HEALTH BENEFITS ANNUAL REPORT

COMMONWEALTH OF VIRGINIA

Department of Human Resource Management

2016

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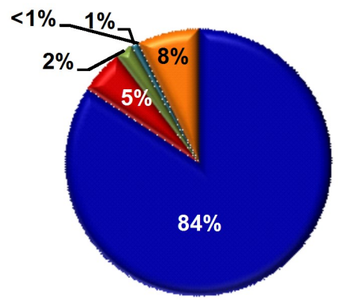
This report is an overview of the state's three self-insured health benefits plans, and where indicated, the regional, fully insured Kaiser Permanente HMO plan offered primarily in Northern Virginia. Unless otherwise stated, this report is based on the experience of health plan members, including the active employee and non-Medicare eligible retiree group, from July 1, 2015 through June 30, 2016. 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.

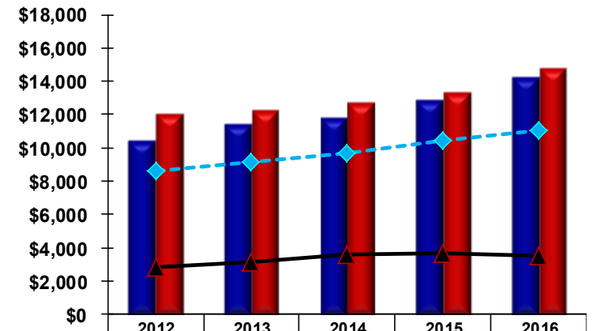
2016 HEALTHCARE SNAPSHOT

2016 Health Plan Enrollment
Total Eligible = 97,016



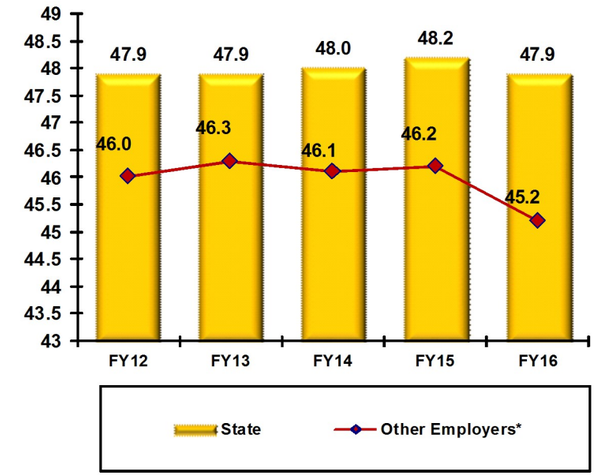
COVA Care (all plan options)
COVA HealthAware (all plan options)
Kaiser Permanente HMO
COVA HDHP (all plan options)
TRICARE
Waived

National and State Average Annual Cost Per Employer and Employee



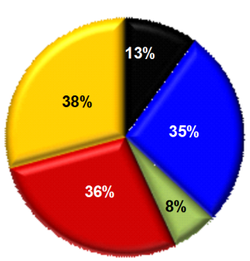
	2012	2013	2014	2015	2016
State Employer Cost Per Employee	$10,431	$11,471	$11,835	$12,883	$14,308 *
National Large Government Employer Cost Per Employee	$12,042	$12,311	$12,761	$13,383	$14,798
State Employee Cost	$2,819	$3,112	$3,611	$3,682	$3,521
National Average Employee Cost	$8,584	$9,144	$9,695	$10,473	$11,033 *

Average State Employee Age



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

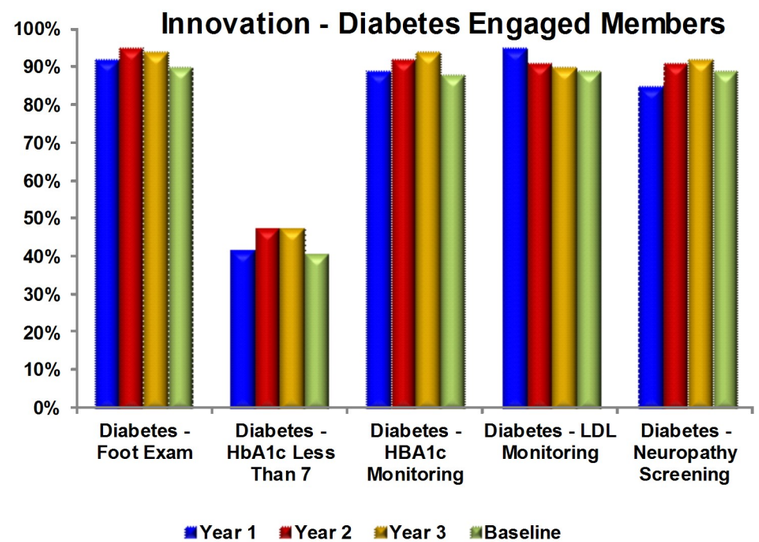
2016 MyActiveHealth Members



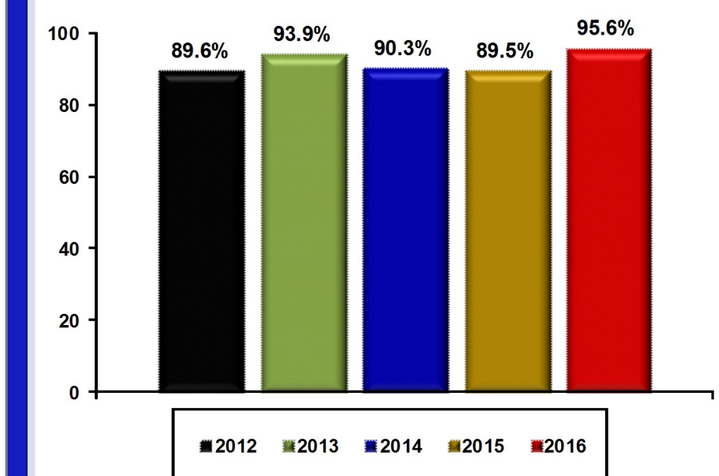
•39% of total eligible population participated
•0% risk change

Completed Health Assessment
Identified for Coaching
Participated in Health Coaching
Completed Health Coaching Program
Used Health Trackers

Innovation - Diabetes Engaged Members



Overall Employee Satisfaction (weighted average)



OUR AIM: A HEALTHIER WORKFORCE

Challenges

- More than seven in 10 state plan members 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
  - Make better plan and health care decisions
  - Help them live a healthier lifestyle

Setting a two-pronged goal of healthier employees and lower costs, the Commonwealth of Virginia health benefits program has been building a foundation for change over the past three years.

Starting with a "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.

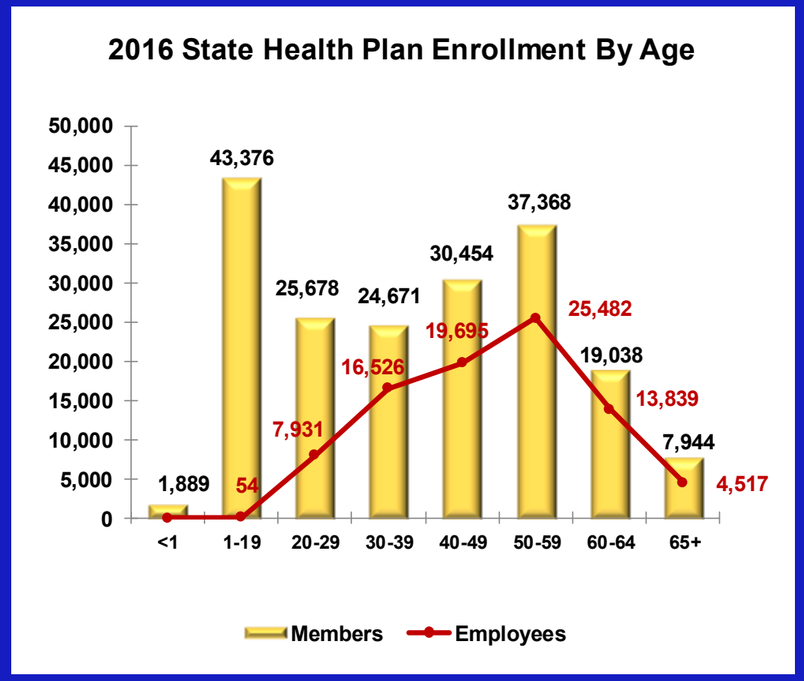
Health

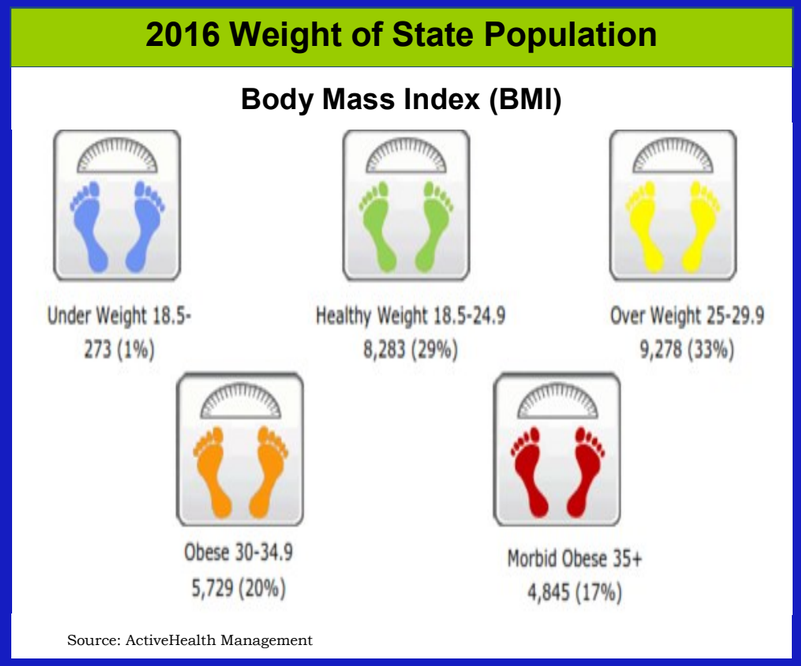
The Commonwealth has also:

- Introduced a consumer-driven health plan to help members budget their own health care spending;
- Launched a Premium Rewards program to help employees, retirees and their spouses save on monthly premiums;
- Initiated innovative value-based insurance design (VBID) programs on diabetes, hypertension, asthma and chronic obstructive pulmonary disease (COPD) for greater member engagement;
- Opened a downtown Richmond employee health and wellness center to improve access, convenience, productivity and morale;
- Introduced 24/7 online telemedicine programs where members can see a doctor using a computer or mobile devices;
- Created a successful pre-bariatric surgery education program which has improved participant health outcomes and reduced costs.

Cost

In addition to implementing these changes, the program in 2016 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 2016, the net cost of the ACA to the state was $7.3 million. Even with higher claims expense and the cost of the ACA, the state health benefits self-insured plans' cost per employee in FY 2016 was 3.4 percent lower than the projected national average for the calendar year, as has been the historical trend.





GOAL 1: IMPROVE HEALTH AND WELL-BEING

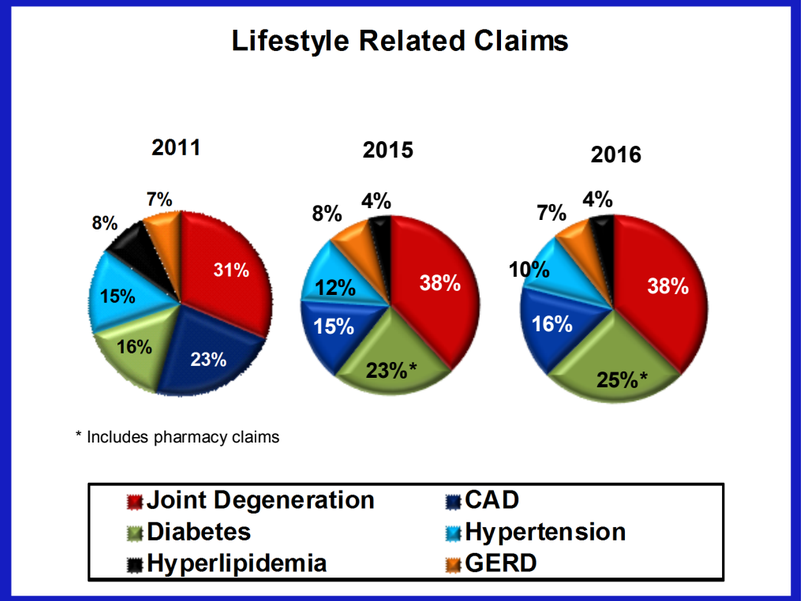
Focus on Wellness

During 2016, 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. Offered in the employee workplace, the *Common-Health* 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 Governor and Secretary of Administration's efforts to encourage employee participation in *CommonHealth,* the program's total participation grew to 32 percent of the workforce in 2016. That result is consistent with the findings of a 2014 Rand Corporation study estimating a 20 to 40 percent national participation rate. Employee participation in *CommonHealth* has almost doubled in the past four years. In 2016, *CommonHealth* programs focused on physical activity, handling stress and managing joint pain.

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 more than 12,000 members. More than 4,000 of those members, or 33 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 2016, screening results showed that members' blood pressure and cholesterol readings continued to improve. On the other hand, only 29 percent had a healthy weight, with a BMI of less than 25.



Challenges

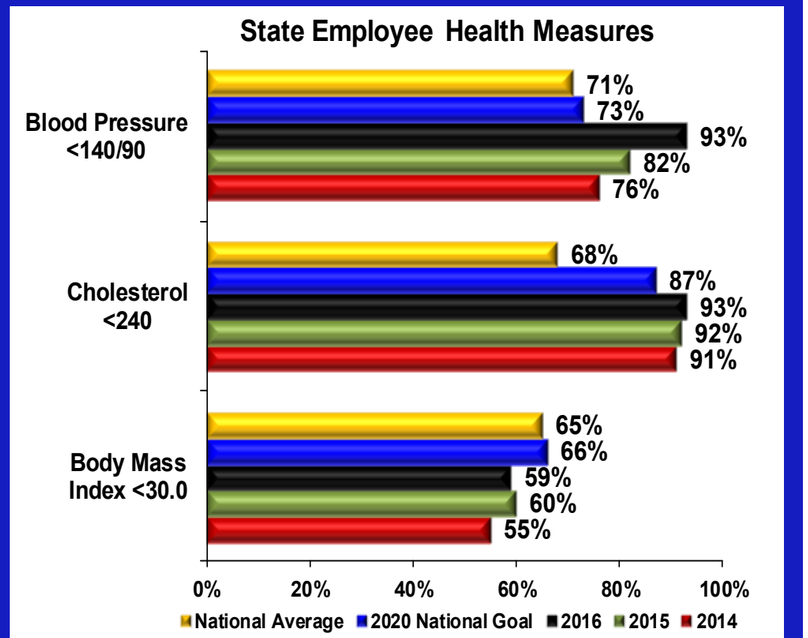
- Biometric screenings show that 74 percent of state health plan members are overweight or obese
- Many health plan members need help with issues related to nutrition, exercise, stress and quitting tobacco use

Opportunities

- Offer education programs through the *CommonHealth* wellness program to promote healthy activities in the workplace
- Implement a 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

Outcomes

- No increase in overall health risk for members
- Blood pressure readings improved
- Cholesterol readings improved
- Overweight and obese members increased



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

GOAL 2: IMPROVE EMOTIONAL HEALTH

Challenges

- Employees often need help with relationship, work and other life issues or with behavioral health concerns

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

Outcomes

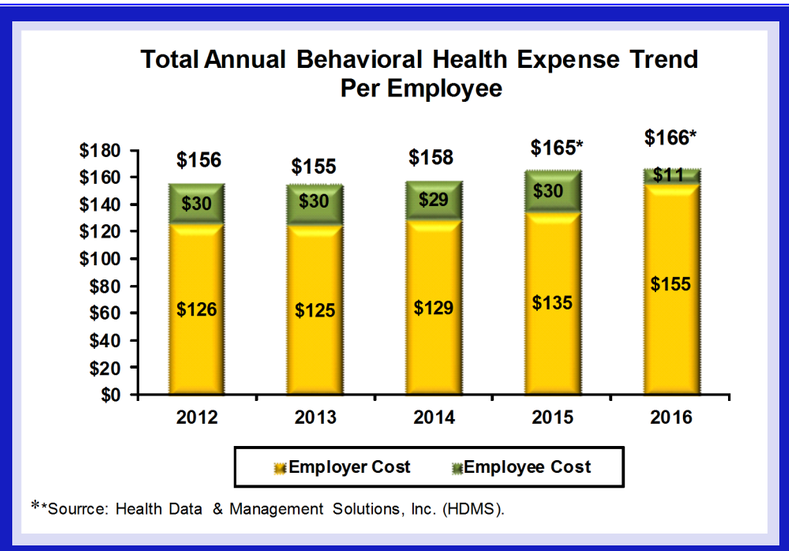
- 73 percent of EAP cases were resolved successfully within the EAP benefit
- 84 percent of members reached by behavioral health providers were treated, better than the 80 percent in other Anthem plans
- 43 percent of referred members with depression showed at least a 5 percent improvement in depression scores
- Only 15 percent of cases remained highly acute after behavioral health intervention, consistent with 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 percent of those enrolled in health plans used the behavioral health benefit during 2016, less than the 11.5 percent rate for comparable Anthem plans. Six behavioral health conditions accounted for 93 percent of claims expense compared to 86 percent the prior year: depressive, adjustment, bipolar, anxiety, psychotic and childhood behavioral disorders. Total claims cost increased 12 percent to $13.6 million in FY 2016 from $12.1 million in FY 2015, driven by higher outpatient facility costs. The top 10 percent highest-cost behavioral health members accounted for 65 percent of behavioral health costs.

Fifty-three percent of claims expense was for outpatient services; 38 percent for inpatient treatment, including new residential treatment services; and 8 percent for alternative levels of care. There were 1,041 referrals in 2016, a 4.5 percent increase over the prior year. Providers and clinicians reached 65 percent of referred members, which is above the 61 percent rate for Anthem's comparable plans. Of referred members with depression, 43 percent showed at least a 5 percent improvement in depression scores. Of those who had inpatient or residential treatment center hospitalization during 2016, the vast majority had only one admission during the year: 84 percent of those who had a primary diagnosis of substance abuse, and 81 percent of those who had a primary diagnosis of mental health.

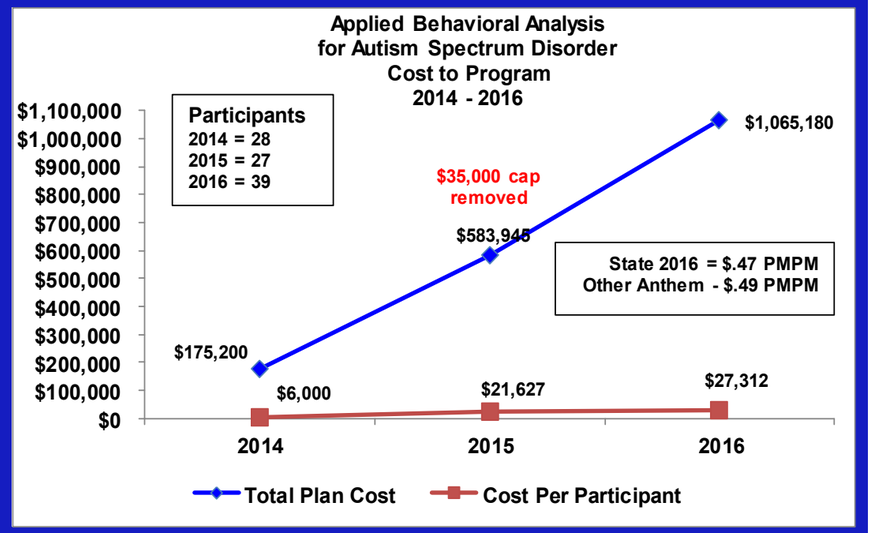


**Sourrce: Health Data & Management Solutions, Inc. (HDMS).

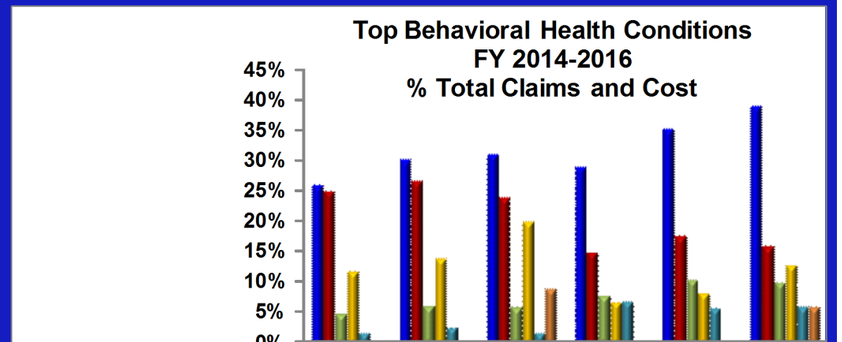
Of the more than 4,300 members who used the EAP in 2016, 84 percent sought services for the top three assessed problems: emotional and psychological concerns, family relationships and legal issues. A total of 712 members used legal and financial services compared to 592 the prior year, or an increase of 20 percent.

The EAP handled 6,204 calls and referred 4,329 cases to a counselor in 2016, up 4 percent from the 4,163 cases in 2015. The annualized 7.0 percent utilization rate in 2016 remained above the 6.4 percent national utilization rate. The program handled 186 onsite trainings, 47 critical incidents, provided 21 EAP orientations and gave onsite counseling to 497 state employees.

Of EAP cases opened in 2016, 73 percent were resolved successfully within the EAP benefit, and 62 percent of members used all four counseling sessions for treatment. An analysis showed that 97.5 percent were satisfied with counseling sessions, 89.8 percent reported improved concentration at work, 89.6 percent said their work performance had improved, and 88 percent reported better work attendance.



In FY 2016, 39 members used the Applied Behavior Analysis (ABA) benefit for autism spectrum disorder for children ages 2 through 6, a 44 percent increase over 27 members in 2015. While the benefit had been capped at $35,000 per year to comply with mental health parity, the limit was removed in January 2015. ABA claims costs were 82 percent higher for FY 2016 than the previous year, at more than $1 million compared to $584,000 in 2015. The average cost per participant was about $27,312 compared to $21,627 the prior year.



	2014 Claims	2015 Claims	2016 Claims	2014 Cost	2015 Cost	2016 Cost
DEPRESSIVE DISORDERS	26%	30%	31%	29%	35%	39%
ADJUSTMENT DISORDERS	25%	27%	24%	15%	18%	16%
BIPOLAR DISORDERS	5%	6%	6%	8%	10%	10%
ANXIETY DISORDERS	12%	14%	20%	7%	8%	13%
PSYCHOTIC DISORDERS	2%	3%	2%	7%	6%	6%
CHILDHOOD BEHAVIORAL			9%			6%

GOAL 3: ENGAGE MEMBERS - Total Population Health

Challenges

- 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

Outcomes

- Members' overall health risk did not increase, which is better than the benchmark of a 1 percent increase in risk
- 17 of 34 population health measures improved, including a 5 percent increase in members with normal blood pressure readings

Total Population Health

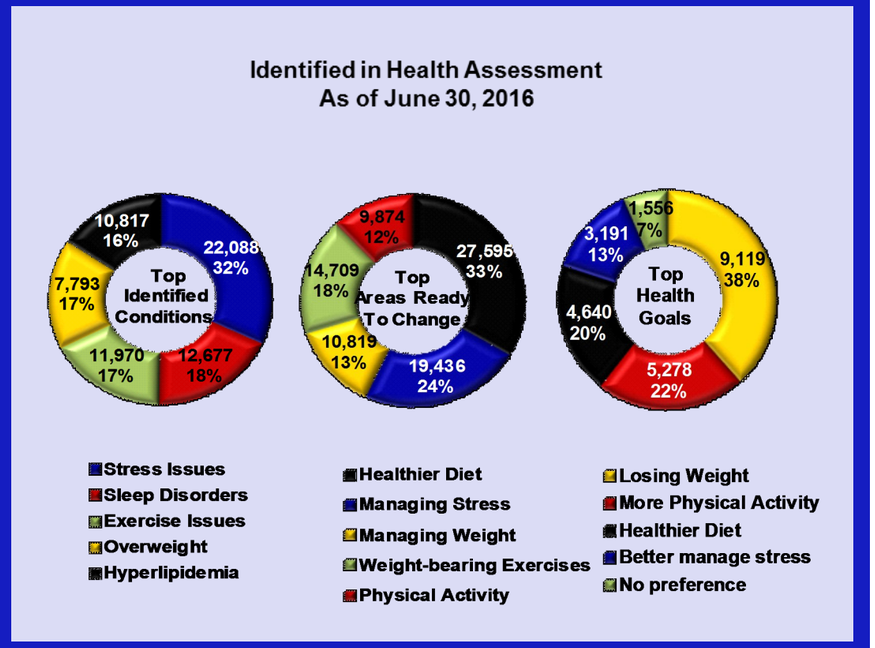
In order to increase member engagement, the Commonwealth provides tools to state plan members to help them be fully involved in their health care, improve their health and reduce costs. These included tools to:

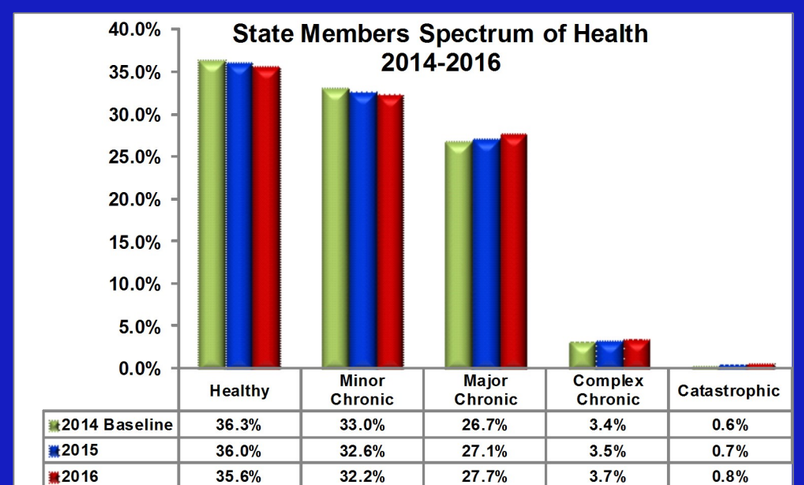
- Evaluate plan cost and quality.
- Help members track their health online and know their numbers.
- Better manage chronic conditions and enroll in coaching on exercise, weight management, nutrition, stress and quitting tobacco.
- Provide Premium Rewards for completing a health assessment and biometric 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 2016, 39 percent of health plan members were enrolled in MyActiveHealth programs. Eight percent of members were fully participating in programs, which is higher than the 6 percent rate for similar MyActiveHealth employee programs.

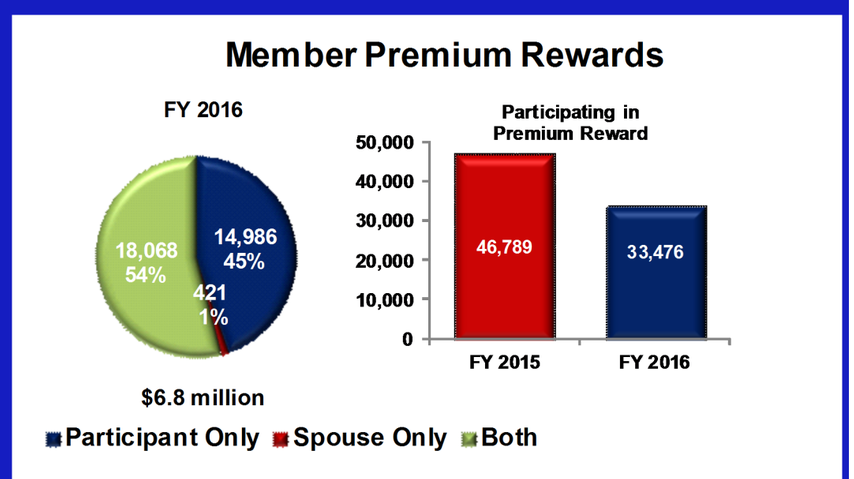
A health assessment available to state plan members has helped identify their top issues of concern. The top two self-reported conditions are stress issues and sleep disorders. These correlate with being overweight, the fourth condition identified by members. Biometric screening results indicate that 74 percent of members in state health plans are overweight or obese.

Premium rewards were offered to encourage participation in total population health. A total of 33,476 eligible COVA Care and COVA HealthAware members earned $ 6.8 million in premium rewards during 2016 for completing a health assessment and biometric screening. About 39% of total claims expense in 2016 was from members who had complex chronic or catastrophic health, who represented 4.5 percent of 445,000 adult members in the program for 11 months. The *Healthy Insight* disease management program engaged 15 percent of eligible members compared to 12 percent for another state's health plan. The number of eligible members engaged in the *Healthy Lifestyles* coaching program increased to 33 percent from 22 percent in 2015.





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



GOAL 3: ENGAGE MEMBERS - Total Population Health Outcomes

Total Population Health Outcomes

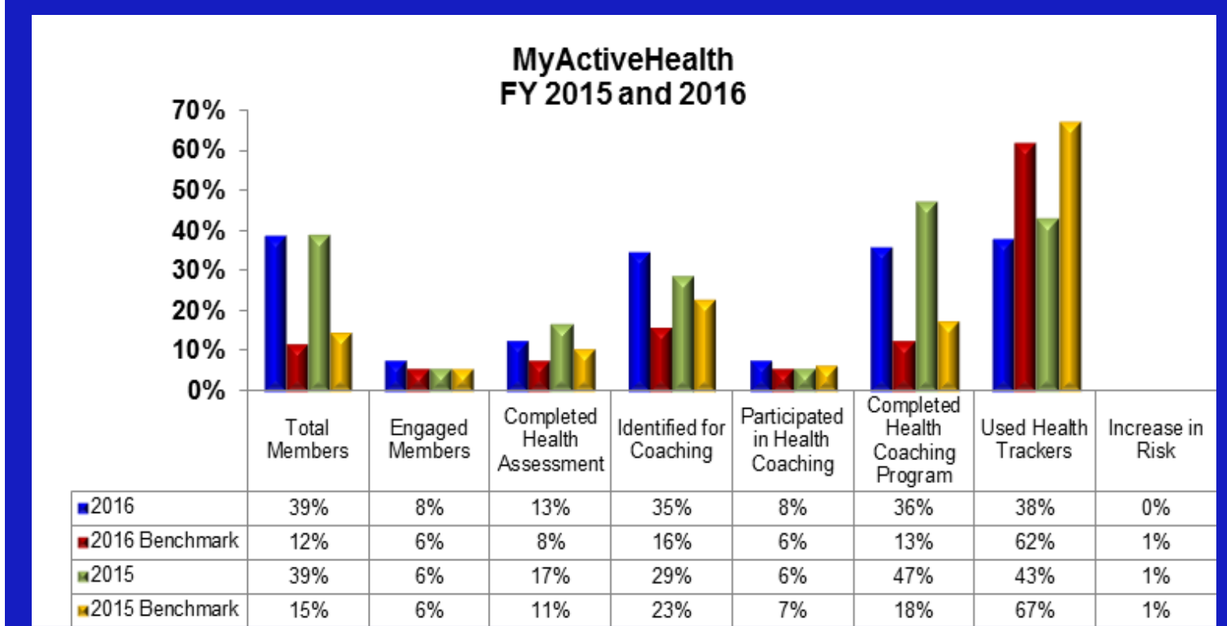
To engage members in their health care, the total population health initiative includes messaging mailed to members and their physicians about individual health issues. These "care considerations" include alerts on medication adherence, health screenings, flu shots, and healthy lifestyle actions. Care considerations also may recommend healthy actions related to disease management, healthy lifestyle coaching and other programs. More than 39 percent of eligible members complied with total care consideration recommendations in 2016, exceeding by 5 percent the 34 percent compliance nationwide for similar ActiveHealth Management programs. About 59 percent of these alerts related to diabetes, cardiovascular and liver diseases.

During 2016, the total population risk rating did not increase compared to the national benchmark of a 1% increase in risk. MyActive Health identified 47,000, or 24.4 percent, of plan members as potential candidates for disease management. It reached out to 21,424 members, or 11.1 percent of all eligible health plan members. Of those, almost 7,900 members were engaged by telephone with a disease management or lifestyle coach. A total of 6,967, or 3.6 percent of all eligible plan members, were engaged with a nurse in 2016 to help them better manage a chronic health condition, compared to 3.0 percent the previous year. Sixty-eight percent of members changed from high or medium to low risk, while 32 percent changed from high to medium risk. Total annual savings from care considerations and disease management programs are estimated at almost $30 million.

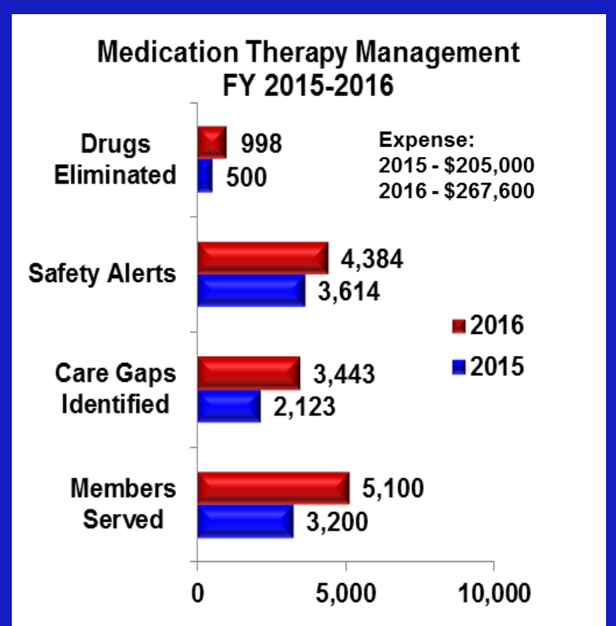
In addition to greater emphasis on engagement, the health benefits program continued its medication therapy management (MTM) pilot program in 2016. The confidential, voluntary program offers one-on-one medication consultations directly with a pharmacist to educate individual members about complying with 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. In 2016, about 5,100 cases were served. Members took 998 fewer drugs as a result of 4,384 total safety alerts; 184 members followed their drug regimen for at least one drug from 1,064 adherence alerts issued; and more than 90 members closed at least one gap in care as a result of 3,443 care gaps identified.

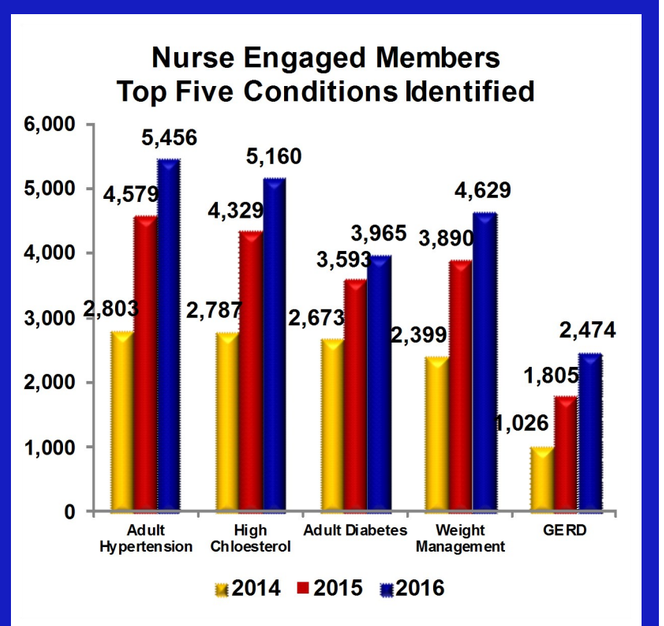
2016 Commonwealth Member Compliance

	Members	State Percent	Benchmark
Care Considerations % members who took healthy actions	76,046	39.4%	34.1%
Identified for disease management opportunity	47,000	24.4%	27.7%
Successful disease management outreach	21,424	11.1%	4.3%
Engaged with nurse	6,967	3.6%	2.7%
Engaged overall in MyActive Programs	15,440	8.0%	10.0%



	Total Members	Engaged Members	Completed Health Assessment	Identified for Coaching	Participated in Health Coaching	Completed Health Coaching Program	Used Health Trackers	Increase in Risk
2016	39%	8%	13%	35%	8%	36%	38%	0%
2016 Benchmark	12%	6%	8%	16%	6%	13%	62%	1%
2015	39%	6%	17%	29%	6%	47%	43%	1%
2015 Benchmark	15%	6%	11%	23%	7%	18%	67%	1%





GOAL 3: ENGAGE MEMBERS - COVA HealthAware Plan

COVA HealthAware Plan Participation

In conjunction with total population health, the Commonwealth introduced a consumer-driven health plan to encourage state plan members to 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 2016 had more than 10,000 plan members.

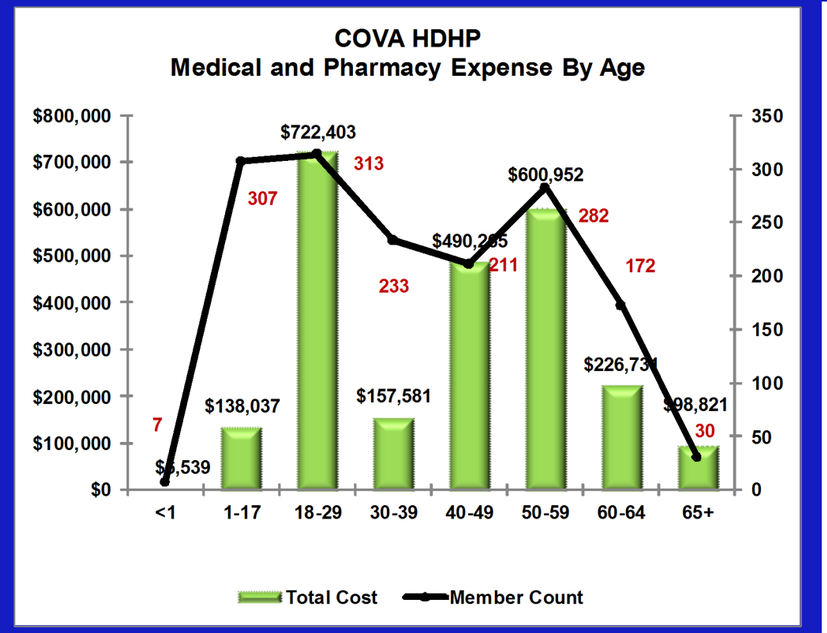
COVA HealthAware enables members to budget their own health care spending and decide how best to spend their own money. The plan includes a health reimbursement arrangement (HRA), a fund to help members pay for family out-of-pocket medical and pharmacy expenses. In FY 2016, the Commonwealth continued 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 22 percent of the $5.4 million in HRA funds available to plan members were from funds rolled over from FY 2015.

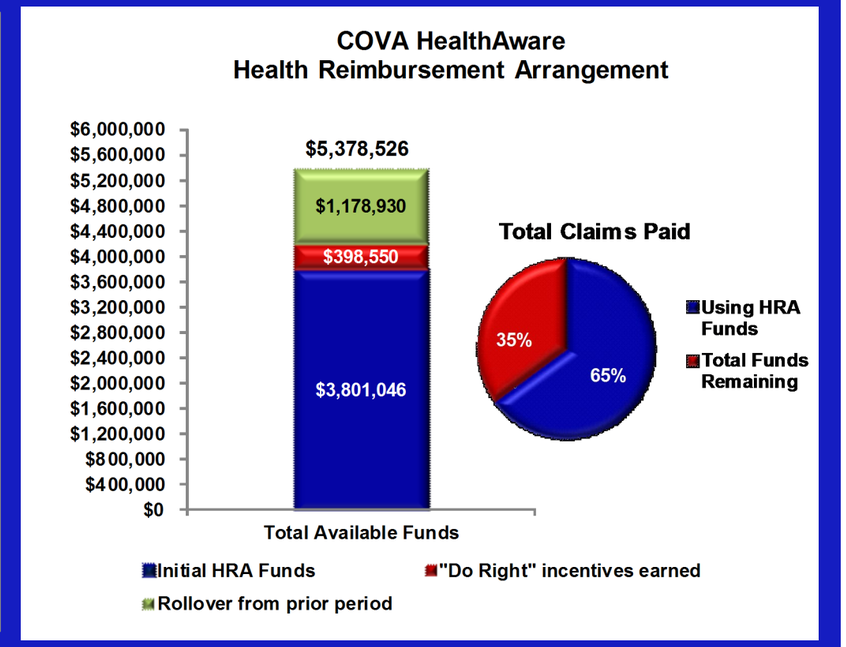
In addition to the HRA, the plan offered several "do right" healthy activities in 2016 which members could complete to add funds to their account. Employees, early retirees, or their spouses could each receive up to $150 in additional HRA funding by completing up to three "do rights": An annual routine exam, flu shot, dental exam, vision exam, online or digital coaching, and tracking certain activities on the MyActiveHealth web portal.

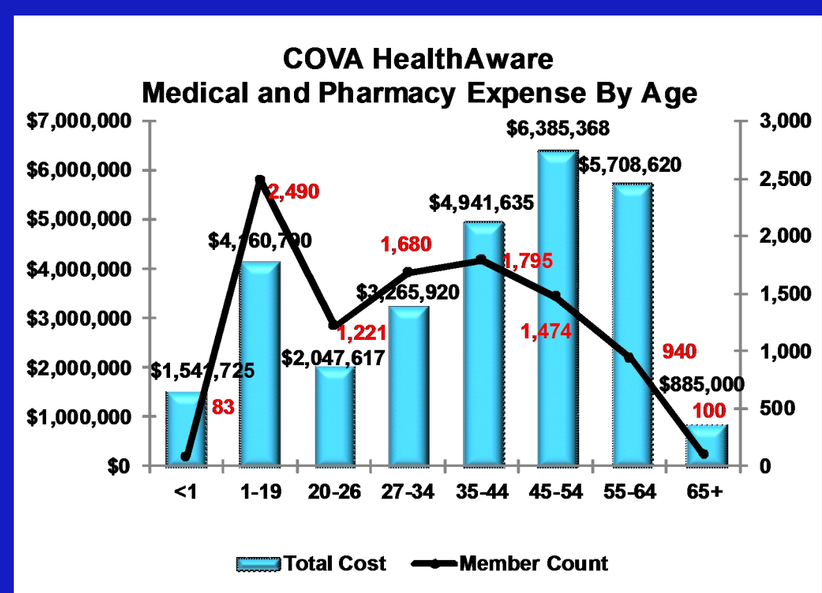
By comparison, the COVA HDHP (High Deductible Health Plan) introduced in 2006 had 1,556 members in 2016. Launched as another plan option to COVA Care, it includes a deductible of $1,750 for single and $3,500 for family coverage. In addition, the COVA HDHP is compatible with a Health Savings Account (HSA), which is a tax-favored account that allows those covered by an HDHP to pay for certain qualified medical expenses.

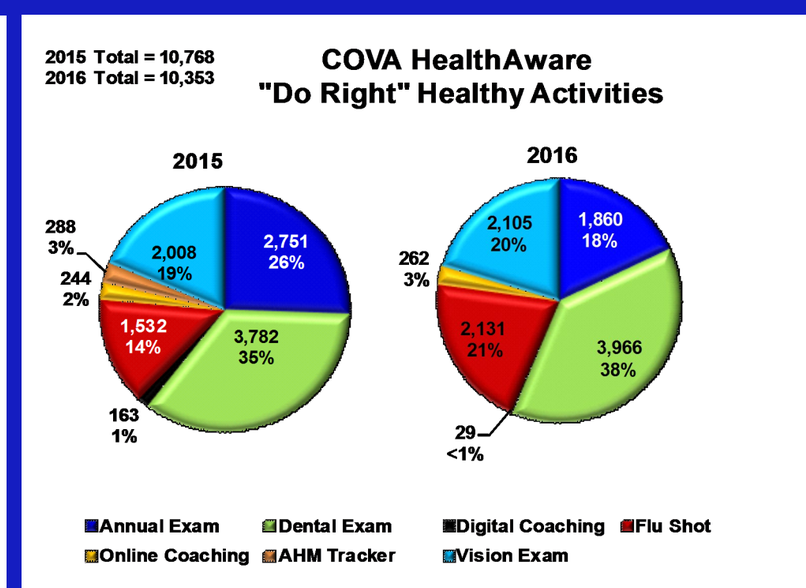
An HSA can help members save on the cost of health insurance and health care expenses, and also helps pay for covered services before the health plan deductible is met. Members set up their own personal HSA at a bank or other financial institution. The Commonwealth does not contribute to HSA accounts.

In 2016, claims expense for the COVA HDHP totaled $2.8 million, with $2.4 million, or 86 percent, in medical and pharmacy claims. The employer claims cost per employee was $3,518 for 796 participants, compared to $ 6,718 for 4,809 participants in COVA HealthAware. COVA HDHP members in the 18-29 age bracket accounted for almost one third of medical and pharmacy expense, due primarily to one high cost claimant. The average employee age for the COVA HDHP was 45, or five years older than the average 40 years of age for employees enrolled in COVA HealthAware.









GOAL 4: BOOST PREVENTIVE CARE

Challenge

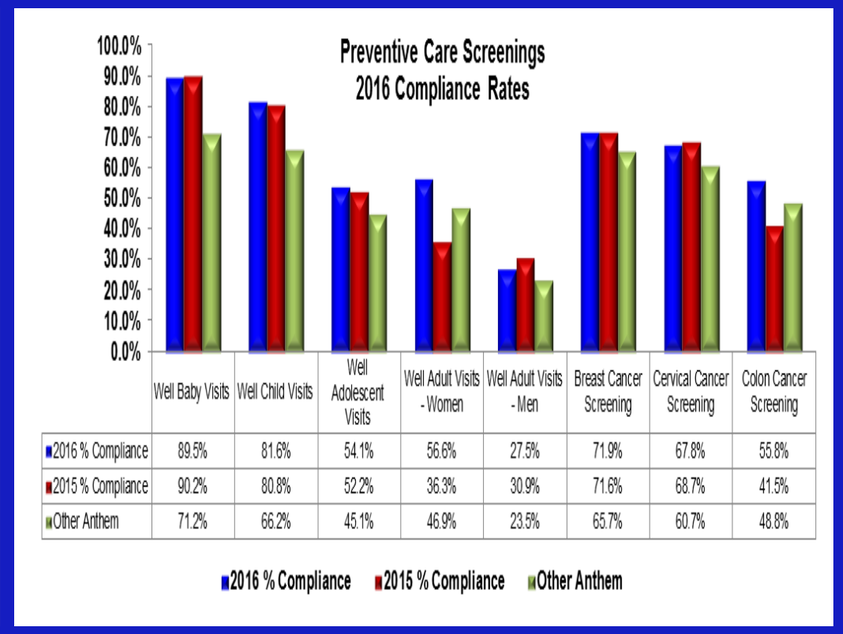
- Preventive screenings can identify serious illness, keep conditions from getting worse, and in some cases may be the difference between life and death, yet many plan members do not get them.
- While getting a flu shot is one of the best ways to stay healthy, many members fail to do so.

Opportunity

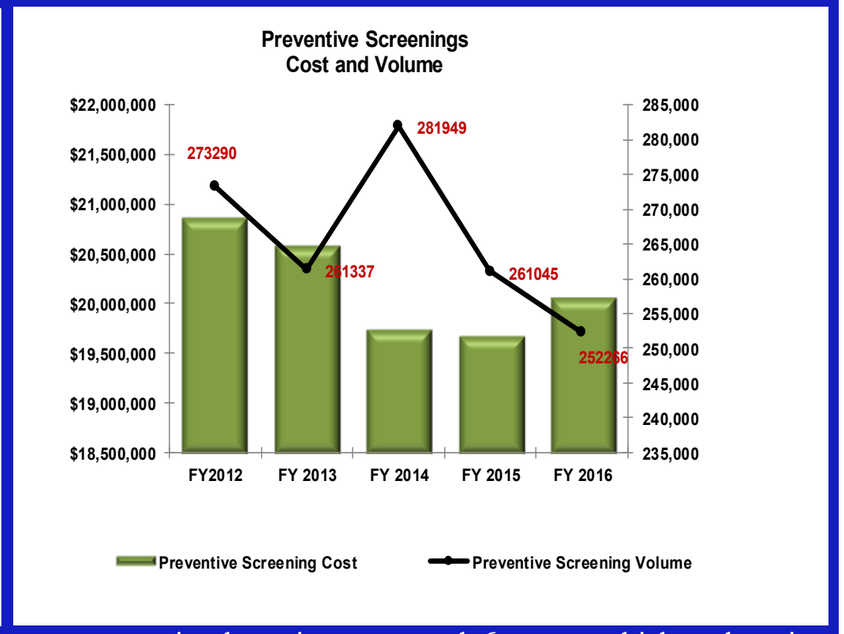
- Increase percentage of members receiving free flu shots.
- Make getting flu shots more convenient.
- Increase the number of members having preventive screenings.

Outcome

- 36 percent of members received free flu shots at local pharmacies, doctors' offices and onsite in 2016, 12.5 percent higher than in 2014 yet 6 percent less than the national average.
- 44 percent of COVA HealthAware members got a flu shot as one of their "do rights," which equals the national average.
- 2016 routine wellness and preventive screening compliance exceeded the benchmark in all categories.



	Well Baby Visits	Well Child Visits	Well Adolescent Visits	Well Adult Visits - Women	Well Adult Visits - Men	Breast Cancer Screening	Cervical Cancer Screening	Colon Cancer Screening
2016 % Compliance	89.5%	81.6%	54.1%	56.6%	27.5%	71.9%	67.8%	55.8%
2015 % Compliance	90.2%	80.8%	52.2%	36.3%	30.9%	71.6%	68.7%	41.5%
Other Anthem	71.2%	66.2%	45.1%	46.9%	23.5%	65.7%	60.7%	48.8%



Preventive Care Benefits

Another way to improve the health of members is to help them avoid more serious illness. In 2016, 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

Baby and adult wellness checkups and cholesterol tests represented about 63 percent of total screening volume, compared to 62 percent in 2015. About 32 percent of preventive care screenings in 2016 were pap smears, mammograms and PSA tests.

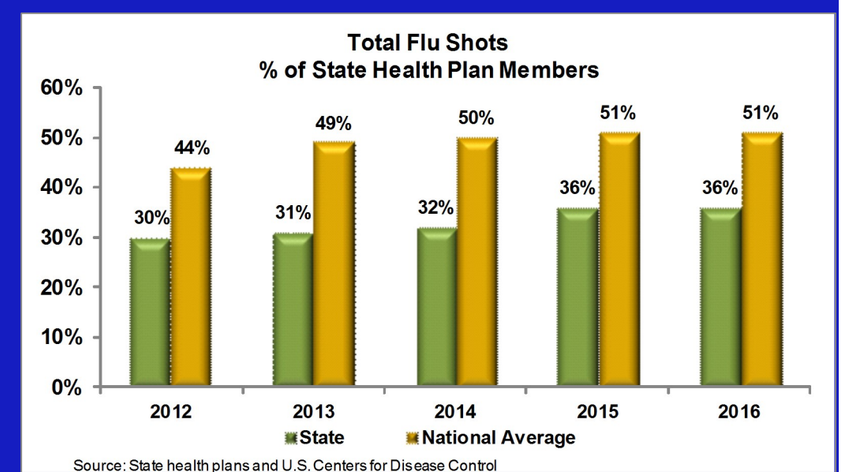
Average routine wellness and screening compliance rates show improvement in five out of eight screening categories during FY 2016, with all categories exceeding the national average. Annual check-ups increased among women, children and adolescents, while age appropriate preventive screenings were up for breast, cervical and colon cancer. Adult well visits rose 9 percent over the previous year.

Among preventive screenings, mammography screenings had the highest compliance in 2016 at 72 percent of women age 40 and older, followed by Pap smears at 68 percent for women age 18 and older, and colonoscopy at 56 percent for those age 50 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 encourage getting annual flu shots, which are free each year. In 2016, approximately 195,000 plan members were eligible to receive a flu shot. About 36 percent of state plan members, or approximately 69,900, received a flu shot in 2016, comparable to the percentage in the prior year, and 6 percent higher than in 2012. While the percentage has increased, it remains below the 51 percent national average.

CommonHealth offered 69 flu shot clinics onsite at state agencies, increasing convenience for plan members and contributing to the number delivered by pharmacies. In addition, more than 2,100 COVA HealthAware members, or 44 percent, got a flu shot for one of their "do right" healthy activities.



GOAL 5: ANALYZE HEALTH TRENDS-Cost

Challenges

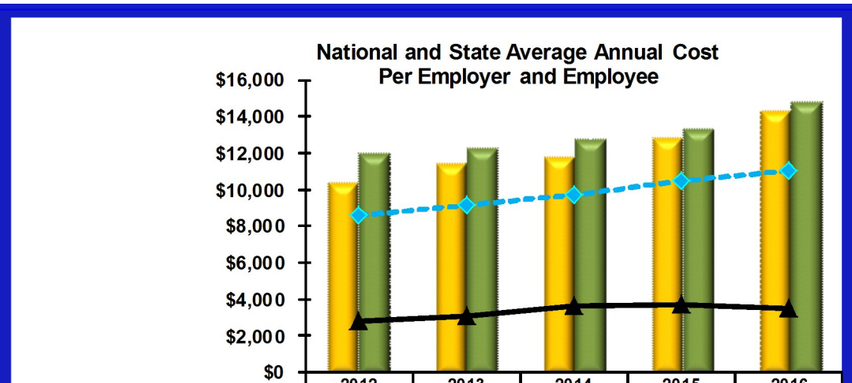
- Total cost increased 9.8 percent for health benefits in FY 2016 over the prior year.
- Cost drivers include expensive procedures, treatment of chronic conditions, the cost of prescription drug therapy, the average employee age and employee lifestyle.
- Claims costs are increasing along with expenses related to the Affordable Care Act (ACA).

Opportunity

- Control health care costs for employees.
- Control health care costs for the plan.
- Keep state costs below the national average expense.

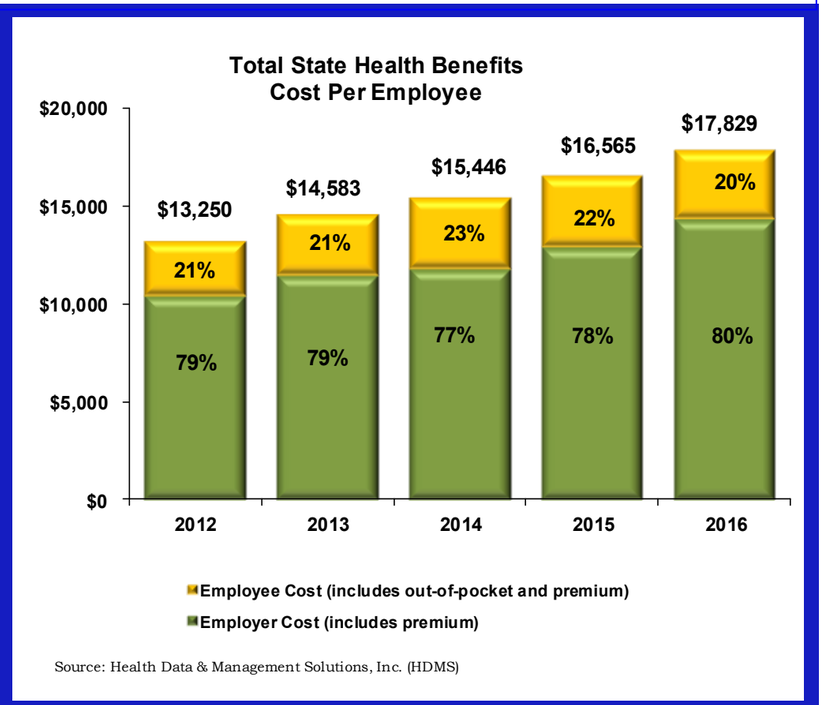
Outcomes

- Claims costs have increased because the COVA Care plan design did not mirror Affordable Care Act (ACA) changes, increasing the employer share by 4.4 percent over the prior year.
- The Commonwealth's total population health program has engaged 8 percent of members, with incentives to help control costs.
- State employee costs have remained consistently about one-third of the national average.



	2012	2013	2014	2015	2016
State Employer Cost Per Employee	$10,431	$11,471	$11,835	$12,883	$14,308
National Large Government Employer Cost Per Employee	$12,042	$12,311	$12,761	$13,383	$14,798 *
State Employee Cost	$2,819	$3,112	$3,611	$3,682	$3,521
National Average Employee Cost	$8,584	$9,144	$9,695	$10,473	$11,033 *

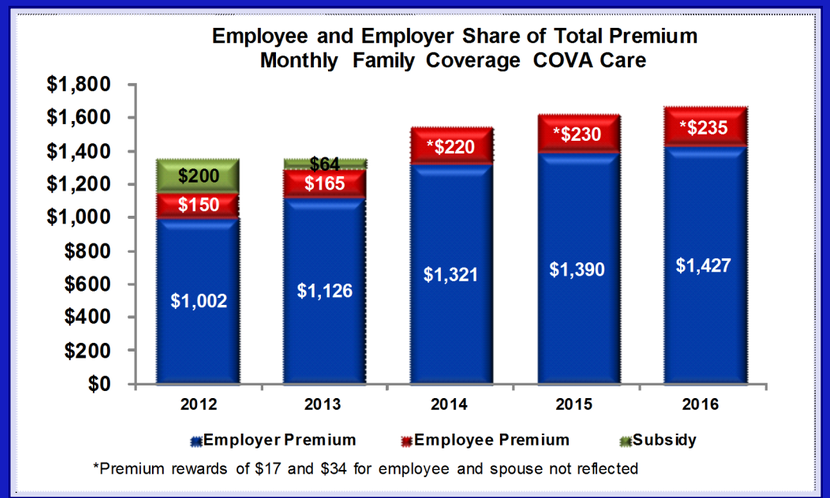
Sources: National average employer and employee costs projected for 2016 by Milliman Medical Index. Health care cost projections vary. The Henry J. Kaiser Family Foundation shows a national average employer cost per employee of $12,865 for CY 2016 and an employee premium contribution of $5,277. Other national data shown is from Milliman and the Mercer National Survey of Employer-Sponsored Health Plans. State data is total program expense..

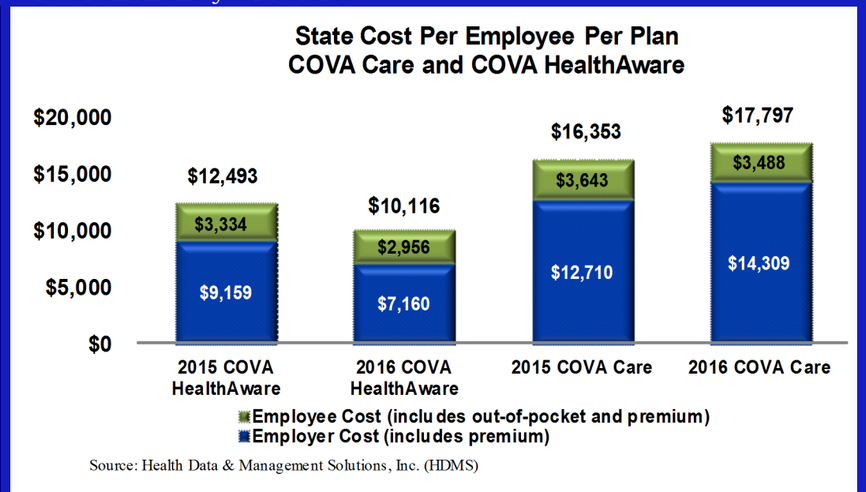


Source: Health Data & Management Solutions, Inc. (HDMS)

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 $14,798 for calendar year 2016. As in previous years, the state health benefits program's annual expenses were lower than the national average in 2016. State expenses were 3.4 percent less than the projected national average. Driven by an 8.1 percent increase in claims costs and the impact of expenses relating to the Affordable Care Act (ACA), the state's cost increased 11.0 percent over the previous year. While plan costs have risen, employee costs have remained significantly lower than the national average. Total state employer cost per employee in fiscal year 2016 was $14,308. The COVA Care plan's employer cost per employee was $14,309, or 12.6 percent higher than in 2015, while COVA HealthAware's employer cost per employee in 2016 was $7,160, or 21.8 percent lower than the year before.





Source: Health Data & Management Solutions, Inc. (HDMS)

COVA HealthAware's cost per employee for out-of-pocket expenses and premium was $2,956, representing 29.2 percent of total cost, while COVA Care's cost per employee was $3,488, or a 19.6 percent cost share. When looking at only deductibles, copayments and coinsurance, the employee cost share drops to 6.7 percent for COVA Care and 17.9 percent for COVA HealthAware.

Higher pharmacy and inpatient hospital costs were significant factors in the overall increase for 2016. Overall the plans' share of total costs continued to grow. The employee share for COVA Care declined for the year, while the COVA HealthAware employee share increased over 2015. In addition to medical and behavioral health, the COVA Care plan's cost share rose primarily because of the ACA. In 2016, ACA requirements changed, adding pharmacy costs to out-of-pocket limit calculations. Although the law changed, the plan design did not. While the plans paid 80 percent of the annual total health benefits cost, up 2 percent from 2015, employees paid 2 percent less, or 20 percent, in 2016. Employees' overall out-of-pocket costs, including deductibles, copayments and coinsurance, decreased 24 percent in 2016 from 2015 and their average premium share remained at 16 percent in 2015. State employee costs were about a third of the national average from 2013—2016.

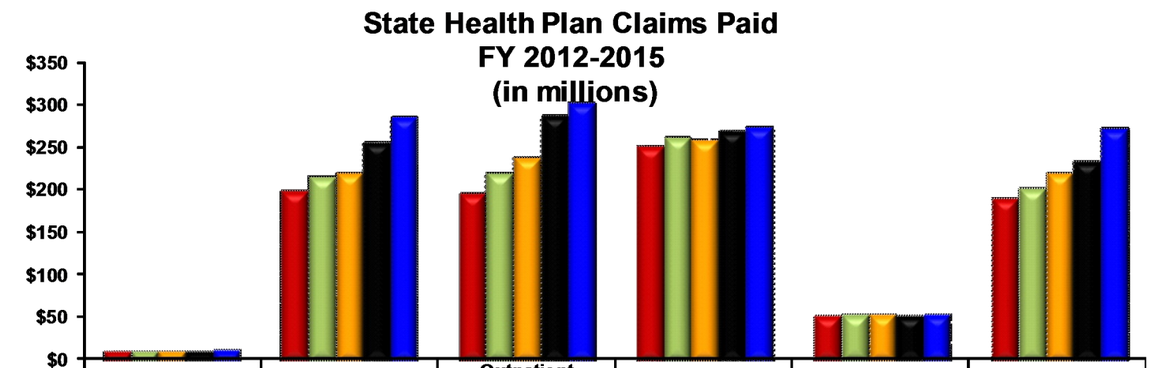
GOAL 5: ANALYZE HEALTH TRENDS-Claims

Total Claims Expense

About 6.7 million claims were processed for the self-insured state plans in FY 2016, about 8.2 percent lower than the 7.3 million claims for the previous year. Fewer claims resulted primarily from fewer eligible employees. Total expense increased, due in part to higher inpatient, outpatient and prescription drug claims costs. Fifty-three percent of claims were medical, accounting for 72 percent of total plan claims expense. Driven by the cost of expensive specialty drugs, prescription drugs experienced the highest cost increase, growing 16.8 percent in 2016 to $273.1 million from $233.9 million the previous year. Inpatient facility expense was the second highest increase at 12.1 percent.

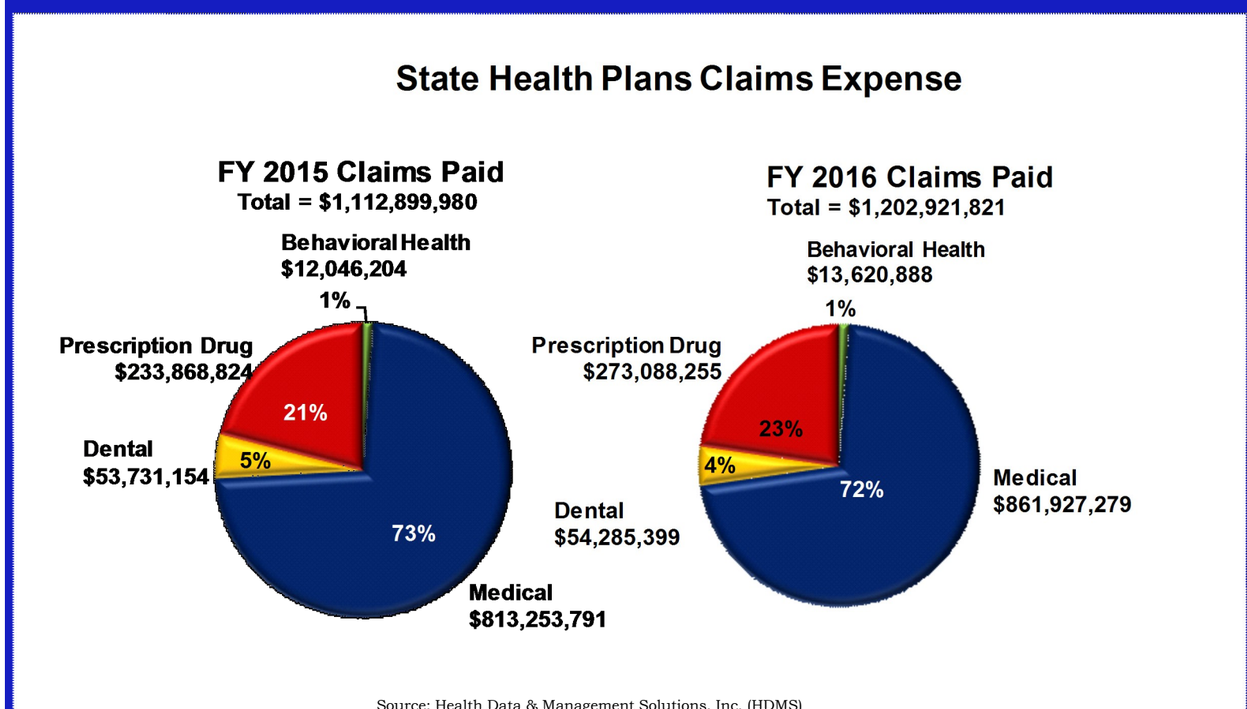
For the COVA Care plan, 6.4 million claims were processed in FY 2016. An average of 178,078 employees, early retirees and family members were eligible for plan services. Medical expenses were 72 percent, prescription drug expenses were 23 percent, dental claims were 4 percent, and behavioral health claims accounted for 1 percent of total claims costs, consistent with prior years.

For the COVA HealthAware plan, about 234,000 claims were processed in FY 2016. An average of 10,305 employees, early retirees and family members were eligible for plan services during the year. Medical expense represented 78 percent, prescription drugs claims accounted for 13 percent, dental claims were 8 percent, and behavioral health represented 1 percent of total claims expense.

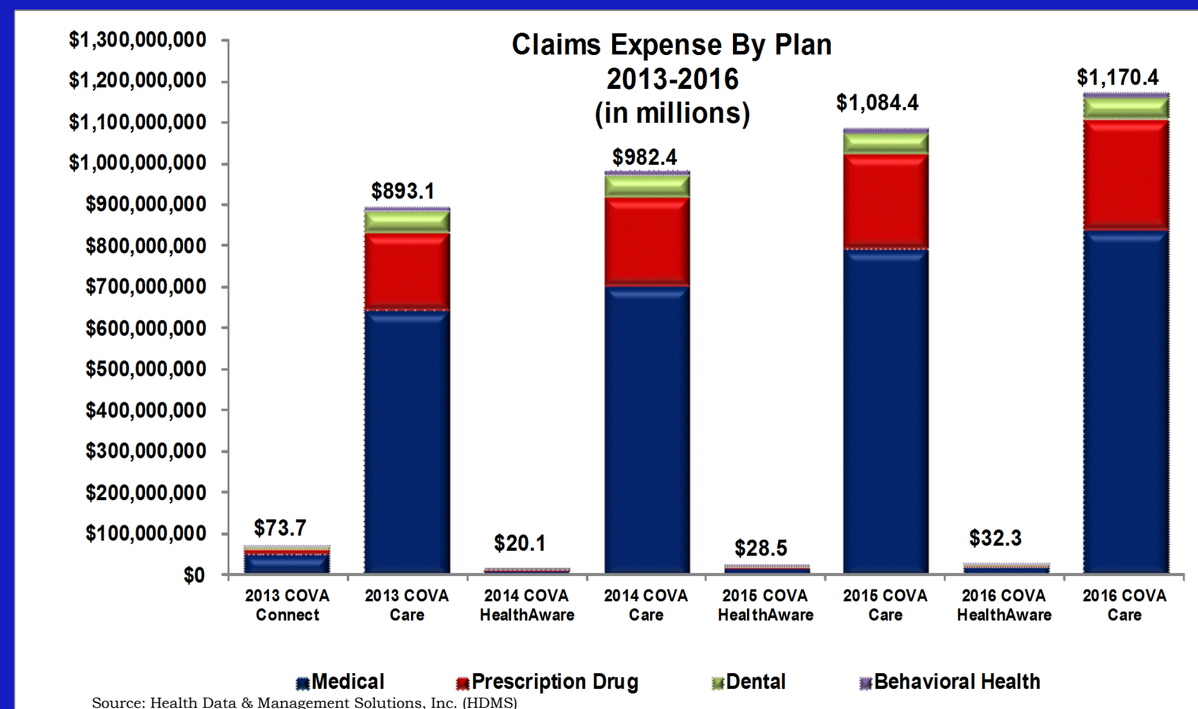


	Behavioral Health	Inpatient Hospital	Outpatient Hospital	Physician	Dental	Prescription Drug
2012	$11.4	$200.0	$196.9	$251.8	$52.7	$191.0
2013	$11.3	$216.0	$220.3	$262.2	$54.1	$202.9
2014	$11.7	$219.7	$238.1	$259.5	$54.9	$219.6
2015	$12.1	$255.4	$288.0	$269.9	$53.7	$233.9
2016	$13.6	$286.2	$301.8	$274.0	$54.3	$273.1

Source: Health Data & Management Solutions, Inc. (HDMS)

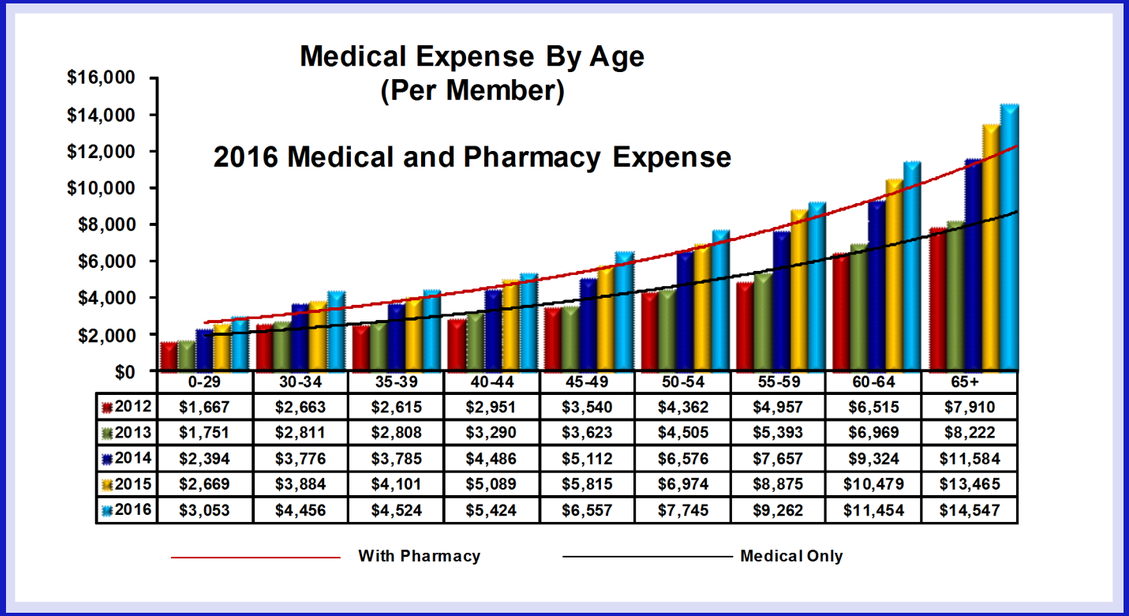


Source: Health Data & Management Solutions, Inc. (HDMS)

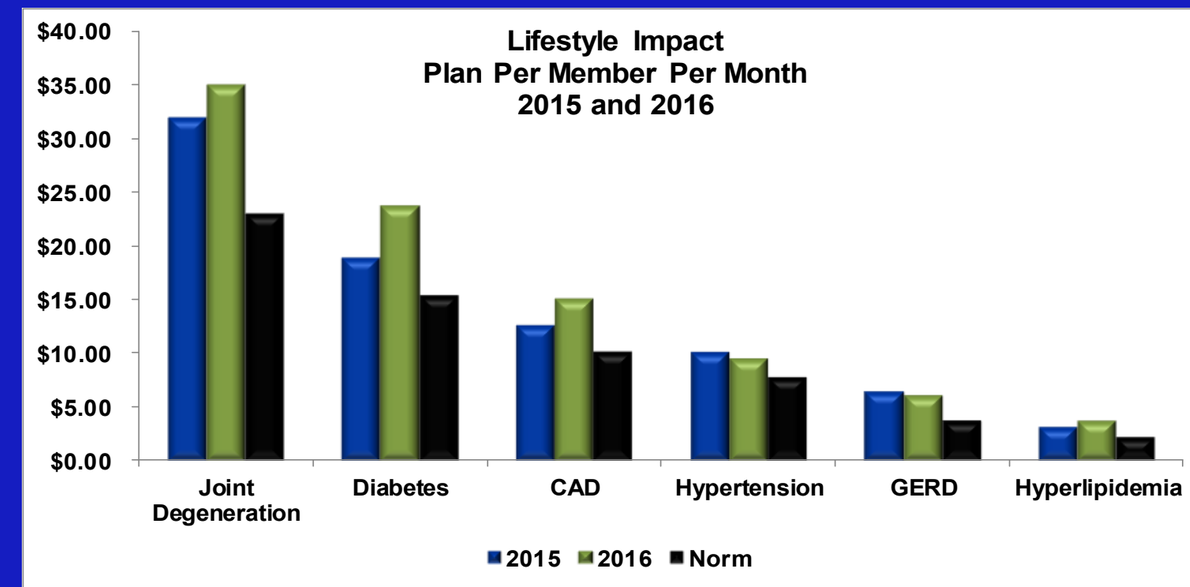


Source: Health Data & Management Solutions, Inc. (HDMS)

GOAL 5: ANALYZE HEALTH TRENDS-Cost Drivers



	0-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
2012	$1,667	$2,663	$2,615	$2,951	$3,540	$4,362	$4,957	$6,515	$7,910
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

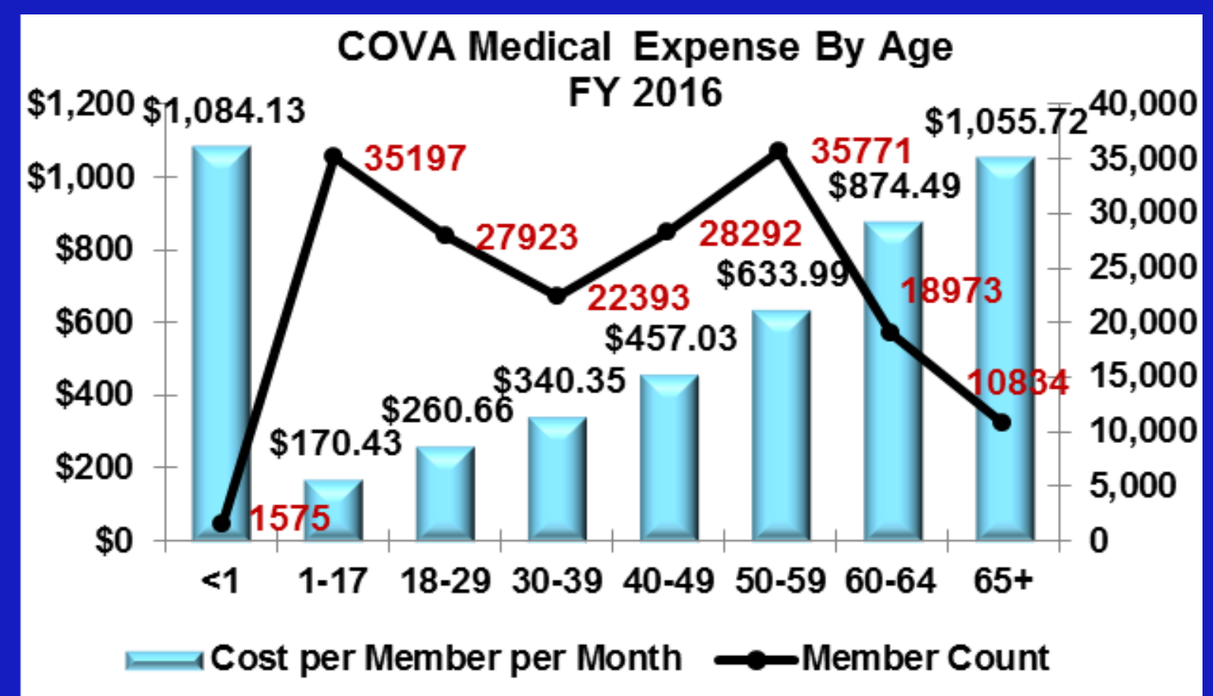


Cost Drivers: Age and Lifestyle

The state's average employee age decreased slightly from the prior year, to 47.9 from 48.2. 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 45.2. 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.

More than 60 percent of total plan members were over the age of 40. Those over the age of 50 represented 35 percent of COVA Care health plan members in FY 2016, and were responsible for 59 percent of COVA Care total plan medical expenses. Members 60 and over were 16.4 percent of membership and accounted for 51 percent of plan medical expenses. Employees in COVA Health Aware had an average age of 40.0 or 8.4 years younger than those in COVA Care, and their health care expenses were less.

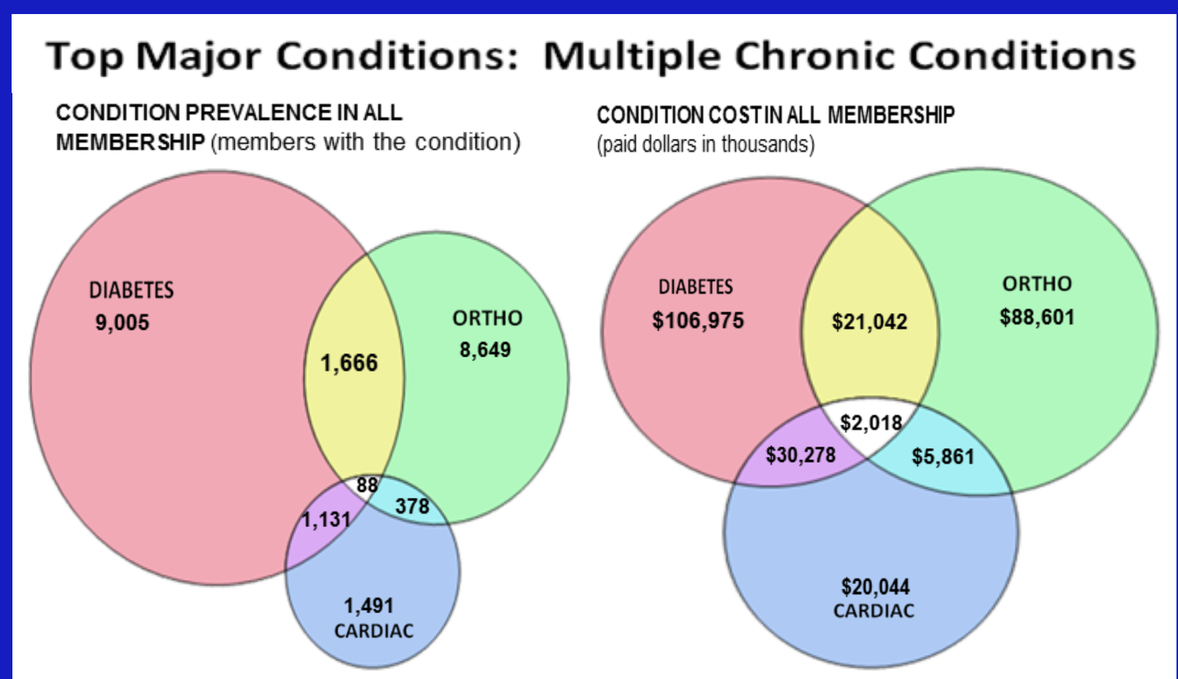
According to the National Institutes of Health, more than two-thirds of American adults and one in three children are overweight or obese. In the state population, that rate from biometric screening data is even greater at 74 percent. Weight issues are being addressed by identifying more at-risk members and improved health outcomes through the total population health initiative, and through healthy lifestyle programs from *CommonHealth*. Six conditions shown in the chart at the top right correlate with being overweight, and represented more than $200.6 million or 18 percent of the state plan's total medical and pharmacy expense in 2016. Of the six conditions, coronary artery disease and joint degeneration accounted for 54 percent of claims expense. Diabetes represented 25 percent of medical and pharmacy claims costs.



GOAL 5: ANALYZE HEALTH TRENDS-Top Ten

"Top Ten" Claims Expense

Medical Procedures	Chronic Uncontrolled Conditions	Chronic Controlled Conditions	Prescription Drugs
1. Unclassified causes	1.Unclassified causes	1. Osteoarthritis (except low back)	1. *Humira* - rheumatoid arthritis
2. Musculoskeletal	2. Oncology	2. Coronary Artery Disease	2. *Enbrel* - rheumatoid arthritis
3. Oncology	3. Musculoskeletal	3. Low Back Problems	3. *Harvoni*- hepatitis C
4. Cardiovascular	4. Cardiovascular	4. Breast Cancer	4. *Crestor*- high cholesterol
5. Gastrointestinal	5. Diabetes, Obesity & Lipid Disorders	5. Chronic kidney disease	5. *Lantus solostar* - diabetes
6. Diabetes, Obesity & Lipid Disorders	6. Gastrointestinal	6. Peripheral vascular disorders	6. *Esomeprazole magnesium* – stomach acid
7. Obstetrics	7. Behavioral Health	7. Diabetes	7. *Tecfidera* – multiple sclerosis
8. Neurology	8. Neurology	8. Gallbladder disease	8. *Victoza 3-Pak* - diabetes
9. Behavioral Health	9. Pulmonary	9. Hypertension	9. *Januvia* - diabetes
10.Pulmonary	10.Dermatology	10.Renal stones	10.*Aripiprazole* - depression



The Health Plan "Top Ten" Claims

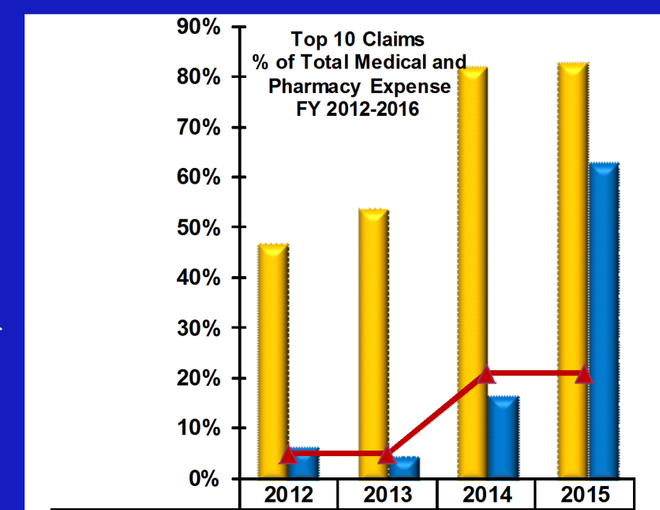
Expensive procedures, treatment of chronic conditions and the cost of prescription drug therapy continue to have a major impact on the state program. Other significant cost drivers relate to employee lifestyle, including: smoking, level of physical activity and weight. Another factor is the average state 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 $846 million, or 74 percent, of medical and pharmacy claims expense during FY 2016 came from claims for the top 10 medical procedures, chronic conditions, including those managed through preventive medicine, and prescription drugs. This compares to $771 million, or nearly 75 percent, in FY 2015.

Ranking in the top 10 for 2016 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 and Enbrel, used to treat rheumatoid arthritis. While the top 10 drugs represented 2.5 percent of prescriptions, they were 20 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 more than $223 million compared to $201 million in 2015. About 13.4 percent of members were treated for endocrinology, cardiology and orthopedics, which cost $274.8 million in 2016. These members represented 37 percent of total plan claims.

Of the members treated for multiple chronic conditions, 53 percent received diabetic services in 2016, down nine percent from 2015. The state program continues its diabetes management VBID initiative with participation incentives to help diabetics better manage their health. In 2016, state program participants had a better compliance rate than similar ActiveHealth programs in three of five diabetic metrics.



	2012	2013	2014	2015
Medical Procedures	47%	54%	82%	83%
Chronic Conditions	7%	5%	17%	63%
Prescription Drugs	5%	5%	21%	21%

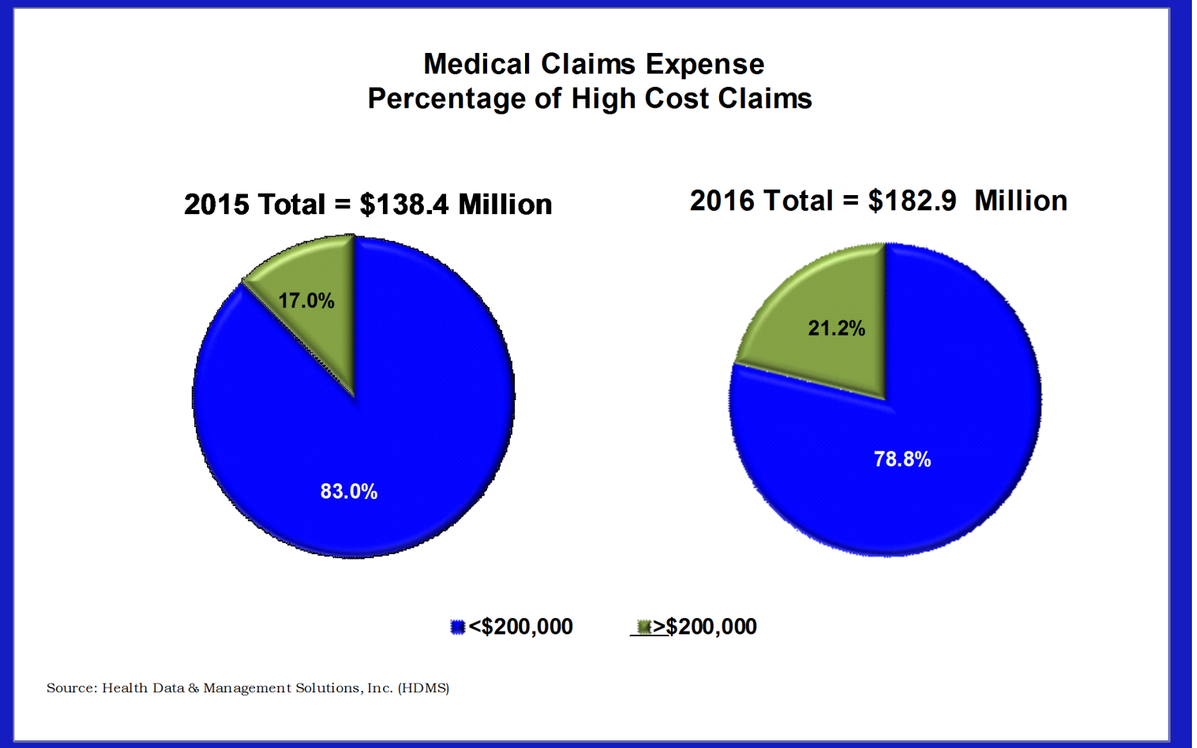
GOAL 5: ANALYZE HEALTH TRENDS-Medical

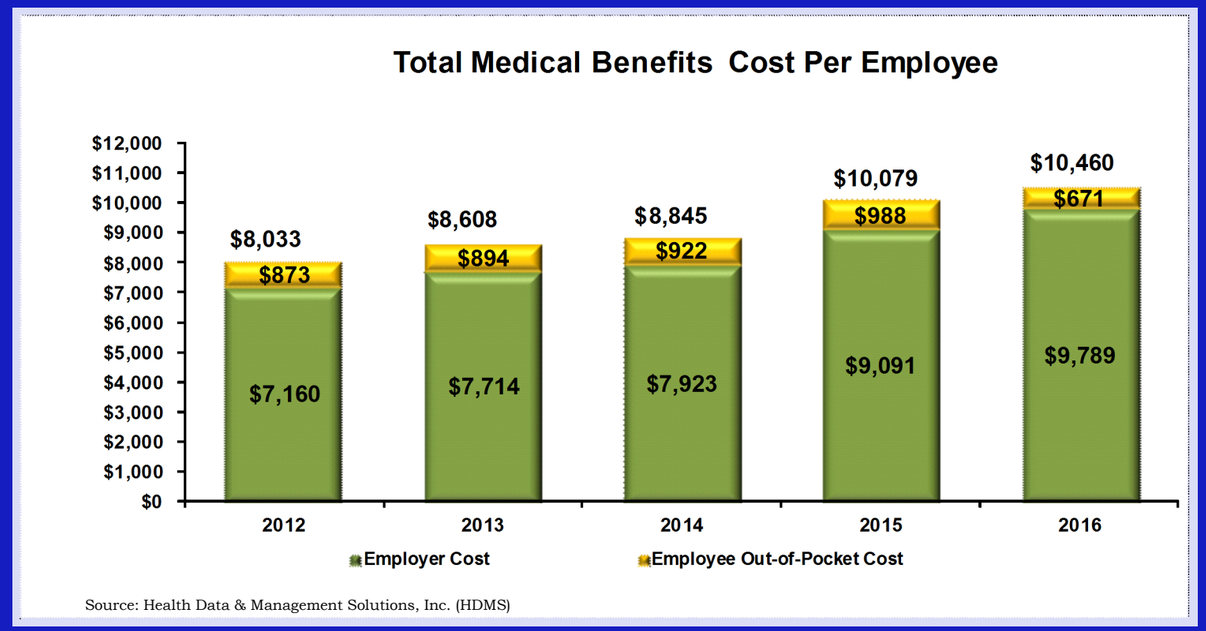
Medical Benefits Expense

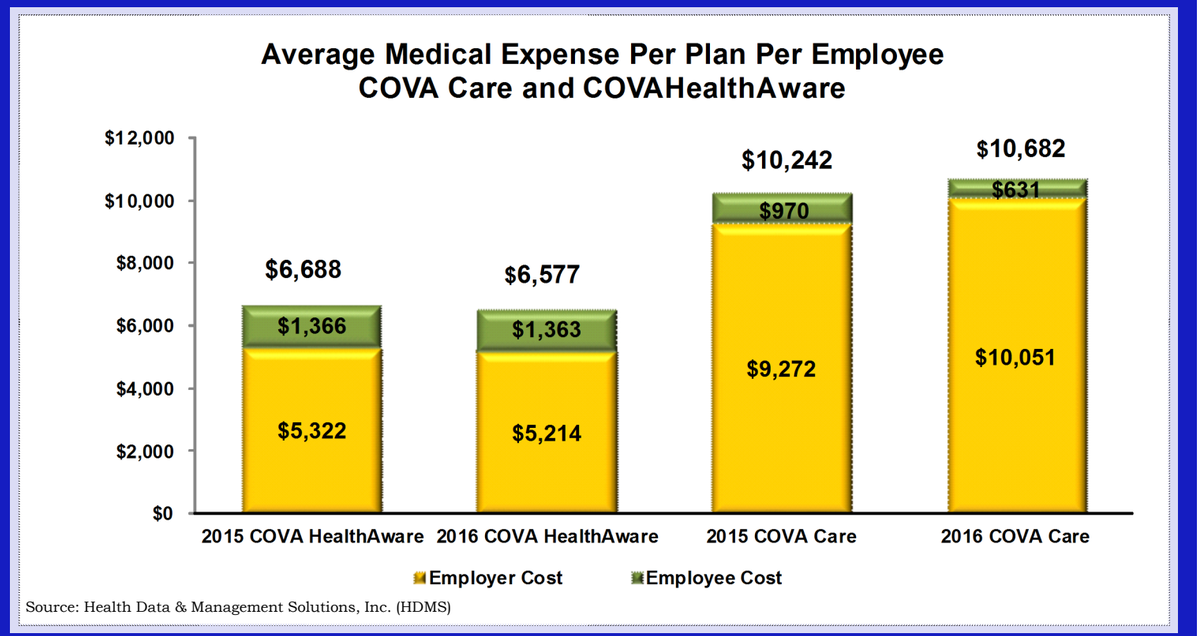
Total medical inpatient and outpatient facility and physician costs increased 6 percent in 2016, to $861.9 million from $813.3 million in 2015. The largest components of medical costs were inpatient facility and inpatient catastrophic claims. Inpatient hospital costs rose 12.1 percent, outpatient costs were up 4.8 percent, and overall physician expense was up 1.5 percent.

There were 450 catastrophic claims in 2016, coming from 0.2 percent of members yet representing 21 percent of total medical expense. These claims were driven primarily by treatment for cancer, heart disease, blood-related diseases and premature births. Catastrophic claims expense totaled $182.9 million in 2016 for those claims $200,000 or more, up 32.5 percent over the $138.0 million cost in 2015. More than 50 percent of catastrophic claims were from employees, and 46 percent of employees drove 55.2 percent of medical expense.

Inpatient hospital claims totaled $286.2 million in 2016, compared to $255.4 million in 2015. The employer portion of total medical benefits cost in 2016 was 93.6 percent, up from 90.2 percent the prior year. Employees paid 6.4 percent in 2016, down from 9.8 percent in 2015.





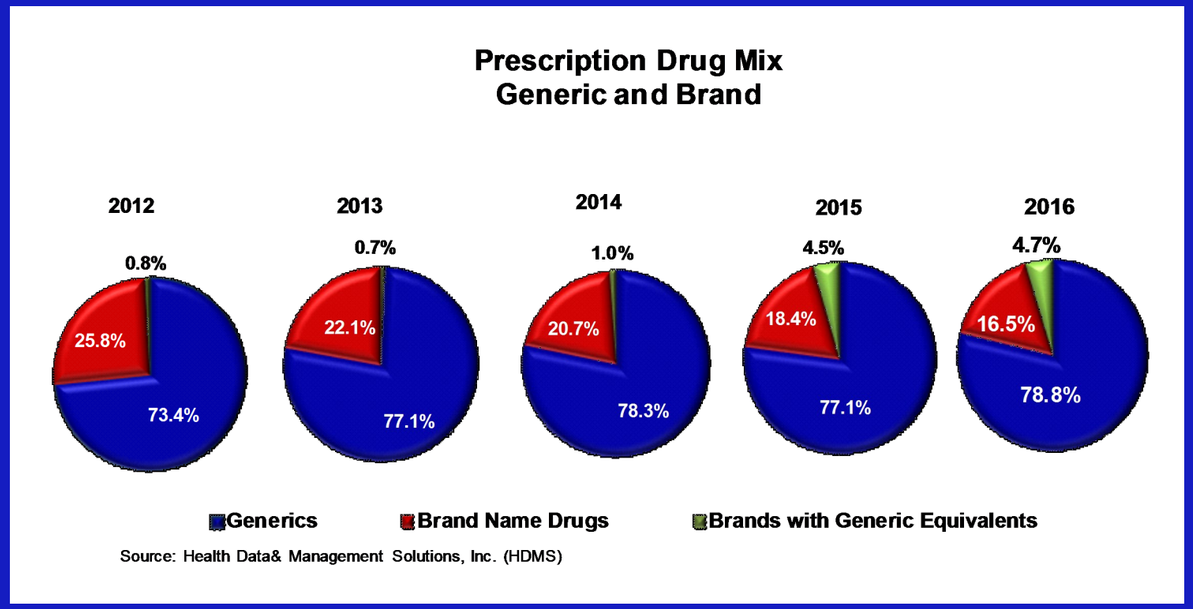


GOAL 5: ANALYZE HEALTH TRENDS-Drugs

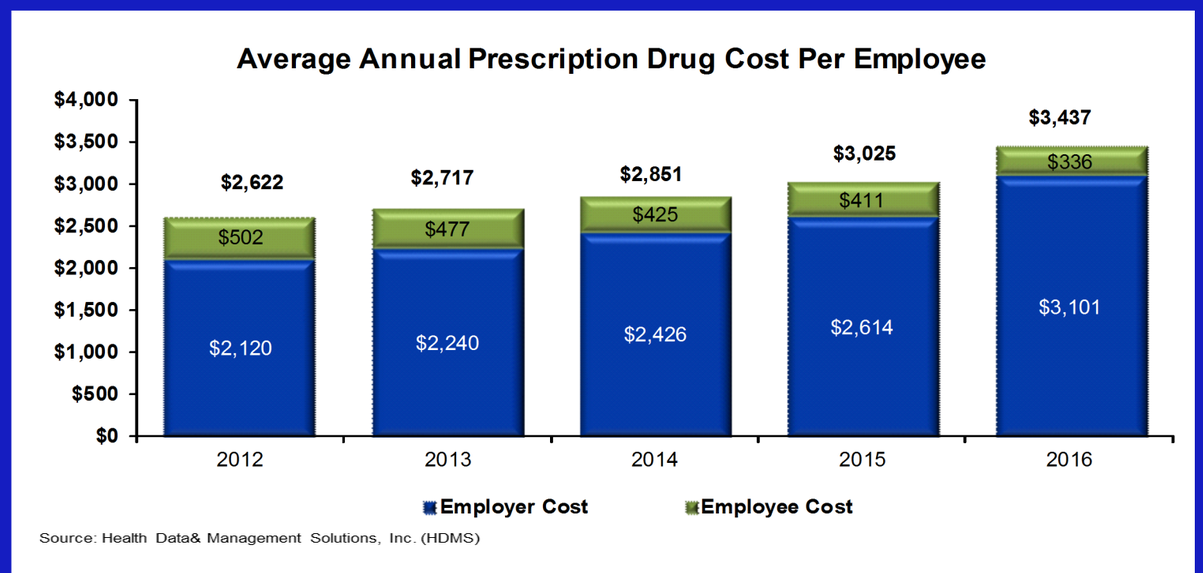
Prescription Drug Costs

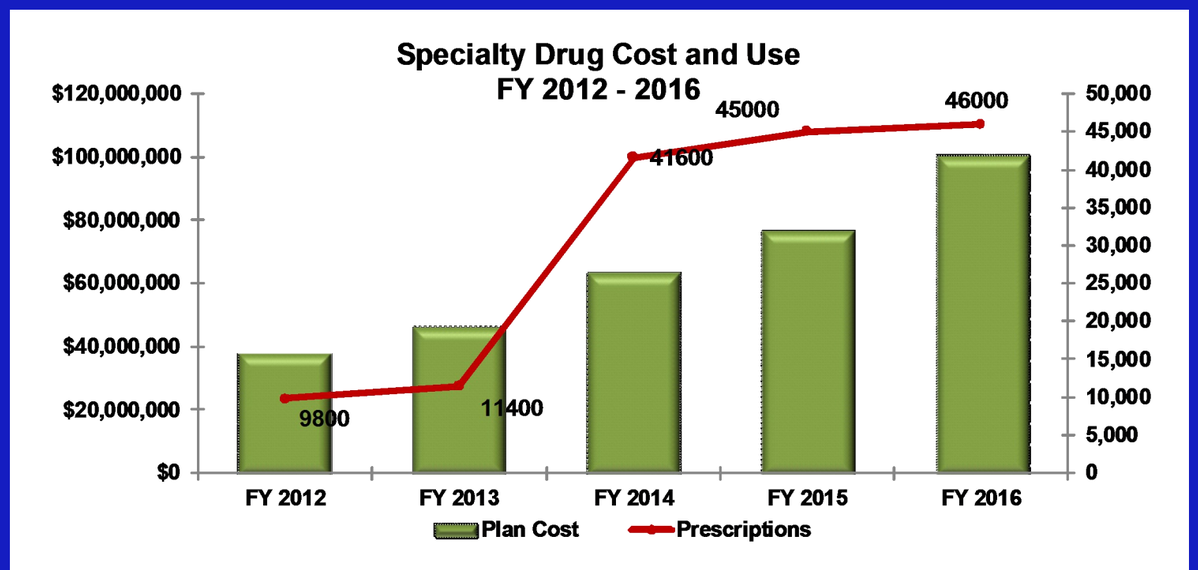
The demand for high cost specialty drugs continues to grow along with their impact on the state program. Specialty drug costs are 2.5 times what they were in FY 2012, and specialty prescriptions are five times more than four years ago. Specialty prescription drug costs were up 30.3 percent in FY 2016, to more than $100.1 million from $76.8 million the prior year. More than 46,000 specialty prescriptions were filled by state plan members during the 2016 plan year, representing 37 percent of drug cost during 2016.

Total prescription drug costs for the state program were up 16.8 percent in 2016, to $273.1 million from $233.8 million in 2015. 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 on 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 if there is a generic equivalent to a brand name drug. 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 increased to 78.8 percent in 2016 from 77.1 percent in 2015. Drug patents continued to expire on many highly utilized brand name drugs. The state paid $49.8 million in 2016 for generic drugs, representing 19 percent of drug costs, and $218.6 million for brand name drugs, reflecting 81 percent of drug cost. This compares to a total cost of $269.3 million for generics (26 percent) and $729.8 million for brands (73 percent) by other Anthem plans in Virginia. Even though the total annual prescription drug cost per state employee increased in 2016, members' share of total costs fell to 9.8 percent, or $336 per employee, from 13.5 percent, or $411 per employee, the previous year. COVA Care's prescription drug expense per employee was almost four times more than the comparable expense for COVA HealthAware. The cost increase was driven by treatment for rheumatoid arthritis, diabetes, multiple sclerosis, high cholesterol and heartburn/ulcer disease.





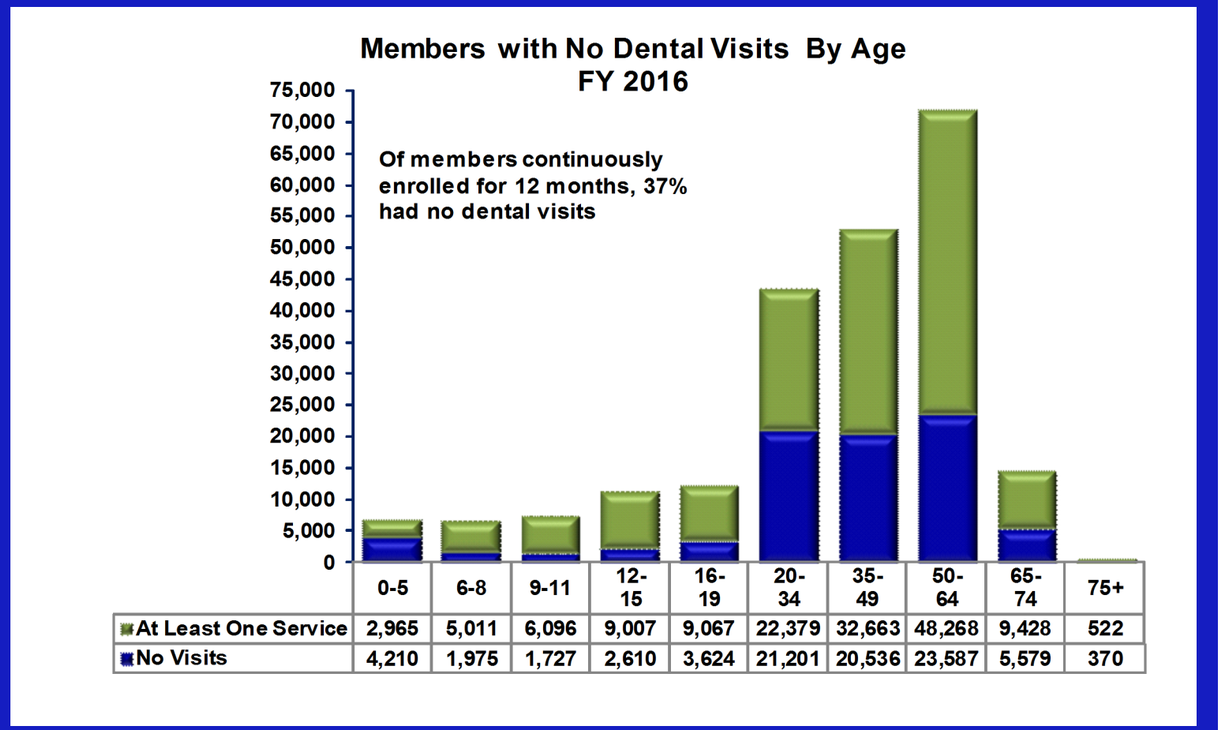
GOAL 5: ANALYZE HEALTH TRENDS-Dental

Dental Care and Expense

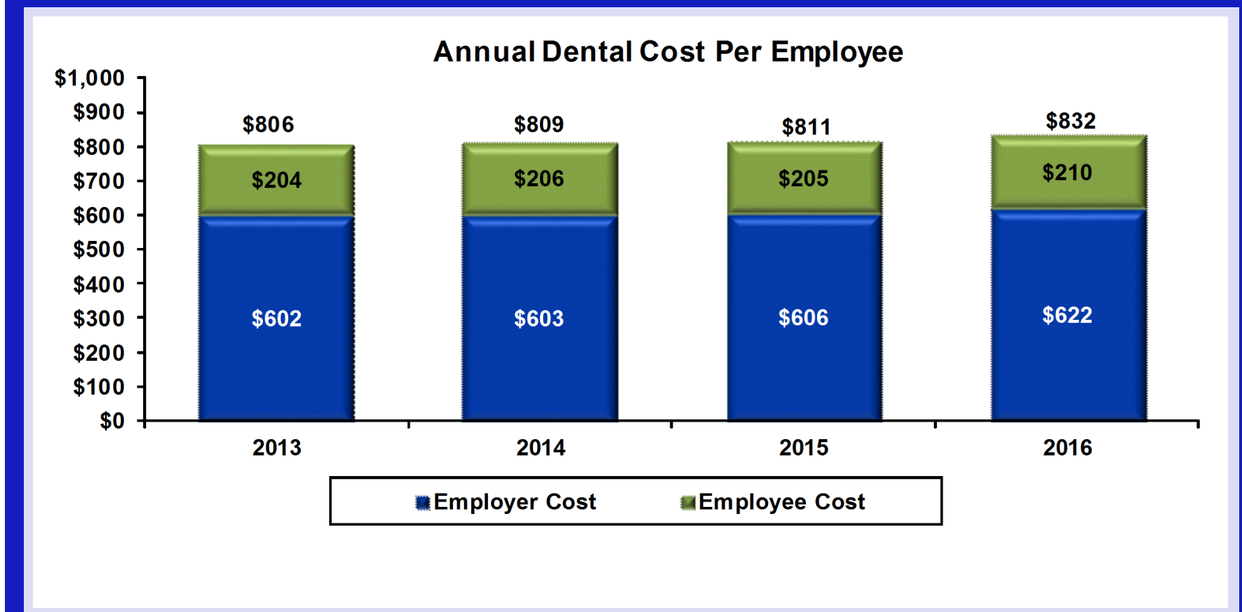
The state's dental costs were $622 per employee in 2016, or about 10 percent lower than the national average for employers of $688 per employee. The employee share of total dental cost increased by 2.4 percent in FY 2016, due primarily to a change in the mix of services and more enrollment in the Expanded Dental option. Approximately 348,000 dental claims were processed in 2016, compared to 350,000 the prior year. Dental benefits represented only 4 percent of total claims expense. Dental claim costs for the state program were up 1 percent in 2016, to $54.3 million from $53.7 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 2015 and 2016. 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.

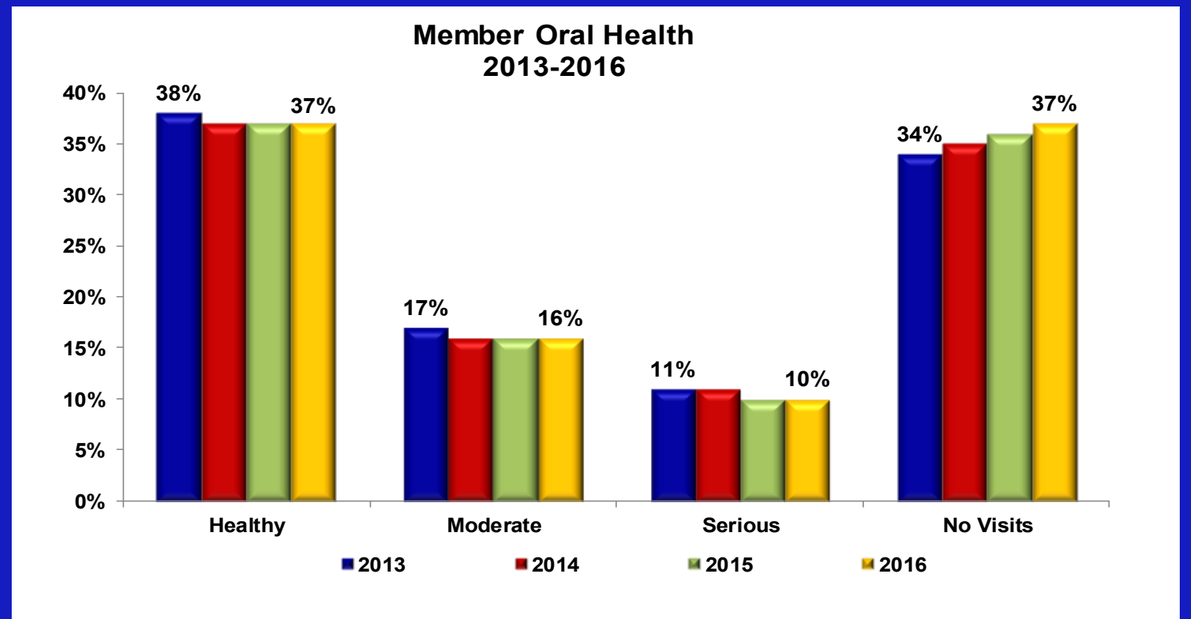
About 42 percent of members had at least one dental visit after a year of no visits. Overall member oral health in 2016 ranged from 37 percent in the healthy category with preventive care only, 16% moderate with preventive care and treatment, and 10 percent serious with emergency or extensive dental 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 $359 annually for each member who has at least one oral exam each year. About 37 percent of plan members are not visiting the dentist at all, an increase of 1 percent over the year before, and 32 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. A new, comprehensive marketing campaign is in development with new tools to more effectively target the no dental visit population.



	0-5	6-8	9-11	12-15	16-19	20-34	35-49	50-64	65-74	75+
At Least One Service	2,965	5,011	6,096	9,007	9,067	22,379	32,663	48,268	9,428	522
No Visits	4,210	1,975	1,727	2,610	3,624	21,201	20,536	23,587	5,579	370





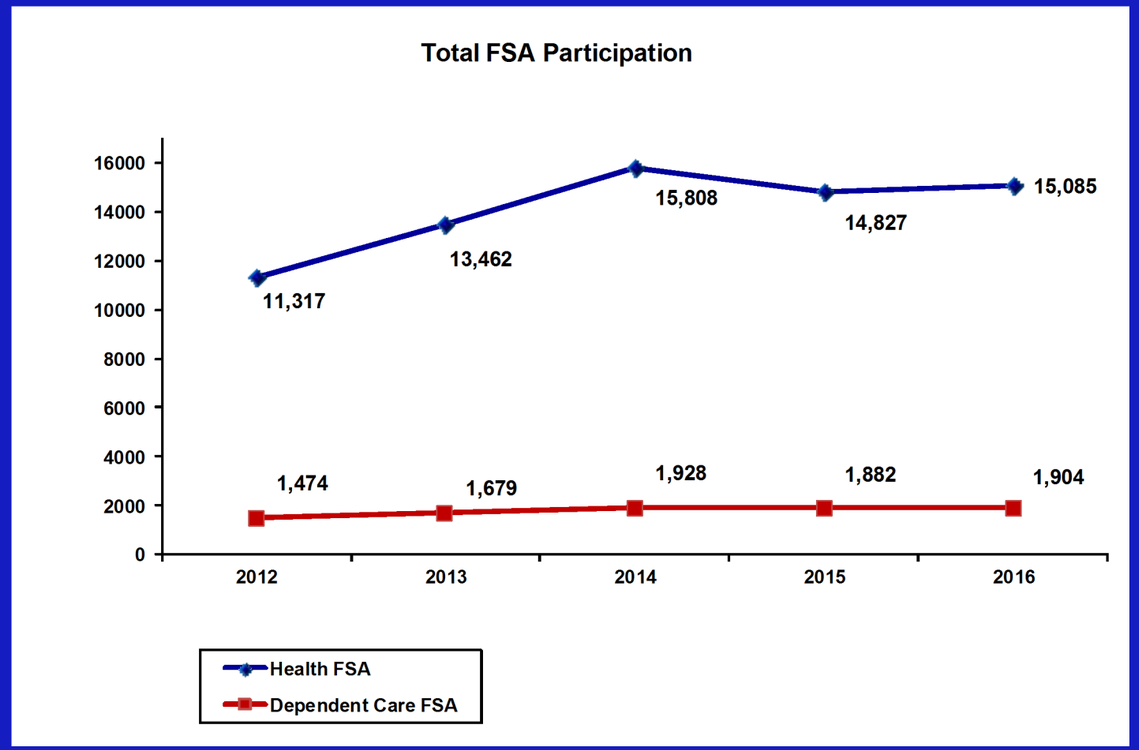
GOAL 5: ANALYZE HEALTH TRENDS-FSAs

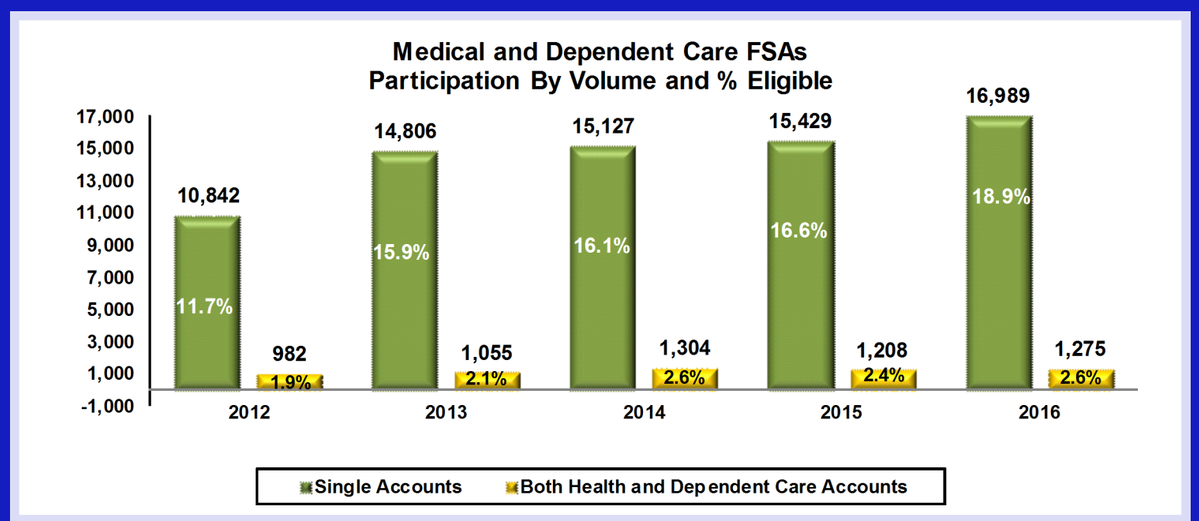
Flexible Spending Accounts (FSAs)

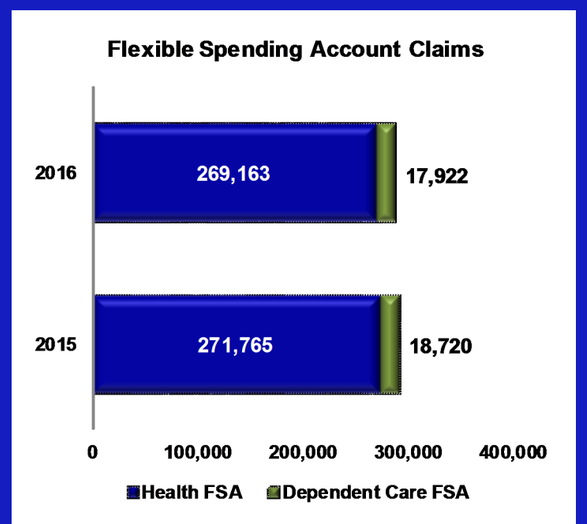
Flexible spending accounts (FSAs) allow employees to set aside part of their income before taxes to pay for certain health or day care expenses not covered by the plan. Employees may contribute up to $2,550 each year to a Health FSA, and up to $5,000 to a Dependent Care FSA depending on their tax status. While FSA participation has been relatively stable in past years, employee interest in these accounts increased slightly in FY 2016 after fluctuating during fiscal years 2014 and 2015.

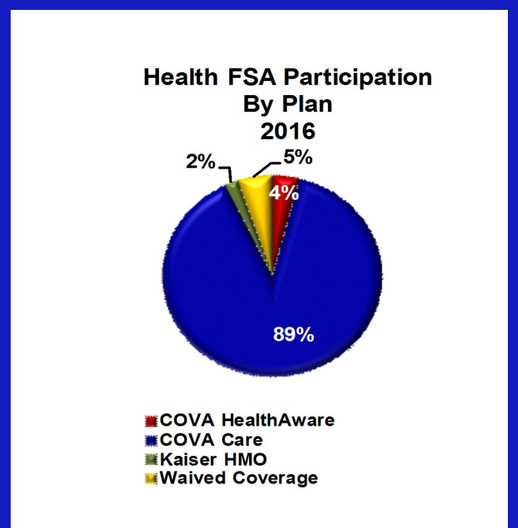
Health FSAs increased in 2016 to 15,085, up 1.8 percent from 14,827 the prior year, and Dependent Care FSAs increased 1.2 percent, to 1,904 from 1,882 in 2015. FSA participation is often contingent on perceptions of complexity and concerns about year-end forfeiture of funds. Younger employees often do not have enough health care expenses to make participation in a Health FSA worthwhile.

In 2016, COVA Care and COVA HDHP members represented 89 percent of Health FSA participants, followed by COVA HealthAware at 4 percent, and Kaiser Permanente HMO at 2 percent, which generally is reflective of the total population in each plan. Employees who waive health coverage remain eligible for an FSA, and approximately 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.









GOAL 6: INNOVATE-VBID Programs

Challenge

- Improve health for the approximately 8 percent of the state population with diabetes, which correlates with obesity.

Opportunity

- Engage members with diabetes in a value-based insurance design (VBID) program for improved health and lower plan costs.

Outcome

- 3,896, or 24 percent, of 16,203 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.
- VBID members are better managing their glucose and cholesterol for improved health, with 91 percent taking medications on schedule, higher than non-VBID members and established baselines for five metrics.

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 2016: diabetes management, hypertension and asthma/chronic obstructive pulmonary disease (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 10,552 members were engaged in these programs for the second and third years.

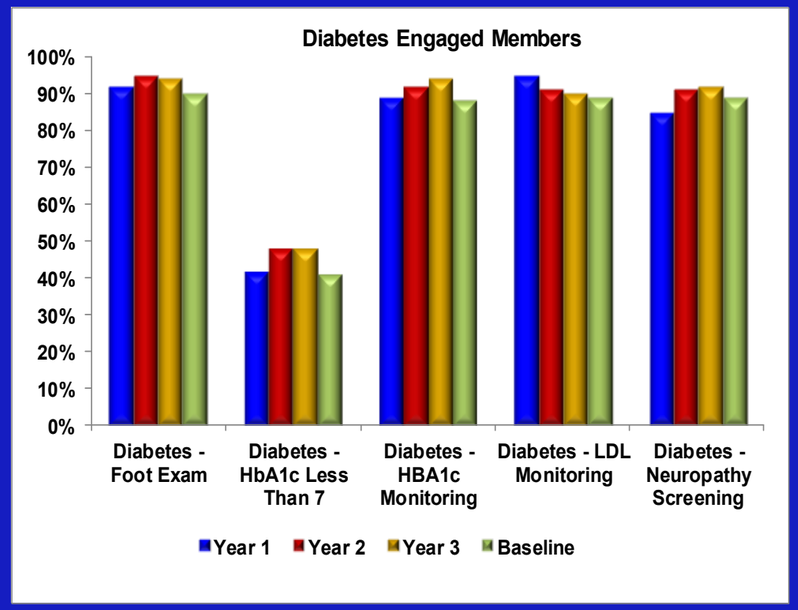
The diabetes management program is showing improved health outcomes for participants. More members are engaged in the program, and in 2016 improved in all five metrics compared to the baseline established for the program. State members also improved in three of five metrics compared to similar ActiveHealth programs. The average number of health conditions for participants has dropped to 2.9 from 4.8.

Most significant is that diabetes VBID members are getting their medications on schedule better than state members that are not in the program, and also better than the established baselines. VBID members in 2016 had a higher adherence rate than non-VBID members, 91 percent in 2016 compared to 78 percent for non-VBID members. They also refilled their medications on schedule more often than the baseline for each of five measures. 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 2016, there were more than 16,000 members in the state population with diabetes. Those in the diabetes VBID program cost $13.5 million in FY 2016.

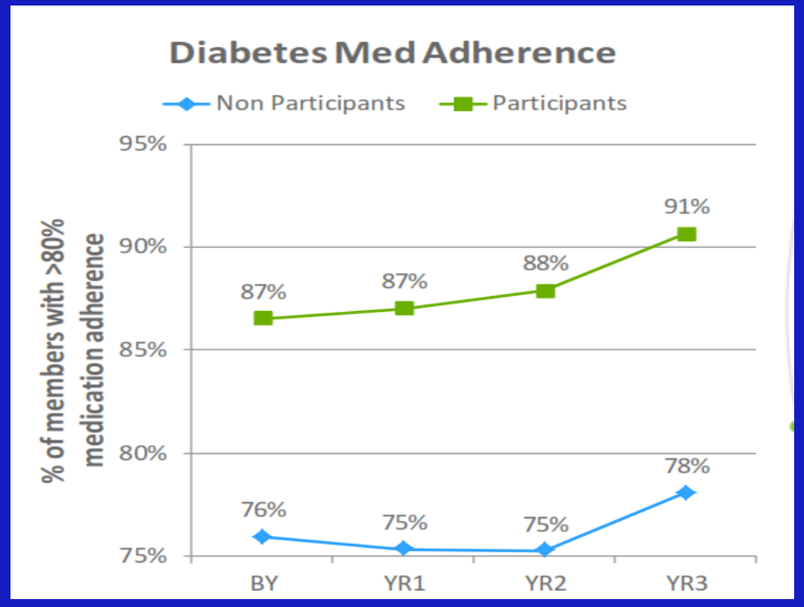
The hypertension and asthma/COPD programs were introduced in 2014, and are outperforming similar MyActiveHealth programs. Members are paying more attention to their health. Of the almost 43,000 members with hypertension, 5,219, or 12.1 percent, are engaged in the hypertension VBID program. Of those engaged, 88 percent had a blood pressure claim and 77 percent had a wellness exam, requirements for the program.

Data for the 1,437 members engaged in the asthma/COPD program, or 9 percent of the 15,800 with these conditions, shows that 88 percent had a wellness check-up and 72 percent had a flu shot. A better picture of health outcomes for these groups should be available in the next year.



Diabetes VBID Program Outcomes

Measures	Diabetes Year 1	Diabetes Year 2	Diabetes Year 3
Total eligible	15,576	16,203	16,203
Total engaged	2,689/17.3%	3,209/19.8%	3,896/24.0%
Average # of conditions	4.8	2.9	2.9
Dropped Out	121/4.5%	164/5.1%	221/5.6%
Wellness check-up	1,216/45%	1,814/57%	2,390/61%
HbA1c claim	2,482/92%	3,149/98%	3,824/98%



GOAL 6: INNOVATE-Bariatric Surgery

Challenges

- Improve health of members who are morbidly obese.
- Improve health outcomes for members who choose bariatric surgery.

Opportunities

- Offer education and coaching to help members improve their health.
- Remove financial barriers to participation.

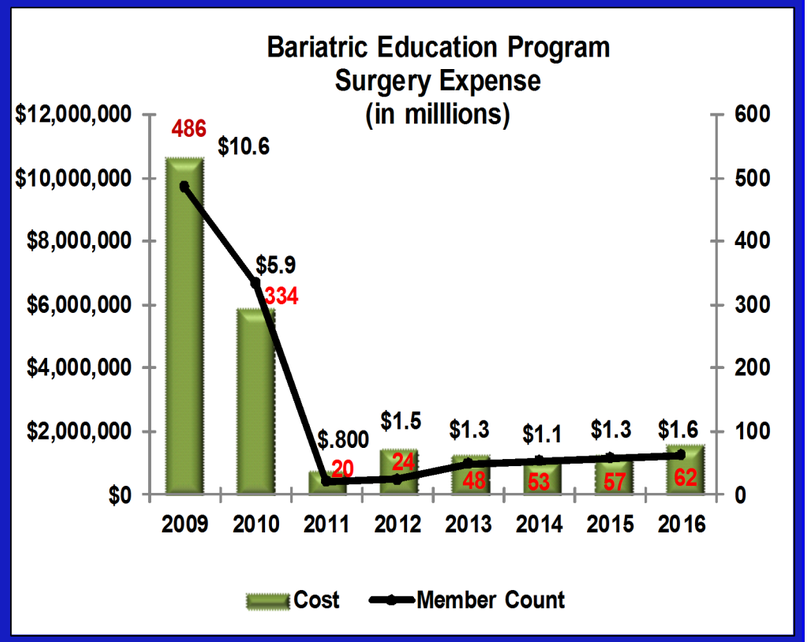
Outcomes

- Average weight loss per patient during the bariatric pre-surgery education program was 8.54 pounds.
- 52 percent of enrolled members reported making healthy lifestyle changes.
- 223 individuals have graduated since the program began.
- 26 members who participated in the 12-month post-surgery program lost an average of 32.24 pounds.
- Bariatric surgery cases have declined 87 percent, and costs have decreased by $9 million annually since 2009.

Positive outcomes have included weight loss, improved nutrition, better coping skills and increased activity/exercise. Bariatric surgery cases have declined by 87 percent, from 486 in 2009 to 62 in 2016, and overall bariatric surgery claims and other claims cost have dropped from $10.6 million to $1.6 million.

Since 2014, 502 plan members have enrolled in the education program, and 27 have dropped out. Of the 475 remaining in the program, 247, or 52 percent, reported changes to their lifestyle such as getting more exercise, feeling less depressed and eating healthier foods. On average, each participant lost 8 and 1/2 pounds. A total of 223 participants have graduated from the program.

Of the 26 participants who continued the coaching program for 12 months after surgery, 96 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 32.24 pounds.



Bariatric Surgery Education Program

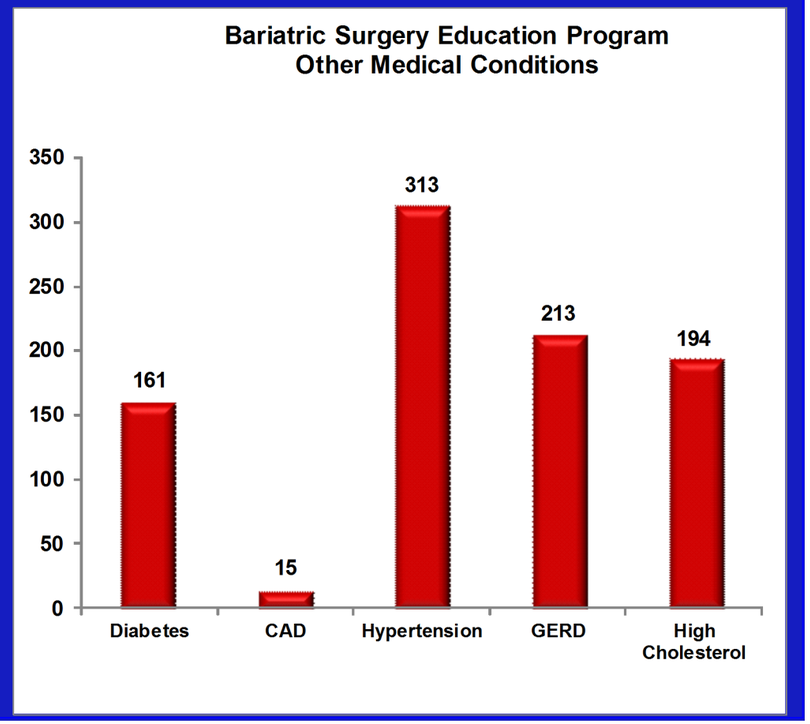
In 2009, the Commonwealth took a very serious look at health outcomes from members who had undergone bariatric surgery. Many of these members had unsuccessful surgery, and worse, a few members had died from complications. In addition, bariatric surgery and obesity medical expense for the Commonwealth 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 995 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.

Bariatric Surgery Program Outcomes

Measures	Count	Result
Total enrolled since 2014	502	
Total graduated	223	• No surgery for some • Lifestyle changes
Dropped out	27/5.4%	
Lifestyle changes	247/52%	• More exercise • Less depressed • Better nutrition • Better portion control • Less stress • Keep food diary
Average weight loss/patient pre-surgery program	-8.54 lbs	
Average weight loss/patient post-surgery program	-32.24 lbs	



GOAL 6: INNOVATE-Maternity Management

Challenges

- Improve the health of at risk expectant mothers to help them deliver healthy babies.

Opportunities

- Offer pregnant health plan members a maternity management program for at risk pregnancies.
- Provide an incentive to increase participation.

Outcomes

- 857 total members were newly enrolled in FY 2016.
- Less than 1 percent of the 542 babies born to members enrolled in *Healthy Beginnings* in FY 2016 were premature, compared to 8.5 percent of the 1,320 live births for other ActiveHealth programs.
- The state program had fewer emergency C-sections than other ActiveHealth programs, 97 or 17.4 percent, compared to 262 or 18.8 percent.

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.

In FY 2016, the *Healthy Beginnings* program newly identified 2,450 pregnant members. A total of 857 were newly enrolled, with 824 at high or medium risk of a complicated pregnancy. Of those who enrolled, 72 percent were between the ages of 26 and 35. There was a 90 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 97 state members, or 17.6 percent, had an emergency C-section compared to 262, or 18.8 percent, in other ActiveHealth programs.

Among those 824 members at risk for pregnancy complications, 9 percent screened positive for depression and 1.2 percent for hyperemesis, which causes severe nausea, vomiting and weight loss.

While 626 members completed the *Healthy Beginnings* program in FY 2016, the number of births and type of birth are recorded during a post–partum assessment. Some members did not complete the assessment until the 2017 fiscal year, so any resulting births were not shown in the 542 live births recorded for 2016.

For other similar ActiveHealth programs, 8.5 percent of live births in FY 2016 were premature infants, compared to less than one percent for the Commonwealth. Other ActiveHealth programs recorded 29 multiple births, compared to five for the state program. The state also had half the number of stillborn babies.

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 96 percent of eligible members enrolled in the program in the first and second trimester, and 91 percent were assessed by the 20th week.

Source: Active Health Management

***Healthy Beginnings* Maternity Management Program**

Outcome of Delivery	Other ActiveHealth	State
Live Birth	1,320	537
Pre Term	113	5
Multiple Live Births	29	5
Stillborn	6	3
Neonatal Death	4	1

Source: Active Health Management

GOAL 6: INNOVATE-Health Care Delivery

Challenge

- Improve access to health care.

Opportunities

- Increase use of telemedicine by adding access to an online doctor available 24/7.
- Open a downtown Richmond pilot health care clinic for employees to use during the workday.

Outcomes

- 92 members or 51 percent of those who visited the online doctor, avoided unnecessary urgent care.
- 16 members or 9 percent of those who visited the online doctor, avoided unnecessary emergency room visits.
- Capitol Square Healthcare had more than 1,000 employee visits in calendar year 2016.
- Patients rate clinic services as 99 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 added two new options in FY 2016 to the way that members receive physician services. Both the online doctor visits introduced in July 2015 and the Capitol Square Healthcare pilot on site for state employees in downtown Richmond provide alternative care options for plan members.

Online technology is now allowing 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 2016, there were 374 registrations and 182 online doctor visits. Since inception of the program, there have been more than 900 registrations and 277 visits. The 30-45 age group has used the service the most. The 2016 annual utilization rate was less than 1 percent for state plans. Of those who have used the online doctor to date, 144 or 52 percent, accessed care through a mobile phone. In 2016, the online doctor program cost the state $27,400 and members $7,530. By using this convenient option, 92 members in 2016, or 51 percent, avoided unnecessary urgent care and 16 members or nine percent, avoided unnecessary emergency room visits.

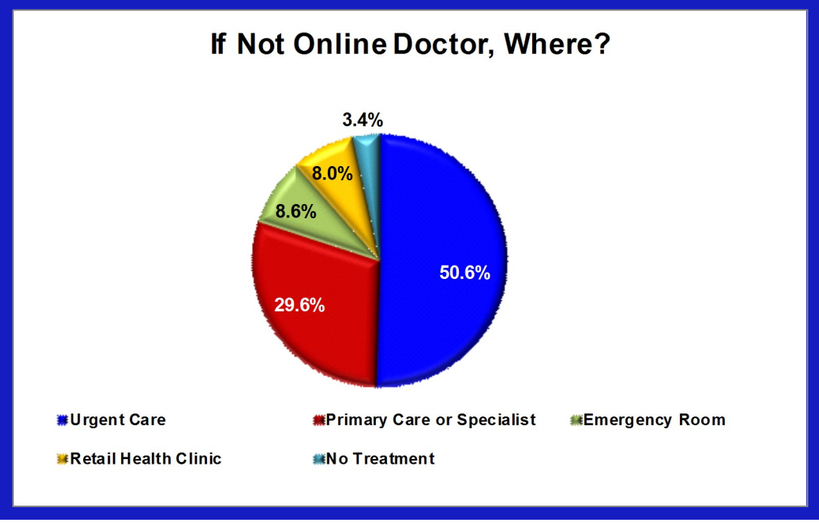
State employees received another convenient way to access health care with the opening in May 2016 of Capitol Square Healthcare for State Employees in downtown Richmond. A partnership between DHRM and the VCU Health System, the new health and wellness clinic in the James Monroe Building makes it easier 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.

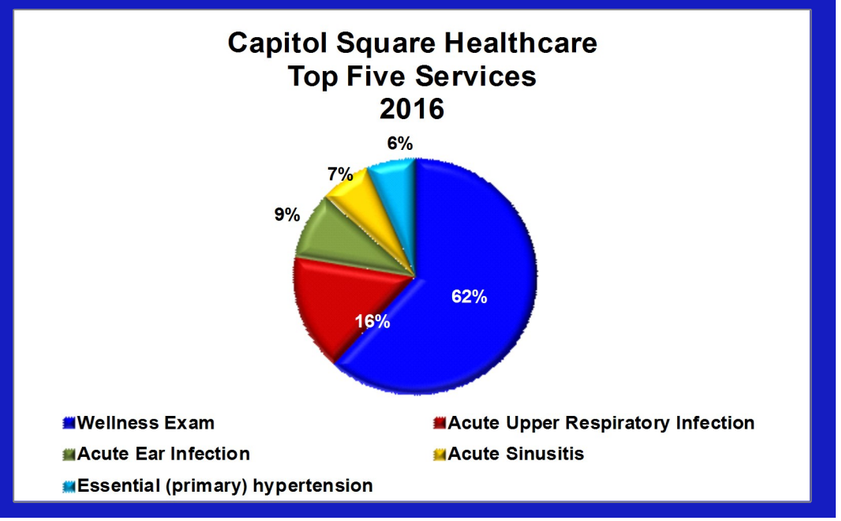
Designed to save employees time, the clinic has a full-time medical director, nurse practitioner and a MyActiveHealth healthy lifestyle coach. Treatment includes services for such illnesses as colds, contusions, eye and ear infections, headaches, and sore throats. Employees may also take biometric screenings required for earning Premium Rewards. 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 calendar year 2016, the clinic had 1,046 visits. An average of 78 percent were for the same day in the final quarter of calendar year 2016. About 47 percent of diagnoses were for urgent care, 46 percent were wellness exams and 7 percent were for ongoing care. Services were rated good or excellent by 99 percent of patients.

Above: Governor McAuliffe joined Secretary of Administration Nancy Rodrigues, DHRM Director Sara Redding Wilson, VCU President Michael Rao, Medical Director Latrina Lemon and VCU Health System officials for the grand opening of Capitol Square Healthcare in May 2016.

Capitol Square Healthcare staff members participated in a number of community events in FY 2016 to increase awareness, including employee events and flu shot clinics.





GOAL 7: ENHANCE CUSTOMER SERVICE

Challenge

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

Opportunity

- Improve customer satisfaction ratings.

Outcome

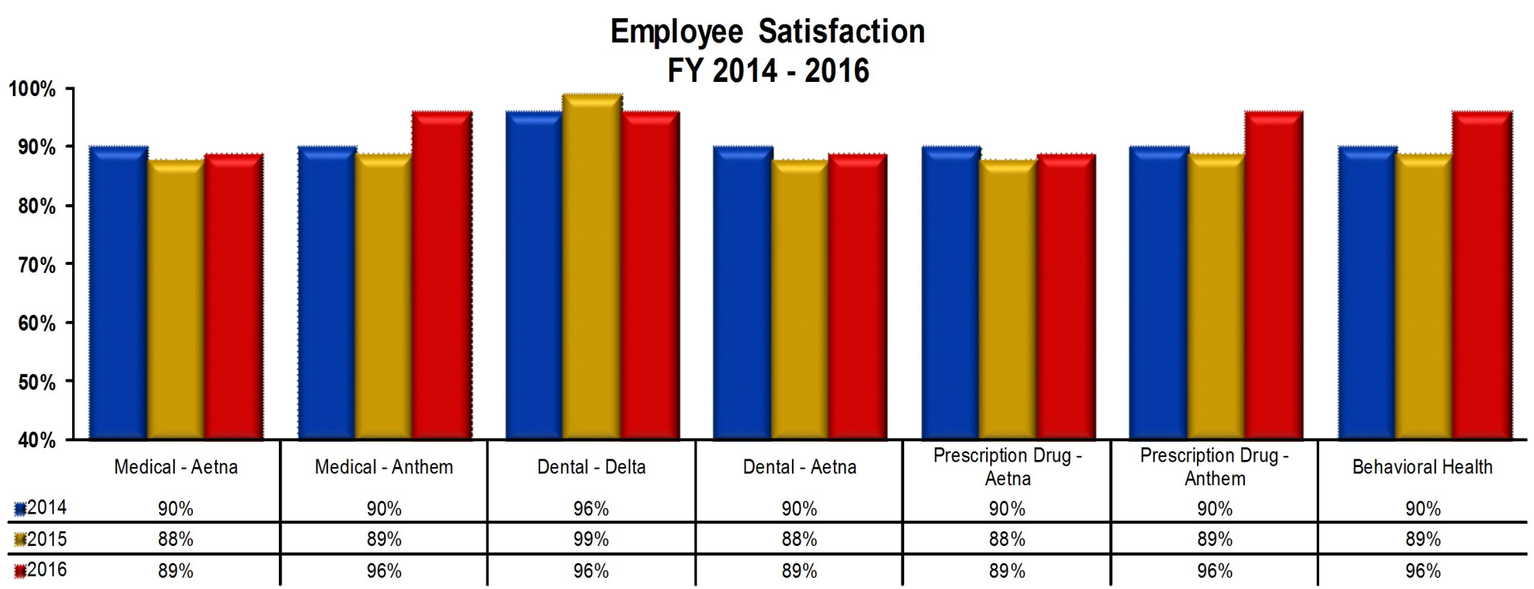
- State health benefits plans had an overall customer satisfaction rating in 2016 of 95.6%, an increase of 6.1 percent over the prior year.
  - COVA Care's customer satisfaction rating in 2016 was 96 percent, up from 89 percent in 2015.
  - COVA HealthAware's customer satisfaction rating in 2016 was 89 percent, a 1 percent increase from the 88 percent rating in 2015.

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 2016 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.

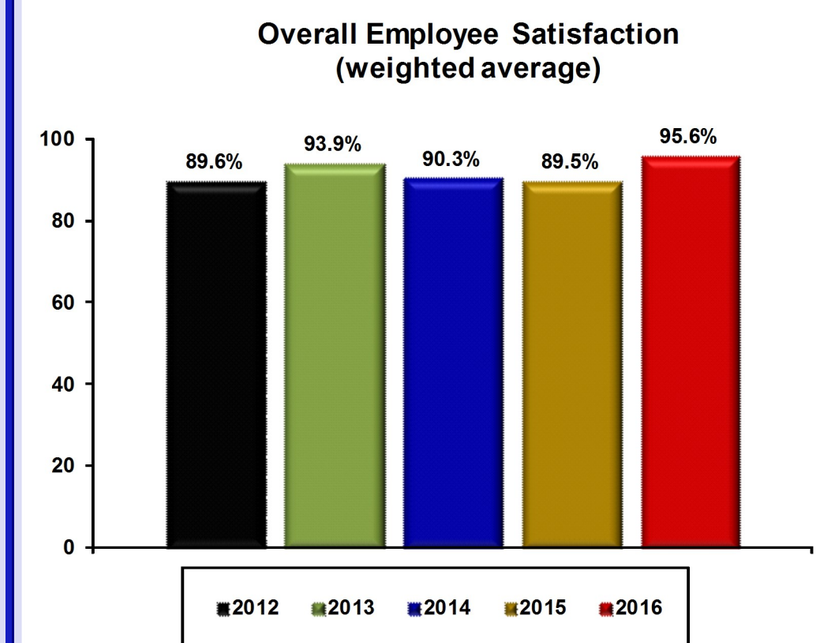
The medical plan satisfaction results are from the standard Healthcare Effectiveness Data and Information Set (HEDIS®) 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Adult Commercial Survey done in cooperation with the National Committee for Quality Assurance. Members surveyed 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 2016. Overall satisfaction with the health plan increased to 95.6 percent from 89.5 percent in 2015. COVA Care's benefits had the highest rating in 2016, at 96 percent, a significant increase from 89 percent in 2015 for all but dental, which was 99 percent. The COVA HealthAware plan experienced a 1 percent increase from the 88 percent rating the previous year. 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 - Delta	Dental - Aetna	Prescription Drug - Aetna	Prescription Drug - Anthem	Behavioral Health
2014	90%	90%	96%	90%	90%	90%	90%
2015	88%	89%	99%	88%	88%	89%	89%
2016	89%	96%	96%	89%	89%	96%	96%



GOAL 8: INCREASE COST EFFECTIVENESS

Challenge

- Manage costs while implementing the Affordable Care Act (ACA) and other changes.

Opportunity

- Focus on better health outcomes for plan members in addition to utilization.
- Change COVA Care plan design to conform with ACA requirements related to out-of-pocket limit calculation.

Outcome

- Additional funds added to build back reserves resulted in a surplus in FY 2015.
- More claims and operational expenses, combined with no changes in the COVA Care plan design, contributed to a deficit in FY 2016.

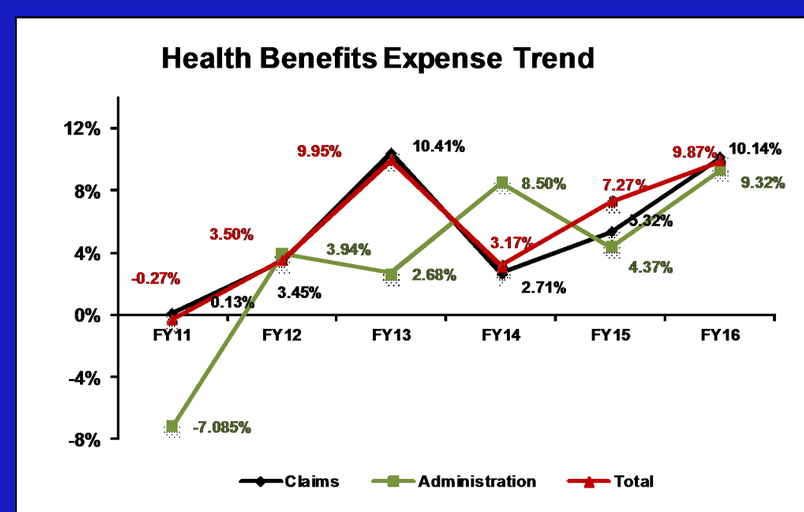
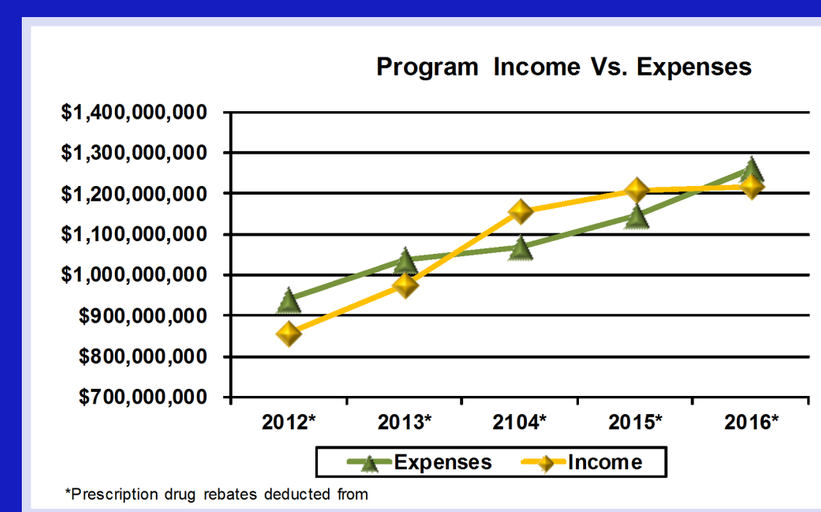
PROGRAM TOTAL	FISCAL YEAR 2012	FISCAL YEAR 2013	FISCAL YEAR 2014	FISCAL YEAR 2015	FISCAL YEAR 2016
Annual Income *(Premiums, Interest, Other)*	$858,355,689	$974,121,189	$1,155,553,236	$1,206,651,640	$1,216,450,352
Annual Expenses *(Claims, Contract Administration, Other)*	$942,600,413*	$1,036,411,426*	$1,069,307,832*	$1,147,096,057*	$1,260,333,640*
Income Less Expenses	($84,244,724)	($62,290,237)	$86,245,404	$59,555,583	($43,883,288)
	*Prescription drug rebates deducted	*Prescription drug rebates deducted	*Prescription drug rebates deducted	*Prescription drug rebates deducted	*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 2016. The other 8 percent accounted for the cost of contract administration, the $5.7 million employer reinsurance fee and other expenses related to the Affordable Care Act (ACA). Claims expense included $8.6 million in incurred but not reported (IBNR) claims.

Cost containment measures combined with less than expected program expense led to program surpluses from 2005-2008. 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, the COVA Care plan design did not. This means that 21,424 members reached the COVA Care out-of-pocket expense limit in 2016, compared to 8,750 in 2015. The COVA Care plan design, combined with higher claims, ACA and operational costs, contributed to higher expenses for the program.

State operating costs totaled almost $1.3 billion in 2016, up 9.8 percent from the prior year. Claims costs grew approximately 8 percent. Administrative costs increased 9 percent in 2016, in part because of an estimated $7.3 million in ACA-related expenses.