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AGENDA ITEM

Action Item

Information Only

Date: October 3, 2013

Item Number: 5.6

Title: Self-Funded Plan Utilization Report for the year ending June 30, 2013

Summary

This report addresses medical, dental, prescription drug and HSA/HRA utilization through June 30, 2013.

Report

Notes Regarding the Data

The medical and dental data provided in this utilization report was prepared by HealthSCOPE Benefits using Benefit Informatics and the HealthSCOPE Benefits claims data system. Detailed drug utilization information was prepared by Catalyst Rx.

Please note the following:

1. This report reflects only self-funded plan activity and does not include any fully insured benefit cost (e.g. HMOs) information.
2. Dollar amounts categorized into various demographic groups (tiers, division, etc.) are reported on a paid basis for the year ending June 30, 2013, compared to the year ending June 30, 2012, unless otherwise noted (except where specifically identified as the quarter ending June 2013 compared to June 2012).
3. A "Participant" is defined as the primary insured. Per participant per month costs are labeled "PPPM". "Member" includes both the primary insured and all dependents. Per member per month costs are labeled "PMPM".
4. Enrollment figures will vary slightly (generally less than 1%) from other financial reports because the information provided in this utilization report includes retroactive enrollment transactions. Other reports provided by PEBP staff use "snap-shots" of enrollment on the first of each month.
5. Unless otherwise noted, state and non-state claims are reported in aggregate.

Key Observations

During the year ending June 30, 2013:

- Total medical spent was \$110.8M (5.9% below PY12 at \$117.8M), of which 61.6% was spent by the State Active population. The average plan cost was \$476 PPPM, 2.1% lower than the year ending June 2012 average cost of \$486.
- There were 167 catastrophic cases in excess of \$100,000 for the year ending June 30, 2013, compared to 157 high cost cases reported for the year ending June 30, 2012. Although representing 0.50% of the total membership, this segment accounted for 33.7% of dollars spent by the plan.
- Most CDHP participants (67.7%) claimed medical expenses of less than \$2,500, and approximately a fifth of all CDHP participants (18.5%) had no claims filed.
- Nearly all paid dollars (93%) were to in-network providers with an average discount of 59.6% of retail cost (the average discount increased 9.6% from 54.4% in plan year 2012).
- Drug utilization (number of members utilizing the PEBP pharmacy benefit as a percent of all PPO self-funded members) decreased from 35.1% to 29.6% from the quarter ending June 30, 2012, to the quarter ending June 30, 2013.
- As of June 30, 2013, HealthSCOPE Benefits administered the reimbursement of approximately \$25.5 million in Health Savings Account (HSA) claims leaving \$12.5 million in unused HSA funds, or \$1,057 per account.

Executive Summary

Financial Summary

Total medical claims spending was \$110.8 million, 5.9% below the same period of PY12 at \$117.8 million.

- The average PPPM plan cost was lower than the year ending June 30, 2012 (\$476 vs. \$486).
- The actual medical plan costs were \$3,292 per member (down 3.1 % from \$3,397 in PY 2012).
- PPPM inpatient claims were higher compared to the same period of PY12 (\$178 vs. \$164).

Medical–Cost Distribution

During the year ending June 30, 2013, the largest group (48.5%) of members had claims paid in the amount of less than \$2,500. Notably, 167 claimants with catastrophic claims (0.50% of the total membership) account for 33.7% of all dollars paid by the plan.

- The average payment per claimant for a catastrophic claim was \$223,883.

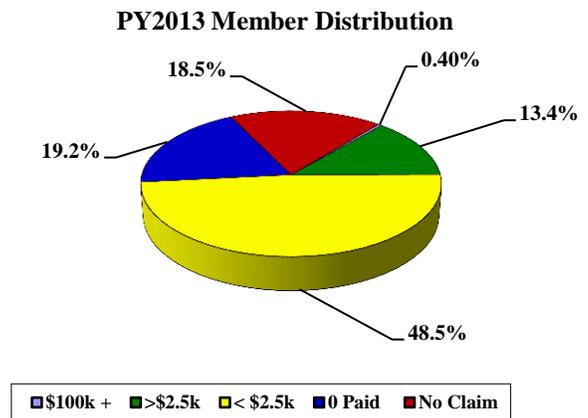
The average medical claim for this period was \$321 or 10.8% above the year ending June 30, 2012 (\$290).

Network Utilization

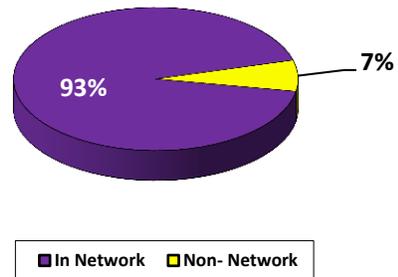
Most participants utilized medical services within the Network resulting in a 59.6% discount; in addition, the in-network utilization rate of 93% was slightly above that noted for the same period of PY12 (92%).

Major Diagnostic

Musculoskeletal, Factors Affecting Health and Neoplasms were the most expensive three diagnostic categories, together accounting for 40.4% of total costs by the plan. The costs associated with these three categories are:



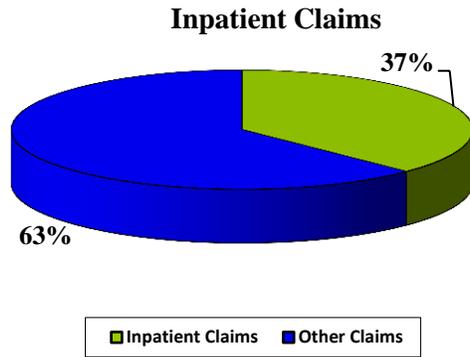
Q3 PY13 Network Utilization



- Musculoskeletal at \$17.1 million
- Factors Affecting Health at \$15.0 million
- Neoplasms at \$12.6 million

Inpatient Summary

Total inpatient claims paid account for 37.4% of the total amount of claims paid by the plan.



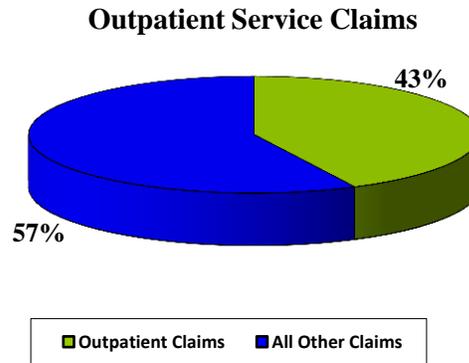
- The top 25 hospitals that receive more money from PEBP for acute visits than any other hospital make up 74.9% of all acute costs.

- The top three healthcare providers (Renown Regional Medical Center, University of California Davis MC, and Sunrise Hospital) together account for 24.3% of all acute costs combined.

Outpatient Services

Total outpatient services account for 42.6% of total plan costs.

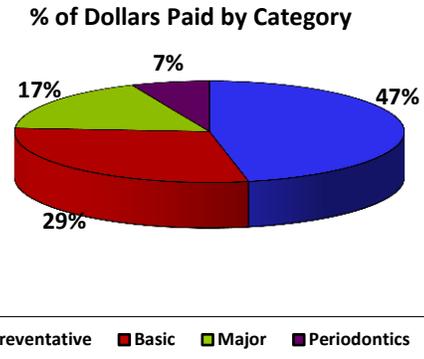
- The top 25 outpatient services account for 98.7% of all outpatient costs.
- The top three services by service code (Hospital Ancillary, Radiology, and Surgery) together account for 61.3% of the total outpatient services.



Dental

The average dental claim for the year ending June 30, 2013, was \$151. This represents a 28.7% increase from the \$117 average dental claim for the year ending June 30, 2012.

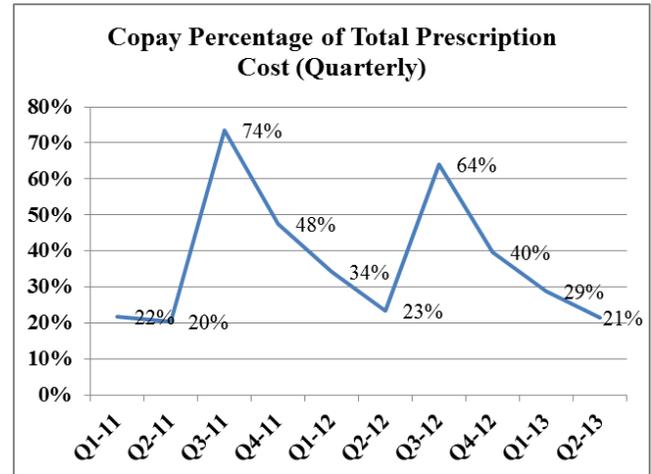
Of the \$18.3 million in paid dental claims, during the year ending June 30, 2013, \$8.6 million (46.8%) was for preventive services.



Drug Utilization

Drug utilization (number of members utilizing the PEBP pharmacy benefit as a percentage of all PPO self-funded members) has decreased from 35.1% to 29.6% from the quarter ending June 30th, 2012, to quarter ending June 30th, 2013.

Generic drug utilization (generic scripts filled as a percent of all scripts) increased from 78.3% to 80.8% from the quarter ending June 30, 2012, to the quarter ending June 30, 2013. This generic utilization rate is among the highest in the nation.



Percent of total prescription costs paid by participants during the ten quarters ending June 30, 2013.

Wellness

In addition to the 30,919 claims for wellness screenings and/or vaccinations, paid through HealthSCOPE, USPM administered 10,629 biometric screenings and 2,286 PSA tests for the year ending June 30, 2013.

Diabetes Compliance

519 of 1,643 or 32%, of active CDHP diabetics, with nine months of service, have received the minimum number of recommended services when the ophthalmologic exam is excluded. This is up from 31% noted in the same period for PY12.

Claims Summary

Total self-funded paid claim dollars decreased \$5.1 million or 3.4% from the year ending June 30, 2012 to the year ending June 30, 2013. On a per participant basis, medical claims paid decreased 2.1%, dental increased 2.3% while prescription decreased 2.5%.

Prescription costs do not include rebates from Catalyst/Catamaran RX or the Retiree Drug Subsidy Program. Prescription rebates are received by PEBP approximately nine to twelve months after they are earned.

Self-Funded Net Paid Claims - Total (Paid Basis)			
	Jul 2011 - Jun 2012	Jul 2012 - Jun 2013	% Change
Medical			
Inpatient	\$ 39,792,715	\$ 41,450,222	4.2%
Outpatient	\$ 36,022,531	\$ 33,852,574	-6.0%
Medical - Other	\$ 41,992,426	\$ 35,522,100	-15.4%
Total Medical	\$ 117,807,672	\$ 110,824,896	-5.9%
Dental	\$ 17,982,727	\$ 18,298,373	1.8%
Prescription	\$ 16,853,361	\$ 18,389,676	9.1%
Total	\$ 152,643,760	\$ 147,512,945	-3.4%
Self-Funded Net Paid Claims - Per Participant Per Month (Paid Basis)			
	Jul 2011 - Jun 2012	Jul 2012 - Jun 2013	% Change
Medical	\$ 485.76	\$ 475.71	-2.1%
Dental	\$ 41.62	\$ 42.64	2.5%
Prescription	\$ 69.49	\$ 78.94	13.6%
Total	\$ 596.88	\$ 597.29	0.1%

HRA Administration

HealthSCOPE paid \$6.7 million and Extend Health paid \$15.9 million in HRA claims for the year ending June 30, 2013. The available balances are \$9.4 million for CDHP participants (\$894 per account) and \$5.9 million for Medicare Retirees (\$608 per account).

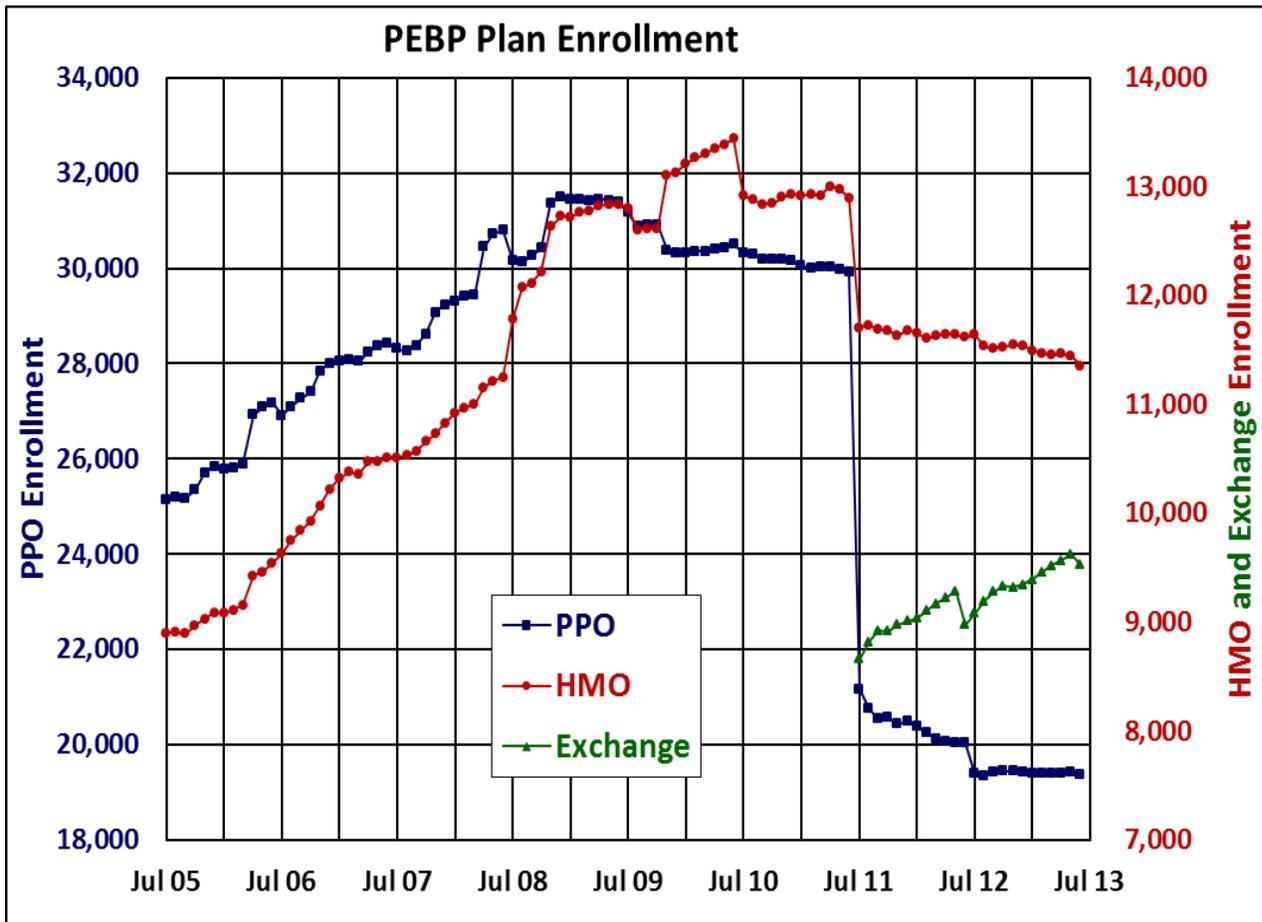
Detailed Findings

Medical Section

Monthly Enrollment Summary

Enrollment in the self-funded PPO medical plan decreased 3.5% from the period ending June 30, 2012, to the period ending June 30, 2013, with dental plan enrollment increasing by 4.1% from June 30, 2012 to June 30, 2013. The average age of all self-funded members decreased 1.6% to 39.38 years.

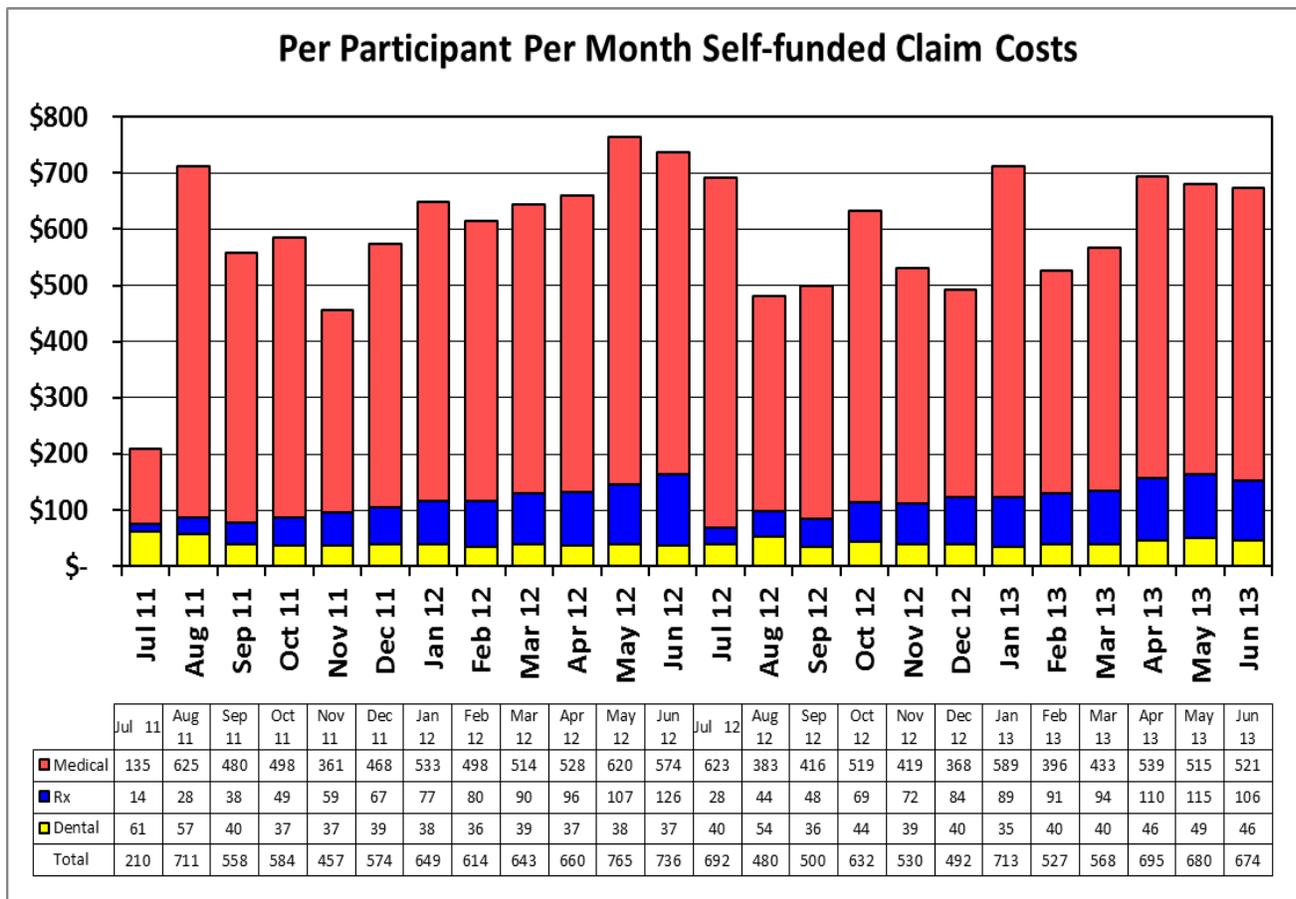
Enrollment in the Northern HMO decreased by 1.7% and by 3.3% for the Southern HMO from June 30, 2012 to June 30, 2013. Total enrollment in the HMOs decreased 2.5%. These changes were largely a result of the migration of Medicare retirees to the Medicare Exchange which increased by 6.2% over the same period.



Monthly Cost Summary

From the year ending June 30, 2012, to the year ending June 30, 2013, the number of medical claims processed per participant decreased 11.6%. Total dollars paid for medical claims decreased 2.1% on a per participant basis while paid dental claims increased 2.4%.

The following graph shows PPPM self-funded claim costs for the 24 months ending June 30, 2013. Data for the graph was compiled directly from the daily check register sent to PEBP by HealthSCOPE Benefits and the monthly claim costs reported by Catamaran (formerly Catalyst).



Extremely low medical claims paid in July 2011 were a result of the transition of third party administrator services from UMR to HealthSCOPE Benefits. The high amount in August reflects HealthSCOPE Benefits' efforts to reduce the backlog created by the transition and pay any run-out claims not paid in July from the plan year ending June 30, 2011.

Utilization

From the year ending June 30, 2012, to the year ending June 30, 2013:

- Admits Acute per 1,000 decreased from 67 to 63
- Days per 1,000 decreased 10.4%
- ER visits per 1,000 decreased from 170 to 160.

All current utilization indexes below except ER Visits per 1,000 are higher overall than that of HealthSCOPE Benefits' book of business in 2012.

Utilization (annualized)	PY13	PY12	HSB 2012 Index
Admits per 1,000	63	67	59
Days per 1,000	327	365	252
Avg Length of Stay	5.2	5.5	4.3
Office Visits per 1,000	3300	3600	3100
ER Visits per 1,000	160	170	170

Claims paid by Division

Net Paid Claims - Total									
State Participants									
	PY13				PY12				% Change
	Pre-Medicare		Medicare		Pre-Medicare		Medicare		
	Actives	Retirees	Retirees	Total	Actives	Retirees	Retirees	Total	Total
Medical									
Inpatient	\$ 27,525,611	\$ 9,161,096	\$ 1,294,792	\$ 37,981,499	\$ 25,456,453	\$ 10,253,077	\$ 1,996,127	\$ 37,705,657	0.7%
Outpatient	\$ 40,647,024	\$ 12,630,039	\$ 1,648,985	\$ 54,926,047	\$ 42,477,074	\$ 11,576,133	\$ 3,179,864	\$ 57,233,071	-4.0%
Total - Medical	\$ 68,172,635	\$ 21,791,134	\$ 2,943,777	\$ 92,907,546	\$ 67,933,527	\$ 21,829,210	\$ 5,175,991	\$ 94,938,728	-2.1%
Dental	\$ 12,667,784	\$ 1,590,320	\$ 1,491,094	\$ 15,749,199	\$ 12,394,218	\$ 1,496,998	\$ 1,339,612	\$ 15,230,828	3.4%
Total	\$ 80,840,419	\$ 23,381,455	\$ 4,434,871	\$ 108,656,745	\$ 80,327,745	\$ 23,326,208	\$ 6,515,603	\$ 110,169,556	-1.4%

Net Paid Claims - Per Participant per Month									
	PY13				PY12				% Change
	Pre-Medicare		Medicare		Pre-Medicare		Medicare		
	Actives	Retirees	Retirees	Total	Actives	Retirees	Retirees	Total	Total
Medical	\$ 396	\$ 696	\$ 545	\$ 445	\$ 395	\$ 747	\$ 914	\$ 459	-3.2%
Dental	\$ 46	\$ 35	\$ 42	\$ 44	\$ 44	\$ 36	\$ 44	\$ 43	2.0%

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Net Paid Claims - Total									
Non-State Participants									
	PY13				PY12				% Change
	Pre-Medicare		Medicare	Total	Pre-Medicare		Medicare	Total	
	Actives	Retirees	Retirees		Actives	Retirees	Retirees		
Medical									
Inpatient	\$ -	\$ 6,945,880	\$ 682,024	\$ 7,627,905	\$ 108,607	\$ 7,839,860	\$ 1,240,609	\$ 9,189,076	-17.0%
Outpatient	\$ 106,778	\$ 9,452,997	\$ 729,670	\$ 10,289,445	\$ 346,831	\$ 11,818,280	\$ 1,514,758	\$ 13,679,868	-24.8%
Total - Medical	\$ 106,778	\$ 16,398,877	\$ 1,411,695	\$ 17,917,350	\$ 455,438	\$ 19,658,140	\$ 2,755,366	\$ 22,868,944	-21.7%
Dental	\$ 13,614	\$ 1,315,267	\$ 1,220,293	\$ 2,549,175	\$ 61,753	\$ 1,571,106	\$ 1,119,040	\$ 2,751,899	-7.4%
Total	\$ 120,392	\$ 17,714,145	\$ 2,631,988	\$ 20,466,524	\$ 517,191	\$ 21,229,246	\$ 3,874,406	\$ 25,620,843	-20.1%

Net Paid Claims - Per Participant per Month									
	PY13				PY12				% Change
	Pre-Medicare		Medicare	Total	Pre-Medicare		Medicare	Total	
	Actives	Retirees	Retirees		Actives	Retirees	Retirees		
Medical	\$ 989	\$ 758	\$ 616	\$ 746	\$ 333	\$ 688	\$ 937	\$ 696	7.2%
Dental	\$ 45	\$ 32	\$ 39	\$ 35	\$ 28	\$ 32	\$ 41	\$ 35	-0.5%

Net Paid Claims - Total									
Total Participants									
	PY13				PY12				% Change
	Pre-Medicare		Medicare	Total	Pre-Medicare		Medicare	Total	
	Actives	Retirees	Retirees		Actives	Retirees	Retirees		
Medical									
Inpatient	\$ 27,525,611	\$ 16,106,976	\$ 1,976,817	\$ 45,609,404	\$ 25,565,060	\$ 18,092,937	\$ 3,236,736	\$ 46,894,733	-2.7%
Outpatient	\$ 40,753,801	\$ 22,083,035	\$ 2,378,655	\$ 65,215,492	\$ 42,823,905	\$ 23,394,412	\$ 4,694,622	\$ 70,912,939	-8.0%
Total - Medical	\$ 68,279,413	\$ 38,190,011	\$ 4,355,472	\$ 110,824,896	\$ 68,388,965	\$ 41,487,349	\$ 7,931,357	\$ 117,807,672	-5.9%
Dental	\$ 12,681,398	\$ 2,905,588	\$ 2,711,387	\$ 18,298,373	\$ 12,455,971	\$ 3,068,105	\$ 2,458,652	\$ 17,982,727	1.8%
Total	\$ 80,960,811	\$ 41,095,599	\$ 7,066,859	\$ 129,123,269	\$ 80,844,936	\$ 44,555,454	\$ 10,390,009	\$ 135,790,399	-4.9%

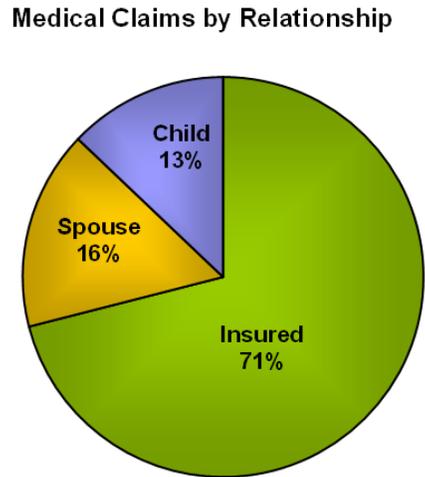
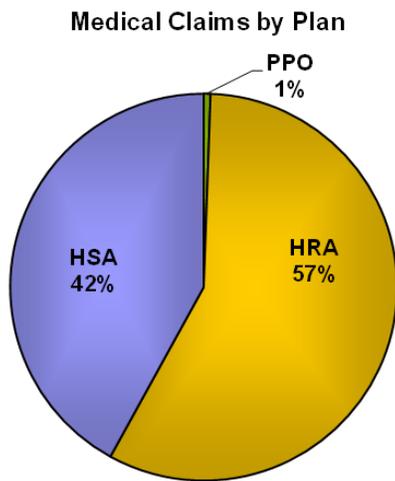
Net Paid Claims - Per Participant per Month									
	PY13				PY12				% Change
	Pre-Medicare		Medicare	Total	Pre-Medicare		Medicare	Total	
	Actives	Retirees	Retirees		Actives	Retirees	Retirees		
Medical	\$ 396	\$ 721	\$ 566	\$ 476	\$ 395	\$ 718	\$ 922	\$ 492	-3.3%
Dental	\$ 46	\$ 34	\$ 41	\$ 43	\$ 44	\$ 34	\$ 43	\$ 42	1.9%

Medical Claims by Plan / Relationship

Medical Claims by Plan - PY13					Total Medical Claims Paid / Relationship						
						1Q	2Q	3Q	4Q	YTD	PMPM
	PPO	HRA	HSA	Total	Insured	Spouse	Child	Total			
Total Costs	\$626,655	\$63,663,509	\$46,534,731	\$110,824,896	\$19,259,329	\$16,681,055	\$20,590,261	\$22,164,138	\$78,694,782	\$338	
PMPM (Per Member per Month)	\$0**	\$427	\$183	\$274	\$4,082,830	\$3,331,680	\$3,331,048	\$3,531,500	\$14,277,058	\$117	
					Total	\$27,305,427	\$25,064,950	\$28,097,047	\$30,357,473	\$110,824,896	\$274

**PPO Plan was for PY11; this reflects run-in claims paid by HSB

Less than 1% of the claims paid in the year ending June 30, 2013, were run-out claims for the \$800 deductible PPO plan that ended on June 30, 2011.



Financial Summary

During the year ending June 30, 2012, participants paid 24.9% of total medical costs owed by the plan and participants combined, after deducting ineligible amounts, network discounts and third party payments from billed charges. During the year ending June 30, 2013, participants' share of costs decreased to 24.6% of the total medical costs paid by the plan and participants.

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	All Combined Groups PY13	All Combined Groups PY12	State Active PY13	State Active PY12	Non-State Active PY13	Non-State Active PY12	State Retirees PY13	State Retirees PY12	Non-State Retirees PY13	Non-State Retirees PY12	HSB 2012 Peer Index
Summary											
# Participants	19,415	20,211	14,529	14,416	9	124	2,884	2,999	1,993	2,672	
# Members	33,664	34,671	27,276	27,143	15	193	4,031	4,120	2,342	3,215	
Mem / Part Ratio	1.73	1.72	1.88	1.88	1.67	1.56	1.40	1.37	1.18	1.20	
Gross Cost	\$146,881,870	\$156,823,450	\$94,272,505	\$93,198,413	\$140,483	\$692,933	\$30,713,299	\$34,585,146	\$21,755,584	\$28,346,958	
Gross Plan Cost	\$110,824,896	\$117,807,672	\$68,172,634	\$67,933,528	\$106,778	\$455,438	\$24,734,912	\$27,005,200	\$17,810,572	\$22,413,506	
Gross Participant Cost	\$36,056,974	\$39,015,778	\$26,099,871	\$25,264,885	\$33,705	\$237,495	\$5,978,387	\$7,579,946	\$3,945,012	\$5,933,452	
PPPM Gross Cost	\$630	\$647	\$541	\$539	\$1,301	\$466	\$887	\$961	\$910	\$884	
PPPM Gross Plan Cost	\$476	\$486	\$391	\$393	\$989	\$306	\$715	\$750	\$745	\$699	\$250
PPPM Gross Participant Cost	\$155	\$161	\$150	\$146	\$312	\$160	\$173	\$211	\$165	\$185	

	All Combined Groups PY13	All Combined Groups PY12	State Active PY13	State Active PY12	Non-State Active PY13	Non-State Active PY12	State Retirees PY13	State Retirees PY12	Non-State Retirees PY13	Non-State Retirees PY12
Catastrophic Summary										
Catastrophic Cases	167	157	85	78	0	0	49	40	33	39
Catastrophic Cases / 1,000	5.0	4.5	3.1	2.9	0.0	0.0	12.2	9.7	14.1	12.1
Avg. Catastrophic Paid / Case	\$223,883	\$234,220	\$220,242	\$227,308	\$0	\$0	\$230,112	\$246,880	\$224,015	\$223,981
Catastrophic % of Gross Dollars	33.7%	31.2%	27.5%	26.1%	0.0%	0.0%	45.6%	32.3%	41.5%	29.4%

	All Combined Groups PY13	All Combined Groups PY12	State Active PY13	State Active PY12	Non-State Active PY13	Non-State Active PY12	State Retirees PY13	State Retirees PY12	Non-State Retirees PY13	Non-State Retirees PY12
Cost Distribution -PPM										
Hospital Inpatient *	\$1,177	\$1,160	\$856	\$789	\$0	\$459	\$2,333	\$2,601	\$2,925	\$2,490
Facility Outpatient*	\$1,583	\$1,651	\$1,211	\$1,249	\$6,320	\$1,547	\$2,897	\$3,022	\$3,549	\$3,301
Physician Office*	\$532	\$586	\$433	\$465	\$798	\$356	\$908	\$936	\$1,044	\$1,188
Total:*	\$3,292	\$3,397	\$2,500	\$2,503	\$7,118	\$2,362	\$6,138	\$6,559	\$7,518	\$6,979
*Annualized										

Cost Distribution

During the year ending June 30, 2013, the plan paid 18,088 claims for members whose total claims paid were in excess of \$100,000 (0.42% of total average number of members; 33.7% of total claim dollars paid). This is 14.6% lower than the 21,182 claims paid for members whose total claims paid were in excess of \$100,000 during the year ending June 30, 2012.

Out of the total CDHP membership:

- 13.8% had total medical claims paid by the plan of \$2,500 or more
- 48.49% had total medical claims paid by the plan of less than \$2,500
- 19.2% had submitted claims that were not paid by the plan (member had not met deductible)
- 18.5% had no claims filed.

The average medical claim for the year ending June 30, 2013, was \$321.74. This represents a 10.8% increase from the \$290.34 average medical claim for the year ending June 30, 2012.

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PY13 COST DISTRIBUTION - MEDICAL CLAIMS							PY12 COST DISTRIBUTION - MEDICAL CLAIMS						
Avg Members	% of Members	# of Claims	% of Claims	Total Paid	% of Paid	Paid Dollar Range	Avg Members	% of Members	# of Claims	% of Claims	Total Paid	% of Paid	
142	0.42%	18,088	5.25%	\$37,388,524	33.73%	\$100,000.01 Plus	138	0.40%	21,182	5.22%	\$36,772,529	31.21%	
240	0.71%	15,839	4.60%	\$17,640,177	15.92%	\$50,000.01 - \$100,000.00	220	0.63%	17,389	4.29%	\$17,757,799	15.07%	
394	1.17%	20,509	5.95%	\$15,072,685	13.60%	\$25,000.01 - \$50,000.00	410	1.18%	25,240	6.22%	\$16,608,430	14.10%	
932	2.77%	34,483	10.01%	\$15,487,858	13.97%	\$10,000.01 - \$25,000.00	920	2.65%	38,944	9.60%	\$16,888,546	14.34%	
1,226	3.64%	35,904	10.42%	\$9,282,642	8.38%	\$5,000.01 - \$10,000.00	1,145	3.30%	39,603	9.76%	\$9,871,717	8.38%	
1,713	5.09%	40,691	11.81%	\$6,581,005	5.94%	\$2,500.01 - \$5,000.00	1,658	4.78%	45,015	11.09%	\$7,374,255	6.26%	
16,322	48.49%	154,460	44.84%	\$9,372,004	8.46%	\$0.01 - \$2,500.00	17,201	49.61%	198,325	48.88%	\$12,534,396	10.64%	
6,479	19.24%	24,478	7.11%	\$0	0.00%	\$0.00	5,598	16.15%	20,061	4.94%	\$0	0.00%	
6,216	18.46%	0	0.00%	\$0	0.00%	No Claims	7,381	21.29%	0	0.00%	\$0	0.00%	
33,663	100.00%	344,452	100.00%	\$110,824,896	100.00%		34,671	100.00%	405,759	100.00%	\$117,807,672	100.00%	

Age Range Summary

The following table shows the medical, prescription drug, dental and total costs per member per month for each age range category. Children under 1 and Adults 60 to 64 had the highest PMPM at \$1,187 and \$764, respectively, compared to the average cost of all members of \$345 PMPM. Adults over the age of 65 had an average PMPM cost of \$654.

Paid Claims by Age Group												
Age Range	PY12		PY13						PY12		% Change	
	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	\$ 3,132,452	\$ 834	\$ 2,797,899	\$ 1,178	\$ 21,473	\$ 9	\$ 868	\$ 0	\$ 2,820,240	\$ 1,187	-10.0%	42.3%
1	\$ 509,626	\$ 436	\$ 665,206	\$ 202	\$ 9,119	\$ 3	\$ 19,628	\$ 4	\$ 693,953	\$ 209	36.2%	-52.1%
2 - 4	\$ 1,247,838	\$ 101	\$ 755,241	\$ 65	\$ 31,668	\$ 3	\$ 294,743	\$ 16	\$ 1,081,651	\$ 83	-13.3%	-17.5%
5 - 9	\$ 2,102,724	\$ 76	\$ 877,212	\$ 39	\$ 80,614	\$ 4	\$ 963,250	\$ 26	\$ 1,921,076	\$ 69	-8.6%	-8.5%
10 - 14	\$ 2,471,253	\$ 79	\$ 1,097,135	\$ 42	\$ 161,948	\$ 6	\$ 981,172	\$ 23	\$ 2,240,255	\$ 72	-9.3%	-9.4%
15 - 19	\$ 5,478,555	\$ 168	\$ 3,815,327	\$ 129	\$ 219,711	\$ 7	\$ 1,123,665	\$ 23	\$ 5,158,703	\$ 160	-5.8%	-4.5%
20 - 24	\$ 6,305,702	\$ 223	\$ 3,960,531	\$ 138	\$ 1,358,541	\$ 47	\$ 682,830	\$ 15	\$ 6,001,902	\$ 201	-4.8%	-10.0%
25 - 29	\$ 2,236,557	\$ 125	\$ 1,566,497	\$ 89	\$ 270,297	\$ 15	\$ 609,032	\$ 21	\$ 2,445,826	\$ 125	9.4%	0.6%
30 - 34	\$ 3,135,387	\$ 141	\$ 3,294,890	\$ 156	\$ 333,241	\$ 16	\$ 780,107	\$ 24	\$ 4,408,238	\$ 195	40.6%	38.7%
35 - 39	\$ 5,430,035	\$ 221	\$ 3,159,705	\$ 135	\$ 715,956	\$ 30	\$ 914,582	\$ 24	\$ 4,790,243	\$ 189	-11.8%	-14.4%
40 - 44	\$ 7,688,386	\$ 256	\$ 5,120,155	\$ 182	\$ 1,130,887	\$ 40	\$ 1,112,219	\$ 24	\$ 7,363,260	\$ 246	-4.2%	-3.9%
45 - 49	\$ 10,890,547	\$ 315	\$ 7,479,304	\$ 235	\$ 1,163,817	\$ 37	\$ 1,293,452	\$ 25	\$ 9,936,574	\$ 297	-8.8%	-5.6%
50 - 54	\$ 14,592,895	\$ 357	\$ 11,088,951	\$ 297	\$ 1,985,462	\$ 53	\$ 1,615,157	\$ 28	\$ 14,689,570	\$ 378	0.7%	6.0%
55 - 59	\$ 25,792,438	\$ 503	\$ 20,822,710	\$ 447	\$ 2,937,874	\$ 63	\$ 2,178,129	\$ 30	\$ 25,938,714	\$ 539	0.6%	7.3%
60 - 64	\$ 43,686,119	\$ 697	\$ 33,210,046	\$ 618	\$ 6,263,200	\$ 117	\$ 2,612,802	\$ 30	\$ 42,086,047	\$ 764	-3.7%	9.7%
65+	\$ 17,946,755	\$ 688	\$ 11,114,089	\$ 541	\$ 1,702,347	\$ 83	\$ 3,116,737	\$ 30	\$ 15,933,173	\$ 654	-11.2%	-5.0%
Total	\$ 152,647,268	\$ 349	\$ 110,824,896	\$ 274	\$ 18,386,154	\$ 46	\$ 18,298,373	\$ 26	\$ 147,509,423	\$ 345	-3.4%	-0.9%

Plan Summary Grid

Cost Distribution – Paid Per Member

The plan paid medical claims in the amount of \$3,292 per member for the reporting period ending June 30, 2013, which is a 3.1% decrease when compared to \$3,397 for the year ending June 30, 2012, (\$274 vs. \$283 PMPM).

Physician Office

The plan paid an average of \$30 per physician office visit compared to \$51 per visit using the HealthSCOPE Benefits' Index. The \$30 average represents payments made by PEBP to providers where participants had met their deductible and/or out-of-pocket maximum offset by office visits paid entirely by the participant prior to meeting the deductible.

Inpatient

Inpatient claims paid PPPM increased 8.3% during the year ending June 30, 2013, vs. the year ending June 30, 2012 from \$164 to \$178. Net inpatient claims paid increased 13.3% per admit, while admits per 1,000 decreased 6.0% during the same period.

	All Combined Groups PY13	All Combined Groups PY12	State Active PY13	State Active PY12	Non-State Active PY13	Non-State Active PY12	State Retirees PY13	State Retirees PY12	Non-State Retirees PY13	Non-State Retirees PY12	HSB 2012 Peer Index
Inpatient:											
# of Admits	2,118	2,307	1,420	1,371	0	8	412	557	286	371	
# of Patient Days	11,012	12,638	6,456	6,078	0	19	2,543	3,836	2,013	2,705	
Paid per Admit	\$19,570	\$17,273	\$17,262	\$15,910	\$0	\$11,818	\$24,051	\$17,888	\$24,576	\$21,509	\$15,913
Paid per Day	\$3,764	\$3,153	\$3,797	\$3,589	\$0	\$4,976	\$3,897	\$2,597	\$3,492	\$2,950	\$3,697
Admits / 1,000	63	67	52	51	0	41	102	135	122	115	59
Days / 1,000	327	365	237	224	0	99	631	931	860	841	252
Average LOS	5.2	5.5	4.5	4.4	0.0	2.4	6.2	6.9	7.0	7.3	4.3

	All Combined Groups PY13	All Combined Groups PY12	State Active PY13	State Active PY12	Non-State Active PY13	Non-State Active PY12	State Retirees PY13	State Retirees PY12	Non-State Retirees PY13	Non-State Retirees PY12	HSB 2012 Peer Index
Physician Office:											
Physician OV Utilization *	3.3	3.6	2.8	2.9	7.5	2.7	4.7	5.9	5.7	6.4	3.1
Physician OV Avg Paid per Visit	\$30	\$30	\$27	\$29	\$47	\$31	\$38	\$32	\$34	\$32	\$51
OV Avg Paid per Member*	\$99	\$108	\$76	\$84	\$353	\$84	\$179	\$189	\$194	\$205	\$158
Physician DX&L Utilization *	9.1	9.8	7.7	7.9	13.6	5.3	13.4	15.5	17.5	18.6	8.8
Physician DX&L Avg Paid per Visit	\$62	\$60	\$55	\$56	\$138	\$91	\$74	\$67	\$78	\$65	\$70
DX&L Avg Paid per Member*	\$564	\$588	\$424	\$442	\$1,877	\$482	\$992	\$1,039	\$1,365	\$1,209	\$616

*DX&L=Diagnostic, Xray, & Lab

	All Combined Groups PY13	All Combined Groups PY12	State Active PY13	State Active PY12	Non-State Active PY13	Non-State Active PY12	State Retirees PY13	State Retirees PY12	Non-State Retirees PY13	Non-State Retirees PY12	HSB 2012 Peer Index
Emergency Room:											
Number of Patients	3,987	4,264	3,042	2,867	7	32	565	803	373	565	
Number of Visits	5,440	5,722	4,019	3,780	7	41	850	1,074	564	827	
Number of Admits	999	1,090	633	553	0	3	226	328	140	206	
Visits/Member*	0.16	0.17	0.15	0.14	0.47	0.21	0.21	0.26	0.24	0.26	0.17
Avg Paid per Visit	\$1,515	\$1,394	\$1,416	\$1,425	\$571	\$1,227	\$1,659	\$1,314	\$2,014	\$1,367	\$1,388
Admits per Visit	0.18	0.19	0.16	0.15	0.00	0.07	0.27	0.31	0.25	0.25	0.14

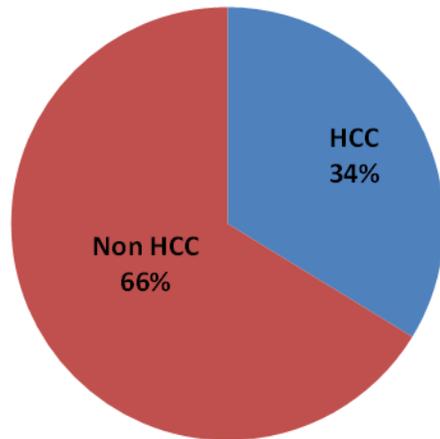
*Annualized

Catastrophic Summary

The plan paid an average of \$223,883 per member for those (167 members) with catastrophic "High Cost Claims" (HCC) in excess of \$100,000. This represents 33.7% of

total (claims paid by the plan). The largest claim cost the plan \$1,653,516 with a primary diagnosis of Cardiovascular Disease.

Distribution of HCC Medical Paid Claims Amount

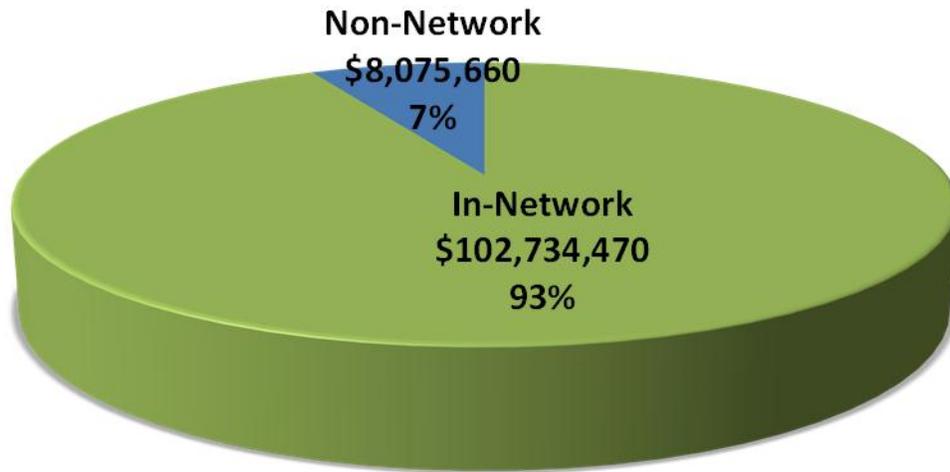


Catastrophic Summary	
HCC Groups	Total Paid
Other Diseases	\$4,471,819
Musculoskeletal Disorders	\$4,397,918
Cardiovascular Disease	\$4,329,039
Complications Med/Surg	\$4,110,883
Chemotherapy Treatment	\$2,744,282
Renal Function Failure	\$2,330,571
Cancer - Other	\$2,302,535
Accident	\$1,988,366
Disease of Respiratory System	\$1,476,463
Disease of Digestive System	\$1,471,862
Nervous System Disorders	\$1,335,631
Complications of Pregnancy	\$1,283,377
Cancer - Brain/Lymph/Organ	\$1,182,848
Diseases of the Blood	\$985,448
Cancer - Breast	\$730,668
Cancer - Lung	\$705,260
Cancer - Reproductive	\$684,405
Cancer - Colorectal	\$454,934
Leukemia	\$217,270
Congenital Anomalies	\$184,943
Total	\$37,388,524

In-Network Medical Discounts

The in-network utilization rate increased from 92% to 93% from the year ending June 30, 2012, to year ending June 30, 2013.

PY13 Network Utilization



Major Diagnostic Category

Total claims decreased 5.9% from \$117.8 million from the year ending June 30, 2012 to \$110.8 million for the year ending June 30, 2013.

Description	# Patients	# Claims	Total Paid	% of Paid	PY12 Total Paid
(MDC 18) DISORDER OF MUSCULOSKELETAL SYSTEM	9,437	62,177	\$17,104,259	15.44%	\$17,204,008
(MDC 25) FACTORS AFFECTING HEALTH	18,961	60,556	\$15,031,645	13.57%	\$15,072,933
(MDC 02) NEOPLASMS	3,767	18,682	\$12,574,056	11.35%	\$14,942,583
(MDC 10) DISORDER OF CIRCULATORY SYSTEM	5,670	21,256	\$10,581,492	9.54%	\$10,293,615
(MDC 23) FRACTURES AND OTHER INJURIES	5,067	16,922	\$9,682,795	8.74%	\$9,040,157
(MDC 22) ILLDEFINED CONDITIONS	11,159	39,257	\$7,110,385	6.42%	\$8,108,610
(MDC 11) DISORDER OF RESPIRATORY SYSTEM	8,965	25,549	\$4,697,773	4.24%	\$5,803,089
(MDC 12) DISORDER OF DIGESTIVE SYSTEM	2,956	8,123	\$4,341,255	3.92%	\$4,752,787
(MDC 07) DISORDER OF NERVOUS SYSTEM	2,401	10,539	\$4,237,356	3.82%	\$3,878,280
(MDC 14) NEPHRITIS / NEPHROSIS	2,391	8,924	\$4,130,291	3.73%	\$4,142,200
(MDC 03) ENDOCRINE, NUTRITIONAL, METABOLIC, IMMUNITY, DISORDERS	7,816	26,560	\$3,691,462	3.33%	\$4,030,542
(MDC 05) PSYCHOTIC CONDITIONS	2,935	14,350	\$2,340,493	2.11%	\$2,356,804
(MDC 13) OTHER DIGESTIVE DISORDERS	849	2,988	\$2,207,665	1.99%	\$2,477,213
(MDC 01) INFECTIOUS / PARASITIC DISEASE	2,604	4,704	\$2,130,085	1.92%	\$3,978,116
(MDC 17) PREGNANCY / CHILDBIRTH	398	2,314	\$1,644,270	1.48%	\$1,739,028
(MDC 08) DISORDER OF EYE / ADNEXA	6,562	12,303	\$1,562,651	1.41%	\$2,140,433
(MDC 04) DISORDER OF BLOOD	905	3,537	\$1,478,594	1.33%	\$1,587,600
(MDC 19) DISORDER OF BREAST OR SKIN	5,810	12,287	\$1,461,418	1.32%	\$2,597,038
(MDC 20) CONGENITAL ANOMALIES	401	983	\$1,305,753	1.18%	\$460,504
(MDC 16) FEMALE DISORDERS	2,438	6,240	\$1,286,252	1.16%	\$1,395,717
(MDC 09) DISORDER OF EAR	2,282	3,937	\$626,432	0.57%	\$802,500
(MDC 24) BURNS / ACCIDENTS BY FIRE	55	133	\$555,264	0.50%	\$5,637
(MDC 15) DISORDER OF MALE GENITAL ORGANS	854	1,976	\$466,108	0.42%	\$243,580
(MDC 21) PERINATAL PERIOD CONDITIONS	95	740	\$288,817	0.26%	\$579,841
(MDC 06) ALCOHOL / DRUG PSYCHOTROPIC DEPENDENCY	50	126	\$288,326	0.26%	\$174,857
	104,828	365,163	\$110,824,896	100.00%	\$117,807,672

Musculoskeletal, Factors Affecting Health and Neoplasms are the most expensive three diagnostic categories, together accounting for 40.4 % of total costs.

MDC (18) DISORDER OF MUSCULOSKELETAL SYSTEM

MDC	Dx Code	Diagnosis Description	# Patients	# Claims	Total Paid
18	7213	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY	324	877	\$960,616
18	71536	OSTEOARTHRISIS LOCALIZED NOT SPECIFIED WHETHER PRIMARY OR SECONDARY INVOLVING LOWER LEG	74	128	\$875,486
18	72252	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC	522	1480	\$811,148
18	71535	OSTEOARTHRISIS LOCALIZED NOT SPECIFIED WHETHER PRIMARY OR SECONDARY INVOLVING PELVIC REGION AND THIGH	47	88	\$808,230
18	72402	SPINAL STENOSIS OF LUMBAR REGION	191	616	\$682,113

MDC (25) FACTORS AFFECTING HEALTH

MDC	Dx Code	Diagnosis Description	# Patients	# Claims	Total Paid
25	V5811	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY	58	309	\$2,083,248
25	V5789	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE	104	210	\$1,604,450
25	V7651	SPECIAL SCREENING FOR MALIGNANT NEOPLASMS OF COLON	1194	2747	\$1,248,639
25	V700	ROUTINE GENERAL MEDICAL EXAMINATION AT A HEALTH CARE FACILITY	6162	9444	\$1,075,518
25	V3001	SINGLE LIVEBORN, BORN IN HOSPITAL, DELIVERED BY CESAREAN SECTION	81	146	\$948,326

MDC (02) NEOPLASMS

MDC	Dx Code	Diagnosis Description	# Patients	# Claims	Total Paid
2	1749	MALIGNANT NEOPLASM OF BREAST (FEMALE), UNSPECIFIED	218	1783	\$1,378,332
2	185	MALIGNANT NEOPLASM OF PROSTATE	156	1093	\$922,478
2	20280	OTHER MALIGNANT LYMPHOMAS UNSPECIFIED SITE	38	481	\$425,864
2	1985	SECONDARY MALIGNANT NEOPLASM OF BONE AND BONE MARROW	25	106	\$396,824
2	1744	MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF FEMALE BREAST	77	571	\$392,696

Inpatient Summary

Claims by the top 25 most utilized hospitals make up 74.9% of all acute costs paid by PEBP on behalf of its members. The top three hospitals (Renown Regional Medical Center, University of California Davis MC, and Sunrise Hospital) account for 24.3% of all acute costs. Total inpatient claims paid account for 37.4% of total plan costs.

University of California Davis, Santa Rosa Memorial Hospital and CA Pacific Medical Center were paid the most on a per-day acute basis. This data should be used only to demonstrate to which hospitals large dollar amounts are going. Determining which hospitals cost more can only be determined via an in-depth study of costs per diagnosis code.

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<i>Tax ID</i>	<i>Hospital</i>	<i>Admits</i>	<i>Bed Days</i>	<i>Avg LOS</i>	<i>Total Paid</i>	<i>Paid per Admit</i>	<i>Paid per Day</i>	<i>% of Admits</i>	<i>% of Paid</i>
88-0213754	RENOWN REGIONAL MEDICAL CENTER	1,665	393	4.2	\$5,113,680	\$3,071	\$13,012	15.12%	12.34%
94-6036494	UNIVERSITY OF CALIFORNIA DAVIS MC	99	7	14.1	\$2,727,623	\$27,552	\$389,660	0.90%	6.58%
62-1762537	SUNRISE HOSPITAL	482	71	6.8	\$2,235,859	\$4,639	\$31,491	4.38%	5.39%
88-0502320	CARSON TAHOE REGIONAL HEALTHCARE	948	244	3.9	\$2,153,406	\$2,272	\$8,825	8.61%	5.20%
88-0455713	ST ROSE DOMINICAN SIENA	528	113	4.7	\$2,101,066	\$3,979	\$18,594	4.79%	5.07%
94-3281657	UCSF MEDICAL CENTER	74	11	6.7	\$1,722,661	\$23,279	\$156,606	0.67%	4.16%
62-1600397	MOUNTAIN VIEW HOSPITAL	384	90	4.3	\$1,568,169	\$4,084	\$17,424	3.49%	3.78%
23-2939047	SUMMERLIN HOSPITAL MEDICAL CENTER	700	121	5.8	\$1,364,537	\$1,949	\$11,277	6.36%	3.29%
77-0465765	STANFORD MEDICAL CENTER	50	13	3.8	\$1,322,004	\$26,440	\$101,693	0.45%	3.19%
23-2973511	VALLEY HOSPITAL MEDICAL CENTER	452	69	6.6	\$998,926	\$2,210	\$14,477	4.10%	2.41%
94-2854057	DIXIE REGIONAL MEDICAL CENTER	204	43	4.7	\$981,304	\$4,810	\$22,821	1.85%	2.37%
38-3667923	SIERRA SURGERY HOSPITAL LLC	95	38	2.5	\$969,520	\$10,205	\$25,514	0.86%	2.34%
88-6000436	UNIVERSITY MEDICAL CENTER	283	64	4.4	\$899,554	\$3,179	\$14,056	2.57%	2.17%
46-0517825	RENOWN SOUTH MEADOWS MEDICAL CENTER	343	60	5.7	\$746,610	\$2,177	\$12,443	3.11%	1.80%
87-6000525	UNIVERSITY OF UTAH HOSPITAL & CLINICS	177	17	10.4	\$698,474	\$3,946	\$41,087	1.61%	1.69%
23-2947273	DESERT SPRINGS HOSPITAL	159	30	5.3	\$640,676	\$4,029	\$21,356	1.44%	1.55%
94-0562680	CA PACIFIC MED CENTER	63	3	21.0	\$640,364	\$10,165	\$213,455	0.57%	1.54%
88-0059427	ST ROSE DOMINICAN HOSPITAL NV	194	25	7.8	\$568,928	\$2,933	\$22,757	1.76%	1.37%
72-1549752	SPRING VALLEY HOSPITAL MEDICAL CENTER	194	55	3.5	\$548,734	\$2,829	\$9,977	1.76%	1.32%
94-1231005	SANTA ROSA MEMORIAL HOSPITAL	41	2	20.5	\$538,137	\$13,125	\$269,069	0.37%	1.30%
20-4993360	CENTENNIAL HILLS HOSPITAL MED CENTE	201	58	3.5	\$522,097	\$2,597	\$9,002	1.83%	1.26%
45-2218443	COMPLEX CARE HOSPITAL AT TENAYA	162	4	40.5	\$505,246	\$3,119	\$126,312	1.47%	1.22%
62-1740235	NORTHEASTERN NEVADA REG HOSP	94	31	3.0	\$501,306	\$5,333	\$16,171	0.85%	1.21%
95-1684089	SCRIPPS MERCY HOSPITAL	49	4	12.3	\$486,488	\$9,928	\$121,622	0.44%	1.17%
38-3730230	ST ROSE DOMINICAN HOSP DBA DIGNITY HEALTH	123	33	3.7	\$484,488	\$3,939	\$14,681	1.12%	1.17%
	Top 25	7,764	1,599	4.9	\$31,039,858	\$3,998	\$19,412	70.50%	74.88%
	All Others	3,248	519	6.3	\$10,410,364	\$3,205	\$20,059	29.50%	25.12%
	Grand Total	11,012	2,118	5.2	\$41,450,222	\$3,764	\$19,570	100.00%	100.00%

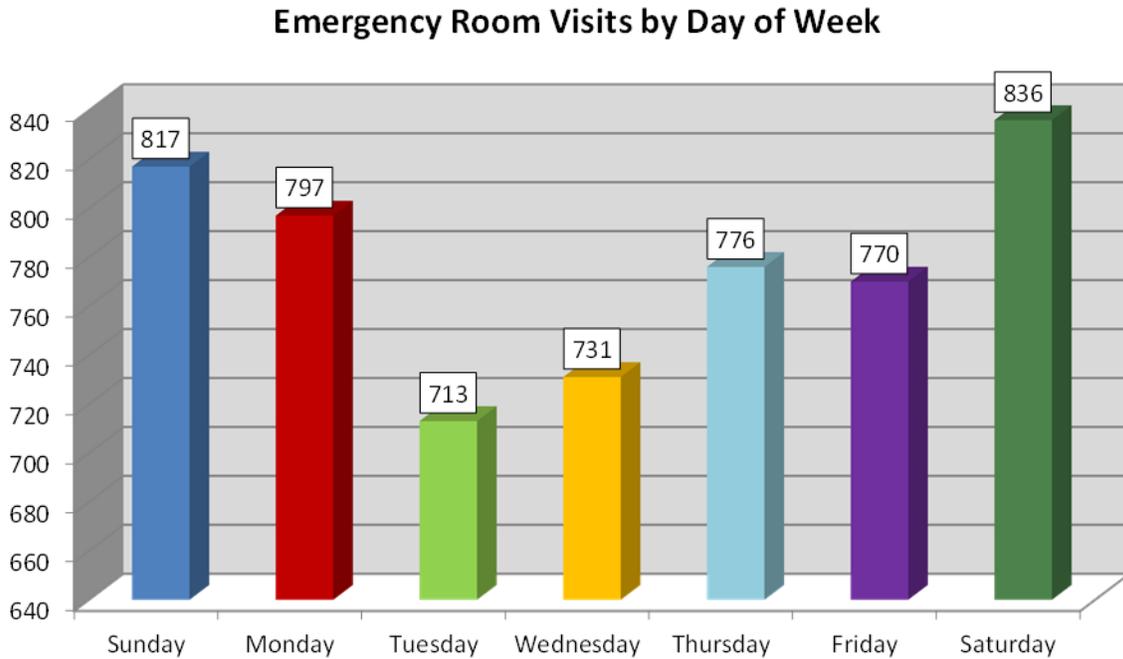
Top 25 Outpatient Type of Service

The top 25 outpatient services account for 98.7% of all outpatient costs. Outpatient services account for 42.6% of plan costs.

<i>Service Code</i>	<i># Patients</i>	<i>% of Patients</i>	<i>Paid</i>	<i>% of Paid</i>
Hospital Ancillary	6,827	9.12%	\$18,225,766	38.57%
Radiology	7,173	9.58%	\$6,444,464	13.64%
Surgery	4,443	5.93%	\$4,295,966	9.09%
Laboratory	16,884	22.55%	\$3,958,905	8.38%
Anesthesia	3,528	4.71%	\$2,089,973	4.42%
Emergency Room	3,663	4.89%	\$1,833,686	3.88%
Ambulance	732	0.98%	\$1,799,286	3.81%
Injection	667	0.89%	\$1,146,376	2.43%
Radiation Therapy	36	0.05%	\$1,056,668	2.24%
ER Professional Fee	3,674	4.91%	\$948,892	2.01%
Medical Equipment	1,176	1.57%	\$826,695	1.75%
Pathology	2,685	3.59%	\$773,175	1.64%
Physical Therapy	482	0.64%	\$499,217	1.06%
Miscellaneous	2,108	2.82%	\$423,678	0.90%
Mammogram	1,885	2.52%	\$390,710	0.83%
Infusion Therapy	168	0.22%	\$385,011	0.81%
Office Visit	5,752	7.68%	\$271,717	0.57%
Pap Smear	4,230	5.65%	\$267,625	0.57%
Psychotherapy	196	0.26%	\$215,532	0.46%
Clinic	1,151	1.54%	\$197,003	0.42%
Chemotherapy	60	0.08%	\$142,460	0.30%
Assistant Surgery	391	0.52%	\$135,920	0.29%
Home Health Care	156	0.21%	\$121,714	0.26%
Hospital Visit	558	0.75%	\$99,423	0.21%
Hospice Care	20	0.03%	\$96,466	0.20%
Top 25	68,645	91.68%	\$46,646,331	98.71%
All Other	6,226	8.32%	\$609,501	1.29%
Grand Total	74,871	100.00%	\$47,255,833	100.00%

Emergency Room Summary

From the year ending June 30, 2012, to the year ending June 30, 2013, ER visits decreased from 170 to 160 per 1,000 members. Emergency rooms are utilized more than average on Friday through Sunday



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Savings Summary

During the year ending June 30, 2012, direct out-of-pocket costs (deductible, co-payment and co-insurance) by participants accounted for 24.9% of total medical costs owed by the plan and participants after deducting ineligible amounts, network discounts and third party payments from billed charges. Direct out-of-pocket costs by participants for the year ending June 30, 2013 decreased to 24.6% of the total medical costs paid by the plan and participants combined. This decrease is due to a combination of fewer claims (344,452 compared to 405,759), lower total costs (\$110,824,896 compared to \$117,807,672) and a higher percent of total costs paid by the plan (75.5% compared to 75.1%) for participants who have met their deductible and out-of-pocket maximums.

Category	Dollars	PPPM	% of Eligible
Eligible Charges	\$402,840,761	\$1,729	100.00%
COB	\$10,974,657	\$47	2.72%
Medicare	\$11,502,633	\$49	2.86%
Excess/Maximums	\$2,831,693	\$12	0.70%
PPO Discount	\$230,649,907	\$990	57.26%
Deductible	\$24,580,189	\$106	6.10%
Coinsurance	\$11,476,786	\$49	2.85%
Total Participant Cost	\$36,056,974	\$155	8.95%
Total Plan Cost	\$110,824,896	\$476	27.51%

Total Participant Cost - PY12	\$161
Total Plan Paid - PY12	\$486

Patient Demographics

During the year ending June 30, 2013, the plan paid \$274 PMPM. The average cost per adult was \$343 PMPM. The average cost per child was \$117 PMPM.

Patient Type	Avg Members	Inpatient Paid	Outpatient Paid	Physician Paid	PCP Paid	Specialist Paid	Other Paid	Total Paid	% of Paid	PMPM
Child	10,175	\$6,150,056	\$1,466,091	\$4,084,711	\$1,569,134	\$2,515,577	\$636,335	\$14,277,058	12.9%	\$117
Husband	1,323	\$4,181,633	\$1,092,074	\$1,537,142	\$320,466	\$1,216,676	\$197,839	\$7,428,410	6.7%	\$468
Insured	19,414	\$26,251,164	\$19,007,880	\$26,487,407	\$5,251,883	\$21,235,524	\$1,836,011	\$78,694,782	71.0%	\$338
Wife	2,752	\$3,029,567	\$2,414,943	\$3,956,491	\$675,182	\$3,281,309	\$254,915	\$10,424,646	9.4%	\$316
Total	33,663	\$39,612,420	\$23,980,988	\$36,065,751	\$7,816,665	\$28,249,086	\$2,925,100	\$110,824,896	100.0%	\$274

Patient Type	Avg Members	Inpatient Paid	Outpatient Paid	Physician Paid	PCP Paid	Specialist Paid	Other Paid	Total Paid	% of Paid	PMPM
Female	17,540	\$19,528,485	\$13,851,811	\$22,030,194	\$4,478,359	\$17,551,835	\$1,252,184	\$60,971,143	55.0%	\$290
Male	16,123	\$20,083,936	\$10,129,177	\$14,035,557	\$3,338,306	\$10,697,251	\$1,672,916	\$49,853,753	45.0%	\$258
Total	33,663	\$39,612,420	\$23,980,988	\$36,065,751	\$7,816,665	\$28,249,086	\$2,925,100	\$110,824,896	100.0%	\$274

Participants by Tier

During the year ending June 30, 2013, the plan paid \$274 PMPM.

<i>Coverage Tier</i>	<i>Avg Members</i>
Single	12,358
Employee + Spouse	3,490
Employee + Children	8,889
Family	8,926
<i>Total</i>	<i>33,663</i>

<i>Member Type</i>	<i># Members</i>	<i>Total Paid</i>	<i>PMPM</i>
Children	10,175	\$14,277,058	\$117
Adults	23,488	\$96,547,838	\$343
<i>Total</i>	<i>33,663</i>	<i>\$110,824,896</i>	<i>\$274</i>

Dental Section

Cost Distribution

The maximum per member dental benefit for Plan Year 2013 is \$1,000. However, claims paid during the year included run-out claims for Plan Year 2012. This accounts for the plan paying in excess of \$1,000 on behalf of 4,282 members.

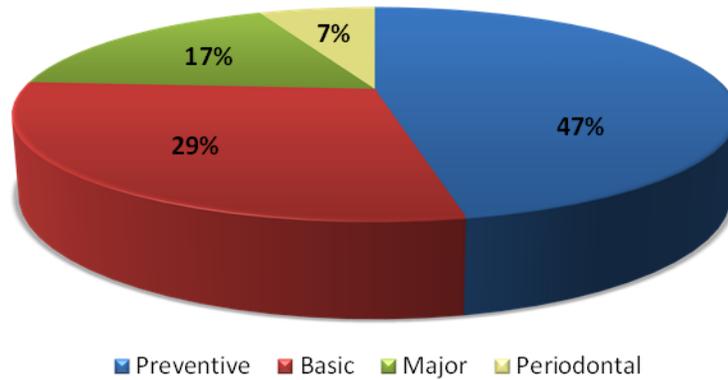
The average dental claim for the year ending June 30, 2013, was \$150.78. This represents a 28.7% increase from the \$117.20 average dental claim for the year ending June 30, 2012. However, the total amount for paid claims represents a 1.8% increase for the year ending June 30, 2013 at \$18.3 million as compared to the same period the previous year at \$18 million.

Paid Dollar Range	Avg Members	of Member	# Claims	% of Claims	Total Paid	% of Paid
\$1,000.01 Plus	4,282	7.16%	22,116	18.22%	\$5,219,754	28.53%
\$750.01 - \$1,000.00	3,212	5.37%	13,239	10.91%	\$2,973,923	16.25%
\$500.01 - \$750.00	4,370	7.31%	16,452	13.56%	\$2,791,845	15.26%
\$250.01 - \$500.00	13,171	22.03%	39,516	32.56%	\$4,631,307	25.31%
\$0.01 - \$250.00	15,986	26.74%	29,439	24.26%	\$2,681,544	14.66%
\$0.00	553	0.93%	596	0.49%	\$0	0.00%
No claims	18,204	30.45%	0	0.00%	\$0	0.00%
	59,778	100.00%	121,358	100.00%	\$18,298,373	100.00%

Dental Paid by Type of Service

Of the \$18.3 million in paid dental claims during the year ending June 30, 2013, \$8.6 million (46.8%) was for preventive services.

TYPE OF DENTAL SERVICE



Savings Summary

During the year ending June 30, 2012, participants paid 34.0% of total dental costs owed by the plan and participants combined, after deducting ineligible amounts, network discounts and third party payments from billed charges. During the year ending June 30, 2013, participants' share of costs remained flat at 34.0% of total dental costs paid by the plan and participants. While participants' share of costs remained flat, the plan cost per member per month amount decreased by 2.3% from \$24.94 for the year ending June 30, 2012 to \$24.50 for the year ending June 30, 2013.

This table is per member per month

Category	Dollars	PPPM	% of Eligible
Eligible Charges	\$37,823,628	\$88	100.00%
COB	\$129,274	\$0	0.34%
PPO Discount	\$5,831,475	\$14	15.42%
Excess/Maximums	\$4,159,995	\$10	11.00%
Deductible	\$2,620,710	\$6	6.93%
Coinsurance	\$6,783,801	\$16	17.94%
Total Participant	\$9,404,511	\$22	24.86%
Total Plan Paid	\$18,298,373	\$43	48.38%

Total Participant Cost - PY12	\$22
Total Plan Paid - PY12	\$42

Patient Demographics

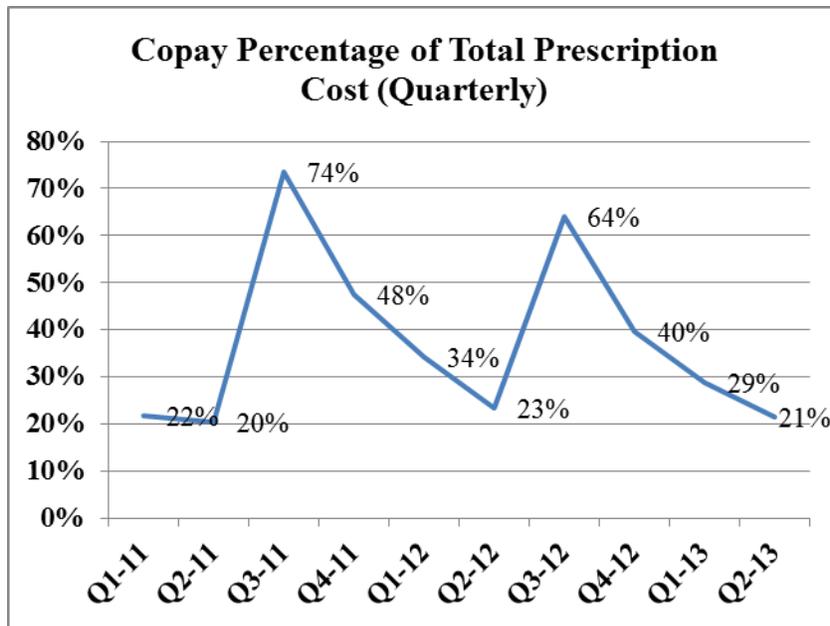
During the year ending June 30, 2013, the plan paid \$26 PMPM. The average cost per adult was \$28 PMPM. The average cost per child was \$20 PMPM.

<i>Member Type</i>	<i># Members</i>	<i>Total Paid</i>	<i>PMPM</i>
Children	16,779	\$4,025,738	\$20
Adults	42,999	\$14,272,635	\$28
<i>Total</i>	<i>59,778</i>	<i>\$18,298,373</i>	<i>\$26</i>

Drug Utilization

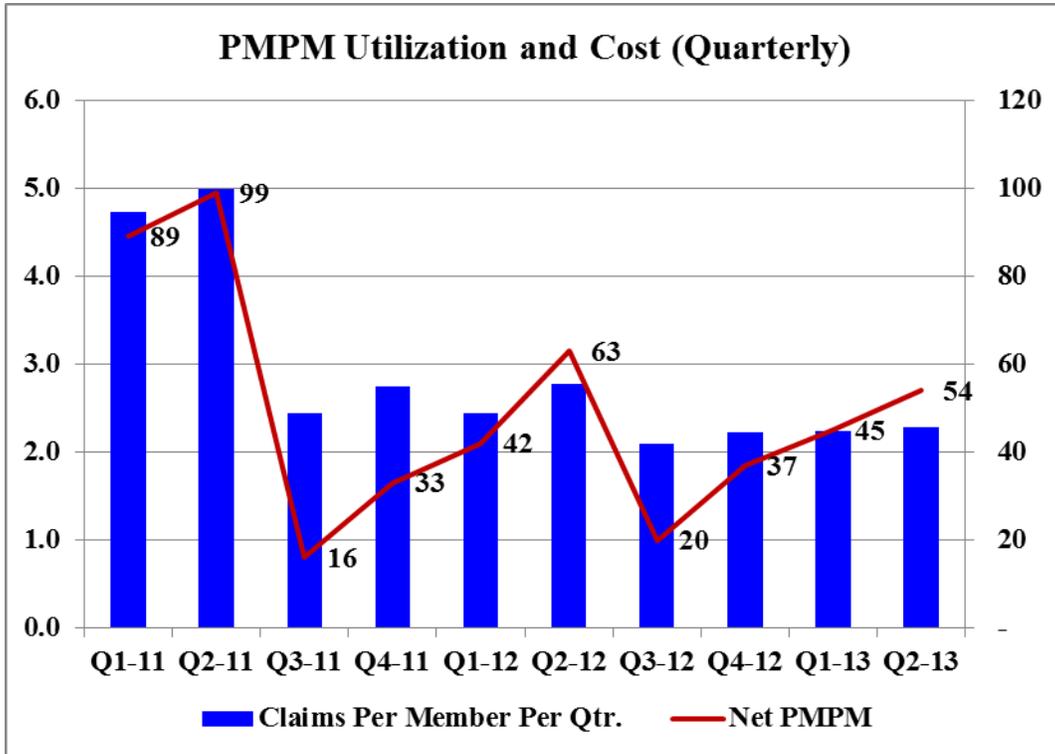
Drug utilization (number of members utilizing the PEBP pharmacy benefit as a percent of all PPO self-funded members) has decreased from 35.1% to 29.6% from the quarter ending June 30, 2012, to the quarter ending June 30, 2013.

For the fourth quarter of FY13, total prescription drug net costs paid by the plan decreased 2.2% (decrease of 14.5% on a PMPM basis due to higher member count) from \$6.6 million to \$6.4 million while prescription drug costs paid by participants decreased (13.0%) from \$2 million to \$1.7 million (23.8% PMPM). Participants paid 23.4% of total drug costs for the quarter ending June 30, 2012 and 21.4% of total drug costs for the quarter ending June 30, 2013. With the introduction of the Consumer Driven Health Plan effective July 1, 2011, participants are now responsible for the full price of their prescription drugs until they meet their deductible. After a participant meets the deductible they will be responsible for 25% of the cost of their drugs until they meet the out-of-pocket maximum. The participant share of costs will decrease through the year as more participants meet their deductible and out-of-pocket maximums. Additionally, the higher prescription drug cost sharing reduces the amount of medical claim cost sharing due to the combined deductibles.



The chart shows the percent of total prescription costs paid by participants for the ten quarters ending June 30, 2013.

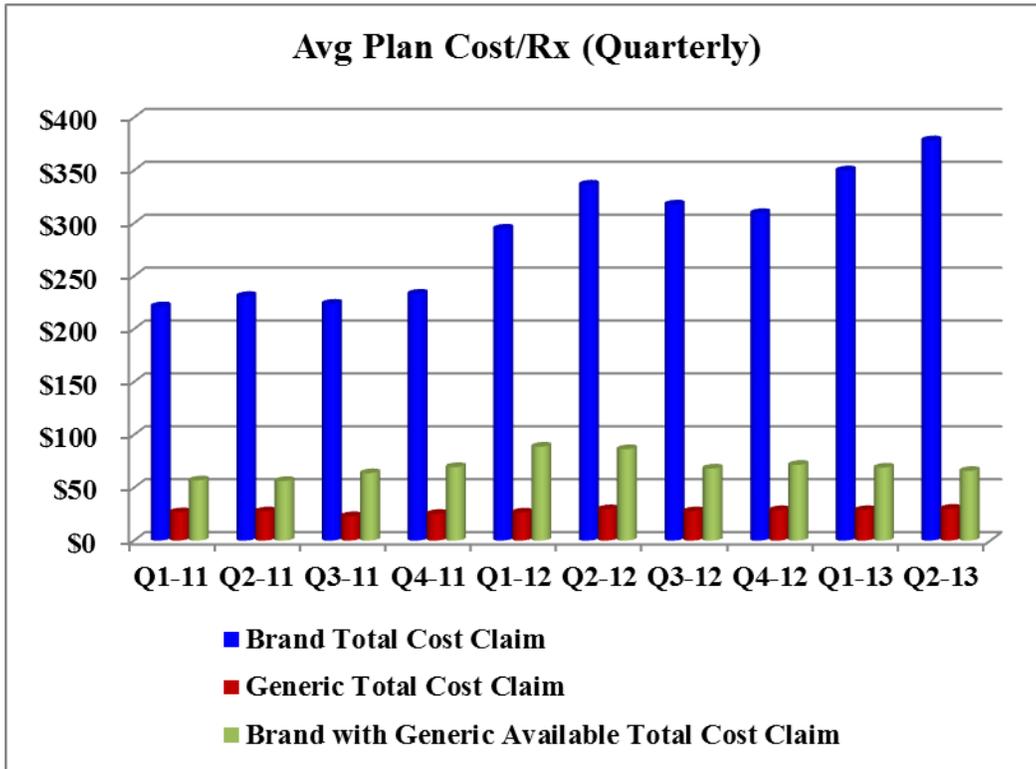
The chart below shows a relatively steady increase in the number of claims per eligible member until June 30, 2011. The decreases in the net PMPM plan costs in the 3rd quarter of calendar year 2011 is due to the implementation of the Consumer Driven Health Plan and the transition of Medicare retirees to the Medicare Exchange effective July 1, 2011. A corresponding drop in claims is also noted to under 3 claims per eligible member for the 3rd quarter of calendar year 2011 through the current quarter ending June 30, 2013.



Generic drug utilization (generic scripts filled as a percent of all scripts) increased from 78.3% in the quarter ending June 30, 2012, to 80.8% in the quarter ending June 30, 2013. This generic utilization rate is among the highest in the nation and is a result of the plan's mandatory generic program. Due to the unavailability of generic equivalents for certain brand drugs, the maximum generic utilization rate the plan could achieve for the quarter ending June 30, 2013, is 82.8%.

From the quarter ending June 30, 2012, to the quarter ending June 30, 2013, the net total number of generic prescriptions filled decreased 3.1%, (15.2% PMPM) while the net total cost of generic drugs to the plan and its participants decreased 1.4%. During the quarter ending June 30, 2013, generic drugs cost were \$2.2 million out of \$8.2 million in total prescription drug costs paid by the plan and participants.

The following table shows the average cost per prescription for brand drugs, generic drugs and brand drugs with generic equivalents for the last ten quarters.



The net cost of specialty drugs increased 3.9% (decrease of 9.1% PMPM) from \$2.7 million during the quarter ending June 30, 2012, to \$2.8 million in the quarter ending June 30, 2013. The average number of patients with 7 or more prescription claims per month decreased 12% from 893 as of June 30, 2012, to 786 as of June 30, 2013.

During the quarter ending June 30, 2013, the five most expensive drugs for the plan and participants (total) were Copaxone, Humira Pen, Rebif, and Enbrel Sureclick, and Cinryze.

Staff continues to work with Catamaran (Catalyst RX) to add information regarding possible therapeutic equivalents to their website and mobile applications so that members have more information and can better compare prescribed drugs and potential generic alternatives in order to provide additional cost savings to participants and the plan.

Self-Funded Plan Utilization Report for the year ending June 30, 2013

October 3, 2013

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	PY13 Q4	PY12 Q4
Membership Summary		
	Rolling Total for 3 Months	
Member Count	39,572	34,629
Utilizing Member Count	11,696	12,149
Percent Utilizing	29.6%	35.1%
Claim Summary		
Net Claims (Mail/Retail)	90,193	96,013
Claims per Elig Member per Month	0.76	0.92
Total Claims for Brand	5,159	6,028
Total Claims for Generic	72,841	75,187
Total Claims for Brand w/Gen Equiv	1,874	2,743
Generic % of Total Claims	80.8%	78.3%
Mail Order Claims	2,780	4,070
Mail Order % of Total Claims	3.1%	4.2%
Generic Effective Rate	97.49%	96.48%
Claims Cost Summary		
Total Prescription Cost	\$8,162,972.83	\$8,570,255.05
Total Ingredient Cost	\$8,046,639.34	\$8,441,970.04
Total Dispensing Fee	\$113,849.29	\$123,538.25
Total Other (e.g. tax)	\$624.20	\$1,846.76
Total Incentive Fee	\$1,860.00	\$2,900.00
Avg Total Cost per Claim	\$90.51	\$89.26
Avg Total Cost for Brand	\$378.48	\$336.60
Avg Total Cost for Generic	\$30.19	\$29.67
Avg Total Cost for Brand w/Gen Equiv	\$65.90	\$86.46
Member Cost Summary		
Total Copay	\$1,745,112.81	\$2,005,400.90
Avg Copay per Claim	\$19.35	\$20.89
Avg Copay for Brand	\$53.99	\$55.73
Avg Copay for Generic	\$11.33	\$11.63
Avg Copay for Brand w/Gen Equiv	\$45.81	\$46.75
Copay % of Total Prescription Cost	21.4%	23.4%

Self-Funded Plan Utilization Report for the year ending June 30, 2013
 October 3, 2013
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Rolling Total for 3 Months (cont.)		
Other Plan Paid Cost Summary		
Total Other Plan Paid Cost	\$0.00	\$0.00
Plan Cost Summary		
Total Plan Cost	\$6,417,860.02	\$6,564,854.15
Total Specialty Drug Cost	\$2,834,490.34	\$2,728,867.19
Avg Plan Cost per Claim	\$71.16	\$68.37
Avg Plan Cost for Brand	\$324.49	\$315.72
Avg Plan Cost for Generic	\$18.85	\$18.05
Avg Plan Cost for Brand w/Gen Equiv	\$20.09	\$39.70
Net PMPM	\$54.06	\$63.19
PMPM for Specialty Only	\$23.88	\$26.27
PMPM without Specialty	\$30.18	\$36.92

Wellness Summary

In addition to the wellness screenings paid through HealthSCOPE, USPM administered 10,629 biometric screenings and 2,286 PSA tests in the year ending June 30, 2013.

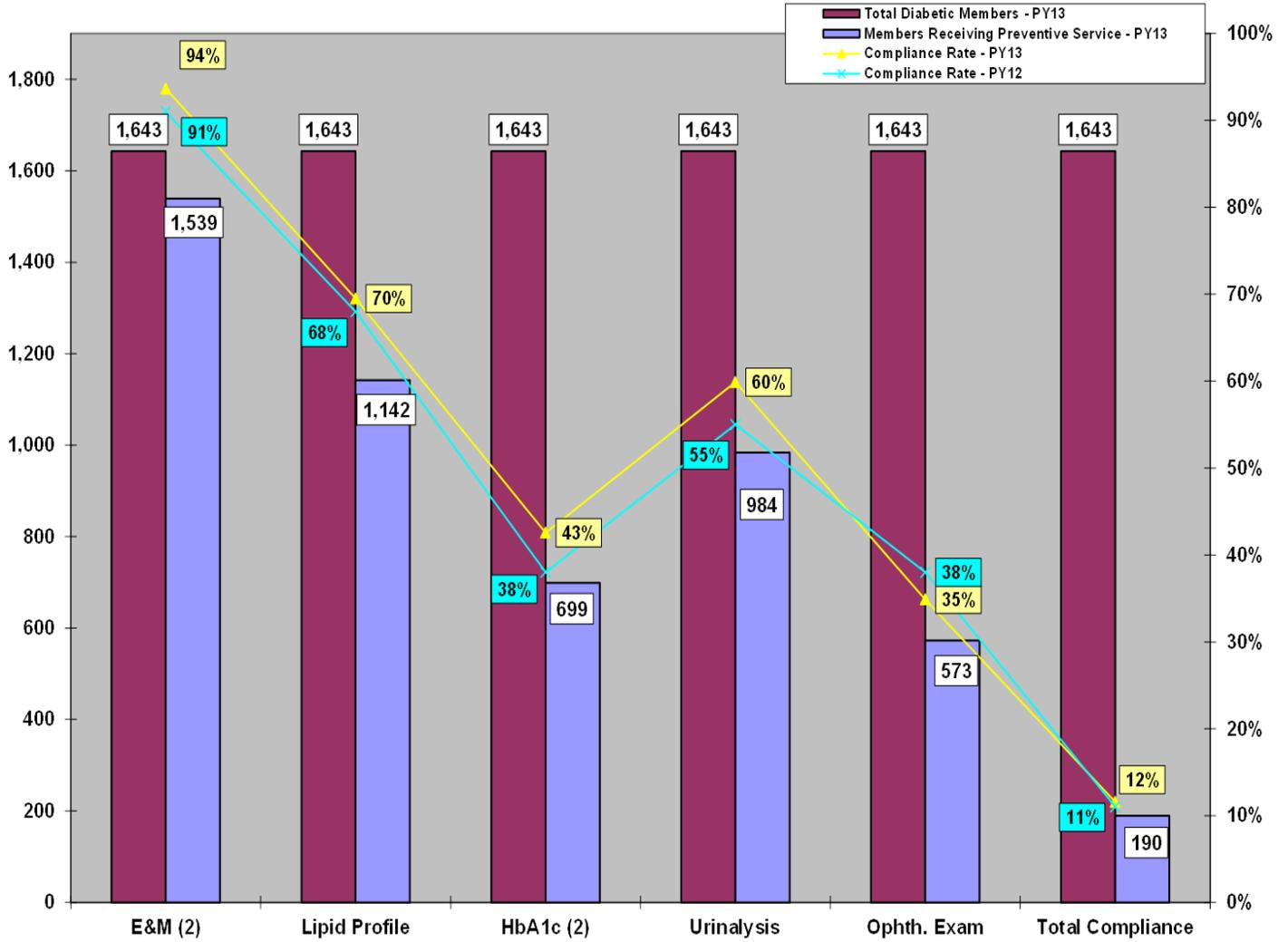
Well Child	# Eligible	# Patients	Per 1,000	HSB Index per 1,000	# Claims	Total Paid	Paid Per Pt
Routine Infant or Child Health Check	7,186	2,771	386	494	3,940	\$357,289	\$129
Prophylactic Vaccinations and Inoculations	7,186	1,652	230	N/A	2,497	\$109,851	\$67

Well Woman	# Eligible	# Patients	Per 1,000	HSB Index per 1,000	# Claims	Total Paid	Paid Per Pt
Mammogram	9,841	4,769	485	410	6,158	\$898,384	\$188
Cervical Screening	13,521	4,812	356	402	5,889	\$434,567	\$90
Colonoscopy	7,237	1,253	173	126	2,235	\$865,135	\$690
Routine General Medical Exam	14,017	2,744	196	637	2,878	\$345,490	\$126
Prophylactic Vaccinations and Inoculations	14,017	875	62	N/A	903	\$24,582	\$28

Well Man	# Eligible	# Patients	Per 1,000	HSB Index per 1,000	# Claims	Total Paid	Paid Per Pt
Prostate Screening	6,190	1,699	274	408	1,780	\$44,362	\$26
Colonoscopy	6,190	734	119	110	1,498	\$664,369	\$905
Routine General Medical Exam	12,460	2,369	190	333	2,494	\$315,487	\$133
Prophylactic Vaccinations and Inoculations	12,460	625	50	N/A	647	\$17,884	\$29

Diabetes Compliance

For the year ending June 30, 2013, 519 of 1,643, or 32%, of active CDHP diabetics, with nine months of service, have received the minimum number of recommended services (semiannual visit, semiannual glycohemoglobin determination, annual urinalysis or micro albuminuria test, annual lipid profile) when the ophthalmologic exams are excluded. However, only 190 of 1,643 active CDHP diabetics with nine months of service (12%) have received the minimum number of recommended services when the annual ophthalmologic evaluation is included. Compliance rates are slightly higher than those noted for the year ending June 2012 with the exception of ophthalmologic evaluation which decreased from 38% to 35%.



- PY13 – 519 members (1,643 total) received all services other than ophth exam (32%)
- PY12 – 517 members (1,651 total) received all services other than ophth exam (31%)

Diabetes Compliance Requirements

- **Semiannual visit**

The American Diabetes Association recommends at least semiannual visits to monitor metabolic control and review laboratory results. Patients who require adjustment of their medical regimen will require more frequent follow-ups.

- **Semiannual glycohemoglobin determination**

Glycohemoglobin determination is a method for assessing long term glycemic control in patients and is recommended at least semiannually by the American Diabetes Association

- **Annual urinalysis or microalbuminuria test**

Diabetes is associated with multiple renal complications, the most serious being renal insufficiency (diabetic nephropathy). One of the earliest manifestations of diabetic nephropathy is microalbuminuria. The American Diabetes Association recommends a urinalysis annually for all patients with diabetes mellitus. Patients with long standing diabetes may benefit from a 24-hour urine albumin determination.

- **Annual ophthalmologic evaluation**

Diabetic ocular complications are the leading cause of blindness among adults 20 to 74 years of age. Early detection and treatment of proliferative retinopathy can prevent or delay progressive vision loss. Yearly dilated ophthalmologic examination by an experienced physician (usually an ophthalmologist) is a proven screening strategy recommended by the American Diabetes Association, American College of Physicians, and the American Academy of Ophthalmology.

- **Annual lipid profile**

One of the complications of diabetes is an increased risk for cardiovascular disease. If a person has diabetes and has an elevated cholesterol, the American Diabetes Association recommends a lipid profile every year.

Semiannual blood glucose monitoring: almost all patients will monitor blood glucose at home. Periodic laboratory testing serves to verify the accuracy of the home glucose meter and, in some patients, correlates with metabolic control. This type of test is recommended, but not required for compliance.

Chronic Conditions

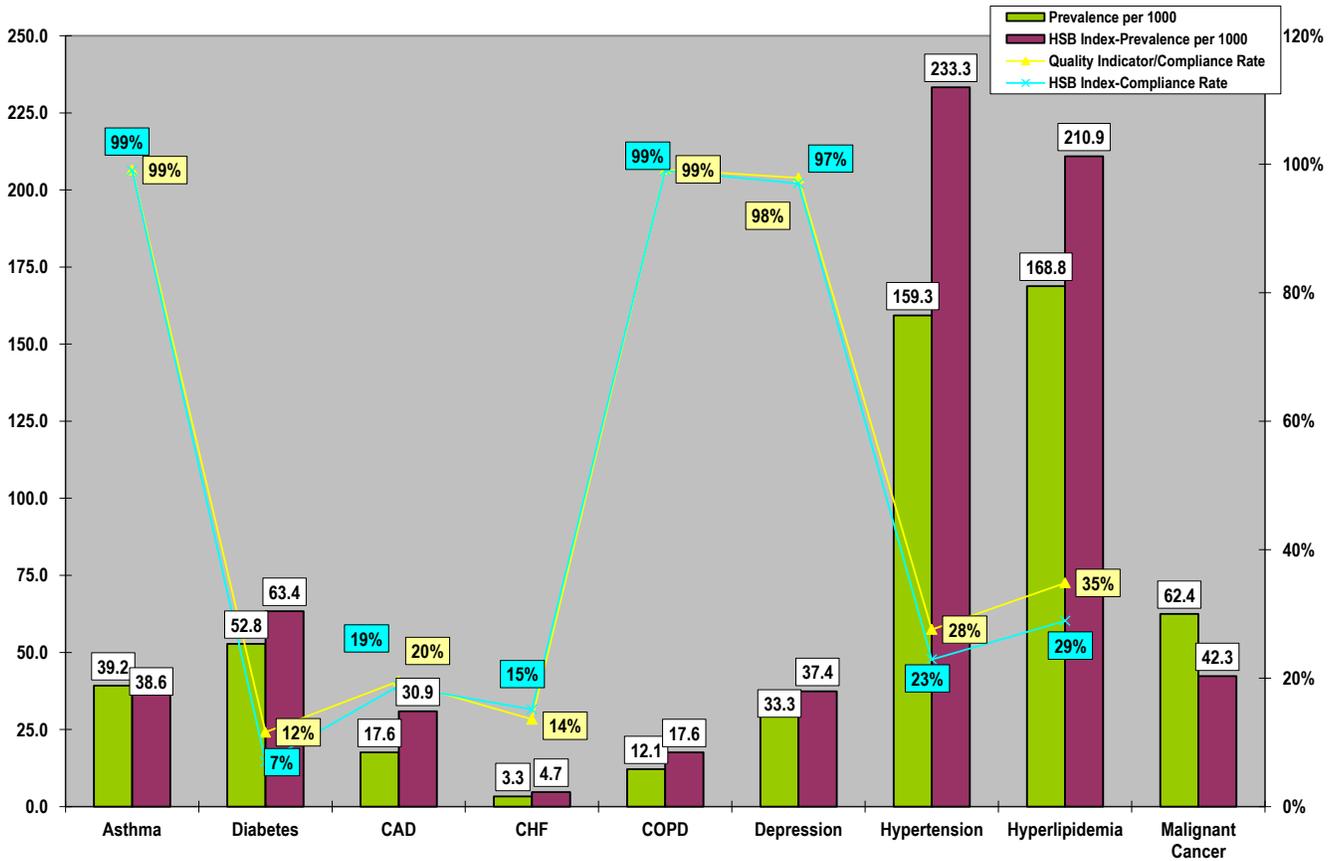
The chronic conditions table below shows the total paid by the plan for chronic conditions for the period ending June 30, 2013, for members with nine continuous months of service. Congestive heart failure was the most expensive chronic condition with an average annual cost per patient of \$45,972, while Hyperlipidemia was the most frequent condition. While the occurrences of diabetes within the PEBP population, as a percentage, were slightly lower than the HealthSCOPE Benefits' Index (5.2% for PEBP to 6.3% for all HSB population), hyperlipidemia (16.8 % for PEBP to 14.5% for all HSB population), cancer (6.2% for PEBP to 4.2% for all HSB population), and COPD (1.2% for PEBP to 1.0% for HSB population) were higher.

Chronic Condition	# Members	% of Population	HSB Index % of Population	Average Age	Total Paid	Avg Cost / Member (Annualized)
Asthma	1,221	3.9%	3.9%	40.0	\$7,537,708	\$6,173
Chronic Obstructive Pulmonary Disease (COPD)	377	1.2%	1.0%	58.5	\$6,501,589	\$17,246
Congestive Heart Failure (CHF)	103	0.3%	0.3%	62.0	\$4,735,072	\$45,972
Coronary Artery Disease (CAD)	548	1.7%	2.1%	60.9	\$9,069,139	\$16,550
Depression	1,037	3.3%	3.7%	45.8	\$10,181,308	\$9,818
Diabetes	1,643	5.2%	6.3%	56.9	\$15,916,444	\$9,687
Hyperlipidemia	5,257	16.8%	14.5%	56.3	\$29,952,897	\$5,698
Hypertension	4,961	15.8%	16.1%	56.9	\$40,743,119	\$8,213
Malignant Cancer	1,945	6.2%	4.2%	55.5	\$24,397,700	\$12,544

Chronic Condition	# of Employees	# of Spouses	# of Dependents	Total # Members
Asthma	719	134	368	1,221
Chronic Obstructive Pulmonary Disease (COPD)	302	58	17	377
Congestive Heart Failure (CHF)	87	15	1	103
Coronary Artery Disease (CAD)	466	80	2	548
Depression	708	137	192	1,037
Diabetes	1,372	231	40	1,643
Hyperlipidemia	4,432	756	69	5,257
Hypertension	4,208	699	54	4,961
Malignant Cancer	1,574	291	80	1,945

Chronic conditions that require only office visits (Asthma, COPD, and Depression) have compliance rates of approximately 99%. When recommendations for chronic conditions include labs (Diabetes, CAD, CHF, Hypertension, and Hyperlipidemia) compliance rates drop to between 12%-35%; however, the compliance levels are generally higher than the compliance rates associated with HealthSCOPE Benefit's Index for the same conditions.

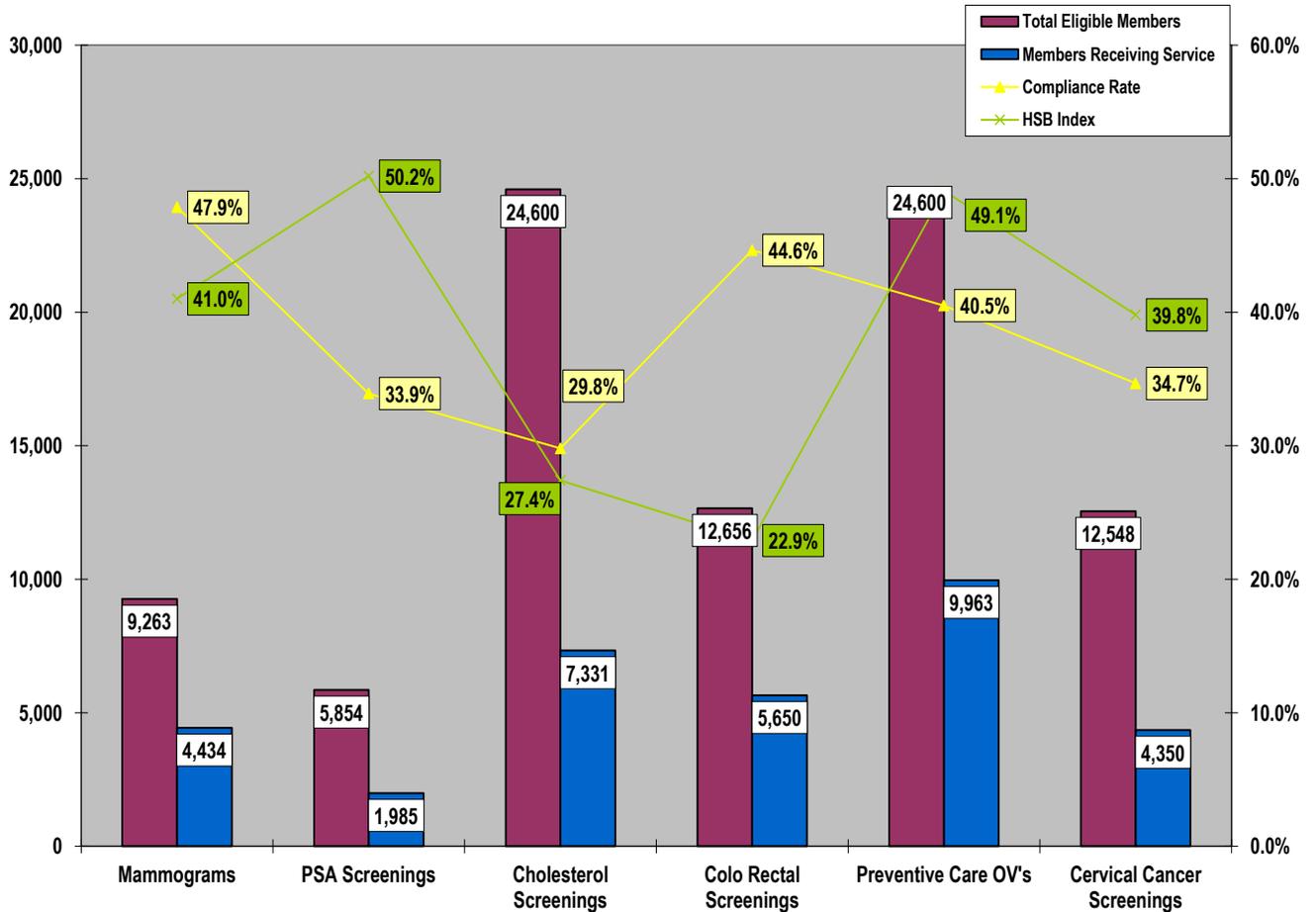
Condition	Compliance Measure
Asthma	Office Visit
Diabetes	2 OV, 1 Lipid Profile, 2 HbA1c, 1 Urinalysis, 1 Eye Exam
CAD	OV, Lipid Profile, Wellness Visit
CHF	OV, Lipid Profile, Wellness Visit
COPD	Office Visit
Depression	Office Visit
Hypertension	OV, Lipid Profile, Wellness Visit
Hyperlipidemia	OV, Lipid Profile, Wellness Visit



*Based on active members with 9 months of service; 15 months of utilization data.

Preventive Services

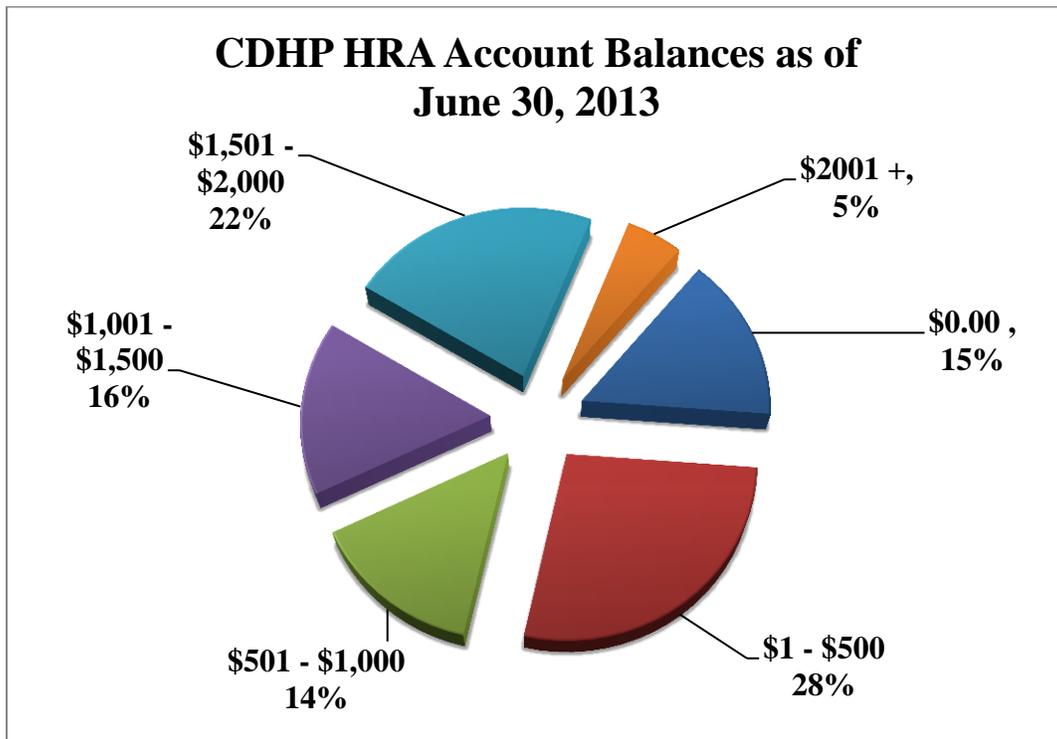
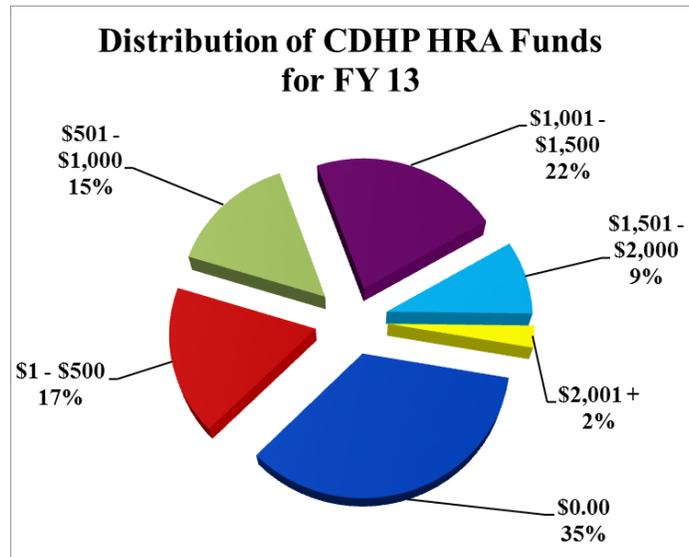
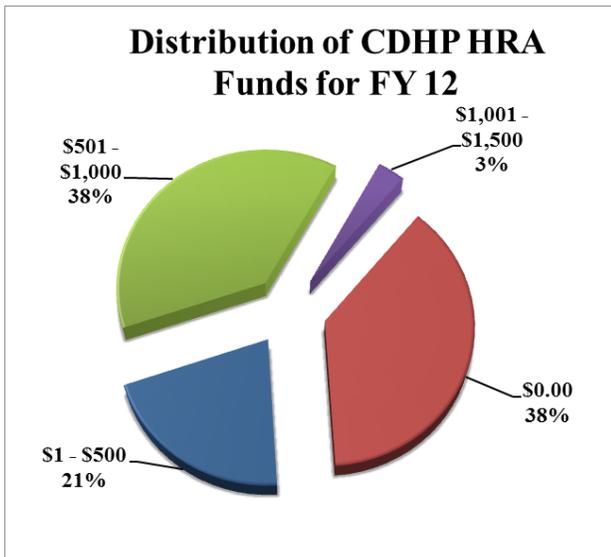
CDHP preventive service compliance rates were nearly split with Mammograms, Cholesterol Screenings and Colon Cancer Screenings being above the HealthSCOPE Benefits' Index while PSA Screenings, Preventive Care OV's and Cervical Cancer Screenings were below the compliance index.



* Based on active members with 9 months of service; 15 months of utilization data – Colon cancer screenings are based on 4 years of incurred data.

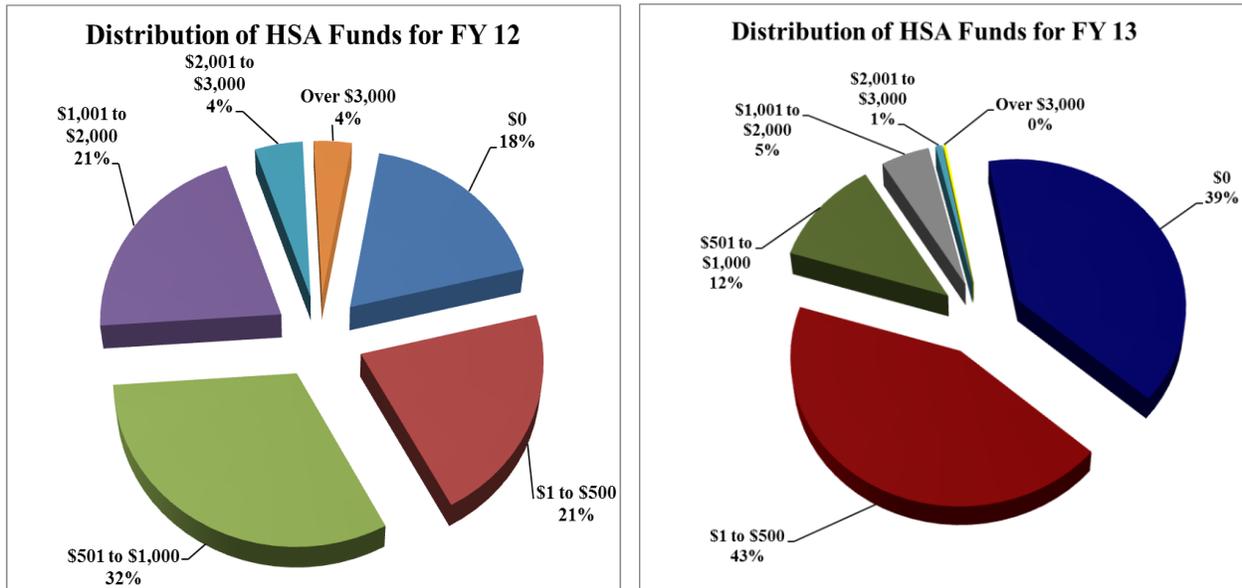
CDHP HSA/HRA Account Balances

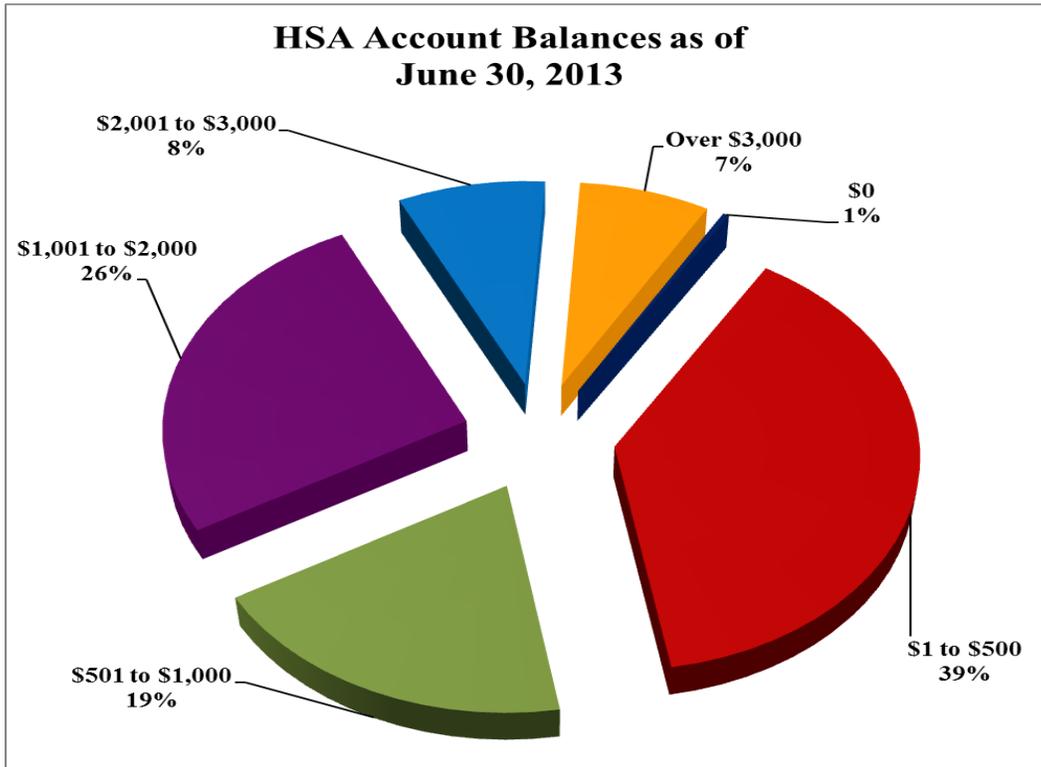
HealthSCOPE Benefits administers approximately 10,250 CDHP Health Reimbursement Arrangement (HRA) accounts with approximately \$13 million in PEBP contributions. The average contribution is \$1,232. PEBP paid approximately \$6.7 million in HRA claims, during fiscal year 2013 leaving a liability of \$9.4 million in unused HRA funds (which includes rollover of \$3.1 million from fiscal year 2012), or \$894 per account.



HealthSCOPE Benefits administers approximately 11,795 CDHP HSA accounts. PEBP contributed approximately \$16.2 million while employees contributed approximately \$5.9 million for the year ending June 30, 2013. This compares to \$9.7 million and \$6.1 million for the same period in 2012 when there were 10,895 accounts. The increase in PEBP contributions is due to the Board actions in March 2012 to reduce excess reserves by providing one-time contributions. The average employee contribution decreased from an average of \$563 for the year ended June 30, 2012 to an average of \$502 for the year ended June 30, 2013.

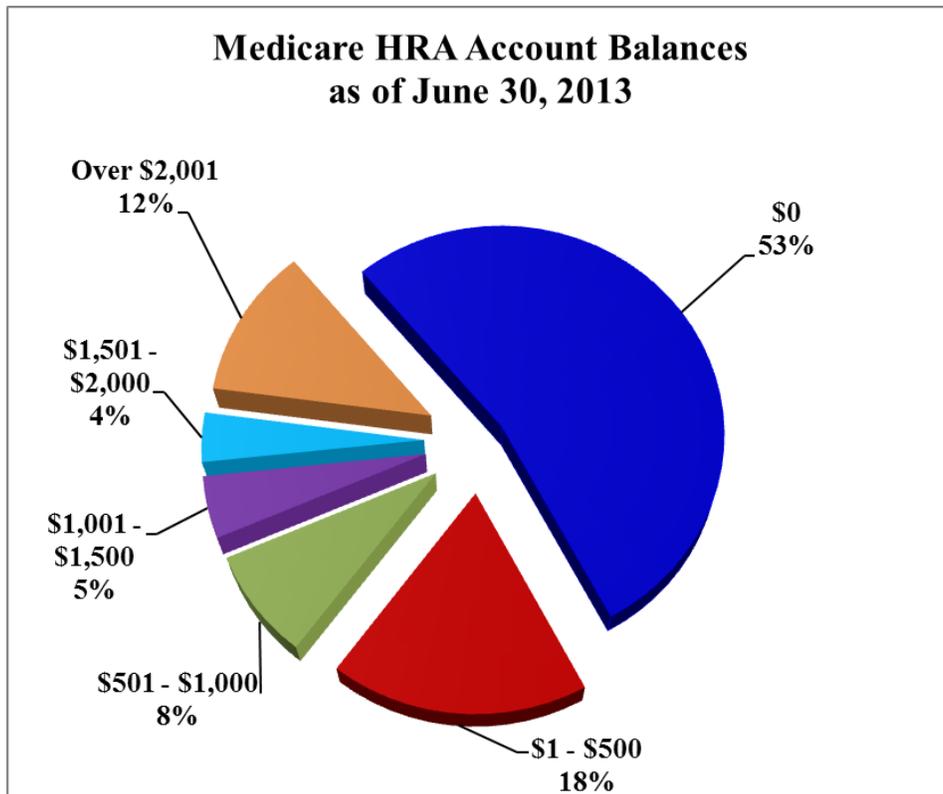
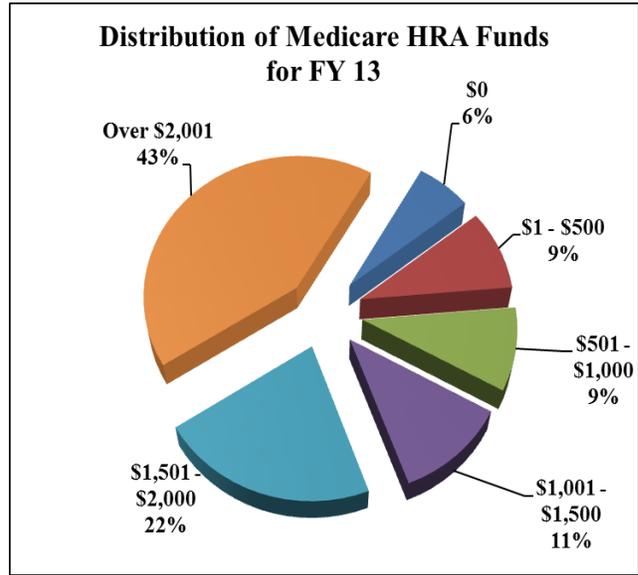
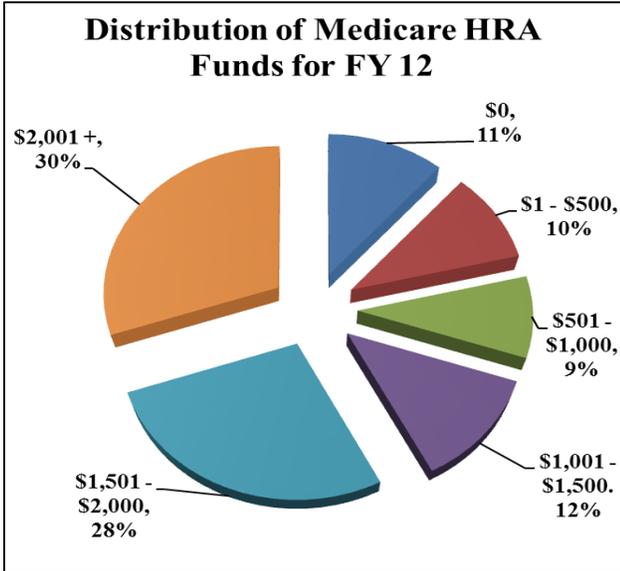
For the year ended June 30, 2013, HealthSCOPE Benefits distributed approximately \$16.1 million from participant accounts compared to approximately \$9.4 million for the same period in 2012. Since inception, HealthSCOPE Benefits has distributed approximately \$25.5 million from participant accounts. As of June 30, 2013, participants have cumulatively saved approximately \$12.5 million in their accounts, an average of \$1,058 per account.





Exchange HRA Account Balances

Extend Health administers approximately 9,619 Medicare Exchange HRA accounts as of June 30, 2013. For the year ending June 30, 2013, PEBP contributed approximately \$21.8 million and paid approximately \$15.9 million in Medicare Exchange HRA claims (\$1,661 per retiree). Including the rollover of \$3.6 million from fiscal year 2012, the remaining liability for unused Medicare Exchange HRA funds is \$5.9 million as of June 30, 2013 (\$608 per account).



Recommendations

None