STATE OF NEBRASKA SERVICE CONTRACT ADDENDUM

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 3	08/17/18
BUSINESS UNIT	BUYER
65080007	JENNIFER ELOGE (AS)

VENDOR NUMBER: 2369150

VENDOR ADDRESS:

THE SEGAL COMPANY SOUTHEAST INC
DBA SEGAL CONSULTING & SEGAL GROUP
333 W 34TH ST
NEW YORK NY 10001-2417

CONTRACT NUMBER
73507 O4

AN AWARD HAS BEEN MADE TO THE VENDOR/CONTRACTOR NAMED ABOVE FOR THE SERVICES AS LISTED BELOW FOR THE PERIOD:

SEPTEMBER 01, 2016 THROUGH AUGUST 31, 2019

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5297 Z1

Contract to supply and deliver professional health and welfare consulting services for the employee insurance benefits program which includes health, wellness, dental, vision, life, long term disability, flexible spending accounts, health savings account, and employee assistance program to the State of Nebraska as per the attached specifications for a three (3) year period from date of award. The contract may be renewed for four (4) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Kenneth Vieira
Phone: 678-306-3154
Cellular: 404-709-9016
Fax: 678-669-1887
E-Mail: kvieira@segalco.com

(08/29/16 djo)

Addendum Three as attached. (08/17/18 ml)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	YEAR 1 ANNUAL RATE INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	12.0000	MO	18,000.0000	216,000.00
2	YEAR 2 ANNUAL RATE INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	12.0000	MO	18,333.3400	220,000.08
3	YEAR 3 ANNUAL RATE INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	12.0000	MO	18,666.6700	224,000.04
4	HEALTH INSURANCE PLAN POSTING OF THE RFP	1.0000	EA	80,000.0000	80,000.00

8/17/18
BUYER
8/17/2018
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT ADDENDUM

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2 of 3	08/17/18
BUSINESS UNIT	BUYER
65080007	JENNIFER ELOGE (AS)

VENDOR NUMBER: 2369150

CONTRACT NUMBER
73507 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT PERIOD SEPTEMBER 1 2016 THROUGH AUGUST 31 2019				
5	HEALTH INSURANCE PLAN POSTING OF INTENT TO AWARD INITIAL CONTRACT PERIOD SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	1.0000	EA	60,000.0000	60,000.00
6	HEALTH INSURANCE PLAN CONTRACTOR START DATE INITIAL CONTRACT PERIOD SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	1.0000	EA	30,000.0000	30,000.00
7	HEALTH INSURANCE PLAN IMPLEMENTATION CLAIMS AUDIT INITIAL CONTRACT PERIOD SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	1.0000	EA	20,000.0000	20,000.00
8	ACCOUNT EXECUTIVE MANAGER INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	15.0000	HR	325.0000	4,875.00
9	ACTUARY INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	62.0000	HR	325.0000	20,150.00
10	UNDERWRITER INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	53.0000	HR	325.0000	17,225.00
11	SME - EXECUTIVE/MANAGER INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	62.0000	HR	325.0000	20,150.00
12	SME - STAFF CONSULTANT INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	46.0000	HR	325.0000	14,950.00
13	2018 GASB 75 VALUATION	1.0000	EA	15,000.0000	15,000.00
14	2019 GASB 75 VALUATION	1.0000	EA	35,000.0000	35,000.00
15	2020 GASB 75 VALUATION OPTION YEAR 1	1.0000	EA	16,000.0000	16,000.00

BUYER INITIALS

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65080007	JENNIFER ELOGE (AS)

VENDOR NUMBER: 2369150

CONTRACT NUMBER
73507 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
16	2021 GASB 75 VALUATION OPTION YEAR 2	1.0000	EA	37,000.0000	37,000.00
17	2022 GASB 75 VALUATION OPTION YEAR 3	1.0000	EA	16,000.0000	16,000.00
18	2023 GASB 75 VALUATION OPTION YEAR 4	1.0000	EA	38,000.0000	38,000.00
	Total Order				**1,084,350.12**

BUYER INITIALS

ADDENDUM THREE
Contract 73507 O4
Health and Welfare Consulting Services Portal
Between
The State of Nebraska and The Segal Company Southeast INC

This Addendum (the "Addendum") is made by the State of Nebraska to Contract 73507 O4 (the "Contract"), adding line and the following statement of work, as entered into and mutually agreed by the respective parties thereto, as permitted by the contract:

A. Add the contract line below.

Line	Description	Estimated Quantity	Unit of Measure	Unit Price
13	2018 GASB 75 valuation	1	EA	$15,000.00
14	2019 GASB 75 valuation	1	EA	$35,000.00
15	2020 GASB 75 valuation Option Year 1	1	EA	$16,000.00
16	2021 GASB 75 valuation Option Year 2	1	EA	$37,000.00
17	2022 GASB 75 valuation Option Year 3	1	EA	$16,000.00
18	2023 GASB 75 valuation Option Year 4	1	EA	$38,000.00

B. Statement of Work One

This addendum will become part of the Contract. Except as set forth in this Addendum, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this addendum and the Contract or any earlier addendum, the terms of this addendum will prevail.

IN WITNESS WHEREOF, the parties have executed this Addendum as of the date of execution by both parties below.

State of Nebraska

By: [signature]

Name: David Zwart

Title: Materiel Administrator

Date: 9/17/18

Contractor:

By: [signature]

Name: Kenneth V. Gifo

Title: Senior VP

Date: 8/15/18

STATEMENT OF WORK ONE
Contract 73507 O4
Health and Welfare Consulting Services Portal
Between
The State of Nebraska and The Segal Company Southeast INC

State of Nebraska office of State Personnel, Employee Wellness & Benefits department, requests Segal Consulting to agree to a Change Order to Contract #73507-04 to accommodate the need for actuarial consulting services as described below.

The State of Nebraska will fully implement accounting and reporting requirements of Governmental Accounting Standards Board (GASB) #75, Other Postemployment Benefits (OPEB) in its Comprehensive Annual Financial Report (CAFR) for the fiscal year ending June 30, 2018.

The State of Nebraska offers OPEB to eligible participants through the Nebraska State Health Plan (SHP), and is required to comply with GASB #75 standards. GASB #75 permits full actuarial valuations on a biennial basis, and allows a modified valuation sufficient to support the OPEB liability when rolled forward as of the end of the interim year.

Segal Consulting previously prepared and presented a full actuarial valuation report for GASB #75 reporting for the State's CAFR for fiscal year ending June 30, 2017. The State now asks Segal Consulting to prepare a modified valuation report for the interim fiscal year ending June 30, 2018, as well as full and modified reports for alternating years beginning with the fiscal year ending June 30, 2019 through the end of the contract period, including extensions, which would include fiscal year ending June 30, 2023.

State of Nebraska has received a proposal from Segal Consulting outlining the scope of work associated with the interim fiscal year June 30, 2018 report and subsequent full scope report for fiscal year ending June 30, 2019. The State accepts this scope of work as being sufficient to comply with GASB #75 requirements.

Scope of Work

The technical items we will include in our report include: Our GASB 75 valuation report will include:

1. Letter of certification
2. Executive summary of the valuation
3. Summary of the key results of the valuation
4. GASB basis accounting disclosures
    a. General Information about the OPEB Plan
    b. Statement of Net OPEB Liability
    c. Sensitivity of Net OPEB Liability to Changes in Trend Rates and Discount Rates
    d. Schedule of Changes in Net OPEB Liability
    e. Schedule of Actuarially Determined Contributions (ADC) and Contributions in Relation to the ADC
    f. OPEB Expense
    g. Deferred Outflows and Inflows of Resources
5. Summaries of participation data, including aggregate numbers of actives, covered salaries, numbers of retirees and beneficiaries, age and service statistics
6. Disclosures of actuarial assumptions, cost methods and procedures.
7. Summary of the principal plan provisions for each group of employees covered by the lan
8. A glossary of terms used in the valuation report.

Project Timing

In preliminary discussions, we collectively decided delivery of a draft report will be provided September 30, 2018 for the June 30, 2018 reporting. In subsequent years the target due date will be the September 15 following the reporting date.

In even-numbered years we will need to collect participant and claims data. This participant data should be provided to us by February 1 of the following year. Segal will send a data request to the State to collect this information.

In mid-July Segal will be available to discuss assumptions and preliminary experience calculations via a conference call.

Project Cost

Our fee for this initial project is $15,000 for an "interim year" GASB 75 valuation.

The five year schedule will be:

2018 Reporting: $15,000
2019 Reporting: $35,000
2020 Reporting: $16,000
2021 Reporting: $37,000
2022 Reporting: $16,000
2023 Reporting: $38,000

Significant changes to the accounting standards could impact the fees.

The fees above reflect that there are no allocations to employers or agencies, no significant plan changes in interim years that might require additional valuations, and the State continues the pay-as-you-go policy.

The Segal Company Southeast INC

By: _____

Printed Name: Kenneth Vieira

Title: SVP

Date: 8/9/18

NEBRASKA

Good Life. Great Service.

DEPT. OF ADMINISTRATIVE SERVICES

August 3, 2018

Segal Consulting
Attn: Patrick Klein
2018 Powers Ferry Road, SE, Suite 850
Atlanta, GA 30339

RE: Segal Consulting Contract #73507-04

State of Nebraska office of State Personnel, Employee Wellness & Benefits department, requests Segal Consulting to agree to a Change Order to Contract #73507-04 to accommodate the need for actuarial consulting services as described below.

The State of Nebraska will fully implement accounting and reporting requirements of Governmental Accounting Standards Board (GASB) #75, Other Postemployment Benefits (OPEB) in its Comprehensive Annual Financial Report (CAFR) for the fiscal year ending June 30, 2018.

The State of Nebraska offers OPEB to eligible participants through the Nebraska State Health Plan (SHP), and is required to comply with GASB #75 standards. GASB #75 permits full actuarial valuations on a biennial basis, and allows a modified valuation sufficient to support the OPEB liability when rolled forward as of the end of the interim year.

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State of Nebraska has received a proposal from Segal Consulting outlining the scope of work associated with the interim fiscal year June 30, 2018 report and subsequent full scope report for fiscal year ending June 30, 2019. The State accepts this scope of work as being sufficient to comply with GASB #75 requirements.

Please acknowledge your approval for the State of Nebraska to proceed with preparing the Change Order; and, provide a proposed schedule of fees.

Warmest Regards,

Christy Osentowski

Christy Osentowski, Employee Wellness & Benefits Manager
Department of Administrative Services | STATE EMPLOYEE WELLNESS & BENEFITS
1526 K Street, Ste. 110
Lincoln, Nebraska 68508
OFFICE 402-471-2075
FAX 402-471-3754
das.nebraska.org

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	08/29/16
BUSINESS UNIT	BUYER
65080007	MICHELLE THOMPSON (AS)

CONTRACT NUMBER
73507 O4

VENDOR NUMBER: 2369150

VENDOR ADDRESS:

THE SEGAL COMPANY SOUTHEAST INC
DBA SEGAL CONSULTING & SEGAL GROUP
333 W 34TH ST
NEW YORK NY 10001-2417

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Original/Bid Document 5297 Z1

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Vendor Contact: Kenneth Vieira
Phone: 678-306-3154
Cellular: 404-709-9016
Fax: 678-669-1887
E-Mail: kvieira@segalco.com

(08/29/16 djo)

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9/2/16 PK Michelle Thompson 9-1-16 MT
BUYER

9/6/16
MATERIEL ADMINISTRATOR

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VENDOR NUMBER: 2369150

CONTRACT NUMBER
73507 O4

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7	HEALTH INSURANCE PLAN IMPLEMENTATION CLAIMS AUDIT INITIAL CONTRACT PERIOD SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	1.0000	EA	20,000.0000	20,000.00
8	ACCOUNT EXECUTIVE MANAGER INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	15.0000	HR	325.0000	4,875.00
9	ACTUARY INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	15.0000	HR	325.0000	4,875.00
10	UNDERWRITER INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	6.0000	HR	325.0000	1,950.00
11	SME - EXECUTIVE/MANAGER INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	6.0000	HR	325.0000	1,950.00
12	SME - STAFF CONSULTANT INITIAL CONTRACT RATE SEPTEMBER 1 2016 THROUGH AUGUST 31 2019	15.0000	HR	325.0000	4,875.00
	Total Order				**868,525.12**

MT 9.1.16
BUYER INITIALS

ADDENDUM ONE to Contract Award
Terms and Conditions
Contract 73507 O4 Benefits Consulting
Between
The State of Nebraska and The Segal Company (Southeast), Inc.

The following Terms and Conditions, Addendum One of Contract 73507 O4 have been reviewed and agreed upon between The Segal Company (Southeast), Inc. "Contractor" and the State of Nebraska "State". This addendum will become part of the contract for Benefits Consulting. The terms and conditions of this Addendum shall supersede, prevail and govern in the case of any inconsistencies with the Terms and Conditions indicated in Section III of the Request for Proposal, except that any section herein marked "Reserved" shall have no effect on the Terms and Conditions indicated in Section III of the Request for Proposal.

By signing this Addendum the Contractor guarantees compliance with the provisions stated herein, agrees to the terms and conditions and certifies Contractor maintains a drug free work place environment.

A. GENERAL

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal, signed in ink
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. RESERVED

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Except to the extent that they incorporate Contractor's software, know-how, techniques, methodologies and report formats (collectively, "Contractor's Information"), all documents, data, and other tangible materials authored or prepared and delivered by Contractor to the State of Nebraska under the terms of this Agreement (collectively, the "Deliverables"), are the sole and exclusive property of the State of Nebraska, once paid for by the State. To the extent Contractor's Information is incorporated into such Deliverables, the State of Nebraska shall have a perpetual, nonexclusive, worldwide, royalty-free license to use, copy, and modify Contractor's Information as part of the Deliverables internally and for their intended purpose.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Subcontractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Subcontractor(s). The Contractor is also responsible for ensuring Subcontractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Subcontractor to commence work on any Subcontract until all similar insurance required of the Subcontractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Insurance coverages shall function independent of all other clauses in the contract, and in no instance shall the limits of recovery from the insurance be reduced below the limits required by this section.

1. **WORKERS' COMPENSATION INSURANCE**
The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**
The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Non-owned, and Hired vehicles.

3. **INSURANCE COVERAGE AMOUNTS REQUIRED**

COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	included in the general aggregate
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$10,000 any one person
Damage to Rented Premises	$300,000 each occurrence
Contractual	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	

Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000
PROFESSIONAL LIABILITY	
Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
SUBROGATION WAIVER	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
LIABILITY WAIVER	
"Commercial General Liability & Commercial Automobile Liability policies shall be primary and any insurance or self-insurance carried by the State shall be considered excess and non-contributory."	

4. EVIDENCE OF COVERAGE

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax)

Administrative Services
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.

2. The Contractor shall agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Subcontractor's services, the Subcontractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work on the project.

Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or Subcontractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

1. any and all employment taxes and/or other payroll withholding;
2. any and all vehicles used by the Contractor's employees, including all insurance required by state law;

3. damages incurred by Contractor's employees within the scope of their duties under the contract;
4. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. CONTRACT CONFLICTS

Contractor shall insure that contracts or agreements with sub-contractors and agents, and the performance of services in relation to this contract by sub-contractors and agents, does not conflict with this contract.

L. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

The Contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project.

M. CONFLICT OF INTEREST

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

N. RESERVED

O. ERRORS AND OMISSIONS

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

P. BEGINNING OF WORK

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Q. ASSIGNMENT BY THE STATE

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

R. ASSIGNMENT BY THE CONTRACTOR

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

S. RESERVED

T. GOVERNING LAW

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

U. ATTORNEY'S FEES

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if ordered by a court of competent jurisdiction, including attorney's fees and costs, if the other party prevails.

V. ADVERTISING

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

W. STATE PROPERTY

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

X. SITE RULES AND REGULATIONS

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

Y. NOTIFICATION

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II.A. Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Z. EARLY TERMINATION

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

   a. if directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   e. an involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
   g. Contractor intentionally discloses confidential information;
   h. Contractor has or announces it will discontinue support of the deliverable;

i. second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or

j. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract.

4. Contractor may terminate this contract upon notice and no less than a thirty (30) day cure period in the event of the State's directing or requiring the Contractor to act in a manner that would violate applicable law or regulation.

AA. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

BB. BREACH BY CONTRACTOR

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

CC. ASSURANCES BEFORE BREACH

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

DD. ADMINISTRATION – CONTRACT TERMINATION

1. Contractor must provide confirmation that upon contract termination all deliverables prepared in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any

information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

EE. FORCE MAJEURE

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

FF. PROHIBITION AGAINST ADVANCE PAYMENT

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.

GG. PAYMENT

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §§ 81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

HH. INVOICES

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices may be mailed to Wellness & Benefits Administrator, State of Nebraska, 1526 K Street, Suite 110, Lincoln, NE 68508. Upon agreement between the State and the Contractor, invoices may be e-mailed. The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

II. RIGHT TO AUDIT

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. Upon reasonable notice and during normal business hours, the State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not limited to those kept by the Contractor, its employees, agents, assigns, successors, and Subcontractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers

including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of five (5) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Subcontractors, and the obligations of these rights shall be explicitly included in any subcontracts or agreements formed between the Contractor and any Subcontractors to the extent that those Subcontracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

JJ. TAXES

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

KK. INSPECTION AND APPROVAL

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

LL. CHANGES IN SCOPE/CHANGE ORDERS

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation

to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, or a pro-rated value.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification. Changes or additions to the contract beyond the scope of the RFP are not permitted.

MM. SEVERABILITY

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

NN. CONFIDENTIALITY

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State as soon as practicable of said breach and take immediate corrective action.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

OO. RESERVED

PP. RESERVED

QQ. STATEMENT OF NON-COLLUSION

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

RR. PRICES

All prices, costs, and terms and conditions outlined in the proposal shall remain fixed and valid commencing on the opening date of the proposal until an award is made or the Request for Proposal is cancelled.

Prices quoted on the Cost Proposal form shall remain fixed for the initial contract period which is three (3) years. Any request for a price increase subsequent to the initial contract period shall not exceed four percent (4%) of the previous Contract period and must be submitted in writing to the State Purchasing Bureau a minimum of 120 days prior to the end of the current contract period, and be accompanied by documentation justifying the price increase. Further documentation may be required by the State to justify the increase. The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

The State will be given full proportionate benefit of any price decrease during the term of the contract. Contractor represents and warrants that all prices for services, now or subsequently specified, are as low as and no higher than prices which the Contractor has charged or intends to charge customers other than the State for the same or similar products and services of the same or equivalent quantity and quality for delivery or performance during the same periods of time. If, during the term of the contract, the Contractor shall reduce any and/or all prices charged to any customers other than the State for the same or similar products or services specified herein, the Contractor shall make an equal or equivalent reduction in corresponding prices for said specified products or services.

Contractor also represents and warrants that all prices set forth in the contract and all prices in addition, which the Contractor may charge under the terms of the contract, do not and will not violate any existing federal, state, or municipal law or regulations concerning price discrimination and/or price fixing. Contractor agrees to hold the State harmless from any such violation. Prices quoted shall not be subject to increase throughout the contract period unless specifically allowed by these specifications.

SS. RESERVED

TT. RESERVED

UU. INDEMNIFICATION

1. GENERAL

The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses, including investigation costs and expenses, settlement costs, and reasonable attorney fees and expenses ("the claims"), sustained or asserted against the State, resulting from, the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims, result from, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of

the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. PERSONNEL

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 *et seq.* and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

VV. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

WW. ANTITRUST

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

XX. DISASTER RECOVERY/BACK UP PLAN

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

YY. TIME IS OF THE ESSENCE

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

ZZ. RECYCLING

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. § 81-15,159.

AAA. DRUG POLICY

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

BBB. EMPLOYEE WORK ELIGIBILITY STATUS

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. § 4-108.

CCC. RESERVED

DDD. POLITICAL SUB-DIVISIONS

The Contractor may extend the contract to political sub-divisions conditioned upon the honoring of the prices charged to the State. Terms and conditions of the Contract must be met by political sub-divisions. Under no circumstances shall the State be contractually obligated or liable for any purchases by political sub-divisions or other public entities not authorized by Neb. Rev. Stat. § 81-145, listed as "all officers of the state, departments, bureaus, boards, commissions, councils, and institutions receiving legislative appropriations."

A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

EEE. OFFICE OF PUBLIC COUNSEL

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

FFF. LONG-TERM CARE OMBUDSMAN

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

This Addendum and any attachments hereto will become part of the Contract. Except as set forth in this Addendum, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this Addendum and the Contract or any earlier Addendum, the terms of this Addendum will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska	Contractor: The Segal Company (Southeast), Inc.
By: _____	By: _____
Name: Bo Botelho	Name: Kenneth C. Vieira
Title: Materiel Administrator	Title: Senior Vice President
Date: 9/6/16	Date: 8/29/16

ADDENDUM TWO
Contract 73507 O4 Benefits Consulting
Between
The State of Nebraska and The Segal Company (Southeast), Inc.

This Addendum (the "Addendum") is made by the State of Nebraska and The Segal Company (Southeast), Inc. parties to Contract 73507 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby add as follows effective September 1, 2016:

BUSINESS ASSOCIATE AGREEMENT

A. Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this contract, shall mean Contractor.

B. Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this contract, shall mean the Nebraska Department of Administrative Services (DAS).

C. HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

D. Other Terms. The following terms shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

E. The Contractor shall do the following:

1. Not use or disclose protected health information other than as permitted or required by this Contract, consistent with DAS' minimum necessary policies and procedures, or as required by law.

2. Implement and maintain appropriate administrative, physical, and technical safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent access to, use, or disclosure of protected health information other than as provided for by the Contract and assess potential risks and vulnerabilities to the individual health data in its care and custody and develop, implement, and maintain reasonable security measures.

3. Report to DAS, any use or disclosure of protected health information not provided for by this Contract of which it becomes aware, including breaches of unsecured protected health information as required by 45 CFR 164.410, and any security incident of which it becomes aware. Contractor shall make its report as soon as practicable and no later than twenty-one (21) calendar days after becoming aware of such improper use or disclosure, breach or security incident. Contractor shall take immediate steps to mitigate any harmful effect of such unauthorized disclosure of protected health information in manner that is mutually agreed upon by the Parties. If requested by DAS, Contractor will coordinate in the preparation and completion of a written Corrective Action Plan and will comply with the terms of any written Corrective Action Plan DAS enters into with HHS. The Contractor

shall report any breach to the individuals affected and to the HHS Office of Civil Rights, and if warranted the media, on behalf of the covered entity, as required by the HIPAA regulations. If necessary, DAS shall furnish Contractor will all contact and other information reasonably necessary to provide such report or otherwise cooperate with contractor to the extent allowed by law.

4. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the Contractor agree to the same or more stringent restrictions, conditions, and requirements that apply to the Contractor with respect to such information;

5. Within fifteen (15) days:

    a. make available protected health information in a designated record set to DAS as necessary to satisfy DAS' obligations under 45 CFR 164.524;

    b. Make any amendment(s) to protected health information in a designated record set as directed or agreed to by DAS pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy DAS' obligations under 45 CFR 164.526;

    c. Maintain and make available the information required to provide an accounting of disclosures to DAS as necessary to satisfy DAS' obligations under 45 CFR 164.528;

6. To the extent the Contractor is to carry out one or more of DAS' obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to DAS in the performance of such obligation(s); and

7. Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

F. The Contractor is permitted to use and disclose protected health information:

    1. As necessary to perform the services set forth in this Contract;

    2. As required or otherwise allowed by law;

    3. Consistent with DAS' minimum necessary policies and procedures;

    4. For the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor; provided that in the case of a disclosure under this Section F.4, such disclosure is required by law, or Contractor obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Contractor of any instances of which it is aware in which the confidentiality of the information has been breached;

    5. To provide data aggregation services relating to the health care operations of DAS; and

    6. That Contractor has de-identified in accordance with the requirements of 45 CFR §164.514(a)-(c) as allowed by law.

G. The Contractor may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by DAS, except for the specific uses and disclosures permitted above in Sections F.4 and F.5.

H. DAS shall:

1. Notify Contractor of any limitation(s) in the notice of privacy practices of DAS under 45 CFR 164.520, to the extent that such limitation may affect Contractor's use or disclosure of protected health information.

2. Notify Contractor of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect Contractor's use or disclosure of protected health information.

3. Notify Contractor of any restriction on the use or disclosure of protected health information that DAS has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect Contractor's use or disclosure of protected health information.

4. Not request Contractor to use or disclose protected health information in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by DAS, , except for the specific uses and disclosures permitted above in Sections F.4 and F.5.

I. Term & Termination

1. The Term of these provisions shall run concurrently with the Contract and, except as otherwise set forth below or required by law, may be terminated under the provisions of the Early Termination Clause of the Contract

2. Upon termination of these provisions for any reason, Contractor, with respect to any protected health information either received from DAS, or created, maintained, or received by Contractor on DAS's behalf, shall:

   i. Where feasible, return or destroy the protected health information, which Contractor still maintains in any form. DAS understands that Contractor's need to maintain portions of the PHI in records of actuarial determinations and for other archival purposes related to memorializing advice provided will render return or destruction infeasible. Nothing in this paragraph shall be read to allow destruction of information that is necessary for continuity of DAS operations at the conclusion of this contract.

   ii. Continue to use appropriate safeguards and comply with the Security Rule with respect to ePHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI; and

   iii. Not use or disclose the PHI retained other than for the purposes for which such PHI was retained and subject to the same conditions set out in Section F.4 of this Agreement which applied prior to termination.

3. The parties' respective obligations under this Section I shall survive the termination of these provisions and the Contact for so long as Contractor maintains any DAS PHI.

J. Miscellaneous

1. Regulatory References. A reference in these Provisions to a section in the HIPAA Rules means the section as in effect or as amended.

2. Amendment. The parties agree to take such action as is necessary to amend these provisions from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law. Any amendment shall be in a writing duly executed by both parties.

3. Interpretation. Any ambiguity in these provisions shall be interpreted to permit compliance with the HIPAA Rules. In the event of any inconsistency or conflict between these provisions, and the Contract, these provisions shall control and govern.

4. Third Party Beneficiaries. Nothing in these provisions, shall be construed to create any third party beneficiary rights in any person, including any participant or beneficiary of DAS, to the extent allowed by law.

5. Informal Resolution. If any controversy, dispute, or claim arises between the parties with respect to these provisions, the parties shall make good faith efforts to resolve such matters informally.

6. Notices. All notices to be given pursuant to the terms of these provisions shall be in writing and shall be sent certified mail, return receipt requested, postage prepaid or by courier service. If to DAS, the notice shall be sent to such address as DAS notifies Contractor of in writing. If to Contractor, the notice shall be sent to the Privacy Official, c/o General Counsel, The Segal Group, 333 West 34th Street, New York, New York 10001.

This Addendum and any attachments hereto will become part of the Contract. Except as set forth in this Addendum, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this Addendum and the Contract or any earlier Addendum, the terms of this Addendum will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska Contractor:

By: _____

Name: Bo Botelho

Title: Materiel Administrator

Date: 9/5/16

The Segal Company (Southeast), Inc.

By: _____

Name: Kenneth C. Vigier

Title: Senior Vice President

Date: 8/29/16

For public information purposes only; not part of contract.

Request for Proposal Number 5297 Z1
Contract Number 73507 O4
Proposal Opening: May 25, 2016

In accordance with Nebraska Revised Statutes §84.712.05(3), the following material(s) has not been included due to it being marked proprietary.

The Segal Company (Southeast), Inc.

1. Consolidated Financial Statements and Independent Auditor's Report, December 31, 2014 and 2013



PROFESSIONAL HEALTH AND WELFARE CONSULTING SERVICES

Cost Proposal – Best and Final Offer

RFP# 5297Z1

June 20, 2016 2:00 p.m.

Segal Consulting
2018 Powers Ferry Road, Suite 850
Atlanta, Georgia 30339
678-306-3100

Segal Consulting

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Transmittal Letter

Segal Consulting

2018 Powers Ferry Road SE Suite 850 Atlanta, GA 30339-7200
T 678.306.3100 www.segalco.com

June 20, 2016

Michelle Thompson/Teresa Fleming, Buyers
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Re: RFP# 5297Z1 Professional Health and Welfare Consulting Services – BEST AND FINAL OFFER (BAFO) RESPONSE

Dear Ms. Thompson and Ms. Fleming:

The Segal Company looks forwasrd to having the opportunity to support and provide professional health and welfare consulting services for the State of Nebraska ("State"). We offer the following in response to your letter on June 14, 2016 requesting a Best and Final Offer (BAFO).

The State has stated that our firm has the opportunity to make our best and final offer during this process, requiring another Cost Proposal submission. Given this opportunity, Segal will take this opportunity to provide the State with our BAFO that includes revised pricing.

These rates are reflected in our BAFO Summary Fee Schedule attached (Attachment A – Cost Proposal and Attachment B – Fixed Hourly Rates) and this letter, along with the approval of the revised rates, has been signed by an appropriate representative of our company.

In short, Segal possesses the skills and expertise, in house, to meet the needs – expected and unexpected – of a complex and sophisticated program like the Plan.

If you have any questions about Segal's proposal, please give me a call at (678) 306-3154. Segal is excited about the opportunity to work with the State team.

Sincerely,

Kenneth Vieira, FSA, FCA, MAAA
Senior Vice President & East Region Public Sector Market Leader

Best and Final Offer

Best and Final Offer (BAFO)

Request for Proposal Number 5297Z1

Bidder: The Segal Company (Southeast), Inc.

A contract resulting from this Request for Proposal will be issued approximately for a period of three (3) years effective the date of award. The contract has the option to be renewed for four (4) additional one (1) year periods as mutually agreed upon by all parties.

Prices quoted below shall remain fixed for the initial contract period which is three (3) years. Any request for a price increase subsequent to the initial contract period shall not exceed four percent (4%) of the previous Contract period and must be submitted in writing to the State Purchasing Bureau a minimum of 120 days prior to the end of the current contract period, and be accompanied by documentation justifying the price increase. Further documentation may be required by the State to justify the increase. The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

Pricing to include all expenses including all travel expenses to Lincoln, NE. The annual rate includes all benefit consulting services included in this RFP, excluding the Health Insurance Plan RFP.

The Annual rate will be paid by the State in 12 equal installments to the contractor.

	Initial Contract Period		
	Year 1	Year 2	Year 3
Annual Rate	$216,000	$220,000	$224,000

HEALTH INSURANCE PLAN RFP CONSULTING FEES – INCLUDES MEDICAL AND PHARMACY

When the State issues the RFP for the health insurance plan which includes both medical and pharmacy, additional resources and time will be expected from the contractor. Implementation Claims Audit will be conducted 30 – 60 days prior to implementation and payment will be made upon completion and approval of the audit by the State.

Milestone	Posting of the RFP	Posting of the Intent to Award	Contractor Start Date	Implementation Claims Audit
Lump sum	$80,000	$60,000	$30,000	$20,000

Best and Final Offer (BAFO)

Fixed Hourly Rates and/or Additional Optional Services and Fees

Request for Proposal Number 5297Z1

Bidder: The Segal Company (Southeast), Inc.

There may arise from time to time a need for work not originally specifically delineated in this RFP but considered within the scope of work. This additional work may stem from legislative mandates, emerging trends, and regulatory changes unknown at the time of the RFP.

The State may request the contractor, subject to mutual agreement by both parties, to engage in short onetime special consulting projects, related to State benefit plans.

The bidder should provide the hourly rate for each Staff position used to complete onetime special consulting projects in the following table. Please identify any additional Staff titles and their appropriate rates, which bidder believes may be used to complete said projects.

The bidder may provide additional optional services that may be provided to the State as identified in a lump sum unit cost.

The hourly rate/unit cost provided below will not be included as part of the evaluation.

All additional costs (hourly rate or unit cost) must be based upon the amounts provided below.

Staff Title/Description	Hourly Rate or Unit Cost
Account Executive Manager (AEM)	$325
Actuary	$325
Underwriter	$325
Subject Matter Expert – Executive/Manager	$325
Subject Matter Expert – Staff Consultant	$325
Office Staff	$0



PROFESSIONAL HEALTH AND WELFARE CONSULTING SERVICES

Cost Proposal

RFP# 5297Z1

ORIGINAL

May 25, 2016 2:00 p.m.

Segal Consulting
2018 Powers Ferry Road, Suite 850
Atlanta, Georgia 30339
678-306-3100

Segal Consulting

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Cost Proposal

This section describes the requirements to be addressed by bidders in preparing the Cost Proposal. The bidder must submit the Cost Proposal in a section of the proposal that is a separate section or is packaged separately as specified in this RFP from the Technical Proposal section.

The component costs of the fixed price proposal for providing the services set forth in the Request for Proposal must be provided by submitting forms substantially equivalent to those described below.1.

Pricing Summary

This summary shall present the total fixed price to perform all of the requirements of the Request for Proposal. The bidder must include details in the Cost Proposal supporting any and all costs. These details must include, at a minimum, detailed descriptions and/or specifications of the goods and/or services to be provided, quantities, and timing and unit costs, if applicable.

The State reserves the right to review all aspects of the Cost Proposal for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

We work hard to be efficient and use those efficiencies to offer the best fee for each client. When selecting a consulting firm, we hope that fees never keep us from being hired. If you find that our fee is not in the range of your budget, please reach out to us. It may be that we proposed more services than are necessary in an effort to address your longer-term needs, or that there is a misinterpretation regarding possible add-on costs. Whatever the case may be, we are happy to discuss pricing with you.

Unlike many of our competitors, The Segal Company is entirely employee-owned and has no ties or commission arrangements with any financial, insurance, or investment entities. This means we have no stake in providing answers tied to products or pre-packaged solutions.

Our independent, objective consulting is based only on your needs and is drawn from our years of experience in providing effective solutions to the challenges you face. We pride ourselves on our close and longstanding relationships with our clients. We have never followed a "one size fits all" philosophy.

2. Prices

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the Request for Proposal. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Segal agrees with the terms stipulated above.

C. Payment Schedule

Monthly invoices may be submitted by the Contractor on specific dates based on the completion and acceptance of related deliverables. No invoice will be approved unless the associated deliverables have been approved.

For additional services not included in the monthly contract fee, no invoices will be approved unless the associated deliverables have been completed and approved

We have included the State's **Attachment A** – Cost Proposal and **Attachment B** – Fixed Hourly Rates on the following pages.

Attachment A

Cost Proposal

Request for Proposal Number 5297Z1

Bidder: The Segal Company (Southeast), Inc.

A contract resulting from this Request for Proposal will be issued approximately for a period of three (3) years effective the date of award. The contract has the option to be renewed for four (4) additional one (1) year periods as mutually agreed upon by all parties.

Prices quoted below shall remain fixed for the initial contract period which is three (3) years. Any request for a price increase subsequent to the initial contract period shall not exceed four percent (4%) of the previous Contract period and must be submitted in writing to the State Purchasing Bureau a minimum of 120 days prior to the end of the current contract period, and be accompanied by documentation justifying the price increase. Further documentation may be required by the State to justify the increase. The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

Pricing to include all expenses including all travel expenses to Lincoln, NE.

The Annual rate will be paid by the State in 12 equal installments to the contractor.

	Initial Contract Period		
	Year 1	Year 2	Year 3
Annual Rate	$230,000	$230,000	$230,000

HEALTH PLAN RFP CONSULTING FEES

When the State issues the RFP for the health insurance plan, additional resources and time will be expected from the contractor. To compensate for this additional time and resources, provide a lump sum cost per milestone. Implementation Claims Audit will be conducted 30 – 60 days prior to implementation and payment will be made upon completion and approval of the audit by the State.

Milestone	Posting of the RFP	Posting of the Intent to Award	Contractor Start Date	Implementation Claims Audit
Lump sum	$80,000	$60,000	$30,000	$20,000

Attachment B

Fixed Hourly Rates

Request for Proposal Number 5297Z1

Bidder: **The Segal Company (Southeast), Inc.**

There may arise from time to time a need for work not originally specifically delineated in this RFP but considered within the scope of work. This additional work may stem from legislative mandates, emerging trends, and regulatory changes unknown at the time of the RFP.

The State may request the contractor, subject to mutual agreement by both parties, to engage in short onetime special consulting projects, related to State benefit plans.

The bidder should provide the hourly rate for each Staff position used to complete onetime special consulting projects in the following table. Please identify any additional Staff titles and their appropriate rates, which bidder believes may be used to complete said projects.

All special consulting project costs must be based upon the hourly rates provided below.

	Hourly Rate
Account Executive Manager (AEM)	$325
Actuary	$325
Underwriter	$325
Subject Matter Expert – Executive/Manager	$325
Subject Matter Expert – Staff Consultant	$325
Office Staff	$0



PROFESSIONAL HEALTH AND WELFARE CONSULTING SERVICES

State of Nebraska

Technical Proposal
RFP# 5297Z1

ORIGINAL

May 25, 2016 2:00 p.m.

Segal Consulting
2018 Powers Ferry Road, Suite 850
Atlanta, GA 30339
678-306-3100

Segal Consulting

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Transmittal Letter

Transmittal Letter

Segal Consulting

2018 Powers Ferry Road SE Suite 850 Atlanta, GA 30339-7200
T 678.306.3100 www.segalco.com

May 25, 2016

Michelle Thompson/Teresa Fleming
Office of Administrative Services
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Re: RFP# 5297Z1 Professional Health and Welfare Consulting Services

Dear Ms. Thompson and Ms. Fleming:

Thank you for the opportunity to submit a proposal to provide professional health and welfare consulting services to the State of Nebraska (the State). Our understanding is that the State wishes to retain a consulting firm with demonstrated successful experience with health and wellness benefit programs. We realize there are numerous benefits consulting firms from which to choose and through this proposal we will show that Segal Consulting (Segal) is the most qualifed firm. Segal will provide the following requested services:

- Strategic consulting services for all health and welfare programs including the State's self-insured medical, pharmacy, wellness programs, and collective bargaining;
- Actuarial services for the State's Employee Health Plan;
- Health plan data analytics and reporting;
- Assist with benefit plan requests for proposals (RFP); and
- Legislative and Regulatory Analysis & Education.

Segal has assembled a team to be fully responsive to the requirements of this RFP. We are prepared to deliver all the services defined under Scope of Work in the RFP. In our proposal response we will clearly show why Segal is the most qualified firm to meet your needs.

Segal has been assisting public plans and employers for more than 70 years and currently consults to more than one-third of the state-level plans in the country. Serving the public sector is a key focus at Segal and is the primary focus for our senior consulting team proposed to the State. Our consultants and actuaries work for a number of state plans surrounding Nebraska, including: Kansas, Colorado, North Dakota, South Dakota, Wisconsin and Illinois.

We are a recognized industry leader, sponsoring and participating in many service and professional organizations, including the State and Local Government Benefits Association (SALGBA), National Association of State Retirement Administrators (NASRA), and participating in the Public Sector Health Benefits Roundtable.

Segal has made a continued and significant commitment to our public sector clients. We reflect that commitment in our organizational structure, where the Public Sector is one of our three primary client markets. By focusing on the particular needs of public sector clients, Segal is able to bring specialized expertise and experience to our clients that may not be emphasized in other consulting firms that cater primarily to private sector corporations.

We understand how the State wants to remain on the cutting edge and show leadership across the nation. Our team pulls from the best actuaries, clinicians and consultants in the field, bringing unmatched experience with large state health plans throughout the nation. Working together, Segal and the State can build on the program recent successes, balancing your current needs with those unanticipated in the near future.

Per the RFP requirements, this transmittal letter is on our company letterhead and signed by an officer authorized to bind our firm. Our letter includes the following:

Per the RFP, Segal complies or addresses following:

- Our proposal is signed by an individual, **Kenneth C. Vieira, FSA, FCA, MAAA, Senior Vice President**, who is authorized to commit Segal to the services, compliance requirements and prices stated in our proposal, for the initial contract year and the two (2) optional contract years. **Kirsten Schatten, ASA, FCA, MAAA**, will be the Back-Up Account Manager to the Ken Vieira.

- Segal has well over five years of business experience providing comprehensive employee benefit consulting services to large public sector and non-public sector employers which more than 10,000 employees and retirees.

- Segal is willing and prepared to comply with all work requirements, general concept requirements and other terms and conditions specified in this solicitation without exception, deletion, qualification or contingency.

- Segal agrees to sign the State's Business Associate Agreement, however we do propose some modifications.

- Segal has no current or pending bids and contracts with the State of Nebraska.

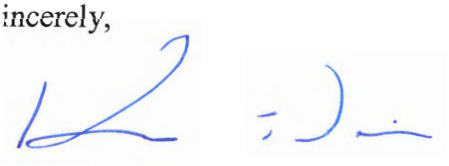
- We have initialed **Section III. Terms of Conditions** of the RFP. Our exceptions are clearly identifiable in the tables provides, we have provided an explanation for our exceptions, and we have included alternative language we would like the State to entertain should the project work be awarded to Segal.

- Segal acknowledges reviewing **Addendum #1 – Questions and Answers** posted on the Administrative Services website on 5/10/16.

Segal would be privileged to be retained as the consultant to the State on this assignment. We bring a useful and pragmatic balance of technical depth and strategic sense to this project and are confident that our recommendations will help the State address the future of its healthcare programs.

Should you or other reviewing staff have questions about the materials contained in this proposal, please do not hesitate to contact me at 678-306-3154. We would welcome the opportunity to meet with representatives of the State to answer any questions or to discuss our experience and qualifications in greater detail.

Sincerely,



Kenneth C. Vieira, FSA, FCA, MAAA
Senior Vice President & East Region Public Sector Market Leader

Request for
Proposal Form

Request for Proposal Form

State of Nebraska (State Purchasing Bureau)

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

RETURN TO:
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
Phone: 402-471-6500
Fax: 402-471-2089

SOLICITATION NUMBER	RELEASE DATE
RFP 5297Z1	**April 15, 2016**
OPENING DATE AND TIME	PROCUREMENT CONTACT
May 25, 2016 2:00 p.m. Central Time	**Michelle Thompson/Teresa Fleming**

This form is part of the specification package and must be signed in ink and returned, along with proposal documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska, Administrative Services (AS), Materiel Division, State Purchasing Bureau, is issuing this Request for Proposal, RFP Number 5297Z1 for the purpose of selecting a qualified contractor to provide professional health and welfare consulting services for the employee insurance benefits program which includes health, wellness, dental, vision, life, long term disability, flexible spending accounts, health savings account, and employee assistance program.

Written questions are due no later than May 2, 2016, and should be submitted via e-mail to as.materielpurchasing@nebraska.gov Written questions may also be sent by facsimile to (402) 471-2089.

Bidder should submit one (1) original of the entire proposal. Proposals must be submitted by the proposal due date and time.

PROPOSALS MUST MEET THE REQUIREMENTS OUTLINED IN THIS REQUEST FOR PROPOSAL TO BE CONSIDERED VALID. PROPOSALS WILL BE REJECTED IF NOT IN COMPLIANCE WITH THESE REQUIREMENTS.

Sealed proposals must be received in State Purchasing Bureau by the date and time of proposal opening per the schedule of events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.

This form "REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES" MUST be manually signed, in ink, and returned by the proposal opening date and time along with bidder's proposal and any other requirements as specified in the Request for Proposal in order for a bidder's proposal to be evaluated.

It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. § 84-602.02, all State contracts in effect as of January 1, 2014, and all contracts entered into thereafter, will be posted to a public website. Beginning July 1, 2014, all contracts will be posted to a public website managed by the Department of Administrative Services.

In addition, all responses to Requests for Proposals will be posted to the Department of Administrative Services public website. The public posting will include figures, illustrations, photographs, charts, or other supplementary material. Proprietary information identified and marked according to state law is exempt from posting. To exempt proprietary information you must submit a written showing that the release of the information would give an advantage to named business competitor(s) and show that the named business competitor(s) will gain a demonstrated advantage by disclosure of information. The mere assertion that information is proprietary is not sufficient. (Attorney General Opinion No. 92068, April 27, 1992) The agency will then determine if the interests served by nondisclosure outweigh any public purpose served by disclosure. Cost proposals will not be considered proprietary.

To facilitate such public postings, the State of Nebraska reserves a royalty-free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract or response to this RFP for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a response to this RFP, specifically waives any copyright or other protection the contract or response to the RFP may have; and, acknowledge that they have the ability and authority to enter into such waiver. This reservation and waiver is a prerequisite for submitting a response to this RFP and award of the contract. Failure to agree to the reservation and waiver of protection will result in the response to the RFP being non-conforming and rejected.

Any entity awarded a contract or submitting a RFP agrees not to sue, file a claim, or make a demand of any kind, and will indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of contracts, RFPs and related documents.

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions unless otherwise agreed to (see Section III) and certifies that bidder maintains a drug free work place environment.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

N/A **NEBRASKA CONTRACTOR AFFIDAVIT**: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

N/A I hereby certify that I am a **Resident disabled veteran or business located in a designated enterprise zone** in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

FIRM: The Segal Company (Southeast), Inc.

COMPLETE ADDRESS: 2018 Powers Ferry Road, Suite 850, Atlanta Georgia 30339-7200

TELEPHONE NUMBER: 678-306-3100 FAX NUMBER: 678-669-1887

SIGNATURE: DATE: 5/24/2016

TYPED NAME & TITLE OF SIGNER: Kenneth C. Vieira, Senior Vice President & East Region Public Sector Market Leader

NEBRASKA
Administrative Services

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM ONE
QUESTIONS and ANSWERS

Date: May 10, 2016

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5297Z1
to be opened May 25, 2016 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.	E(2)(c)	31	Is the State looking for the consulting firm to validate their wellness vendor's calculation of ROI/VOI or is the State requesting that an independent calculation be completed?	The State is requiring the contractor to validate the wellness vendor's prepared ROI/VOI and be able to calculate an independent ROI/VOI if requested by the State.
2.	Attachment D	3 Year Plan worksheet	The preparation for the Vision RFP begins on 6/1/2016 and will be published on 9/1/2016. The consulting contract will begin on 9/1/2016. Will the Vision RFP be handled by the current consulting contract with Aon?	No, the Vision RFP will be prepared by the State of Nebraska. Upon request, the contractor awarded this contract may be asked for input on the evaluation and implementation process.
3.	Attachment D	3 Year Plan worksheet	RFP's for LTD and Life Insurance will be issued within the initial three year consulting contract. Does the State want a separate fee for those RFP projects similar to the medical/pharmacy RFP or	The medical RFP is the only separate cost for this. The cost to support the State on the Life and LTD must be included in the annual rate.

			does the State want the cost of those projects included in the annual fee?	
4.	V.A(3)(d)	36	Under the Technical Approach requirements, is a subsection for "Technical Requirements – HIPAA". Can you be specific as to what is being requested for this subsection as there is no reference to any other section in the RFP.	See IV.C Business Requirements (4 and 5)
5.	III. Terms and Conditions, Letter RR	23	Regarding pricing, please provide compensation paid to the incumbent consultant from the contract award date (2008) to current, broken out by plan year. Please include any special projects that were outside the scope of the original contract.	Contract 25698 O4: 7/2007 – 6/2008 $235,305.53 7/2008 – 6/2009 $300,861.00 7/2009 – 6/2010 $312,716.03 7/2010 – 6/2011 $171,142.81 7/2011 – 6/2012 $293,558.00 7/2012 – 6/2013 $31,857.25 Contract 55000 O4: 2/2013 – 6/2014 $266,833.37 7/2014 – 6/2015 $188,875.00 7/2015 – 6/2016 $214,458.23 There weren't any special projects for either contract. Bidders should provide the best solution to the requirements of this RFP.
6.	IV. Project Description and Scope of Work	30	Regarding item C., 2., years of business experience. How much weight will be using during the scoring of this RFP on this question? To the best of our knowledge, there are no consultants (if any) who have clients with more than 10,000 employees and retirees. Further, there are very few Nebraska based employers who have more than 10,000 employees. Does this question alienate Nebraska based Employee Benefit Consultants from being considered?	In order to protect the integrity of the RFP process, the State will not comment on the evaluation criteria during the question and answer period. No, this does not alienate Nebraska based Employee Benefit Consultants from being considered.
7.	IV. Project Description and Scope of Work	31	Number 2., C., Actuarial Services and Related Reporting, please provide a sample of a current Value on Investment (VOI or ROI) for the State's wellness program.	A return on investment analysis performed for the period of April 1, 2011 to March 31, 2013 and showed a $1.30 return on every dollar spent towards wellness.

8.	IV. Project Description and Scope of Work	36	Letter i: Similar to question 2 above, how much weight will be using during the scoring of the RFP on this question. It is our understanding that there are few (if any) account managers with clients that have more than 10,000 employees enrolled.	See response to question 6.
9.	IV.C(5)	30	Can the State provide a copy of the Business Associate Agreement that it wants the consultant to sign for bidders to review?	Yes, the State will provide a Business Associate Agreement for the contractor to sign. See Exhibit 1 to view the BAA.
10.	Attachment E	----	Please indicate the reason for the consultant RFP at this time. Per Attachment E, the current consultant contract runs through 8/31/19. What is prompting the State to conduct the RFP at this time? What areas of improvement or additional services are desired?	The current contract did not carry all services through 8/31/19; thus it did not meet the business needs of the State.
11.	Attachment E	----	The indicates the current consultant's compensation is $194K. However, the contracts show compensation has exceeded $250K in each of the last three years and is over $269K in the current year. Please explain these differences.	The pricing for the current contract was structured on special projects including RFPs which caused the annual cost to fluctuate.
12.	----	----	The RFP details the extensive services required. How has the cost of providing these services compared to the current compensation being paid by the State.	This RFP is a new scope of work and resulting contract. Bidders should provide the best solution to the requirements of this RFP.
13.	----	----	In the past, the State has not allowed any limits on liability. Has that changed? If so, what is the State's position on such limits?	The State contract is silent on limitation of liability as they are a matter of State law and will be decided accordingly. In the proposal response, provide the proposed alternative language in the box provided under UU. Indemnification for consideration by the State.
14.	---	----	Does the State have (or have access to) a datawarehouse tool, will the new consultant have to provide or will the State/consultant rely on the detailed reports provided by the	The State does not have access to a data warehouse. Currently the State relies on the carriers for all claim-related reports. The contractor is required to provide the reports listed in Section IV.E. Scope of Work, 3. Health Plan Analytics and Reporting.

			carriers?	
15.	IV. Project Description and Scope of Work E.1.b and c	31	The proposal speaks of "regular" and "vendor" meetings – please provide more definition of the expected frequency of these meetings (e.g., monthly, quarterly, etc.).	The State meets quarterly with our health plan vendor. The State has separate annual meetings with our health plan vendor and our wellness vendor to review annual outcomes and conduct planning. The contractor is required to attend these meetings per the RFP. Other meetings are scheduled as needed. The State may provide a minimum of three (3) business days' notice.
16.	IV. Project Description and Scope of Work E.1.e	31	The RFP speaks of assisting labor negotiations? How many labor unions does the State work with? What is the timing of their contracts/negotiations?	The State has three bi-annual labor unions. Each of the contracts includes a component of employee benefits. All three contracts expire June 30, 2017.
17.	IV. Project Description and Scope of Work E.1.f	31	The RFP indicates "training" of the State's staff by the consultant. Do you envision this training as ongoing, formalized training or ad hoc, on the job training?	Ad hoc training.
18.	Attachment E	----	Attachment E indicates the basis for your vendor contracts, each of which is for a base period and multiple one year contracts. Is it your plan to conduct RFPs at the end of these contracts? Or does the State plan to conduct RFPs earlier (during the one year extensions)? If that's the case, can you indicate your expected timing of an RFP for each coverage?	It is the State's intent to conduct RFPs in the last year of the final renewal period for each contract as demonstrated on Attachment D, RFP 3 Year Plan, or as needed based upon State and or Federal requirements. See Attachment D, RFP 3 Year Plan.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

Form A

Form A
Bidder Contact Sheet
Request for Proposal Number 5297Z1

Form A should be completed and submitted with each response to this Request for Proposal. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	The Segal Company (Southeast), Inc./Segal Consulting
Bidder Address:	2018 Powers Ferry Road, Suite 850 Atlanta, Georgia 30339-7200
Contact Person & Title:	Kenneth C. Vieira, SVP & East Region Public Sector Market Leader
E-mail Address:	kvieira@segalco.com
Telephone Number (Office):	678-306-3154
Telephone Number (Cellular):	404-709-9016
Fax Number:	678-669-1887

Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	The Segal Company (Southeast), Inc./Segal Consulting
Bidder Address:	2018 Powers Ferry Road, Suite 850 Atlanta, Georgia 30339-7200
Contact Person & Title:	Kenneth C. Vieira, SVP & East Region Public Sector Market Leader
E-mail Address:	kvieira@segalco.com
Telephone Number (Office):	678-306-3154
Telephone Number (Cellular):	404-709-9016
Fax Number:	678-669-1887

B. AWARD

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
K			

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Grievance and protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to the Internet.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
K			

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
			See below suggested modifications

~~The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or derived by the Contractor pursuant to this contract.~~

Except to the extent that they incorporate Contractor's proprietary software, know-how, techniques, methodologies and report formats (collectively, "Contractor's Proprietary Information"), all documents, data, and other tangible materials authored or prepared and delivered by Contractor to the State of Nebraska under the terms of this Agreement (collectively, the "Deliverables"), are the sole and exclusive property of the State of Nebraska, once paid for by the State. To the extent Contractor's Proprietary Information is incorporated into such Deliverables, the State of Nebraska shall have a perpetual, nonexclusive, worldwide, royalty-free license to use, copy, and modify Contractor's Proprietary Information as part of the Deliverables internally and for their intended purpose.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
			As edited below: Products and Completed Operations are included in the general aggregate. We also have an umbrella of $20M that will cover anything over the $2 aggregate; Segal does not own any vehicles; Segal does not have the coverage deleted below.

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Subcontractors, the

Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Subcontractor(s). The Contractor is also responsible for ensuring Subcontractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Subcontractor to commence work on any Subcontract until all similar insurance required of the Subcontractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Insurance coverages shall function independent of all other clauses in the contract, and in no instance shall the limits of recovery from the insurance be reduced below the limits required by this section.

1. **WORKERS' COMPENSATION INSURANCE**

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all ~~Owned~~, Non-owned, and Hired vehicles.

3. **INSURANCE COVERAGE AMOUNTS REQUIRED**

COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	~~$2,000,000~~ included in the general aggregate
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$10,000 any one person
Damage to Rented Premises	$300,000 each occurrence
Contractual	Included
~~XCU Liability (Explosion, Collapse, and Underground Damage)~~	~~Included~~
~~Independent Contractors~~	~~Included~~

~~Abuse & Molestation~~	~~Included~~
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All ~~Owned~~, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000
PROFESSIONAL LIABILITY	
Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
SUBROGATION WAIVER	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
LIABILITY WAIVER	
"Commercial General Liability & Commercial Automobile Liability policies shall be primary and any insurance or self-insurance carried by the State shall be considered excess and non-contributory."	

4. **EVIDENCE OF COVERAGE**

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax)

Administrative Services
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.
2. The Contractor shall agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Subcontractor's services, the Subcontractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work on the project.

Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or Subcontractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

1. any and all employment taxes and/or other payroll withholding;
2. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. damages incurred by Contractor's employees within the scope of their duties under the contract;
4. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. CONTRACT CONFLICTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall insure that contracts or agreements with sub-contractors and agents, and the performance of services in relation to this contract by sub-contractors and agents, does not conflict with this contract.

L. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project.

M. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

N. PROPOSAL PREPARATION COSTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal.

O. ERRORS AND OMISSIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

P. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Q. ASSIGNMENT BY THE STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

R. ASSIGNMENT BY THE CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

S. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

T. GOVERNING LAW

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

U. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
			See below suggested modifications

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party. Should Contractor be the prevailing party in such action, the State agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs.

V. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

W. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

X. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

Y. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II.A. Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Z. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
			See below suggested modifications

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

   a. if directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   e. an involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
   g. Contractor intentionally discloses confidential information;
   h. Contractor has or announces it will discontinue support of the deliverable;
   i. second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or
   j. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract.

4. Contractor may terminate this contract upon no less than thirty (30) days' written notice in the event of either (1) the State's failure to pay any undisputed invoices in a timely manner or (2) the State's directing or requiring the Contractor to act in a manner that would violate applicable law or regulation

AA. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

BB. BREACH BY CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

CC. ASSURANCES BEFORE BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

DD. ADMINISTRATION – CONTRACT TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. Contractor must provide confirmation that upon contract termination all deliverables prepared in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

EE. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

FF. PROHIBITION AGAINST ADVANCE PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.

GG. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §§ 81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

HH. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices may be mailed to Wellness & Benefits Administrator, State of Nebraska, 1526 K Street, Suite 110, Lincoln, NE 68508. Upon agreement between the State and the Contractor, invoices may be e-mailed. The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

II. RIGHT TO AUDIT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
			See below suggested modifications

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. Upon reasonable notice and during normal business hours, the ~~The~~ State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not limited to those kept by the Contractor, its employees, agents, assigns, successors, and Subcontractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of five (5) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Subcontractors, and the obligations of these rights shall be explicitly included in any subcontracts or agreements formed between the Contractor and any Subcontractors to the extent that those Subcontracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

JJ. TAXES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

KK. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

LL. CHANGES IN SCOPE/CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, or a pro-rated value.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification. Changes or additions to the contract beyond the scope of the RFP are not permitted.

MM. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

NN. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
			See below suggested modifications

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State ~~immediately~~ as soon as practicable of said breach and take immediate corrective action.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

OO. PROPRIETARY INFORMATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary**. The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary**. Bidder's cost proposals may not be marked as proprietary information. Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific

advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

PP. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submission of this proposal, the bidder certifies that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

QQ. STATEMENT OF NON-COLLUSION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

RR. PRICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All prices, costs, and terms and conditions outlined in the proposal shall remain fixed and valid commencing on the opening date of the proposal until an award is made or the Request for Proposal is cancelled.

Prices quoted on the Cost Proposal form shall remain fixed for the initial contract period which is three (3) years. Any request for a price increase subsequent to the initial contract period shall not exceed four percent (4%) of the previous Contract period and must be submitted in writing to the State Purchasing Bureau a minimum of 120 days prior to the end of the current contract period, and be accompanied by documentation justifying the price increase. Further documentation may be required by the State to justify the increase. The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

The State will be given full proportionate benefit of any price decrease during the term of the contract. Contractor represents and warrants that all prices for services, now or subsequently specified, are as low as and no higher than prices which the Contractor has charged or intends to charge customers other than the State for the same or similar products and services of the same or equivalent quantity and quality for delivery or performance during the same periods of time. If, during the term of the contract, the Contractor shall reduce any and/or all prices charged to any customers other than the State for the same or similar products or services specified herein, the Contractor shall make an equal or equivalent reduction in corresponding prices for said specified products or services.

Contractor also represents and warrants that all prices set forth in the contract and all prices in addition, which the Contractor may charge under the terms of the contract, do not and will not violate any existing federal, state, or municipal law or regulations concerning price discrimination and/or price fixing. Contractor agrees to hold the State harmless from any such violation. Prices quoted shall not be subject to increase throughout the contract period unless specifically allowed by these specifications.

SS. BEST AND FINAL OFFER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored, and ranked by the Evaluation Committee. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

TT. ETHICS IN PUBLIC CONTRACTING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions, or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

UU. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
			See below suggested modifications

1. **GENERAL**

The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses ~~of every nature~~, including investigation costs and expenses, settlement costs, and reasonable attorney fees and expenses ("the claims"), sustained or asserted against the State, ~~arising out of~~, resulting from, ~~or attributable to~~ the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. **INTELLECTUAL PROPERTY**

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims ~~arise out of~~, result from, ~~or are attributable to~~, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. **PERSONNEL**

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

4. **SELF-INSURANCE**

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 *et seq.* and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

vv. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

ww. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

XX. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

YY. TIME IS OF THE ESSENCE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

ZZ. RECYCLING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. § 81-15,159.

AAA. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

BBB. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. § 4-108.

CCC. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all Subcontracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

DDD. **POLITICAL SUB-DIVISIONS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may extend the contract to political sub-divisions conditioned upon the honoring of the prices charged to the State. Terms and conditions of the Contract must be met by political sub-divisions. Under no circumstances shall the State be contractually obligated or liable for any purchases by political sub-divisions or other public entities not authorized by Neb. Rev. Stat. § 81-145, listed as "all officers of the state, departments, bureaus, boards, commissions, councils, and institutions receiving legislative appropriations." A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

EEE. **OFFICE OF PUBLIC COUNSEL**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

FFF. **LONG-TERM CARE OMBUDSMAN**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

Corporate Overview

A. BIDDER IDENTIFICATION AND INFORMATION

The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

Name of Firm: The Segal Company (Southeast), Inc.

Division: Segal Consulting

Home (Headquarters) & Office Addresses:

Our headquarters is located in **New York, NY.**

333 West 34th Street
New York, NY 10001-2402
t. (212) 251-5000
f. (646) 365-3243

The State will be managed out of our **Atlanta, Georgia** office.

2018 Powers Ferry Road SE,
Suite 850
Atlanta, GA 30189-7200
[t] (678) 306-3100
[f] (678) 669-1887

Contact Email address:

The Account Manager for this engagement is **Kenneth C. Vieira, FSA, FCA, MAAA**. Ken is in the Atlanta Office at the address and numbers listed above. He is the primary contact for Segal and his email is kvieira@segalco.com and his direct phone is (678) 306-3154.

The Back-Up Account Manager for this engagement is **Kirsten Schatten, ASA, FCA, MAAA**. Kirsten has over 20 years of the same experience with large employer group health plans. She is the secondary contact for Segal and her email is kschatten@segalco.com and her direct phone is (678) 306-3129.

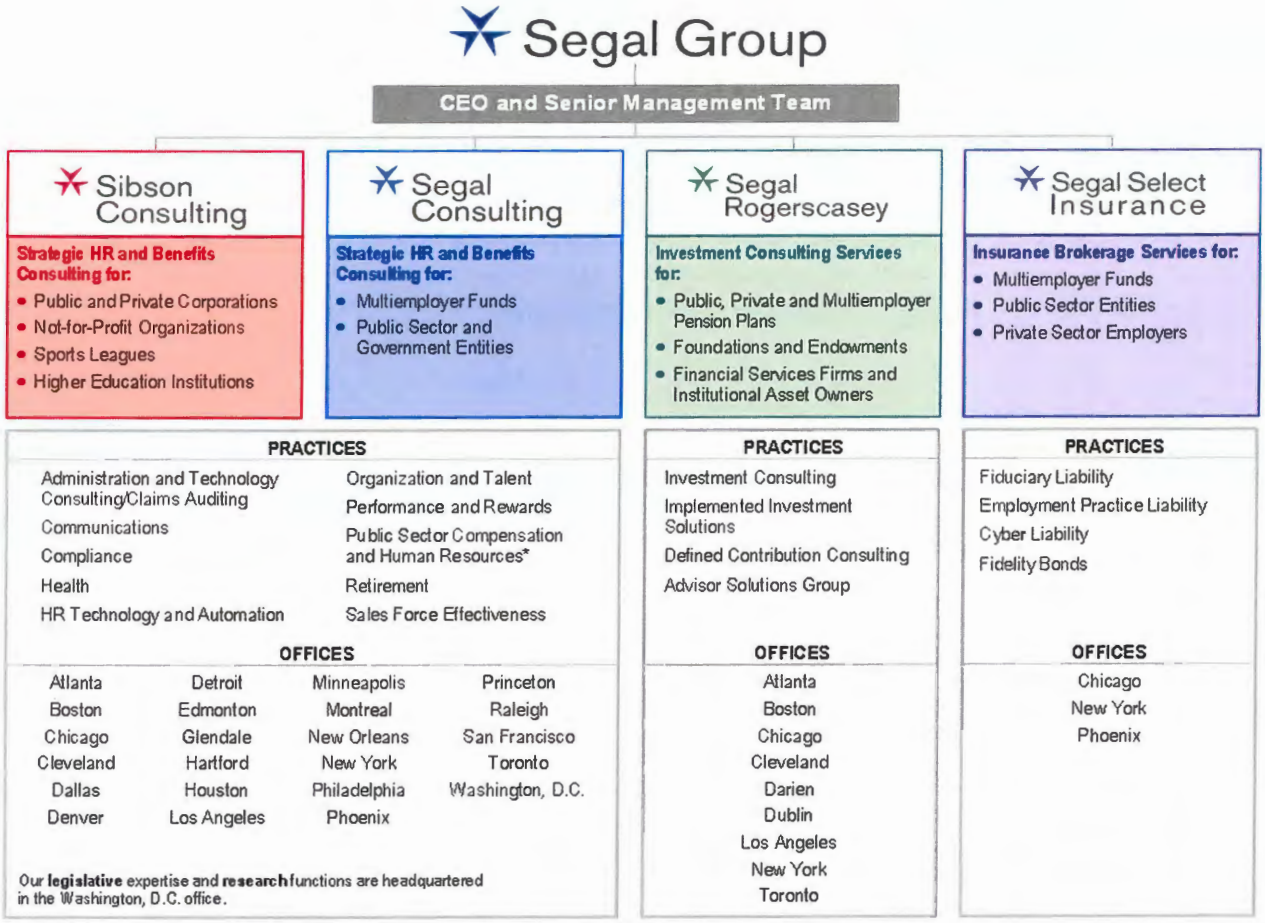
History and Ownership Structure:

The Segal Group is an independent, privately-held consulting firm. It has been employee-owned by its officers since 1978. There are currently 245 employee owners, with no shareholder owning more than 5% of the company. An 11-member Board of Directors sets policy and governs the organization. Implementation of policies, development of strategies and day-to-day operations are the responsibilities of the Chief Executive Officer. This year marks our 77th anniversary.

Segal's stability and ownership structure ensures our continuous, high quality service to our clients. Unlike other actuarial consulting firms who have been acquired or become affiliated with other entities

whose services are not exclusively benefits consulting, our entire business is centered on benefits consulting. Our independence means that our guidance to clients remains client-focused and not altered by conflicts of interest. We do not require a limitation of liability and take great pride in our focus on high quality, value-added consulting services.

Segal is headquartered in New York City and has 23 offices throughout the United States and Canada. Our offices are located in: Atlanta, Boston, Chicago, Cleveland, Dallas, Denver, Detroit, Edmonton, Glendale, Hartford, Houston, Los Angeles, Minneapolis, Montreal, New Orleans, New York, Philadelphia, Phoenix, Princeton, Raleigh, San Francisco, Toronto, and Washington, DC.



*Operating as Segal Waters Consulting

Corporate Officers

- Howard Fluhr
  Chairman
- J. Tim Biddl
  Vice Chair
- Joseph A. LoCicero
  President and Chief Executive Officer
- Ricardo DiBartolo
  Senior Vice President, Chief Financial Officer and Treasurer
- Margery Sinder Friedman, Esq.
  Secretary and General Counsel

Directors

- Joseph A. LoCicero
- Howard Fluhr
- Eugene J. Keilin
- Howard Goldsmith
- J. Tim Biddle
- Rob Lynch
- Ann D. Gineo
- Andrew D. Sherman
- John Flynn
- David Blumenstein
- John Gingell

Segal is owned by its active officers, with no shareholder owning more than 5% of the common stock.

Prior Acquisitions and Mergers:

Most of our growth over the years has been through winning and developing our own clients, although we have, from time to time, made acquisitions that enhance our ability to provide independent consulting services:

- 2001. Segal acquired Marjorie Gross and Company, an award-winning firm specializing in communicating benefits and compensation information, as well as building strategies for effective employer communications. The MGC team was fully integrated into Segal and now provides employee communications consulting services for all Segal clients.
- 2002. Segal acquired Sibson Consulting, a human resources consulting firm dedicated to helping private sector employers improve the return on human capital through talent strategies, effective organization practices, change management, rewards and compensation design, work/life programs and other solutions that help enhance employee performance. Our Sibson consulting division now combines all our corporate consulting services.
- 2006. Segal acquired Irwin Tepper Associates, Inc., a consulting firm that specializes in asset/liability analysis for employee benefit programs and other organizations.
- 2010. Segal acquired Aon Consulting's multiemployer defined benefit plan and related consulting business in the United States.
- 2012. Segal Advisors, Inc., Segal's independent investment consulting subsidiary acquired Rogerscasey, Inc., a similar, independent investment consultancy and is now named by Segal Rogerscasey.
- 2014. The Segal Company has acquired a portion of the business of Moroni Fantin, an employee benefits consulting firm located in the Detroit, Michigan area, specializing in working with Michigan and national, mid-market, self-insured health plans.
- 2014. The Segal Group has acquired Waters Consulting, a compensation and human resources consulting firm in Dallas that specializes in public employers. Our Public Sector Compensation Consulting practice is now named Segal Waters.

The recent acquisitions will have no impact on the services provided to the State.

B. FINANCIAL STATEMENTS

The bidder must provide financial statements applicable to the firm. If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

We have submitted one copy of The Segal Company's audited financial statements for the years ended December 31, 2013 – December 31, 2014, in a sealed white envelope marked "Proprietary/Confidential Materials". We request that these are reviewed directly by the State's staff responsible for the evaluation of this information only. As a privately held organization, we also request that these financial reports are sent back to our Chief Financial Officer after review at the following address:

Mr. Ricardo M. DiBartolo
Chief Financial Officer
The Segal Company
333 West 34th Street
New York, NY 10001-2402

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

None of Segal's past litigation affected its ability to perform services to its clients nor had any material effect on its financial position. No such conditions are known to exist.

The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation.

We acknowledge the State may elect to use a third-party to conduct credit checks as part of the corporate evaluation.

C. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

Segal is a privately held, employee owned company, and as such, we do not anticipate any change in ownership or control of our company in the future.

D. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

The State will primarily be serviced out of our Atlanta, Georgia office. Information for that office is below:

Atlanta, Georgia
2018 Powers Ferry Road SE,
Suite 850
Atlanta, GA 30189-7200
[t] (678) 306-3100
[f] (678) 669-1887

This office currently serves a number of state accounts and is one of Segal's public sector hubs.

E. RELATIONSHIPS WITH THE STATE

The bidder shall describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

Segal has had no previous dealings or contracts with the State of Nebraska in the past five (5) years.

F. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any party named in the bidder's proposal response is or was an employee of the State within the past five (5) years, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

To our knowledge, no such relationship currently exists or has existed in the past.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

To our knowledge, no such relationship currently exists or has existed in the past.

G. CONTRACT PERFORMANCE

If the bidder or any proposed Subcontractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

We have experienced no termination for default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

We have experienced no termination for default.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

We have experienced no termination for default.

H. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

iv. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Request for Proposal. These descriptions must include:

a) The time period of the project;

b) The scheduled and actual completion dates;

c) The Contractor's responsibilities;

d) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and

e) Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

v. Contractor and Subcontractor(s) experience must be listed separately. Narrative descriptions submitted for Subcontractors must be specifically identified as Subcontractor projects.

vi. If the work was performed as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, Subcontractors shall identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.

Segal has extensive experience in providing actuarial and benefits consulting services to public plans and employers. We work with more than 20 state-level health plans across the county. Your senior team works for a number of states throughout the region.

Segal is built on an actuarial foundation. Our professional staff includes more 150 credentialed actuaries in 23 offices. Our actuaries are Fellows or Associates of the Society of Actuaries and Members of the American Academy of Actuaries. Segal's actuaries work with many state and local government clients on their self-funded health benefit programs. The actuarial team assigned for the this engagement has experience with State level plans in North Carolina, Kansas, Georgia, Tennessee, New Mexico, Maryland, Illinois, Texas, Wisconsin and others. In addition, we work with many large cities and counties, some of which approach State level participation.

The tables below illustrates our experience in providing complex, similar services to other large state level clients, in particular the State deliverables and tasks contained in the RFP from our Atlanta and Washington DC offices. We have worked with many of the clients for over 10 years and, in the case of Hawaii, for over 50 years.

Experience	NC	KS	PA	MD	IL	DE	WV	NH	AL	HI	NM	WI	CO	AK
Financial Projections	X	X	X	X	X	X	X	X	X	X	X	X	X	X
IBNR	X	X	X	X		X		X	X			X	X	X
Funding Rates/ Plan Cost Modeling	X	X	X	X	X	X		X	X	X	X	X	X	X
Legislative Support	X	X		X		X	X	X	X		X		X	X
Actuarial Rate Development	X	X	X	X	X	X		X	X	X	X	X	X	X
Data Analysis/Trends	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Participation in Meetings and Workgroups	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Procurement/Marketing	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Reporting	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Pharmacy Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HMOs/PPOs/FFS	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CDHP (HSA/HRA)	X	X				X						X	X	X
Medicare Advantage/ Medicare Supplement	X	X	X	X	X	X	X	X	X	X	X	X		
Part D Consulting	X	X	X	X	X	X	X	X	X	X	X			
ACA Consulting	X	X	X	X	X	X		X	X	X	X		X	X
HIPAA Compliance	X	X	X	X		X		X	X		X		X	
Plan Design Review	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Wellness Plan Designs & Program Analysis	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medical Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Contract Negotiations	X	X	X	X	X	X	X	X	X	X	X	X	X	X
OPEB valuation	X	X		X				X		X	X			X
Strategic Planning/ Migration Strategies	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CAFR Support	X	X		X		X		X	X	X	X			X

Throughout our response we have additional details on a number of these clients. In this section we have focused on three clients serviced by your proposed team: North Carolina, Wisconsin and Alabama. Note that Ken has worked for North Carolina for over 20 years.

References & Narrative Descriptions for Consideration by the State and Selection Committee:

Reference 1

North Carolina State Health Plan (NCSHP)

Contact Information:

Mark Collins
Financial Analyst
State Health Plan
Phone: (919) 814-4410
Fax: (919) 855-5818
MCollins@shpnc.org

Time Period: 2012 - Current

Number of Participants: 680,000

Services Provided:

The NCSHP for Teachers, State Employees and Retirees is one of Segal's largest accounts, covering approximately 680,000 members, with over 130,000 Medicare eligibles. Your Account Manager, Ken Vieira, is the Lead Actuary and managed this account for over 17 years (spanning his prior firm). Segal is currently the Plan's Consultant and Actuary. We provide a broad range of services for NCSHP, including the following projects over the last 12-months:

- Providing ongoing actuarial analyses and financial projections over 5-years
- Calculation of participant and employer rates
- Data mining, warehousing and in depth utilization claims analysis, including EBD dashboards
- Clinical risk group analysis
- GASB OPEB actuarial valuations
- Quarterly and annual pharmacy benefit manager audits of claims, MAC pricing and discounts, and rebates
- Medicare Part D actuarial attestations
- IBNR analysis and reserve recommendations
- Analysis of return on investment of contracted disease management vendor
- Strategic consulting and planning with the Board of Trustees
- Alternative plan design, including incentives, penalties, and value based features
- Wellness program review and consulting
- HIPAA compliance review and consulting
- ACA program consulting, including the evaluation of the financial and compliance implications of upcoming legislation
- Medicare Advantage, PDP and EGWP consulting
- Employee and retiree communications consulting, including development and production of open enrollment materials and videos
- Review of medical management performance guarantees

Segal performed over 90% of the work related to this engagement. Only printing subcontractors for communication materials were are/were utilized.

Reference 2

Alabama Public Education Employees' Health Insurance Plan (PEEHIP)

Contact Information:

Ms. Diane Scott
Chief Financial Officer
P.O. Box 302150
Montgomery, Alabama 36130-2150
334-517-7302 (t)
334-517-7001 (f)
Diane.scott@rsa-al.gov

Time Period: 2014 - Current

Number of Participants: 300,000

Services Provided:

The Public Education Employees' Health Insurance Plan provides hospital medical health insurance benefits for all full-time employees, and certain part-time employees, of the Alabama public educational institutions, which provide instruction at any combination of grades K-14, exclusively under the auspices of the State Board of Education. These insurance benefits are also available to retired employees with a portion of the retiree's cost paid through the employer premium for active employees. The PEEHIP Division maintains insurance records for the approximately 300,000 active and retired members and eligible dependents on-line with on-line insurance status changes. All changes are reported to the third party administrators via electronic file transfer.

Segal began working with PEEHIP in 2013, current projects include:

- Analysis of proper funding levels for the Hospital Medical Insurance Program, Rx and Optional Plans.
- Consulting on plan design issues, focusing on cost effectiveness and competitiveness.
- Advice regarding legal/legislative developments regarding the Patient Protection and Affordable Care Act (ACA) and how it specifically impacts PEEHIP. This will involve keeping the PEEHIP staff and board timely informed of current.
- Negotiations with current plan providers as needed.
- Providing claim projections twice a year
- Retiree benefits design and strategy, including EGWP and prospective Medicare Advantage plans
- Pharmacy consulting and strategy, including contract negotiation
- Providing IBNR calculations by Active and Retired summarized by Medical, Drug, and by optional benefits - Dental, Cancer, Hospital Indemnity, and Vision.
- Request for Proposals

- Provide marketing for all Benefit Products every 3 years.

Segal performed 100% of the work related to this engagement and no subcontractors were utilized.

Reference 3

State of Wisconsin – Department of Employee Trust Fund (ETF)

Contact Information:

Ms. Lisa Ellinger
Administrator
State of Wisconsin
PO Box 7931
Madison, WI 53707
608-264-6627 (t)
lisa.ellinger@etf.wi.gov

Time Period: 2014 to Current

Number of Participants: 250,000

Services Provided:

Segal was recently hired as the health benefits consultant and actuary by the Wisconsin Employee Trust Funds. The total membership is approximately 250,000 that includes 110, 000 active employees. Segal provides the following key areas of service:

- Data analytics and data warehousing needs
- Program structure and vendor array
- How Wisconsin ETF's programs compare to others in the marketplace
- ETF's standard benefit design and its competitiveness in the health insurance marketplace
- Health intervention and cost containment programs
- ETF's program financial and risk structure

We have also been hired to perform actuarial consulting services for ETF, which consist of the following items:

- Provide actuarial consultation and advisory services on any technical, policy or administrative problems arising during the course of operations - by meetings, routine telephone calls and correspondence.
- Make recommendations to the State of Wisconsin Group Insurance Board (GIB) from time to time relative to possible improvements in the financing and benefit structure of the plans (including advice and fiscal estimates on proposed state law changes). Give advice on new developments in the group health insurance industry. Keep the GIB appraised of current trends and progress within the actuarial profession.
- Give consultation and advisory services regarding the fiscal effect and policy and administrative problems of implementing new legislation.
- Assist in establishing and maintaining specifications for group health insurance data files whether maintained by the Department or third parties

- Provide advisement on developments in federal legislation and/or regulations regarding financing, benefits, fiduciary responsibility, taxation, disclosure, etc.
- Review Self-Funded Health and Pharmacy Benefit Plans Annual Review of Alternate Plan (HMO/PPO) Activity
- Review of Medicare Part D Activity

Segal performed 100% of the work related to this engagement and no subcontractors were utilized.

I. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The State prefers the proposed account manager have a minimum of 10 years consulting experience in employee benefits, including a minimum of 5 years consulting experience in governmental benefits or employers with self-insured health plans with more than 10,000 employees enrolled. The State reserves the right to have complete approval rights to the account manager assigned to our account.

Kenneth (Ken) C. Vieira, FSA, FCA, MAAA is a Senior Vice President in our Atlanta office and will serve as the State's Account Manager. Ken is Segal's East Region Public Sector Market Leader. He has a broad range of experience in the design, administration and funding of public employee and retiree benefit plans. He has been working with public employers for more than 25 years.

He joined Segal four years ago with a focus of expanding and growing the public sector. Over the past four years Segal has added over a dozen large public sector clients, many of these at the state-level. Prior to joining Segal, Ken was a Public Sector Practice leader for AonHewitt, where he worked for over 15 years, managing state level accounts throughout the Southeast.

Ken brings a substantial amount of practical experience to the project, combining the knowledge of an experienced consultant with the technical expertise of a seasoned chief actuary. He has been working with public employers his entire career. Ken is committed to the State and the success of this engagement.

Some of his projects include includes the development of a 5-year strategic plan for a large state health plan, providing clinical profiles utilizing risk modeling software, developing a claims data reporting package, providing ongoing actuarial consulting to various state health plans, financial modeling, GASB 43/45 valuations, Medicare Part D impact statements, consumer directed health plan modeling, Medicaid Rate Certification, CHIP claims and liability, Health Care Reform and the evaluation of the impact for implementing a Medicare Advantage-Prescription Drug Plan.

Ken's primary state level clients are the North Carolina State Health Plan (a client of Ken's since 1994), State of Wisconsin, Alabama PEEHIP, Kansas and the State of Illinois (all in our client reference list). Ken also provides strategic support in various capacities to larger state health plans in the East, including the State of Connecticut, Delaware, Maryland and PSERS. Over the past 5-years, prior to joining Segal, Ken has also served as the Account Manager and Lead Actuary for the state of Tennessee, Georgia and Kentucky. In summary, Ken has worked with and supported at least 10 State level plans, all over 100,000 lives. He thoroughly understands the challenges you all face.

Many of the services the State is requesting are performed for the above-mentioned State clients which Ken has/is managing with staff from your Segal Team.

Ken will be responsible for the completion of each service component and deliverable of all work under the scope of this RFP. He will work closely with the leads on each team and has final sign off on all deliverables and/or reports.

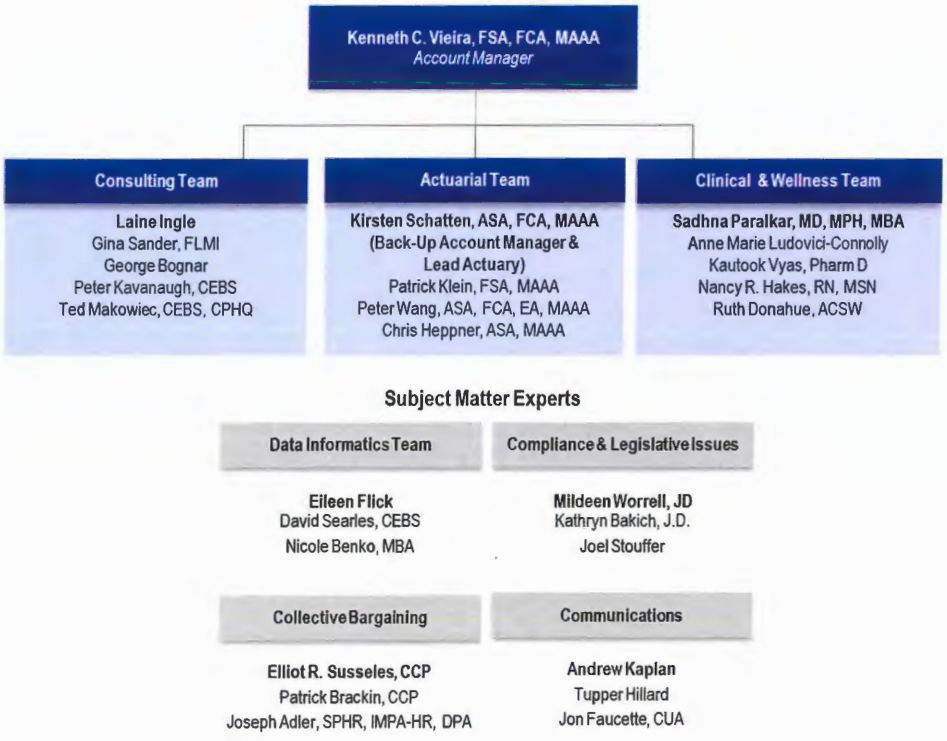
We understand the State reserves the right to have complete approval rights to the account manager assigned to our account.

The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

Segal has assembled a senior team of consultants, actuaries, and clinicians who have experience working with state health plans and have a deep knowledge of the healthcare delivery systems utilized primarily in Nebraska.

This is a challenging assignment, which we believe requires specialized knowledge and skill sets to complement our actuarial team. With that in mind, in addition to our seasoned actuaries, our highly qualified team consists of healthcare consultants, subject matter experts, data specialists, lawyers and clinicians. All were assigned to the team with a public sector focus in mind. The team will be staffed primarily out of the Atlanta office and will be supported, as needed, by our Regional and National Healthcare Practitioners. All of the senior team members meet the minimum requirements described in **C. Business Requirements**.

Below is a summary of our proposed State of Nebraska account team and the lines of responsibility on your account:



Segal's actuaries and consultants work with many state and local government clients on their multi-option health benefit programs, both self and/or fully insured. Your Segal actuaries have experience with State level plans in North Carolina, Georgia, Tennessee, Kansas, Alabama, Maryland, New Mexico, Illinois, Wisconsin, Kentucky, and others. In addition, we work with many large cities and counties, some of which approach State level enrollment.

Key members of your proposed team are summarized on the following pages, highlighting their expertise and role on your account only. We have included detailed resumes of each team member in the Segal Team Resumes section of the proposal.

Segal Senior Team

Segal has assembled a senior team of consultants, actuaries, and clinicians who have experience working with state health plans and have a deep knowledge of State healthcare delivery systems. Key members of your account team have worked with several state programs throughout the country. In addition, our team was assembled to recognize the importance of knowing the Nebraska area marketplace.

In addition to Ken, key members of our actuarial and consulting team include:

The Lead Actuary and Back-Up Account Manager assigned to your account is **Kirsten Schatten, ASA, FCA, MAAA.** Kirsten is an Associate in the Society of Actuaries, a Fellow in the Conference of Consulting Actuaries and a Member of the American Academy of Actuaries.

Kirsten is a Vice President and Actuary in our Atlanta office. She will assist Ken by providing actuarial projections, funding, reserves, Medicare program-specific analyses (EGWP, Medicare Advantage, RDS, etc) and a number of other actuarial assignments. She has been serving public plans and employers for 20 years and currently works on the North Carolina State Health Plan, Maryland Department of Budget Management, Illinois Central Management Services, Alabama PEEHIP, Kansas and the Wisconsin Employee Benefit Trust. Over the past 5 years, Kirsten provided actuarial consulting to the Georgia State Health Benefit Plan, the State of Tennessee, Bureau of Tenncare, and the Commonwealths of Virginia and Kentucky.

Like Ken, Kirsten has worked specifically in the public sector market, working for over 10 large State accounts, performing continuous service for all of these plans. Each of these plans are over 100,000 lives.

Kirsten has worked with Ken for nearly 10 years and will bring continuity to this engagement. She will also be readily available to respond to the State's actuarial needs under this project.

Sadhna Paralkar, MD, MPH, MBA, Segal's Medical Director, Health Management Consultant, will lead the clinical team. Her areas of expertise include health care informatics, on-site clinics, medical management program design, clinical operations, wellness, benefit plan design and network management strategies to optimize health improvement while containing costs, and evaluation and implementation of disease management and wellness programs based on evidence based medicine (EBM) protocols. Sadhna has been most recently involved with health management re-designs with North Carolina and Wisconsin, working closely with Ken.

The Lead Benefit Consultant is **Laine Ingle**. Laine is a Benefits Consultant and Health Practice Leader in our Atlanta, Georgia office. She will serve as Lead for Health Strategies and will help manage the day-to-day projects. Laine has provided operational and administrative strategic support for many large public employers, including the Georgia State Health Benefit Plan, Alabama PEEHIP, Illinois Central

Management Services, the State of Maryland, PSERS, State of Wisconsin, the City of Houston, and Fulton County (GA). She has managed procurements for many of these accounts.

Laine, Sadhna, Kirsten and Ken have a long history and have worked together on numerous assignments.

With the proposed senior management team, the State can be assured that all your needs and expectations will be met. They have extensive experience managing large engagements, specifically in the public sector environment. As a key component of this engagement, Segal has assembled this experienced senior team that will be engaged at various levels on your account and are instrumental in making this engagement successful.

State of Nebraska Proposed Team

Below is a brief summary of each member of our team, their role on the account and how their experience would benefit the State.

Segal Contact Information	Title	Role for the State
Account Manager		
Kenneth C. Vieira, FSA, FCA, MAAA 678-306-3154 kvieira@segalco.com	Senior Vice President and East Region Public Sector Market Leader	Mr. Vieira will serve as Account Executive Manager. He will attend each meeting with the State and assist with health strategy development. He will be responsible for the completion of each service component and deliverable of all work under the scope of this RFP. He will work closely with the leads on each team and has final sign off on all deliverables and/or reports.
Actuarial Team		
Kirsten Schatten, ASA, FCA, MAAA 678-306-3153 kschatten@segalco.com	Vice President and Consulting Actuary	Ms. Schatten will serve as the Lead Actuary and Back-Up Account Manager. Ms. Schatten will lead the actuarial team and be responsible for all the actuarial work conducted for the State. She has extensive experience working with State health plans, including Maryland, Alabama, Illinois, Wisconsin, Georgia, Kentucky and North Carolina.
Patrick J. Klein, FSA, MAAA 678-306-3142 pklein@segalco.com	Senior Health Consultant	Mr. Klein will be responsible for day-to-day execution of all actuarial projects including the renewal negotiations and budgeting. He has specialized expertise in employee benefit strategy, vendor negotiation, and cost projections. He recently joined Segal and has in depth experience with many public sector large group entities.

Segal Contact Information	Title	Role for the State
Peter Wang, Phd, ASA, FCA, EA, MAAA 678-306-3149 pwang@segalco.com	Assistant Actuary	Mr. Wang will assist Kirsten and Patrick by providing actuarial, financial and data analysis. He specializes in integrating data management into our actuarial models. He is an Assistant Actuary in our Atlanta office, and provides actuarial services to support many clients, such as the North Carolina State Health Plan, Alabama PEEHIP, Illinois Central Management Services and the State of Kansas.
Chris Heppner, ASA, MAAA 312-984-8677 cheppner@segalco.com	Senior Vice President, Health Actuary and the Midwest Health Practice Leader	Mr. Heppner will support the entire actuarial team and assist with understanding the State's current cost components so that effective decisions could be made to manage those costs. He has developed interactive budget projection models to address client-specific interests, as well as engaged in successful negotiations with insurers to keep renewal increases consistently below trend. He will also work closely with the Collective Bargaining team during union negotiations.
Clinical & Wellness Team		
Dr. Sadhna Paralkar, MD, MPH, MBA 312-933-7808 sparaklar@segalco.com	Medical Director	Dr. Paralkar will lead the clinical team. She has extensive experience evaluating medical data and using the data to develop plan options. She has worked to develop on-site clinics and nursing strategies. She will work closely with other team members on developing recommendations for the wellness program, plan design and medical management initiatives
Anne Marie Ludovici-Connolly 617-424-7300 ALudovici@segalco.com	Wellness Consultant	Ms. Ludovici-Connolly is a Wellness Consultant in Segal's Boston office with over 30 years of experience working with a variety of organizations in the public, academic and private sectors. Ms. Ludovici-Connolly is a subject matter expert in population health management, well-being and health behavior change. She will work closely with Dr. Paralkar on plan designs, ROI studies, performance guarantee and long-term health management programs.
Kautook Vyas, PharmD 312-984-8587 kvyas@segalco.com	Clinical Pharmacy Consultant	Mr. Vyas will lead the pharmacy team and be the clinical pharmacist supporting your account. The team will provide vendor management, audits, formulary management, utilization programs and plan design recommendations. He will work with Ms. Paralkar on clinical issues. He is an expert in reviewing prescription drug utilization and drug indications.

Segal Contact Information	Title	Role for the State
Nancy R. Hakes, RN, MSN 602-381-4025 nhakes@segalco.com	Vice President and Clinical Consultant	Ms. Hakes is a Registered Nurse and provides a wide array of clinical consulting to our clients. She will work closely with Dr. Paralkar in support of the clinical and wellness activities for the State. She is an expert on operational issues regarding managed care. Nancy provides detailed research on specific health care issues pertinent to medical coverage, plan design, and quality of care, including disability; workers' compensation; wellness and associated incentive programs; EAP and behavioral health; prescription drugs; disease management; telephonic nurse triage programs; and utilization management.
Ruth Donahue, ACSW 312-984-8586 rdonahue@segalco.com	Vice President and Behavioral Health Consultant	Ms. Donahue's comprehensive experience includes more than a decade as a consultant and Human Resources practitioner and over 30 years as a clinician and coach. She brings her broad expertise and specialty background on issues of behavioral health, wellness, and behavior change strategy to her role on Segal's National Health Team. Ms. Hakes will support the clinical and wellness team for the State.
Consulting Team		
Laine Ingle 678-306-3132 lingle@segalco.com	Senior Health Consultant and Health Practice Manager in Atlanta	Ms. Ingle will serve as Lead Health Consultant and will manage the day-to-day consulting projects. She will provide strategic design and supervision of many different areas for health benefit plans, including health plan strategy, vendor evaluation and selection, implementation of new programs, and plan performance management. She has experience in serving as the day-to-day contact for public sector clients focusing on project management, vendor management, benchmarking of benefit plans and renewal marketing.
Gina Sander, FLMI 678-306-3158 gsander@segalco.com	Senior Health Consultant	Ms. Sander has a strong technical underwriting background and brings a full complement of consulting expertise to her clients. She works closely with Ms. Ingle and the project team. She will provide the State with strategic consulting, benefit program/plan design and evaluation, vendor selection and management. She has managed a number of public sector procurements.

Segal Contact Information	Title	Role for the State
George Bognar 202-833-6487 gbognar@segalco.com	Pharmacy and Health Consultant	Mr. Bognar will provide consulting on the pharmacy program, working closely with our clinical team. Having worked for a large pharmacy benefit manager, he brings a wealth of information around the pharmacy program design and management. He will also work closely with Laine and lead the pharmacy procurement, just recently completed for the States of North Carolina and Alabama.
Peter Kavanaugh, CEBS 312-984-8650 pkavanaugh@segalco.com	Consultant and Health Practice Manager in Chicago	Mr. Kavanaugh will support the consulting team and provide assistance with procurements and contract negotiations. He has led public sector, multiemployer and corporate clients through health benefits consulting engagements including health analytics studies; pharmacy benefit manager (PBM) audits; cost forecasting; and budgeting and vendor procurement assignments for medical, dental, prescription drug, wellness and disease management programs. He also established and set procedures for Segal's National Stop Loss Initiative.
Ted Makowiec, CEBS, CPHQ 248-530-6386 tmakowiec@segalco.com	Vice President and Health Consultant	Mr. Makowiec will support the consulting team with strategic initiatives. He has successfully implemented numerous cost control strategies for public sector employers. He has unique experience working with large employers, health systems and health care plans. He has extensive expertise in the implementation of decision support systems designed to create analytics that support major strategies and metric-driven decision making, as well as health reform initiatives, major benefit design changes and provider network development strategies.
Subject Matter Experts		
Data Informatics Team		
Eileen Flick 212-251-5120 eflick@segalco.com	Senior Vice President	Ms. Flick is the National Practice leader for Health Informatics and Data Warehousing. She will lead all efforts in managing the data analytics on the State. She will lead a multi-talented data analytics team that can meet a variety of needs for the State. The team will provide detail reporting and analysis in support of financial projections, reporting, ROI on wellness and care management programs and other activities. She currently manages a number of state engagements, including North Carolina, Maryland, Connecticut and Wisconsin.

Segal Contact Information	Title	Role for the State
David Searles, CEBS 212-251-5148 dsearles@segalco.com	Vice President and Health Analytics Consultant	Mr. Searles will work closely with Ms. Flick and Ms. Benko on all data analytical projects for the State. He will be the lead day-to-day project manager for all activities related to data reporting. He was instrumental to the development of Segal's "Shape" data warehouse, designed to support fact-based data analytics. He also works with clients to provide technical assistance for network discount analysis, pricing, wellness and disease management program effectiveness, and plan design analysis.
Nicole Benko, MBA 212-251-5255 nbenko@segalco.com	Health Benefits Data Analyst	Ms. Benko will work closely with Ms. Flick and Mr. Searles on all data analytical projects for the State. She has specialized expertise in benefit plan designs for self-insured, managed care, Medicare and Medicaid clients. She also has extensive experience working on financial audits, CMS audits and claims audits. She conducts health data analytics to help improve plan performance by determining underlying cost drivers, containing costs and developing strategies to improve patient outcomes.
Compliance & Legislative Issues		
Mildeen Worrell, JD 202.833.6448 mworrell@segalco.com	Vice President, Compliance Practice Leader	Ms. Worrell will Lead the Compliance team on all compliance and legislative issues for the State. She leads all the compliance activites for East Public Sector account. She has unique experience and was prominently involved in the development of significant legislation, including the Affordable Care Act (ACA), Health Portability and Accountability Act (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA), and Mental Health Parity and Addiction Equity Act (MHPAEA).
Kathy Backich, JD 312.984.8582 kschwappach@segalco.com	Senior Vice President and National Compliance Practice Leader	Ms. Bakich will provide strategy and national compliance support to the State, working closely with Ms. Worrell. Ms. Bakich is one of the country's leading experts on employer sponsored health coverage. She specializes in providing research and analysis on federal laws and regulations affecting health coverage, including: ERISA, Medicare, The Affordable Care Act, HIPAA, COBRA, the Newborns' and Mothers' Health Protection Act, the Mental Health Parity and Addictions Act, and the Women's Health and Cancer Rights Act.

Segal Contact Information	Title	Role for the State
Joel Stouffer 678-306-3150 jstouffer@segalco.com	Senior Compliance Consultant	Mr. Stouffer is a Compliance expert in our Atlanta office with over 25 years of experience in the health care industry and 20 years of experience in health care compliance. He will work closely with Ms. Worrell and Ms. Backich. He assists clients with the preparation of plan documentation, including summary plan descriptions (SPDs), summaries of material modification (SMMs), plan amendments, government compliance filings, employee communications and administrative policies and procedures.
Collective Bargaining		
Elliot Susseles, CCP 202-833-6436 esusseles@segalco.com	Senior Vice President and National Collective Bargaining Practice Leader	Mr. Susseles is located in our Washington D.C office and will serve as the Lead Collective Bargaining Consultant. As a member of Segal's Public Sector Leadership Group, Mr. Susseles collaborates with benefits related Practice Leaders to shape Segal's total rewards consulting philosophy. Mr. Susseles also serves as Client Relationship Manager for major projects and provides clients with strategic bargaining assistance regarding all contractual economic issues.
Patrick Brackin, CCP 202-833-6452 pbrackin@segalco.com	Senior Compensation Consultant	Mr. Brakicn will Project Manage, under Mr. Susseles, all union related issues for the State and work on strategy with Mr. Susseles and Mr. Adler. He has 14 years of experience in coordinating and conducting total compensation studies, classification structure re-design, and economic analysis. He specializes at working with unionized, utility, and transit organizations.
Joseph Adler, SPHR, IMPA-CP, DPA 202-833-6498 jadler@segalco.com	Senior Consultant	Mr. Adler is located in our Washington D.C office and will support Patrick and Elliot on all union issues. He joined Segal in August 2015 to provide strategic human resources advice to our public sector clients. Prior to joining Segal, Mr. Adler served as the Director of Human Resources for Montgomery County (MD) government from 2002 to 2015.

Segal Contact Information	Title	Role for the State
Communications		
Andrew Kaplan 212-251-5169 akaplan@segalco.com	Vice President and Senior Communications Consultant	Mr. Kaplan will serve as the Lead Communications Consultant. He will be responsible for communication issues, such as developing electronic and print communications that encourage participation in wellness and preventive care programs by employees. His current and recent clients include BMW, BNP Paribas, Illinois Department of Central Management Services, Yale-New Haven Health System, Greenberg Traurig LLC, Ohio State University, Skidmore College, and Xylem, Inc. He is also heading the current 2016 annual enrollment communications project for the State Health Plan.
Tupper Hillard 602-381-4010 thillard@segalco.com	Vice President and Senior Communications Consultant	Mr. Hillard is will work closely with Mr. Kaplan on a wide array of communications projects. He is a Senior-level resource for Communications/Survey projects. Mr. Hillard has more than 15 years' experience in benefits, specializing in change and branding communications.
Jon Faucette, CUA 609-482-2376 jfaucette@segalco.com	Consultant and Manager of Inhouse Design Group	Mr. Faucette will support Mr. Kaplan and Mr. Hilliard on communication and design strategy and overall general communication support and design. He is located in our Princeton office and helps clients implement sophisticated and sensible communication strategies using a mix of online, print, and multimedia formats. He has provided design and user experience consulting to clients such as the State Health Plan of North Carolina, Pennsylvania School Employees Retirement System, Pfizer, WebMD (Emdeon), ITT Exelis, Avis Budget Group.

The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

We have included resumes of our key associates with references and we have included resumes of the full team assigned to the State in **Appendix A: Team Resumes**.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

All team member resumes meet the above requirements. We have provided references for our top team members only since they will be performing the majority of the work for the State.

J. SUBCONTRACTORS

If the bidder intends to Subcontract any part of its performance hereunder, the bidder must provide:

- ***vii. name, address, and telephone number of the Subcontractor(s);***
- ***viii. specific tasks for each Subcontractor(s);***
- ***ix. percentage of performance hours intended for each Subcontract; and***
- ***x. total percentage of Subcontractor(s) performance hours.***

Segal does not plan to subcontract any part of the work on this project. Should a need arise to engage a subcontractor during the course of work on the project, we will discuss that need with the State and request written approval from the State prior to engaging the subcontractor or committing to the work.

T. Approach- Project Requirements

Technical Approach – Understanding of the Project Requirements

IV.D – Project Requirements

The contractor will provide the following services:

1. ***Strategic consulting services for all health and welfare programs including the State's self-insured medical, pharmacy, wellness programs, and collective bargaining;***
2. ***Actuarial services for the State's Employee Health Plan;***
3. ***Health plan data analytics and reporting;***
4. ***Assist with benefit plan requests for proposals (RFP); and***
5. ***Legislative and Regulatory Analysis & Education.***

We at Segal are pleased to submit this proposal to provide professional health and welfare consulting services for the employee insurance benefits program which includes health, wellness, dental, vision, life, long term disability, flexible spending accounts, health savings account, and employee assistance program for the State of Nebraska.

Segal is prepared to serve as your actuary and health care consultant. Our firm brings to this engagement an established record of experience, hard work and innovation in helping large public and private sector clients manage their benefits programs. Through our work with a broad array of public sector employers at the state, local and federal government levels, we are experienced with many of the complex issues faced by the State.

The Account Manager and day-to-day contact is **Kenneth (Ken) C. Vieira, FSA, FCA, MAAA**. Ken has provided consulting and actuarial services to large state health plans for more than 25 years. He leads a heavily experienced Segal team that focuses on serving state health plans. The core Segal team currently serves state level plans in Alabama, Kansas, North Carolina, Illinois, Wisconsin, and Maryland. Last year your Segal team transitioned a number of clients from AonHewitt, most recently being the State of Kansas. We hope to do this again with the State of Nebraska.

Our Understanding

The State of Nebraska (State) offers comprehensive wellness and health benefits to approximately 16,000 employees. These employees live in all 93 Nebraska counties. The State offers three self-insured medical health plans to 13,800 employees, which includes one wellness health plan requiring participation in the State wellness program (**wellNEssoptions**) and a consumer focused HSA. Dental, vision, FSA, life, LTD and EAP services are also options available for selection.

The State is a leader among states, due to its innovative wellness program. The State and its employees have lived up to its motto: ***"Working Toward a State of Health"***. The program ties health plan enrollment to wellness participation. The results are impressive, supporting a $4.2 million reduction in claims, 16% increase of participation since 2015 has won many prestigious national awards including the 2010 and 2012 Gold Well Workplace by the Wellness Council of America, the Innovations Award from The Council of State Governments, and the coveted 2012 C. Everett Koop National Health Award. With all the positive results of the program the State is still experiencing 8% – 10% annual trend that are not sustainable.

The State's Objectives and Intended Results

The State will continue to manage all employee benefit plans. All aspects of the employee benefit plans are subject to review, and the State understands that all areas of plan management are critical to the program's success.

Based on our experience providing consulting services to other state plans we expect that the State intends for the health benefit plan to accomplish simultaneous goals that may conflict at times, including:

- Provide benefits that are similar to other states;
- Demonstrate that the benefit plan provides value in attracting and retaining well qualified staff;
- Provide cost efficient benefits that contribute to helping the State meet budget goals in other areas; and
- Reduce employee contributions, when appropriate or feasible.

The wellness program has been critical to the success of the State's health benefit program and the State's consultant will be responsible for helping to move this program to the next level. All wellness programs need to grow in order to remain fresh and vibrant. It is equally important that the consultant and its actuaries provide traditional services within the wellness framework, such as:

- Proposing health and wellness plan designs annually;
- Developing the analysis supporting recommendations for premium equivalent rates and contribution rates;
- Monitoring and reporting on the benefit plans' results;
- Preparing requests for proposals;
- Providing strategic consulting and assessment; and
- Performing special projects.

Proposed Services

We propose to provide actuarial and related consulting services requested by the State, including:

- Strategic Consulting Services;
- Actuarial Services and Related Reporting;
- Health Plan Analytics and Reporting;
- Benefit Plan Request for Proposals; and
- Legislative & Legal Support and Compliance

Our proposed team was designed to encompass all the skills and expertise needed to best meet your needs.

Our Approach Is Unique

Segal is known in the benefits, compensation, and human capital industry for the longevity of our client relationships. With over 2,500 clients across the country, we gain and lose some clients each year. Some of our client relationships span a period of as much as 50 years. In a number of cases, former clients that retained the services of other consultants have returned to us.

Segal's consulting approach is based in its dedication to our corporate values and the Segal "brand promise" –

> *"Segal is the firm of choice for clients committed to enhancing their organizations. We are the architects of programs that build and secure the trust between our clients and their people. By continually analyzing our evolving markets, we provide practical advice that looks beyond the numbers to the human side of solutions. Our consultants guide our clients through the challenges confronting them today and prepare them for tomorrow."*

Our consulting approach is client focused, timely, pragmatic and forward thinking. The solutions for the challenges facing public sector health plan sponsors today are not rooted in the past; nor can they be based on simply applying benchmarks to what "everyone else" is doing. To be current and relevant in our work:

- We strive to understand our public sector client needs and are sensitive to their unique environment;
- We pride ourselves in challenging the status quo and delivering the work related to the basic consulting tasks needed to support complex health plans;
- We are unmatched in the consulting industry as creative and innovative thought leaders dedicated to excellent solutions;
- We are committed to integrity, professionalism, and exceeding expectations.

The Segal Health Consulting Model

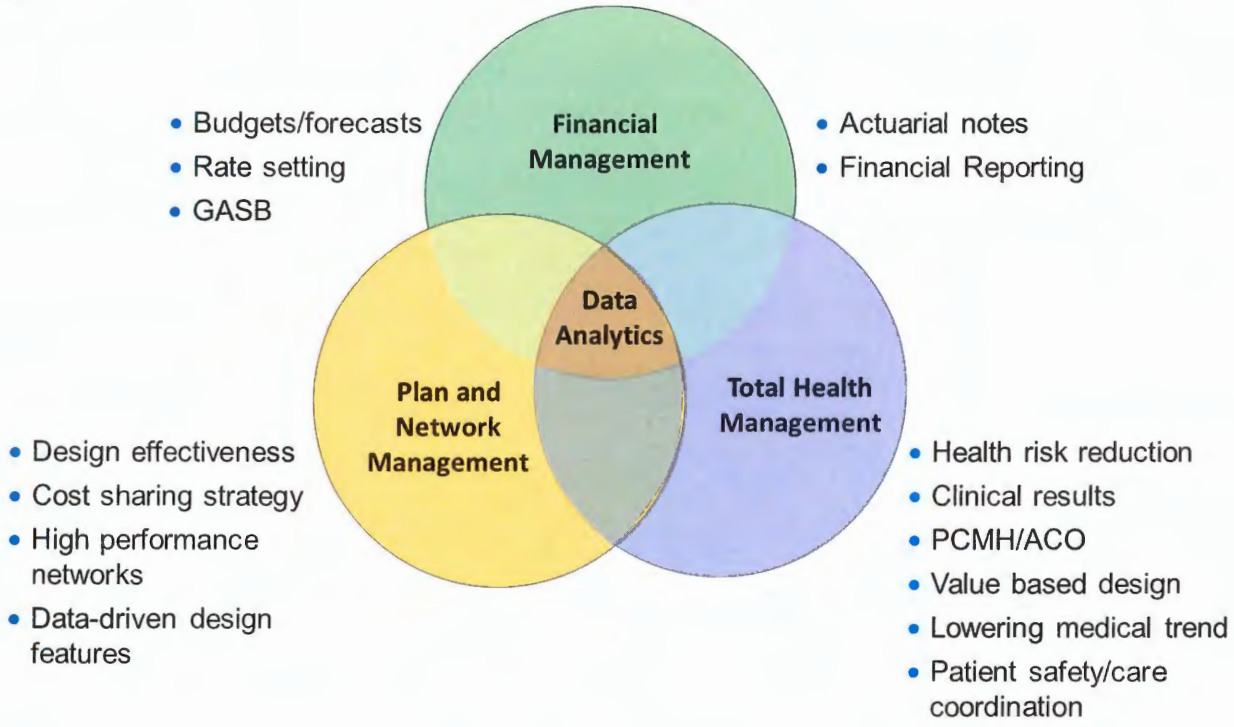
A key element of our service delivery for the State will build off Segal's health consulting model. The model emphasizes the integration of three pillars:

Financial Management: aspects of a health plan that are related to budgets, forecasts, rate setting, and reporting.

Plan and Network Management: advisory services that support design effectiveness, network performance, cost sharing strategies, and vendor management.

Total Health Management: advisory services that support clinical results, health risk factor reduction strategies, innovative delivery systems (e.g. Patient Centered Medical Home, Accountable Care Organization), patient safety and care coordination, and medical trend management.

The following diagram illustrates how these consulting pillars fit together for the best outcomes for our clients:



Segal consultants are skilled in understanding the interrelationships between each consulting pillar and working together across a wide range of consulting specialties to deliver this integrated consulting model. Each of our clients is at a different place in their development of cutting-edge health benefit programs and our approach offers wide flexibility in addressing issues at every level. Even when we are retained only for one aspect of the work, we continually think across all these major concerns to help provide our clients the most appropriate advice for their success.

We understand the value of leveraging client specific data as the engine that links together our work in all three major areas. At Segal, we believe that having a command of the data, knowing how to organize the data, and applying analytical tools to the data is one of our greatest strengths. While benchmarks provide a view of the current state, data offers a glimpse into the future necessary for developing state-of-the-art consulting solutions for the present and future.

Segal Team Experience and Resources

Segal has extensive experience in providing actuarial and benefits consulting services to public plans and employers. We work with more than 20 state-level health plans across the county. We began working with our longest standing state client, Hawaii, more than 50 years ago. Your senior team works for a number of states throughout the region.

The Segal team will be led by **Kenneth (Ken) C. Vieira, FSA, FCA, MAAA,** a Senior Vice President in our Atlanta office who will serve as the State's Account Manager and will have overall responsibility for the services performed under this contract. Ken is Segal's East Region Public Sector Market Leader and sits on Segal's East Leadership Team. He will provide ongoing consultation services to the State under this contract and serve as the day-to-day point of contact for the State. Ken's primary clients are the North Carolina State Health Plan (a client of Ken's since 1994), State of Wisconsin, Alabama PEEHIP, Kansas and the State of Illinois.

Ken will ensure the account remains appropriately staffed and that Segal continues to provide outstanding quality and service to the State of Nebraska.

The Lead Actuary and Back-Up Account Manager assigned to your account is **Kirsten Schatten, ASA, FCA, MAAA** and is a Vice President in our Atlanta Office who also leads the Atlanta Health Actuarial Practice. Kirsten is an Associate in the Society of Actuaries, Fellow in the Conference of Consulting Actuaries and a Member of the American Academy of Actuaries. Kirsten has been serving public plans and employers for 20 years and currently works on the North Carolina State Health Plan, Maryland Department of Budget Management, Illinois Central Management Services, Alabama PEEHIP, Kansas and the Wisconsin Employee Benefit Trust. Ken and Kirsten have worked together for nearly 10 years.

Our senior management team brings a wealth of knowledge to the engagement. Our team has likely worked for nearly every State in our region at some point in their career, some current. The team will engage our SMEs and other expects as we progress through the engagement.

Segal Transition Experience

If we are fortunate enough to be engaged by the State, we will begin work immediately to ensure a smooth transition from your current actuary and consultant. Unlike other firms, we are focused on the public sector and plan for sustainable growth. Segal does not have near the turnover of other firms and in very rare circumstances will our actuary be changed on an account. You will also see in our write-up that your Account Manager has not lost an account while he has been at Segal (since 2012).

Below is brief list of State Health Plans that we have transitioned since 2012. All are still Segal clients and would act as a reference for us.

- The North Carolina State Health Plan (2012) - AonHewitt
- The State of Delaware (2012) - AonHewitt
- The Maryland Department of Budget and Management (2012) - Buck
- Illinois Department of Central Management Services (2013) – Mercer, Willis
- Alabama Public Education Employees' Health Insurance Plan (2013) - Buck
- Wisconsin Department of Employee Trust Funds (2014) – Deloitte
- State of Kansas (2015) – AonHewitt
- State of Connecticut (2015) - Milliman

We believe our combination of talent, approach, resources, experience and public sector focus makes Segal the most qualified firm to work with the State of Nebraska on this important assignment.

Segal understands the project requirements and put together a team to ensure success.

T. Approach- Business Requirements

Technical Approach – Business Requirements

IV.D – Business Requirements

1. ***The contractor shall provide an Account Management team to oversee the services listed in detail under the Scope of Work. The Account Manager shall be accessible by phone and email. A backup to the Account Manager shall also be assigned when the Account Manager is not available.***

Segal has provided an Account Manager, Ken Vieira and a Back-Up Account Manager, Kirsten Schatten. There information is under the **Corporate Overview** but here we are providing it again.

The Account Manager for this engagement is **Kenneth C. Vieira, FSA, FCA, MAAA**. Ken is in the Atlanta Office at the address and numbers listed above. He is the primary contact for Segal and his email is kvieira@segalco.com and his direct phone is (678) 306-3154.

The Back-Up Account Manager for this engagement is **Kirsten Schatten, ASA, FCA, MAAA**. Kirsten has over 20 years of the same experience with large employer group health plans. She is the secondary contact for Segal and her email is kschatten@segalco.com and her direct phone is (678) 306-3129.

Ken and Kirsten will work as an account management team to oversee the services requested under the Scope of Work. They currently provide a similar account management structure and team for the states of Kansas, Wisconsin and Alabama.

2. ***The bidder shall have at least five years of business experience providing comprehensive employee benefit consulting services to large public sector and non-public sector employers which more than 10,000 employees and retirees.***

Segal has been consulting with government entities for over 75 years. A large number of our public sector clients are over 10,000 lives. We have provided additional details in our Corporate Overview.

Segal, as a national firm, has over 2,500 clients. We provide actuarial and consulting services to over half of them. We have provided a list of our top 50 clients by market segment.

Public Sector	Multi-Employer	Corporate
Public School Employee Retirement System	National Elevator/IUEC	L-3 Combined
North Carolina State Health Plan	Central States SE SW Areas Funds	Delta Air Lines Inc
UCRS	IAM National Pension Fund	National Basketball Association NBA
City of Detroit Retiree Committee	73 Sheet Metal Workers PF	BMW
Georgia Municipal Employee Benefit System	Boilermaker Blacksmith Natl PT	L-3 Communications
State of Maryland	Heartland Health and Wellness Fund	Schlumberger
City of Houston	No CA H W	NFL National Football League
State of Colorado	Bakery Conf Un Ind Intl PF	Weil Gotshal Manges LLP
State of Delaware	HEREIU Welfare Fund	Cisco Systems Inc
PSC CUNY Welfare Fund	UFCW National Pension Fund	Loral Combined
State Of New Hampshire	Bakery Conf Un Ind Intl Hlth	Wells Fargo Bank
PERS of Nevada	So Cal Food Benefit	Olin Corporation
Pennsylvania State University	AFL CIO Staff Retirement Plan	Lockheed Martin (LMC) Combined
OCERS	NIGPP	National Hockey League
	So Cal Food Pension	Meggitt MABS Salaried
	Chicago Carpenters Pension Fd	Lyondell Chemical Co

Public Sector	Multi-Employer	Corporate
Illinois Dept Central Mgmt Services	MM P All Plans	Chevron Corporation
North Dakota Public Ees Ret System	SEIU Health Welfare Fund	Curian Capital
Montana Unified Schools Trust	ILWU PMA Pension	University of Minnesota
City of Stockton	Allied Pilots Association	Nomura Securities Co LTD
State of Hawaii	Southern California Local 831 Employer Pension Plan	Scottsdale Healthcare
University of Missouri	Sheet Metal Workers National PF	Daiichi Sankyo Inc
Contra Costa CERA	Iron Wkrs DC So Ohio Vic PT	Community Hospital Pension Plan
City of Boston	Rocky Mountain UFCW Health Pl	Physical Optics Corporation
Los Angeles Unified School District	UFCW Midwest Clerks Pension Fund	Muscular Dystrophy MDA Assoc
LACERS	GCC IBT National Pension Fund	Central National Gottesman Inc
SDCERA	SEIU Affiliates Offcrs Ees PF	Lincoln Center for Performng Arts
ACERA	No CA Joint Pension	Richardson GMP Limited
LAFPPS	Transit Employees Welfare Plan	Skidmore College
CAP	UA LU Officers Ees Pension Fd	H Charles Price
New Jersey Transit NJT All Plans	Natl Automatic Sprinkler Ind WF	Bashas Inc
CTA Retiree Healthcare Trust	Laborers PF Western Canada	BNP Paribas
No Ariz Public Ees Bft Trust	UAW Strike Fund	Honeywell Inc
State of Alaska	RWDSU Pension Fund	Reilly Auto Parts
City of Chattanooga Pol Fire Ins PF	Sheet Metal So Cal Ariz Nev HF	Flagstar Bancorp Inc
Birmingham Water Works Board	IAMAW PP	Genuity
Chicago Teachers Pension Fund	Equity League Pension Fund	SKL
County of Kern	AFL CIO Welfare Fd Consulting	Raymond James LTD
Parochial Employees Retirement	UAW Master Trust	BWXT Pantex
City of Jacksonville Retirement System	California Ironwkrs Field WF	American Basketball Association
Kansas City Public School Retirement System	National Shopmen Pension Fund	Dana Farber Cancer Institute
Salt River Pima Maricopa Indian Comm	Directors Guild of America H WF	Alkermes
City of Memphis Retirement System	Boilermakers National H W Plan	Avnet Inc
Ohio Teachers Retirement System	Southwest Carpenters Pension Trust	Greenberg TraurigLoral Parent
Sacramento CERS	Paper Ind PACE Union Mgt PF	Macquarie Private Wealth
Louisiana School Ees RS	Pipeline Industry PF	Catholic Medical Center
County of Sonoma	Chicago Carpenters Welfare Fund	Charlotte Hungerford Hospital
University of Oklahoma	Iron Workers Tri State WF	Texas Health Resources
NY Virgin Islands Retirement	Greyhound ATU National Local 1700	Wyncote Foundation
LCG Health Plan	MILA	
Transt Mgmt Se LA Ret Income Pl		
SBCERA		
**Cannot be named for contractual purposes*		

The above should allow the State to be comfortable that Segal works with a wide variety of markets and has experience throughout the industry sector.

As the State will see throughout our proposal Segal currently works with over 20 state clients, who all have over 10,000 employees and retirees. Some of these go back many years, including the State of Hawaii, as our longest standing client, with over 50 years of service. The services provided to these states mirror what the State of Nebraska is asking for under this scope of service.

3. The contractor shall have experience providing benefit consult services to large employers who offer a self-insured employee health plan and wellness program.

As the State will see throughout the **Technical Proposal**, Segal has been providing benefit consulting services to large employers, who offer a self-insured employee health plan and wellness program, for nearly 50 years. The answer to Question (2) above demonstrates our large Multi-Employer and Corporate Accounts.

4. ***The contractor shall certify it, as well as any subcontractors that it utilizes, is in full compliance with HIPAA's regulations protecting the privacy of individually identifiable health information.***

Segal certifies that we are in full compliance with HIPAA's regulations protecting the privacy of individually identifiable health information.

In addition, Segal's health plan clients are Covered Entities under the HIPAA Security Rule.

As a HIPAA "business associate" to our health plan clients, Segal implements administrative, physical and technical safeguards designed to protect the confidentiality, integrity and availability of protected health information in electronic form (ePHI). Segal is in compliance with the HIPAA Security Rule and utilizes industry standard technology solutions and best practices to maintain a secure environment for the storage and transmission of ePHI and other confidential data.

Although we do not anticipate any subcontractors on your account, it is standard policy that any subcontractor vendor, working on behalf of Segal, comply with all applicable laws including HIPAA, state laws governing security, and any other federal or state rule or regulation governing Vendor's provision of services to the State.

5. The contractor shall agree to sign the State's Business Associate Agreement.

Segal agrees to sign the Business Associate Agreement.

We have provided the State's Business Associate Agreement with modifications, should the State consider these modifications in place of the current BAA.

T. Approach-Scope
Of Work

Technical Approach – Scope of Work

Segal has responded to every section of the Scope of Work:

1. Strategic Consulting Services
2. Actuarial Services & Related Reporting
3. Health Plan Analytics and Reporting
4. Benefit Plan Request for Proposals (RFP)
5. Legislative and Regulatory Analysis & Education

See below for our responses.

Explain how the bidder will provide the services below to the State by completing the following tables. Response shall demonstrate experience performing similar services for other State or large employers including accomplishments and other information. Include examples of the bidder's work, when applicable.

1. Strategic Consulting Services

The contractor will provide strategic consulting services for all health and welfare programs listed above in Section IV. B. Project Environment. Services include, but not limited to, the following list of services.

a. Regularly consult with the State on strategy and programs to which help manage the State's self-insured health and wellness plan including plan design, networks, pharmacy benefit program, stop loss, and carriers. Renewal timeline:

i. Plan Year begins: July 1

ii. Governor renewal review: February 1

iii. Final rates & plan design: March 1

b. Regularly meet with Employee Wellness and Benefit staff to stay abreast of administrative, programmatic, regulatory, and other issues and opportunities regarding the State's employee benefit programs

c. Attend benefit plan vendor meetings as requested to provide input and recommendations.

d. Provide on-going monitoring of developments in new benefit strategies.

e. Assist in reviews, analysis and recommendations of employee benefits in preparation of labor negotiations and be available to attend onsite preparation meetings as requested.

f. Train Administrative Services staff on topics including regulatory updates, industry trends, data analysis, and compliance.

a	***Describe the bidder's approach to providing strategic consulting services to the State on all of the benefit programs. Include a summarized listing of services included with the proposal.***
	Response: The Actuarial and Consulting staff assigned will work directly with the State on all aspects of the program. The assigned State team will devote the time needed to the account, including being available for frequent telephone and on-site consultation with the State.

Ken Vieira, the States' Account Manager, has assembled an interdisciplinary team of experts, with each member of the team having unique skills and expertise. Ken will be the day-to-day point of contact for the State and manage the Segal resources. The majority of your core team members are located in our Atlanta office. However, we may at times draw on resources from other offices in order to bring the right expertise to a particular situation. Every member of your team is committed to be available in person, via phone or email as often as you deem necessary.

Consulting Philosophy

Segal's consulting philosophy and overall approach is highlighted by our commitment to our clients. By forming a partnership with our clients, we serve as both advisors and advocates. In addition, our work is distinguished by the highest level of professional consulting services, customized solutions, leading edge consulting and cost efficiency through technology. We seek to be innovative and to accommodate the special requirements of each client, rather than merely replicate an approach that worked in another situation.

Our approach to account management and client satisfaction is to be truly "customer intimate"—to understand client business issues and anticipate client needs, rather than react to them. We do not stop thinking about your issues when we get off the phone or leave the meeting. That is why you can expect to get emails from us frequently that convey our additional thinking with respect to the issues at hand.

When working through issues, we will be responsive to your requests and questions and we will anticipate the next set of questions that the results suggest. Although our technical expertise is second to none, we recognize that the technical output is only the first step. Our client managers and engagement leaders seek to position the results of our analyses in ways that help you communicate effectively within your organization. We have extensive experience working with committees in the public sector and have supported our clients at numerous cabinet, board and trustee meetings. Working with our clients in this fashion is a critical part of our client service philosophy.

Team Communication

With an account the size of the State, managing information flow between project teams and even within a team is vital. Segal has much experience in knowledge management, and this experience will be brought to bear on the State assignment. Elements of this include:

- Creation and utilization of e-mail groups to push information to the teams
- Weekly "open item / status update" meetings
- Written tracking of progress and issues in a "shared document" accessible to the entire team
- Creation of a secure internet portal to house contact information, key deliverables and correspondence

Segal is well-qualified to provide all services to the State, as outlined in the Scope of Services section of the RFP.

On-going Project Management

At Segal, we closely monitor the workload of each team member to ensure they have capacity to meet our internal performance expectations, and those of our clients. Specifically, we assess staff's availability to adhere to our high standards for quality work, balanced against the need to meet tight deadlines and be flexible enough to shift gears for the inevitable, unexpected challenges that crop up in the course of client engagements. Prior to being assigned to work on behalf of a client, we assess each team member's current workload.

We define expectations to our staff for the timing of project deliverables, for each stage of the project, and the amount of time involved. Once we have set the parameters of each project, and assign appropriate staff, we then begin to inform clients of progress one we have started the work. During the project, we will assess client satisfaction with our performance. With that in mind, we have assembled a team of benefit professionals with significant experience working with clients who have needs similar to those faced by the State.

An Account Manager oversees the relationship for each client by monitoring workflow, introducing other advisors as needed, and periodically communicating progress to the client. The Account Manager also solicits client feedback and keeps the client updated on any issues that arise in the industry that may be of interest and have an impact on the client's programs.

As a Senior Vice President and a Principal of Segal, **Ken Vieira**, the States' assigned Account Manager, has the ability to deploy personnel on a moment's notice to meet the needs of our clients. This is a key to successfully managing your account since many of the deliverables have a one-week turnaround that we are committed to meet.

Developing Strategy

Segal will assist with the development of a long-term strategic plan for the State that minimizes costs, maximizes cost savings, and provides comprehensive benefits to the employees and retirees of the Nebraska. Segal is constantly monitoring and reviewing strategies for our clients to best manage their program.

At the request of the State, Segal will provide analysis and recommendations regarding potential health care program strategies, fiscal soundness and options for consideration that is consistent with the strategic long-term goals, vision, and objectives established by the State. Our team of experts will propose and evaluate new programs or benefits and provide you with a complete analysis (financial, legal, administrative, etc.) of the impact of such programs. These strategies typically involve a wide array of expertise, requiring the participation of national health care strategists, a consumerism/wellness expert, a clinician with expertise in wellness and chronic condition management programs, data mining analysts, a pharmacy expert, actuaries, and compliance experts.

Any recommendation will need to be practical, actionable and consistent with the overall vision of the State. All our strategies are built on an actuarial foundation, where studies and prior experiences help formulate the financial outcome of the recommendation. We will include best practice benchmarks, industry standards, emerging designs, success/failures of similar programs, etc. We review from a number of angles and want to make sure anything recommended has staying power and causes a minimal amount of noise and disruption.

Our recommendation(s) will be supported by the necessary documentation and findings. We will also meet with the State staff, if requested, to discuss potential risks and the measures that can be taken, and by whom, to minimize these risks. We are also prepared to present such finding to the State.

Our Experience

Segal typically has annual meetings with our clients to develop strategies for program viability. For some clients have developed a long-term strategic plan for them. We have done this recently for two our largest accounts:

North Carolina State Health Plan

Segal recently completed a study of the state's Ten Year Plan for managing health care costs. The study focused on a variety of strategies to modify plan design and to refine medical management programs to improve member health, improve productivity, and decrease medical trend over the next ten years.

State of Wisconsin – Department of Employees Trust Fund

Segal Consulting was retained by the Wisconsin Group Insurance Board to perform a full range of services related to the analysis, design, management and communication of the State's health insurance program for employees and retirees.

The primary objective of the project is to analyze data from a variety of sources to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program.

This report is the first of two deliverables anticipated by the contract and focuses on analysis and recommendations for consideration for calendar year 2016, as well as interim reports on larger analyses in process. The second report to be issued later in 2015 will include findings, recommendations and strategies for consideration for 2017 and future years.

Segal has agreed to a high-level review of the following components for this report:

- Comprehensive Plan Benchmarking – plan costs, designs, access
- Health Management
- Pharmacy
- Consumer Driven Health Care Design
- ACA Review – Excise Tax
- Private and Public Exchanges
- Market Observations
- Self-Insurance Concepts
- WHIO Database

For each component, we collected a wide array of data, both within the state and nationally. We met with all the 18 plans operating in the state, discussing a number of items – emerging markets, plan models, capitation options, risk sharing, value based designs, wellness incentives, etc.

From our research, we recommended options for the program to be implemented in the 2016 plan year, as well as options for the longer term. The initial contract resulted in a 6% decrease in the total cost of the program and a number of improved processes. The full reports can be found on the ETF website at http://etf.wi.gov/boards/agenda-items-2015/gib0325/item4c1.pdf and http://www.etf.wi.gov/boards/agenda-items-2015/gib1117/item3ar.pdf

These are just a couple of examples of work your client team has performed.

b ***Describe the bidder's experience consulting on a self-insured health plan with over 20,000 participants.***

Response:

Segal has consulted to state and local governments and the federal government on their health benefit, including self-insured health plans, and retirement programs for over sixty years. Our experience extends not merely to the routine plan design, premium rate renewals, actuarial valuations and rate setting, but also very strongly to the special projects where jurisdictions are exploring new options to meet new challenges. This provides us with the perspective and experience to understand what will work, and what will not work, in the public sector. Some industry trends are better suited for private sector employers. Your Segal team looks forward to the opportunity to bring this perspective to the State.

Segal has served and currently serves as health consultant to hundreds of governmental clients., including those on a self-insured basis that have over 20,000 participants.

State Public Employee Group Client List

As one of the nation's leading independent consultants to the public sector, Segal has the knowledge, expertise and experience to understand the environment in which decisions are made by public plans. Not every emerging trend or market practice is suitable for every organization. We understand what solutions will work for a public plan, and what options are more suited for the private sector. Below is a visual representation of our state level plan experience and current clients:



We work with more than 20 state-level health plans and your Segal team looks forward to the opportunity to bring this perspective to this engagement. A larger sampling of the clients can be found later in this section. Over the following pages are brief summaries of current clients, many of which are serviced by a member of your senior management team.

Alabama Public Education Employees' Health Insurance Plan (AL PEEHIP)

Number of Participants – 300,000

The Public Education Employees' Health Insurance Plan provides hospital medical health insurance benefits for all full-time employees, and certain part-time employees, of the Alabama public educational institutions, which provide instruction at any combination of grades K-14, exclusively under the auspices of the State Board of Education. These insurance benefits are also available to retired employees with a portion of the retiree's cost paid through the employer premium for active employees. The PEEHIP Division maintains insurance records for the approximately 300,000 active and retired members and eligible dependents on-line with on-line insurance status changes. All changes are reported to the third party administrators via electronic file transfer.

Segal began working with PEEHIP in 2013, current projects include:

- Analysis of proper funding levels for the Hospital Medical Insurance Program, Rx and Optional Plans.
- Consulting on plan design issues, focusing on cost effectiveness and competitiveness.
- Advice regarding legal/legislative developments regarding the Patient Protection and Affordable Care Act (ACA) and how it specifically impacts PEEHIP. This will involve keeping the PEEHIP staff and board timely informed of current.
- Negotiations with current plan providers as needed.
- Providing claim projections twice a year
- Retiree benefits design and strategy, including EGWP and prospective Medicare Advantage plans
- Pharmacy consulting and strategy, including contract negotiation
- Providing IBNR calculations by Active and Retired summarized by Medical, Drug, and by optional benefits - Dental, Cancer, Hospital Indemnity, and Vision.
- Request for Proposals
- Provide marketing for all Benefit Products every 3 years.

Maryland Department of Budget and Management - Employee Benefits Division (EBD)

Number of Participants - 275,000

Segal is retained by the State for ongoing benefits consulting and actuarial services. The state employee and retiree health benefit program, administered and managed by the EBD, covers over 125,000 active employees and retirees, plus dependents. The scope of services in this engagement is similar to the scope of services in this RFP.

We provide a full range of actuarial services, including rate development and budget projections, IBNR reserves, GASB 43/45 OPEB valuations, modeling of alternative benefit designs, and fiscal impact analysis of proposed legislation. We provide detailed monthly and quarterly reporting, tracking financials (including revenue and fund balance) and presenting utilization reports, which trend analysis and recommendations to address gaps and explore opportunities based on what we see in the data.

In the last year, we assisted them with the design of a value based benefit strategy and assisted with the RFP and procurement for the supporting vendors (medical, disease management and wellness). It is anticipated that the new contracts and strategy will provide $4B in savings (out of $20B) over the contract to be shared by the State and the membership.

Currently, we are providing assistance in the development of a policy for tracking and reporting their full-time employees in light of the ACA and IRS regulation 4980H. The State is interested in how to structure their program in order to meet the qualifications for simplified reporting and also to minimize the exposure for incurring any employer penalties under the ACA.

Going forward, we are developing additional reporting processes and formats to support tracking and monitoring the progress of the new value based benefit design.

North Carolina State Health Plan (NCSHP)

Number of Participants – 680,000

The Segal Company has served as health and communications consultant and actuary to the North Carolina State Health Plan since 2010.

The NCSHP for Teachers, State Employees and Retirees is one of Segal's largest accounts, covering approximately 680,000 members, with over 130,000 Medicare eligibles. Your Account Manager, Ken Vieira, is the Lead Actuary and managed this account for over 17 years (spanning his prior firm). We provide a broad range of services for NCSHP, including the following projects over the last 12-months:

- Providing ongoing actuarial analyses and financial projections over 5-years
- Calculation of participant and employer rates
- Data mining, warehousing and in depth utilization claims analysis, including EBD dashboards
- Clinical risk group analysis
- GASB OPEB actuarial valuations
- Quarterly and annual pharmacy benefit manager audits of claims, MAC pricing and discounts, and rebates
- Medicare Part D actuarial attestations
- IBNR analysis and reserve recommendations
- Analysis of return on investment of contracted disease management vendor
- Strategic consulting and planning with the Board of Trustees
- Alternative plan design, including incentives, penalties, and value based features
- Wellness program review and consulting
- HIPAA compliance review and consulting

- ACA program consulting, including the evaluation of the financial and compliance implications of upcoming legislation
- Medicare Advantage, PDP and EGWP consulting
- Employee and retiree communications consulting, including development and production of open enrollment materials and videos
- Review of medical management performance guarantees

Illinois Department of Central Management Services (IL CMS)

Number of Participants - 440,000

The Illinois Department of Central Management Services (CMS), Bureau of Benefits (BOB), oversees the administration of group health benefits for over 440,000 enrollees including the State Employees Group Insurance Plan, the Local EBD Health Plan, the Teachers' Retirement Insurance Program, and the College Insurance Program. There are nearly 180,000 retirees, of which, 123,000 are Medicare eligible. Segal provides a wide range of healthcare consulting and actuarial services to assist the department.

Segal began working with CMS in 2013, current projects include:

- Marketing the Medicare Advantage with Prescription Drug Program, including EGWPs
- Retiree Plan Design Modeling
- Actuarial Attestation for the Retiree Drug Subsidy under Medicare Part D
- Pharmacy Plan Management, including a Market Check of the current pricing as well as performing an annual audit
- Preparing a comprehensive communication campaign for the upcoming Medicare Advantage open enrollment and wellness initiatives
- Working with the wellness committee and various constituencies to develop a long-term wellness strategy and health initiative
- Review of financial information and IBNR/reserving methodologies

As their strategic partner, we consult on a wide range of actuarial and consulting topics, bringing the best of Segal to them.

State of Wisconsin – Department of Employee Trust Funds (ETF)

Number of Participants – 250,000

Segal was recently hired as the health benefits consultant and actuary by the Wisconsin Employee Trust Funds. Segal provides the following key areas of services:

- Data analytics and data warehousing needs
- Program structure and vendor array
- How Wisconsin ETF's programs compare to others in the marketplace
- ETF's standard benefit design and its competitiveness in the health insurance marketplace
- Health intervention and cost containment programs
- ETF's program financial and risk structure

We have also been hired to perform actuarial consulting services for ETF, which consist of the

following items:

- Provide actuarial consultation and advisory services on any technical, policy or administrative problems arising during the course of operations - by meetings, routine telephone calls and correspondence.
- Make recommendations to the State of Wisconsin Group Insurance Board (GIB) from time to time relative to possible improvements in the financing and benefit structure of the plans (including advice and fiscal estimates on proposed state law changes). Give advice on new developments in the group health insurance industry. Keep the GIB appraised of current trends and progress within the actuarial profession.
- Give consultation and advisory services regarding the fiscal effect and policy and administrative problems of implementing new legislation.
- Assist in establishing and maintaining specifications for group health insurance data files whether maintained by the Department or third parties
- Provide advisement on developments in federal legislation and/or regulations regarding financing, benefits, fiduciary responsibility, taxation, disclosure, etc.
- Review Self-Funded Health and Pharmacy Benefit Plans
- Annual Review of Alternate Plan (HMO/PPO) Activity
- Review of Medicare Part D Activity

Georgia State Health Benefit Plan (SHBP)

Number of Participants – 630,000

The Georgia State Health Benefit Plan (SHBP) has been a long time client of Ken Vieira and Richard Ward. The plan covers 630,000 members, including teachers, state employees and retirees (80,000 Medicare eligible). Over the last five years, they have managed a wide array of consulting and actuarial services, all of which were requested in this RFP. A few of the annual services included actuarial projections, funding, IBNR, Medicare Advantage Bid Analysis, Vendor Negotiation, Plan Design, ACA Consulting, EGWP Analysis, Incentives and CDHP Design.

Shortly after they joined Segal in 2012, Segal was engaged to assist SHBP with a reprocurement of their carrier and administrator contracts, to be effective 2014. These contracts have been in place since 2008, which coincided with the implementation of a consumer driven health (CDH) focused program design and strategy. Over the first five (5) years of this CDH strategy, it is estimated that SHBP has saved approximately $1 Billion. Ken and Richard assisted with the design and implementation of that strategy, as well as the vendor procurements.

Under the prior contracts, two vendors provided comprehensive services on an integrated basis: Medical TPA, MA-PD, PBM, wellness and medical management. The procurement was structured so that SHBP will contract in 2014 on a best-in-class approach, which has resulted in the top vendor in each service category being contracted for 2014. The new contracts are expected to reduce costs by more than 10% annually.

Segal also with the design and strategy of the new wellness initiative, as well as assisting with other related projects, such as evaluating how Value Based Purchasing initiatives could be incorporated.

Pennsylvania Public School Employees' Retirement System – Health Options Program (PSERS HOP)

Number of Retirees – 75,000

PSERS HOP is a voluntary retiree-only health benefit program covering over 75,000 of 150,000 Medicare eligible retirees from over 700 school districts across the Commonwealth. More than 400,000 active school employees participate in the statewide PSERS retirement program. The HOP program offers retirees and their dependents an array of seniors' health options, including a Medicare supplement plan, a Medicare Prescription Drug Plan (PDP) and six Medicare Advantage plan options. Retirees pay all premium costs. Some retirees are eligible for a pension supplement for limited reimbursement of medical coverage costs based on long service.

Segal provides all health analytical, actuarial, strategic, communications and procurement consulting for the program, including regular claims audits. We provide ongoing health actuarial services that include development of premium equivalent rates, projections of plan cost, IBNR calculation, and budget reconciliations. We also assist the program with plan design review for both medical and prescription drug plans, Medicare Advantage plan evaluation, support of the program's direct contract Medicare Prescription Drug program, open enrollment communications, newsletters and Web site development and content.

In 2002, PSERS retained Segal to help determine the feasibility of self-insuring their Medicare supplement plan. Our recommendation to self-insure saved the program many millions of dollars and allowed the plan to avoid premium rate increases for most retirees for three years, while still building healthy reserves. One year later, PSERS hired Segal to conduct a similar study on the program's fully insured prescription drug plan, with a similar result.

With the implementation of Medicare Prescription Drug coverage (Part D), PSERS was faced with a dilemma on how to maximize federal subsidies for members' Rx coverage. With no employer contributions to the plan, there was no opportunity to receive the Retiree Drug Subsidy (RDS). Segal recommended that PSERS apply to Medicare for a direct contract PDP, where the plan would provide Part D benefits to its retirees similar to commercial insurers. The application was accepted and PSERS has since saved its members almost half of the cost of the prescription drug program. Segal consults on all aspects of the PDP program.

Segal was retained as PSERS' ongoing consultant in 2004 and since has assisted the client in conducting a number of competitive bid processes, including multiple pharmacy benefit manager bids, a bid for a national Medicare Advantage vendor, and a bids for third party administrator. Segal provides ongoing claims auditing for the medical benefit programs. We provide all communications and marketing consulting for the program, including development of personalized annual option selection statements for all participants; public and secure website development and content; and other special projects as requested. In addition, we have assisted PSERS in implementing a seniors' wellness and fitness program and are tracking the return on investment for that program.

State West Virginia (WV PEIA)

Number of Participants - 200,000

Segal is retained to work with the West Virginia State Senate and House of Delegates as they deliberate how to address health program and budget issues with the West Virginia Public Employees Insurance Agency (PEIA). We have helped the Joint Finance Committee review how the annual costs are determined and how those costs are included in the state budget. In addition, we conducted an extensive survey of benefits for 15 other states and presented results to the Joint Legislative Committee to identify the relative value of the benefits and premium subsidies.

Segal has recently assisted the PEIA with procurements for PBM vendor, which includes an EGWP PDP providing coverage to approximately 40,000 retirees. We provided full assistance with the development of the RFP and assisted in the scoring of both the technical and cost proposals and facilitated finalist interviews and contract negotiations. The resulting contract includes stretch, but achievable, performance guarantees that are projected to provide the Agency with significant savings while also enhancing vendor performance and contract compliance. The RFP generated $28 million dollars of savings.

State of Hawaii, Employer-Union Health Benefits Trust Fund (HI EUTF)

Number of Participants – 150,000

Segal provides regular annual health consulting, including setting the rates and creating the health budget. We have assisted in writing and reviewing bills for the Senate and House of Representatives. Segal has conducted bids for Medical Benefits, Stop Loss Coverage, Pharmacy Benefit Managers, Behavioral Health, Life Insurance, and Long Term Care. We have also performed medical claims audits and prescription drug claims audits. Our consulting has also included prescription drug coverage under Medicare - actuarial analyses for creditable coverage purposes.

Segal's most recent contract term began in 2010. Under that contract, we provide information, advice and recommendations on benefit plan administration, management techniques, operations and support systems, the EUTF's information management system and proposals regarding that system, policies and procedures to streamline the EUTF's centralized enrollment, premium payment and administration operations.

The EUTF offers insured health and other benefit plans to all State and county employees, retirees and their dependents. During FY 2009, EUTF paid carriers approximately $591,000,000 in premiums, benefit claims, and administration expenses.

We have assisted with several life insurance procurements in our long-standing engagement with Hawaii. This assistance include RFP development, vendor selection, negotiation and implementation. We also consult with them on the overall design and pricing of their life and disability benefits.

State of Minnesota

Number of Participants – 814,000

The State of Minnesota through its Department of Human Services has a lengthy history of providing a variety of publically assisted healthcare programs for limited income Minnesotan's. These programs are funded by federal and state revenues and provide a healthcare safety net for those persons in need of assistance. It is in the interests of Minnesota's citizens that these programs be operated in a manner whereby the greatest value is received for the expenditure of state and federal dollars. To assist in obtaining the greatest value in those expenditures the Department must determine that the cost of prepaid medical plans is based upon sound actuarial practices. The actuarial soundness of the Department's calculations to determine a rate to be paid for prepaid medical plans is an essential tool to aid in maintaining the viability of the publicly assisted healthcare programs.

Segal conducting a review and analysis related to the procedures and techniques used in managed care rate setting for Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare) and General Assistance Medical Care (GAMC) during the time period of fiscal years 2003 through FY2011 (July 1, 2002 through June 30, 2011). It is the Department's intent to engage actuarial expert(s) to review the process and methodologies used by prior consultants, actuaries, and departmental personnel to set the rates for PMAP, MNCare, and GAMC, during the relevant time period.

Texas Employee Retirement System – Group Benefits Plan (TX ERS)

Number of Participants – 120,000

The Texas Employees Retirement System (ERS) administers the Group Benefits Plan, which provides health, life and disability benefits to active and retired State employees. In 2012 and 2013, Segal assisted with RFPs for disability and long-term care benefits. For both RFPs we reviewed the initial draft RFPs and bid packages developed by ERS staff and provided recommendations. The recommendations were based on our industry knowledge and expertise as well as direct market feedback. The direct market feedback was obtained by providing prospective bidders a redacted profile of the opportunity (benefits, group size, data to be provided, specific contract minimum requirements, etc) and then incorporating their feedback (as appropriate) into our recommendations.

The disability program is self-insured and our research indicated there would be more market interest if the RFP enabled bidders to propose insured solutions. For the long-term care, the RFP was restructured to encourage carrier/broker partnerships in order to enhance employee communications and enrollment support. Incorporating this direct market feedback was instrumental in the final RFPs and bid packages being as attractive to the market as possible.

State of Michigan (MPERS)

Number of Participants – 107,000

Segal has specific consulting experience in Michigan, in particular with MPSERS. We are just completing claims audits on Blue Cross Blue Shield of Michigan and Catamaran Rx. Prior to that,

	we were retained to assist with compliance consulting regarding the system's ability to place non-Medicare retirees into the state health insurance exchange. We have also conducted other prescription drug analyses as well as retirement program projects. Your Segal team looks forward to the opportunity to build on the various special projects we have completed for MPSERS by taking on the full work load under this contract. *New York State United Teachers' Benefit Fund* Number of Participants – 500,000 New York State United Teachers, a statewide teachers association with about 500,000 members, maintains a trust fund that offers term life insurance, whole life insurance, long term disability, long term care, dental, optical, excess major medical insurance, person lines coverage (homeowners and auto), legal benefits and other coverage. In total, there are about 350,000 participants in the various products. We help the client procure coverage (RFP), negotiate initial and renewal rates, develop marketing plans, design and monitor individual underwriting procedures, perform experience reviews, perform claims audits, provide compliance support and other services.
c	***Describe the services and resources available to assist the State in managing their pharmacy benefit program.***
	Response: Segal has been consulting on pharmacy benefit issues for more than 25 years, and formed a National Pharmacy Benefits Practice nearly 20 years ago. Throughout this entire history, we have conducted audits, contract reviews, RFP procurements, clinical program analysis, and plan design consulting for our clients. Through our National Pharmacy Benefits Practice, our company employs technical and clinical expertise focused on the prescription drug benefit marketplace. Segal has developed innovative PBM contracting terms including rebates applied at point of purchase, MAC pricing guarantees, minimum generic dispensing rate by therapy class guarantees and ingredient cost trend guarantees. We offer an array of services designed to optimize management of the pharmacy benefit, including, but not limited to: ➢ Perform plan design analysis and cost impacts from plan design changes along with assessment of plan coverage if changes are implemented; ➢ Present innovative plan design concepts and strategies that maximum generic drug use, deliver lowest net cost and efficacy per therapy class and take into account expected member implications; ➢ Performing audits to assure all contract provisions are being administered correctly and the State is receiving maximum financial benefit from the guaranteed pricing terms; ➢ Evaluation of administrative fees and miscellaneous fees to ensure contract compliance; • We will review all administrative and miscellaneous fees charged over the course of the audit period to ensure that they were appropriate, authorized, and consistent to contractual terms. Such fees may include charges for member submitted claims, clinical programs, postage increases, and various communication materials.

- Projections of cost savings, increased member copayments, member disruption, and formulary rebate impact;
- Reviewing utilization and cost data to monitor trends and Plan performance;
- Evaluating formulary and clinical program management, including specialty drug cost containment strategies, to ensure Nebraska balances cost containment with appropriate clinical guidelines;
    - Rebates are typically paid six to nine months after claims are incurred posing challenges to reconcile rebates that are earned based on claims experience with rebate payments. Our audit will include a careful reconciliation of audits earned versus paid including a full examination of those claims that did not earn rebates to verify consistency to the contract.
- Reviewing levels of manufacturer and CMS rebates on an ongoing basis;
- Conducting contract pricing reviews to ensure market competitiveness and/or evaluating and negotiating annual renewals. Our contracting expertise will eliminate PBM provisions that are misleading and counter-productive to the State's objective. We are able to substantial improve the level pricing transparency for our clients and expose provisions that may be inflationary to the plan.

Also available to the State, is having Segal's clinical pharmacist(s) perform a Potential Fraud and Abuse Review (or PFAR). This is a Segal tool that identifies potential fraudulent or abusive behavior in the prescription drug benefit. Segal's clinical pharmacy team built a sophisticated algorithm that is able to detect not only the drugs of high abuse potential but also the prescription utilization patters that are indicative of misuse. The identification of which would allow the Plan to see additional financial savings as well as decrease the potentially life threatening risk associated with over utilization.

Key members of the team who would be available to you include the following individuals:

Kautook Vyas, PharmD is a Clinical Pharmacy Consultant in Segal's Chicago office. He is a member of Segal's National Pharmacy Consulting practice and assists clients in optimizing benefit design and drug mix. He provides consulting services that incorporate the latest best-practice guidelines for clinical pharmacy. Dr. Vyas is a national resource for the firm and has experience working with a wide variety of plan sponsors and Pharmacy Benefit Managers.

George Bognar is a Pharmacy and Health Consultant for Segal's Eastern Region, based in Washington, D.C. Georgs works closely with our clinicians on Alabama Public Education Employees Health Insurance Plan, North Carolina State Health Plan and the State of Delaware. For North Carolina he does a broad range of consulting, including pharmacy audits, EGWP analysis, Part D, discounts, rebate audits, marketings, etc. He provides ongoing consulting and advice to Alabama PEEHIP and the Pennsylvania Public School Employees' Retirement System.

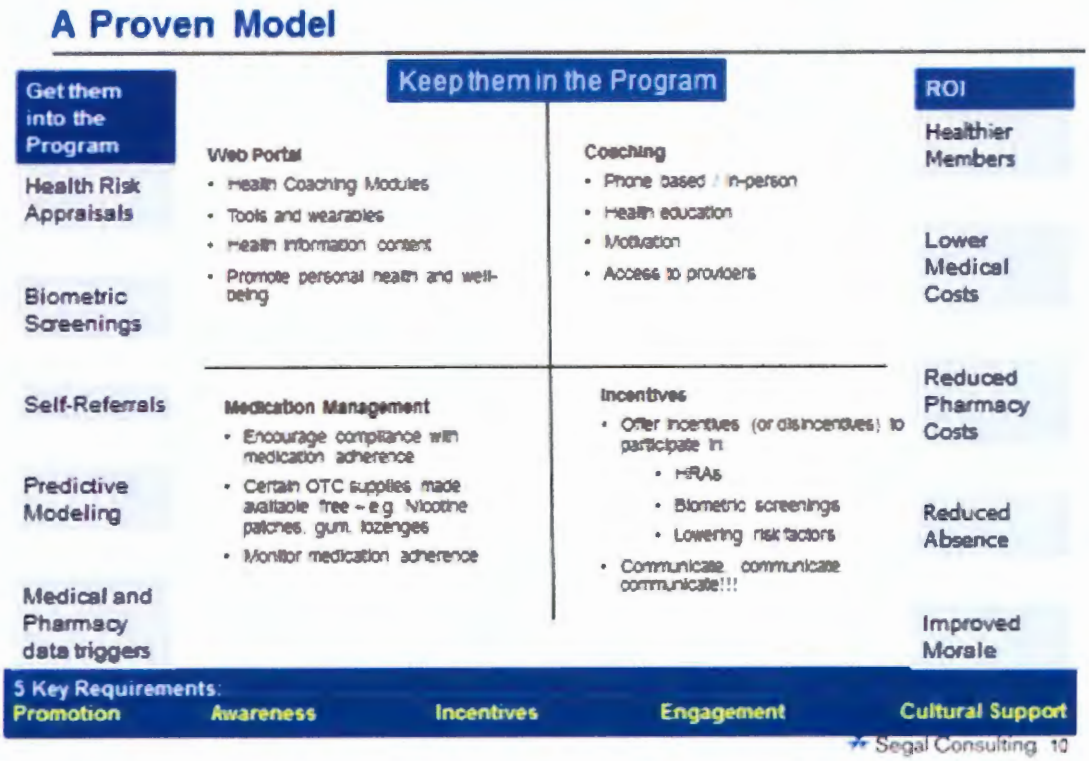
PBM Contractual Negotiations

Segal has a list of minimum contractual requirements and contractual expectations that we expect PBMs to incorporate into their contracts. Our experience in negotiating these terms is that we use the PBMs contract as a starting template, and we review them to ensure our expectations from the RFP are embedded in the contract. If not, we redline their contract with our requirements and discuss any issues with the PBM, if needed. This process has proven to be more effective in obtaining our preferred language from the PBM without having to engage in a prolonged process

	with the PBM's legal team. As a part of our consulting approach with specialty drugs, rebates, and mergers and acquisitions; these are important areas for many of our clients. We addresses these challenges by ensuring that our clients PBM contracts proactively speak to these current and evolving trends in order to ensure the terms are relevant in the upcoming years.
d	***Describe the bidder's experience consulting on a wellness program comparable in size to the State's wellness program.***
	Response: Segal has worked with several large State clients to implement wellness programs. Our clinical and wellness team has recently designed programs for the State of Wisconsin, North Carolina, Maryland, Rhode Island, Alabama and Illinois. The team will primarily be led by Dr. Paralkar and Ms. Ludovici. Both have unique expertise in desigingin and implementing a wellness program, with our without the use of an on-site clinic. **Sadhna Paralkar, MD, MPH, MBA** is our Medical Director and in Chicago. Dr. Paralkar's areas of expertise include health care informatics, medical management program design, clinical operations, benefit plan design and network management strategies to optimize health improvement while containing costs, and evaluation and implementation of disease management and wellness programs based on evidence based medicine (EBM) protocols. Working closely with Sadhna is **Anne Marie Ludovici-Connolly.** She is a nationally recognized Wellness Consultant in Segal's Boston office with over 30 years of experience working with a variety of organizations in the public, academic and private sectors. Ms. Ludovici-Connolly is a subject matter expert in population health management, well-being and health behavior change. They have together designed a model that has been successful in delivering superior clinical and financial returns for our clients.

Our Wellness Model

We have a proven model for Wellness that has 5 key requirements: Promotion, Awareness, Incentives, Engagement and Cultural Support.



With this framework and key requirements in mind, we have developed several wellness tools that will help design, develop and evaluate a wellness program. One such tool is our Wellness Inventory. Using Segal's Wellness Inventory tool we will gather comprehensive information about your current Wellness services. This involves researching your medical, dental and vision plan documents, querying the vendors that administer these programs if the answer to our questions is not in your plan documents, and conversing with designated representatives at the State to record the wellness services offered onsite at each workplace.

Our Wellness Inventory lists 165+ wellness ideas and while you may currently be performing 1/3 to 1/2 of these wellness ideas, the results of the inventory will give you numerous new wellness program ideas. Some of these ideas are no cost or low cost while some wellness ideas need to have a fee projection to determine the financial impact of adding that particular new wellness service to your Wellness program.

Segal will then outline for you the wellness services you already offer and the array of other wellness options available, organized in a chart according to health risk factor using Segal's Wellness Action Plan, a visual gap analysis. You can then see exactly which wellness services you offer to control modifiable health risk factors like weight, exercise, stress/depression/anxiety, smoking/tobacco use, blood pressure, cholesterol, etc. This Action Plan organizes your wellness program so you can focus your future wellness program enhancements on the risk factors you want to help your participants reduce or eliminate.

Using the Wellness Inventory and Action Plan you will be able to easily identify any gaps in wellness support and you can use the ideas Segal outlines to determine if and what you would like to add to your current wellness initiatives.

Segal recommends the following steps and is fully prepared to assist the State with any existing Wellness programs or the design/implementation of a new Wellness program including:

1. Performing an inventory of your current program components,

2. Organizing your wellness efforts according to risk factor support,

3. Pricing the financial impact of any medical/dental/vision benefit enhancements to support wellness,

4. Drafting a wellness business plan,

5. Producing wellness communications,

6. Designing/revising wellness incentives to maximize participation and behavior change,

7. Creating reports to assess wellness program efficacy, etc.

To the extent that the State can prevent employees and their dependents from developing health risk factors, or reduce existing risk factors, the State should see reduced health plan claim experience in the long run.

The best of those programs are designed to support control of the client's biggest health cost drivers and to work within the realistic ability of the workforce to change their health habits. Incentives may encourage initial participation, but self-fulfillment is the real driver for long-term change of behavior. We believe the wellness program should reflect the employer's understanding of those motivations.

Our work on wellness programs always begins with details analysis of the cost drivers. We look first to implement program elements that tap into the most readily changeable factors.

For example, instead of implementing a broad disease management program covering a dozen or more disease states, as vendors bidding on your contracts will encourage, we believe that wellness should be incremental. The program should start with only the few disease states that can best be affected and that will provide the most immediate return. Once those programs are up and running, then we recommend adding more disease states for the second phase.

This incremental approach helps keep the administrative cost of the program down, while keeping management's focus on the few critical areas that will make the most difference.

We will work with the State to find solutions that represent the best alternative for the Nebraska and build off your recent successes of the State's wellness program, **wellNEssoptions**.

e	***Describe the bidder's collective bargaining experience assisting another State government, or large employer similar to the State of Nebraska.***

Response:

Segal is the preeminent benefits consulting firm in the multiemployer market and has extensive experience handling collectively bargained plans. Many of our state clients contain collectively bargained employees so we are intimately familiar with the bargaining process and can share our experiences with the State. We currently consult to over 50 collectively bargained health and pension plans across the country.
Segal will be available to provide technical advice and assistance during labor negotiations and throughout the statutory process should the State and the NAPE/AFSCME be unable to reach a negotiated labor agreement.

Segal has a strong presence in the public sector with emphasis in working with public employers and collectively bargained workforces. The negotiating process can take many forms. Since strategic initiatives of the State have yet to be developed, providing exact definitions of tasks can be difficult. However, we know that assistance may consist of but not limited to, analyzing and reviewing various scenarios for proposed plan design changes, developing various rate scenarios, evaluating proposals from the NAPE/AFSCME attending various negotiation sessions and testifying at the fact finding and interest arbitration proceedings should the issue of medical benefits not be agreed upon during the negotiation proceedings. We are prepared to assist State in any way requested.

In general, our services in support of the collective bargaining process fall into the following steps:

Develop Bargaining Proposals

Segal can meet with the State's lead negotiator to provide guidance and support in the development of bargaining strategies. This includes scoping management's proposals to the unions and the unions' demands. Typically, proposals are segmented into economic and non-economic items. Economic items relate to wages and associated pay policies, health benefits, retirement, and pay differentials. Non-economic items relate to work rules, paid time off, and other working conditions. Segal is most cost effective when we are engaged to assist with the development of all benefit related proposals. Our collaborative process includes meeting with negotiating teams and crafting language for each proposal. Our approach draws on internal financial and operating data, input from senior management, and carefully articulates assumptions, methodologies, and costs attributable to each proposal.

Negotiate with Union(s), Develop Contract Language

Segal can support direct negotiation with the unions at the bargaining table. This requires a review of union proposals beforehand, as well as any analytical work necessary to supplement the discussions. We anticipate receiving detailed benefit plan design and cost information as key pieces of information among other things. We have found that a data-driven approach to bargaining can be effective as a tool for reaching consensus.

Assess Costing Implications

Our work typically includes our development of financial implications of union or management

proposals. For most economic items (wages, health insurance, retirement, etc.), costing the impact is a vital tool for understanding the ramifications of accepting the proposal. The costing will primarily be based on the census file, other relevant financial and operating data, and is usually segmented by contract year. For example, we will calculate the first year cost and subsequent costs in each out-year. For some proposals, the first year cost will be greater than subsequent years (front-loaded) and for other proposals, cost will be back-loaded (more expensive at later years of the contract). Developing the analysis in this manner will assist the State and your constituents in understanding the multi-year financial implication of each proposal, as well as the "steady state" cost for proposals that may have increasing future costs beyond the expiration of the agreement.

Assistance in Mediation/Arbitration

Your Segal team is available to assist with any impasse process, including the development and presentation of the State's position at any mediations or fact-finding hearings. Since at this time it is difficult to determine the precise level of effort with this phase, our work could include the development of exhibit material, presentations to negotiating committees or hearing boards, and time associated with testimony.

Our team is available to support the negotiations and have resources available for a wide variety of requests.

f ***What data analytic tools will be used to analyze medical and pharmacy claims data? Will the State have access to any of the data analytic tools?***

Response:

A critical initial component to implementing meaningful plan management programs is to better understand underlying population health, what issues are particular to it, how they compare to similar groups in terms of medical diagnoses and utilizations patterns, and which tools will be the most effective in managing the population's medical care. Data mining and predictive modeling, an approach many health plans are using, involves identifying trends in data in order to facilitate decision making.

For our state clients we load their claims experience into Segal's Health Analysis of Plan Experience ("SHAPE"). Segal's SHAPE tool is a comprehensive medical data mining service.

SHAPE
Segal's Health Analysis of Plan Experience is a Comprehensive Medical Data Mining Service

Data warehouse that combines data across medical vendors and PBMs and has capability to compare plan to normative benchmarks. Information is used to:

- Determine the medical conditions and treatments that are driving up health care costs which helps us develop more targeted and effective cost containment strategies
- Benchmark cost and utilization patterns of a plan to industry norms and other plan sponsors
- Determine member out-of-pocket cost burdens relative to other plan sponsors (accurately forecast patient disruption)
- Assess impact and effectiveness of wellness, disease management and other clinical programs
- Accurately measure the future saving impact of plan modifications being considered

- Serve as the tool for plan sponsors and vendors to manage "at risk patients" through predictive modeling
- Profile cost and quality of highly used hospitals, labs, physicians and other medical care facilities (e.g. build custom, high performance networks)
- Serves as an audit tool to validate vendor performance guarantees (e.g., vendors discounts, generic fill rates, etc.)

- Investigating Fraud, Claims Coordination and Subrogation Opportunities
- Allows clients to centralize all data from multiple vendors in one locations

We will pull information from your vendors that will allow our Shape system to generate the necessary reports. The combination of Shape with the additional actuarial reports will provide the State a wealth of information and allow you to better manage your program for near and long term.

There are standard reports that come out of this system but our reporting "Dashboard" has been well received by our clients. It provides a high level review of all the key cost drivers in the program. We currently do this reporting for a number of clients, including the North Carolina State Health Plan, Maryland Department of Budget and Management and most recently, the State of Connecticut.

Dashboard Reporting

With the data already loaded into the system we populate a dashboard that it typically presented to senior management and various boards.

The dashboard typically contain 8 main panels:

1. Principal Financial Trends – Claims Cost
2. Claims Summary
3. Key Healthcare Performance Metrics
4. Major Conditions – Prevalence and Cost
5. High Risk High Cost Analysis
6. Clinical Quality Performance
7. Summary of Prescription Drug Expenses
8. Prescription Drug Cost Management Analysis

A number of our state clients have expanded the panels to 12 – adding ones for disease management, value added benefits, specialty drugs, components of trend, etc. As mentioned earlier, once we update the dashboard it is automatically populated each update.

One other key component is the "spotlight" section. Each month we highlight something that was discovered during our data mining. This varies significantly by group.

Our typical process is to update the dashboard panels quarterly.

All of the reports can be exported for clients to customize. There is some functionality similar to "cube" technology. At this point in time we do not provide claim level access.

We have provided a sample dashboard report under **Appendix D: Sample Health Benefits and Actuarial Reports – Tab 1,** *"Using the Dashboard to Monitor the Health Population Profile of the Population, State of Maryland, Department of Budget and Management, September 2015."*

This is our monthly dashboard report provided to the State of Maryland. This is provided monthly but sometimes done quarterly for our other clients, like the State of North Carolina.

Segal's Analytical Tools

Segal's health care consultants and actuarial team utilize several analytical tools to measure, monitor, and predict the costs of health and welfare benefit programs. We customize our array of technical resources for your specific needs, ensuring that we provide the high level of quality consulting that our clients expect. Segal is on the cutting edge of health care industry trends and relevant legislation, and we update and revise our tools as needed to provide maximum value to our clients.

Below are some more examples of the wide range of tools available to our team and indirectly to the State.

APEX *Health Plan Rating*	• Software application designed to calculate medical plan premium rate and to estimate relative values of plan design changes. • Reflects client's benefit plan design, location, and industry. • Annual updates underlying data and assumptions.
CCA *Claims Cost Application Tool for Measuring Costs of Retiree Health Plans*	• Software application that computes baseline health care plan starting costs for valuations of retiree health plans under FAS 106, SOP 92-6 and GASB 45. • Reflects client's own population, claim experience, and plan administration expenses.
Clinical Program Review (CPR)	• Analyzes client specific data and evaluates the effectiveness of clinical programs in managing drug utilization • Provides a detailed assessment of a client's current clinical programs recommendations for improvements to existing edits, and identifies new clinical management opportunities • Delivers a report outlining the findings and key recommendations – tailored specifically for each client
Dental Pricer *Dental Plan Cost Rating Tool*	• Application used for developing dental premium rates and can estimate the effect of a plan changes. • Uses plan design information and summary level claims data
Discount Database *National database of provider discounts*	• Segal participates in the Uniform Data Specification (UDS) task that have devised a common methodology of evaluating provider discount that is accepted by most carriers. • Data is updated twice annually and can be used for client specific discount analyses by service area.

Employee Cost Share Calculator & Benchmarking Tool *Employee Cost Sharing Calculator and Summary-Level Data*	• Allows plan sponsor to compare value of plan designs to determine optimal balance of employee and employer cost • Calculates the "true employee cost share" for a medical / Rx plan, and graphically benchmarks it against other plans (i.e., includes plan copayment features, etc., not just EE payroll contributions / deductions) • Allows the comparison of the total (gross) value of the plans and / or the employee cost share of those plans against other entities
Excise Tax Forecaster *Forecasts excise tax on high-cost health plans*	• ACA Excise Tax Forecaster provides clients with an estimate of the potential tax liability. • Can model whether and when a plan would hit the excise tax annual threshold and the cost of the tax over several years using several different assumptions of plan cost trends. • Can address single and multiemployer health plans, multiple coverage tier arrangements and varied annual trend assumptions. • Allows for the calculation of standard risk groups, high-risk industries, early retirees and Medicare eligible retirees.
Medi-Span *National Drug Data File*	• Drug product descriptive information (*e.g.*, NDC elements, generic classification indicator and packaging examples). • Pricing (such as AWP and direct pricing). • HCFA drug product information. • Clinical data (such as drug interactions & precautions).
HBRs *Health Benefit Reports*	• The HBR series is a routine consulting service provided in response to annual financial planning and reporting needs of health and welfare programs. This approach is modular and permits ad hoc delivery to our clients, as needed. Segal's consulting services include: o Financial Experience and Budget Projections – including interactive modeling application; o Proposed COBRA & Other Self-Pay Rates; o Vendor Renewal Analysis; o Group Insurance Policy Settlement Analysis
IBNR Model *Model for Developing Reserves for Claims Incurred but Not Reported*	• Spreadsheet template used to develop IBNR reserves • Uses claims triangular data (by incurred and paid month)
Ingenix Encoder Pro *Compliance Code Editing Software*	• Online, real-time code lookup software that delivers code detail and reference information on CPT®, HCPCS and ICD-9-CM codes. • Compliance editor checks for coding accuracy and review your code selections for CCI unbundle edits, ICD-9-CM specificity, age, medical necessity and gender. Understand whether a code carries an age or sex edit, is covered by Medicare or contains bundled procedures. • Compliance editor to review your code selections and a fee calculator to compute the Medicare reimbursement rate for your region.
Interactive Projections Modeling	• Enables the modeling of different income and expense assumptions (from completed FEBP reports). • The model allows for various assumption changes and scenarios to be presented to clients in "real-time"

Medical Claim Audit Sampling *Detailed Claimant Data to Support Segal Claims Audit*	• Develops a random sample of claimant records based on various criteria • Assists in validating claims adjudication process and other contractual terms of a benefits plan
Medicare Part D Calculator *Medicare Part D Actuarial Equivalence Calculation*	• It is used to determine whether a plan will pass a gross test (prong 1) or a net test (prong 2) • This proprietary tool estimates a projected federal subsidy (total and per participant) based on client detailed drug claim information
Mental Health Parity Pricer *Mental Health Parity Rating Tool*	• Assessment of the likely cost impact to bring non-compliant design elements into compliance under the Mental Health Parity and Addiction Equity Act (MHPAEA)
MESVAL/STAR *Retiree Health Valuation System*	• A multi-decrement actuarial valuation program that produces a comprehensive set of liability calculations and cost projections associated with a wide range of benefit plans. • The modular structure of the program allows for improvements to be implemented with a high degree of ease, speed and accuracy.
National Dental Advisory Service (NDAS) Pricing Program *Dental Fee Schedule Database*	• The NDAS pricing program contains dental fee information from survey data as published by Yale Wasserman DMD Medical Publishers (primary participants in the survey are dentists in private practices). • This tool allows you to compare fees with NDAS 40th, 50th, 60th, 70th, 80th, 90th & 95th Percentile Fees. It can be used to review, fine-tune or design a fee schedule. It can also be used to support frequency/utilization analyses.
Physician Fee Modeler *Physician Fee Schedule Comparison Tool*	• Proprietary tool to analyze multiple physician fee schedules and compare them against a common point of reference, Medicare RBRVS. • The tool gives Segal a standard and uniform method for comparing various physician fee schedules in a way that is statistically valid, informative, and easy to understand. • The tool also has the ability to breakdown a fee schedule into 28 separate service categories, giving us the ability to detect fee schedule inconsistencies and isolate particular services of interest.
Potential Fraud and Abuse Review *(PFAR)*	• Identifies potential fraudulent or abusive behavior of prescription drugs in their membership. • Uses sophisticated clinical criteria to identify members who may be at risk and offers plan sponsors a clear, detailed report of the utilization patterns of the identified members.
Pharmacy Benefit Diagnostic Check-Up	• Assesses the client's prescription drug benefits across the following categories: Financial, Plan Design, Utilization, Clinical Programs, and Cost/Containment/Summary.
Proposal Tech *Electronic RFP Tool*	• Software to automate the health RFP bidding and analyses processes that are performed on behalf of a health benefits program. • System has the capability to attach necessary data required by a third party administrator, insurance carrier, or vendor in order to calculate and provide competitive quotations. • Offers auction like function and allows for auditing

R&A Comprehensive Medicare Coordination Model *Post-65 Rating Model*	• Prices health care benefits for a Medicare-eligible population. • Models plan design options that coordinate with Medicare.
Rx Omni Pricer *Prescription Drug Cost RatingTool*	• Application used for developing prescription drug premium rates and calculate the value of plan changes to the plan design. • Uses plan design information and summary level claims data (optional). • Also, a version is used for Medicare Part Actuarial Equivalence calculation where client drug claims data is not credible
SHAPE *Segal's Health Analysis of Plan Experience is a Comprehensive Medical Data Mining Service*	• Data warehouse that combines data across medical vendors and PBMs and has capability to compare plan to normative benchmarks. Information is used to: • Determine the medical conditions and treatments that are driving up health care costs which helps us develop more targeted and effective cost containment strategies • Benchmark cost and utilization patterns of a plan to industry norms and other plan sponsors • Determine member out-of-pocket cost burdens relative to other plan sponsors (accurately forecast patient disruption) • Assess impact and effectiveness of wellness, disease management and other clinical programs • Accurately measure the future saving impact of plan modifications being considered • Serve as the tool for plan sponsors and vendors to manage "at risk patients" through predictive modeling • Profile cost and quality of highly used hospitals, labs, physicians and other medical care facilities (e.g. build custom, high performance networks) • Serves as an audit tool to validate vendor performance guarantees (e.g., vendors discounts, generic fill rates, etc) • Investigating Fraud, Claims Coordination and Subrogation Opportunities • Allows clients to centralize all data from multiple vendors in one locations
Segal Multiemployer Health Plan Design Norms *Medical and Prescription Drug Plan Design Database*	• Database consisting of current medical and prescription drug plan designs for ninety plus Segal multiemployer clients on a national and regional basis. • Metrics captured include medical plan deductible, coinsurance, office visit copay, emergency room copay, generic/brand Rx copay, and percent of plans with prescription drug coinsurance.
Stop Loss Database *Stop Loss Benchmarks*	• This proprietary tool allows Segal consultants to help our clients benchmark costs and coverage levels to group peers of similar size and industry. • The Stop Loss Database includes data on over 200 Segal clients

	Stop Loss Deductible Modeler *Customize Stop Loss Deductible*	• Stop Loss Deductible Modeler generates customized stop loss deductible suggestions for your plan based on each client's risk tolerance and reserve position. • Whether you are implementing a new plan, revisiting existing stop loss policies, or considering added coverage, our decision-support tool helps to guide you toward the appropriate level of coverage. • The tool provides a suggested range of deductibles based on several variables including: o Group size o Projected medical plan per capita claim costs and current reserve levels o Dependent ratio o Risk tolerance – The maximum dollars the plan is willing to put at risk each year • Also a version that calculates stop loss premium estimates for both individual and aggregate stop loss based on cost of underlying plan
	Wellness Inventory *Utilization Management Assessment Tool*	• Outlines a plan sponsor's current wellness efforts on over 150 possible wellness services, identifies gaps and prices the financial impact of benefit modifications.

g ***What resources will be utilized to stay informed of best practices in employee benefits in State Government and other employers similar in size?***

Response:

Segal stays in touch with current trends affecting government employee health benefits. We annually survey major insurance carriers, PBMs, TPAs and MCOs to study health plan cost trends and projections and publish our Segal Health Plan Cost Trend Survey. This survey is of use in understanding the overall trends affecting the State's plans. Our most recent release is included at the end of our proposal under Segal Publications. To help clients prepare for future health benefit costs, Segal evaluates the various components (e.g., price and utilization) of the per capita increase in claim costs, from one year to the next, to determine projected health trend.

Additionally, Segal periodically surveys state governments on the health benefits they provide to their employees and retirees. Our 2014 Study of State Employee Health Benefits is a recognized tool for comparing health benefits at the state level, such as type, level and cost of health coverage offered, and the number of covered participants. We publish summary results of the study and maintain the full database to support our work with clients.

Segal is a leader in identifying emerging issues and proposing innovative solutions to assist our clients in meeting operational challenges to their benefit programs. Through application of our research on the aging of the population, we help clients identify employment-related issues arising from client-specific demographics. By understanding the underlying demographic reasons for plan cost and acceptance, we can better help our clients develop strategies for attracting and retaining qualified workers in the future.

Segal consultants and actuaries routinely speak and lead workshop sessions at key benefits conferences and association meetings, including the State and Local Government Benefits Association, the International Foundation for Employee Benefit Plans, the Employers' Council on Flexible Compensation and other groups. Through our contact with clients and other programs

across the country, we integrate knowledge of their programs into an understanding of emerging trends and best practices.

We will include an agenda topic on trends and developments as part of our regular meetings with the State. In addition, we will include short presentations by several of our national health benefits and compliance professionals on the key developing topics. We will also provide continuing updates to the State on developing trends as they are reflected in news and analysis published within the benefits and consulting communities. Segal's Public Sector Letter presents timely analysis of developing trends in public sector benefits. This publication will be provided to the State staff on a regular basis as new issues are published.

Reporting of Surveys and Trends

Segal publishes an array of newsletters, surveys and other informative publications that we routinely provide to our clients. To see the variety of information we offer on benefits, compensation and human capital issues, visit: **http://www.segalco.com/publications-and-resources/**. We also provide helpful and timely webinars, presentations and podcasts, which are also available on our website.

Best Practices Database

Segal operates as a multi-practice consulting firm focusing on public and private organizations in areas as diverse as benefits, compensation, technology and communications. Client projects often involve more than one practice area. We make a point of sharing results and scope of client projects across all our practices and geographic regions to help assure that all Segal consultants and actuaries are aware of developing programs and trends. This guarantees innovative and successful work is always available to future client engagements. Segal has also developed proprietary systems, linked to our intranet, designed to facilitate the sharing of information between consultants, locations, and practices.

In addition, all of our practices conduct annual and sometimes quarterly meetings to share client case studies across our business. Our actuarial practice in particular conducts an annual meeting that is firm-wide. The purpose of the meeting is to discuss emerging trends, best practices and client experiences for the benefit of all of our practitioners' trends, new services, and new concepts to the account team who would service our account.

Lastly, we have an informal rewards program that recognizes collaboration across our business. The reward program encourages our consultants to bring expertise, ideas, client experiences and relationships to our offices firm wide not just where they sit. In living up to our commitment to providing an outstanding customer experience to our clients and their plan participants, we believe it is critical that our consultants not operate in a silo fashion. This program explicitly encourages them to get out of the silo.

We believe the State will find Segal's collaborative approach and our sharing of best practices, and new trends, to be a valuable and comfortable fit with the State's goal of maximizing value and utilizing resources effectively.

Emerging Actuarial Practices

Part of the job of our health and retirement actuaries is to stay abreast of current actuarial trends in the profession. Our actuaries are all accredited under the Society of Actuaries and the

American Academy of Actuaries. Actuaries receive newsletters and publications, on a regular basis, from the Society. Academy membership provides Segal's actuaries with a window on the profession's public policy work, helps our actuaries stay on top of emerging issues, enabling them to help prepare your company for the future, allows them to facilitate having a voice in shaping how the actuarial profession maintains its standards and qualifications, facilitate having a voice in shaping how the actuarial profession applies actuarial principles to public policy issues and provides them easy access to a wealth of resources and information from the Academy. All of this benefits the State and DAS.

Many Segal staff are Fellows and Associates of the Society of Actuaries, Members of the American Academy of Actuaries, Fellows and Members of the Conference of Consulting Actuaries, Enrolled Actuaries and Fellows of the Canadian Institute of Actuaries. In addition, several of our firm's senior actuaries have served on committees of the American Academy of Actuaries, the Society of Actuaries, the Conference of Consulting Actuaries and the Actuarial Standards Board and on the Advisory Committee of the Joint Board for the Enrollment of Actuaries.

Because of staff involvement in professional actuarial organizations, Segal has a Director of Actuarial Continuing Education, who arranges a Technical Actuarial Meeting each year, as well as other professional development opportunities, which help actuarial staff meet continuing education requirements.

Plan Structure & Improvement

Using all the various publications, research, experiences and survey information, as part of our ongoing consulting, we will recommend benefit plan design changes where appropriate. Segal evaluates benefit design alternatives in terms of anticipated results and measures them against the State's philosophy and program objectives. We take into account such things as:

- Competitiveness of current benefit plans to prevailing practices;
- Cost effectiveness of the current third-party administrators;
- Appropriateness of certain benefit provisions;
- Differences in plan design and operation from both the employee and employer points of view;
- Projected cost of the model benefit plan as compared to the current arrangement;
- Available funding techniques and the appropriateness of each to the State's strategic goals and budget, considering cost, cash-flow and risk features;
- Type of service delivery model; and
- Performance standards and guarantees that should be included in vendor contracts to administer the plan design change.

Based on our analysis, we will make recommendations to the State as to appropriate funding approaches and to the degree to which financial risk should be shifted, retained or shared between the State's and the membership.

2. Actuarial Services & Related Reporting

The contractor shall provide actuarial services for the State's employee health insurance plan and wellness program. The following services and reports shall be prepared as part of this contract:

a. ***An annual plan cost analysis and annual calculation of the employer and employee contributions for each of the State's health plans.***

b. ***Analyze and recommend the annual Claims Fluctuation Reserve (CFR) level at the end of the plan year. The State currently maintains a CFR at a 90% confidence level.***

c. ***Analyze and recommend a projected Incurred But Not Recorded (IBNR) amount at the end of the plan year.***

d. ***Help the State prepare a Value on Investment (VOI or ROI) for the State's wellness program each year.***

a	***Describe the bidder's experience in performing actuarial services for other States or companies of similar size.***
	Response:

Actuarial & Consulting Experience with Governmental Entities

Segal's professional staff includes more 150 credentialed actuaries in 23 offices. Our actuaries are Fellows or Associates of the Society of Actuaries and Members of the American Academy of Actuaries with experience providing all of the following services for our public sector clients:

- Annual rate setting analysis
- IBNR and other reserve calculations for self-insured health benefit programs
- GASB/OPEB retiree health valuations and modeling of program changes
- Provider network analysis, including Pay-for-Performance strategies
- RFP/Procurements and vendor management
- Audits and vendor performance review/measurement
- Development of capitation rates
- Multi-year budget development
- Trend and utilization reporting and analysis
- Legislative support and valuation of proposed legislation
- Expert witness and subject matter expert testimony and presentations
- ACA compliance and related strategic consultation
- Pharmacy program consulting
- Medicaid and Children's Health Insurance Program consulting and rate certifications
- Disability and Paid Time Off design and analysis
- Medicare Part D Retiree Drug Subsidy (RDS) calculations and attestations
- Valuation of program changes and comparisons of value among different plans
- Actuarial attestations on the overall rate structure and cost projections

Segal's actuaries work with many state and local government clients on their self-funded health benefit programs. The consulting and actuarial team assigned for the State of Nebraska has experience with State level plans in Georgia, Alabama, Illinois, Kansas, Tennessee, Wisconsin, North Carolina, Kentucky, and others. In addition, we work with many large cities and counties, some of which approach State level participation. In addition, we work with many large cities

and counties, some of which approach State level enrollment.

Segal has served and currently serves as health consultant to hundreds of governmental clients. We clearly meet and exceed the minimum qualifications in of the RFP.

The tables below illustrates our experience in providing complex, similar services to other large state level clients, in particular the State deliverables and tasks contained in the RFP from our Atlanta, Chicago and Washington DC offices. We have worked with many of the clients for over 10 years and, in the case of Hawaii, for over 50 years.

Experience	NC	GA	PA	MD	IL	DE	WV	NH	AL	HI	NM	WI	CO	AK
Financial Projections	X	X	X	X	X	X	X	X	X	X	X	X	X	X
IBNR Reserving	X		X	X		X		X	X			X	X	X
Funding Alternatives Plan Cost Modeling	X	X	X	X	X	X		X	X	X	X	X	X	X
Legislative Support	X			X		X	X	X	X		X		X	X
Actuarial Rate Development	X	X	X	X	X	X		X	X	X	X	X	X	X
Data Analysis/Trends	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Participation in Meetings and Workgroups	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Procurement/Marketing		X	X	X	X	X	X	X	X	X	X	X	X	X
Reporting	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Pharmacy Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HMOs/PPOs/FFS	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CDHP (HSA/HRA)	X	X				X						X	X	X
Medicare Advantage	X	X	X	X	X	X	X	X	X	X	X	X		
Part D Consulting	X	X	X	X	X	X	X	X	X	X	X			
ACA Consulting	X	X	X	X	X	X		X	X	X	X		X	X
HIPAA Compliance	X		X	X		X		X	X		X		X	
Plan Design Review	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Wellness Plan Designs & Program Analysis	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medical Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Contract Negotiations	X	X	X	X	X	X	X	X	X	X	X	X	X	X
OPEB valuation	X			X				X		X	X			X
Strategic Planning/ Migration Strategies	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CAFR Support	X			X		X		X	X	X	X			X
Communications	X		X	X	X			X		X			X	

Segal Public Sector Client List

Below, please see our firm-wide list of our key current and recent State Government and Statewide Retirement Systems:

- Alabama Public Education Employees' Health Insurance Plan
- Alaska Retirement Management Board
- AlaskaCare Health Plan
- State of Delaware
- The District of Columbia
- Georgia Department of Community Health
- Florida Division of State Group Insurance
- State of New Hampshire
- State of Tennessee
- State of West Virginia
- State of Wyoming
- State of Minnesota
- State of South Dakota

- North Carolina State Health Plan
- State of Colorado
- State of Connecticut
- State of Hawaii
- Georgia Municipal Employees' Retirement System
- Illinois Municipal Retirement Fund
- Illinois State Universities Retirement Systems
- Illinois Teachers' Retirement System
- Missouri Local Employees Retirement System
- Ohio School Employees Retirement System
- Pennsylvania Public School Employees' Retirement System
- New Mexico Public Schools Insurance Authority
- New Mexico Educational Retirement Board
- New Mexico Retirees Association
- Texas Group Benefit Plan for State Employees
- Illinois Central Management Services
- Arizona State Retirement Systems
- California State Teachers' Retirement System
- District of Columbia Retirement Board
- Minnesota State Retirement Systems
- Nevada Public Employees' Retirement System
- North Dakota Public Employees Retirement System
- North Dakota Teachers Fund for Retirement
- Michigan Office of Retirement Systems
- Rhode Island Employees' Retirement System
- Texas Municipal Retirement System
- University of California Retirement System
- Wisconsin Retirement System
- Wisconsin Employee Benefit Trust
- State of Maine
- Commonwealth of Massachusetts

b ***Provide an example of a premium equivalents report for a self-insured health plan with multiple plans.***

Response:

The most important part of projecting the costs of a self-insured benefits program is the proper determination of the per capita costs, commonly called "funding rates" or "premium equivalencies". In short, these are the total expected costs of providing coverage over the coming year, either on a per employee or per member basis. Multiplying these rates across the anticipated enrollments results in the total costs of providing the benefits, before netting out employee premium contributions. Funding rates typically vary by plan option election (i.e. by HMO or High/Low PPO options) as well as by coverage tier election (i.e. Single, Family, Employee+Spouse, etc).

Funding rates are comprised of two main components, expected claims costs and fixed costs. The fixed costs are for expenses for claims processing and administration (ASO fees), stop-loss insurance, medical management, wellness and prevention programs, network access, capitation payments, RDS, etc. This is a relatively straightforward process, as these amounts are usually set in the vendor contract, negotiated at renewal, or at vendor selection, and are therefore known amounts.

Projecting expected claims costs is less straightforward. The actuary will look to recent experience for the same covered population, trend forward based on expected increases in claims costs and adjust for things such as changes in benefit design, anticipated enrollment shifts (migration and selection), effect of medical management and wellness programs, changes in provider and drug discount levels, anticipated changes in utilization patterns (such as a result of a consumer-focused approach), and so forth.

Projecting Claims Costs and Funding Levels

A classic example of a multiple-option benefit offering to governmental entities is characterized by different plans, regions, tiers and employer types. These arrangements often carry a high

degree of adverse selection. Employees will likely choose a plan that best meets their needs, based on the perceived value of the plan versus the perceived cost to the employee. The selection patterns will vary between state regions due to many characteristics, the most common being network adequacy and socioeconomic characteristics.

This is especially true in Nebraska, where there are a number of plans. It will be necessary for the actuary to properly assess the health and cost risk between the self-funded options and reflect that risk difference correctly in the rates and budget projections.

Segal has a proven process for developing financial forecasts that produce the most accurate and actuarially sound results possible. Our projection model is on a basic beast-practice methodology, then enhanced. Each step is described briefly below. The basic steps can be reproduced for any specific group the State would like to track separately. The following describes the process, data and insight we will use for each of the steps set forth below.

Step 1. Confirmation of Project Objectives: Scope and Approach

Typically, for state plans like Nebraska, final funding rates, member contributions and budget projections (both plan year and fiscal year) need to be finalized by late February. Segal would first prepare with Department a timeframes for delivering the draft, final report(s) and any supplemental schedule. It is common to run preliminary results and assumptions by staff at an earlier date to ensure that all parties are on the same page. We would also discuss the accuracy rate of prior projections and recommend ways to improve upon past methodologies, if warranted.

This meeting also is imperative for setting strategic direction and ensuring that the entire process supports the short and long-term goals of the program. During this meeting, we would also outline the data needs, minimum reserve requirements and any expected changes in funding from the State or to the State's Program from other sources.

Strategic direction would also be discussed at this meeting, including targeted funding levels for the end of either the plan-year of the fiscal-year, targeted expense reductions, changes in state funding (such as premium holidays), or any other possible changes or considerations for the coming year(s).

Step 2. Capture of Experience Period (EP) claims

Next, we would capture the EP claims. The claims can be on either a paid or incurred basis. We typically capture the data to develop an incurred rate, and then develop an emerging cash flow on a paid basis. Each state has its own unique funding policy, and we will tailor our approach to meet your specific needs and follow established practices.

As the actuary will be receiving and/or developing claim triangles and estimating Incurred But Not Reported (IBNR) claim liabilities, incurred claim estimates will be available. Segal recommends that incurred claims be used for the EP claims. Using incurred claims filters out many payment systems issues, and allows the actuary to isolate the impacts due to enrollment changes, plan design changes, changes in contribution strategy, or other significant events. The claims experience associated with any significant enrollment shift is more appropriately and accurately analyzed using incurred claims for the EP since timing is crucial. We discuss later in this question our methodology for developing IBNRs. This method is integrated into our financial projections.

In most projection methodologies, the EP claims are converted to a unit measure before

application of projection trend. The units are typically referred to as Exposure Units. Employees (also called contracts), members or other measures can be used. Each measure has its pros and cons. We would typically use employees, but capture the influence of the relative ratios of single contracts and contracts with dependents. If that ratio changes over time, an adjustment must be made to the revenue required in the Rating Period to account for a different mix of members between the Rating Period and the EP. We would also review the incurred claims for any very large claims incurred on a single claimant that might distort the costs per member. Depending on the circumstances, we may use one or two years of experience for the experience period claims.

When collecting the data we would ensure that all the reporting groups are delineated appropriately. We understand that rates need to developed separately by plan and by tier. Our model will be built accordingly to recognize each unique group. Due to low volume in some of the cells it may be necessary to integrate our credibility model, developed internally by one of our Health Actuaries, Chuck Fuhrer.

We will work with the State if supplemental information is needed but we expect to be able to pull most of this information from Segal's Shape data warehouse. Our actuarial model needs:

- enrollment data
- claims reports and summaries from vendors
- financial statements of each program
- vendor reports
- plan documents including SPDs, communications, etc.
- strategic plan
- past actuarial reports or premium rates development work papers

A key step after collecting the data is to review and reconcile between different sources. It is imperative that expense data be consistent with claims data, vendor reports and transactional data available to the State staff. This crucial step will help protect against policy decisions being made that are based on projections that, while based on sound methodology, may be developed utilizing data that is not reflective of historical actual experience.

Step 3. Trending EP Claims Forward to the Rating Period

The next step is to trend the EP claims forward to the Rating Period. Rating trend is typically viewed as having three main components: price per service, utilization of services and mix of services. Often the mix of these variables cannot be identified in the data, so it becomes included in one or both of the other components. We will pull some trend data from the Shape system for analysis. Additionally, if there is an expected impact on claims due to changes in technological advances or other external forces, which are not explicitly identified in the rating, this impact may be addressed by increasing or decreasing the rating trend as appropriate.

Financial Trend Analysis

Provider unit price, utilization, and technology are the common influences of health care trends. Price is the cost of services (what the provider is paid) and is often measured by the medical component of consumer price index (CPI). CPI is not a perfect measure of prices for a typical employer plan because it includes costs that are not covered (e.g., over-the-counter medications and cosmetic surgery). Provider reimbursements, the key component of price, are measured over time by observing the change in the same service.

Utilization is a very broad measure and can be further broken down into more discrete

components such as service mix, adverse selection, intensity of services, federal government cost shifting, and other external influences on consumer behavior (e.g., potential loss of coverage, financial incentives to refrain utilization, direct to consumer marketing).

Advancement in medical technology is a key contributor to cost increases. Medical research is constantly inventing new drugs, procedures, and tests. These new products and services contribute to higher overall utilization, and the higher cost of new technology contributes to higher overall prices. These increases are over and above the price and utilization increases on existing products and services, referenced above. For example, advancements in imaging technology has created new demand for those procedures.

An additional component often overlooked is the "net" trend to the State. It is common for plans to have a number of fixed cost sharing elements, such as copays, deductibles and out-of-pocket maximums. In these cases, the trend to the plan sponsor (Department) is leveraged and experiences a higher trend than the overall program. This concept is typically called "deductible leveraging" although it applies to much more than the deductible.

Tracking Regional and National Trends

Segal has a group that maintains and tracks industry trends and normative data. There are a number of different resources they utilize to monitor and analyze health care trends at the state, region, and national level. Some of these resources include:

- Segal's National Compliance Office in Washington, DC;
- Segal's Public Sector National Practice, which monitors both federal and state benefits-related trends (Richard Ward is a member of Segal's Public Sector Leadership Group);
- Segal's participation in a number of industry groups, including, the State and Local Government Benefits Association and the American Benefits Council, wherein we participate in the debate and the analysis of new developments in employee benefits; and
- Segal's National Health Practice which keeps our consultants – and, in turn, our clients – up to date on developments and emerging trends that may impact benefit plans. Semi-Annually Segal's National Health Practice publishes the Segal Health Care Trend Survey. Our trend figures are based on the projections of the leading actuaries at the major health care vendors. This data helps our consultants evaluate health insurance premium renewals and develop self-insured health plan claim projections.
- We also reviewed CPI statistics published by the Bureau of Labor Statistics.

Setting Prospective Trend

The actuary, when developing prospective trend, needs to take into account several variables: what happened in the past with experience period claims, and whether this pattern continued; what is happening currently with trend that can't yet be measured, and what will happen in the future (between the time of the evaluation and the end of the Rating Period). All of these variables (i.e., past, present, and future) need to be assessed when setting rating trend.

Segal will measure the historical trend in each program, report on cost and utilization trend, and identify explicit, external/internal events that would have triggered a change in cost. In addition, we also will monitor emerging trends in the marketplace to assist in developing our recommended rating trends for each of the programs and groups covered.

Our prospective trend will be broken out by plan type (HMO, PPO, POS, etc), group (active, retirees, and Medicare retirees) and benefit type (medical, dental, pharmacy, vision).

Step 4. Determine Impact of Health Care Reform

The State and actuarial team will take into consideration the impact of the Patient Protection and Affordable Care Act (ACA), as it continues to be implemented. We will keep you informed of regulatory releases that could affect the program as well as any changes that may occur to the legislation. Segal will work closely with the State to ensure that it meets all fiscal year financial requirements.

The ACA is arguably the most consequential issue in employee benefits in many years. We have already seen many changes that will need to be considered in our rate development – past and future. A few considerations we will need to be aware of are listed below.

Newly Eligible Full Time Employees

Under the ACA, an employer must offer at least 95 percent of its full-time employees a minimum level of health benefit coverage. ACA defines "full-time" as 30-hours per week or equivalent. As a result, many traditionally part-time public employees who have not been eligible for health benefit coverage must now be taken into account. We will work closely with the State to help determine the impact of these additional eligible persons under the ACA and to help develop approaches for redefining your eligibility requirements and funding subsidies for those groups.

Health Insurance Exchanges

The advent of the Health Insurance Exchanges, or marketplaces, which started in 2014 and continue expanding to larger employers through 2018, must be addressed today, at least based on the current understanding of how those new market delivery vehicles will affect the overall state programs. The State will need to identify and analyze the groups that may be attracted to the Exchange and why they will be attracted, including such factors as low cost for minimal benefit coverage, consistency of coverage when changing jobs, and other factors.

For example, early retirees who are not yet eligible for Medicare may find the cost of coverage on the individual exchanges attractive when compared to their costs under available state plans. The State, on the other hand, does not incur a shared responsibility penalty if retirees are not covered by the employer sponsored health plans. We will need to determine the factors that will be important to employees and dependents who will have the option of migrating to the Exchange and what impact that potential migration could have on the rates and overall budget. We expect that State policy makers will be interested in identifying the value of federal subsidies to the State's employees' health plans.

Expansion of Medicaid

The expansion of Medicaid to provide benefits for a greater range of recipients will directly affect a contingent of the persons covered under the CHIP and Medicaid programs. Even in states that did not immediately expand their Medicaid threshold to include up to 133 percent of the Federal Poverty Level, the increased availability of Medicaid eligibility for those individuals who apply for coverage on the exchange may result in a greater number of persons covered, including potential attraction for lower paid and traditionally part time employees of the state.

This change in the dividing line between employee benefits and recipient benefits needs to be

explored carefully and continually to help the State understand the dynamics that will drive choice of program and source of subsidy in the future. We will work with the State to determine more specifically how these participants should be handled and whether this change at the federal level requires an adjustment in benefits philosophy and plan availability at the State level.

Minimum Contribution and Benefit Levels

The State provides many benefit designs that provide choice of benefits and premium rates to employees/retirees. We will look at the impact of compliance with the contribution and benefit requirements is likely to have on the plan in terms of participation, cost and continuity. We will also examine the cost impacts in the contribution analysis part of our review, and will coordinate those results with the broader review as part of this segment.

These are just a few element of the ACA that we believe should be factored into a projection.

Step 5. Tabular Adjustments

There are numerous reasons why baseline rates may need to be actuarially adjusted. In general, adjustments may be needed due to factors such as the following:

- Claim backlogs, vendor transitions, computer conversions or enhancements, and other causes of altered claims timing;
- Changing financial conditions influencing claimant behavior, including layoffs or contribution changes;
- Revised benefit plan provisions including changes in deductibles, maximum limits, covered benefits, or the introduction of managed care initiatives;
- A change in the demographics or participation of the group caused by such things as the introduction or elimination of health plans or members migrating to the State Insurance Exchange;
- Large claims or other distortions and anomalies that may have unique payment patterns; and
- The deteriorating health status of the group - causes may include aging on a closed or retiree group, or anti-selection from changes in health plans.

It is also likely there will be a number of adjustments to reflect specific changes to the pharmacy program expenditures. The largest components would be due to rebate projections and administrative claims.

Other modifications may be necessary to reflect different circumstances not referenced above. Adjustment techniques will vary, dependent on which modification is used and its impact on the resulting cost. Analysis by medical services, type of health benefit, and adjustment for large claims diagnosis and prognosis are all possible refinements, if cost and data considerations support the refinements.

Step 6. Provisions for Non-Claims Expenses

In formulating rates, non-claim expenses for the Rating Period must be added to the Rating Period expected claims to make appropriate provision for all revenue required in the rating period. Non-claim expenses will consist of at least the following:

- Administrative expenses for the claim payment vendors;
- Administrative expenses for wellness and medical management programs;
- Fulfillment and other non-claim payment expenses not covered above;
- Capitation rates (if any);
- Premiums for fully insured options;
- The State's internal expense allocations; and
- Any surplus management additions or subtractions.

Step 7. Develop Total Plan Expenses

Once all the adjustments and factors are developed in the steps listed above, a monthly per employee per month (PEPM) cost will be calculated. This projected cost would be the baseline calculation and would include timing of the benefit provisions, seasonality of health, enrollment mix, movement impact, etc. A companion per member per month (PMPM) can also be developed if that is the more common measurement for the State.

A similar process will be followed for each component of the projection: medical, pharmacy, administrative, rebates, wellness, etc. We will work through all the various components in our initial meeting during Step 1.

Step 8. Determination of Premium Equivalent Rates

The actuarial team will project the revenue components with great accuracy. This step supports the proposed "rate increase" and variances can result in a potential shortfall over the period. This calculation is fairly straight forward but seems to cause problems for many firms. The fairly basic principle is that once the total expenses are developed you must produce premium rates or funding rates that support these levels.

- Will there be cross subsidies between plans? In many cases a high cost plan will be subsidized by a lower cost plan that encompasses most of the plan membership. This may be due to the plan being catastrophic in nature, Nebraska mandates, long term strategies, etc.
- Will there be subsidies between tiers? It is fairly common to have a tier ratio locked in or rolled forward with time. Typically, these rates are not in sync with experience, even if they were re-based at one point of time. Changing these levels may cause winners and losers and the actuary needs to be sensitive to the strategies in place.
- Movement between plans can cause significant adverse selection. This will produce gains or losses that need to be accurately accounted for in the rates. The actuary will use their experience and training to reasonably predict this impact.
- How will the contribution strategy impact final enrollment numbers and employer/employee revenue splits? Significant changes in methodology could move a large numbers of plan membership.
- Is there any surplus or deficit that needs to be accounted for in the rate? For example, prior year funding deficiencies would cause our rate to be higher in order to re-build the reserve.
- Retiree Subsidy – since there is not a direct contribution by the State for each retiree, the current methodology spreads the costs not funded by retiree premiums over the entire

membership. Changes in the active and retired employee populations will impact this Subsidy and may have a material impact on State funding and employee premiums.

Note that calculating the experience rates in Step 2 will bring in many assumptions that will need to be revisited in this step. We will discuss our final methodologies and will document them.

When the rates are finished the projected revenue from both the State and Employee will be sufficient to cover program expenditures. A final one-page summary (with details of assumptions as an attachment) will be developed covering the projection period. As premium increase scenarios are developed, we will break out the required revenue by each revenue source.

Step 9: Revenue Projections

Projecting anticipated revenue is key to determining the overall fiscal and cash position. This revenue is typically sourced from:

- **Employee/retiree contributions** (unless these are regarded as an offset to expenses, which is not an uncommon practice);
- **Participating employer contributions**, such as State agencies, quasi-governmental entities, or local governments (if covered in the Plan). This funding can be defined as a percentage of payroll, a per capita monthly rate (that may vary plan, tier election, etc.) or some combination;
- **Federal funds**. Many positions in State government are partially or wholly supported by Federal Funds, which provide matching contributions from the federal government for benefits costs. These may be incorporated into the individual agency budgets, or could be passed directly the state health plan's trust;
- **Other Sources** include RDS payments (unless deposited into the OPEB Trust), pharmacy rebates, EGWP revenues and subsidies, penalty payments from vendors for performance shortfalls, transfers from other state operated trusts, etc.

In order to determine an accurate revenue projection it is important to understand how each component is determined and then develop a projection for each factor that determines revenue. For example, if employer contributions are a percentage of payroll, then it is imperative to develop an accurate projection for future salaries. If a per capita method is utilized then the focus will be on forecasting employee/retiree elections for plans, tiers, etc.

Segal will conduct a thorough analysis to make sure that the cash position, in conjunction with our projections discussed above, will produce the desired reserve and surplus at the end of the fiscal year.

Step 10: Total Budget Projections

In order to model the program's cash position, we typically recommend doing projections on a monthly basis first and then view a summary from an annual perspective. Projecting first on a monthly basis enables us to incorporate:

- Invoicing patterns that may vary by month (for example, weekly invoicing may result in 5 invoices one month and 4 the next)

- Quarterly pharmacy rebates
- State or employer revenue that may change on a fiscal year basis that varies from the Plan Year
- Mid-year changes in benefits:
  - New laws or mandates that take effect off-cycle
  - Highly utilized drugs that come off patent
  - Changes in vendor administrative practices
  - January 1 plan changes that have a delayed impact on a cash basis (such as changes in annual deductibles)
- Seasonal variations in employment levels
- Other irregular revenue, such as RDS payments, transfers from other State agencies, etc.
- Claims that increase steadily and/or vary with seasonality versus revenue that is more constant

Once the total revenue and expenses are projected by month, we will project the overall cash position for the various programs, based on the assets at the beginning of the projection period and then adjusting based on the monthly projected net gain/loss through the projection period.

This monthly approach will also enable us to identify any mid-year periods where asset levels may fall below reserve targets or even approach a negative balance. Sometime, when asset levels are low, a projection conducted on an annual basis may indicate a sufficient end-of-year balance, but not identify a mid-year trouble spot.

We will work with the State to best meet your reporting needs.

Step 11. Meeting with the State

After presentation of the preliminary forecast and numerous exhibits to the State, Segal (at your direction) would meet with the appropriate representatives to discuss the results to be presented. After appropriate editing and modification by Segal, the final package will be presented to the appropriate parties.

Both Ken Vieira and Kirsten Schatten have presented to multiple governors, senior executive staff (commissioners, secretaries, etc.), legislative bodies, boards of directors/trustees, as well as their respective staffs.

We commit to providing the support you need in presenting budget projections to the Legislature and other key stakeholders.

Our analysis will be conducted under the supervision of a Fellow of the Society of Actuaries and comply with all applicable Actuarial Standards of Practice (ASOP). Final results will be independently peer reviewed by the Review Actuary, who will also be a Fellow of the Society of Actuaries. Our deliverable and final report will include:

- Rates and the time period(s) for the rates
- Assumptions used, such as trend(s), plan elections, etc and an explanation of how each assumption was developed
- A description of our methodology
- Documentation of the data utilized and confirmation the data was reviewed and found to be reasonable for the analysis

- Description of any adjustments made to the base data for distortions and anomalies
- Our conclusions, findings and any recommendations, including those regarding State-provided reinsurance and/or other risk sharing mechanisms
- Detail on the impact of the impact of any Affordable Care Act requirements

We will also be available as needed to provide other related consulting and advisory services as needed. Both Ken and Kirsten have extensive experience as the Account Manager and Lead Actuary in similar engagements and fully understand the nature of the needs of a large state health plan such as the State.

We have provided an example of this type of report under **Appendix D: Sample Health Benefits & Actuarial Reports – Tab 2,** *"City of Chicago Projected Annuitant Plan Costs 12-Month Rates Effective July 1, 2012 - June 30, 2013".*

c ***Explain the approach to analyzing and recommending a CFR level. Provide an example of a CFR report the State would receive.***

Response:

Segal's national experts maintain industry standards for the calculation of reserves and the underlying assumptions of those calculations. The validation of current assumptions in place for reserve projections is both prospective and retrospective in nature.

Prospectively, each type of reserve is validated independently. Segal would expect to examine the following types of reserves:

- Incurred But Not Reported (IBNR) reserves
- Claims fluctuation reserves

IBNR Reserves

It is imperative that IBNR reserves are maintained for any self-funded group and are set by applying either standard reserve factors or factors based on actual claim lag history. If standard factors are used, those factors would be compared with Segal's national standards. We would expect different factors for each benefit type, for example dental, vision, pharmacy, and medical, with factors varying by level of managed care. If actual claim history is used, validation would encompass the following:

- Significant claim backlogs or pay downs are accounted for appropriately;
- provision is in place for adjusting for large claims;
- A mechanism exists to compensate for the effects of any significant changes in plan design;
- Adjustments for changes in eligibility are in place;
- Benefit levels for run-out claims are acknowledged and accounted for appropriately; and
- There exists a prudent application of margin to offset the volatility of claims experience.

Further information on calculating the IBNR can be found in our response to question (d) that follows.

Claims Fluctuation Reserves

Because the typical client that holds these reserves will find they are adequate to cover

fluctuations in claims experience in 95% of all years, the validation process would ascertain the following:

- That these reserves are being set with an explicit level of safety and this level has been identified to the client;
- That these reserves are being calculated using a published methodology based on an explicit set of risk;
- That these reserves account for the level of Individual Stop Loss purchased by the client; and
- That these reserves account for the credibility of the data that is to be used.

Retrospectively, projected claim levels are measured against actual claim experience. While no model is 100% accurate, results outside an acceptable corridor are of concern and are investigated. A myriad of factors influence the accuracy of any claim projection model: interest rates, trend, utilization, inflation, legislative changes, and claims payment processing. All anomalies are reviewed thoroughly to determine if they are in fact aberrations or systemic in nature.

Calculating Claims Fluctuation Reserves

Segal has developed Medical Claims Fluctuation Reserve factors. The factors:

- are set with an explicit level of safety that will be identified for the State,
- were calculated using a published methodology based on an explicit set of risk, and
- take into account the level of Individual Stop Loss purchased by the State and the credibility of the data that was used in setting the State's expected claim rate.

Our typical client that holds these reserves will find that they are adequate to cover fluctuations in claim experience in 95 percent of all years. Segal will identify this level of safety as desired by the State. Generally, Segal also calculates the reserves for safety levels of 98 percent and 99 percent. However, Segal can calculate the reserves based on any percentage level requested by the state. These higher levels of safety (confidence) are more appropriate for clients that prefer to hold larger reserves to increase the level of financial protection that these reserves provide.

Three specific risks that lead to claim fluctuations were identified and explicitly included in our calculation model. The three risks are:

1. **Large Claims** – This is the risk of unexpected increases in the number and/or size of claims incurred by individual participants. As the size of the group increases the larger claim are spread over a larger total and this risk becomes less significant. The purchase of individual stop-loss coverage by the plan can significantly reduce the plan's exposure to this risk.

2. **Client Claims** – This risk relates to overall plan claims experience developing at a variance from the expected cost per participant, due to insufficiently credible claims experience. As the size of the group involved increases, the level of this risk is generally reduced. However, this also depends on the length of the claims experience period that is used to project expected claim levels.

3. **Trend** – This is the risk inherent in a projection that uses a forecast of the overall increase

	in price and utilization of health care services. This risk is constant for any size of group. Segal will identify and discuss these three risks to the State. The claims fluctuation reserve table provides factors based on three key parameters: 1. **The size of the group** – This parameter is based on total number of adult participants instead of number of employees. 2. **The number of years of experience used in setting the projected claims** – This parameter is designed to more accurately determine the reserve based on risk #2 (client claims), above. 3. **The individual stop-loss level (or annual coverage maximum)** – This parameter is designed to more accurately select the reserve based on risk #1 (large claims), above. If aggregate stop-loss is purchased, the client should hold the lesser of the claim fluctuation reserve and the aggregate stop-loss corridor. The claim fluctuation factors do not vary based on the purchase of aggregate stop-loss insurance. This is because, the purchase of an aggregate stop loss with a probability of claim of less than 5 percent cannot affect the amounts that need to be set aside to be 95 percent sure of covering the claims. In this case, the stop loss has no effect on the probability. Segal's standard report, the Financial Experience and Budget Projections (FEBP), automatically calculates these reserves based on the variables that are entered into the Excel report module, assuming a 95 percent confidence level. Segal does not have a standard CFR reserve report but Segal can provide guidance on our methodology and provide recommendations. We have included a sample FEBP report, noting that the CFR is addressed on Page 18, in **Appendix D: Sample Health Benefits & Actuarial Reports - Tab 3,** *"Local XYZ Plan/Trust/Fund, Health Benefits Report – Fiscal Year Ending 2011".*
d	***Explain the approach to calculating IBNR. Provide an example of IBNR report the State would receive.***
	Response: Segal will develop incurred but not reported claims estimates. This is typically reported annually, but can be in any frequency needed by the State. The Segal actuarial team is highly proficient in performing reserve calculations and estimates for public sector plans. This is a core skill required for all Segal health actuaries. Training begins as an analyst when first employed by our firm. Segal performs this analysis annually for the majority of our public sector clients. Our goal is to provide reasonable estimates of future contingent events using the available data, state-of-the-art methodologies, and our professional judgment developed from years of experience making similar estimates. It is also an integral part of our premium rate development process. It is imperative to accurately measure these liabilities for this reason, as well as it being a key disclosure in the CAFR. We will use traditional actuarial reserve methods and techniques to develop the Reserve for Unpaid Claims. The reserve calculation will continue to be refined by appropriate plan-specific circumstances and actuarial judgment. The approach for accomplishing

the tasks and deliverables associated with this section is as follows:

Methodology

The unpaid claim liability (UCL), commonly called the incurred but not reported (IBNR) reserve, at a specified date is essentially the estimated claims incurred up to that date less the claims that have been (incurred and) paid to that date. Since the incurred and paid claims are known, the UCL is easily determined once the incurred claims have been estimated.

The traditional loss development method uses historical claim payment patterns to develop completion factors that are used to estimate incurred claims. The claims incurred in a given month and paid by the end of the experience period are divided by the completion factor to estimate the incurred claims for that month. The UCL for that month is subsequently determined by subtracting the known incurred and paid claims from the estimated incurred claims. The total UCL is merely the sum of all the appropriate monthly UCL estimates.

This method is relatively easy to understand and is effective when the historical claim payment patterns are deemed to be stable enough to estimate current/future claim payment patterns and when several months of claim payments (run-out) after the incurred month are available. When the run-out for any month is limited, this month is called immature and the associated completion factor is significantly less than one. The resulting incurred claim estimate is unstable. Consequently, a secondary method has traditionally been used to estimate the immature months.

The secondary method for health claims is often an average of historical incurred claims adjusted for claim trend and enrollment between the historical period and the time of interest. One of the shortcomings of this secondary method is that the available claim payment information for the month being estimated is not used. Another problem is that the line of demarcation between mature months and immature months is as much art as science.

The Bornhuetter-Fergeson Method (BFM) addresses both of these issues by blending the loss development method and the secondary method. The BFM uses the available incurred and paid data and the expected UCL developed from the secondary method to estimate incurred claims. This method generally provides a more stable estimate than the pure loss development method, a more responsive estimate than the secondary method, and a reasonable technique for blending the results of both methods.

Analysis of Need for Reserve Adjustments

The preliminary results of the BFM discussed above may require adjustments. There are numerous reasons why the basic approach may not accurately predict future claim run-off patterns. In general, adjustments may be needed due to factors such as the following:

- Claim backlogs, vendor transitions, computer conversions or enhancements, and other causes of altered claims timing.
- Changing financial conditions influencing claimant behavior, including layoffs or contribution changes.
- Revised benefit plan provisions including changes in deductibles, maximum limits, covered benefits, or the introduction of managed care.

- A change in the demographics or participation of the group caused by such things as the introduction or elimination of a plan.
- Large claims that may have unique payment patterns. This is less likely due to the credibility of the Plan.
- The deteriorating health status of the group. Causes may include aging on a closed or retiree group, or anti-selection between benefit options.
- Legislative changes, such as the continuing Medicare provider payment reform
- External factors such as pent up reaction to health care reform initiatives and the continuously changing face of managed care and provider reimbursement methodologies in Kentucky.

Reserve modifications may be necessary to reflect the circumstances referenced above with the modifications used dependent on the cost.

Reasonableness Checks and Refinements

One of the best ways to validate your reserve for unpaid claims is to compare emerging results with projected claims payment patterns. The actuary's judgment and experience is then heavily relied upon to determine any adjustments to previously calculated factors. Actuarial graduation methods or simple smoothing of volatile factors may be performed. A review of historical accuracy under different scenarios may help improve this actuarial process.

In the event of a significant change in the estimate from the prior year, we will provide a draft report summarizing the underlying cause(s) for the change and describing any relevant alternative new ideas to consider. It is expected that continuing experience with emerging data and results will determine if alternatives beyond the traditional approaches will be desirable. A cost versus benefit analysis can be made using more sophisticated approaches, such as claims tape analysis.

Other Considerations

One other key component that would need to be recognized on the State financial statements involves a gap between what is shown on the lag data and the claims costs that have been recognized and tracked in the plan financials. For example, the lag data used to estimate the UCL may have a paid date of June, but the Plan may not have paid that invoice until the following month. In such instances, the Plan would need to accrue on their books an additional amount equal to the difference. This amount is typically referred to as Checks Issued But Not Cleared.

Once complete and numbers reviewed by the State, Segal will produce a final report with all the actuarial assumptions utilized, data and results.

We have provided a sample IBNR report under **Appendix D: Sample Health Benefits and Actuarial Reports – Tab 4,** *"Incurred But Unpaid Valuation as of 6/30/2015".*

This report is Segal's standard reserve report that was delivered to the State of North Carolina.

e	***Describe the bidder's experience calculating VOI on a wellness program. Provide an example of a VOI report.***

Response:

Segal has extensive experience evaluating comprehensive wellness programs, which almost always include retirees (and their dependents) as well as active employees. The State's clinical team has worked together on calculating VOI of state level wellness programs, such as the State of North Carolina and the State of Maryland, listed below.

Segal regularly works with a variety of employer/plan sponsors including corporate, public sector (city/town, county, state and school districts), and multiemployer union funds to help them implement, evaluate and manage both wellness (also called disease prevention or health promotion) and disease management (DM) programs. Because of the uniqueness of these Wellness and Disease Management Programs, no two plan sponsor projects are ever exactly alike - they are highly customized to you and your unique needs.

We at Segal believe that well-designed, diligently implemented and carefully targeted wellness programs can generate substantial VOI — often within five years.

Traditionally, a health benefit plan would measure its success by looking solely at total health care costs: the year-to-year cost increases and trend. While measuring these financial factors remains vitally important, evaluating the success of wellness programs within those health benefit plans requires a different approach: the metrics by which wellness programs are measured should capture whether the "population health" is getting better overall.

In the long run, if wellness programs are truly working, they should keep healthy people healthy and reduce modifiable risk factors to slow down the onset and progression of chronic disease, thereby reducing demand for services, which helps to hold down costs. This, in turn, will reduce future health care costs. Because wellness programs alone can do very little to directly impact the unit costs of care, the expectation for instant reduction in overall medical claim costs by instituting wellness programs, or expecting wellness programs to "bend the cost curve" immediately, is not realistic.

While it is reasonable for employers to desire a hard-dollar return on investment made in wellness programs, they should also track and study the clinical and behavioral progress of the population. The metrics for measuring the performance of wellness programs must capture the value of multiple interventions in delivering various wellness services. The end result could be an estimation of the amount by which clinical interventions were able to control costs by reducing future health care utilization.

For all wellness programs, Segal medical management experts can help employers set clinical goals against which wellness program performance can be monitored and measured. Baselines are established and criteria and targets are customized to each plan's programs and can be drawn from plan-specific performance, national averages and ideal targets. All measures are set to provide a meaningful impact on future direct and indirect cost and quality indicators. Comparing the clinical programs against the established targets is a practical and comprehensive way for employers to assess existing wellness programs. If a plan uses one or more wellness providers, it is important to work with the vendor to set the measures and to implement appropriate performance guarantees for the clinical goals.

To help you track the effectiveness of your wellness programs, Segal has built a tool that defines

and takes a snapshot of the most important metrics that need to be monitored. This "dashboard" provides employers with useful information regarding the direction of important cost and clinical outcomes, such as medication compliance, program participation rates, quit rates, and quality and intensity of participant engagement. The metrics can be divided into process metrics and outcome metrics. The outcome metrics are broken down further into three important categories:

1. Clinical improvements;
2. Impact on utilization; and,
3. Financial metrics

It's important to work with the wellness vendor to make them understand what metrics are important to track and measure.

Below is Segal's sample healthcare dashboard for tracking improvement and results of a weight management program.

Sample Dashboard for Measuring the Success of One Wellness Program (a Weight-Management Program)

		Outcome Metrics**		
	Process Metrics*	Utilization	Clinical	Financial
Metric	Percent of members with Body Mass Index (BMI) >25 participating in weight-management program	ER visits/1000	Prevalence of Type 2 diabetes	Yearly per-person cost of health care by adult members with known Type 2 diabetes
Baseline Data	N/A	143	8.4%	$11,700
Data After One Year from Baseline Measurement	40%	143	8.5%	$11,800
Data After Two Years from Baseline Measurement	43%	137	8.0%	$11,000
Data After Three Years from Baseline Measurement	47%	133	7.8%	$10,200

* All process metrics should be tracked every month. In this dashboard, the baseline data shown in the first row reflects experience at first measurement and the data in the subsequent rows reflects the average for the year.

** Outcome metrics should be tracked annually.

Source: Segal Consulting

** All process metrics should be tracked every month. In this dashboard, the baseline data shown in the first row reflects experience at first measurement and the data in the subsequent rows reflects the average for the year.*
*** Outcome metrics should be tracked annually.*
Source: Segal Consulting

The text box below lists wellness programs and clinical goals.

Sample Clinical Goals for Wellness Programs	
Wellness Program	**Clinical Goals**
Health Assessments	> Personal health assessment survey completion rate > Percent of participants with one annual primary care visit
Smoking-Cessation Program	> Engagement rates > Quit rates
Obesity Reduction	Reduction in Body Mass Index (BMI) for targeted obese participants
Cancer Screenings	> Percent of targeted participants obtaining breast cancer screening > Percent of targeted participants obtaining colonoscopy
Improvement in Health Lifestyle	Participation in activities, such as fitness center, yoga, walks and races
Well-Baby Care	> At-risk pregnant participants assigned personal coach and engaged in prenatal program > Participants who have newborns attend well-baby care education session
High Blood Pressure Reduction	> Reduce percent of participants who have high blood pressure reading > Increase percent of hypertensive participants taking medication to reduce high blood pressure
High Cholesterol Reduction	> Reduce percent of participants with high cholesterol readings and abnormal low-density lipoprotein (LDL) and/or high-density lipoprotein (HDL) cholesterol > Increase percent of participants with high cholesterol taking medication to normalize levels

Our Experience

Segal assists our public sector clients with a wide variety of analytical projects that are either reviewing past experience or projecting future experience, or both. We have included three States that have applied various VOI methodologies.

State of North Carolina

ROI for Active Health Management's contract with the Plan over the last three years. In the first two fiscal years, we reviewed AHM's proposed methodology and provided comments and suggestions to the Plan for the specific components of that calculation. We then reviewed the vendor's calculations and performed the same calculations against our own data base of claims for the period in question to determine whether their results were reasonable.

For the 2014 calendar year, we recommended that the Plan consider an ROI mechanism that includes the 3M Clinical Risk Grouper codes (CRGs) to assign risk to the participants touched by

the disease management vendor. That additional risk factor can help the Plan understand the specific areas where the vendor is succeeding as well as areas needing improvement or modification. Tracking participatory groups against a control group has been shown to be the most accurate ROI financial methodology.

The results of this study were just presented to the Plan. The preliminary results showed far less ROI when compared to the population based approach. It is also interesting to note the results seem to indicate a better return as the evaluation period is extended.

State of Maryland

The State of Maryland, via the Employee Benefits Division in the Department of Budget and Management, covers approximately 240,000 active and retired employees and dependents. Prior to relocating to the West Region, Richard Ward served as the Account Manager in this engagement.

Maryland is exiting a fund balance spend-down period and was looking to design a value-based benefits program to more effectively manage trend by improving member health and the efficiency of how care is provided. The State has a significant collectively bargained population and negotiating benefit reductions that shift costs to employees have been historically difficult to negotiate.

Led by Chris Mathews, Stu Wohl and Richard Ward, Segal reviewed several years of claims data and identified high rates of diabetes, hypertension and hyperlipidemia with many of these patients having significant gaps in care. Additionally, our analysis indicated a very low rate of utilization for primary care physicians (PCP) and certain preventive screenings. A strategy was developed to align member and vendor incentives to address these conditions.

Members

Members will be required to complete a Health Risk Assessment and review the results with their physician. Also, copays for PCP office visits will be waived upon a PCP election. Required "healthy activities" will be expanded in the succeeding years to include required disease management program participation and reward healthy outcomes, such as maintaining blood pressure and cholesterol levels within evidence based medicine determined norms.

Vendors

An RFP was designed and issued to support the new value-based program. A mix of performance guarantees and incentives was built into the RFP (and resulting contract) to hold the vendors accountable for increasing colorectal and mammogram screening rates, PCP elections, cholesterol screenings, reducing blood pressure levels, disease related emergency room visits, etc. The contract includes assessments for poor performance, but also enables the vendors to earn incentives for exceptional performance.

The initial projections forecast approximately $4B in savings over the 10-year contract period. Savings will be achieved from improved provider discounts (versus the prior contracts) and an accumulation of "trend bend" which will be minimal initially but compound over time to be fairly significant.

Pennsylvania Public School Employees' Retirement System Health Options Program

We regularly perform ROI analyses and calculations for all types of programs. Recently, we were asked by PSERS to analyze the return on investment of their seniors' fitness program vendor. That vendor claimed certain very attractive results in reducing health trends for retirees participating in their program.

With no specific ROI methodology included in the contract, Segal developed a methodology that took into account not only the number of times the retiree went to the gym and swiped his or her membership card, but also tied that retiree's specific usage to his or her own claims experience under the plan. The group is large, so we created a control group of retirees with the same demographic and risk profiles who did not participate in the fitness benefit. We looked at various determinative factors such as demographics, frequency of facility use and active longevity in the program to determine whether the program was indeed generating a return on investment and how that return was generated within various cohorts of users.

The results were conclusive that the largest reduction in trend was among seniors that used the fitness facility seven or more times a month over longer periods of time. Those who used the facilities only occasionally actually had worse trend than the control group and the overall plan population. In addition, we noted the increased prevalence of orthopedic injuries and services among the seniors that were average utilizers of the fitness centers. The client has retained the program for now because it provides an attractive feature that supports the general emphasis on healthy lifestyle, but we are periodically updating and reviewing the results to determine whether those lesser use groups are getting any real health benefit.

Michigan Public School Employees' Retirement System (MPSERS)

MPSERS is a statewide retirement system that also provides retiree health coverage to its more than 100,000 annuitants and their dependents. The system provided both its health benefits and its prescription drug benefits through a single contract with Michigan Blue Cross and Blue Shield. The Michigan Blues subcontracted the pharmacy claims administration to a national pharmacy benefit manager.

The MPSERS executive director was challenged by the state government, which maintains the health benefit programs for active state employees and retirees, to demonstrate that its single contract approach was more cost effective than the state's separate medical and PBM contracts. MPSERS hired Segal to help them formulate a methodology to test this question and then to conduct the analysis on a fair basis.

Segal collected two years of prescription drug claims data from both the state government plan and the MPSERS plan. We also were provided the contract pricing terms and other relevant documentation. We conducted an analysis in which we "repaid" each claim over that period using the other entity's contract terms, pricing and formulary tiering structure. Then we compared how each plan had handled the other's claims and the resulting cost levels for that set of claims. Finally, we correlated the two sets of contract differences to determine an overall result. Interestingly, we found no significant differences in cost between the two contracts using the different approaches. Also as part of the analysis, we identified where each plan's PBM had paid their own claims incorrectly and that information was presented to the respective entities for their own use in managing the contracts.

	We have provided a sample VOI/ROI report under **Appendix D: Sample Health Benefits and Actuarial Reports – Tab 5,** *"National Health & Welfare Fund – ROI and Performance Measurement of Wellness and Disease Management, December 2010".* This report was presented to trustees to show them how effective their investment into their wellness and disease management program was working.

3. Health Plan Analytics and Reporting

The contractor shall provide the State with the following services:

a. ***A monthly budget report of the State's health plan performance comparing actual to budgeted costs.***

b. ***Pursuant to Nebraska Revised Statute 50-502, the State of Nebraska Health Insurance Plan Annual Report due November each year. See Attachment C for the most recent report.***

c. ***Health plan reports including cost trending and multi-year forecasting projections as requested by the State.***

d. ***Other reporting requirements may include health plan analytical reports, industry surveys, and benefit program performance and gaps.***

a	***Provide an example of the monthly budget report for self-insured health plan.*** ***Response:*** Segal will prepare monthly budget report to the State to meet your needs. We typically develop a number of customized reports, particular to each of our clients. With a variety of client types – public sector, corporate, and multi-employer funds – and with the variety of plans we service with different funding arrangements, from fully-insured to fully self-funded, we believe we have the experience and expertise to help the State make sense of almost any vendor report provided. Segal has extensive experience working with most commercial and Blue Cross carriers to have them provide the client what is most needed for successful management of the program. We have helped clients create vendor report "dashboards" that capture the most useful management information in a format that lends itself well to reporting to senior management within the State. At the onset of our engagement with the State, we will propose and develop, in conjunction with other state government clients, a monthly reporting system for tracking the health plan expenses. We ensure that our system will permit proactive management of the plan, as well as the methodology for linking claims to wellness initiatives. Segal has extensive experience in tailoring our standard report formats to the needs of our clients. In addition, in working with conjunction with the State's vendors we can utilize a combination of reports for regular production and discussion. We have provided two sample monthly budget report under **Appendix D: Sample Health Benefits & Actuarial Reports.** ➢ **Tab 6,** *"State of Connecticut, Budget Projections Fiscal Years Ending June 30, 2016,*

2017, and 2018 – February 2016"

- **Tab 7,** *"Department of Budget and Management, Fiscal Year 2014, Monthly Budget to Actual Report Through January 2014"*

The first is a standard budget report we provide monthly to the State of Connecticut. The second is a monthly budget to actual variance report we provided for the State of Maryland.

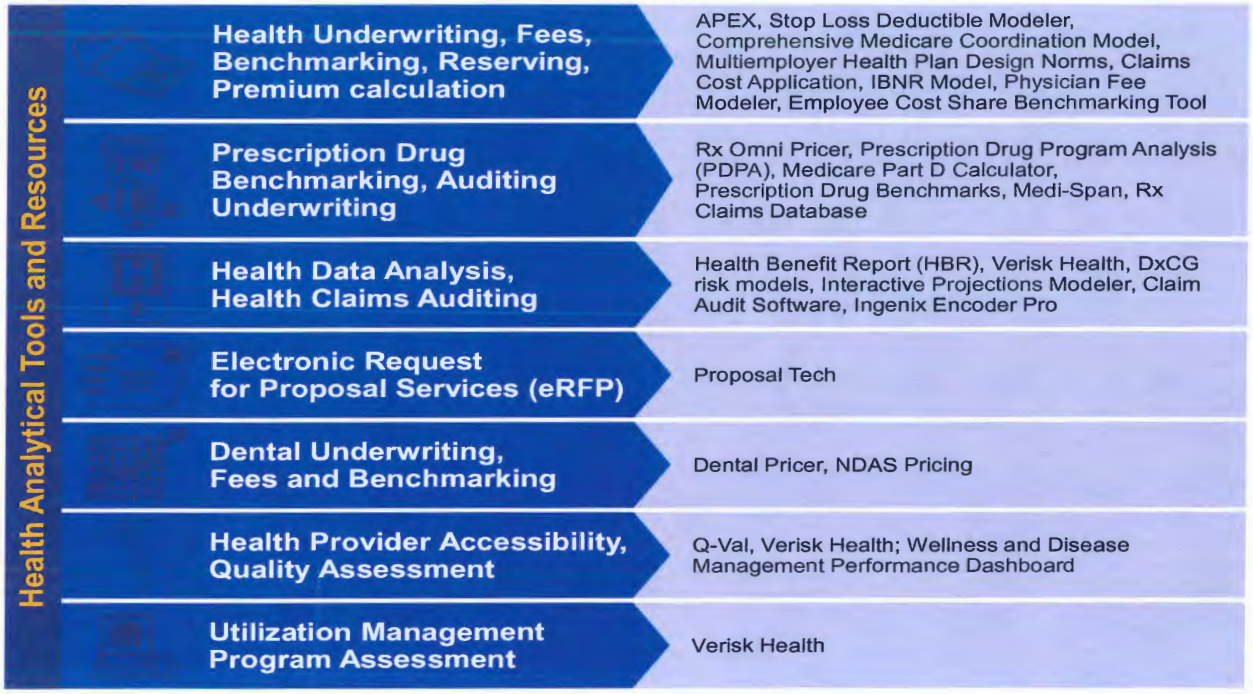
b ***Describe the resources available to prepare a report similar to the State of Nebraska Health Insurance Plan Annual Report.***

Response:

Segal has many resources and tools to the assist with the development of the State's Health Insurance Plan Annual Report. Segal has a multi-disciplined team, with varying disciplines through their staffing and assigned team members. The team consists of actuaries, consultants, data analysts and clinicians who provide a multifaceted analysis of all program operations. Many of the posed team members have worked on other large state clients and their annual reports. They are well aware and have in-depth experience in how to combine all concerted efforts that tie in all areas of the program in order to provide an overall operational picture of the entire program.

Not only do the team members use their own expertise and experience, Segal has many tools the team members use to support their analysis and conclusions. We customize our array of technical resources for your specific needs, ensuring that we provide the high level of quality consulting that our clients expect. Segal is on the cutting edge of health care industry trends and relevant legislation, and we update and revise our tools as needed to provide maximum value to our clients. These tools are used in various capacities, depending on the plan feature under consideration.

We have shown a more detailed list of our analytical tools and resources but here is another snapshot of our wide range of tools available to our team and indirectly to the State.



c	***Provide a sample of a report which would be similar to the State of Nebraska Health Insurance Plan Annual Report.***

Response:

Segal prepares a wide array of annual reports for our clients. Some are standard and similar to our health analytics type reports while other focus on long-term strategic initiatives. We will work with the State to design a custom report that best meets your specific needs.

We have provided a sample of an annual report we prepared for the State of Wisconsin as well as our standard Annual Health Informatics report, drilling down into the claims details under **Appendix D: Sample Health Benefits and Actuarial Reports.**

- **Tab 8,** *"State of Wisconsin Insurance Board Department of Employee Trust Funds, Health Care Benefits Consultant, Second Report – Observations and Recommendations for 2017 and Beyond"*

This report is a strategic report done for the State of Wisconsin. The second report is intended to provide the State insight on how Segal looks at opportunities and experience of a program.

- **Tab 9,** *"Sample Medical Intelligence Report, April 2009 through March 2011"*

This report is our Sample Medical Health Intelligence Report, an analysis of healthcare information.

The core message is our annual report will provide a good summary of where the program has been, showing current initiatives and direction, while providing addition opportunities for the long term. It is meant to be proactive vs. reactive.

Below are the key sections (table of contents) of our Sample Annual Reports that can be provided:

Table of Contents

1. SUMMARY OF FINDINGS
2. POPULATION CHARACTERISTICS
    2.1 Demographics
    2.2 Aggregate Economics
    2.2.1 Monthly Comparison of Paid Claims
    2.2.2 Expense Distribution by Percent Spending Band
    2.3 Clinical Disease Fingerprint
3. ECONOMIC FINDINGS AND OPPORTUNITIES
    3.1 Medical Economics
        3.1.1 Network utilization and contract discounts
        3.1.2 Specialty procedures/consultations
        3.1.3 Diagnostic Testing
        3.1.4 Place of service - Inpatient and high acuity
        3.1.5 Place of service – Outpatient and low acuity (excluding office visits)
    3.2 Pharmacy Economics
        3.2.1 Non-PBM Drug Spend
        3.2.2 PBM drug spend
        3.2.3 Selected prescription cost avoidance opportunities
4 CLINICAL DEEP DIVES

	4.1 General Clinical Quality Performance and Economic Opportunity 4.2 Case Management Opportunities 4.3 Disease Management Opportunities 4.4 Wellness Management Opportunities 5 APPENDIX 5.1 Demographics 5.2 Financial Analyses 5.3 Disease Fingerprint 5.4 "Top 10" Analysis 5.4.1 Providers 5.4.2 Places of Service 5.4.3 Diagnostic groups 5.4.4 Procedure groups 5.4.5 Therapeutic classes 5.5 Clinical Quality Performance and Measures All of these reports will be customized and subdivided to best meet your needs.
d	***Provide a list and examples of other reports that are offered including health plan analytic reports.***
	Response: Segal will prepare other reports as needed by the State to meet your needs. We typically develop a number of customized reports, particular to each of our clients. At the onset of our engagement with the State, we will propose and develop, in conjunction with other state government clients, a monthly reporting system for tracking the health plan expenses. We ensure that our system will permit proactive management of the plan, as well as the methodology for linking claims to wellness initiatives. Segal has extensive experience in tailoring our standard report formats to the needs of our clients. Below is a typical sample set of reports we provide to our clients: ➢ Monthly Claim Reports; ➢ Plan Utilization Reports; ➢ Contribution and Expense Reports; ➢ Budget Projections; ➢ Rate and Plan Design Modeling; ➢ Renewal Analysis Reports; ➢ Benchmark Reports; and ➢ Analysis of Proposals. **Data Analytical Reports** A critical initial component to implementing meaningful plan management programs is to better understand underlying population health, what issues are particular to it, how they compare to similar groups in terms of medical diagnoses and utilizations patterns, and which tools will be the most effective in managing the population's medical care. Data mining and predictive modeling, an approach many health plans are using, involves identifying trends in data in order to facilitate decision making.

For our state clients we load their claims experience into Segal's Health Analysis of Plan Experience ("SHAPE").

For this section we will discuss the two main claims reporting packages we use. The first is a direct output from SHAPE, discussed above in (a). Below is our standard table of contents:

- Executive Summary
- Medical Paid Claims
- RX Paid Claims
- Medical plus RX Paid Claims
- Paid Claims By Service Category (Current Year)
- Paid Claims By Service Category (Prior Year)
- Paid Claims By Service Category (Two Years Prior)
- Utilization Summary
- Medical Paid Claims Summary with Member Cost Sharing
- RX Paid Claims Summary with Member Cost Sharing
- Medical + RX Paid Claims Summary with Member Cost Sharing
- Discounts By Service Category
- Paid Claims By Member Type
- Paid Claims By Coverage Tier
- Medical Incurred Claims Lag Triangle
- RX Incurred Claims Lag Triangle
- Medical+RX Incurred Claims Lag Triangle
- Paid Claims PEPM and Twelve Month Rolling Average (Exhibit)
- Paid Claims PEPM and Twelve Month Rolling Average (Charts)
- Distribution of Claimants By Claim Size
- Cost Sharing and Oout Of Pocket Maximum Penetration
- Utilization By Service Category
- Hospital Inpatient Cost By MDC
- Hospital Inpatient Utilization By MDC
- Hospital Inpatient Cost - High Volume Hospitals
- Hospital Readmission Rates
- Imaging Utilization
- Utilization By Service Category By Paid Month PMPM - Rolling Twelve Months
- RX Summary
- Top Fifty Drugs and Therapeutic Classes
- Paid Claims By Clinical Risk Grouping
- Cost and Utilization By Disease
- Clinical Quality Performance
- Top Fifty Claimants
- Total Membership By Month By Age By Gender
- Subscriber Membership By Month By Age By Gender
- Trend Details

The list above can be customized in a number of ways – including groups, plan features, etc. Once updated it becomes part of the standard reporting.

We recommend SHAPE be updated monthly and used as a detailed tracking mechanism.

	Another data analytics report we provide, as previously mentioned, is the Dashboard. It provides a high level review of all the key cost drivers in the program. We currently do this reporting for a number of clients, including the North Carolina State Health Plan, Maryland Department of Budget and Management and most recently, the State of Connecticut. What is interesting to note it that they system can be used with or without loading the detailed data into our system. For example, the State of Connecticut uses a data aggregator and Segal runs our analytics within their system. Our dashboard is designed to have 8 panels and a "spotlight". The spotlight is intended to highlight an area of concern in the data and drill down on that component. In the sample Maryland report the spotlight was on Opioid Abuse. We've done a wide variety, including emergency room utilization, mental health, wellness and specialty medications. On an annual basis we can do a data forensic on the program. To do this we would utilize our health analytics report. We would also anticipate merging some elements of that report into the State's annual report. With the data and information load, Segal can do a wide variety of ad hoc/custom reporting. After it runs once, it could then be integrated into the monthly or quarterly package.

4. Benefit Plan Request for Proposals (RFP)

The contractor will assist the State in the preparation and evaluation process for all benefit plan RFP and in accordance with processes established by state statute and the State Purchasing Bureau. Services may include but not limited to develop the technical requirements, assist with questions from potential bidders, provide questions for oral interviews, develop scoring methodology, and conduct cost evaluations.

See Attachment D for the anticipated time line of the benefit RFP's.

a	***Describe the bidder's experience in assisting other customers similar to the State with RFP.***
	Response: Segal will provide consultation regarding the procurement of quality and cost-effective vendors that will assist with the administration of the State and its programs. Segal assists hundreds of organizations annually with vendor selection, negotiation, and management/maintenance. This is a core service our health practice provides our clients for all benefit types: ➢ Medical, including Medicare Advantage ➢ Pharmacy, including PDP/EGWPs ➢ Dental ➢ Vision ➢ Life Insurance

- Disability
- Ancillary Benefits (Hospital Indemnity, Cancer, Critical Illness, Accident, Long-Term Care, Universal Life, etc)
- Flexible Spending Accounts

Working with clients on such efforts has been one of our firm's core services since its founding in 1939. Many of the generally accepted techniques involved in the competitive bidding process were developed and have been perfected over the years. In the 1960's, we developed a formalized method of searching for group health insurance through a uniformed, detailed specification letter, objective analysis of responses and negotiation with desired alternatives. Many large insurance carriers developed their bid response techniques based on our specification letters.

More recently, we have incorporated the software tool Proposal Tech, which enables us to efficiently submit uniform, detailed specifications and efficiently obtain detailed responses. This tool, developed by an independent third party software firm, is accepted by most major insurance carriers and broker-administrators. It provides software to automate the RFP bidding and analyses processes that are performed on behalf of the benefits program and has the capability to attach necessary data required by a broker-administrator or insurance carrier or other vendor in order to calculate and provide competitive quotations. This has been used with numerous public procurements, most recently with the Alabama Public Education Employees' Health Insurance Plan (PEEHIP).

We have a rigorous RFP process that we use when procuring large State programs. This serves as a foundation for to custom build a RFP to solicit the best responses possible from the market.

We will also incorporate the requirements in Nebraska and the nuances of the State.

Development and Evaluations of RFPs – Our Approach

The following is a step-by-step description of the complete procurement process. We are capable of "running the show" and handling all aspects of procurement, or providing targeted support on an as-needed basis. We will work with your procurement staff to provide the required level of assistance and ensure the process is compliant with the State's procurement protocols. Based on the specifications of the RFP, we are prepared to provide RFP/procurement support for your medical, pharmacy, wellness, dental, etc.

Step 1: Planning Meeting



The first step on the proposal process is to meet with the State and decide upon future plan benefit objectives. The first step is to develop a detailed RFP (or RFPs) based on your benefit strategy and proposed plan design. We will rely on our knowledge of the Nebraska marketplace, as well as other bid projects and evaluations to develop this RFP.

The purpose of the planning meeting will be to:

- Clarify the State's objectives and requirements of the successful bidder(s).

- Develop and establish the selection criteria.
- Begin the selection process of appropriate vendors to participate in the RFP.
- Update the proposed project timeline with key dates.
- Discuss further the State's contractual requirements.
- Begin to gather the necessary information for sending an RFP to the market.

We will follow-up with meeting notes to document the decisions made. Following this meeting, we will prepare a request for detailed claims and benefit plan information needed to support the process.

Step 2: Identify Criteria, Develop Detailed RFP & Release



We will prepare a detailed set of technical questions and financial templates for the RFPs, based on the plan designs desired by the State. The RFPs will include:

- Details of the requirements to be met by the vendors. We will include any contract terms that the bidders will be required to agree to as part of their proposal. We will also identify data transmission requirements.
- Instructions for bid submission.
- Detailed information about the State's benefit plans. This will include the current plans and any proposed plans. Current plans will be necessary in order for the vendors to interpret historical data properly.
- Summary of demographics and background information on the State's covered population.
- Required mechanism for pricing the plan - insured and/or self-insured or self-insured with Stop Loss insurance.
- Any guarantees that might be required upfront.
- Detailed list of the services the bidder is expected to perform, including administration, network access, care and disease management, wellness, reporting, administration and communications.

Our specifications are prepared by customizing standard materials developed and continually updated by our National Health Practice. These standards help ensure that bid specifications are comprehensive and well organized, and reflect the most current benefit and vendor information. Segal has company-standard specifications for all types of health and welfare benefits RFPs.

Specifications include a detailed questionnaire, as well as financial bid forms designed to ensure that information provided is complete and comparable (from one bidder to another). In addition, we will request multiple year contracts and report on the financial soundness of the proposing institutions.

We would submit the RFP to the State staff for review and comment (and modification, if necessary) prior to distribution. After the RFP has been distributed, we will assist with responding to any inquiries for additional data and clarification.

Identification of the Vendor Market

With an understanding of the State's goals and objectives for a particular vendor marketing, Segal will use our extensive market knowledge to help you determine an appropriate target list for initial distribution.

We will also assist the State in developing the appropriate qualifications and reference requirements to ensure the target market responds and under-qualified firms will find it difficult to "buy the business" with an aggressive cost proposal, but not have the expertise or support structure required to truly service the State and the membership. With these procurements being publicly advertised, this is especially important.

Segal maintains a comprehensive directory of carriers, administrators, and other vendors related to health and welfare benefit plans. This directory is updated frequently to ensure that company names, offerings, and appropriate contacts are current. We will work closely with State to make sure that all likely bidders are notified once the RFP is published. We will encourage carriers to participate in the bid process, while always assuring that the State's procurement department has full knowledge of any contact we have with a carrier. We will refer the carriers to the State's procurement officer for the bid to answer any questions they may have.

Below is a list of the major vendors we help our clients select and manage:

Blue Cross Blue Shield	OptumHealth	Staywell
CIGNA	OptumInsight	US Preventive Health
United HealthCare	Truven	SHPS
Aetna/Coverntry	HCC	Allstate
Kaiser Permanente	Loomis	Hartford
HumanaVitality	VSP	ING
Anthem	MetLife	Liberty Mutual
Express Scripts	Alere	Mutual of Omaha
CVS/Caremark	APS Healthcare	Prudential
Catamaran	Virgin Healthways	Transamerica
OptumRx	Magellan	Unum
Navitus	Value Options	Lincoln Financial Group
Delta Dental	POMCO	Sun Life Financial
WageWorks	Sterling Life	Reliance Standard
Standard Life Superior Vision	PayFlex EyeMed	AFLAC The Standard
Humana	Health Dialog	New York Life
Optimus	Living Well	Cotton States Life
MedImpact CastLight	Active Health ADP	Verisk NVA

Colonial Life	Combined Insurance	Voya (ING)

The marketplace is dynamic and constantly changing. There continues to be mergers, acquisitions, and new entrants to the market. We will make sure all potential vendors are included.

Step 3: Collect Proposal & Interact with Bidders



Interaction with bidders after the proposal is released to the market can be labor-intensive, but is essential to ensuring that proposals are complete, accurate, and competitive. We expect to work within the State's purchasing rules and with the State's Purchasing Department.

Pre-Bid Conference-Generally we recommend a "bidders' conference" at which potential proposers may present their questions. We frequently are asked to organize and host such conferences and plan to do that for the State. Questions and answers addressed in the bidders conference will be documented in writing for subsequent distribution to potential bidders.

Q & A-We also recommend a period of time following the bidders' conference in which written questions from potential bidders will be addressed. We require that interaction with bidders be conducted in writing so that we may share questions and answers with all proposers, thereby ensuring a fair, disinterested process.

After we collect all of the proposals, we will request supplemental data from the carriers, if necessary, and ensure that all bidders meet minimum qualifications. If any red flags are noticed during this phase we will provide the State with updates and analysis points during our initial review of all submitted proposals.

Step 4: Evaluate Proposals



We will assist in the development of an evaluation tool for this analysis as well as assist in the actual proposal review and evaluation. We will compare and analyze all responses, focusing on financial issues such as claims processing fees and network access fees (self-funded), and premium rates (fully insured) guarantees. We also will review the non-financial, qualitative issues identifying the relative strengths and weaknesses each organization possesses in its ability to administer the health care program.

We will meet with you and the selection committee to review the results of our proposal review. Steps in the evaluation typically include the following, along with more specific criteria based on the type of plan being solicited:

- Completeness, accuracy, and thoroughness of the responses
- Network discount analysis

- Provider access
- Competitiveness of the financial quotations
- Responses to key questions

At the conclusion of this meeting, we should be able to identify the best overall bid. If finalist interviews and solicitation of best and final offers or follow-up negotiations are included in the process, we provide assistance in these areas as well. We will also help the State with reference reviews, if needed for the bid.

During this step, we will work with the vendors as permitted by State laws and procurement requirements to resolve any questions or discrepancies in their proposals. The proposal has requested that we act as a technical resource for the evaluators of the RFP responses.

Determining "True" or "Net" Costs

For the self-insured program, like Medical, PBM, Dental, Vision & MHSA procurements present the most difficult cost analysis. Segal will conduct a thorough analysis to make sure the "true cost" or "net cost" is accurately determined. An error in this section can have devastating effect on the financial viability of the program.

Segal uses several approaches to analyze effective discount rates on health claims. Each approach has some advantages and limitations; so Segal prefers to use a combination of analyses to ensure the most accurate picture of our client's potential costs based on:

- ***Claims Repricing by proposing vendors***-In this approach, 6 to 12 months of claims detail is provided by the current vendor. Competitors are then asked to reprice the claims so that comparisons between vendors can be made. This approach can be gamed unless your consultant provides detailed direction on how the analysis is to be performed, identifies the appropriate matrix for reporting the results of the repricing, and requires officer sign off by the vendor on a list of criteria under which the repricing was performed. Results are typically presented on a product basis, show in-network utilization and effective discount rate.

- ***Procedure Code Analysis***-In this approach, a list of specific procedures and facility admissions by diagnosis are provided to the vendors for pricing for each three digit zip code where a significant client population resides. Then, using the service provider's stated discounted rates for those major diagnostic categories (MDC's) for those geographic zip codes, we compile a comparison to other service provider's stated rates and the rates used by the Centers for Medicare and Medicaid. This analysis validates stated discount rates by comparing them to the service provider market place, and uses the baseline of the CMS rates as a universal comparative. We follow a similar process for hospitals.

- ***Self-Reported Discounts***-In this approach, vendors are asked to provide the average discount off billed charges by provider type, i.e., primarily specialist care, surgery, in-patient, out-patient, lab, etc. A weighted average discount can be developed for comparison purposes. In this approach, it is critical that the consultant be experienced and knowledgeable about actual discount outcomes so they can evaluate the quality of the data received. Segal does not rely on self-reported discounts, but does use them as a "reality-check" to validate our own analyses.

The approach above varies slightly for the different product lines being procured. The final determinate always weights fee based submissions with self-reported discounts, comparing both

to our national data warehouse and known published sources.

Provider and Network Matching

Access to providers is a critical feature in the design of any benefit program. If employees and their dependents cannot readily access physicians (both primary care and specialists) and hospitals, dentists, psychologists, ophthalmologist, pharmacists, etc, they are unlikely to use the network to best advantage, thus seriously compromising the program's ability to achieve long-term savings and member satisfaction.

In determining appropriate network access for employees, the State may want to consider these approaches:

- Allow the bidding networks to provide their own "network match" analyses, based on geographic data you would include in the RFP. This approach costs the you nothing, but may not be 100 percent accurate based on the network's varying definitions of a "match" and varying levels of sophistication in matching software. As an alternative or supplement, we could conduct a "network analysis" match using our GeoAccess software.

- To supplement the network matching analysis, we can conduct a disruption analysis. We can assist you in calculating how much provider change would be required if you changed networks.

The approach will need to be modified based on the product being procured. Many optional benefits will not require a network at all, making this step obsolete.

Step 5: Prepare Report of Findings



The result of our proposal evaluation is a summary report highlighting key findings and presenting the detailed evaluation of components of bidders' financial proposals. Our report will include:

- Detailed summary of pros and cons of each bid
- Scoring, for technical and financial and overall scoring
- Recommended follow-up questions for additional clarification
- Recommendations for finalists, and for topics to be addressed at the finalist stage

At the conclusion of the bidding process, our report will ultimately serve as a complete document of the process, including subsequent events and developments including the Best and Final Offer and negotiation phases.

Step 6: Interviews & Finalist Process



After finalists have been identified, we will coordinate the interviews, including. Interviews are typically 1 to 2 hours in length. Working with you, we will facilitate the timing, agenda and logistics. We will attend all meetings and facilitate interaction, when and if required. The interview will allow the State to verify the finalists' services and capabilities beyond the written word. Segal will work with staff to develop vendor-specific meeting agendas and be available to facilitate such meetings, if requested.

Following finalist interviews (and sometimes before), we ask the vendors to prepare "best and final" offers. This process is usually focused on pricing arrangements, but also includes the following:

- ***Performance guarantees*** - these include the standard claim and service guarantees. Although from a contracting perspective these are important to have in place, in our experience they are not a driver of performance.
- ***Cost, trend, and ROI related guarantees*** - we have seen a greater willingness for healthcare providers to provide these kinds of guarantees to larger organizations, like the State. These types of performance guarantees need to be negotiated carefully, as the vendors frequently set a low bar for performance.
- ***Implementation credits*** - most of the vendors, in our experience, are open to providing funds for implementation and post-implementation audits.

Following the analysis of the final offers, we will work with the State to select a winner. We will also conduct any final negotiation that might be required prior to award.

Step 7: Award Contract



Once a preferred vendor is determined, we will assist the State in confirming the decision.

At the end of the evaluation and assessment phase of the solicitation, employers typically begin the process of finalizing the vendor selection. While the "best" vendor for your situation may have been identified, or may currently exist, there are usually a substantial number of details to be resolved and changes to be made to the initial proposal or renewal. Therefore, the two main activities inherent in vendor selection and renewal are negotiation and contract development. Segal proposes to assist the State in this important phase of the project with both of these activities; our extensive negotiation experience in all benefit lines, with all types of employers and vendors, will yield positive results to the State.

Vendor negotiation – Traditionally, negotiation with the potential "winner" of the solicitation or the existing vendor centers on four types of issues:

1. ***Program requirements*** – Frequently, employers need to make modifications to the standard programs (or handling) proposed by the vendor. These modifications may be administrative; for example, regarding banking arrangements, or establishing an Open Enrollment hotline number. Alternatively, the modifications may be operational; such as the requirement for a dedicated claim processing or customer service unit, or special coordination procedures with carve-out vendors. Alternatively, changes may be needed to the reporting package offered by the vendor. While not meant to be exhaustive, these examples illustrate many of the necessary program characteristics that deviate from the standard process offered by the vendor and therefore, need to be negotiated before final vendor selection.

2. ***Performance standards*** – Performance standards, like program requirements, may be desired or needed to focus proper vendor attention to important aspects of the program's operation. For example, claim processing performance standards typically address speed and accuracy requirements; customer service standards relate to telephone and correspondence speed; administrative standards usually require defined performance levels for delivering materials to the employees such as ID cards and certificates or descriptions of coverage.

3. ***Rates/fees*** – Negotiation is frequently used to obtain more favorable rates (for insured business) or fees (for self-insured business) for the employer. Typical negotiation strategies are too numerous to mention, but in general, include attempting to lower rates/fees directly or to employ rate guarantees and/or multi-year guarantees to save money for the employer. Segal, with its network of local offices throughout the U.S. and extensive experience in this area, can suggest alternate approaches and reasonable expectations based on past experience with either that vendor or similar vendors.

4. ***Contract review*** – As the final element in vendor selection and eventual business award, it is necessary to review and finalize the contract with the selected (and "negotiated") vendor. Our role, at Segal, is to assist the employer in finalizing the contract by relying on our experience and skill to alert the employers to possible problems, poorly defined situations, or favorable alternate handling.

Segal will update our summary proposal evaluation report, confirming the final vendor selected, and supplement the material with our interview and site-visit notes, and the outcomes of finalist negotiations. We will present this report to the State, as requested, and be prepared to respond to any questions that may arise. We will also provide support to the State, as is necessary, in notifying unsuccessful bidders and other interested parties that a contract has been awarded, summarizing the decision and award processes and assisting the State in responding to legal or administrative challenges that may be brought by unsuccessful bidders.

Preparation of materials for presentations to the appropriate constituencies, including the Board of Commissioners. Any needed follow-up research or correspondence

Step 8: Implementation



Segal will work closely with the State staff and the selected vendor to ensure the target implementation date is met. A smooth transition from the incumbent vendor to the new vendor is critical. To achieve this goal, we pay close attention to the following:

- ***Data transfers*** – We work with the incumbent vendor to ensure that data provided is completely up to date and accurate, and that it transitions fully to the new vendor's systems.

- ***Transition of care*** – These are often sensitive issues that involve developing approaches that are satisfactory to both vendors and that meet employee needs.

- ***Employee communication*** – We develop communication materials that help employees understand the transition and navigate it successfully. One important element is ID cards. These must be issued in a timely way so that no participant is left without access to coverage.

- ***Run-out claims*** – Segal will negotiate an approach and timeframe that is satisfactory to the State and to both vendors.

As the implementation date approaches, Segal will be available to work with the State staff and the vendors to address any issues that arise.

The process discussed above can be modified to reflect the employer sponsored benefit being procured. Our consultants, actuaries and technicians are highly experienced in providing procurement and RFP support for the procurement of all vendors, carriers and administrators necessary for your benefits program.

In summary, the Segal has the expertise and experience needed to support the State in procuring the best administrators, carriers and vendors to optimize the financial, administrative and operational performance of the State.

Tools Used in the RFP Process

Segal's health care consultants utilize several analytical tools to support the RFP process. We customize our vast array of technical resources for your specific needs, ensuring that we provide the high level of quality consulting that our clients expect and to support our client's decision making process. Segal is on the cutting edge of health care industry trends and relevant legislation, and we update and revise our tools, as needed, to provide maximum value to our clients.

We have at our disposal several analytical tools and resources to support our engagements as may be appropriate, including:

- **Proposal Tech (Electronic RFP Tool)**-This software automates health RFP bidding and

analyses processes. The system has the capability to attach necessary data required by a third party administrator, insurance carrier or vendor in order for them to calculate and provide competitive quotations. This tool allows client access to watch the process unfold and expedites correspondence with vendors as well as revisions to the RFP as necessary.

- **Discount Analyzer**-This tool was developed to create a standard and uniform method for comparing various physician fee schedules in a way that is statistically valid, informative and easy to understand. This is accomplished by comparing multiple physician fee schedules to a common point of reference that is widely known and accepted, Medicare reimbursement levels. This tool also has the ability to break down fee schedules into 28 separate service categories, allowing Segal to detect schedule inconsistencies and/or isolate services of interest.

- **Disruption Modeler**-The model is developed to support our analysis of the bidder networks. The results represent the amount of services or claims that would be "disrupted" as a result of not being in the other carrier's network

- **Performance Guarantee Standards**-While vendors generally are willing to provide performance guarantees and to back them up with specified dollar "penalties" if they should fail to meet the required standards, many vendors have not been asked to include such guarantees of their performance. The objective is to develop performance guarantees that are meaningful and useful to the client, and are measurable. The developed guidelines were prepared to assist Segal staff and the client to accomplish this

- **Industry Pricing Database**-We have access to all industry standard pricing databases, (e.g., Medispan), so we can accurately and independently reprice claims

- **National Claims Database**-Segal is one of a few major consulting firms to purchase claims and discount data from the major healthcare providers. This data is routinely updated and can be used for client specific discount analysis and benchmarking

- **Stop Loss Deductible Modeler Customize Stop Loss Deductible** - Stop Loss Deductible Modeler generates customized stop loss deductible suggestions for your plan based on each client's risk tolerance and reserve position.

- **Scoring Methodology**-Segal developed a robust scoring methodology that is designed to differentiate proposers' capabilities in a number of areas. This methodology is customizable to each client's priorities for a vendor

Segal uses several approaches to analyze effective discount rates on medical claims. Each approach has some advantages and limitations, so Segal prefers to use a combination of analyses to ensure the most accurate picture of our client's potential costs.

We are highly sensitive to client objectives and the specific evaluation criteria of greatest importance to the client. One example of a discussion guide used with a client to help prioritize the evaluation process follows:

Vendor Transition Assistance

When plan sponsors change and provider networks, Segal is often involved in the implementation process as advisor and client advocate. We find it most appropriate for the client and vendor to drive the implementation process so that each organization takes ownership of critical administrative processes. A Segal Consultant usually participates in weekly status calls with the new vendor and client during the implementation process.

Our proposal to the State assumes that Segal would be involved in the vendor implementation milestones shown below.

Vendor Implementation Milestones	Timing
Review Negotiated Financial Terms and Performance Guarantees vs. what the Vendor Documents in the Implementation Process	Weeks 1 – 2 during pre-implementation
Negotiate and Provide Oversight Relative to Run-out Claims administration and stop loss insurance filings with Terminating Vendor	Pre-implementation to 6 months after implementation date
Coordinate Transfer of Information from Prior Vendor to New Vendor (i.e., deductible and lifetime maximum accumulations, care in progress, disease management participation, etc.)	Week 3 during pre-implementation
Coordinate ongoing information transfer (i.e. PBM to carrier for predictive modeling)	Week 5 during pre-implementation
Review vendor's new member orientation plan (i.e., call center welcome calls, letters of introduction, ID cards, meetings, etc.)	Weeks 7 – 9 during pre-implementation

Communication Services

Employee communication strategies are critical in facilitating not only plan design changes, but also behavioral changes for employees making health care purchasing decisions. Segal's National Communications team of more than 30 professionals has extensive experience in managing complex benefits communications initiatives, branding, and projects that leverage multiple media for clients across the public, multiemployer, and private sectors. Our diverse public sector client list utilizing communications services includes the Chicago Transit Authority; County of Alameda; Pennsylvania Public School Employees' Retirement System; the Universities of Oklahoma and Alaska; Iowa Public Employees' Retirement System; the Cities of Chicago, Tempe, Arizona, and Springfield, Missouri; the Coalition of Tennessee and many more. Our experiences with these clients and many others provide us with the subject matter expertise, lessons learned and technology to ensure flawless execution of our project work.

5. Legislative and Regulatory Analysis & Education

The contractor will assure the State is informed of any regulatory laws and changes which affects the State's employee benefit program. Services include:

a. ***Provide guidance, impact analysis and training on all regulatory requirements which affect the State's benefit program. This includes COBRA, ACA, HIPAA, Section 125, IRS, and any other employment laws which affect the State's benefit programs.***

b. ***Keep the State informed of pending and final federal and state legislation which may affect the State's employee benefit program.***

c. ***Provide guidance and training to the State to assist them with complying with the Affordable Care Act.***

d. ***Assist the State with preparing fiscal notes as requested while the Legislature is in session.***

a	***Explain how the bidder educates their customers of updates and changes to ACA regulations. What resources are available specific to ACA?***
	Response: Segal staff are also available to provide a range of training for clients, developed and customized to your specific needs: from a one or two hour session to a week-long session; from specific groups, such as benefits staff or managers to large groups of employees; from orientation of a new employee benefit plan or program to training human resources personnel on use of an employee survey tool. Segal gathers and reports information to clients in various formats, depending on the context of the information. This typically includes contacting clients directly, Segal-hosted educational seminars (or webinars) and several regular Segal publications. ➢ Important and breaking benefits-related issues are communicated to our clients through special issues of Update, a periodic Segal's publication, which provides a concise description of pertinent legislative or regulatory matters with a discussion of the possible implications for our clients' benefit plans. It also summarizes important legislation and regulations concerning administration and compliance on health issues. Examples include: o 2017 Minimums and Maximums for Health Savings Accounts, May 2016 o New Summary of Benefits and Coverage (SBC) Template Released, April 2016 o GASB's Updated Accounting Standards for Other Postemployment Benefits (OPEB), February 2016 o New Guidance on the Mental Health Parity and Addiction Equity Act, December 2015 ➢ Segal conducts external webinars on pertinent topics for our clients to educate them on any developments or guidance. Recent examples include: o Strategies for Coping with the 40% Excise Tax on High-Cost Plans o The Cost of Healthcare: Findings from our 2015 Segal Health Plan Cost Trend Survey ➢ Segal's website serves as a central resource of valuable information and tools for our clients. Webinars and events featuring timely topics, trends, and legislation are listed on

our site. Segal publishes an array of newsletters, surveys and other informative publications on a variety of topics, ranging from annual HRA min/maximums updates to the HIPAA Privacy and Security Audit program announcement. These publications, including archives and articles by Segal experts, are available to our clients through the website.

Segal provides multiple resources to apprise our staff of developing issues, including internal webinars, emails and memos, to provide background information, issues and where applicable, guidance to assist our clients in addressing these new developments. When late-breaking developments can potentially affect a client, our consultants alert clients by telephone, letter or both. Consultants notify their clients as to the relevance and possible impact of a new statute, regulation or other technical release, on a client's plan and discuss possible design options and/or procedures that may be utilized to comply with required changes.

Questions arise on an ongoing basis from our clients in their day-to-day operations, particularly relating to COBRA, HIPAA, dependent eligibility, such as unusual circumstances, conflicting provisions and vague wording. Our Compliance Specialists have significant experience working through implementation issues, including development of materials, on-site training and follow-up questions dealing with the finer nuances of these issues.

Our Compliance Specialists will be involved in the ongoing work performed, providing input from the compliance perspective. In addition, we encourage our clients to work directly with our Compliance Specialist whenever a question arises about an issue that can affect their plan. When legal issues arise, we do advise our clients to supplement the information and observations that we offer by looking to their attorneys for authoritative legal advice.

Client Training

Segal's Compliance staff is prepared to provide assistance and training to the State, if requested. This can range from a discussion with your staff to providing new written processes and procedures, a complete administrative manual, and on-site training of your staff on new technical issues. The extent of the support is dependent upon the nature of the issue. We have conducted training sessions for clients on HIPAA Privacy, which are tailored to the needs of the audience. We have performed high-level training for upper management (one hour), as well as detailed training of benefits' staff (one-half to full-day), addressing the specific rules for maintaining, sharing and storing Protected Health Information (PHI), authorization requirements for customer service staff, rules relating to the right to access or amend PHI.

We have provided training sessions on numerous other issues, including COBRA administration, Working Families' Tax Relief Act (dependent eligibility), USERRA requirements (veteran's rights relating to benefit plans).

Affordable Care Act/Patient Protection and Affordable Care Act (PPACA)

Our website contains Segal's Health Care Reform Resources, which provides updates on the latest legislative developments and guidance on how health care reform will affect your plan.

We have worked with our health fund clients since the passage and signing into law of the Patient Protection and Affordable Care Act (PPACA). Starting with assistance in applying for reimbursements under the Early Retiree Reimbursement Program, we worked with each of our

	health clients to ensure that they complied with the immediate eligibility and benefit mandates. The changes contained in this legislation have staggered effective dates over the next several years and we are currently in the process of advising clients of changes required for 2013 and extending lifetime maximum waivers, if applicable. We will work with the State to model the potential impact on your plans of the Premium Assistance Tax Credit, Health Insurance Exchanges and the potential liability for the Excise Tax in 2020, including providing plan design modifications to mitigate the tax liability. Our ongoing approach during this time of rapid changes and issuance of agency regulations is to continue to keep an eye on reform progress while we help our clients identify and develop responses that make the most sense for their individual plans. We believe it is important to view the new laws as a series of changes that require not only an initial response, but ongoing review, reassessment and program changes as new provisions become effective. Our objective will be to help the State focus on practical modifications to the programs to meet the immediate legal changes and to begin the process for future changes. For our state clients we also program our system to track any legislation, brief, newspaper article or published information. We alert the client team of the issues and link in our client. This is a valuable service that helps our clients be aware of emerging issues.
b	***Describe how the bidder stays updated with Federal and State regulations which affect employee benefit programs.***
	Response: Segal's benefit consultants are fully trained in, and have extensive, practical experience providing our clients consultation related to compliance with all federal and state laws and regulations. In addition, your service team includes local compliance experts and is fully supported by Segal's National Compliance Practice, which regularly provides our clients, consultants, and analysts in-depth technical research and information on current and pending federal and state laws and regulations that may affect our clients' benefit plans. Segal continues to make a sizeable investment in legislative and regulatory research on benefits, compensation and human resource topics. We actively help our clients identify legislative developments and compliance issues and monitor pertinent federal and state legal and regulatory developments through daily review of specialized trade publications such as the BNA Daily Tax Report, Health Care Daily and weekly Pension and Benefits Reporter, Tax Notes Today, and Inside CMS. In addition, we monitor the release of pertinent government material, and have prompt access to all official documents such as proposed and final regulations, Revenue Rulings, and bills introduced or acted on in Congress. When late-breaking developments can potentially affect a client, the consultants involved alert the client by telephone, letter or both. Consultants notify their clients as to the relevance and possible impact of a new statute, regulation or judicial decision on a client's plan(s) and discuss possible design opportunities. However, because Segal does not practice law, if a legal issue arises, clients are advised to supplement the information and observations that we offer by looking to their attorneys for authoritative legal advice. Clients are encouraged to contact Segal staff members who are familiar with their work whenever a question arises about an issue that can affect their plan. **Employee Training** Yes, our employees are our most valuable asset and development of our employees is an

investment not only in their future, but also in the future of Segal.

Some of Segal's Learning and Development Programs are:

- Robust Onboarding program for new employees
- Time management, presentation techniques, business writing and negotiation skills
- Leadership and management development for senior managers

In addition, we offer the following specialized/professional credential training:

Actuarial and Investment Consulting

Segal considers the attainment of professional credentials to be an important element of a successful actuarial career. To encourage the passing of actuarial and other professional credential exams, the company provides support and financial rewards through its exam program and periodically reviews this program to ensure its relevance to the professional credentialing requirements and the professional industry.

Segal has a Director of Actuarial Continuing Education, who arranges a Technical Actuarial Meeting each year, as well as other professional development opportunities, which help actuarial staff meet continuing education requirements.

Health Practice Training

Segal's Health Practice offers a Continuing Education Program to support our ongoing commitment to the training and development of our health staff. The program offers a comprehensive variety of over 50 technical and educational courses for analytical health staff and consultants. Each health practice staff member is required to complete several hours of training.

Insurance License Continuing Education

Segal consultants who provide consulting services to health clients must maintain appropriate insurance licenses. External trainers and programs ensure Segal employees meet the continuing education requirements for license-holders.

c	***Describe tools and resources available to help stay compliant with all federal and state regulatory requirements.***
	Response:

Segal's benefit consultants are fully trained in, and have extensive, practical experience with providing our clients with the highest level of advice and assistance on a continuing basis to ensure that their benefit plans are in full compliance with all federal requirements, including, but not limited to, the Internal Revenue Code, Department of Labor regulations and individual state laws and regulations. We identify legislative developments and compliance issues and monitor pertinent federal and state legal and regulatory developments through daily review of specialized trade publications such as the BNA Daily Tax Report and Health Care Daily and weekly Pension and Benefits Reporter, Tax Notes Today, and Inside HCFA.

	The assigned Compliance team, who is comprised of two (2) national level compliance experts and one (1) local compliance expert, will serve as a resource to the State. We encourage our clients to contact Segal whenever a question arises about an issue that can affect their plan. However, because Segal does not practice law, if a legal issue arises, you should supplement the information and observations that we offer by consulting with your attorneys for authoritative legal advice. In addition, our Washington-based staff of health and pension law experts maintain close relationships with government agencies and this allows them to follow legislative developments and be able to alert clients and respond to questions quickly and efficiently. Segal's compliance experts have wrote and serve as ongoing editors to the Employer's Guide to HIPAA Privacy Requirements (Thompson Publishing Group, Inc.) and serve on the advisory boards of multiple employee benefit publications. In regards to compliance tools, for example, Segal has developed a number of pricing tools to help clients assess the impact of the Patient Protection and Affordable Care Act (PPACA), including: ➢ Early retiree reinsurance subsidy; ➢ Expansion of dependent coverage to age 26; ➢ Evaluating maximum plan changes for the decision on maintaining grandfathered status; ➢ Removing annual and lifetime dollar limits; ➢ Coverage of preventive services without any cost sharing in-network; and ➢ Modeling impact of state health exchanges and federal subsidies. Segal can also provide a full-service compliance review through our proprietary methodology called Crosscheck, if the State would like us to perform an optional in-depth compliance service. In a Crosscheck assessment, specially trained Segal experts conduct an operational, administrative and document review of the client's administrative procedures to help them, their Benefits Department, and their legal counsel determine whether plan operations meet all legal and regulatory requirements and are consistent with what the plan promises.
d	***Provide two (2) examples of recent training the bidder offered to their customers?***
	Response: Below are two (2) examples of where Segal provided recent compliance training to clients. *Example #1* Segal's Compliance Practice out of Washington D.C. conducts monthly "ACA Compliance Series" WebEX meetings for all Segal Health Consultants and employees throughout the U.S. The Compliance Practice conducted these in 2014 and will continue the series in 2015. In addition, our Compliance Practice also provides our Consultants with internal memos and presentations that include more detailed analysis of specific portions of the ACA (e.g., non-calendar year plan transitional relief, verification of health plan enrollment in 2014, excise tax, etc.). In addition, presentations and internal memoranda are developed to expand on particular issues and are made available to all employees. Some of the topics included:

- 2015 Premium Assistance Tax Credits
- ACA Excise Tax Forecasting
- ACA Affordability Safe Harbors
- ACA and Retirees
- Affordability of Group Health Plan Coverage under the ACA
- Application of the Employer Shared Responsibility Provision on Employers with Non-Calendar Year Plans
- Churning Issues – When Do Participants with Employment-Based Coverage Interact with the Health Insurance Marketplaces?
- Comparison of PCORI and Transitional Reinsurance Program Fees under ACA
- Employer Shared Responsibility Final Rule
- Excepted Benefits and Proposed Limited Wraparound Coverage
- Identifying Full-Time Employees under the ACA Using Look-Back Methodology
- New Rules for Wellness Programs
- Pediatric Dental and Vision under ACA
- Reporting under Code Sections 6055 & 6056
- Transitional Reinsurance Program Fees – Counting Methods and Supporting Documentation

As the complexities of the ACA landscape continues to change and evolve, we recognize the importance of keeping our Consultants informed to better serve our clients. A sample set of webinars provided to our client's are listed below. These webinar's are still currently on our website, www.segalco.com.

Segal Public Sector ACA Webinars

Date	Webinar Recording
July 2011	The New Health Benefit Marketplace – Exchanges and Beyond
July 2012	Moving Forward with Health Care Reform: The Ball is Back in Your Court
November 2012	What Health Exchanges Mean to Plan Sponsors and Plan Participants

March 2013	Shared Responsibility Penalties Under ACA: What Public Employees and Plan Sponsors Need to Know BEFORE January 2014
June 2013	Straight Talk on Exchanges: The Questions Participants Ask, The Answers You Should Give
April 2014	Retiree Health Benefits and ACA
May 2014	Employer Shared Responsibility Rules and Reporting Requirements: What You Need to Know
July 2015	King v. Burwell: United States Supreme Court Upholds Affordable Care Act Subsidies in all States
September 2015	ACA's Bid Issues – Strategies for Coping with the 40% Excise Tax

Example #2:

Fulton County Government, Georgia

On September 11, 2014, Segal Consulting conducted HIPAA privacy training for Fulton County, Georgia. The training was led by Joel Stouffer, Senior Compliance Consultant, for more than 40 employees in Fulton County's Finance and Human Resources Departments. A "refresher" training was conducted on March 23, 2015.

These training sessions addressed basic HIPAA privacy concepts (such as, who is subject to HIPAA, what information is protected under HIPAA and which benefits/plans are regulated by HIPAA) as well as broader HIPAA issues (such as, permissible uses and disclosures of protected health information, administrative requirements and individual rights).

In addition, the trainings focused on more recent HIPAA privacy developments (including the Health Information Technology for Economic and Clinical Health Act or HITECH and the final omnibus rule and enforcement of HIPAA privacy), as well as, the County's own privacy policies and procedures.

Technical Approach – Technical Requirements - HIPAA

Segal is not a Covered Entity under the Health Insurance Portability and Accountability Act (HIPAA), although it may, at times, be acting as a Business Associate to HIPAA Covered Entity health plans. Earlier in our proposal, we have reviewed and agree to the following HIPAA Business Requirements:

- Segal certifies, as well as any subcontractors we would utilize, are/would be in full compliance with HIPAA's regulations protecting the privacy of individually identifiable health information; and
- We agree to sign the State's Business Associate Agreement, however, we do ask the State reviews our suggested modifications to the State's current Business Associate Agreement.

Segal is committed to meeting the requirements of Business Associate Agreements into which the Company enters. We have carefully analyzed the impact of HIPAA on our client relationships and have implemented a HIPAA compliance program. We have appointed a HIPAA Steering Committee and an Office of the Privacy Official that have devoted substantial resources toward assessing the use of health data and implementing privacy protections. In addition, outside experts have assisted us in assuring that individually identifiable health information will be protected and secure.

In addition to our internal compliance efforts, we are working to assure that HIPAA does not prevent our clients or us on behalf of our clients from obtaining all of the health information necessary to conduct business. We have held internal strategy meetings to assess HIPAA's impact on information sharing between vendors and clients and have developed techniques to assure that HIPAA does not hinder the receipt and transmission of necessary information. We have developed encryption capabilities that can be easily utilized by clients and vendors when individually identifiable health information is transmitted electronically between Segal and clients and vendors.

Again, to the extent that we use individually identifiable health information to provide consulting or actuarial services to a health plan, Segal is a Business Associate under the HIPAA Privacy Rule. Accordingly, we are providing our standard Business Associate Agreement. As indicated above, Segal is not a Covered Entity under the HIPAA Privacy Rule. It also does not engage in any Covered Transactions on behalf of a client that would require it to be compliant with the HIPAA Electronic Data Interchange (EDI) rules.

Security measures include:

- All network infrastructures (servers, SAN, switches, routers, and related equipment) are housed in secure and environmentally controlled data centers.
- Physical security is controlled by card readers, which limit access to members of the Information Technology Department.
- The WAN is a private network available only through physical access within Segal offices and secure remote access.
- Internet Access gateways are protected by industry standard Checkpoint Firewalls.

- All Segal staff has a unique user ID and password that allows access to network resources as appropriate for the performance of their job.
- Periodic password changes are forced by the system and complex password requirements are enforced.
- All PCs are protected by Intrusion Prevention Software. All PC hard drives are encrypted to prevent exposure of data in the event of lost or stolen equipment.
- Employees were required to undergo refresher security training during the first quarter of each new year, and security training is provided for new hires on an ongoing basis.
- Employees are required to report privacy and security issues or incidents to Segal's Office of the Privacy Official. Members of the Office of the Privacy Official, in conjunction with office management and practice management, work quickly to understand and assess the possible issue or incident, and then act to make certain the issue is ended and the appropriate corrective procedures are followed in accordance with the governing rules and our client's contract. Such actions may involve notification, retrieval of data, and/or development of a change of procedure, among others.

Subcontractor Use with the State of Nebraska

Segal does not plan to subcontract any part of the work on this engagement as currently defined. Should a need arise to engage a subcontractor during the course of work on the project, we will discuss that need with the State and request prior written approval before engaging the subcontractor or committing to the work.

Implementation Plan

As part of the proposal, the bidder shall provide a plan detailing the implementation timeline. The plan shall define responsibilities assigned to the contractor and responsibilities assigned to the State. Implementation must be completed by September 1, 2016.

Your senior account team will be fully engaged during implementation. The Project Manager, Patrick Klein, will also serve as Implementation Manager. Patrick will work closely with Ken Vieira (Account Manager) and Kirsten Schatten (Lead Actuary and Backup Account Manager). With Patrick's project management skills and Ken's experience transitioning accounts, we would foresee a very smooth implementation. As required, it will be complete by September 1st.

As mentioned early, Segal will have weekly scheduled project calls not only during implementation, but throughout our contract. These calls will include all relevant team members that are working on your account.

We recognize that there will typically be a learning curve during the initial months of our partnership, and we anticipate spending as much time as is practical to ensure that we understand your plans as well as your organization so that we can best serve you for many years to come. We will make every effort to perform this "ramp up" quickly and efficiently to be ready for work.

Contact Exchange

As a first step, we will provide the State with a contact list of your primary Segal team members, including work phone numbers, cell phone numbers, email, and role. We will request a similar document from the State, so our communications can run smoothly. As part of our kickoff meeting and ongoing during the year, we will make sure to understand your preferred communication protocols (phone, email, etc.), so we can connect quickly and efficiently with you and your team.

Initial Research

Segal has already assembled some information while developing our proposal. We will work through that material in depth and compose a list of questions to make sure we understand your premiums fully. These questions will be addressed at our kickoff meeting as well as at your convenience during the first few weeks of our engagement.

Our intake process includes a data "wish list" that will be reviewed with your team during the initial kick-off meeting. Your actuaries are highly knowledgeable with regard to the data needed to work with your plan and are also very experienced in coordinating with our clients' vendors to collect the information needed with minimal client assistance.

Documents in our "wish list" will include the most recent and comprehensive reports from the current vendors and actuary, in order to best familiarize ourselves with the current level of analysis and information flow concerning your plans. We will likely want historical actuarial reports to ensure that our new reports are consistent with expectations. This will also be necessary to discuss variances. Given that the Segal actuarial team has significant experience with large public plans, we would anticipate a very smooth transition.

Kickoff Meeting

The initial kickoff meeting serves as an opportunity for our respective teams to meet and become familiar, to clarify questions, to understand and adjust the scope of work to fit the State's needs and to set up next steps for ongoing projects and tasks.

During the kickoff meeting, we will review and test our understanding of your programs and clarify particular questions we have developed during our initial research. We will discuss the role or roles you intend for us to take and how we can be most effective in supporting and guiding your decisions.

In addition, we will work through our review of your reports and discuss the level and types of reporting desired by the State and your expectation of Segal's role in initiating, monitoring, producing, analyzing and distributing program reports.

Annual Service Calendar

We will also review with you a draft Annual Service Calendar or Work Plan, including a list of all known and scheduled projects during the year. Based on our discussions, we will then customize the calendar to ensure we are providing the appropriate services and information to you in order to meet your deadlines and the requirements of your decision-making processes.

The calendar can become both a management tool and a planning tool to help the State manage multiple complex projects for your benefit plans.

Vendor Access

As part of the transition, we will request authorized access to each of your current vendors and carriers.

In accordance with your authorization and our mutual agreement on process, we will immediately begin to contact your vendors to gain access to your information and reduce the need for staff to act as a conduit. We will provide you with draft correspondence for your signature informing all vendors of the change and granting us access to information, and begin working directly with each vendor as soon as possible. Throughout the process, Segal will work directly with the vendors as much as possible on information gathering, minimizing the State's required involvement and efforts.

We would also ask that your vendors make themselves available for an introductory meeting, during which we would be able to gain a better understanding of how information is shared and learn of any issue or concern that may need immediate attention.

Reconciliation with Prior Analysis

As your new actuary, we will want to review the most recent work of the incumbent actuary. This generally involves our actuaries reproducing the most recent reports' results utilizing the same data and assumptions used in the original analysis. This is not necessary for every item mentioned in the scope of services.

Due to the importance of the reports and filings required, we will also request the same data used to develop the main components of the annual filing – primarily the projected costs and revenue for the trust, for the current year, as well as the IBNR.

This step ensures that our models are completely tested and that we have developed a complete understanding of your benefits, data feeds and revenue structure. In addition, this process will produce an audit of the most recent analysis and reports.

Ongoing Planning

While the initial transition between consultants is critical, we believe that the transition should produce documents, materials and approaches that are fine-tuned each year during our planning for the next annual cycle. Each of the documents we will create can be updated and refreshed throughout our contract to meet your evolving needs.

Given our implementation process we will be fully prepared to begin providing the required services listed in this RFP. One of the biggest processes will be to establish data transfers and validate the forecasting models.

Segal has transitioned from nearly every consulting firm – recent State transitions have included AonHewitt, Buck, Deloitte and Milliman. We typically meet with the prior actuary and consultant. Although not comfortable for the either firm, it is of the best interest of our new client.

See our detailed implementation schedule on the following pages.

SEGAL/STATE PRELIMINARY IMPLEMENTATION PLAN

PRIOR TO CONTRACT EFFECTIVE DATE				
Task	**Description**	**Involvement**	**Start**	**End**
Publication of RFP	• State Releases RFP for Health and Welfare Consulting Services	State	April 15	
Initial Research	• Collect data, reports and other public information • Review past published materials	Segal	April 15	May 24
RFP Response	• Vendor proposals due to State	Segal	May 25	
Letter of Intent	• State posts "Letter of Intent to Contract"	State	July 1	
Prepare for Contract Award	• Research program information and begin to catalogue data • Begin warehousing monthly, quarterly and annual reports • Prepare internal system • Meet with State staff as necessary	Segal	July 1	July 31
Kick-off Meeting	• **Finalize work plan and key dates** • **Review and define team roles** • **Review the data sources** • **Develop contacts for State, Segal & Vendors** • **Discuss deliverables and expectations**	**Segal | State**	**July 13**	
Client On-Boarding	• Organize secure file transfers • Finalize contract, billing formats • Upload communications • Develop workgroup • Setup implementation calendar/schedule • Vendor BBAs, NDAs, etc.	Segal	July 15	July 31
Weekly Project Call	**Call with entire project team**	**Segal | State**	**July 27**	
Contract Award	• State awards contract	State	August 1	
Data Request Letter	• Segal will send a data request letter or email focusing on: – Claims extracts – Vendor reports – Latest renewals – Plan documents, SPDs, etc – Prior actuarial reports – Annual report – Vendor contracts – Other items • The information will be needed for all the vendors and plan designs	Segal	August 1	
Weekly Project Call	**Call with entire project team**	**Segal | State**	**August 3**	
Data Receipt	• Start receiving data information • Key data needed for start date of each task	State	Aug 8	Aug 12

PRIOR TO CONTRACT EFFECTIVE DATE				
Task	**Description**	**Involvement**	**Start**	**End**
Review Claims Experience	• Review monthly reports and reconcile to prior reports • Setup database to test interface	Segal	Aug 8	Aug 15
Catalog Data	• Initial review of data elements • Categorize information and setup server	Segal	Aug 8	Aug 15
Strategy	• Review State strategic plan • Understand legislative direction • Review union contracts	Segal	Aug 8	Aug 15
Weekly Project Call	**Call with entire project team**	**Segal | State**	**August 10**	
Plan Financial Review	• Review current rate development for self-insured plans • Review renewals documents for fully insured products if applicable • Validate that data supports calculated rate structure • Tie to latest financial reports • Understand reporting processes • Calls with various vendors • Build premium rate model	Segal	Aug 15	Aug 31
Meeting with Current Actuary	• Discussion of transition • Questions on current data and processes	Segal	Aug 15	
SHAPE	• Load data into SHAPE • Provide initial validation of numbers	Segal	Aug 15	Aug 31
Weekly Project Call	**Call with entire project team**	**Segal | State**	**August 17**	
Finalize Reporting	• Work with State on reports for – Monthly experience reporting – Quarterly board material prep – Other requested reports	Segal	Aug 18	Aug 31
Initiatives & New Plans	• Review CDHP plan recommendations and financials • Understand On-Site Clinics • Analyze wellness program and initiatives • Other initiatives	Segal	Aug 22	Aug 26
Weekly Project Call	**Call with entire project team**	**Segal | State**	**August 24**	
Contract Start Date	**Implementation Fully Complete**	**Segal**	**September 1**	

Appendix A

Appendix A: Team Resumes

Experience & Expertise

Mr. Vieira is a Senior Vice President and Consulting Actuary in Segal's Atlanta office with nearly 25 years of experience as an account manager, actuary and consultant. He serves as Co-East Region Public Sector Market Leader and is a member of the Public Sector Leadership Group and the East Management Team.

Mr. Vieira brings a full complement of actuarial and consulting expertise to his clients. He has extensive experience in strategic consulting, benefit plan design and evaluation, financial forecasting, trend analysis, risk profiling, new product design, plan rating, premium rate development, data analytics, retiree medical, statistical modeling, and other medical management programs.

Mr. Vieira's current public sector clients include:

- North Carolina State Health Plan
- Alabama Public Education Employees Health Insurance Plan
- State of Illinois – Department of Central Management Services
- State of Minnesota – Department of Health & Human Services
- State of Wisconsin – Department of Employee Trust Fund
- State of Kansas
- Metropolitan Atlanta Rapid Transit Authority
- Fulton County, GA

In addition, Ken has managed or provided actuarial support to the following additional state clients over the last 5-years:

- State of Tennessee
- Commonwealth of Kentucky
- Georgia State Health Benefit Plan
- Pennsylvania Public School Employees' Retirement System

Mr. Vieira's clients have spanned a variety of public sector entities. He has worked for Medicaid agencies, school systems, community health departments, medical affairs, state health plans, CMS, etc.

In addition to his specialty in the governmental sector, Mr. Vieira has worked with large employers, healthcare providers and health plans. His varied projects have included packaging and pricing medical services, developing claims data reporting, utilizing risk management software, developing HMO rates and renewal support, and developing prospective payment systems.

Background

Prior to joining Segal, Mr. Vieira was the head of the Government Programs Health Practice at a large consulting firm in Atlanta. He has worked extensively with states and other large governmental employers on state health plans, Medicaid programs and a broad range of actuarial issues. With many of these states,

Mr. Vieira served as both the account manager and actuary, and provided a wide array of strategic consulting.

Professional Qualifications

Mr. Vieira received a BS in Software Engineering from Syracuse University. He is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, a Fellow of the Conference of Consulting Actuaries, and a retired Enrolled Actuary. He is also a licensed Life and Health Insurance Consultant in Georgia, Tennessee, North Carolina and other states.

References

Personal References		
North Carolina State Health Plan (NCSHP) Mr. Mark Collins Financial Analyst 4901 Glenwood Ave. Suite 150 Raleigh, NC 27612 919-785-5000 (t) Mark.Collins@nctreasurer.com	**Wisconsin - Department of Employee Trust Fund (ETF)** Ms. Lisa Ellinger Administrator PO Box 7931 Madison, WI 53707 608-264-6627 lisa.ellinger@etf.wi.gov	**State of Kansas** Mike Michael Director - State Employee Health Benefits Plan State of Kansas - KS. Dept of Health & Environment Division of Health Care Finance 900 SW Jackson St. Room 451 Topeka, KS 66612-1286 785-296-0221 MMichael@kdheks.gov

Expertise

Ms. Schatten is a Vice President and consulting actuary in our Atlanta office. She has 15 years of experience in working with public sector plans and employers.

Kirsten has conferred with many clients to develop innovative benefit designs and pricing strategies to meet unique requests. Most recently, she has assisted plans with consumerism strategies, population health education needs, quality of care initiatives, and drivers of health costs (including drivers of disease prevalence).

She has developed pricing for unprecedented models of care management programs, developed studies to quantify savings from consumer and wellness initiatives, negotiated reimbursement and risk sharing scenarios for managed payers and providers, performed market valuations of health plans for mergers and acquisitions, approved rate filings for DOIs and helped to develop strategies with legal counsel for public rate hearings.

Her experience also includes the analysis and implementation of Retiree medical and prescription drug strategies including coordination of Medicare Advantage plans and Medicare Part D and working extensively with Medicare Advantage plans providing development of business strategies, claims analysis, network strategies, and pricing.

Ms. Schatten's current and recent clients include:

- State of Maryland - Department of Budget and Management
- Georgia State Health Benefit Plan
- North Carolina State Health Plan
- State of Wisconsin – Department of Employee Trust Fund
- Kentucky Employees Benefit Plan
- Alabama Public Education Employees Health Insurance Plan
- State of Illinois – Department of Central Management Services
- Commonwealth of Virginia
- State of Kansas

Education/Professional Designations

Kirsten is an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries. She holds a Bachelor of Business Administration degree in Risk Management/Insurance from the University of Georgia, and a Master of Actuarial Science degree from Georgia State University.

References

Personal References		
State of Maryland Department of Budget and Management Ms. Anne Timmons Director, Employee Benefits Division 45 Calvert St. Annapolis, MD 21401 – 1907 410-767-4787 anne.timmons@maryland.gov	**Wisconsin - Department of Employee Trust Fund (ETF)** Ms. Lisa Ellinger Administrator PO Box 7931 Madison, WI 53707 608-264-6627 lisa.ellinger@etf.wi.gov	**Alabama Public Education Employees' Health Insurance Plan (PEEHIP)** Ms. Diane Scott Chief Financial Officer P.O. Box 302150 Montgomery, Alabama 36130-2150 334-517-7302 Diane.scott@rsa-al.gov

Expertise

Ms. Ingle is a Health Consultant in Segal's Atlanta office with nearly 16 years of industry experience in Project Management and Human Resource Management. Her responsibilities include the strategic design and supervision of many different areas for health benefit plans, including health plan strategy, vendor evaluation and selection, implementation of new programs, and plan performance management.

She has directed implementations and assisted in the plan design and development of a broad scope of projects, including Intensive Case Management, Disease Management and Integrated Health and Productivity Management. Additionally, Laine has experience in serving as the day-to-day contact for public sector clients focusing on project management, vendor management, benchmarking of benefit plans and renewal marketing.

Ms. Ingle's public sector current and recent state clients include:

- Georgia State Health Benefit Plan
- Alabama Public Education Employees Health Insurance Plan
- Illinois Central Management Services
- State of Maryland
- Commonwealth of Kentucky
- State of Tennessee
- North Carolina State Health Plan
- State of Wisconsin – Department of Employee Trust Funds
- Commonwealth of Pennsylvania - PSERS

Professional Background

Prior to joining Segal, Ms. Ingle was a Senior Consultant in the Government Programs Health Practice at a large consulting firm in Atlanta. She has worked extensively with states and other large governmental employers on the evaluation, design and operation of state health plans, on-site healthcare clinics, integrated health promotion and absence management programs as well as Specialty Disease Management and Care Management Programs.

Education/Professional Designations

Ms. Ingle received a BS in Broadcast Communications from Kennesaw State University. She has been a Georgia licensed agent since 2000, as well as holds licenses in Tennessee and Mississippi. She is an ISSA Certified Fitness Trainer and a student of the Certified Employee Benefits Specialist program.

References

Personal References		
Alabama Public Education Employees' Health Insurance Plan (PEEHIP) Ms. Diane Scott Chief Financial Officer P.O. Box 302150 Montgomery, Alabama 36130-2150 334-517-7302 Diane.scott@rsa-al.gov	**City of Houston** Ramiro Cano, CPA Deputy Director Human Resources Department, Director's Office HR Financial and Accounting Management 611 Walker, 4th Floor Houston, Texas 77002 832-393-6060	**Gwinnett County** Debbi Davidson Director, Benefits Division Human Resources, Gwinnett County 75 Langley Dr Lawrenceville, GA 30045 Debbi.Davidson@gwinnettcounty.com 770-822-7956

Expertise

Ms. Sander is a Health Consultant in Segal's Atlanta office with over 25 years of experience as an underwriter, consultant, and account manager. She is a member of the East Region Health Practice and provides benefits consulting to public sector entities and corporate firms.

Ms. Sander has a strong technical underwriting background and brings a full complement of consulting expertise to her clients. She has extensive experience in strategic consulting, benefit program/plan design and evaluation, financial forecasting, trend analysis, plan rating, premium rate development, data analytics, vendor selection and management.

Ms. Sander's recent clients include:

- Alabama Public Education Employees Health Insurance Plan
- City of Houston, TX
- City of Marietta, GA
- City of Tallahassee, FL
- State of Alaska
- Metropolitan Atlanta Rapid Transit Authority (GA)

In addition, Ms. Sander works with large national and international corporations, local governments and school systems, university systems, and hospital/medical systems.

She works with clients on projects including packaging and pricing health programs (medical, Rx, Wellness/DM, Telemedicine, onsite clinics, Dental, Vision, EAP), designing and evaluating ancillary benefit programs (Life/AD&D, Disability, FMLA, supplemental benefits), evaluating the potential financial impact of PPACA legislation, and developing customized reports.

Professional Background

Prior to Segal, Ms. Sander served as a Senior Consultant at another major consulting firm, specializing in medical, prescription, wellness, and other health and welfare benefits. She was responsible for benefit design modeling, vendor management, cost projections, and strategic planning, among other tasks.

Education/Professional Designations

Ms. Sander received a BA in Economics from The University of Georgia. She has earned a Fellowship of Life Management Institute (FLMI) designation, and is a licensed Life and Health Insurance Consultant in 15 states

References

Personal References		
Alabama Public Education Employees' Health Insurance Plan (PEEHIP) Ms. Diane Scott Chief Financial Officer P.O. Box 302150 Montgomery, Alabama 36130-2150 334-517-7302 Diane.scott@rsa-al.gov	**City of Houston** Ramiro Cano, CPA Deputy Director Human Resources Department, Director's Office HR Financial and Accounting Management 611 Walker, 4th Floor Houston, Texas 77002 832-393-6060	**Wisconsin - Department of Employee Trust Fund (ETF)** Ms. Lisa Ellinger Administrator PO Box 7931 Madison, WI 53707 608-264-6627 lisa.ellinger@etf.wi.gov

Expertise

Mr. Bognar is the lead Pharmacy Benefits Consultant for Segal's Eastern Region, based in Washington, D.C. He has worked with managed prescription drug programs since 1994, with special emphasis on plan benefit design and cost reduction strategies. His current focus is the evaluation of PBM services, plan design strategies, and health management. He is a member of Segal's National Prescription Consulting Group.

A sample of Mr. Bognar's current clients are:

- Georgia State Health Benefit Plan
- North Carolina State Health Plan
- City of Houston (TX)
- Alabama Public Education Employees Health Insurance Plan
- Pennsylvania Public School Employees' Retirement System
- Maryland Department of Budget and Management
- State of Delaware

Professional Background

Prior to joining The Segal Company, Mr. Bognar served for 12 years in various financial, analytical, and account executive roles for a major PBM. He has worked with large clients within both the public and private sectors, as well as multi-employer clients on pharmacy issues ranging from plan design, trend analysis, clinical and health management programs, and Medicare Part D.

Education/Professional Designations

Mr. Bognar holds a BA in Economics from Rutgers University and a MBA from Cornell University. He is also a professional designee by the Academy for Healthcare Management

References

Personal References		
North Carolina State Health Plan (NCSHP) Mr. Mark Collins Financial Analyst 4901 Glenwood Ave. Suite 150 Raleigh, NC 27612 919-785-5000 (t) Mark.Collins@nctreasurer.com	**State of Maryland Department of Budget and Management** Ms. Anne Timmons Director, Employee Benefits Division 45 Calvert St. Annapolis, MD 21401 – 1907 410-767-4787 (t) 410-333-7122 (f) anne.timmons@maryland.gov	**Pennsylvania Public School Employees' Retirement System Health Options Program** 5 N. Fifth Street Harrisburg, PA 17108 Mark Schafer, Director, Office of Insurance 717-720-4859 mschafer@pa.gov

Expertise

Mr. Kavanaugh is a Consultant and Health Practice Manager in Segal's Chicago office with over 20 years of experience in the group benefits field and special expertise in vendor procurements and contract negotiations. He has led public sector, multiemployer and corporate clients through health benefits consulting engagements including health analytics studies; pharmacy benefit manager (PBM) audits; cost forecasting; and budgeting and vendor procurement assignments for medical, dental, prescription drug, wellness and disease management programs. Mr. Kavanaugh established and set procedures for Segal's National Stop Loss Initiative.

Some of Mr. Kavanaugh's recent client engagements include:

- For a state teacher's retirement system with 130,000 retirees, Mr. Kavanaugh managed a compliance study on the impact of the Affordable Care Act and recently enacted state laws, as they pertained to the system's non-Medicare retirees. He also managed a study of the cost savings to convert the system's Medicare prescription drug program to an Employer Group Waiver Plan (EGWP).

- For two large public sector clients with over 100,000 employees, Mr. Kavanaugh managed a health analytics study that provided targeted cost saving strategies.

- For a large Ohio-based multiemployer client with 14,000 members, Mr. Kavanaugh developed a smoking cessation program, and assisted in the communications to the members. This involved developing consistent products among three PBMs, as well as ensuring compliance with preventive services requirements under the Affordable Care Act.

- For a large Colorado-based welfare fund, Mr. Kavanaugh negotiated one of the first transparent PBM contracts, saving the client $1.4 million over the existing contract

Professional Background

Prior to joining Segal, Mr. Kavanaugh was a Project Manager in the health and welfare practice of a global human resource and actuarial consulting firm. He assisted Fortune 1,000 companies with their benefits strategies and led merger studies, vendor procurements and employee contribution strategies. Mr. Kavanaugh started his career underwriting group benefits for three large insurance companies

Education/Professional Designations

Mr. Kavanaugh received a BA in Economics from the University of Michigan. He is a designated Certified Employee Benefits Specialist (CEBS). He currently serves as President of the Chicago Chapter of Worldwide Employee Benefits (WEB).

References

Personal References		
Illinois Central Management Services Ms. Nancy King, Benefits Manager 801 S Seventh Franklin Complex Fl 6 Springfield, IL 62706 217–558–1829 nancy.king@doc.illinois.gov	**UFCW 655** Ms. Cathy Sanderson, Fund Administrator 13537 Barrett Parkway Dr, Ste 100 St. Louis, MO 63021 csanderson@655hw.org	**International Union Vice President** **UFCW Union, Local #75** Mr. Lennie Wyatt 7250 Poe Avenue, Suite 400 Dayton, OH 45414 (937) 665-1901 (513) 543-7220 - Cell

Expertise

Mr. Makowiec is a Vice President and Health Consultant in Segal's Detroit office. He has over 20 years of experience in the healthcare and employee benefits industries, including xperience working with large employers, health systems and health care plans. He has extensive expertise in the implementation of decision support systems designed to create analytics that support major strategies and metric-driven decision making, as well as health reform initiatives, major benefit design changes and provider network development strategies. Mr. Makowiec has also successfully implemented numerous cost control strategies for employers

Professional Background

Prior to joining Segal, Mr. Makowiec was most recently the Vice President of Medical Economics for CHE Trinity Health (Livonia, MI) where he led the strategy, staff, systems and analytics for over 80 hospitals, 90 long-term care facilities and 100,000 employees. Prior to his work at CHE Trinity, he was the Sr. Director for Benefits at The University of Michigan where he was responsible for the development, approval and implementation of health benefit and retirement savings strategies for more than 97,000 covered lives. Prior to The University of Michigan, Mr. Makowiec was a key Human Resources Administrator at General Motors where he had the responsibility of managing successful cost reduction initiatives for more than 1.1 million covered lives in over 150 health care plans.

Education/Professional Designations

Mr. Makowiec holds a BS in Finance from Central Michigan University (Mt. Pleasant, MI) and an MBA in Finance from Wayne State University (Detroit, MI). He is a Certified Professional in Healthcare Quality (CPHQ) as well as a Certified Employee Benefits Specialist (CEBS). Mr. Makowiec is a member of the Healthcare Financial Management Association (HFMA), the National Association for Healthcare Quality and the International Society of Certified Employee Benefit Specialists (ISCEBS).

References

Personal References		
The University of Michigan Laurita Thomas Associate Vice President of Human Resources University Human Resources 4008 Wolverine Tower 1281 Ann Arbor, MI 48105-3206 (734) 647-5574 (734) 763-2891 FAX	**The Center for Healthcare Research & Transformation** Marianne Udow-Phillips Director, Center for Healthcare Research & Transformation Lecturer, University of Michigan School of Public Health University of Michigan 2929 Plymouth Road, Suite 245 Ann Arbor, MI 48105-3206	**The State of Michigan** Mark Cascarelli Director, State Innovation Model Implementation Program 1813 Wooded Valley Lane Howell, MI 48855 Phone 734-277-7684

Expertise

Mr. Klein is a Senior Health Consultant in Segal's Atlanta office with nine years of experience. He has specialized expertise in employee benefit strategy, vendor negotiation, and cost projections. Mr. Klein works with clients by certifying estimated incurred but not paid reserves as well as the claims/premium assumptions used in retiree health valuations. He also helps develop employer health care strategies for active and retiree benefit programs, including plan offerings, vendor selection, employee contributions and eligibility provisions. In addition, Mr. Klein calculates budgets and premium rates for employer health plans and estimates health care reform cost impacts to strategically minimize client exposure.

Professional Background

Prior to Segal, Mr. Klein served as a Senior Consultant at Aon Hewitt where he served as the lead actuary and performed actuarial analyses for midsized private sector and public sector clients as well as large state health plans.

Education/Professional Designations

Mr. Klein holds a BS in Actuarial Science from Illinois State University. He is a Fellow of the Society of Actuaries and Member of the American Academy of Actuaries.

References

Personal References		
Chatham County Carolyn A. Smalls, JD, SPHR, SHRM-SCP Human Resources Director 123 Abercorn Street Savannah, Georgia 31401 Phone: (912) 652-7925	**Gwinnett County** Debbi Davidson Director of Benefits 75 Langley Dr Lawrenceville, Georgia 30046-6935 Phone: (770) 822-8000	**Amerciold Logistics** Jed Milstein Executive Vice President & Chief Human Resources Officer 10 Glenlake Parkway Suite 800, South Tower Atlanta, GA 30328 Phone: (678) 441-1400

Expertise

Mr. Wang is an Assistant Actuary in Segal's Atlanta office with over 11 years of actuarial consulting experience. He provides retiree health and related consulting services (including SOP 92-6 valuations and GASB OPEB valuations) to clients.

His recent client work includes:

- Alabama Public Education Employees Health Insurance Plan
- City of Houston
- Metropolitan Atlanta Rapid Transit Authority
- Fulton County, GA
- Illinois Central Management Services
- North Carolina State Health Plan
- City of Atlanta

Professional Background

Prior to joining The Segal Company, Mr. Wang served as a Consulting Actuary for Cuni, Rust and Strenk, where he was responsible for reviewing and co-signing valuation reports for single employer and multiemployer pension and health and welfare funds (including both funding and accounting reports). In addition, he was responsible for signing government forms. Mr. Wang also served as a Consulting Actuary for United Actuarial Services, Inc. where he was responsible for the firm's post-retirement medical valuation practice and worked with several multiemployer pension funds.

Education/Professional Designations

Mr. Wang received a BS in Mathematics from Fudan University (Shanghai, China). He received a PhD in Statistics from Purdue University. Mr. Wang is an Associate of the Society of Actuaries (ASA), a Member of the American Academy of Actuaries (MAAA) and an Enrolled Actuary (EA).

References

Personal References		
State of Kansas Mike Michael Director - State Employee Health Benefits Plan State of Kansas - KS. Dept of Health & Environment Division of Health Care Finance 785-296-0221 MMichael@kdheks.gov	**Wisconsin - Department of Employee Trust Fund (ETF)** Ms. Lisa Ellinger Administrator PO Box 7931 Madison, WI 53707 608-264-6627 lisa.ellinger@etf.wi.gov	**North Carolina State Health Plan (NCSHP)** Mr. Mark Collins Financial Analyst 4901 Glenwood Ave. Suite 150 Raleigh, NC 27612 919-785-5000 (t) Mark.Collins@nctreasurer.com

CHRISTOPHER D. HEPPNER, ASA, MAAA
Senior Vice President, Health Actuary, Health Practice Leader, Chicago

Expertise

Mr. Heppner is a Senior Vice President, Health Actuary and the Midwest Health Practice Leader in Segal's Chicago office with over 20 years of experience working with health plans. He provides retiree health expertise, as well as the development of rating and contribution strategies, to corporate, public sector and multiemployer clients.

Mr. Heppner has been involved in a variety of projects that include flex plan pricing, PPO and prescription drug pricing, renewal negotiations, contribution strategy, plan design analysis, disability plans and valuations, Medicare Part D attestations, and reserve calculations. He also provides litigation support as a resident expert.

In a recent project, Mr. Heppner assisted clients in understanding their current cost components so that effective decisions could be made to manage those costs. He has developed interactive budget projection models to address client-specific interests, as well as engaged in successful negotiations with insurers to keep renewal increases consistently below trend. Mr. Heppner has also developed techniques to test and determine actuarial equivalents for unique plan designs.

In addition to his role as a Health Actuary for clients, Mr. Heppner develops and reviews health actuarial guidelines for the company and manages the firm's Midwest Health Practice.

Professional Background

Prior to joining Segal, Mr. Heppner worked for a major medical insurance company conducting individual health insurance pricing and plan design analysis. He began his career at another international human resources and benefits consulting firm.

Education/Professional Designations

Mr. Heppner received a BS in Business Administration from the University of Illinois at Chicago in 1991. He is an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries

References

Personal References		
City of Chicago - Dept. of Finance Ms. Nancy Currier, Benefits Mgr 333 South State Street, Room 400 Chicago, IL 60604-3978 312-744-6725 CELL: 773-610-0356 ncurrier@cityofchicago.org	**Director of Finance and Programs** **Park District Risk Management Agency** Ms. Martha H. Rademacher, CPCU 2033 Burlington Avenue Lisle, IL 60532 (630) 435-8908 - Direct (312) 518-8210 - Cell (630) 435-8998 - Main mrademacher@pdrma.org	**UFCW Union, Local #75** Mr. Lennie Wyatt International Union Vice President 7250 Poe Avenue, Suite 400 Dayton, OH 45414 (937) 665-1901 – Direct (513) 543-7220 - Cell

Expertise

Dr. Paralkar's areas of expertise include health care informatics, medical management program design, clinical operations, benefit plan design and network management strategies to optimize health improvement while containing costs, and evaluation and implementation of disease management and wellness programs based on evidence based medicine (EBM) protocols.

A sample of recent clients work includes:

- North Carolina State Health Plan
- State of Wisconsin – Department of Employee Trust Fund
- Alabama Public Education Employees Health Insurance Plan
- State of Maryland - Department of Budget and Management
- State of South Dakota
- State of Kansas
- City of Chicago

Professional Background

Dr. Paralkar's extensive experience in health care operations, informatics, and consulting includes positions at UnitedHealth Group (UHG) and Ingenix, where she provided clinical expertise to clients in the payer, provider, public sector, and employer markets. Prior to Ingenix, Dr. Paralkar was at Optum, another UHG company, where she served as Director of Product Development for the Care Management suite of products and was also responsible for the Care Management ROI model.

Prior to joining UHG, Dr. Paralkar worked at a Fortune 500 company, International Truck and Engine Corporation (Navistar, formerly known as International Harvester), in various capacities for six years. The last position Dr. Paralkar held at Navistar was Associate Medical Director, responsible for occupational health and disability, on-site wellness programs, health benefits plan design, and health care purchasing.

Education/Professional Designations

A native of Mumbai (Bombay), India, Dr. Paralkar completed her medical internship in 1992 at L.T.M. General Hospital of University of Bombay, India after earning her baccalaureate degree in Medicine and Surgery from the same institution in 1990.

As a licensed family practitioner, some of Dr. Paralkar's public health achievements include implementation and evaluation of immunization programs in rural India. In 1995, she completed a Master of Science degree in Public Health from the University of Illinois at Urbana-Champaign focusing on health data analysis and epidemiology. Part of her analytic research on health communications in the mass media was funded by the National Institutes of Health. Dr. Paralkar also completed an MBA with a focus on Health Industry Management and Marketing from the prestigious Kellogg School of Management of Northwestern University in 2003.

Dr. Paralkar is a member of the American Public Health Association, American College of Occupational and Environmental Medicine, The Institute of Medicine of Chicago, American Association of Physicians from India, and Women Business Leaders of the U.S. Health Care Industry Foundation

Published Work/Speeches

Dr. Paralkar has published several articles on Health and Productivity in peer-reviewed journals and is a frequent speaker at national conferences concerning health care. Past speaking engagements include the Society of Actuaries conference and the ACOEM (American College of Occupational and Environmental Medicine) conference.

Examples of Dr. Paralkar's recent publications include:

"Genetic Testing: An Ever-Evolving Health Field Raises Complex Coverage Issues," By Dr. Sadhna Paralkar and Joanne Hustead, *Benefits Law Journal*, Spring 2011

"Why Health Care Costs Keep Rising—And What to Do About It," *SHRM Online*, May 1, 2009

"While We're Waiting for Health Care Reform…Things We Can Do Now to Control Rising Costs," *Employersweb*, June 11, 2009

References

Personal References		
State-Wide Schools Cooperative Health Plan Dr. Norman Freimark, Executive Director State-Wide Schools Cooperative Health Plan 12 Metro Park Road, Suite 208, Colonie, New York 12205 nfswschp@hotmail.com	**State of Wisconsin - Department of Employee Trust Fund (ETF)** Lisa Ellinger Administrator Wisconsin Department of Employee Trust Funds 801 W Badger Road PO Box 7931 Madison WI 53707-7931 608-264-6627 Lisa.Ellinger@etf.wi.gov	**North Carolina State Health Plan** Nidu Menon, Ph.D Director of Integrated Health Management The State Health Plan of North Carolina 4901 Glenwood Ave. Suite 150 Raleigh, NC 27612 Nidu.Menon@nctreasurer.com 919-785-5000

Expertise

Ms. Ludovici-Connolly is a Wellness Consultant in Segal's Boston office with over 30 years of experience working with a variety of organizations in the public, academic and private sectors. Ms. Ludovici-Connolly is a subject matter expert in population health management, well-being and health behavior change.

Professional Background

Prior to Segal, Ms. Ludovici-Connolly was a Vice President and the National Wellness Subject Matter Expert for another major consulting firm before starting her own firm in 2008. Prior to consulting, Ms. Ludovici-Connolly was appointed by the Governor of Rhode Island to develop, launch and manage the State's award winning "Get Fit Rhode Island" wellness initiative.

Prior to this appointment, Ms. Ludovici-Connolly served as a professor and researcher for the University of Rhode Island, where she created evidence-based behavior change interventions on a wide range of health and wellness initiatives and research projects.

Ms. Ludovici-Connolly continues to serve as a Scholar in Residence at the University of Rhode Island under the direction of Dr. James Prochaska, where she keeps abreast of health behavior change research.

Education/Professional Designations

Ms. Ludovici-Connolly earned a Bachelor's degree in Business Administration with a major in Marketing/Management and a Master's degree in Kinesiology with a major in Psychology/Social Aspects of Health Behavior Change from the University of Rhode Island. She serves on many national and international professional associations, boards and committees including as a consultant and advisor to The United States Chamber of Commerce. Ms. Ludovici-Connolly has been a featured speaker at many regional, national and international conferences on a variety of population health, wellness and behavior change related topics.

Published Works and Speeches

Ms. Ludovici-Connolly is a two-time published author. She authored her first book for Human Kinetics, a well-respected academic publisher, titled Winning Health Promotion Strategies. Ms. Ludovici-Connolly's second book, Change Your Mind, Change Your Health: 7 Ways to Harness Your Brain to Achieve True Well-Being, recently published by New Page Books, has attracted media attention and received many positive reviews from reputable national book reviewers.

References

Personal References		
Alabama Public Education Employees' Health Insurance Plan (PEEHIP) Ms. Diane Scott Chief Financial Officer P.O. Box 302150 Montgomery, Alabama 36130-2150 334-517-7302 Diane.scott@rsa-al.gov	**State of Wisconsin - Department of Employee Trust Fund (ETF)** Lisa Ellinger Administrator Wisconsin Department of Employee Trust Funds 801 W Badger Road PO Box 7931 Madison WI 53707-7931 Lisa.Ellinger@etf.wi.gov	**North Carolina State Health Plan** Nidu Menon, Ph.D Director of Integrated Health Management The State Health Plan of North Carolina 4901 Glenwood Ave. Suite 150 Raleigh, NC 27612 Nidu.Menon@nctreasurer.com

KAUTOOK VYAS, PHARMD
Clinical Pharmacy Consultant, Chicago

Expertise

Dr. Vyas is a Clinical Pharmacy Consultant in Segal's Chicago office with over 15 years of experience. He is a member of Segal's National Pharmacy Consulting practice and assists clients in optimizing benefit design and drug mix. He provides consulting services that incorporate advanced data analytics with the latest best-practice guidelines for clinical pharmacy. Dr. Vyas' client engagements include Pharmacy Benefit Manager bid procurement, claims auditing and general pharmacy consulting. He has experience working with a wide variety of plan sponsors (including multiemployer, corporate, public sector and coalitions) and the Pharmacy Benefit Managers who service them.

Professional Background

Prior to his role as a Clinical Pharmacy Consultant, Dr. Vyas completed a post-doctoral residency-training program in pharmacy benefits consulting under Segal's National Pharmacy Practice Leader. He has also worked for Astellas Pharmaceuticals in their Scientific Affairs department and has several years of experience working in a community setting for Walgreens Pharmacy.

Education/Professional Designations

Dr. Vyas received both his Doctor of Pharmacy and his BS in Biochemistry from the University of Illinois at Chicago. Dr. Vyas is a licensed pharmacist in the state of Illinois and is a certified immunizer through the American Pharmacist Association (APhA). He is also a licensed as a Life, Accident & Health Producer. Dr. Vyas is also an active member of the Academy of Managed Care Pharmacy (AMCP).

Published Work/Speeches

Dr. Vyas has spoken on a variety of prescription drug benefits topics at the University of Illinois at Chicago College of Pharmacy where he gives an annual lecture on managed care pharmacy. He also published a study through the Academy of Managed Care Pharmacy titled: "Controlling Fraud and Abuse in the Prescription Drug Benefit with the use of Pharmacy Locks."

References

Personal References		
State of Wisconsin - Department of Employee Trust Fund (ETF) Lisa Ellinger Administrator Wisconsin Department of Employee Trust Funds 801 W Badger Road PO Box 7931 Madison WI 53707-7931 Lisa.Ellinger@etf.wi.gov	**State of Kansas** Mike Michael Director - State Employee Health Benefits Plan State of Kansas - KS. Dept of Health & Environment Division of Health Care Finance 900 SW Jackson St. Room 451 Topeka, KS 66612-1286 785-296-0221 MMichael@kdheks.gov	**Alabama Public Education Employees' Health Insurance** Plan (PEEHIP) Ms. Diane Scott Chief Financial Officer P.O. Box 302150 Montgomery, Alabama 36130-2150 334-517-7302 Diane.scott@rsa-al.gov

Expertise

Ms. Hakes is a Vice President and Health Care Benefits Consultant in Segal's Phoenix office. She is the Company's technical expert on operational issues regarding managed care. Ms. Hakes provides detailed research on specific health care issues pertinent to medical coverage, plan design, and quality of care, including disability; workers' compensation; wellness and associated incentive programs; EAP and behavioral health; prescription drugs; disease management; telephonic nurse triage programs; and utilization management. She is skilled in analyzing the effectiveness of health care delivery systems that guide managed care organizations. Ms. Hakes leads the development and maintenance of a proprietary Segal program, Q-ValSM, which allows plan sponsors to assess the extent to which managed care organizations (such as PPOs, POS and HMO plans) oversee and assure the delivery of quality health care to their plan participants.

Ms. Hakes assists employers in the creation and interpretation of technical medical health care coverage language, the design of employee educational information, and the implementation of specific managed care techniques engineered to control health care costs. Additionally, as Health Compliance Manager for the West Region, she researches employee benefit laws and their impact on clients, creates plan amendments and writes plan documents. Ms. Hakes was instrumental in designing the medical text of the Segal Master Plan Document/Summary Plan Description for use with self-funded clients nationwide. Using her past experience as Chief Operating Officer of a nationwide managed health care review organization, she has developed techniques for assessing the comprehensiveness, effectiveness, progressiveness and quality of medical management organizations.

Ms. Hakes performs analyses of medical records as part of her research of complex claims appeals. She additionally conducts assessments of operations and savings assumptions by medical management organizations nationwide, and reviews health records for issues involving cost and quality of care. Ms. Hakes has also customized return-to-work programs and performance guarantees for clients. She is experienced in complex case management and in designing reports that help detail the effectiveness of managed care organizations.

Professional Background

Prior to her 20 years with Segal, Ms. Hakes' background as Director of Health Services and Quality Control for the Arizona division of a national HMO provided her with the expertise to assist Segal clients in the design, implementation, and analysis of unique risk-sharing arrangements for control of medical costs.

Education/Professional Designations

After graduating from the University of Arizona with a BS in Nursing and with an MS from the University of San Diego, Ms. Hakes spent over 10 years providing direct patient care as well as overall nursing unit management in a 650-bed teaching hospital in Southern California. She maintains licensure as a Registered Nurse in Arizona and, until 2004, worked in an urgent care center on weekends.

Published Work/Speeches

Recent articles by Ms. Hakes include:

"Thank You for Not Smoking," Christopher Calvert and Nancy R. Hakes, *Compensation & Benefits,* December 2009

"Is Your Wellness Program a Scattershot Effort…or on Target to Serve Employees and the Organization?" Chris Calvert and Nancy R. Hakes, *Perspectives,* Volume 16, Issue 3, June 2008

References

Ms. Hakes does not have any client references and works internally on client projects.

Expertise

Ms. Donahue provides employee benefits consulting services to Segal clients. Her comprehensive experience includes more than a decade as a consultant and Human Resources practitioner and over 30 years as a clinician and coach. Ms. Donahue brings her broad expertise and specialty background on issues of behavioral health, wellness, and behavior change strategy to her role on Segal's National Health Team.

Some of Ms. Donahue's recent consulting assignments include:

- Benchmarking a large university's employee benefits versus comparable institutions. This resulted in the design of a competitive benefit program and effective contribution strategy. Ms. Donahue also managed projects that include a competitive bid for the university's medical, dental and prescription drug plans and FSA administration, as well as the development of a retiree health care strategy.
- A comparison study for a consolidated metropolitan school district to benchmark their fringe benefits against those of comparable organizations. Ms. Donahue presented the results to the governing body at an open public meeting.
- An evaluation of bids from Employee Assistance Program (EAP) providers for a State government. This work also included choosing and interviewing finalists. Ms. Donahue participated in contract negotiations with the chosen vendor, resulting in a customized program that incorporated measurable performance guarantees.
- Assisting a large organization in developing a cost-efficient strategy for carving their behavioral health benefits out of the medical plan. Ms. Donahue consulted throughout the vendor choice, contract, and implementation phases of the project.

Professional Background

Prior to joining Segal, Ms. Donahue worked as a consultant for major, international behavioral health providers. In these positions, she developed strategies for effectively integrating EAP, managed behavioral health care, work/life, and wellness services into employer sponsored benefit plans. Ms. Donahue has also been responsible for human resources administration, including employee benefits and labor/management relations, in the public sector. As a Clinical Social Worker, Ms. Donahue's past experience included direct clinical practice, management, training and coaching.

Education/Professional Designations

Ms. Donahue received an MSW degree from Indiana University, a BA degree from the University of Illinois and was awarded a Certificate in Administrative Foundations in Public Service from DePaul University. She has participated in post-graduate training at the Adler School of Professional Psychology in Chicago, the Chicago Center for Family Health, The Coaches Training Institute, and the Mediation Training and Consultation Institute. She is a licensed Accident/Health and Life producer in the states of Illinois, Oklahoma, Missouri, Indiana and Wisconsin.

References

Personal References		
Chicago Transit Authority Retiree Health Care Trust Mr. John Kallianis Executive Director 55 West Monroe Street Suite 1950 Chicago, IL 60603 312. 463.0350 jkallianis@ctapension.com	**City of Springfield, MO** Ms. Sheila Maerz Director of Human Resources 840 Boonville Avenue Springfield, MO 65802 417-864-1601 Smaerz@springfieldmo.gov	**Pace Suburban Bus Service** Mr. Marion Roglich Department Manager, Human Resources 550 West Algonguin Road Arlington Heights, IL 60005 847.228.2310 marion.roglich@pacebus.com

Segal Consulting

EILEEN M. FLICK
Senior Vice President, Benefits Consultant,
National Health Services Practice, New York

Expertise

Ms. Flick joined The Segal Company's New York office in 1993 as a Health Consultant. She transferred to the National Health Services Practice in 1997 as Director of Health Technology Systems and was named Vice President in 1999.

Ms. Flick has special expertise in assisting clients with developing health care cost containment strategies, with an emphasis on pricing and plan design. In her capacity as Director of Health Technology Systems, she has managed the development of claims models for retiree health valuations, rate manuals for medical, prescription drug and dental programs, and health care benchmark database systems.

Ms. Flick was instrumental in helping the firm select a data management software partner to enable Segal to effectively analyze key data elements to help decision-makers take action to improve plan performance. Additionally, she has also actively project-managed a number of client engagements in utilizing this data mining software to determine underlying cost drivers, develop strategies for engaging participants in their own care, contain costs and improve patient outcomes.

Ms. Flick's current state clients include:

- State of Maryland - Department of Budget and Management
- North Carolina State Health Plan
- State of Wisconsin – Department of Employee Trust Fund
- Alabama Public Education Employees Health Insurance Plan
- State of Illinois – Department of Central Management Services

Professional Background

Prior to joining The Segal Company, Ms. Flick worked as a Benefits Consultant for a major accounting firm.

Education/Professional Designations

Ms. Flick received a BS in Mathematics and Statistics from the State University of New York at Stony Brook.

DAVID SEARLES, CEBS
Vice President and Consultant, New York

Expertise

Mr. Searles is a Vice President and Consultant in Segal's New York office with over 20 years of experience working with health technology systems. He serves as the project leader for several key health practice initiative, including Segal's medical data mining and pricing tools and analytics. Mr. Searles works with clients to provide technical assistance for network discount analysis, pricing, wellness and disease management program effectiveness, and plan design analysis. Currently, David works with:

- North Carolina State Health Plan
- State of Wisconsin Employee Benefit Trust Fund
- Maryland Department of Budget Management

Professional Background

Prior to joining Segal, Mr. Searles was an Assistant Vice President with Berkley Accident and Health, a direct-writer for a broad range of accident and health insurance products and services including stop loss insurance, HMO reinsurance for health plans and clinical management services to support claim management. Prior to that, Mr. Searles worked for Apex Management Group (owned by Arthur J. Gallagher, Inc.), where he developed their proprietary health care pricing software - Apex.HRM - as well as an online data warehouse and a predictive modeling system.

Education/Professional Designations

Mr. Searles received a BBA from Rutgers University and is a Certified Employee Benefits Specialist (CEBS).

Expertise

Nicole Benko is a Health Benefits Data Analyst in Segal's New York office with five years of health benefits experience. Ms. Benko has specialized expertise in benefit plan designs for self-insured, managed care, Medicare and Medicaid clients. She also has extensive experience working on financial audits, CMS audits and claims audits.

Ms. Benko conducts health data analytics to help improve plan performance by determining underlying cost drivers, containing costs and developing strategies to improve patient outcomes. She also contributes to the analysis featured in the Segal Health Plan Cost Trend Survey.

Professional Background

Prior to Segal, Ms. Benko served as a Prescription Drug Event Analyst at MedImpact Healthcare Systems, a pharmacy benefit management company, in addition to other roles in the benefit configuration and government programs departments. She was the subject matter expert on benefit plan designs for Medicare Part D, Self-Insured and Managed Care Organization clients, and worked with clients to design and build their benefits

Education/Professional Designations

Ms. Benko holds a BS in both Finance and Health Policy and Management from Providence College. She also holds an MBA with a specialization in Health Administration from San Diego State University.

MILDEEN WORRELL, JD, LLM
Vice President, Compliance Practice Leader
Washington, DC

Expertise

Ms. Worrell is a Vice President and Compliance Practice Leader in Segal's Washington, DC office. She has over 25 years of experience and has extensive expertise in the healthcare and benefits industries. Ms. Worrell provides consulting services in the health and retirement areas to a number of corporate organizations, public sector entities, and collectively bargained health, pension and annuity funds.

Professional Background

Prior to joining Segal, Ms. Worrell served as Senior Benefits Counsel to the U.S. House of Representatives Committee on Ways and Means from 1991-2009. Her tenure with the Committee spanned four Committee Chairmanships and five Administrations. She was prominently involved in the development of significant legislation, including the Affordable Care Act (ACA), Health Portability and Accountability Act (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Mental Health Parity and Addiction Equity Act (MHPAEA), Genetic Information Nondiscrimination Act (GINA), Women's Health and Cancer Rights Act (WHCRA), Family Medical Leave Act (FMLA), Employee Retirement Security Act (ERISA), Uniform Services Employment and Reemployment Rights Act (USERRA), and the Pension Protection Act (PPA). Prior to working with the Committee, she gained experience with Sutherland, Asbill & Brennan, a law firm, and completed a clerkship with the U.S. Tax Court.

Education/Professional Designations

Ms. Worrell received a BBA in Accounting from the University of Massachusetts, Amherst where she graduated *cum laude*. She also holds a JD from Boston University School of Law and an LLM from New York University School of Law. Ms. Worrell is a member of the Massachusetts Bar, and was elected Tax Lawyer of the Year by the National Bar Association in 2008. She has previously served as Chair to the ERISA Advisory Council and Advisor to the Secretary of Labor on retirement and health issues. Ms. Worrell is currently an adjunct professor at the University of Baltimore School of Law, where she teaches employee benefits law and the role of government agencies in developing statutory guidance and compliance enforcement.

Expertise

Ms. Bakich is a Senior Vice President in Segal's Washington, DC office with over 20 years of experience in health care compliance. She is the firm's National Health Compliance Practice Leader.

Ms. Bakich is one of the country's leading experts on employer sponsored health coverage. She specializes in providing research and analysis on federal laws and regulations affecting health coverage, including: ERISA, Medicare, HIPAA, COBRA, the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act.

Ms. Bakich is a recognized expert on the Patient Protection and Affordable Care Act passed in 2010. She speaks regularly about the law, helps plan sponsors understand its short and long term effects on their plans, and assists clients with preparing comments on the legislation for submission to regulatory Departments (Treasury, Labor, and Health & Human Services). Some of Ms. Bakich's clients include:

- State of Michigan
- North Carolina State Health Plan
- Alabama Public Education Employees Health Insurance Plan
- Illinois Central Management Services, UAW retiree medical trust, and NCCMP.

Ms. Bakich leads the Segal team responsible for publishing information about new health care laws and regulations, and trains internal staff on all legislation and related developments. She and her staff disseminate health compliance information, monitor federal and state laws and regulations, and prepare amendments for health plans and summary plan descriptions based on national models.

Professional Background

Prior to joining Segal, Ms. Bakich was an attorney in private practice representing multiemployer health plans and an appellate administrative law judge.

Education/Professional Designations

Ms. Bakich graduated in 1979 with a BA in Political Science, in 1982 with an MA in Public Policy, and in 1985 with a JD from the University of Missouri. She has been admitted to the Bar in the District of Columbia, United States Supreme Court, and multiple federal district and appellate courts.

Ms. Bakich is a member of the Working Committee of the National Coordinating Committee for Multiemployer Plans (NCCMP), the Health Technical Issues Taskforce of the American Benefits Council (ABC), the Employers Council on Flexible Compensation (ECFC) Flex Advisory Council, and the American Bar Association (ABA). Ms. Bakich is co-chair of the ABA Joint Committee on Employee Benefits Subcommittee on Welfare Plan Regulation. She was also appointed to the Government Liaison Committee of the International Foundation of Employee Benefit Plans (IFEBP). Ms. Bakich was named a Fellow of the American College of Employee Benefits Counsel in 2012.

Published Works/Speeches

Ms. Bakich has published multiple articles about employee health and welfare benefits, including a series of articles discussing HIPAA Administrative Simplification, EDI, and Privacy in the *Benefits Law Journal*. She is a co-author of the *Employers' Guide to HIPAA Privacy Requirements*, published by Thompson Publishing Group, and a chapter editor of *Employee Benefits Law*. Ms. Bakich speaks regularly on issues related to group health plans.

Expertise

Joel Stouffer is a Compliance Specialist in Segal's Atlanta office with over 25 years of experience in the health care industry and 20 years of experience in health care compliance. He provides clients with technical expertise on employee benefits compliance and legislation affecting health and welfare plans. Mr. Stouffer assists clients with the preparation of plan documentation, including summary plan descriptions (SPDs), summaries of material modification (SMMs), plan amendments, government compliance filings, employee communications and administrative policies and procedures.

Mr. Stouffer's areas of expertise include ERISA, COBRA, HIPAA, Medicare and the Patient Protection and Affordable Care Act. He has experience working with consumer-driven health plans, health reimbursement arrangements, health savings accounts, Section 125 cafeteria plans and voluntary employees' beneficiary associations.

Mr. Stouffer's areas of expertise include ERISA, COBRA, HIPAA (including portability, non-discrimination, privacy and opt-out for governmental plans), Medicare (including Medicare Part D, the Retiree Drug Subsidy and Section 111 Mandatory Secondary Payer Reporting) and the Patient Protection and Affordable Care Act. He also has experience working with consumer-driven health plans, such as flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs); Section 125 (cafeteria) plans; and retirement health voluntary employees' beneficiary associations (VEBAs).

His recent public sector clients include the State of Delaware Group Health Insurance Program, the Florida Division of State Group Insurance, the New Hampshire State Employee and Retiree Health Benefit Program and the North Carolina State Health Plan, as well as various local governments.

Professional Background

Prior to joining Segal, Mr. Stouffer worked with three national insurance companies, tracking state and federal laws and working with state insurance commissioners to ensure the compliance of company documents, policies, and procedures.

Education/Professional Designations

Mr. Stouffer graduated cum laude from Virginia Tech. He completed the FLMI Insurance Education Program's "Fundamentals of Life and Health Insurance" curriculum of courses and received his certification, and has completed coursework in Paralegal Studies at the USDA Graduate School. Mr. Stouffer is licensed by the State of Georgia as a Resident Agent for Life, Accident, and Sickness insurance.

ELLIOT R. SUSSELES, CCP
Senior Vice President, National Practice Leader, Washington, DC

Expertise

Mr. Susseles joined the firm in 1992. He serves as Segal's National Practice Leader for Segal Waters Consulting. As a member of Segal's Public Sector Leadership Group, Mr. Susseles collaborates with benefits related Practice Leaders to shape Segal's total rewards consulting philosophy. Mr. Susseles also serves as Client Relationship Manager for major projects and provides clients with strategic bargaining assistance regarding all contractual economic issues.

Clients

International Association of Firefighters Local 22
International Brotherhood of Electrical Workers Local 50
International Brotherhood of Electrical Workers Local 459
International Brotherhood of Electrical Workers Local 1049International Brotherhood of Electrical Workers
Local 1194
International Brotherhood of Electrical Workers Local 1347
International Brotherhood of Electrical Workers Local 1381
Utility Workers Union of America
Utility Workers Union of America Local 1-2
Utility Workers Union of America Local 270
American Federation of Teachers
American Federation of Television and Radio Artists
AFSCME District Council 4
AFSCME Local 375
AFSCME Local 1407
AFSCME Local 1549
Bricklayers & Allied Craftsman International Union
CMAGE/CWA Local 4502
HERE Local 34
Montgomery County Career Firefighters Association
New York State Nurses Association
SEIU (International)
SEIU Local 1000
SEIU District 1199
Transportation Communication Union
TWU Local 252
UAW Legal Services Staff Association
United Food & Commercial Workers (International)
United Food & Commercial Workers Local 7
United Food & Commercial Workers Local 17A
United Food & Commercial Workers Local 1994

Professional Background

Prior to joining Segal, Mr. Susseles served as Associate Director of Labor Relations for the District of Columbia where he was responsible for the District's labor economics program in support of negotiations.

He has extensive experience in government finance and human resources including working for the Washington Metropolitan Area Transit Authority as a labor economist and with the New York City Transit Authority as Chief of the Office of Labor and Cost Analysis. Mr. Susseles served as Assistant Director of Research and Negotiations for AFSCME's New York City affiliate.

Mr. Susseles has served on the adjunct faculty of the City University of New York, The New School University, USDA Graduate School, Kingsborough Community College, and Prince Georges Community College.

Education/Professional Designations

Mr. Susseles graduated from Hofstra University with a B.A. in Economics and from New York University with an M.A. in Economics. He is a member of WorldatWork and the International Personnel Management Association – Human Resources (IPMA-HR). He is a Certified Compensation Professional (CCP).

Published Works/Speeches

- "Total Compensation, Cost Versus Value", IPMA-HR 2015 National Conference
- "How to Plan a Successful RIF to Meet Restructured Services," Total Rewards in Government, 2010.
- "Maintaining competitiveness in Tough Economic Times," NASPE 2010 National Conference
- "Managing through Fiscal Stress," IPMA-HR 2009 Training Conference.
- "Eight Steps to Instituting a Successful Reduction in Force, and One Interesting Alternative," IPMA-HR News, February 2009.
- "How Employees Value the Rewards of Their Work: Results from Segal's 2007 Public Sector Rewards of WorkSM," IPMA-HR Conference, October 2007.
- "It's Not Just About Pay," IPMA-HR News, June 2006.

"The Key Role of Labor-Management Committees in Achieving Successful Negotiations," *IPMA-HR News*, August 2003.

PATRICK BRACKEN, CCP
Senior Consultant, Washington, DC

Expertise

Mr. Bracken is a Senior Compensation Consultant with Segal Waters Consulting, which he joined in 2004. Mr. Bracken has 14 years of experience in coordinating and conducting total compensation studies, classification structure re-design, and economic analysis. He specializes at working with unionized, utility, and transit organizations.

Clients

Administrative Office of the U.S. Courts
ACS State and Local Solutions
State of Alabama, Department of Mental Health, & Mental Retardation
State of Alaska
State of Washington
District of Columbia Government (DC)
Illinois Municipal Retirement Fund
Jacksonville Police and Fire Pension Fund
City of Bristol (CT)
City of Middletown (CT)
City of New Bedford (MA)
City of San Marcos (TX)
City of San Diego (CA)
City of Wethersfield (CT)
City of Wilmington (DE)
City/County of Denver (CO)
Fairfax County (VA)
Forsyth County (GA)
Los Alamos County (NM)
Mohave County (AZ)
Adams 12 Five Star School District (CO)
Arlington Public Schools (VA)
Boulder Valley School District (CO)
Denver Public Schools (CO)
Jefferson County Public Schools (CO)
Lafayette Parish School System (LA)
City of Springfield Public Schools (MA)
Cuyahoga Library District (OH)
Yale University (CT)
George Mason University (VA)
Alaska Railroad Corporation
Central Ohio Transit Authority
Golden Gate Bridge and Highway Transportation District (CA)
Ben Franklin Transit (WA)
Jacksonville Transportation Authority (FL)
Lehigh Northampton Airport Authority (PA)
Massachusetts Bay Transportation Authority
Massachusetts Department of Transportation
Metro St. Louis (MO)
New Jersey Turnpike Authority
San Francisco Bay Area Rapid Transit (CA)
Transit Management of Washoe (NV)
Valley Metro/RPTA and METRO (AZ)
Virginia Railway Express (VA)
Washington Metropolitan Area Transit Authority
Coachella Valley Water District (CA)
District of Columbia Water and Sewer Authority
Easton Utilities Commission (MD)
Metropolitan District Commission (CT)
Navajo Tribal Utility Authority (AZ)
Platte River Power Authority (CO)
Upper Occoquan Service Authority (VA)

Professional Background

Mr. Bracken was previously employed by The Labor Bureau, Inc. an economics-consulting firm, where he conducted financial analysis and economic research in support of transportation unions' negotiations and interest arbitrations.

Education/Professional Designations

Mr. Bracken graduated from Cornell University with a B.S. in Industrial and Labor Relations, and has a Master's Degree in Economics from The American University. He is a member of WorldatWork and the

International Personnel Management Association – Human Resources (IPMA-HR). He is a Certified Compensation Professional (CCP).

JOSEPH ADLER, SPHR, IPMA-CP, DPA
Senior Consultant, Washington, DC

Expertise

Mr. Adler is joining Segal in August 2015 to provide strategic human resources advice to our public sector clients.

Professional Background

Prior to joining Segal, Mr. Adler served as the Director of Human Resources for Montgomery County (MD) government from 2002 to 2015. In that role, Mr. Adler led a staff of 50+ employees and an annual budget of nearly $8 million to provide a full range of human capital services for over 9,000 employees of the County.

From 1995 to 2002, Mr. Adler served as the Director of Personnel and Labor Relations for Prince George's County (MD) where he was responsible for the development, implementation and administration of all human resources programs for the County's workforce of 6,000+ employees.

Prior to joining Prince George's County, Mr. Adler served as Deputy Secretary and Secretary for the Maryland State Department of Personnel, providing leadership and management of 215 staff members and an annual budget of $12 million. In his role as Secretary, Mr. Adler was responsible to the Governor for the Department's performance in administering the statutes, regulations, and policies concerning Maryland's 60,000 employees.

From 1988 to the present, Mr. Adler has taught graduate and undergraduate courses in Human Resource Management, Organizational Behavior, Labor Relations, and Public Personnel Management at the University of Baltimore and the University of Maryland, Baltimore County.

Education

Master of Public Affairs, (MPA) The Woodrow Wilson School of Public and International Affairs, Princeton University, Princeton, New Jersey.

Bachelor of Arts, (BA) (Political Science) The City College of New York, City University of New York.

Doctorate in Public Administration (DPA) program, The University of Baltimore, Baltimore, MD.

Selected Professional Designations and Professional Recognition

Fellow of the National Academy of Public Administration (NAPA). Elected by peers in 2011.

Senior Professional in Human Resources (SPHR) granted by Society for Human Resource Management (SHRM). Recertified until 2016.

International Personnel Management Association (IPMA) Certified Professional, (IPMA-CP) granted by the Public Human Resource Certification Council. Recertified until 2015.

2006 and 1999 Human Resource Executive of the Year, Awarded by the Local Government Personnel Association. (LGPA)

Customer Service Award, (OHR) 2003, by Montgomery's Best and the National Association of Counties.

Workplace Excellence Seal of Approval 2003, 2004, 2005, 2007, 2011, 2012, awarded by the Maryland Work-Life Alliance for proactive HR work life balance programs.

Montgomery County OHR was awarded the 2006 IPMA-HR Large Agency Award for Excellence for its overall quality, accomplishments, and contributions of an agency human resource program that exceeds the normal operations of a "good government human resource program."

Publications/Speeches

"Grievance Arbitration in New York Public Schools," Occasional paper #1, processed (Ithaca: Institute of Public Employment, New York State School of Industrial and Labor Relations, Cornell University, March 1973).

"Impact of Civil Service on Managerial Promotion: Some Questions," Occasional Paper #5, processed (Ithaca: New York State School of Industrial and Labor Relations, Cornell University, July 1974).

Employment Security in the Public Sector: A Symposium, edited with Robert E. Doherty (Ithaca: New York State School of Industrial and Labor Relations, Cornell University, 1974).

"A Colloquy on Concentrated Bargaining," edited with Robert Donovan, Occasional Paper #6, processed (Ithaca: Institute of Public Employment, New York State School of Industrial and Labor Relations, Cornell University, December 1974).

"Pay Parity for Police and Firefighters," Occasional paper #7, processed (Ithaca: New York State School of Industrial and Labor Relations, Cornell University, 1975, with Marjorie Bird and Tallien Robinson).

"Fact Finders and the Resolution of Issues at Impasse: A Survey of New York State PERB Neutrals," Journal of Collective Negotiations in the Public Sector, (December 1975), Vol. 4, No.4, with Donald Rosenthal.

Book Review: Impasse and Grievance Resolution, H. Kershen, Ed., in The Arbitration Journal, American Arbitration Association, (December 1978). Vol. 33, No. 4,

"New Directions in Public Sector Negotiations," Proceedings, delivered at 1982 SPIDR Conference, Creative Approaches to Dispute Resolution, Detroit, (September 1982).

"Unions Today," The Trooper, Official publication of the Maryland Troopers' Association, Baltimore, Maryland (Fall 1985).

"Reinventing Government: It's Harder Than It Looks," The Baltimore Sun, (August 10, 1994).

"Gaining the Edge on Public Safety Applicant Processing," PA TIMES, (December 2000), Vol.23, No.12, publication of the American Society for Public Administration.

"Building a Learning Organization in Montgomery County, Maryland," IPMA-HR News, (October 2005), publication of the International Public Management Association for Human Resources. (IPMA-HR)

"Implementing Policies to Balance Work and Personal Life: Is There a Bottom Life Benefit? IPMA-HR News, (February 2006) with Angela Dizelos.

"Enterprise Hosting Infrastructure with Single Sign-on: The Experience of Montgomery County, Maryland," IPMA-HR News (September 2006)

"The Past as Prologue? A Brief History of the Labor Movement In the United States," Public Personnel Management, (Winter 2006) Vol.35 No. 4.

Adler, J. (2008). Leadership and Followership. In J. Williams (Ed.), Leadership Secrets of Local Government Human Resource Officials (pp. 9-30). Alexandria, VA: International Public Management Association for Human Resources (IPMA-HR).

Adler, J. (2009). Motivating and Managing the Public Sector Workforce: Challenges and Opportunities. In Inside the Minds: Emerging Issues in State and Local Government Employment, (pp. 103-133). Washington DC: ASPATORE Books, Thomson/Reuters.

"HR 413, The Public Safety Employer-Employee Cooperation Act: How Will it Impact your Jurisdiction?" IPMA-HR News (August 2009)

Review of, The Why of Work: How Great Leaders Build Organizations That Win, by Dave Ulrich and Wendy Ulrich, (2010 McGraw Hill). IPMA-HR News (June 2011).

"Population Change and Local Government Reaction: Examples from the Washington, DC Region," PA TIMES (August/September 2011) Vol.34, No.3 - publication of the American Society for Public Administration.

ANDREW KAPLAN
Vice President and Senior Communications Consultant, New York

Expertise

Mr. Kaplan is a Vice President and Senior Consultant in Segal's Communications practice. He has over 20 years of consulting experience in the development and management of employee-focused communications strategy, tactics, and message creation. His consulting approach emphasizes the importance of using audience research (*e.g.*, surveys, focus groups, one-on-one interviews) to gather the information needed to create targeted messages and content that raise awareness, influence thinking and change behavior.

Mr. Kaplan provides strategic counsel to clients on a wide range of employee communications issues and develops content for a broad array of media channels, including online/interactive, print, and face-to-face. His clients include Ball State University; Illinois Central Management Services; Yale-New Haven Health System; Dana-Farber Cancer Institute; The Ohio State University; Skidmore College; and the University of Arkansas System.

Professional Background

Prior to joining Segal, Mr. Kaplan provided employee communications counsel to clients with two other nationally known human capital consulting firms.

Education/Professional Designations

Mr. Kaplan received a BA in Psychology from Stony Brook University and an MA in Industrial/Organizational Psychology from the University of New Haven.

Published Works/Speeches

Mr. Kaplan's speaking engagements have included addresses to: the Council on Employee Benefits on increasing savings plan participation; the International Society of Certified Employee Benefit Specialists (Northern New Jersey Chapter) on "Communicating Tough Messages in Tough Times"; the New England Employee Benefits Council on "Communicating Health Care with Employees: From Need to Know to Full Disclosure"; and, the International Foundation of Employee Benefits Plans and the Association of Benefit Administrators (ABA) on "From 'Required' to 'Inspired': Moving Beyond the PPA'06 rules of Participant Communications." He has also published an article based on the latter speech in the ABA's quarterly newsletter.

Expertise

Mr. Hillard is a Vice President, National Communications, in Segal's Phoenix office with over 15 years of experience. He is responsible for the development, design, and implementation of communications strategies and initiatives for Sibson clients in Atlanta, Denver, Chicago, Phoenix, San Francisco, Washington, DC and Los Angeles. Mr. Hillard helps clients achieve their business goals and objectives in all areas of employee and management communications, including compensation, benefits and health care, strategic planning and execution. He also closely coordinates the involvement of Sibson's communications team with the firm's other professional practices and resources.

Professional Background

Before joining Sibson, Mr. Hillard served as the Communications Practice Leader for Hewitt Associates in The Woodlands, TX. His responsibilities were focused around benefits outsourcing, plan development and administration. He also served as Hewitt's Global Communications Leader for Corporate Restructuring and Change (M&A). Mr. Hillard provided both local and global communications expertise in merger transactions for companies including Chevron-Texaco, United-US Airways, Multipurpose Bank and Sabre-GetThere.com.

Education/Professional Designations

Mr. Hillard graduated from West Point in 1975. He received an MS in Systems Management from the University of Southern California and an MA in English Literature from the University of North Carolina at Chapel Hill.

Published Works/Speeches

- Recent presentations and publications include:
- "Out with the Old - In With the New in Communications," International Foundation for Employee Benefit Plans (IFEBP) Annual Conference, Honolulu, HI, November 2015
- "Communicating Change and Essential Information," International Foundation of Employee Benefit Plans - Essentials of Multiemployer Trust Fund Administration, June 2015
- "Communicating in Uncertain Times," IFEBP Benefit Communication and Technology Institute, July 2014
- "Communicating ACA to Participants," IFEBP Trustees and Administrators Institutes, June 2014

Expertise

Mr. Faucette is a Consultant and Manager of the Inhouse Design Group in Segal's Princeton office. He helps clients implement sophisticated and sensible communication strategies using a mix of online, print, and multimedia formats. Mr. Faucette has provided design and user experience consulting to clients such as:

- Pfizer
- WebMD (Emdeon)
- The Pennsylvania Public School Employees' Retirement System (PSERS)
- The National Basketball Association (NBA)

In addition, Mr. Faucette directs Segal's own creative services group

Professional Background

Prior to Segal, Mr. Faucette partnered with a broad range of corporate clients on a contractual basis, including Gemini Consulting (Capgemini). Prior to that, he produced multimedia documentaries on several continents as Director of Communications for a Presbyterian missionary and relief organization

Education/Professional Designations

Mr. Faucette earned a BA in Cinema from Bob Jones University in 1988. He is a Certified Usability Analyst and a Member of the Usability Professionals' Association.

Appendix B

Appendix B: Evidence of Insurance Coverage

We have provided copies of proof of insurance on the following two pages for review by the Evaluation Committee.

Client#: 3912 SEGACOMP

ACORD. CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/16/2016

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER BWD Group LLC 45 Executive Drive Plainview, NY 11803	CONTACT NAME: PHONE (A/C, No, Ext): 516 327-2700 FAX (A/C, No): 516-327-2800 E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A: National Fire Insurance Co. of	20478
INSURED The Segal Company (Eastern States), Inc. 2018 Powers Ferry Road, Suite 850 Atlanta, GA 30339-7200	INSURER B: Continental Casualty Company	20443
	INSURER C: Pacific Indemnity Company	20346
	INSURER D: Westchester Fire Insurance Comp	10030
	INSURER E:	
	INSURER F:	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT [X] LOC OTHER			5099474699	02/28/2016	02/28/2017	EACH OCCURRENCE	$1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
							MED EXP (Any one person)	$5,000
							PERSONAL & ADV INJURY	$1,000,000
							GENERAL AGGREGATE	$2,000,000
							PRODUCTS - COMP/OP AGG	$Included
								$
B	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS [X] HIRED AUTOS [X] NON-OWNED AUTOS			5099474704	02/28/2016	02/28/2017	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
B	X UMBRELLA LIAB [X] OCCUR EXCESS LIAB CLAIMS-MADE DED [X] RETENTION $10,000			CUE6024216057	02/28/2016	02/28/2017	EACH OCCURRENCE	$20,000,000
							AGGREGATE	$20,000,000
								$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N [N] N / A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below			71738381	02/28/2016	02/28/2017	X PER STATUTE OTH-ER	
							E.L. EACH ACCIDENT	$1,000,000
							E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000
D	Crime Emp. Dishonesty			G25081663004	02/28/2016	02/28/2017	Limit: $5,000,000 Ded: $50,000	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Evidence of Insurance

CERTIFICATE HOLDER	CANCELLATION
Evidence of Insurance	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE Stuart B. Wilkins

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ALSTR

AON

Summary of Insurance Contract

Sent to:

State of Nebraska
Administrative Services
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

We, the undersigned Insurance Brokers, hereby verify that Greenwich Insurance Company and National Casualty Company have issued the following described insurance, each for their own part and not one for the other, and which is in force as of the date hereof:

Type of Insurance:	Professional Indemnity Insurance
Name of Assured:	THE SEGAL COMPANY (EASTERN STATES), INC., and others, as more fully described in the Policy.
Policy No.:	MPP 0022143 10
Insurer(s):	Greenwich Insurance Company and National Casualty Company
Period:	12:01 a.m. January 30, 2016 to 12:01 a.m. January 30, 2017
Limit:	Not less than US$1,000,000

Subject to the terms, conditions, exclusions and limitations of the Policy(ies).

This document is furnished as a matter of information only. The limits shown are as requested. The issuance of this document does not make the person or organization to whom it is issued an additional Assured, nor does it modify in any manner the contract of insurance between the Assured and the Insurers. Any amendment, change or extension of such contract can only be effected by specific endorsement attached thereto.

Date: May 11, 2016

Aon Risk Services Northeast Inc

Aon Risk Solutions | Specialty | Professional Services
199 Water Street | 9th Floor | New York, NY 10038 | USA
t +1.212.441 1000 | f +1.212.441 1921 | www.aon.com
Aon Risk Services Northeast, Inc.

Appendix C: Segal's Legal Department General & BAA Comments

Segal's Legal Department's Comments

Segal's Office of General Counsel has reviewed the terms and conditions of this Request for Proposal and has suggested the following exceptions in redline format, as required under this RFP. We will be glad to discuss any or all of these requested changes with DAS and the State and to agree on mutually acceptable language to reach a final contract. Please let us know if you desire to discuss any of these items and we will immediately schedule a conference call with our General Counsel at your convenience.

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

Any entity awarded a contract or submitting a RFP agrees not to sue, file a claim, or make a demand of any kind, and will indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses ~~of every nature~~, including investigation costs and expenses, settlement costs, and reasonable attorney fees and expenses ("the claims"), sustained or asserted against the State, ~~arising out of,~~ resulting from, ~~or attributable to~~ the posting of contracts, RFPs and related documents.

STATE OF NEBRASKA

BUSINESS ASSOCIATE AGREEMENT

3. Obligations of Business Associate.

c. Report to the Plan's designated privacy official, ~~without unreasonable delay but in no event more than three (3) business days after discovery by Business Associate~~, any Use or Disclosure of PHI not provided for by this Agreement of which Business Associate becomes aware, including any Breach of Unsecured Protected Health Information as required at 45 CFR 164.410, and any Security Incident of which it becomes aware, together with any remedial or mitigating action taken or proposed to be taken with respect thereto. ~~If Business Associate does not have available complete information in satisfaction of 45 CFR 164.410(c) within three (3) business days of discovery of the impermissible Use or Disclosure, Business Associate shall provide all information it has at such time, and immediately update the Plan with additional information as it becomes available through prompt investigation.~~ In the event of Breach of Unsecured Protected Health Information, such report shall be made without unreasonable delay but in no event more than thirty (30) calendar days after discovery by Business Associate. This Agreement serves as Business Associate's notice to the Plan that attempted but unsuccessful Security Incidents regularly occur and that no further notice will be made by Business Associate unless there has been a successful Security Incident or attempts or patterns of attempts that Business Associate determines to be suspicious.

Business Associate shall cooperate with the Plan in mitigating any harmful effects of any impermissible Use or Disclosure. In the case of a Breach ~~as determined to exist in the sole discretion of the Plan which was due to a violation of this Agreement by Business Associate~~,

Business Associate shall pay for the reasonable and actual costs of ~~investigation~~,agreed upon mitigation and notification to affected Individuals. As an alternative to Business Associate reimbursing Company and the Plan for the costs of notification, the Plan may elect to have Business Associate directly provide the notifications to Individuals for breaches caused by Business Associate, provided that Company and the Plan shall have final approval of all content of notifications to Individuals.

d. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), ensure that any Subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree in writing to the same or more stringent restrictions, conditions, and requirements that apply to Business Associate with respect to such information.

e. Within ten (10) business days of request by an Individual or notification by the Plan, make available to the Individual such Individual's PHI maintained by Business Associate in a Designated Record Set in accordance with 45 CFR 164.524. ~~The parties agree that Individuals will be directed to Business Associate to make all requests for access to PHI. Business Associate will provide such access according to its own procedures for such access in accordance with the requirements of 45 CFR 164.524. If the requested PHI is maintained in one or more Designated Record Sets electronically and if the Individual requests an electronic copy of such PHI, Business Associate must provide the Individual with access to PHI in the electronic form and format requested by the Individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to between Business Associate and the Individual. Business Associate shall provide the requested information directly to the Individual, along with a notice to the Individual that a copy of the individual's request has been furnished to the Plan and that the Plan may provide additional information to the Individual in response to the request.~~

If the Individual's request covers records not maintained by Business Associate, Business Associate shall notify the Plan ~~within three (3) days~~ as soon as possible upon receipt of the request. The Plan will be responsible for providing access or otherwise responding directly to the Individual pursuant to the HIPAA Rules with respect to PHI not in the possession of Business Associate or an agent or subcontractor of Business Associate. Business Associate may charge the Individual reasonable fees related to this access, as determined by Business Associate, but only in such amounts as permitted by the HIPAA Rules. The Plan authorizes Business Associate to require payment of such fees from the Individual prior to releasing any records.

f. Business Associate agrees to receive requests for amendment and amend PHI as required by 45 CFR 164.526 on the Plan's behalf for as long as such information is maintained by Business Associate. ~~The parties agree that Individuals will be directed to Business Associate to make all such requests for amendment of PHI. Business Associate will amend such PHI according to its own procedures for such amendment in accordance with the requirements of 45 CFR 164.526.~~ If the Individual's request covers records not maintained by Business Associate, Business Associate shall notify the Plan ~~within three (3) days~~ as soon as possible upon receipt of such request. The Plan will be responsible for amending or otherwise responding directly to the Individual pursuant to the HIPAA Rules with respect to PHI not in the possession of Business Associate or an agent or contractor of Business Associate. Business Associate shall notify the Plan of any amendments made to PHI.

g. Business Associate agrees to process all requests for disclosure accounting by Individuals for as long as such information is maintained by Business Associate. Individuals will be directed to Business Associate to make all such requests. Business Associate will provide the accounting that is required under 45 CFR 164.528 on the Plan's behalf directly to the

Individual. Business Associate will provide such accounting according to its own procedures for such accounting in accordance with the requirements of 45 CFR 164.528.
Business Associate shall notify the Plan ~~within three (3) days~~ as soon as possible of any request made by an Individual for a disclosure accounting. The Plan will be responsible for responding directly to the Individual (or the Individual's personal representative) pursuant to 45 CFR 164.528 with respect to disclosures of PHI by persons or entities other than Business Associate or a subcontractor or agent of Business Associate. ~~Business Associate shall provide directly to the Individual the requested accounting of disclosures made by Business Associate or a subcontractor or agent of Business Associate, along with a notice to the Individual that a copy of the Individual's request has been furnished to the Plan and that the Plan may provide additional information to the Individual in response to the request.~~

h. Subject to applicable legal privileges or other legally binding confidentiality obligations, ~~Make~~ make its internal practices, books and records relating to this Agreement available to the Secretary of HHS, in the time and manner designated by the Secretary, and to the Plan, upon reasonable notice and during normal business hours, for purposes of determining the Plan's and Business Associate's compliance with the HIPAA Rules.

4. Permitted Uses and Disclosures of PHI.

f. ~~If de-identification is listed as a Business Associate Function in the Services Agreements, or if Business Associate is expressly permitted to de-identify PHI and use data thus de-identified for its own uses in the Services Agreements,~~ Business Associate may Use PHI to de-identify the information in accordance with 45 CFR 164.514(a)-(c). ~~Business Associate may use de-identified data only for the purposes specified in the Services Agreements~~ and may use or disclose information that has been de-identified.

8. Liability and ~~Indemnification~~ Reimbursement.

Each party shall be responsible for the acts and omissions of its own agents, employees and contractors. Notwithstanding the foregoing, and notwithstanding any limitation of liability or disclaimer of damages in the Services Agreements or elsewhere, to the extent that the Secretary determines that Business Associate is acting as an agent of the Plan under the Services Agreements or this Agreement, Business Associate shall ~~indemnify~~ reimburse Company and the Plan for any fines, civil monetary penalties or monetary resolutions incurred by Company or the Plan, ~~plus reasonable attorneys' fees of Company and the Plan, arising out of or relating to the actions or omissions of Business Associate which constitute a breach of this Agreement by Business Associate. This indemnification is in addition to any additional indemnification provided by Business Associate in the Services Agreement resulting from Business Associate's improper use or disclosure of PHI.~~

9. **Term and Termination**.

b. **Termination.** Either party may terminate this Agreement if the other violates a material term of the Agreement, provided that the non-breaching party provides the breaching party with no less than 30 days in which to cure such violation prior to termination becoming effective. However, if the non-breaching party reasonably and in good faith determines that the violation is not curable, it may terminate this Agreement immediately upon written notice to the breaching party. Upon termination of this Agreement, the Services Agreement between the parties also shall terminate to the extent that it requires Business Associate to access, use, disclose and/or maintain PHI in order to provide the Services. ~~Company may immediately terminate this Agreement and the Services Agreements, if Company and/or the Plan makes the determination that Business Associate has breached a material term of this Agreement. Alternatively, Company may choose to provide Business Associate with written notice of the existence of an~~

~~alleged material breach, and afford Business Associate an opportunity to cure the alleged material breach upon mutually agreeable terms. Failure to take reasonable steps to cure the breach is grounds for the immediate termination of this Agreement.~~

c. **Business Associate Obligations Upon Termination.**

(i) Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities or as to which Business Associate reasonably determines such PHI is technically incapable of being returned or destroyed. The Company and the Plan understand that Business Associate's need to maintain portions of the PHI for archival purposes related to memorializing advice provided will render return or destruction infeasible;

10. Miscellaneous.

f. **Informal Resolution**. If any controversy, dispute, or claim arises between the parties with respect to this Agreement, the parties shall make good faith efforts to resolve such matters informally.

g. **Notices**. All notices to be given pursuant to the terms of this Agreement shall be in writing and shall be sent certified mail, return receipt requested, postage prepaid or by courier service. If to Company or the Plan, the notice shall be sent to such address as Company notifies Business Associate of in writing. If to Business Associate, the notice shall be sent to the Privacy Official, c/o General Counsel, The Segal Group, 333 West 34th Street, New York, New York 10001.

Appendix D

Appendix D: Sample Health Benefits & Actuarial Reports

We have provided nine (9) sample health benefits and actuarial client reports in our response to this request for proposal.

In order to conserve space and support the evaluators, we have submitted all of the required reports under a separate Sample Reports Binder and have listed them under our technical proposal under Appendix D.

The below list is the order in which they appear in the proposal response document, by Tab.

- **Tab 1,** *"Using the Dashboard to Monitor the Health Population Profile of the Population, State of Maryland, Department of Budget and Management, September 2015"*
- **Tab 2,** *"City of Chicago Projected Annuitant Plan Costs 12-Month Rates Effective July 1, 2012 - June 30, 2013"*
- **Tab 3,** *"Local XYZ Plan/Trust/Fund, Health Benefits Report – Fiscal Year Ending 2011"*
- **Tab 4,** *"Incurred But Unpaid Valuation as of 6/30/2015"*
- **Tab 5,** *"National Health & Welfare Fund – ROI and Performance Measurement of Wellness and Disease Management, December 2010"*
- **Tab 6,** *"State of Connecticut, Budget Projections Fiscal Years Ending June 30, 2016, 2017, and 2018 – February 2016"*
- **Tab 7,** *"Department of Budget and Management, Fiscal Year 2014, Monthly Budget to Actual Report Through January 2014"*
- **Tab 8,** *"State of Wisconsin Insurance Board Department of Employee Trust Funds, Health Care Benefits Consultant, Second Report – Observations and Recommendations for 2017 and Beyond"*
- **Tab 9,** *"Sample Medical Intelligence Report, April 2009 through March 2011"*





USING THE DASHBOARD TO MONITOR THE HEALTH PROFILE OF THE POPULATION

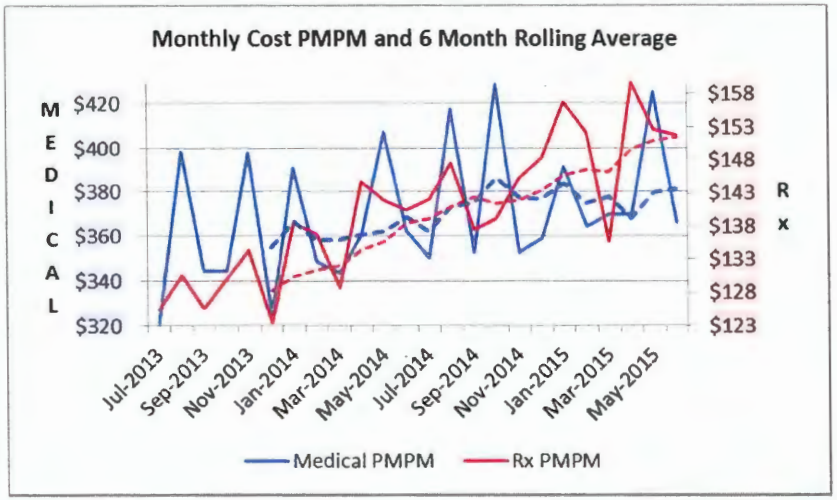
State of Maryland
Department of Budget and Management

September 9, 2015

Doc #: 8235984

Healthcare Dashboard
Current Period: Jul 2014 – Jun 2015

1 Principal Financial Trends – Claims Cost
Active + Non-Medicare Retirees





Observation

- The Rx PMPM increased 10.6%, while Medical PMPM increased 5.7%.

Recommendations

- Continue to work with ESI to mitigate future increases, especially for specialty drugs.

2 Claims Summary
Active + Non-Medicare Retirees

	CURRENT PERIOD			PRIOR PERIOD			
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total	Total Paid Amount	Total Paid PMPM	% of Total	% Change in PMPM
Outpatient Hospital	$248,419,791	$112.27	21.6%	$256,434,597	$114.15	23.5%	-1.6%
Inpatient Hospital	$243,941,709	$110.25	21.2%	$235,249,716	$104.72	21.6%	5.3%
Non-Facility	$257,628,846	$116.43	22.4%	$241,822,163	$107.65	22.2%	8.2%
Ambulatory Surg Center	$17,675,557	$7.99	1.5%	$18,657,633	$8.31	1.7%	-3.8%
Home	$12,105,276	$5.47	1.1%	$12,160,333	$5.41	1.1%	1.1%
Emergency Room	$18,112,781	$8.19	1.6%	$17,440,409	$7.76	1.6%	5.4%
All Others*	$49,014,135	$22.15	4.3%	$31,496,280	$14.02	2.9%	58.0%
Total Medical	**$846,898,096**	**$382.75**	**73.6%**	**$813,261,132**	**$362.02**	**74.6%**	**5.7%**
Total Rx	**$304,347,719**	**$147.13**	**26.4%**	**$277,159,197**	**$133.07**	**25.4%**	**10.6%**
Total Paid	**$1,151,245,815**	**$520.29**	**100.0%**	**$1,090,420,328**	**$485.40**	**100.0%**	**7.2%**
Member Paid	**$89,331,536**	**$40.37**	**7.8%**	**$93,266,054**	**$41.52**	**8.6%**	**-2.8%**
Plan Paid	**$1,061,914,279**	**$479.92**	**92.2%**	**$997,154,275**	**$443.88**	**91.4%**	**8.1%**

*Increase in the All Other category is due to a data change in the CareFirst layout that began including Procedure Codes in the Institutional data set beginning in October 2014.



Observation

- Member Paid PMPM decreased 2.8%, while Plan Paid PMPM increased 8.1%. Overall, total trend increased 7.2%.
- The decrease in Outpatient Hospital is most likely due to data changes in the Carefirst layout. Claims that would have previously fallen into the Outpatient Hospital category are now classified as Ancillaries and fall into the All Others Place of Service.

Recommendations

- Evaluate pharmaceutical claims paid by the medical plan to see if the plan would benefit from having these claims paid by the Rx plan, as nearly 40% of claims paid in the All Others category is attributable to J-Codes.

Healthcare Dashboard
Current Period: Jul 2014 – Jun 2015

3 Key Healthcare Performance Metrics
Active + Non-Medicare Retirees

Category	Current Period	Prior Period	% Change	Norm*	Comparison To Norm
Avg Membership Per Month**	186,193	187,205	-0.5%	N/A	N/A
Office Visits Per 1000	4,241	3,997	6.1%	4,264	-0.5%
Inpatient Admissions Per 1000	74	70	6.5%	70	6.0%
Inpatient Days Per Thousand	350	293	19.4%	333	5.0%
Average Inpatient Day Cost	$3,745	$4,288	-12.7%	$3,555	5.4%
Average Cost Per Admission	$17,656	$18,028	-2.1%	$16,193	9.0%
Readmission within 30 days per 1000	117	137	-14.9%	N/A	N/A
ER Visits Per 1000	226	225	0.8%	258	-12.2%
Rx Scripts Per 1000	11,486	11,409	0.7%	11,857	-3.1%

* Verisk BOB Norms

**Based on average medical membership, including Kaiser members



Observation

- Office Visits continue to increase and are now aligned with the norm.
- The average inpatient day cost and cost per admission both decreased and are becoming closer to the norm.
- Rx scripts per 1,000 remain consistent and are below the norm.

Recommendations

- Continue to monitor Office Visit utilization as the impact of the wellness program should yield more PCP visits throughout the year.

4 Major Conditions – Prevalence and Cost
Active + Non-Medicare Retirees with Conditions

Chronic Condition	CURRENT PERIOD							% Change	
	Members*	% of Total	Norm	Paid	% of Total	PMPY	% of Avg PMPY	Members	PMPY
1. Diabetes	14,631	7.9%	3.5%	$142,831,224	16.9%	$9,762	213%	0.4%	3.6%
2. CAD	6,540	3.5%	1.1%	$102,380,498	12.1%	$15,655	341%	-6.9%	5.3%
3. Asthma	15,691	8.5%	1.1%	$93,044,589	11.0%	$5,930	129%	6.5%	11.5%
4. COPD	2,334	1.3%	0.5%	$38,158,412	4.5%	$16,349	356%	-5.2%	18.4%
5. Hypertension	50,718	27.5%	6.0%	$379,568,765	44.8%	$7,484	163%	-2.7%	4.9%
6. Mental Illness	53,640	29.1%	18.6%	$345,175,507	40.8%	$6,435	140%	10.6%	4.2%
7. Substance Abuse	16,553	9.0%	2.1%	$127,667,910	15.1%	$7,713	168%	6.4%	3.1%
8. CHF	346	0.2%	0.2%	$15,287,317	1.8%	$44,183	962%	-0.6%	12.2%
TOTALS (unique)	**97,794**	**53.0%**		**$570,918,389**		**$5,838**		**2.4%**	**3.4%**

*Members with co-morbidities and their corresponding claims are combined in each applicable category. Kaiser members are included.



Observation

- 53.0% of Active and Non-Medicare Retiree members have been identified with at least one of these chronic diseases.
- The members identified with Mental Illness are well above the norm and the medical paid dollars associated with these members consist of 40.8% of total paid dollars for Actives and Non-Medicare Retirees.

Recommendations

- Evaluate Mental Health and target those members who also have, or are at risk to develop, a comorbid behavioral health condition for intervention.

5 High Risk High Cost Analysis

Active + Non-Medicare Retirees High Cost By Condition

Chronic Condition For High Cost Claimants*	CURRENT PERIOD Members	% Within Condition	PMPY	PRIOR PERIOD Members	% Within Condition	PMPY	% Change in Members	% Change in PMPY
1. Diabetes	1,201	8.2%	$67,980	1,180	8.1%	$66,030	1.8%	3.0%
2. CAD	948	14.5%	$75,061	1,003	14.3%	$71,230	-5.5%	5.4%
3. Asthma	659	4.2%	$65,926	595	4.0%	$56,676	10.8%	16.3%
4. COPD	319	13.7%	$84,732	319	13.0%	$69,954	0.0%	21.1%
5. Hypertension	3,130	6.2%	$64,562	3,072	5.9%	$63,182	1.9%	2.2%
6. CHF	109	31.5%	$122,875	117	33.6%	$102,524	-6.8%	19.8%
7. Breast Cancer	382	17.4%	$72,768	389	18.2%	$76,758	-1.8%	-5.2%
8. Colon Cancer	97	26.1%	$80,979	96	24.2%	$95,329	1.0%	-15.1%
9.Prostate Cancer	160	13.2%	$59,664	175	14.4%	$56,589	-8.6%	5.4%
TOTALS (unique)	**3,893**		**$63,224**	**3,866**		**$60,585**	**0.7%**	**4.4%**

*High Cost Claimants are above $25,000



Observation

- The number of high cost claimants increased 0.7% and the PMPY for those claimants increased 4.4%.
- Asthma had the largest increase in members and COPD had the largest increase in PMPY of all the chronic conditions measured.

Recommendations

- High cost claimants with chronic conditions should be targeted in the disease management program and their participation should be evaluated.

6 Clinical Quality Performance

Active + Non-Medicare Retirees

Chronic Condition	Clinical Quality Metrics	Individuals Population	Performance Current Period	Performance Prior Period	NCQA National Average*
Diabetes	· At least 2 hemoglobin A1C tests in last 12 months	14,631	59.8%	51.4%	87.30%
	· Annual screening for diabetic nephropathy	14,631	70.1%	62.7%	77.90%
	· Annual screening for diabetic retinopathy	14,631	38.6%	46.2%	48.40%
CAD	· Patients currently taking an ACE-Inhibitor	6,540	32.0%	32.8%	78.80%
	· Patients currently taking a statin	6,540	68.5%	68.9%	Not Available
Hyperlipidemia	· Total cholesterol testing in last 12 months	54,197	74.8%	68.7%	Not Available
COPD	· Spirometry testing in last 12 months	2,334	35.0%	32.4%	40.40%
Asthma	·Patients with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	15,691	67.5%	69.6%	91.70%
Preventive Screening	· Cervical cancer	80,941	44.7%	44.9%	74.40%
	· Breast cancer	50,723	49.9%	47.6%	66.80%
	· Colorectal cancer	63,804	32.0%	32.1%	55.20%
	· Prostate cancer	28,433	46.2%	42.2%	Not Available

*Source: NCQA – State of Health Care Quality 2013 – Accredited Plans 2012 Commercial PPO Averages



Observation

- Asthma care gap compliance continues to decrease and is well below the norm. As the number of members with Asthma continues to increase (panel 4) it is crucial that they are compliant to mitigate future costs.
- Clinical compliance rates for Hyperlipidemia and COPD increased significantly from the prior period.

Recommendations

- Monitor improvements in clinical metrics against vendor self-reported results as part of the EBD value-based benefit design and shared savings arrangement.

7 Summary of Prescription Drug Expenses

Active + Non-Medicare Retirees

	Non-Specialty		Specialty		Total		
Category	Current Period	Change	Current Period	Change	Current Period	Prior Period	Change
Total Cost	$230,414,287	9.0%	$73,933,432	12.3%	$304,347,719	$277,159,197	9.8%
% of Total Costs	75.7%	-0.7%	24.3%	2.3%			
Total Scripts	1,952,859	-0.1%	27,062	3.2%	1,979,921	1,980,306	0.0%
% of Total Scripts	98.6%	0.0%	1.4%	3.2%			
Avg Cost PMPM	$111.39	9.8%	$35.74	13.1%	$147.13	$133.07	10.6%
Avg Cost Per Rx	$117.99	9.1%	$2,732.00	8.9%	$153.72	$139.96	9.8%
Number of Scripts PMPM	0.94	0.6%	0.01	3.9%	0.96	0.95	0.7%
PBM Generic Dispensing Rate	81.4%	2.9%	39.7%	1.5%	80.8%	78.6%	2.9%
Member Cost %	11.6%	-12.4%	0.7%	3.9%	9.0%	10.3%	-12.7%



Observation

- Total cost increased 9.8% while average cost PMPM increased 10.6%.
- Specialty drugs account for 24.3% of total cost of prescription drugs.

Recommendations

- Multiple PCSK9 drugs are being introduced into the market this summer (Praluent, Repatha, etc.). Continue to engage ESI to discuss ways to control these costs, including use of guidelines and recommendations on who meets the criteria to use these drugs.

8 Prescription Drug Cost Management Analysis

Active + Non-Medicare Retirees

Top 10 Indications	Rxs	Total Cost	Generic Fill Rate	PMPM
Diabetes	87,319	$29,882,981	56.4%	$14.45
Autoimmune Disease	9,203	$20,795,015	14.9%	$10.05
Hepatitis	1,024	$18,902,025	25.3%	$9.14
Multiple Sclerosis	2,915	$15,785,308	0.0%	$7.63
Lipid/Cholesterol Disorders	114,017	$15,544,752	76.9%	$7.52
Cardiovascular/Hypertension	283,412	$14,185,379	92.4%	$6.86
Viral Infections/HIV AIDS	8,109	$13,403,222	4.9%	$6.48
Skin Disorders	60,157	$12,817,090	78.8%	$6.20
Pain Management	177,678	$12,192,759	92.8%	$5.89
Ulcer	87,755	$11,355,816	79.5%	$5.49
Total Top 10:	**831,589**	**$164,864,346**	**82.1%**	**$79.70**



Observation

- Continue to focus on lifestyle changes for members who fall into the diabetic, lipid/cholesterol and cardiovascular/hypertension categories.
- Pain Management is ranked in the top 10 indicators.

Recommendations

- Continue to monitor the cost of Lipid/Cholesterol Disorders as a result of the newly available PCSK9 inhibitors.
- Hepatitis is still a leading indicator, so continue to work with ESI on evaluating newly introduced drugs to the market.

SPOTLIGHT ON

Opioid Abuse (All Members)

- The below exhibit shows how many prescribers each member visited to get a script for an opioid drug, broken out by members who have not been diagnosed with substance abuse and by members who have been diagnosed with substance abuse.

	Members Not Diagnosed with Substance Abuse		Members Diagnosed with Substance Abuse	
Number of Opioid Prescribers	Count of Members	Percent of Members	Count of Members	Percent of Members
1	30,354	67.38%	3,373	52.87%
2	8,750	19.42%	1,457	22.84%
3	3,349	7.43%	692	10.85%
4	1,380	3.06%	392	6.14%
5	615	1.37%	211	3.31%
6	306	0.68%	115	1.80%
7	126	0.28%	48	0.75%
8	84	0.19%	23	0.36%
9	46	0.10%	19	0.30%
10	14	0.03%	19	0.30%
11	8	0.02%	13	0.20%
12	5	0.01%	5	0.08%
13	0	0.00%	5	0.08%
14	3	0.01%	3	0.05%
15	5	0.01%	1	0.02%
17	0	0.00%	1	0.02%
19	0	0.00%	2	0.03%
20	0	0.00%	1	0.02%
22	1	0.00%	0	0.00%
Grand Total	**45,046**		**6,380**	

SPOTLIGHT ON

Opioid Abuse (All Members)

- The plan paid amount for opioid drugs for members not diagnosed with substance abuse and who had at least one script for an opioid drug represents 4.84% of the total Rx plan paid, compared to 14.97% for members who have been diagnosed with substance abuse.

	Members Not Diagnosed with Substance Abuse			Members Diagnosed with Substance Abuse		
Number of Opioid Prescribers	Rx Plan Paid for Opioid Drugs	Rx Plan Paid for All Drugs	Opioid Percent of Rx Plan Paid	Rx Plan Paid for Opioid Drugs	Rx Plan Paid for All Drugs	Opioid Percent of Rx Plan Paid
1	$2,567,697	$90,830,291	2.83%	$993,386	$10,456,605	9.50%
2	$2,103,634	$42,310,520	4.97%	$875,480	$6,983,755	12.54%
3	$1,644,575	$19,047,282	8.63%	$776,578	$3,800,929	20.43%
4	$804,666	$9,881,419	8.14%	$326,729	$1,979,968	16.50%
5	$554,701	$4,961,708	11.18%	$393,027	$1,276,751	30.78%
6	$304,766	$2,505,750	12.16%	$181,721	$745,512	24.38%
7	$148,095	$1,059,015	13.98%	$60,254	$449,942	13.39%
8	$98,563	$515,487	19.12%	$220,364	$300,870	73.24%
9	$38,291	$361,460	10.59%	$10,404	$110,210	9.44%
10	$28,025	$89,959	31.15%	$35,215	$166,270	21.18%
11	$10,873	$63,580	17.10%	$16,882	$117,346	14.39%
12	$8,166	$40,886	19.97%	$20,623	$28,368	72.70%
13	$0	$0	0.00%	$54,476	$125,178	43.52%
14	$3,347	$15,779	21.21%	$9,548	$21,890	43.62%
15	$2,889	$40,789	7.08%	$91	$2,350	3.89%
17	$0	$0	0.00%	$49	$366	13.29%
19	$0	$0	0.00%	$1,152	$1,580	72.93%
20	$0	$0	0.00%	$199	$1,157	17.20%
22	$163	$5,558	2.94%	$0	$0	0.00%
Grand Total	**$8,318,452**	**$171,729,482**	**4.84%**	**$3,976,180**	**$26,569,047**	**14.97%**

SPOTLIGHT ON

Opioid Abuse (All Members)

	Members Not Diagnosed with Substance Abuse			Members Diagnosed with Substance Abuse		
Number of Opioid Prescribers	Count of Members	Total Rx Plan Paid for Opioid Drugs	Average Rx Plan Paid for Opioid Drugs	Count of Members	Total Rx Plan Paid for Opioid Drugs	Average Rx Plan Paid for Opioid Drugs
1 - 7	44,880	$8,128,134	$181	6,288	$3,607,175	$574
8 +	166	$190,318	$1,146	92	$369,005	$4,011

- Focusing on members who have been prescribed opioids by eight or more prescribers would yield significant plan savings.
- Members with eight or more prescribers had an average plan paid for opioid drugs of $1,146 per member for non-substance abuse members compared to $181 average plan paid for non-substance abuse members who had seven or less prescribers.
- For the substance abuse group, members who had eight or more prescribers had an average plan paid of $4,011 compared to $574 for substance abuse members who had seven or less prescribers.
- The average plan paid for opioid drugs was over three times higher for substance abuse members than non-substance abuse members.

SPOTLIGHT ON

Opioid Abuse (All Members)

- The average plan paid for members with substance abuse is $18,123, compared to $10,948 for members not diagnosed with substance abuse..

	Members Not Diagnosed with Substance Abuse				Members Diagnosed with Substance Abuse			
Number of Opioid Prescribers	Count of Members	Avg. Rx Plan Paid (all drugs)	Avg. Medical Plan Paid	Avg. Plan Paid	Count of Members	Avg. Rx Plan Paid (all drugs)	Avg. Medical Plan Paid	Avg. Plan Paid
1	30,354	$2,992	$5,392	$8,385	3,373	$3,100	$8,761	$11,861
2	8,750	$4,835	$8,664	$13,500	1,457	$4,793	$13,555	$18,349
3	3,349	$5,687	$10,952	$16,639	692	$5,493	$17,603	$23,095
4	1,380	$7,160	$15,568	$22,728	392	$5,051	$27,479	$32,530
5	615	$8,068	$16,134	$24,202	211	$6,051	$28,972	$35,023
6	306	$8,189	$17,370	$25,559	115	$6,483	$34,815	$41,298
7	126	$8,405	$20,563	$28,968	48	$9,374	$41,560	$50,934
8	84	$6,137	$32,118	$38,254	23	$13,081	$29,943	$43,024
9	46	$7,858	$24,721	$32,579	19	$5,801	$43,931	$49,731
10	14	$6,426	$66,240	$72,666	19	$8,751	$52,429	$61,180
11	8	$7,947	$74,686	$82,634	13	$9,027	$69,505	$78,532
12	5	$8,177	$57,653	$65,831	5	$5,674	$65,299	$70,973
13	0	$0	$0	$0	5	$25,036	$67,099	$92,134
14	3	$5,260	$3,848	$9,108	3	$7,297	$58,377	$65,673
15	5	$8,158	$57,858	$66,016	1	$2,350	$70,212	$72,562
17	0	$0	$0	$0	1	$366	$13,011	$13,377
19	0	$0	$0	$0	2	$790	$165,734	$166,524
20	0	$0	$0	$0	1	$1,157	$14,235	$15,392
22	1	$5,558	$0	$5,558	0	$0	$0	$0
Grand Total	**45,046**	**$3,812**	**$7,136**	**$10,948**	**6,380**	**$4,164**	**$13,959**	**$18,123**

SPOTLIGHT ON

Opioid Abuse (All Members)

Top Prescribers by Day Supply

Prescribers	Unique Members	Total Day Supply of Opioids Prescribed	Total Plan Paid for Opioids
Prescriber #1	1	1,543	$71,082
Prescriber #2	1	1,447	$16,777
Prescriber #3	1	1,170	$6,813
Prescriber #4	1	1,140	$5,213
Prescriber #5	1	1,110	$2,151
Prescriber #6	1	1,020	$9,790
Prescriber #7	1	953	$2,468
Prescriber #8	1	845	$1,532
Prescriber #9	1	806	$3,926
Prescriber #10	1	775	$1,311
Grand Total (68):	**110**	**71,207**	**$510,470**

- The above exhibit represents the top 10 prescribers by total day supply of opioid drugs prescribed during the current time period.
- Prescriber #1 prescribed one member a total day supply of 1,543 of opioids during this time period, costing the plan $71,082 in opioid drug cost.
- The grand total at the bottom represents the totals for prescribers who prescribed 500 or more days supply worth of opioids per member. There were 68 prescribers who prescribed 500 or more day supply of opioids to a total of 100 members. The total plan cost of opioid drugs for these members was $510,470.

SPOTLIGHT ON

Opioid Abuse (All Members)

Top Prescribers by Average Plan Cost per Member

Prescriber	Count of Members	Total Day Supply of Opioids Prescribed	Average Day Supply Prescribed per Member	Total Plan Paid of Opioids Prescribed	Average Plan Paid per Member
Prescriber #1	1	345	345	$91,327	$91,327
Prescriber #2	**1**	**1,543**	**1,543**	**$71,082**	**$71,082**
Prescriber #3	2	420	210	$111,102	$55,551
Prescriber #4	2	270	135	$86,597	$43,298
Prescriber #5	3	1,384	461	$128,614	$42,871
Prescriber #6	**1**	**1,447**	**1,447**	**$16,777**	**$16,777**
Prescriber #7	1	390	390	$15,541	$15,541
Prescriber #8	1	623	623	$14,021	$14,021
Prescriber #9	1	602	602	$13,988	$13,988
Prescriber #10	1	170	170	$13,586	$13,586
Top 10 Total:	**14**	**7,194**	**514**	**$562,634**	**$40,188**

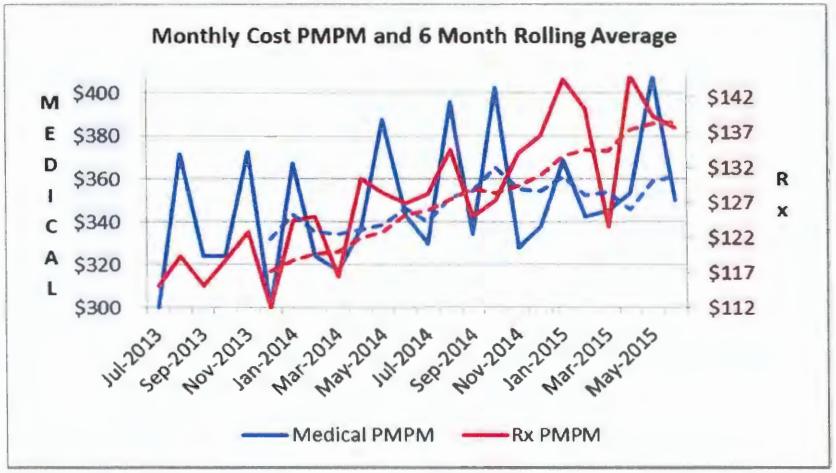
- The above exhibit represents the top 10 prescribers by average plan paid per member for prescribed opioids.
- Prescriber #2 and Prescriber #6 in bold were also captured in the previous slide.
- These top ten providers prescribed opioids for 14 members, averaging 514 day supply per member throughout the current time period. The average cost per member for opioids prescribed by these providers is $40,188.

Appendix

- Dashboards by Status
  - Actives
  - Non-Medicare Retirees
  - Medicare Retirees
  - SLEOLA
  - Non-SLEOLA
  - All
- Dashboard Overview/Methodology
- Benchmarks
- Objective of Dashboard Panels
- Ongoing Use of Dashboard

Healthcare Dashboard
Current Period: Jul 2014 – Jun 2015

1 Principal Financial Trends – Claims Cost
ACTIVE Members



2 Claims Summary –
ACTIVE Members

	CURRENT PERIOD			PRIOR PERIOD			
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total	Total Paid Amount	Total Paid PMPM	% of Total	% Change in PMPM
Outpatient Hospital	$202,335,918	$105.74	21.6%	$206,208,556	$113.61	23.5%	-6.9%
Inpatient Hospital	$199,737,724	$104.38	21.3%	$190,018,873	$104.69	21.7%	-0.3%
Non-Facility	$214,421,245	$112.05	22.9%	$199,373,488	$109.85	22.7%	2.0%
Ambulatory Surg Center	$14,116,302	$7.38	1.5%	$15,040,675	$8.29	1.7%	-11.0%
Home	$9,554,640	$4.99	1.0%	$9,560,108	$5.27	1.1%	-5.2%
Emergency Room	$15,447,203	$8.07	1.6%	$14,889,524	$8.20	1.7%	-1.6%
All Others	$37,133,684	$19.41	4.0%	$23,524,520	$12.96	2.7%	49.7%
Total Medical	**$692,746,717**	**$362.02**	**73.9%**	**$658,615,745**	**$362.87**	**75.1%**	**-0.2%**
Total Rx	**$244,104,462**	**$125.72**	**26.1%**	**$218,881,904**	**$121.08**	**24.9%**	**3.8%**
Total Paid	**$936,851,179**	**$489.58**	**100.0%**	**$877,497,649**	**$483.46**	**100.0%**	**1.3%**
Member Paid	**$70,661,889**	**$36.93**	**7.5%**	**$73,217,845**	**$40.34**	**8.3%**	**-8.5%**
Plan Paid	**$866,189,290**	**$452.66**	**92.5%**	**$804,279,804**	**$443.12**	**91.7%**	**2.2%**

3 Key Healthcare Performance Metrics –
ACTIVE Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison To Norm
Avg Membership Per Month**	161,196	161,802	-0.4%	N/A	N/A
Office Visits Per 1000	4,087	3,856	6.0%	4,205	-2.8%
Inpatient Admissions Per 1000	71	67	7.1%	69	3.5%
Inpatient Days Per Thousand	332	280	18.3%	328	1.1%
Average Inpatient Day Cost	$3,737	$4,192	-10.8%	$3,501	6.8%
Average Cost Per Admission	$17,353	$17,611	-1.5%	$15,760	10.1%
Readmission within 30 days per 1000	113	135	-16.5%	N/A	N/A
ER Visits Per 1000	225	223	0.8%	259	-13.1%
Rx Scripts Per 1000	10,491	10,404	0.8%	11,400	-8.0%

* Verisk BOB Norms

**Based on average medical membership, including Kaiser members

4 Major Conditions – Prevalence and Cost
ACTIVE Members with Conditions

	CURRENT PERIOD							% Change	
Chronic Condition	Members*	% of Total	Norm	Paid	% of Total	PMPY	% of Avg PMPY	Members	PMPY
1. Diabetes	11,326	7.1%	5.7%	$109,092,627	15.7%	$9,632	222%	1.0%	3.0%
2. CAD	4,969	3.1%	1.8%	$78,548,367	11.3%	$15,808	364%	-5.7%	8.7%
3. Asthma	13,306	8.3%	2.1%	$77,450,865	11.2%	$5,821	134%	6.7%	15.2%
4. COPD	1,707	1.1%	0.8%	$28,933,446	4.2%	$16,950	390%	-4.5%	19.9%
5. Hypertension	40,028	25.1%	9.9%	$295,726,006	42.7%	$7,388	170%	-1.8%	5.8%
6. Mental Illness	44,626	28.0%	18.6%	$280,366,361	40.5%	$6,283	145%	11.5%	5.9%
7. Substance Abuse	13,029	8.2%	2.1%	$97,707,836	14.1%	$7,499	173%	6.4%	4.1%
8. CHF	250	0.2%	0.4%	$11,728,286	1.7%	$46,913	1080%	2.9%	15.3%
TOTALS (unique)	**80,752**	**50.6%**		**$460,147,349**		**$5,698**		**3.5%**	**4.3%**

*Members with co-morbidities and their corresponding claims are combined in each applicable category. Kaiser members are included.

5 High Risk High Cost Analysis – ACTIVE Members High Cost By Condition

Chronic Condition For High Cost Claimants*	CURRENT PERIOD			PRIOR PERIOD			% Change in Members	% Change in PMPY
	Members	% Within Condition	PMPY	Members	% Within Condition	PMPY		
1. Diabetes	898	7.9%	$68,105	894	8.0%	$65,781	0.4%	3.5%
2. CAD	728	14.7%	$75,635	736	14.0%	$70,253	-1.1%	7.7%
3. Asthma	513	3.9%	$70,324	469	3.8%	$55,203	9.4%	27.4%
4. COPD	229	13.4%	$91,112	243	13.6%	$69,271	-5.8%	31.5%
5. Hypertension	2,404	6.0%	$65,059	2,320	5.7%	$62,758	3.6%	3.7%
6. CHF	83	33.2%	$125,356	83	34.2%	$103,635	0.0%	21.0%
7. Breast Cancer	293	17.5%	$71,702	293	18.3%	$76,790	0.0%	-6.6%
8. Colon Cancer	80	28.2%	$82,887	68	22.5%	$91,525	17.6%	-9.4%
9.Prostate Cancer	127	13.4%	$56,811	142	14.9%	$56,381	-10.6%	0.8%
TOTALS (unique)	**3,013**		**$64,386**	**2,925**		**$60,635**	**3.0%**	**6.2%**

*High Cost Claimants are above $25,000

6 Clinical Quality Performance – ACTIVE Members

Chronic Condition	Clinical Quality Metrics	Individuals			NCQA National Average*
		Population	Performance Current Period	Performance Prior Period	
Diabetes	· At least 2 hemoglobin A1C tests in last 12 months	11,326	58.4%	50.2%	87.30%
	· Annual screening for diabetic nephropathy	11,326	69.6%	62.4%	77.90%
	· Annual screening for diabetic retinopathy	11,326	37.9%	45.7%	48.40%
CAD	· Patients currently taking an ACE-Inhibitor	4,969	31.6%	32.5%	78.80%
	· Patients currently taking a statin	4,969	66.6%	67.4%	Not Available
Hyperlipidemia	· Total cholesterol testing in last 12 months	42,811	74.1%	67.9%	Not Available
COPD	· Spirometry testing in last 12 months	1,707	34.6%	32.6%	40.40%
Asthma	·Patients with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	13,306	67.7%	69.8%	91.70%
Preventive Screening	· Cervical cancer	68,031	45.0%	45.2%	74.40%
	· Breast cancer	40,174	49.0%	46.5%	66.80%
	· Colorectal cancer	48,039	31.7%	31.6%	55.20%
	· Prostate cancer	22,045	45.8%	41.4%	Not Available

*Source: NCQA – State of Health Care Quality 2013 – Accredited Plans 2012 Commercial PPO Averages

7 Summary of Prescription Drug Expenses – ACTIVE Members

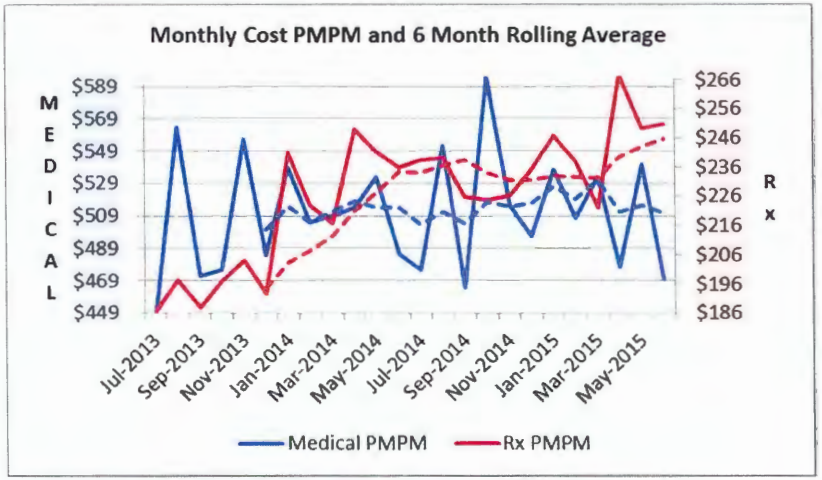
Category	Non-Specialty		Specialty		Total		
	Current Period	Change	Current Period	Change	Current Period	Prior Period	Change
Total Cost	$182,979,499	10.9%	$61,124,963	13.5%	$244,104,462	$218,881,904	11.5%
% of Total Costs	75.0%	-0.6%	25.0%	1.8%			
Total Scripts	1,564,235	1.2%	22,514	4.3%	1,586,749	1,567,269	1.2%
% of Total Scripts	98.6%	0.0%	1.4%	3.0%			
Avg Cost PMPM	$100.81	10.4%	$33.68	13.0%	$134.49	$121.08	11.1%
Avg Cost Per Rx	$116.98	9.6%	$2,714.98	8.8%	$153.84	$139.66	10.2%
Number of Scripts PMPM	0.86	0.8%	0.01	3.9%	0.87	0.87	0.8%
PBM Generic Dispensing Rate	81.5%	2.8%	39.2%	1.9%	80.9%	78.7%	2.8%
Member Cost %	11.5%	-12.8%	0.7%	-0.1%	8.8%	10.1%	-13.1%

8 Prescription Drug Cost Management Analysis – ACTIVE Members

Top 10 Indications	RXs	Total Cost	Generic Fill Rate	PMPM
Diabetes	66,611	$22,803,854	56.3%	$12.56
Autoimmune Disease	7,496	$16,872,659	13.6%	$9.30
Hepatitis	824	$14,957,574	24.9%	$8.24
Multiple Sclerosis	2,348	$12,784,405	0.0%	$7.04
Viral Infections/HIV AIDS	7,030	$11,576,691	5.1%	$6.38
Lipid/Cholesterol Disorders	84,551	$11,288,182	77.3%	$6.22
Cardiovascular/Hypertension	219,149	$10,930,206	92.4%	$6.02
Skin Disorders	50,575	$10,663,123	78.9%	$5.87
Pain Management	140,205	$9,292,195	93.0%	$5.12
ADHD	37,858	$9,064,925	63.6%	$4.99
Total Top 10:	**616,647**	**$130,233,813**	**81.3%**	**$71.75**

Healthcare Dashboard
Current Period: Jul 2014 – Jun 2015

1 Principal Financial Trends – Claims Cost
Non-Medicare Retirees



2 Claims Summary –
Non-Medicare Retirees

	CURRENT PERIOD			PRIOR PERIOD			
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total	Total Paid Amount	Total Paid PMPM	% of Total	% Change in PMPM
Outpatient Hospital	$46,083,873	$154.06	21.5%	$50,226,041	$164.77	23.6%	-6.5%
Inpatient Hospital	$44,203,985	$147.78	20.6%	$45,230,843	$148.38	21.2%	-0.4%
Non-Facility	$43,207,600	$144.45	20.2%	$42,448,675	$139.25	19.9%	3.7%
Ambulatory Surg Center	$3,559,256	$11.90	1.7%	$3,616,958	$11.87	1.7%	0.3%
Home	$2,550,636	$8.53	1.2%	$2,600,225	$8.53	1.2%	0.0%
Emergency Room	$2,665,578	$8.91	1.2%	$2,550,884	$8.37	1.2%	6.5%
All Others	$11,880,451	$39.72	5.5%	$7,971,760	$26.15	3.7%	51.9%
Total Medical	**$154,151,379**	**$515.34**	**71.9%**	**$154,645,387**	**$507.32**	**72.6%**	**1.6%**
Total Rx	$60,243,257	$237.69	28.1%	$58,277,292	$211.87	27.4%	12.2%
Total Paid	$214,394,636	$716.74	100.0%	$212,922,679	$698.50	100.0%	2.6%
Member Paid	$18,669,647	$62.41	8.7%	$20,048,209	$65.77	9.4%	-5.1%
Plan Paid	$195,724,989	$654.33	91.3%	$192,874,471	$632.73	90.6%	3.4%

3 Key Healthcare Performance Metrics –
Non-Medicare Retirees

Category	Current Period	Prior Period	% Change	Norm*	Comparison To Norm
Avg Membership Per Month**	24,997	25,402	-1.6%	N/A	N/A
Office Visits Per 1000	5,252	5,168	1.6%	4,205	24.9%
Inpatient Admissions Per 1000	92	89	3.7%	69	33.7%
Inpatient Days Per Thousand	468	375	24.7%	328	42.6%
Average Inpatient Day Cost	$3,781	$4,747	-20.3%	$3,501	8.0%
Average Cost Per Admission	$19,169	$20,023	-4.3%	$15,760	21.6%
Readmission within 30 days per 1000	135	146	-7.4%	N/A	N/A
ER Visits Per 1000	237	234	1.6%	259	-8.4%
Rx Scripts Per 1000	18,615	18,019	3.3%	11,400	63.3%

* Verisk BOB Norms

**Based on average medical membership, including Kaiser members

4 Major Conditions – Prevalence and Cost
Non-Medicare Retirees with Conditions

	CURRENT PERIOD							% Change	
Chronic Condition	Members*	% of Total	Norm	Paid	% of Total	PMPY	% of Avg PMPY	Members	PMPY
1. Diabetes	3,305	13.3%	8.2%	$33,738,597	21.9%	$10,208	165%	-1.7%	5.3%
2. CAD	1,571	6.3%	2.4%	$23,832,131	15.5%	$15,170	245%	-10.5%	-4.2%
3. Asthma	2,385	9.6%	2.0%	$15,593,725	10.1%	$6,538	106%	5.7%	-3.7%
4. COPD	627	2.5%	1.0%	$9,224,965	6.0%	$14,713	238%	-7.1%	13.6%
5. Hypertension	10,690	42.9%	14.3%	$83,842,759	54.4%	$7,843	127%	-6.0%	1.9%
6. Mental Illness	9,014	36.2%	18.6%	$64,809,147	42.0%	$7,190	116%	6.4%	-2.0%
7. Substance Abuse	3,524	14.1%	2.1%	$29,960,075	19.4%	$8,502	137%	6.2%	-0.2%
8. CHF	96	0.4%	0.4%	$3,559,032	2.3%	$37,073	599%	-8.6%	2.0%
TOTALS (unique)	**17,042**	**68.4%**		**$110,771,041**		**$6,500**		**-2.1%**	**0.4%**

*Members with co-morbidities and their corresponding claims are combined in each applicable category. Kaiser members are included.

5 High Risk High Cost Analysis – Non-Medicare Retirees High Cost By Condition

Chronic Condition For High Cost Claimants*	CURRENT PERIOD			PRIOR PERIOD			% Change in Members	% Change in PMPY
	Members	% Within Condition	PMPY	Members	% Within Condition	PMPY		
1. Diabetes	303	9.2%	$67,612	286	8.5%	$66,807	5.9%	1.2%
2. CAD	220	14.0%	$73,163	267	15.2%	$73,922	-17.6%	-1.0%
3. Asthma	146	6.1%	$50,473	126	5.6%	$62,160	15.9%	-18.8%
4. COPD	90	14.4%	$68,501	76	11.3%	$72,138	18.4%	-5.0%
5. Hypertension	726	6.8%	$62,918	752	6.6%	$64,489	-3.5%	-2.4%
6. CHF	26	27.1%	$114,954	34	32.4%	$99,813	-23.5%	15.2%
7. Breast Cancer	89	17.1%	$76,279	96	17.9%	$76,660	-7.3%	-0.5%
8. Colon Cancer	17	19.5%	$72,001	28	29.5%	$104,567	-39.3%	-31.1%
9.Prostate Cancer	33	12.6%	$70,644	33	12.5%	$57,482	0.0%	22.9%
TOTALS (unique)	880		$59,245	941		$60,429	-6.5%	-2.0%

*High Cost Claimants are above $25,000

6 Clinical Quality Performance – Non-Medicare Retirees

Chronic Condition	Clinical Quality Metrics	Individuals			NCQA National Average*
		Population	Performance Current Period	Performance Prior Period	
Diabetes	· At least 2 hemoglobin A1C tests in last 12 months	3,305	64.8%	55.5%	87.30%
	· Annual screening for diabetic nephropathy	3,305	71.6%	63.6%	77.90%
	· Annual screening for diabetic retinopathy	3,305	40.9%	47.7%	48.40%
CAD	· Patients currently taking an ACE-Inhibitor	1,571	33.3%	33.7%	78.80%
	· Patients currently taking a statin	1,571	74.6%	73.3%	Not Available
Hyperlipidemia	· Total cholesterol testing in last 12 months	11,386	77.5%	71.4%	Not Available
COPD	· Spirometry testing in last 12 months	627	36.0%	31.9%	40.40%
Asthma	·Patients with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	2,385	65.9%	68.6%	91.70%
Preventive Screening	· Cervical cancer	12,910	42.8%	43.4%	74.40%
	· Breast cancer	10,549	53.4%	51.7%	66.80%
	· Colorectal cancer	15,765	32.7%	33.5%	55.20%
	· Prostate cancer	6,388	47.6%	44.7%	Not Available

*Source: NCQA – State of Health Care Quality 2013 – Accredited Plans 2012 Commercial PPO Averages

7 Summary of Prescription Drug Expenses – Non-Medicare Retirees

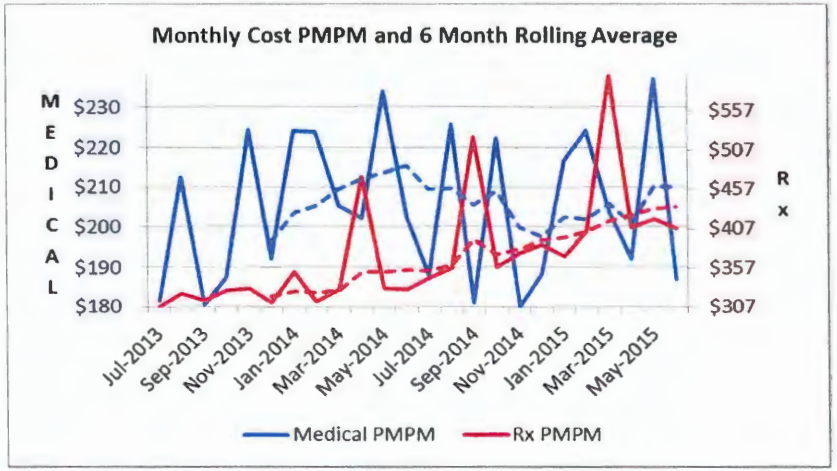
Category	Non-Specialty		Specialty		Total		
	Current Period	Change	Current Period	Change	Current Period	Prior Period	Change
Total Cost	$47,434,789	2.4%	$12,808,468	7.0%	$60,243,257	$58,277,292	3.4%
% of Total Costs	78.7%	-0.9%	21.3%	3.5%			
Total Scripts	388,624	-4.8%	4,548	-2.2%	393,172	413,037	-4.8%
% of Total Scripts	98.8%	0.0%	1.2%	2.7%			
Avg Cost PMPM	$187.16	11.2%	$50.54	16.1%	$237.69	$211.87	12.2%
Avg Cost Per Rx	$122.06	7.6%	$2,816.29	9.5%	$153.22	$141.09	8.6%
Number of Scripts PMPM	1.53	3.3%	0.02	6.1%	1.55	1.50	3.3%
PBM Generic Dispensing Rate	81.1%	3.4%	42.3%	0.5%	80.7%	78.1%	3.3%
Member Cost %	12.1%	-10.5%	0.8%	23.5%	9.7%	10.9%	-10.9%

8 Prescription Drug Cost Management Analysis – Non-Medicare Retirees

Top 10 Indications	RXs	Total Cost	Generic Fill Rate	PMPM
Diabetes	20,708	$7,079,127	56.8%	$27.93
Lipid/Cholesterol Disorders	29,466	$4,256,570	75.8%	$16.79
Hepatitis	200	$3,944,451	27.0%	$15.56
Autoimmune Disease	1,707	$3,922,356	20.4%	$15.48
Cardiovascular/Hypertension	64,263	$3,255,173	92.4%	$12.84
Multiple Sclerosis	567	$3,000,903	0.0%	$11.84
Pain Management	37,473	$2,900,564	91.7%	$11.44
Ulcer	20,170	$2,850,378	78.3%	$11.25
Oncology	2,153	$2,292,294	88.7%	$9.04
Skin Disorders	9,582	$2,153,967	78.6%	$8.50
Total Top 10:	**186,289**	**$35,655,783**	**82.4%**	**$140.68**

Healthcare Dashboard
Current Period: Jul 2014 – Jun 2015

1 Principal Financial Trends – Claims Cost
Medicare Retirees



2 Claims Summary –
Medicare Retirees

	CURRENT PERIOD			PRIOR PERIOD			
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total	Total Paid Amount	Total Paid PMPM	% of Total	% Change in PMPM
Outpatient Hospital	$30,784,374	$59.11	9.9%	$33,497,847	$66.56	12.2%	-11.2%
Inpatient Hospital	$29,200,634	$56.07	9.4%	$28,601,940	$56.83	10.5%	-1.3%
Non-Facility	$32,190,018	$61.81	10.3%	$30,161,310	$59.93	11.0%	3.1%
Ambulatory Surg Center	$525,198	$1.01	0.2%	$757,269	$1.50	0.3%	-33.0%
Home	$2,968,677	$5.70	1.0%	$3,406,302	$6.77	1.2%	-15.8%
Emergency Room	$1,208,752	$2.32	0.4%	$1,165,753	$2.32	0.4%	0.2%
All Others	$9,328,671	$17.91	3.0%	$6,096,956	$12.12	2.2%	47.8%
Total Medical	**$106,206,325**	**$203.93**	**34.1%**	**$103,687,377**	**$206.04**	**37.9%**	**-1.0%**
Total Rx	**$205,660,983**	**$414.34**	**65.9%**	**$169,797,367**	**$338.91**	**62.1%**	**22.3%**
Total Paid	**$311,867,308**	**$598.82**	**100.0%**	**$273,484,744**	**$543.44**	**100.0%**	**10.2%**
Member Paid	**$24,074,482**	**$46.23**	**7.7%**	**$26,046,228**	**$51.76**	**9.5%**	**-10.7%**
Plan Paid	**$287,792,826**	**$552.59**	**92.3%**	**$247,438,516**	**$491.68**	**90.5%**	**12.4%**

3 Key Healthcare Performance Metrics –
Medicare Retirees

Category	Current Period	Prior Period	% Change	Norm*	Comparison To Norm
Avg Membership Per Month**	43,401	41,938	3.5%	N/A	N/A
Office Visits Per 1000	9,081	8,700	4.4%	7,219	25.8%
Inpatient Admissions Per 1000	241	238	1.2%	170	41.9%
Inpatient Days Per Thousand	1444	1486	-2.9%	1,141	26.5%
Average Inpatient Day Cost	$466	$459	1.6%	$357	30.6%
Average Cost Per Admission	$2,790	$2,863	-2.6%	$2,251	23.9%
Readmission within 30 days per 1000	65	110	-41.0%	N/A	N/A
ER Visits Per 1000	338	313	8.1%	346	-2.2%
Rx Scripts Per 1000	33,218	31,045	7.00%	25,794	28.8%

* Verisk BOB Norms

**Based on average medical membership, including Kaiser members

4 Major Conditions – Prevalence and Cost
Medicare Retirees with Conditions

	CURRENT PERIOD							% Change	
Chronic Condition	Members*	% of Total	Norm	Paid	% of Total	PMPY	% of Avg PMPY	Members	PMPY
1. Diabetes	11,512	26.5%	18.5%	$33,997,391	32.0%	$2,953	121%	0.0%	-3.6%
2. CAD	11,192	25.8%	10.9%	$37,240,345	35.1%	$3,327	136%	-2.0%	-7.5%
3. Asthma	3,533	8.1%	2.2%	$9,840,052	9.3%	$2,785	114%	7.0%	1.8%
4. COPD	4,253	9.8%	5.0%	$15,940,954	15.0%	$3,748	153%	-0.3%	0.3%
5. Hypertension	33,992	78.3%	31.7%	$80,780,249	76.1%	$2,376	97%	-1.4%	-1.2%
6. Mental Illness	17,930	41.3%	18.6%	$49,945,854	47.0%	$2,786	114%	11.4%	-7.4%
7. Substance Abuse	5,128	11.8%	2.1%	$14,812,514	13.9%	$2,889	118%	18.3%	-10.7%
8. CHF	1,085	2.5%	3.0%	$6,487,821	6.1%	$5,980	244%	0.7%	-8.2%
TOTALS (unique)	**38,958**	**89.8%**		**$88,693,632**		**$2,277**		**1.6%**	**-2.2%**

*Members with co-morbidities and their corresponding claims are combined in each applicable category. Kaiser members are included.

5 High Risk High Cost Analysis – Medicare Retirees High Cost By Condition

Chronic Condition For High Cost Claimants*	CURRENT PERIOD			PRIOR PERIOD			% Change in Members	% Change in PMPY
	Members	% Within Condition	PMPY	Members	% Within Condition	PMPY		
1. Diabetes	85	0.7%	$65,225	118	1.0%	$66,173	-28.0%	-1.4%
2. CAD	86	0.8%	$56,200	118	1.0%	$78,045	-27.1%	-28.0%
3. Asthma	21	0.6%	$76,771	27	0.8%	$47,107	-22.2%	63.0%
4. COPD	35	0.8%	$70,789	54	1.3%	$51,268	-35.2%	38.1%
5. Hypertension	168	0.5%	$63,213	209	0.6%	$67,949	-19.6%	-7.0%
6. CHF	24	2.2%	$58,163	33	3.1%	$71,208	-27.3%	-18.3%
7. Breast Cancer	34	1.4%	$44,729	28	1.2%	$40,277	21.4%	11.1%
8. Colon Cancer	13	2.5%	$39,812	13	2.6%	$42,517	0.0%	-6.4%
9.Prostate Cancer	15	0.8%	$38,362	13	0.7%	$44,084	15.4%	-13.0%
TOTALS (unique)	185		$61,415	221		$66,885	-16.3%	-8.2%

*High Cost Claimants are above $25,000

6 Clinical Quality Performance – Medicare Retirees

Chronic Condition	Clinical Quality Metrics	Individuals			NCQA National Average*
		Population	Performance Current Period	Performance Prior Period	
Diabetes	· At least 2 hemoglobin A1C tests in last 12 months	11,512	18.3%	14.2%	87.30%
	· Annual screening for diabetic nephropathy	11,512	40.4%	33.0%	77.90%
	· Annual screening for diabetic retinopathy	11,512	63.4%	65.2%	48.40%
CAD	· Patients currently taking an ACE-Inhibitor	11,192	2.0%	33.7%	78.80%
	· Patients currently taking a statin	11,192	10.5%	77.1%	Not Available
Hyperlipidemia	· Total cholesterol testing in last 12 months	31,097	16.4%	13.4%	Not Available
COPD	· Spirometry testing in last 12 months	4,253	36.9%	35.4%	40.40%
Asthma	·Patients with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	3,533	12.1%	73.5%	91.70%
Preventive Screening	· Cervical cancer	9,630	14.7%	14.9%	74.40%
	· Breast cancer	9,572	16.6%	16.6%	66.80%
	· Colorectal cancer	27,894	34.8%	35.2%	55.20%
	· Prostate cancer	11,635	21.8%	21.1%	Not Available

*Source: NCQA – State of Health Care Quality 2013 – Accredited Plans 2012 Commercial PPO Averages

7 Summary of Prescription Drug Expenses – Medicare Retirees

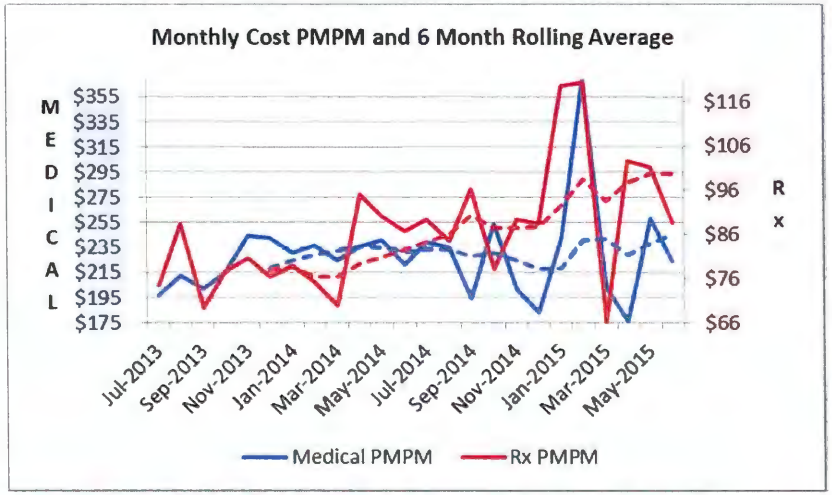
Category	Non-Specialty		Specialty		Total		
	Current Period	Change	Current Period	Change	Current Period	Prior Period	Change
Total Cost	$171,072,749	19.7%	$34,588,234	28.6%	$205,660,983	$169,797,367	21.1%
% of Total Costs	83.2%	-1.2%	16.8%	6.2%			
Total Scripts	1,360,476	6.0%	13,521	11.8%	1,373,997	1,296,128	6.0%
% of Total Scripts	99.0%	-0.1%	1.0%	5.5%			
Avg Cost PMPM	$344.65	20.8%	$69.68	29.9%	$414.34	$338.91	22.3%
Avg Cost Per Rx	$125.74	13.0%	$2,558.11	15.1%	$149.68	$131.00	14.3%
Number of Scripts PMPM	2.74	6.9%	0.03	12.8%	2.77	2.59	7.0%
PBM Generic Dispensing Rate	81.3%	2.3%	52.9%	-1.2%	81.1%	79.3%	2.2%
Member Cost %	10.8%	-21.0%	0.6%	-17.7%	9.1%	11.6%	-21.8%

8 Prescription Drug Cost Management Analysis – Medicare Retirees

Top 10 Indications	RXs	Total Cost	Generic Fill Rate	PMPM
Diabetes	72,491	$23,870,081	55.2%	$48.09
Lipid/Cholesterol Disorders	116,508	$16,221,791	78.1%	$32.68
Cardiovascular/Hypertension	289,131	$13,549,625	94.5%	$27.30
Autoimmune Disease	4,659	$11,137,984	24.0%	$22.44
Asthma/COPD	42,854	$11,088,640	29.4%	$22.34
Ulcer	68,837	$10,552,925	81.6%	$21.26
Oncology	8,364	$9,831,525	86.5%	$19.81
Pain Management	97,047	$9,178,308	90.6%	$18.49
Blood Disorders	41,124	$7,927,659	72.3%	$15.97
Hepatitis	392	$7,922,212	28.1%	$15.96
Total Top 10:	**741,407**	**$121,280,750**	**80.8%**	**$244.34**

Healthcare Dashboard
Current Period: Jul 2014 – Jun 2015

1 Principal Financial Trends – Claims Cost
SLEOLA



2 Claims Summary –
SLEOLA

	CURRENT PERIOD			PRIOR PERIOD			
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total	Total Paid Amount	Total Paid PMPM	% of Total	% Change in PMPM
Outpatient Hospital	$3,177,933	$65.59	20.5%	$3,781,428	$76.49	25.2%	-14.3%
Inpatient Hospital	$2,681,124	$55.33	17.3%	$2,545,209	$51.48	16.9%	7.5%
Non-Facility	$4,177,392	$86.21	26.9%	$3,783,725	$76.53	25.2%	12.6%
Ambulatory Surg Center	$244,274	$5.04	1.6%	$325,407	$6.58	2.2%	-23.4%
Home	$88,872	$1.83	0.6%	$91,620	$1.85	0.6%	-1.0%
Emergency Room	$358,937	$7.41	2.3%	$315,799	$6.39	2.1%	16.0%
All Others	$392,859	$8.11	2.5%	$309,271	$6.26	2.1%	29.6%
Total Medical	**$11,121,392**	**$229.52**	**71.7%**	**$11,152,459**	**$225.58**	**74.2%**	**1.7%**
Total Rx	**$4,390,389**	**$92.77**	**28.3%**	**$3,872,313**	**$79.92**	**25.8%**	**16.1%**
Total Paid	**$15,511,780**	**$320.13**	**100.0%**	**$15,024,773**	**$303.91**	**100.0%**	**5.3%**
Member Paid	**$800,650**	**$16.52**	**5.2%**	**$780,860**	**$15.79**	**5.2%**	**4.6%**
Plan Paid	**$14,711,131**	**$303.60**	**94.8%**	**$14,243,913**	**$288.11**	**94.8%**	**5.4%**

3 Key Healthcare Performance Metrics –
SLEOLA

Category	Current Period	Prior Period	% Change	Norm* **	Comparison To Norm
Avg Membership Per Month**	4,038	4,120	-2.0%	N/A	N/A
Office Visits Per 1000	3,511	3,315	5.9%	4,102	-14.4%
Inpatient Admissions Per 1000	52	33	57.1%	72	-27.3%
Inpatient Days Per Thousand	155	94	64.1%	336	-54.0%
Average Inpatient Day Cost	$4,297	$6,560	-34.5%	3,731	15.2%
Average Cost Per Admission	$12,707	$18,578	-31.6%	17,440	-27.1%
Readmission within 30 days per 1000	62	95	-35.1%	114	-46.0%
ER Visits Per 1000	238	220	8.5%	225	6.0%
Rx Scripts Per 1000	7,413	7,264	2.0%	10,573	-29.9%

* Verisk BOB Norms

**Based on average medical membership, including Kaiser members

***Norm for SLEOLA is the actual Current Period Results for Non-SLEOLA

4 Major Conditions – Prevalence and Cost
SLEOLA with Conditions

	CURRENT PERIOD							% Change	
Chronic Condition	Members*	% of Total	Norm**	Paid	% of Total	PMPY	% of Avg PMPY	Members	PMPY
1. Diabetes	82	2.0%	7.2%	$680,078	6.1%	$8,294	301%	-2.4%	-0.5%
2. CAD	34	0.8%	3.2%	$580,869	5.2%	$17,084	620%	-5.6%	47.0%
3. Asthma	420	10.4%	8.3%	$1,499,037	13.5%	$3,569	130%	8.0%	3.3%
4. COPD	15	0.4%	1.1%	$441,503	4.0%	$29,434	1069%	-25.0%	72.1%
5. Hypertension	475	11.8%	25.4%	$2,462,775	22.1%	$5,185	188%	-4.4%	-3.4%
6. Mental Illness	1,058	26.2%	28.0%	$4,026,510	36.2%	$3,806	138%	10.3%	-11.6%
7. Substance Abuse	169	4.2%	8.3%	$717,772	6.5%	$4,247	154%	5.0%	-34.8%
8. CHF	0	0.0%	0.2%	$0	0.0%	$0	0%	0.0%	0.0%
TOTALS (unique)	**1,703**	**42.2%**		**$6,537,995**	**58.8%**	**$3,839**	**139%**	**4.9%**	**-5.4%**

*Members with co-morbidities and their corresponding claims are combined in each applicable category. Kaiser members are included.

**Norm for SLEOLA is the actual % of Total for Non-SLEOLA.

5 High Risk High Cost Analysis – SLEOLA

Chronic Condition For High Cost Claimants*	CURRENT PERIOD			PRIOR PERIOD			% Change in Members	% Change in PMPY
	Members	% Within Condition	PMPY	Members	% Within Condition	PMPY		
1. Diabetes	5	6.1%	$57,084	8	9.5%	$50,096	-37.5%	13.9%
2. CAD	6	17.6%	$73,918	6	16.7%	$42,857	0.0%	72.5%
3. Asthma	9	2.1%	$64,146	8	2.1%	$60,333	12.5%	6.3%
4. COPD	3	20.0%	$131,527	1	5.0%	$0	N/A	N/A
5. Hypertension	19	4.0%	$49,776	27	5.4%	$47,757	-29.6%	4.2%
6. CHF	0	0.0%	$47,790	9	33.3%	$64,553	-100.0%	-26.0%
7. Breast Cancer	3	13.6%	$47,790	9	11.1%	$64,553	-66.7%	-26.0%
8. Colon Cancer	0	0.0%	$0	0	0.0%	$0	N/A	N/A
9.Prostate Cancer	1	25.0%	$50,227	3	60.0%	$40,259	-66.7%	24.8%
TOTALS (unique)	27		$57,995	43		$51,784	-37.2%	12.0%

*High Cost Claimants are above $25,000

6 Clinical Quality Performance – SLEOLA

Chronic Condition	Clinical Quality Metrics	Individuals			NCQA National Average*
		Population	Performance		
			Current Period	Prior Period	
Diabetes	· At least 2 hemoglobin A1C tests in last 12 months	81	51.9%	44.6%	87.30%
	· Annual screening for diabetic nephropathy	81	65.4%	62.7%	77.90%
	· Annual screening for diabetic retinopathy	81	34.6%	42.2%	48.40%
CAD	· Patients currently taking an ACE-Inhibitor	34	20.6%	22.2%	78.80%
	· Patients currently taking a statin	34	64.7%	63.9%	Not Available
Hyperlipidemia	· Total cholesterol testing in last 12 months	595	67.4%	63.9%	Not Available
COPD	· Spirometry testing in last 12 months	15	33.3%	35.0%	40.40%
Asthma	·Patients with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	410	65.4%	68.6%	91.70%
Preventive Screening	· Cervical cancer	1,182	52.3%	55.3%	74.40%
	· Breast cancer	445	45.4%	46.1%	66.80%
	· Colorectal cancer	241	32.4%	28.9%	55.20%
	· Prostate cancer	144	45.1%	42.5%	Not Available

*Source: NCQA – State of Health Care Quality 2013 – Accredited Plans 2012 Commercial PPO Averages

7 Summary of Prescription Drug Expenses – SLEOLA

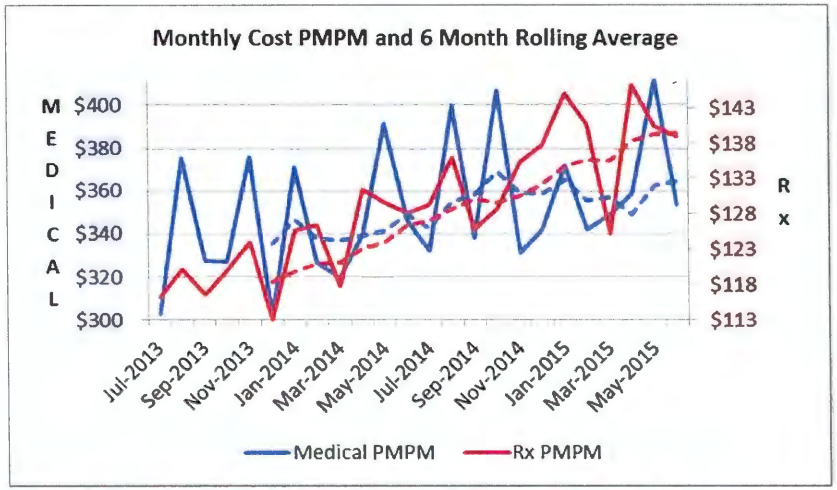
Category	Non-Specialty		Specialty		Total		
	Current Period	Change	Current Period	Change	Current Period	Prior Period	Change
Total Cost	$2,889,356	4.5%	$1,501,033	35.5%	$4,390,389	$3,872,313	13.4%
% of Total Costs	65.8%	-7.8%	34.2%	19.5%			
Total Scripts	28,833	-0.6%	402	24.1%	29,235	29,329	-0.3%
% of Total Scripts	98.6%	-0.3%	1.4%	24.5%			
Avg Cost PMPM	$61.05	7.0%	$31.72	38.8%	$92.77	$79.92	16.1%
Avg Cost Per Rx	$100.21	5.1%	$3,733.91	9.2%	$150.18	$132.03	13.7%
Number of Scripts PMPM	0.61	1.8%	0.01	27.0%	0.62	0.61	2.0%
PBM Generic Dispensing Rate	81.3%	2.0%	40.5%	-15.8%	80.7%	79.3%	1.7%
Member Cost %	7.3%	-6.5%	0.3%	-4.6%	4.9%	5.7%	-13.4%

8 Prescription Drug Cost Management Analysis – SLEOLA

Top 10 Indications	RXs	Total Cost	Generic Fill Rate	PMPM
Rare Disorders	86	$675,855	68.6%	$14.28
ADHD	1,390	$323,971	60.6%	$6.85
Autoimmune Disease	120	$255,821	15.0%	$5.41
Oncology	121	$250,468	74.4%	$5.29
Skin Disorders	1,134	$231,812	74.6%	$4.90
Anti-Infectives	5,039	$231,534	96.5%	$4.89
Multiple Sclerosis	29	$215,511	0.0%	$4.55
Asthma/COPD	1,664	$208,240	47.8%	$4.40
Ulcer	1,247	$165,970	73.2%	$3.51
Lipid/Cholesterol Disorders	978	$155,125	71.5%	$3.28
Total Top 10:	**11,808**	**$2,714,306**	**77.3%**	**$57.35**

Healthcare Dashboard
Current Period: Jul 2014 – Jun 2015

1 Principal Financial Trends – Claims Cost
NON-SLEOLA (Actives Only)



2 Claims Summary –
NON-SLEOLA (Actives Only)

	CURRENT PERIOD			PRIOR PERIOD			
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total	Total Paid Amount	Total Paid PMPM	% of Total	% Change in PMPM
Outpatient Hospital	$199,157,985	$106.78	21.6%	$202,427,128	$106.98	23.5%	-0.2%
Inpatient Hospital	$197,056,600	$105.65	21.4%	$187,473,664	$99.08	21.7%	6.6%
Non-Facility	$210,243,854	$112.72	22.8%	$195,589,763	$103.37	22.7%	9.1%
Ambulatory Surg Center	$13,872,028	$7.44	1.5%	$14,715,268	$7.78	1.7%	-4.4%
Home	$9,465,768	$5.08	1.0%	$9,468,488	$5.00	1.1%	1.4%
Emergency Room	$15,088,267	$8.09	1.6%	$14,573,726	$7.70	1.7%	5.0%
All Others	$36,740,825	$19.70	4.0%	$23,215,249	$12.27	2.7%	60.6%
Total Medical	**$681,625,325**	**$365.46**	**74.0%**	**$647,463,285**	**$342.18**	**75.1%**	**6.8%**
Total Rx	**$239,714,074**	**$135.61**	**26.0%**	**$215,009,591**	**$122.21**	**24.9%**	**11.0%**
Total Paid	**$921,339,398**	**$493.99**	**100.0%**	**$862,472,876**	**$455.81**	**100.0%**	**8.4%**
Member Paid	**$69,861,239**	**$37.46**	**7.6%**	**$72,436,985**	**$38.28**	**8.4%**	**-2.2%**
Plan Paid	**$851,478,159**	**$456.53**	**92.4%**	**$790,035,891**	**$417.53**	**91.6%**	**9.3%**

3 Key Healthcare Performance Metrics –
NON-SLEOLA (Actives Only)

Category	Current Period	Prior Period	% Change	Norm*	Comparison To Norm
Avg Membership Per Month**	157,158	157,682	-0.3%	N/A	N/A
Office Visits Per 1000	4,102	3,870	6.0%	4,205	-2.4%
Inpatient Admissions Per 1000	72	67	6.8%	69	4.2%
Inpatient Days Per Thousand	336	284	18.4%	328	2.5%
Average Inpatient Day Cost	$3,731	$4,187	-10.9%	$3,501	6.6%
Average Cost Per Admission	$17,440	$17,656	-1.2%	$15,760	10.7%
Readmission within 30 days per 1000	114	136	-15.9%	N/A	N/A
ER Visits Per 1000	225	223	0.6%	259	-13.2%
Rx Scripts Per 1000	10,573	10,490	0.8%	11,400	-7.3%

* Verisk BOB Norms

**Based on average medical membership, including Kaiser members\

4 Major Conditions – Prevalence and Cost
NON-SLEOLA (Actives Only) with Conditions

	CURRENT PERIOD							% Change	
Chronic Condition	Members*	% of Total	Norm	Paid	% of Total	PMPY	% of Avg PMPY	Members	PMPY
1. Diabetes	11,244	7.2%	18.5%	$108,412,549	15.9%	$9,642	220%	1.0%	3.1%
2. CAD	4,935	3.2%	10.9%	$77,967,498	11.4%	$15,799	360%	-5.7%	8.5%
3. Asthma	12,886	8.3%	2.2%	$75,951,827	11.1%	$5,894	134%	6.6%	15.5%
4. COPD	1,692	1.1%	5.0%	$28,491,943	4.2%	$16,839	384%	-4.2%	19.4%
5. Hypertension	39,553	25.4%	31.7%	$293,263,230	43.0%	$7,414	169%	-1.8%	5.9%
6. Mental Illness	43,568	28.0%	18.6%	$276,339,850	40.5%	$6,343	145%	11.5%	6.2%
7. Substance Abuse	12,860	8.3%	2.1%	$96,990,063	14.2%	$7,542	172%	6.5%	4.6%
8. CHF	250	0.2%	3.0%	$11,728,286	1.7%	$46,913	1070%	2.9%	15.3%
TOTALS (unique)	**79,049**	**50.9%**		**$453,609,353**		**$5,738**		**3.4%**	**4.5%**

*Members with co-morbidities and their corresponding claims are combined in each applicable category. Kaiser members are included.

5 High Risk High Cost Analysis – NON-SLEOLA (Actives Only)

Chronic Condition For High Cost Claimants*	CURRENT PERIOD			PRIOR PERIOD			% Change in Members	% Change in PMPY
	Members	% Within Condition	PMPY	Members	% Within Condition	PMPY		
1. Diabetes	893	7.9%	$68,167	886	8.0%	$65,923	0.8%	3.4%
2. CAD	722	14.6%	$75,649	730	14.0%	$70,478	-1.1%	7.3%
3. Asthma	504	3.9%	$70,435	461	3.8%	$55,114	9.3%	27.8%
4. COPD	226	13.4%	$90,575	242	13.7%	$68,444	-6.6%	32.3%
5. Hypertension	2,385	6.0%	$65,180	2,293	5.7%	$62,935	4.0%	3.6%
6. CHF	83	33.2%	$125,356	83	34.2%	$103,635	0.0%	21.0%
7. Breast Cancer	290	17.6%	$71,949	284	18.0%	$77,178	2.1%	-6.8%
8. Colon Cancer	80	28.5%	$82,887	68	22.7%	$91,525	17.6 %	-9.4%
9.Prostate Cancer	126	13.4%	$56,863	139	14.6%	$56,729	-9.4%	0.2%
TOTALS (unique)	2,986		$64,444	2,882		$60,767	3.6%	6.0%

*High Cost Claimants are above $25,000

6 Clinical Quality Performance – NON-SLEOLA (Actives Only)

Chronic Condition	Clinical Quality Metrics	Individuals			NCQA National Average*
		Population	Performance Current Period	Performance Prior Period	
Diabetes	· At least 2 hemoglobin A1C tests in last 12 months	11,245	58.4%	50.2%	87.30%
	· Annual screening for diabetic nephropathy	11,245	69.7%	62.4%	77.90%
	· Annual screening for diabetic retinopathy	11,245	38.0%	45.8%	48.40%
CAD	· Patients currently taking an ACE-Inhibitor	4,935	31.7%	32.5%	78.80%
	· Patients currently taking a statin	4,935	66.6%	67.4%	Not Available
Hyperlipidemia	· Total cholesterol testing in last 12 months	42,216	74.2%	68.0%	Not Available
COPD	· Spirometry testing in last 12 months	1,692	34.6%	32.5%	40.40%
Asthma	·Patients with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	12,896	67.8%	69.8%	91.70%
Preventive Screening	· Cervical cancer	66,849	44.9%	45.0%	74.40%
	· Breast cancer	39,729	49.0%	46.5%	66.80%
	· Colorectal cancer	47,798	31.7%	31.7%	55.20%
	· Prostate cancer	21,901	45.8%	41.4%	Not Available

*Source: NCQA – State of Health Care Quality 2013 – Accredited Plans 2012 Commercial PPO Averages

7 Summary of Prescription Drug Expenses – NON-SLEOLA (Actives Only)

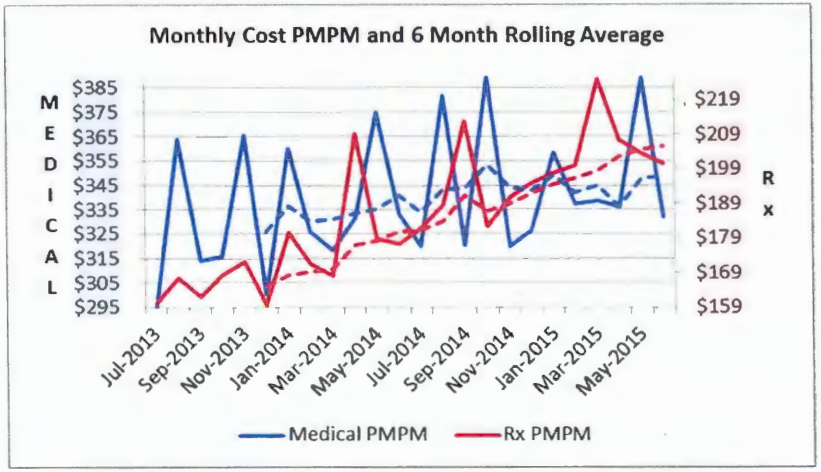
Category	Non-Specialty		Specialty		Total		
	Current Period	Change	Current Period	Change	Current Period	Prior Period	Change
Total Cost	$180,090,143	11.0%	$59,623,931	13.0%	$239,714,074	$215,009,591	11.5%
% of Total Costs	75.1%	-0.4%	24.9%	1.4%			
Total Scripts	1,535,402	1.2%	22,112	4.0%	1,557,514	1,537,940	1.3%
% of Total Scripts	98.6%	0.0%	1.4%	2.7%			
Avg Cost PMPM	$101.88	10.5%	$33.73	12.5%	$135.61	$122.21	11.0%
Avg Cost Per Rx	$117.29	9.6%	$2,696.45	8.7%	$153.91	$139.80	10.1%
Number of Scripts PMPM	0.87	0.8%	0.01	3.5%	0.88	0.87	0.8%
PBM Generic Dispensing Rate	81.5%	2.8%	39.2%	2.2%	80.9%	78.7%	2.8%
Member Cost %	11.6%	-12.9%	0.7%	0.2%	8.9%	10.2%	-13.1%

8 Prescription Drug Cost Management Analysis – NON-SLEOLA (Actives Only)

Top 10 Indications	RXs	Total Cost	Generic Fill Rate	PMPM
Diabetes	66,106	$22,656,558	56.3%	$12.82
Autoimmune Disease	7,376	$16,616,838	13.6%	$9.40
Hepatitis	824	$14,957,574	24.9%	$8.46
Multiple Sclerosis	2,319	$12,568,893	0.0%	$7.11
Viral Infections/HIV AIDS	7,007	$11,552,505	5.1%	$6.54
Lipid/Cholesterol Disorders	83,573	$11,133,057	77.4%	$6.30
Cardiovascular/Hypertension	217,086	$10,829,543	92.4%	$6.13
Skin Disorders	49,441	$10,431,311	79.0%	$5.90
Pain Management	137,913	$9,180,207	93.0%	$5.19
ADHD	36,468	$8,740,954	63.7%	$4.94
Total Top 10:	**608,113**	**$128,667,441**	**81.3%**	**$72.79**

Healthcare Dashboard
Current Period: Jul 2014 – Jun 2015

1 Principal Financial Trends – Claims Cost
ALL Members



2 Claims Summary –
ALL Members

	CURRENT PERIOD			PRIOR PERIOD			
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total	Total Paid Amount	Total Paid PMPM	% of Total	% Change in PMPM
Outpatient Hospital	$279,204,164	$102.14	19.1%	$289,932,444	$105.44	21.3%	-3.1%
Inpatient Hospital	$273,142,343	$99.92	18.7%	$263,851,656	$95.96	19.3%	4.1%
Non-Facility	$289,818,864	$106.03	19.8%	$271,983,473	$98.91	19.9%	7.2%
Ambulatory Surg Center	$18,200,756	$6.66	1.2%	$19,414,902	$7.06	1.4%	-5.7%
Home	$15,073,954	$5.51	1.0%	$15,566,635	$5.66	1.1%	-2.6%
Emergency Room	$19,321,533	$7.07	1.3%	$18,606,162	$6.77	1.4%	4.5%
All Others	$58,342,806	$21.34	4.0%	$37,593,237	$13.67	2.8%	56.1%
Total Medical	**$953,104,420**	**$348.68**	**65.1%**	**$916,948,509**	**$333.47**	**67.2%**	**4.6%**
Total Rx	**$510,008,703**	**$198.84**	**34.9%**	**$446,956,564**	**$172.98**	**32.8%**	**15.0%**
Total Paid	**$1,463,113,123**	**$535.25**	**100.0%**	**$1,363,905,073**	**$496.02**	**100.0%**	**7.9%**
Member Paid	**$113,406,018**	**$41.49**	**7.8%**	**$119,312,282**	**$43.39**	**8.7%**	**-4.4%**
Plan Paid	**$1,349,707,105**	**$493.77**	**92.2%**	**$1,244,592,791**	**$452.63**	**91.3%**	**9.1%**

3 Key Healthcare Performance Metrics –
ALL Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison To Norm
Avg Membership Per Month**	229,594	229,142	0.2%	N/A	N/A
Office Visits Per 1000	5,155	4,857	6.1%	4,850	6.3%
Inpatient Admissions Per 1000	106	101	5.2%	90	17.5%
Inpatient Days Per Thousand	557	511	8.8%	498	11.8%
Average Inpatient Day Cost	$2,138	$2,251	-5.1%	$3,309	-35.4%
Average Cost Per Admission	$11,248	$11,452	-1.8%	$15,916	-29.3%
Readmission within 30 days per 1000	94	125	-24.7%	N/A	N/A
ER Visits Per 1000	247	241	2.9%	275	-10.0%
Rx Scripts Per 1000	15,692	15,217	3.12%	14,619	7.3%

*Verisk BOB Norms

**Based on average medical membership, including Kaiser members

4 Major Conditions – Prevalence and Cost
ALL Members with Conditions

	CURRENT PERIOD							% Change	
Chronic Condition	Members*	% of Total	Norm	Paid	% of Total	PMPY	% of Avg PMPY	Members	PMPY
1. Diabetes	26,143	11.5%	8.6%	$176,828,616	18.6%	$6,764	162%	0.2%	2.2%
2. CAD	17,732	7.8%	3.7%	$139,620,843	14.6%	$7,874	188%	-3.9%	-0.2%
3. Asthma	19,224	8.4%	2.1%	$102,884,641	10.8%	$5,352	128%	6.6%	10.4%
4. COPD	6,587	2.9%	1.7%	$54,099,365	5.7%	$8,213	196%	-2.1%	10.7%
5. Hypertension	84,710	37.2%	14.7%	$460,349,014	48.3%	$5,434	130%	-2.2%	3.4%
6. Mental Illness	71,570	31.4%	18.6%	$395,121,362	41.5%	$5,521	132%	10.8%	2.4%
7. Substance Abuse	21,681	9.5%	2.1%	$142,480,424	14.9%	$6,572	157%	9.0%	0.2%
8. CHF	1,431	0.6%	0.9%	$21,775,138	2.3%	$15,217	364%	0.4%	4.7%
TOTALS (unique)	**136,752**	**60.0%**		**$659,612,021**		**$4,823**		**2.2%**	**2.7%**

*Members with co-morbidities and their corresponding claims are combined in each applicable category. Kaiser members are included.

5 High Risk High Cost Analysis – ALL Members

Chronic Condition For High Cost Claimants*	CURRENT PERIOD			PRIOR PERIOD			% Change in Members	% Change in PMPY
	Members	% Within Condition	PMPY	Members	% Within Condition	PMPY		
1. Diabetes	1,286	4.9%	$67,798	1,298	5.0%	$66,043	-0.9%	2.7%
2. CAD	1,034	5.8%	$73,493	1,121	6.1%	$71,947	-7.8%	2.1%
3. Asthma	680	3.5%	$66,261	622	3.4%	$56,261	9.3%	17.8%
4. COPD	354	5.4%	$83,354	373	5.5%	$67,249	-5.1%	23.9%
5. Hypertension	3,298	3.9%	$64,493	3,281	3.8%	$63,486	0.5%	1.6%
6. CHF	133	9.3%	$111,198	150	10.5%	$95,635	-11.3%	16.3%
7. Breast Cancer	416	8.9%	$70,476	417	9.4%	$74,309	-0.2%	-5.2%
8. Colon Cancer	110	12.4%	$76,114	109	12.3%	$89,030	0.9%	-14.5%
9.Prostate Cancer	175	5.5%	$57,838	188	5.9%	$55,724	-6.9%	3.8%
TOTALS (unique)	4,078		$63,142	4,087		$60,926	-0.2%	3.6%

*High Cost Claimants are above $25,000

6 Clinical Quality Performance – ALL Members

Chronic Condition	Clinical Quality Metrics	Individuals			NCQA National Average*
		Population	Performance Current Period	Performance Prior Period	
Diabetes	· At least 2 hemoglobin A1C tests in last 12 months	26,143	41.5%	35.0%	87.30%
	· Annual screening for diabetic nephropathy	26,143	57.0%	49.6%	77.90%
	· Annual screening for diabetic retinopathy	26,143	49.5%	54.6%	48.40%
CAD	· Patients currently taking an ACE-Inhibitor	17,732	13.1%	33.3%	78.80%
	· Patients currently taking a statin	17,732	31.9%	74.0%	Not Available
Hyperlipidemia	· Total cholesterol testing in last 12 months	85,294	53.5%	48.1%	Not Available
COPD	· Spirometry testing in last 12 months	6,587	36.2%	34.3%	40.40%
Asthma	·Patients with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	19,224	57.3%	70.3%	91.70%
Preventive Screening	· Cervical cancer	90,571	41.5%	41.8%	74.40%
	· Breast cancer	60,295	44.6%	42.9%	66.80%
	· Colorectal cancer	91,698	32.8%	33.0%	55.20%
	· Prostate cancer	40,068	39.1%	36.2%	Not Available

*Source: NCQA – State of Health Care Quality 2013 – Accredited Plans 2012 Commercial PPO Averages

7 Summary of Prescription Drug Expenses – ALL Members

Category	Non-Specialty		Specialty		Total		
	Current Period	Change	Current Period	Change	Current Period	Prior Period	Change
Total Cost	$401,487,037	13.3%	$108,521,666	17.0%	$510,008,703	$446,956,564	14.1%
% of Total Costs	78.7%	-0.7%	21.3%	2.6%			
Total Scripts	3,313,335	2.3%	40,583	5.9%	3,353,918	3,276,434	2.4%
% of Total Scripts	98.8%	0.0%	1.2%	3.4%			
Avg Cost PMPM	$156.53	14.2%	$42.31	17.9%	$198.84	$172.98	15.0%
Avg Cost Per Rx	$121.17	10.8%	$2,674.07	10.5%	$152.06	$136.42	11.5%
Number of Scripts PMPM	1.29	3.1%	0.02	6.7%	1.31	1.27	3.1%
PBM Generic Dispensing Rate	81.4%	2.7%	44.1%	1.0%	80.9%	78.9%	2.6%
Member Cost %	11.3%	-16.1%	0.7%	-2.9%	9.0%	10.8%	-16.4%

8 Prescription Drug Cost Management Analysis – ALL Members

Top 10 Indications	RXs	Total Cost	Generic Fill Rate	PMPM
Diabetes	159,810	$53,753,062	55.9%	$20.96
Autoimmune Disease	13,862	$31,933,000	17.9%	$12.45
Lipid/Cholesterol Disorders	230,525	$31,766,543	77.5%	$12.39
Cardiovascular/Hypertension	572,543	$27,735,004	93.5%	$10.81
Hepatitis	1,416	$26,824,237	26.1%	$10.46
Multiple Sclerosis	4,222	$22,875,334	0.0%	$8.92
Ulcer	156,592	$21,908,741	80.4%	$8.54
Asthma/COPD	115,312	$21,518,652	34.3%	$8.39
Pain Management	274,725	$21,371,067	92.0%	$8.33
Oncology	18,124	$20,728,789	87.3%	$8.08
Total Top 10:	**1,547,131**	**$280,414,428**	**80.2%**	**$109.33**

Dashboard Overview

The purpose of this monthly dashboard is to:

- Highlight key metrics for the State to monitor progress against strategic opportunities
- Provide a mechanism to track:
  - **Claims and trends:** determine cost trend drivers plus analyze data on effective alternatives to manage those trends
  - **Utilization metrics vs. benchmark:** compare the plan's utilization to benchmarks and desired targets
  - **Population health status:** assess disease burden and recommend solutions to lessen future trend increases; Uncover opportunities for the plan to better control plan cost and improve the health of the covered population

Methodology/Definitions

- Source of data includes eligibility from DBM as well as medical claims from Aetna, APS, Carefirst, and UHC. Pharmacy claims data was captured from Express Scripts.
- Generally, financial metrics are reported on a total cost/allowed basis (i.e., total cost includes plan paid and member cost sharing). This allows for tracking of population health status for improvement over time. Medicare excludes COB amounts
- Claims are reported on a paid basis for the periods July 1, 2014 – June 30, 2015 (current period) and July 1, 2013 – June 30, 2014 (prior period)

Norms/Benchmarks

- Where benchmarks are shown, we are using the book-of-business trends reported to us by our data warehouse partner, Verisk Health. Their database represents in excess of 10 million lives across plan types. Benchmark data was adjusted on an age basis
- In certain instances, we use NCQA HEDIS benchmarks for accredited commercial PPO plans, which are nationally recognized health care data standards.
- Risk factors were developed using a linear regression of the Truven Health 2012 Marketscan Commercial data (53 million members nationwide) against the CCS grouper.

Objective of Dashboard Panels

1. Principal Financial Trends

Objective: Provide the State with a visual representation of how claims are trending over the short term.

- Seasonality in claims paid is expected with the highest monthly claims generally occurring in winter; 6-month rolling average is used to smooth the effect of seasonality.
- Monthly claims can fluctuate at the beginning and end of a plan year as members determine if their contribution to the out-of-pocket maximum warrants getting medical treatment in the current year or waiting until the next plan year.

2. Claims Summary

Objective: Provide the State with a comparative overview of claims based on treatment setting. Also provides a summary of plan paid, member paid and total plan allowed costs

- Place of Service can be helpful when investigating changes in utilization patterns or when trying to understand the impact of plan design changes.

3. Key Healthcare Performance Metrics

Objective: Provide the State with some key comparative utilization metrics to track sources of claims increases

- This table allows the plan to understand whether changes in cost are driven by price or change in utilization.

4. Major Chronic Conditions—Prevalence and Cost

Objective: Provide the State metrics to monitor the cost and utilization of chronic conditions.

5. High Risk High Cost Analysis High Cost by Condition

Objective: Provide the State with key metrics to monitor cost and utilization of high risk and high cost chronic conditions. Target high risk groups for medical management interventions

6. Clinical Quality Performance

Objective: Provide the State with clinical metrics related to preventive screening, treatment compliance rates, and quality of care performance measures. This report enables the plan to determine the degree to which participants are receiving adequate care from an NCQA / HEDIS perspective.

7. Summary of Prescription Drug Expenses

Objective: Provide the State with metrics to evaluate year-over-year growth in pharmacy spend, cost and utilization.

- This report enables the plan to determine the effectiveness of the current drug benefit design in terms of cost and utilization, and may help identify improvement opportunities.

8. Prescription Drug Cost Management Analysis

Objective: Provide the State with a list of the top 10 drug indications that are driving pharmacy claim expenses.

- It enables the plan to determine what categories of drugs are driving utilization and cost over time. This may help identify those areas where opportunities exist for improved utilization management or plan design.

Ongoing Use of the Dashboard

- View the current dashboard as a starting point
- Dashboard metrics can be added to be current with ongoing State plan's objectives
- Of key value will be to add performance metrics to monitor the progress vendors are making to support the value based plan design
- Provide insights into plan design alternatives that could be used to encourage behavioral change that will lower risk factors
- Monitor the effectiveness of efforts by vendors to support participants in their efforts to improve their person health and lower health risk factors

CITY OF CHICAGO

Projected Annuitant Plan Costs
12-Month Rates Effective
July 1, 2012 - June 30, 2013

April 16, 2012

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SEGAL

SEGAL

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April 16, 2012

Mr. James Capasso, Jr.
Executive Director
Laborers' and Retirement
Board Employees' Annuity
and Benefit Fund of Chicago

Mr. Kenneth E. Kaczmarz
Executive Director
Firemens' Annuity and
Benefit Fund of Chicago

Ms. Nancy Currier
Benefits Manager
Department of Finance
City of Chicago

Mr. James Mohler
Executive Director
Municipal Employees'
Annuity & Benefit Fund of Chicago

Mr. John Gallagher
Executive Director
Policemen's Annuity and
Benefit Fund of Chicago

Dear Mr. Capasso, Ms. Currier, Mr. Gallagher, Mr. Kaczmarz, and Mr. Mohler:

Enclosed is our report for the projected rating period of July 1, 2012 through June 30, 2013. The calculations are based upon the data provided by BlueCross BlueShield of Illinois, CVS Caremark and the City of Chicago, in accordance with the Korshak Settlement Agreement.

Please let us know if you have any questions.

Sincerely,

THE SEGAL COMPANY

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Vice President

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Vice President and Consulting Actuary

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SECTION 1
BACKGROUND

The enclosed calculations have been performed in accordance with the Korshak Settlement Agreement (Settlement Agreement), effective September 1, 2003, that specifies how the costs of the Annuitants' hospital, medical and prescription drug benefits are to be paid, and includes specific components that must be used to determine the projected cost of the benefits. The projected costs contained in this report have been determined for the 12-month period beginning July 1, 2012 through June 30, 2013, as authorized by the City of Chicago (the "City") and the Executive Directors.

As a result of the Settlement Agreement provisions, there have been additional changes to the Plan of Benefits that have been reflected in this report. Key changes that impacted the projected costs are as follows:

- Effective each January 1, the Settlement Agreement stipulates annual increases in the medical deductible, medical out-of-pocket limits and mail-order pharmacy benefit copayments for the Non-Medicare Plan of Benefits. The following table outlines these changes for Non-Medicare Eligible participants effective January 1, 2011, January 1, 2012 and January 1, 2013.

Non-Medicare Eligible Participants			
Medical Benefit:	**January 1, 2011**	**January 1, 2012**	**January 1, 2013**
Annual Deductible:			
In-Network and Out-of-Area	$369	$380	$391
Out-of-Network	$861	$887	$914
Annual Out of Pocket Limit:			
In-Network and Out-of-Area	$2,152	$2,217	$2,284
Out-of-Network	$4,304	$4,434	$4,568
Mail-Order Pharmacy Benefit:	**January 1, 2011**	**January 1, 2012**	**January 1, 2013**
Brand Formulary Copayment	$56	$59	$62
Generic Copayment	$22	$23	$24
Brand Non-Formulary Copayment	Not Available at Mail		

- Effective each January 1, the Settlement Agreement also stipulates annual increases in the mail-order pharmacy benefit copayments for the Medicare Plan of Benefits. The following table outlines these changes for the Medicare Eligible participants effective January 1, 2011, January 1, 2012 and January 1, 2013.

Medicare Eligible Participants			
Mail-Order Pharmacy Benefit:	**January 1, 2011**	**January 1, 2012**	**January 1, 2013**
Brand Formulary Copayment	$56	$59	$62
Generic Copayment	$22	$23	$24
Brand Non-Formulary Copayment	Not Available at Mail		

- The City negotiated a multi-year pricing contract with CVS Caremark, the Plan's pharmacy benefits manager (PBM), for improved pricing discounts effective June 1, 2010, April 1, 2011, and April 1, 2012. The improved pricing effective April 1, 2012 is estimated to save the City just under 1.0% for 2012. The savings estimate for the improved pricing is included in our projections in this report.

- The City continues to remain eligible to receive a federal subsidy in accordance with the Medicare Prescription Drug Improvement and Modernization Act of 2003 (also known as Medicare Part D) for providing Creditable Prescription Drug Coverage for Medicare-Eligible Participants. A further discussion of the calculations regarding application of the subsidy as an offset to the cost projections are outlined in the prescription drug section of this report (on Exhibit 2-5A). For the 2010 Calendar Year, the Plan received just under $11.0 million in reimbursements (including a $646,735 reconciliation payment) for applicable Medicare-eligible participants. The 2011 reimbursement is currently $10.1 million and is subject to change based on the final reconciliation processing.

- As a reminder, it has been determined that the health plans under the Settlement Agreement are exempt from the provisions of the Affordable Care Act. Therefore, the projected costs contained in this report do not include any financial impact for complying with any provisions contained in the Act.

- The City's application for participation in the Early Retiree Reinsurance Program (ERRP) was approved by the U.S. Department of Health and Human Services (HHS). To-date, the City has received approximately $8.2 million in ERRP subsidies. This report does not include this receipt as an offset, as all payments will be shared with the annuitants through the City's annual reconciliation process.

SECTION 2
TREND, CLAIMS DATA & COST PROJECTIONS

Trend

The *Segal Standard Health Care Cost Trend Rates* are the results of surveys of local, regional and national groups and are used for such projections by our actuaries.

As in prior years' reports, the trend rate applied is the product of two components. Because two or more consecutive 12-month periods of Settlement Plan experience are available for analysis, we determined an actual year-over-year exhibited trend of claims and eligibility data. That actual year-over-year exhibited trend is then blended with the latest factors from the *Segal Standards for Health Care Cost Trend Rates*, to the extent credible, to smooth the affects of any significant fluctuations in actual trend.

The following table illustrates the actual year-over-year trend rates, the *2012 Segal Standards for Health Care Cost Trend Rates,* and the resultant trend rates used for this report. We used the Non-Medicare adult trend rate (5.1%) for the Children trend rate rather than the formula result due to the relatively small size of the Children group.

Covered Group	1/1/10 – 12/31/10 Over 1/1/09 – 12/31/09 Actual Trend	1/1/11 – 12/31/11 Over 1/1/10 – 12/31/10 Actual Trend	2012 Segal Trend Survey	Resultant 7/1/12 – 6/30/13 Trend Rates
Medical:				
Non-Medicare (Annuitants/Spouses)	10.7%	0.1%	10.0%	5.1%
Medicare (Annuitants/Spouses)	1.5%	2.2%	6.6%	4.4%
Children	15.1%	-8.3%	10.0%	5.1%
Prescription Drug:				
Non-Medicare (Annuitants/Spouses/Children)	10.2%	12.2%	7.2%	9.7%
Medicare (Annuitants/Spouses)	5.3%	5.0%	6.5%	5.7%

In comparison to our last report, 2012 Segal Trend Factors have changed as follows:

- Non-Medicare medical trend is projected to be 10.0%, down from last year's trend estimate of 11.0%. Non-Medicare prescription drug trend is projected to be 7.2%, down from last year's trend estimate of 9.2%.
- Medicare medical trend is projected to be 6.6%, slightly higher than last year's trend estimate of 6.4%. The prescription drug trend is projected to be 6.5%, down from last year's trend estimate of 8.2%.

Claims Data

The cost projections in this report are based on medical and prescription drug claims data through December 31, 2011, using only Settlement Plan claims experience.

Medical Claims Information

BlueCross BlueShield of Illinois (BCBS) provides The Segal Company (Segal) with monthly medical data that includes detailed claims by participant and eligible dependent. Effective September 1, 2003, the Settlement Plans began to participate in *Subscriber Share*. Under *Subscriber Share*, claims are adjudicated net of provider discount amounts. Therefore, all monthly data furnished to Segal by BCBS since September 1, 2003 is net of the "ADP" discounts.

To develop the projected medical cost for July 1, 2012, three 12-month periods of paid Settlement Plan claims experience were used. This data was adjusted from a *paid* basis to an *incurred* basis using actuarial formulae. On the rate development exhibits, the following experience periods are shown on an incurred basis:

- January 1, 2009 through December 31, 2009
- January 1, 2010 through December 31, 2010
- January 1, 2011 through December 31, 2011

The table below illustrates the monthly *incurred* medical per capita cost before trend adjustments but inclusive of all plan change adjustments through 2012:

Monthly Adjusted Cost Per Participant				
Exhibit #	**Group**	**1/1/2009–12/31/2009**	**1/1/2010–12/31/2010**	**1/1/2011–12/31/2011**
2-1	Annuitants / Spouses Non-Medicare	$564.09	$624.52	$624.95
	Percentage Change	-	*10.7%*	*0.1%*
2-2	Annuitants / Spouses Medicare	$136.67	$138.70	$141.76
	Percentage Change	-	*1.5%*	*2.2%*
2-3	Children	$101.98	$117.36	$107.60
	Percentage Change	-	*15.1%*	*-8.3%*

Development of Projected Cost – Medical

As noted, the historical costs shown above were adjusted for plan changes through 2012. This was done to assure that the periods under analysis are on a comparable plan design and cost basis. After these adjustments were made, the historical costs were then trended to the projection period and weighted to develop the projected cost. In general, the greater the average number of participants in the period, the more data available with which to analyze, and therefore, the greater credibility applicable to that period. The specific factors were based upon the underwriting standards used by the actuaries of The Segal Company. The projected costs were then adjusted to account for prospective plan design changes effective January 1, 2013 (discussed in Section 1 of this report).

The projected costs were based upon the most recent two years of Settlement Plan experience for the Non-Medicare and Medicare Annuitant and Spouse medical coverage. Due to the smaller group size and volatility in claims fluctuation, the projected costs for Children were based on three years of Settlement Plan experience. The exhibits that follow illustrate our calculations.

		Projection Period:
	From:	**07/01/2012**
	To:	**06/30/2013**

		Settlement Plans		
Experience Period:	From:	01/01/2009	01/01/2010	01/01/2011
	To:	12/31/2009	12/31/2010	12/31/2011
Experience Months:		12	12	12
Paid Claims:		$80,553,853	$87,583,019	$83,225,775
Estimated Incurred But Not Reported Claims				
Beginning of Period IBNR:		$11,465,259	$10,831,995	$9,668,772
Ending of Period IBNR:		$10,831,995	$9,668,772	$9,070,412
Change in IBNR:		($633,264)	($1,163,223)	($598,360)
Incurred Claims [1]:		$79,920,589	$86,419,796	$82,627,415
Average Eligible Participants: Annuitant / Spouse		11,634	11,417	10,965
Monthly Cost Per Participant:		$572.44	$630.77	$627.97
Plan Change Adjustment [2]:		0.9854	0.9901	0.9952
Adjusted Cost:		$564.09	$624.52	$624.95
Trend Rate:		5.1%	5.1%	5.1%
Trend Months:		42.0	30.0	18.0
Trend Factor:		1.188	1.131	1.077
Trend Adjusted Cost:		$670.24	$706.38	$672.89
Method Weights:		0%	10.0%	90.0%
Projected Cost Before 1/1/2013 Plan Changes:				$676.24
1/1/2013 Plan Change Adjustment Factor:				0.9975
Adjusted July 1, 2012 Plan Cost:				**$674.55**

Trend	Actual [3]	Segal Trend Survey [4]
1/1/10 - 1/1/11	0.1%	10.0%
Trend Weighting	50%	50%
Projected Trend:		
7/1/12 - 6/30/13	5.1%	

[1] Incurred Claims: Paid Claims for a period plus the difference between the IBNR at the Beginning and End of the period.

[2] Reflects indexed benefit increases each January 1 for the calendar year deductible and out-of-pocket limits.

[3] Based on adjusted cost.

[4] See attached Segal Trend Survey.

		Projection Period:		
	From:	**07/01/2012**		
	To:	**06/30/2013**		
		Settlement Plans		
Experience Period:	From:	01/01/2009	01/01/2010	01/01/2011
	To:	12/31/2009	12/31/2010	12/31/2011
Experience Months:		12	12	12
Paid Claims:		$36,125,617	$35,199,211	$37,862,561
Estimated Incurred But Not Reported Claims				
Beginning of Period IBNR:		$5,242,243	$4,603,810	$5,480,080
Ending of Period IBNR:		$4,603,810	$5,480,080	$5,105,563
Change in IBNR:		($638,433)	$876,270	($374,517)
Incurred Claims [1]:		$35,487,184	$36,075,481	$37,488,045
Average Eligible Participants: Annuitant / Spouse		21,638	21,674	22,038
Monthly Cost Per Participant:		$136.67	$138.70	$141.76
Plan Change Adjustment:		1.0000	1.0000	1.0000
Adjusted Cost:		$136.67	$138.70	$141.76
Trend Rate:		4.4%	4.4%	4.4%
Trend Months:		42.0	30.0	18.0
Trend Factor:		1.163	1.114	1.067
Trend Adjusted Cost:		$158.91	$154.47	$151.22
Method Weights:		0%	5%	95%
Adjusted July 1, 2012 Plan Cost:				**$151.38**

Trend	Actual [2]	Segal Trend Survey [3]
1/1/10 - 1/1/11	2.2%	6.6%
Trend Weighting	50%	50%
Projected Trend:		
7/1/12 - 6/30/13	4.4%	

[1] Incurred Claims: Paid Claims for a period plus the difference between the IBNR at the Beginning and End of the period.

[2] Based on adjusted cost.

[3] See attached Segal Trend Survey.

		Projection Period:		
	From:	**07/01/2012**		
	To:	**06/30/2013**		
		Settlement Plans		
Experience Period:	From:	01/01/2009	01/01/2010	01/01/2011
	To:	12/31/2009	12/31/2010	12/31/2011
Experience Months:		12	12	12
Paid Claims:		$1,688,775	$1,854,031	$1,556,083
Estimated Incurred But Not Reported Claims				
Beginning of Period IBNR:		$267,660	$239,272	$172,036
End of Period IBNR:		$239,272	$172,036	$164,244
Change in IBNR:		($28,387)	($67,236)	($7,792)
Incurred Claims [1]:		$1,660,387	$1,786,794	$1,548,291
Average Eligible Participants: Children		1,337	1,256	1,193
Monthly Cost Per Participant:		$103.49	$118.53	$108.12
Plan Change Adjustment [2]:		0.9854	0.9901	0.9952
Adjusted Cost:		$101.98	$117.36	$107.60
Trend Rate:		5.1%	5.1%	5.1%
Trend Months:		42.0	30.0	18.0
Trend Factor:		1.188	1.131	1.077
Trend Adjusted Cost:		$121.17	$132.74	$115.85
Method Weights:		15%	30%	55%
Projected Cost Before 1/1/2013 Plan Changes:				$121.72
1/1/2013 Plan Change Adjustment Factor:				0.9975
Adjusted July 1, 2012 Plan Cost:				**$121.42**

Trend	Actual [3]	Segal Trend Survey [4]
1/1/10 - 1/1/11	-8.3%	10.0%
Projected Trend (same as Non-Medicare Group):		
7/1/12 - 6/30/13	5.1%	

[1] Incurred Claims: Paid Claims for a period plus the difference between the IBNR at the Beginning and End of the period.

[2] Reflects indexed benefit increases each January 1 for the calendar year deductible and out-of-pocket limits.

[3] Based on adjusted cost.

[4] See attached Segal Trend Survey.

Prescription Drug Claims Information and Development of Projected Cost

The City provided Segal with CVS Caremark prescription drug data through December 31, 2011. Unlike medical claims, prescription drug claims do not have a material lag between the time the claims are incurred and when they are paid. In fact, when a participant uses a retail drug card, the claim is almost instantly adjudicated and paid. Also, 12 months of prescription drug experience for a group of this size is considered to be 100% credible. Included in our calculations on Exhibits 2-4 and 2-5 are two 12-month periods of claims experience through December 31, 2011. To determine the projected cost for July 1, 2012, we used the latest 12-month period of claims for both the Non-Medicare and Medicare groups, with adjustments to account for the multi-year contract pricing terms effective June 1, 2010, April 1, 2011 and April 1, 2012, and for the applicable indexed mail-order copayments effective each January 1.

As discussed in Section 1 of this report, the City negotiated the contract pricing terms with CVS Caremark. As a result, effective June 1, 2010, the Plan began receiving greater discounts at the point-of-sale. As part of the multi-year guarantee, the discounts increased again on April 1, 2011 and April 1, 2012.

The projected 2012 Medicare prescription drug cost includes an offset to account for the estimated Medicare Part D Federal subsidy. This projection includes subsidy payments that are expected to be earned during the rating period of July 1, 2012 through June 30, 2013. Note that the subsidy only applies to Medicare-Eligible retirees. Exhibit 2-5A illustrates the calculations involved in estimating the subsidy amount.

			Projection Period: From: 07/01/2012 To: 06/30/2013
Plan:			Non-Medicare
Experience Period:		From:	01/01/2010	01/01/2011
		To:	12/31/2010	12/31/2011
Experience Months:			12	12
Paid Claims [1]:			$17,871,585	$18,592,923
Rebates [2]:			-	(15,120)
Paid Claims - Net of Rebates:			$17,871,585	$18,577,803
Average Eligible Participants:	Child		1,256	1,193
	Annuitant / Spouse		11,417	10,965
	Total		12,673	12,158
Monthly Cost Per Participant [3]:			$117.52	$127.34
Plan Change Adjustment [4]:			0.9508	0.9846
Adjusted Cost:			$111.74	$125.38
Trend Months:			30	18
Trend Rate:			9.7%	9.7%
Trend Factors:			1.261	1.149
Trend Adjusted Cost Annuitant / Spouse / Child:			$140.85	$144.07
Method Weights:			0%	100%
Projected Cost Before Plan Changes:				$144.07
1/1/2013 Plan Change Adjustment Factor:				0.9970
Plan Change Adjusted July 1, 2012 Projected Cost:				$143.63
July 1, 2012 Projected Cost [5]:	**Child**			**$38.76**
	Annuitant / Spouse			**$155.04**

Trend	Actual [6]	Segal Trend Survey [7]
1/1/10 - 1/1/11	12.2%	7.2%
Trend Weighting	50%	50%
Projected Trend:		
7/1/12 - 6/30/13	9.7%	

[1] Due to the drug card, paid drug claims are assumed to be equal to incurred drug claims.

[2] As part of the January 1, 2009 pricing change, the City receives higher discounts in lieu of receiving rebate payments. The City received a total rebate amount of $52,108 as part of a rebate reconciliation. An allocation has been estimated across both Medicare and Non-Medicare annuitants.

[3] The eligible participant counts include Annuitants, Spouses & Children.

[4] The plan change adjustment reflects the indexed mail order copayments effective each January 1, and the negotiated CVS Caremark pricing changes.

[5] Assumes that children cost approximately 25% of the annuitant cost.

[6] Based on adjusted cost.

[7] See attached Segal Trend Survey.

		Projection Period:	
		From:	07/01/2012
		To:	06/30/2013
Plan:		Medicare	
Experience Period:	From:	01/01/2010	01/01/2011
	To:	12/31/2010	12/31/2011
Experience Months:		12	12
Paid Claims [1]:		$44,089,764	$45,481,733
Rebates [2]:		-	(36,988)
Paid Claims - Net of Rebates[1,2]:		$44,089,764	$45,444,744
Average Eligible Participants:	Annuitant / Spouse	21,674	22,038
Monthly Cost Per Participant:		$169.52	$171.84
Plan Change Adjustment [3]:		0.9508	0.9846
Adjusted Cost:		$161.18	$169.19
Trend Months:		30	18
Trend Rate:		5.7%	5.7%
Trend Factors:		1.150	1.087
Trend Adjusted Cost Annuitant / Spouse:		$185.29	$183.95
Method Weights:		0%	100%
Projected Cost Before Plan Changes:			$183.95
1/1/2013 Plan Change Adjustment Factor:			0.9970
Plan Change Adjusted July 1, 2012 Projected Cost:			**$183.40**

Trend	Actual [4]	Segal Trend Survey [5]
1/1/10 - 1/1/11	5.0%	6.5%
Trend Weighting	50%	50%
Projected Trend:		
7/1/12 - 6/30/13	5.7%	

[1] Due to the drug card, paid drug claims are assumed to be equal to incurred drug claims.

[2] As part of the January 1, 2009 pricing change, the City receives higher discounts in lieu of receiving rebate payments. The City received a total rebate amount of $52,108 as part of a rebate reconciliation. An allocation has been estimated across both Medicare and Non-Medicare annuitants.

[3] The plan change adjustment reflects the indexed mail order copayments effective each January 1, and the negotiated CVS Caremark pricing changes.

[4] Based on adjusted cost.

[5] See attached Segal Trend Survey.

		Projection Period:	
		From:	**07/01/2012**
		To:	**06/30/2013**

Plan:		Medicare Part D Subsidy			
Experience Period:	From:	01/01/2008	01/01/2009	01/01/2010	01/01/2011
	To:	12/31/2008	12/31/2009	12/31/2010	12/31/2011
Experience Months [1]:		9.8	12.0	12.0	12.0
Net Subsidy Received [2/4]:		($9,461,053)	($11,375,272)	($10,992,555)	($10,117,886)
Average Monthly Eligible Annuitant/Spouse		21,414	21,638	21,674	22,038
Monthly Subsidy Per Annuitant/Spouse Participant:		($45.08)	($43.81)	($42.26)	($38.26)
Method Weights:		0%	0%	100%	0%
July 1, 2012 Projected Medicare Part D Subsidy [3]:					($42.26)

[1] The 2008 experience period represents just under 10 months of actual subsidy approved by CMS.

[2] The net subsidy received amounts shown are based on the CMS reports, which provide a summary of monthly subsidy amounts.

[3] The projected July 1, 2012 Medicare Part D Subsidy is based on the final reconciliation amount for 2010.

[4] Calendar years 2008 through 2010 illustrate the final CMS reconciliation amounts. Calendar year 2011 does not include the final reconciliation reimbursement amount, as the reconciliation process has not been finalized.

SECTION 3
ENROLLMENT DATA

The City provided Segal with actual monthly enrollment for each benefit category.

Exhibit 3-1 outlines the average eligibility figures by participant class for calendar years 2004 through 2011. Exhibit 3-2 graphically illustrates the average eligibility by plan for 2004 through 2011.

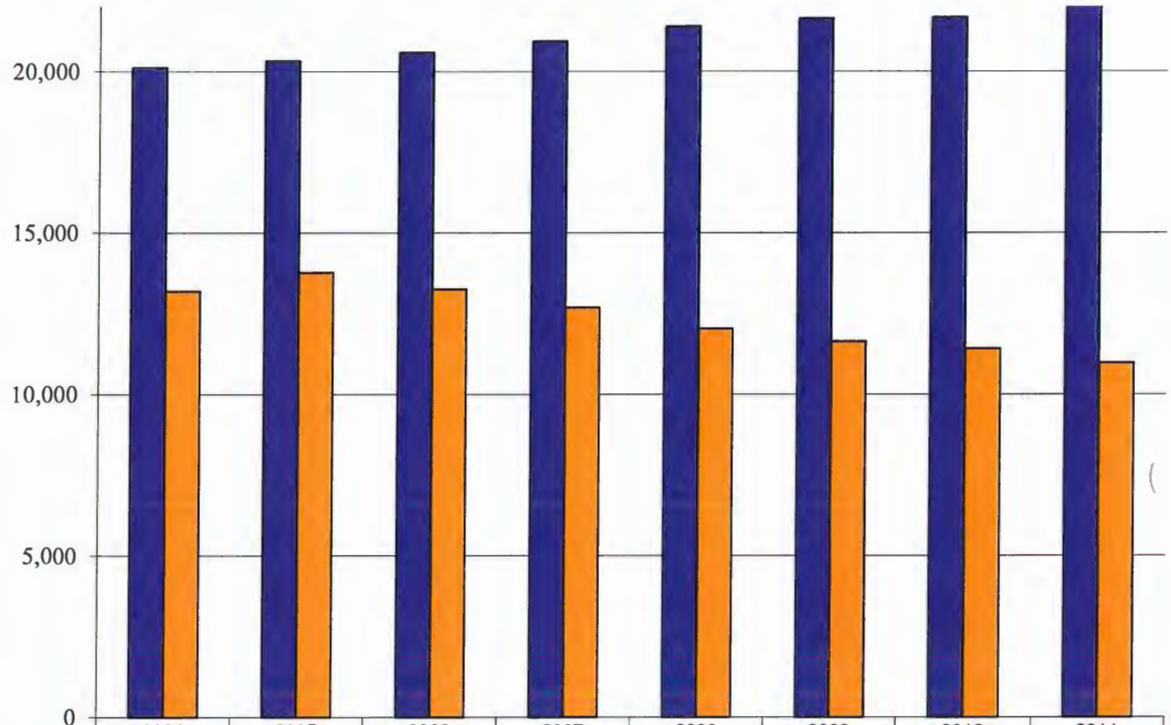
The total number of participants has remained relatively level over the last seven years.

The number of total participants increased in 2005, but has been gradually declining since. During this time, the portion of the participants who are Medicare eligible has been gradually increasing.

FOR CALENDAR YEARS ENDED DECEMBER 31, 2004, 2005, 2006, 2007, 2008, 2009, 2010 AND 2011

	2004	2005	2006	2007	2008	2009	2010	2011
Medicare								
Annuitant	15,437	15,606	15,800	16,113	16,508	16,726	16,754	17,031
Spouse	4,678	4,712	4,778	4,816	4,886	4,912	4,920	5,007
Total	20,115	20,318	20,579	20,929	21,394	21,638	21,674	22,038
Non-Medicare								
Annuitant	8,464	8,901	8,574	8,230	7,814	7,596	7,495	7,221
Spouse	4,730	4,871	4,680	4,462	4,217	4,038	3,922	3,744
Total	13,195	13,772	13,254	12,692	12,031	11,634	11,417	10,965
Children	1,646	1,722	1,602	1,504	1,414	1,337	1,256	1,193
Grand Total	34,956	35,812	35,435	35,125	34,839	34,609	34,347	34,196
Grand Total % Change	--	2.4%	-1.1%	-0.9%	-0.8%	-0.7%	-0.8%	-0.4%
Percentage of the participants Medicare	*57.5%*	*56.7%*	*58.1%*	*59.6%*	*61.4%*	*62.5%*	*63.1%*	*64.4%*

FOR CALENDAR YEARS ENDED DECEMBER 31, 2004, 2005, 2006, 2007, 2008, 2009, 2010 AND 2011



	2004	2005	2006	2007	2008	2009	2010	2011
Medicare - Sett. Plan	20,115	20,318	20,579	20,929	21,394	21,638	21,674	22,038
Non-Medicare - Sett. Plan	13,195	13,772	13,254	12,692	12,031	11,634	11,417	10,965

SECTION 4
SUMMARIZED 2012 COST PROJECTIONS

Exhibit 4-1 provides the cost projections per contract by Medicare status and coverage category for the period July 1, 2012 through June 30, 2013. The cost projections include medical benefit expenses, prescription drug benefit expenses, BCBSIL network access and administrative fees, Telligen care management fees, and CVS Caremark prescription drug fees for the Settlement Plans. The cost projections also include an offset to the Medicare Prescription Drug Cost for the estimated Medicare Part D subsidy for the period July 1, 2012 through June 30, 2013. This calculation is outlined in Exhibit 2-5A.

The fees for BCBSIL, Telligen, and CVS Caremark are as follows:

	BCBSIL Network Access & Administration Fees *(per Annuitant)*	**Telligen Care Management Fees** *(per Annuitant)*	**CVS Caremark Prescription Drug Fees** *(Estimated per Individual)*
Non-Medicare	$27.00	$9.35	$0.00
Medicare	$13.66	$0.00	$0.70

The BCBSIL and Telligen fees are charged per annuitant. If any person in the annuitant family is non-Medicare eligible then the non-Medicare fees apply.

The Medicare Part D processing is charged by CVS Caremark at $0.70 per Medicare eligible individual. Effective January 1, 2011, the City eliminated the CustomCare program provided through CVS Caremark.

The cost developed in the report for Children is on a per child basis. The cost projections in Exhibit 4-1 for coverage in which child(ren) are included assumes that there are on average 1.361 children per contract. The rate is the same whether one child or multiple children are covered.

The costs and fees in Exhibit 4-1 do not take into account Pension Plan subsidies or the amounts paid by the City on behalf of the participants as mandated by the Settlement Agreement.

COST PROJECTIONS PER CONTRACT JULY 1, 2012 THROUGH JUNE 30, 2013

Medicare Status			Medical	Prescription Drug			Fees				Total
Annuitant	Spouse	Child(ren) *	Projected Cost [A]	Projected Cost	Estimated Medicare D Subsidy	Total [B]	BCBSIL	Telligen	CVS Caremark***	Total [C]	[A+B+C]
MED	-	-	$151.38	$183.40	($42.26)	$141.14	$13.66	$0.00	$0.70	$14.36	$306.88
NON	-	-	$674.55	$155.04	$0.00	$155.04	$27.00	$9.35	$0.00	$36.35	$865.94
MED	MED	-	$302.76	$366.80	($84.52)	$282.28	$13.66	$0.00	$1.40	$15.06	$600.10
MED	NON	-	$825.93	$338.44	($42.26)	$296.18	$27.00	$9.35	$0.70	$37.05	$1,159.16
NON	MED	-	$825.93	$338.44	($42.26)	$296.18	$27.00	$9.35	$0.70	$37.05	$1,159.16
NON	NON	-	$1,349.10	$310.08	$0.00	$310.08	$27.00	$9.35	$0.00	$36.35	$1,695.53
MED	MED	Child(ren)	$468.01	$419.55	($84.52)	$335.03	$27.00	$9.35	$1.40	$37.75	$840.79
MED	NON	Child(ren)	$991.18	$391.19	($42.26)	$348.93	$27.00	$9.35	$0.70	$37.05	$1,377.16
NON	MED	Child(ren)	$991.18	$391.19	($42.26)	$348.93	$27.00	$9.35	$0.70	$37.05	$1,377.16
NON	NON	Child(ren)	$1,514.35	$362.83	$0.00	$362.83	$27.00	$9.35	$0.00	$36.35	$1,913.53
MED	-	Child(ren)	$316.63	$236.15	($42.26)	$193.89	$27.00	$9.35	$0.70	$37.05	$547.57
NON	-	Child(ren)	$839.80	$207.79	$0.00	$207.79	$27.00	$9.35	$0.00	$36.35	$1,083.94
-	-	Child(ren)	$165.25	$52.75	$0.00	$52.75	$27.00	$9.35	$0.00	$36.35	$254.35

* The average number of children per contract is 1.361 as provided by the City of Chicago.

AGGREGATE COST PROJECTIONS FOR ANNUITANTS, SPOUSES AND CHILDREN

			Medical	Prescription Drug			Fees				Total
Medicare Status	Annuitants	Covered Participants *	Projected Cost [A]	Projected Cost	Estimated Medicare D Subsidy	Total [B]	BCBSIL **	Telligen **	CVS Caremark***	Total [C]	[A+B+C]
MEDICARE	16,754	22,038	$40,033,300	$48,501,200	($11,175,900)	$37,325,300	$2,584,700	$0	$185,100	$2,769,800	**$80,128,400**
NON-MEDICARE	7,495	10,965	$88,757,300	$20,400,200	$0	$20,400,200	$2,747,800	$951,600	$0	$3,699,400	**$112,856,900**
CHILD(REN)	0	877	$1,739,100	$555,100	$0	$555,100	$0	$0	$0	$0	**$2,294,200**
TOTAL	24,249	33,880	$130,529,700	$69,456,500	($11,175,900)	$58,280,600	$5,332,500	$951,600	$185,100	$6,469,200	**$195,279,500**

* Based on the 12-month average for the period January 1, 2011 through December 31, 2011. The child(ren) participant count represents the number of contracts with child(ren).
** The BCBSIL and Telligen fees are charged based on Medicare Status. In the case of marriages that include both Medicare and Non-Medicare status participants, the Non-Medicare fee applies.
*** The City eliminated the CustomCare program provided through CVS Caremark effective January 1, 2011. The Medicare fees are attributable to the Retiree Drug Subsidy claim submissions.

APPENDIX
Historical Paid Claims

Appendix 1 illustrates the medical claims for the Settlement Plan calendar years ending December 31, 2011.

Appendix 2 graphically illustrates the average monthly medical claims per participant for Medicare, Non-Medicare and an average composite cost for the Settlement Plan calendar years ending December 31, 2011.

Please note that for both Appendix 1 and 2, paid claims incurred on or after September 1, 2003 are net of the BCBS ADP discounts. Also, these exhibits exclude all fees for BCBSIL network access and administration (as described in Section 4), as well as Telligen care management fees.

Appendix 3 illustrates the prescription drug claims for the six calendar years ending December 31, 2011. Note, the paid claims in this exhibit are net of rebates and exclude all fees paid to CVS Caremark for administrative services related to the Medicare Part D Subsidy program and the Custom Care program.

Appendix 4 graphically illustrates the average monthly prescription drug claims per participant for Medicare, Non-Medicare and an average composite cost over the six calendar years ending December 31, 2011.

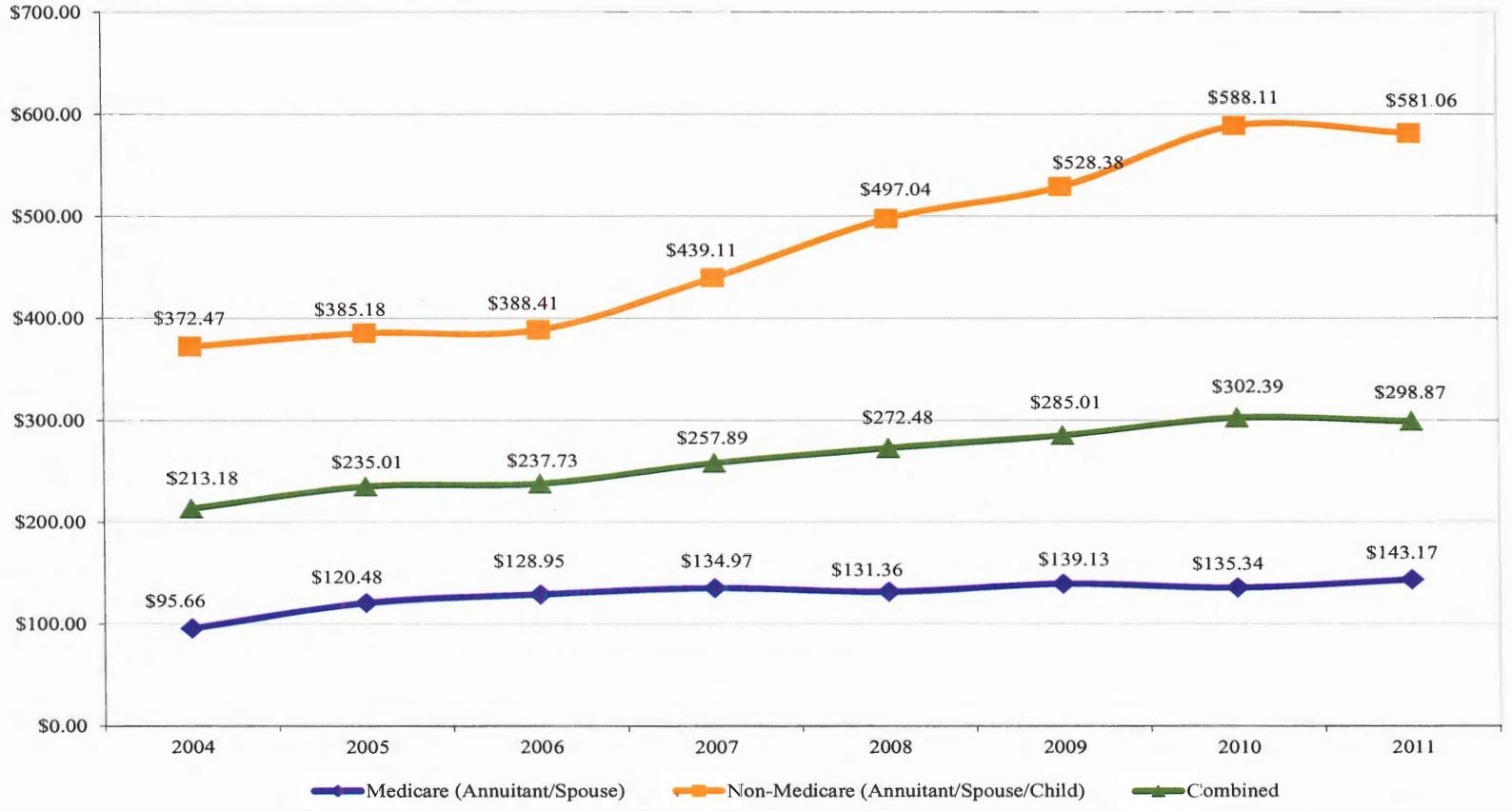
EIGHT YEARS BEGINNING JANUARY 1, 2004 THROUGH DECEMBER 31, 2011

Medical	2004	2005	2006	2007	2008	2009	2010	2011
Medicare (Annuitant/Spouse):								
Total Medicare Claims	$23,090,967	$29,375,422	$31,844,071	$33,896,444	$33,722,865	$36,125,617	$35,199,216	$37,862,411
Average Monthly Eligibility	20,115	20,318	20,579	20,929	21,394	21,638	21,674	22,038
Monthly Per Participant	$95.66	$120.48	$128.95	$134.97	$131.36	$139.13	$135.34	$143.17
Cumulative Per Participant % Change	--	25.9%	34.8%	41.1%	37.3%	45.4%	41.5%	49.7%
Yearly Per Participant % Change	--	25.9%	7.0%	4.7%	-2.7%	5.9%	-2.7%	5.8%
Non-Medicare (Annuitant/Spouse/Children):								
Total Non-Medicare Claims	$66,328,863	$71,616,619	$69,242,505	$74,803,432	$80,191,828	$82,242,628	$89,437,050	$84,781,858
Average Monthly Eligibility	14,840	15,494	14,856	14,196	13,445	12,971	12,673	12,159
Monthly Per Participant	$372.47	$385.18	$388.41	$439.11	$497.04	$528.38	$588.11	$581.06
Cumulative Per Participant % Change	--	3.4%	4.3%	17.9%	33.4%	41.9%	57.9%	56.0%
Yearly Per Participant % Change	--	3.4%	0.8%	13.1%	13.2%	6.3%	11.3%	-1.2%
Medicare and Non-Medicare Combined								
Total Medical Claims:	$89,419,830	$100,992,041	$101,086,575	$108,699,877	$113,914,693	$118,368,244	$124,636,266	$122,644,269
Average Monthly Eligibility	34,955	35,812	35,435	35,125	34,839	34,609	34,347	34,197
Monthly Per Participant	$213.18	$235.01	$237.73	$257.89	$272.48	$285.01	$302.39	$298.87
Cumulative Per Participant % Change	--	10.2%	11.5%	21.0%	27.8%	33.7%	41.8%	40.2%
Yearly Per Participant % Change	--	10.2%	1.2%	8.5%	5.7%	4.6%	6.1%	-1.2%

Notes:

1. Includes all paid medical claims; Settlement and Non-Settlement.
2. Network access and administration fees and care management fees are excluded.
3. Facility paid claims after September 1, 2003 are net of discounts. Physician claims have always been net of discounts.

EIGHT YEARS BEGINNING JANUARY 1, 2004 THROUGH DECEMBER 31, 2011



Note: Facility paid claims after September 1, 2003 are net of discounts. Physician claims have always been net of discounts.

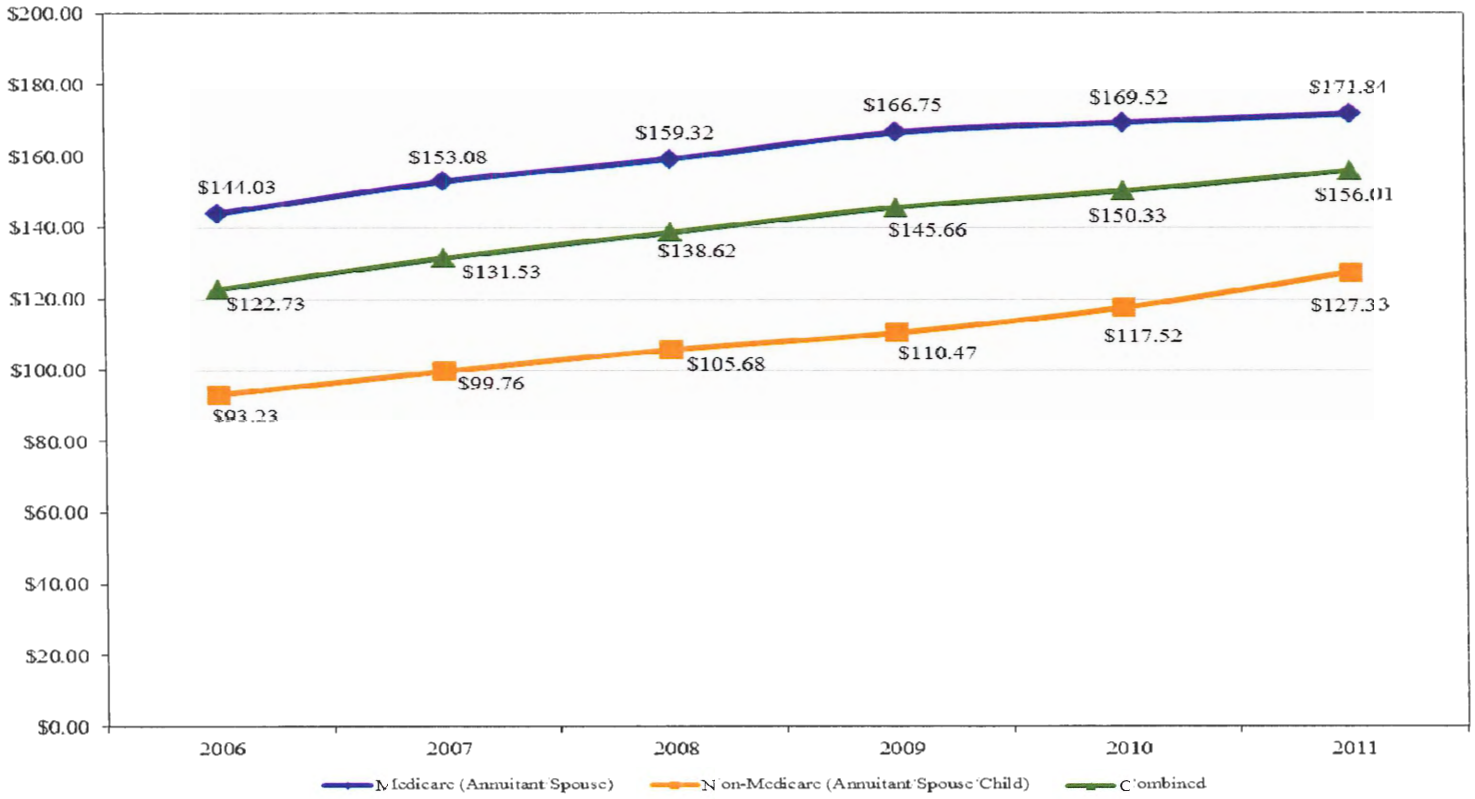
SIX YEARS BEGINNING JANUARY 1, 2006 THROUGH DECEMBER 31, 2011

Prescription Drug	2006	2007	2008	2009 [2]	2010 [2]	2011 [2]
Medicare (Annuitant/Spouse):	$35,566,734	$38,445,966	$40,901,984	$43,296,547	$44,089,764	$45,444,745
Average Monthly Eligibility	20,579	20,929	21,394	21,638	21,674	22,038
Monthly Per Participant	$144.03	$153.08	$159.32	$166.75	$169.52	$171.84
Cumulative Per Participant % Change	--	6.3%	10.6%	15.8%	17.7%	19.3%
Yearly Per Participant % Change	--	6.3%	4.1%	4.7%	1.7%	1.4%
Non-Medicare (Annuitant/Spouse/Children):	$16,620,758	$16,995,143	$17,049,757	$17,195,463	$17,871,585	$18,577,803
Average Monthly Eligibility	14,856	14,196	13,445	12,971	12,673	12,159
Monthly Per Participant	$93.23	$99.76	$105.68	$110.47	$117.52	$127.33
Cumulative Per Participant % Change	--	7.0%	13.4%	18.5%	26.1%	36.6%
Yearly Per Participant % Change	--	7.0%	5.9%	4.5%	6.4%	8.3%
Medicare and Non-Medicare Combined						
Total Prescription Drug:	$52,187,493	$55,441,109	$57,951,741	$60,492,009	$61,961,349	$64,022,548
Average Monthly Eligibility	35,435	35,125	34,839	34,609	34,347	34,197
Monthly Per Participant	$122.73	$131.53	$138.62	$145.66	$150.33	$156.01
Cumulative Per Participant % Change	--	7.2%	12.9%	18.7%	22.5%	27.1%
Yearly Per Participant % Change	--	7.2%	5.4%	5.1%	3.2%	3.8%

Notes:

1. All prescription drug fees for CustomCare Rx and Medicare Part D Processing are excluded.
2. Due to the change in the pricing terms effective January 1, 2009, the Plan receives higher discount at the point-of-sale in lieu of rebate payments. Paid claims are shown net of rebates.

SIX YEARS BEGINNING JANUARY 1, 2006 THROUGH DECEMBER 31, 2011



Note: Per capita prescription drug claims exclude all prescription drug fees for CustomCare Rx and Medicare Part D processing. Prescription claims are net of rebates. Due to the change in the pricing terms effective January 1, 2009, the Plan receives higher discounts at the point-of-sale in lieu of rebate payments.

Local XYZ Plan/Trust/Fund

Health Benefits Reports - Fiscal Year Ending 2011

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SEGAL

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April 15, 2011

Board of Trustees
Local XYZ Plan/Trust/Fund
One World Plaza
Hollywood, CA 9000

Dear Trustees:

We are pleased to present these fiscal 2011 Health Benefits Reports for the Local XYZ Plan/Trust/Fund.

We look forward to reviewing this report with you and answering any questions you may have at the next meeting of the Board of Trustees. However, if there are any questions that need to be addressed prior to the meeting, please do not hesitate to contact us.

Sincerely,

THE SEGAL COMPANY

By: _____

Jim Smith
Health Consultant

cc: *Jim Green*
Linda Black

Section 1 **Financial Experience and Budget Projections**

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The projections in this report are estimates of future costs and are based on information available to The Segal Company at the time the projections were made. The Segal Company has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from the new health care reform legislation or other recently passed state or federal regulations.

The Plan/Trust/Fund Assets do not take into account the cost of paying for benefits which are based on the participants' accumulated eligibility under the Fund's extended eligibility rules.

Projection of retiree costs takes into account only the dollar value of providing benefits for retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled or terminated employees during a period other than that which is referred to in the projection.

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Section 1

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

Key Findings, Recommendations

- *Based on the audited financial statements for the fiscal year ended December 31, 2010, the Plan experienced an operating surplus of $4,539,056. Net gains of $5,309,208 on investments and an experience refund of $87,303 from Insured PPO increased the total addition to Plan Assets to $9,935,567.*
- *We have projected that the Plan will have an operating deficit of $1,429,200 for the 12 months ended December 31, 2011. The Plan is projected to operate with a deficit of $11,156,200 and $25,530,900 for 2012 and 2013, respectively.*
- *As of December 31, 2010, Plan Assets amounted to $85,388,512 and represented 113 percent of targeted reserves. If all assumptions are met, we project that Plan Assets will decrease by 45 percent to $47,272,212 as of December 31, 2013, which will represent 47 percent of targeted reserves.*
- *The number of actives remained relatively stable at 10,437 for fiscal 2010, compared to 10,400 for fiscal 2009. We have assumed 10,435 active employees for the projected years.*
- *Projected employer contributions are based on the 10,435 actives assumption, including 7,495 Regular Actives working a total of 13,266,200 hours annually, about the same as actually experienced for the fiscal 2010. The projected average hourly contribution rates of $5.97 for 2011 and $6.11 for 2012 and 2013 include the negotiated contribution rates through June 1, 2011.*
- *The number of retirees decreased slightly to 2,146 for fiscal 2010 compared to 2,162 for fiscal 2009. Based on the SOP 92-6, we have assumed slight increases for the number of retirees for the projected years. We encourage the Trustees to continue to review their retiree contribution strategy.*
- *Total income is projected to increase 7.8 percent for calendar year 2011 (5.1 percent annually), 2.6 percent for 2012, and then remain relatively flat for 2013, whereas total expenses are projected to increase 13.5 percent for 2011 (8.8 percent annually), and 10.3 percent for each 2012 and 2013.*
- *In light of the economic downturn, we thought it would be useful to estimate the impact of a change in employer contribution hours during the projected period. The alternate scenarios are shown on the Variations in Hours Assumption page. Since we are unable to estimate whether such a change in contributions will also result in a change in the number of participants that are eligible, we have not anticipated a change in the number of eligibles for the projected period.*
- *We note that the Trustees have authorized the implementation of the Total Health Management programs, including the cardiac care and diabetes targeted programs under the Indemnity Medical program.*
- *These budget projections incorporate the PBM contract pricing improvements and the addition of step therapy. We recommend that the Plan continue participant communication and education promoting the use of generic drugs.*
- *The Plan may want to consider the continued value of offering the Insured HMO plan. As shown on the Per Enrollee Per Month exhibit, the Insured HMO plan costs on a per capita basis are significantly greater than the other medical plans that are offered.*

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

SUMMARY

Plan Assets are shown net of Incurred But Not Reported (IBNR) claims reserve.

Based on the assumptions shown on page 3, the Plan's continuation value is projected to be less than four months by December 31, 2013.

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Average Number of Actives	9,834	10,400	10,437	10,435	10,435	10,435
Average Contribution Hours Per Month	149	146	147	148	148	148
Aggregate Hours	12,606,703	13,077,119	13,240,937	13,266,200	13,266,200	13,266,200
Average Contribution Rate	$4.49	$5.12	$5.55	$5.97	$6.11	$6.11
Average Number of Retirees	2,072	2,162	2,146	2,171	2,204	2,226
Total Income	$91,336,259	$106,638,219	$116,218,611	$125,301,300	$128,584,500	$128,549,600
Total Expenses	$87,833,947	$104,374,578	$111,679,555	$126,730,500	$139,740,700	$154,080,500
Average Income Per Active	$773.99	$854.48	$927.93	$1,000.65	$1,026.87	$1,026.58
Average Expenses Per Active	$744.32	$836.34	$891.71	$1,012.08	$1,115.97	$1,230.49
Breakeven Contribution Rate	$4.30	$5.00	$5.31	$6.05	$6.72	$7.49
Recommended Margin				$0.00	$0.00	$0.00
Breakeven Contribution Rate with Margin				$6.05	$6.72	$7.49
Plan/Trust/Fund Assets	$70,379,321	$75,452,944	$85,388,512	$83,959,312	$72,803,112	$47,272,212
Continuation Value (Months)	8.1	8.1	8.1	7.2	5.7	3.3

Observations:

- *Based on the audited financial statements for the fiscal year ended December 31, 2010, the Plan experienced a 13.2 percent increase in assets.*
- *Projected employer contributions are based on 10,435 total active eligibles using the hour and employer contribution rates shown on the following page.*
- *Given the employer and employee contribution rates approved for June 1, 2011 and assuming no further increase, total expenses are projected to exceed total income for the next three calendar years, resulting in operating deficits in each year.*
- *As in prior years, the Plan's continuation value as of December 31, 2010 has remained at 8.1 months. Based on our projection of Plan expenses, the continuation value of Plan assets is expected to decrease to 3.3 months by December 31, 2013, assuming no additional changes to employer contribution rates or changes to the plan of benefits.*

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

Based on projection from SOP 92-6, we have projected slight increases in the number of retirees for future years.

The Trustees may wish to consider soliciting competitive bids for stop loss insurance.

ASSUMPTIONS

12 Months Ending	Dec-11	Dec-12	Dec-13
Average Number of Actives			
Plan A	7,495	7,495	7,495
Plan B	2,115	2,115	2,115
Apprentices	825	825	825
Average Number of Retirees:	2,171	2,204	2,226
Average Contribution Hours per Month:			
Plan A	147.5	147.5	147.5
Plan B	Not Applicable	Not Applicable	Not Applicable
Apprentices	Not Applicable	Not Applicable	Not Applicable
Aggregate Hours	13,266,200	13,266,200	13,266,200
Average Contribution Rate			
Plan A (Per Hour)	$6.55	$6.70	$6.70
Plan B (Per Month)	$697.50	$720.00	$720.00
Apprentices (Per Month)	$570.00	$580.00	$580.00
Trend Factors			
Indemnity Medical	11.00%	11.00%	11.00%
Insured HMO	Renewal	11.00%	11.00%
Insured PPO	Renewal	11.00%	11.00%
Insured POS	Renewal	11.00%	11.00%
Prescription Drugs	10.00%	10.00%	10.00%
Prescription Drug Rebate	6.00%	6.00%	6.00%
Insured Stop Loss	Renewal	16.50%	16.50%
Indemnity Dental	7.00%	7.00%	7.00%
Prepaid Dental	Renewal	2nd Year	5.00%
Vision	3.00%	3.00%	3.00%
EAP, Hearing Aid	3.00%	3.00%	3.00%
Medicare Part D Subsidy	9.00%	9.00%	9.00%
Insured Life and AD&D	0.00%	0.00%	0.00%
Medical ASO Fees	5.00%	5.00%	5.00%
Operating Costs	5.00%	5.00%	5.00%
Investment Yield	3.00%	3.00%	3.00%

Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

AGGREGATE

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$79,079,713	$93,352,708	$102,348,287	$110,238,800	$112,898,800	$112,898,800
Employee Contributions	5,148,204	5,985,264	6,596,712	6,655,500	6,665,400	6,665,400
COBRA Contributions	1,125,067	1,182,940	1,237,138	1,394,900	1,536,600	1,693,500
Retiree Contributions	2,833,012	3,194,837	3,517,292	4,591,900	5,113,700	5,661,500
Investment Income	3,150,263	2,922,470	2,519,182	2,420,200	2,370,000	1,630,400
Total Income	**$91,336,259**	**$106,638,219**	**$116,218,611**	**$125,301,300**	**$128,584,500**	**$128,549,600**
Expenses						
Indemnity Medical	$21,942,301	$26,594,237	$27,184,499	$31,824,300	$35,342,100	$39,239,100
Insured HMO	31,260,874	38,597,782	41,252,533	46,177,100	51,262,700	56,903,600
Insured PPO	10,915,272	12,459,619	14,516,328	15,591,500	17,356,300	19,286,100
Insured POS	4,121,529	4,590,977	5,129,592	5,943,100	6,596,800	7,322,500
Prescription Drugs	6,707,325	7,830,751	8,617,453	9,969,900	10,966,400	11,981,800
Prescription Drug Rebate	(668,038)	(757,187)	(815,696)	(897,900)	(958,500)	(1,021,900)
Insured Stop Loss	568,326	596,394	594,772	785,300	915,100	1,066,400
Indemnity Dental	5,666,076	6,314,221	7,404,957	8,558,700	9,163,600	9,809,300
Prepaid Dental	1,035,595	1,131,567	1,164,150	1,253,700	1,254,500	1,317,600
Vision	1,413,256	1,507,853	1,528,245	1,668,100	1,719,200	1,771,600
EAP, Hearing Aid	350,265	373,721	404,021	422,800	436,000	449,500
Medicare Part D Subsidy	0	(185,968)	(682,618)	(497,700)	(550,900)	(606,200)
Insured Life and AD&D	745,050	868,664	631,000	765,900	766,400	766,800
Medical ASO Fees	397,887	437,539	454,951	478,000	502,000	527,200
Operating Costs	3,378,229	4,014,407	4,295,367	4,687,700	4,969,000	5,267,100
Total Expenses	**$87,833,947**	**$104,374,578**	**$111,679,555**	**$126,730,500**	**$139,740,700**	**$154,080,500**
Operating Surplus (Deficit)	**$3,502,312**	**$2,263,641**	**$4,539,056**	**($1,429,200)**	**($11,156,200)**	**($25,530,900)**
Insured POS Experience Deficit	0	(264,879)	0			
Insured PPO Dividend	34,029	0	87,303			
Life/AD&D Stabilization Reserve Refund	83,250	34,924	0			
Gains (Losses) on Investments	(623,677)	3,039,937	5,309,208			
Total Addition (Reduction) to Plan/Trust/Fu	**$2,995,914**	**$5,073,623**	**$9,935,567**	**($1,429,200)**	**($11,156,200)**	**($25,530,900)**
Beginning Plan/Trust/Fund Assets	**$67,383,407**	**$70,379,321**	**$75,452,944**	**$85,388,512**	**$83,959,312**	**$72,803,112**
Ending Plan/Trust/Fund Assets	**$70,379,321**	**$75,452,944**	**$85,388,512**	**$83,959,312**	**$72,803,112**	**$47,272,212**
Breakeven Contribution Rate	**$4.30**	**$5.00**	**$5.31**	**$6.05**	**$6.72**	**$7.49**
Recommended Margin				**$0.00**	**$0.00**	**$0.00**
Breakeven Contribution Rate with Margin				**$6.05**	**$6.72**	**$7.49**

Note that 2009 & 2010 Indemnity Medical expenses are net of Stop-Loss reimbursements in the amount of $1,419,650 and $30,790, respectively.

Projected employer contributions reflect the current negotiated contribution rate increases. Actual contributions include net reciprocity.

Projected Indemnity Medical expenses have been adjusted for benefit design changes that became effective January 1, 2011. The full impact of the Total Health Management

Projected results have not been adjusted for any plan changes that may be needed to comply with Mental Health Parity & Addiction Equity Act of 2008 or other new legislations.

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

The Indemnity Medical Plan had favorable claims experience (lower than projected) for the fiscal year ended December 31, 2010.

Total expenses are projected to increase 13.5% for 2011 and 10.3% for 2012 and 2013. This compares to income that is estimated to increase 7.8% for 2011, 2.6% for 2012, and remains flat for 2013.

PER ACTIVE PER MONTH

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$670.12	$748.02	$817.19	$880.36	$901.60	$901.60
Employee Contributions	43.63	47.96	52.67	53.15	53.23	53.23
COBRA Contributions	9.53	9.48	9.88	11.14	12.27	13.52
Retiree Contributions	24.01	25.60	28.08	36.67	40.84	45.21
Investment Income	26.70	23.42	20.11	19.33	18.93	13.02
Total Income	**$773.99**	**$854.48**	**$927.93**	**$1,000.65**	**$1,026.87**	**$1,026.58**
Expenses						
Indemnity Medical	$185.94	$213.09	$217.05	$254.15	$282.24	$313.36
Insured HMO	264.90	309.28	329.38	368.77	409.38	454.43
Insured PPO	92.50	99.84	115.90	124.51	138.61	154.02
Insured POS	34.93	36.79	40.96	47.46	52.68	58.48
Prescription Drugs	56.84	62.75	68.81	79.62	87.58	95.69
Prescription Drug Rebate	(5.66)	(6.07)	(6.51)	(7.17)	(7.65)	(8.16)
Insured Stop Loss	4.82	4.78	4.75	6.27	7.31	8.52
Indemnity Dental	48.01	50.59	59.12	68.35	73.18	78.34
Prepaid Dental	8.78	9.07	9.30	10.01	10.02	10.52
Vision	11.98	12.08	12.20	13.32	13.73	14.15
EAP, Hearing Aid	2.97	2.99	3.23	3.38	3.48	3.59
Medicare Part D Subsidy	0.00	(1.49)	(5.45)	(3.97)	(4.40)	(4.84)
Insured Life and AD&D	6.31	6.96	5.04	6.12	6.12	6.12
Medical ASO Fees	3.37	3.51	3.63	3.82	4.01	4.21
Operating Costs	28.63	32.17	34.30	37.44	39.68	42.06
Total Expenses	**$744.32**	**$836.34**	**$891.71**	**$1,012.08**	**$1,115.97**	**$1,230.49**
Operating Surplus (Deficit)	**$29.67**	**$18.14**	**$36.22**	**($11.43)**	**($89.10)**	**($203.91)**
Insured POS Experience Deficit	0.00	(2.12)	0.00			
Insured PPO Dividend	0.29	0.00	0.70			
Life/AD&D Stabilization Reserve Refund	0.71	0.28	0.00			
Gains (Losses) on Investments	(5.29)	24.36	42.39			
Total Addition (Reduction) to Plan/Trust/I	**$25.38**	**$40.66**	**$79.31**	**($11.43)**	**($89.10)**	**($203.91)**
Average Number of Actives	**9,834**	**10,400**	**10,437**	**10,435**	**10,435**	**10,435**
Breakeven Contribution Rate	**$4.30**	**$5.00**	**$5.31**	**$6.05**	**$6.72**	**$7.49**
Recommended Margin				**$0.00**	**$0.00**	**$0.00**
Breakeven Contribution Rate with Margin				**$6.05**	**$6.72**	**$7.49**

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

PER ENROLLEE PER MONTH

Expenses for each benefit item are shown on a per capita basis for those enrolled in each benefit, including both actives and retirees.

The number of enrollees include actives and retirees. We have assumed no change in active plan enrollment and the number of retirees is projected to increase based on SOP 92-6 valuation as of December 31, 2008

				Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Average Expenses Per Enrollee Per Month						
Indemnity Medical	$435.47	$504.02	$518.04	$605.21	$670.27	$742.83
Insured HMO	576.73	670.66	709.98	794.40	881.35	977.93
Insured PPO	383.64	412.52	475.88	508.53	562.13	621.73
Insured POS	419.37	449.04	517.51	600.31	666.34	739.65
Prescription Drugs	100.17	111.09	122.38	141.34	155.10	169.21
Prescription Drug Rebate	(9.98)	(10.74)	(11.58)	(12.73)	(13.56)	(14.43)
Insured Stop Loss	13.52	13.52	13.52	17.85	20.79	24.22
Indemnity Dental	69.39	72.92	84.97	87.74	93.79	100.29
Prepaid Dental	28.49	29.62	30.56	31.82	31.82	33.41
Vision	11.98	12.08	12.20	12.18	12.54	12.91
EAP, Hearing Aid	5.23	5.30	5.74	5.99	6.17	6.35
Medicare Part D Subsidy	0.00	(21.49)	(80.46)	(58.01)	(63.23)	(68.92)
Insured Life and AD&D	5.60	6.18	4.47	5.42	5.41	5.40
Medical ASO Fees	9.47	9.92	10.34	10.86	11.40	11.97
Operating Costs	23.65	26.63	28.45	30.99	32.76	34.67
Average Number of Enrollees						
Indemnity Medical	4,199	4,397	4,373	4,382	4,394	4,402
Insured HMO	4,517	4,796	4,842	4,844	4,847	4,849
Insured PPO	2,371	2,517	2,542	2,555	2,573	2,585
Insured POS	819	852	826	825	825	825
Prescription Drugs	5,580	5,874	5,868	5,878	5,892	5,901
Prescription Drug Rebate	5,580	5,874	5,868	5,878	5,892	5,901
Insured Stop Loss	3,503	3,676	3,666	3,667	3,668	3,669
Indemnity Dental	6,805	7,216	7,262	8,129	8,142	8,151
Prepaid Dental	3,029	3,184	3,175	3,283	3,285	3,286
Vision	9,834	10,400	10,437	11,412	11,427	11,437
EAP, Hearing Aid	5,580	5,874	5,868	5,878	5,892	5,901
Medicare Part D Subsidy	696	721	707	715	726	733
Insured Life and AD&D	11,087	11,710	11,757	11,781	11,814	11,836
Medical ASO Fees	3,503	3,676	3,666	3,667	3,668	3,669
Operating Costs	11,906	12,562	12,583	12,606	12,639	12,661
Total Number of Employees and Retirees	**11,906**	**12,562**	**12,583**	**12,606**	**12,639**	**12,661**

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

Projected contributions were based on 13,266,200 annual aggregate hours for Regular Actives, consistent with the Plan's historical norm. We have shown the impact if actual hours differ from this assumption.

A change in the hourly assumption by 10 hours per active per month (899,400 annually) impacts the asset level at the end of 2013 by approximately $19 million.

Given the current economic and industry outlook, we look to the Trustees for guidance on making the appropriate work-level assumption.

VARIATIONS IN HOURS ASSUMPTIONS

12 Months Ending	Dec-11	Dec-12	Dec-13
Current Assumptions			
Average Hours	147.5	147.5	147.5
Ending Plan/Trust/Fund Assets	$83,959,312	$72,803,112	$47,272,212
Continuation Value (Months)	7.2	5.7	3.3
Breakeven Contribution Rate	$6.05	$6.72	$7.49
Alternate Assumption 1			
Average Hours	157.5	157.5	157.5
Ending Plan/Trust/Fund Assets	$90,022,512	$85,110,512	$66,211,512
Continuation Value (Months)	7.7	6.6	4.7
Breakeven Contribution Rate	$5.65	$6.28	$6.99
Alternate Assumption 2			
Average Hours	137.5	137.5	137.5
Ending Plan/Trust/Fund Assets	$78,063,542	$60,559,962	$28,691,682
Continuation Value (Months)	6.7	4.7	2.0
Breakeven Contribution Rate	$6.49	$7.22	$8.06
Average Contribution Rate Per Hour	$5.97	$6.11	$6.11

Observations:

- *The results of this projection are based on the employer contribution assumption of 7,495 Plan A Actives, a total of 13,266,200 hours annually. The alternate scenarios shown above are intended to illustrate the general effect of changes in employment levels.*
- *Using the current hours assumption, we have projected the Plan to incur a deficit of $1,429,200, $11,156,200 and $25,530,900 for 2011, 2012 and 2013, respectively.*
- *If average hours increase by 10 hours per active per month as shown in the first alternate scenario, the Plan is projected to incur a surplus of $4,634,000 in 2011. The deficits for 2012 and 2013 decrease to $4,912,000 and $18,899,000, respectively. Plan assets as of December 31, 2013 would be about 40 percent greater than currently projected, and the continuation value would increase to 4.7 months.*
- *If average hours decrease by 10 hours per active per month as shown in the second alternate scenario, the deficit in 2011 increases to 7,625,000. The deficits for 2012 and 2013 increase to $17,503,600 and $31,868,300, respectively. Plan assets as of December 31, 2013 would be about 39 percent less than currently projected, and the continuation value would decrease to 2.0 months.*

Financial Experience and Budget Projections for Local XYZ Plan/Trust/Fund

The year-to-date financials are shown here on a paid basis, which differs from the results of the projections, which are shown on an incurred basis.

The Trustees may wish to consider conducting a claims audit for the Indemnity Medical Plan, as the last audit was completed in 2001.

Also note that the year-to-date financial experience does not reflect the full impact of the January 2011 renewals and the seasonality of work.

PAID FINANCIAL INFORMATION – FROM JANUARY 2011 THROUGH SEPTEMBER 2011

	Aggregate	Per Employee Per Month
Income		
Employer Contributions	$80,327,275	$863.93
Employee Contributions	4,873,161	52.41
COBRA Contributions	983,165	10.57
Retiree Contributions	3,381,892	36.37
Investment Income	0	0.00
Total Income	**$90,729,052**	**$975.79**
Expenses		
Indemnity Medical	$23,055,988	$247.97
Insured HMO	33,670,802	362.13
Insured PPO	11,268,857	121.20
Insured POS	4,243,031	45.63
Prescription Drugs	7,141,900	76.81
Prescription Drug Rebate	(651,121)	(7.00)
Insured Stop Loss	569,468	6.12
Indemnity Dental	6,206,429	66.75
Prepaid Dental	909,133	9.78
Vision	1,209,640	13.01
EAP, Hearing Aid	306,598	3.30
Medicare Part D Subsidy	0	0.00
Insured Life and AD&D	257,800	2.77
Medical ASO Fees	347,776	3.74
Operating Costs	0	0.00
Total Expenses	**$91,935,633**	**$952.21**
Operating Surplus (Deficit)	**$(1,206,581)**	**$23.58**
Losses on Investments	**$(1,749,204)**	**$(18.81)**
Total Addition/(Reduction) to Plan/Trust/Fund Asset	**$(2,955,785)**	**$4.77**
Plan/Trust/Fund Assets	**$82,432,727**	
Average Number of Actives	**10,331**	**10,331**

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

The investment income is allocated amongst the actives based on the percentage of total employer contributions attributable to each active group.

The Plan had two significant large claims during the 2009 fiscal year, for which $1.4 million in reimbursements were received in 2008-2010. The amount of reimbursement received during the last three years has offset over 80% of the $1.7 million in stop loss premiums.

PLAN A ACTIVES - AGGREGATE

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$58,028,700	$68,628,700	$74,175,700	$79,597,200	$80,923,800	$80,923,800
COBRA Contributions	908,494	950,830	1,000,441	1,136,800	1,252,000	1,379,700
Investment Income	2,644,210	2,449,475	2,126,239	2,042,900	2,007,400	1,380,900
Total Income	**$61,581,404**	**$72,029,005**	**$77,302,380**	**$82,776,900**	**$84,183,200**	**$83,684,400**
Expense						
Indemnity Medical	$20,160,969	$25,906,944	$25,013,365	$29,252,100	$32,469,800	$36,041,500
Insured HMO	20,894,289	25,717,123	26,917,596	30,397,100	33,740,800	37,452,300
Insured PPO	4,859,980	5,452,699	6,150,519	6,558,300	7,279,800	8,080,500
Prescription Drugs	4,501,075	5,367,560	5,905,198	6,814,300	7,461,700	8,133,200
Prescription Drug Rebate	(507,482)	(574,433)	(621,488)	(678,400)	(719,100)	(762,300)
Insured Stop Loss	558,592	586,173	584,875	772,000	899,400	1,047,800
Stop Loss Reimbursement	0	(1,391,285)	(20,395)	0	0	0
Indemnity Dental	4,636,320	5,242,129	6,139,249	6,792,800	7,268,200	7,777,000
Prepaid Dental	490,670	544,282	561,226	576,000	576,000	604,800
Vision	1,087,332	1,172,634	1,168,036	1,221,300	1,257,900	1,295,700
EAP, Hearing Aid	298,254	316,937	340,782	356,500	367,200	378,200
Insured Life and AD&D	645,500	800,250	483,000	657,800	657,800	657,800
Medical ASO Fees	391,069	430,039	447,382	469,700	493,200	517,800
Operating Costs	1,999,655	2,383,598	2,559,134	2,787,200	2,946,400	3,118,200
Total Expenses	**$60,016,224**	**$71,954,650**	**$75,628,480**	**$85,976,700**	**$94,699,100**	**$104,342,500**
Operating Surplus (Deficit)	**$1,565,181**	**$74,355**	**$1,673,900**	**$(3,199,800)**	**$(10,515,900)**	**$(20,658,100)**
Average Number of Actives	**7,054**	**7,460**	**7,497**	**7,495**	**7,495**	**7,495**
Average Monthly Hours Per Active	**148.9**	**146.1**	**147.2**	**147.5**	**147.5**	**147.5**

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

PLAN A ACTIVES - PER HOUR

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$4.60	$5.25	$5.60	$6.00	$6.10	$6.10
COBRA Contributions	0.07	0.07	0.08	0.09	0.09	0.10
Investment Income	0.21	0.19	0.16	0.15	0.15	0.10
Total Income	**$4.88**	**$5.51**	**$5.84**	**$6.24**	**$6.34**	**$6.30**
Expense						
Indemnity Medical	$1.60	$1.98	$1.89	$2.21	$2.45	$2.72
Insured HMO	1.66	1.97	2.03	2.29	2.54	2.82
Insured PPO	0.39	0.42	0.46	0.49	0.55	0.61
Prescription Drugs	0.36	0.41	0.45	0.51	0.56	0.61
Prescription Drug Rebate	(0.04)	(0.04)	(0.05)	(0.05)	(0.05)	(0.06)
Insured Stop Loss	0.04	0.04	0.04	0.06	0.07	0.08
Stop Loss Reimbursement	0.00	(0.11)	0.00	0.00	0.00	0.00
Indemnity Dental	0.37	0.40	0.46	0.51	0.55	0.59
Prepaid Dental	0.04	0.04	0.04	0.04	0.04	0.05
Vision	0.09	0.09	0.09	0.09	0.09	0.10
EAP, Hearing Aid	0.02	0.02	0.03	0.03	0.03	0.03
Insured Life and AD&D	0.05	0.06	0.04	0.05	0.05	0.05
Medical ASO Fees	0.03	0.03	0.03	0.04	0.04	0.04
Operating Costs	0.00	0.00	0.00	0.00	0.00	0.00
Total Expenses	**$4.77**	**$5.49**	**$5.70**	**$6.48**	**$7.14**	**$7.88**
Operating Surplus (Deficit)	**$0.11**	**$0.02**	**$0.14**	**$(0.24)**	**$(0.80)**	**$(1.58)**
Average Number of Actives	**7,046**	**7,459**	**7,496**	**7,495**	**7,495**	**7,495**
Average Monthly Hours Per Active	**148.9**	**146.1**	**147.2**	**147.5**	**147.5**	**147.5**
Aggregate Hours	**12,606,703**	**13,077,119**	**13,240,934**	**13,266,200**	**13,266,200**	**13,266,200**

Employer contributions shown for the Plan A Actives are net of amounts allocated for the retiree plan.

Assuming a monthly average of 147.5 hours per active, the Plan A Actives is projected to incur a deficit in each of the next three years.

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

PLAN B AGGREGATE - AGGREGATE

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$12,286,560	$14,790,120	$16,497,000	$17,702,600	$18,273,600	$18,273,600
Employee Contributions	4,725,600	5,514,960	6,091,200	6,091,200	6,091,200	6,091,200
COBRA Contributions	192,141	208,633	209,995	227,400	250,800	276,600
Investment Income	519,254	490,499	434,137	416,200	412,700	283,900
Total Income	**$17,723,555**	**$21,004,212**	**$23,232,332**	**$24,437,400**	**$25,028,300**	**$24,925,300**
Expense						
Insured HMO	$9,629,764	$11,997,042	$13,399,662	$14,696,900	$16,313,500	$18,108,000
Insured POS	3,112,009	3,540,723	4,087,450	4,222,300	4,686,700	5,202,300
Prescription Drugs	547,130	632,137	671,409	771,800	845,100	921,200
Prescription Drug Rebate	(55,491)	(61,589)	(64,849)	(70,500)	(74,700)	(79,200)
Indemnity Dental	1,029,756	1,072,092	1,265,708	1,400,900	1,499,000	1,603,900
Prepaid Dental	278,940	306,432	318,240	326,400	326,400	342,700
Vision	237,280	244,358	267,031	279,100	287,500	296,100
EAP, Hearing Aid	30,825	32,854	35,726	37,200	38,300	39,500
Insured Life and AD&D	84,550	48,414	83,000	74,300	74,300	74,300
Operating Costs	558,802	667,561	722,061	786,500	831,400	879,900
Total Expenses	**$15,453,565**	**$18,480,024**	**$20,785,438**	**$22,524,900**	**$24,827,500**	**$27,388,700**
Operating Surplus (Deficit)	**$2,269,990**	**$2,524,188**	**$2,446,894**	**$1,912,500**	**$200,800**	**$(2,463,400)**
Average Number of Actives	**780**	**825**	**825**	**825**	**825**	**825**
Average Monthly Hours Per Active	**149**	**146**	**147**	**148**	**148**	**148**

The current employee contribution is $240 per active per month for Plan B Actives.

Total income is projected to exceed total expenses for the Plan B actives in 2011 and 2012.

After a 6% increase in 2009, the number of Plan B actives increased 1% in 2010. We have assumed the group remains at 2,115 actives for the next three years.

PLAN B - PER ENROLLEE PER MONTH

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Average Expenses Per Enrollee Per Month						
Insured HMO	$553.43	$647.93	$714.42	$782.58	$868.66	$964.22
Insured POS	499.68	540.40	617.07	639.74	710.11	788.22
Prescription Drugs	87.85	96.48	101.36	116.94	128.05	139.57
Prescription Drug Rebate	(8.91)	(9.40)	(9.79)	(10.68)	(11.33)	(12.00)
Indemnity Dental	73.47	71.53	83.38	92.29	98.75	105.66
Prepaid Dental	29.02	30.40	31.20	32.00	32.00	33.60
Vision	10.04	9.75	10.52	11.00	11.33	11.67
EAP, Hearing Aid	4.95	5.01	5.39	5.63	5.80	5.98
Insured Life and AD&D	3.58	1.93	3.27	2.93	2.93	2.93
Operating Costs	23.65	26.63	28.45	30.99	32.76	34.67
Average Number of Enrollees						
Insured HMO	1,450	1,543	1,563	1,565	1,565	1,565
Insured POS	519	546	552	550	550	550
Prescription Drugs	519	546	552	550	550	550
Prescription Drug Rebate	519	546	552	550	550	550
Indemnity Dental	1,168	1,249	1,265	1,265	1,265	1,265
Prepaid Dental	801	840	850	850	850	850
Vision	1,969	2,089	2,115	2,115	2,115	2,115
EAP, Hearing Aid	519	546	552	550	550	550
Insured Life and AD&D	1,969	2,089	2,115	2,115	2,115	2,115
Operating Costs	1,969	2,089	2,115	2,115	2,115	2,115

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

APPRENTICES - AGGREGATE

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$4,226,040	$4,703,040	$5,055,120	$5,643,000	$5,742,000	$5,742,000
Employee Contributions	422,604	470,304	505,512	564,300	574,200	574,200
COBRA Contributions	24,432	23,477	26,702	30,700	33,800	37,200
Investment Income	178,601	155,971	133,031	132,700	129,700	89,200
Total Income	**$4,851,677**	**$5,352,792**	**$5,720,365**	**$6,370,700**	**$6,479,700**	**$6,442,600**
Expense						
Insured POS	$4,121,529	$4,590,977	$5,129,592	$5,943,100	$6,596,800	$7,322,500
Dental DMO	265,985	280,853	284,684	309,900	309,900	325,400
Vision	88,644	90,861	93,178	97,300	100,200	103,200
Operating Costs	232,432	272,265	281,996	306,800	324,300	343,200
Total Expenses	**$4,708,590**	**$5,234,956**	**$5,789,450**	**$6,657,100**	**$7,331,200**	**$8,094,300**
Operating Surplus (Deficit)	**$143,087**	**$117,836**	**$(69,085)**	**$(286,400)**	**$(851,500)**	**$(1,651,700)**
Average Number of Actives	**780**	**825**	**825**	**825**	**825**	**825**
Average Monthly Hours Per Active	**149**	**146**	**147**	**148**	**148**	**148**

The Apprentices are required to enroll in the Insured POS medical and dental plans until they graduate to the Plan A Active Plan.

The number of Apprentices increased 4% in 2008, but decreased 3% last year. We have assumed the participation remains level for the next three years.

As the increase in income is not projected to keep pace with the increase in costs, the Trustees may wish to consider moderate benefit reductions to control costs.

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Local XYZ Plan/Trust/Fund

Dental and vision benefits are offered to retirees on a 100% self-pay basis effective January 1, 2011. We have assumed that 45% of retirees would choose to self-pay for dental and vision coverage.

Per Trustee policy, retiree contributions equal 40% of the cost of medical, drug, and life and AD&D benefits.

Combined income in the retiree plan is projected to exceed expenses in 2011 and 202. There would be a subsidy in 2013 of $0.03 per hour. This subsidy is in addition to the employer contributions allocated for retiree benefits.

RETIREE - PER MONTH

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$182.53	$201.62	$257.09	$280.07	$300.96	$297.99
Retiree Contributions	113.94	123.14	136.58	176.26	193.35	211.95
Total Income	**$296.47**	**$324.76**	**$393.67**	**$456.33**	**$494.31**	**$509.94**
Expense						
Indemnity Medical	$71.64	$81.21	$85.50	$98.73	$108.60	$119.71
Insured HMO	29.63	34.06	36.32	41.57	45.69	50.29
Insured PPO	118.38	133.60	166.14	184.67	203.79	224.74
Prescription Drugs	66.73	70.58	79.25	91.50	100.56	109.59
Prescription Drug Rebate	(4.23)	(4.67)	(5.02)	(5.72)	(6.23)	(6.75)
Insurred Stop Loss	0.39	0.39	0.38	0.51	0.59	0.70
Stop Loss Reimbursement	0.00	(1.09)	(0.40)	0.00	0.00	0.00
Indemnity Dental	0.00	0.00	0.00	14.01	14.99	16.04
Dental DMO	0.00	0.00	0.00	1.59	1.60	1.67
Vision Claims	0.00	0.00	0.00	2.70	2.78	2.87
EAP, Hearing Aid	0.85	0.92	1.07	1.12	1.15	1.19
Medicare Part D Subsidy	0.00	(7.17)	(26.51)	(19.10)	(20.83)	(22.69)
Insured Life and AD&D	0.60	0.77	2.52	1.30	1.30	1.30
Medical ASO Fees	0.27	0.29	0.29	0.32	0.33	0.35
Operating Costs	23.65	26.63	28.45	30.99	32.76	34.67
Total Expenses	**$307.91**	**$335.52**	**$367.99**	**$444.19**	**$487.08**	**$533.68**
Operating Surplus (Deficit)	**$(11.44)**	**$(10.76)**	**$25.68**	**$12.14**	**$7.23**	**$(23.74)**
Subsidy Per Active Per Month	**(2.41)**	**(2.24)**	**5.28**	**2.53**	**1.53**	**(5.06)**
Subsidy Per Active Per Hour	**(0.02)**	**(0.02)**	**0.04**	**0.02**	**0.01**	**(0.03)**
Income as a % of Expense	**96.3%**	**96.8%**	**107.0%**	**102.7%**	**101.5%**	**95.6%**
Average Number of Retirees	**2,072**	**2,162**	**2,146**	**2,171**	**2,204**	**2,226**

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

NON-MEDICARE RETIREES - PER MONTH

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$182.53	$201.62	$257.09	$280.06	$300.95	$298.00
Retiree Contributions	422.39	463.83	514.14	603.72	668.17	739.56
Total Income	**$604.92**	**$665.45**	**$771.23**	**$883.78**	**$969.12**	**$1,037.56**
Expense						
Indemnity Medical	$312.44	$364.56	$382.32	$446.32	$496.77	$555.28
Insured HMO	112.77	124.29	130.45	148.66	162.85	179.18
Insured PPO	461.94	512.05	586.50	646.39	718.80	796.83
Prescription Drugs	162.66	168.52	192.71	221.80	243.39	265.68
Prescription Drug Rebate	(8.01)	(9.57)	(11.07)	(12.57)	(13.66)	(14.77)
Insurred Stop Loss	3.81	3.82	3.75	4.95	5.76	6.77
Stop Loss Reimbursement	0.00	(10.60)	(3.94)	0.00	0.00	0.00
Indemnity Dental	0.00	0.00	0.00	14.06	15.01	16.08
Dental DMO	0.00	0.00	0.00	1.56	1.54	1.60
Vision Claims	0.00	0.00	0.00	2.72	2.79	2.87
EAP, Hearing Aid	2.45	2.71	3.36	3.50	3.63	3.75
Insured Life and AD&D	3.91	1.87	0.00	1.30	1.28	1.31
Medical ASO Fees	2.67	2.80	2.87	3.09	3.23	3.42
Operating Costs	23.65	26.63	28.45	30.99	32.75	34.68
Total Expenses	**$1,078.29**	**$1,187.08**	**$1,315.40**	**$1,512.77**	**$1,674.14**	**$1,852.68**
Operating Surplus (Deficit)	**$(473.37)**	**$(521.63)**	**$(544.17)**	**$(628.99)**	**$(705.02)**	**$(815.12)**
Subsidy Per Active Per Month	**(10.25)**	**(11.18)**	**(11.47)**	**(13.50)**	**(15.34)**	**(17.89)**
Subsidy Per Active Per Hour	**(0.07)**	**(0.08)**	**(0.08)**	**(0.09)**	**(0.10)**	**(0.12)**
Income as a % of Expense	**56.1%**	**56.1%**	**58.6%**	**58.4%**	**57.9%**	**56.0%**
Average Number of Retirees	**213**	**223**	**220**	**224**	**227**	**229**

There was one large claim in the non-Medicare retiree group. The reimbursements received have more than offset the cost for the stop loss coverage in the most recent three-year period.

Non-Medicare retirees represent only 10% of the retiree population but account for 37% of total retiree expenses.

Financial Experience and Budget Projections
Local XYZ Plan/Trust/Fund

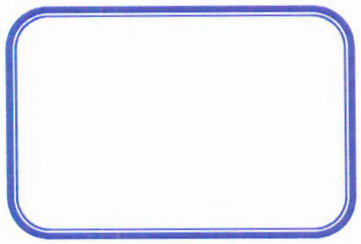
MEDICARE RETIREES - PER MONTH

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Income						
Employer Contributions	$182.53	$201.62	$257.09	$280.07	$300.96	$297.98
Retiree Contributions	78.60	83.96	93.46	127.08	138.83	151.44
Total Income	**$261.13**	**$285.58**	**$350.55**	**$407.15**	**$439.79**	**$449.42**
Expense						
Indemnity Medical	$44.05	$48.62	$51.60	$58.74	$64.03	$69.76
Insured HMO	20.11	23.68	25.57	29.25	32.24	35.51
Insured PPO	79.01	90.08	118.12	131.54	144.66	159.14
Prescription Drugs	55.74	59.31	66.29	76.51	84.16	91.69
Prescription Drug Rebate	(3.79)	(4.11)	(4.33)	(4.93)	(5.37)	(5.83)
Indemnity Dental	0.00	0.00	0.00	14.00	14.98	16.03
Dental DMO	0.00	0.00	0.00	1.59	1.60	1.68
Vision Claims	0.00	0.00	0.00	2.70	2.78	2.87
EAP, Hearing Aid	0.67	0.72	0.81	0.84	0.87	0.90
Medicare Part D Subsidy	0.00	(7.99)	(29.54)	(21.30)	(23.22)	(25.30)
InsuredLife and AD&D	0.22	0.64	2.81	1.30	1.30	1.30
Operating Costs	23.65	26.63	28.45	30.99	32.76	34.67
Total Expenses	**$219.66**	**$237.58**	**$259.78**	**$321.23**	**$350.79**	**$382.42**
Operating Surplus	**$41.47**	**$48.00**	**$90.77**	**$85.92**	**$89.00**	**$67.00**
Subsidy Per Active Per Month	**7.84**	**8.95**	**16.75**	**16.03**	**16.86**	**12.82**
Subsidy Per Active Per Hour	**0.05**	**0.06**	**0.11**	**0.11**	**0.11**	**0.09**
Income as a % of Expense	**118.9%**	**120.2%**	**134.9%**	**126.7%**	**125.4%**	**117.5%**
Average Number of Retirees	**1,859**	**1,939**	**1,926**	**1,947**	**1,977**	**1,997**

The Trustees may wish to consider alternatives to the Medicare Part D Retiree Drug Subsidy.

Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

OTHER OPTIONS/ADDITIONAL PAGES







	Historical Results			Projections		
12 Months Ending	Dec-08	Dec-09	Dec-10	Dec-11	Dec-12	Dec-13

Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

PLAN/TRUST/FUND ASSET POSITION

Plan Assets projected for December 31, 2013, represent 55% of the Plan Assets as of December 31, 2010.

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Plan/Trust/Fund Assets as of Period En	$70,379,321	$75,452,944	$85,388,512	$83,959,312	$72,803,112	$47,272,212
Incurred But Not Reported Claims	6,326,000	7,794,000	7,906,500	9,197,500	10,125,600	11,138,600
Auditor's Statement of Plan/Trust/Fun	$76,705,321	$83,246,944				

TARGETED RESERVES

Plan Assets are projected to be almost even with Targeted Reserves for 2011, but are projected to fall short of Targeted Reserves for 2012 and 2013.

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Claims Fluctuation	$9,801,500	$11,479,100	$12,057,000	$13,938,900	$15,233,900	$16,642,800
Accumulated Eligibility	7,375,500	7,800,000	7,827,800	7,826,300	7,826,300	7,826,300
Economic	43,917,000	52,187,300	55,839,800	63,365,300	69,870,400	77,040,300
Total Targeted Reserves	$61,094,000	$71,466,400	$75,724,600	$85,130,500	$92,930,600	$101,509,400

Claims Incurred But Not Reported Reserve

Purpose: This reserve represents an estimate of the liability at the end of the fiscal year for:

1. Claims that have already been submitted, but on which payment has not been made, and
2. Incurred claims that have not yet been submitted

Claims Fluctuation Reserve

Purpose: Amount set aside to cover the possibility of actual benefit payments exceeding projected claims, commonly due to variations in large claims, claims trend patterns, legislative changes, and other factors.

Accumulated Eligibility

Purpose: Amount needed to cover eligibility earned by active members but not yet provided as of the end of the period, commonly due to the lag between hours worked and eligibility for benefits.

Economic Reserve

Purpose: Amount set aside to preserve financial solvency during a prolonged, adverse economic situation.

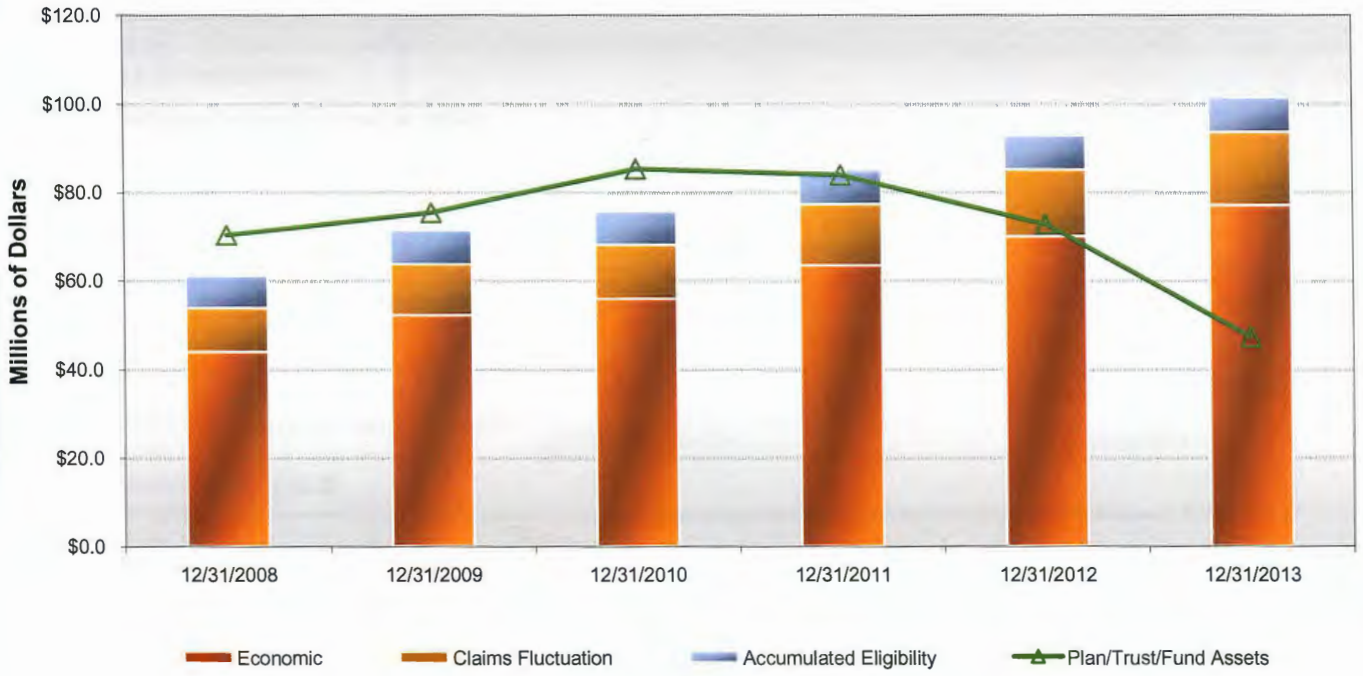
Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

PLAN/TRUST/FUND ASSET POSITION AND TARGETED RESERVES GRAPH

Targeted Reserves equal about 6 months of expenses. This compares to Plan Assets at 5.7 months and 3.3 months at the end of calendar years 2012 and 2013, respectively.

	Historical Results			Projections		
12 Months Ending	**Dec-08**	**Dec-09**	**Dec-10**	**Dec-11**	**Dec-12**	**Dec-13**
Ratio of Plan/Trust/Fund Assets to Targeted Reserve	115.2%	105.6%	112.8%	98.6%	78.3%	46.6%
Ratio of Plan/Trust/Fund Assets to Next Year's Expe	67.4%	67.6%	67.4%	60.1%	47.3%	27.8%
Continuation Value (Months)	8.1	8.1	8.1	7.2	5.7	3.3

These projections are based on assumptions as set forth. We continue to look to the Trustees for input regarding industry outlook, the levels of work, and impact of current economic conditions.



Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

These rates are based on collective bargaining agreements in effect through December 31, 2011.

KNOWN CONTRIBUTION RATES

Plan A	**6/1/2007**	**12/1/2007**	**6/1/2008**	**6/1/2009**	**6/1/2010**	**6/1/2011**
Active Benefits -Per Hour	$4.80	$4.90	$5.25	$5.25	$5.60	$5.90
Retiree Benefits -Per Hour	$0.25	$0.33	$0.39	$0.40	$0.50	$0.60
Plan B	**6/1/2007**	**12/1/2007**	**6/1/2008**	**6/1/2009**	**6/1/2010**	**6/1/2011**
Plan B -Per Month	$500.00	$510.00	$530.00	$590.00	$650.00	$690.00
Apprentices	**6/1/2007**	**6/1/2007**	**6/1/2007**	**6/1/2007**	**6/1/2007**	**6/1/2007**
Apprentices -Per Month	$400.00	$420.00	$440.00	$460.00	$510.00	$560.00
Aggregate Hours						

Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

HISTORICAL INSURANCE PREMIUM RATES AND/OR VENDOR FEES

Medical ASO	**1/1/2007**	**1/1/2008**	**1/1/2009**	**1/1/2010**	**1/1/2011**	**Next Renewal**
Plan A Actives - Composite	$9.45	$9.73	$10.07	$10.07	$10.58	1/1/2012
Non-Medicare Retirees - Composite	$9.45	$9.73	$10.07	$10.07	$10.58	1/1/2012
Insured Stop Loss	**7/1/2007**	**7/1/2008**	**7/1/2009**	**7/1/2010**	**7/1/2011**	**Next Renewal**
Plan A Actives - Composite	$13.52	$13.52	$13.52	$17.05	$18.65	7/1/2012
Non-Medicare Retirees - Composite	$13.52	$13.52	$13.52	$17.05	$18.65	7/1/2012
Insured PPO	**5/1/2007**	**5/1/2008**	**5/1/2009**	**5/1/2010**	**5/1/2011**	**Next Renewal**
Plan A Actives - Composite	$526.25	$549.39	$623.43	$632.63	$697.71	5/1/2012
Plan B Actives - Composite	$480.46	$524.66	$610.96	$629.66	$646.94	5/1/2012
Non-Medicare Retirees - Per Person	$451.07	$444.74	$504.68	$576.72	$640.69	5/1/2012
Medicare Retirees - Per Person	$123.63	$139.96	$173.83	$181.09	$189.57	5/1/2012
Insured HMO	**7/1/2007**	**7/1/2008**	**7/1/2009**	**7/1/2010**	**7/1/2011**	**Next Renewal**
Plan A Actives - Composite	$608.17	$704.27	$729.00	$770.22	$877.32	7/1/2012
Plan B Actives - Composite	$553.42	$648.00	$714.40	$731.71	$833.45	5/1/2012
Non-Medicare Retirees - Per Person	$553.46	$465.68	$514.32	$557.80	$635.89	5/1/2012
Medicare Retirees - Per Person	$144.05	$174.30	$197.43	$225.03	$245.29	5/1/2012
Insured POS	**1/1/2007**	**1/1/2008**	**1/1/2009**	**1/1/2010**	**1/1/2011**	**Next Renewal**
Apprentice - Composite	$411.48	$414.92	$485.45	$548.56	$600.31	1/1/2012
Insured Dental	**1/1/2007**	**1/1/2008**	**1/1/2009**	**1/1/2010**	**1/1/2011**	**Next Renewal**
Plan A Actives - Composite	$26.70	$29.60	$31.20	2nd Year	$32.00	1/1/2013
Plan B Actives - Composite	$26.70	$29.60	$31.20	2nd Year	$32.00	1/1/2013
Dental DMO	**1/1/2007**	**1/1/2008**	**1/1/2009**	**1/1/2010**	**1/1/2011**	**Next Renewal**
Apprentice - Composite	$27.00	2nd Year	$28.00	$29.40	$31.30	1/1/2013

Financial Experience and Budget Projections for
Local XYZ Plan/Trust/Fund

HISTORY OF PLAN CHANGES

Effective Date	Plan Change
1/1/2000	Office visit copay under the HMO plans were decreased from $15 to $5 for both actives and retirees.
1/1/2000	Prescription drug copay for generic drugs was eliminated and for brand name drugs was decreased from $20 to $5 for all plans.
4/1/2003	Due to compliance with mental health parity, Insured HMO does not allow carve out of mental health and chemical dependency benefits. Therefore, these coverages were added to the Insured HMO plan for Insured HMO participants.
8/1/2004	Apprentices joined the Plan, for whom a medical plan and a dental plan through Insured Dental were added.
3/1/2006	The Indemnity Medical Plan was eliminated for Plan B Actives.
1/1/2007	The calendar year deductible under the Indemnity Medical Plan was increased from $200 to $400.
1/1/2007	The plan coinsurance level for the Indemnity Dental Plan were decreased from 100%/90%/80% to 100%/80%/60%.
1/1/2008	A $50 calendar year per-person deductible was added under the Indemnity Prescription Drug Plan.
1/1/2011	Total Health Management programs, including the cardiac care and diabetes targeted programs, were added to the Indemnity Medical Plan.
1/1/2011	Coverage for dental and vision benefits became available to retirees on a 100% self-paid basis.

Definition of Key Terms

Accumulated Eligibility Credits Reserve *– Amount needed to cover eligibility earned by active members but not yet provided as of the end of the period, commonly due to the lag between hours worked and eligibility for benefits.*

Breakeven Contribution Rate – *The income needed to cover benefit expenses, net of participant contributions and investment income. It does not include the amount needed to maintain or achieve targeted reserves.*

Claims Fluctuation Reserve *– Amount set aside to cover the possibility of actual benefit payments exceeding projected claims, commonly due to variations in large claims, claims trend patterns, legislative changes, and other factors.*

Continuation Value *– Plan/Trust/Fund Assets divided by the following year Benefit Expenses times 12 months. A measure of*

Economic Reserve *– Amount set aside to preserve financial solvency during a prolonged, adverse economic situation.*

Incurred But Not Reported Claims *– Reserve needed to cover claims that are known but not yet paid (pending), as well as unknown claims that have been incurred but not yet submitted (unrevealed), as of the end of the period.*

Investment Income *– Amount of interest from fixed income securities and dividends from equities. This does not include other realized or unrealized gains or losses on investments.*

A realized gain or loss is the difference between the proceeds from the sale of an asset and the cost of acquiring the asset. An unrealized gain or loss is the difference between the market value of an asset that is still being held and the cost of acquiring the asset.

Margin *– A recommended amount added to the breakeven contribution rate to cover future fluctuations in expenses.*

Operating Surplus / (Deficit) *– Income less expenses, not including impact of unpredictable items such as realized or unrealized gains or losses on investments.*

Plan/Trust/Fu *– Net assets available for benefits, less Incurred But Not Reported Claims reserves.*

Targeted Reserves - *Minimum desired level of Plan/Trust/Fund Assets, generally including Accumulated Eligibility Credit Claims Fluctuation Reserves, Economic Reserves, and other reserves as determined by Trustee policy.*

Trend Factors *– Expected future increases in benefit and other expenses, expressed as a percentage of the prior year's expense. For insurance premiums and vendor fees, trend is the projected or estimated increases in rates or fees.*

For self-insured benefit expenses, trend is the projected change in per capita claims costs and is influenced by price inflation, utilization changes, the leveraging impact of fixed deductibles and copayments, legislative changes and advances in health care technology.

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MEMORANDUM

To: Mona Moon

From: Chuck Fuhrer, FSA, MAAA
Kenneth C. Vieira, FSA, MAAA

Date: July 31, 2015

Re: Incurred but Unpaid Valuation as of 6/30/2015

Summary

The Segal Company conducted an actuarial valuation of the Incurred but Unpaid claims as of June 30, 2015. The valuation was based on claims paid through June 30, 2015 and enrollment data provided by Blue Cross and Blue Shield of North Carolina and Express Scripts.

The results were an estimated claim reserve liability of approximately $263.1 million. A reserve for Blue Card claims is included for approximately $20.7 million, and a reserve for HRA Balance as of 6/30/2015 is included for approximately $5.3 million. The total reserve includes margin for adverse deviation of approximately $11.6 million and administrative expenses of approximate $15.2 million.

The standard actuarial development method was used to estimate these results, except that a projection method was used for May through June 2015 incurred claims for the Medical, April through June for the Blue Card, and June for the Drug. The projection method is used when there is not enough actual paid data for an incurred month to yield a reliable result. For the projection method we used the estimated incurred claims from the development calculation in the immediately preceding 10 months (June 2014 through March 2015) for the medical and 12 months for the Rx (June 2014 through May 2015) using a 7.0% trend for the medical and 8.5% trend for the drug assumption. A more detailed description of these two methods appears in Appendix 1, below.

These claim reserves do not include any payments billed by the claim vendor before June 30, 2015 but not paid by the plan until after June 30, 2015.

Estimated Unpaid Claim Reserve Liabilities

State Health Plan of North Carolina
Estimated Unpaid Claim Liability Calculation as of June 30,2015

	Medical	Blue Card	Drug	HRA	Total
Unpaid Claim Liability as of June 30,2015	$ 188,633,781	$ 18,647,586	$ 24,317,926	$ 5,275,143	$ 236,874,436
Margin for Adverse Deviation at 5%	$ 9,431,689	$ 932,379	$ 1,215,896		$ 11,579,965
Administrative Expenses Liability (7% Medical, 3% Drug)	$ 13,204,365	$ 1,305,331	$ 729,538		$ 15,239,233
Total (Rounded to Nearest $1,000)	$ 211,270,000	$ 20,885,000	$ 26,264,000	$ 5,275,000	$ 263,694,000
Members June, 2015					576,726
Reserve/Member	$366.33	$36.21	$45.54	$9.15	$457.23

Comparison of Booked vs. Restated Unpaid Claim Reserves as of June 30, 2014

Unpaid Claim Liability Comparison

	Medical	Blue Card	Drug	HRA	Total
Unpaid Claim Liability as of June 30, 2014 - Restated	$ 158,933,825	$ 15,009,913	$ 20,277,849		$ 194,221,588
Unpaid Claim Liability as of June 30, 2014 - Booked	$ 157,643,158	$ 9,850,929	$ 21,871,741		$ 189,365,828
Over/(Under) Booked	-0.8%	-34.4%	7.9%		-2.5%

Note that the restated Blue Card claims were larger than booked because a spike of claims in April-June, 2014.

Actuarial Assumptions

The following are assumptions used in the model:

- We switched over actuarial methods from development to projected, on the dates described in the summary above.
- For the projection method we used 7.0 % trend for medical and 8.5% trend for the drug
- Adverse deviation assumption is 5%
- Medical expense is assumed to be 7%; prescription drug is 3%
- We are not applying negative adjustments for recoveries; the maximum we apply is zero dollars.

We would be glad to discuss these results and our methodology with you and to answer any questions.

Appendix 1

The Development Method for Estimating Unpaid Claim Liabilities

The development method estimates unpaid claims by using claims based on actually paid for an incurred month to date. We estimate the claims that will be paid in each month after the reserve date for each incurred month prior to the reserve date.

First we estimate **Cumulative Reserve Factors** (CRF) based on prior incurred month. The *n*th duration n-CRF for an incurred month is the ratio of cumulative paid claims for that incurred month through n months divided by through month *n*-1. For example, the 5-CRF for January is the ratio of cumulative claims paid through May (the 5th month from January) to cumulative claims paid through April, all incurred in January. We calculate n-CRFs for the last 4 years of data for all durations for each incurred incurred month in which there is sufficient data. We then estimate the **average n-CRF** (n-ACRF) for each duration based on the average of these calculated n-CRFs. We sometimes adjust the average based on changes over time and to smooth out any outliers. We also adjust the n-ACRFs so as that none are below 1.000 to prevent any estimates of future payment being less than zero. This is so that we will not be using an offset to liabilities based on prior history of claim recoveries.

The n-ACRFs then are used to estimate future paid claims for each month. The n-ACRF is multiplied by the cumulative claims incurred in the month that is n-1 month before the reserve date. This yields an estimate of the cumulative paid claims through the month after the reserve date for that incurred month. Then this result is multiplied by n+1-ACRF to get the an estimate of the cumulative paid claims through the 2nd month after the reserve date for that incurred month. This process is carried on until there are no further changes.

An example will illustrate this. The reserve date is June 30, 2015. We take the cumulative paid claims (*i.e.,* paid in April, May or June) incurred in April, 2015 and multiply by 4-ACRF to get an estimate of claims incurred in April 2015 and paid through July, 2015. This result is then multiplied by 5-ACRF, 6-ACRF, 7-ACRF…. This finally gives the estimated total claims incurred in April, 2015.

The cumulative incurred claims for each incurred month are then summed. Then the claims paid to date are subtracted from this sum to yield the reserve.

The Projection Method for Estimating Unpaid Claim Liabilities

We use the estimate of incurred claims from the development method above for each prior month. Then we express the incurred claims as an amount per member. We adjust those claims for any changes in benefits as well as applying seasonal factors to the Medical. Then we select a period from which to project. The claims for this period are trended to the period for which we are estimating the reserve. They are then multiplied by the enrollment in those months to get the

estimated incurred claims. Claim reserve is then the difference of incurred claims less claims paid to date.

Appendix 2

Detail of Claims and Reserves by Incurred Month

State Health Plan of North Carolina
Medical Claims
Claim Completion by Month Exhibit

Month	Incurred Per Member	Number of Members	Estimated Incurred	Paid through June 30, 2015	Reserve	Completion Ratio
Jul-2012	$204.76	661,270	$135,401,000	$135,401,000	$0	100%
Aug-2012	$218.31	659,769	$144,035,825	$144,035,825	$0	100%
Sep-2012	$191.69	666,935	$127,845,678	$127,844,755	$923	100%
Oct-2012	$221.46	668,165	$147,973,431	$147,972,362	$1,069	100%
Nov-2012	$214.72	668,893	$143,625,913	$143,624,876	$1,037	100%
Dec-2012	$208.52	669,007	$139,501,579	$139,500,572	$1,008	100%
Jan-2013	$237.37	668,759	$158,742,037	$158,740,891	$1,147	100%
Feb-2013	$218.20	669,296	$146,043,595	$146,042,540	$1,055	100%
Mar-2013	$231.97	669,444	$155,291,569	$155,290,448	$1,122	100%
Apr-2013	$235.84	669,384	$157,865,626	$157,864,485	$1,140	100%
May-2013	$241.54	669,192	$161,637,805	$161,636,638	$1,167	100%
Jun-2013	$247.17	668,741	$165,291,015	$165,285,276	$5,739	100%
Jul-2013	$244.61	667,848	$163,364,706	$163,359,034	$5,672	100%
Aug-2013	$244.89	666,782	$163,287,145	$163,278,218	$8,927	100%
Sep-2013	$221.38	671,827	$148,727,747	$148,719,616	$8,131	100%
Oct-2013	$256.47	673,085	$172,622,981	$172,613,543	$9,437	100%
Nov-2013	$233.47	673,726	$157,296,024	$157,287,160	$8,864	100%
Dec-2013	$249.87	673,670	$168,329,384	$168,319,899	$9,485	100%
Jan-2014	$243.31	573,734	$139,594,976	$139,587,110	$7,866	100%
Feb-2014	$225.81	576,109	$130,092,710	$130,078,366	$14,344	100%
Mar-2014	$259.39	576,451	$149,523,935	$149,484,900	$39,035	100%
Apr-2014	$263.95	576,333	$152,124,876	$152,069,983	$54,893	100%
May-2014	$260.15	576,050	$149,858,823	$149,777,830	$80,992	100%
Jun-2014	$276.63	575,034	$159,072,424	$158,907,203	$165,222	100%
Jul-2014	$290.78	571,074	$166,058,927	$165,759,384	$299,543	100%
Aug-2014	$266.54	569,128	$151,696,482	$151,292,366	$404,115	100%
Sep-2014	$265.62	572,892	$152,172,670	$151,488,559	$684,112	100%
Oct-2014	$290.15	574,827	$166,783,394	$165,695,601	$1,087,793	99%
Nov-2014	$256.90	575,313	$147,799,196	$146,476,909	$1,322,287	99%
Dec-2014	$316.75	575,567	$182,313,183	$179,961,387	$2,351,797	99%
Jan-2015	$251.35	578,943	$145,516,548	$142,708,732	$2,807,816	98%
Feb-2015	$243.45	576,853	$140,436,888	$136,017,082	$4,419,807	97%
Mar-2015	$284.91	578,553	$164,836,782	$156,420,308	$8,416,473	95%
Apr-2015	$277.19	578,654	$160,394,850	$146,289,747	$14,105,103	91%
May-2015	$292.97	577,908	$169,311,316	$131,655,173	$37,656,143	78%
Jun-2015	$302.91	576,726	$174,696,854	$60,046,337	$114,650,517	34%
Projected Runoff					$188,633,781	
Expenses at 7.0%					$13,204,365	
Margin at 5%					$9,431,689	
Total					**$211,269,835**	

State Health Plan of North Carolina
Blue Card - Out of State Medical
Claim Completion by Month Exhibit

Month	Incurred Per Member	Number of Members	Estimated Incurred	Paid through Jun 30,2015	Reserve	Completion Ratio
Jul-2012	$10.39	661,270	$6,868,975	$6,868,975	$0	100%
Aug-2012	$10.03	659,769	$6,620,333	$6,616,556	$3,777	100%
Sep-2012	$9.10	666,935	$6,071,053	$6,060,837	$10,217	100%
Oct-2012	$11.78	668,165	$7,869,451	$7,856,208	$13,243	100%
Nov-2012	$8.11	668,893	$5,422,872	$5,412,453	$10,419	100%
Dec-2012	$8.18	669,007	$5,473,516	$5,462,371	$11,145	100%
Jan-2013	$8.84	668,759	$5,913,306	$5,901,266	$12,040	100%
Feb-2013	$8.82	669,296	$5,906,096	$5,893,734	$12,362	100%
Mar-2013	$9.22	669,444	$6,173,885	$6,160,963	$12,922	100%
Apr-2013	$9.28	669,384	$6,212,489	$6,196,399	$16,091	100%
May-2013	$10.27	669,192	$6,871,146	$6,853,350	$17,797	100%
Jun-2013	$10.77	668,741	$7,199,293	$7,180,647	$18,647	100%
Jul-2013	$11.79	667,848	$7,873,064	$7,852,672	$20,392	100%
Aug-2013	$10.35	666,782	$6,899,187	$6,880,554	$18,633	100%
Sep-2013	$9.53	671,827	$6,399,514	$6,380,735	$18,779	100%
Oct-2013	$10.01	673,085	$6,738,345	$6,718,572	$19,773	100%
Nov-2013	$9.31	673,726	$6,275,715	$6,257,299	$18,416	100%
Dec-2013	$10.23	673,670	$6,890,339	$6,870,119	$20,219	100%
Jan-2014	$10.67	573,734	$6,122,693	$6,090,372	$32,321	99%
Feb-2014	$9.88	576,109	$5,693,706	$5,662,919	$30,787	99%
Mar-2014	$10.06	576,451	$5,798,788	$5,761,656	$37,132	99%
Apr-2014	$12.73	576,333	$7,337,773	$7,287,537	$50,235	99%
May-2014	$13.16	576,050	$7,582,172	$7,521,626	$60,546	99%
Jun-2014	$17.09	575,034	$9,825,949	$9,710,705	$115,244	99%
Jul-2014	$19.53	571,074	$11,154,096	$10,992,677	$161,419	99%
Aug-2014	$18.60	569,128	$10,588,116	$10,412,420	$175,695	98%
Sep-2014	$14.03	572,892	$8,036,059	$7,876,355	$159,704	98%
Oct-2014	$15.07	574,827	$8,662,113	$8,415,379	$246,735	97%
Nov-2014	$11.43	575,313	$6,578,539	$6,339,692	$238,847	96%
Dec-2014	$14.35	575,567	$8,258,580	$7,886,204	$372,375	95%
Jan-2015	$11.93	578,943	$6,905,050	$6,441,291	$463,759	93%
Feb-2015	$11.05	576,853	$6,375,515	$5,822,509	$553,005	91%
Mar-2015	$12.26	578,553	$7,091,779	$6,216,927	$874,852	88%
Apr-2015	$16.48	578,654	$9,539,072	$5,971,209	$3,567,863	63%
May-2015	$15.66	577,908	$9,051,946	$5,529,000	$3,522,946	61%
Jun-2015	$16.21	576,726	$9,350,716	$1,621,468	$7,729,248	17%
Projected Runoff					$18,647,586	
Expenses at 7.0%					$1,305,331	
Margin at 5%					$932,379	
Total					**$20,885,296**	

State Health Plan of North Carolina
Prescription Drug Claims
Claim Completion by Month Exhibit

Month	Incurred Per Member	Number of Members	Estimated Incurred	Paid through June 30, 2014	Reserve	Completion Ratio
Jul-2012	$89.36	661,270	$59,092,924	$59,092,924	($0)	100%
Aug-2012	$93.69	659,769	$61,813,163	$61,813,163	$0	100%
Sep-2012	$84.82	666,935	$56,571,510	$56,571,510	($0)	100%
Oct-2012	$93.74	668,165	$62,633,464	$62,633,464	$0	100%
Nov-2012	$89.43	668,893	$59,822,438	$59,822,438	$0	100%
Dec-2012	$90.44	669,007	$60,503,091	$60,503,091	$0	100%
Jan-2013	$99.44	668,759	$66,503,297	$66,503,297	$0	100%
Feb-2013	$92.06	669,296	$61,616,753	$61,616,742	$12	100%
Mar-2013	$99.05	669,444	$66,306,887	$66,306,875	$12	100%
Apr-2013	$102.06	669,384	$68,315,503	$68,315,463	$40	100%
May-2013	$106.19	669,192	$71,058,468	$71,058,426	$42	100%
Jun-2013	$100.65	668,741	$67,309,531	$67,309,491	$39	100%
Jul-2013	$108.07	667,848	$72,175,366	$72,175,324	$42	100%
Aug-2013	$109.40	666,782	$72,944,239	$72,944,196	$43	100%
Sep-2013	$104.17	671,827	$69,981,964	$69,981,923	$41	100%
Oct-2013	$113.09	673,085	$76,118,455	$76,118,410	$45	100%
Nov-2013	$102.01	673,726	$68,725,596	$68,725,555	$40	100%
Dec-2013	$105.88	673,670	$71,330,770	$71,330,728	$42	100%
Jan-2014	$84.31	573,734	$48,370,376	$48,370,348	$28	100%
Feb-2014	$79.37	576,109	$45,723,957	$45,723,930	$27	100%
Mar-2014	$86.44	576,451	$49,831,285	$49,831,255	$29	100%
Apr-2014	$89.26	576,333	$51,443,587	$51,443,557	$30	100%
May-2014	$94.18	576,050	$54,252,841	$54,252,809	$32	100%
Jun-2014	$99.20	575,034	$57,046,185	$57,046,152	$33	100%
Jul-2014	$105.50	571,074	$60,250,146	$60,250,111	$35	100%
Aug-2014	$100.37	569,128	$57,124,884	$57,124,850	$34	100%
Sep-2014	$102.96	572,892	$58,985,673	$58,985,639	$35	100%
Oct-2014	$104.91	574,827	$60,305,241	$60,304,709	$532	100%
Nov-2014	$97.35	575,313	$56,007,053	$56,006,559	$494	100%
Dec-2014	$115.60	575,567	$66,537,713	$66,532,306	$5,407	100%
Jan-2015	$110.48	578,943	$63,959,716	$63,943,929	$15,787	100%
Feb-2015	$103.29	576,853	$59,585,290	$59,545,190	$40,101	100%
Mar-2015	$109.25	578,553	$63,207,967	$63,118,584	$89,384	100%
Apr-2015	$107.94	578,654	$62,459,712	$62,297,200	$162,512	100%
May-2015	$105.26	577,908	$60,832,983	$60,353,163	$479,820	99%
Jun-2015	$109.18	576,726	$62,969,741	$39,446,531	$23,523,209	63%
Projected Runoff					$24,317,926	
Expenses at 3.0%					$729,538	
Margin at 5%					$1,215,896	
Total					**$26,263,360**	

cc: .Segal SHPNC Team

National Health & Welfare Fund

ROI AND PERFORMANCE MEASUREMENT OF WELLNESS AND DISEASE MANAGEMENT

December 8, 2010

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Doc #: 7360237









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Key Findings

- The disease burden of participants in the InforMed disease management program is three times higher than non-participants.
- Utilization results (*e.g.,* hospitalization, emergency visits and physician encounters) of chronic conditions are higher for participants who opt-in the InforMed than those who do not participate.
- Overall participation in the InforMed program is low.
- Outreach efforts by InforMed are having an impact on improving preventive efforts (such as screening and preventive tests). However, the gaps in care for the InforMed participants did not improve significantly over the period of the study.
- The InforMed program is experiencing a negative ROI (Return on Investment) since program inception.

Objectives

- In order to help the Trustees determine how effective their investment in wellness, disease management and other medical management program is working, The Segal Company has developed a Performance Dashboard that measures key factors that evaluate a programs impact to plan costs and member health since the InforMed medical management program implementation
- To evaluate the overall effectiveness of this program, we have analyzed the following categories: clinical, utilization, financial and operational:
  - **Financial Results:** evaluate ROI, changes in per capita claim trends, cost savings on programs, savings on targeted patients
  - **Utilization Results:** report on changes in hospitalizations, emergency room visit and physician encounters of chronic diseases
  - **Clinical Results:** determine changes in treatment patterns for key diseases and participation in preventive health measures
  - **Operational Results:** review overall participation rates and members access
- Using claims and eligibility, Segal compares results post program implementation. The report findings presented herein will provide Trustees with information regarding the direction of important cost and clinical outcomes such as program participation rates and the quality and intensity of member engagement

Data and Assumptions

- ISSI provided medical claims and eligibility data. Prescription drug data was provided by CVS/Caremark
- The analysis periods in this report cover the period:
  - July 1, 2007 – June 30, 2008
  - July 1, 2008 – June 30, 2009
  - July 1, 2009 – June 30, 2010
- We conducted an analysis of disease conditions for both participants and non-participants in the medical management program. This approach allows an evaluation of InforMed's program to assess their impact on the entire population, which is a function of program effectiveness and program penetration into the population
- Cohort comparison groups of participants in the InforMed program vs. non-participants were normalized by risk index to reflect comparable disease severities. The analysis focuses on high risk participants
- Claims data for patients with conditions that would make it difficult to gain benefit from chronic care management were excluded from the analysis. These conditions include: Significant Burns, Premature Infants, Major Organ Transplant, HIV/Aids, High Risk Pregnancy, Hemophilia, Congenital Anomalies, Chronic Renal Failure (ESRD) and Cancer
- Where benchmarks are shown, we used Verisk Health's normative database statistics, which consists of 5.84 million members nationally. Normative database statistics on age, industry and geographic distributions are provided in *Appendix 1*

Data and Assumptions *continued*

Terminology

Care Gap Index (CGI)

- The weighted calculation of an individual's compliance with quality measures. A care gaps > 10 indicates a high level of non-compliance

Risk Index (RI)

- Measurement of an individual's disease burden. The higher the RI, the more likely the member is to experience a negative health event in the next 24 months
  - **Low RI: 0 – 7:** Needs screening test only
  - **Medium RI: 8 – 17:** May or has a chronic disease and needs screening or recommended diagnostic testing/therapy
  - **High RI: 18+:** Has chronic disease with complications, may also have some acute issues, and need more recommended diagnostic testing and/or therapy

A Word About Privacy

- The data presented does not contain unique individual identifiers such as name, SSN, etc.
- Specific medical conditions are identified
- If the plan administrator knows the identity of individuals with a specific condition, that information is considered Protected Health Information or "PHI." PHI is subject to the HIPAA Privacy Rule's protections, which means it must be kept confidential and cannot be used for any reason other than health plan administration (e.g., using it for employment purposes, or by other benefit plans, is prohibited)

Demographic
Par vs. Non-Par Cohorts – High Risk Adjusted

- The risk index of disease management participants in the InforMed program is significantly higher than non-participants (three times higher), indicating a higher disease burden.
- Cohort comparison groups of participants in the InforMed program vs. non-participants were normalized by risk index to adjust for comparable disease severities. This analysis focuses on high risk participants with the relative same risk index of 32 (high RI). Below are key statistics of the high risk, severity adjusted cohorts for InforMed participants (Par) vs. non-participants (Non-Par):

Metric	Par	Non-Par
Count	397	144
Average Risk Index (RI)	31.52	31.65
Care Gap Index (CGI)	6.86	5.16
Average Age	54.0	56.2
% Male	48.4%	45.8%
% Female	51.6%	54.2%

- The care gap index for both populations sets is below 10, which indicates that overall, there is compliance with most quality measures (e.g., HEDIS). However, the gaps in care for the InforMed did not improve significantly over the period of the study.
- The tables on the next few pages contain an analysis of the severity adjusted cohorts by top disease conditions for high risk users.

Utilization Results
Admits Per 1,000 Covered Lives

	Admits Per 1,000 Covered Lives			
	All	Diabetes	Asthma	CAD
Participants – High Risk (Severity Adjusted)				
July 1, 2007 - June 30, 2008	307.55	237.26	192.30	463.64
July 1, 2008 - June 30, 2009	421.26	432.00	310.35	266.80
July 1, 2009 - June 30, 2010	556.20	459.75	619.16	353.76
Change – Period 1	37%	82%	61%	-42%
Change – Period 2	32%	6%	100%	33%
Non-participants – High Risk (Severity Adjusted)				
July 1, 2007 - June 30, 2008	157.03	121.27	-	223.38
July 1, 2008 - June 30, 2009	175.96	137.39	523.72	193.59
July 1, 2009 - June 30, 2010	104.51	105.26	130.43	178.05
Change – Period 1	12%	13%	N/A	-13%
Change – Period 2	-41%	-23%	-75%	-8%

- With the exception of asthma admissions in the period July 1, 2008 – June 30, 2009, admissions for InforMed participants is significantly higher than non-participants. This is an indication that medical management is not having as much desired effect

Utilization Results
Admits Per 1,000 Covered Lives

Condition	Description	% of Members with Risk		
		Par	Non-Par	Norm
Hypertension	Patients with more than one hospitalization in the analysis period	34.76%	6.58%	4.72%

- InforMed patients with hypertension (which is the top condition by cost for both periods) have significantly higher rates of patients having more than one hospitalization than non-participants and norms
- Other conditions driving hospital admissions for InforMed participant is reviewed under the gaps in care measurements observed under clinical results

Utilization Results

ER Visits Per 1,000 Covered Lives

	ER Per 1,000 Covered Lives			
	All	**Diabetes**	**Asthma**	**CAD**
Participants – High Risk (Severity Adjusted)				
July 1, 2007 - June 30, 2008	771.31	748.35	715.54	704.11
July 1, 2008 - June 30, 2009	832.49	749.27	874.46	488.14
July 1, 2009 - June 30, 2010	978.32	741.42	1,335.60	752.96
Change – Period 1	8%	0%	22%	-31%
Change – Period 2	18%	-1%	53%	54%
Non-participants – High Risk (Severity Adjusted)				
July 1, 2007 - June 30, 2008	449.18	305.04	297.62	366.31
July 1, 2008 - June 30, 2009	423.24	331.35	492.66	399.91
July 1, 2009 - June 30, 2010	348.63	263.16	486.17	339.05
Change – Period 1	-6%	9%	66%	9%
Change – Period 2	-18%	-21%	-1%	-15%

- ER visits per 1,000 for InforMed participants are increasing (from 8% during first year to 18% in second analysis period). ER visits per 1,000 are significantly higher for InforMed participants

Utilization Results

ER Visits Per 1,000 Covered Lives

Condition	Description	% of Members with Risk		
		Par	Non-Par	Norm
>1 ER visit	Patients without office visit in the last 12 months.	0.52%	2.27%	8.69%
>10 years old with ER visits	Patients with two or more ER visits in the last 12 months.	25.52%	11.39%	26.97%

- Patients in the InforMed program who visit the ER have generally had an office visit in the past 12 months
- While patients in the InforMed program with two or more ER visits is significantly higher than non-participants (more than 2 times), the percentage of these patients are lower than norms

Utilization Results
Office Visits Per 1,000 Covered Lives

	Office Visits Per 1,000 Covered Lives			
	All	**Diabetes**	**Asthma**	**CAD**
Participants – High Risk (Severity Adjusted)				
July 1, 2007 - June 30, 2008	9,709.92	9,802.27	9,628.40	8,029.22
July 1, 2008 - June 30, 2009	10,675.85	10,219.43	11,856.79	6,577.07
July 1, 2009 - June 30, 2010	10,781.61	10,349.97	11,461.54	8,164.03
Change – Period 1	10%	4%	23%	-18%
Change – Period 2	1%	1%	-3%	24%
Non-participants – High Risk (Severity Adjusted)				
July 1, 2007 - June 30, 2008	8,734.20	8,947.75	10,339.68	7,368.75
July 1, 2008 - June 30, 2009	9,207.48	9,812.23	11,369.38	8,178.67
July 1, 2009 - June 30, 2010	8,796.17	6,972.97	10,857.71	7,519.18
Change – Period 1	5%	10%	10%	11%
Change – Period 2	-4%	-29%	-5%	-8%

- Office Visits for InforMed participants increased significantly in the first year of the program (10%). One of the reasons for this increase could be due to increase in preventive office visits after the plan became effective (see clinical preventive measures for discussion on compliance measures)

Financial Results
Trend Results

	Trend Over 2 Years		
	Medical	**Rx**	**Total**
Participants	24%	11%	21%
Non-Participants	6%	17%	8%
Total	**18%**	**13%**	**17%**

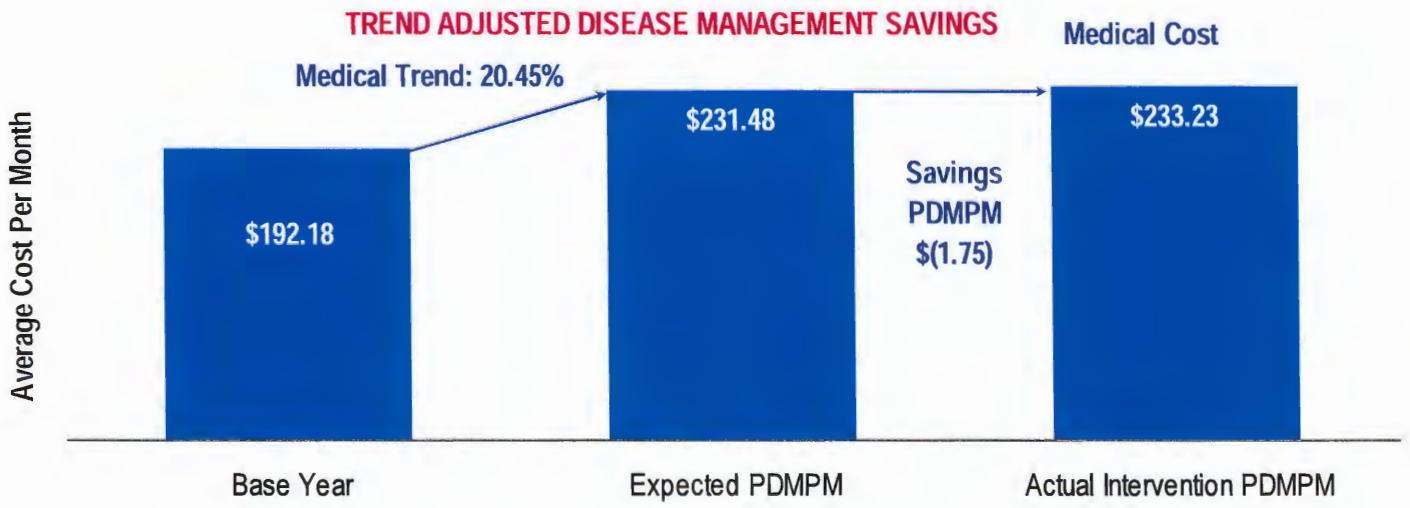
- Overall increase in per capita cost trend rates over the study period (17%) is in-line with trends used to set rates for budget projections (9.75% per year or 20% over 2 years).
- Overall changes in per capita claim trend rates for participants in the InforMed program is higher than non-participants.

Financial Results
ROI Methodology

- Measure the cumulative program impact over several years, starting from program implementation in year 1, using industry trend to project expected as an adjusted control. ROI is difference between expected and actual cost per diagnosed member per month (PDMPM)
- Adjusted for plan design changes
- No adjustment for regression to the mean (i.e., individuals with extreme values one year will tend to move toward the population average the following year) – This overstates the impact of InforMed ROI

Medical Trend: 9.75%

Rx Trend: 9.75%



Financial Results
ROI Calculation

ROI – InforMed

	Baseline Chronic PDMPM		$192.18
x	Benchmark Trend (9.75%x24 months)	x	20.45%
=	**Expected PDMPM**	=	**$231.48**
-	Actual Intervention PDMPM	-	$233.23
=	**Estimated Savings PDMPM**	=	**$(1.75)**
	Program Cost PMPM – 2 years		$6.63
	ROI		**-0.26: 1**

ROI – Non-Participants

	Baseline Chronic PMPM*		$85.57
x	Benchmark Trend (9.75%x24 months)	x	20.45%
=	**Expected PMPM***	=	**$103.07**
-	Actual PMPM*	-	$92.28
=	**Estimated Savings PMPM***	=	**$10.78**
	Program Cost PMPM* – 2 years		$6.63
	ROI		**1.63: 1**

*(Non-participant only)

Financial Results
ROI Calculation

ROI – Total

	Baseline Chronic PDMPM		$277.75
x	Benchmark Trend (9.75%x24 months)	x	20.45%
=	**Expected PDMPM**	=	**$334.55**
-	Actual Intervention PDMPM	-	$325.51
=	**Estimated Savings PDMPM**	=	**$9.04**
	Program Cost PMPM – 2 years		$6.63
	ROI		**1.36: 1**

Clinical

Preventive Measures – Compliance Gaps (Lower the Better)

Group	Condition	Description	% of Members with Gap		
			Par	Non-Par	Norm
Both	>=50 years old	Patients without any colorectal cancer screening in the analysis period.	56.10%	43.64%	73.82%
Male	Men >50 years old	Men without PSA level in the last 2 years (controversial test).	48.23%	45.10%	57.78%
Female	Women between 40 and 49 years old	Women without mammogram in the analysis period.	28.21%	16.67%	53.50%
	Women between 49 and 69 years old	Women without mammogram in the last 18 months.	51.37%	37.29%	48.49%
	Women between 21 and 65 years old	Women without pap smear in the analysis period.	46.39%	37.70%	47.62%
	Women >20 years old	Women without pap smear in the last two years.	57.59%	45.45%	49.65%
	Women between 40 and 49 years old	Women without a mammogram performed at least every two years.	33.33%	16.67%	53.50%
	Women >=49 years old	Women without mammogram in last 12 months.	60.39%	42.86%	54.67%

- Non-participants have lower compliance gaps than InforMed plan participants for screening and preventive tests such as colorectal screening, PSA testing, mammograms and pap smears

Clinical
Diabetics Cohort Comparison: Compliance Gaps/Risk

Condition	Description	% of Members with Gap/Risk		
		Par	Non-Par	Norm
Diabetes - Gap in Care	Patients without flu vaccination in the analysis period.	61.14%	52.63%	70.54%
Diabetes - Gap in Care	Patients without micro or macroalbumin screening test in the last 12 months.	27.43%	26.32%	2.89%
Diabetes - Gap in Care	Patients without office visit in the last 12 months.	2.29%	2.63%	2.89%
Diabetes - Gap in Care	Patients without LDL-C test in the last 12 months.	43.48%	40.63%	28.77%
Diabetes - Gap in Care	Patients without HbA1c test in the last 12 months.	36.65%	37.50%	19.76%
Diabetes - Gap in Care	Patients without retinal eye exam in the last 12 months.	70.81%	71.88%	63.26%
Diabetes - Risk Measure	Patients with diabetes-related ER visit in the analysis period.	7.43%	0.00%	3.94%
Diabetes - Risk Measure	Patients with diabetes-related hospitalization in the analysis period.	4.00%	0.00%	2.35%
Diabetes - Risk Measure	Patients with more than one hospitalization in the analysis period.	30.86%	5.26%	6.20%

- Gaps in care and risk measures of the two population sets were compared to determine if the program was having a significant impact to the quality of care
- With the exception of flu vaccination and office visit in the last 12 months, compliance gaps in care for InforMed participants were higher than norms for diabetics
- InforMed participating diabetics had significantly higher rates of hospitalization and twice the rate of diabetes-related hospitalizations in the analysis period

Clinical

Diabetics Cohort Comparison: Compliance Gaps/Risk

- Of diabetics who participate in the InforMed program, 63.4% had received a hemoglobin A1c test in the past year, compared to 62.5% for non-participants and the national average of 80%. The test is essential for managing blood sugar levels. Studies have shown that every percentage point drop in A1c cuts a patient's risk of eye, kidney or nerve-related complications by 40%
- Compliance with kidney disease monitoring was 73% for participating members vs. 74% for non-participating members. These statistics compared to a 79% norm. According to a study by the American Diabetes Association, kidney disease occurs in 20% to 30% of diabetics, and early detection can delay or, in some cases, prevent it
- Where possible, employees and their primary-care physicians should be encouraged to increase compliance and reduce or eliminate those gaps. Implementing clinical performance guarantees with InforMed will also help
- The overall Care Gap Index of InforMed high risk diabetics was 8.43 vs. 7.61 for non-participants. This suggests non-participants have a higher compliance with quality/standards of care

Clinical

CAD Cohort Comparison: Compliance Gaps/Risk

Condition	Description	% of Members with Gap/Risk		
		Par	Non-Par	Norm
CAD - Gaps in Care	Patients without lipid profile test in the last 12 months.	47.83%	51.47%	38.85%
CAD - Gaps in Care	Patients without long office visit in the last 12 months.	8.70%	10.29%	9.42%
CAD - Gaps in Care	Patients without office visit in the last 12 months.	0.00%	1.47%	2.18%
CAD - Gaps in Care	Patients without antihyperlipidemic drugs in the analysis period.	17.39%	14.71%	29.20%
CAD - Gaps in Care	Patients without flu vaccination in the last 12 months.	78.26%	73.53%	76.95%
CAD - Risk Measures	Patients with complicated lipid disorders.	21.74%	25.00%	19.45%
CAD - Risk Measures	Patients with more than one hospitalization in the analysis period.	17.39%	11.76%	14.78%
CAD - Risk Measures	Patients with MI-related hospitalization in the analysis period.	8.70%	1.47%	6.16%
CAD - Risk Measures	Patients with CAD-related ER visit in the analysis period.	17.39%	8.82%	10.32%
CAD - Risk Measures	Patients with CAD-related hospitalization in the analysis period.	43.48%	26.47%	17.68%

- Gaps in care of the two population sets are lower than norms for office visits. All InforMed high risk CAD participants have had an office visit in the last 12 months
- Risk measures for participants are higher than norms and non-participant patients. These statistics support the higher than average hospital admission rate trends for InforMed members
- The overall Care Gap Index of InforMed high risk CAD was 6.31 vs. 5.94 for non-participants. While the CGI for InforMed is slightly higher, the overall compliance with quality is comparable

Clinical
Asthma Cohort Comparison: Compliance Gaps/Risk

Condition	Description	% of Members with Gap/Risk		
		Par	Non-Par	Norm
Asthma - Gaps	Patients without flu vaccination in the analysis period.	48.08%	47.83%	65.60%
Asthma - Gaps	Patients without inhaled corticosteroids or leukotriene inhibitors in the analysis period.	19.23%	21.74%	31.57%
Asthma - Gaps	Patients without long office visit in the last 12 months.	7.69%	4.35%	13.79%
Asthma - Gaps	Patients without office visit in the analysis period.	0.00%	0.00%	0.94%
Asthma - Gaps	Patients without flu vaccination in the last 12 months.	76.92%	73.91%	74.00%
Asthma - Risk Measures	Patients with more than one hospitalization in the analysis period.	25.00%	13.04%	5.20%
Asthma - Risk Measures	Patients with asthma-related ER visit in the analysis period.	23.08%	17.39%	14.73%
Asthma - Risk Measures	Patients with asthma-related hospitalization in the analysis period.	3.85%	8.70%	3.95%

- Gaps in care of the two population sets are lower than norms, with the exception of flu shots for InforMed participants
- Risk measures for asthmatic participants with more than one hospitalization and asthma-related ER visits are significantly higher than norms and the non-participant patients. These statistics support the higher than average hospital admission rate trends for InforMed members
- The overall Care Gap Index of InforMed high risk asthmatics was 7.02 vs. 6.70 for non-participants. This suggests non-participants have a higher compliance with quality of care

Clinical Results
Rx Conflicts

- There are 53 members with a drug conflict over the study period evaluated, as noted in *Appendix 2*. Rx conflicts identifies members taking a combination of medication that may have adverse interactions or who have an identified condition and are taking a drug that may cause adverse reactions
- Some of the Rx Conflict "warnings" are built into the POS DUR (drug utilization review) messaging that PBMs send to the retail pharmacies. However, most of these messages are "soft" warnings and won't stop the claim from processing if the pharmacist opts to bypass the message. Some (e.g., a statin with a prenatal) are severe drug-drug interaction warnings which will stop the claim unless the PBM is contacted by the pharmacist to obtain and override code
- These are the types of edits which CVS/Caremark have built into their buy-up medical data integration programs. These warnings could result in cost savings on the medical side

Clinical Results
Rx Appropriate Utilization

- One of the top cost drivers is osteoarthritis
- The data found that patients with more than six Oxycontin prescriptions in the analysis period was 2.9% compared to their benchmarks of 0.3%
- Osteoarthritis patients with continuous use of opiates across the analysis period was 17.2% vs. 19.6% norms across the last 12 months
- Patients with prescriptions for more than 15 drug classes in the analysis period was 7.7% compared to norms of 3.6%

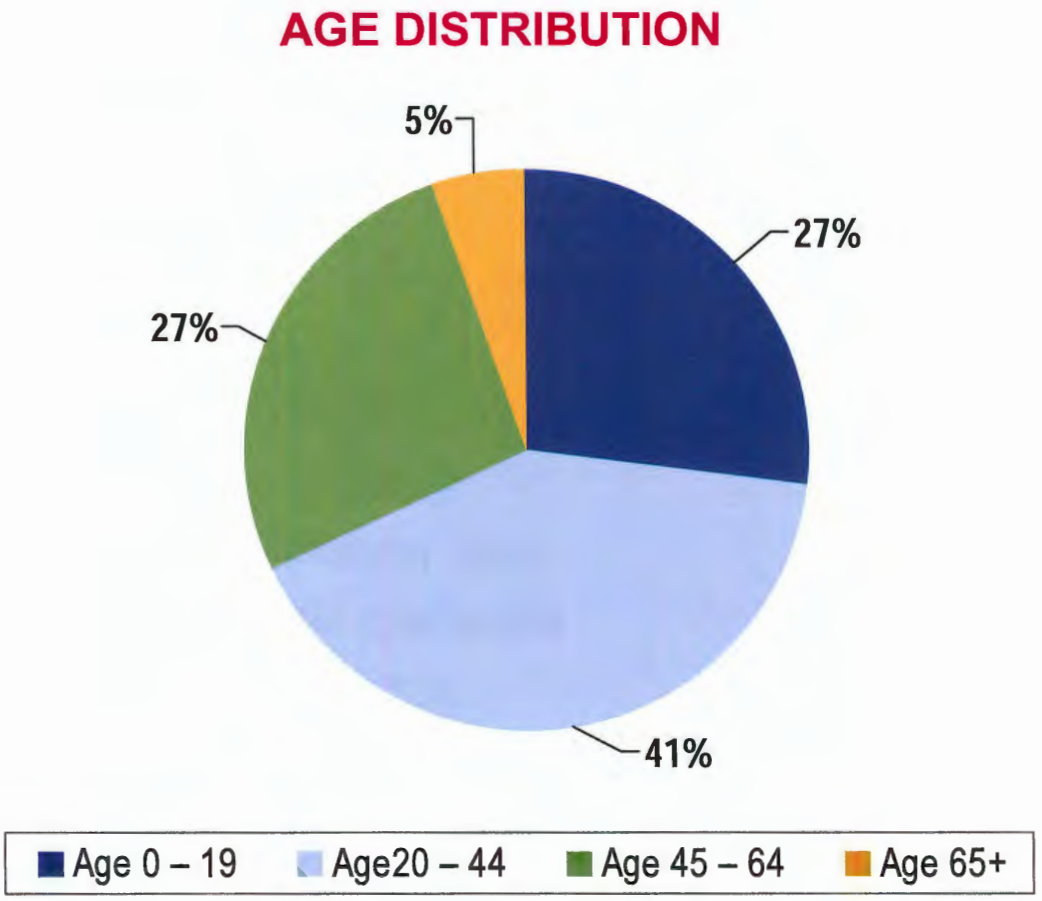
Recommendations/Next Steps

- ROI for programs can range significantly. We have found that the most effective programs achieve results as efforts are modified after they are implemented as emerging data is reviewed. The impact to the program would be greatest with a multifaceted strategy. It must:
  - Demonstrate strong leadership support
  - Define the strategy and objectives for medical management and create programs, incentives, and plan design to achieve the goals
  - Build a communications campaign around the issues identified in your medical management strategy
  - Integrate effective incentives and plan design changes to encourage wellness and prevention
  - Implement vendor performance guarantees
- Implementing performance guarantees and penalties to ensure appropriate levels are being met in the quality of treatment. Put program fees at risk for meeting performance objectives. Suggested categories of reporting performance standards include Financial, Clinical, Utilization and Operational Results
- Restructure fees arrangement (which are currently based on time units). Consider basing fees on the number of members who participate in the program which provides an added incentive for the care management firm
- Introduce an incentive model of rewards and penalties. This can be done using plan design tiers based on plan participants level of adoption of health improvement actions. See *Appendix 3* for a Sample Healthy Rewards Approach

Recommendations/Next Steps (*continued)*

- Develop protocols for medical management firm to communicate Rx conflicts that may have adverse interactions and/or evaluate buy-up medical data integration programs with Caremark
- Review CVS/Caremark options for implementation of quantity limits, prior authorizations, or "pharmacy locks" for specific members to combat future overutilization of potential fraud and abuse

Appendix 1: Normative Database Statistics



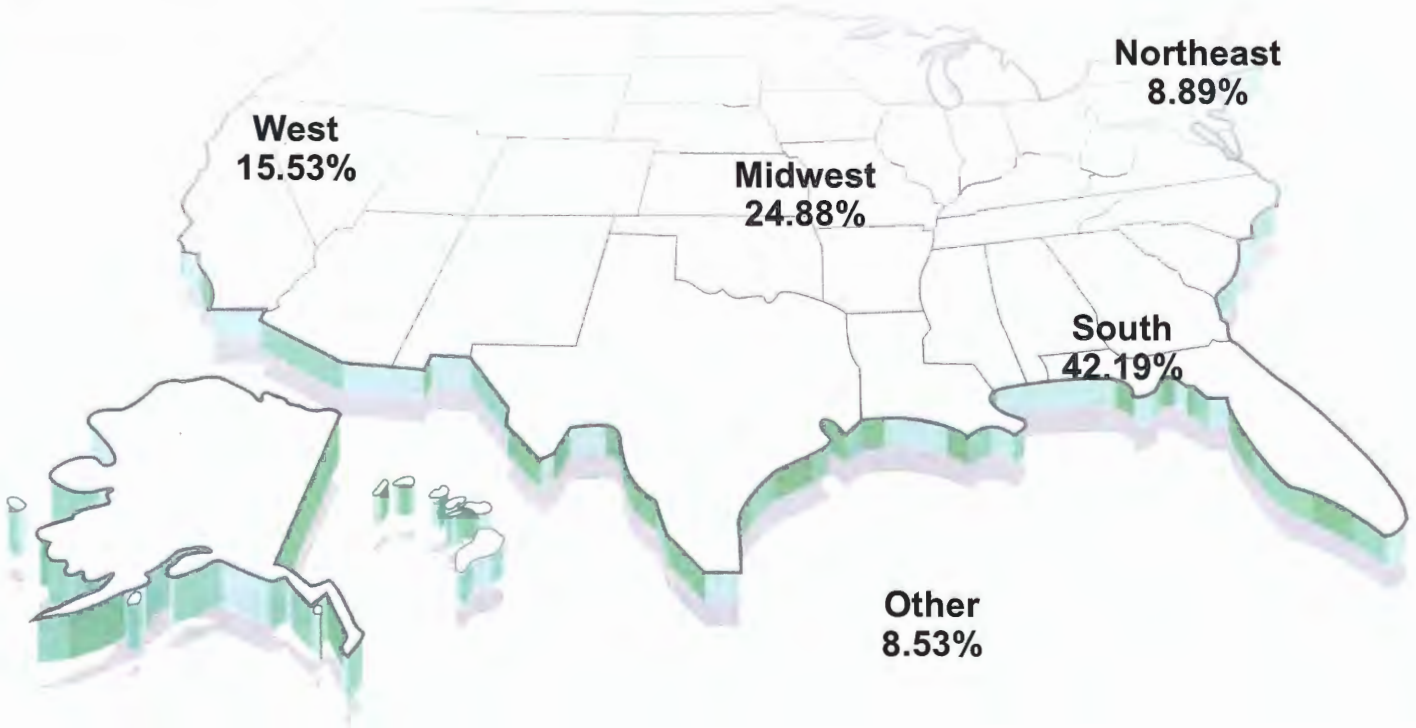
Source: Verisk Health

[1] Average Age:	34.2 years
[2] Average Family Size:	2.2
[3] % Male:	48.60%
[4] % Female:	51.40%

Appendix 1: Normative Database Statistics

GEOGRAPHIC DISTRIBUTION

- **Plan Type:** Commercial Only
- **Number of Employer Groups Used:** 8,271
- **Number of Members in Application:** 5.84 million
- **Analysis Period:** April 1, 2007 – March 31, 2009



Appendix 1: Normative Database Statistics

NAICS Code*	NAICS Description	% of Total Members
44 – 45	Retail Trade	11.22%
54	Professional, scientific and technical services	11.18%
62	Healthcare and social assistance	9.64%
81	Other services—except public administration	8.71%
31 – 33	Manufacturing	7.80%
23	Construction	5.04%
61	Educational services	4.85%
92	Public Administration	4.39%
42	Wholesale trade	3.37%
52	Finance and insurance	3.34%
99	Unclassified establishments	18.80%
—	All others	11.66%

* The North American Industry Classification System (NAICS) is used by the United States, Mexico, and Canada. NAICS uses 20 standardized categories to classify an employer's industry. The NAICS replaced the Standard Industrial Classification (SIC) in 1997.

Appendix 2: Clinical Results
Rx Conflicts

Of Clinical Interest	Member w/Conflicts
Patient has Heart Block and appears to be taking PACERONE	3
Patient has Heart Block and appears to be taking LANOXIN	1
Patient has Ventricular Tachycardia and appears to be taking LANOXIN	1
Patient has Epilepsy and appears to be taking ZYBAN.	1
Patient has Seizure Disorder and appears to be taking ZYBAN.	1
Patient has/had Breast Cancer and appears to be taking ESTRATEST H.S.	4
Patient has/had Breast Cancer and appears to be taking YASMIN.	4
Patient has/had Breast Cancer and appears to be taking APRI	4
Patient has/had Breast Cancer and appears to be taking ESTRADIOL.	4
Patient has/had Breast Cancer and appears to be taking PREMARIN VAGINAL	4
Patient has/had Breast Cancer and appears to be taking ORTHO-CYCLEN.	4
Patient has had MI within last 60 days and appears to be taking CARDIZEM CD	1
Patient has/had Breast Cancer and appears to be taking TRIVORA-28.	4
Patient has/had Breast Cancer and appears to be taking NECON 1/35	4
Patient has/had Breast Cancer and appears to be taking ORTHO EVRA	4
Patient has/had Breast Cancer and appears to be taking ORTHO-NOVUM 7/7/7	4
Patient has Seizure disorder and appears to be taking BUPROPION HCL.	1
Patient has Coronary Artery Disease and appears to be taking AMPHETAMINE SALT COMBO	8
Patient has Hypertension and appears to be taking AMPHETAMINE SALT COMBO	21
Patient has Heart Block and appears to be taking METOPROLOL TARTRATE	10
Patient has/had Deep Vein Thrombosis and appears to be taking ESTRATEST	1
Patient has/had Breast Cancer and appears to be taking ESTRATEST	4
Patient has/had Pulmonary Embolism and appears to be taking ESTRATEST	1
Patient has/ had Myocardial Infarction and appears to be taking IMITREX STATDOSE REFILL	2

There are 53 members with a drug conflict over the study period evaluated. Rx conflicts identifies members taking a combination of medication that may have adverse interactions or who have an identified condition and are taking a drug that may cause adverse reactions.

Appendix 2: Clinical Results
Rx Conflicts continued

Of Clinical Interest	Member w/Conflicts
Patient has Coronary Artery Disease and appears to be taking IMITREX STATDOSE REFILL	8
Patient has Hyperkalemia and appears to be taking POTASSIUM CHLORIDE.	2
Patient has Renal Failure and appears to be taking POTASSIUM CHLORIDE.	17
Patient has Aneurysm and appears to be taking COUMADIN	11
Patient has Leukemia and appears to be taking COUMADIN	2
Patient was Pregnant and appears to have taken COUMADIN.	2
Patient has Heart Block and appears to be taking AMIODARONE HCL	3
Patient has Heart Block and appears to be taking ATENOLOL	4
Patient has Adrenal Insufficiency and appears to be taking LEVOXYL	1
Patient has Renal Failure and appears to be taking GLUCOPHAGE XR.	30
Patient has Renal Failure and appears to be taking GLUCOVANCE.	30
Patient was Pregnant and appears to have taken WARFARIN SODIUM.	2
Patient has Sick Sinus Syndrome and appears to be taking CARTIA XT	1
Patient has Heart Block and appears to be taking CARTIA XT	1
Patient has/had Breast Cancer and appears to be taking ORTHO TRI-CYCLEN.	4
Patient has/had Breast Cancer and appears to be taking PREMPRO.	4
Patient has/ had Stroke or MI and appears to be taking PREMPRO.	19
Patient has/had Deep Vein Thrombosis and appears to be taking PREMPRO	1
Patient has/ had Myocardial Infarction and appears to be taking IMITREX.	2
Patient has Cerebrovascular disease and appears to be taking IMITREX STATDOSE REFILL	12
Patient has CHF and appears to be taking GLUCOPHAGE	28
Patient has Renal Failure and appears to be taking GLUCOPHAGE.	30
Patient has/had Breast Cancer and appears to be taking PREMARIN.	4
Patient has/ had Stroke or MI and appears to be taking PREMARIN.	19
Patient has/had Deep Vein Thrombosis and appears to be taking PREMARIN	1
Patient has Hypocalcemia and appears to be taking FOSAMAX	1
Patient has Seizure disorder and appears to be taking WELLBUTRIN SR.	1
Patient was Pregnant and appears to have taken LIPITOR.	3

Appendix 3: Sample Healthy Rewards Approach

- Increasing Participation with Incentives
- Employees who satisfy the following conditions will receive a premium holiday for x months or a coupon towards reduced plan copayments:
  - Complete an HRA each year AND
  - Individuals identified by disease management or case management as having a chronic condition are required to participate in program by:
    - Engaging with health coach initially a minimum of one phone call per month and ongoing, as determined by health coach
    - Participation with chronic conditions provide evidence of treatment compliance (e.g., annual exam, compliance with medication, etc.)
    - Participants discharge from hospital obtain follow-up outpatient check-up within 30 days of discharge, where applicable
  - Non-chronically ill individuals—required to completed at least two wellness programs per year, including:
    - Lose 5% or more weight for anyone with target BMI level (over 30) and maintain for six months
    - Quit smoking
    - Participate in weight management program
    - Proof of use of qualified fitness program (yoga, gym membership, etc.)
    - Proof of compliance with any of Healthy People 2010 cancer screenings (mammogram, colonoscopy, etc.)
    - Participation (and proof) of at least two walkathons or 5k race or higher
    - Participate in nutrition or dietician counseling
    - Vendor on-line modules

Segal Consulting

STATE OF CONNECTICUT

Budget Projections
Fiscal Years Ending June 30, 2016, 2017, and 2018

February 8, 2016

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STATE OF CONNECTICUT

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The projections in this report are estimates of future costs and are based on information available Segal Consulting at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of ***future results****. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases. The projections do not reflect the potential impact of any future changes due to health care reform legislation, other than those noted or previously adopted.*

Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does ***not*** *reflect the present value of any future retiree benefits for active, disabled or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.*

Segal Consulting has been retained to calculate budget projections on behalf of the State of Connecticut. The calculations in this report were completed in accordance with generally accepted actuarial principles and practices, consistently applied, based on the data described later in this report.

The projections in this report are estimates of future costs and are based on information available to Segal Consulting at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from the new health care reform legislation or other recently passed state or federal regulations.

Projections of retiree costs take into account only the dollar value of providing benefits for retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled or terminated employees during a period other than that which is referred to in the projection.

The signing actuaries are Fellows of the Society of Actuaries and members of the American Academy of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein.

Kenneth C. Vieira, FSA, MAAA

Senior Vice President and Actuary

Daniel J. Rhodes, FSA, MAAA

Vice President and Consulting Actuary

AGGREGATE - TOTAL: LEVEL RETIREE POPULATION

	Projections		
	2016	2017	2018
Medical Claims - Anthem	$907,300,000	$955,900,000	$1,010,900,000
Medical Claims - Oxford	126,600,000	133,900,000	141,600,000
Prescription Drug Claims - CVS/Caremark & Silverscript	578,700,000	646,000,000	721,000,000
Prescription Drug Rebates - CVS/Caremark & Silverscript	(88,700,000)	(96,300,000)	(103,500,000)
EGWP Savings - Silverscript	(62,800,000)	(67,300,000)	(73,600,000)
ASO Fees - Anthem	32,800,000	32,700,000	32,700,000
ASO Fees - Oxford	4,700,000	4,700,000	4,700,000
ASO Fees - Silverscript	5,400,000	7,000,000	7,200,000
ACA Fees	6,400,000	4,200,000	500,000
Medicare Part B and D Reimbursement	60,200,000	63,600,000	66,800,000
Administrative Fees	9,200,000	9,500,000	9,700,000
Dental Premium - CIGNA	92,300,000	97,300,000	103,900,000
Shared Savings Program & ACO Payments	6,000,000	6,000,000	6,000,000
Expense Total	**$1,678,100,000**	**$1,797,200,000**	**$1,927,900,000**
Prior Projection	**$1,682,000,000**	**$1,790,700,000**	
Change ($)	**(3,900,000)**	**6,500,000**	
Change (%)	**-0.2%**	**0.4%**	
Self-Funded IBNR Claim Reserves	$117,600,000	$125,300,000	$133,900,000

Notes:

1. The projections above are estimates of future costs and are based on information available to Segal Consulting at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases. The projections do not reflect the potential impact of any future changes due to health care reform legislation, other than those noted or previously adopted.

2. Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

AGGREGATE - TOTAL: INCREASED RETIREE POPULATION

	Projections		
	2016	2017	2018
Medical Claims - Anthem	$907,300,000	$963,500,000	$1,027,100,000
Medical Claims - Oxford	126,600,000	135,000,000	143,800,000
Prescription Drug Claims - CVS/Caremark & Silverscript	578,700,000	655,300,000	742,000,000
Prescription Drug Rebates - CVS/Caremark & Silverscript	(88,700,000)	(97,800,000)	(106,800,000)
EGWP Savings - Silverscript	(62,800,000)	(68,300,000)	(76,400,000)
ASO Fees - Anthem	32,800,000	33,100,000	33,400,000
ASO Fees - Oxford	4,700,000	4,800,000	4,800,000
ASO Fees - Silverscript	5,400,000	7,200,000	7,600,000
ACA Fees	6,400,000	4,200,000	500,000
Medicare Part B and D Reimbursement	60,200,000	65,200,000	70,200,000
Administrative Fees	9,200,000	9,600,000	9,800,000
Dental Premium - CIGNA	92,300,000	98,100,000	105,400,000
Shared Savings Program & ACO Payments	6,000,000	6,000,000	6,000,000
Expense Total	**$1,678,100,000**	**$1,815,900,000**	**$1,967,400,000**
Prior Projection	**$1,682,000,000**	**$1,790,700,000**	
Change ($)	**(3,900,000)**	**25,200,000**	
Change (%)	**-0.2%**	**1.4%**	
Self-Funded IBNR Claim Reserves	$117,600,000	$126,600,000	$136,700,000

Notes:

1. The projections above are estimates of future costs and are based on information available to Segal Consulting at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases. The projections do not reflect the potential impact of any future changes due to health care reform legislation, other than those noted or previously adopted.

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Budget Projections - Fiscal Years Ending June 30

PER CONTRACT PER MONTH - TOTAL

	Projections		
	2016	2017	2018
Medical Claims - Anthem	$816.97	$862.77	$912.41
Medical Claims - Oxford	836.84	883.48	934.28
Prescription Drug Claims - CVS/Caremark & Silverscript	458.61	512.90	572.45
Prescription Drug Rebates - CVS/Caremark & Silverscript	(70.29)	(76.46)	(82.17)
EGWP Savings - Silverscript	(49.77)	(53.43)	(58.44)
ASO Fees - Anthem	29.53	29.51	29.51
ASO Fees - Oxford	31.07	31.01	31.01
ASO Fees - Silverscript	4.28	5.56	5.72
ACA Fees	5.07	3.33	0.40
Medicare Part B and D Reimbursement	145.13	153.25	160.96
Administrative Fees	7.29	7.54	7.70
Dental Premium - CIGNA	77.68	81.78	87.33
Shared Savings Program & ACO Payments	9.36	9.38	9.38
Expense Total	**$1,329.87**	**$1,426.91**	**$1,530.68**
Prior Projection	**$1,353.62**	**$1,441.10**	
Change ($)	**(23.75)**	**(14.19)**	
Change (%)	**-1.8%**	**-1.0%**	

Notes:

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PER CONTRACT ANNUAL CHANGE - TOTAL

	Projections	
	2017	2018
Medical Claims - Anthem	5.6%	5.8%
Medical Claims - Oxford	5.6%	5.7%
Prescription Drug Claims - CVS/Caremark & Silverscript	11.8%	11.6%
Prescription Drug Rebates - CVS/Caremark & Silverscript	8.8%	7.5%
EGWP Savings - Silverscript	7.4%	9.4%
ASO Fees - Anthem	-0.1%	0.0%
ASO Fees - Oxford	-0.2%	0.0%
ASO Fees - Silverscript	29.9%	2.9%
ACA Fees	-34.3%	-88.0%
Medicare Part B and D Reimbursement	5.6%	5.0%
Administrative Fees	3.4%	2.1%
Dental Premium - CIGNA	5.3%	6.8%
Shared Savings Program & ACO Payments	0.2%	0.0%
Expense Total	**7.3%**	**7.3%**

Notes:

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AGGREGATE - ACTIVES

	Projections		
	2016	2017	2018
Medical Claims - Anthem	$617,300,000	$652,000,000	$691,100,000
Medical Claims - Oxford	88,400,000	93,900,000	99,600,000
Prescription Drug Claims - CVS/Caremark & Silverscript	244,200,000	272,800,000	305,600,000
Prescription Drug Rebates - CVS/Caremark & Silverscript	(33,200,000)	(35,900,000)	(38,800,000)
ASO Fees - Anthem	16,300,000	16,200,000	16,200,000
ASO Fees - Oxford	2,800,000	2,800,000	2,800,000
ACA Fees	4,800,000	3,100,000	300,000
Administrative Fees	5,700,000	5,800,000	5,900,000
Dental Premium - CIGNA	64,500,000	68,000,000	72,600,000
Shared Savings Program & ACO Payments	6,000,000	6,000,000	6,000,000
Active Expense Total	**$1,016,800,000**	**$1,084,700,000**	**$1,161,300,000**
Prior Projection	**$1,014,400,000**	**$1,078,700,000**	
Change ($)	**2,400,000**	**6,000,000**	
Change (%)	**0.2%**	**0.6%**	

Notes:

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AGGREGATE - NON-MEDICARE RETIREES: LEVEL RETIREE POPULATION

	Projections		
	2016	2017	2018
Medical Claims - Anthem	$214,500,000	$226,000,000	$239,600,000
Medical Claims - Oxford	25,700,000	27,100,000	28,700,000
Prescription Drug Claims - CVS/Caremark & Silverscript	97,600,000	108,700,000	121,800,000
Prescription Drug Rebates - CVS/Caremark & Silverscript	(13,500,000)	(14,600,000)	(15,700,000)
ASO Fees - Anthem	5,500,000	5,500,000	5,500,000
ASO Fees - Oxford	600,000	600,000	600,000
ACA Fees	1,500,000	1,000,000	100,000
Administrative Fees	2,600,000	2,700,000	2,800,000
Dental Premium - CIGNA	11,400,000	12,000,000	12,900,000
Non-Medicare Retiree Expense Total	**$345,900,000**	**$369,000,000**	**$396,200,000**
Prior Projection	**$339,000,000**	**$361,400,000**	
Change ($)	**6,900,000**	**7,600,000**	
Change (%)	**2.0%**	**2.1%**	

Notes:

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AGGREGATE - NON-MEDICARE RETIREES: INCREASED RETIREE POPULATION

	Projections		
	2016	2017	2018
Medical Claims - Anthem	$214,500,000	$231,700,000	$251,700,000
Medical Claims - Oxford	25,700,000	27,800,000	30,200,000
Prescription Drug Claims - CVS/Caremark & Silverscript	97,600,000	111,400,000	127,900,000
Prescription Drug Rebates - CVS/Caremark & Silverscript	(13,500,000)	(14,900,000)	(16,500,000)
ASO Fees - Anthem	5,500,000	5,600,000	5,700,000
ASO Fees - Oxford	600,000	600,000	600,000
ACA Fees	1,500,000	1,000,000	100,000
Administrative Fees	2,600,000	2,800,000	2,900,000
Dental Premium - CIGNA	*11,400,000*	*12,300,000*	*13,400,000*
Non-Medicare Retiree Expense Total	**$345,900,000**	**$378,300,000**	**$416,000,000**
Prior Projection	**$339,000,000**	**$361,400,000**	
Change ($)	**6,900,000**	**16,900,000**	
Change (%)	**2.0%**	**4.7%**	

Notes:

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AGGREGATE - MEDICARE RETIREES: LEVEL RETIREE POPULATION

	Projections		
	2016	2017	2018
Medical Claims - Anthem	$75,500,000	$77,900,000	$80,200,000
Medical Claims - Oxford	12,500,000	12,900,000	13,300,000
Prescription Drug Claims - CVS/Caremark & Silverscript	236,900,000	264,500,000	293,600,000
Prescription Drug Rebates - CVS/Caremark & Silverscript	(42,000,000)	(45,800,000)	(49,000,000)
EGWP Savings - Silverscript	(62,800,000)	(67,300,000)	(73,600,000)
ASO Fees - Anthem	11,000,000	11,000,000	11,000,000
ASO Fees - Oxford	1,300,000	1,300,000	1,300,000
ASO Fees - Silverscript*	5,400,000	7,000,000	7,200,000
ACA Fees	100,000	100,000	100,000
Medicare Part B and D Reimbursement	60,200,000	63,600,000	66,800,000
Administrative Fees	900,000	1,000,000	1,000,000
Dental Premium - CIGNA	16,400,000	17,300,000	18,500,000
Medicare Retiree Expense Total	**$315,400,000**	**$343,500,000**	**$370,400,000**
Prior Projection	**$328,700,000**	**$350,600,000**	
Change ($)	**(13,300,000)**	**(7,100,000)**	
Change (%)	**-4.0%**	**-2.0%**	

Notes:

1. The projections above are estimates of future costs and are based on information available to Segal Consulting at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases. The projections do not reflect the potential impact of any future changes due to health care reform legislation, other than those noted or previously adopted.

2. Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

* Silverscript Fees for FYE 2016 include a $1.5 million billing adjustment processed in August 2015.

AGGREGATE - MEDICARE RETIREES: INCREASED RETIREE POPULATION

	Projections		
	2016	2017	2018
Medical Claims - Anthem	$75,500,000	$79,800,000	$84,300,000
Medical Claims - Oxford	12,500,000	13,300,000	14,000,000
Prescription Drug Claims - CVS/Caremark & Silverscript	236,900,000	271,100,000	308,500,000
Prescription Drug Rebates - CVS/Caremark & Silverscript	(42,000,000)	(47,000,000)	(51,500,000)
EGWP Savings - Silverscript	(62,800,000)	(68,300,000)	(76,400,000)
ASO Fees - Anthem	11,000,000	11,300,000	11,500,000
ASO Fees - Oxford	1,300,000	1,400,000	1,400,000
ASO Fees - Silverscript*	5,400,000	7,200,000	7,600,000
ACA Fees	100,000	100,000	100,000
Medicare Part B and D Reimbursement	60,200,000	65,200,000	70,200,000
Administrative Fees	900,000	1,000,000	1,000,000
Dental Premium - CIGNA	16,400,000	17,800,000	19,400,000
Medicare Retiree Expense Total	**$315,400,000**	**$352,900,000**	**$390,100,000**
Prior Projection	**$328,700,000**	**$350,600,000**	
Change ($)	**(13,300,000)**	**2,300,000**	
Change (%)	**-4.0%**	**0.7%**	

Notes:

1. The projections above are estimates of future costs and are based on information available to Segal Consulting at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases. The projections do not reflect the potential impact of any future changes due to health care reform legislation, other than those noted or previously adopted.

2. Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

* Silverscript Fees for FYE 2016 include a $1.5 million billing adjustment processed in August 2015.

ASSUMPTIONS

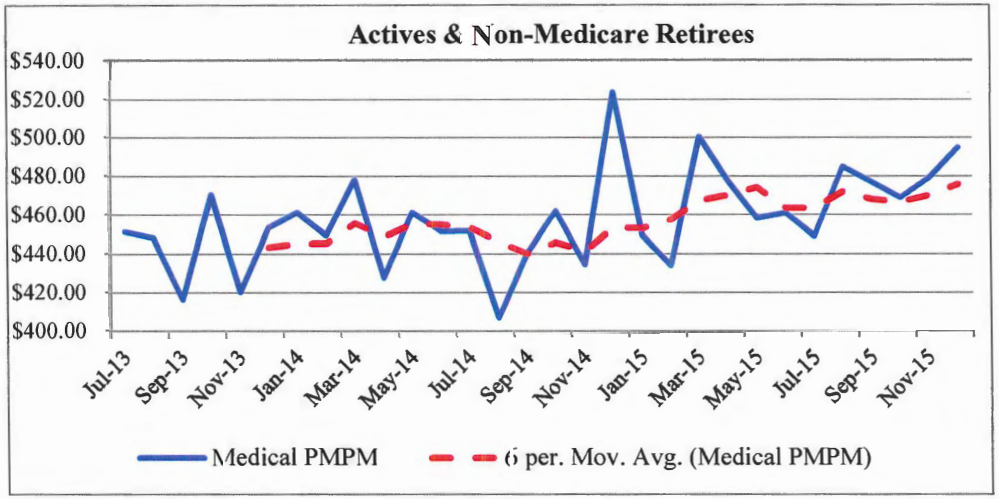
	Projections				
	2016	2017		2018	
		Level Retiree Population	Increased Retiree Population	Level Retiree Population	Increased Retiree Population
Medical Enrollment (Average Number of Contracts)	**105,154**	**104,959**	**106,251**	**104,959**	**107,574**
Actives - Anthem	46,011	45,870	45,870	45,870	45,870
Actives - Oxford	7,434	7,446	7,446	7,446	7,446
Non-Medicare Retirees - Anthem	15,508	15,428	15,814	15,428	16,209
Non-Medicare Retirees - Oxford	1,634	1,630	1,671	1,630	1,713
Medicare Retirees - Anthem	31,028	31,031	31,807	31,031	32,602
Medicare Retirees - Oxford	3,539	3,554	3,643	3,554	3,734
Prescription Drug Enrollment (Average Number of Contrac	**105,154**	**104,959**	**106,251**	**104,959**	**107,574**
Actives	53,445	53,316	53,316	53,316	53,316
Non-Medicare Retirees	17,142	17,058	17,485	17,058	17,922
Medicare Retirees	34,567	34,585	35,450	34,585	36,336
Dental Enrollment (Average Number of Contracts)	**99,021**	**99,150**	**100,222**	**99,150**	**101,321**
Actives	56,271	56,300	56,300	56,300	56,300
Non-Medicare Retirees	17,463	17,504	17,942	17,504	18,391
Medicare Retirees	25,287	25,346	25,980	25,346	26,630
Benefit Cost Trend Factors					
Medical Claims - Non-Medicare	6.0%	6.0%		6.0%	
Medical Claims - Medicare	3.0%	3.0%		3.0%	
Prescription Drug Claims - CVS/Caremark	12.0%	12.0%		12.0%	
Prescription Drug Claims - Silverscript (EGWP)	11.0%	11.0%		11.0%	
Prescription Drug Rebates - CVS/Caremark	12.7%	8.0%		8.0%	
Prescription Drug Rebates - Silverscript (EGWP)	10.6%	7.0%		7.0%	
EGWP Savings - Silverscript	See notes	See notes		See notes	
ASO Fees - Anthem	Guarantee	Guarantee		Guarantee	
ASO Fees - Oxford	Guarantee	Guarantee		Guarantee	
ASO Fees - Silverscript	3.0%	3.0%		3.0%	
ACA Fees	See notes	See notes		See notes	
Medicare Part B and D Reimbursement	5.0%	5.0%		5.0%	
Care Management Solutions Administration Fees	Guarantee	3.0%		3.0%	
Dental Premium - CIGNA	Renewal	Renewal		Guarantee	
Shared Savings Program & ACO Payments	See notes	See notes		See notes	

Notes:

1. The projections above are estimates of future costs and are based on information available to Segal Consulting at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases. The projections do not reflect the potential impact of any future changes due to health care reform legislation, other than those noted or previously adopted.

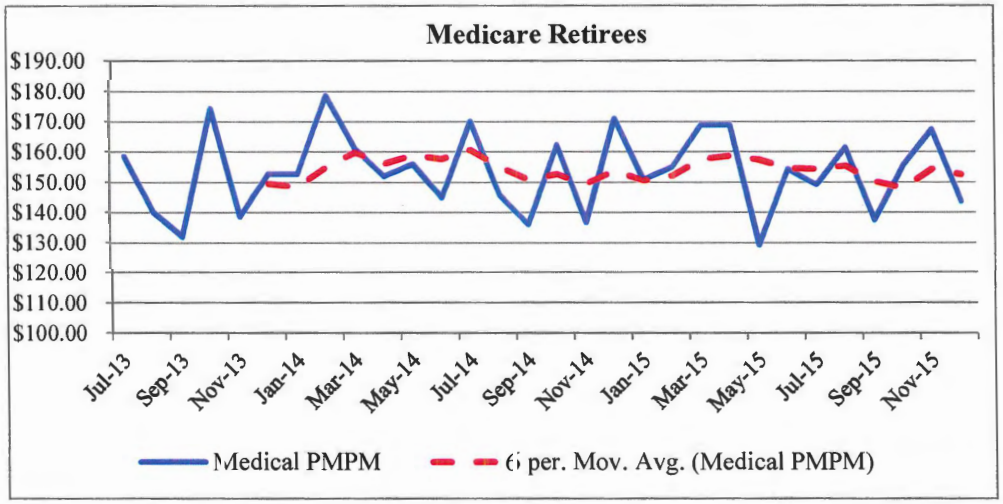
2. Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

MEDICAL TREND ANALYSIS - PAID BASIS



Active/Non-Medicare Retiree medical claims per member per month trended at the following levels for the periods ending:

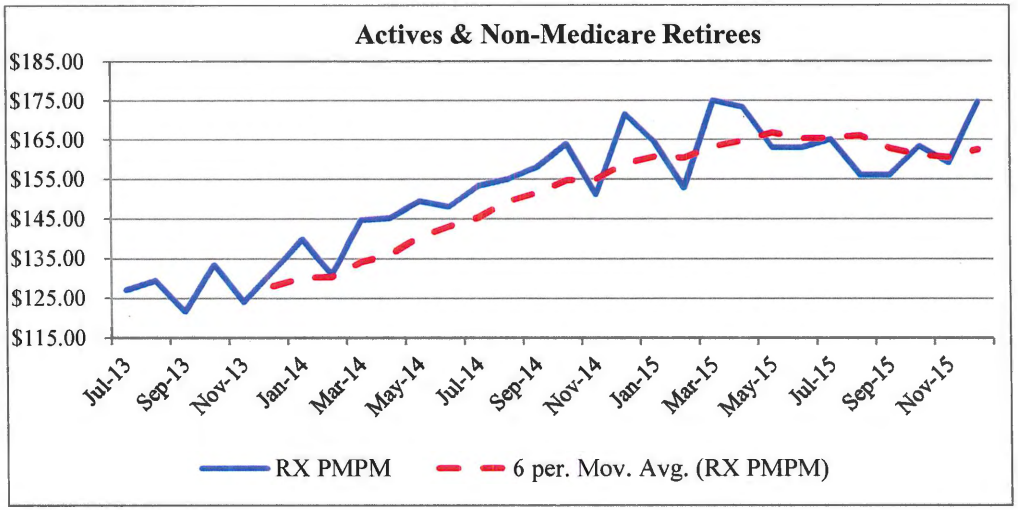
- YE Jun-2015 / YE Jun-2014: **2.1%**
- YE Sep-2015 / YE Sep-2014: **4.5%**
- YE Dec-2015 / YE Dec-2014: **3.4%**



Medicare Retiree medical claims per member per month trended at the following levels for the periods ending:

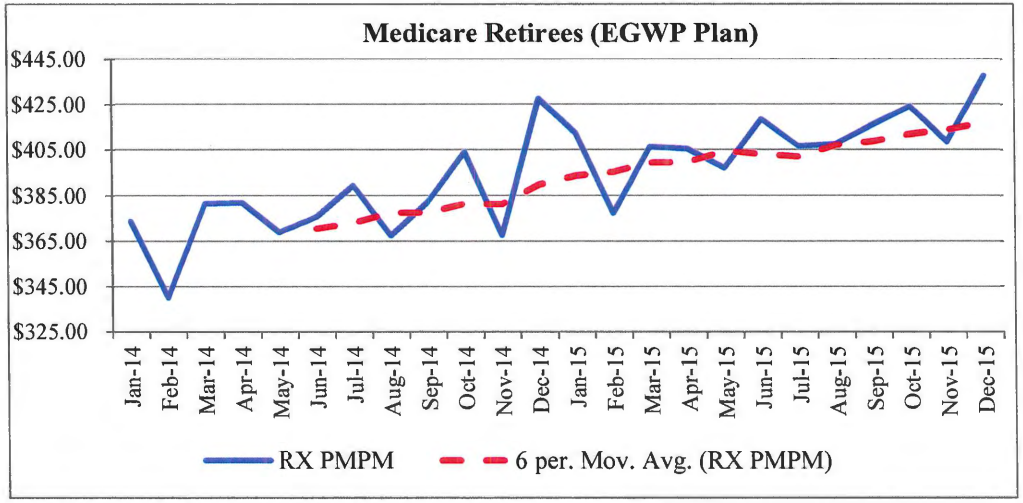
- YE Jun-2015 / YE Jun-2014: **0.4%**
- YE Sep-2015 / YE Sep-2014: **-0.9%**
- YE Dec-2015 / YE Dec-2014: **-1.3%**

PRESCRIPTION DRUG TREND ANALYSIS - PAID BASIS



Active/Non-Medicare Retiree RX claims per member per month trended at the following levels for the periods ending:

- YE Jun-2015 / YE Jun-2014: **19.6%**
- YE Sep-2015 / YE Sep-2014: **14.1%**
- YE Dec-2015 / YE Dec-2014: **8.5%**



Medicare Retiree RX claims per member per month trended at the following levels for the period ending:

- YE Dec-2015 / YE Dec-2014: **7.8%**

Budget Projections - Fiscal Years Ending June 30

Notes and Sources

Covered Groups	• Projections include all state employees and retirees, as well as COBRA and Probate Judges. • Projections exclude Partnership Plan members and UCONN Graduate Assistants
Retiree Lives Assumptions	• Level Population Projections: Assumes no change to current retiree population for FYE 2017 and FYE 2018. • Increased Retiree Population Projections: Reflects a 2.5% increase in Non-Medicare and Medicare Retiree lives effective July 1, 2017 and July 1, 2018. The assumption was provided by Rae-Ellen Roy.
Medical Claims	• Medical claim projections are based on experience from the Conifer data warehouse for the period January 2015 through December 2015.
Prescription Drug Claims - CVS/Caremark & Silverscript	• Active and Non-Medicare Prescription Drug claim projections are based on experience from the Conifer data warehouse for the period January 2015 through December 2015. • Medicare Prescription Drug claim projections are based on experience provided by Silverscript for the period January 2015 through December 2015.
Prescription Drug Rebates - CVS/Caremark & Silverscript	• Active and Non-Medicare Prescription Drug rebate projections are based on rebates provided by CVS/Caremark through September 2015 and rebate terms in effect through June 30, 2016. Rebates are assumed to be paid monthly. • Medicare Prescription Drug rebate projections are based on rebates provided by Silverscript through September 2015. Rebates are assumed to be paid monthly six months after they are incurred.
EGWP Savings - Silverscript	• EGWP savings projections are based on data provided by Silverscript for the period January 2015 through December 2015 and include the following assumptions: - Direct Subsidy: $23.77 PRPM, provided by Silverscript - Coverage Gap Discount: 13.7% of claims (paid quarterly 3 months after end of each quarter) - Federal Reinsurance: 7.2% of claims (paid annually 7 months after end of plan year) - LICS Subsidy: 1.1% of claims (paid annually 7 months after end of plan year) - LIS Premium Subsidy: 0.2% of claims
ASO Fees	• Anthem fees are based on PEPM fee guaranteed through June 30, 2018. • Oxford fees are based on PEPM fee guaranteed through June 30, 2018. • Silverscript EGWP administration fees are projected based on fees paid during for the period January 2015 through December 2015.
ACA Fees	• ACA fee projections include estimated costs for the PCORI fee and the Transitional Reinsurance fee. Fee are shown in the year due. • ACA fees are based on 2015 headcounts provided by Rae-Ellen Roy.
Medicare Part B and D Reimbursement	• Reimbursement projections are based on actual reimbursements through December 2015 from "OSC_State_Healthcare_Premium_Equiv_01_2016.xls" provided by Rae-Ellen Roy.
Administrative Fees	• Administrative fees include the following expenses: - Consultant Fees: Assumption from "FY16 and FY17 Mid-Term Budget Review.xls" - Care Management Solution - Data Warehouse Analytics: Fee from November 2015 Invoice - Care Management Solution - Chronic Condition Management: Fees from November 2015 Invoice - HEP Bonus Payments: Assumption from "FY16 and FY17 Mid-Term Budget Review.xls"
Dental Premium - CIGNA	• Dental projections for FYE2016 and FYE 2017 are based on rates set in the CIGNA renewals effective July 1, 2015 and July 1, 2016. • Dental projections for FYE2018 are based on rate guarantees for the CIGNA renewal effective July 1, 2017.
Shared Savings Program & ACO Payments	• Shared Savings Program & ACO Payment assumption based on "Budget Review 12 15 15.xls".
Prior Projection Comparison	• Comparison is based on Milliman budget memo dated February 9, 2015.
Self-Funded IBNR Claim Reserves	• Self-funded IBNR claim reserves are based on reserve factors assuming 1 month claim lag for Active/Non-Medicare Retiree medical, 2 months claim lag for Medicare Retiree medical, and 0.5 month claim lag for prescription drugs and do not reflect actual claim payment patterns for the State of Connecticut's plans.

DEPARTMENT OF BUDGET AND MANAGEMENT

Fiscal Year 2014

Monthly Budget to Actual Report

Through January 2014

March 14, 2014

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Segal Consulting

Executive Summary - Experience Overview

January, 2014

Executive Summary Experience Overview

As of January 2014 actual experience is running favorably compared to the FY 2014 projection.

For Invoiced Costs the variance due to higher than expected enrollment is being offset by better than expected claims experience.

Paid Data	FY 2014 Budget	FY 2014 Projected Paid	Over/(Under) Budget
Total Annual Paid Costs	$1,277,389,329	$1,269,515,994	($7,873,335)

Invoiced Data	FY 2014 Budget	FY 2014 Invoices to Date	Over/(Under) Budget
Total Invoices to Date	$771,518,260	$770,775,862	($742,398)
		Variance Due to Enrollment	$2,723,093
		Variance Due to Claims	($3,465,491)

Executive Summary Key Observations

January, 2014

- Administrative and network fees for invoiced, paid, and incurred claims were added based on invoiced amounts from XXX through September 2013, through October 2013 for , through November 2013 for XXX and XXX, and through January 2014 for XXX. Where actual invoices are unavailable, administrative fees were added based on contracted fees and monthly enrollment.
- The budgeted amounts in the Invoiced and Paid cost analysis exhibits are pro-rated amounts of the annual budget. For the month of January 2013, the YTD budgeted amount is 60.4% of the annual budget. Some of the variance between the actual cost and the budgeted amounts may be due to the timing of when claims are incurred, paid and invoiced.
- For Fiscal Year 2014 to date, the actual invoiced amount (including insured dental) of $770,775,862 is $742,398 lower than the budgeted amount of $771,518,260. As shown on Table 2, this variance can be attributed to enrollment and claims. The variance due to enrollment is $2,723,093, while the variance due to claims is $(3,465,491).
- For Fiscal Year 2014 to date, the self-funded actual paid amount for Medical and Rx of $734,948,094 is 1.1% lower than the budgeted amount of $742,821,429.
- The total projected self-funded incurred claims for Medical, Rx, and Dental of $1,273,873,478 for FY 2014 is $3,515,851 under the budgeted amount of $1,277,389,329.

Enrollment

- Actual total medical enrollment during the month of January 2014 is shown below, compared to the average enrollment for Fiscal Year 2013 and the budgeted enrollment for Fiscal Year 2014. While there was significant migration from the POS and PPO Plans to the EPO, it was less than budgeted.

	Average FY2013	Budgeted FY2014	January 2014	% Variance from Budget
POS	24,710	20,874	23,350	11.9%
PPO	54,062	49,570	51,150	3.2%
EPO	36,795	45,704	43,041	-5.8%
Total	115,567	116,148	117,541	1.2%

Cost Analysis

The budget projections for the Fiscal Year (FY) 2014 are based on the short plan year renewal report dated April 24, 2013 and the Calendar Year 2014 renewal report dated July 29, 2013. The budget projections also takes into account revised Pharmacy rates for retirees effective January 1, 2014. This report compares the actual cost to these budget projections on the following basis:

- Invoiced Cost Analysis (Exhibit I) - All vendors for the self-funded plans regularly provide the XXX with invoices for claims paid. The amounts reflected on this exhibit are based on the invoice dates. For example, the January 2014 report reflects all invoices dated January 2014.

- Paid Cost Analysis (Exhibit II) – This exhibit reflects the amounts paid by the self-funded plan vendors to health care providers each month. Vendors provide monthly claims cost amounts via electronic file feeds. These files are then retrieved from the data warehouse.

- Incurred Cost Analysis (Exhibit III) – This exhibit reflects self-funded plan costs based on the date incurred. Completion factors are applied based on analysis of actual claims lag reports for each plan. To project future months, incurred claims were estimated based on trended budgeted rates and projected enrollment.

Executive Summary: Table 1

January, 2014

Summary of Exhibit I: Invoiced Cost Analysis - Medical, Rx, and Dental				
Plan Type	Vendor	FY 2014 Budget[1]	FY 2014 YTD Actual Expenditures[2]	Over(Under) Budget
POS Plans	Aetna	$ 14,415,798	$ 17,185,528	$ 2,769,730
	BCBS	$ 36,873,671	$ 39,743,376	$ 2,869,705
	UHC	$ 29,868,330	$ 32,730,227	$ 2,861,897
PPO Plans	BCBS	$ 186,574,209	$ 183,671,333	$ (2,902,876)
	UHC	$ 17,211,219	$ 20,799,219	$ 3,588,001
EPO Plans	Aetna	$ 12,866,335	$ 14,143,842	$ 1,277,507
	BCBS	$ 175,169,150	$ 162,029,052	$ (13,140,098)
	UHC	$ 47,014,362	$ 41,194,390	$ (5,819,972)
Rx Plan	ESI	$ 215,220,940	$ 221,487,233	$ 6,266,293
MH/SA	APS	$ 7,607,415	$ 8,813,402	$ 1,205,987
Dental Plans	DHMO	$ 5,176,835	$ 5,153,415	$ (23,420)
	DPPO	$ 23,519,996	$ 23,824,843	$ 304,847
Total		**$ 771,518,260**	**$ 770,775,862**	**$ (742,398)**

Executive Summary: Table 2

January, 2014

Analysis of Budget vs. Invoiced Variance by Cause - Medical, Rx, and Dental								
		Budget		Enrollment-Adjusted Budget				
Plan Type	Vendor	Budgeted Enrollment	Budgeted Cost	Actual Enrollment	Enrollment-Adjusted Cost	Variance Due to Enrollment	Variance Due to Claims	Total Variance
POS Plans	Aetna	25,298	$ 14,415,798	28,473	$ 16,886,366	$ 2,470,568	$ 299,162	$ 2,769,730
	BCBS	69,237	$ 36,873,671	76,871	$ 42,816,113	$ 5,942,442	$ (3,072,737)	$ 2,869,705
	UHC	51,583	$ 29,868,330	57,044	$ 34,679,266	$ 4,810,935	$ (1,949,039)	$ 2,861,897
	Total POS	**146,118**	**$ 81,157,799**	**162,388**	**$ 94,381,744**	**$ 13,223,945**	**$ (4,722,613)**	**$ 8,501,332**
PPO Plans	BCBS	315,504	$ 186,574,209	324,134	$ 195,551,996	$ 8,977,787	$ (11,880,662)	$ (2,902,876)
	UHC	31,486	$ 17,211,219	32,997	$ 18,325,021	$ 1,113,803	$ 2,474,198	$ 3,588,001
	Total PPO	**346,990**	**$ 203,785,427**	**357,131**	**$ 213,877,017**	**$ 10,091,589**	**$ (9,406,464)**	**$ 685,125**
EPO Plans	Aetna	19,467	$ 12,866,335	22,514	$ 14,304,711	$ 1,438,376	$ (160,869)	$ 1,277,507
	BCBS	240,037	$ 175,169,150	216,737	$ 155,350,247	$ (19,818,903)	$ 6,678,805	$ (13,140,098)
	UHC	60,424	$ 47,014,362	53,066	$ 40,787,777	$ (6,226,585)	$ 406,613	$ (5,819,972)
	Total EPO	**319,928**	**$ 235,049,847**	**292,317**	**$ 210,442,735**	**$ (24,607,112)**	**$ 6,924,550**	**$ (17,682,562)**
Rx Plan	ESI	760,676	$ 215,220,940	764,740	$ 218,285,707	$ 3,064,767	$ 3,201,526	$ 6,266,293
MH/SA	APS	493,108	$ 7,607,415	519,519	$ 8,275,892	$ 668,477	$ 537,510	$ 1,205,987
Dental Plans	DHMO	205,380	$ 5,176,835	192,156	$ 5,153,415	$ (23,420)	$ -	$ (23,420)
	DPPO	480,459	$ 23,519,996	515,861	$ 23,824,843	$ 304,847	$ -	$ 304,847
	Total Dental	**685,839**	**$ 28,696,831**	**708,017**	**$ 28,978,258**	**$ 281,427**	**$ -**	**$ 281,427**
Total[1]		**813,036**	**$ 771,518,260**	**811,836**	**$ 774,241,353**	**$ 2,723,093**	**$ (3,465,491)**	**$ (742,398)**

Executive Summary: Table 3a

January, 2014

Summary of Exhibit III: Incurred Cost Analysis - Medical and Rx				
Plan Type	**Vendor**	**FY 2014 Annual Budget***	**FY 2014 Annual Projected**	**Over/ (Under) Budget**
POS Plans	Aetna	$ 25,269,752	$ 26,993,570	$ 1,723,818
	BCBS	$ 64,522,975	$ 67,454,060	$ 2,931,085
	UHC	$ 52,316,094	$ 53,760,217	$ 1,444,123
	Total POS	**$ 142,108,821**	**$ 148,207,847**	**$ 6,099,026**
PPO Plans	BCBS	$ 324,389,130	$ 319,377,551	$ (5,011,579)
	UHC	$ 30,005,950	$ 31,874,734	$ 1,868,784
	Total PPO	**$ 354,395,079**	**$ 351,252,285**	**$ (3,142,795)**
EPO Plans	Aetna	$ 22,480,784	$ 23,761,337	$ 1,280,553
	BCBS	$ 302,919,731	$ 295,998,864	$ (6,920,867)
	UHC	$ 81,139,100	$ 77,187,204	$ (3,951,896)
	Total EPO	**$ 406,539,615**	**$ 396,947,404**	**$ (9,592,211)**
Rx Plan	ESI	$ 361,063,641	$ 363,374,776	$ 2,311,134
MH/SA	APS	$ 13,282,172	$ 14,091,166	$ 808,994
Total		**$ 1,277,389,329**	**$ 1,273,873,478**	**$ (3,515,851)**

Executive Summary: Table 3b

January, 2014

Summary of Exhibit III: Paid Cost Analysis - Medical and Rx				
Plan Type	**Vendor**	**FY 2014 Annual Budget***	**FY 2014 Annual Projected**	**Over/ (Under) Budget**
POS Plans	Aetna	$ 25,269,752	$ 27,424,111	$ 2,154,359
	BCBS	$ 64,522,975	$ 66,876,220	$ 2,353,245
	UHC	$ 52,316,094	$ 53,655,057	$ 1,338,963
	Total POS	**$ 142,108,821**	**$ 147,955,388**	**$ 5,846,567**
PPO Plans	BCBS	$ 324,389,130	$ 319,478,706	$ (4,910,424)
	UHC	$ 30,005,950	$ 31,816,836	$ 1,810,887
	Total PPO	**$ 354,395,079**	**$ 351,295,542**	**$ (3,099,537)**
EPO Plans	Aetna	$ 22,480,784	$ 23,666,451	$ 1,185,667
	BCBS	$ 302,919,731	$ 292,039,585	$ (10,880,146)
	UHC	$ 81,139,100	$ 76,649,853	$ (4,489,247)
	Total EPO	**$ 406,539,615**	**$ 392,355,889**	**$ (14,183,726)**
Rx Plan	ESI	$ 361,063,641	$ 363,495,194	$ 2,431,553
MH/SA	APS	$ 13,282,172	$ 14,413,981	$ 1,131,809
Total		**$ 1,277,389,329**	**$ 1,269,515,994**	**$ (7,873,335)**

Executive Summary: Table 4

January, 2014

The following table compares historical Per Employee Per Month (PEPM) costs for FY 2011-2013 to current FY 2014 costs.

Medical and Rx PEPM on a Paid Basis[1]					
		All Eligibility Classes			
Plan Type	Vendor	FY 2011	FY 2012	FY 2013	FY 2014[2]
POS Plans	AETNA	$ 578.92	$ 586.40	$ 570.90	$ 545.52
	BCBS	$ 492.01	$ 573.62	$ 498.46	$ 480.50
	UHC	$ 613.47	$ 646.27	$ 548.94	$ 513.39
PPO Plans	BCBS	$ 560.04	$ 618.67	$ 548.14	$ 529.24
	UHC	$ 555.70	$ 549.27	$ 569.38	$ 538.69
EPO Plans	AETNA	$ 433.43	$ 403.84	$ 561.10	$ 578.34
	BCBS	$ 479.67	$ 575.86	$ 639.66	$ 719.77
	UHC	$ 639.26	$ 689.76	$ 725.26	$ 750.41
Rx Plan	ESI	$ 307.14	$ 292.66	$ 267.66	$ 279.94
MH/SA	APS	$ 14.75	$ 16.31	$ 14.09	$ 15.25
Composite[3]		**$ 856.97**	**$ 899.69**	**$ 845.36**	**$ 871.09**

Executive Summary: Table 5

January, 2014

The following table compares trend assumptions for FY 2012 to FY 2014 to actual trends realized

Medical and Rx Trend on a Paid PEPM Basis[1]							
		All Eligibility Classes					
Plan Type	Vendor	FY 2012 Assumed	FY 2012 Actual	FY 2013 Assumed	FY 2013 Actual	FY 2014 Assumed	FY 2014 Actual[2]
POS Plans	AETNA	8.4%	1.3%	7.4%	-2.6%	7.0%	-4.4%
	BCBS	7.9%	16.6%	7.0%	-13.1%	7.0%	-3.6%
	UHC	8.3%	5.3%	7.4%	-15.1%	7.0%	-6.5%
PPO Plans	BCBS	7.4%	10.5%	6.5%	-11.4%	7.0%	-3.4%
	UHC	8.3%	-1.2%	7.5%	3.7%	7.0%	-5.4%
EPO Plans	AETNA	8.0%	-6.8%	7.0%	38.9%	7.0%	3.1%
	BCBS	7.9%	20.1%	7.0%	11.1%	7.0%	12.5%
	UHC	7.9%	7.9%	7.0%	5.1%	7.0%	3.5%
Rx Plan	ESI	7.0%	-4.7%	7.0%	-8.5%	6.0%	4.6%
MH/SA	APS	7.0%	10.6%	7.0%	-13.6%	7.0%	8.2%
Composite[3]		**7.9%**	**5.0%**	**7.0%**	**-6.0%**	**7.0%**	**3.0%**

Executive Summary: Table 6

January, 2014

Table 4: Paid Claims Analysis July 2013 - January 2014				
Plan Type	**Vendor**	**FY 2014 YTD**	**Employee Months**	**PEPM**
POS Plans	Aetna			
	Actives	$ 10,989,478	20,094	$ 546.90
	Direct Pay	$ 111,038	567	$ 195.83
	Satellite	$ 1,017,467	1,636	$ 621.92
	Under 65 Retirees	$ 2,250,172	2,066	$ 1,089.14
	Over 65 Retirees	$ 1,164,359	4,110	$ 283.30
	BCBS			
	Actives	$ 24,655,101	46,501	$ 530.21
	Direct Pay	$ 676,513	2,104	$ 321.54
	Satellite	$ 1,361,034	1,939	$ 701.93
	Under 65 Retirees	$ 5,381,126	6,728	$ 799.81
	Over 65 Retirees	$ 4,862,942	19,599	$ 248.12
	UHC			
	Actives	$ 17,899,748	27,806	$ 643.74
	Direct Pay	$ 306,340	1,061	$ 288.73
	Satellite	$ 606,139	919	$ 659.56
	Under 65 Retirees	$ 5,988,761	7,558	$ 792.37
	Over 65 Retirees	$ 4,484,924	19,700	$ 227.66
	Total POS	**$ 81,755,143**	**162,388**	**$ 503.46**
PPO Plans	BCBS			
	Actives	$ 105,545,329	150,091	$ 703.21
	Direct Pay	$ 2,051,227	7,798	$ 263.05
	Satellite	$ 3,451,465	5,193	$ 664.64
	Under 65 Retirees	$ 27,451,923	30,747	$ 892.83
	Over 65 Retirees	$ 33,043,394	130,305	$ 253.59
	UHC			
	Actives	$ 10,477,265	14,644	$ 715.46
	Direct Pay	$ 223,776	995	$ 224.90
	Satellite	$ 390,374	553	$ 705.92
	Under 65 Retirees	$ 3,112,021	2,329	$ 1,336.20
	Over 65 Retirees	$ 3,571,823	14,476	$ 246.74
	Total PPO	**$ 189,318,597**	**357,131**	**$ 530.11**

[1] Amounts represent claims only. Administrative and network access fees are not included.

[2] Fiscal Year 2014 reflects 6 months of results.

Executive Summary: Table 6 continued

January, 2014

Table 4: Paid Claims Analysis July 2013 - January 2014				
Plan Type	**Vendor**	**FY 2014 YTD**	**Employee Months**	**PEPM**
EPO Plans	Aetna			
	Actives	$ 11,590,531	19,544	$ 593.05
	Direct Pay	$ 47,297	493	$ 95.94
	Satellite	$ 582,735	857	$ 679.97
	Under 65 Retirees	$ 670,067	910	$ 736.34
	Over 65 Retirees	$ 130,019	710	$ 183.13
	BCBS			
	Actives	$ 128,112,506	162,783	$ 787.01
	Direct Pay	$ 687,083	2,475	$ 277.61
	Satellite	$ 4,770,281	6,173	$ 772.77
	Under 65 Retirees	$ 13,724,869	17,114	$ 801.97
	Over 65 Retirees	$ 8,706,219	28,192	$ 308.82
	UHC			
	Actives	$ 33,402,859	40,525	$ 824.25
	Direct Pay	$ 396,606	497	$ 798.00
	Satellite	$ 915,322	1,373	$ 666.66
	Under 65 Retirees	$ 3,104,189	4,491	$ 691.20
	Over 65 Retirees	$ 2,002,171	6,180	$ 323.98
	Total EPO	**$ 208,842,753**	**292,317**	**$ 714.44**
Rx Plan	ESI			
	Actives	$ 116,382,060	446,804	$ 260.48
	Direct Pay	$ 1,155,570	12,084	$ 95.63
	Satellite	$ 3,734,911	14,884	$ 250.94
	Retiree Under 65	$ 24,462,875	96,979	$ 252.25
	Retiree Over 65	$ 68,347,427	192,528	$ 355.00
	Total Rx	**$ 214,082,844**	**763,279**	**$ 280.48**
MH/SA	APS			
	Actives	$ 7,019,401	259,136	$ 27.09
	Direct Pay	$ 78,407	12,525	$ 6.26
	Satellite	$ 102,876	10,240	$ 10.05
	Under 65 Retirees	$ 474,816	49,428	$ 9.61
	Over 65 Retirees	$ 248,709	188,190	$ 1.32
	Total MH/SA	**$ 7,924,207**	**519,519**	**$ 15.25**
Composite[3]				**$ 871.09**

[1] Amounts represent claims only. Administrative and network access fees are not included.

[2] Fiscal Year 2014 reflects 6 months of results.

[3] Based on medical PEPM + Rx PEPM

Exhibit I: FY 2014 Invoiced Cost Analysis

January, 2014

Invoiced Data Through January, 2014																
Self-Funded Plans[1]																
Plan Type	Vendor	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	YTD	FY 2014 Budget[2]	Over/ (Under) Budget
POS Plans	Aetna	$ 2,414,585	$ 3,278,697	$ 2,125,614	$ 2,050,838	$ 2,052,764	$ 2,569,137	$ 2,693,893	$ -	$ -	$ -	$ -	$ -	$ 17,185,528	$ 14,415,798	$ 2,769,730
	BCBS	$ 5,872,001	$ 5,034,442	$ 6,839,524	$ 5,129,465	$ 5,681,291	$ 6,201,681	$ 4,984,972	$ -	$ -	$ -	$ -	$ -	$ 39,743,376	$ 36,873,671	$ 2,869,705
	UHC	$ 5,871,585	$ 4,906,936	$ 4,325,572	$ 3,997,972	$ 4,320,387	$ 5,351,864	$ 3,955,910	$ -	$ -	$ -	$ -	$ -	$ 32,730,227	$ 29,868,330	$ 2,861,897
	Total POS	**$ 14,158,171**	**$ 13,220,076**	**$ 13,290,710**	**$ 11,178,275**	**$ 12,054,442**	**$ 14,122,683**	**$ 11,634,776**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 89,659,131**	**$ 81,157,799**	**$ 8,501,332**
PPO Plans	BCBS	$ 29,645,226	$ 23,884,394	$ 29,731,118	$ 23,815,589	$ 24,327,337	$ 29,565,231	$ 22,702,437	$ -	$ -	$ -	$ -	$ -	$ 183,671,333	$ 186,574,209	$ (2,902,876)
	UHC	$ 3,962,271	$ 3,151,454	$ 2,457,364	$ 2,557,473	$ 2,988,323	$ 2,940,540	$ 2,741,794	$ -	$ -	$ -	$ -	$ -	$ 20,799,219	$ 17,211,219	$ 3,588,001
	Total PPO	**$ 33,607,497**	**$ 27,035,848**	**$ 32,188,483**	**$ 26,373,062**	**$ 27,315,660**	**$ 32,505,770**	**$ 25,444,231**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 204,470,552**	**$ 203,785,427**	**$ 685,125**
EPO Plans	Aetna	$ 1,586,725	$ 2,673,744	$ 1,526,329	$ 2,044,961	$ 1,860,569	$ 2,226,250	$ 2,225,266	$ -	$ -	$ -	$ -	$ -	$ 14,143,842	$ 12,866,335	$ 1,277,507
	BCBS	$ 22,862,681	$ 20,079,864	$ 27,079,287	$ 22,219,169	$ 22,554,138	$ 25,770,275	$ 21,463,638	$ -	$ -	$ -	$ -	$ -	$ 162,029,052	$ 175,169,150	$ (13,140,098)
	UHC	$ 6,318,280	$ 5,112,013	$ 6,534,203	$ 5,930,594	$ 4,702,220	$ 7,185,373	$ 5,411,706	$ -	$ -	$ -	$ -	$ -	$ 41,194,390	$ 47,014,362	$ (5,819,972)
	Total EPO	**$ 30,767,687**	**$ 27,865,620**	**$ 35,139,819**	**$ 30,194,725**	**$ 29,116,927**	**$ 35,181,898**	**$ 29,100,610**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 217,367,285**	**$ 235,049,847**	**$ (17,682,562)**
Rx Plan	ESI	$ 31,128,641	$ 32,285,340	$ 31,320,210	$ 32,805,254	$ 33,725,599	$ 31,565,119	$ 28,657,070	$ -	$ -	$ -	$ -	$ -	$ 221,487,233	$ 215,220,940	$ 6,266,293
MH/SA	APS	$ 1,067,159	$ 1,434,151	$ 1,170,075	$ 1,301,436	$ 1,353,741	$ 1,046,965	$ 1,439,876	$ -	$ -	$ -	$ -	$ -	$ 8,813,402	$ 7,607,415	$ 1,205,987
Total		$ 110,729,155	$ 101,841,035	$ 113,109,297	$ 101,852,751	$ 103,566,369	$ 114,422,435	$ 96,276,562	$ -	$ -	$ -	$ -	$ -	$ 741,797,604	$ 742,821,429	$ (1,023,825)

Invoiced Data Through January, 2014																
Fully-Insured Plans[3]																
Plan Type	Vendor	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	YTD	FY 2014 Budget	Over/ (Under) Budget
Dental Plans	DHMO	$ 738,552	$ 735,811	$ 732,357	$ 736,518	$ 742,243	$ 738,534	$ 729,400	$ -	$ -	$ -	$ -	$ -	$ 5,153,415	$ 5,176,835	$ (23,420)
	DPPO	$ 3,418,223	$ 3,416,004	$ 3,339,097	$ 3,419,727	$ 3,420,450	$ 3,409,952	$ 3,401,390	$ -	$ -	$ -	$ -	$ -	$ 23,824,843	$ 23,519,996	$ 304,847
Total		$ 4,156,775	$ 4,151,815	$ 4,071,454	$ 4,156,245	$ 4,162,692	$ 4,148,486	$ 4,130,790	$ -	$ -	$ -	$ -	$ -	$ 28,978,258	$ 28,696,831	$ 281,427

Grand Total		$ 114,885,930	$ 105,992,850	$ 117,180,751	$ 106,008,996	$ 107,729,062	$ 118,570,920	$ 100,407,352	$ -	$ -	$ -	$ -	$ -	$ 770,775,862	$ 771,518,260	$ (742,398)

Exhibit II: FY 2014 Paid Cost Analysis

January, 2014

Paid Data Through January, 2014																
Self-Funded Plans[1]																
Plan Type	Vendor	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	YTD	FY 2014 Budget[2]	Over/ (Under) Budget
POS Plans	Aetna	$ 2,482,526	$ 2,637,199	$ 2,479,391	$ 2,391,039	$ 2,098,751	$ 2,280,033	$ 2,413,573	$ -	$ -	$ -	$ -	$ -	$ 16,782,513	$ 14,415,798	$ 2,366,715
	BCBS	$ 4,657,645	$ 6,386,273	$ 5,509,136	$ 5,127,598	$ 6,761,575	$ 5,136,753	$ 6,118,042	$ -	$ -	$ -	$ -	$ -	$ 39,697,023	$ 36,873,671	$ 2,823,352
	UHC	$ 5,251,339	$ 4,481,853	$ 3,691,698	$ 4,625,774	$ 4,304,166	$ 4,453,502	$ 4,792,671	$ -	$ -	$ -	$ -	$ -	$ 31,601,001	$ 29,868,330	$ 1,732,671
	Total POS	**$ 12,391,510**	**$ 13,505,325**	**$ 11,680,225**	**$ 12,144,411**	**$ 13,164,492**	**$ 11,870,288**	**$ 13,324,286**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 88,080,537**	**$ 81,157,799**	**$ 6,922,738**
PPO Plans	BCBS	$ 22,974,397	$ 28,783,971	$ 24,801,724	$ 23,834,717	$ 30,011,296	$ 23,881,171	$ 27,897,729	$ -	$ -	$ -	$ -	$ -	$ 182,185,005	$ 186,574,209	$ (4,389,204)
	UHC	$ 2,744,277	$ 3,316,195	$ 2,043,987	$ 2,945,228	$ 2,301,196	$ 2,556,639	$ 3,196,484	$ -	$ -	$ -	$ -	$ -	$ 19,104,005	$ 17,211,219	$ 1,892,786
	Total PPO	**$ 25,718,674**	**$ 32,100,166**	**$ 26,845,711**	**$ 26,779,945**	**$ 32,312,492**	**$ 26,437,809**	**$ 31,094,213**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 201,289,010**	**$ 203,785,427**	**$ (2,496,417)**
EPO Plans	Aetna	$ 1,839,398	$ 2,203,543	$ 1,928,613	$ 2,039,846	$ 1,853,922	$ 2,035,977	$ 2,286,157	$ -	$ -	$ -	$ -	$ -	$ 14,187,457	$ 12,866,335	$ 1,321,121
	BCBS	$ 18,408,301	$ 24,709,615	$ 22,441,757	$ 22,224,252	$ 27,609,555	$ 20,712,393	$ 26,730,421	$ -	$ -	$ -	$ -	$ -	$ 162,836,293	$ 175,169,150	$ (12,332,857)
	UHC	$ 5,458,602	$ 6,281,608	$ 5,648,059	$ 6,261,927	$ 5,740,961	$ 6,149,290	$ 6,437,699	$ -	$ -	$ -	$ -	$ -	$ 41,978,146	$ 47,014,362	$ (5,036,216)
	Total EPO	**$ 25,706,300**	**$ 33,194,766**	**$ 30,018,429**	**$ 30,526,025**	**$ 35,204,438**	**$ 28,897,661**	**$ 35,454,277**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 219,001,896**	**$ 235,049,847**	**$ (16,047,952)**
Rx Plan	ESI	$ 32,198,695	$ 32,012,303	$ 31,285,616	$ 33,825,286	$ 30,663,968	$ 35,328,242	$ 22,448,878	$ -	$ -	$ -	$ -	$ -	$ 217,762,988	$ 215,220,940	$ 2,542,048
MH/SA	APS	$ 1,402,866	$ 1,277,199	$ 1,159,076	$ 1,244,428	$ 1,221,086	$ 1,253,513	$ 1,255,496	$ -	$ -	$ -	$ -	$ -	$ 8,813,664	$ 7,607,415	$ 1,206,248
Total		**$ 97,418,045**	**$112,089,758**	**$100,989,058**	**$ 104,520,094**	**$112,566,476**	**$103,787,512**	**$103,577,150**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 734,948,094**	**$ 742,821,429**	**$ (7,873,335)**

Paid Data Through January, 2014																
Fully-Insured Plans[3]																
Plan Type	Vendor	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	YTD	FY 2014 Budget	Over/ (Under) Budget
Dental Plans	DHMO	$ 738,552	$ 735,811	$ 732,357	$ 736,518	$ 742,243	$ 738,534	$ 729,400	$ -	$ -	$ -	$ -	$ -	$ 5,153,415	$ 5,176,835	$ (23,420)
	DPPO	$ 3,418,223	$ 3,416,004	$ 3,339,097	$ 3,419,727	$ 3,420,450	$ 3,409,952	$ 3,401,390	$ -	$ -	$ -	$ -	$ -	$ 23,824,843	$ 23,519,996	$ 304,847
Total		**$ 4,156,775**	**$ 4,151,815**	**$ 4,071,454**	**$ 4,156,245**	**$ 4,162,692**	**$ 4,148,486**	**$ 4,130,790**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 28,978,258**	**$ 28,696,831**	**$ 281,427**

Grand Total		**$101,574,820**	**$116,241,573**	**$105,060,512**	**$ 108,676,340**	**$116,729,169**	**$107,935,998**	**$107,707,940**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 763,926,352**	**$ 771,518,260**	**$ (7,591,908)**

Exhibit III: FY 2014 Incurred Cost Analysis

January, 2014

Incurred Data Paid Through January, 2014 Then Projected																
Self-Funded Plans[1]																
Plan Type	**Vendor**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**	**Apr-14**	**May-14**	**Jun-14**	**Total**	**FY 2014 Budget[2]**	**Over/ (Under) Projection**
POS Plans	Aetna	$ 2,642,581	$ 2,515,225	$ 2,120,621	$ 2,181,862	$ 2,174,545	$ 2,226,073	$ 2,491,065	$ 2,104,979	$ 2,116,579	$ 2,128,250	$ 2,139,990	$ 2,151,800	$ 26,993,570	$ 25,269,752	$ 1,723,818
	BCBS	$ 5,662,072	$ 6,152,710	$ 5,232,227	$ 6,061,874	$ 6,001,578	$ 5,280,543	$ 5,883,858	$ 5,378,942	$ 5,407,231	$ 5,435,680	$ 5,464,288	$ 5,493,057	$ 67,454,060	$ 64,522,975	$ 2,931,085
	UHC	$ 4,849,933	$ 4,069,509	$ 4,176,205	$ 4,805,260	$ 4,305,718	$ 4,110,486	$ 5,389,050	$ 4,362,080	$ 4,386,301	$ 4,410,666	$ 4,435,176	$ 4,459,832	$ 53,760,217	$ 52,316,094	$ 1,444,123
	Total POS	**$ 13,154,587**	**$ 12,737,444**	**$ 11,529,053**	**$ 13,048,996**	**$ 12,481,842**	**$ 11,617,102**	**$ 13,763,973**	**$ 11,846,001**	**$ 11,910,112**	**$ 11,974,595**	**$ 12,039,454**	**$ 12,104,689**	**$ 148,207,847**	**$ 142,108,821**	**$ 6,099,026**
PPO Plans	BCBS	$ 25,808,787	$ 25,049,169	$ 23,560,873	$ 27,516,596	$ 25,350,620	$ 26,562,984	$ 28,134,822	$ 27,186,548	$ 27,321,930	$ 27,458,024	$ 27,594,834	$ 27,732,364	$ 319,377,551	$ 324,389,130	$ (5,011,579)
	UHC	$ 2,983,783	$ 2,394,255	$ 2,668,583	$ 3,169,074	$ 2,563,655	$ 2,525,587	$ 2,856,967	$ 2,514,176	$ 2,528,286	$ 2,542,481	$ 2,556,761	$ 2,571,128	$ 31,874,734	$ 30,005,950	$ 1,868,784
	Total PPO	**$ 28,892,570**	**$ 27,443,423**	**$ 26,229,456**	**$ 30,685,670**	**$ 27,914,274**	**$ 29,088,571**	**$ 30,991,789**	**$ 29,700,724**	**$ 29,850,216**	**$ 30,000,505**	**$ 30,151,595**	**$ 30,303,492**	**$ 351,252,285**	**$ 354,395,079**	**$ (3,142,795)**
EPO Plans	Aetna	$ 2,027,155	$ 1,867,737	$ 1,952,463	$ 2,001,421	$ 2,097,034	$ 1,920,034	$ 2,416,498	$ 1,876,259	$ 1,885,974	$ 1,895,744	$ 1,905,569	$ 1,915,449	$ 23,761,337	$ 22,480,784	$ 1,280,553
	BCBS	$ 23,692,063	$ 22,761,080	$ 21,886,523	$ 24,424,854	$ 23,830,405	$ 22,940,222	$ 27,260,424	$ 25,564,415	$ 25,701,762	$ 25,839,882	$ 25,978,778	$ 26,118,455	$ 295,998,864	$ 302,919,731	$ (6,920,867)
	UHC	$ 5,996,863	$ 6,253,041	$ 5,757,473	$ 6,252,312	$ 6,109,995	$ 5,922,200	$ 6,223,612	$ 6,860,581	$ 6,897,254	$ 6,934,133	$ 6,971,221	$ 7,008,517	$ 77,187,204	$ 81,139,100	$ (3,951,896)
	Total EPO	**$ 31,716,081**	**$ 30,881,858**	**$ 29,596,460**	**$ 32,678,587**	**$ 32,037,434**	**$ 30,782,457**	**$ 35,900,535**	**$ 34,301,255**	**$ 34,484,990**	**$ 34,669,759**	**$ 34,855,568**	**$ 35,042,422**	**$ 396,947,404**	**$ 406,539,615**	**$ (9,592,211)**
Rx Plan	ESI	$ 32,239,577	$ 31,829,184	$ 31,245,876	$ 33,663,040	$ 31,096,687	$ 35,218,793	$ 22,349,412	$ 28,824,202	$ 28,984,413	$ 29,145,530	$ 29,307,558	$ 29,470,503	$ 363,374,776	$ 361,063,641	$ 2,311,134
MH/SA	APS	$ 1,283,901	$ 1,227,871	$ 1,195,665	$ 1,263,379	$ 1,119,399	$ 1,166,957	$ 1,233,677	$ 1,108,800	$ 1,114,400	$ 1,120,032	$ 1,125,695	$ 1,131,391	$ 14,091,166	$ 13,282,172	$ 808,994
Total		**$107,286,716**	**$ 104,119,780**	**$ 99,796,510**	**$ 111,339,672**	**$ 104,649,636**	**$ 107,873,880**	**$ 104,239,384**	**$ 105,780,982**	**$ 106,344,130**	**$ 106,910,420**	**$ 107,479,870**	**$ 108,052,497**	**$ 1,273,873,478**	**$ 1,277,389,329**	**$ (3,515,851)**

Incurred Data Paid Through January, 2014 Then Projected																
Fully-Insured Plans[3]																
Plan Type	**Vendor**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**	**Apr-14**	**May-14**	**Jun-14**	**Total**	**FY 2014 Budget**	**Over/ (Under) Projection**
Dental Plans	DHMO	$ 733,311	$ 734,188	$ 732,476	$ 733,468	$ 737,342	$ 741,267	$ 729,400	$ 729,400	$ 729,400	$ 729,400	$ 729,400	$ 729,400	$ 8,788,454	$ 8,874,574	$ (86,120)
	DPPO	$ 3,401,185	$ 3,397,366	$ 3,392,982	$ 3,395,465	$ 3,417,537	$ 3,459,529	$ 3,401,390	$ 3,401,390	$ 3,401,390	$ 3,401,390	$ 3,401,390	$ 3,401,390	$ 40,872,402	$ 40,319,992	$ 552,410
Total		**$4,134,496**	**$ 4,131,554**	**$ 4,125,458**	**$ 4,128,933**	**$ 4,154,879**	**$ 4,200,797**	**$ 4,130,790**	**$ 4,130,790**	**$ 4,130,790**	**$ 4,130,790**	**$ 4,130,790**	**$ 4,130,790**	**$ 49,660,857**	**$ 49,194,567**	**$ 466,290**

Grand Total		**$111,421,212**	**$108,251,335**	**$ 103,921,968**	**$ 115,468,605**	**$ 108,804,514**	**$ 112,074,677**	**$ 108,370,174**	**$ 109,911,772**	**$ 110,474,920**	**$ 111,041,210**	**$ 111,610,660**	**$ 112,183,287**	**$ 1,323,534,335**	**$ 1,326,583,896**	**$ (3,049,561)**

Exhibit IIIb: FY 2014 Paid Cost Analysis

January, 2014

Paid Data Through December, 2013 Then Projected

Self-Funded Plans[1]

Plan Type	Vendor	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total	FY 2014 Budget[2]	Over/ (Under) Projection
POS Plans	Aetna	$ 2,482,526	$ 2,637,199	$ 2,479,391	$ 2,391,039	$ 2,098,751	$ 2,280,033	$ 2,413,573	$ 2,104,979	$ 2,116,579	$ 2,128,250	$ 2,139,990	$ 2,151,800	$ 27,424,111	$ 25,269,752	$ 2,154,359
	BCBS	$ 4,657,645	$ 6,386,273	$ 5,509,136	$ 5,127,598	$ 6,761,575	$ 5,136,753	$ 6,118,042	$ 5,378,942	$ 5,407,231	$ 5,435,680	$ 5,464,288	$ 5,493,057	$ 66,876,220	$ 64,522,975	$ 2,353,245
	UHC	$ 5,251,339	$ 4,481,853	$ 3,691,698	$ 4,625,774	$ 4,304,166	$ 4,453,502	$ 4,792,671	$ 4,362,080	$ 4,386,301	$ 4,410,666	$ 4,435,176	$ 4,459,832	$ 53,655,057	$ 52,316,094	$ 1,338,963
	Total POS	**$ 12,391,510**	**$ 13,505,325**	**$ 11,680,225**	**$ 12,144,411**	**$ 13,164,492**	**$ 11,870,288**	**$ 13,324,286**	**$ 11,846,001**	**$ 11,910,112**	**$ 11,974,595**	**$ 12,039,454**	**$ 12,104,689**	**$ 147,955,388**	**$ 142,108,821**	**$ 5,846,567**
PPO Plans	BCBS	$ 22,874,397	$ 28,783,971	$ 24,801,724	$ 23,834,717	$ 30,011,296	$ 23,881,171	$ 27,897,729	$ 27,186,548	$ 27,321,930	$ 27,458,024	$ 27,594,834	$ 27,732,364	$ 319,478,706	$ 324,389,130	$ (4,910,424)
	UHC	$ 2,744,277	$ 3,316,195	$ 2,043,987	$ 2,945,228	$ 2,301,196	$ 2,556,639	$ 3,196,484	$ 2,514,176	$ 2,528,286	$ 2,542,481	$ 2,556,761	$ 2,571,128	$ 31,816,836	$ 30,005,950	$ 1,810,887
	Total PPO	**$ 25,718,674**	**$ 32,100,166**	**$ 26,845,711**	**$ 26,779,945**	**$ 32,312,492**	**$ 26,437,809**	**$ 31,094,213**	**$ 29,700,724**	**$ 29,850,216**	**$ 30,000,505**	**$ 30,151,595**	**$ 30,303,492**	**$ 351,295,542**	**$ 354,395,079**	**$ (3,099,537)**
EPO Plans	Aetna	$ 1,839,398	$ 2,203,543	$ 1,928,613	$ 2,039,846	$ 1,853,922	$ 2,035,977	$ 2,286,157	$ 1,876,259	$ 1,885,974	$ 1,895,744	$ 1,905,569	$ 1,915,449	$ 23,666,451	$ 22,480,784	$ 1,185,667
	BCBS	$ 18,408,301	$ 24,709,615	$ 22,441,757	$ 22,224,252	$ 27,609,555	$ 20,712,393	$ 26,730,421	$ 25,564,415	$ 25,701,762	$ 25,839,882	$ 25,978,778	$ 26,118,455	$ 292,039,585	$ 302,919,731	$ (10,880,146)
	UHC	$ 5,458,602	$ 6,281,608	$ 5,648,059	$ 6,261,927	$ 5,740,961	$ 6,149,290	$ 6,437,699	$ 6,860,581	$ 6,897,254	$ 6,934,133	$ 6,971,221	$ 7,008,517	$ 76,649,853	$ 81,139,100	$ (4,489,247)
	Total EPO	**$ 25,706,300**	**$ 33,194,766**	**$ 30,018,429**	**$ 30,526,025**	**$ 35,204,438**	**$ 28,897,661**	**$ 35,454,277**	**$ 34,301,255**	**$ 34,484,990**	**$ 34,669,759**	**$ 34,855,568**	**$ 35,042,422**	**$ 392,355,889**	**$ 406,539,615**	**$ (14,183,726)**
Rx Plan	ESI	$ 32,198,695	$ 32,012,303	$ 31,285,616	$ 33,825,286	$ 30,663,968	$ 35,328,242	$ 22,448,878	$ 28,824,202	$ 28,984,413	$ 29,145,530	$ 29,307,558	$ 29,470,503	$ 363,495,194	$ 361,063,641	$ 2,431,553
MH/SA	APS	$ 1,402,866	$ 1,277,199	$ 1,159,076	$ 1,244,428	$ 1,221,086	$ 1,253,513	$ 1,255,496	$ 1,108,800	$ 1,114,400	$ 1,120,032	$ 1,125,695	$ 1,131,391	$ 14,413,981	$ 13,282,172	$ 1,131,809
Total		**$ 97,418,045**	**$ 112,089,758**	**$ 100,989,058**	**$ 104,520,094**	**$ 112,566,476**	**$ 103,787,512**	**$ 103,577,150**	**$ 105,780,982**	**$ 106,344,130**	**$ 106,910,420**	**$ 107,479,870**	**$ 108,052,497**	**$ 1,269,515,994**	**$ 1,277,389,329**	**$ (7,873,335)**

Paid Data Through December, 2013 Then Projected

Fully-Insured Plans[3]

Plan Type	Vendor	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total	FY 2014 Budget	Over/ (Under) Projection
Dental Plans	DHMO	$ 733,311	$ 734,188	$ 732,476	$ 733,468	$ 737,342	$ 741,267	$ 729,400	$ 729,400	$ 729,400	$ 729,400	$ 729,400	$ 729,400	$ 8,788,454	$ 8,874,574	$ (86,120)
	DPPO	$ 3,401,185	$ 3,397,366	$ 3,392,982	$ 3,395,465	$ 3,417,537	$ 3,459,529	$ 3,401,390	$ 3,401,390	$ 3,401,390	$ 3,401,390	$ 3,401,390	$ 3,401,390	$ 40,872,402	$ 40,319,992	$ 552,410
Total		**$4,134,496**	**$ 4,131,554**	**$ 4,125,458**	**$ 4,128,933**	**$ 4,154,879**	**$ 4,200,797**	**$ 4,130,790**	**$ 4,130,790**	**$ 4,130,790**	**$ 4,130,790**	**$ 4,130,790**	**$ 4,130,790**	**$ 49,660,857**	**$ 49,194,567**	**$ 466,290**

Grand Total		**$101,552,541**	**$116,221,313**	**$ 105,114,516**	**$ 108,649,028**	**$ 116,721,355**	**$ 107,988,309**	**$ 107,707,940**	**$ 109,911,772**	**$ 110,474,920**	**$ 111,041,210**	**$ 111,610,660**	**$ 112,183,287**	**$ 1,319,176,851**	**$ 1,326,583,896**	**$ (7,407,045)**

Exhibit IV: Active Enrollment Summary

January, 2014

		Actual Enrollment Through January, 2014 Then Projected												
Plan	Budget FY 2014	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Average
Aetna POS														
Individual	1,140	1,228	1,228	1,241	1,284	1,309	1,293	1,301	1,301	1,301	1,301	1,301	1,301	1,282
Double	525	626	626	621	638	636	648	661	661	661	661	661	661	647
Family	700	883	886	880	884	891	905	921	921	921	921	921	921	905
Total	**2,365**	**2,737**	**2,740**	**2,742**	**2,806**	**2,836**	**2,846**	**2,883**	**2,883**	**2,883**	**2,883**	**2,883**	**2,883**	**2,834**
BCBS POS														
Individual	2,172	2,476	2,469	2,455	2,466	2,478	2,431	2,466	2,466	2,466	2,466	2,466	2,466	2,464
Double	1,167	1,525	1,528	1,514	1,524	1,529	1,546	1,563	1,563	1,563	1,563	1,563	1,563	1,545
Family	1,891	2,430	2,422	2,415	2,414	2,421	2,445	2,472	2,472	2,472	2,472	2,472	2,472	2,448
Total	**5,230**	**6,431**	**6,419**	**6,384**	**6,404**	**6,428**	**6,422**	**6,501**	**6,501**	**6,501**	**6,501**	**6,501**	**6,501**	**6,458**
UHC POS														
Individual	1,280	1,436	1,436	1,426	1,430	1,428	1,412	1,433	1,433	1,433	1,433	1,433	1,433	1,431
Double	720	1,014	1,006	1,002	997	1,000	1,022	1,020	1,020	1,020	1,020	1,020	1,020	1,013
Family	1,004	1,403	1,399	1,389	1,380	1,387	1,392	1,406	1,406	1,406	1,406	1,406	1,406	1,399
Total	**3,004**	**3,853**	**3,841**	**3,817**	**3,807**	**3,815**	**3,826**	**3,859**	**3,859**	**3,859**	**3,859**	**3,859**	**3,859**	**3,843**
BCBS PPO														
Individual	8,377	8,829	8,778	8,736	8,733	8,756	8,672	8,698	8,698	8,698	8,698	8,698	8,698	8,724
Double	5,080	5,605	5,599	5,586	5,562	5,561	5,641	5,691	5,691	5,691	5,691	5,691	5,691	5,642
Family	5,598	6,377	6,354	6,335	6,336	6,384	6,419	6,491	6,491	6,491	6,491	6,491	6,491	6,429
Total	**19,055**	**20,811**	**20,731**	**20,657**	**20,631**	**20,701**	**20,732**	**20,880**	**20,880**	**20,880**	**20,880**	**20,880**	**20,880**	**20,795**
UHC PPO														
Individual	845	930	941	962	987	1,014	991	1,006	1,006	1,006	1,006	1,006	1,006	988
Double	481	522	521	516	511	509	530	545	545	545	545	545	545	532
Family	460	510	510	512	510	528	540	552	552	552	552	552	552	535
Total	**1,786**	**1,962**	**1,972**	**1,990**	**2,008**	**2,051**	**2,061**	**2,103**	**2,103**	**2,103**	**2,103**	**2,103**	**2,103**	**2,055**
Aetna EPO														
Individual	900	1,058	1,074	1,128	1,224	1,308	1,282	1,355	1,355	1,355	1,355	1,355	1,355	1,267
Double	586	569	572	576	595	609	615	657	657	657	657	657	657	623
Family	978	927	939	943	957	972	987	1,035	1,035	1,035	1,035	1,035	1,035	995
Total	**2,464**	**2,554**	**2,585**	**2,647**	**2,776**	**2,889**	**2,884**	**3,047**	**3,047**	**3,047**	**3,047**	**3,047**	**3,047**	**2,885**
BCBS EPO														
Individual	10,445	9,244	9,235	9,179	9,244	9,352	9,179	9,372	9,372	9,372	9,372	9,372	9,372	9,305
Double	7,381	6,112	6,103	6,080	6,074	6,124	6,178	6,246	6,246	6,246	6,246	6,246	6,246	6,179
Family	9,033	7,617	7,627	7,584	7,578	7,638	7,664	7,834	7,834	7,834	7,834	7,834	7,834	7,726
Total	**26,859**	**22,973**	**22,965**	**22,843**	**22,896**	**23,114**	**23,021**	**23,452**	**23,452**	**23,452**	**23,452**	**23,452**	**23,452**	**23,210**
UHC EPO														
Individual	2,057	1,795	1,800	1,790	1,800	1,844	1,818	1,844	1,844	1,844	1,844	1,844	1,844	1,826
Double	1,876	1,529	1,523	1,511	1,496	1,501	1,511	1,526	1,526	1,526	1,526	1,526	1,526	1,519
Family	2,850	2,403	2,389	2,381	2,385	2,401	2,401	2,429	2,429	2,429	2,429	2,429	2,429	2,411
Total	**6,783**	**5,727**	**5,712**	**5,682**	**5,681**	**5,746**	**5,730**	**5,799**	**5,799**	**5,799**	**5,799**	**5,799**	**5,799**	**5,756**
Grand Total	**67,546**	**67,048**	**66,965**	**66,762**	**67,009**	**67,580**	**67,522**	**68,524**	**68,524**	**68,524**	**68,524**	**68,524**	**68,524**	**67,836**

Exhibit V: SLEOLA Enrollment Summary

January, 2014

		Actual Enrollment Through January, 2014 Then Projected												
Plan	Budget FY 2014	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Average
Aetna POS														
Individual	33	28	27	26	27	26	28	28	28	28	28	28	28	28
Double	15	10	10	10	10	11	11	10	10	10	10	10	10	10
Family	53	33	34	34	35	35	35	36	36	36	36	36	36	35
Total	**101**	**71**	**71**	**70**	**72**	**72**	**74**	**74**	**74**	**74**	**74**	**74**	**74**	**73**
BCBS POS														
Individual	87	54	52	51	54	55	50	52	52	52	52	52	52	52
Double	44	24	27	27	27	27	26	26	26	26	26	26	26	26
Family	218	138	137	136	136	137	138	138	138	138	138	138	138	138
Total	**349**	**216**	**216**	**214**	**217**	**219**	**214**	**216**	**216**	**216**	**216**	**216**	**216**	**216**
UHC POS														
Individual	45	29	28	29	29	29	29	29	29	29	29	29	29	29
Double	42	26	26	26	26	27	26	27	27	27	27	27	27	27
Family	144	88	88	88	87	86	82	83	83	83	83	83	83	85
Total	**231**	**143**	**142**	**143**	**142**	**142**	**137**	**139**	**139**	**139**	**139**	**139**	**139**	**140**
BCBS PPO														
Individual	371	223	219	217	222	214	213	210	210	210	210	210	210	214
Double	186	124	126	128	126	129	129	133	133	133	133	133	133	130
Family	533	362	364	361	363	364	362	359	359	359	359	359	359	361
Total	**1,090**	**709**	**709**	**706**	**711**	**707**	**704**	**702**	**702**	**702**	**702**	**702**	**702**	**705**
UHC PPO														
Individual	39	34	36	37	37	36	37	38	38	38	38	38	38	37
Double	20	13	13	12	12	13	13	12	12	12	12	12	12	12
Family	38	23	22	22	21	22	21	23	23	23	23	23	23	22
Total	**97**	**70**	**71**	**71**	**70**	**71**	**71**	**73**	**73**	**73**	**73**	**73**	**73**	**72**
Aetna EPO														
Individual	6	8	8	8	8	8	9	9	9	9	9	9	9	9
Double	2	3	3	3	3	3	3	3	3	3	3	3	3	3
Family	9	11	12	12	12	12	12	12	12	12	12	12	12	12
Total	**17**	**22**	**23**	**23**	**23**	**23**	**24**	**24**	**24**	**24**	**24**	**24**	**24**	**24**
BCBS EPO														
Individual	75	56	57	57	59	58	58	56	56	56	56	56	56	57
Double	42	32	32	33	33	34	35	36	36	36	36	36	36	35
Family	174	127	127	126	125	125	127	126	126	126	126	126	126	126
Total	**291**	**215**	**216**	**216**	**217**	**217**	**220**	**218**	**218**	**218**	**218**	**218**	**218**	**217**
UHC EPO														
Individual	15	9	9	9	10	10	10	10	10	10	10	10	10	10
Double	17	9	9	9	8	10	9	10	10	10	10	10	10	10
Family	68	46	47	45	45	44	45	45	45	45	45	45	45	45
Total	**100**	**64**	**65**	**63**	**63**	**64**	**64**	**65**	**65**	**65**	**65**	**65**	**65**	**64**
Grand Total	**2,276**	**1,510**	**1,513**	**1,506**	**1,515**	**1,515**	**1,508**	**1,511**	**1,511**	**1,511**	**1,511**	**1,511**	**1,511**	**1,511**

Exhibit VI: Satellite Enrollment Summary

January, 2014

		Actual Enrollment Through January, 2014 Then Projected												
Plan	Budget FY 2014	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Average
Aetna POS														
Individual	175	167	174	174	171	168	165	169	169	169	169	169	169	169
Double	33	33	32	33	31	31	32	33	33	33	33	33	33	33
Family	34	33	32	32	31	31	32	32	32	32	32	32	32	32
Total	**242**	**233**	**238**	**239**	**233**	**230**	**229**	**234**	**234**	**234**	**234**	**234**	**234**	**234**
BCBS POS														
Individual	197	121	120	121	117	115	113	115	115	115	115	115	115	116
Double	81	65	63	64	63	62	65	66	66	66	66	66	66	65
Family	65	98	95	95	92	94	98	97	97	97	97	97	97	96
Total	**343**	**284**	**278**	**280**	**272**	**271**	**276**	**278**	**278**	**278**	**278**	**278**	**278**	**277**
UHC POS														
Individual	66	53	53	53	54	53	53	53	53	53	53	53	53	53
Double	28	35	33	31	30	30	34	35	35	35	35	35	35	34
Family	41	46	45	46	45	46	45	46	46	46	46	46	46	46
Total	**135**	**134**	**131**	**130**	**129**	**129**	**132**	**134**	**134**	**134**	**134**	**134**	**134**	**132**
BCBS PPO														
Individual	378	340	332	330	321	323	316	320	320	320	320	320	320	324
Double	206	219	218	223	213	212	219	228	228	228	228	228	228	223
Family	193	199	197	197	192	196	196	202	202	202	202	202	202	199
Total	**777**	**758**	**747**	**750**	**726**	**731**	**731**	**750**	**750**	**750**	**750**	**750**	**750**	**745**
UHC PPO														
Individual	44	37	39	38	37	37	36	39	39	39	39	39	39	38
Double	16	18	18	16	16	16	17	18	18	18	18	18	18	17
Family	26	22	22	24	26	25	26	26	26	26	26	26	26	25
Total	**86**	**77**	**79**	**78**	**79**	**78**	**79**	**83**	**83**	**83**	**83**	**83**	**83**	**81**
Aetna EPO														
Individual	31	62	62	67	69	67	67	64	64	64	64	64	64	65
Double	31	29	29	28	26	25	27	28	28	28	28	28	28	28
Family	26	31	28	29	29	29	30	31	31	31	31	31	31	30
Total	**88**	**122**	**119**	**124**	**124**	**121**	**124**	**123**	**123**	**123**	**123**	**123**	**123**	**123**
BCBS EPO														
Individual	642	431	430	428	415	419	413	416	416	416	416	416	416	419
Double	307	231	227	227	219	217	230	233	233	233	233	233	233	229
Family	304	237	231	230	229	229	238	243	243	243	243	243	243	238
Total	**1,253**	**899**	**888**	**885**	**863**	**865**	**881**	**892**	**892**	**892**	**892**	**892**	**892**	**886**
UHC EPO														
Individual	113	85	84	84	85	85	84	84	84	84	84	84	84	84
Double	67	51	49	48	48	48	49	47	47	47	47	47	47	48
Family	92	66	62	61	62	62	64	65	65	65	65	65	65	64
Total	**272**	**202**	**195**	**193**	**195**	**195**	**197**	**196**	**196**	**196**	**196**	**196**	**196**	**196**
Grand Total	**3,196**	**2,709**	**2,675**	**2,679**	**2,621**	**2,620**	**2,649**	**2,690**	**2,690**	**2,690**	**2,690**	**2,690**	**2,690**	**2,674**

Exhibit VII: Direct Pay Enrollment Summary

January, 2014

		Actual Enrollment Through January, 2014 Then Projected												
Plan	Budget FY 2014	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Average
Aetna POS														
Individual	58	50	49	52	53	51	47	51	51	51	51	51	51	51
Double	7	15	16	15	17	17	17	19	19	19	19	19	19	18
Family	12	12	14	14	14	14	12	18	18	18	18	18	18	16
Total	**77**	**77**	**79**	**81**	**84**	**82**	**76**	**88**	**88**	**88**	**88**	**88**	**88**	**84**
BCBS POS														
Individual	190	196	186	196	200	197	186	189	189	189	189	189	189	191
Double	69	71	72	69	64	63	66	76	76	76	76	76	76	72
Family	42	37	43	39	38	34	36	46	46	46	46	46	46	42
Total	**301**	**304**	**301**	**304**	**302**	**294**	**288**	**311**	**311**	**311**	**311**	**311**	**311**	**305**
UHC POS														
Individual	119	106	109	108	106	110	103	99	99	99	99	99	99	103
Double	32	28	29	31	31	30	32	35	35	35	35	35	35	33
Family	15	16	15	14	14	14	15	16	16	16	16	16	16	15
Total	**166**	**150**	**153**	**153**	**151**	**154**	**150**	**150**	**150**	**150**	**150**	**150**	**150**	**151**
BCBS PPO														
Individual	777	759	742	761	747	738	695	729	729	729	729	729	729	735
Double	240	266	272	272	273	276	285	295	295	295	295	295	295	285
Family	99	96	88	95	92	91	109	117	117	117	117	117	117	106
Total	**1,116**	**1,121**	**1,102**	**1,128**	**1,112**	**1,105**	**1,089**	**1,141**	**1,141**	**1,141**	**1,141**	**1,141**	**1,141**	**1,125**
UHC PPO														
Individual	75	95	97	97	94	94	88	88	88	88	88	88	88	91
Double	40	37	38	37	37	40	37	42	42	42	42	42	42	40
Family	11	12	10	6	10	9	12	15	15	15	15	15	15	12
Total	**126**	**144**	**145**	**140**	**141**	**143**	**137**	**145**	**145**	**145**	**145**	**145**	**145**	**143**
Aetna EPO														
Individual	25	58	55	53	52	55	53	59	59	59	59	59	59	57
Double	2	7	7	7	8	10	7	12	12	12	12	12	12	10
Family	3	6	7	7	4	6	8	12	12	12	12	12	12	9
Total	**30**	**71**	**69**	**67**	**64**	**71**	**68**	**83**	**83**	**83**	**83**	**83**	**83**	**76**
BCBS EPO														
Individual	234	240	235	239	230	235	212	244	244	244	244	244	244	238
Double	55	57	62	57	58	57	67	75	75	75	75	75	75	67
Family	42	52	56	54	52	57	63	73	73	73	73	73	73	64
Total	**331**	**349**	**353**	**350**	**340**	**349**	**342**	**392**	**392**	**392**	**392**	**392**	**392**	**370**
UHC EPO														
Individual	49	48	42	42	43	43	41	42	42	42	42	42	42	43
Double	11	11	11	12	12	10	11	13	13	13	13	13	13	12
Family	15	12	16	16	18	16	17	21	21	21	21	21	21	18
Total	**75**	**71**	**69**	**70**	**73**	**69**	**69**	**76**	**76**	**76**	**76**	**76**	**76**	**73**
Grand Total	**2,222**	**2,287**	**2,271**	**2,293**	**2,267**	**2,267**	**2,219**	**2,386**	**2,386**	**2,386**	**2,386**	**2,386**	**2,386**	**2,327**

Exhibit VIII: Pre-65 Retiree Enrollment Summary

January, 2014

		Actual Enrollment Through January, 2014 Then Projected												
Plan	Budget FY 2014	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Average
Aetna POS														
Individual	131	134	134	131	131	134	136	135	135	135	135	135	135	134
Double	90	88	91	92	90	86	87	85	85	85	85	85	85	87
Family	78	72	72	74	73	74	74	73	73	73	73	73	73	73
Total	**299**	**294**	**297**	**297**	**294**	**294**	**297**	**293**	**293**	**293**	**293**	**293**	**293**	**294**
BCBS POS														
Individual	366	371	366	368	367	366	362	355	355	355	355	355	355	361
Double	374	342	337	336	333	333	336	331	331	331	331	331	331	334
Family	270	262	259	260	262	257	263	262	262	262	262	262	262	261
Total	**1,010**	**975**	**962**	**964**	**962**	**956**	**961**	**948**	**948**	**948**	**948**	**948**	**948**	**956**
UHC POS														
Individual	450	392	386	383	382	385	382	374	374	374	374	374	374	380
Double	412	381	376	372	371	374	377	365	365	365	365	365	365	370
Family	330	326	327	323	322	317	322	321	321	321	321	321	321	322
Total	**1,192**	**1,099**	**1,089**	**1,078**	**1,075**	**1,076**	**1,081**	**1,060**	**1,060**	**1,060**	**1,060**	**1,060**	**1,060**	**1,072**
BCBS PPO														
Individual	2,389	2,137	2,122	2,107	2,088	2,091	2,067	2,012	2,012	2,012	2,012	2,012	2,012	2,057
Double	1,760	1,519	1,492	1,480	1,466	1,470	1,463	1,416	1,416	1,416	1,416	1,416	1,416	1,449
Family	882	831	824	842	835	828	833	824	824	824	824	824	824	828
Total	**5,031**	**4,487**	**4,438**	**4,429**	**4,389**	**4,389**	**4,363**	**4,252**	**4,252**	**4,252**	**4,252**	**4,252**	**4,252**	**4,334**
UHC PPO														
Individual	184	162	166	165	162	160	158	157	157	157	157	157	157	160
Double	131	112	113	110	112	111	112	112	112	112	112	112	112	112
Family	62	62	60	59	60	59	58	59	59	59	59	59	59	59
Total	**377**	**336**	**339**	**334**	**334**	**330**	**328**	**328**	**328**	**328**	**328**	**328**	**328**	**331**
Aetna EPO														
Individual	39	48	51	52	52	52	52	52	52	52	52	52	52	52
Double	32	40	40	41	42	43	46	45	45	45	45	45	45	44
Family	35	35	35	35	35	36	39	39	39	39	39	39	39	37
Total	**106**	**123**	**126**	**128**	**129**	**131**	**137**	**136**	**136**	**136**	**136**	**136**	**136**	**133**
BCBS EPO														
Individual	947	1,089	1,102	1,110	1,114	1,131	1,163	1,136	1,136	1,136	1,136	1,136	1,136	1,127
Double	890	803	798	799	790	800	823	809	809	809	809	809	809	806
Family	462	513	516	517	516	519	536	530	530	530	530	530	530	525
Total	**2,299**	**2,405**	**2,416**	**2,426**	**2,420**	**2,450**	**2,522**	**2,475**	**2,475**	**2,475**	**2,475**	**2,475**	**2,475**	**2,457**
UHC EPO														
Individual	227	228	229	228	229	232	227	224	224	224	224	224	224	226
Double	250	244	245	245	247	250	254	247	247	247	247	247	247	247
Family	159	163	161	162	163	166	174	173	173	173	173	173	173	169
Total	**636**	**635**	**635**	**635**	**639**	**648**	**655**	**644**	**644**	**644**	**644**	**644**	**644**	**643**
Grand Total	**10,950**	**10,354**	**10,302**	**10,291**	**10,242**	**10,274**	**10,344**	**10,136**	**10,136**	**10,136**	**10,136**	**10,136**	**10,136**	**10,219**

Exhibit IX: Post-65 Retiree Enrollment Summary

January, 2014

		Actual Enrollment Through January, 2014 Then Projected												
Plan	Budget FY 2014	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Average
Aetna POS														
Individual	287	309	310	312	315	315	318	318	318	318	318	318	318	316
Two Person	214	237	239	240	239	241	252	247	247	247	247	247	247	244
Three Person	20	22	21	21	20	21	19	19	19	19	19	19	19	20
Family	9	11	11	11	11	11	10	10	10	10	10	10	10	10
Total	**530**	**579**	**581**	**584**	**585**	**588**	**599**	**594**	**594**	**594**	**594**	**594**	**594**	**590**
BCBS POS														
Individual	1,464	1,522	1,536	1,544	1,544	1,546	1,528	1,523	1,523	1,523	1,523	1,523	1,523	1,530
Two Person	1,102	1,154	1,152	1,160	1,161	1,161	1,163	1,149	1,149	1,149	1,149	1,149	1,149	1,154
Three Person	53	64	66	63	64	64	72	73	73	73	73	73	73	69
Family	39	43	42	43	43	42	39	38	38	38	38	38	38	40
Total	**2,658**	**2,783**	**2,796**	**2,810**	**2,812**	**2,813**	**2,802**	**2,783**	**2,783**	**2,783**	**2,783**	**2,783**	**2,783**	**2,793**
UHC POS														
Individual	1,343	1,445	1,443	1,453	1,463	1,470	1,468	1,454	1,454	1,454	1,454	1,454	1,454	1,456
Two Person	1,187	1,235	1,240	1,245	1,236	1,245	1,257	1,244	1,244	1,244	1,244	1,244	1,244	1,244
Three Person	74	69	70	69	71	71	71	64	64	64	64	64	64	67
Family	37	47	46	46	46	46	43	43	43	43	43	43	43	44
Total	**2,641**	**2,796**	**2,799**	**2,813**	**2,816**	**2,832**	**2,839**	**2,805**	**2,805**	**2,805**	**2,805**	**2,805**	**2,805**	**2,810**
BCBS PPO														
Individual	10,789	11,186	11,224	11,244	11,278	11,297	11,331	11,277	11,277	11,277	11,277	11,277	11,277	11,269
Two Person	6,733	6,831	6,835	6,833	6,845	6,854	6,993	6,895	6,895	6,895	6,895	6,895	6,895	6,880
Three Person	320	329	327	331	333	337	333	327	327	327	327	327	327	329
Family	161	155	159	158	154	148	149	142	142	142	142	142	142	148
Total	**18,003**	**18,501**	**18,545**	**18,566**	**18,610**	**18,636**	**18,806**	**18,641**	**18,641**	**18,641**	**18,641**	**18,641**	**18,641**	**18,626**
UHC PPO														
Individual	1,216	1,268	1,267	1,266	1,267	1,262	1,264	1,256	1,256	1,256	1,256	1,256	1,256	1,261
Two Person	775	773	767	762	760	756	762	755	755	755	755	755	755	759
Three Person	22	26	27	28	28	29	29	28	28	28	28	28	28	28
Family	13	14	14	14	14	14	13	13	13	13	13	13	13	13
Total	**2,026**	**2,081**	**2,075**	**2,070**	**2,069**	**2,061**	**2,068**	**2,052**	**2,052**	**2,052**	**2,052**	**2,052**	**2,052**	**2,061**
Aetna EPO														
Individual	28	39	42	43	43	43	45	44	44	44	44	44	44	43
Two Person	37	44	45	45	45	44	55	55	55	55	55	55	55	51
Three Person	5	6	6	6	6	6	7	7	7	7	7	7	7	7
Family	6	5	5	5	5	4	5	5	5	5	5	5	5	5
Total	**76**	**94**	**98**	**99**	**99**	**97**	**112**	**111**	**111**	**111**	**111**	**111**	**111**	**105**
BCBS POS														
Individual	1,666	1,907	1,922	1,940	1,954	1,970	2,171	2,165	2,165	2,165	2,165	2,165	2,165	2,071
Two Person	1,438	1,714	1,726	1,744	1,759	1,788	2,021	1,988	1,988	1,988	1,988	1,988	1,988	1,890
Three Person	108	141	141	141	142	145	157	156	156	156	156	156	156	150
Family	46	56	56	58	58	58	57	57	57	57	57	57	57	57
Total	**3,258**	**3,818**	**3,845**	**3,883**	**3,913**	**3,961**	**4,406**	**4,366**	**4,366**	**4,366**	**4,366**	**4,366**	**4,366**	**4,169**
UHC EPO														
Individual	365	397	404	410	416	418	448	445	445	445	445	445	445	430
Two Person	349	380	390	390	393	398	442	437	437	437	437	437	437	418
Three Person	32	35	36	37	37	36	39	39	39	39	39	39	39	38
Family	20	22	21	21	22	23	23	21	21	21	21	21	21	22
Total	**766**	**834**	**851**	**858**	**868**	**875**	**952**	**942**	**942**	**942**	**942**	**942**	**942**	**908**
Grand Total	**29,958**	**31,486**	**31,590**	**31,683**	**31,772**	**31,863**	**32,584**	**32,294**	**32,294**	**32,294**	**32,294**	**32,294**	**32,294**	**32,062**

Exhibit X: Aggregate POS Enrollment Summary

January, 2014

		Actual Enrollment Through January, 2014 Then Projected												
Plan	Budget FY 2014	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Average
Aetna POS														
Individual	1,537	1,607	1,612	1,624	1,666	1,688	1,669	1,684	1,684	1,684	1,684	1,684	1,684	1,664
Double	670	772	775	771	786	781	795	808	808	808	808	808	808	794
Family	877	1,033	1,038	1,034	1,037	1,045	1,058	1,080	1,080	1,080	1,080	1,080	1,080	1,060
Indiv. Medicare	287	309	310	312	315	315	318	318	318	318	318	318	318	316
2, 1 with Medicare	88	92	93	95	94	94	100	95	95	95	95	95	95	95
2, both Medicare	126	145	146	145	145	147	152	152	152	152	152	152	152	149
3, 1 with Medicare	18	20	19	19	18	19	17	17	17	17	17	17	17	18
3, 2 with Medicare	2	2	2	2	2	2	2	2	2	2	2	2	2	2
3+, all with Medicare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4+, 1 not Medicare	9	11	11	11	11	11	10	10	10	10	10	10	10	10
Total	**3,614**	**3,991**	**4,006**	**4,013**	**4,074**	**4,102**	**4,121**	**4,166**	**4,166**	**4,166**	**4,166**	**4,166**	**4,166**	**4,109**
BCBS POS														
Individual	3,012	3,218	3,193	3,191	3,204	3,211	3,142	3,177	3,177	3,177	3,177	3,177	3,177	3,185
Double	1,735	2,027	2,027	2,010	2,011	2,014	2,039	2,062	2,062	2,062	2,062	2,062	2,062	2,042
Family	2,486	2,965	2,956	2,945	2,942	2,943	2,980	3,015	3,015	3,015	3,015	3,015	3,015	2,985
Indiv. Medicare	1,464	1,522	1,536	1,544	1,544	1,546	1,528	1,523	1,523	1,523	1,523	1,523	1,523	1,530
2, 1 with Medicare	288	286	283	284	281	277	292	280	280	280	280	280	280	282
2, both Medicare	814	868	869	876	880	884	871	869	869	869	869	869	869	872
3, 1 with Medicare	40	43	43	42	43	44	47	49	49	49	49	49	49	46
3, 2 with Medicare	7	16	18	16	16	15	18	17	17	17	17	17	17	17
3+, all with Medicare	6	5	5	5	5	5	7	7	7	7	7	7	7	6
4+, 1 not Medicare	39	43	42	43	43	42	39	38	38	38	38	38	38	40
Total	**9,891**	**10,993**	**10,972**	**10,956**	**10,969**	**10,981**	**10,963**	**11,037**	**11,037**	**11,037**	**11,037**	**11,037**	**11,037**	**11,005**
UHC POS														
Individual	1,960	2,016	2,012	1,999	2,001	2,005	1,979	1,988	1,988	1,988	1,988	1,988	1,988	1,995
Double	1,234	1,484	1,470	1,462	1,455	1,461	1,491	1,482	1,482	1,482	1,482	1,482	1,482	1,476
Family	1,534	1,879	1,874	1,860	1,848	1,850	1,856	1,872	1,872	1,872	1,872	1,872	1,872	1,867
Indiv. Medicare	1,343	1,445	1,443	1,453	1,463	1,470	1,468	1,454	1,454	1,454	1,454	1,454	1,454	1,456
2, 1 with Medicare	325	333	334	338	331	336	351	340	340	340	340	340	340	339
2, both Medicare	862	902	906	907	905	909	906	904	904	904	904	904	904	905
3, 1 with Medicare	60	53	54	54	55	55	54	47	47	47	47	47	47	51
3, 2 with Medicare	12	14	14	13	14	14	15	15	15	15	15	15	15	15
3+, all with Medicare	2	2	2	2	2	2	2	2	2	2	2	2	2	2
4+, 1 not Medicare	37	47	46	46	46	46	43	43	43	43	43	43	43	44
Total	**7,369**	**8,175**	**8,155**	**8,134**	**8,120**	**8,148**	**8,165**	**8,147**	**8,147**	**8,147**	**8,147**	**8,147**	**8,147**	**8,148**
Grand Total	**20,874**	**23,159**	**23,133**	**23,103**	**23,163**	**23,231**	**23,249**	**23,350**	**23,350**	**23,350**	**23,350**	**23,350**	**23,350**	**23,262**
Total Members	**41,375**	**47,254**	**47,195**	**47,063**	**47,093**	**47,206**	**47,467**	**47,754**	**47,754**	**47,754**	**47,754**	**47,754**	**47,754**	**47,485**

Exhibit XI: Aggregate PPO Enrollment Summary

January, 2014

		Actual Enrollment Through January, 2014 Then Projected												
Plan	Budget FY 2014	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Average
BCBS PPO														
Individual	12,292	12,288	12,193	12,151	12,111	12,122	11,963	11,969	11,969	11,969	11,969	11,969	11,969	12,054
Double	7,472	7,733	7,707	7,689	7,640	7,648	7,737	7,763	7,763	7,763	7,763	7,763	7,763	7,728
Family	7,305	7,865	7,827	7,830	7,818	7,863	7,919	7,993	7,993	7,993	7,993	7,993	7,993	7,923
Indiv. Medicare	10,789	11,186	11,224	11,244	11,278	11,297	11,331	11,277	11,277	11,277	11,277	11,277	11,277	11,269
2, 1 with Medicare	1,709	1,644	1,641	1,635	1,628	1,630	1,649	1,577	1,577	1,577	1,577	1,577	1,577	1,607
2, both Medicare	5,024	5,187	5,194	5,198	5,217	5,224	5,344	5,318	5,318	5,318	5,318	5,318	5,318	5,273
3, 1 with Medicare	231	213	215	222	220	223	219	214	214	214	214	214	214	216
3, 2 with Medicare	73	99	95	92	94	95	95	94	94	94	94	94	94	95
3+, all with Medicare	16	17	17	17	19	19	19	19	19	19	19	19	19	19
4+, 1 not Medicare	161	155	159	158	154	148	149	142	142	142	142	142	142	148
Total	**45,072**	**46,387**	**46,272**	**46,236**	**46,179**	**46,269**	**46,425**	**46,366**	**46,366**	**46,366**	**46,366**	**46,366**	**46,366**	**46,330**
UHC PPO														
Individual	1,187	1,258	1,279	1,299	1,317	1,341	1,310	1,328	1,328	1,328	1,328	1,328	1,328	1,314
Double	688	702	703	691	688	689	709	729	729	729	729	729	729	713
Family	597	629	624	623	627	643	657	675	675	675	675	675	675	654
Indiv. Medicare	1,216	1,268	1,267	1,266	1,267	1,262	1,264	1,256	1,256	1,256	1,256	1,256	1,256	1,261
2, 1 with Medicare	170	143	143	141	140	138	139	133	133	133	133	133	133	137
2, both Medicare	605	630	624	621	620	618	623	622	622	622	622	622	622	622
3, 1 with Medicare	16	19	20	21	21	22	22	21	21	21	21	21	21	21
3, 2 with Medicare	3	5	5	5	5	5	5	5	5	5	5	5	5	5
3+, all with Medicare	3	2	2	2	2	2	2	2	2	2	2	2	2	2
4+, 1 not Medicare	13	14	14	14	14	14	13	13	13	13	13	13	13	13
Total	**4,498**	**4,670**	**4,681**	**4,683**	**4,701**	**4,734**	**4,744**	**4,784**	**4,784**	**4,784**	**4,784**	**4,784**	**4,784**	**4,743**
Grand Total	**49,570**	**51,057**	**50,953**	**50,919**	**50,880**	**51,003**	**51,169**	**51,150**	**51,150**	**51,150**	**51,150**	**51,150**	**51,150**	**51,073**
Total Members	**88,728**	**92,266**	**92,024**	**91,965**	**91,854**	**92,155**	**92,764**	**92,911**	**92,911**	**92,911**	**92,911**	**92,911**	**92,911**	**92,540**

Exhibit XII: Aggregate EPO Enrollment Summary

January, 2014

		Actual Enrollment Through January, 2014 Then Projected												
Plan	Budget FY 2014	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Average
Aetna EPO														
Individual	1,001	1,234	1,250	1,308	1,405	1,490	1,463	1,539	1,539	1,539	1,539	1,539	1,539	1,449
Double	653	648	651	655	674	690	698	745	745	745	745	745	745	707
Family	1,051	1,010	1,021	1,026	1,037	1,055	1,076	1,129	1,129	1,129	1,129	1,129	1,129	1,083
Indiv. Medicare	28	39	42	43	43	43	45	44	44	44	44	44	44	43
2, 1 with Medicare	21	18	18	18	18	17	25	25	25	25	25	25	25	22
2, both Medicare	16	26	27	27	27	27	30	30	30	30	30	30	30	29
3, 1 with Medicare	5	6	6	6	6	6	7	7	7	7	7	7	7	7
3, 2 with Medicare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3+, all with Medicare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4+, 1 not Medicare	6	5	5	5	5	4	5	5	5	5	5	5	5	5
Total	**2,781**	**2,986**	**3,020**	**3,088**	**3,215**	**3,332**	**3,349**	**3,524**	**3,524**	**3,524**	**3,524**	**3,524**	**3,524**	**3,345**
BCBS EPO														
Individual	12,343	11,060	11,059	11,013	11,062	11,195	11,025	11,224	11,224	11,224	11,224	11,224	11,224	11,147
Double	8,675	7,235	7,222	7,196	7,174	7,232	7,333	7,399	7,399	7,399	7,399	7,399	7,399	7,316
Family	10,015	8,546	8,557	8,511	8,500	8,568	8,628	8,806	8,806	8,806	8,806	8,806	8,806	8,679
Indiv. Medicare	1,666	1,907	1,922	1,940	1,954	1,970	2,171	2,165	2,165	2,165	2,165	2,165	2,165	2,071
2, 1 with Medicare	620	701	701	709	703	718	793	767	767	767	767	767	767	744
2, both Medicare	818	1,013	1,025	1,035	1,056	1,070	1,228	1,221	1,221	1,221	1,221	1,221	1,221	1,146
3, 1 with Medicare	80	112	110	112	109	112	124	123	123	123	123	123	123	118
3, 2 with Medicare	24	24	26	25	28	28	28	28	28	28	28	28	28	27
3+, all with Medicare	4	5	5	4	5	5	5	5	5	5	5	5	5	5
4+, 1 not Medicare	46	56	56	58	58	58	57	57	57	57	57	57	57	57
Total	**34,291**	**30,659**	**30,683**	**30,603**	**30,649**	**30,956**	**31,392**	**31,795**	**31,795**	**31,795**	**31,795**	**31,795**	**31,795**	**31,309**
UHC EPO														
Individual	2,461	2,165	2,164	2,153	2,167	2,214	2,180	2,204	2,204	2,204	2,204	2,204	2,204	2,189
Double	2,221	1,844	1,837	1,825	1,811	1,819	1,834	1,843	1,843	1,843	1,843	1,843	1,843	1,836
Family	3,184	2,690	2,675	2,665	2,673	2,689	2,701	2,733	2,733	2,733	2,733	2,733	2,733	2,708
Indiv. Medicare	365	397	404	410	416	418	448	445	445	445	445	445	445	430
2, 1 with Medicare	161	157	166	164	166	169	184	180	180	180	180	180	180	174
2, both Medicare	188	223	224	226	227	229	258	257	257	257	257	257	257	244
3, 1 with Medicare	27	32	32	33	33	32	33	34	34	34	34	34	34	33
3, 2 with Medicare	5	3	4	4	4	4	6	5	5	5	5	5	5	5
3+, all with Medicare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4+, 1 not Medicare	20	22	21	21	22	23	23	21	21	21	21	21	21	22
Total	**8,632**	**7,533**	**7,527**	**7,501**	**7,519**	**7,597**	**7,667**	**7,722**	**7,722**	**7,722**	**7,722**	**7,722**	**7,722**	**7,640**
Grand Total	**45,704**	**41,178**	**41,230**	**41,192**	**41,383**	**41,885**	**42,408**	**43,041**	**43,041**	**43,041**	**43,041**	**43,041**	**43,041**	**42,294**
Total Members	**99,768**	**88,190**	**88,266**	**88,077**	**88,296**	**89,205**	**90,434**	**91,885**	**91,885**	**91,885**	**91,885**	**91,885**	**91,885**	**90,321**

Exhibit XIII: Prescription Drug Enrollment Summary

January, 2014

Plan	Budget FY 2014	Actual Enrollment Through January, 2014 Then Projected												
		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Average
ESI														
Actives/Satellite/Direct Pay														
Individual	26,785	26,510	26,472	26,469	26,507	26,775	27,529	27,340	27,340	27,340	27,340	27,340	27,340	27,025
Individual + One Child	5,718	5,675	5,657	5,620	5,575	5,604	5,566	5,509	5,509	5,509	5,509	5,509	5,509	5,563
Individual + Spouse	12,522	12,409	12,418	12,397	12,394	12,437	12,736	12,568	12,568	12,568	12,568	12,568	12,568	12,517
Individual + Family	23,472	23,015	22,976	22,899	22,886	23,060	23,228	22,974	22,974	22,974	22,974	22,974	22,974	22,992
Total	**68,497**	**67,609**	**67,523**	**67,385**	**67,362**	**67,876**	**69,059**	**68,391**	**68,391**	**68,391**	**68,391**	**68,391**	**68,391**	**68,097**
Retirees														
Individual	21,407	21,978	22,046	22,082	22,129	22,138	22,041	22,068	22,068	22,068	22,068	22,068	22,068	22,069
Individual + One Child	977	998	990	982	984	977	901	658	658	658	658	658	658	815
Individual + Spouse	14,693	15,029	15,033	15,050	15,057	15,077	15,173	15,252	15,252	15,252	15,252	15,252	15,252	15,161
Individual + Family	3,094	3,275	3,277	3,285	3,285	3,273	3,316	3,181	3,181	3,181	3,181	3,181	3,181	3,233
Total	**40,171**	**41,280**	**41,346**	**41,399**	**41,455**	**41,465**	**41,431**	**41,159**	**41,159**	**41,159**	**41,159**	**41,159**	**41,159**	**41,278**
Grand Total	**108,668**	**108,889**	**108,869**	**108,784**	**108,817**	**109,341**	**110,490**	**109,550**	**109,550**	**109,550**	**109,550**	**109,550**	**109,550**	**109,375**
Total Members	**217,494**	**217,138**	**217,000**	**216,672**	**216,629**	**217,695**	**219,720**	**217,294**	**217,294**	**217,294**	**217,294**	**217,294**	**217,294**	**217,385**

Exhibit XIV: Dental Enrollment Summary

January, 2014

		Actual Enrollment Through January, 2014 Then Projected												
Plan	Budget FY 2014	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Average
DHMO														
Actives/Satellite/Direct Pay														
Individual	8,457	7,576	7,571	7,556	7,624	7,690	7,836	7,654	7,654	7,654	7,654	7,654	7,654	7,648
Individual + Child	1,737	1,591	1,585	1,569	1,561	1,569	1,585	1,539	1,539	1,539	1,539	1,539	1,539	1,558
Individual + Spouse	3,548	3,162	3,175	3,182	3,205	3,215	3,271	3,207	3,207	3,207	3,207	3,207	3,207	3,204
Individual + Family	6,870	6,284	6,292	6,260	6,245	6,295	6,303	6,193	6,193	6,193	6,193	6,193	6,193	6,236
Total	**20,612**	**18,613**	**18,623**	**18,567**	**18,635**	**18,769**	**18,995**	**18,593**	**18,593**	**18,593**	**18,593**	**18,593**	**18,593**	**18,646**
Retirees														
Individual	4,585	4,637	4,654	4,658	4,663	4,674	4,689	4,668	4,668	4,668	4,668	4,668	4,668	4,665
Individual + Child	285	296	293	298	300	301	289	288	288	288	288	288	288	292
Individual + Spouse	2,936	2,888	2,890	2,890	2,892	2,889	2,887	2,879	2,879	2,879	2,879	2,879	2,879	2,884
Individual + Family	922	925	928	926	924	926	911	898	898	898	898	898	898	911
Total	**8,728**	**8,746**	**8,765**	**8,772**	**8,779**	**8,790**	**8,776**	**8,733**	**8,733**	**8,733**	**8,733**	**8,733**	**8,733**	**8,752**
Total UCCI DHMO	**29,340**	**27,359**	**27,388**	**27,339**	**27,414**	**27,559**	**27,771**	**27,326**	**27,326**	**27,326**	**27,326**	**27,326**	**27,326**	**27,398**
DPPO														
Actives/Satellite/Direct Pay														
Individual	20,156	20,982	20,933	20,926	21,048	21,260	21,561	21,019	21,019	21,019	21,019	21,019	21,019	21,069
Individual + Child	4,099	4,303	4,273	4,245	4,208	4,236	4,257	4,169	4,169	4,169	4,169	4,169	4,169	4,211
Individual + Spouse	9,501	9,659	9,657	9,644	9,657	9,700	9,835	9,644	9,644	9,644	9,644	9,644	9,644	9,668
Individual + Family	15,566	16,391	16,339	16,268	16,251	16,370	16,500	16,179	16,179	16,179	16,179	16,179	16,179	16,266
Total	**49,322**	**51,335**	**51,202**	**51,083**	**51,164**	**51,566**	**52,153**	**51,011**	**51,011**	**51,011**	**51,011**	**51,011**	**51,011**	**51,214**
Retirees														
Individual	9,531	10,964	11,021	11,066	11,116	11,162	11,418	11,377	11,377	11,377	11,377	11,377	11,377	11,251
Individual + Child	559	652	648	643	647	646	640	634	634	634	634	634	634	640
Individual + Spouse	7,565	8,504	8,533	8,573	8,587	8,633	8,862	8,839	8,839	8,839	8,839	8,839	8,839	8,727
Individual + Family	1,660	1,867	1,876	1,889	1,891	1,895	1,896	1,868	1,868	1,868	1,868	1,868	1,868	1,877
Total	**19,315**	**21,987**	**22,078**	**22,171**	**22,241**	**22,336**	**22,816**	**22,718**	**22,718**	**22,718**	**22,718**	**22,718**	**22,718**	**22,495**
Total UCCI DPPO	**68,637**	**73,322**	**73,280**	**73,254**	**73,405**	**73,902**	**74,969**	**73,729**	**73,729**	**73,729**	**73,729**	**73,729**	**73,729**	**73,709**
Grand Total	**97,977**	**100,681**	**100,668**	**100,593**	**100,819**	**101,461**	**102,740**	**101,055**	**101,055**	**101,055**	**101,055**	**101,055**	**101,055**	**101,107**
Total Members	**198,758**	**203,553**	**203,449**	**203,104**	**203,253**	**204,521**	**206,586**	**203,143**	**203,143**	**203,143**	**203,143**	**203,143**	**203,143**	**203,609**

Exhibit XV: Historical Enrollment

January, 2014

Plan	Actual Average Enrollment			% Change	
	FY 2011	FY 2012	FY 2013	FY 2012	FY 2013
Aetna POS					
Individual	1,854	1,940	1,633	4.6%	- 15.8%
Double	1,006	1,071	811	6.5%	- 24.3%
Family	1,413	1,515	1,085	7.2%	- 28.4%
Indiv. Medicare	266	308	318	15.8%	3.0%
2, 1 with Medicare	80	96	92	19.5%	- 4.7%
2, both Medicare	124	132	138	6.1%	4.5%
3, 1 with Medicare	13	19	19	43.6%	1.8%
3, 2 with Medicare	4	4	2	0.0%	- 50.0%
3+, all with Medicare	0	0	0	N/A	N/A
4+, 1 not Medicare	4	9	12	145.5%	33.3%
Total	**4,765**	**5,094**	**4,109**	**6.9%**	**- 19.3%**
BCBS POS					
Individual	5,279	4,768	3,427	- 9.7%	- 28.1%
Double	3,689	3,431	2,216	- 7.0%	- 35.4%
Family	4,909	4,780	3,210	- 2.6%	- 32.8%
Indiv. Medicare	1,603	1,642	1,616	2.4%	- 1.6%
2, 1 with Medicare	335	375	304	11.9%	- 19.0%
2, both Medicare	915	934	913	2.1%	- 2.3%
3, 1 with Medicare	38	50	51	31.1%	2.5%
3, 2 with Medicare	7	9	15	30.1%	68.5%
3+, all with Medicare	5	6	6	10.0%	9.1%
4+, 1 not Medicare	30	45	42	50.0%	- 6.7%
Total	**16,809**	**16,039**	**11,801**	**- 4.6%**	**- 26.4%**
UHC POS					
Individual	2,902	2,915	2,165	0.5%	- 25.7%
Double	2,599	2,548	1,622	- 2.0%	- 36.4%
Family	3,164	3,278	2,085	3.6%	- 36.4%
Indiv. Medicare	1,296	1,439	1,496	11.1%	4.0%
2, 1 with Medicare	390	446	347	14.2%	- 22.1%
2, both Medicare	861	925	953	7.4%	3.1%
3, 1 with Medicare	56	67	64	20.1%	- 3.7%
3, 2 with Medicare	16	17	18	6.3%	5.9%
3+, all with Medicare	2	2	2	0.0%	0.0%
4+, 1 not Medicare	25	44	44	74.0%	1.1%
Total	**11,310**	**11,679**	**8,796**	**3.3%**	**- 24.7%**

Plan	Actual Average Enrollment			% Change	
	FY 2011	FY 2012	FY 2013	FY 2012	FY 2013
BCBS PPO					
Individual	17,275	16,852	13,006	- 2.5%	- 22.8%
Double	11,712	11,362	8,359	- 3.0%	- 26.4%
Family	10,993	11,432	8,556	4.0%	- 25.2%
Indiv. Medicare	11,206	11,729	11,727	4.7%	0.0%
2, 1 with Medicare	1,746	1,848	1,714	5.8%	- 7.2%
2, both Medicare	5,018	5,369	5,404	7.0%	0.6%
3, 1 with Medicare	198	236	228	19.4%	- 3.2%
3, 2 with Medicare	72	88	95	22.2%	7.9%
3+, all with Medicare	23	22	20	- 3.3%	- 9.1%
4+, 1 not Medicare	103	151	167	46.4%	10.2%
Total	**58,347**	**59,089**	**49,274**	**1.3%**	**- 16.6%**
UHC PPO					
Individual	1,310	1,363	1,226	4.1%	- 10.1%
Double	811	828	705	2.2%	- 14.8%
Family	716	804	670	12.3%	- 16.6%
Indiv. Medicare	1,306	1,348	1,324	3.3%	- 1.8%
2, 1 with Medicare	151	166	156	9.9%	- 6.4%
2, both Medicare	704	690	655	- 2.0%	- 5.0%
3, 1 with Medicare	18	18	20	2.4%	8.3%
3, 2 with Medicare	3	3	5	0.0%	66.7%
3+, all with Medicare	3	3	3	0.0%	0.0%
4+, 1 not Medicare	9	11	15	22.2%	35.6%
Total	**5,030**	**5,235**	**4,779**	**4.1%**	**- 8.7%**

Exhibit XVI: Historical Enrollment

January, 2014

Plan	Actual Average Enrollment			% Change	
	FY 2011	FY 2012	FY 2013	FY 2012	FY 2013
Aetna EPO					
Individual	349	384	905	10.1%	135.9%
Double	96	133	500	37.7%	276.6%
Family	221	247	811	11.9%	228.3%
Indiv. Medicare	9	15	30	68.5%	98.9%
2, 1 with Medicare	7	3	14	-56.4%	394.1%
2, both Medicare	6	10	20	55.8%	100.0%
3, 1 with Medicare	1	2	4	100.0%	100.0%
3, 2 with Medicare	0	0	0	N/A	N/A
3+, all with Medicare	0	0	0	N/A	N/A
4+, 1 not Medicare	1	1	5	71.4%	391.7%
Total	**689**	**795**	**2,290**	**15.3%**	**188.1%**
BCBS EPO					
Individual	4,455	4,530	9,919	1.7%	118.9%
Double	2,225	2,209	6,464	-0.7%	192.6%
Family	2,926	3,142	7,838	7.4%	149.4%
Indiv. Medicare	981	1,079	1,631	10.0%	51.2%
2, 1 with Medicare	240	269	558	12.3%	107.3%
2, both Medicare	452	493	795	9.2%	61.2%
3, 1 with Medicare	30	39	84	29.5%	115.5%
3, 2 with Medicare	6	9	19	45.9%	109.3%
3+, all with Medicare	2	2	4	0.0%	100.0%
4+, 1 not Medicare	19	31	46	64.1%	50.3%
Total	**11,336**	**11,803**	**27,357**	**4.1%**	**131.8%**
UHC EPO					
Individual	1,359	1,261	2,081	-7.2%	65.0%
Double	804	777	1,729	-3.3%	122.6%
Family	1,512	1,475	2,616	-2.5%	77.4%
Indiv. Medicare	203	232	351	14.4%	51.1%
2, 1 with Medicare	67	66	133	-2.2%	102.8%
2, both Medicare	94	102	183	8.1%	79.8%
3, 1 with Medicare	13	17	31	34.0%	78.0%
3, 2 with Medicare	3	2	4	-33.3%	100.0%
3+, all with Medicare	0	0	0	N/A	N/A
4+, 1 not Medicare	11	15	20	36.4%	33.9%
Total	**4,065**	**3,946**	**7,148**	**-2.9%**	**81.1%**

Plan	Actual Average Enrollment			% Change	
	FY 2011	FY 2012	FY 2013	FY 2012	FY 2013
DHMO					
Actives					
Individual	8,577	8,196	8,035	-4.4%	-2.0%
Individual + Child	1,752	1,711	1,632	-2.3%	-4.6%
Individual + Spouse	3,766	3,457	3,397	-8.2%	-1.8%
Individual + Family	6,851	6,830	6,639	-0.3%	-2.8%
Retirees					
Individual	4,506	4,628	4,642	2.7%	0.3%
Individual + Child	246	284	300	15.5%	5.5%
Individual + Spouse	2,770	2,888	2,889	4.3%	0.0%
Individual + Family	732	869	891	18.7%	2.5%
Total	**29,200**	**28,865**	**28,425**	**-1.1%**	**-1.5%**
DPPO					
Actives					
Individual	19,593	19,747	20,568	0.8%	4.2%
Individual + Child	3,933	4,082	4,181	3.8%	2.4%
Individual + Spouse	9,407	9,272	9,658	-1.4%	4.2%
Individual + Family	14,553	15,435	16,084	6.1%	4.2%
Retirees					
Individual	8,410	9,434	10,389	12.2%	10.1%
Individual + Child	429	532	589	23.8%	10.9%
Individual + Spouse	6,618	7,360	8,004	11.2%	8.7%
Individual + Family	1,313	1,562	1,693	19.0%	8.4%
Total	**64,256**	**67,424**	**71,166**	**4.9%**	**5.6%**

Exhibit XVII: Aggregate POS Rates

January, 2014

Aggregate Rates Through January, 2014													
Plan	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total
Aetna POS													
Individual	$ 625,461	$ 627,382	$ 632,024	$ 648,377	$ 656,908	$ 649,567	$ 655,399	$ -	$ -	$ -	$ -	$ -	$ 4,495,118
Double	$ 540,698	$ 542,797	$ 539,998	$ 550,495	$ 547,037	$ 556,835	$ 565,892	$ -	$ -	$ -	$ -	$ -	$ 3,843,753
Family	$ 1,005,929	$ 1,010,846	$ 1,006,958	$ 1,009,932	$ 1,017,707	$ 1,030,343	$ 1,051,783	$ -	$ -	$ -	$ -	$ -	$ 7,133,498
Indiv. Medicare	$ 60,057	$ 60,252	$ 60,640	$ 61,223	$ 61,223	$ 61,806	$ 61,806	$ -	$ -	$ -	$ -	$ -	$ 427,009
2, 1 with Medicare	$ 53,645	$ 54,228	$ 55,395	$ 54,811	$ 54,811	$ 58,310	$ 55,395	$ -	$ -	$ -	$ -	$ -	$ 386,595
2, both Medicare	$ 56,377	$ 56,766	$ 56,377	$ 56,377	$ 57,155	$ 59,099	$ 59,099	$ -	$ -	$ -	$ -	$ -	$ 401,252
3, 1 with Medicare	$ 17,885	$ 16,991	$ 16,991	$ 16,097	$ 16,991	$ 15,202	$ 15,202	$ -	$ -	$ -	$ -	$ -	$ 115,358
3, 2 with Medicare	$ 1,555	$ 1,555	$ 1,555	$ 1,555	$ 1,555	$ 1,555	$ 1,555	$ -	$ -	$ -	$ -	$ -	$ 10,886
3+, all with Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4+, 1 not Medicare	$ 10,692	$ 10,692	$ 10,692	$ 10,692	$ 10,692	$ 9,720	$ 9,720	$ -	$ -	$ -	$ -	$ -	$ 72,897
Total	**$ 2,372,299**	**$ 2,381,508**	**$ 2,380,630**	**$ 2,409,560**	**$ 2,424,080**	**$ 2,442,437**	**$ 2,475,851**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 16,886,366**
BCBS POS													
Individual	$ 1,187,717	$ 1,178,455	$ 1,177,696	$ 1,182,554	$ 1,185,157	$ 1,159,607	$ 1,172,555	$ -	$ -	$ -	$ -	$ -	$ 8,243,741
Double	$ 1,346,301	$ 1,346,419	$ 1,335,135	$ 1,335,799	$ 1,337,790	$ 1,354,344	$ 1,369,610	$ -	$ -	$ -	$ -	$ -	$ 9,425,398
Family	$ 2,740,620	$ 2,732,270	$ 2,722,075	$ 2,719,310	$ 2,720,286	$ 2,754,447	$ 2,786,710	$ -	$ -	$ -	$ -	$ -	$ 19,175,718
Indiv. Medicare	$ 280,626	$ 283,208	$ 284,683	$ 284,683	$ 285,051	$ 281,733	$ 280,811	$ -	$ -	$ -	$ -	$ -	$ 1,980,794
2, 1 with Medicare	$ 158,189	$ 156,530	$ 157,083	$ 155,424	$ 153,211	$ 161,508	$ 154,871	$ -	$ -	$ -	$ -	$ -	$ 1,096,817
2, both Medicare	$ 320,049	$ 320,418	$ 322,999	$ 324,474	$ 325,948	$ 321,155	$ 320,418	$ -	$ -	$ -	$ -	$ -	$ 2,255,460
3, 1 with Medicare	$ 36,467	$ 36,467	$ 35,619	$ 36,467	$ 37,315	$ 39,859	$ 41,555	$ -	$ -	$ -	$ -	$ -	$ 263,750
3, 2 with Medicare	$ 11,799	$ 13,274	$ 11,799	$ 11,799	$ 11,062	$ 13,274	$ 12,537	$ -	$ -	$ -	$ -	$ -	$ 85,544
3+, all with Medicare	$ 2,766	$ 2,766	$ 2,766	$ 2,766	$ 2,766	$ 3,872	$ 3,872	$ -	$ -	$ -	$ -	$ -	$ 21,571
4+, 1 not Medicare	$ 39,637	$ 38,715	$ 39,637	$ 39,637	$ 38,715	$ 35,950	$ 35,028	$ -	$ -	$ -	$ -	$ -	$ 267,319
Total	**$ 6,124,171**	**$ 6,108,520**	**$ 6,089,492**	**$ 6,092,912**	**$ 6,097,303**	**$ 6,125,749**	**$ 6,177,966**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 42,816,113**
UHC POS													
Individual	$ 852,121	$ 850,406	$ 844,941	$ 845,786	$ 847,475	$ 836,495	$ 840,296	$ -	$ -	$ -	$ -	$ -	$ 5,917,520
Double	$ 1,129,245	$ 1,118,602	$ 1,112,521	$ 1,107,200	$ 1,111,806	$ 1,134,566	$ 1,127,769	$ -	$ -	$ -	$ -	$ -	$ 7,841,709
Family	$ 1,989,390	$ 1,984,111	$ 1,969,330	$ 1,956,597	$ 1,958,647	$ 1,964,732	$ 1,981,688	$ -	$ -	$ -	$ -	$ -	$ 13,804,496
Indiv. Medicare	$ 305,126	$ 304,704	$ 306,815	$ 308,927	$ 310,405	$ 309,983	$ 307,027	$ -	$ -	$ -	$ -	$ -	$ 2,152,987
2, 1 with Medicare	$ 210,952	$ 211,586	$ 214,120	$ 209,685	$ 212,853	$ 222,355	$ 215,387	$ -	$ -	$ -	$ -	$ -	$ 1,496,937
2, both Medicare	$ 380,933	$ 382,622	$ 383,044	$ 382,200	$ 383,889	$ 382,622	$ 381,777	$ -	$ -	$ -	$ -	$ -	$ 2,677,086
3, 1 with Medicare	$ 51,482	$ 52,453	$ 52,453	$ 53,424	$ 53,424	$ 52,453	$ 45,653	$ -	$ -	$ -	$ -	$ -	$ 361,342
3, 2 with Medicare	$ 11,825	$ 11,825	$ 10,981	$ 11,825	$ 11,825	$ 12,670	$ 12,670	$ -	$ -	$ -	$ -	$ -	$ 83,621
3+, all with Medicare	$ 1,267	$ 1,267	$ 1,267	$ 1,267	$ 1,267	$ 1,267	$ 1,267	$ -	$ -	$ -	$ -	$ -	$ 8,869
4+, 1 not Medicare	$ 49,624	$ 48,568	$ 48,568	$ 48,568	$ 48,568	$ 45,401	$ 45,401	$ -	$ -	$ -	$ -	$ -	$ 334,698
Total	**$ 4,981,965**	**$ 4,966,145**	**$ 4,944,040**	**$ 4,925,480**	**$ 4,940,159**	**$ 4,962,543**	**$ 4,958,934**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 34,679,266**
Grand Total	**$13,478,434**	**$13,456,174**	**$13,414,162**	**$13,427,952**	**$13,461,542**	**$13,530,729**	**$13,612,751**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 94,381,744**

Exhibit XVIII: Aggregate PPO Rates

January, 2014

Aggregate Rates Through January, 2014													
Plan	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total
BCBS PPO													
Individual	$ 5,712,416	$ 5,668,190	$ 5,648,632	$ 5,630,193	$ 5,635,082	$ 5,561,218	$ 5,563,922	$ -	$ -	$ -	$ -	$ -	$ 39,419,654
Double	$ 6,469,981	$ 6,448,347	$ 6,433,399	$ 6,392,343	$ 6,399,178	$ 6,473,571	$ 6,495,501	$ -	$ -	$ -	$ -	$ -	$ 45,112,319
Family	$ 9,155,923	$ 9,111,943	$ 9,115,220	$ 9,101,425	$ 9,153,738	$ 9,218,616	$ 9,304,323	$ -	$ -	$ -	$ -	$ -	$ 64,161,187
Indiv. Medicare	$ 2,597,949	$ 2,606,774	$ 2,611,419	$ 2,619,316	$ 2,623,728	$ 2,631,625	$ 2,619,083	$ -	$ -	$ -	$ -	$ -	$ 18,309,893
2, 1 with Medicare	$ 1,145,079	$ 1,142,989	$ 1,138,810	$ 1,133,935	$ 1,135,328	$ 1,148,561	$ 1,098,412	$ -	$ -	$ -	$ -	$ -	$ 7,943,114
2, both Medicare	$ 2,408,739	$ 2,411,990	$ 2,413,847	$ 2,422,670	$ 2,425,921	$ 2,481,647	$ 2,469,573	$ -	$ -	$ -	$ -	$ -	$ 17,034,387
3, 1 with Medicare	$ 227,493	$ 229,629	$ 237,105	$ 234,969	$ 238,173	$ 233,901	$ 228,561	$ -	$ -	$ -	$ -	$ -	$ 1,629,829
3, 2 with Medicare	$ 91,949	$ 88,234	$ 85,448	$ 87,305	$ 88,234	$ 88,234	$ 87,305	$ -	$ -	$ -	$ -	$ -	$ 616,710
3+, all with Medicare	$ 11,841	$ 11,841	$ 11,841	$ 13,234	$ 13,234	$ 13,234	$ 13,234	$ -	$ -	$ -	$ -	$ -	$ 88,458
4+, 1 not Medicare	$ 179,952	$ 184,596	$ 183,435	$ 178,791	$ 171,825	$ 172,986	$ 164,859	$ -	$ -	$ -	$ -	$ -	$ 1,236,444
Total	**$28,001,321**	**$27,904,532**	**$27,879,156**	**$27,814,181**	**$27,884,441**	**$28,023,593**	**$28,044,773**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$195,551,996**
UHC PPO													
Individual	$ 575,358	$ 585,001	$ 594,160	$ 602,380	$ 613,312	$ 599,183	$ 607,430	$ -	$ -	$ -	$ -	$ -	$ 4,176,823
Double	$ 577,640	$ 578,462	$ 568,550	$ 566,084	$ 566,955	$ 583,394	$ 599,784	$ -	$ -	$ -	$ -	$ -	$ 4,040,868
Family	$ 719,636	$ 713,860	$ 712,719	$ 717,218	$ 735,551	$ 751,467	$ 772,151	$ -	$ -	$ -	$ -	$ -	$ 5,122,602
Indiv. Medicare	$ 289,573	$ 289,345	$ 289,116	$ 289,345	$ 288,203	$ 288,660	$ 286,833	$ -	$ -	$ -	$ -	$ -	$ 2,021,075
2, 1 with Medicare	$ 97,945	$ 97,945	$ 96,575	$ 95,890	$ 94,520	$ 95,205	$ 91,096	$ -	$ -	$ -	$ -	$ -	$ 669,177
2, both Medicare	$ 287,677	$ 284,937	$ 283,567	$ 283,111	$ 282,197	$ 284,480	$ 284,024	$ -	$ -	$ -	$ -	$ -	$ 1,989,994
3, 1 with Medicare	$ 19,954	$ 21,005	$ 22,055	$ 22,055	$ 23,105	$ 23,105	$ 22,055	$ -	$ -	$ -	$ -	$ -	$ 153,334
3, 2 with Medicare	$ 4,566	$ 4,566	$ 4,566	$ 4,566	$ 4,566	$ 4,566	$ 4,566	$ -	$ -	$ -	$ -	$ -	$ 31,965
3+, all with Medicare	$ 1,370	$ 1,370	$ 1,370	$ 1,370	$ 1,370	$ 1,370	$ 1,370	$ -	$ -	$ -	$ -	$ -	$ 9,589
4+, 1 not Medicare	$ 15,983	$ 15,983	$ 15,983	$ 15,983	$ 15,983	$ 14,841	$ 14,841	$ -	$ -	$ -	$ -	$ -	$ 109,596
Total	**$ 2,589,702**	**$ 2,592,474**	**$ 2,588,662**	**$ 2,598,001**	**$ 2,625,762**	**$ 2,646,271**	**$ 2,684,149**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 18,325,021**
Grand Total	**$30,591,022**	**$30,497,005**	**$30,467,817**	**$30,412,182**	**$30,510,203**	**$30,669,864**	**$30,728,922**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$213,877,017**

Exhibit XIX: Aggregate APS Rates

January, 2014

Aggregate Rates Through January, 2014													
Plan	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total
APS													
Individual	$ 240,413	$ 239,254	$ 238,958	$ 239,377	$ 240,172	$ 236,588	$ 237,566	$ -	$ -	$ -	$ -	$ -	$ 1,672,328
Double	$ 269,866	$ 269,109	$ 267,859	$ 266,945	$ 267,228	$ 270,999	$ 272,551	$ -	$ -	$ -	$ -	$ -	$ 1,884,558
Family	$ 424,353	$ 422,823	$ 422,021	$ 421,434	$ 423,558	$ 427,258	$ 432,119	$ -	$ -	$ -	$ -	$ -	$ 2,973,566
Indiv. Medicare	$ 92,178	$ 92,471	$ 92,699	$ 92,981	$ 93,115	$ 93,227	$ 92,752	$ -	$ -	$ -	$ -	$ -	$ 649,423
2, 1 with Medicare	$ 44,090	$ 44,019	$ 44,001	$ 43,666	$ 43,684	$ 44,672	$ 42,801	$ -	$ -	$ -	$ -	$ -	$ 306,934
2, both Medicare	$ 91,083	$ 91,165	$ 91,260	$ 91,495	$ 91,672	$ 93,015	$ 92,650	$ -	$ -	$ -	$ -	$ -	$ 642,340
3, 1 with Medicare	$ 9,417	$ 9,498	$ 9,687	$ 9,660	$ 9,823	$ 9,715	$ 9,417	$ -	$ -	$ -	$ -	$ -	$ 67,217
3, 2 with Medicare	$ 3,199	$ 3,152	$ 3,011	$ 3,081	$ 3,081	$ 3,175	$ 3,128	$ -	$ -	$ -	$ -	$ -	$ 21,827
3+, all with Medicare	$ 459	$ 459	$ 459	$ 494	$ 494	$ 530	$ 530	$ -	$ -	$ -	$ -	$ -	$ 3,424
4+, 1 not Medicare	$ 7,952	$ 8,010	$ 8,010	$ 7,893	$ 7,686	$ 7,480	$ 7,245	$ -	$ -	$ -	$ -	$ -	$ 54,276
Total	**$ 1,183,008**	**$ 1,179,961**	**$ 1,177,967**	**$ 1,177,026**	**$ 1,180,513**	**$ 1,186,659**	**$ 1,190,758**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 8,275,892**

Exhibit XX: Aggregate EPO Rates

January, 2014

Aggregate Rates Through January, 2014													
Plan	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total
Aetna EPO													
Individual	$ 458,790	$ 464,739	$ 486,302	$ 522,365	$ 553,966	$ 543,930	$ 572,185	$ -	$ -	$ -	$ -	$ -	$ 3,602,276
Double	$ 481,831	$ 484,061	$ 487,036	$ 501,163	$ 513,060	$ 519,008	$ 553,955	$ -	$ -	$ -	$ -	$ -	$ 3,540,114
Family	$ 940,559	$ 950,807	$ 955,463	$ 965,706	$ 982,468	$ 1,002,023	$ 1,051,376	$ -	$ -	$ -	$ -	$ -	$ 6,848,402
Indiv. Medicare	$ 8,702	$ 9,372	$ 9,595	$ 9,595	$ 9,595	$ 10,041	$ 9,818	$ -	$ -	$ -	$ -	$ -	$ 66,719
2, 1 with Medicare	$ 10,708	$ 10,708	$ 10,708	$ 10,708	$ 10,113	$ 14,873	$ 14,873	$ -	$ -	$ -	$ -	$ -	$ 82,692
2, both Medicare	$ 11,603	$ 12,049	$ 12,049	$ 12,049	$ 12,049	$ 13,388	$ 13,388	$ -	$ -	$ -	$ -	$ -	$ 86,574
3, 1 with Medicare	$ 5,800	$ 5,800	$ 5,800	$ 5,800	$ 5,800	$ 6,767	$ 6,767	$ -	$ -	$ -	$ -	$ -	$ 42,534
3, 2 with Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3+, all with Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4+, 1 not Medicare	$ 5,206	$ 5,206	$ 5,206	$ 5,206	$ 4,165	$ 5,206	$ 5,206	$ -	$ -	$ -	$ -	$ -	$ 35,400
Total	**$ 1,923,200**	**$ 1,942,742**	**$ 1,972,159**	**$ 2,032,592**	**$ 2,091,216**	**$ 2,115,235**	**$ 2,227,568**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 14,304,711**
BCBS EPO													
Individual	$ 4,686,784	$ 4,686,362	$ 4,666,870	$ 4,687,638	$ 4,743,994	$ 4,671,957	$ 4,756,279	$ -	$ -	$ -	$ -	$ -	$ 32,899,884
Double	$ 6,434,000	$ 6,422,439	$ 6,399,322	$ 6,379,758	$ 6,431,340	$ 6,521,160	$ 6,579,856	$ -	$ -	$ -	$ -	$ -	$ 45,167,876
Family	$ 9,415,688	$ 9,427,806	$ 9,377,124	$ 9,365,000	$ 9,439,915	$ 9,506,026	$ 9,702,122	$ -	$ -	$ -	$ -	$ -	$ 66,233,682
Indiv. Medicare	$ 398,334	$ 401,467	$ 405,227	$ 408,152	$ 411,494	$ 453,478	$ 452,225	$ -	$ -	$ -	$ -	$ -	$ 2,930,378
2, 1 with Medicare	$ 441,069	$ 441,069	$ 446,103	$ 442,328	$ 451,766	$ 498,956	$ 482,596	$ -	$ -	$ -	$ -	$ -	$ 3,203,886
2, both Medicare	$ 464,947	$ 470,455	$ 475,044	$ 484,683	$ 491,109	$ 563,627	$ 560,415	$ -	$ -	$ -	$ -	$ -	$ 3,510,279
3, 1 with Medicare	$ 117,550	$ 115,451	$ 117,550	$ 114,401	$ 117,550	$ 130,144	$ 129,095	$ -	$ -	$ -	$ -	$ -	$ 841,739
3, 2 with Medicare	$ 16,066	$ 17,404	$ 16,735	$ 18,743	$ 18,743	$ 18,743	$ 18,743	$ -	$ -	$ -	$ -	$ -	$ 125,178
3+, all with Medicare	$ 2,871	$ 2,871	$ 2,297	$ 2,871	$ 2,871	$ 2,871	$ 2,871	$ -	$ -	$ -	$ -	$ -	$ 19,521
4+, 1 not Medicare	$ 58,495	$ 58,495	$ 60,584	$ 60,584	$ 60,584	$ 59,540	$ 59,540	$ -	$ -	$ -	$ -	$ -	$ 417,824
Total	**$22,035,803**	**$22,043,820**	**$21,966,856**	**$21,964,157**	**$22,169,365**	**$22,426,503**	**$22,743,742**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$155,350,247**
UHC EPO													
Individual	$ 922,957	$ 922,531	$ 917,842	$ 923,812	$ 943,848	$ 929,354	$ 939,585	$ -	$ -	$ -	$ -	$ -	$ 6,499,927
Double	$ 1,634,890	$ 1,628,684	$ 1,618,045	$ 1,605,629	$ 1,612,730	$ 1,626,025	$ 1,634,008	$ -	$ -	$ -	$ -	$ -	$ 11,360,011
Family	$ 2,843,877	$ 2,828,025	$ 2,817,444	$ 2,825,901	$ 2,842,810	$ 2,855,501	$ 2,889,329	$ -	$ -	$ -	$ -	$ -	$ 19,902,888
Indiv. Medicare	$ 111,767	$ 113,738	$ 115,427	$ 117,116	$ 117,680	$ 126,125	$ 125,281	$ -	$ -	$ -	$ -	$ -	$ 827,135
2, 1 with Medicare	$ 111,121	$ 117,491	$ 116,076	$ 117,491	$ 119,615	$ 130,232	$ 127,400	$ -	$ -	$ -	$ -	$ -	$ 839,427
2, both Medicare	$ 125,549	$ 126,112	$ 127,238	$ 127,801	$ 128,927	$ 145,254	$ 144,691	$ -	$ -	$ -	$ -	$ -	$ 925,572
3, 1 with Medicare	$ 33,828	$ 33,828	$ 34,885	$ 34,885	$ 33,828	$ 34,885	$ 35,942	$ -	$ -	$ -	$ -	$ -	$ 242,080
3, 2 with Medicare	$ 2,900	$ 3,866	$ 3,866	$ 3,866	$ 3,866	$ 5,799	$ 4,833	$ -	$ -	$ -	$ -	$ -	$ 28,996
3+, all with Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4+, 1 not Medicare	$ 23,257	$ 22,200	$ 22,200	$ 23,257	$ 24,314	$ 24,314	$ 22,200	$ -	$ -	$ -	$ -	$ -	$ 161,739
Total	**$ 5,810,147**	**$ 5,796,476**	**$ 5,773,023**	**$ 5,779,759**	**$ 5,827,617**	**$ 5,877,488**	**$ 5,923,268**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 40,787,777**
Grand Total	**$29,769,150**	**$29,783,038**	**$29,712,038**	**$29,776,508**	**$30,088,198**	**$30,419,226**	**$30,894,578**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$210,442,735**

Exhibit XXI: Aggregate Rx Rates

January, 2014

Aggregate Rates Through January, 2014													
Plan	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Total
ESI													
Actives/Satellite/Direct Pay													
Individual	$ 5,326,517	$ 5,318,799	$ 5,318,160	$ 5,326,044	$ 5,379,763	$ 5,530,979	$ 5,492,945	$ -	$ -	$ -	$ -	$ -	$ 37,693,207
Individual + One Child	$ 1,515,103	$ 1,510,278	$ 1,500,386	$ 1,488,386	$ 1,496,144	$ 1,485,765	$ 1,470,515	$ -	$ -	$ -	$ -	$ -	$ 10,466,577
Individual + Spouse	$ 4,137,506	$ 4,140,687	$ 4,133,786	$ 4,132,664	$ 4,147,229	$ 4,246,925	$ 4,190,916	$ -	$ -	$ -	$ -	$ -	$ 29,129,712
Individual + Family	$ 9,266,095	$ 9,250,555	$ 9,219,432	$ 9,214,289	$ 9,284,265	$ 9,351,907	$ 9,249,605	$ -	$ -	$ -	$ -	$ -	$ 64,836,149
Total	**$ 20,245,221**	**$ 20,220,320**	**$ 20,171,765**	**$ 20,161,383**	**$ 20,307,401**	**$ 20,615,575**	**$ 20,403,981**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$142,125,645**
Retirees													
Individual	$ 916,051	$ 918,885	$ 920,386	$ 922,345	$ 922,720	$ 918,677	$ 919,802	$ -	$ -	$ -	$ -	$ -	$ 6,438,865
Individual + One Child	$ 167,087	$ 165,748	$ 164,409	$ 164,743	$ 163,571	$ 150,847	$ 110,164	$ -	$ -	$ -	$ -	$ -	$ 1,086,569
Individual + Spouse	$ 1,028,901	$ 1,029,175	$ 1,030,339	$ 1,030,818	$ 1,032,188	$ 1,038,760	$ 1,044,168	$ -	$ -	$ -	$ -	$ -	$ 7,234,350
Individual + Family	$ 897,082	$ 897,630	$ 899,822	$ 899,822	$ 896,535	$ 908,313	$ 871,334	$ -	$ -	$ -	$ -	$ -	$ 6,270,538
Total	**$ 3,009,122**	**$ 3,011,439**	**$ 3,014,955**	**$ 3,017,728**	**$ 3,015,013**	**$ 3,016,597**	**$ 2,945,468**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 21,030,322**
Grand Total	**$ 23,254,343**	**$ 23,231,758**	**$ 23,186,720**	**$ 23,179,111**	**$ 23,322,414**	**$ 23,632,172**	**$ 23,349,449**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$163,155,967**

Exhibit XXII: Aggregate Dental Rates

January, 2014

Aggregate Rates Through January, 2014													
Plan	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**	**Apr-14**	**May-14**	**Jun-14**	**Total**
DHMO													
Actives/Satellite/Direct Pay													
Individual	$ 115,989	$ 115,912	$ 115,682	$ 116,723	$ 117,734	$ 119,969	$ 117,183	$ -	$ -	$ -	$ -	$ -	$ 819,192
Individual + One Child	$ 42,448	$ 42,288	$ 41,861	$ 41,647	$ 41,861	$ 42,288	$ 41,061	$ -	$ -	$ -	$ -	$ -	$ 293,453
Individual + Spouse	$ 96,947	$ 97,346	$ 97,560	$ 98,265	$ 98,572	$ 100,289	$ 98,327	$ -	$ -	$ -	$ -	$ -	$ 687,305
Individual + Family	$ 270,652	$ 270,996	$ 269,618	$ 268,972	$ 271,126	$ 271,470	$ 266,733	$ -	$ -	$ -	$ -	$ -	$ 1,889,567
Total	**$ 526,035**	**$ 526,542**	**$ 524,722**	**$ 525,608**	**$ 529,292**	**$ 534,016**	**$ 523,302**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,689,518**
Retirees													
Individual	$ 70,992	$ 71,253	$ 71,314	$ 71,391	$ 71,559	$ 71,789	$ 71,467	$ -	$ -	$ -	$ -	$ -	$ 499,764
Individual + One Child	$ 7,897	$ 7,817	$ 7,951	$ 8,004	$ 8,031	$ 7,711	$ 7,684	$ -	$ -	$ -	$ -	$ -	$ 55,094
Individual + Spouse	$ 88,546	$ 88,607	$ 88,607	$ 88,669	$ 88,577	$ 88,515	$ 88,270	$ -	$ -	$ -	$ -	$ -	$ 619,792
Individual + Family	$ 39,840	$ 39,969	$ 39,883	$ 39,797	$ 39,883	$ 39,237	$ 38,677	$ -	$ -	$ -	$ -	$ -	$ 277,285
Total	**$ 207,276**	**$ 207,646**	**$ 207,755**	**$ 207,860**	**$ 208,049**	**$ 207,251**	**$ 206,098**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,451,935**
Total UCCI DHMO	**$ 733,311**	**$ 734,188**	**$ 732,476**	**$ 733,468**	**$ 737,342**	**$ 741,267**	**$ 729,400**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 5,141,453**
DPPO													
Actives/Satellite/Direct Pay													
Individual	$ 488,251	$ 487,111	$ 486,948	$ 489,787	$ 494,720	$ 501,724	$ 489,112	$ -	$ -	$ -	$ -	$ -	$ 3,437,654
Individual + One Child	$ 191,397	$ 190,063	$ 188,818	$ 187,172	$ 188,417	$ 189,351	$ 185,437	$ -	$ -	$ -	$ -	$ -	$ 1,320,656
Individual + Spouse	$ 449,530	$ 449,437	$ 448,832	$ 449,437	$ 451,438	$ 457,721	$ 448,832	$ -	$ -	$ -	$ -	$ -	$ 3,155,226
Individual + Family	$ 1,429,295	$ 1,424,761	$ 1,418,570	$ 1,417,087	$ 1,427,464	$ 1,438,800	$ 1,410,809	$ -	$ -	$ -	$ -	$ -	$ 9,966,786
Total	**$ 2,558,474**	**$ 2,551,372**	**$ 2,543,167**	**$ 2,543,483**	**$ 2,562,039**	**$ 2,587,597**	**$ 2,534,190**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 17,880,321**
Retirees													
Individual	$ 255,132	$ 256,459	$ 257,506	$ 258,669	$ 259,740	$ 265,697	$ 264,743	$ -	$ -	$ -	$ -	$ -	$ 1,817,945
Individual + One Child	$ 29,001	$ 28,823	$ 28,601	$ 28,779	$ 28,734	$ 28,467	$ 28,200	$ -	$ -	$ -	$ -	$ -	$ 200,605
Individual + Spouse	$ 395,776	$ 397,126	$ 398,987	$ 399,639	$ 401,780	$ 412,437	$ 411,367	$ -	$ -	$ -	$ -	$ -	$ 2,817,113
Individual + Family	$ 162,802	$ 163,587	$ 164,721	$ 164,895	$ 165,244	$ 165,331	$ 162,890	$ -	$ -	$ -	$ -	$ -	$ 1,149,470
Total	**$ 842,712**	**$ 845,995**	**$ 849,815**	**$ 851,982**	**$ 855,498**	**$ 871,933**	**$ 867,200**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 5,985,133**
Total UCCI DPPO	**$ 3,401,185**	**$ 3,397,366**	**$ 3,392,982**	**$ 3,395,465**	**$ 3,417,537**	**$ 3,459,529**	**$ 3,401,390**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 23,865,454**
Grand Total	**$ 4,134,496**	**$ 4,131,554**	**$ 4,125,458**	**$ 4,128,933**	**$ 4,154,879**	**$ 4,200,797**	**$ 4,130,790**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 29,006,907**

Definitions & Assumptions

- Paid claims - The total of claims actually paid during a specific time period (monthly, quarterly, annually).
- Incurred claims - The total of all claims dollars with dates of service (incurred date) within a specified period (monthly, quarterly, annually, etc.).
- Incurred But Not Reported (IBNR) - The claims dollars that were incurred during a specific time period but have not yet been reported to the insurer as of the date of the report.
- Completion Factor - The factor applied to the paid claim amounts by incurred date in order to estimate what the total incurred claim amount will be. The paid claims are "completed."
- Invoices for administrative fees are sometimes not available for the current month before we deliver our monthly report. Therefore, they are based on actual contracted fees multiplied by enrollment, except for ESI's administrative fees, which are based on actual invoiced amounts. We update the calculated administrative fees for historical months with actual invoiced amounts as we receive them from vendors.
- Invoiced claims are based on invoices provided by self-funded plan vendors.
- FY 2014 Budget is based on the FY 2014 Renewal Report.



Wisconsin Group Insurance Board
Department of Employee Trust Funds

Health Care Benefits Consultant

Second Report—Observations and Recommendations for 2017 and Beyond

November 17, 2015

Segal Consulting

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November 17, 2015

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Executive Summary

Project Overview

The Wisconsin Group Insurance Board (GIB) has authority to retain an actuary and a consultant to support the programs the Board oversees and to make changes to existing health benefit plans, including self-insuring the benefits, provided the changes maintain or reduce premium costs for the State or its employees in the current or any future year. Under this GIB authority, Segal Consulting was retained to perform a full range of services related to the analysis, design, management and communication of the State's health insurance program for employees and retirees.

The primary objective of the project is to analyze data from a variety of sources to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program.

This report is the second of two deliverables anticipated by the contract and includes findings, recommendations and strategies for consideration for 2017 and future years. The first report, presented March 25, 2015, focused on analysis and recommendations for consideration for calendar year 2016.

Segal has agreed to a review of the following components for this second report:

- Total Health Management
- Program Structure
- Pharmacy
- Data Management
- Market Observations
- Self-Insurance
- Retiree Coverage
- Local Government Plan
- ACA Update and Strategies

Segal has completed our review and developed strategic recommendations for consideration, with some initiatives to be considered for possible implementation in 2017 and others to be started in 2016 for longer-term implementation after 2017. We have discussed each component in a separate section of this report, and we have highlighted each section on the following pages.

Summary of First Report

In the first report, we presented our comments and observations on the following topics:

- Benchmarking Comparison
- Total Health Management
- Pharmacy
- Consumer Directed Health (CDH) Care Design
- Private and Public Exchanges
- Affordable Care Act (ACA) 40% Excise Tax
- Market Observations
- Self-Insurance Concepts
- WHIO Database

As a result of our analysis and the discussion that ensued from the first report, the GIB and ETF implemented several changes for 2016:

Benefit Changes

In 2014, the ETF "It's Your Choice Health Plan" (Uniform Benefit Design, UBD) provided one of the highest benefit values in the country (96%), compared to other state employee health benefit programs reviewed in our first report. Note that "benefit value" or "actuarial value" is the percentage of claims paid by the benefit plan. The higher this value, the greater the benefit to the member, resulting in higher costs to the employer. The GIB adjusted medical and pharmacy benefits and still remain competitive in 2016. The GIB approved higher deductibles and out-of-pocket maximums for the UBD and the "It's Your Choice Access Health Plan" (Standard PPO). In the case of the UBD, deductibles were implemented for the first time. Additionally, office visits in the UBD were converted to a copay design (from coinsurance), subject to the out-of-pocket maximum.

The initial enrollment in the It's Your Choice High Deductible Health Plan (HDHP) option was very low (approximately 400 subscribers across all the health plans). We recommended significantly enhancing the State's HSA contribution (to $750 for individual and $1,500 for family) as a measure to help increase the overall value of the HDHP option(s), which would then help to encourage additional enrollment for 2016. The GIB approved this recommendation. Preliminary enrollment shows growth in the program to approximately 1,500 contracts. An improvement over 2015 but still a fairly small percentage of ETF membership.

For 2016, brand and specialty drugs will be covered on a coinsurance basis (with maximums). Generics copays will remain at $5. Out-of-pocket limits will also be increased. This structure should further incent members to utilize lower cost medications. Additional details can be found in the **Introduction** section of this report.

Health Plan Negotiations

During the summer 2015 negotiations and renewal process for the 2016 plan year, some modifications were introduced. Additional data detail, including billed and allowed charges were required, along with an attestation from each plan's CFO or actuary that the data submitted with the proposed premiums was complete and accurate. The additional data provided enhanced clarity and transparency to the process.

2016 Savings

Between the plan changes approved by the GIB for 2016, and the improvements in the renewal and negotiation process, the savings for 2016 was $89 million, slightly higher than the $68 million estimated.

Findings and Recommendations of Second Report

Total Health Management

In our first report, we observed a significant variation in the effectiveness of the health plans' health management programs. Many of the plans appear unable to report basic chronic condition treatment data and therefore are unable to demonstrate their program's effectiveness. However, we do know that ETF's membership has chronic condition rates that exceed national norms (64% vs. 50%), particularly for diabetes, and that significant care gaps exist.

The benefits of the Well Wisconsin program are underutilized, with approximately 17% participation in 2015. Other states report participation in the 70-90% range.

Increasing member engagement in both wellness and disease management programs will improve overall member health and reduce future cost increases to ETF. The programs available to members need to be effective and vendors need to be able to demonstrate their effectiveness.

A combination of incentives for members to engage in health management programs and appropriate required performance metrics with meaningful financial incentives for vendors should accomplish these goals.

The health care market is constantly evolving and additional opportunities for patients to engage with providers are rapidly developing. Telemedicine and employer-sponsored on-site clinics are two primary examples. Both provide additional access to members and present opportunities to improve the efficiency of care.

Recommendations

In the following areas, Segal recommends that ETF:

- **Medical Management:** Integrate disease management and complex case management with the health plans (as is the case currently), but require that vendors meet outcome based performance metrics and attach meaningful financial incentives. For members with a manageable chronic condition, reduce office visit copays and copays for maintenance

medications by $5 or $10 to incent member engagement and reduce barriers to care necessary for condition management.

- **Wellness and Health Promotion:** Utilize a separate vendor and design program to be uniform across the membership. The vendor should be best in class and be able to provide health risk assessments, biometric collection, lifestyle coaching, education, reward tracking, etc. Institute a premium based incentive of $50 per month for completion of designated wellness and health promotion activities. This would apply to both an employee and spouse, as well as non-Medicare retirees.

- **Data Analytics:** Require vendors to provide complete and comprehensive data and engage the technology necessary to perform data analysis and health risk modeling of the covered population.

- **Telemedicine:** Working with the insurers, ETF should develop standards that align with the telehealth services available in the market (that ensure convenience and safety for members).

- **On-site Clinics:** Assess the potential location of on-site clinics that could provide reasonable return for ETF. This is a longer-term initiative designed to integrate clinics into the overall wellness strategy. Collect data at clinics and integrate with the data provided by the plans. As the market matures, we recommend studying how clinics can best support ETF's strategies.

Financial Impact

By our estimation, there is approximately $267 million in unnecessary and avoidable medical services annually in ETF's program. Using the WHIO data, it was estimated that 90% of all claims are due to chronic conditions, slightly higher than 86% CDC reports nationally. Implementing value based incentives to motivate members to engage in medical management and wellness programs should be able to ultimately eliminate approximately $60-$80 million of annual medical expenses. We recognize this will increase gradually and estimate lower first year savings of $10-$30 million, between 1% and 3% of plan costs. Note that THM savings will be cumulative over time.

Possible Timing

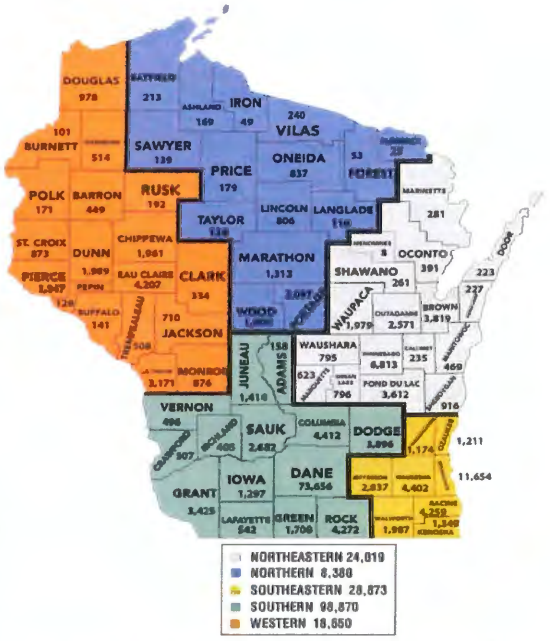
Given broader changes recommended for 2018, much of the above could be implemented for the 2017 plan year. To get these in place, there will need to be changes to the current plan contracts and initiate a number of possible procurements. It could be beneficial to stagger implementation and allow ETF to focus solely on rolling out a comprehensive initiative for 2018.

ETF may also choose to phase in the Total Health Management components, for example implementing wellness related features in 2017 and then implementing medical management in conjunction with broader recommendations in 2018.

Program Structure

Regions and Contracting

ETF currently works with 17 different health plans throughout the State, with all the plans defining their own service area. Using the current Medicaid regional map, we have completed a detailed analysis of how the Medicaid regions overlap with the current ETF health plan operations. The map summarizes membership in each county and state, as well as the regional structure.



Pricing varies significantly among the plans, with risk-adjusted costs varying by $276 per member per month (PMPM) from the lowest to the highest. Some of this is due to geography, as provider discounts vary significantly across the State, with pricing more favorable in the southern and eastern parts of the State and less favorable in the more rural northern and western region. Differences in pricing are also due to variance the plans' negotiated provider discounts.

In isolation, discounts would not be fully reliable. We then looked at the total per member per month (PMPM) costs as well. The table on below summarizes our analysis, looking regionally.

Medicaid Region	Overall	Experience PMPM	Relative Cost	Discount Only PMPM	Relative Cost
Northeastern	41%	$421	1.012	$421	1.014
Northern	29%	$493	1.184	$508	1.223
Southeastern	44%	$439	1.055	$400	0.962
Southern	46%	$383	0.921	$385	0.927
Western	23%	$490	1.179	$551	1.325
Statewide	42%	$416	1.000	$416	1.000

The Discount Only PMPM simply the Statewide PMPM and only adjusting for discounts. So for the Northern Region, the rate would be $416 x (1-0.288)/(1-0.417) or $508. Using the plans' net reported discount does seem to correlate with the resulting costs. Segal has done considerable analysis from the information reports, both specific to plans and within a region. Note that this is self-reported and has **not** been audited.

This detailed data was collected during the negotiations for 2016. However, the information is limited to the currently contracted health plans and to each health plan's current ETF service area and membership. The health plans' full networks generally cover a somewhat broader service area than the area provided to ETF; this data was not collected or necessary when doing 2016 renewals.

In conjunction with ETF, Segal issued a Request for Information (RFI) to receive additional pricing and provider discount information, as well as network and provider access information.

Respondents were not limited to the current health plans contracted with ETF or to their current service areas. Many additional health plan organizations in the market were invited to participate.

Based on our review of the current service areas data, and supported by the discounts and provider access data submitted in response to the RFI, we recommend a structure with three geographic regions:

- In the **Southern Region**, there are many plans with a service area focused in, and around, Madison and Dane County. This region has approximately 99,000 members, which is roughly 50% of the total membership.
- Many plans operate in both the Northeast and Southeast regions, indicating that a combined **Eastern Region** is practical. The combined region would have approximately 53,000 members.
- There are approximately 27,000 members in the Northern and Western regions. There are at least two health plans with an ETF service area currently covering the majority of the combined **Northwestern Region.** Although preliminary results indicate a combined region is feasible, has good access and would be cost effective, there would likely be significant disruption in the Northern region. As ETF moves forward, this region, in particular, may need to remain subdivided initially.

Based on our analysis, we conclude there is an opportunity for ETF to achieve $45-70M in medical claims savings from consolidating the number of health plans and converting to a regional approach with regions determined by ETF and uniform for all health plans. This can be accomplished without sacrificing Provider Access, while improving overall performance of Total Health Management and with a significant Network Match (minimal Disruption).

	Southern Region	Eastern Region	Northwestern Region
Number of Plans with Virtually 100% GeoAccess	9	4	4
Estimated Discount Improvement Opportunity	3.0%	5.0%	5.0%
Estimated Associated Claims Savings	$22.5M	$24.1M	$10.9M

While there are some notable exceptions in the Southern Region, many of the plans' networks overlap to a large degree and consolidation is not likely to result in significant provider disruption for members. If a member utilizes a specific provider on a regular basis and that member's plan's contract is discontinued, then it is very likely that the provider in question is in another plan's network.

Our recommendation would be to contract with up to two health plans per region, alongside a single statewide health plan. This provides a uniform option across the entire membership, while enabling ETF to leverage the very best of the regional health plans. If a single health plan is selected at the regional level, then pricing may be improved without affecting access but there may be some material disruption in selected areas.

We recommend that ETF structure this within a self-insured environment, but the savings detailed above are solely from the regional approach and consolidation and not from self-insurance. There are a tremendous number of advantages to operating in a self-insured environment; these are detailed later in the **Self-Insurance** section of the report.

Benefit Design

Our recommended benefit design incorporates structural features beyond the typical cost-sharing provisions.

- **Tiered Networks:** Providers achieving higher efficiency and/or quality scores are placed in the preferred tier, and patients are given a financial incentive to choose these providers. In the case of physicians, this incentive is typically a moderately lower copayment; for hospitals, it may be a lower coinsurance rate. The ultimate goal is to construct a tiered network to deliver the most efficient care possible and drive utilization to those providers.

- **Reference Based Pricing:** Reference based pricing utilizes an identified network of providers willing to render targeted services at or below a pre-determined price. We recommend working with the contracted plans to develop an array of services subject to reference based pricing. This may initially include hip and knee replacement, colonoscopy, magnetic resonance imaging (MRI) of the spine, computerized tomography (CT) scan of the head or brain, nuclear stress test of the heart, and/or echocardiograms.

- **Centers of Excellence (COE):** All providers are not created equal and outcomes vary widely between providers. The concept of having designated providers, typically hospitals as "centers of excellence" has been around for many years and is being applied to an ever-expanding number of procedures. Typically, the price charged for these services is a bundled price for all associated care. We recommend incorporating an expanded COE component to the program and contract with plans that utilize a comprehensive COE network with demonstrated effectiveness.

Plan Designs

As of 2016, the following plan names have changed and may be referenced differently throughout this document. UBD has become the It's Your Choice (IYC) Health Plan, the HDHP is now the IYC HDHP and the Standard Plan is now the IYC Access Health Plan.

The following recommended designs build off the IYC Access Health Plan, with In-Network benefits similar to the IYC Health Plan. The current In-Network benefit is primarily the Preferred Network Benefit level, with the new In-Network having slightly more cost sharing. The Out-of-Network benefits are similar to current benefits. This should result in the desired steerage towards the higher quality, more efficient providers. Additionally, there is a $5-$10 office visit copay reduction for members engaged in appropriate disease management programs.

RECOMMENDED PLAN OFFERINGS

	IYC Tiered Network Plan Design			IYC HDHP
	Preferred	In-Network	Out-Network	
Annual Deductible				
Individual	N/A	$250	$500	$1,500
Family	N/A	$500	$1,000	$3,000
HSA Employer Contribution				
Individual	N/A	N/A	N/A	$750
Family	N/A	N/A	N/A	$1,500
Office Visit				
PCP	$15	$25	30%	$15, after deductible
Specialist	$25	$35	30%	$25, after deductible
Emergency Room	$75	$75	$75	$75, after deductible
Coinsurance	10%	20%	30%	10%
OOP Limits				
Individual	$1,250		$2,500	$2,500
Family	$2,500		$5,000	$5,000
	Members who engage in disease management have a $5-$10 reduction to their physician copayment (in addition to pharmacy enhancements)			

Employee and Non-Medicare Retiree Premiums

We recommend a modified three-tiered approach for determining employee premiums. However, unlike the current structure, we do not expect all our plans in the program to be in Tier 1. In order to be considered Tier 1, the plan must demonstrate a significant financial advantage over the Tier 2 plan. With that in mind, we expect the bulk of the membership to initially be in Tier 2 plans. As plans demonstrate their capabilities, they can migrate to Tier 1.

Another part of the contribution strategy is the integration of the wellness premium credit/penalty. A member that meets his or her wellness requirements would receive a $50 monthly premium reduction ($100 for family coverage). That member would have lower contributions than in Tier 1 in the current program. This reduction would be funded by the additional premiums paid by the members that do not participate in the wellness program. If plans are truly operating at Tier 1 levels, their contributions would be even lower.

2016 ETF PLAN DESIGNS

	HDHP	Tier 1	Tier 2	Tier 3
Single	$29	$83	$168	$253
Family	$73	$209	$421	$632

RECOMMENDED PLAN OFFERINGS—ILLUSTRATIVE PREMIUMS

	HDHP	Tier 1	Tier 2	Tier 3
W/O Wellness				
Single	$79	$102	$123	$203
Family	$173	$235	$289	$483
W/Wellness				
Single	$29	$52	$73	$153
Family	$73	$135	$189	$383
	Employee and Spouse participation required. Penalty is $50/$100 Single/Family			

The premiums in these tables are for medical and pharmacy coverage only and do not include dental premiums.

Tier 1 premiums will be established to share the value provided by higher performing health plans, which, for purposes of this illustration, are expected to provide costs 10% or more below Tier 2 plans.

Tier 3 premiums will be established to pass the full differential in costs between Tier 3 and Tier 2 plans, which is expected to be 10%. With this approach, ETF will be financially neutral regarding Tier 2 and Tier 3 enrollments.

In Summary

We are not anticipating significant savings from this benefit structure alone. Savings are anticipated over time as the reference-based pricing and centers-of-excellence components are implemented and grow towards maturity. The benefit and premium structure is designed to support the recommended THM strategy and is not designed to generate savings to ETF from member cost shifting.

The additional wellness contributions will enable the plan to provide a number of value based benefits, offering plan members reduced cost sharing and lower contributions. The benefit design drives utilization and provider choices that will result in more efficient and higher quality care.

Note that the benefit design is meant to be a greater value than the current program provides. There is no cost-shifting if members engage appropriately and use preferred providers. If members choose non-participating providers and do not engage in their health, they will likely have increased cost sharing and a higher contribution rate (wellness premium).

Below is a comparison of some of the key design differences between the current plan and the recommended plan.

	Current Plan	Recommended Plan
Statewide/National Option	✓	✓
Competitive Statewide Plan	✗	✓
Service Areas Defined by Plans	✓	✗
Uniform Regions	✗	✓
Tiered Networks	✗	✓
Closed Network Option	✓	✓ (Maybe)
Value Based Copays	✗	✓
Wellness Incentives	✓	✓
Wellness Participation Premium Incentive/Penalty	✗	✓
Reference Based Pricing	✗	✓
Integrated Telemedicine	✗	✓
Gain Sharing	✗	✓

We do note that some of the current plans may have an element marked with "✗" above, but this would be considered an outlier and not representative of the entire program structure.

Pharmacy

Increasingly, pharmaceutical treatments are the most cost effective option to treat illness and disease. Advances in technology and research will continue to present new treatments that keep workers out of the hospital, avoid surgical intervention, reduce complications from disease, reduce the frequency of disability and in some cases offer cures to once life threatening disease.

However, Americans consume roughly 50% more prescription drugs than the average citizen in other developed countries (*source: IMS Health*) without better mortality rates. This situation is partly driven by industry promotion, partly by the practice of defensive medicine by providers, and partly by a lack of price controls on drugs in the United States. Plan sponsors need to take steps to balance the need to provide their members access to the right medication at the right time with the need to combat excessive price inflation and manipulative marketing tactics employed by the pharmaceutical industry.

Strategies that improve the health of the population covered by the employer's plan will reduce waste and the frequency and intensity of polypharmacy patient demands in the future. Improving the health care literacy of plan participants will improve medication adherence results and increase rational consumerism. Finally, tactics that apply new ideas that encourage appropriate utilization of benefit dollars and secure best-in-class pricing terms will be required to get the best economic value for ETF.

ETF's pharmacy benefit expenses as a percentage of overall medical plan costs (medical and drug combined) are reasonable compared to other large plan sponsors. Also, the program already

includes a number of important and effective measures to control costs and manage expenses appropriately.

Overall, the steps ETF has taken for 2016 will mitigate a portion of their future plan cost trends. More steps will need to be taken to continue to manage per capita cost trends to single digits in the years ahead.

Additional strategies include:

- **Generic Dispensing Rate (GDR) Targets** - ETF should encourage the current Pharmacy Benefit Manager (PBM), Navitus, to take an active role in driving utilization toward generics. A future performance guarantee to consider may be to set target GDR increases in some key disease states with pay for performance incentives that the PBM can earn when targets are met. For example, for every 2% increase in the GDR for that disease, the PBM might earn .25% in case management fees to a set maximum dollar amount per year.

- **Limited or Tiered Networks:** Segal's experience suggests that by limiting the retail pharmacy network, additional savings can be realized. Plan sponsors typically can save up to an estimated 1.5% to 3% of retail drug costs.

- **Specialty Drug Network:** Deeper discounts exist for specialty pharmacies by concentrating the volume through fewer providers. However, the true savings and benefits lie in the enhanced clinical outcomes and reduction of waste these specialty pharmacies provide. Savings from use of an exclusive specialty pharmacy manager would require additional study but has been seen in other large employers to reduce both medical and specialty Rx claims by several percentage points over time.

The upcoming PBM RFP should explore the market's ability to support these strategies for ETF.

Long-Term Strategies

A number of longer-term strategies are developing that may be of use to ETF in managing its pharmacy benefit program. Segal highlights five such developments that should be discussed and considered by ETF.

- Prospective Maximum Acquisition Cost (MAC) Price List for Generics
- Targeted Reference Based Pricing for Brand Drugs
- Integration with medical data
- Per Member Per Year (PMPY) cost trend guarantees by class
- Leaner and Rational Plan Design Concepts

These strategies are less evolved but with the size and influence of ETF, we believe you can shape the market during your next PBM procurement.

Summary of Recommendations

In our initial report, Segal made a number of recommendations for specific changes to ETF's pharmacy benefit program for 2016. This report focuses on opportunities for 2017 and beyond.

We are recommending the following changes:

1. **Consider narrow or tiered networks:** Annual savings $3 to $3.5 million per year on retail non-specialty ingredient costs

2. **Move to exclusive contracting for specialty drugs:** Annual savings $2 to $3 million per year in specialty savings from improved pricing and utilization controls

3. **Obtain better Retail 90 pricing either through bids or custom contracting:** Annual savings will vary based on custom contracting and current terms for 90 day retail supply

4. **Tighten up medication management services -** Annual savings of 1% to 2% of program costs. Medication management strategies is the general term that includes clinical programs and member education programs that address both specialty and non-specialty treatments. It includes strategies that support medication adherence, step therapy, prior authorization, quantity limits, patient education around polypharmacy and side effects, etc.

5. **Add a new lower cost Medicare Part D plan option:** This will allow for the offering of substantially lower cost retiree premium option will provide greater choice for retirees

6. **Pursue several new contracting concepts with either the current PBM or through bids**

7. **Adding performance guarantees around clinical outcomes**

Additionally, given the high level of satisfaction with Navitus' service and relatively good financial performance, Segal supports extending the contract through 2017. Extending for another contract year will allow time for the development of a comprehensive PBM RFP and allow for sufficient time for a comprehensive bid process.

With the above we would estimate savings of $10-$20 million could be achieved. Further research will need to be performed to solidify these estimates.

Data Management

ETF participates in the Wisconsin Health Information Organization (WHIO) initiative, which includes access to a statewide, centralized health database consisting of reporting on quality and cost of health insurance experience. WHIO contracts with OptumInsight to provide the platform of its data warehouse through license to an enhanced DataMart.

As noted in our first report, there are limitations within the WHIO DataMart, which in turn limit ETF's ability to analyze opportunities for population health improvement while maintaining costs.

As additional strategic options are considered, including additional value-based elements, ETF needs to be better positioned with comprehensive data to support its ongoing plan management needs.

- **Financial Management:** ETF needs to be able to measure and analyze the aspects of a health plan that are related to budgets, forecasts, rate setting, and reporting.

- **Benefit Design & Network Management:** ETF needs to be able to identify and evaluate services that support design effectiveness, network performance, cost sharing strategies, and vendor management.

- **Medical and Pharmacy Quality Adherence:** ETF needs to have the ability to measure and evaluate preventative services compliance, compliance with standards of care, and prescription drug adherence.

- **Health Management & Wellness Program Design:** ETF needs the ability to perform analyses that support wellness design, including health risk assessment data analysis, chronic conditions profiling and program design modeling.

- **Vendor Performance & Contract Adherence:** ETF needs to have an enhanced ability to evaluate and monitor targeted performance guarantees, conduct discount analysis and review payment accuracy.

- **Provider Quality:** As ETF considers longer term and additional value based components in the program's design and strategy, there needs to be the capability to evaluate and compare quality and efficiency at the provider, or provider group, level.

ETF needs a warehouse option that has rigorous data cleansing processes with comprehensive benchmarking and an ability to go beyond canned reporting. ETF also needs an option to supplement ETF staff capabilities cost effectively (e.g., enhanced analytics assistance).

With a number of structural changes, it is possible that WHIO could be enhanced to meet these needs. Based on our conversations with WHIO, it does not appear likely these changes could be implemented timely. Alternatively, there are a number of vendors in the marketplace that can meet the needs of ETF. In our opinion, a better option for ETF is to competitively bid and contract with an external data warehouse system vendor that could provide a ready-made system tailored to ETF's specific structure and data and functional needs.

It is our recommendation to issue an RFP in 2016 for a 2017 implementation. This will enable ETF to have a data management solution in place as the additional detailed data is provided by the plans during the transition to self-insurance and for ETF to begin to more effectively manage the program in a relatively immediate fashion.

Market Observations

We have reviewed and provide observations on a number of topics of direct relevance to ETF's health benefit plan.

Minnesota State Employees Group Insurance Program

The Minnesota State Employees Group Insurance Program (SEGIP) provides an interesting point of comparison with ETF's program. Not only is this the plan for state employees in a neighboring state, but SEGIP formerly utilized an insured managed competition model similar to ETF's and transitioned some years ago to a self-insured strategy with a more focused number of health plans.

Currently, SEGIP utilizes three statewide plan options and utilizes a tiered provider network approach. Providers are tiered by SEGIP, with tiering uniform across all three plans. Pharmacy is carved out, with the same benefit provided to all members and administered by Navitus.

SEGIP benefits are richer than ETF's. However, the full funding rate for single coverage is approximately $525 per month, which is about 24% less than the average single rate for ETF's UBD, which is $689. About 9% of this difference is explainable by geographic cost differentials (Wisconsin is a more expensive market than Minnesota, generally speaking). This leaves approximately 15% remaining unaccounted, some of which could be due to differences in demographic or health risk. In our opinion, the difference between the two memberships' risk is not likely to account for much of this difference. Therefore, there is something about the SEGIP self-insured, three health plan strategy that results in relatively well-managed costs.

National and Regional Market Changes

Regionally, we examined three organizations that are evolving and working to improve efficiency and quality in the Wisconsin marketplace: The Alliance, AboutHealth and the Integrated Health Network. All three are growing, expanding and developing organizations that reported attractive provider pricing and access in some areas of the State. However, at this point, none has evolved to the point of being a health plan and would be most viable to ETF as a partner with an existing health plan.

Nationally, there are a few significant mergers underway, or proposed. Four of the country's largest health plans are involved. Aetna is acquiring Humana and Anthem has proposed to buy Cigna. If both the mergers succeed, they would effectively consolidate the number of large health insurance carriers from five to three. The Anthem-Cigna merger would result in the combined organization being the largest U.S. health insurer by membership. These deals are being reviewed by the Department of Justice and state insurance regulators.

In addition, there has also been activity on the national PBM level. United Health Group has agreed to purchase Catamaran, a large PBM. Catamaran will be folded into United Health's OptumRx pharmacy care services unit. Once combined, OptumRx projects that it will fill over 1 billion prescriptions. As a point of reference, Express Scripts, another large PBM, filled about 1.3 billion prescriptions in 2014.

Observations on Wisconsin State Marketplace/Exchange

Similar to the results in our prior report, in 2016, ETF will offer five UBD options in Madison, with premiums that will range from $576 to $655. By comparison, there will be eleven platinum plans available in Madison on the state marketplace with premiums ranging from $389 to $513. As in 2015, all of the ETF plans are higher cost than the highest cost option on the Exchange.

Plan options and premiums vary on the Exchange by age and location, but if State employees used the Exchange to purchase coverage under Gold Plans, the total plan costs would be 18% to 32% ($207 million to $371 million) lower in 2016. Note that ETF plans are approximately 12% richer than the Gold Plans on the Exchange, providing explanation for some of the difference.

A well-designed state employee health plan like ETF should be able to provide benefits in a more cost efficient manner than those available in the same state's healthcare marketplace. We believe that ETF should continually be addressing the cost efficiency of its programs, and Wisconsin's public Exchange provides a comparison point to measure this efficiency.

Health Care Pricing Transparency Tools

Transparency in health care can be broadly defined as the availability of reliable health information about the cost and quality of health care services. A variety of tools exist in the marketplace and are becoming increasingly sophisticated and are based on an expanding database of provider and pharmacy pricing.

Despite these developments, consumer utilization of transparency tools has not increased significantly. Some plans and employers are including member incentives to increase utilization. However, there is not currently conclusive evidence available to measure and report on the impact increased utilization has on costs and care efficiency.

Consumer Directed Health Update

According to the Kaiser Family Foundation 2015 Employer Health Benefits Survey, almost a quarter, 24 percent, of covered workers are enrolled in an HDHP with a savings option. That percentage is nearly double the enrollment of those plans from just 5 years ago. In addition, in 2015, seven percent of firms providing health benefits offered an HDHP with an HRA and twenty percent offered a qualified HDHP with HSA.

The Kaiser information is consistent with information presented in our first report and provides additional evidence that consumers access healthcare via these plans at a growing rate. For 2016, the State contribution to ETF's HDHP was increased and enrollment is expected to increase from approximately 400 subscribers in 2015 to approximately 1,500.

Self-Insurance

Self-insurance is not a new concept for the State of Wisconsin. ETF has maintained a self-insured pharmacy program since 2004 and results appear to have been successful. With Navitus contracted as the Pharmacy Benefit Manager, ETF has a transparent program providing full access to claims data, a partner that is both flexible and proactive in managing costs on behalf of ETF, and a uniform plan experience for all members wherever their location. For 2016, the dental benefits will migrate to a self-insured approach with Delta Dental contracted as the administrator. The State's Worker's Compensation program is also self-insured.

Large plans generally self-insure the risk and costs for medical and pharmacy benefits. As noted in our first report, the large majority of state health plans self-insure all their health plan options. Some even self-insure their HMO offerings. As noted in the **Market Observations** section in our first report, all but one of the current ETF health plans report the ability to support a self-insurance approach.

What Are the Benefits of Self-Insuring?

There are several reasons why employers choose the self-insurance option. The following are the most common reasons and are primarily financial:

- **Elimination of premium tax:** Wisconsin health plans do not pay a premium tax. However, some ETF plans pay a premium tax in their home state, depending on that state's regulations. Nationally, this rate is approximately 2% of premium. With many ETF plans not subject to premium tax, the aggregate rate is quite low, approximately 0.1% of total ETF premium. This equates to an immediate savings of $0.9 million annually in 2016. There is no premium tax on the current self-insured plans.

- **Elimination of Affordable Care Act (ACA) Market Share Fees:** This fee was introduced with the ACA and applies to all fully insured medical and/or dental business. The fee is to be divided between all health insurance issuers and is expected to increase beyond 2018. The fee allocation is not uniform, with larger plans paying a larger portion and the smallest plans not subject to the fee. This fee is not applicable to self-funded health plans. In aggregate across ETF's health plans, the fee is approximately 2% of health premiums, or $18.3 million annually in 2016.

- **Lower cost of administration:** Employers find that administrative costs for a self-insured program administered through a contracted third party administrator (TPA) – even if that TPA is also a carrier—are generally lower than those included in the fully insured premium by an insurance carrier or health plan. We compared the current ETF administrative fees with those paid by other state plans, other Wisconsin employers, and rates reported in national benefits surveys. It is estimated the current ETF per subscriber per month (PSPM) rate is $44 (reduced from $84 at the beginning of this year's negotiations). The highest rate in the expected range for other state plans is $30 PSPM. This $14 difference equates to $11.2 million annually in 2016.

- **Carrier profit margin and risk charge eliminated:** The profit margin and risk charge of an insurance carrier/health plan are eliminated for the bulk of the plan. Normally these represent 2-4%. However, the loads reported by ETF plans are lower, with the average profit

and risk load in 2016 reported at 1.2% in aggregate. Eliminating this 1.2% load results in an immediate savings of $11.0 million annually in 2016.

- **Cash flow benefit:** The employer does not have to pre-pay for coverage on monthly premium basis, but can fund claims dollars just as they are needed for payment. This can result in improved cash flow. The employer also maintains control over the health plan reserves, enabling maximization of interest income that would otherwise accrue to the insurance carrier through their investment of premium dollars not yet needed for claims payments and other expenses. A typical lag for medical claims is approximately one month, which equates to an estimated $72.1 million in 2016. At a modest investment return of 1.0%, the additional investment income would be approximately $0.7 million annually in 2016.

- **Management of Excise Tax Exposure:** While the regulations have not yet been finalized, it is anticipated that the 40% Excise Tax will be determined for each individual subscriber within assigned groups based on coverage tier and plan groupings. Therefore, employees and retirees in health plans with higher premiums will produce a larger Excise Tax exposure for ETF and the State. It is anticipated that self-insurance will provide more flexibility in establishing rates than available with fully insured premiums. Currently, the Excise Tax exposure is approximately $3-4 million, and the immediate impact of self-insurance is fairly minimal in the short term. However, the impact grows over time and is estimated to be as much as $41 million by 2027.

There are also other non-financial reasons plans choose to self-insure their programs. These include:

- Control of plan design
- Data collection
- National provider network
- Custom Provider Network
- Mandatory benefits are optional
- Cost reporting

Financial Impact

The projected annual savings associated with a conversion of ETF's current plans to self-insurance is $42.1 million and is summarized in the following table.

Component	First Year Impact
Premium Tax	$0.9 M
ACA Market Share Fees	$18.3 M
Administrative Costs	$11.2M
Profit Margin and Risk Charge	$11.0 M
Improved Cashflow (Investment only)	$0.7 M
Total	**$42.1 M**

This is an estimate of the impact on fixed dollar costs and does not account for any changes in plans, claims or program structure that could also affect costs. In theory, the current program could be converted to self-insurance and remain otherwise largely unchanged. However, converting 17 fully-insured plans to self-insured is not considered practical, nor feasible, and is not recommended. Our recommendation is to combine a conversion to self-insurance with the regional restructuring and plan designs provided in the **Program Structure** section. This may be best structured through a phased-in approach.

Cash Flow and Reserving

As previously stated, the transition to self-insurance alone is not anticipated to change the underlying claims costs, with savings resulting from a reduction in the fixed, non-claims costs. The conversion will result in a change in the timing of payments made by ETF. Where fully-insured premiums are paid up-front, self-insured claims are paid after the date of service, which results in a run-in period from which both a cash balance and reserve will be built. Therefore, the conversion to self-insurance should produce a month or so of claims cash flow improvement.

The GIB has a policy to maintain cash reserves in a target range of 15-25% of paid claims (including 20% of insured premiums). So overall, the current fully-insured reserve was 3-5% of total annual premiums. A typical reserve for a self-insured medical plan will be 1-2 months of paid claims or 10-15% of total incurred claims. This change in cash flow is similar to what occurred with the transition to self-insuring the pharmacy benefits and what will occur in early 2016 with the dental program. So larger reserve may be necessary, but the cash account will also be higher to compensate for that. We would recommend maintaining the higher 25% first year, to compensate for the run-in and build the reserve needed to fund the IBNR. This should result in a reserve of approximately 10% over the IBNR.

Gain Sharing

In some corners of the industry, there are those that remain skeptical that a health plan will not remain as diligent in managing member utilization and provider costs as it would in a fully-insured arrangement. To mitigate this potential threat, we propose incorporating incentives and penalties for plans as well as for members. The incentives/penalties for members are based on plan design and contribution differentials described in an earlier section. To align incentives for plans, we anticipate incorporating performance metrics with rewards and penalties that are designed to improve member health and manage expenses for ETF. We also recommend that ETF incorporate a gain-sharing component that shares a portion of any financial gains with health plans when they manage costs to be lower than expected for their specific membership.

In Summary

ETF has the opportunity to realize an estimated $42.3 million annually in savings from reductions in fixed costs paid to the health plans by converting to a self-insured model for the plans providing the Uniform Benefit Design. These savings, along with gains associated with the initial lag between service and payment dates should be sufficient to fund the initial reserves for IBNR and solvency needs.

It is worth noting that in the **Self-Insurance Concepts** section of our first report, we estimated that a conversion to self-insurance could result in savings of $50-$70 million. That estimate was

based on a preliminary review of the data and the program and included the expectation that ETF would restructure the program and consolidate health plans. The **Program Structure** section of this report includes our recommendations for health plan consolidation and a regional approach to selecting and contracting vendors. We demonstrated the associated savings for the restructuring and consolidation to be $45-$70 million. Coupled with the savings estimated in this section of the report, the combined annual savings opportunity is $85-120 million, slightly greater than originally estimated.

A self-insured program would provide ETF with significantly improved transparency and access to the detailed data necessary to sufficiently manage the program. ETF and the GIB would also have increased flexibility in benefit design beyond that available through a fully insured plan. Self-insurance may very well provide ETF with additional capabilities to manage exposure to the Excise Tax.

The vast majority of other states utilize self-insurance for their state employee health plans and, in our analysis, there does not appear to be a compelling reason for ETF to remain fully insured over the long-term strategy.

We recommend a phased-in approach to transition to self-insurance. Beginning in 2016, for the 2017 health plan renewal, ETF should require all health plans to provide complete encounter, claims and pricing data at claim level detail. Thereafter, ETF could move toward self-insurance on a timeframe that is most advantageous to the program and also allows ETF staff to manage the transition in a thoughtful manner. Future phases will include the collection of additional data within the new regional structure, the potential inclusion of gain-sharing and a double-sided risk-sharing approach.

Retiree Coverage

In Wisconsin, when state employees retire, they have the option to continue medical, dental and pharmacy benefits at the full cost of coverage. In order to pay for the benefit, retirees use their accrued sick leave. At retirement, unused leave, in conjunction with pay, is converted into a notional account balance that can be used to cover the cost of medical, drug and dental premiums.

Monthly premiums for Pre-Medicare retirees vary by as much as $200. Not surprisingly, the plans with the lowest premiums generally have the highest enrollment. Pre-Medicare retiree premiums are based on experience that is pooled with the active membership. This results in premiums for these retirees being significantly lower than would be the case if they were rated solely on their experience.

In order to reduce costs for the Medicare retirees, we will need to consider some new plan alternatives. We believe additional options exist with lower costs, while maintaining benefit levels. The goal is to contract with Plans to better manage care under group Medicare Advantage programs. Many other states have implemented MA plans with great success. Illinois reduced monthly costs from over $450 to approximately $200 without a reduction in benefits or sacrificing provider access. Actually, group MA PPO plans, meeting the 51% access rule, provide the same provider access as a traditional Medicare Supplement plan and greater access than your HMOs. The 51% rule simply means that the PPO network supporting the plan must cover 51% of the eligible members. If that condition is met, members can use any provider that

accepts Medicare, making the plan a "passive" network, with the same level of benefits in or out of network.

Segal has performed a number of Medicare Advantage opportunity assessments for States. We conducted and Request for Information (RFI) and provided participating organizations summary eligibly and medical claims, as well as detailed pharmacy information. The study included the two largest Group MA Plans – United Healthcare and Humana. We also included one of the largest commercial plans – Anthem.

Below is a summary of the results and the estimated rates provided by the participants:

	Medical Only	Medical & Pharmacy
ETF - Medicare Plus	$188	$400
ETF - Medicare UBD	$246	$447
RFI - Medicare Advantage Plans	$100 – $150	$300 – $350

For the Medical Only rates, we would expect to pair the new MA plan with the existing EGWP program. The rates in the Medical & Pharmacy column are for a potential MAPD with both medical and pharmacy benefits that would potentially also replace the current EGWP program. Note that these rates do not include dental.

Recommendations & Timing

The results of the RFI show that a National Passive PPO with the best-in-class plans could produce savings of $50 to $100 per member, a reduction of 10-20% with no benefit changes. This would result in a total premium reduction of $17 to $34 million annually for retirees.

To coordinate with the active recommendations, we would recommend one National (and Statewide) plan. We would enable the plans selected in each region to have a competitive Medicare product, preferably an MA HMO. This will allow retirees a number of options to best meet their needs and budget.

Like the Total Health Management recommendation, we believe this recommendation can be phased-in. The National Passive PPO could be marketed and implemented for 2017 while the Regional plans implemented in conjunction with the 2018 plan and network changes.

Local Government Plan

The current program utilizes 18 health plans to offer 8 benefit options. Enrollment in many of these options is sparse and there is a significant variation in premiums.

Our recommendation is to revise the program to match the state plan, for simplification. This would include the same regional structure and plans in each region and a statewide carrier. Pricing would be based on the regional alignment, as defined for the state plan. The wellness component may need to be handled differently, based on potential difficulty for local governments to administer the contribution differentials while paying full rates to ETF. However, this may not produce an issue as we have seen states that are able to administer a wellness contribution differential similar to this with a separate local plan, successfully.

We also recommend the program transition to self-insurance for the same reasons we recommend self-insurance for the state plan. This would require a similar reserving structure as recommended for the state. If the plans were combined, the WPE program would have no need for reinsurance and plans could still be rated separately. North Carolina is one example of a state plan that allows local governments to enter the state plan. Experience analysis of that plan shows local participants typically cost less than the state employees, primarily due to age differences.

If the programs cannot be combined into one pool due to statutory limitations, ETF could purchase reinsurance, if desired, with amounts determined based on reserve level and risk tolerance. It could also be structured to buy the insurance from the larger State pool, eliminating the unnecessary profits built into that product.

Affordable Care Act (ACA) Update and Strategies

Since Segal's initial report, the Internal Revenue Service and U.S. Treasury have issued two calls for comments on various aspects of the 40% Excise Tax that will become effective in 2018. The report updates our earlier report on these developments.

ETF will continue to face a potential hit from the 40% Excise Tax that goes into effect for 2018. With the current plans just below or already exceeding the benefit value thresholds for 2018, ETF will need to make changes to reduce the value of its plans in order to avoid the tax.

The Excise Tax calculation must take into account all types of health benefit plans offered by the employer, including not just the primary medical benefit plan, but also pharmacy benefits, dental and vision benefits, Medical Flexible Spending Accounts, Health Savings Accounts, Health Reimbursement Arrangements, Archer Medical Savings Accounts, and even Employee Assistance Plans and on-site clinics providing services to employees and their dependents.

With ETF's current structure of separate, fully-insured health plans with widely varying premiums, the calculation and allocation of any Excise Tax to the appropriate plans and participants will be problematic at best, and likely a virtual nightmare to administer.

We recommend that ETF start now reviewing its situation and the major decisions that will need to be made. Those decisions will include at least: which plans must be counted; how the participants enrolled can be aggregated or disaggregated to minimize the possibility of hitting the Excise Tax thresholds; which agencies will have responsibility in the process; which plans may have to be modified or eliminated; and how any tax liability will be allocated across all the contracted vendors.

Segal updated ETF's potential Excise Tax liability using the negotiated 2016 premium rates, assuming no plan changes are made and the Medical Flexible Spending Account continues to be used at about the same level as currently. The projected tax liability has reduced significantly.

ETF Projected Excise Tax
($ Millions)

	Based on 2015 Premiums		Based on 2016 Premiums	
Year	Tax with 4% Trend	Tax with 6% Trend	Tax with 4% Trend	Tax with 6% Trend
2018	$7	$13	$3	$5
2019	$7	$20	$4	$7
2020	$8	$31	$4	$11
2021	$11	$43	$5	$17
2022	$14	$58	$6	$28
2023	$17	$76	$7	$40
2024	$21	$99	$9	$55
2025	$26	$127	$11	$71
2026	$32	$158	$14	$93
2027	$39	$193	$18	$118

We also included a reminder that the ACA's Employer Shared Responsibility Penalty is now in effect and ETF and the State must continue to monitor eligibility for the plan and the employer subsidy levels to avoid a potential penalty. We understand that the State currently allows employees working at least 1,040 hours per year to join the plan with full employer subsidy, so there is likely little potential for penalty. However, it is important that ETF and the State continue to work together to identify any part-time employees that may be working multiple jobs which together make them a full-time employee under ACA.

In Summary

The report provides specific recommendations for ETF and the GIB to consider for 2017 and beyond, along with our rationale for making these changes. We recognize there are a number of recommendations in this report and have summarized the estimated financial impact for each below, including the timing of the key activities.

Recommendation	Estimated ETF Annual Savings	Potential Timing of Key Activities
Total Health Management	$10 – 30M	• Market wellness vendor for 2017 (RFP in 2016) • Implement wellness and premium surcharges for 2017 • Health management performance initiatives for 2018
Program Structure	$45 – 70M	• Market Statewide Self-Insured PPO/HDHP for 2017 (RFP in 2016) • Market Regional Plans for 2018 • Implement Value-Based Benefit Design with Tiered Provider Networks in 2018 • New employee premium structure in 2018

Recommendation	Estimated ETF Annual Savings	Potential Timing of Key Activities
Pharmacy	$10 – 20M	• Extend Navitus contract for 2017 • Begin implementing strategic changes in 2017 • Conduct pharmacy RFI in 2016 in preparation for RFP • Fully implement changes in 2018 (RFP in 2017)
Data Warehouse	($0.2M) – COST	• Market in 2016 and implement in 2017 (RFP)
Self-Insurance	$40 – 50M	• Expand self-insurance with improved State-wide PPO/HDHP for 2017 • Require collection of detailed claims information for 2017 renewals • Begin transition to self-insurance
Retirees	None[1]	• Statewide MAPD for 2017 (RFP in 2016) • Additional Medicare choices in 2018 in conjunction with regional plans
Local Government	None	• Match changes in State plan (2017-2020)
ACA/Excise Tax	Varies	• Now through 2018

It should be noted that the time and effort required to appropriately plan and implement these changes will be significant. Changes in vendor contracts, benefit design, program structure, budgeting, cash-flow timing, will require extensive communications programs, numerous RFPs, revised vendor contracts, different banking arrangements and potentially additional expertise.

ETF's Office of Strategic Health Policy currently has 14 individuals on staff and the effort required during the multi-year transition will likely tax existing resources and require careful planning, resource allocation and potentially additional resources. Assistance from other state agencies and GIB approval will be required for many of the steps required (such as RFPs and vendor contracting) to implement these recommendations. Given the size of the program and the savings potential, the addition of a few FTEs to staff is a negligible cost.

[1] Savings of $17-34M annually for retirees

Introduction

Segal Consulting was retained by the Group Insurance Board to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program. This report is the second of two and focuses on analysis and recommendations for consideration for the longer-term, with some possibly being implemented as early as 2017. The first report, presented March 25, 2015, focused primarily on opportunities and considerations for 2016.

Background

The State of Wisconsin Employee Trust Fund currently administers retirement, health, life, income continuation, disability, and other insurance programs for 570,000 state and local government employees and annuitants. ETF's Office of Strategic Health Policy administers the state employee health insurance program.

The Group Insurance Board, consisting of 11 members, sets policy and oversees administration of the group health, life insurance, and income continuation insurance plans for state employees and retirees and the group health and life insurance plans for local jurisdictional employers who choose to offer them. The Board also can provide other insurance plans, if employees pay the entire premium.

Membership and Costs

The State and local health insurance programs cover over 245,000 lives. This includes 69,000 active state employees and 26,000 retired state employees and their dependents, and 13,000 active local government employees and 2,000 retired local government employees and their dependents. The program administers nearly $1.41 billion in annual insurance premiums, compared to $1.37 billion projected for 2016.

Based on current premiums, member enrollment, administrative costs and recent claims experience, Segal projects the following costs and expenses for 2016 (amounts in $millions).

	Actives/Non-Medicare Retirees	Medicare Retirees	Total
Total Medical Costs	$896	$84	$980
Total Pharmacy Costs	$176	$69	$245
Total Dental Costs	$44	$8	$52
Total Administrative Fees	$80	$12	$92[1]
Total Annual Costs	**$1,196**	**$173**	**$1,369**
Member Premiums	($204)	($173)	($377)[2]
Net ETF Costs	**$992**	**$0**	**$992**

[1] Note that this is lower than prior report due to discoveries during the annual renewals and is a net post-negotiation effective administrative cost

[2] Retiree Premiums include sick leave funding from the State.

Current Benefits

Most health insurance benefits (98%) are administered through 17 competing, fully insured health plans. Health insurance benefits follow a "uniform benefit" design or "UBD", in that all participating health plans are required to offer the same benefits package. The pharmacy benefit has been administered separately from the insured health plans through a self-insured Pharmacy Benefits Manager (PBM) since 2004.

Also in 2004, the State implemented a three-tier rating system for the health plans that anticipates different levels of employee contribution for each tier. Most plans are offered in Tier 1.

- **Tier 1:** includes the top plans in efficiency and quality, and has the lowest employee contribution.
- **Tier 2:** includes lower ranking plans in efficiency and/or quality, and has a higher employee contribution.
- **Tier 3:** are the lowest ranking plans in efficiency and quality, and highest employee contribution.

The State also administers two self-insured plans—the "Standard Plan" and the "State Maintenance Plan". The Standard Plan is a PPO administered by Wisconsin Physicians Service ("WPS") that provides comprehensive freedom of choice among hospitals and physicians across Wisconsin and nationwide. The Standard Plan is a Tier 3 health plan for employees.

The State Maintenance Plan ("SMP") is available only in counties that lack a qualified Tier 1 Plan. It offers the same UBD benefit design, consistent with the other 17 Health Plans.

For the first time, in 2015 the State is offering employees the option of a high deductible health plan (HDHP). Each participating health plan approved to offer the UBD must also offer the HDHP option. In addition, those participants who enroll in the HDHP will be enrolled in a health savings account (HSA). The HDHP plan option has a minimum annual deductible and maximum out-of-pocket limit. Except as required by federal law, the health plan does not pay any medical, dental or prescription drug costs until the annual deductible has been met. Members must enroll in an HDHP in order to have the state-sponsored HSA. Amounts contributed to the HSA by the state belong to the member and can be used to pay for eligible medical expenses.

Health Management and Wellness

ETF requires the participating health plans to identify members with a moderate or high health risk and have in place a process to enroll them into appropriate health management programs.

Disease Management

ETF has identified five specific areas for disease management, which are covered by the following requirements in the health plan contract:

1. **Low Back Surgery:** Prior authorization for referrals to orthopedists and neurosurgeons for low back pain in members who have not completed an optimal regimen of conservative care. This is not applicable to members who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty referral.

2. **High-Tech Radiology:** Prior authorization for high-tech radiology tests, including MRI, CT scan, and PET scans.

3. **Shared Decision Making (SDM) for Low Back Surgery:** Plans must utilize Patient Decision Aids (PDA) according to International Patient Decision Aids Standards (IPDAS) for members considering low back surgery.

4. **Advance Care Planning (ACP):** Health plans and their contracting providers must provide an ACP program that meet one of the five options outlined in ETF's guidance. Those options include:

    a. Health plan is actively participating in Honoring Choices of Wisconsin, Gundersen's Respecting Choices or the Institute for Healthcare Improvement's The Conversation Project;

    b. Palliative care specialists are added to care teams that commonly care for ETF members with advanced or life-threatening disease;

    c. All ETF members over 60 are offered an opportunity for ACP with a trained facilitator;

    d. All ETF members with a serious disease and a likely survival of less than 1 year will be offered an ACP and/or palliative care consultation; OR,

    e. All ETF members with a likely survival of less than 90 days will be offered hospice services.

    The 2016 contract requires all health plans to offer ACP to the majority of members with a terminal diagnosis.

5. **Coordination of Care (COC)**: With the intent of reducing hospital admissions, health plans (or their contracted hospital/provider groups) must contact members who have been discharged from an in-patient hospital and have a diagnosis of heart failure, myocardial infarction, pneumonia, or any other high-risk health condition within 3 – 5 business days after the initial hospital discharge.

ETF also holds an annual Disease Management Symposium with the contracted health plans as well as meetings with the health plan chief medical officers. These meetings are an opportunity for health plans to share best practices for the areas targeted by ETF and to express challenges that may exist for ETF proposed program expansion.

Wellness

In 2013 the Group Insurance Board (GIB) approved a Uniform Wellness Incentive to begin in plan year 2014. The Uniform Wellness Incentive required all health plans to issue $150 to adult members who completed a biometric screening and a health plan administered health risk assessment (HRA).

Members have the option to complete the biometric screening with their physician or at a worksite biometric screening event. To improve the availability of worksite biometric screenings, the Department of Administration contracted with a single vendor, OptumHealth, in December 2013.

All employers participating in the State of Wisconsin Group Insurance program may access the OptumHealth contract to host worksite biometric screening events. The OptumHealth contract costs for 2016 are covered by a wellness fee of $.40 per contract per month added to the employer health insurance administrative fee paid to ETF. ETF assists with the transfer of screening results from OptumHealth to the health plans. To date in 2015, approximately 17% of eligible members completed the requirements to earn the $150 incentive, compared to 13% in 2014.

WHIO Data Mart

The Wisconsin Health Information Organization (WHIO) is a database resource for health claims information for the state employee health insurance program. WHIO's database is intended to improve health care transparency, quality and efficiency. Fifteen of the state employee health plans currently submit data to WHIO. Beginning in 2015, all ETF health plans are required to submit data to WHIO, and the three plans that have not previously submitted data are being on-boarded this year.

The WHIO Health Analytics Data Mart functions as a data-driven marketplace that enables members to submit information and receive reports that analyze health system and physician performance based on hundreds of variables. The Data Mart is intended for use in identifying gaps in care for treatment of chronic conditions, costs per episode of care, population health, preventable hospital readmissions and variations in generic prescribing.

The Data Mart contains a volume and depth of data on medical services that spans multiple health care systems across the state and multiple service settings, including physician's offices, outpatient services, pharmacy claims, labs, radiology and hospitals.

The Data Mart maintains a rolling 27 months of claims data that comprises the experiences of more than 4 million people and 255 million treatment services. A total of 21.5 million episodes of care are currently in the database and its scope will grow as new members join and contribute to the cooperative effort. An episode of care is defined as the series of treatments and follow-up related to a single medical event, such as a broken leg or heart surgery or the year-long care of a diabetic patient.

Each successive version of the database, refreshed every six months, is intended to capture the most recent health care experiences of additional consumers. The current version of the database contains more than $70 billion of health care expenditures and allows comparisons of those

expenditures by region, county, 3-digit ZIP code and medical system. The WHIO database is Health Insurance Portability and Accessibility Act (HIPAA) compliant.

Benefits Consultant Contract

In May 2014, the State of Wisconsin issued a Request for Proposal (RFP) for a Health Care Benefits Consultant for the Employee Trust Fund (ETF). The RFP stated that the consultant's primary objective is to analyze data from a variety of sources to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program.

Segal Consulting (Segal) was selected for this engagement, with the contract commencing in November 2014. The contract anticipates two main project deliverables:

- Within 6 months of the beginning of the contract, the vendor will provide a documented report ("Report 1") and a presentation to the Group Insurance Board (Board) outlining potential benefit design changes and strategies for the 2016 plan year.
- Within 12 months of the beginning of the contract, the vendor will provide a documented report ("Report 2") and a presentation to the Board outlining potential benefit design changes and strategies for the 2017 plan year.

The RFP also states that the Consultant would receive a large data set from the Wisconsin Health Information Organization (WHIO) immediately once under contract. WHIO provided data to Segal on January 16, 2015.

To fit the timing required for consideration, approval and implementation of changes for 2016, it was agreed that Report 1 would be presented to GIB at a meeting in March 2015. Segal and ETF agreed upon a modified scope for the first report to reflect the delay in receiving usable data from WHIO.

In Report 1, we presented our comments and observations on the following topics:

- **Benchmarking Comparison:** comparison of ETF benefits with regional and national practices, with recommendations for 2016
- **Total Health Management:** review of ETF membership's current health risk and comparison of the health plans' risk and care gaps
- **Pharmacy:** comparison of PBM contract with current market practices and review of current benefits, with recommendations for 2016
- **Consumer Directed Health (CDH) Care Design:** comments and observations on recently implemented CDH options, with recommendations for 2016 to increase enrollment
- **Private and Public Exchanges:** overview of private and public exchanges, and comparison of ETF benefits and costs with those of Gold and Platinum plans available in the Wisconsin Healthcare Marketplace

- **Affordable Care Act (ACA):** review of the Excise Tax due to be implemented in 2018 and ETF's potential exposure
- **Market Observations:** comments and observations on current practices, emerging trends and potential opportunities in the Wisconsin market
- **Self-Insurance Concepts:** summary of the advantages and disadvantages of self-insurance and the feasibility of implementation by ETF
- **WHIO Database:** comparison of WHIO capabilities with best practices for ETF and options for improved ETF data management

As a result of our analysis and the discussion that ensued from the first report, the GIB and ETF implemented several changes for 2016.

Benefit changes

The 2015 UBD provides one of the highest benefit value in the country (96%), presenting an opportunity to adjust benefits and remain competitive. The initial enrollment in the HDHP option was very low (approximately 400 contracts). We recommended enhancing the State's HSA contribution (to $750 for an individual and $1,500 for family) as a measure to help increase the overall value of the CDH option(s), which would then help to encourage additional enrollment for 2016.

Note that some of the plan names have changed and may be referenced differently throughout this document. UBD has become the IYC Health Plan, the HDHP is now the IYC HDHP and the Standard Plan is now the IYC Access Health Plan.

UNIFORM BENEFIT DESIGN (IYC HEALTH PLAN)

	2015	2016
Annual Deductible		
Single	None	$250
Family	None	$500
Annual Maximum Out-of-Pocket[1]		
Single	$500	$1,250
Family	$1,000	$2,500
Office Visit Copays		
Primary Care Physician	10%	$15
Specialist	10%	$25
Therapy Copays		
Chiropractic Physical Therapy, Speech Therapy and Occupational Therapy	10%	$15
Actuarial Value	**96%**	**92%**

[1] Annual Out-of-Pocket Maximum was increased to include all Copays

The Actuarial Value is the percentage of the total claim paid by the benefit plan. The higher the value, the greater the benefit to the member.

THE STANDARD PLAN (IYC ACCESS HEALTH PLAN)

	2015 In/Out Network	2016 In/Out Network
Annual Deductible		
Single	$200/$500	$250/$500
Family	$400/$1,000	$500/$1,000
Annual Maximum Out-of-Pocket		
Single	$800/$2,000	$1,000/$2,000
Family	$1,600/$4,000	$2,000/$4,000
Office Visit Copays		
Primary Care Physician	10%/30%	$15/30% after ded
Specialist	10%/30%	$25/30% after ded
Therapy Copays		
Chiropractic Physical Therapy, Speech Therapy and Occupational Therapy	10%/30%	$15/30% after ded
Actuarial Value	**93%**	**91%**

The benefits were changed to be consistent with the UBD benefit design. Note the actuarial value is slightly lower due to the out-of-network provisions.

HIGH DEDUCTIBLE HEALTH PLAN (IYC HDHP)

	2015	2016
Office visit copays now apply once deductible is met. No other changes to the medical benefit provisions were made.		
Annual State HSA Deposit		
Single	$170	$750
Family	$340	$1,500
Actuarial Value	**83%**	**87%**

The plan changes make the HDHP more competitive, especially with the higher contribution to the HSA.

For 2016, brand and specialty drugs will be covered on a coinsurance basis. Generics will still have a $5 copay. Out of Pocket limits will also be increased. This structure should further incent members to utilize lower cost medications.

PHARMACY—ALL PLANS

		2015	2016
Level 1		$5	$5
Level 2		$15	20% ($50 max)
Level 3		$35	40% ($150 max)
Level 4 – Preferred Level 4 – Non-preferred		$15 $50	$50 40% ($200 max)
Out-of-Pocket Limits	Level 1&2	$410	$600
	Level 4	$1,000	$1,200
ACA MOOP (Medical & Rx)		$6,600	$6,600
Actuarial Value (UBD)		**92%**	**89%**

Note that for the HDHP, the pharmacy benefits apply after meeting the annual deductible.

Health Plan Negotiations

During the summer 2015 negotiations and renewal process for the 2016 plan year, some program and operational modifications were introduced for the participating health plans. Additional data detail, including billed and allowed charges were required, along with an attestation from each plan's CFO or actuary that the data submitted was complete and accurate. The additional data provided enhanced clarity and transparency to the process.

2016 Savings

Between the plan changes approved by the GIB for 2016, and the improvements in the renewal and negotiation process, the realized savings for 2016 are significant and greater than Segal's initial estimates.

SAVINGS/(COSTS) ESTIMATE
(IN $MILLIONS)

	Original Estimate	After Negotiations
Medical Benefit Changes	$50	$46
Pharmacy Benefit Changes	$8	$8
Health Plan Negotiations (Above Typical 2% Year)	$10	$35
Total Calendar 2016	**$68**	**$89**

Observations and Recommendations for 2017 and Beyond

For this Report 2, we present our comments, observations and recommendations on the following topics:

- **Total Health Management:** This section presents our analysis of the WHIO data to identify the most prevalent diseases, health risks and corresponding gaps in care. The report includes recommendations for a value-based incentive structure that includes incentives for members, vendors and providers in a fashion that is aligned to address care gaps and manage the membership's health risk.

- **Program Structure:** This report section includes an illustrative benefit structure to support the value-based benefit design, and is presented along with a recommendation to improve overall provider discounts and pricing while maintaining access and quality health management. Recommendations are supported by market data and analysis.

- **Pharmacy:** In collaboration with Navitus, we examined opportunities to improve net drug costs by reviewing such strategies as tiered networks, specialty drug management, alternative formularies and value-based benefit designs.

- **Data Management:** In the time since the first report, we facilitated ETF discussions with several of the major data management and warehouse vendors. The report identifies several ETF needs and best practices for effectively managing the program, along with a recommendation for meeting those needs and incorporating as many of those best practices as possible.

- **Market Observations:** This section includes our comments and observations regarding the current marketplace in Wisconsin, along with a comparison with the state plan in Minnesota, whose local and state market is similar to that in Wisconsin.

- **Self-Insurance Analysis:** The report analyzes the financial impact of implementing self-insurance, and discusses the advantages and potential disadvantages of self-insurance.

- **Retiree Coverage:** While retirees essentially pay for the full cost of coverage, resulting in virtually no costs to the State, there exist opportunities to improve the efficiencies of the program to benefit both the State and the retirees. In the time since the first report, we worked with the main vendors in the Medicare Advantage (MA) market to assess the potential financial opportunity for an expanded MA presence in the ETF program.

- **Local Government Plan:** Our report includes commentary on implementing many of our recommendations for the State plan, with a discussion on particular issues and considerations specific to the Local Government Plan.

- **Affordable Care Act (ACA) Update:** Since the initial report, the Internal Revenue Service and U.S. Treasury have issued two calls for comments on various aspects of the 40% Excise Tax that will become effective in 2018. The report updates our earlier report on these developments.

- **Recommendations and Next Steps:** The report provides specific recommendations for ETF and the GIB to consider over the longer term, along with our rationale for making these changes to improve the overall program for the State and its active and retired employees. The report addresses necessary steps to implement recommended changes beginning 2016 as well as to begin discussions and planning for changes beginning as early as 2017.

Throughout this report, Segal presents recommendations for consideration by the GIB for future implementation. We present these recommendations as a set of changes that will result in a positive impact to future plan costs and participant health status with the understanding that they may be discussed and implemented in separate actions over time.

Following the main narrative of the report, Segal also provides a number of Appendices that include detailed data tables not included in the main body of the report, as well as a listing of our data sources and methodology.

Total Health Management

In the first Segal report, we indicated that improvements in the health risk profile of ETF's membership could significantly hold down the escalation of plan costs. We estimated that ETF incurs over $267 million annually in unnecessary and avoidable medical services due to the following risk factors - obesity, smoking, non-adherence to drug regimens, alcohol abuse and non-compliance with treatment protocols. That equates to nearly 19% of annual claims saving opportunities if these five risk factors were eliminated. While ETF is not likely to fully eliminate all of these risk factors, the opportunity to achieve savings of $60 - $80 million annually is very achievable (see Report 1 reference to PriceWaterhouse Coopers study). We recognize this will increase gradually and estimate lower first year savings of $10 – $30 million, between 1% and 3% of plan costs. Note that these savings are cumulative.

Unlike traditional medical management and wellness programs offered on a voluntary basis, Total Health Management uses behavior economics to motivate members to make changes in their health habits. Leveraging incentives (rewards and penalties) to create extrinsic motivators, members must be proactive in addressing basic health issues, participate in the programs or contribute more towards the cost of the health benefits. The research shows that using the appropriate rewards and penalties increases engagement in programs like disease management to at least 70%, while voluntary plans achieve engagement rates of less than 20%. We have seen many plans with incentives. With more people engaged in receiving personal health counseling, there are more who make the necessary changes in their health to lower risk factors and reduce their utilization of medical services. The State of Connecticut increased engagement from less than 20% to over 95% using a reward/penalty THM model. We have seen other programs (Alabama, Tennessee, Kansas, North Carolina) with incentives of $50 per month achieve similar results.

With a concerted effort by ETF to reduce health risk factors, plan costs can be reduced well below the current medical trends, typically shaving 1%-3% off current projected trends. The balance of this section of the report will provide a pathway forward for making a meaningful impact on improving the health of ETF's covered membership, which should help to support the reduction in future cost increases.

Total Health Management: A Model for Reducing Health Risk Factors

As stated in our initial report, Total Health Management (THM) is Segal's population health care management methodology model that combines four major plan management components: Vendor and Plan Management; Data Management and Predictive Modeling; Consumer Directed Plan Features; and Patient Outreach and Intervention. The THM model seeks to improve health outcomes through: the use of aggregated patient claim data; the analysis of that data into a single, actionable record; and the creation of access sources for providers to use the information to improve patient interaction both clinically and financially.

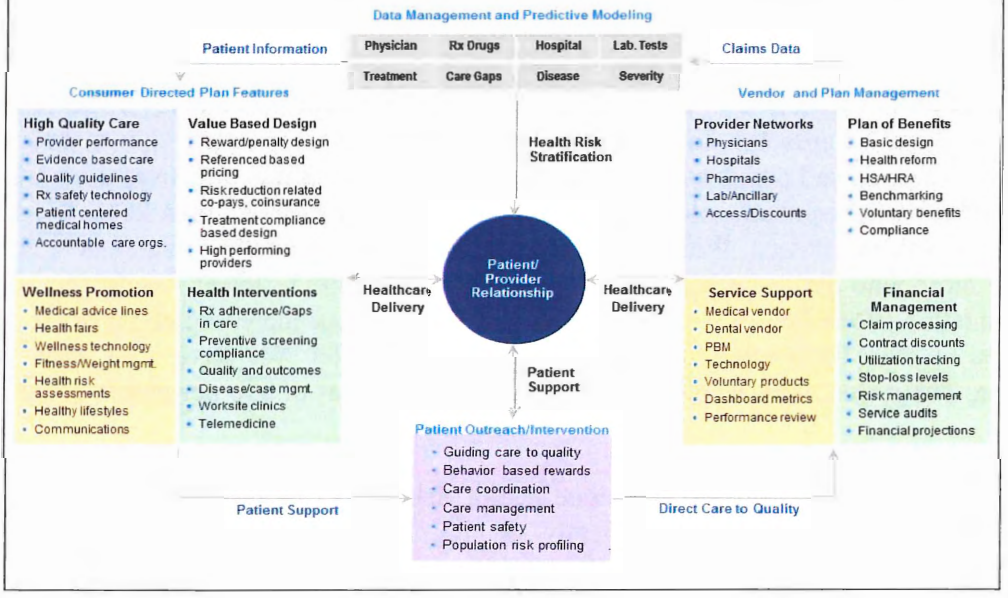
THM as a health management model highlights (Fig. 1) the critical components:

- The coordination of primary care physician access and services;

- A mechanism for patient activation (behavioral changes to improve health through personal responsibility); and
- The coordinated improvement of patient care using wellness, chronic condition management and medical management programs.

The success of a THM model for ETF will be closely aligned with the partnership developed with the operators of the contracted health plans. With a clear vision established by ETF coupled with metrics to measure program improvements linked to the health risk profile of ETF's membership, health plans could be evaluated on key metrics that measure their ability to improve medical outcomes, reduce unnecessary care and produce lower medical utilization.

Figure 1 - **TOTAL HEALTH MANAGEMENT OPERATING MODEL**



A Total Health Management operating model brings together the functions of vendor management, data management, patient directed plan design and patient support. Each aspect is critical to a plan sponsor operating its health care plans in a way that not only effectively manages cost, but assures that the care that is provided to patients is focused on using medical resources efficiently and effectively, while improving the wellbeing of each individual accessing health plan benefits. There have been many studies about the effectiveness of wellness and medical management programs. Each of these studies demonstrates that without a committed plan sponsor, like the state, willing to take responsibility to get those covered by the plans to engage in the programs, the programs will have little impact. It is all about doing what it takes to motivate participation, and not merely making wellness and medical management programs available to members.

Review of Health Plan Performance

As referenced in the first report, ETF needs to contract with health plans that can provide a health care delivery model that supports ETF's efforts to effectively reduce health risk factors in the covered membership. To understand and monitor how the contracted health plans are doing in managing and reducing health risk factors, ETF needs the technology resources to identify patient health risk factors and to analyze and manage coordinated health care through the health plans.

With chronic illness (asthma, diabetes, heart disease, and others) being a primary driver of medical cost for ETF, the data shows that health care delivery of health plans varies significantly. Segal highlighted this in the initial report and pointed out "that there is a significant variance in the quality of health management program, (case management, disease management, and wellness) among the health plans". While the degree of variations may be unclear due to the quality of data currently available, the analysis points towards a significant opportunity for ETF to improve the overall efficiency of care management across all health plans.

What we do know is the following:

- There is a higher than expected prevalence of diabetics.
- Many of the plans were not able to provide basic chronic condition treatment compliance data, while some provided information that was suspect.
- The Health Plans were not able to demonstrate that their medical management programs are having a positive impact on improving the health risk profile of the covered population.
- There is significant opportunity to improve the treatment compliance rates of ETF's covered membership.
- There is a wide variation in the health risk profiles between the covered populations of ETF's health plans.

Because certain medical management programs (e.g. disease management, case management, pre-authorization) are integrated with the medical delivery model of each health plan, there will be some variation in approach. This will require ETF to apply consistent performance metrics to their medical management program to assure that each plan is performing in accordance with ETF objectives.

Ability to Report on Basic Measurements

With clearly defined metrics in place, ETF will be able to monitor performance across a set of common standards and manage the health plans to those standards. The standards will measure improvement in population health that is not impacted by the variations in the specific health risk profile of each plan's current population. Our first report determined that there are plans with serious shortcomings in their risk factor reporting technology. Segal's position would be if the reporting gaps are not remedied, ETF should consider that the health plan is not meeting the established standards in the areas where data is not reported. Continued lack of reporting of this important information should be a factor that weighs into that health plan's contribution tier

rating and that could trigger ETF to consider terminating the plan (or not contracting with them to begin with). Some of the gaps reported in our first report included:

- Six of the plans were not able to provide complete Asthma care compliance information.
- Two plans provided no treatment compliance information related to the diabetes population they covered while four plans provided complete information.
- Three plans provided no treatment compliance information about the covered membership with Coronary Artery Disease, while seven provided complete information.
- Six plans provided no treatment compliance information for the covered population with Congestive Heart Failure, while six provided complete information.

For ETF's Total Health Management strategy to be effective, it will be critical for plans to be able to report these key measures of wellbeing. Cost savings can be realized through improving both treatment compliance and wellbeing (e.g. lab results, biometric measures) related to the specific conditions. The tracking and reporting of health metrics is vital to increasing the success of Total Health Management. If a health plan lacks the ability to track these basic metrics, that plan may lack the ability to be an effective partner for ETF moving forward.

Basic Utilization Reporting

The reduction in unnecessary or avoidable medical care can also be measured. Research shows that when patients are compliant with physician recommended treatment and care, emergency room visits, hospital admissions and ancillary care are reduced. Therefore, ETF will depend on each health plan to be able to report basic metrics on utilization, to measure program impact. In the first report, Segal presented the following findings:

- One of ETF's sponsored plans reported hospital readmission rates of nearly 14%, while the next highest rate was 8%. The health plan with the highest hospital readmission rate also had the second lowest population risk profile reported.
- Seven health plans reported Hospital Admission rates higher than reported for averages in the Midwest, but lower than national average.
- Three plans reported Hospital Days well below the other plans and the average reported for the Midwest. The hospital with the highest risk profile reported the lowest Hospital Days, which indicates effective care coordination.
- Two plans reported Average Length of Stay (ALOS) for hospitals well below the other plans, while four hospitals reported significantly higher ALOS than the plan with the lowest ALOS.
- Emergency room visits in one plan were reported as significantly higher than all of the other plan averages, the Midwest average and national average. That same plan also had very high Ancillary Services utilization.

ETF currently contracts with some health plans that appear to be unable or unwilling to report on basic standards of care management and utilization. These plans will not be able to demonstrate

if their medical care and health management initiatives are having a positive impact on the segment of the ETF population that they cover.

Building Standards to Track Performance Metrics

Prior to building standards for reporting performance metrics, ETF will need to reevaluate the reporting capabilities of every plan. This will result in changes and possibly the termination of some health plan contracts. Once that process is completed, ETF can develop its own customized performance metrics.

It will be necessary for ETF to have a data warehouse in place that can accurately measure each of the key elements. For each plan, there would be a set of baseline metrics established for each of the areas below, with a target to achieve over the next 3-5 years.

- Treatment compliance and medication adherence
- Clinical outcomes and utilization improvement
- Engagement in medical management and wellness programs

Using these metrics, ETF will be able to measure the impact that a specific health plan's medical management programs are having on reducing unnecessary claims, avoidable claims and reducing risk factors in the plan's covered population.

Differentiating between Cost Management and Utilization Management

Cost Management

Vendor and plan management to contain costs has traditionally involved the operational aspects related to addressing:

- **Provider networks:** members access to physicians, hospital, pharmacies, ancillary services, discounts, etc;
- **Design of plans:** co-pays, deductibles, co-insurance, coverage limits, legal compliance, etc;
- **Financial management:** risk management, claim cost projections, medical trend, stop-loss, etc; and
- **Service support:** member services, vendor responsiveness, technology, etc.

For the most part, these are functional components of a health plan that are driven by **price inflation**, the **number of units purchased**, and the **price per unit** that is negotiated.

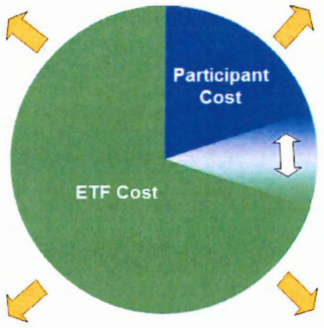
The allocation of these costs are between the plan sponsor and the covered employees through the features of plan design, the member contributions, and the plan sponsor share of the budgeted costs. This is illustrated in Fig. 2 by the divisions in the pie chart. It is more or less a cost accounting process coupled with financial forecasting and risk management. Over time, plan

sponsors have become very efficient at cost management and have driven these costs to a very narrow range of variance.

Figure 2 - **Allocation of ETF Plans Claim Costs**
Balance Cost Management and Utilization Management

Potential Strategies

- **Cost Management:**
  - Change deductibles, copays, coinsurance and employee premium costs
  - Increase network discounts, lower provider fees
  - Eliminate coverage (Shifting 100% of cost to participant); reduce retiree health coverage
  - Negotiate better prices with providers
- **Utilization Management:**
  - Reduce population health risk factors
  - Increase treatment compliance & medication adherence
  - Improve health care coordination
  - Encourage use of quality providers for better outcomes



Successful health care cost management must first identify the health risk factors that drive medical costs and then develop a strategy that addresses each medical cost driver separately.

Utilization Management

Unlike cost management, the factors that drive utilization of medical services involve very complex relationships:

- **The consumer:** age, gender, health risk profile, the state of their health, life-style, treatment compliance, etc; and
- **The health care system:** quality & outcomes variations, poor care coordination, site of care options, evidenced based guidelines, etc.

Utilization of medical services is the portion of medical trend that measures the growth in or expansion of the consumption of medical services. The increasing rate of utilization of medical services adds more to the overall health care costs than does unit cost increases of health care services. This is caused by the aging population, advances in technology, and greater use of diagnostic tools used prior to treatment. This is illustrated in Fig. 2 above by the increase in size of the pie chart.

Utilization management faces the challenge of a very disjointed health care delivery system that is not well coordinated and functions more like a "cottage industry" in terms of integration of services. While efforts have been made over the years to address the shortcoming of the US healthcare delivery system, the system is still very much focused on providing service to people who are sick and not as focused on keeping people healthy.

Plan sponsors like ETF tend to focus very little time and effort on utilization management, even though utilization is a primary driver of cost. The consumer typically accesses care very inefficiently and takes very little responsibility or accountability for the level or number of

services provided. This pattern leaves plan sponsors hoping that their contracted health plans will take responsibility for the proper application of utilization management. That rarely happens unless the health plan is monitored closely.

More recently, population health models like Total Health Management have begun to have an impact on utilization management and plan sponsors are employing behavioral economics, value based plan design, integrated care delivery and other means to more efficiently manage medical care utilization, improve care delivery, improve care quality and slow medical trend. In the next section, we discuss how this can be done.

Overall Strategy and Design

It is clear that any improvements in the health risk profile of ETF's population should help reduce program cost inflation. Our review indicates that there is a wide variation in health plan performance related to patient utilization and coordination of care. ETF has conducted various meetings and seminars with the contracted health plans and have adopted five areas of focus that are part of contract and reporting requirements for the plans. Moving forward it will be important to include a strategic focus on each health plan's ability to improve the health of ETF's covered population under their control. This is best measured using set reporting metrics that measure reductions in health risk factors, show closures in gaps in care, and measure an improvement in the aggregate risk profile.

Any strategy must include the following:

- **Employer Communication and Support:** ETF will need to develop a comprehensive communications package that addresses the new plan initiatives and why they are necessary. Member communication will help to reduce the amount of questions within the employee population. Additionally, the State will need a top-down support structure backing these initiatives.

- **Patient Engagement:** The health plan must be able to work with physicians to deliver appropriate, evidence based care that addresses care gaps even when patients do not come into a physician's office.

- **Patient Behavior:** ETF must create a plan design that motivates employees to take personal responsibility for their health and supports that motivation through appropriate incentives. These design elements will need to be mechanisms that will engage employees in ongoing wellness and medical management activities.

- **Team Based Intervention:** Effective primary care is at the heart of total health management to ensure that patients receive appropriate and coordinated care. In the ideal structure, primary care physicians work with other clinicians in integrated teams to focus the level of needed care. These teams may include mid-level practitioners, nurses, medical assistants, care managers and specialists.

- **Measuring Outcomes:** Health plans must provide comprehensive data that can be used to measure results across each of the factors identified in the strategy. Well-designed tools for

predictive modeling and data analysis are critical to measure treatment compliance, health outcomes, health status, disease severity and patient engagement.

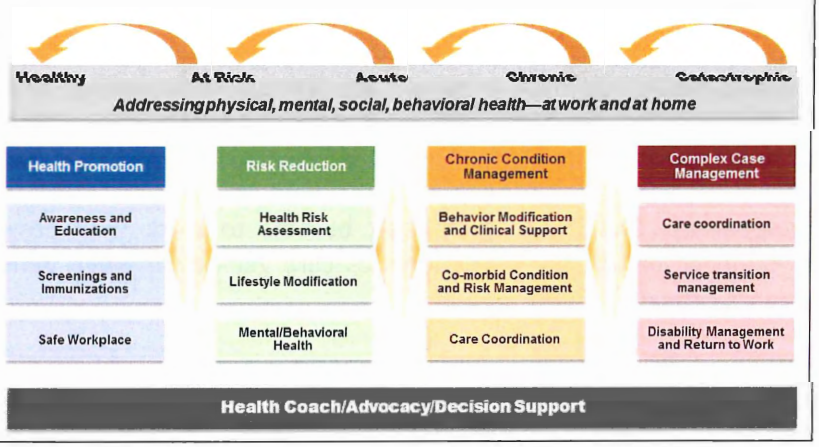
Each of these is a critical component of ETF's strategy going forward. For some of the support required to drive the health improvement initiative, ETF will need to rely on the health plans and their direct services and reporting. ETF will also need to require cooperation between vendors.

To properly manage the health of ETF's membership, health plans will need to have internal systems that allow for the aggregation of member health data (e.g. electronic medical record capabilities). This provides the needed source of patient information for the treating physicians to support the patient/physician relationship and facilitate high quality/efficient patient care.

Medical Management Integration

Segal recommends that medical management services—complex case management, chronic condition management, pre-authorization, and care coordination - be provided through each health plan. Since medical management requires the evaluation of a medical condition, developing and implementing a plan of care, coordinating medical resources, communicating health care needs to patients and promoting cost effective care, we believe that those objectives are best accomplished when integrated. In addition, these services should only be provided to active employees and pre-Medicare retirees, where ETF is the primary insurer.

Figure #3 – **Health Management Across the Spectrum**
Use data to determine programs and services mix



Medical care of patients with acute, chronic and catastrophic treatment needs is identified in the diagnosis that results from episodes of care tracked in each health plan's claims management system. By analyzing the patient claims, each health plan assesses health risk – acute, chronic or catastrophic – triggering the appropriate level of outreach. With medical management services integrated with the health plans, response times to patients needing chronic condition management support or case management is expedited.

Medical management initiatives – case management, disease management, discharge planning, pre-authorization – focus on the needs of those members whose health risks are categorized as – acute, chronic and catastrophic through claims data analysis. On the other hand, wellness and health promotion initiatives – tobacco cessation, weight management, health education – focus

on the needs of those members categorized as healthy or at-risk through direct contact with individuals, where claims data is not sufficient to categorize the individual's health risk. These types of encounters occur during a member's participation in a health risk assessment or some type of wellness coaching session. Coordination of information and referrals between a medical management vendor and a wellness vendor is very useful in leveraging the value of their work to support patient care and patient education. This can be accomplished in a variety of ways – cross referrals, data sharing, and soft transfers during member encounters with a medical management personal health counselor or a wellness coach. In any event, it will be important to have the medical management and wellness vendors working cooperatively and sharing information resources to produce the best outcome for ETF and the members.

Using Data Analytics to Motivate Healthy Behavior

Each participant in an ETF health plan can be categorized in one of five major risk levels – healthy, at risk, acute, chronic, or catastrophic. The data is not used by ETF in any way, but rather is made available by each health plan to network providers to enhance the patient/physician relationship. With that information available, each health plan is able to populate patient health records and make that information available to physicians. With more specific patient information, the provider of care can more effectively treat the specific needs of each individual patient.

The challenge all plan sponsors face is getting individuals to engage in programs designed to support or to improve their health. Since chronic illness is a major source of cost to ETF, incentives will need to be in place for individuals to engage in medical management programs. Plan sponsors in the public sector are turning to value based plan design to motivate engagement in medical management programs. A growing body of evidence supports the notion that people need to be motivated by both extrinsic and intrinsic factors in order to improve their health. This has led many public sector sponsors to include rewards and penalties in their plan design to encourage change of unhealthy behaviors that result in unnecessary and avoidable health care costs. Some of the prominent states that have adopted effective behavior changing plan designs include:

- Alabama
- Connecticut
- Georgia
- Indiana
- Kansas
- Kentucky
- Maryland
- Missouri
- Nebraska
- North Carolina
- Tennessee
- West Virginia

Those states utilizing incentive-based models to motivate positive reductions in health risk factors are seeing progress in reducing waste in health care spending and improvements in the health of the covered population.

Improving treatment compliance of people with chronic conditions should be a high priority for ETF. A plan design should motivate individuals with chronic conditions to engage in a chronic condition management program. While there are a variety of approaches for applying rewards and penalties to motivate program engagement, the two approaches outlined below are quite common, though the dollar amounts used may vary among plan sponsors.

Approach 1: Plan Design Incentives & Premium (Variety of States)

For individuals identified as eligible for disease management

- If they engage in the disease management program they receive co-pays for their condition-related medication that are $5 to $10 less than normal copays. This logic can also be applied for co-pays paid to managing physician.
- If they do not engage in the disease management program, they pay a higher monthly premium contribution ($50-$100).

Approach 2: Plan Design Penalty & Premiums (Connecticut)

For the Connecticut Health Enhancement Plan employees are required to complete three or four healthy activities – wellness exam, early diagnostic screening(s), annual dental cleaning and (for those with a chronic condition) participation in a disease education and counseling program

- If they complete the activities they receive a reduction in their deductible (50% reduction or waived).
- If they do not complete the activities their deductible is increased (100% increase, non-compliance results in double the original deductible) and premium contributions are increased by $100 per month.

These are just a couple of examples to demonstrate how simple designs can be effective. We believe a design incorporating elements in Approach 1 may be the best fit for ETF, but would need to be worked out after going through the strategic planning process for ETF's THM plan design.

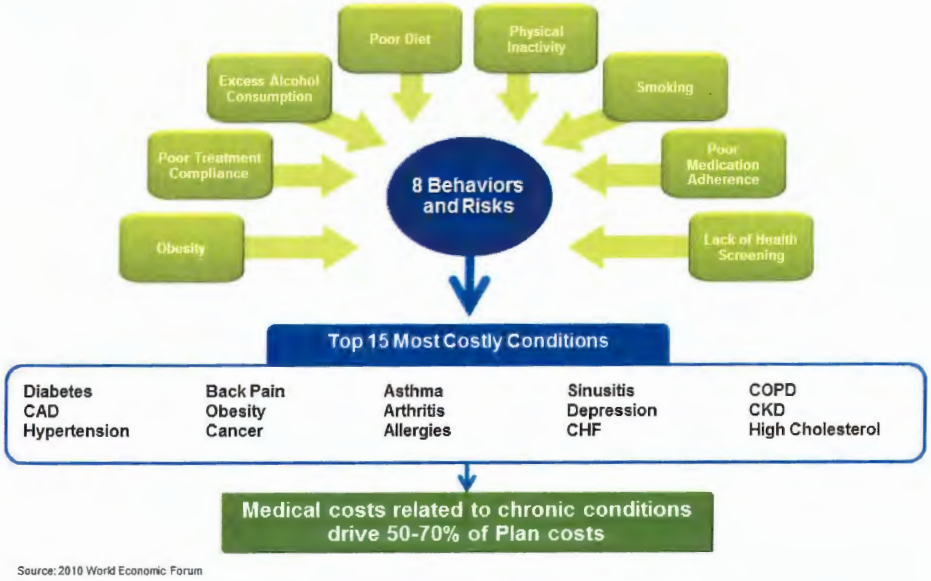
Using a sufficient penalty/reward approach should push engagement in disease management programs to 60%-70% of those eligible. We have recently seen premium-based incentives get participation as high as 90% in Alabama and 95% in Connecticut. This is supported by a 2014 RAND study that showed employers using no incentives reported lower participation, only 20% on average; while those using rewards experienced participation rates on average of 40% and those using penalties experienced participation rates of 73%.With people engaged in a medical management program like disease management, ETF will be in a positon to monitor how effective each health plan is at improving the health of those engaged.

Some of the metrics that should be monitored from a clinical perspective for those with chronic conditions include:

- Reduced use of the E/R
- Lower hospital readmission rates
- Lower hospital admission rates
- Lower Average Length of Stay (ALOS) in hospital
- Reduced use of ancillary services

Figure 4 below identifies the key behaviors we are trying to alter from an incentive based design. All have an impact on the chronic disease prevalence and cost.

Figure 4 – **Identifying the Health Risk Factors Driving Cost**
Behaviors That Can Be Altered



Source: 2010 World Economic Forum

Using behavior based plan design and effective medical management, ETF and its health plans should be successful in modifying the unhealthy behaviors that contribute to unnecessary and avoidable medical care costs. According to the CDC Chronic Disease Prevention and Health Promotion Reports, "*As of 2012, about half of all adults—117 million people—had one or more chronic health conditions. One of four adults had two or more chronic health conditions*" and "*86% percent of all 2010 health care spending was for people with one or more chronic medical conditions*". Using the WHIO data Segal was able to identity that 64% of ETF members had a chronic condition and chronic conditions represented 90% of claims (based on WHIO defined charges). So ETF is slightly higher than the CDC statistics but reasonably consistent. As such, behavior modification resulting in lowering health risk factors of members with chronic conditions, can deliver substantial savings and trend mitigation.

Another way to get the health plans to take an active role in the management of population health is through shared savings arrangements based on plan performance. Health plans are rewarded/penalized based on their success in meeting established performance metrics. Each plan would be tracked and measured on the success of their utilization management programs for ETF participants. This type of arrangement could also encourage health plans to take a more active role in managing the health risk for all of their enrolled population.

Appendix 1 provides an example of the data metrics that ETF may want to track and measure. When the metrics are implemented, a baseline will be created, and then target levels will be set for each component measurement. Health plans can be awarded points on the success of their utilization management programs by measuring the actual result of the improvement on the baseline. This is discussed in more detail in the Gain Sharing model reviewed in the **Self-Insurance** section of the report.

Wellness and Health Promotion

Segal recommends that wellness and health promotion services – health education, nutrition counseling, coaching, tobacco cessation, and weight management – be carved out of the health plans and offered as a single comprehensive program through a single vendor. Unlike medical management programs, like disease management, the health needs serviced by wellness and health promotion vendors are rarely identifiable through claims data, but rather relate to life-style choices. Wellness programs are less associated with the day-to-day care of an individual and more involved in the dynamic process of improving the state of a person's health physically, socially, and mentally. While the goals of wellness and health promotion are similar, there is enough variation in the approach and the models used that ETF would be best served by having a single wellness vendor managing all of the wellness services. This will enable one consistent message and strategy for your entire population.

We recognize similar options have been considered by the GIB in the past and there was some concern about implementing a strategy that could be limited by the, then new, ACA regulations, or possibly required to be revised or limited by other legislation. The strategies recommended in this report are well within the requirements of the ACA, HIPAA and other related guidelines, including the recently proposed regulations by the Equal Employment Opportunity Commission (EEOC).

Offering Wellness services to employees provides a plan sponsor like ETF the opportunity to build a culture focused on good health. Like medical management programs, getting the covered membership to engage and actively participate is key. A starting list of wellness services includes:

- Health risk assessment
- Lifestyle management and coaching
- Tobacco cessation
- Biometrics screening
- Weight management
- Health Advisor calls
- Goal tracking

Segal recommends that the design of wellness programs should be incentive based, using a design that applies the incentives using a common design or a separate points based model applied to the wellness program.

During the first year, the focus should be on disease management, by identifying risk factors and providing the necessary tools so that employees properly manage their health risks. To support that focus, ETF should require all employees to complete a health risk assessment and also complete basic biometric screening for LDL, HDL, triglycerides, blood pressure, and body mass. In addition, ETF should consider if tobacco use in the population is a pressing enough problem to be addressed in the first year. If it is, most public sector organization are adding tobacco premium surcharges ($40-$50/month) for tobacco users who decline participation in a tobacco cessation program. Other wellness services – weight management, nutrition assistance, health coaching, others - should be incorporated into the Total Health Management plan over time.

The goal is to create program incentives that maximize participation in wellness activities. The most common approaches for an incentive-based wellness plan design follow one of two models:

- ***Wellness incentive integrated with medical management plan (Maryland)***

  Individuals are given a list of activities that must be completed during the plan year to avoid a penalty or to gain program incentives. Participants identified for Disease Management must complete additional activities, failure to complete those activities results in higher participant premiums. Those that are identified as tobacco users must participate in a Tobacco Cessation Program. Please see **Appendix 2** for an example of required program activities.

- ***Wellness incentive is determined by a points based program (Kansas)***

  Individuals are offered a list of wellness activities to choose from, and must complete a minimum number each year to gain points for a plan reward or credit. This allows a tremendous amount of flexibility in plan design. An example of this option can be found in **Appendix 3**.

The Kansas wellness design was cited favorably in a Duke University's Sanford School of Public Policy Study in 2015. The type of wellness design should be determined based on the life-style issues prevalent in ETF's population. For example, if tobacco use is relatively low but obesity rates are high, then the wellness program would likely focus more on weight related life-style awareness. The wellness program should provide an avenue for employees to get the education and support needed to make the right life-style choices. The program should be dynamic and change over time as the needs of ETF's population change and as progress is made in the targeted areas.

Given the culture in Wisconsin, we believe a point-based system would provide the best likelihood of success. This will allow ETF to have a number of targeted programs and can evolve over time.

Measuring Wellness Program Success

As with the medical management components of the Total Health Management program, ETF would set metrics for measuring the success of the wellness services. Of particular interest would be the clinical measures that are indicators of health improvements such as –

- # of people with blood pressures less than 120/80
- # of people with cholesterol total less than 200
- # of people who have achieved a healthy/appropriate BMI
- # of people who have quit smoking
- # of people who completed preventive screening exams
- # of people who have completed a weight management program

We recommend that when ETF establishes metrics, the first year used as a baseline measure from which progress can be tracked. Once the baseline is set, subsequent years are then used to measure progress against the baseline metric.

Expanding Healthcare Access

Access to healthcare is ever more challenging for families where time is limited and working parents are pressed with increasing job demands. As plan sponsors look for ways to provide easier access to medical care, two medical delivery approaches are emerging – telemedicine and worksite clinics. This section provides ETF with some background on each one as it considers its health plan design in the future.

Telemedicine

With rapid advances in telecommunication and smartphone technology, the doctor-patient encounter does not need to happen in person anymore. It is rapidly being enhanced and even replaced by what is called "Telemedicine". At this time, we think that it is premature for ETF to be considering selecting a single telemedicine vendor, but it would be important for ETF to encourage its health plans to incorporate this type of technology to improve member access to medical care. Patients can now connect directly with a doctor from home or other suitable venue using a web cam, and the provider can offer:

- a basic diagnosis
- a referral
- a prescription

Research shows tremendous potential for new models such as telemedicine to emerge and grow in the near future. The global telemedicine market likely to increase to about $4.5 billion by 2018 from about $440 million in 2013, according to a 2014 study from IHS Inc. About three-quarters of large employers plan to offer telemedicine services to their workers next year, up from about half in 2015, according to a National Business Group on Health survey.

The concept is still evolving, but has some appeal to doctors and patients, especially in remote communities where doctors and patients have long distances to cover for short in-person visits. Telemedicine is also becoming very popular with individuals who do not have the time to leave work and get to a face-to-face appointment during regular working hours. For ailments that fit the limitations of telemedicine, they can tap into medical services at any time of the day.

Why Telemedicine

- Adoption will increase as the healthcare model realigns under healthcare reform, where:
  - Payment is value-driven, not volume-driven,
  - Providers (hospitals, physicians, and ancillary caregivers) are paid for results
  - The venue does not matter (for example, where no sophisticated medical testing machinery or x-rays are required)

- Quality is measured and payments made for meeting targets
- There are incentives for preventive care—for keeping participants healthy

- Telemedicine can help meet the increased care demands of an aging population
- Telemedicine offers an approach to overcome provider shortages
- In most cases there is no wait time and almost instant service, which can lead to enhanced patient satisfaction
- Depending on how the program is structured, telemedicine encounter and cost information can be fed back to the employer's primary health benefit plan for payment or simply to capture the utilization information for a data warehouse.

Telemedicine providers can typically diagnose and support the following types of conditions, and can submit prescriptions electronically or by call-in at a nearby pharmacy, if needed:

- Sinus, ear and eye infections
- Cold, cough and flu
- Allergies
- Acne
- Burn and sunburn
- Insect bite
- Urinary tract infection
- Upper respiratory tract infection
- Headaches
- Bronchitis
- Stomach-ache

New innovations in Telemedicine services are also supporting services such as Behavioral Health, EAP, and Dermatology.

Developing the Right Standards

Segal suggests integrating Telemedicine with each of the health plans, assuming each vendor meets ETF defined best practices. Below are some discussion points when developing standards for a telemedicine program:

- Are the physicians in the Telemedicine offering required to complete a credentialing process?
- Is the process of reaching an actual doctor (not a nurse or nurse-practitioner) simple, convenient and fast? ETF should avoid programs that promise that a caller will get a call back "within a few hours".
- Can the doctor write a prescription when appropriate?
- Are their communication channels, information sharing and technology HIPAA compliant?
- Does the program offer a complete survey of the patient's pertinent medical information upon enrollment and forward the information from each call to the employee's PCP?

- Can the program provide full data transfers to the employer's primary health plan or to a data warehouse?

- Does the program have a history of proven success working with employees and helping employers save money?

Working with the insurers, ETF will develop standards that align with the telemedicine services available in the market (that ensure convenience and safety for members). While Telemedicine can provide an additional access point at a low cost point, ETF will need to monitor the utilization to ensure that members are receiving accurate diagnoses, the health plans have the proper technological systems in place, and that members understand when it is appropriate to access Telemedicine and when an in-person evaluation is needed.

Benefits to Employees

Telemedicine provides a subscriber with quick access to a doctor over the phone, email or video call. Unlike a doctor's office, urgent care center, or emergency room, there is no waiting for an appointment in a room full of other sick people. Even if there is a wait during a peak period, the technology usually provides an estimated wait time and offers the opportunity to leave a number and have the doctor call back when you reach the top of the queue.

Telemedicine has been found to be an efficient route to care—97% of patients are treated in their first dial-in attempt with an average response time of eight minutes, according to Teladoc, one of the major telemedicine network providers. When appropriate, the consulting doctor can prescribe a medication and send the prescription to the member's preferred pharmacy.

This program can often eliminate time-consuming visits to a primary care doctor, urgent care center, or emergency room, along with the higher costs associated with those visits. With the right partner in place, we believe ETF should begin to integrate Telemedicine services into your benefit structure and that members should be provided financial incentives to use the program, such as a copayment of $5 to $10 below the PCP level. The final amount will depend on the financial arrangements with the vendor to ensure a win/win for ETF.

Onsite Clinics

With plan sponsors facing persistent growth in health care spending, demand for workplace health clinics has increased. Historically, many manufacturing facilities or plants have had occupational health clinics located in the plant facility. Those clinics usually provide services related directly to the workplace, but some do provide broader services for routine or acute illnesses. While we do not advocate building onsite clinic at this time, at some point we think that ETF should assess the availability of state run medical facilities and explore if there may be some opportunity to leverage those facilities for the ETF covered population. They would never become a substitute for the services offered through the health plan. Most common would be to be the location for a biometric screening program.

The use of onsite clinics is also growing among non-manufacturing employers. About 25% of Fortune 1000 Companies now have some type of onsite clinic capability—occupational or non-occupational. The current trend is to include more primary care in conjunction with health promotion and wellness services, rather than merely occupational health or convenience care.

Indeed, the Affordable Care Act has increased the interest level in onsite clinics that can provide workplace wellness programs.

In general, public sector employers have been lagging the market and very few states have implemented a comprehensive clinic program. The ones who have are typically running a more comprehensive medical management program and using the onsite clinics as a delivery site.

By far the strongest motivation for implementing workplace clinics is to contain direct medical costs. Onsite clinics generate savings from:

- Utilization savings—patient compliance and program participation, over time, leads to decreased:
  - Specialist referrals and visits
  - Discretionary ER visits
  - Inpatient hospitalizations—due to increased compliance with medications and treatment
  - Pharmacy costs (Longer term, through generic and over the counter drugs, and appropriate prescribing.)
- Increased medication compliance
- Improved compliance with preventive screenings
- Increased compliance with evidence-based medicine
- Increased participation in disease management programs
- Increased participation in wellness/health promotion/health coaching programs
- Savings from steerage to high-quality/ high-efficiency health care professionals and facilities

Major features of onsite clinics

- The onsite clinic is typically located on a primary worksite campus or at the "fenceline" surrounding that work location.
- The clinic usually requires a footprint of about 1,000 square feet to start with a minimum group size of about 600 centrally located members. For larger groups, larger, or additional locations are generally utilized.
- Primary care is delivered by a combination of contracted or employed physicians, nurse practitioners, and/or Physicians Assistants. Primary care often includes:
  - Office visits
  - Acute care—ranging from low-acuity episodic care, such as sore throats or sprains, to treatment of more severe symptoms requiring urgent attention, such as exacerbations of chronic conditions
  - Preventive care—physical exams, immunizations and screenings

- Wellness—health risk assessment follow up, biometric screenings, health coaching, lifestyle management programs and educational programs
- Disease management—ongoing care for and management of chronic conditions
- Basic laboratory and radiology
- Physical therapy (customizable)
- Pharmacy—generic drug dispensing
- Often treat members not covered by medical plan for a small fee
- Occupational health—treatment of work-related injuries, employment physicals and screenings, travel medicine, and compliance with federal workplace safety regulations

Clinic can become a "Patient Centered Medical Home"

Beyond a convenient onsite location, workplace clinics aim to transform primary care delivery in several key ways. In contrast to most community-based primary care, the typical workplace clinic model offers much shorter wait times and much longer clinician-patient encounters, resulting in a "trusted clinician" primary care model.

When patients need referrals to specialists or other providers not available within the clinic, referral processes and networks can limit referrals to "high-performance networks".

The clinics need approximately 600 centrally located eligible members to break-even, and about 2,500 eligible members to achieve maximum economies of scale. Ideally, membership should be located at least within a 20-mile radius.

The economics of sponsoring an onsite clinic are also highly sensitive to the local price and ease of access for primary care doctors and specialists. The largest cost for an onsite clinic is staffing.

Benefits to Employees

A majority of employers sponsoring onsite clinics seek to supplement rather than replace community-based care, and they offer a wide variety of cost-sharing arrangements for clinic visits. Many employers waive deductibles or copayments altogether—an approach endorsed by many clinic vendors because it provides a strong incentive to use the clinic. Some employers also provide generic medications free if the prescription is filled through the clinic.

While we do not see the use of Onsite Clinic as the highest priority at this time, there is an opportunity to assess the availability of clinical resources currently in use by the state that at a future time, could be used as an access point for members. This could be to participate in a biometric screening program or be a venue for community health education such as tobacco cessation or nutrition education, for example. Before constructing an onsite clinic, a feasibility study should be undertaken to make sure an appropriate ROI could be achieved for the program.

ACA Considerations

Addition of an onsite clinic would likely add another medical plan to be tracked for purposes of the ACA 40% Excise Tax that becomes effective in 2018. The cost of any onsite clinic program

that provides more than nominal services must be included in determining the value of the plan relative to the statutory thresholds. While an onsite clinic would be expected to help contain or lower overall medical costs in the long run (which would help avoid Excise Tax), there may be net additional costs in the first few years until the clinic's impact begins to show up, which would increase the Excise Tax exposure.

The IRS has not yet provided guidance on how the cost for an onsite clinic must be calculated and allocated to participants. These potential tax implications should be factored into the overall decision to proceed.

Summary of Recommendations

This section of the report provides a framework for developing an ETF Total Health Management strategy. We have suggested ideas and recommendations for the structure of a plan design and the types of reporting needed to operate a successful plan. Assuming that ETF decides to move in the direction of implementing a THM strategy, we would recommend the following:

1. **Medical Management**
   - Allow each plan to administer the medical management component. This would include complex case management, disease management, prior-authorization and care coordination.
   - Assess the capabilities of the health plans individually to determine their ability to support the strategy through medical management, data analysis, data reporting, applying the needed technology, and driving market change. Make this requirement mandatory and only include the higher performing plans.
   - Define the specific metrics necessary to monitor the health plans' effectiveness at medical management and programs designed to improve population health, reduce health risk factors and close gaps care. Put in place performance guarantees that place 20-25% of fees at risk.
   - Have value-based designs for those participants that engage with the medical management program, such as a $5 or $10 reduction for office visit copayments to applicable physician and a $5 or $10 reduction on pharmacy maintenance medications related to those particular diagnoses. Final details would be determined as final decisions are made regarding the program structure.
2. **Wellness and Health Promotion**
   - Carve-out and place wellness and health promotion with a single vendor. The vendor should be best in class and be able to provide health risk assessments, biometric collection, lifestyle coaching, education, etc.
   - Institute a premium based incentive of $50 per month for completion of designated wellness and health promotion activities. This would apply to both an employee and spouse, as well as non-Medicare retirees.

- A point-based system, similar to one utilized by Kansas, is desirable. Various programs within this design would have value-based incentives for participation. The initial requirement should be relatively modest at the outset, ramping up over a few years.

3. **Data Analytics**
   - Collect the data and engage the technology necessary to perform data analysis and health risk modeling of the covered population.
   - Put in place a data management strategy to allow ETF to better manage the financial outcomes and progress of the program. See the Data Management section for a more extensive recommendation.

4. **Telemedicine**
   - Working with the insurers, ETF will develop standards that align with the telemedicine services available in the market (that ensure convenience and safety for members).

5. **On-Site Clinic**
   - Assess the potential location of on-site clinics that could provide reasonable return for ETF. It is likely that ETF could partner with a number of systems to meet this requirement.
   - Integrate clinics into the overall wellness strategy. Reduced copayments and credits toward meeting the annual wellness goals provide good incentives and should result in desired volume.
   - ETF would want to collect data at clinics and integrate with the plans.

Financial Impact of THM

When measuring or evaluating the financial impact of a THM program our experience shows that the program itself produces no measurable financial impact unless a number of conditions are met:

- **Condition 1:** Medical management and wellness programs produce a return on investment (ROI) when designed to target known health risk factors in a covered population. With knowledge about the characteristics of participants, a program can be designed to fit the population's needs.
- **Condition 2:** If those covered by the plan do not participate in a wellness program or make needed lifestyle changes, the program ROI will be negative.
- **Condition 3:** All plan design barriers must be removed and the design of the program aligned with the objective to facilitate participation and reduce targeted health risk factors.
- **Condition 4:** Any program offered on a casual basis without the appropriate design or incentives to reduce health risk factors will fail.
- **Condition 5:** If the leaders of the organization sponsoring the program are not 100% committed to its success, the program's financial impact will be minimal.

With the above conditions assumed met, the financial impact of fully implementing a THM model can affect three major categories of cost: those related to Behaviors of covered members (e.g. treatment compliance, medication adherence, healthy life styles); those related to Administrative complexity of the US healthcare delivery system (e.g. billing, collections, credentialing, oversight, system fragmentation); and those related to Clinical effectiveness (e.g. better preventive care, replacing services with less resource intensive alternatives, variations in practices and standards of care). In total, these three areas offer the opportunity to reduce health care expenditures in the US by 35-40%, over $1.0 trillion.

The initial focus by ETF should be on chronic conditions where changes in behavior can materially affect the health of patients with these conditions, or even prevent members from developing the conditions. These would be the focus of medical management and wellness initiatives, which proactively address the prevalent health risk factors in the covered population. Of principal importance is an intensive effort to reduce the high incidence to chronic illness with its epidemic challenges of motivating patients to comply with treatment and medication protocols related to their conditions.

We discussed earlier in this section that breakdowns in care management are estimated to be costing ETF $267 million in unnecessary and avoidable medical services. Implementing value based incentives to motivate members to engage in medical management and wellness programs should be able to ultimately eliminate at least $60-$80 million of annual unnecessary medical expenses. We recognize this will increase gradually and estimate lower first year savings of $10 – $30 million, between 1% and 3% of plan costs. Note that these savings are cumulative.

Financial impact begins with improving engagement in medical management and wellness initiatives. We know that engagement in ETF's wellness program in 2014 was 12.9% and is projected to be at the 17% level in 2015. For programs to have an impact on population health, the engagement needs to be at least 50% and preferably 70% and higher. With covered members participating actively in medical management and wellness programs, the health plans can be held accountable for managing the care and treatment of those engaged. The role that ETF must play is to create the extrinsic motivators, using tools such as plan design, to get members to engage in the wellness and medical management programs. Once engaged in the programs, it is the job of the wellness or medical management vendors to work with the members to create the intrinsic motivators to take responsibility for their personal wellbeing.

While ETF is in a position to influence the marketplace that delivers care, the opportunities to drive change will likely involve more complexity and will need to be addressed through the State working cooperatively with the healthcare industry and those organizations that support the delivery of care in the state of Wisconsin. At this point in the development of the THM model, these opportunities will require a much longer lead-time and have to be discussed with many stakeholders within the state, many not part of ETF.

Possible Timing

The recommendations in this section can be implemented independently of most other sections of this report. Given broader changes recommended for 2018, much of the above could be implemented for the 2017 plan year. To get these in place, there will need to be changes to the current plan contracts, and number of possible procurements should be initiated. It could be

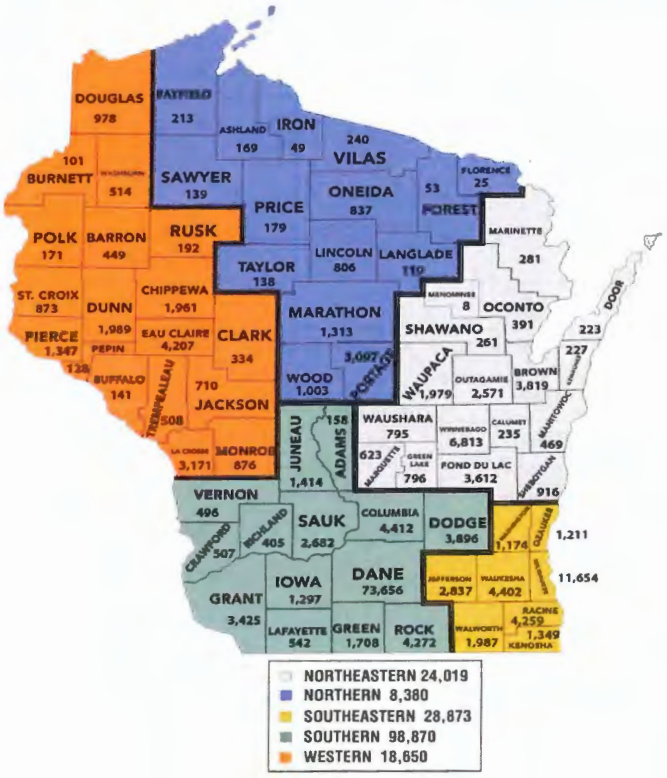
beneficial to stagger implementation and allow ETF to focus solely on rolling out a comprehensive initiative for 2018.

ETF may also choose to phase in the Total Health Management components, for example implementing wellness related features in 2017 and then implementing medical management in conjunction with broader recommendations in 2018.

Program Structure

Review of Current Health Plans

ETF currently works with 17 different health plans throughout the state. All the health plans bid on a self-identified defined service area. Using the current Medicaid regional map, we have completed a detailed analysis of how the Medicaid regions overlap with the current ETF health plan operations. Below is a summary of the non-Medicare membership in the state, as well as the regional structure. We recognize that the plans also have Medicare Retiree and Local plan membership that was not included in any figures in this section. Both of these groups are discussed in later sections, "Retiree Coverage" and "Local Government Plan", of this report.



As indicated in the chart above, we reviewed how the plans fit the five Medicaid regions:

- Northern
- Northeastern
- Southeastern
- Southern
- Western

The Southern Region, which includes Dane County, is the largest region, with nearly 100,000 ETF members. The Northeastern and Southeastern regions are of similar size and combined represent about 53,000 ETF members. These three regions have some of the State's most

populous counties. The Northern and Western regions are smaller in population and more rural, having 27,000 ETF lives combined.

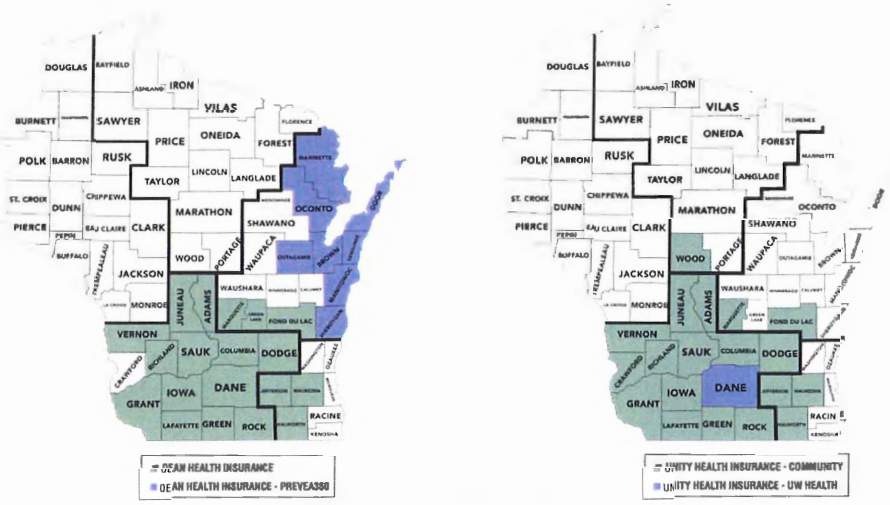
Currently, some ETF health plans fit nicely, having self-defined service areas within a region. Others tend to overlap regions, at least for their current ETF population. Below is a brief summary of ETF plan membership by Medicaid region:

Plan	Northeastern	Northern	Southeastern	Southern	Western	Statewide
Anthem	388	2	2,877	65	2	3,334
Arise	1,586	156	22	4	1	1,769
Dean Prevea	1,427	37	2,818	35,573	43	39,898
Gunderson Health	4	1	—	1,281	2,958	4,244
Health Tradition	3	—	—	749	1,964	2,716
HealthPartners	1	55	4	2	1,783	1,845
Humana	807	4	8,988	112	727	10,638
GHC EC	1	227	—	—	685	913
GHC SCW	25	10	107	9,632	7	9,781
Medical Association	—	—	—	1,066	—	1,066
MercyCare	—	—	402	739	—	1,141
Network Health	8,615	23	20	243	5	8,906
Physician Plus	95	12	151	10,730	8	10,996
Security Health	221	6,209	7	87	1,496	8,020
UHC	5,761	41	4,264	92	—	10,158
Unity	182	23	781	37,571	28	38,585
WEA Trust	4,903	1,580	8,432	924	8,943	24,782
Total	**24,019**	**8,380**	**28,873**	**98,870**	**18,650**	**178,792**

From the table above it is easy to see where plans primarily operate for ETF. This is not to say the plans don't have broader service areas, however, the table captures the areas upon which the plans had bid and been qualified in for ETF.

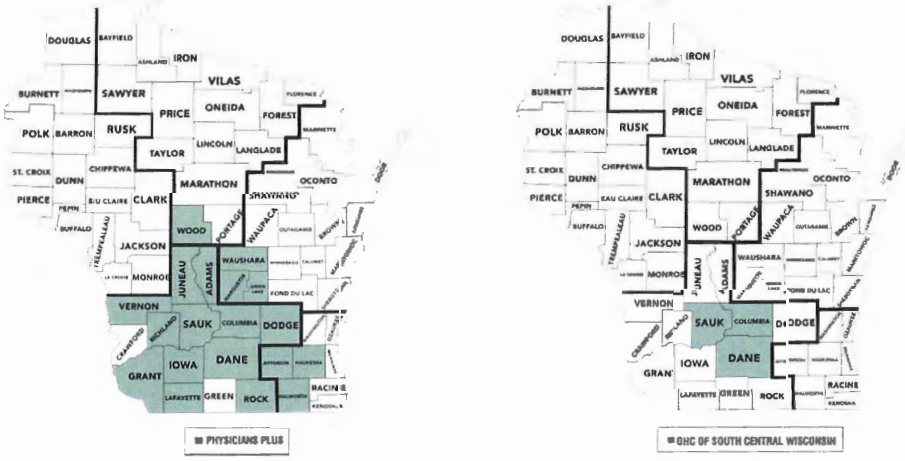
Southern Region

This is the largest region and houses two of the largest plans – Dean Health and Unity. Dean Health has over 35,000 members, while Unity has over 37,000 members. The two combined have 74% of the membership in the Southern region. Dean Health also has membership in the Eastern region through Dean Prevea360, while Unity covers most of region through Unity Community.



By membership alone, it would be difficult to see this region without their representation. That said, there are substantial financial differences between them. The capitation arrangement by Unity needs to be further investigated by ETF since the majority of their premium is based on capitated claims.

The next two plans, Physicians Plus and GHC-SCW, both have around 10,000 lives in the Southern Region and have total costs that are very competitive within the region. Physicians Plus (10,700) currently covers the entire region but GHC-SCW (9,600) has a narrower focus and only covers Dane and couple of adjacent counties.



The remaining five plans operate in a subset of the counties in the Southern Region, with some crossing into neighboring regions. They all have around 1,000 lives and are fairly small compared to the previously mentioned plans. Although their membership is small, each offers their own advantages in the market.

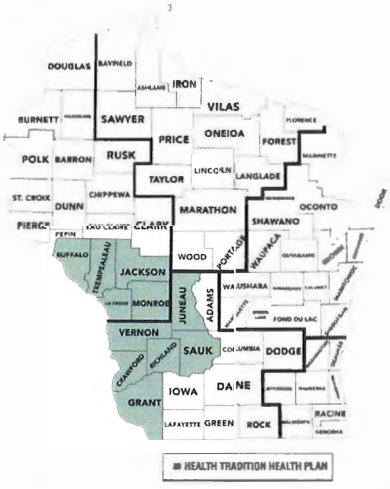
Medical Associates operates exclusively in the region, but only in four southwestern counties. Similarly, MercyCare also covers four counties, but only two of those are in the Southern Region and the other two are in the Southeastern Region.

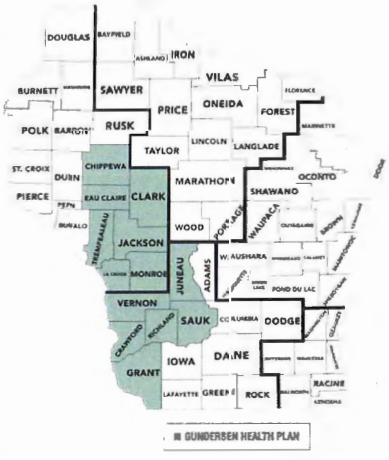
Although focused in those counties, the membership for each plan only represents 12% of the members in their respective service area.





Gundersen Health and Health Tradition have very similar footprints and membership profiles. Each plan's top three counties are identical. Gundersen Health also consistently ranks among the highest quality plans. It is also important to note that they have formed a partnership with Unity Health.





The final plan is WEA Trust. Although their membership is not large in the Southern Region, it is important to recognize that they are the third largest plan by membership statewide, approaching 25,000 lives.



Eastern (Includes Northeastern and Southeastern)

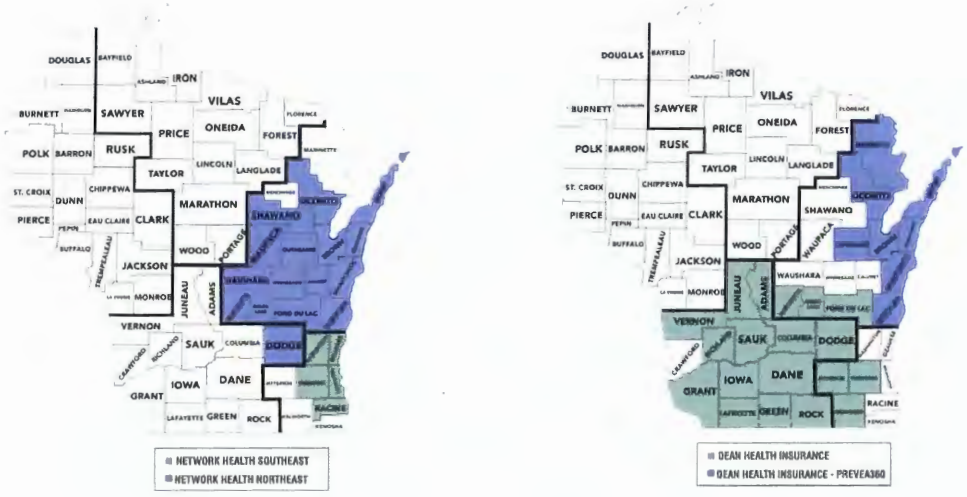
When reviewing ETF enrollment in the Northeastern and Southeastern Medicaid Regions, it becomes obvious that nearly all plans operate in both regions. We believe it is a natural fit to combine these regions into a common "Eastern" Region for this report.

The three largest plans in the region primarily cover the entire combined Eastern Region. The largest membership is WEA Trust, a PPO plan, with 13,300 lives. The other two plans have a national presence – Humana and UnitedHealthcare, each with about 10,000 members.



Network Health is nearly as large as those above, with nearly 9,000 members. They are unique in that their membership is in primarily in the Northeastern Region. They also were approved to operate in some counties in the Southeastern Region for 2016 (in green on map) and should get additional membership after open enrollment.

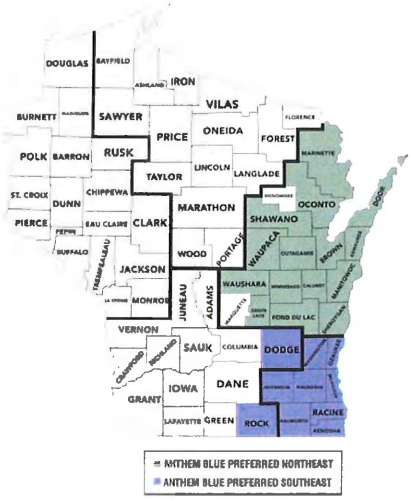
Dean Health is the next largest plan, with 4,200 members split proportionally in both the Northeastern and Southeastern Regions. Members are primarily covered through the Dean Prevea360 Plan.

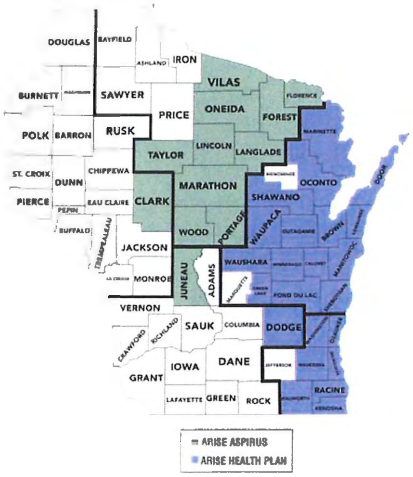


The last two plans operating in the region primarily have enrollment in either the Northeastern or Southeastern Region. Anthem Blue Preferred is the larger of the two, with 3,200 members, most of which are in the Southeastern Region. Note that Anthem is the third national plan in this region and has a significant block of members within the local program.

Also, Anthem, like many in this region, almost perfectly covers the combined region.

The final plan is Arise Health Plan. They currently have 1,600 members and have recently expanded their service area. The membership may not accurately reflect their new network coverage and might likely expand.





Like the Southern Region, the boundaries for the combined Eastern Region should cause limited network disruption. It is very clear that the Northeastern and Southeastern Regions could be combined into one Eastern Region for ETF purposes.

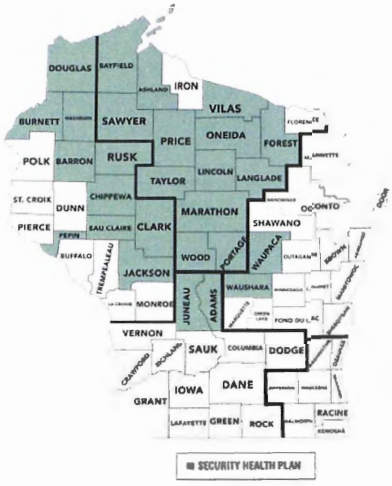
Northwestern (Includes Northern and Western)

This region is slightly more challenging and less obvious than the other regions. The Western Region is nearly the size of each of the Eastern regions, with 18,600 lives. The Northern Region is more rural and by far the smallest region at 8,300 members. Given the level of financial arrangements in these regions, we believe there will be adequate coverage to combine these regions into one "Northwestern" Region.

Unlike the Southern and Eastern Regions, the levels of managed care and provider compensation in the Northern and Western Regions are much less competitive. Their PMPMs are nearly identical to each other and are the highest of all the regions. They appear to be financially similar.

The two largest plans in the region operate across both regions, with each representing the largest membership in each sub-region. We have discussed WEA Trust earlier in this section. They are one of the largest statewide, but also the largest in the Western Region with 8,900 members (10,500 in the combined Northwestern Region). The second largest is Security Health, at 7,700 members. Like WEA Trust, Security Health covers both regions but has more membership (6,200) in the Northern sub-region. Security dominates the north, having over 75% of ETF membership in that region.





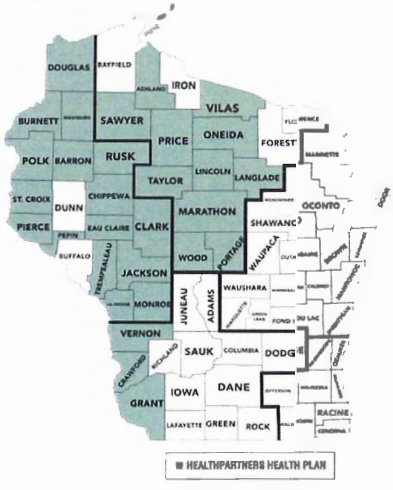
There are no other plans in the Northern Region that have any sizeable membership. The next largest plan is GHC-EC with only 300 members.

The Western Region has a number of plans, in addition to the largest two mentioned above. There are three plans with over 1,000 lives. The largest is Gundersen at 3,000 lives. They have been discussed earlier as being high quality, lower cost and have a new partnership with Unity.

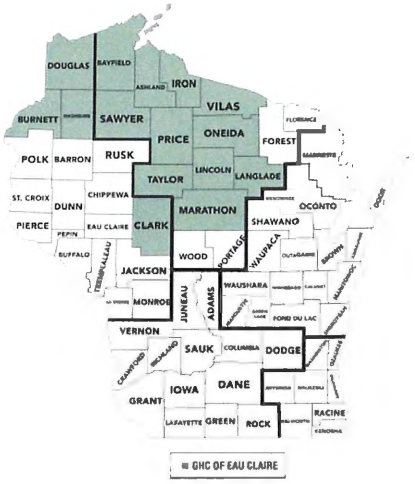
Health Tradition is slightly smaller at 2,000 lives in the region. It is interesting to note that these two plans cover similar counties in the Southern Region as well. The third plan, HealthPartners, provides excellent coverage over the two regions and has 1,800 lives, with very few in the other regions they cover. The majority of their membership is in the Western region.

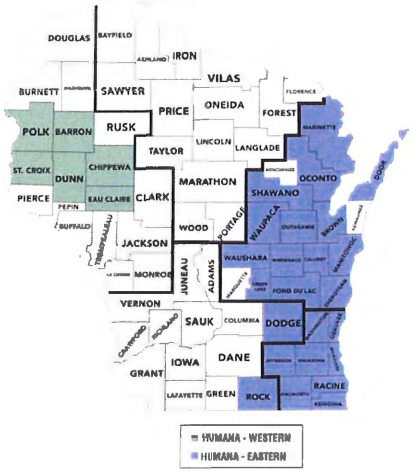




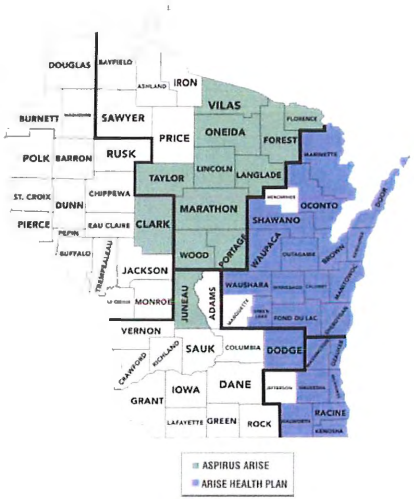


Two other plans with membership are Humana and GHC-EC. Both have around 700 lives in the Western region. Humana is part of a number of regions, having total ETF membership over 10,000 lives. GHC-EC has small additional membership in the Northern Region, making their total membership still less than 1,000.





The final plan is Aspirus Arise. This is also a new service area so the membership representation may not be an accurate assessment of their coverage. What is apparent is that they currently cover virtually no counties in the Western Region and would have challenges in the combined Northwestern Region.



Combining the Northern and Western Medicaid regions into a Northwestern Region is less absolute as the Eastern Region, where a number of vendors cover both geographic sub-regions. There still exists a number of viable options in a combined Northwestern Region that would be very feasible for ETF. To avoid initial disruption in the market, it may be preferable and more practical to have separate Northern and Western regions initially, with a longer term goal to have them combined. This will need to be explored further during a procurement cycle.

Regional Modifications

The analysis in this section was focused on utilizing the Medicaid regions primarily because plans are currently familiar and operate within those boundaries. Our conclusion is that a regional approach, with pre-determined defined counties, can be of great benefit to ETF. We believe there should be three to four regions initially. We also note that the maps will need to be further defined by ETF, where it might make sense to move counties between regions. A good example might be to move those counties in the southern part of the Western Region into the Southern Region, given the geographic footprints of Gundersen and Health Tradition. There may be similar "tweaks" in other regions as well, but we anticipate these changes would be relatively minor and would not materially affect the ultimate recommendation.

Regional Discount Analysis

During the 2016 plan renewal process, Segal received a number of additional exhibits that allowed us to access the financial competitiveness of the various plans. There are obviously a number of elements to consider in the analysis. With the larger picture in mind, Segal requested detailed claims information from the plans. Unfortunately, Plans were not willing to include complete financial information with their data. Only summary level financial data was provided, which was more information than ETF had received from the plans in the past.

Using the best information made available to us, Segal estimated the "net" discounts in each region. To do this we assumed reported discounts for each plan bid were uniformly distributed over their membership. Although not 100% accurate, we believe this method is a reasonable assessment of financial variation between the plans and regions. Below is summary of our results:

Medicaid Region	Hospital Inpatient	Hospital Outpatient	Physician Services	Overall
Northeastern	31%	42%	46%	41%
Northern	19%	27%	34%	29%
Southeastern	35%	44%	49%	44%
Southern	46%	45%	50%	46%
Western	18%	19%	27%	23%
Statewide	38%	41%	46%	42%

In isolation, discounts would not be fully reliable. We then looked at the total per member per month (PMPM) costs as well. The table on the following pages summarizes our analysis, looking regionally. The first column shows overall PMPMs submitted and represent their experience from which rates were built. The second column calculates the relative cost, based on the PMPM, calculated as the region rate divided by the statewide rate. We then took the statewide average and adjusted to the region by using the Statewide PMPM and only adjusting for discounts. So for the Northern Region, the rate would be $416 x (1-0.288)/(1-0.417) or $508.

Medicaid Region	Experience PMPM	Relative Cost	Discount Only	Relative Cost
Northeastern	$421	1.012	$421	1.014
Northern	$493	1.184	$508	1.223
Southeastern	$439	1.055	$400	0.962
Southern	$383	0.921	$385	0.927
Western	$490	1.179	$551	1.325
Statewide	$416	1.000	$416	1.000

Using the plans' net reported discount does seem to correlate with the resulting costs. Segal has done considerable analysis from the information reports, both specific to plans and within a region.

The combination of the operations of the current plans and their self-reported financials provides further support for the recommendations made later in the section. It also supports the structure of the RFI, also discussed later in this section, and the preliminary results. A summary of the various plans can be found in **Appendix 4**.

Vendors and Contracting

This health-plan-unique service area approach seeks to maximize member choice and access to providers and instill competition among the plans to manage costs. With virtually every healthcare provider in the State participating in at least one of the plans' networks, members certainly have sufficient provider access and most have significant choice when it comes to health plans. Service areas are not necessarily consistent from year to year. From 2015 to 2016, one plan dropped several counties, while others expanded to new counties. Although these changes did not affect many members overall, ETF must deal with a number of service area modifications each year.

Pricing varies greatly among the health plans. In prior years, it was believed that the variation in premiums was largely due to variations in geography and health risk between the plans. This year, plans were required to provide more detailed claims and cost data and this transparency has enabled us to see how the plans' net effective pricing varies. The following table lists the Overall Reported Net Discounts for each of the health plan networks:

Health Plan	Addendum 3a and 3b Overall Reported Net Discounts
Plan Network 1	57.7%
Plan Network 2	51.2%
Plan Network 3	50.4%
Plan Network 4	48.4%
Plan Network 5	47.5%
Plan Network 6	47.1%
Plan Network 7	45.8%
Plan Network 8	45.7%
Plan Network 9	45.3%
Plan Network 10	43.4%

Health Plan	Addendum 3a and 3b Overall Reported Net Discounts
Plan Network 11	40.9%
Plan Network 12	38.7%
Plan Network 13	38.6%
Plan Network 14	37.2%
Plan Network 15	34.9%
Plan Network 16	33.6%
Plan Network 17	32.5%
Plan Network 18	26.2%
Plan Network 19	25.5%
Plan Network 20	25.3%
Plan Network 21	23.0%
Plan Network 22	20.0%
Plan Network 23	15.2%
Plan Network 24	15.2%
Overall Average	**41.7%**

We recognize that discount analysis alone does not provide the complete picture for cost comparisons or financial performance. With that in mind, we reviewed a number of complementary data points, including net cost per service, key utilization components and overall risk adjusted per member monthly costs. This detailed analysis is confidential information to the plans.

The analysis indicates a correlation of discounts to cost per service. Reviewing the four larger plans in Dane County for example, we found that the lowest discount produced the highest cost per day and the highest discounts produced the lowest cost per day. This suggests a correlation between discounts and costs. The prior section also reviewed the markets overall and discussed a similar correlation.

This observation begs the question of how the program could be structured to better utilize the plans with the more effective pricing, but without sacrificing provider access for members. Additionally, in our first report, we presented data showing that there is a significant variation in performance in the current plans' health management programs. The quality of a plan's customer service is also important. All these elements will need to be factored in during a procurement.

A redesigned program should:

- Maximize gains in pricing and provider discounts
- Maintain provider access
- Manage member disruption
- Improve overall performance of the plans' health management
- Provide quality customer service

While additional data was collected during the summer of 2015 for the 2016 health plan negotiations, it was still limited to the currently contracted health plans and to each health plan's

current ETF service area and membership. The health plans' full networks generally cover a broader service area than the area provided to ETF; this data was not collected or necessary when doing 2016 renewals. Also, there are organizations that do not currently contract with ETF. We do not collect cost and access data for those organizations either during the renewal process.

Request for Information

In order to supplement our renewal analysis, Segal, in conjunction with ETF, issued a Request for Information to receive additional pricing and provider discount information, as well as network and provider access information. Respondents were not limited to the current health plans contracted with ETF or to their current service areas. Many additional health plan organizations in the market were invited to participate.



Information was collected on a statewide basis, as well as on a regional basis, with the five regions for this analysis aligned with the regions used by the State's Medicaid agency.

We collected information and analyzed three major network components:

Provider discounts – net effective discounts from billed charges, separately for Inpatient Facility, Outpatient Facility and Professional. Net effective discounts are the allowed costs net of discounts from billed charges and account for value-based, shared risk or other innovative provider payment methods, such as capitated programs, accountable care organizations, patient medical homes, bundled payments, quality bonus payments, etc.

Access to Providers – member access to providers, both professional and facility is measured as the percentage of members with "sufficient access", which was defined to be:

	Urban[1]	Other
Hospital	1 in 20 miles	1 in 35 miles
Primary Care Physician	2 in 10 miles	2 in 20 miles
Pediatrician	2 in 10 miles	2 in 20 miles
Specialist	2 in 10 miles	2 in 35 miles

Member disruption – a list of providers was provided for each participating group in the RFI to indicate network participation. The information was extracted from the WHIO database and

[1] Urban counties are: Brown, Dane, Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha.

represents over 7,000 individual medical providers that together represent over 90% of the claims.

Regions

The ideal regional structure accomplishes the above goals with as few regions as possible. With fewer regions, member communications, vendor contracting and plan administration are simplified. This results in fewer ETF resources necessary to run the program, enabling more resources utilized for strategic planning.

Many states utilize a statewide structure for their primary health benefit plan, which actually requires a national network to accommodate retirees that have moved out-of-state. These states often provide statewide options with multiple vendors. For example, the Minnesota State Employee Group Insurance Plan has three statewide vendors, all with the same plan design. The Wisconsin market, although similar to Minnesota, has several very strong health plans that do not operate on a statewide basis. The regional structure is necessary to accommodate the footprint of the various vendors currently operating in the market. This does not mean that consolidation will not happen, with more statewide vendors, it just means that it may be a phased-in approach to some of the concepts.

As we have previously noted, an inspection of current health plan service areas indicates that many health plans operate in more than one of the five Medicaid regions. This indicates that fewer and larger regions might be considered for ETF.

Based on our review, and supported by the provider access submitted in response to the RFI, we recommend a structure with three geographic regions:

- In the **Southern Region**, there are many plans with a service area focused in, and around, Madison and Dane County. This region has approximately 99,000 members, which is roughly 50% of the total membership.
- Many plans operate in both the Northeast and Southeast regions, indicating that a combined **Eastern Region** may be practical. The combined region would have 53,000 members.
- There are approximately 27,000 members in the Northern and Western regions. There are at least two health plans with an ETF service area currently covering the majority of the combined **Northwestern Region.** Although preliminary results indicate a combined region is feasible, provides good access and would be cost effective, there would likely be significant disruption in the Northern region. As ETF moves forward, this region, in particular, may need to initially remain subdivided.

As we have mentioned earlier, we believe there will need to be some "tweaks" in the regional structure, possibly moving individual counties between regions.

RFI Responses

Each of the current ETF health plans were invited to participate in the RFI, along with additional targeted organizations. While not every organization that received an invitation provided a submission, the overall response was strong, and we believe the data provided is credible and suitable for our analysis. The following is a summary of the requests issued and responses received.

Organization	Discount Data	GeoAccess	Disruption	Declined
Current ETF Plans				
Anthem BCBS	X	X	X	
Arise		X	X	
Dean Health Plan	X	X	X	
GHC – EC				X
GHC – SCW	X	X	X	
Gundersen Health Plan	X	X	X	
Health Tradition Health Plan		X	X	
HealthPartners	X	X	X	
Humana	X	X	X	
Medical Associates Health Plans	X	X	X	
MercyCare Health Plans		X	X	
Network Health	X	X	X	
Physicians Plus				X
Security Health Plan of WI	X	X	X	
UHC	X	X	X	
Unity Health Plan	X	X	X	
WEA Trust	X	X	X	
WPS		X	X	
Prospective Vendors				
AboutHealth	X	X	X	
Aetna				X
CIGNA				X
Integrated Health Network	X	X	X	
The Alliance	X	X	X	

Provider Discounts

Respondents were requested to provide average expected net provider discount levels for their book of business (BOB) for three major categories of services:

- Inpatient Facility;
- Outpatient Facility; and
- Professional.

The provider discount information submitted with the RFI is not ETF specific and results may vary if the analysis were conducted using ETF claims and utilization patterns. However, a comparison with net provider discount data collected during the negotiations for 2016 indicates the BOB data to be largely consistent. Therefore, we consider the information provided in response to the RFI to be sufficient for the purposes of this analysis, which is to identify and analyze the potential opportunity in the market to improve overall pricing for ETF through consolidation. An actual request for proposals (RFP), accompanied with full claims and encounter data, would be necessary to confirm and validate the RFI results.

However, between the data from the RFI and the renewal, it is possible to estimate the opportunity to improve pricing, without sacrificing access, with a regional approach with a more focused health plan contracting approach. Although access should not be affected, there would likely be some initial provider disruption within a region. We would expect this to become less over time, as the market matures and providers alter their contracting strategies to meet ETF needs.

Southern Region

The Southern Region covers the most members and is served by nine (9) health plans which, according to the renewal data, provide an aggregate provider discount of 46.0%. However, discounts vary among the health plans within a range of approximately 38%-49%, which contributes to a spread in risk-adjusted costs of approximately $159.

Some RFI respondents report discounts greater than 50%. But these are BOB figures and may not be realized once the provider contracts are matched with ETF's utilization. There are also capitation arrangements whose encounter data conflict with RFI vendor reported discounts. So looking at a number of data points, it does seem reasonable that pricing could be improved by 2-4% with a more consolidated contracting approach. This would result in the average moving towards the top of the current range. A more competitive environment may also drive additional gains. Claims for the Southern Region are projected to be $405.1M in 2016. Therefore, a 3% midpoint improvement in provider discounts (46% to 49%) produces $22.5M in savings.

All nine (9) current plans, plus three (3) additional respondents reported provider access near 100% based on the GeoAccess standards for the RFI. So, provider access is not an issue under virtually any contracting structure.

The Southern Region is unique in that some of the plans' networks do not significantly overlap, particularly between Dean and Unity. However, per the RFI, providers in both networks do

contract and coexist in other plans' networks. Therefore, it may not be necessary to contract with both plans in order to have access to the various providers. It could also result in not all providers being in the preferred network tier (Tiered networks are discussed later in this section).

Note that Unity is the only health plan with resistance to data sharing and are currently the only plan that has not yet signed the 2016 contract with the GIB.

Eastern Region

The new combined Eastern Region would cover 53,000 members. The area is currently served primarily by four (4) health plans which, according to the renewal data, provide an aggregate provider discount of 42.7%. Reported discounts vary among the health plans within a range of approximately 41-50%, which contributes to a spread in risk-adjusted costs of approximately $167 (similar to the variation in the Southern region). More plans are toward the lower end of the discount range.

Some RFI respondents report discounts in the range of 53-56%. However, these are BOB figures and may not be realized once the provider contracts are matched with ETF's utilization. It does seem reasonable that pricing could be improved by 4-6% with a more consolidated contracting approach. This would result in the average moving towards the top of the current range. Claims for the Eastern Region are projected to be $276.1M in 2016. Therefore, a 5% improvement in provider discounts (42.7% to 47.7%) produces $24.1M in savings to ETF.

All four (4) current plans that primarily serve the region, plus two (2) additional respondents reported provider access near 100% based on the GeoAccess standards for the RFI. So, provider access is not expected to be an issue. Additionally, these plans' networks overlap to a high degree. Therefore, plan consolidation is not anticipated to result in significant disruption at the provider level.

Northwestern Region

The new combined Northwestern Region would cover approximately 27,000 members. The area is currently served primarily by five (5) health plans which, according to the renewal data, provide an aggregate provider discount of 24.7%, much less than the Southern and Eastern Regions. There was a wide variation in this region, with discounts among the health plans having a range of approximately 15-26%, which contributes to a spread in risk-adjusted costs of approximately $272. We do believe some of the variation is from additional risk not fully reflected in the risk adjustment, primarily since many of the plans are much smaller.

Not surprisingly, given the poor discounts, the plans in this region generally have the highest premiums. This is not a unique dynamic to Wisconsin. In many rural areas across the country, health plans often have difficulty negotiating favorable terms with providers who, given the usually limited competition, have less of an incentive, or need, to rely on network steerage for patients.

Some RFI respondents report discounts in excess of 30%. Again, these are BOB figures and may not be realized once the provider contracts are matched with ETF's utilization. It does seem reasonable that pricing could be improved by 4-6% with a more consolidated contracting approach. This would result in the average moving towards the top of the reported range. A more

competitive environment may also drive additional gains. Claims for the Northwestern Region are projected to be $164.4M in 2016. Therefore, a 5% improvement in provider discounts (24.7% to 29.7%) produces $10.9M in savings to ETF.

Four (4) of the current primary plans reported provider access near 100% based on the GeoAccess standards for the RFI. The other plan currently operates primarily in one of the subregions. Nonetheless, provider access is not expected to be an issue. Additionally, these plans' networks overlap to a high degree. Therefore, plan consolidation is not anticipated to result in significant disruption at the provider level.

Statewide Options

Our analysis indicates that there are at least two plans that could provide discounts above the current aggregate average. Both plans also report nearly 100% provider access. Three (3) other plans report nearly 100% access but report discounts below the current average. With the addition of a statewide option we would expect the market to form alliances and partnerships to possibly provide ETF with additional choices than currently available in the market. We have seen this already in certain regions and would expect more over the next few years. Since our approach is primarily regionalized, the savings for the Statewide option, that replaces the current Standard Plan, would produce marginal savings above those already detailed within the State.

The statewide vendor would also be required to provide an out-of-state network. We would expect savings for out-of-state members, primarily retirees, but that was not included in our RFI and doesn't impact the regional structure recommendation.

It is also important to note that we received information from organizations that are not currently health plans. The Alliance, IHN and AboutHealth reported favorable discounts and access in several regions. However, since they are not currently health plans, it is not practical to contract directly with ETF. A partnership of some kind, such as AboutHealth's arrangement with Anthem and Arise or IHN's with Network Health, would be necessary. Therefore we did not include their results directly in our analysis.

Member Disruption

It is important to fully understand the terms "access" and "disruption". We discussed earlier in this report that access is just that, access to necessary healthcare providers that meet the GeoAccess requirements defined. The requirements vary by type of provider and whether the member resides in an urban, suburban or rural location. This is quite different from disruption. Disruption defines whether a member will need to change their current provider(s). Therefore, in Dane County, for example, most members will have 100% access but we would likely expect disruption, since some of the providers are exclusive to a particular plan. This is what we attempted to capture in this section.

A list of currently utilized providers for ETF was provided with the RFI and respondents were requested to indicate which of these providers are in their respective networks. The file contained over 7,000 individual providers and represented more than 90% of claims/encounters. (A file with 100% of all providers and claims/encounters would have been significantly more extensive and more cumbersome for the plans to analyze.)

Currently, very few providers contract with a single, or limited number of, plan(s). The great majority of providers contract with multiple plans. We reviewed the major provider groups and facilities and compared them with what the plans reported as their network providers. Several plans indicate that many or almost all of the hospitals utilized most by ETF members are in their respective networks. There were only a few exceptions to this – primarily in Dane County, where two of the larger plans operate. From a statewide perspective, several plans report that all but a handful of these highly utilized hospitals are in their network. Detail showing network participation by hospital is included in **Appendix 5.**

Note that the statewide model will have all providers in the plan. The delineation will be that the majority of network providers will be In-Network. Some high performing providers will be in the preferred network tier and those not accepting the In-Network pricing will be paid as an Out-of-Network provider. We would expect very few members to use Out-of-Network providers. We also believe some regional plans could operate in a similar structure, but as a minimum, the statewide plan will have this design incorporated (Tiered networks are discussed later in this section).

Summary

Based on our analysis, we conclude there is an opportunity for ETF to ultimately achieve $45-70M in medical claims savings from consolidating the number of health plans and converting to a regional approach with regions *determined* by ETF and uniform for all health plans. We believe this can be accomplished without sacrificing Provider Access and with a significant Network Match (minimal Disruption). The approach will also support improving overall performance of Total Health Management, discussed in that section. Below is the midpoint summary:

	Southern Region	Eastern Region	Northwestern Region
Number of Plans with Virtually 100% GeoAccess	9	4	4
Estimated Discount Improvement Opportunity	3.0%	5.0%	5.0%
Estimated Associated Claims Savings	$22.5M	$24.1M	$10.9M

While there are some notable exceptions in the Southern Region, many of the plans' networks overlap to a large degree and consolidation is not likely to result in significant provider disruption for members. If a member utilizes a specific provider on a regular basis and that member's plan's contract is discontinued, then it is very likely that the provider in question is in another plan's network. Also note that further review of the Northwestern region may result in that combined region occurring over time, initially being split up to avoid unnecessary disruption.

Our recommendation would be to contract with up to two health plans per region, alongside a single statewide health plan. This provides a uniform option across the entire membership, while enabling ETF to leverage the very best of the regional health plans. If a single health plan is selected at the regional level, then pricing may be improved without affecting access but there may be some material disruption in selected areas.

We recommend that ETF structure this within a self-insured environment, but the savings detailed above are solely from the regional approach and consolidation and not from self-insurance. There are a tremendous number of advantages to operating in a self-insured environment; these are detailed later in the Self-Insurance section of the report.

Total Health Management capabilities can vary significantly from employer to employer for a single health plan. Depending on the employer's program design and contractual requirements, a particular health plan or wellness vendor may allocate additional and more comprehensive resources and provide better results to a plan sponsor that is more committed to Total Health Management than to a less committed organization. This is best explored and evaluated through a bid and RFP process.

The same can be said of member and customer service capabilities. Member satisfaction can also vary based on contractual requirements and is best explored and evaluated through a bid and RFP process.

Additionally, the local Wisconsin and national health plan markets are in flux, with mergers and acquisitions at both the local and national levels. In Wisconsin, new organizations are evolving and may provide additional health plan choices for ETF in the near future. As the market continues to evolve, we would anticipate changes in health plan capabilities.

Benefit Design

Our last report provided an extensive review of the plan designs. We compared ETF to:

- Wisconsin Exchange
- Federal Employee Benefit Plan
- National Public Sector Plans
- States within your Region (IA, MN, IL, IN, MI)
- Private Sector Plans
- Emerging Trends

The analysis compared plan design structure, elements, pricing, contributions, etc. Further details and analysis can be found at: http://etf.wi.gov/boards/agenda-items-2015/gib0325/item4c1.pdf.

In general, ETF benefits were on the high end of both the cost and benefit value. For 2016, ETF made changes that will move costs closer to regional norms and achieve budget targets. The long-term goal is to develop a sustainable program while maintaining a similar benefit value plan.

We will incorporate a best-in-class design that best fits Wisconsin and ETF's membership. Our goal is to reward those who participate and actively manage their health, while maintaining competitive benefits for all.

Tiered Network

Health plans and large self-insured employers have long attempted to direct patients to certain "preferred" providers. These efforts face a renewed sense of urgency given the escalating pressure to contain health care costs and improve efficiency, coupled with mounting evidence that high prices do not necessarily signal high quality. In contrast to the mid-1990s, however, when HMOs directed patients to particular providers by using closed networks, health plans today are increasingly likely to channel patients through value-based network designs.

Value-based, or tiered, provider networks attempt to engage consumers in making informed decisions about their care, while maintaining consumer choice of provider. This network and benefit design reflects the lessons learned from the managed care backlash against restricted provider choice and has been enabled by improvements in recent years in measuring individual provider performance. In a tiered network, health insurers sort providers into tiers based on cost-efficiency and quality performance measures. Efficiency is typically gauged using case-mix adjusted episode level costs and utilization, while quality is judged through claims-based process measures, external certification, and, in some cases, use of health information technology.

Providers achieving higher efficiency and/or quality scores are placed in the preferred tier, and patients are given a financial incentive to choose these providers. In the case of physicians, this incentive is typically a moderately lower copayment; for hospitals it may be a lower coinsurance rate.

In addition to encouraging individual consumers to seek value in their health care choices, tiered networks also hold the potential to improve the value of the health care system overall as lower-performing providers work to enhance the quality or efficiency of their care in order to improve their ranking, either to recover lost market share or simply to improve their position within the network.



The ultimate goal is to construct a tiered network to deliver the most efficient care possible and drive utilization to those providers.

Commonwealth Study

Commonwealth Fund–supported researchers at Harvard University explored how tiered networks affiliated with Blue Cross Blue Shield of Massachusetts (BCBSMA), the state's largest insurer, affect hospital admission choices. The study used patient-level claims data for 2009-2012 from Blue Cross Blue Shield of Massachusetts (BCBSMA) to analyze the impact of their tiered model within the State.

What the Study Found

BCBSMA's three-tiered hospital network employs large differential cost sharing to encourage patients to seek care at hospitals on the preferred tier. During the study period, 44 percent of

hospitals were moved to a different tier based on changes in cost or quality performance. We relied on this longitudinal variation for identification and specified conditional logic models to estimate the effect of the tiered network (TN) on patients' hospital choices relative to a non-TN comparison group.

The authors predicted that if all BCBSMA members were in a tiered plan instead of a monitored plan, scheduled admissions to hospitals in the nonpreferred tier would drop by 7.6 percentage points, while admissions to middle- and preferred-tier hospitals would rise by 0.9 and 6.6 percentage points, respectively.

Their Conclusion

Tiered-network designs that feature large cost differences between tiers are successful at steering patients toward preferred hospitals—those offering lower costs and higher quality—while preserving a greater degree of provider choice. The authors warn, however, that tiered networks have potential drawbacks. For example, they may transfer risk to patients in the form of higher out-of-pocket payments for lower-tiered providers.

In summary, Tiered Networks:

- Rank providers based on cost and quality and create a plan design with financial incentives to steer members toward lower cost care
- Allow the Member to maintain control of provider decision as well as responsibility to research and understand often complex decisions regarding cost and quality of care
- May include tiering of hospitals only for some plans while others tier primary care physicians and specialists as well
- Vary because each insurer tiers based on a different formula of cost and quality criteria

Discern Health Study

ETF has engaged Discern Health to analyze the possibility of using provider tiers and reference based pricing. In May 2015, they released a report entitled: "***Tiering and Reference Value: Principles and Strategies".*** Discern also conducted a webinar discussing their results and recommendations.

Without going into great detail, Discern had two recommended strategies for ETF:

- ***Physician Tiering***- a program in which individual physicians are evaluated against measures of cost and quality and are then grouped into tiers based on their performance results.
- ***Reference Value for Hospitals***- a program in which a fixed reimbursement level is set for specified services for which there are wide variations in price across a group of hospitals.

The recommendations presented in their report outline a phased framework intended to allow consumers to equilibrate culturally to the idea of seeking out information to make informed health care decisions. The framework also allows time for stakeholder input, review and opportunities to build on previous successes and lessons learned.

By incentivizing consumers to make informed, value-based decisions, they propose that ETF can offer not only more value to its members and Wisconsin taxpayers, but may positively influence overall efforts to improve the experience of care for consumers, improve health outcomes for the population, and lower health care costs overall.

Many of the items we recommend are in sync with this report.

Reference Based Pricing

Going forward, we are likely to see further evolution in how tiered provider networks are utilized. One variant of the concept that has already appeared is the use of reference pricing in combination with an identified network of providers willing to render targeted services at or below the pre-determined price.

For example, in collaboration with CalPERS, Anthem Blue Cross in California launched a program whereby it agreed to pay up to $30,000 for a single hip or knee replacement and identified 47 hospitals across the state willing to provide those services for that "reference" price. Patients using the identified hospitals face only their required cost sharing, but those opting to use a more expensive facility must also pay all allowed charges above $30,000. To the extent that health plans see only muted consumer responses to the relatively modest copayment differences commonly used today, we may start to see more employers and health plans move in the direction of a reference based pricing model, especially for these types of "big ticket" items.

We recommend working with the contracted plans to develop an array of services subject to reference based pricing. This may initially include hip and knee replacement, colonoscopy, magnetic resonance imaging (MRI) of the spine, computerized tomography (CT) scan of the head or brain, nuclear stress test of the heart, and/or echocardiograms. It is desirable to use this strategy for services that have fairly uniform protocols, and that are less likely to experience variation in quality, both of which characteristics make price comparisons easier for patients.

There are, however, pitfalls to any strategy. Some employers that have implemented reference-based pricing plans do not see the desired results because they have not addressed all the related considerations, such as - lack of established markets; safe haven hospitals; and disruption from non-participating providers.

When implementing a referenced-based pricing plan, choose a vendor with experience, as well as clear, transparent processes and safeguards in place to protect patients.

Centers of Excellence

The concept of having designated providers, typically hospitals as "centers of excellence" has been around for many years and had its origins in the notion that for complex medical procedures like heart, kidney, and liver transplants and complex cancer treatment - all providers are not created equal. This notion has been confirmed by the pilots that were initially run and subsequently by research studies. We know that outcomes vary widely and the incidence of unintended consequences like wound inflections, pneumonia rates, kidney inflections, etc. are directly linked to the variations in care delivery and standards of treatment that exist between providers.

Today, the "centers of excellence" concept is being applied to other less complex procedures where variations in outcomes have been measured. The Leap Frog Group and other organizations that measure provider quality and procedure outcomes find there is enough difference among networks to warrant a plan sponsor to implement quality assessments of hospitals and focus care delivery on procedures like – heart by-pass surgery, joint replacement surgery, bariatric surgery along with the traditional complex surgeries referenced above. Typically, the price charged for these services is a bundled price for all associated care.

Recommended Plan Designs

Below is a brief summary of the main plans currently being offered for 2016. As of 2016, the following plan names have changed and may be referenced differently throughout this document. UBD has become the It's Your Choice (IYC) Health Plan, the HDHP is now the IYC HDHP and the Standard Plan is now the IYC Access Health Plan.

2016 ETF PLAN DESIGNS

			IYC Access Health Plan	
	IYC Health Plan	IYC HDHP	In-Network	Out-Network
Annual Deductible				
Individual	$250	$1,500	$250	$500
Family	$500	$3,000	$500	$1,000
HSA Employer Contribution				
Individual	N/A	$750	N/A	N/A
Family	N/A	$1,500	N/A	N/A
Office Visit				
PCP	$15	$15, after deductible	$15	30%, after deductible
Specialist	$25	$25, after deductible	$25	30%, after deductible
Emergency Room	$75	$75, after deductible	$75	$75
Coinsurance	10%	10%	10%	30%
OOP Limits				
Individual	$1,250	$2,500	$1,000	$2,000
Family	$2,500	$5,000	$2,000	$4,000

The following recommended designs build off the IYC Access Health Plan, with In-Network benefits similar to the IYC Health Plan. The current In-Network benefit is primarily the Preferred Network Benefit level, with the new In-Network having slightly more cost sharing. The Out-of-Network benefits are similar to current benefits. This should result in the desired steerage towards the higher quality, more efficient providers. Additionally, there is a $5 office visit copay reduction for members engaged in appropriate disease management programs.

The Preferred Network should only be the high performing hospitals and physicians, a narrower network vs. the current structure. The In-Network would be the remainder of the contracted network and the Out-of-Network would be all other providers. Out-of-Network providers would be paid according to the in-network schedule, with any excess being paid by the member.

Below is a brief summary of the proposed design:

RECOMMENDED PLAN OFFERINGS

	IYC Tiered Network Plan Design			
	Preferred	In-Network	Out-Network	IYC HDHP
Annual Deductible				
Individual	N/A	$250	$500	$1,500
Family	N/A	$500	$1,000	$3,000
HSA Employer Contribution				
Individual	N/A	N/A	N/A	$750
Family	N/A	N/A	N/A	$1,500
Office Visit				
PCP	$15	$25	30%	$15, after deductible
Specialist	$25	$35	30%	$25, after deductible
Emergency Room	$75	$75	$75	$75, after deductible
Coinsurance	10%	20%	30%	10%
OOP Limits				
Individual	$1,250		$2,500	$2,500
Family	$2,500		$5,000	$5,000
	Members who engage in disease management have a $5-$10 reduction to their physician copayment (in addition to pharmacy enhancements)			

The copay reduction for disease management would be managed by the plan and would be initiated when members engage in their disease management program. They would also need to provide a feed to the PBM to manage the pharmacy eligibility or possibly use a "coupon" if easier to administer.

As discussed in an earlier section we would anticipate using reference-based pricing as appropriate. We would expect this to be minimal initially but grow over the next 5 years. Hospitals and/or Physicians who accept the pricing will be considered Tier 1 for that procedure.

We recommend integration of Telemedicine at a reduced copayment of $5 to $10, depending on how the contracting is negotiated. Similarly, if ETF moves forward with implementation of an On-Site Clinic, similar financial incentives would be instituted. Note that the HDHP plan would need to be charged the "full cost" while in the deductible, in order to comply with federal regulation.

We also expect to have centers of excellence in place. ETF would need to work with the plans to determine appropriate complex procedures to be placed in this category. Note that ETF already uses centers of excellence for Bariatric Surgery in the Standard Plan. The Standard Plan experience shows costs for patients with surgeries performed in centers of excellence since 2010 are 30-40% less than for patients with surgeries in non-centers of excellence.

Recommended Contribution Rates

Unlike the current structure, we do not expect all our plans in the program to be in Tier 1. In order to be considered Tier 1, the plan must demonstrate a significant financial advantage over the Tier 2 plan. With that in mind, we expect the bulk of the membership to initially be in Tier 2 plans. As plans demonstrate their capabilities, they can migrate to Tier 1.

Another part of the contribution strategy is the integration of the wellness premium credit/penalty discussed in the **Total Health Management** section earlier in this report. A member that meets his or her wellness requirements would receive a $50 monthly premium reduction ($100 for family coverage). That member would have lower contributions than those currently in Tier 1. This reduction would be funded by the additional premiums paid by the members that do not participate in the wellness program. For the subset of plans operating at Tier 1 levels, their contributions would be even lower.

2016 ETF PLAN DESIGNS

	HDHP	Tier 1	Tier 2	Tier 3
Single	$29	$83	$168	$253
Family	$73	$209	$421	$632

RECOMMENDED PLAN OFFERINGS—ILLUSTRATIVE PREMIUMS

	HDHP	Tier 1[1]	Tier 2	Tier 3[2]
W/O Wellness				
Single	$79	$102	$123	$203
Family	$173	$235	$289	$483
W/Wellness				
Single	$29	$52	$73	$153
Family	$73	$135	$189	$383
	Employee and Spouse participation required. Penalty is $50/$100 Single/Family			

[1] Tier 1 premiums will be established to share the value provided by higher performing health plans, which, for purposes of this illustration, are expected to provide costs 10% or more below Tier 2 plans.

[2] Tier 3 premiums will be established to pass the full differential in costs between Tier 3 and Tier 2 plans, which is expected to be 10%. With this approach, ETF will be financially neutral regarding Tier 2 and Tier 3 enrollments.

The numbers above are illustrative and would need to be finalized during the rate development cycle. These numbers may need to be adjusted to meet any regulatory requirements in place.

Note that the premiums in these tables are for medical and pharmacy coverage only and do not include dental premiums.

In Summary

We are not anticipating significant savings from this benefit structure alone. Savings are anticipated over time as the reference-based pricing and centers-of-excellence components are implemented and grow towards maturity. The benefit and premium structure is designed to support the recommended THM strategy and is not designed to generate savings to ETF from member cost shifting.

The additional wellness contributions will enable the plan to provide a number of value based benefits, offering plan members reduced cost sharing and lower contributions. The benefit design drives utilization and provider choices that will result in more efficient and higher quality care.

Note that the benefit design is meant to be a greater value than the current program provides. There is no cost-shifting if members engage appropriately and use preferred providers. If members choose non-participating providers and do not engage in their health, they will likely have increased cost sharing and a higher contribution rate (wellness premium).

Below is a comparison of some of the key design differences between the current plan and the recommended plan.

	Current Plan	Recommended Plan
Statewide/National Option	✓	✓
Competitive Statewide Plan	✗	✓
Service Areas Defined by Plans	✓	✗
Uniform Regions	✗	✓
Tiered Networks	✗	✓
Closed Network Option	✓	✓ (Maybe)
Value Based Copays	✗	✓
Wellness Incentives	✓	✓
Wellness Participation Premium Incentive/Penalty	✗	✓
Reference Based Pricing	✗	✓
Integrated Telemedicine	✗	✓
Gain Sharing	✗	✓

We do note that some of the current plans may have an element marked with "✗" above, but this would be considered an outlier and not representative of the entire program structure.

Pharmacy

The Value of Pharmaceutical Treatment

Increasingly, pharmaceutical treatments are the most cost effective option to treat illness and disease. Advances in technology and research will continue to present new treatments that keep workers out of the hospital, avoid surgical intervention, reduce complications from disease, reduce the frequency of disability and in some cases offer cures to once life threatening disease.

However, Americans consume roughly 50% more prescription drugs than the average citizen in other developed countries (*source: IMS Health*) without better mortality rates. This situation is partly driven by industry promotion, partly by the practice of defensive medicine by providers, and partly by a lack of price controls on drugs in the United States. Plan sponsors need to take steps to balance the need to provide their members access to the right medication at the right time with the need to combat excessive price inflation and manipulative marketing tactics employed by the pharmaceutical industry.

Strategies that improve the health of the population covered by the employer's plan will reduce waste and the frequency and intensity of polypharmacy patient demands in the future. Improving the health care literacy of plan participants will improve medication adherence results and increase rational consumerism. Finally, tactics that apply new ideas to better ration benefit dollars and secure best-in-class pricing terms will be required to get the best economic value for ETF.

Current State of Wisconsin's Pharmacy Benefit Program

ETF's pharmacy benefit expenses as a percentage of overall medical plan costs (medical and drug combined) are reasonable compared to other large plan sponsors. Also, the program already includes a number of important and effective measures to control costs and manage expenses appropriately.

The following are selected financial highlights about ETF's current pharmacy benefit plan in comparison to other large programs:

- Active and Non-Medicare Retiree prescription drug costs represent about 12% of total medical and Rx program spend. This is lower than the typical large employer range of 15% to 18% Rx spend.
- Medicare Retiree Rx costs are about 38% of total medical and Rx spend. This is lower than the national average range of 45% to 55% of Medicare total per capita spending.
- ETF's pharmacy per capita claim cost trend rates are running around 9%. This compares favorably to Segal's book of business norms of 11% to 13% per capita. Additional efforts will be needed to keep trend increases in the single digits the next few years.
- ETF's generic dispensing rate (GDR) is also higher than observed norms for a number of therapy classes.

Overall, the steps ETF has taken for 2016 will mitigate a portion of the future plan cost trends. More steps will need to be taken to continue to manage per capita cost trends to single digits in the years ahead. We will discuss some of these concepts and strategies in the pages that follow.

Changes in the pharmacy benefit plan to percentage copays for brand drugs will impact utilization to a modest degree. Some patients will become more prudent consumers of their prescription options and request lower cost brands or generics as a result of higher copays for level 2 and level 3 drugs.

Generic Dispensing Rate Targets

Greater use of generics means lower costs and lower future price inflation. Even with the continued rise in use of generic drugs instead of brand drugs, there is still more room for plan savings. ETF should encourage its PBM to take an active role in driving utilization further toward generics.

Segal reviewed ETF's current generic dispensing rate (GDR) for a variety of diseases against commercial averages and against other similar state employee health plans in our book of business. ETF is doing well compared to the GDR averages for the following disease states:

SELECT DISEASE STATE WHERE THE GDRS ARE HIGHER THAN NORMS*

Disease Indication	Wisconsin ETF GDR	PBM GDR (Commercial Average)	Difference from PBM	Similar State Plan GDR
Diabetes	58.9%	45.9%	13.0%	57.1%
Oncology	91.4%	90.1%	1.3%	87.7%
Depression	97.2%	95.5%	1.7%	95.9%
Skin Disorders	85.2%	84.6%	0.6%	77.5%
Pain Management	92.5%	90.7%	1.8%	91.3%
Contraceptives	78.3%	74.7%	3.6%	74.0%
Cardiovascular/Hypertension	94.8%	93.4%	1.4%	90.8%
Mental Health/Neurological Disorders	72.9%	65.7%	7.2%	69.9%

* Results are unadjusted for differences in demographics or plan features.

The following disease states are examples of ones where ETF has room for improvement in its GDR:

DISEASE STATES WHERE GREATER FOCUS BY NAVITUS SHOULD BE EXPLORED

Disease Indication	Wisconsin ETF GDR	PBM GDR (Commercial Average)	Difference from PBM	Similar State Plan GDR
Autoimmune Disease	19.2%	25.8%	-6.6%	14.4%
ADHD	45.9%	67.1%	-21.2%	60.7%
Asthma/COPD	26.2%	42.8%	-16.6%	37.9%

A future performance guarantee to consider may to be set target GDR increases in some key disease states with pay for performance incentives that the PBM can earn when targets are met. For every 2% increase in the GDR for that disease, the PBM might earn .25% in case management fees, to a set maximum dollar amount per year.

Design of a GDR target should be a joint discussion with the PBM to assure that realistic levels are set to have the desired impact. We recommend that ETF engage Navitus in discussion of adding a GDR target for one or more disease states where ETF is lagging the general market. This will offer an opportunity to focus efforts on utilization of lower cost drugs to help hold down the overall trend increase.

Limited or Tiered Networks

One method of garnering additional savings in a pharmacy benefit plan is by limiting or tiering the retail pharmacy choices. By eliminating or restricting the pharmacies covered under the program, deeper discounts may be negotiated with the remaining pharmacy groups.

Segal's experience suggests that by restricting the retail pharmacy network, additional plan savings can be realized. Plan sponsors typically can save up to an estimated 1.5% to 3% of retail drug costs. However, to capture meaningful savings from deeper discounts, ETF would have to make substantial moves to remove some participant choice of retail pharmacy and steer market share for savings.

Segal has helped implement several custom and limited pharmacy networks that remove one or more competing national or regional retail pharmacy chains. By eliminating one or more major competitors the plan can then negotiate more favorable discount pricing with the remaining pharmacy groups. This type of arrangement can reduce costs for plan sponsors and still maintain adequate market access for participants with minimal disruption. For example, a Food workers multiemployer health plan worked with their PBM to create a custom network that excludes Walmart, Walgreens, Price Chopper and Big Y pharmacies in New England. The remaining network continued to provide adequate participant access and improved retail discounts by 2.5%.

ETF data suggests a natural concentration of members using Walgreens retail pharmacies (50% of retail use). If a custom retail network is considered, Segal would recommend first approaching Walgreens to determine what concessions would need to be made from improved pricing for this

chain. Would ETF be able to negotiate close to mail order level discounts from Walgreen's for exclusive access to 90-day retail maintenance fills? Only if Walgreens is willing to offer near mail service pricing would such a move produce value to both ETF and participants.

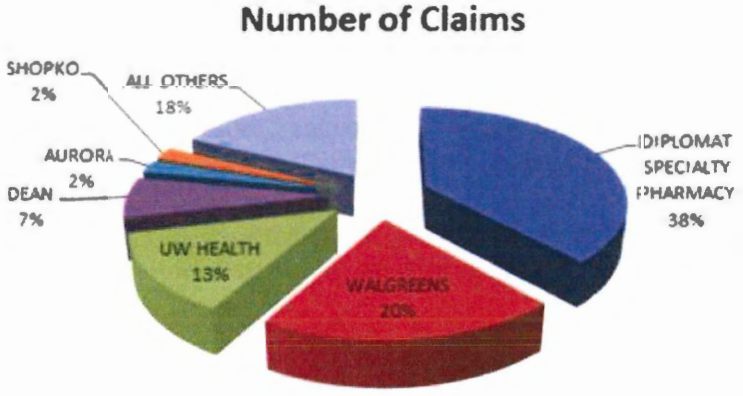
Some plan sponsors are not prepared to completely eliminate access for major pharmacy chains. It is also possible to create a tiered network where pharmacy groups that provide the best discounts and fee arrangements are preferred and those that don't are in a non-preferred tier. Members could be rewarded for using the preferred pharmacy groups by paying lower copayments or lower maximum coinsurance. This plan design approach to steering members toward low cost pharmacies would also mean less disruption, since all pharmacies would still be available; some would just cost more. Prior to implementation of either approach, a member disruption report and a savings estimate with the consolidated network would need to be completed. In some cases and in some geographical areas, the savings potential for the more limited pharmacy network may not outweigh the member disruption and potential political fallout from local providers.

Navitus is currently in negotiations with the retail pharmacies serving ETF. They have estimated that ETF could see an additional $2 million in network savings by remaining with the current pharmacy network. However, additional savings from creating a narrow network could be expected, possibly up to 1% to 3% of retail pharmacy claims. A 2% savings from creation of a narrow retail pharmacy network would equate to between $2 million and $2.5 million per year.

Optimized Specialty Drug Distribution Network

Specialty drug utilization continues to grow and is expected to represent 50% of the spend for most plan sponsors by 2018. ETF's Commercial Plan specialty drug utilization represented 28.6% of spend in the 2nd quarter of 2014 and increased to 33% by 2nd quarter of 2015. While ETF has put in good clinical management programs (e.g. split fill program, prior authorizations), more can be done to control the rising costs of specialty drugs for ETF and to better manage the utilization. One such approach ETF may consider is optimizing the specialty pharmacy network by limiting the dispensing to certain select pharmacy vendors.

Currently, ETF's plan design provides incentives for using a preferred specialty pharmacy network but still allows specialty drugs to be dispensed by any participating network pharmacy. The specialty drug distribution for the 1st and 2nd quarters of 2015 in displayed in the chart below.



Diplomat Specialty Pharmacy dispenses the majority of ETF's specialty drugs at 38% followed by Walgreens Specialty Pharmacy and UW Health Pharmacy at 20% and 13%, respectively. The remaining 29% of the specialty claims are dispensed by other retail pharmacies. It is important to note that this 29% includes other specialty pharmacies where the patient has been directed by the doctor.

To illustrate the impact of careful specialty pharmacy selection and management, Segal analyzed the potential savings that could be achieved if members moved from retail Walgreens pharmacies to either Lumicera or Diplomat (two different specialty pharmacies) based on current contract terms. Although the savings are modest, carving out all specialty drugs from Walgreens, including tablets that are now dispensed at retail pharmacies, will produce savings and create a consistent clinical point of contact for all specialty drugs.

The first table presents the potential savings for the first two quarters of 2015 that could result from moving specialty drugs for active and non-Medicare members for a number of health conditions from retail to specialty pharmacy.

COMMERCIAL (NVTETF) Q1 & Q2 2015: POTENTIAL LUMICERA AND DIPLOMAT SAVINGS VS. WALGREENS RETAIL

Health Condition	Total Approved Ingredient Cost (Walgreens Retail)	Total Claims	Total Potential Lumicera Savings	Total Potential Diplomat Savings
Anemia	$8,877	4	$67	$126
Chronic Hepatitis Infection	$29,945	5	$1,508	$482
Chronic Inflammatory Disease	$3,198,824	945	$98,640	$65,277
Cystic Fibrosis	$95,563	25	$5,738	$668
Growth Hormone	$5,883	6	-$240	$170
Hyperparathyroidism	$19,010	21	-$828	$155
Multiple Sclerosis	$424,578	79	$16,579	$9,801
Neutropenia	$39,276	7	$1,556	$581
Oral Chemotherapy	$104,946	15	$7,779	$2,236
Osteoporosis	$10,861	6	-$51	$217
Pulmonary Arterial Hypertension (PAH)	$14,524	6	$319	$115
Grand Total	**$3,952,286**	**1,119**	**$131,066**	**$79,827**
Grand Total (%)			**3.32%**	**2.02%**

The following table presents results for a similar selection of health conditions for Medicare eligible retirees for the first two quarters of 2015, assuming those specialty drugs are dispensed by one of two different specialty pharmacies.

MEDICARERX (MRXWIE) Q1 & Q2 2015: POTENTIAL LUMICERA AND DIPLOMAT SAVINGS VS. WALGREENS RETAIL

Health Condition	Total Approved Ingredient Cost (Walgreens Retail)	Total Claims	Total Potential Lumicera Savings	Total Potential Diplomat Savings
Acromegaly	$111	1	-$135	-$92
Chronic Hepatitis Infection	$6,241	7	-$95	$0
Chronic Inflammatory Disease	$488,233	137	$15,523	$9,489
Growth Hormone	$489	1	-$71	$13
Hyperparathyroidism	$25,434	26	-$1,559	-$480
Multiple Sclerosis	$104,119	21	$3,841	$2,435
Neutropenia	$14,246	3	$517	$340
Osteoporosis	$71,923	39	-$278	$1,411
Pulmonary Arterial Hypertension (PAH)	$24,133	10	$530	$196
Grand Total	**$734,930**	**245**	**$18,274**	**$13,313**
Grand Total (%)			**2.49%**	**1.81%**

While the analysis above may not appear to show significant financial savings for moving to a more consolidated network for specialty medications, the true benefit of driving utilization to specialty pharmacies can be seen from the better clinical outcomes a specialized pharmacy can provide.

Some key clinical differentiators of pharmacies that specialize in dispensing specialty medications include the following:

- Enhanced patient monitoring
  - A patient is monitored throughout the course of their therapy to ensure they are adhering to approved FDA treatment protocols as well as evidence-based clinical pathways/guidelines. These guidelines are subject to change as new research emerges and pharmacies that do not specifically specialize in specialty medications may not be aware of new research that could impact the members clinical therapy trajectory.
  - This enhanced patient monitoring to measure adherence to prescribed therapy is key in achieving optimal clinical outcomes. This monitoring can help reduce duration of therapy by preventing relapses in certain disease states that can occur from breaks in therapy. Also, certain specialty drug therapies (e.g., Hepatitis C) have a predisposition to developing resistance if therapy is stopped and then restarted. The close monitoring by a specialty pharmacy helps to reduce the need to extend therapy beyond what was originally prescribed and thereby helps to contain the total cost of these usually very expensive therapies.

- Pharmacy personnel
  - The pharmacist and pharmacy technicians that staff these specialty pharmacies are dedicated to these specific specialty medications (and not supporting all prescription drugs) and therefore have gained greater insight on the manner in which these drugs need to be handled as compared to a general pharmacist or pharmacy technician at a retail location.
  - Additionally, the pharmacists at these specialty pharmacies often are required to obtain additional training and are specialized in specific disease states and therefore are able to offer a higher level of care to the member.

Segal recommends that ETF consider optimizing the specialty drug dispensing network to include only pharmacies that can offer specialty drug dispensing expertise and clinical management for these expensive and complex drugs. While deeper discounts do exist for these specialty pharmacies by concentrating the volume through fewer providers, the true savings and benefit lie in the enhanced clinical outcomes and reduction of waste these specialized pharmacies provide.

Savings from use of an exclusive specialty pharmacy manager would require additional study but has been seen in other large employers to reduce both medical and specialty Rx claims by several percentage points over time.

Clinical Program Strategies

ETF could also benefit from more tightly focused efforts on specific disease states.

With regard to clinical pharmacy program strategies, the two most impacted disease states over the last couple of years have been Hepatitis C (with the introduction of Sovaldi, Harvoni, Olysio, and Vikera Pak) and Cholesterol lowering agents (with the introduction of Praluent and Repatha).

The following represents Segal's analysis of these two disease states based on the data available.

Hepatitis C

Hepatitis C treatment is ranked in the top five disease states by utilization cost to ETF for Q1 and Q2 of 2015. For this time period ETF has spent $3.5 million in plan paid costs for 74 utilizing members for the commercial prescription benefit plan and $2.5 million in plan paid costs for 26 utilizing members for the MedicareRx plan. Currently a prior authorization coverage review is mandated by ETF and the plan maintains a 46% approval rate for the commercial plan and a 65% approval rate for the MedicareRx plan. These approval rates are consistent with Segal's expectations for a large plan similar to ETF.

Hepatitis C also consistently ranks among the top five disease states by cost for many of Segal's plan sponsors. While the high price tag for this medication is often seen as the only cause for this, there are also other factors that have resulted in the appearance of this medication in the top five disease states. One of the primary drivers has been an apparent "warehousing" effect by physicians.

The anticipation of the new release of these cures resulted in greater utilization in the first years of the launch 2014-2015). Due to the detrimental side effects that older traditional Hepatitis C therapies would cause many patients, many prescribers delayed treatment of these patients until these more effective medications with reduced side effects were available. Essentially patients were "warehoused" until the launch of these medications.

Segal expects there to be continued utilization of these medications in years to come; however we expect a gradual drop off in utilization rates of these expensive Hepatitis-C treatments. We also expect to see prices stabilize as additional new drugs in this therapeutic category enter the market, resulting in potential cost savings to ETF's pharmacy benefit plan in the coming years.

PCSK9 Inhibitors

PCSK9 (proprotein convertase subtilisin/kexin type 9) inhibitors are a new generation of specialty cholesterol-lowering drugs. On July 24, 2015, the U.S. Food and Drug Administration (FDA) approved Praluent (alirocumab), the first cholesterol-lowering treatment approved in this new class of drugs. Praluent is approved for use in addition to diet and maximally tolerated statin or traditional cholesterol lowering therapy in adult patients with genetic condition known as Heterozygous Familial Hypercholesterolemia (HeFH) or patients with clinical atherosclerotic cardiovascular disease such as heart attacks or strokes, who require additional lowering of cholesterol. This was a more stringent indication than expected by many in the industry and has contributed to the slower than expected uptake of these medications.

Repatha (evolocumab; Amgen) was the second medication in this drug class approved by the FDA on August 27, 2015. In addition to the indications that Praluent carries, Repatha also was approved to treat the genetic condition known as Homozygous Familial Hypercholesterolemia (HoFH). Prior to Repatha's approval, the medications available to treat HoFH cost roughly $1.2 million a year per patient. The cost of the new therapies is approximately $12,000 annually per patient.

The introduction of high-cost specialty brand medications in a predominantly maintenance drug category, such as high cholesterol (which could be lifelong treatments), has the potential to expose plan sponsors to significant increases in pharmacy costs if the appropriate utilization management techniques are not employed. Currently ETF does not allow for "new to market" medications to be covered unless they have been on the market for at least 180 days.

The Navitus P&T Committee, on which ETF has a representative, will not add either of these PCSK9 drugs to its formulary until additional clinical outcome data is available. Evaluations of the clinical efficacy of the drugs are expected in late 2016. The drugs could still be covered on an exception basis.

This recommendation is consistent with Segal's view on the management of these medications. Segal has recommended this approach due to a variety of factors, predominately being that this disease state already contains widely available medications that are clinically appropriate and very successful in lowering cholesterol for the vast majority of patients. The circumstances in which Segal would currently recommend coverage for these medications would be for those members who have a diagnosis of HoFH, as mentioned above. While the PCSK9 inhibitor (Repatha) has significant cost implications, it is significantly more cost effective than alternative therapy (Juxtapid or Kynamro). Segal asked for a review of the ETF's claims utilization and it

was determined that the ETF does not currently have any members utilizing Juxtapid or Kynamro.

Segal's national pharmacy team clinicians monitor closely the utilization of this drug class and the clinical endpoints after the new drugs are launched. Segal will work with ETF and its pharmacy benefit manager to discuss the latest developments for this drug class, provide industry standard best practices once coverage is allowed, and design protocols for these medications to control for the right balance of coverage.

From our review of the results and utilization of the ETF prescription drug program, we believe that the ETF has a very solid grasp on their active clinical programs. In addition, we conclude that there are no other clinical programs that will generate significant savings for the plan. At this point we would recommend that ETF focus on optimizing its pharmacy network and move forward with the already selected clinical programs.

Long-Term Strategies

A number of longer-term strategies are developing that may be of use to ETF in managing its pharmacy benefit program. The following describes five such developments that should be discussed and considered by ETF.

Prospective MAC Price List for Generics

The current process to set pricing terms as a discount off of Average Wholesale Price (AWP) for generic drugs with multiple suppliers can leave clients open to inflationary manipulation of generic drug prices. It is possible that a PBM or pharmacy chain can manipulate the use of the AWP source to demonstrate that it meets the agreed percentage discount guarantees, yet still have higher actual drug pricing than another PBM with the same discount percentage guarantees calculated based on a more cost-effective starting AWP.

Given the need for buyers to contain the price increases of established and well supplied generic pricing, Segal proposes that large employer plans push the market in attempt to secure prospective price ceilings for future generic drugs. By working with the PBM to set a cap on next year pricing per unit of generic therapy, a client can effectively transfer some of the price increase risk to the PBM and supplier to keep their increases in generic prices closer to overall CPI or some multiple of CPI. This process can start most easily with pricing caps for generic drugs at mail service where the PBM is the buyer and has a relationship with wholesalers. Rules can be imposed that exclude new generic entrants or drugs with limited suppliers to help PBMs engage in potential contracting. Instead of comparing discount percentages off of a moving and potentially manipulated AWP target, the plan can compare pricing offers for generic drugs in a more effective way to contract for generic drugs that caps price inflation. Today price inflation, not increased utilization, is a major driver of plan cost trends.

Although Navitus currently offers a pass-through pricing arrangement to ETF, it is no longer enough to simply pass through excessive price increases and take no responsibility to manage these increases. To that end, ETF should expect its PBM to begin to negotiate prospective price increases from generic drug wholesalers and retailers. ETF requirements should now include commitments from Navitus or any other PBM to find ways to control supplier price increases for

generic drugs where multiple suppliers exist. It should be possible to use market competition and auctions from generic suppliers, wholesalers or retailers to include caps on product price increases. This approach should not impact the current pass through retail arrangement.

Targeted Reference Based Pricing for Brand Drugs

Borrowing from the medical community, a prescription drug plan sponsor could set a reference based maximum reimbursement (per day of therapy or per 30-day supply) within a therapy class where there are many interchangeable competing products.

For example, in the cholesterol lowering class, the plan can set a maximum allowance for reimbursement equal to 80% of some fair cost-per-day metric (median or 80th percentile price of all brand products on the formulary that treat hyper-lipidemia). The member would pay 100% of the excess price per day or per 30-day supply. This approach could be implemented for several high cost therapy classes and could dramatically change market share as consumer behavior gradually changes away from higher couponed or rebated drugs to the most cost effective options. In effect, the plan would give the member a nudge to pay attention to the cost of the drug being purchased and to ask tough questions about the available options, whether brand or generic, that would keep the participant's cost below the subsidized threshold.

Of course, this concept requires not only plan design changes, but also a significant and ongoing investment in systems support and member education and communications. Such a plan design change could reverse the pharmaceutical pricing logic to begin to put downward pressure on brand pricing for drugs in crowded therapy classes to make sure their drugs doesn't lose market share. At the same time, this protocol would begin to generate significant savings to ETF.

This approach could also be considered for certain specialty drug classes where interchangeable therapies are available. Finally, such a strategy will likely reduce rebate revenue as a percent of total plan expenses; however, with proper design, overall net plan cost could be lowered.

Integration with Medical Data

When provided with participant medical data, specialty pharmacies can use specific medical data, such as lab test results, to ensure the medication that is being dispensed does not pose significant health risk to the member. This coordination of medical data across employer sponsored programs can result in both pharmacy savings and medical plan savings.

Laboratory tests to monitor toxicity versus effectiveness are important parameters to consider with specialty medications as many are very potent and can potentially carry significant side effects. In the future genetic testing for key markers will also allow plans to avoid the cost of wasted supplies and treatments. We encourage ETF to begin to look at adopting more clinically intense protocols for select therapies by providing the vendors with requisite data to allow them to help manage the program.

PMPY Cost Trend Guarantees by Class

In addition to securing discounts and rebates in the traditional PBM contracting manner, ETF can explore implementation of cost guarantees by patient that will incorporate all elements of discounts, rebates, generic dispensing rates, and dispensing fees. For example, assuming the

current industry trend for prescription drug treatment of diabetes patients is 15%, the PBM would be asked to place a per member per year (PMPY) cap on the next year costs to treat those same diabetics at a price increase less than 15%. Simply demanding a pass through contract is no longer adequate as it allows the PBM to sit on the sidelines when suppliers, wholesalers and retailers do nothing to limit the spiraling cost inflation of some drugs and therapies.

Creating a new financial arrangement that shares the risk of cost trends with the PBM should be the next step in the evolution of PBM contracting. Excess PMPY cost trends would need to be returned as PBM refunds to ETF if the PBM misses the target. The PBM will likely require several rules and pre-established metrics in order to create a fair risk-sharing contract that the PBM can help control. The PBM will need to be able to propose clinical management programs that would be attached to the trend guarantees, and possibly the inclusion of some gain sharing with the PBM should they reduce the PMPY trend rates below an agreed threshold.

Segal recommends starting with a discussion with Navitus and establishment of an initial pilot program for a few important but manageable therapy classes. This would allow the PBM to take on manageable risk and allow ETF to limit the exposure of new plan management rules to a controlled number of patients before wider scale use is pursued.

Leaner and Rational Plan Design Concepts

Not all therapies are equal in value. Consider a plan design that provides higher levels of coverage for lifesaving or life-sustaining drug therapies and lower coverage for treatments of minor illnesses.

In most cases, conditions like cough and cold, allergies acid indigestion, minor pain (treatable with NSAIDs) or lifestyle needs like contraceptives and erectile dysfunction may require only modest "monthly maximum allowances" rather than an across the board 80% reimbursement. For example, a plan could design coverage for such less serious treatments that include a maximum monthly allowance of $25 to $35 with patients paying 100% of any excess charges above the allowance. Such a design would limit the plan sponsor's exposure to inflation for these therapies and reduce the impact of manufacturer coupons and other promotional activity that increase plan costs and utilization. The program could also result in some patients moving from prescription medications to over the counter (OTC) products, increase generic drug use where applicable, and potentially remove some excess utilization, allowing the plan to maintain a high level of coverage for more costly but serious conditions.

We recommend that ETF discuss this type of approach as part of its ongoing prescription drug design planning each year.

Retiree Drug Plan Design Issues

In addition to changes for the overall pharmacy benefit program, ETF should consider changes that help to contain and reduce cost for the retiree prescription drug program.

The current per member per month (PMPM) cost for the Medicare retiree prescription drug plan is over $200 for Rx coverage alone. Adding a lower value plan will allow the State to offer a plan with much lower premiums.

The dollars coming from the CMS reinsurance payments for catastrophic claimants and the manufacturer discounts on brand drugs in the coverage gap have become and will continue to be a bigger source of funding over time for plans. This is because a growing portion of drug plan expenses are coming from high cost specialty brand drugs which can largely be funded by the 80% reinsurance payments from CMS. At the same time, the direct payments to PBMs from CMS for the initial tier coverage are stagnant or even reduced year over year.

This situation of decreased initial tier Medicare subsidies and increased coverage gap and catastrophic claims subsidies is in part driven by the national bids submitted by the commercial Medicare Prescription Drug Plans and health insurers (MAPDs) that are trying to keep overall plan costs down by leveraging savings from the narrow pharmacy networks, more restricted formularies covering fewer drugs, and use of maximum available member out-of-pocket annual maximums. Unless ETF can follow and adopt these cost containment elements, there will be continued pressure on the standard part D subsidy as it becomes a smaller and smaller portion of the overall plan costs.

We offer the following recommendations as a starting place to lower retiree drug premiums in the future:

- To take advantage of these shifts in Medicare funding, ETF may actually want to increase the amount of retiree out of pocket costs selectively to get those members into the catastrophic level sooner. More claims would then be reimbursed by the CMS 80% reinsurance payment source. By doing so, the value of premium savings will more than outweigh the benefit cuts required to be made. This approach is, of course, counterintuitive to most retirees' sense of purchasing insurance. They believe they should buy the greatest level of coverage available or that they can afford. In this case, the Medicare Part D catastrophic coverage provides a better benefit for those retirees with very high annual drug costs.

- The changes being made for 2016 will help move in this direction and lower future premium rates. ETF should plan on making changes to the retiree prescription coverage every year to maximize the potential for Medicare reimbursements.

- We know from extensive analysis of retiree buying decisions that retirees often cite affordable premium as the most important feature when selecting a Part D plan. We also know that retirees want some choice (but not too many choices) in benefit selection. To address these factors, we suggest ETF create multiple prescription drug options for Medicare retirees. A starting point would be to keep the current plan as a high value plan and add another lower premium cost option. That plan would need to have perhaps 25% brand copays, higher annual member out of pocket maximums and even tiered generic copays (e.g. $3 for low cost generics and $10 for higher cost generics). Such a design could help ETF encourage retiree self-management of their prescription drug benefits by being able to trade premiums cost for point-of-sale costs.

  An example of a plan design for a lower premium Medicare Part D design would have the following benefit provisions. Apply a 25% coinsurance to all preferred brand and generic drugs with per Rx copay maximums

  - Apply a 35% coinsurance to all non-preferred brand drugs with no per Rx copay maximums

- Exclude all non-covered Part D drugs
- Consider annual deductibles

➢ Adverse Selection is a factor to address when multiple plan options are offered among a population. Such selection will need to be addressed and accounted for when pricing out the retiree annual cost to enroll in each option. While adverse selection can certainly affect the cost and success of a second plan, Segal's experience with retiree selection and the relative lack of mass migration tendency among retirees to change health plan options will enable us to adequately account for adverse selection over time to create stable pricing options and minimize cross subsidies between groups.

Formulary Concepts to Consider

Another concept to consider is limiting ETF's formulary to help lower pharmacy spending. ETF currently operates a broad and open formulary, where most drugs are covered. A limited formulary would have only a selected few drug choices in each therapeutic category. The choices would be limited to proven drugs with an attractive price point. Drugs not on the limited formulary could be covered, but not at the same level of cost sharing.

Adopting more aggressive formulary strategies, as is observed with some other buyers such as Medicaid state agencies and even commercial insurers offering coverage on the public health marketplaces, requires investment in clinical expertise and a willingness to take on greater risk. The potential return is significant, with lowered overall pharmacy benefit costs of possibly 5% to 10%

It should be noted there is a legal risk associated with potential negative clinical results from the use of chosen formulary products. All plans have some modest fiduciary risk already with respect to the formulary that is adopted or selected. However, to date we are not aware of any plan sponsor suffering major losses as a result of the formulary they offer or support. Moving to a more aggressive and restrictive formulary could increase that exposure. Having a qualified P and T committee and independent experts to help validate the steps taken would be an important requirement of adopting a more narrow formulary.

Restrictive formularies have been in place for years and the track record of plans to lower pharmacy spending with restrictive formularies has been good. Plans can lower overall pharmacy benefit claim costs by 5% to 10% by adopting a restrictive but still effective formulary. The ability to appeal to get non-formulary coverage must be managed appropriately to limit the potential liability to the plan. ETF will need to weigh the cost savings benefits against the risks and effort to properly support a restricted lower-cost formulary.

Summary of Recommendations

In our initial report, Segal made a number of recommendations for specific changes to ETF's pharmacy benefit program for 2016. This report focuses on opportunities for 2017 and beyond.

We are recommending the following:

1. **Consider narrow or tiered networks:** Annual savings $3 to $3.5 million per year on retail non-specialty ingredient costs

2. **Move to exclusive contracting for specialty drugs:** Annual savings $2 to $3 million per year in specialty savings from improved pricing and utilization controls

3. **Obtain better Retail 90 pricing either through bids or custom contracting:** Annual savings will vary based on custom contracting and current terms for 90 day retail supply

4. **Tighten up medication management services -** Annual savings of 1% to 2% of program costs. Medication management strategies is the general term that includes clinical programs and member education programs that address both specialty and non-specialty treatments. It includes strategies that support medication adherence, step therapy, prior authorization, quantity limits, patient education around polypharmacy and side effects, etc.

5. **Add a new lower cost Medicare Part D plan option:** This will allow for the offering of substantially lower cost retiree premium option and will provide greater choice for retirees

6. **Pursue several new contracting concepts with either the current PBM or through bids**

7. **Add performance guarantees around clinical outcomes**

Additionally, given the high level of satisfaction with Navitus's service and relatively good financial performance, Segal supports extending the contract through 2017. Extending for another contract year will allow time for the development of a comprehensive PBM RFP and allow for sufficient time for a comprehensive bid process.

With the above, we would estimate savings of $10-$20 million in total could be achieved. Further research will need to be performed to solidify these estimates.

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Data Management

In our initial report, we presented a model of the features and functions that would be present in a current best practice claims data warehouse and how those features would allow a large health benefit plan like ETF to more closely manage its costs, utilization, health risk, provider quality and plan performance. We also discussed our preliminary findings on the Wisconsin Health Information Organization (WHIO) initiative as a possible vehicle to provide that best practice data warehouse for ETF.

As part of that report, we identified four possible approaches for ETF to consider with regard to WHIO as a health plan management warehouse, including:

- Working with WHIO and Optum to expand the current WHIO capabilities;
- Using WHIO for the clinical and enrollment factors and developing plan financial information separately;
- Bidding and contracting a new data warehouse system specifically for ETF; or
- Building your own data warehouse.

This report picks up from that initial analysis and looks in more detail at ETF's particular needs ETF for health plan data management. We review ETF's current data mining status, identify the long-term needs for the program, present potential approaches to achieve that desired level of data accessibility and recommend next steps for ETF action.

Current State

ETF is a leading purchaser of healthcare in the State of Wisconsin, with an increasing focus on value based purchasing. The objective is to attain the best cost value for employees and improve efficiency and quality within the health care system. Access to the plan's data and the ability to perform analysis is crucial to ETF's ability to effectively manage the program to maximum efficiency and to support, develop and monitor achievement of its strategic and tactical objectives.

Currently, ETF does not have the ability to evaluate and analyze costs, utilization, health risk, provider quality and plan performance from a single data source. It is unclear whether ETF even has access to all of this data from all its health plans and vendors. In addition, the data that is available is housed in multiple locations, covering different historical periods and in varying formats and quality.

WHIO Access

ETF participates in the Wisconsin Health Information Organization (WHIO) initiative, which includes access to a statewide, centralized health database consisting of reporting on quality and cost of health insurance experience. WHIO contracts with OptumInsight to provide the platform of its data warehouse through license to an enhanced DataMart.

As noted in our first report, there are limitations within the WHIO DataMart, which in turn limit ETF's ability to analyze opportunities for population health improvement while maintaining costs. Care gap levels and utilization patterns do not necessarily correspond to health risk levels between the health plans. Financial information is limited and there are inconsistencies in reporting of key metrics across plans. In addition, until recently not all of ETF's contracted health plans provided data to WHIO, which has resulted in gaps in the data. Even with the remaining non-submitter plans now being incorporated into the WHIO database, it will be another year or two before the DataMart includes a comprehensive history for the entire ETF membership. Finally, the reporting package provided by WHIO is targeted more for carriers who submit data to WHIO, not for plan sponsors trying to manage a complex employer health benefit program.

After further evaluation of the capabilities and potentials of the current WHIO database, we believe it will not constitute a long-term solution for ETF's data-focused management of its benefit programs. While WHIO provides some of the features needed, it lacks crucial data elements and functions, such as the actual reported cost and allowed cost of services reported, and ad hoc data access for detailed analyses of selected procedures, providers or effective discounts.

While ETF has continued involvement with WHIO, it does not control the mission or contracting of WHIO, so will not have full influence over the data or services that will be available in the future. We believe that full control over ETF's plan data is important for successful ongoing management of the program.

ETF Needs

As additional strategic options are considered, including additional value-based elements, ETF needs to be better positioned with comprehensive data to support its ongoing plan management needs. For example, ETF needs to be able to analyze and manage targeted interventions; improvement in participant compliance; outcomes-based payments; and quality at the individual provider level.

The following provides a summary of features we believe ETF needs for best practice ongoing management of its program. These features also support ETF's ability to develop supportable strategies for improving efficiency in delivery of health care, and for managing cost and pricing for long-term plan sustainability.

- **Financial Management**: ETF needs to be able to measure and analyze the aspects of a health plan that are related to budgets, forecasts, rate setting, and reporting.

For 2016, ETF improved the health plan renewal process with a goal of more accurate assessment of costs and efficiencies of competing health plans utilizing detailed claims and encounter data. It is expected that additional information and enhanced transparency will be achieved in subsequent renewals and negotiations. More comprehensive data management capabilities are essential to manage and effectively analyze this data.

- **Benefit Design & Network Management**: ETF needs to be able to identify and evaluate services that support design effectiveness, network performance, cost sharing strategies, and vendor management.

  ETF continues to analyze data and investigate market options for 2017 to improve the health management and wellness programs. The Plan is in the process of designing effective cost sharing strategies that steer patients away from overpriced hospitals, physicians or drugs for specific procedures or conditions, where the higher cost is not justified by demonstration of better outcomes. The Plan is also reviewing the feasibility of implementing tiered networks.

  Data warehousing is frequently used to monitor high-quality/high-performance providers and to tie those providers to their underlying cost. ETF can also utilize data warehousing to evaluate provider reimbursement arrangements as you consider a shift from the fee-for-service model to alternative payment models, such as bundled payments, which are designed to encourage providers to coordinate care and reward efficiency.

- **Medical and Pharmacy Quality Adherence**: ETF needs to have the ability to measure and evaluate preventative services compliance, compliance with standards of care, and prescription drug adherence.

  An integrated data warehouse is key to monitoring quality of care compliance with evidence-based medicine for programs such as cancer screenings, diabetes treatment, flu shots, and hypertension control.

- **Medical Management & Wellness Program Design**: ETF needs the ability to perform analyses that support wellness design, including health risk assessment data analysis, chronic conditions profiling and track the metrics developed to measure the progress of the Total Health Management program design.

  There are additional needs as ETF continues to require tools though use of data mining to support health management and wellness design efforts:

  - ETF's use of risk modeling to support and enhance the three-tier premium program to and negotiate with providers to price plans within Tier 1 (plans with top efficiency and quality). The current risk modeling and adjustments are performed utilizing pharmacy data. A comprehensive data warehouse will provide the ability to incorporate medical data, which provides a more comprehensive member risk profile and therefore a better basis for comparing performance and quality between plans and providers.

- ETF's requirement of health plans to identify members with moderate or high health risk and enroll them into appropriate health management programs. Data mining is used to determine members who currently are driving a high percentage of costs as well as those projected to drive costs in the future. Those members could benefit from targeted, clinical intervention that aims to reduce future costs that may result from hospital readmissions for the same illness, or early detection of disease that can be treated with less invasive and less costly treatment options. Reviewing the severity of employees' diseases and conditions will help ETF identify those who have complex needs and require significant care management and verify that the health plans are utilizing appropriate outreach
- Evaluate the Uniform Wellness Incentives required of all health plans to issue $150 to adjust members who complete biometric screenings and a health plan administered HRA. Correlation of biometric screening results and intent to change behaviors collected from the Health Risk Assessments can be evaluated to monitor improvement to health risk and costs.

➢ **Vendor Performance & Contract Adherence**: ETF needs to have an enhanced ability to evaluate and monitor targeted performance guarantees, conduct discount analysis and review payment accuracy.

Through the program's coordination of care, health plans (or their contracted hospital / physician groups) must contact a member who has been discharged from an inpatient hospital with a diagnosis of heart failure, myocardial infarction, pneumonia, or any other high-risk health condition, within 3-5 business days with the intent of reducing hospital admissions. ETF can utilize data mining to independently monitor vendor performance related to reduction in hospital readmissions. ETF can also utilize data mining in support of to proactively detect fraud and abuse (e.g., identify ineligible dependents and excessive or unnecessary prescriptions).

➢ **Provider Quality:** As ETF considers longer term and additional value based components in the program's design and strategy, there needs to be the capability to evaluate and compare quality and efficiency at the provider, or provider group, level.

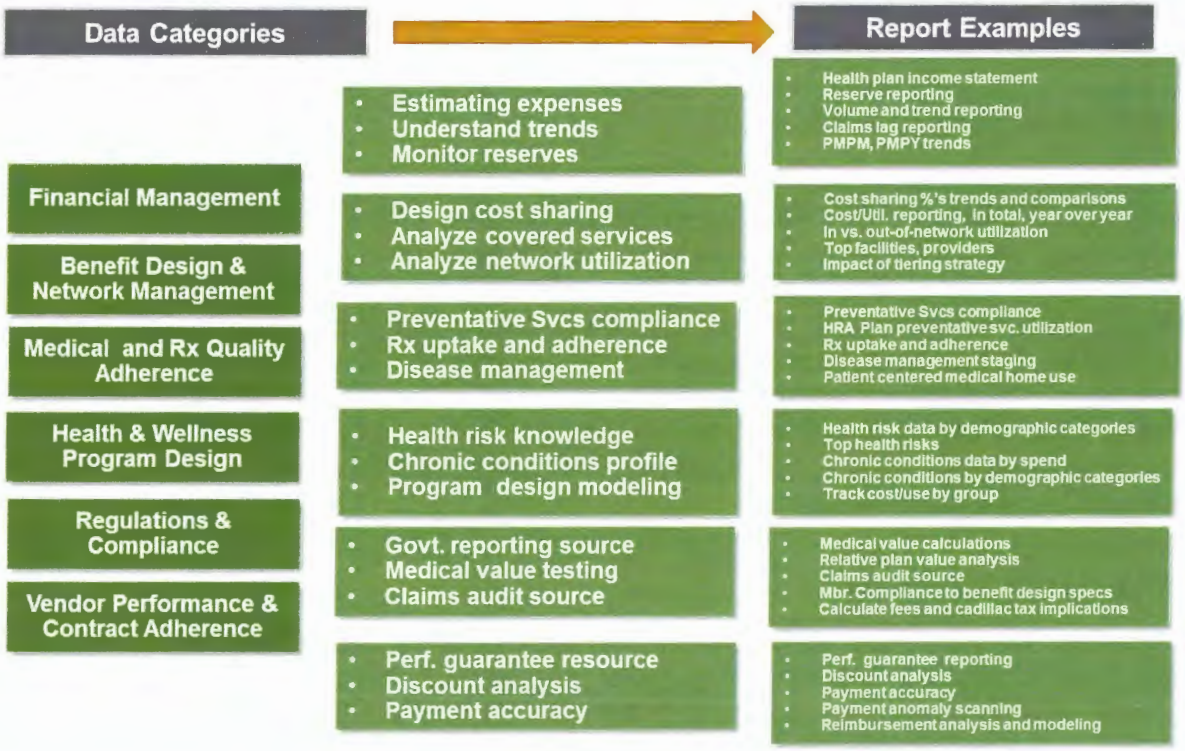
An integrated data warehouse specifically designed for ETF's structure and needs can also be valuable in analyzing provider quality. This would allow ETF to make determinations on how to encourage employee and retiree use of the highest quality and most reasonable cost providers.

ETF needs a warehouse option that has rigorous data cleansing processes with comprehensive benchmarking and an ability to go beyond canned reporting. ETF also needs an option to supplement ETF staff capabilities cost effectively (e.g., enhanced analytics assistance).

In summary, the objective is to have the ability to analyze data from a variety of sources on a fully consistent and continuing basis. This will allow ETF to develop and monitor strategies for improving health outcomes and for increasing the outcome-efficient and cost-efficient delivery of quality health care to ETF participants.

Data Warehouse Architecture

The most efficient data warehouse installations are those specifically designed for the health plan's needs. While numbers of different health data warehouse structures exist, all typically include the following major categories of data, functionality and reporting:



ETF needs its own comprehensive health plan data warehouse. With such a data warehouse, ETF will be able to convert health utilization data into actionable information and make well-informed decisions that improve the value of the plan.

Data Warehouses Among State and Local Government Health Plans

The world of health plan data warehousing has developed enormously over recent years. Most state plans now employ data warehousing to identify and support strategies that reduce waste, mitigate cost increases and improve the overall health and well-being of their participants. As an example, every other Segal state-level client has a comprehensive data management and warehousing system, with many having been in place for more than 10 years.

In addition, many of our larger local government, multi-employer and private sector clients utilize a customized data warehousing system as well. Even smaller local government entities now have access to low-cost, standardized data warehouse platforms that capture key data from their health plan carrier or administrator and provide standardized and some ad hoc reporting functions for many of the important management factors.

Typical data housed in the data warehouse includes complete medical and pharmacy claims data (encounter, diagnosis, costs, etc), biometric screening results, laboratory results, health risk assessments, disease management program participation and wellness program participation.

Some plans have state sponsored clinics and they track encounters. Additional elements sometimes include dental and vision experience, as well as disability and worker's compensation program related data.

A small number of states have developed and now maintain their own data warehouse systems; however, it is far more common for state plans to license access to a highly sophisticated data warehouse system managed by an external vendor. For almost all states, the significant cost and staff time and effort required to design, build, operate and maintain a home-built system, plus the specialized expertise required on staff to support the system, have encouraged them to bid and contract use of a ready-made warehouse.

Additionally, state health plans typically rely on their actuaries and consultants for technical and analytical assistance. These outside professionals are given access to the data warehouse and help develop specialized reports and analyses using the system functions and data. Some of those reports are designed to allow the Plan's staff to update and run regular reports needed for day-to-day operation. In addition, the data can be used to develop highly customized analyses such as dashboards. For example, Segal has worked with a number of large state plans to develop a sophisticated dashboard of key management and utilization factors specifically targeted for the plan's needs. These dashboard can provide perspectives on emerging trends (e.g., forecast to pharmacy trend with the introduction of PCSK9 in the marketplace) as well as ongoing measures of important plan performance.

Marketplace Capabilities

There are a number of data mining firms in the marketplace with significant years of experience (20+ years) that have capabilities and experience aligned with ETF's needs. Major data warehouse players operating efficiently at the state health plan level include: HDMS; Optum; Truven; and Verisk Health. In late summer 2015, Segal conducted market educational webinars for ETF with each of these vendors to have them demonstrate the depth of their capabilities in the marketplace.

These firms demonstrated processes to perform extensive data quality validation, including: unique member ID matching; link to enrollment records; financial reconciliation; population of fields with expected results; review of key dates; and custom fields. Application functionality for these systems include dynamic dashboard reporting; scorecards; automated reporting; trend analysis; comparison to comprehensive benchmarks; risk profiling / predictive modeling; analysis of disease severity; analysis of episodes of care; HRA and biometric data integration; provider profiling; and cohorts / population segmentation.

Each vendor in the market also provides rigorous safeguards to protect and secure all data to meet all applicable Federal and State standards, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. On each of the systems, data can be stored with each member's sensitive personal information (SSN, names, etc) redacted for reporting purposes, to keep reports on an "anonymous" basis. Reporting and analysis is generally performed in aggregate, and under no circumstances would an individual's personal information become available to the State or ETF.

Each of the firms that participated in the webinar demonstration has experience with large public sector plans and we expect could provide an effective warehouse solution to support ETF's plan management and strategic needs.

Additional Cost

Currently, ETFs annual direct cost for use of WHIO is $50,000.

As part of our market survey, Segal received ballpark estimates of implementing a data warehouse solution from the firms discussed above assuming 4-8 medical carriers (along with Rx and eligibility feeds). One-time, up-front, implementation fees ranged between $75,000 - $155,000. Ongoing maintenance fees ranged between $200,000 - $260,000 annually for quarterly updates and $220,000 - $330,000 annually for monthly updates. These should be taken only as market estimates, but are generally in line with our experience with other state and large government plans. Actual pricing would be subject to negotiation based on the actual specifications and requirements of the contract.

While these data warehouse and data mining fees are greater than ETF's current cost for WHIO, the capabilities and flexibility of these systems are far superior than the current WHIO structure. The investment in a customized data warehouse is likely to be offset by the plan savings that should result from the enhanced analytic capabilities and the ability for ETF to identify and quantify opportunities to improve efficiencies within the program. Relative to the current annual program cost of $1.4B, fees for a customized data warehouse would be less than 0.02% and additionally, there generally is room to negotiate costs and potentially reduce implementation fees with a multi-year agreement.

Recommendations and Next Steps

Our first report commented that augmenting WHIO could be a possible approach to meeting ETF's program management needs. However, to accomplish this, it would be necessary to make a number of structural changes to the current WHIO architecture, including:

- Incorporating additional charge fields, many of which are sensitive to plans and providers
- Increasing the frequency of data updates and reduce the time necessary for each update
- Enhancing access for ETF, and others working on behalf of ETF, directly into the system to run reports and conduct analyses on the all the data available, including cost and charge fields
- Increasing the amount of historical data maintained in the DataMart

This last item may be achievable, but in our opinion, based on conversations with WHIO and ETF, the other three items pose significantly greater challenges.

In our opinion, a better option for ETF is to competitively bid and contract with an external data warehouse system vendor that could provide a ready-made system tailored to ETF's specific structure and data and functional needs.

We recommend bidding the data warehouse system in early 2016, with a decision target of mid-2016. Initial implementation of a warehouse solution typically takes four to six months, so with such a bid schedule, ETF's data warehouse vendor could be operational as early as January 2017.

It is our recommendation to issue an RFP in 2016 for a 2017 implementation. This will enable ETF to have a data management solution in place as the additional detailed data is provided by the plans during the transition to self-insurance and for ETF to begin to more effectively manage the program in a relatively immediate fashion.

A rough proposed timeline is as follows:

Task	Timing
Draft RFP	January-February, 2016
RFP Release	March 1, 2016
Intent to Bid	March 15, 2016
Deadline to Submit Questions	March 15, 2016
RFP Deadline	March 31, 2016
Evaluation of Proposals	April, 2016
Interviews and Demos	May, 2016
Final Selection & Award	May 31, 2016
Contract Execution	June, 2016
Contract Effective Date	July 1, 2016
Implementation	July to December, 2016
Operational Date	January 1, 2017

ETF would need procurement assistance from the Department of Administration to meet the above timeline. We also believe it may be necessary to expand ETF staff (currently 2) to focus on data management initiatives.

Segal also recommends that ETF continue its participation in and support of the WHIO data system. While that system will not provide the full data solution for management of ETF plans, the breadth of utilization and provider information collected by WHIO may continue to provide a useful enhancement and broader statewide health benefit perspective. In addition, with its own data warehouse, ETF's data feed to WHIO could be accomplished on a consolidated and regularly scheduled basis from a single data source, which over time should help reduce WHIO's reconciliation and data scrubbing efforts.

Market Observations

This section presents Segal's review and observations on a number of topics of direct relevance to ETF's health benefit plan. These descriptions help to provide a broader perspective of current developments across a variety of state health benefit programs.

Minnesota State Employees Group Insurance Program

The Minnesota State Employees Group Insurance Program (SEGIP) provides an interesting point of comparison with ETF's program. Not only is this the plan for state employees in a neighboring state, but SEGIP formerly utilized an insured managed competition model similar to ETF's and transitioned some years ago to a self-insured strategy with a more focused number of health plans. While the Minnesota and Wisconsin healthcare markets are unique relative to one another in many ways, there are some interesting observations regarding SEGIP's current program and its recent history that may help inform ETF as it considers future plan and program changes.

Current Program

SEGIP provides coverage to approximately 54,000 active and retired State employees, plus their eligible dependents for a total membership covering about 127,000 members. Medical coverage is provided on a statewide and national basis by three claims administrators:

- Blue Cross Blue Shield of Minnesota
- Health Partners
- PreferredOne

Pharmacy benefits are provided by Navitus, Both medical and pharmacy benefits are self-insured. SEGIP purchases an aggregate stop loss insurance policy with a 125% attachment point (this is apparently primarily for political reasons, to provide an additional measure of protection against unexpected spikes in plan cost).

Most employees have coverage via the Advantage Health Plan, which provides coverage at one of four levels, or Tiers. See the benefit details in the following table.

Benefit Provision	Tier 1	Tier 2	Tier 3	Tier 4
Preventive Care Services	No cost to member	No cost to member	No cost to member	No cost to member
Deductible (single/family)	$75/$150	$180/$360	$400/$800	$1,000/$2,000
Max Out of Pocket (single/family)	$1,100/$2,200	$1,100/ $2,200	$1,500/ $3,000	$2,500/$5,000
Office Visits[1]	$18/$23	$23/$28	$36/$41	$55/$60
Emergency Care	$100 copay after Ded.	$100 copay after Ded.	$100 copay after Ded.	25% coinsurance after Ded.
Inpatient Hospital	$100 copay after Ded.	$200 copay after Ded.	$500 copay after Ded.	25% coinsurance after Ded.
Outpatient Surgery	$60 copay after Ded.	$120 copay after Ded.	$250 copay after Ded.	25% coinsurance after Ded.

Members that complete a Health Risk Assessment and agree to take a phone call from a health coach or nurse have their physician office visit copays reduced by $5.

Each member is required to select a Primary Care Clinic (PCC), which is essentially a provider practice that acts like a Primary Care Physician in a traditional HMO model. Each PCC is evaluated annually on risk-adjusted cost only, assuming quality and efficiency result in lower costs. The PCCs are grouped into one of four tiers. A member's PCC tiering determines the benefits and cost sharing for the member for all medical services. Most members (50%) utilize a Tier 2 PCC, with about 20% in Tier 1. The remaining 30% are in Tiers 3 & 4.

Rigorous utilization management protocols are in place, requiring referrals or prior authorizations for most services provided by providers not within the member's PCC. Since the tiering is on a total cost basis, the assumption is that PCCs have an incentive to treat and refer members in most efficient and high-quality fashion possible.

Pharmacy benefits are uniform across all tiers. The pharmacy data is not utilized in the PCC tiering.

Benefit Provision	Generic Copay	Preferred Brand Copay	Non-Preferred Brand Copay
Prescription Drugs	$12	$18	$38

A Consumer Directed Health Plan is also offered to management and employees that are not collectively bargained, but only about 50 employees are enrolled. The plan is an HDHP with an accompanying Health Savings Account (HSA). It is called the Advantage Consumer Directed Health Plan (ACDHP). The premium for the ACDHP is based on the Advantage Plan. The employer contributes to the premium on the same basis as it contributes to Advantage (e.g., 95% of single premium, 85% for dependent premium). The employer contributes $500 (single)/ $1,000 (family) to the HSA. Employees that participate in the Biometric Health Screening had who complete the Health Assessment and agree to accept a coaching call can earn additional employer contributions into their HSA.

[1] Copay level dependent upon whether the employee has completed the Health Assessment.

Most active employees do not pay a monthly premium. However, much like in Wisconsin, retirees pay the full cost of coverage. Medicare retirees have a choice between Advantage plans that coordinate with Medicare and a Medicare Advantage option.

Background

Prior to 2002, SEGIP utilized a managed competition model similar to ETF's model. At one time 12 plans competed to provide coverage on an insured basis with member choices varying by county. Market consolidation and volatility (significant premium increases) led the State to determine that converting to a self-funded approach, with limited plans, was the best strategy to take control of the situation and reduce, or at least manage, the volatility.

The conversion to self-insurance was also driven by a desire to "own" its own healthcare claims data and have the ability to utilize the data as necessary to manage the program. They had a number of issues collecting data from their insured vendors and the state was pushing for full transparency in their contracting. After three years, it was determined there was sufficient data to compare providers and the current PCC tiering approach was implemented.

SEGIP reports that annual trends have been low or manageable, but that is at least in part due to the State implementing and adhering to a reserving policy that has enabled SEGIP to manage annual claims volatility.

Comments and Observations

The PCC tiering approach is interesting as a value-based provider payment strategy to incent high quality, efficient care. However, this may be of interest mostly at a theoretical level, as SEGIP has not conducted a thorough study to examine and verify the impact of this approach.

Virtually all providers are in each of the claims administrators' network. With this lack of differentiation between the networks, it is unclear how each administrator has the leverage to negotiate as effectively as possible with the providers. Also, SEGIP has not analyzed the data to determine if, and to what degree, each of the administrators is providing different levels of provider pricing and health management. There is no difference in the full funding rates by claims administrator.

However, it should be noted that the full funding rate for single coverage is approximately $525 per month, which is about 24% less than the average single rate for ETF's UBD, which is $689. It is important to note that the benefit levels in Minnesota are higher than ETF, making the above even more perplexing. The data utilized by our manual health premium rating model indicates that, on average, healthcare in Wisconsin is approximately 9% more expensive than in Minnesota. This leaves approximately 15% remaining unaccounted, some of which could be due to differences in demographic or health risk. In our opinion, the difference between the two memberships' risk is not likely to account for much of this difference. Therefore, there is something about the SEGIP self-insured, three health plan strategy that results in relatively well-managed costs.

National and Regional Market Changes

Health care is a fluid and ever-changing marketplace. Staying abreast of new developments in the health care landscape is important for plan sponsors. Significant regional vendor alliances and consolidations are underway in Wisconsin and major national level mergers are also currently in process. Below is a brief review of some of the more notable events influencing and modifying today's health care market.

Local and Regional

In addition to ETF's current health plans, we reviewed three local/ regional organizations of note that may impact health care in Wisconsin. One is an organization called The Alliance. Founded in 1990 by seven Madison-area employers, the Alliance is a cooperative of employers that self-fund their health benefits and claim to be "moving health care forward by controlling costs, improving quality, and engaging individuals in their health."

Currently, this organization includes over 240 self-funded employers and insurance trusts that cover more than 100,000 individuals. The Alliance negotiates directly with providers, evaluating both quality outcomes and service costs. They also provide data management services and claims reporting detail allowing their members to better understand the factors driving their costs. In addition, the Alliance provides education and resources to help members design benefit plans and implement employee wellness and prevention programs.

Their service area includes providers in Wisconsin, Illinois and Iowa. The Alliance contracts with 80 participating hospitals, over 7,000 physicians, 13,500 professional service providers and 4,400 medical, chiropractic and mental health clinic sites. A transparency tool is provided to their employers' plan participants to encourage informed decision-making and health care consumerism among their in-network providers.

While they may offer attractive provider discounts and their focus on quality outcomes and efficient care is in-line with ETF's mission, utilizing The Alliance would likely require special procurement and contracting consideration. The Alliance does not process claims; all of its employer partners (who are also part owners) utilize a separate Third Party Administrator under their own separate contract. Also, a portion of the provider discounts are retained by The Alliance.

Originally launched in 2010 as Quality Health Solutions, Integrated Health Network (IHN) of Wisconsin is a relative newcomer to the local health care market. IHN is an Accountable Care network and the first clinically integrated Accountable Care Organization (ACO) in the state. This consortium of independent health systems, hospitals and physicians have come together voluntarily, intent on providing coordinated care to improve the quality, efficiency and value of health care.

IHN has more than 5,700 physicians and participating providers, 550 clinics and 45 hospitals in their network. IHN delivers care to Wisconsinites across 44 counties. IHN's network members include:

- Agnesian HealthCare
- Columbia St. Mary's

- Froedtert Health
- Hospital Sisters Health System
- The Medical College of Wisconsin
- Ministry Health Care
- SSM Health
- Wheaton Franciscan Healthcare

IHN, in its current configuration is not likely a viable vendor for ETF. If IHN evolves into a full service health plan, that may very well change. However, IHN may be an attractive component within a larger network and full-service contract between a health plan and ETF. For example, Froedtert Health and Ministry Health Care, have partnered to pursue co-ownership of Network Health. This transaction will expand the Network Health service area into southeastern Wisconsin and enable Network Health to offer IHN within its provider network in SE Wisconsin.

AboutHealth is another ACO new to the Wisconsin area. AboutHealth is a strategic partnership formed in the summer of 2014 and includes eight Wisconsin health systems and provider groups. These are:

- Aspirus
- Aurora Health Care
- Bellin Health
- Gundersen Health System
- Marshfield Clinic Health System (MCHS)
- ProHealth Care
- ThedaCareACO

AboutHealth is focused on improving overall population health for the communities they serve while working together to advance clinical quality, efficiency and the customer experience. The provider organizations that make up AboutHealth are recognized as leaders in delivering high quality, low cost care. Members have the same electronic health record platforms across provider groups and patients have access to 48 hospitals and over 8,000 providers.

Over 90% of Wisconsin's population resides within the AboutHealth network. An initial commercial insurance plan featuring the AboutHealth's organizations is currently being offered through Anthem Blue Cross Blue Shield's Blue Priority network. In addition, AboutHealth and Arise Health Plan announced an agreement in the summer of 2015 to offer co-branded individual and group coverage products with AboutHealth providers for 2016, and will have individual and small-group plans on the Wisconsin State Marketplace, or Exchange.

AboutHealth, in its current configuration also is not likely a viable vendor for ETF. If it evolves into a full service health plan, that may very well change. However, as demonstrated in the recent relationship with Arise, AboutHealth may become more attractive if it continues to partner

with health plans within a larger network and full-service contract between a health plan and ETF.

In addition to the presence of the three organizations above, there has also been a recent local merger of two of ETF's health plans. Unity Health Insurance, an affiliate of UW Health and Gundersen Health Plan, a subsidiary of Gundersen Health System, are making their partnership official. The resulting merger will represent a combined 250,000 patients. The goal of the partnership is to facilitate access to local health care and more effectively manage the health of the combined plans' population.

National

At a national level, news headlines report on the planned mergers of four major health insurers – namely, Aetna's acquisition of Humana and Anthem's proposal to buy Cigna. If both the mergers succeed, they would effectively consolidate the number of large health insurance carriers from five to three. The Anthem-Cigna merger would result in the combined organization being the largest U.S. health insurer by membership. These deals are being reviewed by the Department of Justice and state insurance regulators.

In addition, there has also been activity on the national PBM level. United Health Group has agreed to purchase Catamaran, a large PBM. Catamaran will be folded into United Health's OptumRx pharmacy care services unit. Once combined, OptumRx projects that it will fill over 1 billion prescriptions. As a point of reference, Express Scripts, another large PBM, filled about 1.3 billion prescriptions in 2014.

As the local and national health care marketplace evolves, ETF can monitor the developments of the changing environment. With respect to ACOs for example, large provider communities may yield significant influence that can affect change. Insurer consolidations may drive additional competition. With such a rapidly changing landscape, today's health care environment will likely be very different from the environment one year, five years and a decade from now. Remaining informed on current health care events affords ETF the ability to evaluate such changes prospectively and properly assess what potential impact market changes may have on ETF and its health plans.

Observations on Wisconsin State Marketplace/Exchange

In the first report to the GIB in March of 2015, we compared ETF premiums with premiums on the State Exchange for plans of similar value. For example, for people in one of the UBD options or Standard Plan, we compared their current 2015 premiums with premiums for Platinum Plans available on the Exchange. For members in the HDHP, premiums for Gold Plans were utilized. We excluded Medicare-eligible retirees since the State Exchange does not provide coverage for those retirees. In 2015, with the exception of about 2,000 members, all members in Wisconsin would have at least one Platinum Plan option on the Exchange.

According to the database released by the Federal Government on October 30, 2015, the number of rating areas with Platinum Plan options will be reduced in 2016 in Wisconsin. The result is that approximately 40,000 ETF members would not have a Platinum Plan option, if they were to be eligible for the Exchange. However, all members would have a Gold Plan option. Therefore, we compared 2016 ETF premiums, without dental coverage, with 2016 premiums for Gold Plans

on the State Exchange. Some of the plans on the Exchange include dental coverage; no adjustment was made to the Exchange plans' premiums.

As in our first report, we conducted the analysis under three scenarios:

1. Each member would choose the plan with the highest premium available;
2. Members would choose plans resulting in an average premium in aggregate;
3. Each member would choose the plan with the lower premium available.

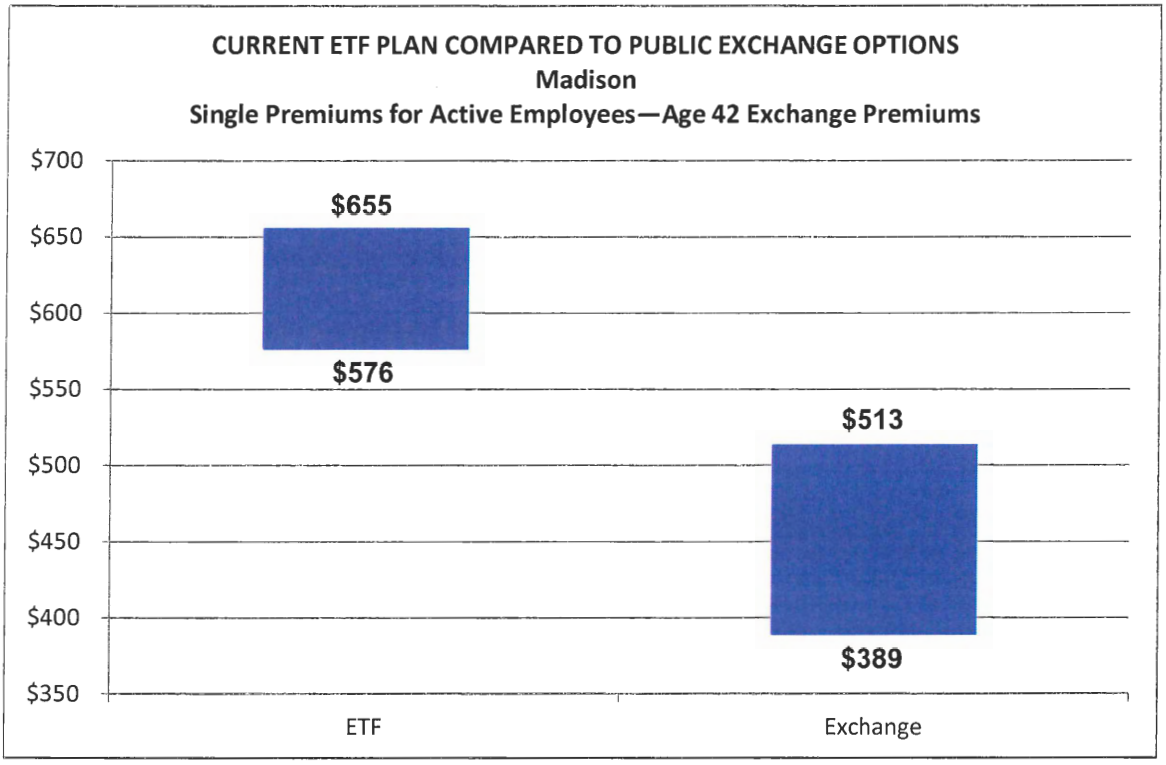
Based on projected ETF costs for 2016 of $1.152 billion for medical, pharmacy, and related administration costs (no dental) for non-Medicare ETF members, the three scenarios produce the following results:

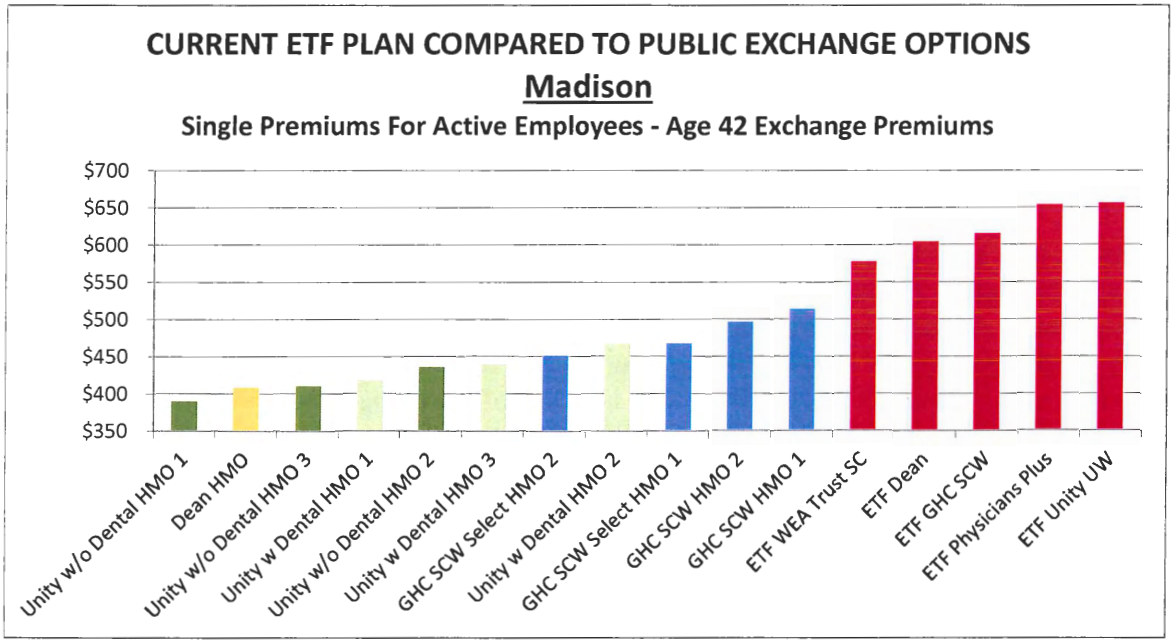
Scenario	2016 Projected Costs	Difference
Baseline/ETF	$1.152 B	
Choose Highest Gold Plans	$1.164 B	$12 M (1.0%)
Choose Average Gold Plans	$0.945 B	-$207 M (-18.0%)
Choose Lowest Gold Plans	$0.781 B	-$371 M (-32.2%)

It is somewhat expected that the plans on the Exchange would generally have lower premiums, due to the Gold Plans having an actuarial value of 80%, which is lower than that for the UBD (92%), Standard (91%) and HDHP (86%). We would expect the difference to be approximately 13% when comparing an average plan, since 98% of members are in the UBD, but the analysis shows an 18% difference, leaving 5% unaccounted. In the comparison of the most competitive plans, we see a difference of 32%, leaving 19% unaccounted.

Similar to the analysis in the first report, Segal compared the 2016 UBD premiums, without dental, with Age 42 Platinum Plan premiums available in Madison. Platinum Plans have a 90% actuarial value, which means they cover 90% of covered expenses on average. Some of the plans on the Exchange include dental coverage. In the first report, we provided this for Madison and Milwaukee. However, for 2016, Milwaukee is in one of the rating areas without Platinum Plans. Therefore, we have provided the results for only Madison below.

In 2016, ETF will offer five UBD options in Madison, with premiums that will range from $576 to $655. By comparison, there will be eleven platinum plans available in Madison on the state marketplace with premiums ranging from $389 to $513. On average, Platinum Plan premiums in Madison increased by 2.5% since 2015. As in 2015, all of the ETF plans are higher cost than the highest cost option on the Exchange.





All of these comparisons against the State Exchange options suggest there is room for improvement in ETF's cost efficiency in delivering benefits. In short, the plans on the Exchange are delivering, on average, a comparably-rich benefit plan design at a lower cost for an individual. A well-designed state employee health plan like ETF should be able to provide group benefits in a more cost-effective manner than those available in the same state's healthcare market place, which is populated with individual policies.

During the transition to self-insurance, while plans are fully-insured, it may be advisable to have the State Exchange plan bids provide a cap on the premium rates to ETF. This could easily be done, adjusting for appropriate demographics and geography.

Health Care Pricing Transparency Tools

Transparency in health care can be broadly defined as the availability of reliable health information about the cost and quality of health care services. Accessing this information empowers the consumer to make educated decisions about a needed service based upon the expected out of pocket cost of that service, the quality of the provider or facility, clinical outcomes, patient satisfaction and other pertinent data. The information can be utilized to facilitate more informed, responsible discussions to further the patient/ provider relationship. And it can serve as an avenue to make health plans more accountable with respect to the quality of the providers with whom they are contracting. While information is more readily available, the public lacks the understanding that such information is necessary in order to navigate the health care system in the United States. Too many consumers are unaware of the wide variations in the cost of medical services, the capabilities of medical service providers and the outcomes of the services provided.

As costs for physician services, hospitals and prescription drugs have escalated and continued to outpace Consumer Price Inflation (CPI), and as health plan sponsors shift more of the cost of these plans to their employees, patients are becoming increasingly aware of the price they pay for their health care as well as variability in cost among providers. This awareness coupled with the need to understand more about provider quality provides an impetus for the health care transparency movement. In addition, the introduction of consumer driven health plans to the health care benefits landscape marked a true shift in how patients view their health care. The patient is becoming more of an informed, price sensitive "consumer" wanting to learn more about the cost and quality associated with medical tests and procedures. Cost shifting designed into consumer driven health plans is driving consumers to have a vested interest in controlling higher out of pocket costs due to increased deductibles and larger out of pocket maximums.

In 2009, a national, independent, nonprofit corporation named FAIR Health was established to "bring transparency to healthcare costs and health insurance information through comprehensive data products, consumer resources and the support of health services research." FAIR Health created a database of claims data for health care procedures as an avenue for consumers to better estimate their out of pocket expenses. Supporting this trend, certain states including Washington and Massachusetts passed laws requiring insurance companies to provide pricing transparency directly to patients. Because of these and other developments, the health care marketplace responded to meet the growing demand.

Insurance companies and PBMs have developed their own transparency pricing tools and data analytics services for their members. Third party cost and quality transparency intermediaries have created technological platforms and tools that compare actual costs for medical procedures and prescription drugs and offer other services such as providing benefits information, quality metrics about providers performing specific tests and procedures and utilization data. Organizations that work on behalf of employers and other health care purchasers further the transparency effort by offering specifications for evaluating transparency tools, promoting open dialogue between providers and their patients, and advocating payment model reforms.

Large insurers like Aetna, Blue Cross, and United Healthcare offer their own individual transparency tools through their member web sites. The sites include cost estimator tools that typically address total estimated costs, detailed breakdowns by cost, and variations in price for the same treatment. The tools also identify specific providers or facilities as top quality and efficiency performers and display which providers or facilities participate in select performance networks. The breadth and depth of the data available, technological advancements, and overall transparency continue to improve.

Transparency information educates the consumer, acts as a springboard for conversations between patients and their doctors, and promotes better health care. In fact, when searching for providers, many of the large insurers' web sites list their top performing providers and facilities first and then display providers by the prices they charge per treatment. The focus on quality data, clinical outcomes, designated specialists, and tiered networks are a reminder that transparency tools are more than an online price shopping mechanism, but are truly meant to improve the entire health care experience.

The Market

Some of the largest insurers have agreed to contribute data to the Health Care Cost Institute (HCCI), a research facility and data repository. HCCI has developed a secure, online, and free transparency tool that gives consumers timely and accurate information about the price and quality of health care procedures.

Other proponents of health care transparency have created initiatives to aid in transparency. The American Board of Internal Medicine Foundation advises providers and patients to select treatment plans based on evidence-based guidelines that are not duplicative of other tests and procedures already received. The Emergency Care Research Institute is dedicated to discovering which medical procedures, devices, drugs, and processes that best further improved patient care. Healthcare Bluebook provides free online tools to help consumers find fair 'fair market cash prices' for medical care.

There are also a number of third party vendors that work towards improving patient care through transparency tools and benefits solutions such as Castlight Health, Change Healthcare, Vitals and the Leapfrog Group, to name a few. There are also firms that provide transparency information specific to prescription drugs and allow consumers to compare drug prices across therapeutic categories, delivery channels and retailers. These include Castlight Pharmacy, BidRx, and DestinationRx (DRX).

Qualities and Capabilities

As transparency tools evolve in the marketplace, plan sponsors should assess the vendors and tools that best fit their organizational needs. While there is much competition and differentiation among the solutions available, many tools often have common features. Third party tools are typically available to consumers through their employer who has subscribed to the service. Information is available via a secure web application. The application includes cost data for health related treatments and procedures from the subscribers' health insurers and often other sources, clinical outcomes and quality data, utilization information, provider and facility contact information and membership satisfaction rates and reviews. Many tools also include vehicles to help consumers take the full advantage of their health care benefits coverage. The process and

available information allow the consumers to understand the overall value of a test, service, or procedure as well as the value of their employer provided benefits.

While there are many aspects to consider when evaluating transparency tools, the group, Catalyst for Payment Reform, a nonprofit firm that works on behalf of large employers to initiative improvements in how health services are paid for, has developed a comprehensive list of specifications that optimal tools should possess. The specifications fall into five categories:

- **Scope:** the comprehensiveness of the provider network and information on price quality and consumer rating
- **Utility:** the capability of the tool to facilitate consumer decision making through comparative data
- **Accuracy:** the extent to which consumers can rely on the provider, service and benefit information
- **Consumer Experience:** The user-friendly nature of the tool and the intuitive ability to find information. The availability of a mobile application
- **Data Exchange, Reporting and Evaluation:** the extent to which claims data is exchanged with purchasers and the ability of purchasers to use the data with third party vendors in a private secure manner as well as ongoing tool improvements and the ability of users to rate the tool

The tools can empower consumers to choose lower cost, high quality providers, and they can help plans manage trend and reduce unnecessary utilization. As the movement towards transparency matures, tools and platforms available are constantly upgraded, becoming more sophisticated. Transparency technology is more comprehensive and precise, incorporating actual data in real time and using data that is updated more frequently than the technology from several years ago.

Consumer Utilization

As transparency tools have become more robust and more accessible, usage of the tools, however, have not kept pace. According to a Consumer Survey from FAIR Health, most consumers reported that they do not use the Internet to comparison shop for medical services. In fact, Millennials, a generation known for its technological savvy, do not use the Internet any more than older generations as it relates to searching online for medical services, the survey reports. In addition, research shows that consumers often incorrectly associate more tests and services and higher costs with better quality health care. These cultural trends raise questions about how we educate consumers on how to shop for cost and quality and how we teach plan participants to be better consumers.

Health plan sponsors can design benefit plans to promote consumer engagement and responsibility. Health care insurers can be held accountable for how they use quality information in transparency tools to improve the quality measures of their contracted providers, manage care, influence referral patterns and educate providers on how to advise their patents to make the best use of the data available in the tools. Plan sponsors also can incent their members to utilize the

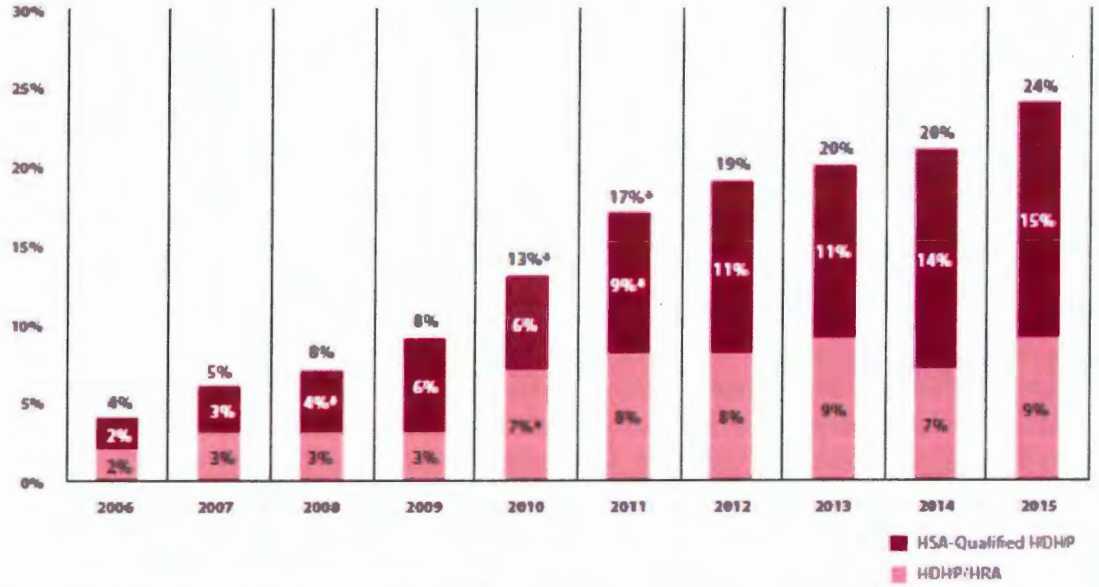
tools to gain a better understanding of the true value of their health benefits. As consumers become more aware of the variations in cost and quality, the use of transparency tools will increase. Transparency tools are available to support those consumers who are ready to become more engaged in making medical choices

Consumer Directed Health Update

Consumer driven health plans provide a financial incentive for consumers to make informed health care decisions based on cost and quality. With low monthly premiums and high deductibles and out of pocket costs characteristic of CDH plans, consumers carry a greater financial risk than participants in a typical managed care plan. As a result, they are usually more motivated to shop for health care services providing the greatest value.

With the health care industry placing such an emphasis on consumer accountability, it is not surprising that enrollment in consumer driven plans is on the rise. According to the Kaiser Family Foundation 2015 Employer Health Benefits Survey, almost a quarter, 24 percent, of covered workers are enrolled in an HDHP with a savings option. That percentage is nearly double the enrollment of those plans from just 5 years ago. In addition, in 2015, seven percent of firms providing health benefits offered an HDHP with an HRA and twenty percent offered a qualified HDHP with HSA.

PERCENTAGE OF COVERED WORKERS ENROLLED IN A HDHP/HRA OR HSA-QUALIFIED HDHP, 2006–2015



*Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: Covered Workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. For more information see the Survey Methodology Section. The percentages of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-Qualified HDHP enrollment estimates due to rounding.

SOURCE: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2006-2015.

Although PPO plans are still the most prevalent plan type offered by employers sponsoring health care benefits, CDH plans continue to generate interest. It is likely that enrollment in such

plans will continue to increase in the future. These plans are a viable and robust component in a list of employer strategies and well-designed benefits packages.

The Kaiser information is consistent with information presented in our first report and provides additional evidence that consumers access healthcare via these plans at a growing rate. For 2016, the State contribution to the ETF HDHP was increased and enrollment increased from approximately 400 subscribers in 2015 to approximately 1,500.

Self-Insurance

Current State

Self-insurance is not a new concept for the State of Wisconsin. ETF has had a self-insured pharmacy program since 2004 and results appear to have been successful. With Navitus contracted as the Pharmacy Benefit Manager, ETF has a transparent program providing full access to claims data, a partner that is both flexible and proactive in managing costs on behalf of ETF, and a uniform plan experience for all members wherever their location. For 2016, the dental benefits will migrate to a self-insured approach with Delta Dental contracted as the administrator. The State's Worker's Compensation program is also self-insured.

Additionally, two medical plans are currently self-insured, the Standard Plan and State Maintenance Plan. Enrollment in these plans is less than 5% of the total membership, with many of the members in these being out-of-state retirees. The remainder of the membership is covered in one of 17 fully insured HMO or PPO plans offering the Uniform Benefit Design.

With the above in mind, our review concentrates on the fully-insured managed competition health plan model ETF has had in place since 2004. The model was designed to encourage competition among the health plans and, in theory, to reduce the corresponding premium rates charged to ETF. Recent annual trends have been low. However, during negotiations the plans' premiums are tiered based on an internal comparison among the group of bidders and, without an external benchmark, the plans have little incentive as a group to manage overall cost levels. As shown in our first report, full premiums for single and family coverage are high within the region when compared with other state plans, even when adjusted for benefit levels.

Large employers generally self-insure the risk and costs for medical and pharmacy benefits. As noted in our first report, the large majority of state health plans self-insure all their health plan options. Some even self-insure their HMO offerings. As noted in the Market Observations section in our first report, all but one of the current ETF health plans report the ability to support a self-insurance approach.

California is an example of a state that utilizes a blended approach between self-insurance and fully-insured contracts. Large portions of the membership are in plan options that are self-insured and equally sizeable portions of the membership are in plan options that are fully-insured. The fully-insured options largely utilize a staff-model HMO, where the providers are directly employed and compensated by the health plan. Most members choose between fully-insured or self-insured options, although the members are likely unaware of this distinction. Kaiser is primarily the fully-insured plan and will not/cannot operate in a self-insured environment.

The staff-model HMO type does not have a significant presence in Wisconsin, although Dane county has similar attributes. The market favors more traditional group-model HMOs, where provider payment structures that are transferrable between self-insured or fully-insured. Therefore in the Wisconsin market, a conversion from fully-insured to self-insured is expected to provide the plan sponsor access to the same provider contract terms and pricing negotiated by the health plan that is utilized for its fully insured business. In other words, the providers are

typically neutral as to which approach is utilized and likely are not even aware of who holds the risk for the employer's plan.

What Are the Benefits of Self-Insuring?

There are several reasons why employers choose the self-insurance option. The following are the most common reasons and are primarily financial:

- **Elimination of premium tax:** Wisconsin health plans do not pay a premium tax. However, some ETF plans pay a premium tax in their home state, depending on that state's regulations. Nationally, this rate is approximately 2% of premium. With many ETF plans not subject to premium tax, the aggregate rate is quite low, approximately 0.1% of total ETF premium. There is no premium tax on the current self-insured plans.

- **Elimination of Affordable Care Act (ACA) Market Share Fees:** This fee was introduced with the ACA and applies to all fully insured medical and/or dental business. The fee is to be divided between all health insurance issuers and is expected to increase beyond 2018. The fee allocation is not uniform, with larger plans paying a larger portion and the smallest plans not subject to the fee. This fee is not applicable to self-funded health plans. In aggregate across ETF's health plans, the fee is approximately 2% of health premiums.

- **Lower cost of administration:** Employers find that administrative costs for a self-insured program administered through a contracted third party administrator (TPA) – even if that TPA is also a carrier – are generally lower than those included in the fully insured premium by an insurance carrier or health plan.

- **Carrier profit margin and risk charge eliminated:** The profit margin and risk charge of an insurance carrier/health plan are eliminated for the bulk of the plan. Normally these represent 2-4% but upon our review of various Health Plan Market Reports, it appears to be lower in Wisconsin. These reports are somewhat suspect, since in many occasions they own the hospitals and their margins are well over norms.

- **Cash flow benefit:** The employer does not have to pre-pay for coverage on monthly premium basis, but can fund claims dollars just as they are needed for payment. ETF now pays at the end of the month but the concept remains the same. Not requiring the employer to pre-fund the full incurred amount can result in improved cash flow. The employer also maintains control over the health plan reserves, enabling maximization of interest income that would otherwise accrue to the insurance carrier through their investment of premium dollars not yet needed for claims payments and other expenses.

- **Management of Excise Tax Exposure:** While the regulations have not yet been finalized, it is anticipated that the 40% Excise Tax will be determined for each individual subscriber within assigned groups based on coverage tier and plan groupings. Therefore, employees and retirees in health plans with higher premiums will produce a larger Excise Tax exposure for ETF and the State. It is anticipated that self-insurance will provide more flexibility in establishing rates than available with fully insured premiums.

There are also other non-financial reasons plans choose to self-insure their programs. These include:

- **Control of plan design:** The employer has complete flexibility in determining the appropriate plan design to meet the needs of the employer and employees. The employer can redesign the plan at any time.

- **Data collection:** In a self-insured program, ETF would receive and own detailed claims and encounter data. This would allow more efficient management of the plan's financials. Availability of fully detailed data about members and their claims is a major problem for the program right now, with the plans often claiming that confidentiality issues prevent them from providing ETF full data about its own plans. This lack of detailed data was addressed with the health plans with partial success this past summer during the 2016 health plan negotiations.

- **National provider network:** The third party administrator for a self-insured plan should be able to offer a national integrated program of networks for retirees and out-of-state workers. While some out-of-area coverage is available now, a self-insured program essentially has no arbitrary plan or network boundaries.

- **Custom Provider Network:** Under a self-insured plan, the employer is free to contract with the providers or provider networks best suited to meet the health care needs of its employees. Self-insured plans can easily design and initiate pilot programs or value based initiatives for all or portions of their covered membership. These types of initiatives are difficult, if not impossible, to implement under a fully-insured plan structure.

- **Mandatory benefits are optional:** State regulations mandating costly benefits are usually optional because self-funding is regulated by federal legislation only. *(Note: mandated benefits would typically not apply to ETF, although ETF may be included in the scope of state legislation.)*

- **Cost reporting:** Under a self-insured arrangement, the TPA can provide detailed reporting of costs by month or other desired cycle, by department or location, and by type of medical service. Utilization and lag reports would also be available. In addition, since the self-insured employer owns the detailed data for the plan, that data can be captured and loaded on a frequent basis to a data warehouse, where it can be combined and analyzed with similar data from the employer's other self-insured plans.

Financial Impact

Based on the information from the 2016 negotiations and renewal, the average monthly per subscriber premium for the insured non-Medicare UBD portion of the program is $1,143.

Premium Tax

Health plans domiciled in Wisconsin do not pay a premium tax. However, some of the ETF health plans pay a premium tax, depending upon the rules and regulations in their home state. For the 2016 renewals Segal requested a detailed breakdown of each plan's administrative

expenses. Premium tax was a required line item and detailed the amount currently paid or charged to the ETF plans. Overall, the average premium tax was only 0.1%, as most of the plans are domiciled in Wisconsin. This equates to an immediate savings of $1.14 per subscriber per month, or $0.9 million annually in 2016.

ACA Market Share Fees

In aggregate, the ACA Market Share Fees are approximately 2% of premium and are only paid by insured plans that have written over $25 million in net premium during the year. This fee is only paid by insured plans, with the fee allocation larger for the largest health plans and the smallest plans not assessed the fee. Based on the information provided by the health plans in the negotiations for 2016, moving to self-insurance would result in an immediate savings of $22.86 per subscriber per month, or $18.3 million annually in 2016, for ACA Market Share Fees alone.

Administrative Costs

The health plans provided a detailed breakdown of their administration costs in the required addendum submission during the 2016 renewal cycle. The net administrative costs component averaged approximately $84 per subscriber per month (PSPM). Although this was the amount reported and anticipated to have been put in the rate development, we believe it is overstated and not an accurate assessment of the true administrative costs.

Due to the negotiation and renewal process it was necessary to estimate the final net administrative costs. Subsequent submissions focused on only the total premium. As the total premiums were reduced during the negotiations, it is not known for certain exactly how each of the individual premium components were adjusted. Our estimate is derived from a comparison between the final aggregate premium and aggregate claims projected at 3%. Based on the information provided by the health plans in the negotiations for 2016, the current net administrative cost per subscriber per month (PSPM) is estimated to be approximately $44.

This $44 PSPM (and $84 PSPM) figure is net of ACA fees, profit, and contingency loads. What remains is a rate that covers administrative-only services (ASO), including claims processing, member services, network contracting and maintenance, reporting, as well as wellness, health management and the administration of health savings accounts (HSAs) and health reimbursement arrangements (HRAs). In our experience, ETF's administrative cost rate is significantly higher than rates for other similarly situated employers regionally and nationally.

Segal collected per subscriber per month rates from a variety of sources:

- **Other state health plans** – Segal surveyed several state-level health plans, receiving data from Illinois, Minnesota, Colorado, Alaska, New Mexico, Hawaii, Tennessee, North Carolina, Alabama, Georgia, New Hampshire, West Virginia, Maryland, Delaware and Kentucky
- **Other Wisconsin employers** – Segal collected administrative fee information from several private sector entities whose primary operations are in Wisconsin
- **National survey data** – The 2014 Mercer Health Benefits Survey includes administrative fee data

Information from these sources was utilized to develop the following expected administrative fee range for each group:

Group	Per Subscriber Per Month ASO Rate
Wisconsin ETF	$44
Other States	$15 to $30
Other Wisconsin Employers	$20 to $30
Other Regional Employers	$30 to $40
Other Government Plans Nationally	$25 to $35
Other Large Employers Nationally (5K+)	$25 to $35

The large majority of the plans represented in the data for other states are self-insured. In our opinion, the most appropriate comparison is to other states. The rates for other regional and Wisconsin employers, as well as for other governments nationally are similar. However, other states are, in general, more similar in size and composition than the organizations in the other groups. That said, taking the conservative approach and comparing the 2016 ETF PSPM rate ($44) with the highest rate in the expected range for other state plans ($30) still shows a savings opportunity. This $14 difference equates to $11.2 million annually in 2016.

Profit Margin and Risk Charge

While it may be perfectly understandable and a standard practice for health plans to include profit and risk loads in an insured premium, there is no reason to do so in a self-funded arrangement. In these instances, the health plan or administrator includes the profit in the ASO fee.

Typically, a profit and risk load is in the 2-4% range. However, the loads reported by ETF plans are lower, with the average profit and risk load in 2016 reported at 1.2% in aggregate. It should be noted that hospitals show net income over industry norms, with some greater than 10%. So although provider owned HMOs may show a low profit, their owned providers show a higher profit.

Eliminating this 1.2% load results in an immediate savings of $13.72 per subscriber per month, or $11.0 million annually in 2016.

Cash Flow Benefit

For self-insured programs, claims are paid as they are invoiced, which includes an inherent lag between service and paid dates. ETF would retain the associated assets and have the ability to earn investment income for the time it holds the assets before they are actually paid out for claims. A typical lag for medical claims is approximately one month, which equates to an estimated $72.1 million in 2016. At a modest investment return of 1.0%, the additional investment income would be approximately $0.7 million annually in 2016.

Managing Excise Tax Exposure

The 40% Excise Tax goes into effect for 2018. While final regulations are yet to be provided by the Federal government, it appears the Excise Tax will have to be calculated based on the actual plan elections for each individual subscriber. In a self-insured plan, the plan sponsor has more flexibility in developing rates for each plan option and in adjusting specific benefit features to help hold costs down. Pooling may also be utilized between active and retiree rates. For insured plans, the current expectation is that the specific premiums must be used.

Single premiums in the UBD vary by as much as $250, and even more for family coverage. If the average cost per member could be utilized across the membership groups that must be aggregated for Excise Tax purposes, the State's Excise Tax exposure would be managed to a lower level. Currently, the Excise Tax exposure is approximately $3-4 million, and the immediate impact of self-insurance is fairly minimal in the short term. However, the impact grows over time and is estimated to be as much as $41 million by 2027.

Note that these figures measure the impact of the reduction on the fixed costs and the effect of utilizing a more aggregate rating structure to calculate the Excise Tax exposure. The impact of other strategic initiatives, such as health plan consolidation and an enhanced approach to total health management would further reduce the exposure.

ETF PROJECTED EXCISE TAX IMPACT OF SELF-INSURANCE ($ MILLIONS)

	Projected with Current 2016 Premiums		Projected with Aggregate Rates and Fee Reductions from Self-Insurance	
Year	Tax with 4% Trend	Tax with 6% Trend	Tax with 4% Trend	Tax with 6% Trend
2018	$3	$5	$3	$3
2019	$4	$7	$3	$4
2020	$4	$11	$3	$4
2021	$5	$17	$3	$5
2022	$6	$28	$4	$6
2023	$7	$40	$4	$9
2024	$9	$55	$4	$14
2025	$11	$71	$5	$25
2026	$14	$93	$5	$49
2027	$18	$118	$5	$75

Savings Summary

The projected annual savings associated with a conversion of ETF's current plans to self-insurance is $42.1 million and is summarized in the following table.

Component	First Year Impact
Premium Tax	$0.9 M
ACA Market Share Fees	$18.3 M
Administrative Costs	$11.2M
Profit Margin and Risk Charge	$11.0 M
Improved Cashflow (Investment only)	$0.7 M
Total	$42.1 M

This is an estimate of the impact on fixed dollar costs and does not account for any changes in plans, claims or program structure that could also affect costs. In theory, the current program could be converted to self-insurance and remain otherwise largely unchanged. However, converting 17 fully-insured plans to self-insurance is not considered practical, nor feasible and is not recommended. Our recommendation is to combine a conversion to self-insurance with the regional restructuring provided in the **Program Structure** section. This may be best structured through a phase-in approach.

Cash Flow and Reserving

As previously stated, the transition to self-insurance alone is not anticipated to change the underlying claims costs, with savings resulting from a reduction in the fixed, non-claims costs. The conversion will result in a change in the timing of payments made by ETF. Where fully-insured premiums are paid up-front, self-insured claims are paid after the date of service, which results in a run-in period from which both a cash balance and reserve will be built. Therefore, the conversion to self-insurance should produce a month or so of claims cash flow improvement.

Incurred But Not Reported Reserve

Claims in a self-insured plan have a "lag" between the date of service and the date the claim is paid. There may also be a lag from the date the health plan pays the claims and the date ETF pays the health plan. Claims for services already provided, but not yet settled, are often referred to as Incurred But Not Reported (IBNR) or Incurred But not Paid (IBNP) claims. In this discussion, we will not draw a distinction between IBNR and IBNP and simply use IBNR to refer to claims incurred but not fully settled.

Generally speaking, medical claims have an average lag of one month. Some claims, like office visits that are adjudicated at the point-of-sale are generally settled sooner while inpatient hospital claims, or other more complicated situations, may take months or even years to be completely settled and paid.

At any given time, there is a liability for these unresolved claims and it is common to estimate and book an IBNR Reserve. ETF already follows this practice for the self-insured pharmacy program and for the Standard and State Maintenance Plans.

When a program first transitions to self-insurance, there is a drop in expenses for about 4-8 weeks. Assuming a transition on January 1 (of any year), the premiums paid prior to changeover will cover all claims incurred until December 31, but claims in January will need some time to work their way through the health plans claims submittal and processing system before assets are transferred from ETF to cover the expenses. During this lag time, ETF should be able to accumulate enough assets to fund the IBNR. In other words, the gains during this "run-in" period should cover the liability of the "run-out" period on the other end. This is what will happen for the dental plan at the start of 2016.

Solvency Reserve

In a self-funded approach, ETF will be exposed to the natural, and expected, claim and expense volatility. Utilization and expenses will inevitably vary from month-to-month and from year-to-year and many self-funded plans maintain an asset reserve above the IBNR to provide protection against this volatility and to smooth out funding requirements for the State and the members.

For the Pharmacy program, as well as for the Standard and State Maintenance plans, ETF currently has a formal reserving policy that seeks to maintain assets at a level above the IBNR. More accurately, ETF seeks to maintain assets within a range where there are sufficient assets to fund the IBNR with additional assets to fund a solvency reserve. The expense lag will fund the IBNR, but additional assets will be required to provide the initial funding for the solvency reserve.

The GIB has a policy to maintain cash reserves in a target range of 15-25% of paid claims (including 20% of insured premiums). So overall, the current fully-insured reserve was 3-5% of total annual premiums. A typical reserve for a self-insured medical plan will be 1-2 months of paid claims or 10-15% of total incurred claims. This change in cash flow is the same as what was experienced when the plan converted on the pharmacy side and more recently the dental program. So you will need a larger reserve but the cash account will be higher to compensate for that. We would recommend maintaining the higher 25% first year, to compensate for the run-in and build the reserve needed to fund the IBNR. This should result in a reserve of approximately 10% over the IBNR.

The additional funding for the solvency or claims fluctuation reserve in the first year could be sourced from the savings from the reduction in administrative fees and other fixed costs. The amount needed will be included in the premium rate development, consistent with current processes.

Gain Sharing

In some corners of the industry, there are those that remain skeptical that a health plan will not remain as diligent in managing member utilization and provider costs as it would in a fully-insured arrangement. To mitigate this potential threat, we propose incorporating incentives and penalties for plans as well as for members. The incentives/penalties for members are based on plan design and contribution differentials described in an earlier section. To align incentives for plans, we anticipate incorporating performance metrics with rewards and penalties that are designed to improve member health and manage expenses for ETF. We also recommend that ETF incorporate a gain-sharing component that shares a portion of any financial gains with health plans when they manage costs to be lower than expected for their specific membership.

Gain-sharing is a methodology in which cost savings compared to a targeted cost are shared between ETF and the plans. Cost savings are defined as performing better than a benchmark cost target. To share in cost savings, the plans will need to demonstrate quality and reduce spending below targets. Quality requirements are needed to ensure quality is not compromised as providers reduce services. This type of arrangement helps align financial and quality of care initiatives and can be used by ETF to encourage plans to use lower-cost or higher-quality providers as well as to work with providers to coordinate care for members. This approach works well in a model where medical management is integrated with the plan, and eliminates the difficulty of trying to quantify a return on investment (ROI) from a medical management vendor.

The ACA defined several approaches for new models of payment to be tested. The Medicare Share Savings Program (MSSP) was the first model for which rules were issued. The MSSP is a two-sided risk model where payment can be either received based on cost being lower than the benchmark or paid based on cost being higher than the benchmark. The gain-sharing methodology outlined here is similar to the MSSP approach but with a one-sided risk model which only seeks to reward a plan when savings are achieved. Any amounts paid to the plans would result in a bonus payment to the plans based on savings to ETF. This type of methodology provides funding for bonus payments without the need for ETF to separately fund a bonus pool.

Plans that meet specified quality performance standards are eligible to receive payments for savings if they can reduce spending growth below cost target amounts. Quality performance will be measured based on metrics related to care coordination and patient safety, preventive health, and caring for at-risk populations. Performance on these measures will affect the amount of shared savings for a plan. Cost performance compared against benchmarks will determine whether or not the plan is eligible to receive an additional bonus from savings.

To calculate a payment methodology, a baseline expenditure estimate will be developed in order to project cost benchmarks that will be used to determine cost savings. The baseline will be based on cost data and trended to the benchmark year. Benchmarks will be calculated separately for each region and adjusted for health status for each plan. To generate savings, plans must reduce spending below their benchmark amounts. To help ensure that payments are based on true savings below the benchmark rather than simply random fluctuations, plans must reduce spending by more than a minimum percentage (e.g. 2%) in order to receive any savings. However, once the minimum percentage is met, all savings (even the amount that is less than the minimum percentage) are eligible. Final expenditures will be calculated after the end of the plan year using a 3-month run-out of claims to determine the final amount of savings to be shared. Note that reduction in the number of plans is an essential component of this methodology since it would be difficult to determine the minimum percentage for random fluctuations for plans with low membership.

Plans that meet the minimum percentage of savings and become eligible for payment will share in up to a certain percentage (e.g. 50%) of their achieved savings, depending on how well they exceed minimum quality performance standards.

The gain-sharing model will require plans to report on quality performance measures. The measures will be developed as described in the Total Health Management section of this report and similar to the measures shown in **Appendix 1,** with some measures based on processes and other measures based on outcomes. The first year of the program will be a pay-for-reporting system where plans will be eligible for shared savings if they report accurately on 100% of the measures, regardless of their actual performance. This will determine baselines on the measures. In the second year, process measures will be based on actual performance and outcome measures

will continue to be based on a pay-for-reporting basis. Year 3 and beyond will be based on actual performance of all measures. A scoring system will be implemented to calculate the percentage of performance measures achieved. The percentage of performance measures achieved will be multiplied by the financial percentage (e.g. 50%) of savings to determine final payment to the plans.

For plans to be successful in this type of arrangement, they will be required to become accountable to and report on quality, cost, and overall care of the beneficiaries. In a procurement, the plans will be required to describe its plans to promote evidence-based medicine, promote beneficiary engagement, coordinate care and report on quality and cost metrics. They will be required to have systems to identify high-risk individuals and develop individualized care plans for targeted populations. They will also need to be able to communicate clinical knowledge to beneficiaries in an understandable way to allow for shared decision making. These processes for measuring clinical and/or service performance will be critical for them to use these results to improve care and service.

Health status adjustments for gain-sharing will be determined through a diagnoses based risk model. This type of model will be useful to incentivize plans to incentivize providers to use correct coding as it will improve the risk scores of their populations.

One downside of the CMS MSSP model is the concern of whether plans already operating with high efficiency have a reasonable chance of meeting target reductions. The model we are recommending would have targets based on a regional benchmark with cost levels adjusted to a plan specific benchmark based on health status adjustments. This would allow the plans operating better in a region the ability to be rewarded.

In Summary

ETF has the opportunity to realize an estimated $42.3 million annually in savings from reductions in fixed costs paid to the health plans by converting to a self-insured model for the plans providing the Uniform Benefit Design. These savings, along with gains associated with the initial lag between service and payment dates should be sufficient to fund the initial reserves for IBNR and solvency needs.

It is worth noting that in the **Self-Insurance Concepts** section of our first report, we estimated that a conversion to self-insurance could result in savings of $50-70 million. That estimate was based on a preliminary review of the data and the program and included the expectation that ETF would restructure the program and consolidate health plans. The Program Structure section of this report includes our recommendations for health plan consolidation and a regional approach to selecting and contracting vendors. We believe the associated savings for the restructuring and consolidation is $45-70 million. Coupled with the $40-50 million savings estimated in this section of the report, the combined annual savings opportunity is approximately $85-120 million.

A self-insured program would provide ETF with significantly improved transparency and access to the detailed data necessary to sufficiently manage the program. ETF and the GIB would also have increased flexibility in benefit design beyond that available through a fully insured plan. Self-insurance may very well provide ETF with additional capabilities to manage exposure to the Excise Tax.

The vast majority of other states utilize self-insurance for their state employee health plans and, in our analysis, there does not appear to be a compelling reason for ETF to remain fully insured over the long-term strategy.

We recommend a phased-in approach to transition to self-insurance. Beginning in 2016, for the 2017 health plan renewal, ETF should require all health plans to provide complete encounter, claims and pricing data at claim level detail. Thereafter, ETF could move toward self-insurance on a timeframe that is most advantageous to the program and also allows ETF staff to manage the transition in a thoughtful manner. Future phases will include the collection of additional data within the new regional structure, the potential inclusion of gain-sharing and a double-sided risk-sharing approach.

Retiree Coverage

Program Structure

In Wisconsin, when State employees retire they are given the option to continue medical, dental and pharmacy benefits at the full cost of coverage. Those not yet eligible for Medicare are given the same plan options as active employees, but at the total rate of the combined non-Medicare group (active and retirees). This rate has an implicit subsidy for the retiree, since non-Medicare retirees are much older and would have experience 150% to 200%, or more, of an active employee.

Benefits for Medicare retirees are slightly different. All of the current plans provide a Medicare option for retirees. There is no implied subsidy in these rates, since the Medicare rate is meant to cover the full cost of that population only. There are some issues with the rate setting that tends to make these rates higher than what we believe a reasonable cost to be.

In order to pay for the benefit, retirees use their accrued sick leave. At retirement, unused leave, in conjunction with pay, is converted into a notional account balance that can be used to cover the cost of medical, drug and dental premiums. This can be a sizeable amount and will typically last 6-10 years into retirement. So, the goal of this section is to provide more cost effective options for retirees, allowing their sick leave balance to last longer into retirement.

Plan Options

As mentioned earlier the non-Medicare retirees get the same benefit options as active employees, details can be found in the **Program Structure** section of the report. When retirees become Medicare eligible they would have a somewhat different set of options.

All health plans have coverage options which are coordinated with Medicare, except the HDHP.

- Members in an alternate health plan who become Medicare eligible transition into the Medicare Traditional Uniform Benefits plan.
- Members enrolled in the Standard Plan or the SMP transition to the Medicare Plus Plan on the member's Medicare effective date.
- Members enrolled in Humana will be enrolled in Humana's Medicare Advantage Preferred Provider Organization (MA-PPO) after enrolling in Medicare Parts A and B.

Medicare Plus is a fee-for-service Medicare supplement plan administered by WPS. This plan is available to eligible annuitants enrolled in Medicare Parts A and B. Medicare Plus permits eligible members to receive care from any qualified health care provider anywhere in the world for treatment covered by the plan.

Medicare Advantage Preferred Provider Organization (MA-PPO) allows members to use any health care provider accepting Medicare; however, they will not have greater out-of-pocket

expenses when using out-of-network providers. The in-network MA-PPO benefit is modeled to replicate the Uniform Benefits package.

Pre-Medicare Retiree Risk Pool

Most state government health plans include both active employees and non-Medicare eligible retirees in the primary rating pool. For self-insured plans, this typically takes the form of a single rating pool for all participant experience, where everyone in the plan pays the same rate for their respective coverage level (single, family, etc.) and there is no differential in premium made for age or other factors. The same rating approach is used for most fully-insured plans, where a single rate structure applies to all participants, except for Medicare eligible employees still employed where a reduced rate may apply to reflect the fact that Medicare is a secondary insurance while those eligible persons are still working.

This "one for all" traditional rating approach contributes to the stability of the health benefit program, and helps to build confidence among older employees that when they retire, they will not be charged any different premium base than what they paid during their employment.

However, there is a direct relationship between age and illness. The older a person, the more likely he or she is to have one or more serious conditions. More conditions generally correlate to greater medical cost, and increased medical cost results in higher premiums required to fund those medical costs. In effect, the older and sicker persons covered in the plan will drive up the required premium cost for younger and healthier members, so with a broad based employer health plan covering active employees and non-Medicare retirees, premium cost will be higher per person than in a plan that does not cover the non-Medicare retirees.

We estimate on the following page that approximately $62 million in premiums are paid by pre-Medicare retirees, primarily through their accrued sick-leave. The average premium rate paid is approximately $700 per member per month. If the retirees were rated separately, we would expect this rate to go up 50-100%, $30-$60 million in aggregate.

Many other states with an implied pre-Medicare subsidy have reviewed strategies and approaches towards addressing the associated costs and liability. These strategies incorporate grandfathering or incremental changes phased in over time, such as service based contributions. However, Wisconsin is fairly unique in that retirees pay 100% of the premium. Therefore, a significant change in premium structure could significantly affect the cost to retirees. Generally speaking, in other states that have addressed the implicit subsidy, retirees pay a portion of the premium and therefore, the financial impact to those states' retirees is less.

Given that this is a limited benefit for retirees, who in total are much smaller than the group, we would recommend no changes to the pooling methodology at this point in time.

Pricing and Enrollment

During the annual renewal cycle, Plans are asked to separately bid a Medicare only rate. This rate is limited to a maximum of 50% of the non-Medicare rate. The Medicare Plus plan is self-insured and rates are developed by the actuaries, in consultation with WPS.

Note that the full rate would involve adding components for pharmacy, dental and administrative costs. Pharmacy is fully transparent and self-insured, as is the dental plan. The costs are rated separately for the Medicare Plus and Medicare Traditional Uniform Benefit Plan. With total costs being paid by the retiree, enrollment is highly dependent on premiums.

Below is summary of the enrollment by plan and the single premium rates. The non-Medicare rates vary by nearly $200 for the Plans, with the Standard Plan over $1,300. The enrollment tracks fairly close to the active enrollment. The recommendations being made for actives will be beneficial to holding these costs down.

For Medicare retirees, enrollment tends to follow the premiums to a greater extent. Plans with lower premiums have higher membership. Note also that since a number of retirees travel and leave the state, the Medicare Plus plan has the greatest enrollment. The plan changes addressed earlier have limited impact on the Medicare eligible retirees.

	Non-Medicare				Medicare			
Plan	**Rank**	**Single Rate**	**Contract**	**Members**	**Rank**	**Single Rate**	**Contract**	**Members**
Anthem Northeast	12	$744	25	39	24	$520	18	32
Anthem Southeast	18	$767	74	107	27	$532	171	253
Arise Health Plan	13	$747	65	106	25	$521	214	309
Aspirus Arise	10	$728	0	0	23	$512	1	2
Dean Health Plan	2	$603	1,275	1,896	10	$423	3,830	5,728
Dean Prevea 360	7	$659	2	2	19	$471	2	3
GHC EC	20	$780	52	86	21	$493	106	151
GHC SC	3	$614	317	435	16	$455	648	958
Gundersen Lutheran	19	$772	117	186	9	$421	488	761
Health Tradition	15	$749	56	83	8	$410	146	216
HealthPartners	9	$692	117	194	22	$494	94	160
Humana Eastern/MA-PPO	21	$781	228	315	3	$396	1,124	1,659
Humana Western/MA-PPO	27	$836	32	46	3	$396	289	444
Medical Associates	8	$661	23	34	2	$379	89	142
Mercycare	4	$614	28	38	7	$408	60	88
Network Northeast	14	$749	279	410	17	$462	554	860
Network Southeast	22	$785	2	5	12	$435	0	0
Physicians Plus	5	$653	394	560	18	$462	1,850	2,690
Security	26	$809	326	495	28	$553	552	875
Standard Plan/Medicare Plus	28	$1,305	146	186	5	$400	6,269	8,534
State Maintenance Plan (SMP)	25	$808	3	3	5	$400	11	15
UnitedHealthcare	17	$758	297	437	26	$527	603	941
Unity Community	11	$743	30	50	20	$488	57	83
Unity UW	6	$655	653	955	15	$449	2,425	3,769
WEA Trust East	16	$757	194	302	11	$431	230	402
WEA Trust NW – Chippewa	23	$797	70	104	13	$445	135	211
WEA Trust NW – Mayo	23	$797	156	227	13	$445	339	541
WEA Trust Southcentral	1	$576	3	7	1	$367	3	4
Total		**$707**	**4,964**	**7,308**		**$433**	**20,308**	**29,831**
Total Cost	**$62.0 million**				**$154.9 million**			

In order to reduce costs for the Medicare retirees, we will need to consider some new plan alternatives. We believe additional options exist with lower costs and with comparable benefit levels. The goal is to contract with Plans to better manage care under group Medicare Advantage programs.

Experience of Other States

All states are struggling to cost-effectively manage their Medicare retirees. The vast majority of States have converted their Part D program into an Employer Group Waiver Plan (EGWP). States make this transition to best maximize federal subsidies and offset net costs. Where the logic is pretty straightforward for this program, similar logic could be applied to the medical program as well.

Under a Medicare Supplement arrangement, which is the primary ETF structure, a claim is paid by Medicare first and then the remaining benefit is shared by the member and ETF. If a Medicare Supplement plan has great success managing the Medicare members, the cost savings primarily goes to Medicare, which pays 85%+ of the claim. With Medicare Advantage plans, CMS pays the plan the average of what a Medicare member costs. There are number of complexities in the calculation but payment of the average risk adjusted cost is the primary method. Plans with higher quality get more money as well.

A number of states, including Illinois, have implemented Medicare Advantage plans to maximize the federal money and minimize their premiums. Illinois saw their rates drop from over $450 PMPM to around $200 PMPM in the first year. This spread has been maintained over the first three years. The typical design is to have a Passive PPO, where the in/out of network benefits are the same and care is provided at the in network schedule of benefits when a provider that accepts Medicare is utilized. This important feature of a Passive PPO results in no difference in access between the MA plan and Medicare Supplement plan. As long as 51% of members are within their network, Per CMS regulations, as long as 51% of ETF's Medicare retirees enroll in an MA plan in a particular service area, this type of plan can be provided. This is very different that an individual MA-HMO, where the network is a closed panel. The only requirement would be that the provider accepts Medicare.

If Wisconsin could get pricing similar to what we have seen in other states, the rates for Medicare retirees would be much less and their paid sick leave account will last much longer.

RFI – Medicare Advantage Passive PPO

Segal has performed a number of Medicare Advantage opportunity assessments for States. We conducted and Request for Information (RFI) and provided participating organizations summary eligibly and medical claims, as well as detailed pharmacy information. The study included the two largest Group MA Plans – United Healthcare and Humana. We also included one of the largest commercial plans – Anthem.

With the passive PPO product, it is not necessary to do a detailed network analysis. As long as they meet the 51% rule, the network will be virtually identical for each health plan. During a procurement we will do some network analysis to determine long term sustainability of the program but it was not necessary for this assessment.

There is sometimes additional savings on the pharmacy side, where the integration and coding can influence reimbursement and CMS subsidies as well. With that in mind we requested estimated rates for medical only (MA), as well as combined medical and pharmacy (MA-PDP).

Below is a summary of the results and the estimated rates provided by the participants:

	Medical Only	Medical & Pharmacy
ETF - Medicare Plus	$188	$400
ETF - Medicare UBD	$246	$447
RFI - Medicare Advantage Plans	$100 – $150	$300 – $350

For the Medical Only rates, we would expect to pair the new MA plan with the existing EGWP program. The rates in the Medical & Pharmacy column are for a potential MAPD with both medical and pharmacy benefits that would potentially also replace the current EGWP program. None of these rates include dental premiums.

Recommendations & Timing

The results of the RFI show that a National Passive PPO with the best-in-class plans could produce savings of $50 to $100 per member, a reduction of 10-20% with no benefit changes. This would result in a total premium reduction of $17 to $34 million annually for retirees.

To coordinate with the active recommendations, we would recommend one National (and Statewide) plan. We would enable the plans selected in each region to have a competitive Medicare product, preferably an MA HMO. This will allow retirees a number of options to best meet their needs and budget.

Like the Total Health Management recommendation, we believe this recommendation can be phased- in. The National Passive PPO could be marketed and implemented for 2017 while the Regional plans are implemented in conjunction with the 2018 plan and network changes.

It is expected this would have a positive impact on the State's liability for Other Post Employment Benefits (OPEB). While the retirees' sick leave accounts would not be affected, with lower premiums, the pay-out would take place over a longer period of time, which would result in a reduction of the expected present value of those premium payments. This change may be minimal and estimating the impact is beyond the scope of this report.

Local Government Plan

Program Structure

The current local government plan, Wisconsin Public Employers' Group Health Insurance Program (WPE), is similar to the state plan in that it offers benefits through the same 17 fully-insured HMOs and a self-insured PPO. Coverage is available for active employees, non-Medicare retirees and Medicare retirees.

Employer groups apply for entry into the WPE on a quarterly basis. Groups undergo risk evaluation, based on general group and individual underwriting principles, according to the number of eligible employees. Historical experience and the overall health risk of the group will dictate whether a surcharge may need to be assessed during the first 24 months of program membership. Other pool stabilization techniques are employed such as employer cost-share/contribution requirements, minimum participation requirements, and a lock-out period, for groups that withdraw from participation in the program.

The WPE program is different from the State plan in that Locals have multiple options from which to choose. There are currently four program options. Each program option offers two plans—one fully-insured HMO benefit design and one self-insured PPO benefit design. In total, there are eight plan options—four HMO plans and four PPO plans. Many of these plans were created in response to requests for certain designs; however, there is not much difference in benefit value for three of the programs, with the fourth program being an HDHP. The three non-HDHP programs each have an actuarial value that is at or above the Uniform Benefits design offered to state employees.

Enrollment and Costs

While the WPE program offers more choice in terms of number of plan options, enrollment in the WPE program is currently less than 20% of the state enrollment figure. With 18 vendors and 8 benefit plan options, enrollment is sparse in most plans—particularly in the self-insured plans. WPE enrollment, as of January 2015, is shown below, by vendor. Note that only seven vendors have enrollment of at least 5%, Eighty percent of WPE enrollment is spread across these 7 vendors, with 50% in Unity, alone. These vendors are highlighted in red.

Plan	Number of Contracts	Number of Members	Percent of Contracts
Standard - Dane	1	1	0%
Standard – Milwaukee	6	9	0%
Standard – Waukesha	0	0	0%
Standard - Balance of State	6	7	0%
SMP	24	63	0%
Anthem Northeast	698	1,965	5%
Anthem Southeast	754	2,217	5%

Plan	Number of Contracts	Number of Members	Percent of Contracts
Arise Health Plan	4	11	0%
Arise Aspirus	0	0	0%
Dean Health Plan	1,387	3,479	10%
Dean Prevea 360	0	0	0%
GHC EC	2	6	0%
GHC SC	1,007	2,750	7%
Gundersen Lutheran	421	1,172	3%
HealthPartners	82	241	1%
Health Tradition	832	2,354	6%
Humana Eastern	3	5	0%
Humana Western	0	0	0%
Medical Associates	222	664	2%
Mercycare	558	1,646	4%
Network Northeast	368	991	3%
Network Southeast	0	0	0%
Physicians Plus	244	543	2%
Security	0	0	0%
UnitedHealthcare	313	753	2%
Unity Community	3,531	9,854	25%
Unity UW	2,950	7,877	21%
WEA Trust East	344	924	2%
WEA Trust NW - Chippewa	70	171	1%
WEA Trust NW - Mayo	55	118	0%
WEA Trust Southcentral	0	0	0%
TOTAL	**13,882**	**37,821**	**100%**

To compare costs between the state members and the WPE members, we compared the 2016 premiums. Premiums in the state program are set through the managed competition model, based on a tiering structure. WPE premiums do not go through the same process, as it would be difficult to apply the model to a structure with so few members in each plan. When comparing the WPE rates to the state rates by HMO, the rate differences vary greatly among the vendors. Computing a straight average of both programs produces a WPE rate that is 17.7% higher than the average state rate. However, the higher WPE premiums appear to be in the plans with no or low membership. Computing a weighted average of both, based on enrollment, produces a WPE rate that is 1.5% lower than the average state rate. This indicates that there is no selection issue under the current WPE underwriting process. The 2016 premium rates for WPE and state plans are shown below, with these calculated percentages.

PLAN	Percent Of Contracts	Local 2016 Premiums	State 2016 Premiums	Local % Above/ Below State
State Standard			$1,305	
Local Standard - Dane	0%	$1,130		
Local Standard – Milwaukee	0%	$1,320		
Local Standard – Waukesha	0%	$1,219		
Local Standard - Balance of State	0%	$1,219		
SMP	0%	$811	$808	0.4%
Anthem Northeast	5%	$740	$771	-4.0%
Anthem Southeast	5%	$824	$794	3.8%
Arise Health Plan	0%	$1,088	$773	40.7%
Arise Aspirus	0%	$1,041	$755	37.9%
Dean Health Plan	10%	$737	$629	17.1%
Dean Prevea 360	0%	$713	$686	4.0%
GHC EC	0%	$1,028	$806	27.5%
GHC SC	7%	$684	$641	6.8%
Gundersen Lutheran	3%	$831	$799	4.0%
HealthPartners	1%	$912	$718	27.0%
Health Tradition	6%	$729	$776	-6.0%
Humana Eastern	0%	$1,218	$807	50.9%
Humana Western	0%	$1,273	$862	47.7%
Medical Associates	2%	$689	$688	0.1%
Mercycare	4%	$695	$641	8.5%
Network Northeast	3%	$786	$775	1.4%
Network Southeast	0%	$838	$812	3.2%
Physicians Plus	2%	$715	$680	5.3%
Security	0%	$1,064	$836	27.3%
UnitedHealthcare	2%	$934	$784	19.1%
Unity Community	25%	$679	$769	-11.7%
Unity UW	21%	$620	$681	-9.0%
WEA Trust East	2%	$844	$784	7.7%
WEA Trust NW – Chippewa	1%	$1,069	$823	30.0%
WEA Trust NW – Mayo	0%	$1,069	$823	30.0%
WEA Trust Southcentral	0%	$650	$603	7.8%
Average		**$909**	**$772**	**17.7%**
Weighted Average		**$715**	**$726**	**-1.5%**

Recommendations

Based on the observations noted above, we recommend revising the WPE program to match the state plan, for simplification. This would include the same regional structure with plans in each region and a statewide carrier. This would also include the same benefit design options with benefits based on provider tiers and separate contribution tiers. Pricing would be based on the regions as defined for the state plan. The wellness component may need to be handled differently, based on potential difficulty for local governments to administer the contribution differentials while paying full rates to ETF. However, this may not produce an issue as we have seen states that are able to administer a wellness contribution differential similar to this with a separate local plan, successfully. Tennessee is an example.

We also recommend the WPE program transition to self-insurance for the same reasons we recommend self-insurance for the state plan. A similar phase-in approach would be practical and allow appropriate data to be collected and monitored. This would require a similar reserving structure as recommended for the state. If the plans were combined, the WPE program would have no need for reinsurance and plans could still be rated separately. North Carolina is one example of a state plan that allows local governments to enter the state plan. Experience analysis of that plan shows local participants typically cost less than the state employees, primarily due to age differences.

If the programs cannot be combined into one pool due to statutory limitations, ETF could purchase reinsurance, if desired, with amounts determined based on reserve level and risk tolerance. It could also be structured to buy the insurance from the larger State pool, eliminating the unnecessary profits built into that product.

ACA Update and Strategies

With the implementation of the Patient Protection and Affordable Care Act (ACA) of 2010 well under way, ETF has already been moving into compliance with the various coverage, benefit and reporting mandates and requirements of the Act. This second report provides an update on the next major coming concern – the 40% Excise Tax that will become effective in 2018. We also provide a reminder about another of the key ACA requirements – the Employer Shared Responsibility Penalty.

40% Excise Tax—Update

In Segal's initial study, we reported on the 40% Excise Tax that will be in effect starting in 2018. Our report described how the tax works in general terms prior to issuance of any regulatory guidance. We also provided preliminary calculations of how the Excise Tax could affect ETF's health benefit programs and illustrations of the amount of Excise Tax that might be payable if no changes are made to the program.

The ACA provides that an employer must consider those covered for self-only coverage separately from those covered for other tiers of coverage (such as family coverage, employee plus spouse, etc.). Different threshold values apply based on whether a person is covered for self-only coverage, or another tier of coverage.

Since the initial report in March 2015, the Internal Revenue Service and U.S. Treasury have issued two separate requests for comments from the employer community on various aspects of the 40% Excise Tax and how it should be regulated. Each of these requests for comments included questions relating to how an employer must or should aggregate (or disaggregate) employees or participants for purposes of calculating the Excise Tax. Comments on the initial request (Notice 2015-16) were due by May 15, 2015 and on the second request (Notice 2015-52) by October 1, 2015. As of this writing, IRS has not issued any response to the comments.

While these calculation methods will likely end up very complicated and conditional, they are nevertheless important for ETF to monitor, since the flexibility that may be granted to aggregate or disaggregate groups may make the difference between owing the Excise Tax or not.

Impact of Medical Flexible Spending Account and Other Plans

The Excise Tax must take into account not only the primary health benefit plan (medical and prescription drug), but also other health benefit programs offered by the employer. Such plans include dental and vision plans that are part of the medical benefit, Health Flexible Spending Accounts (FSAs) under a cafeteria plan, Health Reimbursement Arrangements (HRAs) Health Savings Accounts (HSAs), Archer Medical Savings Accounts (MSAs), and onsite medical clinics.

As illustrated in our original report, the largest single variable in the Excise Tax calculation for ETF will likely be the availability of employee salary reductions through a Health Flexible Spending Account (FSA) under a cafeteria plan. Having the ability for an employee to reduce pay by up to $2,550 per year can immediately create an Excise Tax situation for the plan.

The IRS and Treasury requests for comments also included questions and preliminary positions on whether other types of health benefit plans should be included in the Excise Tax threshold calculation and the appropriate cost basis. For example:

- Dental and vision benefits that are under a separate contract from the medical plan or that a participant can decline would be excluded from the calculation.
- Health Flexible Spending Accounts (FSA) would be counted and would include the amount of the employee's salary reduction plus any employer reimbursement in excess of the salary reduction amount.
- Archer Medical Savings Accounts (MSAs) and Health Savings Accounts (HSAs) would include only employer contributions, not after-tax employee contributions.
- Health Reimbursement Arrangements (HRAs) would be counted and include the applicable premium for health coverage provided through the HRA.
- Employee Assistance Programs (EAPs) might be deemed by the IRS to be an excepted benefit and would be excluded from the calculation, provided they met all four of the following requirements:
  - Not provide significant medical care benefits
  - Not be coordinated with benefits under another group health plan or contingent upon participation in another group health plan
  - Not require participant premiums or contributions to participate in the EAP
  - Not have cost sharing
- On-site medical clinics would generally be included in the cost of health coverage, although IRS is considering excluding on-site clinics that offer only *de minimis* medical care, such as first aid, immunizations, allergy shots, pain relievers, or treatment of workplace accidents. There are also questions about how the cost for on-site medical clinics would be established and allocated across the covered participants.

Other programs would need to be reviewed by legal counsel to determine whether they must be included in the Excise Tax calculation. For example, there is no federal guidance yet on whether an Opt-Out program that pays cash or alternate benefit credits under a cafeteria plan would have to be counted as a health plan. ETF should monitor the regulatory process closely as guidance is forthcoming.

Significant questions are also under consideration about which employees and retirees actually qualify for the higher thresholds for high-risk professions and retirees. While the State will have some employees that work in high-risk positions (law enforcement officers, fire protection employees, emergency medical technicians, paramedics, first responders, etc.), there is as yet no guidance regarding the additional requirement that the majority of employees covered by the plan be in high-risk positions to qualify for the higher thresholds.

The IRS and Treasury Notices have been clear that the cost of coverage would be determined under rules similar to calculating COBRA premiums for continuation of coverage. Also, the

calculation must be made based on the plan in which the employee is enrolled, not coverage offered to the employee in which they do not enroll. This differs from the new health plan and employer reporting under Sections 6055 and 6056 of the Internal Revenue Code, where the employer must report the lowest value plan offered to the employee, whether that employee enrolled in that plan or not. We anticipate considerable confusion among employers as these filing and Excise Tax calculation processes move into full operation.

Who Calculates? Who Files? Who Pays?

The 40% Excise Tax is to be paid by the "coverage provider". For an insured plan (such as ETF's current insured health plans) the insurer would be the coverage provider. For a self-insured group health plan, Health FSA or HRA, the coverage provider is the "Plan Administrator", which in many cases will be the Plan or the employer. For other self-insured benefits, the coverage provider is the person that administers the benefits. The IRS/Treasury have sought input on how to define "coverage provider", recognizing that, like the State, many employers will have multiple plans cutting across all different types, so there could be multiple parties responsible for paying the tax.

Also, a big area of concern raised by the IRS and Treasury is how to calculate the Excise Tax values when an employee has self-only coverage for one plan, but other than self-only coverage in another plan. For example, if the employee has self-only coverage for the medical plan (because his or her spouse is covered under another employer's plan), but also has family coverage under an includable dental plan. Again, there is no guidance published yet and whatever guidance is published will likely be highly complex.

To calculate the Excise Tax values, the employer must combine the cost of the different included benefits and calculate the amount of the excess benefit over the applicable statutory threshold. The employer then must determine the pro rata share of the excess benefit attributable to each "coverage provider" and report the taxable excess benefit share to each coverage provider and to the IRS. If the employer or plan sponsor does not accurately perform the required calculations, the coverage provider must pay any additional tax due, but the employer is subject to a penalty of 100% of the amount of the additional tax, plus interest based on the IRS underpayment of taxes rates.

ETF Strategy Recommendations

While the Excise Tax will not be applicable until 2018, there will be considerable work to be accomplished by that date and we recommend that ETF start now. Major decisions will need to made on a variety of key issues, including, for example:

- Which plans must be counted and which can be excluded;
- How to aggregate or disaggregate participants counted under each plan to minimize the possibility of hitting the Excise Tax thresholds;
- Identification of the appropriate coverage provider for each plan or contract and determination of that provider's role in the process – what data is needed, etc.;

- Negotiation across organizational lines within the State as to which entity does which calculations, particularly where plans may be administered by different agencies;

- Establishing how the cost for each plan will be determined and setting up processes to support that determination on an annual basis;

- Determining how to allocate any excess cost across the various health plans, administrators or the State as the Plan Administrator; and/or

- Setting up the reporting process for coverage providers and the IRS.

We recommend that ETF initiate the process by establishing a working group composed of representatives from any State agency that may sponsor or administer a plan that might be covered, along with legal counsel and actuarial firm representation for cost calculation methodology. After an initial survey of plans, that group could become the core for coordinating the data flow and calculations necessary to the annual process.

We also remind the Board that as long as health benefit cost trends continue at a higher rate than general inflation, at some point every health plan will hit the Excise Tax threshold. ETF should continue to monitor the projections of cost carefully and take progressive steps to reduce the total cost of the program and hold it below the tax threshold. This process will require ETF to manage the cost of the program in a corridor between the floor of mandates, plan coverage and employer subsidy requirements and the ceiling of the Excise Tax thresholds.

As of this writing, there are four bills pending in Congress that would change or repeal the 40% Excise Tax. Changes among these bills would include delaying the effective date for two to five years, increasing the statutory thresholds, pegging the tax to be triggered at the 90% or 85% actuarial value level, exempting retiree-only plans, allowing geographic adjustments to the thresholds, improving adjustments for age/gender, exempting various plans (such as FSAs, HSAs or HRAs) from the calculation, and providing broader language to cover more workers as high-risk positions. Under the Congress' own rules, any changes involving reduction of revenue would need to have offsetting provisions to increase revenue, so the way forward for any changes will be complicated. ETF should continue to monitor these potential changes as they may have a significant effect on future plan design and maximum benefit limitations.

ETF Excise Tax Exposure

In our prior report, we estimated the following potential Excise Tax assessments:

ETF PROJECTED EXCISE TAX
($ Millions)

Year	Tax with 4% Trend	Tax with 6% Trend
2018	$7	$13
2019	$7	$20
2020	$8	$31
2021	$11	$43
2022	$14	$58
2023	$17	$76
2024	$21	$99
2025	$26	$127
2026	$32	$158
2027	$39	$193

The health plan negotiations, along with some benefit changes for 2016 improved ETF's Excise Tax exposure:

ETF PROJECTED EXCISE TAX – UPDATED FOR 2016 PREMIUMS
($ Millions)

Year	Tax with 4% Trend	Tax with 6% Trend
2018	$3	$5
2019	$4	$7
2020	$4	$11
2021	$5	$17
2022	$6	$28
2023	$7	$40
2024	$9	$55
2025	$11	$71
2026	$14	$93
2027	$18	$118

Implementing the full array of recommendations presented in this report will further mitigate the Excise Tax exposure. Please see the Executive Summary.

Shared Responsibility Penalty

Under the ACA, employers must provide minimum essential health benefit coverage to at least 95% their full-time employees and subsidize that coverage at the minimum required employer contribution level of 60% of the cost, or face a Shared Responsibility Penalty. Employees working 30 hours per week or equivalent are considered full-time employees for ACA purposes.

ETF has not had difficulty meeting these requirements as they have phased in because state employees working at least 1,040 hours per year are eligible to participate in the health plan at the full subsidy levels. That level roughly equates to 20 hours per week, which is well below the minimum requirement to cover employees working 30 hours per week.

Recommendations for Shared Responsibility Penalty Management

We recommend that ETF continue discussions with the Department of Administration Division of Personnel Management to ensure there are no groups of employees hired by any agency that would be excluded from the eligibility for the plan even if working more than the equivalent of 30 hours per week. Diligence is needed to check all persons receiving a W-2 from the State to avoid missing pockets of employees that might be considered full-time. We have worked with state health plans where their penalty situation was triggered by numbers of rehired annuitants, short-term employees who keep working, part-time employees with two or three part-time job positions with the same employer, or specifically excluded groups like Adjunct Professors or Teaching Assistants at the university.

In addition, for local participating government entities where ETF does not have control over employment policies, there may be employees working well over the 30 hour ACA rule that are excluded from coverage because they are not considered permanent employees or budgeted employees and that are never reported to ETF. We recommend that ETF initiate and maintain a dialogue with participating local governments to help understand whether there are such groups of employees. While the Shared Responsibility Penalty for those groups would generally fall on employer, the Plan will need to know about those non-covered groups and individuals and help the local employers take appropriate steps to deal with them.

Appendices

1. Performance Metrics
2. Sample—Medical Management and Wellness Health Plan
3. Sample—Goal for Plan Year 2016 Premium Incentive Discount
4. Plan Regional Analysis
5. Network Participation by Hospital

Appendix 1: Performance Metrics

Shared savings will be based on the 100 point performance metric scale. Each metric has a target goal based on NCQA guidelines. The vendor's baseline for each metric will be determined by self-reported 2015 data. Carriers will achieve points based on increases in these metrics for 2016, 2017, 2018, 2019, and 2020. Need to address if baseline is higher than target for any year, should the incentive be for improving on baseline data? Each vendor will be required to reach the compliance level each year beginning 2016. The target levels and available points are as follows:

Clinical Compliance Metric	Available Points	Target Level	Compliance (Percent of Target)				
			2016	2017	2018	2019	2020
			50%	65%	80%	90%	100%
Diabetes							
Patient(s) that had 1 Hb A1c tests in last 12 reported month	3	90%	45%	59%	72%	81%	90%
Increase participants with HbA1c tests of < 8.0% (target < 7.0%)	6	75%	38%	49%	60%	68%	75%
Patient(s) that had an annual screening test for diabetic nephropathy.	3	80%	40%	52%	64%	72%	80%
Increase percentage of participants with BP control of <140/90	5	75%	38%	49%	60%	68%	75%
Increase the percentage of participants with HbA1c < 9%	5	90%	45%	59%	72%	81%	90%
Hypertension							
Patient(s) on anti-hypertensives that had a serum potassium in last 12 reported months.	6	80%	40%	52%	64%	72%	80%
Patient(s) that had a serum creatinine in last 12 reported months.	6	80%	40%	52%	64%	72%	80%
Increase percentage of participants with BP control of <140/90	10	70%	35%	46%	56%	63%	70%
Hyperlipidemia							
Patient(s) with a LDL/HDL cholesterol test in last 12 reported months.	6	85%	43%	55%	68%	77%	85%
Patient(s) with a triglyceride test in the last 12 reported months.	6	85%	43%	55%	68%	77%	85%
Increase the percentage of participants with cholesterol level below the high range	10	70%	35%	46%	56%	63%	70%

Clinical Compliance Metric	Available Points	Target Level	Compliance (Percent of Target)				
			2016	2017	2018	2019	2020
			50%	65%	80%	90%	100%
Preventive Screening							
Increase percentage of women age 40-69 who have had at least 1 mammogram in last 24 months to screen for breast cancer	3	75%	38%	49%	60%	68%	75%
Increase percentage of participants age 50-75 who have had appropriate colorectal cancer screening	3	75%	38%	49%	60%	68%	75%
% of population with attestation of HRA discussion with PCP	6	100%	50%	65%	80%	90%	100%
Utilization Rates							
Increase the number of participants with major cardiac events, COPD, asthma, or congested heart failure that do not require readmission within 6 months of discharge.	11	80%	40%	52%	64%	72%	80%
Increase the percentage of participants with asthma/COPD and diabetes that do not have a disease related ER visit	11	90%	45%	59%	72%	81%	90%

Appendix 2: Sample - Medical Management and Wellness Health Plan

SAMPLE

Sample—Medical Management and Wellness Health Plan
Healthy Activity Requirements

All Employees & Covered Spouses	Additional Requirements for Participants with a Chronic Condition & Eligible for the Disease Management Program
1/1/2016 – 7/1/2016: Health Activity Requirements – Surcharge Applies for 2017 Plan Year	
• Complete the online Personal Health Assessment, give a copy to your physician and discuss results with your PCP • Designate a Primary Care Physician • Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program	
7/1/2016 – 6/30/2017: Health Activity Requirements – Surcharge Applies for 2018 Plan Year	
• Complete all recommended age/gender specific biometric screenings & discuss with your PCP	• Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program
• Complete the online Personal Health Assessment, give copy to your PCP & discuss findings with your PCP	• Set a health related goal with your personal nurse advisor that will be helpful in better managing your chronic condition
• Complete a Nutrition Education, Weight Management, or other health related educational program sponsored by your health plan	• Complete all chronic condition related medical testing and follow medical guidelines prescribed by the treating physician
7/1/2017 – 6/30/2018: Healthy Activity Requirements – Surcharge Applies for 2019 Plan Year	
• Complete all recommended age/gender specific biometric screening & discuss with your PCP	• Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program
• Complete the online Personal Health Assessment (PHA), including your current blood pressure, BMI, cholesterol levels and take a copy of the PHA to your physician & discuss results with your PCP	• Set a health related goal with your personal nurse advisor that will be helpful in better managing your chronic condition
• Document the achievement of a personal health improvement goal in consultation with your PCP through your health plan's health tracker	• Complete all chronic condition related medical testing and follow medical guidelines prescribed by the treating physician in consultation with your D/M care manager

Note: Participants with a chronic condition who are notified as eligible for the disease management program before July 1 of 2016 must meet the disease mangement related healthy activities requirements to be eligible for the rewards and avoid the penalty for 2017

Segal Consulting 1

Sample—Medical Management and Wellness Plan *continued*
Healthy Activity Requirements

All Employees & Covered Spouses	Additional Requirements for Participants with a Chronic Condition & Eligible for the Disease Management Program
7/1/2018 – 6/30/2019: Health Activity Requirements – Surcharge Applies for the 2020 Plan Year	
• Complete all recommended age/gender specific biometric screening & complete a physical exam showing blood pressure, and cholesterol in the normal range, & discuss with your PCP. Document testing results in your health plan's online Personal Health Assessment (PHA)	• Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program
• Complete a Nutrition Education, Weight Management, or other health education program sponsored by your health plan (i.e. online or class setting)	• Set a health related goal with your personal nurse advisor that will be helpful in better managing your chronic condition
• Document the achievement of a personal health improvement goal in consultation with your PCP through your health plan's health tracker	• Complete all chronic condition related medical testing and follow medical guidelines prescribed by the treating physician
7/1/2019 – 6/30/2020: Healthy Activity Requirements – Surcharge Applies for the 2021 Plan Year	
• Complete a Nutrition Education, Weight Management, or health education program sponsored by your health plan (i.e. online or class setting)	• Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program
• Complete all recommended age/gender specific biometric screening, maintain blood pressure and cholesterol in the normal ranges, & discuss with your PCP	• Set a health related goal with your personal nurse advisor that will be helpful in better managing your chronic condition
• Complete all recommended age/gender specific biometric screening, maintain blood pressure and cholesterol in the normal ranges, & discuss with your PCP	• Complete all chronic condition related medical testing and follow medical guidelines prescribed by the treating physician
• Document the achievement of a personal health improvement goal in consultation with your PCP through your health plan's health tracker	
7/1/2020 – 6/30/2021: Healthy Activity Requirements – Surcharge Applies for the 2022 Plan Year	
• Complete all recommended age/gender specific biometric screening, maintain blood pressure and cholesterol in the normal ranges, & discuss with your PCP	• Actively participate in the disease management (D/M) program & follow disease management call-in & treatment guidelines of the care manager, or complete/graduate from the D/M program
• Document the achievement of a personal health improvement goal in consultation with your PCP through your health plan's health tracker	• Set a health related goal with your personal nurse advisor that will be helpful in better managing your chronic condition
• Complete the online Personal Health Assessment (PHA), including your current blood pressure, BMI, cholesterol levels and take a copy of the PHA to your physician & discuss results with your PCP	• Complete all chronic condition related medical testing and follow medical guidelines prescribed by the treating physician

Segal Consulting 2

Sample—Medical Management and Wellness Plan *continued*
Requirements for Tobacco users

Employees who are Tobacco Users*
7/1/2015 – 6/30/2016 (Year 1): Healthy Activity Requirements – Surcharge Applies for the 2017 Plan Year
• Participate in a Tobacco Cessation program sponsored by your health plan (i.e. online or class setting)
• Complete a Nutrition Education or Weight Management program sponsored by your health plan (i.e. online or class setting)
• In consultation with your PCP and Tobacco Cessation coach, develop a plan to achieve the goal to reduce your tobacco use by 25%
7/1/2016 – 6/30/2017 (Year 2): Healthy Activity Requirements – Surcharge Applies for the 2018 Plan Year
• Participate in a Tobacco Cessation program sponsored by your health plan (i.e. online or class setting)
• Complete a Nutrition Education or Weight Management program sponsored by your health plan (i.e. online or class setting)
• In consultation with your PCP, achieve the goal to reduce your tobacco use by 25%
7/1 – 6/30 (Year 3+) Going Forward: Healthy Activity Requirements – Surcharge Applies Next Year
• Stop the use of tobacco products
• Provide an alternative tobacco cessation approach as documented by physician

Note: Participants will be required to attest to not using tobacco to avoid having to complete the additional healthy activity requirements related to tobacco use

* New employees must complete the healthy activities during the following qualification period beginning with Year 1 requirements and going forward.

Sample—Qualification Period Explained *continued*

Enrolled in Plan on January 1st 2016

All Employees & Covered Spouses

- Must complete designated healthy activities in Qualification Period beginning January 1, 2016 through June 30, 2016
- $50 monthly premium surcharge in 2017 for non-compliance
- Surcharge increase in 2018 to $75 and 2019+ to $100
- Must complete designated healthy activities in Qualification Period 2016 to avoid $50 surcharge in 2017 for non-compliance

Join During Calendar Plan Year 2016

All Employees & Covered Spouses:

- Requirement of healthy activities begins the following Qualification Period of July 1, 2017 to June 30, 2017
- Surcharge not applicable in 2017
- Eligible for higher surcharge beginning 2018

Identified for Disease Management:

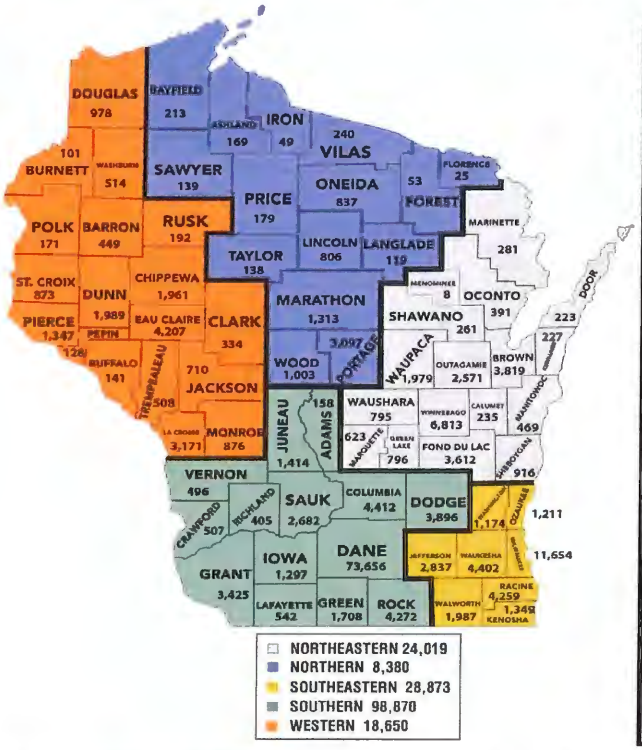
- Those identified through carrier outreach are subject to healthy activity requirements during following Qualification Period
- Ex. Join in October 2016; surcharge not applicable in 2018. Participate in Qualification Period beginning July 1, 2017; surcharge in 2019

Appendix 3: Sample - Premium Incentive Discount Using Points Based Activities

Earning Period: November 16, 2014 – November 15, 2015 **Goal for Plan Year 2016 Premium Incentive Discount:** **1) Complete the Health Assessment Questionnaire (worth 10 credits) AND** **2) Earn 20 additional credits for a total of 30 credits by November 15, 2015**	**Credit Value**	**Credit Max**
Health Assessment Questionnaire - REQUIRED (online/paper)	10	10
Lifestyle Coaching - 6 interactions + Survey (telephonic, email)	10	10
Tobacco Cessation Program Completion (telephonic)	10	10
Condition Management - Enrollment + 3 calls (telephonic)	10	10
Health Advisor Call (telephonic)	5	5
Virtual Coaching (online)	5	15
Non-Tobacco User Declaration (online)	5	5
Wellness Challenges (online)	5	20
Preventive Exam - Well Woman/Well Man (in-person/self-reported)	5	5
Preventive Exams - 2 Dental/Year (in-person/self-reported)	5	10
Preventive Exam - 1 Vision/Year (in-person/self-reported)	5	5
Agency Training Classes (in-person/self-reported)	3	6
Agency Wellness Programs (in-person/self-reported)	5	10
Monthly Seminars (online)	1	3
Conversations (online)	1	3
Health & Fitness Activities (in-person, online, telephonic/self-reported)	1	3
Blood Pressure Less Than 120/80	2	2
Total Cholesterol Less Than 200	2	2
Glucose Less Than 100	2	2
Kansas Financial Learning Center Modules	1	5
Register for Castlight Health	3	3
Castlight Health - Complete Quiz and Video	2	2
EAP Webinars (telephonic)	1	3
Total Credits Possible = 149		
Total Credits Required = 30		

Appendix 4: Plan Regional Analysis

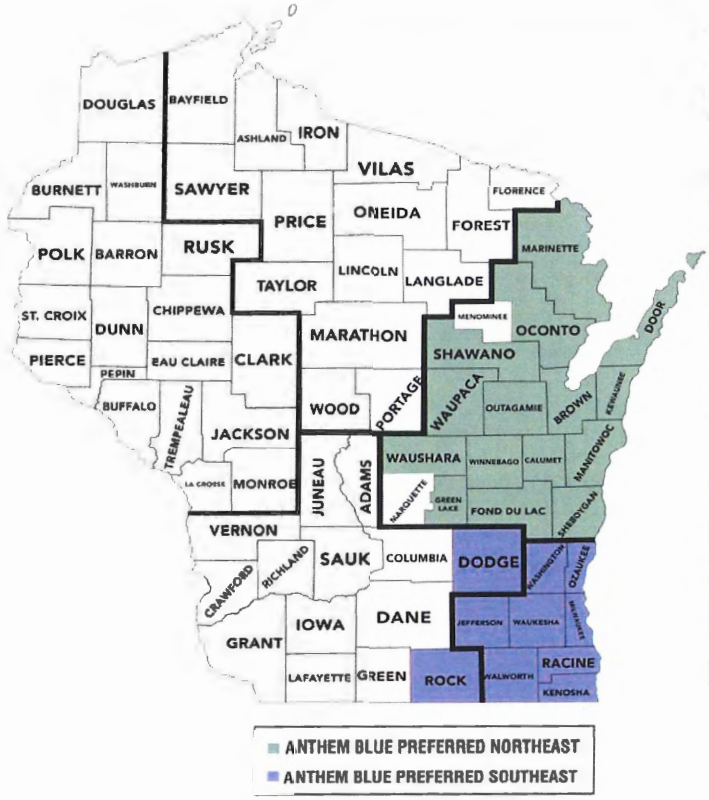
Wisconsin ETF Membership By Region



Top 5 Plans By Region	
Northeastern	
Network Health	8,615
UHC Northeast	5,761
WEA Trust East	4,901
Arise	1,586
Dean Health	1,331
Northern	
Security Health	6,209
WEA Trust East	1,438
GHC EC	227
Arise	156
WEA Trust NW Chippewa	134
Southeastern	
Humana Eastern	8,988
WEA Trust East	8,422
UHC Northeast	4,264
Anthem Southeast	2,872
Dean Health	2,818
Southern	
Dean Health	35,573
Unity (Dane)	35,043
Physician Plus	10,730
GHC SCW	9,632
Unity Community	2,528
Western	
WEA Trust NW Mayo	5,250
WEA Trust NW Chippewa	3,684
Gunderson Health	2,958
Health Tradition	1,964
HealthPartners	1,783

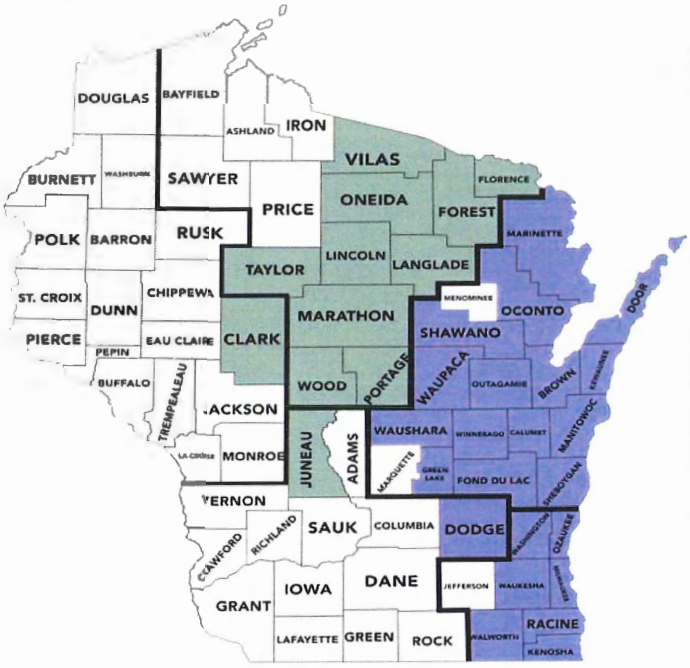
Discounts	Northeastern	Northern	Southeastern	Southern	Western	Statewide
IP	31.0%	19.2%	35.4%	45.5%	18.5%	38.2%
OP	41.9%	26.9%	43.9%	44.8%	18.7%	41.5%
Prof	45.9%	33.9%	48.9%	50.3%	26.9%	45.8%
Total	40.9%	28.8%	44.0%	46.0%	22.8%	41.7%

ANTHEM BLUE PREFERRED



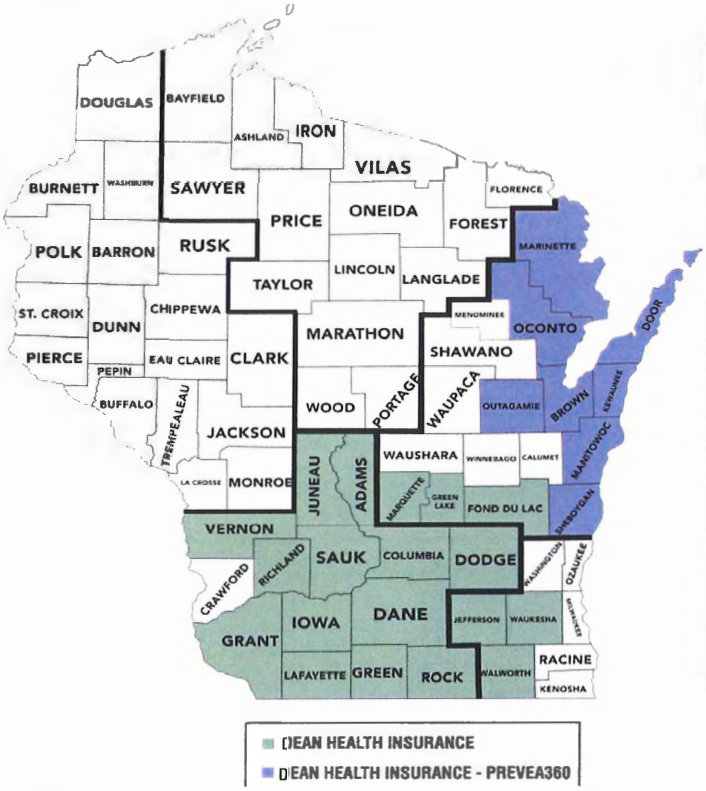
Members	
By Plan:	
Northeast	379
Southeast	2,955
Total	3,334
By Region:	
Northeastern	388
Northern	2
Southeastern	2,877
Southern	65
Western	2
Total	3,334
Top 5 Counties	
Southeast	
Milwaukee	1,497
Waukesha	478
Racine	394
Kenosha	154
Washington	133
Northeast	
Winnebago	88
Brown	82
Outagamie	38
Waupaca	32
Fond Du Lac	29

ARISE HEALTH PLAN



Members	
By Plan:	
Arise	1,753
Arise SE	16
Total	1,769
By Region:	
Northeastern	1,586
Northern	156
Southeastern	22
Southern	4
Western	1
Total	1,769
Top 5 Counties	
Arise	
Brown	858
Outagamie	120
Oconto	107
Manitowoc	102
Marinette	100

DEAN HEALTH INSURANCE



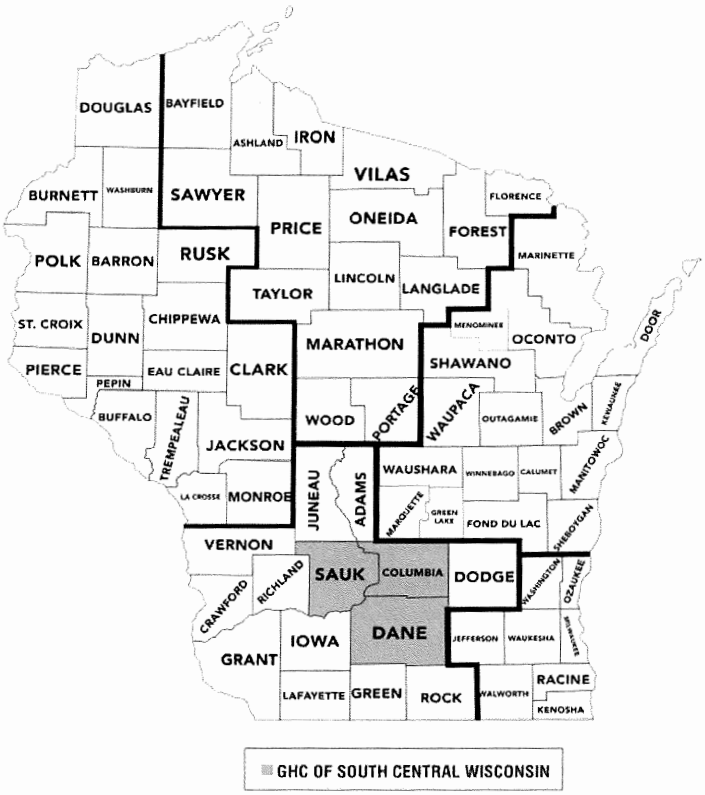
Members	
By Plan:	
Dean	39,799
Prevea360	99
Total	39,898
By Region:	
Northeastern	1,427
Northern	37
Southeastern	2,818
Southern	35,573
Western	43
Total	39,898
Top 5 Counties	
Dean	
Dane	22,484
Dodge	2,495
Columbia	2,413
Rock	2,380
Grant	1,814
Prevea360	
Brown	70
Kewaunee	8
Oconto	6
Sheboygan	6
Ashland	3

GHC OF EAU CLAIRE



Members	
By Plan:	
GHC of EC	913
Total	913
By Region:	
Northeastern	1
Northern	227
Southeastern	-
Southern	-
Western	685
Total	913
Top 5 Counties	
GHC of EC	
Douglas	586
Bayfield	108
Washburn	80
Ashland	76
Sawyer	31

GHC OF SOUTH CENTRAL WISCONSIN



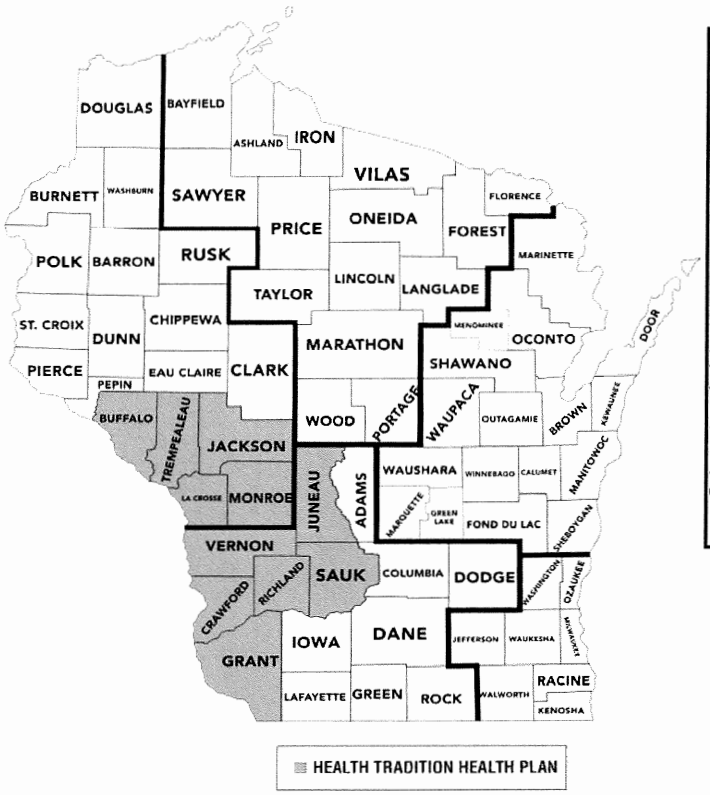
Members	
By Plan:	
GHC of SCW	9,781
Total	9,781
By Region:	
Northeastern	25
Northern	10
Southeastern	107
Southern	9,632
Western	7
Total	9,781
Top 5 Counties GHC of SCW	
Dane	9,060
Columbia	208
Rock	122
Green	103
Jefferson	71

GUNDERSEN HEALTH PLAN



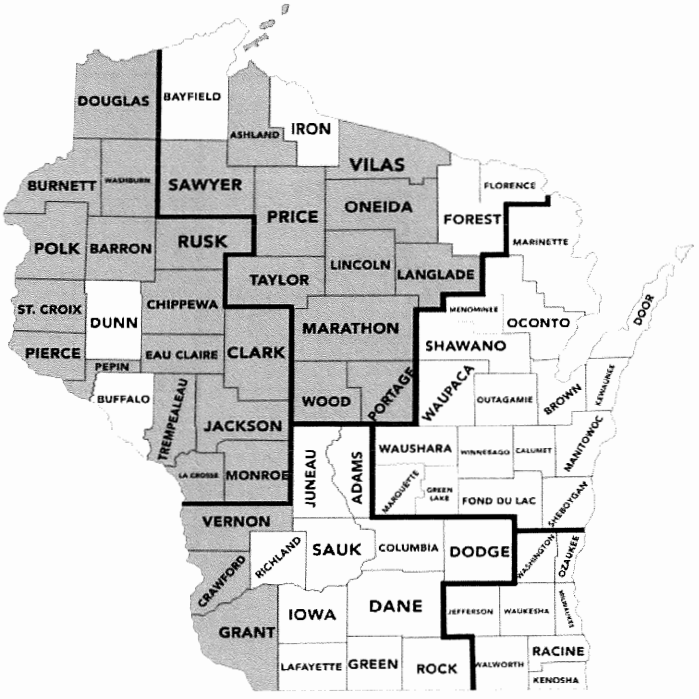
Members	
By Plan:	
Gundersen	4,244
Total	4,244
By Region:	
Northeastern	4
Northern	1
Southeastern	-
Southern	1,281
Western	2,958
Total	4,244
Top 5 Counties Gundersen	
La Crosse	2,005
Juneau	429
Monroe	409
Vernon	343
Crawford	281

HEALTH TRADITION HEALTH PLAN



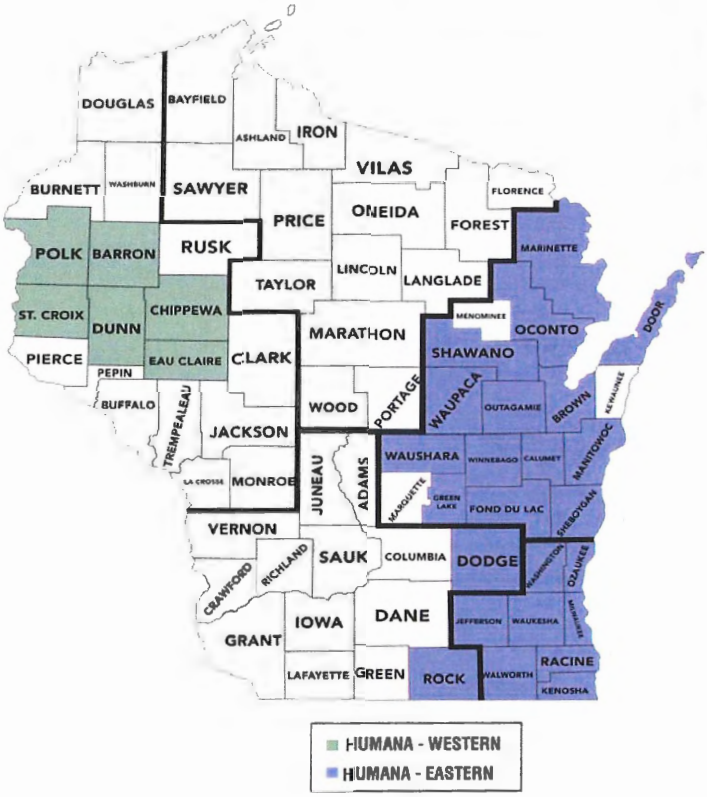
Members	
By Plan:	
Health Tradition	2,716
Total	2,716
By Region:	
Northeastern	3
Northern	-
Southeastern	-
Southern	749
Western	1,964
Total	2,716
Top 5 Counties Health Tradition	
La Crosse	1,140
Juneau	448
Monroe	435
Jackson	290
Crawford	135

HEALTHPARTNERS HEALTH PLAN



Members	
By Plan:	
Healthpartners	1,845
Total	1,845
By Region:	
Northeastern	1
Northern	55
Southeastern	4
Southern	2
Western	1,783
Total	1,845
Top 5 Counties Healthpartners	
Pierce	884
ST. Croix	504
Douglas	94
Polk	94
Eau Claire	55

HUMANA



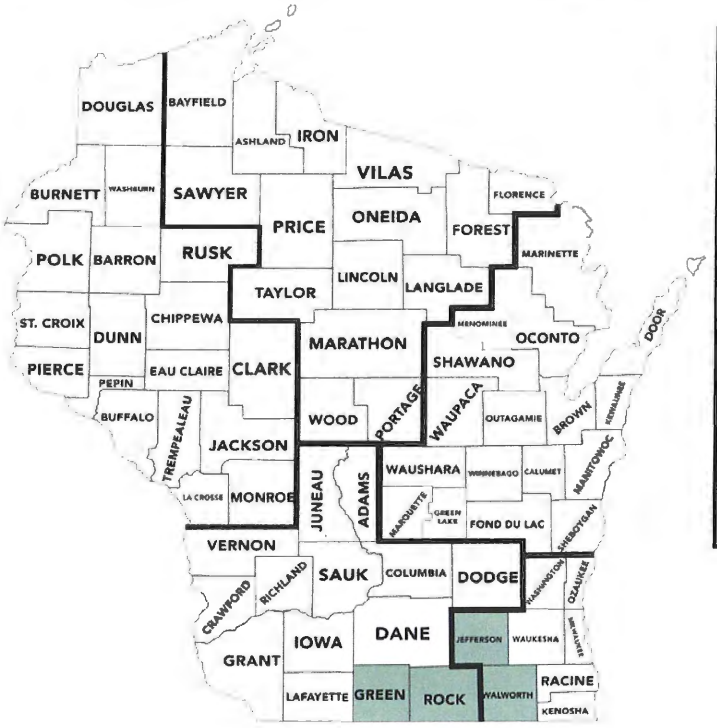
Members	
By Plan:	
East	9,916
West	722
Total	10,638
By Region:	
Northeastern	807
Northern	4
Southeastern	8,988
Southern	112
Western	727
Total	10,638
Top 5 Counties	
East	
Milwaukee	3,974
Racine	1,688
Waukesha	1,543
Ozaukee	545
Kenosha	498
West	
Eau Claire	182
Pierce	163
Dunn	143
ST. Croix	90
Chippewa	80

MEDICAL ASSOCIATES HEALTH PLANS



Members	
By Plan:	
Med Associates	1,066
Total	1,066
By Region:	
Northeastern	-
Northern	-
Southeastern	-
Southern	1,066
Western	-
Total	1,066
Top 5 Counties	
Med Associates	
Grant	969
Lafayette	57
Crawford	24
Iowa	12
Dane	4

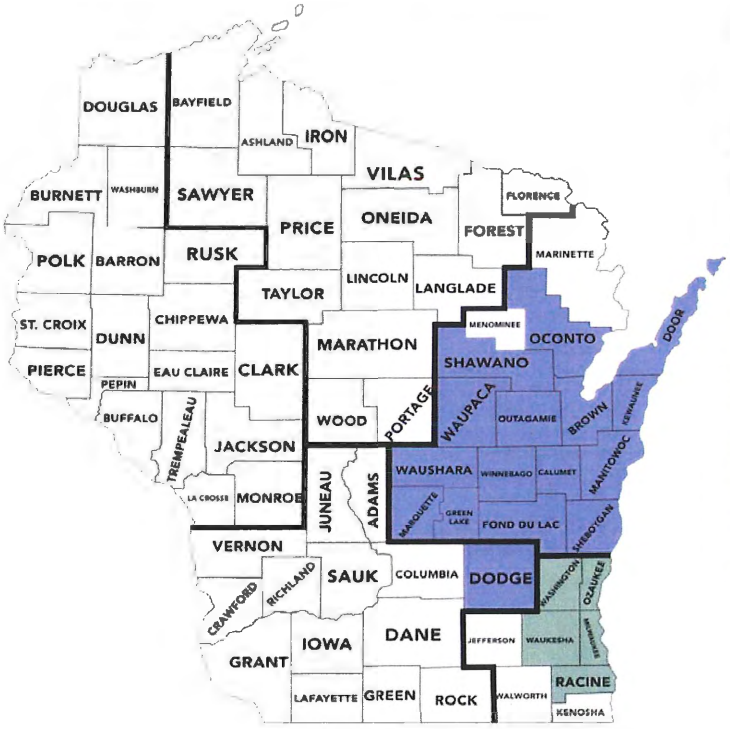
MERCYCARE HEALTH PLANS



MERCYCARE HEALTH PLANS

Members	
By Plan:	
MercyCare	1,141
Total	1,141
By Region:	
Northeastern	-
Northern	-
Southeastern	402
Southern	739
Western	-
Total	1,141
Top 5 Counties	
MercyCare	
Rock	690
Walworth	284
Jefferson	108
Green	23
Dane	14

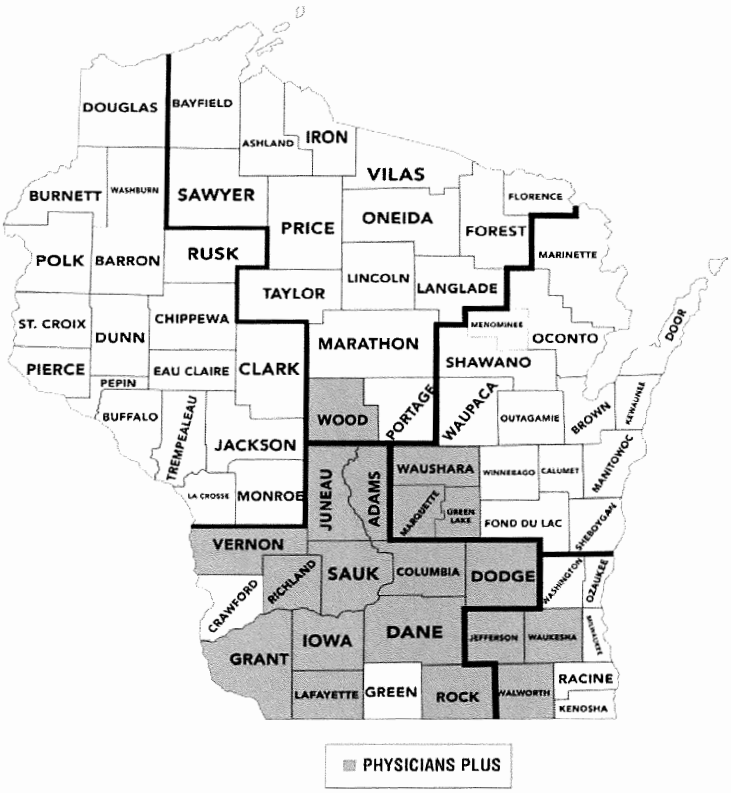
NETWORK HEALTH



NETWORK HEALTH SOUTHEAST
NETWORK HEALTH NORTHEAST

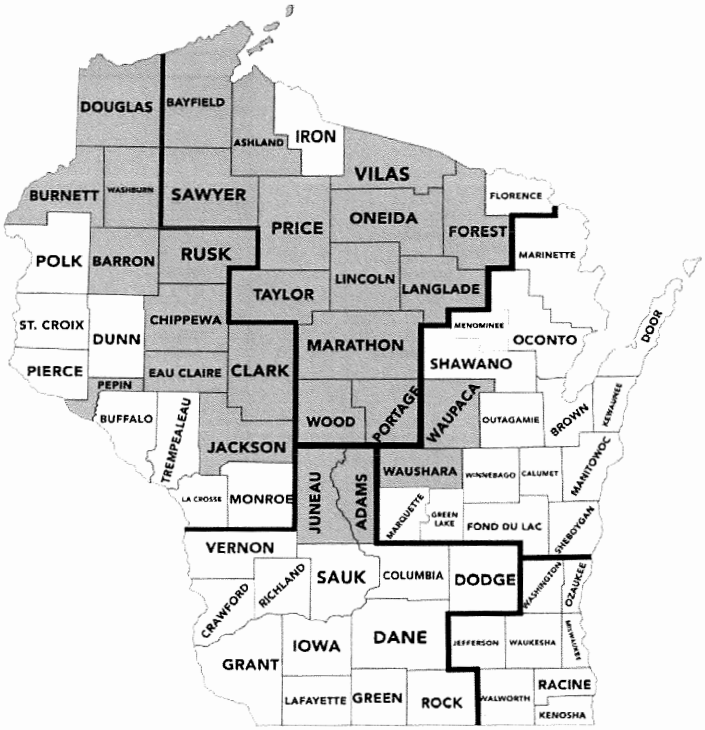
Members	
By Plan:	
Network	8,906
Total	8,906
By Region:	
Northeastern	8,615
Northern	23
Southeastern	20
Southern	243
Western	5
Total	8,906
Top 5 Counties	
Network	
Winnebago	3,693
Fond Du Lac	1,550
Outagamie	1,256
Waupaca	634
Waushara	433

PHYSICIANS PLUS



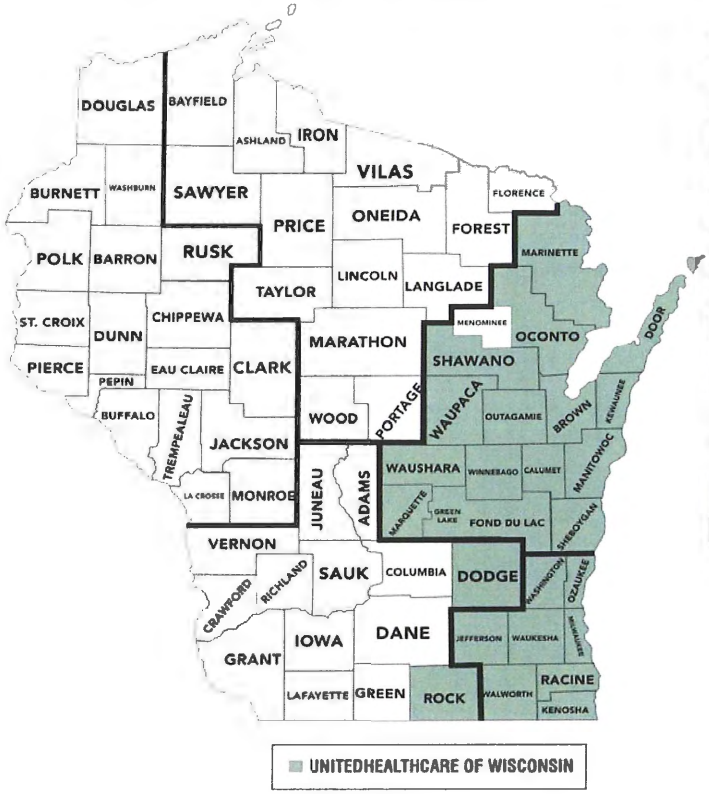
Members	
By Plan:	
Physicians Plus	10,996
Total	10,996
By Region:	
Northeastern	95
Northern	12
Southeastern	151
Southern	10,730
Western	8
Total	10,996
Top 5 Counties Physicians Plus	
Dane	9,134
Columbia	665
Sauk	261
Rock	166
Green	149

SECURITY HEALTH PLAN



Members	
By Plan:	
Security	8,020
Total	8,020
By Region:	
Northeastern	221
Northern	6,209
Southeastern	7
Southern	87
Western	1,496
Total	8,020
Top 5 Counties Security	
Portage	2,166
Marathon	1,031
Oneida	791
Wood	749
Lincoln	674

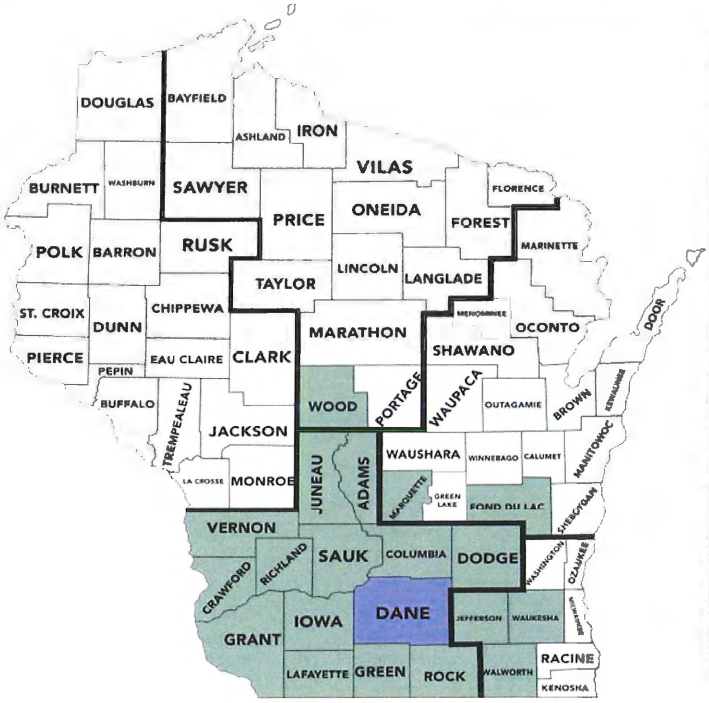
UNITEDHEALTHCARE OF WISCONSIN



UNITEDHEALTHCARE OF WISCONSIN

Members	
By Plan:	
UHC	10,158
Total	10,158
By Region	
Northeastern	5,761
Northern	41
Southeastern	4,264
Southern	92
Western	-
Total	10,158
Top 5 Counties	
UHC	
Milwaukee	2,116
Winnebago	1,954
Brown	1,415
Waukesha	768
Outagamie	736

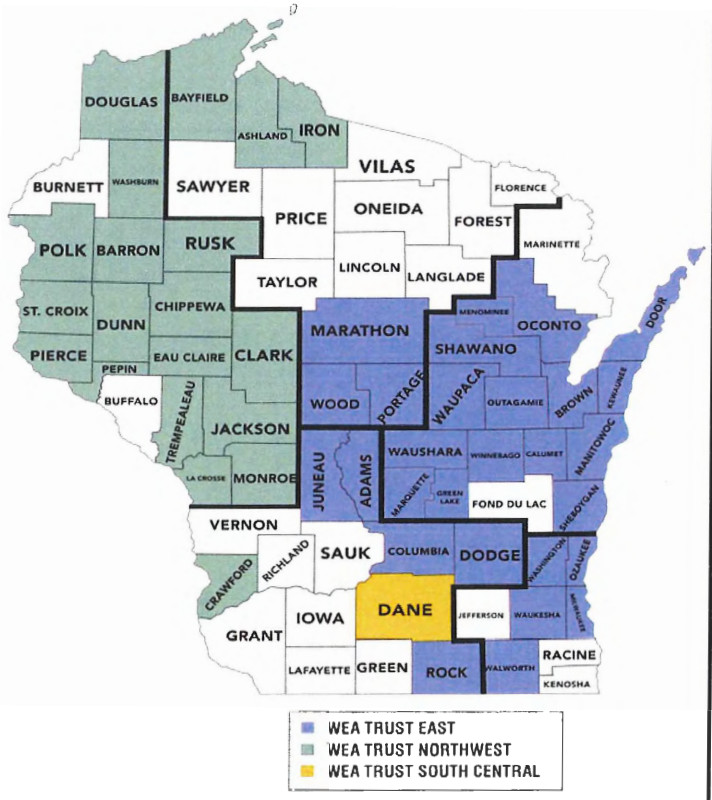
UNITY HEALTH INSURANCE



Members	
By Plan:	
UW Health	35,465
Community	3,120
Total	38,585
By Region:	
Northeastern	182
Northern	23
Southeastern	781
Southern	37,571
Western	28
Total	38,585
Top 5 Counties	
UW Health	
Dane	32,676
Columbia	747
Green	514
Rock	432
Sauk	286
Community	
Sauk	403
Grant	385
Jefferson	329
Dodge	308
Columbia	299

UNITY HEALTH INSURANCE - COMMUNITY
UNITY HEALTH INSURANCE - UW HEALTH

WEA TRUST



Other Specifics

Members	
By Plan:	
East	15,612
NW Chippewa	3,819
NW Mayo	5,263
South Central	88
Total	24,782
By Region:	
Northeastern	4,903
Northern	1,580
Southeastern	8,432
Southern	924
Western	8,943
Total	24,782
Top 5 Counties	
East	
Milwaukee	3,972
Racine	1,499
Waukesha	1,274
Brown	965
Winnebago	860
NW Chippewa	
Eau Claire	1,142
Chippewa	865
Pierce	254
Washburn	247
ST. Croix	218
NW Mayo	
Eau Claire	2,396
Dunn	1,643
Chippewa	591
Trempealeau	194
Barron	104
South Central	
Dane	67
Rock	10
Walworth	8

Appendix 5: Network Participation by Hospital

	Provider Name	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Southern	UW Hospital and Clinics	◆	◆	◆						◆	
	Meriter Hospital		◆					◆		◆	
	St. Mary's Hospital		◆		◆						◆
	Beaver Dam Community Hospitals		◆		◆			◆	◆	◆	
	Divine Savior Healthcare		◆		◆	◆		◆		◆	
	Mile Bluff Medical Center		◆				◆				
	Watertown Regional Medical Center	◆	◆		◆			◆		◆	
	Stoughton Hospital Association		◆		◆			◆		◆	
	Mercy Hospital and Trauma Center		◆					◆		◆	
	Sauk Prairie Memorial Hospital		◆		◆	◆				◆	
	Monroe Clinic		◆		◆	◆		◆		◆	
	St. Clare Hospital & Health Services		◆		◆				◆	◆	◆
	Upland Hills Health		◆		◆			◆		◆	
	Richland Hospital		◆		◆						
	Columbus Community Hospital		◆		◆			◆	◆	◆	
	Southwest Health Center		◆		◆		◆			◆	
	Reedsburg Area Medical Center		◆		◆	◆	◆			◆	
	St. Mary's Surgery and Care Center				◆	◆					◆
	Grant Regional Health Center		◆		◆		◆	◆		◆	
	St. Mary's Janesville Hospital		◆		◆	◆					◆
	Beloit Health System		◆		◆			◆	◆	◆	
	Memorial Hospital of Lafayette Co.		◆		◆				◆	◆	
	Prairie Du Chien Memorial Hospital	◆	◆				◆		◆	◆	
Northeastern & Southeastern	St. Elizabeth Hospital		◆					◆		◆	◆
	Fort Healthcare		◆		◆			◆		◆	
	St. Agnes Hospital		◆	◆	◆			◆		◆	◆
	Mercy Medical Center		◆					◆		◆	◆
	Froedtert Memorial Lutheran Hospital		◆					◆		◆	◆
	Waupun Memorial Hospital		◆	◆	◆			◆		◆	◆
	Wheaton Franciscan Healthcare-All Saints		◆					◆		◆	◆
	Columbia St. Mary's Hospital Milwaukee		◆					◆		◆	◆
	Aurora Medical Center in Oshkosh	◆	◆	◆				◆		◆	
	Aurora St. Luke's Medical Center	◆	◆	◆				◆		◆	
	Berlin Memorial Hospital	◆	◆	◆				◆		◆	
	Waukesha Memorial Hospital	◆	◆	◆	◆			◆		◆	
	Theda Clark Medical Center	◆	◆	◆				◆		◆	
	Appleton Medical Center	◆	◆	◆				◆		◆	
	Aurora Baycare Medical Center in Green Bay	◆	◆	◆				◆		◆	
	Mercy Walworth Hospital and Medical Center		◆					◆		◆	
	Aurora Sinai Medical Center	◆	◆	◆				◆		◆	
	Riverside Medical Center	◆	◆	◆				◆		◆	
	Oconomowoc Memorial Hospital	◆	◆	◆	◆			◆		◆	
Northern & Western	Gundersen Lutheran Medical Center	◆	◆	◆			◆	◆	◆	◆	
	Mayo Clinic Health System - Franciscan Healthcare		◆						◆	◆	
	Marshfield Clinic	◆	◆					◆		◆	
	Ministry Saint Michael's Hospital		◆					◆		◆	◆
	Aspirus Wausau Hospital	◆	◆	◆				◆		◆	
	Black River Memorial Hospital	◆	◆				◆	◆		◆	
	Tomah Memorial Hospital	◆	◆				◆	◆		◆	
	Ministry Saint Mary's Hospital		◆					◆		◆	◆

	Provider Name	Plan K	Plan L	Plan M	Plan N	Plan O	Plan P	Plan Q	Plan R	Plan S
Southern	UW Hospital and Clinics					◆	◆	◆	◆	◆
	Meriter Hospital					◆		◆	◆	◆
	St. Mary's Hospital					◆	◆		◆	◆
	Beaver Dam Community Hospitals			◆		◆	◆	◆	◆	◆
	Divine Savior Healthcare					◆	◆	◆	◆	◆
	Mile Bluff Medical Center				◆	◆		◆	◆	◆
	Watertown Regional Medical Center		◆			◆	◆	◆	◆	◆
	Stoughton Hospital Association					◆	◆	◆	◆	◆
	Mercy Hospital and Trauma Center		◆			◆	◆	◆	◆	◆
	Sauk Prairie Memorial Hospital					◆	◆	◆	◆	◆
	Monroe Clinic					◆	◆	◆	◆	◆
	St. Clare Hospital & Health Services					◆	◆	◆	◆	◆
	Upland Hills Health	◆				◆	◆	◆	◆	◆
	Richland Hospital					◆		◆	◆	
	Columbus Community Hospital					◆		◆	◆	
	Southwest Health Center					◆	◆	◆	◆	◆
	Reedsburg Area Medical Center					◆	◆	◆	◆	◆
	St. Mary's Surgery and Care Center					◆	◆		◆	◆
	Grant Regional Health Center	◆				◆	◆	◆	◆	◆
	St. Mary's Janesville Hospital					◆	◆		◆	◆
	Beloit Health System					◆	◆		◆	
	Memorial Hospital of Lafayette Co.					◆	◆	◆	◆	◆
	Prairie Du Chien Memorial Hospital	◆				◆		◆	◆	◆
Northeastern & Southeastern	St. Elizabeth Hospital			◆			◆		◆	◆
	Fort Healthcare		◆			◆	◆	◆	◆	◆
	St. Agnes Hospital			◆		◆	◆	◆	◆	◆
	Mercy Medical Center			◆			◆		◆	◆
	Froedtert Memorial Lutheran Hospital			◆			◆		◆	
	Waupun Memorial Hospital			◆		◆	◆	◆	◆	◆
	Wheaton Franciscan Healthcare-All Saints			◆			◆		◆	
	Columbia St. Mary's Hospital Milwaukee			◆			◆		◆	◆
	Aurora Medical Center in Oshkosh						◆		◆	◆
	Aurora St. Luke's Medical Center						◆		◆	◆
	Berlin Memorial Hospital			◆	◆	◆	◆	◆	◆	◆
	Waukesha Memorial Hospital					◆	◆	◆	◆	◆
	Theda Clark Medical Center			◆			◆		◆	
	Appleton Medical Center			◆			◆		◆	◆
	Aurora Baycare Medical Center in Green Bay						◆		◆	◆
	Mercy Walworth Hospital and Medical Center		◆			◆	◆	◆	◆	◆
	Aurora Sinai Medical Center					◆	◆		◆	
	Riverside Medical Center			◆	◆		◆		◆	◆
	Oconomowoc Memorial Hospital					◆	◆		◆	◆
Northern & Western	Gundersen Lutheran Medical Center					◆	◆		◆	◆
	Mayo Clinic Health System - Franciscan Healthcare						◆		◆	◆
	Marshfield Clinic				◆		◆	◆	◆	◆
	Ministry Saint Michael's Hospital			◆	◆		◆		◆	◆
	Aspirus Wausau Hospital				◆	◆	◆		◆	◆
	Black River Memorial Hospital				◆	◆			◆	◆
	Tomah Memorial Hospital					◆	◆		◆	◆
	Ministry Saint Mary's Hospital			◆	◆		◆		◆	◆

SEGAL

Sample Medical Intelligence Report

April 2009 through March 2011

Full Cycle, Paid

SEGAL

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Introduction

Financial metrics are calculated on a paid basis during the time frame April 2009 through March 2011. Utilization metrics are calculated from claims incurred from April 2009 to March 2011.

Period-over-period comparisons are performed on selected reports within this package. The two periods selected for financial measures are:

1. Paid basis
    a. From April 2009 through March 2010
    b. To April 2010 through March 2011

All reported analyses reflect the financial time frame unless otherwise specified on the graphic, reflecting the utilization time frame. The periods selected for utilization measures are:

1. Incurred basis
    a. From April 2009 through March 2010
    b. To April 2010 through March 2011

Please Note:

1. This report displays Plan Paid Amounts unless otherwise specified.
2. Medical Plan Paid amount does not include any Dental, Vision or Lab specific claims.
3. Many dollar values are rounded to the nearest dollar for increased readability. However, calculated values (such as total sums) are calculated precisely and then rounded afterwards. This produces more accurate results, but may occasionally cause calculated fields to appear inexact.
4. This report requires at least 24 months of data in order to display a good comparative analysis for the reported population. Not having claims experience in the first 12 months will result in an incomplete report.
5. Some sections in the Appendix are dependent on previous sections. If the underlying previous sections are not requested, then the corresponding sections in the Appendix will not be populated.
6. The information contained in report has been produced from data provided to Verisk Health, which has not been independently verified by Verisk Health for accuracy or completeness. Additional information, including, but not limited to, any claims that have been incurred but not paid as of the date of this report, or claims that were subject to subsequent adjustment, should be considered before any action is taken on the basis of the contents of this report. This report does not constitute the provision of medical or legal advice by Verisk Health to any party.

1. SUMMARY OF FINDINGS [1]

This report provides an analysis of the healthcare information for Metropolitan System. The information is based on eligibility, medical claims, and pharmacy claims data for employees and their families during the reporting period April 2009 through March 2011 on a paid basis. The cost figures below reflect the time frame specified.

Summary of Expenses Paid by Plan

		Commercial Norms
Medical Claims	$133,200,450.59	
Pharmacy Claims	$20,648,946.77	
Total Claims	**$153,849,397.36**	
PEPM Medical Expenses	$568.94	$497.26
PEPM Pharmacy Expenses	$88.20	$105.64
Total PEPM Expenses	**$657.14**	**$602.90**

[1] Source: Sightlines Medical Intelligence : Executive Summary Module

2. POPULATION CHARACTERISTICS

This section explores the aggregate demographic, economic and clinical characteristics of this population.

Section 2.1 contains the population's demographic characteristics, including the change in total and current membership levels; and age and gender breakouts with associated economics.

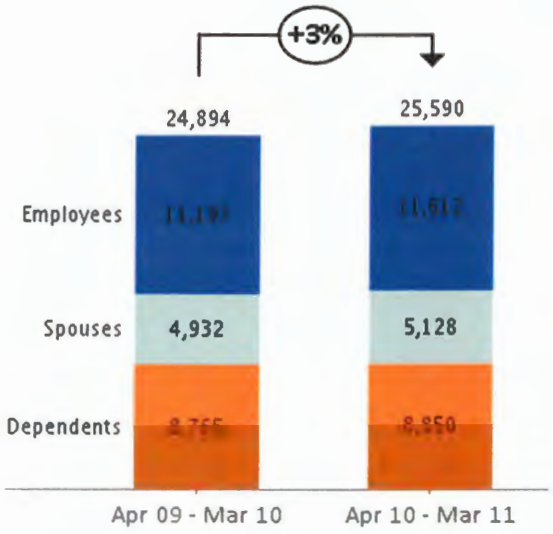
Section 2.2 details the population's high-level economic characteristics. This includes an assessment of the drivers of cost growth, such as change in member volume, change in PEPM, and medical versus pharmaceutical PEPM. Trends in total and PEPM costs over time - both medical and pharmaceutical - are calculated. Finally, cost distribution by spending band is explored. Deeper economic analyses into the drivers of pharmaceutical and medical expenses are detailed in *Section 3: Economic Findings and Opportunities.*

Section 2.3 analyzes the population's high-level clinical characteristics. The first breakout shows the relationship between age and disease burden (as quantified by the Relative Risk Score (RRS)) and the related Care Gap Index (CGI). These are analyzed both relative to each other and relative to the Verisk Health book of business benchmark. The second relationship describes the distribution of diseases across the population - identifying what is large or growing rapidly from a prevalence standpoint. The prevalence of high-frequency diseases is then shown relative to benchmarks.

2.1 Demographics

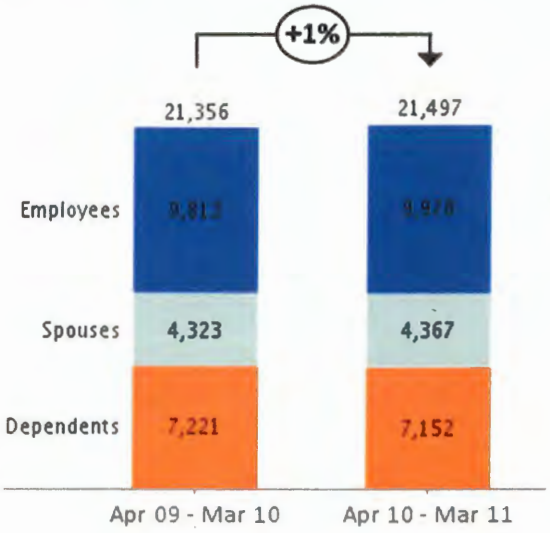
Figure 2.1.1 presents total membership change, by relationship status, from period one to period two. The percentage changes are also provided so that period-over-period trends can be evaluated. Figure 2.1.2 presents the distribution of current members in that specific period. For both total and current members, average PMPM is provided, where dependents typically spend the least amount per month. Finally, Figure 2.1.3 and Table 2.1.1 show the total claims paid and membership profile by age group and gender; in absolute terms employees and spouses typically constitute proportionally more spend than dependents.

Figure 2.1.1 Total Member Count by relationship status [2]



Member Growth	Average PMPM Apr 09 - Mar 10	Average PMPM Apr 10 - Mar 11	PMPM Growth
3.7%	$383.93	$428.75	11.7%
4.0%	$368.26	$402.60	9.3%
1.0%	$107.09	$112.59	5.1%

Figure 2.1.2 Current Members



Member Growth	Average PMPM Apr 09 - Mar 10	Average PMPM Apr 10 - Mar 11	PMPM Growth
1.7%	$372.91	$400.67	7.4%
1.0%	$348.89	$369.97	6.0%
-1.0%	$103.53	$107.96	4.3%

[2] ***Note:*** Refer to Appendix 5.1 for more information on member expenses by relationship status.
Source: Sightlines Medical Intelligence : Individuals Module. For Relationship, filter using Rel Flag (E = Employees, S=Spouses, D = Dependents). For Current Members, Current = 'Y'.

Figure 2.1.3 Claims Paid by Gender and Age [3]

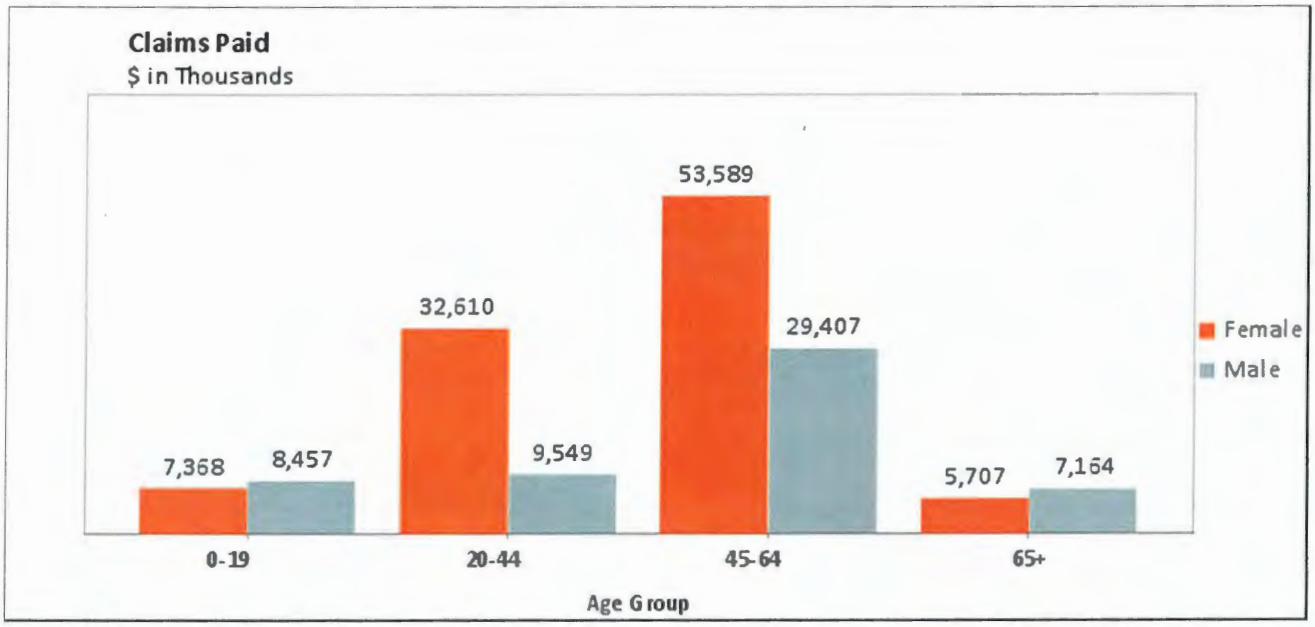


Table 2.1.1 Membership Profile [4]

	Female Member		Male Member		Total Member	
	Count	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Employee	10,510	37.2%	2,153	7.6%	12,663	44.8%
Spouse	1,077	3.8%	4,518	16.0%	5,595	19.8%
Dependent	4,938	17.5%	5,076	18.0%	10,014	35.4%
Total	**16,525**	**58.5%**	**11,747**	**41.5%**	**28,272**	**100%**

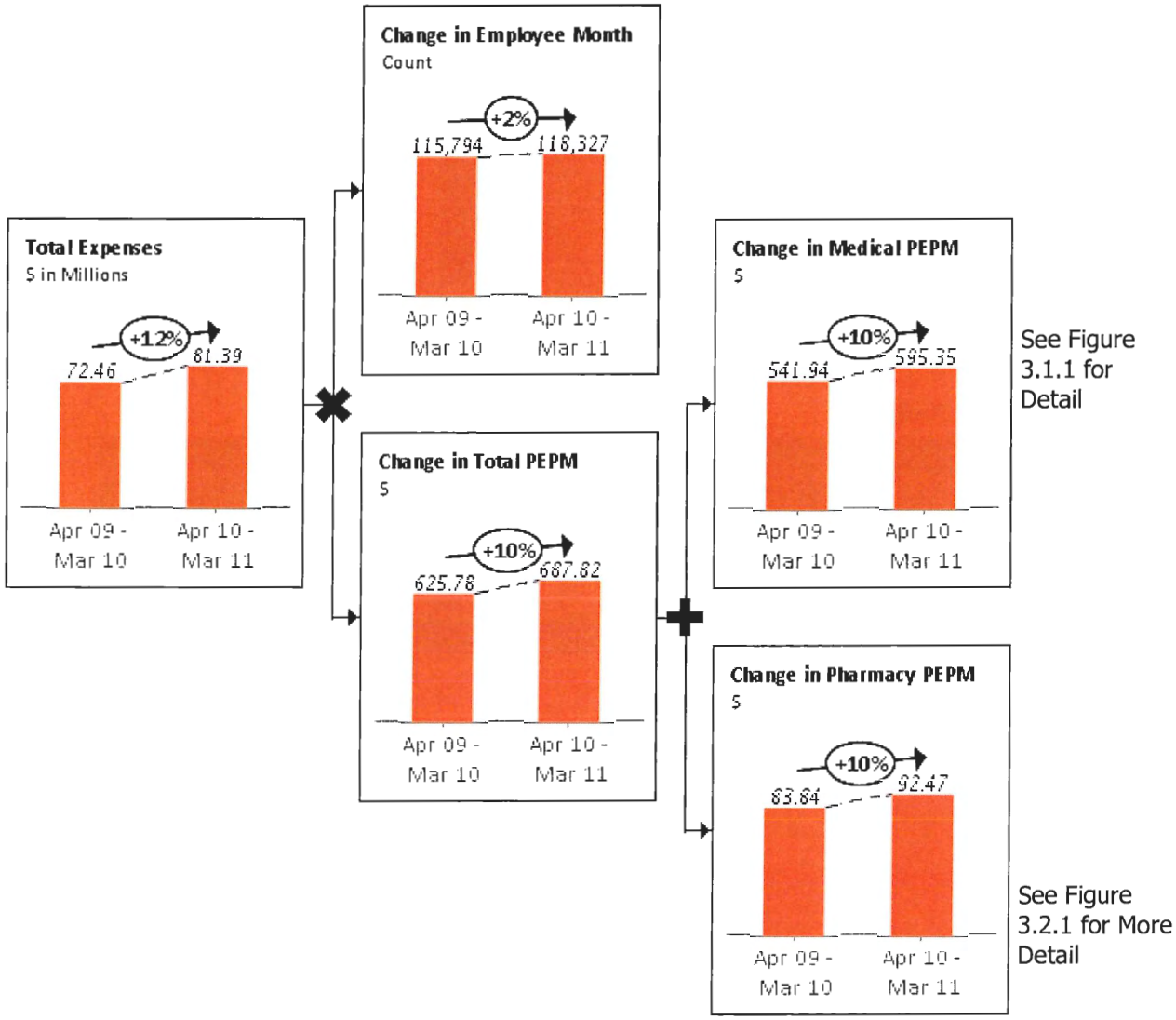
[3] ***Note:*** Average age for males is 31.6. Average age for females is 34.7.
Source: Sightlines Medical Intelligence : Demography module / Age Group

[4] Source: Sightlines Medical Intelligence : Individuals module / filter on Gender and Rel. Flag

2.2 Aggregate Economics

Figure 2.2.1 breaks out cost growth into discrete drivers, such as change in member volume, change in PEPM, and medical versus pharmaceutical PEPM. The change in Employee Months will closely approximate the change in current members. This analysis help delineate whether absolute costs are growing because the population is growing, or the cost per member is growing. Further cost breakouts are present in *Section 3: Economic Findings and Opportunities.*

Figure 2.2.1 Distribution of Expenses [5]



[5] ***Note:*** Medical PEPM includes Non-PBM drug spend (J-Codes).
The distribution by employee and plan is calculated by Verisk Health.
Source: Sightlines Medical Intelligence : Claims Module / custom timeframes for medical and pharmacy expenses.

2.2.1 Monthly Comparison of Paid Claims

Figures 2.2.2 and 2.2.3 track monthly claim paid amounts for the most recent 24 months. Seasonality in claims paid (in terms of date incurred) is expected, with the highest monthly claims generally occurring in the winter. Claim volumes may also rise just before or after installation of a new health plan. Claims are presented both as total and PEPM calculations.

Figure 2.2.2 Medical and Pharmacy Claims- Total [6]

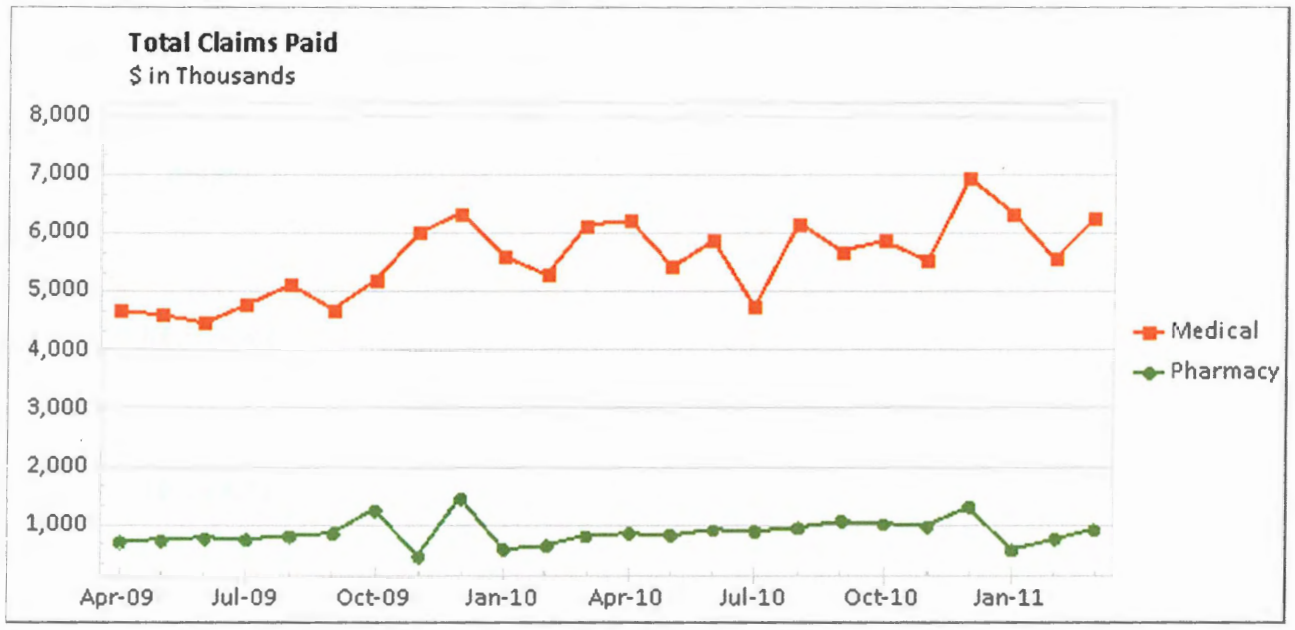
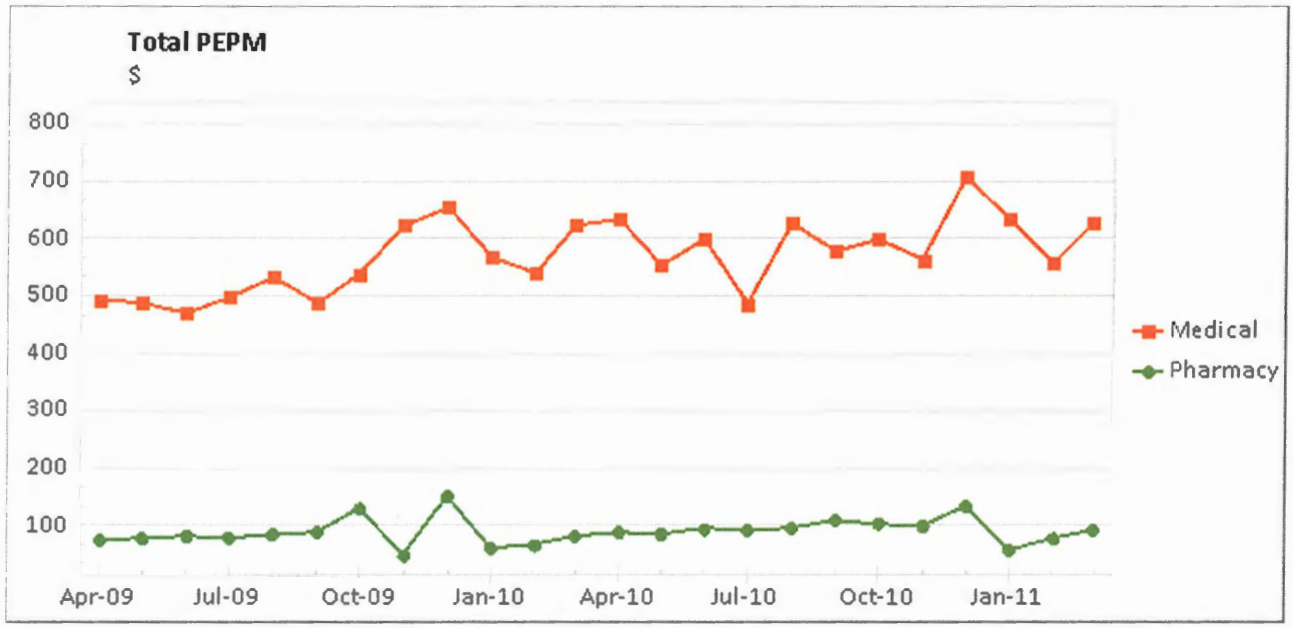


Figure 2.2.3 Medical and Pharmacy Claims-PEPM

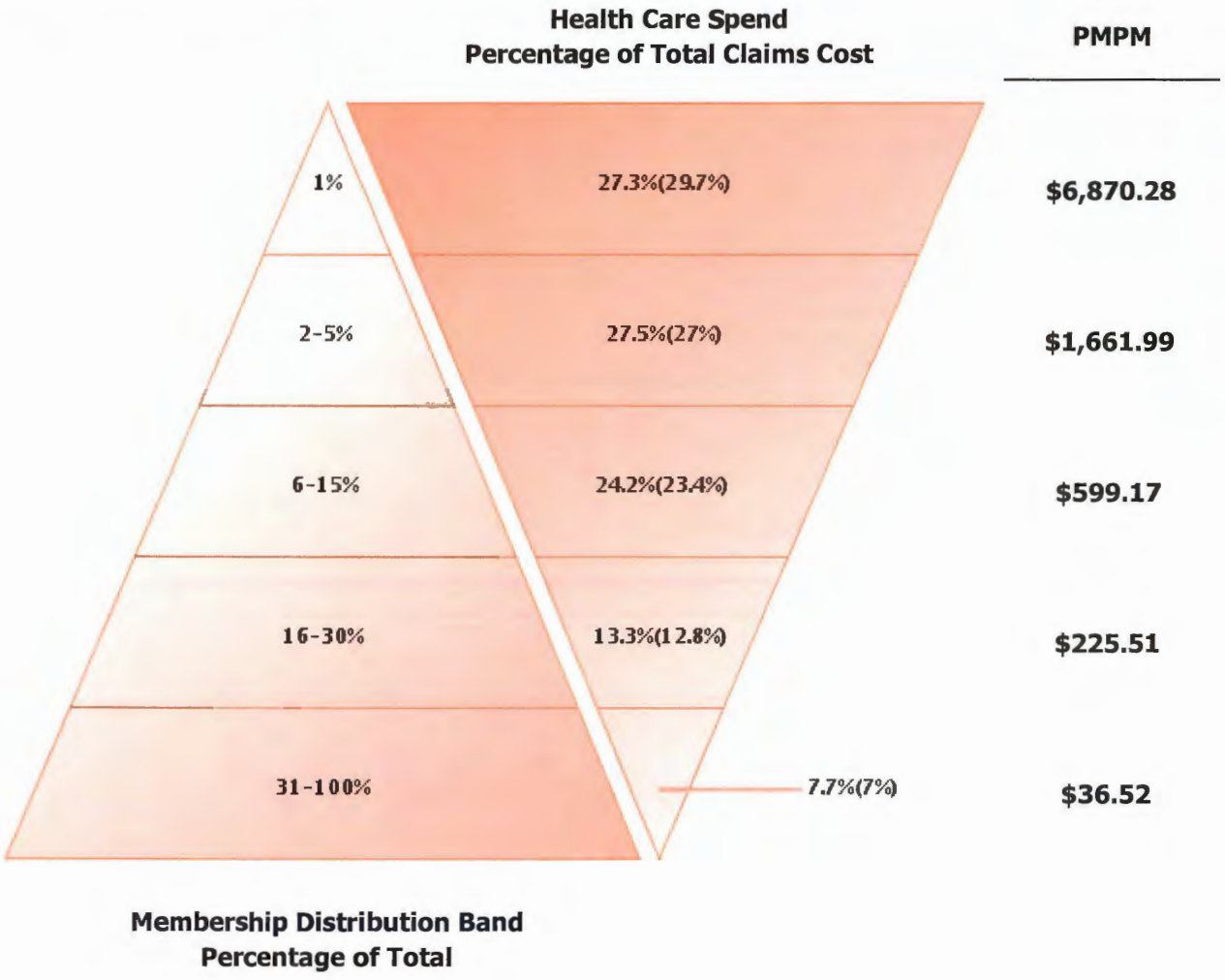


[6] ***Note:*** Refer to Table 5.2.1 and 5.2.2 in Appendix 5.2 for supporting monthly detail.
Source: Sightlines Medical Intelligence : Claims Module / Medical or Pharmacy / Trend by Month.

2.2.2 Expense Distribution by Percent Spending Band

Figure 2.2.4 shows claim payments for 5 different population bands including both current and termed members. Members are ranked by total claims for purposes of creating the bands. For example, the band representing 1% of the population consists of the most expensive 1% of members; approximately one-third of the total claims expense is generally accounted for by this group. These members have extremely high claims expense and should be reviewed to verify their case management status. A significant number of members in the next two bands will be high risk members, often with multiple chronic conditions. The risk associated with these members, many of whom to date have not generated significant claims expense, can be further evaluated using the Sightlines Medical Intelligence Expense Distribution module.

Figure 2.2.4 Claims Expense Distribution [7]



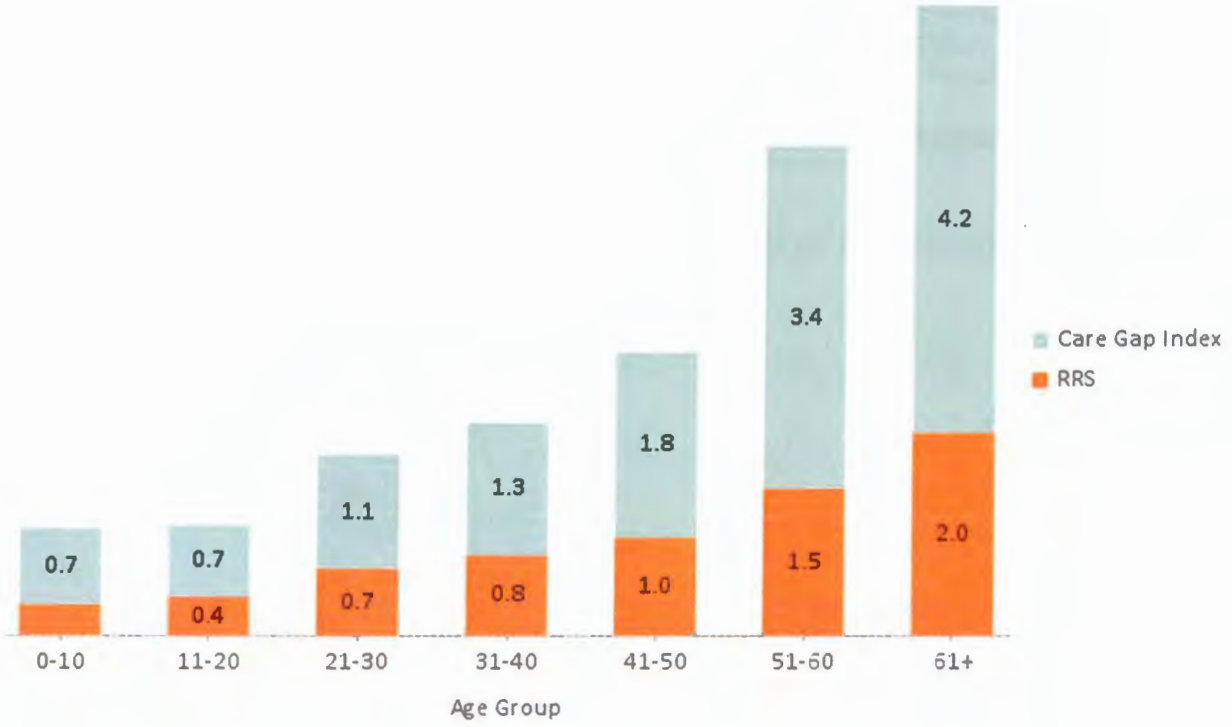
[7] ***Note:*** Refer to Table 5.2.3 in Appendix 5.2 for further detail.
Source: Sightlines Medical Intelligence : Expense Distribution Module.
PEPM Source: Sightlines Medical Intelligence : Expense Distribution Module / Individual

2.3 Clinical Disease Fingerprint

The RRS quantifies the disease burden of an individual member, while the Care Gap Index (CGI) quantifies the gaps in appropriate medical care that a member is receiving. Depending on the diseases that a member has, the extent of care gaps present serves as one assessment of the quality of care they receive.

Figures 2.3.1 show the relationship between the RRS and the CGI. As age increases, RRS and CGI usually increase proportionally. Figure 2.3.2 shows the RRS and CGI relative to benchmark performance and discusses how to determine the extent to which your CGI is driven by high disease burden or poor quality care.

Figure 2.3.1 Average Care Gap and RRS [8]



[8] Source: Sightlines Medical Intelligence : Average of RRS and CGI fields, grouping members by age in the individuals module

Figure 2.3.2 shows the RRS and CGI relative to the VH Norm. Four scenarios are possible:

1. The population has a **higher RRS but a lower CGI** relative to the norm. This is a positive finding. The population has a higher disease burden, yet compliance with evidence-based medicine generates CGI lower than the norm.

2. The population has a **higher RRS and a higher CGI** relative to the norm. This is a mixed finding. The population is sicker than the VH norm. Because it is sicker, we expect gaps in care to be more prevalent as well. This population presents an opportunity to reduce care gaps and claims cost through disease management.

3. The population has a **lower RRS and a lower CGI** relative to the norm. This is a positive finding. The population is healthier than the VH norm and also enjoys correspondingly fewer gaps in care.

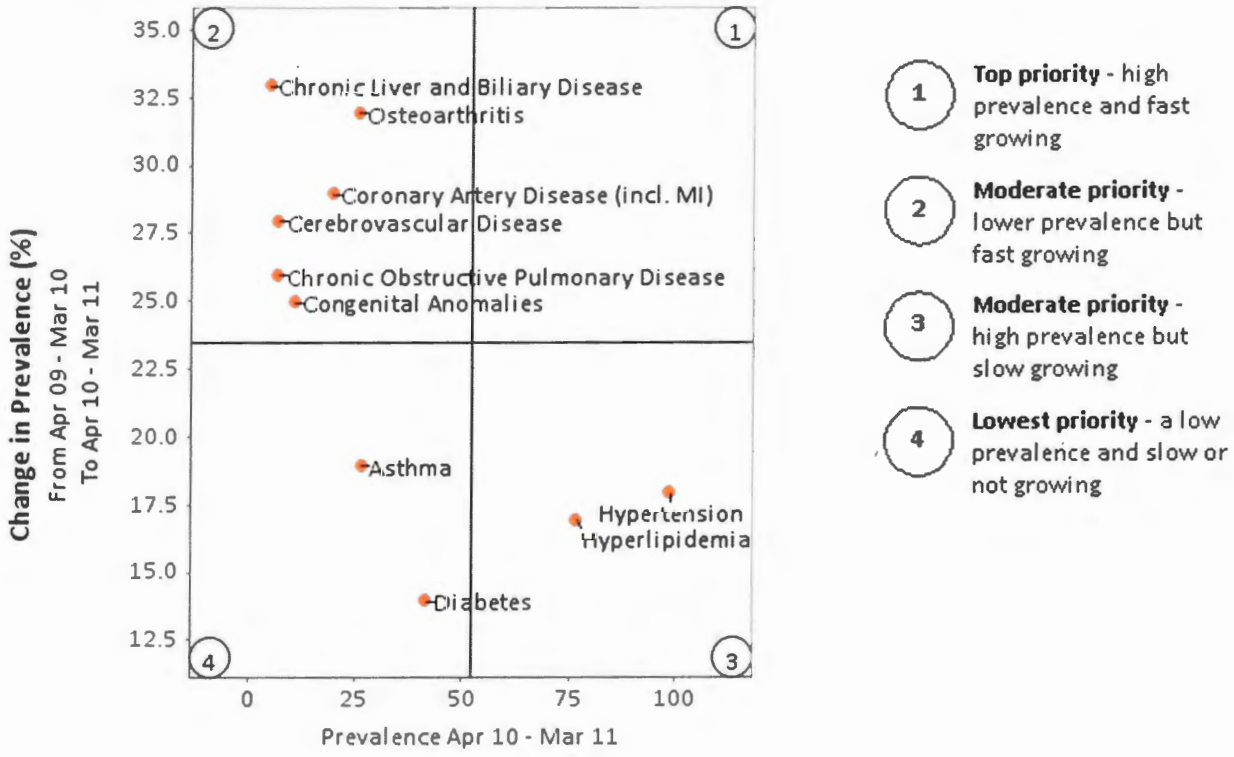
4. The population has a **lower RRS but a higher CGI** relative to the norm. This is a negative finding. Although the illness burden is low for this population, there exist disproportionate gaps in compliance with evidence-based care guidelines - either through member non-compliance or poor provider quality.

Figure 2.3.2 Spread of disease burden and gaps in care by age groups.



Figure 2.3.3 presents the top ten chronic diseases using the VH Disease classification scheme - this is the population's "disease fingerprint". Reducing the cost associated with these diseases is typically achieved with Disease Management programs; Disease management program typically reduce absolute utilization, and shift utilization from high cost setting to low cost settings.

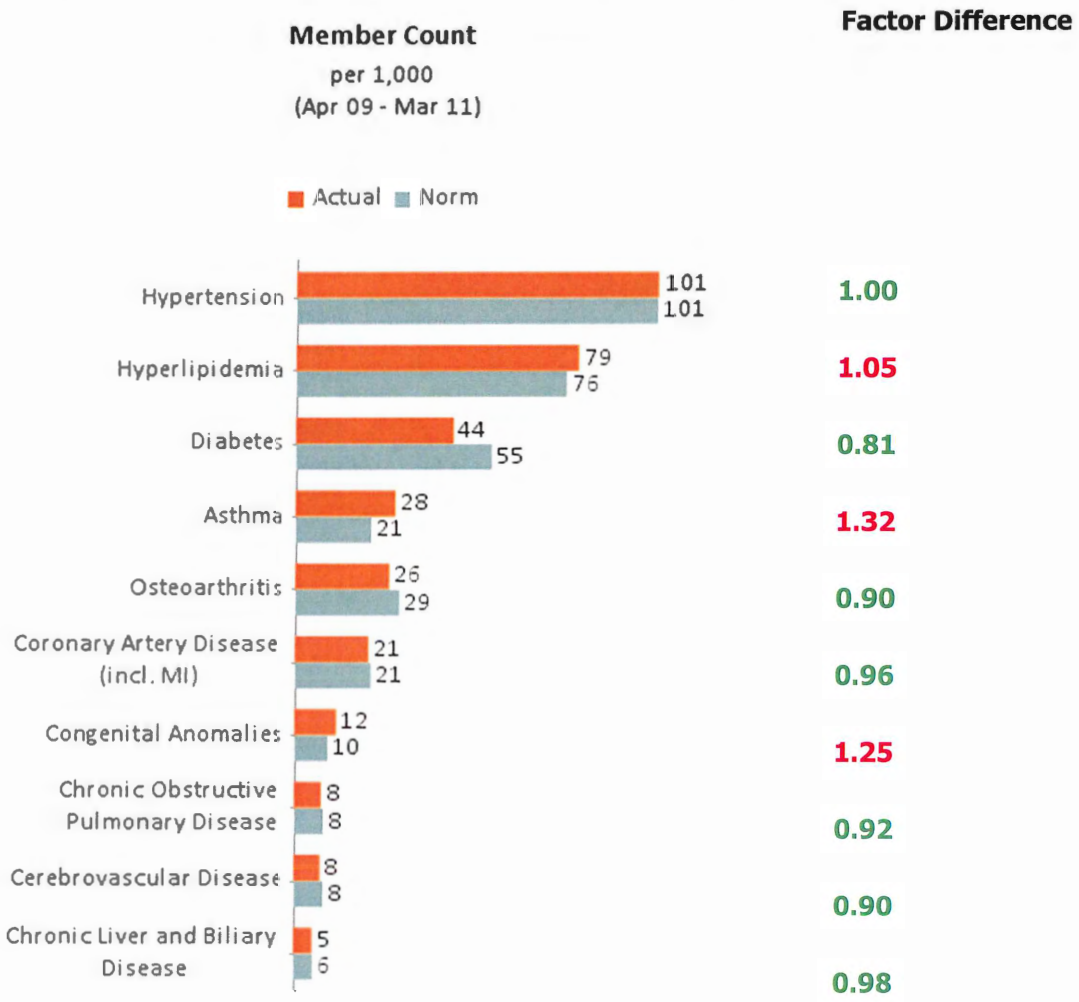
Figure 2.3.3 Prevalence and Growth of Top 10 Chronic Diseases [9]



[9] ***Note:*** Figure 2.3.3 is based on members having a qualifying primary diagnosis (ICD9 diagnosis code).
Source: Sightlines Medical Intelligence : Disease Registry Module / sort by Actual Members per 1000 / Top 10 records

Figure 2.3.4 shows the prevalence of the population's top 10 chronic diseases relative to the Verisk Health Commercial Norm benchmark values. Diseases with a factor difference less than 1, labeled in green, have lower prevalence than the VH norm, while diseases labeled in red have higher prevalence. A high prevalence relative to the norm means that the high cost in claims is in part driven by intrinsic population disease burden, which can be addressed by Disease and Wellness Management programs.

Figure 2.3.4 Prevalence View of top 10 Chronic Diseases. [10]



[10] ***Note:*** Factor Difference = Actual Members per 1000 / Norm Members per 1000
Source: Sightlines Medical Intelligence : Disease Registry module / sort by Actual Members per 1000 / Top 10 records

3. ECONOMIC FINDINGS AND OPPORTUNITIES

Economic findings are broken out into Medical and Pharmaceutical subsections.

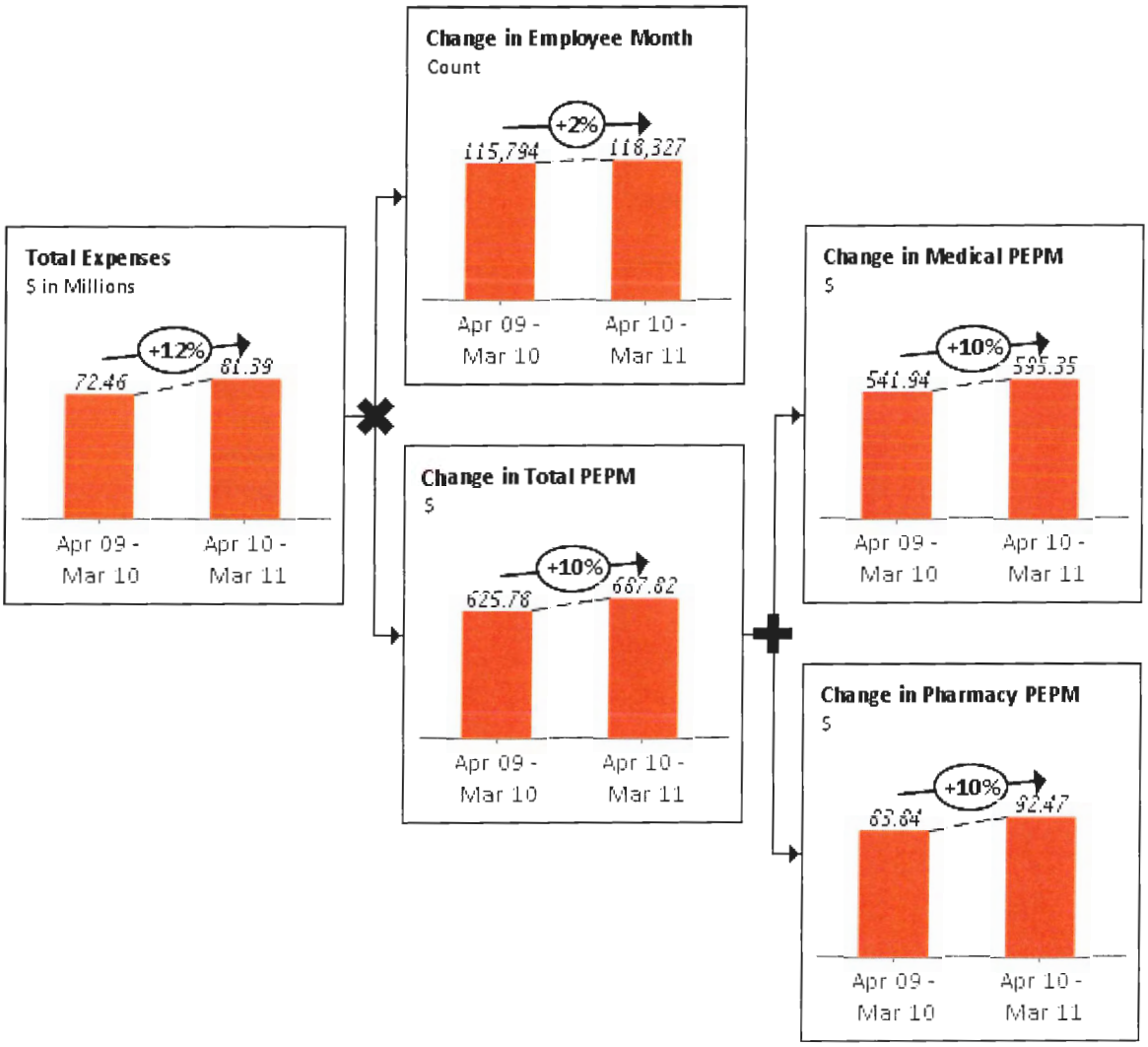
In section 3.1 - the Medical Economics subsection- this report examines:

- Factors that primarily impact *unit pricing,* including contract discount power and in versus out-of-network utilization rates. We also examine which geographic areas are associated with the most out-of-network spend.
- Factors that drive *utilization,* including specialty procedures and consultations, diagnostic testing, and the place of service. For these utilization-based drivers, we assess both changes in utilization and cost.

In section 3.2 - the Pharmaceutical section - this report examines:

- Drug classes that affect PBM drug spend, and whether the change in this spend is due to pricing growth or utilization growth. This section also details the highest cost drugs and opportunities for generic and branded switching.
- Overall Non-PBM drug spend: because this spend is a "medical" cost - not a PBM cost - the impact of these high-cost drugs is often hidden.

Figure 3.1 Expense Drivers [11]



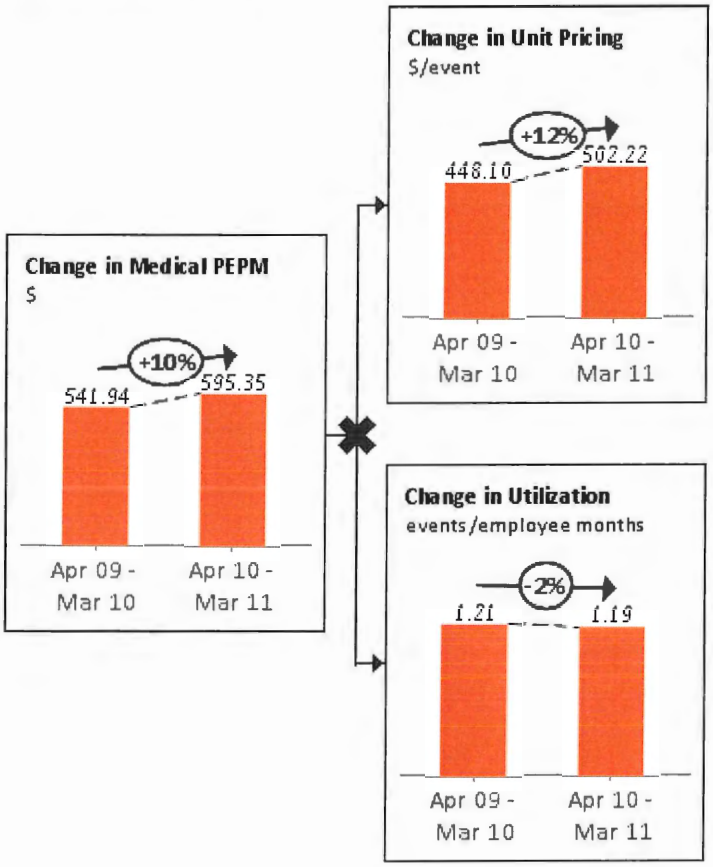
[11] ***Note:*** Medical PEPM includes Non-PBM drug spend (J-Codes).
The distribution by employee and plan is calculated by Verisk Health.
Source: Sightlines Medical Intelligence : Claims Module / Custom timeframes for medical and pharmacy expenses.

3.1 Medical Economics

Section 3.1 assesses medical economics - where cost increases are occurring, what is driving them, and how they can be controlled. While the areas and opportunities assessed are not additive, they are complementary. For example, managing Coronary Artery Disease more effectively can be expected to reduce the number of cardiac catheterizations, reduce the overall number of cardiology consultations, and move cardiology consultations from the inpatient setting to the lower-cost office setting.

Figure 3.1.1 shows the change in Medical expenses over time. This chart is related to chart 2.2.1 from our assessment of aggregate economics.

Figure 3.1.1 Medical Expense Growth over Time (Refer to Figure 3.1) [12]



Changes in unit pricing are typically a function of overall medical inflation, Payor discount power, and the amount of services that are delivered in-network versus out-of-network. Payor contracting is the primary lever to control this cost driver.

Changes in utilization are typically a function of the overall disease burden of a population, benefits design and physician referral patterns. Disease and Wellness management programs, rational benefits structuring, and close network management are the primary levers to control this cost driver.

[12] ***Note:*** Events are a distinct count of Member ID and Date of Service for the reported population and reporting period. Source: Sightlines Medical Intelligence : Claims Module / Custom timeframes for medical expenses.

Section 3.1 will analyze the five areas listed directly below.

	What the analysis assesses	How excessive costs are incurred
Contract discount power	• The percent discount that a payor is able to achieve from provider	• Payors with weaker networks - and lower network discount rates - will pay higher per-unit costs
Network utilization	• The percentage and location of out-of-network claims occurrences	• On a per-unit basis, out-of-network costs are generally higher than in-network costs
Specialty procedures & consultations **Diagnostic testing** **Place of service**	• Costs are prioritized by total amount and growth rate • Cost growth drivers are disaggregated into change-in-utilization and change-in-price drivers	• High rates of utilization will drive excessive costs; utilization is typically driven by excessive specialty procedures or diagnostic testing • Excessive costs can also be driven by inappropriate location of care; for example, if a disease is treated in the ER instead of clinic

3.1.1 Network utilization and contract discounts

Table 3.1.1 details in-network (Par) and out-of-network (Non-Par) costs, ranked by plan paid, for the various networks used by your plan participants. This analysis also provides a comparison of discounts for the top ten participating networks. Most benefit plans utilize a provider network where providers have agreed to accept lower reimbursements in return for inclusion on a preferred provider list. Some out-of-network utilization is expected; examples are members seeing a provider while away from home (out-of-area claims), or seeing an out-of-network provider for an urgent or emergent healthcare condition. Out-of-network claims result in higher than expected claims expense for the service provided. A high incidence of out-of-network provider visits is usually an indication that there are access issues. These access issues can be impacted through network restructuring. Improved in-network usage can be accomplished by limiting coverage for out-of-network services.

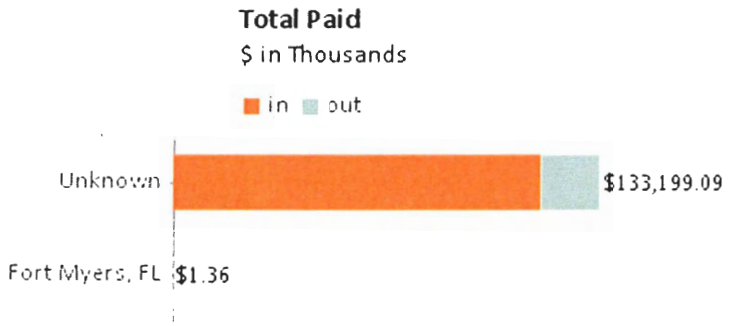
Table 3.1.1 Carrier Discounts and Network Utilization [13]

Network	Total					
	Claims Billed	Claims Allowed	Claims Paid	Employee Contribution	Network Discount	% Discount
Network - 007427	$87,186,952	$66,928,516	$59,262,877	$6,197,399	$20,258,436	23.2%
Network - 007798	$40,433,587	$27,016,899	$22,151,584	$4,270,764	$13,416,688	33.2%
Network - 018557	$25,795,686	$20,680,901	$17,348,257	$3,315,946	$5,114,785	19.8%
Network - 017444	$17,777,624	$9,867,557	$8,408,796	$1,304,935	$7,910,067	44.5%
Network - 006314	$10,512,362	$8,891,373	$7,477,643	$1,390,863	$1,620,989	15.4%
Network - 009653	$261,923	$168,609	$156,435	$9,954	$93,313	35.6%
Network - 020041	$27,774	$6,232	$5,096	$1,136	$21,542	77.6%
All Other Par (In Network)	**$0**	**$0**	**$0**	**$0**	**$0**	**0.0%**
All Non-Par (Out Of Network)	**$27,910,226**	**$21,942,950**	**$18,389,763**	**$2,715,801**	**$5,967,276**	**21.4%**
Total	**$209,906,135**	**$155,503,038**	**$133,200,451**	**$19,206,799**	**$54,403,097**	**25.9%**

[13] ***Note:*** Refer to Table 5.2.6 in Appendix 5.2 for network summary.
Source: Sightlines Medical Intelligence : Network Utilization Module / Discount

Figure 3.1.2 shows the cost distribution by city and state for the members utilizing out-of-network providers. Efforts to move utilization in-network should begin with an understanding of why members located in these cities are seeing out-of-network (OON) providers.

Figure 3.1.2 Top 10 Cities for Out-of-Network Claims Paid [14]



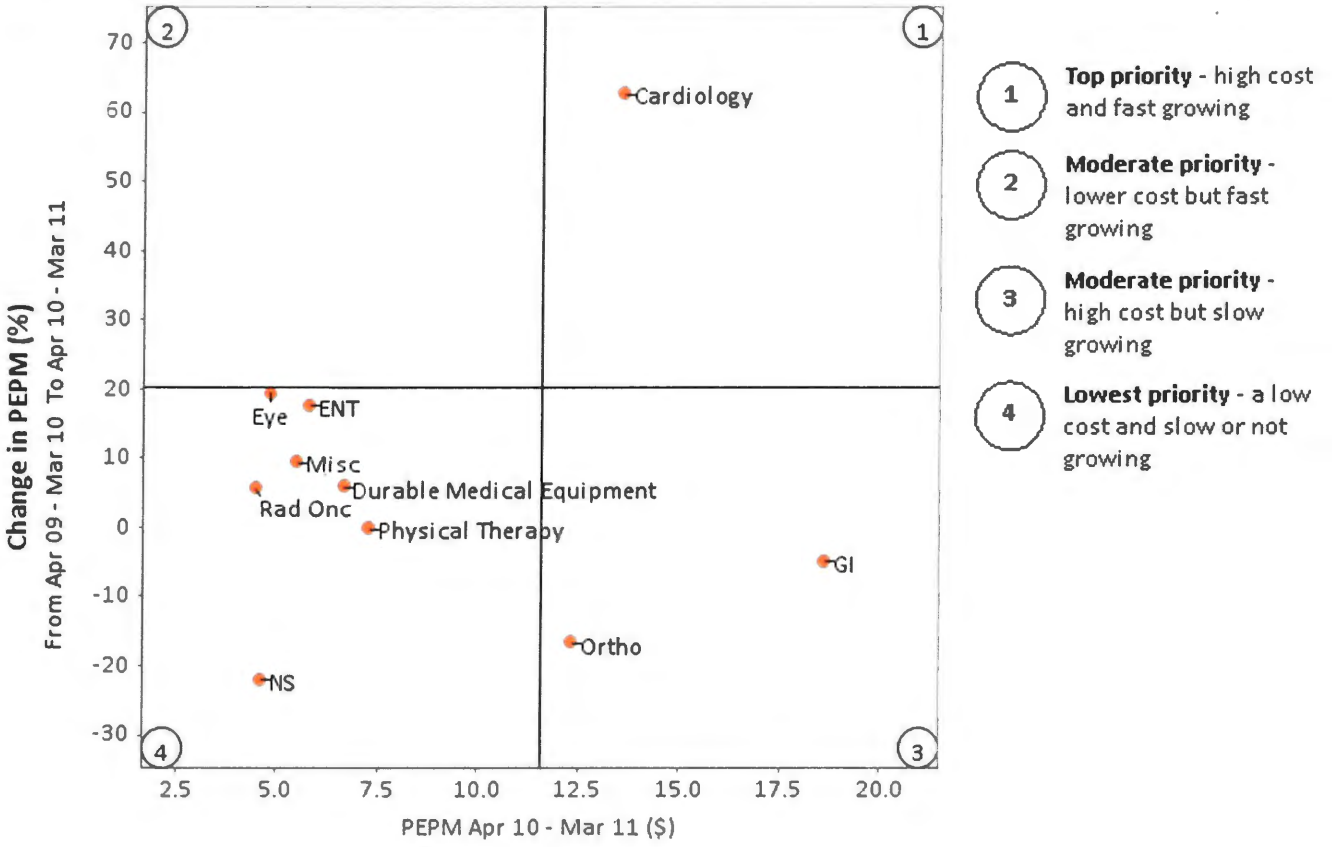
	OON Spend $ in Thousands	OON Spend	all OON Spend
Unknown	$18,389.20	13.8%	13.8%
Fort Myers, FL	$0.57	41.8%	0.0%
	Total = $18.39 M		

[14] Source: Sightlines Medical Intelligence : Network Utilization Module / Drill by Zip / Top 10 Cities based on Total Paid

3.1.2 Specialty procedures/consultations

Specialty procedures, and the consultations that lead to those procedures, are a common driver of excess utilization. The chart below shows what procedures are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred get larger. Moving bottom to top on the vertical axis, year-on-year growth in costs increases. Therefore, specialties in the upper right corner are both large and growing fast.

Figure 3.1.3 Cost drivers: Areas of cost and cost growth for specialty procedures and consultations [15]



[15] ***Note:*** Figure 3.1.3 is based on select categories of VHProcedure Groups which utilize CPT4 procedure codes.
Source: Sightlines Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the changes in cost are driven by a change in pricing or a change in utilization. Also displayed is the average cost from the Verisk Health Normative Database, and the population's cost rank relative to the Norm.

Table 3.1.2 Cost drivers: Change in unit price and change in utilization breakout for specialty procedures and consultations [16]

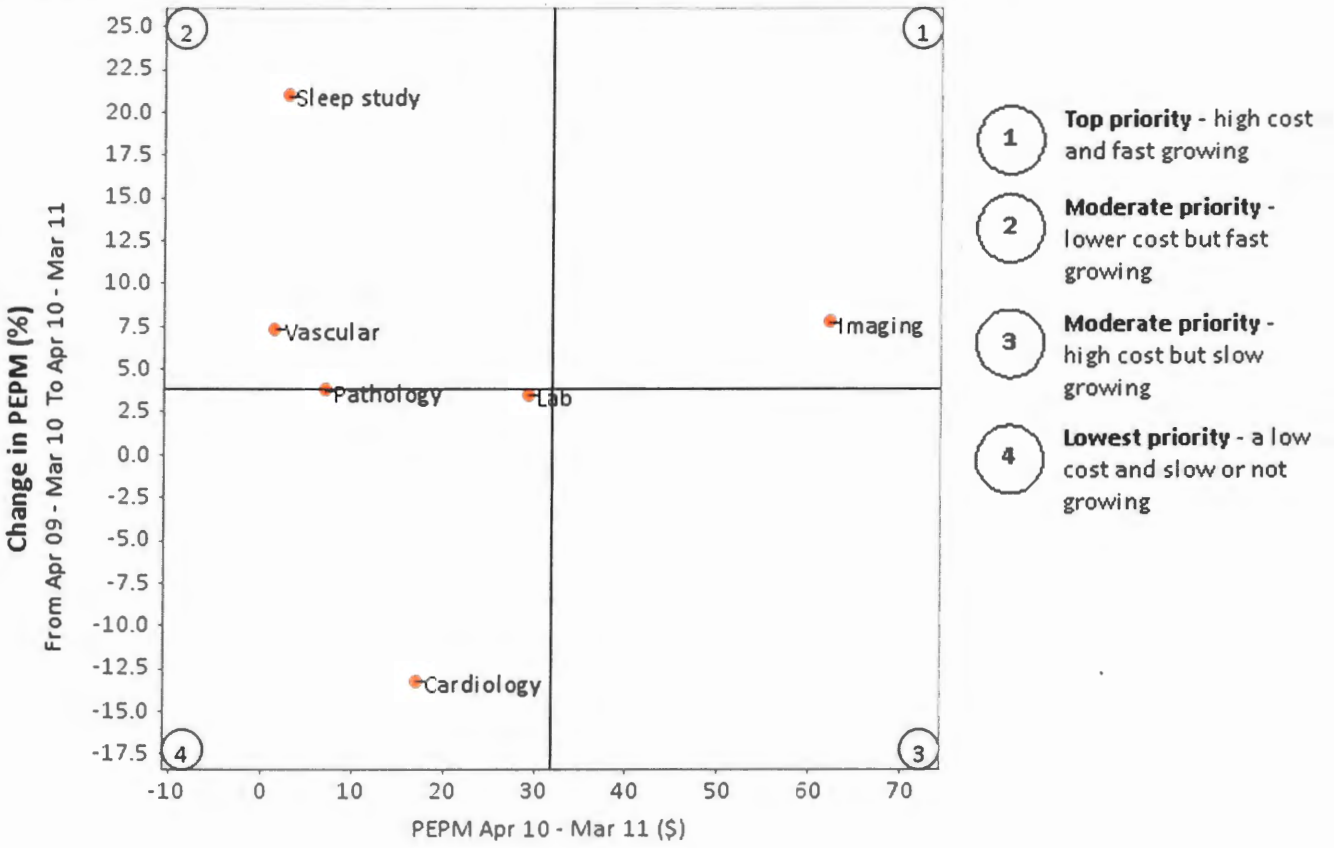
Specialty Procedures/ Consultations	Current PEPM	Change in PEPM	Change in Utilization per 1,000	Change in Unit Pricing	Norm value of PEPM	Percent Rank (Norm value = 50%)
GI	$18.61	-4.8%	-1.2%	-3.6%	$19.88	-
Cardiology	$13.56	62.7%	-4.7%	70.8%	$9.26	-
Ortho	$12.31	-16.7%	-7.1%	-10.4%	$17.29	-
Physical Therapy	$7.26	-0.1%	2.0%	-2.0%	$8.76	-
Durable Medical Equipment	$6.66	5.9%	-5.7%	12.3%	$11.46	-
ENT	$5.79	17.7%	-4.6%	23.4%	$6.18	-
Misc	$5.49	9.5%	-3.4%	13.3%	$17.77	-
Eye	$4.83	19.4%	4.0%	14.8%	$5.11	-
NS	$4.60	-22.0%	-9.6%	-13.7%	$4.46	-
Rad Onc	$4.48	5.7%	18.9%	-11.1%	$6.24	-

[16] ***Note:*** Table 3.1.2 is based on select categories of VHProcedure Groups which utilize CPT4 procedure codes.
Source: Sightlines Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

3.1.3 Diagnostic Testing

The chart below shows what diagnostic tests are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred get larger. Moving bottom to top on the vertical axis, year-on-year growth in costs increases. Therefore, tests in the upper right corner are both large and growing fast.

Figure 3.1.4 Cost drivers: Areas of cost and cost growth for diagnostic tests [17]



[17] ***Note:*** Figure 3.1.4 is based on select categories of VHProcedure Groups which utilize CPT4 procedure codes.
Source: Sightlines Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the changes in cost are driven by a change in pricing or changes in utilization. Also displayed is the average cost from the Verisk Health Normative Database, and the population's cost rank relative to the Norm.

Table 3.1.3 Cost drivers: Change in unit price and change in utilization breakout for diagnostic tests [18]

Testing Category	Subcategory	Current PEPM	Change in PEPM	Change in utilization per 1,000	Change in Unit pricing	Norm value of PEPM	Percent Rank(Norm value = 50%)
Cardiology	All	$16.98	-13.2%	-2.6%	-2.0%	$7.73	-
	Ultrasound/Doppler	$12.88	-15.8%	-6.9%	-9.6%	$2.94	-
	Cardiography	$3.47	4.7%	-0.5%	5.2%	$3.82	-
	Electrophysiology	$0.63	-34.7%	-36.3%	2.5%	$0.77	-
	Nuclear Medicine Imaging	$0.00	0.0%	0.0%	0.0%	$0.20	-
Imaging	All	$62.09	7.8%	3.5%	5.8%	$53.51	-
	MRI	$16.30	10.7%	3.5%	6.9%	$12.23	-
	CT	$14.92	9.1%	-2.5%	11.8%	$15.38	-
	Plain film	$9.45	-1.9%	-6.6%	5.0%	$5.61	-
	Nuc Med	$7.95	14.0%	6.1%	7.4%	$4.61	-
	US	$7.93	6.9%	38.8%	-23.0%	$6.43	-
	Not classified	$5.54	7.2%	3.7%	3.4%	$9.26	-
Lab	All	$29.21	3.5%	-4.6%	8.6%	$26.78	-
Pathology	All	$7.01	3.8%	-13.9%	20.6%	$6.67	-
Sleep study	All	$2.84	21.0%	16.9%	3.5%	$2.04	-
Vascular	All	$1.43	7.4%	-0.9%	8.4%	$1.23	-

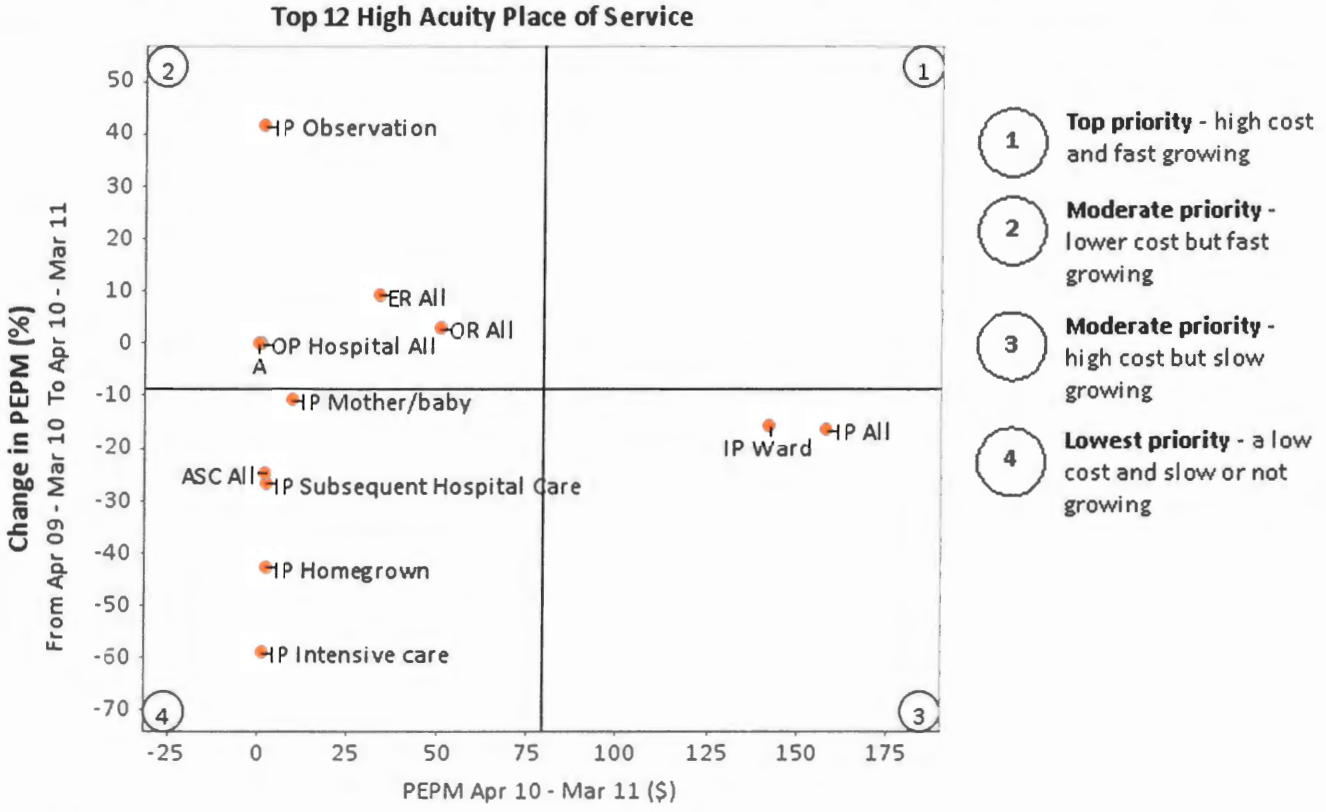
[18] ***Note:*** Table 3.1.3 is based on select categories of VHProcedure Groups which utilize CPT4 procedure codes.
Source: Sightlines Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

3.1.4 Place of service - Inpatient and high acuity

Monitoring the utilization patterns for chronic conditions offers valuable insight into benefit design and/or case and disease management program performance. In general, high utilization rates for such measures as inpatient admissions and emergency room services in these conditions bring into question the adequacy of outpatient care, plan design incentives to encourage outpatient care, and medical management performance.

The chart below shows which inpatient and high acuity places of service are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred get larger. Moving bottom to top on the vertical axis, year-on-year growth in costs increases. Therefore, locations in the upper right corner are both large and growing fast.

Figure 3.1.5 Cost drivers: Areas of cost and cost growth for hospital and ASC based utilization [19]



A. IP Psychiatry

[19] ***Note:*** Figure 3.1.5 is based on select categories of VHProcedure Groups which utilize CPT4 procedure codes.
Source: Sightlines Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the changes in cost are driven by a change in pricing or a change in utilization. Also displayed is the average cost from the VH Normative Database, and the population's cost rank relative to the Norm.

Table 3.1.4 Cost drivers: Change in unit price and change in utilization breakout for Inpatient and high acuity locations of care [20]

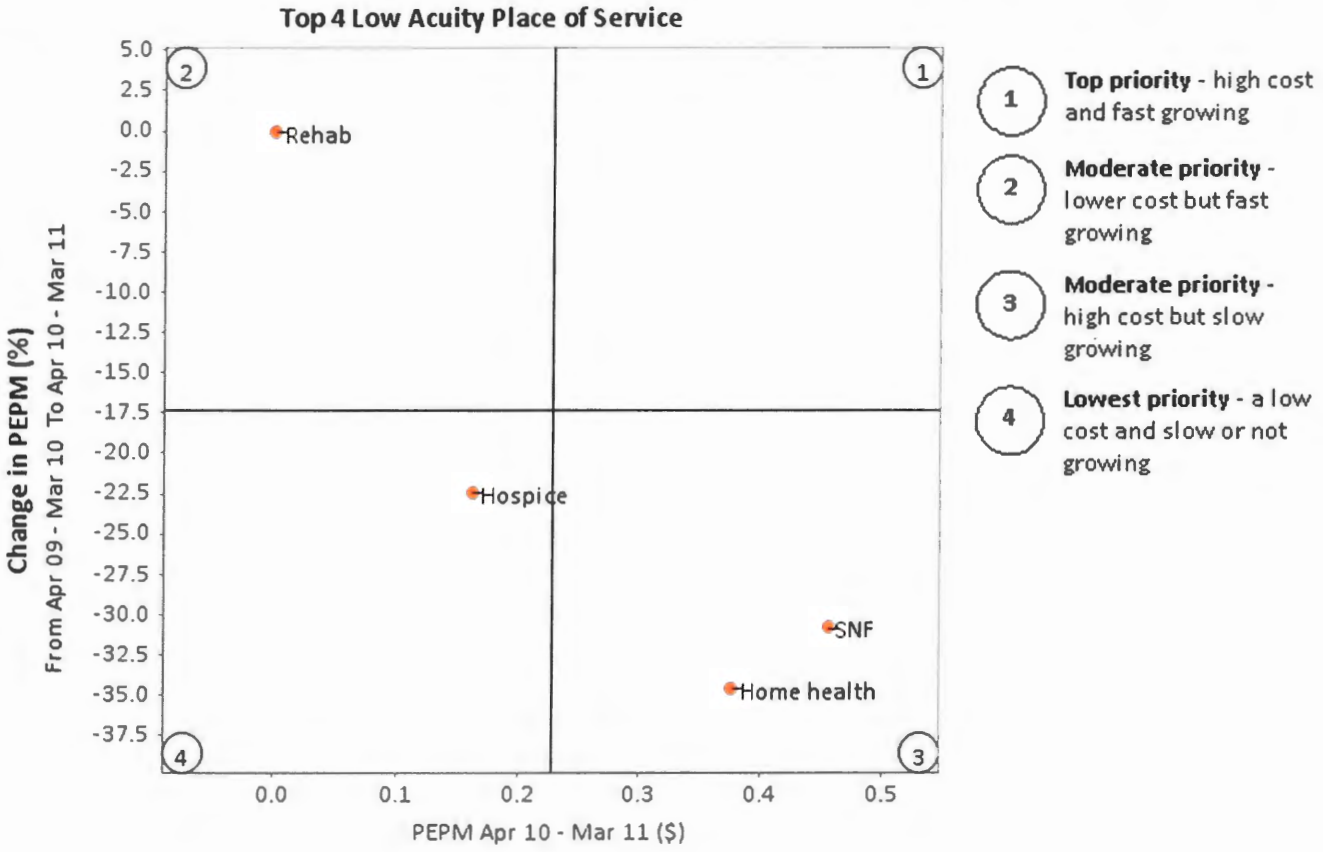
Category	Subcategory	Current PEPM	Change in PEPM	Change in utilization per 1,000	Change in Unit pricing	Norm value of PEPM	Percent Rank(Norm value = 50%)
ASC	All	$1.97	-24.7%	-15.2%	-11.2%	$3.92	-
ER	All	$33.14	9.5%	-5.8%	16.3%	$21.21	-
IP	All	$158.05	-16.4%	-18.4%	3.7%	$78.88	-
	Ward	$141.88	-15.6%	-15.5%	-0.1%	$28.97	-
	Mother/baby	$9.39	-10.7%	-20.9%	12.9%	$11.16	-
	Subsequent Hospital Care	$2.31	-26.5%	-16.7%	-11.8%	$2.17	-
	Homegrown	$2.06	-42.6%	-50.2%	15.2%	$20.27	-
	Observation	$1.32	41.7%	2.1%	38.7%	$2.15	-
	Intensive care	$1.11	-58.9%	-54.8%	-9.0%	$12.66	-
	Psychiatry	$0.00	0.0%	0.0%	0.0%	$1.49	-
OP Hospital	All	$0.82	0.0%	0.0%	0.0%	$0.14	-
OR	All	$50.30	3.0%	-1.4%	4.5%	$19.26	-

[20] ***Note:*** Table 3.1.4 is based on select categories of VHProcedure Groups which utilize CPT4 procedure codes.
Source: Sightlines Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

3.1.5 Place of service - Outpatient and low acuity (excluding office visits)

The chart below shows which outpatient and low-acuity places of service are large and are growing fast. Moving left to right on the horizontal axis, costs incurred by location get larger. Moving bottom to top on the vertical axis, year-on-year growth in costs increases. Therefore, locations in the upper right corner are both large and growing fast.

Figure 3.1.6 Cost drivers: Areas of cost and cost growth for outpatient and community based utilization (excluding office visits) [21]



[21] ***Note:*** Figure 3.1.6 is based on select categories of VHProcedure Groups which utilize CPT4 procedure codes.
Source: Sightlines Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the change in cost seen in chart 3.1.1 is driven by a change in unit price or a change in utilization. Also displayed is the average cost from the VH Normative Database and the population's cost rank relative to the Norm.

Table 3.1.5 Cost drivers: Change in unit price and change in utilization breakout for Outpatient and low acuity care (excluding office visits) [22]

Category	Current PEPM	Change in PEPM	Change in Utilization per 1,000	Change in Unit Pricing	Norm value of PEPM	Percent Rank (Norm value = 50%)
SNF	$0.45	-30.8%	-7.0%	-25.6%	$0.69	-
Home health	$0.38	-34.6%	-68.9%	110.3%	$1.80	
Hospice	$0.16	-22.4%	80.3%	-57.0%	$0.23	-
Rehab	$0.00	0.0%	0.0%	0.0%	$0.86	-

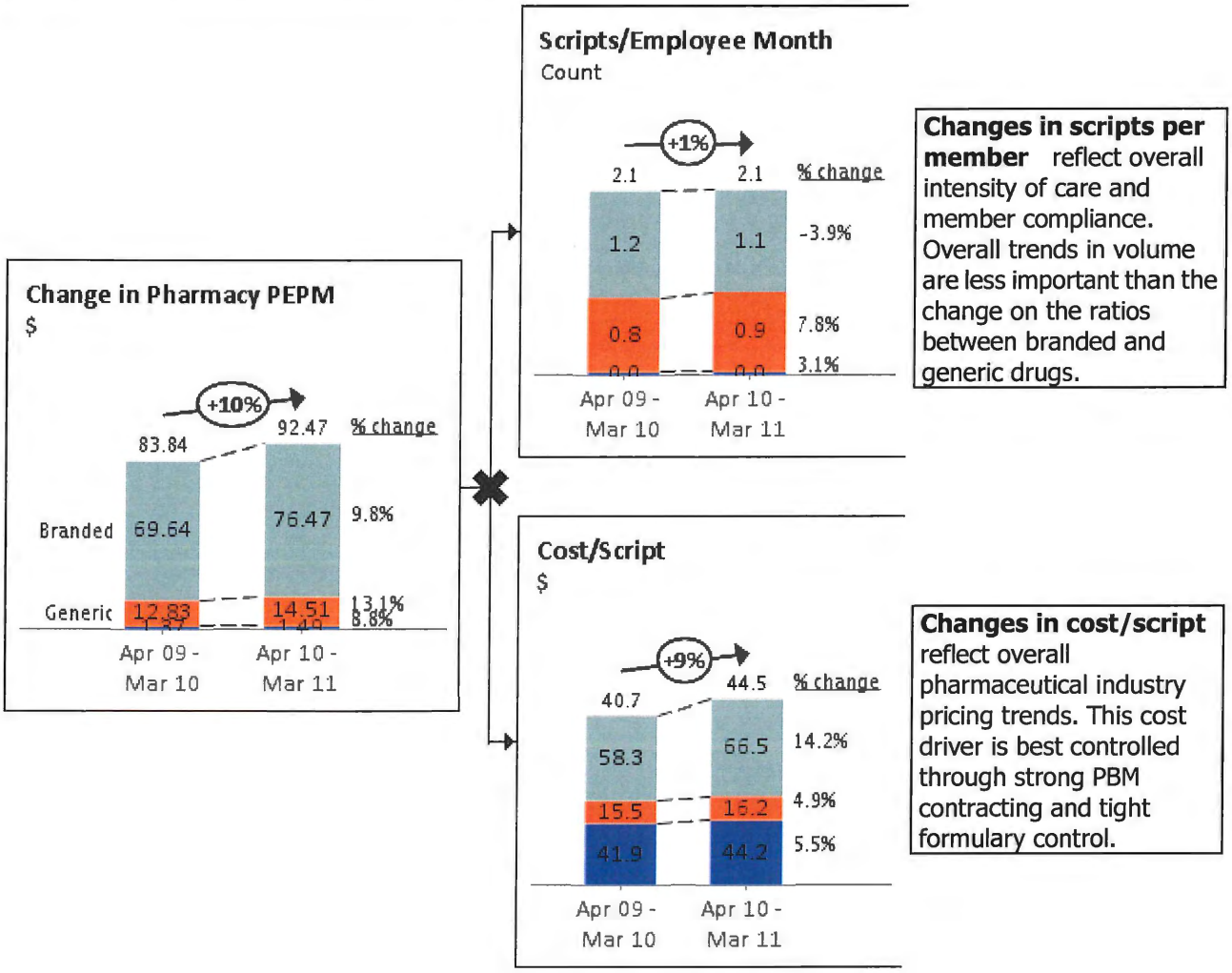
[22] ***Note:*** Table 3.1.5 is based on select categories of VHProcedure Groups which utilize CPT4 procedure codes.
Source: Sightlines Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

3.2 Pharmacy Economics

Year-on-year growth in pharmacy expenses can be attributed to changes in Employee Months and pharmacy PEPM cost , as shown in chart 2.2.1 .

Increase or decrease of pharmacy PEPM is caused by changes in the number of prescriptions written per Employee Month and changes in the cost per prescription.

Figure 3.2.1 Pharmacy Expenses (Refer to Figure 2.2.1) [23]



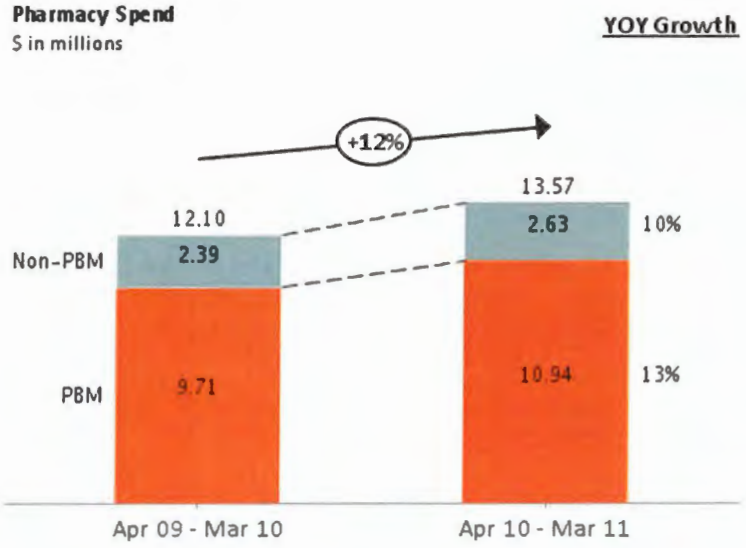
[23] ***Note:*** Pharmacy PEPM totals reflect branded, generic and non drug costs. Non drug costs include items like diabetic supplies and syringes which are generally negligible costs. Within the Medical Intelligence application, non- drug charges are located within the non- generic category.
Source: Sightlines Medical Intelligence : Claims Module / Pharmacy / Plan Type

3.2.1 Non-PBM Drug Spend

Non-PBM spend on pharmaceuticals is paid by Health Plan, not the PBM. It is therefore included in medical expenses and usually includes the J-Codes. However, many non-PBM drugs are exceptionally expensive and deserve special attention. Non-PBM drug spend is often best controlled through the use of contracting Specialty Pharmacy networks.

Figure 3.2.2 shows the total pharmacy spend as seen in chart 3.2.1, now with the non-PBM spend added in.

Figure 3.2.2 Distribution of Pharmacy Spend (Refer to Figure 3.2.1) [24]



The top 10 drugs driving non-PBM spend are listed in table 3.2.1, with unit price and utilization values broken out.

Table 3.2.1 Top 10 drugs driving non-PBM spend [25]

Drug	Current PEPM	Change in PEPM	Change in # Scripts	Change in Unit Pricing	Norm value of PEPM	Percent Rank (Norm value = 50%)
Drugs Requiring Detail Codes	$3.49	15.0%	3.6%	13.5%	$4.25	-
Trastuzumab	$1.83	31.6%	14.8%	17.2%	$0.85	-
Injection, Pegfilgrastim, 6 Mg-J2505	$1.45	2,625.8%	2,400.0%	11.4%	$1.38	-
Pharmacy-R250	$1.43	-36.5%	-14.8%	-23.8%	$7.29	-
Non Esrd Epoetin Alpha Inj	$1.09	181.1%	104.5%	40.5%	-	-
Drugs Unclassified Injecti	$1.02	-20.1%	33.9%	-39.0%	-	-
Drugs - Epo Under 10,000 Units	$0.93	8.7%	16.6%	-4.8%	$0.17	-

[24] Source: Sightlines Medical Intelligence : PBM Cost: Claims Module / Pharmacy
Non PBM Cost: Claims Module / Medical / drill by Plan Type / Zoom Forward / drill by Procedure Group / Non-PBM Drug

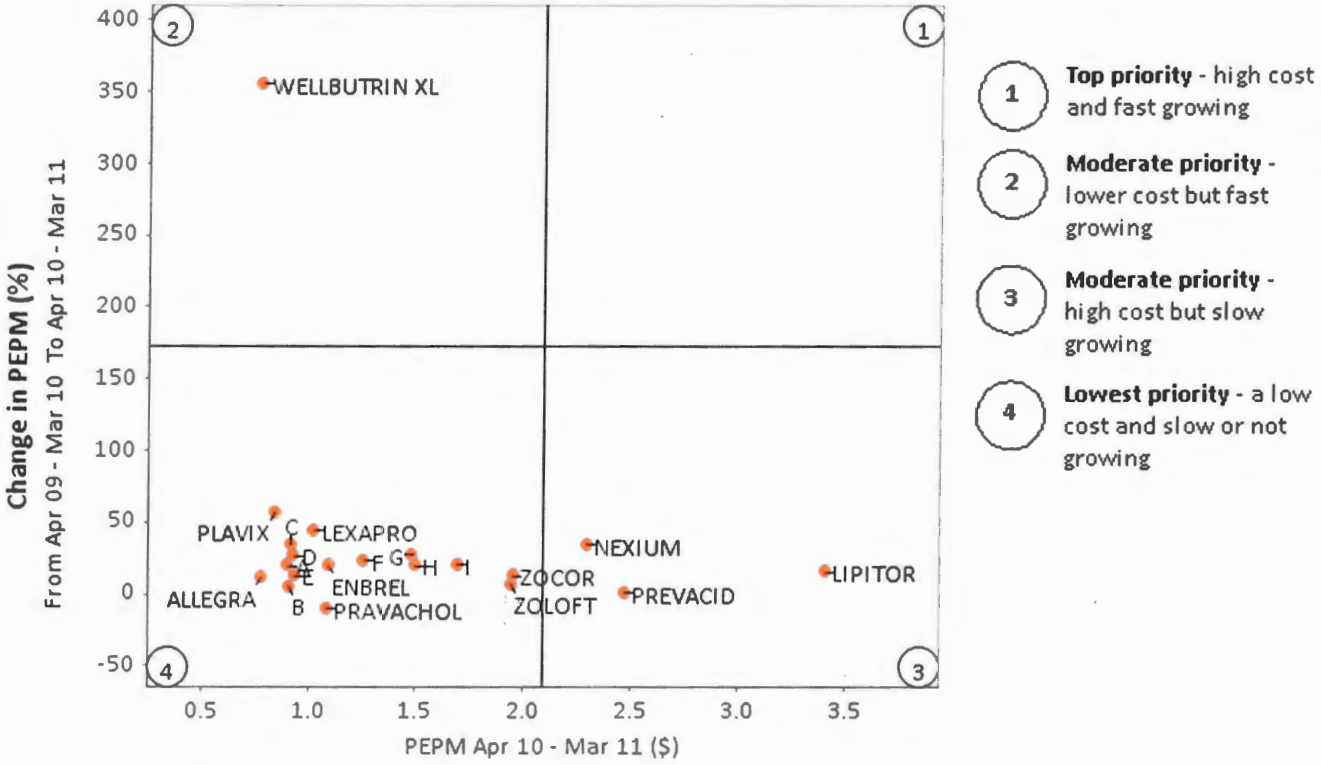
[25] Source: Sightlines Medical Intelligence : Claims module / Medical / Plan Type / Zoom Forward / drill by Procedure Group / Non-PBM Drug / Source

Drug	Current PEPM	Change in PEPM	Change in # Scripts	Change in Unit Pricing	Norm value of PEPM	Percent Rank (Norm value = 50%)
Pharmacy - Incident to Radiolo	$0.80	-6.5%	-11.5%	7.8%	$0.30	-
Drugs - Epo Over 10,000 Units	$0.69	308.6%	162.5%	59.1%	$0.27	-
Rituximab Cancer Treatment	$0.67	-32.8%	-43.3%	21.2%	$0.90	-

3.2.2 PBM drug spend

The chart below shows which drugs are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred by drug get larger. Moving bottom to top on the vertical axis, year-on-year growth in costs increases. Therefore, locations in the upper right corner are both large and growing fast. In general, drugs that do not have generic or branded substitutes will typically have the highest rates of cost inflation, but lower overall absolute costs.

Figure 3.2.3 Cost drivers: Areas of cost and cost growth by drug [26]



A. COPAXONE B. ZYRTEC C. TOPROL XL D. PROTONIX E. ACTOS
F. SINGULAIR G. ADVAIR DISKUS H. CELEBREX I. EFFEXOR XR

[26] Source: Sightlines Medical Intelligence : Claims module / Trend / Pharmacy / drill by Plan Type / Zoom Forward / drill by Rx Class / drill by Drug

Table 3.2.2 Top 20 Drugs [27]

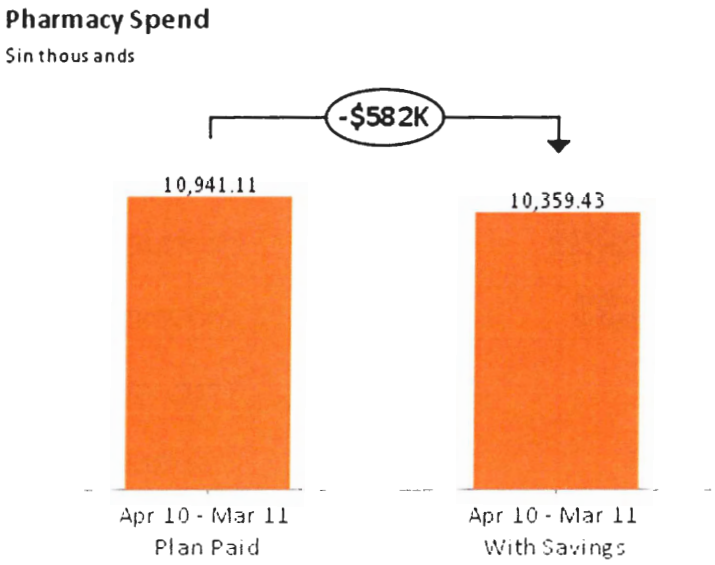
Drugs	Branded to Generic ratio	Current PEPM	Change in PEPM	Change in # Scripts	Change in Unit Pricing	Norm value of PEPM	Percent Rank (Norm value = 50%)
LIPITOR	0.00	$3.41	15.8%	15.6%	2.3%	$3.09	-
PREVACID	0.00	$2.47	0.8%	-2.9%	6.0%	$1.48	-
NEXIUM	0.00	$2.29	34.5%	25.7%	9.3%	$3.16	-
ZOCOR	0.00	$1.95	13.2%	10.6%	4.6%	$0.02	-
ZOLOFT	0.00	$1.94	6.6%	2.5%	6.3%	$0.04	-
EFFEXOR XR	0.00	$1.69	20.7%	13.5%	8.7%	$1.50	-
CELEBREX	0.00	$1.49	20.0%	13.1%	8.4%	$0.83	-
ADVAIR DISKUS	0.00	$1.48	27.7%	20.9%	7.9%	$1.72	-
SINGULAIR	0.00	$1.26	23.7%	20.8%	4.6%	$1.63	-
ENBREL	0.00	$1.09	19.7%	11.8%	9.4%	$2.26	-
PRAVACHOL	0.00	$1.08	-9.9%	-13.8%	6.8%	$0.01	-
LEXAPRO	0.00	$1.02	44.5%	38.1%	7.0%	$1.19	-
ACTOS	0.00	$0.93	13.0%	13.0%	2.2%	$1.34	-
PROTONIX	0.00	$0.93	27.3%	20.7%	7.7%	$0.21	-
TOPROL XL	0.00	$0.92	34.8%	25.5%	9.8%	$0.08	-
ZYRTEC	0.00	$0.91	5.3%	0.4%	7.2%	$0.01	-
COPAXONE	0.00	$0.90	20.1%	14.4%	7.3%	$1.13	-
PLAVIX	0.00	$0.84	57.3%	51.5%	6.1%	$1.44	-
ALLEGRA	0.00	$0.78	11.2%	7.6%	5.6%	$0.02	
WELLBUTRIN XL	1.66	$0.78	356.1%	316.9%	11.8%	$0.20	-

[27] Source: Sightlines Medical Intelligence : Claims module / Trend / Pharmacy / drill by Plan Type / Zoom Forward / drill by Rx Class / drill by Drug

3.2.3 Selected prescription cost avoidance opportunities

This cost avoidance analysis is a cost comparison between two therapeutically equivalent drugs. Substantial cost differences can exist between therapeutically equivalent drugs, regardless of whether they are brand or generic. In practice, physician prescribing patterns, consumer demand, and formulary benefit design drive drug utilization. If a less expensive alternative is identified, substitution or formulary design change should be approved by appropriate clinicians.

Figure 3.2.4 Pharmacy spend [28]

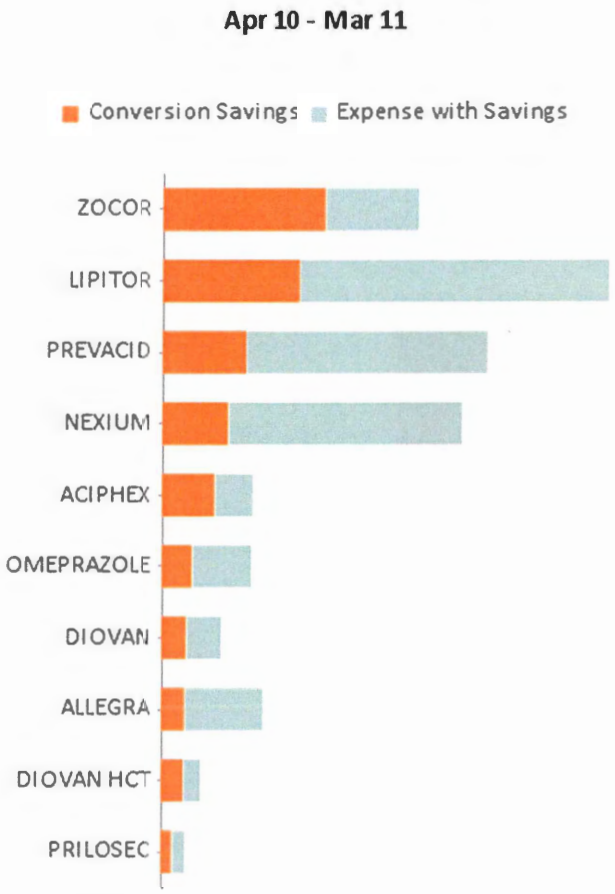


We estimate that savings of $581,679 in pharmaceutical spend from Apr 10 - Mar 11 exist.

[28] Source: Sightlines Medical Intelligence : Conversion Analyzer module

Our drug Conversion Analyzer feature compares the cost that a company pays for a drug, at the company level, to the average cost of a clinically equivalent substitute, at the portfolio level. The conversion opportunities we assess are non-controversial, clinically acceptable substitutions.

Figure 3.2.5 Top 10 Savings opportunity through Conversion Analyzer [29]



Current Drug Expense $ in K	Alternate Drug	Conversion Savings	Alternate Drug Expense $ in K
$232.83	CRESTOR	63.6%	$84.64
$406.36	CRESTOR	30.7%	$281.42
$295.17	PROTONIX	25.8%	$218.98
$272.75	PROTONIX	22.2%	$212.06
$83.17	PROTONIX	57.9%	$35.05
$81.61	PROTONIX	34.2%	$53.69
$54.43	BENICAR	41.9%	$31.62
$93.20	ZYRTEC	22.9%	$71.82
$36.39	BENICAR HCT	55.4%	$16.24
$21.97	PROTONIX	46.8%	$11.68
	All Other Drugs	18.0%	$95.86
		Total =	**$1,113.06K**

[29] ***Note:***

1. The Potential Savings are calculated by comparing the Current Drug average cost for Metropolitan System to the average cost of the Alternate Drug derived from the selected group(s). This can occasionally lead to there being a cost avoidance opportunity from switching both to and from a drug and its substitute
2. Verisk Health does not take into consideration any pharmacy rebate information
3. Statin conversion opportunities account for differential drug potencies and dose sizes
4. Plavix and Celebrex opportunity calculations exclude members that meet standard prescribing indications for those drugs
5. Conversion savings refers to the percent of the plan paid pharmacy expense that can potentially be saved.

Source: Sightlines Medical Intelligence : Conversion Analyzer module

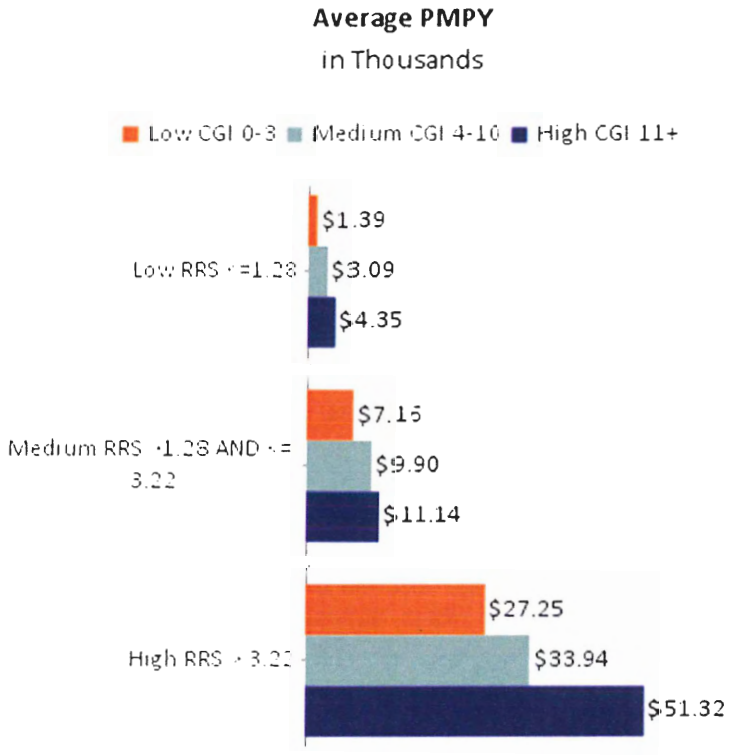
4 CLINICAL DEEP DIVES

4.1 General Clinical Quality Performance and Economic Opportunity

The RRS is a quantitative assessment of disease and risk burden at a population level. The Care Gap Index (CGI) quantifies the gaps identified for a population. Verisk Health utilizes these two factors to understand the association between disease burden, quality, and cost.

In figure 4.1.1, members are grouped by RRS, and then by CGI. Members with a high RRS generally incur higher costs and have more gaps in care. However, for each RRS bucket, corresponding decreases in care gaps (and the CGI) are associated with decreases in the total medical spend.

Figure 4.1.1 Member costs by Risk and CGI buckets [30]



	Members Count	Total Spend $ in Millions
Low RRS < =1.28	15,081	37.31
	1,826	10.53
	26	0.22
Medium RRS >1.28 AND < = 3.22	1,526	20.06
	1,171	22.15
	63	1.34
High RRS > 3.22	192	9.6
	287	18.9
	36	3.53
	20,208	**123.63**

[30] ***Note:***
Refer to Table 5.5.1 in Appendix 5.5 for further detail about RRS buckets.

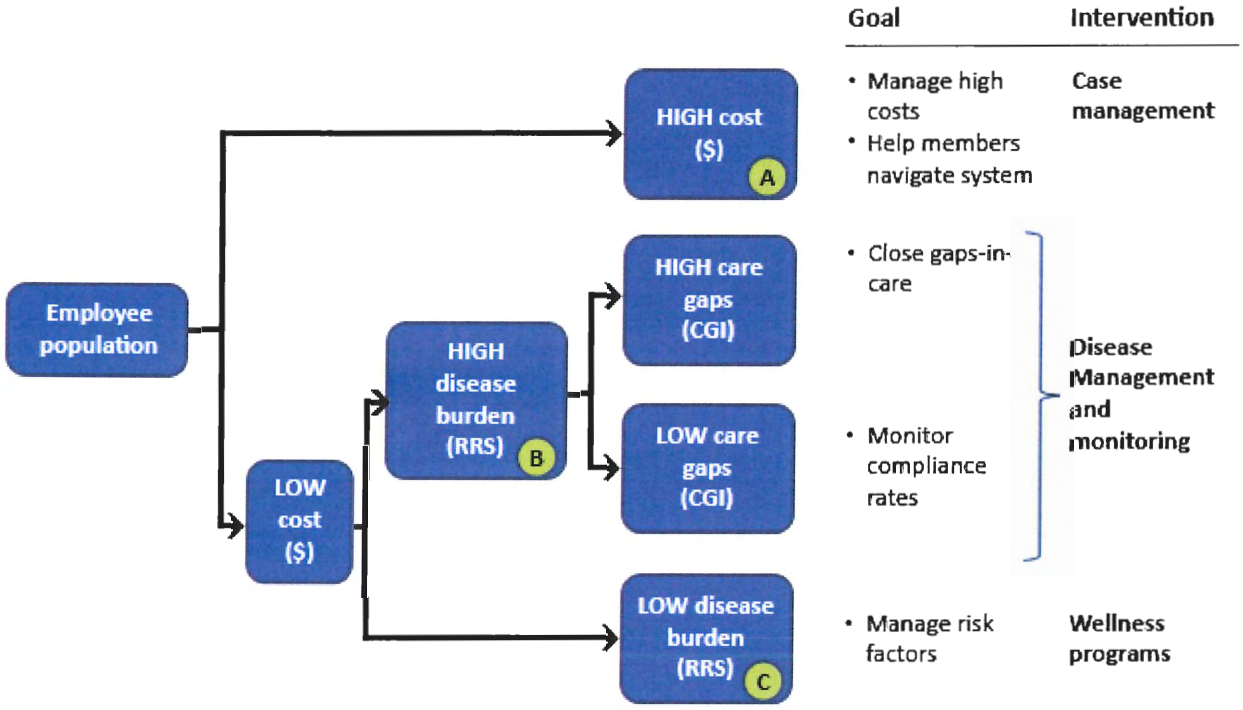
Gautam Ph.D., Shiva, and Surya Singh, M.D. "Predicting Overall and Impactable Future Cost with the Verisk Health Risk Modeling System".

The ranges for risk index/relative risk score and care gap index are calculated based on an approximate distribution of 80%, 15%, and 5% of members for low, medium, and high groups respectively from the Verisk Health Normative database.

Source: Sightlines Medical Intelligence : Individuals module / Filter on RRS, CGI and Current = 'Y'

To stratify a total population for health management, we use the RRS (disease burden), the Care Gap Index (gaps in clinical care), and cost. Using these factors, any population can be comprehensively categorized into the mutually exclusive categories, each with specific interventions. Below is a graphical representation of the Verisk Health recommended classification approach. Sections 4.2 through 4.4 correspond to the recommended category-based interventions.

Figure 4.1.2 Framework for Population based Health Management [31]



A: Case Management opportunities:
Members with annual total spend greater than $25,000 are considered high cost and should be managed closely. The cut-off value of $25,000 can be modified while doing stratification within Sightlines Medical Intelligence; we recommend choosing a cutoff point that is consistent with ones individual reinsurance threshold.

B: Disease Management opportunities:
Members with annual spending less than $25,000 are considered low cost. Of the low cost members, those with a disease burden greater than 95% of the population are considered high disease burden, and should be addressed through Disease Management monitoring and intervention. (As with the total cost cutoff, the disease burden cutoff that is chosen can be modified in Sightlines Medical Intelligence).

Those with a high disease burden and numerous gaps in care (a high CGI) require disease management to reduce gaps and prevent high cost claims. On the other hand, members with high compliance rates - as manifest by a low care gap index should be monitored for continued compliance.

C: Wellness opportunities:
Members with low cost and low disease burden should be primarily addressed through Wellness Programs that reduce the risk factors for developing chronic diseases.

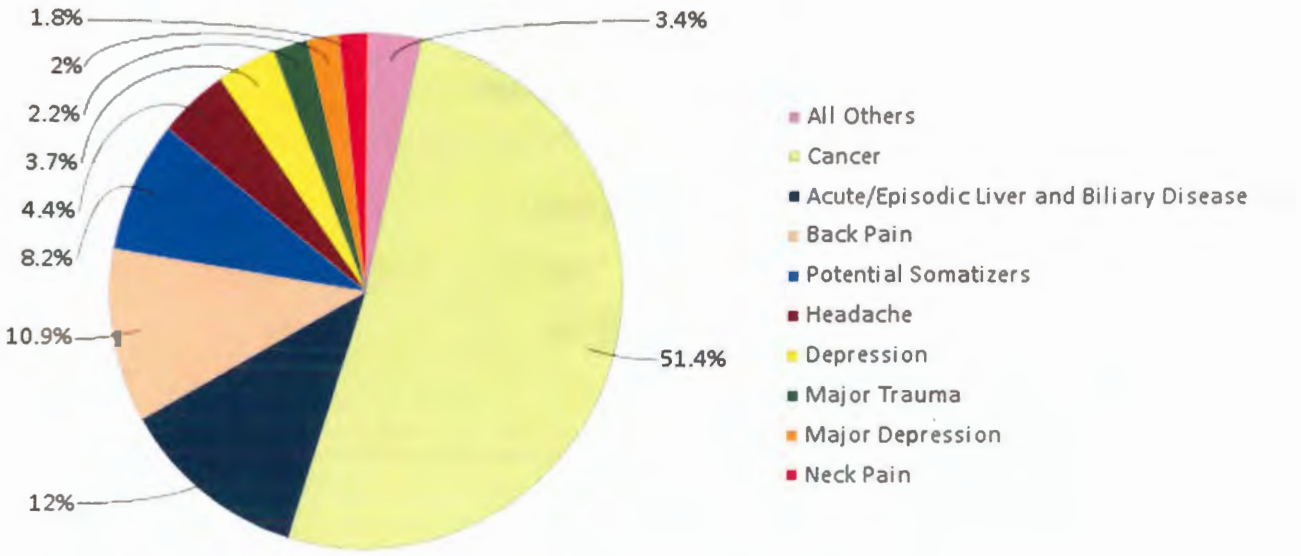
[31] Source: Sightlines Medical Intelligence : Individuals module / filter on RRS, CGI and Total Paid

4.2 Case Management Opportunities

As discussed in Figure 4.1.2, Verisk Health uses the RRS, Care Gap Index (CGI) and total cost to stratify a population for Disease Management. Patients who have incurred a high total spend (>$25,000 PMPY) will generally benefit from Case Management. This corresponds to Category "A" in Figure 4.1.2. If the data is sent to Verisk Health, Sightlines Medical Intelligence can be used to assess what proportion of high-cost members is currently enrolled in Case Management.

Figure 4.2.1 displays the highest paid diagnoses for members of this population.

Figure 4.2.1 Frequency of primary diagnosis of high cost members (>$25,000 PMPY)



4.3 Disease Management Opportunities

As discussed in Figure 4.1.2, Verisk Health uses the RRS, Care Gap Index (CGI) and total cost to stratify a population for Disease management. Patients who are low cost, have a high RRS, and have a numerous addressable gaps in care (i.e., have a high CGI) will generally benefit from Disease Management. This corresponds to Category "B" in Figure 4.1.2.

Table 4.3.1 synthesizes the 'clinical condition'/disease severity and the associated Care Gap Index for the entire population across key 'clinical condition'/disease categories into a "heat map". Focused intervention (e.g. an initiative to increase compliance with ace-inhibitors and beta-blockers in patients with heart failure) based on this information can significantly improve health plan performance over time. These Quality & Risk Measures can become the basis for identification and stratification of plan participants for disease management and case management program participation.

Table 4.3.1 Verisk Health Quality & Risk Measures [32]

Clinical Condition	Disease Burden Summary	Care Gap Measure Performance Summary
Asthma	45.7%	3.3%
Cardiac	23.7%	47.7%
COPD	30.0%	-23.3%
Diabetes	27.0%	-4.6%
Geriatric	12.8%	12.1%
Mental Health	52.1%	-30.5%
Pregnancy	-17.9%	-21.9%
Renal Failure	46.6%	-23.5%

Performance Relative to Verisk Health Norms	Disease Burden Ranges	Care Gap Ranges
Good	<=-10%	<=-5%
Average	>-10% and <10%	>-5% and <5%
Poor	>=10%	>=5%

Please Note: If the underlying CPT codes for each laboratory test or panel are not submitted to Verisk Health in the medical claims then the compliance in the Quality and Risk Measures will appear lower than they actually are.

[32] ***Note:*** Refer to Table 5.5.3 and 5.5.4 in Appendix 5.5 for further detail.

1. This analysis is based upon the full cycle period of data within Sightlines Medical Intelligence; this is typically a 24 month period.
2. The results displayed in this table are based on current members.
3. COPD: Chronic Obstructive Pulmonary Disease

4.4 Wellness Management Opportunities

As discussed in Figure 4.1.2, Verisk Health uses the RRS, Care Gap Index (CGI) and total cost to stratify a population for Disease management. Patients who are well are most efficiently addressed through Wellness Programs. This corresponds to Category "C" in Figure 4.1.2.

Table 4.4.1 details screening and preventative tests - and the associated compliance with these tests - for the entire population. These data are benchmarked against the Verisk Health Commercial Norm. Wellness programs (e.g. an initiative to increase mammogram compliance rates) based on this information can significantly improve health plan performance on these measures.

Table 4.4.1 Preventative Measures [33]

Performance Relative to Verisk Health Norms

Good	<=-5%
Average	>-5% and <5%
Poor	>=5%

Group	Condition	Screening/Preventive	Variation from Norm
Both	>=50 years old	Patients without any colorectal cancer screening in the analysis period.	-4.7%
	>= 51 years old	Patients without long office visit in the last 2 years.	4.8%
Male	Men >50 years old	Men without PSA level in the last 2 years (controversial test).	12.8%
Female	Women >20 y/o	Women without pap smear in the last two years.	-4.3%
	Women between 40 and 49 y/o	Women without mammogram in the last 2 years.	-1.9%
	Women between 21 and 65 y/o	Women without pap smear in the analysis period.	-3.7%
	Women >=49 y/o	Women without mammogram in last 12 months.	-2.2%
	Women between 40 and 49 y/o	Women without mammogram in the analysis period.	-1.9%
	Women between 49 and 69 y/o	Women without mammogram in the last 18 months.	-2.4%

Please Note: If the underlying CPT codes for each laboratory test or panel are not submitted to Verisk Health in the medical claims then the compliance in the Quality and Risk Measures will appear lower than they actually are.

*(E) = Enrollment criterion is applied to the Quality and Risk Measure and its Condition

[33] ***Note:*** Refer to Table 5.5.2 in Appendix 5.5 for further detail.

1. This analysis is based upon the full cycle period of data within Sightlines Medical Intelligence; this is typically a 24 month period.
2. The results displayed in this table are based on current members.

5 APPENDIX

5.1 Demographics

Table 5.1.1 Breakdown of membership by relationship

	Avg. Age	Members		Total Amount Billed	Employee Paid	Member Expenses	
		Total	Current			Total	% of Total
Employee	43.7	12,663	9,978	$138,640,051	$15,113,127	$95,189,066	61.9%
Spouse	46.2	5,595	4,367	$60,945,630	$5,337,838	$39,608,260	25.7%
Dependent	13.3	10,014	7,152	$31,148,629	$4,492,435	$19,052,071	12.4%
Total	**33.4**	**28,272**	**21,497**	**$230,734,309**	**$24,943,400**	**$153,849,397**	**100.0%**

5.2 Financial Analyses

Table 5.2.1 Medical and Pharmacy Claims by Month (Apr 09 - Mar 10)

Category	Paid Date												
	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Total
Medical	$4,659,638	$4,599,637	$4,448,100	$4,750,572	$5,101,970	$4,679,427	$5,183,021	$6,007,985	$6,323,062	$5,593,826	$5,288,972	$6,117,712	$62,753,922
Medical PEPM	$491	$485	$469	$497	$531	$486	$537	$622	$654	$566	$537	$622	$6,497
Pharmacy	$694,655	$724,588	$761,640	$740,212	$797,533	$847,259	$1,240,133	$448,372	$1,444,774	$579,332	$630,324	$799,014	$9,707,836
Pharmacy PEPM	$73	$76	$80	$77	$83	$88	$128	$46	$150	$59	$64	$81	$1,007
Total	$5,354,293	$5,324,225	$5,209,740	$5,490,783	$5,899,504	$5,526,686	$6,423,154	$6,456,357	$7,767,836	$6,173,157	$5,919,296	$6,916,727	$72,461,758
Total PEPM	$564	$561	$550	$575	$614	$574	$665	$669	$804	$625	$601	$703	$7,504

Table 5.2.2 Medical and Pharmacy Claims by Month (Apr 10 - Mar 11)

Category	Paid Date												
	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Total
Medical	$6,195,243	$5,406,694	$5,854,188	$4,721,338	$6,153,017	$5,671,020	$5,865,883	$5,527,493	$6,934,247	$6,326,096	$5,550,176	$6,241,134	$70,446,529
Medical PEPM	$631	$552	$598	$483	$625	$577	$596	$561	$707	$632	$557	$624	$7,143
Pharmacy	$848,138	$820,976	$901,790	$881,614	$936,988	$1,059,271	$1,003,830	$965,425	$1,305,117	$560,449	$754,644	$902,867	$10,941,110
Pharmacy PEPM	$86	$84	$92	$90	$95	$108	$102	$98	$133	$56	$76	$90	$1,110
Total	$7,043,381	$6,227,669	$6,755,979	$5,602,952	$7,090,005	$6,730,291	$6,869,714	$6,492,918	$8,239,364	$6,886,545	$6,304,820	$7,144,001	$81,387,639
Total PEPM	$718	$636	$690	$574	$720	$685	$698	$659	$840	$688	$632	$715	$8,254

Table 5.2.3 Expense Distribution

Band	# Members	Total Member Expenses	Avg. Expense per Member	% Total Paid	
				Actual	Norm
1%	283	$41,936,197	$148,184	27.3%	29.7%
2-5%	1,131	$42,251,000	$37,357	27.5%	27.0%
6-15%	2,827	$37,298,090	$13,194	24.2%	23.4%
16-30%	4,241	$20,467,334	$4,826	13.3%	12.8%
31-60%	8,481	$10,797,929	$1,273	7.0%	6.6%
61-100%	11,309	$1,098,848	$97	0.7%	0.5%
Total	**28,272**	**$153,849,397**	**$204,932**	**100.0%**	**100.0%**

This table shows medical claim payments in relation to the date when the claims were incurred (date of service). The table is useful for developing completion factors which allow forward projections of monthly payments and for estimating incurred but not reported (IBNR) claims.

Table 5.2.4 Medical Claim Lag Report [34]

Paid Date	Service Date													
	All Prior	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Total
Apr-10	$5,312,267	$882,976												$6,195,243
May-10	$2,081,381	$2,604,984	$720,329											$5,406,694
Jun-10	$1,382,116	$866,129	$2,655,021	$950,922										$5,854,188
Jul-10	$601,399	$289,329	$741,535	$2,227,868	$861,208									$4,721,338
Aug-10	$486,427	$139,008	$469,256	$1,158,197	$2,913,168	$986,960								$6,153,017
Sep-10	$398,792	$104,610	$238,141	$276,497	$912,578	$2,476,771	$1,263,630							$5,671,020
Oct-10	$299,647	$56,015	$96,201	$217,133	$385,813	$910,225	$2,850,393	$1,050,458						$5,865,883
Nov-10	$241,484	$12,891	$56,021	$210,497	$99,293	$331,373	$683,317	$2,825,275	$1,067,343					$5,527,493
Dec-10	$97,281	$55,333	$16,527	$47,383	$348,638	$283,914	$348,234	$1,089,519	$3,314,243	$1,333,174				$6,934,247
Jan-11	$87,594	$7,406	$73,781	$16,171	$28,933	$108,817	$194,599	$509,252	$1,297,080	$2,998,638	$1,003,824			$6,326,096
Feb-11	$122,800	$2,815	$9,982	$38,584	$19,191	$92,848	$256,384	$200,116	$314,018	$855,500	$2,598,076	$1,039,862		$5,550,176
Mar-11	$75,161	$4,550	$15,379	$23,051	$49,203	$58,842	$71,677	$120,906	$410,282	$547,364	$1,068,597	$2,453,321	$1,342,801	$6,241,134
Total Plan Paid Medical	$11,186,350	$5,026,046	$5,092,174	$5,166,302	$5,618,024	$5,249,750	$5,668,235	$5,795,526	$6,402,966	$5,734,676	$4,670,497	$3,493,183	$1,342,801	$70,446,529

[34] ***Note:***

1. Utilization metrics are always calculated on an incurred basis.
2. The last two or three months of the year will show decreased values due to 'claims lag', and should be interpreted with caution.

Table 5.2.5: Medical Claim Lag Report and IBNR

Paid	Incurred													Monthly Paid			Lag	
	0Mths	1Mths	2Mths	3Mths	4Mths	5Mths	6Mths	7Mths	8Mths	9Mths	10Mths	11Mths	12+ Mths	Total	Current 12Mths	Prior 12Mths	Mthly	Qtly
Apr-10	$882,976	$2,562,905	$1,093,088	$815,265	$434,789	$110,102	$84,128	$105,724	$25,765	$12,921	$4,786	$37,940	$24,855	$6,195,243	$882,976	$5,312,267	1.91	
May-10	$720,329	$2,604,984	$928,279	$474,774	$199,846	$60,321	$39,734	$60,295	$57,514	$30,139	$132,994	$3,136	$94,349	$5,406,694	$3,325,313	$2,081,381	2.01	
Jun-10	$950,922	$2,655,021	$866,129	$394,081	$548,818	$142,322	$149,969	$29,780	$32,083	$9,505	$35,811	$5,757	$33,989	$5,854,188	$4,472,072	$1,382,116	1.84	1.92
Jul-10	$861,208	$2,227,868	$741,535	$289,329	$224,197	$53,195	$97,639	$59,426	$56,310	$37,616	$26,187	$9,841	$36,988	$4,721,338	$4,119,939	$601,399	1.77	
Aug-10	$986,960	$2,913,168	$1,158,197	$469,256	$139,008	$165,220	$38,974	$56,667	$45,822	$34,659	$74,747	$9,990	$60,347	$6,153,017	$5,666,590	$486,427	1.77	
Sep-10	$1,263,630	$2,476,771	$912,578	$276,497	$238,141	$104,610	$46,433	$38,945	$94,458	$66,253	$13,811	$34,231	$104,662	$5,671,020	$5,272,228	$398,792	1.81	1.79
Oct-10	$1,050,458	$2,850,393	$910,225	$385,813	$217,133	$96,201	$56,015	$132,322	$35,071	$31,737	$16,488	$11,801	$72,227	$5,865,883	$5,566,237	$299,647	1.73	
Nov-10	$1,067,343	$2,825,275	$683,317	$331,373	$99,293	$210,497	$56,021	$12,891	$41,604	$21,406	$67,972	$37,310	$73,192	$5,527,493	$5,286,009	$241,484	1.73	
Dec-10	$1,333,174	$3,314,243	$1,089,519	$348,234	$283,914	$348,638	$47,383	$16,527	$55,333	$19,854	$10,093	$16,321	$51,013	$6,934,247	$6,836,965	$97,281	1.63	1.69
Jan-11	$1,003,824	$2,998,638	$1,297,080	$509,252	$194,599	$108,817	$28,933	$16,171	$73,781	$7,406	$8,575	$7,558	$71,461	$6,326,096	$6,238,502	$87,594	1.65	
Feb-11	$1,039,862	$2,598,076	$855,500	$314,018	$200,116	$256,384	$92,848	$19,191	$38,584	$9,982	$2,815	$11,094	$111,707	$5,550,176	$5,427,376	$122,800	1.79	
Mar-11	$1,342,801	$2,453,321	$1,068,597	$547,364	$410,282	$120,906	$71,677	$58,842	$49,203	$23,051	$15,379	$4,550	$75,161	$6,241,134	$6,165,973	$75,161	1.77	1.73
Total														**$70,446,529**	**$59,260,179**	**$11,186,350**		
Average Monthly Paid														**$5,870,544**				
IBNR in Months																	**1.78**	

	Projected IBNR Based on Last Month's Lag	Projected IBNR Based on Last Quarter's Lag	Projected IBNR Based on Last Year's Average Lag
Incurred and Paid in Current Period	$59,260,179	$59,260,179	$59,260,179
Lag Factor	1.77	1.73	1.78
Incurred and Paid as a % of Total	0.85	0.86	0.85
Total Incurred	$69,491,932	$69,246,842	$69,581,241
Projected IBNR	$10,231,753	$9,986,662	$10,321,062

Table 5.2.6 Network Utilization and Contract Discount Summary

Network	Total					
	Claims Billed	Claims Allowed	Claims Paid	Employee Contribution	Network Discount	% Discount
All In Network	$181,995,909	$133,560,088	$114,810,688	$16,490,998	$48,435,821	26.6%
All Out-of-Network	$27,910,226	$21,942,950	$18,389,763	$2,715,801	$5,967,276	21.4%
Total	**$209,906,135**	**$155,503,038**	**$133,200,451**	**$19,206,799**	**$54,403,097**	**25.9%**

5.3 Disease Fingerprint

Table 5.3.1 presents utilization patterns of members with chronic conditions, ranked by number of members, for total office visits, emergency room visits and hospital admissions.

Table 5.3.1 Chronic Conditions Utilization Summary

Chronic Condition	# of Members	Members per 1000	Office Visits per 1000	ER Visits per 1000	Admissions per 1000	PMPY
Hypertension	2,156	101.4	6,302.8	426.8	226.4	$10,599.27
Hyperlipidemia	1,684	79.2	5,917.6	309.4	158.3	$8,894.45
Diabetes	941	44.3	7,324.5	536.8	317.8	$15,365.04
Asthma	595	28.0	8,395.5	648.6	247.2	$9,743.92
Osteoarthritis	562	26.4	8,246.1	474.0	280.6	$14,969.60
Coronary Artery Disease (incl. MI)	438	20.6	7,931.4	731.6	622.5	$26,263.93
Congenital Anomalies	254	11.9	8,630.4	577.9	513.4	$20,704.11
Chronic Obstructive Pulmonary Disease	165	7.8	10,378.0	1,022.5	749.4	$29,058.27
Cerebrovascular Disease	160	7.5	8,951.0	1,043.2	857.6	$32,982.64
Chronic Liver and Biliary Disease	115	5.4	10,296.0	823.3	674.9	$27,843.71
Rheumatoid Arthritis	107	5.0	9,193.3	404.6	194.6	$13,140.93
Atrial Fibrillation	104	4.9	8,795.0	718.2	637.8	$29,698.77
Bipolar Disorder	98	4.6	13,140.2	900.8	554.3	$9,945.47
Congestive Heart Failure	88	4.1	10,813.7	1,546.6	1,149.1	$41,072.08
Inflammatory Bowel Diseases	76	3.6	8,545.8	598.1	508.4	$17,809.27
Coagulopathy	53	2.5	9,978.4	832.4	778.4	$43,518.47
Chronic Renal Failure	51	2.4	12,581.7	1,129.3	1,368.8	$74,549.55
Immune Disorders	45	2.1	16,071.4	920.2	756.3	$49,593.29
Osteoporosis	41	1.9	7,005.5	394.3	184.0	$8,822.53
Demyelinating Diseases	35	1.6	6,116.1	340.6	185.8	$16,272.89
Ulcerative Colitis	33	1.6	8,401.7	322.5	390.4	$15,423.81
Major Organ Transplant	26	1.2	9,493.8	509.7	658.4	$55,433.51
Schizophrenia	15	0.7	11,864.8	1,487.3	1,352.1	$21,729.09
Cirrhosis	12	0.6	10,627.3	708.5	1,107.0	$29,344.83
HIV/Aids	11	0.5	7,405.4	378.4	270.3	$20,007.32
Parkinson's Disease	9	0.4	12,963.0	2,148.1	1,703.7	$17,295.28
Chronic Pancreatitis	6	0.3	9,463.4	1,170.7	1,463.4	$37,347.53
Cystic Fibrosis	6	0.3	4,864.9	216.2	0.0	$8,390.84
Sickle Cell Anemia	4	0.2	6,508.5	1,830.5	2,440.7	$21,483.60
Gaucher's Disease	2	0.1	6,500.0	500.0	500.0	$33,592.80
Hemophilia	1	0.0	5,454.5	545.5	545.5	$38,744.49

Note:

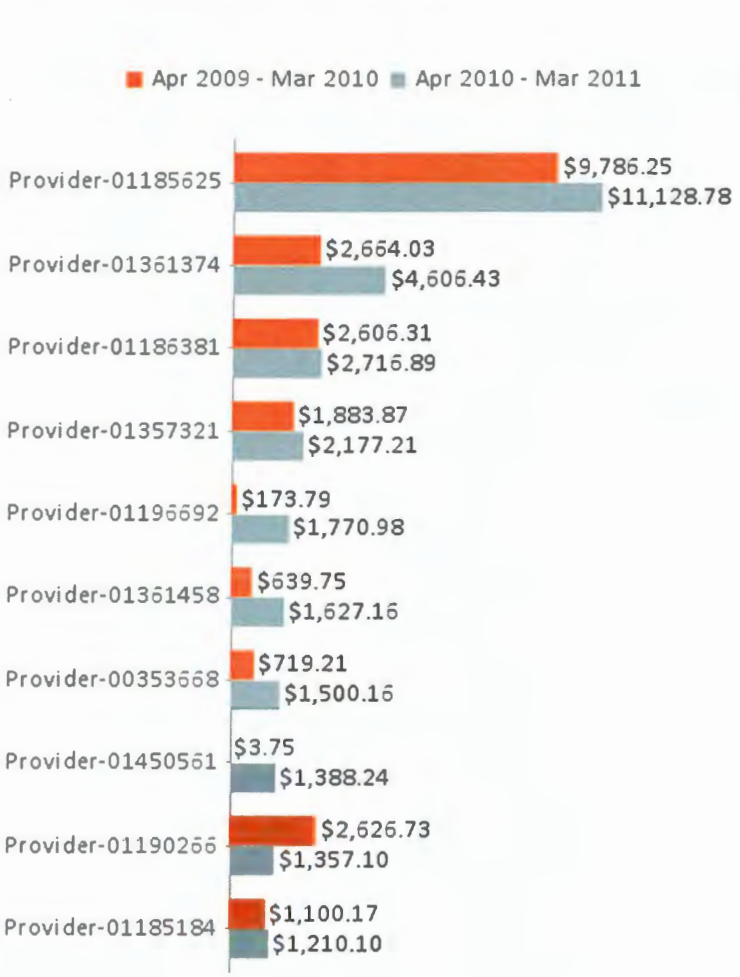
1. In this table a member can have multiple chronic conditions.
2. The results displayed in this table are based on claims incurred.

5.4 "Top 10" Analysis

5.4.1 Providers

Table 5.4.1 shows the top 10 providers, based on medical claim expenses, providing services to the members of your population. The providers generating the most claim expenses are usually institutional. Network changes or changes in provider reimbursement strategy may cause period-over-period percentage changes.

Table 5.4.1 Total Plan Paid ($K) by Providers



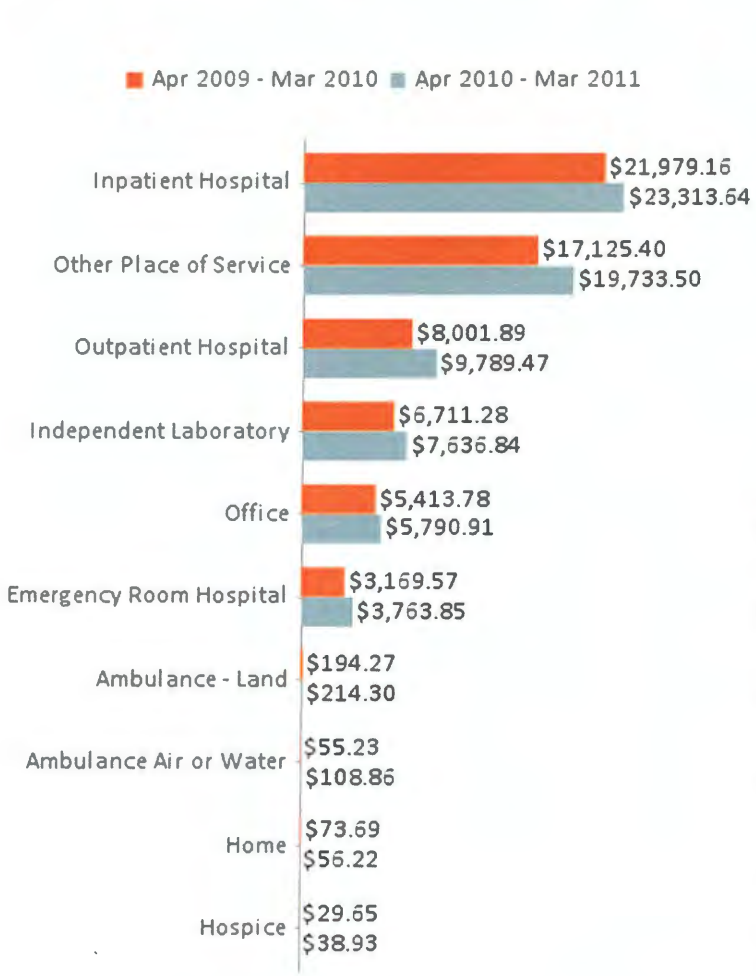
% of Total Plan Paid Apr 2010 - Mar 2011	% Change in Plan Paid
15.8%	13.7%
6.5%	72.9%
3.9%	4.2%
3.1%	15.6%
2.5%	919.1%
2.3%	154.3%
2.1%	108.6%
2.0%	36,952.4%
1.9%	-48.3%
1.7%	10.0%

Provider	Apr 2009 - Mar 2010		Apr 2010 - Mar 2011		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$22,203,855	35.4%	$29,483,070	41.9%	32.8%
All Others	$40,550,067	64.6%	$40,963,459	58.1%	1.0%
Total	$62,753,922	100.0%	$70,446,529	100.0%	12.3%

5.4.2 Places of Service

Table 5.4.2 shows places of service ranked according to medical claim expenses. Period-over-period percentage changes in Place of Service can be helpful when investigating changes in utilization patterns or when trying to understand the impact of plan design change. Increases in some categories may be appropriate. For example, outpatient hospital experience and office visits may increase as inpatient hospital services are more efficiently provided in the outpatient setting. Places of service experiencing large increases for many employers are Emergency Room, Outpatient Hospital, and Laboratory services.

Table 5.4.2 Total Plan Paid ($K) by Place of Service



% of Total Plan Paid Apr 2010 - Mar 2011	% Change in Plan Paid
33.1%	6.1%
28.0%	15.2%
13.9%	22.3%
10.8%	13.8%
8.2%	7.0%
5.3%	18.7%
0.3%	10.3%
0.2%	97.1%
0.1%	-23.7%
0.1%	31.3%

Service	Apr 2009 - Mar 2010		Apr 2010 - Mar 2011		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$62,753,922	100.0%	$70,446,529	100.0%	12.3%
All Others	$0	0.0%	$0	0.0%	0.0%
Total	$62,753,922	100.0%	$70,446,529	100.0%	12.3%

5.4.3 Diagnostic groups

Table 5.4.3 shows the top 10 diagnostic groups ranked according to medical claim expenses. Grouping of data into broad diagnostic categories assists in the identification of illness patterns that are unique to your population. Diagnostic groups with significant period-over-period increases should be examined in more detail. The distribution will be different depending on whether the group in question is Medicaid, Medicare or commercial. For a commercial population, diagnostic groups usually at or near the top of the list include ENT and upper respiratory disorders, gynecological disorders, and musculoskeletal conditions.

Table 5.4.3 Total Plan Paid ($K) by Diagnostic Groups



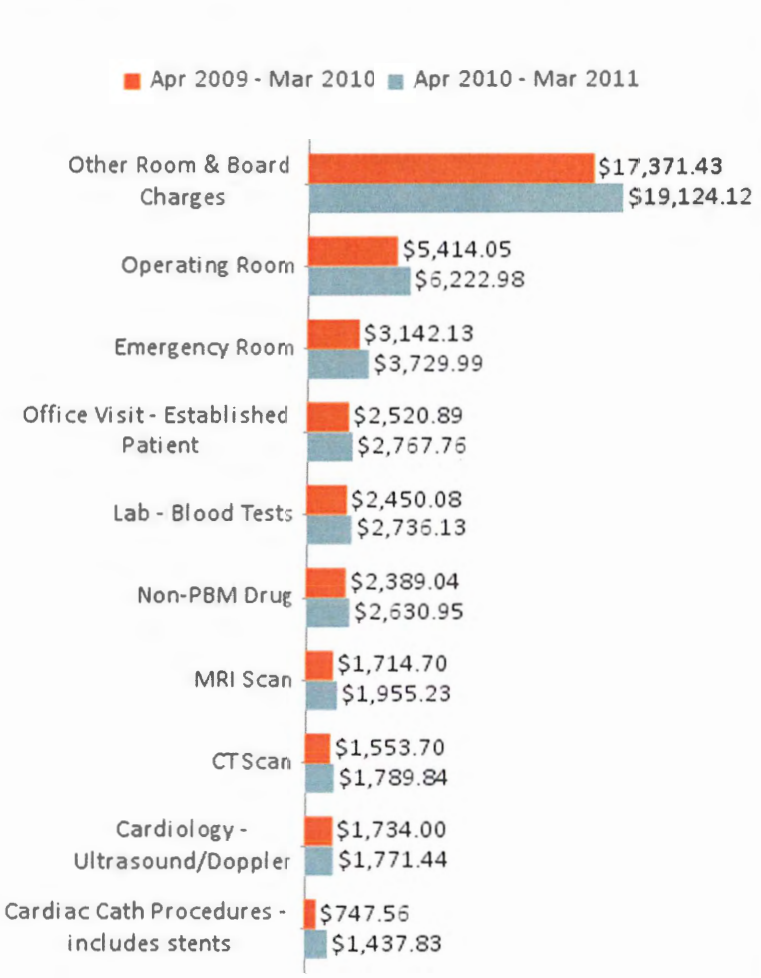
	% of Total Plan Paid Apr 2010 - Mar 2011	% Change in Plan Paid
CAD	**4.1%**	**111.6%**
Musculoskeletal Disorders	**3.5%**	**-0.9%**
ENT and Upper Resp Disorders	**3.3%**	**15.0%**
Chest Pain	**3.0%**	**86.1%**
Intervertebral Disc Disorders	**2.9%**	**53.8%**
Gynecological Disorders	**2.7%**	**2.6%**
Joint Derangement	**2.3%**	**27.8%**
Procedure Complications	**2.0%**	**46.1%**
Abdominal Pain	**2.0%**	**25.9%**
Osteoarthritis	**1.9%**	**17.9%**

Diagnostic Group	Apr 2009 - Mar 2010		Apr 2010 - Mar 2011		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$14,710,277	23.4%	$19,553,890	27.8%	32.9%
All Others	$48,043,645	76.6%	$50,892,638	72.2%	5.9%
Total	$62,753,922	100.0%	$70,446,529	100.0%	12.3%

5.4.4 Procedure groups

Table 5.4.4 shows the top 10 procedures, ranked according to medical claim expenses. For purposes of health plan analysis, period-over-period percentage changes may be more important than absolute dollars. Changes in membership must be considered when any such analysis is performed. Many employers are considering contracting with free-standing lab/x-ray facilities to better manage the growth in these areas.

Table 5.4.4 Total Plan Paid ($K) by Procedure Groups



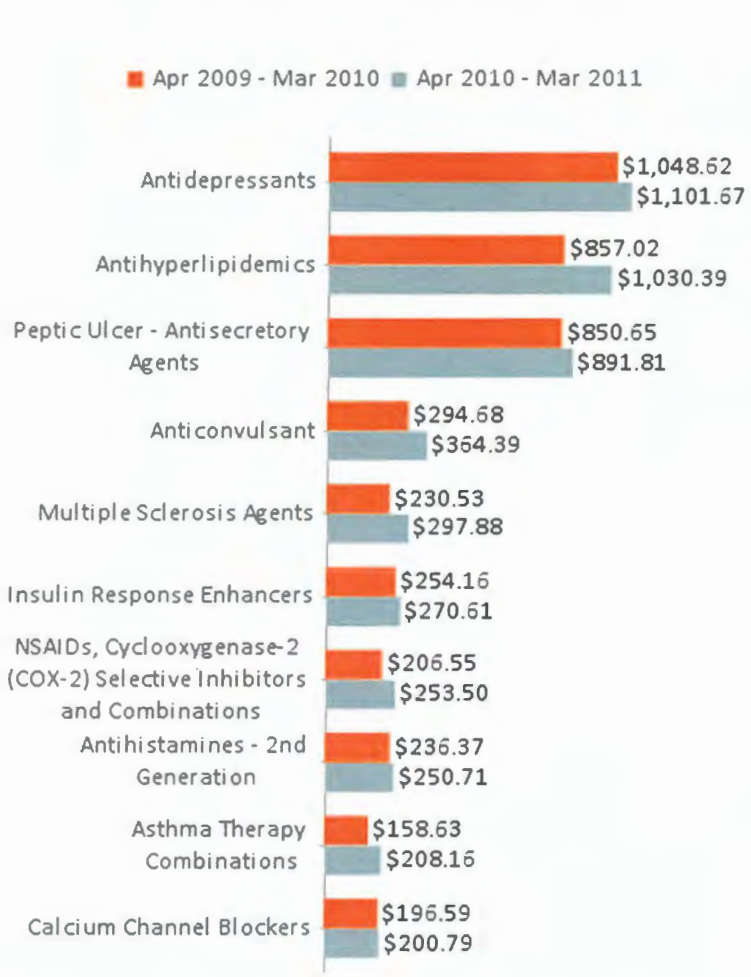
	% of Total Plan Paid Apr 2010 - Mar 2011	% Change in Plan Paid
Other Room & Board Charges	**27.1%**	**10.1%**
Operating Room	**8.8%**	**14.9%**
Emergency Room	**5.3%**	**18.7%**
Office Visit - Established Patient	**3.9%**	**9.8%**
Lab - Blood Tests	**3.9%**	**11.7%**
Non-PBM Drug	**3.7%**	**10.1%**
MRI Scan	**2.8%**	**14.0%**
CT Scan	**2.5%**	**15.2%**
Cardiology - Ultrasound/Doppler	**2.5%**	**2.2%**
Cardiac Cath Procedures - includes stents	**2.0%**	**92.3%**

Procedure Group	Apr 2009 - Mar 2010		Apr 2010 - Mar 2011		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$39,037,588	62.2%	$44,166,279	62.7%	13.1%
All Others	$23,716,334	37.8%	$26,280,250	37.3%	10.8%
Total	$62,753,922	100.0%	$70,446,529	100.0%	12.3%

5.4.5 Therapeutic classes

Table 5.4.5 shows the top 10 therapeutic drug classes ranked according to pharmacy claim expenses. For a commercial population, antihyperlipidemics, antidepressants, and gastrointestinal drugs are usually the three most expensive therapeutic classes. The anticonvulsants class is of particular interest because of the increasing use of certain anticonvulsants for pain control. If the anticonvulsants fall in the top 10, institution of a drug utilization review program should be considered.

Table 5.4.5 Total Plan Paid ($K) by Therapeutic Class



% of Total Plan Paid Apr 2010 - Mar 2011	% Change in Plan Paid
10.1%	**5.1%**
9.4%	**20.2%**
8.2%	**4.8%**
3.3%	**23.7%**
2.7%	**29.2%**
2.5%	**6.5%**
2.3%	**22.7%**
2.3%	**6.1%**
1.9%	**31.2%**
1.8%	**2.1%**

Therapeutic Class	Apr 2009 - Mar 2010		Apr 2010 - Mar 2011		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$4,333,798	44.6%	$4,869,921	44.5%	12.4%
All Others	$5,374,038	55.4%	$6,071,190	55.5%	13.0%
Total	$9,707,836	100.0%	$10,941,110	100.0%	12.7%

5.5 Clinical Quality Performance and Measures

Table 5.5.1 RRS bucket characteristics

RRS "Bucket"	RRS Range	% of Individuals	Average Age	Characteristics of individuals and types of care gaps in each range
Low	<=1.28	83.8%	31.8	Need screening tests only
Medium	>1.28 AND <= 3.22	13.7%	50.02	May or has a chronic disease and needs screening or recommended diagnostic testing/therapy
High	> 3.22	2.5%	52.14	Have chronic disease with complications, may also have some acute issues, and need more recommended diagnostic testing and/or therapy

Please Note: If the underlying CPT codes for each laboratory test or panel are not submitted to Verisk Health in the medical claims then the compliance in the Quality and Risk Measures will appear lower than they actually are.
*(E) = Enrollment criterion is applied to the Quality and Risk Measure and its Condition

Table 5.5.2 Wellness Measures

Screening/Preventative				% of Individual with Gap/Risk	
Group	**Condition**	**Members with Condition**	**Description**	**Actual**	**Norm**
Both	>= 51 years old	4,839	Patients without long office visit in the last 2 years.	26.5%	24.1%
	>=50 years old	5,286	Patients without any colorectal cancer screening in the analysis period.	67.7%	74.4%
Male	Men >50 years old	1,809	Men without PSA level in the last 2 years (controversial test).	64.2%	56.9%
Female	Women >20 y/o	9,290	Women without pap smear in the last two years.	44.0%	51.5%
	Women >=49 y/o	3,608	Women without mammogram in last 12 months.	47.4%	58.4%
	Women between 21 and 65 y/o	9,119	Women without pap smear in the analysis period.	43.6%	49.9%
	Women between 40 and 49 y/o	2,800	Women without mammogram in the analysis period.	43.4%	54.8%
		2,800	Women without mammogram in the last 2 years.	43.4%	54.8%
	Women between 49 and 69 y/o	3,552	Women without mammogram in the last 18 months.	37.9%	48.3%

Table 5.5.3 Gaps in Care

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		**Members with Condition**	**Description**	**Actual**	**Norm**
Asthma	Asthma	501	Patients without office visit in the analysis period.	0.2%	0.6%
		501	Patients without flu vaccination in the analysis period.	73.1%	62.3%
		501	Patients without inhaled corticosteroids or leukotriene inhibitors in the analysis period.	34.1%	32.4%
		501	Patients without long office visit in the last 12 months.	23.2%	15.5%
		501	Patients without flu vaccination in the last 12 months.	80.8%	73.0%
Cardiac	Anti-Hyperlipidemic Agents	1,869	Patients without laboratory tests in the last 12 months.	11.7%	22.8%
	Atrial fibrillation	86	Patients without anticoagulant drugs in	50.0%	42.3%

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
			the analysis period.		
	Atrial fibrillation on coumadin	43	Patients with prescription refill gaps of more than six months.	4.7%	5.0%
	Atrial Fibrillation on coumadin	43	Patients with more than sixty days between protimes.	9.3%	36.6%
	CAD	359	Patients without office visit in the analysis period.	0.3%	0.6%
		359	Patients without flu vaccination in the last 12 months.	86.9%	82.7%
		359	Patients without antihyperlipidemic drugs in the analysis period.	26.7%	25.5%
		359	Patients without office visit in the last 12 months.	1.9%	4.5%
		359	Patients without long office visit in the last 12 months.	21.2%	12.2%
		359	Patients without lipid profile test in the last 12 months.	25.1%	43.0%
		359	Patients without flu vaccination in the analysis period.	82.5%	72.7%
	CAD and Hypertension	151	Patients without antihypertensive drugs in the analysis period.	9.3%	12.8%
	CHF	73	Patients without LDL-C or lipid profile test in the last 12 months.	31.5%	58.6%
		73	Patients without long office visit in the last 12 months.	16.4%	12.6%
		73	Patients without beta-blocker drugs in the analysis period.	30.1%	31.5%
		73	Patients without flu vaccination in the analysis period.	69.9%	67.4%
		73	Patients without ACE inhibitors or ARBs or vasodilator drugs in the analysis period.	32.9%	32.2%
		73	Patients without office visit in the analysis period.	1.4%	1.3%
	Digoxin in last 12 months	81	Patients without digoxin level in the last 12 months.	74.1%	79.8%
	Females < 55 years old	10,839	Women with diagnosis of CAD or MI who should be a candidate for genetic testing to evaluate for the LDLR (low density lipoprotein receptor) genetic variant.	0.4%	0.3%
	Hypertension	1,894	Patients without office visit in the last 12 months.	3.1%	4.8%
		1,894	Patients without flu vaccination in the analysis period.	90.3%	77.9%

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
	Males < 45 years old	5,824	Men with diagnosis of CAD or MI who should be a candidate for genetic testing to evaluate for the LDLR (low density lipoprotein receptor) genetic variant.	0.4%	0.1%
	MI	47	Patients without beta-blocker drugs in the analysis period.	21.3%	23.1%
		47	Patients without statin drugs in the analysis period.	31.9%	24.3%
COPD	COPD	137	Patients without flu vaccination in the analysis period.	73.0%	65.1%
		137	Patients without COPD-related long office visit in the last 12 months.	75.2%	63.7%
		137	Patients without office visit in the analysis period.	0.0%	0.9%
Diabetes	Diabetes	785	Patients without office visit in the last 12 months.	2.3%	6.1%
		785	Patients with insulin and oral antidiabetic agents in the analysis period.	16.6%	13.2%
		785	Patients with oral antidiabetic agents in the analysis period.	63.9%	63.4%
		785	Patients without micro or macroalbumin screening test in the last 12 months.	42.7%	45.8%
		785	Patients without serum creatinine in the last 12 months.	21.1%	31.3%
		785	Patients without long office visit in the last 12 months.	23.9%	15.5%
		785	Patients without statin drugs in the analysis period.	51.8%	47.0%
		785	Patients with insulin in the analysis period .	29.6%	23.3%
		785	Patients without ACE inhibitor or ARB drugs in the analysis period.	41.8%	42.9%
		785	Patients without lipid profile test in the last 12 months.	26.8%	38.0%
		785	Patients without retinal eye exam in the last 12 months.	68.5%	70.6%
		785	Patients without semiannual HbA1c test.	75.3%	82.1%
		785	Patients without flu vaccination in the analysis period.	79.0%	72.5%
		785	Patients without HbA1c test in the last 12 months.	16.7%	30.6%
General	All individuals	21,497	Patients with prescriptions for more than 15 drug classes in the analysis period.	3.2%	3.3%
	Opiates	4,340	Patients with more than six Oxycontin	0.9%	1.8%

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		**Members with Condition**	**Description**	**Actual**	**Norm**
			prescriptions in the analysis period.		
Geriatric	>= 65 years old	461	Patients without long office visit in the last 12 months.	37.5%	33.5%
Mental Health	Depakote / Depakene in last 6 months	65	Patients without valproic acid level in the last six months.	67.7%	75.2%
	Depression	964	Patients without office visit in the last 12 months.	3.5%	5.9%
	Depression-related admission	101	Patients without mental health office visit within 14 days of discharge.	37.6%	25.2%
	Dilantin in last 12 months	43	Patients without dilantin level in the last 12 months.	37.2%	56.2%
	Lithium in last 6 months	29	Patients without lithium level in the last 6 months.	41.4%	63.1%
		29	Patients without serum creatinine test in the last 6 months.	48.3%	52.4%
Misc.	Demyelinating Disease	32	Patients without flu vaccination in the analysis period.	84.4%	79.1%
		32	Patients without office visit in the analysis period.	0.0%	0.8%
		32	Patients without office visit in the last 12 months.	0.0%	5.5%
	Inflammatory Bowel Disease	66	Patients without Flu Vaccination in the analysis period.	95.5%	77.9%
	Migraine/ Headache	245	Patients without office visit in the analysis period.	0.0%	0.5%
		245	Patients without office visit in the last 12 months.	0.8%	4.6%
	Rheumatoid Arthritis	93	Patients without office visit in the last 12 months.	3.2%	4.2%
		93	Patients without flu vaccination in the analysis period.	87.1%	71.8%
Osteoarthritis	Osteoarthritis	490	Patients with continuous use of opiates across the last 12 months.	10.2%	8.7%
Pregnancy	Pregnancy	517	Women with oral antidiabetic agents in the analysis period.	2.5%	3.2%
Renal Failure	Renal Failure/ESRD	43	Patients without serum creatinine test in the last 12 months.	18.6%	29.2%
		43	Patients without flu vaccination in the analysis period.	74.4%	68.3%
		43	Patients without urinalysis in the last 12 months.	55.8%	47.7%
		43	Patients without lipid profile test in the last 12 months.	39.5%	52.7%

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
		43	Patients without office visit in the last 12 months.	0.0%	6.3%
	Renal Failure/ESRD-not on Dialysis	24	Patients without serum albumin test every three months.	91.7%	96.8%
	Renal Failure/ESRD-on Dialysis	19	Patients without serum albumin test in the last 12 months.	36.8%	39.5%

Table 5.5.4 Risk Measures

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
Asthma	>60 years old with ER visits	390	Patients with asthma-related ER visit in the analysis period.	1.5%	0.8%
	Asthma	501	Patients with asthma-related hospitalization in the analysis period.	4.2%	3.9%
		501	Patients with asthma-related ER visit in the analysis period.	16.4%	13.4%
		501	Patients with more than one hospitalization in the analysis period.	8.8%	5.4%
Cancer	Cancer	398	Patients with liver or biliary cancers.	0.5%	0.7%
		398	Patients with cancer therapies in the last 12 months.	11.8%	11.1%
		398	Patients with upper GI cancer.	1.0%	1.3%
		398	Patients with ENT cancer.	2.3%	2.0%
		398	Patients with urinary tract cancer.	6.0%	5.0%
		398	Patients with leukemia.	1.8%	2.6%
		398	Patients with secondary malignancy.	5.5%	4.7%
		398	Patients with lymphoma or lymphosarcoma	3.8%	5.0%
		398	Patients with colorectal cancer.	11.6%	5.0%
		398	Patients with lung cancer.	3.0%	3.5%
		398	Patients with infusions for oncology and hematology in the analysis period.	14.8%	15.7%
		398	Patients with miscellaneous cancer.	16.1%	11.2%
		398	Patients with melanoma.	2.5%	3.7%
		398	Patients with skin cancer (excludes melanoma).	19.3%	28.3%
		398	Patients with breast cancer.	22.4%	20.8%
		398	Patients with pancreatic cancer.	0.5%	0.7%
Cardiac	All individuals	21,497	Patients with chest pain-related	0.4%	0.3%

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
			hospitalization in the analysis period.		
		21,497	Patients with chest pain-related ER visit in the analysis period.	2.1%	1.8%
	CAD	359	Patients with hyperlipidemia.	47.1%	32.5%
		359	Patients on both antiarrhythmic and antiplatelet agents in the analysis period.	1.4%	2.0%
		359	Patients with CAD-related hospitalization in the analysis period.	31.2%	19.6%
		359	Patients with hypertension or taking antihypertensive drugs.	84.7%	84.1%
		359	Patients with obesity.	2.5%	0.8%
		359	Patients with complicated lipid disorders.	29.2%	29.4%
		359	Patients with peripheral vascular disease (PVD).	7.8%	6.2%
		359	Patients with cerebrovascular disease (CVD).	5.6%	9.1%
		359	Patients with cardiac stenting in the analysis period.	18.7%	14.0%
		359	Patients with cardiac catheterization in the analysis period.	47.9%	36.5%
		359	Patients with CABG in the analysis period.	6.1%	4.9%
		359	Patients with nitrate class drugs in the analysis period.	38.7%	29.0%
		359	Patients with erythropoietin in the analysis period.	1.7%	1.8%
		359	Patients with depression.	5.3%	4.3%
		359	Patients with antiplatelet or anticoagulants in the analysis period.	36.2%	42.2%
		359	Patients with antidepressants in the analysis period.	34.3%	23.7%
		359	Patients with MI-related hospitalization in the analysis period.	2.8%	4.6%
		359	Patients with more than one hospitalization in the analysis period.	25.1%	17.9%
		359	Patients with CAD-related ER visit in the analysis period.	12.8%	12.8%
	CHF	73	Patients with more than one hospitalization in the analysis period.	46.6%	44.6%
		73	Patients with CHF or pulmonary edema-related ER visit in the analysis period.	5.5%	22.4%
		73	Patients with CHF or pulmonary edema-related hospitalization in the	24.7%	23.1%

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		**Members with Condition**	**Description**	**Actual**	**Norm**
			analysis period.		
		73	Patients with renal failure.	12.3%	21.2%
	CHF-related admission	20	Patients with readmission within 30 days of CHF-related hospital discharge.	5.0%	6.4%
	MI	47	Patients with subsequent cardiac-related hospitalization in the analysis period.	21.3%	14.7%
COPD	COPD	137	Patients with more than one hospitalization in the analysis period.	26.3%	23.3%
		137	Patients with COPD-related ER visit in the analysis period.	9.5%	13.6%
		137	Patients with home oxygen in the analysis period.	18.2%	27.0%
		137	Patients with tobacco use disorder.	2.9%	0.8%
		137	Patients with COPD-related hospitalization in the analysis period.	4.4%	12.0%
	COPD-related admission	7	Patients with readmission within 30 days of COPD-related hospital discharge.	14.3%	5.5%
Diabetes	Diabetes	785	Patients with diabetes-related ER visit in the analysis period.	4.8%	3.6%
		785	Patients with diabetes-related hospitalization in the analysis period.	4.6%	2.0%
		785	Patients with more than one hospitalization in the analysis period.	11.5%	7.2%
		785	Patients without claims for home glucose testing supplies in the last 12 months.	38.0%	49.5%
		785	Patients with antiplatelet agent in the analysis period.	6.1%	6.7%
		785	Patients with drug augmented stress test in the analysis period.	1.3%	3.3%
		785	Patients with peripheral vascular disease (PVD).	2.8%	2.3%
		785	Patients with renal failure.	2.3%	4.3%
		785	Patients with amputation in the analysis period.	0.1%	0.4%
		785	Patients with ulcer or open wound.	8.8%	7.1%
		785	Patients with drugs for a serious, or potentially very high risk, cardiac condition in the analysis period.	2.9%	5.9%
		785	Patients with hyperlipidemia.	39.5%	21.9%
		785	Patients with CAD.	12.6%	11.0%
		785	Patients with depression.	5.5%	4.4%
		785	Patients with dialysis in the analysis period.	1.9%	1.7%
		785	Patients with erythropoietin in the	1.8%	1.2%

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		**Members with Condition**	**Description**	**Actual**	**Norm**
			analysis period.		
		785	Patients with hypertension or taking antihypertensive drugs.	75.3%	71.3%
		785	Patients with obesity.	3.8%	1.7%
		785	Patients with complicated lipid disorders.	17.5%	20.0%
		785	Patients with test for creatinine clearance in the analysis period.	3.9%	1.4%
		785	Patients with retinopathy.	5.4%	2.7%
	Diabetes + Hypertension + Obesity	9	Patients without antihyperlipidemic drugs in the analysis period.	55.6%	42.7%
	Men > 60 years old	522	Patients with diabetes.	19.2%	17.2%
General	<10 years old with ER visits	703	Patients with two or more ER visits in the last 12 months.	14.8%	14.1%
	> $1,000 in ambulatory cost	8,213	Patients without office visit in the last 12 months.	5.8%	8.4%
	> 1 ER visit	1,896	Patients without office visit in the last 12 months.	8.1%	10.8%
	> 3 visits for Pain	659	Patients without pain management consultation in the analysis period.	0.0%	0.1%
	>10 years old with ER visits	4,922	Patients with two or more ER visits in the last 12 months.	15.1%	15.7%
	All individuals	21,497	Patients with hospice care claims in the analysis period.	0.0%	0.0%
		21,497	Individuals without any claim in the analysis period.	12.6%	14.3%
	ER Visits	5,689	Patients with ER visits on Saturday and/or Sunday.	42.0%	41.6%
	Home Health	44	Patients with home health cost of at least $10K in the analysis period.	4.5%	3.9%
	Home infusion	31	Patients with more than $5,000 paid in home infusion claims in the analysis period.	9.7%	17.3%
	Hospitalization	2,310	Patients without office visit within 7 days after discharge.	67.0%	61.1%
	Hypertension	1,894	Patients with more than one hospitalization in the analysis period.	7.9%	5.9%
	Individuals 16 to 50 y/o with $5,000 to $25,000 spend in the last 12 months	1,285	Patients identified as potential somatizers.	6.1%	6.4%

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		**Members with Condition**	**Description**	**Actual**	**Norm**
	Medical Cost > $1000	9,801	Patients with pharmacy costs >50% of their medical cost.	17.8%	18.9%
	Migraine/ Headache	245	Patients with migraine/ headache-related ER visit in the analysis period.	30.2%	18.9%
	Multiple Hospitalizations	459	Patients with more than two hospitalizations in the last six months.	5.4%	4.9%
	Office Visits	17,535	Patients with office visits to more than two types of specialists every three months.	0.0%	0.1%
	Pain Syndrome related ER visit	845	Patients without prior office visit(s) in the analysis period.	65.7%	68.1%
	Potential Somatizers	3	Patients with disease-related ER visit in the analysis period.	0.0%	3.4%
Geriatric	>= 65 years old	461	Patients with an ER visit in the last 12 months.	19.5%	17.6%
		461	Patients with antidepressants in the analysis period.	19.5%	17.0%
Mental Health	Depression	964	Patients with depression-related hospitalization in the analysis period.	9.3%	4.6%
		964	Patients with depression-related ER visit in the analysis period.	4.9%	4.0%
		964	Patients with more than one hospitalization in the analysis period.	7.9%	5.6%
	Depression-related admission	101	Patients without prior outpatient mental health office visit(s) in the analysis period.	49.5%	41.0%
	Depression-related ER visit	57	Patients without prior mental health-related office visit(s) in the analysis period.	42.1%	47.2%
Misc.	All individuals	21,497	Patients with Gaucher disease, with injections for the disease in the analysis period.	0.0%	0.0%
		21,497	Patients with gastric stapling, bypass, or banding procedures in the analysis period.	0.1%	0.2%
	Demyelinating Disease	32	Patients with more than one hospitalization in the analysis period.	12.5%	6.5%
	Female with cancer	252	Patients with female genital organ cancer.	13.1%	11.0%
	Inflammatory Bowel Disease	66	Patients with more than one hospitalization in the analysis period.	25.8%	10.5%
	Rheumatoid Arthritis	93	Patients with TNF drugs in the analysis period.	18.3%	22.5%

Risk Measures				% of Individual with Gap/Risk	
Clinical Condition		**Members with Condition**	**Description**	**Actual**	**Norm**
	Sleep Apnea	302	Patients with polysomnography study and CPAP in the analysis period.	50.7%	46.1%
	Women <40 y/o	6,626	Women with menopause before age 40.	0.1%	0.1%
Osteoarthritis	Osteoarthritis	490	Patients with hylan injections in the analysis period.	16.7%	12.2%
Pregnancy	Pregnancy	517	Pregnant women delivered with more than 15 prenatal visits.	0.2%	0.3%
		517	Pregnant women delivered with fewer than six prenatal visits.	30.8%	33.2%
		517	Women with hospitalization for pregnancy-related diagnosis other than delivery.	7.5%	6.9%
		517	Women with high-risk pregnancy.	13.2%	16.8%
		517	Women with pregnancy-related ER visit in the analysis period.	9.5%	15.5%
		517	Women with pregnancy or delivery complications.	65.4%	73.9%
Renal Failure	Renal Failure/ESRD	43	Patients with renal failure/ESRD-related hospitalization in the analysis period.	27.9%	13.2%
		43	Patients with renal failure/ESRD-related ER visit in the last 12 months.	4.7%	5.7%

ORIGIN ID:TMAA (678) 306-3100
ZANDRA HALLEY
THE SEGAL COMPANY
2018 POWERS FERRY ROAD SE
SUITE 850
ATLANTA, GA 30339
UNITED STATES US

SHIP DATE: 24MAY16
ACTWGT: 17.00 LB
CAD: 8174738/INET3730

BILL SENDER

TO MICHELLE THOMPSON/TERESA FLEMING
STATE OF NEBRASKA
STATE PURCHASING BUREAU
1526 K. STREET, SUITE 130
LINCOLN NE 68508
(402) 471-6500 REF:
INV:
PO: DEPT:

540J163231727F

FedEx Express

WED - 25 MAY 10:30A
PRIORITY OVERNIGHT

TRK# 0201 7763 6391 4008

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2016 MAY 25 AM 8 52

State of Nebraska (State Purchasing Bureau)
REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

RETURN TO:
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
Phone: 402-471-6500
Fax: 402-471-2089

SOLICITATION NUMBER	RELEASE DATE
RFP 5297Z1	**April 15, 2016**
OPENING DATE AND TIME	PROCUREMENT CONTACT
May 25, 2016 2:00 p.m. Central Time	**Michelle Thompson/Teresa Fleming**

This form is part of the specification package and must be signed in ink and returned, along with proposal documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska, Administrative Services (AS), Materiel Division, State Purchasing Bureau, is issuing this Request for Proposal, RFP Number 5297Z1 for the purpose of selecting a qualified contractor to provide professional health and welfare consulting services for the employee insurance benefits program which includes health, wellness, dental, vision, life, long term disability, flexible spending accounts, health savings account, and employee assistance program.

Written questions are due no later than May 2, 2016, and should be submitted via e-mail to as.materielpurchasing@nebraska.gov Written questions may also be sent by facsimile to (402) 471-2089.

Bidder should submit one (1) original of the entire proposal. Proposals must be submitted by the proposal due date and time.

PROPOSALS MUST MEET THE REQUIREMENTS OUTLINED IN THIS REQUEST FOR PROPOSAL TO BE CONSIDERED VALID. PROPOSALS WILL BE REJECTED IF NOT IN COMPLIANCE WITH THESE REQUIREMENTS.

1. Sealed proposals must be received in State Purchasing Bureau by the date and time of proposal opening per the schedule of events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.
2. This form "REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES" MUST be manually signed, in ink, and returned by the proposal opening date and time along with bidder's proposal and any other requirements as specified in the Request for Proposal in order for a bidder's proposal to be evaluated.
3. It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. § 84-602.02, all State contracts in effect as of January 1, 2014, and all contracts entered into thereafter, will be posted to a public website. Beginning July 1, 2014, all contracts will be posted to a public website managed by the Department of Administrative Services.

In addition, all responses to Requests for Proposals will be posted to the Department of Administrative Services public website. The public posting will include figures, illustrations, photographs, charts, or other supplementary material. Proprietary information identified and marked according to state law is exempt from posting. To exempt proprietary information you must submit a written showing that the release of the information would give an advantage to named business competitor(s) and show that the named business competitor(s) will gain a demonstrated advantage by disclosure of information. The mere assertion that information is proprietary is not sufficient. (Attorney General Opinion No. 92068, April 27, 1992) The agency will then determine if the interests served by nondisclosure outweigh any public purpose served by disclosure. Cost proposals will not be considered proprietary.

To facilitate such public postings, the State of Nebraska reserves a royalty-free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract or response to this RFP for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a response to this RFP, specifically waives any copyright or other protection the contract or response to the RFP may have; and, acknowledge that they have the ability and authority to enter into such waiver. This reservation and waiver is a prerequisite for submitting a response to this RFP and award of the contract. Failure to agree to the reservation and waiver of protection will result in the response to the RFP being non-conforming and rejected.

Any entity awarded a contract or submitting a RFP agrees not to sue, file a claim, or make a demand of any kind, and will indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of contracts, RFPs and related documents.

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions unless otherwise agreed to (see Section III) and certifies that bidder maintains a drug free work place environment.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ **NEBRASKA CONTRACTOR AFFIDAVIT**: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

_____ I hereby certify that I am a **Resident disabled veteran or business located in a designated enterprise zone** in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

FIRM: _____

COMPLETE ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

SIGNATURE: _____ DATE: _____

TYPED NAME & TITLE OF SIGNER: _____

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GLOSSARY OF TERMS

Acceptance Test Procedure: Benchmarks and other performance criteria, developed by the State of Nebraska or other sources of testing standards, for measuring the effectiveness of products or services and the means used for testing such performance.

Addendum: Something to be added or deleted to an existing document; a supplement.

After Receipt of Order (ARO): After Receipt of Order

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Constitution of Nebraska.

Agent/Representative: A person authorized to act on behalf of another.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

Award: All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

Best and Final Offer (BAFO): In a competitive bid, the final offer submitted which contains the bidder's (vendor's) most favorable terms for price.

Bid/Proposal: The offer submitted by a vendor in a response to written solicitation.

Bid Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the vendor will not withdraw the bid.

Bidder: A vendor who submits an offer bid in response to a written solicitation.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.

Cancellation: To call off or revoke a purchase order without expectation of conducting or performing it at a later time.

Central Processing Unit (CPU): Any computer or computer system that is used by the State to store, process, or retrieve data or perform other functions using Operating Systems and applications software.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Commodities: Any equipment, material, supply or goods; anything movable or tangible that is provided or sold.

Commodities Description: Detailed descriptions of the items to be purchased; may include information necessary to obtain the desired quality, type, color, size, shape, or special characteristics necessary to perform the work intended to produce the desired results.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Confidential Information: Unless otherwise defined below, "Confidential Information" shall also mean proprietary trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires

identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement.

Contract Administration: The management of the contract which includes and is not limited to; contract signing, contract amendments and any necessary legal actions.

Contract Management: The management of day to day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Contractor.

Contract Period: The duration of the contract.

Contractor: Any individual or entity having a contract to furnish commodities or services.

Cooperative Purchasing: The combining of requirements of two or more political entities to obtain advantages of volume purchases, reduction in administrative expenses or other public benefits.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Critical Program Error: Any Program Error, whether or not known to the State, which prohibits or significantly impairs use of the Licensed Software as set forth in the documentation and intended in the contract.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice on those products or services provided by the Contractor.

Default: The omission or failure to perform a contractual duty.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of the written solicitation or contract.

Evaluation: The process of examining an offer after opening to determine the vendor's responsibility, responsiveness to requirements, and to ascertain other characteristics of the offer that relate to determination of the successful award.

Evaluation Committee: Committee(s) appointed by the requesting agency that advises and assists the procuring office in the evaluation of bids/proposals (offers made in response to written solicitations).

Extension: Continuance of a contract for a specified duration upon the agreement of the parties beyond the original Contract Period. Not to be confused with "Renewal Period".

Free on Board (F.O.B.) Destination: The delivery charges are included in the quoted price and prepaid by the vendor. Vendor is responsible for all claims associated with damages during delivery of product.

Free on Board (F.O.B.) Point of Origin: The delivery charges are not included in the quoted price and are the responsibility of the agency. Agency is responsible for all claims associated with damages during delivery of product.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Installation Date: The date when the procedures described in "Installation by Contractor", and "Installation by State", as found in the RFP, or contract, are completed.

Late Bid/Proposal: An offer received after the Opening Date and Time.

Licensed Software Documentation: The user manuals and any other materials in any form or medium customarily provided by the Contractor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

Mandatory/Must: Required, compulsory, or obligatory.

May: Discretionary, permitted; used to express possibility.

Module (see System): A collection of routines and data structures that perform a specific function of software.

Must: See Shall/Will/Must.

National Institute for Governmental Purchasing (NIGP): National Institute of Governmental Purchasing – Source used for assignment of universal commodity codes to goods and services.

Open Market Purchase: Authorization may be given to an agency to purchase items above direct purchase authority due to the unique nature, price, quantity, location of the using agency, or time limitations by the AS Materiel Division, State Purchasing Bureau.

Opening Date and Time: Specified date and time for the public opening of received, labeled, and sealed formal proposals.

Operating System: The control program in a computer that provides the interface to the computer hardware and peripheral devices, and the usage and allocation of memory resources, processor resources, input/output resources, and security resources.

Outsourcing: The contracting out of a business process which an organization may have previously performed internally or has a new need for, to an independent organization from which the process is purchased back.

Payroll & Financial Center (PFC): Electronic procurement system of record.

Performance Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the Contractor fulfills any and all obligations under the contract.

Platform: A specific hardware and Operating System combination that is different from other hardware and Operating System combinations to the extent that a different version of the Licensed Software product is required to execute properly in the environment established by such hardware and Operating System combination.

Pre-Bid/Pre-Proposal Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Program Error: Code in Licensed Software which produces unintended results or actions, or which produces results or actions other than those described in the specifications. A program error includes, without limitation, any Critical Program Error.

Program Set: The group of programs and products, including the Licensed Software specified in the RFP, plus any additional programs and products licensed by the State under the contract for use by the State.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under the contract.

Proposal: See Bid/Proposal.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and service no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific named competitor(s) advantaged by release of the information and the demonstrated advantage the named competitor(s) would gain by the release of information.

Protest/Grievance: A complaint about a governmental action or decision related to a Request for Proposal or resultant contract, brought by a vendor who has timely submitted a bid response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Recommended Hardware Configuration: The data processing hardware (including all terminals, auxiliary storage, communication, and other peripheral devices) to the extent utilized by the State as recommended by the Contractor.

Release Date: The date of public release of the written solicitation to seek offers

Renewal Period: Optional contract periods subsequent to the original Contract Period for a specified duration with previously agreed to terms and conditions. Not to be confused with Extension.

Request for Information (RFI): A general invitation to vendors requesting information for a potential future solicitation. The RFI is typically used as a research and information gathering tool for preparation of a solicitation.

Request for Proposal (RFP): A written solicitation utilized for obtaining competitive offers.

Responsible Bidder: A bidder who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to assure good faith performance.

Responsive Bidder: A bidder who has submitted a bid which conforms to all requirements of the solicitation document.

Shall/Will/Must: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Sole Source – Commodity: When an item is available from only one source due to the unique nature of the requirement, its supplier, or market conditions.

Sole Source – Services: A service of such a unique nature that the vendor selected is clearly and justifiably the only practical source to provide the service. Determination that the vendor selected is justifiably the sole source is based on either the uniqueness of the service or sole availability at the location required.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a contract.

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Contractor as functioning or being capable of functioning, as an entity.

Termination: Occurs when either party, pursuant to a power created by agreement or law, puts an end to the contract prior to the stated expiration date. All obligations which are still executory on both sides are discharged but any right based on prior breach or performance survives.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. §87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Upgrade: Any change that improves or alters the basic function of a product of service.

Vendor: An individual or entity lawfully conducting business in the State of Nebraska, or licensed to do so, who seeks to provide goods or services under the terms of a written solicitation.

Vendor Performance Report: A report issued to the Contractor by State Purchasing Bureau when products or services delivered or performed fail to meet the terms of the purchase order, contract, and/or specifications, as reported to State Purchasing Bureau by the agency. The State Purchasing Bureau shall contact the Contractor regarding any such report. The vendor performance report will become a part of the permanent record for the Contractor. The State may require vendor to cure. Two such reports may be cause for immediate termination.

Will: See Shall/Will/Must.

Work Day: See Business Day.

I. SCOPE OF THE REQUEST FOR PROPOSAL

The State of Nebraska, Administrative Services (AS), Materiel Division, State Purchasing Bureau (hereafter known as State Purchasing Bureau), is issuing this Request for Proposal, RFP Number 5297Z1 for the purpose of selecting a qualified Contractor to provide professional health and welfare consulting services for the employee insurance benefits program which includes health, wellness, dental, vision, life, long term disability, flexible spending accounts, health savings account, and employee assistance program. Any resulting contract is not an exclusive contract to furnish the services provided for in this Request for Proposal, and does not preclude the purchase of similar services from other sources.

A contract resulting from this Request for Proposal will be issued approximately for a period of three (3) years effective the date of award. The contract has the option to be renewed for four (4) additional one (1) year periods as mutually agreed upon by all parties. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the Contractor and the State of Nebraska.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: http://das.nebraska.gov/materiel/purchasing.html

A. SCHEDULE OF EVENTS

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change.

	ACTIVITY	DATE/TIME
1.	Release Request for Proposal	4/15/2016
2.	Last day to submit written questions	5/2/2016
3.	State responds to written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	5/11/2016
4.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	5/25/2016 2:00 PM Central Time
5.	Review for conformance of mandatory requirements	5/25/2016
6.	Evaluation period	5/31/2016 – 6/14/2016
7.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
8.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	7/1/2016
9.	Contract finalization period	7/1/2016 – 7/31/2016
10.	Contract award	8/1/2016
11.	Contractor start date	9/1/2016

II. PROCUREMENT PROCEDURES

A. PROCURING OFFICE AND CONTACT PERSON

Procurement responsibilities related to this Request for Proposal reside with the State Purchasing Bureau. The point of contact for the procurement is as follows:

Name:	Michelle Thompson/Teresa Fleming
Agency:	State Purchasing Bureau
Address:	1526 K Street, Suite 130
	Lincoln, NE 68508
Telephone:	402-471-6500
Facsimile:	402-471-2089
E-Mail:	as.materielpurchasing@nebraska.gov

B. GENERAL INFORMATION

The Request for Proposal is designed to solicit proposals from qualified vendors who will be responsible for providing professional health and welfare consulting services for the employee insurance benefits program which includes health, wellness, dental, vision, life, long term disability, flexible spending accounts, health savings account, and employee assistance program at a competitive and reasonable cost. Proposals that do not conform to the mandatory items as indicated in the Request for Proposal will not be considered.

Proposals shall conform to all instructions, conditions, and requirements included in the Request for Proposal. Prospective bidders are expected to carefully examine all documentation, schedules, and requirements stipulated in this Request for Proposal, and respond to each requirement in the format prescribed.

A fixed-price contract will be awarded as a result of this proposal. In addition to the provisions of this Request for Proposal and the awarded proposal, which shall be incorporated by reference in the contract, any additional clauses or provisions required by the terms and conditions will be included as an amendment to the contract.

C. CUSTOMER SERVICE

In addition to any specified service requirements contained in this agreement, the Contractor agrees and understands that satisfactory customer service is required. Contractor will develop or provide technology and business procedures designed to enhance the level of customer satisfaction and to provide the customer appropriate information given their situation. Contractor, its employees, Subcontractors, and agents must be accountable, responsive, reliable, patient, and have well-developed communication skills as set forth by the customer service industry's best practices and processes.

D. COMMUNICATION WITH STATE STAFF AND EVALUATORS

From the date the Request for Proposal is issued until a determination is announced regarding the selection of the Contractor, contact regarding this project between potential Contractors and individuals employed by the State is restricted to only written communication with the staff designated above as the point of contact for this Request for Proposal. Bidders shall not have any communication with, or attempt to communicate with or influence in any way, any evaluator involved in this RFP.

Once a Contractor is preliminarily selected, as documented in the intent to contract, that Contractor is restricted from communicating with State staff until a contract is signed. Violation of this condition may be considered sufficient cause to reject a Contractor's proposal and/or selection irrespective of any other condition.

The following exceptions to these restrictions are permitted:

1. written communication with the person(s) designated as the point(s) of contact for this Request for Proposal or procurement;
2. contacts made pursuant to any pre-existing contracts or obligations; and
3. State-requested presentations, key personnel interviews, clarification sessions or discussions to finalize a contract.

Violations of these conditions may be considered sufficient cause to reject a bidder's proposal and/or selection irrespective of any other condition. No individual member of the State, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this Request for Proposal. The buyer will issue any clarifications or opinions regarding this Request for Proposal in writing.

E. WRITTEN QUESTIONS AND ANSWERS

Any explanation desired by a bidder regarding the meaning or interpretation of any Request for Proposal provision must be submitted in writing to the State Purchasing Bureau and clearly marked "RFP Number 5297Z1; Benefits

Consulting Questions". It is preferred that questions be sent via e-mail to as.materielpurchasing@nebraska.gov. Questions may also be sent by facsimile to 402-471-2089, but must include a cover sheet clearly indicating that the transmission is to the attention of Michelle Thompson/Teresa Fleming, showing the total number of pages transmitted, and clearly marked "RFP Number 5297Z1; Benefits Consulting Questions".

It is recommended that Bidders submit questions sequentially numbered, include the RFP reference and page number using the following format.

Question Number	RFP Section Reference	RFP Page Number	Question

Written answers will be provided through an addendum to be posted on the Internet at http://das.nebraska.gov/materiel/purchasing.html on or before the date shown in the Schedule of Events.

F. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The Evaluation Committee(s) may conclude after the completion of the Technical and Cost Proposal evaluation that oral interviews/presentations and/or demonstrations are required in order to determine the successful bidder. All bidders may not have an opportunity to interview/present and/or give demonstrations; the State reserves the right to select only the top scoring bidders to present/give oral interviews in its sole discretion. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical and Cost Proposals. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Bidders shall not be allowed to alter or amend their proposals. Only representatives of the State and the presenting bidders will be permitted to attend the oral interviews/presentations and/or demonstrations.

Once the oral interviews/presentations and/or demonstrations have been completed the State reserves the right to make a contract award without any further discussion with the bidders regarding the proposals received.

Detailed notes of oral interviews/presentations and/or demonstrations may be recorded and supplemental information (such as briefing charts, et cetera) may be accepted; however, such supplemental information shall not be considered an amendment to a bidders' proposal. Additional written information gathered in this manner shall not constitute replacement of proposal contents.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

G. SUBMISSION OF PROPOSALS

The following describes the requirements related to proposal submission, proposal handling, and review by the State.

To facilitate the proposal evaluation process, one (1) original of the entire proposal must be submitted. Proposals must be submitted by the proposal due date and time. A separate sheet must be provided that clearly states which sections have been submitted as proprietary or have copyrighted materials. All proprietary information the bidder wishes the State to withhold must be submitted in accordance with the instructions outlined in Section III, Proprietary Information. Proposal responses should include the completed Form A, Bidder Contact Sheet. Proposals must reference the Request for Proposal number and be sent to the specified address. Please note that the address label should appear as specified in Section II part A on the face of each container or bidder's bid response packet. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. If a recipient phone number is required for delivery purposes, 402-471-6500 should be used. The Request for Proposal number must be included in all correspondence.

Emphasis should be concentrated on conformance to the Request for Proposal instructions, responsiveness to requirements, completeness, and clarity of content. If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming, it is likely that the proposal will be rejected.

The Technical and Cost Proposals should be packaged separately (loose-leaf binders are preferred) on standard 8 ½" by 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables must be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text. The Technical Proposal must not contain any reference to dollar amounts. However, information such as data concerning labor hours and categories, materials, subcontracts

and so forth, shall be considered in the Technical Proposal so that the bidder's understanding of the scope of work may be evaluated. The Technical Proposal shall disclose the bidder's technical approach in as much detail as possible, including, but not limited to, the information required by the Technical Proposal instructions.

H. PROPOSAL OPENING

The sealed proposals will be publicly opened and the bidding entities announced on the date, time, and location shown in the Schedule of Events. Proposals will be available for viewing by those present at the proposal opening. Vendors may also contact the State to schedule an appointment for viewing proposals after the Intent to Award has been posted to the website.

I. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. The State is not responsible for proposals that are late or lost due to mail service inadequacies, traffic, or any other reason(s).

J. REJECTION OF PROPOSALS

The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

K. EVALUATION OF PROPOSALS

All proposals that are responsive to the Request for Proposal will be evaluated. Each category will have a maximum possible point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all responsive proposals in accordance with the criteria set forth below. The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview should include but is not limited to:
- **a.** the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the Request for Proposal;
- **b.** the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
- **c.** whether the bidder can perform the contract within the specified time frame;
- **d.** the quality of bidder performance on prior contracts;
- **e.** such other information that may be secured and that has a bearing on the decision to award the contract;

2. Technical Approach; and
3. Cost Proposal.

Neb. Rev. Stat. § 73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision(a) of this subsection. Any contract entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a bid in accordance with Neb. Rev. Stat. § 73-107 and has so indicated on the RFP cover page under "Bidder must complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the vendor within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service;
4. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
5. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and

6. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Evaluation criteria weighting will be released with the Request for Proposal. Evaluation criteria weighting and a list of respondents will be posted to the State Purchasing Bureau website at http://das.nebraska.gov/materiel/purchasing.html

L. EVALUATION COMMITTEE

Proposals will be independently evaluated by members of the Evaluation Committee(s). The Evaluation Committee(s) will consist of staff with the appropriate expertise to conduct such proposal evaluations. Names of the members of the Evaluation Committee(s) will not be published.

Prior to award, bidders are advised that only the point of contact indicated on the front cover of this Request for Proposal For Contractual Services Form can clarify issues or render any opinion regarding this Request for Proposal. No individual member of the State, employee of the State, or member of the Evaluation Committee(s) is empowered to make binding statements regarding this Request for Proposal.

Any contact, or attempted contact, with an evaluator that is involved with this RFP may result in the rejection of this proposal and further administrative actions may be taken.

M. MANDATORY REQUIREMENTS

The proposals will first be examined to determine if all mandatory requirements listed below have been addressed to warrant further evaluation. Proposals not meeting mandatory requirements will be excluded from further evaluation. The mandatory requirement items are as follows:

1. Request for Proposal For Contractual Services form, signed in ink;
2. Corporate Overview;
3. Completed Section III;
4. Technical Approach; and
5. Cost Proposal.

N. REFERENCE CHECKS

The State reserves the right to check any reference(s), regardless of the source of the reference information, including but not limited to, those that are identified by the company in the proposal, those indicated through the explicitly specified contacts, those that are identified during the review of the proposal, or those that result from communication with other entities involved with similar projects. The State may use a third-party to conduct reference checks.

Information to be requested and evaluated from references may include, but is not limited to, some or all of the following: financial stability of the company, project description and background, job performed, functional and technical abilities, communication skills and timeliness, cost and schedule estimates and accuracy, problems (poor quality deliverables, contract disputes, work stoppages, et cetera), overall performance, and whether or not the reference would rehire the firm or individual. Only top scoring bidders may receive reference checks, and negative references may eliminate bidders from consideration for award.

O. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS

All bidders should be authorized to transact business in the State of Nebraska. All bidders are expected to comply with all Nebraska Secretary of State Registration requirements. It is the responsibility of the bidder to comply with any registration requirements pertaining to types of business entities (e.g. person, partnership, foreign or domestic limited liability company, association, or foreign or domestic corporation or other type of business entity). The bidder who is the recipient of an Intent to Award will be required to certify that it has so complied and produce a true and exact copy of its current (within ninety (90) calendar days), valid Certificate of Good Standing or Letter of Good Standing; or in the case of a sole proprietorship, provide written documentation of sole proprietorship. This must be accomplished prior to the award of the contract. Construction Contractors are expected to meet all applicable requirements of the Nebraska Contractor Registration Act and provide a current, valid certificate of registration. Further, all bidders shall comply with any and all other applicable Nebraska statutes regarding transacting business in the State of Nebraska. Bidders should submit the above certification(s) with their bid.

If a bank is registered with the Office of Comptroller of Currency, it is not required to register with the State. However, the Office of Comptroller of Currency does have a certificate of good standing/registration. The bank could provide that for verification. (Optional)

P. VIOLATION OF TERMS AND CONDITIONS

Violation of the terms and conditions contained in this Request for Proposal or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal;
2. Withdrawal of the Intent to Award
3. Termination of the resulting contract.
4. Legal action.
5. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

III. TERMS AND CONDITIONS

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. **Bidders must include completed Section III with their proposal response.**

The State of Nebraska is soliciting bids in response to the RFP. The State of Nebraska will not consider proposals that propose the substitution of the bidder's contract, agreements, or terms for those of the State of Nebraska's. Any License, Service Agreement, Customer Agreement, User Agreement, Bidder Terms and Conditions, Document, or Clause purported or offered to be included as a part of this RFP must be submitted as individual clauses, as either a counter-offer or additional language, and each clause must be acknowledged and accepted in writing by the State. If the Bidder's clause is later found to be in conflict with the RFP or resulting contract the Bidder's clause shall be subordinate to the RFP or resulting contract.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal, signed in ink
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Grievance and protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to the Internet.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or derived by the Contractor pursuant to this contract.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Subcontractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Subcontractor(s). The Contractor is also responsible for ensuring Subcontractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Subcontractor to commence work on any Subcontract until all similar insurance required of the Subcontractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Insurance coverages shall function independent of all other clauses in the contract, and in no instance shall the limits of recovery from the insurance be reduced below the limits required by this section.

1. WORKERS' COMPENSATION INSURANCE

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in

work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

3. INSURANCE COVERAGE AMOUNTS REQUIRED

COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$10,000 any one person
Damage to Rented Premises	$300,000 each occurrence
Contractual	Included
XCU Liability (Explosion, Collapse, and Underground Damage)	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000
PROFESSIONAL LIABILITY	
Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
SUBROGATION WAIVER	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
LIABILITY WAIVER	
"Commercial General Liability & Commercial Automobile Liability policies shall be primary and any insurance or self-insurance carried by the State shall be considered excess and non-contributory."	

4. EVIDENCE OF COVERAGE

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax)

Administrative Services
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.

2. The Contractor shall agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Subcontractor's services, the Subcontractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work on the project.

Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or Subcontractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

1. any and all employment taxes and/or other payroll withholding;
2. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. damages incurred by Contractor's employees within the scope of their duties under the contract;
4. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. CONTRACT CONFLICTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall insure that contracts or agreements with sub-contractors and agents, and the performance of services in relation to this contract by sub-contractors and agents, does not conflict with this contract.

L. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project.

M. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

N. PROPOSAL PREPARATION COSTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal.

O. ERRORS AND OMISSIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

P. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Q. ASSIGNMENT BY THE STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

R. ASSIGNMENT BY THE CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

S. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

T. GOVERNING LAW

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

U. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

V. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

W. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

X. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

Y. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II.A. Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Z. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

- **a.** if directed to do so by statute;
- **b.** Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
- **c.** a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
- **d.** fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
- **e.** an involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
- **f.** a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
- **g.** Contractor intentionally discloses confidential information;
- **h.** Contractor has or announces it will discontinue support of the deliverable;
- **i.** second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or
- **j.** Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract.

AA. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

BB. BREACH BY CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

CC. ASSURANCES BEFORE BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

DD. ADMINISTRATION – CONTRACT TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. Contractor must provide confirmation that upon contract termination all deliverables prepared in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

EE. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

FF. PROHIBITION AGAINST ADVANCE PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.

GG. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §§ 81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

HH. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices may be mailed to Wellness & Benefits Administrator, State of Nebraska, 1526 K Street, Suite 110, Lincoln, NE 68508. Upon agreement between the State and the Contractor, invoices may be e-mailed. The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the

convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

II. RIGHT TO AUDIT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. The State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not limited to those kept by the Contractor, its employees, agents, assigns, successors, and Subcontractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of five (5) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Subcontractors, and the obligations of these rights shall be explicitly included in any subcontracts or agreements formed between the Contractor and any Subcontractors to the extent that those Subcontracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

JJ. TAXES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

KK. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

LL. CHANGES IN SCOPE/CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, or a pro-rated value.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification. Changes or additions to the contract beyond the scope of the RFP are not permitted.

MM. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

NN. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the

Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State immediately of said breach and take immediate corrective action.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

OO. PROPRIETARY INFORMATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary**. The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary**. Bidder's cost proposals may not be marked as proprietary information. Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

PP. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submission of this proposal, the bidder certifies that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and

will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

QQ. STATEMENT OF NON-COLLUSION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

RR. PRICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All prices, costs, and terms and conditions outlined in the proposal shall remain fixed and valid commencing on the opening date of the proposal until an award is made or the Request for Proposal is cancelled.

Prices quoted on the Cost Proposal form shall remain fixed for the initial contract period which is three (3) years. Any request for a price increase subsequent to the initial contract period shall not exceed four percent (4%) of the previous Contract period and must be submitted in writing to the State Purchasing Bureau a minimum of 120 days prior to the end of the current contract period, and be accompanied by documentation justifying the price increase. Further documentation may be required by the State to justify the increase. The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

The State will be given full proportionate benefit of any price decrease during the term of the contract.
Contractor represents and warrants that all prices for services, now or subsequently specified, are as low as and no higher than prices which the Contractor has charged or intends to charge customers other than the State for the same or similar products and services of the same or equivalent quantity and quality for delivery or performance during the same periods of time. If, during the term of the contract, the Contractor shall reduce any and/or all prices charged to any customers other than the State for the same or similar products or services specified herein, the Contractor shall make an equal or equivalent reduction in corresponding prices for said specified products or services.

Contractor also represents and warrants that all prices set forth in the contract and all prices in addition, which the Contractor may charge under the terms of the contract, do not and will not violate any existing federal, state, or municipal law or regulations concerning price discrimination and/or price fixing. Contractor agrees to hold the State harmless from any such violation. Prices quoted shall not be subject to increase throughout the contract period unless specifically allowed by these specifications.

SS. BEST AND FINAL OFFER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored, and ranked by the Evaluation Committee. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

TT. ETHICS IN PUBLIC CONTRACTING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions, or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

UU. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. GENERAL

The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. PERSONNEL

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 *et seq.* and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

VV. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

WW. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

XX. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

YY. TIME IS OF THE ESSENCE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

ZZ. RECYCLING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. § 81-15,159.

AAA. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

BBB. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. § 4-108.

CCC. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all Subcontracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

DDD. POLITICAL SUB-DIVISIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may extend the contract to political sub-divisions conditioned upon the honoring of the prices charged to the State. Terms and conditions of the Contract must be met by political sub-divisions. Under no circumstances shall the State be contractually obligated or liable for any purchases by political sub-divisions or other public entities not authorized by Neb. Rev. Stat. § 81-145, listed as "all officers of the state, departments, bureaus, boards, commissions, councils, and institutions receiving legislative appropriations." A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

EEE. OFFICE OF PUBLIC COUNSEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

FFF. LONG-TERM CARE OMBUDSMAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

IV. PROJECT DESCRIPTION AND SCOPE OF WORK

A. PROJECT OVERVIEW

The purpose of this Request for Proposal (RFP) is to select a qualified contractor to provide professional health and welfare consulting services for the employee insurance benefits program which includes health, wellness, dental, vision, life, long term disability, flexible spending accounts, health savings account, and employee assistance program.

B. PROJECT ENVIRONMENT

AON Hewitt is the current benefit consultant for the State's employee benefit program. The State has contracted with AON since 2008. The State is bidding to assure continuity of services through upcoming request for proposals for other employee benefit contracts.

The State of Nebraska, by virtue of Neb. Rev. Stat. § 84-1601 et. seq. and the negotiated labor contracts, offers its employees the following employee insurance benefits:

1. **Health Insurance** - The State of Nebraska offers employees, retirees, and Cobra participants a choice of three self-insured health plans administered by one health insurance contractor:
   - **a.** Regular Health Plan - negotiated through the NAPE/AFSCME employee union.
   - **b.** Wellness Health Plan – requires specific participation in the State's wellness program.
   - **c.** Consumer Focused Health Plan – A qualified health plan eligible for a Health Savings Accounts (HSA).

   The self-insured health plans include both medical and pharmacy benefits. Annual health plan costs for the State are about $184 million.

2. **Wellness program** – All employees and spouses enrolled in either of the three health insurance plans are eligible to participate in the State's wellness program, **wellNEssoptions**. The Wellness program is funded by health plan premiums.

3. **Fully insured plans** - Dental, Vision, Life, Flex Savings Account (FSA) and Long Term Disability, and Employee Assistance Program (EAP).

See Attachment E for all Benefits & Wellness contracts.

All benefit programs have a fiscal plan year of July through June.

The bidder can view the Options Guide and additional information on the State of Nebraska benefits plans and programs by reviewing the material found at the following web site address.

http://das.nebraska.gov/benefits.html

Current benefit plan enrollments statistics as of January 2016

Self-insured health plan funded 79% by the State and 21% by the employee.
88% of eligible employees enroll in a State health plan.

Self-Insured Health Plans	*Active Employees*	*COBRA*	*Retirees (pre-65)*	*Total*
Wellness	7,043	43	96	7,182
Regular	5,439	35	101	5,575
Consumer Focused	977	20	67	1,064
	13,459	98	264	13,821

Wellness Program	11,150 participants (includes employees & spouses)

Dental Insurance - Premiums paid 100% by employee. 76% enrollment ratio

	Active Employees	*COBRA*	*Retirees*	*Total*
Premium Dental	5,396	58	73	5,527
Basic Dental	6,372	109	111	6,592
	11,768	167	184	12,119

Vision Insurance - Premiums paid 100% by employee. 65% enrollment ratio.

	Active Employees	*COBRA*	*Retirees*	*Total*
Basic Vision	3,136	25	40	3,201
Premium Vision	6,828	67	95	6,990
	9,964	92	135	10,191

	Medical	*Dependent Care*
Flexible Spending Account	3,934	477

Health Savings Account	379

Life Insurance	
Employee Basic Life	15,395
Supplemental Life	8,850
Dependent Life	5,437
Accidental Death & Dismemberment	10,377

Long Term Disability	6,645

Employee Assistance Program	15,721

C. BUSINESS REQUIREMENTS

1. The contractor shall provide an Account Management team to oversee the services listed in detail under the Scope of Work. The Account Manager shall be accessible by phone and email. A backup to the Account Manager shall also be assigned when the Account Manager is not available.

2. The bidder shall have at least five years of business experience providing comprehensive employee benefit consulting services to large public sector and non-public sector employers which more than 10,000 employees and retirees.

3. The contractor shall have experience providing benefit consult services to large employers who offer a self-insured employee health plan and wellness program.

4. The contractor shall certify it, as well as any subcontractors that it utilizes, is in full compliance with HIPAA's regulations protecting the privacy of individually identifiable health information.

5. The contractor shall agree to sign the State's Business Associate Agreement.

D. PROJECT REQUIREMENTS

The contractor will provide the following services:

1. Strategic consulting services for all health and welfare programs including the State's self-insured medical, pharmacy, wellness programs, and collective bargaining;
2. Actuarial services for the State's Employee Health Plan;
3. Health plan data analytics and reporting;
4. Assist with benefit plan requests for proposals (RFP); and
5. Legislative and Regulatory Analysis & Education.

E. SCOPE OF WORK

Explain how the bidder will provide the services below to the State by completing the following tables. Response shall demonstrate experience performing similar services for other State or large employers including accomplishments and other information. Include examples of the bidder's work, when applicable.

1. Strategic Consulting Services

The contractor will provide strategic consulting services for all health and welfare programs listed above in Section IV. B. Project Environment. Services include, but not limited to, the following list of services.

a. Regularly consult with the State on strategy and programs to which help manage the State's self-insured health and wellness plan including plan design, networks, pharmacy benefit program, stop loss, and carriers. Renewal timeline:
  i. Plan Year begins: July 1
  ii. Governor renewal review: February 1
  iii. Final rates & plan design: March 1

b. Regularly meet with Employee Wellness and Benefit staff to stay abreast of administrative, programmatic, regulatory, and other issues and opportunities regarding the State's employee benefit programs
c. Attend benefit plan vendor meetings as requested to provide input and recommendations.
d. Provide on-going monitoring of developments in new benefit strategies.
e. Assist in reviews, analysis and recommendations of employee benefits in preparation of labor negotiations and be available to attend onsite preparation meetings as requested.
f. Train Administrative Services staff on topics including regulatory updates, industry trends, data analysis, and compliance.

a	Describe the bidder's approach to providing strategic consulting services to the State on all of the benefit programs. Include a summarized listing of services included with the proposal.
	Response:
b	Describe the bidder's experience consulting on a self-insured health plan with over 20,000 participants.
	Response:
c	Describe the services and resources available to assist the State in managing their pharmacy benefit program.
	Response:
d	Describe the bidder's experience consulting on a wellness program comparable in size to the State's wellness program.
	Response:
e	Describe the bidder's collective bargaining experience assisting another State government, or large employer similar to the State of Nebraska.
	Response:
f	What data analytic tools will be used to analyze medical and pharmacy claims data? Will the State have access to any of the data analytic tools?
	Response:
g	What resources will be utilized to stay informed of best practices in employee benefits in State Government and other employers similar in size?
	Response:

2. Actuarial Services & Related Reporting

The contractor shall provide actuarial services for the State's employee health insurance plan and wellness program. The following services and reports shall be prepared as part of this contract:

a. An annual plan cost analysis and annual calculation of the employer and employee contributions for each of the State's health plans.
a. Analyze and recommend the annual Claims Fluctuation Reserve (CFR) level at the end of the plan year. The State currently maintains a CFR at a 90% confidence level.
b. Analyze and recommend a projected Incurred But Not Recorded (IBNR) amount at the end of the plan year.
c. Help the State prepare a Value on Investment (VOI or ROI) for the State's wellness program each year.

a	Describe the bidder's experience in performing actuarial services for other States or companies of similar size.
	Response:
b	Provide an example of a premium equivalents report for a self-insured health plan with multiple plans.
	Response:
c	Explain the approach to analyzing and recommending a CFR level. Provide an example of a CFR report the State would receive.
	Response:
d	Explain the approach to calculating IBNR. Provide an example of IBNR report the State would receive.
	Response:
e	Describe the bidder's experience calculating VOI on a wellness program. Provide an example of a VOI report.
	Response:

3. Health Plan Analytics and Reporting

The contractor shall provide the State with the following services:

a. A monthly budget report of the State's health plan performance comparing actual to budgeted costs.

b. Pursuant to Nebraska Revised Statute 50-502, the State of Nebraska Health Insurance Plan Annual Report due November each year. See Attachment C for the most recent report.

c. Health plan reports including cost trending and multi-year forecasting projections as requested by the State.

d. Other reporting requirements may include health plan analytical reports, industry surveys, and benefit program performance and gaps.

a	Provide an example of the monthly budget report for self-insured health plan.
	Response:
b	Describe the resources available to prepare a report similar to the *State of Nebraska Health Insurance Plan Annual Report.*
	Response:
c	Provide a sample of a report which would be similar to the *State of Nebraska Health Insurance Plan Annual Report.*
	Response:
d	Provide a list and examples of other reports that are offered including health plan analytic reports.
	Response:

4. Benefit Plan Request for Proposals (RFP)

The contractor will assist the State in the preparation and evaluation process for all benefit plan RFP and in accordance with processes established by state statute and the State Purchasing Bureau. Services may include but not limited to develop the technical requirements, assist with questions from potential bidders, provide questions for oral interviews, develop scoring methodology, and conduct cost evaluations.

See Attachment D for the anticipated time line of the benefit RFP's.

a	Describe the bidder's experience in assisting other customers similar to the State with RFP.
	Response:

5. Legislative and Regulatory Analysis & Education

The contractor will assure the State is informed of any regulatory laws and changes which affects the State's employee benefit program. Services include:

a. Provide guidance, impact analysis and training on all regulatory requirements which affect the State's benefit program. This includes COBRA, ACA, HIPAA, Section 125, IRS, and any other employment laws which affect the State's benefit programs.

b. Keep the State informed of pending and final federal and state legislation which may affect the State's employee benefit program.

c. Provide guidance and training to the State to assist them with complying with the Affordable Care Act.

d. Assist the State with preparing fiscal notes as requested while the Legislature is in session.

a	Explain how the bidder educates their customers of updates and changes to ACA regulations. What resources are available specific to ACA?
	Response:
b	Describe how the bidder stays updated with Federal and State regulations which affect employee benefit programs.
	Response:
c	Describe tools and resources available to help stay compliant with all federal and state regulatory requirements.
	Response:
d	Provide two (2) examples of recent training the bidder offered to their customers?
	Response:

F. PERFORM IMPLEMENTATION

As part of the proposal, the bidder shall provide a plan detailing the implementation timeline. The plan shall define responsibilities assigned to the contractor and responsibilities assigned to the State. Implementation must be completed by September 1, 2016.

V. PROPOSAL INSTRUCTIONS

This section documents the mandatory requirements that must be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. PROPOSAL SUBMISSION

1. REQUEST FOR PROPOSAL FORM

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions stated in this Request for Proposal unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

The Request for Proposal for Contractual Services form must be signed in ink and returned by the stated date and time in order to be considered for an award.

Further, Section III. Terms and Conditions must be returned with the proposal response.

2. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

b. FINANCIAL STATEMENTS

The bidder must provide financial statements applicable to the firm. If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

e. RELATIONSHIPS WITH THE STATE

The bidder shall describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any party named in the bidder's proposal response is or was an employee of the State within the past five (5) years, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

g. CONTRACT PERFORMANCE

If the bidder or any proposed Subcontractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

iv. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Request for Proposal. These descriptions must include:

- **a)** The time period of the project;
- **b)** The scheduled and actual completion dates;
- **c)** The Contractor's responsibilities;
- **d)** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **e)** Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

v. Contractor and Subcontractor(s) experience must be listed separately. Narrative descriptions submitted for Subcontractors must be specifically identified as Subcontractor projects.

vi. If the work was performed as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, Subcontractors shall identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The State prefers the proposed account manager have a minimum of 10 years consulting experience in employee benefits, including a minimum of 5 years consulting experience in governmental benefits or employers with self-insured health plans with more than 10,000 employees enrolled. The State reserves the right to have complete approval rights to the account manager assigned to our account.

i.

The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. SUBCONTRACTORS

If the bidder intends to Subcontract any part of its performance hereunder, the bidder must provide:

vii. name, address, and telephone number of the Subcontractor(s);
viii. specific tasks for each Subcontractor(s);
ix. percentage of performance hours intended for each Subcontract; and
x. total percentage of Subcontractor(s) performance hours.

3. TECHNICAL APPROACH

The technical approach section of the Technical Proposal must consist of the following subsections:

a. Understanding of the project requirements;
b. Business Requirements;
c. Respond to each section in Scope of Work; and
d. Technical Requirements - HIPAA

B. COST PROPOSAL REQUIREMENTS

This section describes the requirements to be addressed by bidders in preparing the Cost Proposal. The bidder must submit the Cost Proposal in a section of the proposal that is a separate section or is packaged separately as specified in this RFP from the Technical Proposal section.

The component costs of the fixed price proposal for providing the services set forth in the Request for Proposal must be provided by submitting forms substantially equivalent to those described below.

1. PRICING SUMMARY

This summary shall present the total fixed price to perform all of the requirements of the Request for Proposal. The bidder must include details in the Cost Proposal supporting any and all costs. These details must include, at a minimum, detailed descriptions and/or specifications of the goods and/or services to be provided, quantities, and timing and unit costs, if applicable.

The State reserves the right to review all aspects of the Cost Proposal for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

2. PRICES

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the Request for Proposal. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

C. PAYMENT SCHEDULE

Monthly invoices may be submitted by the Contractor on specific dates based on the completion and acceptance of related deliverables. No invoice will be approved unless the associated deliverables have been approved.

For additional services not included in the monthly contract fee, no invoices will be approved unless the associated deliverables have been completed and approved

Form A
Bidder Contact Sheet
Request for Proposal Number 5297Z1

Form A should be completed and submitted with each response to this Request for Proposal. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Attachment A

Cost Proposal

Request for Proposal Number 5297Z1

Bidder: _____

A contract resulting from this Request for Proposal will be issued approximately for a period of three (3) years effective the date of award. The contract has the option to be renewed for four (4) additional one (1) year periods as mutually agreed upon by all parties.

Prices quoted below shall remain fixed for the initial contract period which is three (3) years. Any request for a price increase subsequent to the initial contract period shall not exceed four percent (4%) of the previous Contract period and must be submitted in writing to the State Purchasing Bureau a minimum of 120 days prior to the end of the current contract period, and be accompanied by documentation justifying the price increase. Further documentation may be required by the State to justify the increase. The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

Pricing to include all expenses including all travel expenses to Lincoln, NE.

The Annual rate will be paid by the State in 12 equal installments to the contractor.

	Initial Contract Period		
	Year 1	Year 2	Year 3
Annual Rate			

HEALTH PLAN RFP CONSULTING FEES

When the State issues the RFP for the health insurance plan, additional resources and time will be expected from the contractor. To compensate for this additional time and resources, provide a lump sum cost per milestone. Implementation Claims Audit will be conducted 30 – 60 days prior to implementation and payment will be made upon completion and approval of the audit by the State.

Milestone	Posting of the RFP	Posting of the Intent to Award	Contractor Start Date	Implementation Claims Audit
Lump sum				

Attachment B

Fixed Hourly Rates

Request for Proposal Number 5297Z1

Bidder: _____

There may arise from time to time a need for work not originally specifically delineated in this RFP but considered within the scope of work. This additional work may stem from legislative mandates, emerging trends, and regulatory changes unknown at the time of the RFP.

The State may request the contractor, subject to mutual agreement by both parties, to engage in short onetime special consulting projects, related to State benefit plans.

The bidder should provide the hourly rate for each Staff position used to complete onetime special consulting projects in the following table. Please identify any additional Staff titles and their appropriate rates, which bidder believes may be used to complete said projects.

All special consulting project costs must be based upon the hourly rates provided below.

	Hourly Rate
Account Executive Manager (AEM)	
Actuary	
Underwriter	
Subject Matter Expert – Executive/Manager	
Subject Matter Expert – Staff Consultant	
Office Staff	

Attachment C

State of Nebraska

Health Insurance Plan Annual Report

Presented to the

Legislature's Appropriations Committee

November 2015

For the Plan Year

July 1, 2014 to June 30, 2015

Prepared by

State of Nebraska

Department of Administrative Services

NEBRASKA
AS
AdministrativeServices

Introduction

The Nebraska Department of Administrative Services (DAS) submits this annual report pursuant to Nebraska Revised Statute 50-502. The agency assures the State's health plans and all other benefits programs comply with state and federal guidelines; provides assistance to state agencies and employees regarding wellness and benefit issues; manages third party administrators and actuarial consultants; provides financial management to the health plan; and continuously researches health care and benefit program trends to assure the State continues to offer a competitive employment package to State employees.

Providing employees health insurance is one of the largest costs of doing business in the modern economy. This is no exception for the State of Nebraska.

In order to manage costs and ensure the program is on solid financial footing, significant plan design changes have been implemented over the last several years including but not limited to: increasing deductibles, adjusting copays and coinsurance, and increasing maximum out-of-pocket expenses for employees.

And like many businesses, in 2009, the State of Nebraska began focusing on employee wellness as a means to contain health care costs and improve the health of employees and their spouses. The State created a Wellness health plan, becoming one of the first states to launch an integrated plan for health coverage tied to wellness program participation. The Wellness health plan, in conjunction with its wellness program, called **wellNEssoptions**, is a unique value-based package which emphasizes smart use of health care along with individually tailored wellness programs.

The State of Nebraska has set a standard for others in the public sector to follow. Since its implementation, the State of Nebraska has earned several prestigious national awards.

DAS will continue to evaluate programs and take steps to control costs, which benefits agencies, employees, and taxpayers across the state. A glossary of commonly used health plan terms used throughout this report has been added at the end of this document.

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Health Plan Overview

For 2014-2015, the State of Nebraska's health insurance program consisted of four (4) self-insured health plans that included the Wellness Plan, Regular Plan, Consumer Focused Plan and High Deductible Plan. The Consumer-Focused Health Plan was added to provide an option for employees to take advantage of Health Savings Accounts to set aside pre-tax funds for future health care expenses.



The Choice Health Plan was no longer offered after June 30, 2014. The State also notified employees the High Deduction Health Plan would be discontinued on June 30, 2015.

Each plan included medical and pharmacy coverage for in-network and out-of-network providers, as well as wellness benefits. The plan year ran from July 1, 2014 through June 30, 2015 with open enrollment running from May 13, 2014 – May 27, 2014. The State ran an active open enrollment, thus, all employees were required to enroll or re-enroll in health insurance during Open Enrollment.

Coverage was offered to eligible State of Nebraska employees and COBRA participants. There were no prerequisites or requirements for employees to participate in the Consumer Focused Plan, Regular Plan or High Deductible Plan. To enroll in the Wellness Health Plan, employees and spouses were required to completed specific programs in the wellNEssoptions program, the requirements include (1) Complete an annual biometric health screening; (2) Complete the annual online health assessment; and (3) Enroll and complete a Wellness Program.

When covered employees and their dependents incurred medical claims, health providers (hospitals, doctors, etc.) sent claims to the State's third party administrators. For the 2014-2015 plan year, United Healthcare (UHC) was the third party administrator for health care claims and its subsidiary, OptumRx, was the third party administrator for pharmacy claims. UHC and OptumRx assured that submitted claims were adjudicated correctly under the provisions outlined in the plan documents set forth by the State of Nebraska. UHC and OptumRx then paid the providers, and once payment cleared the bank, the State reimbursed UHC or OptumRx for the claims through the State Employee Insurance Fund.

What does Self-Insured mean?

The State assumes the financial risk for providing health care benefits to its employees and contracts with United Healthcare (UHC) to process the claims. Instead of paying fixed premiums to UHC, which are inflated to include profit margins and taxes, the State collects contributions from employees and State agencies which are deposited in to a trust fund and used to pay for health care claims for plan participants after copays and deductibles.

Enrollment & Eligibility

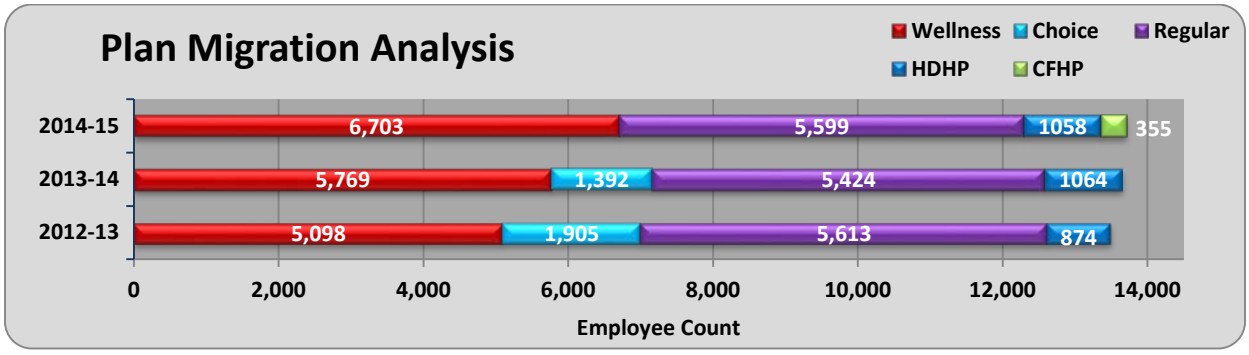
State statute 84-1601 and statute 84-1604 allows for permanent full-time and part-time employees who work a minimum of 20 hours per week to participate in the State health plans. These employees are eligible for coverage the first of the month following 30 days of employment. In addition, state statute 84-1601 and statute 84-1604 also allows temporary employees working a minimum of 20 hours per week and hired into an assignment that is 6 months or longer to also be eligible for coverage in the State health plans after the standard waiting period. State of Nebraska retirees can continue coverage in a State health insurance plan until they are Medicare eligible, which is age 65, as allowed in State of Nebraska Personnel Rules and Regulations, Chapter 17.014; and the NAPE/AFSCME (NAPE) and State of Nebraska Labor Contract, Article 13.2.

As of June 30, 2015, the plan had 13,715 employees enrolled, which included about 277 retirees and 62 COBRA participants. The total number of covered lives was 28,897 which increased .5% from 2013-2014 plan year. Ongoing dependent verification audits were conducted for all new dependents added to the health plan.



Approximately 56% of employees were female and 44% were male. The average age of employees enrolled in the plan was 47.4, slightly lower than prior year's average of 47.6.

Total enrollment in the State Health Insurance Plan over the past two years has increased 1.7%, potentially due to the impact from the ACA requirement that everyone have healthcare. Individual plan enrollments have changed significantly. Since the Choice plan was eliminated, employees have migrated to the Regular, Wellness or High Deductible plan. The Wellness plan had 49% of the employees enrolled in a health plan during the 2014-2015 plan year, which reflects the importance of the wellness program.



Plan Management & Fund Management

DAS assures the State's health plans and all other benefits programs comply with state and federal guidelines and provides financial management to the health plan. DAS consults with experts in health plan management including AON Hewitt, UHC, and attorneys to constantly monitor changes in health plan management and assure our plan and documentation is in compliance.

Regulatory Mandates

- State Statutes
- Department of Insurance
- PPACA
- IRS
- COBRA
- HIPAA
- Medicare
- Employment Laws - FMLA, USERRA, ADA, Title VII, GINA

Health Plan Documents

- Summary Plan Document (SPD)
- Summary of Benefits & Coverage (SBC)
- Section 125 Plan Document
- Business Associate Agreements
- Benefits Administration Manual for State HR Partners
- Wellness & Benefits Options Guide
- Wellness & Benefits Website

State statute 84-1613 established the State Employees Insurance Fund #68960 to pay medical and pharmacy claims, administrative fees and wellness program fees. This fund was administered by DAS and reserve targets were adjusted annually using cost projections from the State's actuary and health care consulting firm. For the 2014-2015 plan year the actuary and health care consultant was Aon Hewitt.

Reserves are imperative to successful management of a self-insured health plan for over 28,000 covered lives. The Health Insurance History Fund #68922 is a subsidiary fund of the State Employees Insurance Fund #68960 and contained the Claims Fluctuation Reserve (CFR). Health Insurance History Fund #68922 is designed to pay for the costs of coverage of unusual or high volume claims that may occur. Health Insurance History Fund #68922 also contains the amount to finance the operation of Program 606, Wellness and Benefits Administration, as approved by and stated in the biennium budget bill. The amount required for Program 606 operation was transferred by the State Treasurer from Fund Health Insurance History Fund #68922 to Health and Life Benefit Administration Fund #28010, established in state statute 84-1616.

During the 2014-2015 plan, the first payment of the Transitional Reinsurance Fee, required under the PPACA, was made. For the calendar year 2014, the fee was $63 per participant, or approximately $1.5M. The first installment of $1.25M was paid in January, 2015. The second installment will be paid in November, 2015. For the calendar year 2015, the fee will be reduced to $44 per participant.

Another new fee required under PPACA is the PCORI (Patient-Centered Outcomes Research Institute) fee. This fee will be paid every July. In July 2014 the State paid $23,500 for PCORI and in July 2015 the fee increased to $47,300.

Self-insured health plans can purchase Stop Loss insurance to limit the amount a plan pays each year for each participant. In 2012-2013 the State of Nebraska purchased a Specific Stop Loss insurance policy through UHC with a $1 million deductible. Thus, the State's health fund is only responsible for the first $1 million of claims paid for an individual participant for the plan year.

Each year during renewal, the State analyzes whether or not to continue purchasing Stop Loss Insurance. The State looked at claims for the State and industry health care. Based on the growing frequency of high cost claimants who exceed $100,000 and health care cost trends, the State decided to continue Stop Loss insurance for 2014-2015 plan year.

In 2014-2015 one participant exceeded $2 million in claims and eight additional participants exceeded $500,000. This illustrates the continuing trend of high cost claimants. In 2013-2014, only four claimants exceeded $500,000 in claims. The State recovered $1,642,000 in stop loss insurance payments and paid $653,000 in stop loss premiums.

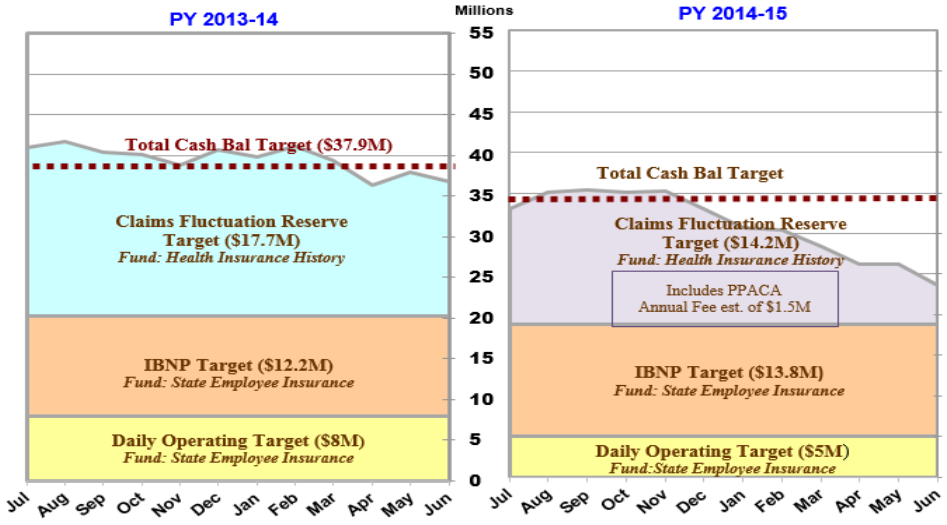
During 2014-15, DAS conducted three audits of the State's 2013-14 health plan. DAS contracted with AON Hewitt to conduct a medical claims audit. DAS contracted with Myers & Stauffer to complete a pharmacy claims audit which also included rebates, customer service, and appeals. Myers & Stauffer also completed a UHC customer service audit. DAS has shared outcomes and recommendations from these audits with our vendors to assure accuracy of claims processing and an improved customer service for our participants.

Aon Hewitt in conjunction with DAS prepared an Incurred But Not Paid (IBNP) Analysis Report, Premium Rate Analysis Report, and Claims Fluctuation Reserve (CFR) Analysis Report for the State. These reports were reviewed at meetings conducted between the Wellness and Benefits Administrator, Personnel Director, Director of DAS, Budget Division, and the Governor to establish plan contribution funding, effective plan designs, and set targets for the plan year.

For plan year 2014-2015, Aon Hewitt recommended a CFR of at least $14.2 million and IBNP of $13.8 million. In accordance, the State established a CFR targeted balance of $14.2 million in Health Insurance History Fund and a targeted balance of $18.8 million in the State Employees Insurance Fund #68960 which included a Daily Operating Target of $5 million to cover daily expenses and IBNP of $13.8 million to cover claims run out from the prior plan year. The Cash Balance Target was reduced from $37.9 million to $34.5 million as recommended by AON Hewitt.

A summary of financial activities in State Employees Insurance Fund #68960 for the plan years ending June 30, 2014 and June 30, 2015 are shown on the following page.

PY 2013-14 vs. PY 2014-15
Health Cash Balance*
PY = Plan Year = Fiscal Year



State of Nebraska Health Insurance Fund
Summary of State Employees Insurance Fund #68960 Activity
Comparison of Plan Years Ending June 30, 2014 and 2015

	Plan Year 2014-2015	Plan Year 2013-2014	Change	
Contributions			**Dollars**	**Percent**
Contributions	$167,392,946	$160,848,652	$6,544,294	4%
Investment Income	$331,073	$330,572	$501	0%
Total Contributions	$167,724,019	$161,179,214	$6,544,795	4%
Distributions				
Medical Claims & IBNR	$131,211,499	$124,130,373	$7,081,126	5%
Pharmacy Claims	$37,971,608	$33,098,022	$4,873,586	13%
Wellness-Health Fitness	*$2,885,150	$2,042,507	$842,643	29%
Administration Fees	$8,390,622	**$6,912,538	$1,478,084	18%
Total Distributions	$180,458,879	$166,183,440	$14,275,439	8%
Net Difference	**-$12,734,859**	**-$5,004,227**		

***2014-2015 Wellness-Health Fitness fees included carry over from prior year.**

****2013-2014 Administration Fee were lower due to performance guarantees.**

State of Nebraska Health Insurance Funds
As of June 30, 2015

	6/30/2015	6/30/2014	$ Change	% Change
State Employees Insurance Fund #68960	$9,675,057	$17,793,411	-$8,118,354	-46%
Health Insurance History Fund #68922	$14,499,927	$18,922,188	-$4,422,261	-23%
Total Reserves	**$24,174,984**	**$36,715,599**	**-$12,540,615**	**-34%**

2013-2014 contributions included a $7.3 million subsidy from reserves.

2014-15 contributions included a $5.2 million subsidy from reserves.

Health Plan Contributions

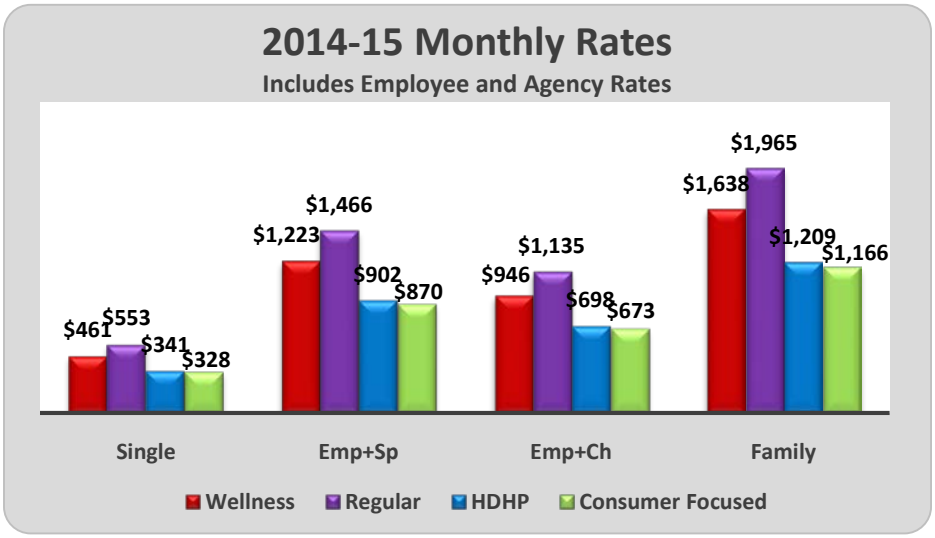
The State Employees Insurance Fund #68960 is funded by health plan contributions from participants and the State. Contributions are collected from employees through payroll deductions and combined with State contributions.

In accordance with state statute 84-1611, the State pays 79% of monthly rates and active, full-time employees pay 21%. Statute 84-1604 requires part-time employees (21-39 hours a week) receive only a proportion of the State contribution. Part-time employees pay 21% of the monthly rate plus a pro-rated amount of the State's share. Retirees pay 100% of the monthly rate and COBRA participants pay 100% of the monthly rate plus a 2% administration fee.

Health plan contributions are reviewed each year. In December 2013, Aon Hewitt provided the Wellness and Benefits Administrator with a Preliminary Premium Rate Analysis Report. The Wellness and Benefits Administrator, Personnel Director, and Director of DAS reviewed the report along with the State Budget Division and Governor. Contributions and plan design changes were approved in February 2014 and communicated to employees in April 2014, prior to Open Enrollment, and implemented on July 1, 2015.

Contributions to the plan increased from $161 million to $168 million.

Monthly rates for all State health plans are determined by actual claims history, projected enrollment, and projected health plan costs. Each health plan is adjusted individually for plan design and experience which can result in different rate changes by plan. In addition, the Regular plan is negotiated as part of the Nebraska Association of Public Employees (NAPE) labor contract. The projected cost increases for 2014-2015 were offset by a $5.2 million premium subsidy.



2014-15 Rate Increases

Wellness – 9.6%

HDHP – 9.7%

Regular – 10.8%

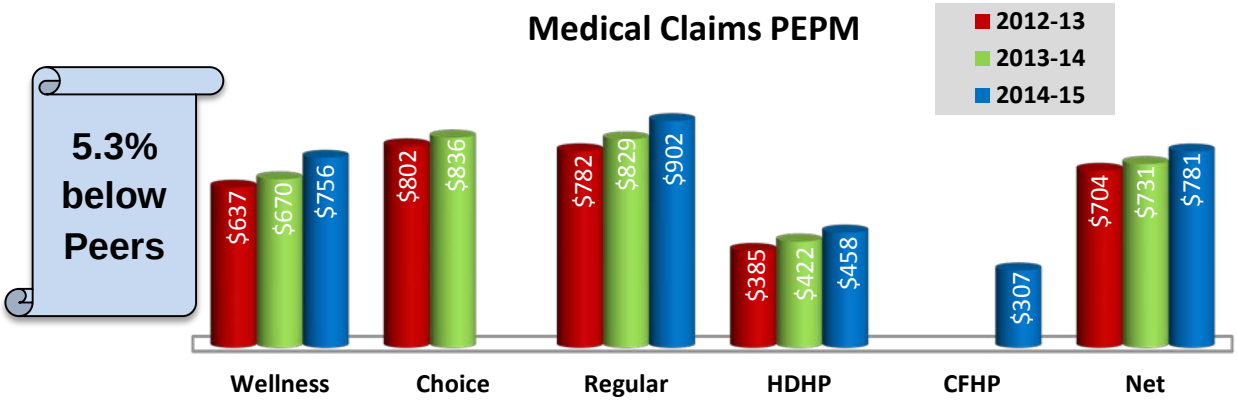
Medical Claims Review

Medical claims were administered by UHC and include costs associated with hospital stays, outpatient services, emergency care, behavior health care, physician office visits and preventive health care, among other services.

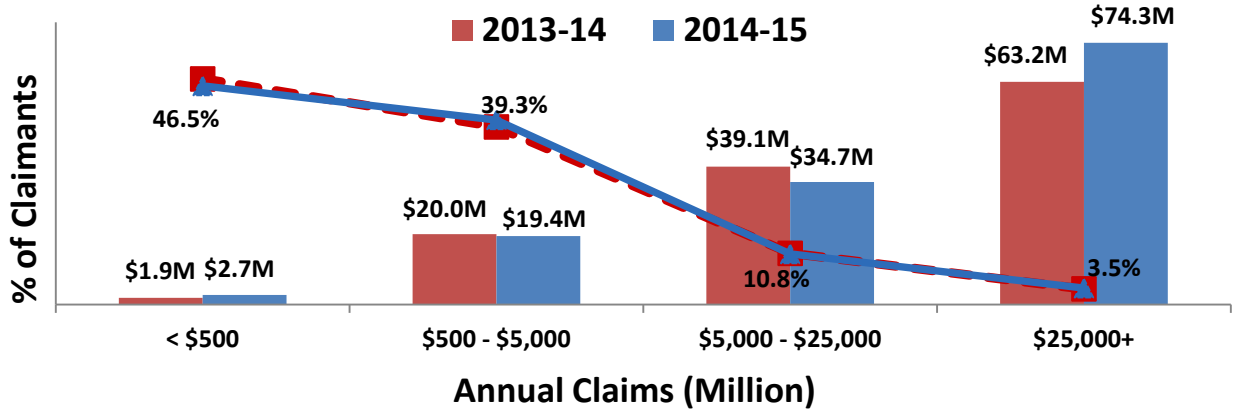
The State Employees Insurance Fund #68960 paid approximately $131 million of medical claims during plan year 2014-2015, which reflected a 5% increase from the prior year. Factors attributed to this increase include a 13.5% increase in claimants exceeding $100,000 of medical claims (High Cost Claimants), increase in participants, and increased number of participants utilizing medical benefits.

Consistent with 2013-2014, treatment for musculoskeletal conditions, neoplasms (cancer), and circulatory (heart disease) were the top cost driver of medical claims. Combined, these three diagnosis drive 36% of total medical claims paid per employee per month (PEPM).

The Net Paid PEPM of $781 reflects a 6.8% increase from the previous year but was 5.3% below our peer group according to UHC. Despite an increase, the Net PEPM remains below 2011-2012 cost per employee.



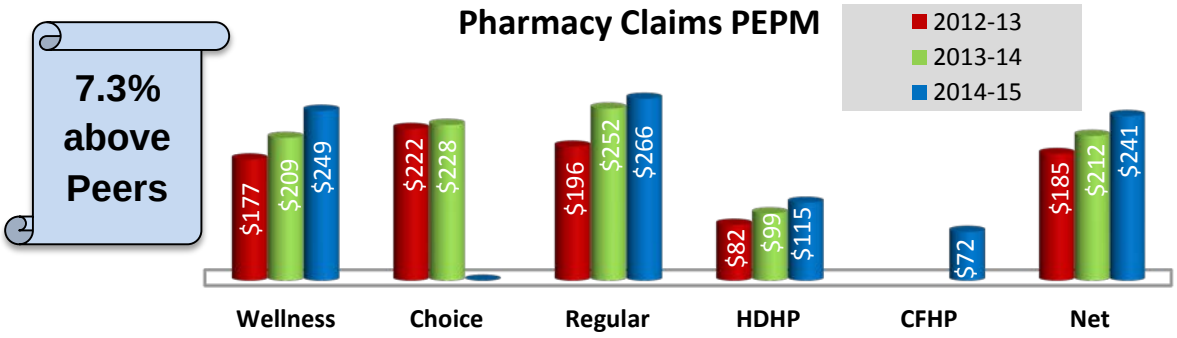
Consistent with other group health plans, a small percentage of participants incurred a high proportion of total medical claims paid. Of the $131 million spent on medical claims, the plan paid nearly $74.3 million for 3.5% (998 lives) of the total plan participation of 28,897. Compared to prior year, the percentage of claimants remained consistent for each claims group, however, the plan saw a $11.1 million increase in claims paid for those who incurred claims of $25,000 or more.



Pharmacy Claims Review

Pharmacy claims were administered by OptumRx, an affiliate of UHC. The plan paid about $38M for prescription claims in 2014-2015, a 13% increase from the previous year. The cost paid by the plan per employee was 7.3% higher than the peer group due to higher utilization of specialty drugs, according to UHC.

Roughly 24,700 participants utilized pharmacy benefits in the health plan, filling about 433,000 prescriptions. The average cost per prescription of $91 increased from $82 paid the prior year. On average, each participant filled 15.0 prescriptions annually compared to peer group of 10.6.



Members pay a copay for each prescription and the remainder of the cost is paid by the plan.

UHC's plan breaks drugs in to 3 tiers by cost. Tier 1 includes mostly generic plus some low-cost brand name drugs. Encouraging participants to choose generic prescriptions, primarily in Tier 1, reduces costs for both the employee and the plan.

	2014-15	2013-14	% Change	Peer
Annual Scripts per Participant	15.0	14.6	3.1%	10.6
Average Cost	$126.25	$113.44	11.3%	$116.07
Plan Cost Share	89.9%	87.9%	2.0	87.8%
Employee Cost Share	10.1%	12.2%	-2.1	15.2%
Generic Utilization	82.8%	81.2%	1.6	

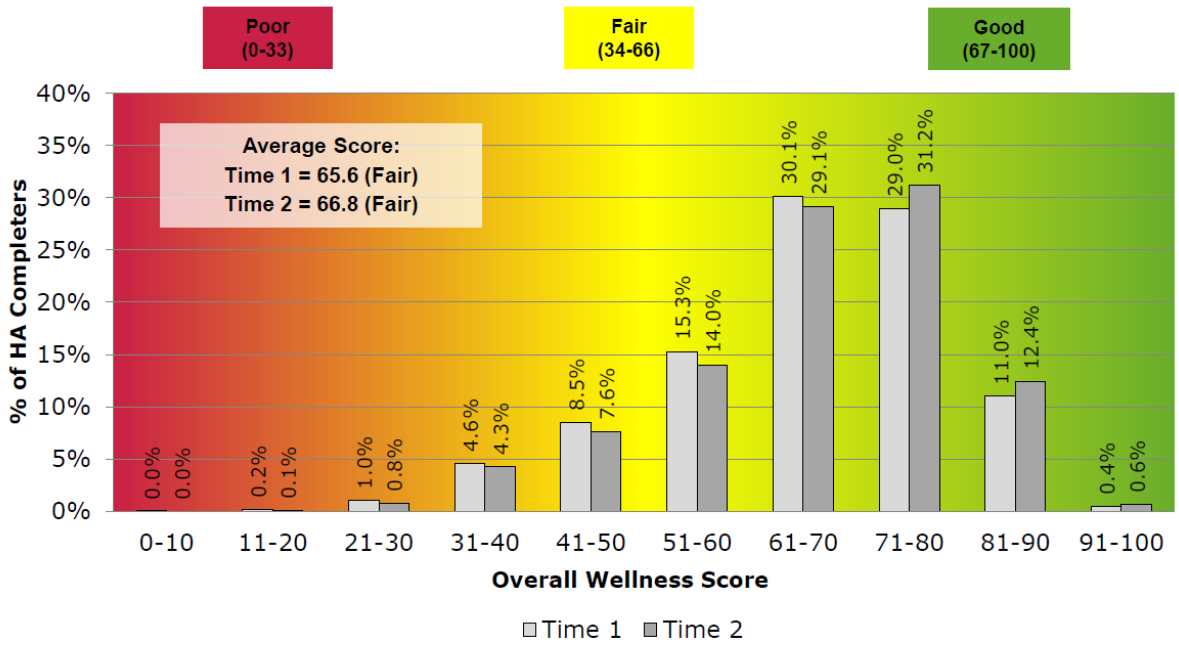
Wellness Program - wellNEssoptions

Wellness Programs
Interactive Health Platform
Biometric Screenings
Health Risk Assessment
EMPOWERED Coaching
Personalized Lifestyle Program
Walk This Way
Cardio Log
Preventive Reminders
Chronic Care Reminders
Online Resources

The State's wellness program was administered by *HealthFitness™,* which provided the State with two dedicated, onsite Wellness employees. Wellness program fees were paid through the State Employees Insurance Fund #68960 and cost about $2.9 million for the plan year ending June 30, 2015. The fees in the report include some expenses incurred in 2013-2014 but paid in 2014-15 due to timing of billing. These costs, shared by the State and employees enrolled in the State health plans, provided a comprehensive wellness program that yielded positive health and economic benefits now and likely will in the future.

Employees and spouses who complete each of (1) Biometric Screening, (2) Health Risk Assessment, and (3) their choice of a wellness program are eligible to elect the Wellness Health Plan which offers lower out of pocket costs for medical and pharmacy health care. For 2014-2015, about 49% of health plan participants qualified and enrolled in the Wellness Health Plan.

Participation in the health screenings and health risk assessments offered during April through May 2015 through **wellNEssoptions** remained consistent with prior year. About 10,700 employees and spouses participated in these event. Employees and spouses who completed a health assessment in 2014 and 2015 saw their overall health score improve 1.8%.



State of Nebraska recognizes individuals and agencies who participate in the **wellNEssoptions** program throughout the year.

Wellness Incentive

Employees and spouses who complete the incentive requirements receive an incentive to elect the Wellness Health Plan for the upcoming year. Over 6,400 employees met the incentive requirements in 2014-2015 and were eligible to elect the wellness health plan on July 1, 2015.

Walk This Way Recognition

In April 2015 Governor Pete Ricketts honored participants in the **wellNEssoptions** Walk This Way® program in the Capitol. Participants in the program averaged over 1.9 million steps during the program year.



Wellness Award Luncheon

On September 11, 2015, over 100 employees joined Governor Ricketts at the Wellness Award Luncheon to honor our 140 Wellness Champions, Wall of Fame recipients, and Agency Directors for their help with promoting and supporting a culture of wellness. This year the following individuals and agencies were recognized for going above and beyond in promoting and establishing a healthy lifestyle.

Wellness Champion Awards

Douglas Barry, Department of Environmental Quality
Kris Bourke, Department of Administrative Services

Agency Wellness Culture Awards

Department of Education
Department of Roads
Nebraska State Treasurer's Office

Snapshot of 2014-2015 Health Program Outcomes

Financial

- Net PEPM for medical increased 6.8%.
- Excluding catastrophic claims, medical PEPM is trending 1.9%.
- Net PEPM for pharmacy increased 13.6%
- Medical PEPM was 5.3% below peer group.
- Pharmacy PEPM was 7.3% above peer group.
- Back and joint replacement surgery account for 8% medical spend.
- Network discount rate was 39% and saved $91 million.
- 168 participants drive 26% of total spend and exceed $100,000 in claims.
- 1 participant exceeded $2 million in claims.

Clinical

- Age/gender risk is 10.4% higher than peer.
- Emergency room visits are 35.0% lower than UHC Peer group.
- Inpatient utilization decreased 2.0%; Outpatient decreased 0.5%.
- Top three diagnosis was diabetes, hypertension, and back pain.
- Muskeletal, cancer, and diabetes drive 36% of medical costs.
- Increased prevalence since 2012-2013 of Chronic Obstructive Pulmonary Disease (COPD), diabetes, and pregnancy.
- Claimants with COPD increased 21% over the last two years.
- 9.2% of members have primary diagnosis of diabetes.

Engagement

- 53.5% of eligible employees and spouses participate in wellness.
- Wellness Health Plan participation increased 16%.
- Over 4,000 employees received a flu shot at a State onsite clinic.
- Over 11,900 participants participated in **wellNEssoptions** programs.
- 95% of high cost claimants engaged in clinical program with UHC.
- Overall wellness score increased 1.8% for for 2-year participants.
- Healthy eating and physical activity are top coaching goals.
- 5,793 participants enrolled in wellNEssoptions coaching programs.
- Wellness & Benefits traveled statewide hosting education meetings and help desks about health plans and wellness.

Looking Ahead

The State continues to focus on providing employees with a quality health insurance program integrated with wellness. The State discontinued the High Deductible Health Plan on June 30, 2015. The strategy of the plan designs is to offer three distinct options: a wellness and non-wellness PPO plan and a qualified high deductible plan with lower premiums. This strategy is designed to leverage the value of wellness and the value of a tax advantaged consumer-focused health plan.

Aon Hewitt provided the State with actuarial cost projections. Costs were impacted by new PPACA plan design requirements and fees, health care trend of 5 to 7%, and eliminating premium subsidies which reduced premium increases in previous years but also reduced reserves in the State Health Insurance Funds. Plan design changes were bargained for the Regular plan with NAPE for the 2015-16 and 2016-17 plan years through negotiations.

	2015-2016 Contribution Increases
Wellness Health Plan	**11.0%**
Regular Health Plan	**11.0%**
Consumer Focused Health Plan	**6.5%**

The Accountable Care Act continues to impact the State's health plan cost and administrative requirements for compliance. Beginning July 1, 2015, the State is required to offer health insurance at full-time rates for employees working 30 hours or more on average. The State determines eligibility for employees working more than 30 hours a week through a 12-month look-back measurement.

Also, in January 2016, the State will be required to report to the IRS and to employees eligible and enrolled on the State's health insurance coverage during 2015.

Finally, the State continues to monitor the impact of the excise tax exposure that will affect the health plans and other tax advantaged benefits beginning in 2018.

HealthFitness continues to administer **wellNEssoptions** for 2015-16. The following changes were implemented beginning April 1, 2015:

- ✓ Added a nutrition program called Colorful Choices.
- ✓ Coaching participants must complete 10 or more goals to qualify for Wellness Health Plan.

The State is continually monitoring health care trends in the industry and partnering with groups such as Aon Hewitt, UHC and others to seek out, analyze and provide the best features and options for employees and taxpayers. The State is researching alternative cost management solutions including value based network agreements.

The State also recognizes the total health of our workforce extends beyond physical well-being to also include other personal and economic needs. In addition to a competitive health and wellness program, DAS also works to ensure that employees and their families are able to participate in other group benefits including dental, vision, employee assistance program, flexible spending accounts, life and long term disability. We offer a quality benefit package designed to attract and retain a best in class State of Nebraska workforce.

Glossary

Aon Hewitt – An independent, nationally recognized actuary and health care consulting firm.

Brand Name Drug - A drug that has a trade name and is protected by a patent (It can be produced and sold only by the company holding the patent).

CFR (Claims Fluctuation Reserve) - An amount of money set aside (reserved) to pay for an unusually high volume of claims or unexpected number of claims.

Chronic Conditions - A diagnosis of diabetes mellitus, migraine, hypertension, hypertensive heart disease, heart failure, chronic bronchitis, asthma, etc.

Claimant - A unique participant for whom a claim was submitted for payment.

Claims Fluctuation Reserve Report – Report illustrating the appropriate level for various claim fluctuation reserves developed through simulation modeling of expected claims.

COBRA (Consolidated Omnibus Budget Reconciliation Act) - An option for a worker to continue group health benefits for a limited time following the termination of those benefits due to job loss, reduction in work hours, etc.

Employee - The primary subscriber of the health benefits. Employee includes active employees, retirees, and COBRA participants.

Generic Drug - Drug which contains the same active ingredients as brand-name medications but often cost less. Once the patent of a brand-name medication ends, the FDA can approve a generic version with the same active ingredients.

HealthFitness™ - Administrator of the State's wellness program, **wellNEssoptions**.

High Cost Claimant - A claimant whose total net payments for a given time period are equal to or in excess of $100,000.

HIPAA (Health Insurance Portability and Accountability Act of 1996) – Law designed to help people keep health insurance and provide privacy standards to protect healthcare information.

IBNP (Incurred But Not Paid) - Estimate of health plan claims incurred for a time period for which payments have not been processed.

IBNR Analysis Report – Report prepared by Aon Hewitt for the State which provides an estimate of medical and pharmacy claims incurred as of the last day of the plan year but not yet processed for payment.

Glossary (continued)

NAPE/AFSCME – Nebraska Association of Public Employees, Local 61, of the American Federation of State, County and Municipal Employees. The labor union who represents several groups of employees who work at the State of Nebraska.

Net Paid - The total amount paid by the plan, after the application of discounts and after any member responsibility and coordination of benefits.

Network Discount Percent - Amount of reduction from billed amount that the third party administrator has negotiated with the provider.

Network Utilization - Eligible charges incurred using in-network providers.

OptumRx – Pharmacy benefit manager affiliated with UHC and administrator of the State's pharmacy benefit plan.

Norm - Based on a peer group average and not adjusted for characteristics of covered population.

Outpatient – Medicare care or treatment that does not require an overnight stay in a hospital or medical facility. It may be provided in a medical office, hospital or outpatient surgery center.

Participant - A person eligible for plan benefits. A participant may be an employee, covered spouse or other legal dependent.

Peer Group - A group of city, state, and county public employers selected by UHC.

PEPM (Per Employee Per Month) - The average revenues, expense, or utilization of services for one employee for one month.

PMPM (Per Member Per Month) - The average revenues, expense or utilization of services for one participant for one month.

PPACA (Patient Protected and Affordable Care Act) – Health care legislation signed in to law March 23, 2010. The law includes new health plan provisions rolled out over multiple years.

Premium Rate Analysis Report – Report used to project contribution rates for the upcoming plan year(s) based on claims experience and participant data.

Preventive Visits - Professional office visits considered precautionary.

United Healthcare (UHC) – Administrator of the State's health insurance program.

wellNEssoptions - The State of Nebraska's wellness program, administered by HealthFitness™.

Employee Wellness & Benefits

RFP Schedule

Updated March 2016

Attachment D

	Last Day of Contract	Additional Renewals	Last Day of Contract	Note	July 2015 - June 2016	July 2016 - June 2017	July 2017 - June 2018	July 2018 - June 2019	July 2019
Benefit Consutant #55000 04 (AON)	8/31/2015	4 - 1 Year Renewals	8/31/2019	RFP for 9/1/16 contract	**RFP Prep Begin Oct 2015**; **Publish April 2016 Select by 7-1-16**; **Award 8-1-16**; **Start 9-1-16**				
Wellness / Flu Shot Emergency Contract (Health Fitness)	4/30/2017	None	4/30/2017	New Wellness Contract	**RFP Prep**; **Publish April 2016 Select by 9-1-16**; **Award 10-1-16 Implement by 4-1-17**; **Start 4-1-2017**				
Vision #42499 04 (Eyemed)	6/30/2015	2 - 1 Year Renewals	6/30/2017	Exhaust all renewals	**RFP Prep 6-1-16**; **Publish by 9-1-16 Select by 1-1-17**; **Award 2-1-17 Implement by 5-1-17**	**Contract Start 7-1-17**			
Medical/Rx/HSA #51597 04 (UHC)	6/30/2015	3 - 1 Year Renewals	6/30/2018	Exhaust all renewals		**RFP Prep 12-1-17**; **Publish 6-1-17 Select 11-1-17**; **Award 1-1-18 Implement by 5-1-18**	**Start 7-1-18**		
Stop Loss #51764 04 (UHC)	6/30/2015	3 - 1 Year Renewals	6/30/2018	Exhaust all renewals		**RFP Prep 12-1-17**; **Publish 6-1-17 Select 11-1-17**; **Award 1-1-18 Implement by 7-1-18**	**Start 7-1-18**		
Long Term Disability 55674 07 (United of Omaha)	6/30/2016	3 - 1 Year Renewals	6/30/2019	Exhaust all renewals			**RFP Prep 6-1-18**; **Publish 9-1-18 Select 1-1-19**; **Award 2-1-19 Implement by 5-1-19**	**Start 7-1-19**	
Life Insurance #55660 04 (Aetna)	6/30/2017	2 - 1 Year Renewals	6/30/2019	Exhaust all renewals			**RFP Prep 6-1-18**; **Publish 9-1-18 Select 1-1-19**; **Award 2-1-19 Implement by 5-1-19**	**Start 7-1-19**	

Attachment E

Benefits & Wellness Contracts - **Contracts may be viewed at http://www.nebraska.gov/das/materiel/purchasing/contract_search/index.php**

Contract #	Description	Contractor	Start date of the contract	Number of years of term with number of renewable extensions	End date of the contract	Total cost of the contract per year
Emergency Contract	**Wellness/Flu Shot**	Health Fitness	4/1/2016	1 year contract	4/30/2017	$2,600,000
#55000 O4	**Benefits Consultant**	AON Hewitt	2/1/2013	2 year contract with 4 one-year renewals	8/31/2019	$194,500
#42499 O4	**Vision Insurance**	Eyemed	4/1/2010	5 year contract with 2 one-year renewals	6/30/2017	$1,308,000
#51597 O4	**Medical / Rx / Health Savings Accounts**	UnitedHealthcare	7/1/2012	2 year contract with 4 one-year renewals	6/30/2018	$6,396,000
#52764 O4	**Stop Loss**	UnitedHealthcare	7/1/2012	2 year contract with 4 one-year renewals	6/30/2018	$660,000
#55674 O4	**Long Term Disability**	United of Omaha	7/1/2013	3 year contract with 3 one-year renewals	6/30/2019	$1,307,700
#55660 O4	**Life Insurance**	Aetna	7/1/2013	4 year contract with 2 one-year renewals	6/30/2019	$4,056,000
#56047 O4	**FSA & COBRA Administrator**	ASI	7/1/2013	3 year contract with 4 one-year renewals	6/30/2020	$208,800
#56248 O4	**Employee Assistance Program**	Deer Oaks	7/1/2013	4 year contract with 4 one-year renewals	6/30/2021	$181,750
#59801 O4	**Dental Insurance**	Ameritas	7/1/2013	3 year contract with 3 two-year renewals	6/30/2022	$6,507,600