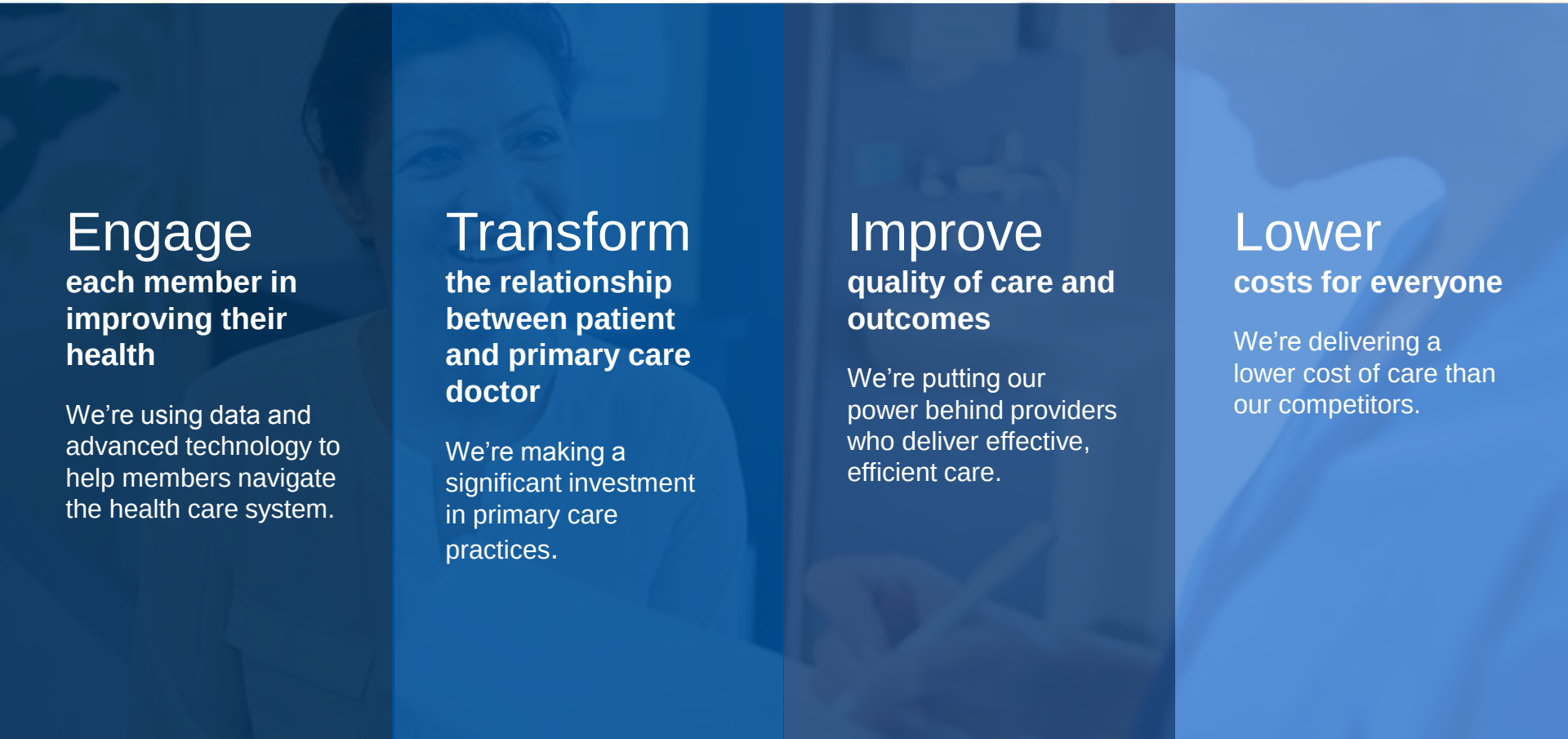
Know your trends. Drive your results.

2016 Annual Review for
UFCW Union and Participating Employers Health and Welfare Fund – Richmond/Tidewater

Leading the shift to outcomes-based health care

Our size and strength give us the ability to influence the health care system in profound ways



Engage

each member in improving their health

We're using data and advanced technology to help members navigate the health care system.

Transform

the relationship between patient and primary care doctor

We're making a significant investment in primary care practices.

Improve

quality of care and outcomes

We're putting our power behind providers who deliver effective, efficient care.

Lower

costs for everyone

We're delivering a lower cost of care than our competitors.

YOUR FINANCIAL HEALTH

Executive Summary

MAJOR OBSERVATIONS

- **Medical Trend – d**ecreased 14.2% on a PMPM basis (11.7% adjusted)
- **Total Network Discount** – 63.3%
- **Population Health Risk** – current risk score is 1.87 up from prior year and 87.7% higher than benchmark
- **Avoidable ER Visits** – 64.4% of all ER visits could have been treated in a lower cost alternative site of care
- **High Cost Claimants** – 11 members drove 33.1% of all plan costs
- **Top 3 Clinical Cost Drivers** – genitourinary system, musculoskeletal system, and malignant cancers
- **Lifestyle Conditions**– claims attributed to lifestyle make up 37% of total dollars spent

REPORTING PARAMETERS

Reporting Period(s)	**Medical Utilization Financials** Paid during the following periods - Current Period - Jan 2016 - Dec 2016 Compared to Prior Period - Jan 2015 - Dec 2015
Benchmark	Medical Utilization: The Benchmark is comprised of the Anthem Book of Business
PMPM	Members are defined as plan eligible Employees, Spouses and Child/dependents PMPM paid amount is the metric used throughout this analysis to understand paid amount trends by individual plan participants (per member) over the duration of the plan period (per month)
High Cost Claimants	High cost claimants (HCCs) are referenced in this analysis and are defined as those members with a cumulative total paid amount of medical claims ≥ $100,000 during the current reporting period HCC PMPM = Per Member Per Month cost of Members with paid claims ≥ $100K Adjusted PMPM = Per Member Per Month cost of Members with paid claims ≤ $100K
Settings	Plan expenditures and utilization are broken down into the following settings: Inpatient facility, Outpatient facility and Professional

SUMMARY OF PLAN PERFORMANCE

Total Current Plan PMPM:

$372.04

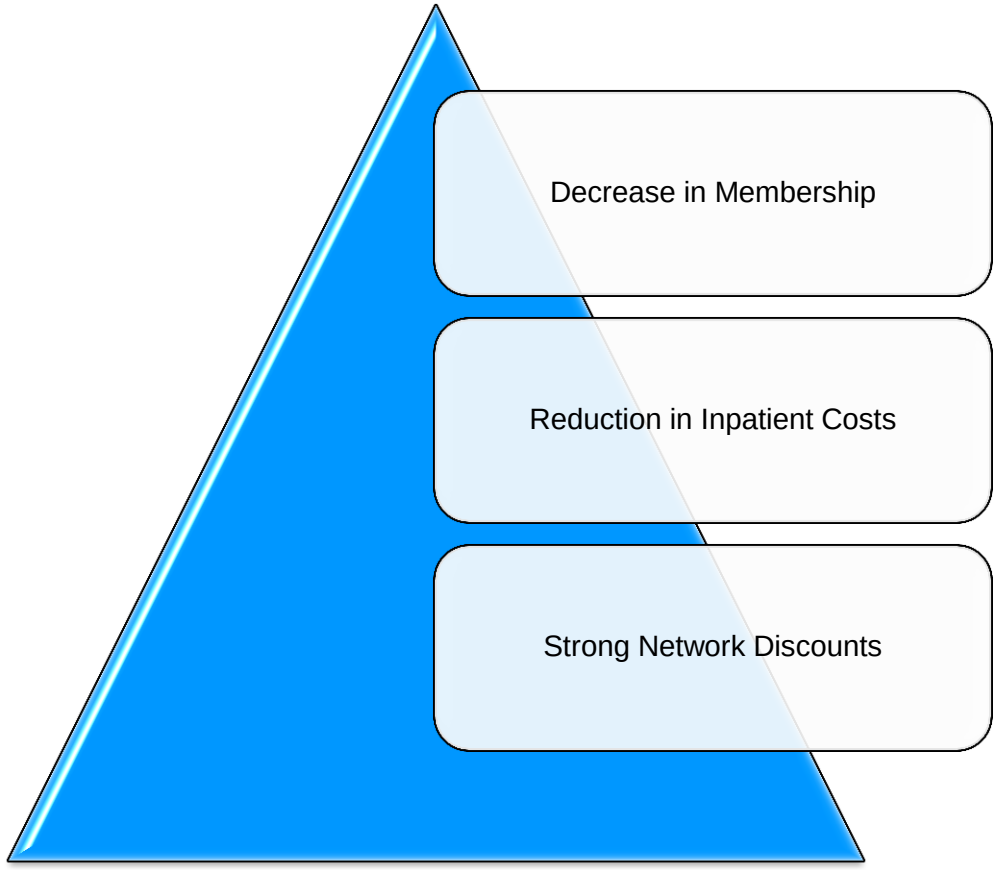
Total Health Plan PMPM Trend:

-14.2%

Total Adjusted PMPM Trend*:

-11.7%

Top Three Contributing Factors to Trend



* Adjusted PMPM = Per Member Per Month cost of Members with paid claims ≤ $100K

MEDICAL PLAN PERFORMANCE *BY THE NUMBERS*

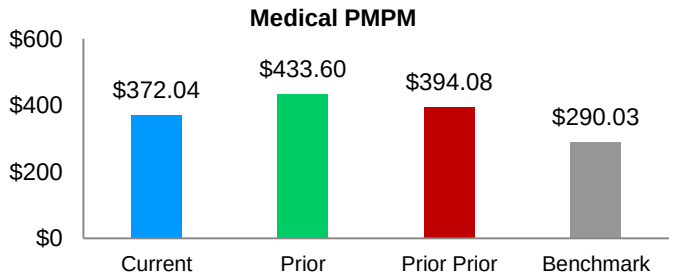
Medical Paid Claims Change:	-18.2%
Medical Membership Change:	-4.7%
Medical Plan PMPM:	$372.04
Medical Plan PMPM Trend:	-14.2%
Adjusted Medical PMPM*:	$248.90
Adjusted Medical PMPM Trend*:	-11.7%

* Adjusted PMPM = Per Member Per Month cost of Members with paid claims ≤ $100K

EXECUTIVE SUMMARY: COST AND MEMBERSHIP

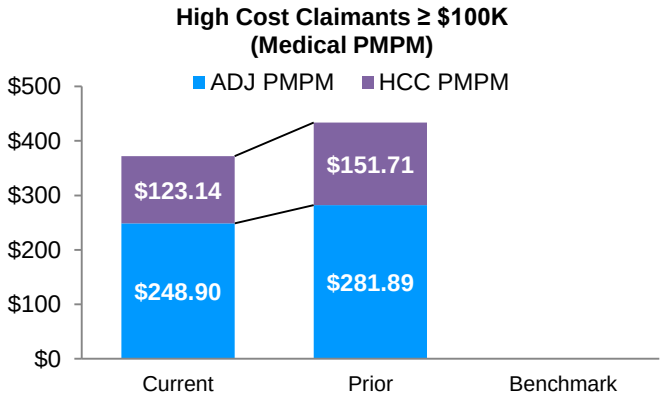
Medical Plan Expenditures:

- Paid medical claims = $6,286,670 (18.2% decrease from the prior period)
- The medical PMPM of $372.04 represents a -14.2% trend from the prior period
  - Adjusted medical PMPM (excluding HCCs) trend: -11.7%
- 90.7% of paid claims were paid in-network
- Network discounts totaled 63.3%



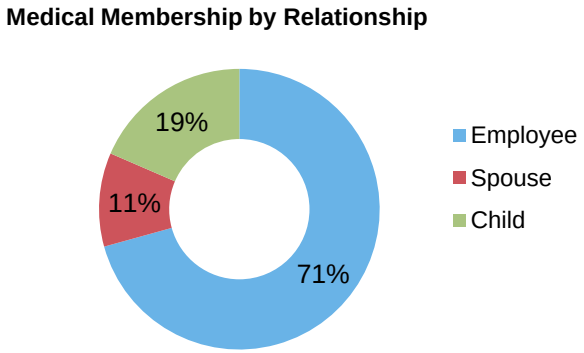
High Cost Claimants ≥ $100K*:

- 11 claimants accounted for $2,080,679 (33.1% of total medical)
  - ≥ $100k threshold:
    - 11 claimants accounted for $2,080,679 of total medical
- Genitourinary System, Neoplasms - Malignant, Musculoskeletal System, and Infectious/Parasitic were predominant conditions



Membership:

- Membership decreased 4.7%
- Average contract size was 1.4; lower than the Benchmark of 2.0
- Employee consumes 77.6% of total plan costs
- Employee PMPM: $408.70; Spouse: $468.64; Child: $175.41
- Average employee age = 47.8 (benchmark = 44.8)
- Average member age = 42.3 (benchmark = 34.8)



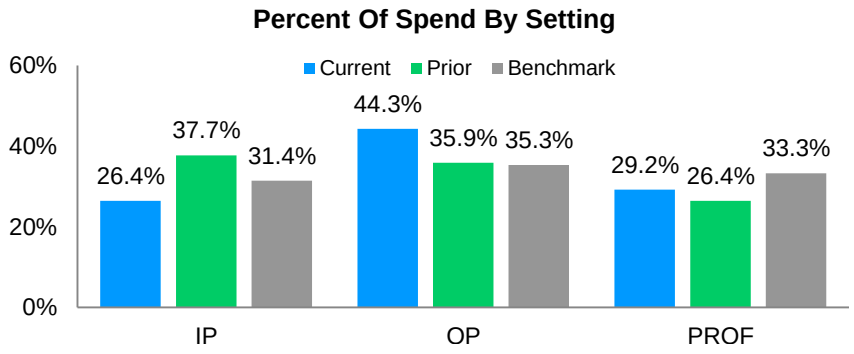
* HCC threshold determined by the member's total cost, medical plus pharmacy (if group has Rx benefit)

EXECUTIVE SUMMARY: UTILIZATION

Medical Utilization Trends:

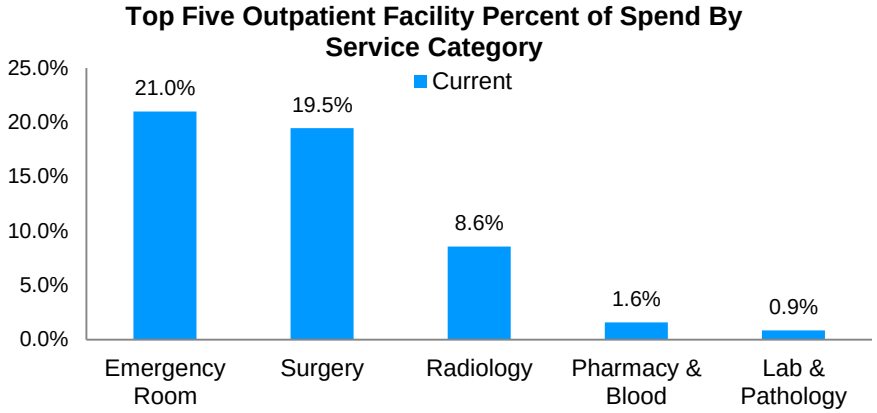
Inpatient Facility:

- Overall PMPM decreased 39.8% (8.0% above Benchmark)
- Acute Admits/1,000 decreased 18.5%
  - Cost/admit decreased 26.5%
- Acute ALOS increased 13.8%



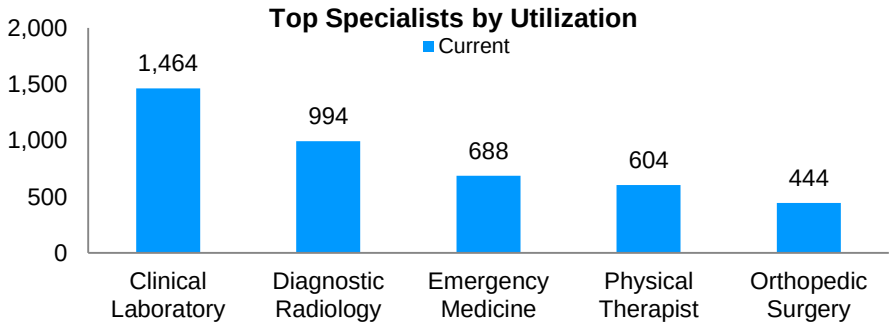
Outpatient Facility:

- Overall PMPM increased 6.1% (61.1% above Benchmark)
- Outpatient visits/1,000 increased 2.4%
  - Emergency Room: + 13.9%
  - Other: - 0.9%
- Cost/visit increased 3.6%
  - Emergency Room: + 1.1%
  - Other: + 4.8%



Professional:

- Total Professional PMPM decreased 5.2% (12.5% above Benchmark)
- Professional visits/1,000 decreased 1.3%
  - PCP: - 1.6%
  - Specialist: - 1.2%
- Cost/visit decreased 3.9%
  - PCP: - 2.2%
  - Specialist: - 4.5%

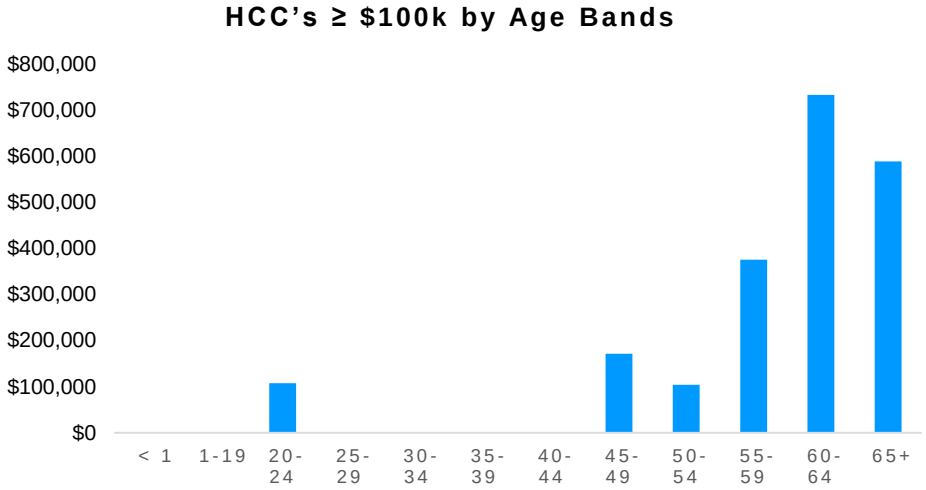


HIGH COST CLAIMANTS $100K+

Summary*:

- A total of 11 members [0.8% of membership] drove 33.1% of all costs. In the prior period, 13 of members drove 35.0% of all costs.

- 63.6% of members with claims paid greater than $100k are in an Active status in the plan
- Employees are responsible for 89.2% of HCC cost



Top Ten High Cost Claimants ($100,000)

Case	Diagnosis	Paid Amount	Relationship	Active Plan Status
1	CHRONIC KIDNEY DISEASE	$582,591	Employee	Yes
2	MALIGNANT NEOPLASM OF BREAST	$255,779	Employee	Yes
3	ENC ADJ & MANAGEMENT IMPLANTED DEVC	$193,721	Employee	Yes
4	OTHER SEPSIS	$171,573	Employee	No
5	INTRACRN INTRASPINAL ABSC GRANULOMA	$150,466	Employee	Yes
6	RESPIRATORY FAILURE NEC	$145,969	Employee	No
7	OTH D/O OF FLUID ELECTROLYTE & ABB	$132,593	Employee	Yes
8	MALIG NEOPLASM OTH UNS PARTS MOUTH	$119,828	Employee	No
9	OTHER DEFORMING DORSOPATHIES	$116,735	Spouse	Yes
10	ENCOUNTER FOR OTHER AFTERCARE	$107,346	Child	Yes

- HCC threshold determined by the member's total medical cost

PAID CLAIMS DISTRIBUTION

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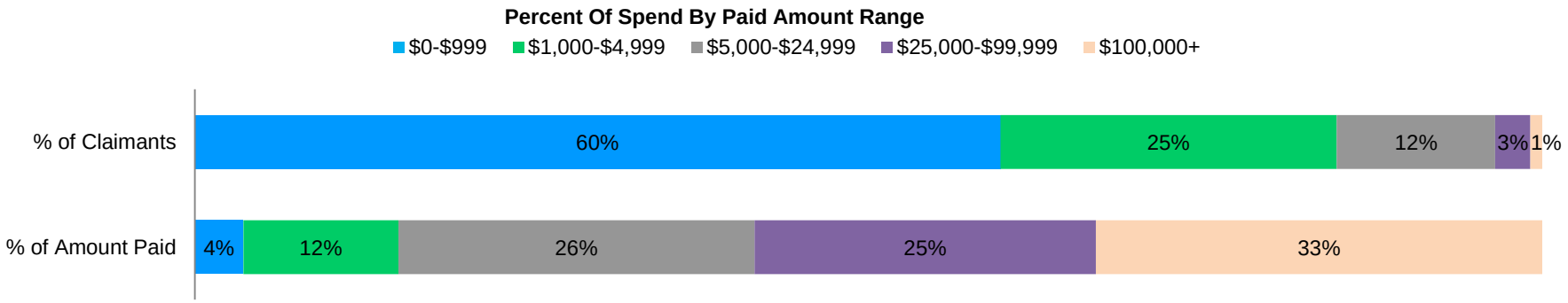
Summary:

- 59.8% of members had less than $1,000 in medical plan paid benefit coverage in the current period
- 24.9% of members had between $1,000 and $4,999 in medical plan paid benefit coverage in the current period
- 11.8% of members had between $5,000 and $24,999 in medical plan paid benefit coverage in the current period
- 2.6% of members had between $25,000 and $99,999 in medical plan paid benefit coverage in the current period
- 0.9% of members had $100K+ in medical plan paid benefit coverage in the current period

Medical Paid Amount						
Paid Amount Range	Current Unique Claimants	Current Percent Total Claimants	Current Total	Current Percent Paid Amount	Current Average per Claimant	Commercial Benchmark
<$0	16	1.3%	-$35,224	-0.6%	-$2,201	-0.5%
$0 to $999	743	58.6%	$261,565	4.2%	$352	4.6%
$1,000 to $1,999	162	12.8%	$229,378	3.6%	$1,416	4.3%
$2,000 to $2,999	71	5.6%	$174,901	2.8%	$2,463	3.7%
$3,000 to $3,999	44	3.5%	$152,469	2.4%	$3,465	3.2%
$4,000 to $4,999	39	3.1%	$171,295	2.7%	$4,392	2.8%
$5,000 to $9,999	74	5.8%	$502,638	8.0%	$6,792	10.3%
$10,000 to $24,999	76	6.0%	$1,156,522	18.4%	$15,217	17.5%
$25,000 to $49,999	23	1.8%	$819,640	13.0%	$35,637	14.3%
$50,000 to $74,999	5	0.4%	$322,143	5.1%	$64,429	8.0%
$75,000 to $99,999	5	0.4%	$450,666	7.2%	$90,133	5.3%
$100,000+	11	0.9%	$2,080,679	33.1%	$189,153	26.7%
Total - All Claimants	1,269	100.0%	$6,286,670	100.0%	$4,954	100.0%



UTILIZATION BY SETTING

	Unique Claimants	In Network	Out of Network	Current Period	Prior Period 1	Prior Period 2	Trend	Benchmark	Variance to Benchmark
Inpatient Facility	67								
Acute Admissions per 1000		61.1	0.7	61.8	75.8	76.6	-18.5%	55.3	11.7%
Acute Days per 1000		382.1	7.8	389.9	420.2	458.2	-7.2%	241.9	61.2%
Average Length of Stay - Acute		6.3	11.0	6.3	5.5	6.0	13.8%	4.4	44.3%
Paid Amount per Acute Admit		$18,743	$12,477	$18,671	$25,413	$24,728	-26.5%	$19,579	-4.6%
Inpatient Paid Amount		$1,650,326	$12,477	$1,662,803	$2,898,365	$3,024,363			
Paid Amount PMPM		$97.66	$0.74	$98.40	$163.44	$158.19	-39.8%	$91.07	8.0%
Outpatient Facility	589								
ER Annual Visits per 1000		424.7	0.0	424.7	372.8	409.2	13.9%	178.4	138.0%
ER Paid Amount per Visit		$979	$0	$979	$968	$817	1.1%	$1,319	-25.8%
Total Outpatient Visits per 1000		1,584.3	117.9	1,702.2	1,661.9	1,856.6	2.4%	1,232.0	38.2%
Total Paid Amount per Visit		$996	$3,414	$1,163	$1,123	$800	3.6%	$998	16.6%
Total Outpatient Paid Amount		$2,221,458	$566,651	$2,788,109	$2,758,344	$2,366,424			
Total Outpatient PMPM		$131.46	$33.53	$165.00	$155.54	$123.77	6.1%	$102.42	61.1%
Professional	1,257								
Primary Care									
Annual Visits per 1000		2,568.6	15.6	2,584.2	2,626.1	2,513.1	-1.6%	2,162.7	19.5%
Paid Amount per Visit		$114	$67	$114	$116	$111	-2.2%	$117	-3.0%
Specialty Care									
Annual Visits per 1000		6,157.7	58.9	6,216.6	6,294.3	6,135.9	-1.2%	5,785.0	7.5%
Paid Amount per Visit		$164	$24	$162	$170	$174	-4.5%	$156	3.9%
Total Professional Paid Amount		$1,832,291	$3,468	$1,835,759	$2,032,810	$2,143,684			
Total Professional PMPM		$108.43	$0.21	$108.64	$114.63	$112.12	-5.2%	$96.54	12.5%
Total									
Paid Amount		$5,704,074	$582,596	$6,286,670	$7,689,518	$7,534,471			
Total Medical PMPM		$337.56	$34.48	$372.04	$433.60	$394.08	-14.2%	$290.03	28.3%

INPATIENT FACILITY METRICS

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Summary:

- Paid PMPM for inpatient facility claims decreased by 39.8%
- Acute Admissions/1000 decreased 18.5% while average length of stay increased 13.8% suggesting conditions for which members were hospitalized had a higher severity level.

Inpatient Facility	Current	Prior	Trend	Benchmark	Percent Variance
Paid Amount	$1,662,803	$2,898,365			
Paid Amount PMPM	$98.40	$163.44	-39.8%	$91.07	8.0%
Acute Admissions Per 1000	61.8	75.8	-18.5%	55.3	11.7%
Annual Acute Days Per 1000	389.9	420.2	-7.2%	241.9	61.2%
Average Length Of Stay - Acute	6.31	5.54	13.8%	4.37	44.3%
Paid Amount Per Acute Admission	$18,671	$25,413	-26.5%	$19,579	-4.6%

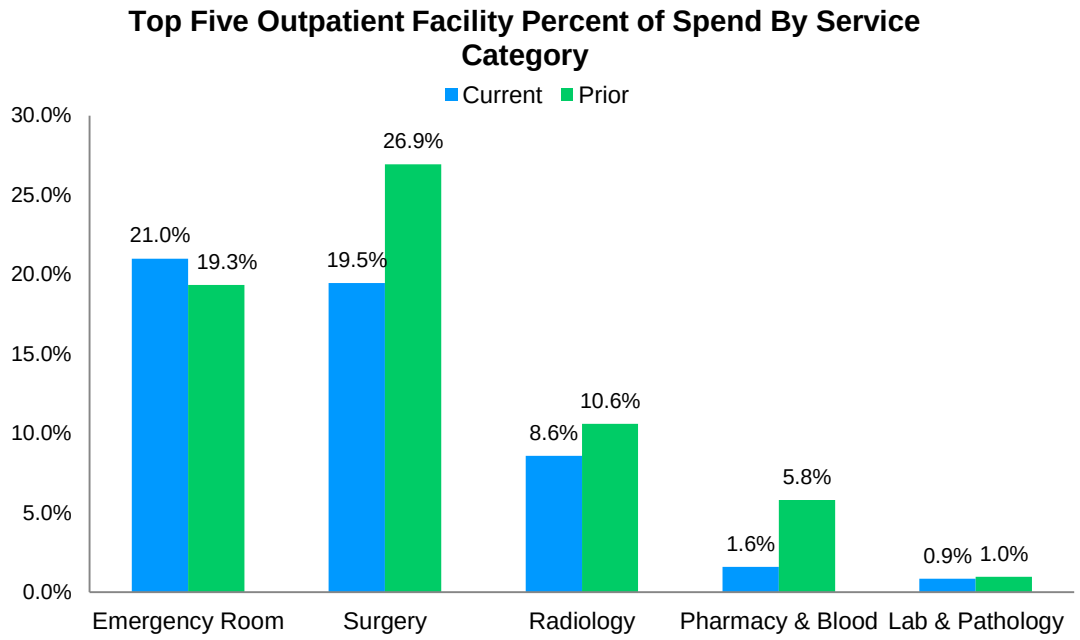
Inpatient Service Category	Average LOS	Admits/ 1000	Days/ 1000	Paid Amount	Current PMPM	Prior PMPM	Trend	Benchmark	Percent Variance
Medical	7.79	36.9	287.6	$917,167	$54.28	$50.40	7.7%	$26.43	105.4%
Surgical	4.20	14.2	59.7	$627,259	$37.12	$102.33	-63.7%	$47.15	-21.3%
Mental Health/Substance Abuse	4.78	6.4	30.5	$46,614	$2.76	$0.84	227.6%	$3.10	-11.1%
Skilled Nursing	16.00	5.0	79.5	$38,450	$2.28	$1.13	101.8%	$0.67	239.0%
Maternity	*	3.6	9.2	$28,763	$1.70	$6.93	-75.4%	$12.57	-86.5%
Other	*	0.7	2.8	$4,549	$0.27	$0.00	0.0%	$0.24	9.9%
Rehabilitation	0.00	0.0	0.0	$0	$0.00	$1.81	-100.0%	$0.13	-100.0%
Well New Born	0.00	0.0	0.0	$0	$0.00	$0.00	0.0%	$0.78	-100.0%
Total	*****	**66.8**	**469.4**	**$1,662,803**	**$98.40**	**$163.44**	**-39.8%**	**$91.07**	**8.0%**

* This value is not shown due to small numbers.

OUTPATIENT FACILITY METRICS

Summary:

- 4 of the top 5 outpatient facility categories decreased, but overall outpatient increased 6.1%
- ER visits are up over prior year, and there is an opportunity to move avoidable ER visits to lower site of care. (See ER Summary and Opportunity Analysis)



Top Five Outpatient Service Categories	Visits per 1,000	Current Paid PMPM	Prior Paid PMPM	Trend	Benchmark Paid PMPM	Percent Variance
Emergency Room	424.7	$34.64	$30.08	15.2%	$19.61	76.6%
Surgery	90.9	$32.10	$41.89	-23.4%	$33.00	-2.7%
Radiology	262.0	$14.15	$16.47	-14.1%	$9.03	56.6%
Pharmacy & Blood	7.8	$2.62	$9.02	-71.0%	$2.56	2.2%
Lab & Pathology	51.8	$1.41	$1.52	-7.6%	$4.06	-65.3%
All Outpatient	**1,702.2**	**$165.00**	**$155.54**	**6.1%**	**$102.42**	**61.1%**

EMERGENCY ROOM SUMMARY & OPPORTUNITY ANALYSIS

- Emergency Room facility paid amount was 9.3% of the total medical plan paid amount
- ER utilization was 424.7 visits per 1000, compared to the Benchmark of 178.4 visits per 1000

- 64.4% of ER visits were potentially “low intensity” in the current period compared to 66.1% in the prior period, which means these were diagnoses that could have been treated in an alternative setting such as retail health clinic or urgent care
- Low intensity ER utilization was 255.7 visits per 1000 compared to the Benchmark of 95.5 visits per 1000

Opportunity Analysis	Current	Prior Period 1	Prior Period 2	Trend
Total Avoidable ER Visits	360	336	420	7.14%
Avoidable ER Visits per 1000 members	255.7	227.4	263.6	12.44%
Avoidable ER Visits Paid Amount PMPM	$16.89	$12.57	$14.76	34.29%
Average cost per Avoidable ER Visit	$793	$664	$672	19.43%
Less offset cost: retail/urgent visit	-$74	-$74	-$74	
Savings per visit re-directed	$719	$590	$598	21.87%
Total Potential Savings Opportunity	$258,716	$198,134	$251,035	30.58%
Percentage of Avoidable ER visits to all ambulatory ER visits	64.40%	66.14%	70.47%	-2.63%
Potential Savings Opportunity				
Savings if 5% of Avoidable ER visits redirected	$12,936	$9,907	$12,552	30.58%
Savings if 10% of Avoidable ER visits redirected	$25,872	$19,813	$25,104	30.58%
Savings if 15% of Avoidable ER visits redirected	$38,807	$29,720	$37,655	30.58%
Average Membership	1,408	1,478	1,593	-4.71%
Total of all ER visits	598	551	652	8.53%
Total of all Ambulatory ER visits	559	508	596	10.04%
Avoidable ER costs	$285,356	$222,998	$282,115	27.96%

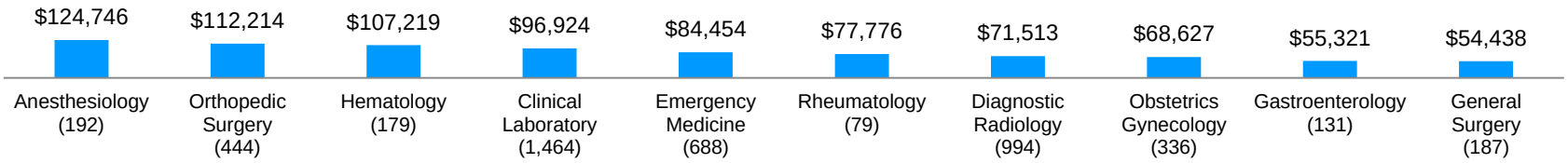
PROFESSIONAL METRICS

Summary:

- The cost of professional visits decreased 5.2% on a PMPM basis ($108.64 from $114.63) and are 12.5% higher than benchmark

Professional Service Categories	Visits Per 1,000	Total Paid	Current PMPM	Prior PMPM	Trend	Benchmark PMPM	Variance to Benchmark
Office/Home Visits	2,840.6	$369,471	$21.86	$21.65	1.0%	$13.98	56.4%
OP Surgery	397.7	$305,717	$18.09	$20.14	-10.2%	$14.75	22.7%
Professional Other	1,312.3	$171,472	$10.15	$8.15	24.5%	$8.41	20.6%
Lab & Pathology	1,188.8	$141,348	$8.36	$8.14	2.8%	$5.91	41.5%
Radiology	846.5	$135,022	$7.99	$7.89	1.3%	$6.97	14.6%
Medical	275.5	$133,364	$7.89	$8.34	-5.4%	$5.99	31.8%
Therapeutic Injections	49.7	$124,693	$7.38	$8.58	-14.0%	$4.31	71.0%
IP Surgery	43.3	$105,070	$6.22	$8.65	-28.1%	$4.95	25.5%
Preventive Services	409.0	$101,712	$6.02	$6.17	-2.5%	$9.54	-36.9%
IP Visits	419.0	$64,462	$3.81	$4.41	-13.6%	$2.56	49.1%
Mental Health / Substance Abuse	582.3	$59,639	$3.53	$3.81	-7.4%	$5.66	-37.6%
Maternity	85.2	$26,241	$1.55	$3.18	-51.2%	$4.31	-64.0%
Other	350.8	$97,547	$5.77	$5.51	4.8%	$9.18	-37.1%
Total	**8,800.8**	**$1,835,759**	**$108.64**	**$114.63**	**-5.2%**	**$96.54**	**12.5%**
Online Care	0.0	$0	$0.00	$0.00	0.0%	$0.01	-100.0%

Top 10 Provider Specialties by Paid Amount (Visits)



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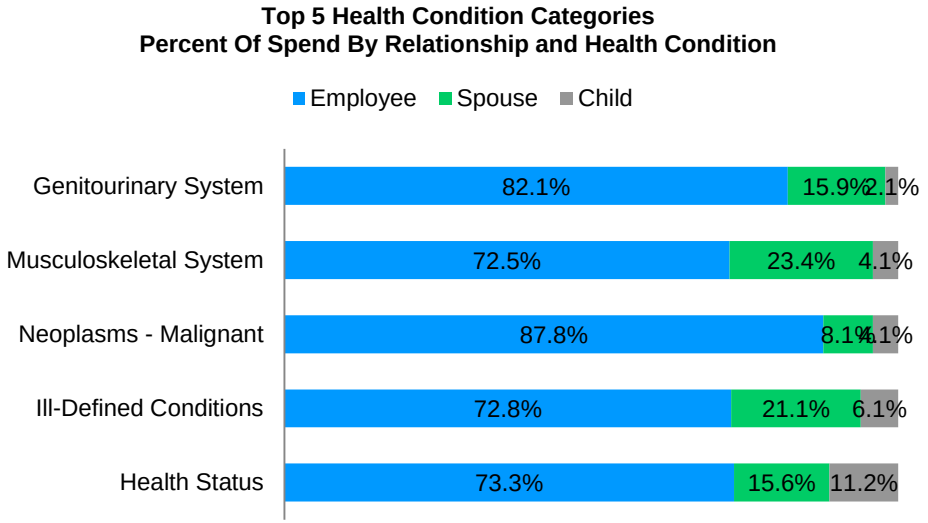
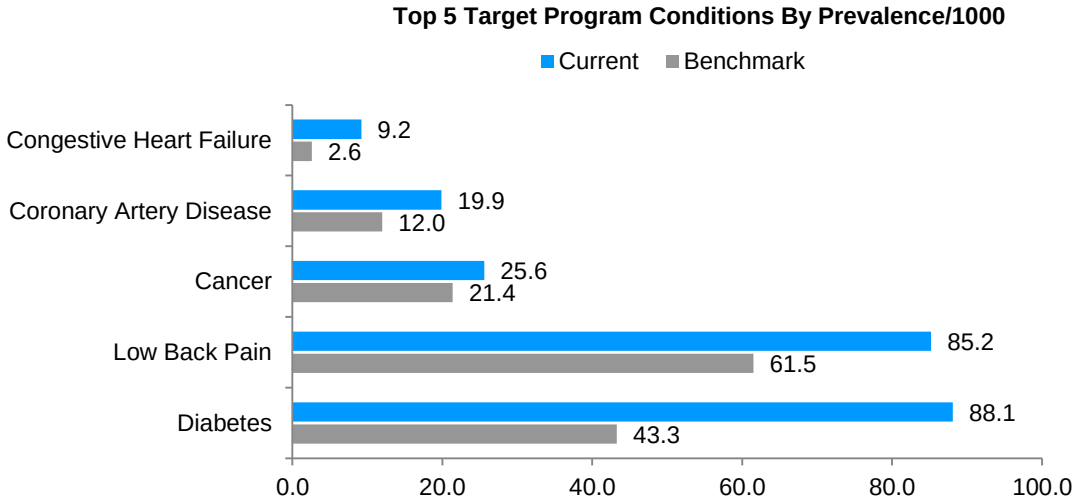
YOUR CLINICAL OUTCOMES

EXECUTIVE SUMMARY: CLINICAL COST DRIVERS

Summary:

- The Health Risk Index is a diagnostic and age/sex adjusted projection of the population's likely level of risk for the period indicated. The Benchmark is presented for comparison The comparison population reflects the healthcare experience of employees and dependents from a large national dataset. A score higher than 1.0 indicates a higher level of risk as compared to the national dataset.
    - The group's current risk score is 1.87 up from 1.74 in the prior year. (87.7% above benchmark)
- The Top 5 health condition categories accounted for 53.3% of claims paid for the period
    - The Employee is responsible for 77.6% of spend; the Spouse is responsible for 13.6% and the Child 8.7%
- Prevalence rates for Targeted Program Conditions are significantly above benchmark.
- Changes in lifestyle could greatly affect the spend for these conditions.



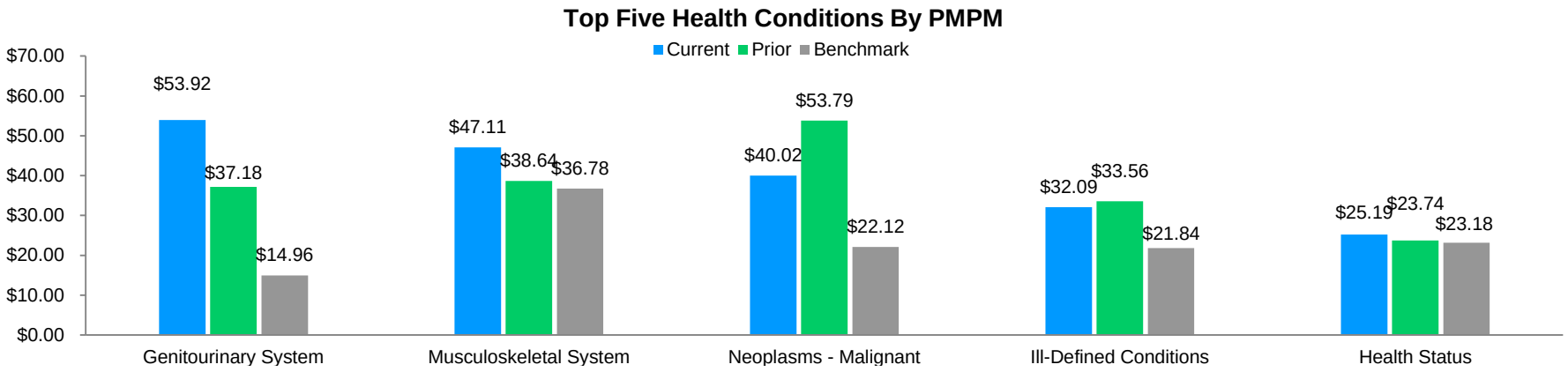


TOP HEALTH CONDITIONS

Summary:

- The top five health condition categories accounted for 53.3% of claims paid for the total plan
- Employees drove 78.3% of the expense in the top five health condition categories, the spouses drove 16.9%
- Chronic Kidney Disease $656K represented 72% of the total Genitourinary System conditions
- Breast cancer was the leading diagnosis in the Neoplasms-Malignant condition.

Health Condition	Unique Claimants	Inpatient	Outpatient	Professional	Total	% of Total	Paid Amount per Unique Claimant
Genitourinary System	230	$50,338	$772,453	$88,300	$911,092	14.5%	$3,961
Musculoskeletal System	435	$251,777	$220,933	$323,309	$796,020	12.7%	$1,830
Neoplasms - Malignant	40	$72,416	$403,514	$200,249	$676,178	10.8%	$16,904
Ill-Defined Conditions	503	$65,111	$290,973	$186,127	$542,210	8.6%	$1,078
Health Status	642	$21,263	$178,838	$225,601	$425,702	6.8%	$663



TOP HEALTH CONDITIONS BY RELATIONSHIP AND PMPM

Summary:

- While the Top Health Conditions experienced an overall -22.5% PMPM trend compared to the prior 12 month period
- 7 of the Top 10 conditions have PMPMs that higher than benchmark.

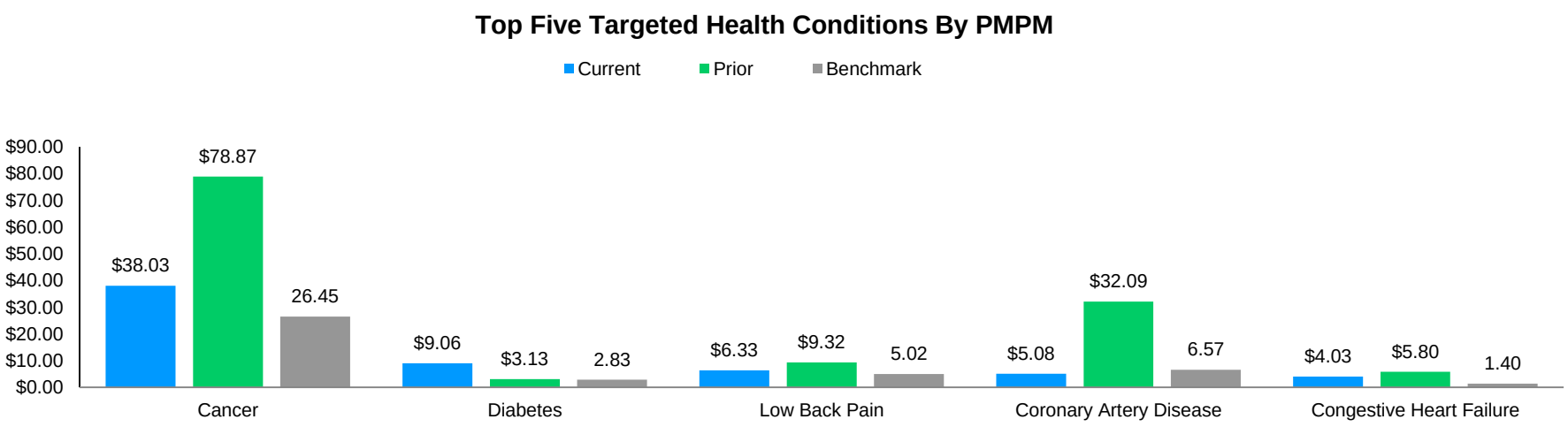
	Employee		Spouse		Child		Total	Total	PMPM	Variance to
	Paid	PMPM	Paid	PMPM	Paid	PMPM	Paid Amount	PMPM	Trend	Benchmark
Genitourinary System	$747,757	$62.62	$144,408	$78.91	$18,927	$6.05	$911,092	$53.92	45.0%	260.3%
Musculoskeletal System	$576,741	$48.30	$186,419	$101.87	$32,860	$10.51	$796,020	$47.11	21.9%	28.1%
Neoplasms - Malignant	$593,910	$49.73	$54,658	$29.87	$27,610	$8.83	$676,178	$40.02	-25.6%	80.9%
Ill-Defined Conditions	$394,941	$33.07	$114,170	$62.39	$33,099	$10.59	$542,210	$32.09	-4.4%	46.9%
Health Status	$311,911	$26.12	$66,236	$36.19	$47,555	$15.21	$425,702	$25.19	6.1%	8.7%
Respiratory System	$293,883	$24.61	$80,744	$44.12	$27,127	$8.68	$401,754	$23.78	-9.0%	93.6%
Circulatory System	$268,808	$22.51	$67,105	$36.67	$390	$0.12	$336,303	$19.90	-79.1%	-21.0%
Injury & Poisoning	$243,795	$20.41	$9,037	$4.94	$70,284	$22.48	$323,115	$19.12	-37.7%	-7.9%
Digestive System	$257,229	$21.54	$18,771	$10.26	$3,986	$1.28	$279,986	$16.57	-23.2%	-23.8%
Aftercare	$204,431	$17.12	$350	$0.19	$70,814	$22.65	$275,595	$16.31	-13.0%	65.8%
Subtotal	$3,893,406	$326.03	$741,898	$405.41	$332,651	$106.41	$4,967,956	$294.00	-22.5%	
All Other	$987,306	$82.68	$115,719	$63.23	$215,689	$69.00	$1,318,715	$78.04	43.3%	
Total	**$4,880,713**	**$408.70**	**$857,617**	**$468.64**	**$548,341**	**$175.41**	**$6,286,670**	**$372.04**	**-14.2%**	**28.27%**

TOP FIVE TARGETED HEALTH CONDITIONS

Summary:

- For the target program conditions, listed below, employees account for 72.8% of total paid claims.
- Compared to the prior period, PMPM decreased 49.1%, but is still 27.9% higher than the Benchmark.
- Renal failure/Chronic Kidney Disease is a downstream impact for many of the uncontrolled conditions below which is your top HCC spend.

Type	Number of Claimants	Paid Amount	Inpatient Facility	Outpatient Facility	Professional	Prevalence per 1,000	Benchmark Prevalence per 1,000
Cancer	36	$642,705	$72,416	$395,119	$175,171	25.6	21.4
Diabetes	124	$153,163	$95,441	$6,893	$50,828	88.1	43.3
Low Back Pain	120	$106,942	$0	$55,256	$51,686	85.2	61.5
Coronary Artery Disease	28	$85,864	$44,730	$30,681	$10,453	19.9	12.0
Congestive Heart Failure	13	$68,158	$58,670	$2,276	$7,212	9.2	2.6



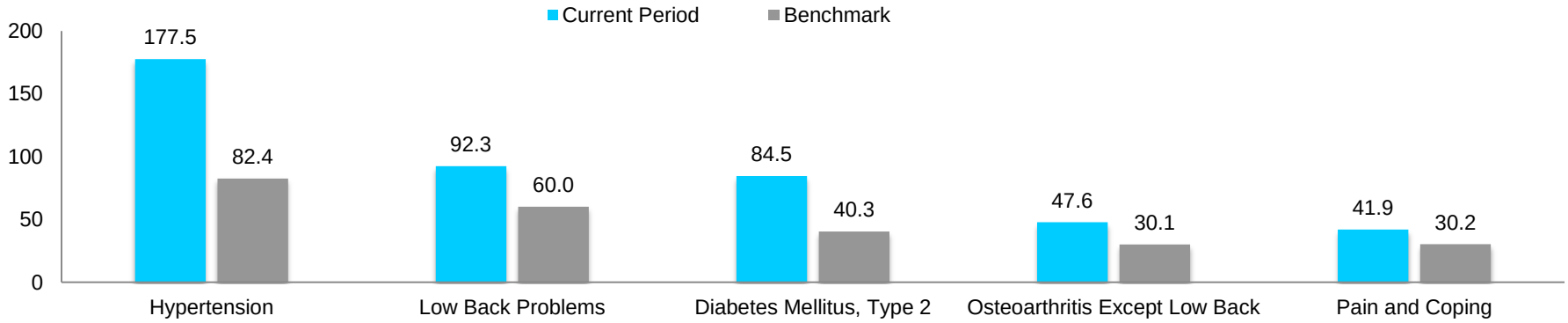
TOP TEN LIFESTYLE CONDITIONS

Summary:

- Claims attributed to specific Lifestyle conditions make up 37.0% of the total dollars spent
- Chronic Kidney Disease represents the primary Lifestyle Related Condition by paid amount and is 11.7% of the total paid claims amount in the current period.
- Hypertension represents the highest Lifestyle Related Condition per 1000 and is 115.5% above the Benchmark.

Top Ten Lifestyle Conditions by Paid Amount	Paid Amount	Unique Members	Current Period PMPM	Benchmark PMPM	Variance to Benchmark
Chronic Kidney Disease	$605,332	15	$35.82	$2.81	1177.1%
Cancer - Breast	$204,411	12	$12.10	$3.99	203.3%
Osteoarthritis Except Low Back	$115,318	67	$6.82	$7.91	-13.7%
Low Back Problems	$109,119	130	$6.46	$5.17	25.0%
Coronary Artery Disease	$84,313	27	$4.99	$6.47	-22.9%
Pain and Coping	$83,310	59	$4.93	$1.60	207.2%
Heart Failure	$68,158	13	$4.03	$1.23	228.8%
Diabetes Mellitus, Type 2	$61,951	119	$3.67	$1.78	106.3%
COPD and Bronchitis	$60,565	26	$3.58	$0.61	492.4%
Hypertension	$55,284	250	$3.27	$1.34	144.9%

Top Five Lifestyle Conditions Prevalence Per 1000 Ranked by Paid Amount



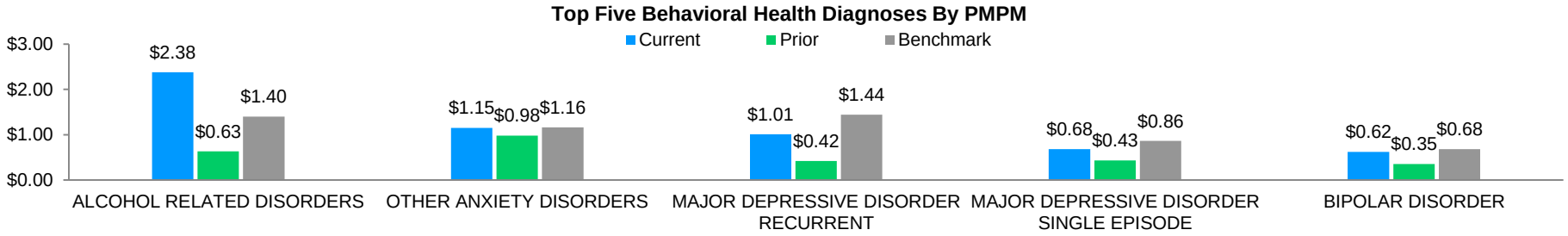
MENTAL HEALTH AND SUBSTANCE ABUSE

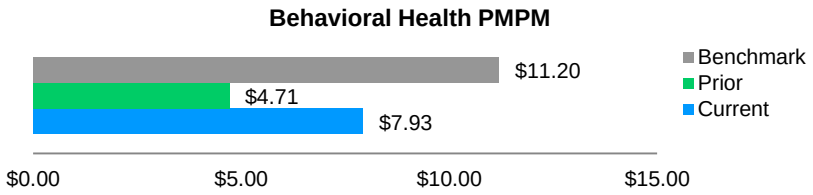
Anthem. National Accounts

Summary:

- Total spend was $134,449 or $7.93 PMPM, well below the benchmark.
- 69% of the BHSA spend was driven by behavioral health diagnoses while 30.6% was driven by substance abuse.
- Total BHSA spend was 0.2% of total claims paid. We generally see this much higher at about 4% of spend total claim spend.
- We are seeing Opioid abuse and Residential Treatment Centers spike across our book of business, but are absent in this population.

Mental Condition	Unique Claimants	Paid Amount per Unique Claimant	Inpatient	Outpatient	Professional	Total	% of Total
ALCOHOL RELATED DISORDERS	12	$3,359	$15,637	$14,979	$9,698	$40,314	30.0%
OTHER ANXIETY DISORDERS	63	$309	$0	$5,091	$14,378	$19,469	14.5%
MAJOR DEPRESSIVE DISORDER RECURRENT	26	$657	$11,188	$0	$5,900	$17,088	12.7%
MAJOR DEPRESSIVE DISORDER SINGLE EPISODE	35	$331	$4,722	$483	$6,376	$11,581	8.6%
BIPOLAR DISORDER	18	$581	$6,657	$0	$3,804	$10,460	7.8%

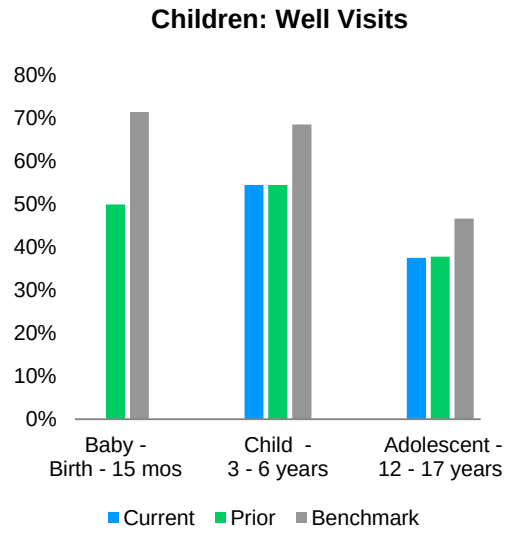


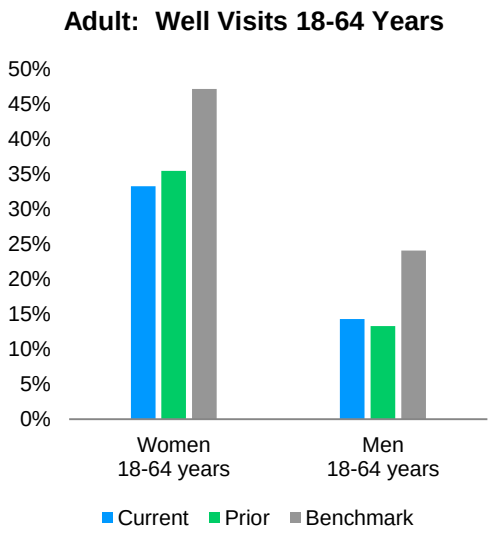


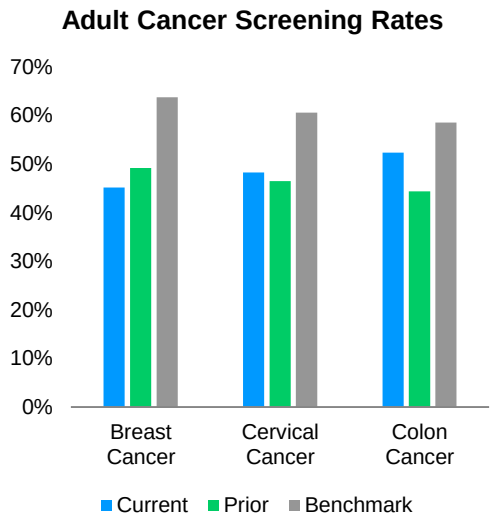
PREVENTIVE SCREENINGS

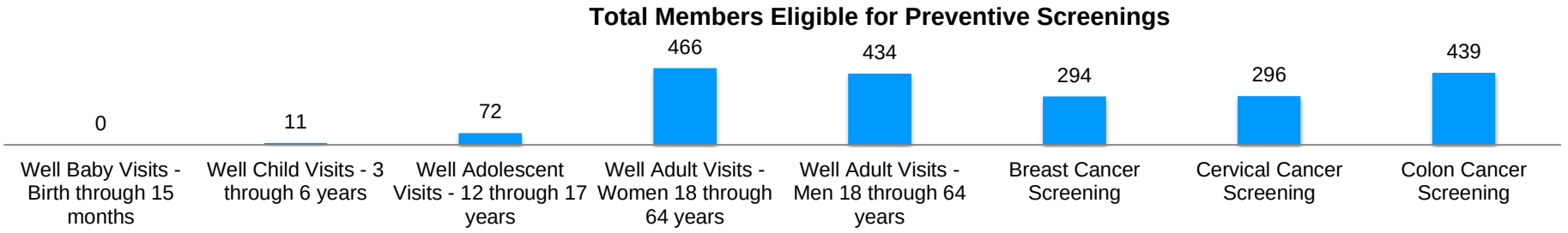
Summary:

- Screening compliance rates improved from prior period for 37.5% of Preventive Care Screenings; however all screening categories are still below the benchmark.
- Membership compliance with Preventive Care Screenings and Immunizations that had the greatest difference from the Anthem Benchmark were:
  - Well Baby Visits - Birth through 15 months: -21.5% variance from the Benchmark
  - Breast Cancer Screening: -18.6% variance from the Benchmark
  - Well Child Visits - 3 through 6 years: -14.1% variance from the Benchmark









YOUR NETWORK PERFORMANCE

WHAT DOES BLUE DO FOR YOU?

Total Medical Claims

Total Discount Savings

Total Allowed Amount

Total Discount Achieved

Not Covered/COB

UFCW Claim Expense

Associate OOP Expense

Each Point of Discount

Summary of observations and Anthem's recommendations

Avoidable ER use is increasing

OPPORTUNITIES:

- Utilize Kroger's The Little Clinic – 9 locations in VA in Kroger stores
- Consider benefit plan change to steer members -- $5 copay for TLC $15 copay for non-Kroger RHC
- Add LiveHealth OnLine telemedicine at no cost -- $49 online MD visit; BH visits also available

High prevalence of targeted program conditions (CHF, CAD, Diabetes, Cancer)

OPPORTUNITIES:

- Add Full Suite of Medical Management Services (Integrated Health Model "lite") -- condition agnostic and targets 20% of moderate/high acuity conditions $4.50 PEPM
- Add Disease Management only – Core 5 $0.92 PEPM
- Add Diabetes Prevention Program – New with Anthem mid-2017 Claims based and cost per qualifying member is approx. $770

Preventive Care -- Cancer Screenings Lower than Benchmark

OPPORTUNITIES:

- Promote preventive care to assure compliance with age and gender appropriate
- Promote compliance with cancer screenings
- Campaign to promote PCP relationship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APPENDIX

TERMINOLOGY

Adult Annual Well Visit: is the number of adult patients who received a well visit provided under medical coverage, expressed as a percentage of the average number of members for whom this test is appropriate. Candidates are members aged 21 or older with greater than 12 months of continuous enrollment, and a procedure code, or any diagnosis code equal to Well Visit.

Adolescent Annual Well Visit: is the number of adolescent patients who received a well visit provided under medical coverage, expressed as a percentage of the average number of members for whom this test is appropriate. Candidates are members aged 12 to 20 with greater than 12 months of continuous enrollment, and a procedure code, or any diagnosis code equal to Well Visit.

Admissions Per 1,000 (IP Admits): is the average number of admissions per 1,000 members per year.

Allowed Amount: is the amount of submitted charges eligible for payment.

Average Length of Stay: is the average number of days per Inpatient admission**.**

Baby Routine Well Visits: is the average number of Outpatient professional well child visits provided to children aged 0 through 15 months under medical coverage, per 1,000 members aged 0 through 15 months with medical coverage per year. The number of visits is based on the count of unique patient, service date, and provider combinations.

Cervical Cancer Screening Rate: is the number of patients who received facility or professional cervical Cancer screening services provided under medical coverage, expressed as a percentage of the average number of members for whom this test is appropriate. Candidates for cervical Cancer screening tests are defined as females aged 21 to 64 years.

Child Routine Well Visits: is the average number of Outpatient professional well child visits provided to children aged 3 through 6 years under medical coverage, per 1,000 members aged 3 through 6 years with medical coverage per year. The number of visits is based on the count of unique patient, service date, and provider combinations.
Childhood Immunization Services: is the average number of immunization services provided to children aged 0 through 23 months under medical coverage, per 1,000 members aged 0 through 23 months with medical coverage per year.

Cholesterol Screening Rate: is the number of patients who received facility or professional cholesterol screening services provided under medical coverage, expressed as a percentage of the average number of members for whom this test is appropriate. Candidates are defined as males aged 35 years and older , and females aged 45 years and older.

Claimant: A subscriber or dependent who received medical services covered under the health plan.

Colon Cancer Screening Rate: is the number of patients who received facility or professional colon Cancer screening services provided under medical coverage, expressed as a percentage of the average number of members for whom this test is appropriate. Candidates for colorectal Cancer screening tests and procedures are defined as adults aged 50 to 75 years of age.

TERMINOLOGY

Contract Size: is the average number of family members per employee or subscriber.

Cost Share: is the amount paid out-of-pocket by the member for healthcare services. This generally includes coinsurance, copayment, and deductible amounts.

Days Per 1,000: is the average number of days from admissions per 1,000 members per year.

Discount Savings: Savings resulted from discounts for network providers**.**

High Cost Claimants (HCC): are individuals with $75,000 or more in claims during the analyzed period.

Mammogram Screening Rate: is the number of patients who received facility or professional mammography services provided under medical coverage, expressed as a percentage of the average number of members for whom this test is appropriate. Candidates for breast Cancer screening procedures are defined as females aged 40 to 69 years.
OP Facility Visits Per 1,000: is the average number of Outpatient facility visits, per 1,000 members with medical coverage per year.

Out-of-Pocket (OOP): is the amount paid out-of-pocket by the member healthcare services. This generally includes coinsurance, copayment, and deductible amounts.

Paid Amount: is the amount the plan paid. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.

PEPM/PEPY: Per Employee Per Month and Per Employee Per Year.

PMPM/PMPY: Per Member Per Month and Per Member Per Year. Members are defined as all participants in the plan including employees, spouses, and dependents.

PSA Screening Rate: is the number of patients who received facility or professional Prostate Specific Antigen (PSA) screening services provided under medical coverage, expressed as a percentage of the average number of members for whom this test is appropriate. Candidates for prostate Cancer screening tests are defined as males aged 50 to 70 years.

Visits Per 1,000 ER: is the average number of emergency room facility visits per 1,000 members with medical coverage.

Visits Per 1,000 OP Facility: is the average number of OP Facility visits, per 1,000 members with medical coverage per year.

Visits Per 1,000 Professional Office: is the average number of Professional Office visits, per 1,000 members with medical coverage per year.

HEALTH CONDITION DESCRIPTIONS

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AFTERCARE (ICD-10: Z51)
Definition: Encounter for other aftercare (typically cancer).
Examples: Chemotherapy, radiotherapy, immunotherapy.

BEHAVORIAL HEALTH DISORDERS (ICD-9: 290-319) (ICD-10: F01-F99 excluding F49)
Definition: Illness caused by psychiatric or psychological conditions.
Examples: Drug and alcohol abuse, anorexia nervosa, bulimia, depression, paranoia, schizophrenia.

CANCER SCREENINGS (ICD-10: Z08, Z12)
Definition: Screening for cancer and cancer precursors in asymptomatic individuals so that early detection and treatment can be provided for those who test positive for disease.
Examples: Colon cancer screening, breast cancer screening, prostate cancer screening.

CIRCULATORY SYSTEM (ICD-9: 390-459) (ICD-10: I00-I02, I05-I15, I20-I28, I30-I52, I60-I89, I95-I99)
Definition: Illness caused by heart and blood vessel disorders.
Examples: High or low blood pressure, hemorrhoids, varicose veins, heart attack, heart valve disease, stroke, aneurysm.

CONGENITAL ABNORMALITIES (ICD-9: 740-759) (ICD-10: Q00-Q07, Q10-Q18, Q20-Q28, Q30-Q45, Q50-Q56, Q60-Q99)
Definition: Congenital malformations, deformations and chromosomal abnormalities .
Examples: Cleft palate and/or lip, Down's syndrome, hydrocephalus, congenital cataracts, abnormal fetal development of the eyes, ears, nose, face, heart, lungs, etc.

DIGESTIVE SYSTEM (ICD-9: 520-579) (ICD-10: K00-K14, K20-K31, K35-K38, K40-K46, K50-K52, K55-K68, K70-K77, K80-K87, K90-K95)
Definition: Illness caused by disorders of the teeth, mouth, jaw, salivary glands, esophagus, stomach, intestine, rectum, gallbladder, and liver.
Examples: Dental cavities, ulcers, appendicitis, hernias, noninfectious colitis, anal fissure, gall stones, cirrhosis of the liver.

DISEASES OF THE BLOOD (ICD-9: 280-289) (ICD-10: D50-D53, D55-D78, D80-D89)
Definition: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism .
Examples: Anemia, hemophilia, blood and spleen disorders.

DISEASES OF THE EAR (ICD-10: H60-H62, H65-H75, H80-H83, H90-H95)
Definition: Disease of the auditory and mastoid processes.
Examples: Otitis media, hearing loss, middle ear mastoid

HEALTH CONDITION DESCRIPTIONS

DISEASES OF THE EYE (ICD-10: H00-H05, H10-H11, H15-H22, H25-H28, H30-H36, H40-H44, H46-H47, H49-H57, H59)
Definition: Disease of the visual sensory and adnexa processes.
Examples: Retinal detachments and breaks, glaucoma, cataracts, corneal scars and opacities

ENDOCRINE/METABOLIC (ICD-9: 240 – 279) (ICD-10: E00-E13, E15-E16, E20-E36, E40-E46, E50-E68, E70-E89)
Definition: Endocrine - illness caused by increased, decreased, or imbalanced hormones. Metabolic - illness caused by the body's inability to turn food into energy.
Examples: Thyroid disease, diabetes, parathyroid disease, ovarian and testicular hormonal disease, vitamin and mineral excess or deficiency, obesity.

GENITOURINARY SYSTEM (ICD-9: 580 – 629) (ICD-10: N00-N08, N10-N23, N25-N53, N60-N65, N70-N77, N80-N99)
Definition: Illness caused by disorders of the kidney, bladder, prostate, testes, breast, ovaries, and uterus.

HEALTH STATUS (ICD-9: V01-V83) (ICD-10: Z00-Z04, Z18, Z20-Z23, Z28, Z30, Z40-Z49, Z52-Z53, Z55-Z57, Z59-Z60, Z62-Z93, Z95-Z99)
Definition: Occasions when circumstances other than a disease or injury exists that are not classifiable to the other ICD-9 OR ICD-10 categories. This occurs in one of two ways: 1) when a person is not currently sick but encounters health services for some specific purpose, such as organ donation, vaccination, or to discuss a problem which itself is not an injury or disease; 2) some circumstance or problem is present which influences the persons health status but it is not a current illness or injury.
Examples: General medical exam, contraceptive management, personal history of disease, post-procedural aftercare

ILL-DEFINED CONDITIONS (ICD-9: 780-799) (ICD-10: R00-R23, R25-R94, R97, R99)
Definition: This classification will be utilized when 1) cases for which no more specific ICD-10 diagnosis code can be made even after all of the facts bearing on a case have been investigated; 2) signs or symptoms existing at the time of the initial visit proved to be short term, and the cause has not or could not be determined; and 3) the symptoms represent important medical problems, and the physician desired to classify the symptom and an additional ICD-10 diagnosis code.
Examples: 'Symptoms' include fainting, convulsions, fever, edema, headache, shock, chest pain, nausea, etc. 'Signs' include nonspecific abnormal blood tests, urine tests, x-rays, EEG, EKG, etc. 'Ill-defined conditions' include senility, crib death, nervousness, etc.
INFECTIOUS/PARASITIC (ICD-9: 001-139) (ICD-10: A00-A09, A15-A28, A30-A99, B00-B10, B15-B20, B25-B83, B85-B97, B99)
Definition: A disease caused by bacteria, germs, virus, or parasites (e.g., worms, ticks). The illness may be contagious.
Examples: Infectious diarrhea, chicken pox, measles, herpes, viral hepatitis, bacterial meningitis, food poisoning, blood poisoning, tuberculosis, AIDS.

INJURY & POISONING (ICD-9: 800-999) (ICD-10: S00-S99, T07, T14-T88)
Definition: Injury, poisoning and certain other consequences of external causes.
Examples: Procedural complications, dislocations & sprains, fractures, open wounds.

HEALTH CONDITION DESCRIPTIONS

INJURY & POISONING - EXTERNAL (ICD-9: V00-V99, W00-W74, W85-W99, X00-X08, X10-X19, X30-X39, X52-X58, X71-X83, X92-X99, Y00-Y09, Y21-Y33, Y35-Y38, Y62-Y84, Y90-Y99) (ICD-10: E000-E019, E029, E030, E800-E807, E810-E838, E840-E857, E860-E876, E878-E888, E890-E907, E909-E960, E962-E989, E991-E999)
Definition: External causes of morbidity.
Examples: Burns, falls, transportation accidents.

MATERNAL COMPLICATION OF PREGNANCY (ICD-10: O10-O16, O20-O48, O60-O77, O85-O92, O94, O98, O99, O9A)
Definition: Pregnancy, childbirth and the puerperium.
Examples: Abnormality of pelvic region, perineal laceration during delivery, obstetric trauma.

MATERNAL OUTCOME OF DELIVERY (ICD-10: O00-O08, O80-O82, Z37, Z3A)
Definition: Pregnancy, childbirth and the puerperium/Factors influencing health status and contact with health services.
Examples: Full-term uncomplicated delivery, ectopic pregnancy, hydatidiform mole.

MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUES (ICD-9: 710-739) (ICD-10: M00-M02, M05-M19, M1A, M20-M27, M30-M36, M40-M43, M45-M51, M53-M54, M60-M63, M65-M67, M70-M96, M99)
Definition: Illness caused by disorders of the joints, muscles, ligaments, and bone (excluding fractures).
Examples: Arthritis, back pain, bursitis, ganglions, bunions.

NEOPLASMS, BENIGN (ICD-10: D10-D36, D3A)
Definition: A tumor or cell growth that does not spread beyond its origin (non-Cancer).
Examples: Benign neoplasm of meninges (brain), benign neoplasm of colon, leiomyoma of uterus.

NEOPLASMS, MALIGNANT (ICD-10: C00-C26, C30-C41, C43-C49, C4A, C50-C58, C60-C79, C7A, C7B, C80-C96, D00-D09)
Definition: A tumor or uncontrolled cell growth (Cancer).
Examples: Hodgkin lymphoma, lymphoid leukemia, malignant neoplasm of breast, multiple myeloma.

NEOPLASMS, UNCERTAIN/UNSPECIFIED (ICD-10: D37-D49)
Definition: A tumor or uncontrolled cell growth whose behavior is unknown or not specified.

NERVOUS SYSTEM (ICD-9: 320-389) (ICD-10: G00-G14, G20-G26, G30-G32, G35-G37, G40-G47, G50-G65, G70-G73, G80-G83, G89-G99)
Definition: Nervous system - illness caused by brain, spinal cord, and nerve disorders. Sense organs - illness caused by disorders of the eyes and ears.
Examples: Migraine headache, meningitis, encephalitis, Alzheimer's disease, Parkinson's disease, cerebral palsy, muscular dystrophy, quadriplegia, epilepsy, cataract, retinal detachment, glaucoma, color blindness, otitis media, hearing loss.

HEALTH CONDITION DESCRIPTIONS

NEWBORN INITIAL RECORD (ICD-10: Z38)
Definition: Code used to designate the birth of a newborn infant.

NON-CANCER RELATED SCREENING AND TESTING (ICD-10: Z09-Z11, Z13-Z17, Z32)
Definition: Diagnostic codes related to the treatment of various (non-cancer) diseases and conditions.
Examples: Genetic carrier testing, pregnancy testing, infectious and parasitic disease testing.

PROCREATIVE MANAGEMENT (ICD-10: Z31)
Definition: Services related to the treatment of infertility.

RESPIRATORY SYSTEM (ICD-9: 460-519) (ICD-10: J00-J06, J09-J18, J20-J22, J30-J47, J60-J70, J80-J86, J90-J99)
Definition: Illness caused by nose, larynx, bronchus, and lung disorders.
Examples: Common cold, laryngitis, tonsillitis, deviated nasal septum, viral pneumonia, emphysema, asthma, lung disease.

SHORT GESTATION, LOW BIRTH WEIGHT (ICD-10: P07)
Definition: Services related to the occurrence and care of a low birth weight infant.

SUPERVISION OF PREGNANCY (ICD-10: O09, Z33-Z34, Z36, Z39)
Definition: Services related to pregnancy and related care.
Examples: Supervision of normal pregnancy, supervision of high risk pregnancy, postpartum care and examination.

TRANSPLANT EXCLUDES COMPLICATIONS (ICD-10: Z94)
Definition: Care related to the identification, preparation, and surgical removal of a healthy organ from one person and its transplantation into another person whose organ has failed or was injured.
Examples: Heart transplant, kidney transplant, bone marrow transplant, liver transplant.