

Public Employees Benefits Board Meeting

June 24, 2015

Public Employees Benefits Board Meeting

June 24, 2015

1:30 p.m. – 3:30 p.m.

Health Care Authority
Sue Crystal Rooms A & B
626 8th Avenue SE
Olympia, Washington

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TAB 1

AGENDA





Public Employees Benefits Board

June 24, 2015

1:30 p.m. – 3:30 p.m.

Health Care Authority
Cherry Street Plaza
Sue Crystal Rooms A & B
626 8th Avenue SE
Olympia, WA 98501

Conference Call Dial In: 1-888-450-5996, Participant Passcode: 546026

1:30 p.m.*	Welcome and Introductions		Dorothy Teeter	
1:40 p.m.	Approval of April 15, 2015 Minutes	TAB 3	Dorothy Teeter	Action
1:45 p.m.	 Legislative Update  Accountable Care Program (ACP) Update		Lou McDermott	Information
2:00 p.m.	UMP Bundled Payments for Total Joint Replacement	TAB 4	Marcia Peterson	Information
2:20 p.m.	SmartHealth Update	TAB 5	Scott Pritchard	Information
2:50 p.m.	Policy Recommendations	TAB 6	Barb Scott	Information
3:05 p.m.	Affordable Care Act (ACA) Update  Cadillac Tax  Play or Pay	TAB 7	Mary Fliss	Information
3:20 p.m.	Public Comment			
3:30 p.m.	Adjourn			

*All Times Approximate

The Public Employees Benefits Board will meet Wednesday, June 24, 2015, at the Health Care Authority, Sue Crystal Rooms A & B, 626 8th Avenue SE, Olympia, WA. The Board will consider all matters on the agenda plus any items that may normally come before them.

Prior to the meeting, pursuant to RCW 42.30.110(I), the Board will meet in Executive Session to "consider proprietary or confidential non published information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026." The Executive Session will begin at noon on June 24, 2015, and be concluded no later 1:30 p.m.

No "action," as defined in RCW 42.30.020(3), will be taken at the Executive Session.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

Direct email to: board@hca.wa.gov

Materials posted at: <http://www.pebb.hca.wa.gov/board/> no later than COB 6/22/15.

PEB Board Members

Name	Representing
Dorothy Teeter, Director Health Care Authority 626 8 th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-1523 dorothy.teeter@hca.wa.gov	Chair
Greg Devereux, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 greg@wfse.org	State Employees
Myra Johnson* 6234 South Wapato Lake Drive Tacoma, WA 98408 V 253-473-0789 mjohnson@washingtonea.org	K-12 Employees
Gwen Rench 3420 E Huron Seattle WA 98122 V 206-324-2786 gwenrench@covad.net	State Retirees
Mary Lindquist 4212 Eastern AVE N Seattle WA 98103-7631 C 425-591-5698 marylindquist@comcast.net	K-12 Retirees

PEB Board Members

Name	Representing
Vacant	Benefits Management/Cost Containment
Yvonne Tate 1407 169 th PL NE Bellevue WA 98008 V 425-417-4416 ytate@comcast.net	Benefits Management/Cost Containment
Marilyn Guthrie 1640 W Beaver Lake DR SE Sammamish WA 98075 V 206-715-2760 marilynguthrie52@gmail.com	Benefits Management/Cost Containment
Harry Bossi* 160 E Soderberg RD J-27 Allyn WA 98524 V 360-689-9275 udubfan93@yahoo.com	Benefits Management/Cost Containment
Legal Counsel Katy Hatfield, Assistant Attorney General 7141 Cleanwater Dr SW PO Box 40124 Olympia WA 98504-0124 V 360-586-6561 KatyK1@atg.wa.gov	

*non-voting members

6/19/15



Washington State Health Care Authority
Public Employees Benefits Board

P.O. Box 42713 • Olympia, Washington 98504-2713
360-725-0856 • TTY 711 • FAX 360-586-9551 • www.pebb.hca.wa.gov

2015 Public Employees Benefits Board Meeting Schedule

The PEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501. The meetings begin at 1:30 p.m., unless otherwise noted below.

January 29, 2015 (Board Retreat) 9:00 a.m. – 3:00 p.m.

March 31, 2015 (10:00 a.m. – 12:00 p.m.)

April 15, 2015

May 27, 2015

June 24, 2015

July 8, 2015

July 15, 2015

July 22, 2015

If you are a person with a disability and need a special accommodation, please contact Connie Bergener at 360-725-0856

Updated 7/15/14

TAB 2

PEB BOARD BY-LAWS

ARTICLE I

The Board and its Members

1. **Board Function**—The Public Employee Benefits Board (hereinafter “the PEBB” or “Board”) is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB’s function is to design and approve insurance benefit plans for State employees and school district employees.
2. **Staff**—Health Care Authority staff shall serve as staff to the Board.
3. **Appointment**—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.
4. **Non-Voting Members**—Until there are no less than twelve thousand school district employee subscribers enrolled with the authority for health care coverage, there shall be two non-voting Members of the Board. One non-voting Member shall be the Member who is appointed to represent an association of school employees. The second non-voting Member shall be designated by the Chair from the four Members appointed because of experience in health benefit management and cost containment.
5. **Privileges of Non-Voting Members**—Non-voting Members shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.
6. **Board Compensation**—Members of the Board shall be compensated in accordance with RCW [43.03.250](#) and shall be reimbursed for their travel expenses while on official business in accordance with RCW [43.03.050](#) and [43.03.060](#).

ARTICLE II

Board Officers and Duties

1. **Chair of the Board**—The Health Care Authority Administrator shall serve as Chair of the Board and shall preside at all meetings of the Board and shall have all powers and duties conferred by law and the Board’s By-laws. If the Chair cannot attend a regular or special meeting, he or she shall designate a Chair Pro-Tem to preside during such meeting.
2. **Other Officers**—(*reserved*)

ARTICLE III
Board Committees

(RESERVED)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.
2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.
3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.
4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.
5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 10 days prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. Minutes summarizing the significant action of the Board shall be taken by a member of the HCA staff during the Board meeting, and an audio recording (or other generally-accepted) electronic recording shall also be made. The audio recording shall be reduced to a verbatim transcript within 30 days of the meeting and shall be made available to the public. The audio tapes shall be retained for six (6) months. After six (6) months, the written record shall become the permanent record. Summary minutes shall be provided to the Board for review and adoption at the next board meeting.
6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board Members at the meeting for the minutes.

ARTICLE V
Meeting Procedures

1. Quorum— Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.
2. Order of Business—The order of business shall be determined by the agenda.
3. Teleconference Permitted— A Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, A Member may attend a meeting by telephone conference call or video conference when in-person attendance is impracticable.
4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at board meetings may also occur in conjunction with a public hearing or during the board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.
5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .
6. Representing the Board's Position on an Issue—No Member of the Board may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.
7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted.
8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order [RONR]. Board staff shall provide a copy of *Robert's Rules* at all Board meetings.
9. Civility—While engaged in Board duties, Board Members conduct shall demonstrate civility, respect and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.
10. State Ethics Law—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW.

ARTICLE VI

Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.
2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

TAB 3

Public Employees Benefits Board
Meeting Minutes

D*R*A*F*T

April 15, 2015
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:45 p.m. – 3:30 p.m.

Members Present:

Dorothy Teeter, Chair
Greg Devereux, State Employees
Yvonne Tate, Benefits Management / Cost Containment
Harry Bossi, Benefits Management / Cost Containment
Gwen Rench, State Retirees
Mary Lindquist, K-12 Retirees
Marc Provence, Benefits Management / Cost Containment
Marilyn Guthrie, Benefits Management / Cost Containment
Myra Johnson, K-12 Employees
Katy Hatfield, Legal Counsel

Call to Order

Dorothy Teeter, Chair, called the meeting to order at 1:45 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed. Myra Johnson, the new PEB Board member, was introduced. Ms. Johnson is President of the Clover Park Education Association.

Approval of PEBB Meeting Minutes

It was moved and seconded to approve the July 16, 2014 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

It was moved and seconded to approve the July 31, 2014 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

It was moved and seconded to approve the October 22, 2014 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

Lou McDermott, PEB Division Director and **Mary Fliss**, PEB Division Deputy Director provided a legislative update. Mary reported that after seven years of effort, Senate Bill 5466 was passed and on its way to the Governor for signature. SB 5466 is the PEBB Technical Correction bill that clarified employee eligibility for benefits from the PEBB Program and conforming the eligibility provisions to federal law.

Lou updated the Board on other PEBB Program impacted high priority bills. House Bill 1740 would change how we currently review counties wishing to join the PEBB Program. Today when a county applies, we have a Litmus test based on the size of the county. For smaller counties, we look at age and sex for a risk adjustment factor. Are they more expensive to insure than the average PEBB member, just as expensive, or less expensive. If they're just as expensive or less expensive, they are approved. If they are more expensive, they are not approved. HB 1740 would remove that Litmus test and allow all counties with under 5,000 employees into the PEBB Program, which is all counties except King. It also allows HCA to charge the difference. We would determine how much additional money the counties are costing the agency over the average PEBB member and then create a surcharge to those counties so they carry their own weight. That bill is in the House budget and considered Necessary to Implement the Budget (NTIB). We are monitoring this bill.

Senate Bill 6096 would take the \$25 tobacco surcharge currently assessed and increase it to \$100. That money would go to cancer research. This would have a substantive impact on some of our members. We are monitoring this bill.

ESSB 5077 is the Operating Appropriations Budget out of the Senate and is including a proviso that basically removes spouses from PEBB Program eligibility if they have other insurance available to them. It is in the Senate budget but not the House budget.

Gwen Rench asked about ESSB 5077 which also includes a \$40 reduction in the Medicaid premium, reducing the current premium of \$150 to \$110. Lou indicated it's too difficult to predict if we think it will pass or not.

Senate Bill 5976 would bring all retiree and active K-12 employees into the PEBB Program. It would create another board called SEBB. There would be infrastructure requirements within PEBB to be able to facilitate this effort. The effective date would be January 1, 2017. This would be a huge workload for the agency. HCA is closely monitoring this bill.

Lou McDermott also provided an update on the Accountable Care Program (ACP). HCA is negotiating with three vendors, Puget Sound High Value Network (Virginia Mason plus other partners), the Providence network, and the University of Washington. We are looking at clinical and quality goals and trend guarantees. There are many details in each one of those concepts. There is a lot to do to get from general framework to the final product.

Greg Devereux: Are these three vendors part of UMP? How do they function?

Lou McDermott: Yes, they are currently part of the Regence network, but as an Accountable Care Program (ACP). They are affiliated with Regence by contract. The ACP product is a tighter network. The plan design would discourage members from going out of network. The member signs up for the ACP product, understands the network and the restrictions, and the financial benefits and consequences of in network versus out of network. The goal is to create a premium differential to encourage members to select the ACP. The vendor then controls trend, high quality, and ensures that Bree criteria are being implemented. There are more requirements with the ACP and a stiff penalty for going outside the network. Services covered will be the same.

Greg Devereux: How does this impact self-funding?

Lou McDermott: HCA will still write the checks, however with the trend guarantee, there will be upside and downside risk to the delivery system. As an example, if the delivery system spent \$100 last year, and then through this arrangement we determined they are going to spend \$110 the next year, but they actually spend \$115, then the delivery system would owe us \$5. They would have to pay the amount that they were over. That's the downside risk. The upside risk or upside gain would be if they came in under what they said they were going to and we would split a percent of that amount. That's the general framework. All of this is tied to quality. If a vendor did well on the financial terms but not so well on the quality terms, it would impact the reimbursement.

Mary Fliss, PEB Division Deputy Director: I would add that we are anticipating up to five plan options for our members in 2016 if we come to terms with all three of these ACPs. We would have UMP Classic, UMP CDHP/HSA, and UMP ACP one, two, and three. We're excited about creating some promotional materials so our members can understand and appreciate the value of an enhanced member experience. We're having member experience criteria built in, as well as the idea of trend management and quality management. We want our members to understand the immense advantage we anticipate these plans will have for them starting January 1, 2016.

Dorothy Teeter: As Lou pointed out, we're in negotiations now. As this unfolds, we'll make sure we continue to keep you informed.

Renee Bourbeau, PEB Division Benefits Accounts Manager: Renee provided an update on 2015 open enrollment activities. This was the first open enrollment in which 53,000 employees and non-Medicare subscribers, who cover a spouse or registered domestic partner on their PEBB Program medical coverage for 2015, had to reattest whether the spousal coverage premium surcharge applied to them for the next plan year.

The PEBB Program heavily communicated the spousal reattestation via an October mailing and throughout open enrollment. Communications emphasized the usage of My Account to reattest to the spousal surcharge. Our partners (agencies, higher institutions, and community and technical colleges) also played a significant role in assisting with the attestation process by promoting My Account, providing paper forms upon request, and sending reminders to their employees. As of December 31, 2014, 90% of our subscribers responded to the spousal reattestation.

Subscribers with spouses who are not employed or receiving any employer-sponsored coverage will not have to reattest to the spousal surcharges for coverage year 2016. This means that approximately 20,000 members will need to reattest compared to 53,000 members.

The PEBB Program website was revised to simplify use and navigation for self-pay subscribers and employees. New web pages and detailed information were also created on the HCA website, in addition to 20 new letters, forms, and 95 Frequently Asked Questions that were either posted for subscriber use or for agencies to use as talking points with their employees. We also included information on transgender services.

Staff travelled to 26 benefits fairs across the state and shared information about open enrollment and spousal reattestation. Twenty-six ListServ messages were distributed to agency personnel, payroll, and benefits office staff throughout open enrollment for them to forward to their employees.

The wellness activities required in 2014 were structured to support a high success rate by only requiring employees to do three things to earn the \$125 wellness incentive. About 76,000 subscribers out of 130,000 earned the \$125 wellness incentive. Major effort went in to working with the health plans to put a system in place to administer the wellness incentive.

There were minor changes in the active pool for account changes at Open Enrollment. Group Health Cooperative enrollment decreased slightly but increased in the CDHP/HSA.

For the Medicare pool, changes are driven by increase in enrollment. For the Medicare retiree pool, UMP continues to be the plan with the highest enrollment with 60% and Group Health Medicare with 25%.

Scott Pritchard, PEB Division Health Management Coordinator: Scott and Logan Van Meter and Nancy Board of Limeade provided an update on SmartHealth. Limeade is the successful vendor selected to provide a health and wellness portal for the SmartHealth Program. After working with the PEB Board and Limeade, SmartHealth launched January 1, 2015. Over 35,000 state employees have already signed up. Governor Inslee participated in a video, which is on the SmartHealth website, to kick off the program.

What are our SmartHealth Program goals? What are we trying to accomplish? Year one is engagement, year two is measuring improvement and individual population health, and year three is to see a positive impact on the medical cost trend.

Year One - engage the workforce in SmartHealth. We need to get the word out, get people to sign up online, and to participate. We are measuring the percent of people we're trying to reach and we are able to measure closely how many people we're reaching. We will look at population health and individual health. We want healthy people doing healthy things to improve their health. We want the program to help people identify their health risks and either reduce or eliminate them. We also want to have program options to manage chronic conditions.

Year Two – improve individual and population health.

Year Three (and Five) – Achieve a positive impact on the medical cost trend.

The SmartHealth Program has a financial incentive, which is intended to get the person's attention. Financial incentives are one of the best ways to get people's attention and to direct them to something of value. The SmartHealth Program has significant value, but each person, as they try it, will be their own judge of that value. We strove to create equal incentives for eligible subscribers across all the health plans so everyone can attain the same incentive with about the same amount of work.

The \$125 incentive is earned by taking the Well-being Assessment and by participating in activities of your choice. There are multiple choices that change throughout the year. 2,000 points must be earned by June 30 in order to qualify for the incentive. The \$125 comes off your plan medical deductible, or if you're in a Consumer Directed Health Plan with an HSA, it goes directly into the HSA. You earn it if you are still PEBB Program eligible in January.

Logan Van Meter, Limeade, did a demonstration of how SmartHealth works. She walked the Board through the Well-being Assessment and how to navigate the program. Once the Well-

being Assessment (WBA) is completed, additional information appears that applies to you specifically based on your WBA. You cannot earn points until you complete the WBA. To date, approximately 35,000 members have completed their assessments. There is also information from your communications team to give additional information on eligibility and the requirements.

The infographic page explains how the program works. There are three levels of points: You Earned It! (2,000); Keep Going! (2,500); and You Arrived (3,000).

Assessments often give you things to work on and you can also see what you are doing well. We want to keep healthy people healthy, so SmartHealth starts out by sharing three things that you are doing well to get you on the right track. You can view your results; and throughout the program year if you click on the assessment, it will automatically bring you to the results. You can get the overall results score and an explanation of what that score means – how well you're doing across all six life areas. You will see your top three strengths and the top three things you need to improve. It is based on a 1 to 5 Likert scale. Your options will be based on your personal health plan. It's very personalized and a unique experience for everyone so that they can work on the things that they need to work on with the resources that they have available to them. The SmartHealth Program allows you to click back and forth to see what you've already done.

SmartHealth activities span all areas of well-being. Some are activity-based, exercise activities, but others focus around your work-life balance, your emotional health, or just enjoying life. Some may be recommended and some are just available for you to work on. Once you select an activity, you will start tracking for the duration of that activity. You will be able to see the day you completed each activity.

If you have indicated health risks based on your Well-being Assessment, you will see that information and your scores associated with that risk. There will be tiles you can select to work on that risk. As you continue onto the next program year, you'll be able to see how you've improved in that score year over year.

With SmartHealth, there's always something different to keep people engaged. There are also activities that last all year, including dental and others like Track Your Activity.

Scott Pritchard: There are benefits that are underused, including programs to reduce risks and to manage chronic conditions. Preventive dental care was underused even though there was no out of pocket cost. We are hoping that this particular activity will increase the utilization of preventive dental care.

Myra Johnson: How did you come up with the point value for each of the activities? Can you elaborate on the verbiage under preventive dental care?

Logan Van Meter: Regarding the verbiage under preventive dental care, the number of comments indicates the number of people who have joined this activity and participating in it. With dental care, there are zero comments because this is a health plan activity. Health plan activities will be zero because it's personal and private information. You are not able to leave comments. It is actually verified from the health plan. You can add it to your plan the same way you would with anything else, but there's no tracker. You'll be able to see it in your plan once you've actually had your dental visit and that claim is filed. That information is securely transferred to the site to load those points automatically.

Scott Pritchard: Limeade helped us determine the point values based on their experience. The goal was to find a middle ground, to make this easy enough to get those 2,000 points. On the other hand, the goal is also to make this a behavior change program where people do a few hard things and change behaviors. We will continue to watch and adjust. The points were chosen based on how easy to the activity was to complete, how much change would occur, and what's the right number for the population as a whole.

Marc Provence: Is there a convenient way to share the health risk information with my primary care provider? Could I print it out and carry it with me to my next visit?

Logan Van Meter: Yes, You can print out the results.

Marc Provence: Is there any way for members to provide feedback with regard to why it might have been difficult to accomplish a particular task? I was thinking about the low dental participation. Maybe it has to do with access to a dentist who speaks my language or something similar. Is there an opportunity to do that?

Logan Van Meter: Absolutely. The comments are very telling. I scroll through all of our activities and see what people are saying and gather that feedback. There is a support and feedback section which automatically goes into the Limeade customer service queue. It gets marked as feedback for us to respond to. If people are having trouble or confused by an activity, they've called customer service and we've been able to adjust any of the activity tile language to make that more clear.

Mary Lindquist: Do you have an estimate on how much face time a person has to have with this program in order to get to the 2,000?

Logan Van Meter: It depends on which activities you've joined. We actually have the ability to connect your physical activity device or free apps, if you've got Map My Run, for example, on your phone. Any of our activity challenges that are appropriate for an activity device will give you an indicator to connect a device. It will take you to the settings page which lists all of the different apps and devices that SmartHealth automatically syncs with. In some cases, you can earn points every week without actually having to go into the site as long as your activity is syncing each week.

Scott Pritchard: Mary, we don't want this to be intrusive. Once you've done the assessment, which is around twenty minutes, and once you're familiar with the program, I would estimate a couple minutes a day would be necessary. If you forget a couple of days, you can track back up to two weeks. The important part is how much of your life it takes changing to healthy activities and that's really the point of all this is are you changing your life.

Logan Van Meter: Once an activity comes to an end, there is a warning email. If you haven't deactivated your emails, it will say, "This is coming to an end, go in and track." Then there's actually a three-day grace period after the end of the activity to go back and track the two weeks in the past if you forgot a day.

Nancy Board, Limeade: We hope that you go in more than once a week or more than once a month. It's about behavior change. Behavior change is developing new habits. Our goal is to get everyone to engage in the platform on a regular basis with the hopes that there is enough engaging information there that people want to go back.

Harry Bossi: Is there a SmartHealth app for phones?

Logan Van Meter: It's mobile-optimized so you can use it on your smart phone or tablet, but it is not yet an app that you can buy in the app store.

Scott Pritchard: What I can tell you is that if you view this on your tablet or your smart phone, it really shows up well and is easy to use.

Logan Van Meter: We are also able to target by agencies and institutions of higher education. Through the Wellness Coordinators of Washington Wellness, we are able to target and create that unique experience for every member down to the agency, sub-agency, and institution level so that any of the wellness programs they have there, any of the challenges that they're putting on, they can integrate that into SmartHealth. You see something that's specific to you, your workplace, and your agency.

Nancy Board: We've been sitting for the last hour and Limeade and SmartHealth is not just a wellness program. It's also an engagement program. In order to really live our values and demonstrate engagement, I'm going to ask everybody to stand up and do what we call, "Take a Stand." This is one of our activities. It's something that many of us sometimes forget to do, or don't give ourselves permission to do. It's good for our health and well-being to take a break to stop and think about what we're doing and to get healthier.

Scott Pritchard: We are serious about privacy. We have the HIPAA laws we must conform to and we work hard to protect it. To assist with protecting the information, we report everything in aggregate. We have rules about how small an aggregate number can be so that no one can identify you, unless you choose to self-identify. Data is provided in aggregate form and we protect any of those aggregate pieces of data with a lower number so that there is no chance that we can figure out an individual from an aggregate number.

We did set some metrics. Year One is about participation. There are two parts. The first part is reach. How many people did we get involved, and the second part is impact. Once they're involved, what happens? Now we're in the reach area, trying to get people involved. We have a very aggressive set of goals. Our goal is 70% registered subscribers out of those eligible for the incentive, which is approximately 130,000 people. We want 60% of those registered to earn the incentive. Once the Well-being Assessment is completed, it's important to complete activities, selecting activities that fit your life. After a month or two, if you're serious about the activity, you've made a change.

Engagement is different than participation. Engagement means are you continuing to work at SmartHealth, and the engagement measure that Limeade tracks is a two-week engagement over a rolling two weeks. What percent of the population has come to the site and done something? We want to reach 25% engagement up to June 30, inside the financial incentive. After June 30, we want to reach 15% engagement. Eventually we want engagement throughout the entire year and we have strategies to do that. Our overall engagement of PEBB-insured employees is 131,680 members. The number of registered members is 37,000+. As of April 13, 18,000 members have been active in the two-week time period. Through April 6, there were 35,461 completed Well-being Assessments. Our goal is 70,000. The IVR reference is a term about voice recognition. For members unable to do this online, there is a really good telephonic alternative. Forty people have done that.

One of the ways to look at a population is for individuals - how many have one risk, how many have zero, how many have one, two, three, and more than four risks? It's a common way of looking at a population. The goal is to move more people into the zero to one risk category. The first wave of people who joined SmartHealth are on the healthier side. There are a lot of people with zero and one risks. We want to keep healthy people healthy and provide activities that appeal to them. We also want to attract people who have more health risks and keep them involved. We'll be watching this going forward. We expect that this will change and those with three and four risks will increase.

The first 35,000 members skew a little bit healthy, so the health risks also skew on the healthy side. The top risks are healthy weight and back health. Back Health is often the number one reason that adults visit a primary care provider. Sleep is becoming a huge issue. Exercise, fitness, and healthy blood sugar are things we will be looking at. It will help us understand our population and decide where to put our resources. We also collect employee comments to see what our members like, what do they dislike, what are they saying?

In summary, Limeade tells us we got off to a strong start. We communicated well and members knew how to access the program. There are robust reporting capabilities which will help us improve. It will require innovative marketing to meet our participation and engagement goals. Our long-term focus is not participation, but individual and population health improvement. We will have a broad set of data that we can follow through the years to determine if the population is getting healthier.

Greg Devereux: I think the Health Care Authority and Limeade have done a superb job with the overall site and ease of use. Last year there weren't many things that you had to do to earn the incentive. This year we've gone the other way. I don't agree that it's a couple minutes a day. I think it's an effort to put in. If you do it every day, it probably is lessened, but I think it does require effort. Only 3,900 people have completed Level 1. 35,000 have engaged, but less than 4,000 have finished and less than 5,600 have finished all three levels. I'll go into more detail tomorrow at the Steering Committee, but I'm actually concerned about whether we are going come anywhere close to last year's numbers. I do think there are things we can do. I think there's some confusion about some of the activities. I think we could have more activities so people would have more choices. So those are some of my comments. I'll have more tomorrow.

Scott Pritchard: Those comments in some way mirror what we've seen also. We have challenges ahead to make this work really well. We'll look forward to your comments tomorrow at the Steering Committee.

Greg Devereux: It's probably not unexpected given we went from next to nothing to a full-blown program. It takes a while to get used to it. What I think would be useful is if we had some idea of how many people are close to 2,000 at this point. Engagement doesn't mean a lot if people are closer to 900 than they are to 2,000.

Scott Pritchard: That's a number we can access. We can bring to the Steering Committee meeting tomorrow?

Greg Devereux: That would be useful.

Dorothy Teeter: Greg, I took this information to the Cabinet yesterday and we actually had their agency-by-agency levels of participation, not the points, which I think is a great idea. We've got to start challenging each other. Members are familiar with the site and the word is

that the site is fun and easy to use. I think you will see more agency interactions, like Dept. of Health challenging the Health Care Authority, for example, or different divisions within a Cabinet agency challenging each other. There are going to be more activities during the next three months that will help provide even more opportunities to earn points so that we don't have disappointment.

It can be fun to pick a few people to compete with, for those of us that have a little bit of competitive spirit. Thank you for the launch of this and we're learning as we go. I'm looking forward to more data and consistent improvement as we go forward.

Barb Scott, PEB Policy & Rules Section Manager: The Board needs to take action on an eligibility-related policy for the SmartHealth Program. Last year the Board adopted a policy that read:

“In order to receive a PEBB Wellness Incentive in the following plan year, eligible subscribers must complete the PEBB Wellness Incentive Program requirements by the latest date of: June 30, or Within sixty days after the effective date of their PEBB medical, but no later than December 31.”

While working with the implementation team, it became clear to us that 60 days is not a sufficient amount of time for newly eligible folks to complete their activities and be successful. Because of that, we are recommending a change to the policy resolution that the Board adopted last year. The proposal allows more time for the member to reach their points based on their enrollment effective date.

Dorothy Teeter: The new proposal reads as follows:

Resolved, that to receive a PEBB Program Wellness Incentive in the following plan year, eligible subscribers must complete Wellness Incentive Program requirements by the following deadline:

- For subscribers continuing medical enrollment and subscribers enrolling in medical with an effective date in January, February, or March, the deadline is June 30
- For subscribers with a medical effective date in April, May, June, July, or August, the deadline is 120 days from the subscriber's medical effective date
- For subscribers with a medical effective date in September, October, November, or December, the deadline is December 31

Moved. Seconded. Approved.

Voting to Approve: 7

Voting No: 0

Barb Scott: The next steps will be to administer the benefit under the Board's adopted resolution as of today so our new members benefit from the additional amount of time in order to be successful in completing their activities. We'll be updating the current rule during the upcoming PEBB rulemaking with an effective date of January 1, 2016.

Beth Heston, PEB Division Portfolio Management Contract Manager: I manage the life insurance contract. Our current vendor is Reliastar/Voya Financial. HCA will propose a

reprocurement of the life insurance benefit for PEBB for an effective date of January 1, 2017. This is an informational presentation.

The PEBB Program's current life insurance product was purchased in 1977 when PEBB was the State Employees Insurance Board (SEIB). The SEIB was very small in comparison to the current number of covered lives, which is 354,000. There were no procurement rules in place at that time, so no state contract was put in place. Instead have a policy with our insurance carrier.

In 1993, a complete reprocurement was attempted, but didn't produce any competitive bids. We asked bidders to match exactly the administration and systems of the benefits that we had in place and they found that to be too expensive to lower their prices and match the computerized system that we had. We've done some work towards re-procuring since 1993 but have not gone out to bid.

The last change we made to the benefit was in 2012 when we closed out the salary-based supplemental employee insurance because it was confusing to members and was difficult to administer. We believe that it's appropriate at this time to go back out into the life insurance market and locate the best value for our members. At the same time, we can evaluate and design a benefit that will eliminate a number of reoccurring administrative and system issues and improve member experience.

Greg Devereux: What you do mean by best value?

Beth Heston: Best value in terms of pricing and administration. We'd like to see if we can do better.

Greg Devereux: Rate increase for above the \$25,000?

Beth Heston: No, rate increase in terms of the premiums that members are paying.

Greg Devereux: But, above and beyond the \$25,000 base? People aren't paying for the \$25,000.

Beth Heston: Correct. People aren't paying for the \$25,000. We think we can do better for supplemental insurance.

Greg Devereux: I agree with that. One point that wasn't made was for many years this was a \$5,000 life insurance benefit. It was referred to by state employees as the burial amount of money. My union had to sue the state because the state was using the employee's money that was surplus. That settlement moved the basic to \$25,000. I completely support a better value, but I also don't want to have something come back and harm what people have.

Dorothy Teeter: Greg, is your question are we going to consider lowering the \$25,000?

Beth Heston: We absolutely will not do that.

Dorothy Teeter: It's the incremental pieces that people buy over and above that, correct?

Beth Heston: We are looking to improve the benefit for our members and improve it in terms of price and what they can afford. We won't be changing the basic.

Greg Devereux: I understand that and I support looking at making the supplemental more advantageous for employees.

Yvonne Tate: I would encourage you to take a look at that \$25,000 basic and try to increase it. It seems very small to me if you look across employers. The basic amount of life insurance that's offered is far more than that.

Beth Heston: We don't know what our benefit looks like compared to what's available now. That's one of the reasons we want to check the market place.

Yvonne Tate: It's small compared to other employers.

Marc Provence: Are you also looking at how the demographics have changed over the last 22 years?

Beth Heston: Our demographic is actually fairly stable. We don't have a lot of change. We're looking at the way we're rated, the way prices are set, etc., to see where we can get the best value.

Marc Provence: So conceivably that stability could work in our favor.

Beth Heston: Yes. We're a big stable group. The benefit design has changed very little over the years. Our goals for reprourement are: to align with Results Washington and Procurement Reform; explore more modern, efficient, and cost effective options for benefit administration; improve benefit design and cost; and to bring benefit current with life insurance industry standards and practices.

We won't know until we go out to reprocur whether or not our benefit needs to be updated. This is an informational presentation. We would return next year during the regular procurement cycle and share our findings if we were able to find something.

Dorothy Teeter: There would be a briefing prior to voting on this issue. This is a time to step back and see if that refreshed strategy is going to make sense. We would be definitely bringing back what was found and some recommendations prior to any vote. We've heard the concern - if reprourement occurs, it will be done on behalf of the PEBB Program members, not to decrease or have decrements in value from what we currently have.

Dorothy Teeter: The next PEB Board meeting is May 27 at 1:30 p.m., at Cherry Street Plaza.

Meeting adjourned at 3:20 p.m.

TAB 4

Washington State
Health Care Authority

UMP Bundled Payments for
Total Joint Replacement

Marcia Peterson
Benefit Strategy & Design
6/24/2015

“As we continue our efforts to improve our health care system, we want to make sure we’re emphasizing quality and coordinated care...That’s why we’re bringing new health care options to our state employees that will provide the choices and high quality care they deserve.”

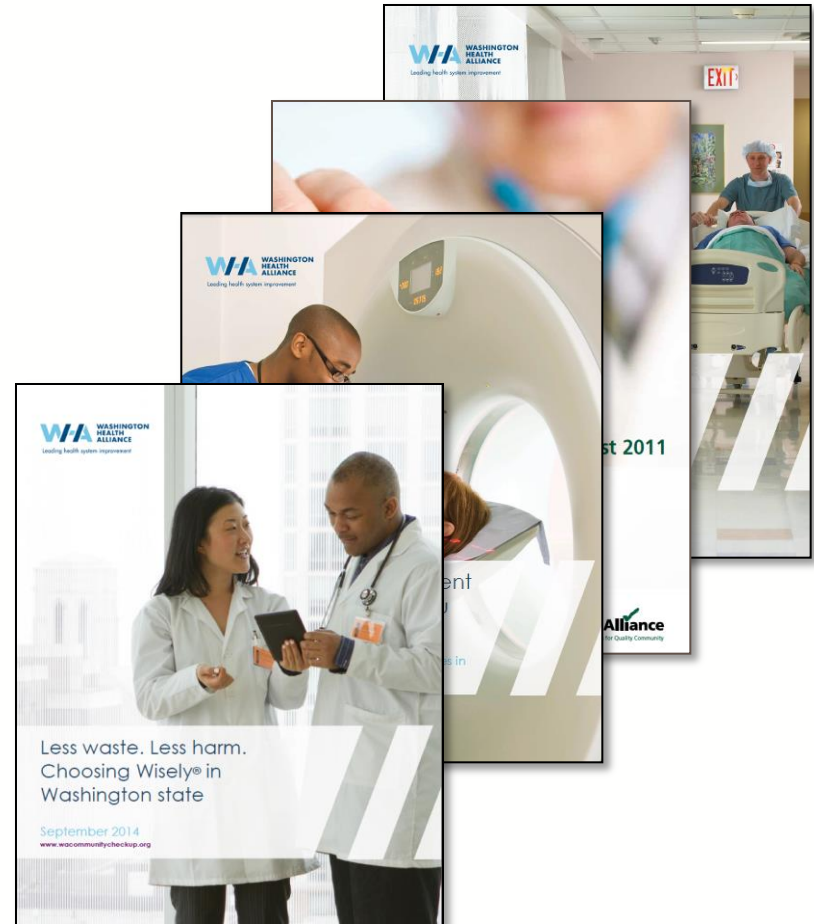
- Governor Jay Inslee
June 8, 2015

HCA's Leadership Role

- Accelerating adoption of value based reimbursement methods
 - Focus on the whole person
 - Quality and coordinated care
 - Reimbursement for high-quality outcomes
- Triple Aim of better health, better care, and lower costs

Value in health care

<u>VARIABLE</u>	Is the Health Care Service. . .
Appropriateness	Really Needed?
Process Quality	Provided in the most effective and safe manner?
Price	Produced at a fair price for the buyer?
Outcomes	Producing the best possible results for the patient?
Intensity/ Utilization	Provided in the most efficient manner?
Experience	Provided in a patient-centered way?



Bree Collaborative



- Established in 2011 by Washington State Legislature
- Identify areas for improvement in health care
 - High variation in the way that care is delivered,
 - Frequently used but do not lead to better care or patient health,
 - Patient safety issues.

Bree Collaborative



- Lumbar Fusion
- Total Knee and Hip Replacement
- Addiction and Dependence
- Cardiovascular Health
- End of Life Care
- Hospital Readmissions
- Maternity Care
- Spine and Low Back Pain



“Bundle” for Total Knee and Hip Surgeries

Clinical Components

- Documentation of disability due to osteoarthritis despite conservative therapy
- Documentation of fitness for surgery
- Repair of the osteoarthritic joint
- Post-operative care and return to function

Quality Standards

- Appropriateness
- Evidence-based surgery
- Rapid return to function
- Patient care experience
- Patient safety

UMP Members Total Hip and Knee Replacement

2013	Procedures	Members	Cost per Procedure	Total Cost
Total Hips	238	210	\$28,375	\$6,753,202
Total Knees	377	334	\$29,284	\$11,040,244
	615	544		\$17,793,446

Bree Standards for a Surgical Team Performing Total Knee/Hip Surgery



1. The surgeon must perform at least 50 joint replacements a year.
2. Members of the surgical team must have documented credentials, training, and experience. The roster of the surgical team should be consistent.
3. Elective joint arthroplasty must be scheduled to begin before 5:00 p.m.
4. Facilities in which surgery is performed should have policies that align with the American College of Surgeons Statement on Health Care Industry Representatives in the Operating Room.

Total Joint Replacement Bundled Program Planning

Develop a Bundle for Total Knees and Total Hips, following the Bree Criteria, to be fully implemented by benefit year 2017.

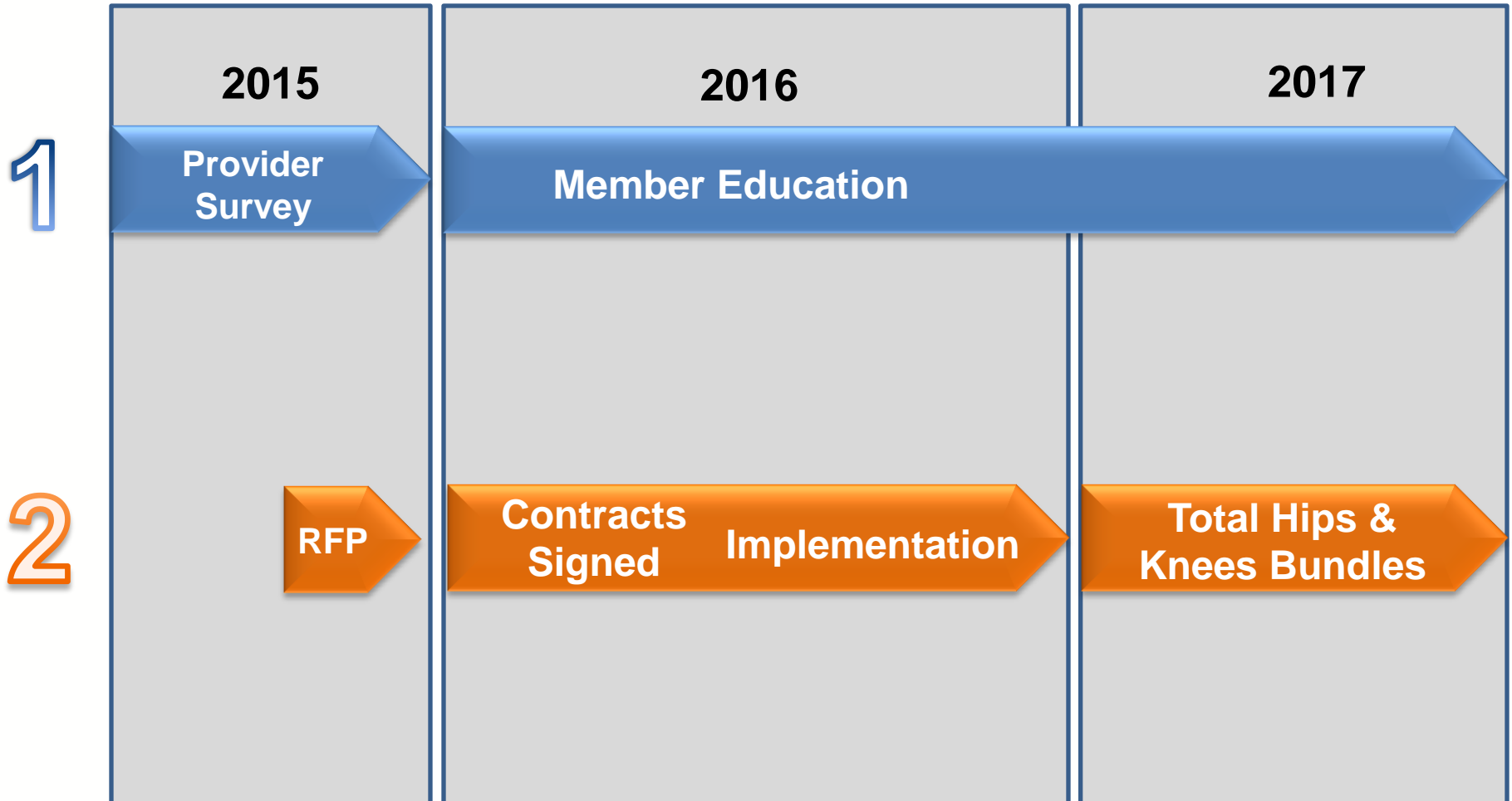
Phased Approach

- Letter and Survey to Providers regarding their intention to follow Bree Criteria
- RFP with intention to Contract with Providers who meet quality standards

Member involvement

- Member education about quality providers
- Shared Decision Making tools
- Benefit design

Total Joint Bundles Two Phases



Questions?



TAB 5

Washington State
Health Care Authority

SmartHealth Presentation
PEB Board Meeting

Scott Pritchard
PEB Division
June 24, 2015

2015 Engagement Goals

	Baseline Goal (of eligibles)	Stretch Goal (of eligibles)
Subscribers Registered On Site	70%	80%
Incentive Earned	60%	70%
Assessment Completion	65%	70%
Challenge/Activity Participation	60%	70%
2-Week Engagement (avg): Incentive Period / Q3 and Q4	25% / 15%	30% / 20%

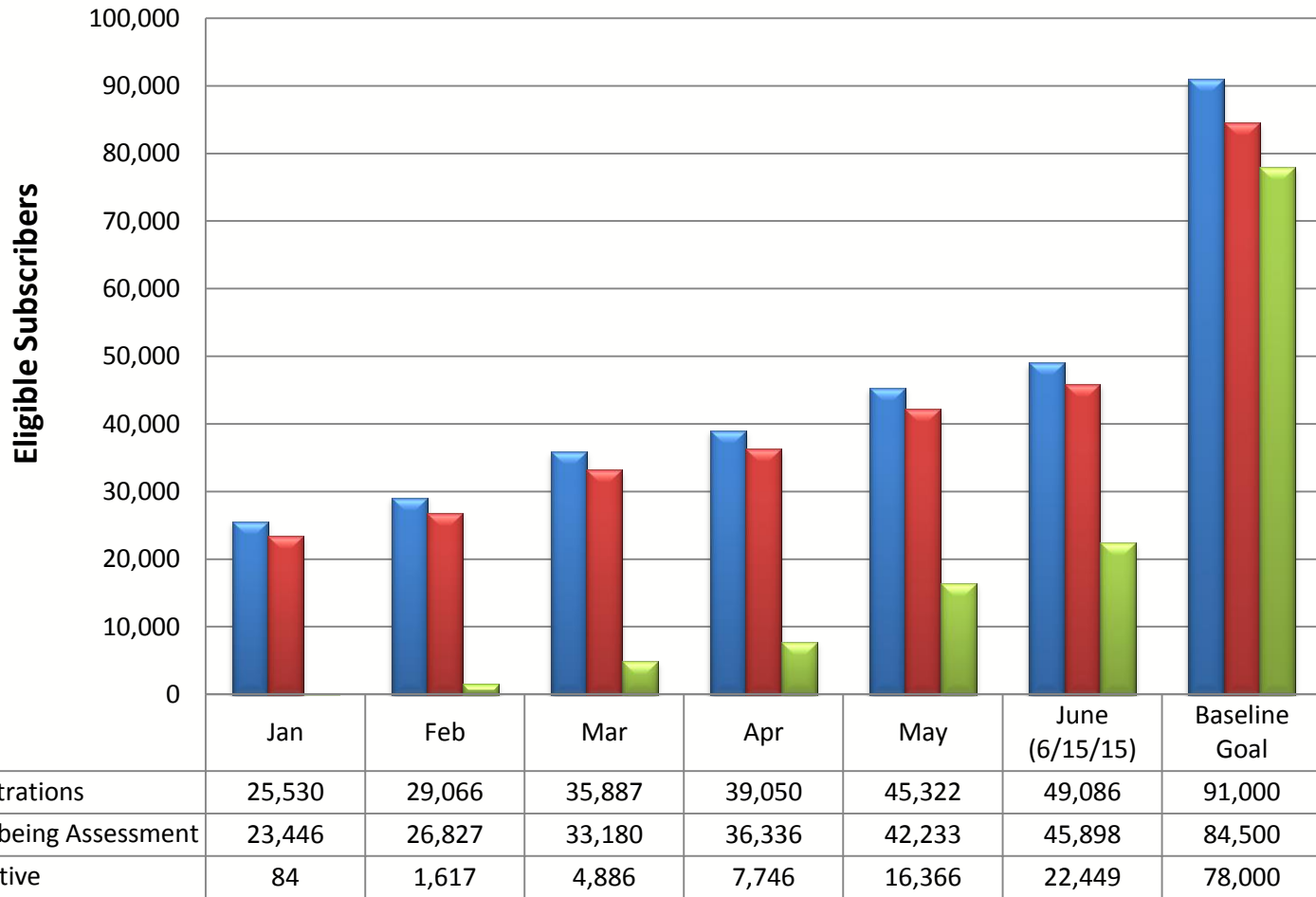
2-week engagement is defined as having participated in an activity (e.g., tracked progress) within 2 weeks.

Challenge participation is having participated in at least one activity.

SmartHealth Results

(as of June 15)

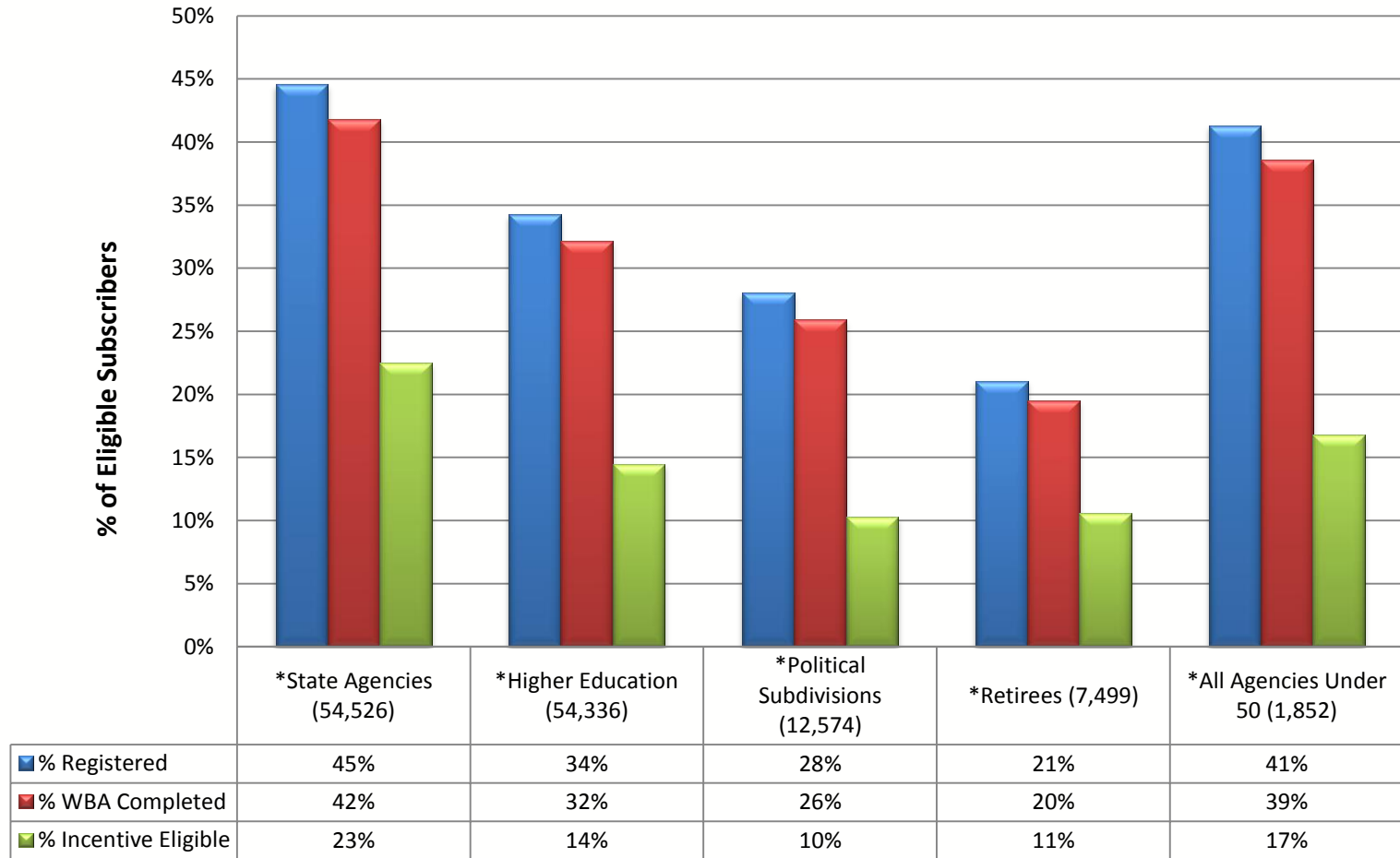
Total SmartHealth Eligible Subscriber Completions



Data current as of 6/15/2015.
SmartHealth eligible subscribers only.

Registrations, Well-being Assessments, & Incentive Percentages

Completion by Population Type



Data current as of 6/15/2015.
*SmartHealth eligible subscribers only.

Top 20 Completion Rates (Ranked by Well-being Assessment)

Agency	Total Eligible Subscribers	Total Registered	% Registered	% Completed Well-being Assessment	% Incentive Qualified
STUDENT ACHVMNT COUNCIL	95	77	81%	79%	35%
DEPT OF FINANCIAL INST	176	135	77%	74%	56%
HEALTH CARE AUTHORITY	1,006	732	73%	70%	46%
DEPARTMENT OF HEALTH	1,499	1,075	72%	69%	41%
WASHINGTON STATE LOTTERY	113	79	70%	68%	35%
INSURANCE COMMISSIONER	212	153	72%	67%	38%
DEPT RETIREMENT SYSTEM	219	156	71%	67%	39%
OFM/GOV	276	194	70%	67%	42%
DEPT OF COMMERCE	274	187	68%	66%	36%
STATE TREASURER	61	43	70%	66%	38%
STATE BD FOR COMM COLL	182	120	66%	64%	38%
UTILITIES/TRANS COMM	130	86	66%	63%	40%
DEPT/LICENSING	1,126	714	63%	61%	35%
DEPT REVENUE	1,056	628	59%	57%	36%
LIQUOR CONTROL BOARD	265	155	58%	56%	28%
DEPT OF ECOLOGY	1,499	866	58%	55%	35%
DEPT LABOR & INDUSTRIES	2,650	1,521	57%	55%	32%
CONSOLIDATED TECH SERV	248	142	57%	54%	32%
SECRETARY OF STATE	222	124	56%	54%	25%
BD OF INDUSTRIAL APPEALS	144	81	56%	53%	33%
STATE AUDITOR	337	183	54%	53%	30%
BELLINGHAM TECH COLLEGE	207	113	55%	53%	33%
DEPT SERVICES FOR BLIND	76	43	57%	53%	32%
TOTALS	12,073	7,607	63%	60%	36%

Data current as of 6/15/2015.
SmartHealth eligible subscribers only.

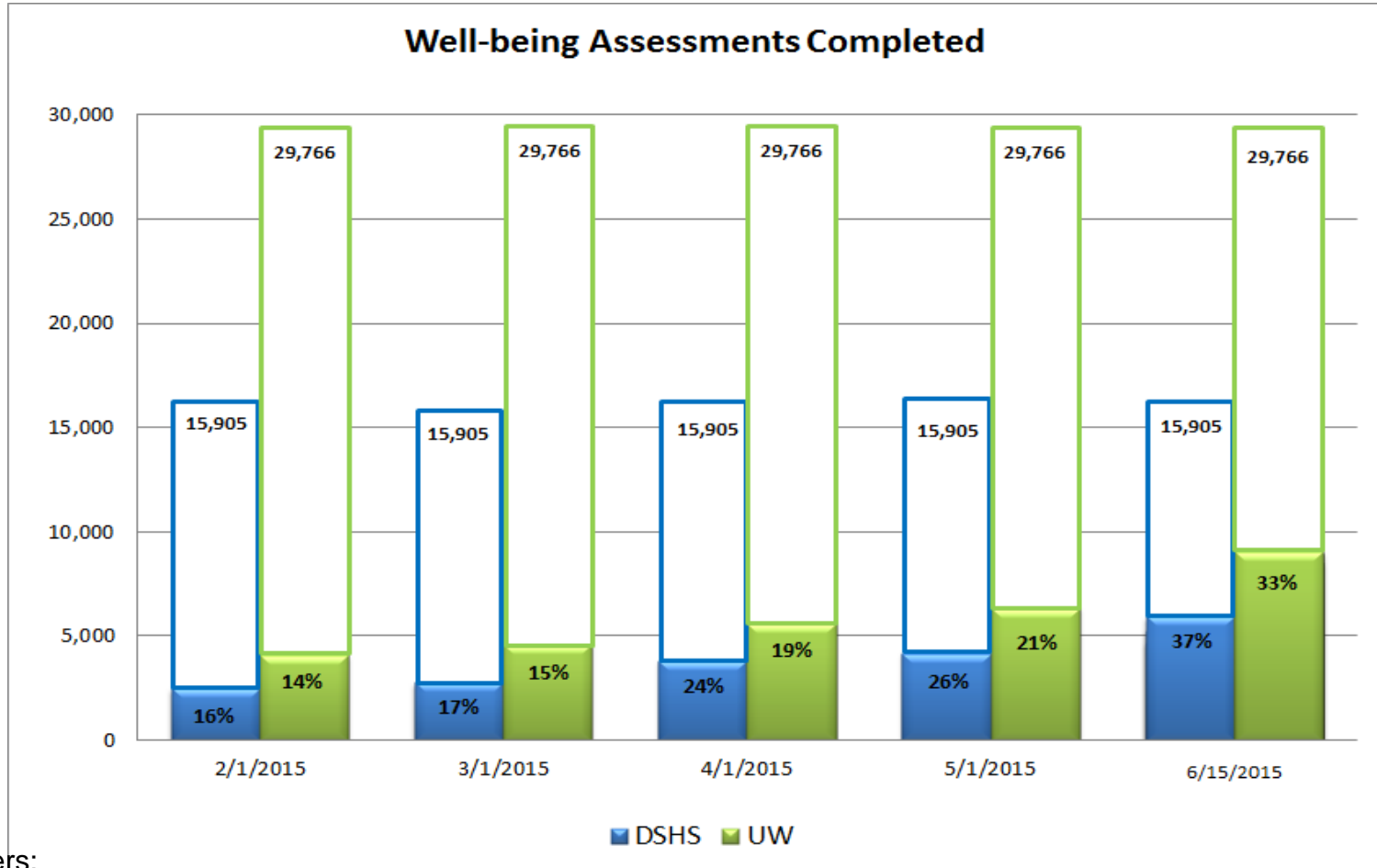
Cabinet Agency Completion Rates

(Ranked by Well-being Assessment)

Agency	Total Eligible Subscribers	# Registered	% Registered	% Completed WBA	% Incentive Qualified
STUDENT ACHIEVEMENT COUNCIL	95	77	81%	79%	35%
DEPT OF FINANCIAL INST	176	135	77%	74%	56%
HEALTH CARE AUTHORITY	1,006	732	73%	70%	46%
DEPARTMENT OF HEALTH	1,499	1,075	72%	69%	41%
DEPT OF RETIREMENT SYS	219	156	71%	67%	39%
OFM/GOV	276	194	70%	67%	42%
DEPT OF COMMERCE	274	187	68%	66%	36%
UTILITIES & TRANSPORTATION COMM	130	86	66%	63%	40%
DEPT OF LICENSING	1,126	714	63%	61%	35%
DEPT OF REVENUE	1,056	628	59%	57%	36%
DEPT OF ECOLOGY	1,499	866	58%	55%	35%
DEPT OF LABOR & INDUSTRIES	2,650	1,521	57%	55%	32%
CONSOLIDATED TECH SERV	248	142	57%	54%	32%
DEPT OF EARLY LEARNING	227	130	57%	52%	28%
EMPLOYMENT SECURITY DEPT	1,242	633	51%	47%	20%
MILITARY DEPARTMENT	231	108	47%	44%	20%
DEPT OF ENTERPRISE SVS	928	424	46%	42%	25%
DEPT OF TRANSPORTATION	6,273	2,370	38%	35%	19%
DEPT OF CORRECTIONS	7,460	2,834	38%	35%	17%
WASHINGTON STATE PATROL	2,022	757	37%	35%	19%
DEPT OF SOCIAL & HEALTH SERVICES	15,905	5,936	37%	34%	17%
DEPT OF AGRICULTURE	673	242	36%	33%	19%
DEPT OF VETERANS AFFAIRS	584	214	37%	32%	15%
Totals	45,799	20,161	44%	41%	22%

Data current as of 6/15/2015.
SmartHealth eligible subscribers only.

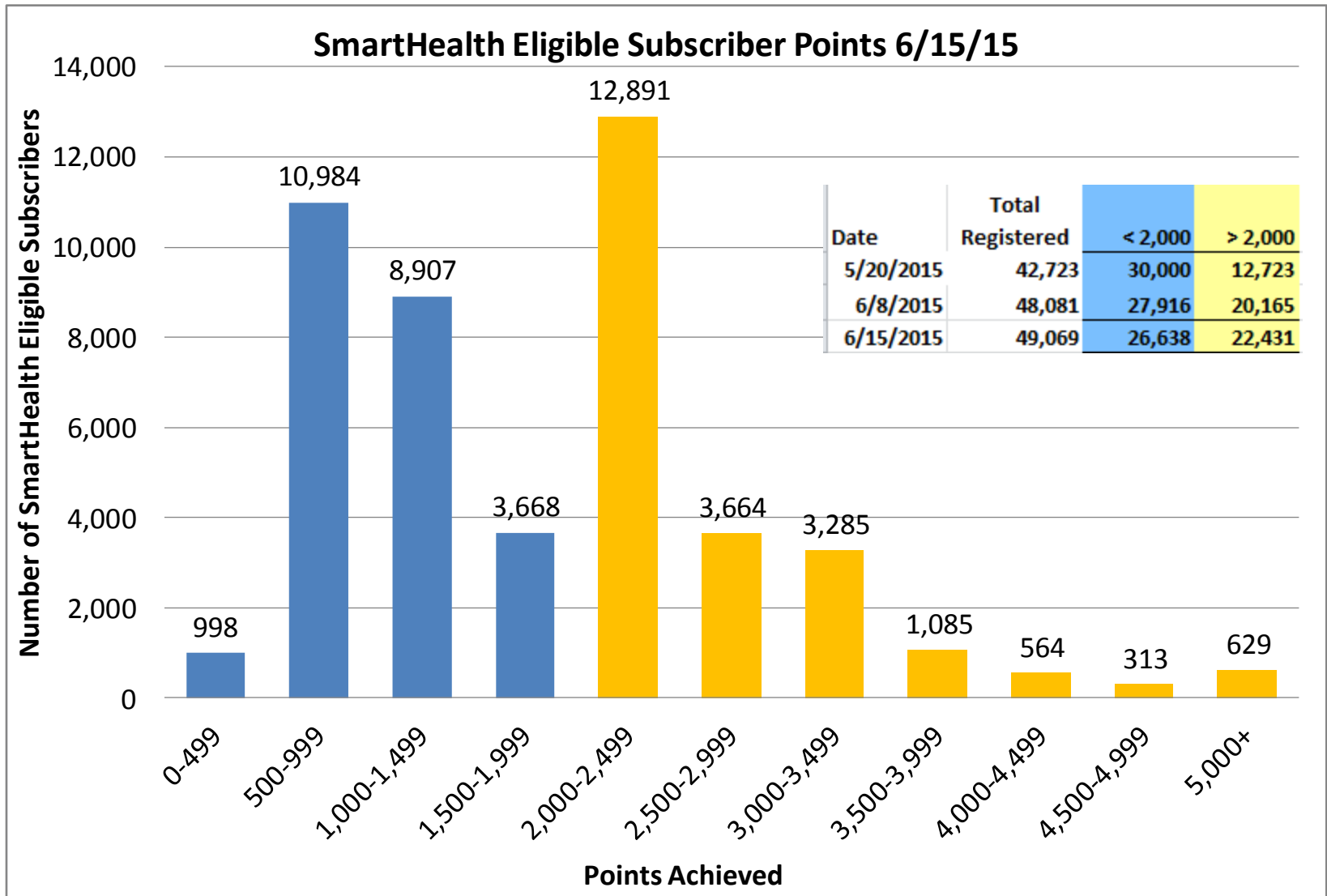
Dept. of Social & Health Services & University of Washington



Subscribers:
 DSHS = 15,905
 UW = 29,766

Data current as of 6/15/2015.
 SmartHealth eligible subscribers only.

SmartHealth Incentive Points Distribution



SmartHealth Promotions

- Mariners Ticket Packages (3)
 - Well-being Assessment Completion, 2,000 points, 3,000 points
- Points
 - Increased # Points and # Activities Available
- Messaging
 - Home mailer to all, email to those registered, Governor's email
- Governor's Walk in Support of SmartHealth
 - June 17
- Executive Cabinet "Completion Ranking" Promotion
 - Well-being Assessment percent completion ranking
- UW and DSHS Engagement
 - UW (29,679) and DSHS (15,900) = 45,576 SmartHealth eligible subscribers
 - 34.5% (45,576 /132,084) SmartHealth eligible subscribers

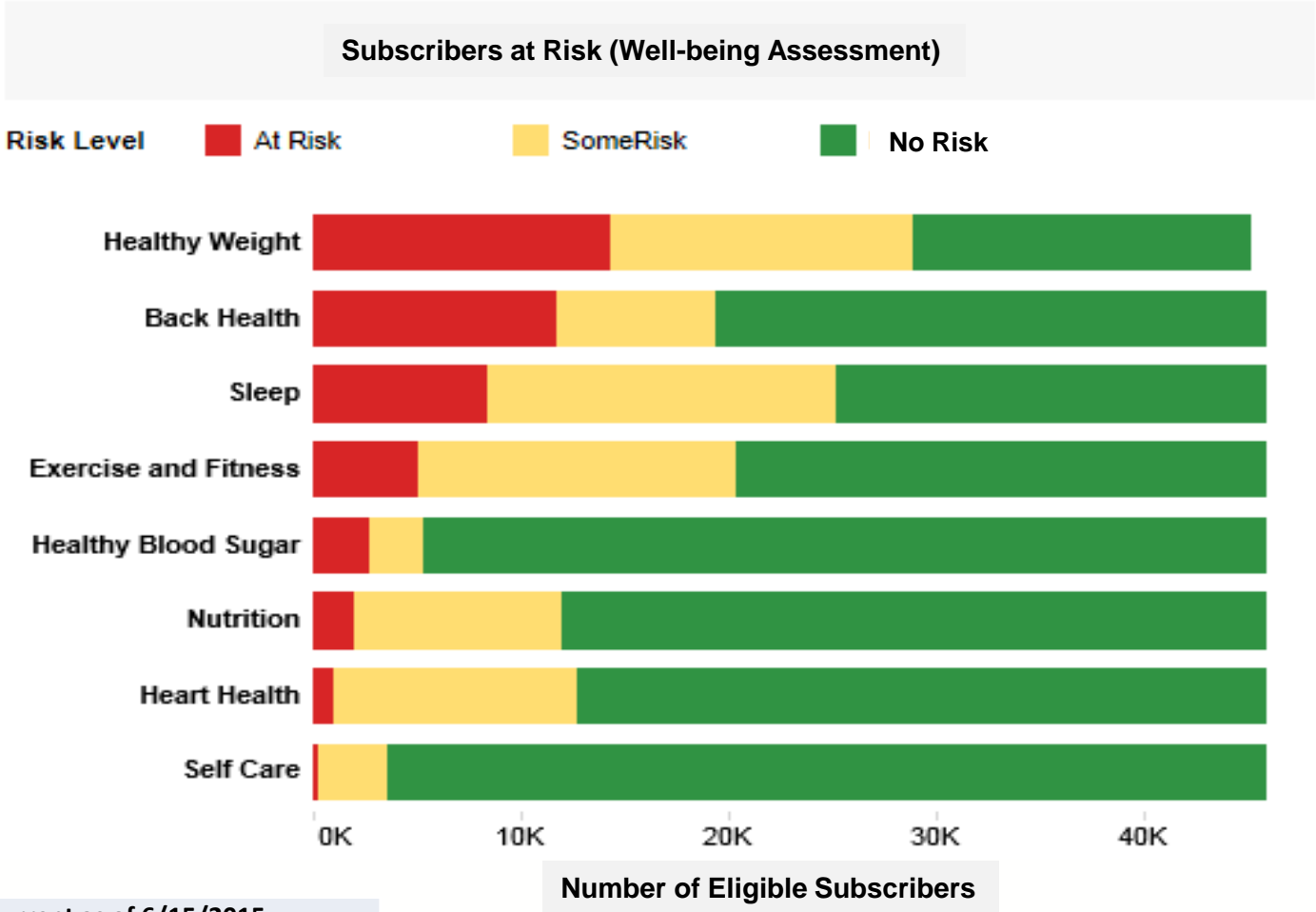
Governor Inslee Walks for SmartHealth



Hundreds of people met on the Capitol steps to walk with the governor on 6/17/2015 at noon. Over 3,000 people joined across the state. Governor Inslee said, “More walking, less talking! Let’s go!”



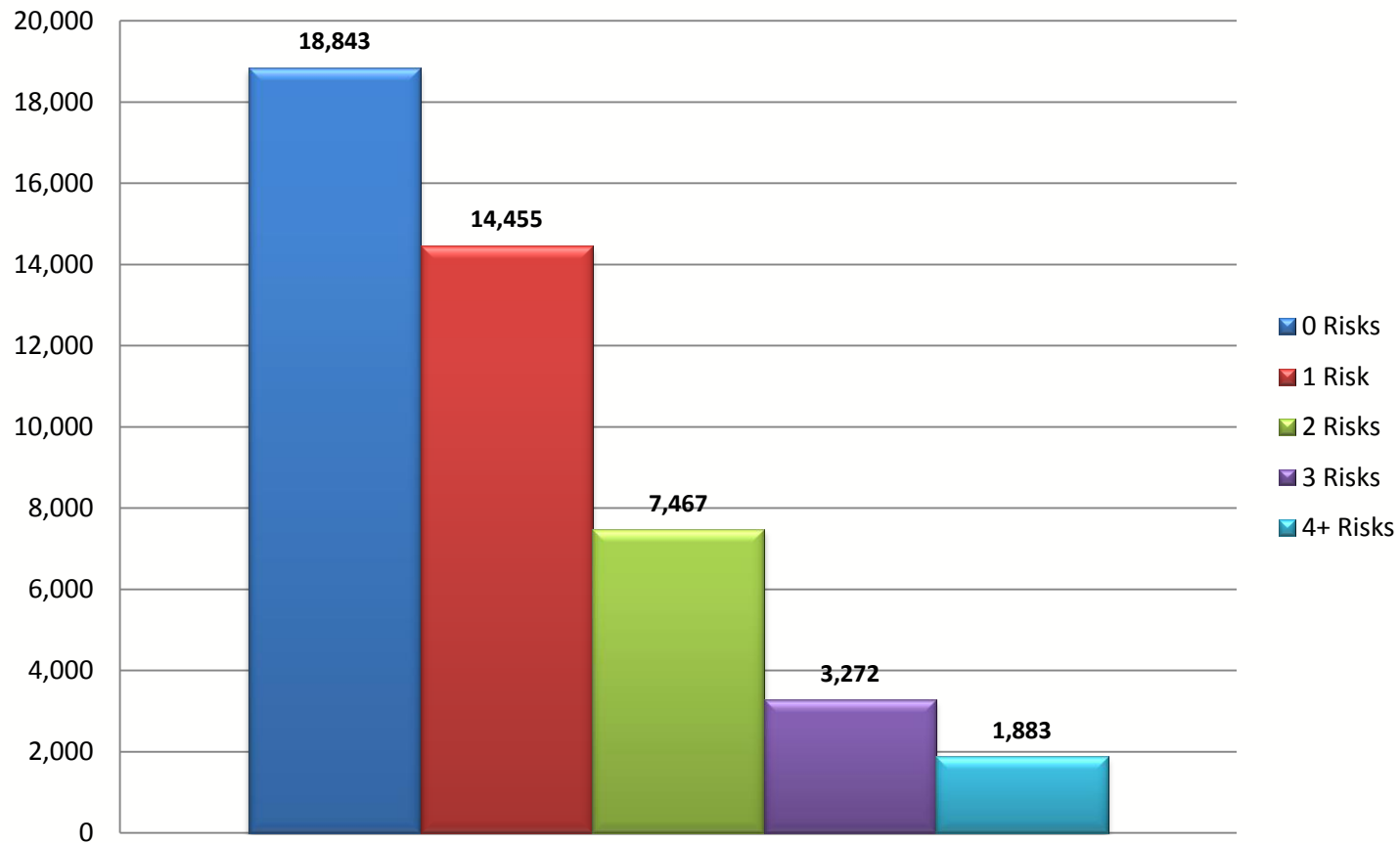
Health Risk Status – What We are Learning



Data current as of 6/15/2015.
SmartHealth eligible subscribers only.

Health Risk Status – What We are Learning

Number of Risk Factors
(for population completed Well-being Assessments)



Data current as of 6/15/2015.
SmartHealth eligible subscribers only.

SmartHealth Activities

- Activity Participation
 - Track Your Activity: 14,927
 - More Veggies: 13,728
 - Visit a State Park: 11,985
 - Healthy Start: 11,490
 - Connect Your Device: 10,001
 - 7-Minute Workout: 8,182
 - Advance Directive: 5,331
 - Healthy Spending: 5,149
 - Governor’s Walk: Over 3,100 and still counting!
- External Program Participation
 - Health Coaching – Group Health: 316
 - Diabetes Prevention Program: 244
 - Quit Tobacco (UMP and Group Health): 214
 - Living Well – Group Health: 134
 - Diabetes Control Program: 62

SmartHealth Customer Research

- Anecdotal
 - Presentations to professional groups and agencies
 - Conversations with Wellness Coordinators
- Survey
 - 2 each: agency, higher education, political subgroup
 - Participant and non-participant
- Focus groups
 - Planned for Q3
- UW research
 - Impact of mid-manager engagement
- Intern
 - Value Proposition for Senior Leader

TAB 6

The logo for the Washington State Health Care Authority. It features the text "Washington State Health Care Authority" in a dark blue, sans-serif font. The word "Authority" is significantly larger than the other words. A thick, dark red swoosh underline starts under the 'A' in "Authority" and curves over the top of the word, extending to the right.

Washington State
Health Care Authority

Policy Recommendations

Barb Scott
Policy and Rules Section Manager
PEB Division
June 24, 2015

Purpose of Briefing

- To review two policy proposals we will ask the Board to take action on during their next meeting

Proposed Policy - SmartHealth

Effective January 1, 2016, to receive a Public Employees Benefits Board (PEBB) Wellness Incentive in the following plan year, eligible subscribers must complete PEBB Wellness Incentive Program requirements by the following deadline:

- For subscribers continuing enrollment in PEBB medical and subscribers enrolling in PEBB medical with an effective date in January, February, March, April, May, or June, the deadline is September 30
- For subscribers enrolling in PEBB medical with an effective date in July or August, the deadline is 120 days from the subscriber's PEBB medical effective date
- For subscribers enrolling in PEBB medical with an effective date in September, October, November, or December, the deadline is December 31

Proposed Policy - Tricare

An employee may waive enrollment in Public Employees Benefits Board (PEBB) medical if he or she is enrolled in Tricare.

Next Steps

- Next Board meeting we will ask the Board to take action on these policy proposals and brief the Board on our annual rule making activity

Questions?

Barbara Scott, Policy and Rules Manager
PEB Division

Barbara.Scott@HCA.WA.GOV

Tel: 360-725-0830

TAB 7

Washington State Health Care Authority

PEB Board Affordable Care Act Update: Cadillac Tax Play or Pay

Mary Fliss
PEB Division
June 24, 2015

Purpose

- Provide the Board with an update on:
 - the current analysis related to the Cadillac Tax
 - our efforts to comply with Play or Pay reporting

Cadillac Tax

- Requirement:
 - 40% excise tax on health plans with annual premiums more than \$10,200 individual/\$27,500 families
 - Includes payroll deductions to an FSA or HSA
 - Does not include dental, vision, accident, disability, or long-term care insurance coverage
 - Structured as a per individual assessment to the employer
 - Begins with 2018 health plans

Cadillac Tax cont.

- Status:
 - Provided to the IRS comments on the most current rules
 - Analyzed tax amounts
- Next Steps:
 - Evaluate options to reduce the tax
 - Consider options for the 2017 or 2018 plan years

Play or Pay Reporting

- Requirement:
 - All large employers either provide benefits to “full-time” employees (FTEs) or pay a penalty if the employee receives subsidized coverage through the exchange
 - Employers report to the IRS:
 - For all those covered in our self-insured plans, the months enrolled in coverage by person
 - If an FTE, the months affordable, minimum value coverage was offered
 - Employers report to subscribers:
 - For FTEs: a copy of the return sent to the IRS
 - For non-FTEs receiving self-insured coverage: Proof (by month) that they received coverage

Play or Pay Reporting

- **Status:**
 - Completed the analysis of how to determine an FTE
 - Set up the operating environment and, working with the state HR database, the 8 state payrolls, and others, operationalized the bulk of data collection
- **Next Steps:**
 - Build a new reporting database
 - Test and validate data and reports
 - Train agencies and inform members
 - Implement reports to members (1/2016) and IRS (3/2016)
 - Support operations including analysis and reporting

Questions?

Mary Fliss, PEB Division

Mary.Fliss@HCA.WA.GOV

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