PEBA
SC Retirement Systems and State Health Plan

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

Meeting Agenda

Health Care Policy Committee |Finance, Administration, Audit and Compliance Committee Retirement Policy Committee| Board of Directors

Wednesday, August 5, 2026 | 202 Arbor Lake Dr., Columbia, SC 29223| 1st Floor Conference Room

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

I. Call to order
II. Approval of meeting minutes – June 3, 2026
III. Election of Vice Chairman
IV. Plan year 2027 approval of benefits and contributions
V. Strategic key measures review
VI. Value-based programs update
VII. Old business/Director's report
VIII. Adjournment

Notice of public meeting

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

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
Health Care Policy Committee

Meeting Date: August 5, 2026

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1. Subject: Election of HCP Committee Vice-Chairman

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2. Summary*:* According to the PEBA Board Bylaws: At the first committee meeting after the Chairman's appointment of the standing committee members and chairmen each even-numbered year, each standing committee shall elect a vice-chairman to preside over the committee and oversee committee business in the absence of the committee chairman.

3. What is the Committee asked to do? Elect a Health Care Policy Committee Vice-Chairman

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4. Supporting Documents:

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
HEALTH CARE POLICY COMMITTEE

Meeting Date: August 5, 2026

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1. Subject: Approval of 2027 State Health Plan of Benefits and Contributions

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2. Summary: There is a zero percent increase in the employer and employee premium for the State Health Plan for the 2027 plan year.

Ms. Laura Smoak will present contribution rates and plan design changes for the State Health Plan for the 2027 plan year. The plan design changes reflect proposals that achieve savings and/or enhance program value.

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3. What is the Committee asked to do? Recommend that the PEBA Board approve the State Health Plan of Benefits and Contributions for the 2027 plan year as presented.

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4. Supporting Documents:

(a) Attached: 1. Summary of 2027 State Health Plan of Benefits and Contributions

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Approval of State Health Plan benefits and contributions for plan year 2027

State Health Plan funding proviso from Appropriations Act

108.5. (PEBA: State Health Plan) Of the funds authorized for the State Health Plan pursuant to Section 1 11 710(A)(2) of the 1976 Code, an employer premium increase of zero percent and a subscriber premium increase of zero percent will result for the standard State Health Plan for Plan Year 2027. Notwithstanding the foregoing, pursuant to Section 1 11 710(A)(3), the Public Employee Benefit Authority may adjust the plan, benefits or contributions of the State Health Plan during Plan Year 2027 to ensure the fiscal stability of the Plan.

There are no changes for 2027 in employer and employee/retiree contributions in force in 2026.

2027 will mark the 15th consecutive year with no increase in employee/retiree contributions in the State Health Plan.

2027 Employer contributions (no change from 2026)

Coverage level	Rate
Subscriber only	$551.48
Subscriber/spouse	$1,161.96
Subscriber/children	$946.88
Full family	$1,517.80

2027 Employee/retiree premiums (no change from 2026)

Coverage level	Standard Plan and Medicare Supplemental Plan	Savings Plan
Subscriber only	$97.68	$9.70
Subscriber/spouse	$253.36	$77.40
Subscriber/children	$143.86	$20.48
Full family	$306.56	$113.00

Plan Design—GLP-1 fill limit for Medicare population

At the June 26, 2024 Committee meeting, staff recommended a 30-day fill limit for all GLP-1 pharmacy products, as a means to address the surging expense in this drug category. The Committee and PEBA Board approved this recommendation. This change became effective for the Plan's Commercial (non-Medicare) membership, but, subsequent to the June 2024 meeting, PEBA's then-pharmacy benefits manager (PBM) informed us that it was unable to enact this limit for our Medicare membership. Medicare members continue to be able to obtain up to a 90-day supply of GLP-1s.

From the outset of our contractual relationship, PEBA staff has informed our current PBM, Caremark, that instituting the Board-approved 30-day fill limit in the Medicare group is a priority. Caremark has notified us that all regulatory clearances have been achieved, and the Plan's 30-day fill limit for GLP-1s will go into effect January 1, 2027.

5.26.2026

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
Health Care Policy Committee

Meeting Date: August 5, 2026

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1. Subject: Strategic Key Measures Review

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2. Summary: We have developed metrics that are presented annually to illustrate performance of the State Health Plan and other employee insurance products. Ms. Laura Smoak, PEBA's Insurance Policy Director, will present and discuss the 2026 version of the Health Care Policy Committee's Key Measures.

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

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4. Supporting Documents:

(a) Attached: 1. Health Care Policy Committee Key Measures August 2026

PEBA
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Health Care Policy Committee Key Measures

August 2026

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State Health Plan enrollment as of August 2026

Represents enrollment in the State Health Plan, the MUSC Health Plan and TRICARE.

Participants

Subscribers		310,481
Actives	211,357	
Retirees	95,880	
Others	3,244	
Spouses		92,477
Children		147,734
Total covered lives		**550,692**

Active subscribers

State agencies	35,032
Higher education	28,061
School districts	86,061
Charter schools	4,045
Local subdivisions	40,678
MUSC hospitals	14,771
Other	2,709
Total active subscribers	**211,357**

Retirees

Medicare	79,970
Non-Medicare	15,910
Total retirees	**95,880**
Funded retirees	89,060
Non-funded retirees	6,820

State Health Plan participating employers as of August 2026

Employers

State agencies	Higher education	School districts	Charter schools	Local subdivisions	MUSC hospitals	Other
88	26	79	78	573	9	20
Total employers: 873						

State Health Plan financial analysis as of June 2026[1]

	2024	2025[2]	24/25 Trend	Projected 2026[3]	25/26 Trend
Total State Health Plan net expenditures (in millions)	$2,930.9	$3,206.5		$3,331.3	
Average membership	501,366	508,131		515,278	
Medical – net expenditure PMPM	$333.17	$361.48	8.5%	$378.79	4.8%
Pharmacy – net expenditure PMPM	$153.98	$164.39	6.8%	$152.65	(7.1%)
Total State Health Plan	$487.15	$525.87	7.9%	$531.44	1.1%
Total loss ratio	97.8%	96.4%		93.7%	

[1]Excludes the MUSC Health Plan
[2]Incurred in 12 months; paid in 18 months
[3]Annual projection based on claims incurred and paid in six months.

Cash performance

Expenditure/income ratio for all health plans and dental plan should be 100% or less. Cash/liability ratio greater than or equal to 1.4 is optimal (benchmark). Cash/liability should be greater than or equal to 1.0

2025 Expenditure/income ratio	
All health plans	97.8%
Standard Plan	101.7%
MUSC Health Plan	103.9%
Standard + MUSC plans	101.9%
Dental	96.0%

Cash/liability ratio as of December 31, 2025	
All health plans	1.81
Dental	9.38
All self-funded plans	1.88

2026 Actuarial value

Actuarial value as defined by the ACA is plan payments ÷ (plan payments + patient cost share)
The goal is for the State Health Plan actuarial value ratio (AVR) to be equal to or higher than the benchmark of the average of bordering peer plans (Florida, Georgia, North Carolina and Tennessee) and the southeast regional states.

State Health Plan Standard Plan	84.0
Average of bordering peer plans	83.5
All southern states MEP	81.1

Benefit design for each plan applied to the Centers for Medicare and Medicaid Service's 2026 Actuarial Calculator.

Bronze	Silver	Gold	Platinum
actuarial value **60%**	actuarial value **70%**	actuarial value **80%**	actuarial value **90%**

State Health Plan network access | July 1, 2025 – June 30, 2026 (paid)

% of hospital claims paid in network	99.53%
% of professional claims paid in network	98.91%

State Health Plan net expenditure growth per member is at least two percentage points below the five-year average national benchmark.

	2021	2022	2023	2024	2025	5-year average (2021-2025)
State Health Plan	7.3%	1.1%	8.0%	4.1%	7.9%	5.7%
Benchmark	8.6%	6.9%	8.4%	8.4%	8.6%	8.2%

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

State Health Plan net expenditure to revenue loss ratio is less than or equal to 1.0.

	2024 incurred claims (paid through 06.30.2025)	2025 incurred claims (paid through 06.30.2026)
State Health Plan	0.974	0.964

Cumulative cash balance of self-funded health plan reserves is at least 140% of current estimated outstanding liability.

	As of 12.31.25	Cash balance compared to estimated outstanding liability
State Health Plan cash balance	$513,791,084	181%
Outstanding liability	$284,518,589	

2025 Average monthly total premiums[1]

Totals include employee and employer contributions

	Single	Family
State Health Plan	$625	$1,756
Large employers[2]	$819	$2,355
Employers in South[3]	$763	$2,188
Public employers	$789	$2,204
Private – manufacturing	$824	$2,311
Private – financial services	$914	$2,589

[1]Average monthly total premiums in PPO (Preferred Provider Organization) plans
[2]Large public and private sector employers: ≥ 200 employees in public and private sector
[3]Public and private sector employers in South includes Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

Data from the Kaiser Family Foundation Employer Health Benefits 2025 Annual Survey

2025 Average annual deductible[1]

	Amount
State Health Plan	$515
Large employers[2]	$1,145
All employers	$1,337

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

Data from the Kaiser Family Foundation Employer Health Benefits 2025 Annual Survey

State Health Plan average monthly composite premium is at or below the southeast regional state employee plan average for the employer, enrollee and total premium (2026 rates).[1]

	Employer	Employee	Total
State Health Plan	$831.46	$159.60	$991.06
South[2]	$1,047.78	$235.54	$1,283.32
State Health Plan percentage of regional average	79.4%	67.8%	77.2%
United States	$1,269.76	$219.00	$1,488.76
State Health Plan percentage of national average	65.5%	72.9%	66.6%

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

Data from PEBA's 50-State Survey

2025 Average annual gross plan cost per active employee[1]

	Amount[2]
State Health Plan	$15,670
Public employers	$17,294
Private – manufacturing	$18,189
Private – financial services	$20,680
All employers	$17,955
Employers – 500+	$18,116
Employers – 20k+	$16,738
South[3]	$16,347

[1]Average cost in PPO (Preferred Provider Organization) and POS (Point of Service) plans
[2]Average annual gross plan cost per employee (medical and pharmacy only for active employees and their dependents) = (Claims cost for employee and dependents + administrative costs + employee contributions)/number of active employees
[3]South includes Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

Data from 2025 Mercer National Survey of Employer-sponsored Health Plans

Historical State Health Plan increases and funding

Plan year	Employee increase	Employer increase	Overall increase	Notable plan design changes
2017	0	0.8%	0.6%	
2018	0	3.3%	2.5%	
2019	0	7.4%	5.7%	Added adult well visit coverage; increased copayments, deductible and coinsurance maximum
2020	0	0	0	
2021	0	0	0	
2022	0	0.8%	0.6%	
2023	0	18.1%	14.2%	Expanded adult well visit coverage; increased copayments, deductible and coinsurance maximum
2024	0	3.7%	3.0%	Added annual well woman exam coverage; added birth control coverage for covered dependent children
2025	0	11.8%	9.7%	Repealed PCMH patient cost share incentive
2026	0	4.6%	3.9%	
2027	0	0	0	

2025 Prevalence of certain chronic conditions in State Health Plan

	Ages 18-64			Ages 65+			Ages 0-17
Chronic condition	SHP primary adults	South Carolina	United States	SHP Medicare primary adults	South Carolina	United States	SHP dependent children
Diabetes	12.4%	13.9%	12.0%	30.9%	27.6%	24.0%	1.2%
High blood pressure	30.4%	38.8%	34.0%	74.3%	66.4%	65.0%	2.1%
High cholesterol	24.0%	39.3%	36.9%	68.2%	58.4%	66.0%	0.3%
Diabetes or high blood pressure or high cholesterol	39.9%			84.4%			3.5%
Diabetes and high blood pressure and high cholesterol	7.0%			25.5%			0.0%
Behavioral health							
Depression	11.2%	20.7%	22.0%	15.7%	14.4%	17.0%	2.8%
Any mental health diagnosis	30.8%			34.5%			21.7%

State Health Plan prevalence from State Health Plan claims data incurred in 2025.
State and national prevalence for ages 18-64 from CDC's Behavioral Risk Factor Surveillance System (BRFSS) for 2025.
State and national prevalence for ages 65+ from CMS's Mapping Medicare Disparities Tool using 2025 Medicare Fee-for-Service administrative claims data.

Meet or exceed reported benchmarks for appropriate measures as established by Healthcare Effectiveness Data and Information Set (HEDIS).

Benchmark data is for preferred provider organizations (PPOs) except the dental claim benchmark. The dental claim benchmark is for Medicaid Health Management Organization (HMO).

Measures for behavior or services that improve member health outcomes and reduce costs

	Benchmark	State Health Plan
Adults who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year. ↑	**94.4%** (2024)	**95.7%** (2025) **95.8%** (2024)
Adults and children ages 0 through 20 who had at least one oral evaluation during the measurement year. ↑	**40.6%** (2024)	**72.0%** (2025) **71.6%** (2024)
At least six well child visits in the first 15 months of life with a primary care physician. ↑	**81.6%** (2024)	**86.8%** (2025) **85.8%** (2024)

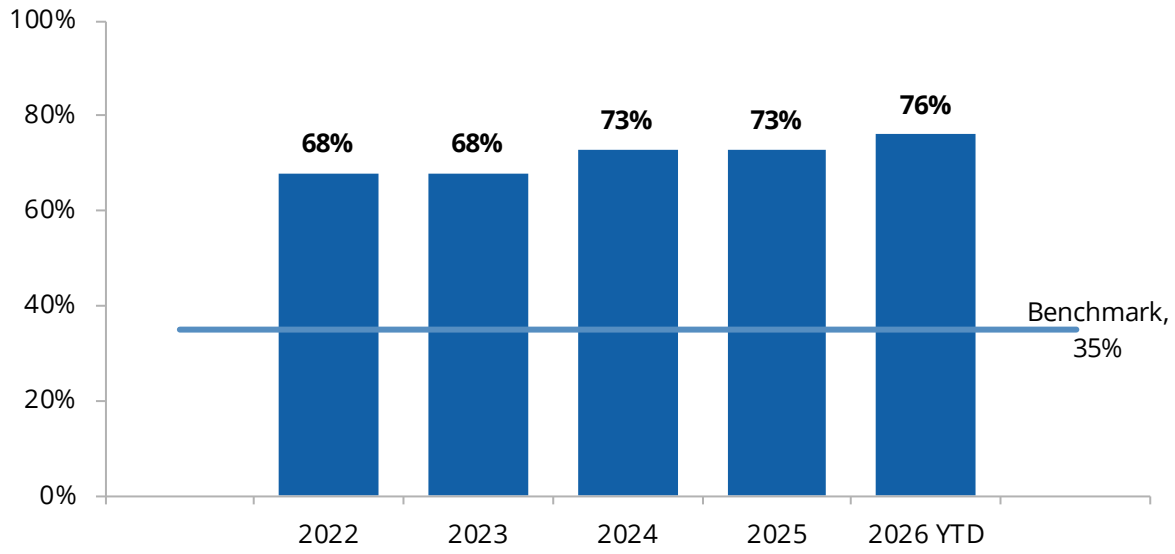
Measures for behavior or services that improve member health outcomes and reduce costs

	Benchmark	State Health Plan
Well child visits in the first 30 months of life (15 months to 30 months). ↑	**86.5%** (2024)	**91.9%** (2025) **91.0%** (2024)
Child and adolescent well care between ages 3 and 19 who had at least one comprehensive well-care visit with a primary care physician or OB/GYN practitioner during the measurement year. ↑	**58.9%** (2024)	**57.6%** (2025) **56.2%** (2024)
Women ages 50 through 74 who had at least one mammogram to screen for breast cancer in the past two years. ↑	**74.5%** (2024)	**76.3%** (2025) **76.0%** (2024)
Women ages 21 through 64 who were screened for cervical cancer using either of the following criteria: • Women ages 21 through 64 who had cervical cytology performed every three years. • Women ages 30 through 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years. ↑	**70.5%** (2024)	**68.5%** (2025) **67.8%** (2024)
Adults ages 45 through 75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test; flexible sigmoidoscopy every five years; colonoscopy every 10 years; computed tomography colonography every five years; or stool DNA test every three years. ↑	**59.4%** (2024)	**65.9%** (2025) **63.5%** (2024)
Adolescent females ages 16 through 20 who were screened unnecessarily for cervical cancer. ↓	**0.4%** (2024)	**0.6%** (2025) **0.6%** (2024)
Adults ages 18 through 75 who had a primary diagnosis of low back pain and did not have an imaging study (plain X-ray, MRI or CT scan) within 28 days of the diagnosis (a higher score indicates better performance). ↑	**73.1%** (2024)	**70.7%** (2025) **70.1%** (2024)

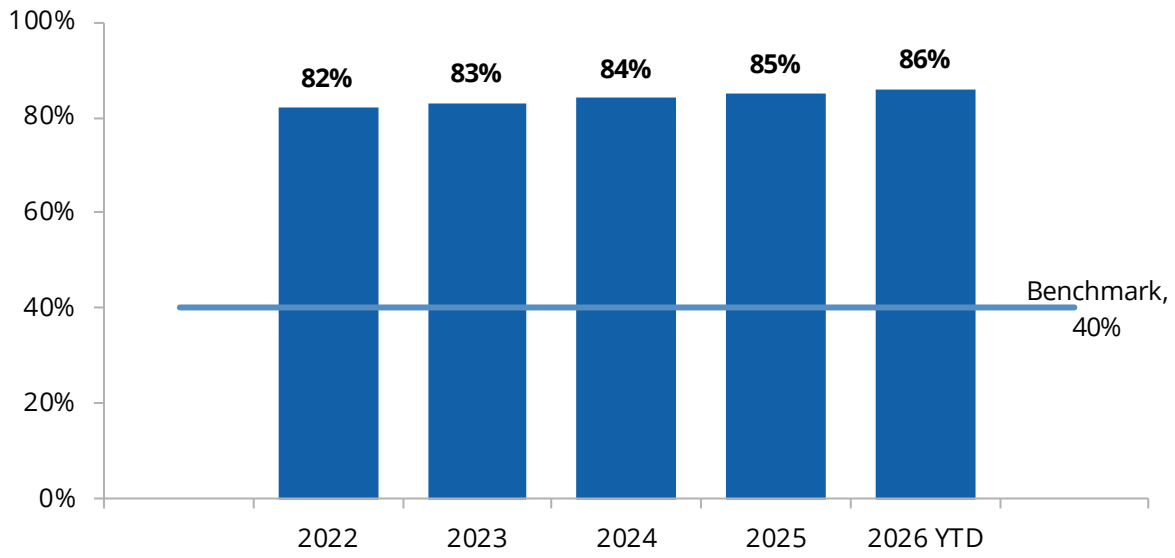
Measures for behavior or services that improve member health outcomes and reduce costs

	Benchmark	State Health Plan
Among opioid users, the percentage of members ages 18 and older who receive prescription opioids at a high dosage for greater than or equal to 15 days during the measurement year (average morphine equivalent dose [MED] greater than 90 mg). ↓	**3.6%** (2024)	**3.8%** (2025) **3.8%** (2024)
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses, who had a follow-up visit with a mental health provider within 7 days and within 30 days. ↑ ↑	Within 7 days: **49.0%** (2024) Within 30 days: **70.5%** (2024)	Within 7 days: **40.4%** (2025) **40.8%** (2024) Within 30 days: **71.2%** (2025) **67.5%** (2024)
Adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications, acute and continuation. ↑ ↑	Acute: **80.0%** (2024) Continuation: **65.0%** (2024)	Acute: **77.6%** (2025) **77.1%** (2024) Continuation: **61.4%** (2025) **59.2%** (2024)
Children 2 years of age who had their Combo 3 vaccines: four DTaP, three polio (IPV), one MMR, three haemophilus influenza type B (HiB), three hepatitis B (HepB), one chicken pox (VZV), and four pneumococcal conjugate (PCV) by their second birthday. ↑	**64.1%** (2024)	**87.1%** (2025) **85.6%** (2024)
Adolescents 13 years of age who had their Combo 2 vaccines: one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. ↑	**29.4%** (2024)	**31.6%** (2025) **29.8%** (2024)

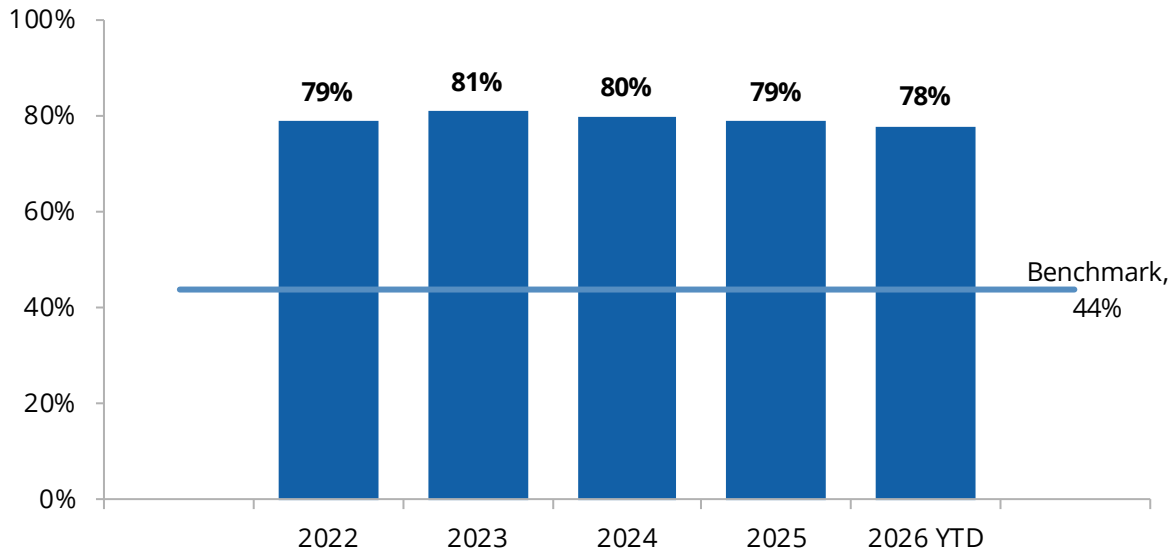
Enrollment in Dental Plus compared to industry benchmark



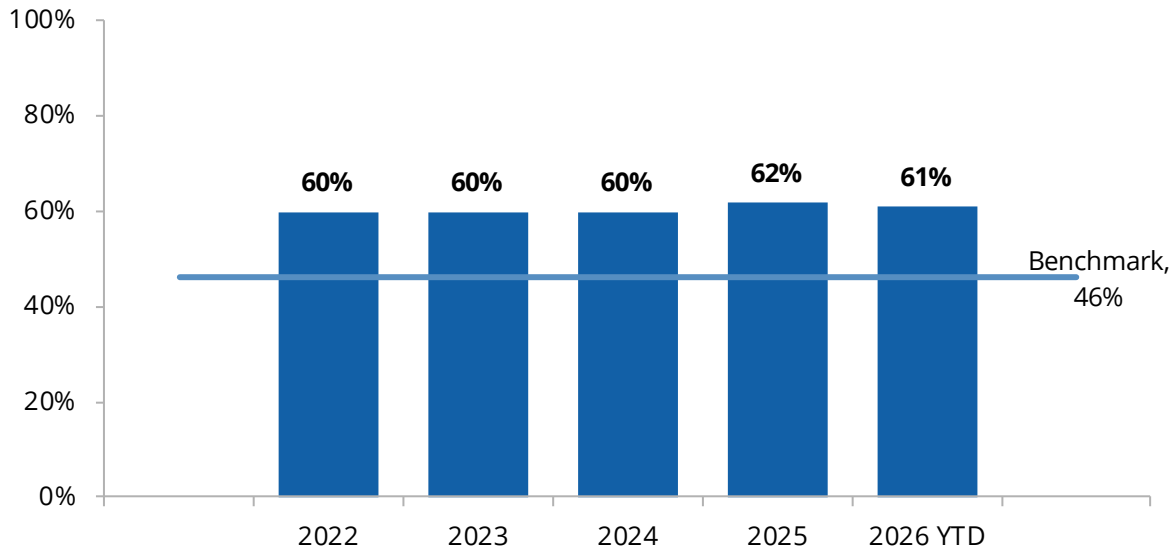
Enrollment in State Vision Plan compared to industry benchmark



Enrollment in Optional Life compared to industry benchmark



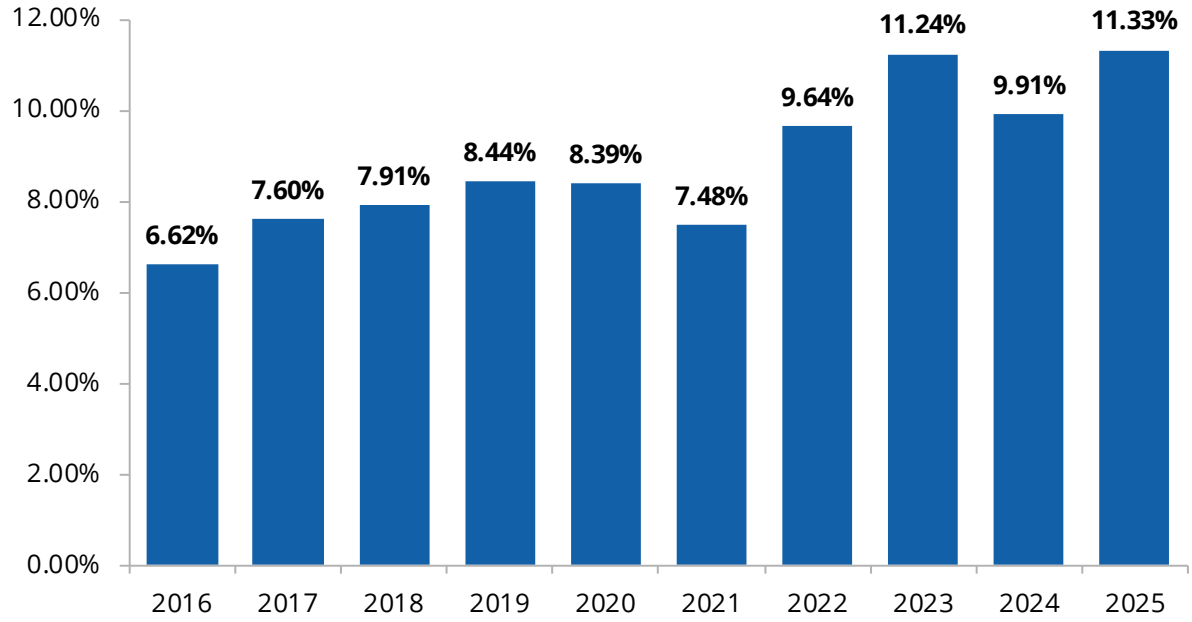
Enrollment in Supplemental Long Term Disability compared to industry benchmark



Benchmark provided by Understanding Voluntary Participation Rates, Eastbridge Consulting Group, Inc., 2024 for groups with 10,000 or more lives.

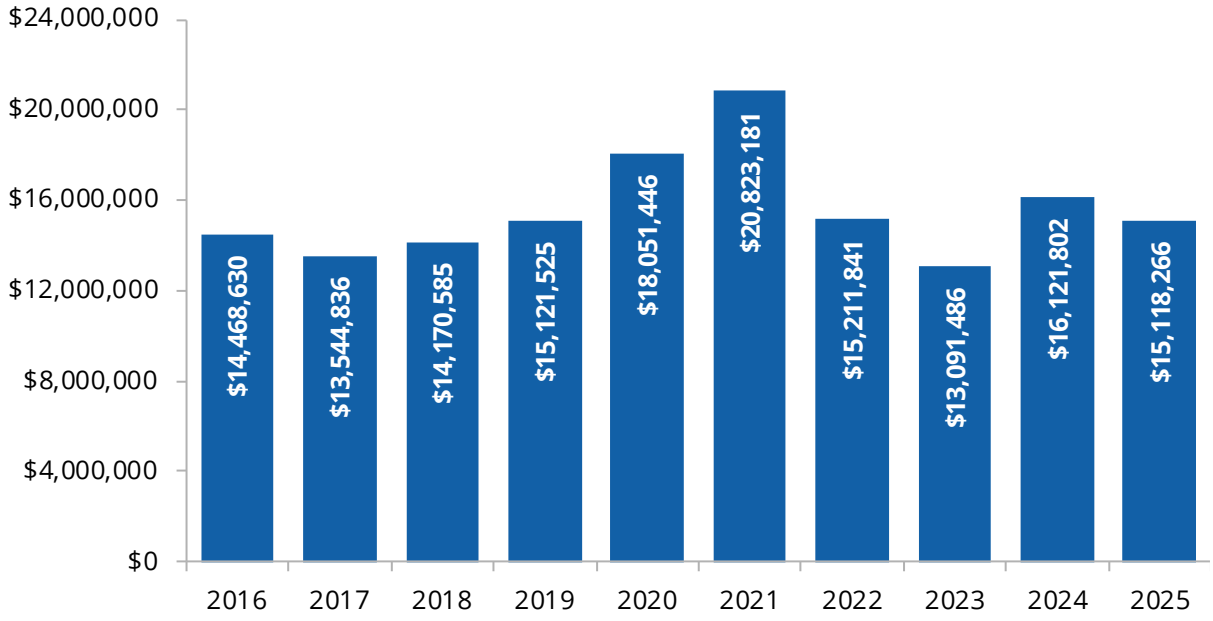
OPEB funded ratio as of June 30[1]

Actuarial assets as a percentage of actuarial accrued liabilities



OPEB unfunded accrued liabilities as of June 30[1]

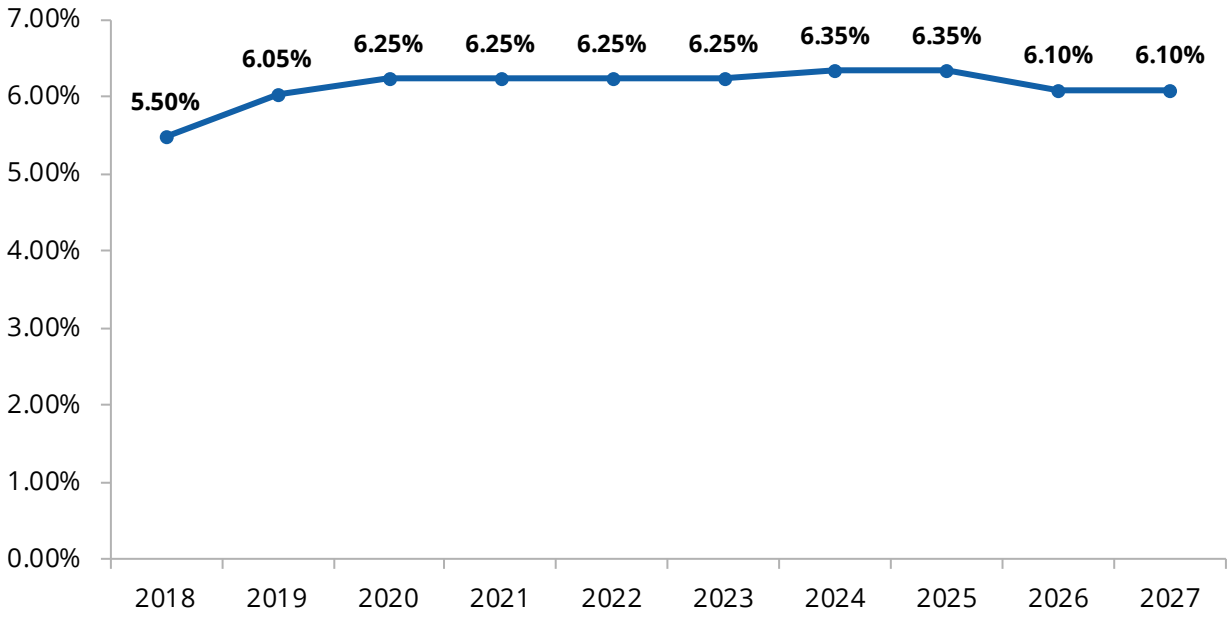
Amounts expressed in thousands



[1]*There was a change in methodology in 2016 due to GASB standards changes.*

Historical employer surcharge to fund retiree insurance by fiscal year

The employer retiree insurance surcharge collects employer contributions on behalf of retirees. The surcharge is the total amount of employer contributions divided by agency and school district payroll.



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202 Arbor Lake Drive | Columbia, SC 29223

803.737.6800 | 888.260.9430

peba.sc.gov

SCPEBA 082026
Data classification: public information

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
Health Care Policy Committee

Meeting Date: August 5, 2026

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1. **Subject**: Value-based programs update

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2. Summary*:* In recent years, health plans in large measure have sought to replace traditional fee-for-service payment with value-based payment. Value-based payment may be generally defined as allowing at least some portion of fees to be determined according to care quality and patient outcomes, rather than solely service volume. Ms. Heather Kirby, PEBA's Analytics and Planning Director, will present the current status of value-based care and prospects for future growth and development.

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

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4. **Supporting Documents:**
   A. Health initiatives and value-based benefits annual review

PEBA
SC Retirement Systems and State Health Plan

Health initiatives and value-based benefits annual review

State Health Plan
August 2026

Serving those who serve South Carolina

Table of Contents

Executive summary

Throughout 2025, the State Health Plan furthered its mission to enhance member health outcomes by evaluating engagement in value-based initiatives and leveraging targeted promotion and communications strategies. Key highlights include:

Chronic conditions

- Prevalence of chronic conditions in the State Health Plan is considerable but not disproportionate to state and national prevalence rates for adults ages 18–64. Prevalence of chronic conditions for adults ages 65 and older exceeds state and national prevalence rates. Forty percent of State Health Plan primary adults and nearly 85% of Medicare primary adults have high blood pressure, high cholesterol or diabetes.
- **No-Pay Copay** saved members $1.2 million in 2025 on copayments for medications for chronic conditions. Qualification activities for No-Pay Copay have been streamlined for 2027.
- **Hello Heart** continues to experience strong engagement, averaging 4,600 new enrollments per month in 2025. Within the first 12 months of program engagement, Hello Heart participants with cardiovascular disease showed fewer emergency room visits and hospital admissions and greater use of lower-cost outpatient visits, primary care services and medication adherence.
- **Virta** participants who remained active for a full year saw sustained improvements: HbA1c levels dropped by an average of 1.19 points, weight decreased by 7.3% and one-third of diabetes medications were eliminated.
- **Wondr Health** helped 53% of participants achieve meaningful weight loss (≥3%) in 2025 and participation in WondrUp for continued support after the initial 12-week program steadily increased. Wondr started offering AI-enabled digital coaching in 2026.

Behavioral health

- The need for behavioral health services remains substantial. Nearly one in three Plan adults and one in five children had a mental health-related medical claim in 2025.
- **Meru Health** reduced depression severity by 32 percentage points and anxiety severity by 39 percentage points in 2025. With the 2025 expansion to include young teens, the share of participants under age 25 has increased by 4.2 percentage points.
- The State Health Plan has experienced increased utilization across all virtual behavioral health care options. The No Obsessive-Compulsive Disorder (**NOCD**) program saw an 85% increase from 2024 to 2025.

Prevention and early detection

- While worksite preventive screening events have stabilized, the scheduling of regional screening events has increased. Approximately 45% of screening data was shared in 2025.
- Preventive screenings and immunizations are improving but remain below benchmarks in some areas.
- Colorectal cancer screening rates and mammogram rates continue to exceed national benchmarks. Approximately 86% of screened individuals received a gold-standard colonoscopy in 2025.

- Well child visit rates for children ages 0–30 months continue to surpass national benchmarks, with 89% completing all recommended visits in 2025.
- While national vaccination benchmarks have declined—and State Health Plan rates have dipped slightly—the State Health Plan still outperforms national standards for both childhood and adolescent immunizations.
- Flu and shingles vaccination rates for adults ages 66 years and older significantly surpass national benchmarks.
- New campaigns were launched earlier in 2026 to close care gaps in cancer screenings and well child visits.

Maternal health

- The State Health Plan has maintained approximately 4,300 annual deliveries.
- Enrollment in **Coming Attractions** increased 4.2% from 2024 to 2025 following a maternal health campaign focused on boosting engagement and highlighting available benefits during and post-pregnancy. The Plan also saw notable growth in breast pump utilization and enrollment in the **Moms** behavioral health management program.
- The rate of recommended vaccinations among members delivering in 2025 surpassed national benchmarks.

Patient-centered medical home

- With nearly 700 practices engaged in the PCMH program, member utilization continues to rise even after the patient incentive ended in 2025. Shared savings payments totaled $6.3 million in 2025, a 66% increase over 2024. The Plan continues collaborating with partners to evaluate how PCMH can best support value-based care.

Evidence-based medicine

- **Active Health** was awarded the evidence-based medicine contract effective May 1, 2026, and will continue delivering high value to the Plan by supporting providers in closing gaps in care using clinical guidelines.
- Approximately 70% of providers received their care considerations through their electronic medical record in 2025.
- Active Health incorporated customized language promoting the Plan's tobacco cessation programs into relevant care considerations in 2025.
- The Plan saw a 6% increase in savings from 2024 to 2025.
- In 2026, the Plan has asked Active Health and BlueCross BlueShield of South Carolina, our third-party claims administrator, to work together on strategies to close additional gaps in care.

Dental and vision care

- Oral and vision care continue to be important focus areas, especially for members managing chronic conditions.
- More than 70% of children enrolled in a dental plan received a dental cleaning, and just over half of adults enrolled in a dental plan received a cleaning. The State Health Plan continues to perform well above national benchmarks for oral and dental care for children.

- In 2026, PEBA launched BlueSmiles, a mobile dental program that brings routine dental services directly to worksites, and Firstgrin, early dental care kits for babies and toddlers. We will evaluate the impact of these programs on access to dental care and dental utilization in 2027.
- Utilization of the vision plan remains consistent with just over a third of enrolled adults and a fourth of enrolled children receiving an eye exam in 2025. It should be noted that many children receive a vision screening at their well child visit or at school.
- In 2026, PEBA incorporated care considerations and gaps in care campaigns for recommended dental visits and eye exams for members with diabetes or hypertension.

HEDIS

- Overall, the Plan continues to outperform national benchmarks for preventive care, screenings and immunizations. In areas where performance remains just below national benchmarks, rates have improved and are now approaching national levels. By assessing member engagement and analyzing the outcomes of our initiatives, staff will identify the most effective strategies to further enhance PEBA's performance.

Program performance

PEBA's Health Initiatives unit provides programs and services designed to enable covered State Health Plan members to lead healthier lives. The unit's focus is disease prevention, early detection of disease and disease management. From preventive worksite screenings to health management programs and beyond, Health Initiatives coordinates a variety of resources to promote health within the workplace. In recent years, efforts have been made toward removing the financial hurdles of many value-based benefits and programs for State Health Plan members. To promote these benefits, PEBA collaborates with BlueCross BlueShield of South Carolina (BlueCross) to create the PEBA Health Hub, an online resource that provides employers with turnkey toolkits they can share with employees.

The Health Initiatives unit uses rates from the Healthcare Effectiveness Data and Information Set (HEDIS) to measure State Health Plan performance for several of the programs and services offered to members.

HEDIS is one of the most widely used sets of health care performance measures in the United States. The term HEDIS originated in the late 1980s and was entrusted to the National Committee for Quality Assurance (NCQA) in the early 1990s. NCQA has expanded the size and scope of HEDIS to include measures for physicians, Accountable Care Organizations, and other organizations. HEDIS 2024 includes more than 90 measures across six domains of care:

1. Effectiveness of Care
2. Access/Availability of Care
3. Experience of Care
4. Utilization and Risk Adjusted Utilization
5. Health Plan Descriptive Information
6. Measures Reported Using Electronic Clinical Data Systems[1]

The measures reported in this document are uncertified, unaudited health plan HEDIS rates. The green and red arrows in this document indicate State Health Plan performance. The direction of the arrow indicates the desired outcome (whether better performance is defined as being a higher or lower number). The color indicates if the State Health Plan performed better than the HEDIS measure (green) or below the HEDIS measure (red).

[1] *Information taken directly from NCQA website: https://www.ncqa.org/hedis*

Value-based services chronology

1989

Established Mammography Testing Program for employees only.

1991

Expanded Mammography Testing Program to provide routine mammograms for female employees and retirees and their eligible dependents ages 35 to 74 at no member cost.

Began covering the cost of the lab work associated with a Pap test each calendar year at no member cost.

1996

Added coverage for well child visits and immunizations.

1998

Began offering preventive screenings for a $10 copayment to active employees.

2001

Increased copayment to $15 for preventive biometric screenings.

2002

Added coverage for birth control for members and spouses with member cost sharing.

2004

Began offering preventive screenings for State Health Plan primary retirees.

2006

Began offering a tobacco use treatment program, Free & Clear Quit for Life, at no cost to eligible members.

Contracted with Active Health to provide evidence-based medicine promotion using claims data analysis for the State Health Plan. The contractor applies the latest evidence-based clinical research and guidelines to Plan members' medical (including laboratory claims) and prescription drug claims data with the purpose of communicating specific and timely treatment improvement recommendations to health care providers that will improve quality of care for members, identify gaps and errors in care and reduce aggregate costs.

2008

Began covering routine colonoscopies for members ages 50 and older with member cost sharing.

Began covering Zostavax shingles vaccine for members ages 60 and older with member cost sharing.

Began offering preventive screenings for covered State Health Plan primary spouses.

2011

Established the No-Pay Copay program, through which State Health Plan primary members who have high blood pressure, high cholesterol, congestive heart failure, cardiovascular disease, coronary artery disease or diabetes can qualify for a copayment waiver for generic drugs that treat these conditions. All diabetic supplies are brand names, but the Plan applied the generic copay to them because they were typically low cost. This classification made diabetic supplies eligible for the No-Pay Copay.

Launched the Birth Outcomes Initiative (BOI) in July as a public/private collaboration with the goal of reducing the state's high preterm birth and NICU utilization rates. The first BOI initiative was to end payments for elective inductions prior to 39 weeks gestation. The focus was the implementation of Centering Pregnancy and Screening, Brief Intervention and Referral to Treatment (SBIRT). Centering Pregnancy is a group model for prenatal care that targets low risk mothers and has demonstrated reductions in preterm deliveries. SBIRT is an approach to intervention and treatment for pregnant women who have substance abuse disorders, depression or anxiety, or who are at risk for developing these conditions.

2015

Began offering preventive screenings with no member cost to eligible subscribers and spouses.

Began covering Zostavax shingles vaccine with no member cost for members ages 60 and older.

Began coverage of diabetes education with certified diabetes educators with member cost sharing.

Extended coverage of flu vaccine to Standard Plan members with member cost sharing.

2016

Began offering Moms program for women diagnosed with behavioral health needs during pregnancy through those who are two years' postpartum, as well as women who lost a pregnancy.

Began coverage of CDC-recommended adult immunizations, including flu vaccine, at no member cost.

Removed member cost for both diagnostic and routine colonoscopies, as well as the consultation, generic prep kit and anesthesia.

Removed member cost for diabetes education with certified diabetes educators.

Removed member cost for birth control for subscribers and covered spouses.

Removed member cost for tobacco cessation prescription drug products.

Removed $12 office visit copayment and reduced Savings Plan and Standard Plan coinsurance to 10% for care received at a BlueCross-affiliated patient-centered medical home.

2017

Began providing manual and electric breast pumps and lactation counseling received from a participating provider at no cost to eligible subscribers and covered spouses.

Began offering telehealth services through Blue CareOnDemand. A visit is covered as a traditional office visit.

Began offering Rally Health, a digital wellness platform (full implementation April 1) through BlueCross.

Added HPV test coverage every five years at no member cost in conjunction with a Pap test screening per United States Preventive Services Task Force (USPSTF) recommendations.

Added fecal immunochemical test (FIT) and fecal occult blood test (FOBT) at no member cost to the colorectal cancer screening benefit.

Began covering Shingrix shingles vaccine at no member cost for members ages 50 and older in December (CDC updated recommended age based on new vaccine).

2018

Blue CareOnDemand began offering breastfeeding lactation support, as well as behavioral health counseling, care and medication management, at no member cost.

Began offering the Naturally Slim program at no cost to members.

2019

Transitioned to Express Scripts' Preferred90 Network for members enrolled in Express Scripts Medicare.

Added adult well visits coverage, subject to copayments, deductibles and coinsurance in covered years.

Added site-of-care program, through which State Health Plan primary members who are receiving specialty drugs at a higher cost site of service, such as an outpatient hospital setting, are moved to an equally appropriate but less costly site of service, such as an infusion center or home.

2020

Beginning March 17, made special provisions regarding telehealth services for network providers credentialed by BlueCross in response to the COVID-19 pandemic. These special provisions were monitored and extended as needed.

Began covering administration of COVID-19 vaccines at no member cost.

2021

Effective May 1, normal plan provisions regarding telehealth services resumed.

Began offering BioIQ, an at-home colorectal cancer screening program for members older than 55 who have not had a recent colorectal cancer screening, at no cost to members.

Began offering Meru Health, a 12-week mental health treatment program designed to reduce anxiety, stress, depression and burnout.

Naturally Slim rebranded as Wondr Health.

Began offering No Obsessive-Compulsive Disorder program, an online therapy program designed to reduce OCD severity and comorbid anxiety and depression.

2023

Strive replaced Rally as the platform eligible members use to qualify for the No-Pay Copay.

In February, began offering Hello Heart, a digital-based program focused on managing hypertension.

In March, began offering Virta, an evidence-based program focused on safely and sustainably reversing Type 2 diabetes without medications or surgery.

In May, began offering Youturn, a substance use disorder peer recovery support service for members and their families.

The COVID-19 pandemic ended May 11. The Plan began covering the cost of the vaccine after the federally-funded vaccines were exhausted.

BioIQ rebranded as LetsGetChecked.

In November, began offering Within Health, which offers intensive outpatient and partial hospitalization treatment programs for eating disorders.

2024

In April, began offering Bend Health, a network of virtual providers that work with families with children, adolescents and young adults up to 25 to address mental illness and substance use.

In April, began offering Equip, a virtual treatment for all eating disorder diagnoses.

2025

Strive rebranded as Personify Health.

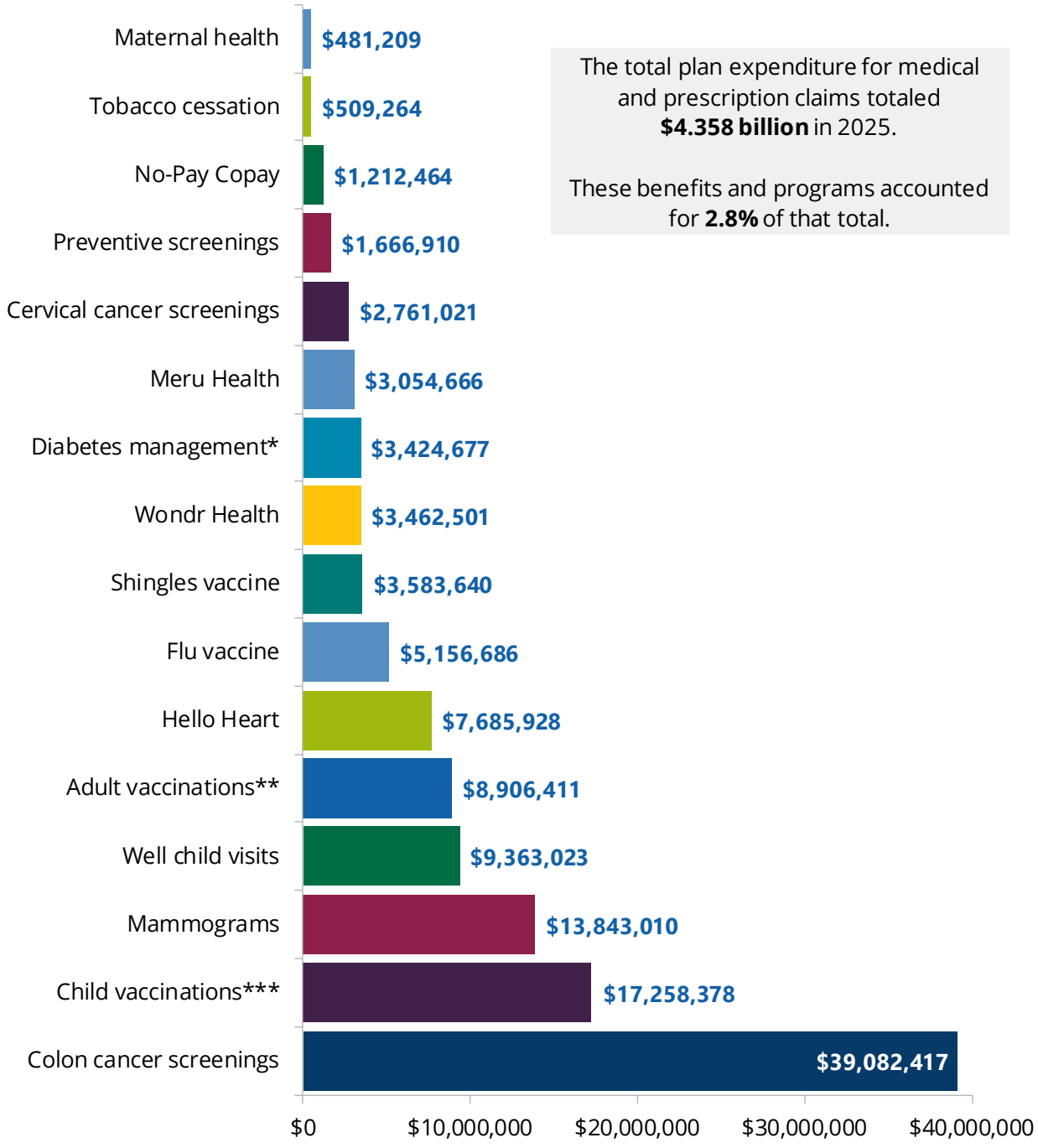
2026

Everlywell replaced LetsGetChecked as the vendor for the at-home colorectal cancer screening program.

Expanded breast cancer screening, including biopsy, MRI, surgical pathology and ultrasound, with no member cost share.

Plan spending for value-based benefits and programs

Incurred 2025, paid through March 2026



The total plan expenditure for medical and prescription claims totaled **$4.358 billion** in 2025.

These benefits and programs accounted for **2.8%** of that total.

Includes plan spending for Virta and diabetes management.

**Amount does not include flu or shingles vaccinations.*

***Amount does not include flu vaccinations.*

2025 Prevalence of certain chronic conditions in the State Health Plan

	Ages 18–64			Ages 65+			Ages 0-17
Chronic condition	SHP primary adults	South Carolina	United States	SHP Medicare primary adults	South Carolina	United States	SHP dependent children
Diabetes	12.4%	13.9%	12.0%	30.9%	27.6%	24.0%	1.2%
High blood pressure	30.4%	38.8%	34.0%	74.3%	66.4%	65.0%	2.1%
High cholesterol	24.0%	39.3%	36.9%	68.2%	58.4%	66.0%	0.3%
Diabetes or high blood pressure or high cholesterol	39.9%			84.4%			3.5%
Diabetes and high blood pressure and high cholesterol	7.0%			25.5%			0.0%

	Ages 18–64			Ages 65+			Ages 0-17
Behavioral health	SHP primary adults	South Carolina	United States	SHP Medicare primary adults	South Carolina	United States	SHP dependent children
Depression	11.2%	20.7%	22.0%	15.7%	14.4%	17.0%	2.8%
Any mental health diagnosis	30.8%			34.5%			21.7%

State Health Plan prevalence from State Health Plan claims data incurred in 2025.

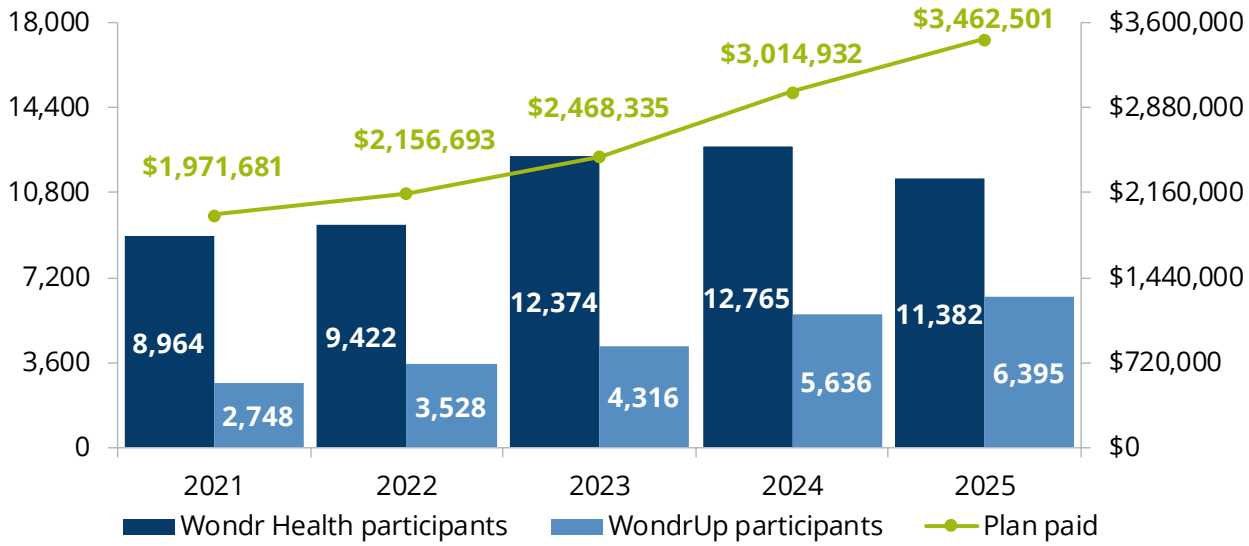
State and national prevalence for ages 18–64 from CDC's Behavioral Risk Factor Surveillance System (BRFSS) for 2025.

State and national prevalence for ages 65+ from CMS's Mapping Medicare Disparities Tool using 2025 Medicare Fee-for-Service administrative claims data.

Digital-based programs

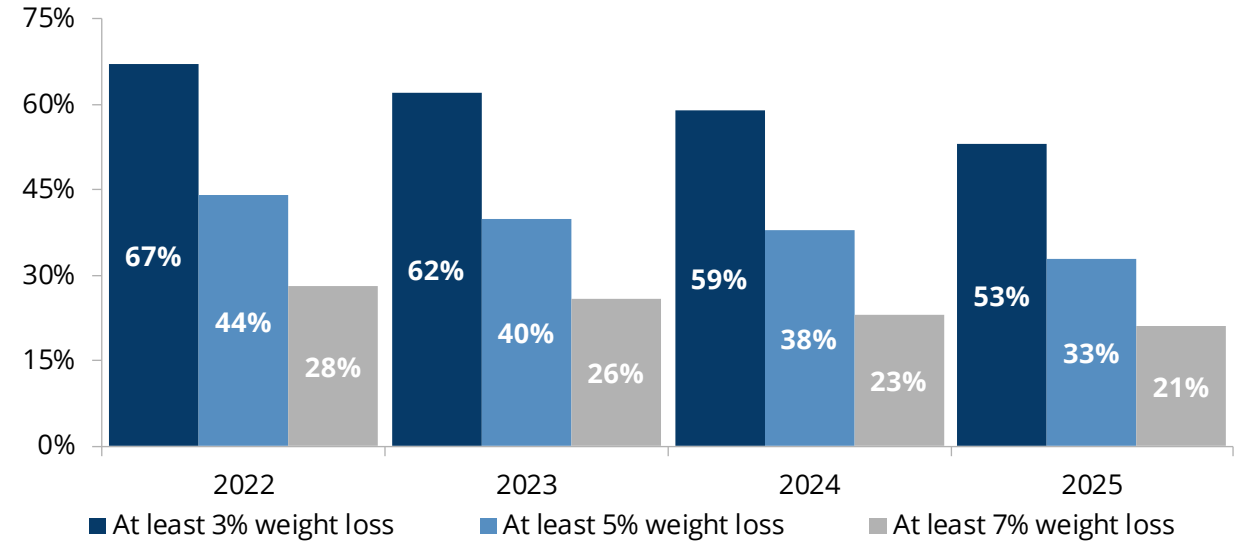
Wondr Health (healthy weight)

2021–2025



Wondr Health is a 12-week, online program that uses weekly video lessons and interactive tools to teach the behavioral skills necessary to lose weight and keep it off long-term. The first quarterly class began in September 2018. Following the first 12 weeks (WondrSkills stage), participants receive seven biweekly sessions and six months of continued support, as needed, through the WondrUp and WondrLast stages.

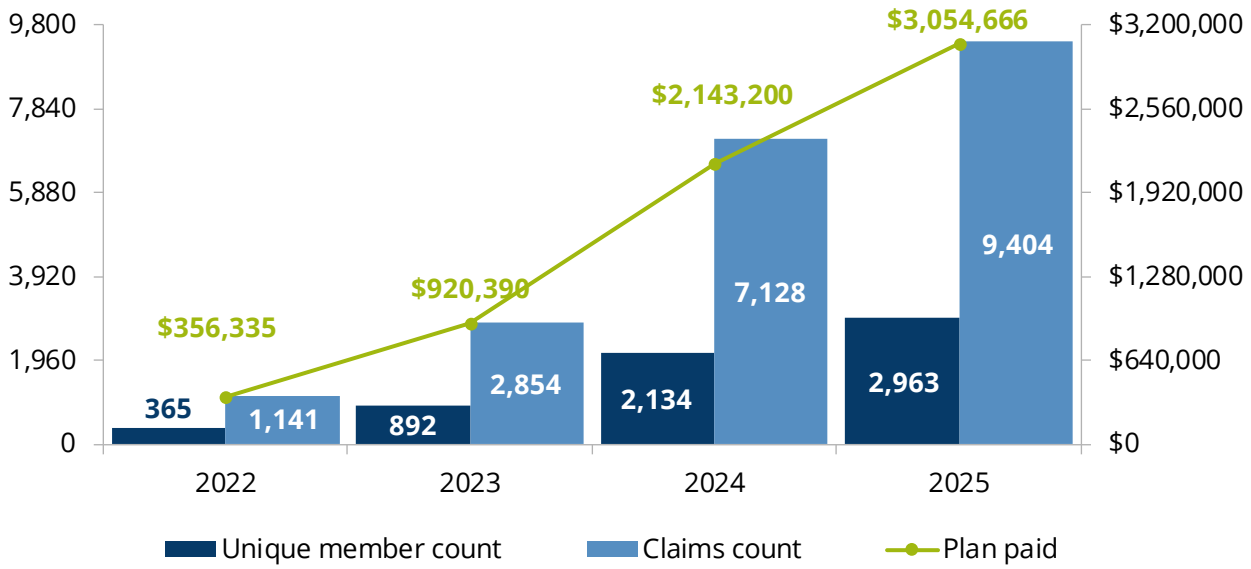
Participants with meaningful weight loss



The data in the chart includes participants with a BMI greater than 25 who met a 3%, 5% or 7% weight loss after at least eight sessions. According to the American Medical Association, sustained weight loss of as little as 3% to 5% is likely to result in clinically meaningful reductions in levels of triglycerides, blood glucose, and glycated hemoglobin and in the risk of developing Type 2 diabetes.

Meru Health (behavioral health management)

2022–2025



Meru Health offers services through a licensed clinical therapist to help treat depression, anxiety and burnout. Members are screened to find an appropriate provider based on questionnaires. The 12-week program is delivered via a smartphone app. This was launched on May 7, 2021, at no member cost for all eligible State Health Plan members. After completing the program, participants will have continued access to the biofeedback device and digital content. Among participants who completed the program in 2025, the treatment reduced moderate to severe depression from 50% to 18%, and it reduced moderate to severe anxiety from 54% to 15%.

Other virtual behavioral health services

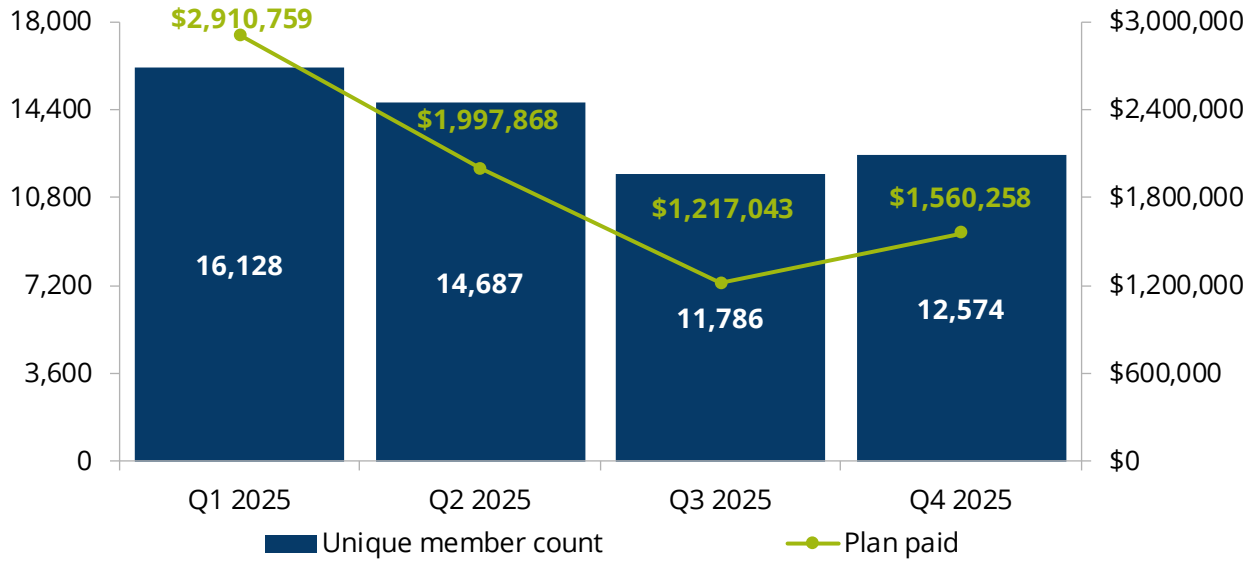
Bend Health treats adolescent mental illness and substance use; No Obsessive-Compulsive Disorder treats OCD; Youturn treats substance use disorder in a peer setting; Equip and Within Health treat eating disorders.

Service	Distinct patient count	Claim count	Plan paid
Bend Health	43	105	$4,656.14
NOCD	167	2,576	$136,019.34
Youturn	22	160	$42,900.00
Equip	21	355	$197,841.22
Within Health	19	168	$477,162.36

HEDIS measure: Diagnosed Mental Health Disorders

Age group	Year	Eligible members	Members diagnosed with any mental health disorder	Percentage
1–17 years	2024	80,158	17,387	21.7%
	2025	82,158	18,847	22.9%
18–39 years	2024	123,558	38,966	31.5%
	2025	127,582	41,861	32.8%
40–64 years	2024	176,685	57,019	32.3%
	2025	178,461	59,734	33.5%
65 years and older	2024	15,274	3,744	24.5%
	2025	16,150	4,013	24.9%
All ages	2024	395,675	117,116	29.6%
	2025	404,351	124,455	30.8%
National prevalence				**26.7%**

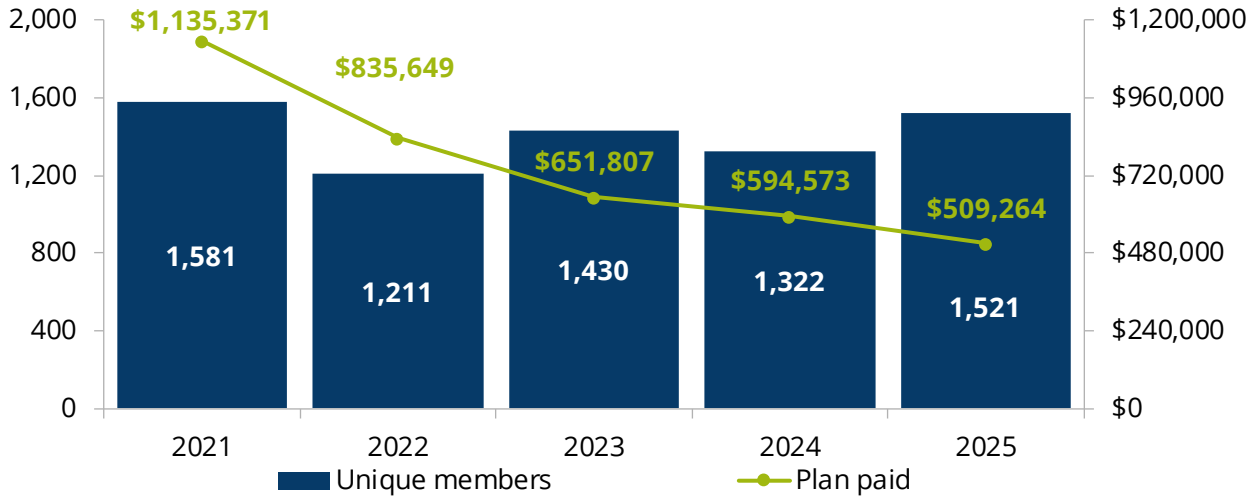
Hello Heart (heart health)



Hello Heart is a digital-based program focused on managing hypertension available to State Health Plan primary members ages 18 to 79. It provides members with tools to track their medication usage and tips on managing their hypertension. The above chart shows new enrollments per quarter.

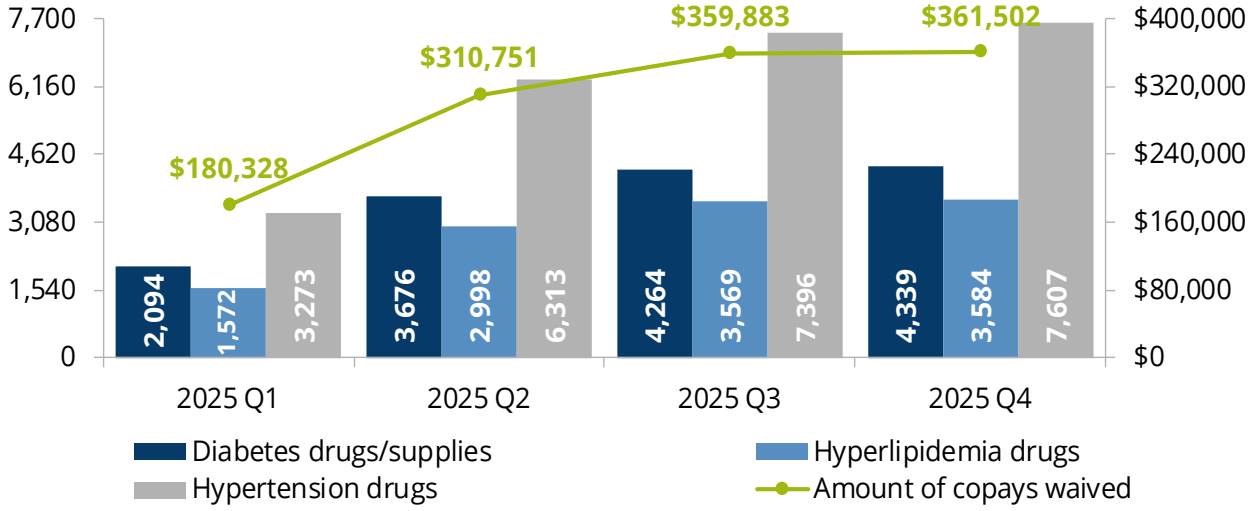
Tobacco cessation

2021–2025



Member count includes those who are enrolled in the Plan's tobacco cessation program, those who are receiving prescription smoking cessation medications and those who fall into both categories. The percentage of unique members who received a tobacco cessation product was 73.4% in 2025.

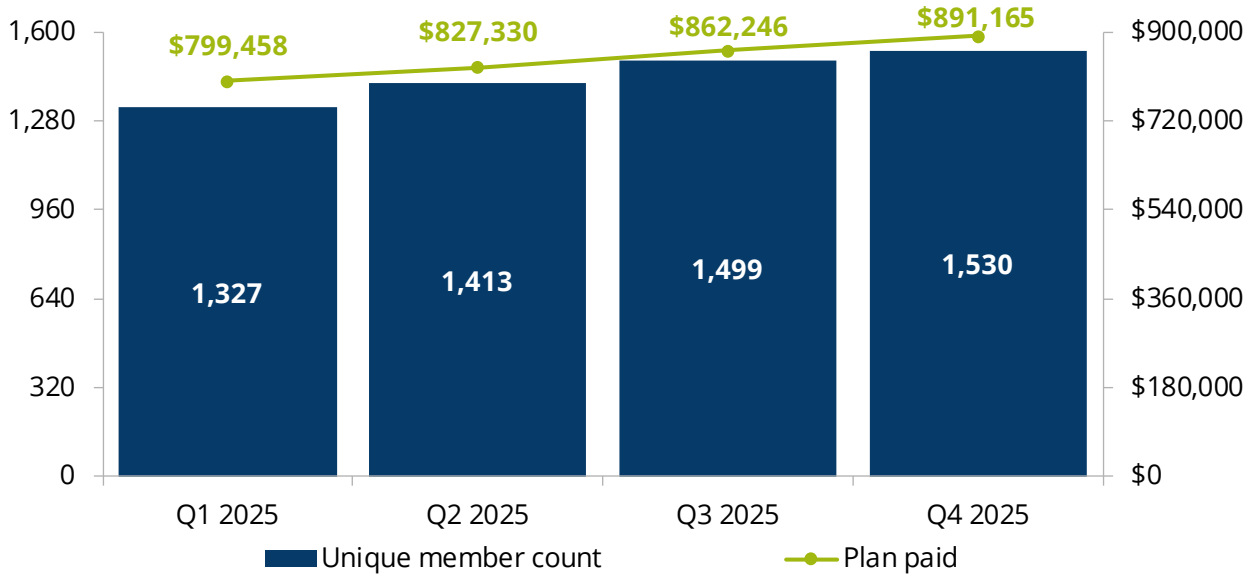
No-Pay Copay (chronic disease management)



Introduced in 2011, the No-Pay Copay program requires members to do annual activities to receive certain generic drugs for certain conditions at a lower or no member cost. Members qualify for the No-Pay Copay using the Personify platform. The total number of unique members who received a prescription drug through the program was 4,656 in 2025, regardless of condition.

Diabetes management

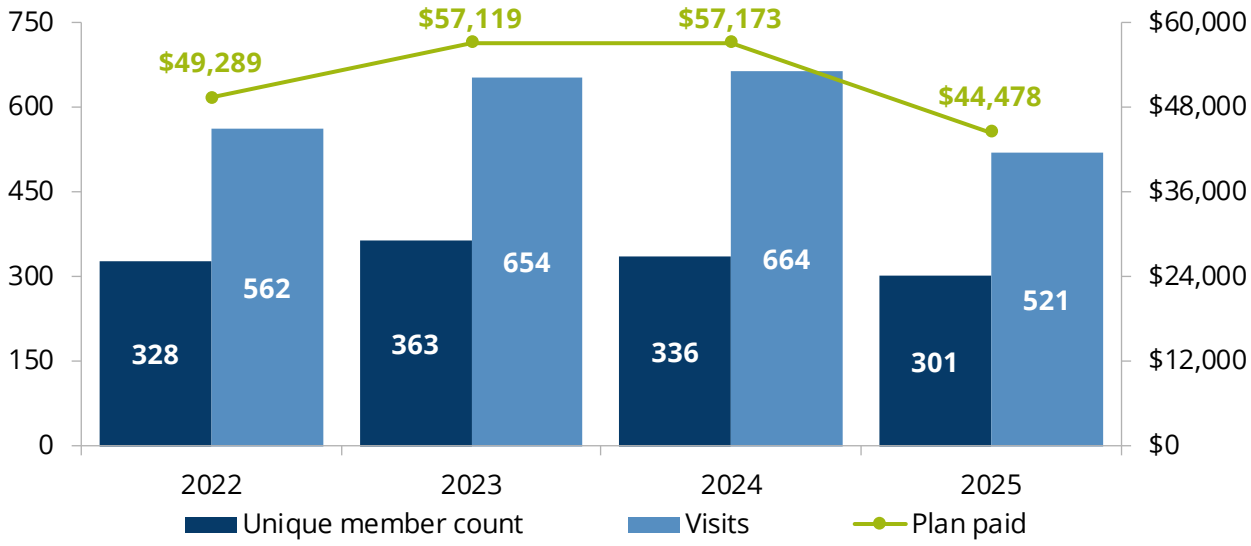
Virta (Type 2 diabetes reversal)



Virta is a medically supervised, research-backed program that can help participants reverse Type 2 diabetes. With Virta, participants can naturally lower and control their average blood sugar (HbA1c) while also reducing or eliminating diabetes medication and losing weight. Virta is offered at no cost to eligible State Health Plan primary members ages 18 and older.

Diabetes education

2022–2025

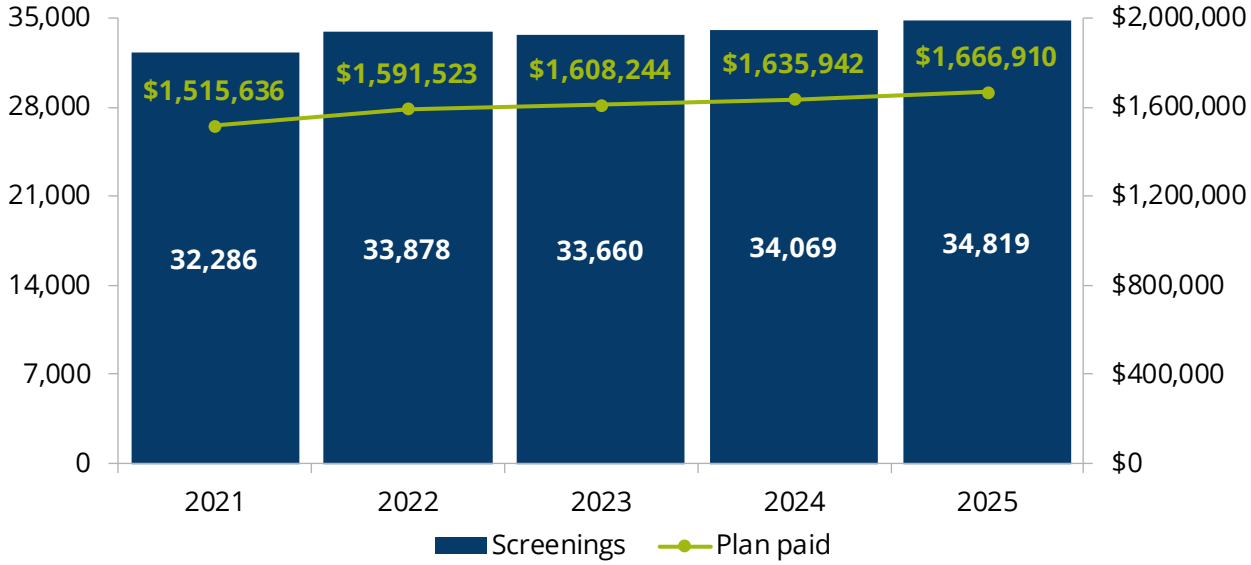


Beginning in 2016, diabetes education services offered by network providers were covered at no cost to State Health Plan primary members.

Screenings and vaccines

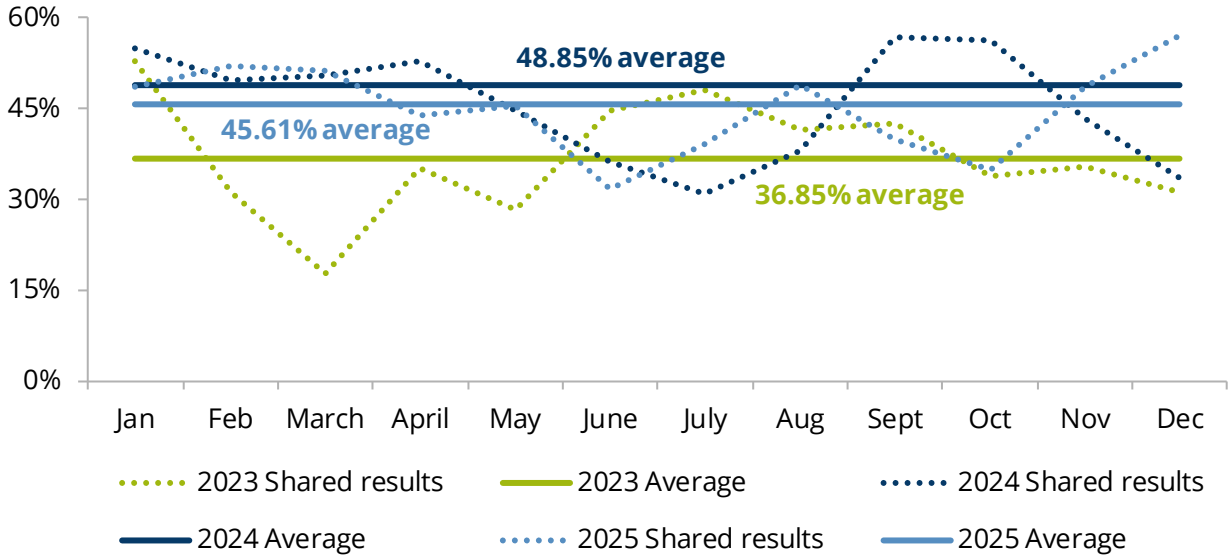
Preventive screenings

2021–2025



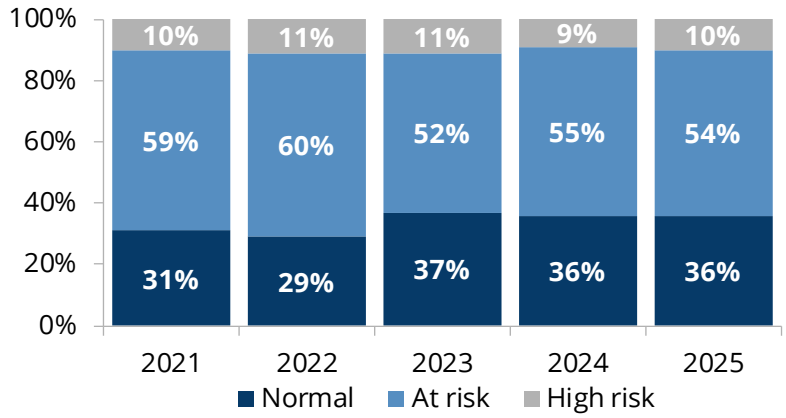
The number of worksite screening events has averaged about 1,000 a year since 2015. For 2025, there were 882 screening events, down from a high of 1,117 in 2019.

Screening data shared | 2023–2025



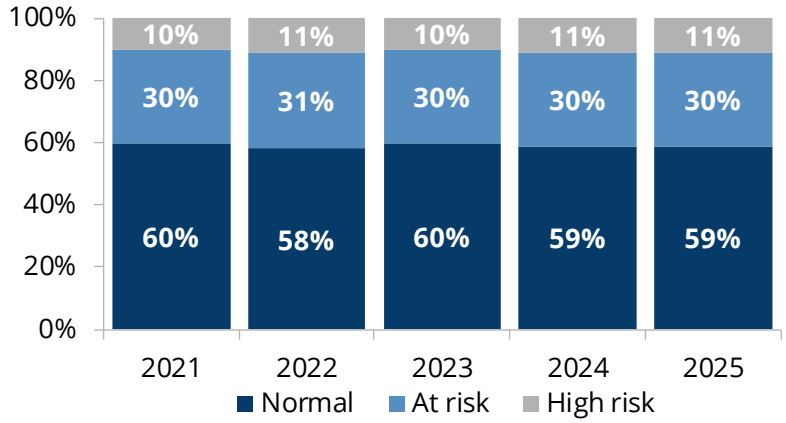
These measures were compiled from results from worksite screening events and biometric screenings completed at walk-in locations.

Blood pressure biometrics | 2021–2025



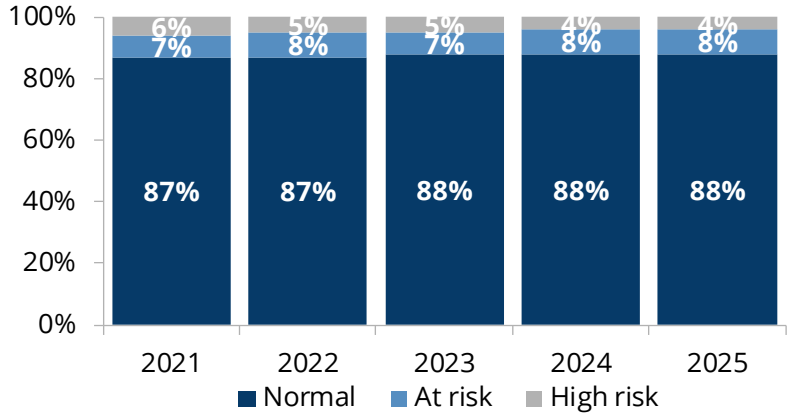
Normal: *blood pressure is in the normal range (SBP<120 and DBP<80)*
At risk: *blood pressure is in the prehypertension range (SBP is 120-139 or DBP is 80-89)*
High risk: *blood pressure is in Stage 1 hypertension (SBP is 140-159 or DBP is 90-99) and Stage 2 hypertension (SBP>=160 or DBP >=100)*

Cholesterol biometrics | 2021–2025



Normal: *cholesterol is in the normal range (<200)*
At risk: *cholesterol is in the borderline range (200-239)*
High risk: *cholesterol is in the high risk range (>=240)*

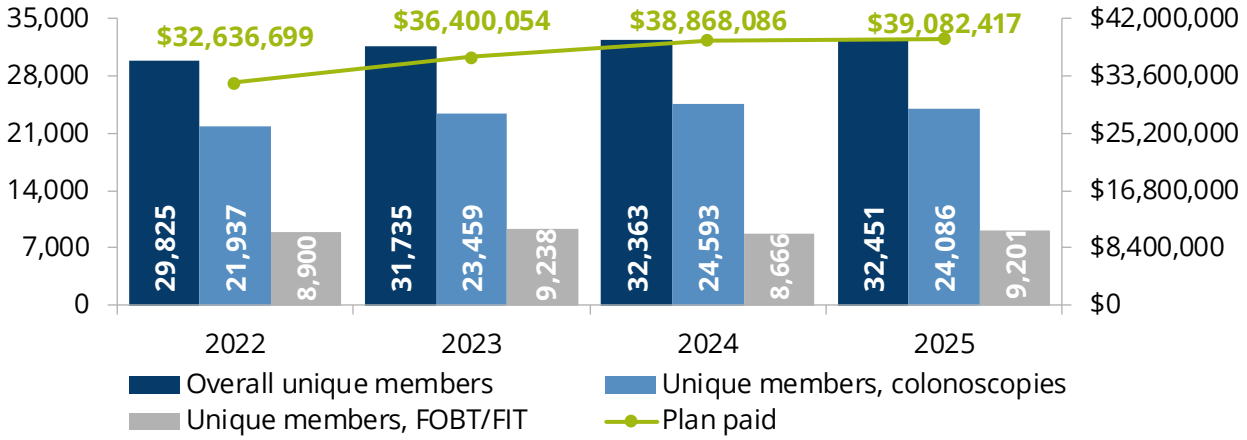
Blood glucose biometrics | 2021–2025



Normal: *blood glucose is in the normal range (<110)*
At risk: *blood glucose is in the borderline range (110-130)*
High risk: *blood glucose is high range (131–199) and immediate follow-up (>=200)*

Colon cancer screenings

2022–2025



In 2025, 65.9% of members ages 46–75 were current for colon cancer screenings. The percentage of members who had a take-home FOBT/FIT test and a follow-up colonoscopy within six months of the test was 8.3% in 2025. The data in the chart reflects unique members who got a colonoscopy or an FOBT/FIT and the overall unique members who got one or both types. LetsGetChecked results are also included. The Plan covers both diagnostic and routine colonoscopies for State Health Plan primary members ages 45 and older at no cost.

LetsGetChecked utilization

LetsGetChecked, formerly the BioIQ program, began in 2021 and is an at-home colorectal cancer screening program for members older than 55 who have not had a recent colorectal cancer screening. Eligible members receive a letter in the mail explaining the program, along with an at-home colorectal cancer screening kit, or FIT test, at no member cost.

Number of kits shipped	Number of kits with results	Number of kits with positive test	Number of members who got a follow-up colonoscopy	Percentage of members who got a follow-up colonoscopy
49,714	6,337	442	291	65.8%

HEDIS measure: Colorectal Cancer Screening (ages 46–75)

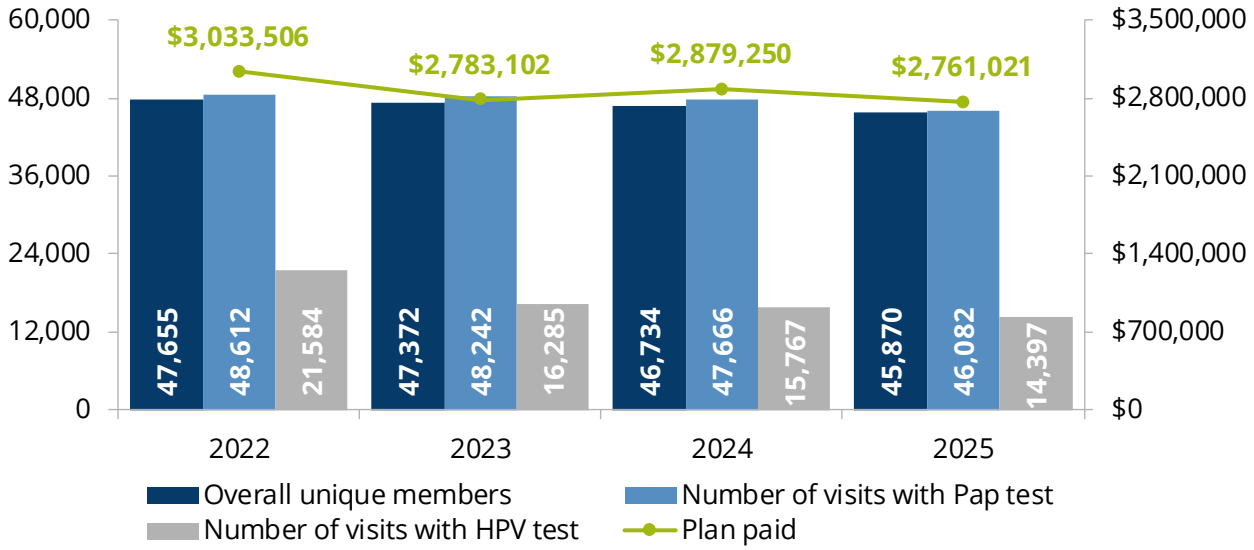
Year	Eligible members	Members screened for colorectal cancer	Screening percentage
2024	140,275	89,061	63.5%
2025	142,812	94,086	65.9%
Benchmark			**59.4%**

Percentage of colonoscopies for all screenings

Year	Screening percentage
2024	87.4%
2025	86.1%

Cervical cancer screenings

2022–2025



In 2025, 68.5% of eligible members were current on cervical cancer screenings. The Plan covers a Pap test yearly for ages 18–65. The data in the chart reflect services paid for ages 21–64, the recommended ages for the screening. The Plan pays a benefit for the HPV test once every five years for ages 30–65 with or without a Pap test.

HEDIS measure: Cervical Cancer Screening

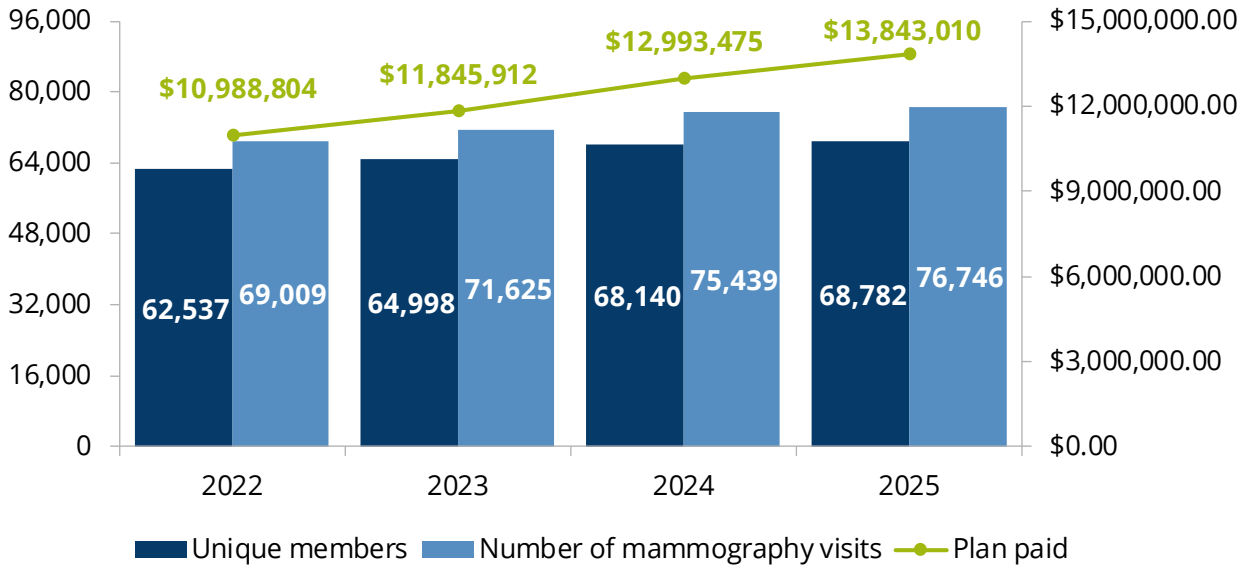
Year	Eligible members	Members screened for cervical cancer	Screening percentage
2024	112,346	76,173	67.8%
2025	114,634	78,558	68.5%
Benchmark			**70.5%**

HEDIS measure: Non-Recommended Cervical Cancer Screening in Adolescent Females (low value)

Year	Number of members	Members screened for cervical cancer	Screening percentage
2024	15,667	93	0.6%
2025	16,077	91	0.6%
Benchmark			**0.4%**

Mammograms (routine and diagnostic)

2022–2025



In 2025, 76.3% of eligible members were current for mammograms. The Plan covers one baseline routine mammogram for women ages 35–39. Women ages 40 and older can receive one routine mammogram each calendar year.

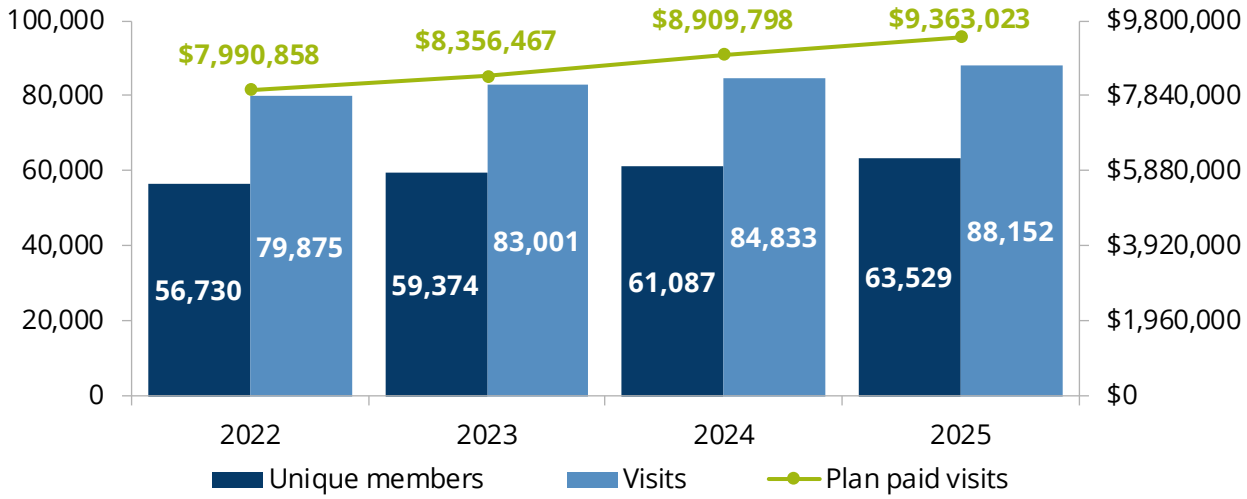
HEDIS measure: Breast Cancer Screening

Year	Eligible members	Members with at least one mammogram	Screening percentage
2024	58,837	44,696	76.0%
2025	59,736	45,588	76.3%
Benchmark			**74.5%**

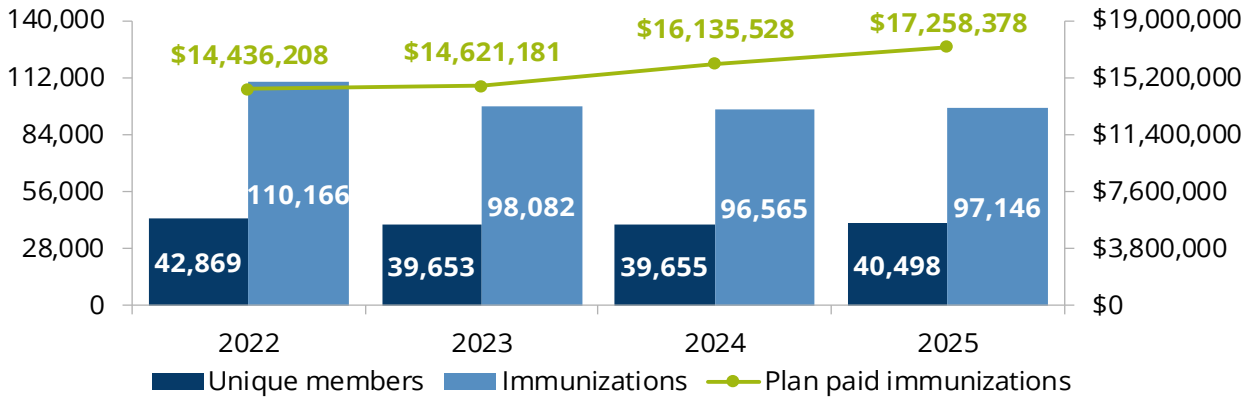
Well child benefit

Covered children are eligible for well child care visits until age 19. This benefit covers well child care exams and immunizations recommended by the Centers for Disease Control. Flu vaccinations are not included in the immunization count.

Well child visits | 2022–2025



Well child immunizations (excludes flu vaccinations) | 2022–2025



HEDIS measure: Well-Child Visits in the First 15 Months

Year	Total members	No visit	One visit	Two visits	Three visits	Four visits	Five visits	Six visits
2024	3,312	0.8%	99.2%	98.4%	97.6%	96.0%	93.1%	85.8%
2025	3,275	1.1%	98.9%	98.1%	97.1%	96.1%	93.7%	86.8%
Benchmark								**81.6%**

HEDIS measure: Well-Child Visits from 15 Months to 30 Months

Year	Total members	No visit	One visit	Two visits
2024	3,494	3.5%	96.5%	91.0%
2025	3,572	3.1%	96.9%	91.9%
Benchmark				**86.5%**

HEDIS measure: Child and Adolescent Well-Care Visits

	Ages 3 to 11		Ages 12 to17		Ages 18 to 19		Ages 3 to 19	
Year	Total members	One visit	Total members	One visit	Total members	One visit	Total members	One visit
2024	38,794	66.0%	34,047	53.6%	12,852	33.7%	85,693	56.2%
2025	39,842	67.1%	34,935	55.2%	13,345	35.7%	88,122	57.6%
Benchmark								**58.9%**

HEDIS measure: Child Immunization Status

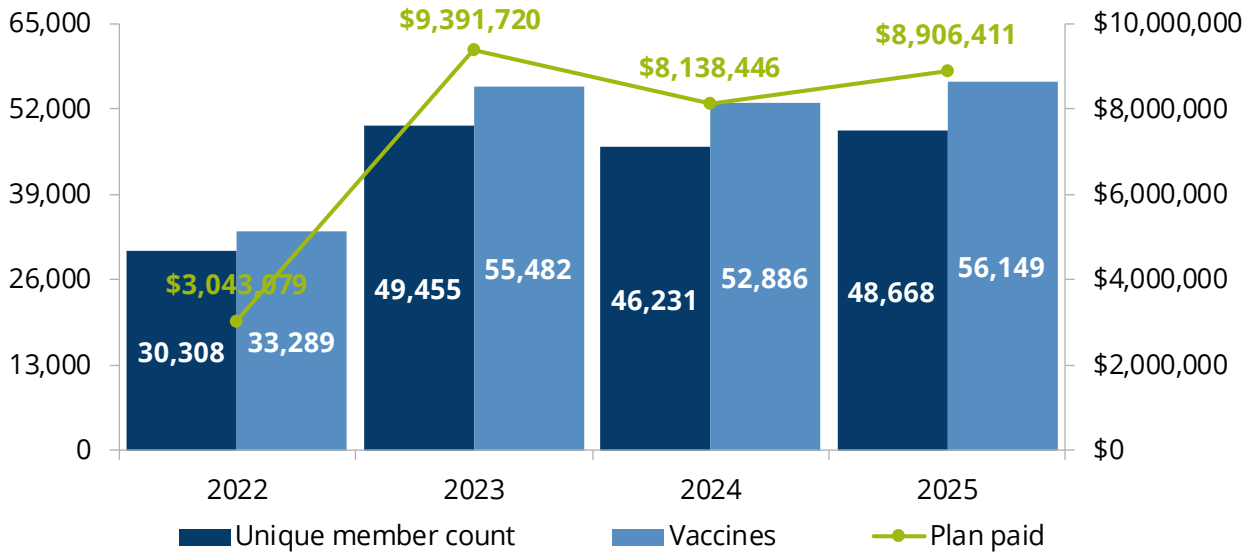
Vaccine	Year	Eligible members	Vaccinated members	Vaccination percentage
Combination 10 (four DTaP, three IPV, one MMR, three HiB, two HepB, one VZV, four PCV, one HepA, three RV and two seasonal flu by their second birthday)	2024	3,056	1,364	44.6%
	2025	3,029	1,278	42.2%
Combination 10 benchmark				**39.3%**

HEDIS measure: Immunizations for Adolescents

Vaccine	Year	Eligible members	Vaccinated members	Vaccination percentage
Adolescent Immunization Combination 2 (MCV4, TDaP/TD, HPV)	2024	3,890	1,160	29.8%
	2025	3,807	1,203	31.6%
Adolescent Combination 2 benchmark				**29.4%**

Adult vaccines (excludes flu and shingles vaccinations)

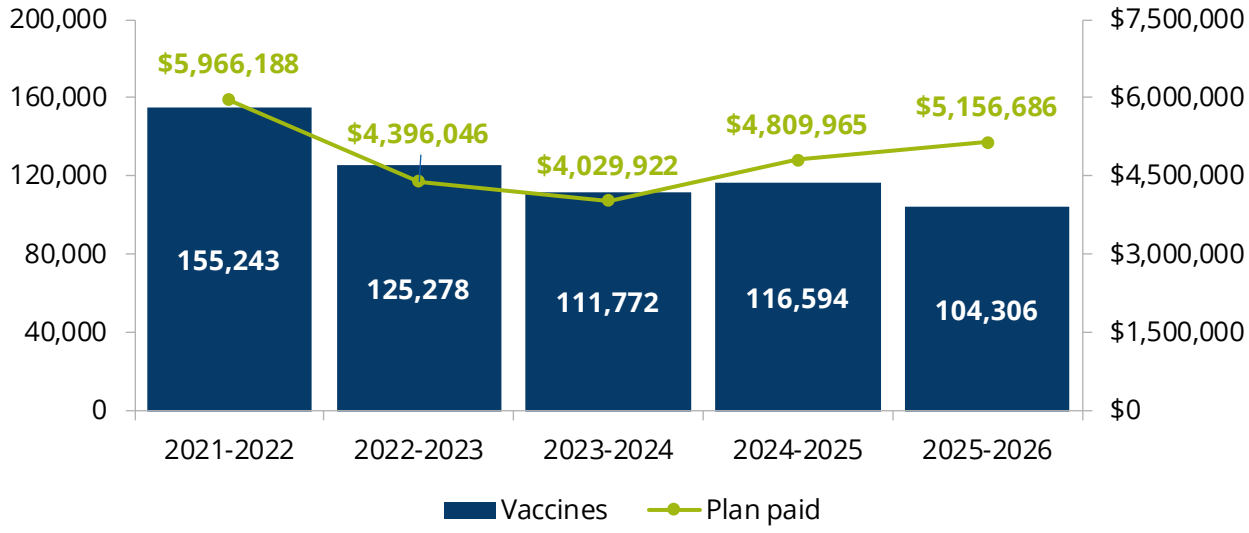
2022–2025



Beginning in 2016, adult vaccinations at the intervals recommended by the Centers for Disease Control were offered at no cost to State Health Plan primary members.

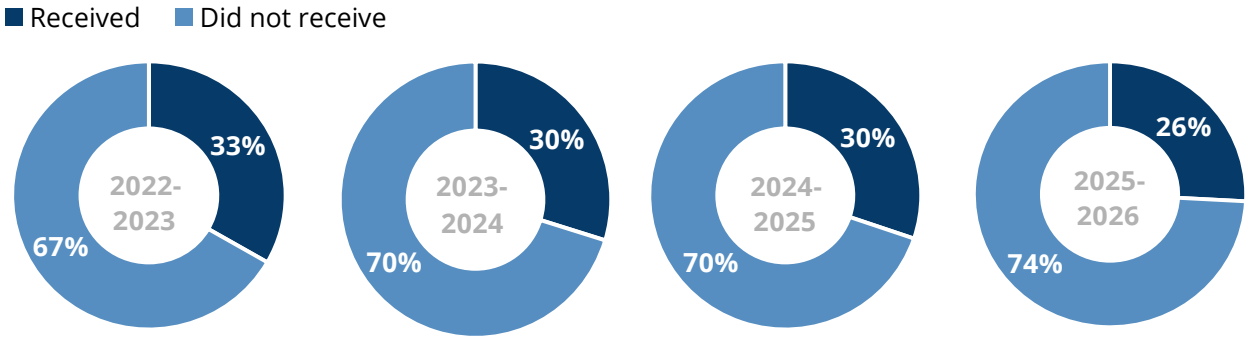
Flu vaccines for adults and children

2021–2026



Adults 19 and older accounted for 81.9% of the flu vaccines during the 2025–2026 season. Flu season is defined as July-June. This chart does not include data from the S.C. Department of Public Health Immunization Registry.

Flu vaccines utilization | 2022–2026



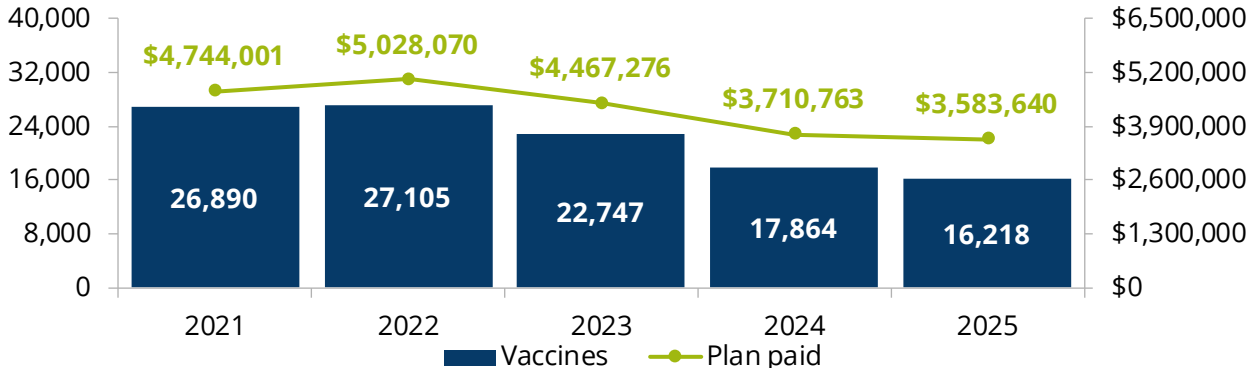
According to medical claims and data from the immunization registry, 25.8% of State Health Plan members received flu vaccines during the 2025–2026 season.

HEDIS measure: Flu vaccinations

	Ages 19 and older		Ages 19–65		Ages 66+	
Year	**Members**	**Vaccinated**	**Members**	**Vaccinated**	**Members**	**Vaccinated**
2024	295,183	26.6%	285,785	25.8%	9,398	50.2%
2025	300,338	26.1%	290,408	25.3%	9,930	48.7%
Benchmark				**23.2%**		**34.9%**

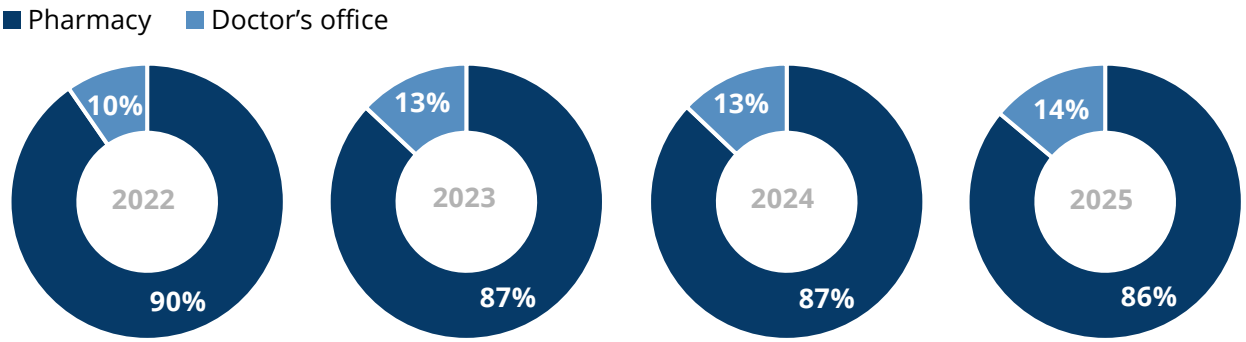
Shingles vaccines

2021–2025



From 2008 to 2014, Zostavax was covered with member cost sharing. Since 2015, it has been covered at no member cost. Shingrix, also covered with no patient liability, became available in December 2017. When Shingrix was released, the CDC lowered the recommended age to get the vaccine from 60 to 50. As a result, more members became eligible for the vaccine, increasing the number of members included in the measure, thereby lowering the percentage of members who were current. Using a two-year lookback period, the percentage of State Health Plan members who received an initial dose of Shingrix and received a follow-up dose was 73.2% in 2025.

Shingles vaccine service providers | 2022–2025



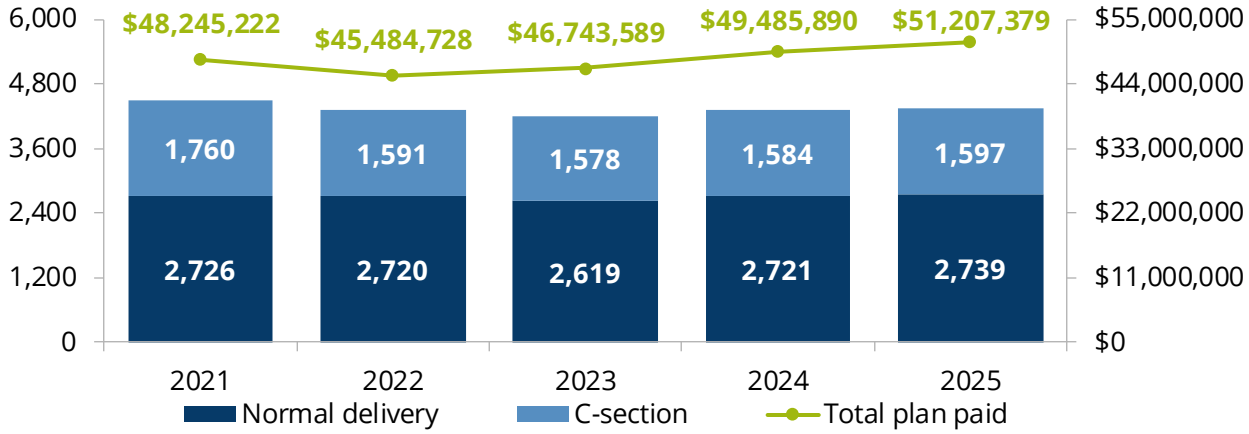
HEDIS measure: Shingles vaccinations

	Ages 50+		Ages 50-65		Ages 66+	
Year	**Members**	**Vaccinated**	**Members**	**Vaccinated**	**Members**	**Vaccinated**
2024	118,590	25.3%	109,361	23.9%	9,229	42.0%
2025	120,174	26.2%	110,351	24.8%	9,823	42.0%
Benchmark				**23.9%**		**20.4%**

Maternal health

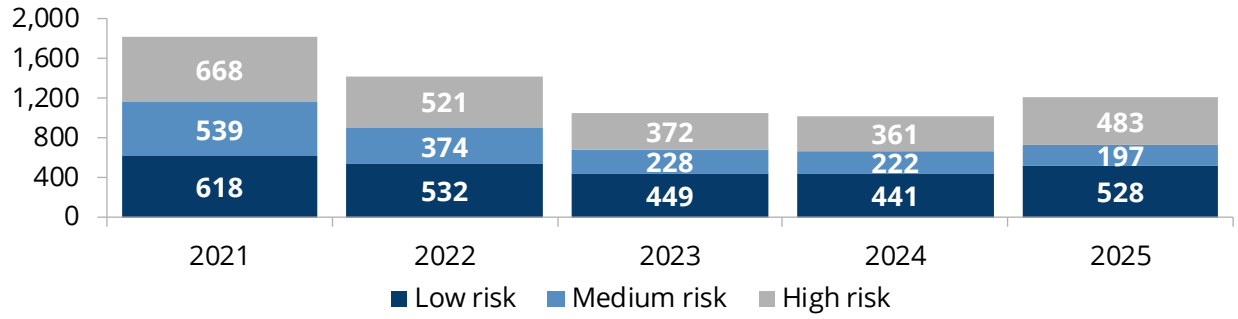
Deliveries

2021–2025



Enrollment in Coming Attractions (maternal health program)

2021–2025



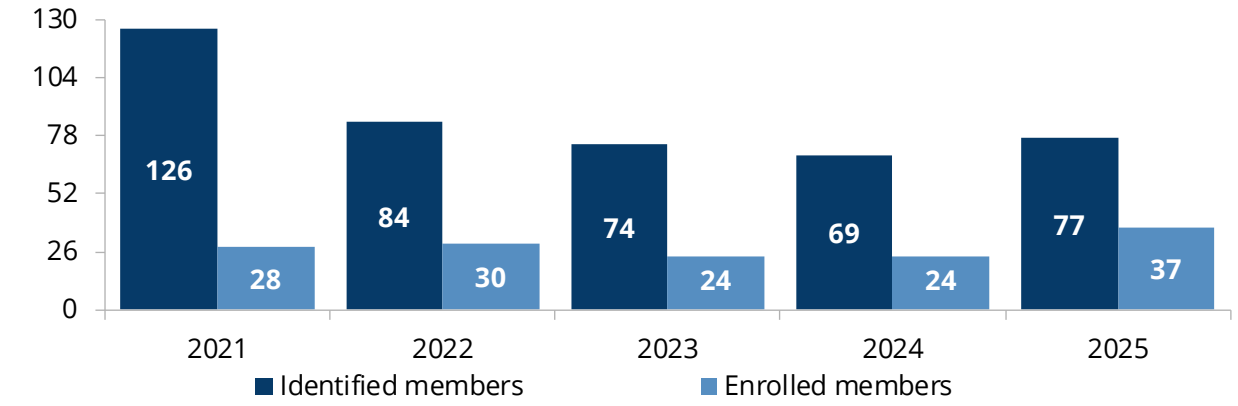
BlueCross administers PEBA's comprehensive maternity management program, Coming Attractions. The program monitors expectant mothers throughout pregnancy and manages Neonatal Intensive Care Unit (NICU) infants or other babies with special needs until they are 1 year old. Of the 483 high risk pregnancies for participants in 2025, 45 worked with a case manager.

Risk levels for members not enrolled in Coming Attractions

Year	Low risk	Medium risk	High risk	Unknown
2022	2,461	31	85	148
2023	2,868	3	7	164
2024	2,987	10	53	159
2025	2,472	18	306	243

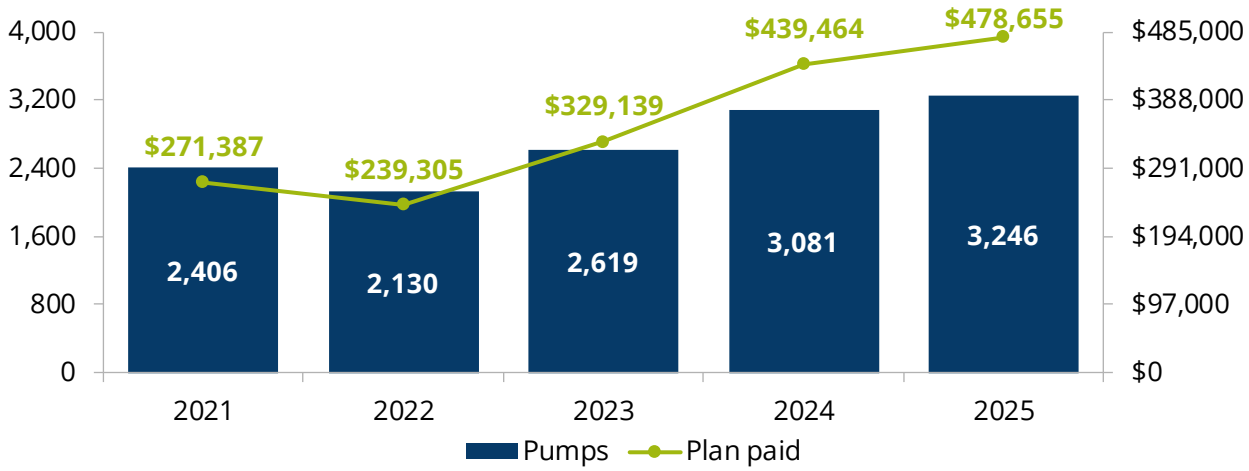
Enrollment in Moms program (behavioral health management)

2021–2025

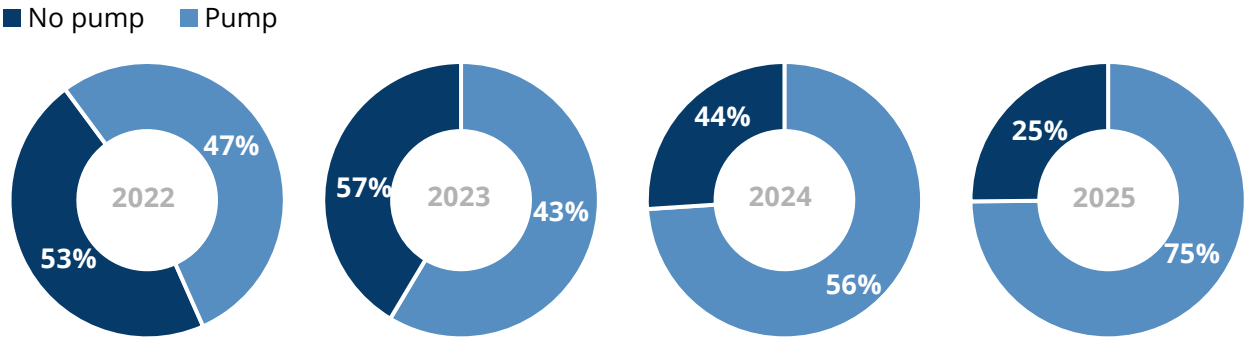


Breast pumps

2021–2025

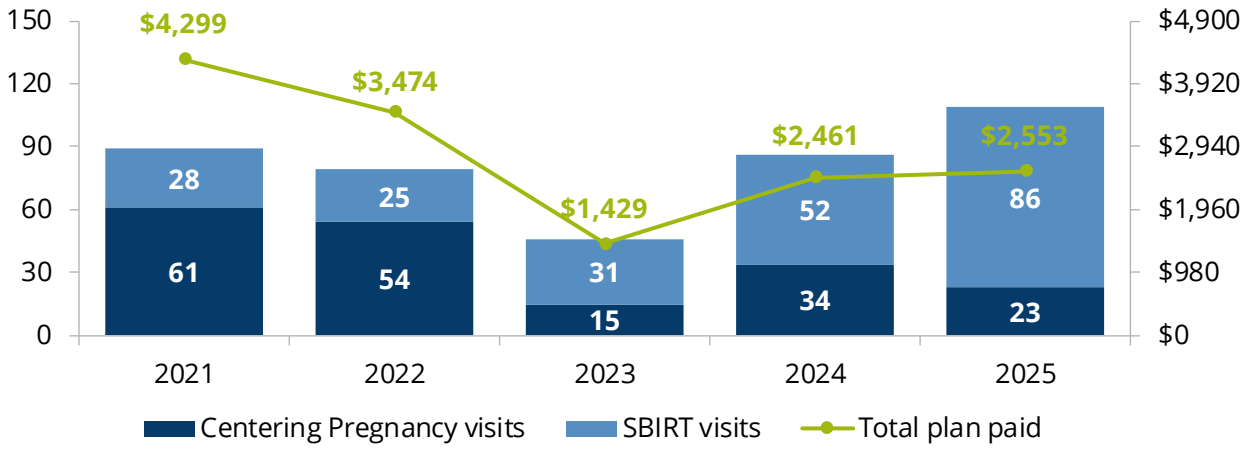


Breast pump utilization by year | 2022–2025



Centering Pregnancy, SBIRT

2021–2025



Launched in July 2011, the goal of the Birth Outcomes Initiative (BOI) is to reduce South Carolina's high elective cesarean section birth rate and to reduce Neonatal Intensive Care Unit admissions. It is a statewide initiative involving public and private stakeholders.

An approach of the Birth Outcomes Initiative, Centering Pregnancy is a nationally recognized model of group prenatal care supported by the Centering Healthcare Institute. Patients are organized into groups of eight to 12 women who have due dates in the same month. Groups meet for 10 two-hour sessions that include a physical assessment, childbirth education and time for socializing.

Another approach of the Birth Outcomes Initiative is SBIRT (Screening, Brief Intervention, and Referral to Treatment). Screening assesses the severity of substance abuse and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance abuse and motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

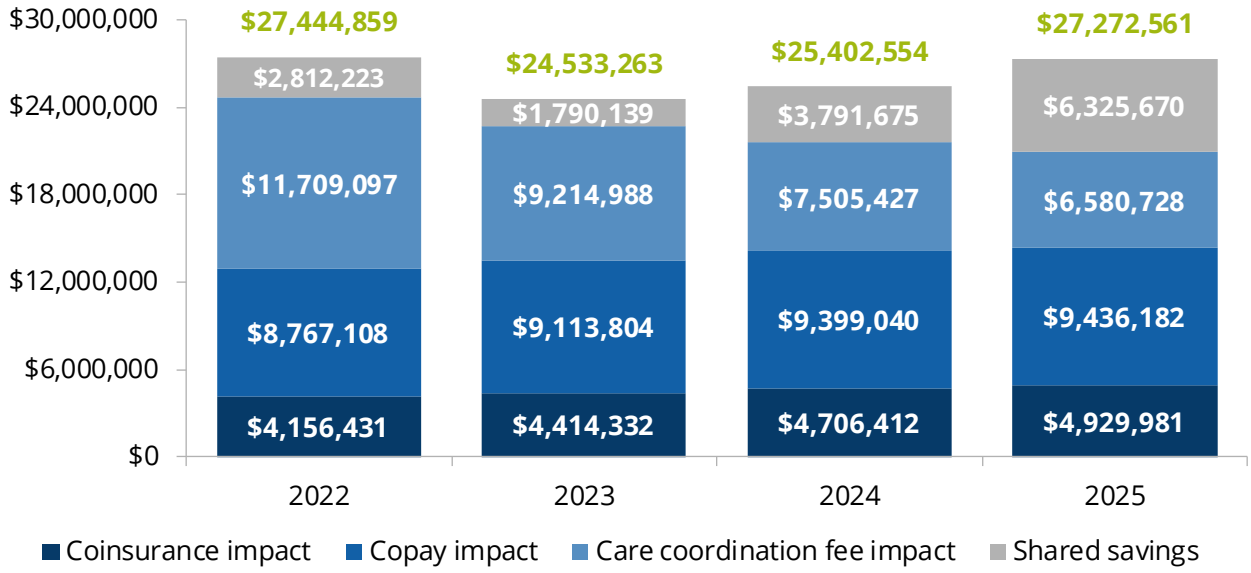
HEDIS measure: Prenatal Immunization Status

Vaccine	Year	Number of deliveries	Vaccinated members	Percent vaccinated
Influenza	2024	3,855	1,757	45.6%
	2025	3,921	1,633	41.6%
Influenza benchmark				**36.9%**
Diphtheria, tetanus, and acellular pertussis (TDAP/TD)	2024	3,855	2,946	76.4%
	2025	3,921	2,944	75.1%
TDAP/TD benchmark				**69.8%**

Patient-centered medical home (PCMH)

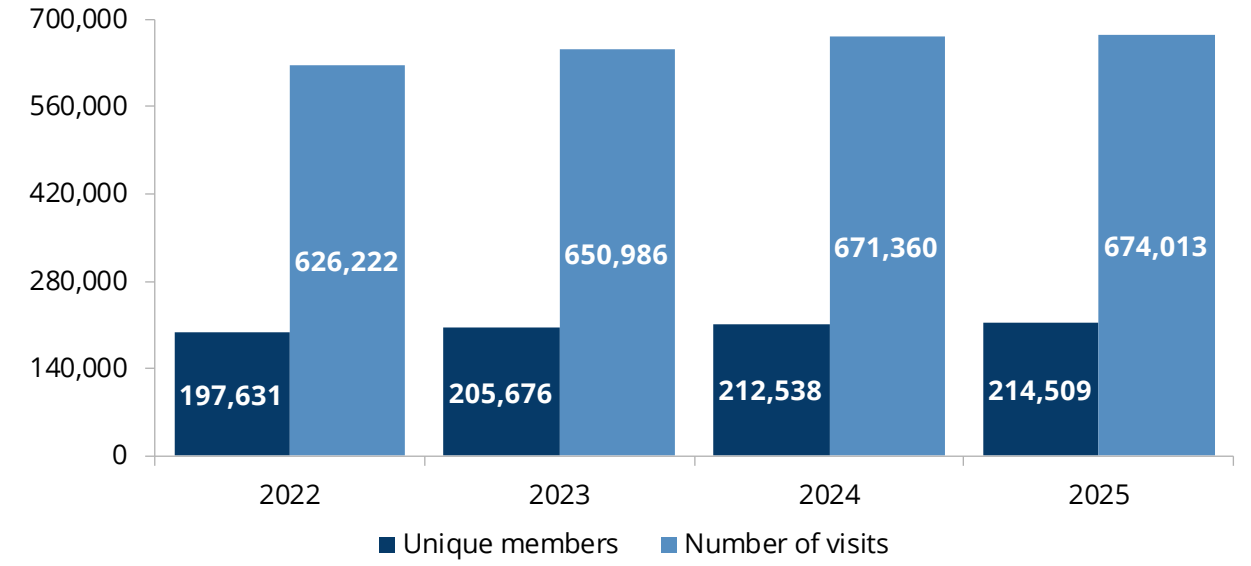
Patient-centered medical homes

Financial impact | 2022–2025



The State Health Plan assumes more financial liability with a patient-centered medical home by paying a care coordination fee to PCMH providers.

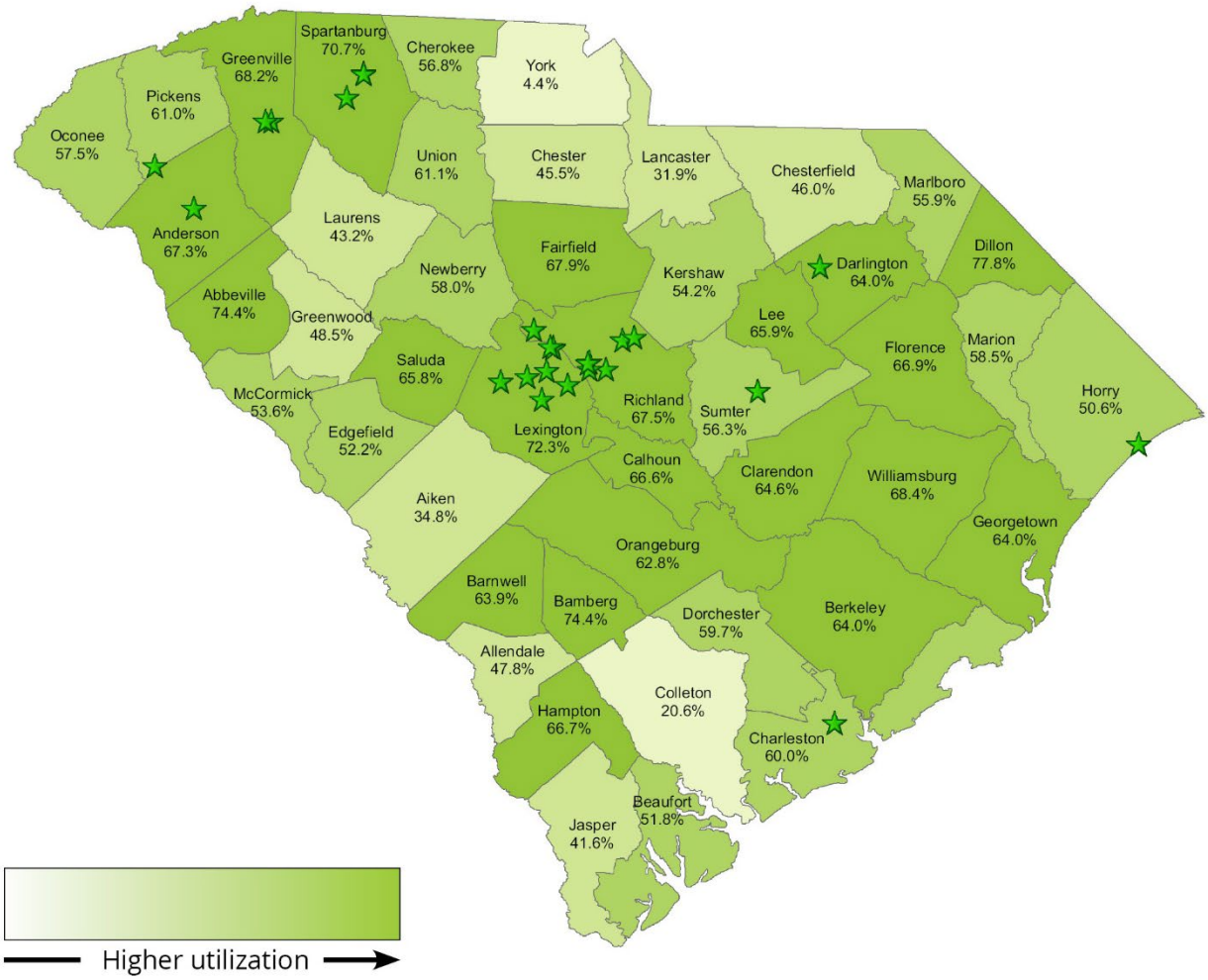
Utilization of all patients | 2022–2025



The State Health Plan began participating in BlueCross' PCMH pilot in 2009. The pilot began with one provider practice serving about 500 State Health Plan adult members.

Beginning January 1, 2016, the PCMH program was fully implemented, and financial incentives for using a PCMH were offered to all State Health Plan primary members. During that year, there were 237 PCMH practices and 2,785 PCMH practitioners. As of 2025, there were 697 PCMH practices and 10,519 PCMH practitioners.

Percentage of State Health Plan primary members utilizing a PCMH | 2025



★ High-volume PCMH practices (1,000 patients or more)

Upstate
- PH Pediatrics Spartanburg
- Internal Medicine Associates
- Amed Pediatrics Anderson
- Family Physicians of Spartanburg PC
- Brio Primary Care with MUSC Health
- MGC-Medical Affiliates-North Grove
- PH Pediatric & Internal Medicine Patrick Square

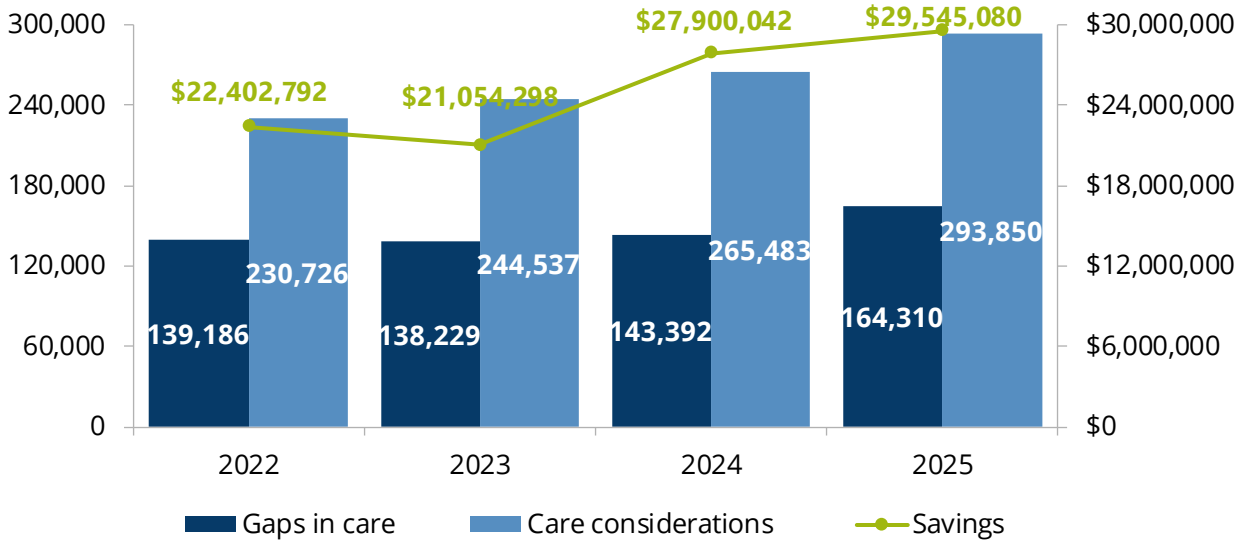
Midlands
- Colonial Family Practice LLC
- SC Internal Medicine Assoc & Rehab
- Lexington Family Practice (8 locations)
- The Columbia Medical Group
- Harbison Medical Associates
- Sandhills Pediatrics
- PH Primary Care
- Palmetto Pediatrics (2 locations)

Lowcountry/Pee Dee
- MUSC Physicians PCP West Ashley
- Grand Strand Pediatrics & Adolescent
- Hartsville Medical Group LLC

Active Health

Active Health

2022–2025



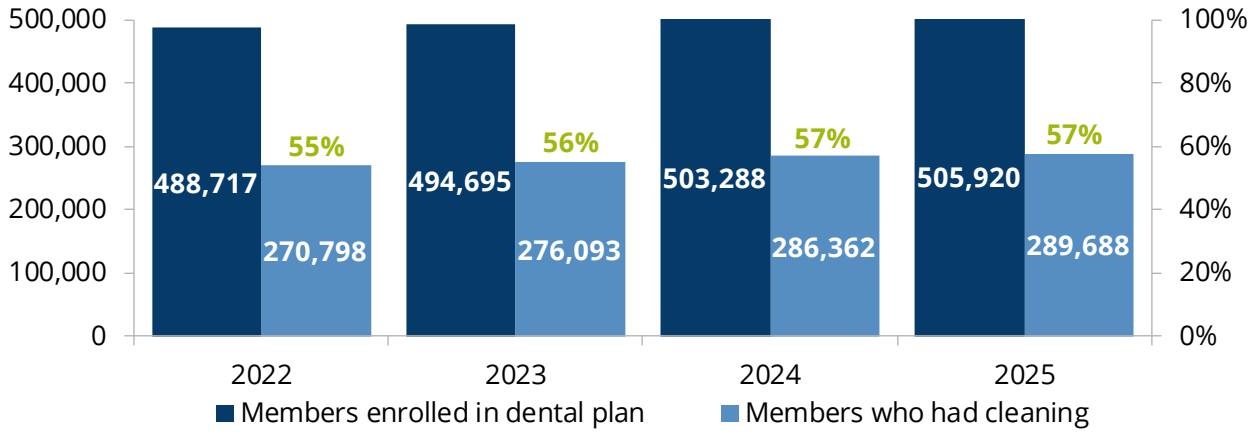
After analyzing claims data, Active Health sends care considerations to providers to help close gaps in care. Improved clinical outcomes lead to Plan savings. The care consideration compliance rate was 36.7% in 2025. There were less projected savings in 2023 because there was a decrease in the gaps in care identified from 2022 to 2023.

PEBA is interested in a holistic approach to improving member health outcomes by identifying members for intervention recommendations based on best-practice, clinical protocols. Beginning in 2022, dental and vision claims were added to the medical and pharmacy claims to help achieve this goal. Based on evidence-based medicine, dental exams and eye exams may be recommended for certain conditions. Having the dental and vision claims helps close any potential gaps in care.

Dental and vision

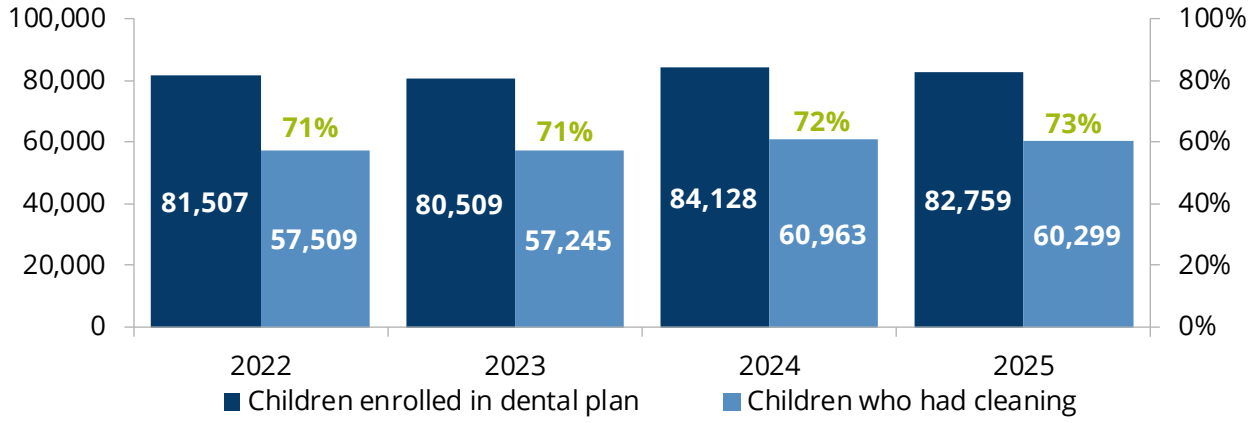
Dental cleanings

Adults | 2022–2025



Adults are defined as ages 18 and older. The total count is the number of adults who had at least one cleaning, and who are enrolled in Dental Plus or Basic Dental.

Children | 2022–2025



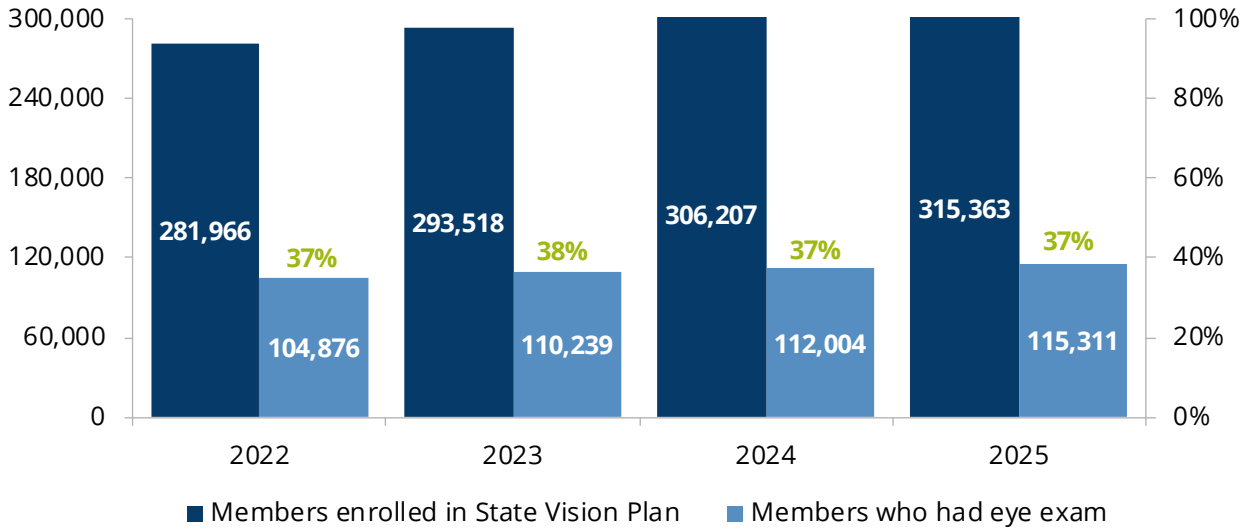
Children are defined as ages 2 through 17. The total count is the number of children who had at least one cleaning, and who are enrolled in Dental Plus or Basic Dental.

HEDIS measure: Oral Evaluation, Dental Services

	Year	Total members	Members with dental claim	Dental claim rate
Ages 2–20	2024	90,322	64,701	71.6%
	2025	90,166	64,893	72.0%
Benchmark				**40.6%**

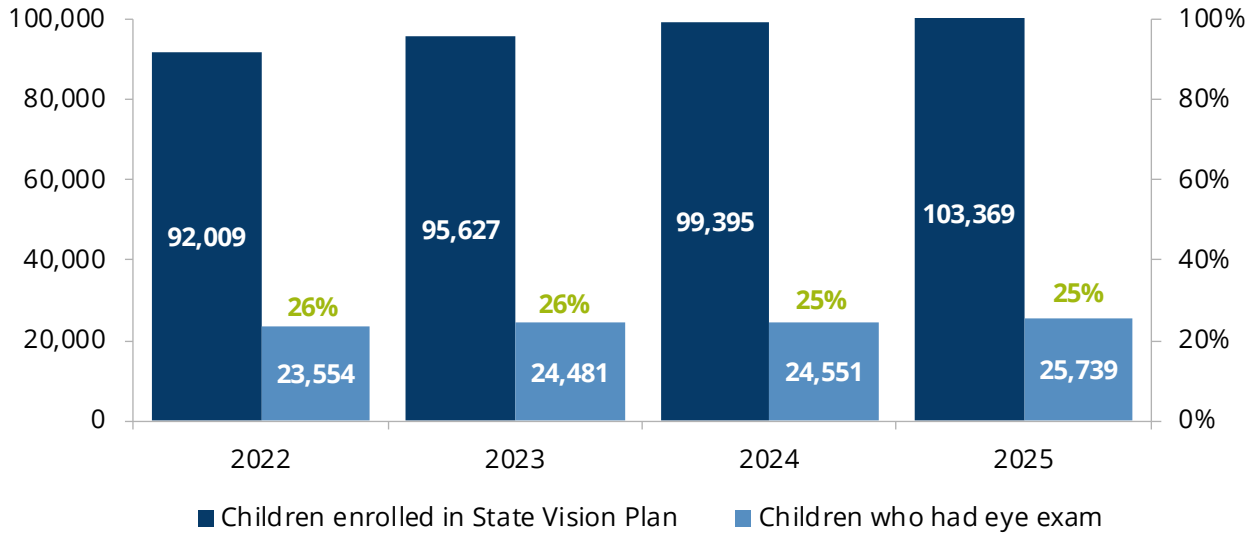
Eye exams

Subscribers and spouses | 2022–2025



The State Vision Plan covers an annual comprehensive eye exam with a $10 copay. An eye exam not only detects the need for vision correction, but it can also reveal early signs of many medical conditions, including diabetes, high blood pressure and heart disease.

Dependent children | 2022–2025



The percentages of children who had an eye exam under the State Vision Plan do not account for children who may have had vision screenings at their school or at their well child visit. Also, subscribers who elect child coverage for a benefit typically add all eligible children at the same time. Combined, this could explain the low exam counts if not all covered children have used the vision benefit.

HEDIS Performance Measures

HEDIS Performance Measures

How HEDIS is developed

NCQA's Committee on Performance Measurement, which includes representation from purchasers, consumers, health plans, health care providers and policy makers, oversees the evolution of the measurement set. Multiple Measurement Advisory Panels provide clinical and technical knowledge required to develop the measures. Additional HEDIS Expert Panels and the Technical Measurement Advisory Panel provide invaluable assistance by identifying methodological issues and providing feedback on new and existing measures.

Technical notes

The measures reported in this document are uncertified, unaudited Health Plan HEDIS rates. The results are compiled by PEBA's internal analytic team and have not been certified through NCQA's Measure Certification Program and may only be used for internal, quality improvement purposes.

Members with SHP primary coverage as determined by eligibility files were selected for the performance measures included in this report (i.e., members with Medicare primary coverage were excluded from the analysis). Members with the following health plan categories were selected: 1) Blue Cross/Blue Shield Standard Plan, 2) Blue Cross/Blue Shield Savings Plan and 3) MUSC Health Plan. Unless a HEDIS measure specifically notes to include rejected or reversed claims, only non-rejected, non-reversed medical, dental and pharmacy claims were used in the analyses for this report. Source information includes claims and immunization registry data for vaccination measures.

Most measures allow for one gap in enrollment of up to 45 days during each measurement year. The opioid measure does not allow for any gap in enrollment. Age is calculated as of December 31 of the measurement year except for opioid measures. Age is calculated as of January 1 of each measurement year for the opioid measure. Inpatient claims and emergency department claims are not included in well child and adolescent well care measures. HEDIS guidelines require specialty of primary care physician for well child visit measures and primary care or OB/GYN physician for the adolescent measure. Due to the number of practice groups reporting multi-specialty instead of a specific specialty designation, as well as data quality issues inherent in the specialty data field, this requirement was not included in the creation of child and adolescent well-care for this report.

When a measure specified an exclusion "to be any time during the member's history through December 31 of the measurement year", a lookback of seven years including the measurement year was applied. Eligibility was not considered for member history (i.e., member did not have to have at least 320 days of coverage in each year of the lookback if the excluding diagnosis or procedure was identified in the claims).

There are more than 235 million people enrolled in plans that report HEDIS results. Rates for several measures by plan type — commercial HMO, commercial PPO, Medicaid HMO, Medicare HMO, and Medicare PPO — are provided on the NCQA website. For the purposes of this report, these results are included and are used as a comparison or benchmark.

How the State Health Plan fared

Benchmark data is for preferred provider organizations (PPOs) except the dental claim benchmark. The dental claim benchmark is for Medicaid Health Management Organization (HMO).

	Benchmark	SHP
Measures for behavior or services that improve member health outcomes and reduce costs		
Adults who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.	**94.4%** (2024)	**95.7%** (2025) **95.8%** (2024)
Adults and children ages 0 through 20 who had at least one oral evaluation during the measurement year.	**40.6%** (2024)	**72.0%** (2025) **71.6%** (2024)
At least six well child visits in the first 15 months of life with a primary care physician.	**81.6%** (2024)	**86.8%** (2025) **85.8%** (2024)
Well child visits in the first 30 months of life (15 months to 30 months).	**86.5%** (2024)	**91.9%** (2025) **91.0%** (2024)
Child and adolescent well care between ages 3 and 19 who had at least one comprehensive well-care visit with a primary care physician or OB/GYN practitioner during the measurement year.	**58.9%** (2024)	**57.6%** (2025) **56.2%** (2024)
Children 2 years of age who had their Combo 3 vaccines: four DTaP, three polio (IPV), one MMR, three haemophilus influenza type B (HiB), three hepatitis B (HepB), one chicken pox (VZV), and four pneumococcal conjugate (PCV) by their second birthday.	**64.1%** (2024)	**87.1%** (2025) **85.6%** (2024)
The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one TDaP/TD vaccine and the complete human papillomavirus vaccine series by their 13th birthday.	**29.4%** (2024)	**31.6%** (2024) **29.8%** (2024)
The percentage of members ages 19 to 65 who had a flu vaccine during the measurement year.	**23.2%** (2024)	**25.3%** (2025) **25.8%** (2024)
The percentage of adults ages 50 to 65 who were current for the shingles vaccine during the measurement year.	**23.9%** (2024)	**24.8%** (2025) **23.9%** (2024)
The percentage of adults ages 19–65 who were current for the TDaP vaccine during the measurement year.	**42.6%** (2024)	**42.6%** (2025) **40.6%** (2024)
The percentage of adults ages 66 and older who were current for the pneumococcal vaccine during the measurement year.	No current benchmark	**57.2%** (2025) **57.5%** (2024)
Women ages 50 through 74 who had at least one mammogram to screen for breast cancer in the past two years.	**74.5%** (2024)	**76.3%** (2025) **76.0%** (2024)

	Benchmark	SHP
Measures for behavior or services that improve member health outcomes and reduce costs		
Women ages 21 through 64 who were screened for cervical cancer using either of the following criteria: Women ages 21 through 64 who had cervical cytology performed every three years or women ages 30 through 64 who had human papillomavirus testing performed every five years.	**70.5%** (2024)	**68.5%** (2025) **67.8%** (2024)
Adults ages 45 through 75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test; flexible sigmoidoscopy every five years; colonoscopy every 10 years; computed tomography colonography every five years; or stool DNA test every three years.	**59.4%** (2024)	**65.9%** (2025) **63.5%** (2024)
Among opioid users, the percentage of members ages 18 and older who receive prescription opioids at a high dosage for greater than or equal to 15 days during the measurement year (average morphine equivalent dose [MED] greater than 90 mg).	**3.6%** (2024)	**3.8%** (2025) **3.8%** (2024)
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses, who had a follow-up visit with a mental health provider within 7 days.	**49.0%** (2024)	**40.4%** (2025) **40.8%** (2024)
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses, who had a follow-up visit with a mental health provider within 30 days.	**70.5%** (2024)	**71.2%** (2025) **67.5%** (2024)
Members 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications for at least 12 weeks.	**80.0%** (2024)	**77.6%** (2025) **77.1%** (2024)
Members 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications for at least 6 months.	**65.0%** (2024)	**61.4%** (2025) **59.2%** (2024)
HEDIS measures for low-value services		
Adolescent females ages 16 through 20 who were screened unnecessarily for cervical cancer.	**0.4%** (2024)	**0.6%** (2025) **0.6%** (2024)
Adults ages 18 through 75 who had a primary diagnosis of low back pain and did not have an imaging study (plain X-ray, MRI or CT scan) within 28 days of the diagnosis (a higher score indicates better performance).	**73.1%** (2024)	**70.7%** (2025) **70.1%** (2024)

Measure descriptions information on the following pages is derived from HEDIS Measures and Technical Resources. https://www.ncqa.org/hedis/measures/.

Adults' Access to Preventive/Ambulatory Health Services

This measure assesses whether adult health plan members had a preventive or ambulatory visit to their physician. Health care visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can address acute issues or manage chronic conditions.

The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Age group	Year	Total members	Members with at least one visit	AAP%
20–44 years	2019–2021	103,807	98,055	94.5%
	2020–2022	104,655	98,813	94.4%
	2021–2023	101,851	96,093	94.3%
	2022–2024	103,551	97,136	93.8%
	2023–2025	106,964	100,213	93.7%
45–64 years	2019–2021	123,953	120,377	97.1%
	2020–2022	124,807	121,412	97.3%
	2021–2023	123,073	119,850	97.4%
	2022–2024	124,308	120,867	97.2%
	2023–2025	126,472	122,907	97.2%
65 years & older	2019–2021	11,736	11,463	97.7%
	2020–2022	12,367	12,087	97.7%
	2021–2023	12,857	12,611	98.1%
	2022–2024	13,654	13,375	98.0%
	2023–2025	14,589	14,305	98.1%
Total	2019–2021	239,496	229,895	96.0%
	2020–2022	241,829	232,312	96.1%
	2021–2023	237,781	228,554	96.1%
	2022–2024	241,513	231,378	95.8%
	2023–2025	248,025	237,425	95.7%
Benchmark				**94.4%**

Oral Evaluation, Dental Services

Regular dental visits provide access to cleaning, early diagnosis, treatment and education about caring for teeth to prevent problems.

Percentage of active SHP members with dental coverage (includes members with Basic and Dental Plus) who received a comprehensive or periodic oral evaluation with a dental provider. **Benchmark is based on ages 2–20 for Medicaid HMO 2024; no commercial benchmark results are available.**

Age group	Year	Total members	Members with oral evaluation	Oral evaluation rate
0 to 2 years	2024	5,171	1,883	36.4%
	2025	4,781	1,649	34.5%
3 to 5 years	2024	9,733	7,233	74.3%
	2025	9,535	7,110	74.6%
6 to 14 years	2024	40,468	32,779	81.0%
	2025	40,700	33,046	81.2%
15 to 20 years	2024	34,950	22,806	65.3%
	2025	35,150	23,088	65.7%
21 to 29 years	2024	47,716	21,898	45.9%
	2025	48,893	22,658	46.3%
30 to 39 years	2024	51,812	26,550	51.2%
	2025	52,152	26,920	51.6%
40 to 49 years	2024	64,031	35,293	55.1%
	2025	64,817	36,099	55.7%
50 to 64 years	2024	90,997	50,939	56.0%
	2025	91,653	51,791	56.5%
65 years and older	2024	17,022	9,695	57.0%
	2025	17,860	10,229	57.3%
All ages	2024	361,900	209,076	57.8%
	2025	365,541	212,590	58.2%
0 to 20 years	2024	90,322	64,701	71.6%
	2025	90,166	64,893	72.0%
Benchmark (ages 2 to 20)				**40.6%**

Oral Evaluation, Dental Services Additional Results

		Dental Basic & Dental Plus		Dental Basic		Dental Plus	
Age group	Year	Total members	Members with dental evaluation	Total members	Members with dental evaluation	Total members	Members with dental evaluation
0 to 2 years	2024	5,171	36.4%	1,444	26.0%	3,727	40.4%
	2025	4,781	34.5%	1,477	26.4%	3,304	38.1%
3 to 5 years	2024	9,733	74.3%	2,291	60.1%	7,442	78.7%
	2025	9,535	74.6%	2,484	57.6%	7,051	80.6%
6 to 14 years	2024	40,468	81.0%	7,393	67.2%	33,075	84.1%
	2025	40,700	81.2%	7,881	65.3%	32,819	85.0%
15 to 20 years	2024	34,950	65.3%	6,455	51.0%	28,495	68.5%
	2025	35,150	65.7%	6,555	50.7%	28,595	69.1%
21 to 29 years	2024	47,716	45.9%	13,644	34.2%	34,072	50.6%
	2025	48,893	46.3%	14,060	34.0%	34,833	51.3%
30 to 39 years	2024	51,812	51.2%	14,861	35.9%	36,951	57.4%
	2025	52,152	51.6%	15,747	35.2%	36,405	58.7%
40 to 49 years	2024	64,031	55.1%	14,634	38.9%	49,397	59.9%
	2025	64,817	55.7%	15,031	38.5%	49,786	60.9%
50 to 64 years	2024	90,997	56.0%	20,857	39.3%	70,140	60.9%
	2025	91,653	56.5%	21,064	39.8%	70,589	61.5%
65 years and older	2024	17,022	57.0%	3,776	36.4%	13,246	62.8%
	2025	17,860	57.3%	3,897	37.2%	13,963	62.9%

Well-Child Visits in the First 15 Months

These well-child visits measures are based on the American Academy of Pediatrics Bright Futures guidelines for Health Supervision of Infants, Children and Adolescents.[1]

The visits that occur before the 15-month birthday are of particular importance because this is the period when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. They are foundational to preventive health care, such as evidence-based screenings and immunizations, because they promote better social, developmental and health outcomes.[2]

1 Hagan, J.F., J.S. Shaw, and P.M. Duncan, eds. 2017. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Fourth edition. Elk Grove Village, IL: Bright Futures/American Academy of Pediatrics.
2 Bright Futures & American Academy of Pediatrics. 2020. Periodicity Schedule—Recommendations for Preventive Pediatric Health Care. https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

For purposes of SHP, the maximum age for the Child and Adolescent Well-Care Visit Measure is 19.

Well-Child Visits in the First 15 Months of Life: Assesses children who turned 15 months old during the measurement year and had 0–6 well-child visits with a primary care physician during their first 15 months of life.

Year	Total members	No visit	One visit	Two visits	Three visits	Four visits	Five visits	Six visits
2021	3,303	0.8%	99.2%	98.5%	97.7%	96.5%	94.0%	85.0%
2022	3,341	1.0%	99.0%	98.4%	97.8%	96.5%	94.1%	84.3%
2023	3,334	1.0%	99.0%	98.4%	97.8%	96.2%	93.3%	85.3%
2024	3,312	0.8%	99.2%	98.4%	97.6%	96.0%	93.1%	85.8%
2025	3,275	1.1%	98.9%	98.1%	97.1%	96.1%	93.7%	86.8%
Benchmark								**81.6%**

Well-Child Visits from 15 Months to 30 Months

The AAP/Bright Futures guidelines also recommend two or more visits between 15 months and 30 months, an important period for early assessment and screenings. Early identification of developmental disorders is critical to the well-being of children and their families.

Assesses children who turned 30 months old during the measurement year and had two or more well-child visits with a primary care physician from their first 15 months plus one day through 30 months of life.

Year	Total members	No visit	One visit	Two visits
2021	3,525	3.6%	96.4%	90.2%
2022	3,278	3.2%	96.8%	91.4%
2023	3,356	3.7%	96.3%	91.2%
2024	3,494	3.5%	96.5%	91.0%
2025	3,572	3.2%	96.8%	91.4%
Benchmark				**86.5%**

Child and Adolescent Well-Care Visits

Well-child visits during the preschool and early school years are particularly important. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems.

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. Report three age stratifications and total rate: 3–11 years, 12–17 years, 18–21 years and the sum of the age stratifications.

	Ages 3 to 11		Ages 12 to 17		Ages 18 to 19		Ages 3 to 19	
Year	Total members	One visit	Total members	One visit	Total members	One visit	Total members	One visit
2021	38,236	62.7%	33,373	50.5%	12,302	31.0%	83,911	53.2%
2022	37,899	62.5%	33,194	49.9%	12,359	31.5%	83,452	52.9%
2023	37,826	65.2%	33,480	52.7%	12,429	33.6%	83,735	55.5%
2024	38,794	66.0%	34,047	53.6%	12,852	33.7%	85,693	56.2%
2025	39,842	67.1%	34,935	55.2%	13,345	35.7%	88,122	57.6%
Benchmark								**58.9%**

Childhood Immunization Status

This measure follows the CDC Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations.[1]

Childhood immunizations help prevent serious illnesses such as polio, tetanus and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles.

1 Wodi, A.P., N. Murthy, V.V. McNally, M.F. Daley, S. Cinea. 2024. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger – United States, 2024." MMWR Morb Mortal Wkly Rep 73:6–10. https://doi.org/10.15585/mmwr.mm7301a

The percentage of children 2 years of age who had a four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three Haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugates (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

The measure calculates a rate for each vaccine plus separate combination rates.

Methodology change: Measures follow HEDIS guidelines with one exception. HEDIS specifies eligibility in the 12 months prior to member's second birthday with one allowable gap. For measure below, eligibility in the 24 months prior to a member's second birthday was used with one allowable gap of 45 days per year.

A child's initial HepB vaccination is often recorded under the mother's hospital stay. Therefore, only 2 HepB vaccinations were required.

Vaccine	Year	Eligible members	Vaccinated members	Vaccination percentage
Four diphtheria (DTaP) vaccinations during their first two years of life	2021	3,133	2,654	84.7%
	2022	2,870	2,638	91.9%
	2023	3,027	2,792	92.2%
	2024	3,056	2,783	91.1%
	2025	3,029	2,712	89.5%
DTaP benchmark				**75.8%**

Three polio (IPV) vaccinations during their first two years of life	2021	3,133	2,825	90.2%
	2022	2,870	2,768	96.4%
	2023	3,027	2,908	96.1%
	2024	3,056	2,926	95.7%
	2025	3,029	2,846	94.0%
IPV benchmark				**82.3%**
One measles, mumps and rubella (MMR) vaccination between first and second birthdays	2021	3,126	2,904	92.9%
	2022	2,870	2,759	96.1%
	2023	3,027	2,881	95.2%
	2024	3,056	2,890	94.6%
	2025	3,029	2,808	92.7%
MMR benchmark				**82.3%**
Three Haemophilus influenza type B (HiB) vaccinations during their first two years of life	2021	3,133	2,848	90.9%
	2022	2,870	2,742	95.5%
	2023	3,027	2,890	95.5%
	2024	3,056	2,902	95.0%
	2025	3,029	2,823	93.2%
HiB benchmark				**82.9%**
Two hepatitis B (HepB) vaccinations during their first two years of life	2021	3,133	2,905	92.7%
	2022	2,870	2,774	96.7%
	2023	3,027	2,928	96.7%
	2024	3,056	2,931	95.9%
	2025	3,029	2,859	94.4%
HepB benchmark				**73.2%**

One chicken pox (VZV) vaccination between first and second birthdays	2021	3,126	2,890	92.5%
	2022	2,870	2,746	95.7%
	2023	3,027	2,882	95.2%
	2024	3,056	2,881	94.3%
	2025	3,029	2,793	92.2%
VZV benchmark				**86.9%**
Four pneumococcal conjugate (PCV) vaccinations during their first two years of life	2021	3,133	2,724	87.0%
	2022	2,870	2,672	93.1%
	2023	3,027	2,833	93.6%
	2024	3,056	2,741	89.7%
	2025	3,029	2,735	90.3%
PCV benchmark				**77.0%**
One hepatitis A (HepA) vaccination between member's first and second birthdays	2021	3,133	2,923	93.3%
	2022	2,870	2,748	95.7%
	2023	3,027	2,883	95.2%
	2024	3,056	2,893	94.7%
	2025	3,029	2,805	92.6%
HepA benchmark				**85.6%**
Three rotavirus (RV) vaccinations during their first 2 years of life	2021	3,126	2,646	84.6%
	2022	2,870	2,615	91.1%
	2023	3,027	2,752	90.9%
	2024	3,056	2,755	90.2%
	2025	3,029	2,673	88.2%
RV benchmark				**75.4%**

Two influenza vaccinations during their first two years of life	2021	3,133	2,253	71.9%
	2022	2,870	1,842	64.2%
	2023	3,027	1,653	54.6%
	2024	3,056	1,491	48.8%
	2025	3,029	1,362	45.0%
Flu benchmark				**52.4%**
Combination 10 (four DTaP, three IPV, one MMR, three HiB, two HepB, one VZV, four PCV, one HepA, three RV and two seasonal flu by their second birthday)	2021	3,126	1,925	61.6%
	2022	2,870	1,691	58.9%
	2023	3,027	1,562	51.6%
	2024	3,056	1,364	44.6%
	2025	3,029	1,278	42.2%
Combination 10 benchmark				**39.3%**
Combination 3 (four DTaP, three IPV, one MMR, three HiB, two HepB, one VZV and four PCV by their second birthday)	2022	2,870	2,568	89.5%
	2023	3,027	2,726	90.1%
	2024	3,056	2,616	85.6%
	2025	3,029	2,637	87.1%
Combination 3 benchmark				**64.1%**

Immunizations for Adolescents

This measure follows the Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations. [1, 2, 3]

These vaccines are available for adolescents to prevent them from acquiring serious diseases and help protect against disease in populations that lack immunity, such as infants, the elderly and individuals with chronic conditions.

1 Meites, E., A. Kempe, L.E. Markowitz. 2016. "Use of a 2-Dose Schedule for Human Papillomavirus Vaccination—Updated Recommendations of the Advisory Committee on Immunization Practices." MMWR Morb Mortal Wkly Rep 65:1405–08. http://dx.doi.org/10.15585/mmwr.mm6549a5

2 Havers, F.P., P.L. Moro, P. Hunter, S. Hariri, H. Bernstein. 2020. "Use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis Vaccines: Updated Recommendations of the Advisory Committee on Immunization Practices—United States, 2019." MMWR Morb Mortal Wkly Rep 69:77–83. http://dx.doi.org/10.15585/mmwr.mm6903a5

3 Mbaeyi, S.A., C.H. Bozio, J. Duffy et al. 2020. "Meningococcal Vaccination: Recommendations of the Advisory Committee on Immunization Practices, U.S., 2020." MMWR Recomm Rep 69(No. RR-9):1–41. http://dx.doi.org/10.15585/mmwr.rr6909a1

Assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one TDaP/TD vaccine and the complete human papillomavirus vaccine series by their 13th birthday.

Methodology change: HEDIS specifies eligibility in the 12 months prior to member's 13th birthday with one allowable gap. For measures above, eligibility from 11th to 13th birthday was used for MCV4 measure, from 10th to 13th birthday for TDAP, and from 9th to 13th for HPV measure (w/ an allowable gap of 45 days per year for each measure).

Vaccine	Year	Eligible members	Vaccinated members	Vaccination percentage
One dose of Meningococcal vaccine (MCV4)	2021	4,756	3,640	76.5%
	2022	4,621	3,737	80.9%
	2023	4,496	3,568	79.4%
	2024	4,576	3,449	75.4%
	2025	4,575	3,499	76.5%
MCV4 benchmark				**78.6%**
One dose of diphtheria, tetanus, and acellular pertussis (TDAP/TD)	2021	4,242	3,524	83.1%
	2022	4,248	3,969	93.4%
	2023	4,149	3,905	94.1%
	2024	4,176	3,746	89.7%
	2025	4,575	3,818	91.8%
TDAP/TD benchmark				**83.8%**
Human Papillomavirus for Adolescents (HPV)	2021	3,853	1,178	30.6%
	2022	3,827	1,216	31.8%
	2023	3,854	1,238	32.1%
	2024	3,890	1,237	31.8%
	2025	3,807	1,213	31.9%
HPV benchmark				**30.5%**
Adolescent Immunization Combination 2 (MCV4, TDaP/TD, HPV)	2021	3,853	1,078	28.0%
	2022	3,827	1,187	31.0%
	2023	3,854	1,191	30.9%
	2024	3,890	1,160	29.8%
	2025	3,807	1,203	31.6%
Adolescent Combination 10 benchmark				**29.4%**

Adult Immunization Status

The Advisory Committee on Immunization Practices (ACIP) recommends influenza and Td/Tdap vaccination for all adults 19 years of age and older; herpes zoster vaccination for all adults 50 years and older; pneumococcal vaccination for all adults 65 and older and for those 18–64 with certain underlying conditions.[1] These vaccines have been included in recommendations to prevent serious disease, but vaccination coverage remains low[2], leaving many adults unprotected against vaccine-preventable diseases.

1 Murthy, N., A.P Wodi., V.V. McNally, M.F. Daley, S. Cineas,. 2024. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older—United States, 2024." MMWR Morb Mortal Wkly Rep 73:11–15. http://dx.doi.org/10.15585/mmwr.mm7301a3
2 Hung, M.-C. et al. 2024. "Vaccination Coverage among Adults in the United States, National Health Interview Survey, 2022." Updated October 4. https://www.cdc.gov/adultvaxview/publications-resources/adult-vaccination-

The percentage of **eligible** SHP members who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.

Vaccine	Year	Ages 19–65	Vaccinated members	Ages 66 and older	Vaccinated members
Influenza	2023	278,591	26.6%	8,780	52.3%
	2024	285,785	25.8%	9,398	50.2%
	2025	290,408	25.3%	9,930	48.7%
Influenza benchmark			**23.2%**		**34.9%**
Diphtheria, tetanus, and acellular pertussis (TDAP/TD)	2023	282,138	39.2%	8,754	39.7%
	2024	288,593	40.6%	9,229	42.6%
	2025	294,136	42.6%	9,823	44.7%
TDAP/TD benchmark			**42.6%**		**29.6%**
Zoster (Shingles)	2023	108,456	22.1%	8,846	34.5%
	2024	109,361	23.9%	9,229	42.0%
	2025	110,351	24.8%	9,823	42.0%
Zoster (Shingles) benchmark			**23.9%**		**20.4%**
Pneumococcal	2023			8,754	58.5%
	2024			9,229	57.5%
	2025			9,823	57.2%
Pneumococcal benchmark				**No current benchmark**	

Prenatal Immunization Status

The Advisory Committee on Immunization Practices (ACIP) recommends influenza and Tdap vaccines for pregnant women to help protect them from serious illness and death, as well as to provide protection for their infants after birth. [1] [2] [3] [4]

1 Grohskopf, L.A., L.H. Blanton, J.M. Ferdinands, J.R. Chung, K.R. Broder, H.K. Talbot. 2023. "Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, 2023–24 Influenza Season." MMWR Recomm Rep 72(No. RR-2):1–25. http://dx.doi.org/10.15585/mmwr.rr7202a1
2 CDC Advisory Committee on Immunization Practices. 2023. "Recommended Child and Adolescent Immunization Schedule for Ages 18 Years and Younger." November 16, 2023. https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-combined-schedule-bw.pdf
3 CDC Advisory Committee on Immunization Practices. 2023. "Recommended Adult Immunization Schedule for Ages 19 Years and Older." December 28, 2023. https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf
4 Havers, F.P., P.L. Moro, P. Hunter, S. Hariri, H. Bernstein. 2020. "Use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis Vaccines: Updated Recommendations of the Advisory Committee on Immunization Practices—United States, 2019." MMWR Morb Mortal Wkly Rep 69:77–83. http://dx.doi.org/10.15585/mmwr.mm6903a5

The percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

Vaccine	Year	Number of deliveries	Vaccinated members	Percent vaccinated
Influenza	2022	3,902	2,042	52.3%
	2023	3,784	1,864	49.3%
	2024	3,855	1,757	45.6%
	2025	3,921	1,633	41.6%
Influenza benchmark				**36.9%**
Diphtheria, tetanus, and acellular pertussis (TDAP/TD)	2022	3,902	2,891	74.1%
	2023	3,784	2,818	74.5%
	2024	3,855	2,946	76.4%
	2025	3,921	2,944	75.1%
TDAP/TD benchmark				**69.8%**

Breast Cancer Screening

Breast cancer is the second most common type of cancer among American women. There are over 4 million women estimated to be living with breast cancer. Advancing age is the primary risk factor for breast cancer, with the median age of diagnosis at 62 years.[1]

1 American Cancer Society. 2025. "Key Statistics for Breast Cancer." https://www.cancer.org/cancer/types/breast-cancer/about/how-common-is-breast-cancer.html (Accessed March 21, 2025).

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Year	Eligible members	Members with at least one mammogram	Screening percentage
2021	58,196	42,118	72.4%
2022	57,593	42,369	73.6%
2023	58,601	43,943	75.0%
2024	58,837	44,696	76.0%
2025	59,736	45,588	76.3%
Benchmark			**74.5%**

Cervical Cancer Screening

Cervical cancer can be detected in its early stages by regular screening. Due to the success of cervical cancer screening in the U.S., dramatic decreases have been observed in both mortality and incidence of invasive cervical cancer.

The percentage of women 21–64 years of age who were screened for cervical cancer.

Year	Eligible members	Members screened for cervical cancer	Screening percentage
2021	113,014	72,928	64.5%
2022	112,338	73,420	65.4%
2023	112,158	74,969	66.8%
2024	112,346	76,173	67.8%
2025	114,634	78,558	68.5%
Benchmark			**70.5%**

Non-Recommended Cervical Cancer Screening in Adolescent Females (low value)

Cervical cancer screening can result in more harm than benefits for adolescent females. Adolescent females tend to have high rates of transient HPV infection and regressive cervical abnormalities. This may produce false-positive results and lead to unnecessary and potentially detrimental follow-up tests and treatment.[1]

1 Kulasingam, S.L, L. Havrilesky, R. Ghebre, E.R Myers. 2011. "Screening for Cervical Cancer: A Decision Analysis for the U.S. Preventive Services Task Force." Agency for Healthcare Research and Quality. Report No.: 11-05157-EF-1. Rockville, MD

The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer. A lower rate indicates better performance.

Year	Number of members	Members screened for cervical cancer	Screening percentage
2021	14,685	123	0.8%
2022	14,761	115	0.8%
2023	15,134	121	0.8%
2024	15,667	93	0.6%
2025	16,077	91	0.6%
Benchmark			**0.4%**

Colorectal Cancer Screening

Colorectal cancer represents 8% of all new cancer cases and is the second leading cause of cancer deaths in the United States. Screening can be effective for finding precancerous lesions (polyps) that could later become malignant, and for detecting early cancers that can be more easily and effectively treated.

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer. In 2023, the measure changed to 46–75 years of age.

Year	Eligible members	Members screened for colorectal cancer	Screening percentage
2021	107,439	69,437	64.6%
2022	106,835	68,306	63.9%
2023	138,108	83,498	60.5%
2024	140,275	89,061	63.5%
2025	142,812	94,086	65.9%
Benchmark			**59.4%**

Percentage of colonoscopies for all screenings

Year	Screening percentage
2021	88.8%
2022	91.1%
2023	88.6%
2024	87.4%
2025	86.1%

Use of Imaging Studies for Low Back Pain (low value)

Clinical guidelines for treating patients with acute low back pain strongly recommend against the use of imaging in the absence of "red flags" (i.e., indications of a serious underlying pathology such as a fracture or tumor).[1] Routine imaging is problematic because it is not associated with improved outcomes and exposes patients to harms such as radiation exposure and unnecessary treatment.[2] – Red flag conditions include history of cancer, osteoporosis and IV drug use.

1 Downie, A., et al. 2013. "Red Flags to Screen for Malignancy and Fracture in Patients with Low Back Pain: Systematic Review." BMJ 347:f7095. doi: 10.1136/bmj.f7095
2 Chou, R., R. Fu, J.A. Carrino, R.A. Deyo. 2009. "Imaging Strategies for Low-Back Pain: Systematic Review and Meta-Analysis." Lancet 373:463-72. doi: 10.1016/S0140-673

The percentage of members 18–50 years with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Year	Number of members with primary diagnosis of low back pain	Number of members with primary diagnosis of low back pain with an imaging study	Imaging percentage
2021	10,456	2,797	73.3%
2022	9,296	2,509	73.0%
2023	9,148	2,513	72.5%
2024	9,180	2,643	71.2%
2025	9,092	2,680	70.5%
Benchmark			**73.1%**

Diagnosed Substance Use Disorders

This measure provides information on the diagnosed prevalence of substance use disorders. Neither a higher nor lower rate indicates better performance. By providing data on the diagnosed-prevalence of SUD, this measure allows plans to understand the size of the population affected and provide case management services to the members and coordinate treatment as appropriate.

The percentage of members 13 years of age and older who were diagnosed with a substance use disorder during the measurement year.

Age group	Year	Eligible members	Members diagnosed with any substance use disorder	Percentage
13–17 years	2022	28,334	109	0.4%
	2023	28,411	113	0.4%
	2024	29,014	117	0.4%
	2025	29,613	124	0.4%
18–39 years	2022	117,452	1,353	1.2%
	2023	119,608	1,223	1.0%
	2024	123,558	1,229	1.0%
	2025	127,582	1,263	1.0%
40–64 years	2022	171,422	1,972	1.2%
	2023	174,037	2,030	1.2%
	2024	176,685	2,197	1.2%
	2025	178,461	2,142	1.2%
65 years and older	2022	13,669	155	1.1%
	2023	14,475	165	1.1%
	2024	15,274	198	1.3%
	2025	16,150	196	1.2%
All ages	2022	330,877	3,589	1.1%
	2023	336,531	3,531	1.0%
	2024	344,531	3,741	1.1%
	2025	351,806	3,725	1.1%
National prevalence				**1.8%**

Use of Opioids at High Dosage

The proportion of members receiving prescription opioids for ≥15 days during the measurement year at a high dosage (average milligram morphine dose [MME] ≥ 90). Members must be 18 years of age or older. A lower rate indicates better performance.

Year	SHP primary members 18 and older with 365 days of coverage	Members with at least one opioid prescription fill	Members with ≥2 Opioid prescription fills with ≥15 days supply	Members with Average MME ≥90 mg in treatment period	Members with average MME ≥90 mg / Members with ≥2 opioid prescription fills with ≥15 days supply
2021	279,481	43,048	7,391	344	4.7%
2022	278,013	40,827	6,872	297	4.3%
2023	283,696	39,740	6,434	257	4.0%
2024	290,163	39,094	5,926	227	3.8%
2025	295,967	39,374	5,908	225	3.8%
Benchmark					**3.6%**

Diagnosed Mental Health Disorders

This measure provides information on the diagnosed prevalence of mental health disorders. Neither a higher nor lower rate indicates better performance. Understanding the diagnosed prevalence of mental health disorders within a population allows health plans to understand the size of the population in need of mental health services, and may encourage the provision of case management and care coordination services, as appropriate.

The percentage of members 1 year of age and older who were diagnosed with a mental health disorder during the measurement year.

Age group	Year	Eligible members	Members diagnosed with any mental health disorder	Percentage
1–17 years	2022	78,197	16,002	20.5%
	2023	78,580	16,575	21.1%
	2024	80,158	17,387	21.7%
	2025	82,158	18,847	22.9%
18–39 years	2022	117,452	34,230	29.1%
	2023	119,608	36,519	30.5%
	2024	123,558	38,966	31.5%
	2025	127,582	41,861	32.8%
40–64 years	2022	171,422	50,286	29.3%
	2023	174,037	53,699	30.9%
	2024	176,685	57,019	32.3%
	2025	178,461	59,734	33.5%
65 years and older	2022	13,669	3,137	23.0%
	2023	14,475	3,393	23.5%
	2024	15,274	3,744	24.5%
	2025	16,150	4,013	24.8%
All ages	2022	380,740	103,655	27.2%
	2023	386,700	110,186	28.5%
	2024	395,675	117,116	29.6%
	2025	404,351	124,455	30.8%
National prevalence				**26.7%**

Follow-Up After Hospitalization for Mental Illness

Ensuring coordination of care for individuals leaving the inpatient setting is critical. Individuals discharged from these settings may face health risks, including potential medication non-compliance, social isolation, substance use, suicidal ideation or self-harm, as well as financial or practical challenges, such as stable housing.[1, 2, 3]

1 Fontanella, C.A., L.A. Warner, J.D. Steelesmith, G. Brock, J.A. Bridge, & J.V. Campo. 2020. "Association of Timely Outpatient Mental Health Services for Youths after Psychiatric Hospitalization with Risk of Death by Suicide." JAMA Network Open 3(8), E2012887-E2012887.
2 Chung, D.T. C.J. Ryan, D. Hadzi-Pavlovic, S.P. Singh, C. Stanton, & M.M. Large. 2017. "Suicide Rates After Discharge From Psychiatric Facilities: A Systematic Review and Meta-Analysis." JAMA Psychiatry, 74(7), 694–702
3 Fontanella, C.A., J.A. Bridge, S.C. Marcus, & Campo, J.V. 2011. "Factors Associated with Antidepressant Adherence for Medicaid-Enrolled Children and Adolescents. Annals of Pharmacotherapy 45(7-8), 898–909.

Assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients aged 6 years and older that resulted in follow-up care with a mental health provider within seven and 30 days.

	Acute Care Discharges for Mental Illness/Self-Harm	Discharges with Follow-up within 7 Days		Discharges with Follow-up within 30 Days	
Year		**Number**	**Percentage**	**Number**	**Percentage**
2022	980	453	46.2%	680	69.4%
2023	938	515	54.9%	745	79.4%
2024	1,419	579	40.8%	958	67.5%
2025	1,723	696	40.4%	1,227	71.2%
Benchmark			**49.0%**		**70.5%**

Antidepressant Medication Management

Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year.[1,2] Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.[3]

1 National Alliance on Mental Illness. 2013. "Major Depression Fact Sheet: What is Major Depression?"
2 Centers for Disease Control and Prevention. 2012. "Suicide Facts at a Glance 2012."
3 Birnbaum, H.G., R.C. Kessler, D. Kelley, R. Ben-Hamadi, V.N. Joish, P.E. Greenberg. 2010. "Employer burden of mild, moderate, and severe major depressive disorder: Mental health services utilization and costs, and work performance." Depression and Anxiety; 27(1) 78–89.

Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.

	# SHP Members Started	Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 12 weeks		Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least six months	
Year		**Number**	**Percentage**	**Number**	**Percentage**
2022	4,271	3,295	77.3%	2,603	60.9%
2023	3,313	2,595	78.2%	2,013	60.8%
2024	3,419	2,635	77.1%	2,023	59.2%
2025	3,636	2,823	77.6%	2,231	61.4%
Benchmark			**80.0%**		**65.0%**

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