ProducerPulse

JUNE 2015

Improving health care quality by sharing our 'secret sauce' with network providers

Group Health is well known for the patient-centered, evidence-based, high-quality care we provide at our 25 medical centers throughout Washington state. Extending that level of care throughout our entire service area is the goal of a multi-year quality improvement program that began in 2012.

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Lonnie Goodell, Director, Small Business Group and Producer Relations

GUEST COLUMN

A big shift in 2016 for groups with 51–100 employees

By Lonnie Goodell

A seismic change will rock a segment of the large group market in 2016, and it's very likely many of these businesses are not fully aware that it's coming. I believe what's ahead for this group in 2016 is similar in impact to what the market experienced with the opening of the state exchange and other aspects of the Affordable Care Act.

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INDIVIDUAL AND FAMILY

The ins and outs of qualifying events

Most members who enroll in an I&F plan with Group Health do so during the open enrollment period. However, some people are eligible to enroll any time of the year based on a qualifying event, such as marriage or divorce, having a baby or adopting a child, or loss of minimum essential health coverage.

No matter what the reason for the change in coverage, enrollment must take place no more than 60 days from the date of the qualifying event.

State regulations specify what qualifying events a carrier must accept, along with some events that are specific to Washington

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GroupHealth®

What's next? Telling our story a little more loudly

Debbie Huntington
VP of Sales

Over the past few months, I've had a chance to talk with many of you. The message I heard over and over is this: Group Health offers quality health plans and health care, but why hasn't that story reached more people? And despite the high-quality ratings we've received, why do questions about quality continue to linger among consumers?

What I've learned from this is that we need to do a better job telling our story. I want you to know that we're taking this message seriously. In the weeks and months ahead, you can expect to hear much more about Group Health in all kinds of places.

In May, we re-launched the ad campaign that debuted last year. We made a few subtle adjustments to more directly communicate the benefits of choosing Group Health. We're taking this campaign to TV, radio, transit, and billboards. And because so much communication these days happens in the digital world and on social media, our campaign is reaching far into those channels as well. We're also evaluating other tools at our disposal to make sure that we make the most of every opportunity to share our story.

Research has revealed another uncomfortable truth. While organizations such as the Centers for Medicare & Medicaid Services and the Washington Health Alliance have lauded us for helping patients manage chronic conditions, keeping them healthy and safe, out of the hospital, and more—our patients measure quality in different ways. And on those quality measures, we don't do as well.

What does that mean? Frankly, the experience our patients have at our medical centers must be more consistent. We need to make sure that every time at every touch point—from when a patient makes an appointment to when they're greeted in the exam room—they feel valued and have their needs met in a way that resonates with them. We've engaged Press Ganey, a performance improvement tool, to help us understand where we need to do better. Based on feedback we've received, we're already making changes.

At Group Health, we've never been afraid to reach for the high bar. It's the reason our health plans and care delivery are so good. In the months ahead, I think our patients will notice a change, and if we're successful in our efforts to share our story, you'll be hearing about it too.

Regards,

Debbie Huntington

Expanded all-payer claims database among industry bills okayed during 2015 state session

When this issue of *Producer Pulse* was being finalized, the Washington State Legislature was in its second special session, and budget negotiations continued with a number of budget-related bills awaiting resolution. But it did act on several bills not related to the budget during the regular session which ended on April 24.

Bills that passed

SB 5084 ALL-PAYER CLAIMS DATABASE

Legislation passed in 2014 required state employee (PEB) and Medicaid insurers to submit data to the statewide all-payer claims database (APCD) but omitted K-12 and fully insured commercial claims. The bill that passed this year, drafted by a broad coalition including Group Health, expands the APCD to include all fully insured claims.

SB 5935 INTERCHANGEABLE BIOLOGICS

This bill provides a pathway for interchangeable biologics. An interchangeable biologic is one that the FDA has determined meets the safety standards of interchangeability with another biologic or is therapeutically equivalent to another product. The bill initially required burdensome notice to physicians if substitutions are made and requires mandatory substitution. Group Health and other stakeholders worked to negotiate notification language that is less burdensome. That language was included in the final bill.

HB 1471 PRIOR AUTHORIZATION

This legislation imposes restrictions on carriers related to prior authorization (for example, carriers cannot require a prior authorization for the first encounter with a contracting provider in a new episode of care). Group Health worked with other carriers to minimize

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Expanded all-payer claims database among industry bills okayed during 2015 state session

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the negative impact of this bill. As a result, a section was removed that would have prohibited carriers from imposing cost-sharing requirements for habilitative, rehabilitative, East Asian medicine, or chiropractic care that exceeds the cost-sharing requirements for primary care. Another change involved a clarification that "contracted provider" does not include providers employed in an integrated delivery system. The new language was included in the final bill.

TELEMEDICINE

This bill requires health carriers to reimburse providers for telemedicine. However, payment may be less than for in-person visits.

Budget-related bills

These two bills are among those awaiting a budget resolution.

K-12 HEALTH BENEFITS

This bill would consolidate health benefit purchasing for teachers and classified school staff into one entity, a School Employee Benefit Board, which would function similarly to the existing Public Employee Benefit Board (PEBB).

EXCHANGE FUNDING

The Senate and House budget versions were far apart on funding for the Washington State Health Benefit Exchange (HBE). The House budget includes $124 million in funding, close to the requested amount. But the Senate budget only includes $86 million and does not allow HBE to utilize the two percent premium tax it currently uses to partially fund its operations. To fill the gap, under the Senate budget the HBE carrier assessment would increase from the current $4.19 per member per month rate to $13.66.

Producer tip

Large and small employer groups, and individual and family members will see changes to their premium statements in July. These will include a new look and a new remittance address. Look for more information in the August *Producer Pulse*.

SMALL GROUP

Five surprising features of our small group plans

2015 As renewal dates approach for our mutual small group clients throughout 2015, there are many attractive reasons that they'll want to choose a Group Health plan for the coming year. Here are a few conditions-of-offering features they may not be aware of.

1. Groups have waiting period choices that include date of hire, first of the month following date of hire, first of the month following 30 or 60 days, and 90 days from the date of hire. If they choose 90 days from the date of hire, we will pro-rate the first month's premium by the day, not by the month or half-month.
2. The small group determines the conditions for employee eligibility, not us. There are no minimum hour requirements. In other words, they can decide how many hours an employee must work before becoming eligible to participate in the health plan. It could be 10 hours a week, or 40. They decide.
3. For groups of 1–3, 100 percent of eligible employees not covered by similar existing coverage must enroll. For groups of 4–50, there's no minimum participation requirement. Only a few employees can choose to join the health plan, or they all can.
4. For those same groups of 4–50, the employer contribution only needs to be 50 percent, and there's no minimum contribution for dependents.
5. Groups of 10–50 employees can offer one or two plans, and there is no plan combination requirement. They can choose one of our Core plans and one of our Connect plans. Or two Core plans. Or two Connect plans. It's up to them. For 10–24 employees, at least 3 employees must enroll in each plan. For 25–50 employees, at least 5 employees must enroll on each plan.

"With the Affordable Care Act, everyone has to have a health plan. We wanted to make that easy," says Kelly Chrisman, manager, Producer Management and Small Business Group. "We don't want to put up barriers to participation."

Other plan attractions

Of course, there are other important reasons small employers will like our 2015 plans. Among the most important are quality, price, and choice.

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SMALL GROUP

Five surprising features of our small group plans

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Quality: We consistently receive high ratings from organizations— such as the National Committee for Quality Assurance and the Centers for Medicare & Medicaid Services—which rate health plans and health care on quality. A few areas where our plans score high include helping patients stay healthier, take the medications they need to manage chronic conditions, and get care needed to maintain or improve health.

Price: Our bestselling Core Silver plans are priced lower than other Silver plans on the market, and the other plans in our portfolio are competitively priced too. The overall average rate change between our 2014 and 2015 Core plans is less than one percent, and our Connect plans have decreased by an overall average of 3.1 percent.

Choice: We have nine plans available at all metal levels, from Bronze HSA to Platinum. All of these have significant provider choice. Our Core plans feature 25 Group Health Medical Centers with roughly 1,000 Group Health providers and 9,000 contracted providers in our service area. Our Connect plans include these same providers as well as Virginia Mason and The Everett Clinic in-network, plus out-of-network coverage for any licensed physician or discounted costs using First Choice Health in Washington, Idaho, Montana, Oregon, and Alaska or First Health network in other states.

If you're pleasantly surprised by some of our small group plan features, our mutual clients may be surprised too. Please contact us if we can provide you with more information.

SMALL GROUP

Big changes ahead in 2016 for small group plans

2016 A larger variety of plans, consumer-friendly benefits, and plans that include our Access PPO are among the changes you can expect for the small group market for 2016. While details won't be available until the plans receive approval from the OIC, here's an early look at some significant features of our 2016 small group portfolio.

More plans. We've expanded our portfolio where it makes sense and will offer more than 15 plans. Plans will include the full range of metal levels, from Bronze to Platinum.

Plan variations for a new market segment. With the reclassification of groups with 51 to 100 employees from large to small group (see article on page 1), we've designed several plans to include features that this market segment wants. These include employee-only plans that offer comparable benefits and cost shares to plans these groups currently have in place.

"We are offering a full breadth of plans but we're still keeping it simple," explains Lonnie Goodell, director, Producer Management and Small Business Group. "We wanted to expand to meet the needs of employers, without offering 57 flavors of the same thing. We started 2014 and the implementation of the ACA with a guiding principle–keep it simple. The 2016 small group portfolio continues to reflect that approach."

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SMALL GROUP: 51–100 employees

ACA changes small group definition

Starting in 2016, some employer groups will be affected by a requirement of the Affordable Care Act which expands the definition of a small group to include groups of up to 100 employees. In 2016, as these groups renew or purchase new coverage, they must follow the regulations governing this market segment.

SMALL GROUP

Big changes ahead in 2016 for small group plans

continued from page 6

Access PPO. For the first time, we are making Access PPO available to the small group market. "It's the only PPO plan in the state that includes access to Group Health Medical Centers and the quality care that we provide our members in that setting," points out Goodell.

User-friendly benefits. Many plans will feature no deductible requirement for office visits—only a copay—and simplified pharmacy benefits and cost shares.

Rate reductions. We've continued our focus on reducing costs. A number of our plans will have rate reductions over 2015 offerings.

New dental vendor. Dental coverage in 2016 will be with a new vendor, Delta Dental of Washington.

We'll share all the details of our plans with you after they've been approved by the OIC. It's not too early to plan to attend one of our fall workshops where you can learn about the plans and have all of your questions answered.

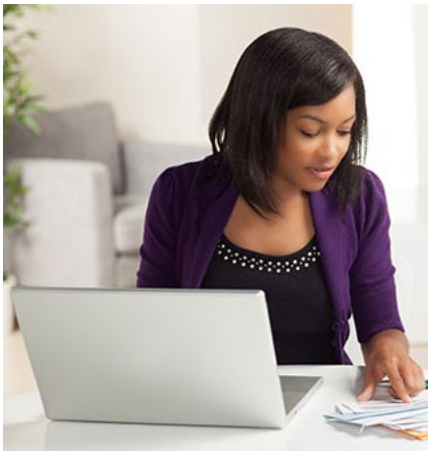
INDIVIDUAL AND FAMILY

New billing and payment process for Washington Healthplanfinder clients

Beginning in October, clients who have purchased a health plan through Washington Healthplanfinder will receive a bill for their premium from their carrier, and will pay premiums directly to that carrier. Until now, this transaction has been handled by Washington Healthplanfinder. The last date they can make a payment to Washington Healthplanfinder is Sept. 23.

Clients are being encouraged by Washington Healthplanfinder to begin making premium payments directly to their carrier now. Group Health is prepared to accept these payments from individuals and families enrolled through the exchange in a Group Health dental or health plan.

While communication about this payment change has begun, it's possible that some clients may not become aware of it. If you receive payment questions from a client with a Group Health plan purchased through Washington Healthplanfinder, you can refer them to our Customer Service at 1-800-290-8900.



This billing and payment change was first announced late last year when the state's Health Benefit Exchange board, which oversees the state exchange, voted to return health plan billing responsibilities to payers. In doing so, the board took a big step toward resolving one of the biggest issues that has dogged the exchange.

Washington Healthplanfinder has 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 information has not been forwarded to the health plan provider. As a result, when they've tried to access their coverage, they've been told that they don't have coverage.

It's also been an issue for producers who may have had commissions held up. We pay commissions based on reconciled premiums so if members aren't enrolled correctly, producers don't get paid in a timely way. That issue should be minimized with this change to carrier billing.

INDIVIDUAL AND FAMILY

Access PPO to join the family of plans in 2016

Our individual and family plans for 2016 will bring some noteworthy changes and additions. One of the most significant will be making Access PPO—our broadest offering of providers and networks—available for the first time to the I&F market. We've also continued our dedicated work on costs in order to be sure we're offering competitively priced plans. While we can't speak to specifics before our plans are approved by the OIC, there are exciting elements we can share.

Access PPO

With Access PPO, individuals and families will have access to more than 16,000 providers in our 2016 Group Health Options I&F service area, as well as more than 1 million across the United States. This is in addition to the convenience and high-quality care from the nearly 1,000 doctors at Group Health Medical Centers, the top-rated medical group in the state in the latest Community Checkup by Washington Health Alliance. Included in our Access PPO portfolio will be Bronze, Silver, and Gold level plans. The Access PPO plans will replace the Connect Plans from Group Health Options, Inc.

Other portfolio updates

In addition, based on producer feedback, we're expanding our portfolio to include a variety of Silver-metal level, HSA-compatible plans. Plus, we're enhancing the number of upfront visits members have without paying a deductible on a subset of our non-HSA metallic plans.

A collaboration with Delta Dental

For 2016, I&F plans will have a new dental vendor, Delta Dental of Washington, for dental coverage. One change you can expect is that enrollees who do not have dependents under the age of 19 will not have to have pediatric dental as part of their plan when purchasing a plan directly from Group Health.

> "Based on adjustments and improvements made, our 2015 plans became much more competitive in the marketplace."
>
> Rick Henshaw,
> director of Individual and Family and Medicare Sales

More of a good thing

"For 2016, we set out to build on a strong foundation by offering consumers even more choice," said Rick Henshaw, director of Individual and Family and Medicare Sales.

Learn more

We'll share all the details about the new I&F plans at our fall Producer Workshops. Check out the schedule and plan to join us.

Producer tip

Do you have a new agent working with your agency? If so, please remember that all agents who sell Group Health products need to be recorded in our system.

To add a new agent, send their name, phone number, e-mail address, and a copy of the agent's certificate of affiliation to the agency's license with the OIC.

E-mail this information to brokerappt.commission@ghc.org. If you have questions, call Producer Relations at 1-800-337-3196.

INDIVIDUAL AND FAMILY

The ins and outs of qualifying events

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Healthplanfinder, our state's exchange. For example, qualified Native Americans and Alaskan Natives are eligible to change plans within the exchange once a month. And individuals who qualify for Apple Health may enroll year-round.

You can view all qualifying events here.

Supporting documentation

Before an applicant is accepted for coverage, however, supporting documentation that substantiates their qualifying event must be approved. Be sure to tell your clients that if they are already with, or have just left Group Health, we're likely to already have some documentation on hand, making their transition easier. If more is needed, we'll contact our mutual client to let them know what's needed to complete the enrollment process.

See information at far right for details about required documentation and procedures.

Documentation and procedures at a glance

Lost employer group coverage A COBRA offer letter or a letter from the employer (including the reason for loss of coverage and date coverage was terminated) must be provided. At least one of the documents must include the names of each family member who was on the previous plan (these are the individuals eligible to enroll). If the COBRA offer letter or employer letter doesn't include the names of those previously covered, a certificate of coverage that lists all previously covered individuals is also needed. Providing a certificate of coverage is not sufficient proof of prior coverage.

COBRA Early, voluntary termination of COBRA coverage is **not** a qualifying event. COBRA coverage must be exhausted first.

Enrolling a newborn To enroll a newborn, an official state birth certificate is required. If the parent is not a current Group Health member, proof of residency within our service area for the parent is also required.

Child-only enrollment When a parent or legal guardian only enrolls a child or children, the parent's or legal guardian's information—including their date of birth and Social Security number—must be entered into the Subscriber/Applicant section of the application. The child **cannot** be listed as the Subscriber and Dependent. The parent or legal guardian will be set up as a Subscriber for the child or children but will not have medical benefits.

Eligibility loss for Apple Health If an applicant loses eligibility for Apple Health, a term letter needs to be provided. The letter can be obtained through the Washington Healthplanfinder website.

Relocating into our service area When relocating into our service area is chosen as the qualifying event, needed documentation is:

- A certificate of creditable coverage from the prior carrier showing coverage has been terminated, and/or
- A letter from the prior carrier indicating the applicant is no longer eligible for their plan because they have left their service area.
- A copy of the applicant's passport and Visa if they're relocating from outside the U.S., and moving from a country that has national health care.

Losing employer group coverage due to turning age 26 A certificate of coverage showing loss of coverage should be included with an application. It must include the name of the parent under whom the applicant was previously covered.

Details on required documentation can be found here.

WHY MEDICARE 5-STAR MATTERS

Quality rating reflects commitment to keeping members healthy

One of the goals of the Medicare 5-star rating system is to make it easier for consumers to identify and select a high-quality Medicare plan. The Centers for Medicare & Medicaid Services (CMS) evaluates the quality of plans every year based on 50 measures, many related to how well plans do at keeping members healthy.

Here are some of the ways we help our members stay healthy, and the reasons the Group Health Medicare Advantage HMO plans have earned a 5-star rating four years in a row:

Reminders about preventive care. All of our members—no matter where they receive care or what their age—get annual letters, automated calls, and other reminders to encourage them to come in for the screenings and tests, well-care visits, and immunizations that they're due for.

Care for chronic conditions. Patients who have chronic conditions such as diabetes or hypertension consistently get the tests, treatments, and support they need to effectively manage their health issues. We also offer Living Well With Chronic Conditions workshops: six-week, in-person group sessions—and an online version as well—that help participants learn to manage chronic conditions and live healthier lives.

Focus on medication safety. CMS measures how often members with certain medical conditions get prescription drugs that are considered safe and clinically recommended for their condition—another measure we do well on. Medications on our drug formulary are selected based on safety, effectiveness, and cost. Our physicians frequently review patients' medications, and our electronic medical system at Group Health Medical Centers automatically flags any possible drug interactions.

Check-in on overall well-being. It's standard procedure for our primary care clinicians at Group Health Medical Centers to talk to their patients about improving mental health, preventing falls, managing pain, and other issues that contribute to quality of life.

Fitness made easy. Primary care clinicians at our medical centers regularly talk to patients about starting, increasing, or maintaining physical activities. We make fitness easy for our Medicare Advantage members by offering two fitness programs, SilverSneakers® and EnhanceFitness, held at fitness clubs, YMCAs, senior centers, and community centers across Washington state.

Top-rated quality extends to all our plans

While our Medicare 5-star rating receives a lot of fanfare, the quality care and service that results in that top rating is extended throughout all our lines of business, and all our plans.

That consistent quality is frequently recognized by top rankings from the National Committee for Quality Assurance (NCQA), the Washington Health Alliance, and the National Business Coalition on Health. You'll find more information about our quality ratings and awards at awards and recognition.

MEDICARE COMPLIANCE

Marketing guidelines: What the rules say about 'unsolicited contact'

If you want someone's business, or want to maintain contact with a client, you might want to connect with them, perhaps by sending them an e-mail or a direct message via social media.

Sections 70.4 and 70.5 of the Medicare Marketing Guidelines (also known as "Chapter 3" of the Medicare Managed Care Manual)—the blueprint for sales and marketing compliance programs—address unsolicited contact like this, focusing specifically on electronic communication methods.

While this type of outreach might seem like a logical step, Medicare rules say otherwise. The rules don't allow Group Health or our producer partners to initiate contact via e-mail, direct message, or other electronic means unless someone has agreed to receive those communications.

If you have obtained permission for contact, it must be event-specific. In other words, you can't treat it as open-ended permission for future contacts. Also, if the permission you have is specifically for electronic communication, you have to provide an "opt out" option for enrollees who no longer want to receive e-mail communication.

What constitutes "agreement?"

When someone comments, likes, or follows Group Health or a producer on social media—for instance on Facebook, Twitter, or Instagram—this doesn't constitute agreement to receive communications from Group Health or the producer outside of that social media forum. We're prohibited from initiating separate communications to specific social media users. Pop-ups or targeted advertisements are allowed however. We can also respond to a question or statement initiated by a Medicare beneficiary, but may not address topics beyond the scope of their question or statement.

E-mail lists and social media connections

Medicare guidelines clearly prohibit us from renting or purchasing e-mail lists for the purpose of distributing information about MA or MAPD plans. We're also not allowed to send electronic communications to individuals using e-mail addresses or via social media connections that we obtained through friends or referrals.

This is an important limitation in contrast to the allowance for unsolicited contacts via conventional mail and other print media (such as advertisements, direct mail).

Other unsolicited contacts

In general, we may not market to anyone through direct contact. This means that door-to-door solicitation, and leaving information at a residence or on a car isn't allowed. The only exception involves scheduled appointments. If you have a scheduled appointment and the person is a "no show," you can leave information at that person's residence.

Additionally, we can't approach Medicare beneficiaries in parking lots, hallways, lobbies, or other common areas, or engage in telephone or electronic solicitation. That includes leaving voice mail messages, direct messaging, or text messaging.

Oversight responsibilities

As representatives of Group Health, we are responsible for the oversight of your activities. We monitor your sales activities with a variety of methods including (but not limited to) periodic site visits, reviewing scopes of appointment, and researching complaints. As the plan sponsor, we are required to self-report any compliance issues we become aware of.

Although these deficiencies can be minor, or easily corrected—a trend or increase in deficiencies can have a

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MEDICARE COMPLIANCE

Don't miss new training requirement

To continue to represent Group Health Medicare Advantage products or any Medicare Advantage plan, we've recently learned that producers will need to complete the Fraud, Waste, and Abuse (FWA) training required by the Centers for Medicare & Medicaid Services (CMS). This is in addition to general compliance training.

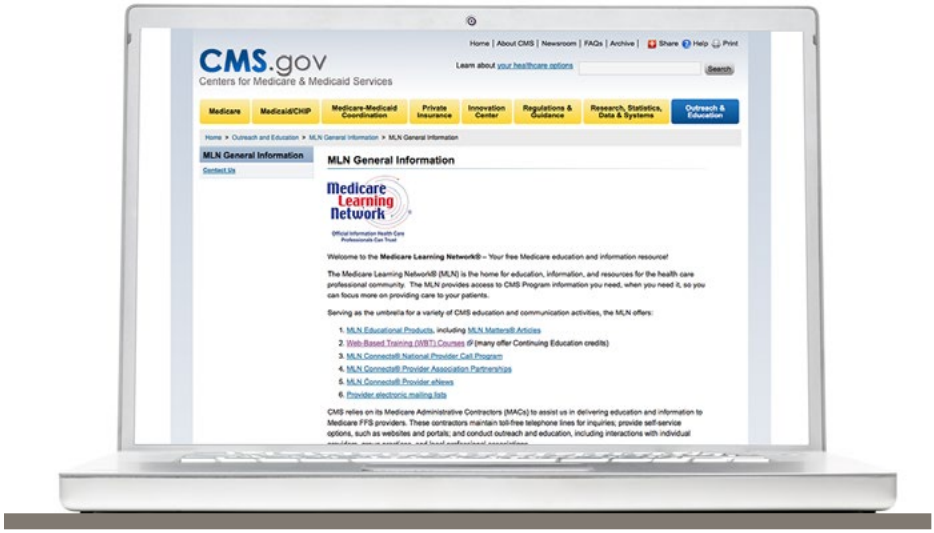
The purpose of the training is to ensure that everyone who represents Medicare products understands the rules and regulations.

We are collaborating with our Medicare Certification training vendor, Gorman Health Group, to see if CMS will allow them to include the FWA training as part of our 2016 Annual Medicare Certification training which will be available in late August. Watch the August *Producer Pulse* for an update about this.

In the meantime, you can access the training at the CMS Medicare Learning Network. Select "Web-based training" and the course that's called "Medicare Parts C and D Fraud, Waste and Abuse Training and Medicare Parts C and D General Compliance Training (February 2013)."

If you take this training through CMS, be sure to retain your Compliance/ FWA certificate since we will request that you upload it within our Medicare Certification Training.

It's important that all producers who want to represent Group Health Medicare Advantage 2016 products obtain this required training by Oct. 1.



Marketing guidelines: What the rules say about 'unsolicited contact'

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variety of consequences, including adversely impacting our Star Ratings, Corrective Action Plans, Notices of Non-Compliance, and Civil Monetary Penalties. Because it benefits all of us to comply with all the Medicare rules and regulations, we have a number of policies and procedures that address disciplinary actions for our representatives. They range from minor actions such as coaching/ follow-up, to more severe actions such as removal of appointment and loss of commissions.

Group Health is grateful for your continued professionalism and attention to detail that make us all successful, and compliant. If you have questions about any Medicare compliance issue, please contact your sales representative.

LARGE GROUP

The PPP team: Helping clients understand and influence employee health trends

Group Health offers a tool for large group employers with 1,000 or more enrollees. Plan Performance Profile (PPP) meetings are designed to help employers understand how their employees and dependents are using services offered by their health plan, and what strategies can be put in place to influence health improvement.

As part of the PPP program, Group Health medical directors and others meet annually with these large group plan sponsors. They review medical claims and clinical experiences of staff that use Group Health's integrated care delivery system.

"Purchasers have told us for some time that they are interested in more transparency," says David Grossman, MD, who is leading this program. "They want to know about real outcomes. They want to know what we are doing to improve their employees' health."

The profile includes:

- A three- to five-year look at utilization and per-member-per-month (PMPM) expense, and a comparison to the Group Health commercial book of business.
- Recommendations that address utilization trends that could be improved.
- A review of where participants are receiving care, as well as virtual care strategies.
- Aggregate results for participants who have completed the Health Profile, clinic-based and on-site programs and classes, and engagement in other wellness programs.
- A look at group-specific HEDIS (Healthcare Effectiveness Data and Information Set) and quality measures. (HEDIS is a tool used by most health plans to measure performance in areas of care and service.)
- A summary of Group Health initiatives underway to reduce medical trend.

"Employers are looking for this type of information and insight," says Kevin Klein, Health Strategies manager. "Because Group Health is an organization that has both health plans and health care, we can offer a clinical expertise that's rare in the industry."

Dr. Grossman adds, "We actually see many patients—their employees—so we can take the high level data and bring it down to what's happening in the exam room with real people."

For more information on this program, contact your account executive.

Successful collaboration with SEIU featured in *New York Times*

Group Health's successful collaboration with SEIU Healthcare NW Health Benefits Trust was recently featured in an op-ed article that appeared in the *New York Times*. Group Health plans are offered to members of SEIU 775.

Written by Ezekiel J. Emanuel, an oncologist, author of *Reinventing American Health Care*, and frequent contributor to the *New York Times*, the article described a successful campaign to reduce emergency room use among SEIU 775 membership. Most members are between ages 46 and 64 and their primary language is not English.

The campaign reduced emergency room use by 27 percent over four years. How did Group Health and SEIU accomplish a reduction in ER use? A four-pronged approach included these elements:

- A $100 cash incentive if workers:
  - (1) Signed up for MyGroupHealth, our secure online portal which allows patients who get care at Group Health clinics to e-mail their doctor, order prescriptions, view lab results, and access health information;
  - (2) Completed a health risk assessment; and
  - (3) Completed preventive primary care and dental appointments.
- Increased the cost of an emergency room visit to $200, and kept the cost of an urgent care visit at $15.
- Began a social media campaign to educate workers about the proper use of the emergency room, and when to use urgent care.
- Reminded workers of the locations and hours of urgent care centers, and the availability of a 24/7 consulting nurse by phone.

The program prevented 1,200 unnecessary ER visits since 2010.

Dr. Emanuel concluded, "The good news is this strategy is not neurosurgery. It is a relatively simple set of interventions that could easily spread to almost every other employer and insurer."

Improving quality by sharing our 'secret sauce' with network providers

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"By sharing the tools and techniques we use to achieve gold-standard care at Group Health clinics with providers in the community, we are extending that level of quality to all our members, no matter where they receive care," says Wilhelmina Delostrinos, manager, Quality Improvement and Accreditation, who is leading this program.

Some of our quality improvement tools, such as patient outreach lists and clinical guidelines, are already used by most of our primary care providers at Group Health Medical Centers and in our network to provide needed preventive care at every patient encounter (also known as opportunistic care). The quality improvement program involves sharing even more of that secret sauce with our network providers.

"Providers see us as their peers, not as a health plan, and they know that we're a recognized leader in providing high-quality care," says Delostrinos. "They want to know how we've achieved that, and what steps they can take to follow in our footsteps. They're interested in everything from how our care teams maximize opportunistic preventive care to how we utilize our electronic medical record system for population health management and performance reporting."

Performance and quality discussions

Since 2012, Group Health quality consultants and health plan medical directors regularly meet with the leaders of contracted provider groups across Washington state to discuss their performance on the National Committee for Quality Assurance's (NCQA) HEDIS quality measures and share approaches to quality improvement. HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized measures used by more than 90 percent of health plans in the nation to rate quality of care, access to care, and member satisfaction.

Part of providers' interest in quality improvement stems from health care reform and upcoming payment reform, says Delostrinos. "Reimbursement for health care services is beginning to revolve around incentives for improving health outcomes and the patient experience, and also affordability. Those who succeed will excel at evidence-based, patient-centered medical management. By sharing our proven tools and approaches, we're giving our contracted providers a head start on getting ready for that."

Bonuses introduced for quality improvements

Another component of our statewide quality improvement effort that we started in 2013 is an incentive program that awards bonuses to providers who raise their scores on select HEDIS quality measures. That paid off for the initial four provider groups who piloted the program. They doubled their quality improvement efforts and saw a hike in their HEDIS rates.

"In 2014, we expanded the quality incentive program to include eight provider groups and have seen similar results in improved HEDIS rates. Because of the success of this program

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Rallying preventive care advocates in Eastern Washington and beyond

In 2013, we began partnering with network imaging facilities and eye care specialists in Eastern Washington to do direct outreach to Group Health members who are due for breast cancer screening and/or diabetic retinal exams. These are two areas where we've found that preventive screening can make a significant difference.

This year, we're expanding that effort to include colorectal cancer screening, another important area of focus, and we're extending the initial outreach strategy to Western Washington.

CareClinic expands with a new location

CareClinic , the retail walk-in clinic collaboration between Group Health and Bartell Drugs, will expand this summer. A new clinic will open in the Seattle suburb of Sammamish at the Bartell Drugs location on 228th Avenue. It joins existing clinics in Seattle (Ballard and University Village) and Bellevue (Crossroads). Plans are in development to bring CareClinic to even more Bartell stores in the future.

"Customers and patients have expressed tremendous satisfaction with the quick and high-quality care they've received at the CareClinic," says Justin Teruya, director, Innovation and Business Development, Group Practice Division. "We've had the opportunity to serve more than 10,000 patients since opening and the feedback we hear most often is 'this is so convenient and just works.' The question we hear most frequently is, 'When will a CareClinic be coming to my local Bartell store?' We're happy to say that a CareClinic will be serving more neighborhoods very soon."

Group Health and Bartell Drugs joined forces in 2014 to bring a retail health care experience to neighborhoods by establishing CareClinic. Staffed by board-certified nurse practitioners or physician assistants, CareClinic is open to Group Health members and non-members alike (age 2 and older). It's a convenient resource for addressing minor medical needs such as sore throats, urinary tract infections, allergies, ear aches, and vaccinations. Most insurance is accepted.

Along with Group Health Medical Centers, in- and out-of network providers, and even online diagnosis with CareNow—CareClinic offers employers and their employees yet another avenue to convenient, quality care.

Improving quality by sharing our 'secret sauce' with network providers

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in its first two years, in 2015 we're offering the incentive program to 17 key provider groups throughout Washington state," says Delostrinos.

The ultimate goal of the quality improvement program is to identify high-performing providers within our network— providers who practice like we do and achieve similar results in improving the health of their patients and their communities. Plan designs, enhanced benefits, and other incentives are being introduced to encourage our members to use those high-performing providers.

"We value our partnerships with the providers in our community network, and we want all of them to succeed and thrive in the new world of payment reform," says Delostrinos. "The end result of their success will be high-quality, affordable care for all Group Health members."

GUEST COLUMN:

A big shift in 2016 for groups with 51–100 employees

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What is this huge shift? I'm speaking of the reclassification of businesses with 51 to 100 employees. On Jan. 1, 2016, these employers will move from the large group market to small group. Each of the impacted groups will be required to make a health plan purchasing decision that's new and different from what they've purchased in the past.

When a change this big comes along, I believe that a successful outcome is the result of collaboration. The producer community is our valued partner in this endeavor, and it's critical in the months ahead that we work together to reach out to and educate our mutual clients.

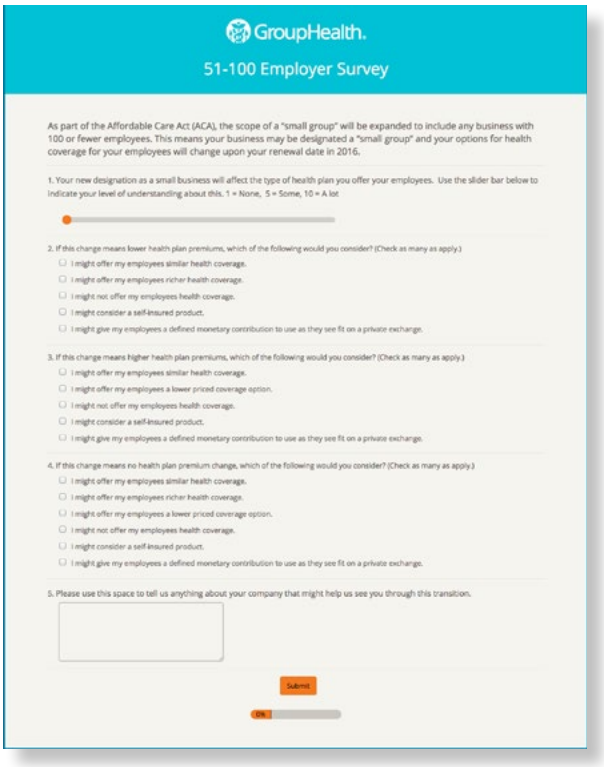
At Group Health, we've already spent months preparing for this change. There are three key points we'll need to share with clients:

- They will need to choose a completely new health plan.
- That plan will have predetermined benefits, unlike the plan they've been able to customize in the past.
- They'll have a condensed timeframe—from receipt of their renewal to their renewal decision—in which to make the choice.

How we can ease this transition

Renewal dates for these reclassified groups could come at any time in 2016, but the largest renewal month will be the Jan. 1 renewals. That means that we have a few critical months to begin a conversation with them about this pending change.

To arm you with the tools for these conversations, we have a few things in place.



GroupHealth.

51-100 Employer Survey

As part of the Affordable Care Act (ACA), the scope of a "small group" will be expanded to include any business with 100 or fewer employees. This means your business may be designated a "small group" and your options for health coverage for your employees will change upon your renewal date in 2016.

1. Your new designation as a small business will affect the type of health plan you offer your employees. Use the slider bar below to indicate your level of understanding about this. 1 = None, 5 = Some, 10 = A lot

2. If this change means lower health plan premiums, which of the following would you consider? (Check as many as apply.)
- I might offer my employees similar health coverage.
- I might offer my employees richer health coverage.
- I might not offer my employees health coverage.
- I might consider a self-insured product.
- I might give my employees a defined monetary contribution to use as they see fit on a private exchange.

3. If this change means higher health plan premiums, which of the following would you consider? (Check as many as apply.)
- I might offer my employees similar health coverage.
- I might offer my employees a lower priced coverage option.
- I might not offer my employees health coverage.
- I might consider a self-insured product.
- I might give my employees a defined monetary contribution to use as they see fit on a private exchange.

4. If this change means no health plan premium change, which of the following would you consider? (Check as many as apply.)
- I might offer my employees similar health coverage.
- I might offer my employees richer health coverage.
- I might offer my employees a lower priced coverage option.
- I might not offer my employees health coverage.
- I might consider a self-insured product.
- I might give my employees a defined monetary contribution to use as they see fit on a private exchange.

5. Please use this space to tell us anything about your company that might help us see you through this transition.

Submit

An employer survey. We're launching one this month to help us understand the priorities of these groups. Are they reconsidering their ability to offer a health plan? Would they consider a self-insured plan offering? Do they want to consider a private exchange? Their answers to these questions and others will help guide marketing activities and conversations with these employers in the months ahead.

Our 2016 health plans. Our small group health plan offerings for 2016—currently filed with the OIC—were designed with this new segment of the small group market in mind. We're offering a larger portfolio of plans that includes the range of benefits this group of employers traditionally seeks.

Education for producers. A significant portion of our fall workshops in September will be about this segment of the market. We'll give you the information you need to have a productive conversation with these employers—one that will help them choose a plan for 2016 that works for them, and for their employees.

Working together

Fall is always a busy time for all of us. With this latest change, we know that much work will need to happen in a very short time. We're here to help you and our mutual clients through this transition however we can. By working together, I know we'll manage this latest shift, and help our clients do the same.

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
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- Matt Cotto, cotto.m@ghc.org
  Producer Operations Analyst
- Lori Stanford, stanford.l@ghc.org
  Producer Relations Consultant

SAVE THE DATE

Fall Producer Workshops

SEPT. 22 | TACOMA
SEPT. 23 | SEATTLE
SEPT. 24 | BELLINGHAM
SEPT. 24 | EVERETT
SEPT. 28 | SPOKANE
SEPT. 30 | WALLA WALLA
OCT. 1 | RICHLAND
OCT. 2 | YAKIMA

Contact us

Phone
206-448-4384 or 1-800-337-3196

Press 1 for Producer Operations (commissions, licensing, and appointments). **Press 2** for Producer Relations (producer website and events)

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