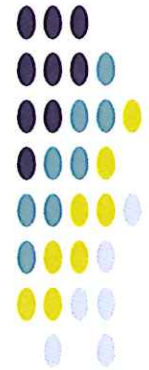


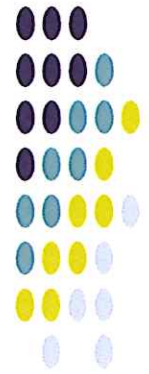
Agenda



- | | | |
|----|--|-------------|
| 1. | Housekeeping/Introductions/Sign in (Benefits Office) | 10:00-10:05 |
| 2. | Announcements & Communications (Benefits Office) | 10:05-10:15 |
| 3. | JPA Exploration –Where we are to-date | 10:15-10:30 |
| 4. | Medicare 2013 (Benefits Office) | 10:30-10:45 |

11:00 - noon

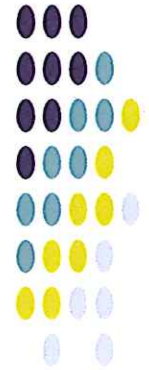
1. Update of out of non-California network options (PSW Benefit Resources)
2. Health Care Reform, A timeline-where we are? (PSW Benefits Resources)
3. PSW-Review of Health & Wellness Plan (PSW Benefits Resources)
4. Next Meeting 2/7/13 & Other Topics?
 1. Medicare Coordination Letters and Process per union agreement
 2. JPA Exploration
 3. Review of current budget expenses for fiscal year July 1 through December 2012
 4. Continued discussion on wellness



Housekeeping

- Please sign – in (include preferred email)
- Welcome new faces to the committee and around the District.

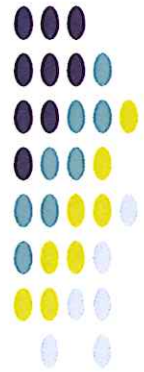
Announcement & Communications



1. January Newsletter
 - 403(b) and 457 Plan and MidAmerica-an update
 - Limits have increased for 2013
 - Continue to use MidAmerica, even retirees
 - Compliance Corner
 - Required information on the employer-issued w-2's, active and working retirees
 - Fiscal Cliff and Flexible Benefit Plan under IRS Code 132, employee contribution limit increased
 - Enrollment Tables
 - Subsidy information
 - Approaching 1.5m in subsidies
 - Retiree Distribution by Date
2. Review of Website Usage

YEAR	Retiree Benefits Information Center		
	Active	Retiree	Total
2011	6067	1305	7372
2012	7125	1800	8925
increase hits over the prior year	17%	38%	21%

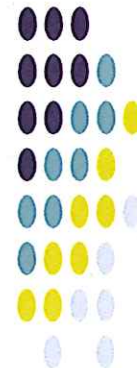
Medicare Enrollment Drive 2013



3. Review of progress toward 100 participation-Medicare non-enrollment statistics 2011 and 2012

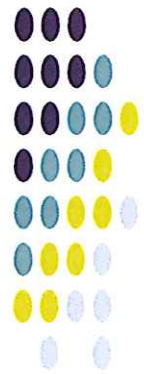
	Non-Coordinated Retirees and Dependents January 2013		
YEAR	Kaiser	CoreSource	Total
2011	46	29	
2012	20	14	pending TPA & PSW Verification
change in population	-57%	-52%	

Medicare Enrollment Drive 2013- Exceptions and/or annual re- validation with the District



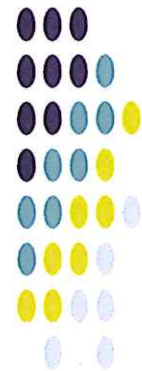
- Exceptions resulting from 2012 efforts:
 1. Primary other coverage exist because or current coverage under another group
 2. The requirement for Medicare coordination does not exist based on retirement date and then current union affiliation
 3. The requirement of Medicare coordination does not exist based on retirement date or retirement as of management, confidential
 4. Enrollment in Kaiser Senior Advantage out-of-area plan non serviced by Medicare or approved by the Centers for Medicare and Medicaid Services (self-funding enrollment is a non-preferred option)

Medicare Enrollment Drive 2013- Purge



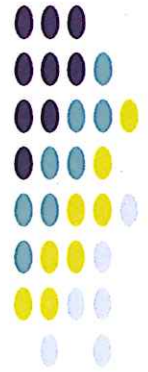
- Part of our on-going process includes the quarterly purge of deceased records for retirees and their enrolled dependents
- We are performing this exercise now through
 - Mailings, returned mail
 - Interactive database which is coordinated by Social Security, but is not the Social Security database

Medicare Enrollment Drive 2013- Fifth Annual Meeting 2/5/13



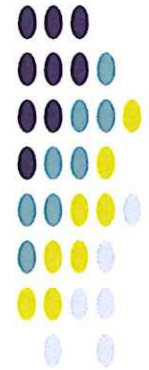
1. Announcement sent to retirees in the *January 8, 2013 Peralta Benefits Everyone Newsletter*
 - Caretakers are welcome
2. Kaiser Senior Advantage, Benefit Dynamics, Social Security/Medicare Administration represented
 - Onsite enrollment for Medicare and/or Kaiser Senior Advantage
 - Onsite acceptance of Medicare statements
3. Another postcard or announcement will go out in 2 weeks
4. We will integrate the two topics:
 - Medicare Coordination
 - What every survivor should know
 - Lunch provided, no rsvp necessary
5. Hardcopies will continue to be available
 - 2013 Medicare A & B Premium Plan Document, Claim forms

Medicare Enrollment Drive 2013- Personal Calls & Appointments



1. In March, we will continue efforts and schedule personal appointments
2. Medicare enrollment becomes effective July 1 unless there is a qualifying reason to allow earlier enrollment

Joint Powers Authority Exploration



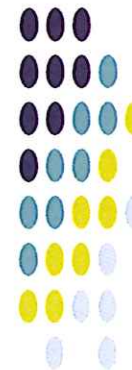
- Language and Spirit of the Charge: Why are we exploring?

Excerpt from 2012 Successor Agreement
(PFT Version)

Feasibility study of post-2004 hires buying into Peralta's retiree benefits

The District will look into the feasibility of allowing post-2004 unit members access to Kaiser and Peralta's PPO in retirement at no cost to the District, after the District becomes a part of a JPA for Kaiser.

Joint Powers Authority Exploration

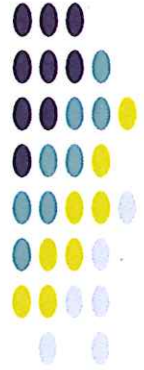


Feasibility study of post-2004 hires buying into Peralta's retiree benefits

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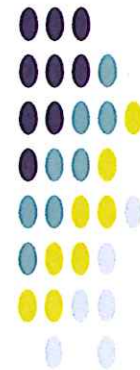
1. Brief recap for the benefit of new committee members-Kaiser increase of 18%, language as referenced above.
2. Considerations-
 - Who can mirror the plan design we currently offer to our active employees
 - Which partnership will mirror the plan design we currently offer to our retirees
 - Which partnership will accept our Kaiser population exclusively (active or retired)
 - There are specific entry and exit times which are not currently in synch with our negotiation schedule
 - Ease of entry and exit, minimal commitment periods
3. Who did we look at and why?
 - Alliant (currently partners with us for the Dental Plan)
 - ASCIP (currently partners with us for workers comp)
 - SISC-Self-Insured Schools of California (Recovery Team)
4. During the exploration, what did we learn?
 1. While we speak of JPA in terms of a shared risk pool, there are other similar types of arrangements to consider.
 2. CalPERS is a Joint Trust (JT)
 3. Joint Trusts, JPA's and the like can become insolvent
 4. We carry forward our Kaiser Renewal rates event if the JPA or JT rates are higher and we may therefore not recognize any savings.
 5. We are committed to the "train-in" rate
 6. We lose our flexibility on exceptional processes
 7. We lose our subsidies (ie Medicare D)
 8. Some partnerships will now allow cash in-lieu
 9. Some partnerships REQUIRE Medicare coordination without exception
 10. Cost savings is an outcome of which plan design with which we partner
 11. JPAs offer more than one-which would fit and help us reach goal
 12. We would incur old expenses on top of new expenses concurrently (\$1-2 m)
 13. ANYTHING ELSE needed as part of the feasibility study
 14. Impact of Patient Protection and Affordable Care Act Health Care Reforms unknown as exchanges are introduced
 15. Impact to Other Post Employment Benefits (OPEB) unknown
 16. We can join a partnership with or without a consultant or broker
5. WHAT MORE DO WE NEED IN ORDER FOR THE COMMITTEE TO MAKE A RECOMMENDATION?

Out of California claims-what types of claims were paid? Follow up question from December 2012 meeting



- During the December 2012 meeting, it appears that the District would have saved quite a bit (over a million dollars) if Anthem had a national network available and for our use last year. What types of claims were re-priced in the analysis which estimated a savings of \$1m savings?

Answer and analysis from consultant analysis



Peralta

Volume Weighted Discount Based on Group's Claims Experience

Charges Submitted - Priced

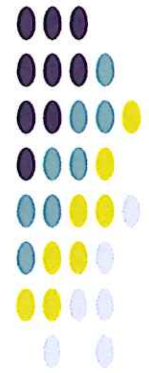
Pricing Based on JAA Rates

Hospital/Facility	Submitted Charges	Anthem JAA Allowed	Discount	% of Total Priced Utilization
Inpatient	297,873	132,620	55.5%	
Sub-total Inpatient	\$297,873	\$132,620	55.5%	29.0%
Outpatient/ASC	217,660	106,976	50.9%	
Sub-total Outpatient/ASC/Other	\$217,660	\$106,976	50.9%	21.2%
Sub-total Hospital/Facility	\$515,533	\$239,596	53.5%	50.2%
Professional/Nonfacility	511,929	235,454	54.0%	49.8%
Sub-total Professional/Nonfacility	\$511,929	\$235,454	54.0%	49.8%
Total Charges Submitted - Priced	\$1,027,462	\$475,050	53.8%	100.0%

Charges Submitted - Not Priced*

Hospital/Facility	
Inpatient	\$0
Outpatient/ASC	\$0
Total Hospital/Facility	-
Professional/Nonfacility	-
Total Professional/Nonfacility	108,725
Total Charges Submitted - Not Priced	\$108,725
Total Charges Submitted	\$1,136,187

Health Care Reform, an updated timeline-PSW Benefit Resources





Service Excellence Through Dedicated Resources

January 8, 2013

Health Care Reform Timeline 2012 - 2018

PSW Benefit Resources and Insurance Services is providing this timeline of the implementation of key reform provisions that affect employers and individuals. Please read below for more information and contact PSW Benefit Resources and Insurance Services with any questions about how you can prepare for any of the health care reform requirements.

2012

HEALTH PLAN ADMINISTRATION

- **Uniform Summary of Benefits and Coverage.** All non-grandfathered and grandfathered health plans will be required to provide a uniform summary of the plan's benefits and coverage to participants. The summary will have to be written in easily understood language and will be limited to four pages. Any mid-year changes to the information contained in the summary will have to be provided to participants 60 days in advance. The health care reform law indicated that plans would be required to start providing the summary by March 23, 2012.

Note: On Nov. 17, 2011, the Department of Labor (DOL) issued guidance that delayed the deadline for plans to begin providing the summary until after the release of final regulations. On Feb. 9, 2012, HHS, the DOL and the Treasury Department issued final regulations on the summary of benefits and coverage requirement.

The final guidance provides that plans and issuers must start providing the summary by the following deadlines:

- Issuers must provide the summary to health plans effective **Sept. 23, 2012**;
- Plans and issuers must provide the summary to participants and beneficiaries who enroll or re-enroll during an open enrollment period starting with the first day of the first **open enrollment period** that begins on or after **Sept. 23, 2012**;
- Plans and issuers must provide the summary to participants who enroll for coverage other than through an open enrollment period (for example, newly eligible individuals and special enrollees) starting with the first day of the first **plan year** that begins on or after **Sept. 23, 2012**.

The Department of Labor's basic approach to ACA implementation is: "to work together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and to work with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Department of Labor. Their approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are **working diligently and in good faith** to understand and come into compliance with the new law." Accordingly, consistent with this guidance, during this first year of applicability, the Departments will not impose penalties on plans and issuers that are **working diligently and in good faith to comply**.

CoreSource and Kaiser will have SBC's for distribution during the next open enrollment scheduled for February 2013.

- **Reporting Health Coverage Costs on Form W-2.** Employers will be required to disclose the value of the health coverage provided by the employer to each employee on the employee's annual Form W-2.

Peralta Community College District is providing employees with the required value of medical and EAP health coverage on Form W-2 issued in 2013.

Fees and taxes

- **Comparative Effectiveness Research (CER) Fees.** Effective for plan years ending on or after Oct. 1, 2012, insurers and sponsors of self-insured health plans must pay CER fees to fund health care research. The CER fees do not apply for plan years ending on or after Oct. 1, 2019. Thus, for calendar year plans, the CER fees will be effective for the 2012 through 2018 plan years. For plan years ending before Oct. 1, 2013 (that is, 2012 for calendar year plans), the research fee is \$1 multiplied by the average number of lives covered under the plan. The fee goes up to \$2 for plan years ending on or after Oct. 1, 2013 and before Oct. 1, 2014, and will be indexed for future years. CER fees must be reported and paid by July 31 of each year, and will generally cover plan years that end during the preceding calendar year. The first possible due date for paying CER fees is July 31, 2013.

Remittance of Fees

Insurers and plan sponsors must report and pay these fees annually on IRS Form 720, which will be due by July 31 of each year. The first due date is July 31, 2013. A return will generally cover policy or plan years that end during the preceding calendar year. In other words, fees for a plan year are due by July 31 of the calendar year following the calendar year containing the plan year end. Form 720 may be filed electronically. **The IRS has not yet updated Form 720 to reflect the reporting of these fees.**

No additional information or guidance has been released.

2013

HEALTH PLAN ADMINISTRATION

- **Limiting Health Flexible Savings Account Contributions.** The health care law will limit the amount of salary reduction contributions to health FSAs to \$2,500 per year, indexed by CPI for subsequent years.

Peralta Community College District is already in compliance.

- **Employee Notice of Exchanges.** Effective March 1, 2013, employers must provide a notice to employees regarding the availability of the health care reform insurance exchanges. HHS has indicated that it plans on issuing model exchange notices in the future for employers to use.
- **HIPAA Certification.** By Dec. 31, 2013, employers with group health plans must certify that their plans comply with HIPAA's rules on electronic transactions. HHS intends to issue more guidance on this requirement in the future.

FEES AND TAXES

- **Eliminating Deduction for Medicare Part D Subsidy.** Currently, employers that receive the Medicare Part D retiree drug subsidy may take a tax deduction for their prescription drug costs, including costs attributable to the subsidy. The deduction for the retiree drug subsidy will be eliminated in 2013.

No additional information or guidance has been released.

- **Increased Threshold for Medical Expense Deductions.** The health care reform law increases the (IRS) income threshold for claiming the itemized deduction for medical expenses from 7.5 percent of income to 10 percent. However, individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.
- **Additional Medicare Tax for High Wage Workers.** The new law increases the Medicare tax rate by 0.9 percentage points on wages over \$200,000 for an individual (\$250,000 for married couples filing jointly).

The tax is also expanded to include a 3.8 percent tax on net investment income in the case of taxpayers earning over \$200,000 (\$250,000 for joint returns).

2014

COVERAGE MANDATES

- **Individual Coverage Mandates.** The health care reform legislation requires most individuals to obtain acceptable health insurance coverage or pay a penalty, beginning in 2014. The penalty will start at \$95 per person for 2014 and increase each year. The penalty amount increases to \$325 in 2015 and to \$695 (or up to 2.5 percent of income) in 2016, up to a cap of the national average bronze plan premium. After 2016, dollar amounts are indexed. Families will pay half the penalty amount for children, up to a cap of \$2,250 per family. Individuals may be eligible for an exemption from the penalty if they cannot obtain affordable coverage.
 - Legal challenges to the health care reform law have focused on whether Congress had the constitutional authority to enact the individual coverage mandate.
 - On June 28, 2012, the U.S. Supreme Court addressed these legal challenges and upheld the individual coverage mandate as constitutional. This means that the mandate will go into effect in 2014 as planned, unless it is repealed by Congress.
- **Employer Coverage Requirements.** Employers with 50 or more employees that do not offer coverage to their employees will be subject to penalties if any employee receives a government subsidy for health coverage. The penalty amount is up to \$2,000 annually for each full-time employee, excluding the first 30 employees. Employers who offer coverage, but whose employees receive tax credits, will be subject to a fine of \$3,000 for each worker receiving a tax credit, up to an aggregate cap of \$2,000 per full-time employee. Employers will be required to report to the federal government on health coverage they provide.

HEALTH INSURANCE EXCHANGES

The health care reform legislation provides for **health insurance exchanges** to be established in each state in 2014. Individuals and small employers will be able to shop for insurance through the exchanges. Small employers are those with no more than 100 employees. If a small employer later grows above 100 employees, it may still be treated as a small employer. However, states may limit employers' participation in the exchanges to businesses with up to 50 employees until 2016. Large employers with over 100 employees are to be allowed into the exchanges in 2017. The health care reform legislation provided that workers who qualified for an affordability exemption to the coverage mandate, but did not qualify for tax credits, could use their employer contribution to join an exchange plan. This requirement is known as the "free choice voucher" provision. The federal appropriations bill signed by President Obama on April 15, 2011, eliminated the free choice voucher provision from health care reform.

HEALTH INSURANCE REFORM

Additional health insurance reform measures will be implemented beginning in 2014.

- **Guaranteed Issue and Renewability.** Health insurance issuers offering health insurance coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage and must renew or continue to enforce the coverage at the option of the plan sponsor or the individual.
- **Pre-existing Condition Exclusions.** Effective Jan. 1, 2014, group health plans and health insurance issuers may not impose pre-existing condition exclusions on any covered individual, regardless of the individual's age.
- **Insurance Premium Restrictions.** Health insurance issuers in the individual and small group markets will not be permitted to charge higher rates due to health status, gender or other factors. Premiums will be able to vary based only on age (no more than 3:1), geography, family size and tobacco use. The rating limitations will not apply to health insurance issuers that offer coverage in the large group market unless the state elects to offer large group coverage through the state exchange (beginning on or after 2017).

- ***Nondiscrimination Based on Health Status.*** Group health plans and health insurance issuers offering group or individual health insurance coverage (except grandfathered plans) may not establish rules for eligibility or continued eligibility based on health status-related factors.
- ***Nondiscrimination in Health Care.*** Group health plans and health insurance issuers offering group or individual insurance coverage may not discriminate against any provider operating within their scope of practice. However, this provision does not require a plan to contract with any willing provider or prevent tiered networks. It also does not apply to grandfathered plans. Plans and issuers also may not discriminate against individuals based on whether they receive subsidies or cooperate in a Fair Labor Standards Act investigation.
- ***Annual Limits.*** Restricted annual limits will be permitted until 2014. However, in 2014, the plans and issuers may not impose annual limits on the amount of coverage an individual may receive.
- ***Excessive Waiting Periods.*** Group health plans and health insurance issuers offering group or individual health insurance coverage will not be able to require a waiting period of more than 90 days.
- ***Coverage for Clinical Trial Participants.*** Non-grandfathered group health plans and insurance policies will not be able to decline coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.

EMPLOYER WELLNESS PROGRAMS

FEES AND TAXES

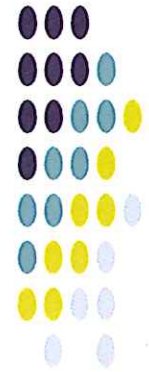
- ***Individual Health Care Tax Credits.*** The new law makes premium tax credits available through the exchanges to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty level who are not eligible for or offered other acceptable coverage. The credits apply to both premiums and cost-sharing.
- ***Employee Health Incentives/rewards.*** The total of all rewards offered to an individual under the program cannot exceed 20 percent of the total cost (employer and employee portions) of individual employee health benefits coverage. In 2010, the federal Secretaries indicated that they intend to use their regulatory authority to raise the limit to 30 percent as of 2014, accompanied by additional consumer protections to prevent discrimination against employees. However, to date, no additional information or regulations have been issued.

2018

HIGH COST PLAN EXCISE TAX

A 40 percent excise tax is to be imposed on the excess benefit of high cost employer-sponsored health insurance. This tax is also known as a "Cadillac tax." The annual limit for purposes of calculating the excess benefits is \$10,200 for individuals and \$27,500 for other than individual coverage. Responsibility for the tax is on the "coverage provider" which can be the insurer, the employer, or a third-party administrator. There are a number of exceptions and special rules for high coverage cost states and different job classifications (not yet defined).

A review of Health and Wellness - PSW Benefits Resources



1. Self-Funding

1. Medical Wellness Claims Data through CoreSource
2. At-A-Glance View of Chronic Conditions @Year End

2. Kaiser HMO :Prevention and LifeStyle Risk:

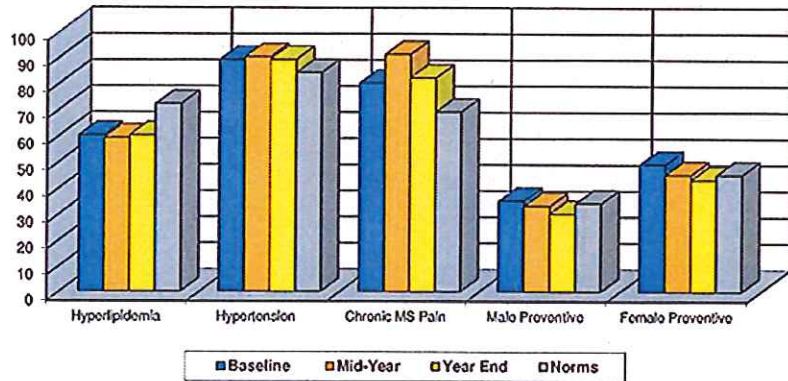
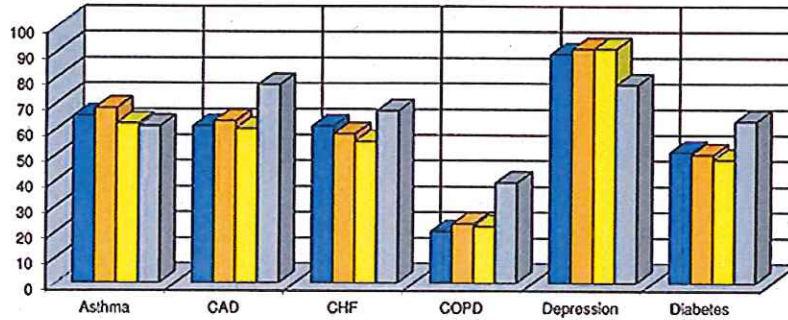
1. Your results: overview
2. Your recommended action plan
3. Create a culture of health at work
4. Use the tools included in your coverage
5. More included programs and tools
6. Broaden your reach with HealthWorks

PERALTA COMMUNITY COLLEGE DISTRICT
MEDICAL WELLNESS CLAIMS DATA THROUGH CORESOURCE
NOVEMBER 1, 2010 THROUGH OCTOBER 31, 2012

POPULATION BEING REVIEWED	DESCRIPTION	INDIVIDUAL		ACTUAL	ALL CORESOURCE NORM*
		TOTAL RELEVANT	NOT COMPLETED		
More than 50 years old	Patients without any Colorectal Cancer screening in the analysis period.	967	719	74.4%	75.8%
Men more than 50 years old	Men without PSA test in the last 2 years	400	262	65.5%	57.4%
More than 51 years old	Patients without Preventive Care Exam in the last 2 years	962	153	15.9%	26.9%
Women more than 49 years old	Patients without Colorectal Cancer screening in the analysis period	537	396	73.7%	73.9%
Women more than 39 years old	More than 39 years old without Mammogram in the last 12 months	605	428	70.7%	61.7%
Women more than 20 years old	Women without Pap Smear in the last two years	680	441	64.9%	53.8%
Women more than 49 years old	Women without Mammogram in the last 12 months	546	401	73.4%	60.4%
Women between 21 and 65 years old	Women without Pap Smear in the last 2 years	393	195	49.6%	56.4%
Women between 40 and 49 years old	Women without Mammogram in the last 2 years	67	38	56.7%	56.0%
Women between 49 and 69 years old	Women without Mammogram in the last 18 months	338	166	49.1%	50.1%

*Based upon national data base of over 6 million lives

At-a-Glance View of all Conditions at Year End



Overall Compliance Summary	Baseline	Mid-Year	Year End	Change from Baseline	Norm
	60	61	59	-1	63

Care Index	Baseline	Mid-Year	Year End	Change from Baseline	Norm
Asthma	65	63	62	-3	61
CAD	61	63	60	-1	77
CHF	61	53	55	-6	67
COPD	20	23	22	+2	39
Depression	89	91	91	+2	77
Diabetes	51	50	48	-3	63
Hyperlipidemia (High Cholesterol)	60	59	60	0	72
Hypertension (High Blood Pressure)	89	90	89	0	84
Chronic Musculoskeletal Pain	80	91	82	+2	69
Male Preventive	35	33	30	-5	34
Female Preventive	49	45	43	-6	45

** Group currently has no members identified with this condition.

Key Points:

- * Compliance scores for 5 of the 11 conditions improved or remain unchanged at Year End.
- * The average overall year end compliance score of 59 for all of the conditions lost 1 point over the baseline and was 4 points lower than the normative average.

Prevention and Lifestyle Risk

Your results: overview

Measure	Description	Your Results, 2011 Q4	Your Results, 2012 Q1	Year-Over-Year Change
BMI: Weight Management+	% of adult members who are overweight or obese	70.16%	70.18%	Declined
Cholesterol management+	% of members borderline high or high total cholesterol	36.86%	37.74%	Declined
Blood pressure management+	% of members with blood pressure \geq 140/90	12.33%	12.92%	Declined
Smoking rates+	% of members who smoke	10.6%	10.37%	Improved
Breast cancer screenings**	% of eligible population screened	85.96%	85.31%	Declined
Cervical cancer screenings**	% of eligible population screened	87.58%	86.86%	Declined
Colorectal cancer screenings**	% of eligible population screened	76.67%	68.72%	Declined
Childhood immunization rates**	% of eligible population screened	ISS	ISS	
Childhood obesity+	% of child members who are overweight or obese	38.98%	34.15%	Improved

*Continuously enrolled members during measurement period.

**ISS (Insufficient Sample Size) will be displayed if eligible member population for the prevention measure is less than 30.

Your recommended action plan

Three steps to a healthier workforce



Create a culture of
health at work



Use the tools included
in your coverage—
Kaiser Permanente
HealthWorks



Broaden your reach

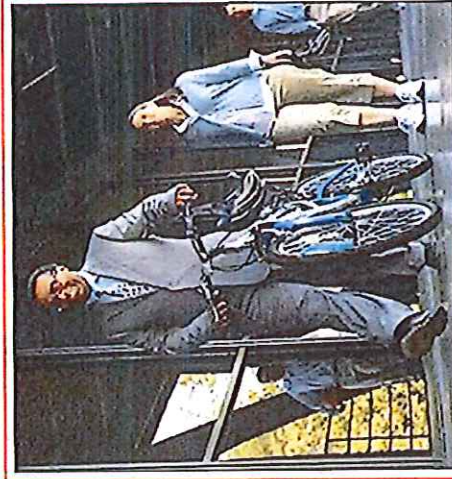
Create a culture of health at work

Worksite health promotion boosts employee wellness program participation by 40 percent*

Use your worksite to encourage:



Better eating habits



More exercise



Smoking cessation

*Closing the Gap: 2008/2009 Employee Perspectives on Health Care, Watson Wyatt, 2008.

Use the tools included in your coverage



Online resources

- HealthWorks workbook
- Total health and productivity library at businessnet.kp.org
- Total health assessment
- Online services, including e-mail your doctor's office, view lab results, prescription refills, and more
- Digital coaching sessions
- BMI and health calculators
- Health and drug encyclopedias
- Health screening, self-exam, and symptom tools
- Fitness widget and podcasts

More included programs and tools

Membership extras

- Fitness clubs reduced rates
- Complementary medicine reduced rates
- Individual and phone counseling
- Educational theater program
- Kids in Dynamic Shape program



Facility resources

- Healthy living classes and support groups*
- Calorie counts in hospital cafeterias



*Availability varies by region. Some classes require an additional fee.

Broaden your reach with HealthWorks



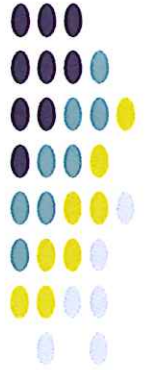
Onsite

- The FruitGuys produce delivery service
- Healthy Picks vending machine program
- Health promotion classes
- Biometric screenings for cholesterol, blood pressure, and BMI
- Customized communications—flyers, posters, etc.



Online

- Total health assessments for all employees
- Customized e-mail coaching for your entire workforce
- Customized Web site with information and links on participating in the total health assessment, digital coaching sessions, or 10,000 Steps®
- Participation reports and summaries



Next Meetings

- Dates:
 - February 7
 - March 7
- Topics?
 - JPA Exploration
 - Medicare Coordination progress
 - Review of budget expenses