-person health care as the aspiration. Whole person care is care that focuses on both the person's physical health, their behavioral health, and their social needs. It emphasizes coordination across sectors. Not just within the health care system, but across a community. And we would argue that it requires a new way of financing care that really is data, and a system that's data driven and collaboratively led.

Slide 22. This is a slide I borrowed from a colleague who you will all probably meet at some point, the Deputy Chief Medical Officer at HCA, Charissa Fotinos, who I think has created a slide which really captures the current state and where we want to go. The current state has care that is really siloed. The medical system, the mental health system, the substance use disorder system, and even within the medical system, there's even further siloing; and it's really not built around the patient as a system.

What we need to be driving toward is a system that is built around patients that provides the right level of care, in the right place, the right time, and so forth, where that care is

coordinated and connected to community supports where that can really help a person lead a healthier life. That's where we want to go.

Slide 23. I would argue that to get there we need to change the way in which we pay for care. I've already alluded to this in the slide that described fee-for-service and how that fragments care. Fee-for-service really is a volume-based system and what you get is really what we have, which is articulated in the left side of this slide in terms of fragmentation, lack of coordination. I would argue unengaged, less engaged, or not optimally engaged, patients, families, and a great degree of variation. Where we want to go is toward the right side of the slide. This is the transformation we desire which is integrated care as was illustrated on the previous slide that's focused on the whole person, well-coordinated, well educated, engaged patients and families who understand the health care system, and are able to engage with their providers in a way that their values and needs are well understood and addressed.

Slide 24. And then, really standardized performance. Some degree of variation is always going to be present; but if to the extent that it is present, it should be justified. There should be a reason for it, which isn't the case currently. Slide 24 is a bit complicated. I want to direct you to the far left box which says, "Supportive payment and regulatory environment." This actually is a slide from the Institute of Medicine Report called "Crossing the Quality Chasm" which was published about 15 years ago. It's trying to describe the idealized elements of a care system, what those elements should be driving toward, and what needs to be a part of that care system. The point I want to make here is as I've been describing and is well captured by the Institute of Medicine, it begins with a supportive payment and regulatory environment; and particularly with respect to how we pay for care. That's not what we have now. It would not be possible in our current system to drive towards those outcomes listed in the box on the right, a system that is safe, effective, efficient, personalized, timely, equitable. We need to change how we pay for care.

Slide 25. What we talk about in terms of making that change is going from volume-based purchasing to value-based purchasing of health care; and value-based purchasing and associated incentives. By incentive, we mean simply something that motivates or rewards an individual to perform an action. In health care the desired action is to provide coordinated, integrated, high-value care. What value-based payment does is reward the provider community for providing the right care at the right time; and it moves what is really population based, and moves away from piecemeal fee-for-service payment. We've been working toward this at the Health Care Authority in terms of really trying to move towards a value-based purchasing model.

Slide 26. In the column on the left, Public Employees Benefits Board – State Employees, we describe some of that work with respect to the Public Employees Benefits Board (PEBB). There are three bullets I want to briefly review. First, under the Uniform Medical Plan, there is now an offering called an Accountable Care Program. There are two of these Accountable Care Programs where the Health Care Authority has contracted with two health system networks, initially in the Puget Sound Region, but

now they have a footprint that covers other large areas of the state out in Spokane County, Yakima, and in Grays Harbor. This is a contract where there are very high expectations in terms of the quality of care that we expect them to provide and also detailed expectations around how we expect them to deliver that care. For example, how will they coordinate care? How will they communicate with PEBB Program members and so forth? They are held accountable for achieving a certain trend. There is what is known as upside and downside risk, which is to say that financially if they do better than target, they can share in some savings; and if they don't hit that target, they pay us back some money. In both cases, the quality of care that they provide can either increase the amount of savings that they share or reduce the amount that they pay back if they owe money. That's an important step towards value-based purchasing and gets away from narrow fee-for-service.

The second bullet talks about our Center of Excellence for joint replacements. That is a contract that we awarded a year ago to Virginia Mason. Essentially, the Health Care Authority has a fixed amount of dollars that it pays for people who go to Virginia Mason to have their joint replaced, and that doesn't change. This is the amount they get and they do it with that. They're held accountable for their outcomes because there's a warranty. If there's a bad outcome they pay for it. If there is a surgical site infection or readmission, that's on them, not on the Health Care Authority. That's another example of value-based purchasing.

Finally, bullet three, we are currently in the process of a third party administrator Request for Proposal (RFP) for PEBB where there is, in that RFP, a lot of expectations around performance with respect to value-based initiatives.

Dave Iseminger: I want to highlight that Dan has previewed some of the very benefits that this Board may be able to leverage in its upcoming meetings as offerings within the SEBB portfolio. We'll be providing more detail at the next meeting. I just wanted to make sure you saw that connection.

Dan Lessler: This is trying to provide you with an overview, food for thought, and ideas to consider. We've done similar kinds of work with Medicaid, which is called Apple Health in our contracting with Managed Care Organizations. The right section of Slide 26 we talk about Apple Health – Medicaid. There is a withhold there, an expectation of the plans in terms of quality and performance; and then importantly as well, for Medicaid the state is moving toward a model we call fully-integrated managed care. This takes the dollars that were once separate and combines the behavioral health dollars, the mental health dollars, and substance use dollars with those for physical health. It puts them in one pool of money and has a single point of accountability because, as somebody who's practiced primary care at Harborview for 21 years, I can tell you the head is attached to the body.

Slide 27 provides some sense of the common elements that are needed to move toward value-based purchasing model of care. I've mentioned some of these in terms of the risk sharing at the provider level (in the upper left hand box) that I talked about with the Accountable Care Programs to data and measurement (in the upper right hand corner)

which is extraordinarily important, something else I alluded to earlier. In the lower left hand corner of the slide, we actually have what I think is a quite innovated model of rewarding improvement, because the Accountable Care Programs can demonstrate their quality either through improvement or by achieving a benchmark performance goal. If they improve on any number of indicators, even though they don't reach some benchmark level of performance, they're still able to capture their full share of that quality incentive. And then care transformation strategies in the lower right hand corner of the slide that are based on Bree Collaborative recommendations.

The Bree Collaborative, for people that don't know, is a legislatively charged gubernatorial appointed stakeholder group of health care leaders and health care purchasers from across the state who come together to identify best practices and make best practice recommendations to purchasers and plans in the state.

Dave Iseminger: Dan, I saw a couple of inquisitive looks on something you said. I want to try to reiterate in a different way. When we are talking about rewards for improvement and attainment, for example if our benchmark is an "A" in your school and you are starting at a "C" and you don't hit "A" but you hit "B," we reward you for that journey of getting and improving your grade. We'll also reward you when you hit "A" as well. We give you a reward or incentivize your journey, as well as your ultimate attainment.

Also, when it came to the Bree Collaborative, I wanted to highlight an example of that is total joint replacement. That was a Bree Collaborative recommendation about best standards of care and the Health Care Authority used it as the basis for procuring the benefit of a bundled payment as Dr. Lessler described on the previous slide.

Pete Cutler: Will we also have additional Board briefings on the Bree Collective and what its recommendations are?

Dave Iseminger: We can come back with something that describes a couple of the different environments for the standards of care that are utilized in our products.

Pete Cutler: And in addition, from Slide 27, a little more specifics about the nature of the incentives for the contracting for quality?

Dave Iseminger: We can definitely include that. It will fit well with the benefits presentation next month.

Dan Lessler: Slide 28 and Slide 29. Coming back to that Institute of Medicine report, "Crossing the Quality Chasm," crossing that chasm is very much about a transitioning from fee-for-service to value-based payment. This is not easy work, hardly straight forward, and actually quite challenging; but as I'm fond of quoting John Gardner who wrote a book called Self-Renewal, he was actually the Secretary of Health Education and Welfare when it was HEW in the Kennedy administration, he says, "Hopelessness does not make for renewal." Going forward, we really need to bring to bear what we have with the Accountable Care Programs, for example, and the joint bundled

purchasing that I've described, really proactive, upfront systems' thinking. We need to do that kind of work, make the commitments of resources, and take the calculated risks.

Slide 30. I want to close by saying that I think that our Accountable Care Program performance to date really demonstrates that this kind of approach can work. What we have found is that in 2016, those networks; and it's the UW Medicine Accountable Care Network and the Puget Sound High-Value Network, the ladder is anchored by Virginia Mason, both of them were able to achieve our high standards in terms of the benchmarks that we set, or if they didn't meet the benchmark, they made improvement. We were quite pleased with their performance; and actually, I think they surprised themselves in terms of how well they were able to perform as they implemented systems that could help them to achieve the desired outcomes.

On the left, and these might be a little bit too abbreviated, these are the measures that they were being measured on. There's a cross section of chronic disease and preventive measures. The benchmarks here that we're asking them to achieve were typically 75th or 90th percentile of National Committee for Quality Assurance (NCQA). That gives you some idea of what's possible when you proactively do the systems thinking upfront and with careful design.

Slide 31. The Health Care Authority does have a roadmap. We have a desired path that we want to go down and a place where we want to end up. That's what you see here. You can see the goal is by 2021 to have 90% of our purchasing by Medicaid, PEBB, and SEBB, in value-based payment arrangements.

Alison Carl White: I'm curious on Slide 21, the Value-Based Roadmap. I know those targets for the Medicaid, Apple Health contracts. Do they match up with the PEBB contracts as well? Is that the same as hitting 80% in 2019 and 90% in 2021? Or are those Apple Health goals?

Dan Lessler: This is for across all of HCA's purchasing.

Alison Carl White: Excellent. Thank you.

Pete Cutler: Just a follow-up on Alison's question. What I infer from that in the Apple Health Program, that's hitting those targets, will involve having your Managed Care Organization, your carriers, whoever bids on them, arranging for having Accountable Care Organization-type dynamics in terms of the care they deliver or they pay for?

Dan Lessler: It doesn't necessarily have to be an Accountable Care Organization arrangement because that is a specific type of arrangement, but there is an expectation that's well defined that a large proportion of their payment to the provider community will be in value-based payment arrangements. In fact, the withhold in terms of the incentive, about 25% of that, they can earn by contracting through such arrangements. The other 75% is based on the quality of care that is being provided. So there's actually an incentive for them to drive towards more value-based payment arrangements.

Katy Henry: In the future, is there going to be something that we hear about the members who are participating in these programs, how they feel about the care they've received? What it's been like for them? Will we get some of that information?

Dave Iseminger: That will be December 11.

Katy Henry: Great.

Dave Iseminger: Whenever we go through the product offerings that you may be able to leverage, those are some of the things we are going to describe. We'll take the opportunity to also preview some of the results of the PEBB Open Enrollment that is ongoing this month, as we're anticipating a lot of people may be switching to some value-based purchasing plans. And that way we can describe to you why you may want to leverage one of, some of, the value-based products the Health Care Authority already has experience with. So, yes, yes, and yes.

Lou McDermott: I have a question and I'm going to go a little off script. I know staff are getting nervous as I'm speaking. I'm wondering, with the speed at which all this has to happen, starting from scratch with the Board, and saying okay we've got to do By-Laws and all of these different things that have to be done, we need to create eligibility requirements, etc. Does the Board feel like they're being brought up to speed at the appropriate speed? Do you think the information we're providing you is useful? Do you think other things need to be provided? I know Dave is trying to walk you along the logical path - here's the framework. Let's get the Board set up and make sure we have our rules of engagement all tidied up; and then let's talk about health care, Dan's presentation; and I know Marcia's giving a presentation coming up soon about some other benefit arrangements, some definitional information like what is an HMO, what is a high deductible plan? Do we feel? Are we going at the right speed? Do we feel like we're going too slow? Too fast? Any thoughts?

Alison Carl White: I would say this feels like the right speed, though when you start saying things like that, I feel anxious. I thought it was good. Seems like the complexity of what comes in the next few months isn't as grounded in if you have listened to any health care debate in the last ten years, a lot of this is familiar.

Lou McDermott: I think part of it is that the agency's tasked with doing some of this work. So coming in here, sitting down, and going over the financial modelling that's going to take place, to be able to provide a certain benefit level with certain bells and whistles and things, I don't know how beneficial it is. It's like there's some intuitive things about modelling that you would know if you want a richer benefit with more bells and whistles, it costs more. How we risk adjust it and how we do all of these things to it, I don't know the granularity that we'll get into in those items. But there will be general themes and discussions. Like why is the Accountable Care Program's premium less? There's reasons for it. We can talk about that. I just want to make sure that we're giving the information at the appropriate granularity that the Board is feeling comfortable with. We could take it all the way to the floor and you could go nuts and bolts, ground up, how to build a benefit, etc. I just don't know if that's useful to the Board.

As we go through the process and you do your check-ins with Dave on the agenda, make sure everyone's good. If there's additional granularity, if there's more things that are wanted, the Board needs to articulate that so we can provide that because it takes time. Each one of these Board meetings is very well orchestrated, three part session that occurs with hundreds of hours of work in between, which may or may not be evident. The fact that it goes fairly smoothly, the agendas look good, and the presentations aren't contradicting each other indicates that work has been done. We just want to make sure everyone is feeling comfortable with where we're at and where we're going each Board meeting as we get a little deeper into the technical aspects? Everybody good? Alright.

Setting the Stage: Health Benefits and Insurance Overview

Marcia Peterson, Manager, Benefit Strategy and Design Section, ERB Division:

Today, my colleague, Kim Wallace, and I are going to present some principles of health benefits and insurance, including types of health plans, and benefit design that we hope will be helpful to you as you begin the process of selecting and designing benefits for school employees. We'll discuss the regulatory environment, concepts of insurance risk, key trends in employer sponsored health plans, how benefit design impacts or can impact costs and trends in other benefits, such as dental and other types of plans. I want to preface this by saying that we realize there are experts in this room on this. We want you to feel free to speak up and talk to each other and flesh out some of the things that we're talking about.

Slide 3, Regulatory Environment. There are a lot of federal and state regulatory requirements that provide us with guide posts when we're designing a broad range of benefit structure. We will not be taking a deep dive into every one of these today, but I wanted to acknowledge those external regulatory forces and assure you that within the Health Care authority, we do have experts in each of these areas. It is our job to understand these guideposts. Things are changing constantly and we'll be working with the Board to ensure compliance with those as we go forward.

Dave Iseminger: I'll just add that there'll be times where the Board asks questions, "can we do this with the benefit design?" At that point we may come back to these regulatory environments and say because of HIPAA, that can't work; or because of GINA, that can't work. We'll explain things as those specific questions come up and we're addressing different benefit design pieces.

Another piece I want to highlight on Slide 3 is the Employment Retirement Income Security Act (ERISA). You may have heard about ERISA but don't see it here. That's because HCA administered plans are governmental plans. There are exemptions from ERISA, but if you look in the upper 11 o'clock region of this slide, you'll see the Public Health Services Act. That has a lot of analogies in federal law to ERISA.

You also don't see the Office of Insurance Commissioner (OIC) on this list as a regulatory environment. That relationship is very complicated, but to suffice it to say that with self-insured plans, the Office of Insurance Commissioner doesn't have

regulatory authority over the self-insured plans. They have authority over fully-insured medical and dental plans, so there are implications for the medical offerings of the Health Care Authority to try and have a similar benefit design between self-insured and fully-insured so it will trickle back into the self-insured plans because of the regulatory environment of the fully-insured medical and dental. There are policy documents that have to be submitted to OIC for review for life insurance and disability products. But there isn't a direct relationship of regulatory authority for self-insured plans from OIC, but there's always an exception. The Legislature, from time to time, does mandate certain parts of OIC's laws and rules as being applicable to the Health Care Authority, and the Health Care Authority is then responsible for monitoring and ensuring compliance with those areas.

Marcia Peterson: Going back to the talk that you just heard from Dr. Lessler, he identified a few of the important trends that we are seeing in health care that are of great concern. So how do we make sure that school employees get the best possible care at an affordable cost? Is there a way to do that? The answer lies in the types of plans that we are going to offer, the types of benefits that we're going to be able to provide, and the benefit design. Kim and I are going to walk through some of those.

Slide 4, Insurance Risk. I love this picture of the sailboat because of what it typifies. What is insurance risk? It is the likelihood, a risk, that something will happen that will require the insurer to pay a claim. Normally you would secure coverage for an unlikely event through an insurer. I like to think of insurance as we bet that something bad will happen and the insurer bets that it won't. So in a way, you bet against yourself, but that's the concept of insurance risk.

Slide 5. The diagram on the left shows the claims cost for a population over their entire lives. This is just a model, it's not real data. It's for purposes of illustration. What you can see on that left hand side, the left axis, is the number of people within that population within each of those bars. Around the bottom is what people essentially spend in terms of claim costs over the course of their lives. It goes into a bell curve. It shapes itself into a normal distribution over a population. Some people, like those on the left in the purple bars, are really lucky. They're healthy, they go through their whole life without using much health care. Most of us are right in the middle represented by the red bars. We use some health care over the course of our lives. And then the folks on the right, for whatever reason, whether they're born with a pre-existing condition, whether they suffer from an accident, whether they have diagnoses later on, they are going to use a lot of health care over time. The rule of thumb our actuaries tell us is that 80% of the cost of health care is consumed by 10% of us.

Risk in this sense is a risk that someone within our population is going to incur a claim cost. Actuaries are really good at predicting with pretty good accuracy, the risk of the cost of claims for a given population if you give them a few years of claims' data. What they're not very good at is predicting exactly who's going to have that happen to them. That's probability. That's getting into the area of risk. So, we don't know who's going to incur those costs within our population so we want to ensure against that happening.

Insuring a smaller group, by its very nature, is riskier than insuring a larger group because you really have no way of knowing with any certainty in a small population which end of that spectrum your population's going to be. Are you going to have really healthy people or will you have people who incur some catastrophic events? If you're a small employer, you're much more at risk of having something that will impact your population that could drive up the cost of insurance for everyone within your population. If you're a larger employer, you tend to be kind of insulated from that because you may have some catastrophic events that happen within your population; but those can be offset by the fact that you have a lot of people who don't incur costs that year. It averages out over time.

Pete Cutler: Can you remind me what the number was for any given year, what percentage of the population generated that 80% of the cost?

Marcia Peterson: Ten percent. A small, small percentage.

Dave Iseminger: I'm going to tie this together very pointedly. In the world that school districts are in right now, many of them are searching for benefits on a school district by school district basis. Some of our school districts are very large and some of them are very small. So part of this consolidation into a single purchasing could allow for a more normal distribution and insulating from catastrophic events by combining all of the different districts together into a larger purchaser. Tying that together for this program that you're working on could help insulate the wider range of variability currently in the school districts from an insurance standpoint.

Wayne Leonard: How large does a population or a group need to be before the outcomes are somewhat predictable?

Dave Iseminger: I don't quite know the lower end of it, but you will see populations that are in the 10,000-20,000 trying to self-insure and insulating at that level. I'm not sure what our actuaries would advise us on that point, but in the Public Employees Benefits Board Program we are around 370,000 covered lives in the medical benefits. It's projected to be 200,000-300,000 covered lives once all dependents are included in the School Employees Benefits Board Program. That's certainly large enough for self-insurance options. We are seeing cities and counties that are getting into the low five digits looking at self-insuring.

Lou McDermott: The number I've heard is about 20,000 covered lives.

Marcia Peterson: That's a good number. Slides 6 and 7 - Employer-Sponsored Health Plan Funding Arrangements. If you haven't heard before, employer-sponsored health plans are how most people in the United States get health insurance and there are a couple of funding arrangements. One of those is fully-insured health plans. In this model of funding arrangements, the employer will contract with a health plan to provide insurance coverage. The monthly premiums are based on the employer's size, population characteristics, and health care use based on looking at claims use over time. That is what tends to set that premium cost. In this case, the health plan bears

the risk. If there's unexpected expenses that year, it's on the health plan. If actual costs are lower, the health plan gets the savings. For reasons that Dave just mentioned, smaller employers tend to offer fully-insured plans. It insulates the employer from the risk, particularly if they have some catastrophic events within their populations in a year. If you're a small employer you have a known premium cost. If there are extra claims costs that year you're insulated from that. That would be very important to you as a small employer.

The other main employer-sponsored health plan funding arrangement is a self-insured health plan. In this plan, the employer pulls together their own pool and they act as their own insurer. They are paying claims costs directly. If they have a lot of claims costs that year, it could affect their bottom line. They will often use a third-party administrator to process the claims because even though they are a large employer, like Boeing, they don't necessarily process their own claims. Within the Health Care Authority for the Uniform Medical Plan Program, we contract with Regence to administer our claims costs. In this plan, the employer bears the risk and has to pay all of the claims even if they are much higher than predicted. It is possible that this could be more cost effective for a larger employer since they're not having to pay the administrative costs necessarily. Large employers tend to offer self-insured plans. As Dave mentioned, recently we're seeing more smaller employers going self-insured for a variety of reasons.

Dave Iseminger: Just to preview, at the December meeting when we go over benefits, you'll see offerings that are both fully-insured and self-insured.

Marcia Peterson: Slide 8. Now we'll talk about types of plans. This is where we get into our acronyms. There are several types of health plan designs that have been devised over the years to deal with the issue that Dan Lessler talked about of the ever increasing costs in health care.

The first plan type is the Preferred Provider Organization (PPO). In this arrangement the health plan contracts with a set of providers who've agreed to offer services for a lower fee in turn for getting those patients. They're preferred in the sense that if you choose to see a provider outside of that preferred group, you will likely pay a higher fee out of pocket because those providers outside of that network have not agreed to that rate. The insurer will say those out of network providers are not preferred and they're trying to get you to see the ones within the network.

The second plan type is the Health Maintenance Organization (HMO). For an HMO, there are as many definitions of HMOs as there are HMOs. Basically it's a network of providers very much like a PPO, but usually there are systems in place, including sometimes financial incentives around quality for the providers to keep you healthy, much like what Dan was talking about earlier when he was talking about accountable care. They may have incentives around quality for screening, for prevention, wellness, and using evidence-based care. We have experienced that within the Health Care Authority.

Costs kept rising in employer health plans in spite of the fact that we've tried these different types of plans and models. Some in policy argued that in these employer-sponsored health plans, the reason costs are going up is because between the consumer and the provider neither one of them are really responsible for the costs. They are essentially insulated from the costs. That's a policy perspective and if you made the member responsible for at least some of those costs, they might be more careful with their health care utilization. Thus, the Consumer Directed Health Plan (CDHP) was born. Under Consumer Directed Health Plans, consumers have an incentive to keep costs down because they're usually given some money up front in a health savings account or a health reimbursement arrangement. They're given money that they can use for health care costs and it makes them responsible for costs. It's the fastest growing form of health plan in the employer-sponsored world.

Lou McDermott: Where does an Accountable Care Organization fit within the constructs of those three?

Marcia Peterson: That's a really good question. Accountable Care Organizations, I would say within the last five years, have been a policy direction that we've seen within the country overall. The concept of those is just as Dan was talking about. Organizations or providers come together and they can either directly contract with an employer like us or they can do this through a health plan. The concept is that they are accountable for the care. They are financially at risk. The providers themselves are financially at risk for meeting certain quality targets.

Pete Cutler: I have a question. Would they be more like a Preferred Provider Organization? This is really a question in terms of the PEBB Program. Are persons who sign up for one of the two Accountable Care Organizations within that program able to go to other providers out-of-network and pay the higher co-insurance, or whatever? Or are they more in arrangements similar to being with an HMO, like Kaiser Permanente, where there will be no reimbursement except under the very limited circumstances if you use care outside of the organization?

Marcia Peterson: Within the Uniform Medical Plan Accountable Care Program, which we refer to as UMP Plus, there is an out-of-network cost similar to what you would see in a Preferred Provider Organization. There are, I believe, some providers who are completely out-of-network, for instance if you go out of state. You can design the plan any way you want based on the premiums and the cost, etc. That's how we designed that one.

Dave Iseminger: I'll add to that. As we get into describing the benefit offerings next month, one of the most popular benefits within the PEBB Program is the Uniform Medical Plan Classic and that is a PPO plan. The UMP Plus is built upon that UMP Classic framework and has network partners that have an incentivized member cost share to see providers within those partners' networks. Members still have opportunity to go out into the broader PPO network that is administered by Regence, but they'll have a higher cost share to those providers. Then there are truly out-of-network providers in which the member has an even larger cost share obligation.

Kim Wallace: I'd like to add one thing with regard to the UMP Plus plan from a member experience standpoint. There are requirements that we have in place for how the members in UMP Plus receive communications about the plan, about their care, coordination, etc. You can imagine that when a person is seeking care and they're seeing a provider within the Accountable Care Network, the other providers, specialists, etc., in the Accountable Care Network also have increased access to information and increased expectations about care coordination and information flow. So one of the things we're really seeking to do with the UMP Plus Accountable Care Program is not just arranging the payments. We're taking a more holistic view as we design the UMP Plus plan. We're not just moving dollars around. We're looking for ways to improve and secure the right experience for the member, from the time they choose that plan to the time they first seek care with a provider in the Accountable Care Network, through their entire process. When they're on the phone lines with customer service, we have requirements for dedicated member service interactions. It's a nice marrying up of financial incentives and setting new standards for how people navigate care process.

Dave Iseminger: In the benefit offerings that you'll hear more about next month, you'll hear about PPOs, HMOs, and CDHPs. The one thing you won't hear about is a CDHP with a health reimbursement account (HRA). The plans that we'll present and describe next month have HSAs. An HSA, or a Health Savings Account, is employee owned. The employee or the employer, both of them, can add funds to it. The amounts are pre-tax contributions and they rollover from year to year and that's important with the employee-owned aspect of it because once the money is in there, whatever the source was, it is that employee's account. It's like a bank account, they own it. And from year to year it rolls over; and an HSA could be invested. You could use investment funds to grow that.

HSAs are not what are called a pre-funded benefit. Pre-funded benefit refers to benefit structures where you can immediately access all deposited funds on January 1 even though money hasn't been deducted from your pay check for the whole year yet. Over the course of the year, you pay back the elected amount so that ultimately the account is filled by contributions from your paycheck. But HSAs are not pre-funded. You can only spend what is in your HSA after the contributions that you or your employer have made.

Now, contrast HSAs with the Health Reimbursement Account. Those are employer owned. Thus, the employer has more control over those accounts. They're funded only by the employer. They, again, are tax-free contributions, but the employer has the discretion whether to allow those funds to rollover year over year. Those benefits typically are pre-funded. You may hear about plans where if you get your flu shot right now, we'll put \$100 into your HRA next year to lower your deductible cost. Your employer puts some money into an account and you use it how you see fit for the health care that you use. The benefits that you'll hear about next month describe an HSA setting rather than an HRA setting. But those are different funding options and design structures.

Marcia Peterson: There is another type of plan within a Preferred Provider Organization that we've seen some health plans come up with. It's a Narrow Network Plan, kind of like a PPO in the sense that the health plan is contracting with providers to create a network who will accept less in terms of payment if they direct patients to them. From a policy perspective, it's the difference between that approach which is purely price oriented and an approach where you, as the employer, are vetting those providers. Are they the best providers? Are there quality incentives? It's not that you can't have both, you absolutely can. But as you're looking and thinking about plans, think about those factors of narrow network and lower cost, but what about quality? Is that something to include to ensure we have?

Slide 9 covers member cost sharing. There are a number of ways that health plans have incorporated financial incentives in order to keep the costs of health care down by making the subscribers responsible for some of the cost of their care. An example is co-payments, which are usually \$15-\$35 paid per visit and collected at the time of the visit. Co-insurance is another way of cost sharing, and those are usually collected after the claim is adjudicated. Co-insurance is usually a percentage of the cost, such as a percentage of your inpatient stay or a percentage of your physical therapy visit that you're paying to, again, make you feel a bit of the pain to maybe keep the utilization down. That was the policy reason some of these were put into place in some plans.

We have found that, in general, people are most confused about the concept of the deductible. The deductible is an amount that your health plan sets that the member has to pay. So the member pays for care in that plan year and once they meet that deductible amount, then their insurance kicks in. With all of those things, they can get some pretty high out-of-pocket costs by the end of the year depending on what's going on. Normally there is an out-of-pocket maximum beyond which if the member hits that ceiling then they no longer pay anything out-of-pocket and the plan then pays 100%.

We've learned from research over the last few years, particularly with the Affordable Care Act and with people getting health care for the first time who maybe didn't have it before, they are really confused about all of these co-insurances and cost sharing. It can be very difficult for people to make a good decision for themselves and their families in terms of what's the right plan for them. They may need to consider the lowest cost, best quality, I have kids who go to college, or whatever impacts their family. There are a lot of things that people need to take into consideration.

The Affordable Care Act has tried to group them into the metal classes where you have a Platinum Plan, a Gold Plan, and a Silver Plan to help people do a better job of choosing a plan. The confusion that people can have when they're trying to choose a plan with these different kinds of cost sharing is something to keep in mind as we move forward.

Patty Estes: Does that out-of-pocket maximum typically include the deductible or not?

Kim Wallace: Yes, it does. The out-of-pocket maximum (OOPM) is really a protection per person so that one individual person doesn't have to incur exorbitant out-of-pocket

expenses in any one plan year. It does start over the next year. It can also be called maximum out-of-pocket (MOOP). OOPM and MOOP can be used interchangeably.

Lou McDermott: But Kim, it's true that in some plans pharmaceuticals weren't counted, so it wasn't all of the dollars that came out of your pocket toward all of your health care. It was the ones that counted toward the maximum out-of-pocket.

Kim Wallace: Yes, correct. You will hear some people talk about the medical out-of-pocket maximum versus a prescription drug out-of-pocket maximum to your point, Lou. And there are, on occasion, certain fees or expenses that are specified and excluded. There are layers of details, but essentially the medical versus prescription drug is an important distinction. There are plans that have separate maximums for those two and sometimes separate deductibles, too.

Pete Cutler: I can't resist asking, so if you, with a Preferred Provider Organization, get care out-of-network, does the larger amount that you pay all count towards your MOOP or whatever?

Dave Iseminger: We will need to follow up with you on that rather than guess in a public meeting.

Pete Cutler: That would be fine. Thank you.

Kim Wallace: I am going to walk you through the concept of basic benefits versus optional benefits which are on Slide 10. Basic benefits are provided and largely paid for by the employer. You will be thinking about basic benefits in your work, whereas, optional benefits tend to be offered through the employer; but the employees pay the premium. I believe that you may also be considering some optional benefits in your work ahead.

A good example of the distinction between basic and optional is something that's in place currently with the Public Employees Benefits Board Program life insurance. With Basic Life the state pays the premium for a certain amount of life insurance. There's optional life insurance where employees can choose to pay premiums to obtain more coverage, for example an additional \$100,000 in life insurance, and those premiums that the employee pays are typically driven by factors related to age and sometimes tobacco use.

Another concept of particular importance is the approach to funding. There's a distinct contrast between these two bullets on the slide. A set dollar amount is like the current state allocation for school benefits versus setting the benefits, or the coverage, like with the current PEBB Program benefits. Under the second bullet, imagine that the state is paying what it costs to provide those benefits and coverage: the claims and the administration for a self-insured plan *or* paying all the premiums to the health insurance companies for fully-insured plans. Of course, typically employees are paying some premiums as well. The big distinction is that under the second bullet where there are benefits in coverage that are defined and set in place that everyone has access to, the amount of money that it costs per employee is not known. It is estimated, predicted,

projected, and budgeted; but then we reconcile after the end of the year and we check in to see what really happened. We wanted to highlight for you that with the School Employees Benefits Board Program, you are now stepping into the world of the second bullet, not the first bullet.

Pete Cutler: Kim, the second bullet sounds like if the Board decided we wanted to have very generous benefits, we could just do very generous benefits, very generous eligibility, and say yes, that's good. And somebody else would pay for it. So I know I must be missing some key part of that.

Kim Wallace: Good point. You will have the benefit of the Health Care Authority staff, consultants, actuaries, etc., who will be sharing with you the financial estimates and impacts. It is true there is no blank check, wide-open funding opportunity. The state knows, the Legislature knows, OFM, everyone knows what has typically been spent on average for public employees, the average public employee. We anticipate that when the funding and financing is discussed over these next few months, that there will be careful thinking about what, from a budgetary standpoint, the right place to land is. We don't know what that is now, of course. But we know that we will be bringing that information to you so that you are fully informed.

Dave Iseminger: And I think it's fair to say that the Board has authority, but it also has guardrails that are provided by the Legislature. Whatever the funding mechanism is that is authorized by the Legislature is one of those guardrails. Just as in the eligibility framework, the statutory benchmark is 630 hours of eligibility. That is a guardrail that wraps around the Board's discretion. This funding mechanism similarly wraps around it.

Lou McDermott: And I think one of the things that always makes it kind of tough is there's also the interplay between the Legislature, the Board, and the judicial system. So if there is a lawsuit that says you will now cover X, the Board doesn't get to say, "No we're not going to do that." At the Health Care Authority, you can think of them as being the translator between all of those different components. We're working with the Board, we're working with the Legislature, and we're working with the judicial system. Hopefully not a lot, but we do work with the judicial system to try and figure out what that balance is and to bring you options that lie within that balance. That's always interesting because there is statutory authority given to the Board, but there is also the Legislature that has authority as well. It's overlapping circles at the end of the day. Our job as the Health Care Authority is to try and make sure we present you with legitimate options that you have before you; and when the Board wants to have a benefit that pays for everything that costs nothing to anyone, to tell the Board that that's unrealistic. That's the delicate dance that we go through in this process.

Kim Wallace: Slide 11. A third concept is the risk pool. The legislation creates a new single risk pool for all employees and dependents from K-12 school districts, ESDs, and charter schools across the state. Marcia talked about how the likelihood or the risk that a person will generate claims costs for health services varies person by person. The effect of that fact is that people who use a lot of health services, or what might be referred to as high cost enrollees, are now in the same risk pool as people who use few

or no health services, the low cost enrollees. When the rates and the premiums are set, all of the funding that Pete was just asking about, the funds must cover the expected costs for all the people in the entire risk pool. There is this notion of the average. We don't think there is such a thing as the average person in the risk pool; but we have to think in terms of the average cost, the average person. People vary greatly but they're all in the same pool together.

Dave Iseminger: Some of you may wonder why next month we're not going to present premiums to you and that's because the risk pool that those premiums are set on is the Public Employees Benefits Board Program risk pool versus yours. Yours will be the separate, community rated SEBB risk pool. So if you go outside these doors and you start to pick up handouts and think this is what the premium might look like, I just want to caution you against drawing those conclusions so directly because the risk assessment for this risk pool may be different than the PEBB Program risk pool.

Wayne Leonard: I'm trying to formulate a thought in my mind, I guess, on the concept of a single risk pool statewide, because some of the things that HB 2242 did as well in terms to school districts, is regionalize pay across the state based on costs of living. And we saw in Dr. Lessler's presentation that there is wide, unexplained variation in costs and outcomes of patients. So in terms of a single risk pool and regionalized pay for school employees, would it be reasonable to have regionalized risk pools?

Kim Wallace: I believe I understand what you are asking. I will answer at a high level that in setting - deciding how to distribute the responsibility financially to people who are in the risk pool by what plan they choose, by what county they live in, by other factors, theoretically there are many, many different factors that can be applied to sort and manage that kind of variation I think that you're asking about. I think that while we know that technically, actuarially, that we can calculate many, differentiate in those slices and dices of people, it is not clear, at all at this time, what is advisable or what is permitted to be done with the SEBB single community rated risk pool. We need to dig in to understand the different types of groupings or sub-groupings that can be dealt with.

Lou McDermott: I think what we're talking about is we would probably have it as the same risk pool. But what we're looking at is differentiating premiums. I don't think what we want to do is to carve up the state in all of these different blocks and put them in a risk pool. I think what I'm hearing you say is yes, but people are getting paid different amounts in different areas, and should we make an adjustment for that? And basically the actuaries can do anything we want. They can make those calculations on the PEBB Program side. It doesn't happen because all state employees are paid the same. So if you're a State Patrol Officer 1 in Wenatchee, you get paid the same as the one in Seattle. They don't make adjustments. It is something to consider. It is something that could be done, but we also have legislative intent; and we need to take a close look at the legislation and how much specificity they are getting into. It helps guide the conversation. But I hear what you are saying and it does, on the surface, seem like a reasonable area we need to explore because of the pay differential.

Wayne Leonard: And I also, at least if I understood Dr. Lessler's presentation, there are potentially costs of certain procedure differentials between various parts of the state as well, which would also impact the insurance premiums.

Lou McDermott: There are, but what's unusual about that pay variation as you would discover that the more rural areas cost more, the more urban areas are cheaper in rates. But then you're probably given pay enhancements to those living in the urban areas because the cost of living is more. So what you would find, in a strange way if you did that, if you segmented the population by the given area, you would have a double whammy. People in the rural area, who are making less money, would then pay more on their premiums. So part of the calculus is taking a look at both sides. Where are the costs and how much are they? What is the pay of the employees? Looking at both of those, but that is a strange anomaly in the data.

Dave Iseminger: I will add to the equation, as somebody who knows much of the legislation but doesn't have it all memorized, there are still a lot of questions that need to be answered. I don't want anybody to walk away from Kim's presentation believing that we, or you, or anyone, has the complete definitive answer as to the exact funding mechanism. A lot of these details still need to be worked out and we'll hopefully get more insight during this upcoming legislative session. That's one of the challenges we have in describing some of those important guardrails for your discretion in setting benefit design because they are still being built while we're starting to tell you we need some high level decisions about what you are building. It is the delicate process that we are working through. I want to make sure that people on the Board don't think that we know all of the answers yet. We can't just read all pages of House Bill 2242, because not all of the answers are crystal clear there either. We'll be learning more and describing more to you as we understand more.

Kim Wallace: You have a couple more comments on risk pool in front of you on Slides 12 and 13. One note is that of course employees will choose different health plans. For example, some PPO and some HMO, which will affect the premiums and the cost sharing they themselves pay during the year. So the people in this one big risk pool together, they all have lots of differences and they're experiencing variation. The fourth bullet actually speaks to your point Wayne, even when employees choose different health plans they are still all in the same risk pool. They will effect one another's rates and premiums. I mentioned it will take funding for all of the benefits that are set, and the fact that there's this average per employee average amount of funding, even though some people actually spend or account for much less than that dollar amount and some people account for more in terms of their needs, because they are all in the same risk pool. The funding that it takes to cover everyone as a whole, the next year that funding need could go up; and when that goes up, there can be effects on people, even people whose own health care wasn't high last year. The HCA has a lot of experience managing those changes and that variation from year to year, plan by plan, so that it's reasonable and fair; but this is a concept that we will be talking quite a bit more about.

Slide 14. Just a little bit more to add to supplement some of the comments that Marcia made specifically about the types of services covered in medical plans, and then a little bit more about provider network structure.

Slide 15 – Types of Services Covered. Many services defined to be covered are regulated by government as Marcia said. We will be standing ready to help clarify, keep you informed, and up-to-date regarding all of these changing requirements. One interesting example is the United States Preventive Services Task Force, the USPSTF. The USPSTF is a group of experts nationally recognized that meet regularly and come up with recommendations regarding certain types of services that should be, in terms of their clinical efficacy and effectiveness and cost effectiveness, covered by health plans. Specifically, the Affordable Care Act requires coverage of screenings and counselling services that are rated A or B (those are the top two levels) by the USPSTF, as well as selected immunizations and certain preventative services for women and children at no member cost share. That last phrase is the kicker. The USPSTF rated A/B preventive services must be covered by all health plans with no member cost share. That's something that we have implemented in all of the plans that the Health Care Authority currently administers and will be applicable to the SEBB Program as well.

The second bullet refers to additional services that can be added to a medical plan. Oftentimes people take these for granted and they don't really think of them as separate, like prescription drugs and vision care. We do acknowledge that many employees in Washington currently have separate vision care and some have separate prescription drug plans as well. There are reasons that some people favor separating out a vision care plan and there are reasons why some like to see it integrated. More to come on that, but that's something that you will be considering in the coming months.

Dave Iseminger: This is something that over time we'll bring to you and give you information saying this is a benefit change that is happening for X plan year because of Y source. You don't have discretion to change it, but we just wanted you to know about this enhancement or this change. They might not necessarily be an enhancement, but the benefit change will happen.

Kim Wallace: Slide 16 – Provider Network Structure. Marcia talked about types of plans: PPOs, HMOs, CDHPs. The point I want to make here is at one level down and more detailed about the network itself. I want to share that in a Preferred Provider Organization (PPO), these tend to have a lot of providers in them, they're broad based, they typically cover a wide geographic area. So in addition to the point about the member usually pays more to go out-of-network than if they stay in network, we also want to make the point that PPOs have traditionally been appealing for groups that have lots of members in rural or remote locations. PPOs tend to include a physician, a provider, a nurse practitioner who practices in a solo practice in a rural area who may not be part of a clinic or an established medical group. That's one of the features that becomes important when considering the access across your entire service area. We want to acknowledge that.

Health Maintenance Organization Networks (HMOs): They have typically fewer providers than a PPO network. The providers can be employed even by the carrier or plan, like a Kaiser Permanente. But the main point is often emergency care and urgent care are the only care covered outside the HMO network. Marcia mentioned a person who may fall into this group who has a child, a dependent away at college and out of area. So it's important to consider if a dependent is on your health plan and your health plan is one that has a limited defined closed network with no providers in the city where your dependent is going to school, your dependent will be able to get emergency care and increasingly urgent care, but not the full breadth of typical health services coverage. And that's something that's important to consider as you'll see this come up when you're looking at different plan options.

Dave Iseminger: Just to add to that, the Uniform Medical Plan Classic, one of the PPO offerings, had statewide and nationwide provider access. So there is a plan offering that you could leverage that instantly ensures access to a plan for the entire SEBB Program.

Kim Wallace: Slide 17. We've already talked about the Accountable Care Program and the Accountable Care Networks, so I won't reiterate points about that, but we're clearly making a commitment and inroads in this innovative type of program.

Slide 18 – Dental Plans. We want to make a couple of comments about dental plans. We talk and think a lot about medical. But our dental coverage and dental plans are also very important. We've made a lot of comments about PPOs and HMOs. There are also DMOs (Dental Maintenance Organizations). Managed dental plans and networks exist. Both the PEBB Program and school employees across the state do have access right now to managed-care dental plans. The point with this slide is to say, there are lots of similarities. The structure and the organization of networks, though not identical, have many of the same concepts.

Slide 19 discusses insurance risk for dental plans. Fully-insured you've heard about. Self-insured you've also heard about. And these apply to dental plans just like they do to medical plans.

Pete Cutler: Kim, am I correct that with the dental plans it's permissible for the plan design to include something kind of the opposite of an out-of-pocket maximum, instead just saying there is a maximum amount we're going to pay no matter how much dental service you need - as compared in the medical plans where that would be forbidden under the Affordable Care Act?

Kim Wallace: Right, there are actual caps or maximum payment levels that are still permitted in dental plans. I don't know exactly how to characterize the applicability of their relationship between the typical cap on a dental plan and SEBB dental plans. I think we should maybe look into that specifically to see if there's any sort of nuance there. But you're right, there are absolutely dental plans in existence currently in Washington, in the PEBB Program, and lots of other places that have an absolute limit on plan paid benefits.

Patty Estes: So all school employees currently are offered dental. It's something that is just given to us as far as I understand, I could be wrong, that's fully funded. It's included for the employee only. Is that something the Legislature is including in our realm that we have to give to them? That we have to offer?

Dave Iseminger: Patty, I think what you are describing is a mandatory benefit that's included for all employees.

Patty Estes: Yes.

Dave Iseminger: We're going to have to get back to you on the details, what would be included in the funding, because there's still a lot of details to be worked out. What I can compare it to would be on the Public Employees Benefits Board Program. The funding mechanism there is similar to what you are describing where all state employees have dental that is fully paid by the state.

Patty Estes: Okay, but we just don't know yet?

Dave Iseminger: We don't know the full answer to that question yet.

Before we adjourn, I'll provide a brief preview of upcoming topics for our meeting on December 11. We'll be going over the survey results from the school district business officials about the types of benefit offerings they offer to current employees in school districts, ESDs, and charter schools. That survey has been out for about two weeks and we have about a one third response rate at this point. We'll be able to use this information to describe to you more about what we are seeing from the medical, dental, vision carve outs on benefits, wellness plans, HMOs versus PPOs versus CDHPs. We'll also be able to describe to you the different optional benefits that we are seeing, including usage of Flexible Spending Arrangements (FSAs), and short-term and long-term disability, as well as the voluntary employee benefits administration plans or VEBA.

We'll do an overview of many of the PEBB benefits offerings that you may be able to leverage. I think I highlighted that enough today.

Then we will have Katy Hatfield discuss Executive Ethics, or the Ethics in Public Service Act, and some of your obligations there.

We'll be bringing you the By-Laws, which at this point would look very similar to those that were presented today. However, if there's anything that you think of in the next couple of weeks that you would like us to do some research on to be able to be better prepared for the meeting, let us know.

Meeting Adjourned.