North Carolina
State Health Plan
for Teachers and State Employees
www.shpnc.org

Board of Trustees' Meeting
February 17, 2009
9:30 a.m.
North Carolina State University
Centennial Campus

AGENDA

1.	Welcome	D. Steven Beam, Chairman Dr. Jack W. Walker
2.	Conflict of Interest Statement * ***(Verbal presentation)***	D. Steven Beam
3.	State Health Plan Medical Director Announcement ***(Verbal Presentation)***	Dr. Jack W. Walker
4.	Approval of Minutes (*Requires Board Approval*)	D. Steven Beam
•	November 18, 2008	
5.	Follow-up Items from Previous Board Meeting *	D. Steven Beam
•	BCBSNC Contracting Process	Lacey Barnes
•	Amendment #18 to Claims Processing Contractor Contract ***(Verbal Presentation)***	Lacey Barnes
•	Employees by State Report Update ***(Verbal Presentation)***	Linda Forsberg
•	Dependent Eligibility Audit Update ***(Verbal Presentation)***	Linda Forsberg
•	Electronic Enrollment Update ***(Verbal Presentation)***	Linda Forsberg
•	Cholesterol-Lowering Medication Adherence Program Copay Revision	Sally Morton, PharmD

- Warfarin Pilot Update — Sally Morton, PharmD

- Tobacco Settlement Follow-up — Anne Rogers

6. Hospital Data Report (Follow-up from September 2008 Meeting) — Dr. Jack W. Walker

7. BOT Subcommittee Report ***(Verbal Presentation)*** — Dr. John Hammond

8. Clinic Project — Carol Durrell, Anne Rogers

9. Disease Management ROI — Anne Rogers

10. Pharmacy Initiatives – First Quarter 2009 — Tracy Stephenson

    - Triptan Formulary Coverage Review
    - Enhanced Refill Logic
    - Enhanced Proton Pump Inhibitor Formulary Coverage Review
    - Quantity Limits for Antiemetics

11. BCBSNC Billing Correction ***(Verbal Presentation)*** — Carol Sutton

12. Financial Reports *

    - December Financials — Mona Moon
    - State Health Plan Quarterly Report (October - December) — Mona Moon, Anne Rogers, Lacey Barnes, Tracy Stephenson
    - January Financials (***Verbal Presentation***) — Mona Moon
    - Claims Audit Reports (***Verbal Presentation***) — Mona Moon
    - Performance and Financial State Auditor Report Status (***Verbal Presentation***) — Dr. Jack Walker, Mona Moon

Working Lunch (provided for Board members and Plan staff)

13.	Premium Tiers – Benefit Modeling (***Requires Board Action***)	Dr. Jack W. Walker
14.	Medical Policies **(*Requires Board Action)***	Derek Prentice, MD
15	Next Board of Trustees' Meeting	D. Steven Beam
16.	Rulemaking Policy ***(To be distributed at meeting)***	Wendy Greene
17.	Legislative Update ***(Verbal Presentation)***	Marci Wilding

Executive Session *(for Board members only*)

Benefit Modeling and Financial Forecast *Pursuant to G.S. 120-131.1(a)*	Dr. Jack W. Walker
Comprehensive Wellness Plan *Pursuant to G.S. 120-131.1(a)*	Anne Rogers Derek Prentice, MD
OAH Cases (***Requires Board Action***) *Pursuant to G.S. 135-37 and G.S. 143-318.11*	Wendy Greene

- 08INS 0846
- 08INS 1039

Adjourn

* Standing agenda items

Board of Trustees
State Health Plan for Teachers and State Employees
November 18, 2008

The North Carolina State Health Plan for Teachers and State Employees began its scheduled meeting at 9:40 a.m. on Tuesday, November 18, 2008.

Members Participating:

Steve Beam, Chairman
John Hammond
Charles Hayek, M.D.
Dan Myers, M.D.
Andrew Perkins
Neppie Stevens
Linda Sutton

State Health Plan Staff Participating:

Jack W. Walker
Lacey Barnes
Linda Forsberg
Wendy Greene
Linda McCrudden
Mona Moon
Sally Morton, PharmD
Lorraine Munk
Bruce Norman, M.D.
Anne Rogers
Becky Sandling
Tracy Stephenson
Marci Wilding

Welcome

Mr. Beam welcomed Board members, State Health Plan staff and guests to the meeting and thanked Mr. Perkins for hosting the meeting on the campus of North Carolina A&T University. Mr. Perkins, in turn, also welcomed the Board to the campus on behalf of the Chancellor and the University.

Dr. Walker requested the Board's permission to move the Actuarial RFP Results and Recommendations to Executive Session due to confidentiality of information that will be presented until the Department of Purchase and Contracts makes the award announcement. The Board agreed to revise the agenda accordingly.

Approval of Minutes

Following review of the minutes and one correction noted in the second full paragraph on page 3, changing the word fine to five, Mr. Perkins moved to approve them and Dr. Myers seconded the motion. The Board members voted unanimously to approve the minutes as amended.

Follow-up from Previous Board Meeting

Fiduciary Analysis

Ms. Greene presented information on five state agency boards to assist the Board in determining their fiduciary responsibility as a member of the Plan Board. Several boards assume a greater fiduciary role and others serve in an advisory role. It was noted, however, that each of the state boards included in the presentation have greater responsibilities than the Plan Board and are also covered under the State Ethics act. The Plan is not covered under the State Ethics Act.

As the Plan moves forward in requesting clarification from the legislature regarding the roles and responsibilities of the Board, it is important to understand the overall structure and possibilities.

Mr. Beam stated that, given the content of the Auditor's report, a new Governor, and a change in Plan leadership, the Board would like to consider establishing a subcommittee comprised of Board members. This committee would further explore the structure of the Plan Board, its function, roles and responsibilities and present their recommendations back to the Board and Plan staff. These recommendations would then be presented to the legislative Oversight Committee for their consideration.

Dr. Myers moved to appoint Pam Silberman as chair of the committee, and Dr. Hammond, Neppie Stevens and Linda Sutton as members. Dr. Hayek seconded the motion and the Board voted unanimously to approve the committee and its members. Mr. Beam requested that Ms. Greene provide additional information and models to the subcommittee and also appointed Ms. Greene to facilitate and advise the subcommittee on behalf of the Plan.

Benefits by State Report

Ms. Forsberg presented detailed benefit information to the Board comparing the Plan with eight surrounding states and other PPO plans within North Carolina. The average deductible is $330 and the average primary provider copay is $20. The Plan is the only group to offer a 4th tier for pharmacy benefits. The State of West Virginia charges premiums based on income.

The Board requested that the Plan provide further information regarding the number of members in each of these states, if possible, and also commended Plan staff for the level of detail included in the document. The Plan will post the report on its website.

Clinical Risk Group Analysis

Ms. Rogers stated that the baseline data presented to the Board was from the period of October 2003 to September 2004 and that follow-up data from 2006-2007 did not depict much change.

The population profiles included both PPO and Indemnity members and, as expected, the cost of care was higher for chronic members in the Indemnity Plan. The Plan will continue to focus on aligning health costs and assisting members in improving their health care choices. The three primary categories are pharmacy, disease management and benefits.

The Plan will review several ideas around cost sharing and whether they would apply across the board or based on income. Incentive and disincentive options will also be considered, for example, in the area of smoking cessation.

Currently, nearly sixteen percent of Plan members account for sixty-eight percent of the cost and the data indicates that Plan programs are serving only five percent of that membership. Sixty percent of active employees are pre-diabetic or have diabetes and ninety percent are pre-hypertensive.

Ms. Rogers continued by presenting the Plan's comprehensive wellness proposal and emphasized that these are suggestions at this point and that the Plan would carefully consider all options. First, members would be encouraged to participate in wellness programs and use health coaching to improve overall health. Several options to consider would be to establish premiums for all members and waive them with participation in wellness programs. The Plan could also consider mandatory completion of Personal Health Risk Assessments and personal health coaching for certain risk factors. The Health Dialog contract could be expanded to include Healthy Living Initiative modules for wellness coaching around diet and exercise.

The Plan will research funding for the above options beginning with the Golden Leaf Fund and the Health and Wellness Trust Fund and continue to provide information to the Board.

Contracting Policy Overview

In 2007, the Plan began to develop a contracting policy and standard operating procedure regarding procurement of services. The policy was formally implemented in July 2008 with emphasis placed on contract ownership. The Contracting Department assumes responsibility for procurement and the terms, conditions and financial performance of a

contract and works closely with the contract's business owner. The Executive Administrator is ultimately responsible for all contracts.
Following the procurement of a service, the single most important aspect is monitoring and managing the contract, including the need to amend a contract. The recommendation is to conduct an annual review of each contract but quarterly contract reconciliation is encouraged.

The Plan has recently procured an automated contract management system to assist in meeting contractual obligations. Key staff members have been trained on the system which will be fully implemented in December 2008.

The Board inquired if the Plan went through the RFP process to procure claims processing services. Ms. Sandling said, to her knowledge, the Plan did go through that process in 1997 but did not initiate the RFP process for the PPO in 2005. Board members discussed the need for more than one bidder to compete for claims processing services and emphasized that the Plan should not be reliant upon one company exclusively.

The Board requested that the PPO contract process be added to the February 2009 meeting agenda.

Financial Reports

State Health Plan Quarterly Report (July to September 208)

Ms. Durrell stated that the Plan is retooling the monthly and quarterly reporting process and documentation.

The July to Sept quarterly shows the migration of 180,000 Indemnity plan members to the PPO. The overall population did not grow as much as in past quarters. This anticipated migration was factored into the recasted budget with current figures in line with budged projections.

Ms. Moon reviewed the September and first quarter financial results (July – September 2008), noting that although the Plan expenses for the month of September and the first quarter were less than the recasted budget projection, the difference is primarily related to the timing of vendor payments. Overall, actual budget results are tracking closely to the recasted budget projections.

October Preview

Ms. Moon stated that the October financials are not currently available for review but that she expected the information would be sent to the Board prior to November 26. The ending cash balance for October is expected to be significantly higher than projected. Ms. Moon explained the result is attributed to increased premium receipts due to a recent increase in enrollment as well as the timing of various payments and receipts.

Financial Forecast FY 2009/2011 and Trends

Dr. Walker stated that the current numbers are better than recasted projections but that it may be a timing issue of vendor payments. The Plan has, through negotiation, rescheduled major vendor payments of around $45 million. These payments were moved from the October 2008 to March 2009 period to the last quarter of the fiscal year.

If the General Assembly allocates $300 million to the Plan in April 2009, the Plan should have sufficient cash to operate through September 2009.

Claims Audit Report Followup – January to March 2008

Ms. Moon presented follow-up information to the report presented at the September Board meeting. She stated that the Plan uses these audits to determine vendor compliance with contractual requirements and obligations, as well as the extent to which errors are being made in processing claims.

The specific issue of concern is a coding mistake identified by the auditor that resulted in a large pricing error. As a result of the error, the Claims Processing Contractor exceeded the maximum payment error rate allowed under the contract. However, the error did not impact performance guarantees. Ms. Carol Sutton, Vice President for State Operations at BCBSNC, stated that corrective actions have been put into place to prevent future occurrences of this problem. She also said that a subsequent refund of the overpayment was received. In addition to modification of the procedures for manual review of claims, BCBSNC increased the frequency of the system query designed to catch this particular type of coding error.

Premiums Survey

Dr. Walker presented information on a 2007 survey which compares premiums for North Carolina private sector companies to those of the State Health Plan. Nearly seventy-four percent of premiums for dependent coverage are paid by employers in the private sector compared to nearly forty-one percent paid by the State Health Plan. However, nearly ninety-seven percent of individual premiums are paid by the employer for State employees as compared to eighty-two percent in the private sector.

Dependent Eligibility Audit

Ms. Forsberg presented a Plan initiative that would ensure that only people eligible for the State Health Plan are covered. It's possible that between five and ten percent of current dependents are ineligible due to various reasons such as divorce, stepchildren, common law partners and custody arrangements, etc.

The Plan will send letters only to those members who have dependent coverage informing them of the audit and that documentation for dependents will be required. This will be followed by a verification process and then a claims recovery process. The Plan is intending to complete the entire process by June 2009, including letters of termination to members who have not submitted dependent documentation.

The Board suggested that any ineligible member with a medical disaster be exempt from the recovery process.

Electronic Enrollment

Ms. Forsberg stated that the Plan is reviewing the possibility of electronic enrollment for nearly 200,000 non-Beacon members, including employees within the university and community college systems, state teachers, charter schools and municipalities. Electronic enrollment would provide greater accuracy and eliminate the many printing and mailing expenses.

However, the agencies involved would need to assume responsibility for payment for the interface with their payroll system. The Plan also acknowledges that not all employees have computer access and a work-around has been developed. Prior to implementation, the Plan would need to provide numerous HBR training sessions and a letter to impacted members would be sent.

The timeline to implement this project is Spring 2009.

Municipality Data Update

As requested by the Board at the September meeting, Ms. Forsberg provided additional information on municipalities covered under the Plan. Financially, the Plan is breaking even on these members. The age/sex breakdown of employees is relatively even in each category.

Strategic Plan Foundation

Ms. Barnes stated that the Plan has revised its Strategic Plan. Management and staff participated in the process of identifying the Plan's Mission, Vision, Strategic Goals and Values. The Strategic Plan is now more focused on the core business of the Plan, namely providing health insurance coverage to Plan participants. Departmental initiatives and individual work plans for all staff are being created which are in alignment with the Strategic Plan.

The Board suggested posting the strategic plan on the Plan's website.

Pilot Programs

Salary Band Benefit Plan Option

The concept of this pilot is to determine if cost sharing with low income employees would result in lowering health care costs.

If the legislature deems this pilot appropriate, the Plan will need to consider the level of participant involvement to initiate a measurable project.

Generic Lipid Lowering Drug Adherence

The Plan would like to consider a pilot program using generic lipid lowering medications, a category which twenty percent of the Plan's population currently use. All generic lipid lowering medications would be available for a $4 copay/34 days supply.

The short term benefit for implementing this program would be the increase in the generic dispensing rate (GDR) in this drug category. If the GDR were to increase by four percent, the money saved is projected to offset the $1.9 million program cost. The long term benefit would hopefully show a decrease in hospitalizations and long term illnesses due to elevated cholesterol levels.

This would be an 18 month program with an initial analysis of the GDR and medication adherence using the first 12 months of experience.

The Board unanimously approved the generic lipid lowering drug adherence pilot program.

Warfarin/Genetic Testing

By way of information, Ms. Morton informed the Board that Medco, the Plan's pharmacy benefit manager, is currently looking for 1500 members to participate in a study to determine if new users of Warfarin, who participate in a genetic study, will achieve optimal dosing of this drug. Optimal dosing will decrease hospitalizations. There would be no cost to participants or providers.

The Plan would have access to the study data to determine long term plans for continuing this program.

Pharmacy Management Initiatives

Ms. Stephenson reported on several pharmacy initiatives aimed at lowering costs while maintaining clinical appropriateness. The Plan implemented a prior authorization program November 1, 2008 for new users of specialty medications used to treat psoriasis, multiple sclerosis and diseases related to immune system abnormalities.

By seeking prior authorization for drugs in these categories, it will ensure that members are taking clinically appropriate drugs for these conditions. The Plan spends nearly $20 million annually on these drugs and is projected to save around $760,000 annually with minimal impact to members.

The Plan also implemented a step therapy program November 1, 2008 for new users of Effexor XR and Pristiq, two drugs used to treat depression and other psychiatric disorders. Members will be required to try an approved medication in the same class of drugs before coverage for these two drugs is approved.

The annual total spend for drugs in this class is around $67 million. The projected annual savings for this program, in conjunction with a similar program for Lexapro implemented in October, 2008, is around $3.8 million.

Ms. Stephenson also reported that, effective January 1, 2009, the Plan will move several medications to the highest copay tier as there are many alternatives for these drugs, including several generic choices. The annual savings to the Plan is projected to be about $1.1 million.

The Plan will send a revised Preferred Drug List brochure to members at the end of November, along with the annual *PharmacyWise* newsletter. This publication provides pharmacy benefit information, along with cost savings information

Medical Policies

Several mental health policy changes were made to align the Indemnity benefit plan language with the PPO benefit language. The Plan will need to ensure that the language in the statute is also changes during the next session.

The following policies were reviewed: IN0510, IN0520, IN0450, AD0420, IN0560, IN0550, ME0495, ME0650, AH0725, IN0300, AD0430

Ms. Sutton moved to adopt the policy changes and Ms. Stevens seconded the motion. The Board voted unanimously to approve the mental health policy changes.

Future Board Meetings

Mr. Beam suggested that the Board meet on the second or third Tuesday in February and in June. He requested that Ms. Munk send the Board several dates for their consideration. The next meeting will be held in the Raleigh area.

At the request of Mr. Beam, Mr. Perkins made a motion to move into executive session and Dr. Myers seconded the motion. The Board voted unanimously to move into executive session.

Actuarial RFP Results and Recommendations

State Health Plan RFP

Ms. Moon presented the results of the actuarial RFP evaluation. The Plan received five proposals, two of which were disqualified, one for not meeting the minimum requirements and credentials and the second for taking exception with the State's terms and conditions.

Plan staff completed the technical scoring before reviewing the financial portion of the RFP.

Dr. Hammond made a motion to approve the Plan's actuarial consulting choice and Mr. Perkins seconded the motion. The Board voted unanimously to approve the actuarial consulting vendor chosen by the Plan.

Health Choice RFP

The Plan received two proposals to provide actuarial services related to the NC Health Choice program administered by the Plan. A separate actuarial contract for NC Health Choice will assist in the transition of the administration of NC Health Choice from the Plan to DHHS. This transition is required by law and must be completed no later than July 1, 2010.

Dr. Hayek made a motion to approve the vendor the Plan recommended and Dr. Hammond seconded the motion. The Board voted unanimously to approve the vendor recommended by the Plan to assist in the transition of the administration of NC Health Choice from the Plan to DHHS.

Ms. Moon stated that the recommendations of the vendors for both SHP and NC Health Choice actuarial services contracts would be submitted to Department of Purchase and Contracts for processing and approval on November 19.

ASO Survey and Contract Administration Expenses

Ms. Barnes presented confidential information regarding the Plan's annual administrative expenses.

OAH Cases

Board rulings in OAH case 07 INS 1319 and OAH Case 08 INS 0035 can be found on Attachment A

Following a motion by Dr. Myers to return to open session and seconded by Ms. Sutton, the Board voted unanimously to return to open session. Mr. Beam then called for a motion to ratify the matters considered in Executive Session. The motion was made by Ms. Sutton and seconded by Dr. Hayek. The Board members voted unanimously to ratify the items discussed in Executive Session.

There being no further business, the Board meeting was adjourned at 2:00 p.m.

BCBSNC Contracting Process

Board of Trustees' Meeting

February 17, 2009

Contracting Process

The Claims Processing Contract was last put out for bid in 1996 and BCBSNC was the sole bidder. The RFP # was 601905 and was issued on 4-19-1996 by Barbara Stone-Newton (P&C), who is now retired. The Plan maintains copies of the RFP and the response from BCBSNC.

Contracting Process

This Claims Processing Contract that was entered into in 1996, applied to the Comprehensive Major Medical or Indemnity Plan. It is currently in a claims run out period, since all members have shifted to the PPO. The Indemnity Contract will remain in effect until run out is complete, which is at least 18 months from June 30, 2008. The PPO Contract was effective February 28, 2006. It will expire June 30, 2013.

Contracting Process

The PPO Contract was not procured under a competitive bid process. The Plan exercised its statutory authority, as outlined at that time in G.S. 135-39.5(b), titled “Optional plans” and now repealed, which stated in part, “Contracts for an optional program under this subsection are not subject to Article 3 of Chapter 143 of the General Statutes.”

Contracting Process

For future contracts, please note that G.S. 135-43(b) which states in part, "…The design, adoption and implementation of the preferred provider contracts, network and optional…health benefit plans…are not subject to the requirements of Chapter 143 of the General Statutes." This provision could be invoked in the future.

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Generic Cholesterol Lowering Medication Adherence Pilot Program Update

Plans are underway to launch the generic cholesterol lowering medication adherence pilot program April 1, 2009 as approved at the last Board meeting. This program is designed to help members with high cholesterol avoid the risks of not taking their medications as prescribed by reducing the costs of their medications. A slight change in the program design was made from the previous presentation to allow generic coverage for $4/month OR $10 for a 3 month supply. It is estimated that the addition of the $10 benefit will add an additional $106,000 to the cost of the program. The cost of the program is anticipated to be covered by savings seen with the increase in generic dispensing in this drug category.

An extensive communication plan has been developed to notify all members currently taking brand and generic cholesterol medications of this medication adherence program, as well as for providers and pharmacists. A list of the medications included in the program is included below. Members currently taking generic medications will save $80 per year, and if the member switches to a generic alternative their savings would range from $320 to $560 annually. Quarterly outreach to members to remind them about the importance of taking their cholesterol medications as prescribed are also planned.

Generic Medication	Equivalent Brand Name
Cholestyramine/sucrose	Generic for Questran®
Cholestyramine/aspartame	Generic for Questran Light®
Colestipol 1g tablets & 5g packets	Generic for Colestid®
Fenofibrate	Generic for Tricor®
Gemfibrozil	Generic for Lopid®
Lovastatin	Generic for Mevacor®
Pravastatin	Generic for Pravachol®
Simvastatin	Generic for Zocor®

Warfarin Pilot Program Update

For the State Health Plan there have been 316 eligible members identified, with 77 members accepting the program and 49 providers accepting the program.

As of 1/19/09, 24 of the 49 State Health Plan members and providers that accepted the program have received completed warfarin genetic testing results (listed below), 15 members have results pending, and 10 did not pursue testing after accepting. Medco has a total of 1,456 completed results out of a total goal of 1500. At this point testing will most likely end in February.

Medco and the Mayo Clinic are planning to publish results of the study once completed.

Lab Results	24	100%
Less than normal sensitivity to warfarin. Dose increase may be required to maintain optimal INR.	7	29.17%
Normal response to warfarin.	5	20.83%
Mild sensitivity to warfarin. Frequent INR monitoring should be considered.	4	16.67%
Moderate sensitivity to warfarin. Dose decrease & frequent INR monitoring should be considered.	6	25.00%
High sensitivity to warfarin. Dose decrease & frequent INR monitoring should be considered.	1	4.17%
Very high sensitivity to warfarin. Dose decrease & frequent INR monitoring should be considered. Rare genotype.	1	4.17%

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Tobacco Master Settlement Agreement Follow Up

The State of NC received funds through the Tobacco Master Settlement Agreement allocated as follows:

A. Fifty percent (50%) of funds created the Golden Leaf Foundation, whose mission is to provide economic impact assistance to economically affected or tobacco-dependent regions of NC.

B. Fifty percent (50%) of funds allocated to the Settlement Reserve Fund, a restricted reserve in the General Fund, established by NC Gen Stat 143-16.4. The NCGA then allocated these funds as follows

a. Twenty five percent (25%) to a trust fund for the direct and indirect financial assistance to tobacco producers, allotment holders, and persons engaged in tobacco-related businesses.

b. Twenty five percent (25%) to create the Health and Wellness Trust Fund whose mission is to address health and wellness issues for North Carolinians.

Golden Leaf Foundation Grants

Focus Most Pertinent to SHP: Job creation and retention projects of particular interest include efforts to create opportunities for employment with new and existing businesses in tobacco-dependent, economically distressed, and/or rural communities, particularly in the healthcare sector.

Health and Wellness Trust Fund

Areas of Focus Most Pertinent to SHP: HWTF has focused mostly on tobacco cessation campaigns, including supporting the NC Quitline for teens and college students, and started addressing obesity reduction, increased fitness and health disparities in the last five years.

Wake County Superior Court (98 Cvs 14377) Consent Decree and Final Judgment in the State of NC vs. Philip Morris Inc., et al, December 21, 1998. See Section VI “Monetary Relief.”

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State Health Plan
Active Member Admissions

Calendar/Fiscal Incurred-Inpatient Facility Claims: Top 9 hospitals								
Reporting Period = 2007								
Provider Name	**Product**	**Services**	**Days**	**Average Length of Stay**	**Billed**	**Allowed**	**Paid**	**Allowed/Service**
Hospital A	PPO	310	1,306	4.2	$5,245,635	$2,341,335	$2,053,608	$7,552.69
Hospital A	CMM	587	2,893	5.4	$15,081,189	$8,941,790	$8,449,918	$15,233.03
Hospital B	PPO	574	3,502	6.2	$21,253,905	$9,411,093	$9,102,397	$16,395.63
Hospital B	CMM	609	3,412	5.8	$23,641,242	$9,553,380	$9,094,439	$15,687.00
Hospital C	PPO	393	2,160	5.3	$13,448,636	$7,366,162	$6,931,831	$18,743.41
Hospital C	CMM	259	1,129	4.4	$7,118,792	$3,202,104	$2,992,831	$12,363.34
Hospital D	PPO	295	1,220	4.1	$4,251,995	$3,557,367	$3,281,307	$12,058.87
Hospital D	CMM	309	1,177	3.8	$4,950,210	$2,700,807	$2,408,754	$8,740.48
Hospital E	PPO	633	2,801	4.5	$15,873,668	$7,871,570	$7,262,883	$12,435.34
Hospital E	CMM	652	3,268	4.9	$18,492,679	$9,282,549	$8,684,245	$14,237.04
Hospital F	PPO	486	1,555	3.2	$6,995,968	$3,098,462	$2,769,621	$6,375.44
Hospital F	CMM	433	1,131	2.6	$7,302,788	$3,525,324	$3,141,035	$8,141.63
Hospital G	PPO	471	2,498	5.2	$16,917,428	$5,776,452	$5,225,533	$12,264.23
Hospital G	CMM	453	2,143	4.8	$15,757,338	$6,110,806	$5,697,937	$13,489.64
Hospital H	PPO	521	2,265	4.5	$9,992,955	$7,467,375	$6,919,085	$14,332.77
Hospital H	CMM	434	1,571	3.7	$8,145,191	$5,803,618	$5,435,342	$13,372.39
Hospital I	PPO	394	1,465	3.7	$4,949,947	$3,396,937	$2,951,678	$8,621.67
Hospital I	CMM	358	1,212	3.4	$4,383,718	$2,857,022	$2,543,345	$7,980.51
Total Average	**PPO**							**$12,086.67**
	CMM							**$12,138.34**

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Clinic Services Pilot Proposal – February 2009

Investigate the effectiveness of health and wellness promotion and its impact on health care costs by offering acute and health and wellness focused care in a work place setting.

- Utilize the clinic model to promote health and wellness by effectively identifying, managing and educating patients with chronic conditions and those at risk for chronic conditions.
- Make referrals to the member's Primary Care Provider or secure PCP services as needed.
- Provide basic biometric screenings members for risk factor identification and provide support for lifestyle changes.
- Assist members in navigating the health care system and refer to care management programs as appropriate.
- Promote the use of generic medications as appropriate.
- Study the impact of the intervention on outcomes/cost.

Project Status

SHP has met with representatives from Eastern Carolina University School of Medicine (ECU), and UNC-Chapel Hill School of Medicine to gain provider insight and recommendations into clinic models. In addition, SHP staff discussed potential clinic models and approaches with Watson-Wyatt Worldwide consulting firm. Informational sessions have been held with several vendors, including CVS's Minute Clinic, Take-Care Health Systems (formerly CHD Meridian), Marathon-Health, HealthStat and CHS; these are the top providers of on-site employee clinic services in the United States.

Additional meetings with area physicians will be scheduled.

An RFP is in process and targeted for posting in July.

The goal is to implement the model in the first quarter of 2010.

North Carolina
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NC Health*Smart*
Disease Management
Return on Investment

February 17, 2009

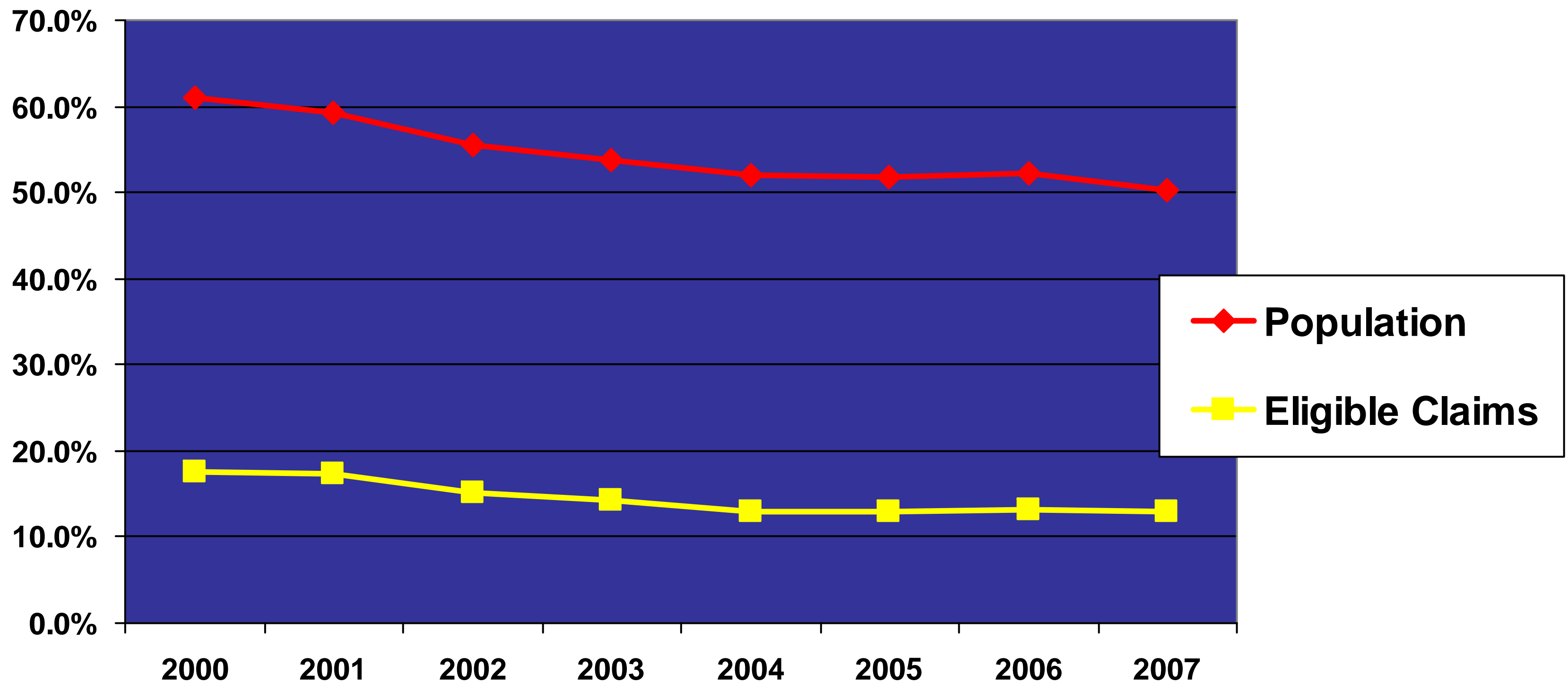
Chronic Disease Prevalence/Cost

- Chronic Disease Trend Report (2004)
  - Showed a decline in % of “healthy” members (non-Medicare primary) from 64% in 2000 to 58% in 2003 and a projected 51% in 2008
  - Costs expected to increase 59% pm/py over the next 5 years
- NC Health*Smart* Program Implemented (2005)

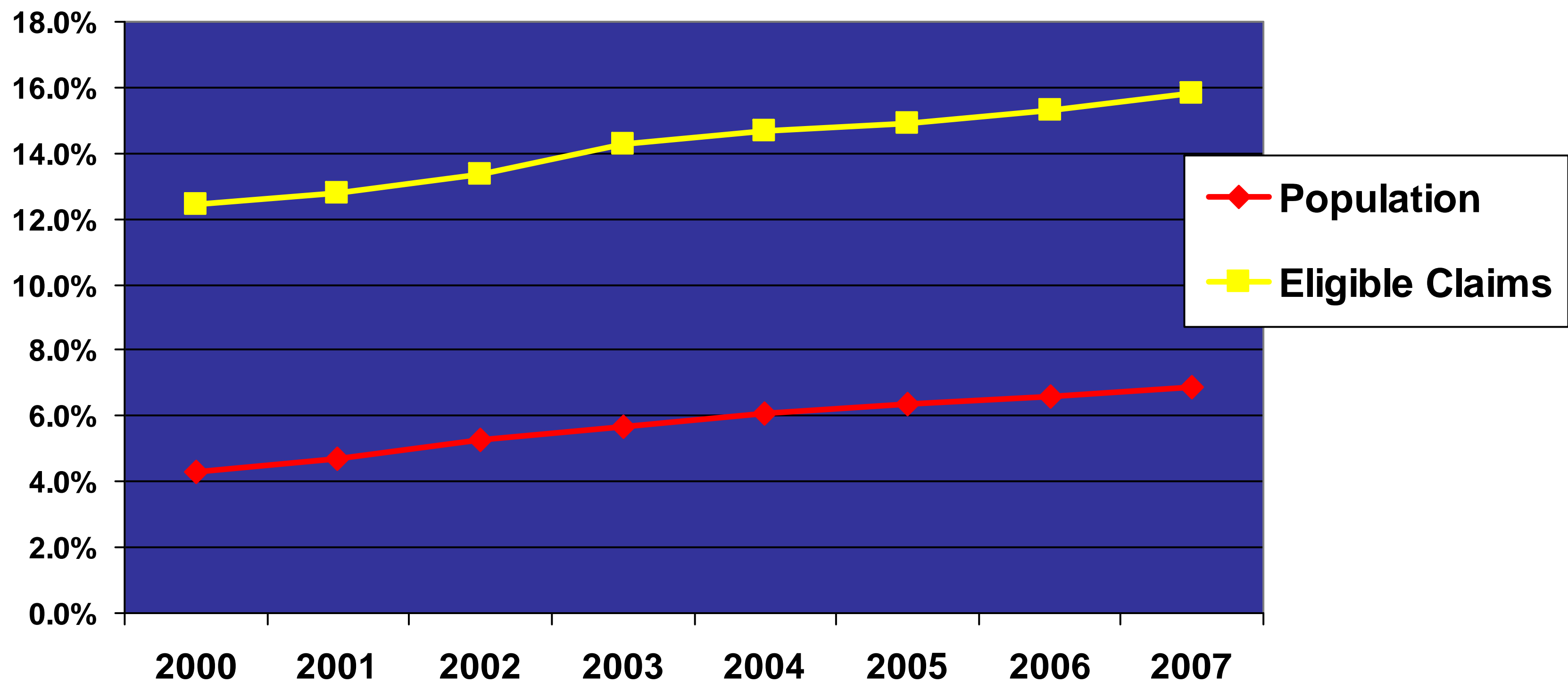
So how are we doing??

Part I. Analysis of claims data through CY 2007 in “The State of Member Health 2008” report *(3M Chronic Risk Grouper - Aon)*

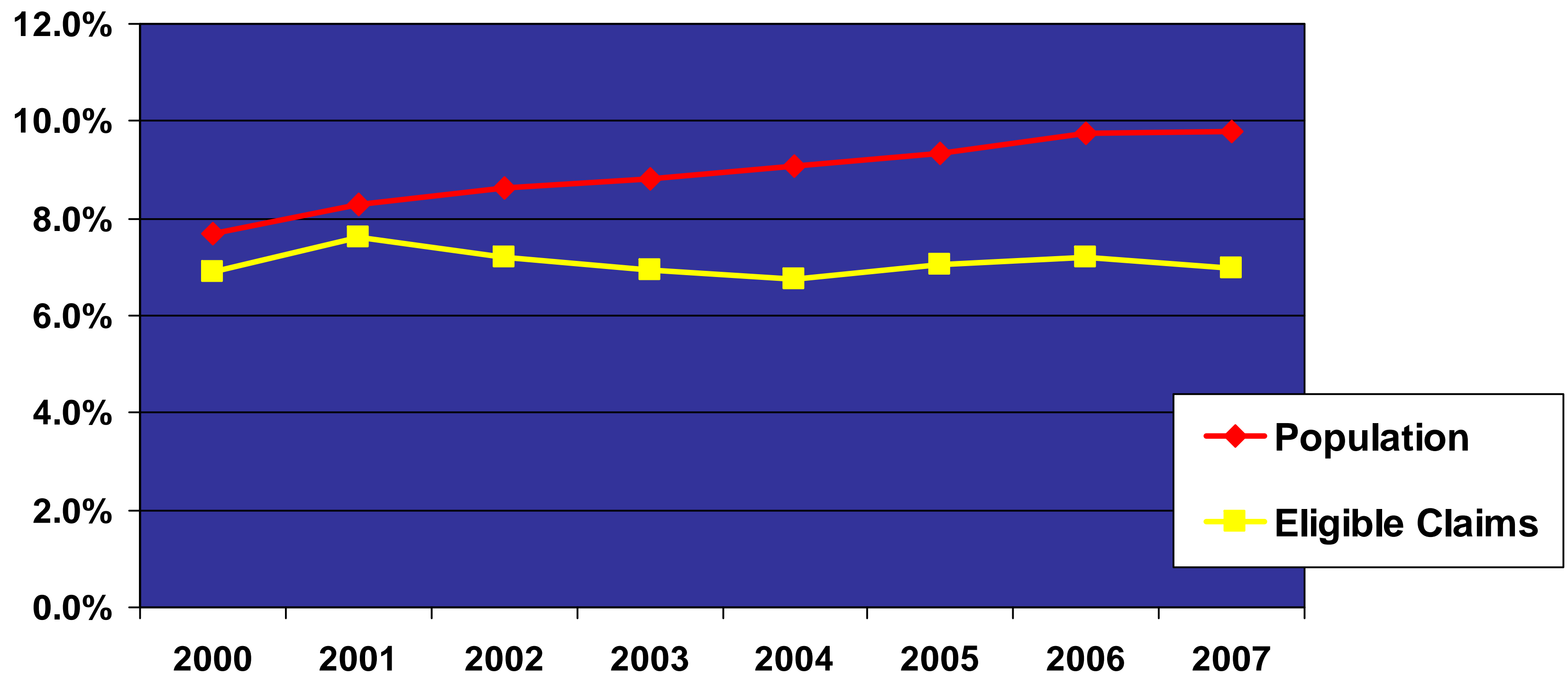
Chronic Disease Prevalence/Cost



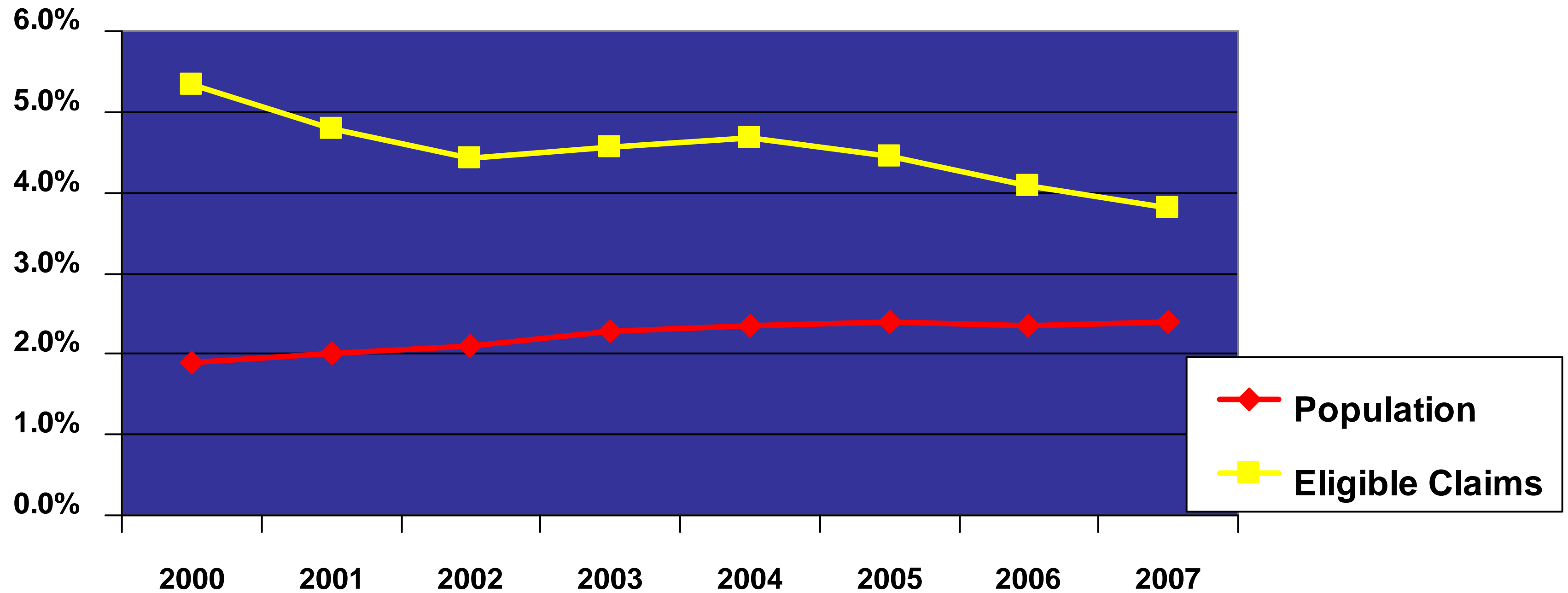
Chronic Disease Prevalence/Cost



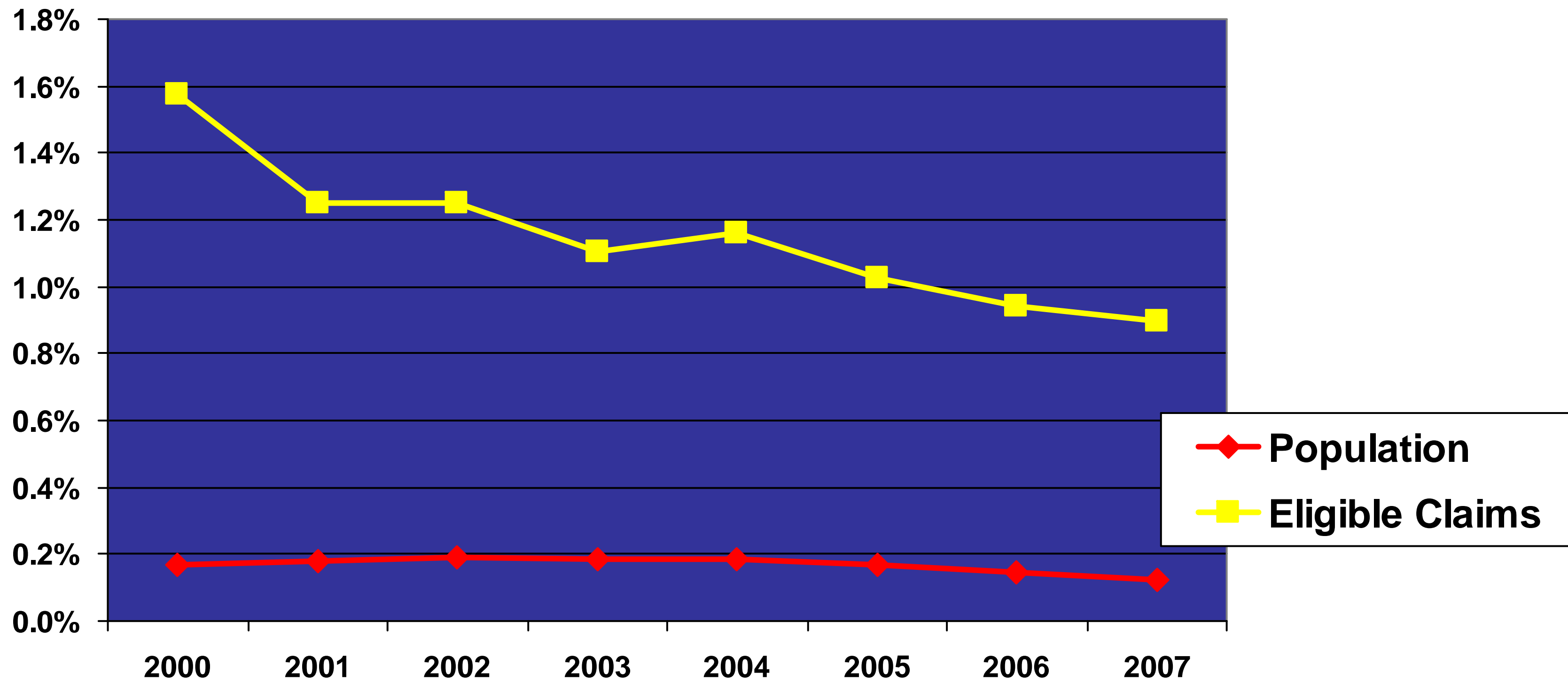
Chronic Disease Prevalence/Cost



Chronic Disease Prevalence/Cost



Chronic Disease Prevalence/Cost



So how are we doing??

Part II. Sub-analysis of members with at least one Health Coach contact for a chronic illness or preference sensitive condition (CY 2006/2007)

2008 Chronic Disease Trend Report

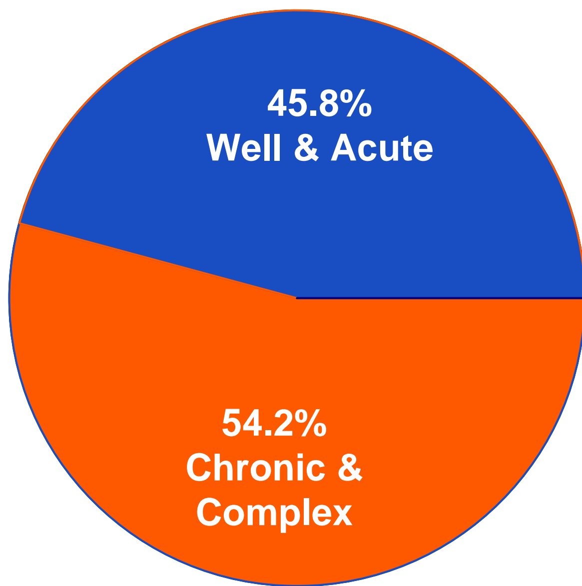
- Good news!! NC Health*Smart* Disease Management programs are making a difference for the chronic population and Plan costs!
  - Independent validation of a 2:1 ROI
  - Savings of approximately $18 million in CY 2007 (targeted disease states only)

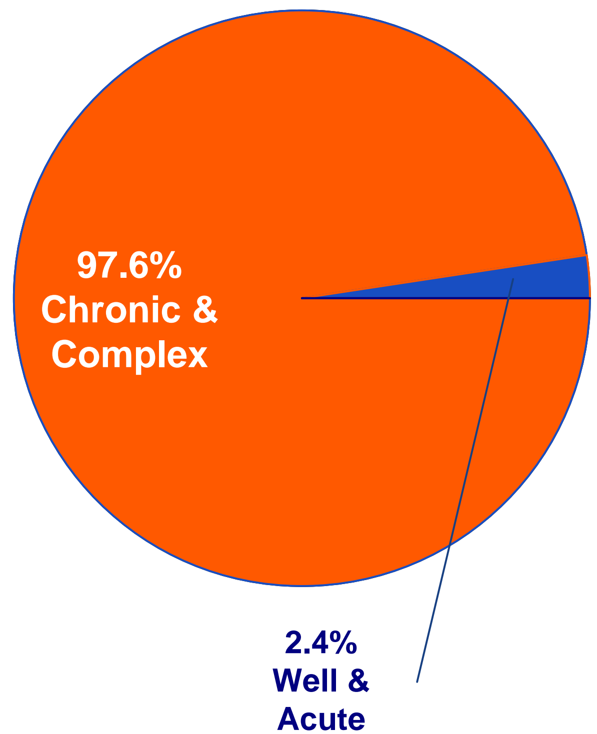
Example: Diabetes

CY 2007 Actual Cost	$252,375,636
With No Intervention Cost	$263,494,985
Savings	$ 11,119,349

Pharmacy Utilization – by Patient Health Status

All Members





Plan Spend Per Member Per Year: $50 for Acute & Well
$1,688 for Chronic & Complex

North Carolina
State Health Plan
for Teachers and State Employees
www.shpnc.org

State Health Plan Pharmacy Management Initiatives (1Q & 2Q, 09)

In continuing with the efforts to strengthen the financial health of the State Health Plan, the pharmacy department has continued to identify clinically appropriate, cost effective pharmacy programs.

Prior Authorization Programs

Heartburn medication step therapy program: Beginning February 2, 2009 additional heartburn medications will be added to the existing step therapy program to maximize pharmacy contracts and continue to encourage the use of over-the-counter, generic and certain cost-effective brand name medications as first-line therapy. The medications that will be targeted are Prevacid Solutabs and suspension, brand Prilosec capsules, Protonix suspension and Zegerid capsules and suspension. Generic omeprazole, Prilosec OTC, omeprazole OTC and Nexium do not require a coverage review. This program revision has projected savings of $1.1M with approximately 1200 members impacted.

Migraine medication step therapy program: In December the most commonly prescribed migraine medication, Imitrex, became generically available. In order to encourage members to use the generic agent and preferred brands as first line therapy, the Plan will implement a step therapy program on May 1st for all Triptan migraine medications and will move a few Triptans to the highest copay tier. Generic Imitrex (Sumatriptan), Maxalt, Maxalt MLT and Relpax will be preferred and Amerge, Axert, Frova, Treximet, Zomig, and Zomig ZMT will move to the highest copay tier and will require a coverage review. This program, as well as the generic availability of Imitrex and movement of some of the medications to the highest copay tier, is projected to save the Plan over $2M and impact approximately 14,000 members. If members switch to the generic Imitrex product they could save $240 annually in copays.

Antiemetic quantity limit program: As of May 1, 2009 the Plan will implement a quantity limit on antiemetic medications to allow for coverage of 7 treatment days in a 30 day period. The total Plan cost of antiemetic medications last year was $4.4M with an average ingredient cost per Rx of $670. This quantity limit will ensure the appropriate utilization of expensive antiemetic medications and will align the Plan's utilization management programs with other large Plans such as United, Coventry and Cigna other government Plans. The antiemetics included in this program are Zofran (ondansetron), Kytril (granisetron), Anzemet, Emend, and Cesamet. Implementation of the quantity limits is estimated to save the Plan $1.5M and impact approximately 2,100 members.

Enhanced Refill Too Soon Program

As of March 2, 2009, the State Health Plan will implement an Enhanced Refill Too Soon program. The program is being implemented to enhance the State Health Plan system to comply with pharmacy practice standards and regulatory requirements, as they apply to the utilization of prescription medication.

Currently, the “Refill Too Soon” logic looks back 30 days to determine if a prescription can be filled. With the enhanced program, the pharmacy system will review the prescription history for the prior 180 days. Although the look back period is changing from 30 days to 180 days, a member can still receive a refill once 75% of the current medication on hand is used. The guideline is that no more than 30 days supply should be on hand when requesting a prescription fill.

Due to the enhancement of the edit, refill dates which are calculated based on the new "look back" timeframe of 180 days may cause new prescriptions and refills to reject "refill too soon" when previously they did not.

Summary

The pharmacy initiatives outlined above are key in managing the overall finances of the State Health Plan. The total savings of these initiatives are projected to result in an annual savings of approximately $5 million for the Plan. An extensive member and provider education program has been developed to accompany all of these changes.

THE STATE HEALTH PLAN OF NORTH CAROLINA
SUMMARY OF OPERATIONS (CASH BASIS REPORTING)
CONSOLIDATED
For the Period Ended December 2008
Fiscal Year 2008- 2009

		A	B	C	D	E	F	G	H
		Actual December 2008	**Budget December 2008 original ver: 7/9/2007**	**Monthly Actual Variance Over (Under) Budget**	**Actual Year to Date 2008-2009**	**Budget Year To Date 2008-2009 original ver: 7/9/2007**	**Variance Year To Date 2008-2009**	**Annual Budget 2008-2009 original Ver: 7/9/2007**	**YTD Actual Variance Over (Under) Annual Budget**
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 230,495,014	$ 181,642,306	$ 48,852,708	$ 1,193,361,807	$ 1,089,853,836	$ 103,507,971	$ 2,179,707,669	$ (986,345,862)
4	Retro Disenrollments			-	-	-	-	-	-
5	Premium Refunds	(143,007)		(143,007)	(1,495,169)	-	(1,495,169)	-	(1,495,169)
6	Medicare Part D Subsidy	5,438,065	4,039,630	1,398,435	27,204,213	20,798,489	6,405,724	45,898,872	(18,694,659)
7	Non-Capital Gifts			-	-	-	-	-	-
8									-
9	**Net Premium & Other Contributions**	**235,790,072**	**185,681,936**	**50,108,136**	**1,219,070,851**	**1,110,652,325**	**108,418,526**	**2,225,606,541**	**(1,006,535,690)**
10									
11	**Other Revenue**	**419,638**	**320,049**	**99,589**	**2,957,311**	**1,942,701**	**1,014,610**	**3,862,999**	**(905,688)**
12									
13	**Total Plan Revenue (excludes internal transfers)**	**236,209,710**	**186,001,985**	**50,207,725**	**1,222,028,162**	**1,112,595,026**	**109,433,136**	**2,229,469,540**	**(1,007,441,378)**
14									
15	**Plan Expenses:**								
16									
17	Medical Claim Payments	158,618,033	193,222,368	(34,604,335)	900,722,810	1,024,315,062	(123,592,252)	2,200,237,966	(1,299,515,156)
18	Pharmacy Claim Payments	48,604,636		48,604,636	306,682,165	-	306,682,165		306,682,165
19	Claim Refunds	(2,147,615)		(2,147,615)	(15,345,526)	-	(15,345,526)	-	(15,345,526)
20	Cost Savings		(2,522,754)	2,522,754	-	(23,076,963)	23,076,963	(38,216,704)	38,216,704
21									
22	**Net Claim Payments**	**205,075,054**	**190,699,614**	**14,375,440**	**1,192,059,449**	**1,001,238,099**	**190,821,350**	**2,162,021,262**	**(969,961,813)**
23									
24	**Net Administrative Expenses**	**18,778,512**	**10,949,295**	**7,829,217**	**80,128,557**	**63,602,051**	**16,526,506**	**129,297,821**	**(49,169,264)**
25									
26	**Total Plan Expenses (excludes internal transfers)**	**223,853,566**	**201,648,909**	**22,204,657**	**1,272,188,006**	**1,064,840,150**	**207,347,856**	**2,291,319,083**	**(1,019,131,077)**
27									
28	**Plan Income (Loss)**	**12,356,144**	**(15,646,924)**	**28,003,068**	**(50,159,844)**	**47,754,876**	**(97,914,720)**	**(61,849,543)**	**11,689,699**
29									
30	**Cash Availability:**								
31									
32	Beginning Cash Balance	77,228,510	277,468,895	(200,240,385)	139,744,498	214,067,095	(74,322,597)	214,067,095	(74,322,597)
33									-
34	Ending Cash Balance (Deficit)	89,584,654	261,821,971	(172,237,317)	89,584,654	261,821,971	(172,237,317)	152,217,552	(62,632,898)
35									
36	Target Stabilization Reserve @ 6/30/09	181,958,060	164,401,595	17,556,465	181,958,060	164,401,595	17,556,465	164,401,595	17,556,465
37									
38	**Cash Balance Over/(Under) Reserve Target**	**$ (92,373,406)**	**$ 97,420,376**	**$ (189,793,782)**	**$ (92,373,406)**	**$ 97,420,376**	**$ (189,793,782)**	**$ (12,184,043)**	**$ (80,189,363)**

Actual vs. Original Budget
December 2008

THE STATE HEALTH PLAN OF NORTH CAROLINA
SUMMARY OF OPERATIONS (CASH BASIS REPORTING)
CONSOLIDATED
For the Month Ended December 2008
Fiscal Year 2008- 2009

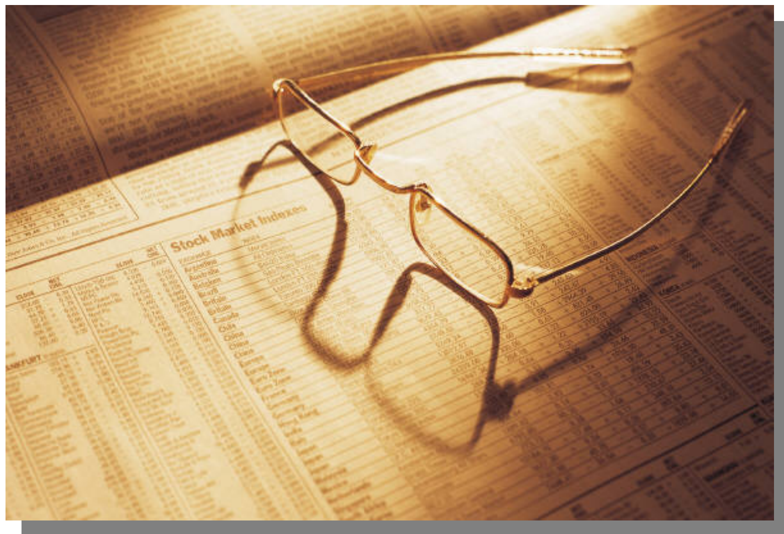
		A	B	C	D	E	F	G	H
		Actual December 2008	**Budget December 2008 recasted ver. 7/30/08**	**Monthly Actual Variance Over (Under) Budget**	**Actual Year To Date 2008-2009**	**Budget Year To Date 2008-2009 recasted ver. 7/30/08**	**Variance Year To Date 2008-2009 Over (Under) Budget**	**Annual Budget 2008-2009 recasted ver. 7/30/08**	**YTD Actual Variance Over (Under) Annual Budget**
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 230,495,014	$ 190,132,928	$ 40,362,086	$ 1,193,361,807	$ 1,140,797,568	$ 52,564,239	$ 2,281,595,143	$ (1,088,233,336)
4	Retro Disenrollments	-	(651,049)	651,049	-	(3,906,294)	3,906,294	(7,812,586)	7,812,586
5	Premium Refunds	(143,007)	-	(143,007)	(1,495,169)	-	(1,495,169)	-	(1,495,169)
6	Medicare Part D Subsidy	5,438,065	4,434,922	1,003,143	27,204,213	27,869,806	(665,593)	53,886,565	(26,682,352)
7	Non-Capital Gifts	-	-	-	-	-	-		-
8									-
9	**Net Premium & Other Contributions**	**235,790,072**	**193,916,801**	**41,873,271**	**1,219,070,851**	**1,164,761,080**	**54,309,771**	**2,327,669,122**	**(1,108,598,271)**
10									
11	**Other Revenue**	**419,638**	**273,227**	**146,411**	**2,957,311**	**1,706,213**	**1,251,098**	**2,711,451**	**245,859**
12									
13	**Total Plan Revenue (excludes internal transfers)**	**236,209,710**	**194,190,028**	**42,019,682**	**1,222,028,162**	**1,166,467,293**	**55,560,869**	**2,330,380,573**	**(1,108,352,412)**
14									
15	**Plan Expenses:**								
16									
17	Medical Claim Payments	158,618,033	169,266,547	(10,648,514)	900,722,810	919,447,823	(18,725,013)	1,835,578,715	(934,855,905)
18	Pharmacy Claim Payments	48,604,636	49,521,201	(916,565)	306,682,165	319,604,743	(12,922,578)	629,013,163	(322,330,999)
19	Claim Refunds	(2,147,615)	(1,977,316)	(170,299)	(15,345,526)	(11,873,814)	(3,471,712)	(24,477,232)	9,131,705
20	Cost Savings	-	(1,117,372)	1,117,372	-	(4,646,554)	4,646,554	(14,007,170)	14,007,170
21									
22	**Net Claim Payments**	**205,075,054**	**215,693,060**	**(10,618,006)**	**1,192,059,449**	**1,222,532,198**	**(30,472,749)**	**2,426,107,476**	**(1,234,048,029)**
23									
24	**Net Administrative Expenses**	**18,778,512**	**18,966,329**	**(187,817)**	**80,128,557**	**84,577,462**	**(4,448,905)**	**168,696,644**	**(88,568,088)**
25									
26	**Total Plan Expenses (excludes internal transfers)**	**223,853,566**	**234,659,389**	**(10,805,823)**	**1,272,188,006**	**1,307,109,660**	**(34,921,654)**	**2,594,804,120**	**(1,322,616,117)**
27									
28	**Plan Income (Loss)**	**12,356,144**	**(40,469,361)**	**52,825,505**	**(50,159,844)**	**(140,642,367)**	**90,482,523**	**(264,423,547)**	**214,263,705**
29									
30	**Cash Availability:**								
31									
32	Beginning Cash Balance	77,228,510	39,571,494	37,657,016	139,744,498	139,744,497	1	139,744,497	1
33									
34	Ending Cash Balance (Deficit)	89,584,654	(897,867)	90,482,521	89,584,654	(897,870)	90,482,524	(124,679,050)	214,263,706
35									
36	Target Stabilization Reserve @ 6/30/09	181,958,060	181,958,060	-	181,958,060	181,958,060	-	181,958,061	(1)
37									
38	**Cash Balance Over/(Under) Reserve Target**	**$ (92,373,406)**	**$ (182,855,927)**	**$ 90,482,521**	**$ (92,373,406)**	**$ (182,855,930)**	**$ 90,482,524**	**$ (306,637,110)**	**$ 214,263,706**

Comments:

a. Total delinquent receivables outstanding as of December 31, 2008 was $7,927 for Indemnity and $428,821.77 for PPO Plans.
b. The average weekly medical claims cost net of claims refunds was $31,294,083.60
c. Pharmacy claims include two bi-weekly invoice cycles and averaged $24,302,318 per cycle.
d. Stabilization reserve is 7.5% of the funding projection for net claims for Fiscal Year 2008-2009 or $181,958,060.
e. Minor differences between budget amounts for this report compared to Aon's budget projections are due to rounding.
f. Variance in member premiums is due to several groups paying January 2009 premiums in December.

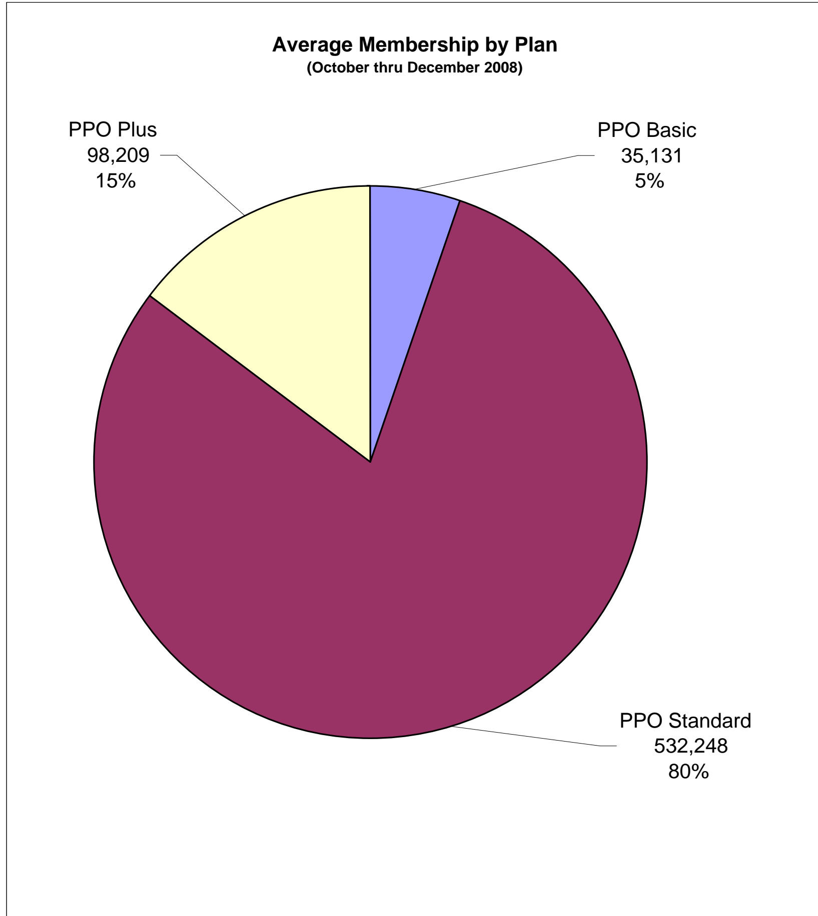
Actual vs. Recasted Budget
December 2008

State Health Plan Quarterly Report
2nd Qtr FY08-09
(October 08 – December 08)



February 17, 2009

Membership by Plan 2nd Quarter FY 08-09



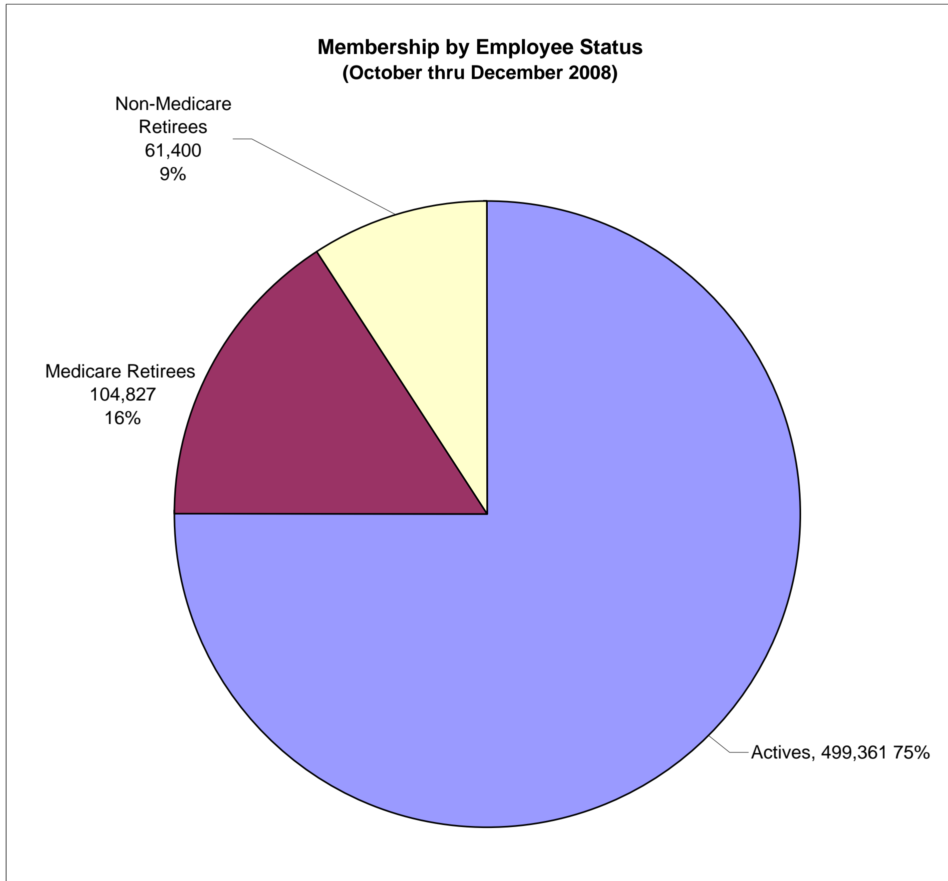
	October 2008				
	Employees	Dependents	Total	% of SHP Mbrshp	Average Family Size
PPO Basic	13,298	21,703	35,001	5.27%	2.63
PPO Standard	400,195	131,077	531,272	79.97%	1.33
PPO Plus	66,183	31,891	98,074	14.76%	1.48
Totals	479,676	184,671	664,347	100%	

	November 2008				
	Employees	Dependents	Total	% of SHP Mbrshp	Average Family Size
PPO Basic	13,393	21,744	35,137	5.28%	2.62
PPO Standard	400,756	131,511	532,267	79.97%	1.33
PPO Plus	66,254	31,949	98,203	14.75%	1.48
Totals	480,403	185,204	665,607	100%	

	December 2008				
	Employees	Dependents	Total	% of SHP Mbrshp	Average Family Size
PPO Basic	13,481	21,773	35,254	5.29%	2.62
PPO Standard	401,254	131,951	533,205	79.96%	1.33
PPO Plus	66,319	32,032	98,351	14.75%	1.48
Totals	481,054	185,756	666,810	100%	

	Average Membership (October thru December 2008)				
	Employees	Dependents	Total	% of SHP Mbrshp	Average Family Size
PPO Basic	13,390	21,740	35,131	5.18%	2.62
PPO Standard	400,735	131,513	532,248	80.01%	1.33
PPO Plus	66,252	31,957	98,209	14.82%	1.48
Totals	480,378	185,210	665,588	100%	

Membership by Employee Status 2nd Quarter FY 08-09



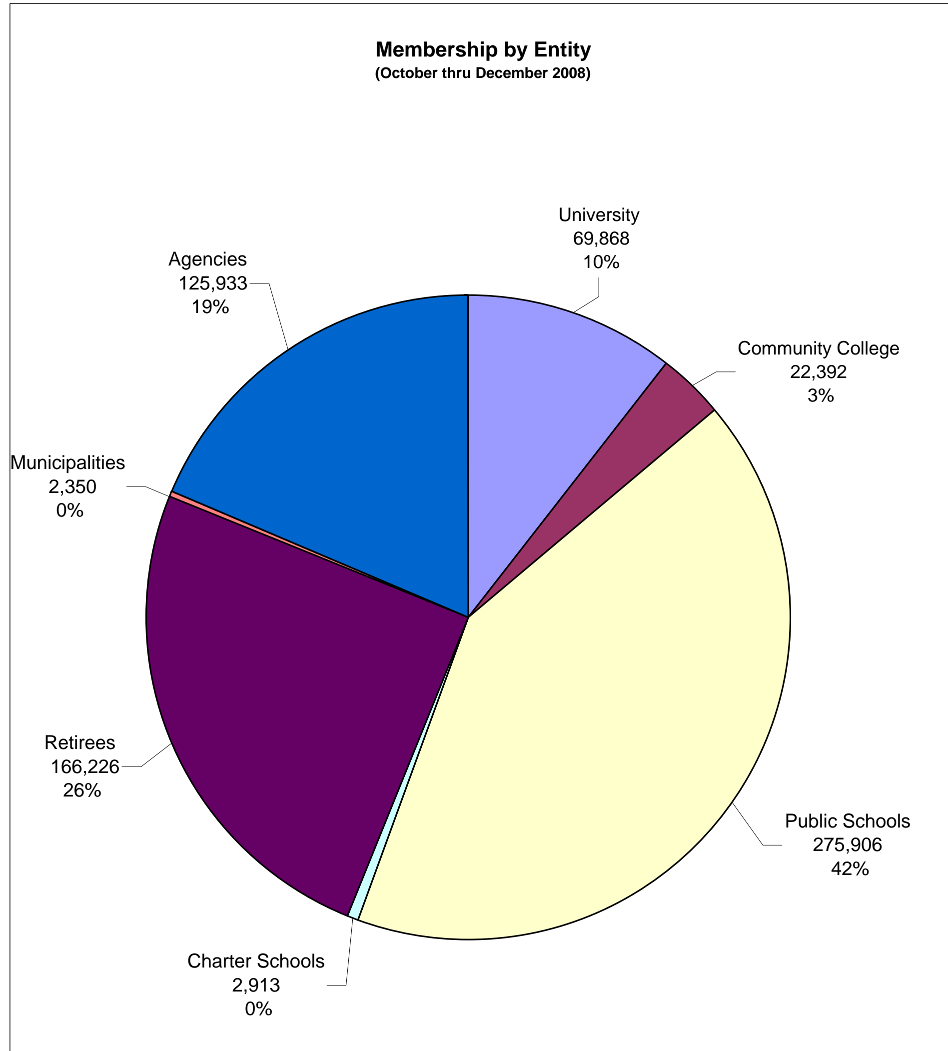
		October 2008		
	Employees	Dependents	Total	Average Family Size
Actives	333,086	165,039	498,125	1.50
Medicare Retirees	97,375	7,360	104,735	1.08
Non-Medicare Retirees	49,215	12,272	61,487	1.25
	479,676	184,671	664,347	

		November 2008		
	Employees	Dependents	Total	Average Family Size
Actives	333,823	165,628	499,451	1.50
Medicare Retirees	97,571	7,487	105,058	1.08
Non-Medicare Retirees	49,009	12,089	61,098	1.25
	480,403	185,204	665,607	

		December 2008		
	Employees	Dependents	Total	Average Family Size
Actives	334,280	166,228	500,508	1.50
Medicare Retirees	97,240	7,448	104,688	1.08
Non-Medicare Retirees	49,534	12,080	61,614	1.24
	481,054	185,756	666,810	

Average Membership (October thru December 2008)				
	Employees	Dependents	Total	Average Family Size
Actives	333,730	165,632	499,361	1.50
Medicare Retirees	97,395	7,432	104,827	1.08
Non-Medicare Retirees	49,253	12,147	61,400	1.25
	480,378	185,210	665,588	

Membership by Entity 2nd Quarter FY 08-09



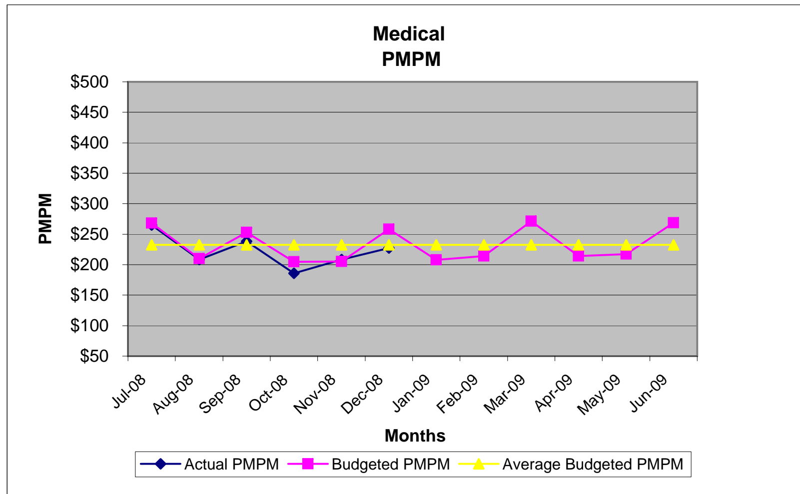
	October 2008			
	Employees	Dependents	Total	Average Family Size
University	43,745	25,854	69,599	1.59
Community College	14,742	7,617	22,359	1.52
Public Schools	185,975	89,273	275,248	1.48
Charter Schools	1,835	1,069	2,904	1.58
Retirees	146,589	19,632	166,221	1.13
Municipalities	2,001	995	2,996	1.50
Agencies	84,789	40,231	125,020	1.47
Total	479,676	184,671	664,347	

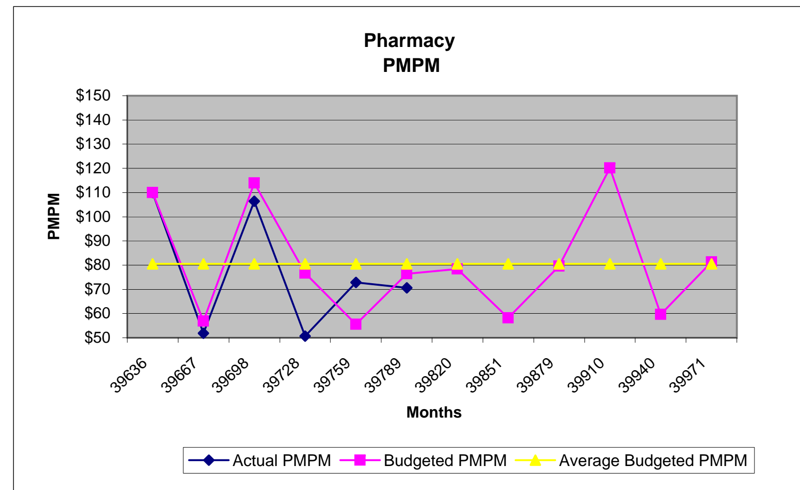
	November 2008			
	Employees	Dependents	Total	Average Family Size
University	43,919	25,937	69,856	1.59
Community College	14,771	7,619	22,390	1.52
Public Schools	186,308	89,616	275,924	1.48
Charter Schools	1,848	1,071	2,919	1.58
Retirees	146,580	19,576	166,156	1.13
Municipalities	1,345	675	2,020	1.50
Agencies	85,632	40,710	126,342	1.48
Total	480,403	185,204	665,607	

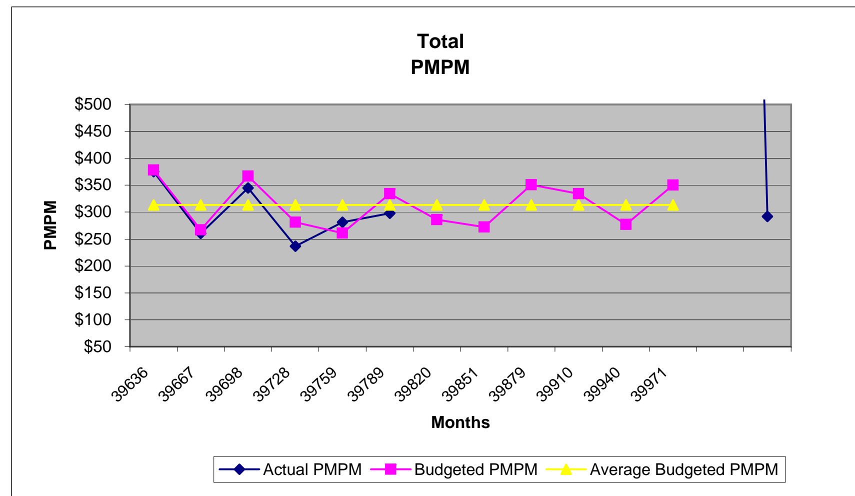
	December 2008			
	Employees	Dependents	Total	Average Family Size
University	44,076	26,073	70,149	1.59
Community College	14,809	7,617	22,426	1.51
Public Schools	186,532	90,015	276,547	1.48
Charter Schools	1,834	1,083	2,917	1.59
Retirees	146,774	19,528	166,302	1.13
Municipalities	1,351	682	2,033	1.50
Agencies	85,678	40,758	126,436	1.48
Total	481,054	185,756	666,810	

	Average Membership (October thru December 2008)			
	Employees	Dependents	Total	Average Family Size
University	43,913	25,955	69,868	1.59
Community College	14,774	7,618	22,392	1.52
Public Schools	186,272	89,635	275,906	1.48
Charter Schools	1,839	1,074	2,913	1.58
Retirees	146,648	19,579	166,226	1.13
Municipalities	1,566	784	2,350	1.50
Agencies	85,366	40,566	125,933	1.48
Total	480,378	185,210	665,588	

Medical/Pharmacy PMPM's FY 08-09







Medical/Pharmacy PMPM's Data FY 08-09

Actual

	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08
Official Monthly Membership	651,707	652,865	662,571	664,347	665,607	668,810
Gross Medical Claims Payments	$ 175,451,114	$ 138,916,662	$ 160,061,529	$ 126,393,524	$ 141,281,948	$ 158,618,033
(Medical Claims Refunds)	$ (2,727,036)	$ (2,763,664)	$ (2,120,259)	$ (2,930,224)	$ (2,656,728)	$ (2,147,615)
Net Medical Claims Payments	$ 172,724,078	$ 136,152,998	$ 157,941,270	$ 123,463,300	$ 138,625,220	$ 156,470,418
Medical PMPM	$ 265.03	$ 208.55	$ 238.38	$ 185.84	$ 208.27	$ 233.95
Net Pharmacy Claims Payments	$ 71,661,856.00	$ 33,809,260.00	$ 70,461,628.00	$ 33,662,190.00	$ 48,482,595.00	$ 48,604,636.00
Pharmacy PMPM	$ 109.96	$ 51.79	$ 106.35	$ 50.67	$ 72.84	$ 72.67
Total Medical/Pharmacy PMPM	$ 374.99	$ 260.33	$ 344.72	$ 236.51	$ 281.11	$ 306.63

Budget

	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08
Official Monthly Membership	648,420	648,420	648,420	648,420	648,420	648,420
Gross Medical Claims Payments	$176,016,386	$138,151,797	$166,004,335	$134,802,025	$135,206,732	$169,266,547
(Medical Claims Refunds)	$ (1,955,134)	$ (1,974,775)	$ (1,941,027)	$ (2,062,671)	$ (1,962,891)	$ (1,977,316)
Net Medical Claims Payments	$ 174,061,252	$ 136,177,022	$ 164,063,308	$ 132,739,354	$ 133,243,841	$ 167,289,231
Medical PMPM	$ 268.44	$ 210.01	$ 253.02	$ 204.71	$ 205.49	$ 258.00
Net Pharmacy Claims Payments	$ 71,661,856.00	$ 37,141,265.00	$ 75,492,661.00	$ 49,753,094.00	$ 36,034,666.00	$ 49,521,201.00
Pharmacy PMPM	$ 109.96	$ 56.89	$ 113.94	$ 76.73	$ 55.57	$ 76.37
Total Medical/Pharmacy PMPM	$ 378.40	$ 266.90	$ 366.96	$ 281.44	$ 261.06	$ 334.37

State Health Plan
Comparison of Budget Projections
Fiscal Year 2008- 2009
Recasted (7/30/08 version) vs.
Original (7/8/07 version)

		RECASTED BUDGET			ORIGINAL BUDGET					
		A	B	C	D	E	F	G	H	I
		Actual Year to Date through Dec-08	Budget Year to Date through Dec-08 recasted ver. 7/30/08	Variance Year to Date Over (Under) Recasted Budget	Actual Year to Date through Dec-08	Budget Year to Date through Dec-08 original ver. 7/9/07	Year to Date Variance Over (Under) Original Budget	Annual Budget 2008-2009 recasted ver. 7/30/08	Annual Budget 2008-2009 original ver. 7/9/07	Variance Annual Recasted vs Original Budget
1	**Plan Revenue:**									
2										
3	Member Premiums	$ 1,193,361,807	$ 1,140,797,568	$ 52,564,239	$ 1,193,361,807	$ 1,089,853,836	$ 103,507,971	$ 2,281,595,143	$ 2,179,707,669	$ 101,887,474
4	Retro Disenrollments	-	(3,906,294)	3,906,294	-	-	-	(7,812,586)		(7,812,586)
5	Premium Refunds	(1,495,169)	-	(1,495,169)	(1,495,169)	-	(1,495,169)	-		-
6	Medicare Part D Subsidy	27,204,213	27,869,806	(665,593)	27,204,213	20,798,489	6,405,724	53,886,565	45,898,872	7,987,693
7	Non-Capital Gifts	-	-	-	-	-	-	-	-	-
8										
9	**Net Premium & Other Contributions**	**1,219,070,851**	**1,164,761,080**	**54,309,771**	**1,219,070,851**	**1,110,652,325**	**108,418,526**	**2,327,669,122**	**2,225,606,541**	**102,062,581**
10										
11	**Other Revenue**	**2,957,311**	**1,706,213**	**1,251,098**	**2,957,311**	**1,942,701**	**1,014,610**	**2,711,451**	**3,862,999**	**(1,151,548)**
12										
13	**Total Plan Revenue (excludes internal transfers)**	**1,222,028,162**	**1,166,467,293**	**55,560,869**	**1,222,028,162**	**1,112,595,026**	**109,433,136**	**2,330,380,573**	**2,229,469,540**	**100,911,033**
14										
15	**Plan Expenses:**									
16										
17	Medical Claim Payments	900,722,810	919,447,823	(18,725,013)	900,722,810	1,024,315,062	(123,592,252)	1,835,578,715	2,200,237,966	(364,659,251)
18	Pharmacy Claim Payments	306,682,165	319,604,743	(12,922,578)	306,682,165	-	306,682,165	629,013,163		629,013,163
19	Claim Refunds	(15,345,526)	(11,873,814)	(3,471,712)	(15,345,526)	-	(15,345,526)	(24,477,232)		(24,477,232)
20	Cost Savings		(4,646,554)	4,646,554	-	(23,076,963)	23,076,963	(14,007,170)	(38,216,704)	24,209,534
21										
22	**Net Claim Payments**	**1,192,059,449**	**1,222,532,198**	**(30,472,749)**	**1,192,059,449**	**1,001,238,099**	**190,821,350**	**2,426,107,476**	**2,162,021,262**	**264,086,214**
23				-			-			-
24	**Net Administrative Expenses**	**80,128,557**	**84,577,462**	**(4,448,905)**	**80,128,557**	**63,602,051**	**16,526,506**	**168,696,644**	**129,297,821**	**39,398,823**
25										
26	**Total Plan Expenses (excludes internal transfers)**	**1,272,188,006**	**1,307,109,660**	**(34,921,654)**	**1,272,188,006**	**1,064,840,150**	**207,347,856**	**2,594,804,120**	**2,291,319,083**	**303,485,037**
27										
28	**Plan Income (Loss)**	**(50,159,844)**	**(140,642,367)**	**90,482,523**	**(50,159,844)**	**47,754,876**	**(97,914,720)**	**(264,423,547)**	**(61,849,543)**	**(202,574,004)**
29										
30	**Cash Availability:**									
31										
32	Beginning Cash Balance	139,744,498	139,744,497	1	139,744,498	214,067,095	(74,322,597)	139,744,497	214,067,095	(74,322,598)
33										
34	Ending Cash Balance (Deficit)	89,584,654	(897,870)	90,482,524	89,584,654	261,821,971	(172,237,317)	(124,679,050)	152,217,552	(276,896,602)
35										
36	Target Stabilization Reserve @ 6/30/09	181,958,060	181,958,060	-	181,958,060	164,401,595	17,556,465	181,958,061	164,401,595	17,556,466
37										
38	**Cash Balance Over/(Under) Reserve Target**	**$ (92,373,406)**	**$ (182,855,930)**	**$ 90,482,524**	**$ (92,373,406)**	**$ 97,420,376**	**$ (189,793,782)**	**$ (306,637,111)**	**$ (12,184,043)**	**$ (294,453,068)**

Comments:
a. Stabilization reserve is 7.5% of the funding projection net claims for Fiscal Year 2008-2009.
b. Minor differences between budget amounts for this report compared to Aon budget projections are due to rounding.

December Budget Summary	Recasted	Original	Difference
Budgeted Income/(Loss)	(40,469,361)	(15,646,924)	(24,822,437)
Actual	12,356,144	12,356,144	-
Over(Under) Budget	**52,825,505**	**28,003,068**	
Budgeted Ending Cash	(897,870)	261,821,971	(262,719,841)
Actual	89,584,654	89,584,654	-
Over(Under) Budget	**90,482,524**	**(172,237,317)**	

January Budget Summary & Estimated Cash	Recasted	Original	Difference
Budgeted Income/(Loss)	(8,939,121)	3,287,476	(12,226,597)
Budgeted Ending Cash	(8,725,871)	265,109,448	(273,835,319)
Actual (estimate)	*not available at printing*		-
Over(Under) Budget	**8,725,871**	**(265,109,448)**	

Employee + Spouse Premium Proposal

Option	Employee Enrollment	Dependent Enrollment	Total Enrollment	Current Contribution	Experience Pricing	Proposed Pricing	EE Anticipated Growth
BASIC							
EE+Spouse - <30	126	126	252	$388.18	$176.33	$180.00	300
EE+Spouse – 30+	1,686	1,686	3,372	$388.18	$373.31	$388.18	0
EE+Spouse - Total	1,812	1,812	0	0	0	0	0
CHOICE							
EE+Spouse - <30	321	321	642	$461.64	$209.70	$212.00	3,000
EE+Spouse – 30+	13,912	13,912	27,824	$461.64	$443.95	$461.64	0
EE+Spouse - Total	14,233	14,233	28,466	$461.64	$0	0	0

Annual Cost Impact – Negligible

Employee + Child(ren) Premium Proposal

Option	Employee Enrollment	Dependent Enrollment	Total Enrollment	Current Contribution	Experience Pricing	Proposed Pricing	EE Anticipated Growth
BASIC							
EE+Child(ren) - 1	1,986	1,986	3,972	$150.66	$114.00	Freeze	?
EE+Child(ren) – 2+	2,929	6,857	9,786	$150.66	$188.15	Let Rise	?
EE+Child(ren) – Total	4,915	8,843	13,758				
CHOICE							
EE+Child(ren) - 1	18,578	18,578	37,157	$200.36	$150.60	Freeze	?
EE+Child(ren) – 2+	26,114	60,456	86,569	$200.36	$250.18	Let Rise	?
EE+Child(ren) - Total	44,692	79,034	123,726				

Annual Cost Impact - $7.2 million
If Plan adds 10% to 2+ category in addition to normal increase - $0.4 million

SHP BOT Roles and Responsibilities Revisions
DRAFT 2/11/09

The current design of the SHP BOT provides the Board with an extremely broad range of responsibilities but provides very little real ability for this body to oversee the Plan. There is also confusion about the role of the Board and that of the Legislative bodies also charged with oversight.

We hereby recommend that the duties be refined to focus on the key areas of plan administration and budgetary performance as outlined below. We suggest limiting the statutory duties and increasing the Plan's reporting and accountability to the BOT in those areas for which the Board is responsible. We do not recommend eliminating the Board's fiduciary responsibilities, but rather limiting the accountability to those areas for which it is responsible. This may require a change in the selection criteria for Board members in terms of their experience and qualifications.

Generally, then, we see the General Assembly as responsible for Plan design, including benefits and premiums, and funding decisions and the BOT for administrative oversight of the Plan. Both the GA and BOT would participate in evaluating, hiring and firing the EA through an amended Administration Commission which was created in statute in the last Legislative session.

Contracting

The BOT should continue to review/approve key contracts, particularly those having an annual cost of $550,000 or more.

1. Procurement: The BOT will be advised of the need to procure services whether it is a newly identified need or the re-procurement of an existing service. EA will provide information to the BOT about the selection process and the Plan's recommendation prior to finalizing the selection. The BOT chair or designee may participate on the RFP review committee.
2. Contract Management: The Plan will advise the BOT of any performance issues with any major contractor. The Plan will provide audit reports on a regular basis to inform the Board and facilitate their oversight of Plan activities in this regard.

Financial Oversight

1. Budget Development: the BOT will receive the Plan's budget proposals prior to final submission to the General Assembly annually. The Plan will seek input and recommendations from the BOT, but final approval will remain with the Legislature.
2. Financial Performance: the BOT will receive monthly financial and operating reports to enable effective oversight into the effective and efficient operation of the plan, particularly in regards to variance to budgetary targets. The reports will be sent electronically to Board members as soon as they are available. Summaries of pertinent factors will be sent with the actual reports and conference calls may be arranged should the situation warrant. Quarterly reports and discussion will also be held at regularly scheduled BOT meetings.

Oversight of Executive Administrator and Plan Operations

1. EA/Plan Oversight – the BOT should participate in the evaluation of the EA and the Plan as a whole. Chair or a designee should be assigned to participate in the Administrative Commission.
2. BOT will receive reports quarterly on NCHC until its transition to DMA and the Plan's Long Term Care Insurance offering.

Current Continuing Responsibilities

1. Electing Officers (NCGS § 135-44.1)
2. Making Final Agency Decisions on Administrative Appeals (NCGS § 135-44.7(c))
3. Adopting Rules: The BOT may adopt rules to implement the State Health Plan, long term care benefits or North Carolina Health Choice. (NCGS §135-44.8). However, before issuing rules, the EA or Board must provide the public written notice of the proposed rules and at least 30 days to comment.