

Meeting Agenda | Health Care Policy Committee

Thursday, March 17, 2016 | 10:00 a.m.

200 Arbor Lake Dr., Columbia, SC 29223 | Second Floor Conference Room

- I. Call to Order
- II. Adoption of Proposed Agenda
- III. Approval of Meeting Minutes- February 18, 2016
- IV. Continued Strategic Planning Discussion
- V. Adopt Mission Statement
- VI. Old Business/Director's Report
- VII. Adjournment

Notice of Public Meeting

This notice is given to meet the requirements of the S.C. Freedom of Information Act and the Americans with Disabilities Act. Furthermore, this facility is accessible to individuals with disabilities, and special accommodations will be provided if requested in advance.

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
Health Care Policy Committee

Meeting Date: March 17, 2016

1. Subject: Strategic Planning Discussion

2. Summary: Bobby George from Human Resources will facilitate a strategic planning discussion

3. What is Committee asked to do? Participate in the interactive discussion and make changes to strategic plan as needed

4. Supporting Documents:

(a) Attached:

1. Health Care Policy Committee Meeting Agenda Suggestions
2. Health Care Policy Mission Statement
3. PEBA-HCPC Key Measurements
4. HCP Plan Summary
5. HCP Committee Quarterly Dashboard
6. Key Cost Drivers
7. Population Health Report- Risk Score Analysis
8. Health Management Program Descriptions
9. ACA Compliance Timeline
10. SHP Proposed Quarterly Update
11. ESI Quarterly Report
12. Active Health Quarterly Report
13. Active Health Executive Summary- Standard Plan

Health Care Policy Committee Meeting Agenda Suggestions

Strategic Items – February 18, 2016

Mission (1 hour)

Dialogue

- Review the current mission statement in the health care committee charter.
- Review PEBA's statutory guidance
- Review what is within PEBA's control and what is outside of PEBA's control
- Review what is within PEBA's influence
- Review the key mission expectations (measurable)

Expected Result

- Gain consensus on the mission and key mission expectations

Goals (1 hour)

Dialogue

- Review PEBA's current goals for the health care committee
- Discuss any new goals for the health care committee

Expected Result

- Gain consensus on the goals for the health care committee

March 17, 2016

- Review Mission as developed from the February 18, 2016 meeting
- Review Key Measurements developed from the Mission

Expected Result

Gain consensus on the Mission and the Key Measurements

- Review set of draft reports

Expected Result

Gain consensus on how staff should communicate with the Board to support effective communication, the accomplishment of strategic goals and the fulfillment of the mission. Clearly identify a set of reports to meet the purpose of on-going standard reporting to the Board.

Reports to be reviewed

- A - Plan Summary Report
- B - Dashboard
- C - Key cost drivers
- D - Population Health Report
- E – Health Management Programs
- F - ACA (plan design) roadmap
 - Show roadmap since PEBA's inception
- G - Quarterly Reports from BC/BS on the following (should include dollar impact, number of members and overview of the current aspects of each program.):
 - UM
 - CM
 - DM
- H - Quarterly from ESI on the following (should include dollar impact, number of members and overview of the current aspects of each program):
 - Drug Utilization
 - Rx Count
 - Quantity
 - Unit cost
 - Generic dispensing rate
- I - Quarterly reports on active health

April Meeting (We could do this at the retreat or at a separate meeting)

Action Items (2 hours)

Dialogue

- Review the process from 2015
- Review the current action items
- Review items from December 2015
- Review and prioritize any new action items

Expected Result

- Consensus on action items for 2016
- Consensus on direction of action items for 2017-2018

On-going Health Care Agenda Items (1 hour)

Normal Schedule

January

- Communications update – Goals for the Year
- Active Health Quarterly Presentation
- Strategic Action Plan Review

February

- Benchmark Update
- Strategic Plan Review
- ASO TPA Quarterly Presentation

March

- Financial Overview
 - Presentation of Financial Statements
 - Presentation of Plan Summary Report
- OPEB education session and annual valuation review
- Pharmacy TPA Quarterly Presentation

April

- Active Health Quarterly Presentation
- Strategic Action Plan Review

May

- ASO TPA Quarterly Presentation

June

- MUSC plan review
- Strategic planning updates (if needed – are there any recommended changes from February?)
- Pharmacy TPA Quarterly Presentation

July

- Approval of plan design
- Active Health Quarterly Presentation

- Strategic Action Plan Review

August

- Review 5 largest cost drivers and current and future plans to address them
- ASO TPA Quarterly Presentation

September

- Pharmacy TPA Quarterly Presentation

October

- Active Health Quarterly Presentation
- Strategic Action Plan Review

November

- Finalize funding requirements
 - Need to do a plan accounting that shows money saved
 - Format with options
- ASO TPA Quarterly Presentation

December

- Pharmacy TPA Quarterly Presentation

2016 Schedule – Additional Topics

Communications Review

- Health Hub Overview
- New Website Overview
- BC/BS Website Overview
- ESI Website Overview
- Employer Services Overview
- Communications Collaboration Overview

OPEB education session and annual valuation review

- What is OPEB?
- How does the trust fund work?
- What are the statutory constraints?
- How is it funded?
- Which employers/members are covered?
- How do we compare with other states?
- How is our plan different from private sector? How is it the same?

- How will the new GASB statements work?

Other Retreat Topics

- Review OPEB with Actuary
- Review the updated mission and key measurables from the health care committee
- Discuss well visit project
- Education session on Accountable Care Organizations (ACO) (GRS)
 - What are the key components?
 - Who has done this?
 - What have the results been?
- If ASO TPA is finished, review the scope and new initiatives going forward
- Review of other State's Plans (GRS)
 - What are the major differences in our plans and other states?
 - What are the major differences between our plan and an employer based plan?
 - What can we learn from other plans?



Serving those who serve South Carolina

Health Care Policy Committee

Mission:

To ensure a financially sustainable health program that improves member health and provides a positive member experience.

Health Care Policy Committee

Goals and key measures- financially sustainable, improve member health outcomes and positive member experience

Goal: Financially sustainable

Key Measures:

1. State Health Plan expenditure growth per subscriber for the SHP is at least 2 percentage points below 5 year average national benchmark. (annual)

	5 year average (2011-2015)
State Health Plan	4.1%
National benchmark	7.0%

Source: Most recent Segal Health Plan Cost Survey.

2. State Health Plan Actuarial Value Ratio (AVR) is equal to or higher than the benchmark of the average of bordering peer plans (North Carolina, Georgia, Florida and Tennessee) and the southeast regional states. (annual)

	2016 Actuarial Value Ratio
State Health Plan-Standard Plan option	80.2
Average of bordering peer plans	79.02
All southern states MEP	73.758

Source: Benefit design for each plan applied to the Centers for Medicare and Medicaid Service's 2015 Actuarial Calculator.

3. State Health Plan net expenditure to revenue loss ratio is than 1.0. (monthly)

	As of 12.31.15
State Health Plan	.959

Source: PEBA

4. Cumulative cash balance of self-funded health plan reserves is at least 140 percent of current estimated outstanding liability. (quarterly)

	As of 12.31.15	Cash balance compared to estimated outstanding liability
SHP cash balance	\$272,990,827	1.86
Outstanding liability	\$146,695,978	

Source: PEBA, quarterly GRS IBNR report

5. State Health Plan average monthly Employer premium at or below the southeast state employee plan average. (annual)

2016	Employer composite premium	% of southern regional
State Health Plan	\$510.60	62.2%
Southern Regional States	\$821.46	

Source: PEBA 2016 50 State Survey

6. State Health Plan average monthly Enrollee premium at or below the southeast state employee plan average. (annual)

2016	Enrollee composite premium	% of southern regional
State Health Plan	\$159.51	93.1%
Southern Regional States	\$171.31	

Source: PEBA 2016 50 State Survey

7. State Health Plan average monthly Total premiums at or below the southeast regional state employee plan average. (annual)

2016	Total composite premium	% of southern regional
State Health Plan	\$670.11	67.5%
Southern Regional States	\$992.76	

Source: PEBA 2016 50 State Survey

Goal: Improve member health

Key Measure:

1. Maintain overall patient health risk score for non-Medicare primary adult State Health Plan members that is adjusted for demographics. (annual)

	Low risk (00-01)	Medium risk (02-03)	High risk (04-05)	Overall Risk
2011	0.4757	1.4429	4.7305	1.5651
2013	0.4172	1.3942	4.5589	1.5148
2015	0.4160	1.4047	4.4710	1.4665

Source: SHP eligibility and claims data evaluated using Johns Hopkins Adjusted Clinical Grouper 10.0

Goal: Provide positive member experience:

Key Measures:

1. Trust: members feel the State Health Plan is a Plan they can trust: score at least an 8 out of 10 where “1” means strongly disagree and “10” means strongly agree. (annual)

	2015 survey score
State Health Plan	8.3
System average for all survey participants	8.1

Source: 2015 BCBS Consumer Brand Index Survey- this survey is an index of measures developed by the BlueCross Association in collaboration with the American Customer Satisfaction Index (ACSI). This survey is designed to measure business outcomes of customer experience such as loyalty and retention. The survey is conducted by the BlueCross Association and members from each BlueCross Plan are surveyed twice a year.

2. Likelihood to recommend: how likely members are to recommend the State Health Plan to family and friends; score at least an 8 out of 10 where “1” means very unlikely to recommend and “10” means likely to recommend. (annual)

	2015 survey score
State Health Plan	8.3
System average for all survey participants	8.1

Source: *2015 BCBS Consumer Brand Index Survey*- this survey is an index of measures developed by the BlueCross Association in collaboration with the American Customer Satisfaction Index (ACSI). This survey is designed to measure business outcomes of customer experience such as loyalty and retention. The survey is conducted by the BlueCross Association and members from each BlueCross Plan are surveyed twice a year.

3. State Health Plan Medical Third Party Administrator Customer Satisfaction After-Call Survey average total score is greater than or equal to 4.5 where “1” means very dissatisfied and “5” means very satisfied. (annual)

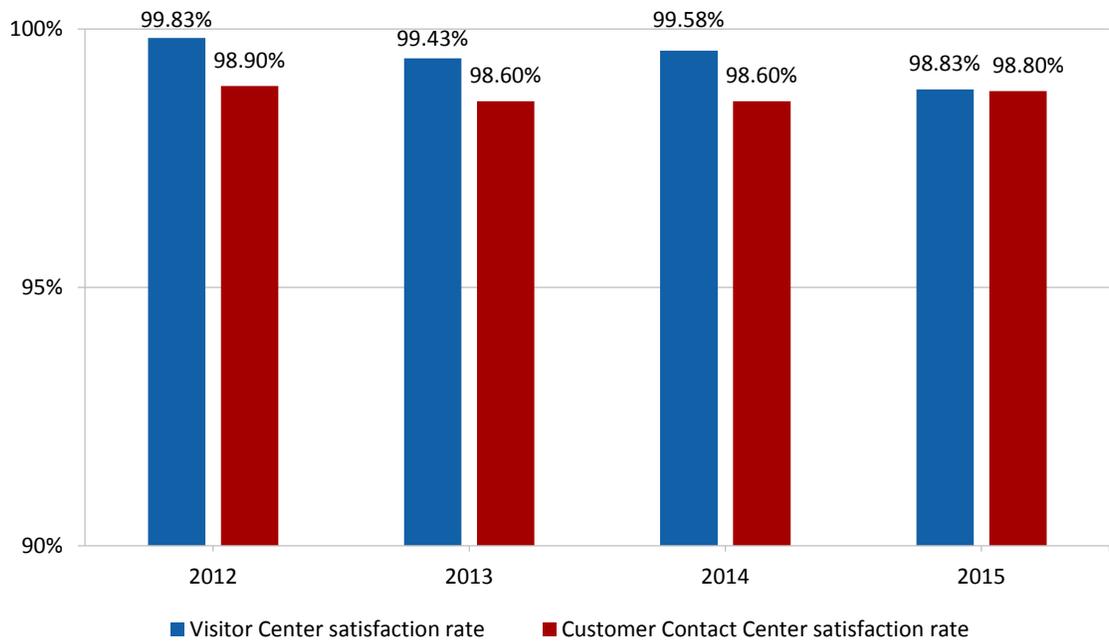
	2015 survey score
BCBSSC	4.5

Source: *2015 BCBSSC State Health Plan After-Call survey*- this brief six question survey is offered after each customer service call to a BCBSSC Customer Service representative.

4. PEBA Customer Satisfaction survey score should be greater than or equal to a 95 percent satisfaction rate for both the Visitor and Customer Contact Center. (annual)

Customer satisfaction

Visitor Center survey results procedure changed in November 2013 to begin using automated email surveys.



Source: 2015 PEBA Customer Satisfaction survey.



Health Care Policy Committee

Plan summary
March 2016

State Health Plan enrollment

As of March 2016

Subscribers		
Subscribers		270,423
Actives	186,656	
Retirees	80,501	
Others	3,266	
Spouses		78,205
Children		126,783
Total covered lives		475,411

Active subscribers	
State agencies	35,190
Higher education	25,487
School districts	85,471
Local subdivisions	32,150
Other	8,358
Total employees	186,656

Retirees	
Medicare	59,698
Non-Medicare	20,803
Total retirees	80,501

State Health Plan participating employers

As of March 2016

Employers	
State agencies	83
Higher education	27
School districts	92
Local subdivisions	449
Other	26
Total employers	677

State Health Plan financial analysis

As of December 2015

	2014	2015 projected	Trend
Total SHP net expenditures (in millions)	\$1,704.20	\$1,905.10	
Average membership	434,062	446,646	
Medical – net expenditure PMPM	\$226.45	\$236.98	4.7%
Pharmacy – net expenditure PMPM	\$100.73	\$117.80	16.9%
Total SHP	\$327.18	\$354.77	8.4%
Total loss ratio	91.0%	95.9%	

Cash/liability ratio

As of December 2015

A ratio greater than or equal to 1.4 is optimal (benchmark)

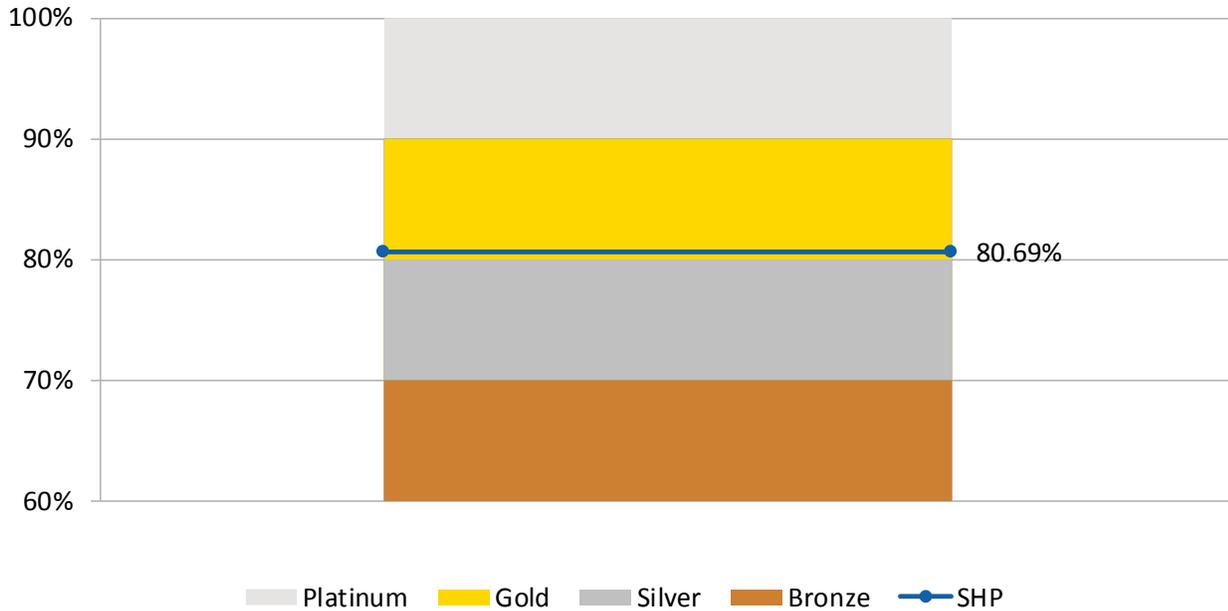
Cash reserves/outstanding liability should be greater than or equal to 1.0

State Health Plan	1.87
MUSC Health Plan	1.49
Dental	0.49

Actuarial value

As of December 2015

Actuarial value as defined by the ACA = plan payments + patient liability



State Health Plan network access

November 2014-October 2015

% of hospital claims paid in network	98.1%
% of professional claims paid in network	97.4%

State Health Plan vs. national trends

Data from the 2016 Segal Health Plan Cost Trend Survey

	Public and private sector insurance plans ¹	State Health Plan ²
2011	6.7%	2.3%
2012	6.7%	6.4%
2013	5.6%	4.0%
2014	7.9%	-1.4%
2015	8.1%	8.8% (12/12) ³

¹Includes active participants and retirees under the age of 65 in private and public sector insurance plans.

²Trend is defined as claims paid per member (includes employee and dependents).

³"12/12" means incurred in 12 months; paid in 12 months

2015 average monthly total premiums

Data from the Kaiser Family Foundation Employer Health Benefits 2015 Annual Survey

Totals include employee and employer contributions

	Single	Family
State Health Plan	\$442	\$1,161
Lg. public & private sector employers ¹	\$549	\$1,554
Public & private sector in South ²	\$521	\$1,453
Public employers	\$585	\$1,455
Private – manufacturing	\$516	\$1,474
Private – financial services	\$582	\$1,664

¹Lg. public and private sector employers: ≥ 200 employees in public and private sectors

²Public & private sector employers in South: Includes Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

2015 average annual deductible

Data from the Kaiser Family Foundation Employer Health Benefits
2015 Annual Survey

	Amount
State Health Plan	\$445
Lg. public & private sector employers ¹	\$775
Public & private sector in South ²	\$1,026

¹Lg. public and private sector employers: ≥ 200 employees in public and private sectors

²Public & private sector employers in South: Includes Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

2016 composite monthly premiums¹

Data from the 2016 PEBA 50-State Survey of State Employee Health
Plans

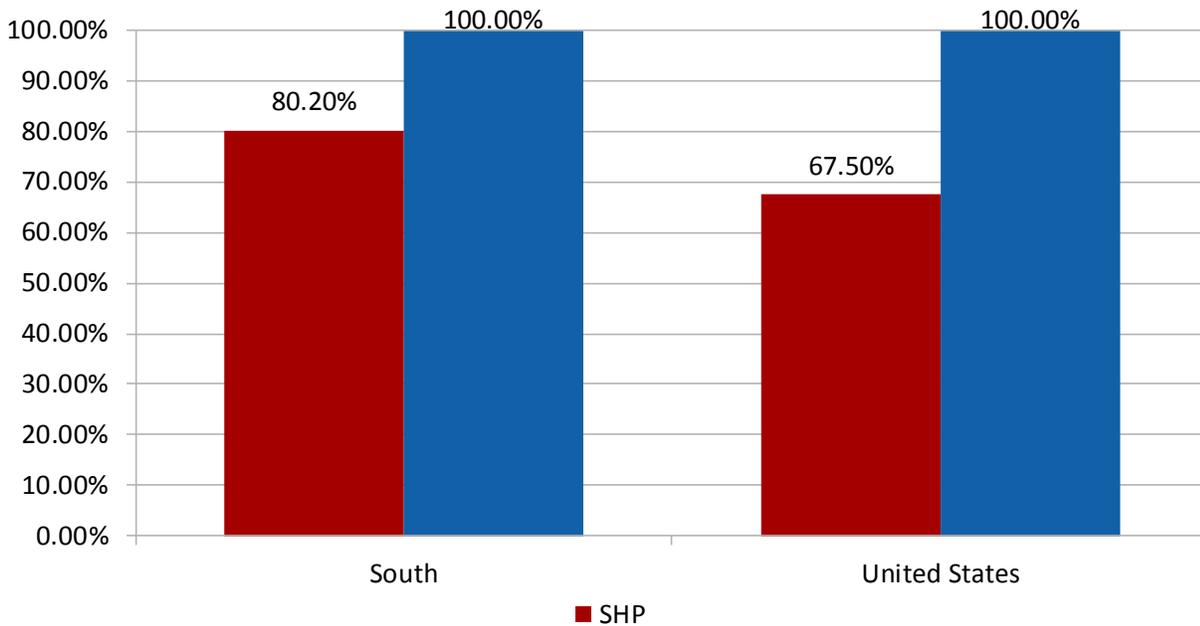
	Employer	Employee	Total
State Health Plan	\$510.60	\$159.51	\$670.11
South ²	\$661.21	\$174.80	\$836.00
United States	\$821.46	\$171.31	\$992.76

¹Composite monthly premiums: Weighted average of all PEBA health subscribers enrolled in each coverage level

²South: Includes Alabama, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

2016 SHP composite monthly premiums¹ as a percentage of regional and national averages

Data from the PEBA 50-State Survey of State Employee Health Plans
Compared to other state employee health plans



¹Composite monthly premiums: Weighted average of all PEBA health subscribers enrolled in each coverage level

²South: Includes Alabama, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

Average annual gross plan cost per active employee¹

Data from 2014 Mercer National Survey of Employer-sponsored Health Plans

	Amount ²		Amount ²
State Health Plan	\$9,129	All employers	\$10,664
Public employers	\$11,796	Employers – 500+	\$11,121
Private – mfg.	\$11,043	Employers – 20k+	\$11,697
Private – financial svcs.	\$11,525	South ³	\$10,239

¹Average cost in PPO (Preferred Provider Organization) and POS (Point of Service) plans

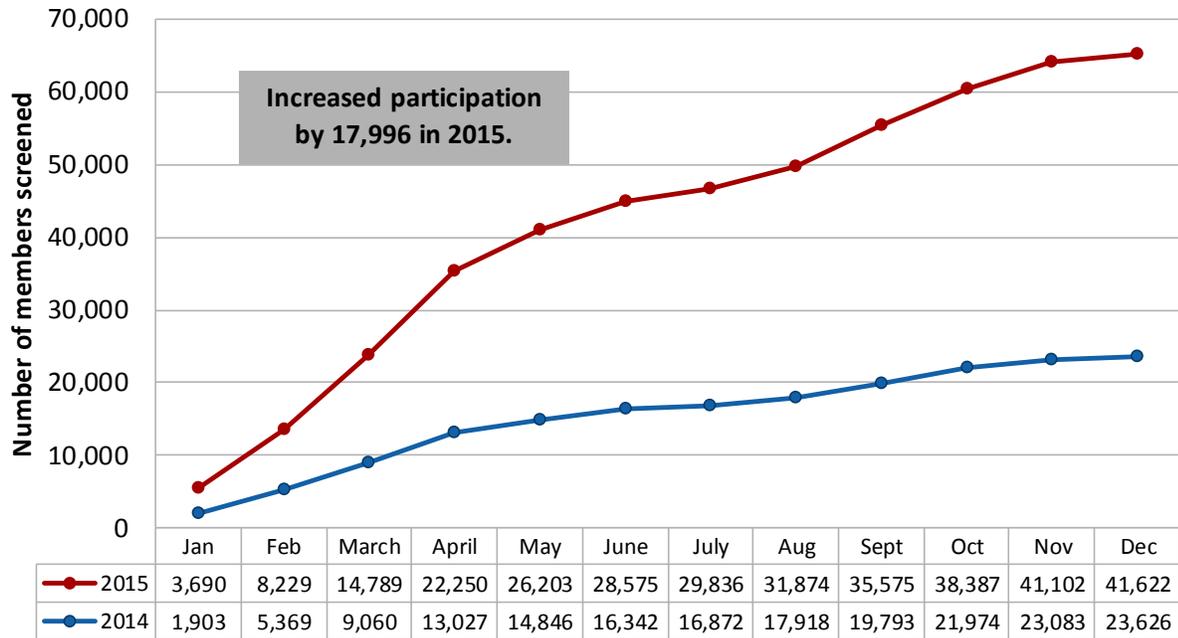
²Average annual gross plan cost per employee (medical and pharmacy only for active employees and their dependents) = (claims cost for employee and dependents + administrative costs + employee contributions)/number of active employees

³South: Includes Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

PEBA Perks initiatives

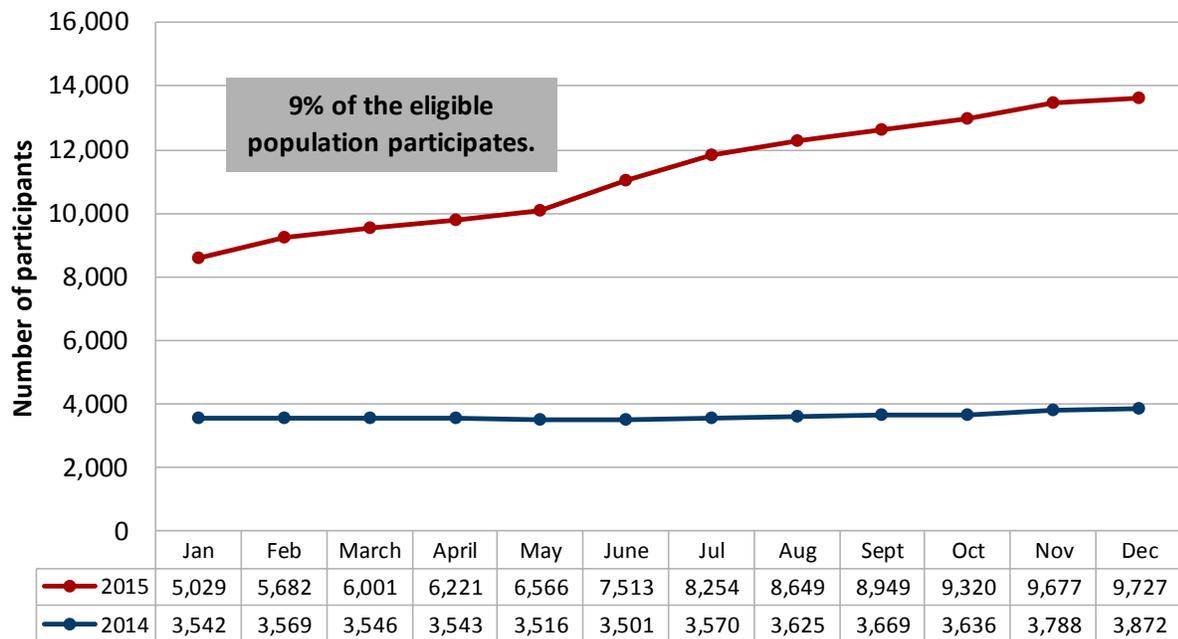
Preventive screenings | incurred and paid January-December 2015

2015 goal: increase participation by 10,000

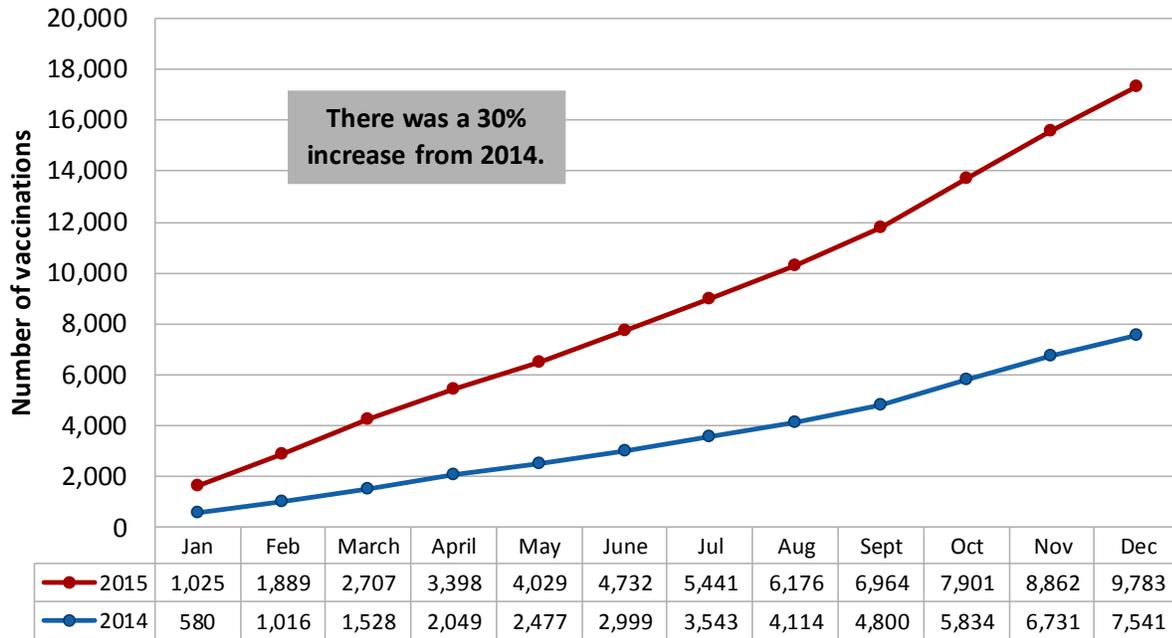


No-Pay Copay | January-December 2015

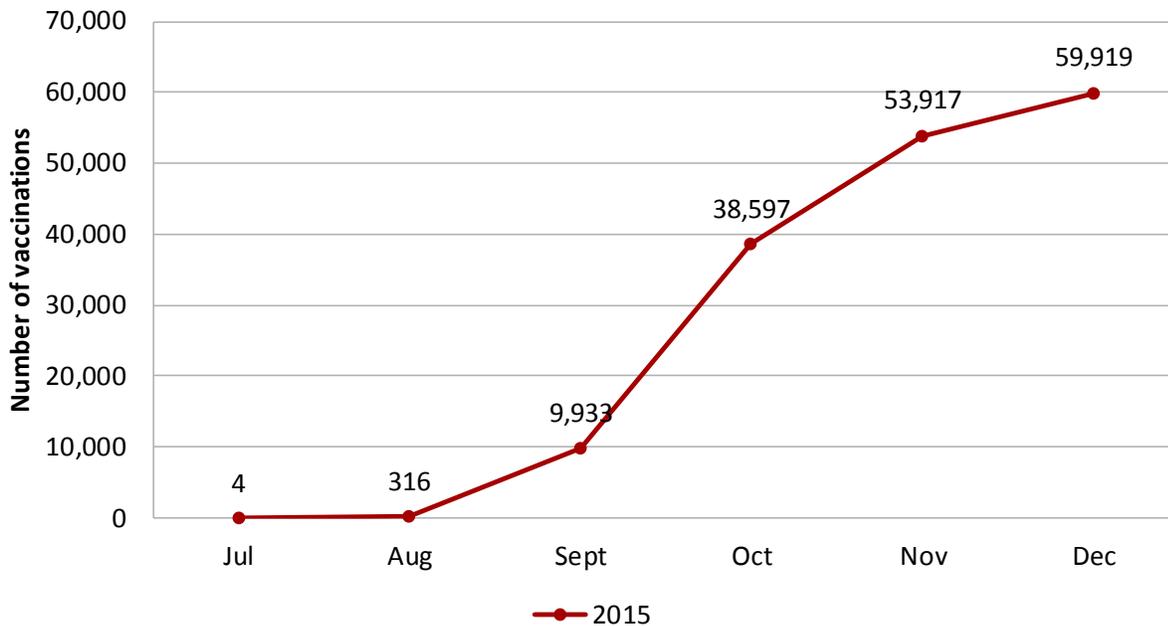
2015 goal: increase participation by 7% of eligible population



Shingles vaccine | incurred and paid January-December 2015



Flu vaccines | paid and incurred July 2015-December 2015

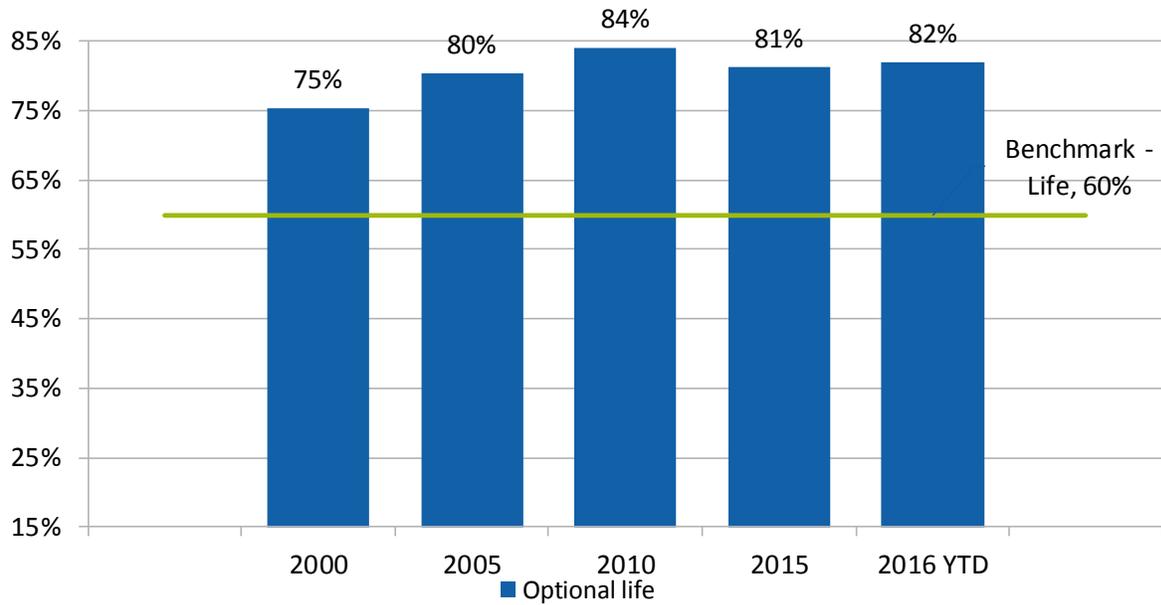


Information to be added:

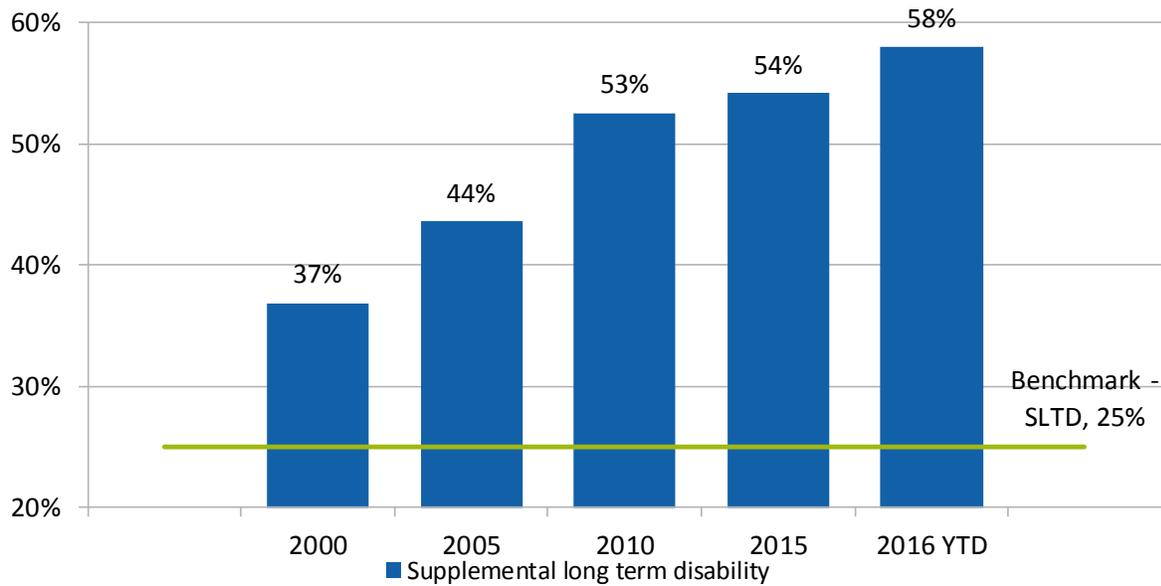
- 2016 PEBA Perks: adult vaccinations, colonoscopy, diabetes education and tobacco cessation

Enrollment in voluntary programs compared to industry benchmarks

Optional life

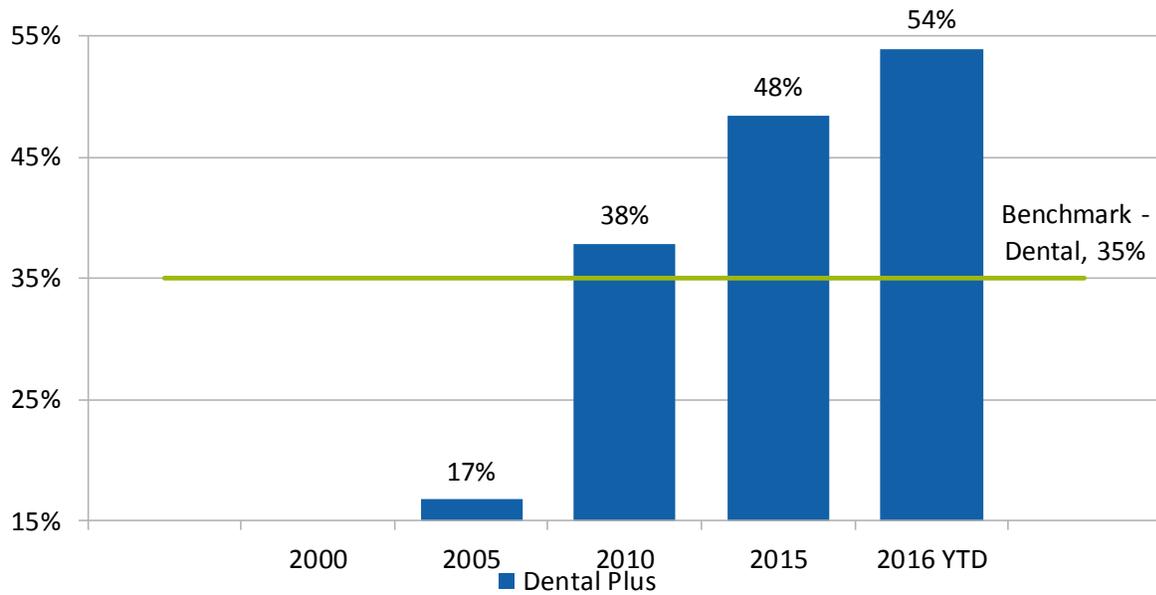


Supplemental long term disability



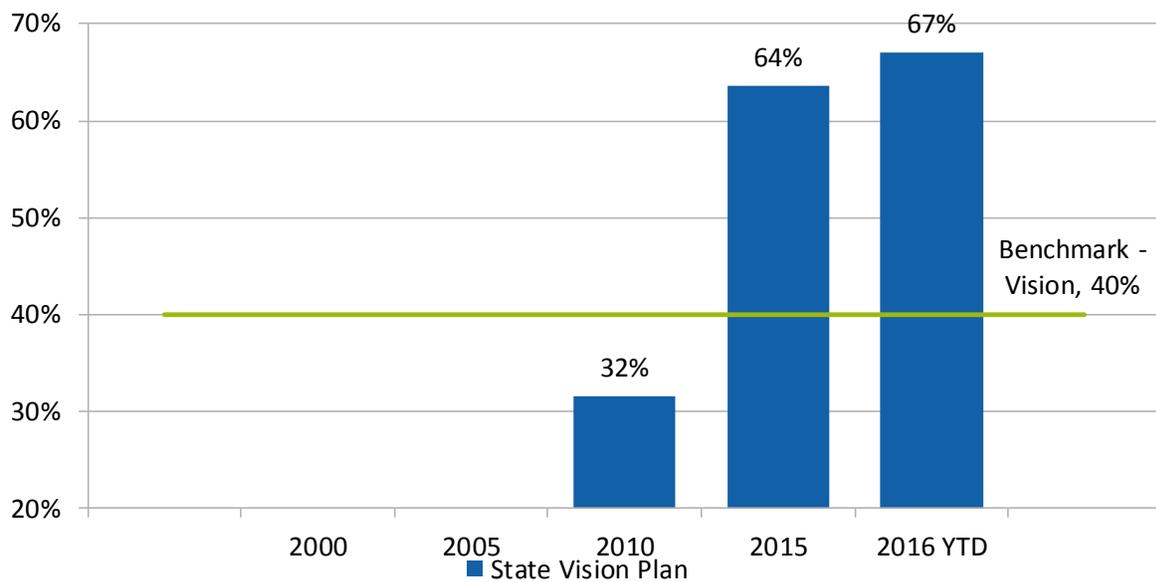
Dental Plus

Dental Plus was offered beginning in 2002



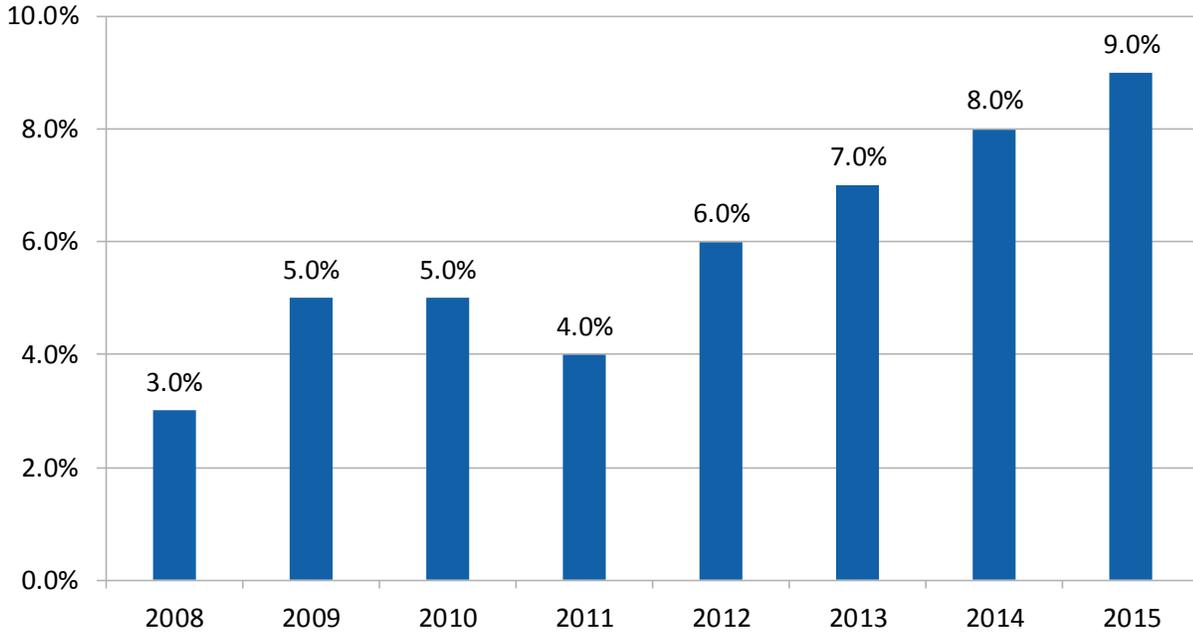
State Vision Plan

State Vision Plan was offered beginning in 2010



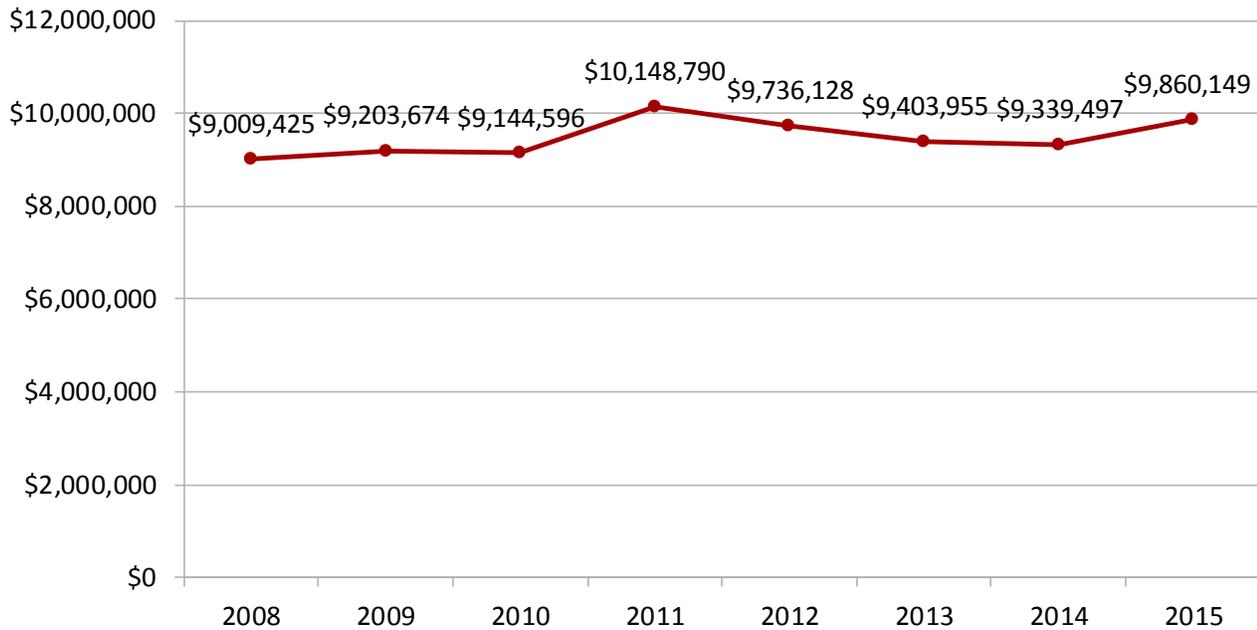
OPEB funded ratio

Actuarial assets as a percentage of actuarial accrued liabilities



OPEB unfunded accrued liabilities

Amounts expressed in thousands

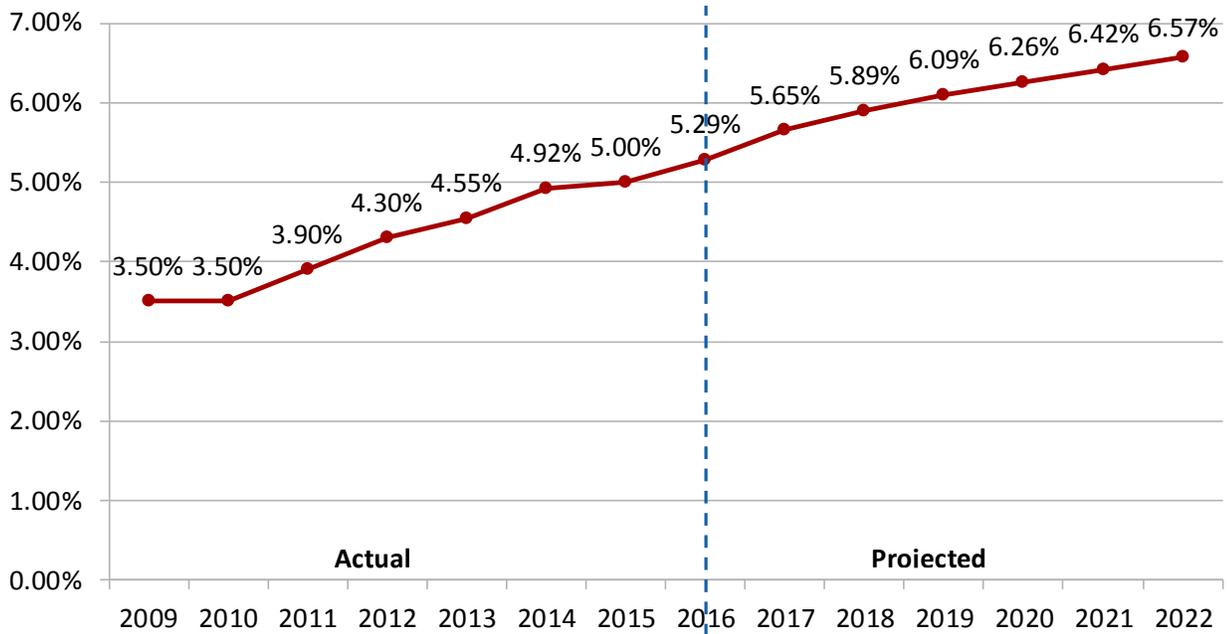


Employer surcharge

Historical and projected by calendar year

The employer surcharge collects employer contributions on behalf of retirees.

Surcharge = total amount of employer contribution/agency and school district payroll



PEBA Health Care Policy Committee Quaterly Dashboard

State Health Plan enrollem through March 2015

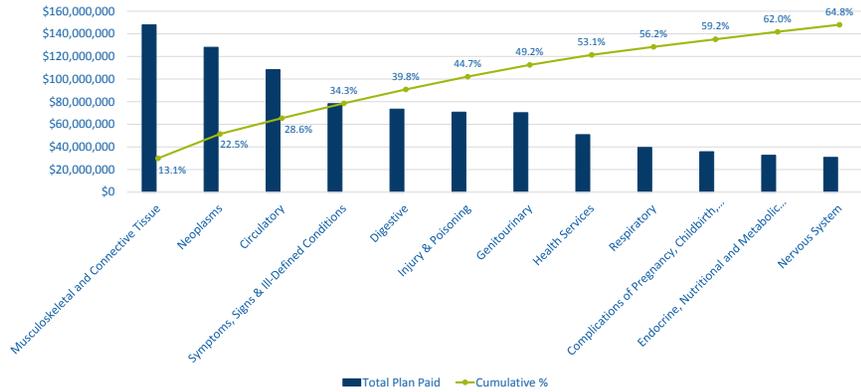
Employers	
State agencies	83
Higher education	27
School district	92
Local subdivision	449
Other	26
Total employers	677

Subscribers	
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Spouses	78,205
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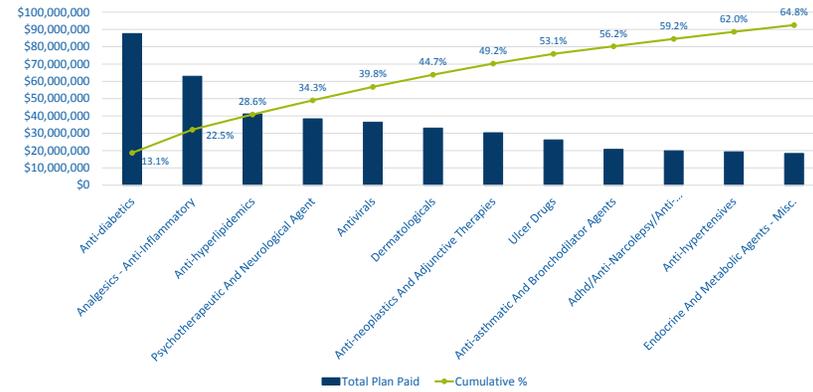
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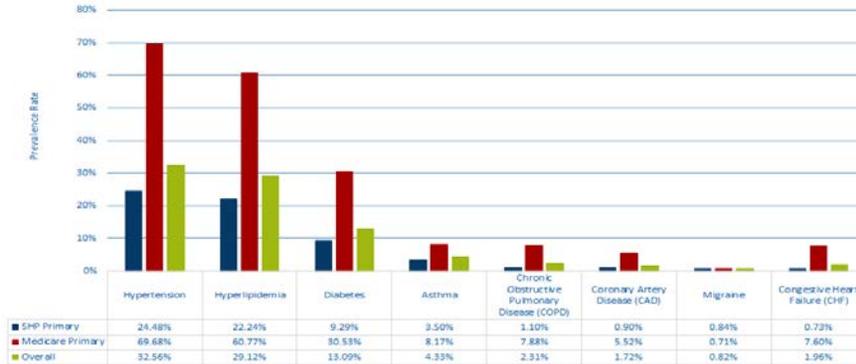
SHP top 12 medical cost drivers
Claims incurred between Oct. 14-Sept. 15
Paid through Dec. 15 (excludes MUSC/MUHA)



SHP top 12 Rx cost drivers
Claims incurred between Oct. 14-Sept. 15
Paid through Dec. 15 (excludes MUSC/MUHA)



SHP chronic condition prevalence rates
Incurred Oct. 14-Sept. 15
Paid through Dec. 15



State Health Plan financial analysis
through December 2015

	2014	2015 projected	Trend
Total SHP net expenditures (in millions)	\$1,704.2	\$1,905.1	
Average membership	434,062	447,494	
Medical--net expenditure PMPM	\$226.45	\$236.98	4.7%
Pharmacy--net expenditure PMPM	\$100.73	\$117.80	16.9%
Total SHP	\$327.18	\$354.77	8.4%
Total loss ratio	91%	95.9%	

Health management programs and value-based initiatives targeting top SHP medical cost drivers: claims incurred between Oct. 2014-Sept. 2015

Condition				
	Musculoskeletal & connective tissue	Neoplasms	Circulatory	Diabetes
Health management program	<ul style="list-style-type: none"> • Back care (BCBSSC) • Back-to-work (The Standard) • Behavioral health management • Orthopedic readmission avoidance program • Weight management 	<ul style="list-style-type: none"> • Behavioral health management • Complex care management • Intensive care readmission avoidance program • Oncology pathways • Weight management 	<ul style="list-style-type: none"> • Behavioral health management • Disease management • Metabolic health • Weight management 	<ul style="list-style-type: none"> • Behavioral health management • Disease management • Metabolic health • Weight management
Value-based benefit (reduced or no member cost share)	<ul style="list-style-type: none"> • Biometric screening 	<ul style="list-style-type: none"> • Biometric screening • Mammogram • Pap-test • Tobacco cessation program "Quit 4 Life" • Tobacco cessation medication 	<ul style="list-style-type: none"> • Biometric screening • PCMH • No-Pay Copay • Tobacco cessation program "Quit 4 Life" • Tobacco cessation 	<ul style="list-style-type: none"> • Biometric screening • PCMH • No-Pay Copay
Benefit limit	<ul style="list-style-type: none"> • Chiropractic services limits 			
Communication efforts	<ul style="list-style-type: none"> • Health Hub • Member messaging • PEBA Perks 	<ul style="list-style-type: none"> • Health Hub • Member messaging • PEBA Perks 	<ul style="list-style-type: none"> • Health Hub • Member messaging • PEBA Perks 	<ul style="list-style-type: none"> • Health Hub • Member messaging • PEBA Perks

SHP health risk score analysis

2011 risk segments

Metric	Low risk (00-01)	Medium risk (02-03)	High risk (04-05)	Overall
2011 exposure	51,529.76	149,727.88	25,315.32	226,572.96
Average age	41.68	47.32	49.39	46.12
Risk score	0.4757	1.4429	4.7305	1.5651
Per Capita claims	\$183.62	\$2,930.66	\$20,168.88	\$4,231.95
% of claims	0.99%	45.76%	53.25%	100%
% of population	22.74%	66.08%	11.17%	100%
Inpatient admits per 1,000	0.08	37.50	702.58	103.30
Emergency room visits per 1,000	22.61	209.34	652.73	216.41
Top diagnoses (patients)	Acute sinusitis	Hypertension	Hypertension	
	Acute pharyngitis	Evalated lipids	Evalated lipids	
	Acute upper respiratory	Joint pain	Diabetes	

2013 risk segments

Metric	Low risk (00-01)	Medium risk (02-03)	High risk (04-05)	Overall
2013 exposure	50,953.34	153,042.28	26,532.11	230,527.73
Average age	41.19	46.99	49.09	45.79
Risk score	0.4172	1.3942	4.5589	1.5148
Per Capita claims	\$191.77	\$3,235.03	\$21,603.66	\$4,676.48
% of claims	0.91%	45.92%	53.17%	100%
% of population	22.10%	66.39%	11.51%	100%
Inpatient admits per 1,000	0.10	31.17	682.64	99.28
Emergency room visits per 1,000	23.96	217.28	644.31	223.70
Top diagnoses (patients)	Acute sinusitis	Hypertension	Hypertension	
	Acute pharyngitis	Evalated lipids	Evalated lipids	
	Acute upper respiratory	Acute sinusitis	Diabetes	

2015 risk segments

Metric	Low risk (00-01)	Medium risk (02-03)	High risk (04-05)	Overall
2015 exposure	54,999.80	154,238.43	25,161.40	234,399.63
Average age	41.48	47.46	49.50	46.07
Risk score	0.4160	1.4047	4.4710	1.4665
Per Capita claims	\$451.28	\$3,515.61	\$20,641.00	\$4,634.90
% of claims	2.28%	49.91%	47.80%	100%
% of population	23.46%	65.80%	10.73%	100%
Inpatient admits per 1,000	10.53	39.08	507.88	82.70
Emergency room visits per 1,000	58.27	217.16	616.54	222.75
Top diagnoses (patients)	Acute pharyngitis	Hypertension	Hypertension	
	Acute sinusitis	Evalated Lipids	Diabetes	
	Hypertension	Diabetes	Spinal conditions	

Top 10 diagnoses for members who shifted from low/medium risk in 2011 to high risk in 2015

Top diagnoses by volume
Malignant neoplasm- breast unspecified
Chemotherapy
Renal failure
Coronary atherosclerosis- native coronary artery
Subendocardial infarction- initial episode
Rehabilitation procedure
Malignant neoplasm- breast, upper, outer quadrant
Radiotherapy
Septicemia
Malignant neoplasm- prostate

Notes:

All SHP primary covered members (excluding MUSC Health Plan and dependent children)
 Claims incurred in calendar 2015, paid through 12/31/2015
 Eligibility and claims is evaluated using ACG Grouper 10.0 (Johns Hopkins University). The system assigns concurrent and prospective risk scores.

Case management programs

Birth outcomes initiative (BOI)

The BOI is a public health effort that was launched with the goal of reducing South Carolina's high preterm birth and NICU utilization rates.

- The first initiative of the BOI implemented a payment convention to end elective inductions prior to 39 weeks gestation. South Carolina was able to reduce the rate of early elective inductions by 50 percent.
- The next focus of the BOI was the implementation of two provider incentive programs.
 - Centering Pregnancy is a group model for prenatal care that targets low risk mothers and has demonstrated reductions in pre-term deliveries.
 - SBIRT (Screening, Brief Intervention, and Referral to Treatment) is a comprehensive evidence based approach to early intervention and treatment for pregnant women who have substance abuse disorders, depression, anxiety or who are at risk for developing these conditions.

Blue Cross Medi-Call case management

Care/case management and discharge planning are programs provided by Medi-Call. Care/case management is a service through which a comprehensive and holistic patient assessment generates proactive care solutions to identify risks and quality alternative treatment options that fulfill the needs of the patient and their caregiver(s) in the most cost effective and efficient manner.

Complex care management

This program is designed to assist seriously ill patients. This includes those with complex medical conditions, who may have more than one illness or injury, who have critical barriers to their care and who are frequently hospitalized. This program provides these patients with education about their illness and treatment options in order to assist them in determining the course of their own treatment while coordinating this care with their physicians. A registered nurse, that is located within the geographic region of the patient, provides face-to-face contact with patients and their families to perform care management. These nurses assist the patient and families in taking the time to plan and make decisions about their care, especially concerning end of life care.

Oncology pathways program

Effective September 2015, the SHP covers BlueCross BlueShield's clinical pathway program with the goal of improving members' cancer care and hopefully their outcomes. The pathway program includes members who have been diagnosed with colon cancer, non-small cell lung cancer or breast cancer. The program partners with oncology providers to improve the quality of care and access to care that meets

the needs of the patient at the lowest cost. In addition to meeting quality measures, evidence-based cancer treatment pathways are used by participating oncologists.

These pathways are based on National Comprehensive Cancer Network (NCCN) guidelines. Expected rates of pathway adherence is 80 percent or greater. This goal recognizes that a significant number of patients have needs that require deviation from the pathway. For each patient placed on the pathway, the oncology practice receives an initial care coordination. There is a recurrent payment for each month that the patient remains on the pathway for six months. In order to receive this payment, the practice must attest to participation in the pathway and submit evidence of meeting quality metrics established as part of the program. The pathway program is designed to target lower cost oncology drugs when appropriate to ensure the lowest cost to the member and employer.

Renal disease management

This is a renal disease patient support and education program, which develops and administers an end-stage renal disease (ESRD) program for improving the care and outcomes of ESRD patients. BlueCross BlueShield partners with VillageHealth to promote cost-effective and quality driven delivery of comprehensive services for members by coordinating and integrating care across the multi-specialty, multi-setting and continuum of care necessary to improve outcomes and enhance quality of life of ESRD patients.

Readmission avoidance outbound call program (REAP)

This program provides early intervention for at-risk members post hospitalization, thus avoiding potential discharge complications and re-admission. A registered nurse identifies gaps in care and initiates an action to close these gaps. The nurse serves as a resource to the member and the provider after discharge. This extends the continuum of care for members at risk who are not currently followed through care management programs. Using a secure web-based intranet platform, the nurse implements interventions telephonically; providing education, collaboration between healthcare providers and access to care, and potentially reducing the incidence of avoidable emergency room visits or admissions.

- **REAP OrthoCare** targets those members scheduled for a knee, hip, or back surgery and who are screened to be at risk for re-admission to the hospital.
- **REAP IntensiveCare** targets those members with complex health care needs identified by an inpatient census report (outside of hips, knees and back surgeries) and who are screened and have multiple comorbid conditions, behavioral health comorbid conditions and a history of multiple admissions.

Transplant case management

Every transplant patient is case managed. Transplant contracting arrangements include the BlueCross BlueShield Association national transplant network—Blue Distinction Centers for Transplants (BDCT). Through the BDCT network, enrollees have access to the leading organ transplant facilities in the nation.

Health management programs

Back pain management

Health coaches educate members with back pain on techniques to help prevent or reduce the frequency and severity of their pain, proper lifting techniques, exercises to help them strengthen their posture and abdominal core and weight management.

Behavioral health management

Health coaches work one-on-one and offer support to members diagnosed with the following diseases. Health coaches encourage the member to follow his or her treatment plan, help the member set goals and teach the member how to handle symptoms.

- Addiction recovery
- Attention Deficit/Hyperactivity Disorder (ADHD)
- Bipolar disorder
- Depression

Chronic disease management

Health coaches work one-on-one with members diagnosed with the following chronic diseases. The coaches will help participants learn more about their condition and how to manage it. The health coach will also work with the member's physician to develop a plan to take charge of your illness.

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes (adult and pediatric)
- High cholesterol
- Hypertension (high blood pressure)
- Metabolic syndrome

Maternity management

Mothers-to-be are encouraged to participate in the maternity management program. Medi-Call administers PEBA's comprehensive maternity management program. The program monitors expectant mothers throughout pregnancy and manages Neonatal Intensive Care Unit (NICU) infants or other babies with special needs until they are one year old. To enroll in the program, notify Medi-Call during the first trimester of your pregnancy.

Migraine management

This program encourages participants to work with his or her doctor to create a plan to ease the pain of migraine headaches. A health coach helps the member learn to identify migraine triggers, develop healthy habits to prevent migraines and comply with his or her treatment plan.

Tobacco cessation program

Enrollment in this program is available to any eligible member age 13 and older. The Quit for Life Program® helps participants stop using various tobacco products. A professionally trained Quit Coach® works with each participant to create a personalized quit plan. For eligible participants, the Quit for Life® program provides free nicotine replacement therapy, like patches, gum or lozenges and is offered at no cost to the member. There is also a \$0 copayment for tobacco cessation drugs, such as bupropion or Chantix, available through the member's prescription drug benefit at network pharmacies for eligible Plan members.

Weight management

The weight management program assists members, ages 18 and older, in helping achieve weight-loss goals through small changes made in the member's everyday life. When you enroll, you will receive information about weight management and a confidential survey that will help a registered nurse tailor the program to meet your needs.

Weight management for kids and teens

This confidential program is for overweight and obese dependents between the ages of two and 17. It is designed to teach children and their parents about healthy habits and help them work with their doctor on weight management. When you enroll, you will receive a parent's guide and tailored educational materials for your child. A personal health coach will be assigned to your child and will provide education and support to help you and your child overcome barriers to living a healthy lifestyle.

Utilization management

Discharge coordination or planning (DCP) review

DCP review assesses a member's need for treatment after hospitalization and ensures an appropriate and timely discharge by avoiding delays in arranging for post-hospitalization care. Discharge planning promotes continuity of care and when initiated early in the hospital admission contributes to a timely discharge and a reduction in medically unnecessary days. BlueCross BlueShield initiates DCP on the day the initial service request is approved as medically necessary by the utilization review nurse.

Laboratory services management

BlueCross BlueShield implemented a new comprehensive suite of laboratory benefits management services in the fourth quarter of 2015 and in collaboration with Avalon Health Care Solutions. This is a clinically driven company that uses evidence-based medicine to develop and deploy appropriate policies and protocols in the high-volume, dynamic and complex lab environment.

Potentially investigational, experimental or cosmetic services review

BlueCross BlueShield applies a medical necessity review for any procedure that could potentially be considered cosmetic, investigational or experimental. Utilization review and case management nurses apply decision support program guidelines and BlueCross BlueShield medical policy as appropriate.

Pre-admission and pre-operative reviews

Pre-admission review is the process for evaluating the medical necessity, efficiency and appropriateness of health care services and treatment plans for a given patient. Utilization review nurses conduct prior authorization review to bridge all aspects of the continuum of care, including emergency admission review, pre-admission review and continued stay review. The goal of utilization review is to determine the most appropriate use of medical resources and treatment in the most appropriate setting at the most beneficial time in the treatment plan.

Radiology program

This is an advanced radiology authorization program. This program performs pre-service authorizations for all outpatient, non-emergency CT, MRI, MRA and PET scans. This program performs retrospective reviews for certain CT, PET, MRI and MRA scans and increase communication and coordination with radiology providers as well.

Value-based benefits

Adult vaccinations

As recommended by the CDC, the Plan covers all adult vaccinations within specified age parameters at no cost to the member. If a member receives the shot in a network doctor's office, the vaccine and the administration fee will be paid in full; any associated office visit charges will be processed according to regular Plan coverage rules.

Colonoscopy

The Plan removed out-of-pocket cost for diagnostic colonoscopies and routine screenings, including the pre-surgical consultation, the generic prep kit, the procedure itself and associated anesthesia.

Diabetes education

This benefit provides diabetes education to an eligible member. The diabetes education is conducted through educators certified by the American Diabetes Association and/or the American Association of Diabetes Educators. The diabetes education curriculum includes the following subject areas:

- describing the disease process and treatment options, incorporating nutritional management and physical activity into lifestyle,
- using medication(s) safely and for maximum therapeutic effectiveness, monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making, preventing, detecting, and treating chronic complications,
- developing personal strategies to address psychosocial issues and concerns and developing personal strategies to promote health and behavior change.

Mammography

If you are age 35 through 39 years old, one baseline mammogram (four-view) will be covered during those years. If you are age 40 through 74, one routine mammogram (four-view) each year will be covered. Preventive mammogram benefits are in addition to benefits for diagnostic mammograms.

No-Pay Copay

SHP members with high blood pressure, high cholesterol, congestive heart failure or diabetes can qualify for 12 months of generic drugs that treat these conditions at no cost. The program also covers children under age 18 who have diabetes. The 12-month waiver can be renewed each year.

Pap test

The Plan covers the cost of the lab work associated with a Pap test for women ages 18 through 65 each calendar year. The cost of the portion of the office visit associated with the Pap test is covered.

Patient-centered medical home (PCMH)

In a PCMH, a patient has a health care team that is typically led by a doctor and may include nurses, a nutritionist, health educators, pharmacists and behavioral health specialists. The focus in a PCMH is on coordinating care and preventing illnesses rather than waiting until an illness occurs and then treating it. This approach may be particularly beneficial to members with chronic illnesses. Typically, a PCMH offers same-day appointments whether the patient is sick or needs routine care.

To encourage members to receive care at a BlueCross BlueShield of South Carolina-affiliated PCMH, the State Health Plan, beginning January 1, 2016, will not charge Standard Plan members the \$12 copayment for a physician office visit. After Savings Plan and Standard Plan subscribers meet their deductible, they will pay 10 percent coinsurance, rather than 20 percent, for care at a PCMH.

Preventive biometric screening

This benefit is provided at no cost to employees, retirees, COBRA subscribers and their covered spouses if their primary coverage is the Standard Plan or the Savings Plan. The screening includes blood work, a health risk appraisal, height and weight measurements, blood pressure and lipid panels.

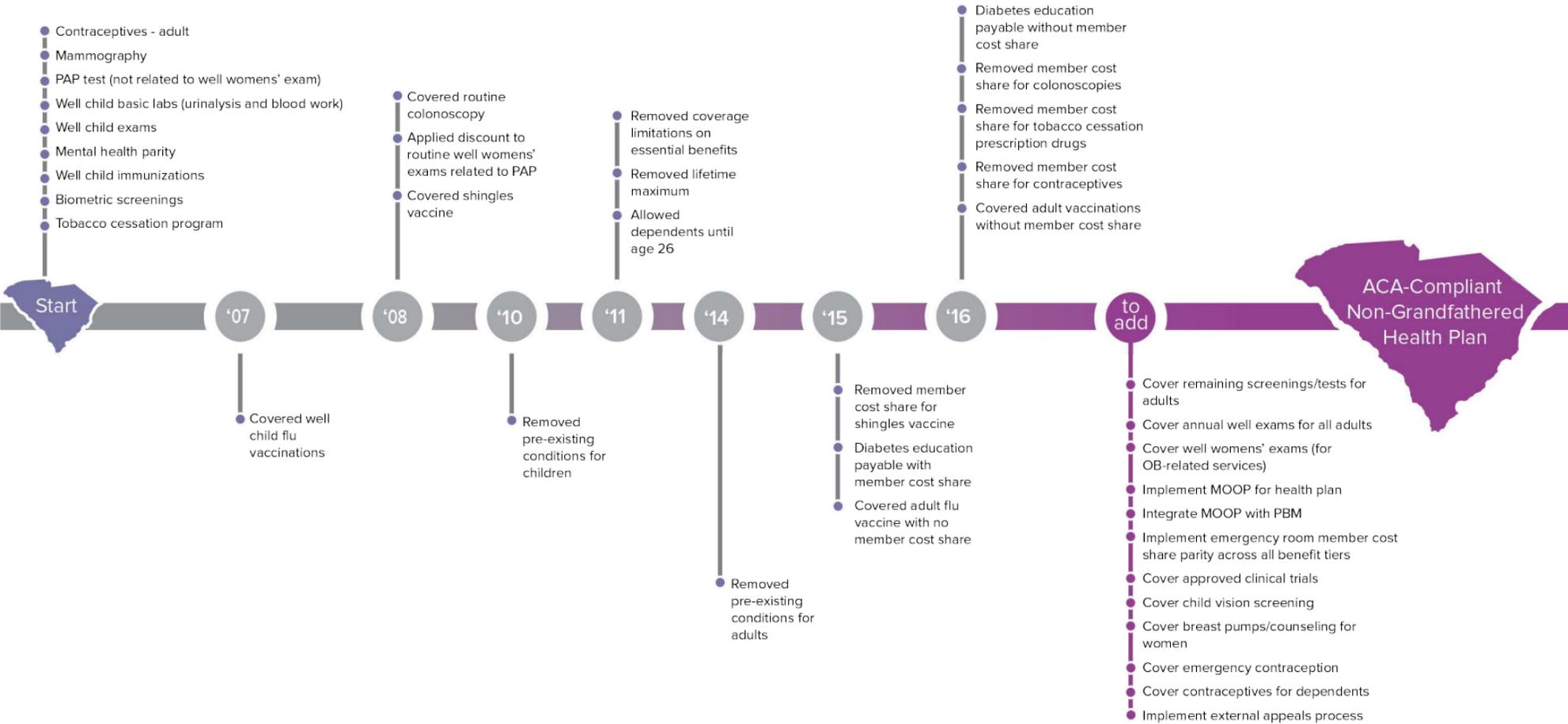
Tobacco cessation

This benefit includes enrollment in the Quit for Life program and \$0 copay for tobacco cessation drugs to eligible participants (i.e. bupropion or Chantix).

Well child care benefit—exams and immunizations

Covered dependents through age 18 are eligible for the well-child care benefit. This benefit covers both regular doctor visits and timely immunizations. When services are received from a network provider, benefits will be paid at 100 percent.

State Health Plan ACA Requirements Migration

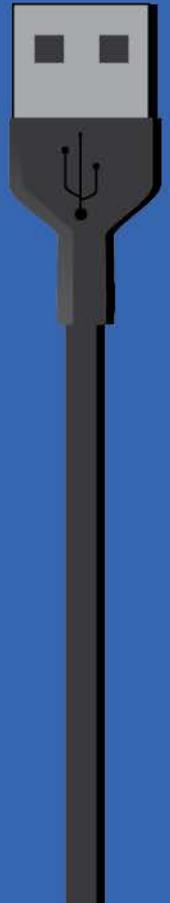


Connected

To Blue[®]

State Health Plan Quarterly Update

Data incurred through Nov. 2015



NOTES

Plan information based on:

- Rolling incurred dates
- Medical claims only

Exclusions:

- MUSC population
- Retirees 65 and older

Book of Business (BoB):

- Includes all ASO business
- Includes members in South Carolina
- Excludes retirees 65 and older

Claimants

Claimant %	Paid	Claimants	Claimants %	Paid/Claimant	Paid	Paid %
	\$0 - \$999	246,477	69.3%	\$216	\$53,210,817	4.9%
	\$1,000 - \$4,999	71,691	20.2%	\$2,263	\$162,203,839	15.1%
	\$5,000 - \$9,999	17,940	5.0%	\$7,242	\$129,929,135	12.1%
	\$10,000 - \$19,999	9,618	2.7%	\$13,716	\$131,923,345	12.3%
	\$20,000 - \$29,999	3,635	1.0%	\$24,648	\$89,596,761	8.3%
	\$30,000 - \$39,999	1,794	0.5%	\$34,293	\$61,521,161	5.7%
	\$40,000 - \$49,999	1,075	0.3%	\$44,743	\$48,099,250	4.5%
	\$50,000 - \$74,999	1,506	0.4%	\$61,156	\$92,100,875	8.6%
	\$75,000 - \$99,999	704	0.2%	\$85,922	\$60,488,792	5.6%
	Greater Than \$100,000	1,247	0.4%	\$198,141	\$247,081,870	23.0%
	Summary	355,687	100.0%	\$3,026	\$1,076,155,845	100.0%

BoB has 62% of claimants in the \$0-\$999 range and 0.5% of claimants with payments greater than \$100,000.

The majority of claimants with payments over \$100,000 are being treated for neoplasms.

Key Statistics

Current Intervention and Stratification (through Nov 2015)

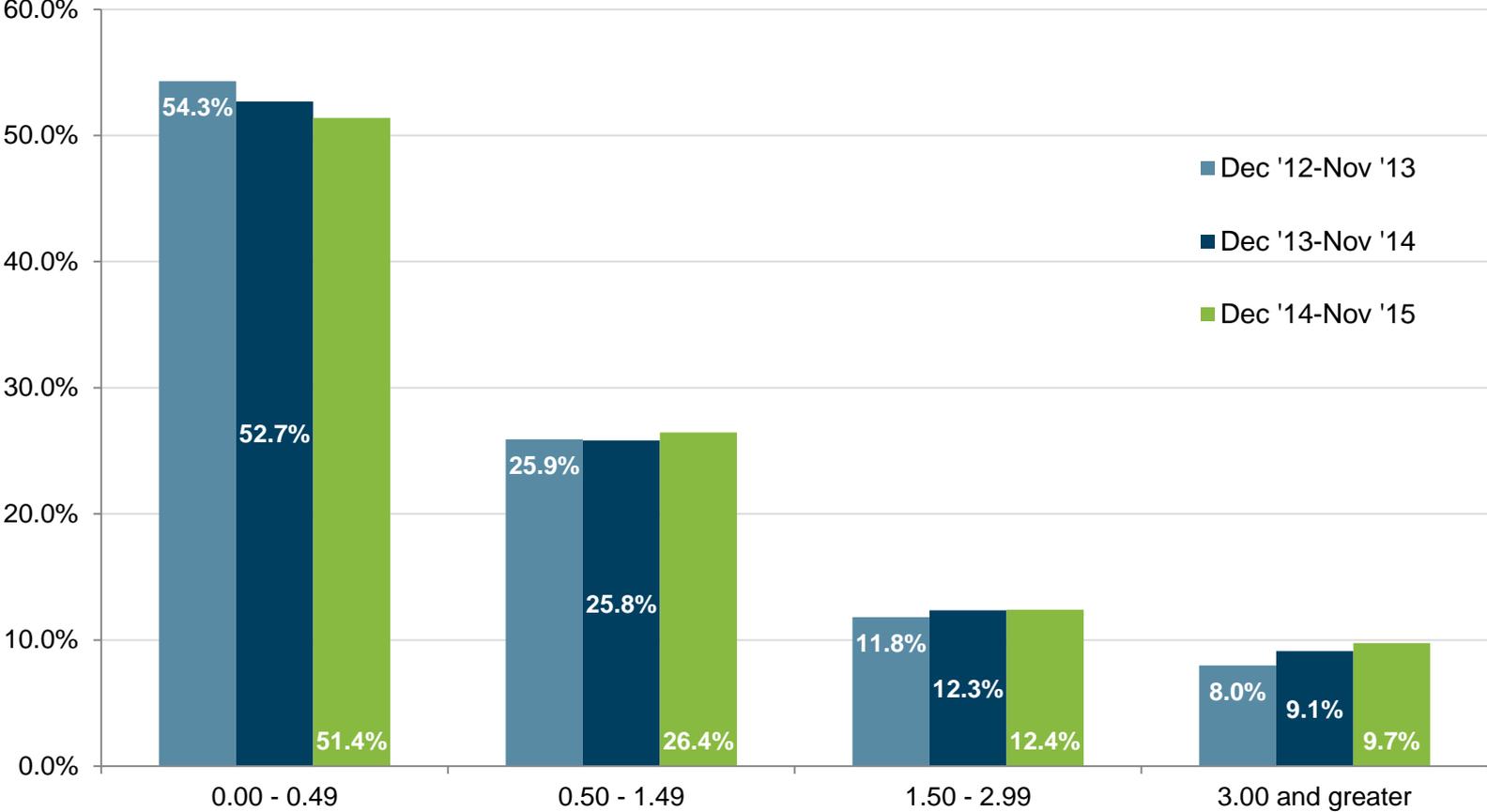
Program	Total	High Risk	Low Risk
Disease Management			
Total Enrolled	158,408	12,924	140,519
Asthma	26,078	884	25,194
CAD	53,346	1,617	51,729
CHF	4,571	819	3,752
COPD	7,545	562	6,983
Diabetes	41,548	1,555	39,993
Hyperlipidemia	91,567	992	90,575
Hypertension	106,054	2,018	104,036
Migraine	5,058	4,343	715
Lifestyle Coaching			
Weight Management: Adult	6,310	--	--
Weight Management: Pediatric	295	--	--
Coming Attraction (Maternity)	4,840	1,330	3,510

Members may be enrolled in more than one program

Risk Profile

Over Time Based On a Stable Population

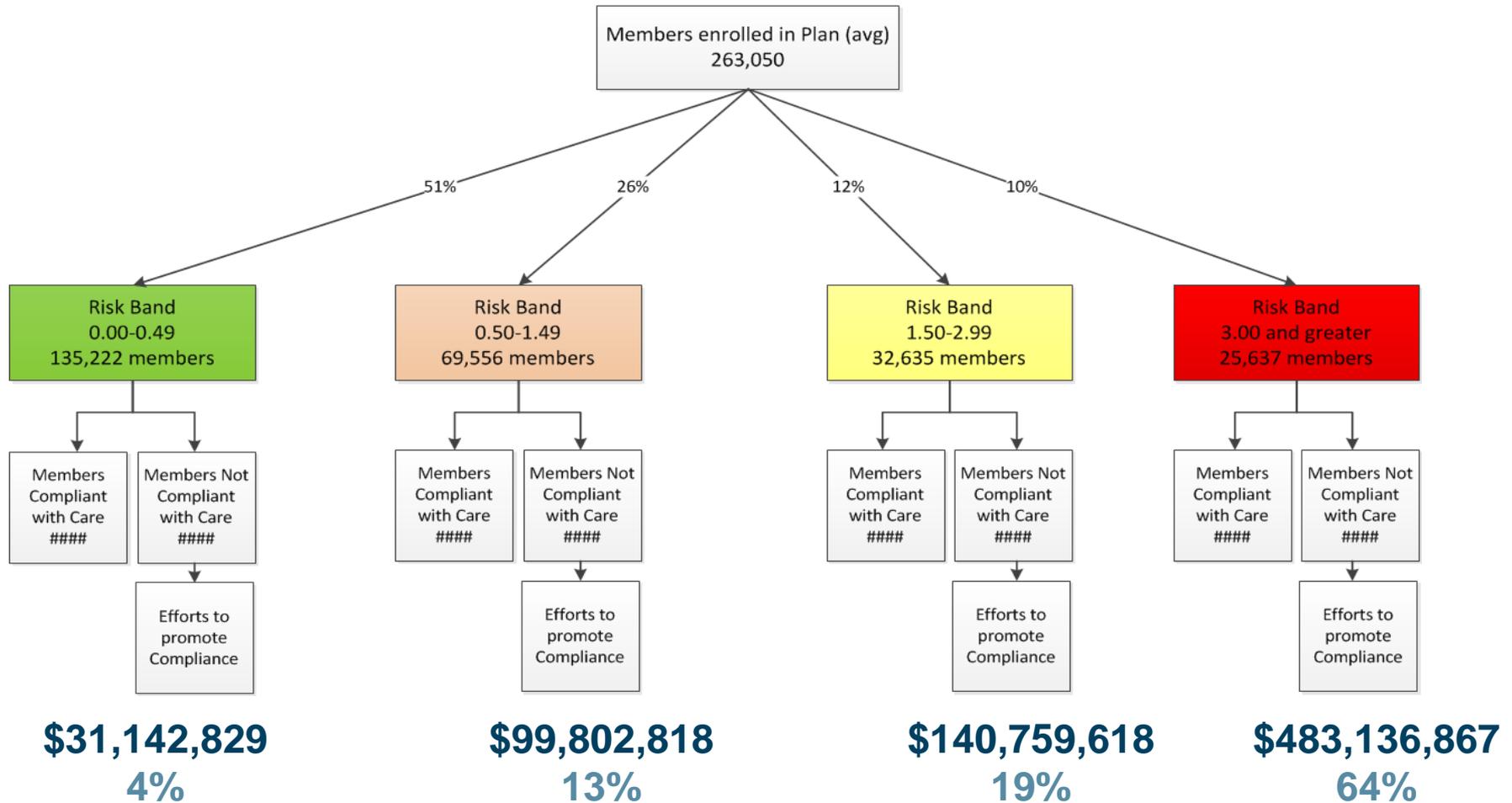
Cohort of 263,050 Members: Percentage by Risk Band



- Members Continuously Enrolled Over 36 Months
- MUSC and Retirees over 65 excluded; Medical Claims Only

Risk Profile Cascade

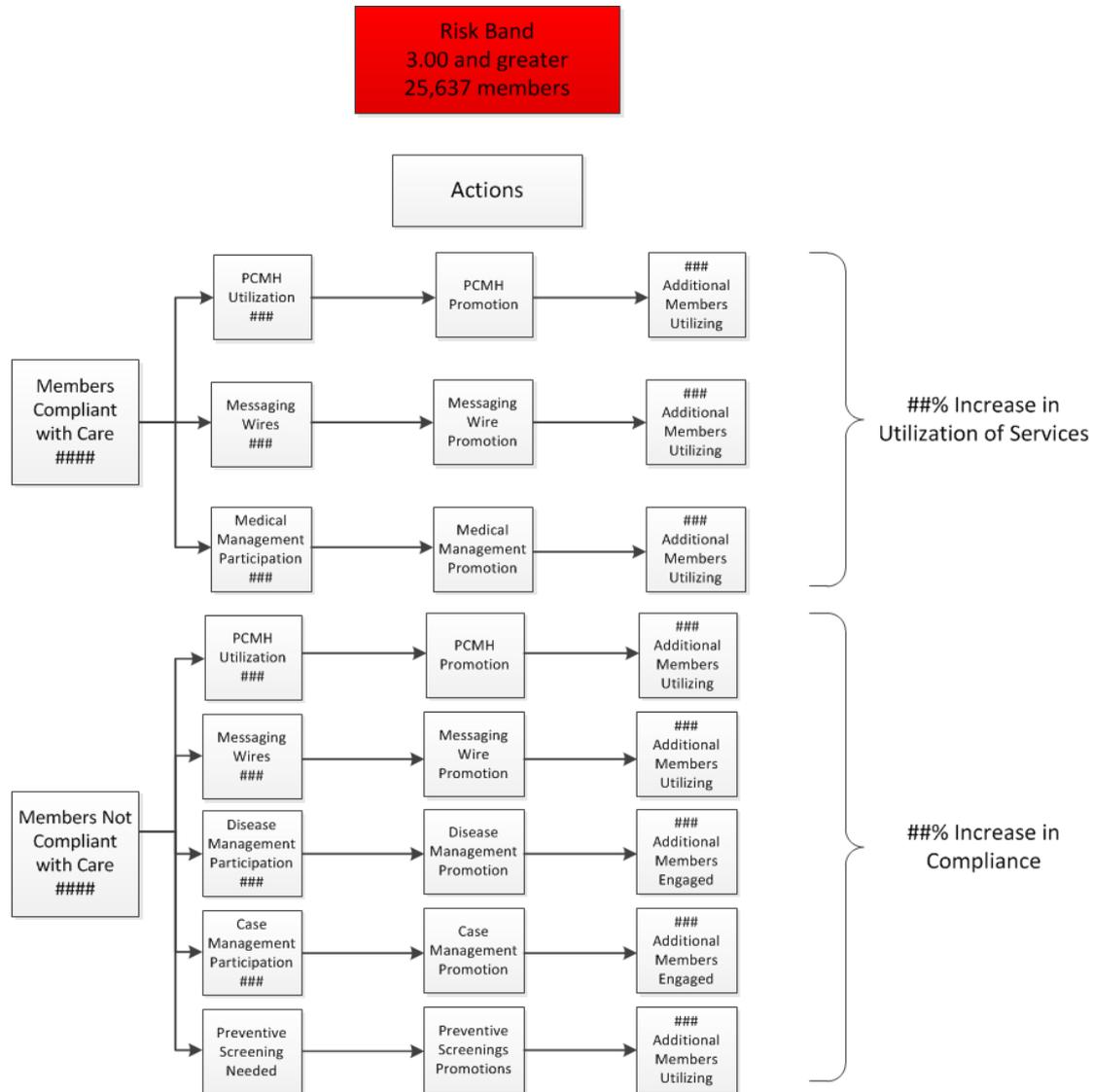
Future Population Health Stratification and Compliance Model



Total Paid

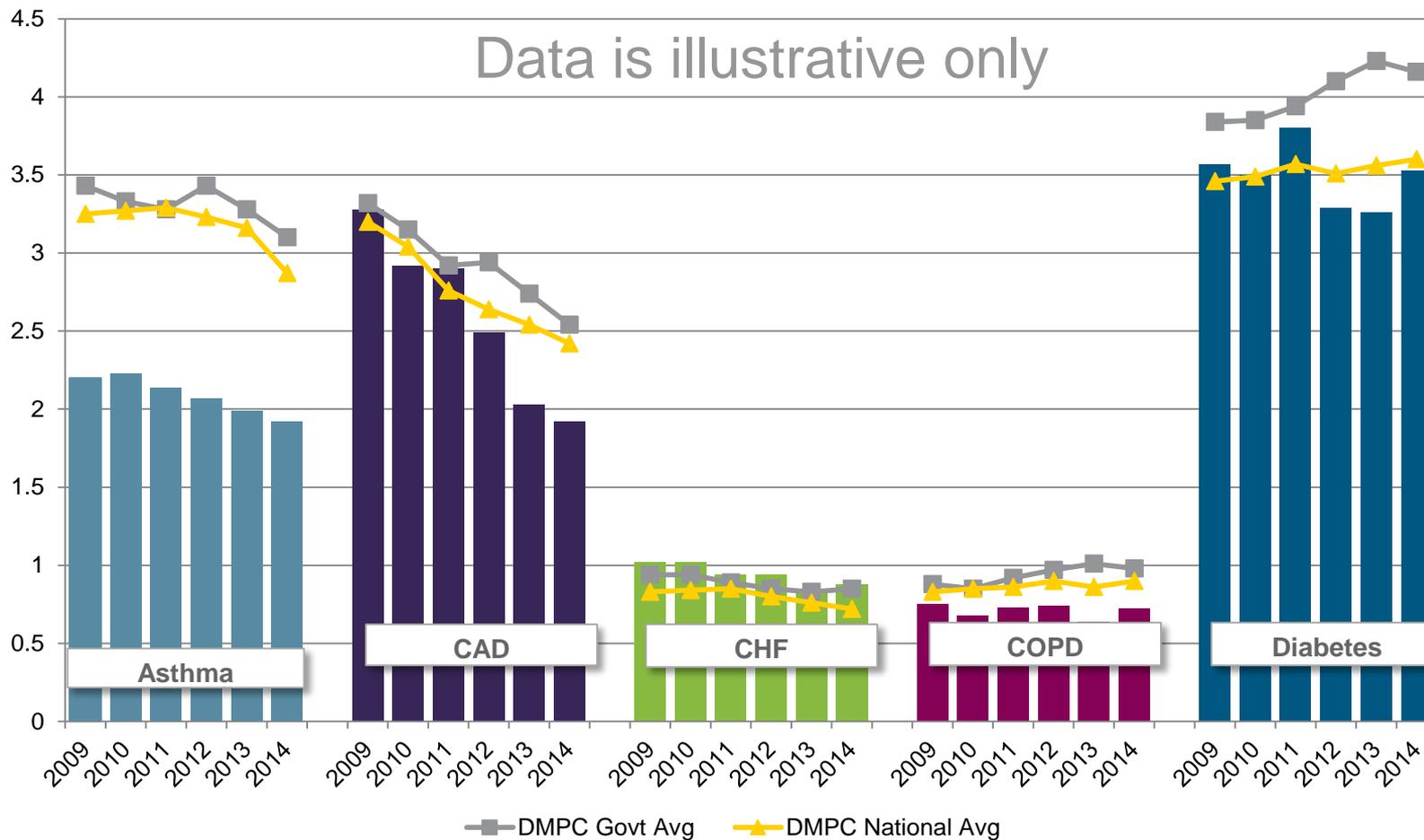
Risk Profile Cascade

Population Health Compliance



Disease Management Purchasing Consortium Analysis

Event Rates



*Event = Inpatient admission or ER visit with primary diagnosis of specified condition

Cost Drivers

Condition Prevalence

Dec '14-Nov '15

ETG Base	Episodes per 1,000			Solutions
	SHP	BoB	Variance	
Hypertension	205.3	196.3	4.65%	Health Coaching: Hypertension, Tobacco Cessation; No-Pay Copay, Biometric Screening, PCMH
Tonsillectomy/Adenoidectomy or Pharyngitis	142.8	139.3	2.5%	N/A
Hyperlipidemia, Other	92.9	97.1	-4.3%	Health Coaching: Hyperlipidemia, No-Pay Copay, Biometric Screening
Diabetes	86.5	69.8	24.0%	Health Coaching: Diabetes, Tobacco Cessation, Metabolic Health, Weight Management, No-Pay Copay, Biometric Screening, PCMH
Acute Sinusitis	86.1	79.9	7.8%	N/A
Non-Malignant Neoplasm Skin	77.0	69.7	10.4%	Case Management, Oncology Pathways, Behavioral Health Mgmt, Intensive Care Readmission Avoidance Program
Chronic Sinusitis	74.2	80.1	-7.4%	N/A
Otitis Media	71.6	73.6	-2.8%	N/A
Other Skin Inflammation	70.4	78.9	-10.8%	N/A
Joint Degeneration: Back	58.7	51.9	13.1%	Health Coaching: Back Care, Weight Management, Orthopedic Readmission Avoidance Program

	Below BoB
	1-10% above BoB
	>10% above BoB

Cost Drivers

Paid PMPM for Top 10 ETG Bases

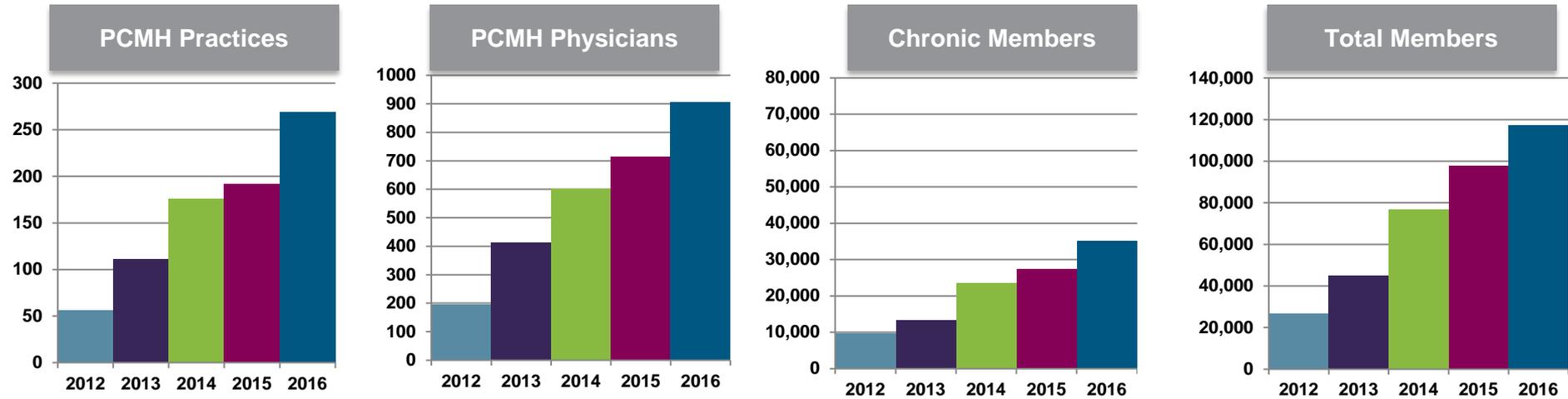
Dec '14-Nov '15

ETG Base	Paid PMPM			Solutions
	SHP	BoB	Variance	
Ischemic heart disease	\$8.15	\$8.55	-4.6%	Health Coaching: CAD, Metabolic Health, Weight Management, Tobacco Cessation
Joint Degeneration: Back	\$6.78	\$7.49	-9.5%	Health Coaching: Back Care, Weight Management, Orthopedic Readmission Avoidance Program
Join Degeneration: Knee/Leg	\$5.10	\$4.64	9.9%	Health Coaching: Weight Management, Orthopedic Readmission Avoidance Program
Malignant Neoplasm Breast	\$5.06	\$2.75	83.8%	Complex Case Management, Oncology Pathways, Behavioral Health Management, Intensive Care Readmission Avoidance Program, Metabolic Health Program; Mammogram
Chronic Renal Failure	\$4.97	\$3.59	38.5%	Case Management, Dialysis Management Program
Hypertension	\$3.56	\$3.38	5.3%	Health Coaching: Hypertension, Tobacco Cessation, No-Pay Copay, Biometric Screening, PCMH
Joint Degeneration: Neck	\$3.41	\$3.72	-8.2%	NIA
Diabetes	\$2.90	\$2.81	5.0%	Health Coaching: Diabetes, Tobacco Cessation, Metabolic Health, No-Pay Copay Program, Biometric Screening, PCMH
Pregnancy w/ Delivery	\$2.90	\$3.80	-23.7%	Maternity Management Program, Birth Outcomes Initiatives
Cerebral Vascular Disease	\$2.44	\$2.21	10.2%	Case Management

	Below BoB
	1-10% above BoB
	>10% above BoB

Patient-Centered Medical Home (PCMH) Growth

State Health Plan expansion since 2012



	2012	2013	2014	2015	2016
Practices	56	111	176	192	269
Physicians	195	414	601	715	906
SHP Chronic Members	9,562	13,227	23,380	27,461	35,087
SHP Total Membership	26,929	44,883	76,962	97,675	117,140

Patient-Centered Medical Home (PCMH) State Health Plan Participation

Condition	Jan 2016
Diabetes	8,070
Hypertension	15,079
Heart Failure	343
Asthma	992
Pediatric Wellness	10,603
Total	35,087

Glossary

Retrospective Risk Score:

Using the current period's claims, a population's current risk is calculated using the diagnoses present on claims. A risk score of 1.00 indicates average risk as compared to the benchmark population (i.e. average healthy people)

SC PEBA SHP Standard Plan– Executive Summary of January 2016

03/01/16



Plan Performance – SHP Standard Plan

- Total Plan Cost is \$38,038,701
- Total Gross Cost is \$44,241,978
- Total Member Cost is \$6,203,079

Plan Performance	
1-16 - 1-16	
AWP	\$87,576,419
Network & Mail Discount Savings (includes dispensing fees)	-\$43,335,894
Tax	\$1,452
Gross Cost	\$44,241,978
Member Cost	-\$6,203,079
Plan Cost	\$38,038,701
Member	362,639
Plan Cost PMPM	\$104.89
Net Cost PMPM	\$104.89

* Rebates are estimated based on paid and expected to be paid amounts. Actual rebate payments may differ from estimates.

Top Line Performance Metrics – SHP Standard Plan

- Plan Cost PMPM is \$104.89
- Generic Fill Rate (GFR) is 84.7%
- Specialty Plan Cost PMPM is \$31.47

SC PEBA Commercial - SHP			
Description	1-16 - 1-16	Government - State	Government - Southeast Region
Avg Subscribers per Month	189,244		
Avg Members per Month	362,639		
Number of Unique Patients	155,647		
Pct Members Utilizing Benefit	42.9%		
Total Plan Cost	\$38,038,701		
Total Days	13,487,197		
Total Rxs	412,686		
Average Member Age	37.2	1-16 - 1-16	1-16 - 1-16
Plan Cost PMPM	\$104.89	37.3	38.8
Plan Cost/Day	\$2.82	\$93.65	\$105.31
Plan Cost per Rx	\$92.17	\$2.57	\$2.77
Nbr Rxs PMPM	1.14	\$84.07	\$94.03
Generic Fill Rate	84.7%	1.11	1.12
Home Delivery Utilization	4.9%	85.4%	84.2%
Member Cost %	14.0%	15.0%	9.4%
Specialty Percent of Plan Cost	30.0%	14.0%	14.1%
Specialty Plan Cost PMPM	\$31.47	0.0%	0.0%
Formulary Compliance Rate	97.4%	\$0.00	\$0.00
		97.8%	95.7%

Key Statistics: Specialty – SHP Standard Plan

- Plan Cost PMPM in specialty drugs is \$31.47, compared to \$73.43 Plan Cost PMPM in non-specialty drugs
- There are 1,795 unique specialty patients

SC PEBA Commercial - SHP		
	Non-Specialty	Specialty
Description	1-16 - 1-16	1-16 - 1-16
Avg Subscribers per Month	189,244	189,244
Avg Members per Month	362,639	362,639
Number of Unique Patients	155,237	1,795
Pct Members Utilizing Benefit	42.8%	0.5%
Total Plan Cost	\$26,628,092	\$11,410,610
Percent of Total Plan Cost	70.0%	30.0%
Total Days	13,420,957	66,240
Total Rxs	410,681	2,005
Percent of Total Rxs	99.51%	0.49%
Plan Cost PMPM	\$73.43	\$31.47
Plan Cost/Day	\$1.98	\$172.26
Plan Cost per Rx	\$64.84	\$5,691.08
Nbr Rxs PMPM	1.13	0.006
Generic Fill Rate	85.1%	9.7%
Member Cost %	18.6%	1.2%

Specialty Government - State
1-16 - 1-16
\$0.00
\$0.00
\$0.00
0.00
0.0%
0.0%

Clinical Savings and Impact – SHP Standard Plan

- SC PEBA Commercial - SHP saved \$2,780,306 by helping patients make clinically appropriate decisions via Clinical Programs
- Savings from these programs decreased Plan Cost PMPM by 6.8%

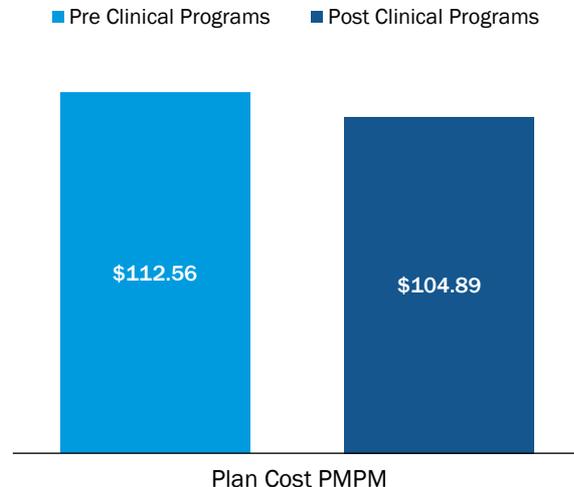
1-16 - 1-16	
Program	Plan Cost Savings
AUM	\$1,771,013
CDUR	\$991,801
RDUR	\$0
Interchange	\$17,492

AUM - Advanced Utilization Management

CDUR - Concurrent Drug Utilization Review (health and safety edits)

RDUR - Retrospective Drug Utilization Review

Interchange - Consists of two primary programs the first targets Multi-Source Brand drugs with DAW 1 or 2 alerting patients or prescribers of a Generic equivalent. The second program targets non-preferred Single-Source Brand drugs alerting prescribers of a therapeutically equivalent lower cost Generic alternative or Preferred Brand.



Program fees are not included in these savings numbers.

Top 10 Indications – SHP Standard Plan

- Diabetes represents \$6,763,904, or 17.8% of your total Plan Cost

REPRESENT
62.5%
OF YOUR TOTAL
PLAN COST

Top Indications by Plan Cost

1-16 - 1-16

AUM Strategy	Rank	Peer Rank	Indication	Rxs	Patients	Plan Cost	Peer		
							Generic Fill Rate	Generic Fill Rate	Plan Cost PMPM
ST/DQM	1	1	DIABETES	25,966	16,623	\$6,763,904	45.2%	52.9%	\$18.65
ST/PA/DQM	2	2	INFLAMMATORY CONDITIONS	1,658	1,552	\$4,960,770	15.7%	21.1%	\$13.68
ST/PA/DQM	3	5	MULTIPLE SCLEROSIS	264	245	\$2,312,450	1.5%	3.1%	\$6.38
ST/PA/DQM	4	3	CANCER	1,887	1,809	\$1,815,495	91.1%	90.2%	\$5.01
ST/PA/DQM	5	6	PAIN/INFLAMMATION	35,137	26,428	\$1,768,257	94.2%	95.2%	\$4.88
PA	6	7	ATTENTION DISORDERS	12,017	10,414	\$1,542,468	70.7%	67.3%	\$4.25
ST/DQM	7	13	HEARTBURN/ULCER DISEASE	16,785	16,339	\$1,414,790	93.1%	95.3%	\$3.90
ST/PA/DQM	8	4	HIGH BLOOD CHOLESTEROL	23,777	22,398	\$1,172,179	86.6%	83.8%	\$3.23
PA	9	9	HIV	680	428	\$1,106,145	7.5%	6.1%	\$3.05
ST/PA/DQM	10	10	ASTHMA	11,960	10,262	\$919,153	51.9%	47.2%	\$2.53
Total Top 10:				130,131		\$23,775,611	75.1%		\$65.56

Peer = Express Scripts Peer 'Government - State' market segment

Top 10 Specialty Indications – SHP Standard Plan

Top Specialty Indications by Plan Cost							
1-16 - 1-16							
AUM Strategy	Overall Rank	Overall Peer Rank	Indication	Rxs	Patients	Plan Cost	Plan Cost PMPM
ST/PA/DQM	2	2	INFLAMMATORY CONDITIONS	941	901	\$4,509,912	\$12.44
ST/PA/DQM	3	5	MULTIPLE SCLEROSIS	264	245	\$2,312,450	\$6.38
ST/PA/DQM	4	3	CANCER	200	182	\$1,692,280	\$4.67
N/A	17	42	HEMOPHILIA	14	8	\$581,882	\$1.60
ST/PA	18	12	HEPATITIS C	21	15	\$513,902	\$1.42
ST/PA	29	33	GROWTH DEFICIENCY	57	55	\$270,682	\$0.75
ST/PA/DQM	32	30	PULMONARY HYPERTENSION	40	27	\$229,106	\$0.63
PA/DQM	33	27	CYSTIC FIBROSIS	24	16	\$227,884	\$0.63
ST/DQM	37	82	INFERTILITY	137	60	\$148,426	\$0.41
ST/PA/DQM	10	10	ASTHMA	46	43	\$133,803	\$0.37
Total Top 10:				1,744		\$10,620,326	\$29.29

Peer = Express Scripts Peer 'Government - State' market segment

Patient Stratification – SHP Standard Plan

Patient Care Needs

Well

Smoking Cessation, Allergies, Constipation/Anti diarrheals, Topical Antifungal / Anti-bacterial infection treatment

Acute

Colds & Flu, Strep Throat, Ear Infection, Headache, Sprains

Chronic

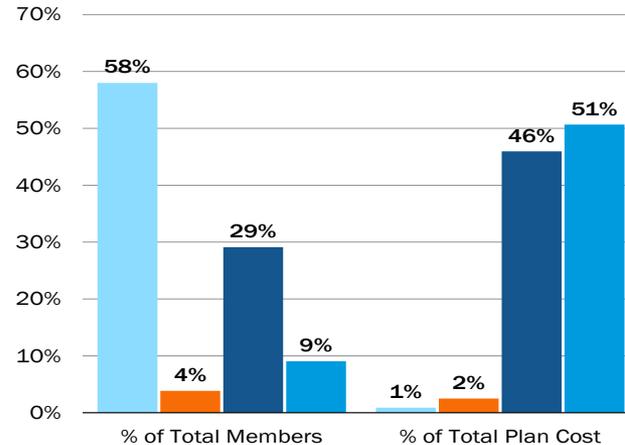
Heart Disease, Diabetes, Arthritis, High Blood Pressure, High Cholesterol, Dementia, Back Pain

Complex

Multiple Chronic Conditions such as Heart Failure & Diabetes, Cancer, AIDS, Multiple Sclerosis, Metabolic Syndrome

GFR % calculated with Unadjusted Rx

Current



	Well	Acute	Chronic	Complex	Total
Members	210,318	13,937	105,569	32,815	362,639
Members %	58.0%	3.8%	29.1%	9.0%	100.0%
Plan Cost	\$343,599	\$945,008	\$17,478,959	\$19,271,135	\$38,038,701
Plan Cost %	0.9%	2.5%	46.0%	50.7%	100.0%
Member Age (Avg.)	29.1	27.5	46.2	53.5	37.2
Copay	\$35,892	\$208,371	\$3,726,785	\$2,232,031	\$6,203,079
Copay/Member	\$0	\$15	\$35	\$68	\$17
Plan Spend/Member	\$2	\$68	\$166	\$587	\$105
Days of Therapy/Member	0.5	23.2	77.4	148.9	37.2
GFR %	81.2%	89.8%	85.9%	82.0%	84.7%
Home Delivery Utilization	2.9%	1.1%	4.7%	5.6%	4.9%



Our Technology Transforms data into individualized action

Our CareEngine technology monitors SC PEBA health plan members for opportunities to improve the quality of medical care they receive and reduce healthcare costs by preventing avoidable hospitalizations and urgent medical care.

Opportunities for improved healthcare, “Care Considerations” are sent to physicians treating your plan members. These Care Considerations when acted upon result in better healthcare and lower overall healthcare costs.



CareEngine Technology

- Most current evidence-based literature supporting over 10,000 clinical rules
- Tracks individual member health status
- Ingests and scans multiple medical and consumer data sources
 - ✓ Medical claims
 - ✓ Lab
 - ✓ Rx
 - ✓ Financial
 - ✓ Disability
 - ✓ HIE
 - ✓ Providers
 - ✓ Biometrics
- Communicates Care Considerations to providers via phone, fax and mail
- Supports better, more appropriate care and lower costs
- Spreads awareness of established medical guidelines
- Encourages the use of evidence-based services
- Encourages and incorporate feedback from providers

Types of Care Considerations

Consider adding certain medications:

- ✓ Recommend adding a classification of medication called an ACE/ARB in someone with a history of heart disease or heart attack. This medication can lower the risk of another heart attack or stroke preventing emergency room use or hospitalization or even death.

Consider appropriate condition monitoring:

- ✓ Recommend HbA1c monitoring when not being done routinely. This measures average blood sugar level over time in diabetics. Blood sugar control is key to preventing the worsening of diabetes, and avoiding urgent care needs or hospitalizations for uncontrollable diabetes.

Consider a diagnostic work-up:

- ✓ Claims evidence shows a person with blood in their urine (hematuria) but with no diagnosis or evidence of a workup to determine the cause. Recommendation that a work up be completed. Unexplained persistent hematuria should be evaluated for bladder or kidney disease including infection, stone or cancer.

There are 3 levels of intensity with Care Considerations:

- ✓ Severity Level 1 - Clinically Urgent, potential for life threatening consequences for the member such as a heart attack or stroke
- ✓ Severity Level 2 - Clinically Important, potential for adverse consequences to a member's health such as worsening of diabetes
- ✓ Severity Level 3 – Health Maintenance, potential for better overall health through screenings for undetected health issues or age appropriate immunizations.



Executive Summary Report

Client Name :

STATE OF SC EIP - STANDARD PLAN NON-MEDICARE

Care Consideration Activity :

January 1, 2015 - December 31, 2015

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Client Profile

Total Eligible Members	340,979
Number of Eligible Employees	178,616
Number of Members to Employees	1.9
Program Implementation Date	02/01/2006
Average Age of Members	35.0
Female/Male Split	57.1/ 42.9
Population Type	Standard

Care Consideration - Book of Business Profile

Total Eligible Members	8,498,121
Number of Eligible Employees	4,055,278
Number of Members to Employees	2.1
Average Age of Members	33.0
Female/Male Split	50.8/ 49.2

Executive Summary Report
Executive Summary
January 1, 2015 - December 31, 2015

Care Consideration (CC) Opportunities			
	CCs	CCs/ 1,000	BoB CCs/ 1,000
Total Care Consideration Volume	65,526	192.2	224.4
Severity 1 CCs	1,882	5.5	4.1
Severity 2 CCs	57,317	168.1	169.0
Severity 3 CCs	6,327	18.6	51.3

Care Consideration Results (% Compliance)		
	Client %	BoB %
Total Care Consideration Compliance	35.6%	33.3%
Severity 1 CCs	75.5%	63.8%
Severity 2 CCs	35.5%	35.3%
Severity 3 CCs	27.0%	24.7%

Note: These results show your % compliance ("resolution") projected for the 12-month reporting period, based on measured compliance for the first 6 months and volume-issued for the second 6 months. We provide a projection because compliance is not measured until 6 months after the close of the quarter a CC is issued.

Care Consideration Savings	
Total PMPM Savings	\$4.73
Total Annual Savings	\$19,351,060

**Executive Summary Report
Care Consideration Results
January 1, 2015 - December 31, 2015**

	01/01/15 thru 12/31/15	01/01/15 thru 12/31/15 per 1,000	BoB 01/01/15 thru 12/31/15 per 1,000	10/01/14 thru 09/30/15	07/01/14 thru 06/30/15	04/01/14 thru 03/31/15
Total Eligible Population	340,979			339,361	337,604	338,636
Volume of CCs	65,526	192.2	224.4	69,106	73,487	82,884
Severity 1	1,882	5.5	4.1	2,289	2,288	2,564
Severity 2	57,317	168.1	169.0	59,351	62,389	68,427
Severity 3	6,327	18.6	51.3	7,466	8,810	11,893
% of Total CCs that were Member Derived	0.0%			0.0%	0.0%	0.0%
Unique Members with CCs	36,132	106.0	108.7	37,606	37,990	39,600
% of Total Population with CCs	10.6%			11.0%	11.0%	12.0%
Compliance	35.6%					
Severity 1 Compliance	75.5%					
Severity 2 Compliance	35.5%					
Severity 3 Compliance	27.0%					
CC Savings	\$ 4.73					
Total Annual Savings	\$19,351,060					

**Executive Summary Report
Care Consideration Actual Volumes
January 1, 2015 - December 31, 2015**

Care Consideration Actual Volumes						
	10/01/15 thru 12/31/15			01/01/15 thru 12/31/15		
	CCs	CCs/ 1,000	BoB CCs/ 1,000	CCs	CCs/ 1,000	BoB CCs/ 1,000
TOTAL CC VOLUMES	16,870	49.4	48.0	65,526	192.2	224.4
By Severity Level						
Severity 1	323	0.9	0.9	1,882	5.5	4.1
Severity 2	15,123	44.3	35.6	57,317	168.1	169.0
Severity 3	1,424	4.2	11.5	6,327	18.6	51.3
By Severity Level Total	16,870	49.4	48.0	65,526	192.2	224.4
By Type						
Add/Intensify Medical Therapy	8,668	25.4	18.4	27,022	79.2	91.1
Condition/Drug Monitoring	5,775	16.9	20.5	27,162	79.7	94.8
Diagnostic Workup	429	1.3	1.7	2,145	6.3	8.3
Drug-Drug Interaction	632	1.9	0.9	2,737	8.0	3.9
Stop/Modify a Drug	1,051	3.1	3.3	4,854	14.2	14.7
Others	315	0.9	3.1	1,606	4.7	11.6
By Type Total	16,870	49.4	48.0	65,526	192.2	224.4
By Condition						
Asthma	247	0.7	1.2	1,192	3.5	5.4
Cardiovascular Diseases	1,823	5.3	6.7	7,423	21.8	35.2
Chronic Kidney Disease	319	0.9	1.2	1,529	4.5	5.6
Diabetes	9,099	26.6	21.8	29,459	86.4	101.8
Heart Failure	202	0.6	0.7	1,110	3.3	3.9
Lipid Disorders	29	0.1	0.2	410	1.2	1.7
Liver Diseases	460	1.3	0.7	1,831	5.4	2.8
Nervous System Diseases	271	0.8	0.6	1,149	3.4	2.7
Osteoporosis	235	0.7	1.2	1,142	3.3	5.7
Peripheral Arterial Disease	25	0.1	0.1	118	0.3	0.4
Others	4,160	12.2	13.5	20,163	59.1	59.2
By Condition Total	16,870	49.4	48.0	65,526	192.2	224.4

**Executive Summary Report
Care Consideration Savings
January 1, 2015 - December 31, 2015**

Care Consideration Savings - PMPM Savings								
	10/01/15 thru 12/31/15				01/01/15 thru 12/31/15			
	CC Volume	% Compliance	% of Total Savings	PMPM Savings	CC Volume	% Compliance	% of Total Savings	PMPM Savings
Total	16,870	35.6%		\$4.93	65,526	35.6%		\$4.73
Measured - by Severity Level								
Severity 1	323	75.5%	2.1%	\$0.10	1,882	75.5%	13.4%	\$0.63
Severity 2	15,123	35.5%	97.9%	\$4.83	57,317	35.5%	86.6%	\$4.10
Severity 3	1,424	27.0%	0.0%	\$0.00	6,327	27.0%	0.0%	\$0.00
Measured - by Type								
Add/Intensify Medical Therapy	8,668	24.2%	56.1%	\$2.77	27,022	24.2%	37.6%	\$1.78
Condition/Drug Monitoring	5,775	43.5%	30.0%	\$1.48	27,162	43.5%	29.6%	\$1.40
Diagnostic Workup	429	17.8%	1.9%	\$0.09	2,145	17.8%	2.3%	\$0.11
Drug-Drug Interaction	632	70.3%	4.1%	\$0.20	2,737	70.3%	12.8%	\$0.61
Stop/Modify a Drug	1,051	56.5%	6.8%	\$0.34	4,854	56.5%	16.7%	\$0.79
Others	315	11.0%	1.1%	\$0.05	1,606	11.0%	0.9%	\$0.04
Measured - by Condition								
Asthma	247	36.8%	1.6%	\$0.08	1,192	36.8%	2.3%	\$0.11
Cardiovascular Diseases	1,823	26.9%	11.8%	\$0.58	7,423	26.9%	10.6%	\$0.50
Chronic Kidney Disease	319	47.2%	1.6%	\$0.08	1,529	47.2%	2.0%	\$0.09
Diabetes	9,099	32.3%	58.3%	\$2.87	29,459	32.3%	34.0%	\$1.61
Heart Failure	202	21.3%	1.3%	\$0.06	1,110	21.3%	4.1%	\$0.19
Lipid Disorders	29	32.1%	0.2%	\$0.01	410	32.1%	0.2%	\$0.01
Liver Diseases	460	25.1%	0.4%	\$0.02	1,831	25.1%	0.3%	\$0.01
Nervous System Diseases	271	59.5%	1.8%	\$0.09	1,149	59.5%	4.3%	\$0.20
Osteoporosis	235	11.3%	1.4%	\$0.07	1,142	11.3%	0.9%	\$0.04
Peripheral Arterial Disease	25	31.0%	0.2%	\$0.01	118	31.0%	0.2%	\$0.01
Others	4,160	27.9%	21.5%	\$1.06	20,163	27.9%	41.3%	\$1.95

Note: Due to rounding, individual lines items may appear not to add up to the total.

Report Notes

* Savings are projected for the 12-month reporting period, based on (a) first 6 months: measured, from severity 1 and 2 CCs showing actual evidence of compliance; (b) second 6 months: projected, from severity 1 and 2 CCs issued and the compliance rate from the first 6 months carried-forward. This projection for the most recent 6 months is necessary because CC compliance is measured six months following the quarter in which the CC was issued.

* Reported savings are cost-avoidance, based on the health economic model (which is based on avoided clinical events from the medical literature and the cost of such events), and do not include CareEngine fees. Please see the glossary for discussion of the savings model.

APPENDIX

Executive Summary Report
CC Appendix 1 : Top 25 CC Details
January 1, 2015 - December 31, 2015

CC ID	Severity	Adverse Event	Condition Category	Care Consideration Description	Claims Derived CCs	Member Derived CCs	Total CC Count
1312	2	Cardiovascular event (e.g., heart attack)	Diabetes	Diabetes - Consider Adding a Statin	13,825	0	13,825
75	2	Diabetic complications (e.g., kidney disease)	Diabetes	Diabetes - Consider HbA1c Monitoring	6,823	0	6,823
120	2	Diabetic complications (e.g., kidney disease)	Diabetes	Diabetes - Consider Screening for Microalbuminuria	4,868	0	4,868
608	2	Low or high thyroid hormone level (hypo- or hyperthyroidism)	Thyroid Diseases	Levothyroxine - Consider TSH Monitoring	4,284	0	4,284
610	2	Cardiovascular event (e.g., heart attack)	Cardiovascular Diseases	Atherosclerotic Cardiovascular Disease - Consider Adding a Statin	3,238	0	3,238
1314	2	Cardiovascular event (e.g., heart attack)	Cardiovascular Diseases	At Risk for Atherosclerotic Cardiovascular Disease (Primary Prevention) - Consider Adding a Statin	3,057	0	3,057
913	2	Cardiovascular event (e.g., heart attack);Kidney disease	Diabetes	Diabetes and Hypertension - Consider Adding an ACE Inhibitor or ARB	1,459	0	1,459
152	2	Build up of acid in body fluids (acidosis)	Diabetes	Metformin - Consider Renal Function Monitoring	1,360	0	1,360
775	3	Inflammation of liver (hepatitis)	Liver Diseases	NSAIDS - Consider Liver Function Monitoring	1,130	0	1,130
684	2	High potassium level;Slow heart beat	Water-Electrolyte Imbalance	Concomitant Use of Drugs Known to Cause Hyperkalemia - Consider Potassium Monitoring	1,035	0	1,035
544	2	Recurrent breast cancer	Breast Cancer	History of Breast Cancer - Consider Cancer Surveillance	917	0	917
80	2	Cardiovascular event (e.g., heart attack)	Cardiovascular Diseases	CAD with Risk Factors - Consider Adding an ACE Inhibitor	832	0	832
807	2	Gastrointestinal (GI) bleeding	Drug Toxicity	SSRI with NSAIDs - Increase Risk of GI Bleeding	642	0	642
1177	2	Disease of muscle (myopathy)	Hyperlipidemia (High Cholesterol)	Amlodipine or Ranolazine - Avoid with Simvastatin Greater Than 20mg	628	0	628
978	3	Build up of acid in body fluids (acidosis)	Acid-Base Imbalance	Topiramate or Zonisamide - Consider Bicarbonate Monitoring	563	0	563
456	2	Worsening of asthma	Asthma	Asthma - Consider Adding a Short-Acting Beta Agonist Inhaler for Rescue Therapy	549	0	549
1299	3	Diabetes	Mental Health	Atypical Antipsychotics - Consider Screening for Diabetes	506	0	506
90	2	Bleeding	Peptic Ulcer Disease	NSAIDs and Antithrombotic Therapy - Avoid Concomitant Use	473	0	473
91	2	Worsening of high blood pressure	Hypertension	NSAIDS - May Exacerbate Hypertension	467	0	467
412	2	Worsening of asthma	Asthma	Asthma - Consider Step 2 Therapy	461	0	461
711	2	Worsening of allergic rhinitis	Rhinitis	Chronic Antihistamine Use - Consider Adding Nasal Steroid Therapy	449	0	449
487	3	Inflammation of liver (hepatitis)	Liver Diseases	Terbinafine - Consider Liver Function Monitoring	439	0	439
393	2	Uncontrolled high blood pressure	Hypertension	Resistant Hypertension - Consider Workup for Renal Artery Stenosis	420	0	420
512	2	Tuberculosis	Immune System Diseases	TNF Inhibitors - Consider Screening for Latent TB	420	0	420
566	2	Diabetic complications (e.g., kidney disease)	Diabetes	Elevated HbA1C - Consider Follow-up HbA1C	398	0	398
-	-	-	-	All Other	16,259	24	16,283

Glossary of Terms

Care Consideration Related

Adverse Event

An unfavorable health outcome. In the case of this report, The Adverse Event is the health issue that the Care Consideration is designed to prevent

Care Consideration Description

A brief summary of the Care Consideration used in reports and other documents where a quick reference is helpful.

Care Consideration Savings

The number shown is a one-year projection. It reflects the cost of adverse clinical events avoided through compliance with Severity 1 and Severity 2 Care Considerations issued during the reporting period. The cost of complying (e.g., starting a medication, doing a test or procedure) is taken into account when calculating the savings. CCs for which compliance cannot be accurately measured by an automated process are given an average compliance rate and savings derived from the book of business compliance rate and savings for their Severity level.

Care Consideration Severity

Care Considerations are categorized according to the degree of urgency.

- **Severity 1:** Clinically urgent. A potentially serious issue where urgent communication with the treating physician could have a significant impact. Communicated via fax or letter if no fax number available.
- **Severity 2:** Clinically important. A potentially serious but non-urgent issue. Communicated via letter.
- **Severity 3:** Clinically Notable. A less severe issue involving generally recognized standards of care. Communicated via letter.

Care Consideration Type

The "type" refers to the kind of gap in care the Care Consideration addresses (e.g., drug/condition monitoring, add/intensify medical therapy, diagnostic workup).

Compliance

The percentage of Care Considerations that have been successfully resolved (the action discussed in the Care Consideration was implemented by the treating provider and/or patient). When a 12-month compliance rate is shown, it is a combination of actual compliance measured from claims for the first six months of the period and projected compliance for the second six months. (This projection is needed because compliance cannot be documented from claims until 6 months after the close of the quarter in which the CC is issued.)

Condition Classification

A way of categorizing Care Considerations according to the high level condition or issue they address.

Claims-Derived Care Considerations

These Care Considerations are generated based on information from medical claims, lab results and/or drug data.

Member-Derived Care Considerations

These Care Considerations are generated based on at least one piece of clinical information provided by the member (e.g., through the MyActiveHealth website or an ActiveHealth nurse), such as smoking status or use of OTC medications.

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
Health Care Policy Committee

Meeting Date: March 17, 2016

1. Subject: Adopt Mission Statement and Approve Health Care Committee Charter

2. Summary: The Health Care Policy Mission Statement has been revised and the Committee Charter must be approved to reflect this change.

3. What is Committee asked to do? Adopt the revised mission statement and approve the revised Health Care Committee Charter.

4. Supporting Documents:

(a) Attached:

1. Revised Health Care Policy Charter

Health Care Policy Committee Charter

[As amended by Health Care Policy Committee on 3.17.16]

(A) Mission: To ensure a financially sustainable health program that improves member health, and provides a positive member experience.

(B) Authority: The authority of the Health Care Policy Committee is limited to information-gathering and advice and recommendations to, and on behalf of, the Board, and to ministerial acts. The Committee may invite administrators, consultants, staff, external auditors, and/or others to attend meetings and provide pertinent information as necessary. PEBA Board of Directors Bylaws, Section V(C).

(C) Composition: The Health Care Policy Committee shall be established pursuant to the process defined in the PEBA Board of Directors Bylaws.

(D) Meetings:

- (1) The Health Care Policy Committee will meet as circumstances require upon the call of the Committee Chair.
- (2) Health Care Policy Committee meetings shall adhere to the rules outlined in the PEBA Board of Directors Bylaws and with applicable law.

(E) Responsibilities: The Health Care Policy Committee will carry out the following responsibilities:

- (1) Develop a strategic plan for PEBA insurance functions in conjunction with PEBA staff and consultants, make recommendations to the PEBA Board, and evaluate the implementation and success of the plan.
- (2) Approve pilot projects for upcoming plan years that focuses on improved health and lower costs, with appropriate evaluation methods of health outcomes, costs, and resources identified;
- (3) At least quarterly, meet with the PEBA Executive Director, or a designee, regarding the operational and financial performance of the PEBA insurance programs to monitor progress toward strategic objectives and make recommendations to the PEBA Board;
- (4) No later than November of each year, develop recommendations to the PEBA Board concerning proposed premiums for the proposed State Health Plan for the Plan Year beginning thirteen months later for purposes of the State's budgeting process;
- (5) No later than July of each year, considering the final State budget, make recommendations to the PEBA Board regarding the final State Health Plan design and final premiums for the State Health Plan for the Plan Year beginning six months later;
- (6) Receive information from the actuaries concerning the Other Post Employment Benefits (OPEB) valuations for retirees in the State Health Plan and for beneficiaries of Long-Term Disability benefits and make recommendations to the PEBA Board; and

(7) Oversee agency communications involving areas of Health Care responsibilities.

As approved and adopted:

**SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
BOARD OF DIRECTORS**

By: _____
John A. Sowards, Chairman

By: _____
Stephen C. Osborne

By: _____
Frank W. Fusco

By: _____
Stephen Heisler

By: _____
Stacy Kubu

By: _____
Sheriff Leon Lott

By: _____
Steve A. Matthews

By: _____
Joe W. "Rocky" Pearce, Jr.

By: _____
Audie Penn

By: _____
David J. Tigges

Dated: _____