School Employees Benefits Board
Meeting Minutes

December 11, 2017
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:00 p.m. – 5:00 p.m.

Members Present:
Lou McDermott
Dan Gossett
Sean Corry
Patty Estes
Terri House
Katy Henry
Wayne Leonard
Pete Cutler

Members Absent:
Alison Carl White

SEB Board Counsel:
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 1:03 p.m. TVW, Washington's Public Affairs Network, taped the meeting. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Agenda Overview
Dave Iseminger, ERB Division Acting Director, provided an overview of the agenda.

Follow Up on Prior Meeting Questions
Dave Iseminger, ERB Division Acting Director: I have a variety of different questions that you've asked from the last two meetings. First, there was a request for Katy to give legal advice on the AGO's representation related to Open Public Meeting Act violations. Katy responded directly to the Board in an attorney-client privileged email. If you have additional questions or don't feel you got that email, please let me know, or you can email questions directly to Katy.

Second, there was a request for Bree Collaborative information and you'll be getting that shortly with Dr. Lessler's presentation.

Next, there have been a variety of questions at prior meetings about what the agency knows or hears could be improved, clarified, or fixed in House Bill 2242's SEBB Program laws. For some general information, I want to make sure you're aware that state agencies provide technical assistance to other parts of state government. Examples of that would be other state agencies, Office of Financial Management (OFM), and even individual legislators. That technical assistance can include doing an impact analysis of draft language that someone else has produced, or even drafting language to achieve a goal that the requester is asking for so they can consider using it in an upcoming bill. I want to respond to your questions by giving you high-level descriptions of some of the topical areas that we have been asked to provide technical assistance on. This doesn't mean that it will or won't be in legislation.

The first area relates to a question from Katy Henry, who asked for some insight about giving HCA the authority to reimburse school districts for substitutes related to Board Member duties.

Second is data collection requirements. The legislation (HB 2242) allows HCA to use data to assist you with benefit design, procurement when we do the actual procurements, and then the rate-setting process. The date that data is due to the agency is January 1, 2019, which is after the procurements will likely need to be completed. There have been some questions about how to address those statutory provisions to make sure that the data is here to be able to do those functions. I'll also address the relationship of data from the school districts with the agency, as well as the Insurance Commissioner's Office (OIC), because there were multiple pieces of legislation passed last session that impacted the same section of the RCW.

A third area is clarifying that the salary reduction plan, the Cafeteria Plan, is something that can be accessed and utilized for school employees.

Fourth, we've been asked about what other fiscal accounts the agency uses that weren't created in the original legislation. There are about seven different accounts that are used on the Public Employees Benefits Board (PEBB) side of the world to be able to track funds separately for separate benefits, and not all of those were created in House Bill 2242. We've been asked what other accounts would need to be created for future use to be able to separately track those funds for the SEBB Program.

Pete Cutler: Dave, just on that last one, so there will be a presentation, or memo, or something at some point on those funds?

Dave Iseminger: Yes, we will go over the funding structure when we get further along in the process. This question we've been asked is, "were all the appropriate accounts physically created in legislation." And the answer was some of them were and some of them weren't, so this is just the actual physical

creation of the account. As we describe the fiscal impacts to you, we'll make sure that we're clear in presenting what accounts are used when and for what.

Pete Cutler: Thank you.

Dave Iseminger: The next two areas are related because of the way the SEBB Program was overlaid into Chapter 4105, RCW. There were several parts in the definitional part of the statute that when you wear your SEBB hat, you can read the statutory scheme this way and when you wear your PEBB hat, you can read the statutory scheme that way. It gets very confusing.

There were two definitions in particular that we've been asked for insight on. One is the definition of employee in statute. There's a discussion about simply inserting the word "school" in front of “employee”. Then you have definitions of “employee” for state agencies and higher education and “school employee” for the K-12 world to be able to distinguish better in the statute. The other area is actually the way the Board is referred to in statute. Our understanding is that all of the statutes that relate to Board roles and responsibilities weren't fully reviewed in RCW 41.05 in the original legislation. We've been asked to provide insight about clarifying parts of statutes that weren't addressed in House Bill 2242 that relate to Board roles and responsibilities.

Next, we've had several questions come about whether the statute includes a three-to-one premium ratio description that has historically existed in Title 28A. We've described that we don't see a three-to-one ratio expressly in statute. There have been questions about how that could be written into RCW 41.05 to be clear on this point in the Health Care Authority statutes.

Another question is related slightly to eligibility rules, which is one of your core functions. We were asked how the core eligibility statute compares to the world that the Health Care Authority administers in the Public Employees Benefits Board (PEBB) Program. One of the differences identified is the concept of “anticipated to work” was not written into the school employee eligibility statute. This concept distinguishes between if an individual has benefits eligibility based on whether they're anticipated to ultimately meet the eligibility requirements, or whether they actually have to meet the eligibility requirements before they are able to have benefits.

Finally, there are requests for some clarity around charter school employees. There were some references throughout RCW 41.05 where the bill referenced charter school employees, but it didn't systemically get all of the references. There were questions about what else would need to be amended in statute to make sure that was systemically addressed.

Those are areas I wanted to make sure you were aware of for agency technical assistance. When we come back to the Board in January, session will have

started. We'll definitely have a briefing on any legislation that's been dropped that impacts the School Employees Benefits Board (SEBB) Program.

For the fourth area of prior meeting follow-up questions, the Board asked some technical benefits questions. This is a preview of medical and dental presentations to come next month, but I will answer questions that you've asked so far. There was a question about whether the medical out-of-pocket maximum in the PEBB Program plans applies to out-of-network costs. The answer is no. Co-insurance paid to an out-of-network provider does not count for out-of-pocket maximums, nor do balance billed amounts that result from going to an out-of-network provider. We'll go through more granular details when we go into the medical benefits next month.

The other high-level benefit question so far is what is the annual cap on PEBB Program dental benefits? For the Uniform Dental Plan, which is the self-insured state plan, the annual benefit maximum is $1,750. There is no maximum on the two managed care plans, administered by Delta Care and Willamette Dental.

The next two follow-up question areas are still in pending status. Wayne, I believe you asked the first question of the Board, which was about whether the eligibility requirements include School Board Members. I just want to assure you that is still on our radar. We want to address that whenever we start presenting about the eligibility framework for you as a Board to be discussing. The agency does have experience with elected commissions and their eligibility, so we have a framework that we'll be able to pull from to answer that question.

The other prior meeting question we'll wait to answer until we get more into the medical benefits. You asked for testimonial information about how different public employees are experiencing their benefits. In particular, this came up in the concept of the Uniform Medical Plan Plus, as well as the Centers of Excellence Total Joint Hip Replacement Program. As we're presenting benefits, we will find ways to get you information about how members are experiencing those benefits.

The last thing I want to revisit from the last meeting were your questions about why Dr. Lessler gave a presentation on value-based purchasing. I want to make sure you understand that the value-based purchasing efforts for the Health Care Authority were established by legislation. In particular, in 2014 House Bill 2572 was passed and directed the Health Care Authority to increase value-based purchasing contracting in the agency's work. Over the past several years, medical and dental insurance products developed through HCA's contracting efforts have been modified to include value-based purchasing concepts promoting quality, efficiency, cost-savings, and health improvement. Dr. Lessler talked about all of those things at the last meeting. I wanted you to know how the products that the Health Care Authority has developed over the past years

changed as a result of the value-based purchasing legislation and to give you that background information.

<u>**The Bree Collaborative and the Health Technology Assessment Program**</u>

Dan Lessler, HCA Chief Medical Officer: As Dave mentioned, there was a request from a Board Member for a briefing on this topic. I'm very familiar and very involved with these programs in my role as Chief Medical Officer. Both the Bree Collaborative and the Health Technology Assessment Program illustrate ways that the Legislature can influence directly or indirectly benefit design. It's particularly important to note that these two programs demonstrate the state's commitment to evidence-based medicine, which is very important.

I want to begin by discussing the Robert Bree Collaborative and a word about Dr. Robert Bree. This effort is named after him. Dr. Bree died tragically a number of years ago. I knew him well and I worked with him at Harborview. He was a very respected radiologist, both nationally and internationally. He was very committed to evidence-based care, and evidence-based radiology, and especially the appropriate use of advanced imaging techniques like MRI and CT Scan, and so forth. The Bree really was preceded by a group that was looking specifically at evidence-based imaging and how to promote appropriate evidence-based imaging across the state. It was that effort that subsequently evolved into The Bree.

Slide 4: The Bree was created in legislation in 2011. Its purpose is to identify areas where there is high degrees of variation in how care is delivered, or very high levels of cost and utilization, or salient safety concerns. What the bill directed was the creation of a committee that is multi-stakeholder with 22 members. There is broad representation, including purchasers, plans, clinicians, etc. The Bree is directed to meet every two months to undertake its work in addressing these areas of high variation and high utilization. They are areas where there are salient safety concerns.

Slide 5: The committee itself if appointed by the Governor and this slide is a list of those people who are currently on the Committee, myself included in my role as Chief Medical Officer. You'll see quite broad representation in terms of the different sectors related to health care.

Slide 6: How does The Bree select topics? The process begins by casting a very wide net for ideas, including from Bree members themselves and their experience, their professional understanding of health care delivery; the Agency Medical Directors Group, on which I participate, which is a cross-state agency group of physicians who come together and look at our own experience in our respected programs; and also the public. Through that process, there is an identification of salient opportunities around topics that represent inefficiencies, observed variation in utilization, patient harm, etc. Then also, and very importantly within the context of those specific topics, there are strategies that

are demonstrated to really lead the appropriate use and clinical care when implemented. It's both the identification of a topic, as well as an awareness, that there's actually something we know we can do to improve how this care is provided relevant to that topic.

Slide 7: This slide shows what happens once topics are chosen. This begins with the formation of a Clinical Committee. You see that in the middle of the slide. We refer to them as clinical work groups. These clinical work groups are constituted from experts across the community, not just clinicians, but others as well, frequently, people from the community, stakeholders, advocates, and so forth. They come together to meet regularly to identify appropriate strategies that can influence and drive care in a more appropriate direction. In doing that, they work with information that they gather on evidence-based guidelines, provider feedback reports, what the influence of public reporting may have been, etc. Over that course of time, they promulgate a set of recommendations. I would emphasize that this process is entirely public; the work of the work groups is open to the public and the work of The Bree is open to the public. Everything that goes on is completely transparent.

Lou McDermott: Dr. Lessler. Where do you meet? Is there a call-in number?

Dan Lessler: We meet in Seattle at the Puget Sound Business Council close to Pioneer Square. There's always a call-in number. All of the information is at The Bree Collaborative website.

People who participate and do this work do it voluntarily, which I think is truly remarkable and represents an incredible collaborative commitment on the part of the people of this state. Once the recommendations have been formulated, they are reviewed and voted on by The Bree. If approved by The Bree, they come back to the Health Care Authority for review and formal endorsement.

Lou McDermott: I want to do a quick update. Katy Henry had a family issue and needed to leave the meeting.

Dan Lessler: Slide 8 lists the topics on which The Bree has made recommendations. The details and recommendations themselves are available at The Bree website. They are well done. If people have an interest in a particular topic, I would encourage you to take a look at those products.

Slide 9 is a list of current topics that The Bree has been working on in 2017. The formal recommendations have been promulgated by each work group. Most of them, except for the hysterectomy topic, have been voted on and approved by The Bree and are now at the HCA for review.

Slide 10 is a list of topics that are on The Bree's plate for 2018. The suicide prevention has special meaning for The Bree as Bob Bree's daughter

participated as a member of the public in advocating for this topic. The family is very public about that fact that Bob Bree took his own life. He had suffered with depression for much of his life. In some sense, it has come full circle that this Collaborative is named after him and that his daughter would be there. She is a family physician advocating for this topic, very publically discussing her father's death.

Slide 11 has two examples of how the HCA takes action on Bree recommendations. The first example and the two top bullets are about The Bree total joint replacement (TJR) bundled purchasing model. This recommendation describes best practices for providing knee and hip replacements. There are four cycles described in the model. It impressively includes the notion of a warranty – if a person experiences certain complications within a certain timeframe and needs further care, then that care should be covered within the initial cost of the procedure.

The Health Care Authority actually procured a total joint bundle in 2016. The benefit began in January 2017 and is currently active with Virginia Mason for many PEBB Program members. This example, which does involve a benefit change, was discussed with and approved by the PEB Board. The final bullet relates to what Dave mentioned earlier regarding our work on fulfilling the legislative direction to undertake value-based purchasing. We have incorporated many Bree recommendations into care transformation elements in our Health Care Authority contracts as part of the Uniform Medical Plan Plus. Those are the Accountable Care Programs that the Uniform Medical Plan has contracted with the UW Medicine Accountable Care Network and the Puget Sound High-Value Network. Again, that was done in consultation and approval of the PEB Board.

Lou McDermott: Dan, would you share a bit about what we discovered? I think The Bree does a great job of standardizing a protocol in saying, "This is how it should be done." When we looked at bundles, we felt hip and knee was a good example of that. Can you talk about some of the variation we discovered in that RFP process to highlight why something like Bree is important?

Dan Lessler: That's a good question. When we issued the RFP, we actually thought we would contract with multiple Centers of Excellence. The Bree has set a very high bar in terms of expectations around those four cycles of care. We had around 14 RFP responses. We made site visits to four sites. In looking at the data that was submitted and the data we had, there was a two and a half fold difference just in charges or costs for the hip and knee joint replacements across the state. There was wide variation in readmission rates and in infection rates. It really was clear that there was not just practice variation but incredible price variation. Working with the recommendations in The Bree really allowed us to address concerns that arise in that context.

Dave Iseminger: Dan, would you describe some of the aspects of The Bree decision that are helping ensure a good outcome for patients, like the number of surgeries that would be performed, no after hours surgeries, etc.?

Dan Lessler: There's good data that demonstrates the number of surgeries performed in a hospital, or the number of surgeries performed by a provider, correlate with outcome. The Bree recommendation actually requires that a provider have performed at least 50 surgeries in a year, they're doing that on an ongoing basis, and the hospital has provided at least 100 such surgeries. There can be no surgeries on the weekends and no surgeries starting after 5 p.m. Again, there's good data around all of this in terms of The Bree recommendation.

Dave Iseminger: I want to add that when Dan referenced the role of the PEB Board, you could insert SEB Board in its place. That's exactly how the benefit process will work. We'll talk with you about benefit design, get your general insight about what you want us to go out for procurement, do a procurement, and bring back the results. Ultimately, when it's a benefit design decision, you'll let us know whether to include it in the benefits offering. I want to be clear that just because the PEB Board did something that doesn't mean you have to do it. The same framework though will apply for this Board.

Dan Lessler: The Health Technology Assessment Program, like The Bree, was created in law. There was legislation in 2006 which created the Health Technology Clinical Committee (HTCC) and directed it to use an evidence report and a clinician panel to make coverage decisions about whether agencies can pay for certain medical procedures and tests based on safety, efficacy or effectiveness, and cost effectiveness. The Health Care Authority administratively supports the Health Technology Clinical Committee. The Office of Technology Assessment defines health technology assessment as a structured analysis of a health technology, a set of related technologies, or a technology-related issue that is performed for the purpose of providing input to a policy decision.

In terms of that structured analysis, I would emphasize that what we're talking about is bringing to bear a thorough and careful evaluation of research literature in terms of what that literature is saying around the effectiveness and the safety of a particular technology. The purpose of the HTCC, or Health Technology Clinical Committee, is stated very simply, which is to pay for what works. The literature just on health care costs and the health care cost inflation in this country over decades is pretty clear that one of the major contributors to health care inflation is health care technology. And not just health care technology per se, but many technologies that have not been well evaluated and are finding their way into practice quite widely. The purpose of this Committee is really to sort through the evidence and say we're going to pay for those things that work and we're not going to pay for those things that don't work.

Slide 16 is a description of the agencies that are required in law to participate in the Health Technology Clinical Committee decisions, and required by law to implement the coverage determinations of the Committee. That includes the Health Care Authority, and under the Health Care Authority the self-insured medical plans and Medicaid.

Pete Cutler: Dr. Lessler, for the Medicaid Program, does that include the managed care organizations? Are they subject to this?

Dan Lessler: Yes.

Dave Iseminger: Related to that, Pete, your underlying question is that you don't see on that list PEBB Program fully insured medical plans. In statute, there's a specific carve out for health care services that are purchased by the Health Care Authority in a fully insured model for entities that are Health Maintenance Organizations (HMOs) or Health Care Service Contractors (HCSCs) that are specific regulated entities and are defined under the Insurance Commissioner codes. Fully insured medical plans for the SEBB Program would be carved out from Health Technology Clinical Committee (HTCC), but a self-insured medical plan offered to SEBB employees would be subject to HTCC determinations.

Dan Lessler: Slide 17: As I mentioned, the agencies are required in law to implement the coverage decisions of the Health Technology Clinical Committee. This would be relevant to one of the purposes of this presentation just to describe certain times where SEBB would not, in the case of self-insured, be able to direct a benefit. This would be a specific example of that. There are a couple of exceptions and they're noted here where there is conflict with the existing statute or law and then in certain cases where we're talking about experimental treatments.

Slide 18 goes into more detail about the program, its organization, and operation. The Health Care Authority administratively supports the HTCC through the Health Technology Assessment Program that is staffed as described here. Then there is the independent Clinical Committee. It is composed of eleven professionals. There are the technology assessment centers with which the program contracts for these detailed clinical reviews of specific topics.

Slide 19 describes the composition of the Clinical Committee. There are eleven members, six physicians, five other practicing licensed health professionals, at least two members having professional experience treating women, children, elderly persons, and people with diverse ethnic and racial backgrounds. Particularly important is that there can be no conflict of interest. Committee members cannot be contracted or employed by a health technology manufacturer or a participating agency during their term, or in the 18 months prior to appointment. They all agree to conflict of interest conditions and disclosure.

Slide 20 lists the key attributes of the HTCC. There are some overlapping themes with The Bree transparency. In a moment, I'll walk through the process from start to end. But all along the way, everything is open to the public. The meetings of the HTCC are open to the public, the reports that get generated are open for comment before they're finalized, etc. The assessments are thorough and independent. Decisions are made only by the committee.

Slide 21 provides an overview of the Health Technology Clinical Committee process. It begins with identification of a topic. Again, the Agency Medical Directors Group participates in generating ideas, but the public also has the opportunity to submit topics. Topics are reviewed, prioritized, and decided on by the Committee. Once the topic is decided, there is deeper level work and analysis that's done to specify the key questions that need to be answered about the technology. Those questions and that process are all open to the public and public input. Ultimately, the key questions get finalized and a vendor undertakes its work reviewing the literature and providing an evidence-based report. That report is open to public comment before it's finalized. The report then is used to inform the Committee deliberations about the topic when the Committee meets to hold a hearing and make a coverage decision. The hearings that the Committee have are open to the public. The draft decision is reviewed and is open to the public before it's finally finalized by the Committee and sent on to this agency and the other agencies to implement.

Since 2007, the Committee has issued about 60 coverage decisions. Slide 22 lists those decisions that occurred in 2016-2017. There's a website if people are interested in reading more about any of these. You can actually get the full detail. It's all online and quite accessible.

Pete Cutler: What kind of organizations do the assessment of the efficacy?

Dan Lessler: There is a formal procurement to identify those organizations. This year the Oregon Health Sciences University evidence-based practice center is one. The evidence-based practice center at the University of North Carolina is the second. The third is Spectrum, which is an organization that does technology assessment.

Pete Cutler: At least the first two are academic-based.

Dan Lessler: Yes, but they are not always academic-based. They can be. Those first two are. Spectrum is not academic-based.

<u>School Employees Benefits Offerings Survey Results</u>

John Bowden, HCA School Employees Benefits Section Manager: Today, I am here to present information obtained from the most recent S275 and a recent HCA survey of school district officials about benefits currently offered to school employees.

Slide 3 is a reminder about SEBB Program statutory provisions about benefits. The SEB Board is to “study all matters connected with the provision of health care coverage, life insurance, liability insurance, accidental death and dismemberment (AD&D) and disability insurance,…with relation both to the welfare of the employees and the state.” (RCW 41.05.740(6)(a)).

The second bullet is to “…leverage efficient purchasing by coordinating with the Public Employees Benefits Board.” (RCW 41.05.740(6)(v)).

Slide 4 lists the employers included in the SEBB Program. In statute, school districts are included. They're responsible for providing the basic education to students in this state. The common schools are maintained at the public expense. Educational Service Districts (ESDs) are regional agencies that provide types of services usually on a fee basis to the school districts. Funding for many of these comes either through the fees that are charged or from grants that the ESDs write. Lastly, charter schools. They're also publicly funded schools. They're operated by nonprofit organizations, and they are alternatives to traditional common schools.

Slide 5: The data I'm going to be talking about comes today from the Office of Superintendent of Public Instruction’s (OSPI) school personnel report, sometimes referred to as the S275. Secondly, most of the data comes from the high-level benefits offering survey that HCA conducted.

Slide 6: We have about 144,000 school employees across the state. 295 school districts have the majority of those employees, a little over 142,000. There are nine educational service districts with a little more than 2,000 employees and ten charter schools with a little more than 200 employees. A little over 144,000 school employees total.

Slide 7 is a map of Washington school districts. The colors have no designation other than to help you see the 295 school districts. The first public school in Washington was opened in 1852. By 1910, there were 2,888 schools in the state, which is more than we have currently, and 2,710 school districts. Basically, every school was its own school district. In the 1940s, a huge effort was undertaken to start consolidating school districts. The aim was 270 and we now have 295.

School districts are not all contained within county boundaries. Some school districts cross county boundaries. Much of the health care benefits provided in Washington are by county. We will be keeping an eye that as we go forward.

The number of employees in the school districts ranges from five employees up to 6,500 employees. The number of bargaining units in school districts range from two to 19. The SEBB Program consolidation is more than just school districts, it is also across many bargaining units.

Slide 8: There are nine educational service districts. They were created in statute in 1969 to help school districts. They are entrepreneurial, which means they receive most of their funding through fees they charge for services or grants. The size and number of school districts can only change by approval of the School Board of Education if the majority of the school district superintendents within that region petition the School Board to do so. The employee count in the ESDs range from a little over 100 employees to about 550 employees.

Slide 9: The map shows eight of the ten charter schools. They are either in the Seattle/Tacoma area or in Spokane. The two schools not shown on this map are also within the Seattle/Tacoma area. By statute, there can be up to 40 charter schools across the state. That would be the high end of it if charter schools are opened in each area. Charter schools were created by the initiative process in 2012. The State Supreme Court struck down that initiative in a decision in 2015 and the Legislature recreated the charter schools in 2016. We now have ten of them with more planned. Employee ranges for the charter schools are somewhere in the 10 to 25 range.

Slide 10 looks at where the employees are by the size of their employer. Employers with fewer than 500 employees are to the left of the red line. That is 239 employers and 32,000 employees. This equates to approximately three quarters of the employers and one fifth of the employees in the state that come under the jurisdiction of the SEB Board.

The over 575 employers with more than 500 employees are to the right of the red line, which is about a quarter of the employers and four fifths of the employees in the state that come under the jurisdiction of the SEB Board.

Slide 11 is another way of looking at the percentage of the employees by the size of the employer. In the 1,000 or fewer employees' box, there are 286 employers or 91% of all the school employers in Washington have less than 1,000 employees.

Slide 12 - High-level Benefit Offerings Survey Design: The survey design was a voluntary online survey collection. We looked for a snapshot of the benefits currently offered to school employees. The Washington Association of School Business Officials (WASBO) and Educational Service District 113 provided design input. We sent an invitation to the Superintendent's Benefit Officers, HR, and finance people in school districts, as well as leaders in the charter schools. We sent the survey to all 314 school districts, ESDs, and charter schools. We did follow-up reminder emails and made phone calls to some of the employers trying to get as much information as possible.

Slide 12: We had 239 responses, however, some of these responses were duplicates and some of them were incomplete and not usable. Once the duplicate and unusable surveys were removed, we had 189 solid responses. Of

these responses, 182 were from school districts, six from the ESDs, and one from a charter school. While this data represents 60% of the employers, we did have over 83% of all school employees in the state represented by the survey responders.

Slide 14: The survey included questions about medical plans, if employees had access or were offered preferred provider organization plans (PPOs), health maintenance organization (HMOs), a high-performing network (HPN), which is basically a PPO with more exclusive provider network. We asked if these plans included or excluded prescription drugs. We asked about dental plans, PPOs, dental maintenance organizations (DMO), high-performing networks for the medical. We also asked about indemnity, which basically means that the employee can go anywhere and be reimbursed for the medical/dental/vision service received. We asked if any of these plans were included within a medical plan and did the same with the vision PPO, HMO, HPN, and indemnity.

Slide 15 shows the first set of survey results of what is offered to employees. Enrollment information will come after more data is collected. This slide shows the percentage of employees from the responding employers that have access to these types of benefits. 100% of employees for the responding employers have access to a preferred provider network; 93% have access to a plan that includes prescription drugs and 7% have access to a plan that does not; 93% have access to an HMO; 49% have access to an HPN.

Sean Corry: It might be helpful if you explained circumstances in which school districts offered medical plans that did not have prescription drugs.

John Bowden: In those cases, I can't say absolutely in all the cases, the employees would have stand-alone prescription drug plans. The employees had a choice of a plan without prescription drug and they could marry it up with a choice that also had a prescription drug plan specifically. I believe there were five instances of this reported and a little under 6,000 employees that had stand-alone prescription drug plans offered to them.

Slide 16: In looking at dental coverage that is offered to employees, 100% of employees are offered dental coverage. This slide shows the different types of plan options offered to them. 72% have a preferred provider organization dental plan offered; 42% have a DMO; there are some in an HPN; and some that have indemnity. An interesting piece is that thirteen had dental coverage described as being included within their medical plan. We didn't get enough information to explain that to you, whether that was something beyond regular dental checkups. We can look into that when we get information on the types of enrollment and the claims data.

Slide 17: In terms of vision, 100% of employees are offered vision coverage, but when you look at these numbers, they add up to more than 100 because multiple options are available to employees. PPOs 71%; HMOs 13%; and so forth.

Slide 18 takes us to other types of benefits like life, accidental death and dismemberment, long-term disability, and short-term disability. We also asked questions about employee access to wellness programs.

Slide 20: For life insurance, 100% percent of employees are offered some type of life insurance benefit; 96% are also offered optional increases in life insurance ability to cover family members. However, life insurance options are widespread across the state. Survey results show 84% of employees are offered accidental death and dismemberment coverage.

Dave Iseminger: It's good to remember that this is self-reported data. The numbers may not make sense with expected numbers based on how the question was interpreted.

John Bowden: Dave's point is very pertinent in terms of long-term insurance. The survey shows 63% of employees are offered long-term disability from the responding employers, but I believe it's 100%. It varies in terms of the payout with the benefits, the cost of what purchasing optional pieces might be. For short-term coverage, 96% of the employees for the responding employers indicated they have access to this coverage.

Pete Cutler: Does this indicate that those are the percentages of employees that the school districts indicated are offered these options? Does that include those who offered the option where the employee paid 100% of the premium cost?

John Bowden: We don't know all of the funding mechanisms for all of the employers across the state. There are basic coverages, which include the medical/dental/vision/life and long-term.

Pete Cutler: So do I understand correctly? The question was just to the school district, what percentage of your employers are offered each of these? It didn't ask them to explain what the fund source was when they offered it?

John Bowden: Correct. The employers that we asked also included the ESDs and charter schools. While the majority of the responses are based on what we heard from school districts, we did include those two types of employers as well.

The far right of Slide 19 is the response to a question about wellness programs offered to employees. From the responses, 29% of employees have access to a wellness program and for 13% of those employees it includes some type of incentive.

Slide 20 identifies additional survey questions having to do with Cafeteria Plan options and what types of things are currently offered. One question addressed asked how many of these different types of Cafeteria Plan options are available on a pretax basis. We asked about the medical Flexible Spending Arrangement (FSA) offerings, Dependent Care Assistant Program (DCAP) offerings, Health Reimbursement Accounts (HRA), Health Savings Accounts (HSA) tied to a high deductable plan available to the employee, and the Voluntary Employee Benefits Association.

Slide 21 shows the responses from employers: 95% of employees have access to the pretax types of plan options; Flexible Spending Arrangement was 99%; DCAP was 87%, HRA at 59%; HSA at 17%; 87% have some sort of VEBA offering, which may differ in terms of what you hear about VEBA offered on the Public Employees Benefits side.

Slide 22 shows procurement questions we asked about whether the employer utilized the services of a broker, whether they secured commercial products on their own, whether they used any of the Health Care Authority's benefits through the Public Employees Benefits Board Program, and whether they used the services of the Washington Education Association.

Slide 23: Previous slides dealt with the numbers referencing percentages of employees. Here we have the number of employer responses. This is useful in terms of what assistance various employers use when securing benefits to offer their employees. Out of 189, 135 use a broker, which is about 71% of the employers; 57 do some by trying to secure commercial products on their own; 37 use the Public Employees Benefits Board; and 120 use WEA.

While I don't think the survey responses really impact what is offered to employees in terms of percentages, the non-respondents to the surveys tended to be the smaller to midsize school districts. I think the percentages using brokers and WEA would be higher if the percentages were based on these numbers. There are actually 71 school districts and five ESDs that either partially or fully use PEBB products.

On the survey we asked them to submit high priority questions or concerns that school employees may have so we can build FAQs to post on our website so anyone in the school districts, ESDs, and charter schools that have questions can find the latest information.

Slide 24 lists some of the questions we received. A lot have to do with what types of plans will the program offer, will they be able to keep their provider, how much is it going to cost them; and eligibility questions, how many hours a year, do I need to work in order to be covered? Statute indicates 630 hours, but there might be additional eligibility pieces. The question has also come up of what

happens if I want to waive coverage. Currently, school employees can waive coverage and the funding goes into pools.

Dave Iseminger: We are capturing questions even if we don't have answers yet so that people know we're aware that the questions are being asked and that there will be a place for them to get those answers. We're posting information even if we are only acknowledging that we don't have the answer yet.

John Bowden: Slide 25 is next steps. We have two more data collection efforts underway. Profile Data is collecting the best information we can on each school employee in the state. Milliman, our consulting actuary, is working with the Washington School Information Processing Cooperative (WSIPC) for districts that utilize their financial packages, specifically those related to benefits. I believe there are 17 districts that are not utilizing WSIPC products to get the profile information. The profile data is enrollment information, information about hours an employees works, and things that will be used for more than just decisions about what benefits to offer. We hope to have that information collected by the end of this month. We'll do the analysis as quickly as we can and tell you about what types of benefits school employees have actually enrolled or signed up for.

Secondly is Claims Data. This is specific to the health types of benefits. Milliman is making a voluntary data request directly to the carriers, signing data sharing agreements to make sure that the information about claims data are only used for the purposes that this Board and the Health Care Authority will need in doing procurement. This is protected information and does not come to this agency. It stays at Milliman. The projected completion date for obtaining the claims data is the end of January of 2018. Milliman will provide an analysis that will be shared here.

Dan Gossett: I know this is a high-level survey that you did. I think it would be helpful for me if I could see the specific questions that were asked so I could interpret the responses and answers. I would really appreciate that.

Dave Iseminger: We'll definitely follow up with the Board. We'll get a copy of the survey itself.

Lou McDermott: We will take a 15-minute break.

[BREAK]

Overview of Benefits
Scott Palafox, Acting Deputy Director for the Employees and Retirees Benefits (ERB) Division. Today I'll give an overview of the benefit offerings we'll be providing to the SEBB Program members on January 1, 2020. We'll talk about procurement, life and accidental death and dismemberment, long-term disability

short- term disability, the Cafeteria Plan, the medical Flexible Spending Arrangement, Dependent Care Assistance Program, and the Health Savings Account.

Slide 3: What is procurement? Procurement is the act of acquiring or buying goods, services, or works from an external source. Slide 4 gives you a high-level overview of how procurement works. The key to procurement is allowing time to complete each process before moving to the next step. It can take a lot of time from the initial researching, stakeholdering, and benefit designing in the planning phase through the Go Live phase, which is in the implementation phase. When you think about offering a new benefit for a calendar year, we look at the open enrollment date, which usually occurs in November. We start from the end of the timeline to see what other activities are needed in order to get to done.

Lou McDermott: Scott, as an example, could you talk about our Third Party Administrator (TPA) re-procurement for the PEBB Program? What is the total timeframe, sort of the worst-case procurement cycle example?

Scott Palafox: The TPA procurement actually is one of the lengthier of the examples. We had discussions on this starting back in 2014. In order to get through that procurement cycle and select the apparent successful bidder, we had a two-year implementation window to get us a Go Live date. At this point we're in the third step of that process of the negotiations and contracting with the implementation dates looming. Because of the work the TPA does, the two-year window is needed to ensure the systems, eligibility, connections, and file transfers are in place for the TPA to do their work. It's critical we have that large window of time in order for us to get there.

Dave Iseminger: On the opposite end of that spectrum, the life insurance benefit RFP we did in 2016 started in February and we had open enrollment Go Live on November 1 of the same year. There's a wide range of lengths of times for getting through the process.

The other piece I want to make you aware of is there are state procurement laws that the agencies follow. You may not be as familiar with those pieces but that's part of what the agency brings to the table, monitoring and ensuring compliance with those procurement laws. There is a vast legal framework for the RFP process and the entire contract negotiation process.

Scott Palafox: Slides 5 through 12 talk about Life, AD&D, long-term disability and short-term disability. We'll get into comparisons of benefit offerings that we've seen in the K-12 world, as compared to the offerings of the Health Care Authority under the PEBB Program.

It's important to go over the three bullets on Slide 6 to set the stage. We are not indicating we know everything that's available, but this is for illustration purposes

only. The first bullet talks about the following illustrations that show examples of the different benefit designs currently offered to K-12 employees. The second bullet identifies some of the benefit selections for illustration purposes that are offered to many of the K-12 employees and is information that was most readily available to us. The last bullet is important to know that we are not trying to convey eligibility information with regards to these benefits.

Slide 7 Life insurance: One correction note on the footnote of Slides 7 through 12. You'll see that the one, two, three, and four denote the headings of the columns of each of the benefit selections. It's Slide 20 that has the sources, not Slide 18.

Dave Iseminger: Scott, are you going to describe how we selected the four at the top or would you like me to do that?

Scott Palafox: Go ahead.

Dave Iseminger: I want to level set as to why we have the four columns we have for these comparison charts. The Health Care Authority was included in the table because there is the legislative language of leveraging some of the PEBB Program benefits that the Health Care Authority helps administer. In addition, there are 71 school districts that have some, or all, bargaining units where those members have plans through PEBB benefits. A significant portion of those PEBB Program participating school districts are in Eastern Washington, which is why we did not include a specific Eastern Washington school district.

We included the WEA select plans as many school districts and school employees access their benefits. The Seattle Public School District was included as the largest K-12 employer in the state.

Finally, we wanted to identify a school district where we had a variety of different ways to validate the information. The Lynden School District actually responded fully to our benefit survey twice. They were actively engaged and wanting to ensure their benefits were described correctly. We were able to validate that against plan documents found online. We did some outreach with the Lynden School District to make sure we were understanding their benefits. We similarly did outreach with the WEA to make sure that we were trying to convey the benefit design as best we could.

This table represents a systemic review of either plan documents of direct communications coupled with survey data of these different school districts.

Scott Palafox: An additional note for the WEA's select plans, we did have some email communications with WEA staff for that information.

The top half of this table in the light blue shows the employer paid coverage for employees. The Health Care Authority under the PEBB Program offers employer paid coverage of $35,000 with no Statement of Health required. Statement of Health, sometimes referred to as medical evidence of insurability, is a document that includes a series of questions about overall health. The bottom portion of this table shows the employee paid additional coverage. That employee can choose to opt to purchase in $10,000 increments up to $500,000 without a Statement of Health and up to $1,000,000 with a Statement of Health. And then you see the comparisons across the board.

Dave Iseminger: As we go through these comparisons, let us know if this will meet your needs as Board Members for comparisons of the current variability in the system. We wanted to start with a comparison of a benefit that has a little less variability so we can then craft the best comparison process for the medical and dental benefits. I particularly want your feedback on this structure and if this meets your needs. As you can see in these charts, there is no clear best plan. Benefit by benefit, you'll be able to go through and identify under one offering it's column A, under another offering it's column B, and there are different subsets. It really is a complicated matrix of the variability that exists in the current system for school employees.

Scott Palafox: Slide 8 is a continuation of life insurance for spouse or state-registered partners and children. Again, the employee can pay for these additional coverages. You can see the increments in the boxes of what those are and the maximum amounts for each.

Dave Iseminger: Before we go on to AD&D, these are the types of questions we will need your insight on in the form of either discussion or we'll tee up some resolutions about the general structure of benefit design. Do you want a benefit that crafts an employee buy-up option for a spouse? Do you want a plan that has child coverage that can be employee paid? At this point, we're not going to be asking you what exact level of coverage of life insurance you want, but what lines of coverage do you want? That's the macro structure questions we need direction on so we can identify which areas need procurements and which ones the Health Care Authority can seek to access with current contracts and see if there's a benefit that can be crafted under those current contracts. It's structured this way so we can have the lines of coverage, at least in the life insurance context. That's the type of information we need back from the Board to be able to proceed with any necessary procurements.

Scott Palafox: Slide 9 Accidental Death and Dismemberment Insurance: The table on this slide is set up in a similar way. The top half shows the employer paid portion of coverage and then Health Care Authority (HCA) PEBB benefits. The HCA offers $5,000 employer paid coverage. On the bottom half of the table it shows the additional employee paid coverage in $10,000 increments up to $250,000 without a Statement of Health. You can compare that across the table

as well. Slide 10 is a continuation of AD&D for spouse or state-registered partner, employee paid, as well as children, employee paid coverages. Each column denotes the increments and the maximum amounts based on no Statement of Health as well.

Dave Iseminger: Is this the right level of information? Does the structure make sense and does it meet your needs? What other information do you want presented, especially as we march towards creating a comparator document for medical and dental plans for next month?

Lou McDermott: I have some questions. What if someone is transitioning from one life insurance policy to another life insurance policy and you have issues with insurability, and whether you're covering the subscriber or the spouse, and what the maximums are, and if your prior plan had a maximum that was higher than your new plan? Have you started thinking about all those permutations?

Dave Iseminger: Yes. With the number of benefits there are, you've described cut-over issues that would happen from the end of December 2019 to the beginning of January 2020 on just the life insurance benefit or just the AD&D. Staff are thinking about the various challenges with that transition on a benefit-by-benefit basis. That will be something that we'll be looking at when we're going through contract negotiations or in procurements themselves, getting commitments to protect employees in the current benefits they have, especially in the context of life and disability insurance to avoid as much disruption as possible during the transition.

Lou McDermott: How are you planning on working with the Board? I'm teeing this up because you and I both know how many decisions have to be made on any procurement. If you want more of this or less of that, can they do it? Can they not? What's the trade? How long do you lock the rates in to give up something? There's all these negotiations back and forth. How do you do that and inform the Board of these twists and turns?

Dave Iseminger: Some of it depends on exactly how the Board meetings fall with where we are with negotiations. During the negotiation process, we may be able to access executive sessions to be able to talk about the status of a procurement so that we can provide insight as to the status. Other pieces we'll bring to the Board and explain, as best we can, the global picture of all the various different interests during negotiations, I don't envision going through a step-by-step negotiation with the Board. I'm not anticipating describing all the steps along the journey but rather the overall global factors that went into what the agency was able to procure from a pricing standpoint. Each of these will be complicated negotiations because of the various efforts related to avoiding as much member disruption and harm in a process that is inherently disruptive by forming the single consolidated purchasing pool.

Lou McDermott: The one part I'm concerned about is when we renegotiate for PEBB, we know what the before is. When negotiating the after, you understand sort of winners and losers, and you understand how it's better and how it's worse. But with something like this, it seems like we won't fully understand before so we're negotiating after. I think that's going to be challenging.

Dave Iseminger: As we get more ideas and work through the various different benefit lines and different ways to minimize disruption, we'll make sure that we keep the Board as informed as we can about different ways the disruption could be avoided while also being careful about where we are in the negotiation processes.

Lou McDermott: Thanks, Dave.

Scott Palafox: Slide 11 Long-term Disability Insurance: This table is broken down in the same fashion as the others with the employer paid and the employee paid portions on the top and the bottom half.

If we look at the employer paid portion on the Health Care Authority PEBB benefits, 60% of the first $400 is a pre-disability earnings, monthly-based pay reduced by any deductible income. You get a maximum of $240 or a minimum of $50 per month. Looking at the employee paid possible additional coverage, you have 60% of the first $10,000 of pre-disability earnings, which is monthly-based pay reduced by any deductible income for a maximum of $6,000 or a minimum of $50 dollars a month.

For context, I'll give you a high-level calculation of what that would look like. If someone's monthly base pay is $4,000 dollars, for the employer paid portion of that, it would hit the maximum of $240 per month. If you're looking at the employee paid portion of that calculation, it would be $2,400 plus the $240 for a monthly payment of $2,640. Now that would be assuming there isn't any deductible income. But let's say the person is receiving $1,000 in Social Security disability, you would subtract $1,000 off the $2,640, so their monthly payment would be $1,640.

Slide 12 Short-term disability: The HCA currently doesn't offer a short-term disability benefit for either the employer paid or the employee paid portions. In looking across the table for the employer pay pieces to the illustrations we have, they're somewhat similar. The employee paid piece becomes a bit different as you look at those examples.

Slide 14 Cafeteria Plan: A Cafeteria Plan is an Internal Revenue Service regulated program that allows employers to offer employees the ability to pay for certain expenses with pre-tax payroll dollars. Under state law RCW 41.05.310, the Health Care Authority maintains and administers the Cafeteria Plan for all state and higher education employees. Benefits offered under the state's

Cafeteria Plan are the Premium Payment Plan, the medical Flexible Spending Arrangement (FSA), the Dependent Care Assistance Program (DCAP), and the Health Savings Account (HSA).

Slide 15 Premium Payment Plan: This plan allows employees to pay their health plan premiums using pre-taxed dollars. Currently, for PEBB Program members this is the medical premiums only, because dental is paid by the employer.

Slide 16 Medical Flexible Spending Arrangement (FSA): This arrangement is an employer-sponsored benefit that allows enrollees to redirect a portion of their salary on a pre-tax basis to pay for out-of-pocket qualified medical expenses. These benefits operate on a plan-year basis starting on January 1 and ending on December 31 of each year. The medical FSA is a pre-funded benefit and enrollees have access to their full election amount at the beginning of the plan year. Some of the eligible expenses governed by the IRS rules include office visits and prescription co-pays, deductibles, dental orthodontia expenses, vision expenses, expenses such as lenses, frames, contact lens solutions, acupuncture, chiropractic rehabilitation. Some of the ineligible expenses include cosmetic surgery, teeth bleaching, club memberships, Sonicare toothbrush, and missed appointment fees. Some over-the-counter medications are not covered as well. The IRS maximum contribution amount for 2018 is up to $2,650. To use these funds, employees can make claims for reimbursement or use a debit card. All the elective funds are available at the start of the year and deductions are made from the employees' paychecks in equal amounts across the year.

Dave Iseminger: It is important to note that the IRS maximum is what federal government allows as the ceiling for the contributions. But an employer can set a different amount that is lower. Often, the IRS releases its annual amount refresh after most employers' open enrollment for the next year, which makes it difficult to maintain perfect alignment with the IRS allowed maximum and an employer's maximum. The state has traditionally tried to maintain as much alignment as possible with the maximum IRS allowed amount, but as I said, typically the IRS allowed amount comes out after all the open enrollment publication materials are printed, which then results in a bit of a lag from year to year.

Scott Palafox: Slide 17 Dependent Care Assistance Program (DCAP): DCAP allows members to set aside pre-taxed dollars to pay for qualifying child or elder care services. Eligible and ineligible expenses are governed by the IRS. The main purpose must be that the qualifying dependent's well-being and protection while an employee and spouse, if married, are working or attending school. Some eligible expenses include daycare expenses for children that are enrolled. Elder care expenses are for a qualifying dependent age 13 or older who is physically or mentally incapable of self-care and regularly has spent at least eight hours each day in the enrollee's household. Ineligible expenses include overnight camp, nursing home expenses, meals, activity, supply fees, transportation costs, and tuition for school at the kindergarten level or above.

The maximum contributions is $5,000 if the enrollee is married and filing jointly, $5,000 if the enrollee is single, or $2,500 if the enrollee is married and filing separately.

Dave Iseminger: Unlike medical FSA, there is no indexing to any inflationary measures. These are the maximums that have been around for years.

Scott Palafox: DCAP works like a bank account. Reimbursements and claims requests cannot exceed the account balance and the enrollee cannot receive reimbursement until after the service has been provided.

Slide 18 Health Savings Account (HSA): HSAs were created in 2003 so that individuals covered by a qualifying high-deductible health plan could receive tax-deferred treatment of money saved from medical expenses. You are eligible if you are covered by an HSA qualified health plan and have no other coverage such as another health plan, Medicare, military health benefits, or a medical FSA. The IRS maximum allowed contribution is $3,450 for an individual and $6,900 for a family in 2018.

Dave Iseminger: I want to add a couple things related to this concept. The state, and the Health Care Authority in particular, manages these benefit offerings. They are carved out from the Board's authority, both this Board and the PEB Board. HCA administers those benefits directly by contracts. We will maintain those relationships and give you updates. These benefit offerings would presumably be part of our discussions, but the Health Care Authority is given the statutory basis for doing this benefits. There is a relationship with the Board's decisions because we will not administer a Health Savings Account if there is no comparable related qualifying high-deductible health plan, because there would be no basis on which an individual could put money into that HSA. There is a relationship, but whatever decisions you make, whatever benefits are able to be offered under this separate statutory authority, the Health Care Authority will proceed with and keep you up-to-date as to the implementation of those benefits.

Ethics In Public Service Act Overview

Katy Hatfield, Assistant Attorney General: I want to apologize for the incorrect title on the agenda. This is not the Executive Ethics Act, it's the Ethics in Public Service Act. I point that out because Executive Act implies that it only applies to the Executive Branch of the government but it doesn't. In Washington State, the Ethics in Public Service Act applies to the Executive Branch, the Legislative Branch, and the Judicial Branch of the state government equally. I wanted to point that out because it is an interesting part of the legislation in Washington.

This is a brief training. I can't possibly go over every single nuance of the Ethics in Public Service Act during this presentation. I did provide you in the materials a copy of the complete law. In the presentation at the end, I'm going to point you to

some other materials that are online and available for you to look at that give some training and other quiz-like functions if you want more information. Of course, you can always send me an email or call me on the phone if you have any specific questions about your circumstance or if something comes up.

The Ethics in Public Service Act is codified in law. It does apply to all branches of state government. It was created in the early 1990s when there were many different laws governing various officers and employees throughout the state. There was just too many standards. It just got too confusing. At that point, Governor Lowry and Attorney General Chris Gregoire asked the Legislature to create a special commission to address this issue and the Ethics in Public Service Act is the result of that. It passed in 1994. We are having this training because the Ethics in Public Service Act applies to you. It applies to all state employees and state officers, and that includes all persons holding a position of public trust, including members of boards and commissions.

The two purposes for the Ethics in Public Service Act are to maintain public confidence in government and to prevent abuse of state offices. It's really to remind everybody, not just people who work for the state, but also for the members of the public that government does derive its power from the people. That maintenance of public confidence is very important.

The key principle of the Ethics in Public Service Act is codified in the statute that state officials and employees of government hold a public trust that obligates them in a special way to honesty and integrity in fulfilling responsibilities to which they are elected and appointed. Paramount in that trust is the principle that public office, whether elected or appointed, may not be used for personal gain or private advantage. The Ethics in Public Service Act covers many different subject areas. Slide 7 of is an example of most of the areas that are covered in a general sense. There are more details in the law itself, as well as in some of the regulations. There is a lot of discussion about use of state resources for personal gain, gifts and limitations on receiving gifts, using your office in order to obtain special privileges for yourself or for a family member, conflicts of interest, outside employment, confidential information, and then employment after public service. I'm not going over all of these today, but there are materials online, in the law itself, and in the regulations if you have any specific questions.

I'm going to discuss topics that are the most common for people to have questions about. One of those topics is conflict of interest. The law is clear that no state officer may have a financial interest or engage in an activity that's in conflict with the discharge of his official duties. No state officer may disclose confidential information to a person who's not authorized to receive it; and no state officer may use his official position to secure special privileges for himself, family members, or another person.

One thing we may have touched upon at one of our earlier trainings is that the protection for confidential information also would include attorney-client privileged information that I or another AAG provides this Board. The Board did get one email from me. I'll always be providing information to you very clearly marked that it is privileged so that you know and there's not any ambiguity or confusion about that. The same protections about disclosing confidential information would apply when the Board is in Executive Session. And again, that will be very clear. You'll know when you're in Executive Session and that it's not a public session where you're learning things that are available for everyone to know.

Sean Corry: I have a question about disclosure. I routinely talk with members of my staff, for example, about work that I'm doing. Usually it's work in the office. Could you help me understand the restrictions that might be in play for me or people in my position, like any Board Member who has coworkers at a school district, for example, where they need to discuss things? Can you help me see a line or two?

Katy Hatfield: One good example might be in terms of during procurements, there are certain aspects that the Board Members are entitled to learn about during procurement that is proprietary information or is confidential information from bidders. So a life insurance company or a medical insurance company, they might submit some information about their formulas or their actuarial analysis that supports their bid. That information is not available to the public but might be shared with the Board in a specially called Executive Session where we're communicating to you that this piece of information is confidential to help you form your decision as a Board. But it's not something that's available to be disseminated to all the school districts or used in your private employment. When we get to situations, hopefully they'll start to make more sense when we actually can see them in front of us and then we can talk about a specific example when it comes up.

Another example might be, the Health Care Authority has some contracts where a piece of the contract has been marked as proprietary. If there is a public records request or something for that piece of the contract, that would not be disclosed. Usually what the Health Care Authority would do is give that person an opportunity to object, but there's a process in place. The underlying assumption is that it would be kept confidential unless ordered otherwise. We can talk about it more when a real example comes up. Everything we talk about in a meeting like this is public, and everything that's in the materials that we provide is public. That part is not meant to be confidential. One of the core tenets of a Board like this where people are representing a constituency of people is that you will go back and talk to your community of people that you're representing at your school or in your office. There's going to be a very small amount of information that's proprietary.

Lou McDermott: And I think when we do get to those pieces of information, we'll reiterate the nature.

Katy Hatfield: I think it will always be clear whether or not something is confidential. At least we'll always try to make it be clear. One thing about the Ethics in Public Service law is that the regulated entity is the state officer, the Board Member, not the agency. This is added not to be scary but to make you aware that ethics violations are considered to be personal in nature and you're personally responsible for violations. For that reason, I am providing you quite a bit of additional material that's online if you have additional questions.

One thing to also keep in mind is there's actually an ethics Board that does regulate only the Executive Branch of government. I'll go over that shortly. That Board is the one who brings actions against people for ethics violations. Members of the public do not. The public would file a complaint with the Board, the Board would do an investigation, and then bring action. There's a level of screening that happens rather than just someone filing a lawsuit.

Some of the potential penalties that the Ethics Board might impose include things like a letter of reprimand, a recommendation to the Governor to suspend or remove you from your current position. For situations where there was a finding of self-dealing, they can impose up to a $5,000 civil penalty or up to three times the economic value of the item that was received in violation of law.

The law is quite broad in terms of how it describes it but it talks about that you cannot do anything that's incompatible with the proper discharge of your official duties. That could mean things like outside employment, a volunteer activity, ownership in a private business, relationship, anything that would impair or conflict with your ability to make decisions on behalf of the state. I want to also emphasize that the Legislature recognizes that there's a lot of Boards like you where there are people who have businesses, companies and ownership of entities. That's not necessarily automatically a conflict. There's a recognition that people who are engaged in the private industry and other activities have a great service to provide to the state. The law allows for that. There are some parameters around it but they're quite reasonable when you look into them deeper. I want to make sure people recognize that.

Slide 11 is examples of possible conflicts of interest like:

- having a personal financial interest in a contract sale, lease, purchase, or grant that's under your specific authority or supervision in your role as a Board Member;
- acting in a state matter or transaction involving a business or organization in which you own, or in which you serve as an employee;
- assisting other persons in transactions involving the state in which you have a responsibility for these transactions as a state officer.

In the setting of this Board, that would be perhaps assisting a company in submitting a bid for a procurement in which this Board is going to be selecting the final entity that will be the apparent contract winner.

These are obviously very fact-specific considerations. I realize some of you may have to ask yourself some questions more times than others. If you think you might have a conflict of interest, some of the questions you might consider asking yourself is whether or not your outside interests will benefit as a result of your official action. And then also, whether or not a reasonable person would conclude that your private or personal interests impairs your independent and impartial judgment in the exercise of your official duties.

Dave Iseminger: Katy, I remember during the Open Public Meetings Act (OPMA), you talked about the difference between an actual fairness problem and an appearance of fairness, and you talked about newspaper headlines. Is there something comparable in the Ethics in Public Service Act or can you talk about whether that concept that you talked about in the OPMA is something that should be considered here?

Katy Hatfield: That's a good question. I think in the context of the Open Public Meetings Act, there is a concern for reputational issues because lawsuits are filed directly by members of the public. Whereas in this setting, complaints are filed with the Board and the Board investigates. So there is that level of scrutiny that's placed on complaints. So hopefully complaints that are retaliatory or totally without basis are screened out.

On the other hand, I think it is also important to remember that one of the purposes of the Act is to build public confidence. Even if there is not an actual conflict, if there is a concern about an appearance of conflict, that might be an opportunity that you would want to at least consider raising or recusing yourself. We're going to talk about some of the things to do if you think there is a conflict. But if you think there's even a possibility that a reasonable person would view it as a conflict, that might be one of the times to elevate the situation.

Slide 13: This statute regarding representing an identifiable group speaks to what I was trying to say earlier. Nothing in this chapter shall be interpreted to prevent a member of a board, committee, advisory commission, or other body required or permitted by statute to be appointed from any identifiable group or interest from serving on such body in accordance with the intent of the Legislature in establishing such a body.

In the case for the SEB Board, several of you are appointed to represent a specific constituency. It's not considered to be a conflict to be representing the ideas or the thoughts of that group in terms of the Act itself. Your alliance to that organization is not in conflict so long as you're there to represent them and people know that. Conflicts might happen and that's okay.

What do you do if you think you have a conflict? Most conflict of interest issues can be resolved without needing to resign from the Board. There are options and I'm happy to talk with you by phone or email if anyone thinks they have a conflict. One possible option is to abstain or recuse yourself from a specific vote or a specific deliberation if there's an idea that there might be a specific company that's going to be awarded a contract or something of that nature. Another option is to disclose the possible conflict to the Board Chair, Mr. McDermott, and let him decide whether or not to remove you from a particular vote or activity. Another option is to write a screening memo, which is something that I would help you with to inform other Board Members about a specific topic in which you should be screened. These are just a few of the options.

Slide 15 - Gifts: Reading this slide may sound very scary, but there are a lot of exceptions. The general rule is that no state officer or state employee may receive, accept, take, seek, solicit directly or indirectly, anything of economic value as a gift, a gratuity, or favor from a person if it could be reasonably expected that the gift, gratuity, or favor would influence the vote, action, or judgment of the officer or employee, or be considered as part of a reward for action or inaction.

People get nervous about what this means. On Slide 16 there are a lot of exceptions to the rule that really make sense in terms of items that you receive from bona fide friends and family members which are not part of the limitation on gifts. Also, if there are items that are related to an outside business that are customary and not related to the recipient's performance of official duties, those are also exempted from the gift rule. The gift rule is meant to be about bribery and an undo influence of people to misuse their official position. So the hard line rule that the Legislature has set is $50 as a source of a gift in a single calendar year. But again, the exceptions apply for family members and friends. Those don't count towards the $50.

Slide 17 - Section 4 Employees: In some of the other materials that the Executive Ethics Board has online, they have a lot of Q&As about Section 4 Employees. Section 4 refers to a specific provision of the Act which has to do with situations where your duties involve a specific decision about contracting or purchasing with a specific entity or vendor. In those situations where your decision that is before you has to do with contracting or purchasing from a specific vendor, the gift rules are more strict. That's the important takeaway. Even the $50 limit doesn't exist and is not allowed. There's a lot more information about gifts if you go on the Executive Ethics Board's website. I did hyperlink everything on the online materials you got.

Slide 18 has information on Governor Inslee's website. These pages are also hyperlinked. Governor Inslee has training available online for all members of Boards and there is a specific training about Ethics and Government that's online

for you to look at that goes into some of the things I talked about, some of it's a bit different, and some of it goes into the history of the ethics law.

Slide 19: The Executive Ethics Board is a five-member Board of persons appointed by the Governor and they enforce the Ethics in Public Service Act, but only for the Executive Branch. They don't enforce it for the Judicial Branch or the Legislative Branch, but they have jurisdiction over the statewide elected officials and state employees in all the Executive Branch agencies, including boards and commissions. They also have online materials that are very helpful.

One of the things that is nice about the Executive Ethics Board is that all line state employees are subject to the law so they have made the materials very accessible for all state employees to be able to read and understand the rules. They have online quizzes that make the rules understandable and easy to digest. And they also have some Washington Administrative Code citations that drill down into a lot more detail about some of the rules and penalties. They also have advisory opinions by subject matter. I really recommend that you go to this website. It's well done and helpful. Ethics may be a bit overwhelming, but again, all state employees and all Board Members are subject to it and it is accessible. It does have a logic to it when you get into the terms that people should not be personally gaining or benefitting from their position of trust and that the public should have confidence in state government and in state employees and their role.

Lou McDermott: If anyone has any questions, they you can ask Katy directly or you can communicate with Dave or me.

Proposed SEBB By-laws and Vice Chair Selection

Dave Iseminger: At our last Board meeting, Katy Henry had some questions related to including the ability to reimburse school districts for Board Member service time. We talked about how the authority for being able to spend that expenditure out of the Health Care Authority's budget has to be in statute. The agency can provide insight as to how that could be addressed in statute.

The By-laws before you are exactly what you had at the last meeting. The hope for today is to have a discussion, determine if there are changes you would like to make, and take action if there are not changes. You will be able to visit them at any point in the future as well. We went through the Ethics in Public Service Act training just before taking action on the By-laws to remind you about your obligations when taking votes. This is the one action item for today. The By-laws is probably one of the less controversial things that you'll vote on in the next year and a half, but it does mark the first step in that voting journey as a Board.

Pete Cutler: Do I remember correctly that these draft By-laws closely reflect the By-laws that the Public Employees Benefits Board operates under?

Dave Iseminger: This draft was created from two sources. It was, in part, the Public Employees Benefits Board By-laws and a comparison of other educational entities like the State Board of Education to see if there were any relevant provisions. There are differences. For example, there is no Vice Chair in the PEBB By-laws. Those provisions are completely different. There are more granular details in some of the other By-laws about exactly the timeline for doing transcripts of meeting minutes. But the way that the law has developed around them, we wanted to make sure that there was as much flexibility to be able to get those done in the robust manner as possible. These By-laws are more aligned with the exact requirements with modern day law. That's the origin.

Pete Cutler: Thank you.

Lou McDermott: Do we have other questions or discussion from the Board on the By-laws?

Wayne Leonard: I just have one question. On Article 6 at the end, it says "two-thirds majority are required to amend the By-laws." Would that be two-thirds of those Board Members present or six out of the nine members?

Katy Hatfield: I would read that to mean that it's two-thirds of all of the whole body, regardless of how many people are present.

SEB Board By-laws

Moved. Seconded. Approved.
Voting to Approve: 8
Voting No: 0
Absent: Alison Carl White

Vice Chair

Dave Iseminger: Article 2, Section 2 of the newly enacted By-laws builds off of what the description is in statute. The vice chair serves as the presiding officer at a regular or special meeting of the Board if the regular or temporary chair can't serve. As a reminder, the regular or temporary chair that it is referring to is the Director of the Health Care Authority, or his or her designee, who serves on the Board. The regular chair would be the actual Director of the agency, the temporary would be their delegate, and then in the absence of either of those, then the vice chair would serve as the presiding officer. So that's the primary function of the vice chair. If the vice chair were in the position of serving as the officer for the meeting, there would be administrative support from Connie and me. Lou has an annotated agenda to help make sure that we have the order. You'll certainly be provided the administrative support to serve in that function as well.

Lou McDermott: Is there a Board Member who's interested in serving as the vice chair? Is this the part where we encourage fellow members? Pete? You are very familiar with government process. I'm nominating you.

Pete Cutler: I'm willing to do it. Frankly, my thought was given that the purpose of this Board is to develop plans in eligibility criteria for school employees. I was inclined to hope that one of the four or five school employees would want to step forward.

Lou McDermott: Would you like to nominate one of them?

Pete Cutler: I would nominate Terri House because she's sitting right next to you!

Lou McDermott: Terri, what do you think about that?

Terri House: That would be fine.

Lou McDermott: Outstanding. Any other folks interested in taking this on? Ok, no other volunteers

Vice Chair

Moved. Seconded. Approved.
Voting to Approve: 8
Voting No: 0
Absent: Alison Carl White

Lou McDermott: Congratulations, Terri. Like I said, if you have to do it, Connie will take great, great care of you.

Terri House: Thank you. Thanks, Connie.

Dave Iseminger: I know that the Board's come to appreciate having a sense of what's on the next meeting's agenda. In January, we'll discuss medical and dental benefit structures. There will be quite robust comparison charts because the variability that exists with the medical and dental is pretty significant.

We'll also be presenting some draft resolutions for your consideration on benefit structure before we ask you to vote. We don't want to surprise you with the vote on the same day they are presented to you. We like to present to you and give you enough information and very specific things to be able to critique, discuss, and debate, and then give you time to go back to constituencies and think about those pieces, and then vote at a subsequent meeting.

I'll provide an update on the first ten days of the short session of the Legislature. If there's anything that the Board is wanting us to look at specifically, now would

be the time to help tee up topics for us to prepare for the two January meetings. Somewhere between those two meetings will also be information about the enrollment data that John referenced. I'm not quite sure exactly how that's going to land and having meeting materials ready, so It might not be until the end of January.

Meeting Adjourned