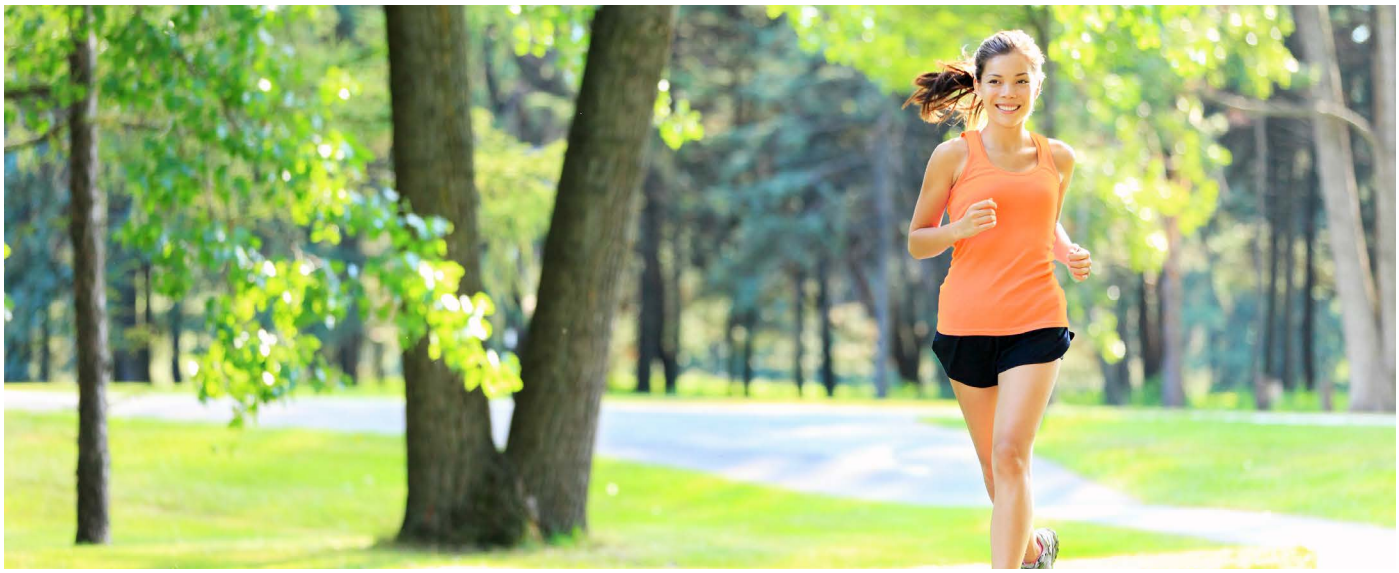
APRIL
2013

ProducerPulse



Spring producer seminars: What you need to know about the ACA and the exchange

If you are still uncertain about how the Accountable Care Act will affect your business and how the exchange will work, you'll find answers at our May producer seminar, Preparing for the ACA and Exchange.

For your convenience, we're offering this two-hour seminar at eight locations throughout the state. By attending one, you'll feel more confident about the new health care world that's unfolding, and get answers to your most pressing questions such as:

- How the exchange will affect your business.
- What our mutual clients need to know.
- How the Washington Healthplanfinder, our state's exchange marketplace, will work.
- Group Health's 2014 offerings in and out of the exchange.
- Group Health's business strategy and goals.

Click to register

more on page 9

State legislative update: What bills matter? We're watching those that impact our industry.

As the state legislature nears the end of its regular session, we're continuing to monitor legislation that will impact the health care industry.

more on page 3

GUEST COLUMN:

New collaboration offers worksite clinics

By Elisabeth Buchman
Director, Product Development and Management

Early last month we announced that Group Health has joined forces with Seattle-based Vera Whole Health to offer worksite primary care clinics to employers in Washington state.

Increasingly we've heard from employers that worksite clinics are a valuable benefit for their employees. By joining with a company that already has a successful workplace clinic model in place, we're able to immediately meet this need for producers and employers throughout our service area—including areas where Group Health doesn't operate

more on page 17

GroupHealth

Many ways to work together in this time of change

Spring signifies a time of renewal and growth, and that is exactly what is happening at Group Health. We are renewing our focus on providing high quality medical care and coverage, and ensuring that it is affordable for our members and clients.

We are focusing on the future, with an eye on our heritage, through our new "One Goal" ad campaign that you can read about in this issue (with a link, so you can also view the ads). It illustrates our philosophy of integrated care and coverage, and our unique outlook on health care.

Many employers have been looking for creative ways to manage their health care expenses, including onsite clinics. I am particularly excited about our new alliance with Vera Whole Health, outlined in this issue. By teaming up with Vera, an expert in worksite clinics, Group Health can offer integrated health care and wellness services to clients that would benefit from an on-site clinic solution.

How the exchange markets will impact our industry is a question that's top of mind for all of us these days. That's why we are offering a producer seminar at eight locations across the state in May with information on the Accountable Care Act and the exchange. We also have an article this month that sheds some light on how the exchange will work in our state. And don't miss our updates on what's happening at the federal and state level in regard to health care reform. Federal regulations continue to roll out, and even as you read this, our state legislators are making decisions about issues that impact our industry—such as how our exchange market will be funded. Count on us to keep you informed about issues that are important to you and your clients.

I have been fortunate to meet and spend time with many of you in the last couple of months, and this time has renewed my commitment to continue our conversations. As I've been saying in our meetings, we intend to be a force for positive change in the health care industry. And we know that we can only do that by working closely with each of you. We'll continue to seek your advice and ensure that our business relationship is strong and profitable.

Regards,

Debbie Huntington

What bills matter? We're watching those that impact our industry

continued from page 1

HB 1947 FUNDING FOR THE WASHINGTON STATE HEALTH CARE EXCHANGE

Background: The Accountable Care Act requires that exchange operations be financially self-sustaining by 2014. The Washington Health Benefits Exchange board recommended that the legislature choose one of three funding options for exchange operations:

- **Option 1:** A 1 percent premium tax increase on all fully insured products sold in Washington state;
- **Option 2:** A per member per month (PMPM) assessment from carriers selling products in the exchange; and
- **Option 3:** A hybrid model that diverts existing premium taxes collected from sales of qualified health plans within the exchange, augmented by an assessment from plans in the exchange.

What HB 1947 says: HB 1947 proposes a modified version of the hybrid model (option 3). It funds the exchange with premium tax revenues collected from the sale of health and dental plans inside the exchange and from the sale of Medicaid expansion coverage. The remaining revenue comes from a PMPM assessment charged to carriers selling health and dental plans in the exchange. Federal market rules, however, require that the assessment be spread across a carrier's entire individual or small group pool. Even enrollees outside the exchange will pay premiums that include the cost of the assessment. The bill requires the state legislature to appropriate the premium tax funds and in the process gives state budget writers new controls over the exchange.

By adding Medicaid expansion premium taxes to the exchange's total revenue, HB 1947 minimizes the burden that new assessments place on consumers. Many observers are also concerned about the exchange's projected $50 million budget and this bill authorizes legislative oversight on administrative spending.

Status:* HB 1947 has been referred to the Senate Ways and Means Committee. The Senate budget uses a separate method for financing the exchange, limiting assessments to 1.8 percent of premiums paid and making an appropriation of $6.2 million

continued on page 4

What bills matter? We're watching those that impact our industry

continued from page 3

to cover Medicaid's contribution. It does not allow use of the premium tax. This bill is evolving. Since it's tied to the state budget, it's unlikely to be resolved until the end of session.

SB 5540 SB 5605 LEVELING THE PLAYING FIELD IN THE INDIVIDUAL AND SMALL GROUP MARKETS

Background: When open enrollment begins in the exchange, individuals and small employers will have the choice of shopping for health coverage in the exchange or in the individual and small group markets outside of the exchange. If there is not similarity in the market and rating rules governing the design and sale of benefits plans inside and outside of the exchange, it's possible that healthier individuals will disproportionately seek coverage outside the exchange. This could lead to an upward spiral of prices inside the exchange. These two bills affect the level playing field in individual and small group markets.

What SB 5605 says: Health plans provided through associations of individuals and small employers are treated as large employers. This allows them to remain exempt from many of the market rules implemented by the ACA. The federal government has indicated that it intends to treat most association health plans as a collection of small employers, subjecting them to the same rules as the small group market.

There is a disparity between SB 5605 and federal law. If enacted, SB 5605 would allow the continuation of a second small group market outside of the exchange that doesn't follow the same rules. This could deter small groups' participation in the small group exchange (called the SHOP) due to creating an adverse risk pool in the SHOP and outside market.

Status:* Federal government officials have informed the Office of the Insurance Commissioner (OIC) that they believe SB 5605 is incompatible with federal law. The bill missed the cutoff deadline to be passed out of committee but is still included in the Senate budget.

What SB 5540 says: It allows insurance carriers from other states to sell insurance products registered in their home states in the Washington state small group market. Originally, these plans would have been exempt from meeting Washington benefit mandates and the new market rules passed last year. But, based on testimony provided by concerned stakeholders, the Senate Health Care Committee amended the bill to require that out-of-state plans follow Washington's market rules and provide benefits substantially equal to Washington's essential health benefits.

Status:* The bill received a hearing in the House Appropriations Committee but has not been voted out, though funding for the bill is included in the Senate budget.

SB 5267 PRIOR AUTHORIZATION FORM

Background: This bill originally required that all carriers use the same prior authorization form for all services. Many carriers, however, expressed concern that SB 5267 would duplicate the administrative simplification work already started several years ago by OneHealthPort, a private sector group. OneHealthGroup was charged with recommending best practices for prior authorization. The bill has since been amended several times.

What SB 5267 says: In its current form, SB 5267 requires legislators to convene their own study group to review national standards for data transmission and prior authorization timelines. The OIC is required to write rules implementing the workgroup's recommendations by July of 2014.

Status:* The bill is waiting in the Rules Committee to be scheduled for a vote of the full House of Representatives.

continued on page 5

* Bill status updated just prior to completion of this edition of *Producer Pulse*.

What bills matter? We're watching those that impact our industry

continued from page 4

SB 5215 PROVIDER CONTRACTING FAIRNESS

What SB 5215 says: The original bill—which would have required carriers to obtain approval from every contracted provider for any material changes in a contract—was amended to give providers 60 days to reject changes to a contract. The change from an "opt-in" to an "opt-out" process will save insurance carriers many hours of unnecessary paper work.

Status:* The bill is waiting in the Rules Committee to be scheduled for a vote of the full House of Representatives.

SB 5434 PROVIDER PAYMENT CONFIDENTIALITY

What SB 5434 says: Over the summer, the OIC required that carriers begin to disclose the financial terms of their contracts. This means provider payment information is open to public disclosure requests for information—and therefore accessible to competitors. SB 5434 prevents public disclosure requests for provider payment rates.

Status:* The bill is waiting in the Rules Committee to be scheduled for a vote of the full House of Representatives.

Several other bills related to the health care industry did not make it out of committee. They include: HB 1448, telemedicine and reimbursement; and HB 1044, voluntary pregnancy termination coverage mandate.

You'll find more information on bills we're watching at the Washington State Legislature website.

* Bill status updated just prior to completion of this edition of *Producer Pulse.*

What you need to know about the proposed contraceptive services rule

By Megan Howell, Director, Policy and Regulatory Affairs

A proposed rule addressing coverage of contraceptive services under the preventive services requirements of the Affordable Care Act (ACA) was recently issued by the Internal Revenue Service, Department of Labor, and Department of Health and Human Services (HHS).

It's important to remember that this is only a proposal, and is likely to change before a final regulation is issued sometime later this year. But here's what we know at the moment.

A previous proposal already exempted some religious groups. The new proposed rule does two things:

- It broadens which religious groups are exempt from providing contraceptive services.
- It adds a separate group of employees (see below) who would be eligible for "accommodations." This means the organizations would not be responsible for paying the cost of providing contraceptive services. However, it gives employees the ability to receive contraception through separate health policies at no charge.

Coverage of contraceptive services includes all FDA-approved contraceptive methods, including birth control, sterilization procedures, and patient education and counseling for all women who might become pregnant.

Groups that are exempt or accommodated

Exempt groups. The proposed rule continues to exempt religious employers from providing contraceptive services under their sponsored health plans, but it broadens the definition of religious employer to include any nonprofit entity the existing tax code describes as a house of worship. This means a soup kitchen or parochial school operated by a house of worship would qualify for exemption, even if the purpose of these organizations extend beyond instilling religious values or if they serve or hire people of a different religious faith.

Accommodated groups. These are religious nonprofit organizations that oppose providing coverage for some or all contraceptive services on religious grounds. These can include religious nonprofit hospitals, universities, and charities.

> It's important to remember that this is only a proposal, and is likely to change before a final regulation is issued sometime later this year.

Who pays?

Fully insured plans. The carrier will be required to provide the contraceptive coverage under a separate individual health insurance policy, in which the enrollees will be automatically enrolled. HHS believes that providing this coverage is "cost neutral" because the carrier will be insuring the same set of individuals under both policies and will experience lower costs from improvements in women's health and fewer childbirths.

Self-funded plans. The third party administrator (TPA) will arrange separate individual health insurance policies for contraceptive coverage from a carrier that provides such policies. The carrier providing the coverage (or a carrier that is affiliated) will receive an adjustment in the user fees otherwise charged by a federally-facilitated exchange (FFE). This reduces the amount of such fees for the carrier providing the coverage. The carrier would also pass a portion of the adjustment amount on to the TPA to help offset a reasonable charge by the TPA for administering the policies.

We'll continue to monitor this proposed ruling, and will share information with you as it becomes available.

LARGE GROUP:

Our 2014 school district plans maximize choices

A diversity of health plans that can be customized to meet the specific needs of individual school districts throughout the state are included in our 2014 plan offerings. We began producing quotes for these plans at the end of March.

"We're offering a set of nine plans as a starting point, including Group Health HMO plans, point-of-service (POS) plans, a health savings account (HSA), and a preferred provider organization (PPO) plan that's not usually offered in Western Washington," says Connie Marvik, director, Commercial Large Group Sales & Account Management. "We made an exception with the PPO for school districts so they'll have enough choices for total replacement—the preference in this marketplace."

From the basic menu of nine plans, each school district can choose an HMO, an HSA, and three others, in any combination—for a total of five plans. From there, districts can customize benefits, deductibles, copays, and other plan features. "We're making it as easy as possible for school districts to gain control of their benefits," says Marvik.

Blending KPS and Group Health rates

We will continue to offer KPS Health Plans' PPO plans and, for the first time ever, we'll blend their claims experience with Group Health's to ensure consistency of rates and the stability of all plans.

more on page 8

Want more information—or a quote?

Ask your account manager for our brochure that lists specifics about the Group Health 2014 plans for school districts. It's a great tool you can use to explain the plan options to your clients. We'll also be glad to prepare quotes for your clients. All we'll need is their employee census (in Excel) and details on their current benefits.

The lingo: Exchange terms you should know

Here are just a few of the terms you'll be hearing a lot about in the coming months as the exchange market gets up and rolling.

PUBLIC EXCHANGE

A government-regulated online marketplace that can be run by the federal or state government. It will be the only place where individuals, families, and small groups may purchase health insurance that's eligible for new federal subsidies—tax credits and cost-sharing assistance—as of Jan. 1, 2014. (Small groups are only eligible for tax credits.) In Washington state, it's called the Washington Healthplanfinder.

WASHINGTON HEALTHPLANFINDER

The online marketplace for individuals, families, and small businesses (1–50 employees) that provides side-by-side plan comparisons based on factors such as cost and quality. For individuals, it will include a calculator to help consumers determine if they qualify for financial assistance (subsidy) to help pay for their coverage, and allows them to purchase coverage online. It becomes operational on Oct. 1, 2013 for enrollment in plans becoming effective Jan. 1, 2014.

SHOP

This is an acronym for the Small Business Health Options Program, the part of the exchange specifically for small employers and the self-employed. It begins in 2014, and Group Health plans to participate in 2015.

10 ESSENTIAL BENEFITS

The minimum health benefits all I&F and small business plans must provide in Washington state: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative services and devices, lab services, preventive and wellness services and chronic disease management, and pediatric services—including dental and vision care.

METAL TIERS

Plan options will be broken down into tiers based on the level of coverage they provide. Each tier corresponds to an actuarial value. The actuarial values are bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent).

LARGE GROUP: Our 2014 school district plans maximize choices

continued from page 7

"In total replacement groups where both Group Health and KPS plans are offered, experience will be blended for renewal calculations," says Marvik. "Our goal is to provide consistent renewal increases, no matter which product is purchased. Bremerton-based KPS is an important subsidiary of Group Health, and their plans bring value to customers that we don't want to disrupt."

Complying with new legislation

We've made changes to be sure that all of our offerings comply with regulations in SB 5940, legislation that was passed by the state last year. We're offering a high-deductible health saving account plan, as required, and are complying with the new regulations around data reporting. In addition, we're available to help you and your clients strategize benefit and contribution solutions to easily satisfy the new requirements.

Spring seminars: What you need to know about the ACA and the exchange

continued from page 1

Sign up today. Group Health Producer Seminar – Preparing for the ACA and Exchange

Click to register

Spokane
Monday, May 6
8–10 a.m.
Holiday Inn

Walla Walla
Tuesday, May 7
8–10 a.m.
Marcus Whitman Hotel

Richland
Tuesday, May 7
1–3 p.m.
Hampton Inn

Yakima
Wednesday, May 8
9–11 a.m.
Hilton Garden Inn

Bellingham
Friday, May 10
8–10 a.m.
Bellingham Golf & Country Club

Seattle
Monday, May 13
8–10 a.m.
McCormick & Schmick's Harborside

Everett
Tuesday, May 14
1–3 p.m.
Holiday Inn

Tacoma
Wednesday, May 15
8–10 a.m.
Courtyard by Marriott

SMALL GROUP AND INDIVIDUAL AND FAMILY:

Ready for the exchange? We're ready to help

The arrival of the exchange market is right around the corner, and there are several things you need to do between now and then to prepare for this major change in the marketplace.

For small group and individual and family producers

1. **Get the required training and certification.** You need training and certification from the State of Washington to qualify for selling exchange products. State training programs will be held this summer. Keep an eye out for dates, times, and locations by visiting the Washington Health Benefit Exchange website periodically.

2. **Learn about Group Health's 2014 plan offerings.** All of our plans will change from those being offered in 2013, and the new plans and rates won't be approved until this summer—probably in late August. When the details become available, you'll want to be ready to field questions from your clients as they review the new plans and make choices.

For individual and family producers

3. **Communicate with and engage your clients.** This will put you foremost in their minds when they go to enroll. Here's why that's so important:

- If a current I&F member or mutual client chooses a non-exchange Group Health I&F plan, you automatically remain their producer of record—and continue to receive the commission—unless otherwise directed by the member.
- If they choose a Group Health plan through the exchange, that guarantee is eliminated. Instead, it's up to your client to remember to designate you as their producer. Chances are they'll remember to do so if you've been communicating with them regularly prior to open enrollment beginning on the Washington Healthplanfinder (the name of our state's exchange marketplace) on Oct. 1.

In the next few months, we'll begin communicating with our members and mutual clients about the changes related to the exchange, and will provide them with the tools and resources to understand their options. We'll let you know about these communications before we send them to any of your clients.

"As we all go through this significant market shift, we want you to know that we're fully committed to assisting you and supporting you and our mutual clients, both in and out of the exchange market," says Rick Henshaw, director of Individual and Family and Medicare Sales.

SMALL GROUP:

Big savings on HMO premium

Since the launch of the small group portfolio of plans in 2008, the Group Health Cooperative HMO utilization pool has performed significantly better than the Group Health Options, Inc. Alliant Plus pool. As a result, rates for the HMO product are currently more than 30 percent lower than rates for Alliant Plus.

If any of your small employer groups are on Alliant Plus or Options, but could be served just as well with the Group Health HMO product offerings and its network of providers, a switch in plans will give them an immediate and significant premium savings, while still providing the same types of benefit designs and cost shares.

The Resource Stewardship initiative: Can it help keep down costs?

Better use of health care resources, which includes maintaining quality and access to care, is one way to hold down health care costs. That's what the Group Health Resource Stewardship initiative is all about. Eric B. Larson, executive director at the Group Health Research Institute explains this initiative and an evaluation of it being conducted by the Institute. Read more.

Heart problems? Group Health is among the best for care

Group Health Cooperative was recently identified by the National Committee for Quality Assurance (NCQA) as a health plan that provides superior care to patients with heart conditions.

The recognition earns Group Health a spot on the coveted list of high performing health plans across the country, that will be used as a resource for Million Hearts. This effort, led by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services, is a national initiative to prevent one million strokes and heart attacks by 2017.

The NCQA is a private, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of heath care organizations and recognizes clinicians in key clinical areas.

INDIVIDUAL AND FAMILY:

Important steps to keep your business running smoothly

Submit a producer of record request

Are you a producer for I&F and Medicare Advantage plans? If so, did you know that you need to submit a producer of record request to Group Health whenever there is an add or change to a subscriber's producer of record?

It's easy to request this change. Just submit one of the following: a letter to Group Health signed by the subscriber indicating the new producer of record; or ask the subscriber to send you an e-mail requesting you as a producer of record. Then just forward the e-mail directly to Group Health (you must show that the e-mail originated from the subscriber).

To ensure that a change or addition to the producer of record is properly documented, you must also provide the following information in your request:

- Subscriber's full name
- Subscriber's member ID number
- The effective date of the new producer of record
- Producer name
- Producer number (agent ID)
- House/agency name
- House/agency number
- Signature of the subscriber and signature date

Changing a book of business

There is a process you need to follow when transferring an entire book of business from one producer to another. For a multi-agent house, submit a release letter signed by the office manager/ president. For an individual producer, submit a new agent of record letter from each client.

Assigning initial applications

For our producer partners with multiple appointments, it's critical that you indicate which house or broker number you would like an application assigned to on the initial application. By adding this information, you will help our pre-enrollment team process these applications more efficiently, resulting in prompt commissions for you and a quicker turnaround time for our clients.

Please contact your sales executive if you need any assistance or have any questions about adding or changing a producer of record.

INDIVIDUAL AND FAMILY:

Remind your I&F clients to add dependents now

It's not too late. Open enrollment for I&F plan subscribers and dependents under age 19 doesn't close until April 30. This is a good time to remind any current members who have asked about adding dependents to their plan to submit a complete application by April 30 for a May 1 effective date.

You can ensure that the enrollment process goes smoothly for our mutual clients by verifying the following:

- When completing an application for a child subscriber (under age 18), make sure the financial guarantor is indicated on page 4, Section 3.
- When moving a child from one subscriber's policy to another, make sure the subscriber who is currently providing coverage for the child has submitted written permission for the change.
- Before making any plan change, the subscriber's current account must be paid in full.

The next opportunity for open enrollment for under age 19 will be Sept. 15 to Oct. 31. To learn more about under age 19 open enrollment, please visit the Producer Portal.

INDIVIDUAL AND FAMILY:

Go green with less paper, more electronic tools

In response to feedback from you and our mutual clients, and to drive down costs, we continue to ramp up initiatives that will increase your access to and use of online tools and electronic processes.

Weekly status reports via e-mail

In February you began receiving weekly reports via e-mail to keep you abreast of the status of your clients' I&F enrollment applications. This weekly e-mail ensures more timely information than sending these reports via regular mail, and eliminates unnecessary paper and postage costs.

Online coverage agreements

Members can review their coverage agreements online through MyGroupHealth at ghc.org to get a detailed look at the services and benefits available to them. While this information has been available to members for several years, we have previously also mailed hard copy coverage agreements to all new members.

VIEW POSTCARD

New members who still want to receive a hard copy of their coverage agreement can e-mail a request to Customer Service. They can also return a postcard, which will be sent to all new members as part of their welcome letter. The letter will encourage them to register for secure access to many useful online tools, such as prescription renewal, benefit information, and more.

MEDICARE ADVANTAGE:

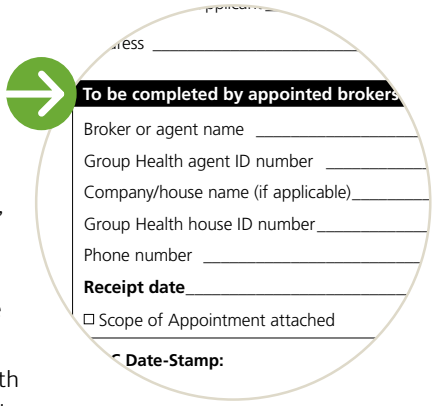
An enrollment increase (thanks!) and new forms to complete

The hard work of our Medicare certified brokers has achieved outstanding results during the Medicare Advantage Annual Enrollment period that ended Dec. 7, 2012. Thanks to you, we ended the period with nearly 6,000 new Group Health Medicare Advantage enrollees. We also observed a 25 percent increase in new enrollees represented by a broker or agent over the same period last year.

Despite plan changes and rate increases, Group Health's 2013 5-star Medicare Advantage HMO plans continue to offer a competitive choice for prospective subscribers. The growth in new enrollees is due to several factors, including marketplace disruptions that resulted in more individuals with other carriers seeking new coverage, as well as the high quality ratings for our Group Health's Medicare Advantage plans, and continued improvements in our brand.

A quick reminder

To ensure we meet all Medicare enrollment process requirements, which are regulated by the Centers for Medicare & Medicaid services (CMS), it's critical that all information required on Medicare Advantage HMO and PPO enrollment forms is complete. There's been a recent uptick of incomplete information, particularly within the appointed broker/agent section located on page 6 of these forms. Your continued assistance with this is much appreciated.



It's also vitally important that you submit all completed enrollment forms to us immediately upon receipt. As noted in the Medicare Managed Care Manual, the date of receipt is based upon the date the broker (not Group Health) receives a completed enrollment request. To ensure our compliance with these regulations, we rely on your ongoing efforts to promptly process completed enrollment forms.

ACOs? They're all about working together and we're leading the way

Accountable care organizations (ACOs)—where doctors, hospitals, and other providers join together to deliver better coordinated care, often at lower cost—are popping up all over the United States. In fact, Cigna, First Choice, and United Healthcare reported on their organizations' progress in forming ACOs at the recent Employee Benefits Planning Association (EBPA) meeting in Seattle. Many of you were there.

What you may not know is that Group Health is also an ACO leader. "During the last few years, we've been working on forming ACOs in Spokane, Snohomish, and Tacoma with like-minded organizations who share our commitment to affordable, evidence-based care," says Group Health president and CEO Scott Armstrong. "Our goal is to deliver care to the greatest number of patients, in the most integrated and cost-effective way possible, while responding to the individual needs of each distinct market."

Creating Spokane's largest physician group

In 2011, we purchased Columbia Medical Associates (CMA), a multispecialty medical group, in Spokane. Then late last year we formed a limited liability company (LLC) with Providence Health Care—creating the largest physician organization in the Spokane area (source: OIC Provider Network Form A).

"We expect that the quality and cost of care will improve as our clinicians follow standard protocols and share medical records," says Kelly Stanford, vice president of East and Central Markets. "Fewer tests will be repeated because doctors will see the same records and communicate more reliably with each other about their patients' needs."

One of the first tangible improvements will be expanding urgent care services for Group Health members. This summer, Providence is opening its second urgent care facility in Spokane, where Group Health and Providence physicians will work side by side.

Earlier this month, we cosponsored a continuing medical education (CME) workshop in Spokane with Providence and Northwest Orthopaedic Specialists. Panelists discussed best practices for diagnosing and treating acute injury and chronic pain of the knee, and explored ways clinicians can collaborate to provide the highest quality and most cost-effective care. The event was the first in a new Clinical Integration Workshop series we're launching in both Spokane and Tacoma this year.

continued on page 14

ACOs? They're all about working together and we're leading the way

continued from page 13

Alliance Agreement strengthens relationship in Snohomish

Building on a collaboration that began in 2010, Group Health Physicians, Group Health Cooperative, and The Everett Clinic (TEC) created a new Alliance Agreement late last year. Group Health and TEC will remain independent, with the possibility of forming an LLC down the road.

Plans for an ACO are in the works, where providers will share responsibility for delivering seamless, coordinated care, and implementing joint clinical programs and approaches to help patients avoid unnecessary emergency room visits and hospital admissions.

We've expanded the Group Health Medicare Advantage HMO network to include TEC, and together are focusing on maintaining our Medicare 5-star rating. We're also exploring care coordination and an integrated network for several large employers in the area, and working to share best practices and resources.

Collaboration expands with Franciscan in Tacoma

A new five-year agreement with Franciscan Health System went fully into effect in January. In this expansion of our previous contract, we made a formal commitment to work more closely together on early management of chronic diseases and better collaboration between patients' primary care physicians and hospitals. We're also striving to maximize the use of electronic health records between our organizations, and share best practices.

In addition, we're continuing to work with MultiCare Health System and others in the Tacoma region to promote better care practices and care integration.

In June, Group Health, Franciscan, and MultiCare will cosponsor a workshop for clinical professionals, medical executives, medical administrators, and government policymakers on creating a healthier community—with specific focus on ways we can collaborate to improve heart health in the Tacoma area.

Our recent collaborations in Spokane, Snohomish, and Tacoma are just the start of the relationships we intend to develop in each of our key markets—and beyond. Stay tuned for more details in the coming months.

What's an accountable care organization (ACO)?

It's a group of health care providers—including physicians and/or hospitals—that take on shared responsibility for quality, cost, and overall care of a defined patient population.

We're building or extending relationships with these organizations, and sharing ideas and resources in a variety of ways.

A smart solution to the provider shortage

By Barbara Trehearne, PhD, RN
Vice President, Clinical Excellence and Nursing Operations

As reported recently in the *New York Times*, the Association of American Medical Colleges projects a shortage of 45,000 primary care doctors in the United States by 2020 and a shortage of 65,000 by 2025. Other sources put that number even higher, at 90,000.

Even today, we're seeing signs of this. Around the country, wait times to see a primary care doctor can be long, and emergency rooms are packed. Fewer and fewer medical students are choosing primary care, which includes internal medicine, family medicine, and pediatrics. Among the reasons for this: Primary care doctors face long hours in many practices, as well as lower annual incomes than doctors who choose a specialty.

One solution: Greater use of nurse practitioners

One way to address this critical shortage is being embraced by many healthcare organizations, including Group Health. It's through the greater use of advanced registered nurse practitioners. Here in Washington, progressive laws allow nurse practitioners to prescribe medications, as well as diagnose and treat patients in a comprehensive manner, the same way a physician does.

Most new nurse practitioners are prepared to work in a primary care environment, and we know that 80 percent of adult primary care can be managed successfully by nurse practitioners. In pediatrics, that percentage climbs to 90 percent.

Nurse practitioners who hold advanced degrees, either a master's degree or a doctorate in nursing, represent one of the most rapidly growing segments of the health care workforce. Their graduation rates are climbing, and 89 percent of those graduates are being prepared to serve in primary care roles.

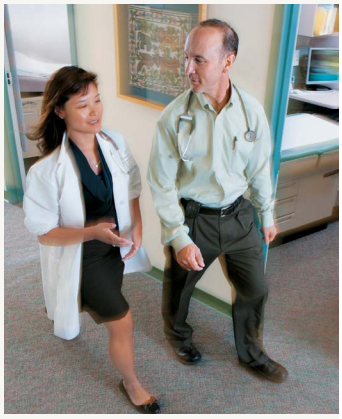
Costs and patient satisfaction

Amidst the news of health care's ever growing costs, nurse practitioners are a bright spot. Data suggests that per-patient visit costs can be decreased by a third with a nurse practitioner compared with a physician. Nurse practitioners can reduce wait times, ease access, and free up physicians to manage more complex patients. Many studies also show patient satisfaction with nurse practitioners is very high. Clinical and cost outcomes are equal to a physician practice.

One of the promising models used by Group Health—and other large health systems such as Kaiser Permanente—is a shared or collaborative practice model that allows nurse practitioners, physicians, other nurses, and physician assistants to work closely with one another. This model offers the best of all worlds. It's one that other systems that also want to provide top notch and affordable care would do well to examine as we move even deeper into health care reform.

Training new physicians at Group Health

As the nation faces a shortage of primary care physicians, Group Health's Family Medicine Residency program, established in 1969, ensures a steady influx of well-trained physicians. Each year, the highly selective program accepts seven new residents. On average, half of the residents choose to practice at Group Health after they graduate.



New advertising campaign highlights care and coverage

Group Health's unusual position in the health care world—offering both care and coverage—is highlighted in our new One Goal advertising campaign that kicked off last month. The campaign focuses on Group Health's single goal of better health for those it serves, a goal which is fully shared by its members and purchasers and that can only be realized through the advantages of care and coverage working together.

"The campaign is designed to help our customers understand the Group Health difference and why it offers them a better choice for their health care," says Randy Wise, vice president of marketing.

The campaign will be delivered through TV, radio, and online outlets in the greater Seattle and Spokane regions of the state, and will continue year-round with emphasis in the spring and during open enrollment in the fall. It drives viewers and listeners to a website, ghc.org/onegoal where they can learn more details about what Group Health offers, and how it stands apart from the alternatives.

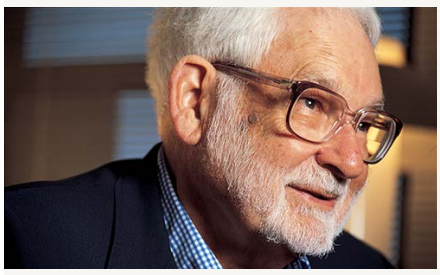
Ideals of a Group Health pioneer and visionary live on

Aubrey Davis, a civic giant who helped pioneer Group Health—and considered his work with our organization his greatest lifetime achievement—passed away in February. He was 95.

"The forces that drove Aubrey, his wife Rhetta, and other community members to found Group Health 66 years ago—the pursuit of affordable high quality health care—continue to drive our work today," said Scott Armstrong, president and CEO, and Porsche Everson, Board president, in a joint message. "Aubrey's passion for a smarter model of integrated health care delivery and financing lives on in everything we do."

Davis joined Group Health Cooperative in 1947, a month after it was founded. He was elected to the Board of Trustees in 1951, and held a seat on the Board for 38 years. He served seven terms as Board president, and three years as president and CEO.

In addition to his work with Group Health, Davis served on the Mercer Island City Council, and as Mercer Island's mayor. He chaired Seattle's Metro Transit Committee, helping to create the ride-free zone, use of higher-capacity articulated buses, and accessibility for the disabled. He served as regional administrator of the federal Urban Mass Transportation Administration, lobbying for funds for Portland's light rail system and Seattle's bus tunnel. Davis also ran businesses that created products ranging from military weather stations to waterproofing for decks.



> People often ask me how I made it to age 95. I had good genes. I had good luck. I had Group Health. What else could I want?
>
> Aubrey Davis, 1918–2013

GUEST COLUMN: New collaboration offers worksite clinics

continued from page 1

Elisabeth Buchman, Director, Product Development and Management

medical centers, such as in the Tri-Cities. It's a service your competitors most likely can't offer.

We chose Vera Whole Health not only because they offer a highly effective model for worksite primary care and wellness, but because their philosophy of care and commitment to best practices match our own.

I'm sure many of you have questions about this new service. So I've created the following Q&A to answer the questions I hear most often. If you'd like more information, I encourage you to contact your sales representative or account manager.

How do worksite clinics benefit employers?

As health care costs continue to climb, employers are looking for ways to keep employees healthy, control health care costs, and manage productivity. On-site clinics can help with all of these.

Because the clinics are so convenient, employees are more likely to get care before health issues become serious and costly. Health coaching in our model makes it easier for employees to get help managing chronic conditions such as diabetes, hypertension, and obesity. This focus on prevention and early interventions reduces emergency room use, the need for specialty care, and rates for hospitalizations and surgery.

Don't you need to be a large employer for a worksite clinic to make sense?

The concept was out of reach for smaller employers, who didn't have enough workers—or not enough workers in one place—to justify the expense. Vera's clinic model overcomes that hurdle by giving employers the opportunity to band together to open a shared clinic, with shared expenses. Vera clinics usually serve around 3,000 employees and dependents. If your client has fewer employees, or just wants to make the clinic more affordable, Vera will work with you, and with them, to find other companies in the immediate geographic area that would like to collaborate on a clinic. Each employer pays their pro rata share for the startup, but the company that hosts the clinic actually owns the space and equipment.

What services does Vera provide?

The clinics offer all employees—Group Health members and nonmembers—and their dependents primary and urgent care, preventive care, onsite lab services, wellness and nutrition coaching, chronic disease management, and medical coordination and referrals. Clinics will also dispense medications. Services can be customized, depending on the organization's needs. Clinics are typically open between 40 and 50 hours a week.

continued on page 18

More about Vera Whole Health

Seattle-based Vera was founded in 2008 to provide high-end fitness services for women. Later that year it expanded to include wellness services for corporate clients' employees, and in 2011 they partnered with Indianapolis-based Activate Healthcare, a company that develops on-site medical clinics. The partnership enabled Vera to expand its offerings to include medical care, and Activate to incorporate wellness programs into its services.

Activate Healthcare operates nine clinics in the Midwest and six more are in development. Clients include MacAllister Machinery, North Lawrence Community Schools, the Pratt Corporation, and Monroe County in Indiana.

In the Seattle area, Vera recently signed a contract with Seattle Children's for a worksite clinic across the street from the hospital. They also opened a "stand alone" primary care clinic in Seattle's International District this year that's designed to serve multiple smaller employer groups in the immediate area.

GUEST COLUMN: New collaboration offers worksite clinics

continued from page 17

For employers who are considering a clinic, Vera provides a workplace assessment of the organization's health care needs and feasibility of a clinic. They facilitate build-out of the clinic, and recruit and hire staff—with input from the employer to make sure the clinic staff fits well with the organization's culture.

They also manage clinic operations and provide reports on utilization, patient satisfaction, and total cost of care. Detailed reporting enables ongoing review of the clinic's effectiveness, and timely adjustment of clinic services when needed.

How are clinics staffed?

They have a board-certified physician, an advanced registered nurse practitioner (ARNP) who's certified as a health coach after 150 hours of intensive training, medical assistants, and others, depending on company size.

Like Group Health, Vera clinicians are paid a salary, so their income isn't based on the number of patients they see in a day. That means they're free to spend extra time to get to the bottom of patients' health issues and provide thoughtful, effective health coaching.

How will Group Health and Vera work together?

When Group Health members need specialty care, complex care follow-up, radiology, complex lab work, mail-order prescriptions, or case management, they will be referred to Group Health clinicians for that care. Non–Group Health members will be referred to their own providers if additional care is needed.

The Vera clinical staff will use Group Health's nationally recognized clinical guidelines and evidence-based best practices, and have access to our continuing medical education courses. Additionally, Group Health will participate in the data analytics and reporting to the employer about outcomes and reduced cost of care.

What's the average price of Vera's services?

All clinic services are free to employees and their dependents. Vera charges the employer an average of $40 per member per month. The price depends on the size of the company and the results of its claims analysis. There is no charge from Group Health related to clinic operations.

What does it cost to open a clinic, and how long does the process take?

A standard clinic that's 1,000–1,200 square feet typically costs about $150,000, but it depends on the employer's specific needs and the available space. Startup usually takes about 4–10 months—a month to get a contract signed, then 3–9 months for build-out of the facility and hiring the staff.

Award recognizes doctor's achievements in women's health

Jane Dimer, MD, chief of Women's Health at Group Health, was one of three finalists to receive the "Outstanding Health Care Practitioner" award at the recent 2013 Leaders in Health Care event sponsored by *Seattle Business* magazine.

The award recognized Dr. Dimer's team-focused, collaborative work with midwives, obstetricians, nurses, and residents at Family Beginnings Birthing Center to help reduce the rate of cesarean births. Group Health now has one of the lowest cesarean birth rates in Washington state, a nationally recognized achievement.

Dr. Dimer has also been an international advocate for reproductive health, traveling to Vietnam and Laos with the U.S. State Department to teach and learn.

Group Health Medical Centers clinics go cashless

Beginning in May, Group Health is going cashless at all of our clinic locations that accept patient payments. This change will save money, and is also expected to reduce wait times for patients. Read more.

Top performing producers

Individual and Family—January 2013

Ucentris Insured Solutions Inc	Steven Gleason Samuel Strok William Clem Michael Daugherty John McDonald Chris Wickizer Michael Kerner
Vernon Bonfield	
Wallace Rice Benefits LLC	Keith Wallace
Burroughs and Associates	Russell Burroughs
Health Insurance Connection Inc.	Becky Hart Kyle Hart

Individual and Family—February 2013

Vernon Bonfield	
Robert L. May & Associates	Robert May
Wallace Rice Benefits LLC	Keith Wallace
Daniel Jacobs	
Aklins	Linda Dodman
NW Insurance Inc.	Justin Rhodes
Ucentris Insured Solutions Inc.	Nick Lamb
Mutual Benefits Inc.	Sarah Freeman
Aaron Swanson	
Benefit Partners Unlimited Inc.	Laprele Hernandez
Benefits NW Inc.	Robert Mori

Small group—February 2013

Rice Insurance LLC	Keith Wallace
S A S Brokerage, Inc.	Ross Abbe
The Advisor Benefits Group Inc.	Marvin Liebe

Small group—February 2013

Snapper Shuler Kenner Insurance	Deana Lewis
D. Hagen Associates Inc.	David Hagen

Small group—March 2013

The Unity Group	Sheldon Smith
Smith Financial Group Inc.	Todd Smith
Robert Wilkin	
Shane Van Dalen	
John Hill	

Large group—March 2013

Barker & Associates LLC	Richard P. Barker
Albers & Company Inc.	Brett A. Meade

Event calendar

May events

May 9 | Lakewood | 8 p.m. | IHOP

South Sound Association of Health Underwriters (SSAHU)
Open Boards Meeting
www.ss-ahu.org

June events

June 6 | Seattle | 7–10 p.m. | McCormick & Schmick's Harborside Restaurant

Employee Benefits Planning Association (EBPA)
Monthly Meeting
www.ebpa.org

June 6 | Vancouver | Club Green Meadows

Tri-County Association of Health Underwriters (TCAHU)
Education Symposium
www.tcahu.org/eventsinfo.html