PEBA
SC Retirement Systems and State Health Plan

South Carolina Public Employee Benefit Authority
Serving those who serve South Carolina

Meeting Agenda

|Health Care Policy Committee |Finance, Administration, Audit and Compliance Committee |Retirement Policy Committee| Board of Directors
Wednesday, March 12, 2025 | 202 Arbor Lake Drive., Columbia, SC 29223| 1st Floor Conference Room

Health Care Policy Committee |9:30 a.m.

I. Call to Order
II. Approval of Meeting Minutes – December 4, 2024
III. State Health Plan Benchmark Review
IV. Virta Clinical Outcomes Annual Review
V. AI in the Healthcare Industry: Artificial or Intelligent?
VI. Committee Charter Review
VII. Old Business/Director's Report
VIII. 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 12, 2025

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1. Subject: State Health Plan Benchmarks

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2. Summary: Rob Tester will review the latest iteration of the State Health Plan's annual comparison with national and regional benchmarks.

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3. What is Committee asked to do? Receive as information

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4. Supporting Documents:

(a) Attached: 1. SHP Benchmarks March 2025
2. SHP Benchmarks Appendix March 2025

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State Health Plan benchmarks

Health Care Policy Committee

March 12, 2025

State Health Plan enrollment as of March 2025

Participants		
Subscribers		307,252
Actives	210,089	
Retirees	94,157	
Others	3,006	
Spouses		90,754
Children		145,748
Total covered lives		**543,754**

Total employer groups: 863

Active subscribers	
State agencies	35,642
Higher education	27,731
School districts	88,022
Charter schools	3,917
Local subdivisions	39,542
MUSC hospitals	12,505
Other	2,730
Total employees	**210,089**

Retirees	
Medicare	78,279
Non-Medicare	15,878
Total retirees	**94,157**
Funded retirees	***87,528***

Numbers represent enrollment in the State Health Plan, the MUSC Health Plan and TRICARE Supplement Plan.

State Health Plan versus national trends

Target is to maintain net expenditure growth at least two points below benchmark.

	Benchmark	State Health Plan
2020	5.7%	3.7%
2021	8.6%	7.3%
2022	6.9%	1.1%
2023	8.2%	7.8%
2024	8.3%	5.1%[1]
5-year average (2020-2024)	**7.6%**	**5.0%**

[1]Incurred in 12 months; paid in 13 months.

The benchmark is a blended number derived from annual health care cost trend surveys produced by national consulting firms including Aon, Buck, Mercer, PriceWaterhouseCoopers, Segal and Willis Towers Watson, when available.

State Health Plan contribution rate increases versus CPI growth for medical care

Target is to control annual contribution increase to no more than CPI for medical care plus 3 percentage points. Two-year lag in CPI data used for measure because of timing of the State Health Plan rate setting process.

	State Health Plan total rate increase		Medical care CPI increase
2022	0.6%	**2020**	1.8%
2023	14.2%	**2021**	2.2%
2024	3.0%	**2022**	4.0%
2025	9.7%	**2023**	0.5%
2026	3.9%	**2024**	2.8%
5-year average (2022-2026)	**6.3%**	**5-year average (2020-2024)**	**2.3%**

2024 Average monthly total premiums[1]

	Single	Family
State Health Plan	$575	$1,578
Large public and private sector employers[2]	$769	$2,206
Public and private sector in South[3]	$754	$2,178
Public employers	$749	$1,978
Private – manufacturing	$757	$2,208
Private – financial services	$797	$2,327

[1]Average monthly total premiums in PPO (Preferred Provider Organization) plans
[2]Large public and private sector employers: ≥ 200 employees in public and private sectors
[3]Public and 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

Data from the *Kaiser Family Foundation Employer Health Benefits 2024 Annual Survey*

2024 Average annual deductible[1]

	Amount
State Health Plan	$515
Large public and private sector employers[2]	$1,048
All employers	$1,252

[1]Average annual deductible in PPO (Preferred Provider Organization) plans
[2]Large public and private sector employers: ≥ 200 employees in public and private sectors

Data from the *Kaiser Family Foundation Employer Health Benefits 2024 Annual Survey*

2023 Average annual gross plan cost per active employee[1]

	Amount[2]
State Health Plan	$14,051
Public employers	$16,457
Private – manufacturing	$16,359
Private – financial services	$17,695
All employers	$16,309
Employers – 500+	$16,249
Employers – 20k+	$15,569
South[3]	$15,311

[1]Average cost in PPO (Preferred Provider Organization) and POS (Point of Service) plans
[2]Average 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
[3]South includes Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

Data from the 2023 *Mercer National Survey of Employer-Sponsored Health Plans*

2025 Composite monthly premiums[1]

	Employer	Employee	Total
State Health Plan	$792.37	$159.31	$951.68
South[2]	$926.91	$209.95	$1,136.86
United States	$1,145.80	$199.25	$1,345.05
State Health Plan percentage of regional average	85.5%	75.9%	83.7%
State Health Plan percentage of national average	69.2%	80.0%	70.8%

Survey uses most prevalent plan among state employee options for analysis.
[1]Composite monthly premiums: Weighted average of all PEBA health subscribers enrolled in each coverage level
[2]South includes Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

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

Compensation study findings

The South Carolina Department of State Human Resources (DSHR) engaged Mercer to evaluate the competitiveness of compensation across the state and to review the pay structures and practices in place today.

	Vs. Public Sector	Vs. Private Sector	Observations
Retiree medical	=	↑	• Providing employer-subsidized coverage is aligned with Public Sector and above market practice for the Private sector
Medical	=	↑ / =	• Aligned with market in offering both PPO and HDHP options • PPO plan is aligned with or more generous than market for most plan features • HDHP cost share is more generous than median for both markets; however, this is offset by higher deductibles and out-of-pocket limits compared to market; lack of employer contributions to the HSA also lags the market

Medical market positioning

	Cost share	Deductibles	Out-of-pocket maximums	Coinsurance
PPO	Aligned with Public Sector	More generous than both markets	More generous than both markets	Aligned with both markets
	More generous than Private Sector			
HDHP	More generous than both markets	Less generous than both markets	Less generous than both markets	Aligned with both markets

Data from the Mercer *Compensation Study Summary and Outcomes*

Disclaimer

This presentation does not constitute a comprehensive or binding representation of the employee benefit programs PEBA administers. The terms and conditions of the employee benefit programs PEBA administers are set out in the applicable statutes and plan documents and are subject to change. Benefits administrators and others chosen by your employer to assist you with your participation in these employee benefit programs are not agents or employees of PEBA and are not authorized to bind PEBA or make representations on behalf of PEBA. Please contact PEBA for the most current information. The language used in this presentation does not create any contractual rights or entitlements for any person.

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Appendix: State Health Plan benchmarks

Health Care Policy Committee

March 12, 2025

2024 Average monthly contribution by employees

	Single	Family
State Health Plan	$98	$307
Large public and private sector employers[1]	$135	$514
Public and private sector in South[2]	$126	$610

[1]Large public and private sector employers: ≥ 200 employees in public and private sectors
[2]Public and 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

Data from the *Kaiser Family Foundation Employer Health Benefits 2024 Annual Survey*

2024 Average percentage of contribution by employer

	EE contribution	Total premium	ER contribution
State Health Plan			
Single	$98	$575	82.9%
Family	$307	$1,578	80.6%
Large public and private sector employers[1]			
Single	$135	$769	82.4%
Family	$514	$2,206	76.7%
Public and private sector employers in South[2]			
Single	$127	$747	83.0%
Family	$649	$2,103	71.0%

[1]Large public and private sector employers: ≥ 200 employees in public and private sectors
[2]Public and 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

Data from the *Kaiser Family Foundation Employer Health Benefits 2024 Annual Survey*

2024 Average Rx copayment

	Amount
State Health Plan	$13/$46/$70
Public and private sectors[1]	$12/$36/$65

[1]Public and private sectors includes small and large firms with Health Maintenance Organizations, Preferred Provider Organizations

Data from the *Kaiser Family Foundation Employer Health Benefits 2024 Annual Survey*

2023 Median individual in-network deductible amount[1]

	Amount
State Health Plan	$515
Public employers	$500
Private – manufacturing	$750
Private – financial services	$750
All employers[2]	$1000
Employers – 500+	$750
Employers – 20k+	$750
Public and private sector employers in South[3]	$750

[1]Median deductible amount in PPO (Preferred Provider Organization) and POS (Point of Service) plans
2Public and private employers in South includes Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

Data from the 2023 *Mercer National Survey of Employer-Sponsored Health Plans*

2023 Median individual in-network coinsurance maximum amount[1]

	Amount
State Health Plan	$3,000
Public employers	$2,750
Private – manufacturing	$3,500
Private – financial services	$3,000
All employers	$3,750
Employers – 500+	$3,500
Employers – 20k+	$4,000
Public and private sector employers in South[2]	$4,000

[1]Median coinsurance maximum amount in PPO (Preferred Provider Organization) and POS (Point of Service) plans
[2]Public and private employers in South includes Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

Data from the 2023 *Mercer National Survey of Employer-Sponsored Health Plans*

2023 Median prescription drug retail 3-tier copayment amounts

	Amount
State Health Plan	$13/$46/$77
Public employers	$10/$30/$60
Private – manufacturing	$10/$30/$60
Private – financial services	$10/$35/$60
All employers	$10/$35/$60
Employers – 500+	$10/$35/$60
Employers – 20k+	$10/$35/$60
Public and private sector employers in South[1]	$10/$35/$60

[1]Public and private employers in South includes Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

Data from the 2023 *Mercer National Survey of Employer-Sponsored Health Plans*

2025 State Health Plan member benefits, contributions compared to other State Health Plans in the Southeast

	Lower	Higher	Same
Deductible	6	7	
Coinsurance max	8	3	2
Generic copay	5	8	
Brand copay	4	9	
Employer contribution	9	4	
Employee contribution	9	4	
Total contribution	11	2	

Data from PEBAs *2025 50-State Survey*

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PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
Health Care Policy Committee

Meeting Date: March 12, 2025

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1. Subject: Virta Clinical Outcomes Annual Review

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2. Summary*:* Over the past year or so, the State Health Plan has included Virta's diabetes reversal program as an offering to qualified participants. Virta is a telehealth provider whose approach centers around nutritional therapy. Dr. Frank Dumont and Desi Romanowski of Virta will discuss clinical outcomes and observations from our first year with this initiative.

3. What is Committee asked to do? Receive as information

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4. Supporting Documents:
A. PEBA/BCBSSC Annual Clinical Outcomes Review

virta +

PEBA
SC Retirement Systems and State Health Plan

PEBA/BCBSSC
Annual Clinical Outcomes Review

March 12, 2025

Virta Introductions

Desi Romanowski

Team Lead, Client Success

Frank Dumont, MD, FACP

Commercial Medical Director

Agenda

Virta Overview	**5 Min**
Member Voice	5 Min
Clinical Outcomes	10 Min

Virta is **a leading telehealth provider clinically proven** to reverse type 2 diabetes.

Reversal is possible through nutritional therapy + fully virtual, provider-led medical group.

100% of our fees are at risk.

virta

How Virta Works

Reverse metabolic disease through nutrition, while addressing real-world obstacles as they arise.

Health Coach

Virta Provider

Validated results proven at scale

Real world impact

Members see Virta as a forever lifestyle change

Clinically proven

10+ Peer-reviewed results, 5 yr clinical trial, cited in ADA

3rd-party validated

Third-party validated outcomes and up to 3:1 ROI

PETERSON HEALTH TECHNOLOGY INSTITUTE

OUTCOMES AND SAVINGS PROGRAM VALIDATION ValidationInstitute VALID THROUGH 2025

INDEPENDENTLY VALIDATED PERFORMANCE EXP SEP 25 ValidationInstitute

1. McKenzie AL, Athinarayanan SJ, McCue JJ, Adams RN, Keyes M, McCarter JP, Volek JS, Phinney SD, Hallberg SJ. Type 2 Diabetes Prevention Focused on Normalization of Glycemia: A Two-Year Pilot Study. Nutrients. 2021 Feb 26;13(3):749.
2. Sepah S et al. J Med Internet Res 2015
3. Hallberg SJ et al. Diabetes Ther. 2018; 9(2): 583-612. Outcomes among one year completers (83% retention in Virta Treatment; 90% retention in Standard Care). Rx refers to the volume of diabetes prescriptions at one year (which excludes metformin) compared to baseline and multiple insulins prescribed to a patient were counted as one Rx.

Agenda

Virta Overview	5 Min
Member Voice	**5 Min**
Clinical Outcomes	10 Min

Virta Health Impact: Satisfaction

Your members are highly satisfied and engaged with Virta

Net Promoter Score[1]

78

Scale	-100 - 100
Good	0 - 50
Excellent	51 - 69
World Class Healthcare	70 - 100
Industry Average	38[3]

Member Retention[2]

60%

Retained at 365 days

"Thank you, PEBA! I am most appreciative that Virta was offered and has continued to be supported. I would never have taken the initiative to do this on my own. This shows me that PEBA is foresighted and knows the benefit of improving my health rather than simply being reactive to the things that happen to my health due to poor diet management. One of the very best things about the VIRTA program is being monitored by a team of medical professionals and a health coach (not just a computer algorithm). Being able to interact with real people who care about my success has been the key to my success. Thank you again for offering such an amazing program!

Again, thank you! 2025 is my year."

Participant, PEBA 1.10.25

1. Members who provided an NPS score 180 days before time of analysis. n = 121 responses
2. Members who have completed ≥ 365 days in Virta treatment and registered before 2/4/2024
3. https://www.retently.com/blog/good-net-promoter-score

Renee Graham

Myrtle Beach, SC

Results after 21 months on Virta:

- ✓ **A1c reduced from 8.4 to 6.6**
- ✓ **Lost 40 lbs**
- ✓ **Eliminated Rx medications**, including insulin and Ozempic
- ✓ **Improvements in liver enzymes, total cholesterol, and triglyercides. All within normal range.**

Quote, Photos and Video provided in Feb 2025

virta

Agenda

Virta Overview	5 Min
Member Voice	5 Min
Clinical Outcomes	**10 Min**

Type 2 Diabetes Reversal at PEBA

virta

PEBA members see sustained clinical improvements at 1 year on Virta

Average A1c change	Medication Change	Weight Change
Virta [1] (n=800)		
-0.7	-38%	-7.9%
from 7.3 to 6.6% [1]	371 of 979 eliminated	from 227.7 lbs to 209.7 lbs
Usual Care [2]		
+0.2	+7%	+0.6%

1. Virta internal EMR data for PEBA member population with type 2 diabetes enrolled ≥365 days at time of analysis (n=800). Results as of 2/3/2025. Baseline HbA1c was laboratory measured. In the absence of follow up laboratory data, eA1c is derived from a proprietary model which estimates A1c on each day based on baseline information and actual biomarker data recorded on each member in the last 120 days. The median absolute error is 0.23. 128 members do not have a calculated estimated A1c on the given day of measurement. Medication data includes all diabetes-related medication other than metformin. members prescribed multiple drugs within the same class are counted as one prescription and only considered eliminated when both drugs are de-prescribed.
2. Hallberg et al. Diabetes Ther. 2018; 9(2): 583-612. Outcomes among one year completers. Metformin is excluded from diabetes-specific medications.

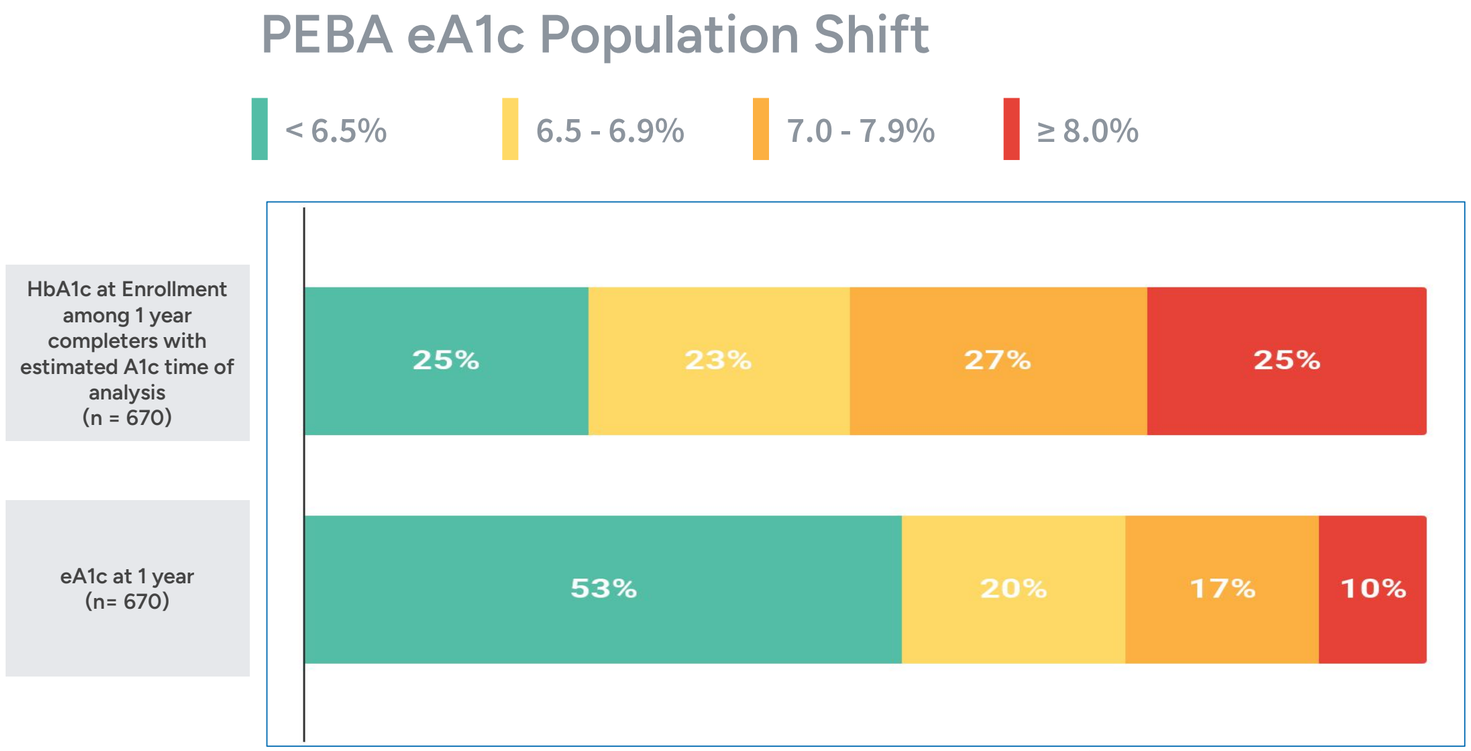
PEBA members Clinical progress at 365 days

(GLP-1 Users vs Non-GLP-1s)

	Average A1c change	Medication Change	Weight Loss
GLP-1 Users (n=399)[1]	**-0.62** from 7.29 to 6.67%[1]	**-39%** 275 of 708 of diabetes-specific medications eliminated	**-8.3%** from 235.2 lbs to 215.6 lbs
Non-GLP-1 Users (n=401)[1]	**-0.76** from 7.31 to 6.55%[2]	**-51%** 106 of 206 of diabetes-specific medications eliminated	**-7.4%** from 216.2 lbs to 200.3 lbs

1. Virta internal EMR data for PEBA patient population with type 2 diabetes enrolled ≥365 days at time of analysis (n=800). Results as of 2.3.25. Baseline HbA1c was laboratory measured. In the absence of follow up laboratory data, eA1c is derived from a proprietary model which estimates A1c on each day based on baseline information and actual biomarker data recorded on each patient in the last 120 days. The median absolute error is 0.23. 78 patients do not have a calculated estimated A1c on the given day of measurement. Medication data includes all diabetes-related medication other than metformin. Patients prescribed multiple drugs within the same class are counted as one prescription and only considered eliminated when both drugs are de-prescribed.
2. Hallberg et al. Diabetes Ther. 2018; 9(2): 583-612. Outcomes among one year completers. Metformin is excluded from diabetes-specific medications.

PEBA members are improving their blood sugar and eliminating diabetes-specific medications



Medication Change

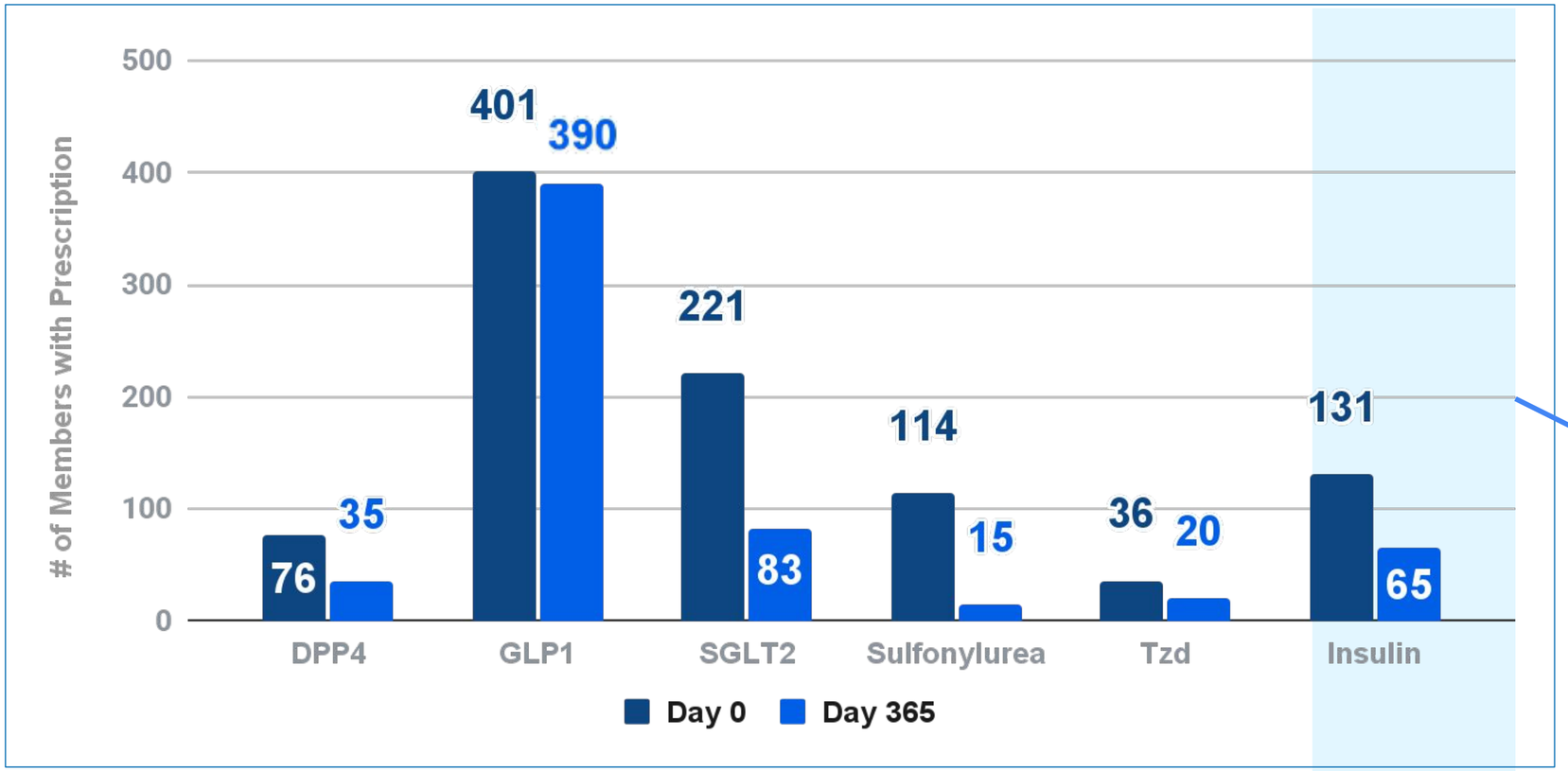
-38%

371 of 979 of diabetes-specific medications eliminated

Usual Care: **7% increase** in T2D meds [3]

Virta internal EMR data for PEBA member population with type 2 diabetes enrolled ≥365 days at time of analysis (n=800). Results as of 2/3/2025. Baseline HbA1c was laboratory measured. In the absence of follow up laboratory data, eA1c is derived from a proprietary model which estimates A1c on each day based on baseline information and actual biomarker data recorded on each member in the last 120 days. The median absolute error is 0.23. 128 members do not have a calculated estimated A1c on the given day of measurement. Medication data includes all diabetes-related medication other than metformin. members prescribed multiple drugs within the same class are counted as one prescription and only considered eliminated when both drugs are de-prescribed.

PEBA members are eliminating diabetes medications, including costly medications like insulin



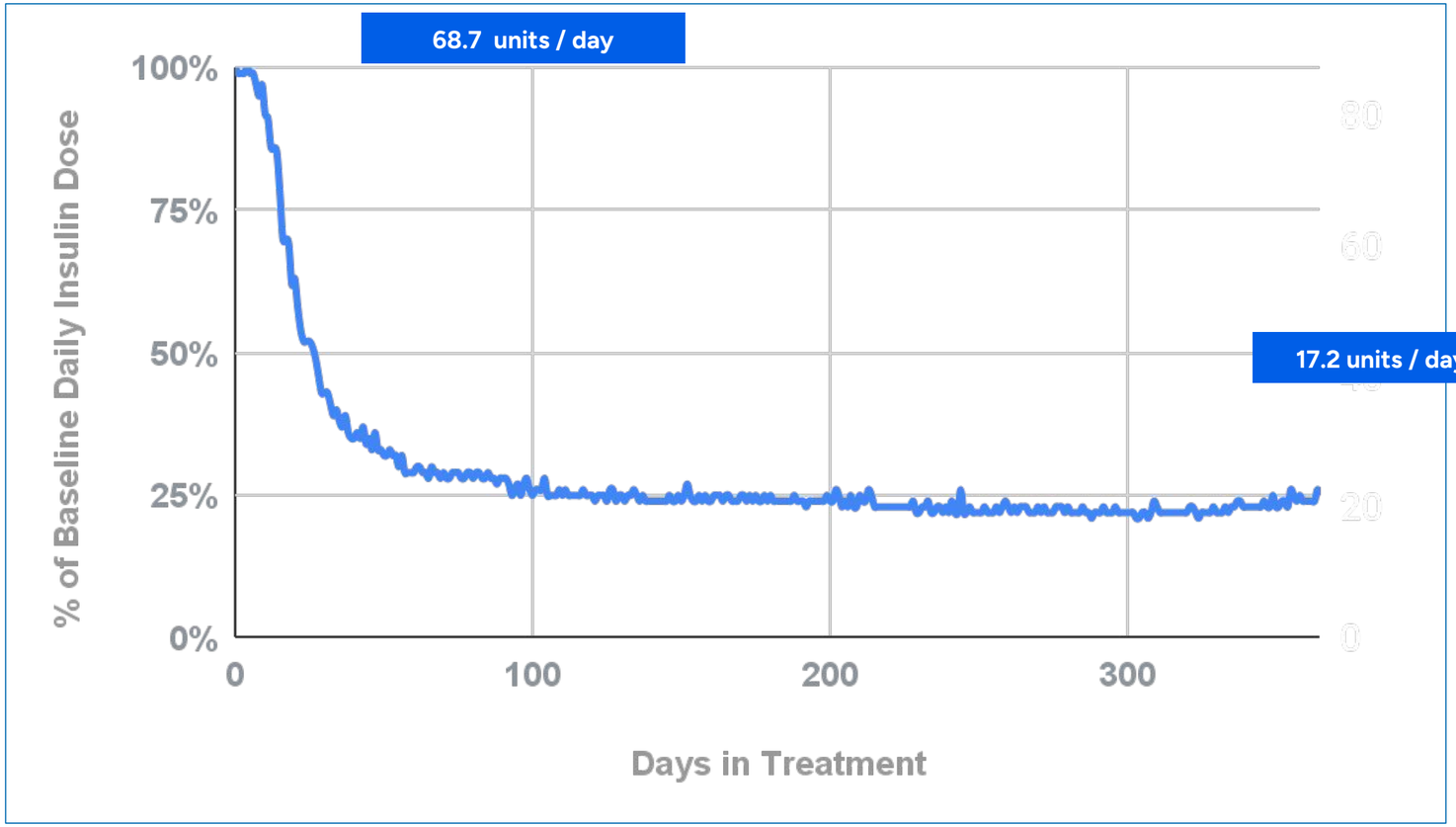
50%
of members completely eliminated insulin

Virta internal EMR data for PEBA member population with type 2 diabetes enrolled ≥365 days at time of analysis (n=800). Results as of 2/3/2025. Medication data includes all diabetes-related medication other than metformin. Multiple types of insulin prescribed to the same member were counted as one prescription and only considered eliminated when all insulin was discontinued. Meglitinides not charted due to member privacy.

TYPE 2 DIABETES REVERSAL

PEBA members have reduced their insulin dosages by 75%, or 52 units/day

Usual Care: **16% increase** in insulin [2]



1. Virta internal EMR data for PEBA member population with type 2 diabetes enrolled ≥365 days at time of analysis (n=800). Results as of 2/3/2025.
2. Hallberg et al. Diabetes Ther. 2018; 9(2): 583-612. Outcomes among one year completers.

Reducing insulin improves quality of life for members

"My life revolved around sticking myself. My stomach was black and blue. It was really expensive. It was getting too expensive for me to deal with, when you're on disability and have limited income."

- Virta member Robin

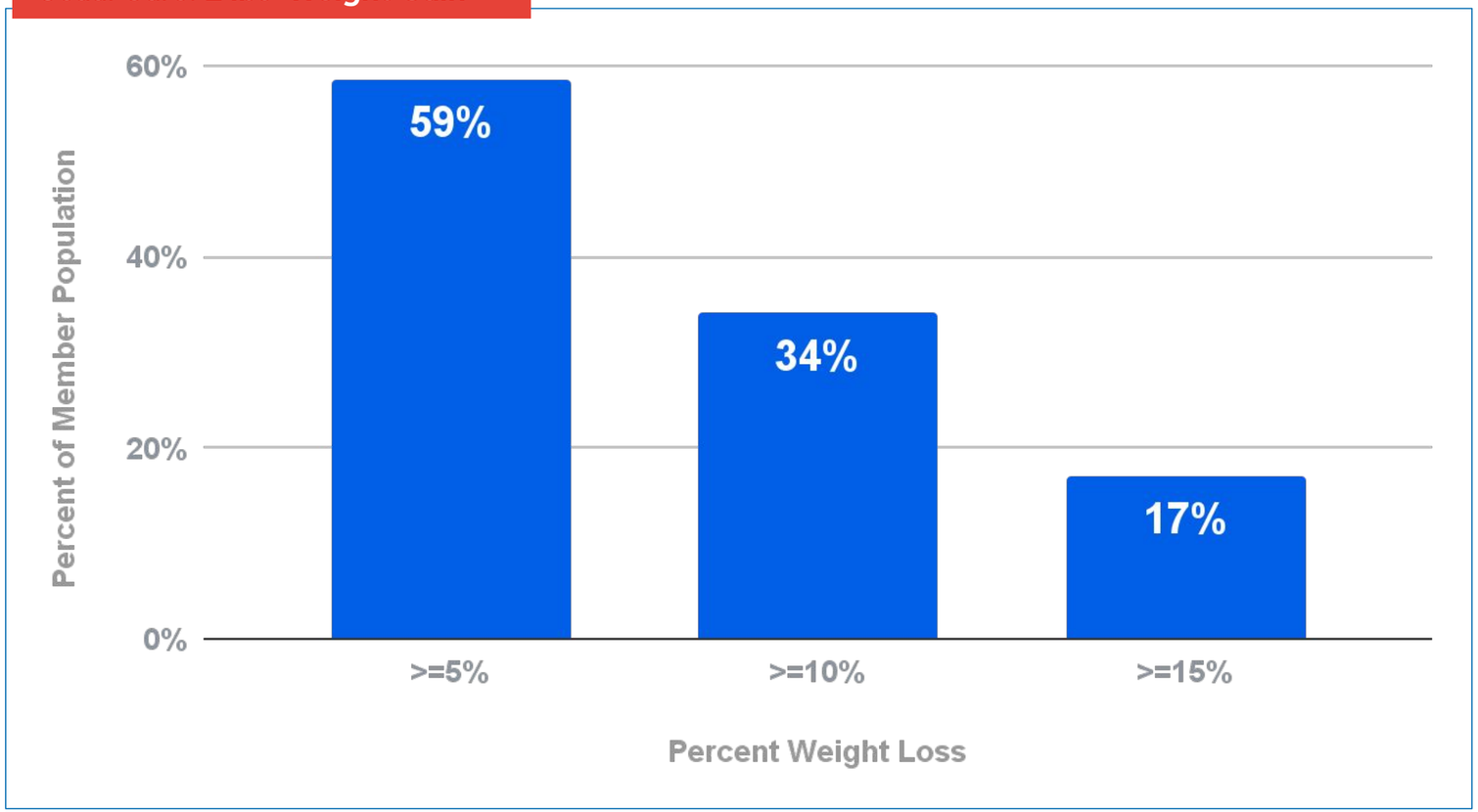
"As a procrastinator when it comes to taking care of my health, I appreciate an alternative to adding more prescriptions to my medicine cabinet."

- Virta member

TYPE 2 DIABETES REVERSAL

59% of PEBA members with type 2 diabetes have achieved clinically significant weight loss

Usual Care: **2 lbs Weight Gain** [2]



1. Virta internal EMR data for PEBA member population with type 2 diabetes enrolled ≥365 days at time of analysis (n=800). Results as of 2/3/2025. In the case of missing weight data, a 3-day average was carried forward until the next weight was logged.
2. Hallberg SJ et al. Diabetes Ther. 2018; 9(2): 583-612. Outcomes among one year completers.

Members who lose clinically significant amount of weight (5%) typically experience:

- ✓ Better sleep
- ✓ Reduced inflammation
- ✓ Improved blood pressure
- ✓ Reduced risk of heart disease and other chronic conditions
- ✓ Positive impacts on arthritis and fatty liver disease


virta

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
Health Care Policy Committee

Meeting Date: March 12, 2025

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1. Subject: AI in the Healthcare Industry: Artificial or Intelligent?

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2. Summary*:* Dr. Tripp Jennings of Blue Cross will present an overview of artificial intelligence in health care, from trends to ongoing applications to prospects going forward.

3. What is Committee asked to do? Receive as information

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4. Supporting Documents:
A. AI in the Healthcare Industry: Artificial or Intelligent?

AI in the Healthcare Industry: Artificial or Intelligent?

Payor Innovations

3/12/2025

PRESENTER:
Tripp Jennings, MD
VP Innovations Officer

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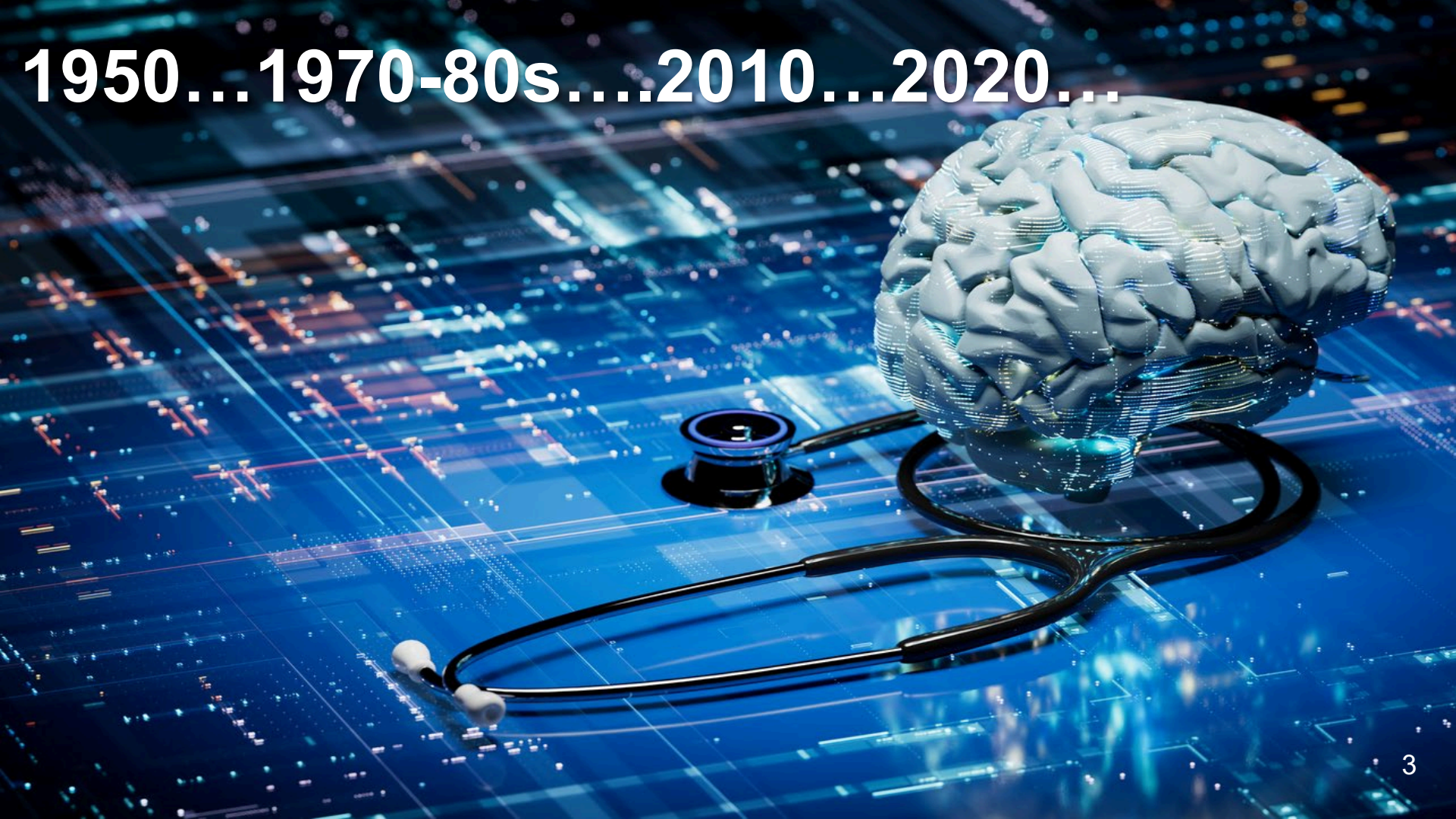
SC Retirement Systems and State Health Plan

- Introduction
- AI Trends
- Managing Risks and Regulations
- AI Application
- Change Management and Workforce Readiness
- Outlook

South Carolina

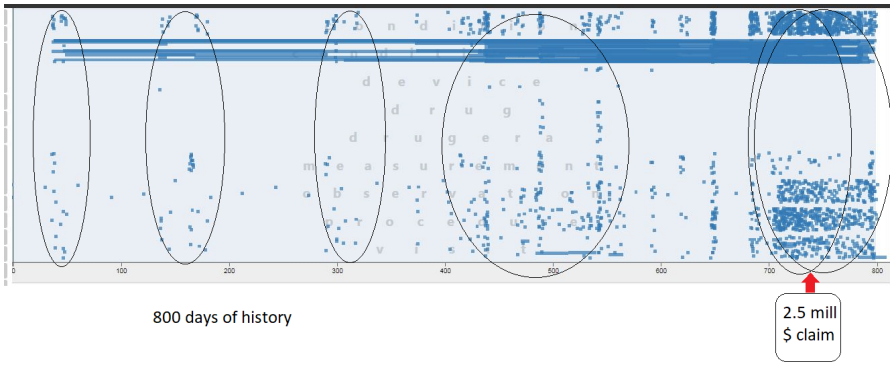
1950…1970-80s….2010…2020…

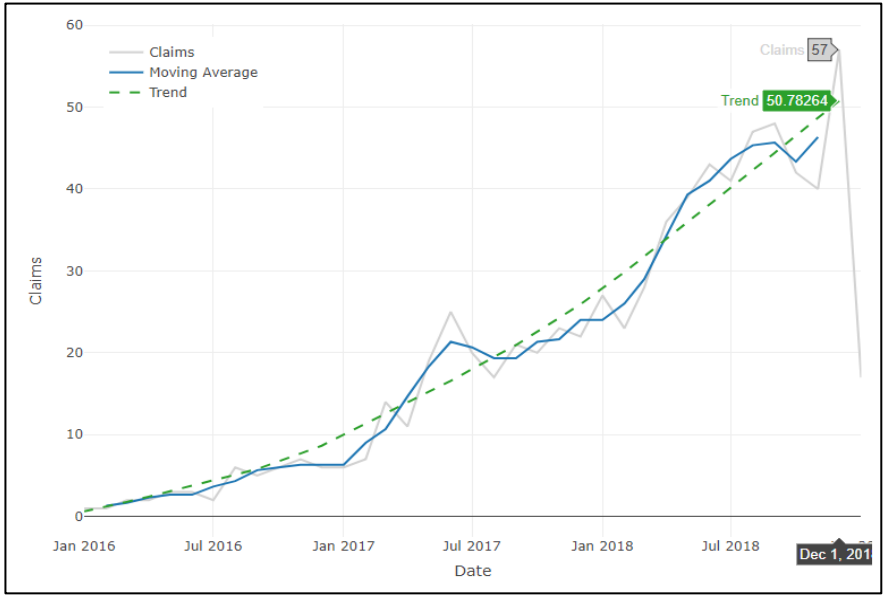


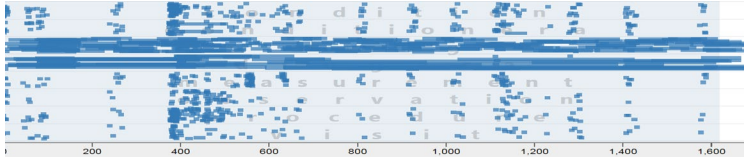
2019

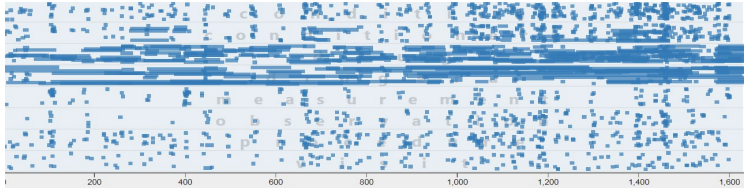
PREDICTION & IDENTIFICATION

of high-risk employees using market-leading analytics & predictive modeling

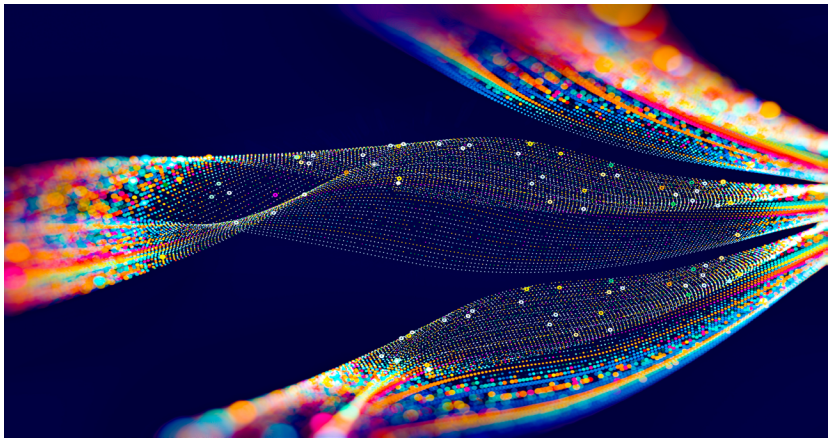


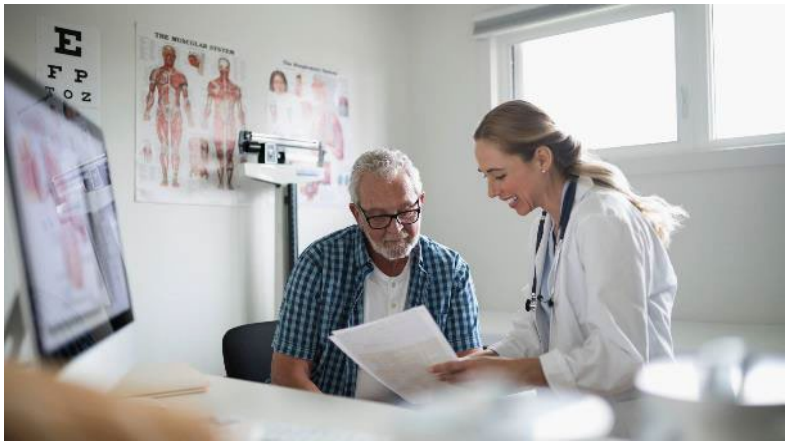






2022





Predictive Care Models

- Chronic Condition Hospitalization Model predicts inpatient admission in the next 12 months for the following conditions:
  - Type 2 Diabetes
  - Type 1 Diabetes
  - Coronary Artery Disease (CAD)
  - Congestive Heart Failure (CHF)
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Asthma
  - Depression
- Medicare Advantage Avoidable ER Model
  - Predicts ER visit that does not require admission among those aged 60+ in the next 6 months
- Postpartum depression predictive model
- High-risk maternity model
- High-Cost Claimant (HCC) prediction model

2024

Data-Driven Transformation Strategy

Transforming into a data-driven industry requires a holistic approach. Companies have prioritized these key areas to align data initiatives with business strategy.

Data Strategy and Governance

Develop a comprehensive data strategy aligned with business goals. Establish robust data governance policies for quality and compliance. Create a dedicated data governance team.

Data Culture and Talent Development

Foster a data-driven culture across the organization. Invest in data literacy training programs. Hire or upskill data professionals (data scientists, analysts, engineers).

Data Infrastructure and Architecture

Invest in modern data infrastructure (data lakes, warehouses, cloud). Implement data integration and ETL processes. Explore technologies like data virtualization and containerization

Security and Compliance

Strengthen data security measures. Ensure compliance with data protection regulations. Conduct regular security and compliance audits.

Data Analytics and Machine Learning

Enhance data analytics capabilities for reporting and BI. Develop data science and machine learning capabilities.

AI in Healthcare

Market Growth

- The global AI in healthcare market grew from **$1.1 billion** in 2016 to **$22.4 billion** in 2023, and is projected to reach **$45.2 billion** by 2026, according to DialogHealth

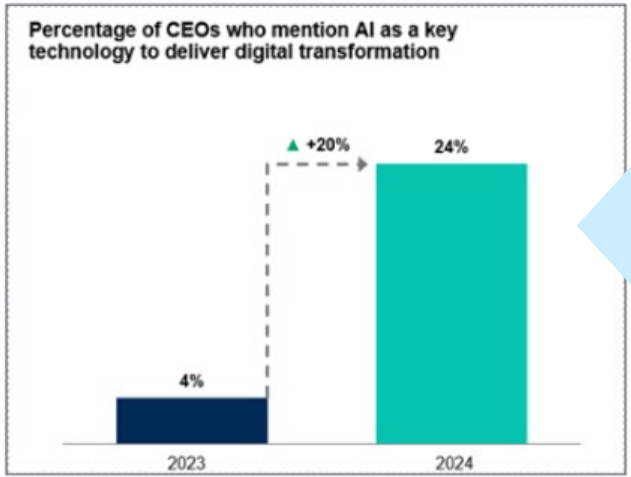
Adoption Rate

- By 2024, **76%** of U.S. insurance firms had implemented generative AI capabilities in at least one business function, with claims processing, customer service, and distribution leading adoption, according to Statista
- By 2025, **90%** of large healthcare organizations are expected to have adopted AI and machine learning technologies

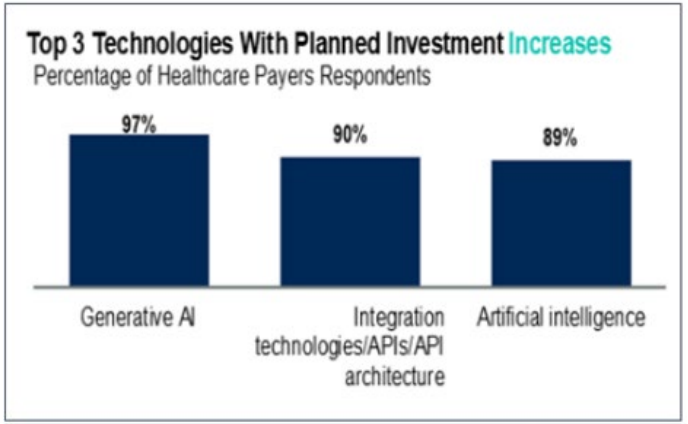
Cost Savings

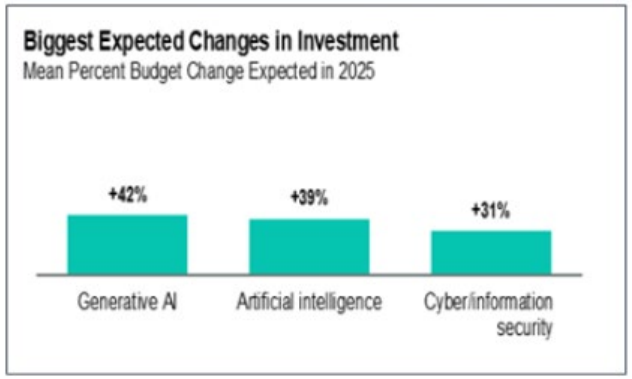
- According to DialogHealth, the integration of AI in healthcare insurance is projected to save the industry approximately **$7 billion** annually **by** 2025 through improved **operational efficiencies and reduced fraud**

AI Trends – Gartner 2025

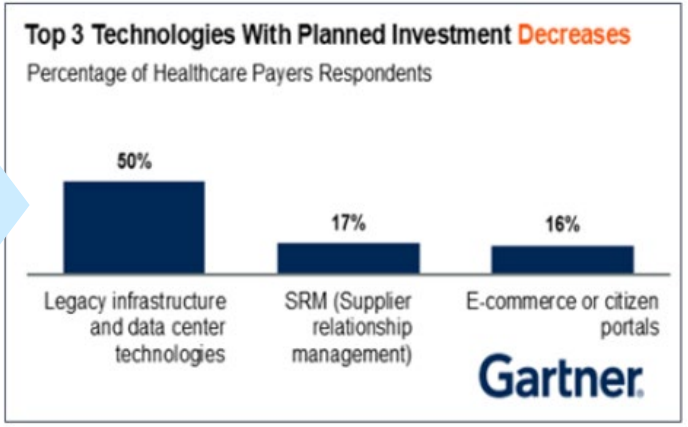


Increase in AI development prioritization and spend seen in surveys done with over 3,000 CIOs (43 Healthcare Payers worldwide)





CIOs are focusing on AI applications that drive efficiency and productivity



Adapted from 2025 CIO Top Priorities and Technology Plans Healthcare Payers | Gartner

MANAGING RISKS AND REGULATIONS

Health and Human Services (HHS)

- In January, **(HHS) released their AI strategic plan**. Their vision is to be the global leader in responsible AI use to improve health and well-being.

- Plan is **split into 7 different plan domains**. Each domain **has identified opportunities, trends, and risks.**

- HHS aims to **focus on innovation, ethical use, access, and workforce empowerment**. The goal is to expand the breadth of AI usage by helping to modernize infrastructure to implement AI , provide support for AI adoption and helping to clarify regulatory oversight.

- **Potential Healthcare Payer Impacts:** Cost Efficiency, Improved Patient Outcomes,
  Enhanced Risk Management, Regulatory Compliance, and Competitive Advantage.

HHS AI Update - HealthCare Delivery and Financing Highlights

Opportunities:

- Improve quality and safety of patient care
- Improve patient experience
- Automate administrative processes and reduce workforce burden and burnout
- Enhancing equity and access
- Bending cost curve

Trends:

- Large investments in AI space
- Mixed enthusiasm by all stakeholders
- Wide variation in adoption
- Increased innovation and update for administrative use
- Lack of heterogeneity in organization data and technology systems

Risks:

- Introduction of bias
- Unexpected or inappropriate outcomes

RISKS

- **Misinformation amplification**: Advanced AI systems can generate increasingly convincing fake content
- **Cybersecurity vulnerabilities**: AI tools are enhancing both offensive and defensive capabilities in cybersecurity, with concerns about AI-powered attacks.
- **Privacy erosion**: More sophisticated AI surveillance and data analysis capabilities are raising concerns about unprecedented tracking and profiling of individuals.
- **Labor market disruption**: AI automation is accelerating job displacement in various sectors, including knowledge work, creating economic uncertainty for many workers.

RISKS

- **Algorithmic bias and discrimination**: AI systems continue to exhibit biases that can lead to unfair treatment in areas like hiring, lending, and criminal justice.
- **Concentration of power**: A small number of companies and nations controlling advanced AI capabilities creates imbalances.
- **Environmental impact**: The growing energy consumption and resource requirements of large AI models pose environmental sustainability challenges.
- **Over-reliance and deskilling**: Growing dependence on AI systems for decision-making could lead to atrophy of human skills and judgment capabilities.
- **Alignment challenges**: Ensuring AI systems reliably act in accordance with human values and intentions remains a significant technical and philosophical challenge.

Artificial or Intelligent?

Achieving feasibility is still challenging, yet the performance and application of AI is finally emerging

	Description	Example
Automated Claims Processing	▪ Natural Language Processing (NLP) algorithms process unstructured data ▪ Automated workflows manage the entire lifecycle of a claim	▪ A policyholder in a car accident uses an AI chatbot to describe the incident and provide necessary documents and photos.
Personalized Insurance Plans	▪ Predictive analytics forecasts future health risks based on historical data	▪ Insurers may offer personalized preventive care recommendations to improve health outcomes and potentially reduce expense. • Vaccine recommendations
Fraud Detection	▪ Pattern recognition, anomaly detection, and adaptive learning	▪ Machine learning algorithms identify typical claim patterns. ▪ Significant deviations are flagged as potentially fraudulent. ▪ The system adapts to new fraud patterns, such as detecting multiple small claims instead of one large claim.

Firm	Result	Application
UnitedHealthcare	▪ **Saved $300 million in fraud-related losses** ▪ **Uncovered a $10 million fraudulent billing scheme involving fake medical providers**	AI system scans 50 million claims annually (Lee, 2023)
Ping An (Chinese insurance giant)	▪ **30% increase in operational efficiency**	Utilized AI to handle over 90% of customer interactions (Suleman, 2021)
AXA (global insurance leader)	▪ **Detected 30% more fraudulent claims and saved over €200 million ($208.56M) annually**	Cross-referenced historical fraud data (Suleman, 2021)
Lemonade (digital insurance company)	▪ **Reduced operating costs by 70%**	Uses Maya, a chatbot that processes claims in 3 minutes (Quillion, 2021)

PEBA
SC Retirement Systems and State Health Plan

- Introduction
- AI Trends
- Managing Risks and Regulations
- AI Application
- **Change Management and Workforce Readiness**
- Outlook

South Carolina

Historical Parallels to AI Job Displacement Fears

Industrial Revolution (1760s-1840s): Luddites feared automated looms would eliminate jobs, yet overall employment grew in new sectors

Office Automation (1960s-1980s): Word processors threatened clerical positions but created new technical roles

ATMs (1970s): Counter-intuitively led to more bank tellers as banks opened additional branches with lower operating costs

Spreadsheet Software (1980s): Changed accountants' work from calculation to analysis rather than replacing them

Key Difference with AI: Current technological change is happening much faster, giving workers and organizations less time to adapt

Change Management and Workforce Readiness

	Description
Managing the perception of AI within the public workforce	▪ AI is an enabler, not a replacement ▪ Automation of routine tasks: AI can handle repetitive tasks, freeing up employees to concentrate on higher-value activities
Employee training and upskilling programs	▪ Foundational AI Training ▪ Role-Specific Training
Adoption through AI literacy	▪ Prompt Training ▪ How AI systems perceive the world, process data, and make decisions

PEBA
SC Retirement Systems and State Health Plan

- Introduction
- AI Applications
- Data Strategy and AI Case Study
- Managing risks
- Change Management and Workforce Readiness
- **Outlook**

South Carolina

AI Trends – Agents and Agentic Frameworks

…from AI assistants and towards AI agents.

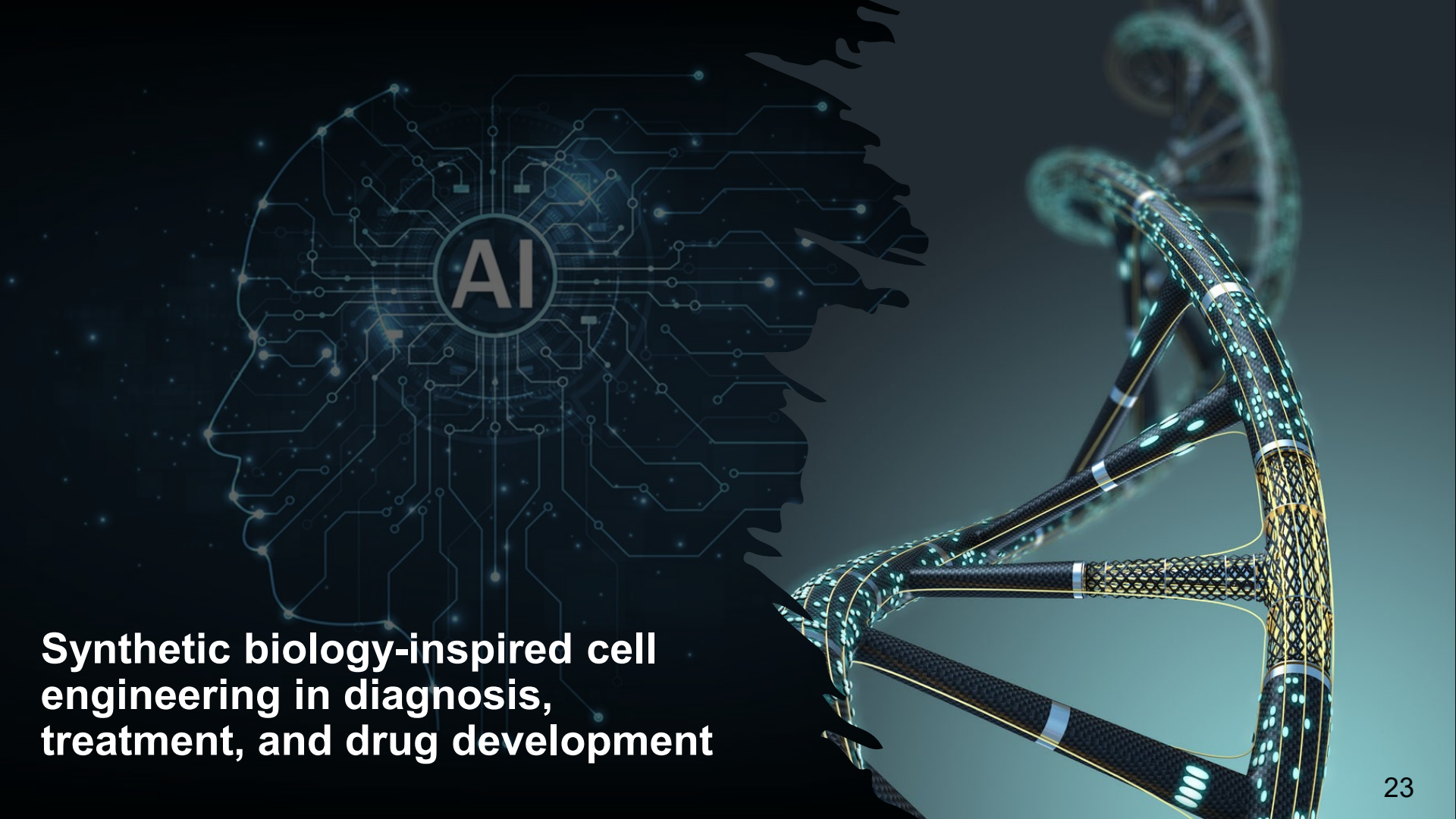
Agentic AI refers to a type of artificial intelligence that can act autonomously, making decisions and taking actions to achieve specific goals with minimal human intervention

Agentic frameworks are tools for developing AI systems capable of autonomy, self-directed workflows, and decision-making.

ASPECT	ASSISTIVE AI	AGENTIC AI
Purpose	Helps users complete tasks	Performs tasks on behalf of the user
Role	Co-pilot, providing information and suggestions	Autonomous executor of tasks
Control	Human agent remains in control	Minimal human intervention
Example Usage	Customer contact center: provides real-time info and recommended responses	Customer service agent: handles Q&A tasks entirely
Benefit to Human Agents	Enhances performance	Frees agents to focus on more complex issues

An agent uses generative AI to not only assist you but also work with or for you. They can handle tasks from answering questions to complex, multi-step projects. Unlike personal assistants, agents can be customized to have specific expertise.


Over 550 FDA-Approved, AI-Based Medical Devices



Synthetic biology-inspired cell engineering in diagnosis, treatment, and drug development

Global Economic Implications:
- Operational Impact
- Provision of Healthcare

Workforce Evolution:
- Impact of automation and AI on jobs
- Need for reskilling and lifelong learning

Policy and Regulation:
- Examination of necessary governmental policy adjustments
- Legal challenges posed by new technologies

Social and Ethical Considerations:
- Exploration of the ethical dilemmas raised by innovation
- The social responsibility of businesses in the new wave

Preparing for Change:
- Strategic differentiator for businesses to stay ahead
- Importance of agility and innovation in business culture

*"At Waymo, we believe the status quo is not acceptable. Our mission is to **innovate** beyond the impossible **in order to save lives** that are tragically lost to traffic crashes"*

1.35 million
deaths worldwide due to vehicle crashes every year

36,096
road deaths in the U.S. in 2019

94%
crashes involve human error in the US

In our first 33 million miles:

81%
Fewer airbag deployment crashes
↓ 44 FEWER

78%
Fewer injury-causing crashes
↓ 98 FEWER

62%
Fewer police-reported crashes
↓ 114 FEWER

compared to a human driving the same distance in the cities where we operate. Learn more

Thank you.

South Carolina

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
HEALTH CARE POLICY COMMITTEE

Meeting Date: March 12, 2025

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1. Subject: Committee Charter Review

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2. Summary: The PEBA Board's standing committees periodically review their committee charters to ensure the charters remain relevant and appropriate. This review is now scheduled to occur at the same time as the triennial review of the Board's governance manual.

PEBA staff does not have any recommended changes to the Health Care Policy Committee's Charter.

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3. What is the Committee asked to do? Review the Health Care Policy Committee Charter.

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4. Supporting Documents:

(a) List those attached:

1. Health Care Policy Committee Charter (as last amended October 1, 2020).

PEBA
SC Retirement Systems and State Health Plan

South Carolina Public Employee Benefit Authority
202 Arbor Lake Drive | Columbia, SC 29223
803.737.6800 | 888.260.9430
www.peba.sc.gov

Health Care Policy Committee Charter

[As adopted by the PEBA Board on October 1, 2020]

(A) **Purpose:** To ensure the State Health Plan and other insurance plans and programs administered by PEBA are financially sustainable, improve member health, and provide 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 will 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 will 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) Ensure the PEBA strategic plan includes strategic issues and projects within the Health Care Policy Committee's purpose, noted in Section A.

(2) Approve pilot projects for upcoming plan years that focus on improved health and lower costs, with appropriate evaluation methods of health outcomes, costs, and resources identified;

(3) 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