Keenan

PO Box 1538
Rancho Cordova, CA 95741
assuredpartners.com

July 22, 2022

RE: San Joaquin Valley Insurance Authority (SJVIA)
Medical and Prescription Drug (Rx) Request for Proposal (RFP) Final Report

Under the direction of the SJVIA Board, Keenan prepared an RFP to secure the following services:

Services Requested for the SJVIA's Self-Funded Medical and Prescription Drug Program

- Medical: Administrative Services Contract Only (ASC or ASO) or Third-Party Administration (TPA)
- Medical: Preferred Provider Organization (PPO) network
- Prescription Drug (Rx): Pharmacy Benefits Manager (PBM)

Contract Term

- Medical: An initial period of three (3) years, followed by annual renewals
- Prescription Drug: An initial period of three (3) years, followed by another three (3) year optional renewal
- Note: The SJVIA reserves the right to end the contract period for cause at any point in time, or without cause based on mutual agreement between the SJVIA and the Vendor

Effective Date of Coverage

- SJVIA County of Tulare: January 1, 2023
- SJVIA County of Fresno: January 1, 2023 for some covered members, and December 12, 2022 for the balance of Fresno County

Keenan invited the following vendors to submit proposals:

Medical ASO/ASC/TPA Vendors	Prescription Drug PBM Vendors
Aetna	Aetna (CVS)
Anthem	IngenioRx (Anthem)
Blue Shield of CA	Blue Shield of CA
United HealthCare	Optum Rx
Compass Health Administrators	EmpiRx
Delta Health Systems	ExpressScripts
HealthComp	IPM
Pinnacle	MedImpact

All vendors submitted proposals except for MedImpact. OptumRx submitted a proposal through UHC.

Recommendation

The responses from the vendors were thorough and competitive. Each vendor is to be thanked for their participation in the process and for their time and effort given to respond to this RFP. After careful review of each proposal, impact on members (disruption analysis), EPO/PPO network strength, PBM rebate guarantees, PBM discount evaluation, reference checks, vendor interviews, and pricing, SJVIA staff and Keenan request the SJVIA Board approve the recommendation to contract with the following vendors:

Medical EPO/PPO provider Network: Anthem Blue Cross

Medical Administrative Services: Anthem Blue Cross

Pharmacy Benefit Manager: EmpiRx

The only change recommended is the elimination of IngenioRx as the PBM for the SJVIA's high deductible health plans (HDHPs). EmpiRx would provide the services to the HDHPs as well.

EVALUATION OF PROPOSALS

SJVIA staff and Keenan undertook a three-phase review process to evaluate the vendors:

PHASE ONE - PRELIMINARY REVIEW PROCESS

Proposals were reviewed to determine:

(a) completeness of required documentation,

(b) compliance with the SJVIA's administrative and general contracting requirements, and

(c) ability to meet the minimum requirements outlined in this RFP.

Proposers who failed to submit or complete the required documentation, failed to satisfactorily comply with the SJVIA's general contracting requirements, or failed to meet the SJVIA's minimum requirements were deemed non-responsive, eliminated from further consideration, and did not proceed to the Level Two review process. Proposers were notified in writing or email regarding the results of the Level One review.

In the preliminary review phase only Drexi, a PBM quoted through Delta Health Systems was eliminated.

PHASE TWO - REVIEW CRITERIA AND EVALUATION PROCESS

Keenan evaluated and scored the technical competence of all proposals and generated findings for the SJVIA.

Review Criteria - All written responses to the RFP questionnaire were considered and evaluated.

Evaluation Process – The SJVIA's evaluation process included the following:

- A review by SJVIA staff of the SJVIA consultant's report and recommendation.
- In rating vendors, Keenan reviewed RFP responses from each Proposer.
- Evaluation Methodology – Quantitative and qualitative methods were applied to evaluate each Proposer's Response.

- Quantitative analysis were applied to these selection criteria:
  - Access to Care/Network
  - Member Disruption
  - Cost Proposal
  - Plan Design
- Qualitative analysis were applied to these selection criteria:
  - Organizational Strength and Plan Sponsor Services
  - Administration Support and Account Management
  - Member Quality of Care, Resources, and Service

As presented at the May 6, 2022 SJVIA Board Meeting, Keenan reported the Quantitative analysis for:

- Access to Care/Network
- Member Disruption

And, Qualitative analysis (Questionnaire and content responses to RFP) for:

- Organizational Strength and Plan Sponsor Services
- Administration Support and Account Management
- Member Quality of Care, Resources, and Service

This final report will provide Quantitiative analysis for:

- Overall proposed cost
- Performance guarantees
- Plan design

PHASE THREE - SELECTION OF FINALISTS, REFERENCE CHECKS, INTERVIEWS

Keenan conducted reference checks on all qualifying vendors (four carriers, four TPAs, and three PBMs). All references provided positive endorsments.

The RFP process was competitive for all vendors, as each demonstratated ares of strength and some defficiencies. Based on Phase One, Phase Two and Phase Three reference checks, SJVIA staff and Keenan conducted finalist interviews with:

- Anthem Blue Cross
- Blue Shield of California
- CVS Aetna
- HealthComp
- EmpiRx (PBM)
- Integrated Pharmacy Management (PBM)

Based on Keenan's analysis and reporting, reference checks, and finalist inteviews, SJVIA staff and Keenan made the vendor recommendations. Should the SJVIA Board have any questions regarding this report, SJVIA staff and Keenan are happy to respond.

Sincerely,

Bordan Darm
Vice President
AP Keenan

Questionnaire – The following chart summarizes the scoring of each vendor from the Questionnaire. Scoring was done on a 1-3 point basis (3 being the best).

SJVIA Questionnaire Evaluation Summary		Aetna	UMR	Anthem	Blue Shield	Compass	HealthComp	Pinnacle	DHS	Express Scripts	EmpiRx	IPM
Question #	GENERAL INFORMATION (1-12 NOT RATED)											
1-5a	General Information											
5b-12	Required Documentation & Disclosure											
ORGANIZATIONAL STRENGTH AND PLAN SPONSOR SERVICES (10%)		1.98	2.00	2.03	2.03	2.00	1.95	1.98	1.98	2.03	1.95	1.98
13-18	Background	2.00	2.00	2.00	2.00	2.00	1.80	2.00	2.00	2.00	1.90	1.90
19-21	Contractual Issues	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
22-27	Firm Experience	1.90	2.00	2.10	2.10	2.00	2.00	1.90	1.90	2.10	1.90	2.00
28-33	Regulatory and Compliance	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
ADMINISTRATION SUPPORT AND ACCOUNT MANAGEMENT (15%)		2.02	2.00	2.02	2.07	2.00	1.98	2.00	2.02	1.97	2.02	2.00
34-36	Implementation	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
37-40	Claims Processing	2.10	2.00	2.20	2.30	2.00	2.00	1.90	2.00	2.00	2.00	2.00
41-51	Billing	2.00	2.00	2.00	2.00	2.00	1.90	2.00	2.00	2.00	2.00	2.00
52-57	Plan Sponsor Services	2.00	2.00	2.00	2.00	1.90	1.90	2.00	2.00	1.90	2.00	1.90
58-59	Call Center Administration	2.00	2.00	2.00	2.10	2.10	2.10	2.10	2.10	1.90	2.10	2.10
60-67	Systems and Cybersecurity	2.00	2.00	1.90	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
MEMBER QUALITY OF CARE, RESOURCES, AND SERVICES (15%)		1.98	2.00	1.96	2.00	2.00	2.01	2.02	2.02	1.88	2.03	2.02
68-69	Enrollment	2.00	2.00	2.00	2.00	2.10	2.10	2.10	2.10	2.20	2.20	2.20
70-74	Call Center Member Services	1.80	2.00	1.80	2.00	2.10	2.10	2.10	2.10	2.10	2.10	2.10
75-78	Customer Service and Quality Control	2.00	2.00	1.90	2.00	1.90	1.90	2.00	2.00	1.00	2.00	1.90
79-83	Grievances and Appeals	2.00	2.00	1.90	2.00	2.00	2.00	2.00	2.00	1.50	2.00	2.00
84-85	Member Advocacy and Support Services	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
89-92	Quality Measurement Standards	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
93-95	Online Resources	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
96-101	Wellness Resources	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
102-104	Condition Management Resources	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
105-106	Miscellaneous Services	2.00	2.00	2.00	2.00	1.90	2.00	2.00	2.00	2.00	2.00	2.00
ACCESS TO CARE/NETWORK (30%)		2.00	1.95	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
107-108	Provider Groups, Networks, and Geographic Access	2.00	1.90	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
109-110	Emergency and Urgent Care Access & Extended Hours	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
COST PROPOSAL AND PLAN DESIGN (30%)		2.05	1.98	2.00	2.03	2.03	2.00	2.00	2.03	2.00	1.98	2.00
111-112	Premium Costs and Fee Commitments	2.00	1.90	2.00	2.00	2.00	1.90	2.00	2.00	2.00	1.90	2.00
113-117	Provider Reimbursements and Discounts	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
118-120	Hospital and Outpatient Facility Charges	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
121-122	Fee Guarantees and/or Fee Caps	2.20	2.00	2.00	2.10	2.10	2.10	2.00	2.10	2.00	2.00	2.00
Total Summary (100%)		2.012	1.978	1.999	2.020	2.008	1.994	2.001	2.011	1.980	1.995	2.001
13-125	Total All Rated Questions	52.00	51.80	51.80	52.60	52.10	51.80	52.10	52.30	50.70	52.10	52.10

Based on the results of the questionnaire, all vendors responded favorably.

GeoAccess –

Four PPO networks are being considered for the SJVIA. Anthem Blue Cross PPO network, Aetna PPO network, Blue Shield of CA PPO network, and UHC (UMR) PPO network. We asked the carriers to show the number of providers and facilities available by each zip code in each County and outside of the two Counties based on where members live. The following Chart summarizes the number of providers and facilities in each County.

Anthem	Employees	Primary Care	Internist	OB/GYN	Pediatrician	MH/SA Providers	Other Specialist	Urgent Care Facilities	Outpatient Facility	MH/SA Facility	Hospitals
Fresno	6,193	616	977	188	386	381	4,106	21	3	6	11
Tulare	3,374	288	301	77	155	172	1,083	6	1	1	4
All Other	516	2,227	3,243	859	1,222	4,792	16,506	118	38	64	62
Total	10,083	3,131	4,521	1,124	1,763	5,345	21,695	145	42	71	77
Blue Shield	**Employees**	**Primary Care**	**Internist**	**OB/GYN**	**Pediatrician**	**MH/SA Providers**	**Other Specialist**	**Urgent Care Facilities**	**Outpatient Facility**	**MH/SA Facility**	**Hospitals**
Fresno	6,193	276	630	117	190	285	2,110	18	33	10	11
Tulare	3,374	136	225	44	71	74	759	9	14	2	4
All Other	516	498	472	461	464	487	492	128	485	117	124
Total	10,083	910	1,327	622	725	846	3,361	155	532	129	139
Aetna CPII	**Employees**	**Primary Care**	**Internist**	**OB/GYN**	**Pediatrician**	**MH/SA Providers**	**Other Specialist**	**Urgent Care Facilities**	**Outpatient Facility**	**MH/SA Facility**	**Hospitals**
Fresno	6,193	948	528	157	355	273	5,382	23	2	5	18
Tulare	3,374	467	231	65	137	126	1,800	8	1	4	9
All Other	516	4,236	2,376	1,009	1,619	2,176	28,014	280	14	14	93
Total	10,083	5,651	3,135	1,231	2,111	2,575	35,196	311	17	23	120
UHC	**Employees**	**Primary Care**	**Internist**	**OB/GYN**	**Pediatrician**	**MH/SA Providers**	**Other Specialist**	**Urgent Care Facilities**	**Outpatient Facility**	**MH/SA Facility**	**Hospitals**
Fresno	6,193	709	1,643	270	454	866	2,739	19	42	10	7
Tulare	3,374	380	401	108	206	720	892	10	17	3	4
All Other	516	2,828	4,560	1,158	1,686	4,019	11,528	116	199	48	55
Total	10,083	3,917	6,604	1,536	2,346	5,605	15,159	145	258	61	66

Based on the GeoAccess report, all four carriers provide adequate coverage to cover the required SJVIA areas.

PPO/EPO In-Network Disruption –

Keenan had each carrier reprice and determine whether the provider was in-network or out-of-network for all 2021 medical charges. This included 385,235 claims valued at $161,629,455 in medical charges. The following chart illustrates the results:

Disruption Summary	Charges		Provider Encounters	
	In-Network	Out-Network	In-Network	Out-Network
Anthem	93.3%	6.7%	88.3%	11.7%
Blue Shield	97.4%	2.6%	95.2%	4.8%
Aetna CPII	94.8%	5.2%	89.2%	10.8%
UMR	95.2%	4.8%	95.0%	5.0%
Disruption Summary	**Charges**		**Provider Encounters**	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**
Anthem	$ 156,329,937	$ 5,299,518	339,989	45,246
Blue Shield	$ 157,384,399	$ 4,245,056	366,664	18,571
Aetna CPII	$ 153,176,298	$ 8,453,157	343,587	41,648
UMR	$ 153,805,826	$ 7,823,629	365,960	19,275

All four carriers provide strong in-network coverage. Having in-network coverage in the 93% to 97% range is acceptable.

PPO/EPO Network Discount Analysis –

Keenan had each carrier reprice 2021 eligible medical charges to determine each carrier's average in-network PPO/EPO discount. Each carrier reported the following discounts:

SJVIA EPO/PPO Network Discount Analysis - Summary				
PPO	**Anthem**	**Blue Shield**	**Aetna**	**UMR**
In-Network				
IP Facility	62.3%	58.5%	63.0%	55.7%
OP Facility	70.8%	67.0%	64.4%	67.9%
Professional	63.5%	60.4%	57.7%	57.2%
Total	66.3%	62.9%	61.8%	61.3%

All carriers had in-network discounts above 60%. Anthem slightly outperformed the others with a 66.3% in-network discount.

Strength of PPO/EPO Network –

Based on the Disruption and Discount analysis, Keenan was able to complete a strength of network analysis. Out-of-network claims were treated equal among the carriers assuming each utilized a similar usual and customary value.

PPO/EPO Network Strength Analysis	Anthem	Blue Shield	Aetna	UMR
Total Billed Charges	$161,629,455	$161,629,455	$161,629,455	$161,629,455
In-Network Utilization	93.3%	97.4%	94.8%	95.2%
In-Network Charges	$150,801,196	$157,384,399	$153,176,298	$153,805,826
In-Network Discount	66.3%	62.9%	61.8%	61.3%
Total In-Network Discount	$100,041,512	$98,951,451	$94,658,059	$94,338,911
Total Net In-Network Charges	**$50,759,684**	**$58,432,948**	**$58,518,239**	**$59,466,914**
Out of Network Utilization	6.7%	2.6%	5.2%	4.8%
Out of Network Charges	$10,828,259	$4,245,056	$8,453,157	$7,823,629
Out of Network Discount	22.3%	22.3%	22.3%	22.3%
Total Out of Network Discount	$2,416,016	$947,163	$1,886,080	$1,745,619
Total Net Out of Network Charges	**$8,412,243**	**$3,297,893**	**$6,567,077**	**$6,078,011**
Total Charges	**$59,171,927**	**$61,730,841**	**$65,085,316**	**$65,544,925**
$ Difference		$2,558,914	$5,913,389	$6,372,998
% Difference		4.3%	10.0%	10.8%

Anthem has a 4.3% ($2.5 million) claim cost advantage over Blue Shield and 10.0% to 10.8% ($5.9 to $6.3 million) advantage over Aetna and UMR.

Prescription Drug Evaluation – Disruption Analysis

Currently SJVIA utilizes EmpiRx for PPO/EPO and Anthem IngenioRx for HDHP prescription drug benefit administration. Seven different PBMs bid on the SJVIA. Based on 2021 data (46,239 drug transactions), EmpiRx would minimize disruption by only having 180 drug transactions negatively impact SJVIA covered members. CVS Aetna came in second with 697 drug transactions with only 53 excluded transactions.

SJVIA Prescription Drug Disruption Analysis							
# of Drugs	Anthem IngenioRx	Blue Shield	CVS Aetna	UHC/UMR OptumRx	EmpiRx	IPM	ESI
EPO/PPO # of Drugs							
No Change	36,248	31,793	37,580	35,012	38,639	37,452	36,852
Positive Change	209	1,488	374	139	0	8	79
Negative Change	2,124	3,728	639	1,606	0	53	461
Excluded	58	1,630	46	1,882	0	1,126	1,247
Total	38,639	38,639	38,639	38,639	38,639	38,639	38,639
HDHP # of Drugs							
No Change	4,901	6,079	7,362	6,758	6,651	404	6,487
Positive Change	460	735	173	260	769	63	563
Negative Change	525	551	58	160	180	23	195
Excluded	1,714	235	7	422	0	7,110	355
Total	7,600	7,600	7,600	7,600	7,600	7,600	7,600
EPO/PPO/HDHP # of Drugs							
No Change	41,149	37,872	44,942	41,770	45,290	37,856	43,339
Positive Change	669	2,223	547	399	769	71	642
Negative Change	2,649	4,279	697	1,766	180	76	656
Excluded	1,772	1,865	53	2,304	0	8,236	1,602
Total	46,239	46,239	46,239	46,239	46,239	46,239	46,239

Prescription Drug Discount Comparison

The PBMs offered the following AWP discounts for 2023. Discount offers increased with each PBM for 2024 and 2025. Keenan recognizes that AWP discounts and pricing is based on each PBM's contractual obligations with manufacturers and formulary arrangements. To quantify the cost proposal of each vendor Keenan needed to make assumptions on pre-AWP discount values for SJVIA based its utilization of Generic, Brand, and Specialty measured over Retail, Retail 90, and Mail Order. Assumptions were equally applied towards each PBM to determine overall values.

SJVIA Prescription Drug Discount from AWP Summary Coverage EPO/PPO/HDHP Discount from AWP							
Retail	EmpiRx	IPM	ESI	Anthem IngenioRx	Blue Shield	CVS Aetna	UMR OptumRx
1 Generic	85.00%	82.75%	84.70%	85.00%	85.25%	85.00%	84.50%
2 Preferred Brand	19.00%	19.00%	19.00%	19.50%	19.10%	19.90%	19.25%
3 Non-Preferred / Specialty	19.00%	19.00%	19.00%	22.00%	N/A	19.90%	19.25%
4 Specialty	19.00%	17.00%	20.00%	22.00%	20.00%	19.90%	19.25%
Mail Order							
1 Generic	90.00%	84.15%	86.75%	87.00%	86.75%	89.25%	87.00%
2 Preferred Brand	25.50%	23.15%	23.50%	25.00%	26.25%	24.75%	25.50%
3 Non-Preferred / Specialty	23.00%	23.15%	23.50%	22.00%	N/A	24.75%	25.50%
4 Specialty	23.00%	17.00%	20.00%	22.00%	20.00%	20.00%	21.50%
Retail 90							
1 Generic	86.00%	84.25%	84.70%	85.00%	85.75%	85.00%	85.50%
2 Preferred Brand	23.00%	23.50%	23.00%	21.50%	22.00%	21.40%	22.50%
3 Non-Preferred / Specialty	19.00%	23.50%	23.00%	22.00%	N/A	21.40%	22.50%
4 Specialty	19.00%	See Note	20.00%	22.00%	N/A	21.40%	22.50%
AP Keenan Valuation							
Average AWP Discount	54.20%	52.67%	53.98%	54.50%	54.29%	54.09%	53.94%
Projected 2023 RX Spend	$25,087,651	$25,479,616	$25,146,482	$25,011,748	$25,066,657	$25,117,440	$25,156,564
$ Difference		$391,965	$58,831	-$75,903	-$20,994	$29,789	$68,913
% Difference		1.56%	0.23%	-0.30%	-0.08%	0.12%	0.27%

Keenan estimates a range differential between carriers of $467,868.

Prescription Drug Rebate Comparison

The PBMs proposed and projected the following prescription drug rebates. Based on five years of experience, the EmpiRx rebate annual total is accurate.

Rx Rebate PG per Script	EmpiRx	IPM	ESI	Anthem	Blue Shield	CVS Aetna	UHC(UMR) OptumRX
Retail 30-day supply	$190.00	$138.34	$220.00	$209.16	$205.00	$253.99	$280.00
Retail 90-day supply	$475.00	$423.17	$660.00	$787.02	$450.00	$651.22	$820.00
Retail Specialty	$1,800.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mail Order	$500.00	$423.17	$660.00	$720.31	$540.00	$723.58	$875.00
Specialty Mail Order	$1,800.00	$1,802.29	$2,100.00	$3,069.40	$1,800.00	$2,911.29	$2,350.00
Projected Annual Rebate	**$3,796,860**	**$2,995,428**	**$4,260,480**	**$3,151,884**	**$2,304,520**	**$7,306,564**	**$5,170,005**
$ Difference		-$801,432	$463,620	-$644,976	-$1,492,340	$3,509,704	$1,373,145
% Difference		-21.1%	12.2%	-17.0%	-39.3%	92.4%	36.2%
% to SJVIA	100%	100%	100%	100%	100%	100%	100%
Rebate Basis	# of Scripts	# of Scripts	# of Scripts	$35.00 PEPM	# of Scripts	$96.04 PEPM	UMR Estimate

ESI, CVS Aetna, and UMR (OptumRx) offer higher rebates, but did not provide the required number of qualifying scripts in each category with their original proposal. CVS Aetna did provide the backup for their calculation, the number of scripts utilized was substantially higher than the other PBMs. In general, there is a concern as to whether these higher rebate levels would be achieved.

Performance Guarantees – Medical Carriers, Medical TPAs, and PBMs

SJVIA Performance Guarantees	Response:	Yes or Yes w/ Adj. or No or To Be determined (TBD)									
Medical PGs	**Anthem**	**Blue Shield**	**CVS Aetna**	**UHC/UMR**	**Compass**	**DHS**	**HealthComp**	**Pinnacle**	**ESI**	**EmpiRx**	**IPM**
Claims Timeliness (14 Calendar Days)	Yes with Adj.	Yes	Yes	Yes		Yes	Yes	Yes			
Claim Timeliness (30 Calendar Days)	Yes with Adj.	Yes	Yes with Adj.	Yes with Adj.		Yes	Yes with Adj.	Yes			
Claim Payment Accuracy	Yes with Adj.	Yes	Yes	Yes		Yes	Yes	Yes			
Claim Financial Accuracy	Yes with Adj.	Yes	Yes	Yes		Yes	Yes	Yes			
Open Enrollment ID Card Issuance	Yes with Adj.	Yes	Yes with Adj.	Yes with Adj.		Yes	Yes	Yes			
Processing of Ongoing Eligibility Information	Yes with Adj.	Yes	Yes with Adj.	Yes with Adj.		Yes	Yes with Adj.	Yes			
Ongoing ID Cards Issuance	Yes	Yes	Yes	Yes		Yes	Yes	Yes			
Eligibility Error Reports - Ongoing	Yes	Yes	Yes	Yes with Adj.		Yes	Yes	Yes			
Average Speed to Answer	Yes with Adj.	Yes	No	Yes		Yes	Yes with Adj.	Yes			
Call Abandonment Rate	Yes with Adj.	Yes	Yes with Adj.	Yes		Yes	Yes	Yes	Does Not Apply	Does Not Apply	Does Not Apply
First Call Resolution	Yes with Adj.	Yes	Yes	Yes		TBD	Yes	Yes			
Member Satisfaction	Yes with Adj.	Yes	Yes with Adj.	Yes		TBD	Yes with Adj.	Yes			
Management Reports	Yes with Adj.	Yes	Yes with Adj.	Yes		Yes	Yes	Yes			
Annual Performance Report	Yes with Adj.	Yes	Yes with Adj.	Yes with Adj.		Yes	Yes	Yes			
Performance Guarantee Objectives Results Report	Yes	Yes	Yes with Adj.	Yes		Yes	Yes	Yes			
Account Management Satisfaction	Yes with Adj.	Yes	Yes with Adj.	Yes with Adj.		Yes	Yes with Adj.	Yes			
Appeals	No	Yes	Yes	Yes		No	No	Yes			
Network Alerts	Yes with Adj.	Yes	Yes with Adj.	Yes with Adj.		No	No	Yes			
Provider Accessibility	Yes with Adj.	Yes	Yes with Adj.	Yes with Adj.		No	No	Yes			
Security Breach	Yes with Adj.	Yes	Yes with Adj.	Yes with Adj.		Yes	Yes	Yes			
PBM PGs	**Anthem**	**Blue Shield**	**CVS Aetna**	**UHC/UMR**	**Compass**	**DHS**	**HealthComp**	**Pinnacle**	**ESI**	**EmpiRx**	**IPM**
Claims Accuracy - Retail	Yes	Yes	Yes with Adj.	Yes						Yes	Yes
Claims Accuracy - Mail Order	Yes	Yes	Yes with Adj.	Yes						Yes	Yes
Dispensing Accuracy – Retail	No	Yes	No	Yes with Adj.						Yes	Yes
Dispensing Accuracy – Mail Order	Yes	Yes	Yes with Adj.	Yes	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply		Yes	Yes
Claim Processing Turnaround Time - Mail Order Claims (no Intervention)	Yes	Yes	Yes with Adj.	Yes						Yes	Yes
Claim Processing Turnaround Time - Mail Order Claims (w/ Intervention)	Yes	Yes	Yes with Adj.	Yes						Yes	Yes
PBM Rebate PGs Category	**Anthem**	**Blue Shield**	**CVS Aetna**	**UHC/UMR**	**Compass**	**DHS**	**HealthComp**	**Pinnacle**	**ESI**	**EmpiRx**	**IPM**
Prescription Drug Rebates	Yes	Yes	No	No						Yes	Yes
Prescription Drug Discounts	Yes	Yes	No	No						Yes	Yes
Prescription Drug Dispensing Fee	Yes	Yes	No	No	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply		Yes	Yes
Prescription Drug - Clinical Management	No	No	No	No						Yes	TBD

Performance Guarantees – Condition Management and Case Management

Condition Mgmt PGs	Anthem	Blue Shield	CVS Aetna	UHC/UMR	Compass	DHS	HealthComp	Pinnacle	ESI	EmpiRx	IPM
Condition Care Enrollment Rate	No	Yes	No	No		Yes with Adj.	Yes with Adj.	No			
Condition Care Engagement Rate	Yes with Adj.	Yes	No	Yes		Yes with Adj.	Yes with Adj.				
Heart Failure ACE Inhibitors/ARB	No	Yes with Adj.	No	No		No	Yes				
Diabetes Annual Hemoglobin A1c (HbA1c) Testing	No	Yes	No	No		Yes with Adj.	Yes		Does Not Apply	Does Not Apply	Does Not Apply
Persistent Asthma Prescription Drug	No	Yes	No	No		No	TBD				
Diabetes Nephropathy Testing/Identification	No	Yes	No	No		Yes with Adj.	No				
Case Management PGs	**Anthem**	**Blue Shield**	**CVS Aetna**	**UHC/UMR**	**Compass**	**DHS**	**HealthComp**	**Pinnacle**	**ESI**	**EmpiRx**	**IPM**
Case Management High Dollar Claimant Outreach	Yes with Adj.	Yes	No	No		Yes with Adj.	Yes	No			
Case Management Member Outreach for Preadmission Counseling	Yes with Adj.	Yes	No	No		Yes with Adj.	Yes with Adj.		Does Not Apply	Does Not Apply	Does Not Apply
Case Management Member Outreach for Post Discharge Counseling	Yes with Adj.	Yes	No	No		Yes with Adj.	Yes with Adj.				

Note: Anthem PBM PGs $75,000
Aetna/CVS Condition and Case Mgmt PG $10.03 PEPM

Prescription Drug Total Cost Comparison

Keenan added the Projected claim cost, subtracted the Prescription drug rebates, and added the PBM Administration fee to arrive at the prescription drug total cost. Please note Anthem, Blue Shield, CVS Aetna, and UMR OptumRx included their prescription drug administration cost in with the medical cost.

AP Keenan Valuation with Rebate and Administration	EmpiRx	IPM	ESI	Anthem IngenioRx	Blue Shield	CVS Aetna	UMR OptumRx
Projected 2023 RX Spend	$25,087,651	$25,479,616	$25,146,482	$25,011,748	$25,066,657	$25,117,440	$25,156,564
Projected Rebate	$3,796,860	$2,995,428	$4,260,480	$3,151,884	$2,304,520	$7,306,564	$5,170,005
Administration Cost	$277,452	$0	$0	w/ med	w/ med	w/ med	w/ med
Total RX Cost	**$21,568,243**	**$22,484,188**	**$20,886,002**	**$21,859,864**	**$22,762,137**	**$17,810,876**	**$19,986,559**
$ Difference		**$915,945**	**-$682,241**	**$291,621**	**$1,193,894**	**-$3,757,367**	**-$1,581,684**
% Difference		**4.25%**	**-3.16%**	**1.35%**	**5.54%**	**-17.42%**	**-7.33%**

Both IPM and ESI are offering a $0 administration fee. IPM was asked to provide their estimated revenue from SJVIA and did not provide the value. ESI was asked to review their proposal with Keenan and declined the invitation, so validation of their administrative revenue could not be accomplished.

Given the concerns with CVS Aetna, ESI, and UMR (OptumRx) rebate realization, EmpiRx then Anthem's IngenioRx would be the preferred PBM vendors.

Administrative Costs, The Carriers - The following chart illustrated the administration costs per carrier. Fee descriptions are provided on each vendor.

SJVIA First Year Administrative Cost Summary		Anthem Blue Cross				Blue Shield		Aetna	UHC/UMR
Per Employee per Month (PEPM)	Enrollment Assumption	Option 1 Medical Only	Option 2 Medical Only	Option 3 Med/RX	Option 4 Med/RX	Option 1 Medical Only	Option 2 Med/RX	Med/RX	Med/RX
Administration Fee EPO/PPO	6,189	$37.90	$34.90	$37.90	$34.90	$28.40	$25.90	$37.19	$27.50
Administration Fee HSA Compatible HDHP PPO	720	$37.90	$34.90	$37.90	$34.90	$28.40	$25.90	$37.19	$27.50
EPO/PPO Network Access Fee	6,909	Included	Included	Included	Included	Included*	Included*	Included	Included
Case Management Fee (Shield Support)	6,909	Included	Included	Included	Included	$2.30	$2.30	Included	Included
Condition/Disease Management Fee	6,909	$0.10	$0.10	$0.10	$0.10	Included**	Included**	Included	$3.85
Clinical Management Fee	6,909	Included	Included	Included	Included	Included**	Included**	Included	Included
Utilization Review Fee	6,909	Included	Included	Included	Included	Included	Included	Included	Included
Wellness Fee	6,909	Included	Included	Included	Included	Included	Included	Included	Included
1 Other (Name)	6,909		$250,104		$250,104	$5.42	$5.42		
2 Other (Name)	6,909			$100,000	$100,000	$500K annual	$1 million	$250,000	$100,000
3 Wellness Fund	6,909	$60,000	$60,000	$60,000	$60,000	$100,000	$100,000	$231,313	$100,000
4 Other (Name)	6,909					Included	Included		$698,914
5 Other (Name)	6,909			($35.00)	($35.00)				$2.37
Total Cost (PEPM)	**6,909**	**$38.00**	**$35.00**	**$3.00**	**$0.00**	**$36.12**	**$33.62**	**$37.19**	**$33.72**
Gross 2023 Annual Cost	**6,909**	**$3,150,504**	**$3,151,884**	**$248,724**	**$250,104**	**$2,994,637**	**$2,787,367**	**$3,083,349**	**$2,795,658**
First Year Credit	**6,909**	**$0**	**$0**	**$100,000**	**$100,000**	**$400,000**	**$900,000**	**$250,000**	**$798,914**
Net 2023 Annual Cost	**6,909**	**$3,150,504**	**$3,151,884**	**$148,724**	**$150,104**	**$2,594,637**	**$1,887,367**	**$2,833,349**	**$1,996,743**

Among the four insurance carriers, each offered competitive pricing for plan administration with a range of $33.62 to $38.00 PEPM prior to first year credits.

The Carriers – Fee Descriptions

Fee Descriptions - Anthem
Medical Only ASO: ASO Basic Foundational Package plus Anthem Health Guide (AHG), Claims Fiduciary Coverage, LiveHealth Online, Blue Distinction
Blue Association Fees are billed in claim invoice
Case Management – Behavioral Health (includes Behavioral Health Advantage with CBT), Case Management – Medical (includes ESRD, NICU and Transplant) , ESRD (cost included in Case Management), Transplant (costs included in Case Management)
Future Moms with pro-active identification and lactation support
Clinical Review Cancer Care Quality program (through AIM)
Utilization Management – Medical and Behavioral Health
• Anthem Health Guide
• Budget - An annual Wellness/Communication credit in the amount of $60,000 will be applied for the purchase of services provided from Anthem, or an outside vendor through 12/31/2023. Credit will be forfeited if not used by 12/31/2023. This credit is also extended towards years 2 (2024) through 5 (2027). The annual credit value must be used within each policy year, and forfeited if not used within the applicable policy year. Anthem must receive all invoices no later than the 8th of December for each policy year. Examples of communications include magnets, posters, brochures and flyers. Expenses for items such as programming, personnel expenses and travel are not reimbursable. The credit could also be applied towards Wellness programs purchased by the client from Anthem Blue Cross or an outside vendor. This credit can be split between communication and wellness, but it cannot be cross-applied.
Option 2 & 4 - Discount Share The fee will be equal to 0.25% of in-network discounts. In-network discount is the difference between billed charges for covered services and the negotiated amount.The negotiated amount is the amount Anthem is contractually obligated to pay a network provider under a negotiated reimbursement arrangement, before application of member cost-share amounts, such as deductibles, copayments and coinsurance.Prescription drug claims, claims paid on a capitated basis, Traditional network fee schedule and Payment Innovation program payments are excluded from the fee calculation. This fee will be limited as follows: Up to $5,000 per Claim.
1 Discount Share the fee cost $250,104
2 First year RX Implementation allowance $100,000.
Fee Descriptions - Blue Shield
EPO/PPO Network Access Fee: *Network access is included for CA network. Blue Card fees for non-CA network will be invoiced.
Case Management Fee: Shield Support Program
Condition/Disease Management Fee: ** Included in Shield Support OR Connect Program
Clinical Management Fee: **Included in Shield Support OR Connect Program
1 Connect Program - Connect our Concierge integrated clinical and customer service model with a designated team including integration of 3rd party
2 Implementation Credit for Medical/RX (can be used for implementation, wellness, audits, communications and more)
3 $100,000 wellness fund included in $500k Medical Only $1 million Medical/RX credit for year 1, wellness fund provided annually
4 Health Improvement Program - Wellvolution: comprehensive life-style and disease prevention and reversal program, including coaching. Personaliz
Fee Descriptions - CVS Aetna
Our network access fee is included in the proposed administrative fees; however our National Advantage Program, Subrogation, Coordination of
Offering Aetna One Flex care management model and Enhanced Maternity program
Our proposed administrative fees include our Aetna One Flex care management model which also includes disease management.
Offering Member Engagement Platform w/reward and Lifestyle Conditioning and Coaching
Offering Aetna Conierge (includes First Impression Treatment)
Including Managed Behavioral Health and Behavioral Health Condition Management Program - Standard
2 Implementation Credit
3 Offering a wellness allowance of $2.48 PEPM and a communication/technology allowance of $0.31 PEPM that can be used towards audits and benefits administration
Fee Descriptions - UHC / UMR
2 Implementation Credit
3 Wellness fund included in the implementation credit for year 1, and annually $100,000 thereafter
4 Three month fee waiver (requires UHC be inplace through 1/1/26
5 NurseLine (NL) $0.50
5 Maternity CARE $0.65
Ongoing Condition CARE $3,85
5 Optum Benefits Analytic Manager (BAM) $0.25
5 Telemedicine (Teladoc)* $0.97
5 Total $2.37

Administrative Costs, The TPAs -

SJVIA First Year Administrative Cost Summary		DHS	Compass	HealthComp		Pinnacle	
Per Employee per Month (PEPM)	Enrollment Assumption	Anthem Medical Only	Blue Shield Medical Only	Option 1 Medical Only	Option 2 Med/RX	Option 1 Medical Only	Option 2 Med/RX
Administration Fee EPO/PPO	6,189	$18.45	$22.50	$19.75	$19.75	$20.75	$20.75
Administration Fee HSA Compatible HDHP PPO	720	$18.45	$22.50	$19.75	$19.75	$20.75	$20.75
EPO/PPO Network Access Fee	6,909	$17.94	$18.00	$18.54	$5.60	$17.94	$5.00
Case Management Fee	6,909	$175 per hour	$2.30	$160/Hour	$160/Hour	Included	Included
Condition/Disease Management Fee	6,909	$3.95	See Blue	included	included	$0.30	$0.30
Clinical Management Fee	6,909		Shield	$5.60	$5.60	Included	Included
Utilization Review Fee	6,909	Included	Included	Included	Included	Included	Included
Wellness Fee	6,909	$0.70	Included	$0.70	$0.70	$2.50	$2.50
1 Other (Name)	6,909						
2 Other (Name)	6,909		$350,000				
3 Wellness Fund	6,909	$50,000	$75,000	$58,036	$58,036	$207,270	$207,270
4 Other (Name)	6,909						
5 Other (Name)	6,909			$1.70	$1.70		
Total Cost (PEPM)	**6,909**	**$41.04**	**$42.80**	**$46.29**	**$33.35**	**$41.49**	**$28.55**
Gross 2023 Annual Cost	**6,909**	**$3,402,544**	**$3,548,462**	**$3,837,811**	**$2,764,982**	**$3,439,853**	**$2,367,023**
First Year Credit	**6,909**	**$0**	**$350,000**	**$0**	**$0**	**$0**	**$0**
Net 2023 Annual Cost	**6,909**	**$3,402,544**	**$3,198,462**	**$3,837,811**	**$2,764,982**	**$3,439,853**	**$2,367,023**

The TPAs – Fee Description

Fee Descriptions - Compass Health Administrators	
$75,000 annual wellness fund	
$350,000 first year credit	
Fee Descriptions - Delta Health Systems	
Case Management Fee	$175 per hour/$4.45 PEPM
Condition/Disease Management Fee	$3.95
Clinical Management Fee	Included w/Network Fees
Utilization Review Fee	Included w/Network Fees
Wellness Fee ($50,000 Stipend from Delta)	$0.70 PEPM
1 Other ACA Reporting 1095 Reporting - State & Federal	$6.75 per form
2 Other Delta Navigator (includes Condition/Disease Management)	$7.75
3 Other Dependent Audit	$1,200 plus depending on scope of work (# of dependents)
4 Other HSA Account Admin	$4.95 PPPM
5 Other Medical Bill Review	25% of Savings
6 Other Remote Patient Monitoring	$75 PPPM
7 No Co-pay Telemedicine (Requires Navigator Enrollment)	$1.50
8 Premium Accounting (Non Delta enrolled members - Kaiser & D&V Only)	$3.95
Fee Descriptions - HealthComp	
Administration Fee EPO/PPO: HealthComp admin fee includes various features. Please see SJVIA HealthComp Proposal for more details.	
Administration Fee HSA Compatible HDHP PPO: HealthComp admin fee includes various features. Please see attachment SJVIA HealthComp Proposal	
EPO/PPO Network Access Fee: Represents the Anthem Network Access fee if HealthComp is chosen as the TPA and the RX is carved out. HealthComp is proposing OptumRx as the PBM should RX be carved out.	
Case Management Fee: The fee is $160.00 Per Hour (billed in 6 min increments)	
Condition/Disease Management Fee: HealthComp's program proactively engages the riskiest members before any hospitalizations (and before case management) to help them address gaps in care.	
Clinical Management Fee: HealthComp's Population Preventive Care is inclusive of Disease Management: helping members with chronic conditions and also members without chronic conditions but other high risk factors. Leveraging advanced analytics to create personalized care plans for each member, HealthComp's clinical team then applies a high-touch service model to proactively engage members, co-create goals, and consistently follow-up with members to remind and remove barriers – all while reviewing for site of care optimization opportunities and adverse medication interactions.	
Utilization Review Fee: HealthComp does not provide this service when utilizing the Anthem network. Anthem does this.	
Wellness Fee: HealthComp's wellness solution analyzes the member's historical data to create a personalized wellness plan.	
1 Other - Cancer Awareness: Program is designed to promote a culture of health at your company, create awareness, and ultimately reduce the participants' risk of cancer through early detection and intervention.	
2 Other - Emergency Room Solutions: ER Solutions program identifies members who have recently visited the Emergency Room and performs outreach to educate them on alternatives to the ER.	
3 Other - Mommies 2-B: HealthComp's program provides expectant mothers with services and educational materials that are designed to help give their babies a healthy start.	
4 Other - Teladoc: 24/7 access to care by web, phone or mobile app. Care is delivered through a network of U.S. board-certified physicians with 20 years average experience.	
5 Other - Compliance Fee: Covers compliance on CAA and NSA, 1099's, PCORI Reporting Data, W2 Reporting Data, Medicare Part D Notices (includes mailings), State Surcharge Reporting and Form 5500 (Schedule A) Reporting	
Fee Descriptions - Pinnacle	
1 Other - Set-Up Fee	$1,500
2 Other - Deerwalk Reporting	$0.50
3 Other - 1-800 Dedicated Customer Support Number (one time fee)	$500
4 Other - $50k wellness budget (per year)	$0.60
5 Other - Data File Feed	Included
6 Other - PCMI Disease Management Program	$5.00

Administrative Costs – The PBMs

SJVIA First Year Administrative Cost Summary		ESI	EmpiRx	IPM
Per Employee per Month (PEPM)	Enrollment Assumption	RX Only	RX Only	RX Only
Administration Fee EPO/PPO	6,189	$0.00	$0.00	$0.00
Administration Fee HSA Compatible HDHP PPO	720	$0.00	$0.00	$0.00
EPO/PPO Network Access Fee	6,909	Does Not Apply	Does Not Apply	Does Not Apply
Case Management Fee	6,909			
Condition/Disease Management Fee	6,909			
Clinical Management Fee	6,909			
Utilization Review Fee	6,909			
Wellness Fee	6,909			
1 Other (Name)	6,909	See Fee Description	See Fee Description	See Fee Description
2 Other (Name)	6,909			
3 Wellness Fund	6,909			
4 Other (Name)	6,909			
5 Other (Name)	6,909			
Total Cost (PEPM)	**6,909**	**$0.00**	**$3.35**	**$0.00**
Gross 2023 Annual Cost	**6,909**	**$0**	**$277,452**	**$0**
First Year Credit	**6,909**	**$0**	**$0**	**$0**
Net 2023 Annual Cost	**6,909**	**$0**	**$277,452**	**$0**

Both ESI and IPM use a no cost administrative fee model. Their revenue from SJVIA is based on the spread in pricing between the purchase price of prescription drugs for SJVIA and the price the PBMs charge SJVIA for those same prescription drugs. We asked IPM to provide an estimate of expected revenue from SJVIA based on this model but did not receive it.

The PBMs – Fee Description

Fee Descriptions - ESI	
Manual Submissions	
Member Submit Fee	$3.00 per claim
Medicaid Subrogation Claims	$3.00 per paid claim
Medicare Subrogation Claims	$3.00 per paid claim
Communication with physicians and/or members (e.g., program descriptions, notifications, formulary compliance, non-Medicare EOBs, etc.)	$1.35/letter plus postage
Medicare Explanation of Benefits (EOB)	
Custom non-standard materials	
Claims reverse and reprocessing	$1.75/letter plus postage
Coordination of Benefits (COB)	
• Custom reimbursement formula	$0.01 PMPM
• Setup and ongoing maintenance	
• Product support	
Electronic Medicare Part D EOB	
Electronic Medicare EOB is an e-mail notification to the member informing them at the time of EOB production that their Medicare Part D Explanation of Benefits is available for viewing.	$0.95/EOB
Electronic EOB includes:	
· Email notification to the member	
· Solicitation e-mail sent to registered members	
· Prominent Web messaging	
Reporting Services	
Custom ad hoc reporting – applies for reporting outside of self-services reporting tool	$150/hour, with a minimum of $500
Replacement Member Communication Packets	
Member-requested replacement packets	$1.50 per packet
Sponsor-requested re-carding	$1.50 per packet
Communication Fee	
Mail (EHD, SHD & HDE) Programs	No charge for electronic communications
Announcement Letters and Communications after each Courtesy Fill	Postage (on-going fee) for mailed communications
Cost Exceeds Maximum	
Cost Exceeds Maximum (CEM) edit	$10,000 CEM limit – included in pricing
(For non-compound drugs)	Custom CEM limit less than $10,000 - $0.01 PMPM fee
Cost Exceeds Maximum (CEM) edit	Included in pricing

Fee Descriptions - EmpiRx	
1 Other - Per Rx Administration fee	$6 per Rx (est annual projected cost $277,452)
2 Other - Direct Reimbursement Claims Processin	$5.00 per Direct Reimbursement Claim
3 Other - Annual Benefit Summary (EOB)	$3.00 per summary, plus postage
4 Other - Replacement ID Cards	$2.50 per card, plus postage for 10mil card stock
5 Other - Administrative Prior Authorization	$15.00 per plan prior authorization
6 Other - Clinical Prior Authorization (including re	$55.00 per determination
7 Other - Clinical Program Mailings (e.g., Step The	$1.75 per communication, plus postage
8 Other - Fraud, Waste & Abuse – Retrospective	$5.00 per letter, plus postage
9 Other - External Third-Party Appeals	$500.00 Per Hour for preparation / participation in external appeals, + reasonable travel expenses
10 Other - Medicare Part D RDS Support	Annual base charge of $10,000 and an additional per eligible life per month fee
11 Other - Integration with health plan providers	As mutually agreed by the parties on a case-by-case basis
Total Cost PEPM ($3.35) based on $277,452/6,909/12	

Fee Descriptions - IPM	
Clinical Prior Authorization by a Pharmacist	$45/PA
Third Party Independent Review	$300/review
Direct Member Reimbursement	$5/claim
Custom ad-hoc Reporting (Five included per year	$150/hr

Total Cost Summary

Keenan conducted analysis on

- medical: member disruption, network pricing, network adequacy, network valuations, and cost valuation
- prescription drug: member disruption, AWP discount, rebating, and cost valuations

The following chart summarized Keenan's cost findings.:

Medical Vendor PBM Vendor	Anthem EmpiRx	Anthem IngenioRx	Blue Shield EmpiRx	Blue Shield Blue Shield	Aetna CVS	UMR OptumRx
Claim Cost						
Medical	$59,171,927	$59,171,927	$61,730,841	$61,730,841	$65,085,316	$65,544,925
RX	$25,087,651	$25,011,748	$25,087,651	$25,066,657	$25,117,440	$25,156,564
RX Rebates	$3,796,860	$0	$3,796,860	$2,304,520	$7,306,564	$5,170,005
Total	$80,462,718	$84,183,675	$83,021,632	$84,492,978	$82,896,192	$85,531,484
Administrative Cost						
Medical	$3,150,504	$248,724	$2,994,637	$2,787,367	$3,083,349	$2,795,658
RX	$277,452	w/ Med	$277,452	w/ Med	w/ Med	w/ Med
Total	$3,427,956	$248,724	$3,272,089	$2,787,367	$3,083,349	$2,795,658
Total Cost						
Total Claims and Admin	**$83,890,674**	**$84,432,399**	**$86,293,721**	**$87,280,345**	**$85,979,541**	**$88,327,142**
$ Difference		**$541,725**	**$2,403,047**	**$3,389,671**	**$2,088,867**	**$4,436,468**
% Difference		**0.6%**	**2.9%**	**4.0%**	**2.5%**	**5.3%**
Total Cost w/ Credits						
First Year	$0	$100,000	$400,000	$900,000	$250,000	$698,914
Wellness Annually	$60,000	$60,000	$100,000	$100,000	$231,313	$100,000
Total Cost w/ Credits	**$83,830,674**	**$84,272,399**	**$85,793,721**	**$86,280,345**	**$85,498,228**	**$87,528,227**
$ Difference		**$441,725**	**$1,963,047**	**$2,449,671**	**$1,667,553**	**$3,697,553**
% Difference		**0.5%**	**2.3%**	**2.9%**	**2.0%**	**4.4%**

Based on Keenan's analysis, Anthem with IngenioRx offers the greatest cost savings.

Medical Vendor PBM Vendor	DHS EmpiRx	Compass EmpiRx	HealthComp EmpiRx	HealthComp IngenioRx	Pinnacle EmpiRx	Pinnacle IngenioRx
Claim Cost						
Medical	$59,171,927	$61,730,841	$59,171,927	$59,171,927	$59,171,927	$59,171,927
RX	$25,087,651	$25,087,651	$25,087,651	$25,011,748	$25,087,651	$25,011,748
RX Rebates	$3,796,860	$3,796,860	$3,796,860	$0	$3,796,860	$0
Total	$80,462,718	$83,021,632	$80,462,718	$84,183,675	$80,462,718	$84,183,675
Administrative Cost						
Medical	$3,402,544	$3,548,462	$3,837,811	$2,764,982	$3,439,853	$2,367,023
RX	$277,452	$277,452	$277,452	w/ Med	$277,452	w/ Med
Total	$3,679,996	$3,825,914	$4,115,263	$2,764,982	$3,717,305	$2,367,023
Total Cost						
Total Claims and Admin	**$84,142,714**	**$86,847,547**	**$84,577,981**	**$86,948,657**	**$84,180,023**	**$86,550,699**
$ Difference	**$252,040**	**$2,956,872**	**$687,307**	**$3,057,983**	**$289,349**	**$2,660,024**
% Difference	**0.3%**	**3.5%**	**0.8%**	**3.6%**	**0.3%**	**3.2%**
Total Cost w/ Credits						
First Year	$0	$350,000	$0	$0	$0	$0
Wellness Annually	$0	$75,000	$58,036	$58,036	$207,270	$207,270
Total Cost w/ Credits	**$84,142,714**	**$86,422,547**	**$84,519,946**	**$86,890,621**	**$83,972,753**	**$86,343,429**
$ Difference	**$312,040**	**$2,591,872**	**$689,272**	**$3,059,947**	**$142,079**	**$2,512,754**
% Difference	**0.4%**	**3.1%**	**0.8%**	**3.7%**	**0.2%**	**3.0%**

Value Proposition Statements

Keenan asked each carrier/vendor to briefly state their value proposition. Some carriers/vendors complied while others provided lengthier responses (lengthier responses are attached as files).

Value Statement – Anthem Blue Cross

We know that the health plan SJVIA selects will be the most valued employee benefit, as well as a significant business investment. We are committed to delivering a customized, coordinated solution that will help your employees take control of their health and become their healthiest self, and improve cost savings for all. We will continue to leverage our superior network discounts and access, while delivering innovative, cost saving programs, tools, and services to achieve the best outcomes for your employees now and for years to come.

Our specific value proposition and key differentiators for SJVIA's consideration include the following:

Integrated Benefits Solutions

We feel our integrated medical and pharmacy programs and services offer the best value to you. The integration of Anthem's medical and pharmacy services will allow you to offer your employees access to the care they need, all packaged in a seamless, simple experience. We provide guidance and coordinated solutions for better total health. Our extensive resources and networks allow us to be flexible, building the ideal benefit solution to fit your needs. We coordinate our information, programs, and interactions to help enrollees manage their conditions and live healthier lives. Healthier enrollees mean increased productivity and lower health care costs for you. We coordinate our data between doctors, pharmacists, members, and our disease management teams. This gives us the power to help ensure that good health does not fall through the cracks.

We help improve member health outcomes and reduce total healthcare costs by integrating our medical and pharmacy programs — and by focusing on our members holistically. We integrate our medical, pharmacy, and lab data — and we go beyond the data to ensure coordination of our people, programs, and knowledge. We work to drive consistent strategies for our medical and pharmacy programs.

Based on a 2020 HealthCore, Inc., Value of Medical and Pharmacy Integration study analyzing our 2015 to 2018 data, clients with our integrated pharmacy and medical benefits through Anthem experienced on average medical costs $30.70 PMPM lower compared to those who carved out pharmacy. This translates to an average of $315 PMPY client savings and $53 in member out-of-pocket savings — a total of $368 lower average medical costs PMPY.

Other key findings illustrate the following for the carve-in population:

- 11.6% lower outpatient costs
- 5.5% lower inpatient costs

Our integrated medical and pharmacy benefits help drive lower costs, better outcomes, and increased member satisfaction through the following:

- • Outcomes-based formulary that includes medications proven to improve and lower total costs
- • Aligned medical and pharmacy clinical criteria and policies
- • Effective, coordinated medication management programs
- • Proactive site-of-care management
- • More closely and quickly identified care gaps because of connected data that leads to more actionable insights
- • Seamless and coordinated experience for members, clients, and providers

Member Engagement Platform — A Smarter Personalized Healthcare Journey

Like SJVIA, Anthem values innovative member resources designed to help members make informed decisions and increase engagement with their health plan. Sydney Health, our member engagement platform, focuses on driving a smarter healthcare journey for members by putting health management tools in their hands. Sydney Health integrates all benefits together for whole-person care. It not only supplies information but also, uses the information, driven by artificial intelligence (AI), to help members proactively stay healthier. Proactive support includes alerting members to gaps in care notifications, helping them find a provider based upon quality and cost information, and providing health tips based on each member's history and interests.

By delivering a member-personalized experience, Sydney Health will support your employees to achieve goals. Sydney Health is all about saving members time and connecting them with the care they need, when they need it. It delivers total procedure cost estimates, member pay cost estimates, plan pay cost estimates, and the capability to view costs for all procedures performed by a provider. Sydney Health sorts data and recommend products, programs, and content according to a member's unique needs to deliver better outcomes and lower costs. Leveraging the Blue Cross Blue Shield Association national data, Sydney Health accurately provides cost estimates and expenses for more than 700 procedures, and that list continues to grow.

Additional features for members include, but are not limited to, the following:

- • Curated, personalized experiences that drive members toward outcomes
- • The ability to set personal goals, sync their fitness trackers, and review content related to their unique needs
- • Integrated benefits, claims and health and wellness programs
- • Members will receive content based on their personal risk factors, identified by our AI engine
    - They can select areas of interest, such as weight loss or getting active
    - They can enter goals for monetary or non-monetary rewards
    - They receive personalized program recommendations

We look forward to further discussion about the many programs and services Anthem has to offer you and a continued partnership and a mutually successful relationship between our two organizations.

Value Statement – Blue Shield

Below is a summary of our differentiated value proposition for SJVIA **Our commitment to the San Joaquin Valley Insurance Authority is significant:**

- **Blue Shield is a leader in serving public sector entities.** We partner with over **1,300** public sector entities in California, including direct client relationships with 18 cities and towns, 7 counties, and associations with a variety of public agencies through joint powers authorities and trusts. We have a deep understanding of the particular challenges that organizations such as SJVIA face, including the need for predictable budgeting, reducing costs while increasing efficiencies, and addressing the expectations of multiple stakeholders.

- **A 5 year-comprehensive core service fee of $25.90 PEPM**, including flat fees for years 1 and 2 with 3% escalator for years 3-5 that includes comprehensive administrative services as well as telehealth, tele-behavioral health, NurseHelp 24/7, Fiduciary and **Wellvolution** comprehensive health improvement program: lifestyle and chronic care management services personalized for every SJVIA member
- **Network Strength –** little to no disruption for SJVIA given a Blue-to-Blue transition AND given we expanded our PPO ACO models in both Fresno and Tulare County in 2022, our Network Discount/Total Cost of Care is even stronger **– we expect a 2% improvement for SJVIA given these new PPO ACO provider contracts.** Through claims evaluation, 35% of SJVIA are already using these providers, so the value will happen without any disruption.

- **Strong Performance guarantees with 36% of fees at risk including**:
    - 21% for operational and account management performance
    - Discount guarantee with 15% of fees at risk
- **A comprehensive fund offer:**
    - Transition fund of $500,000 for Medical services and $1,000,000 for the Medical and Pharmacy offering (can be used for Wellness, Communications, audits, staffing, implementation costs, etc.)
    - Annual wellness and audit fund in Year 2 and 3: $100,000/year

- **Expanded Access to Primary and Specialty Care through Health@Home and Walgreens** – In addition to our PPO network we have a new Health@Home offering that includes near-site primary care at Walgreens Health Corners and Dispatch Health – increasing access to primary care and removing barriers to care. This will expand primary care and chronic condition support for SJVIA employees and family members. **The Walgreen Health Corners will be available in both Tulare and Fresno Counties!** Blue Shield also offers the CVS minute clinics as a part of our PPO network… therefore, through Blue Shield, SVJIA would get access to the CVS Minute Clinics, and the exclusive Walgreens Health Corners

- **Wellvolution®, our digital healthcare platform that offers a large scope of services, from prevention (e.g., diet, physical activity, stress, sleep, social support, smoking cessation) to the treatment and reversal of conditions (e.g., heart disease, diabetes, hypertension, hyperlipidemia, metabolic syndrome, obesity)** to support optimal health. Wellvolution's digital platform uses decades of research and leading technology to deliver personalized support. Offering multiple digital applications and 30,000 brick-and-mortar locations, members have unprecedented choice in preventing, treating, and reversing a number of health conditions.

- **Expanded Mental Health Services: On-demand mental health support day or night through Ginger and Briteline** including behavioral health coaching 24/7/365 via text-based chat, informational content, self-guided activities, and support from licensed therapists and psychiatrists via video.
- **Integrated medical and pharmacy offering: Blue Shield serves as its own pharmacy benefits manager (PBM),** making us uniquely qualified to provide quality and affordable pharmacy benefits to SJVIA. The advantages of our fully integrated model include:
    - **Simplified administration** through a single source and consolidated reporting to ensure you have a complete picture of your health benefits program
    - **Better value and results** through technology-driven solutions, pharmacist outreach, and coordinated case management
    - **Lower total cost of care** through competitive pricing, end-to-end specialty solutions, and integrated analytics
    - **Seamless and engaging member-facing experience** through an integrated and consistent online and mobile platform and high-touch and high-tech pharmacist support

  Our model saves **$16–$24 per member per month** compared to carve-out PBM models and lowers hospitalization and emergency room rates. We also provide consolidated reporting for a comprehensive insight into both financials and the qualitative member experience.

- **Executive Commitment** By partnering with Blue Shield, you will be collaborating with a company whose leadership will be engaged in your interests and needs at every turn and stand by our commitments!

Value Statement – Aetna CVS

We're taking health care where you want us to be by creating unrivaled connections on every corner in every neighborhood close to home.

With the combined capabilities of CVS Health and Aetna, our care support and health guidance are so deeply embedded, they become part of our members' everyday lives. And perhaps most important of all, we deliver better costs and greater simplicity than ever, helping our members get on and stay on an affordable, connected path to better health.

A new health care experience

Being where you want us to be isn't just about being the most local as Fresno County. It's about going farther – reaching out, making ourselves more accessible, and by doing so, creating a more whole, more connected experience. The result is unmatched human connections, digital access whenever and wherever our members need it and a new reality where our members know that no matter where they are or when they're reaching out, we'll be there to answer.

We've structured our approach on three simple, but meaningful ideas: more caring, more connected, and closer to home. Here's what that means for our members in Fresno and Tulare Counties:

- More caring means we provide health care solutions how they need them by using connected data that creates insights for a more personalized experience, giving members more reasons to engage and helping them take the right health actions.

- More connected means we provide health care solutions based on a simpler, more integrated approach that delivers a better health care experience that feels whole.

- Closer to home means we provide health care solutions where they want them by reaching members in more ways and at more times than any other health care provider. Through our nearly 9,900 CVS Pharmacy® locations, more than 1,100 MinuteClinic® locations and a growing list of CVS HealthHUB® locations, our unmatched local footprint provides access to our members where they live and work because that's where health happens.

What better health feels like

The connected, personalized, and affordable experience we're creating feels different. We're providing our members:

- Unmatched engagement touchpoints for a personalized "what's best for me" experience

- A holistic approach to health that takes both physical health and mental well-being into account

- A complete member view driven by robust, integrated data that powers our behavioral insights and member outreach

- Pharmacy solutions in your neighborhood and cost-effective retail and specialty drug costs

- Benefits that encourage appropriate and convenient sites of care

- Innovative and low-cost relationships with providers

Value Statement – UHC/UMR

SJVIA UMR Summary Response.

See attached file

Value Statement – HealthComp

HealthComp SJVIA - Value Proposition.p

See attached file

Value Statement – Delta Health System

Delta Health Systems - Value Prop

See attached file

Value Statement – Compass Health Administrators

Compass Health Administrators is a true Third-Party Administrator. We work on behalf of the plan sponsor and the membership. We are not beholden to private equity or large health plan interests. Your agenda becomes our agenda with no conflicts. We perform 100% of our work in Fresno CA with no offshoring of claims or calls. We answer all of the calls LIVE, with no IVR. We view our callers as people, and not as transactions. We never assign work to a caller. Our Advocates call pharmacies, PBMs, UM companies and provider offices on behalf of our membership when necessary. We have a very robust set of online (mobile and browser based) tools for both the membership and the plan administrators.

Value Statement – Pinnacle Administrators

Pinnacle SJVIA highlights.pdf

See attached file

Value Statement – EmpiRx

EmpiRx Health Follow-up Value Prc

See attached file

Value Statement – Integrated Pharmacy Management (IPM)

IPM is an independently owned, central CA based, mid-market pharmacy benefit manager. IPMs success is driven through our award-winning account management organization, enhanced by our rigorous pursuit of actionable analytics, and displayed in our extremely high client retention rate (98%).

We pride ourselves on our abilities: flexibility, adaptability, and availability. Our clients are all different and a one size or off the shelf benefit approach fails to meet the unique needs of the mid-market.

What clients find at IPM is a value driven health care partner. Thoughtful benefit design recommendations consider disruption, member experience and bottom-line savings to the plan. Knowing each of our clients have different goals, benefit design conversations always focus on those goals and enhancements that can further our clients' pursuits.

Clinical programs are designed through this value-based care lens as well. Evidence based clinical protocols guide decisions and a lowest net cost approach always prevails when assessing treatment options.

IPM would be proud to partner with the SJVIA in keeping healthcare local.

Value Statement – ExpressScripts (ESI)

Value Proposition: The past year has presented unprecedented challenges that have impacted all of us in different ways. Healthcare, in particular, faced a particular strain in the context of the COVID-19 pandemic, and these tensions have translated to employers and employees alike. Rising healthcare costs, economic downturn, increased employee time away from work, moving to virtual work and healthcare settings—you name it, this past year has had it.

At Express Scripts, we're working to solve for these challenges differently, because we see a better path forward to make healthcare more affordable, predictable, and simple for those we serve. To that end, we're building on our legacy with health services designed to redefine healthcare as we know it with Evernorth, a new brand that unites all of our game-changing health services capabilities.

We thoughtfully crafted our proposal specifically for San Joaquin Valley Insurance Authority to make the choice to join Evernorth on our journey to better health easy.

Total Cost Management

At the core of our proposal for San Joaquin Valley Insurance Authority, we promise to manage drug spend and lower the total cost of care for San Joaquin Valley Insurance Authority and your members, without sacrificing quality of care. We will achieve this goal through a combination of competitive program costs, industry-leading trend management, and avoiding or reducing high-cost claims before they happen.

We are prepared with a unique, flexible suite of programs to optimize your population's generic utilization, savings opportunities, and trend management alongside targeted messaging to help San Joaquin Valley Insurance Authority eliminate waste from your pharmacy benefit. A few key examples of how we will save you and your members money include:

Industry-Leading Trend Management – Our clients have achieved an average drug trend of 1.4% over the past three years, the lowest in the industry.

Specialty Management through Accredo – Accredo, Express Scripts' Specialty pharmacy, provides industry-leading specialty drug management programs to get results. For example, through our SaveonSP copay assistance program, we achieved specialty drug trend of -5.2% for enrolled clients.

Chronic Care Management – Through advanced utilization management procedures, we improve outcomes and control costs for members with chronic conditions. Tightly managed commercials plans enrolled in our top clinical programs achieved a trend of -4.8% in 2019.

Caring for the whole person.

Our care delivery model goes beyond the pharmacy—we coordinate throughout the entire healthcare ecosystem for the health of the whole person to ensure that every member gets the right care, at the right time, in the right place, and at an affordable price. We have highlighted some of our key whole person health enhancements below:

Health Connect 360 provides the industry's most comprehensive clinical care solution. This program combines personalization, an outcomes-based methodology, and care coordination to take a transformative approach whole person health.

Our open architecture and ability to partner freely across businesses means we are equipped to solve complex problems across a fragmented landscape like no one else can.

Through an in-depth innovation process, we have created programs designed to ensure members receive the best care with the most value.

Further, we are expanding the ways we include social determinants of health in our program design, and with this emphasis we will continue to remove social barriers and help members get the care they need. As we advance as an organization, we will keep treating the health of the whole person front of mind.

Innovations designed around you.

Express Scripts, through Evernorth, is committed to unlocking new value and taking on your toughest challenges through innovation that benefits you, your members, and healthcare as a whole. We drive innovation through close partnership with our clients, embedding feedback and participation throughout the strategic process. We have accomplished our most important and groundbreaking work by partnering hand-in-hand with clients through our test-and-learn process.

Technology designed with simplicity in mind.

With an eye towards the future, we are concentrating our efforts, as well as our investments, on driving technological advancements focused on interoperability, lower total cost of care, and optimized care coordination.

With these enhancements, we will keep San Joaquin Valley Insurance Authority on the cutting edge of technology in healthcare, dynamically evolving your plan and sharing new technologies with you as the healthcare landscape shifts to help you make healthcare affordable, predictable, and simple for your members. Some of our recent flagship enhancements include automatic prior authorization, the industry's first, stand-alone Digital Health Formulary, and an upgraded Express Scripts Client Website.

We continually push the envelope on new ideas, interventions, and pilots to improve health outcomes, adherence, and member satisfaction. Looking ahead your members will see chat capabilities, more self-service, prescription photo uploading, virtual consultations with physicians and pharmacists, and more.

Service and implementation in mind.

We keep simplicity at the heart of everything we do. When we introduce new clients to an Express Scripts plan, our goal is simple: make it easy. This includes using core fundamentals like plain language instead of health insurance jargon on all of our customer communications, providing a user-friendly customer app, open enrollment support, and more.

Express Scripts will provide San Joaquin Valley Insurance Authority with an experienced, talented, and committed account team, staffed with knowledgeable team members. This team will lead the transition process to ensure we: understand your requirements; assure quality data; educate your members; and support a smooth implementation.

Our service experience continues beyond the walls of Express Scripts. Our service model through Evernorth allows us to collaborate freely across businesses, meaning we are equipped to partner without boundaries with all of San Joaquin Valley Insurance Authority's vendor partners across a fragmented healthcare landscape like no other company can.

We know that making healthcare affordable, predictable, and simple is challenging, and we know that it takes a partner with unparalleled commitment to San Joaquin Valley Insurance Authority to get that done. We want to be that partner for San Joaquin Valley Insurance Authority.

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A Summary of UMR's Capabilities

San Joaquin Valley Insurance Authority (SJVIA) serves a vital role in providing access to quality health care services at affordable costs to covered employees and their families. The sustained success and longevity of this essential benefit calls for a dedicated claims and network services partner with a proven track record and innovative solutions for the years ahead.

UMR, the third-party administrator (TPA) line of business for UnitedHealthcare, provides benefit plan administration for more than 3,500 customers and their 5.7 million members, We offer the resources of a highly diversified health and well-being company with a focused mission to help people live healthier lives and to make the health system work better for everyone. Our TPA expertise and flexibility enables us to manage your plan your way, as we work closely with you to provide consultative strategies and advanced technology for meeting your evolving needs. We are confident that our experience makes us ideally suited for administering self-funded medical and prescription drug benefits for SJVIA

As a TPA, UMR's strength lies in our ability to be flexible. This includes our established partnerships with public sector entities across the country. We start by taking a consultative approach to each new relationship and meet the customer where they are. Our commitment to providing personalized, attentive service begins during implementation. During your transition to UMR, we will take the time to fully understand SJVIA. This includes getting to know SJVIA's culture, member demographics,

This summary highlights all of the programs we included in our administrative cost proposal response and outline how they will benefit SJVIA. If awarded your business, building this partnership together using these programs and services will create an easier to use, rewarding and results oriented program than your members have experienced! Creating a healthier program—together!

Personalized Member Advocacy

Our Plan Advisor advocacy service offers a simple, personalized experience for connecting families to the care they need and helping them make the most of the resources available to them in managing their health.

Your plan advisor team will follow a consumer-oriented, relationship-based approach. Your members will be connected to their personal plan advisor each time they call. This connection assures your members that the person on the other end of the line understands them, their personal health and call history.

Plan advisors use extensive data to anticipate members' needs. They promote the benefits of selecting a primary care provider, encourage pursuit of improved health and wellness, help connect callers to any applicable clinical programs and provide proactive steerage to in-network providers.

Advanced Data Analytics

UMR has included within our proposal fees, Optum Benefits Analytic Manager an online decision support system for analytical reporting powered by Optum. Your SAE, Karla, will assist you with access to the reporting application to analyze the health care cost drivers, utilization, quality and performance trends, and overall health measures of your member population. You can also use the suite of analytical report templates to create custom reports, conduct analysis and compare your plan's performance and demographic trends against a comprehensive set of industry norms.

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Your account management team, in partnership with a designated plan analyst, will play a consultative role in helping you monitor your plan's performance. They work with a team of analytics specialists to analyze your plan data and prepare reports to help you identify emerging trends and potential areas for improvement.

Improving Clinical Outcomes

UMR's fully-integrated Clinical Advocacy Relationships to Empower (CARE) solutions work to ensure members receive clinically appropriate care, resulting in improved outcomes and lower costs for customers and their plan members. We provide our CARE programs internally. As your single source for CARE services and integration, our CARE program offers these efficiencies:

Decreases fragmentation of CARE services

Decreases incidence of members getting lost in the health care system

Allows early identification of members eligible for services

Helps connect the member with an appropriate health care professional in another care management program

Our Utilization Management service monitors hospital admissions and other designated medical services, from prior authorization through discharge, to ensure they do not deviate from the expected treatment plan. Through our Complex Condition CARE program (case management), we aim to reduce the variability of complex and catastrophic cases by supporting patients and their caregivers throughout the course of treatment and representing the medical plan in coordinating care among different providers.

Population Health Management

UMR's Wellness CARE program uses integrated and configurable components to identify and engage individuals at-risk for future disease based on their current health status and lifestyle factors. These may include:

- **Clinical health risk assessments (CHRAs)**
- **Biometric health screenings**
- **One-on-one health coaching**
- **Online tools and challenges**
- **Health education resources**
- **Incentive/reward administration**

Obesity is a challenge for Californians. We also offer access to Real Appeal, an interactive weight loss solution powered by Optum's digital platform Rally Health, and UnitedHealthcare's Motion program. Real Appeal incorporates online coaching and videos with evidence-based weight loss strategies to drive small behavior changes that help participants manage their weight and lower their risk for diabetes and heart disease. Motion, meanwhile, provides incentives to plan participants for tracking their movement. Members sync their wearable device to the Motion mobile app and earn rewards when the meet their daily FIT (Frequency, Intensity, Tenacity) goals.

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Real Appeal is a proprietary, year-long intensive lifestyle intervention program that focuses on helping participants lose weight and maintain weight loss with the ultimate goal of preventing or mitigating obesity-related issues such as pre-diabetes, diabetes and cardiovascular disease. The program is delivered live over the Internet and combines entertaining and educational videos, live virtual coaching and online group participation. Real Appeal is customized to meet the preferences of each participant to maximize outcomes and results. The program supports an organization's desire to target obesity-related conditions.

Participants receive access to all of the tools they need to succeed in the program. These tools may include a success kit, an integrative app, popular nutrition and exercise tracking software, a blender (after the eighth session), a printed nutrition guide, printed books and DVDs that parallel the video content, and a fitness guide.

Key components of the program include:

- **Twenty-six weekly, then six monthly, group coaching and discussion sessions live over the Internet**
- **On demand one-on-one coaching, live over the Internet**
- **Tools to help support success based on individualized needs: nutrition guides, meal plans, recipes, shopping lists and tips for dining out**
- **Video workouts and fitness guides**
- **Entertaining and educational videos featuring popular celebrities and experts**
- **Online support tools, including interactive website and digital applications**
- **Online or mobile tracking tools to monitor nutrition and activity**

From participation in Real Appeal, participants will have developed an ongoing path towards a healthy lifestyle, weight loss and medical expense savings through disease prevention or mitigation. With strong marketing and promotion, engagement rates may exceed 20 percent, and ROI can average 2.0:1.

With Diabetes and Heart Disease being two prevalent conditions with members of the SJVIA, UMR offers the following programs to manage cost and support quality and compliance for diabetics:

- **Protocol Driven Health, Inc. (PDHI), includes diabetes and pre-diabetes modules that provide an opportunity for self-paced learning.**
- **Obesity quality improvement.**
  - **Focusing on reducing obesity improves A1C test results and reduces risk factors for further complications.**
  - **By improving eating habits to lose weight, improved eating habits help to maintain stable diabetes.**
- **Incentives tied to diabetes coaching, including eliminating copayments for diabetes medication and supplies.**

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- **Working one on one with a CARE coach regarding proper blood sugar testing.**
- **Regular discussions on weight management, making small dietary changes, and incorporating exercise to reduce and maintain blood sugar.**
- **Increased knowledge of the newest guidelines by the American Diabetes Association regarding recommendations and appropriate testing.**

- **Additional:**
  - **Keeping on Track with Your Diabetes, a summary of self-care and medical management required for effective blood sugar control.**
  - **Reminders to diabetic members to update eye exams, maintain regular appointments with doctors and/or their endocrinologist team, foot exams, dental exams, etc.**
  - **Assisting members in understanding their multiple medications and how they work, watching for potential side effects.**
  - **Supporting members to understand hypoglycemia (low blood sugar) and how to treat it effectively.**
  - **Foot care guidelines/support.**
  - **Goals for diabetes and comorbid conditions, such as cholesterol and hypertension.**
  - **Supporting the member with carbohydrate counting basics.**
- **Referral to Real Appeal for customers who have purchased this benefit:**
  - **Real Appeal focuses on helping participants lose weight and maintain weight loss, with the goal of preventing or mitigating obesity-related issues such as pre-diabetes, diabetes and cardiovascular disease. This is an excellent opportunity for focused nutritional counseling.**

UMR retains an extensive set of diagnosis and procedure code data for processed claims. These codes support the creation of prevalence reporting. Multiple diagnoses are captured for each encounter, so we can report on the incidence of comorbidities.

UMR's Ongoing Condition CARE nurses identify comorbidities the patient- nurse assessment. The focus is to discern the member's main concern whether it is the trigger diagnosis or not. If the member's concern is family, housing, food or comorbidities, the nurse and member work together to close gaps in care and to expand their self-management skills. During the coaching sessions, the CARE nurse, if the member identifies or if the nurse assesses a comorbidity, the nurse adds those conditions to the nursing care plan. A referral is sent to Complex Condition CARE should an acute condition or complex medical need be identified. Depending on the severity of the chronic condition, in relation to the comorbid condition, the more acute health risk receives primary treatment precedence in Complex Condition CARE. UMR CARE RN's address social determinants of health routinely in all CARE programs.

UMR's Complex Condition CARE approach is to provide a seamless, holistic experience for the member with one point of contact and one plan of care to address co-morbidities that could be complicating treatment.

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The member will have one CARE nurse manager to assist in their episode of care. We have specialized behavioral health substance use disorder (BHSUD) nurses. Because our CARE nurses are dual trained in both medical and BHSUD, they can provide for the member's comorbidities whether they are medical or other BHSUD diagnoses. We also manage catastrophic behavioral health and substance use disorder cases within our care management program.

An example of the importance of medical and BHSUD integration is a member who presents with cirrhosis of the liver with alcoholic hallucinations and detox. In an instance of a carve-out behavioral health solution, the member would have two case managers providing a very disjointed and confusing member experience. If UMR provides both, one case manager would be working with this patient to support his/her recovery.

By focusing on holistic member support and evidence-based interventions, we can deploy a multi-faceted approach to meet the needs of your membership throughout their continuum of care.

SJVIA noted frustrations with prior case management and Disease Management experiences.

UMR's Complex Condition CARE program targets complicated cases to achieve better medical outcomes for members and greater cost savings for employers. Our criteria and systems are specifically designed to identify catastrophic and complex illnesses, transplants and trauma cases. Once high-risk cases are identified, UMR matches the level and method of CARE services to the intensity of the case in the most cost-efficient manner possible. Due to all of the CARE programs operating on one system, we are able to refer members into Complex Condition CARE as soon as they are identified, allowing our RN's to quickly begin outreach. Key to our success is the CARE nurse manager's ability to identify available Centers of Excellence, coordinate and negotiate alternative treatments and related costs. Remote patient monitoring is available through the CARE app, powered by Vivify Health.

Your UMR CARE Consultant is available to review CARE reports and facilitate high dollar/complex case review at the cadence you prefer. They will include a Director in our Complex CARE Team to provide a clinical overview of cases. Notifications of new cases identified for management are available weekly and case updates are reported monthly with an overview of the case, diagnosis, prognosis and expected cost for that episode of care. Savings are reported on a quarterly basis.

Complex Condition CARE is a multi-faceted program that is comprised of the following roles:

- **Employer: Offers a health benefit plan that supports Complex Condition CARE and promotes it to employees**
- **Member: Actively participates and complies with physician's plan of care**
- **Physician: Manages the member's care according to best practices and collaborates with UMR's CARE nurse manager**
- **Complex Condition CARE Staff: Applies resources to maximize the member's health status, while reinforcing the physician-patient relationship**

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UMR CARE programs added the following enhancements in 2021

- **The CARE app, powered by Vivify Health, effective January 1, 2022. It is for every member and provides remote patient monitoring to help them learn self-management techniques. CARE nurses can view individual health metrics and connect with members via chat or streaming video. With this addition, the goal of reaching the total population succeeds regardless of risk.**
- **Ongoing Condition CARE shifts its focus to closing gaps in care and enhancing the member's self-management and self-advocacy skills. This member-focused program addresses the member's main concern whether it is family, transportation, lodging or comorbidities. Once the concern has been addressed, the member and nurse work together to effectively manage the condition. We have added 15 new conditions to our core program, expanding our reach to high-risk members in a variety of diagnostic groups.**
- **New Emerging CARE program focuses on at-risk members who are showing exacerbating behaviors, procedures or health condition which could result in progression to a more complex illness. Members are armed with education, innovative digital tools and resources setting the foundation for improved long-term empowerment. Key areas of focus include, but are not limited to, specialty medication support, ER visits of four or more, behavioral health and substance use disorder (BHSUD) support and preadmission counseling for elective surgeries. This program is a true total population health program.**
- **Advocacy for members and their families to ensure their health needs are well supported**
- **Expansive and thoughtful stratification to identify individuals with a wide variety of clinical circumstances**
- **Promotion of clinically appropriate treatment and cost-effective care**
- **Support of patients and caregivers during behavioral health/substance use disorder stays, inpatient discharge and with claims denial or appeals questions**
- **Work with providers to best manage care on behalf of patients**
- **Education and empowerment of members to care for themselves**

Integrated Medical with UMR and Optum RX

Our integrated proposal responds to many key market imperatives to deliver superior and expert implementation; provide specialty pharmacy expertise that manages trend while focusing on the member; have technologically-advanced pharmacy management processes; support safe and effective clinical and utilization management rules and programs; focus on responsive account management and quality customer service; coordinate with our UMR disease and case management partners; and offer SJVIA other critical areas to support day-to-day patient care and intelligent medical management.

UnitedHealthcare®

UMR℠

Together with our sister company UMR, OptumRx offers a full spectrum of pharmacy management services including specialty pharmacy and medical spend care. The following advantages highlight some of the features our combined companies can offer:

- **Single health management solution**
- **Clinical synchronization**
- **Coordinated implementation and plan management**
- **Specialty pharmacy Integration**

These innovations and strengths are outlined below.

<u>The Value of a Single Health Management Solution</u>

The strength of an integrated model lies in the complete alignment of programming that eliminates the silos and fragmentation inherent in multiple-vendor models, and synchronized data and analytics that enable deep, 360-degree insights into clinical opportunities that are actionable regardless of where the member is in the health management environment.

There are many advantages to creating a fully integrated health management program by selecting OptumRx, including:

Consistent member engagement and advocacy services across your entire population for all programs, eliminating complexity and guesswork and increasing satisfaction and engagement

Simplified billing and administration

Clinical Synchronization – The connection of pharmacy and care management systems through shared clinical protocols and aligned staffing, all of which allows for deeper clinical insights and better member outcomes and savings. We have provided more information on clinical synchronization below.

<u>Clinical Synchronization</u>

At Optum and UMR, we have eliminated the barriers between a health plan's medical, clinical and pharmacy benefit solutions so that historically separated data, systems, staff and processes can be connected and aligned in ways that deliver value to both members and employers. This synchronization helps to improve medication adherence, identify possible drug interactions and maximize cost-saving opportunities. The connection enables us to engage members faster through a single clinical system and a care team with access to a 360 degree view of total health for each member, to speed critical decision-making.

Key components of our clinical synchronization approach are:

Pharmacist Interventions. Pharmacists are integral members of our clinical teams of personal nurses and medical directors, providing multifaceted care management interventions that are closely coordinated, highly efficient, and result in better, more holistic member care management.

Better data. The population data that is accessible in the clinical care platform is higher quality and more immediately accessible, including medical conditions, risk scores, medication history, current medications, and even insights into medication pricing and the availability of lower cost alternative medications—all of which can be viewed without having to consult an external vendor's portal.

UnitedHealthcare

UMR

Innovative analytics. Better data, along with close collaboration of pharmacy and clinical resources, make possible innovations in medication-focused population risk scoring and gap-in-care analysis, including a proprietary model for predicting medication compliance issues, as well as a scoring model for a member's medication adherence.

Value-driven referrals. Referrals make the most of every member engagement. A member calling into the mail service pharmacy may learn of an available condition management program. A member who is working with a nurse may learn which medications are available by mail, with support options including our staff reaching out the member's physician to obtain the prescription in mail service quantity (90 days).

Effective Implementation and Ongoing Plan Management

SJVIA has our commitment to an immediate and efficient implementation: The underlying infrastructure that supports your plans, eligibility, banking, reporting, billing and other administrative provisions will be managed by UMR. Accordingly, your pharmacy implementation will focus on any pharmacy specific changes to these provisions, such as plan design, eligibility structure variances, pharmacy product adoptions, or open enrollment needs. One of our major goals throughout the implementation process is to minimize disruption for members while providing them with all of the information necessary to understand and maximize their new benefits.

From the initial implementation checklists, milestones and meetings to ongoing maintenance and support, we focus on quality and efficiency. You can expect a "no shades" view of the work we are performing on your behalf, including detailed documentation of client intent. Moreover, we maintain that focus on quality and efficiency even after the pharmacy implementation is complete.

Specialty Pharmacy

Specialty pharmacy trend is one of the greatest threats to health care sustainability across the nation. OptumRx responds to this risk by offering a cost-effective integrated specialty program. Its scale, flexibility and leverage to navigate the financial challenges associated with complex and high-cost therapies, while helping members stay adherent with their chronic conditions helps make us a leader in specialty drug management.

Our service model offers care management, medication distribution, program referrals, utilization and disease management programs, outcomes analysis and reporting and member education to provide comprehensive care. This includes a specialty pharmacy live video consultation program, offering members personal contact with clinical pharmacists with face-to-face interaction that promotes adherence and provides member engagement, hands-on counseling services, and assistance to master medication administration. These virtual consultations improve member confidence and satisfaction, and facilitate better management of high-cost specialty medication.

Additionally, our specialty pharmacy program takes advantage of the expertise that UnitedHealth Group's family of health care companies has to offer. Members in need of additional support—clinically or otherwise—are referred to our case or disease management nurses who coordinate additional care and support, as necessary. These services provide the high-touch support required for chronic and complex conditions. As an example, our hepatitis C and multiple sclerosis clinical management programs include screening for depression and, if necessary, referrals to the appropriate health care service. Similarly, referrals to our oncology disease management program are provided for members receiving oral oncolytics.

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<u>Eliminating any RX disruption:</u> UMR and OptumRx are very cognizant of SJVIA's concerns about member disruption and medication adherence. Accordingly, we are offering an additional service of Continuation of Therapy / grandfathering for excluded medications.

Continuation of Therapy is an exception process when a member receives an exception to a benefit coverage limit or other plan restriction. It is applied when a customer transitions from one PBM provider to another or when a benefit change occurs during the plan year. These exceptions can help minimize member disruption and support safety and continuity of care and may apply for a specific time period.

OptumRx is offering SJVIA Continuation of Therapy. We will work with SJVIA to develop appropriate Continuation of Therapy policies and offer recommendations that have a positive impact on member care and satisfaction.

Additionally, during implementation of SJVIA's plan, we analyze the recent, incumbent, pharmacy claims data to determine potential disruption due to formulary transition. We are able to load historical prior authorizations for formulary drugs with utilization management programs; however, such claims are excluded from rebate guarantees.

Our technical platform fully supports programming of Continuation of Therapy policies within our claims system at the plan and member level. This enables us to implement exceptions in real time, which avoids member disruption at the point of service and reduces the need for pharmacist or Help Desk intervention.

We do not apply charges for programming our system to accommodate these exceptions. However, when these exceptions are implemented, any savings estimates may need to be adjusted.

<u>UMR's ability to work with other PBM's</u>: We currently interface with 30 national and regional PBMs in serving customers and their plan members. This includes process and system integration for sharing claims and eligibility data and single sign-on (SSO) connectivity with umr.com.

<u>OptumRx's ability to work with other TPA's:</u> OptumRx is willing to work with most National TPA's in the market, should UMR not be selected as the Medical TPA.

UMR's Network solutions, Disruption and Repricing

UMR offers access to the broad reach, deep discounts and innovation of the UnitedHealth Select and Select Plus Network, which continues to transform the health care system to achieve higher quality, and cost-effective care delivery. This is our solution for the SJVIA's EPO and PPO plan designs.

The UnitedHealthcare Select/Select Plus network offers a wide selection of quality health care providers, including 350 hospitals and more than 109,000 health care professionals throughout California. Our national network is automatically available for any members needing access outside of California.

Specific to the network discount analysis and repricing tools we are able to identify, from the information provided in the RFP to the level of detail associated with the amount of $1,240,054 in Unable to Process amount.

These providers are not contracted with UHC or are competitor products and we do not include them in medical disruption (ie: within these records, Coram is example which is a pharmacy benefit and is always exclude it from our medical disruptions.)

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Cost Exhibits

UMR is offering a $100,000 Wellness Credit to be used at SJVIA discretion.

UMR is offering $50,000 Implementation and a $50,000 Communications credit also to be used at SJVIA discretion.

UMR has updated the Cost Proposal Tab as instructed.

Performance Guarantees

UMR has updated the Performance Guarantee Tab as instructed.

Why HealthComp?

HealthComp At-A-Glance

- Founded in 1994
- Largest Independent TPA: Medical, Dental, Vision, COBRA, HIPAA, Flexible Spending Accounts
- Serve over 900K medical and 1.5M total members nationwide
- Client size range: 30,000-150,000 medical members
- National footprint: Operations center in Fresno (CA), Homewood (IL), Covington (LA), Lancaster (PA), and Ripley (WV), Lexington (KY)

Extensive network access:

Anthem
CA, NY, GA, CO, OH (Student and Hospital Plans), VA (Student and Hospital Plans)

blue california
BlueCross BlueShield of Arizona
aetna™

Cigna
Reference-based Pricing

ACOS/Narrow Networks

Operational Excellence: Measurable, Repeatable, and Predictable

Our clients work with an designated team (pod) of associates from various departments. This ensures that you receive the best service from a team that understands your benefits offering.

99.7% claims accuracy

2.8 days claims turnaround time

63% of claims processed in 1 day

97%+ client retention

Lower Health Plan Costs

HealthComp operates independently, with no ties to providers. Our cost management program utilizes claims and quality excellence, payment integrity, and care management to optimize your health plan spend.

Claims and Quality Excellence

Operational excellence, auto-adjudication, QA processes, post-claims reviews, 100% audit above $5,000

Payment Integrity

Out-of-network negotiations, subrogation, fraud protection, waste & abuse monitoring, stop loss processing

Care Management

- Large case management, care coordination, claims review and negotiation, member education
- Chronic Condition Management
- Specialized programs to control ER and dialysis costs
- Preventive care programs: Cancer Awareness, Mommies 2-Be

Clients see **30% lower utilization** and **19% lower medical costs** than the industry average using **HealthComp's Clinical Care Management Program**

Help your employees get affordable, high-quality medical care. HealthComp's high-touch clinical care management programs nurture healthy employee populations.

Wakely, an independent actuarial firm crunched our numbers and revealed how HealthComp's high-touch, personalized approach to care administration ensures more plan members receive tailored, appropriate medical care.

Our clinical care management team serves as the change-making advocates that health plan members need most.

KEY FINDINGS

30%
lower utilization

through inpatient, outpatient, and professional services, or **$3,000 in savings per employee per year**, without changing benefits or network design

48%
lower inpatient costs
for **HealthComp members**

40%
lower maternity spend
for members in HealthComp's **Mommies 2-Be Program**

80
NPS score,
compared to the **healthcare industry's average of 12**

32%
lower emergency room utilization,
representing **$16.09 PEPM in savings**

19%
lower medical costs

across every service category for managed HealthComp members compared to the industry average

COMPLETE TRANSPARENCY

HealthComp's analytics provide complete transparency into your data, so you can develop insights to better manage your benefits offering.

- Integrated dashboards
- A reports library, custom reports and on-demand reports
- HCNavigator, a proprietary tool that allows you to drill into your data and identify trends

Get the **full report by Wakely** at
HealthComp.com/Clinical-Care-Management
or **scan the QR code** below.

Learn more at HealthComp.com

Savings Analysis

Wakely
An HMA Company

HealthComp

Summary:

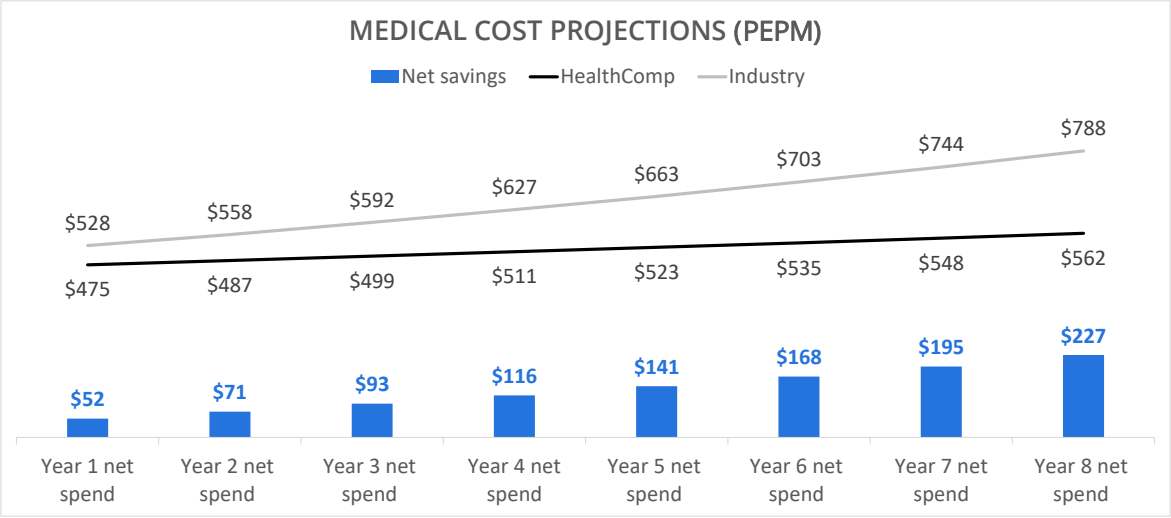
Savings estimates are based on HealthComp's book-of-business results and have been independently validated by actuarial firm, Wakely**. Furthermore, HealthComp's programs have achieved a Level 1 Validation for Savings from the Validation Institute, featuring their $25,000 credibility guarantee***. These savings have then been scaled back for conservatism (see table for exact figures). With this conservatism, we estimate a cost reduction (i.e., PEPM compared to prior year) of 10.7% (equivalent to $52 PEPM). Furthermore, by measuring HealthComp's market-leading cost trend relative to industry average trend, we can not only account for immediate cost reduction but also long-term cost avoidance. Cost reduction plus cost avoidance equals $4,300K in year 1 savings, with annual savings of $11,700K by year 5. Year 5 equates to a 21%+ medical cost savings versus staying with the incumbent. In addition to these savings, HealthComp also boasts an 80 Net Promoter Score (on a scale of -100 to +100; relative to Healthcare Industry 27).

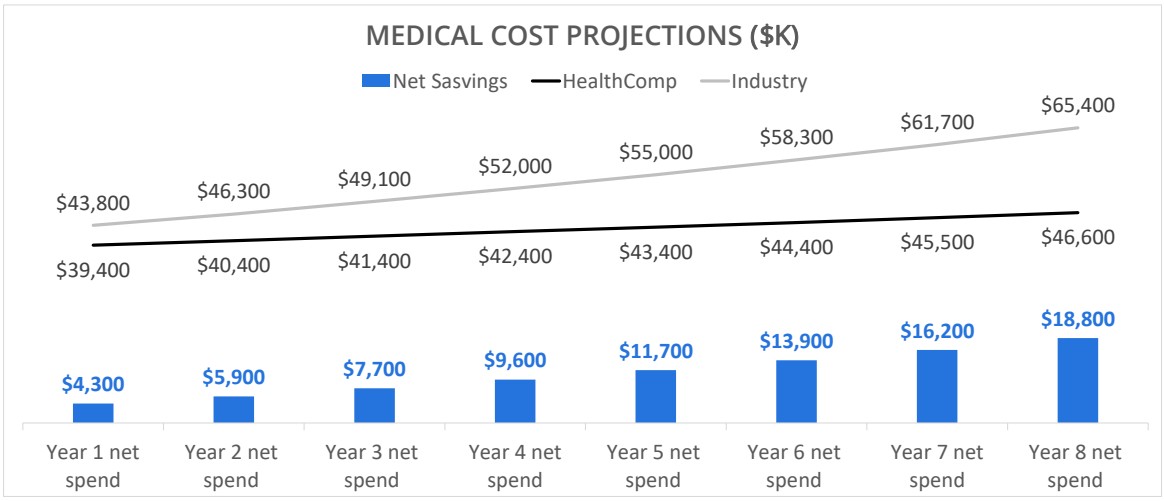
Wakely An HMA Company

Independently Validated Performance · ValidationInstitute

healthcomp.com/clinical-care-management

validationinstitute.com/wp-content/uploads/2022/04/HealthComp_Savings_2022_Final.pdf





Projected EE	6,915
Prior Year PEPM	$484
Projected EE * Prior Year PEPM	$40,149,043

	With HealthComp	Without HealthComp	Net savings with HealthComp	*Cost reduction and avoidance: Savings as % of status quo*	*Cost reduction: Savings as % of prior year spend*
Prior Year spend (adjusted for projected enrollment)		**$40,149,043**	N/A		
Year 1 spend pre-savings with industry trend	$43,754,139	$43,754,139	$0		
Year 1 savings	$4,307,432	$0	$ 4,307,432		
- Reduction in duplicates (conservative estimate of $7 improvement; compared to HealthComp's typical $46 in savings)	*580860*				
- Enhanced claims processing (conservative estimate of $6 improvement; compared to HealthComp's typical $44 in savings)	*497880*				
- Additional savings from Fraud, Waste, and Abuse (conservative estimate of $13 improvement; compared to HealthComp's typical $20 in savings)	*1078740*				
- Additional savings from Out-of-Network management (conservative estimate of $11 improvement; compared to HealthComp's typical $17 in savings)	*912780*				
- Additional savings from Third Party Liability (conservative estimate of $7 improvement; compared to HealthComp's typical $9 in savings)	*580860*				
*- Enhanced clinical solutions (conservative estimate of 1.5% utilization reduction; compared to independent actuarially validated HealthComp utilization reduction of 30%**)*	*656312*				
Year 1 net spend	**$39,446,707**	**$43,754,139**	**$4,307,432**	*9.8%*	*10.7%*
Year 2 net spend	**$40,393,428**	**$46,335,633**	**$5,942,205**	*12.8%*	
Year 3 net spend	**$41,362,870**	**$49,069,435**	**$7,706,565**	*15.7%*	
Year 4 net spend	**$42,355,579**	**$51,964,532**	**$9,608,953**	*18.5%*	
Year 5 net spend	**$43,372,113**	**$55,030,439**	**$11,658,327**	*21.2%*	
Year 6 net spend	**$44,413,043**	**$58,277,235**	**$13,864,192**	*23.8%*	
Year 7 net spend	**$45,478,956**	**$61,715,592**	**$16,236,636**	*26.3%*	
Year 8 net spend	**$46,570,451**	**$65,356,812**	**$18,786,361**	*28.7%*	
*8-year projected trend (including recurring savings from reduction in duplicates, enhanced claims processing, additional savings from FW&A, clinical services driving reduced utilization; savings mix may change over time and index towards FW&A and clinical savings)****	*2.40%*	*5.90%*			

Cumul 8 year spend	**$343,393,147**	**$431,503,818**	**$88,110,671**	*20.4%*

**Independent actuarial firm, Wakely, conducted a risk-adjusted, geographically-adjusted analysis of HealthComp's 2019 book, showing that HealthComp drives:

- 30% utilization reduction
- 19% medical cost savings
- 27% lower radiology/lab spend
- 48% lower inpatient spend
- 40% lower maternity spend
- 32% lower emergency room utilization
- Claims projections based off elected clinical buy-ups where two of the following three are elected by the group to be serviced through HealthComp: Case Management, Population Preventive Care, Utilization Review.

https://healthcomp.com/clinical-care-management/

***Validation Institute is willing to provide up to a $25,000 guarantee as part of their Credibility Guarantee Program.

https://validationinstitute.com/credibility-guarantee/

****5.9% is industry average medical cost trend (excluding admin fees) for employers, based on benchmarks from PWC, IBM Truven. HealthComp's 2.4% trend is based on "all-HealthComp-clients" results, including member costs.

March 23, 2022

VALUE PROPOSITION:

Delta Health Systems is committed to providing single- and multi- employer groups of all sizes competent administration, timely response to all inquiries and forward-looking technology driven programs that will guarantee to improve employer, employee, and professional partners experience.

OUR VALUES

Delta Health Systems is a family-owned and operated business. This allows us to prioritize our employees and our members instead of investors. Delta's people-focused leadership empowers and supports our employees. This has allowed us to build a knowledgeable and committed team with many long-tenured employees being part of our team for 20, 30 and even 40 years. Our mission is simple: Deliver as Promised. We recognize that serving our customers means serving their members, and that our customer's success is our success.

OUR FOCUS

At Delta Health Systems our focus is on helping our customers to deliver cost effective health benefits to their employees and members. We accomplish this not only by timely and accurate administration, but also by supporting a wide range of brokers, consultants, and vendor partners to develop and affect meaningful cost-containment and health-focused strategies.

OUR APPROACH

Through our innovative approach, Delta Health Systems offers and demonstrates programs that improve overall healthcare spend while maximizing the employer, member, and professional partner's experience. We have over 50 years of experience working with multi-stakeholder teams to administer complex benefit plans successfully. Delta Health Systems believes that the success of any program requires a true partnership between all parties and will work diligently to ensure these lines of communications are purposeful and solution based.

OUR CORE COMPETENCIES

- Rigorously tested implementation program ensures a smooth transition.
- Engaged partner on plan design to improved member experience and risk management.
- Transparent administration to know where your dollars are spent.
- Best in class claims processing ensures high accuracy at a low cost of administration.
- Plan analytics to identify emergent risk drivers.
- Cost containment strategies to achieve risk mitigation.

DELIVERING AS PROMISED

Through the combination of our values, focus, approach, and core competencies, Delta Health Systems improves member experience, lowers manageable spend, and achieves better outcomes.

I certify that my value proposition is a true reflection of my company.

Name of Authorized Representative: Patrick McTighe

Signature of Authorized Representative

Date: 03.23.22
Phone # of Authorized Representative: 209.939.3489
Email of Authorized Representative: Patrick.McTighe@DeltaTPA.com

SJVIA
San Joaquin Valley
Insurance Authority

PINNACLE™
CLAIMS MANAGEMENT, INC.

SJVIA has unique needs.

Pinnacle has the expertise and ability to provide solutions that are designed to address SJVIA's specific challenges.

- Commitment to Exceptional Customer Service
- Keeping Your Members Healthy
- Cost-Savings Solutions
- Cedar Health Centers
- Mexico Cross-Border Network
- Flexibility and Customization
- Tools and Data-Driven Analytics

Commitment to Exceptional Service

We take great pride in our member-centric approach to service, and our local presence enables us to react quickly to any changes we see in the health care industry and address the unique needs of our clients. We operate in several locations throughout California, with a dedicated office in Fresno, and administer self-funded plans to more than 100 clients in the Fresno and Tulare counties. As such, we serve the communities of SJVIA and have dedicated and bilingual support staff to meet your needs.

We understand the importance of maximizing SJVIA's health plan savings, which is why we developed a claims processing system that guarantees accuracy, efficiency and convenience for members.

$5,000

We audit all claims in excess of $5,000 to ensure accurate medical billing, medical necessity, and claims payment.

We have the ability to notify SJVIA of any claims in excess of $50,000 before they're paid.

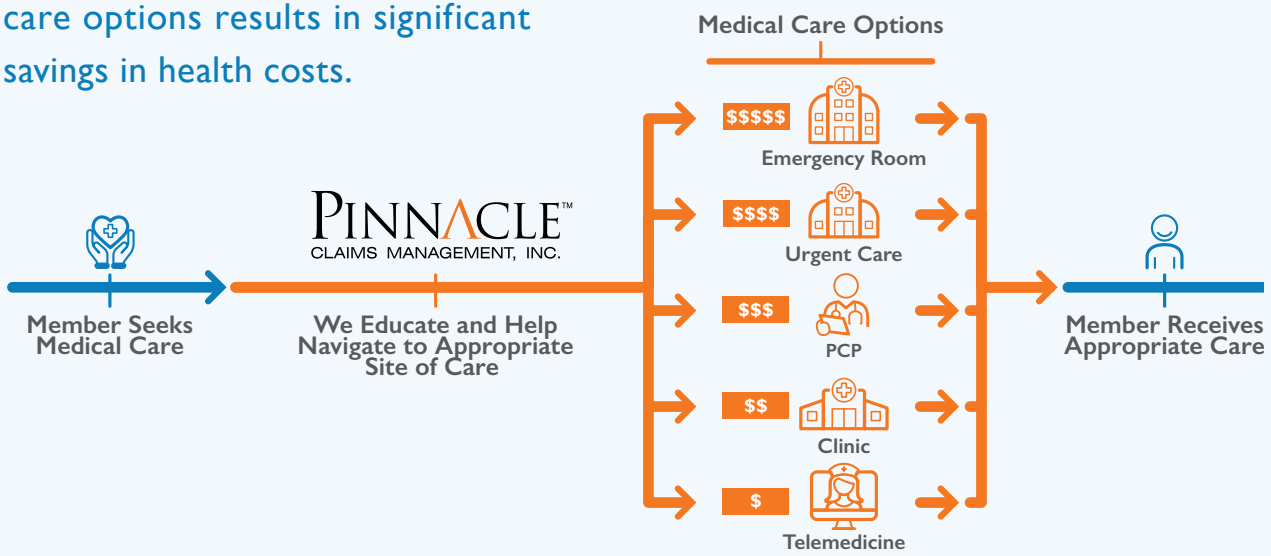
$50,000

SJVIA San Joaquin Valley Insurance Authority | PINNACLE™ CLAIMS MANAGEMENT, INC.

Cost-Savings Solutions

Pinnacle doesn't just pay your claims – we also educate your members and help them navigate to find the most efficient and cost-effective access to care. Our dedicated customer support team is always available to help members navigate the complexities of the health care system.

Guiding members toward alternative care options results in significant savings in health costs.



We analyze utilization data and health management data to identify areas for potential claims interventions and savings, helping to control your bottom line. Our cost management programs include utilization review, case management, discharge planning, and large dollar claims review.

SJVIA San Joaquin Valley Insurance Authority | PINNACLE™ CLAIMS MANAGEMENT, INC.

Flexibility and Customization

Pinnacle has the flexibility of offering a broad range of services and programs that can be customized and seamlessly integrated with your vendor partners. In addition to offering a custom solution for SJVIA, we can tailor different aspects of your health program to accommodate the needs and objectives of the individual counties.

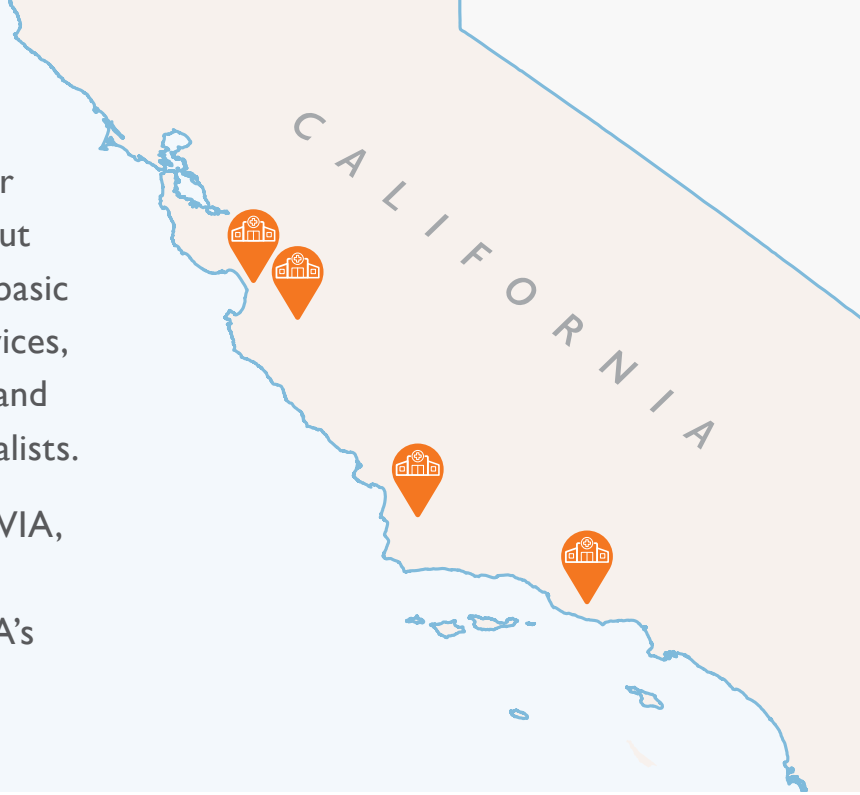
We partner with the top Preferred Provider Organization Networks to provide ease of access to physicians and hospitals and also have the ability to contract with additional hospitals and physicians that are important to the members we serve.

SJVIA San Joaquin Valley Insurance Authority | PINNACLE™ CLAIMS MANAGEMENT, INC.

Cedar Health Centers

Pinnacle operates several Cedar Health Center clinics throughout California. Our clinics provide basic and preventive health care services, including biometric screenings and referrals to cost-efficient specialists.

These clinics are available to SJVIA, and Pinnacle has the ability to set up new ones based on SJVIA's unique needs.



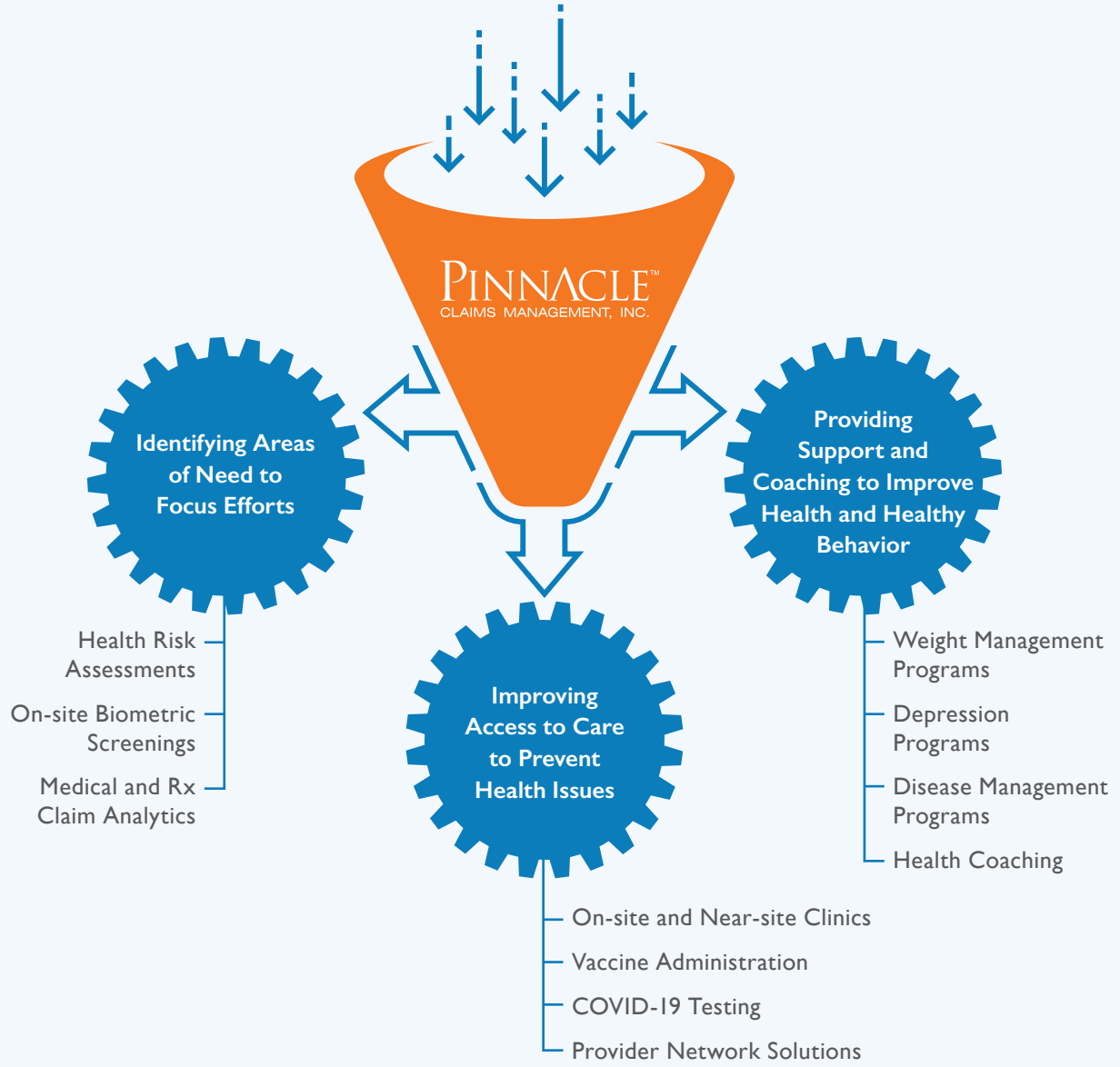
Mexico Cross-Border Network

Our Mexico Cross-Border network provides services at a significantly lower cost for members who prefer to receive care in Mexico. Our network consists of state-of the-art facilities and offers an extensive list of specialty and diagnostic services.

SJVIA San Joaquin Valley Insurance Authority | PINNACLE™ CLAIMS MANAGEMENT, INC.

Keeping Your Members Healthy

Pinnacle can support SJVIA members' health through our data-driven custom programs and services.

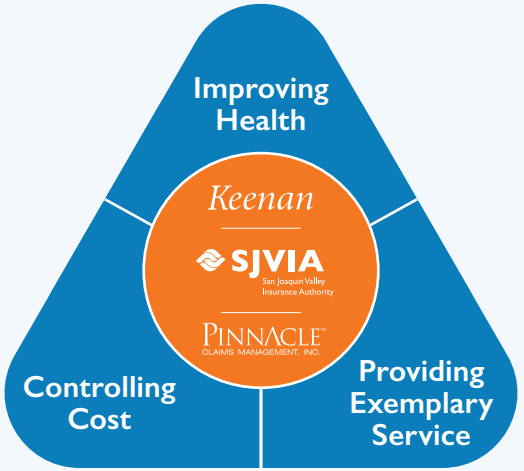


SJVIA San Joaquin Valley Insurance Authority | PINNACLE™ CLAIMS MANAGEMENT, INC.

Tools and Data-Driven Analytics

We empower our clients to make the best decisions when it comes to their health care spending. We use consumer-centric, data-driven analytics to evaluate the performance of each plan design. Our data analytics platform and predictive risk profiles enable us to analyze program costs and provide members with insights and recommendations to enhance their plans. We also have the ability to coordinate custom analytics relative to claims, health management, costs and control outcomes.

Success Driven Through Collaboration



With our tenured experience providing health benefits solutions across all industries, we are confident our team can assist SJVIA in obtaining your health program's objectives.

If you have any questions, please feel free to contact me directly at (949) 466-6104.

Debra Feuerman
Director of Sales
dfeuerman@pinnacletpa.com

SJVIA San Joaquin Valley Insurance Authority | PINNACLE CLAIMS MANAGEMENT, INC.

Follow-up Value Proposition for SJVIA

Why EmpiRx Health

As the most clinically advanced PBM in the industry, EmpiRx Health is SJVIA's healthcare partner—and we're proud of it. Since 2017, we have successfully worked together with SJVIA to deliver best-in-class pharmacy benefits to you and your members. **More than $16.5M in fully-auditable clinical savings and less than 5% YOY trend, compared to an industry trend of 12-18%,** all with the highest level of clinical integrity, is the reason why our partnership with, and results for SJVIA are market-differentiated.

100% auditable Clinical Savings Guarantee. Our pay-for-performance model holds us accountable and is 100% auditable and transparent. We take downside risk to lower SJVIA's costs—if we don't meet our guarantee, we cover the difference. **No other PBM in this market does this**.

A data-enriched, human-delivered population health strategy tailored to your membership at no charge. We drive equal or better outcomes for SJVIA members while eliminating waste and excess cost. Our pharmacists are at the center of our patient care team, collaborating with prescribers to ensure the right therapy for your members at the right price.

SJVIA receives white-glove service 24/7/365. EmpiRx Health is SJVIA's service destination—a high-touch, people-focused level of concierge service no other PBM can offer. We recently implemented our **Member Care Advocacy model for SJVIA at no additional charge.** Specially trained clinical advocates deliver a heightened patient experience and reduce gaps in care for members with healthcare or service complexities.

National presence with a local PBM feel, including client management support from our Head of Client Services, Lisa Krajewski, **located in California.**

100% pass-through of guaranteed rebates for the 2023 renewal and an increased clinical savings guarantee of an additional $250,000 per year.

No burdensome or risky implementation process. Your pharmacy program is in place and your members know us, which affords continuity of service and zero member interruption and noise.

Our broad pharmacy network and formulary ensures equitable access to healthcare. **No messy transition** of care, no stress, just comfort and convenience.

By remaining with EmpiRx Health, SJVIA can expect a clinical-first approach to improving health outcomes while delivering deep and sustainable savings—and we do it in a way no one else does.

Healthcare Done Right for SJVIA

We ensure that SJVIA members receive the **highest quality care in the most cost-effective manner**, maximizing value and preserving your benefit dollars. Over the last four years, we have provided high-touch concierge service with every interaction, lowered your Rx costs, and delivered significant clinical savings, and we have zero intention of stopping the momentum.

Employers need a truly different solution in which value is the focus, not volume and rebates—a solution that will guarantee cost savings and trend management, and employers should hold the benefit manager financially accountable for those guarantees with a high degree of transparency**. EmpiRx Health is that solution**—we are the only truly value-based PBM in the market.

Financial Stability. We take downside risk to reduce drug spend, with a fully-auditable Clinical Savings Guarantee over three years and a cover-the-difference warranty. Our guarantee mitigates inflation as we optimize drug mix and utilization-waste in the current spend to protect employers from runaway pharmacy trend. EmpiRx Health manages appropriate trend and spend by driving fully auditable clinical savings.

Tailored, Personalized, Population Health Management. Our unique model emphasizes value, savings, and accountability—without SJVIA having to choose between care, access, and savings. We understand the need for wellness across your organization and our core model is dedicated to exactly that. We stratify by risk factors, not conditions, and we use the Johns Hopkins ACG system and factors in a combination of Rx claims, medical claims and other data for a distinct employee population. Please refer to Figure 1 for an SJVIA member's clinical success story.

As indicated by SJVIA's interest in **weight-management**, EmpiRx Health can specifically tailor our Population Health model around this initiative for your membership. Weight management and the comorbid conditions that accompany a diagnosis of obesity are complex, and not every patient faces the same risks. Simply checking off a box that there is a one-size-fits-all Weight Management Program doesn't mean success will follow. It fails to consider medication adherence, severity of disease, nor behavioral factors that influence patient outcomes. We understand that no two members are the same and the conversations that we have with their respective providers will not be the same either.

EmpiRx Health deploys **the industry's only population health management program** along with a best-in-class clinical concierge model for patients with complex healthcare needs:

- Our care management playbook tailored to your population, **delivers the right clinical and cost containment solutions for your plan.**
- Pharmacist-Physician engagement and complex care management are how we execute on the playbook.
- Our pharmacists review the clinical and financial risk factors of your population and go deep with physicians on the patients' whole health—not just their dominant conditions. Pharmacists working directly with physicians as a part of the patient's care team can influence healthier, more cost-effective drug selections for patients.
- Strategies used by our pharmacists deliver a very strong physician engagement **model with 88% in overall engagement and 64% therapeutic switch rate—both industry leading numbers.**
- We continually monitor the member's treatment for safety and efficacy.
- Members with service or healthcare complexities are handheld by Member Care Advocates to ensure they receive the therapies and services they need.

  At no additional cost, we provide an AlertRx News Flash that identifies critical findings and provides actionable recommendations that have a direct impact on, and save money for, the plan. It's provided to SJVIA within 24 to 48 hours of critical activity, such as members being transitioned to medications, cured of conditions, or new drugs entering the market. **The AlertRx News Flash is the first proactive communication of its type in the industry.** Please refer to Figure 2.

Member Care Advocacy

EmpiRx Health is providing our Member Care Advocacy program to SJVIA at **no additional cost**. We have found that 3%-5% of a member population have markedly higher healthcare complexity and need much greater care and attention. Patients with healthcare complexity have a disproportionate set of healthcare needs and are getting lost in the mix, right when they need care the most.

Our Member Care Advocacy program provides them with a personal care advocate who stays close to their pharmacy needs and coordinates with their doctor's office and pharmacy as needed to ensure they feel taken care of. This program **eases any escalated traffic away from your HR and benefits teams,** improves the patient experience and helps reduce gaps in care. EmpiRx Health's Member Care Advocacy model offers complex care management on the scale of the Medicaid/Medicare space, **a one-of-a-kind service not found anywhere else in the commercial PBM market.**

- **We call these patients before they call us.** We identify common member issues and difficulties and proactively reach out to members, physicians, and prescribers to make the prescription process easy. Any service issues identified by our call center or escalated by a client will be assigned to a Member Care Advocate who will handle the case from beginning to end. The Member Care Advocate is a liaison between the member, the prescriber, the pharmacy to ensure that the member gets the therapies and the service they need.
- SJVIA has the option to provide a pre-determined list of members who will be assigned a Member Care Advocate should a need arise.
- A member will have a **24x7 direct line to their Member Care Advocate.**
- Our advocates conduct regular follow up outreach to ensure these members are doing well or if they require any additional support.

Compassionate care is what you should expect from the industry's most clinically advanced PBM—and that is what we deliver. EmpiRx Health puts the care back in healthcare—providing a world-class care management solution for your plan membership. **SJVIA members deserve nothing less.**

Figure 1:

Figure 2: