HBE Board vote should resolve billing issues

Late last year, the state’s Health Benefit Exchange (HBE) Board, which oversees the state’s exchange, voted to return health plan billing responsibilities to payers. This decision applies to residents who sign up for a health plan through the state exchange, Washington Healthplanfinder. With this change, the board took a big step toward resolving one of the biggest issues that’s dogged the exchange.

Along with offering Washington residents a chance to shop for and sign up for a health plan, the Washington Healthplanfinder has also been responsible for forwarding enrollment information to health plans, and collecting payment. But for about 20 percent of customers, this process has not worked well. A number of individuals have signed up for a health plan and made payments but that

more on page 4

MEDICARE:

Thanks to producer support, our Annual Election Period was successful

Major changes in our 2015 Medicare product line—including regionalizing our plan offerings, eliminating most of our existing plans in certain areas, and introducing new plans—resulted in a challenging Annual Election Period for producers.

more on page 8

GUEST COLUMN

Sure we have an HMO. But did you hear about our PPO?

By Michael Garrett
Director, Large Group Sales

I was in a meeting recently with a producer who had a client looking for a new health plan carrier. When I suggested Group Health, her first words were along these lines: “But we’re not looking for an HMO plan. I know my client’s employees really want to be able to choose where to get their health care.”

It’s not the first time I’ve heard this objection and probably won’t be the last.

more on page 15
We’re not a fresh face, and that’s a good thing

In December and January, Group Health marked its 69th year since incorporation and 67th year giving patient care, respectively. Those aren’t milestone anniversaries, like a 50th or 75th, but I bring them up for a couple of reasons.

As all organizations must change to stay relevant, we’ve evolved with the times. One of the big changes we made in the 1990s was the introduction of health plans that offered choices beyond getting care with our HMO network. Today, we have a portfolio that includes our new Access PPO, POS plans and, of course, our HMO plans. And yet, as guest columnist Michael Garrett notes, there are many employers and individuals who still think of us as “just an HMO.” We offer so much more.

Another thing about our anniversary dates: They’re a tribute to a legacy of focusing on quality and improvement. We’ve long promoted things that many of our competitors are just waking up to, like integrating care and coverage, coordinating patient care across the entire care spectrum, and developing payment strategies that reward quality of care and outcomes rather than the quantity of visits and procedures. We’ve also successfully managed the total cost of care for large employee populations for years. Our quality standards are demonstrated by the ratings we receive from NCQA, the Centers for Medicare & Medicaid Services (CMS), and eValue8.

With a focus on continuous improvement, it’s not surprising that we’re developing new ways to deliver care. (Check out this article on some of our care innovations.) But we’re also looking for different ways to serve you and your clients through new product developments. What can you expect in the months ahead? John Harris, our new vice president of Lines of Business and Product Management, is an expert in rapid product development, honed in his previous role as director of product management for Blue Cross and Blue Shield of Minnesota, and in product development and manager roles at companies including United Health Group and General Mills. I know he’ll be a catalyst for innovation and growth in our portfolio of offerings. Stay tuned for more on this soon.

Finally, with the open enrollment period just ended, I want to thank all of you for your help in making it a successful one for Group Health. We couldn’t do it without you.

Regards,

Debbie Huntington
VP of Sales
Changes to ACA possible during 114th Congress despite gridlock

Continued gridlock is expected during the 114th Congressional session in Washington D.C. that began in January. Republicans are expected to propose, and perhaps pass, significant changes to the Affordable Care Act, only to be vetoed by President Obama.

However, it’s possible that some changes having bipartisan support may survive a veto, and we could also see some changes to the Affordable Care Act (ACA) made with executive authority. The Supreme Court could even have an impact. Some potential issues we’re watching closely are:

**Changes to the employer mandate.** The law currently requires that employers with 50 or more full time equivalent (FTE) employees offer health care to employees who work at least 30 hours a week or pay a penalty. There is some support for changing that to employees who work 40 hours a week.

**Repeal of the medical device tax.** The tax, which went into effect in 2013, was initially passed to help offset the cost of expanding health care coverage to more Americans. There is bipartisan support in Congress for repealing this tax.

**Cadillac tax.** The ACA established a tax on employers that offer high cost health benefits—or “Cadillac” plans—to their employees. This tax is due to be implemented in 2018. However, because this type of tax is difficult to operationalize, and with significant resistance from employers and unions, there is speculation that the administration could delay or modify its implementation.

**King v. Burwell.** The Supreme Court recently agreed to hear a case that challenges whether the federal government can legally provide subsidies through the federally facilitated exchange. Given that Washington runs its own state-based exchange (Washington Healthplanfinder), the decision in this case won’t directly affect our market. But it could affect roughly half the states, putting the ACA on weaker footing nationally.

Of course, none of these changes are certain, and we expect many surprises as well. Watch future editions of Producer Pulse for news of other major changes to the ACA.
CMS issues more ACA regulations

Late last year, the Centers for Medicare & Medicaid Services (CMS) issued several regulations pertaining to the Affordable Care Act (ACA) including the proposed Notice of Benefit and Payment Parameters for 2016. This is the annual rule that makes adjustments to the insurance market, including changes to the actuarial value calculator, out-of-pocket maximums, essential health benefits, and exchange enrollment.

A few of the most critical proposed changes for 2016 include an open enrollment period for the individual market that runs from Oct. 1 to Dec. 15, 2015; an option for exchanges to re-enroll enrollees automatically into the lowest cost plan in the metal tier in which their current plan is placed; and continued reliance on state-developed essential-health-benefits benchmark plans for 2017. The final version of the Notice of Benefit and Payment Parameters for 2016 was expected early in 2015.

At the end of December, CMS also issued proposed rules regarding updates and streamlining to the Summary of Benefits and Coverage and Uniform Glossary that carriers are required to provide to employer groups and enrollees. The Administration believes such proposed updates will make health plan information more easily understood by consumers.

HBE vote should resolve billing issues for 2016

The billing change won’t take effect until the 2016 open enrollment period. “We are now working with the HBE board to be sure we can make the billing transition before our next open enrollment. Thankfully, having the HBE board make this decision in December—rather than a couple of months later which we had expected—gives us more time to do things right for the next open enrollment.”

Overall, the 2015 open enrollment for individuals and families, which just ended, has gone more smoothly than the first year of the exchange with fewer technical hiccups. Hews will continue to work closely with the HBE to find solutions to other ongoing issues. But the good news? “Our system is maturing.” And with maturity will come—hopefully—fewer problems.
In Olympia, expect a long, long session with some surprises

There are a few things you can count on during a Washington state legislative session. Some expected bills will be introduced, but there will be surprises too. And during a budget year, you can count on at least one special session. The 2015 session began on Jan. 12 and officially ends on April 26. But special sessions—more than one is likely—may take the 2015 legislative session into June.

The special sessions are anticipated because of the state’s extraordinary budget situation. The McCleary decision (compelling the state to completely fund basic education) combined with a voter-passed initiative to lower class size, significantly contribute to a state budget shortfall estimated at $4–5 billion. While it would be difficult to find a resolution to a shortfall this large in the best of times, this year’s budget situation is even more difficult because of a contentious political climate. Democrats and Republicans each hold only a slim majority in the House and Senate respectively, and two Senate Democrats have crossed the aisle to join the Republicans in forming what’s referred to as a majority coalition caucus.

While the budget is a big focus of this year’s session, other business will still be conducted. Here are bills that we’re watching that impact our industry.

**All-payer claims database.** Legislation passed in 2014 requires state employee and Medicaid insurers to submit data to the statewide all-payer claims database (APCD), but omitted K–12 and fully insured commercial claims. A coalition led by the National Federation of Independent Business has negotiated a bill that has been introduced in this session that would expand the APCD to include all fully insured claims.

**The exchange (Washington Healthplanfinder).** The Washington State Health Benefit Exchange (HBE) has projected a 2015 budget shortfall of $19 million. The HBE Board would like permission from the legislature to make up the difference through one of these methods: increased carrier assessments; a general fund appropriation; or by appropriating funds from the $20.8 million that the Washington State Health Insurance Pool (WSHIP) contributed to the state general fund to help support the HBE. WSHIP was required to contribute these funds by the legislature.

**Interchangeable biosimilar drugs.** A bill regarding biosimilar drugs was introduced, and failed, in 2014. Two bills have been introduced this year. The two bills are similar—both providing a pathway for FDA-approved biosimilars (a drug that has active properties similar to a licensed biologic drug) to be substituted in place of biologics. Where the bills differ is in a requirement that pharmacists dispensing biologics be required to record the name of the product and manufacturer and share that information with the prescribing provider. This requirement has been removed from one bill but remains in the other.

**Specialty drugs.** The recently released hepatitis C pharmaceutical, Sovaldi, is effective but expensive and has a significant fiscal impact for insurers. More specialty drugs of this kind are expected to come to the marketplace in the near future and their costs will raise difficult questions around access. The legislature will see proposals that impact this developing industry.  


Providing employees and their dependents with health coverage is an increasingly expensive proposition for employers. But adoption of a value-based benefit design (VBBD) plan can help employers lower costs while continuing to offer a robust health plan.

The goal of a VBBD plan is to encourage employees to use high-value medical services, and discourage them from using services of lower value. High value services are those with a strong evidence base, which enhance clinical outcomes, and increase efficiency. Low value services have a weak evidence base, minimal or no clinical benefit, and increase inefficiency. When high-value services are used, it should result in greater employee health and productivity.

A number of employers who have implemented VBBD plans have had positive results, including Neighborcare Health. Group Health worked with Neighborcare to design a plan that eliminated cost shares for primary and preventive care and encouraged specific wellness actions. By the third year of this plan, Neighborcare saw a per member per month (PMPM) cost reduction of 6 percent, compared with PMPM cost increases of 23 percent before the program was implemented.

A pilot program of a VBBD design that began in 2011 with three employers had these results after two years:

- Reduced PMPM costs for employers.
- High participation in preventive screenings for breast, colorectal, and cervical cancer.
- Fewer high-cost visits to the emergency room (ER) and lower total PMPM ER costs, compared to non-VBBD business at Group Health.
- A trend toward increased utilization of generic prescriptions and decreased costs for brand-name prescriptions.

Other organizations—from Caterpillar to Pitney Bowes—have seen improvement in employee health and cost trends after implementing a VBBD plan.
“Value-based benefit design is all about removing barriers,” says Matt Handley, MD, medical director for Quality at Group Health and an advisor to large groups on how to tailor VBBD strategy. “We know for sure that even small barriers make it harder for patients to do what’s in their best interest.”

For example, if someone with a chronic condition such as high blood pressure has a difficult time affording their medications, they may choose to stretch their medication supply by taking a half dose, or taking it every other day. “If they took their medication as prescribed, they would reduce their risk of complications and overall health costs,” says Dr. Handley. “If they have a health plan that has no copay or a very low copay for their chronic condition medication, this removes their barrier to doing what’s best for their health.”

**A customized benefit design**

It’s important to customize a VBBD for each employer since every employee population is unique. That’s why we assign a health-plan expert and physician to work with an employer and their account manager in designing a VBBD strategy.

We’ll ask you for information on your current benefit structure so we can analyze it for potential opportunities, and we’ll gather data about your employee population. Based on this and our experience with large populations, we’ll offer advice on benefits. For example, if we know your population is likely to experience multiple chronic conditions, we can design benefits to encourage preventive care visits and prescription drug compliance.

After the plan is put in place, we track how employees are using services to fine-tune the benefit design for even better results in future years.

**Tools that we can put at your disposal include these:**

- Incentives to use high-performing providers with access to Group Health Medical Centers. If you choose our Access PPO, your plan design can include incentives for employees to use Group Health Medical Centers for their health care, a high performing medical system. Group Health Medical Centers coordinates care between providers and is organized around the patient-centered medical home model of care.

- Differential costs for provider type. Primary care providers can have lower copays, with higher copays for specialists.

- Chronic condition management. Incentives can help employees improve management of chronic conditions by waiving costs shares for medical supplies such as diabetes monitors.

- Range of benefits to encourage use of preventive care. Plan design can include no cost shares for high value services such as preventive care visits and screenings paired with low (or no) cost shares for primary care, and high cost shares for services of low value services that are often inappropriately used such as ER visits and high-end imaging.

- 3-tiered formulary. Drugs that are evidence-based treatments for chronic conditions have no cost shares, generic drugs have low cost shares, while cost shares increase significantly for top-tier name-brand drugs.

Ready to get started? We’re ready to help. Call your account executive to set up an appointment.
MEDICARE:

Buyer’s remorse? Because of our 5-star rating, your clients can still make a change

Are any of your clients disappointed in the health plan they chose with another carrier? Or do they regret not switching from one Group Health Medicare Advantage HMO plan to another?

Group Health’s 5-star rating from the Centers for Medicare & Medicaid Services (CMS) for 2015 means they don’t have to wait until the next annual enrollment period to switch plans. They can move to one of our Medicare Advantage HMO plans anytime through Nov. 30, 2015, for a 2015 effective date.

There are a few restrictions on how your clients can use this special election period (SEP):

- They can only use it once during a 12-month period. That means if your client changed plans during December 2014—but after Dec. 7, when the regular annual enrollment period was over—they can’t change again until the next annual enrollment period because they’ve already used their SEP opportunity for that 12-month period.
- They can’t use it to just add dental coverage outside of the annual enrollment period. However, they can add dental coverage in combination with selecting a new Medicare Advantage HMO plan.
- They can’t use it if they have another SEP available to them. This can happen if someone loses their group retiree Medicare Advantage coverage and is granted a SEP to enroll in an individual Medicare Advantage plan, or if someone moves out of their current health plan’s service area and is given a SEP to enroll in another plan.

Your Medicare Advantage account representative will be happy to answer questions if you’re not sure how to apply the Medicare 5-star SEP period. You can also call our Sales Department.

MEDICARE:

Thanks to producer support, Annual Election Period was successful continued from page 1

We recognize that helping thousands of mutual clients re-enroll created a lot of extra work in terms of time, staffing, and your availability to prospect new business.

“Despite this, your response to our new portfolio, which was crafted to maintain competitive rates and benefits while leveling risk, was overwhelmingly positive,” says Rick Henshaw, director of Individual and Family/Medicare Sales. “We greatly appreciate your outstanding support and commitment, and we couldn’t have accomplished what we did without you.”

In addition to supporting our new direction and patiently working with us on new processes, producers submitted fewer incomplete election forms, eliminating rework. Many sent in enrollment materials electronically, online or via secure e-mail, rather than hard copies via snail mail, which also helped expedite the enrollment process.

“Although this AEP produced challenges along the way, we received a lot of valuable feedback and suggestions from you that we’ll use to improve our portfolio and processes for 2016,” says Henshaw.

Where’s Clear Care?

In recent years, our Medicare products have been called Clear Care Medicare Advantage HMO and PPO plans—but that’s changed. Beginning with our 2015 portfolio, our Medicare products are simply called Group Health Medicare Advantage HMO and PPO plans.

“The name change makes it easy for potential members to identify Group Health’s products,” says Rick Henshaw, director of Individual and Family/Medicare Sales. You’ll find the new names on all of our 2015 Medicare Advantage collateral.
SMALL GROUP:
Clients like what they see in our 2015 plans

The calendar has only recently turned to a new year, but already small business clients are responding with enthusiasm to our 2015 small group plans. At the end of January, the overwhelming majority of clients had renewed, with a number of them signing up for our new platinum plan. We also had a successful month of new sales with continued interest in our silver plan as well as our platinum plan.

“We’re offering one of the few platinum plans in the small group market,” notes Lonnie Goodell, director, Producer Management and Small Business Group. “It’s a robust plan with low deductible and low out-of-pocket costs. It’s a good match for groups moving out of a trust or association plan. The benefits are very comparable to what these groups are accustomed to.” Better yet, we have one of the best-priced platinum plans on the market.

More good news
We know that many of our mutual clients identify us as a company with a superior HMO product. But they’re concerned that the HMO will limit them to a narrow network of providers.

The truth? Our HMO plans give members access to the Group Health Network which includes 9,000 providers in our service area—not just the more than 1,000 doctors who practice at our 25 medical clinics. Those numbers represent the breadth of the provider network embedded in our Group Health plans. “The next time you are having a client conversation about Group Health and our providers, it’s worth doing a quick provider search on our website,” suggests Goodell. “I know you’ll be pleasantly surprised with the number of providers available to our Group Health members.”

Another pleasant surprise is the rates for our silver plan. “We continue to have the best-selling silver plan (featuring the Group Health Network). It’s priced dramatically lower—up to 35 percent lower—than other silver plans on the market.”

Quality matters
You’ve probably heard that our Medicare Advantage HMO plans have earned the 5-star designation for the fourth year in a row from the Centers for Medicare & Medicaid Services (CMS). While this is great news for our Medicare members, it’s also very good news for all Group Health members. That’s because all of our members—not just our Medicare members—receive the same great quality and care that CMS recognizes with its 5-star rating.

Plans that have earned 5-star have scored high on more than 50 care and service quality measures in five categories: staying healthy, managing chronic conditions, member satisfaction, customer service, and pharmacy service. Those are measures of quality that benefit all of our members.

We focus on helping members maintain their optimum health. And we do this with one of the best-priced portfolio of plans on the market. “If you compare our Group Health small group rates to some of the discounted wellness program rates that other carriers have on the market, our rates are still priced lower,” says Goodell.
Large group? Small group?
Next year will mean change for some employers

You probably have some clients who have more than 50 employees but fewer than 100. Today, these employers can purchase a large group health plan which they can customize to best meet their needs and those of their employees.

That changes in 2016 when, per the Affordable Care Act (ACA), employers with 51–100 employees will be defined as a small employer group for the purposes of health plan purchasing. As a small employer group, they’ll be required to purchase one of the small group health plans available to small employers. These plans come with a predetermined set of benefits, and are part of a portfolio of small group employer plans sold by most major carriers.

All of these newly classified small employers will see a change in what they’ll be able to offer their employees. “This change is likely to especially affect employer groups who currently offer their employees a customized and very rich set of health benefits,” says Lonnie Goodell, director, Producer Management and Small Business Group.

The rules and regulations around the health plans they can offer will be different than they’re used to. And they’ll need to choose a metal-tier (actuarial value): bronze, silver, gold, or platinum.

“It’s important that we begin to talk with our mutual clients about this change,” says Goodell. “Our goal is to be a resource and prevent late-year surprises to some of these newly defined small employer group businesses. We want to be sure they understand what’s happening, and what their options are.”

If you have questions now about this change, please contact your account executive. In the coming months, we’ll keep you informed about the options for clients affected by this change.

**SMALL GROUP:**
Employers say it best

What advantages do our plans have for small group employers?
You can hear from a few of them—and their employees—in this video series.

**Producer tip**

When you tell your clients about our [Occupational Health Services](#), you’ll be sharing information that will help injured employees return to work safely, quickly, and cost effectively.

Do young people care about health care coverage? You betcha.
INDIVIDUAL AND FAMILY:

Online application process made easier for qualifying event enrollees

Group Health has a useful tool for I&F clients enrolling in a health plan on or after Feb. 16 as the result of a qualifying event. If these clients enroll via an online application, they can upload the qualifying event documentation as part of the application process. You’ll find details about qualifying events here and the required documentation here.

When your clients enroll online, they should use your personalized URL to ensure you’re listed as the broker of record on their application. If you need an account for online I&F quoting, click here.

When the application is complete, your client will be instructed to upload their documentation via “My Account” on the enrollment site. They can click immediately on the “My Account” link, or return to the application site at a later time and log back in to be taken to their account center. They should then follow these steps:

1. Click on the application details link to find their pending application.
2. Begin the process to upload their documents in the “related documents” section.
3. Click browse to locate the applicable document on their computer.
4. Click upload file.

Repeat steps 3 and 4 if multiple documents need to be uploaded. Only certain file formats can be uploaded. These include PDF, TIFF, JPEG, and GIF files. Once the file or files are uploaded, the Group Health pre-enrollment team will review the document(s) to validate the qualifying event before completing the enrollment.

Clients can count on our customer service

Group Health is known for its customer service. Now you and your clients can meet some of the faces behind the voices in our Customer Service Profile video series. Our Customer Service experts are specially trained to provide patient and knowledgeable guidance to members and prospective members throughout the year. Your clients can call Customer Service anytime for answers to their questions and help with re-enrollment.

Meet FeLecia Boudy
Embedded deductibles an added advantage to our plans

Did you know that embedded deductibles, also known as traditional deductibles, are standard with all of our individual and family (I&F) plans? This is true of our I&F HSA plans, too, which is a unique feature in the market.

Our competitors commonly feature aggregate deductibles in their HSA-compatible plans. These require a larger family deductible to be met before the health plan kicks in and provides full coverage for any family member. Our embedded deductibles allow each member of a family to get full coverage from the health plan once he or she has satisfied the individual deductible.

There are two ways to achieve full health plan coverage* with our embedded deductible.

• One member of a family enrolled in a single plan has incurred enough personal health care expenses to meet the individual deductible. When this occurs, the health plan provides full coverage for this individual.

• Different members of a family enrolled under one plan have paid enough toward their individual deductibles to satisfy the family deductible. In this case, the health plan provides full coverage for the entire family, even family members who haven’t yet incurred any medical expenses or those who haven’t yet met their individual deductible.

If you have I&F clients who have been enrolling each member of the family separately to avoid having to meet a higher family deductible, you can let them know this isn’t necessary if they enroll in a Group Health I&F plan, including a HSA-compatible plan. If all family members enroll in the same I&F plan, they need only one application for the whole family. When a family enrolls in one plan all together, expense tracking for the family is easier, and administration of benefits by the health plan is easier too.

Help your clients find quality health care

“For the first time in the health industry’s history, there are numerous objective quality measures available if purchasers are willing to take a little time and look for them.”

That’s the message that Group Health CEO Scott Armstrong and co-author Patricia Smith, president and CEO of the Alliance of Community Health Plans, share in this Seattle Times opinion article.

The article details a number of organizations which rate health plans. The resources are easily available online at no cost.
Innovations making health care more convenient

These days, if you need transportation you can call a car service like Uber using your smartphone. Need groceries? Order them online from a service like Amazon Fresh and have them delivered to your porch. Need to find your way around a new city? Your GPS program will guide you door to door.

Group Health CareNow is a new service available to adult members and non-members that offers a similar type of convenience. It’s a secure online diagnostic tool that can be quickly accessed from a computer, tablet, or smartphone. It debuted late last year. With CareNow, individuals answer a series of questions about their condition, and receive a reply within an hour instructing them about next steps.

CareNow isn’t for every health problem—but it works well for some common conditions, like urinary tract infections, sinus infections, allergies, and pink eye, says Wellesley Chapman, MD, medical director of Innovation and Development. “If we ask the right questions in the right way, we can evaluate the responses and make a decision. About 40 percent of the time, we can arrive at a diagnosis,” says Dr. Chapman. That means the user doesn’t need to spend the time and effort needed to come to a clinic. And a $25 fee is charged only if a diagnosis is made.

Dr. Chapman is part of a group within Group Health that’s working to improve health care—including making it more convenient for consumers. The group did the work behind CareClinic, a collaboration with Bartell Drugs that was launched early last year. CareClinic is another example of delivering health care in an untraditional way. At CareClinic locations, no appointments are needed, they’re conveniently housed within neighborhood Bartell stores, and there are set prices for visits and for services such as vaccinations and lab tests. Three locations (two in Seattle and one in Bellevue) opened in 2014, and a handful more are planned for 2015.

The clinics are staffed by advanced nurse practitioners and certified physician assistants, and offer care for minor medical conditions such as sinus infections, allergies, bronchitis, and minor cuts. “It’s high quality care that’s fast and efficient from a resource standpoint,” says Dr. Chapman.

While other innovations in care delivery aren’t yet ready for public discussion, Dr. Chapman sees many possibilities. “I see escalating pathways,” says Dr. Chapman. “For instance, what if a patient answered diagnostic questions via an e-visit, but a physician needed a little more information to make a
Group Health invests in Seattle bike share program

Cities around the country—from Boston to San Francisco—have invested in bike share programs with rent-a-bike stations that offer a two-wheeled way for locals and visitors to get around town. When Seattle joined their ranks last fall with the Pronto Cycle Share program, Group Health was part of the kick-off celebration.

That’s because Group Health is sponsoring 15 docking stations for the bikes in the Capitol Hill and South Lake Union neighborhoods. “Investing in Pronto Cycle Share is a great way to promote health,” says Diana Rakow, executive vice president, Marketing and Public Relations, and Group Health Foundation president. Rakow was part of the group, which also included Seattle Mayor Ed Murray, which took an inaugural ride through Seattle’s downtown.

Matt Handley, MD, medical director of Quality for Group Health and an avid cyclist, added, “Not only does Group Health have a long history of supporting health and wellness—including through community programs and sponsorships—but as a large health provider that draws thousands of people to Capitol Hill, downtown Seattle, and South Lake Union, our support of the bike share stations is one way Group Health can help put fewer cars on the road at any given time. This has health, environmental and economic benefits for the entire community.”

Innovations making health care more convenient

continued from page 13

diagnosis. Instead of sending the patient to a clinic, the next step could be a virtual visit.”

There are many new technologies being developed to do things like gather health data remotely and monitor health conditions. But it’s important not to invest in something just because it’s new and sounds interesting. “Does it improve outcomes or quality? Does it lower costs?” asks Dr. Chapman. “We want to make health care easy, but in everything we do, we also need to be clear about what adds value.”

Producer tip

E-mail us if you have an inquiry about your commission, or questions about becoming appointed at brokerappt.commission@ghc.org
But here’s what I told her: “No problem. We have plan options that your client and their employees will really like.”

We know that choice is important, which is why we’ve offered a variety of network options for quite a while. But in the spring of 2014, we added the Access PPO to our portfolio for large group clients. That’s right. A PPO plan. It’s been warmly received by a number of large plan sponsors, including single employers and multi-employer plan sponsors. It might be just what your clients are looking for, too.

We also offer a range of funding choices for large employers: self-funded, fully insured, and other risk sharing plans that include our Access PPO, HMO, and other plan products. Our Access PPO includes providers at Group Health Medical Centers clinics, providers we have contracted with in our service area, our First Choice Health network for employees who live in the Northwest outside our service area, and the First Health Network for care in other parts of the country. By creating our own PPO network for Washington state residents, we’re able to offer a more competitive product.

And our plans include numerous services to improve employee health. I hear from plan sponsors that they want their health plan to help them create and sustain a healthy workforce. Through our products, plan sponsors receive a range of services for their employees that support appropriate and cost effective care, including care management, health coaching, wellness, transition management, 24/7 consulting nurse services, and more.

Whether your clients are interested in our PPO or our high-performing HMO, they’ll have access to our nationally recognized care delivery model which has been proven to reduce the total cost of care. Getting care at one of our 25 Group Health Medical Centers locations means employees experience the patient-centered medical home model of care, proactive management of chronic diseases, a focus on prevention and wellness, and—should someone need care in a hospital—a transition-of-care intervention that’s been shown to lower hospital readmissions. We’ve found that once employees try our brand of care, they often don’t want to go anywhere else—even when their plan gives them the option to.

I know that putting together a benefit plan that offers the right components can be challenging. After all, every employee population is different. Fortunately, our sales team has help from Kevin Klein, our resident expert in health and wellness offerings. Kevin, along with one of our medical directors, will help plan sponsors design, implement, and monitor wellness offerings and plan design elements to help improve their population’s health while controlling costs. Should you offer incentives for preventive care visits? Does a part of your population need some encouragement to take the medication needed to manage a chronic condition? Are a lot of employees using the emergency room rather than an urgent care center? We’ll analyze employee demographics and utilization data to evaluate your population in order to make data-driven recommendations on how to improve the plan design and communications with your clients.

Some of you may know that I am relatively new to Group Health. I joined the team here about six months ago. I came because I believe Group Health offers the right kind of solutions for plan sponsors. I look forward to working with you on the best solution for your clients.

Michael Garrett
Director, Large Group Sales
We’re here to help
The Group Health Producer Management Team can always assist with any of the following:

**PRODUCER OPERATIONS**
- Licensing and appointing
- Onboarding a new producer
- Onboarding new staff at an agency

**COMMISSIONS**
- General commission inquiries
- Monthly statement questions and discrepancies
- ACH setup for electronic deposit of monthly commission

**PRODUCER UPDATES**
- New mail or e-mail address
- Notification of mergers, acquisitions, or business transfers

**PRODUCER RELATIONS**
**Producer website at producer.ghc.org**
- Questions about access to the website
- Troubleshooting
- Training/navigation of site

**PRODUCER EVENTS**
- RSVP
- CE credit certificates, when applicable
- Questions about upcoming producer events

**PRODUCER MANAGEMENT TEAM**
- Lonnie Goodell, goodell.l@ghc.org
  Director, Producer Management and Small Business Group
- Kelly Chrisman, chrisman.k@ghc.org
  Manager, Producer Management and Small Business Group
- Matt Cotto, cotto.m@ghc.org
  Producer Operations Analyst
- Lori Stanford, stanford.l@ghc.org
  Producer Relations Consultant

Event calendar

March 17
**Western Pension & Benefits Council (WP&BC)**
Chapter meeting
Bellevue, breakfast meeting, Daniel’s Broiler
Seattle, lunch meeting, Seattle Sheraton Hotel
For information, visit [wpbcseattle.org](http://wpbcseattle.org)

March 25 and 26
**Washington Association of Health Underwriters (WAHU)**
2015 Spring Symposium
March 25, Hilton Seattle Airport & Conference Center, Seattle
March 26, Lincoln Center, Spokane
For information, visit [wahu-online.org](http://wahu-online.org)

March 26–27
**Seattle Society of Human Resource Management (SHRM)**
17th Annual Washington State Employment Law & HR Conference
Meydenbauer Convention Center, Bellevue
For information, visit [shrm-seattle.site](http://shrm-seattle.site)

April 2
**Employee Benefits Planning Association (EBPA)**
Breakfast seminar
For information, visit [ebpa.org](http://ebpa.org)

April 22
**Western Pension & Benefits Council (WP&BC)**
Spring Seminar, Bell Harbor International Conference Center
For information, visit [wpbcseattle.org](http://wpbcseattle.org)

June 3–5
**NAIFA Washington**
State Convention, Best Western Plus Tacoma Dome Hotel, Tacoma
For information, visit [naifawashington.org](http://naifawashington.org)