Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

June 24, 2015
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:00 p.m.

Members Present:
Dorothy Teeter
Greg Devereux
Gwen Rench
Yvonne Tate
Marilyn Guthrie
Myra Johnson

Members Absent:
Mary Lindquist
Harry Bossi

PEB Board Counsel:
Katy Hatfield

Call to Order

Dorothy Teeter, Chair, called the meeting to order at 1:30 p.m. Sufficient members were present to allow a quorum. Dorothy stated: Pursuant to RCW 42-30-110, the Board met this afternoon in Executive Session to consider proprietary or confidential non-published information related to development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session began at 12:00 p.m. and concluded at 1:00 p.m. No action, as defined by RCW 42.30.020(3), was taken during Executive Session."

Dorothy told the Board that Marc Provence resigned from the PEB Board and is now working for the Health Care Authority in the Healthier Washington Program. A search for Marc's replacement is underway.

Board and audience self-introductions followed.

Approval of April 15, 2015 PEBB Meeting Minutes

It was moved and seconded to approve the April 15, 2015 PEB Board meeting minutes with one correction. On page 2 of the minutes, in Gwen Rench's comments, change Medicare subsidy to Medicaid premium. Minutes approved by unanimous vote with noted correction.

Legislative Update and Accountable Care Program Update

Lou McDermott, PEB Division Director, indicated that the legislature was still in session. The Public Employees Benefits (PEB) Division has done an analysis of the House budget and we're still waiting on the Senate budget. The retiree subsidy in the House budget is $150. County Bill 1740 is still in the budget which would require the PEBB Program to accept all counties regardless of their claim history.

The smoking surcharge remains at $25 and the spousal surcharge remains at $50 with a 95% actuarial value of the Uniform Medical Plan, as in previous years. The funding rate is less than our model projections, so it appears they may have adjusted the funding rate by projecting a lower trend.

We will do an analysis on both budget bills when they come out.

All non-essential state employees were given layoff notices, effective July 1, 2015. If the budget isn't signed, HCA will close June 30, 2015. Without a budget resolution, there may be an impact on how soon we can gather information and prepare for our 2015 Open Enrollment season.

The Accountable Care Program (ACP) will take effect January 1, 2016. ACP is a subset of the Uniform Medical Plan (UMP) Program. The Health Care Authority signed with two delivery systems: 1) Providence UW and 2) Puget Sound High Value Network centered around Virginia Mason and their partners Multi-Care and Evergreen. We are still working with attorneys to determine what elements of the contracts are proprietary and what elements are not. There are care components and member experience components.

Numerous delivery systems applied and three were considered. HCA was unable to come to an agreement with Providence.

HCA is now going through the process of clarifying the contract. It is a four-year contract for calendar year 2016 through calendar year 2019. These two options will be offered in King, Kitsap, Snohomish, Pierce, and Thurston Counties. We are still waiting for the network to be finalized so we can communicate that information to our third party administrator, Regence. They need to program their system so they know who is inside the ACP.

Some aspects of the ACP:

- Members who sign up for this product must reside in the county where the product is offered.
- There will be a lower premium share for the member.
- The benefits are the same as in UMP Classic, but certain aspects of the benefit design are different, such as the deductible, cost share for primary care visits, and out-of-network patient responsibility.
- Enhanced member experience.
- A Toll-Free number for members to call with issues, make appointments, care coordination, and any other questions they may have.
- Web portal to provide information on provider services, link to other HCA activities, medical charts where they can get test results, see appointments, refill requests, and ultimately have conversations with their doctors. (This currently is available in Group Health.)

The financial component provides a trend guarantee over that four-year period. This allows us to offer a richer benefit. Quality metrics are important to the trend guarantee. The quality of service provided will have a positive or negative impact on finances for the providers depending on their level of quality.

We are still in the process of finalizing the benefit design. Our goal is a 30% premium differential, which will bring the cost down for the member. If you compared this to today's UMP premium of $84 for 2015, the ACP product would have been $59. We are also looking at a reduction in the deductible – from $250 to $125. If the member was in an ACP, participated in the SmartHealth Program, and earned the wellness incentive for the following year, potentially their deductible could be zero.

There will be deductibles for drugs. Today, the deductible is $100 for a single member and $300 for a family. In the ACP, the deductible would be zero for both. The maximum out-of-pocket (MOOP) will remain the same.

There will be a slight increase in the coinsurance on the out-of-network. It will go from 40% to 50%. We are looking at no coinsurance for office visits with your Preferred Care Provider (PCP). You may go to your PCP as many times as you like with no coinsurance.

This is the basic framework of the benefit design we are looking at now. We continue to make tweaks as we go through procurement. It's all tied to rates, trend, and now they tie together.

Dan Lessler, HCA Chief Medical Officer, discussed the care transformation component of the Accountable Care Program (ACP). There are three core elements to the care transformation:

- Patient Centered Medical Home
- Care Coordination for Patients with Complex Chronic Illness
- Implementation of Bree Recommendations – Bree best practices

Patient Centered Medical Home – The Accountable Care Program offers an opportunity to emphasize primary care and have a system that is primary-care driven and able to report out on population-based metrics of outcomes. The concept of Patient Centered Medical Home involves core elements related to delivery of primary care that ensures optimal care and drives good population health. The ACPs are required to meet a very high standard of accomplishment with respect to Patient Centered Medical Home. The NCQA, the accrediting body for health plans and clinics, has a set of criteria around Patient Centered Medical Home. Over the course of the contract, the ACPs will be required to meet an equivalent, if not the actual Level 3 NCQA accreditation criteria.

Care Coordination for Patients with Complex Chronic Illness – From a cost utilization and quality standpoint, it is important to address the needs of those with complex chronic illness. Intensive care management is an evidence-based option for addressing this need and is a requirement in the ACP contract for high risk PEBB Program beneficiaries who are participating or enrolled in the ACP.

Implementation of Bree Recommendations – Bree best practices – The Bree Collaborative is a legislatively charted stakeholder group in the state of Washington that brings together experts, clinicians, plans, and purchasers to identify best practices in terms of high cost, high utilization, or practice variation. This is an opportunity to drive those best practices into the delivery systems. There are expectations that the ACPs will adopt, disseminate, and implement the

Bree recommendations. The existing Bree recommendations include recommendations on joint replacements, obstetrical care, end-of-life care, care for patients with substance use disorders, care related to spine, and cardiac care; and especially in the outpatient setting, optimal care for those with low back pain; and then transitions of care – to coordination of care from inpatient to outpatient. These elements are incorporated into the contract with very clear expectations.

Marilyn Guthrie: Care management, care coordination is a concept that is easy to talk about but hard to do. How will you ensure that the delivery systems are actually meeting the expectations?

Dan Lessler: It will be possible to do. There is good literature around what components are needed to provide complex care management. Essentially, the contract contains the well vetted and researched elements and is clearly spelled out in terms of what needs to be included. There are measures in terms of regular reporting of the numbers of people who are being identified as in need of complex care management. They would need to meet the identified quality metrics that tie back to the work that's being done in terms of complex care management.

Dorothy Teeter: This is our introduction to the concept of an Accountable Care Program. You will be hearing more as the programs are developing, what those performance measures are, and how they're being achieved.

UMP Bundled Payments for Total Joint Replacement

Marcia Peterson, PEB Division Benefit Strategy & Design Manager, shared information on the Uniform Medical Plan (UMP) bundled payments for the total joint replacement project. As background, Governor Inslee encouraged us to be a leader in improving our health care system, emphasizing quality and coordinated care. The new Accountable Care Program and the bundles are designed to offer choices and high quality care to our members. HCA has taken a leadership role in accelerating the adoption of value-based reimbursement methods, the focus on the whole person, that provide quality and coordinated care and that reward providers for high quality outcomes. Our goal is to achieve the Triple Aim of better health, better care, and lower costs.

In developing our models, we are using resources like the Washington Health Alliance and the Bree Collaborative. The Washington Health Alliance helps us define value in health care. The Bree Collaborative was established in 2011 by the Washington State legislature to allow public and private entities and stakeholders the ability to identify areas for improvement in health care and provide information on best practices. The Bree Collaborative is focusing on areas around high variation in the way care is delivered; areas where care or treatment is frequently used but doesn't necessarily lead to better care or patient health; and in areas of patient safety.

The use of the Bree criteria is largely voluntary among providers throughout the state; but as a purchaser, we will offer incentives to those using the criteria. HCA has identified an opportunity to ensure that our members receive high quality care following the Bree criteria for quality around the area of total knee and hip replacement. For this area, Bree has recommended a bundled approach along with a warranty on both the materials and the hospital stay.

One of the challenges of improving health care quality is the fragmented way it's currently organized, particularly in surgery. You have the surgeon, the pre-surgical work, an operating team, nursing care, post-operative care, physical therapy, and all of the other elements, who are often not on the same team. This lack of coordination that can take place between the players can result in poor quality outcomes, as well as a confusing and frustrating experience for the patient and the family. By bundling the components of these procedures together, identifying the evidence-based quality components of care and tying payment to the whole bundle of care rather than to the pieces of it, providers are incentivized to work together to provide high quality care.

The bundle, as defined by Bree, identifies expected components of pre-operative, intraoperative, and post-operative care that are needed for successful knee and hip replacement. It includes both clinical components and quality standards. In 2013, there were 544 UMP members that had at least one of these procedures, some having more than one. The overall cost in claims paid was approximately $18M. That averages about $30,000 in claims per procedure, with some of those costs borne by the members.

A surgery like this is a significant life event; and as Bree and others within the health care industry have identified, it has great potential for variation in quality. It's an area we feel should be considered for payment reform, linking quality with finances. While total joint replacement can result in vastly improved quality of life for the individual, there are other less aggressive treatments that are available; and in some cases, those can be tried first to see whether or not surgery is necessary.

There's an upward trend in the volume of these procedures being done nationwide. We expect to see that going forward, partly driven by demographics, but partly driven by technology and what we are now able to do. An example of Bree standards for the surgical team performing total knee and hip surgery includes things from how many procedures a surgeon must have performed in a year to the types of credentials, training, and experience that members of the team must have. It even speaks to the latest time a procedure should be scheduled. Most lay people wouldn't think to ask these types of questions before scheduling a procedure. These are evidence-based details the Bree Collaborative is recommending.

The bundled payment program for hips and knees, following the Bree criteria, is scheduled to be fully implemented by benefit year 2017. A phased approach is planned to implement this program, with the first phase being a letter and survey to providers requesting they tell us if they have adopted the Bree criteria, or if they plan to. This request will draw attention in the industry to the Bree criteria and will signal to the market that we are serious about quality within the PEBB Program. An RFP will be issued in the fall for a bundled product for knees and hips, to be effective January 2017. Member involvement, member education, shared decision-making tools, and benefit design are important components of the bundle.

As mentioned, the first phase of this project has started, with an RFP to providers scheduled to go out in the fall for the second phase. Throughout 2016 we will embark on a campaign to educate members on purchasing health care and quality within health care, not just around hips and knees. Tentatively around first quarter of 2016, contracts will be signed with the apparent successful bidders, with implementation to begin in 2017.

Yvonne Tate: Would you go to your primary care doctor first and they would know the physicians in this group to refer you to?

Dr. Lessler: Yes, you would go to your primary care doctor who would make an initial diagnosis as to whether or not you might be a candidate. A surgical recommendation would be made by an orthopedist. Primary care doctors would know who those orthopedists and facilities were that contracted with UMP to provide joint replacement surgery. The member should know the advantages of having their joint replacement with a contracted orthopedist and facility. The benefit design would be such that it would be less expensive for you to have it done in this context as a part of the bundle than if you were to choose an orthopedist or facility not contracted with UMP for the bundle.

Yvonne Tate: Does that mean if I participate in this program, I would still have the choice of not using one of your recommended orthopods?

Marcia Peterson: The benefit design is being developed. That phase hasn't started, but that's certainly something we've talked about. You could be paying more if you selected a physician that wasn't contracted with UMP. The Bree criteria involves appropriateness, and if the physician didn't meet the criteria and you selected them anyway, the cost could be greater. That is yet to be determined.

Myra Johnson: On the phased approach, when will the letters and surveys go out and how many providers will receive them? Regarding the RFP for proposals, how many do you anticipate hearing back from? Will it be limited to Eastern Washington, Western Washington, or the entire state? How will member education be disseminated to the members? What will that look like?

Marcia Peterson: We're hoping the letter and survey will be sent next week. We're still editing. They are being sent to physicians, orthopedists, and facilities in the Regence network that provide this service.

As to how many will participate, we'll have to wait and see since this is so new. There are providers in the community who are working on bundles, but we're the first purchaser in this market to go forward with the idea. There are health plans trying to do the same thing. It's unclear how many will meet our criteria for the RFP.

Myra Johnson: Worst case scenario, if no one responds, what is the next step? What is option B or C?

Marcia Peterson: It would definitely cause a discussion. We would have some quality information from those surveys. I would be surprised if there was no response. The market is very interested in this concept. Providers have been working on putting these together but haven't had a purchaser.

Dr. Lessler: We do know of a number of places that are working on developing bundles. Some already contract with other entities through a bundle-like methodology.

Myra Johnson: You're thinking you'll get the responses you're looking for and it won't be an issue, and they'll meet your qualifications?

Dr. Lessler: Yes.

Myra Johnson: How will the members' education be given? Will it come from their primary care provider? How will it be disseminated to the members?

Marcia Peterson: That is part of our implementation plan yet to be determined. We are looking at patient/member education in general and how to choose wisely. There is a national Choose Wisely campaign that we are reviewing; and we anticipate communicating through our website, through direct mail, and through the providers themselves. There are shared decision-making tools, too, that Dr. Lessler is providing leadership on. It's a whole package to help consumers become more aware of their choices in health care; how to make wise choices around quality.

Dr. Lessler: In terms of the mechanics, there are details to be worked out. The member needs to be made aware of the need for prior authorization before a procedure is covered by Regence, our TPA. Preauthorization provides the opportunity to make sure the patient is connected to the information they need when making that medical decision. It allows that shared decision making. There will be opportunities along the way to ensure the member is engaged.

Dorothy Teeter: We will be following this with great interest. Hopefully others will join us in this way of doing value-based purchasing.

SmartHealth Update

Scott Pritchard, PEB Division Health Management Unit, provided a SmartHealth update. We are almost half way through the first year and nearing the end of the qualification period for the financial incentive. Our vendor, Limeade, provides weekly reports allowing us to track how we're doing. We will measure our progress against the goals we set for ourselves.

Data is updated every Monday, and today's numbers are through June 15. It appears that members who register with SmartHealth complete their well-being assessment. As expected, there was a sharp upturn in participation as we neared the deadline for completion. The registrations increased to 50,500 (49,086), well-being assessments went to 47,300 (45,898), and the incentive completion is now 25,600 (22,449).

Our population works at different places and we have segmented the different work types. There are state employees in state agencies, 54,000; higher education, about the same number; political subdivisions, which are public employers not employed by the state but get insurance through the PEBB Program; retirees; and then all those agencies that have under 50 employees, about 1,800 people. We track them separately. The agencies have the highest participation; higher ed, political subdivisions, not as many. This tracks with our outreach work.

The top twenty participating agencies, ranked by completion of the well-being assessment, were identified. The Health Care Authority is the leader among the large agencies. Three agencies reached our goal of a seventy percent completion rate, with ten agencies near that rate. Cabinet agencies were tracked as well. Three achieved the goal seventy percent well-being assessment completion rate and six other cabinet agencies are near that goal.

We're working with the Department of Social & Health Services (DSHS) and the University of Washington, the two largest state employers. DSHS has over 15,905 employees that are insured through the PEBB Program and the University of Washington has well over 29,000 employees. Both of these programs have made significant progress since they started this year. They've been good partners and we'll continue to work closely with them because they represent about 34% of all state employees.

As we monitored state employee participation, we identified three groups. One group wasn't registered. They either weren't getting the message or chose not to participate. The second group registered, completed their well-being assessment, but didn't complete enough activities to earn the incentive qualification level of 2,000 points. The third group completed their well-being assessment, earned the required 2,000 points for the incentive, and continued to earn additional points. Some of our promotions were based on this breakdown. Our goal was to get employees to register who hadn't, to get those employees to 2,000 points who weren't, and to create enough interest for those who earned the incentive to continue earning points. Our registrations went from 42,700 to 51,700; those earning the incentive went from 12,723 to 26,075.

Our two most successful promotions were from Governor Inslee's email to state employees and the Seahawks ticket giveaway! We also gave away three Mariner's ticket packages. Each Mariner's package included four tickets at the diamond level, free food and drink, and two parking passes. The first drawing was for those who completed their well-being assessment. The other two drawings will take place June 30 – one for those who completed their well-being assessment and earned 2,000 points, and the other drawing for those who earned 3,000 points.

Hoping to get employees to earn 2,000 points, we brought back some of the most popular activities. Some point levels were increased and the number of activities increased. The initial goal of the program is to get employees to register and take their well-being assessment; to get them to participate. Going forward, we'll start emphasizing behavior change and the importance of choosing activities that can improve their health.

A special activity was the Governor's Walk on June 17. He called it the Walk for SmartHealth. Employees met on the Capitol steps, listened to the Governor give a speech, and then took a thirty-minute walk. You could participate in the Governor's Walk by walking thirty minutes wherever you were. 3,941 people indicated they completed this activity.

We have worked to engage senior leaders, which helps create an authorizing environment and a culture within their organization that says wellness is important. It helps engage from top management to mid management, and down to all agency employees. Chair Dorothy Teeter and DOH Secretary John Wiesman shared the Executive Cabinet Completion Ranking Table with Cabinet leaders. The response was good and some leaders wanted to improve their numbers. This table is updated weekly and has been a great tool for awareness. There is value in senior leader engagement. Competition is great, but we really want senior leadership to understand that employees with well-being can help accomplish their agency's mission. Again, we focused on UW and DSHS because they are tasked with engaging 29,000 plus, or 15,000 plus, employees across different parts of an organization.

As the data from the well-being assessments is collected - it's in aggregate, privacy-protected, no individual data - the aggregate begins to show us the health risk status. Healthy weight is one of the highest risks within the population, back health is high, and sleep is high. Exercise and fitness is always important. As this information is gathered, we are looking at available resources. We will add to the PEBB Program portfolio resources that will help improve the health of our members.

We are approaching the fifty percent level of people that have registered and done their well-being assessment, which is excellent. That's about 50,000 people and larger than any other employer in the state if everybody completed it. Data indicates that this group is the healthier part of our population. This would be unusual if this continued as we get to the 75% completion rate. As we continue to collect data on health risks, the information will identify some of the challenges moving forward of whom we need to reach.

Well over 50 activities have been offered to employees to assist them in achieving better health. Some of those activities are: Track Your Activity, More Veggies, Visit a State Park, Connect Your Device, 7-Minute Workout, to name a few. External program options were also offered, such as Health Coaching with Group Health, Diabetes Prevention Program, Quit Tobacco, and a Diabetes Control Program. These help to reduce risk and to manage health conditions through health plans.

Myra Johnson: Could you talk about Healthy Start?

Scott Pritchard: Healthy Start is eating a good breakfast.

Scott Pritchard: Our goal is to reach 132,000 PEBB Program-insured people and we've currently reached 50,000. Customer research will be important in helping us shape a product they want to use. We're listening to our customers and gathering their feedback. We just finished a survey and we're analyzing the data now. It went to two agencies, two higher eds, and two political sub groups. We are doing a non-participant and participant survey and our vendor Limeade will send a survey that they use.

We are planning focus groups for September; we'll work with the UW Health Promotion Research Center to do research around the impact of mid-manager engagement; and we have an intern working with us this summer to help develop the value proposition for senior leaders. The intern will address the value of healthy employees to the mission of the agency. That is an essential part of moving forward.

Marilyn Guthrie: Scott, this is really remarkable. I have to commend you and your team for doing what I think is really great work. And to be at this point in the year, is especially commendable.

Dorothy Teeter: I don't think there is anyone more enthusiastic than Scott about the data. We are a data driven program in PEB. It's been really interesting to see the curve of people's adoption rates for this, and how we want to make our next challenge will be how to keep it going throughout the rest of the year.

Policy Recommendations

Barb Scott, PEB Division Policy & Rules Section Manager, shared information on two policy recommendations requiring Board action at the next Board meeting.

The first proposal is related to the SmartHealth Program deadline for completing program requirements. In 2014, eligible subscribers were required to complete wellness incentive program requirements by the later of June 30, or within 60 days of their medical effective date, in order to be eligible to receive a wellness incentive in January 2015. Last month the Board

adopted a change to the policy so newly eligible subscribers now have 120 days instead of 60 days from their medical effective date to complete wellness incentive program requirements. The policy change was adopted for the 2015 plan year and will be used to determine eligibility to receive a wellness incentive in January of 2016.

The proposed policy would change the current June 30 deadline to September 30. The policy change would be effective for the 2017 plan year and forward. It would not impact the upcoming 2016 plan year.

The proposed policy states:

> 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:
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> - For subscribers continuing enrollment in PEBB medical and subscribers enrolled 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

Originally we needed data by June 30 for rate development. Going forward, we will rely on historical data to set rates. The September 30 deadline will provide health plans with a sufficient amount of time to have accurate accounts displayed for Open Enrollment so members will know whether or not they're receiving an incentive in the upcoming plan year.

The second policy proposal is related to Tricare. We received a request to review our administration of the PEBB rule that allows an employee to waive enrollment in PEBB medical if they're enrolled in medical through another employer; for example their spouse's employer-based medical insurance.

Currently, our rule allows an employee to waive PEBB medical if enrolled in Tricare coverage related to current employment. This policy proposal will allow an employee to waive PEBB medical when enrolled in Tricare coverage related to retirement.

The Proposed Policy States:

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

Based on a review of the federal regulation, we recommend making this adjustment in order to fully comply with federal Department of Defense regulation governing Tricare coverage.

Our next step is to bring this back to the Board for a vote at the next Board meeting.

Affordable Care Act Update – Cadillac Tax and Play or Pay

Mary Fliss, PEB Division Deputy Director, gave a brief highlight on the actions taken to date related to the Cadillac Tax, as well as our efforts to comply with Play or Pay reporting. The last time these topics were shared with the Board was at the Board Retreat in 2013. This is in addition to that presentation and I anticipate continued periodic updates related to these efforts.

By way of background, the Cadillac Tax requirement is a 40% excise tax on health plans with an annual premium of more than $10,200 for an individual and $27,500 for families. These amounts do include any payroll deductions related to Flexible Medical Spending Accounts (FSA) or Health Savings Accounts (HSA), both of which we offer to our employees. It does not include, however, any carved out programs we have related to dental or vision, or accidental disability, or long-term care insurance coverage. It is structured as a per-individual assessment to the employer and will begin with 2018 health plans.

The current status is that we have provided comments to the IRS on their most current rule making. In addition, we've started conducting the analysis required for the tax amounts. Our next steps will be to evaluate the available options if we need to take action to reduce any tax liability, and then to be considering those options for the 2017 or 2018 plan years.

Dorothy Teeter: Will we know during this Board session what the analysis looks like regarding the Cadillac Tax? Or is this something that will be ongoing into next year?

Mary Fliss: This will be ongoing into next year. We could, however, bring information forward as it becomes available.

Greg Devereux: Is the Health Care Authority looking at any options to reduce the tax?

Mary Fliss: Some of the options before us include limiting the amount of the election for Flexible Medical Spending Accounts. It's currently set at $2,500 as a maximum. This is a per-employee assessment so we could look at reducing both the FSA, as well as the Health Savings Account payroll deductions that our employees take. Another option would be to look at our vision coverage to see if there would be any feasibility of creating that instead of having it imbedded in the medical plan, to carve it out of the medical plan leaving the benefit levels the same. We continuously look at the trend for the health expenditure. Hopefully, some of the efforts shared earlier today related to ACPs, bundled care, and the SmartHealth Program will be bending that cost curve as we look at reducing the overall trend as part of the Triple Aim.

Greg Devereux: Who is the tax on?

Mary Fliss: The tax is assessed against the employer on a per-individual basis for those employees receiving a benefit over that amount because individuals have their election amount in terms of how much FSA or HSA elections they can take.

Yvonne Tate: I am guessing that this will probably have a bigger impact on government employers than most private employers because the government plans tend to be a bit richer.

Mary Fliss: It is based upon the cost of those plans. It does correlate to those costs. Sometimes there's that factor of richness in addition to other factors.

Yvonne Tate: The other thing I worry about is public safety employees that typically get free health care, what is that impact? Do you have the State Patrol in your plan?

Mary Fliss: We do have the Washington State Patrol and other safety officers as part of our plan and they are part of our pool. In the case of PEBB, all of those expenditures are pooled together as one reporting for that cost component.

The second requirement we're working on for the Affordable Care Act is our Play or Pay reporting. The requirement is for all large employers to either provide benefits to full-time employees or pay a penalty if that employee receives subsidized coverage through an Exchange. Full-time is defined by the IRS and there are several rules and requirements related to how a full-time employee is defined. The requirement of the employer is to report to the IRS for all of those covered on our self-insured plan the months they've been enrolled in coverage, by person; and if they are an FTE according to that definition, the month's affordable minimum value coverage has been offered. Employers are also required to report to subscribers for FTEs, a copy of the return that we sent to the IRS with that report; and for non-FTEs (retirees or self-pay members), as well as those employees who don't meet the full-time criteria, proof by month that they received coverage. This is to help them report for the IRS, if needed, that they have complied with the individual mandate. This is a dual purpose for that reporting.

Currently we have completed the analysis in terms of how to determine an FTE and set up the operating environment. We are working with the state HR database, the eight state payroll systems, as well as others, to operationalize the bulk of the data collection. In terms of next steps, we're working on building a new reporting database; then we'll test and validate the data and reports. We will continue to train agencies, inform our members, implement the reporting for our members in January of 2016, and complete IRS reporting by March 2016. We'll also work on supporting other operations for analysis and reporting now that we will have this information.

Dorothy Teeter: We are canceling our next meeting which is July 8. We will meet again on July 15 and then again on July 22.

Meeting adjourned at 2:55 p.m.