HEALTH BENEFITS ANNUAL REPORT

Commonwealth of Virginia

Fiscal Year 2017

dhrm

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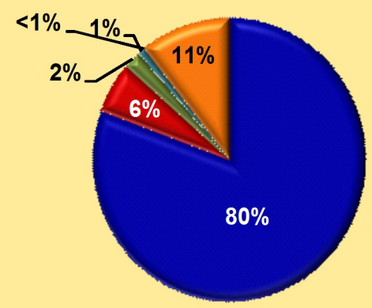
This report is an overview of the state's three self-insured health benefits plans, and where indicated, the regional, fully insured Kaiser Permanente HMO plan offered primarily in Northern Virginia. Unless otherwise stated, this report is based on the experience of health plan members, including the active employee and non-Medicare eligible retiree group, from July 1, 2016 through June 30, 2017. The third party administrators for the state self-insured plans were: Anthem Blue Cross and Blue Shield for medical, pharmacy, behavioral health and employee assistance program (EAP) services for COVA Care and COVA HDHP; Delta Dental of Virginia for those plans' dental benefits; and Aetna for all COVA HealthAware benefits. ActiveHealth Management administered the total population health program and Anthem administered flexible spending accounts (FSAs) for all eligible and enrolled employees. The data source for this report is Health Data & Management Solutions, Inc. (HDMS) unless otherwise noted.

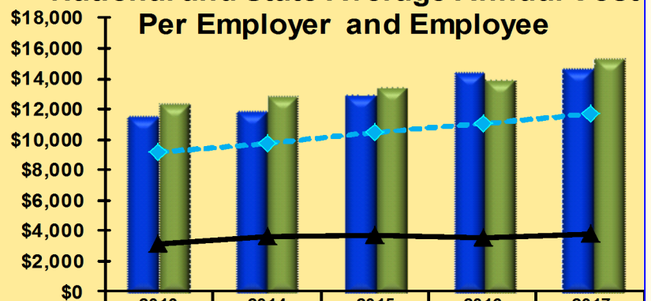
2017 HEALTHCARE DASHBOARD

2017 Health Plan Enrollment
Total Eligible = 99,524



- COVA Care (all plan options)
- COVA HealthAware (all plan options)
- Kaiser Permanente HMO
- COVA HDHP (all plan options)
- TRICARE
- Waived

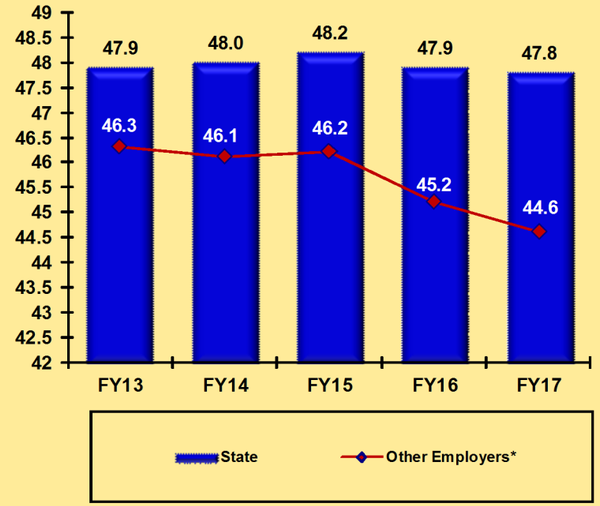
National and State Average Annual Cost Per Employer and Employee



	2013	2014	2015	2016	2017
State Employer Cost Per Employee	$11,471	$11,835	$12,883	$14,308	$14,608
National Large Government Employer Cost Per Employee	$12,311	$12,761	$13,383	$13,868	$15,259*
State Employee Cost	$3,112	$3,611	$3,682	$3,521	$3,788
National Average Employee Cost	$9,144	$9,695	$10,473	$11,033	$11,685*

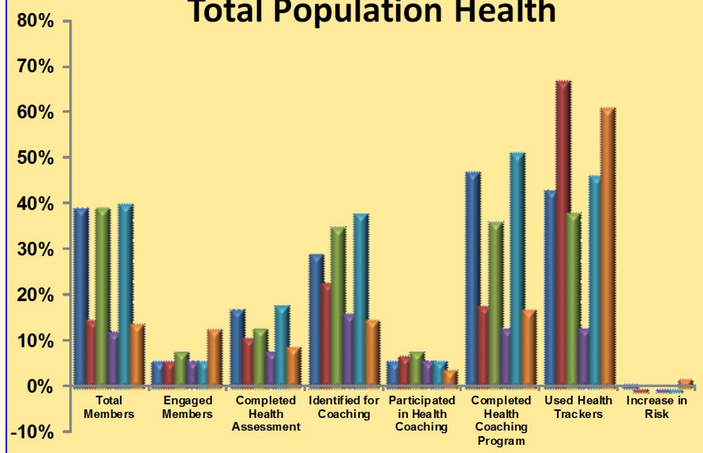
*Sources: National average employer and employee costs projected for 2017 by Milliman Medical Index. Health care cost projections vary. The Henry J. Kaiser Family Foundation shows a national average employer cost per employee of $13,049 for CY 2017 and an employee premium contribution of $5,714. Other national data shown is from Milliman and the Mercer National Survey of Employer-Sponsored Health Plans. State data is total program expense.

Average Enrolled State Employee Age

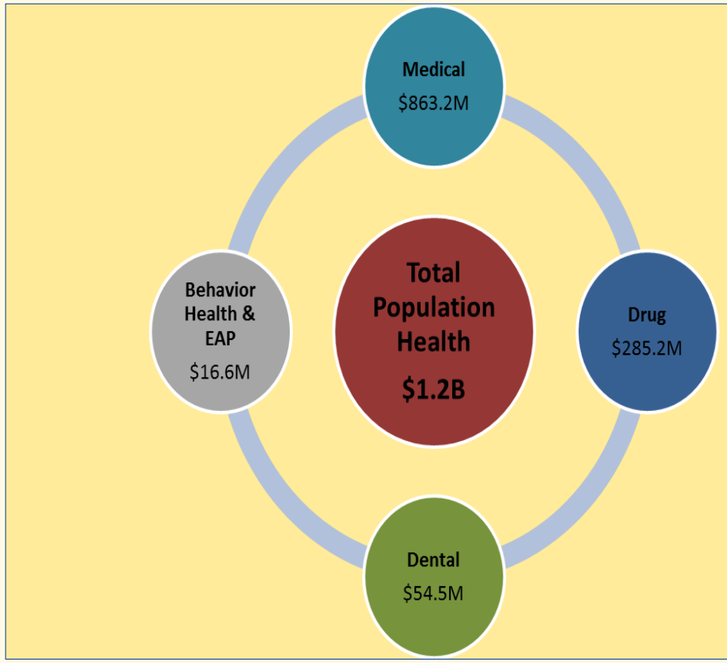


*Employers with Anthem, Optima Health or Aetna depending on the year shown.

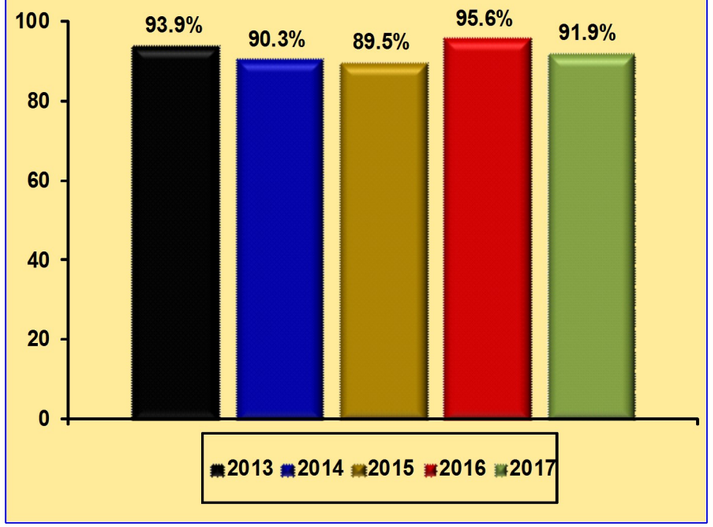
Total Population Health



- 40 percent of total eligible population registered on the MyActiveHealth portal
- 6 percent of participants were engaged in any part of the program
- 51 percent of those who had health coaching completed the health coaching program
- 1 percent reduction in risk in 2017 compared to 2 percent benchmark



Overall Employee Satisfaction (weighted average)



TAKING STEPS FOR BETTER EMPLOYEE HEALTH

Assessment

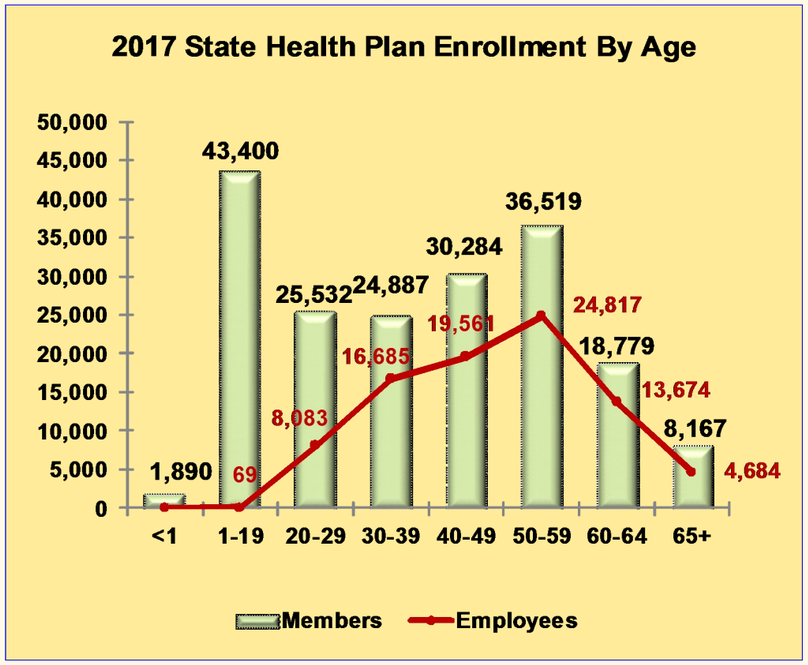
- 67 percent of state plan members with a biometric screening are overweight or obese, affecting their health and productivity
- Lifestyle-related health issues and chronic conditions tied to obesity are generating more health care costs
- The state employee population is older than average for other employers

Opportunities

- Encourage members to:
  - Be more engaged in their health
  - Understand the cost of healthcare
  - Be better consumers of healthcare
- Offer members tools to:
  - Evaluate quality and cost

In fiscal year 2017, the Commonwealth employee health benefits program's foundation for change continued to progress after three years, based on twin goals of healthier employees and lower costs. The program's total cost increased 1.4 percent compared to 9.8 percent the prior year.

Through its "total population health" initiative, the program has provided tools to help employees be more engaged in their health and better consumers of healthcare. It has focused on improving employee health and well-being, helping employees make better plan and healthcare decisions, and engaging them to take ownership of their health. An analysis of health care trends has resulted in innovative approaches and incentives to encourage healthy actions.



Health Outcomes

During 2017:

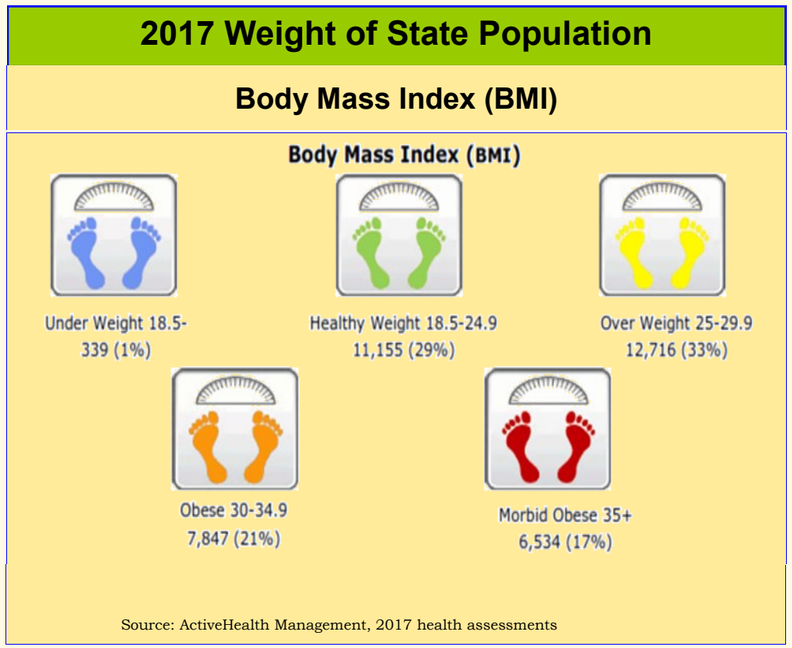
- Health plan members had an overall health risk of –1 percent for total population health, three percentage points better than the benchmark of 2 percent and one percent lower than the 0 percent risk in 2016.
- 2.1 percent more members were in the healthy or minor health conditions category than the prior year, and 80 percent reduced their health risk to low risk.
- 67 percent of state health plan members who completed a biometric screening were overweight or obese, comparable to the 2016 measure.
- Engagement with a MyActiveHealth nurse increased for the top five conditions of adult hypertension, diabetes, weight management, high cholesterol and GERD.
- In the third year of the diabetes value-based insurance design (VBID) program, the average number of health conditions for participants dropped to 2.9 from 4.8, while in year two of the hypertension VBID, the average number of health conditions dropped to 2.9 from 3.1.

Cost

- Total cost per employee for the COVA HealthAware consumer-driven health plan was almost half of the comparable expense for the COVA Care plan.
- 58 percent of COVA HealthAware members rolled over a total of $1.6 million in Health Reimbursement Account (HRA) funds to use for expenses in future years.
- About 75 percent of COVA HealthAware members are under 45 years of age, with an average member age of 31, and their health care costs less.

During 2017, plan design changes for all state plans included expanding coverage for applied behavioral analysis (ABA) for autism spectrum disorder from ages 2 through 10 from 2 through 6. In addition to implementing these changes, the program in 2017 also dealt with the impact of the federal Affordable Care Act (ACA), distributing Internal Revenue Service (IRS)-required healthcare reporting forms and paying

employer reinsurance to subsidize the individual health insurance market. During 2017, the net cost of the ACA to the state was $4.6 million. Even with higher ACA costs, the state health benefits self-insured plans' cost per employee in FY 2017 was 4.3 percent lower than the projected national average for the calendar year.



Source: ActiveHealth Management, 2017 health assessments

STEP 1: BETTER HEALTH AND WELL-BEING

Focus on Wellness

During 2016 and 2017, the Commonwealth invested in programs that use workplace activities and coaching to help employees lead healthier lives. It also focused on ways to prevent illness by providing flu shots and preventive screenings at no cost to plan members.

The *Healthy Lifestyles* program helps members who are generally healthy but need a little extra support to stay on the right track. It includes coaching on nutrition, exercise, stress management and quitting tobacco. During the plan year, the program reached out to 10,594 members. More than 3,000 of the members contacted by the program, or 29 percent, were engaged in telephonic and online coaching. The top areas of focus were weight management, nutrition, stress, fitness and exercise, and reducing cholesterol.

Biometric screenings are another indicator of the health of state plan members. The Commonwealth has targeted blood pressure, cholesterol and Body Mass Index (BMI) levels to measure employee health. In 2017, screening results showed that members' blood pressure and cholesterol readings continued to improve. On the other hand, only 33 percent had a healthy weight, with a BMI of less than 25.

Offered in the employee workplace, the *CommonHealth* wellness education program encouraged employees to lead healthier lives. Directed by employees within the Department of Human Resource Management, the program promotes healthy employee lifestyles and encourages integration of health and physical activity into the work culture.

Assisted by the efforts of the Governor and the Secretary of Administration, to encourage employee participation in *CommonHealth,* the program's total participation grew to 40 percent of the workforce in 2017, 8 percent higher than in 2016. This is consistent with the findings of a 2014 Rand Corporation study estimating a 20 to 40 percent national participation rate. In 2017, *CommonHealth* programs focused on fitness, managing joint pain and brain health.

Assessment

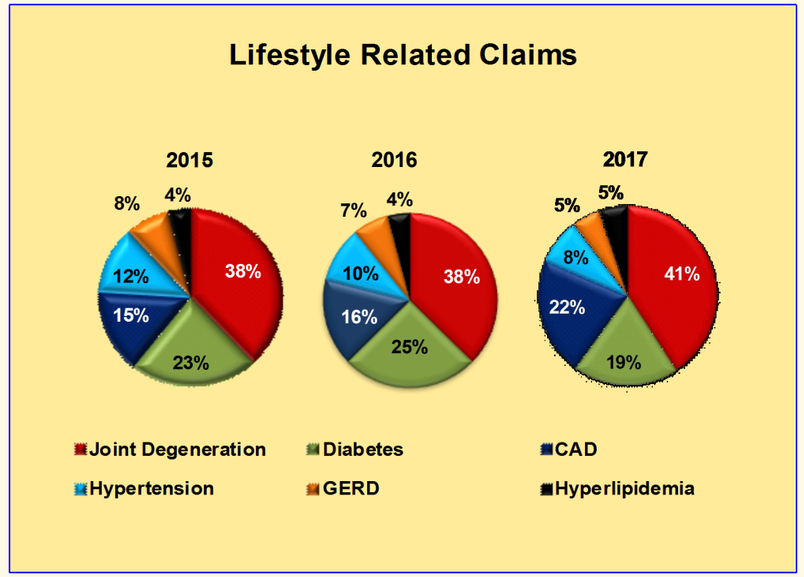
- While biometric screenings show a 7 percent improvement in overweight or obese members over the prior year, the percentage remains high
- Many health plan members need help with issues related to nutrition, exercise, stress and quitting tobacco use

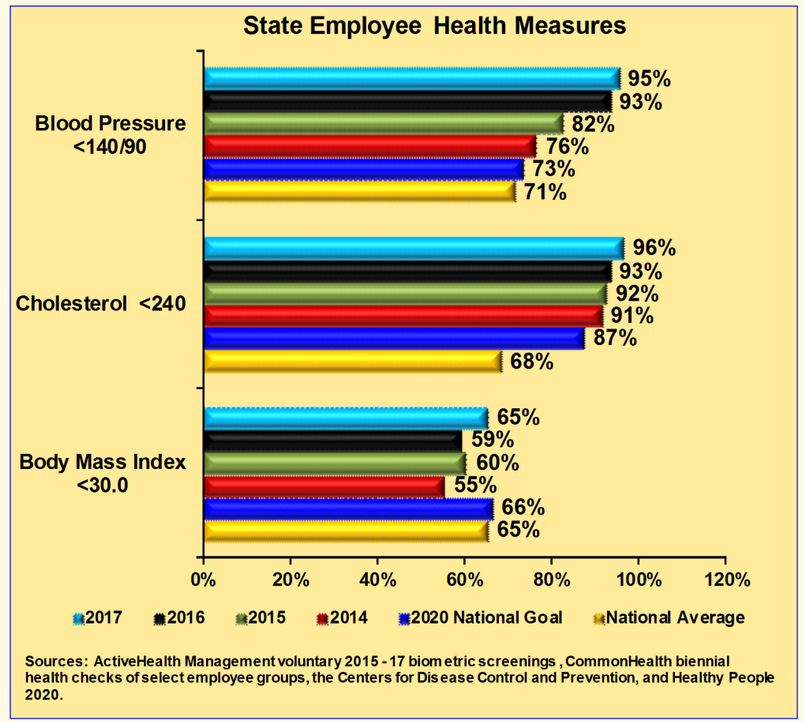
Opportunities

- Increase use of the lifestyle coaching program to help members stay on track
- Encourage employees to stay healthy by getting an annual flu shot and age-appropriate preventive screenings
- Offer education programs through the *CommonHealth* wellness program to promote healthy activities in the workplace

Milestones

- A 1 percent decrease in overall health risk for members
- A 2 percent improvement in blood pressure readings
- A 3 percent improvement in cholesterol readings





Sources: ActiveHealth Management voluntary 2015 - 17 biometric screenings , CommonHealth biennial health checks of select employee groups, the Centers for Disease Control and Prevention, and Healthy People 2020.

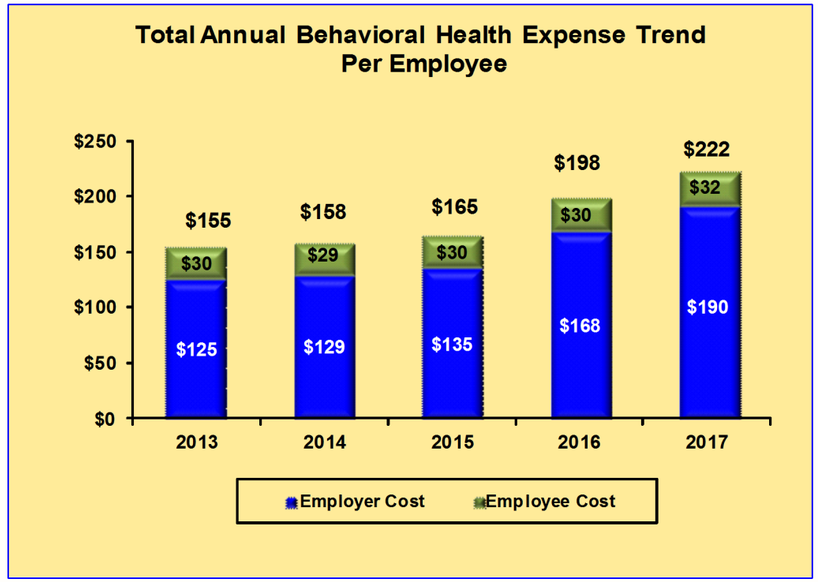
STEP 2: BETTER EMOTIONAL HEALTH

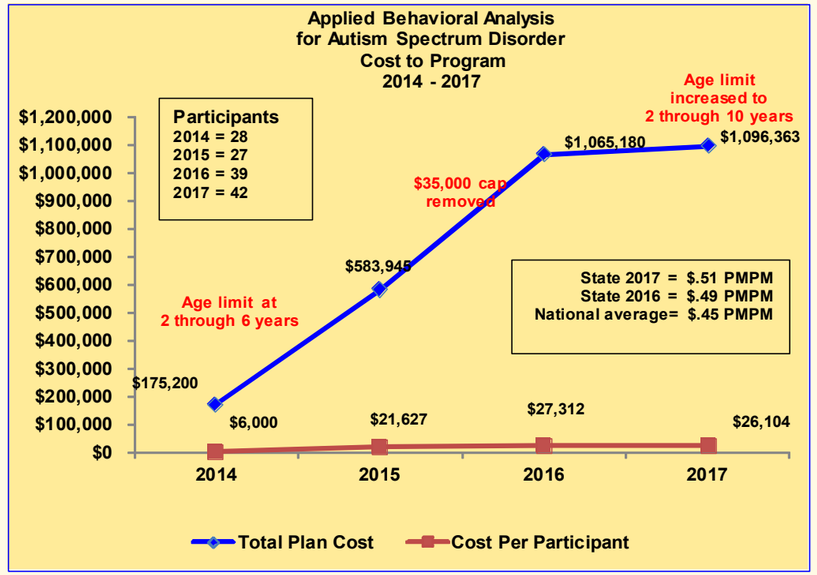
Opportunities

- Provide Employee Assistance Program (EAP) counseling to employees who need help with life issues such as family relationships, legal, financial and workplace concerns
- Offer behavioral health services to employees who need them

Milestones

- 74 percent of EAP cases were resolved successfully within the EAP benefit, compared to 68 percent in Anthem's book of business
- 83 percent of referred members reached by behavioral health providers were engaged in their treatment, better than the 80 percent in other Anthem plans
- 53 percent of referred members with depression showed at least a 5 percent improvement in depression scores
- Only 4 percent of cases remained highly acute after behavioral health intervention, better than National Alliance on Mental Illness estimates of 10 to 30 percent





Emotional and Behavioral Health

Emotional health is as important to individual well-being as physical health. To deal with emotional health issues, the Commonwealth offers a behavioral health benefit and an Employee Assistance Program (EAP) which provides up to four free counseling sessions per issue each plan year.

About 8.8 percent of those enrolled in health plans used the behavioral health benefit during 2017, less than the 11.7 percent rate for comparable Anthem plans. Six behavioral health conditions accounted for 98 percent of claims expense: mood disorders, anxiety and stress, substance abuse, autism, behavioral and emotional disorders, and behavioral syndromes related to physiology. Total claims cost increased 22 percent to $16.6 million in FY 2017 from $13.6 million in FY 2016, driven by higher outpatient facility costs. The 5 percent highest-cost behavioral health members accounted for 15 percent of behavioral health costs.

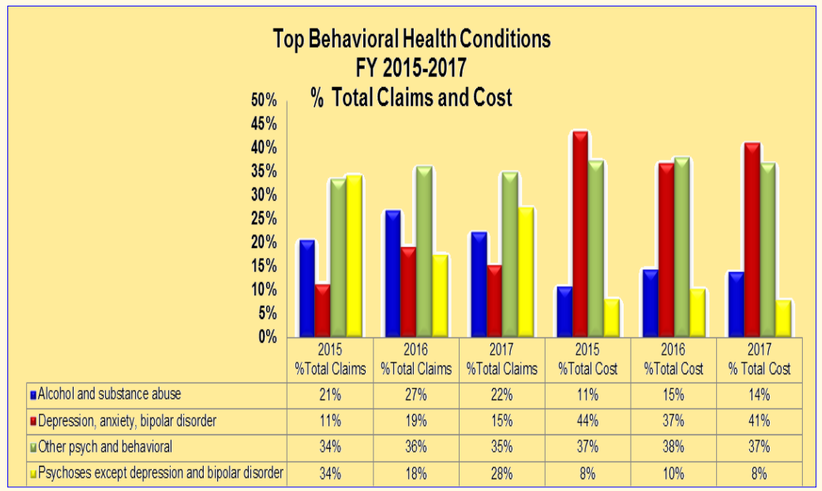
Fifty-seven percent of claims expense was for outpatient services; 37 percent for inpatient treatment, including new residential treatment services; and 6 percent for alternative levels of care. There were 1,051 referrals in 2017, about a 1 percent increase over the prior year. Providers and clinicians reached 57 percent of referred members, which is above the 54 percent rate for Anthem's comparable plans. Of referred members with depression, 53 percent showed at least a 5 percent improvement in depression scores, a rate 10 percent higher than 2016. Of those who had inpatient or residential treatment center hospitalization during FY 2017, 79 percent of those with a primary diagnosis of substance abuse, and 83 percent of those with a primary diagnosis of mental health, had only one admission during the year. Alcohol dependence accounted for the highest number of admissions, with a total of 256. There were 145 admissions for major depressive disorders and 118 admissions for opioid dependence.

Of the more than 4,200 members who used the EAP in 2017, 85 percent sought services for the top three assessed problems: emotional and psychological concerns, family relationships and legal issues. A total of 550 members used legal and financial services compared to 712 the prior year, or a decline of about 23 percent.

The EAP handled 5,731 calls and referred 4,240 cases to a counselor in 2017, down 2 percent from the 4,329 cases in 2016. The annualized 6.5 percent utilization rate in 2017 was comparable to the 6.4 percent national utilization rate. The program handled 202 onsite trainings and 43 critical incidents, and gave onsite counseling to 378 state employees.

Of EAP cases opened in 2017, 74 percent were resolved successfully within the EAP benefit, and 61 percent of members used all four counseling sessions for treatment. An analysis showed that 92.9 percent were satisfied with counseling sessions, 85.9 percent reported improved concentration at work, 85.6 percent said their work performance had improved, and 80.9 percent reported better work attendance.

In FY 2017, 42 members used the Applied Behavior Analysis (ABA) benefit for autism spectrum disorder. The program expanded coverage to children from ages 2 through 10 during the plan year. ABA claims costs were 3 percent higher for FY 2017 than the previous year, at more than $1 million both years. The average cost per participant was about $26,104 compared to $27,312 the prior year.



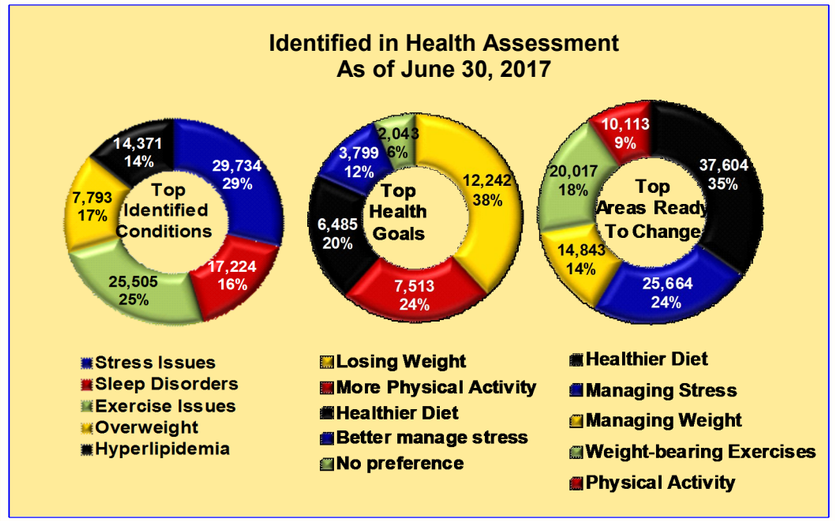
	2015 %Total Claims	2016 %Total Claims	2017 %Total Claims	2015 %Total Cost	2016 %Total Cost	2017 % Total Cost
Alcohol and substance abuse	21%	27%	22%	11%	15%	14%
Depression, anxiety, bipolar disorder	11%	19%	15%	44%	37%	41%
Other psych and behavioral	34%	36%	35%	37%	38%	37%
Psychoses except depression and bipolar disorder	34%	18%	28%	8%	10%	8%

STEP 3: GETTING MORE ENGAGED - Total Population Health

Assessment
- Improve total population health risk
- Help employees improve work-life balance
- Engage members in their healthcare
- Remove financial barriers to members' success

Opportunities
- Provide convenient access to healthcare
- Offer tools to help members identify their health risks and manage them effectively
- Help members reduce the cost of healthcare

Milestones
- Members' overall health risk improved by 1 percent compared to a 2 percent decline for the benchmark population
- 12 of 23 population health measures improved



Total Population Health

In order to increase member engagement, the Commonwealth provides tools to state plan members to help them be fully involved in their health care, improve their health and reduce costs. Members are offered resources to:

- Evaluate plan cost and quality.
- Help members track their health online and know their numbers.
- Better manage chronic conditions and enroll in coaching on exercise, weight management, nutrition, stress and quitting tobacco.
- Provide Premium Rewards for completing a health assessment and biometric screening.
- Eliminate financial barriers to encourage compliance with diabetes management, hypertension and asthma/chronic obstructive pulmonary disease (COPD) programs.
- Increase understanding of individual health risks, how to improve health and the impact on both out-of-pocket costs and plan costs.

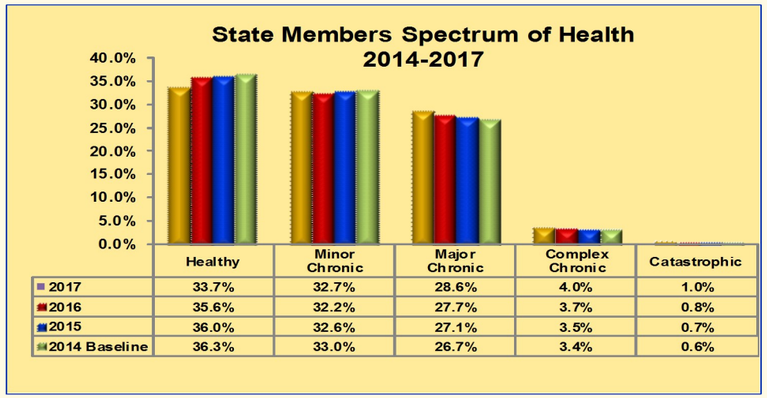
During 2017, 28 percent of health plan members were engaged with ActiveHealth Management (AHM) programs, compared to 9 percent engagement the prior year. Members are engaging in an average of 2.4 programs. By the close of 2017, 40 percent of health plan members were registered at MyActiveHealth.com/COVA. Six percent had engaged in some aspect of the wellness program, from completing a health assessment, to using online resources such as health trackers or telephonic or digital health coaching programs. The MyActiveHealth engagement rate declined from 8 percent in 2016 and is lower than the AHM State Plans' 13 percent benchmark rate for 2017.

A health assessment available to state plan members has helped identify their top issues of concern. The top two self-reported conditions are stress issues and sleep disorders. These correlate with being overweight, the fourth condition identified by members. Biometric screening results indicate that 67 percent of members in state health plans are overweight or obese.

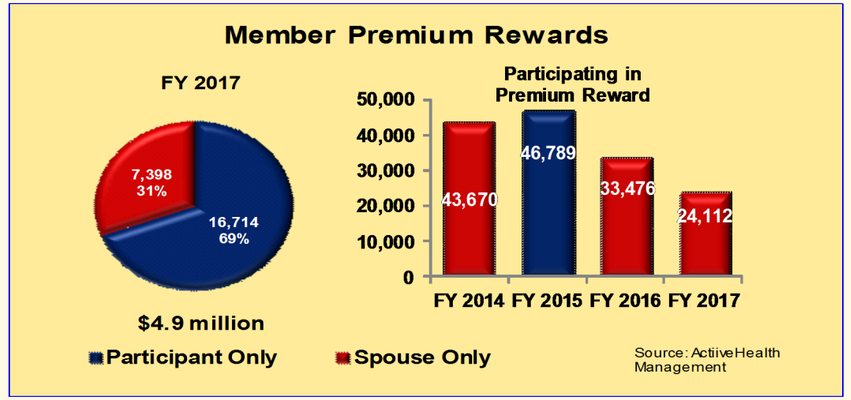
About 39% of total claims expense in 2017 was from members with complex chronic or catastrophic health, who represented 5 percent of 445,000 adult members in the program for 11 months.

Premium rewards were offered to encourage participation in total population health. A total of 126,311 health plan members were eligible to earn premium rewards in 2017. Of those eligible, 24,112 COVA Care and COVA HealthAware members, or 19 percent, completed a health assessment and biometric screening to earn $ 4.9 million in premium rewards.

The *Healthy Insight* disease management program engaged 15 percent of eligible members identified for disease management compared to 11 percent for another state's health plan. The number of eligible members engaged in the *Healthy Lifestyles* coaching program was 29 percent compared to 41 percent for the AHM book of business.



	Healthy	Minor Chronic	Major Chronic	Complex Chronic	Catastrophic
2017	33.7%	32.7%	28.6%	4.0%	1.0%
2016	35.6%	32.2%	27.7%	3.7%	0.8%
2015	36.0%	32.6%	27.1%	3.5%	0.7%
2014 Baseline	36.3%	33.0%	26.7%	3.4%	0.6%



STEP 3: GETTING MORE ENGAGED - Total Population Health Outcomes

Total Population Health

Member compliance with evidence-based care has been scientifically linked to improved health and avoidance of ER visits and hospitalizations. To engage members in their health care, the total population health initiative identifies gaps in care, then notifies members, and in certain cases, their physicians. These "Care Considerations" include clinically urgent or important notices of potentially serious health impacts if action is not taken. For example, they may include drug/condition monitoring, to add or intensify medical therapy, or recommend a diagnostic workup. "Care Considerations" also include patient safety alerts about potential risks associated with medications the member is taking and wellness alerts focused on preventive care such as vaccinations and cancer screenings.

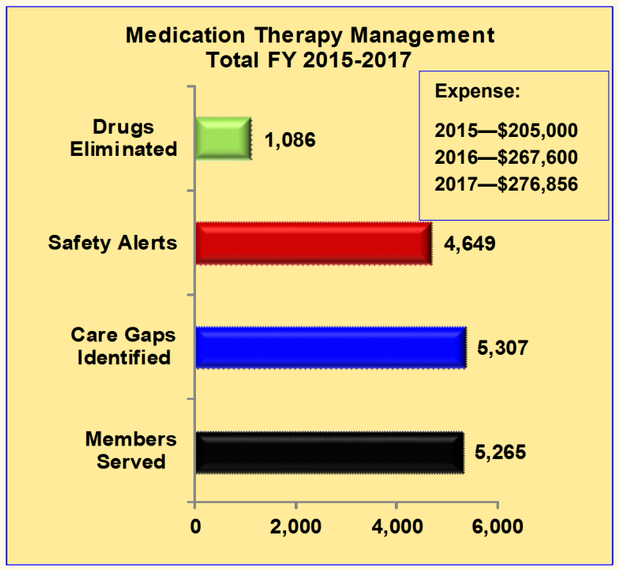
During 2017, the total population improved their risk category by one percent, while the AHM book of business benchmark saw a 2 percent decline. ActiveHealth Management (AHM) identified 54,124, or 28.3 percent, of plan members as potential candidates for disease management. It reached out to 52,825 members, or 27.6 percent of all eligible health plan members. Of those, almost 7,900 members, or 15 percent, were engaged by telephone with a disease management or lifestyle coach. A total of 7,687, or 4 percent of all eligible plan members, were engaged with a nurse in 2017 to help them better manage a chronic health condition, compared to 3.6 percent the previous year.

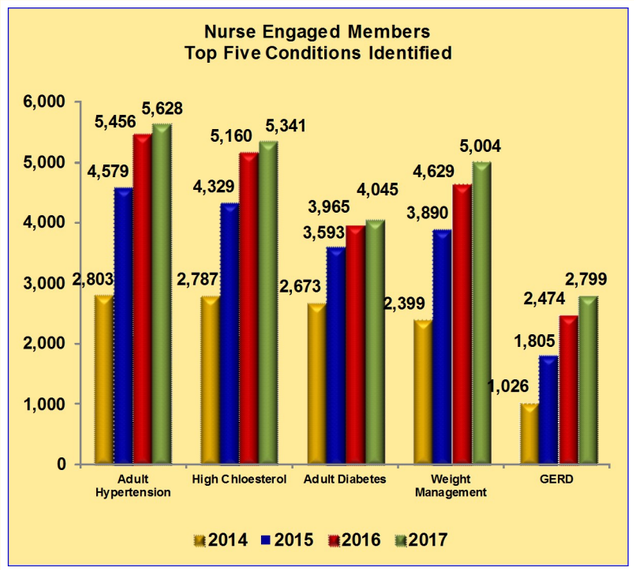
For the 24,729 members completing a health assessment in plan year 2017, 6 percent of members improved their risk category. Of those who improved, 65.3 percent moved from High or Medium to Low Risk, and 34.7 percent moved from High to Medium Risk. Total annual savings from care considerations and disease management programs are estimated at almost $26 million.

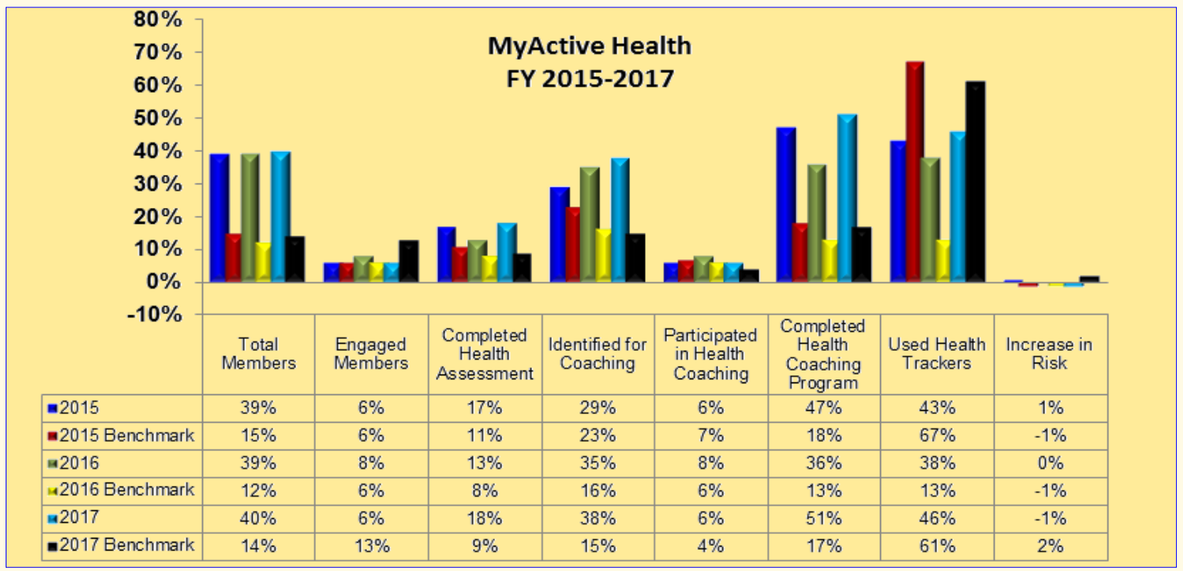
2017 Commonwealth Member Compliance

	Members	State Percent	Benchmark
% of Care Considerations resolved when members took healthy actions	64,817	37.0%	34.7%
Identified for disease management opportunity	54,124	28.3%	35.0%
Successful disease management outreach	35,294	18.4%	17.6%
Engaged with nurse	7,687	4.0%	3.0%
Engaged overall in MyActive Programs	53,469	28.0%	26.0%

The health benefits program continued its medication therapy management (MTM) pilot program in 2017. The confidential, voluntary program offers one-on-one medication consultations directly with a pharmacist to educate individual members about complying with their drug regimen, how to best use the drug formulary, possible drug reactions and other issues relating to their conditions. MTM includes a comprehensive annual visit with up to three follow-up visits for patients who have at least three of eight disease states and take seven or more medications for chronic illness. Since 2015, about 5,265 cases have been served. Members have taken 1,086 fewer drugs as a result of 4,649 total safety alerts; more than 300 members followed their drug regimen for at least one drug, and more than 130 members closed at least one gap in care as a result of 5,307 care gaps identified.







	Total Members	Engaged Members	Completed Health Assessment	Identified for Coaching	Participated in Health Coaching	Completed Health Coaching Program	Used Health Trackers	Increase in Risk
2015	39%	6%	17%	29%	6%	47%	43%	1%
2015 Benchmark	15%	6%	11%	23%	7%	18%	67%	-1%
2016	39%	8%	13%	35%	8%	36%	38%	0%
2016 Benchmark	12%	6%	8%	16%	6%	13%	13%	-1%
2017	40%	6%	18%	38%	6%	51%	46%	-1%
2017 Benchmark	14%	13%	9%	15%	4%	17%	61%	2%

STEP 3: GETTING MORE ENGAGED - Consumer-Driven Health

COVA HealthAware and COVA HDHP Plan Participation

In conjunction with total population health, the Commonwealth introduced a consumer-driven health plan in FY 2014 to encourage state plan members to be wise consumers of their health care, know their health numbers and take positive steps to improve their health. The COVA HealthAware health plan includes built-in incentives for engagement, and in FY 2017 had almost 12,000 plan members, a growth of 44 percent from the first year.

COVA HealthAware

COVA HealthAware enables members to budget their own health care spending and decide how best to spend their own money. It includes a deductible of $1,500 for single and $3,000 for family coverage. The plan also has a health reimbursement arrangement (HRA), a fund to help members pay for out-of-pocket medical and pharmacy expenses. In FY 2017, the Commonwealth continued to fund the HRA with $600 for employees and early retirees, and $1,200 for employees/early retirees with spouses enrolled in the COVA HealthAware plan. About 24 percent of the $6.7 million in HRA funds available to plan members were from funds rolled over from FY 2016.

In addition to the HRA, the plan continued to offer several "do right" healthy activities in 2017 which members could complete to add funds to their account. Employees, early retirees, or their spouses could each receive up to $150 in additional HRA funding by completing up to three "do rights": An annual routine exam, flu shot, dental exam, vision exam, online or digital coaching, and tracking certain activities on the MyActiveHealth web portal. The plan continues to be attractive to new employees comfortable with this approach. Health care services utilization declined in FY 2017 and continues to be well below that of Aetna's book of business and other state health plans.

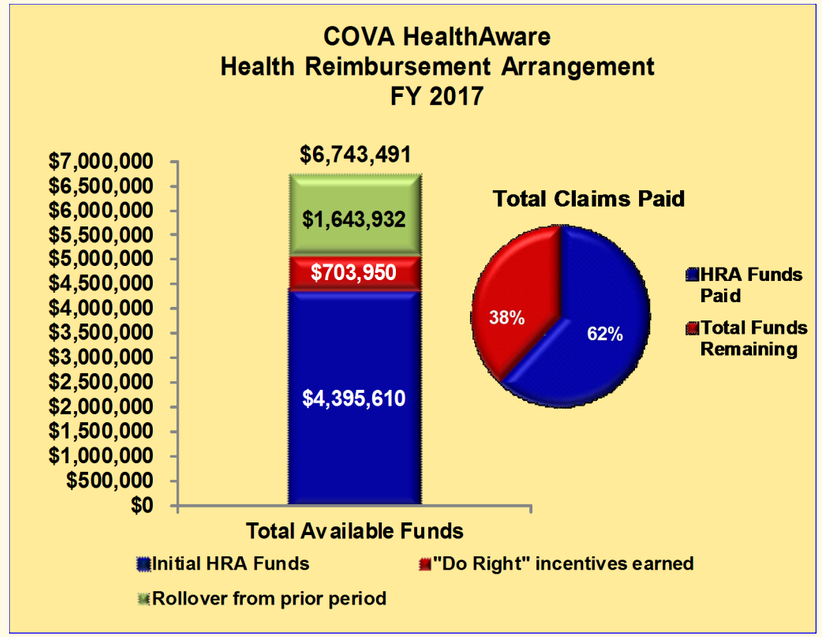
COVA HDHP

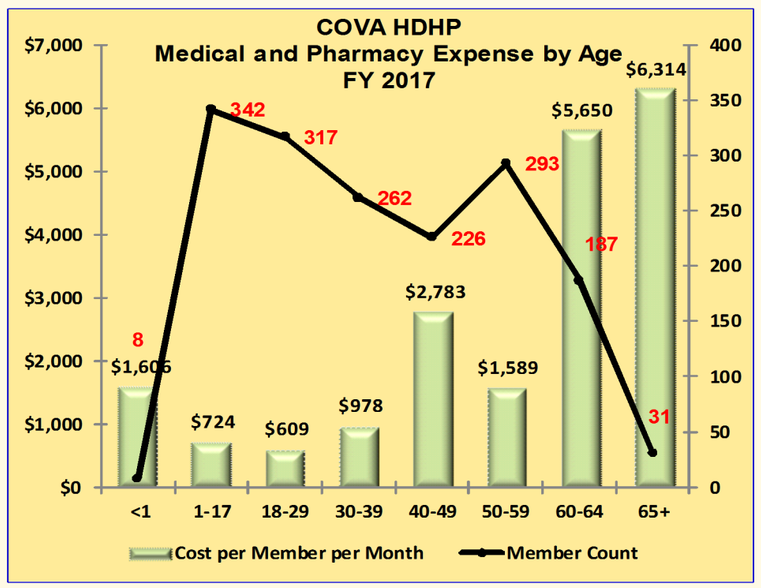
By comparison, the COVA HDHP (High Deductible Health Plan) introduced in FY 2007 had 1,648 members in 2017, doubling in membership after 10 years. Launched as another plan option to COVA Care, it includes a deductible of $1,750 for single and $3,500 for family coverage. In addition, the COVA HDHP is compatible with a Health Savings Account (HSA), which is a tax-favored account that allows those covered by an HDHP to pay for certain qualified medical expenses.

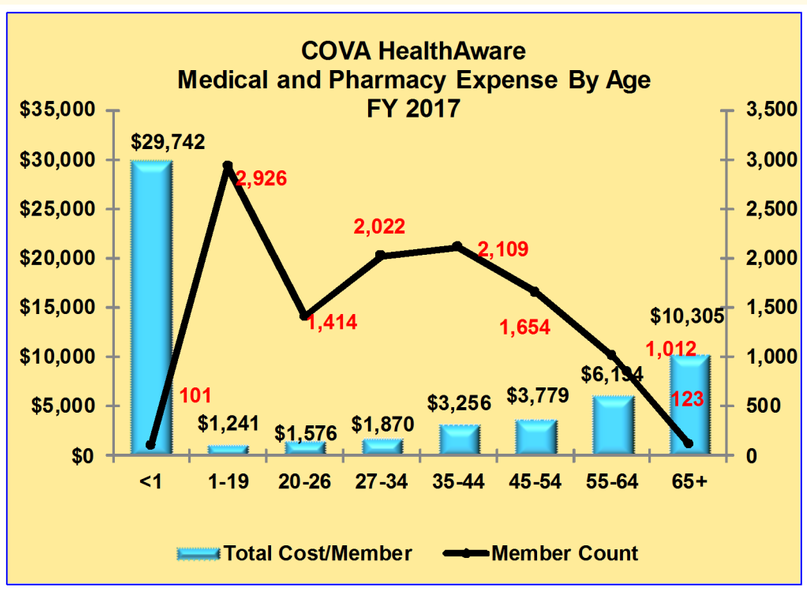
An HSA can help members save on the cost of health insurance and health care expenses, and also helps pay for covered services before the health plan deductible is met. Members set up their own personal HSA at a bank or other financial institutions. The Commonwealth does not contribute to HSA accounts.

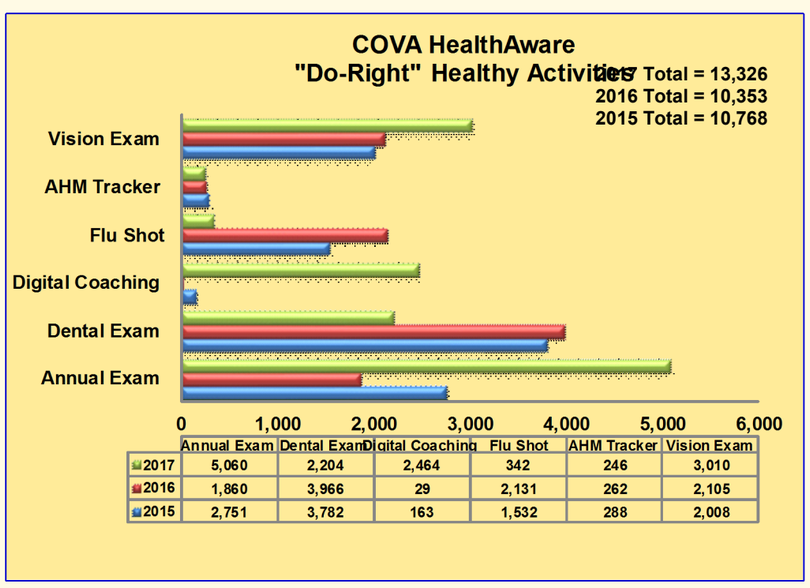
Consumer-Driven Health

In 2017, claims expense for the COVA HDHP totaled $3.6 million, with $3.1 million, or 85 percent, in medical and pharmacy claims. The employer claims cost per employee was $4,231 for 848 participants, compared to $ 6,307 for 5,558 participants in COVA HealthAware. The cost of premature infants was the primary reason for the COVA HealthAware expense for children under one year of age. The average employee age for the COVA HDHP was 44.8 or five years older than the average of 39.6 for employees enrolled in COVA HealthAware.









STEP 4: ENCOURAGE PREVENTIVE CARE

Assessment

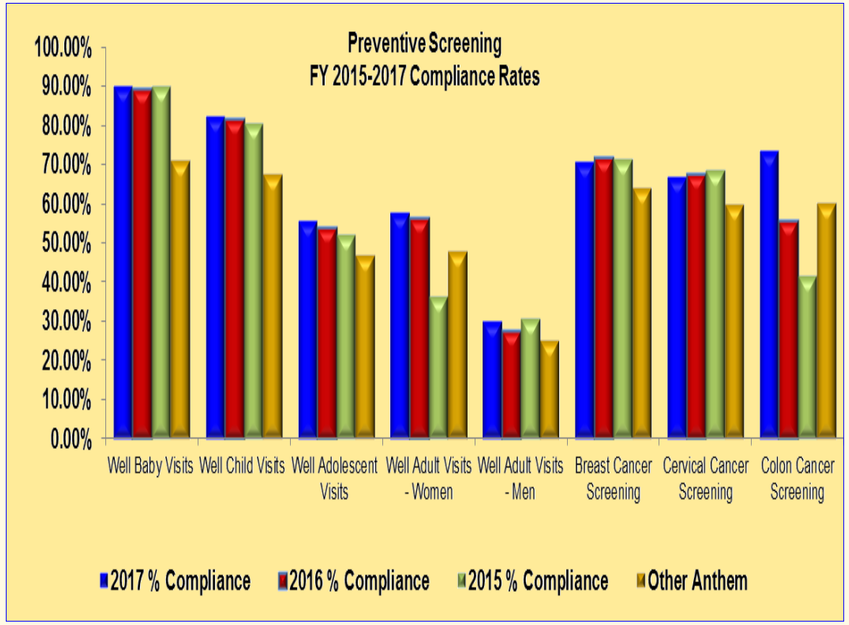
- Preventive screenings can identify serious illness and keep conditions from getting worse, yet many plan members do not get them.
- While getting a flu shot is one of the best ways to stay healthy, only 35 percent received one in FY 2017.

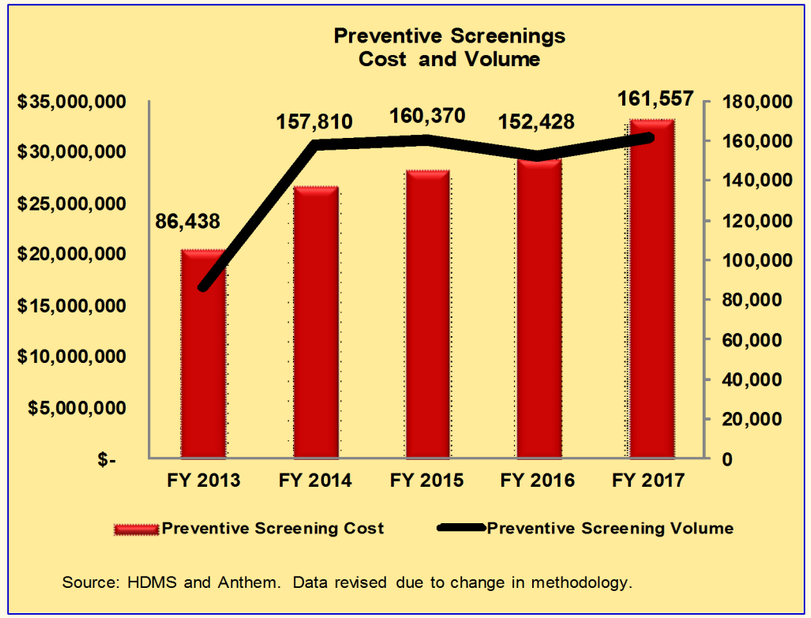
Opportunities

- Increase the number of members having preventive screenings.
- Increase percentage of members receiving free flu shots.
- Make getting flu shots more convenient.

Milestones

- 2017 routine wellness and preventive screening compliance exceeded the benchmark in all categories.
- The percent of members who received free flu shots at local pharmacies, doctors' offices and onsite in 2017 was comparable to the year before, yet 15 percent less than the national average.
- 38 percent of COVA HealthAware members got an annual exam as one of their "do rights," in line with the national average for well adult visits.





Source: HDMS and Anthem. Data revised due to change in methodology.

Preventive Care Benefits

Another way to improve the health of members is to help them avoid more serious illness. In 2017, the Commonwealth continued to provide annual wellness visits and preventive care screenings at no cost to members. The plan also paid 100 percent for flu shots.

Preventive Screenings

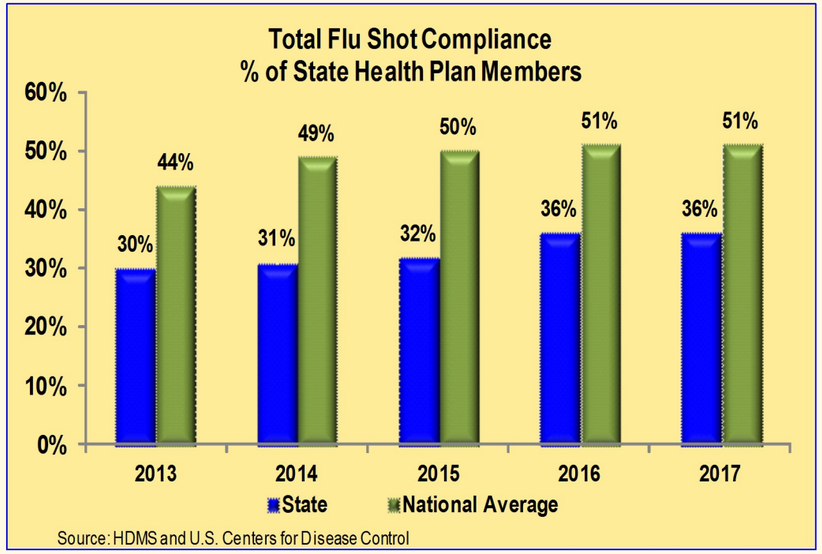
Average routine wellness and screening compliance rates showed improvement in all eight screening categories during FY 2017, with all categories exceeding the national average. Annual check-ups increased among women, men, children and adolescents, while age appropriate preventive screenings were up for colon cancer.

Among preventive screenings, almost 73 percent of members age 50 and older who met the requirements for a colon cancer screening in FY 2017 had one done. The typical screening frequency is once every 10 years.

Annual breast cancer screenings were at 71 percent for women age 18 and older. The state health benefits program continues to consider ways to increase preventive screenings.

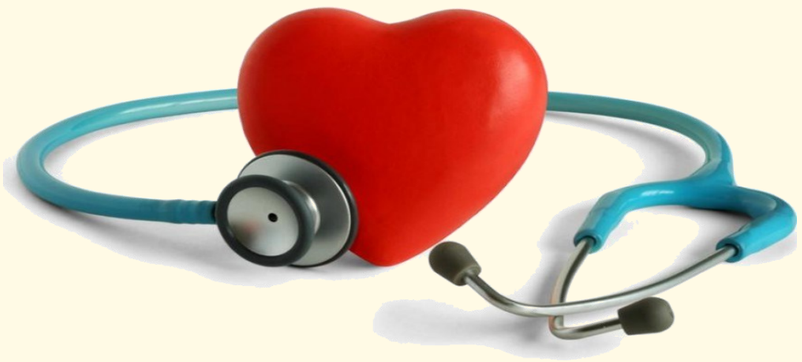
Flu Shots at No Cost to Members

One other way to help plan members stay healthy is to provide a free flu shot each year. In 2017, about 36 percent of state plan members received a flu shot, comparable to the 2016 percentage. While the percentage has increased over time, it remains below the 51 percent national average.



Source: HDMS and U.S. Centers for Disease Control

CommonHealth coordinated 720 flu shots at state agencies, increasing convenience for plan members and contributing to the number delivered by pharmacies. In addition, three percent of COVA HealthAware participants got a flu shot for one of their "do right" healthy activities. About 38 percent completed an annual exam for their "do right."



STEP 5: KNOW HEALTH TRENDS-Cost

Assessment

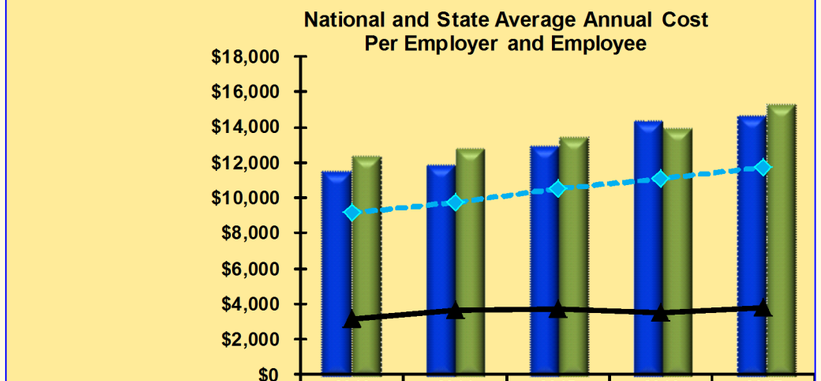
- Total cost increased 1.4 percent for health benefits in FY 2017 over the prior year.
- Cost drivers include expensive procedures, treatment of chronic conditions, the cost of prescription drug therapy, the average employee age and employee lifestyle.
- Claims costs are increasing along with expenses related to the Affordable Care Act (ACA).

Opportunities

- Increase participation in total population health and value-based insurance design (VBID) initiatives to control health care costs.
- Provide tools to help members monitor their health and develop healthy behaviors.
- Reward members for appropriate behavior.

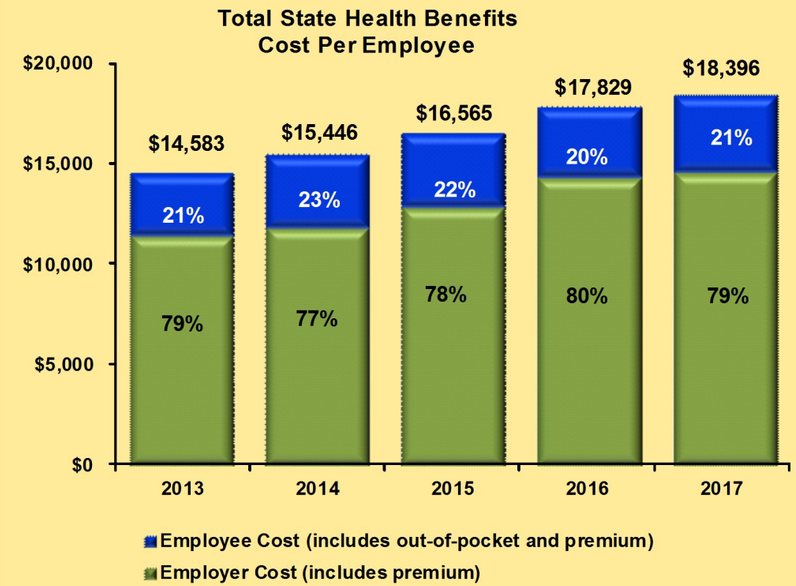
Milestones

- State employee costs have remained consistently about one-third of the national average.
- Claims costs increased 1.4 percent because the COVA Care plan design did not mirror ACA changes for the out-of-pocket expense limit, increasing the employer share by 2.1 percent over the prior year.



	2013	2014	2015	2016	2017
State Employer Cost Per Employee	$11,471	$11,835	$12,883	$14,308	$14,608
National Large Government Employer Cost Per Employee	$12,311	$12,761	$13,383	$13,868	$15,259*
State Employee Cost	$3,112	$3,611	$3,682	$3,521	$3,788
National Average Employee Cost	$9,144	$9,695	$10,473	$11,033	$11,685*

*Sources: National average employer and employee costs projected for 2017 by Milliman Medical Index. Health care cost projections vary. The Henry J. Kaiser Family Foundation shows a national average employer cost per employee of $13,049 for CY 2017 and an employee premium contribution of $5,714. Other national data shown is from Milliman and the Mercer National Survey of Employer-Sponsored Health Plans. State data is total program expense.



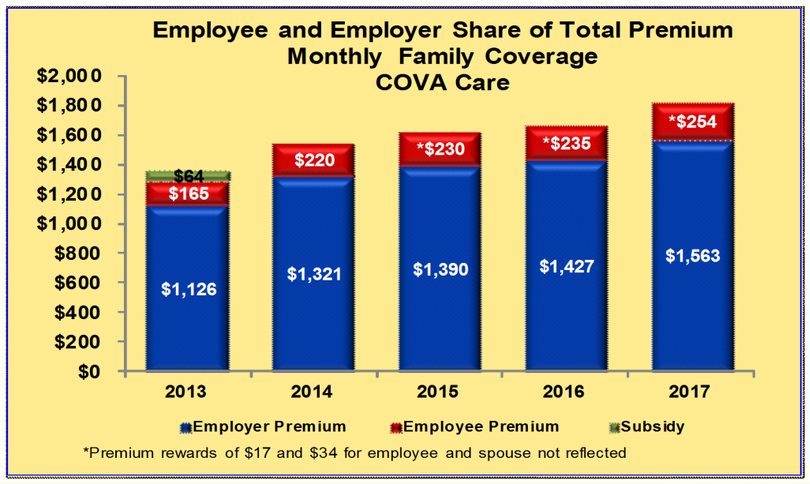
Cost of Health Coverage

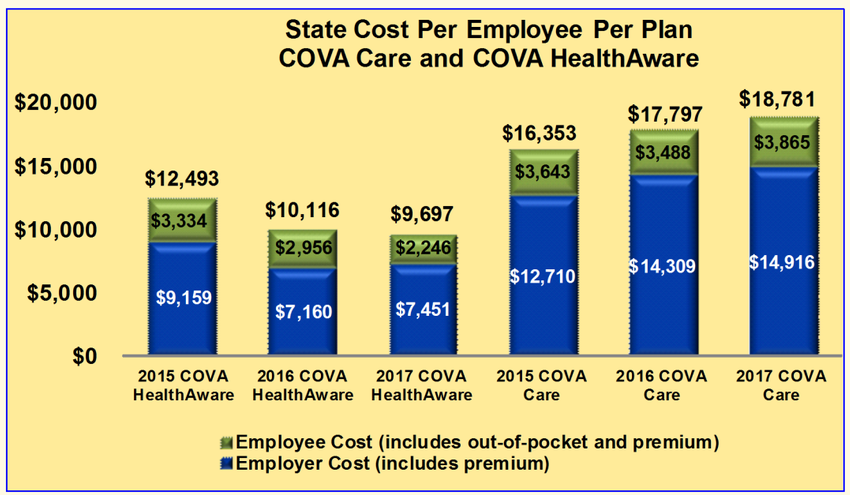
The Milliman Medical Index projects that the national average cost per employee for all employers providing health coverage will rise to $15,259 for calendar year 2017. As in previous years, the state health benefits program's annual expenses were lower than the national average in 2017. State expenses were 4.3 percent less than the projected national average. Claims costs were up 1.4 percent, administrative costs rose 3.2 percent and total program cost increased 1.4 percent. The lower trend in claims cost was driven in part by lower expense for COVA HealthAware members. While plan costs have risen, employee costs have remained significantly lower than the national average.

Total state employer cost per employee in fiscal year 2017 was $14,608. The COVA Care plan's employer cost per employee was $14,916, or 4.2 percent higher than in 2016, while COVA HealthAware's employer cost per employee in 2017 was $7,451, or 4.1 percent higher than the year before.

COVA HealthAware's cost per employee for out-of-pocket expenses and premium was $2,246, representing 23 percent of total cost, while COVA Care's cost per employee was $3,865, or a 21 percent cost share. When looking at only deductibles, copayments and coinsurance, the employee cost share drops to 7.9 percent for COVA Care and 10.8 percent for COVA HealthAware.

Higher behavioral health, pharmacy and physician costs were significant factors in the overall increase for 2017. Overall the plans' share of total costs continued to grow. The employer share will continue to increase each year if the COVA Care out-of-pocket expense limit is not adjusted to mirror ACA changes. The employee share for COVA Care increased for the year, while the COVA HealthAware employee share declined over 2016. The COVA Care plan's cost share rose primarily because of medical and behavioral health costs. The plans paid 79 percent of the annual total health benefits cost in 2017, and employees paid about 21 percent. State employee costs have been about a third of the national average since 2013.





STEP 5: KNOW HEALTH TRENDS-Claims

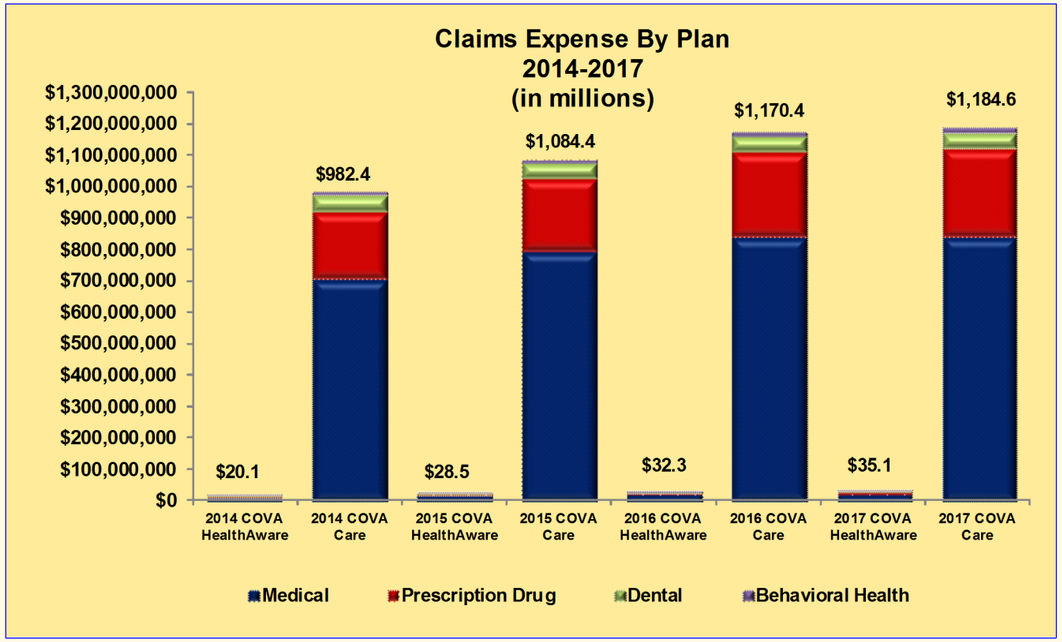
Total Claims Expense

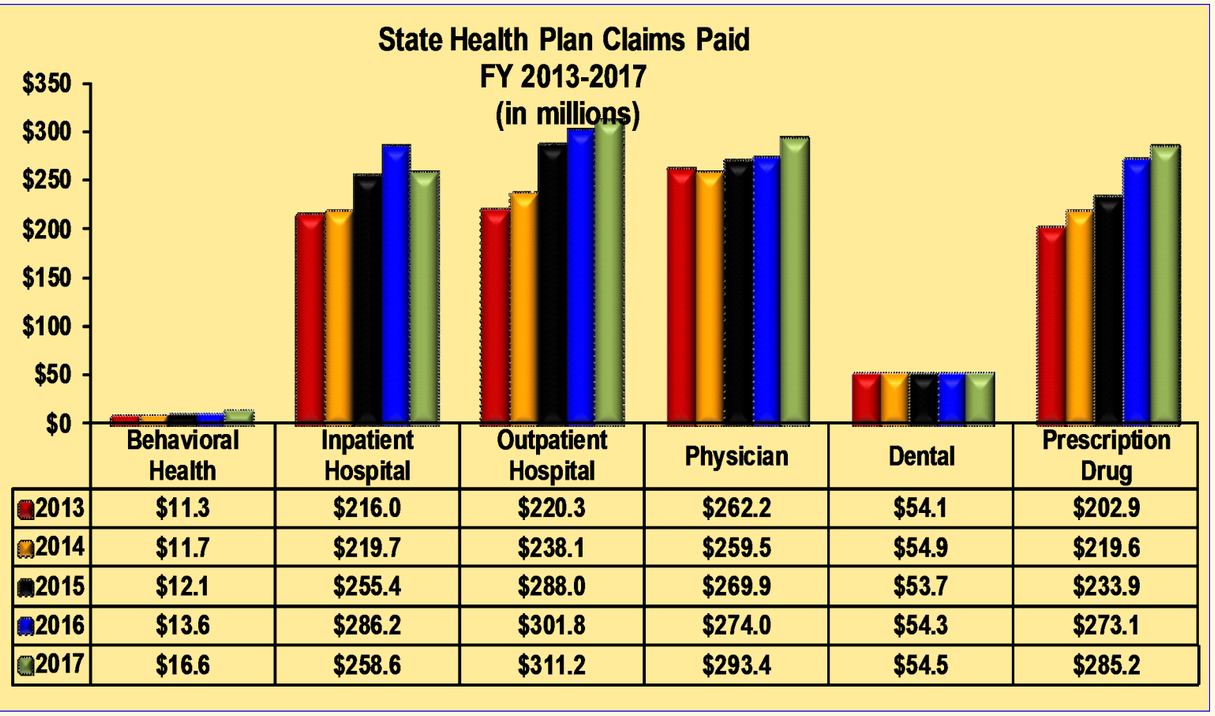
About 7.5 million claims were processed for the self-insured state plans in FY 2017, about 12 percent higher than the 6.7 million claims for the previous year. Total expense increased, due in part to higher behavioral health, physician and prescription drug claims costs. Fifty-nine percent of claims were medical, accounting for 71 percent of total plan claims expense.

Behavioral health had the highest cost increase in 2017, growing 22 percent to $16.6 million from $13.6 million in 2016. The upsurge was due primarily to a rise in claims for substance abuse treatment, which accounted for 13 percent of behavioral health claims expense compared to 5 percent in 2016. Physician expense had the second highest cost increase, 7.4% in 2017 to $293.4 million from $273.1 million the previous year. Prescription drug cost increased 4.4 percent in FY 2017 and over 20 percent in the past two years, with most of the increase attributed to high cost specialty drugs. Outpatient facility expense grew 3.8 percent.

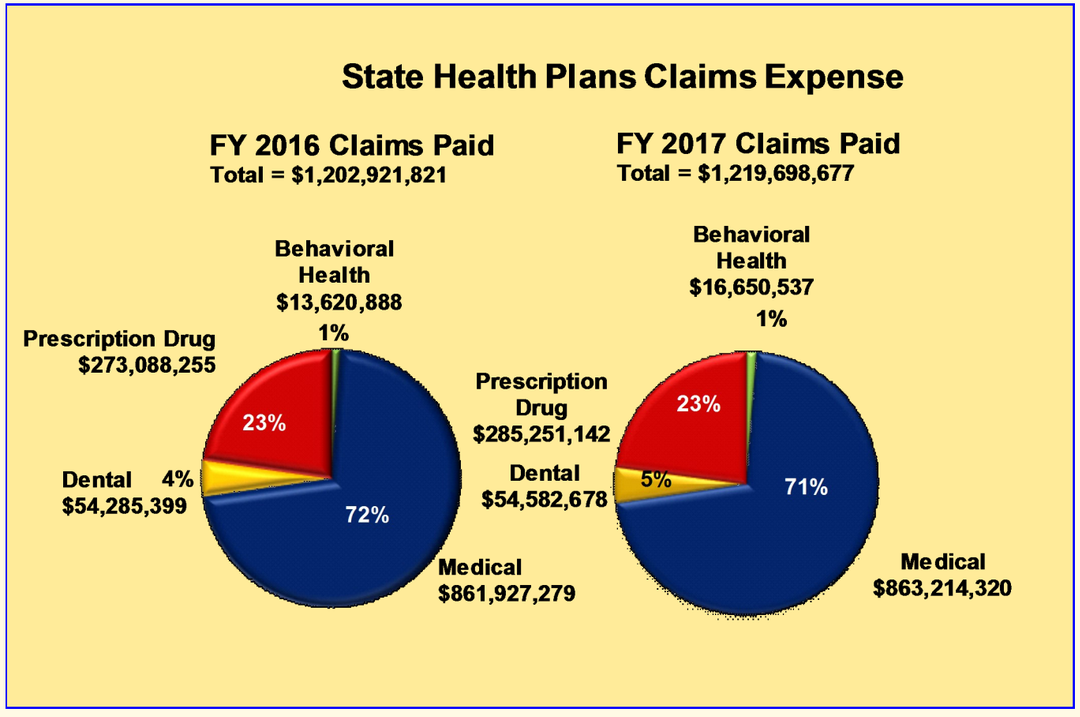
For the COVA Care plan, 7.2 million claims were processed in FY 2017. An average of 178,349 employees, early retirees and family members were eligible for plan services. Medical expenses were 71 percent, prescription drug expenses were 24 percent, dental claims were 4 percent, and behavioral health claims accounted for 1 percent of total claims costs.

For the COVA HealthAware plan, about 269,000 claims were processed in FY 2017. An average of 11,749 employees, early retirees and family members were eligible for plan services during the year. Medical expense represented 75 percent, prescription drugs claims accounted for 15 percent, dental claims were 9 percent, and behavioral health represented 1 percent of total claims expense.





	Behavioral Health	Inpatient Hospital	Outpatient Hospital	Physician	Dental	Prescription Drug
2013	$11.3	$216.0	$220.3	$262.2	$54.1	$202.9
2014	$11.7	$219.7	$238.1	$259.5	$54.9	$219.6
2015	$12.1	$255.4	$288.0	$269.9	$53.7	$233.9
2016	$13.6	$286.2	$301.8	$274.0	$54.3	$273.1
2017	$16.6	$258.6	$311.2	$293.4	$54.5	$285.2



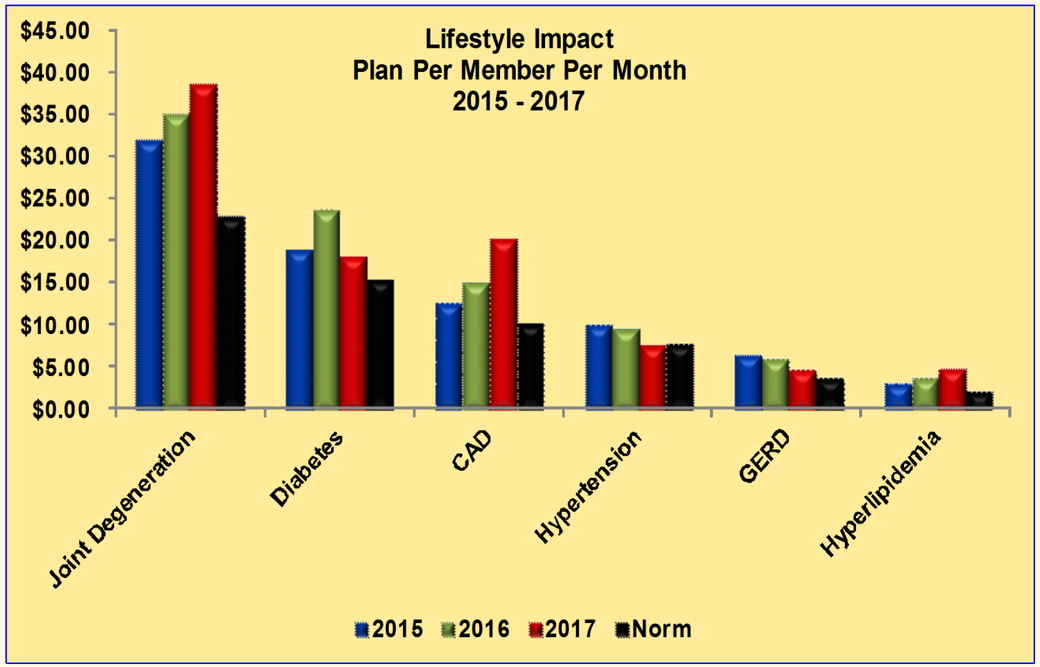
STEP 5: KNOW HEALTH TRENDS-Cost Drivers

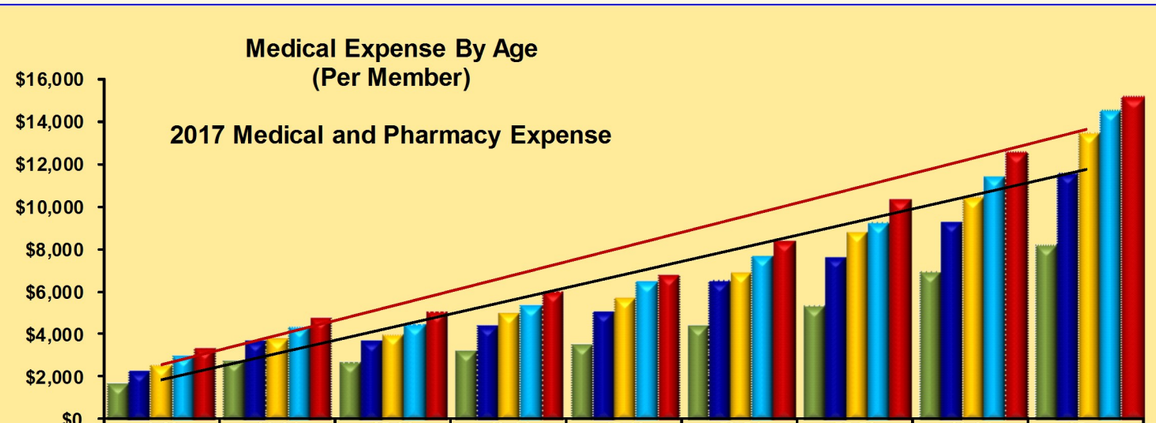
Cost Drivers: Age and Lifestyle

The state's average employee age decreased slightly in FY 2017 from the prior year, to 47.8 from 47.9. Employees in the state workforce enrolled in the health benefits program were older than employees at other Anthem or Aetna clients, whose average age was 44.6. According to the American Medical Association, many diseases correlate with an aging population. As people age, they are more likely to develop chronic conditions such as high cholesterol, high blood pressure, heart disease and diabetes.

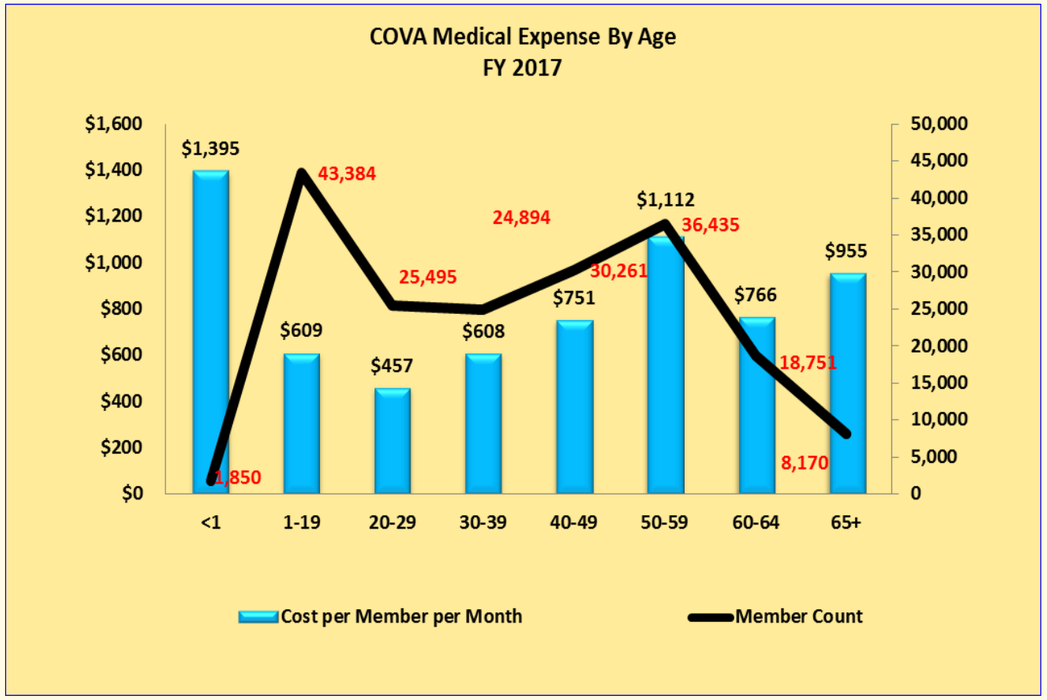
About half of total plan members were over the age of 40, down from the 60 percent in the previous year. Those over the age of 50 represented 33 percent of health plan members in FY 2017, and were responsible for 64 percent of total plan medical expenses. Members ages 50-59 were 19 percent of membership and accounted for 26 percent of plan medical expenses in 2017. Employees in COVA HealthAware had an average age of 39.6, or 8.8 years younger than those in COVA Care, and 2.5 years younger than other Aetna clients. In addition, their health care expenses were less.

According to the National Institutes of Health, more than two-thirds of American adults and one in three children are over weight or obese. In the state population, that rate from biometric screening data is 67 percent, down from 74 percent in 2016. The program is addressing weight issues by offering programs and outreach on healthy lifestyles, including resources to address chronic conditions. Six conditions shown in the chart at the top right correlate with being overweight, and represented $215.2 million or 18 percent of the state plan's total medical and pharmacy expense in 2017. Of the six conditions, coronary artery disease and joint degeneration accounted for 62 percent of claims expense. Diabetes represented 19 percent of claims cost for those conditions, down from 25 percent in 2016.





	0-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
2013	$1,751	$2,811	$2,808	$3,290	$3,623	$4,505	$5,393	$6,969	$8,222
2014	$2,394	$3,776	$3,785	$4,486	$5,112	$6,576	$7,657	$9,324	$11,584
2015	$2,669	$3,884	$4,101	$5,089	$5,815	$6,974	$8,875	$10,479	$13,465
2016	$3,053	$4,456	$4,524	$5,424	$6,557	$7,745	$9,262	$11,454	$14,547
2017	$3,414	$4,828	$5,122	$6,065	$6,878	$8,452	$10,389	$12,578	$15,154



STEP 5: KNOW HEALTH TRENDS-Top Ten

The Health Plan "Top Ten" Claims

Expensive procedures, treatment of chronic conditions and the cost of prescription drug therapy continue to have a major impact on the state program. Other significant cost drivers relate to employee lifestyle, including: smoking, level of physical activity and weight. Another factor is the average state employee age, which remains higher than the norm for other employers. Chronic conditions require care over a long period, often lifelong, without a definitive cure. These types of conditions managed through preventive medicine can be avoided, or the effects controlled and limited, through proper, regular preventive care.

Approximately $989 million, or 86 percent, of medical and pharmacy claims expense during FY 2017 came from claims for the top 10 medical procedures, chronic conditions, including those managed through preventive medicine, and prescription drugs. This compares to $846 million, or 74 percent, in FY 2016.

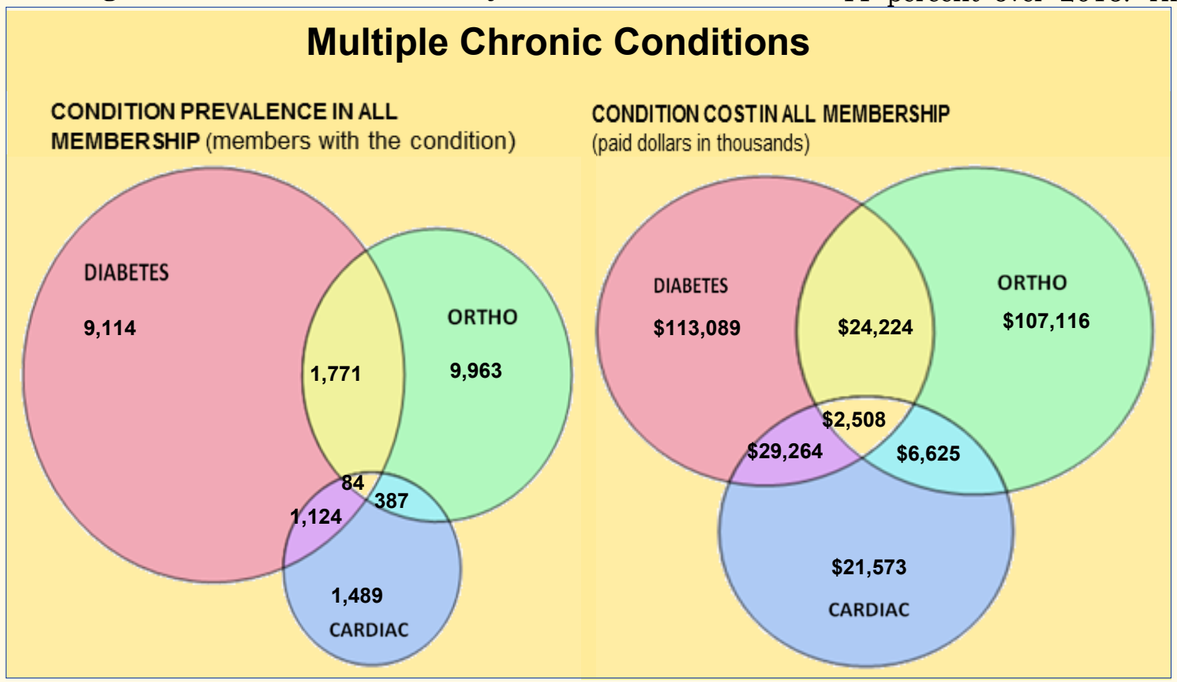
Ranking in the top 10 for 2017 were conditions identified with obesity: diabetes, cardiovascular disease, musculoskeletal and gastrointestinal disorders. Many of these conditions also correlate with heart attack and stroke, like cardiovascular disease, diabetes and lipid disorders. The two top prescription drugs were *Humira Pen* and *Enbrel*, used to treat rheumatoid arthritis. While the top 10 drugs represented 2 percent of prescriptions, they were 19 percent of total pharmacy expense.

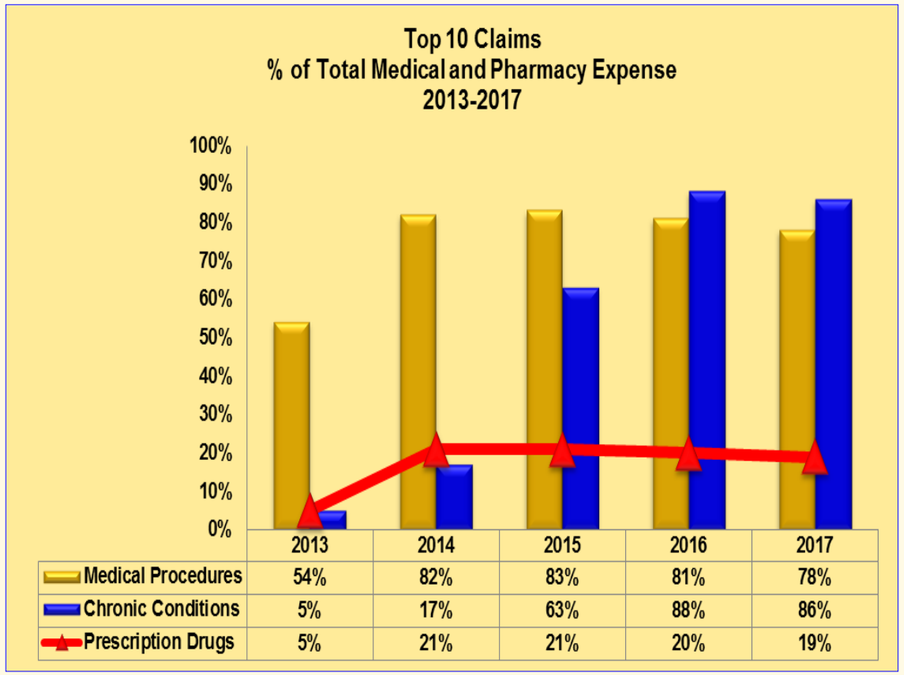
Many of the chronic conditions occurring among state employees are related to lifestyle. Smoking and overeating contribute to diabetes, heart disease, arthritis and other musculoskeletal issues. Treatment for diabetes, cardiac and orthopedic conditions cost the state program $251.8 million in 2017, compared to almost $223 million in 2016. About 13 percent of members were treated for endocrinology, cardiology and orthopedics, which cost $304.4 million in 2017, an increase of 11 percent over 2016. These members represented 37 percent of total plan claims.

Of the members treated for multiple chronic conditions, 50 percent received diabetic services in 2017, down three percent from 2016. The state program continues its diabetes management value based insurance design (VBID) initiative with participation incentives to help diabetics better manage their health. In 2017, state program participants had a better compliance rate than similar ActiveHealth programs in three of five diabetes metrics. They also improved in all five metrics compared to the AHM book of business.

"Top Ten" Claims Expense

Medical Procedures	Chronic Uncontrolled Conditions	Chronic Controlled Conditions	Prescription Drugs
1. Unclassified causes and preventive-related	1. Unclassified causes and preventive-related	1. Osteoarthritis (except low back)	1. *Humira Pen*- rheumatoid arthritis
2. Musculoskeletal	2. Musculoskeletal	2. Coronary Artery Disease	2. *Enbrel* - rheumatoid arthritis
3. Oncology	3. Oncology	3. Low Back Problems	3. *Harvoni*- hepatitis C
4. Cardiovascular	4. Cardiovascular	4. Breast Cancer	4. *Tecfidera* – multiple sclerosis
5. Gastrointestinal	5. Gastrointestinal	5. Chronic kidney disease	5. *Victoza 3-Pak* - diabetes
6. Obstetrics	6. Diabetes, Obesity & Lipid Disorders	6. Diabetes	6. *Lantus solostar* - diabetes
7. Diabetes, Obesity & Lipid Disorders	7. Neurology	7. Gallbladder disease	7. *Januvia* - diabetes
8. Neurology	8. Behavioral Health	8. Colon cancer	8. *Metformin HCL ER* - diabetes
9. Behavioral Health	9. Pulmonary	9. Prostate cancer	9. *Stelara* - psoriasis
10. Pulmonary	10. Dermatology	10. Renal stones	10. *Gilenya*—multiple sclerosis



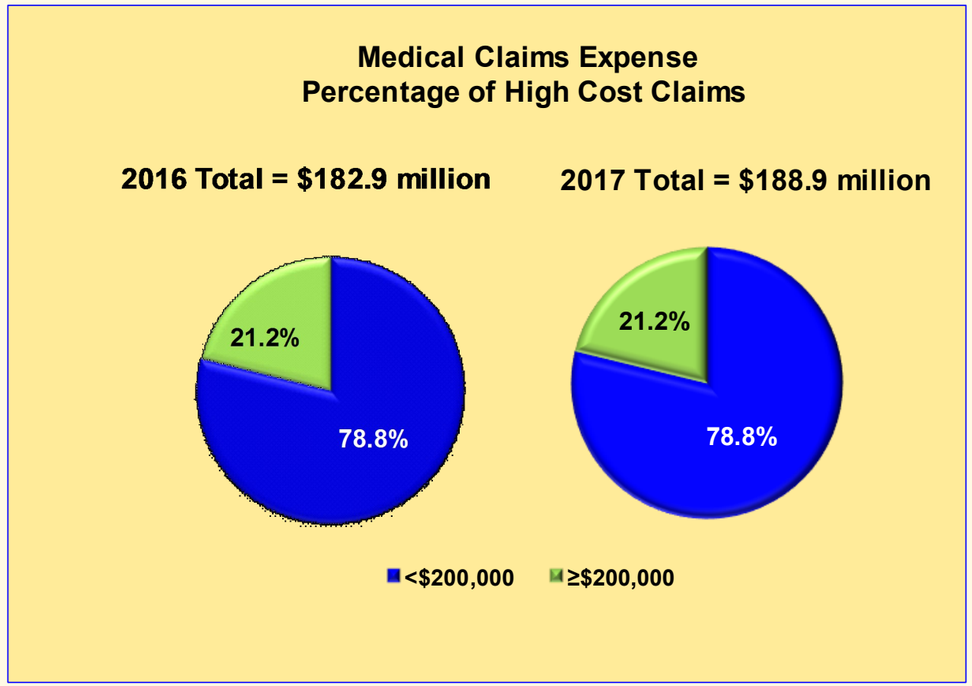


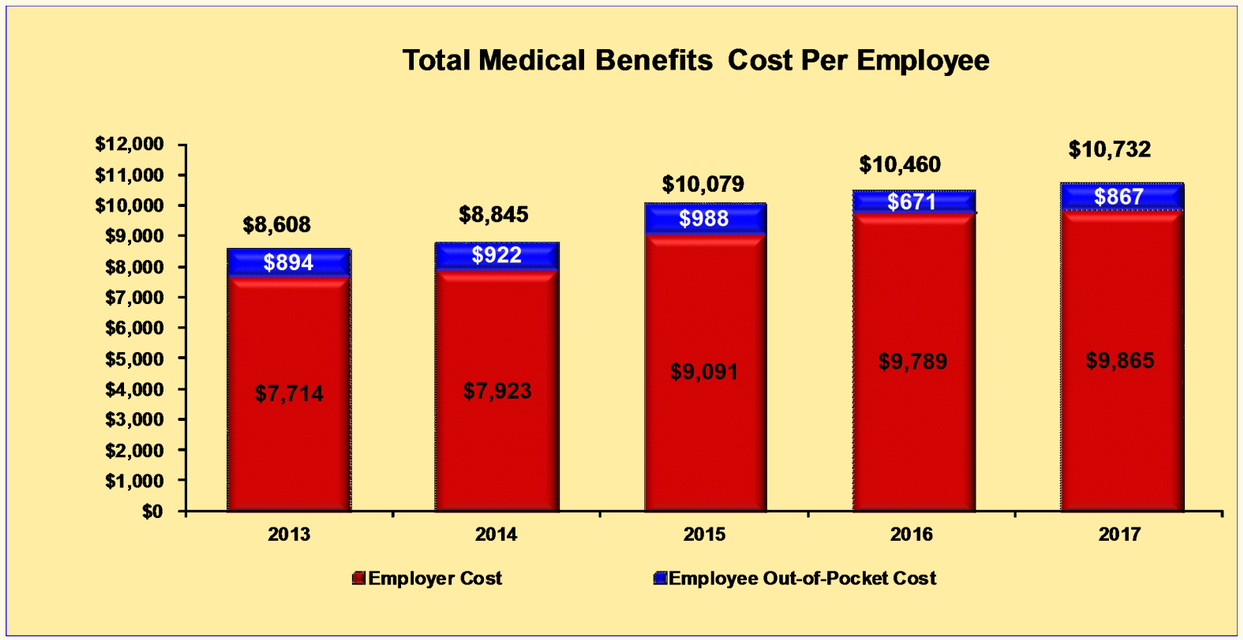
STEP 5: KNOW HEALTH TRENDS-Medical

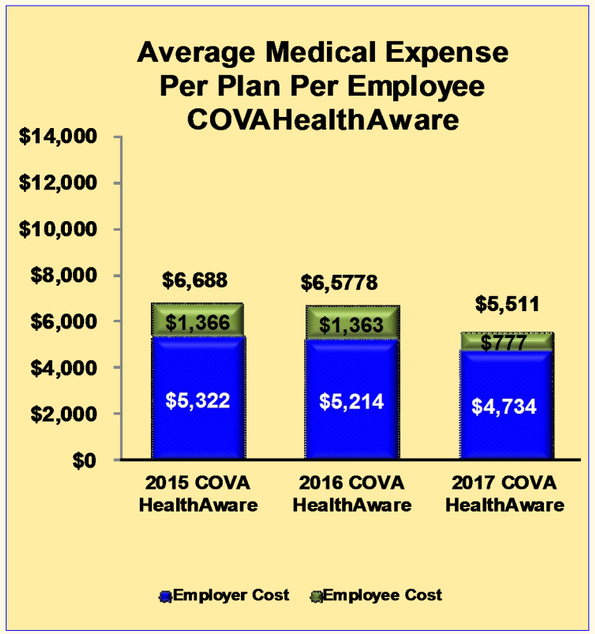
Medical Benefits Expense

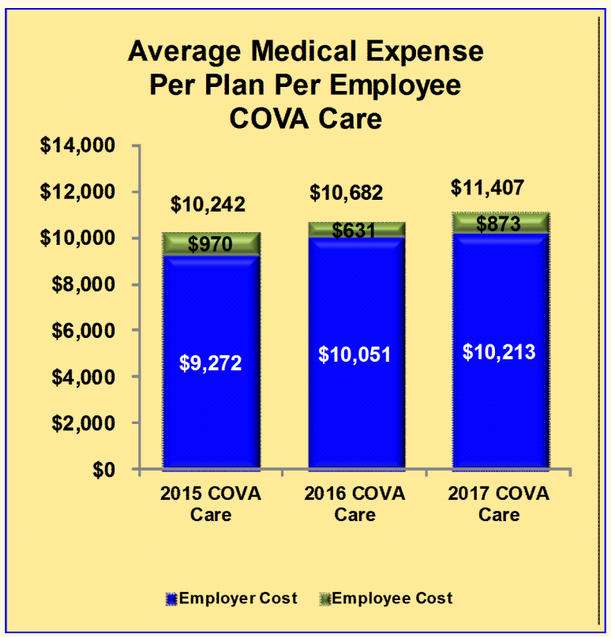
Total medical inpatient and outpatient facility and physician costs increased less than 1 percent in 2017, to $863.2 million from $861.9 million in 2016. The largest components of medical costs were physician and outpatient claims. While physician costs rose 7.1 percent, and outpatient facility costs were up 3.1 percent, overall inpatient facility expense was down 9.7 percent.

There were 516 catastrophic claims in 2017, coming from 0.3 percent of members yet representing 21 percent of total medical expense. Claims of more than $1 million were driven primarily by treatment for cancer, heart disease, gastrointestinal conditions and premature infants. Catastrophic claims expense totaled $188.9 million in 2017 for those claims $200,000 or more, up 3.3 percent over the $182.9 million cost in 2016. More than 200 catastrophic claims of $300,000 or more accounted for $98 million in COVA Care claims expense. About 50 percent of these catastrophic claims were from employees, and 46 percent of employees drove 45.1 percent of medical expense.







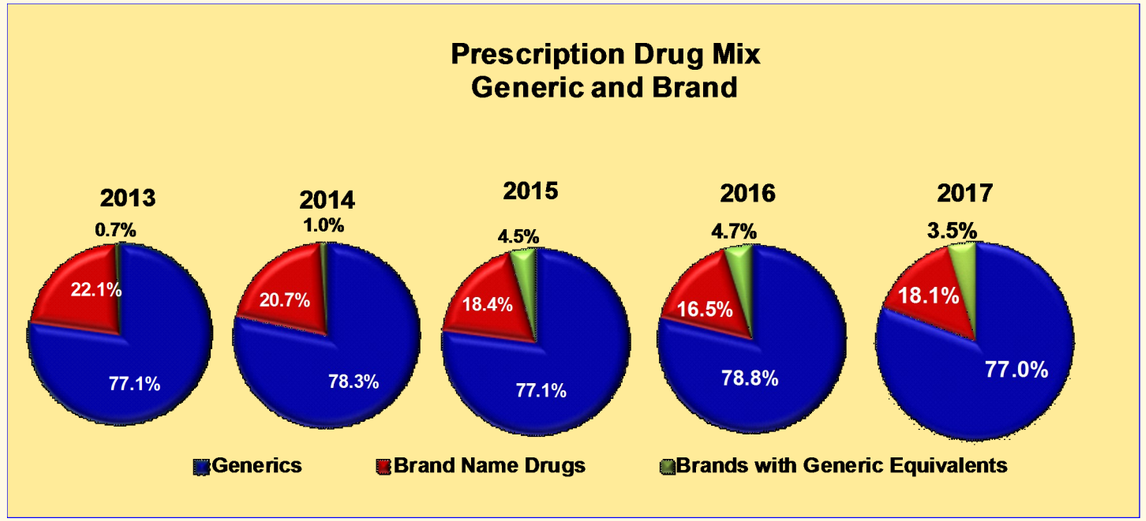


STEP 5: KNOW HEALTH TRENDS– Prescription Drugs

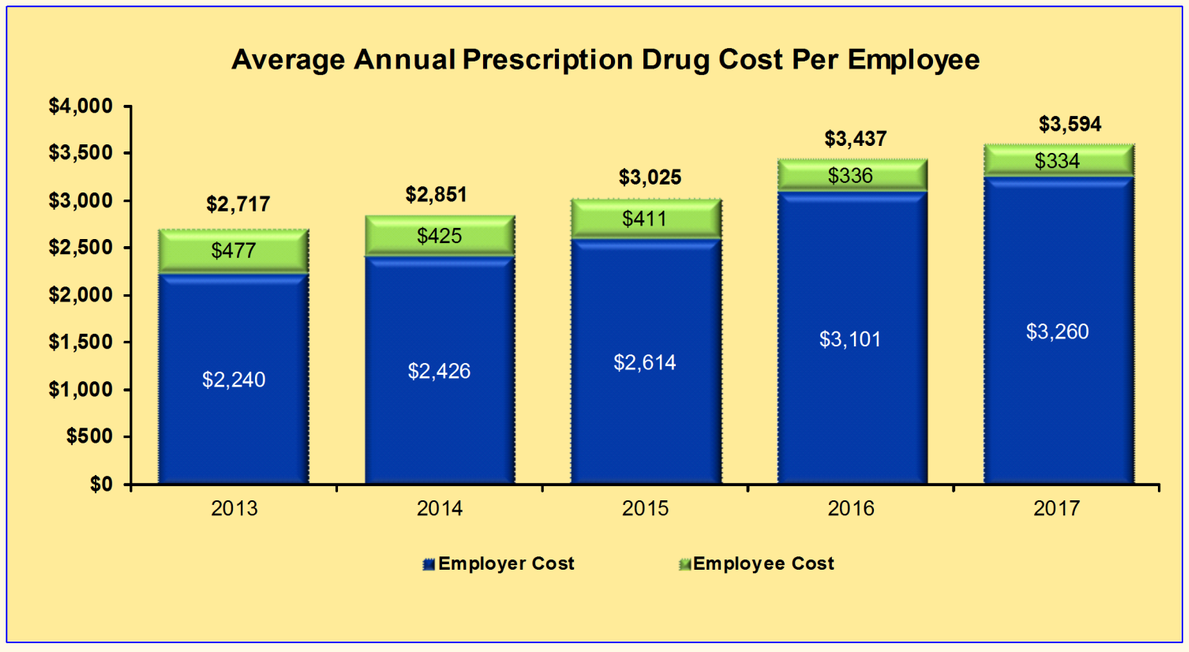
Prescription Drug Costs

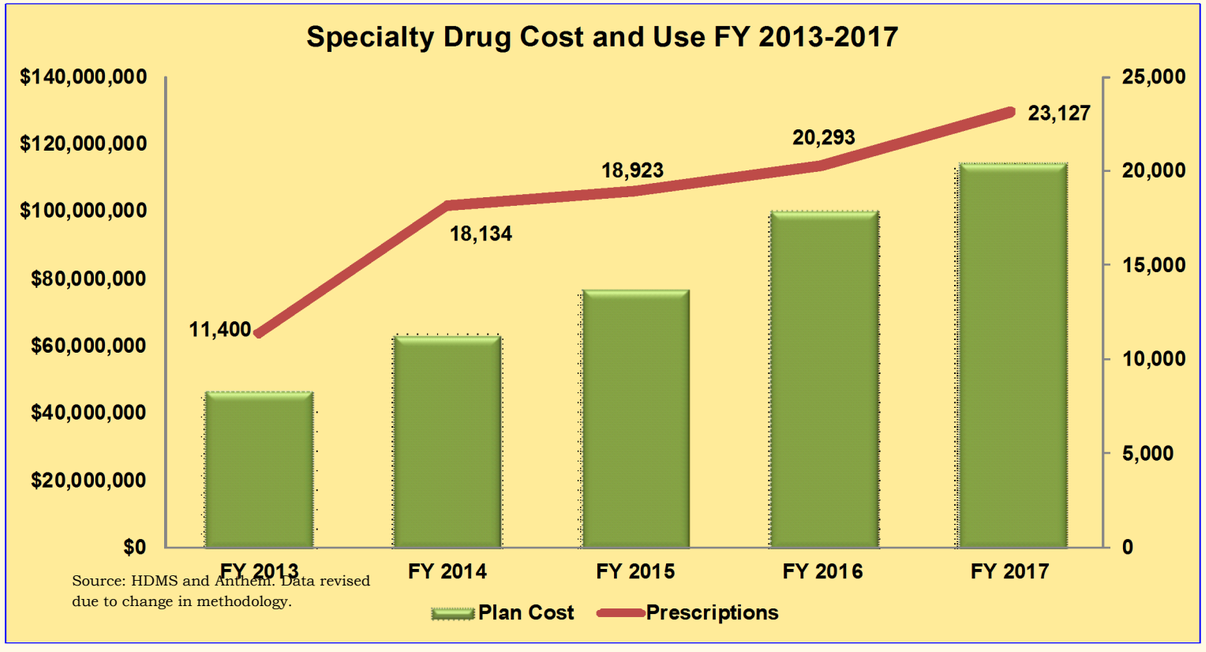
The demand for high cost specialty drugs continues to grow along with their impact on the state program. Specialty drug costs are about two–and-a-half times what they were in FY 2013, and the number of specialty prescriptions is two times more than four years ago. Specialty prescription drug costs were up 14.2 percent in FY 2017, to $114.4 million from $100.1 million the prior year. More than 23,000 specialty prescriptions were filled by state plan members during the 2017 plan year, representing 1 percent of total prescriptions and 40 percent of drug cost during 2017.

Total prescription drug costs for the state program were up 4.4 percent in 2017, to $285.2 million from $273.1 million in 2016. Inflation remained a major driver of overall pharmacy trend. Significant factors in inflation were manufacturer price increases as brand drugs approached patent expiration, higher costs for generic drugs, and cost increases for newer specialty medications. Another reason for high drug expense is the cost of bringing a new drug to the market, estimated by the Tufts Center for the Study of Drug Development (CSDD) at $2.6 billion. The use of generic drugs is mandatory for members, and they pay more for a brand name drug if there is a generic equivalent. Members are encouraged to use lower cost retail pharmacies or mail order, and reduce unnecessary prescriptions. Factors also helping the plan control expenses include prior authorization and step therapy.



The generic drug portion of the prescription drug mix dropped slightly to 77 percent in 2017 from 78.8 percent in 2016. Drug patents continued to expire on many highly utilized brand name drugs. The state paid $51.2 million in 2017 for generic drugs, representing 18 percent of drug costs, and $230.0 million for brand name drugs and brands with generic equivalents, reflecting 81 percent of drug cost. This compares to a total cost of $2.3 billion for generics (24 percent) and $7.1 billion for brands (76 percent) by other Anthem plans in Virginia. Even though the total annual prescription drug cost per state employee increased in 2017, members' share of total costs fell slightly to 9.3 percent, or $334 per employee, from 9.8 percent or $336 per employee, the previous year. COVA Care's prescription drug expense per employee was about three times more than the comparable expense for COVA HealthAware, which has a significantly younger population. The cost increase was driven by treatment for rheumatoid arthritis, hepatitis C, diabetes, multiple sclerosis, and psoriasis.





Source: HDMS and Anthem. Data revised due to change in methodology.

STEP 5: KNOW HEALTH TRENDS-Dental

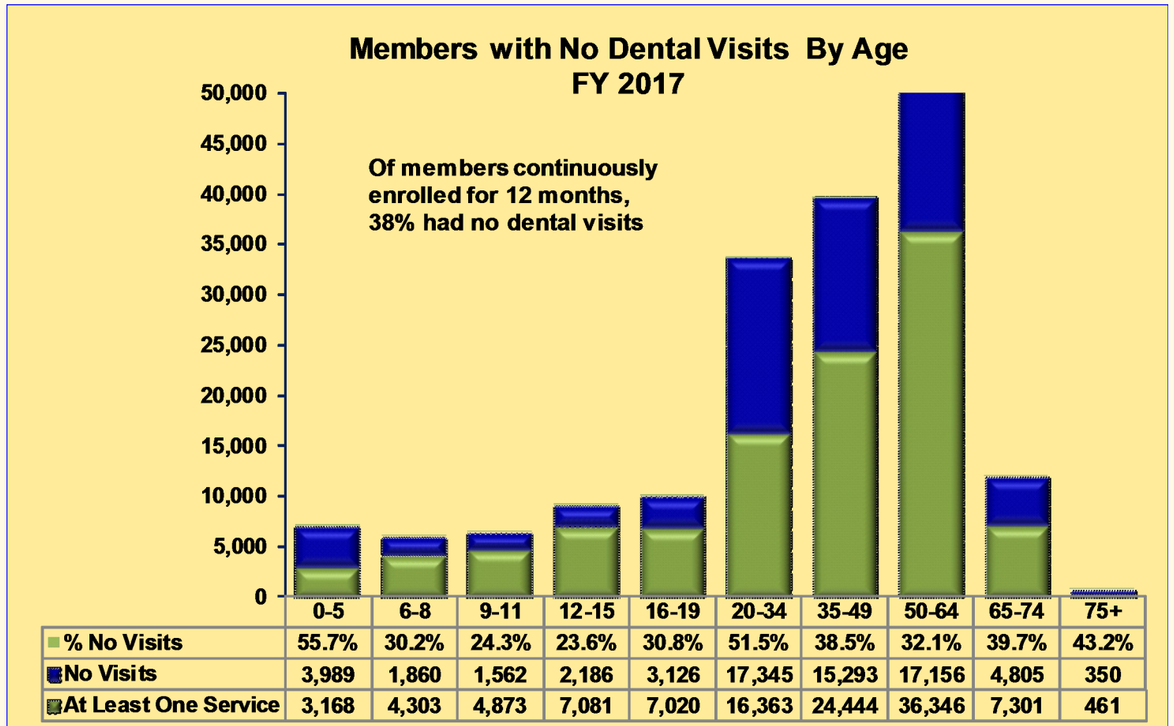
Dental Care and Expense

The state's dental costs were $624 per employee in 2017, or about 9 percent lower than the national average for employers of $688 per employee. The employee share of total dental cost increased by 3.8 percent in FY 2017, due primarily to a change in the mix of services and more enrollment in the Expanded Dental option. Approximately 343,000 dental claims were processed in 2016, compared to 348,000 the prior year. Dental benefits represented only 5 percent of total claims expense. Dental claim costs for the state program were up 0.5 percent in 2017, to $54.6 million from $54.3 million the previous year. Diagnostic and preventive services, which are paid 100 percent by the plan, accounted for 51 percent of claims expense for both 2016 and 2017. A change in the dental benefits structure in FY 2014 to comply with Affordable Care Act (ACA) provisions moved some services previously covered at 100 percent to the Expanded Dental program with a deductible and coinsurance paid by the member.

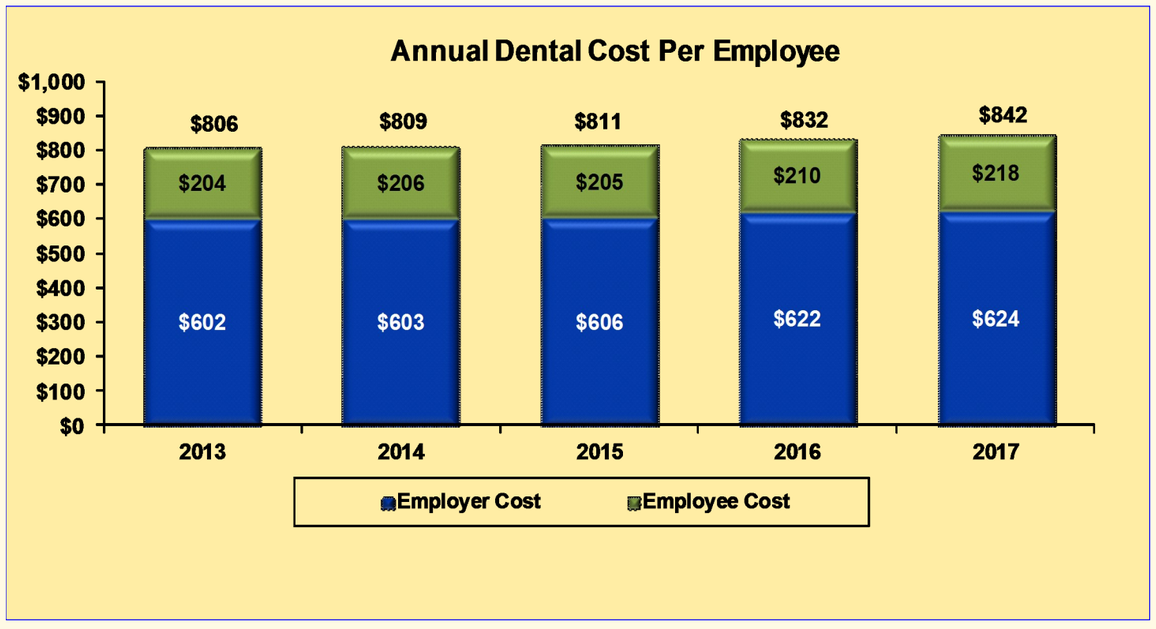
About 26 percent of members have not had a dental visit for two years in a row. Overall member oral health in 2017 ranged from 37 percent in the healthy category with preventive care only, 15% moderate with preventive care and treatment, and 10 percent serious with emergency or extensive dental care only.

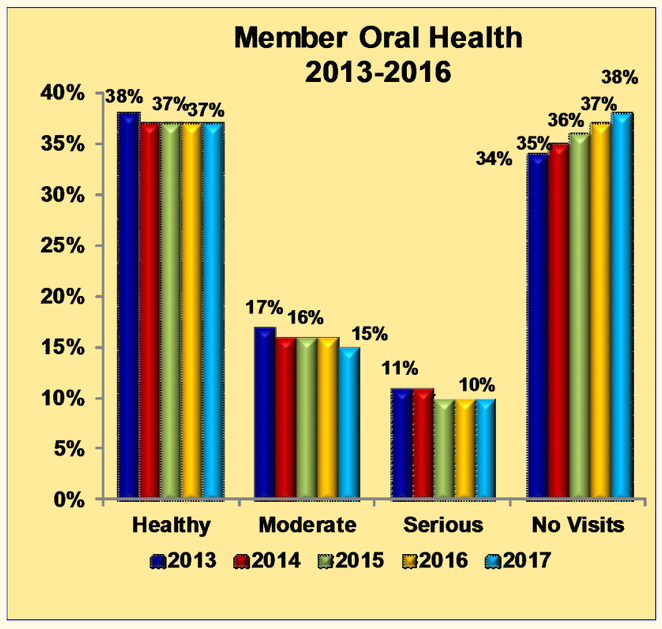
These categories are based on members' utilization of preventive, restorative and periodontal services, as well as no visits, for each 12-month reporting period.

Regular dental check-ups prevent major dental problems and reduce overall dental expense. Prevention reduces the cost by $436 annually for each member who has at least one oral exam each year. About 38 percent of plan members are not visiting the dentist at all, an increase of 1 percent over the year before, and 27 percent worse than other government groups. Regular dental care is important because gum disease is linked to a number of medical conditions, including diabetes, heart disease, and lung cancer.



	0-5	6-8	9-11	12-15	16-19	20-34	35-49	50-64	65-74	75+
% No Visits	55.7%	30.2%	24.3%	23.6%	30.8%	51.5%	38.5%	32.1%	39.7%	43.2%
No Visits	3,989	1,860	1,562	2,186	3,126	17,345	15,293	17,156	4,805	350
At Least One Service	3,168	4,303	4,873	7,081	7,020	16,363	24,444	36,346	7,301	461





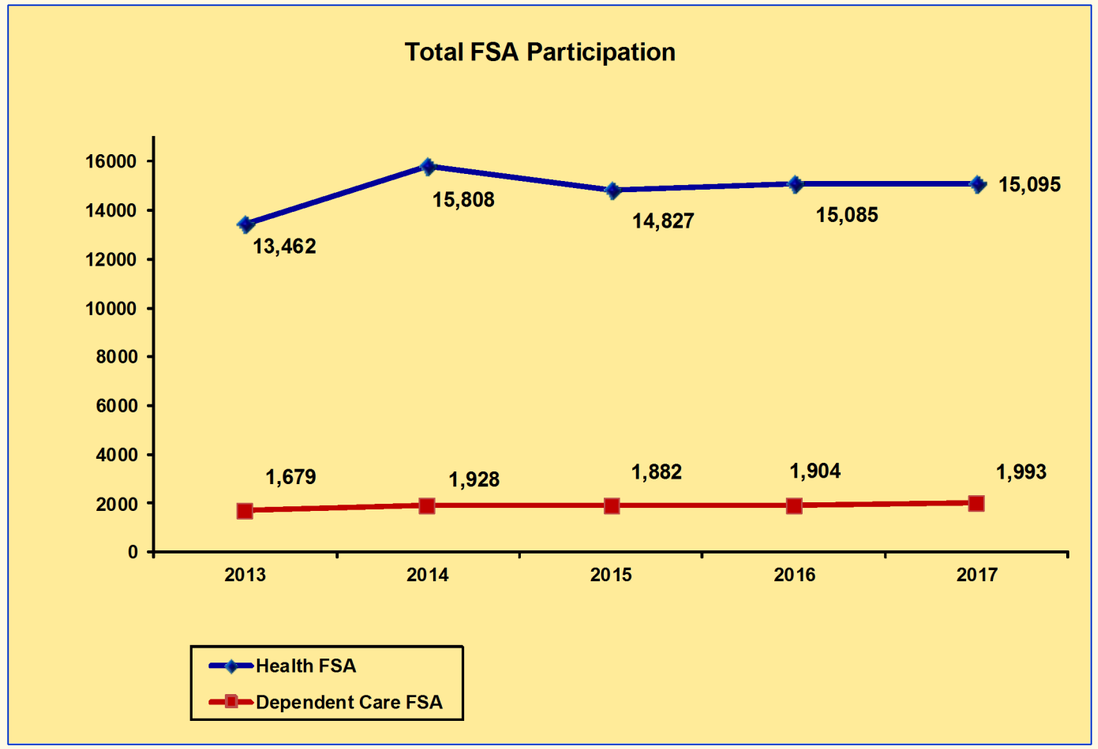
STEP 5: KNOW HEALTH TRENDS—Flexible Spending Accounts

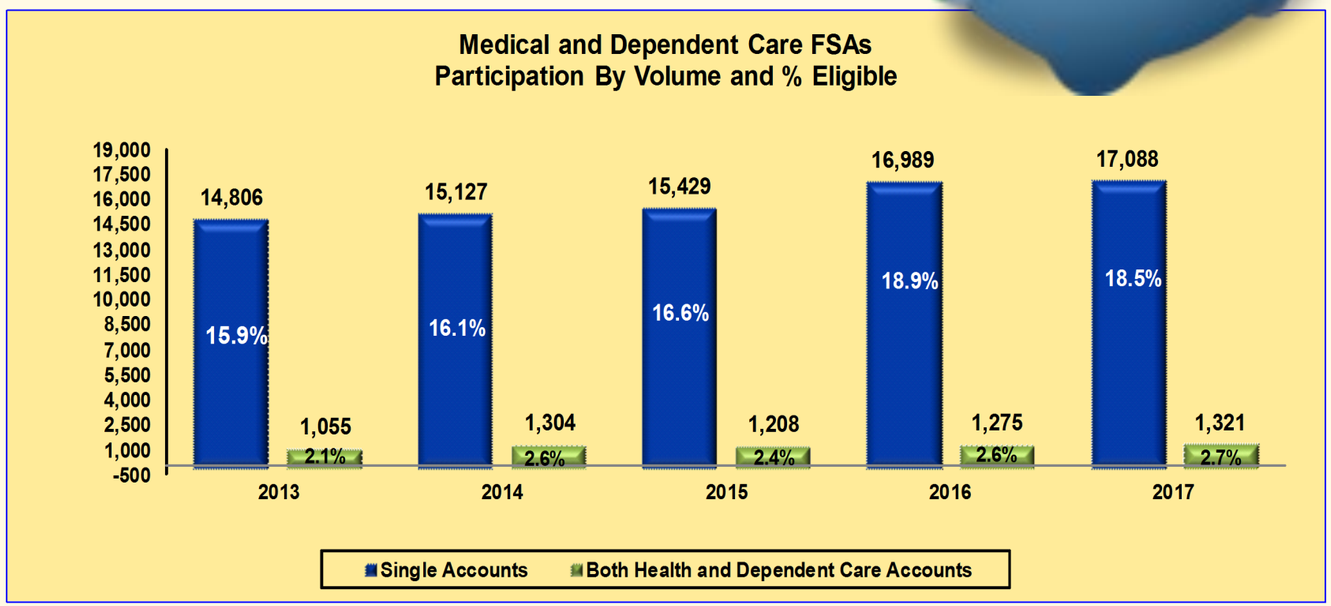
Flexible Spending Accounts (FSAs)

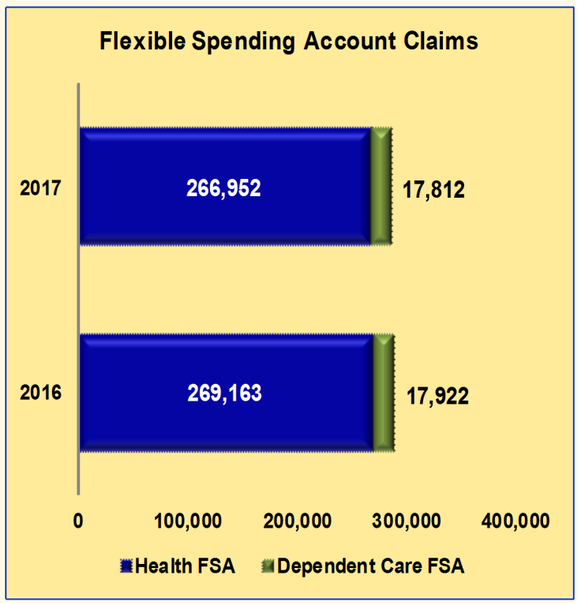
Flexible spending accounts (FSAs) allow employees to set aside part of their income before taxes to pay for certain health or day care expenses not covered by the plan. In FY 2017, employees could contribute up to $2,550 each year to a Health FSA, and up to $5,000 to a Dependent Care FSA depending on their tax status. Employees showed more interest in Dependent Care FSAs during 2017, while Health FSA participation remained stable.

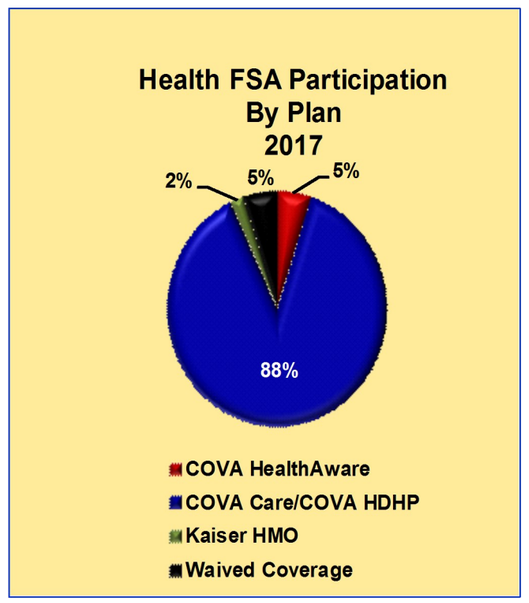
Health FSAs increased in 2017 to 15,095, up less than 1 percent from 15,085 the prior year, with contributions of $26.7 million. Dependent Care FSAs increased 4.7 percent, to 1,993 from 1,904 in 2016, with $7.2 million in contributions. The increase in Dependent Care FSAs is due primarily to changing employee demographics. Younger employees are being hired who may have children meeting the under 13 years of age participation requirement.

In 2017, 21 percent of employees enrolled in state health plans participated in FSAs. Employees who waive health coverage remain eligible for an FSA, and 5 percent of employees in that category had a Health FSA account. A stored value card, similar to a debit card, remained popular for Health FSAs to pay for eligible health care expenses at the point of service. Of total FSA claims, the Health FSA represented 94 percent, and the Dependent Care FSA 6 percent.









STEP 6: TRANSFORM—VBID PROGRAMS

Opportunity

- Engage 5 percent more plan members with diabetes, hypertension, and asthma/chronic obstructive pulmonary disease (COPD) in value-based insurance design (VBID) programs for improved health and lower plan costs.

Milestones

- 3,896, or 24 percent, of 16,289 eligible members were engaged in the diabetes VBID program after three years.
- The average number of conditions for diabetes VBID participants has dropped to 2.9 from 4.8 the first year, to 2.9 from 3.1 for hypertension VBID participants, and remained stable at 3.6 conditions for asthma/COPD participants.
- Diabetes VBID members are more effectively managing their glucose, with 90 percent taking medications on schedule, higher than non-VBID members.
- Hypertension and asthma/COPD VBID members performed better on 2 of 3 metrics than the ActiveHealth Management (AHM) baseline in the second year.
- Annual cost reductions for VBID participants are estimated at $487 per person for diabetics and hypertensives, $1,690 for asthmatics, and $2,038 for multiple conditions.

Value-Based Insurance Design (VBID)

Introduction of the total population health initiative has brought new options to encourage employees and their families to take a more proactive role in their own health. State plan members were offered three VBID programs in FY 2017: diabetes management, hypertension and asthma/(COPD).

The premise of these programs is to improve health and lower costs by removing any financial barriers to better compliance with medications and treatment. Participants receive certain free medications and supplies for meeting certain compliance requirements. A total of 7,752 unique members were engaged in these programs for the second and third years.

The diabetes management program is showing improved health outcomes for participants. Year 3 saw 687 new program engagements, resulting in a total of 3,896 engaged. Diabetes participants performed better in four out of five outcomes metrics in Year 3 compared to the non-participants. Participants also performed better in Year 3 than Year 2 on five of five metrics. They outperformed the AHM book of business across all measures as well as year over year. The measures were a foot exam, HbA1C less than 7, HbA1C monitoring, LDL cholesterol monitoring, and nephropathy screening.

Most significant is that diabetes VBID members have a 90 percent adherence rate compared to 84 percent for non-VBID members. About 98 percent had an AbA1c claim in the third year compared to 92 percent in year one, and 61 percent had a wellness check-up with a doctor the third year compared to 45 percent the first year.

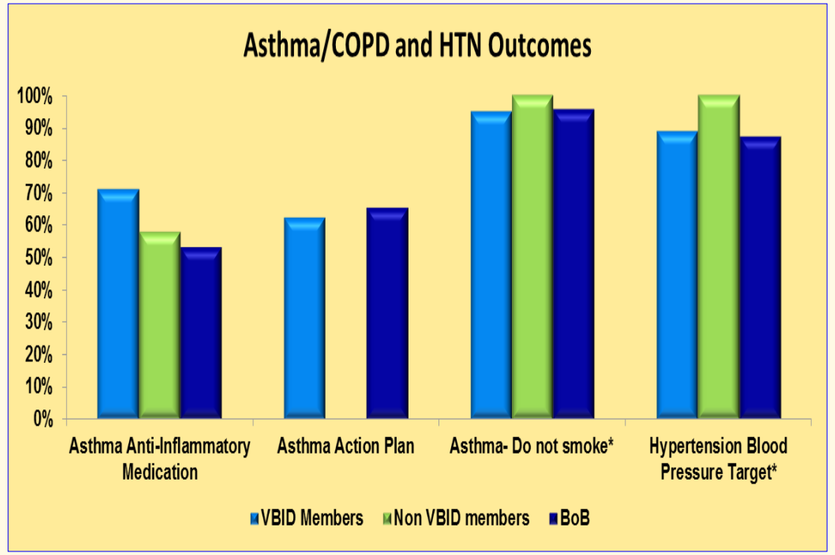
In 2017, there were 16,000 members in the state population with diabetes. About a quarter of members with validated biometrics were pre-diabetic. This compares with about 34 percent of pre-diabetic adults ages 18 and over in the U.S. population.

The Commonwealth is also addressing the almost 44,000 members with hypertension and the 16,500 with asthma or COPD. The hypertension and asthma/COPD programs are outperforming similar AHM programs. Of the almost 44,000 members with hypertension, 5,219, or 11.9 percent, are engaged in the hypertension VBID program. Of those engaged, 88 percent had a blood pressure claim and 77percent had a wellness exam, requirements for the program.

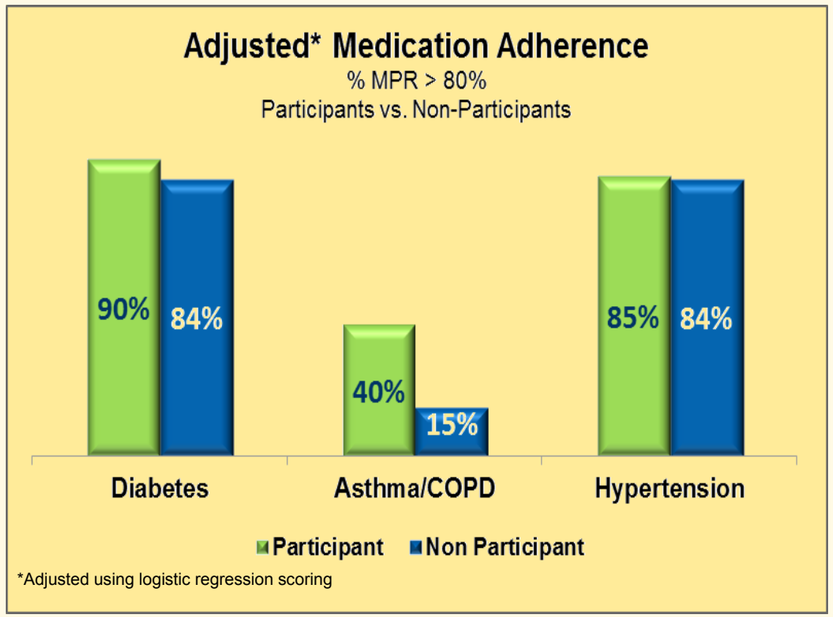
Data for the 1,437 members engaged in the asthma/COPD program, or 8.6 percent of those with these conditions, shows that

VBID Program Outcomes

Measures	Diabetes Year 3	Hypertension Year 2	Asthma/ COPD Year 2
Total eligible	16,289	43,738	16,571
Total engaged	3,896/24.0%	5,219/11.9%	1,437/8.6%
Average # of conditions	2.9	2.9	3.6
Dropped Out	221/5.6%	298/5.6%	91/6.2%
Wellness check-up	2,390/61%	4,029/77%	981/68%
HbA1c claim	3,824/98%	N/A	N/A



68 percent had a wellness check-up and 72 percent had a flu shot. The hypertension VBID performed better than the AHM book of business on target blood pressure, and asthma/COPD VBID members performed better on two of three metrics compared to the AHM baseline for year two: anti-inflammatory medication and asthma action plan.



STEP 6: TRANSFORM—Bariatric Surgery

Opportunities

- Offer education and coaching to help members who are morbidly obese and choose bariatric surgery improve their health.
- Continue to offer incentives for participation.

Milestones

- Average weight loss per patient during the bariatric pre-surgery education program was 9.56 pounds.
- 71 percent of enrolled members reported making healthy lifestyle changes.
- 302 individuals have graduated since the program began.
- 37 members who participated in the 12-month post-surgery program in 2017 lost an average of 35.88 pounds.
- Bariatric surgery cases have declined 94 percent, and costs have decreased by $9 million annually since 2009.

Bariatric Surgery Education Program

In 2009, the Commonwealth took a very serious look at health outcomes from members who had undergone bariatric surgery. Many of these members had unsuccessful surgery, and worse, a few members had died from complications. In addition, bariatric surgery and obesity medical expense for the Commonwealth that year totaled $10.6 million, and was on track to reach $12 million in 2010. In response, the state health benefits program launched a bariatric surgery education program.

A total of 1,062 members have participated on a rolling basis since the inception of the program in 2010. The program includes prior medical authorization for the surgery and participation in a disease management program. In addition, weight management, nutritional counseling, and personalized coaching and support services are provided through the ActiveHealth program. If surgery is approved, the program offers continued support after surgery to ensure the best possible health outcomes.

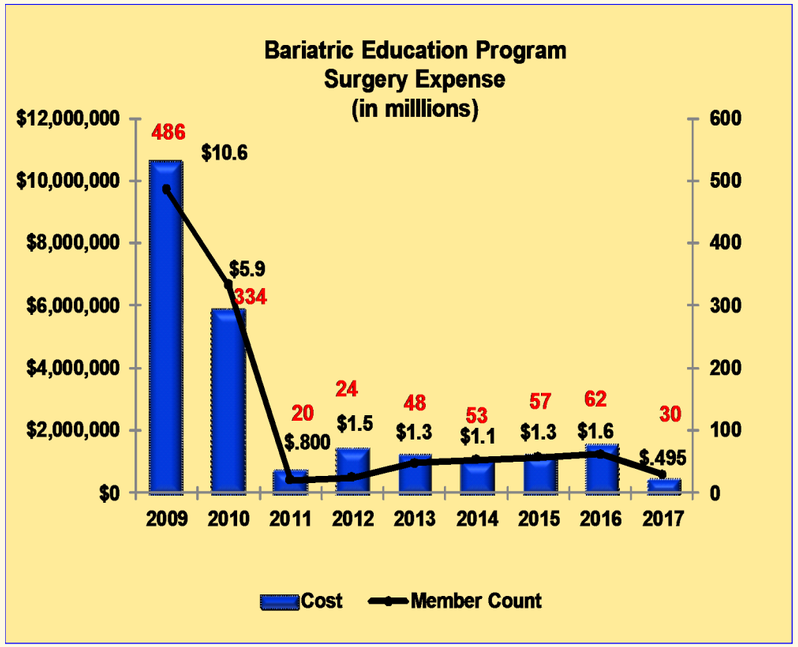
COVA Care members are offered a $300 incentive for inpatient, or a $125 incentive for outpatient surgery, while COVA HealthAware members receive additional Health Reimbursement Account (HRA) funds for completing the program.

Positive outcomes have included weight loss, improved nutrition, better coping skills and increased activity/exercise. Bariatric surgery cases have declined by 94 percent, from 486 in 2009 to 30 in 2017, and overall bariatric surgery claims and other claims cost have dropped from $10.6 million to $495,000.

Since 2014, 667 plan members have enrolled in the education program, and 111 have dropped out. Of the 556 remaining in the program, 399, or 71 percent, reported changes to their lifestyle such as getting more exercise, feeling less depressed and eating healthier foods. On average, each participant lost 9 and 1/2 pounds.

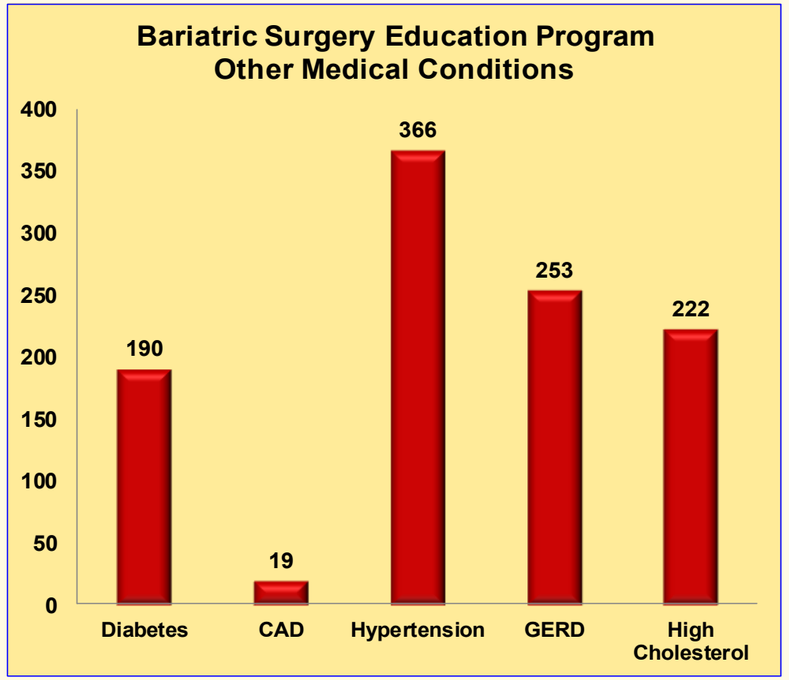
A total of 302 participants have graduated from the program. A total of 246, or 82 percent, did not have surgery. Of those, 134 who had both a first assessment and graduated from the program lost an average of 8.3 pounds per person. The 84 members of the non-surgery group who lost weight and did not gain it back had an average weight loss of 12 pounds.

Of the 37 participants who continued the coaching program for 12 months after surgery, 81 percent indicated that they had made lifestyle changes. At the top of the list was more exercise, followed by feeling less depressed, eating more fruits and vegetables, food portion control and less stress. The average weight loss for this group was 35.88 pounds.



Bariatric Surgery Program Outcomes

Measures	Count	Result
Total enrolled since 2014	667	
Total graduated	302/45%	• No surgery for some • Lifestyle changes
Dropped out	111/17%	
Lifestyle changes	399/71%	• More exercise • Less depressed • Better nutrition • Better portion control • Less stress • Keep food diary
Average weight loss/patient pre-surgery program	-9.56 lbs	
Average weight loss/patient post-surgery program	-35.88 lbs	



STEP 6: TRANSFORM—Maternity Management

Opportunities
- Help at risk expectant mothers deliver healthy babies.
- Offer pregnant health plan members a maternity management program for at risk pregnancies.
- Increase participation 5 percent using the current incentive.

Milestones
- 923 total members were newly enrolled in FY 2017.
- About 10 percent of the 551 babies born to members enrolled in *Healthy Beginnings* in FY 2017 were premature, compared to the March of Dimes statistic of 11 percent statewide.
- The state program had fewer emergency C-sections, multiple births and half the number of stillborn babies than other ActiveHealth programs.

Maternity Management Program

The Commonwealth's innovative maternity management program has for more than a decade helped at risk mothers enrolled in state coverage deliver healthy babies. According to the March of Dimes, the rate of premature births is 10 percent nationally and 11 percent in Virginia overall. Premature births take place more than three weeks before the estimated due date. The Commonwealth's program was in line with the national rate and, at 10 percent, scored lower than the Virginia rate.

In FY 2017, the *Healthy Beginnings* program newly identified 2,280 pregnant members. A total of 923 were newly enrolled, with 884 at high or medium risk of a complicated pregnancy. Of those who enrolled, 71 percent were between the ages of 26 and 35. There was a 96 percent engagement rate among high/medium risk members successfully contacted.

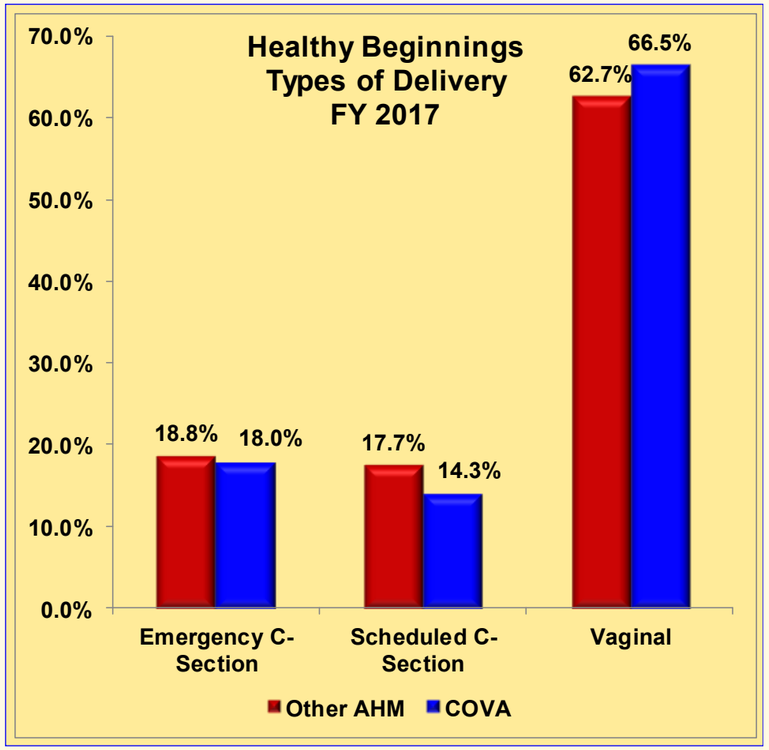
Commonwealth members enrolled in *Healthy Beginnings* had fewer emergency Caesarean sections (C-sections) than members in similar ActiveHealth programs. A total of 108 state members, or 18 percent, had an emergency C-section compared to 423, or 18.8 percent, in other ActiveHealth programs.

Among those 884 members at risk for pregnancy complications, 7.9 percent screened positive for depression and 1.1 percent for hyperemesis, which causes severe nausea, vomiting and weight loss.

The Commonwealth recorded 12 multiple births during FY 2017, compared to 35 for other ActiveHealth programs. It also had half the number of stillborn babies.

While 727 members completed the *Healthy Beginnings* program in FY 2017, the number of births and type of birth are recorded during a post–partum assessment. Some members did not complete the assessment until the 2018 fiscal year, so any resulting births were not shown in the 551 live births recorded for 2017.

For enrolling in the program, COVA Care and COVA HealthAware members can earn a $300 copay waiver or HRA contribution. To qualify, members enroll in the *Healthy Beginnings* program within their first 16 weeks of pregnancy, actively participate in the program and complete a 28 week health assessment. About 94 percent of members enrolled in the program in the first and second trimesters.



Source: Active Health Management

HEALTHY BEGINNINGS		
Outcome of Delivery	Other ActiveHealth Employers	State Employees
Live Birth	2,280	551
Pre Term	196	55
Multiple Live Births	35	12
Stillborn	4	2
Neonatal Death	1	0

Source: Active Health Management

STEP 6: TRANSFORM—Health Care Delivery

Opportunities
- Increase use of the online doctor by 5 percent.
- Increase use of the downtown Richmond pilot health care clinic by 5 percent during the workday.

Milestones
- 150 members, or 48 percent of those who visited the online doctor, avoided unnecessary urgent care.
- 16 members, or 5 percent of those who visited the online doctor, avoided unnecessary emergency room visits.
- Capitol Square Healthcare had 1,354 employee visits in FY 2017, with 985 same day visits.
- Patients rate clinic services as 99.4 percent good or excellent.

New Healthcare Delivery Options

Access to healthcare is extremely important for everyone in today's world, including state health plan members. To address this issue, the state health benefits program has added two new options to the way that members receive physician services. Both online doctor visits and the Capitol Square Healthcare pilot on site for state employees in downtown Richmond continue to provide alternative care options for plan members.

Online technology now allows members to talk to a doctor anytime, anywhere. Members may discuss common health issues right away with a doctor using a smartphone, tablet or computer with a webcam. This service is available to employees and covered family members who are 18 years of age or older. Online visits can be paid with a credit card.

For FY 2017, there were 425 registrations and 315 online doctor visits, up 57 percent from the 182 online doctor visits in 2016. Since inception of the program, there have been more than 900 registrations and 400 visits. The 30-45 age group continues to use the service the most. The 2017 annual utilization rate was less than 1 percent for state plans. Of those who have used the online doctor to date, 208 or 66 percent, accessed care through a mobile phone. In 2017, the online doctor program demonstrated average cost of care savings of an estimated $89,000.

By using this convenient option, 150 members in 2017, or 48 percent, avoided unnecessary urgent care and 16 members or 5 percent, avoided unnecessary emergency room visits.

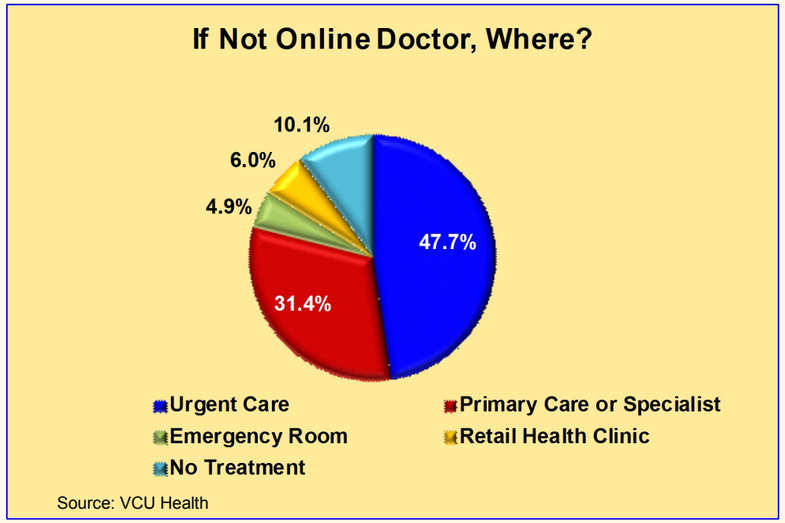
State employees also continued to use Capitol Square Healthcare, the health and wellness clinic in the James Monroe Building in downtown Richmond. A partnership between the Department of Human Resource Management (DHRM) and the VCU Health System, the clinic makes it easier for employees to manage their health during the workday. While located in Richmond, all state employees are welcome to use the clinic's service when they are in town.

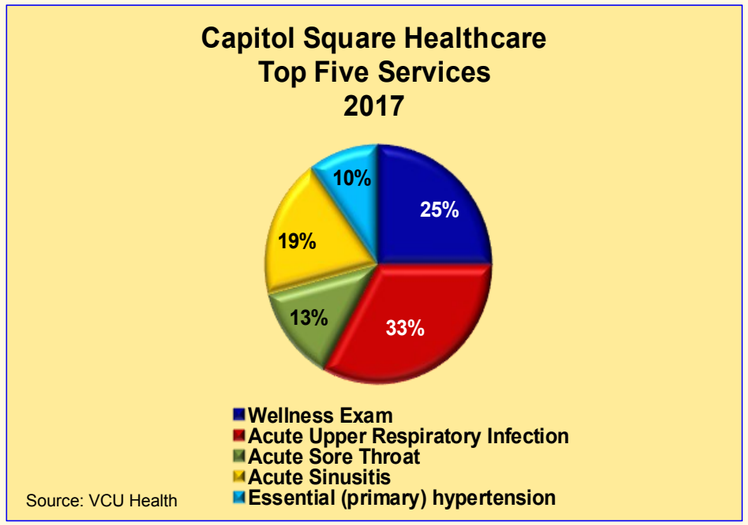
The clinic has a full-time medical director, nurse practitioner and a MyActiveHealth healthy lifestyle coach. Treatment includes services for both primary care and minor illnesses such as colds, contusions, eye and ear infections, headaches, and sore throats. Employees may also visit a healthy lifestyles coach, who offers programs and consultations during the year. The clinic also offers helpful tools such as online appointment scheduling.

In addition to access, having a clinic on Capitol Square is expected to improve employee efficiency, productivity and morale, and help prevent absenteeism. For FY 2017, the clinic had 1,354 visits. An average of 73 percent were seen on the same day that they contacted the clinic. About 73 percent of diagnoses were for urgent care, 17 percent were wellness exams and 10 percent were for ongoing care. Services were rated good or excellent by 99.4 percent of patients.

Above: Capitol Square Healthcare Medical Director Latrina Lemon, M.D, right, consults on a project with Lou Winterling, ActiveHealth coach for the clinic. Ms. Winterling brings wellness programs and activities to employees in the Richmond Capitol Square area.

Capitol Square Healthcare staff members participated in a number of Richmond community events in FY 2017 to increase awareness, including employee events and flu shot clinics.





STEP 7: IMPROVE CUSTOMER SERVICE

Assessment
- Provide services that receive a 90 percent good or better customer satisfaction rating from members.

Opportunity
- Improve customer satisfaction ratings.

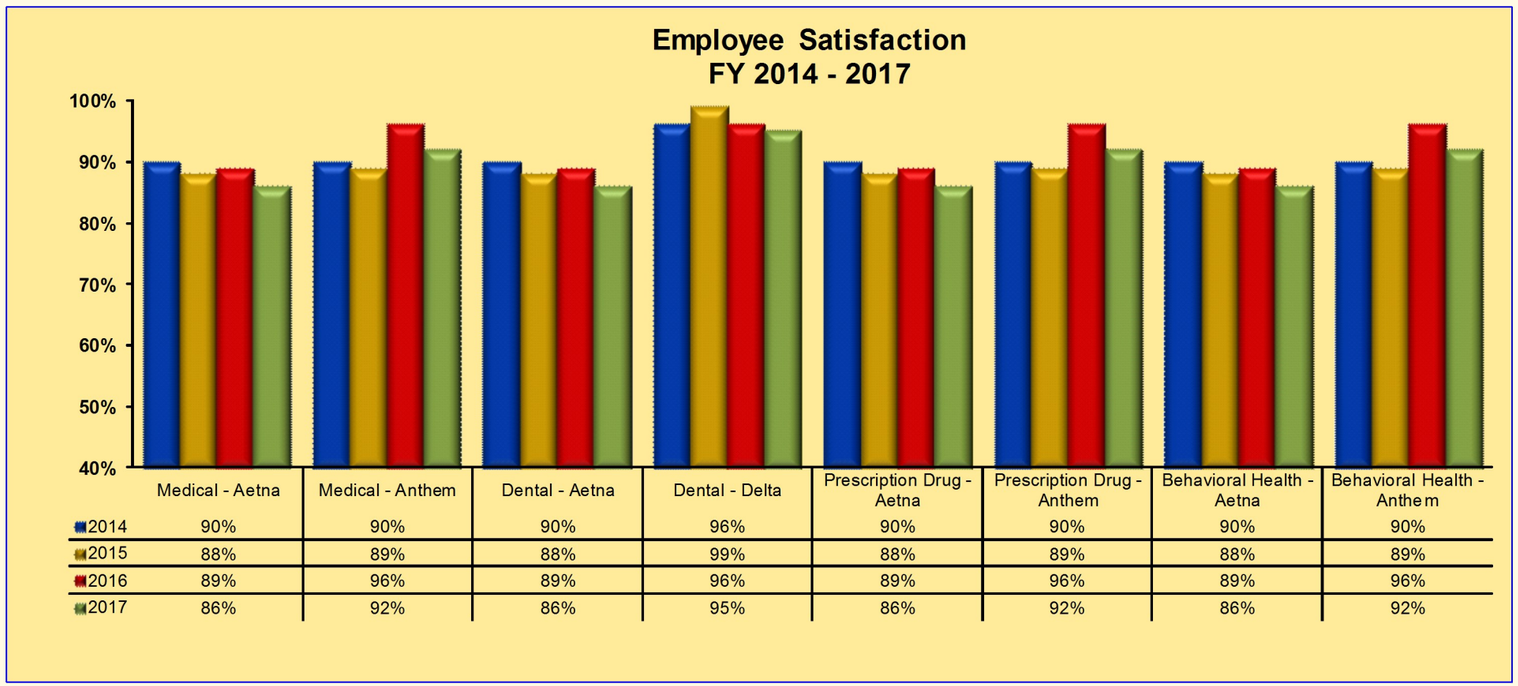
Milestones
- State health benefits plans had an overall customer satisfaction rating in 2017 of 91.9 percent.
  - COVA Care's customer satisfaction rating was 92 percent compared to 58.6 percent for similar Anthem plans.
  - COVA HealthAware's customer satisfaction rating was 86 percent compared to a national range of 58 to 69 percent for consumer-driven health plans.

Measuring customer satisfaction is important to ensure members are receiving value from their benefits. Getting input from employees is essential for the health benefits program to measure its progress in improving both the quality and the effectiveness of covered services. Employees' level of satisfaction is measured through periodic surveys, with state employees rating specific aspects of their health care. Measurements are from the administrator surveys for the health plans, which in 2017 included medical, prescription drug, and behavioral health services. Since the surveys are random, results may vary depending on which members are surveyed and the experience respondents have with their benefits.

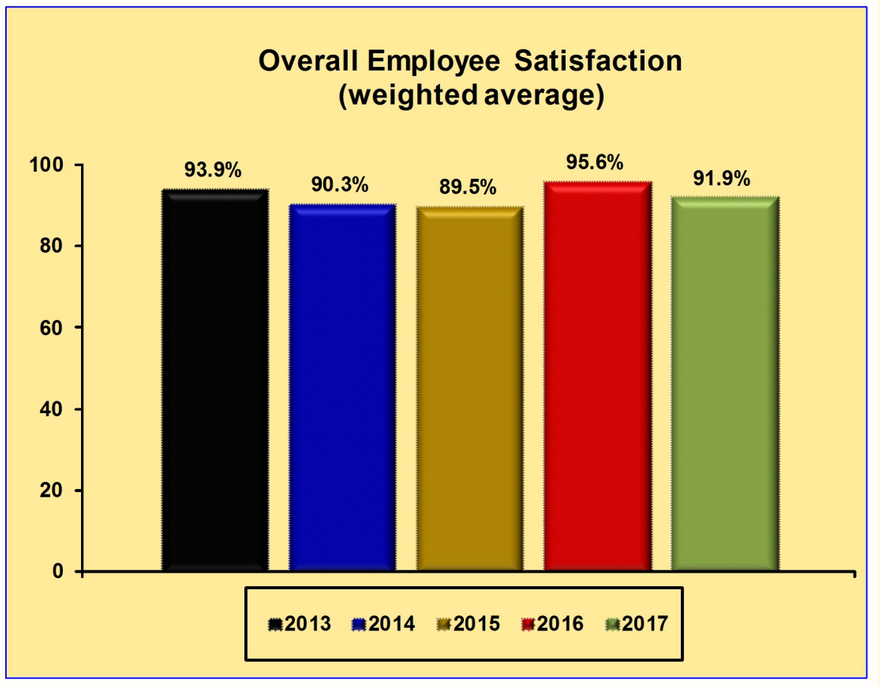
The medical plan satisfaction results are from the standard Healthcare Effectiveness Data and Information Set (HEDIS®) 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Adult Commercial Survey done in cooperation with the National Committee for Quality Assurance. Members surveyed are asked the question "using any number from 0 to 10, where 0 is the worst plan possible and 10 is the best plan possible, what number would you use to rate your health plan?"

DHRM met the customer satisfaction goal in FY 2017. Overall satisfaction with the health plan was 91.9 percent, down 3.7 percent from 95.6 percent in 2016. Delta Dental's benefits had the highest rating in 2017, at 95 percent. The COVA HealthAware plan experienced a 3 percent decrease from the 89 percent rating the previous year. While COVA HealthAware satisfaction dropped, its rating is in line with other consumer-driven health plans.

DHRM is reviewing these results to identify and address employee satisfaction issues. Employee satisfaction is important to the Department of Human Resource Management, and is one of the Governor's key performance measures for the agency.



	Medical - Aetna	Medical - Anthem	Dental - Aetna	Dental - Delta	Prescription Drug - Aetna	Prescription Drug - Anthem	Behavioral Health - Aetna	Behavioral Health - Anthem
2014	90%	90%	90%	96%	90%	90%	90%	90%
2015	88%	89%	88%	99%	88%	89%	88%	89%
2016	89%	96%	89%	96%	89%	96%	89%	96%
2017	86%	92%	86%	95%	86%	92%	86%	92%



STEP 8: ENHANCE COST EFFECTIVENESS

Assessment
- Manage costs while meeting the Affordable Care Act (ACA) requirements and other changes.

Opportunities
- Focus on better health outcomes for plan members in addition to utilization.
- Modify plan provisions to mitigate healthcare trend impact
- Implement value-driven programs and edits to enhance the member experience and improve plan utilization.

Milestones
- Additional funds added to build back reserves resulted in a surplus in FY 2017.
- Claims expense trend was 1.3 percent versus 10.1 percent in 2016.
- Administrative cost trend was 3.2 percent in 2017 versus 9.32 percent the prior year.
- Total cost trend was 1.41 percent in 2017, down from 9.87 percent in 2016.

PROGRAM TOTAL	FISCAL YEAR 2013	FISCAL YEAR 2014	FISCAL YEAR 2015	FISCAL YEAR 2016	FISCAL YEAR 2017
Annual Income *(Premiums, Interest, Other)*	$974,121,189	$1,155,553,236	$1,206,651,640	$1,216,450,352	$1,318,935,036
Annual Expenses *(Claims, Contract Administration, Other)*	$1,036,411,426*	$1,069,307,832*	$1,147,096,057*	$1,260,333,640*	$1,278,043,872
Income Less Expenses	($62,290,237) *Prescription drug rebates deducted	$86,245,404 *Prescription drug rebates deducted	$59,555,583 *Prescription drug rebates deducted	($43,883,288) *Prescription drug rebates deducted	$40,891,164 *Prescription drug rebates deducted

Premiums provided 99.9 percent of the health program's income, with the remainder coming from interest paid to the program. Claims payments represented 92 percent of expenses in 2017. The other 8 percent accounted for the cost of contract administration, the $4.6 million employer reinsurance fee and other expenses related to the Affordable Care Act (ACA).

Beginning in FY 2009, the program used its reserves to fund premium subsidies during difficult financial times and these funds were exhausted in FY 2013. In fiscal years 2014 and 2015, the program increased premiums to replenish reserves, fund Affordable Care Act (ACA) fees and required plan changes.

A lower than expected increase in claims cost in 2014 favorably impacted program expenses, resulting in a continued surplus for the program. The balance was directed to pay for claim contingencies and to fund program reserves.

The surplus in FY 2015 was due primarily to lower than expected utilization coupled with fewer member premium rewards. In FY 2016, ACA requirements changed, adding pharmacy costs to out-of-pocket limit calculations. Although the law changed and created additional claim liability for the plan, the out-of-pocket maximum for the COVA Care plan design did not increase commensurate with ACA changes. This means that 23,428 members reached the COVA Care out-of-pocket expense limit in 2017, compared to 21,424 in 2016 and 8,750 in 2015. The COVA Care plan design, combined with higher claims, ACA and operational costs, contributed to higher expenses for the program.

Less than expected program expense led to a program surplus in 2017. State operating costs totaled almost $1.3 billion in 2017, up 1.4 percent from the prior year. Claims costs grew 1.3 percent. Administrative costs increased 3.2 percent in 2017 compared to 9 percent in 2016.