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Carrier	Category	Efforts and Achievements
Carrier 01	**Administrative Cost Reduction**	The WEA Select Medical Plans through Premera have reduced admin costs through the following: A. Premera has been a leader in implementing "Lean" thinking since 2005. The goal is to be able to improve quality, improve the enrollee experience, and improve efficiency while eliminating non-value added time and work effort and lowering expenses. Premera uses this method, on an ongoing basis, to continue to evaluate and improve internal/external processes throughout the organization. Other organizations participate in Premera's "Lean" workshops so they can incorporate them in their own business – including the State of Washington, various provider groups, etc. Through Lean Premera has reduced overall administrative costs from 8.8% in 2005 to 5.9% in 2015. The administrative costs specific to the WEA Plans are approximately 5% of premium and have been under 6% for over 13 years. B. BlueCard provides significant savings to WEA/Premera enrollees traveling or residing outside the Premera service area. C. The percentage of WEA claims paid through auto adjudication remains some of the highest within Premera, which reduces the need for manual intervention. This provides peace of mind for providers as well as for enrollees with quick turnaround on payments for services and lower administrative costs.
Carrier 01	**Cost Savings**	The WEA Select Medical Plans through Premera provide the following cost savings measures: A. The high number of Premera members, currently over 2 million, helps Premera negotiate greater provider discounts locally and nationally. In addition to WEA's over 110,000 enrollees, Premera also provides coverage to enrollees on the state Exchange, Individual, small and large group accounts. Furthermore, Premera provides coverage for many large, national accounts, including: Microsoft, Amazon, Starbucks, Weyerhaeuser, Alaska Air Group, etc. a. Provider contracting - Premera has the highest number of providers "in network" in the state (resulting in 98%+ of all paid claims are "in-network"). Substantial provider discounts result in lower claims cost for the plan and lower out-of-of pocket costs for enrollees on a WEA Plan. b. BlueCard – (Premera's national "Blue" network) has negotiated significant discounts which are passed on to WEA Premera enrollees who travel or reside outside the Premera service area.

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		B. Evidence-based medical initiatives that allow Premera to provide efficient and cost-effective care as well as to identify appropriate alternative care based on the enrollees needs. C. Real-time access to consumer decision-support resources to help enrollees understand and direct their health care needs. D. Provider advisory groups continually monitor Premera's medical and pharmacy policies and procedures, and make changes to formularies to ensure they are appropriate level/tier, and cost and care-efficient. E. Member 360 dashboard - Proprietary tool used by Premera Case Managers to identify enrollees with specific healthcare needs and ensure they are receiving the appropriate services. F. Plans that include copayments for Emergency Room service (waived if admitted), copayments for inpatient hospital admissions, and higher copayments for brand, non-preferred and specialty drugs. G. Programs that monitor controlled medication substances to ensure appropriate use for enrollees. H. An open 4-tiered drug formulary that provides choice for enrollees and their physicians while being prudent and ensuring the drugs are cost and care-effective. I. Child COBRA Rate – Overage dependents pay the lower child rate rather than a subscriber rate. J. The premium rate for dependent children is the same whether there is one or more enrolled K. Prior Authorization – Some services require an approval for coverage from Premera before a planned medical service or procedure occurs, which provides financial protection and prevents unnecessary services. L. Choice – 7 freestanding medical plans available statewide with a broad range of benefits and rate levels to meet the diverse needs of school district employees and their families. Lower cost plans are available such as the QHDHP or the EasyChoice Plan.

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		The EasyChoice Plan provides several options all at the same rate. It was developed so employees could pick the plan most appropriate for their needs, and take the cost decision off the table. This plan has copays for office visits and generic drugs are covered with low copay. M. Waiver – employees can waive medical coverage under WEA. Any left-over state allocation is put back into the insurance pool to reduce the cost for those with monthly co-premiums.
Carrier 01	**Customer Service**	Premera's WEA claims, customer service and field service teams are all dedicated to the WEA account and are based in Washington. These teams: A. Provide a website with access to information about the employee's benefits, including a cost estimator. This tool helps them determine which providers require less out-of pocket costs. The website provides educational information about wellness programs, plan benefits, and houses forms commonly used by employers and enrollees. B. Conduct independent surveys to measure enrollee satisfaction and then put a focus on making changes to improve satisfaction. C. Use "Ulysses Learning™" – leading to first call resolution and a higher level of satisfaction from enrollees. D. Conduct "Lean" workshops which improve policies and processes for all areas within the company that support WEA enrollees. Premera places a high value on continuing to enhance the enrollee experience. E. Provide year-round servicing and are available to work directly with enrollees or family members who may need additional assistance with their plans. Premera provides an array of services from providing education about the benefits and the plan choices to when a plan change can be made. Premera also works to resolve claim issues for enrollees. This provides additional support to the district as well as direct support to their employees. F. Create the newsletters for WEA enrollees, which are published twice a year and provide information on a variety of topics including how to maximize their benefits, wellness resources, provider updates, and benefit and rate changes.

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		G. Work with enrollees or their provider to address escalated or complex issues. H. Accept input from enrollees or school districts which has led to making modifications to processes or benefit changes to the plans.
Carrier 01	**District Management of Health Plans**	A. Premera passed on lower increases to dependents than to employee only tiers four out of the past five years for all school district business. B. Premera added lower cost options, such as the QHDHP, that have lowered premiums for all school district plans. C. Premera provides a website with access to information about the employee's benefits – this includes a cost estimator which helps enrollees determine which providers require less out of pocket costs. The website provides educational information about wellness programs and their plan benefits. D. Premera does independent surveys to measure enrollee satisfaction and then puts a focus on making changes to improve satisfaction. E. Premera has "Ulysses Learning™" which leads to first call resolution and a higher level of overall satisfaction from enrollees. F. Premera's "Lean" workshops include Customer Service, Claims, Billing, and Sales and Marketing processes which we continue to focus on in order to improve the enrollee experience. In addition, Premera has: A. Patient-centered medical home program that has enabled enrollees to select a clinic at which they received their non-emergent health care without having a copayment. B. BlueCard national network of providers and international network via BlueCard Worldwide

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		C. Integrated Utilization Management that works with members and providers across the care continuum, focused disease management program for lung and breast cancer as well as high-risk pregnancy. WEA Select Plans: A. Provide year-round service for enrollees and districts is available for those who may need additional assistance with their plans. Premera provides an array of services from providing education about the benefits, the plan choices, network status, special enrollment rights, etc. Premera works to resolve claim issues for the enrollees as well. This provides additional support to the district as well as direct support to the employees. B. Offers a lower cost option (EasyChoice) that has a lower premium. C. WEA has their own claim review process, separately, that allows enrollees to go before a board of their peers and have the claim upheld, denied, or have an administrative allowance made. The input from the enrollees has assisted the WEA in developing benefit revisions to their plans. D. Approved Leave of Absence coverage for up to 18-months E. Coverage during a Labor Dispute F. Coverage for those affected by a Reduction in Force G. Semi-annual newsletters are sent to enrollees to educate them on their plans and provide access to information to help support decision making and healthier lifestyle decisions. H. Meetings to assist payroll and HR with plan information, updates, education, etc.

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Carrier 01	**Part-Time Employee Coverage Protection**	The WEA Select Medical Plans through Premera: A. Have provided access to coverage for part-time employees working 17.5 hours a week for over 30 years. Individual districts can choose to allow participation for employees working fewer hours, providing that the employer is contributing towards the cost of the medical plan. B. Offer lower cost options, such as the EasyChoice plan and the Basic plan that have lower premiums. Additionally, a QHDHP is available.
Carrier 02	**Administrative Cost Reduction**	In 2015, Group Health continued to focus our efforts on existing technology, making needed improvements to Premier and other legacy systems in order to meet federal, state, and industry guidelines and continue to provide the best service to our customers. On December 4, 2015, Group Health Cooperative announced that it signed an agreement to be acquired by Kaiser Foundation Health Plan of Washington. The approval process for the acquisition may take up to a year or more to complete. The acquisition was approved by Group Health's voting membership and is pending regulatory approval. Group Health's operations will not change right away. Upon the completion of the acquisition process, Kaiser Foundation Health Plan of Washington will become the parent company of Group Health Cooperative, Group Health Options, Inc., and certain other current Group Health subsidiaries. Group Health Cooperative and Group Health Options, Inc. will continue to hold their existing health plan contracts with employer group purchasers and other purchasers at the close of the acquisition. By joining with the larger Kaiser Permanente organization, Group Health will have access to greater resources and capital that will expand our capacity to care for and attract more people in Washington state.
Carrier 02	**Cost Savings**	1. We work closely with the client to find the right benefit designs and network options and integrate them with our own delivery system to ensure that the group can maximize cost controls.

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		2. We offer patient-centered care that promotes collaboration between physicians, specialists, and other members of the health care team. We empower employees to improve health through cost effective care management, wellness solutions, and occupational health services. All of these can result in a more productive workforce and lower overall costs.
		3. In order to ensure claims timeliness and accuracy, we have online systems that catch inappropriate billing, review coding, identify duplicate billings and COB/subrogation opportunities. We perform pre-payment review of high dollar claims and post-payment audits.
		4. Group Health recently selected OptumRx to handle our pharmacy benefits management (claims and related network administration). As part of our continuing focus on cost savings across the enterprise, we identified our PBM relationship as a potential opportunity. By switching from our current vendor, MedImpact, to OptumRx, we will achieve significant savings and industry-leading capabilities to better manage the fastest growing component of health care costs into the future.
		5. Optimizing and actively managing transitions of care is a core competency and differentiator for Group Health. With onsite hospitalists and CMLNs to assist with transitions of care from one site to another and referrals to specialty programs or services, for both PPO and HMO members, Group Health is able to achieve better outcomes and lower costs. Coordinating these "hand-offs" results in lower costs and fewer days in the hospital. The most apparent objective measure of this performance is fewer readmissions and lower total cost of care.

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		6. With our Optum Impact Intelligence tool, Group Health is able to analyze and dissect clinical and financial data to track utilization trends, patient outcomes, and provider performance and better manage the total cost of care and identify improvement opportunities. 7. Group Health Care Management uses a number of approaches to identify individuals with high utilization of specific services and overall high utilization. Specifically, we use a predictive modeling tool - the Johns Hopkins Adjusted Clinical Groups (ACG) system - to identify members with specific conditions and high risk of hospitalization or high cost. We also receive routine reports of members with high utilization of Emergency Department Services. Additionally, we work with one of our purchasers around ED utilization for their enrollees. Care Management clinical staff (including registered nurses and licensed independent clinical social workers) reach out to individuals identified through these processes. The key concepts in working with these members are to support identification of and bonding with a primary care provider, to offer education regarding ways to access same day care through their provider, urgent care centers, and the use of our Consulting Nurse Service (CNS.) The work with members identified by the ACG focuses on supporting the medical treatment plan for any chronic conditions, assisting the member in improving their self-management skills and offering various organizational and community resources. This work may include focus on improved compliance with medications, routine care, and preventive care; management of sick days, education tailored to each individual and resolving any barriers to success that are identified by the patient or caregiver. We have also implemented a collaborative process between the Consulting Nurse Service, Behavioral Health Access (BHA) and Care Management (CM) areas. This process identifies individuals with high utilization of CNS and includes a review by CNS managers to determine if the calls were appropriate for the CNS program to manage. When it appears that members are accessing CNS for support with behavioral health concerns or because a behavioral health concern is driving frequent calls, e.g. depression,

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		anxiety; BHA reviews and reaches out to the individuals or forwards the referrals to the CM case managers, who then reach out to the patients directly. If appropriate, the behavioral health and CM clinicians will collaborate on the care offered to members with co-occurring behavioral health and medical concerns. In addition to the utilization management activities discussed above, Group Health Care Management has recently implemented a strategy to further ensure that short hospital stays are appropriately coded as observation stays, which is anticipated to yield significant savings. The CM staff working with hospitalized patients and following recently discharged patients are also focused on effective transition management to provide patients with a plan for a safe transition that includes post-discharge telephone calls, follow up appointments, confirmation that home health, etc. is in place, and medication reconciliation. These efforts are planned to mitigate the risk of readmission, thereby improving outcomes for patients and avoiding additional costs. Care Management staff track financial savings associated with working with patients in all areas. The outpatient CM staff work on improving outcomes for members by working with them on improving their health and their self-management skills; navigating the health care system; evaluating and working through barriers to meeting goals; and accessing routine care. All this work is done with the understanding of the patient's benefits and specific needs. Our efforts in identifying patients for case management are focused on those individuals with chronic conditions, including diabetes and congestive heart failure, recent hospitalizations, and new diagnoses of serious conditions. By working with these higher risk, higher need patients to improve their outcomes, and assisting them in accessing care more effectively, we are also avoiding additional costs. We have one Care Management RN who is dedicated to pediatric and perinatal care. She provides support to families of premature infants and seriously ill infants and children in inpatient and outpatient settings to optimize their outcomes and manage costs. Her responsibilities include utilization management activities associated with facility-based care.

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		The efforts of the EPRO physicians and staff also save costs by avoiding unnecessary hospital admissions and providing alternatives, including home health and same or next day appointments with medical and behavioral health providers. We are also supporting the avoidance of unnecessary testing when we can provide results of recent labs, ECG's, and imaging procedures. The social work clinicians in EPRO are trained to complete assessments of patients with chemical dependency concerns to determine if admission or outpatient care is most appropriate, often avoiding an unnecessary admission and coordinating prompt access to outpatient care.
		The CNS program also contributes to the improved outcomes and saving costs for patients and the health plan by offering 24/7 access to advice from registered nurses. In addition to the RN staff, CNS is also staffed with a Physician's Assistant and physician. This allows for RN consultation with the provider and direct treatment of patients by the providers. The CNS MD/PA is also able to assist patients with abnormal lab results after hours to prevent Emergency Department and Urgent Care visits. The CNS program also includes standing physician orders for the RN's to use in the treatment of some common diagnoses. This allows members to begin treatment earlier, avoid additional appointments and costs, and avoid costs for the health plan.
		We have recently started a pilot project to improve the pre-operative planning of patients undergoing elective joint replacement procedures. This project is focused on patients from a contracted orthopedic practice and includes a phone call to patients several days prior to their admission to review the expectations and plans for post-discharge care. We have consistently identified the perception of many members and providers that not having caregiver support following discharge is reason to admit to a skilled nursing facility, which is not a legitimate reason for SNF care according to CMS. By working with the patients prior to admission to help them problem-solve any anticipated issues, plan for help at home, and expect discharge to home, we believe we can improve patient outcomes by avoiding more exposure to infections in facility-based care and also avoid the associated costs.

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Carrier 02	**Customer Service**	Group Health's Customer Service Centers in Seattle and Spokane serve as a vital source of quick, accurate information for members, staff, providers, and brokers. They support inquiries for all lines of business and provide support for our health plans and clinics, as well as the self-service tools on our website and mobile app. In addition to taking over 4,000 calls each day, representatives also handle e-mails, written correspondence, and walk-in inquiries. Customer Service Representatives are prepared to answer all manners of health care inquiries, including questions about health plan benefits, enrollment, billing, and accessing care. While striving to resolve questions or concerns on the first contact, they also work with partner departments, care teams, and individuals throughout Group Health to ensure every issue is handled thoroughly and professionally. Whether welcoming a new member, answering a question, or solving a problem for someone in need of help, Customer Service makes it a priority to embody Group Health's mission and values on every contact. Customer Serive Centers hours of operation: Monday through Friday 8:00 a.m. till 5:00 p.m. Closed weekends. Members can conviently access customer service 24/7 via our member website, MyGroupHealth, at www.ghc.org, or our mobile app, which is available for download on the iPhone and Android Smartphones. It includes many features available on our MyGroupHealth for Members Website, and has added features, such as Symptom Checker and clinic locations and wait times. From the website, members can use online forms to order a new ID card, file a claim, update their personal information, and provide feedback about Group Health.

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		Using MyGroupHealth, members receiving care in Group Health medical centers have online access to a shared electronic health record (EHR) consisting of their entire medical record (except chart notes). Patients are able to communicate directly with their primary care team – at their convenience – which improves service and builds a stronger provider-patient relationship. Members can view their online records any time. Features available to them include: • Access to lab/test/radiology results, after-visit summaries, allergy and immunization records, medication histories, blood pressure, weight, and current health conditions for health care services provided at owned and operated medical centers • Secure messaging with their primary care team if at an owned and operated medical center • View Coverage Agreements and Summary of Benefits • Access Explanation of Benefits statements with payment information on claims • Check benefits usage and remaining coverage • Order prescriptions and have them delivered to their homes
Carrier 02	**District Management of Health Plans**	Group Health's online employer portal, MyGroupHealth for Employers, offers secure, convenient access to the transactional tools employers need to effectively manage their health care benefit programs. You can login to enroll new subscribers and their dependents online, and make changes for your existing employees — adding or terminating dependents, or terminating the entire subscriber record. You can order ID cards with a few simple clicks. The site also features content that helps employers understand

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		the value of Group Health's business solutions for health care.
Carrier 02	**Part-Time Employee Coverage Protection**	We allow access for part-time employees working a minimum of 17.5 hours per week.
Carrier 03	**Administrative Cost Reduction**	Regence has continued to increase efficiency and reduce administrative cost and complexity for providers. Provider offices can access member information through enhancements in our online tools including eligibility, claims status and benefits. Our Provider Web portal includes all administrative, reimbursement and medical policies in a searchable format with documentation. The Web portal also includes all pre-authorization information, formularies, manuals, forms, and critical, timely information. Through our relationship with Availity, we have supplied providers a no cost way to submit claims electronically to Regence, as well as a number of other payers. These tools have reduced administrative complexity and administrative cost for providers.
Carrier 03	**Cost Savings**	Regence Healthcare Informatics evaluates the financial impact of our full suite of medical management programs on an annual basis and produces a per member per month savings metric to estimate their group's savings from medical management interventions. There are four cost savings "levers" evaluated: 1.) Healthcare Management - savings are heavily weighted toward utilization management activities; 2.) Claims Review - includes all the behind-the-scenes activities such as post-service review, fraud and abuse activities, and other-party liability activities; 3.) Pharmacy - includes utilization management and specialty programs like the Site of Care Program for specialty drug infusion; 4.) Provider - includes all cost savings related to Accountable Care contracting. The evaluation is performed by Regence's Actuarial team and is balanced back to claims.
Carrier 03	**Customer Service**	Our 2015 Customer Experience initiatives were focused on enhancing how we interact and engage with our customers. We are establishing a partnership to deliver a highly engaged member experience. Through the Partners in Care program, Regence looks to provide a comprehensive experience that can address members' clinical and administrative needs. Regence Customer Service focuses on First Contact Resolution to measure the quality of the experience we provide. Throughout 2015, we have utilized Voice of the Customer data to determine opportunities for improvement and coaching. Member/consumer experience improvements

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		will focus on delivering new digital experience along with advancing our data enabled personalization through an omni-channel, customer-360 approach.
Carrier 03	**District Management of Health Plans**	Regence offers an array of servives and tools to help Districts manage benefits. We start by assigning each District a Senior Account Executive. This person is the strategic liasion between the District, it's broker, and Regence. This individual is responsible to work with the District to help manage benefits, look at plan design options, discuss cost containment services, and to focus on member engagement while directing the appropriate resources from a service perspective. In addition, we offer Real-time access to consumer decision-support resources (ie: myregence.com- as described below) to help enrollees understand and direct their health care needs.
Carrier 03	**Part-Time Employee Coverage Protection**	When a full time employee's hours are decreased, we will work with the member to review other plan options that allow the individual to remain covered on a medical program. We also offer lower cost plan options to help part time employees.
Carrier 04	**Administrative Cost Reduction**	The principles of the Patient Centered Medical Home (PCMH) are fundamental to the way we've been practicing medicine and delivering care for over 65 years. The Patient Centered Medical Home (PCMH) at Kaiser Permanente Northwest (KPNW) is our model for proactively delivering patient-centered care and achieving dramatic improvements in quality, member satisfaction, clinician and staff morale, and affordability. Our PCMH is a primary care team-based practice centered on the patient as an active and informed participant in his or her own care. With a proactive approach to prevention and by eliminating delays in needed care, we believe we can make a big difference in the health of individuals and the entire population. Kaiser Permanente has developed advanced technology and processes to support the PCMH model: • Personal physician – each patient has an ongoing relationship with a personal physician trained to provide first contact,

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		continuous, and comprehensive care. Because they are uniformly recruited, paid, and trained to practice medicine in ways consistent with the PCMH model, Northwest Permanente, PC, physicians have extensive personal experience and the support of their colleagues in providing a patient-centered approach to care. • Physician-directed medical practice – the personal physician leads a team of care providers at the practice level who collectively take responsibility for the ongoing care of patients. Kaiser Permanente has the advantage of having one medical record that follows employees wherever they receive care within our system. This helps their care teams stay informed about their medical history, evaluations, tests, and overall treatment plan. • Whole-person orientation – the personal physician is responsible for coordinating care for all of the patient's health needs at all stages of life – preventive services, acute care, chronic care, and end-of-life care. Kaiser Permanente's electronic medical record tracks biometric data and other risk factors (such as lifetime exposure to radiation from medical scans) so that his or her care team can monitor and respond to incremental changes in health status. • Care is coordinated and integrated across all elements of the complex health care system and the patient's community. Thanks to electronic evidence-based treatment guidelines, Northwest Permanente physicians can order many of the tests a patient will need prior to his or her first visit with a specialist, consulting physician, or other caregiver. • Quality and safety are hallmarks of the medical home. In a comparison of all health plans in the markets we serve, Aon Hewitt Associates reported that we consistently outperform other plans in clinical quality. We report regularly to the Quality Corporation. Independent organizations like NCQA and Quality Corporation provide the most objective assessment of a care delivery system and health plan performance; and are often more reliable than self-reporting system improvements. • Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication. At Kaiser Permanente, patients not only communicate with their care team through secure email, but they can also see openings in their doctor's schedules and make appointments online, review lab results, refill prescriptions and review prior visit information and visit summaries. We have implemented a process in our member services call center to ensure that patients who ask for a same-day appointment can reliably get such appointments scheduled with one phone call.

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		• Payment appropriately recognizes the added value provided to patients who have patient-centered medical home. Northwest Permanente physicians have a pay-for-performance payment model that is heavily weighted towards quality and service measures as compared to personal financial results that currently take place in other medical groups. The PCMH serves to either directly provide, or coordinate, all care needs (preventive, acute, chronic) for patients who are part of that medical home. The patient's primary care needs are provided directly by his or her PCMH team. Almost all care is provided within the KPNW Medical Neighborhood (including specialty care, hospital, and continuing care). The PCMH also coordinates and supervises all care provided to patients outside of KPNW. Patient Centered Medical Home Recognition The National Committee for Quality Assurance (NCQA) awarded all 17 of our primary care medical offices with Level III Patient Centered Medical Home (PCMH) Recognition - the highest level of recognition possible. Each medical office was reviewed and scored independently against 168 specific items across a set of 9 standard categories. All medical offices received 100% of points sought. Level III PCMH recognition is granted through July of 2016 . As a nonprofit organization, we reinvest our revenues to support programs that benefit individuals and communities across our service areas. We: • increased access to healthy food and safe walkways

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		• promoted healthy lifestyles in underserved communities • supported community clinics • conducted research • trained health care workers • expanded access to health care • subsidized members and patients who needed help covering medically necessary care. Supporting Affordability through Investments at KPNW • Westside Medical Center — Opening new medical centers allows Kaiser Permanente to provide expanded services, meet regulatory requirements, and build with an eye to saving energy and resources. The Northwest Region's Westside Medical Center opened in August 2013, in Portland, Oregon. The facility became Kaiser Permanente's first hospital to earn Leadership in Energy and Environmental Design (LEED) gold certification. LEED's calls for such things as pedestrian friendliness, sustainable site development, efficient water and energy use, indoor environmental quality, and chemical avoidance make it one of the most influential forces in building design in the world. Kaiser Permanente used the occasion of Westside's opening to announce our commitment to pursuing the same environmentally rigorous standards on construction of all new hospitals and medical offices going forward.

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		People didn't have to wait long to see that commitment in action. In December, the Northwest's Gateway Medical Offices opened in Portland in what was formerly a vacant Circuit City building. The foreclosed big-box store was completely redesigned to become a light-filled LEED gold certified medical office with a bright, colorful interior and outdoor patio. The conversion of the building is sparking additional neighborhood improvements in the urban East Portland community. • Northwest Region Improves Quality, Saves Money — Medical and dental integration allows caregivers to prevent and address significant dental conditions before they become serious and costly medical conditions. Being an integrated care system is at the core of Kaiser Permanente's ability to deliver high-quality, affordable health care. In the Northwest Region, one team recognized how they could take the integrated approach to a whole new level. The Medical/Dental Integration Project is a collaborative effort between four entities: Northwest Permanente, Permanente Dental Associates, Kaiser Foundation Health Plan medical plan, and Kaiser Foundation Health Plan dental plan. The Medical/Dental Integration Project involved three phases: The first phase first internalized about 250 dental surgery cases for patients who have Kaiser Permanente medical benefits but not Kaiser Permanente dental benefits, and improved coordination of care for another 175 patients who have both Kaiser Permanente medical and dental benefits. In addition to improving quality and the care experience, the cost savings are significant: The Northwest Region no longer spends up to $10,000 per case in operating suite and anesthesia charges for patients who were previously treated in external settings. Phase Two provided physicians and patients with seamless access to dental services for acute conditions and dental clearances of

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		all medically necessary dental work prior to certain medical treatments. This work will integrate care so that patients' oral health is satisfactory before they undergo major procedures provided by Kaiser Permanente physicians. Phase Three occurred when Permanente Dental Associates and Northwest Permanente partnered for the first time to recruit and hire an oral and maxillofacial surgeon for complex oral surgery, ensuring that patients with severe medical head and neck conditions receive the right care at the right time. With this integrated program in place, the Northwest Region will now have the ability to address significant dental conditions before they become acute systemic medical conditions
Carrier 04	**Cost Savings**	The primary ways Kaiser Permanente controls costs are by engaging members to participate in their own health, and by reducing waste—helping healthy members stay healthy and motivating those with unhealthy habits to make positive lifestyle changes, eliminating unnecessary procedures, decreasing unwarranted variation in care and reducing paper costs. Unlike traditional health care providers, we offer a fundamentally different approach to care. Our health plan, doctors, hospitals, medical offices, pharmacies, labs, and more are all part of one organization. Because our doctors are salaried and measured according to how well they raise the bar for member health, our model frees doctors to focus on patients—not the itemization of services or the collection of claims. Their personalized, dedicated approach to member health is supercharged with the incredible tools and information within Kaiser Permanente HealthConnect®. This award-winning system is at the fingertips of every caregiver in every one of our facilities. Our investment in our industry-leading electronic health record (EHR) system is not only our most effective member engagement tool; it also helps reduce overutilization and maximizes information sharing. All Kaiser Permanente providers can securely access this system and view a member's previous test results and other physician notations, which help reduce duplication of lab tests, unnecessary medical visits, redundant utilization of services, and pharmacy errors.

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		Because we are set up differently, we are aligned to better deliver what matters to you: improved health, better clinical outcomes, more value, and consistent service. We are caregivers, hospitals, and health plans working in concert to set the benchmark for quality, affordability, and service. It allows us to deliver some powerful benefits: • consistent service and consistent value across the country • more stability and better cost management • better health for employees so your clients' businesses can thrive • the right care at the right time for healthier, more productive employees Strategies we use to contain costs include: Cost effective disease management Members with chronic conditions drive 85 percent of health care costs, so it's essential that these individuals learn ways to manage their conditions. We have disease management programs, which can help members with chronic conditions. Some key features of the program are: • We intervene with members early, even before they have symptoms or have been diagnosed with a disease, using member health status, risk factors, and family history to assess their risk status for a chronic condition. This means conditions are well controlled or prevented before they reach an advanced stage that requires usage of more services.

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		• We don't use dollar triggers to initiate case management. We use the more direct and effective method of automatically enrolling members in disease management registries based on health status and member information, rather than anecdotal information. • Our program is seamlessly integrated into our member-centered, "whole person" continuum of care — it's not a separate carve-out program through a vendor that costs employer groups extra money. Online health care management tools My Health Manager, available at kp.org, provides member-facing online tools that uniquely empower members to manage their family's health care through secure online access. It's easy and convenient for members to email their doctor's office, make routine appointments, order prescription refills, view lab results, and much more. Often times saving a phone call or an unnecessary trip to the doctor's office: • Members who used the free secure email service were 7 to 10 percent less likely to schedule an office visit. • Members using Kaiser Permanente HealthConnect®, our industry-leading electronic health record system, called their physician 14 percent less than those not using Kaiser Permanente HealthConnect®. These online services aren't available through other health plans. Broad consumer engagement and preventive care

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		To encourage members to take a more proactive role in their own health care, we provide a full range of health and wellness resources that include: • Health education classes and online self-care programs to help members learn how to make healthier lifestyle choices. • Online decision-support tools that empower consumers to make better health care decisions, resulting in better health outcomes and appropriate service utilization. • Preventive services and screenings at either reduced copayment or no cost to encourage members to stay healthy. Elimination of redundancies and improved member safety Our investment in Kaiser Permanente HealthConnect® is greatly enhancing efficiency by maximizing information sharing. All of our providers can securely access this system and view a member's previous test results and other physician notations among the many features, which helps reduce, duplication of lab tests, unnecessary medical visits, redundant utilization of services, and pharmacy errors. Wider selection of affordable price points We've added several competitive plan designs to our core HMO offerings so that employer groups and members can select lower premium products with higher deductibles and more copayment options. This added flexibility allows groups the opportunity to select the plan that best fits their specific needs.

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		Recognized for cost efficiency In the six regions where we operate, the Kaiser Permanente plan is ranked #1 for financial efficiency across all product and funding offerings, according to the Hewitt Health Value Initiative™ report. Further, the report shows that in all six regions we offer the most cost-efficient plans for: • HMO • PPO • Self-funding Also, Aon Hewitt and Associates rated Kaiser Permanente with the highest clinical quality in every region. Employer groups can receive the full Hewitt Health Value Initiative report by contacting their sales representative or account manager.
Carrier 04	**Customer Service**	Member, patient, and customer perceptions, experiences, feedback (comments and complaints) and requests drive Service Quality improvement initiatives for our Member Services. One of the pillars of our Operating Plan is "People and Culture" with a vision to create a culture of high performance that epitomizes partnership and mutual support with a focus on care and service to members. With this vision come four goals and the aspiration of having a flexible, agile, empowered work force. Performance is measured by the People Pulse work unit index defined by specific measures.
Carrier 04	**District Management of Health**	We engage with each district to provide personalized service and consultation that fits the district's preference. We provide extensive reporting that analyzes plan utilization and demonstrates the value and cost savings achieved through our integrated care. We provide consultation on industry trends, product innovations, workplace wellness strategies, and benefit plan design

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	Plans	options. We are available for member education events regarding health plan benefits, as well as wellness events. Our goal is to make it easy for the district's employees to engage in their health at home, online and at our facilities. This is our all-inclusive approach that saves the district money, which supports the school's budget, as well as the health and well-being of their employees. Kaiser Permanente's Thriving Schools program is a comprehensive, multi-year effort to support the health of students, staff and teachers in the communities that KP serves. Priority areas for Thriving Schools include promoting healthy eating, encouraging physical activity, supporting social and emotional health and creating a healthy school environment. In order to meet our goals, KP partners with several non-profit community organizations: The Alliance for a Healthier Generation supports districts and schools through their Healthy Schools Program designed to create a healthy school environment by engaging wellness champions, and providing evidence-based practices and technical support. Kaiser Permanente augments the work by direct grant funding to schools. Longview and Evergreen School Districts participate. Playworks provides professional coaches and training for adults to lead active play in several schools in the Evergreen and Longview School Districts. Schools in Clark and Cowlitz County have signed up to participate in Fire Up Your Feet, in partnership with Safe Routes to School. Fire Up Your Feet encourages staff, students and their families to be physically active before, during and after school. Kaiser Permanente provides cash awards to those schools that engage the highest percentage of students, staff and families.

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		Kaiser Permanente's Educational Theatre Productions including the Adventures of the Tartar Patrol and The Pressure Point!, was hosted in schools in Clark and Cowlitz County engaging kids and adults in good oral health and making healthy life decisions.
		Ecotrust is supporting nutrition services staff in Longview and Evergreen School Districts to expand availability of local, healthy foods to students and staff during the school day. Ecotrust creates a bridge between local farmers and schools as purchasers.
		The School Based Health Alliance's Hallways to Health program expands the role of school based health centers in advancing obesity prevention and social and emotional health. Washington Middle School Based Health Center in Seattle is part of the learning collaborative supported by Kaiser Permanente.
Carrier 04	**Part-Time Employee Coverage Protection**	Benefit eligibility is determined by the group. We accommodate covering part-time employees at the group request.
Carrier 05	**Administrative Cost Reduction**	Operating cost management and productivity disciplines are embedded throughout UnitedHealth Group's businesses. Productivity is also generated by leveraging the increasing scale of our business. Strong growth in Medicaid enrollment and the insourcing of commercial pharmacy benefits management have contributed to productivity gains in those areas. Over the past several years, we have generated significant productivity gains through actions in five principal categories: ? Quality: Eliminating waste and improving core operating process performance;

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Carrier	Category	Efforts and Achievements
		? Automation: Reducing manual processing by leveraging technology; ? Integration and Modernization: Advancing a more integrated, simple and modern processing environment, including significant cost savings from decommissioning legacy acquired and redundant platforms; ? Procurement and Sourcing: Cost reductions related to optimizing procurement and sourcing; and ? Payment Integrity: Medical cost reductions from improving payment accuracy and from various program integrity offerings and other initiatives to reduce improper billing and payment. Overall we expect productivity efforts to improve our operating cost ratio on an equivalent business mix by an average of 20 to 40 basis points per year over the next several years. Our consolidated ratio, however, may not decrease by this amount in any given year as we expect an increasing mix of services business and business from Amil. Both our services businesses and Amil carry higher operating cost ratios. The operating cost ratio is also significantly impacted by the insurer tax that took effect in 2014 and has scheduled increases through 2018.
Carrier 05	**Cost Savings**	We have provided overviews of our efforts and achievements toward controlling the cost of health care. CONTROLLING COST AND IMPROVING AFFORDABILITY Informed by over 30 years of experience with innovative contracting strategies, the foundation of our network offerings is our Accountable Care Platform. This platform was developed with the recognition that all providers are not the same in terms of their readiness to move towards a risk-based contract, yet we want each of them to take more accountability for the care they deliver. Therefore, we developed a modular suite of value-based incentive models that we can leverage with providers based on their risk readiness and other criteria. We recognize that a “one-size-fits-all” approach will not be effective and thus we have not prioritized one single model. Our modular suite of value-based programs enables us to customize our approach with providers across all stages of the risk continuum and support them as they become more accountable for cost, quality and experience outcomes. We currently have value-based contracts in place with more than 850 hospitals and 100,000 unique physicians participating in our

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		Accountable Care Platform. More than $39 billion of our network health care spend is tied to value-based contracts across our commercial, Medicare and Medicaid businesses. We expect this figure to increase to $65 billion by 2018 year-end. We segment our value-based models into the following categories: PERFORMANCE-BASED PROGRAMS Encompassing such payment models as primary care incentives and performance-based programs for physicians, facilities, and other service providers (e.g. laboratory and dialysis services), our performance-based programs reward care providers for performance against specific metrics, such as readmissions, hospital-acquired conditions and some HEDIS measures. Spanning over 55,000 physicians and 1,000 hospitals, these programs have driven the following results: ? $75 million in estimated savings for 2014 ? 3.6 percent reduction in readmissions ? 9 percent reduction in inpatient length of stay ? Reduction in the use of non-participating laboratory services ? Reduction in the use of non-tier 1 prescriptions CONDITION OR SERVICE LINE PROGRAMS Our condition / service line programs encompass centers of excellence, ancillary capitation, and bundled/episodic payments and include over 2,300 physicians, 25 ancillary providers, and 160 facilities. Specific results attributed to these programs include: ? 25 percent decrease in the average length of hospital stays for transplants

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		? 34 percent reduction in medical cost savings for cancer therapy program ? Improved transplant survival rates at centers of excellence ? 3 percent reduction in one-year mortality for liver transplants ? 5 percent reduction in one-year mortality for heart transplants ? 16 percent reduction in the incidence of transplants through application of evidence-based appropriateness criteria ACCOUNTABLE CARE PROGRAMS At the most advanced end of the value-based spectrum are our programs focusing on population health, encompassing shared savings/shared risk models like accountable care organizations (ACOs) and patient-centered medical homes (PCMHs), as well as capitation and capitation-plus-PBC. We are currently involved in more than 30 ACOs across the country, including Southern Arizona, California, Colorado, New York, North Carolina, Texas, Ohio and Rhode Island. These organizations are focused on driving innovation in payment and delivery system reform with the Triple Aim of improving population health and patient experience, delivering the best possible quality outcomes, and reducing medical cost and medical trend. Select results that these ACOs have demonstrated include: ? 7 percent reduction in readmissions ? 11 percent reduction in inpatient hospital admissions ? 8 percent reduction in emergency room visits per 1,000 ? NCQA recognition

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		? Improvement in HEDIS measures ? Significant number of metrics at or above 90th percentile of Quality Compass ? 3 percent reduction in total medical cost ? Improvement in generic prescription prescribing rate Our PCMH programs with at least 3 years of completed evaluation demonstrate: ? 1.5 to 3.5 percent lower than expected annual medical cost ? 4.5 to 11 percent lower than expected cumulative medical cost trend ? 4:1 return on investment (ROI) ? 1 to 11 percent lower than expected annual inpatient length of stay ? 1 to 6 percent lower than expected annual emergency visit utilization ? Clinical quality results trending above program targets on 95 percent of all measures We align the development of our network strategies, clinical programs and innovative benefit plan designs. We believe our strategy uniquely maximizes value by aligning incentives across customers, consumers and care providers to achieve the triple aim of better health, better care and lower costs. CONTROLLING CLAIM DOLLAR PAYOUT We designed our claim system specifically to control costs, prevent payment of non-covered services and protect from fraud and

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		abuse. CONTROLLING COSTS ? Secure, tested load of the benefit plan for online benefit calculation ? Online eligibility determination ? Online coordination of benefits detection and calculation ? Online duplicate detection ? Online deductible and out-of-pocket calculations ? Online application of negotiated rates ? Online utilization review and calculation PREVENTING PAYMENT OF NON-COVERED SERVICES ? Secure tested load of the benefit plan to include non-covered services ? Online medical guidelines that can specifically indicate non-covered procedures ? Complete quality review to focus on non-covered services ? Complete training of specialists about coverage specifics PROTECTING FROM FRAUD AND ABUSE

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		? Online security module prevents unauthorized access to the claim system or payment beyond authorized limits ? National physician and other health care professionals file unit prevents loading a physician or other health care professional into the claim system until a detailed investigation is completed ? Anti-Fraud and Recovery Solutions (AFRS), a comprehensive program designed to limit the impact of abuse and fraud for customers and for us ? A comprehensive training and fraud awareness program used to train transaction teams, underwriting and advocates to identify potential fraud issues ? Designated transaction center and health plan staff throughout the country who work with AFRS to detect and prevent inappropriate medical benefit payments resulting from abuse or fraud ? A clinical prospective review program uses internal flags to review suspect claims prior to payment ? A recovery team investigates possible overpayments related to abuse and fraud and recovers funds lost through those practices ? A compliance program ensures adherence to local, state and federal laws related to potential fraud matters and how they are handled HOSPITAL BILL AUDITS Our hospital audit vendor receives a monthly claim payment extract for inpatient and outpatient claims that exceed $10,000 in billed charges. The vendor runs those claims against its database and selects those that are candidates for audit. Selection is based on diagnosis, type of services rendered and previous billing history with a facility. In an up-front review of the claim information against a copy of the hospital bill, the audit vendor may detect a hospital billing error.

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		Other claims may be subjected to an in-depth review of all charges against the hospital's medical records. This is referred to as a line-by-line review of billed charges. Our vendor will schedule and complete the audit. The vendor collects the refund, deducts its fee for services and sends the net refund amount to us. The fee is contingent upon recovery. HIGH-DOLLAR CLAIM NOTIFICATION PROCESS The high-dollar claim notification process notifies various business areas of claims in excess of $250,000. It includes an additional operational review of claim payments of $250,000 or more before the payment is released. Designated claims representatives ensure that benefits are paid according to existing policies and procedures, and audit the claim using established audit criteria. After this review, an Operations High-dollar Claim Review Committee reviews the proposed claim payment to confirm that it is reasonable and accurate according to benefit plan guidelines, contracts with physicians and other health care professionals, industry guidelines and our reimbursement policy. OVERPAYMENT RECOVERY We have a comprehensive internal recovery program. In addition to our team of employees dedicated exclusively to recovering overpayments, we can recover overpayments from physicians and other health care professionals by offsetting future payments. To supplement our internal recovery efforts, we use a number of vendors to maximize recovery. CREDIT BALANCE RECOVERY Credit balance recovery is a component of our overpayment recovery and is provided internally. Our service provides on-site and remote location resources to help hospitals and health systems research and resolve their inventory of credit balance accounts on behalf of our health plan clients. We retain 10 percent of the recovered amount as reimbursement for the cost of this service. NETWORK SAVINGS

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		We offer our customers and members three levels of reimbursement programs. While our traditional discounts save expenses on network services, we also have two non-network strategies that lower the costs of non-network and out-of-area claims. FIRST TIER - TRADITIONAL DISCOUNTS Our traditional networks are broad with easy access and benefit designs that encourage members to use our network services whenever possible, resulting in the highest possible claim savings. Our contracting process capitalizes on both our national strengths and our local market knowledge and expertise to achieve our national network goals. Our contracting efforts are designed to: ? Increase access by maintaining a large number of physician and other health care professionals in a variety of specialties ? Establish positive and supportive physician relationships that promote delivery of quality health care to all of our members ? Reimburse physicians only for those services actually rendered and only for services that are medically appropriate ? Achieve the most favorable price through fixed, negotiated rates SECOND TIER - PHYSICIAN SHARED SAVINGS PROGRAM The Physician Shared Savings Program (SSP) makes up the second-tier level of discounts in our discount program by enhancing our traditional participating network. It includes both wrap network discounts and claim-specific negotiations. We have contracted with MultiPlan, First Health Group, and other non-logo networks, which have thousands physicians contracted nationally for vendor wrap. SSP discounts can apply regardless of the member's benefit level. This means that SSP may apply to non-participating claims, including radiology, anesthesiology, pathology and laboratory services (RAPL), regardless of benefit level. Through these programs, a discount may be applied when a member accesses a wrap network physician. ADVANTAGES TO EMPLOYERS

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		? The programs are easy to administer. Discounts are automatically applied when a claim is processed and are noted on the member's explanation of benefits (EOB), eliminating any need for employer intervention. ? Plan changes are not required. ADVANTAGES TO MEMBERS ? Members who receive services from these programs benefit from reduced coinsurance dollars for their discounted fees. ? Physicians and other health care professionals participating in the SSP vendor's network are prohibited from balance billing members when their contractual discount is taken (*). ? Members will not receive a separate SSP provider directory, but electronic access to the SSP vendor directory is available to the member through myuhc.com. Savings are applied post-service when an SSP physician or other health care professional has been used. ? Easy-to-read billing identifies when an SSP physician and other health care professional was accessed that resulted in cost savings. ? Special claim forms are not required when a member accesses the SSP physician or other health care professional. (*) There may be situations in which the SSP providers are not paid per the SSP, but are instead paid like other non-network providers. In such cases, the member's out-of-pocket cost will be the same as if discounts were not available through the SSP. THIRD TIER – MAXIMUM NON-NETWORK REIMBURSEMENT PROGRAM In addition to our SSP program, our Maximum Non-Network Reimbursement Program (MNRP) offers yet another alternative to help reduce the impact of rapidly rising, uncontrolled non-network expenses. Instead of basing non-network reimbursement on

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		uncontrolled, charge-based prevailing fees, we reimburse plan expenses according to standards established by the federal government (such as Medicare). Members retain the freedom of choice to access either network or non-network health care services but, realize they may carry a more significant financial responsibility when using non-emergency, non-network services, thereby creating a member incentive to use our broad, discounted network. Under this approach: ? Reimbursement for non-emergency, non-network physicians and other health care professionals including non-network facilities is based on a percentage of the published rates allowed by Medicare for the same or similar services. These standards are cost-based payment methodologies established by the Centers for Medicare and Medicaid Services (CMS). Medicare's payment methodologies are widely understood and accepted by physicians and other health care professionals. ? The program applies only to non-emergency services that are provided by non-network physicians and other health care professionals including non-network facilities. However, it does not apply when non-network services are coordinated and approved by UnitedHealthcare as covered network services, or to any other non-network services that are considered payable as a network benefit. ? If no Medicare rate exists for a particular service, then the eligible charges will default to 50 percent of billed charges. ? This program can be administered alongside our Shared Savings Program (SSP), with the Medicare-based reimbursement levels applying only where savings are not obtained under that program. We make information available in a variety of ways to assist employees in understanding how the program works. This includes written consumer materials, conversations with customer service representatives, consumer activation messaging on health statements and information on myuhc.com. RESULTS SHOW MNRP WORKS For employers with MNRP, the rate of total cost trend on average slowed 1 percent to 2 percent within the first year. We expect

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		additional savings beyond the first year. These savings can be attributed to a combination of change in employee behavior from non-network physicians to network physicians, and to lower reimbursement to non-network physicians. For employers who experience high non-network utilization, savings can be significantly higher. This program is not only reducing the impact of escalating non-network cost trend, but is also encouraging physicians to join our network. It is just one more component of our commitment to providing practical, affordable products and services, along with extensive network access to quality care.
Carrier 05	**Customer Service**	At UnitedHealthcare, we like to keep things simple. So we offer members an array of easy ways to learn more when they have questions, whether that's through mobile apps, educational websites, communications, digital newsletters or our Advocate4Me member services. The combination of mobile devices, our portal or member services help us meet our members where they are, in location and in functionality. Turns out we're meeting a lot of them. In 2015, our mobile app Health4Me was visited over 3.4 million times, providing members with personalized information and support – claim status, network locations, personal and general health information – wherever and wherever they needed it. Our member tools and mobile applications are integrated and access our core systems – the same systems accessed by member services and clinical staff. Advocate4Me reaches across all operations through the desktop dashboard. Advocate4Me lifts our integrated customer care, claim and clinical services to a new level, addresses what each consumer needs, and provides support through a relationship-based approach that focuses on promoting their health and wellness. Advocates engage plan participants for as long as it takes to resolve issues, whether it involves a complicated claim, the services available for a complex new diagnosis or obtaining needed care. We strive to deliver valuable experiences by having knowledgeable advocates address a member's needs in the first phone call without transferring them, provide accurate health care cost information and benefit and health management guidance, and – perhaps most importantly – be sensitive and compassionate in our interaction with each member. We want each member to feel supported, and to know that we respect their preferences by meeting them where they are, aligning with our corporate values of integrity, compassion, relationships, innovation and performance. Our advocates have a strong sense of compassion, understand the importance of building relationships, and can be a trusted advisor for our members. Our ongoing objectives: keep it simple, instill trust, accommodate channel of choice – phone, apps, email or online – and make it all easy. Oh, and help improve your

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		employees' health and the health of your bottom line.
Carrier 05	**District Management of Health Plans**	UnitedHealthcare uses two proprietary tools, the Motivating Health Ownership (MHO) and the Consumer Activation Index (CAI) to evaluate employee populations. These tools identify where changes in the health plan would yield the greatest clinical and financial gain, while also providing solutions in meeting the needs of individual employees. POPULATION SEGMENTATION AND THE CONSUMER ACTIVATION INDEX By breaking down a customer's aggregate population into smaller groups of employees with similar demographic, socioeconomic, and health care engagement levels, we can more fully understand how health benefits are used. We can then identify areas of a customer's health care plan that may not be optimally leveraged and develop strategies that encourage positive behavior change. As an example, we might determine that a disproportionate share of low-income women ages 40 to 55 in a company's Chicago factory are not using preventive benefits and are diabetic. Once that information has been isolated, we can work collaboratively with the customer to design a solution that targets these women through communications programs or by implementing incentive or health programs that promote positive behavior (e.g., taking their diabetes medications). HOW THE CONSUMER ACTIVATION INDEX OPERATES The CAI uses a scorecard to evaluate the quality of members' health care-related decisions based on a question: "When faced with a health care decision, did the member make the optimal choice from a clinical, financial, and service perspective?" For example, from an economic perspective, did the employee fund her health savings account (HSA) when she had the opportunity? Clinically, did she obtain her yearly mammogram? From a service standpoint, did she log onto myuhc.com and choose a UnitedHealth Premium-designated provider for her surgery? The model traces 24 months of decisions to assess behavior. It also determines the best case and worst case for that individual had she made the right decisions versus the wrong decisions.

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		By grouping members into five life stages characterized by demographics and circumstances relating to health status, and by augmenting the scorecard analysis with workplace information and consumer marketing data (income levels, ethnicity, location, etc.), we can identify clusters of employees that display patterns, or areas that need more attention to improve the overall performance of the employer's health plan. The results enable the customer to prioritize areas where behavioral change would yield the greatest value. Once that's determined, a comprehensive program with appropriate health plan modifications buttressed by customized communications plans targeted to those specific employees can have a dramatic impact on health care costs and member compliance. For example, early results of a program to improve the number of mammograms are showing a significant increase in compliance rates in the three months following a targeted communications program. MOTIVATING HEALTH OWNERSHIP FRAMEWORK Building on the principle of consumer accountability and empowerment advocated by account-based plans, the Motivating Health Ownership Framework moves this agenda further through broader reinforcement of all aspects of the employer-sponsored health plan, ultimately driving toward individual health ownership. This is done by combining plan components, such as clinical programs, rewards and technology, in a way that meets your specific population health needs and overall goals. Moving toward a plan design that inspires Individual Health Ownership takes time. Our goal is to collaborate with you to develop a multiyear set of moves that fits your goals, your culture and the current and future health needs of your population. By incorporating the following plan components at different intensities, we can customize a plan that works for your population today, and remains adaptable as your needs change and the market evolves in the future: ? Health plan Design – Choose the best plan for me ? Network Design and Transparency – Make smart healthcare choices

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		? Population Health and Productivity – Help me manage my health ? Personal Experience – Make the experience fit my life Customers who adopt this strategy can generate medical net paid savings up to 24 percent lower when compared to customers who do not. These substantial savings remain unmatched by any other single, integrated carrier in the health care industry. TO SUMMARIZE Differences abound with respect to members' abilities to make optimal health care decisions and the levels at which they're engaged in managing their own health. By grouping those with similar profiles within a customer's aggregate population, and by crafting customized, targeted health programs, UnitedHealthcare is better able to modify consumer behavior and improve decision-making. As employees make better decisions, clinical outcomes improve, lowering health care expenses, raising consumer satisfaction levels and improving the overall performance of the health care plan.
Carrier 05	**Part-Time Employee Coverage Protection**	Employee eligibility is determined by the employer. Individuals working 20 or more hours per week are considered eligible according to the terms of the Policy.
Carrier 06	**Administrative Cost Reduction**	Providence Health Plan has significantly reduced administrative costs over the last few years. We have targeted cost increases closer to CPI, rather than associating administrative cost with medical cost inflation. This has resulted in reduced percentage of premium administrative cost. As such, as much as 90%-91% of premium dollars go towards claims expense costs. PHP is also not required to refund any premiums due to not meeting the MLR (medical loss ratio) requirements of PPACA.
Carrier 06	**Cost Savings**	Providence Health Plan has invested in preventive care and chronic Case and Disease Management Programs to improve on health care outcomes, implementation of inteventions to prevent inpatient hospital readmissions, early adoption of voluntary patient safety reporting, inititatives in place to reduce complaints and potential medical errors, the Health Plan includes a comprehensive array of health and wellness promotion and preventive services through our Fit Together program and a best-in-class pharmacy

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		management program.
Carrier 06	**Customer Service**	Providence Health Plan Customer Service and Claims are located in Beaverton, Oregon, hours of operation 8:00 am to 5:00 pm PST, toll free 800 number for members. Customer Service Representatives are trained to answer all calls with 92% of calls answered at the point of service. Translation services available, automated voice response systement and call tracking software for real time an historical activty. The Health Plan has invested heavily in web based tools for members for outside of standard business hours which includes a variety of self service options and tools.
Carrier 06	**District Management of Health Plans**	Providence Health Plan has best-in-class medical and care management services designed to achieve the Triple Aim (better care, better patient satisfaction at a lower cost). Through our care management programs and provider contracting efforts, we have the best regional PPO medical trends per recent surveys conducted by various consulting firms. In addition, our pharmacy management program has been recognized nationally as having the highest generic adoption rate and realizing reduced pharmacy costs and trend through our pharmacy benefit management efforts. Our pharmacy trend has been, and continues to be, the lowest in our regional market for several years. PHP will work with the districts and their producers or consultants to identify benefit design strategies to help meet budget goals and mitigate future cost increases.
Carrier 06	**Part-Time Employee Coverage Protection**	Providence Health Plan will allow districts to offer exend medical benefits to their part-time eligible employees should the district choose to do so.
Carrier 07	**Administrative Cost Reduction**	Continued integration of operational and administrative function into the GHC parent organization eliminates redundancy and controls admistrative costs.
Carrier 07	**Cost Savings**	Pre-authorization requirements and large-case management services
Carrier 07	**Customer Service**	KPS continues to maintain levels of customer service for all customers that consistently earn high ratings from OPM for the KPS FEHB program.

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Carrier	Category	Efforts and Achievements
Carrier 07	**District Management of Health Plans**	Select negotiated accounts receive their rate-development projection and basic experience data
Carrier 07	**Part-Time Employee Coverage Protection**	Yes, on a negotiated case-specific basis
Carrier 08	**Administrative Cost Reduction**	Uniform Medical Plan: 1. Renegotiated our pharmacy network discounts to achieve significant savings for 2014-15 drug claims 2. We expanded the types of services requiring preauthorization to ensure quality, cost-effective care is provided by the UMP.
Carrier 08	**Cost Savings**	Uniform Medical Plan: 1. Renegotiated our pharmacy network discounts to achieve significant savings for 2014-15 drug claims 2. Expanded the types of services requiring preauthorization to ensure quality, cost-effective care is provided by the UMP.
Carrier 08	**Customer Service**	Uniform Medical Plan: The Health Care Authority has industry standard customer service requirements in place with our contracted Third Party Adminsitrator (TPA). The standards are measured and subject to financial penalties and a corrective action plan if the goals are not met.
Carrier 08	**District Management**	Uniform Medical Plan:

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Carrier	Category	Efforts and Achievements
	of Health Plans	All PEBB programs in effect are directed to the entire PEBB population within a community rated risk pool. There are no programs specifically targeted to K-12 district populations.
Carrier 08	**Part-Time Employee Coverage Protection**	Uniform Medical Plan: Eligibility for PEBB benefits, as determined by the PEBB Program, includes eligibility for part-time employees who work an average of at least 80 hours per month with at least eight hours in each month for more than six consecutive months. Eligibility for benefits also includes eligibility for employees who work a recurring season of three or more months.
Carrier 09	**Administrative Cost Reduction**	We are continually exploring innovative ways to help control costs while seeing that our members receive quality care. We have initiated several efforts to better manage our health care costs, as well as our selling, general and administrative (SG&A) expenses. For example, the Executive Management Information System (EMIS) is an automated single source of certain financial, medical cost management, operational reporting, sales and human resources data which fosters a "one-company" view and culture, allowing for greater profit and loss (P&L) accountability. Another key process in managing operating costs is a monthly review of our SG&A expenses by type of spend and business area with a goal of improving discipline, consistency and accountability. Additionally, we have developed a robust forecasting and planning tool to foster accountability, enhance predictability and ultimately reduce SG&A costs.
Carrier 09	**Cost Savings**	Aetna uses a rigorous, dual approach to evaluate medical costs and identify opportunities to manage medical cost and trend. This process allows for proactive development and timely implementation of action plans and initiatives that control medical costs and improve utilization patterns. Examples of initiatives that were implemented to address medical cost opportunities are: (1) Emergency room frequent utilizers, (2) Home health care steerage to efficient and effective providers, (3) Multiple strategies to promote the use of participating providers, (4) High-tech radiology steerage, and others.
Carrier 09	**Customer Service**	At Aetna, we make very deliberate decisions and investments to connect our customers and members with solutions that meet their changing needs. A smarter health plan helps members take charge of their health and health care and to think and act like informed consumers. We offer members a variety of ways to get customer service information through our use of : (1) friendly, knowledgeable and proactive customer service representatives (CSRs), (2) Secure member website, (3) Interactive voice response technology, and (4) Smartphone applications When members call, our CSRs not only answer their questions, they proactively educate callers about their plan of benefits, tell

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Carrier	Category	Efforts and Achievements
		them about programs available to them and encourage them to use – and assist them with – our online resources to help them become more informed health care consumers. Our online services are continually monitored and improved to make self-service a pleasant, productive and hassle-free experience.
Carrier 09	**District Management of Health Plans**	With the right tools and technology, school districts can streamline their interactions with us, manage employee benefits, and understand where health care dollars are being spent. We have the technology, tools and expertise to help achieve exactly that. Our Employer Secure Website adds a “single sign-on” site for districts to access Aetna online tools. Districts will see additional eligibility, enrollment, online billing and report capabilities, as well as forms and content as we continue to roll out and develop the Employer Secure Website. Internet-based eligibility transfer solutions enable districts to quickly and efficiently transmit information to us. Through systems such as SecureTransport?, EZLinkTM and EZenroll, districts receive the advantages of e-commerce; eliminating the need to submit paper forms, tapes, cartridges or diskettes
Carrier 09	**Part-Time Employee Coverage Protection**	We typically follow the plan sponsor’s definition of eligible employee as long as the customer’s definition is otherwise consistent with applicable laws. Customers are responsible for confirming eligibility to enroll in coverage. We do not determine eligibility for individuals. We advise customers to seek their own legal counsel concerning the effect of applicable laws on their plans.
Carrier 10	**Administrative Cost Reduction**	We continuously look for ways to reduce administrative costs. We have a team which meets regularly to identify, prioritize and implement efficiencies. We maintain a "green" mentality to protect natural resources and reduce our carbon footprint. Primarily we focus on: ? -streamlining processes -leveraging electronic capabilities -eliminating duplicate work with our providers, groups and members

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Carrier	Category	Efforts and Achievements
		Some of the initiatives that already have been implemented to address administrative costs are the following: ? -electronic Explanation of Benefits (EOBs) -electronic claims submissions (837) and payments to providers (835) -electronic eligibility verification (270/271) -IVR for member payments ? In addition, we currently are in the process of implementing the following initiatives: ? -automating group set up -auto authorization (this is preparing to go live) -streamlining provider data management

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Carrier	Category	Efforts and Achievements
		-increasing claims auto adjudication rates
Carrier 10	**Cost Savings**	Moda Health (Moda) strives to manage costs while providing the highest quality service and care for our members. Our programs help members meet their health care needs through prevention, wellness and condition specific programs. We are continually looking for opportunities to help members maximize the effectiveness of their health care dollars. ? We prioritize member service as our number one strategic initiative because helping members be better is at the essence of our existence. Our priority is to assist members in getting the right care, at the right time, at the right place, at the right cost. To accomplish this, we examine every way and medium, (current and emerging) that members will access information from us. We work on new approaches to improve the member's experience, as well as new ways to be accountable to members. We strongly believe it is our duty to manage benefits within a global budget. Accomplishing this allows for healthcare costs to be more predictable and therefore compete less with member's wages and other benefits. We also work diligently to design benefit plans that promote quality, improve health outcomes and reward members, their families and providers for reaching sustaining health goals. ? The world of health insurance is changing and changing rapidly. To accommodate this change and continue to provide plans and benefits that reach the Triple Aim in a comprehensive manner, we've focused much of our time on building new kinds of partnerships. These new partnerships focus on engaging providers and patients in new ways. Instead of focusing on the traditional provider/insurer/payor contracts and employer/payor relationship, we've chosen to focus our time, energy and talents on developing partnerships that are transformational to patient care and provider payments. ?

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Carrier	Category	Efforts and Achievements
		We have a history of innovation in benefit design, predictive modeling, medical management, population health management and coordination of care. We were one of the early pioneers in the Patient Centered Medical Home Pilot program. In addition, we partnered with the Oregon Educators Benefits Board to define, design and implement evidence-based,value-based benefit designs and value tiers which reduce patient barriers to care. Our work also includes the development of unique approaches to address sleep studies and advanced imaging management. Our comprehensive data warehouse, which combines all medical, pharmacy, dental, vision and other data into a single data source, allows us to approach predictive modeling in innovative ways. To aide this initiative, we combined the data warehouse with an analytics department. The primary purpose of this department is to analyze the date, and from the analysis, make suggestions and recommendations regarding benefit designs to achieve the Triple Aim. We also have built a coordinated care organization from the ground up and in a geographical location that has previously not had managed care. On a continual basis, we work to grow and strengthen our innovative regional partnerships. ? Here are a few examples of ongoing cost containment and quality improvement efforts at Moda. ? - Medical Quality Improvement Committee (MQIC) - Comprised of representatives from multiple departments that oversees Moda quality improvement programs. This committee monitors and evaluates the health care services provided to Moda members to ensure that they meet current medical practice and service standards. The MQIC meets at least six times per year and facilitates communication among Moda departments, providers, employer groups and members to ensure the delivery of healthcare services in an efficient management of resources. ? - Pharmacy and Therapeutics Committee - Chaired by a Moda medical director, this multidepartment committee oversees drug formulary decisions to ensure the availability of safe and effective drug choices by: promoting evidence-based standards in the

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Carrier	Category	Efforts and Achievements
		formulary decision-making process to ensure clinical efficacy, patient safety, and cost-effective medication options; establishing policies and procedures to educate and inform health care providers, members and clients about drug products and appropriate use; as well as developing protocols and procedures for the ease of and access to non-formulary drugs. ?
		- Case Management and Care Coordination - Our programs use evidence-based medicine and best practice clinical care guidelines. The guidelines are used when prior authorizing inpatient and surgical admissions, durable medical equipment, outpatient therapies and chiropractic care, acupuncture and massage therapy. In addition, evidence based-guidelines are used to assign initial length of stay, continued stay, and to confirm the appropriate level of care for inpatient, acute rehabilitation and skilled nursing facility admissions. ?
		Care coordination nurses follow members through preauthorization of an inpatient admission, inaptient concurrent review, discharge planning, and the recovery phase of an acute condition, when coordination of additional services is needed. The care management programs use nationally recognized clinical care guidelines developed through evidence-based medicine and best practice. This approach supports our readmission prevention program. ?
		Moda has ongoing quality improvement projects for congestive heart failure (CHF), inpatient readmissions, depression screening, and hospice utilization. These efforts also include communication among case managers, health coaches, and behavioral healthcare coordinators to ensure the members receive the appropriate level of care with the appropriate provider. To ensure quality centers of excellence are available for transplant care, specialized cancer care that is nto available locally, kidney dialysis, and complex neonatal case management.
Carrier 10	**Customer**	Moda has consistently recognized that exceptional customer service is a core value. We have taken a "voice of the customer" approach (e.g., survey tools, focus groups) to better understand what is valued by our customers. Our goal is to deliver a consistent

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Carrier	Category	Efforts and Achievements
	Service	and satisfying customer experience across the consumer lifecycle through all our channels of communication. ? We have used multiple approaches to improve the experience for our members. ? -Increased customer staff throughout 2014 and 2015 -Opened a call center in Bend, OR and Anchorage, AK. -Made changes to the customer services representatives schedules to better meet customer's need. -Enhanced our training for our group plans -Moda continues to evaluate root causes for phone calls for process improvement opportunities. -Moda continues to evaluate staffing needs and adjust accordingly. ? In 2016 we are working on the following intiatives: ? -24/7 interactive voice response (IVR) for our members and providers to get benefit and claims information. -Enhance myModa password change process.

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Carrier	Category	Efforts and Achievements
		-After call member surveys. -Implement ePrescribing by 7/15/16.
Carrier 10	**District Management of Health Plans**	Moda works with clients to administer their benefits and assist with benefit design recommendations. We evaluate performance metrics, anticipate utilization trends and recommend changes to support evidence and value-based plan designs. ? Moda applies a consultative approach to client services. We use clinical experts and data analytics to evaluate opportunities for plan enhancements and modifications. ? We have an open forum with our clients, their consultants and ofter other health plans services the same population, to discuss opportunities for improvement in care and the management of health benefits. Collectively, we review utilization trends and evaluate modifications to the plan that will ensure appropriate and cost effective care. Moda shares claims and utilization experience for school districts with 100 or more employees. It is through this active collaboration that we are able to identify opportunities that meet the specific needs of the client.
Carrier 10	**Part-Time Employee Coverage Protection**	Employee eligibility is determined by the employer. Eligibility must be compliant with the Patient Protection and Affordability Care Act regulations.