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# AGENDA ITEM

☐ Action Item
☒ Information Only

**Date:** September 13, 2012

**Item Number:** XII

**Title:** Self-Funded Plan Utilization Report for the year ending June 30, 2012

## Summary

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the year ending June 30, 2012.

## 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. Comparisons to claims data paid prior to June 30, 2011, use information from prior utilization reports. Information for previous utilization reports was provided by UMR through Medstat, a secure on-line eligibility based claims system. Medstat data typically varied from actual claims data by about 1%. This may result in a slight overstatement (approximately 1%) of increases in claims costs and a slight understatement (approximately 1%) of decreases in claims costs, when current period claims are compared to prior period claims.
2. This report reflects only self-funded plan activity and does not include any fully insured benefit cost (e.g. HMOs) information.
3. Dollar amounts categorized into various demographic groups (tiers, division, etc.) are reported on a paid basis for the twelve months ending June 30, 2012, compared to the year ending June 30, 2011.
4. 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".

5. 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.
6. Unless otherwise noted, state and non-state claims are reported in aggregate.

## Key Observations

During the year ending June 30, 2012:

- Total medical spent was $117.8M (25% below PY11 at $157M), of which 57.1% was spent by the State Active population. However, the average plan cost was $486 PPPM, 7% higher than the PY11 average cost of $454.

- $28.2M of $117.8M, or 23.9%, of paid medical claims, was attributable to run-in claims from the prior plan year, ending June 30, 2011, down from 32.5%, reported in the first nine months of PY12.

- The plan paid 157 claimants in excess of $100,000, compared to 100 high cost claimants reported in the first nine months of PY12. Although representing 0.4% of the total membership, this segment accounted for 31.2% of dollars spent by the plan.

- Approximately two-thirds of all PPO HDHP participants (65.8%) claimed medical expenses of less than $2,500, and nearly a quarter of all PPO HDHP participants (21.3%) had no claims filed.

- 92% of all paid dollars were to in-network providers with an average discount of 54% of retail cost.

- Drug utilization (number of members utilizing the PEBP pharmacy benefit as a percent of all PPO self-funded members) decreased from 49.0% to 36.3% from the year ending June 30, 2011, to the year ending June 30, 2012.

- Employees continue to fund their HSA, with an average employee contribution of $540 during PY12.

# Executive Summary

***Financial Summary***

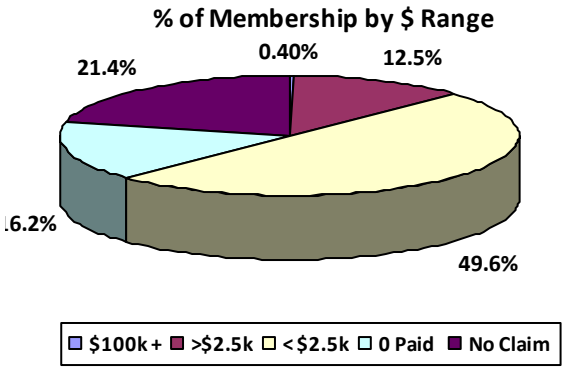
Total medical claims spending was $117.8 million, 25% below PY11 at $157 million.

- The average PPPM plan cost was higher than PY11 ($486 vs. $454).
- The plan paid on average $3,398 per member (up 42% from the previous quarter).
- PPPM inpatient claims were higher compared to PY11 ($164 vs. $159).

***Medical–Cost Distribution***

During the year ending June 30th, the largest group (66%) of members had claims paid in the amount of less than $2,500. Notably, 157 claimants with catastrophic claims (.40% of the total membership) account for 31.2% of all dollars paid by the plan.

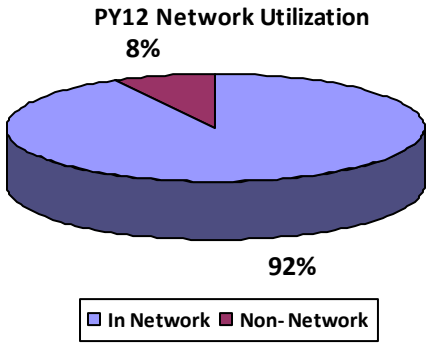
- The average payment per claimant for a catastrophic claim was $234,220.




The average medical claim for this period was $290, or 3% below PY11 ($298).

***Network Utilization***

Most participants utilized medical service within the Network resulting in a 54% discount; however, the in-network utilization rate of 92.3% was slightly below that noted in PY11 (94.6%).



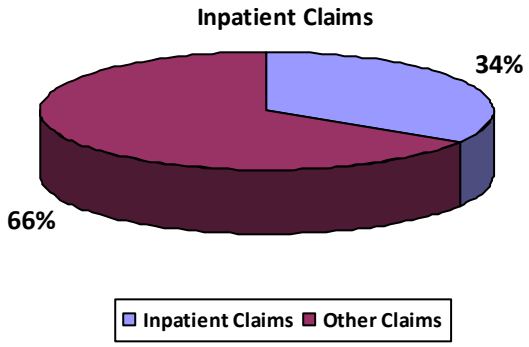

***Major Diagnostic***

Musculoskeletal, Factors Affecting Health and Neoplasms are the most expensive three diagnostic categories, together accounting for 40.8% of total costs by the plan. The costs associated with these three categories are:

- Musculoskeletal at $17.2 million
- Factors Affecting Health at $15.0 million
- Neoplasms at $14.9 million

### *Inpatient Summary*

Total inpatient claims paid account, for 33.8% of the total amount of claims paid by the plan.

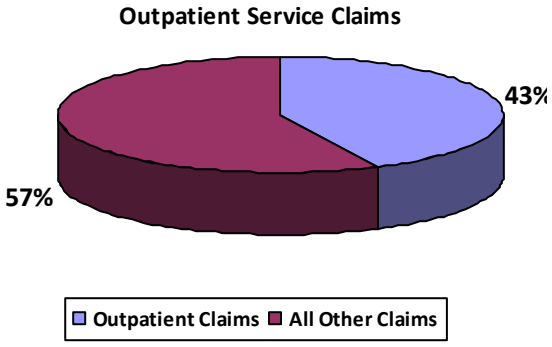



- The top 25 hospitals that receive more money from PEBP for acute visits than any other hospital make up 74.9% of all acute costs.
- The top three healthcare providers (Renown Regional Medical Center, Carson Tahoe Regional Healthcare and St. Rose Dominican Siena) together account for 29.3% of all acute costs.

### *Outpatient Services*

Total outpatient services account for 42.9% of total plan costs.

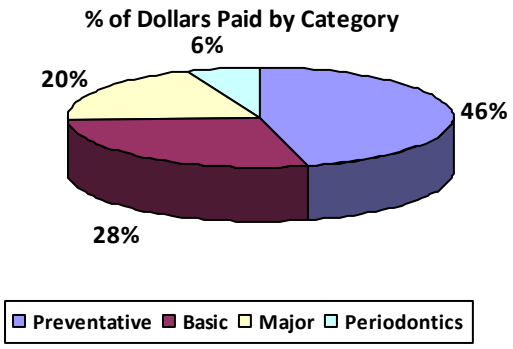
- The top 25 outpatient services account for 98.2% of all outpatient costs.
- The top three services by service code (Hospital Ancillary, Radiology, and Surgery) together account for 61.2% of the total outpatient services.




### *Dental*

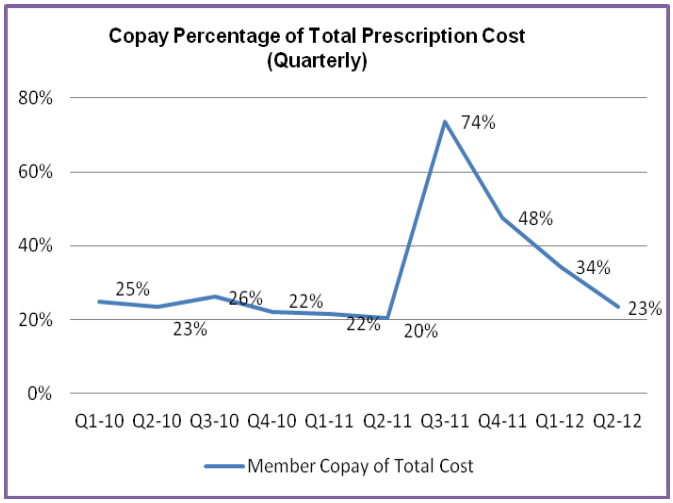
The average dental claim for the year ending June 30, 2012, was $117. This represents a 36.7% decrease from the $185 average dental claim for the year ending June 30, 2011.

Of the $17.9 million in paid dental claims, during the year ending June 30, 2012, $8.3 million (46%) 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 49.0% to 36.3% from the year ending June 30, 2011, to year ending June 30, 2012.




The participant's share of costs has decreased throughout the year as more participants met their deductible and out-of-pocket maximums.

Generic drug utilization (generic scripts filled as a percent of all scripts) increased from 74.6% to 78.0% from the year ending June 30, 2011, to the year ending June 30, 2012. This generic utilization rate is among the highest in the nation.

***Wellness***

In addition to the 23,500 patients receiving wellness screenings and/or vaccinations, paid through HealthSCOPE, USPM administered 15,457 biometric screenings and 3,697 PSA tests in the year ending June 30, 2012.

***Diabetes Compliance***

212 of 1,651, or 12.4%, of active PPO HDHP diabetics, with nine months of service, have received the minimum number of recommended services. This is up from 9.2% noted in the previous quarterly report.

***PPO HDHP HSA/HRA***

The amount of HRA claims paid was nearly half of $8.4 million in PEBP contributions leaving a liability of $4.2 million in unused HRA funds for fiscal year 2012.

Employees continue to contribute to their HSA account with an average employee contribution of $540 during the year ending June 30th.

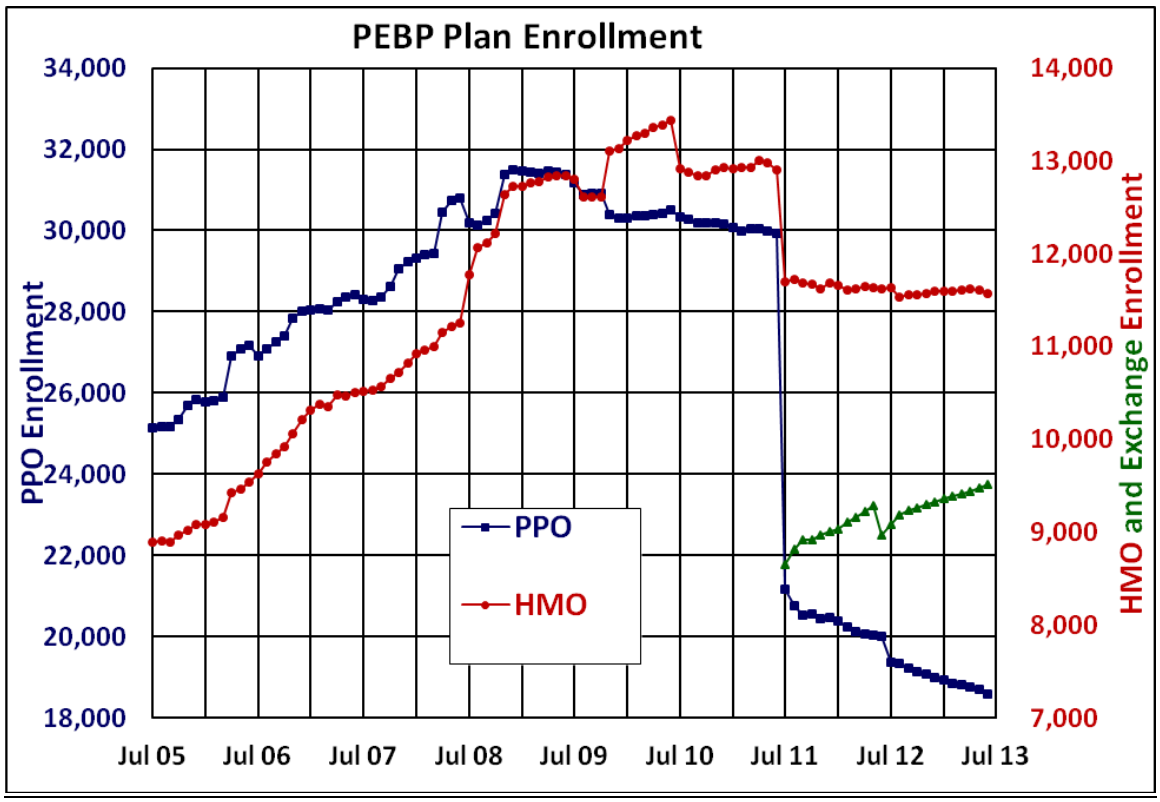
# Detailed Findings

## *Medical Section*

*Monthly Enrollment Summary*

Average enrollment in the self-funded PPO medical plan decreased 32.3% from the year ending June 30, 2011, to the year ending June 30, 2012, with dental plan enrollment decreasing by 16.80% during the same period. The average age of all self-funded members decreased 11.5% to 40.2 years. These changes were largely a result of the migration of most Medicare retirees to the Medicare Exchange.

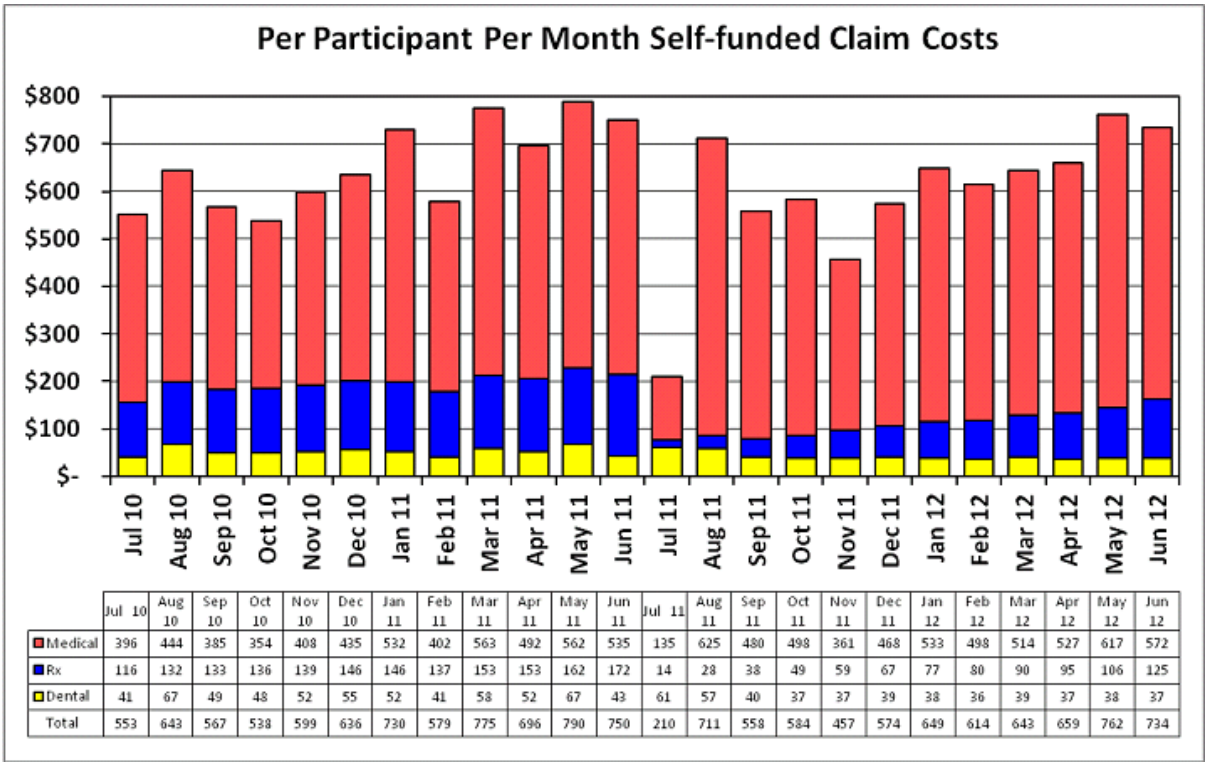
Enrollment in the Northern HMO increased by 14.4% while it decreased by 20.5% in the Southern HMO during the same periods. These changes were largely a result of the policy to blend HMO rates, effective July 1, 2011, combined with the migration of most Medicare retirees to the Medicare Exchange. Total enrollment in the HMOs decreased 9.7%.



*Monthly Cost Summary*

From the year ending June 30, 2011, to the year ending June 30, 2012, the number of medical claims paid per participant increased 9.4%. Total dollars paid for medical claims increased 7.0% on a per participant basis while paid dental claims decreased 19.2%.

The following graph shows PPPM self-funded claim costs for the 24 months ending June 30, 2012. Data for the graph was compiled directly from the daily check register sent to PEBP by UMR/HealthSCOPE Benefits and the monthly claim costs reported by Catalyst, rather than from the Medstat/Benefit Informatics reporting tools.




| | Jul 10 | Aug 10 | Sep 10 | Oct 10 | Nov 10 | Dec 10 | Jan 11 | Feb 11 | Mar 11 | Apr 11 | May 11 | Jun 11 | Jul 11 | Aug 11 | Sep 11 | Oct 11 | Nov 11 | Dec 11 | Jan 12 | Feb 12 | Mar 12 | Apr 12 | May 12 | Jun 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical | 396 | 444 | 385 | 354 | 408 | 435 | 532 | 402 | 563 | 492 | 562 | 535 | 135 | 625 | 480 | 498 | 361 | 468 | 533 | 498 | 514 | 527 | 617 | 572 |
| Rx | 116 | 132 | 133 | 136 | 139 | 146 | 146 | 137 | 153 | 153 | 162 | 172 | 14 | 28 | 38 | 49 | 59 | 67 | 77 | 80 | 90 | 95 | 106 | 125 |
| Dental | 41 | 67 | 49 | 48 | 52 | 55 | 52 | 41 | 58 | 52 | 67 | 43 | 61 | 57 | 40 | 37 | 37 | 39 | 38 | 36 | 39 | 37 | 38 | 37 |
| Total | 553 | 643 | 567 | 538 | 599 | 636 | 730 | 579 | 775 | 696 | 790 | 750 | 210 | 711 | 558 | 584 | 457 | 574 | 649 | 614 | 643 | 659 | 762 | 734 |

*Utilization*

From the year ending June 30, 2011, to the year ending June 30, 2012:

- Admits Acute per 1,000 decreased 25.6%
- Days per 1,000 decreased 14.3%
- ER visits per 1,000 remained flat at 170

Despite these decreases, all utilization measures, except ER visits per 1,000, are higher than those of HealthSCOPE Benefits' other clients during 2010.

| Utilization (Annualized) | | | |
|---|---|---|---|
| | Jun-12 | PY12 | HSB 2010 Index |
| Admits per 1,000 | 87 | 67 | 61 |
| Days per 1,000 | 479 | 365 | 261 |
| Avg Length of Stay | 5.5 | 5.4 | 4.3 |
| Office Visits per 1,000 | 3800 | 3600 | 3000 |
| ER Visits per 1,000 | 170 | 170 | 210 |

## *Claims paid by Division*

Extremely low medical claims paid in July are 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.

| Paid by Division - Medical Claims | | | | | | |
|---|---|---|---|---|---|---|
| Month | State Active | Non-State Active | State Retirees | Non-State Retirees | Cobra | Total |
| July | $1,728,509 | $16,486 | $588,070 | $511,461 | $8,578 | $2,853,104 |
| August | $7,231,664 | $44,344 | $2,794,512 | $2,756,453 | $89,104 | $12,916,078 |
| September | $6,231,039 | $26,604 | $1,887,031 | $1,583,464 | $47,827 | $9,775,964 |
| October | $6,356,102 | $41,012 | $1,992,368 | $1,747,596 | $38,215 | $10,175,293 |
| November | $4,042,039 | $77,655 | $2,009,536 | $1,025,144 | $129,305 | $7,283,680 |
| December | $5,340,624 | $86,492 | $2,501,538 | $1,490,144 | $64,135 | $9,482,933 |
| January | $5,714,009 | $48,928 | $2,744,153 | $2,142,712 | $49,087 | $10,698,889 |
| February | $5,445,391 | $13,677 | $2,275,509 | $2,172,714 | $60,693 | $9,967,984 |
| March | $5,929,860 | $36,599 | $2,306,300 | $1,945,972 | $78,939 | $10,297,670 |
| April | $6,402,369 | $21,500 | $2,087,047 | $1,882,928 | $93,157 | $10,487,001 |
| May | $6,251,813 | $20,753 | $3,186,182 | $2,771,469 | $107,346 | $12,337,563 |
| June | $6,646,738 | $21,388 | $2,594,978 | $2,215,405 | $53,006 | $11,531,515 |
| **Year To Date** | **$67,320,157** | **$455,438** | **$26,967,224** | **$22,245,462** | **$819,392** | **$117,807,672** |

## *Medical Claims by Plan / Relationship*

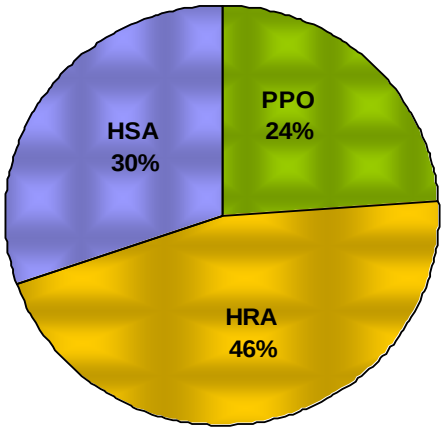
| Medical Claims by Plan - 4Q YTD | | | |
|---|---|---|---|
| | PPO | HRA | HSA |
| Total Costs | $28,159,327 | $53,906,814 | $35,741,530 |
| PMPM (Per Member per Month) | $0** | $420 | $193 |

**PPO Plan was for PY2011; this reflects run-in claims paid by HSB

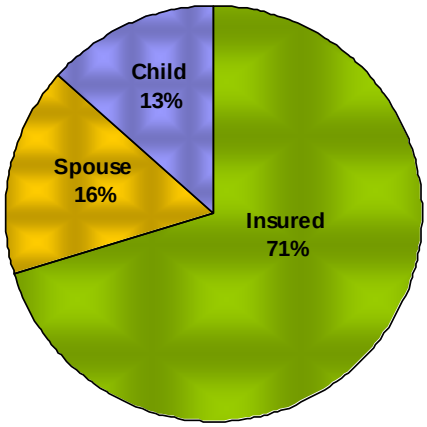
| Total Medical Claims Paid / Relationship | | | | | | |
|---|---|---|---|---|---|---|
| | 1Q | 2Q | 3Q | 4Q | YTD | PMPM |
| Insured | $17,671,205 | $19,088,659 | $21,791,135 | $24,285,677 | $82,836,676 | $346 |
| Spouse | $4,677,597 | $5,128,628 | $4,860,752 | $4,511,560 | $19,178,538 | $377 |
| Child | $3,196,343 | $2,724,618 | $4,312,655 | $5,558,843 | $15,792,458 | $131 |
| **Total** | **$25,545,145** | **$26,941,905** | **$30,964,542** | **$34,356,080** | **$117,807,672** | **$287** |

It is important to note that 23.9% of the claims paid in the year ending June 30, 2012, were run-out claims for the $800 deductible PPO plan that ended on June 30, 2011.

**Medical Claims by Plan**




**Medical Claims by Relationship**




## *Financial Summary*

During the year ending June 30, 2011, participants paid 26.8% 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 31, 2012, participants' share of costs decreased to 24.9% of the total medical costs paid by the plan and participants.

| *Summary* | All Combined Groups | State Active | Non-State Active | State Retirees | Non-State Retirees | PY11 | HSB 2010 Index |
|---|---|---|---|---|---|---|---|
| # Participants | 20,211 | 14,416 | 124 | 2,999 | 2,672 | 30,120 | |
| # Members | 34,671 | 27,143 | 193 | 4,120 | 3,215 | 49,525 | |
| Mem / Part Ratio | 1.72 | 1.88 | 1.56 | 1.37 | 1.20 | 1.64 | |
| | | | | | | | |
| Gross Cost | $156,823,450 | $93,198,413 | $692,933 | $34,585,146 | $28,346,958 | | |
| Gross Plan Cost | $117,807,672 | $67,933,528 | $455,438 | $27,005,200 | $22,413,506 | $163,949,107 | |
| Gross Participant Cost | $39,015,778 | $25,264,885 | $237,495 | $7,579,946 | $5,933,452 | | |
| | | | | | | | |
| PPPM Gross Cost | $647 | $539 | $466 | $961 | $884 | | |
| PPPM Gross Plan Cost | $486 | $393 | $306 | $750 | $699 | $454 | $533 |
| PPPM Gross Participant Cost | $161 | $146 | $160 | $211 | $185 | | |
| | | | | | | | |
| *Catastrophic Summary* | | | | | | | |
| Catastrophic Cases | 157 | 78 | 0 | 40 | 39 | 213 | |
| Catastrophic Cases / 1,000 | 4.5 | 2.9 | 0.0 | 9.7 | 12.1 | 4.3 | 9.2 |
| Avg. Catastrophic Paid / Case | $234,220 | $227,308 | $0 | $257,680 | $223,981 | ---- | $115,079 |
| Catastrophic % of Gross Dollars | 31.2% | 26.1% | 0.0% | 38.2% | 39.0% | 25.0% | |
| | | | | | | | |
| *Cost Distribution -Paid Per Member* | | | | | | | |
| Hospital Inpatient | $1,160 | $789 | $459 | $2,601 | $2,490 | $1,164 | $443 |
| Facility Outpatient | $1,651 | $1,249 | $1,547 | $3,022 | $3,301 | $2,112 | $839 |
| Physician Office | $586 | $465 | $356 | $936 | $1,188 | ---- | $273 |
| Total: | $3,397 | $2,503 | $2,362 | $6,559 | $6,979 | $3,276 | $1,554 |

## *Cost Distribution*

During the year ending June 30, 2012, the plan paid 157 claimants in excess of $100,000 (0.40% of total members; 31.2% of total claim dollars paid) for an average of 138 members. This is 57% higher than the level noted during the first nine months of the year at 100 claimants.

Out of the total PPO HDHP membership:

- 12.9% had total medical claims paid by the plan of $2,500 or more
- 49.6% had total medical claims paid by the plan of less than $2,500
- 16.2% had submitted claims that were not paid by the plan (member had not met deductible)
- 21.3% had no claims filed.

The average medical claim for the year ending June 30, 2012, was $290.34. This represents a 2.6% decrease from the $297.96 average medical claim for the year ending June 30, 2011.

| *COST DISTRIBUTION - MEDICAL CLAIMS* | | | | | | |
|---|---|---|---|---|---|---|
| *Paid Dollar Range* | *Avg Members* | *% of Members* | *# of Claims* | *% of Claims* | *Total Paid* | *% of Paid* |
| $100,000.01 Plus | 138 | 0.40% | 21,182 | 5.22% | $36,772,529 | 31.21% |
| $50,000.01 - $100,000.00 | 220 | 0.63% | 17,389 | 4.29% | $17,757,799 | 15.07% |
| $25,000.01 - $50,000.00 | 410 | 1.18% | 25,240 | 6.22% | $16,608,430 | 14.10% |
| $10,000.01 - $25,000.00 | 920 | 2.65% | 38,944 | 9.60% | $16,888,546 | 14.34% |
| $5,000.01 - $10,000.00 | 1,145 | 3.30% | 39,603 | 9.76% | $9,871,717 | 8.38% |
| $2,500.01 - $5,000.00 | 1,658 | 4.78% | 45,015 | 11.09% | $7,374,255 | 6.26% |
| $0.01 - $2,500.00 | 17,201 | 49.61% | 198,325 | 48.88% | $12,534,396 | 10.64% |
| $0.00 | 5,598 | 16.15% | 20,061 | 4.94% | $0 | 0.00% |
| No Claims Filed | 7,381 | 21.29% | 0 | 0.00% | $0 | 0.00% |
| | **34,671** | **100.00%** | **405,759** | **100.00%** | **$117,807,672** | **100.00%** |

*Member count is an average over the 12 month period

## *Plan Summary Grid*

*Cost Distribution – Paid Per Member*

The plan paid medical claims in the amount of $3,398 per member for the reporting period ending June 30, 2012, a 3.0% increase from the year ending June 30, 2011, and ($283 vs. $275 PMPM).

*Physician Office*

The plan paid an average of $30 per physician office visit compared to $55 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.

*Emergency Room*

ER visits remained flat at a rate of 170 per 1,000 during the year ending June 30, 2012, vs. the year ending June 30, 2011.

*Inpatient*

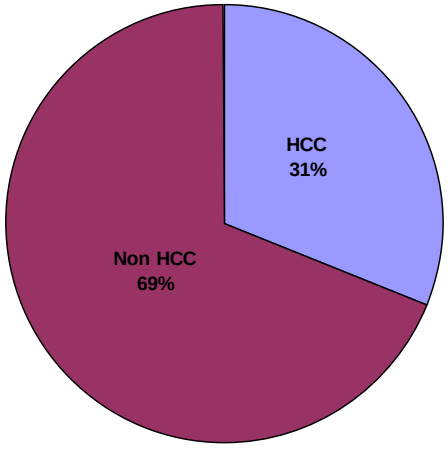
Inpatient claims paid PPPM increased 3.3% during the year ending June 30, 2012, vs. the year ending June 30, 2011, increasing from $159.06 to $164.30. Net inpatient claims paid decreased 30.7%, while admits per 1,000 decreased 25.6% during the same period.

| | All Combined Groups | State Active (incl Cobra) | Non-State Active (incl Cobra) | State Retirees (incl Cobra) | Non-State Retirees (incl Cobra) | PY11 | HSB 2010 Index |
|---|---|---|---|---|---|---|---|
| ***Inpatient:*** | | | | | | | |
| **# of Admits** | 2,307 | 1,371 | 8 | 557 | 371 | | |
| **# of Patient Days** | 12,638 | 6,078 | 19 | 3,836 | 2,705 | | |
| **Paid per Admit** | $17,273 | $15,910 | $11,818 | $17,888 | $21,509 | $12,922 | $14,303 |
| **Paid per Day** | $3,153 | $3,589 | $4,976 | $2,597 | $2,950 | $2,775 | $3,360 |
| **Admits / 1,000** | 67 | 51 | 41 | 135 | 115 | 90 | 61 |
| **Days / 1,000** | 365 | 224 | 99 | 931 | 841 | 426 | 261 |
| **Average LOS** | 5.5 | 4.4 | 2.4 | 6.9 | 7.3 | 4.7 | 4.3 |
| ***Physician Office:*** | | | | | | | |
| **Physician OV Utilization** | 3.6 | 2.9 | 2.7 | 5.9 | 6.4 | | 1.5 |
| **Physician OV Avg Paid per Visit** | $30 | $29 | $31 | $32 | $32 | | $55 |
| **OV Avg Paid per Member** | $108 | $84 | $84 | $189 | $205 | | $83 |
| **Physician DX&L Utilization** | 9.8 | 7.9 | 5.3 | 15.5 | 18.6 | | 4.5 |
| **Physician DX&L Avg Paid per Visit** | $60 | $56 | $91 | $67 | $65 | | $78 |
| **DX&L Avg Paid per Member** | $588 | $442 | $482 | $1,039 | $1,209 | | $347 |
| *DX&L=Diagnostic, Xray, & Lab | | | | | | | |
| ***Emergency Room:*** | | | | | | | |
| **Number of Patients** | 4,264 | 2,867 | 32 | 803 | 565 | | |
| **Number of Visits** | 5,722 | 3,780 | 41 | 1,074 | 827 | 8,269 | |
| **Number of Admits** | 1,090 | 553 | 3 | 328 | 206 | 1,105 | |
| **Visits/Member*** | 0.17 | 0.14 | 0.21 | 0.26 | 0.26 | 0.17 | 0.21 |
| **Avg Paid per Visit** | $1,394 | $1,425 | $1,227 | $1,314 | $1,367 | $2,313 | $1,180 |
| **Admits per Visit** | 0.19 | 0.15 | 0.07 | 0.31 | 0.25 | 0.13 | 0.13 |

*Catastrophic Summary*

The plan paid an average of $234,220 per member for those (157 members) with catastrophic "High Cost Claims" (HCC) in excess of $100,000. This represents 31.2% of total allowable claims (claims paid by the participant and the plan). The number of catastrophic cases per 1,000 (4.5) compares favorably to HealthSCOPE Benefits' book of business for 2010 (9.2); however, the average payment per case ($234,220) far exceeds the average for HealthSCOPE Benefits' other customers ($115,079) the largest of which cost the plan $1,611,864 with a primary diagnosis of Acute and Chronic Respiratory Failure**.**

**Distribution of HCC Medical Paid Claims Amount**

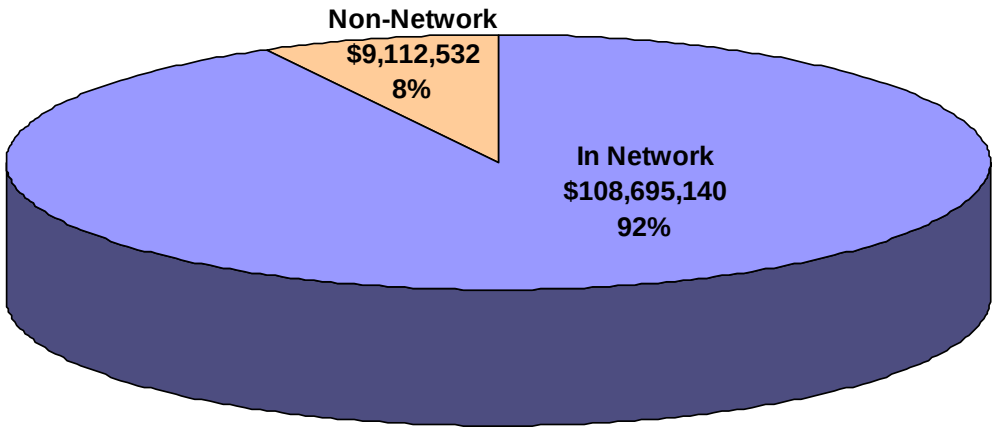



| ***Catastrophic Summary*** | |
|---|---|
| ***HCC Groups*** | ***Total Paid*** |
| Disease of Respiratory System | $3,586,182 |
| Chemotherapy Treatment | $3,486,023 |
| Musculoskeletal Disorders | $3,285,749 |
| Other Diseases | $3,150,794 |
| Complications Med/Surg | $3,012,725 |
| Cardiovascular Disease | $2,738,587 |
| Renal Function Failure | $2,218,543 |
| Accident | $1,778,282 |
| Complications of Pregnancy | $1,722,914 |
| Disease of Digestive System | $1,635,706 |
| Cancer - Other | $1,593,768 |
| Metabolic & Immunity Disorders | $1,564,088 |
| Nervous System Disorders | $1,357,009 |
| Cancer - Breast | $1,280,792 |
| Cancer - Reproductive | $1,121,970 |
| Cancer - Stomach | $997,327 |
| Cancer - Brain/Lymph/Organ | $658,031 |
| Cancer - Lung | $599,059 |
| Leukemia | $535,521 |
| Cancer - Colorectal | $449,459 |
| ***Total*** | ***$36,772,528*** |

### *In-Network Medical Discounts*

The in-network utilization rate decreased from 94.6% to 92.3% from the year ending June 30, 2011, to year ending June 30, 2012.

**PY12 Network Utilization**




### *Major Diagnostic Category*

Total claims decreased 24.8% from $156.6 million from the year ending June 30, 2011.

| *Description* | *# Patients* | *# Claims* | *Total Paid* | *% of Paid* |
|---|---|---|---|---|
| (MDC 18) DISORDER OF MUSCULOSKELETAL SYSTEM | 12,058 | 66,698 | $17,204,008 | 14.60% |
| (MDC 25) FACTORS AFFECTING HEALTH | 20,088 | 61,601 | $15,072,933 | 12.80% |
| (MDC 02) NEOPLASMS | 4,995 | 24,040 | $14,942,583 | 12.68% |
| (MDC 10) DISORDER OF CIRCULATORY SYSTEM | 7,798 | 25,966 | $10,293,615 | 8.74% |
| (MDC 23) FRACTURES AND OTHER INJURIES | 5,747 | 18,994 | $9,040,157 | 7.67% |
| (MDC 22) ILLDEFINED CONDITIONS | 13,288 | 43,984 | $8,108,610 | 6.88% |
| (MDC 11) DISORDER OF RESPIRATORY SYSTEM | 10,072 | 29,106 | $5,803,089 | 4.93% |
| (MDC 12) DISORDER OF DIGESTIVE SYSTEM | 3,428 | 9,110 | $4,752,787 | 4.03% |
| (MDC 14) NEPHRITIS / NEPHROSIS | 2,955 | 10,398 | $4,142,200 | 3.51% |
| (MDC 03) ENDOCRINE, NUTRITIONAL, METABOLIC, IMMUNITY, DISORDERS | 9,497 | 28,392 | $4,030,542 | 3.42% |
| (MDC 01) INFECTIOUS / PARASITIC DISEASE | 2,906 | 5,214 | $3,978,116 | 3.38% |
| (MDC 07) DISORDER OF NERVOUS SYSTEM | 3,174 | 11,991 | $3,878,280 | 3.29% |
| (MDC 19) DISORDER OF BREAST OR SKIN | 6,906 | 13,883 | $2,597,038 | 2.20% |
| (MDC 13) OTHER DIGESTIVE DISORDERS | 984 | 3,446 | $2,477,213 | 2.10% |
| (MDC 05) PSYCHOTIC CONDITIONS | 3,270 | 14,308 | $2,356,804 | 2.00% |
| (MDC 08) DISORDER OF EYE / ADNEXA | 9,972 | 17,323 | $2,140,433 | 1.81% |
| (MDC 17) PREGNANCY / CHILDBIRTH | 401 | 2,408 | $1,739,028 | 1.48% |
| (MDC 04) DISORDER OF BLOOD | 1,094 | 3,739 | $1,587,600 | 1.35% |
| (MDC 16) FEMALE DISORDERS | 2,599 | 6,124 | $1,395,717 | 1.18% |
| (MDC 09) DISORDER OF EAR | 2,574 | 4,364 | $802,500 | 0.68% |
| (MDC 21) PERINATAL PERIOD CONDITIONS | 144 | 1,041 | $579,841 | 0.49% |
| (MDC 20) CONGENITAL ANOMALIES | 519 | 1,274 | $460,504 | 0.39% |
| (MDC 15) DISORDER OF MALE GENITAL ORGANS | 1,005 | 2,139 | $243,580 | 0.21% |
| (MDC 06) ALCOHOL / DRUG PSYCHOTROPIC DEPENDENCY | 36 | 110 | $174,857 | 0.15% |
| (MDC 24) BURNS / ACCIDENTS BY FIRE | 53 | 106 | $5,637 | 0.00% |
| **TOTAL** | **125,563** | **405,759** | **$117,807,672** | **100.00%** |

Musculoskeletal, Factors Affecting Health and Neoplasms are the most expensive three diagnostic categories, together accounting for 40.8 % of total costs.

**MDC (18) DISORDER OF MUSCULOSKELETAL SYSTEM**

| MDC | Diag Code | Diagnosis Description | # Patients | # Claims | Total Paid |
|---|---|---|---|---|---|
| 18 | 71536 | OSTEOARTHROSIS, LOCALIZED, NOT SPECIFIED WHETHER PRIMARY OR SECONDARY, LOWER LEG | 113 | 228 | $1,143,973 |
| 18 | 72252 | DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC | 646 | 1591 | $1,066,765 |
| 18 | 72210 | DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY | 389 | 1322 | $768,828 |
| 18 | 7213 | LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY | 450 | 1025 | $618,727 |
| 18 | 71596 | OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING LOWER LEG | 367 | 839 | $612,073 |

**MDC (25) FACTORS AFFECTING HEALTH**

| MDC | Diag Code | Diagnosis Description | # Patients | # Claims | Total Paid |
|---|---|---|---|---|---|
| 25 | V5811 | ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY | 79 | 640 | $1,997,299 |
| 25 | V7651 | SPECIAL SCREENING FOR MALIGNANT NEOPLASMS OF COLON | 1332 | 3161 | $1,453,710 |
| 25 | V5789 | CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE | 125 | 264 | $1,417,239 |
| 25 | V202 | ROUTINE INFANT OR CHILD HEALTH CHECK | 2874 | 5055 | $944,917 |
| 25 | V700 | ROUTINE GENERAL MEDICAL EXAMINATION AT A HEALTH CARE FACILITY | 4548 | 7102 | $944,153 |

**MDC (02) NEOPLASMS**

| MDC | Diag Code | Diagnosis Description | # Patients | # Claims | Total Paid |
|---|---|---|---|---|---|
| 2 | 185 | MALIGNANT NEOPLASM OF PROSTATE | 252 | 2096 | $1,511,934 |
| 2 | 1749 | MALIGNANT NEOPLASM OF BREAST (FEMALE) UNSPECIFIED SITE | 312 | 2049 | $1,391,540 |
| 2 | 23875 | MYELODYSPLASTIC SYNDROME, UNSPECIFIED | 12 | 244 | $642,287 |
| 2 | 1830 | MALIGNANT NEOPLASM OF OVARY | 37 | 513 | $632,848 |
| 2 | 20280 | OTHER MALIGNANT LYMPHOMAS UNSPECIFIED SITE | 52 | 524 | $481,546 |

### *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, Carson Tahoe Regional Healthcare and St. Rose Dominican Siena) together account for 29.3% of all acute costs. Total inpatient claims paid account for 33.8% of total plan costs.

Cedars Sinai Medical Center, Stanford University Hospital, and UCSF 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.

| *Tax ID* | *Hospital* | *Admits* | *Bed Days* | *Avg LOS* | *Total Paid* | *Paid per Admit* | *Paid per Day* | *% of Admits* | *% of Paid* |
|---|---|---|---|---|---|---|---|---|---|
| 88-0213754 | RENOWN BEHAVIORAL HEALTH | 489 | 2,399 | 4.9 | $5,852,614 | $11,969 | $2,440 | 21.20% | 14.71% |
| 88-0502320 | CARSON TAHOE REGIONAL MEDICAL CENTER | 255 | 1,007 | 3.9 | $2,986,669 | $11,712 | $2,966 | 11.05% | 7.51% |
| 88-0455713 | ST ROSE DOMINICAN SIENA | 124 | 771 | 6.2 | $2,826,325 | $22,793 | $3,666 | 5.37% | 7.10% |
| 62-1762537 | SUNRISE HOSPTIAL AND MED CTR LLC | 95 | 806 | 8.5 | $2,107,879 | $22,188 | $2,615 | 4.12% | 5.30% |
| 94-3281657 | UCSF MEDICAL CENTER | 11 | 95 | 8.6 | $1,611,487 | $146,499 | $16,963 | 0.48% | 4.05% |
| 38-3667923 | SIERRA SURGERY & IMAGING LLC | 45 | 143 | 3.2 | $1,205,619 | $26,792 | $8,431 | 1.95% | 3.03% |
| 23-2939047 | SUMMERLIN MEDICAL CENTER | 103 | 496 | 4.8 | $995,270 | $9,663 | $2,007 | 4.46% | 2.50% |
| 94-2854057 | MCKAY DEE HOSPITAL CENTER | 50 | 216 | 4.3 | $986,693 | $19,734 | $4,568 | 2.17% | 2.48% |
| 30-0291277 | VISTA RANCHO SPECIALITY HOSPITAL | 2 | 125 | 62.5 | $985,370 | $492,685 | $7,883 | 0.09% | 2.48% |
| 62-1600397 | MOUNTAIN VIEW HOSPITAL | 74 | 293 | 4.0 | $977,904 | $13,215 | $3,338 | 3.21% | 2.46% |
| 94-6036494 | U.C. DAVIS MEDICAL CENTER | 8 | 70 | 8.8 | $966,868 | $120,859 | $13,812 | 0.35% | 2.43% |
| 77-0465765 | STANFORD UNIVERSITY HOSPITAL | 9 | 44 | 4.9 | $961,558 | $106,840 | $21,854 | 0.39% | 2.42% |
| 88-6000436 | UNIVERSITY MEDICAL CENTER | 50 | 247 | 4.9 | $671,083 | $13,422 | $2,717 | 2.17% | 1.69% |
| 23-2973511 | VALLEY HOSPITAL MEDICAL CENTER | 60 | 347 | 5.8 | $624,725 | $10,412 | $1,800 | 2.60% | 1.57% |
| 95-1644600 | CEDARS SINAI MEDICAL CENTER | 3 | 15 | 5.0 | $601,256 | $200,419 | $40,084 | 0.13% | 1.51% |
| 74-3048428 | SO HILLS HOSPITAL MEDICAL CTR LLC | 36 | 109 | 3.0 | $600,783 | $16,688 | $5,512 | 1.56% | 1.51% |
| 46-0517825 | RENOWN REHAB HOSPITAL | 81 | 277 | 3.4 | $600,132 | $7,409 | $2,167 | 3.51% | 1.51% |
| 20-4993360 | CENTENNIAL HILLS HOSPITAL MED CENTE | 48 | 180 | 3.8 | $598,065 | $12,460 | $3,323 | 2.08% | 1.50% |
| 94-0562680 | CALIFORNIA PACIFIC MEDICAL CENTER | 2 | 35 | 17.5 | $593,408 | $296,704 | $16,955 | 0.09% | 1.49% |
| 95-3522679 | LOMA LINDA UNIVERSITY MED CENTER | 1 | 39 | 39.0 | $562,871 | $562,871 | $14,433 | 0.04% | 1.41% |
| 72-1549752 | SPRING VALLEY HOSPITAL MEDICAL CENTER | 54 | 225 | 4.2 | $561,064 | $10,390 | $2,494 | 2.34% | 1.41% |
| 38-3730230 | ST ROSE DOMINICAN HOSP DBA DIGNITY HEALTH | 50 | 200 | 4.0 | $519,551 | $10,391 | $2,598 | 2.17% | 1.31% |
| 62-1740235 | NORTHEASTERN NEVADA REG HOSP | 35 | 94 | 2.7 | $477,526 | $13,644 | $5,080 | 1.52% | 1.20% |
| 87-6000525 | UNIVERSITY OF UTAH | 25 | 130 | 5.2 | $468,984 | $18,759 | $3,608 | 1.08% | 1.18% |
| 94-6050274 | BARTON MEMORIAL HOSPITAL | 16 | 53 | 3.3 | $453,585 | $28,349 | $8,558 | 0.69% | 1.14% |
| | **Top 25** | **1,726** | **8,416** | **4.9** | **$29,797,287** | **$17,264** | **$3,541** | **74.82%** | **74.88%** |
| | **Total All Other** | **581** | **4,190** | **7.2** | **$9,995,427** | **$17,204** | **$2,386** | **25.18%** | **25.12%** |
| | **Grand Total** | **2,307** | **12,638** | **5.5** | **$39,792,715** | **$17,249** | **$3,149** | **100.00%** | **100.00%** |

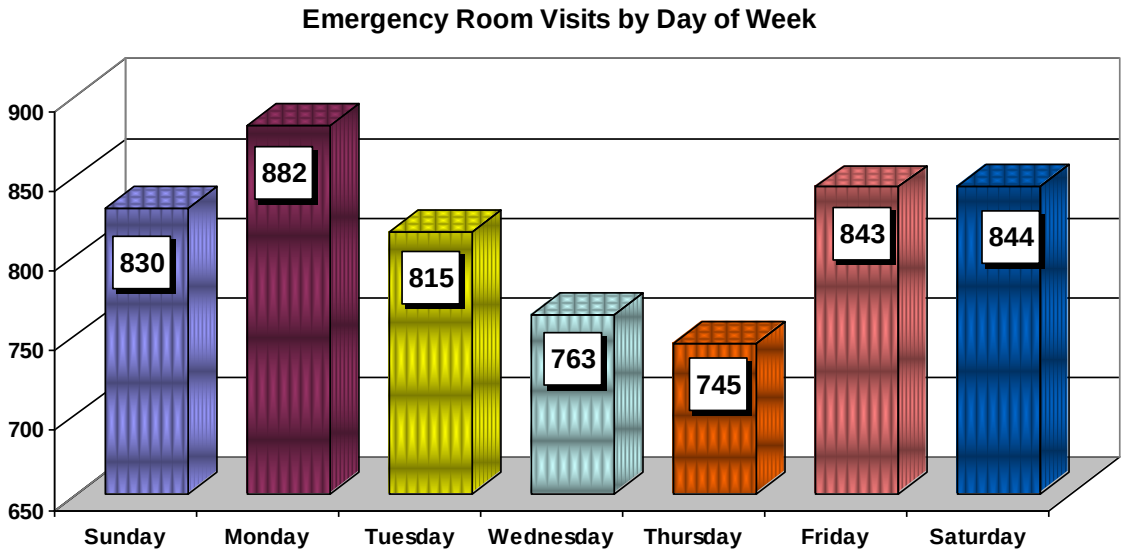
***Top 25 Outpatient Type of Service***

The top 25 outpatient services account for 98.2% of all outpatient costs. Outpatient services account for 42.9% of plan costs.

| *Service Code* | *# Patients* | *% of Patients* | *Paid* | *% of Paid* |
|---|---|---|---|---|
| Hospital Ancillary | 7,906 | 9.12% | $18,510,955 | 36.66% |
| Radiology | 8,939 | 10.32% | $7,126,127 | 14.11% |
| Surgery | 5,652 | 6.52% | $5,284,042 | 10.46% |
| Laboratory | 17,899 | 20.66% | $3,874,119 | 7.67% |
| Anesthesia | 4,290 | 4.95% | $2,217,886 | 4.39% |
| Injection | 723 | 0.83% | $1,867,994 | 3.70% |
| Emergency Room | 4,017 | 4.64% | $1,820,469 | 3.60% |
| Ambulance | 822 | 0.95% | $1,398,436 | 2.77% |
| Radiation Therapy | 56 | 0.06% | $1,091,914 | 2.16% |
| ER Professional Fee | 4,090 | 4.72% | $964,985 | 1.91% |
| Pathology | 3,155 | 3.64% | $895,423 | 1.77% |
| Medical Equipment | 1,905 | 2.20% | $717,699 | 1.42% |
| Miscellaneous | 2,658 | 3.07% | $671,077 | 1.33% |
| Infusion Therapy | 178 | 0.21% | $435,721 | 0.86% |
| Physical Therapy | 645 | 0.74% | $411,220 | 0.81% |
| Mammogram | 2,057 | 2.37% | $400,202 | 0.79% |
| Pap Smear | 4,611 | 5.32% | $340,788 | 0.67% |
| Psychotherapy | 238 | 0.27% | $312,670 | 0.62% |
| Office Visit | 6,027 | 6.96% | $299,711 | 0.59% |
| Assistant Surgery | 424 | 0.49% | $194,610 | 0.39% |
| Chemotherapy | 93 | 0.11% | $189,942 | 0.38% |
| Clinic | 1,429 | 1.65% | $189,271 | 0.37% |
| Hospice Care | 33 | 0.04% | $127,341 | 0.25% |
| Dialysis | 61 | 0.07% | $118,497 | 0.23% |
| Home Health Care | 111 | 0.13% | $113,807 | 0.23% |
| **Total Top 25** | **78,019** | **90.04%** | **$49,574,908** | **98.17%** |
| **Total All Other** | **8,633** | **9.96%** | **$924,447** | **1.83%** |
| **Grand Total** | **86,652** | **100.00%** | **$50,499,355** | **100.00%** |

***Emergency Room Summary***

From the year ending June 30, 2011, to the year ending June 30, 2012, ER visits remained flat at 170 per 1,000 members. Emergency rooms are utilized more than average on Friday through Monday. Further analysis of the use of emergency rooms may provide potential areas for cost savings and reducing spikes in weekend utilization, including amending network contracts to incentivize family practice doctors to keep their offices open over the weekend.



### *Savings Summary*

During the year ending June 30, 2011, direct out-of-pocket costs (deductible, co-payment and co-insurance) by participants accounted for 26.4% of total medical costs owed by the plan and participants after deducting ineligible amounts, network discounts and third party payments from billed charges. During the year ending June 30, 2012, direct out-of-pocket costs by participants decreased to 24.8% of the total medical costs paid by the plan and participants. This decrease is due to the implementation of the Consumer Driven High Deductible Health Plan effective July 1, 2011, offset by claims run-out from Plan Year 2011 and the impact of high cost claims.

| *Category* | *Dollars* | *PPPM* | *% of Eligible* |
|---|---|---|---|
| Eligible Charges | $428,855,448 | $1,768 | 100.00% |
| COB | $31,018,330 | $128 | 7.23% |
| Medicare | $20,839,568 | $86 | 4.86% |
| Excess/Maximums | $3,039,940 | $13 | 0.71% |
| PPO Discount | $217,134,160 | $895 | 50.63% |
| Deductible | $23,959,212 | $99 | 5.59% |
| Coinsurance | $14,249,095 | $59 | 3.32% |
| Copay | $807,471 | $3 | 0.19% |
| **Total Participant Cost** | **$39,015,778** | **$161** | **9.10%** |
| **Total Plan Paid** | **$117,807,672** | **$486** | **27.47%** |

| | |
|---|---|
| **Plan Year 2011** | **$454** |

### *Patient Demographics*

During the year ending June 30, 2012, the plan paid $283 PMPM. The average cost per adult was $347 PMPM. The average cost per child was $129 PMPM.

| *Patient Type* | *Patient Relationship* | *# Members* | *Inpatient Paid* | *Outpatient Paid* | *PCP Paid* | *Specialist Paid* | *Other Paid* | *Total Paid* | *PMPM* |
|---|---|---|---|---|---|---|---|---|---|
| Child | Child | 10,111 | $5,194,313 | $3,622,233 | $1,620,885 | $3,435,239 | $513,178 | $14,385,847 | $119 |
| | Disabled Dependent | 55 | $1,087,570 | $118,898 | $64,591 | $105,646 | $29,906 | $1,406,612 | $2,131 |
| | | ***10,166*** | ***$6,281,883*** | ***$3,741,132*** | ***$1,685,476*** | ***$3,540,885*** | ***$543,084*** | ***$15,792,459*** | ***$129*** |
| Self | Insured | 20,210 | $27,191,486 | $24,685,535 | $5,527,597 | $23,973,408 | $1,458,649 | $82,836,676 | $342 |
| | | ***20,210*** | ***$27,191,486*** | ***$24,685,535*** | ***$5,527,597*** | ***$23,973,408*** | ***$1,458,649*** | ***$82,836,676*** | ***$342*** |
| Spouse | Domestic Partner | 9 | $0 | $11,162 | $1,902 | $8,631 | $402 | $22,097 | $205 |
| | Husband | 1,414 | $2,314,878 | $2,268,802 | $485,275 | $1,514,066 | $102,379 | $6,685,400 | $394 |
| | Wife | 2,873 | $4,434,594 | $3,452,596 | $692,845 | $3,663,698 | $227,307 | $12,471,040 | $362 |
| | | ***4,296*** | ***$6,749,473*** | ***$5,732,559*** | ***$1,180,023*** | ***$5,186,395*** | ***$330,088*** | ***$19,178,537*** | ***$372*** |
| Female | | 18,029 | $21,371,390 | $19,138,280 | $5,094,824 | $19,503,424 | $1,154,835 | $66,262,752 | $306 |
| Male | | 16,642 | **$18,851,452** | **$15,020,946** | **$3,298,272** | **$13,197,263** | **$1,176,987** | **$51,544,920** | **$258** |
| ***Total:*** | | ***34,671*** | ***$40,222,842*** | ***$34,159,227*** | ***$8,393,096*** | ***$32,700,687*** | ***$2,331,821*** | ***$117,807,672*** | ***$283*** |

### *Age Range Summary*

The column on the right of the table shows per patient per month costs in each age category. Children under 1 and Adults 65 and older had the highest PMPM at $825 and $579, respectively. The average cost per adult between the ages of 55 and 64 was $502 PMPM, compared to the average cost of all members of $283 PMPM.

| Age Range | # Members | # Patients | % of Patients | Inpatient Paid | Outpatient Paid | ER Paid | Physician Paid | Other Paid | Total Paid | % of Paid | PMPM |
|---|---|---|---|---|---|---|---|---|---|---|---|
| <1 | 313 | 547 | 0.87% | $2,061,214 | $27,730 | $28,764 | $955,207 | $27,469 | $3,100,384 | 2.63% | $825 |
| 1 | 94 | 580 | 0.92% | $62,670 | $83,618 | $44,339 | $274,024 | $12,603 | $477,254 | 0.41% | $423 |
| 2 - 4 | 933 | 1,442 | 2.29% | $127,893 | $140,195 | $189,326 | $379,075 | $101,078 | $937,567 | 0.80% | $84 |
| 5 - 9 | 1888 | 2,260 | 3.59% | $304,716 | $107,753 | $169,679 | $410,990 | $66,452 | $1,059,591 | 0.90% | $47 |
| 10 - 14 | 2163 | 2,645 | 4.20% | $235,417 | $176,956 | $261,624 | $574,893 | $46,551 | $1,295,441 | 1.10% | $50 |
| 15 - 19 | 2504 | 3,163 | 5.02% | $1,459,501 | $908,298 | $474,699 | $1,125,478 | $132,206 | $4,100,182 | 3.48% | $136 |
| 20 - 24 | 2268 | 2,405 | 3.82% | $2,225,971 | $481,302 | $593,406 | $1,578,875 | $128,592 | $5,008,146 | 4.25% | $184 |
| 25 - 29 | 1352 | 1,731 | 2.75% | $465,819 | $285,300 | $180,473 | $601,036 | $37,958 | $1,570,586 | 1.33% | $97 |
| 30 - 34 | 1689 | 2,332 | 3.70% | $455,029 | $410,057 | $320,503 | $795,184 | $64,899 | $2,045,672 | 1.74% | $101 |
| 35 - 39 | 1911 | 2,811 | 4.46% | $1,258,494 | $906,997 | $309,813 | $1,343,422 | $71,880 | $3,890,606 | 3.30% | $170 |
| 40 - 44 | 2360 | 3,627 | 5.76% | $2,051,246 | $1,092,992 | $453,057 | $1,923,197 | $83,530 | $5,604,022 | 4.76% | $198 |
| 45 - 49 | 2753 | 4,425 | 7.02% | $2,543,187 | $2,092,924 | $669,215 | $3,011,744 | $108,850 | $8,425,920 | 7.15% | $255 |
| 50 - 54 | 3263 | 5,634 | 8.94% | $2,989,688 | $2,911,477 | $807,148 | $4,277,396 | $199,024 | $11,184,733 | 9.49% | $286 |
| 55 - 59 | 4144 | 7,586 | 12.04% | $6,057,748 | $4,868,069 | $1,264,901 | $7,786,410 | $457,243 | $20,434,371 | 17.35% | $411 |
| 60 - 64 | 5118 | 9,560 | 15.17% | $13,170,439 | $8,755,901 | $1,682,918 | $11,198,681 | $543,294 | $35,351,234 | 30.01% | $576 |
| 65 + | 1918 | 12,261 | 19.46% | $4,753,810 | $2,846,405 | $613,386 | $4,858,170 | $250,194 | $13,321,965 | 11.31% | $579 |
| | ***34,671*** | ***63,009*** | ***100.00%*** | ***$40,222,842*** | ***$26,095,976*** | ***$8,063,251*** | ***$41,093,783*** | ***$2,331,821*** | ***$117,807,672*** | ***100.00%*** | ***$283*** |

### *Participants by Tier*

During the year ending June 30, 2012, the plan paid $283 PMPM.

| Coverage Tier | Members |
|---|---|
| Single | 12,766 |
| Employee + Spouse | 3,778 |
| Employee + Children | 8,633 |
| Family | 9,494 |
| ***Total*** | ***34,671*** |

| Member Type | # Members | Total Paid | PMPM |
|---|---|---|---|
| Children | 10,166 | $15,792,459 | $129 |
| Adults | 24,505 | $102,015,213 | $347 |
| ***Total*** | ***34,671*** | ***$117,807,672*** | ***$283*** |

# *Dental Section*

### *Cost Distribution*

The maximum per member dental benefit for Plan Year 2012 is $1,000. However, claims paid during the year included run-out claims for Plan Year 2011. This accounts for the plan paying in excess of $1,000 on behalf of 1,493 members.

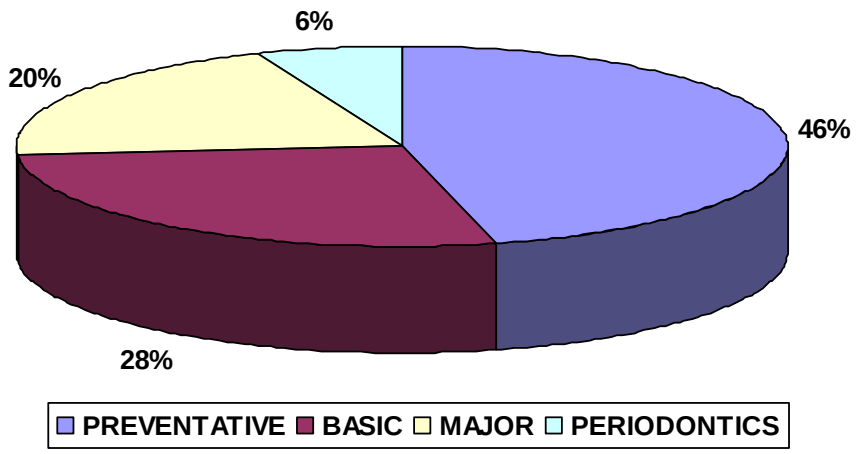
The average dental claim for the year ending June 30, 2012, was $117.20. This represents a 36.7% decrease from the $185.02 average dental claim for the year ending June 30, 2011.

| *Paid Dollar Range* | *Avg Members* | *% of Members* | *# of Claims* | *% of Claims* | *Total Paid* | *% of Paid* |
|---|---|---|---|---|---|---|
| $1,000.01 Plus | 1,493 | 2.48% | 11,333 | 7.39% | $2,195,889 | 12.21% |
| $750.01 - $1,000.00 | 5,363 | 8.93% | 32,992 | 21.50% | $5,463,779 | 30.38% |
| $500.01 - $750.00 | 4,262 | 7.09% | 21,661 | 14.12% | $2,883,881 | 16.04% |
| $250.01 - $500.00 | 12,543 | 20.88% | 47,846 | 31.18% | $4,688,222 | 26.07% |
| $0.01 - $250.00 | 15,034 | 25.02% | 38,905 | 25.35% | $2,750,957 | 15.30% |
| $0.00 | 488 | 0.81% | 705 | 0.46% | $0 | 0.00% |
| No Claims Filed | 20,898 | 34.78% | 0 | 0.00% | $0 | 0.00% |
| | **60,081** | **100.00%** | **153,442** | **100.00%** | **$17,982,727** | **100.00%** |

* Member count is an average over the 12 month period

### *Dental Paid by Type of Service*

Of the $17.9 million in paid dental claims during the year ending June 30, 2012, $8.3 million (46%) was for preventive services.



***Savings Summary***

During the year ending June 30, 2011, participants paid 30.5% 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, 2012, participants' share of costs increased to 34.0% of total dental costs paid by the plan and participants. This increase is due to patients meeting their benefit maximum for the plan year ending June 30, 2011, (claims paid after June 30, 2011), the higher deductible reset on July 1, 2011, and the higher coinsurance effective July 1, 2011.

| *Category* | *Dollars* | *PPPM* | *% of Eligible* |
|---|---|---|---|
| Eligible Charges | $37,520,400 | $87 | 100.00% |
| COB | $169,209 | $0 | 0.45% |
| PPO Discount | $5,468,461 | $13 | 14.57% |
| Excess/Maximums | $4,628,109 | $11 | 12.33% |
| Deductible | $2,428,333 | $6 | 6.47% |
| Coinsurance | $6,843,560 | $16 | 18.24% |
| **Total Participant Paid** | **$9,271,894** | **$22** | **24.71%** |
| **Total Plan Paid** | **$17,982,727** | **$42** | **47.93%** |

| | |
|---|---|
| **Plan Year 2011** | **$52** |

***Patient Demographics***

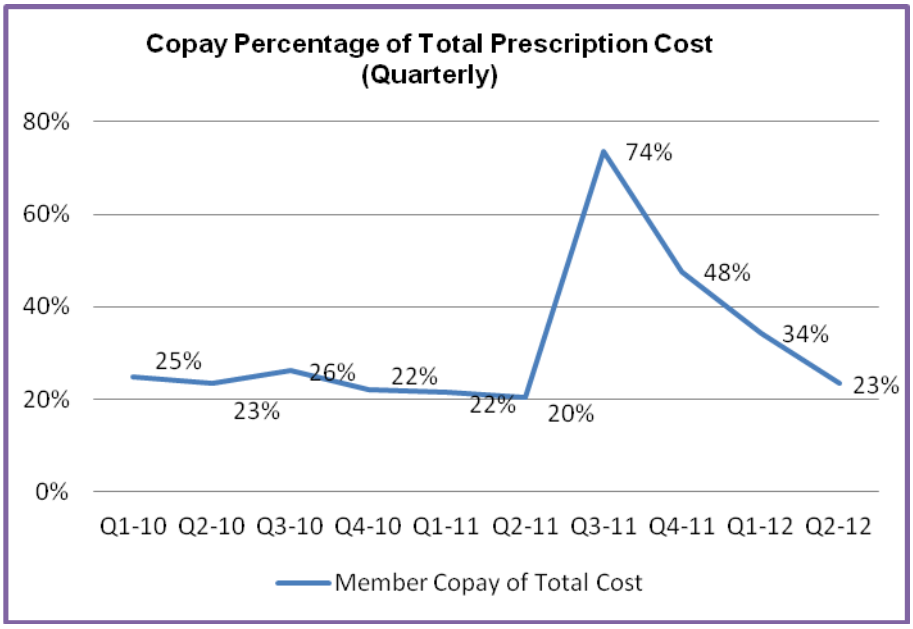
During the year ending June 30, 2012, the plan paid $25 PMPM. The average cost per adult was $27 PMPM. The average cost per child was $20 PMPM.

| *Member Type* | *# Members* | *Total Paid* | *PMPM* |
|---|---|---|---|
| Children | 16,772 | $3,975,707 | $19.75 |
| Adults | 43,309 | $14,007,020 | $26.95 |
| ***Total*** | ***60,081*** | ***$17,982,727*** | ***$24.94*** |

# *Drug Utilization*

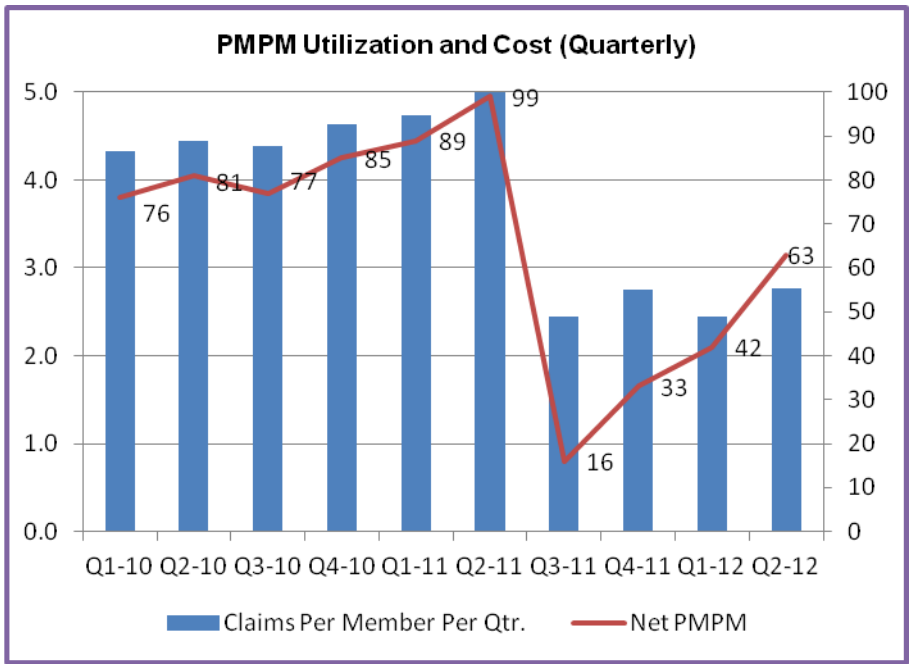
Drug utilization (number of members utilizing the PEBP pharmacy benefit as a percent of all PPO self-funded members) has decreased from 49.0% to 36.3% from the year ending June 30, 2011, to the year ending June 30, 2012. Total prescription drug net costs decreased 56.2% (38.4% PMPM) from $67.0 million to $29.3 million. A large share of the reduction in prescription drug costs is attributable to the Medicare retirees being moved to the Medicare Exchange.

Total prescription drug net costs paid by the plan decreased 67.5% (54.4% PMPM) from $51.9 million to $16.8 million while prescription drug costs paid by participants decreased (17.0%) from $15.1 million to $12.5 million, PMPM costs increased 16.6%. Participants paid 22.5% of total drug costs for the year ending June 30, 2011, and 42.6% of total drug costs for the year ending June 30, 2012. However, it should be noted much of this can be attributed to the introduction of the Consumer Driven High Deductible 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, 2012.*

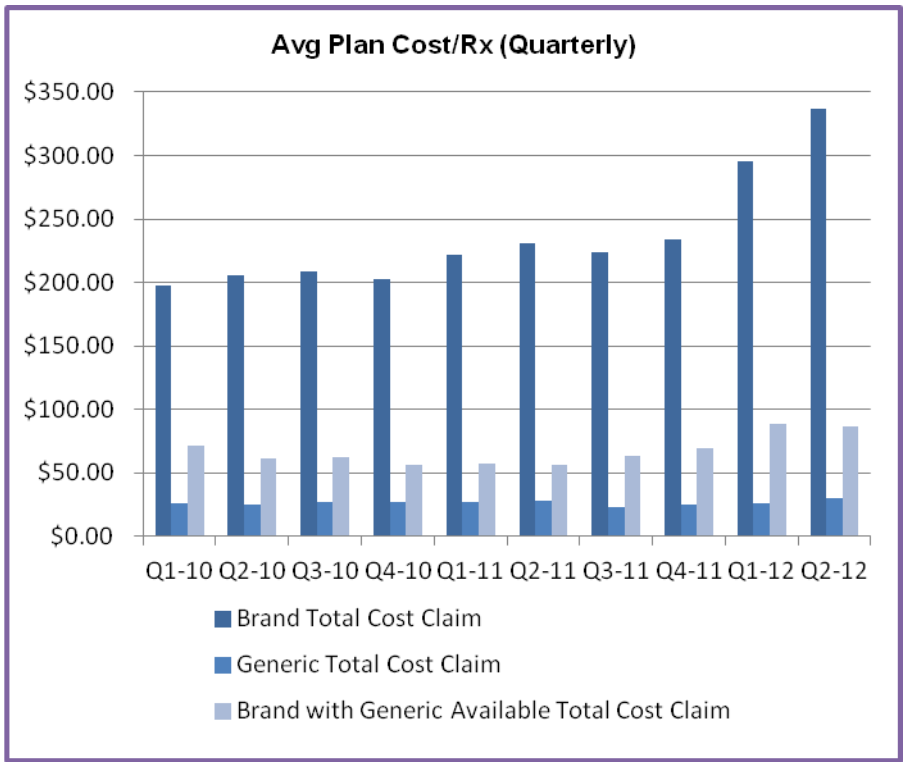
The chart below shows a relatively steady increase in the number of claims per eligible member until June 30, 2011. The decreases in the net PMPM plan costs in the 3rd quarter of calendar years 2010 and 2011 are due to the prescription drug deductible reset on July 1, 2010 and the implementation of the Consumer Driven High Deductible Health Plan effective July 1, 2011.




Generic drug utilization (generic scripts filled as a percent of all scripts) increased from 74.6% in the year ending June 30, 2011, to 78.0% in the year ending June 30, 2012. 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 year ending June 30, 2012, is 91.5%.

From the year ending June 30, 2011, to the year ending June 30, 2012, the net total number of generic prescriptions filled decreased 55.8%, (37.8% PMPM) while the net total cost of generic drugs to the plan and its participants decreased 57.5% (40.2% PMPM). During the year ending June 30, 2012, generic drugs cost $8.0 million out of $29.3 million in total prescription drug costs paid by the plan and participants. Again, a large share of the reduction in generic prescription drug costs is attributable to the migration of Medicare retirees to the Medicare Exchange.

The following table shows the average plan cost per prescription for brand drugs, generic drugs and brand drugs with generic equivalents for the year ending June 30, 2012.




The net cost of specialty drugs decreased 35.8% (9.8% PMPM) from $11.5 million during the year ending June 30, 2011, to $7.4 million in the year ending June 30, 2012. The average number of patients with 7 or more prescription claims per month decreased 74.5% from 3,281 as of June 30, 2011, to 834 as of June 30, 2012. As with the other aspects of prescription drugs, a large share of these reductions is attributable to the migration of Medicare retirees to the Medicare Exchange.

During the year ending June 30, 2012, the five most expensive drugs for the plan and participants (total) were Copaxone, Lipitor, Rebif, Enbrel (includes Endrel Sureclick), and Avonex. Lipitor was scheduled to have a generic equivalent in May 2012, and fell from the list of the five most expensive drugs in June. A list of brand drugs that are scheduled to have a generic equivalent can be found in the Catalyst Rx quarterly report.

Staff is working with 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.


| | Rolling Total for 12 Months |
|---|---|
| **Membership Summary** | |
| Member Count | **35,162** |
| Utilizing Member Count | **12,777** |
| Percent Utilizing | **36.3%** |
| **Claim Summary** | |
| Net Claims (Mail/Retail) | **392,067** |
| Claims per Elig Member per Month | **0.93** |
| Total Claims for Brand | **76,209** |
| Total Claims for Generic | **305,668** |
| Total Claims for Brand w/Gen Equiv | **10,190** |
| Generic % of Total Claims | **78.0%** |
| Mail Order Claims | **17,682** |
| Mail Order % of Total Claims | **4.5%** |
| **Claims Cost Summary** | |
| Total Prescription Cost | **$29,339,073.51** |
| Total Ingredient Cost | **$28,730,535.16** |
| Total Dispensing Fee | **$524,457.22** |
| Total Other (e.g. tax) | **$5,231.07** |
| Total Incentive Fee | **$78,850.06** |
| Avg Total Cost per Claim | **$74.83** |
| Avg Total Cost for Brand | **$269.54** |
| Avg Total Cost for Generic | **$26.15** |
| Avg Total Cost for Brand w/Gen Equiv | **$78.97** |

| | Rolling Total for 12 Months (cont.) |
|---|---|
| **Member Cost Summary** | |
| Total Copay | **$12,485,712.93** |
| Avg Copay per Claim | **$31.85** |
| Avg Copay for Brand | **$91.91** |
| Avg Copay for Generic | **$16.25** |
| Avg Copay for Brand w/Gen Equiv | **$50.39** |
| Copay % of Total Prescription Cost | **42.6%** |
| **Other Plan Paid Cost Summary** | |
| Total Other Plan Paid Cost | **$0.00** |
| **Plan Cost Summary** | |
| Total Plan Cost | **$16,853,360.58** |
| Total Specialty Drug Cost | **$7,350,004.50** |
| | |
| Increase % Total Cost over Last 3 Mos. | |
| Avg Plan Cost per Claim | **$42.99** |
| Avg Plan Cost for Brand | **$177.63** |
| Avg Plan Cost for Generic | **$9.90** |
| Avg Plan Cost for Brand w/Gen Equiv | **$28.59** |
| | |
| Net PMPM | **$39.94** |
| PMPM for Specialty Only | **$17.42** |
| PMPM without Specialty | **$22.52** |

# *Wellness Summary*

In addition to the wellness screenings paid through HealthSCOPE, USPM administered 15,457 biometric screenings and 3,697 PSA tests in the year ending June 30, 2012. Note, many of the USPM labs (7,344) and PSA tests (1,753) conducted in the fourth quarter were needed by participants to qualify for premium incentives in the next plan year.

| **Well Child** | *# Eligible* | *# Patients* | *Per 1,000* | *HSB Index per 1,000* | *Total Paid* | *Paid Per Pt* |
|---|---|---|---|---|---|---|
| Routine Infant or Child Health Check | 7,292 | 2,797 | 384 | 494 | $377,175 | $135 |
| Prophylactic Vaccinations and Inoculations | 7,292 | 1,592 | 218 | N/A | $105,560 | $66 |

| **Well Woman** | *# Eligible* | *# Patients* | *Per 1,000* | *HSB Index per 1,000* | *Total Paid* | *Paid Per Pt* |
|---|---|---|---|---|---|---|
| Mammogram | 10,362 | 5,229 | 505 | 410 | $955,807 | $183 |
| Colonoscopy | 7,703 | 1,413 | 183 | 126 | $804,030 | $569 |
| Cervical Screening | 13,748 | 5,177 | 377 | 402 | $532,296 | $103 |
| Routine General Medical Exam | 14,225 | 1,674 | 118 | 637 | $218,578 | $131 |
| Prophylactic Vaccinations and Inoculations | 14,225 | 749 | 53 | N/A | $18,524 | $25 |

| **Well Man** | *# Eligible* | *# Patients* | *Per 1,000* | *HSB Index per 1,000* | *Total Paid* | *Paid Per Pt* |
|---|---|---|---|---|---|---|
| Colonoscopy | 6,564 | 792 | 121 | 110 | $740,453 | $935 |
| Routine General Medical Exam | 12,717 | 1,692 | 133 | 333 | $231,502 | $137 |
| Prostate Screening | 6,564 | 1,834 | 279 | 408 | $54,353 | $30 |
| Prophylactic Vaccinations and Inoculations | 12,717 | 554 | 44 | N/A | $14,873 | $27 |

# *Diabetes Compliance*

212 of 1,651 active PPO HDHP diabetics with nine months of service (12.4%) have received the minimum number of recommended services (semiannual visit, semiannual glycohemoglobin determination, annual urinalysis or microalbuminuria test, annual ophthalmologic evaluation, annual lipid profile) in the 12 months ending June 30, 2012. 517 members (31%) have received all of the recommended services when the ophthalmologic exams are excluded. With the exception of the annual urinalysis test, the compliance rates for all other tests were below those noted in PY11.

## *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.

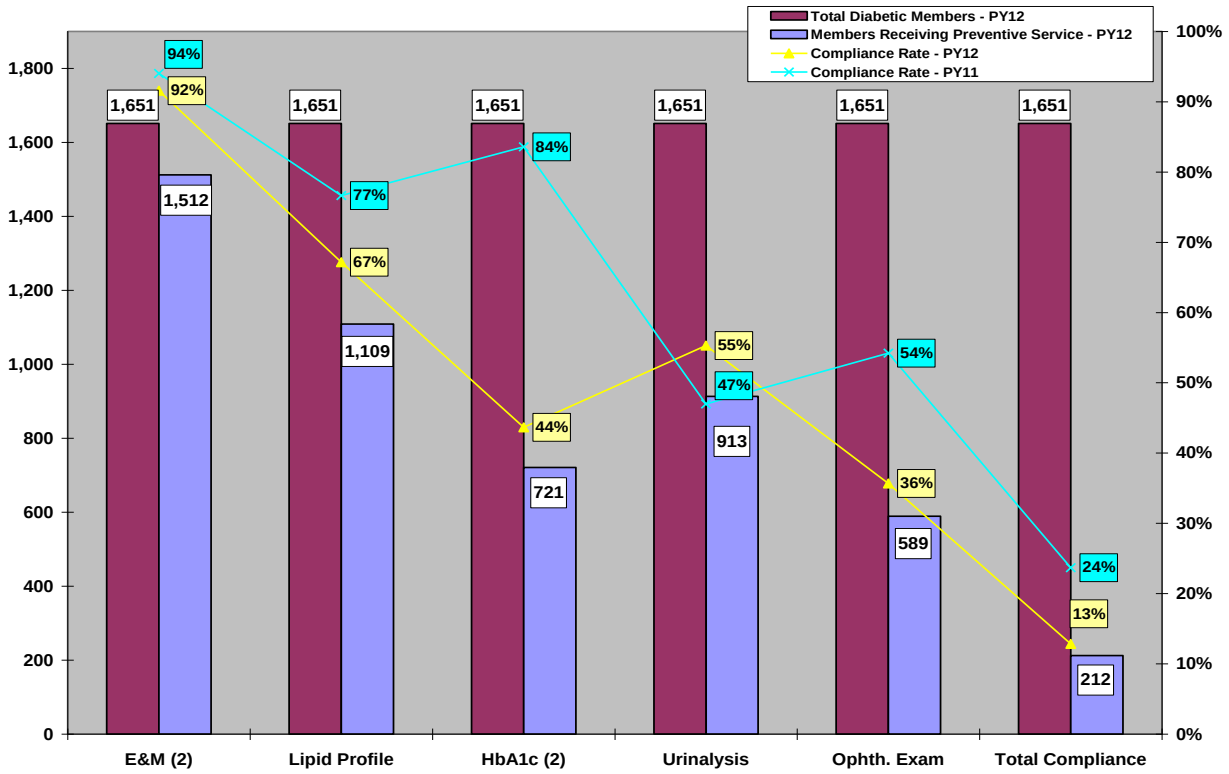
- **Annual ophthalmologic evaluation**

  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.




*** Based on active members with 9 months of service; 12 months of utilization data.**

- PY12 -- 517 members (1,651 total) received all services other than ophth exam (31%)
- PY11 – 679 members (1,656 total) received all services other than ophth exam (41%)

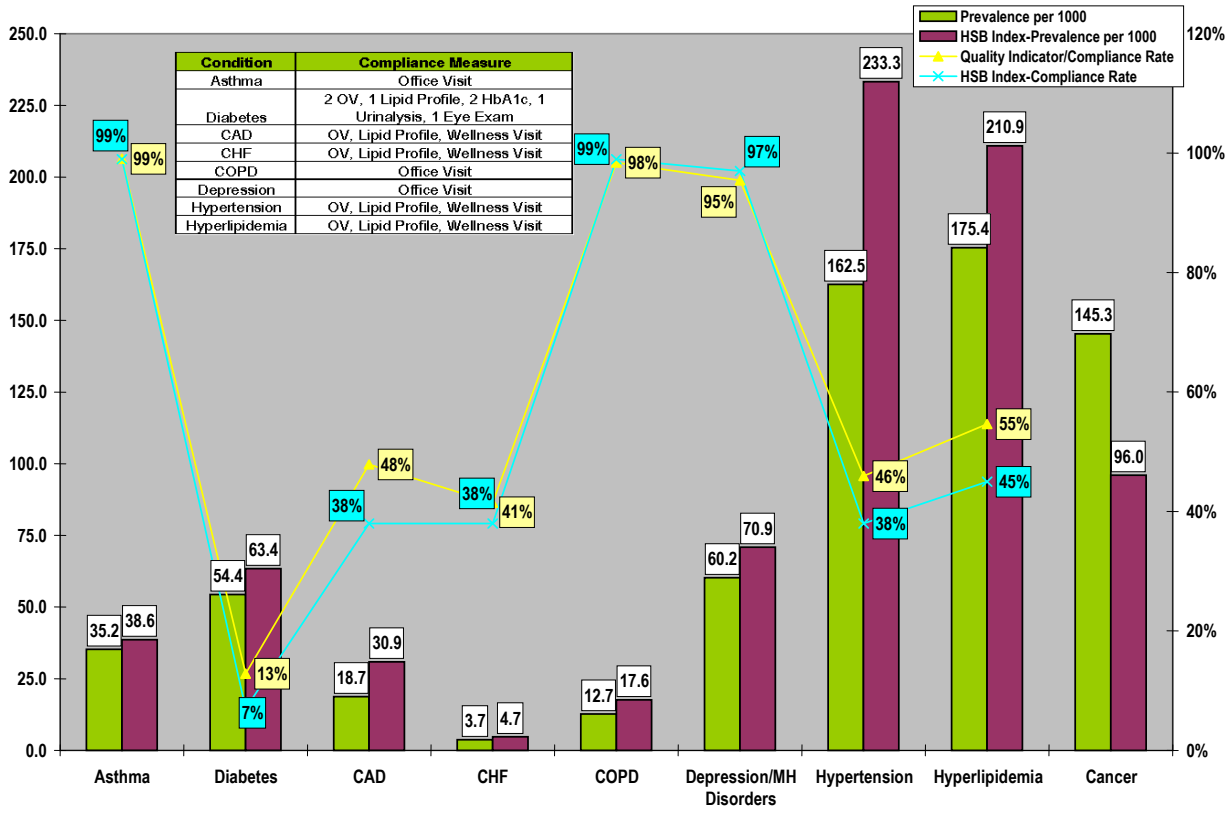
# *Chronic Conditions*

The Chronic Conditions Overview shows the total paid by the plan for chronic conditions for the period ending June 30, 2012, 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 $47,416, while Hyperlipidemia was the most frequent condition. Occurrences of cancer (14.5%) within the PEBP population, as a percentage, were considerably higher than the level noted in HealthSCOPE Benefits' Index (9.6%).

| *Chronic Condition* | *# Members* | *% of Population* | *HSB Index % of Population* | *Average Age* | *Total Paid* | *Avg Cost / Member (Annualized)* |
|---|---|---|---|---|---|---|
| Asthma | 1,068 | 3.5% | 3.9% | 41.6 | $7,940,717 | $7,435 |
| Cancer | 4,408 | 14.5% | 9.6% | 53.8 | $41,371,155 | $9,385 |
| Chronic Obstructive Pulmonary Disease (COPD) | 384 | 1.3% | 1.0% | 59.7 | $6,999,458 | $18,228 |
| Congestive Heart Failure (CHF) | 111 | 0.4% | 0.3% | 63.8 | $5,263,199 | $47,416 |
| Coronary Artery Disease (CAD) | 568 | 1.9% | 2.1% | 61.0 | $9,703,060 | $17,083 |
| Depression / Mental Health Disorders | 1,827 | 6.0% | 7.1% | 45.4 | $18,463,278 | $10,106 |
| Diabetes | 1,651 | 5.4% | 6.3% | 57.7 | $16,808,354 | $10,181 |
| Hyperlipidemia | 5,321 | 17.5% | 14.5% | 56.8 | $27,114,672 | $5,096 |
| Hypertension | 4,932 | 16.3% | 16.1% | 57.4 | $38,293,299 | $7,764 |

| *Chronic Condition* | *# of Employees* | *# of Spouses* | *# of Dependents* | *Total # Members* |
|---|---|---|---|---|
| Asthma | 635 | 129 | 304 | 1,068 |
| Cancer | 3,508 | 658 | 242 | 4,408 |
| Chronic Obstructive Pulmonary Disease (COPD) | 297 | 77 | 10 | 384 |
| Congestive Heart Failure (CHF) | 93 | 18 | 0 | 111 |
| Coronary Artery Disease (CAD) | 487 | 78 | 3 | 568 |
| Depression / Mental Health Disorders | 1,191 | 296 | 340 | 1,827 |
| Diabetes | 1,391 | 226 | 34 | 1,651 |
| Hyperlipidemia | 4,486 | 781 | 54 | 5,321 |
| Hypertension | 4,174 | 718 | 40 | 4,932 |

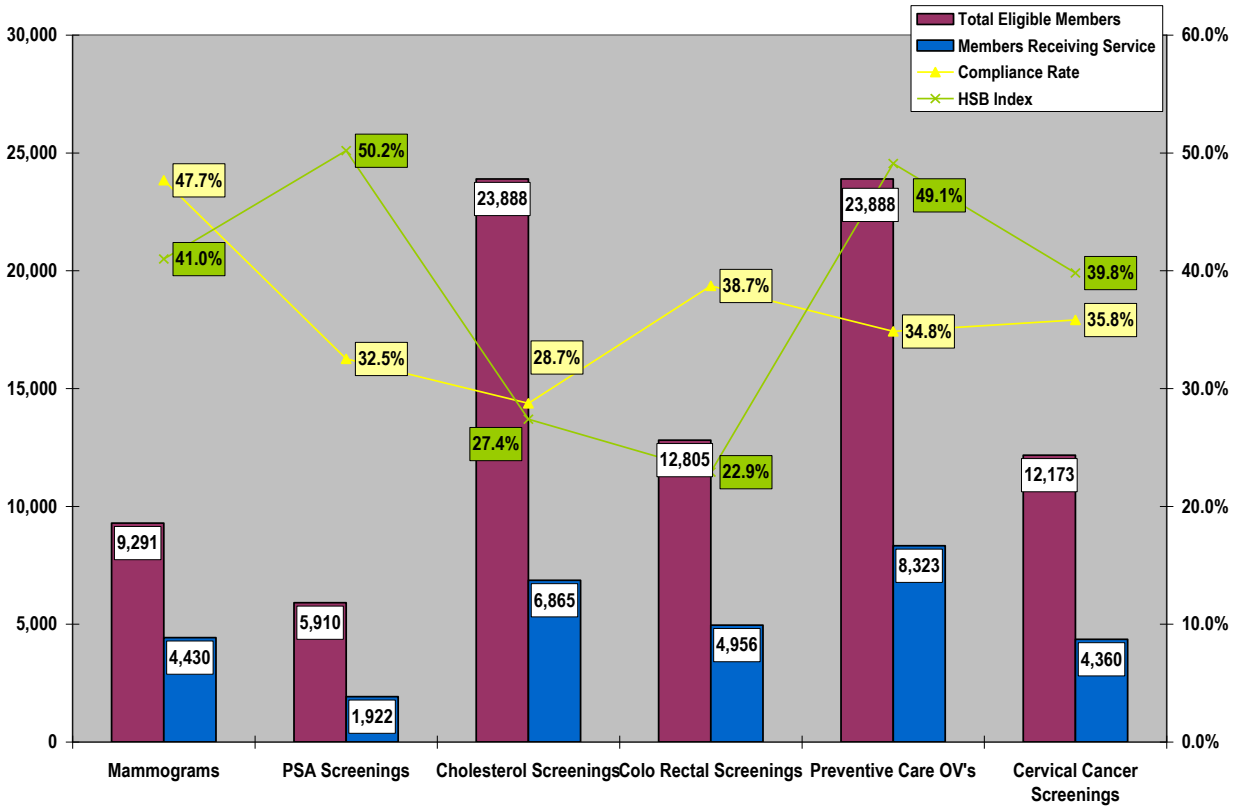
Chronic conditions that require only office visits (Asthma, COPD, and Depression) have compliance rates of approximately 97%. When recommendations for chronic conditions include labs (Diabetes, CAD, CHF, Hypertension, and Hyperlipidemia) compliance rates drop to between 13%-55%; however, the compliance levels are generally higher than the compliance rates associated with HealthSCOPE Benefit's Index for the same conditions.




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

# *Preventive Services*

PPO HDHP 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 well below the compliance index.




*** Based on active members with 9 months of service; 15 months of utilization data – Colo Rectal based on 35 months.**

# *PPO HDHP HSA/HRA Account Balances*

HealthSCOPE Benefits administers approximately 11,694 PO HDHP HRA accounts with approximately $8.4 million in PEBP contributions. The average contribution is $724. In the year ending June 30, 2012, PEBP paid approximately $4.2 million in HRA claims, leaving a liability of $4.2 million in unused HRA funds, or $363 per account, at the end of Fiscal Year 2012.

HealthSCOPE Benefits administers approximately 11,342 PPO HDHP HSA accounts with approximately $9.7 million in PEBP contributions and $6.1 million in employee contributions. The average PEBP contribution is $855. The average employee contribution is $540. During the year ending June 30, 2012, HealthSCOPE Benefits administered the reimbursement of approximately $7.9 million in HSA claims leaving $7.9 million in unused HSA funds, or $699 per account, at the end of Fiscal Year 2012.

| HRA Account Balance Details | | | | | |
|---|---|---|---|---|---|
| Total Accounts | Employer Contribution | Paid* | Employer Deposits | Available Balance | Avg Acct Balance |
| 11,694 | $8,471,238 | ($4,199,196) | $8,428,388 | $4,245,785 | $363 |

* Paid amounts are based on the date the payment is generated not the effective date of the payment.

| HSA Savers Plan Year 2012 | | | | | | |
|---|---|---|---|---|---|---|
| Category | TotalAccounts | PctTotal | AvgEEContr | AvgERContr | AvgBalance | AvgAcctAge |
| Very Low | 425 | 3.75% | $7.21 | $247.78 | 202.69 | 4.5 |
| Low | 5,222 | 46.04% | $16.19 | $739.44 | $515.84 | 11.6 |
| Medium | 4,323 | 38.11% | $422.05 | $1,015.24 | $747.73 | 12.3 |
| High | 1,372 | 12.10% | $3,073.32 | $977.45 | $1,399.06 | 12.7 |

| HSA Spenders Plan Year 2012 | | | | | | |
|---|---|---|---|---|---|---|
| Category | TotalAccounts | PctTotal | AvgContr | AvgDistr | SaveSpend | AvgBal |
| Low Activity | 6,400 | 56.43% | $68.63 | $36.97 | $31.65 | $532.97 |
| Spender - High | 2,481 | 21.87% | $195.62 | $181.45 | $14.17 | $556.46 |
| Spender - Mid | 1,457 | 12.85% | $214.40 | $113.13 | $101.27 | $1,109.99 |
| Saver - Mid | 532 | 4.69% | $221.11 | $29.95 | $191.16 | $1,612.16 |
| Saver - Aggressive | 472 | 4.16% | $182.56 | $0.00 | $182.56 | $1,409.51 |

***Exchange HRA Account Balances***

Extend Health administers approximately 9,210 Medicare Exchange HRA accounts, with an annual contribution of $16.9 million. In the year ending June 30, 2012, PEBP paid $13.1 million in Medicare Exchange HRA claims ($119 per retiree per month) leaving a liability of $3.8 million (22.7%) in unused Medicare Exchange HRA funds, or $417 per account, at the end of Fiscal Year 2012.

**Recommendations**

None