State of Delaware - Quarterly Financial Reporting

FY18 Q3 Cost Analysis

June 2018

Willis Towers Watson

State of Delaware
Health Plan Quarterly Financial Reporting
FY18 Q3 Executive Summary

Summary plan information

- Summary Plan Information for FY18 Q1-Q3 compared to FY17 Q1-Q3:

Summary (total)	FY18 (Q1-Q3)			FY17 (Q1-Q3)			% Change		
	Medical	Rx	Total*	Medical	Rx	Total*	Medical	Rx	Total
Total program cost ($M)	$439.8	$120.1	$561.7	$438.9	$123.5	$564.5	▲ 0.2%	▼ 2.8%	▼ 0.5%
Budgeted cost ($M)	$472.2	$139.8	$612.1	$461.7	$140.0	$601.8	▲ 2.3%	▼ 0.1%	▲ 1.7%
Total cost PEPM	$8,368	$2,285	$10,689	$8,461	$2,381	$10,883	▼ 1.1%	▼ 4.0%	▼ 1.8%
Total cost PMPM	$4,710	$1,286	$6,016	$4,706	$1,324	$6,053	▲ 0.1%	▼ 2.9%	▼ 0.6%
Average employees	70,066			69,164			▲ 1.3%		
Average members	124,508			124,345			▲ 0.1%		
Loss ratio	92%			93%					
Surplus/(Deficit) ($M)	$50.3			$41.4					

*Total program cost includes office operational expenses

- Detailed Utilization and Cost Per Service Breakout for FY18 Q1-Q3 compared to FY17 Q1-Q3:

	Utilization (per 1,000 members	Net Pay (per service)	Overall (PMPM)
Inpatient admits	▼ 4.2%	▼ 4.1%	▼ 8.1%
ER visits	▲ 5.1%	▲ 5.4%	▲ 12.3%
Office visits	▼ 1.5%	▼ 2.9%	▼ 4.6%
Adult preventive visits	▲ 1.8%	▼ 8.5%	▼ 6.9%
Rx scripts (all)	TBD	TBD	TBD
- Rx scripts (specialty)	TBD	TBD	TBD

Source: IBM Watson Health

Other key observations

- Truven Executive Dashboard for April 2017 - March 2018 (compared to April 2016 - March 2017) details the following trends and cost drivers:
  - The percent of prescription drug allowed amounts attributable to specialty medications increased by 5 percentage points over the prior period to 39%
  - Chronic condition prevalence remains well above benchmark for all top conditions, with increases in prevalence for diabetes and depression
  - Breast cancer screening rates declined 12% from prior period (from 54% to 42%) and the percent with annual screenings is now 8% below benchmark

Additional notes

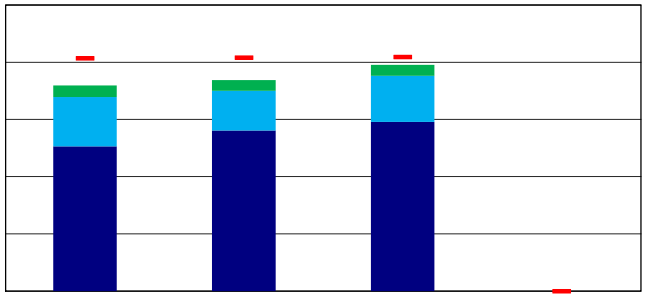
- Claims and expenses are reported on a paid basis
- Medical/Rx budget is based on FY18 budget rates, which were held flat from FY17
- Paid claims and enrollment data based on reports from Aetna, highmark, and ESI; costs include operating expenses
- Expenses are broken down into two cateogires:
  - ASO Fees: includes fees for vendor administration, COBRA administration, ACA-related (TRF & PCORI), Truven data analytics, EAP, and Segal and WTW consulting
  - Office Operational Expenses: includes expenses for items such as staff salaries, supplies, etc.
- Rx rebates and EGWP payments are shown based on the period ot which offsets are attributable, rather than actual payment received in a given period
- No adjustments made to cost tracking for large claims as the State does not have stop loss insurance
- HRA dollars are assumed to be included in the reported claims
- Participating groups (such as University of DE) are included in the cost tracking, but are assumed to be 100% employee paid; as a result, reported net cost and cost share percentages may be skewed

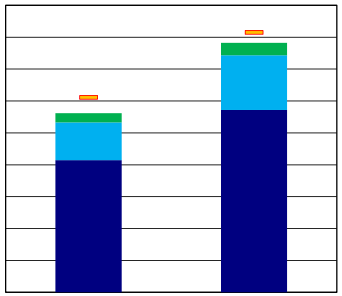
State of Delaware
Health Plan Quarterly Financial Reporting
FY18 Q3 Plan Cost Analysis

	Drop-Down Choices
Status	Total
Vendor	Total
Plan	Total

Legend

- Medical/Rx Budget
- Fees and Op. Expenses
- Rx (incl. Rebates and EGWP)
- Medical (incl. capitation)





	Q1 2018	Q2 2018	Q3 2018	Q4 2018	YTD 2018	Proj. FY2018[6]
Total Program Cost[1]	**$179,673,085**	**$184,441,784**	**$197,630,680**		**$561,745,549**	**$782,446,671**
- Paid Claims	169,486,230	175,016,107	188,071,616		532,573,953	743,599,144
- Medical (includes capitation[2])	126,441,323	140,283,995	147,907,605		414,632,922	571,781,429
- Capitation	2,758,791	2,772,018	2,924,801		8,455,610	11,560,999
- Rx (Including Rebates and EGWP)	43,044,907	34,732,112	40,164,011		117,941,031	171,817,715
- Rx Paid Claims	63,458,837	55,181,910	57,588,156		176,228,903	246,238,807
- EGWP	(7,802,622)	(7,364,947)	(5,857,331)		(21,024,900)	(27,535,796)
- Direct Subsidy	(1,406,523)	(1,286,724)	(988,096)		(3,681,343)	(4,635,846)
- CGDP	(4,110,986)	(3,778,059)	(2,045,424)		(9,934,468)	(12,661,701)
- Catastrophic Reinsurance	(2,285,113)	(2,300,165)	(2,823,810)		(7,409,089)	(10,238,249)
- Rx Rebates[3]	(12,611,307)	(13,084,851)	(11,566,814)		(37,262,972)	(46,885,296)
- ASO Fees	9,533,474	8,834,684	8,954,771		27,322,929	36,277,700
- Operational Expenses	653,382	590,993	604,293		1,848,667	2,569,827
Medical/Rx Budget	**$203,451,156**	**$204,084,021**	**$204,515,206**		**$612,050,384**	**$816,067,178**
- Surplus/(Deficit)	23,778,071	19,642,237	6,884,527		50,304,834	33,620,507
- Total Cost as % of Budget	88%	90%	97%		92%	96%
Current Year Per Capita						
- Total per employee per year[4]	10,302	10,527	11,237		10,689	11,156
- Total % change over prior	-8.3%	2.7%	0.6%		-1.8%	1.3%
- Medical per employee per year	7,749	8,473	8,882		8,368	8,630
- Medical % change over prior	-11.2%	3.5%	4.9%		-1.1%	1.1%
- Rx per employee per year	2,516	2,020	2,320		2,285	2,489
- Rx % change over prior	2.1%	0.1%	-12.8%		-4.0%	2.2%
- Medical per member per year	4,350	4,761	5,018		4,710	4,861
- Rx per member per year	1,413	1,135	1,311		1,286	1,402
- Total per member per year[4]	5,784	5,915	6,348		6,016	6,284
Prior Year Results	**Q1 2017**	**Q2 2017**	**Q3 2017**			
- Total Program Cost[4]	192,489,481	177,399,275	194,616,244		564,505,000	762,939,276
- Total Program Cost $ Change	-12,816,395	7,042,509	3,014,435		(2,759,451)	19,507,396
- Total per employee per year[4]	11,231	10,248	11,170		10,883	11,017
- Medical per employee per year	8,725	8,190	8,468		8,461	8,540
- Rx per employee per year	2,465	2,017	2,661		2,381	2,436
EE Contributions	**$41,098,154**	**$39,856,517**	**$39,986,950**		**$121,069,829**	**$161,426,439**
- Net SoD[5]	138,574,932	144,585,267	157,643,730		440,675,720	621,020,232
- SoD Subsidy %	77%	78%	80%		78%	79%
Headcount						
- Enrolled Ees	69,762	70,083	70,352		70,066	70,137
- Enrolled Members	124,258	124,731	124,534		124,508	124,514
- Member/EE Ratio	1.8	1.8	1.8		1.8	1.8

[1] Aggregate totals includes run-off medical and pharmacy claims from Highmark BlueCare HMO ($9,756,202) and Highmark CDH Gold ($897,988) plans terminated 7/1/2017

[2] Capitation payments apply to HMO and POS plans only

[3] Reflects estimated rebates attributable to FY18, based on WTW analysis of expected rebates under new ESI contract and actual paid rebates attributable to FY17

[4] Program cost and PEPM values also include ASO fees and operational expenses

[5] Participating groups are assumed to be 100% EE funded, and Medicare retirees are assumed to be fully subsidized

[6] Projections based on most recent 12 months of claims experience (4/1/2017 through 3/31/2018)

State of Delaware
Health Plan Quarterly Financial Reporting
FY18 Q3 Reporting Reconciliation (WTW vs OMB Fund Equity Report)

FY18 YTD Reporting Reconciliation	WTW FY18 Q3 Financial Report	OMB March 2018 Fund Equity Report
Total Program Cost	**$561,745,549**	**$632,932,227**
Paid Claims	590,861,825	603,760,630
Medical Claims	414,632,922	417,887,102
Rx Claims[1]	117,941,031	185,873,528
Rx Paid Claims	176,228,903	185,873,528
EGWP	(21,024,900)	29,306,807
Direct Subsidy	(3,681,343)	3,692,098
CGDP	(9,934,468)	8,730,109
Catastrophic Reinsurance	(7,409,089)	16,884,601
Rx Rebates	(37,262,972)	38,723,264
Total Rx Claim (Offsets)/Revenue[2]	(58,287,872)	68,030,072
Total Fees	29,171,596	29,171,596
ASO Fees	27,322,929	27,322,929
Operational Expenses	1,848,667	1,848,667
Premium Contributions	**$612,050,384**	**$607,382,688**
Budget[3]	**$612,050,384**	**$675,781,854**
Surplus/(Deficit)	50,304,834	42,849,627
Total Cost as % of Budget	92%	94%

[1]WTW Rx claims shown net of EGWP revenue and Rx rebates. OMB Rx claims reflect gross claim dollars excluding additional revenue (EGWP and rebates).
[2]WTW reflects EGWP revenue and Rx rebates as offsets to Rx claims. OMB reflects these items as additions to operating revenues.
[3]OMB Budget includes premium contributions, Rx revenues (EGWP and rebates) and Other Revenues totaling $369,094; excludes participating group fees totaling $1,580,619.

State of Delaware
Health Plan Quarterly Financial Reporting
Assumptions and Caveats

Claim basis and timing

1 All reporting provided on a paid basis within this document.
2 FY2018 represents the time period July 1, 2017 through June 30, 2018 for all statuses; note Medicfill plan for Medicare eligible retirees runs from January 1, 2018 through December 31, 2018. Therefore, FY2018 financial results span two plan years for the Medicare eligible population.

Enrollment

3 Medical and Rx enrollment based on quarterly tiered enrollment data from Highmark and Aetna.
4 Highmark quarterly reports did not provide enrollment data split by State and Participating for FY2018 Q1. Following FY2018 Q2, WTW assumed Q1 State / Participating split follows the same ratio as subsequent Q2 enrollment provided by Highmark. The ratio is calculated by status (Active, non-Medicare eligible retiree, and Medicare eligible retiree), by plan and by contracts/members.
5 All Medicare eligible retirees are assumed to be enrolled in medical and Rx coverage.

Benefit costs/fees

6 Medical quarterly paid claims from Highmark and Aetna; Rx quarterly paid claims from ESI; EGWP subsidies and Rx rebates (Active, non-Medicare eligible retiree, and Medicare eligible retiree) from OMB; Rx rebates include assumed formulary true-ups.
7 Administration fees and operational expenses from OMB-provided March 2018 monthly fund equity report, as PEPM values were not provided; total quarterly fees are assigned to each plan on a contract count basis.
   a. ASO Fees: includes fees for vendor administration, COBRA administration, ACA-related (TRF & PCORI), Truven data analytics, EAP and Segal and WTW consulting fees.
   b. Operational Expenses: includes expenses for items such as staff salaries, supplies, etc.
8 Pharmacy drug rebates are shown based on the period to which rebates are attributable and reflect actual rebates for Q1/Q2 and estimated rebates for Q3/Q4 based on prior quarters as a percentage of paid claims; active/non-Medicare eligible retiree rebates assigned to each plan on a contract count basis. May differ from actual payments received during FY2018 due to payment timing lag; these rebates reflect updated ESI contract effective 7/1/2017 following WTW independent contract analysis.
9 EGWP payments based on actual and expected payments attributable to the period July 1, 2017 through June 30, 2018; reflects estimated direct subsidy reimbursements, projected coverage gap discount payments, and estimated Calendar Year 2017 catastrophic reinsurance payments from ESI (calculated by WTW). May differ from actual payments received during FY2018 due to payment timing lag.
10 Prior year costs calculated from WTW's FY17 Q4 Financial Reporting.
11 FY18 costs projected based on the most recent 12 months of data (4/1/2017 – 3/31/2018) using trend assumptions of 10.0% prescription drug, 6.5% medical for active/non-Medicare eligible retiree, 3.0% medical for Medicare eligible retiree.

Budget/contributions

12 Active and non-Medicare eligible retiree budget rates and contributions reflect rates effective July 1, 2017. Medicare eligible retiree budget rates reflect rates effective January 1, 2017 for FY18 Q1 and Q2, and rates effective January 1, 2018 for FY18 Q3 and Q4. Budget rates include FY18 risk fees for Participating groups (excludes $2.70 PEPM charge). FY18 budget rates were held flat from FY17.
13 Premiums and employee contributions are the product of monthly budget rate/contribution and quarterly average tiered contract counts provided by the medical vendors.
14 Highmark quarterly reports do not provide enrollment data split by retirement date. All Medicare eligible retirees are assumed to have retired prior to July 1, 2012, and therefore do not contribute towards the cost of premiums. As a result of this conservative assumption, the healthcare program's net cost to the State may be overstated.
15 Participating groups are assumed to be 100% employee paid in order to estimate the healthcare program's net cost to the State; actual employee contributions vary and are difficult to capture since each group pays premiums at different times.
16 While COBRA enrollment and claims are reflected in the expenses, all medical/Rx participants are assumed to pay active contributions since COBRA participants make up less than 0.1% of the total population.
17 HRA funding for CDH plans are included in the paid claims reported in this document.

State of Delaware
Health Plan Quarterly Financial Reporting
Glossary of Important Health Care Terms

Terminology	Acronym	Definition
Administrative Services Only	ASO	When an organization funds its own employee benefit plan, such as a health insurance program, and it hires an outside firm to perform specific administrative services. Also referred to as "self-funded". Currently, the GHIP has ASO contracts with Aetna, Highmark and Express Scripts.
Capitation	n/a	Fixed payment amount (per member) to a physician or group of physicians for a defined set of services for a defined set of members. Fixed or "capitated" payment per member provides physician with an incentive for meeting quality and cost efficiency outcomes, since the physician is responsible for any costs incurred above the capitated amount. May be risk adjusted based on the demographics of the member population or changes in the member population. Often used for *bundled payments* or other *value-based payments*.
Consumer Driven Health Plan	CDHP	Allows members to use health savings accounts (HSA), health reimbursement accounts *(HRA)*, or other similar medical payment products to pay routine health care expenses directly. GHIP currently offers a CDHP with *HRA*.
Coverage Gap Discount Program	CGDP	One of the funding components of an *EGWP*. Manufacturers provide discounts on covered Part D brand prescription drugs to Medicare beneficiaries while in the coverage gap.
Employee	EE	A person employed for wages or salary.
Employer Group Waiver Plans	EGWP	A Center for Medicare Service (CMS) approved program for both employers and unions. An employer may contract directly with CMS or go through an approved TPA, such as ESI, to establish the plan. They are usually Self Funded, are integrated with Medicare Part D, and sometimes include a fully insured "wrapper" around the plan to cover non-Medicare Part D prescription drugs. GHIP currently contracts with ESI as the TPA and includes a "wrapper," which is referred to as an enhanced benefit.
Fiscal Year	FY	A year as reckoned for taxing or accounting purposes. GHIP fiscal year runs from July 1st through June 30th.
Health Maintenance Organization	HMO	A form of health insurance combining a range of coverages in a group basis. A group of doctors and other medical professionals offer care through the HMO for a flat monthly rate. However, only visits to professionals within the HMO network are covered by the policy. All visits, prescriptions and other care must be cleared by the HMO in order to be covered. A primary physician within the HMO handles referrals.
Health Reimbursement Account	HRA	Employer-funded account that reimburses employees for out-of-pocket medical expenses. Employees can choose how to use their HRA funds to pay for medical expenses, but the employer can determine what expenses are reimbursable by the HRA (e.g., employers often designate prescription drug expenses as ineligible for reimbursement by an HRA). Funds are owned by the employer and are tax-deductible to the employee. GHIP only offers HRA to employees and non-Medicare eligible retirees who enroll in the CDH Gold plan.
High Cost Claimant	HCC	An insured who incurs claims over a catastrophic claim limit during the plan year. For purposes of cost tracking, this threshold is $100K.
Per Employee Per Month	PEPM	A monthly cost basis measured on an employee/contract/subscriber level
Per Employee Per Year	PEPY	A yearly cost basis measured on an employee/contract/subscriber level
Per Member Per Month	PMPM	A monthly cost basis measured on a member level
Per Member Per Year	PMPY	A yearly cost basis measured on a member level
Patient-Centered Outcomes Research Trust Fund Fee	PCORI	The Patient-Centered Outcomes Research Trust Fund fee is a fee on plan sponsors of self-insured health plans that helps to fund the Patient-Centered Outcomes Research Institute (PCORI). The institute will assist, through research, patients, clinicians, purchasers and policy-makers, in making informed health decisions by advancing the quality and relevance of evidence-based medicine. The institute will compile and distribute comparative clinical effectiveness research findings. This fee is part of the Affordable Care Act legislation.

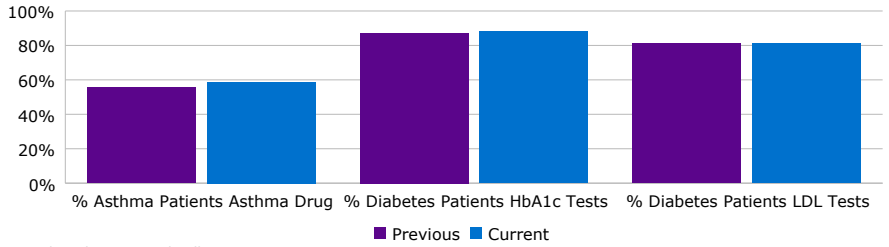
State of Delaware
Health Plan Quarterly Financial Reporting
Glossary of Important Health Care Terms

Terminology	Acronym	Definition
Point-of-Service	POS	A type of managed care plan that is a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services. GHIP only offers this type of plan to Port of Wilmington employees.
Preferred Provider Organization	PPO	A health care organization composed of physicians, hospitals, or other providers which provides health care services at a reduced fee. A PPO is similar to an HMO, but care is paid for as it is received instead of in advance in the form of a scheduled fee. PPOs may also offer more flexibility by allowing for visits to out-of-network professionals at a greater expense to the policy holder. Visits within the network require only the payment of a small fee. There is often a deductible for out-of-network expenses and a higher co-payment.
Transitional Reinsurance Fee	TRF	Fee collected by the transitional reinsurance program to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury for the 2014, 2015, and 2016 benefit years. This fee is part of the Affordable Care Act legislation, and ends after the 2016 benefit year.
Year to Date	YTD	A period, starting from the beginning of the current year (either the calendar year or fiscal year) and continuing up to the present day. For this financial reporting document, YTD refers to the time period of July 1, 2017 to March 31, 2018

State of Delaware Medical and Prescription Drug Dashboard - Actives

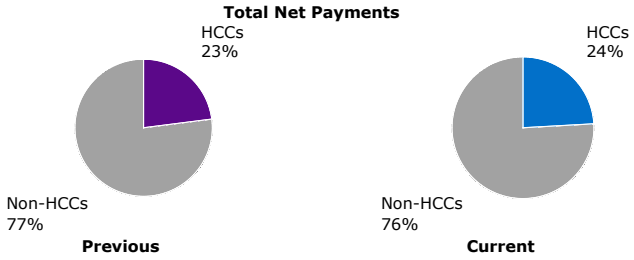
Previous Period: Apr 2016 - Mar 2017 (Paid)
Current Period: Apr 2017 - Mar 2018 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

2. High Cost Claimants*



*Members with >=$100,000 in Medical and Rx Net Payments

	Previous	Current	Trend
Patients	634	672	6%
Patients per 1,000	6.4	6.8	6%
Payments (in millions)	$118.6	$125.4	6%
Payment per Patient	$187,025	$186,612	0%

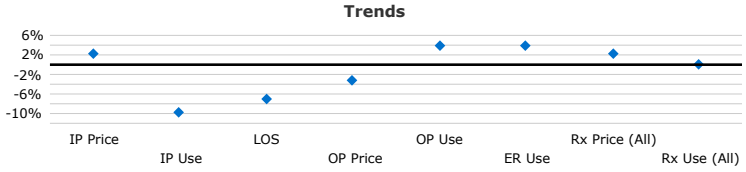
3. Well Care and Preventive Visits

	Previous	Current	Trend
Visits Per 1000 Well Baby	5,859.9	5,741.3	-2.0%
Visits Per 1000 Well Child	811.3	832.5	2.6%
Visits Per 1000 Prevent Adult	451.3	455.8	1.0%

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	37,574	37,783	1%
Average Members	88,633	88,525	0%
Family Size	2.4	2.3	-1%
Member Age	33.0	33.0	0%
Members % Male	47%	47%	0% pts

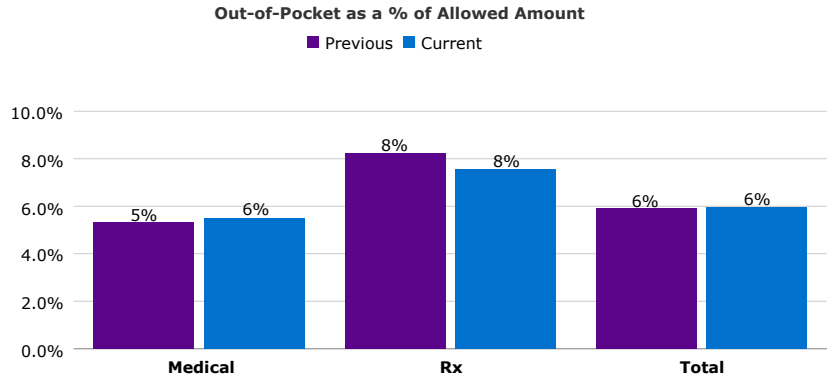
5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$24,604	$24,962	◆	2%
Admits per 1,000	61.6	54.9	■	-10%
Days LOS	4.3	4.2	◆	-7%
Outpatient				
Allowed per Service	$127	$123	◆	-3%
Services PMPY	29.5	29.4	◆	4%
Emergency Room Visits per 1,000	283	229	■	4%
Prescription Drugs				
Allowed/Days Supply	$2			-5%
Days Supply PMPY	376			0%
Specialty Drugs				
Allowed/Days Supply	$76			6%
Days Supply PMPY	7			11%
All Prescription Drugs				
Allowed/Days Supply	$3	$4	◆	2%
Days Supply PMPY	383	333	●	0%

● Represents a lower than -3% comparison to the benchmark
◆ Represents a comparison to the benchmark within +/-3%
■ Represents a higher than 3% comparison to the benchmark

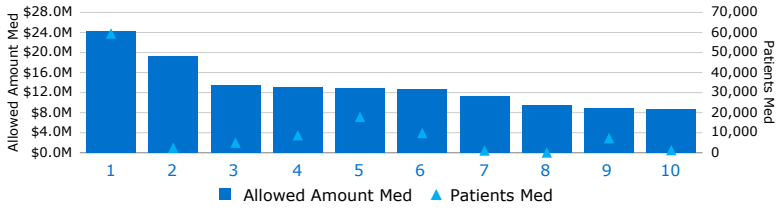
6. Cost Sharing



State of Delaware Medical and Prescription Drug Dashboard - Actives

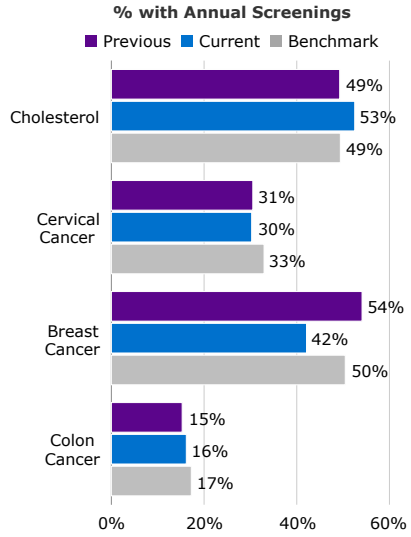
Previous Period: Apr 2016 - Mar 2017 (Paid)
Current Period: Apr 2017 - Mar 2018 (Paid)

7. Top Medical Conditions (by cost)

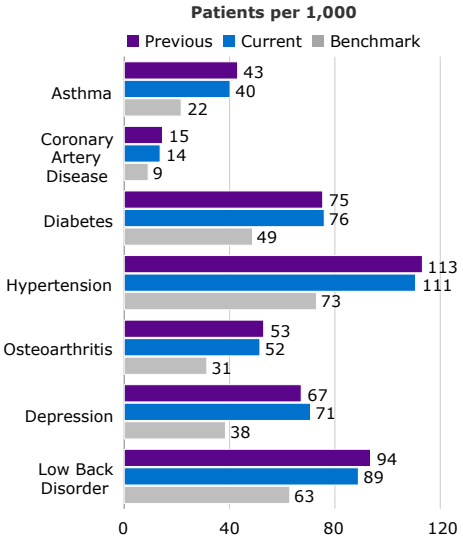


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Prevent/Admin Hlth Encounters	$24,205,204	59,495	$407
2	Pregnancy without Delivery	$19,290,636	2,562	$7,530
3	Osteoarthritis	$13,409,578	5,075	$2,642
4	Spinal/Back Disord, Low Back	$12,985,672	8,758	$1,483
5	Arthropathies/Joint Disord NEC	$12,920,143	17,926	$721
6	Gastroint Disord, NEC	$12,657,809	9,844	$1,286
7	Newborns, w/wo Complication	$11,286,769	1,172	$9,630
8	Chemotherapy Encounters	$9,464,595	173	$54,709
9	Respiratory Disord, NEC	$8,938,306	7,322	$1,221
10	Coronary Artery Disease	$8,715,338	1,343	$6,489

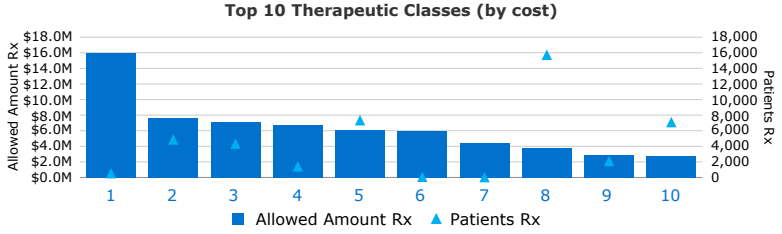
8. Screening Rates



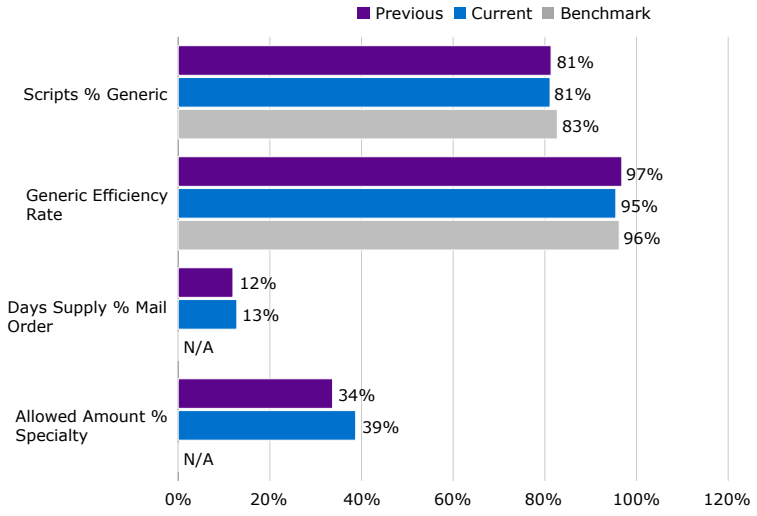
9. Chronic Condition Prevalence



10. Prescription Drug Metrics



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Immunosuppressants, NEC	$16,032,872	549	$29,204
2	Stimulant, Amphetamine Type	$7,623,110	4,871	$1,565
3	Antidiabetic Agents, Misc	$7,119,970	4,347	$1,638
4	Antidiabetic Agents, Insulins	$6,793,545	1,433	$4,741
5	Antivirals, NEC	$6,045,154	7,350	$822
6	Biological Response Modifiers	$5,908,556	97	$60,913
7	Molecular Targeted Therapy	$4,438,147	53	$83,739
8	Adrenals & Comb, NEC	$3,738,646	15,747	$237
9	Misc Therapeutic Agents, NEC	$2,855,005	2,122	$1,345
10	Gastrointestinal Drug Misc,NEC	$2,795,118	7,107	$393



State of Delaware Medical and Prescription Drug Dashboard - Actives

Dashboard Glossary

General

- **Claims** are completed for claims incurred but not yet recorded (IBNR)
- **Benchmark** represents 2016 U.S. Total MarketScan norms that are age, gender, geographic, and/or severity adjusted as appropriate
- **PMPY** stands for Per Member Per Year and is weighted based on the number of months a member was enrolled in medical benefits
- **Allowed Amount (Allowed)** is the amount of submitted charges eligible for payment for medical and prescription drug claims; it is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts
- **Net Payment (Payment)** is the net amount paid by the company for medical and prescription drug claims; it represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted
- **Inpatient (IP)** represents claims for services provided under medical coverage in an acute inpatient setting; acute inpatient settings include inpatient hospitals, birthing centers, inpatient psychiatric facilities, and residential substance abuse treatment facilities
- **Outpatient (OP)** represents claims for medical services provided in any non-inpatient setting
- **Prescription Drug (Rx)** represents any claim paid under the pharmacy benefit
- **Patients** represents any member with a claim for the service (e.g., medical or prescription drug) being reported during the time period

1. Well Care and Preventive Visits

2. High Cost Claimants

- High Cost Claimants (HCCs) are members with $100,000 or more in medical and prescription drug net payments incurred during the year
- Non-High Cost Claimants (HCCs) are members with less than $100,000 in medical and prescription drug net payments incurred during the year

3. Quality Metrics

4. Medical Plan Eligibility

- **Average Employees** represents the number of employees with medical coverage; each employee is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Average Members** represents the number of members with medical coverage; each member is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Family Size** represents the average number of covered members per subscriber
- **Member Age** represents the average age of covered members during the year
- **Members % Male** represents the number of male members as a percent of total members

5. Risk Score

The Member Risk Score represents the DCG non-rescaled concurrent score

- The Member Risk Score is produced using the Verisk DCG® model
- This model measures the health risk of a population relative to the national average as of the time the model was developed (i.e., 100)

6. Price and Use

- **Current** represents your Price or Use rate in the Current year
- **Benchmark** represents the U.S. Total MarketScan norm for the Price or Use rate
- The **Symbol** next to the Benchmark represents your Current rate compared to the Norm
- The **Trend** represents your year-over-year trend for the Price or Use rate

7. Cost Sharing

The cost sharing percentage represents Out-of-Pocket divided by Allowed Amounts

- Out-of-Pocket represents the amount paid out-of-pocket by the member for facility, professional, and prescription drug services; this generally includes coinsurance, copayment, and deductible amounts

8. Top Medical Conditions (by cost)

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Clinical conditions include medical claims (i.e., prescription drug is not included)
- Note: The clinical condition of *Signs/Symptoms/Oth Cond, NEC* is excluded from this exhibit

9. Screening Rates

- **Cholesterol** identifies lipid screening tests for males aged 35+ years and females aged 45+ years; lipid screening tests include lipid panels, serum cholesterol tests, blood lipoprotein tests (e.g., HDL, LDL), and triglyceride tests *[source for age and gender criteria: US Preventive Services Task Force]*
- **Cervical Cancer** identifies the percentage of females aged 21 to 64 who received cervical cancer screening services *[source for age, gender, procedure, diagnosis, and revenue code criteria: NCQA HEDIS 2014]*
- **Breast Cancer** identifies the percentage of females aged 50 to 74 who received mammography services *[source for age, gender, diagnosis, procedure, and revenue code criteria: NCQA HEDIS 2014]*
- **Colon Cancer** identifies the percentage of adults aged 50 to 75 who received colon cancer screening services *[source for age, diagnosis and procedure criteria: NCQA HEDIS 2014]*

10. Chronic Condition Prevalence

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Chronic conditions identified based on medical claims

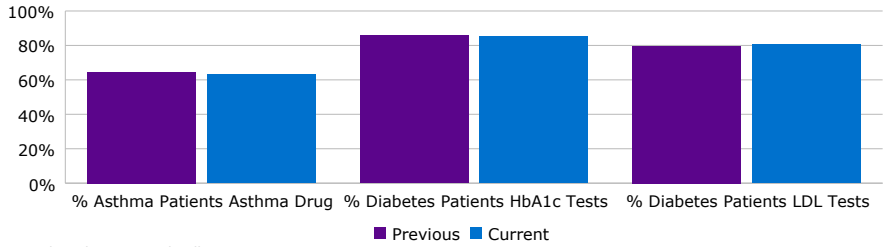
11. Prescription Drug Metrics

- **Therapeutic Class** represents the Redbook Therapeutic Class Intermediary
- **Scripts % Generic** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled
- **Generic Efficiency Rate** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled that could have been filled with a generic drug
- **Days Supply % Mail Order** is the percent of all prescription days supply filled via mail order
- **Allowed Amount % Specialty** is the percent of total prescription drug allowed amounts that were for medications considered to be specialty drugs (identified using Truven Health Service Categories)

Medical and Prescription Drug Dashboard - Early Retirees

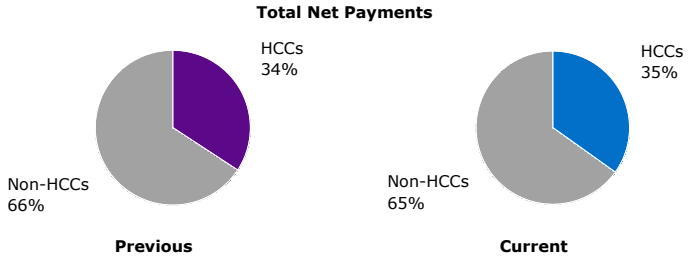
Previous Period: Apr 2016 - Mar 2017 (Paid)
Current Period: Apr 2017 - Mar 2018 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

2. High Cost Claimants*



*Members with >=$100,000 in Medical and Rx Net Payments

	Previous	Current	Trend
Patients	223	226	1%
Patients per 1,000	19.7	20	1%
Payments (in millions)	$34.9	$35.7	2%
Payment per Patient	$156,482	$157,875	1%

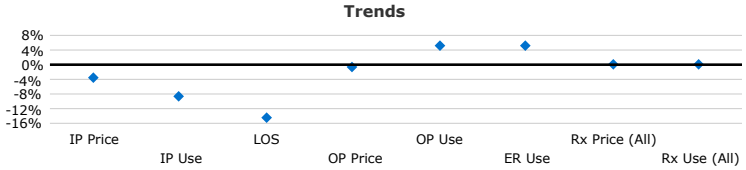
3. Well Care and Preventive Visits

	Previous	Current	Trend
Visits Per 1000 Well Baby	5,647.1	4,682.9	-17.1%
Visits Per 1000 Well Child	696.0	844.7	21.4%
Visits Per 1000 Prevent Adult	458.4	463.2	1.1%

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	6,004	5,936	-1%
Average Members	9,243	9,151	-1%
Family Size	1.5	1.5	0%
Member Age	51.1	50.9	0%
Members % Male	40%	41%	1% pts

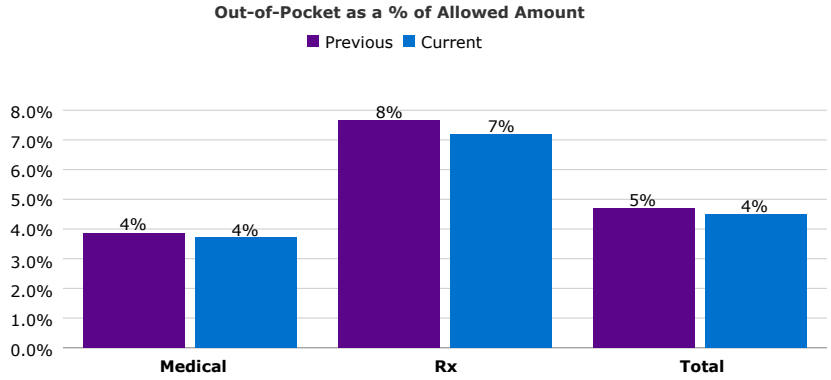
5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$32,843	$31,813	■	-4%
Admits per 1,000	87.8	67.6	■	-8%
Days LOS	5.3	4.8	■	-14%
Outpatient				
Allowed per Service	$147	$123	■	0%
Services PMPY	48.0	42.1	■	5%
Emergency Room Visits per 1,000	350	235	■	5%
Prescription Drugs				
Allowed/Days Supply	$2			-8%
Days Supply PMPY	801			0%
Specialty Drugs				
Allowed/Days Supply	$74			-2%
Days Supply PMPY	15			18%
All Prescription Drugs				
Allowed/Days Supply	$3	$3	■	0%
Days Supply PMPY	816	679	●	0%

● Represents a lower than -3% comparison to the benchmark
◆ Represents a comparison to the benchmark within +/-3%
■ Represents a higher than 3% comparison to the benchmark

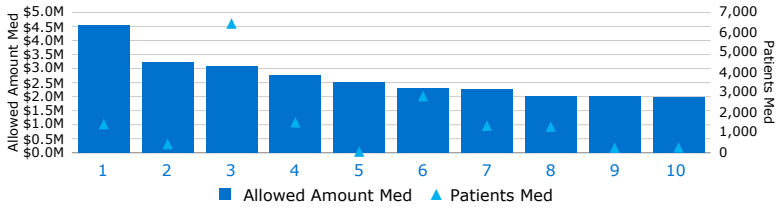
6. Cost Sharing



Medical and Prescription Drug Dashboard - Early Retirees

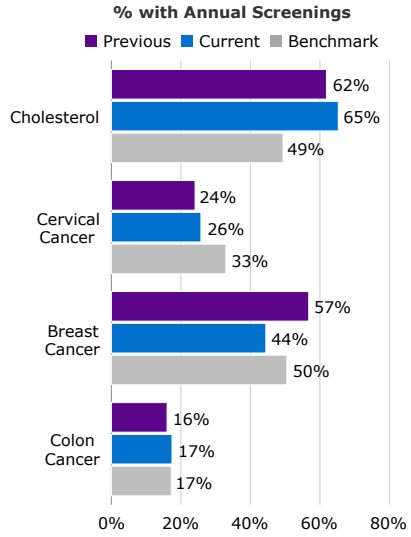
Previous Period: Apr 2016 - Mar 2017 (Paid)
Current Period: Apr 2017 - Mar 2018 (Paid)

7. Top Medical Conditions (by cost)

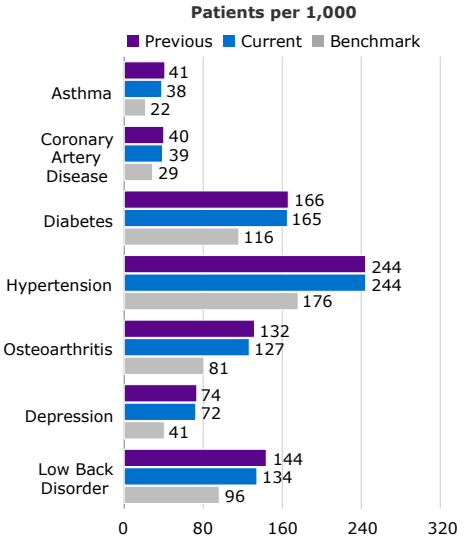


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Osteoarthritis	$4,560,079	1,432	$3,184
2	Coronary Artery Disease	$3,226,449	439	$7,350
3	Prevent/Admin Hlth Encounters	$3,078,110	6,448	$477
4	Spinal/Back Disord, Low Back	$2,747,951	1,520	$1,808
5	Chemotherapy Encounters	$2,518,097	58	$43,415
6	Arthropathies/Joint Disord NEC	$2,298,896	2,829	$813
7	Gastroint Disord, NEC	$2,268,357	1,351	$1,679
8	Respiratory Disord, NEC	$2,026,042	1,306	$1,551
9	Renal Function Failure	$2,004,069	250	$8,016
10	Mental Hlth - Substance Abuse	$1,971,969	267	$7,386

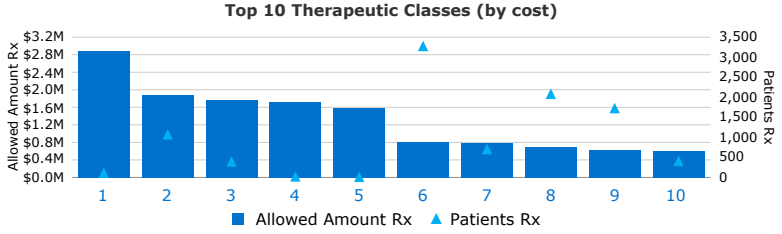
8. Screening Rates



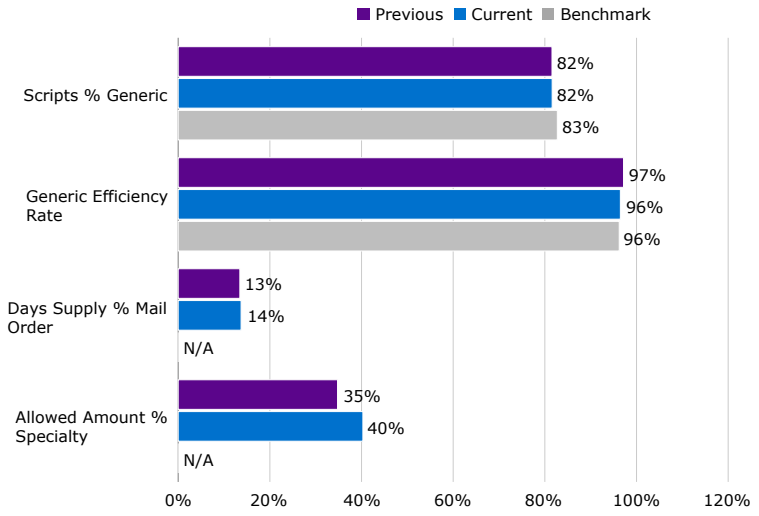
9. Chronic Condition Prevalence



10. Prescription Drug Metrics



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Immunosuppressants, NEC	$2,883,966	117	$24,649
2	Antidiabetic Agents, Misc	$1,874,580	1,077	$1,741
3	Antidiabetic Agents, Insulins	$1,761,315	400	$4,403
4	Biological Response Modifiers	$1,718,700	28	$61,382
5	Molecular Targeted Therapy	$1,583,306	19	$83,332
6	Antihyperlipidemic Drugs, NEC	$817,634	3,281	$249
7	Antivirals, NEC	$780,860	708	$1,103
8	Adrenals & Comb, NEC	$696,962	2,088	$334
9	Gastrointestinal Drug Misc,NEC	$633,686	1,732	$366
10	Stimulant, Amphetamine Type	$607,555	412	$1,475



Medical and Prescription Drug Dashboard - Early Retirees

Dashboard Glossary

General

- **Claims** are completed for claims incurred but not yet recorded (IBNR)
- **Benchmark** represents 2016 U.S. Total MarketScan norms that are age, gender, geographic, and/or severity adjusted as appropriate
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- **Patients** represents any member with a claim for the service (e.g., medical or prescription drug) being reported during the time period

1. Well Care and Preventive Visits

2. High Cost Claimants

- High Cost Claimants (HCCs) are members with $100,000 or more in medical and prescription drug net payments incurred during the year
- Non-High Cost Claimants (HCCs) are members with less than $100,000 in medical and prescription drug net payments incurred during the year

3. Quality Metrics

4. Medical Plan Eligibility

- **Average Employees** represents the number of employees with medical coverage; each employee is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Average Members** represents the number of members with medical coverage; each member is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Family Size** represents the average number of covered members per subscriber
- **Member Age** represents the average age of covered members during the year
- **Members % Male** represents the number of male members as a percent of total members

5. Risk Score

The Member Risk Score represents the DCG non-rescaled concurrent score

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- This model measures the health risk of a population relative to the national average as of the time the model was developed (i.e., 100)

6. Price and Use

- **Current** represents your Price or Use rate in the Current year
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- The **Trend** represents your year-over-year trend for the Price or Use rate

7. Cost Sharing

The cost sharing percentage represents Out-of-Pocket divided by Allowed Amounts

- Out-of-Pocket represents the amount paid out-of-pocket by the member for facility, professional, and prescription drug services; this generally includes coinsurance, copayment, and deductible amounts

8. Top Medical Conditions (by cost)

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Clinical conditions include medical claims (i.e., prescription drug is not included)
- Note: The clinical condition of *Signs/Symptoms/Oth Cond, NEC* is excluded from this exhibit

9. Screening Rates

- **Cholesterol** identifies lipid screening tests for males aged 35+ years and females aged 45+ years; lipid screening tests include lipid panels, serum cholesterol tests, blood lipoprotein tests (e.g., HDL, LDL), and triglyceride tests *[source for age and gender criteria: US Preventive Services Task Force]*
- **Cervical Cancer** identifies the percentage of females aged 21 to 64 who received cervical cancer screening services *[source for age, gender, procedure, diagnosis, and revenue code criteria: NCQA HEDIS 2014]*
- **Breast Cancer** identifies the percentage of females aged 50 to 74 who received mammography services *[source for age, gender, diagnosis, procedure, and revenue code criteria: NCQA HEDIS 2014]*
- **Colon Cancer** identifies the percentage of adults aged 50 to 75 who received colon cancer screening services *[source for age, diagnosis and procedure criteria: NCQA HEDIS 2014]*

10. Chronic Condition Prevalence

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Chronic conditions identified based on medical claims

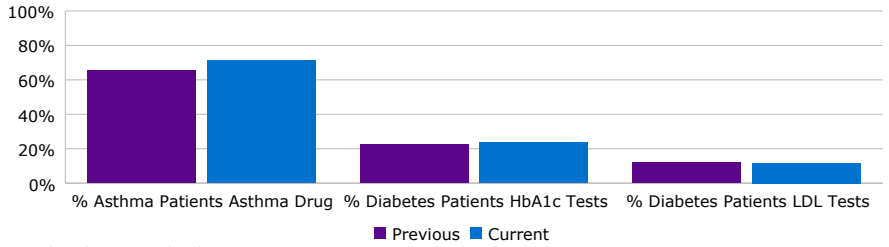
11. Prescription Drug Metrics

- **Therapeutic Class** represents the Redbook Therapeutic Class Intermediary
- **Scripts % Generic** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled
- **Generic Efficiency Rate** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled that could have been filled with a generic drug
- **Days Supply % Mail Order** is the percent of all prescription days supply filled via mail order
- **Allowed Amount % Specialty** is the percent of total prescription drug allowed amounts that were for medications considered to be specialty drugs (identified using Truven Health Service Categories)

Medical and Prescription Drug Dashboard - Medicare Retirees

Previous Period: Apr 2016 - Mar 2017 (Paid)
Current Period: Apr 2017 - Mar 2018 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

2. High Cost Claimants*

*Members with >=$100,000 in Medical and Rx Net Payments

	Previous	Current	Trend
Patients	111	126	14%
Patients per 1,000	4.6	5	9%
Payments (in millions)	$11.4	$14.5	28%
Payment per Patient	$102,346	$115,284	13%

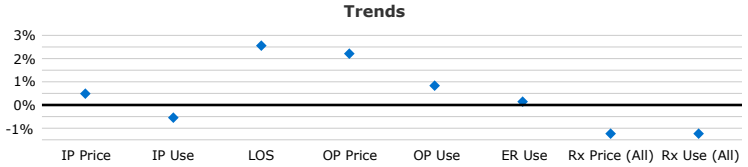
3. Well Care and Preventive Visits

	Previous	Current	Trend
Visits Per 1000 Prevent Adult	172.7	204.7	18.5%

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	22,866	23,823	4%
Average Members	22,879	23,904	4%
Family Size	1.0	1.0	0%
Member Age	73.3	73.2	0%
Members % Male	42%	42%	0% pts

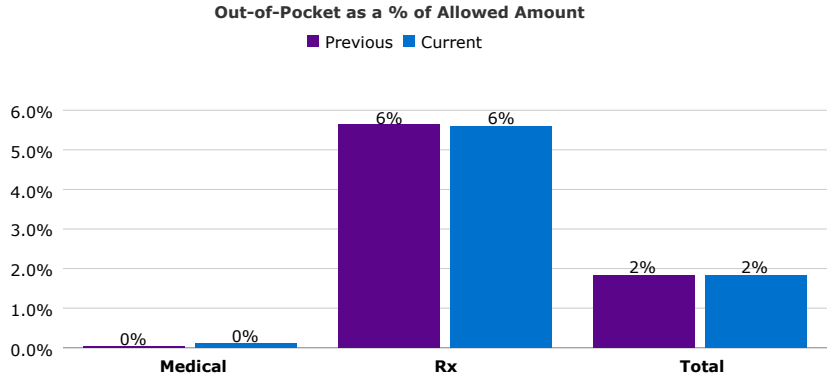
5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$15,733	$30,332	●	0%
Admits per 1,000	179.0	57.2	■	-1%
Days LOS	5.5	4.5	■	3%
Outpatient				
Allowed per Service	$106	$122	●	2%
Services PMPY	72.2	31.0	■	1%
Emergency Room Visits per 1,000	547	228	■	0%
Prescription Drugs				
Allowed/Days Supply	$2			-9%
Days Supply PMPY	1,470			-1%
Specialty Drugs				
Allowed/Days Supply	$65			10%
Days Supply PMPY	23			7%
All Prescription Drugs				
Allowed/Days Supply	$3	$3	●	-1%
Days Supply PMPY	1,493	381	◆	-1%

● Represents a lower than -3% comparison to the benchmark
◆ Represents a comparison to the benchmark within +/-3%
■ Represents a higher than 3% comparison to the benchmark

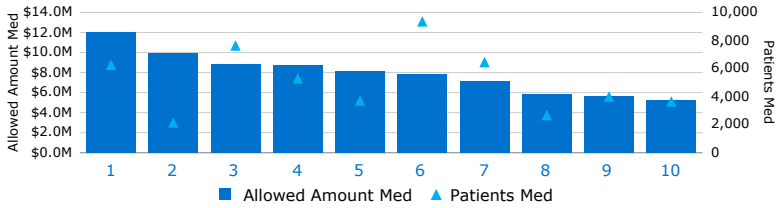
6. Cost Sharing



Medical and Prescription Drug Dashboard - Medicare Retirees

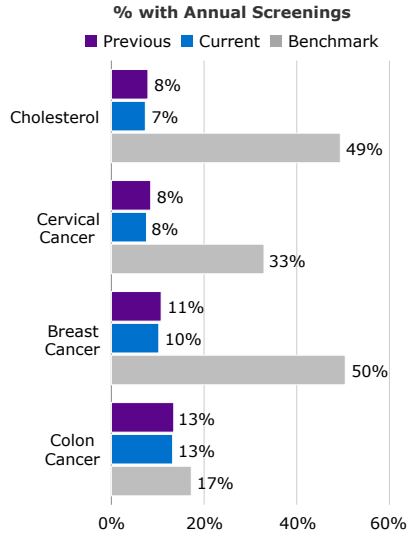
Previous Period: Apr 2016 - Mar 2017 (Paid)
Current Period: Apr 2017 - Mar 2018 (Paid)

7. Top Medical Conditions (by cost)

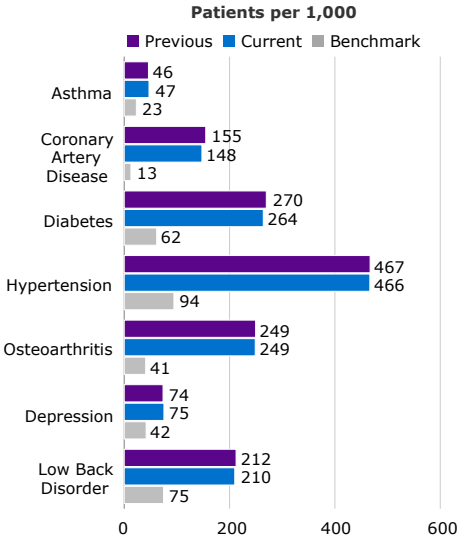


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Osteoarthritis	$12,015,620	6,274	$1,915
2	Renal Function Failure	$9,881,466	2,160	$4,575
3	Eye Disorders, Degenerative	$8,789,147	7,647	$1,149
4	Spinal/Back Disord, Low Back	$8,695,547	5,294	$1,643
5	Coronary Artery Disease	$8,095,748	3,721	$2,176
6	Arthropathies/Joint Disord NEC	$7,847,304	9,367	$838
7	Respiratory Disord, NEC	$7,129,438	6,463	$1,103
8	Cerebrovascular Disease	$5,853,355	2,687	$2,178
9	Cardiac Arrhythmias	$5,678,609	4,011	$1,416
10	Infections, NEC	$5,198,315	3,656	$1,422

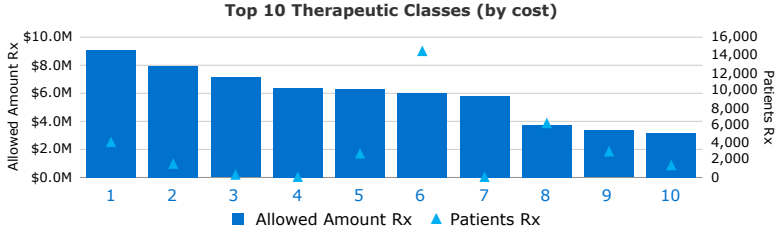
8. Screening Rates



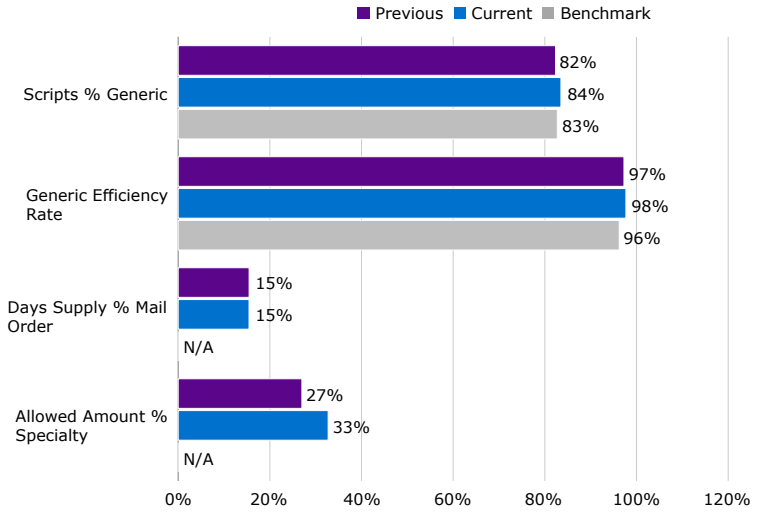
9. Chronic Condition Prevalence



10. Prescription Drug Metrics



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Antidiabetic Agents, Misc	$9,102,011	4,063	$2,240
2	Antidiabetic Agents, Insulins	$7,944,906	1,580	$5,028
3	Immunosuppressants, NEC	$7,124,633	334	$21,331
4	Molecular Targeted Therapy	$6,403,026	89	$71,944
5	Coag/Anticoag, Anticoagulants	$6,339,932	2,745	$2,310
6	Antihyperlipidemic Drugs, NEC	$6,009,981	14,444	$416
7	Biological Response Modifiers	$5,815,385	81	$71,795
8	Adrenals & Comb, NEC	$3,748,068	6,213	$603
9	Misc Therapeutic Agents, NEC	$3,347,811	2,993	$1,119
10	CNS Agents, Misc.	$3,152,034	1,421	$2,218



Medical and Prescription Drug Dashboard - Medicare Retirees

Dashboard Glossary

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4. Medical Plan Eligibility

- **Average Employees** represents the number of employees with medical coverage; each employee is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Average Members** represents the number of members with medical coverage; each member is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Family Size** represents the average number of covered members per subscriber
- **Member Age** represents the average age of covered members during the year
- **Members % Male** represents the number of male members as a percent of total members

5. Risk Score

The Member Risk Score represents the DCG non-rescaled concurrent score

- The Member Risk Score is produced using the Verisk DCG® model
- This model measures the health risk of a population relative to the national average as of the time the model was developed (i.e., 100)

6. Price and Use

- **Current** represents your Price or Use rate in the Current year
- **Benchmark** represents the U.S. Total MarketScan norm for the Price or Use rate
- The **Symbol** next to the Benchmark represents your Current rate compared to the Norm
- The **Trend** represents your year-over-year trend for the Price or Use rate

7. Cost Sharing

The cost sharing percentage represents Out-of-Pocket divided by Allowed Amounts

- Out-of-Pocket represents the amount paid out-of-pocket by the member for facility, professional, and prescription drug services; this generally includes coinsurance, copayment, and deductible amounts

8. Top Medical Conditions (by cost)

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Clinical conditions include medical claims (i.e., prescription drug is not included)
- Note: The clinical condition of *Signs/Symptoms/Oth Cond, NEC* is excluded from this exhibit

9. Screening Rates

- **Cholesterol** identifies lipid screening tests for males aged 35+ years and females aged 45+ years; lipid screening tests include lipid panels, serum cholesterol tests, blood lipoprotein tests (e.g., HDL, LDL), and triglyceride tests *[source for age and gender criteria: US Preventive Services Task Force]*
- **Cervical Cancer** identifies the percentage of females aged 21 to 64 who received cervical cancer screening services *[source for age, gender, procedure, diagnosis, and revenue code criteria: NCQA HEDIS 2014]*
- **Breast Cancer** identifies the percentage of females aged 50 to 74 who received mammography services *[source for age, gender, diagnosis, procedure, and revenue code criteria: NCQA HEDIS 2014]*
- **Colon Cancer** identifies the percentage of adults aged 50 to 75 who received colon cancer screening services *[source for age, diagnosis and procedure criteria: NCQA HEDIS 2014]*

10. Chronic Condition Prevalence

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Chronic conditions identified based on medical claims

11. Prescription Drug Metrics

- **Therapeutic Class** represents the Redbook Therapeutic Class Intermediary
- **Scripts % Generic** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled
- **Generic Efficiency Rate** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled that could have been filled with a generic drug
- **Days Supply % Mail Order** is the percent of all prescription days supply filled via mail order
- **Allowed Amount % Specialty** is the percent of total prescription drug allowed amounts that were for medications considered to be specialty drugs (identified using Truven Health Service Categories)