Food Employers Labor Relations Association (FELRA) and United Food and Commercial Workers (UFCW) VEBA Fund

VENDOR DISCUSSION GUIDE

July 2017

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Reason for Discussion

- The Trustees have asked Segal to provide the Trustees with a review of the FELRA H&W Fund programs outlining their efficacy, costs, integration with each other, and in the most simplistic terms:

  “Are the Trustees getting the best bang for their buck?”

- A competitive bid was recently conducted for PPO medical services. The results of the bid process provided the Trustees with information showing the current arrangement with CareFirst was market competitive.
- The Trustees have retained Heritage Rx to assist with the PBM program and to determine if ESI’s programs and services are competitive in the market.
- The focus of this presentation is on the Care Management programs and whether the Trustees are providing the members with the most effective level of care at the lowest costs.
- There is an *Appendix* at the end with related information and data.

FELRA's Vendors

The following vendors provide services and programs to the Fund. Each will be discussed in the following pages.

Benefit Type	Carrier	Active Participants	Medicare Retirees
Medical	Carefirst PPO	◆	
	Kaiser HMO	◆	◆
Prescription Drug	Express Scripts	◆	◆
Dental	Group Dental Service	◆	◆
Vision	Advantica	◆	◆
Life and AD&D	Voya Financial	◆	
Medical Management	Carewise Health	◆	
	Health Dialog	◆	
	Beacon Health	◆	◆

Executive Summary

The Trustees have asked Segal to evaluate the Fund's vendor arrangements in terms of industry best practices. The evaluation of vendors and Fund-sponsored programs is an **ongoing process**. Our initial findings are:

- The Fund's programs are **generally appropriate** for the members and the administrative fees **are industry competitive**;
- The Trustees may wish to evaluate the Fund's care management programs as the chronic condition program appears to be underutilized. The most effective way to determine whether there are programs which can better meet the needs of the members and the Trustees is to conduct a bid process for care management, including disease management services.
- Due to the lack of integration between the various vendors, data analytics for the Fund is not optimal. The Trustees may wish to implement a data analytics warehousing solution which will allow the Trustees to make educated decisions based on Fund specific data.

Medical PPO Provider

Current Vendor: CareFirst

Pros	Cons
• Fees, network access and provider discounts are competitive • Provides network that members are used to	• Weak internal supplementary and care management programs

Responsibilities

- The Medical PPO is available to all active members of the Fund in Plans I, X, and XX through Carefirst Blue Cross Blue Shield (Carefirst) and Flexlink.

Supporting Data

- A formal RFP for PPO services was recently conducted. CareFirst, Aetna and UHC all have strong provider networks. Remaining with CareFirst avoids provider disruption.
- The administrative fees proposed by the carriers ranged between $2.6M (CareFirst) to $4.25M (Aetna).
- Network discounts ranged from 46.5% to 48.9% depending on the carrier. CareFirst's proposed network discount is 48.0% placing it within a percent of the most competitive discount.
- Switching medical carriers would provide minimal savings. In discussions with the Trustees, there appears to be little desire to change carriers at this time, given the factors noted above.

Medical PPO Provider *continued*

Short-term Observations/Recommendations

- After the analysis of bids, conducted in 2016, for Medical PPO services, the Fund decided to remain with CareFirst. The following items played a role in this decision:
  - Provider disruption
  - Implementation concerns
  - Fees

Long-term Observations/Recommendations

- If CareFirst continues to offer competitive fees, access and discounts, but the Fund observes disjointed care with all of their offered benefits. Implementing data analytic warehousing could provide improvements.
- If the Trustees move away from CareFirst, in the future, an integrated services approach may be considered. Currently, the CareFirst integrated model is, by their admission, a less than optimal solution given the membership locations of VA and MD, the use of two Blue Cross and Blue Shield programs and the desire of CareFirst to have the prescription drug program integrated with CVS.

Fees

- Flexlink Administration: $19.61 PMPM
- Network Lease Fee: $3.88 PMPM
- As noted above, the fees are competitive, based on the results of the bid process.

Prescription Drug Management

Current Vendor: ESI

- The Trustees have retained Heritage Rx to assist with the reviewing of the plan and current vendor. They have in the past prepared formal RFP's to determine the competiveness of the PBM program as well as periodic market checks. In addition, they have audited ESI for compliance with contract terms and performance guarantees.

Supporting Data

- The Fund completed a Market Check with ESI in early 2017, securing highly competitive PBM pricing while retaining best in class contract terms.
- Pricing improvements, effective March 2017 – December 31, 2019, include:
  - Deeper point of sale discounts for brand and generic drugs (specialty and non-specialty) and a substantial increase in the per-claim rebate amounts payable for retail and specialty drug claims;
  - Each pricing component is guaranteed and reconciled annually, backed dollar for dollar to perform at or above guaranteed levels;
  - In the aggregate, the Market Check is projected to yield savings of 9.01% ($4,394,561) from current pharmacy costs for the 34-month period; and
  - The Fund may reasonably expect the Market Check adjustments to have a positive effect on cash flow, resulting from the cumulative effects of lower unit costs for prescription drugs applied at the point of sale (real time) and the substantive increase in quarterly rebate disbursements.

Prescription Drug Management *continued*

Short-term Observations/Recommendations

- The Fund may realize additional value from their PBM, while concurrently yielding a higher return on investment in their employee health and welfare benefits programs, by taking advantage of key capabilities of ESI and their PBM peers that process and pay prescription drug claims.
  - Some additional programs to consider include ESI's Multiple Sclerosis Care Value Program and Pulmonary Care Value Program.
- The Fund is uniquely positioned to leverage ESI's capacity for driving a number of qualitative and quantitative improvements in the current healthcare delivery system;
  - The Fund's 2014 procurement included a requirement for the winning PBM to underwrite and guarantee their willingness to provide the Fund a more advanced, strategic and customized level of clinical pharmacy management and decision support, that is in addition to the monthly paid claims data provided to the Fund's DM and UM vendors;
  - The Fund's PBM contract contemplates this requirement; to date, ESI has been both accountable and proactive in proving the requisite data feeds to the Fund's designated vendors.
- Heritage has been party to other clients' successful engagement of ESI and other PBMs at these more advanced and strategic levels.

Prescription Drug Management *continued*

Pricing

	Participating Pharmacies		Non-Participating Pharmacies	
	Current	Market Check Results	Current	Market Check Results
Calendar Year	**2017**	**2017 – 2019**	**2017**	**2017 – 2019**
Retail Discounts				
Retail Brand <60	17.50%	17.75%	17.00%	17.25%
Retail Brand >60	18.50%	18.75%	18.00%	18.25%
Retail Generic <60	80.00%	81.50% / 82.00% / 82.50%	80.00%	81.50% / 82.00% / 82.50%
Retail Generic >60	80.00%	81.50% / 82.00% / 82.50%	80.00%	81.50% / 82.00% / 82.50%
Dispensing Fees				
Brand <60	$0.70	$0.70	$0.95	$0.80
Brand >60	$0.90	$0.70	$1.10	$0.80
Generic <60	$0.70	$0.70	$0.95	$0.80
Generic >60	$0.90	$0.70	$1.10	$0.80
Rebates				
Retail Brand <60	$68.20	$90.00 / $95.00 / $100.00	$68.20	$90.00 / $95.00 / $100.00
Retail Brand >60	$155.00	$225.00 / $237.50 / $250.00	$155.00	$225.00 / $237.50 / $250.00
Specialty Retail	$68.20	$200.00	$68.20	$200.00
Specialty Mail	$155.00	$850 / $950 / $1,050	$155.00	$850 / $950 / $1,050
Specialty Discounts				
Net Effective Discount Mail	16.75%	17.25%	16.75%	17.25%
Net Effective Discount Retail	14.25%	15.25%	14.25%	15.25%

Disease Management

Current Vendor: Health Dialog

Pros	Cons
• Attempts to engage high cost plan participants • Provides resources for chronically ill participants wishing to change	• Provides inaccurate reporting • Provides unclear cost savings calculations • Uses robo-calls

Responsibilities

- Health Dialog provides Disease Management (DM) services and is available for all members of the plan except for those enrolled in the Kaiser HMO.
- Health Dialog provides access to “Health Coaches” and “Chronic Condition Support” focused on managing illness

Supporting Data

- Health Dialog shows that of the chronically ill members reached, nearly 70% engage. However:
  - Only 20% of the population identified for telephonic coaching was reached in 2016.
  - Only 14% of the population identified for telephonic coaching became engaged in a relationship in 2016.
  - Industry research has found that, on average, 17% of identified individuals will engage in a disease management program, meaning these numbers appear low.
  - The use of robo-calls may not be well received and may be part of the reason for low utilization.

Disease Management *continued*

Short-term Observations/Recommendations

- There are innumerable disease management vendors that can provide similar services as Health Dialog.
- Health Dialog's impact, service, reporting and results are in question. One example of their poor reporting was the recent revelation that for 9 years, they have been loading the member files with their spouses conditions.
- This firm has had turnover at the senior management level, having recently been purchased by Rite Aid, and subsequently Walgreens.
- Health Dialog has struggled with responding in a timely manner to certain Fund requests.
- The Trustees may wish to evaluate the relationship with Health Dialog through the RFP process.

Long-term Observations/Recommendations

- It is possible, but difficult, to attain significant financial gains through a wellness/disease management program. Success requires plan design, leadership support, coordinated efforts and data analytics.
- The Fund may consider eliminating the disease management program and focusing on other services.
- The integrated model of care management might be considered with one-carrier offering all services, including pre-certification, large case management and disease management.

Summary

- Our recommendation is that the Trustees perform a competitive bid to determine what other providers may provide. Upon review of this information, the Trustees may discuss whether to move away from disease management.

Fees

- Disease Management: $2.06 PMPM
- This fee is competitive in the DM market.

Managed Behavioral Health & Employee Assistance

Current Vendor: Beacon Health Options

Pros	Cons
• Decreases in admission to inpatient facilities since 2013 • Fees, network access and provider discounts are competitive	• EAP Utilization is low • High out-of-network substance abuse utilization • Poor management of high cost claimants

Responsibilities

- Beacon, formerly ValueOptions, has provided an integrated Mental Health/Substance Abuse (MHSA) and Employee Assistance Program (EAP) for the Fund since the 1990s.
- Behavioral service benefits are available to all participants in the Fund.
- EAP benefits are only available to active participants in Plan I and X.

Supporting Data

- The EAP access rate for 2016 was 0.88%. Utilization below 5% is considered low. The program is not offered to new hires which may be impacting the number of members who utilize the benefit. The EAP is a capped benefit so members who are in a program may run up against the maximum number of visits and no longer be receiving treatment.
- EAP legal and financial services were unused in 2016.
- There were a total of 18 high cost claimants in 2016 which accounted for 59% of the behavioral health claims. On average each high cost claimant had cumulative paid behavioral health claims of $66,000.

Managed Behavioral Health & Employee Assistance *continued*

Short-term Observations/Recommendations

- The Trustees may consider initiatives to help members become more aware of their EAP benefit:
  - Utilizing legal and financial services initially may aid in assisting members to be more comfortable using their EAP in the future.

Long-term Observations/Recommendations

- If the Fund cannot drive higher EAP engagement, the Trustees may wish to reconsider offering this service.

Fees

- EAP – All Plans: $0.67 PMPM
- Behavioral Health: $2.59 PMPM
- These fees are market competitive.

Utilization Management

Current Vendor: Carewise Health

Pros	Cons
• Low inpatient admissions per 1,000 • Low inpatient days per 1,000	• Data not integrated

Responsibilities

- Carewise Health provides Utilization Management (UM) services and is available for all members of the plan except for those enrolled in the Kaiser HMO.

Supporting Data

- The National average admits per 1,000 are 57.2, while FELRA is at 49 for 2016 and 47 for 2015.
- The National average inpatient days per 1,000 are 221.9, while FELRA is at 221.8 for 2016 and 199.25 for 2015.

Short-term Observations/Recommendations

- The only reason to bid Carewise may be to consolidate vendors.
- The Trustees may include U/M services in a D/M RFP to identify what savings and integration possibilities.

Utilization Management *continued*

Long-term Observations/Recommendations

- In order to use Carewise's reports for big picture observations, it would be helpful if the data was integrated with all other vendors.

Fees

- Administration: $2.35 PMPM
- Clinical Review (RN): $125 per hour
- Clinical Review (MD): $350 per hour
- These fees are market competitive.

Fully Insured Dental HMO

Current Vendor: Group Dental Services (GDS)

Pros	Cons
• Competitive fee schedule	• Annual premium unusually high compared to claims • Restricted network access

Responsibilities

- GDS provides dental services on a fully-insured, HMO basis for all participants of the Fund.
- Family dental benefits are not available to part-time employees in Plan XX or retirees

Supporting Data

- The 2016 premium paid was $6,882,371, while the claims paid were $4,437,443.
- A recent dental bid of a similarly situated Fund suggests the following:
  - Saving could be achieved, but the current fee schedule would be sacrificed.
  - Switching to a PPO network would likely increase network penetration.
  - Dental discounts are difficult to compare, as GDS does not provide discount data on their DHMO product.

Fully Insured Dental HMO *continued*

Short-term Observations/Recommendations

- The Trustees contract with GDS has a legacy fee schedule that is difficult for other vendors to match.
- PPO dental networks gives the members a larger provider network, but increase plan utilization.
- The Trustees may wish to negotiate a better premium rate with GDS, upon the next renewal.

Long-term Observations/Recommendations

- Should the loss ratio continue to run advantageously for GDS, the Trustees may wish to consider a bid.
- Should the Trustees consider switching to a different vendor with a different fee schedule, the claims may increase, as could the premiums.

Fees

- Average: $36 PMPM
- Range: $17.46 PMPM – $142.33 PMPM
- These fees appear high based on the Funds claim costs.

FELRA Strategic Opportunities and Next Steps

- Increase the Health Plan participants' awareness of their health status and the available medical management support resources through a communications campaign.
- Focus efforts on significantly increasing the engagement rates in the disease management program of those with high/moderate risk chronic conditions.
- Bid the disease management program to ensure best-in-class services and fees are obtained.
- Improve medication adherence and treatment compliance of the FELRA participants with chronic conditions
- Improve the overall health of the FELRA covered population by reducing the health risk factors and minimize avoidable and unnecessary health care expenditures.
- Implement a data warehousing system that can integrate all vendor data

Data Integration and Data Warehouse

- The Trustees have indicated a desire to:
  - Outline the issues driving the Fund's costs;
  - Identify counter measures to moderate the Fund's cost drivers;
  - Coordinate initiatives and data between the Fund's vendors; and
  - Be more nimble when preparing budgets and program proposals during collective bargaining.
- There are various data warehouse tools available such as Ingenix, Truveh, and Shape (which is Segal's proprietary software). Each has pros and cons and varying price tags.
- Each tool will provide the following benefits:
  - Consolidation of the vendors data in one flexible tool.
  - Maintenance of historical data when vendors terminate.
  - Ability to evaluate the Plan's performance across various vendors.
  - Flexibility when responding to Trustee questions.
- The primary benefit of any data warehouse is to add flexibility responding to Trustee requests and to promote more proactive consulting.

Data Warehouse Fees

- Data warehouse vendors charge different fees depending on the complexity of the clients eligibility files, medical, Rx and carved out vendor relationships.
- The Trustees may see fees/charges in the following areas:
  - Data warehouse licensing fees.
  - Charges from the medical vendors and Fund Administrator for coordinating data feeds.
  - Legal fees for coordinating non-disclosure agreements.

Appendices

1. Population Health Overview
2. Health Dialog Integration
3. Prescription Drug Medication Adherence
4. Fund Provider Fees

Appendix 1: Population Health Management Strategies

Population Management		Episodic Management
Healthy	**At-Risk**	**Chronically Ill to Catastrophic**
Health Promotion Strategies	**Disease Management Strategies**	**Case Management Strategies**
• Promote healthy lifestyle and health maintenance • Health risk assessments • Screenings • Immunizations • Self-care education • Nurse-line resources • Stress management	• Patient identification and enrollment • Behavior modification • Intervention and Coaching • Provider/patient collaboration • Adopt practice guidelines • Create financial rewards • Measure program results	• Early intervention • Patient advocacy • Utilization management • Transitional care planning • Practice guidelines for episodes of care • Centers of Excellence

GOALS:

• Individual responsibility • Early detection • Health maintenance	• Patient empowerment • Improved outcomes • Efficient resource utilization (lower claim costs) • Timely access to the right care	• Patient support • Improved outcomes • Optimal integration of resources

Effectiveness of Wellness and Prevention Programs

Appendix 1: Healthcare Delivery

Ala Carte (Current)	Service	Integrated Shared Claims PPO Provider [1]
CareFirst	PPO Network	Carefirst, Cigna, etc
Express Scripts	Prescription Drug Management	
Carewise Health	U/R and Case Management	
CareFirst	Maternity Management	
—	Wellness/Health Promotion	
Health Dialog	Disease Management	
Health Dialog	Patient Coaching	
Associated Administrators, LLC	Vendor Coordination	
Beacon Health	Behavioral Health	

- If the Fund chooses to stick with the "ala carte" method, it is important to monitor the coordination of the separate vendors.
- If the Fund chooses an integrated PPO approach to provide all health management services, the carrier's tools to help members navigate between services should be taken into consideration.

CareFirst has a large provider network, but may not be the most effective care manager. Cigna, United Health Care, and Aetna are available, but may have different networks.

[1] The Fund would maintain Associated Administrators as their claims adjudicator and the office administrator.

Appendix 2: Health Dialog Integration

- Health Dialog was hired to manage five pre-determined disease states. Segal used both Health Dialog and ESI data to evaluate how well managed these are.
- In order to identify the Fund's cost drivers, an analysis of all medical and prescription drug claims would have to be done.

	Asthma	COPD	Diabetes	CHD and Heart Failure
Prevalence	9% of population	2% of population	10% of population	4% of population
Engaged with Health Dialog	9%	15%	13%	15%
Medication Possession Ratio	49.3%	40.4%	79.0%	81.5%

- The Medication Possession Ratio (MPR) represents the average measurement for total day supply/total report days.

Appendix 2: Member Outreach by Health Dialog in 2016

The following table represents data from January 1, 2016 – December 31, 2016 (12 months).

	Chronic Conditions						
	Asthma	**COPD**	**Diabetes**	**CHD**	**Heart Failure**	**Total (Chronic) [4]**	**Percentage**
Individuals Identified with a Chronic Condition	1,942	506	2,055	680	195	4,292	—
Claims Dollars Associated with Individuals Identified with a Chronic Condition	$12,351,535	$6,820,215	$21,305,547	$10,607,600	$6,285,742	$35,429,059	—
Individuals Attempted via Telephonic Counseling	1,207	427	1,711	562	153	3,171	—
Reached	246	102	379	129	37	668	21%
Opt Out	12	6	28	8	2	41	1%
Engaged in a Relationship	179	75	268	99	29	478	15%
Engaged %	**15%**	**18%**	**16%**	**18%**	**19%**	**—**	**—**
Unique Eligible Individuals [3]	**21,448**						

[1] The “Total Medical Spend” should include all medical claims dollars from January 1, 2016 – December 31, 2016 regardless of whether or not they are tied to an individual with a chronic condition.

[2] The “Total Prescription Drug Spend” should include all prescription drug claims dollars from January 1, 2016 – December 31, 2016, regardless of whether or not they are tied to an individual with a chronic condition.

[3] The “Unique Eligible Individuals” should include all eligible for Health Dialog’s services from January 1, 2016 – December 31, 2016.

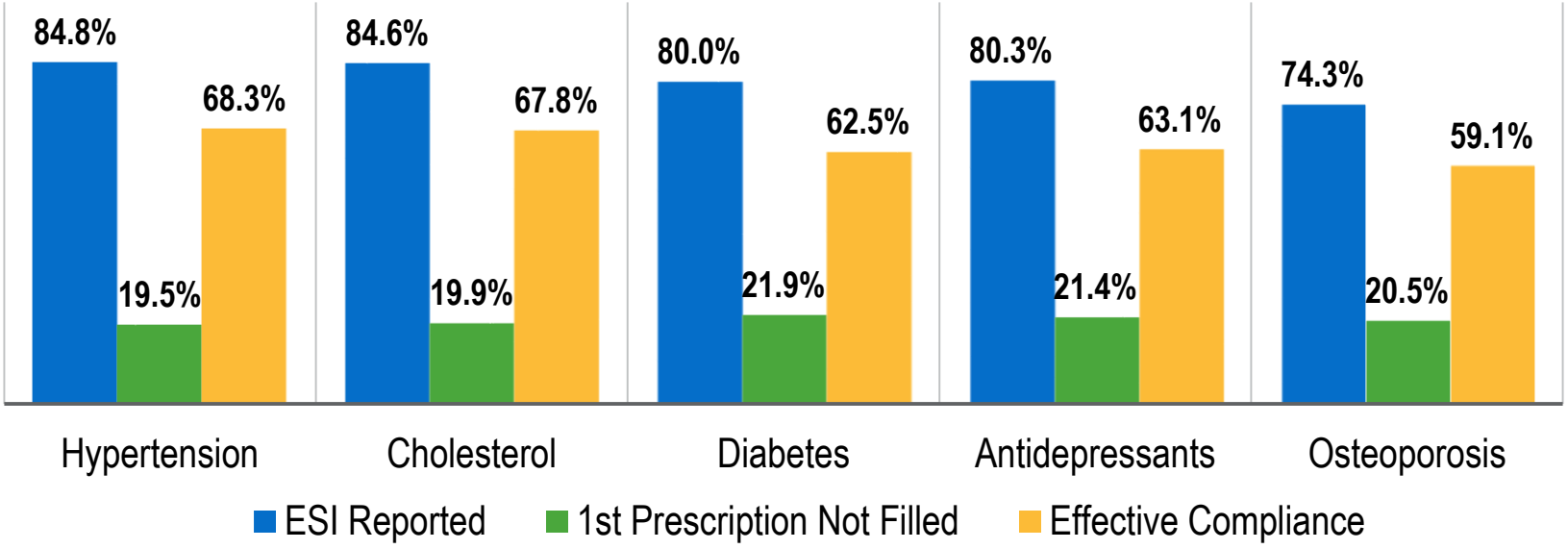
[4] Many individuals are identified with more than one chronic condition. The "Total" column represents a unique count of indivudals in the program and their associated claims dollars. The sum of the chronic condition columns will be greater than the “Total.”

Appendix 3: Medication Adherence

- ESI data indicates generally good compliance to prescribed medications for those who fill their prescriptions. However, emerging research regarding prescription first-fill rates suggest routine reporting of adherence may be overstated.
  - Research studies show that "28 to 31% of new prescriptions are not filled," meaning that medication possession rates reported by PBMs may be an overstated indicator of medication adherence.

—Journal of General Internal Medicine 2010 April, 25(4) 284-290

- For FELRA, adjusting the ESI reported compliance rates to account for estimated new prescriptions that are not filled, shows "effective compliance" is likely lower.



Appendix 3: Patient Stratification
ESI Data

The following table represents data from June 2015 – May 2016 (12 months).

Patient Care Needs

Well

Smoking Cessation, Allergies, Constipation/
Anti diarrheals, Topical Antifungal / Anti-bacterial infection treatment

Acute

Colds & Flu, Strep Throat, Ear Infection, Headache, Sprains

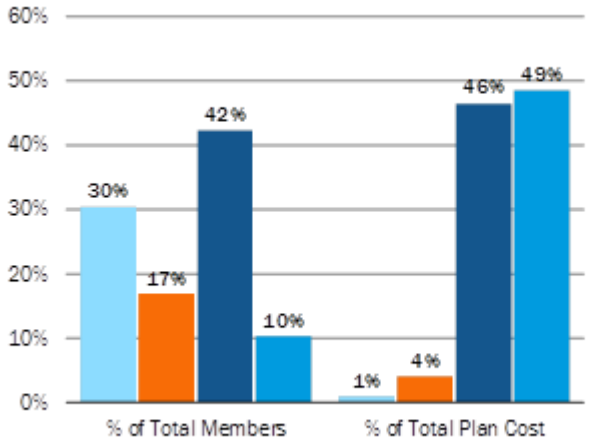
Chronic

Heart Disease, Diabetes, Arthritis, High Blood Pressure, High Cholesterol, Dementia, Back Pain

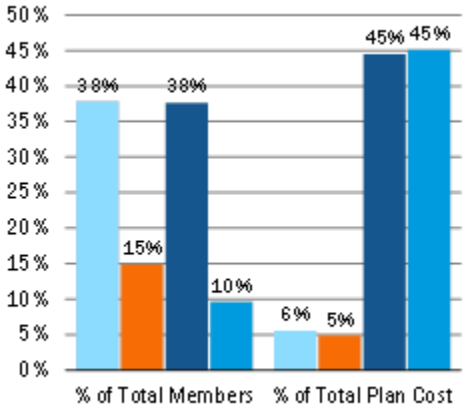
Complex

Multiple Chronic Conditions such as Heart Failure & Diabetes, Cancer, AIDS, Multiple Sclerosis, Metabolic Syndrome

Current



Previous



	Well	Acute	Chronic	Complex	Total
Members	6,359	3,523	8,836	2,166	20,884
Members %	30.4%	16.9%	42.3%	10.4%	100.0%
Plan Cost	$234,814	$1,006,065	$11,564,672	$12,089,800	$24,895,351
Plan Cost %	0.9%	4.0%	46.5%	48.6%	100.0%
Member Age (Avg.)	31.3	35.6	49.6	54.6	41.0
Copay	$16,757	$74,728	$925,673	$1,012,121	$2,029,280
Copay/Member	$3	$21	$105	$467	$97
Plan Spend/Member	$37	$286	$1,309	$5,582	$1,192
Days of Therapy/Member	12.6	73.6	573.2	1,491.9	413.5
GFR %	74.9%	84.5%	82.6%	79.9%	81.7%
Home Delivery Utilization	0.1%	0.2%	0.1%	0.4%	0.2%

Appendix 3: Top Trend Drivers: Increases

The following table represents data from January 1, 2016– December 31, 2016 (12 months).

Overall Trend	
Current Plan Cost PMPM	$125.44
Previous Plan Cost PMPM	112.64
% Change Plan Cost PMPM	11.4%

					Total Trend %		
Trend Driver Rank	Indication	Curr Plan Cost Rank	Curr Plan Cost PMPM	Prev Plan Cost PMPM	Plan Cost PMPM % Change	Plan Cost PMPM $ Change	Primary Trend Driver (+)
1	CANCER	5	$7.97	$4.60	73.1%	$3.37	Inflation/ Mix
2	INFLAMMATORY CONDITIONS	2	$11.43	$8.94	27.8%	$2.49	Inflation/ Mix
3	HEPATITIS C	4	$8.03	$5.80	38.3%	$2.22	Utilization
4	DIABETES	1	$15.94	$14.45	10.3%	$1.49	Inflation/ Mix
5	HIV	6	$7.13	$5.68	25.5%	$1.45	Inflation/ Mix
6	ANTICOAGULANT	12	$2.71	$1.98	36.7%	$0.73	Inflation/ Mix
7	ASTHMA	9	$4.40	$3.86	13.9%	$0.54	Inflation/ Mix
8	PAIN/INFLAMMATION	3	$8.63	$8.13	6.1%	$0.49	Inflation/ Mix
9	GI DISORDERS	26	$0.97	$0.58	67.5%	$0.39	Inflation/ Mix
10	CONTRACEPTIVES	16	$1.68	$1.38	21.7%	$0.30	Utilization

Appendix 3: Top 10 Indications

The largest trend is in Cancer at 73.1%

REPRESENT

64.7%

OF YOUR TOTAL RX PLAN COST

Top Indications by Plan Cost															
1-16 - 12-16										1-15 - 12-15					% Change
AUM Strategy	Rank	Peer Rank	Indication	Adjusted Rxs	Patients	Plan Cost	Generic Fill Rate	Peer Generic Fill Rate	Plan Cost PMPM	Rank	Adjusted Rxs	Patients	Generic Fill Rate	Plan Cost PMPM	Plan Cost PMPM
ST/PA/DQM	1	2	DIABETES	34,599	2,295	$4,325,075	55.8%	51.3%	$15.94	1	38,546	2,453	55.2%	$14.45	10.3%
ST/PA/DQM	2	1	INFLAMMATORY CONDITIONS	1,395	205	$3,100,273	20.4%	16.7%	$11.43	2	1,613	214	24.7%	$8.94	27.8%
ST/PA/DQM	3	5	PAIN/INFLAMMATION	40,129	7,761	$2,340,519	91.8%	94.3%	$8.63	3	46,438	8,715	91.1%	$8.13	6.1%
ST/PA/DQM	4	9	HEPATITIS C	128	22	$2,177,542	35.2%	26.7%	$8.03	6	102	28	37.3%	$5.80	38.3%
ST/PA/DQM	5	3	CANCER	2,342	300	$2,162,450	90.2%	88.7%	$7.97	8	2,436	326	92.7%	$4.60	73.1%
PA	6	6	HIV	1,215	98	$1,934,170	2.8%	5.9%	$7.13	7	1,267	97	3.2%	$5.68	25.5%
ST/DQM	7	10	HIGH BLOOD PRESS/HEART DISEASE	103,911	6,866	$1,866,661	94.8%	96.0%	$6.88	5	117,202	7,658	94.0%	$7.14	-3.7%
ST/PA/DQM	8	8	HIGH BLOOD CHOLESTEROL	43,191	4,646	$1,864,388	89.6%	89.5%	$6.87	4	50,164	5,199	80.9%	$7.96	-13.7%
ST/PA/DQM	9	7	ASTHMA	13,103	2,629	$1,193,711	37.5%	37.6%	$4.40	9	14,166	2,799	37.5%	$3.86	13.9%
ST/PA/DQM	10	4	MULTIPLE SCLEROSIS	191	20	$1,048,539	0.0%	3.8%	$3.86	10	236	25	0.0%	$3.85	0.3%
			Total Top 10:	240,204		$22,013,326	83.5%		$81.14		272,170		81.7%	$70.43	15.2%
			Differences Between Periods:	-31,966		$723,719	1.8%		$10.71						

Appendix 4: Fund Provider Fees

It is important to know what the Fund is paying for each service being rendered.
The chart below provides the rates for each vendor as of March 1. 2017.

Vendor	Benefit / Plan	Current Rate Effective October 1, 2016
Associated Administration	General Admin - Actives	$12.65
	General Admin - Retirees	$6.04
	Medical Claims Admin	$12.96
	HIPAA	Included Above
Advantica Optical	Bi-Annual Benefit	$4.95
	Annual Benefit	$6.95
CareFirst	Flexlink Administration	$19.61
	Network Lease Fee	$3.88
Group Dental Service (GDS)	Active Plan I - Individual	$29.20
	Active Plan I - Family	$57.88
	Active Plan I – “227” or “H.O. FT”	$142.33
	Active Plan X - Individual	$29.63
	Active Plan X - Family	$60.98
	Active Plan XX/XXX/XL - Individual	$17.46
	Active Plan XX/XXX/XL - Family	$35.95
	Medicare Retiree	$29.39
Health Dialog	Disease Management	$2.06
Reliastar Life Insurance	Life (Per $1,000)	$0.175
	AD&D (Per $1,000)	$0.018
SHPS	Admin	$2.35
	Prof clin rec & retro respective reviews - RN	$125 per hour
	Prof clin rec & retro respective reviews - MD	$350 per hour
Value Options	EAP - All Plans	$0.67
	Behavioral Health - Admin	$2.59
	Behavioral Health - Claims	Billed as they occur
Kaiser Permanente	Plan I FT - HMO	$1,457.33
	Plan I PT - HMO	$1,391.67
	Plan X FT - HMO	$927.84
	Plan X PT - HMO	$1,164.88
	Plan X PT Dep - HMO	$668.28
	Plan XX FT - HMO	$582.05
	Plan XX PT - HMO	$286.30