North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Board of Trustees Meeting
Thursday, January 22, 2015, 4:00 – 6:00 p.m.

1. Welcome	Janet Cowell, Chair
2. Conflict of Interest Statement	Janet Cowell, Chair
3. Review of Minutes – November 20 and 21, 2014	Janet Cowell, Chair
4. Financial Report, Forecasting and Monitoring	Mark Collins
A. November 2014 Financial Report	
B. CY 2014 3rd Quarter Actuarial Forecast Update	
5. Contracting and Vendor Partnerships	Caroline Smart
A. Aon Hewitt Implementation Update	
6. Other Updates	
A. Legislative Agenda & Update	Lotta Crabtree Tom Friedman
B. Pharmacy & Therapeutics Committee Meeting Summary	Glenda Adams
7. Wrap-Up	Janet Cowell, Chair

Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Board of Trustees Meeting
Friday, January 23, 2015, 9:00 a.m. – 3:00 p.m.

1. Welcome	Janet Cowell, Chair
2. Conflict of Interest Statement	Janet Cowell, Chair
3. Benefit Design, Plan Options and Premiums	
A. Value-Based Insurance Design Recommendations	David E. Edmam A. Mark Fendrick, MD VBID Health
B. Proposed 2016 Benefit Design Changes	Mona Moon Tom Friedman Nidu Menon Mark Collins Lotta Crabtree
BREAK	
C. Public Comment on Proposed Benefit Changes	TBD
D. Discussion	Board Members
LUNCH	
4. Provider Engagement Initiatives	Nidu Menon David Boerner, MD
5. ACO Update and Move to Value	Susan Weaver, MD Chief Medical Officer BCBSNC Susan Jackson, V-P Health Delivery Redesign BCBSNC
6. Wrap-up	Janet Cowell, Chair

Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

November 2014 Financial Report

Board of Trustees Meeting

January 22, 2015

A Division of the Department of State Treasurer

Financial Results: Actual v. Budgeted
Calendar Year to Date November 2014

Calendar Year 2014	Actual thru Nov 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Beginning Cash Balance	**$838.5 m**	**$695.0 m**	**$143.5 m**
Plan Revenue	**$2.735 b**	**$2.717 b**	**$18.1 m**
Net Claims Payments	$2.271 b	$2.316 b	($45.4 m)
Medicare Advantage Premiums	$143.6 m	$159.6 m	($16.0 m)
Net Administrative Expenses	$136.3 m	$165.0 m	($28.7 m)
Total Plan Expenses	**$2.551 b**	**$2.641 b**	**($90.1 m)**
Net Income/(Loss)	**$183.7 m**	**$75.5 m**	**$108.2 m**
Ending Cash Balance	**$1.022 b**	**$770.5 m**	**$251.7 m**

Adjusted Variance Report
Calendar Year to Date November 2014

Calendar Year 2014	Actual thru Nov 2014, As Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$2.757 b**	**$2.717 b**	**$40.0 m**
Net Claims Payments ^	$2.281 b	$2.316 b	($35.8 m)
Medicare Advantage Premiums	$143.6 m	$159.6 m	($16.0 m)
Net Administrative Expenses †	$127.8 m	$165.0 m	($37.2 m)
Total Plan Expenses	**$2.552 b**	**$2.641 b**	**($89.0 m)**
Net Income/(Loss)	**$204.5 m**	**$75.5 m**	**$129.0 m**

Note: Numbers might not sum to totals due to rounding

* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues and to remove the impact of unanticipated pharmacy rebate true-up payments.
† Adjusted for timing issues.

Financial Results Actual v. Budgeted
Calendar Year to Date November 2014

Per Member Per Month (PMPM) Analysis

Calendar Year 2014	Actual thru Nov 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue	**$366.71**	**$371.27**	**($4.56)**
Net Claims Payments	$305.14	$316.38	($11.24)
Medicare Advantage Premiums	$19.29	$21.79	($2.50)
Net Administrative Expenses	$18.31	$22.54	($4.23)
Total Plan Expenses	**$342.74**	**$360.71**	**($17.97)**
Net Income/(Loss)	**$23.97**	**$10.56**	**$13.41**

Comparing actual results to the budget projection on a PMPM basis helps correct for changes in membership that occurred during the year.

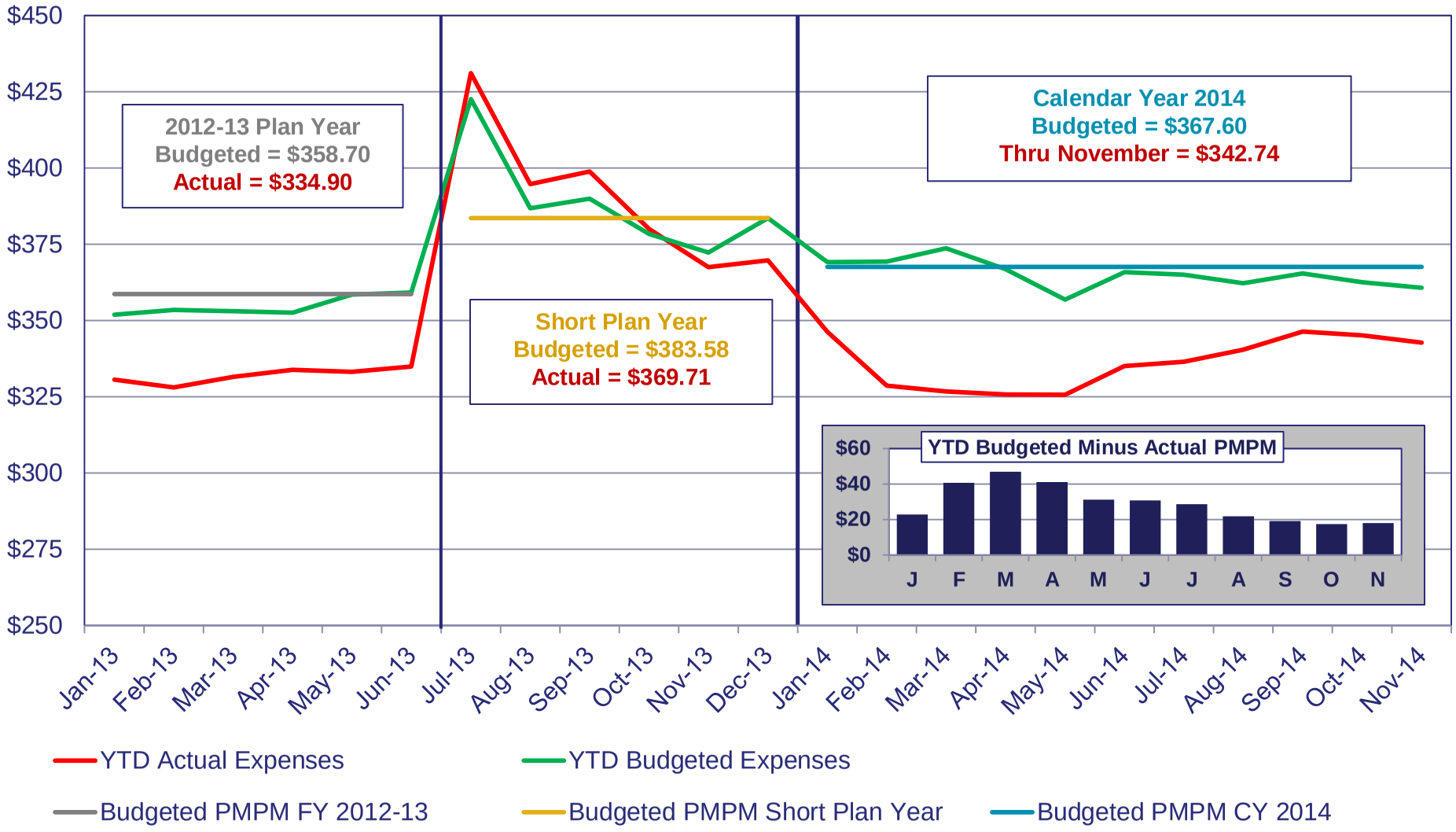
Adjusted Variance Report
Calendar Year to Date November 2014

Per Member Per Month (PMPM) Analysis

Calendar Year 2014	Actual thru Nov 2014, as Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$369.64**	**$371.27**	**($1.63)**
Net Claims Payments ^	$306.42	$316.38	($9.96)
Medicare Advantage Premiums	$19.29	$21.79	($2.50)
Net Administrative Expenses †	$17.17	$22.54	($5.37)
Total Plan Expenses	**$342.88**	**$360.71**	**($17.83)**
Net Income/(Loss)	**$26.76**	**$10.56**	**$16.20**

* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues and to remove the impact of a larger-than-expected pharmacy rebate true-up payment.
† Adjusted for timing issues.

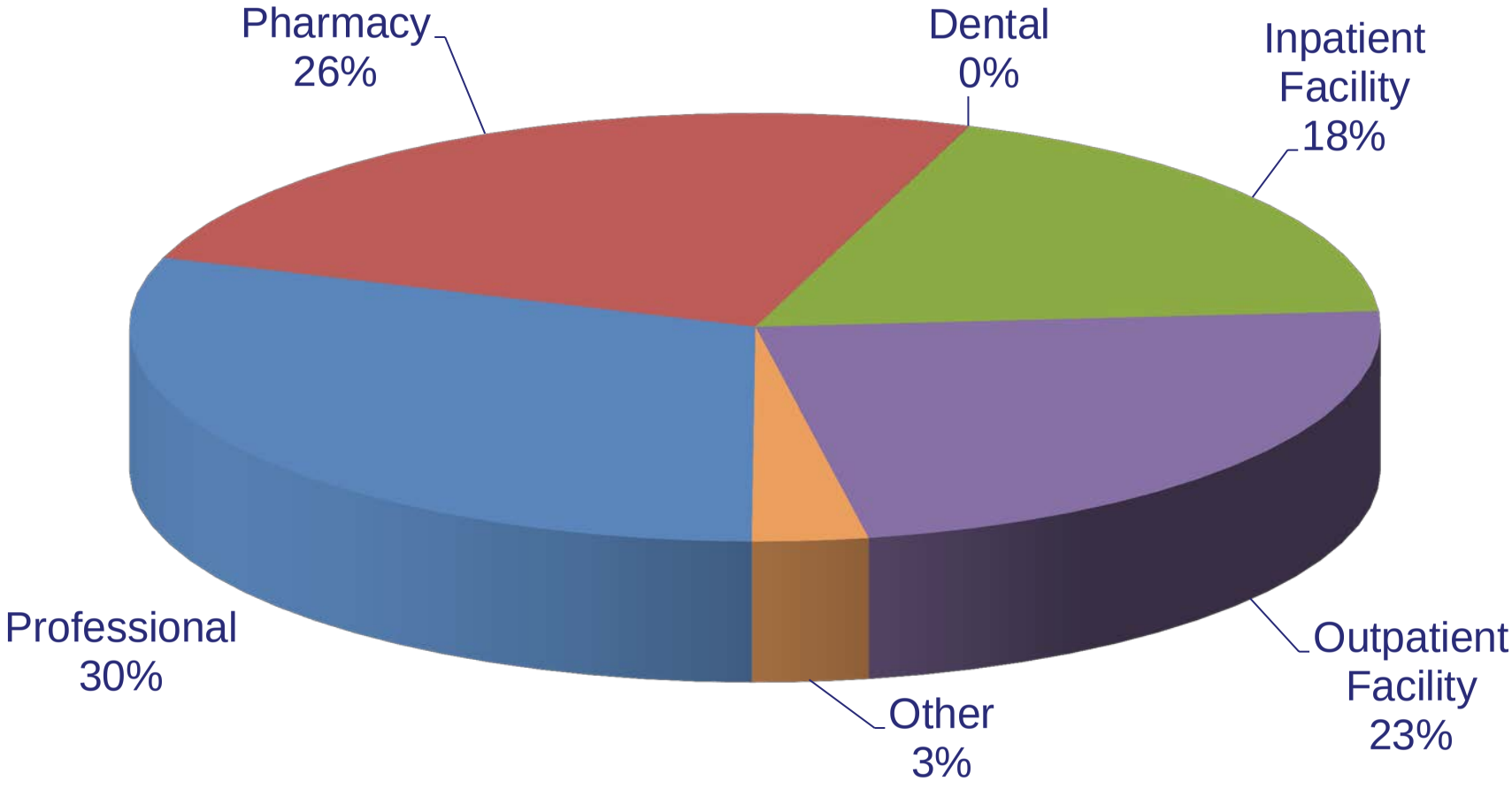
Plan Year to Date (YTD) Expenditure Trend Per Member Per Month



Allocation of Claims Expenditures

Calendar Year to Date: November 2014

Includes Medical, Blue Card & Pharmacy Payments



Source: BCBSNC Summary of Billed Charges

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Certified Budget
For the Month Ended November 2014
Calendar Year 2014

		A	B	C	D	E	F	G	H
		Actual November 2014	Certified Budget November 2014	Monthly Variance Over/(Under) Certified Budget	Actual 2014 Calendar Year To Date	Certified Budget 2014 Calendar Year to Date	Calendar Year to Date Variance Over/(Under) Certified Budget	Calendar Year Certified Budget (Jan- Dec 2014)	Calendar Year to Date Variance Over/(Under) Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 244,430,403	$ 243,103,488	$ 1,326,915	$ 2,681,711,150	$ 2,678,860,217	$ 2,850,933	$ 2,921,878,532	$ (240,167,382)
4	Premium Refunds/Retroactive Disenrollments	-	(123,925)	123,925	(28,401)	(1,365,526)	1,337,125	(1,489,408)	1,461,007
5	Medicare Part D (RDS) Subsidy	2,321,961	539,213	1,782,748	20,326,396	5,724,445	14,601,951	6,344,076	13,982,320
6	Medicare PDP (EGWP + Wrap) Subsidy	-	13,047,904	(13,047,904)	28,378,401	31,047,005	(2,668,604)	31,047,005	(2,668,604)
7	Medicare Advantage (MA) Subsidy	76,717	-	76,717	649,586	-	649,586	-	649,586
8	Federal Early Retiree Reinsurance Program (ERRP)	(1,949)	-	(1,949)	(1,949)	-	(1,949)	-	(1,949)
9	**Net Premium & Other Contributions**	246,827,132	256,566,680	(9,739,548)	2,731,035,183	2,714,266,141	16,769,042	2,957,780,205	(226,745,022)
10									
11	Investment Earnings	413,715	250,468	163,247	3,974,718	2,643,000	1,331,718	2,892,005	1,082,713
12	Miscellaneous Revenue	-	-	-	-	-	-	-	-
13	**Other Revenue**	413,715	250,468	163,247	3,974,718	2,643,000	1,331,718	2,892,005	1,082,713
14									
15	**Total Plan Revenue (excludes internal transfers)**	247,240,847	256,817,148	(9,576,301)	2,735,009,901	2,716,909,141	18,100,760	2,960,672,210	(225,662,309)
16									
17	**Plan Expenses:**								
18									
19	Medical Claim Payments	150,895,281	165,709,767	(14,814,486)	1,777,879,533	1,877,420,377	(99,540,844)	2,062,826,346	(284,946,813)
20	Medical Claim Refunds/Recoveries	(2,037,534)	(2,073,041)	35,507	(21,123,612)	(23,416,845)	2,293,233	(25,469,051)	4,345,439
21	**Net Medical Claims**	148,857,747	163,636,726	(14,778,979)	1,756,755,921	1,854,003,532	(97,247,611)	2,037,357,295	(280,601,374)
22									
23	Pharmacy Claim Payments	54,036,740	46,241,957	7,794,783	613,312,862	517,577,450	95,735,412	599,541,594	13,771,268
24	Pharmacy Claim Rebates	(10,405,210)	(11,556,391)	1,151,181	(98,763,203)	(54,794,623)	(43,968,580)	(54,794,623)	(43,968,580)
25	Pharmacy Claim Refunds/Recoveries	(8,327)	-	(8,327)	91,788	-	91,788	-	91,788
26	**Net Pharmacy Claims**	43,623,203	34,685,566	8,937,637	514,641,447	462,782,827	51,858,620	544,746,971	(30,105,524)
27									
28	**Net Claim Payments**	192,480,950	198,322,292	(5,841,342)	2,271,397,368	2,316,786,359	(45,388,991)	2,582,104,266	(310,706,898)
29									
30	**Medicare Advantage Premium Payments**	12,919,472	14,567,758	(1,648,286)	143,622,842	159,582,890	(15,960,048)	174,162,733	(30,539,891)
31									
32	**Net Administrative Expenses**	10,718,302	14,770,155	(4,051,853)	136,317,059	165,049,916	(28,732,857)	179,815,010	(43,497,951)
33									
34	**Total Plan Expenses (excludes internal transfers)**	216,118,724	227,660,205	(11,541,481)	2,551,337,269	2,641,419,165	(90,081,896)	2,936,082,009	(384,744,740)
35									
36	Plan Income/(Loss)	31,122,123	29,156,943	1,965,180	183,672,632	75,489,976	108,182,656	24,590,201	159,082,431
37									
38	**Cash Availability:**								
39									
40	Beginning Cash Balance/(Deficit)	990,997,646	741,308,166	249,689,480	838,447,137	694,975,133	143,472,004	694,975,133	143,472,004
41	**Ending Cash Balance/(Deficit)**	1,022,119,769	770,465,109	251,654,660	1,022,119,769	770,465,109	251,654,660	719,565,334	302,554,435
42									
43	Target Stabilization Reserve @ 12/31/14	234,282,695	234,282,695	-	234,282,695	234,282,695	-	234,282,695	-
44									
45	**Cash Balance Over/(Under) Reserve Target**	$ 787,837,074	$ 536,182,414	$ 251,654,660	$ 787,837,074	$ 536,182,414	$ 251,654,660	$ 485,282,639	$ 302,554,435

Comments:
a. Premium receivables totaled $137,825.13 as of November 30, 2014.
b. The average weekly medical claims cost net of claims refunds was $37,214,436.75 for the four scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $27,018,370.00 per cycle.
d. The target stabilization reserve is 8.5% of the projected net claims and Medicare Advantage premiums for Calendar Year 2014.
e. Minor differences compared to other reports are due to rounding.

Actual vs Certified Budget (i.e. ***Original Budget*** per SL 2013-360 and Board Approved Design)
November - 2014 Calendar Year

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Authorized Budget
For the Month Ended November 2014
Fiscal Year 2014- 2015

		A	B	C	D	E	F	G	H
		Actual November 2014	Authorized Budget November 2014	Monthly Variance Over/(Under) Authorized Budget	Actual Year to Date FY 2014-15	Authorized Budget Year to Date FY 2014-15	Year to Date Variance Over/(Under) Authorized Budget	Annual Authorized Budget FY 2014-15	Year to Date Variance Over/(Under) Annual Authorized Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 244,430,403	$ 245,023,311	$ (592,908)	$ 1,243,191,472	$ 1,225,940,095	$ 17,251,377	$ 2,937,906,736	$ (1,694,715,264)
4	Premium Refunds/Retroactive Disenrollments	-	(123,284)	123,284	(6,016)	(616,835)	610,819	(1,478,664)	1,472,648
5	Medicare Part D (RDS) Subsidy	2,321,961.00	515,080	1,806,881	7,418,856	2,256,550	5,162,306	6,276,386	1,142,470
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	1,680,417	1,680,417	-	33,414,689	(31,734,272)
7	Medicare Advantage (MA) Subsidy	76,717.00	-	76,717	232,021	-	232,021	-	232,021
8	Federal Early Retiree Reinsurance Program (ERRP)	(1,949.00)	-	(1,949)	(1,949)	-	(1,949)	-	(1,949)
9	**Net Premium & Other Contributions**	**246,827,132**	**245,415,107**	**1,412,025**	**1,252,514,801**	**1,229,260,227**	**23,254,574**	**2,976,119,147**	**(1,723,604,346)**
10									
11	Investment Earnings	413,715	334,080	79,635	1,899,570	1,630,127	269,443	3,933,340	(2,033,770)
12	Miscellaneous Revenue	-	-	-	-	-	-	-	-
13	**Other Revenue**	**413,715**	**334,080**	**79,635**	**1,899,570**	**1,630,127**	**269,443**	**3,933,340**	**(2,033,770)**
14									
15	**Total Plan Revenue (excludes internal transfers)**	**247,240,847**	**245,749,187**	**1,491,660**	**1,254,414,371**	**1,230,890,354**	**23,524,017**	**2,980,052,487**	**(1,725,638,116)**
16									
17	**Plan Expenses:**								
18									
19	Medical Claim Payments	150,895,281	146,760,364	4,134,917	821,462,600	794,070,474	27,392,126	1,995,716,227	(1,174,253,627)
20	Medical Claim Refunds/Recoveries	(2,037,534)	(1,925,958)	(111,576)	(9,507,224)	(9,878,780)	371,556	(23,520,519)	14,013,295
21	**Net Medical Claims**	**148,857,747**	**144,834,406**	**4,023,341**	**811,955,376**	**784,191,694**	**27,763,682**	**1,972,195,708**	**(1,160,240,332)**
22									
23	Pharmacy Claim Payments	54,036,740	51,834,144	2,202,596	295,448,217	282,730,110	12,718,107	686,943,428	(391,495,211)
24	Pharmacy Claim Rebates	(10,405,210)	(11,775,815)	1,370,605	(39,298,739)	(40,313,276)	1,014,537	(74,166,940)	34,868,201
25	Pharmacy Claim Refunds/Recoveries	(8,327)	-	(8,327)	(67,090)	-	(67,090)	-	(67,090)
26	**Net Pharmacy Claims**	**43,623,203**	**40,058,329**	**3,564,874**	**256,082,388**	**242,416,834**	**13,665,554**	**612,776,488**	**(356,694,100)**
27									
28	**Net Claim Payments**	**192,480,950**	**184,892,735**	**7,588,215**	**1,068,037,764**	**1,026,608,528**	**41,429,236**	**2,584,972,196**	**(1,516,934,432)**
29									
30	**Medicare Advantage Premium Payments**	**12,919,472**	**13,193,010**	**(273,538)**	**65,083,995**	**65,855,790**	**(771,795)**	**163,281,044**	**(98,197,049)**
31									
32	**Net Administrative Expenses**	**10,718,302**	**15,837,214**	**(5,118,912)**	**57,730,883**	**79,239,542**	**(21,508,659)**	**223,971,245**	**(166,240,362)**
33									
34	**Total Plan Expenses (excludes internal transfers)**	**216,118,724**	**213,922,959**	**2,195,765**	**1,190,852,642**	**1,171,703,860**	**19,148,782**	**2,972,224,485**	**(1,781,371,843)**
35									
36	Plan Income/(Loss)	31,122,123	31,826,228	(704,105)	63,561,729	59,186,494	4,375,235	7,828,002	55,733,727
37									
38	**Cash Availability:**								
39									
40	Beginning Cash Balance/(Deficit)	990,997,646	985,918,306	5,079,340	958,558,040	958,558,040	-	958,558,040	-
41	**Ending Cash Balance/(Deficit)**	**1,022,119,769**	**1,017,744,534**	**4,375,235**	**1,022,119,769**	**1,017,744,534**	**4,375,235**	**966,386,042**	**55,733,727**
42									
43	Target Stabilization Reserve @ 6/30/15	232,647,498	232,647,498	-	232,647,498	232,647,498	-	232,647,498	-
44									
45	**Cash Balance Over/(Under) Reserve Target**	$ 789,472,271	$ 785,097,036	$ 4,375,235	$ 789,472,271	$ 785,097,036	$ 4,375,235	$ 733,738,544	$ 55,733,727

Comments:
a. Premium receivables totaled $137,825.13 as of November 30, 2014.
b. The average weekly medical claims cost net of claims refunds was $37,214,436.75 for the four scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $27,018,370.00 per cycle.
d. The target stabilization reserve is 9% of the projected net claims for Fiscal Year 2014-15.
e. Minor differences compared to other reports are due to rounding.

North Carolina State Health Plan for Teachers and State Employees

Summary of Operations (Cash Basis)
Current Year Actual vs. Prior Year Actual
For the Month Ended November 2014
Fiscal Year 2014-2015

		A	B	C	D	E	F	G
		Current Year Actual November 2014	Prior Year Actual November 2013	Current Year to Date Actual FY 2014-15 thru November	Prior Year to Date Actual FY 2013-14 thru November	Current Year Authorized Annual Budget FY 2014-15	Prior Year Annual Budget FY 2013-14	Prior Year Actual Results FY 2013-14
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 244,430,403	$ 241,838,070	$ 1,243,191,472	$ 1,235,073,317	$ 2,937,906,736	$ 2,902,567,015	$ 2,941,097,678
4	Premium Refunds/Retroactive Disenrollments	-	(3,338)	(6,016)	(276,753)	(1,478,664)	(1,466,766)	(299,923)
5	Medicare Part D (RDS) Subsidy	2,321,961	880,925	7,418,856	(2,223,658)	6,276,386	6,218,762	11,583,652
6	Medicare PDP (EGWP + Wrap) Subsidy	-	12,783,477	1,680,417	33,004,755	33,414,689	50,346,402	63,780,569
7	Medicare Advantage (MA) Subsidy	76,717	-	232,021	-	-	-	417,565
8	Federal Early Retiree Reinsurance Program (ERRP)	(1,949)	-	(1,949)	-	-	-	-
9	**Net Premium & Other Contributions**	246,827,132	255,499,134	1,252,514,801	1,265,577,661	2,976,119,147	2,957,665,413	3,016,579,541
10								
11	Investment Earnings	413,715	306,691	1,899,570	1,456,201	3,933,340	2,868,131	3,861,263
12	Miscellaneous Revenue	-	-	-	54,972	-	-	54,972
13	**Other Revenue**	413,715	306,691	1,899,570	1,511,173	3,933,340	2,868,131	3,916,235
14								
15	**Total Plan Revenue (excludes internal transfers)**	247,240,847	255,805,825	1,254,414,371	1,267,088,834	2,980,052,487	2,960,533,544	3,020,495,776
16								
17	**Plan Expenses:**							
18								
19	Medical Claim Payments	150,895,281	150,301,981	821,462,600	846,100,029	1,995,716,227	2,107,493,114	1,989,574,333
20	Medical Claim Refunds/Recoveries	(2,037,534)	(1,728,488)	(9,507,224)	(9,177,862)	(23,520,519)	(24,643,884)	(22,450,766)
21	**Net Medical Claims**	148,857,747	148,573,493	811,955,376	836,922,167	1,972,195,708	2,082,849,230	1,967,123,567
22								
23	Pharmacy Claim Payments	54,036,740	67,293,096	295,448,217	361,258,953	686,943,428	699,653,578	743,680,114
24	Pharmacy Claim Rebates	(10,405,210)	(14,108,362)	(39,298,739)	(32,188,641)	(74,166,940)	(52,353,361)	(91,653,105)
25	Pharmacy Claim Refunds/Recoveries	(8,327)	(393,478)	(67,090)	(543,320)	-	-	(398,652)
26	**Net Pharmacy Claims**	43,623,203	52,791,256	256,082,388	328,526,992	612,776,488	647,300,217	651,628,357
27								
28	**Net Claim Payments**	192,480,950	201,364,749	1,068,037,764	1,165,449,159	2,584,972,196	2,730,149,447	2,618,751,924
29								
30	**Medicare Advantage Premium Payments**	12,919,472	-	65,083,995	-	163,281,044	86,864,744	78,538,847
31								
32	**Net Administrative Expenses**	10,718,302	12,015,487	57,730,883	63,587,831	223,971,245	182,446,628	148,134,913
33								
34	**Total Plan Expenses (excludes internal transfers)**	216,118,724	213,380,236	1,190,852,642	1,229,036,990	2,972,224,485	2,999,460,819	2,845,425,684
35								
36	**Plan Income/(Loss)**	31,122,123	42,425,589	63,561,729	38,051,844	7,828,002	(38,927,275)	175,070,092
37								
38	**Cash Availability:**							
39								
40	Beginning Cash Balance/(Deficit)	990,997,646	779,114,203	958,558,040	783,487,948	958,558,040	755,749,494	783,487,948
41	**Ending Cash Balance/(Deficit)**	1,022,119,769	821,539,792	1,022,119,769	821,539,792	966,386,042	716,822,219	958,558,040
42								
43	Target Stabilization Reserve @ 6/30/15	232,647,498	239,446,206	232,647,498	239,446,206	232,647,498	239,446,206	229,269,716
44								
45	**Cash Balance Over/(Under) Reserve Target**	$ 789,472,271	$ 582,093,586	$ 789,472,271	$ 582,093,586	$ 733,738,544	$ 477,376,013	$ 729,288,324

Comments:
a. Minor differences compared to other reports are due to rounding

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended November 2014
Calendar Year 2014

		A	B	C	D	E	F
		Actual Year to Date Calendar Year thru November	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Calendar Year to Date thru November	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 2,681,711,150	$ 31,092,802	$ 2,712,803,952	$ 2,678,860,217	$ 33,943,735	1.27%
4	Premium Refunds/Retroactive Disenrollments	(28,401)		(28,401)	(1,365,526)	1,337,125	-97.92%
5	Medicare Part D (RDS) Subsidy (Note 3)	20,326,396	(6,855,182)	13,471,214	5,724,445	7,746,769	135.33%
6	Medicare PDP (EGWP + Wrap) Subsidy (Note 4)	28,378,401	(1,680,417)	26,697,984	31,047,005	(4,349,021)	-14.01%
7	Medicare Advantage (MA) Subsidy (Note 5)	649,586	(649,586)	-	-	-	
8	Federal Early Retiree Reinsurance Program (ERRP) (Note 6)	(1,949)	1,949	-	-	-	
9	**Net Premium & Other Contributions**	**2,731,035,183**	**21,909,567**	**2,752,944,750**	**2,714,266,141**	**38,678,609**	**1.43%**
10							
11	**Other Revenue**	**3,974,718**		**3,974,718**	**2,643,000**	**1,331,718**	**50.39%**
12							
13	**Total Plan Revenue (excludes internal transfers)**	**2,735,009,901**	**21,909,567**	**2,756,919,468**	**2,716,909,141**	**40,010,327**	**1.47%**
14							
15	**Plan Expenses:**						
16							
17	Net Medical Claims	1,756,755,921		1,756,755,921	1,854,003,532	(97,247,611)	-5.25%
18	Net Pharmacy Claims (Notes 7 and 8)	514,641,447	9,575,016	524,216,463	462,782,827	61,433,636	13.27%
19	**Net Claim Payments**	**2,271,397,368**	**9,575,016**	**2,280,972,384**	**2,316,786,359**	**(35,813,975)**	**-1.55%**
20							
21	**Medicare Advantage Premiums**	**143,622,842**		**143,622,842**	**159,582,890**	**(15,960,048)**	**-10.00%**
22							
23	**Net Administrative Expenses (Note 9)**	**136,317,059**	**(8,491,208)**	**127,825,851**	**165,049,916**	**(37,224,065)**	**-22.55%**
24							
25	**Total Plan Expenses (excludes internal transfers)**	**2,551,337,269**	**1,083,809**	**2,552,421,078**	**2,641,419,165**	**(88,998,088)**	**-3.37%**
26							
27	**Plan Income/(Loss)**	**183,672,632**	**20,825,758**	**204,498,390**	**75,489,976**	**129,008,414**	**170.89%**
28							
29	**Cash Availability:**						
30							
31	Beginning Cash Balance/(Deficit)	838,447,137		838,447,137	694,975,133	143,472,004	20.64%
32	**Ending Cash Balance/(Deficit)**	**1,022,119,769**	**20,825,758**	**1,042,945,527**	**770,465,109**	**272,480,418**	**35.37%**
33							
34	Target Stabilization Reserve @ 12/31/2014	234,282,695		234,282,695	234,282,695	-	
35							
36	**Cash Balance Over/(Under) Reserve Target**	**$ 787,837,074**	**$ 20,825,758**	**$ 808,662,832**	**$ 536,182,414**	**$ 272,480,418**	**50.82%**

Adjustment Notes:

1. Member premiums adjusted to include $60.8 million in prepaid January premiums received in December 2013.
2. Member premiums adjusted to exclude $29.7 million in prepaid December premiums received in November.
3. Medicare Part D subsidy adjusted to exclude a $6.9 million unbudgeted subsidy refund related to prior plan years.
4. EGWP subsidy adjusted to exclude unbudgeted subsidy payments received in July.
5. Medicare Advantage low income premium subsidies were not budgeted and therefore are excluded.
6. ERRP revenues adjusted to exclude an unbudgeted repayment of ERRP funds resulting from an audit finding.
7. Pharmacy claims adjusted to exclude a $33.1 million claims payment that was budgeted for payment in December 2013 but was not paid until January 2014.
8. Pharmacy claims adjusted to remove unbudgeted rebate true-ups totaling $42.7 million.
9. Administrative expenses adjusted to exclude December 2013 vendor invoices that were not processed until January 2014.

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended November 2014
Fiscal Year 2014-2015

		A	B	C	D	E	F
		Actual Year to Date Fiscal Year thru November	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Authorized Budget Fiscal Year to Date thru November	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 1,243,191,472	$ (13,721,013)	$ 1,229,470,459	$ 1,225,940,095	$ 3,530,364	0.29%
4	Premium Refunds/Retroactive Disenrollments	(6,016)		(6,016)	(616,835)	610,819	-99.02%
5	Medicare Part D (RDS) Subsidy	7,418,856		7,418,856	2,256,550	5,162,306	228.77%
6	Medicare PDP (EGWP + Wrap) Subsidy	1,680,417		1,680,417	1,680,417	-	
7	Medicare Advantage (MA) Subsidy (Note 3)	232,021	(232,021)	-	-	-	
8	Federal Early Retiree Reinsurance Program (ERRP) (Note 4)	(1,949)	1,949	-	-	-	
9	**Net Premium & Other Contributions**	**1,252,514,801**	**(13,951,085)**	**1,238,563,716**	**1,229,260,227**	**9,303,489**	**0.76%**
10							
11	**Other Revenue**	**1,899,570**		**1,899,570**	**1,630,127**	**269,443**	**16.53%**
12							
13	**Total Plan Revenue (excludes internal transfers)**	**1,254,414,371**	**(13,951,085)**	**1,240,463,286**	**1,230,890,354**	**9,572,932**	**0.78%**
14							
15	**Plan Expenses:**						
16							
17	Net Medical Claims	811,955,376		811,955,376	784,191,694	27,763,682	3.54%
18	Net Pharmacy Claims	256,082,388		256,082,388	242,416,834	13,665,554	5.64%
19	**Net Claim Payments**	**1,068,037,764**	-	**1,068,037,764**	**1,026,608,528**	**41,429,236**	**4.04%**
20							
21	**Medicare Advantage Premiums**	**65,083,995**		**65,083,995**	**65,855,790**	**(771,795)**	**-1.17%**
22							
23	**Net Administrative Expenses**	**57,730,883**		**57,730,883**	**79,239,542**	**(21,508,659)**	**-27.14%**
24							
25	**Total Plan Expenses (excludes internal transfers)**	**1,190,852,642**	-	**1,190,852,642**	**1,171,703,860**	**19,148,782**	**1.63%**
26							
27	Plan Income/(Loss)	**63,561,729**	**(13,951,085)**	**49,610,644**	**59,186,494**	**(9,575,850)**	**-16.18%**
28							
29	**Cash Availability:**						
30							
31	Beginning Cash Balance/(Deficit)	958,558,040		958,558,040	958,558,040	-	
32	**Ending Cash Balance/(Deficit)**	**1,022,119,769**	**(13,951,085)**	**1,008,168,684**	**1,017,744,534**	**(9,575,850)**	**-0.94%**
33							
34	Target Stabilization Reserve @ 6/30/15	232,647,498		232,647,498	232,647,498	-	
35							
36	**Cash Balance Over/(Under) Reserve Target**	**$ 789,472,271**	**$ (13,951,085)**	**$ 775,521,186**	**$ 785,097,036**	**$ (9,575,850)**	**-1.22%**

Adjustment Notes:
1. Member premiums adjusted to include $16.0 million in prepaid July premiums received in June.
2. Member premiums adjusted to exclude $29.7 million in prepaid December premiums received in November.
3. Medicare Advantage low income premium subsidies were not budgeted and therefore are excluded.
4. ERRP revenues adjusted to exclude an unbudgeted repayment of ERRP funds resulting from an audit finding.

Adjusted Variance Report Based on Authorized (Revised) Budget
Fiscal Year to Date Through November 2014

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

CY 2014 3rd Quarter Actuarial Forecast Update

Board of Trustees Meeting

January 22, 2015

Forecast prepared by The Segal Company
Final version dated 1-20-15

Presentation Overview

- Forecast Update Schedule
- Updated Assumptions: Certified Budget vs. CY 2014 3rd Quarter Projection
- Updated Forecast for CY 2014
- Summary Graphs
- Summary and Future Outlook
- Baseline Model

Actuarial Forecast Update Schedule

- The Plan's actuary updates the forecast quarterly and at the end of each calendar year and fiscal year
- Updates take into account more recent information:
  - Actual financial results and cash balance
  - Membership data, including the impact of enrollment changes
  - Claims experience
  - Changes in anticipated costs or revenues

Forecast Assumptions Maintained in the Update
Certified Budget vs. CY 2014 3rd Quarter Update

- Membership trends
  - 1% annual decrease in actives
  - 1% annual increase in retirees
- Pharmacy trend assumption of 8.5%
- New benefit design effective January 1, 2014
- 2014 revenues reflect 3.57% across the board premium increases effective January 1, 2014, and the wellness premium structure
- Wellness premium structure extended to the Traditional 70/30 Plan beginning in 2016

Forecast Assumptions Changed/Revised in the Update Certified Budget vs. CY 2014 2nd Quarter Update

Changes Always Included in Updates

- Membership based on actual September 2014 counts (instead of March 2013)
- Anticipated claims expenditures based on actual experience through September 2014 (instead of through March 2013)
- Adjustments for timing of revenues and expenses

Additional Changes Included in Earlier Updates

- Medical trend assumption reduced to 7% annually
- Premium freeze for 2015 (Certified Budget assumed 2.14% increase)
- Medicare Advantage premium costs projected to increase with medical trend (7% annually)
- Costs of benefit enhancements: Applied Behavior Analysis (effective January 2015); ACA requirements (additional preventive services; elimination of lifetime limits on essential health benefits)
- Additional FY 2014-15 administrative costs approved by the General Assembly
- 100% coverage of preventive services and medications is assumed for Traditional 70/30 Plan effective January 1, 2016
- Target Stabilization Reserve balances to 9% of claims costs only as of December 31, 2017; Certified Budget balanced to 9% of claims costs *plus* Medicare Advantage premium payments
- Projections extended to include Calendar Years 2018 and 2019

Forecast Assumptions Changed/Revised in the Update Certified Budget vs. CY 2014 3rd Quarter Update

New Changes in the CY 2014 3rd Quarter Update

- Enrollment pattern for 2015 estimated from subscriber Annual Enrollment results
- Pharmacy claims reflect new contracted prescription drug discounts negotiated with ESI effective January 1, 2015
- Projected ACA Transitional Reinsurance fee payments reflect more recent information on the cost and timing of the payments
- Modest migration of Medicare retirees to Medicare Advantage is assumed over time (the Certified Budget assumed a stable proportion of Medicare retirees opting for the Medicare Advantage products)

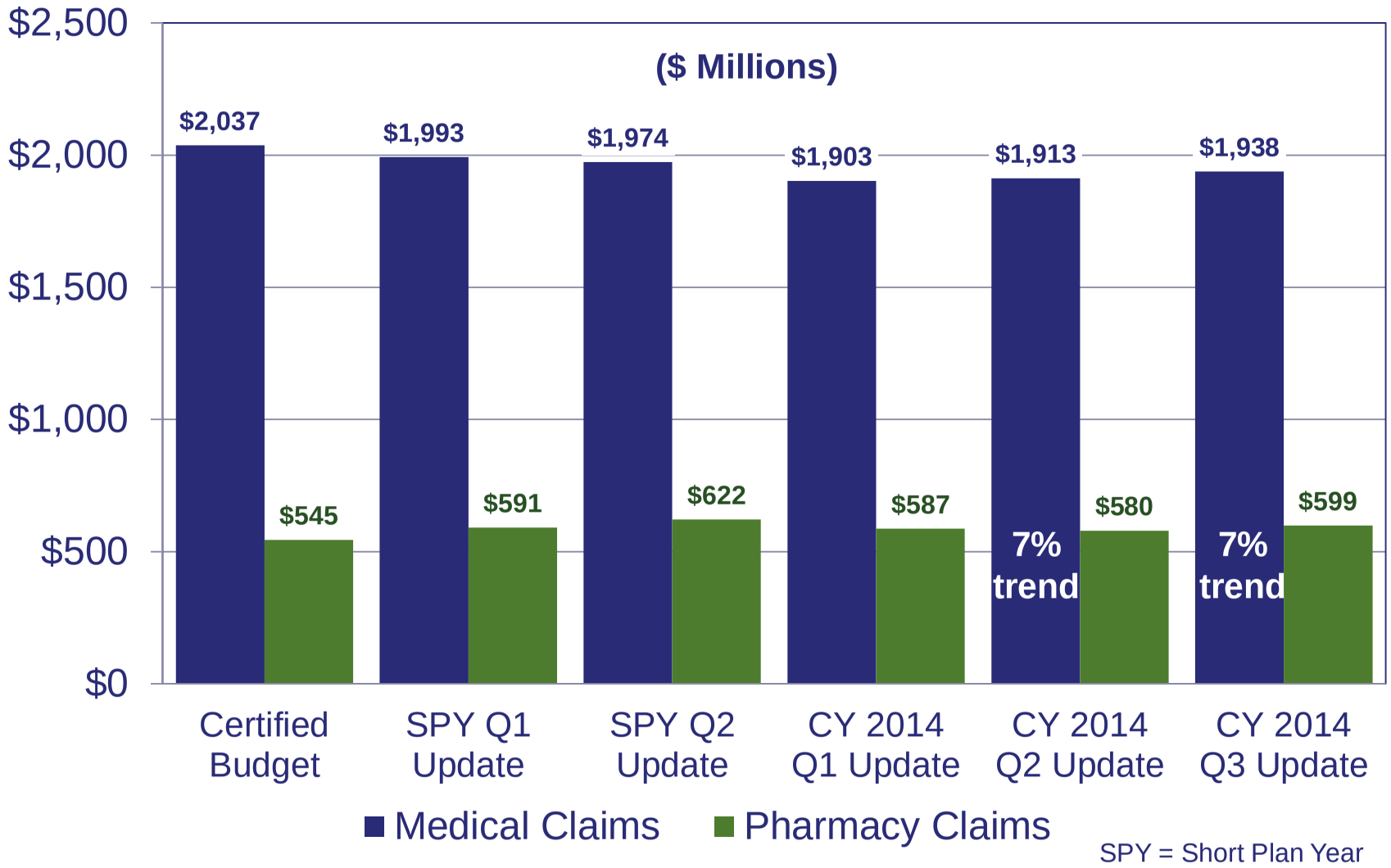
Comparison of Models
Certified Budget vs. CY 2014 3rd Quarter Update

Calendar Year 2014	CY 2014 3rd Quarter Update (per Segal 1-9-15)	Certified Budget (per Segal 8-19-13)	Difference: Increase/ (Decrease) From Budget
Beginning Cash Balance	**$838.5 m**	**$695.0 m**	**$143.5 m**
Plan Revenue	**$2.981 b**	**$2.961 b**	**$20.3 m**
Net Claims Payments	$2.537 b	$2.582 b	($45.1 m)
Medicare Advantage Premiums	$157.6 m	$174.2 m	($16.6 m)
Net Admin. Expenses	$161.8 m	$179.8 m	($18.0 m)
Total Plan Expenses	**$2.856 b**	**$2.936 b**	**($79.7 m)**
Net Income/(Loss)	**$124.6 m**	**$24.6 m**	**$100.0 m**
Ending Cash Balance	**$963.1 m**	**$719.6 m**	**$243.5 m**

Comparison of Models:
CY 2014 Q3 Update vs. Certified and CY 2014 Q2 Budgets

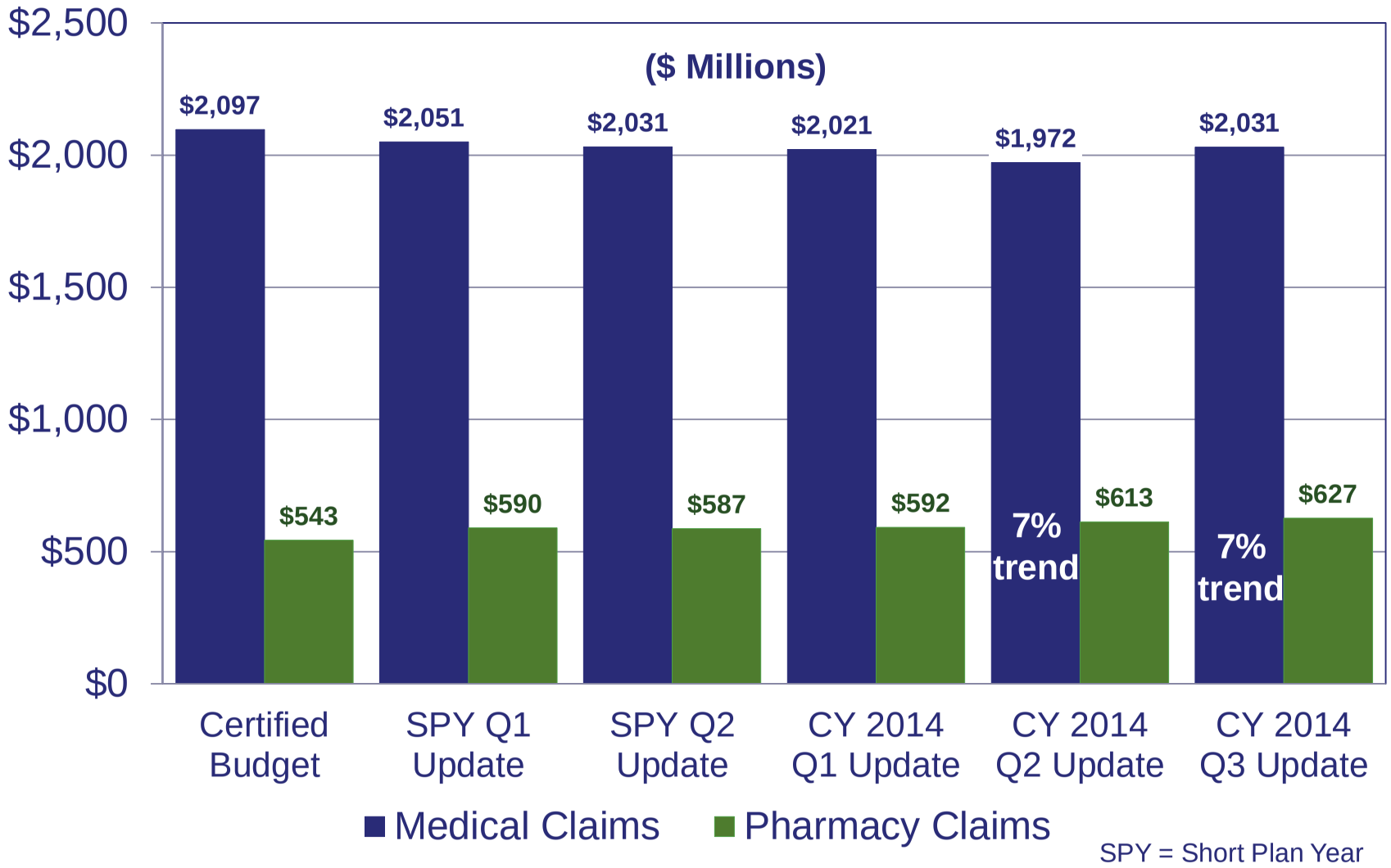
Projected Required Premium Increases (January 1st of each year)	CY 2014 3rd Quarter Update (per Segal 1-9-15)	Certified Budget (per Segal 8-19-13)	Difference: Increase/ (Decrease) From Certified Budget	CY 2014 2nd Quarter Update (per Segal 9-9-14)	Difference: Increase/ (Decrease) From CY 2014 2nd Quarter Update
2016 & 2017	5.05%	8.22%	(3.17%)	3.53%	1.52%
2018 & 2019	12.55%	(not estimated)	NA	13.71%	(1.16%)

Forecast Comparisons: Calendar Year 2014 Claims



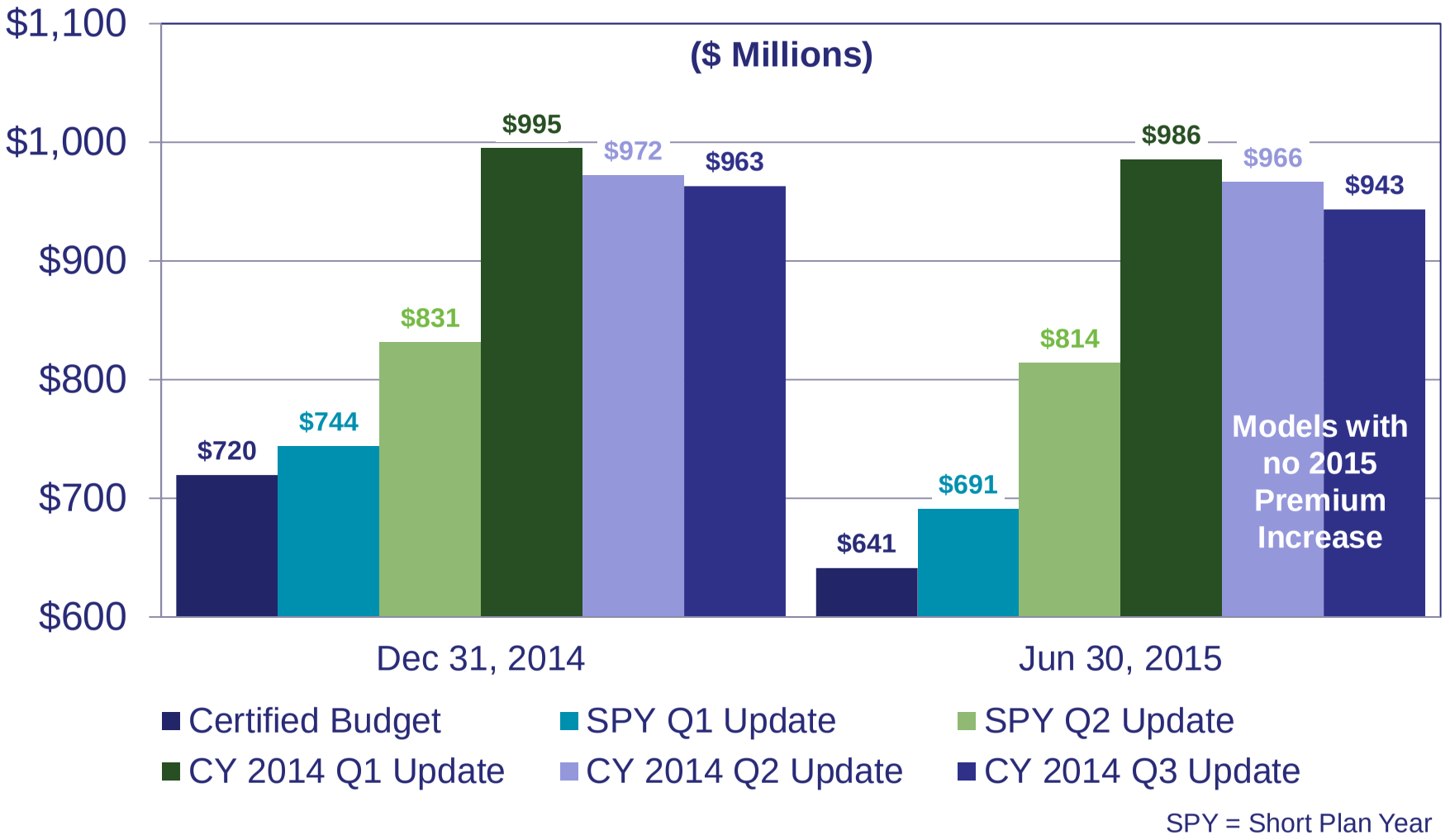
SPY = Short Plan Year

Forecast Comparisons: Fiscal Year 2014-15 Claims



SPY = Short Plan Year

Forecast Comparisons: Ending Cash Balances



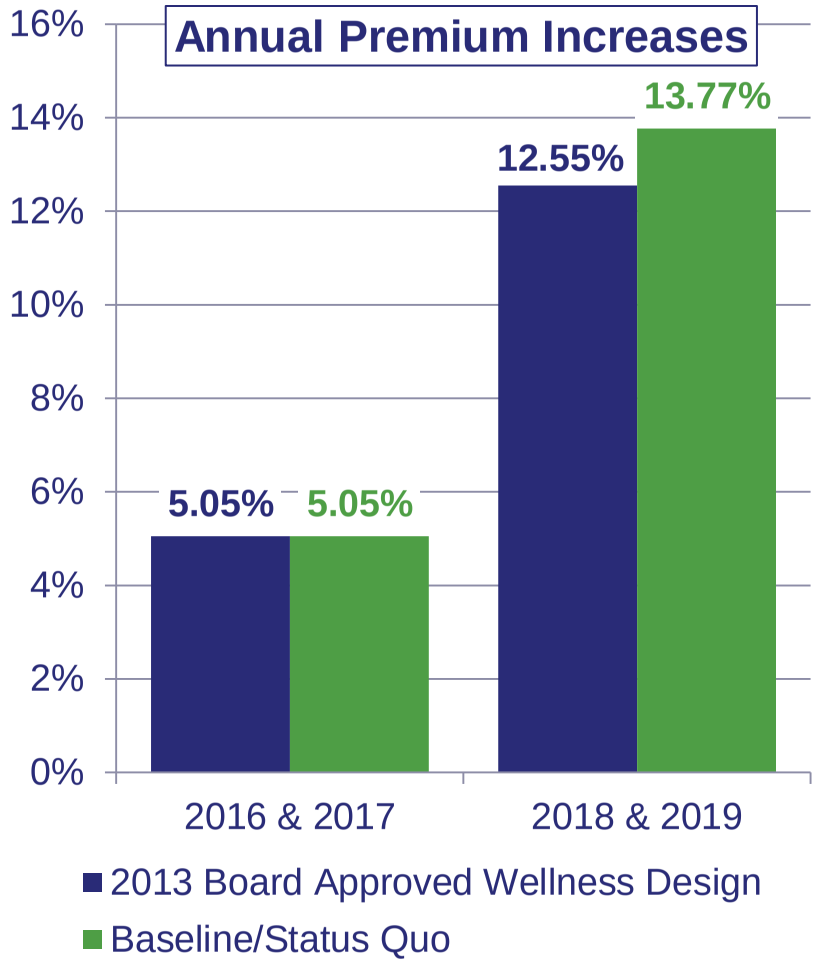
SPY = Short Plan Year

Summary/Future Outlook

- Relative to the Certified Budget, the CY 2014 3rd Quarter Update projects lower medical claims costs and higher pharmacy claims costs
- The $943.3 million cash balance projected for June 30, 2015:
  - Is $302.0 million higher than the Certified Budget projection
  - Exceeds the 9.0% target stabilization reserve amount by $688.1 million
  - Equates to 15 weeks of FY 2015-16 projected operating expenses
- ***Assuming no changes in benefits from the design the Board articulated in 2013***, the CY 2014 3rd Quarter Update projects a 5.05% premium increase for January of 2016 and 2017. This is lower than the Certified Budget projection (8.22%) but higher than the CY 2014 2nd Quarter projection (3.53%)

Baseline Model: *Status Quo*

- The Board is reviewing potential changes to the wellness benefit design it envisioned in 2013
- If the benefit designs and plan options were to remain the same as they are today (a "Status Quo" forecast), the projected premium increases would be:
  - *the same* for 2016 and 2017 as the 2013 Board Approved Wellness Design forecast; and
  - *higher* in 2018 and 2019 than the 2013 Board Approved Wellness Design forecast



Certified Budget
(Segal 8-19-13)

North Carolina State Health Plan
Financial Projections - Mar 2013
Trends - 8.5% Medical & Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP
Incentives start at $15/$15/$20 and increase to $25/$25/$40 in Calendar 2016, $10 Standard Premium Credit
Certified Budget

	2011 - 2013 Biennium		2013 - 2015 Biennium				2015 - 2017 Biennium				
	Actual FY 2012	Projection FY 2013	Projection Short Plan Year Jul-Dec 2013	Projection Calendar 2014 Jan-June	Projection Calendar 2014 July-Dec	Projection Calendar 2015 Jan-Jun	Projection Calendar 2015 Jul-Dec	Projection Calendar 2016 Jan-June	Projection Calendar 2016 July-Dec	Projection Calendar 2017 Jan-Jun	Projection Calendar 2017 Jul-Dec
PLAN INCOME:											
Net Contribution Income	2,750,368,851	2,895,761,603	1,442,578,008	1,490,952,575	1,487,864,429	1,516,588,534	1,513,510,299	1,634,606,643	1,631,357,328	1,761,956,879	1,758,528,795
EGWP/PDP Spouse Premium Reduction		(1,244,665)	(2,498,637)	(14,615,034)	(14,687,927)	(14,761,184)	(14,834,807)	(14,908,796)	(14,983,155)	(15,057,884)	(15,132,986)
MA Spouse Premium Reduction				(5,898,039)	(5,927,456)	(5,957,019)	(5,986,730)	(6,016,589)	(6,046,598)	(6,076,755)	(6,107,063)
MA Buy-up Premium				10,940,979	10,995,548	15,140,644	15,216,158	19,774,355	19,872,981	24,884,033	25,008,144
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(714,727)	(721,289)	(745,476)	(743,932)	(758,294)	(756,755)	(817,303)	(815,679)	(880,978)	(879,264)
Premium Incentive			-	(15,363,911)	(15,332,089)	(14,299,813)	(14,287,662)	18,347,595	18,311,123	18,164,492	18,129,151
CDHP Premium Reduction			-	(3,528,927)	(3,521,618)	(4,751,766)	(4,747,728)	(5,957,822)	(5,945,979)	(7,139,050)	(7,125,160)
Medicare Part D	57,583,602	36,936,224	2,784,744	3,434,018	2,910,058	3,588,549	3,041,010	3,750,033	3,177,856	3,918,785	3,320,859
EGWP+Wrap											
Direct Subsidy	-	25,008,159	25,151,533	-	-	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	7,195,769	17,999,102	-	-	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	13,047,904	-	-	-	-	-	-
Total	-	25,008,159	32,347,302	17,999,102	13,047,904	-	-	-	-	-	-
Appropriations from State Reserve				-							
Investment Earnings	3,015,815	3,063,553	1,448,002	1,420,130	1,471,875	1,364,138	1,187,237	977,122	864,507	734,935	644,071
Total Plan Income	2,852,680,163	2,958,251,928	1,475,938,129	1,484,595,416	1,476,076,792	1,496,153,788	1,492,341,023	1,649,755,238	1,645,792,386	1,780,504,456	1,776,386,545
PLAN EXPENSE:											
Medical Claims Payment	1,849,410,105	1,882,949,142	997,508,625	1,111,574,513	1,036,956,734	1,201,076,486	1,130,686,863	1,298,249,706	1,217,598,950	1,400,256,154	1,312,797,082
Claim Refunds	(22,634,615)	(23,855,443)	(12,060,684)	(12,583,200)	(12,885,851)	(13,596,192)	(14,362,157)	(14,789,230)	(15,257,502)	(15,736,111)	(16,451,838)
Dental & MHSA Enhancement			1,965,794	3,370,442	3,144,191	3,641,824	3,428,393	3,936,466	3,691,922	4,245,763	3,980,576
Medicare Advantage Claims Reduction				(51,495,701)	(60,190,041)	(65,631,913)	(65,959,257)	(71,922,732)	(72,281,451)	(78,816,526)	(79,209,628)
Calendar Year Adjustments		-	44,524,878	(4,229,258)	14,039,329	(14,419,571)	18,622,423	(17,792,129)	20,205,328	(19,304,460)	21,922,781
Preventative at 100% in Standard Plan				9,805,123	13,733,526	15,553,431	15,012,324	16,765,870	16,153,784	18,067,218	17,400,803
Premium Incentive				(7,995,527)	(11,972,541)	(11,462,987)	(11,446,086)	(12,527,363)	(12,502,373)	(19,984,282)	(19,945,259)
CDHP Claims Reduction				(2,705,932)	(4,051,876)	(5,771,199)	(5,762,690)	(8,941,127)	(8,923,291)	(12,953,021)	(12,927,728)
Limited Network Savings				310,434	464,845	390,200	389,624	602,750	601,547	576,589	575,463
PCP Copay Waiver				4,407,787	6,600,242	(367,417)	(366,875)	(4,086,355)	(4,078,203)	(17,078,970)	(17,045,620)
Mental Health Enhancements				451,938	608,120	704,185	662,915	765,427	717,877	830,633	778,752
Net Medical Claims	1,826,775,490	1,859,093,698	1,031,938,612	1,050,910,619	986,446,678	1,110,116,847	1,070,905,478	1,190,261,283	1,145,926,587	1,260,102,988	1,211,875,383
Medicare Advantage Premiums			-	86,864,745	87,297,988	108,861,089	109,404,040	133,102,486	133,766,343	159,805,493	160,602,532
Pharmacy Claims Payment	721,163,013	749,090,373	426,782,431	389,095,527	461,133,212	420,430,469	498,290,216	492,888,065	499,857,994	532,671,371	540,226,350
Rebates	(93,130,160)	(72,024,902)	(22,208,556)	(32,607,518)	(23,014,123)	(26,428,528)	(23,850,891)	(27,281,378)	(24,724,242)	(28,163,286)	(25,623,274)
Calendar Year Adjustments			6,211,534	(9,511,046)	11,406,548	(10,470,311)	12,325,781	(12,201,284)	12,627,650	(13,186,116)	13,647,560
Net Pharmacy Claims	628,032,853	677,065,471	410,785,408	346,976,963	449,525,637	383,531,630	486,765,106	453,405,403	487,761,402	491,321,968	528,250,635
MA-PDP Claims Reduction			-	(114,577,245)	(139,255,710)	(151,846,028)	(152,603,370)	(166,400,470)	(167,230,403)	(182,349,955)	(183,259,437)
EGWP+Wrap Reduction in Rebates		808,689	1,635,695	827,018	-	-	-	-	-	-	-
EGWP+Wrap Claim Increase		222,762	462,707	-	-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips		-	591,768	686,454	813,546	741,737	879,099	869,568	881,865	939,755	953,084
HB 675 - Pharmacy Audit Changes				100,000	104,617	95,383	113,047	111,821	113,403	120,847	122,561
Specialty Pharmacy Tier				(188,553)	(265,758)	(258,101)	(305,899)	(321,725)	(326,275)	(370,373)	(375,627)
Total Pharmacy Claims	628,032,853	678,096,922	413,475,579	233,824,638	310,922,331	232,264,620	334,847,983	287,664,597	321,199,992	309,662,242	345,691,217
Total Claims	2,454,808,343	2,537,190,620	1,445,414,191	1,371,600,002	1,384,666,997	1,451,242,555	1,515,157,501	1,611,028,367	1,600,892,923	1,729,570,723	1,718,169,132
Administrative Costs	165,480,561	164,665,404	85,504,284	91,148,330	88,666,681	88,484,867	91,324,774	91,141,320	93,688,951	93,504,688	96,122,447
ACA Reinsurance Fee				-	-	34,632,846	-	21,039,454	-	14,201,632	-
Extra EGWP+Wrap Administration	-	2,893,881	5,794,014	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,704,749,905	1,536,712,490	1,462,748,331	1,473,333,678	1,574,360,269	1,606,482,275	1,723,209,141	1,694,581,874	1,837,277,042	1,814,291,579
Plan Income (Loss)	232,391,259	253,502,023	(60,774,360)	21,847,084	2,743,114	(78,206,481)	(114,141,252)	(73,453,903)	(48,789,488)	(56,772,586)	(37,905,034)
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	755,749,494	694,975,134	716,822,218	719,565,332	641,358,851	527,217,599	453,763,696	404,974,207	348,201,621
Ending Cash Balance (Deficit)	502,247,471	755,749,494	694,975,134	716,822,218	719,565,332	641,358,851	527,217,599	453,763,696	404,974,207	348,201,621	310,296,587
Target Stabilization Reserve	184,110,626	202,975,250	219,485,780	239,446,206	234,282,695	255,231,860	266,976,005	281,356,728	289,072,916	299,741,728	310,296,587
	7.5%	8.0%	8.0%	8.5%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase		1/1 Increase		1/1 Increase		1/1 Increase		1/1 Increase	
Premium Increase:	5.3%	5.3%		3.57%		2.14%		8.22%		8.22%	

Short Plan Year Q1 Update

(Segal 11-14-13)

North Carolina State Health Plan
Financial Projections - Sep 2013
Trends - 8.5% Medical & Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase to $25/$25/$40 in Calendar 2016, $10 Standard Premium Credit

	2012 - 2013 Biennium		2014 - 2015 Biennium				2016 - 2017 Biennium				
	Actual FY 2012	Actual FY 2013	Projection Short Plan Year Jul-Dec 2013	Projection Calendar 2014 Jan-June	Projection Calendar 2014 July-Dec	Projection Calendar 2015 Jan-Jun	Projection Calendar 2015 Jul-Dec	Projection Calendar 2016 Jan-June	Projection Calendar 2016 July-Dec	Projection Calendar 2017 Jan-Jun	Projection Calendar 2017 Jul-Dec
PLAN INCOME:											
Net Contribution Income	2,750,368,851	2,895,366,140	1,454,995,731	1,497,179,531	1,494,163,089	1,523,095,383	1,520,090,707	1,634,253,292	1,631,098,518	1,753,672,738	1,750,362,250
EGWP/PDP Spouse Premium Reduction		-	(1,231,103)	(14,552,685)	(14,625,268)	(14,698,212)	(14,771,520)	(14,845,194)	(14,919,235)	(14,993,646)	(15,068,428)
MA Spouse Premium Reduction				(5,856,638)	(5,885,849)	(5,915,205)	(5,944,707)	(5,974,357)	(6,004,154)	(6,034,100)	(6,064,196)
MA Buy-up Premium				11,144,450	11,200,034	15,391,702	15,468,469	20,077,844	20,177,983	25,245,260	25,371,173
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(613,406)	(748,590)	(747,082)	(761,548)	(760,045)	(817,127)	(815,549)	(876,836)	(875,181)
Premium Incentive			-	(15,132,835)	(15,102,346)	(14,099,776)	(14,071,961)	18,234,558	18,199,358	18,052,395	18,018,317
CDHP Premium Reduction			-	(3,486,444)	(3,479,420)	(4,693,593)	(4,684,333)	(5,878,790)	(5,867,442)	(7,042,406)	(7,029,111)
Medicare Part D	57,583,602	38,056,016	(2,045,274)	3,280,324	2,779,814	3,427,938	2,904,906	3,582,196	3,035,627	3,743,394	3,172,230
EGWP+Wrap											
Direct Subsidy	-	24,435,483	25,741,422	-	-	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	8,953,844	18,169,771	-	-	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	-	13,171,626	-	-	-	-	-
Total	-	24,435,483	34,695,267	18,169,771	-	13,171,626	-	-	-	-	-
				-							
Appropriations from State Reserve											
Investment Earnings	3,015,815	3,236,713	1,663,868	1,489,193	1,545,098	1,447,760	1,284,123	1,065,908	939,801	788,054	665,776
Total Plan Income	2,852,680,163	2,960,048,314	1,487,465,082	1,491,486,077	1,469,848,073	1,516,366,077	1,499,515,639	1,649,698,330	1,645,844,906	1,772,554,853	1,768,552,830
PLAN EXPENSE:											
Medical Claims Payment	1,849,410,105	1,858,096,405	1,004,924,154	1,087,845,343	1,014,877,297	1,175,569,905	1,106,736,822	1,270,823,703	1,191,944,159	1,370,832,602	1,285,284,566
Claim Refunds	(22,634,615)	(23,467,914)	(11,861,694)	(12,309,995)	(12,611,230)	(13,307,208)	(13,868,798)	(14,476,540)	(14,935,747)	(15,405,170)	(16,106,749)
Dental & MHSA Enhancement			1,424,066	3,370,351	3,144,282	3,642,138	3,428,880	3,937,253	3,692,869	4,247,099	3,982,055
Medicare Advantage Claims Reduction				(51,959,107)	(60,778,121)	(66,273,163)	(66,603,704)	(72,625,445)	(72,987,669)	(79,586,594)	(79,983,537)
Calendar Year Adjustments		-	33,053,694	(4,229,258)	14,039,329	(14,419,571)	18,622,423	(17,792,129)	20,205,328	(19,304,460)	21,922,781
Preventative at 100% in Standard Plan				9,572,332	13,420,058	15,191,448	14,674,949	16,376,496	15,789,284	17,649,201	17,009,684
Premium Incentive				(7,929,050)	(11,873,557)	(11,380,262)	(11,357,731)	(12,581,387)	(12,557,011)	(19,995,303)	(19,957,415)
CDHP Claims Reduction				(2,637,947)	(3,950,260)	(5,647,915)	(5,636,733)	(8,766,694)	(8,749,709)	(12,719,839)	(12,695,736)
Limited Network Savings				304,325	455,720	382,506	381,748	595,478	594,324	569,136	568,057
PCP Copay Waiver				4,337,145	6,494,768	(398,650)	(397,860)	(4,021,959)	(4,014,166)	(16,995,135)	(16,962,932)
Essential Health Benefits/MH Parity				1,411,202	1,898,981	2,198,838	2,070,089	2,390,068	2,241,718	2,593,674	2,431,814
Net Medical Claims	1,826,775,490	1,834,628,491	1,027,540,221	1,027,775,341	965,117,266	1,085,558,067	1,048,050,085	1,163,858,843	1,121,223,380	1,231,885,210	1,185,492,589
Medicare Advantage Premiums			-	88,480,183	88,921,483	110,744,961	111,297,308	135,281,658	135,956,384	162,309,415	163,118,944
Pharmacy Claims Payment	721,163,013	752,419,650	456,411,374	414,627,765	491,418,537	448,066,596	531,072,633	525,343,967	532,801,144	567,808,369	575,892,516
Rebates	(93,130,160)	(69,641,941)	(29,386,434)	(37,921,448)	(23,335,020)	(33,756,553)	(24,186,211)	(27,624,160)	(25,074,597)	(28,521,582)	(25,989,500)
Calendar Year Adjustments			4,259,545	(10,817,063)	12,155,834	(11,158,568)	13,136,856	(13,004,731)	13,460,008	(14,055,935)	14,548,727
Net Pharmacy Claims	628,032,853	682,777,709	431,284,485	365,889,254	480,239,351	403,151,475	520,023,278	484,715,076	521,186,555	525,230,852	564,451,743
MA-PDP Claims Reduction			-	(116,068,145)	(141,087,642)	(153,843,588)	(154,610,892)	(168,589,496)	(169,430,346)	(184,748,799)	(185,670,245)
EGWP+Wrap Reduction in Rebates		-	834,594	842,398	-	-	-	-	-	-	-
EGWP+Wrap Claim Increase		-	238,622	-	-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips		-	380,804	686,435	813,565	741,794	879,214	869,730	882,076	940,032	953,416
HB 675 - Pharmacy Audit Changes				100,000	104,614	95,386	113,056	111,837	113,424	120,876	122,597
Specialty Pharmacy Tier				(188,549)	(265,765)	(258,094)	(305,906)	(321,717)	(326,283)	(370,363)	(375,637)
Total Pharmacy Claims	628,032,853	682,777,709	432,738,506	251,261,393	339,804,124	249,886,974	366,098,750	316,785,430	352,425,425	341,172,598	379,481,875
Total Claims	2,454,808,343	2,517,406,200	1,460,278,726	1,367,516,917	1,393,842,873	1,446,190,002	1,525,446,144	1,615,925,931	1,609,605,189	1,735,367,224	1,728,093,407
Administrative Costs	165,480,561	161,401,639	83,826,787	91,261,895	88,664,163	88,487,385	91,322,160	91,143,934	93,697,029	93,518,151	96,141,860
ACA Reinsurance Fee				-	-	34,632,846	-	21,039,454	-	14,201,632	-
Extra EGWP+Wrap Administration	-	-	2,904,645	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,547,010,159	1,458,778,811	1,482,507,036	1,569,310,234	1,616,768,304	1,728,109,320	1,703,302,218	1,843,087,006	1,824,235,268
Plan Income (Loss)	232,391,259	281,240,475	(59,545,076)	32,707,266	(12,658,963)	(52,944,157)	(117,252,665)	(78,410,990)	(57,457,313)	(70,532,153)	(55,682,438)
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	723,942,870	756,650,136	743,991,173	691,047,016	573,794,351	495,383,360	437,926,048	367,393,895
Ending Cash Balance (Deficit)	502,247,471	783,487,946	723,942,870	756,650,136	743,991,173	691,047,016	573,794,351	495,383,360	437,926,048	367,393,895	311,711,457
Target Stabilization Reserve	184,110,626	201,392,496	116,822,298	240,362,630	234,715,582	255,602,959	267,447,253	282,723,487	290,297,801	301,047,517	311,711,457
	7.5%	8.0%	8.0%	8.5%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase		1/1 Increase		1/1 Increase		1/1 Increase		1/1 Increase	
Premium Increase:	5.3%	5.3%		3.57%		2.14%		7.72%		7.72%	

Short Plan Year Q2 Update

Page 1 (CY)

(Segal 3-20-14)

North Carolina State Health Plan
Financial Projections - Dec 2013
Trends - 8.5% Medical & Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2012 - 2013 Biennium								
	Actual FY 2012	Actual FY 2013	Actual Short Plan Year Jul-Dec 2013	Projection Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019
PLAN INCOME:									
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	2,970,543,666	3,051,421,272	3,208,031,812	3,372,966,690	3,824,203,625	4,336,181,113
EGWP/PDP Spouse Premium Reduction		-	-	(28,758,859)	(29,046,448)	(29,336,913)	(29,630,282)	(29,926,584)	(30,225,850)
MA Spouse Premium Reduction				(11,584,206)	(11,700,048)	(11,817,049)	(11,935,219)	(12,054,571)	(12,175,117)
MA Buy-up Premium				22,174,902	30,658,726	40,019,308	50,341,322	50,844,735	51,353,182
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(1,485,272)	(1,525,711)	(1,604,016)	(1,686,483)	(1,912,102)	(2,168,091)
Premium Incentive			-	(30,069,702)	(28,000,094)	37,232,486	36,860,749	53,391,313	55,247,217
CDHP Premium Reduction			-	(6,988,511)	(9,406,300)	(11,779,904)	(14,110,059)	(14,083,447)	(14,057,443)
Medicare Part D	57,583,602	38,056,016	(1,323,888)	11,777,523	6,332,844	6,617,822	6,915,624	7,226,827	7,552,035
EGWP+Wrap									
Direct Subsidy	-	24,435,483	25,202,822	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,765	24,177,036	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	31,734,272	-	-	-	-
Total	-	24,435,483	37,082,587	24,177,036	31,734,272	-	-	-	-
Appropriations from State Reserve									
Investment Earnings	3,015,815	3,236,713	1,841,087	3,321,318	3,217,073	2,472,854	1,579,006	949,878	1,134,624
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	2,953,107,894	3,043,685,587	3,239,836,402	3,411,301,348	3,878,639,674	4,392,841,669
PLAN EXPENSE:									
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	2,083,673,638	2,261,596,481	2,440,333,727	2,631,827,805	2,897,278,791	3,072,605,012
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(24,973,844)	(26,929,550)	(29,144,515)	(31,223,916)	(33,784,572)	(36,623,068)
Dental & MHSA Enhancement			-	6,514,633	7,070,911	7,629,735	8,228,444	9,058,380	9,606,540
Medicare Advantage Claims Reduction				(112,463,601)	(132,498,969)	(145,198,995)	(159,116,318)	(174,367,618)	(191,080,754)
Calendar Year Adjustments		-	-	9,810,071	4,202,852	2,413,200	2,618,322	2,840,879	3,082,354
Preventative at 100%				22,773,966	29,585,221	49,841,453	55,369,746	60,984,799	64,519,766
Premium Incentive				(19,576,815)	(22,464,351)	(24,693,344)	(39,441,246)	(41,875,309)	(44,809,245)
CDHP Claims Reduction				(6,536,570)	(11,217,934)	(17,432,379)	(25,312,620)	(28,054,532)	(30,750,194)
Limited Network Savings				755,079	759,503	1,192,777	1,139,976	980,250	803,548
PCP Copay Waiver				10,761,897	(794,450)	(7,830,362)	(33,815,869)	(49,197,620)	(66,311,558)
Essential Health Benefits/MH Parity				3,310,240	4,268,927	4,631,786	5,025,488	5,532,368	5,867,154
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,974,048,693	2,113,578,641	2,281,743,083	2,415,299,812	2,649,395,817	2,786,909,556
Medicare Advantage Premiums			-	176,055,285	220,532,743	269,549,392	323,543,071	372,120,793	425,530,349
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	934,478,295	974,347,743	1,052,930,005	1,138,023,343	1,230,098,785	1,329,738,481
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(60,868,702)	(57,539,179)	(52,278,672)	(54,073,772)	(52,947,389)	(54,894,471)
Calendar Year Adjustments			-	1,940,054	1,968,345	452,762	490,050	530,460	574,256
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	875,549,647	918,776,908	1,001,104,094	1,084,439,621	1,177,681,856	1,275,418,266
MA-PDP Claims Reduction			-	(256,316,210)	(307,306,809)	(336,762,167)	(369,040,821)	(404,413,383)	(443,176,406)
EGWP+Wrap Reduction in Rebates		-	-	839,332	-	-	-	-	-
EGWP+Wrap Claim Increase		-	-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips		-	-	1,500,000	1,563,997	1,690,136	1,826,725	1,974,522	2,134,461
HB 675 - Pharmacy Audit Changes				204,615	208,438	225,248	243,452	263,149	284,465
Specialty Pharmacy Tier				(227,226)	(292,000)	(336,000)	(386,000)	(417,231)	(451,027)
Total Pharmacy Claims	628,032,853	682,777,709	393,069,298	621,550,158	612,950,534	665,921,311	717,082,978	775,088,914	834,209,759
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,771,654,136	2,947,061,919	3,217,213,786	3,455,925,861	3,796,605,524	4,046,649,664
Administrative Costs	165,480,561	161,401,639	69,548,737	188,437,262	179,809,574	184,837,642	189,649,805	192,119,934	192,119,934
ACA Reinsurance Fee				-	34,632,846	21,039,454	14,201,632	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,960,091,398	3,161,504,339	3,423,090,882	3,659,777,298	3,988,725,458	4,238,769,598
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	(6,983,504)	(117,818,752)	(183,254,480)	(248,475,950)	(110,085,784)	154,072,071
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	831,463,633	713,644,881	530,390,401	281,914,451	171,828,667
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	831,463,633	713,644,881	530,390,401	281,914,451	171,828,667	325,900,738
Target Stabilization Reserve	184,110,626	201,392,496	113,231,386	220,625,902	245,387,626	265,289,795	281,914,451	308,203,626	325,900,738
	7.5%	8.0%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase		1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	5.3%	5.3%		3.57%	2.14%	5.55%	5.55%	13.81%	13.81%

Short Plan Year Q2 Update

Page 2 (FY)

(Segal 3-20-14)

North Carolina State Health Plan
Financial Projections - Dec 2013
Trends - 8.5% Medical & Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2010-2011 Biennium		2012 - 2013 Biennium		2014 - 2015 Biennium		2016 - 2017 Biennium		2018 - 2019 Biennium	
	Actual FY 2010	Actual FY 2011	Actual FY 2012	Actual FY 2013	Projection FY 2014	Projection FY2015	Projection FY2016	Projection FY2017	Projection FY2018	Projection FY2019
PLAN INCOME:										
Net Contribution Income	2,413,877,944	2,684,814,172	2,750,368,851	2,895,366,140	2,974,875,415	3,025,476,833	3,129,770,621	3,290,543,712	3,598,759,274	4,080,384,112
EGWP/PDP Spouse Premium Reduction				-	(14,343,660)	(28,902,296)	(29,191,319)	(29,483,232)	(29,778,065)	(30,075,845)
MA Spouse Premium Reduction					(5,777,695)	(11,641,983)	(11,758,403)	(11,875,987)	(11,994,747)	(12,114,694)
MA Buy-up Premium					11,059,870	26,406,262	35,327,375	45,167,477	50,592,402	51,098,326
Health care Reform ERRP	-	45,298,812	42,163,391	(558,219)	-	-	-	-	-	-
Retro Disenrollments	(1,310,146)	(1,281,584)	(451,496)	(487,819)	(1,013,687)	(1,512,738)	(1,564,885)	(1,645,272)	(1,799,380)	(2,040,192)
Premium Incentive					(15,050,145)	(29,033,551)	4,648,296	37,046,043	45,133,340	54,319,532
CDHP Premium Reduction					(3,497,810)	(8,198,537)	(10,594,160)	(12,945,967)	(14,096,677)	(14,070,368)
Medicare Part D	74,357,704	66,276,535	57,583,602	38,056,016	7,673,821	6,207,753	6,487,102	6,779,021	7,084,077	7,402,861
EGWP+Wrap										
Direct Subsidy	-	-	-	24,435,483	25,202,822	-	-	-	-	-
Coverage Gap Subsidy	-	-	-	-	36,056,800	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	-	31,734,272	-	-	-	-
Total	-	-	-	24,435,483	61,259,622	31,734,272	-	-	-	-
Appropriations from State Reserve										
Investment Earnings	3,532,448	2,861,085	3,015,815	3,236,713	3,458,328	3,374,214	2,870,577	2,060,786	1,170,721	942,963
Total Plan Income	2,490,457,950	2,797,969,020	2,852,680,163	2,960,048,314	3,018,644,061	3,013,910,229	3,125,995,203	3,325,646,582	3,645,070,948	4,135,846,695
PLAN EXPENSE:										
Medical Claims Payment	1,829,432,245	1,852,549,690	1,849,410,105	1,858,096,405	2,111,136,595	2,170,606,720	2,355,942,280	2,539,384,035	2,744,609,210	2,957,011,522
Claim Refunds	(31,916,831)	(24,723,681)	(22,634,615)	(23,467,914)	(23,311,025)	(25,683,840)	(28,087,779)	(30,064,154)	(32,703,421)	(35,022,891)
Dental & MHSA Enhancement					3,370,316	6,786,430	7,365,884	7,939,418	8,581,057	9,245,135
Medicare Advantage Claims Reduction					(51,858,331)	(126,689,953)	(138,833,186)	(152,140,346)	(166,722,999)	(182,703,398)
Calendar Year Adjustments				-	(4,229,258)	(380,241)	830,294	900,869	977,443	1,060,525
Preventative at 100%					9,478,438	28,342,109	39,151,144	53,420,904	57,681,930	62,081,319
Premium Incentive					(7,838,711)	(22,981,509)	(23,579,701)	(32,074,091)	(40,658,993)	(43,343,166)
CDHP Claims Reduction					(2,617,294)	(9,533,851)	(14,328,079)	(21,376,086)	(26,684,587)	(29,403,292)
Limited Network Savings					302,340	832,871	976,344	1,166,339	1,060,026	891,808
PCP Copay Waiver					4,309,148	6,055,127	(4,315,840)	(20,835,470)	(41,513,579)	(57,761,881)
Essential Health Benefits/MH Parity					1,411,238	4,097,858	4,460,159	4,835,394	5,240,844	5,646,428
Net Medical Claims	1,797,515,414	1,827,826,009	1,826,775,490	1,834,628,491	2,040,153,456	2,031,451,720	2,199,581,522	2,351,156,809	2,509,866,931	2,687,702,109
Medicare Advantage Premiums					87,808,667	198,238,694	244,980,101	296,479,075	347,771,512	398,759,141
Pharmacy Claims Payment	N/A	N/A	721,163,013	752,419,650	870,709,119	934,905,342	1,051,228,929	1,095,165,283	1,183,723,074	1,279,551,736
Rebates	N/A	N/A	(93,130,160)	(69,641,941)	(69,918,142)	(56,695,982)	(51,398,622)	(53,167,573)	(52,001,558)	(53,911,531)
Calendar Year Adjustments					(10,156,576)	992,565	131,662	(592,770)	(641,245)	(693,747)
Net Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	790,634,401	879,201,925	999,961,970	1,041,404,939	1,131,080,272	1,224,946,458
MA-PDP Claims Reduction					(115,753,515)	(293,833,875)	(321,997,852)	(352,861,346)	(386,683,106)	(423,746,682)
EGWP+Wrap Reduction in Rebates				-	839,332	-	-	-	-	-
EGWP+Wrap Claim Increase				-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips				-	715,027	1,500,685	1,687,405	1,757,931	1,900,081	2,053,903
HB 675 - Pharmacy Audit Changes					100,000	200,000	224,885	234,284	253,228	273,729
Specialty Pharmacy Tier					(94,304)	(266,546)	(325,193)	(360,820)	(401,501)	(434,004)
Total Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	676,440,941	586,802,189	679,551,215	690,174,988	746,148,975	803,093,403
Total Claims	2,394,225,189	2,483,694,744	2,454,808,343	2,517,406,200	2,804,403,064	2,816,492,603	3,124,112,838	3,337,810,872	3,603,787,417	3,889,554,653
Administrative Costs	164,649,780	165,902,094	165,480,561	161,401,639	169,321,052	177,151,548	182,466,094	187,208,490	192,195,802	192,119,934
ACA Reinsurance Fee					-	34,632,846	21,039,454	14,201,632	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,558,874,969	2,649,596,838	2,620,288,904	2,678,807,839	2,973,724,116	3,028,276,997	3,327,618,386	3,539,220,994	3,795,983,219	4,081,674,587
Plan Income (Loss)	(68,417,019)	148,372,182	232,391,259	281,240,475	44,919,945	(14,366,769)	(201,623,183)	(213,574,412)	(150,912,271)	54,172,108
Beginning Cash Balance (Deficit)	189,901,049	121,484,030	269,856,212	502,247,471	783,487,946	828,407,891	814,041,122	612,417,939	398,843,527	247,931,256
Ending Cash Balance (Deficit)	121,484,030	269,856,212	502,247,471	783,487,946	828,407,891	814,041,122	612,417,939	398,843,527	247,931,256	302,103,363
Target Stabilization Reserve	179,566,889	186,277,106	184,110,626	201,392,496	230,910,524	235,642,852	259,121,946	273,719,862	293,041,432	314,171,596
			7.5%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase	7/1 Increase	7/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	8.9%	8.9%	5.3%	5.3%	3.57%	2.14%	5.55%	5.55%	13.81%	13.81%

CY 2014 Q1 Update

Page 1 (CY) (Segal 5-16-14)

North Carolina State Health Plan
Financial Projections - Mar 2014
Trends - 8.5% Medical & Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2012 - 2013 Biennium								
	Actual FY 2012	Actual FY 2013	Actual Short Plan Year Jul-Dec 2013	Projection Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019
PLAN INCOME:									
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	3,028,890,369	3,128,803,824	3,481,139,560	3,605,236,066	4,275,034,734	4,865,853,386
EGWP/PDP Spouse Premium Reduction		-	-	-	-	-	-	-	-
MA Spouse Premium Reduction				-	-	-	-	-	-
MA Buy-up Premium				-	-	-	-	-	-
Medicare Advantae Subsidy				152,149	-	-	-	-	-
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(1,147,610)	(1,564,402)	(1,740,570)	(1,802,618)	(2,137,517)	(2,432,927)
Wellness Credit			-	(86,126,636)	(115,224,546)	(336,693,892)	(333,629,435)	(486,724,546)	(486,445,952)
Premium Reduction due to Movement			-	-	(9,808,137)	(4,684,389)	(7,458,634)	(10,854,215)	(13,682,766)
Medicare Part D	57,583,602	38,056,016	(1,323,888)	14,528,165	6,332,844	6,617,822	6,915,624	7,226,827	7,552,035
EGWP+Wrap									
Direct Subsidy	-	24,435,483	25,202,822	572,152	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,765	23,747,921	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	31,734,272	-	-	-	-
Total	-	24,435,483	37,082,587	24,320,074	31,734,272	-	-	-	-
Investment Earnings	3,015,815	3,236,713	1,841,087	4,013,866	3,918,968	3,125,545	1,868,283	947,440	1,121,086
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	2,984,630,376	3,044,192,823	3,147,764,077	3,271,129,287	3,783,492,723	4,371,964,862
PLAN EXPENSE:									
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	1,998,101,810	2,237,889,787	2,414,753,829	2,604,241,245	2,866,910,701	3,040,400,426
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(23,670,288)	(26,647,267)	(28,839,018)	(30,896,629)	(33,430,454)	(36,239,211)
Dental & MHSA Enhancement			-	4,999,489	7,296,440	7,873,090	8,490,897	9,347,307	9,912,955
Medicare Advantage Claims Reduction				(78,444,877)	(115,388,404)	(126,448,382)	(138,568,460)	(151,850,247)	(166,405,093)
Calendar Year Adjustments		-	-	(4,650,956)	4,202,852	2,413,200	2,618,322	2,840,879	3,082,354
Preventative at 100% in Standard Plan				20,115,500	29,499,993	49,702,868	55,224,139	60,822,061	64,365,360
Wellness Comply Savings				(2,518,767)	(8,952,914)	(24,669,613)	(43,903,034)	(47,586,599)	(51,953,092)
Claims Reduction due to Movement				(22,567,495)	(30,328,293)	(14,443,883)	(19,442,907)	(28,102,594)	(36,731,934)
Limited Network Savings				705,306	924,795	1,517,412	1,396,118	1,252,501	1,076,509
PCP Copay Waiver				7,958,584	270,005	(10,422,866)	(32,068,571)	(55,361,216)	(80,571,041)
Essential Health Benefits/MH Parity				3,019,428	4,268,927	4,631,786	5,025,488	5,532,369	5,867,158
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,903,047,735	2,103,035,923	2,276,068,423	2,412,116,608	2,630,374,708	2,752,804,391
Medicare Advantage Premiums			-	158,450,497	193,034,335	232,276,427	275,487,271	316,071,947	360,688,456
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	845,130,445	937,199,494	1,012,785,871	1,094,635,194	1,183,200,557	1,279,041,944
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(95,427,102)	(58,014,645)	(52,771,544)	(54,584,611)	(53,476,984)	(55,443,564)
Calendar Year Adjustments			-	6,343,463	1,893,300	435,501	471,369	510,239	552,367
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	756,046,806	881,078,150	960,449,828	1,040,521,953	1,130,233,812	1,224,150,747
MA-PDP Claims Reduction			-	(170,590,776)	(251,548,637)	(275,659,573)	(302,081,544)	(331,036,060)	(362,765,866)
EGWP+Wrap Reduction in Rebates		-	-	-	-	-	-	-	-
EGWP+Wrap Claim Increase		-	-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips		-	-	1,193,853	1,663,411	1,797,567	1,942,839	2,100,032	2,270,138
HB 675 - Pharmacy Audit Changes				158,587	208,438	225,249	243,452	263,150	284,465
Specialty Pharmacy Tier				(202,159)	(292,000)	(336,000)	(386,000)	(417,231)	(451,027)
Total Pharmacy Claims	628,032,853	682,777,709	393,069,298	586,606,311	631,109,362	686,477,071	740,240,701	801,143,703	863,488,457
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,648,104,543	2,927,179,620	3,194,821,920	3,427,844,580	3,747,590,358	3,976,981,304
Administrative Costs	165,480,561	161,401,639	69,548,737	180,329,844	179,809,572	184,837,659	189,649,870	194,604,037	194,527,688
ACA Reinsurance Fee				-	34,632,846	21,039,454	14,201,632	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,828,434,388	3,141,622,038	3,400,699,034	3,631,696,082	3,942,194,395	4,171,508,992
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	156,195,988	(97,429,216)	(252,934,957)	(360,566,794)	(158,701,671)	200,455,870
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	994,643,125	897,213,909	644,278,952	283,712,158	125,010,486
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	994,643,125	897,213,909	644,278,952	283,712,158	125,010,486	325,466,356
Target Stabilization Reserve	184,110,626	201,392,496	113,231,386	211,620,594	246,073,076	266,629,094	283,712,158	308,836,657	325,466,356
	7.5%	8.0%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase		1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	5.3%	5.3%		3.57%	2.14%	4.47%	4.47%	16.11%	16.11%

CY 2014 Q1 Update

Page 2 (FY)

(Segal 5-16-14)

North Carolina State Health Plan
Financial Projections - Mar 2014
Trends - 8.5% Medical & Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2010-2011 Biennium		2012 - 2013 Biennium		2014 - 2015 Biennium		2016 - 2017 Biennium		2018 - 2019 Biennium	
	Actual FY 2010	Actual FY 2011	Actual FY 2012	Actual FY 2013	Projection FY 2014	Projection FY2015	Projection FY2016	Projection FY2017	Projection FY2018	Projection FY2019
PLAN INCOME:										
Net Contribution Income	2,413,877,944	2,684,814,172	2,750,368,851	2,895,366,140	2,994,394,148	3,103,079,247	3,305,254,358	3,543,210,326	3,940,507,313	4,570,671,983
EGWP/PDP Spouse Premium Reduction				-	-	-	-	-	-	-
MA Spouse Premium Reduction					-	-	-	-	-	-
MA Buy-up Premium					-	-	-	-	-	-
Medicare Advantae Subsidy					152,149	-	-	-	-	-
Health care Reform ERRP	-	45,298,812	42,163,391	(558,219)	-	-	-	-	-	-
Retro Disenrollments	(1,310,146)	(1,281,584)	(451,496)	(487,819)	(656,611)	(1,551,540)	(1,652,627)	(1,771,605)	(1,970,254)	(2,285,336)
Wellness Credit					(28,759,106)	(115,080,257)	(226,204,540)	(335,157,115)	(410,339,598)	(486,584,965)
Premium Reduction due to Movement					-	(4,919,289)	(7,237,917)	(6,074,468)	(9,158,848)	(12,271,619)
Medicare Part D	74,357,704	66,276,535	57,583,602	38,056,016	10,355,829	6,276,386	6,487,102	6,779,021	7,084,077	7,402,861
EGWP+Wrap										
Direct Subsidy	-	-	-	24,435,483	25,774,974	-	-	-	-	-
Coverage Gap Subsidy	-	-	-	-	35,627,686	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	-	31,734,272	-	-	-	-
Total	-	-	-	24,435,483	61,402,661	31,734,272	-	-	-	-
Investment Earnings	3,532,448	2,861,085	3,015,815	3,236,713	3,839,168	4,026,509	3,592,708	2,552,944	1,282,719	887,099
Total Plan Income	2,490,457,950	2,797,969,020	2,852,680,163	2,960,048,314	3,040,728,238	3,023,565,328	3,080,239,084	3,209,539,103	3,527,405,410	4,077,820,022
PLAN EXPENSE:										
Medical Claims Payment	1,829,432,245	1,852,549,690	1,849,410,105	1,858,096,405	2,036,106,807	2,147,853,708	2,331,246,792	2,512,766,161	2,715,840,904	2,926,017,901
Claim Refunds	(31,916,831)	(24,723,681)	(22,634,615)	(23,467,914)	(22,138,601)	(25,414,481)	(27,793,356)	(29,749,020)	(32,360,630)	(34,655,800)
Dental & MHSA Enhancement					1,754,883	7,002,886	7,600,823	8,192,650	8,854,757	9,540,021
Medicare Advantage Claims Reduction					(25,666,010)	(110,329,549)	(120,904,637)	(132,493,346)	(145,192,833)	(159,109,567)
Calendar Year Adjustments				-	(18,690,285)	(380,241)	830,294	900,869	977,443	1,060,525
Preventative at 100% in Standard Plan					6,854,749	28,259,422	39,036,399	53,276,346	57,532,424	61,929,190
Wellness Comply Savings					(828,478)	(6,107,341)	(16,704,734)	(34,154,969)	(45,720,880)	(49,740,728)
Claims Reduction due to Movement					(7,525,283)	(30,174,831)	(22,157,948)	(16,836,015)	(23,653,924)	(32,262,373)
Limited Network Savings					237,351	936,304	1,228,691	1,460,151	1,328,348	1,169,261
PCP Copay Waiver					2,631,058	5,519,195	(4,975,565)	(21,046,701)	(43,500,701)	(67,734,584)
Essential Health Benefits/MH Parity					1,059,857	4,158,427	4,460,159	4,835,394	5,240,845	5,646,430
Net Medical Claims	1,797,515,414	1,827,826,009	1,826,775,490	1,834,628,491	1,973,796,047	2,021,323,499	2,191,866,918	2,347,151,519	2,499,345,752	2,661,860,276
Medicare Advantage Premiums					79,548,716	175,178,855	212,606,572	253,828,104	295,729,130	338,324,708
Pharmacy Claims Payment	N/A	N/A	721,163,013	752,419,650	800,006,086	899,260,836	1,011,149,558	1,053,411,000	1,138,592,756	1,230,768,323
Rebates	N/A	N/A	(93,130,160)	(69,641,941)	(92,245,116)	(69,163,011)	(51,882,687)	(53,669,341)	(52,521,684)	(54,450,781)
Calendar Year Adjustments					(5,291,967)	954,722	126,642	(570,171)	(616,799)	(667,300)
Net Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	702,469,003	831,052,546	959,393,513	999,171,487	1,085,454,274	1,175,650,242
MA-PDP Claims Reduction					(55,531,971)	(240,520,250)	(263,574,116)	(288,837,695)	(316,522,788)	(346,861,498)
EGWP+Wrap Reduction in Rebates				-	-	-	-	-	-	-
EGWP+Wrap Claim Increase				-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips				-	358,984	1,596,075	1,794,663	1,869,672	2,020,859	2,184,459
HB 675 - Pharmacy Audit Changes					53,972	200,000	224,885	234,284	253,229	273,729
Specialty Pharmacy Tier					(60,788)	(274,995)	(325,193)	(360,820)	(401,501)	(434,004)
Total Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	647,289,201	592,053,375	697,513,751	712,076,928	770,804,072	830,812,927
Total Claims	2,394,225,189	2,483,694,744	2,454,808,343	2,517,406,200	2,700,633,964	2,788,555,728	3,101,987,242	3,313,056,551	3,565,878,954	3,830,997,912
Administrative Costs	164,649,780	165,902,094	165,480,561	161,401,639	161,213,637	177,151,548	182,466,094	187,208,529	192,090,617	197,116,970
ACA Reinsurance Fee					-	34,632,846	21,039,454	14,201,632	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,558,874,969	2,649,596,838	2,620,288,904	2,678,807,839	2,861,847,600	3,000,340,123	3,305,492,790	3,514,466,711	3,757,969,570	4,028,114,882
Plan Income (Loss)	(68,417,019)	148,372,182	232,391,259	281,240,475	178,880,637	23,225,205	(225,253,707)	(304,927,609)	(230,564,161)	49,705,141
Beginning Cash Balance (Deficit)	189,901,049	121,484,030	269,856,212	502,247,471	783,487,946	962,368,583	985,593,789	760,340,082	455,412,473	224,848,313
Ending Cash Balance (Deficit)	121,484,030	269,856,212	502,247,471	783,487,946	962,368,583	985,593,789	760,340,082	455,412,473	224,848,313	274,553,453
Target Stabilization Reserve	179,566,889	186,277,106	184,110,626	201,392,496	222,792,246	235,203,919	260,044,260	275,330,560	294,313,484	314,340,588
			7.5%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase	7/1 Increase	7/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	8.9%	8.9%	5.3%	5.3%	3.57%	2.14%	4.47%	4.47%	16.11%	16.11%

CY 2014 Q2 Update
Authorized Budget

Page 1 (CY)
(Segal 9-9-14)

North Carolina State Health Plan
Financial Projections - Jun 2014
Trends - 7.0% Medical & 8.5% Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2012 - 2013 Biennium								
	Actual FY 2012	Actual FY 2013	Actual Short Plan Year Jul-Dec 2013	Projection Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019
PLAN INCOME:									
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	2,918,674,381	2,951,410,895	3,043,513,806	3,138,757,776	3,555,599,708	4,028,147,898
Additional Contribution/(Credit)		-	-	(9,273,308)	(18,200,330)	7,540,905	7,708,496	22,956,365	23,188,935
Medicare Advantae Subsidy				417,565	-	-	-	-	-
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(762,462)	(1,475,705)	(1,521,757)	(1,569,379)	(1,777,800)	(2,014,074)
Premium Change due to Movement			-	-	(2,069,875)	3,562,316	757,514	1,088,179	1,393,967
Medicare Part D	57,583,602	38,056,016	(1,323,888)	15,755,988	6,332,844	6,617,822	6,915,624	7,226,827	7,552,035
EGWP+Wrap									
Direct Subsidy	-	24,435,483	25,202,822	216,170	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,765	28,162,232	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	31,734,272	-	-	-	-
Total	-	24,435,483	37,082,587	28,378,402	31,734,272	-	-	-	-
Investment Earnings	3,015,815	3,236,713	1,841,087	4,037,042	3,795,447	2,968,598	1,760,825	919,811	1,067,149
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	2,957,227,608	2,971,527,548	3,062,681,690	3,154,330,856	3,586,013,091	4,059,335,910
PLAN EXPENSE:									
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	1,923,771,653	2,043,049,477	2,168,271,136	2,306,114,623	2,498,646,651	2,610,832,157
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(23,379,887)	(24,429,422)	(25,933,873)	(27,414,731)	(29,146,209)	(31,193,353)
Claims Adjustment for Changes				12,361,978	(533,548)	54,626,340	13,499,983	(12,249,983)	(43,217,635)
Cost of Autism				-	4,000,000	5,000,000	5,200,000	5,500,000	5,778,219
Cost of Add Towns				-	894,905	956,522	996,952	1,055,371	1,052,756
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,912,753,744	2,022,981,411	2,202,920,124	2,298,396,827	2,463,805,830	2,543,252,144
Medicare Advantage Premiums				157,598,589	168,862,661	181,496,934	194,973,718	209,526,378	225,241,621
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	679,332,594	714,742,901	769,323,996	829,338,691	894,087,930	963,950,031
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(99,777,740)	(58,107,239)	(52,742,044)	(54,414,583)	(56,160,834)	(57,969,685)
Claims Adjustment for Changes			-	-	-	-	-	-	-
Additional ACA Preventive Medicine			-	-	692,000	1,276,000	1,366,000	1,462,000	1,511,248
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	579,554,855	657,327,662	717,857,952	776,290,108	839,389,096	907,491,593
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,649,907,187	2,849,171,734	3,102,275,010	3,269,660,653	3,512,721,304	3,675,985,358
Administrative Costs	165,480,561	161,401,639	69,548,737	173,657,606	192,801,628	198,192,837	203,352,385	208,664,127	214,133,099
ACA Reinsurance Fee				-	34,019,697	20,569,718	13,884,560	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,823,564,794	3,075,993,058	3,321,037,565	3,486,897,598	3,721,385,432	3,890,118,457
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	133,662,815	(104,465,510)	(258,355,875)	(332,566,741)	(135,372,341)	169,217,453
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	972,109,951	867,644,441	609,288,566	276,721,824	141,349,483
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	972,109,951	867,644,441	609,288,566	276,721,824	141,349,483	310,566,936
Target Stabilization Reserve	184,110,626	201,392,496	113,231,386	211,846,231	241,227,817	262,870,027	276,721,824	297,287,543	310,566,936
	7.5%	8.0%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase		1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	5.3%	5.3%		3.57%	0.00%	3.53%	3.53%	13.71%	13.71%

CY 2014 Q2 Update
Authorized Budget
Page 2 (FY)
(Segal 9-9-14)

North Carolina State Health Plan
Financial Projections - Jun 2014
Trends - 7.0% Medical & 8.5% Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2010-2011 Biennium		2012 - 2013 Biennium		2014 - 2015 Biennium		2016 - 2017 Biennium		2018 - 2019 Biennium	
	Actual FY 2010	Actual FY 2011	Actual FY 2012	Actual FY 2013	Projection FY 2014	Projection FY2015	Projection FY2016	Projection FY2017	Projection FY2018	Projection FY2019
PLAN INCOME:										
Net Contribution Income	2,413,877,944	2,684,814,172	2,750,368,851	2,895,366,140	2,941,097,678	2,957,330,894	2,997,476,025	3,091,148,757	3,347,339,381	3,792,050,539
Additional Contribution/(Credit)				-	-	(18,389,215)	(5,299,800)	7,624,855	15,349,640	23,072,825
Medicare Advantae Subsidy					417,565	-	-	-	-	-
Health care Reform ERRP	-	45,298,812	42,163,391	(558,219)	-	-	-	-	-	-
Retro Disenrollments	(1,310,146)	(1,281,584)	(451,496)	(487,819)	(299,923)	(1,478,665)	(1,498,738)	(1,545,574)	(1,673,670)	(1,896,025)
0					-	-	-	-	-	-
Premium Change due to Movement					-	(1,034,938)	746,221	2,159,915	922,847	1,241,073
Medicare Part D	74,357,704	66,276,535	57,583,602	38,056,016	11,583,652	6,276,386	6,487,102	6,779,021	7,084,077	7,402,861
EGWP+Wrap										
Direct Subsidy	-	-	-	24,435,483	25,216,663	202,329	-	-	-	-
Coverage Gap Subsidy	-	-	-	-	38,563,909	1,478,088	-	-	-	-
Catastrophic Subsidy	-	-	-	-	-	31,734,272	-	-	-	-
Total	-	-	-	24,435,483	63,780,571	33,414,689	-	-	-	-
Investment Earnings	3,532,448	2,861,085	3,015,815	3,236,713	3,916,235	3,933,340	3,456,019	2,406,449	1,221,707	870,198
Total Plan Income	2,490,457,950	2,797,969,020	2,852,680,163	2,960,048,314	3,020,495,778	2,980,052,493	3,001,366,829	3,108,573,423	3,370,243,983	3,822,741,471
PLAN EXPENSE:										
Medical Claims Payment	1,829,432,245	1,852,549,690	1,849,410,105	1,858,096,405	1,989,574,333	1,981,132,627	2,104,367,930	2,236,473,423	2,378,323,219	2,527,382,130
Claim Refunds	(31,916,831)	(24,723,681)	(22,634,615)	(23,467,914)	(22,450,766)	(23,520,519)	(25,159,105)	(26,558,401)	(28,433,075)	(30,024,340)
Claims Adjustment for Changes					-	12,149,156	26,519,120	35,022,403	617,098	(27,583,637)
Cost of Autism						2,001,993	4,500,445	5,100,042	5,350,084	5,639,177
Cost of Add Towns						432,449	924,000	989,000	1,022,182	1,089,662
Net Medical Claims	1,797,515,414	1,827,826,009	1,826,775,490	1,834,628,491	1,967,123,567	1,972,195,706	2,111,152,391	2,251,026,467	2,356,879,507	2,476,502,992
Medicare Advantage Premiums					78,538,847	163,281,043	175,164,083	188,218,563	202,231,947	217,364,453
Pharmacy Claims Payment	N/A	N/A	721,163,013	752,419,650	743,281,462	686,597,084	769,269,941	798,947,229	861,298,346	928,570,652
Rebates	N/A	N/A	(93,130,160)	(69,641,941)	(91,653,105)	(74,166,940)	(51,914,121)	(53,570,874)	(55,279,945)	(57,057,201)
Claims Adjustment for Changes					-	-	-	-	-	-
Additional ACA Preventive Medicine						346,345	984,278	1,321,029	1,414,030	1,473,850
Net Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	651,628,357	612,776,489	718,340,098	746,697,384	807,432,432	872,987,301
Total Claims	2,394,225,189	2,483,694,744	2,454,808,343	2,517,406,200	2,697,290,771	2,748,253,238	3,004,656,572	3,185,942,415	3,366,543,886	3,566,854,745
Administrative Costs	164,649,780	165,902,094	165,480,561	161,401,639	148,134,913	189,951,548	195,650,094	200,734,833	205,969,298	211,358,434
ACA Reinsurance Fee					-	34,019,697	20,569,718	13,884,560	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,558,874,969	2,649,596,838	2,620,288,904	2,678,807,839	2,845,425,684	2,972,224,483	3,220,876,384	3,400,561,808	3,572,513,183	3,778,213,179
Plan Income (Loss)	(68,417,019)	148,372,182	232,391,259	281,240,475	175,070,094	7,828,010	(219,509,556)	(291,988,384)	(202,269,200)	44,528,292
Beginning Cash Balance (Deficit)	189,901,049	121,484,030	269,856,212	502,247,471	783,487,946	958,558,040	966,386,050	746,876,494	454,888,110	252,618,909
Ending Cash Balance (Deficit)	121,484,030	269,856,212	502,247,471	783,487,946	958,558,040	966,386,050	746,876,494	454,888,110	252,618,909	297,147,201
Target Stabilization Reserve	179,566,889	186,277,106	184,110,626	201,392,496	222,593,914	232,647,498	254,654,324	269,795,147	284,788,074	301,454,126
			7.5%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase	7/1 Increase	7/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	8.9%	8.9%	5.3%	5.3%	3.57%	0.00%	3.53%	3.53%	13.71%	13.71%

CY 2014 Q3 Update

Page 1 (CY)

(Segal 1-20-15)

North Carolina State Health Plan
Financial Projections - Sep 2014
Trends - 7.0% Medical & 8.5% Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With 2015 Open Enrollment Statistics Presented to Board
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2012 - 2013 Biennium								
	Actual FY 2012	Actual FY 2013	Actual Short Plan Year Jul-Dec 2013	Projection Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019
PLAN INCOME:									
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	2,930,652,229	2,949,220,454	3,086,399,013	3,230,235,259	3,622,342,100	4,062,398,942
Additional Contribution/(Credit)		-	-	(4,544,193)	(11,755,275)	5,047,114	3,462,141	15,190,766	13,042,607
Medicare Advantae Subsidy			-	739,315	821,240	834,810	848,735	862,855	877,172
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(397,955)	(1,474,610)	(1,543,200)	(1,615,118)	(1,811,171)	(2,031,199)
Premium Change due to Movement			-	-	3,817,527	10,007,610	11,185,997	11,918,851	13,005,825
Medicare Part D	57,583,602	38,056,016	(1,323,888)	21,933,585	15,214,020	15,792,782	16,353,189	16,927,188	17,514,561
EGWP+Wrap									
Direct Subsidy	-	24,435,483	25,202,822	216,170	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,765	28,162,232	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	31,734,272	-	-	-	-
Total	-	24,435,483	37,082,587	28,378,402	31,734,272	-	-	-	-
Investment Earnings	3,015,815	3,236,713	1,841,087	4,223,387	3,698,015	2,819,138	1,714,182	968,877	1,116,648
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	2,980,984,770	2,991,275,642	3,119,357,268	3,262,184,385	3,666,399,465	4,105,924,557
PLAN EXPENSE:									
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	1,954,826,712	2,076,162,263	2,203,345,580	2,343,620,097	2,539,506,422	2,653,762,451
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(23,079,322)	(24,824,081)	(26,353,034)	(27,860,220)	(29,622,409)	(31,705,794)
Claims Adjustment for Changes				6,644,117	32,911,072	77,394,512	54,958,247	23,780,037	(13,111,432)
Cost of Autism				-	4,000,000	5,000,000	5,200,000	5,500,000	5,800,000
Cost of Add Towns				-	894,898	956,521	997,003	1,055,534	1,053,025
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,938,391,507	2,089,144,152	2,260,343,579	2,376,915,127	2,540,219,584	2,615,798,250
Medicare Advantage Premiums				157,588,332	172,021,713	186,089,065	201,180,125	217,563,831	235,351,986
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	698,011,969	699,434,807	750,445,002	809,056,736	872,298,660	940,541,323
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(99,449,279)	(56,730,957)	(51,122,543)	(52,336,714)	(53,590,219)	(54,877,521)
Claims Adjustment for Changes			-	-	-	-	-	-	-
Additional ACA Preventive Medicine			-	-	692,000	1,276,000	1,366,000	1,462,000	1,511,404
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	598,562,690	643,395,850	700,598,459	758,086,022	820,170,441	887,175,206
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,694,542,528	2,904,561,715	3,147,031,102	3,336,181,274	3,577,953,856	3,738,325,442
Administrative Costs	165,480,561	161,401,639	69,548,737	161,777,050	192,886,339	198,202,938	203,383,437	208,717,374	214,209,842
ACA Reinsurance Fee				-	33,856,390	23,416,249	14,260,074	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,856,319,579	3,131,304,444	3,368,650,289	3,553,824,786	3,786,671,230	3,952,535,284
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	124,665,192	(140,028,802)	(249,293,021)	(291,640,401)	(120,271,765)	153,389,273
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	963,112,328	823,083,525	573,790,504	282,150,103	161,878,338
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	963,112,328	823,083,525	573,790,504	282,150,103	161,878,338	315,267,611
Target Stabilization Reserve	184,110,626	201,392,496	113,231,386	215,641,107	245,928,600	266,484,783	282,150,103	302,435,102	315,267,611
	7.5%	8.0%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase		1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	5.3%	5.3%		3.57%	0.00%	5.05%	5.05%	12.55%	12.55%

CY 2014 Q3 Update

Page 2 (FY)

(Segal 1-20-15)

North Carolina State Health Plan
Financial Projections - Sep 2014
Trends - 7.0% Medical & 8.5% Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With 2015 Open Enrollment Statistics Presented to Board
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2010-2011 Biennium		2012 - 2013 Biennium		2014 - 2015 Biennium		2016 - 2017 Biennium		2018 - 2019 Biennium	
	Actual FY 2010	Actual FY 2011	Actual FY 2012	Actual FY 2013	Actual FY 2014	Projection FY2015	Projection FY2016	Projection FY2017	Projection FY2018	Projection FY2019
PLAN INCOME:										
Net Contribution Income	2,413,877,944	2,684,814,172	2,750,368,851	2,895,366,140	2,941,097,678	2,968,175,339	3,017,843,403	3,158,350,707	3,426,431,469	3,842,525,718
Additional Contribution/(Credit)				-	-	(10,431,844)	(3,332,632)	4,252,830	9,339,142	14,114,086
Medicare Advantae Subsidy					417,565	731,202	827,924	841,753	855,775	869,993
Health care Reform ERRP	-	45,298,812	42,163,391	(558,219)	-	-	-	-	-	-
Retro Disenrollments	(1,310,146)	(1,281,584)	(451,496)	(487,819)	(299,923)	(1,113,591)	(1,508,922)	(1,579,175)	(1,713,216)	(1,921,263)
Premium Change due to Movement					-	1,908,763	6,912,502	10,596,746	11,552,419	12,462,384
Medicare Part D	74,357,704	66,276,535	57,583,602	38,056,016	11,583,652	16,850,239	15,528,475	16,082,292	16,649,783	17,230,759
EGWP+Wrap										
Direct Subsidy	-	-	-	24,435,483	25,216,663	202,329	-	-	-	-
Coverage Gap Subsidy	-	-	-	-	38,563,909	1,478,088	-	-	-	-
Catastrophic Subsidy	-	-	-	-	-	31,734,272	-	-	-	-
Total	-	-	-	24,435,483	63,780,571	33,414,689	-	-	-	-
Investment Earnings	3,532,448	2,861,085	3,015,815	3,236,713	3,916,235	4,089,885	3,309,775	2,293,751	1,234,167	935,755
Total Plan Income	2,490,457,950	2,797,969,020	2,852,680,163	2,960,048,314	3,020,495,778	3,013,624,684	3,039,580,526	3,190,838,904	3,464,349,539	3,886,217,433
PLAN EXPENSE:										
Medical Claims Payment	1,829,432,245	1,852,549,690	1,849,410,105	1,858,096,405	1,989,574,333	2,028,718,028	2,138,318,328	2,272,749,137	2,417,108,551	2,568,823,346
Claim Refunds	(31,916,831)	(24,723,681)	(22,634,615)	(23,467,914)	(22,450,766)	(23,410,628)	(25,564,630)	(26,988,783)	(28,896,338)	(30,516,203)
Claims Adjustment for Changes					-	23,134,016	54,619,385	67,167,168	39,120,987	5,359,743
Cost of Autism						2,001,943	4,500,432	5,100,039	5,350,080	5,650,073
Cost of Add Towns						432,455	924,000	989,000	1,022,287	1,089,886
Net Medical Claims	1,797,515,414	1,827,826,009	1,826,775,490	1,834,628,491	1,967,123,567	2,030,875,814	2,172,797,516	2,319,016,561	2,433,705,566	2,550,406,845
Medicare Advantage Premiums					78,538,847	164,846,382	179,037,892	193,615,825	209,351,600	226,435,784
Pharmacy Claims Payment	N/A	N/A	721,163,013	752,419,650	743,281,462	699,550,098	750,359,717	779,375,014	840,271,609	905,981,199
Rebates	N/A	N/A	(93,130,160)	(69,641,941)	(91,653,105)	(73,155,564)	(50,464,389)	(51,728,731)	(52,959,242)	(54,229,533)
Claims Adjustment for Changes					-	-	-	-	-	-
Additional ACA Preventive Medicine						346,336	984,270	1,321,028	1,414,029	1,473,927
Net Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	651,628,357	626,740,870	700,879,598	728,967,312	788,726,395	853,225,593
Total Claims	2,394,225,189	2,483,694,744	2,454,808,343	2,517,406,200	2,697,290,771	2,822,463,067	3,052,715,006	3,241,599,697	3,431,783,562	3,630,068,223
Administrative Costs	164,649,780	165,902,094	165,480,561	161,401,639	148,134,913	178,158,173	195,650,094	200,755,180	206,011,206	211,423,176
ACA Reinsurance Fee					-	28,213,658	23,204,919	14,304,477	5,809,660	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,558,874,969	2,649,596,838	2,620,288,904	2,678,807,839	2,845,425,684	3,028,834,899	3,271,570,019	3,456,659,354	3,643,604,428	3,841,491,398
Plan Income (Loss)	(68,417,019)	148,372,182	232,391,259	281,240,475	175,070,094	(15,210,214)	(231,989,493)	(265,820,450)	(179,254,889)	44,726,035
Beginning Cash Balance (Deficit)	189,901,049	121,484,030	269,856,212	502,247,471	783,487,946	958,558,040	943,347,825	711,358,332	445,537,882	266,282,993
Ending Cash Balance (Deficit)	121,484,030	269,856,212	502,247,471	783,487,946	958,558,040	943,347,825	711,358,332	445,537,882	266,282,993	311,009,028
Target Stabilization Reserve	179,566,889	186,277,106	184,110,626	201,392,496	222,593,914	239,185,502	258,630,940	274,318,549	290,018,877	306,326,919
			7.5%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase	7/1 Increase	7/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	8.9%	8.9%	5.3%	5.3%	3.57%	0.00%	5.05%	5.05%	12.55%	12.55%

CY 2014 Q3 Update

Page 1 (CY)

(Segal 1-20-15)

North Carolina State Health Plan
Financial Projections - Sep 2014
Trends - 7.0% Medical & 8.5% Pharmacy
Wellness Incentives - No Wellness and No 100% Preventive on 70/30 Plan
With 2015 Open Enrollment Statistics Presented to Board
Incentives start at $15/$15/$20 and no Changes Through 2019

Baseline/Status Quo Model

	2012 - 2013 Biennium								
	Actual FY 2012	Actual FY 2013	Actual Short Plan Year Jul-Dec 2013	Projection Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019
PLAN INCOME:									
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	2,930,652,229	2,949,220,454	3,086,275,735	3,229,977,216	3,661,254,815	4,150,479,277
Additional Contribution/(Credit)		-	-	(4,544,193)	(11,755,275)	(19,398,164)	(19,919,308)	(20,433,212)	(20,940,058)
Medicare Advantae Subsidy			-	739,315	821,240	834,810	848,735	862,855	877,172
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(397,955)	(1,474,610)	(1,543,138)	(1,614,989)	(1,830,627)	(2,075,240)
Premium Change due to Movement			-	-	3,817,527	6,925,669	10,003,359	13,009,774	15,946,680
Medicare Part D	57,583,602	38,056,016	(1,323,888)	21,933,585	15,214,020	15,792,782	16,353,189	16,927,188	17,514,561
EGWP+Wrap									
Direct Subsidy	-	24,435,483	25,202,822	216,170	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,765	28,162,232	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	31,734,272	-	-	-	-
Total	-	24,435,483	37,082,587	28,378,402	31,734,272	-	-	-	-
Investment Earnings	3,015,815	3,236,713	1,841,087	4,223,387	3,698,015	2,838,856	1,733,688	951,195	1,110,000
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	2,980,984,770	2,991,275,642	3,091,726,550	3,237,381,891	3,670,741,987	4,162,912,393
PLAN EXPENSE:									
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	1,954,826,712	2,076,162,263	2,203,345,580	2,343,620,097	2,539,506,422	2,653,762,451
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(23,079,322)	(24,824,081)	(26,353,034)	(27,860,220)	(29,622,409)	(31,705,794)
Claims Adjustment for Changes				6,644,117	32,911,072	41,089,639	40,161,607	37,574,199	29,278,016
Cost of Autism				-	4,000,000	5,000,000	5,200,000	5,500,000	5,800,000
Cost of Add Towns				-	894,898	956,521	997,003	1,055,534	1,053,025
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,938,391,507	2,089,144,152	2,224,038,705	2,362,118,486	2,554,013,746	2,658,187,697
Medicare Advantage Premiums				157,588,332	172,021,713	186,089,065	201,180,125	217,563,831	235,351,986
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	698,011,969	699,434,807	750,445,002	809,056,736	872,298,660	940,541,323
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(99,449,279)	(56,730,957)	(51,122,543)	(52,336,714)	(53,590,219)	(54,877,521)
Claims Adjustment for Changes			-	-	-	-	-	-	-
Additional ACA Preventive Medicine			-	-	692,000	1,276,000	1,366,000	1,462,000	1,511,404
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	598,562,690	643,395,850	700,598,459	758,086,022	820,170,441	887,175,206
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,694,542,528	2,904,561,715	3,110,726,228	3,321,384,634	3,591,748,018	3,780,714,890
Administrative Costs	165,480,561	161,401,639	69,548,737	161,777,050	192,886,339	198,202,938	203,383,437	208,717,374	214,209,842
ACA Reinsurance Fee				-	33,856,390	23,416,249	14,260,074	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,856,319,579	3,131,304,444	3,332,345,415	3,539,028,145	3,800,465,393	3,994,924,732
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	124,665,192	(140,028,802)	(240,618,866)	(301,646,254)	(129,723,405)	167,987,661
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	963,112,328	823,083,525	582,464,660	280,818,406	151,095,000
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	963,112,328	823,083,525	582,464,660	280,818,406	151,095,000	319,082,661
Target Stabilization Reserve	184,110,626	201,392,496	113,231,386	215,641,107	245,928,600	263,217,345	280,818,406	303,676,577	319,082,661
	7.5%	8.0%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase		1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	5.3%	5.3%		3.57%	0.00%	5.05%	5.05%	13.77%	13.77%

CY 2014 Q3 Update

Page 2 (FY)

(Segal 1-20-15)

North Carolina State Health Plan
Financial Projections - Sep 2014
Trends - 7.0% Medical & 8.5% Pharmacy
Wellness Incentives - No Wellness and No 100% Preventive on 70/30 Plan
With 2015 Open Enrollment Statistics Presented to Board
Incentives start at $15/$15/$20 and no Changes Through 2019

Baseline/Status Quo Model

	2010-2011 Biennium		2012 - 2013 Biennium		2014 - 2015 Biennium		2016 - 2017 Biennium		2018 - 2019 Biennium	
	Actual FY 2010	Actual FY 2011	Actual FY 2012	Actual FY 2013	Actual FY 2014	Projection FY2015	Projection FY2016	Projection FY2017	Projection FY2018	Projection FY2019
PLAN INCOME:										
Net Contribution Income	2,413,877,944	2,684,814,172	2,750,368,851	2,895,366,140	2,941,097,678	2,968,175,339	3,017,781,705	3,158,159,986	3,445,776,571	3,906,043,577
Additional Contribution/(Credit)				-	-	(10,431,844)	(15,583,254)	(19,659,071)	(20,176,580)	(20,686,940)
Medicare Advantae Subsidy					417,565	731,202	827,924	841,753	855,775	869,993
Health care Reform ERRP	-	45,298,812	42,163,391	(558,219)	-	-	-	-	-	-
Retro Disenrollments	(1,310,146)	(1,281,584)	(451,496)	(487,819)	(299,923)	(1,113,591)	(1,508,891)	(1,579,080)	(1,722,888)	(1,953,022)
Premium Change due to Movement					-	1,908,763	5,371,532	8,464,457	11,506,569	14,478,288
Medicare Part D	74,357,704	66,276,535	57,583,602	38,056,016	11,583,652	16,850,239	15,528,475	16,082,292	16,649,783	17,230,759
EGWP+Wrap										
Direct Subsidy	-	-	-	24,435,483	25,216,663	202,329	-	-	-	-
Coverage Gap Subsidy	-	-	-	-	38,563,909	1,478,088	-	-	-	-
Catastrophic Subsidy	-	-	-	-	-	31,734,272	-	-	-	-
Total	-	-	-	24,435,483	63,780,571	33,414,689	-	-	-	-
Investment Earnings	3,532,448	2,861,085	3,015,815	3,236,713	3,916,235	4,089,885	3,314,380	2,323,452	1,234,978	911,872
Total Plan Income	2,490,457,950	2,797,969,020	2,852,680,163	2,960,048,314	3,020,495,778	3,013,624,684	3,025,731,871	3,164,633,789	3,454,124,207	3,916,894,527
PLAN EXPENSE:										
Medical Claims Payment	1,829,432,245	1,852,549,690	1,849,410,105	1,858,096,405	1,989,574,333	2,028,718,028	2,138,318,328	2,272,749,137	2,417,108,551	2,568,823,346
Claim Refunds	(31,916,831)	(24,723,681)	(22,634,615)	(23,467,914)	(22,450,766)	(23,410,628)	(25,564,630)	(26,988,783)	(28,896,338)	(30,516,203)
Claims Adjustment for Changes					-	23,134,016	37,115,345	40,799,507	38,429,596	32,828,982
Cost of Autism						2,001,943	4,500,432	5,100,039	5,350,080	5,650,073
Cost of Add Towns						432,455	924,000	989,000	1,022,287	1,089,886
Net Medical Claims	1,797,515,414	1,827,826,009	1,826,775,490	1,834,628,491	1,967,123,567	2,030,875,814	2,155,293,475	2,292,648,900	2,433,014,175	2,577,876,084
Medicare Advantage Premiums					78,538,847	164,846,382	179,037,892	193,615,825	209,351,600	226,435,784
Pharmacy Claims Payment	N/A	N/A	721,163,013	752,419,650	743,281,462	699,550,098	750,359,717	779,375,014	840,271,609	905,981,199
Rebates	N/A	N/A	(93,130,160)	(69,641,941)	(91,653,105)	(73,155,564)	(50,464,389)	(51,728,731)	(52,959,242)	(54,229,533)
Claims Adjustment for Changes					-	-	-	-	-	-
Additional ACA Preventive Medicine						346,336	984,270	1,321,028	1,414,029	1,473,927
Net Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	651,628,357	626,740,870	700,879,598	728,967,312	788,726,395	853,225,593
Total Claims	2,394,225,189	2,483,694,744	2,454,808,343	2,517,406,200	2,697,290,771	2,822,463,067	3,035,210,965	3,215,232,036	3,431,092,171	3,657,537,462
Administrative Costs	164,649,780	165,902,094	165,480,561	161,401,639	148,134,913	178,158,173	195,650,094	200,755,180	206,011,206	211,423,176
ACA Reinsurance Fee					-	28,213,658	23,204,919	14,304,477	5,809,660	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,558,874,969	2,649,596,838	2,620,288,904	2,678,807,839	2,845,425,684	3,028,834,899	3,254,065,979	3,430,291,693	3,642,913,037	3,868,960,637
Plan Income (Loss)	(68,417,019)	148,372,182	232,391,259	281,240,475	175,070,094	(15,210,214)	(228,334,108)	(265,657,904)	(188,788,830)	47,933,890
Beginning Cash Balance (Deficit)	189,901,049	121,484,030	269,856,212	502,247,471	783,487,946	958,558,040	943,347,825	715,013,718	449,355,814	260,566,984
Ending Cash Balance (Deficit)	121,484,030	269,856,212	502,247,471	783,487,946	958,558,040	943,347,825	715,013,718	449,355,814	260,566,984	308,500,873
Target Stabilization Reserve	179,566,889	186,277,106	184,110,626	201,392,496	222,593,914	239,185,502	257,055,577	271,945,459	289,956,651	308,799,151
			7.5%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase	7/1 Increase	7/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	8.9%	8.9%	5.3%	5.3%	3.57%	0.00%	5.05%	5.05%	13.77%	13.77%

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Aon Hewitt Implementation Update

Board of Trustees Meeting

January 22, 2015

Aon Hewitt Implementation Status

The Aon Hewitt transition is underway. All Plan vendors, partners and employing units are fully engaged. The Plan has project managers in place overseeing all aspects of the transition.

Important Transition Items:

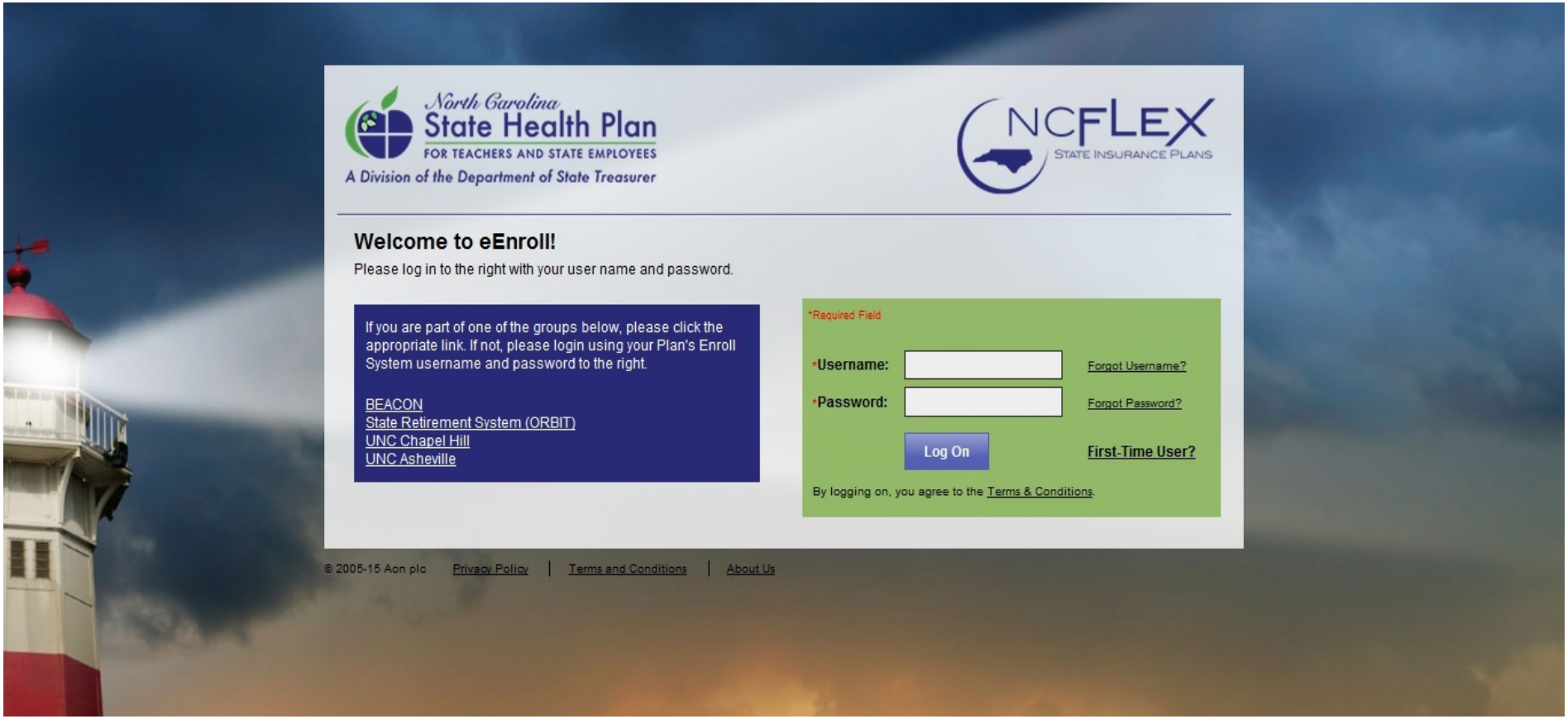
- As a reminder, all members, including BEACON members will enroll via the Aon Hewitt platform.
- **Transition Date** – or "go live date" for the transition of service will be **June 1, 2015.** This means the Benefitfocus platform will no longer be available and all changes will need to be made in the Aon Hewitt system as of this date.
- **Platform Name** – The enrollment platform will continue to be called eEnroll.
- **Call Support** – The current eEnroll telephone number will transition to Aon Hewitt, which will be seamless to members.
- **Email Support** - Aon Hewitt offers members the option of "going green" which means that if they choose, members can have all enrollment communications that would normally be mailed from the Eligibility and Enrollment Support Center, emailed (*Note: The Plan would continue to mail materials to members*).

Aon Hewitt Implementation Status

- **Communications –** We recognize this is a big change. We are planning to launch a communication campaign similar to an Annual Enrollment campaign for this transition. The Plan will be sending both direct mail pieces to members' homes and will provide materials to employing units to share with their employees.
- **HBR Support–** In May, the Plan will offer onsite HBR training locations across the state. A command center will be established to address their questions when we go live.
- **Annual Enrollment (AE) –** Since our last BOT meeting, we met with our vendors and partners to discuss the possibility of adjusting or extending the AE window for 2016. Each vendor and/or partner has a cut-off time for receiving the enrollment in time to support the January premium billing cycle. In order to extend the AE timeframe, Aon Hewitt would need to send AE enrollment files to BCBSNC throughout AE instead of one file at the end. Unfortunately, Aon Hewitt is unable to support this requirement; therefore, we will not be able to extend the AE timeframe.

New Hire Member Experience

Log In Screen



Welcome Screen

Get Started

Josh Smith | Secure Mailbox (0) | Contact Us | Help | Chat | Print | Log Off

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Home | Health Benefits | Tools & Resources | Life Events

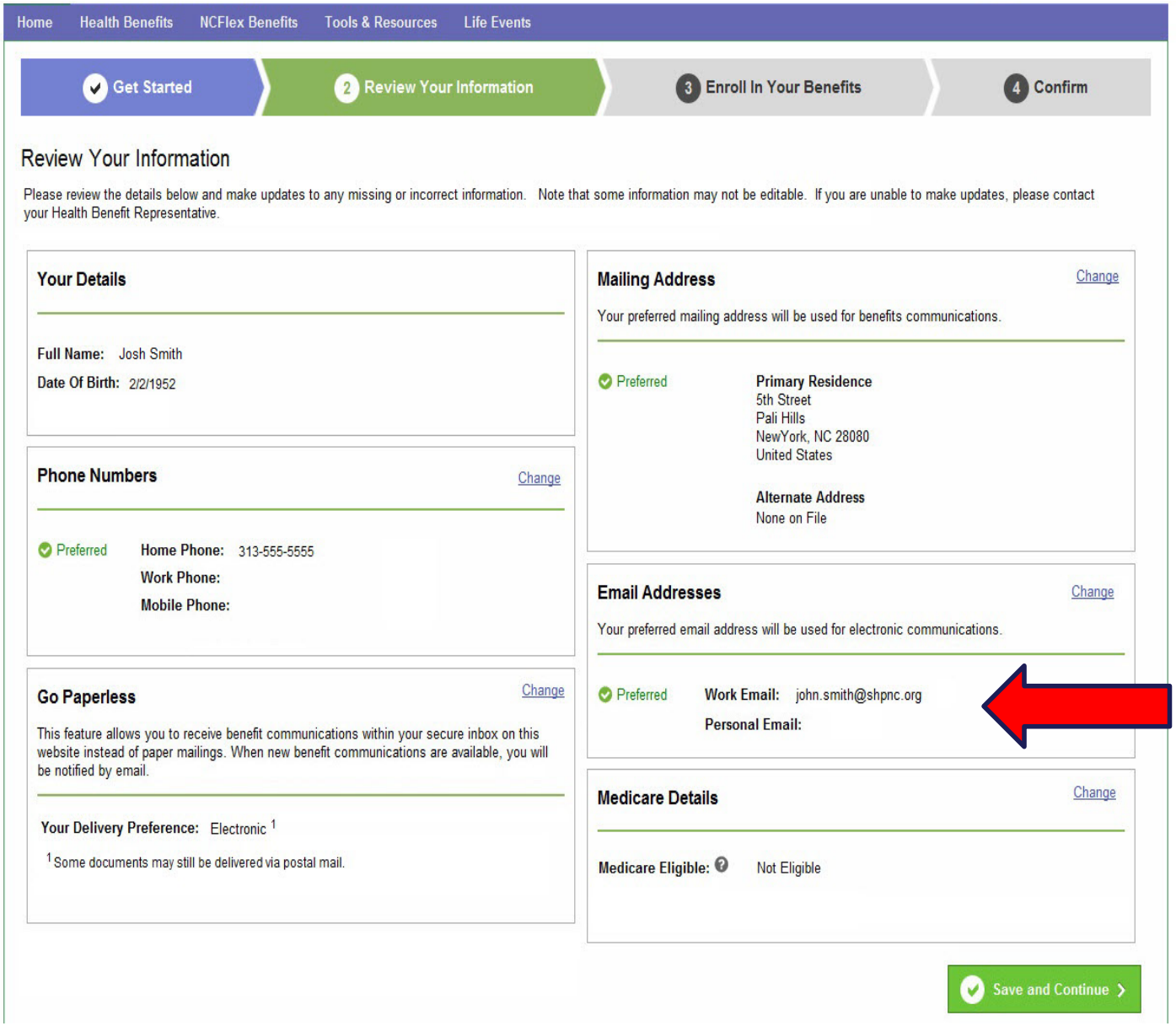
1 Get Started | 2 Review Your Information | 3 Enroll In Your Benefits | 4 Confirm

It's Time to Enroll in Your Benefits!

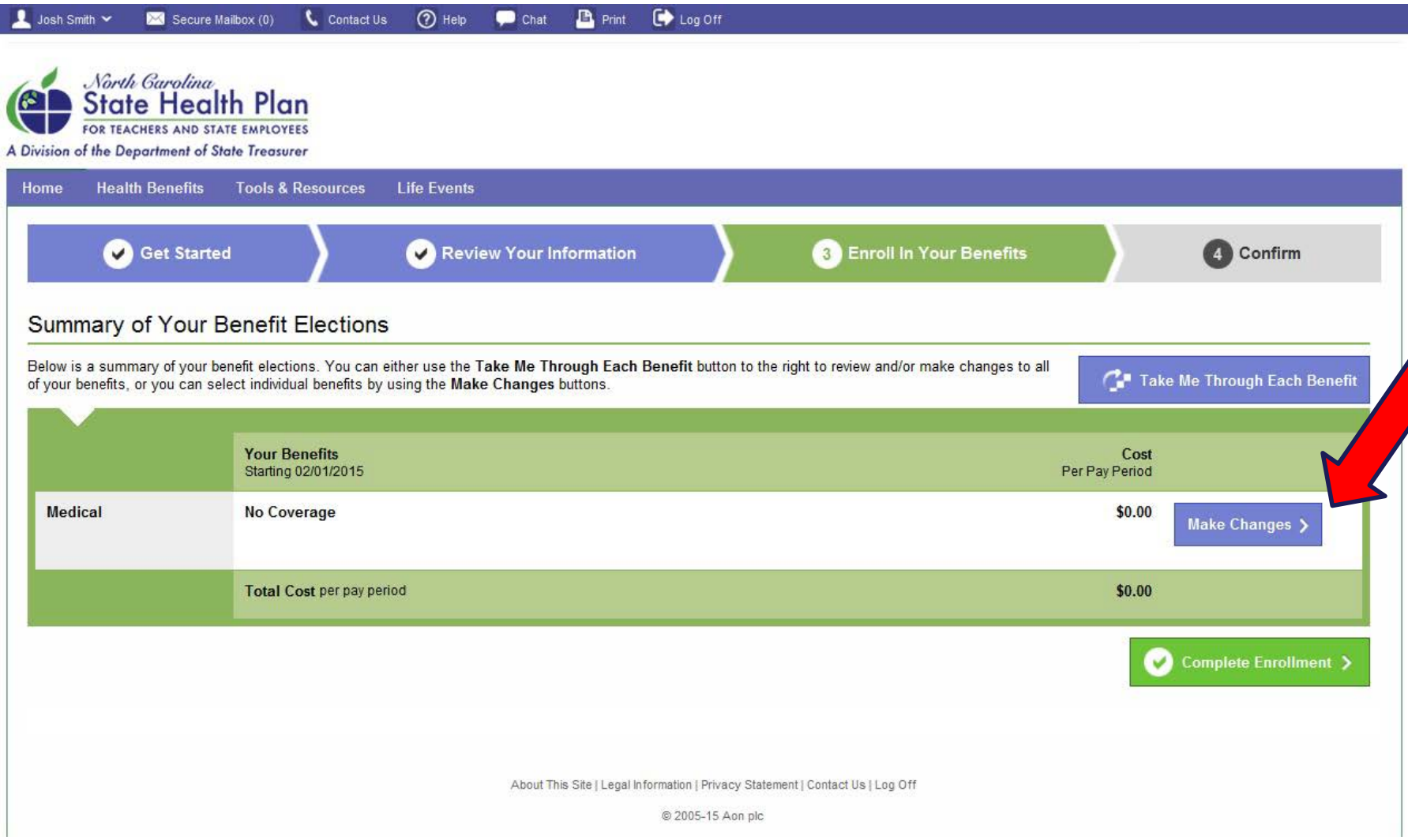
Please Note: You may exit the enrollment system at any time. Any elections made up until that point will automatically be saved.

Continue >

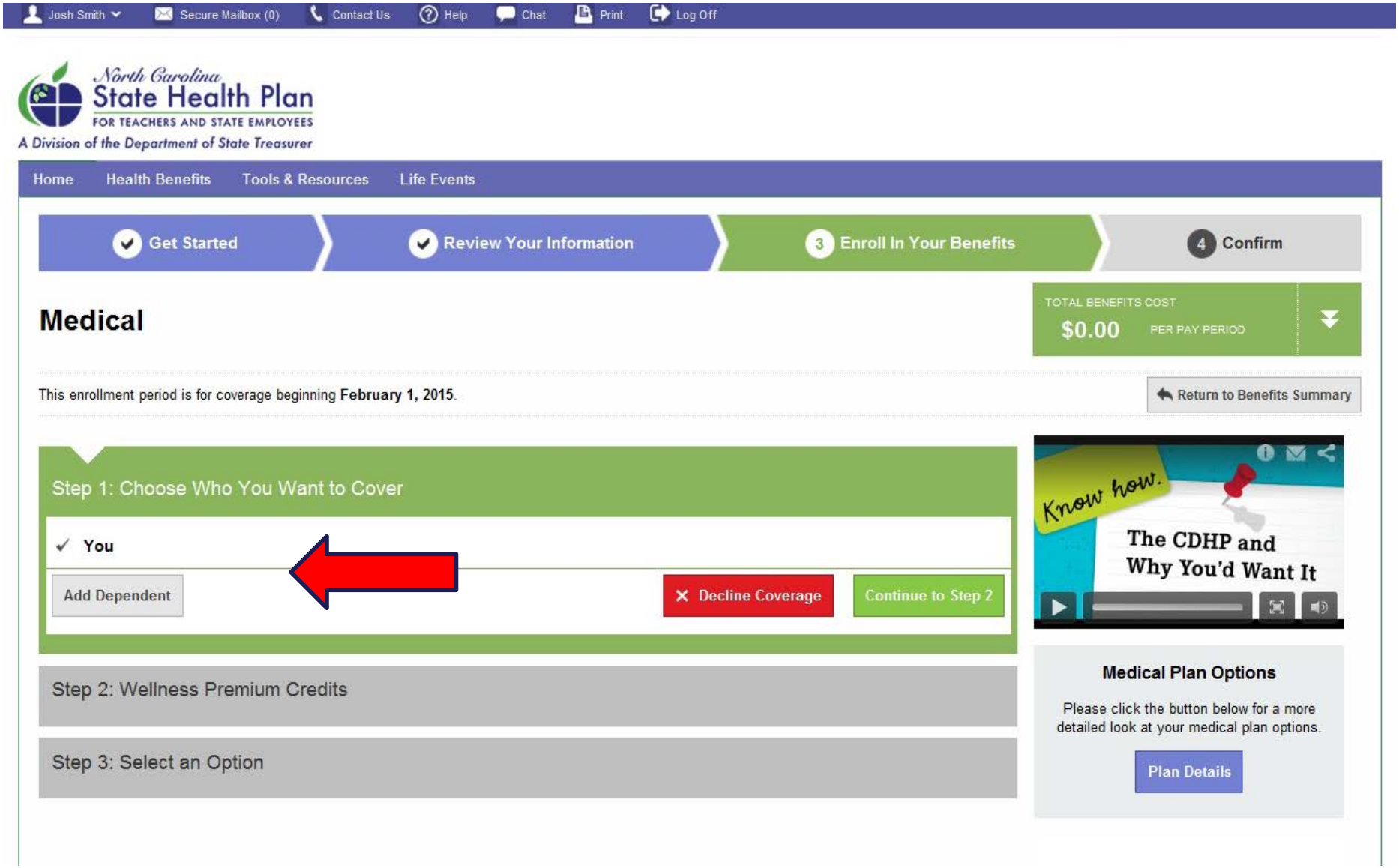
Review Your Information



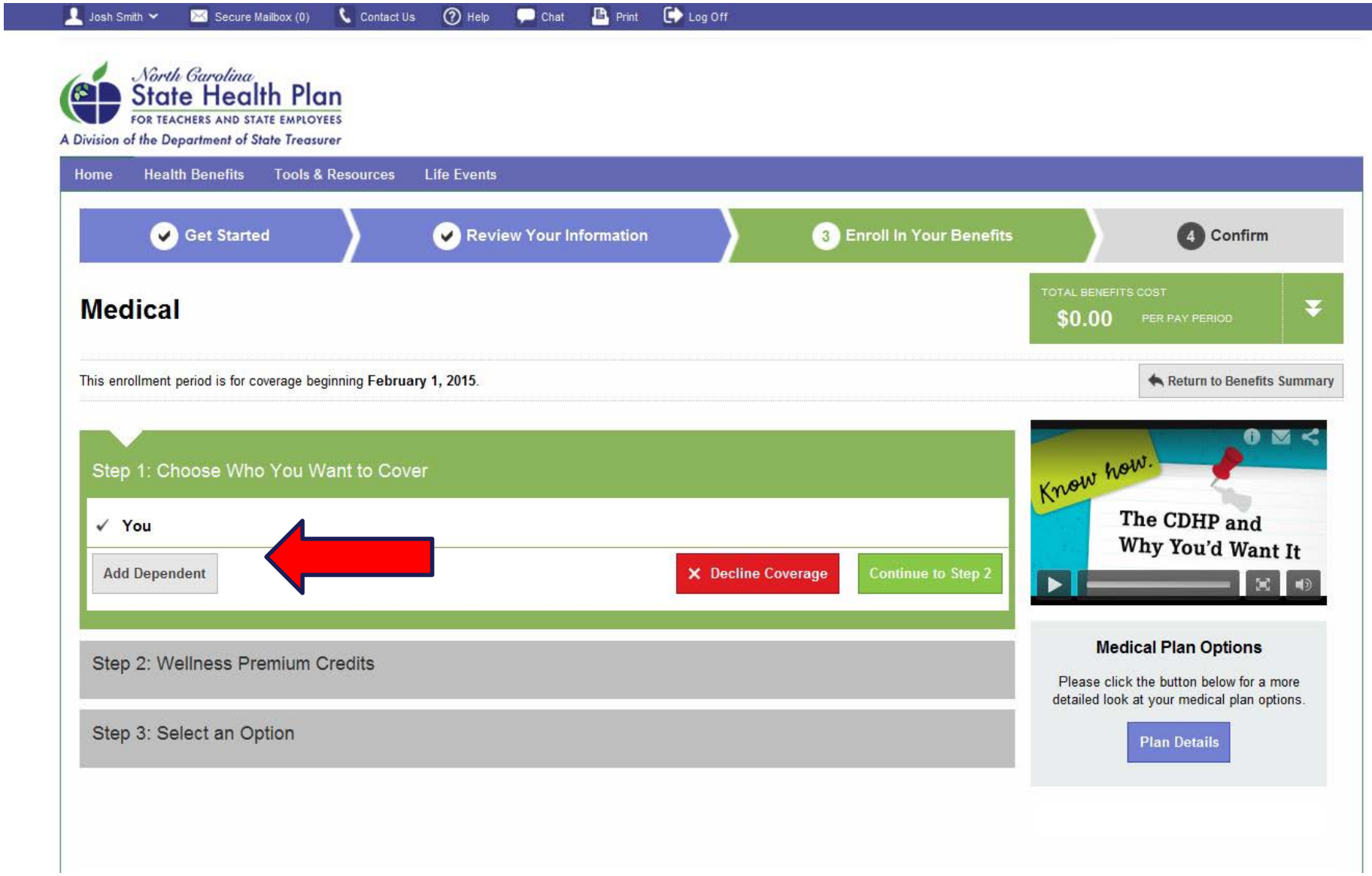
Edit Your Benefits



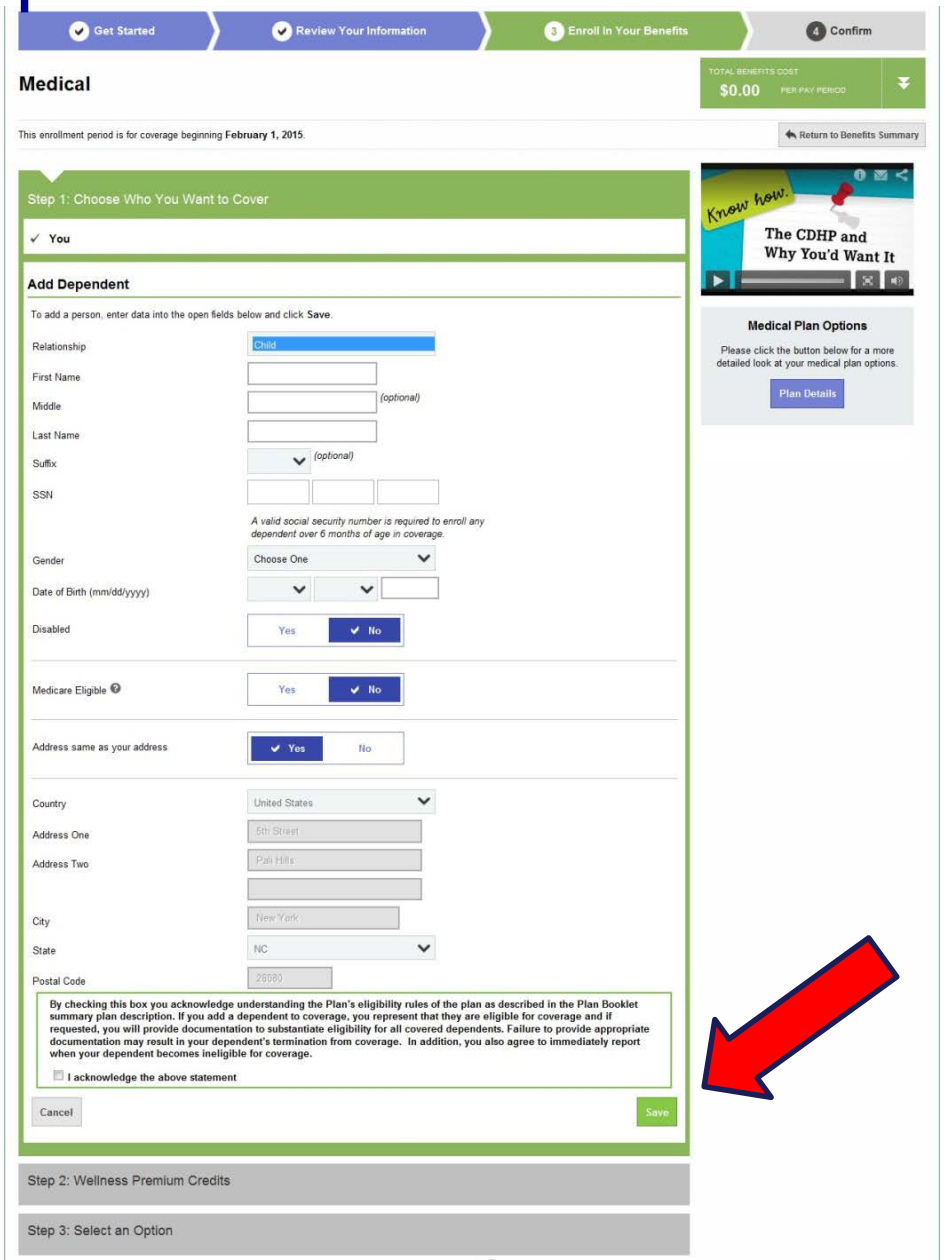
Choose Who You Want to Cover



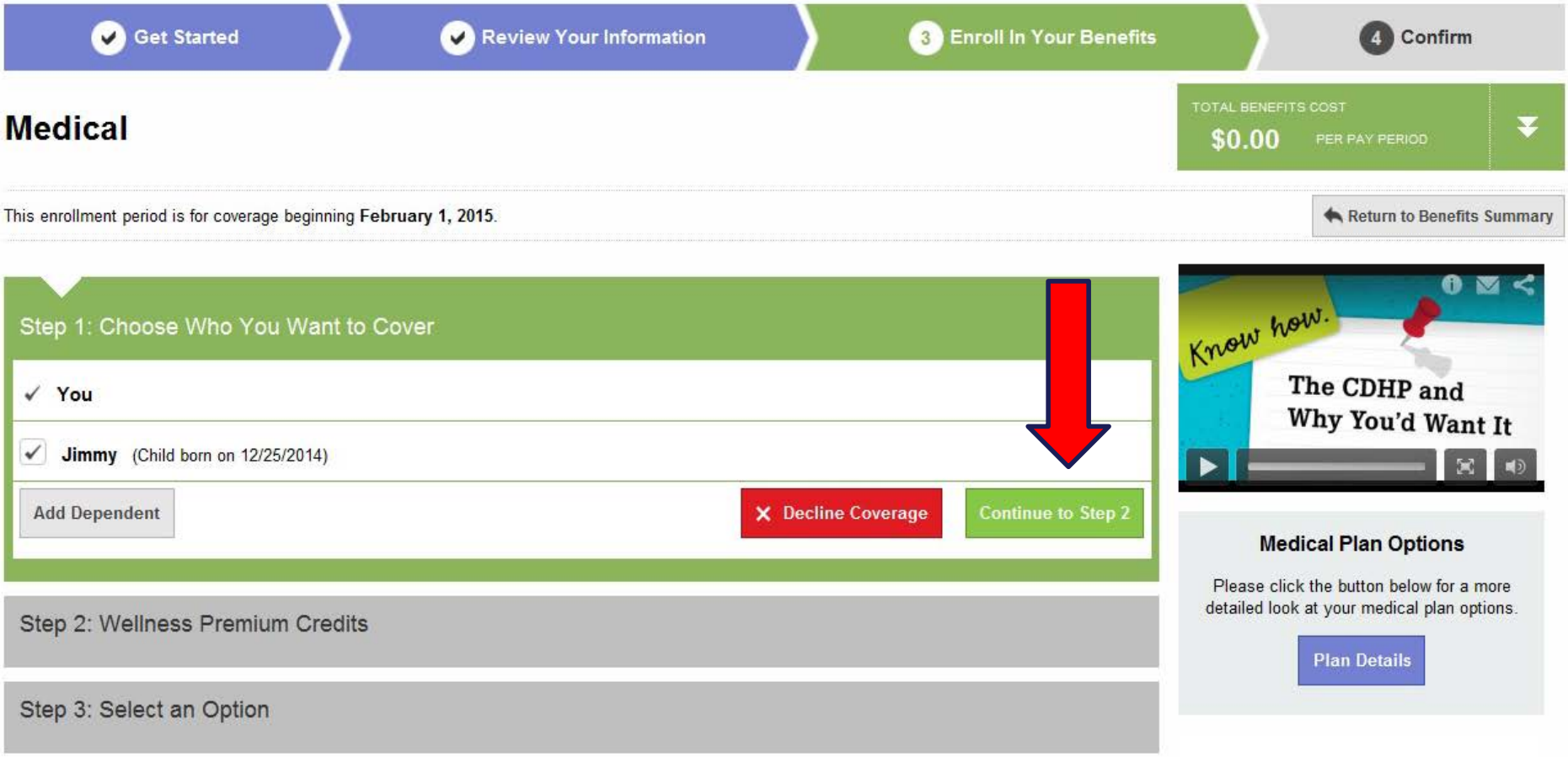
Adding a Dependent



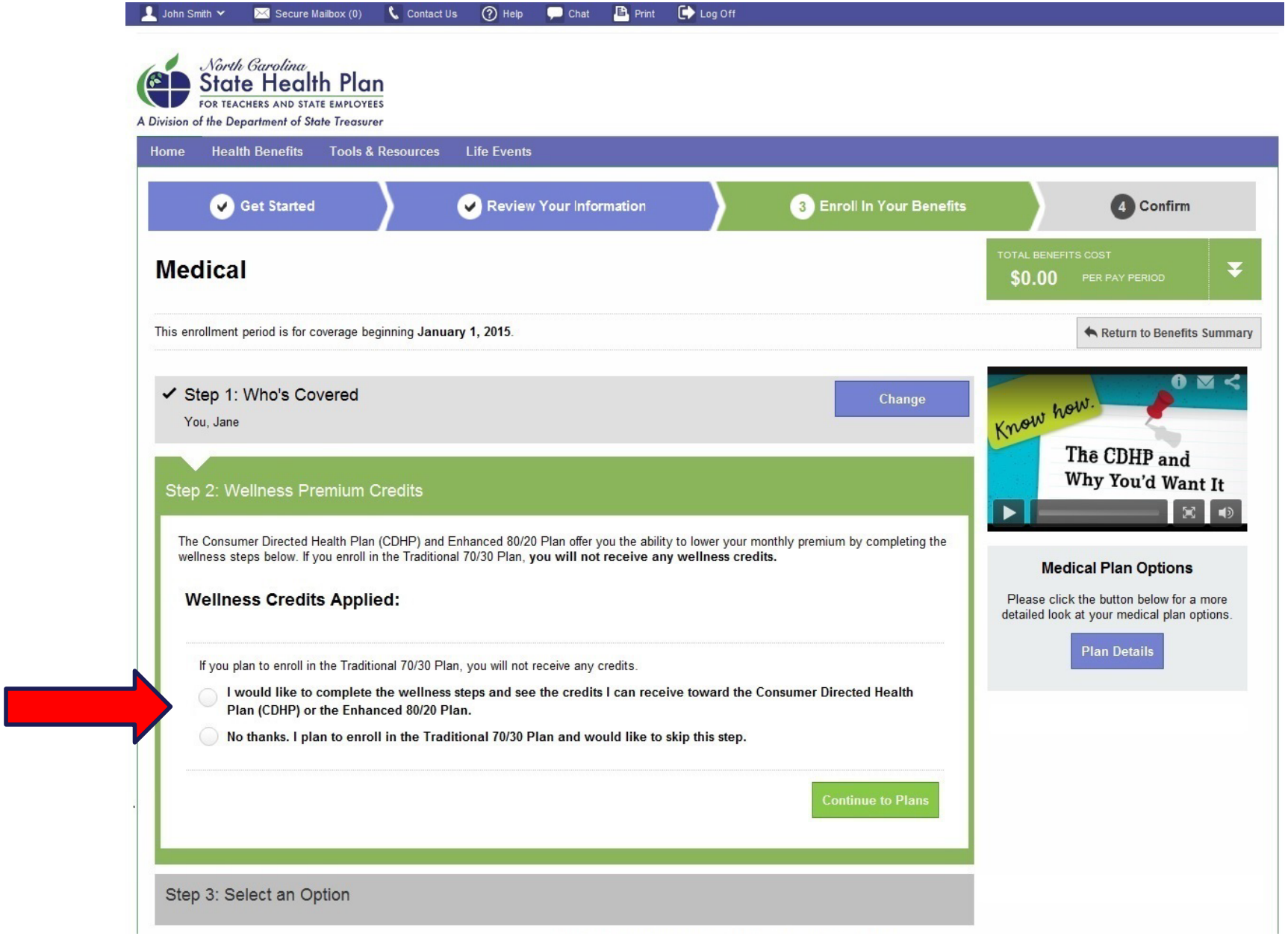
Adding a Dependent



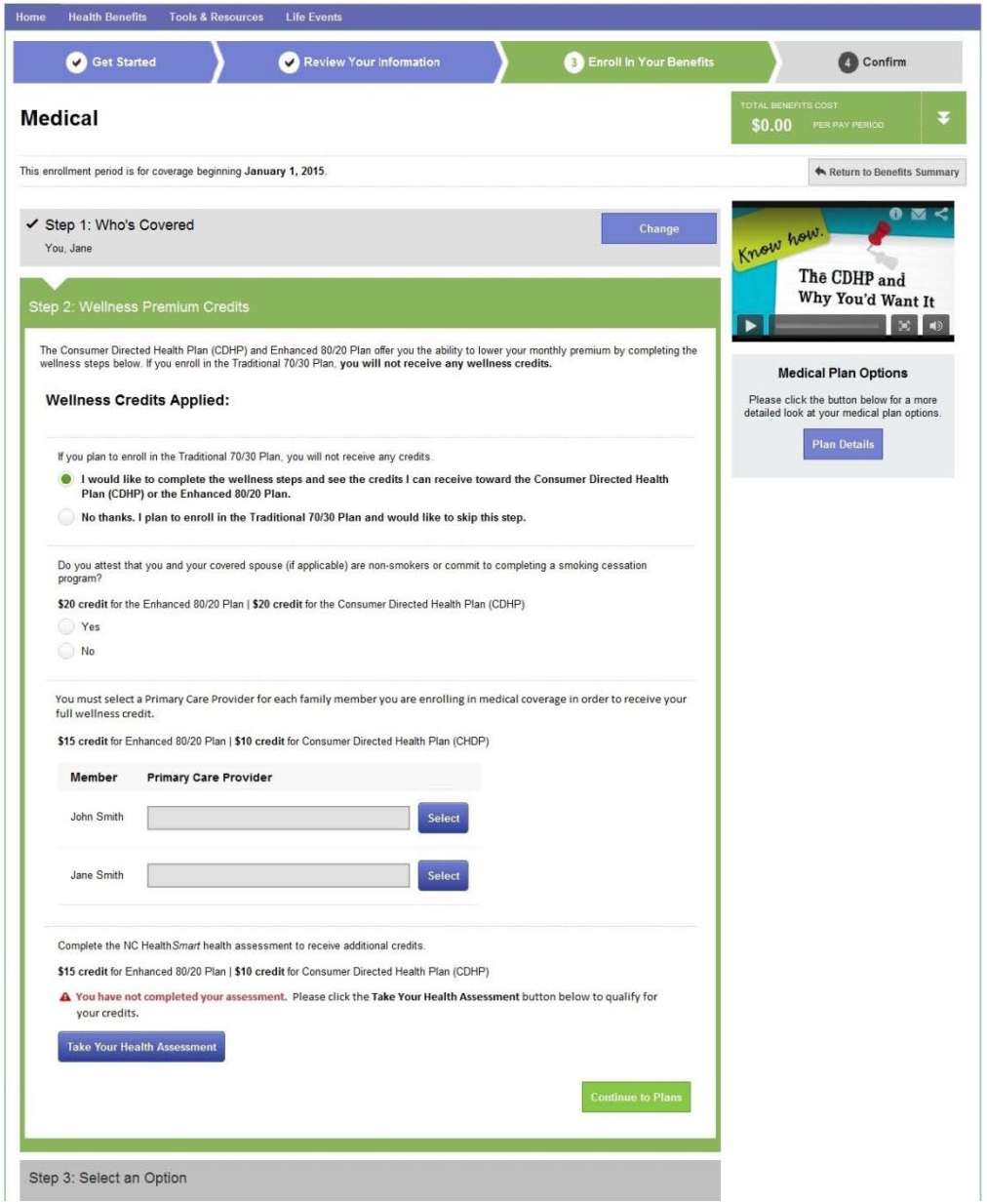
Continue to Wellness Premium Credits



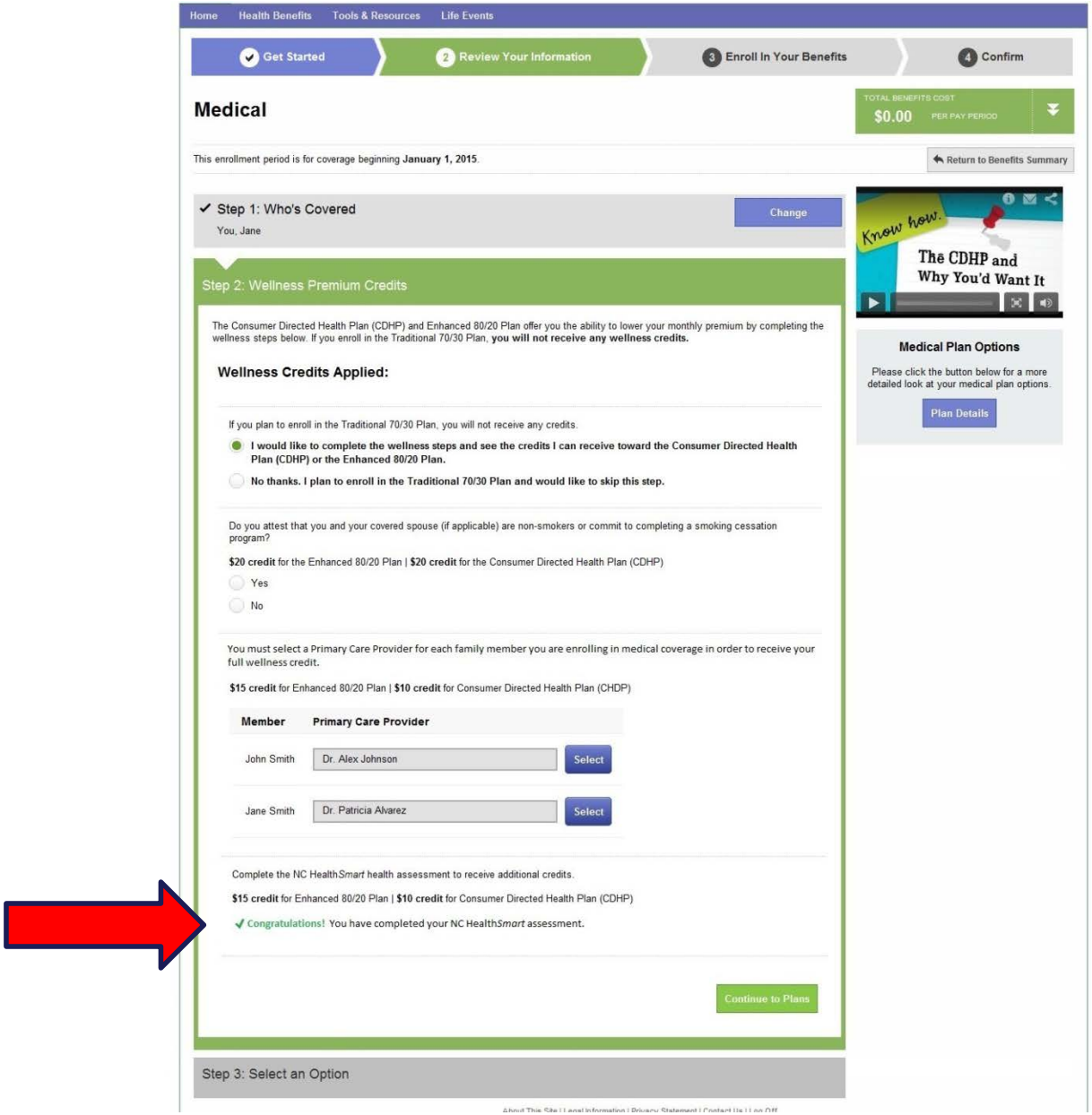
Wellness Premium Credits



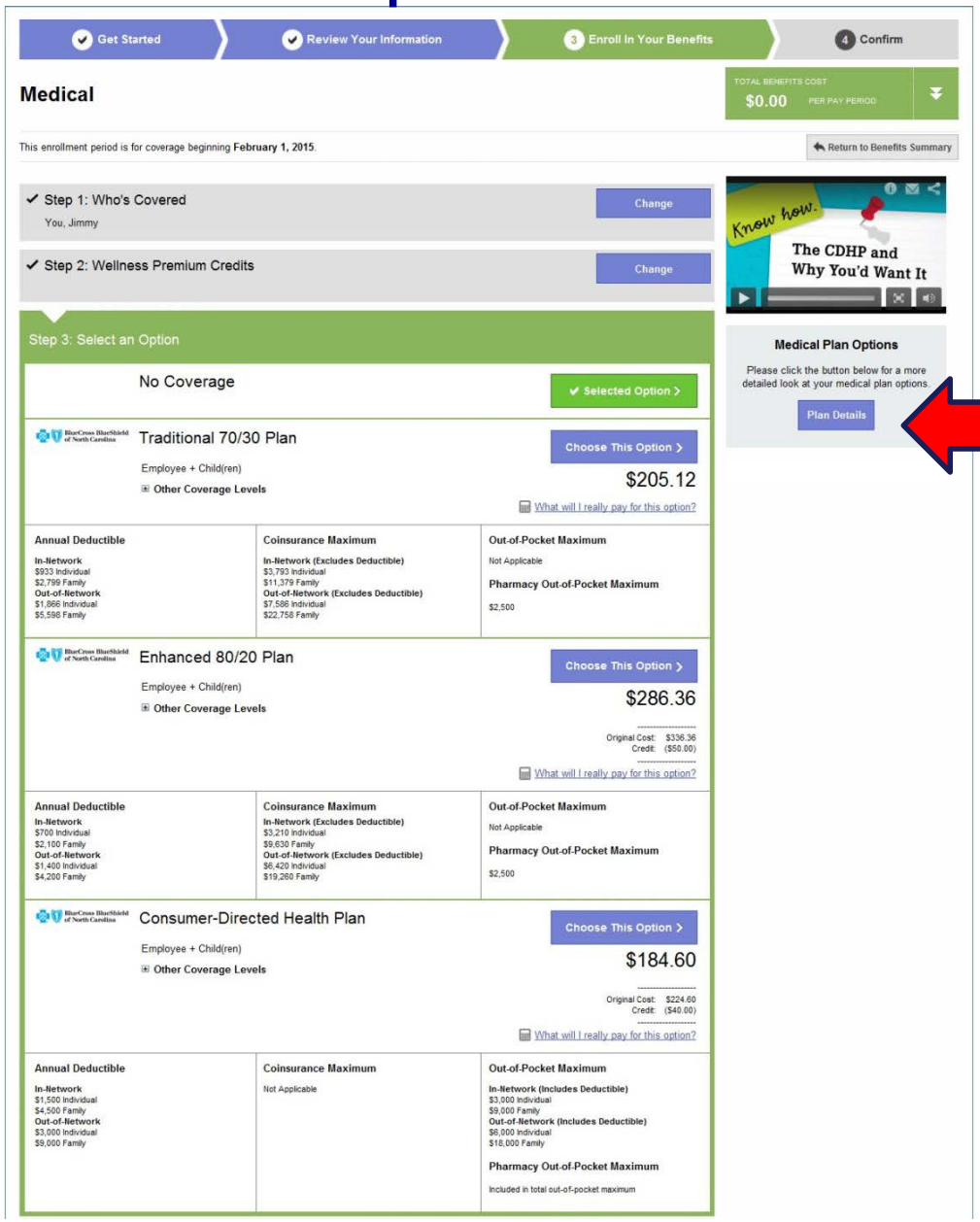
Wellness Premium Credits



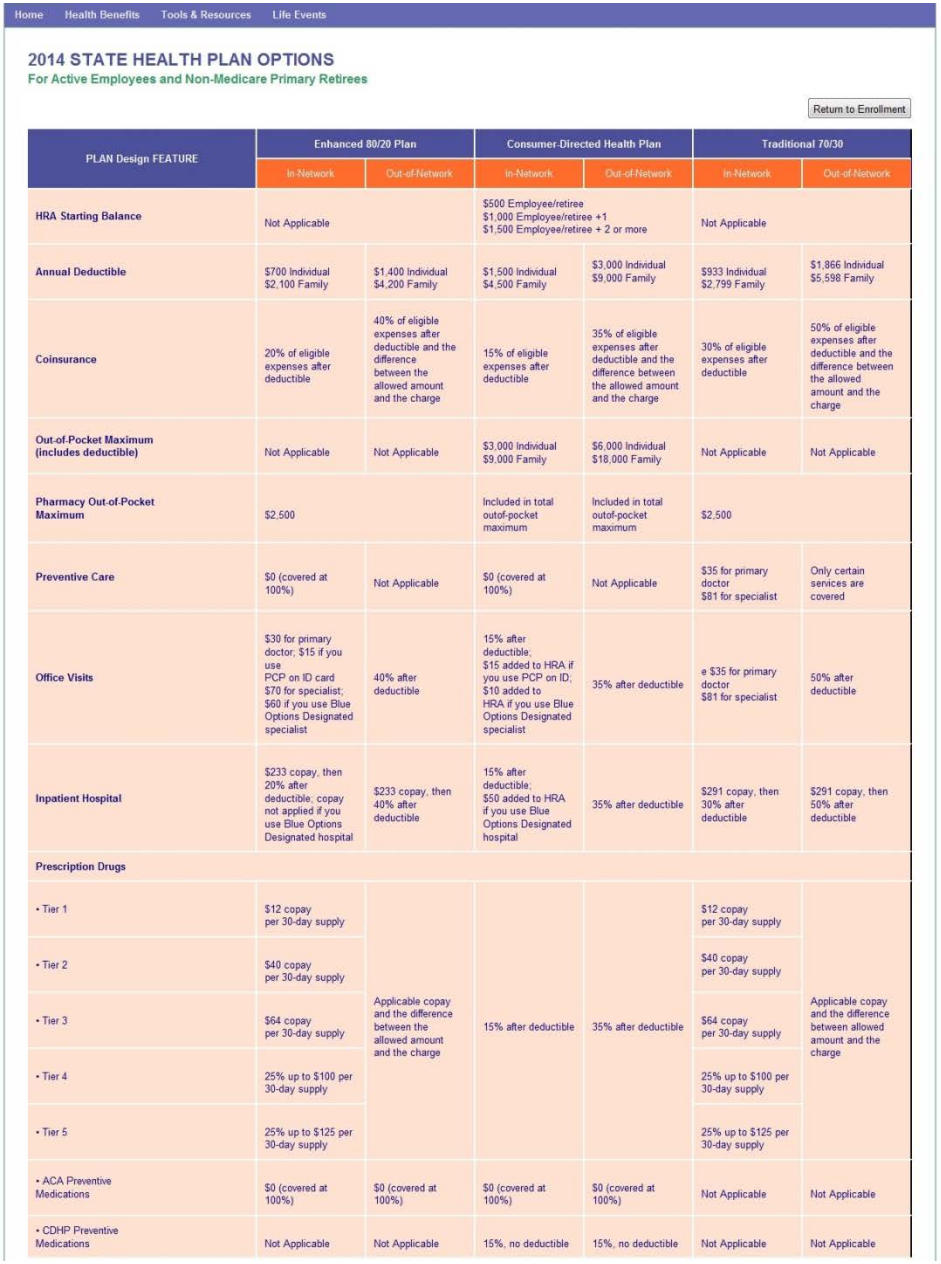
Wellness Premium Credits



Select a Health Plan Option



Medical Plan Comparison



Home Health Benefits Tools & Resources Life Events

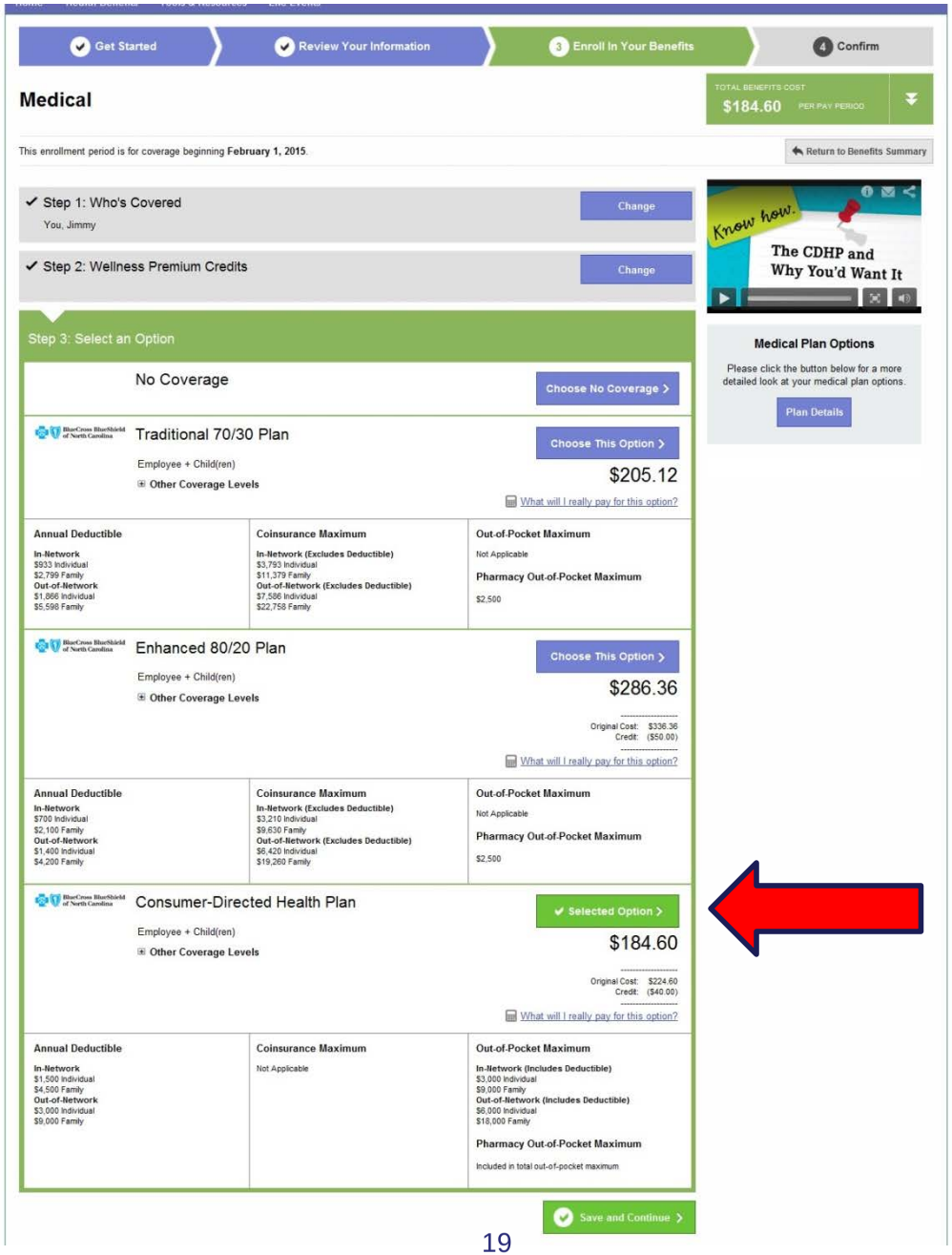
2014 STATE HEALTH PLAN OPTIONS

For Active Employees and Non-Medicare Primary Retirees

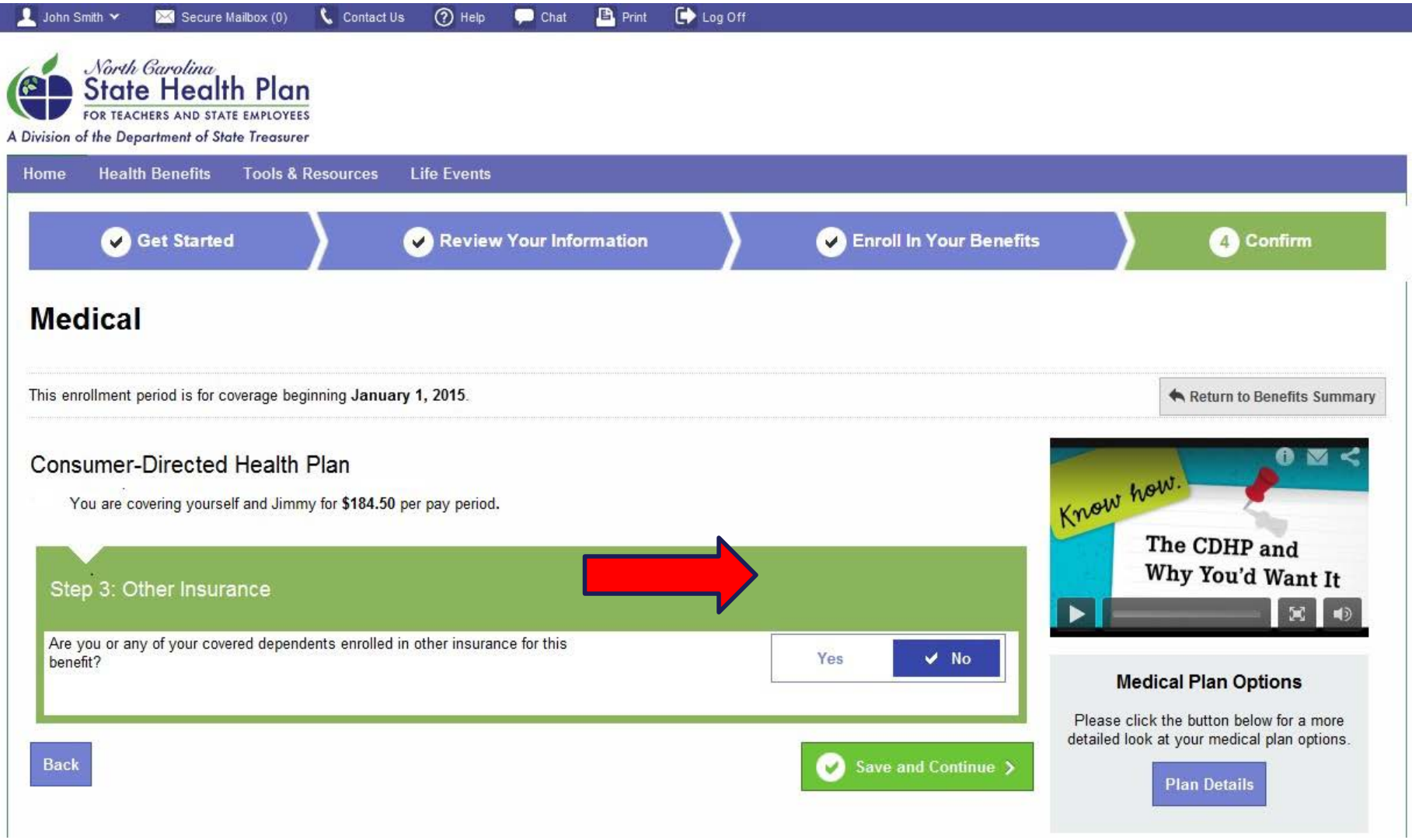
Return to Enrollment

PLAN Design FEATURE	Enhanced 80/20 Plan		Consumer-Directed Health Plan		Traditional 70/30	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
HRA Starting Balance	Not Applicable		$500 Employee/retiree $1,000 Employee/retiree +1 $1,500 Employee/retiree + 2 or more		Not Applicable	
Annual Deductible	$700 Individual $2,100 Family	$1,400 Individual $4,200 Family	$1,500 Individual $4,500 Family	$3,000 Individual $9,000 Family	$933 Individual $2,799 Family	$1,866 Individual $5,598 Family
Coinsurance	20% of eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge	15% of eligible expenses after deductible	35% of eligible expenses after deductible and the difference between the allowed amount and the charge	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Out-of-Pocket Maximum (includes deductible)	Not Applicable	Not Applicable	$3,000 Individual $9,000 Family	$6,000 Individual $18,000 Family	Not Applicable	Not Applicable
Pharmacy Out-of-Pocket Maximum	$2,500		Included in total outof-pocket maximum	Included in total outof-pocket maximum	$2,500	
Preventive Care	$0 (covered at 100%)	Not Applicable	$0 (covered at 100%)	Not Applicable	$35 for primary doctor $81 for specialist	Only certain services are covered
Office Visits	$30 for primary doctor; $15 if you use PCP on ID card $70 for specialist; $60 if you use Blue Options Designated specialist	40% after deductible	15% after deductible; $15 added to HRA if you use PCP on ID; $10 added to HRA if you use Blue Options Designated specialist	35% after deductible	e $35 for primary doctor $81 for specialist	50% after deductible
Inpatient Hospital	$233 copay, then 20% after deductible; copay not applied if you use Blue Options Designated hospital	$233 copay, then 40% after deductible	15% after deductible; $50 added to HRA if you use Blue Options Designated hospital	35% after deductible	$291 copay, then 30% after deductible	$291 copay, then 50% after deductible
Prescription Drugs						
• Tier 1	$12 copay per 30-day supply	Applicable copay and the difference between the allowed amount and the charge	15% after deductible	35% after deductible	$12 copay per 30-day supply	Applicable copay and the difference between allowed amount and the charge
• Tier 2	$40 copay per 30-day supply				$40 copay per 30-day supply	
• Tier 3	$64 copay per 30-day supply				$64 copay per 30-day supply	
• Tier 4	25% up to $100 per 30-day supply				25% up to $100 per 30-day supply	
• Tier 5	25% up to $125 per 30-day supply				25% up to $125 per 30-day supply	
• ACA Preventive Medications	$0 (covered at 100%)	$0 (covered at 100%)	$0 (covered at 100%)	$0 (covered at 100%)	Not Applicable	Not Applicable
• CDHP Preventive Medications	Not Applicable	Not Applicable	15%, no deductible	15%, no deductible	Not Applicable	Not Applicable

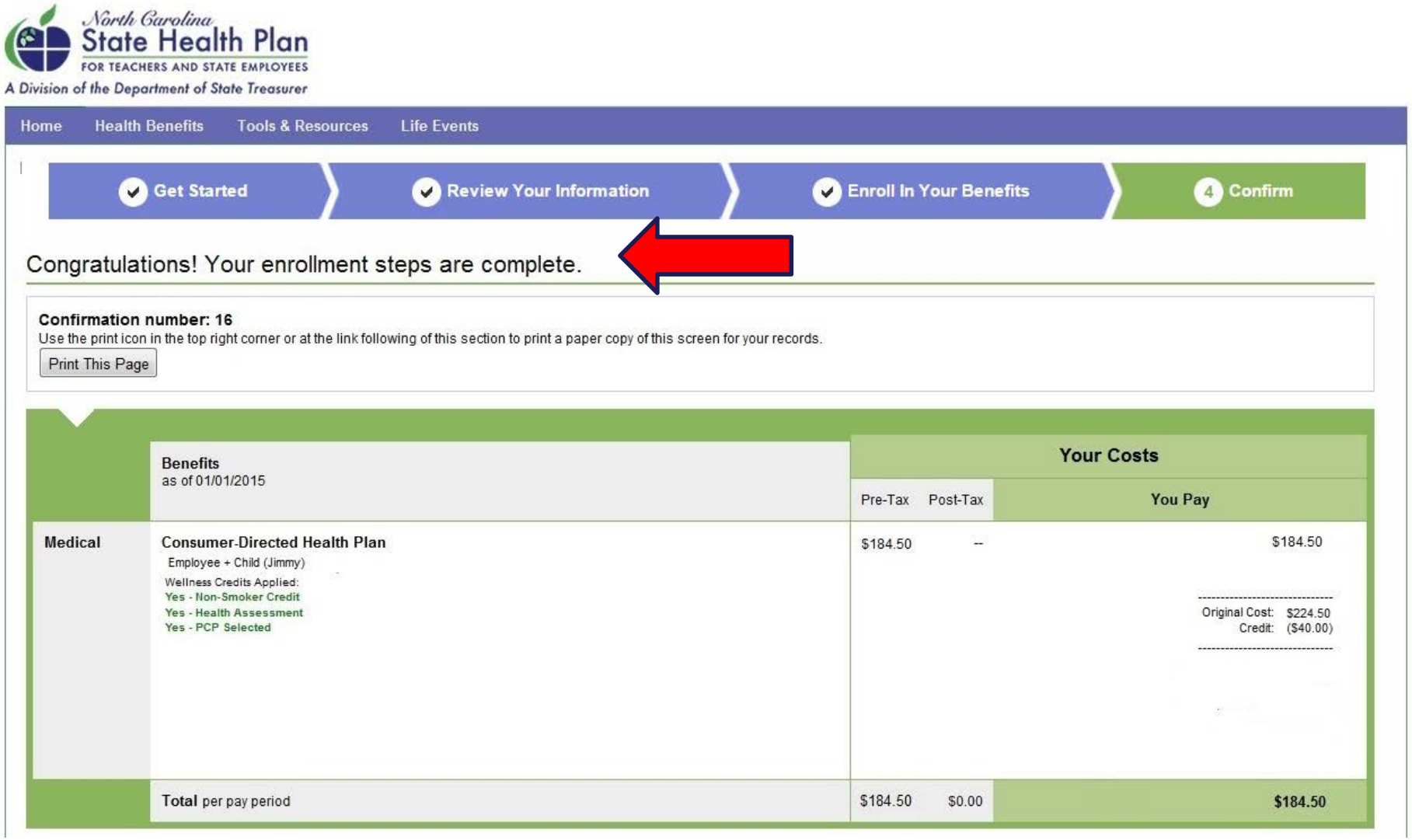
Health Plan Option Selected



Other Insurance



Enrollment Confirmation



North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Legislative Agenda

Board of Trustees Meeting

January 22, 2015

A Division of the Department of State Treasurer

2015 Legislative Agenda

Plan staff has identified several statutory changes to clarify eligibility and enrollment requirements and facilitate administration of benefits:

- Modify the provision that requires retirees to have a qualifying life event for disenrollment
- Align cancellation of coverage with 135-48.42(e)
- Clarify that retired employees eligible for coverage on a noncontributory basis are not eligible for coverage as RIF employees
- Align statutory provisions with the Affordable Care Act
- Flexibility regarding the State's banking requirements to facilitate procurement of third party administrative services

Retiree Disenrollment

- 135-48.42(e) Add language allowing a retiree to disenroll from the Plan during the Plan year without a qualifying event

Rationale

This requirement was imposed by the State to prevent members from only joining the Plan when they need services. There are members who may have other coverage with a former employer and coverage with the Plan is preventing them from getting that coverage or interfering with coordination of benefits. Allowing retirees to disenroll will not frustrate the intent behind the original legislation and is beneficial to the retiree.

Cancellation of Coverage

- 135-48.44(a)(4) Add language to this cessation of coverage provision that recognizes coverage will be cancelled if approved by the Plan and by the last day of the month of approval or as soon thereafter as administratively feasible

Rationale

The change will bring this provision into alignment with 135-48.42(e) which requires a qualifying life event for subscribers to disenroll and recognizes that all cancellations may not take place by the last day of the month in which a cancellation is requested by retirees. The change clarifies that an employee cannot request a cancellation of coverage, i.e. a cancellation would have to be due to a qualifying life event which would require administrative approval. For retirees enrolled in a Medicare Advantage product it may take longer than 30 days to effectuate disenrollment due to federal processes.

Reduction in Force Clarification

- 135-48.40(b)(8) Add language clarifying that retired employees eligible for coverage on a noncontributory basis are not eligible for coverage as RIF employees

Rationale

We believe this language should have been updated when changes to eligibility for retirees requiring 20 years of service for noncontributory coverage went into effect. In order for RIF employees who become retirees but are not eligible for noncontributory coverage to have the same treatment as other RIF employees, they need to be eligible for continued coverage as a RIF employee not a retiree.

Affordable Care Act

- Delete/remove all references to waiting periods and pre-existing conditions to bring the Plan's statute into alignment with existing law

Rationale

This will ensure consistency between the State's law and the ACA.

Banking Requirements

- The Plan will collaborate with the Financial Operations Division of the Department of State Treasurer to determine whether to request authority for the State Treasurer and State Controller to approve exceptions to the state's banking requirements to provide flexibility to agencies in certain circumstances while continuing to protect the State's interests.

Rationale

When the Plan solicited proposals for third party administrative services in 2012, potential vendors declined to bid due to the State's banking requirements, which require our contractors to establish and manage depository and disbursing accounts in the name of the State Treasurer. The current requirements ensure proper control of State funds and help maximize interest earnings, but can be cost prohibitive to vendors whose claims processing systems cannot easily accommodate such an arrangement, which must include check writing and electronic funds transfer (EFT) capabilities specific to the Plan's members and bank accounts. The Plan is interested in more flexibly in its contracts for third party administrative services (e.g. claims processing), and other agencies have identified needs as well.

NORTH CAROLINA GENERAL ASSEMBLY

JOINT LEGISLATIVE EDUCATION OVERSIGHT COMMITTEE

REPORT TO THE 2015 SESSION of the GENERAL ASSEMBLY OF NORTH CAROLINA

JANUARY 6, 2015

TABLE OF CONTENTS

History I: The Founding Principles and ensured that specific principles were covered in the course. Dr. Atkinson and Mr. Cobey then stated that there were numerous opportunities for college level history courses in high school, including advanced placement (AP) and international baccalaureate (IB) programs. The SBE policy allows students to take the AP US History in lieu of American History I: Founding Principles. The policy further provides that AP US History along with one additional social studies elective satisfies the American History I and American History II requirements for high school graduation. They stated that it was important for students to continue to take AP US History because there were fewer opportunities for students to take other advanced courses and that the General Assembly had encouraged more access and successful participation in AP and IB courses. They stated that the documents and principles required by the General Assembly in the Founding Principles Act had to be followed even in the AP classes and that AP teachers and local boards of education have the flexibility to ensure that the law is followed.

Trevor Packer, Senior Vice President of AP and Instruction at the College Board, then presented to the Committee about the AP Program, including North Carolina statistics for AP participation and credit placement. He stated that the College Board feels that instruction in the Founding Principles can be fulfilled within the AP US History course. He further provided information about the new course framework adopted by the College Board for AP US History and stated that it encourages focus on the Founding Principles along with more questions requiring the examination of historical documents.

The following three presenters next spoke opposing a requirement that students taking IB History of the Americas also take American History I: The Founding Principles.

- Heather LaJoie, IB Coordinator, East Mecklenburg High School, Charlotte, NC
- Lee Quinn, Teacher & IB Coordinator, Broughton High School, Raleigh, NC
- David Brooks, IB Coordinator, Broughton High School, Raleigh, NC

They stated that the NC teachers of IB History of the Americas can fulfill the provisions of the Founding Principles Act by teaching the specified principles within the existing IB course.

Jennifer Haygood, Executive Vice President for Operations and Chief Financial Officer, North Carolina Community College System, provided an update to the Committee on the work of the Program Audit Study Committee established by S.L. 2013-360, Sec. 10.15. Ms. Haygood detailed the work of the Study Committee and its data-gathering process, and summarized the key proposed reforms to the program audit process for community colleges. The recommendations included changes to State Board of Community College rules, statutory changes, and changes to current processes for staff conducting compliance reviews.

December 2, 2014

Mona Moon, Executive Administrator for the NC State Health Plan, presented an overview of new health benefit coverage requirements for full-time employees. She stated that under the federal Affordable Care Act (ACA), the State must offer health care

benefits to non-permanent full-time employees who traditionally were not eligible for coverage under the State Health Plan. The State responded to this requirement by offering coverage that provides minimal essential coverage at no greater than the ACA "Bronze" level coverage that also minimizes the employer contribution. This option is known as the High Deductible Health Plan Option (HDHP). Ms. Moon explained that, in 2015, rehired retirees working on a temporary basis more than 30 hours per week would be required to switch to the HDHP and that rehired retirees found this to be less attractive than the regular State Health Plan coverage for retirees.

Carrie Tulbert, NC Principal of the Year and the principal of Mooresville Middle School, and Brady Johnson, Superintendent of Iredell-Statesville School System, next spoke to the Committee about how this health benefit coverage change is keeping many rehired retirees from working in the public schools in long-term assignments, such as substitute teachers, and therefore negatively impacting the public schools.

David Vanderweide, Fiscal Analyst in the Fiscal Research Division of the NC General Assembly, next presented options to the Committee to make changes to the health benefit coverage options provided to the rehired retirees.

Philip Price, Chief Finance Officer at the Department of Public Instruction, provided an overview to the Committee on the implementation of S.L. 2014-100, Section 8.35, which directed the State Board of Education (SBE) to create a virtual charter school pilot program for the 2015-2016 year. Mr. Price presented the timeline the SBE was following to implement the pilot program and stated that two applications had been submitted to the SBE prior to the deadline for applications. The SBE will discuss recommendations for the virtual charter school pilot program in January 2015 and vote to select the applicants in February of 2015. By August of 2015, the virtual charter school pilots will open to serve students with a maximum of 1500 students per school.

Dr. Rebecca Garland, Deputy State Superintendent, Department of Public Instruction, and Carolyn Guthrie, Director, K-3 Literacy, Department of Public Instruction, addressed the Committee on the implementation of the Read to Achieve Program part of S.L. 2012-142, Sec. 7A.1(b). They discussed the grade level implementation plan and covered information in a report that was submitted to the Committee in October 2014. The report is comprised of four sections that include the overall strategic plan implemented by the Department of Public Instruction by component, the accountability measures of numbers of students falling within specific categories of the program, overall findings of an external evaluation, and response to feedback with recommendations for future legislation. The recommended legislation includes: providing instructional coaches, providing reading camps for younger students, expanding the number and future development of Master Literacy Trainers, providing funding for reading camps, increasing funding in general for the program, and staying the course.

Next, Ms. Brenda Hammond, Third Grade Teacher, Timber Drive Elementary School in Garner, North Carolina, spoke to the Committee about her personal experience as a teacher in the Read to Achieve program.

FINDINGS AND RECOMMENDATIONS

Based on information presented to the Joint Legislative Education Oversight Committee during their regularly scheduled meetings, the Committee makes the following findings and recommendations to the 2015 General Assembly:

1. Elizabeth City State University

The Committee recognizes the challenges that Elizabeth City State University has faced over the past several years, in particular its declining enrollment numbers. The Committee finds that the "rightsizing" initiative is a step in the correct direction that could lead the University to financial and enrollment stability and ultimately successful outcomes for its students, alumni, faculty, staff, and larger community. The Committee strongly encourages Elizabeth City State University to continue to refine its "rightsizing" initiative and focus on increasing financial, administrative, operational, and academic efficiencies in order to exemplify its commitment to providing a high quality college education and continuing to be a key stakeholder in the northeastern region of North Carolina.

2. Vocational Training for Individuals with Intellectual and Developmental Disabilities

The Committee continues to support efforts and programs designed to improve employment outcomes for individuals with intellectual and developmental disabilities. It finds that increased collaboration across various agencies, including the Department of Public Instruction, the Department of Health and Human Services, the North Carolina Community College System, The University of North Carolina, and the Department of Commerce, would be helpful in creating stronger employment outcomes for these individuals. The Committee also recognizes and encourages individual school systems, community colleges, and UNC campuses to be innovative in their approach to providing high quality educational opportunities as well as strong vocational and job skills training to individuals with intellectual and developmental disabilities. They should continue to focus on creating and sustaining partnerships with business and industry in order to effectively meet the needs of the individuals and the employers, with an emphasis placed on creating and refining plans for transitions from school to training programs to employment. Finally, the Committee strongly urges that successful programs be supported and replicated in the State in order to help these individuals live up to their full potential and be engaged and productive citizens.

3. Health Coverage for Reemployed Retirees in 2015

Due to a complex interaction of State and federal law, rehired retirees working on a temporary basis more than 30 hours per week will be required to switch to the High Deductible Health Plan (HDHP) in 2015, which the rehired retirees find to be a much less attractive offering than the regular State Health Plan (SHP) coverage for retirees. The Committee finds that, in response, many rehired retirees working in the public schools are leaving these positions or refusing to take new long-term assignments as substitute teachers, interim superintendents, or other roles. Therefore, the Committee recommends

a statutory change to cover these retirees as active employees with regular SHP coverage, with the school districts paying the full employer premium but later being reimbursed for that premium by the Retiree Health Benefit Fund.
See attached Legislative Proposal 2015-MEz-4.

4. Read to Achieve Reading Camp Flexibility

The 2013-2014 school year completed the first year of implementation of the Read to Achieve program enacted in Section 7A.1 of S.L. 2012-142. One of the requirements of the Read to Achieve program is for local school administrative units to offer a reading camp to students who have been retained in third grade due to failure to demonstrate reading competency at this grade level. Preliminary analysis of the initial implementation indicates that it may be helpful to local school administrative units to allow them additional flexibility to also offer reading camps to students in kindergarten, first, and second grades to address student remediation needs in a more timely manner. The Committee therefore recommends that as additional data becomes available, the 2015 General Assembly consider the possibility of providing such flexibility to local school administrative units to allow them to offer reading camps to younger students.

LEGISLATIVE PROPOSAL

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S **D**

BILL DRAFT 2015-MEz-4* [v.13] (11/05)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/18/2014 10:53:51 AM

Short Title: State Health Plan/Rehired Retiree Eligibility. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ALLOW RETIREES WHO RETURN TO WORK FOR THE STATE IN NONPERMANENT POSITIONS TO RETAIN THEIR COVERAGE OPTIONS UNDER THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES RATHER THAN LIMITING SUCH RETIREES' COVERAGE OPTIONS TO THE "BRONZE LEVEL" HIGH-DEDUCTIBLE HEALTH PLAN NECESSITATED BY THE AFFORDABLE CARE ACT, AS RECOMMENDED BY THE JOINT LEGISLATIVE EDUCATION OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.40, as amended by Section 35.16 of S.L. 2014-100, reads as rewritten:

"**§ 135-48.40. Categories of eligibility.**

...

(b) Partially Contributory Coverage. – The following persons are eligible for coverage under the Plan, on a partially contributory basis, subject to the provisions of G.S. 135-48.43:

(1) All permanent full-time employees of an employing unit who meet either of the following conditions:

a. Paid from general or special State funds.

b. Paid from non-State funds and in a group for which his or her employing unit has agreed to provide coverage.

Employees of State agencies, departments, institutions, boards, and commissions not otherwise covered by the Plan who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year are covered by the provisions of this subdivision.

(1a) All retirees who (i) are employed by an employing unit, (ii) do not qualify for coverage under subdivision (1) of this section, and (iii) are determined to be "full-time" by their employing unit in accordance with section 4980H of the Internal Revenue Code and the applicable regulations, as amended. The Department of State Treasurer shall, using a process developed by the Department, reimburse an employing unit the employing unit's cost to cover such a retiree who enrolls in the Plan. The reimbursement shall be made at least once per plan year and shall be paid from the Retiree Health Benefit Fund.

...

(e) Other Contributory Coverage. – Any employee of an employing unit is eligible for coverage under this section on a contributory basis, subject to the provisions of G.S. 135-48.43 and of this section, if (i) the employee's employing unit determines that the employee is a full-time employee and (ii) the employee does not qualify for coverage under subdivision (1), (1a), (5), (6), (7), (8), (9), or (10) of G.S. 135-48.40(b). For the purposes of this subsection, the full-time status of an employee shall be determined by the employing unit, in its sole discretion, in accordance with Section 4980H of the Internal Revenue Code and the applicable regulations, as amended. The coverage offered and the contribution required for coverage under this section shall be determined by the Treasurer and approved by the Board of Trustees. Such coverage shall do all of the following:

(1) Be designed to meet the requirements of minimum essential coverage under the Patient Protection and Affordable Care Act, P.L. 111-148, and the applicable regulations, as amended (Affordable Care Act).

(2) Provide no greater coverage than a bronze-level plan, as defined under the Affordable Care Act.

(3) Minimize the required employer contribution in an administratively feasible manner."

SECTION 2. G.S. 135-48.41(j), as enacted by Section 35.16A of S.L. 2014-100, reads as rewritten:

"(j) If a retiree has been hired by an employing unit and is eligible for coverage under subdivision (1), (1a), (5), (6), (7), (8), (9), or (10) of G.S. 135-48.40(b) or under G.S. 135-48.40(e), then the hired retiree shall not, during the time of employment, be eligible for retiree coverage under G.S. 135-48.40(a)(1), G.S. 135-48.40(b)(3), G.S. 135-48.40(c)(2), or G.S. 135-48.40(d)(11)."

SECTION 3. This act becomes effective July 1, 2015.

Bill Draft 2015-TRza-5*: Medicaid Reorganization (JLPEOC).

2015-2016 General Assembly

Committee:	Joint Legislative Program Evaluation Oversight Committee	**Date:**	January 21, 2015
Introduced by:		**Prepared by:**	Jennifer Hillman Committee Counsel
Analysis of:	2015-TRza-5*		

SUMMARY: Bill draft 2015-TRza-5 would transfer the Division of Medical Assistance to a new board-managed Health Benefits Authority, which would be administratively housed in the Department of Health and Human Services but which would exercise its statutory authority independently of the Department.

CURRENT LAW: The Medicaid and Health Choice programs are currently managed by the Division of Medical Assistance within the Department of Health and Human Services.

BILL ANALYSIS: Sections 1 and 2 of the bill draft transfer the current Division of Medical Assistance within the Department of Health and Human Services to the Health Benefits Authority, a new, board-managed entity within the Department of Health and Human Services. The transfer would occur October 1, 2015.

The main elements of the new Health Benefits Authority are as follows:

- **Management by compensated board of experts.** The new Health Benefits Authority would be managed by a group of compensated experts in health administration, health insurance, health actuarial science, health economics, and health law and policy. The Board would include three appointees from the Governor, two on the recommendation of the Senate President Pro Tempore, two on the recommendation of the House Speaker, and the Secretary of Health and Human Services. The Board would be compensated comparably to boards of large hospital systems and insurance companies, with initial compensation determined by the Office of State Human Resources.
- **Independent exercise of authority.** The Board would have broad authority to operate the Medicaid and Health Choice programs, including the ability to adjust all program elements except for eligibility categories. Although administratively housed in the Department of Health and Human Services, the Health Benefits Authority would exercise its statutory powers independently of the Secretary of Health and Human Services. Unlike the current Division of Medical Assistance, the Secretary would not be able to transfer funds into or out of the Health Benefits Authority's programs without explicit permission of the Board. Budget proposals would be submitted directly to the Office of State Budget and Management. Existing administrative agreements between the Division of Medical Assistance and other State entities, including divisions of the Department of Health and Human Services, would continue until July 1, 2016, at which point the Health Benefits Authority would be able to enter into new administrative arrangements.
- **Increased fiscal responsibility.** The bill draft requires the new Health Benefits Authority to keep the Medicaid and Health Choice programs within their budgets. The Authority would annually publish a forecast of the next four years of the Medicaid and Health Choice programs, including (i) the expected enrollment growth and enrollment mix changes, (ii) what changes, such as service reductions, would have to be made to keep the programs

within their existing budget, and (iii) how much additional funding would be required to maintain the programs without any changes. The Authority would have to make mid-year reductions to programming if experiencing a shortfall. If those reductions were not sufficient, then the Board of the Health Benefits Authority would be able access funds from the Medicaid Reserve Account, a new, non-reverting special fund.

- **Strategic planning and performance measures.** The Board would have to clearly define its strategic plans and goals, as well as a performance management system for measuring how well it achieves its goals.
- **Increased transparency and reporting.** The bill draft requires increased reporting, including information on performance measures and an audited financial statement, as well as the monthly publishing of enrollment, per member spending, spending by fund code, and an analysis of each month's performance compared to the forecast.
- **Staff "at will" employees with "cooling off" period.** Staff hired after the date of transfer (October 1, 2015) would be exempt from several provisions of the State Personnel Act in order to be "at will" employees. Staff could be offered contracts for a term, however. Staff would also be subject to a six month "cooling off" period. Specifically, during the six months following the end of employment, (i) an employee could not work for an entity whose contract the employee negotiated or supervised and (ii) an officer could not work for any entity that contracted with the the Health Benefits Authority.

Sections 3 through 8 address technical issues ranging from when the Board can begin meeting to conforming statutory changes. **Section 3** provides for when the Board can meet and how the Office of State Human Resources determines the initial compensation for the members of the Board. **Section 4** continues existing Medicaid and Health Choice administrative agreements until July 1, 2016. **Section 5** requires the Department of Health and Human Services to report on the allocation of Medicaid costs. **Section 6** requires the Department of Health and Human Services to submit the appropriate state plan amendments (SPAs) to change the designation of the federally recognized "single state agency" from the Department of Health and Human Services to the Health Benefits Authority. **Section 7** provides additional details on the transfer of rules, contracts, and legal actions. **Section 8** creates a new legislative oversight committee to oversee the Health Benefits Authority and removes the oversight of Medicaid and Health Choice from the Joint Legislative Oversight Committee on Health and Human Services. **Section 9** makes technical and conforming changes, and also recodifies existing Medicaid law into a single Chapter.

EFFECTIVE DATE: The majority of the bill draft would be effective October 1, 2015. A few provisions that facilitate that October 2015 effective date are effective when the act becomes law.

BACKGROUND: In Report Number 2013-03, "Options for Creating a Separate Department of Medicaid Require Transition Planning (March 2013)," the Program Evaluation Division presented options and considerations for adjusting the existing governance of the Medicaid program, which is currently administered by the Division of Medical Assistance of the Department of Health and Human Services. The Sixth Edition of HB 1181 of the 2014 session, which the Senate passed on July 28, 2014, contained a plan to create a separate board-governed Department of Medical Benefits to manage the Medicaid and Health Choice programs. The House did not concur with that version of the bill. In August 2014, the Joint Legislative Program Evaluation Oversight Committee formed a subcommittee to study Medicaid, including the governance of Medicaid.

Ryan Blackledge, former counsel to the Joint Legislative Program Evaluation Oversight Committee, substantially contributed to this summary.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Pharmacy & Therapeutics Committee
November 2014 Meeting Summary

Board of Trustees Meeting

January 22, 2015

A Division of the Department of State Treasurer

Updates to Utilization Management Programs

Programs	Update
Compound Medications Prior Authorization	Implemented ESI's compound program which looks at all the compound ingredients instead of only the primary ingredient.
Kuvan Prior Authorization	Policy updated to include all Kuvan products.
Ilaris Prior Authorization	Policy updated to include Systemic Juvenile Idiopathic Arthritis (SJIA) criteria requirements.
Promacta Prior Authorization	Policy updated to allow coverage for new indication in patients with severe aplastic anemia.
Tetracycline Step Therapy	Policy updated to add new product Acticlate as a non-preferred step 2 medication.
Zelboraf Prior Authorization	Policy updates consistent with recent National Comprehensive Cancer Network (NCCN) clinical guidelines.
Buprenorphine and Buprenorphine/Naloxone Prior Authorization and Quantity Limits	Policy updated to add new medication Bunavail.

Updates to Utilization Management Programs

Programs	Update
Omega-3 Fatty Acid Products Prior Authorization	Policy updated to add new medications Epanova and Omtryg.
Weight Loss Agents Prior Authorization	Policy updated to add new medication Contrave.
Immune Globulin Prior Authorization	Policy updated to add new subcutaneous medication HyQvia.
Otezla Prior Authorization	Policy updated to add plaque psoriasis as an approved indication.
Hereditary Angioedema Prior Authorization	Policy updated to add criteria for Cinryze and Berinert and new medication Ruconest.
Humira Prior Authorization	Policy updated to add coverage for pediatric Crohn's patients 6 years of age and older.
Stelara Prior Authorization and Step Therapy	Policy updated to remove the step therapy requirements for Stelara.

Updates to Utilization Management Programs

Programs	Update
Hepatitis C Agents Prior Authorization	Policy updates consistent with guidance from American Association for the Study of Liver Diseases.
Multiple Sclerosis Prior Authorization	Policy added for Plegridy which was recently FDA approved for the treatment of relapsing forms of multiple sclerosis.
Migraine Agents Preferred Step Therapy and Quantity Limit Policy	Policy updated to add new 4 mg strength of Sumavel DosePro injection.
Anti-emetic Prior Authorization and Quantity Limit Policy	Emend policy updated to add new antiemetic Akynzeo.
Androgen and Anabolic Steroid Prior Authorization and Step Therapy Policy	Policy updated to add new medications, Vogexlo and testosterone gel, and change the coverage duration for all indications from 5 years to 12 months with the exception of the treatment of delayed puberty where coverage duration is 6 months.
Growth Hormones Step Therapy Policy	Humatrope is now non-preferred step 2; Norditropin and Genotropin are the preferred step 1 medications.

Updates to Utilization Management Programs

Programs	Update
Oral Corticosteroid Inhalers Preferred Step Therapy Program	Policy updated to add new medication Aerospan and new formulation of Asmanex HFA.
Osteoporosis Step Therapy Policy	Policy updated to add generic risedronate (Actonel) 150 mg tablets as a preferred step 1 agent.
Topical Acne Policies	Policies updated to reflect all available strengths for applicable products.
Angiotensin Receptor Blocker Step Therapy Policy	Policy updated to add generic valsartan as a preferred step 1 medication and brand Diovan as step 2.
Antifungal Prior Authorization Policy	Policy updated to add new medications Jublia and Kerydin.
Pulmonary Arterial Hypertension Prior Authorization Policies	Policy updates consistent with treatment guidelines.
Nasal Steroids Step Therapy	Policy updated to add generic budesonide as a preferred step 1 medication and add brand QNASL as a non-preferred step 2 medication.

New Utilization Management Programs Reviewed

Program	Description	Member Impact	Estimated Projected Savings	P&T Recommendation	Target Implementation
Overactive bladder Step Therapy Program	Step Therapy	728	$925,000	Yes	TBD
Pulmonary Fibrosis Medication	Prior Authorization	Current users grand-fathered	Not modeled (new products)	Yes	1/1/2015
Sublingual Immuno-allergens	Prior Authorization	Current users grand-fathered	Not modeled (new products)	Yes	2/16/15

New Drugs for Formulary Consideration

Drug	Indication	Tier Placement
Duavee (bazedoxifene/conjugated estrogens tablets)	Menopausal vasomotor symptoms and prevention of postmenopausal osteoporosis	3
Zohydro ER (extended-release hydrocodone capsules)	Pain management	3
Xartemis XR (oxycodone/APAP extended-release tablets)	Pain management	3
Anoro Ellipta (umeclidinium/vilanterol inhalation powder)	COPD	2
Grastek (timothy grass pollen extract)	Allergen immunotherapy	3
Ragwitek (short ragweed pollen extract)	Allergen immunotherapy	3

New Drugs for Formulary Consideration

Drug	Indication	Tier Placement
Farxiga (dapagliflozin tablets)	Type 2 Diabetes Mellitus	3
Jardiance (empaglifozin tablets)	Type 2 Diabetes Mellitus	3
Invokana (canagliflozin) (previously reviewed)	Type 2 Diabetes Mellitus	2
Aptiom (eslicarbazepine tablets)	Seizures	3
Luzu (luliconazole 1% topical cream)	Topical antifungal	3
Zontivity (vorapaxar tablets)	Anti-platelet	3
Otrexup (methotrexate injection)	Rheumatoid arthritis; polyarticular juvenile idiopathic arthritis; severe psoriasis	3
Hemangeol (propranolol oral solution)	Infantile hemangioma	3

Additional Topics Discussed

- The Affordable Care Act (ACA) Preventive Medication List will be updated for the calendar year 2015 with the following additions:
  - Coverage of medications for primary prevention of breast cancer at a $0 cost-share for women who are at high risk and enrolled in the Enhanced 80/20 Plan or Consumer Directed Health Plan (CDHP) if authorization criteria are met.
  - Tobacco cessation category added coverage of OTC lozenges through the QuitlineNC, prescription brand Chantix limited to a six month supply in 12 months and for generic extended-release bupropion 12 hour.

- Oral Long-Acting Opioid Quantity Limit policy was implemented on November 3, 2014, as a quantity limit policy and did not incorporate a step therapy policy as initially proposed.

- A UV Light Therapy Pilot Program has been proposed by BCBSNC for the treatment of moderate-to-severe psoriasis. This program will work with 24 BCBSNC contracted dermatologists in North Carolina.

From "How Much" To "How Well"

State Health Plan of North Carolina

Application of 'Value-Based Insurance Design' Principles

January 2015

175 Strafford Avenue ♦ Suite One ♦ Wayne, PA 19087 ♦ 610-247-0461 ♦ www.VBIDHealth.com

VBIDHEALTH

From "How Much" To "How Well"

State Health Plan (SHP) of North Carolina—Evolution of Health Plan Benefits

Mission	Guiding Principles
Improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.	• Improve Affordability • Improve Members' Health • Ensure Access to Quality Care • Incent Member Engagement • Expand Value Based Design Elements • Promote Health Literacy • Provide Member Choice • Maintain Financial Stability

Current Plan Offerings

- Enhanced 80/20, 52% of membership, Monthly cost for single coverage is $13.56 to $63.56.
- Traditional 70/30, 45% of membership, No monthly premium for single coverage.
- CDHP (high deductible with HRA), 3% of membership, Monthly cost for single coverage is $0 to $40.

Opportunity for SHP. It is a well-documented fact that there is significant underuse of evidence-based clinical services and significant wasteful spending (for unnecessary care, inappropriate care, and poor quality care) in the US healthcare system. Therefore, large healthcare purchasers and their members can benefit from efforts to 'get more for less', or achieve the same or better outcomes for the same or less money. We recommend that plan sponsors seek to modify incentives in a way that positively impacts underuse, overuse, and misuse of the system.

Value-Based Insurance Design (VBID) and the Concept of Clinical Nuance. VBID plans align patients' out-of-pocket costs, such as copayments and coinsurance, with the clinical value of services. These innovative products are designed with the tenets of "clinical nuance" in mind. These tenets recognize that 1) medical services differ in the amount of health produced, and 2) the clinical benefit derived from a specific service depends on the consumer using it, as well as when and where the service is provided. In order to achieve greater 'value', the VBID concept seeks to pay more (up to 100%) for high value services, and pay less (or 0%) for low or no value services ("carrots" and "sticks"). Carrots include secondary preventive care (e.g, for patients with chronic illness such as asthma or high blood pressure, paying for medications and/or services that prevent complications or deterioration in the patient's condition). Examples of sticks include wasteful services such as expensive testing for lower back pain, certain treatments for knee pain, and elective inductions for childbirth. The addition of incentives and disincentives results in higher utilization of high value services and reductions in use of low value services.

Summary of Recommendations. VBID Health commends the SHP for its early work in value-based insurance design and supports continuation of SHP decisions to incorporate VBID elements related to prevention and wellness. The next step(s) are to increasingly build in incentives to use specific services that are correlated to specific populations, thereby increasing the degree of 'clinical nuance' in the plan designs. VBID Health's specific recommendations for the SHP over the next three years are summarized by year on the next page, with existing VBID elements shown in red. The final five pages are appendices that summarize idealized VBID plan design elements for the management of 5 specific chronic illnesses—diabetes, COPD, asthma, hyperlipidemia, and hypertension. These elements may be considered by the BOT in succeeding policy year deliberations around VBID.

Potential Progression of Value-Based Insurance Design

2016

- Preventive services with no cost-sharing (ACA)
- Premium credits tied to wellness activities
- Incentives to choose PCP
- Steerage to Blue Option high-performing providers
- Deductible-exempt chronic disease medications (standard co-insurance)
- HRA credits for engaging in health management activities
- Select services with $0 cost-sharing:
  - diabetes, asthma, or hypertension :
    - 2 additional PCP visits
  - diabetes:
    - HbA1c test (2/yr)
    - microalbumin test (1/yr)
    - Certified Diabetes Educator visits
    - Access to Diabetes Primary Prevention program

2017

- Enhance existing VBID elements in place and under consideration
  - Broaden diabetes health engagement program to include additional metrics (e.g. eye exams)
- Add selected high value services (e.g. diagnostic tests) for clinical conditions in addition to diabetes (e.g. asthma, hyperlipidemia) with similar administrative complexity
  - LDL testing
  - Asthma action plan
- Consider reducing co-insurance levels for high-value drug classes that are deductible-exempt
- Consider cost-sharing reductions for NCQA certified PCMH providers

2018

- Optimize member engagement and plan selection based on benefit value
- Align consumer engagement initiatives with payment reform efforts
- Better utilize wellness, satisfaction and claims data to refine plan offerings
- Expand high value service for selected conditions across entire spectrum of care

VBIDHEALTH

Value Based Insurance Design for Enrollees with Diabetes
Prepared by VBID Health

A clinically nuanced, Value Based Insurance Design benefit for patients with diabetes includes the covered benefits listed below with little or no patient cost sharing.
RED - services already implemented or under consideration per November Board meeting presentation.
GREEN - medication specific. "Reduced pharmacy copays" under consideration per Nov. Board presentation for these conditions, but specific drug classes not yet specified.
BLUE - Expanded high value service for selected conditions across entire condition spectrum.

Categories of Covered Benefits							
Clinician Visits	**Diagnostic Testing**	**Medications****	**DME**	**Monitor**	**Physician Extenders**	**Specialists**	**Other**
Primary Care Physician (SHP suggests 2 additional). Incentives to choose and use PCP in place	Blood pressure* unlimited no cost visits for blood pressure checks	BP meds	BP cuff		Dietician	Cardiologist - up to 2 visits	Incentivize member to complete a diabetes action plan
Physician's Assistant up to 6 visits	LDL testing on diagnosis and one yearly assess adherence	Statins/TRG lowering			Certified Diabetes Educator - SHP recommends 2 visits		Incentivize member to complete an education program
Nurse Practitioner up to 6 visits	A1c - SHP recommends at least twice yearly	Insulin/other glycemic lowering agents	Glucometer & test strips		Wound care	Endocrinologist - up to 2 visits	SHP recommends access to DPP program
Patient-Centered Medical Home - reduce cost share for visits if NCQA acceditation	Urinalysis - SHP recommends at least 1 yearly				Weight watchers	Nephrologist - up to 2 visits	
	Retinal eye exam - yearly					Ophthalmologist- as needed for retonoptahy treatment	
	Podiatry exam - yearly		Orthotics as prescribed			Podiatrist - up to 2 visits	
	Depression screening - yearly	All classes of anti-depression meds				Psychiatritist - up to 2 visits	
	Tobacco use screening- yearly	All classes of meds used for smoking cessation (consider similar benefit for spouse or other coinhabitant)			Behavioral therapy for smoking cessation	Vascular Surgeon - up to 2 visits	Incentivize member to enroll in smoking cessation program
	BMI screening - yearly	Influenza Vaccination					
	Age appropriate Hepatitis C screening - one time	Pneumovax Vaccination					
		HBV Vaccination					

*The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
**Discuss branded vs. generic drugs, and the difference between generics and therapeutic substitutions

Value Based Insurance Design for Enrollees with COPD
Prepared by VBID Health

A clinically nuanced, Value Based Insurance Design benefit for patients with COPD includes the covered benefits listed below with little or no patient cost sharing.
RED - services already implemented or under consideration per November Board meeting presentation.
GREEN - medication specific. "Reduced pharmacy copays" under consideration per Nov. Board presentation for these conditions, but specific drug classes not yet specified.
ORANGE - similar to diabetes, but for other conditions mentioned (e.g., blood sugar test (HgA1c) under consideration for diabetics $0 copay 2 per year, urine test $0 copay once per year (BOT slide 22). Recommend similar high value tests (same administrative complexity) in other conditions in orange (e.g. cholesterol testing for hyperlipidemia).
BLUE - Expanded high value service for selected conditions across entire condition spectrum.

Categories of Covered Benefits							
Clinician Visits	**Diagnostic Testing**	**Medications***	**DME**	**Monitor**	**Physician Extenders**	**Specialists**	**Other**
Primary Care Physician- 2 additional per year	Pulmonary Function test	Bronchodilators (quick acting/rescue medication; metered dose inhaler and/or nebulized)	Home Spirometer	Spirometry	Behavioral therapy for smoking cessation	Pulmonologist	Pulmonary rehabilitation and ongoing exercise program for moderate and severe COPD (defined as FEV <80%)
Physician's Assistant- up to 6	Long-term oxygen assessment	Inhaled Steroids	Prescription for long-term home oxygen for those who are hypoxic and meet criteria				Incentivize member to complete an action plan
Nurse Practitioner- up to 6		Long-acting beta-agonists (only in combination with inhaled steroids; not as a stand alone medication)					Incentivize member to complete an education program
Patient-Centered Medical Home- reduce cost share if NCQA acceditation		Anticholinergics (Spiriva, Combivent)					
	Depression screening	All classes of anti depression meds					
	Tobacco use screening	All classes of meds used for smoking cessation (consider similar benefit for spouse or other coinhabitant)					Incentivize member to enroll in smoking cessation program
	BMI screening	Influenza Vaccination					
		Pneumovax Vaccination					
		HBV Vaccination					

*Discuss branded vs. generic drugs, and the difference between generics and therapeutic substitutions

Value Based Insurance Design for Enrollees with Asthma
Prepared by VBID Health

A clinically nuanced, Value Based Insurance Design benefit for patients with asthma includes the covered benefits listed below with little or no patient cost sharing.
RED - services already implemented or under consideration per November Board meeting presentation.
GREEN - medication specific. "Reduced pharmacy copays" under consideration per Nov. Board presentation for these conditions, but specific drug classes not yet specified.
ORANGE - similar to diabetes, but for other conditions mentioned (e.g., blood sugar test (HgA1c) under consideration for diabetics $0 copay 2 per year, urine test $0 copay once per year (BOT slide 22). Recommend similar high value tests (same administrative complexity) in other conditions in orange (e.g. cholesterol testing for hyperlipidemia).
BLUE - Expanded high value service for selected conditions across entire condition spectrum.

Categories of Covered Benefits							
Clinician Visits	**Diagnostic Testing**	**Medications***	**DME**	**Monitor**	**Physician Extenders**	**Specialists**	**Other**
Primary Care Physician- 2 additional per year	Pulmonary Function test	All classes of Antibiotic or Anti-Viral medication used to treat bacterial or viral infections for asthmatics	Peak Flow Meter	Spirometry	Inhaler training	Pulmonologist	Incentivize member to complete an asthma action plan
Physician's Assistant- up to 6	Allergy sensitivity test	All classes of long acting controllers to help manage asthma	Home Spirometer		Education to identify causes and reduce incidence of asthma flares	Allergist	Incentivize member to complete an asthma allergens/triggers education program
Nurse Practitioner- up to 6		All classes of rescue inhalers to provide temporary relief					
Patient-Centered Medical Home- reduce cost share if NCQA acceditation							
	Depression screening	All classes of anti depression meds					
	Tobacco use screening	All classes of meds used for smoking cessation (consider similar benefit for spouse or other coinhabitant)					Incentivize member to enroll in smoking cessation program
	BMI screening	Influenza Vaccination					
		Pneumovax Vaccination					
		HBV Vaccination					

*Discuss branded vs. generic drugs, and the difference between generics and therapeutic substitutions

Value Based Insurance Design for Enrollees with Hyperlipidemia
Prepared by VBID Health

A clinically nuanced, Value Based Insurance Design benefit for patients with hyperlipidemia includes the covered benefits listed below with little or no patient cost sharing.
RED - services already implemented or under consideration per November Board meeting presentation.
GREEN - medication specific. "Reduced pharmacy copays" under consideration per Nov. Board presentation for these conditions, but specific drug classes not yet specified.
ORANGE - similar to diabetes, but for other conditions mentioned (e.g., blood sugar test (HgA1c) under consideration for diabetics $0 copay 2 per year, urine test $0 copay once per year (BOT slide 22). Recommend similar high value tests (same administrative complexity) in other conditions in orange (e.g. cholesterol testing for hyperlipidemia).
BLUE - Expanded high value service for selected conditions across entire condition spectrum.

Categories of Covered Benefits							
Clinician Visits	**Diagnostic Testing**	**Medications***	**DME**	**Monitor**	**Physician Extenders**	**Specialists**	**Other**
Primary Care Physician- 2 additional per year	Lipid profile	Statins**		LDL	Dietician	Cardiologist	Hyperlipidemia education covered annually
Physician's Assistant- up to 6	Blood pressure*** - unlimited MA visits	BP meds - encourage combination therapy	BP cuff	BP	MA	Endocrinologist	Dietary consult or counseling
Nurse Practitioner- up to 6	Liver profile					Nephrologist	Incentivize member to complete an action plan
Patient-Centered Medical Home- reduce cost share if NCQA acceditation	Diabetes screening	Fibric acid derivatives/Fibrates					Incentivize member to complete an education program
		Niacin					
		Selective cholesterol absorption inhibitor					
		Bile-acid sequestrants					
	Depression screening	All classes of anti depression meds					
	Tobacco use screening	All classes of meds used for smoking cessation (consider similar benefit for spouse or other coinhabitant)			Behavioral therapist for smoking cessation		Incentivize member to enroll in smoking cessation program
	BMI Screening	Influenza Vaccination					
		Pneumovax Vaccination					
		HBV Vaccination					

*Discuss branded vs. generic drugs, and the difference between generics and therapeutic substitutions
**Strongly push generic statins; if compliant and LDL is still too high, allow Crestor (for someone who fails Lipitor (atorva statin) or Zocor (simva statin))
***The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.

Value Based Insurance Design for Enrollees with Hypertension
Prepared by VBID Health

A clinically nuanced, Value Based Insurance Design benefit for patients with hypertension includes the covered benefits listed below with little or no patient cost sharing.
RED - services already implemented or under consideration per November Board meeting presentation.
GREEN - medication specific. "Reduced pharmacy copays" under consideration per Nov. Board presentation for these conditions, but specific drug classes not yet specified.
ORANGE - similar to diabetes, but for other conditions mentioned (e.g., blood sugar test (HgA1c) under consideration for diabetics $0 copay 2 per year, urine test $0 copay once per year (BOT slide 22). Recommend similar high value tests (same administrative complexity) in other conditions in orange (e.g. cholesterol testing for hyperlipidemia).
BLUE - Expanded high value service for selected conditions across entire condition spectrum.

Categories of Covered Benefits							
Clinician Visits	**Diagnostic Testing**	**Medications***	**DME**	**Monitor**	**Physician Extenders**	**Specialists**	**Other**
Primary Care Physician- 2 additional per year	Blood pressure	BP meds	BP cuff	BP	Dietician	Cardiologist	Hypertension education
Physician's Assistant up to 6	Lipid profile	Statins		LDL		Hypertension Specialist	Incentivize member to complete an action plan
Nurse Practitioner up to 6	Electrolytes						Incentivize member to complete an education program
Patient-Centered Medical Home reduce cost share if NCQA acceditation	Diabetes screening*						
	Depression screening	All classes of anti-depression meds					
	Tobacco use screening	All classes of meds used for smoking cessation (consider similar benefit for spouse or other coinhabitant)			Behavioral therapist for smoking cessation		Incentivize member to enroll in smoking cessation program
	BMI screening	Influenza Vaccination					
		Pneumovax Vaccination					
		HBV Vaccination					

*The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
**Discuss branded vs. generic drugs, and the difference between generics and therapeutic substitutions

Incorporation of Value-Based Insurance Design Principles into the North Carolina State Employee Health Plan

Meeting of the Board of Trustees
January 23, 2015

VBIDHEALTH

NCSHP: Mission

Improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.

VBIDHEALTH

NCSHP:
Guiding Principles

- Improve Affordability
- Improve Members' Health
- Ensure Access to Quality Care
- Incent Member Engagement
- Promote Health Literacy
- Provide Member Choice
- Maintain Financial Stability

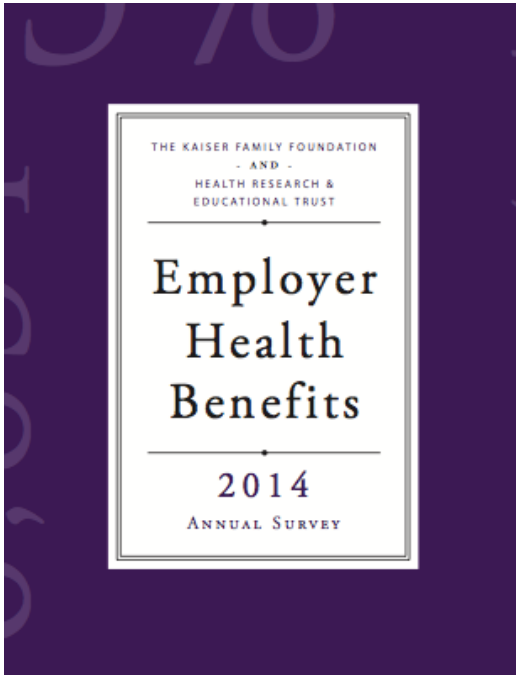
NCSHP
Guiding Principles

Expand Value Based Design Elements

- **Improve Affordability**
- **Improve Members' Health**
- **Ensure Access to Quality Care**
- **Incent Member Engagement**
- **Promote Health Literacy**
- **Provide Member Choice**
- **Maintain Financial Stability**

Motivation for VBID

- **For today, our focus is on costs paid by the member**
- **Ideally cost-sharing levels would be set to encourage the clinically appropriate use of health care services**
- **"One-size-fits-all" cost-sharing fails to acknowledge the differences in clinical value among medical interventions**
- **Despite a slowing in cost growth, consumer contributions are rising**



VBIDHEALTH

Health Affairs 2014. doi: 10.1377/hlthaff.2014.0792

December 9, 2013

Costs Still Keep 30% of Americans From Getting Treatment

Lower-income and younger adults most likely to have delayed treatment

- **A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential care and in some cases leads to greater overall costs**
- **Effects worse in low-income individuals and beneficiaries with chronic illness**

VBIDHEALTH

Goldman D. *JAMA*. 2007;298(1):61–9. Trivedi A. *NEJM*. 2008;358:375-383. Trivedi A. *NEJM*. 2010;362(4):320-8.. Chernew M. J Gen Intern Med 23(8):1131–6.

A New Approach: Clinical Nuance

1. Services differ in clinical benefit produced

2. Clinical benefits from a specific service depend on:

Value-Based Insurance Design

- **Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service**
  - **Reduce or eliminate financial barriers to high-value clinical services**
- **Successfully implemented by hundreds of public and private payers**


WSJ.com THE WALL STREET JOURNAL ONLINE

June 16, 2004

FOLLOW THE MONEY

From 'One Size Fits All' To Tailored Co-Payments

June 16, 2004

University of Michigan researchers say a patient's drug should depend on how much he or she will medication -- a move that would likely lower co

VBIDHEALTH

Evidence Supporting Value-Based Insurance Design: Improving Adherence Without Increasing Costs

- **Improved adherence**
- **Lower consumer out-of-pocket costs**
- **No significant increase in total spending**
- **Reduction in health care disparities**

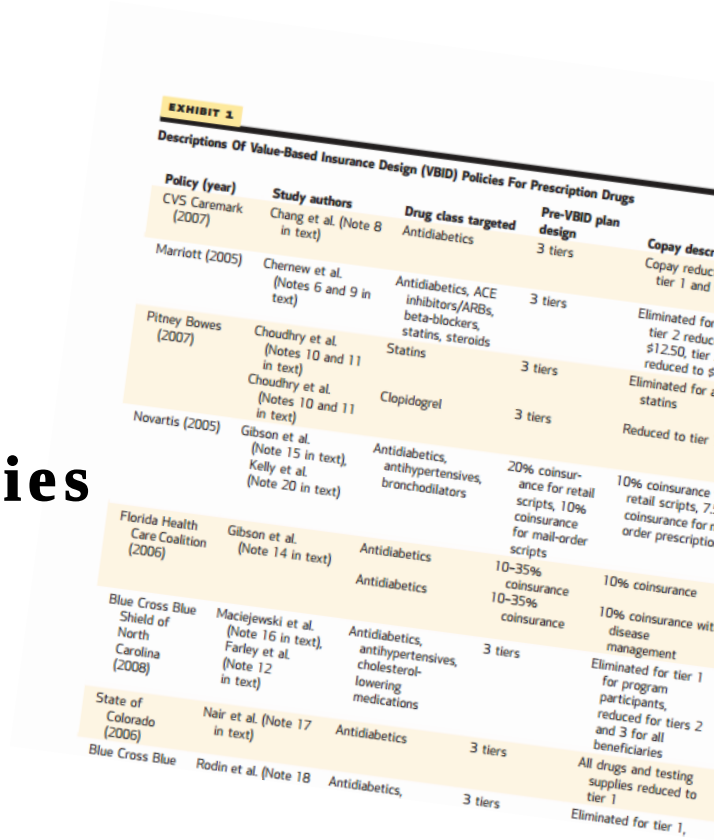


EXHIBIT 1

Descriptions Of Value-Based Insurance Design (VBID) Policies For Prescription Drugs

Policy (year)	Study authors	Drug class targeted	Pre-VBID plan design	Copay descr
CVS Caremark (2007)	Chang et al. (Note 8 in text)	Antidiabetics	3 tiers	Copay reduc tier 1 and
Marriott (2005)	Chernew et al. (Notes 6 and 9 in text)	Antidiabetics, ACE inhibitors/ARBs, beta-blockers, statins, steroids	3 tiers	Eliminated for tier 2 reduc $12.50, tier reduced to $
Pitney Bowes (2007)	Choudhry et al. (Notes 10 and 11 in text)	Statins	3 tiers	Eliminated for statins
	Choudhry et al. (Notes 10 and 11 in text)	Clopidogrel	3 tiers	Reduced to tier
Novartis (2005)	Gibson et al. (Note 15 in text), Kelly et al. (Note 20 in text)	Antidiabetics, antihypertensives, bronchodilators	20% coinsur-ance for retail scripts, 10% coinsurance for mail-order scripts	10% coinsurance retail scripts, 7 coinsurance for order prescriptio
Florida Health Care Coalition (2006)	Gibson et al. (Note 14 in text)	Antidiabetics	10–35% coinsurance	10% coinsurance
		Antidiabetics	10–35% coinsurance	10% coinsurance wit disease management
Blue Cross Blue Shield of North Carolina (2008)	Maciejewski et al. (Note 16 in text), Farley et al. (Note 12 in text)	Antidiabetics, antihypertensives, cholesterol-lowering medications	3 tiers	Eliminated for tier 1 for program participants, reduced for tiers 2 and 3 for all beneficiaries
State of Colorado (2006)	Nair et al. (Note 17 in text)	Antidiabetics	3 tiers	All drugs and testing supplies reduced to tier 1
Blue Cross Blue	Rodin et al. (Note 18	Antidiabetics,	3 tiers	Eliminated for tier 1,

VBIDHEALTH

Lee J. *Health Affairs*.. 2013;32(7):1251-1257

Value-Based Insurance Design
Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- PhRMA
- AHIP
- NBCH
- National Governor's Assoc.
- Academy of Actuaries
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- US Chamber of Commerce

VBIDHEALTH

Lewin. *JAMA*. 2013;310(16):1669-1670

Value-Based Insurance Design Growing Role in State Health Reform

- **State Employees Benefit Plans**
  - **Connecticut**
  - **Oregon**
  - **Virginia**
  - **Minnesota**
  - **Maine**
  - **New York**

V-BID Center brief

EVIDENCE, EXAMPLES, AND INSIGHT ON VALUE-BASED INSURANCE DESIGN

V-BID in Action: A Profile of Connecticut's Health Enhancement Program

Value-Based Insurance Design (V-BID)—hailed as a "game changer" by the National Coalition on Health Care—refers to insurance designs that vary consumer cost-sharing to distinguish between high-value and low-value health care services and providers. V-BID entails (1) reducing financial barriers that deter use of evidence-based services and high-performing providers, and (2) imposing disincentives to discourage use of low-value care. Through the incorporation of greater clinical nuance in benefit design, payers, purchasers, taxpayers, and consumers can attain more health for every dollar spent. The University of Michigan Center for V-BID leads in research, development, and advocacy for innovative health benefit plans and payment reform initiatives.

Connecticut Seeks to Improve Health and Contain Costs

The State of Connecticut faced a projected budget gap of $3.8 billion in fiscal year 2012, and state employees were asked to help address the shortfall. The Governor's Office and a coalition of unions representing state employees met throughout 2011 to discuss a wide range of topics, including the health plan covering active and retired state employees. The parties focused health care discussions on possibilities for improving health as a means to control long-term costs. Discussions involving unions, the

The Key Features of HEP

Prior to 2012, Connecticut's state employee health plan did not distinguish between high-value services and low-value services in determining cost-sharing for beneficiaries. HEP is different.

Accountability. HEP rewards state employees, select retirees, and dependents who commit to a number of responsibilities. The "ask" of beneficiaries is as follows:

- Obtain specified age and gender-appropriate health risk assessments, evidence-based screenings, and physical and vision examinations;
- Undergo two dental cleanings per year;[a] and
- Participate in condition-appropriate chronic disease management services.[b]

Specified guideline-based clinical services are required of HEP enrollees with diabetes, high cholesterol, high blood pressure, heart disease, asthma, and chronic obstructive pulmonary disorder (COPD). There are provisions to exempt enrollees with unusual or special circumstances from requirements as appropriate.

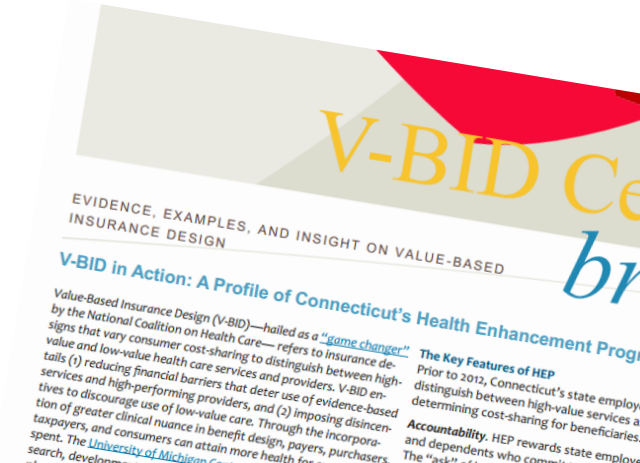
Beneficiaries may be disenrolled from HEP if they do not adhere to the requirements outlined above. HEP strives to avoid this

VBIDHEALTH

Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

- **Participating employees receive a reprieve from higher premiums ($100/month) if they commit to:**
  - **Yearly physicals, age-appropriate screenings/preventive care, free dental cleanings**
  - **If employees have one of five chronic conditions, they must participate in disease management programs (which include free office visits and lower drug co-pays)**

VBIDHEALTH


V-BID Ce
EVIDENCE, EXAMPLES, AND INSIGHT ON VALUE-BASED INSURANCE DESIGN
br
V-BID in Action: A Profile of Connecticut's Health Enhancement Progr
Value-Based Insurance Design (V-BID)—hailed as a "game changer" by the National Coalition on Health Care— refers to insurance designs that vary consumer cost-sharing to distinguish between high-value and low-value health care services and providers. V-BID entails (1) reducing financial barriers that deter use of evidence-based services and high-performing providers, and (2) imposing disincentives to discourage use of low-value care. Through the incorporation of greater clinical nuance in benefit design, payers, purchasers, taxpayers, and consumers can attain more health for
spent. The University of Michigan
search, develop
The Key Features of HEP
Prior to 2012, Connecticut's state employ
distinguish between high-value services a
determining cost-sharing for beneficiaries.
Accountability. HEP rewards state employ
and dependents who comm
The "ask"

Connecticut State Employees Health Benefit Plan Positive Year 1 Results

Relative to enrollees in state employee health plans in four other states that did not have a comparable intervention, preventive services rose:

- **receipt of at least one preventive office visit - 11.7%,**
- **colonoscopy - 4.2%**
- **fecal occult screening - 3.6%**
- **mammography - 7.1%**
- **pap smear - 4.9%**
- **lipid screen - 13.2%.**

Among chronic condition cohorts, use of recommended services rose 3.1-9.5%

Current Plan Offerings

- **Enhanced 80/20, 52% of membership,**
- **Traditional 70/30, 45% of membership,**
- **CDHP (with HRA), 3% of membership**

VBIDHEALTH

Guiding Principles

- Improve Affordability
- Improve Members' Health
- Ensure Access to Quality Care
- Incent Member Engagement
- Promote Health Literacy
- Provide Member Choice
- Maintain Financial Stability
- Expand Value Based Design Elements
- Plan Differentiation

VBIDHEALTH

Summary of Recommendations Enhanced VBID in CDHP

- Approve existing VBID elements
- Review and endorse incremental VBID elements under consideration
- Recommend additional elements that have synergy with other ongoing transformation activities

VBIDHEALTH

Potential Progression of Value-Based Insurance Design CDHP

2016

- Preventive services with no cost-sharing (ACA)
- Premium credits tied to wellness activities
- Incentives to choose PCP
- Steerage to Blue Option high- performing providers
- Deductible-exempt chronic disease medications (standard co-insurance)
- HRA credits for engaging in health management activities
- Select services with $0 cost-sharing:
  - diabetes, asthma, or hypertension :
    - 2 additional PCP visits
  - diabetes:
    - HbA1c test (2/yr)
    - microalbumin test (1/yr)
    - Certified Diabetes Educator visits
    - Access to Diabetes Primary Prevention program

2017

- Enhance existing VBID elements in place and under consideration
  - Broaden diabetes health engagement program to include additional metrics (e.g. eye exams)
- Add selected high value services (e.g. diagnostic tests) for clinical conditions in addition to diabetes (e.g. asthma, hyperlipidemia) with similar administrative complexity
  - LDL testing
  - Asthma action plan
- Consider reducing co-insurance levels for high-value drug classes that are deductible-exempt
- Consider cost-sharing reductions for NCQA certified PCMH providers

2018

- Optimize member engagement and plan selection based on benefit value
- Align consumer engagement initiatives with payment reform efforts
- Better utilize wellness, satisfaction and claims data to refine plan offerings
- Expand high value service for selected conditions across entire spectrum of care

VBIDHEALTH

Progression of Value-Based Insurance Design
2016 – Approve Existing VBID elements

- Preventive services with no cost-sharing (ACA)
- Premium credits tied to wellness activities
- Incentives to choose PCP
- Steerage to Blue Option high-performing providers
- Deductible-exempt chronic disease medications (standard co-insurance)

Progression of Value-Based Insurance Design 2016 – Endorse VBID Elements under Consideration

- HRA credits for engaging in health management activities
- Select services with $0 cost-sharing:
  - Diabetes, Asthma, or Hypertension:
    - 2 additional PCP visits
  - Diabetes:
    - HbA1c test (2/yr)
    - Microalbumin test (1/yr)
    - Certified Diabetes Educator visits
    - Access to Diabetes Primary Prevention Program

VBIDHEALTH

VBID Progression: 2017 – Enhance Existing VBID Elements in Place and under Consideration

- Consider broadening diabetes health engagement program to include additional services (e.g. eye exams)
- Consider adding selected high value services (e.g. diagnostic tests) for clinical conditions in addition to diabetes (e.g. asthma, hyperlipidemia) with similar administrative complexity
  - LDL testing
  - Asthma action plan
- Consider reducing co-insurance levels for high-value drug classes that are deductible-exempt
- Consider cost-sharing reductions for NCQA certified PCMH providers

VBID Progression: 2018 – Expand VBID and Align with Broader Health Transformation Initiatives

- Consider expand high value services for selected conditions across entire spectrum of care
- Better utilize wellness, satisfaction and claims data to refine plan offerings
- Optimize member engagement and plan selection based on benefit value
- Align consumer engagement initiatives with payment reform efforts

VBIDHEALTH

Discussion

Proposed changes to plan options, benefit designs, healthy activities, premiums & credits referenced in this presentation are subject to approval by the Board of Trustees

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Proposed 2016 Benefit Design Changes

Board of Trustees Meeting

January 23, 2015

Presentation Overview

- Strategy and Vision
- Proposed Benefit Design Changes
- Engaging Members
- Impact on Actuarial Forecast
- Member Cost Sharing Scenarios
- Discussion
- Appendix

This presentation is primarily focused on plan options for Active Employees and Non-Medicare Retirees due to timing of Medicare Advantage rate renewals.

State Health Plan Mission and Guiding Principles

Mission

Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.

Elements of the Strategic Plan & Guiding Principles

- Ensure Access to Quality Care
- Expand Value-Based Design Elements
- Improve Affordability
- Improve Members' Health
- Incent Member Engagement
- Maintain Financial Stability
- Promote Health Literacy
- Provide Member Choice

Wellness Benefit Design: Premium Credits and Incentives

2014 & 2015: Where We Have Been

- Encouraged member engagement through incentives and rewards:
  - Reduced premium for completing healthy activities
  - Reduced copays or additional health reimbursement account (HRA) funds for visiting member's selected primary care provider (PCP) or a Blue Options Designated specialist or hospital
  - Waived deductible for certain chronic disease medications in the Consumer-Directed Health Plan (CDHP)

2016 & 2017: Where We Are Going

- Continue or increase incentives and rewards from previous years
- Offer new programs and incentives to further reduce cost share for members diagnosed with asthma, COPD, diabetes, cardiovascular disease
- Promote programs to support healthy lifestyles and offer incentives to complete fitness, nutrition or other healthy milestones

Value-Based Insurance Design (VBID) Concept

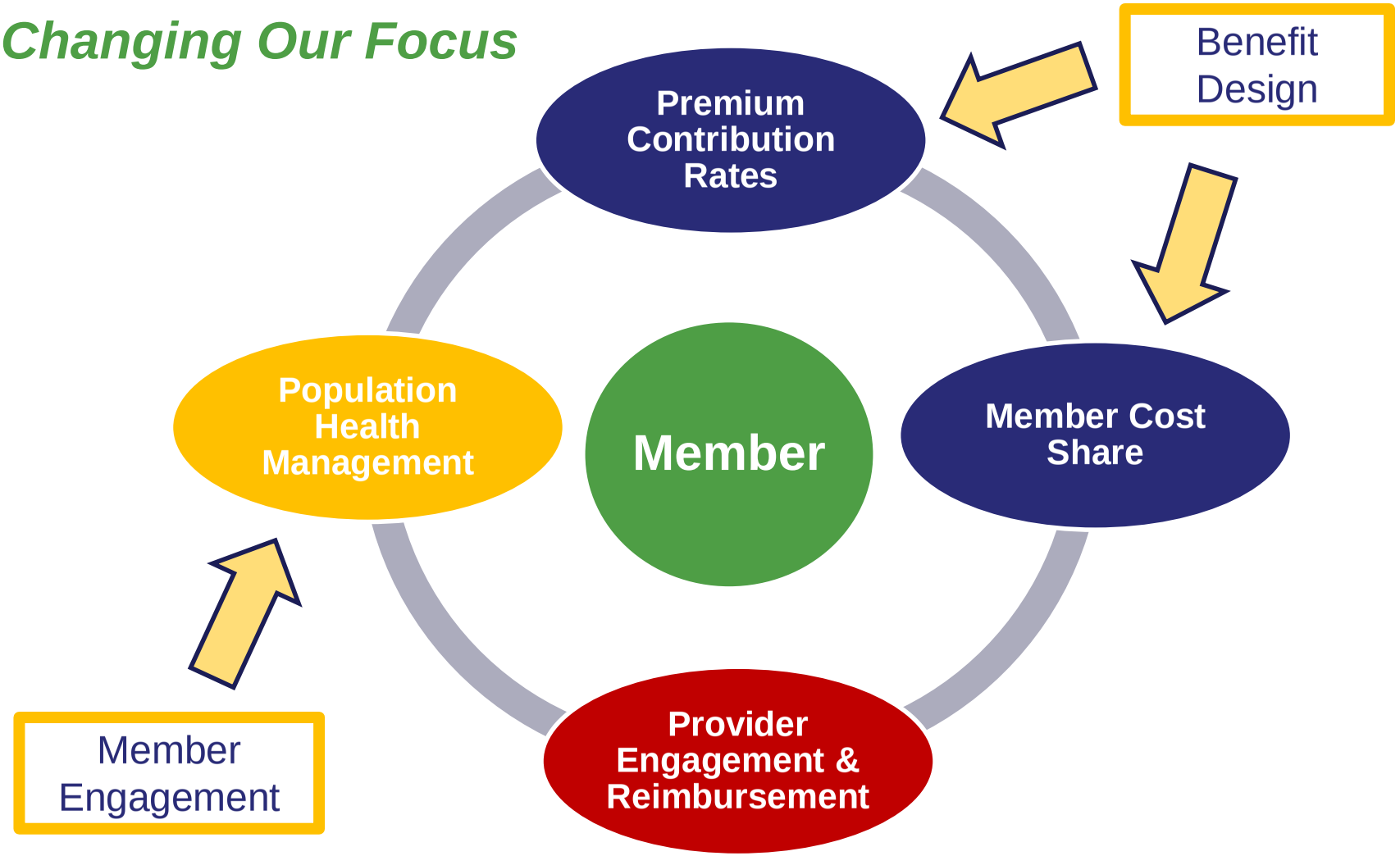
- Contracted with Value-Based Insurance Design (VBID) experts to help incorporate value-based design elements into plan options
- Focuses on how health care dollars are spent:

  From "How Much" to "How Well"

- Lower member cost share for services that have high clinical value
  - Office visits or medications for members with a chronic disease covered at a reduced cost share
- Increased cost share for services that have low clinical value
  - Non-evidence based or wasteful services, such as expensive testing for low back pain, would have a higher member cost share

Financing the Health Benefit & Bending the Cost Curve

Changing Our Focus



The Value of the Consumer-Directed Health Plan

Consumer-Directed Health Plan (CDHP) with HRA Features

- 85/15 Coinsurance
- $1,500 Deductible (employee only)
- $500 in Health Reimbursement Account (HRA) funds to help offset the deductible
- $0 premium by completing wellness activities
- Additional HRA funds for visiting certain providers
- $0 ACA Preventive Services
- $0 ACA Preventive Medications
- CDHP Preventive Medication List ($0 deductible)
- Maximum Out-of-Pocket includes medical and pharmacy expenses

- CDHP is already the richest plan option
- 16% difference in relative value of richest plan (CDHP) and least rich plan (Traditional 70/30)
- Proposing enhancements to the CDHP by incorporating more value-based benefit design elements to lower the member cost share for certain services

How the Consumer-Directed Health Plan Works

Member Presents ID Card at Doctor's Office → Office submits claim of $175, which applies to the deductible

Doctor's Office Submits Claim → Since member has funds in HRA account, payment will be sent to provider → If member went to the PCP on their ID card, $15 will be added to their HRA account

Member Presents ID card at Pharmacy → Since the deductible hasn't been met, member pays in full for prescription ($65) at the Pharmacy **or** If prescription is for a CDHP preventive medication, member pays $9.75 (15% coinsurance, deductible exempt/waived)

Pharmacy Submits Claim → Since HRA funds are available, member is reimbursed $65 **or** If prescription is for a CDHP preventive medication, member is reimbursed $9.75 in a couple of weeks

Member Deductible		w/ CDHP Rx
Beginning Deductible	$1,500	$1,500
Office Visit	($175)	($175)
Rx	($65)	n/a
Remaining Deductible	$1,260	$1,325

HRA Balance		w/ CDHP Rx
Beginning Balance	$500	$500
Office Visit	($175)	($175)
PCP Credit	$15	$15
Rx	($65)	($9.75)
Remaining Balance	$275	$330.25

Proposed
Benefit Design Changes

Summary of Proposed Benefit Design Changes

Consumer-Directed Health Plan (CDHP) with HRA

- Increase premium approximately $40 with the opportunity to earn it down to $0
- Modify healthy activities to earn premium credits
- Increase HRA contribution by $100 to help offset member cost share
- Increase out-of-pocket max by $500
- Establish Health Engagement Program to earn additional contributions to HRA:
  - Increase credits for PCP visits and use of Blue Options Designated Providers
  - Target members with chronic conditions
  - Healthy lifestyle program for all members

Enhanced 80/20 Plan

- Increase premium approximately $40 with the opportunity to earn it down to approximately $15
- Modify healthy activities to earn premium credits
- Increase Tier 5 (non-preferred specialty medications) pharmacy coinsurance maximum

Traditional 70/30 Plan

Active Employees Only

- Establish a $60 premium with the opportunity to earn it down to approximately $20
- Establish healthy activity to earn premium credit:
  - Tobacco attestation

Active Employees and Retirees

- Increase member cost share
  - copays, deductible, coinsurance max, and pharmacy out-of-pocket max

Premium amounts referenced on this slide are estimates and subject to change pending final benefit design, actuarial forecast and Board approval

Rationale for CDHP Benefit Recommendation

Proposed Change	Rationale	Strategic Plan Elements Addressed
Increase Premiums, Employee Only Premium can be Earned Down to Zero	• The Board's original Wellness Design strategy assumed increases in premiums over time to coincide with increases in premium credits. • The Board, employees and other stakeholders have expressed a strong desire in maintaining a premium-free plan option.	• Incent Member Engagement • Improve Affordability • Provide Member Choice • Maintain Financial Stability
Modify Healthy Activities and Premium Credits	• The Board's original Wellness Design strategy assumed increases in premium credits and the evolution of healthy activities over time. • Provides a significant financial reward for employees/non-Medicare retirees who complete all wellness activities. • The progression of activities establishes a process for improving members' health through increased engagement.	• Incent Member Engagement • Promote Health Literacy • Improve Members' Health • Provide Member Choice • Maintain Financial Stability
Increase Out-of-Pocket (OOP) Maximum Increase Annual Contribution to HRA Increase Opportunities to Earn Additional HRA Funds Implement Health Engagement/Secondary Prevention Program	• To ensure financial stability of the benefit plans over the long term the Plan must be willing to increase member cost share to keep pace with medical inflation and cost increases, but also do so in a strategic manner. • The CDHP will still have the lowest out-of-pocket maximum and additional HRA funds will be provided to help offset the OOP increase. • The OOP maximum has not changed in two years and unused HRA balances remaining at year-end carry over to the next plan year. • Members will earn higher HRA credit amounts for PCP visits and utilizing Blue Options Designated providers to incent engagement with their PCP and use of high quality, low cost providers. • Members with chronic conditions can earn additional HRA credits for engaging in secondary prevention, adhering to their medications, and engaging with the Plan to help offset the cost of managing their condition. • Members can earn HRA credits for participating in healthy lifestyle programs.	• Maintain Financial Stability • Incent Member Engagement • Promote Health Literacy • Expand Value-Based Design Elements • Improve Affordability • Improve Members' Health • Ensure Access to Quality Care • Provide Member Choice

Rationale for Enhanced 80/20 Benefit Recommendation

Proposed Change	Rationale	Strategic Plan Elements Addressed
Increase Premiums, Employee Only Premium can be Earned Down	• The Board's original Wellness Design strategy assumed increases in premiums over time to coincide with increases in premium credits. • Premiums will continue to increase as indicated by actuarial forecasts, consistent with the recent approach to the Enhanced 80/20 plan.	• Incent Member Engagement • Improve Affordability • Provide Member Choice • Maintain Financial Stability
Modify Healthy Activities and Premium Credits	• The Board's original Wellness Design strategy assumed increases in premium credits and the evolution of healthy activities over time. • Provides a significant financial reward for employees/non-Medicare retirees who complete all wellness activities. • The progression of activities establishes a process for improving members' health through increased engagement.	• Incent Member Engagement • Promote Health Literacy • Improve Members' Health • Provide Member Choice • Maintain Financial Stability
No Changes to Medical Cost Sharing	• Maintaining the current benefit structure provides members with a familiar option while continuing to incent engagement with their selected PCP and utilization of Blue Options Designated providers.	• Incent Member Engagement • Promote Health Literacy • Improve Affordability • Improve Members' Health • Ensure Access to Quality Care • Provide Member Choice
Increase Tier 5 Pharmacy Copay (non-preferred specialty medications)	• Specialty pharmacy is the fastest growing cost for the State Health Plan. • The Board originally approved a higher coinsurance maximum for Tier 5 medications, but the amount was later reduced to maintain Grandfather status under the Affordable Care Act. • The increase is allowable under the ACA and is consistent with the Plan's original strategy. • Incents members to use Tier 4 medications and help manage the long-term pharmacy trend.	• Maintain Financial Stability • Promote Health Literacy

Rationale for Traditional 70/30 Benefit Recommendation

Proposed Change	Rationale	Strategic Plan Elements Addressed
Active Employees Only Establish a Premium for Employee Only Coverage that can be Earned Down	• To ensure financial stability of the benefit plans over the long term the Plan must be willing to increase member cost share to keep pace with medical inflation and cost increases, but also do so in a strategic manner. • Allows the Plan to maintain a "low engagement" option for members who prefer to not to engage with the Plan. • Provides a financial incentive to consider selecting a richer benefit option that includes incentives to improve health and reduce out of pocket costs.	• Incent Member Engagement • Provide Member Choice • Promote Health Literacy • Maintain Financial Stability
Active Employees Only Establish Tobacco Attestation Premium Credit	• Increased costs associated with tobacco use are well-documented. • Consistent with the Plan's strategy to improve members' health through incentives, promotes consistency across plans by requiring some level of engagement in all benefit options, and expands and reinforces the philosophy that on-going engagement across all plan options is necessary to achieve the Plan's strategic priorities.	• Incent Member Engagement • Promote Health Literacy • Improve Members' Health • Provide Member Choice • Maintain Financial Stability
Increase Member Cost Share for Medical and Pharmacy Services	• To ensure financial stability of the benefit plans over the long term the Plan must be willing to increase member cost share to keep pace with medical inflation and cost increases, but also do so in a strategic manner. • Provides a financial incentive to consider selecting a richer benefit option that includes lower out-of-pocket costs and incentives to improve health and further reduce out-of-pocket costs.	• Provide Member Choice • Promote Health Literacy • Maintain Financial Stability

Proposed Plan Design Changes

	70/30 Current	70/30 2016 Proposed	80/20 Current /Proposed	CDHP Current	CDHP Proposed
Annual Contribution to Health Reimbursement Account (HRA)	N/A	**N/A**	N/A	$500 Individual $1,500 Family	**$600 Individual $1,800 Family**
Annual Deductible	$933 Individual $2,799 Family	**$1,054 Individual $3,162 Family**	$700 Individual $2,100 Family	$1,500 Individual $4,500 Family	$1,500 Individual $4,500 Family
Coinsurance Maximum	$3,793 Individual $11,379 Family	**$4,282 Individual $12,846 Family**	$3,210 Individual $9,630 Family	N/A	N/A
Out-of-Pocket (OOP) Maximum	N/A	**N/A**	N/A	$3,000 Individual $9,000 Family	**$3,500 Individual $10,500 Family**
Pharmacy Out-of-Pocket Maximum	$2,500	**$3,294**	$2,500	Included in OOP	Included in OOP
Preventive Care	$35 PCP $81 Specialist	**$39 PCP $92 Specialist**	$0 ACA Services	$0 ACA Services	$0 ACA Services
PCP Visit	$35	**$39**	$30 for primary doctor; $15 if you use PCP on ID card	15% after deductible; $15 added to HRA if you use PCP on ID	**15% after deductible; $25 added to HRA if you use PCP on ID**
Specialist Visit	$81	**$92**	$70 for specialist; $60 if you use Blue Options Designated specialist	15% after deductible; $10 added to HRA if you use Blue Options Designated specialist	**15% after deductible; $20 added to HRA if you use Blue Options Designated specialist**
Urgent Care	$87	**$98**	$87	15% after deductible	15% after deductible
Chiro/PT/OT	$64	**$72**	$52	15% after deductible	15% after deductible
Emergency Care	$291, then 30% after deductible	**$329, then 30% after deductible**	$233, then 20% after deductible	15% after deductible	15% after deductible
Inpatient Hospital	$291, then 30% after deductible	**$329, then 30% after deductible**	$233 copay, then 20% after deductible; copay not applied if you use Blue Options Designated hospital	15% after deductible; $50 added to HRA if you use Blue Options Designated hospital	**15% after deductible; $200 added to HRA if you use Blue Options Designated hospital**

Proposed Plan Design Changes

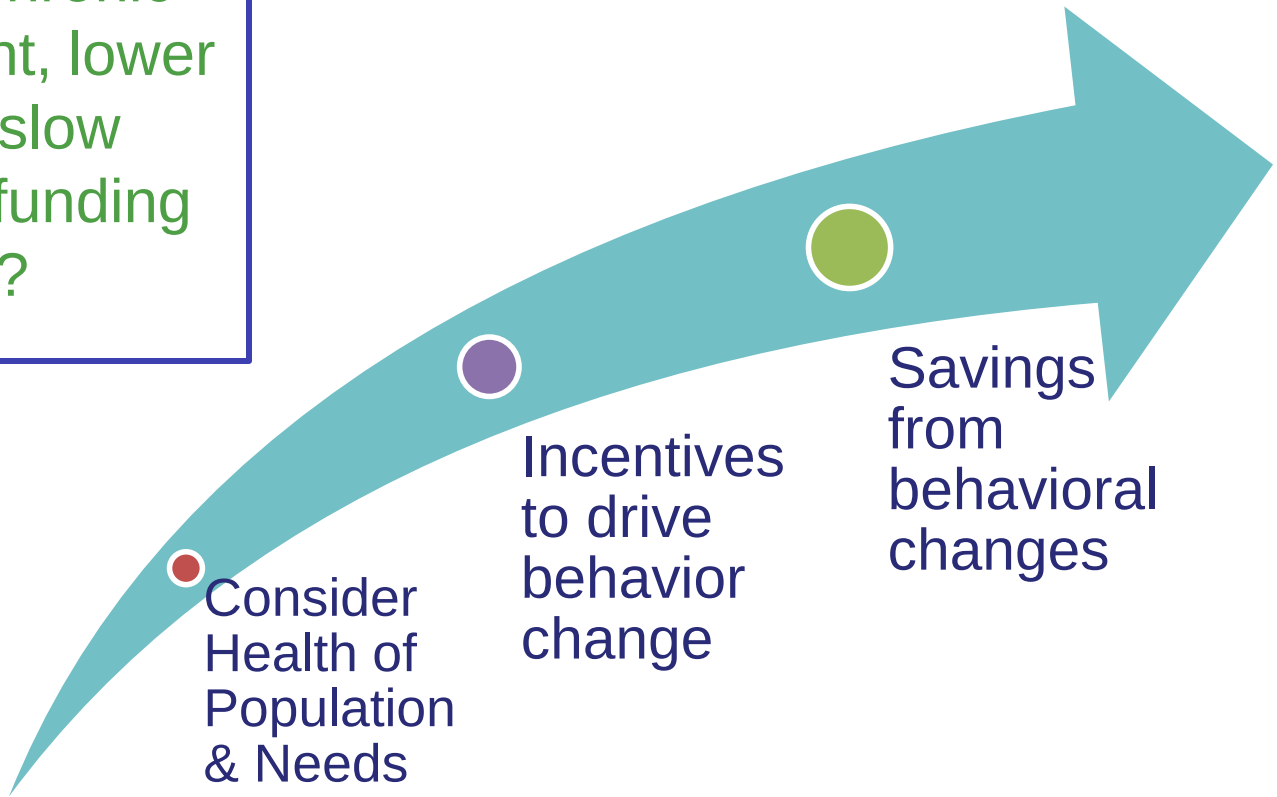
	70/30 Current	70/30 2016 Proposed	80/20 Current	80/20 2016 Proposed	CDHP Current	CDHP 2016 Proposed
Pharmacy Benefit						
Tier 1	$12	**$15**	$12	$12	15% after deducible for in network benefits, 35% after deductible out of network	15% after deducible for in network benefits, 35% after deductible out of network
Tier 2	$40	**$46**	$40	$40		
Tier 3	$64	**$72**	$64	$64		
Tier 4	25% up to $100	25% up to $100	25% up to $100	25% up to $100		
Tier 5	25% up to $125	**25% up to $132**	25% up to $125	**25% up to $132**		
OOP	$2,500 Rx Only	**$3,294 Rx Only**	$2,500 Rx Only	$2,500 Rx Only	Integrated with Medical	Integrated with Medical
ACA Preventive Medications	No	No	Covered 100%	Covered 100%	Covered 100%	Covered 100%
CDHP Preventive Medications	N/A	N/A	N/A	N/A	Waive deductible, 15% coinsurance only	Waive deductible, 15% coinsurance only
Grandfather Status	Grandfathered	Grandfathered	Grandfathered	Grandfathered	Non-Grandfathered	Non-Grandfathered

Engaging Members

Health Engagement Program

Adapted From SEGAL

How can benefit design elements be used to promote healthy lifestyles, chronic disease management, lower cost trends, and slow increases in future funding requirements?



Health Engagement Program

All Members Enrolled in CDHP

Create and promote awareness and engagement with Plan benefit and resources

- Promote and incent healthy lifestyle choices
- Earn HRA funds for completion of milestone activities
  - Nutrition, fitness and other wellness program offerings

Health Engagement Program

CDHP Members with Chronic Conditions

Improve management of members with certain chronic conditions by promoting and incenting engagement

- Target members with the following chronic conditions:
  - Diabetes
  - Asthma/COPD
  - Cardiovascular diseases (Hypertension, Hyperlipidemia, Coronary Artery Disease and Congestive Heart Failure)
- Earn HRA funds for completion of milestone activities
  - Engagement with a health coach twice in a 12 month period (high risk members follow guidance of health coach for additional engagement)
  - Completion of Health Assessment and submission of biometric measures
  - Completion of clinical care requirements recommended for each condition

Proposed Healthy Activities & Premium Credits

2016

Healthy Activity	CDHP	Enhanced 80/20	Traditional 70/30
Non-Tobacco User or QuitlineNC Enrollment	$40	$40	$40
PCP Selection and PCMH Module	$20	$25	N/A
Health Assessment with Self-reported Biometrics	$20	$25	N/A
Total Credits Available	$80	$90	$40

2017

Healthy Activity	CDHP	Enhanced 80/20	Traditional 70/30
Non-Tobacco User or QuitlineNC Enrollment	$40	$40	$40
PCMH Selection	$20	$25	N/A
Health Assessment with Provider-reported Biometrics	$20	$25	N/A
Total Credits Available	$80	$90	$40

2018

Healthy Activity	CDHP	Enhanced 80/20	Traditional 70/30
Non-Tobacco User or QuitlineNC Enrollment	$60	$60	$60
PCMH Selection	TBD	TBD	N/A
Health Engagement Program	TBD	TBD	N/A
Other Activity(ies)	TBD	TBD	N/A
Total Credits Available	$120	$130	$60

Changes to healthy activities, premiums & credits are subject to approval by the Board of Trustees

Impact on Actuarial Forecast

Baseline Model – Status Quo

Major Plan Design Features

- Plan benefits do not change from current design
- Wellness premiums remain at $40, same premium credits available
- Traditional 70/30 Plan employee premium stays at $0 with no wellness premiums and credits
- No changes in member cost-sharing

Projected Member Impact

- Membership remains relatively stable
- Engagement opportunities and incentives do not change
- Members electing Traditional 70/30 Plan can continue to be non-engaged without further consequences

Financial Impact

- 2016 and 2017 premium increases of 5.05%
- General Funds Needed: $50.2m in FY 2015-16; $152.5m in FY 2016-17

2013 Board Approved Wellness Design

Major Plan Design Features

- Wellness Design expanded to Traditional 70/30 Plan
  - 100% coverage of preventive services
  - Wellness premium structure and credits for Active Employees
- Wellness premiums and credits increase by $40 in Enhanced 80/20 Plan and CDHP
- Traditional 70/30 Plan employee premium can be earned down to $0
- No changes in member cost-sharing

Projected Member Impact

- Members migrate out of the Traditional 70/30 Plan
- Greater member engagement generated through overlay of the wellness design on the Traditional 70/30 Plan

Financial Impact

- 2016 and 2017 premium increases of 5.05%
- General Funds Needed: $50.2m in FY 2015-16; $152.7m in FY 2016-17

Staff Recommendation

Major Plan Design Features

- Smoker surcharge/credit of $40 added to the Traditional 70/30 Plan for Active Employees
- Base employee premium of $20 added to the Traditional 70/30 Plan
- Wellness premiums and credits increase by $40 in Enhanced 80/20 Plan and CDHP
- Increase member cost-sharing in the Traditional 70/30 Plan
- Increase out of pocket maximum in CDHP, but HRA starting balance is also increased and members have additional engagement opportunities

Projected Member Impact

- Members migrate out of the Traditional 70/30 Plan; many enroll in CDHP
- Greater member engagement generated through the value differential

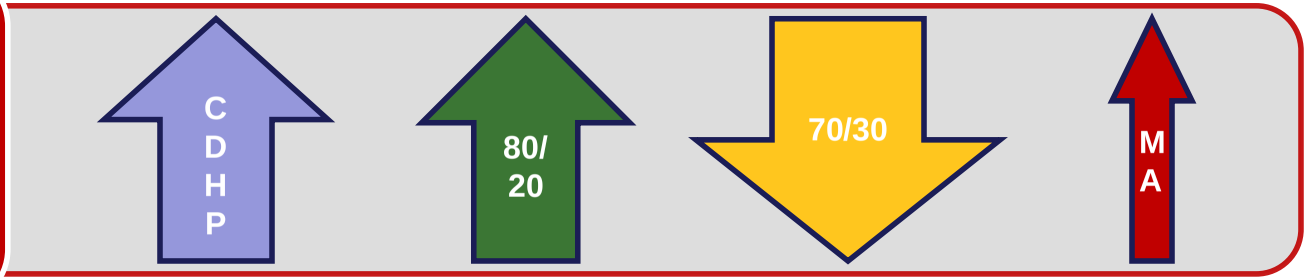
Financial Impact

- 2016 and 2017 premium increases of 4.53%
- General Funds Needed: $45.0m in FY 2015-16; $136.5m in FY 2016-17

Projected Member Migration: Projected Changes in Membership

Baseline:
Very modest movement

2013 Board Wellness Design:
Some movement expected among Active Employees



Staff Recommendation:
More significant movement out of 70/30 and into CDHP and Medicare Advantage

Wider arrows indicate projection of greater movement

Major Cost and Savings Drivers
Staff Recommendation

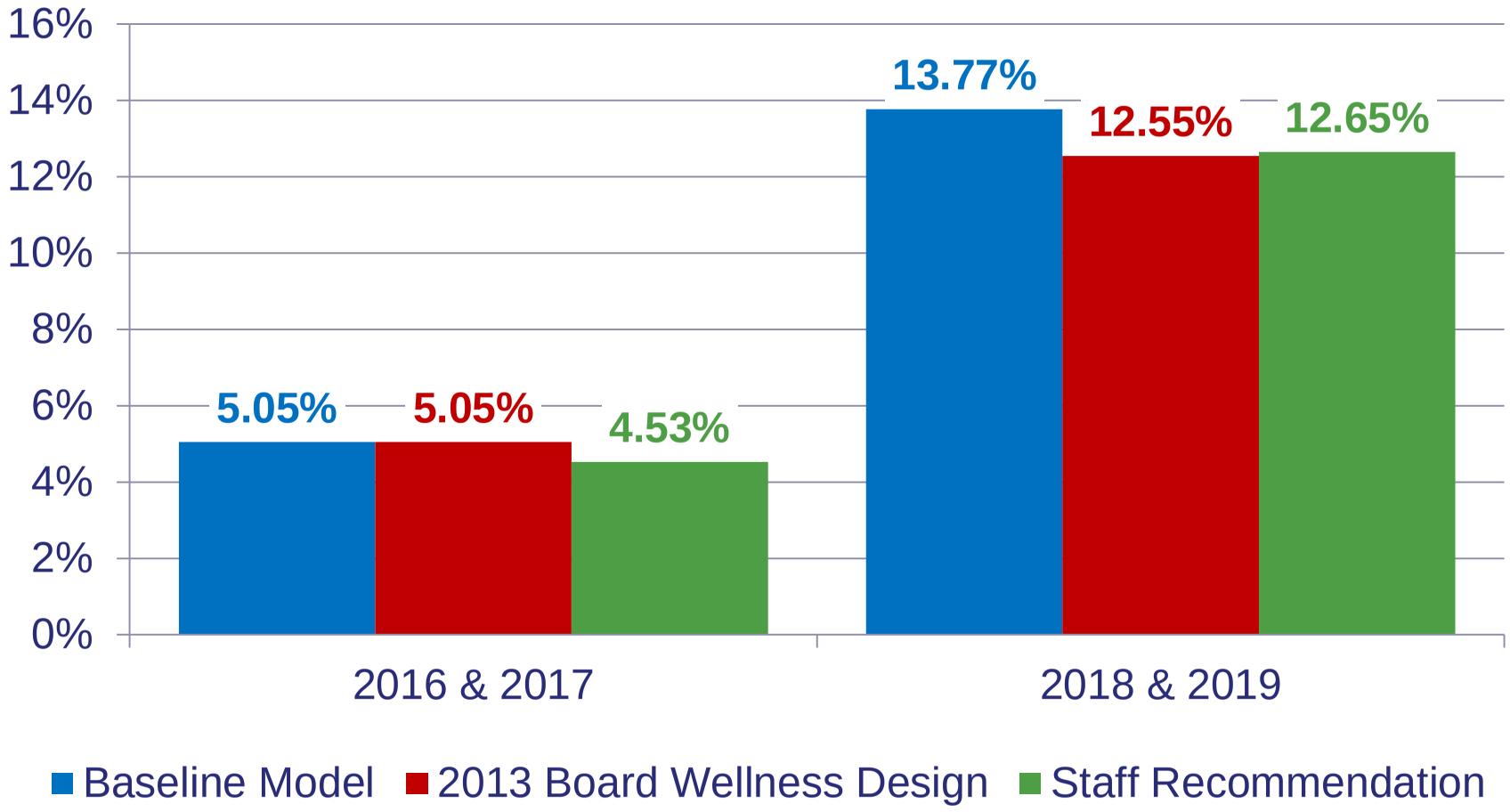
Cost Drivers

- Richer CDHP plan design (approximately 2.7% richer)
- Movement away from Traditional 70/30 Plan to Enhanced 80/20 and CDHP plan options, which provide richer benefits to members (i.e. the Plan pays a higher percentage of total claims costs under those options)

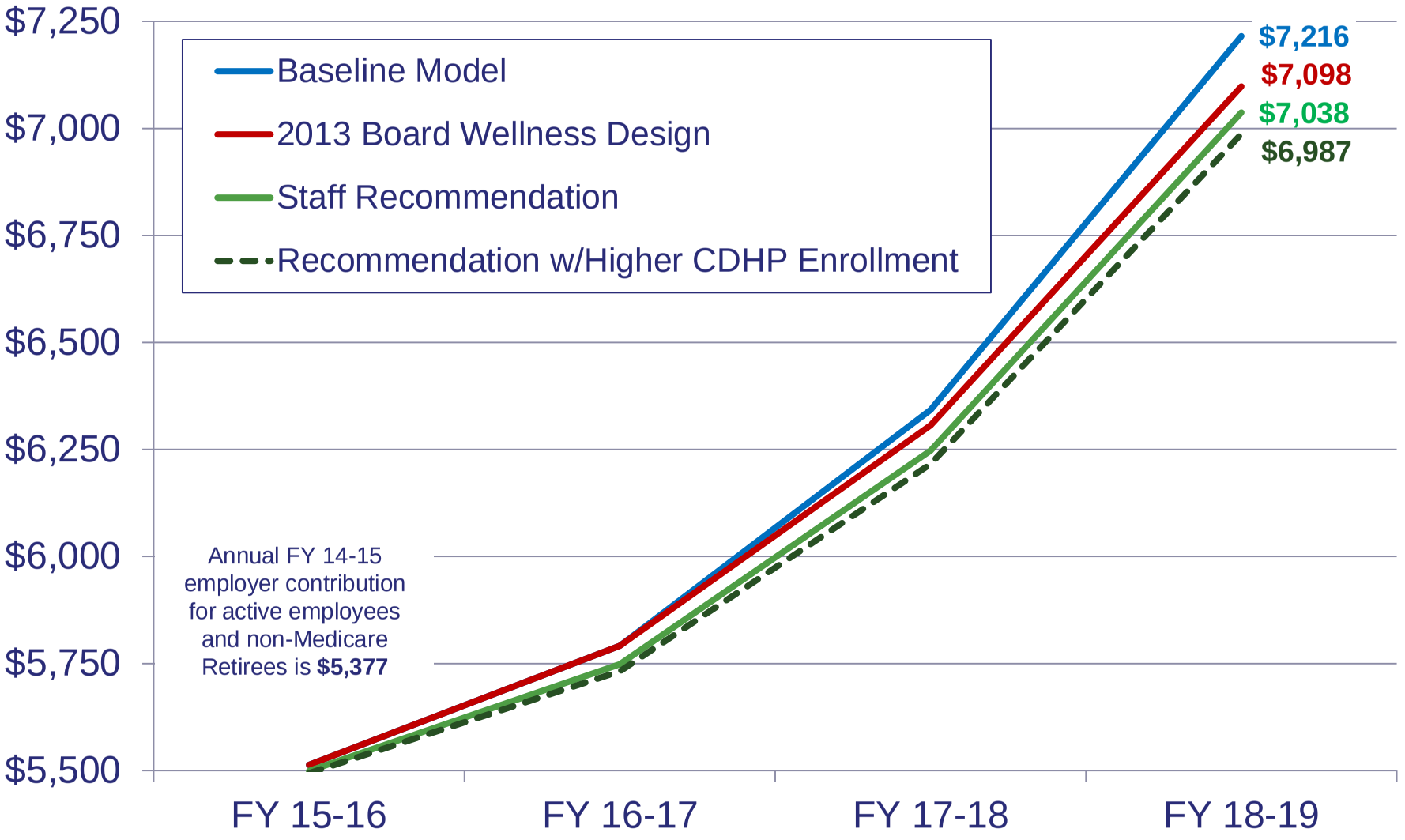
Savings Drivers

- Increased member cost-sharing in Traditional 70/30 Plan
- Movement of Medicare members away from Traditional 70/30 Plan and to Medicare Advantage plans
- Potential behavior changes when moving to the CDHP
- Increased premium receipts from members who do not complete healthy activities/earn premium credits
- Members are healthier, more engaged, and better informed consumers who purchase more value-based health care services

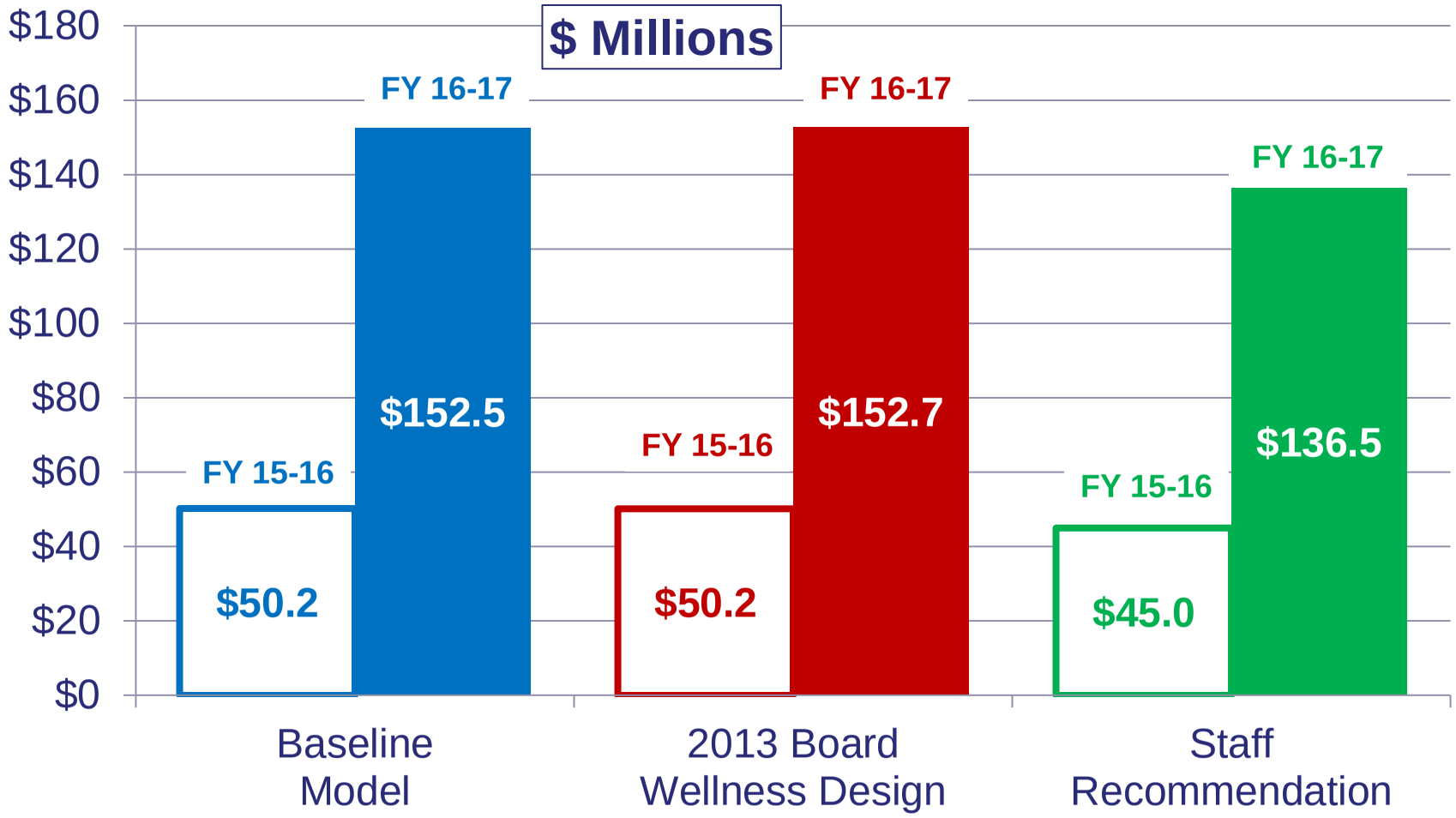
Annual Premium Increases
January 1st of Each Year



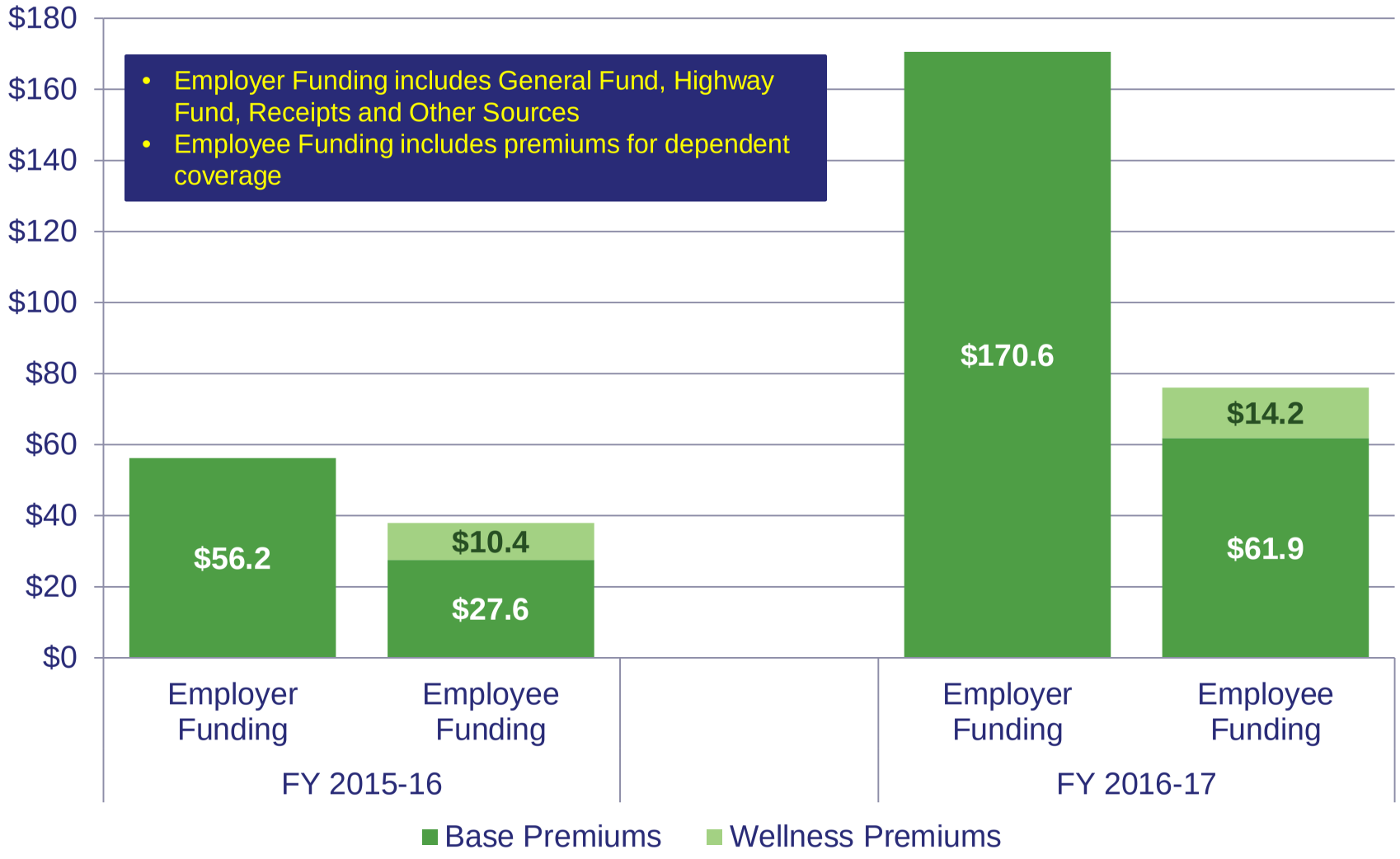
Annual Employer Contributions
Active Employees and Non-Medicare Retirees



General Fund Increases
2015-2017 Fiscal Biennium



Projected Increases in Employer and Employee Contributions Staff Recommendation



Wellness Premium Credits – Consumer Directed Health Plan

Active Employee/Non-Medicare Retiree Only Coverage

Wellness Design	2014	2015	2016	2017
Estimated Employee/Retiree Premium	**$40**	**$40**	**$80**	**$80**
Monthly Earnable Premium Credits	**2014**	**2015**	**2016**	**2017**
Healthy Activity #1: Non-Tobacco User or QuitlineNC Enrollment	$20	$20	$40	$40
Healthy Activity #2: Choose PCP, complete PCMH Module/Select PCMH	$10	$10	$20	$20
Healthy Activity #3: Personal Health Assessment w/ Biometrics	$10	$10	$20	$20
Total Available Monthly Premium Credits	**$40**	**$40**	**$80**	**$80**
Net Employee/Retiree Premium With All Credits	**$0**	**$0**	**$0**	**$0**

Premium and credit amounts referenced on this slide are estimates and subject to change pending final benefit design, actuarial forecast and Board approval

Wellness Premium Credits – Enhanced 80/20 Plan

Active Employee/Non-Medicare Retiree Only Coverage

Wellness Design	2014	2015	2016	2017
Estimated Employee/Retiree Premium	**$63.56**	**$63.56**	**$104.64**	**$105.76**
Monthly Earnable Premium Credits	**2014**	**2015**	**2016**	**2017**
Healthy Activity #1: Non-Tobacco User or QuitlineNC Enrollment	$20	$20	$40	$40
Healthy Activity #2: Choose PCP, complete PCMH Module/Select PCMH	$15	$15	$25	$25
Healthy Activity #3: Personal Health Assessment w/ Biometrics	$15	$15	$25	$25
Total Available Monthly Premium Credits	**$50**	**$50**	**$90**	**$90**
Net Employee/Retiree Premium With All Credits	**$13.56**	**$13.56**	**$14.64**	**$15.76**

Premium and credit amounts referenced on this slide are estimates and subject to change pending final benefit design, actuarial forecast and Board approval

Wellness Premium Credits – Traditional 70/30 Plan

Active Employee Coverage Only

Wellness Design	2014	2015	2016	2017
Estimated Employee Premium	$0.00	$0.00	$60.00	$60.92
Monthly Earnable Premium Credits	**2014**	**2015**	**2016**	**2017**
Healthy Activity #1: Non-Tobacco User or QuitlineNC Enrollment	$0	$0	$40	$40
Total Available Monthly Premium Credits	$0	$0	$40	$40
Net Employee Premium With All Credits	$0.00	$0.00	$20.00	$20.92

Premium and credit amounts referenced on this slide are estimates and subject to change pending final benefit design, actuarial forecast and Board approval

Member Cost Share Scenarios

Active Employees

Member Scenarios – Meet Holly

A State Health Plan member with two children covered on her plan trying to decide which plan is right for her and her family.

- As an active employee, she has three plan options:
  - Consumer-Directed Health Plan
  - Enhanced 80/20 Plan
  - Traditional 70/30 Plan
- A typical year of medical and pharmacy services for Holly and her children might include the following:
  - 3 Preventive Care Visits with PCP
  - 2 Additional Primary Care Visits
  - 1 Specialist Visit
  - 2 Urgent Care Visits
  - 1 Monthly Maintenance Prescription (Tier 1, ACA Preventive Medication)
  - 1 Tier 1 Prescription

Photo credit: Thinkstock Images

Holly's Projected Health Care Costs for 2016

Annual Member Costs	Traditional 70/30 Plan	Enhanced 80/20 Plan	CDHP
If Holly's "Engaged"*			
Premium Payments	$2,825	$3,617	$2,326
Out-of-Pocket Costs	$680	$276	$0**
Engaged Member Total	**$3,505**	**$3,893**	**$2,326**
If Holly's "Non-Engaged"*			
Premium Payments	$3,305	$4,697	$3,286
Out-of-Pocket Costs	$680	$316	$0**
Non-Engaged Member Total	**$3,985**	**$5,013**	**$3,286**

Holly's lowest-cost option

- The CDHP has lower dependent premiums, and Holly's projected 2016 out-of-pocket costs are less than the initial CDHP starting balance of $1,800. The CDHP is Holly's best option.
- A willingness to engage in healthy activities and to use selected PCPs and Blue Options Designated providers reduces member out-of-pocket costs in the CDHP and Enhanced 80/20.

*An "engaged member" has completed all wellness activities to receive premium credits and uses their selected PCP and Blue Options Designated providers. A "non-engaged member" has earned no premium credits and does not use a selected PCP or Blue Options Designated providers.

**Holly's HRA will cover all of her out-of-pocket expenses, and Holly will have an estimated $1,125 in her HRA to use in 2017 if she is engaged or approximately $980 if she is not.

Member Scenario Cost Detail – Active Employee Holly

		Traditional 70/30				Enhanced 80/20				Consumer-Directed Health Plan			
		Non-Engaged		Engaged		Non-Engaged		Engaged		Non-Engaged		Engaged	
Medical Services	#	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total
Preventive Visits with PCP	3	$39	$117	$39	$117	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Visits	2	$39	$78	$39	$78	$30	$60	$15	$30	$140	$280	$140	$280
Specialist Visit	1	$92	$92	$92	$92	$70	$70	$60	$60	$200	$200	$200	$200
Urgent Care Visit	2	$99	$198	$99	$198	$87	$174	$87	$174	$150	$300	$150	$300
Drugs													
ACA Preventive Drugs (Tier 1)	12	$15	$180	$15	$180	$0	$0	$0	$0	$0	$0	$0	$0
Tier 1 Prescription	1	$15	$15	$15	$15	$12	$12	$12	$12	$40	$40	$40	$40
Total (before considering HRA)			**$680**		**$680**		**$316**		**$276**		**$820**		**$820**
HRA Funds Provided by SHP													
Starting Balance											$1,800		$1,800
HRA Incentive Dollars													
Identified PCP											$0		$125
Blue Options Designated Specialist											$0		$20
Blue Options Designated Hospital											$0		$0
Engagement Activities											$0		$0
Total HRA Dollars to Use											**$1,800**		**$1,945**
Member Cost-sharing with HRA			$680		$680		$316		$276		$0		$0
HRA Balance for Use in 2017			--		--		--		--		$980		$1,125
Annual Premium			$3,305		$2,825		$4,697		$3,617		$3,286		$2,326
Total Member Cost			**$3,985**		**$3,505**		**$5,013**		**$3,893**		**$3,286**		**$2,326**

Red numbers in the Unit Copay/Cost column indicate a copayment amount.
Green numbers in the Unit Copay/Cost column indicate estimated actual allowed cost for a service that could be subject to copay (in 70/30 and 80/20), deductible, and/or coinsurance.

Member Scenarios – Meet Pete

A State Health Plan member with employee-only coverage who visits doctors regularly and is trying to decide which plan is right for him.

- As an active employee, he has three plan options:
  - Consumer-Directed Health Plan
  - Enhanced 80/20 Plan
  - Traditional 70/30 Plan

- A year of medical and pharmacy services for Pete might include:
  - 1 Preventive Care Visit with PCP
  - 3 Additional Primary Care Visits
  - 2 Specialist Visits
  - 2 Chiropractor Visits
  - 1 Urgent Care Visit
  - 4 Tier 1 Prescriptions
  - 2 Tier 2 Prescriptions

Photo credit: Thinkstock Images

Pete's Projected Health Care Costs for 2016

Annual Member Costs	Traditional 70/30 Plan	Enhanced 80/20 Plan	CDHP
If Pete is "Engaged"*			
Premium Payments	$240	$180	$0
Out-of-Pocket Costs	$735	$484	$720
Engaged Member Total	**$975**	**$664**	**$720**
If Pete is "Non-Engaged"*			
Premium Payments	$720	$1,260	$960
Out-of-Pocket Costs	$735	$549	$860
Non-Engaged Member Total	**$1,455**	**$1,809**	**$1,820**

Pete's lowest-cost option

- Because he uses a relatively large number of services that are subject to copays in the 70/30 and 80/20 plans, Pete does best in the Enhanced 80/20 Plan if he is engaged, or the Traditional 70/30 if he is non-engaged.
- The year of services described for Pete would approach the $1,500 deductible in the CDHP, so one major health event would likely make the CDHP a lower-cost option for him due to the lower coinsurance and the combined medical and pharmacy out-of-pocket maximum.

*An "engaged member" has completed all wellness activities to receive premium credits and uses their selected PCP and Blue Options Designated providers. A "non-engaged member" has earned no premium credits and does not use a selected PCP or Blue Options Designated providers.

Member Scenario Cost Detail – Active Employee Pete

		Traditional 70/30				Enhanced 80/20				Consumer-Directed Health Plan			
		Non-Engaged		Engaged		Non-Engaged		Engaged		Non-Engaged		Engaged	
Medical Services	#	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total
Preventive Visits with PCP	1	$39	$39	$39	$39	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Visits	3	$39	$117	$39	$117	$30	$90	$15	$45	$140	$420	$140	$420
Specialist Visits	2	$92	$184	$92	$184	$70	$140	$60	$120	$200	$400	$200	$400
Mid-Level Office Visits	2	$72	$144	$72	$144	$52	$104	$52	$104	$85	$170	$85	$170
Urgent Care Visit	1	$99	$99	$99	$99	$87	$87	$87	$87	$150	$150	$150	$150
Drugs													
Tier 1 Prescriptions	4	$15	$60	$15	$60	$12	$48	$12	$48	$40	$160	$40	$160
Tier 2 Prescriptions	2	$46	$92	$46	$92	$40	$80	$40	$80	$80	$160	$80	$160
Total (before considering HRA)			**$735**		**$735**		**$549**		**$452**		**$1,460**		**$1,460**
HRA Funds Provided by SHP													
Starting Balance											$600		$600
HRA Incentive Dollars													
Identified PCP											$0		$100
Blue Options Designated Specialist											$0		$40
Blue Designated Options Hospital											$0		$0
Engagement Activities											$0		$0
Total HRA Dollars to Use											**$600**		**$740**
Member Cost-sharing with HRA			$735		$735		$549		$484		$860		$720
HRA Balance for Use in 2017			--		--		--		--		$0		$0
Annual Premium			$720		$240		$1,260		$180		$960		$0
Total Member Cost			**$1,455**		**$975**		**$1,809**		**$664**		**$1,820**		**$720**

Red numbers in the Unit Copay/Cost column indicate a copayment amount.

Green numbers in the Unit Copay/Cost column indicate estimated actual allowed cost for a service that could be subject to copay (in 70/30 and 80/20), deductible, and/or coinsurance.

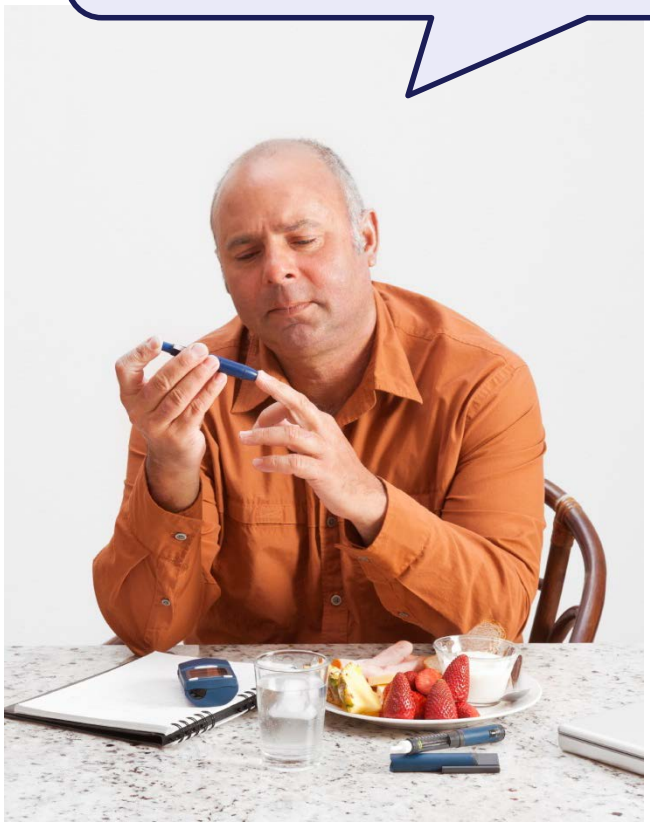
Member Scenarios – Meet Bentley

A State Health Plan member with employee-only coverage who has been diagnosed with diabetes and is trying to decide which plan is right for his chronic condition.

- As an active employee, he has three plan options:
  - Consumer-Directed Health Plan
  - Enhanced 80/20 Plan
  - Traditional 70/30 Plan

- A year of medical and pharmacy services for Bentley might include:
  - 1 Preventive Care Visit with PCP
  - 4 Additional Primary Care Visits
  - 3 Specialist Visits
  - 1 Inpatient Hospitalization
  - 2 Monthly Maintenance Prescriptions (Tier 1)*
  - 1 Monthly Maintenance Prescription (Tier 2)*
  - 1 Tier 1 Prescription

"I was recently diagnosed with diabetes, so I'm trying to determine how much I will have to pay under each plan option."



* Maintenance Prescriptions assumed to be on CDHP Preventive Medications List

Bentley's Projected Health Care Costs for 2016

Annual Member Costs	Traditional 70/30 Plan	Enhanced 80/20 Plan	CDHP
If Bentley is "Engaged"*			
Premium Payments	$240	$180	$0
Out-of-Pocket Costs	$5,844	$3,900	$2,298
Engaged Member Total	**$6,084**	**$4,080**	**$2,298**
If Bentley is "Non-Engaged"*			
Premium Payments	$720	$1,260	$960
Out-of-Pocket Costs	$7,068	$5,253	$2,900
Non-Engaged Member Total	**$7,788**	**$6,513**	**$3,860**

Bentley's lowest-cost option

- Because he is a high utilizer, Bentley will come close to the CDHP out-of-pocket maximum of $3,500 (He will reach the out-of-pocket maximum if he is non-engaged).
- Engaging with a health coach to manage his condition and using Blue Options Designated providers and his selected PCP could earn nearly $600 in additional HRA incentive funds, reducing Bentley's true out-of-pocket costs. (Using Blue Options Designated providers reduces member out-of-pocket costs in all the plan options.)
- Although there are fewer healthy activities to complete when enrolling in the Traditional 70/30 Plan, it would be a poor option for Bentley because of the high out-of-pocket costs.

*An "engaged member" has completed all wellness activities to receive premium credits and uses their selected PCP and Blue Options Designated providers. A "non-engaged member" has earned no premium credits and does not use a selected PCP or Blue Options Designated providers.

Member Scenario Cost Detail – Active Employee Bentley

		Traditional 70/30				Enhanced 80/20				Consumer-Directed Health Plan*			
		Non-Engaged		Engaged		Non-Engaged		Engaged		Non-Engaged		Engaged	
Medical Services	#	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total
Preventive Visits with PCP	1	$39	$39	$39	$39	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Visits	4	$39	$156	$39	$156	$30	$120	$15	$60	$140	$280	$140	$322
Specialist Visit	3	$92	$276	$92	$276	$70	$210	$60	$180	$200	$200	$200	$260
Inpatient Hospital Admission	1	$19,000	$5,670	$11,600	$4,446	$19,000	$4,143	$11,600	$2,880	$19,000	$2,884	$11,600	$2,573
Drugs													
Maintenance Drugs (Tier 1)	24	$15	$360	$15	$360	$12	$288	$12	$288	$40	$48	$40	$144
Tier 1 Prescription	1	$15	$15	$15	$15	$12	$12	$12	$12	$40	$40	$40	$40
Maintenance Drugs (Tier 2)	12	$46	$552	$46	$552	$40	$480	$40	$480	$80	$48	$80	$144
Total (before considering HRA)			**$7,068**		**$5,844**		**$5,253**		**$3,900**		**$3,500**		**$3,483**
HRA Funds Provided by SHP													
Starting Balance											$600		$600
HRA Incentive Dollars													
Identified PCP											$0		$125
Blue Options Specialist											$0		$60
Blue Options Hospital											$0		$200
Engagement Activities											$0		$200
Total HRA Dollars to Use											**$600**		**$1,185**
Member Cost-sharing with HRA			$7,068		$5,844		$5,253		$3,900		$2,900		$2,298
HRA Balance for Use in 2017			--		--		--		--		$0		$0
Annual Premium			$720		$240		$1,260		$180		$960		$0
Total Member Cost			**$7,788**		**$6,084**		**$6,513**		**$4,080**		**$3,860**		**$2,298**

Red numbers in the Unit Copay/Cost column indicate a copayment amount. Green numbers in the Unit Copay/Cost column indicate estimated actual allowed cost for a service that could be subject to copay (in 70/30 and 80/20), deductible, and/or coinsurance.

*CDHP costs by service depend on the timing of services and costs. The numbers in the chart assume a specific ordering of services until the deductible and out-of-pocket maximum are reached.

Member Cost Share Scenarios

Non-Medicare Retirees

Member Scenarios – Meet Holly

"As we enter the Annual Enrollment period for 2016, how much will I have to pay under each plan option?"

A retired State Health Plan member with two children covered on her plan trying to decide which plan is right for her and her family.

- As an early retiree, she has three plan options:
  - Consumer-Directed Health Plan
  - Enhanced 80/20 Plan
  - Traditional 70/30 Plan
- A typical year of medical and pharmacy services for Holly and her children might include the following:
  - 3 Preventive Care Visits with PCP
  - 2 Additional Primary Care Visits
  - 1 Specialist Visit
  - 2 Urgent Care Visits
  - 1 Monthly Maintenance Prescription (Tier 1, ACA Preventive Medication)
  - 1 Tier 1 Prescription

Retired Holly's Projected Health Care Costs for 2016

Annual Member Costs	Traditional 70/30 Plan	Enhanced 80/20 Plan	CDHP
If Holly's "Engaged"*			
Premium Payments	$2,585	$3,617	$2,326
Out-of-Pocket Costs	$680	$276	$0**
Engaged Member Total	**$3,265**	**$3,893**	**$2,326**
If Holly's "Non-Engaged"*			
Premium Payments	$2,585	$4,697	$3,286
Out-of-Pocket Costs	$680	$316	$0**
Non-Engaged Member Total	**$3,265**	**$5,013**	**$3,286**

Holly's lowest-cost option

- The CDHP has lower dependent premiums, and Holly's projected 2016 out-of-pocket costs are less than the initial CDHP starting balance of $1,800. The CDHP is Holly's best option.
- A willingness to engage in healthy activities and to use selected PCPs and Blue Options Designated providers reduces member out-of-pocket costs in the CDHP and Enhanced 80/20.

*An "engaged member" has completed all wellness activities to receive premium credits and uses their selected PCP and Blue Options Designated providers. A "non-engaged member" has earned no premium credits and does not use a selected PCP or Blue Options Designated providers.

**Holly's HRA will cover all of her out-of-pocket expenses, and Holly will have an estimated $1,125 in her HRA to use in 2017 if she is engaged or approximately $980 if she is not.

Member Scenario Cost Detail – Non-Medicare Retiree Holly

		Traditional 70/30				Enhanced 80/20				Consumer-Directed Health Plan			
		Non-Engaged		Engaged		Non-Engaged		Engaged		Non-Engaged		Engaged	
Medical Services	#	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total
Preventive Visits with PCP	3	$39	$117	$39	$117	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Visits	2	$39	$78	$39	$78	$30	$60	$15	$30	$140	$280	$140	$280
Specialist Visit	1	$92	$92	$92	$92	$70	$70	$60	$60	$200	$200	$200	$200
Urgent Care Visit	2	$99	$198	$99	$198	$87	$174	$87	$174	$150	$300	$150	$300
Drugs													
ACA Preventive Drugs (Tier 1)	12	$15	$180	$15	$180	$0	$0	$0	$0	$0	$0	$0	$0
Tier 1 Prescription	1	$15	$15	$15	$15	$12	$12	$12	$12	$40	$40	$40	$40
Total (before considering HRA)			**$680**		**$680**		**$316**		**$276**		**$820**		**$820**
HRA Funds Provided by SHP													
Starting Balance											$1,800		$1,800
HRA Incentive Dollars													
Identified PCP											$0		$125
Blue Options Designated Specialist											$0		$20
Blue Options Designated Hospital											$0		$0
Engagement Activities											$0		$0
Total HRA Dollars to Use											**$1,800**		**$1,945**
Member Cost-sharing with HRA			$680		$680		$316		$276		$0		$0
HRA Balance for Use in 2017			--		--		--		--		$980		$1,125
Annual Premium			$2,585		$2,585		$4,697		$3,617		$3,286		$2,326
Total Member Cost			**$3,265**		**$3,265**		**$5,013**		**$3,893**		**$3,286**		**$2,326**

Red numbers in the Unit Copay/Cost column indicate a copayment amount.
Green numbers in the Unit Copay/Cost column indicate estimated actual allowed cost for a service that could be subject to copay (in 70/30 and 80/20), deductible, and/or coinsurance.

Member Scenarios – Meet Pete

A State Health Plan member with retiree-only coverage who visits doctors regularly and is trying to decide which plan is right for him.

- As an early retiree, he has three plan options:
  - Consumer-Directed Health Plan
  - Enhanced 80/20 Plan
  - Traditional 70/30 Plan

- A year of medical and pharmacy services for Pete might include:
  - 1 Preventive Care Visit with PCP
  - 3 Additional Primary Care Visits
  - 2 Specialist Visits
  - 2 Chiropractor Visits
  - 1 Urgent Care Visit
  - 4 Tier 1 Prescriptions
  - 2 Tier 2 Prescriptions

Photo credit: Thinkstock Images

Retired Pete's Projected Health Care Costs for 2016

Annual Member Costs	Traditional 70/30 Plan	Enhanced 80/20 Plan	CDHP
If Pete is "Engaged"*			
Premium Payments	$0	$180	$0
Out-of-Pocket Costs	$735	$484	$720
Engaged Member Total	**$735**	**$664**	**$720**
If Pete is "Non-Engaged"*			
Premium Payments	$0	$1,260	$960
Out-of-Pocket Costs	$735	$549	$860
Non-Engaged Member Total	**$735**	**$1,809**	**$1,820**

Pete's lowest-cost option

- Because he uses a relatively large number of services that are subject to copays in the 70/30 and 80/20 plans, Pete does best in the Enhanced 80/20 Plan if he is engaged, or the Traditional 70/30 if he is non-engaged.
- The year of services described for Pete would approach the $1,500 deductible in the CDHP, so one major health event would likely make the CDHP a lower-cost option for him due to the lower coinsurance and the combined medical and pharmacy out-of-pocket maximum.

*An "engaged member" has completed all wellness activities to receive premium credits and uses their selected PCP and Blue Options Designated providers. A "non-engaged member" has earned no premium credits and does not use a selected PCP or Blue Options Designated providers.

Member Scenario Cost Detail – Non-Medicare Retiree Pete

		Traditional 70/30				Enhanced 80/20				Consumer-Directed Health Plan			
		Non-Engaged		Engaged		Non-Engaged		Engaged		Non-Engaged		Engaged	
Medical Services	#	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total
Preventive Visits with PCP	1	$39	$39	$39	$39	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Visits	3	$39	$117	$39	$117	$30	$90	$15	$45	$140	$420	$140	$420
Specialist Visits	2	$92	$184	$92	$184	$70	$140	$60	$120	$200	$400	$200	$400
Mid-Level Office Visits	2	$72	$144	$72	$144	$52	$104	$52	$104	$85	$170	$85	$170
Urgent Care Visit	1	$99	$99	$99	$99	$87	$87	$87	$87	$150	$150	$150	$150
Drugs													
Tier 1 Prescriptions	4	$15	$60	$15	$60	$12	$48	$12	$48	$40	$160	$40	$160
Tier 2 Prescriptions	2	$46	$92	$46	$92	$40	$80	$40	$80	$80	$160	$80	$160
Total (before considering HRA)			**$735**		**$735**		**$549**		**$452**		**$1,460**		**$1,460**
HRA Funds Provided by SHP													
Starting Balance											$600		$600
HRA Incentive Dollars													
Identified PCP											$0		$100
Blue Options Designated Specialist											$0		$40
Blue Options Designated Hospital											$0		$0
Engagement Activities											$0		$0
Total HRA Dollars to Use											**$600**		**$740**
Member Cost-sharing with HRA			$735		$735		$549		$484		$860		$720
HRA Balance for Use in 2017			--		--		--		--		$0		$0
Annual Premium			$0		$0		$1,260		$180		$960		$0
Total Member Cost			**$735**		**$735**		**$1,809**		**$664**		**$1,820**		**$720**

Red numbers in the Unit Copay/Cost column indicate a copayment amount.
Green numbers in the Unit Copay/Cost column indicate estimated actual allowed cost for a service that could be subject to copay (in 70/30 and 80/20), deductible, and/or coinsurance.

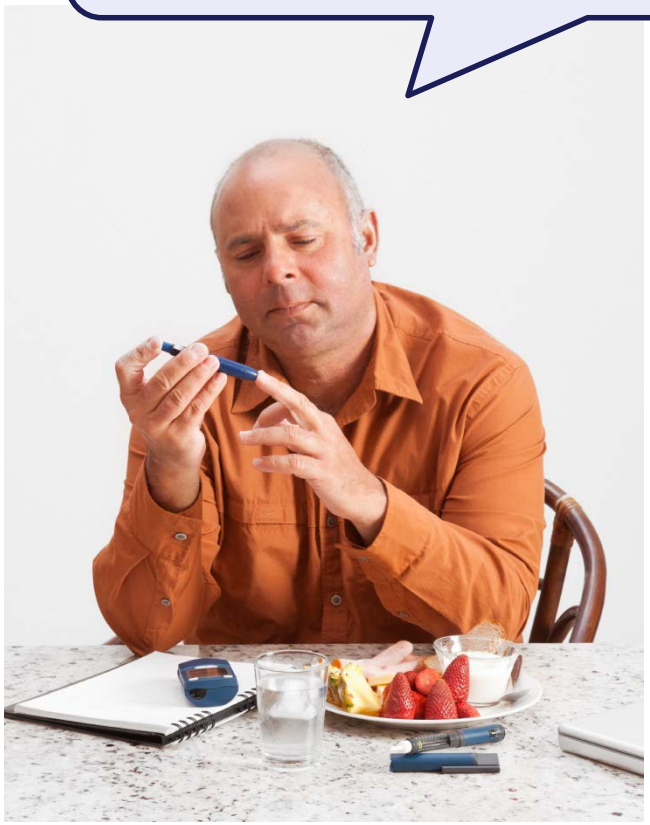
Member Scenarios – Meet Bentley

A State Health Plan member with retiree-only coverage who has been diagnosed with diabetes and is trying to decide which plan is right for his chronic condition.

- As an early retiree, he has three plan options:
  - Consumer-Directed Health Plan
  - Enhanced 80/20 Plan
  - Traditional 70/30 Plan

- A year of medical and pharmacy services for Bentley might include:
  - 1 Preventive Care Visit with PCP
  - 4 Additional Primary Care Visits
  - 3 Specialist Visits
  - 1 Inpatient Hospitalization
  - 2 Monthly Maintenance Prescriptions (Tier 1)*
  - 1 Monthly Maintenance Prescription (Tier 2)*
  - 1 Tier 1 Prescription

"I was recently diagnosed with diabetes, so I'm trying to determine how much I will have to pay under each plan option."



* Maintenance Prescriptions assumed to be on CDHP Preventive Medications List

Retired Bentley's Projected Health Care Costs for 2016

Annual Member Costs	Traditional 70/30 Plan	Enhanced 80/20 Plan	CDHP
If Bentley is "Engaged"*			
Premium Payments	$0	$180	$0
Out-of-Pocket Costs	$5,844	$3,900	$2,298
Engaged Member Total	**$5,844**	**$4,080**	**$2,298**
If Bentley is "Non-Engaged "*			
Premium Payments	$0	$1,260	$960
Out-of-Pocket Costs	$7,068	$5,253	$2,900
Non-Engaged Member Total	**$7,068**	**$6,513**	**$3,860**

Bentley's lowest-cost option

- Because he is a high utilizer, Bentley will come close to the CDHP out-of-pocket maximum of $3,500 (He will reach the out-of-pocket maximum if he is non-engaged).
- Engaging with a health coach to manage his condition and using Blue Options Designated providers and his selected PCP could earn nearly $600 in additional HRA incentive funds, reducing Bentley's true out-of-pocket costs. (Using Blue Options Designated providers reduces member out-of-pocket costs in all the plan options.)
- Although there are fewer healthy activities to complete when enrolling in the Traditional 70/30 Plan, it would be a poor option for Bentley because of the high out-of-pocket costs.

*An "engaged member" has completed all wellness activities to receive premium credits and uses their selected PCP and Blue Options Designated providers. A "non-engaged member" has earned no premium credits and does not use a selected PCP or Blue Options Designated providers.

Member Scenario Cost Detail – Non-Medicare Retiree Bentley

		Traditional 70/30				Enhanced 80/20				Consumer-Directed Health Plan*			
		Non-Engaged		Engaged		Non-Engaged		Engaged		Non-Engaged		Engaged	
Medical Services	#	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total	Unit Copay/ Cost	Mbr Total
Preventive Visits with PCP	1	$39	$39	$39	$39	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Visits	4	$39	$156	$39	$156	$30	$120	$15	$60	$140	$280	$140	$322
Specialist Visit	3	$92	$276	$92	$276	$70	$210	$60	$180	$200	$200	$200	$260
Inpatient Hospital Admission	1	$19,000	$5,670	$11,600	$4,446	$19,000	$4,143	$11,600	$2,880	$19,000	$2,884	$11,600	$2,573
Drugs													
Maintenance Drugs (Tier 1)	24	$15	$360	$15	$360	$12	$288	$12	$288	$40	$48	$40	$144
Tier 1 Prescription	1	$15	$15	$15	$15	$12	$12	$12	$12	$40	$40	$40	$40
Maintenance Drugs (Tier 2)	12	$46	$552	$46	$552	$40	$480	$40	$480	$80	$48	$80	$144
Total (before considering HRA)			**$7,068**		**$5,844**		**$5,253**		**$3,900**		**$3,500**		**$3,483**
HRA Funds Provided by SHP													
Starting Balance											$600		$600
HRA Incentive Dollars													
Identified PCP											$0		$125
Blue Options Designated Specialist											$0		$60
Blue Options Designated Hospital											$0		$200
Engagement Activities											$0		$200
Total HRA Dollars to Use											**$600**		**$1,185**
Member Cost-sharing with HRA			$7,068		$5,844		$5,253		$3,900		$2,900		$2,298
HRA Balance for Use in 2017			--		--		--		--		$0		$0
Annual Premium			$0		$0		$1,260		$180		$960		$0
Total Member Cost			**$7,068**		**$5,844**		**$6,513**		**$4,080**		**$3,860**		**$2,298**

Red numbers in the Unit Copay/Cost column indicate a copayment amount. Green numbers in the Unit Copay/Cost column indicate estimated actual allowed cost for a service that could be subject to copay (in 70/30 and 80/20), deductible, and/or coinsurance.

*CDHP costs by service depend on the timing of services and costs. The numbers in the chart assume a specific ordering of services until the deductible and out-of-pocket maximum are reached.

Questions, Comments and Discussion

- To ensure adequate time for implementation the Board will be asked to approve benefit design changes at its next meeting:

February 11, 2015, 2:00 to 5:00 pm

Appendix

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

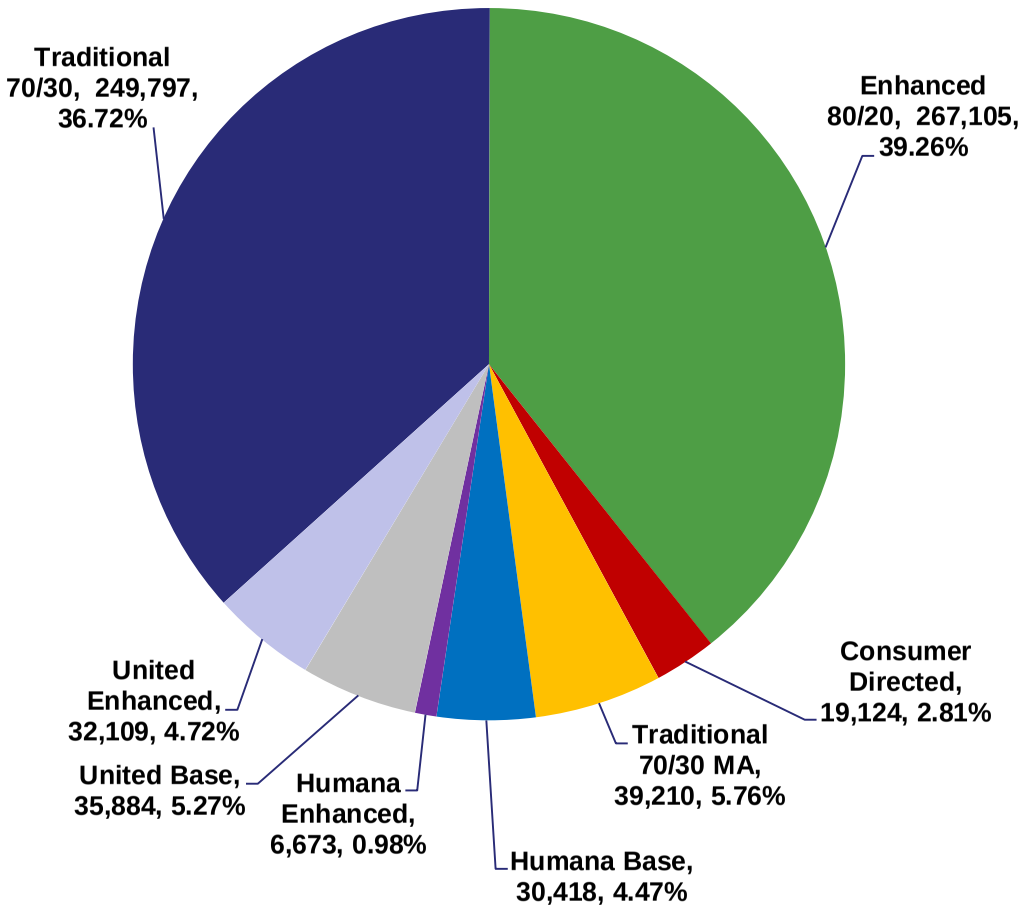
1. Membership
2. Plan Richness
3. Overall Benefit Value
4. Definitions

www.shpnc.org

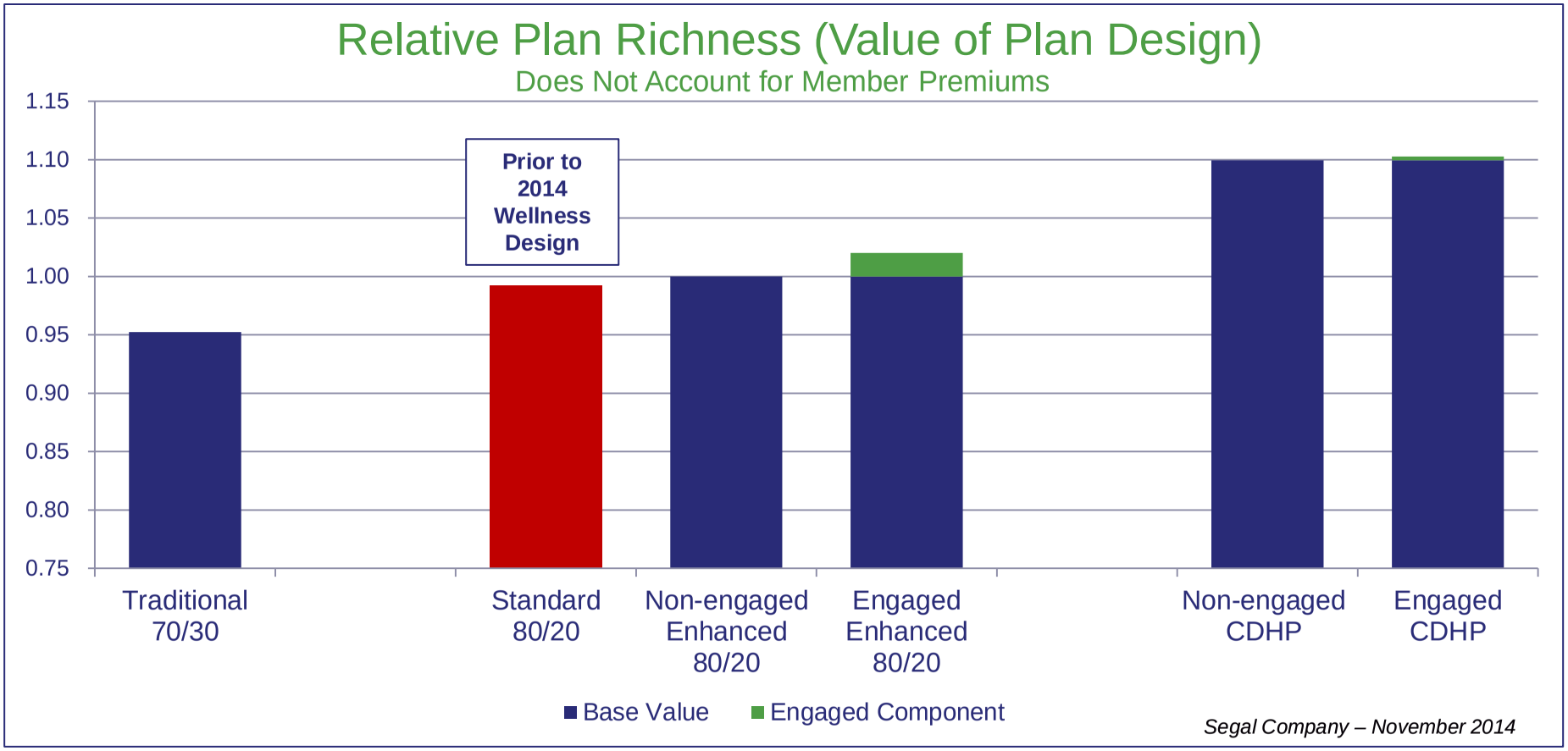
www.nctreasurer.com

Average Membership by Plan

October to December 2014

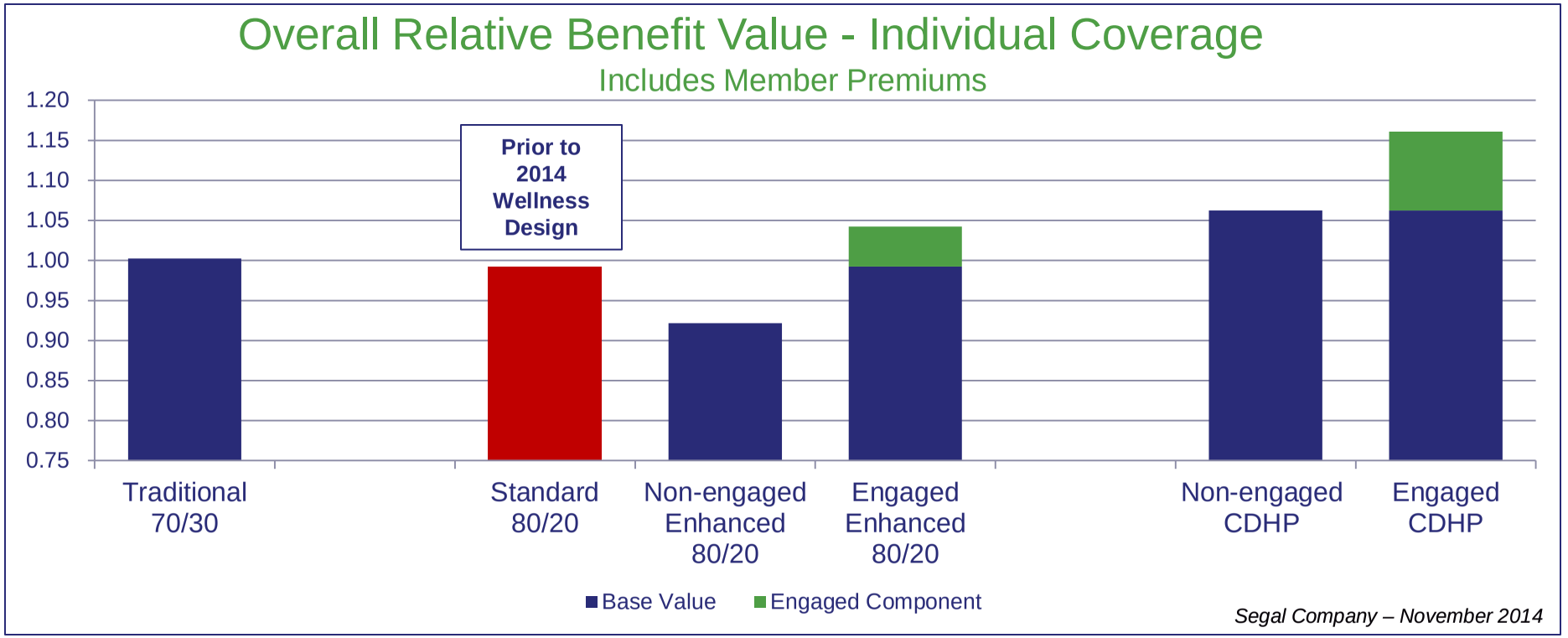


Engaged Employees/Retirees Earn Richer Plan



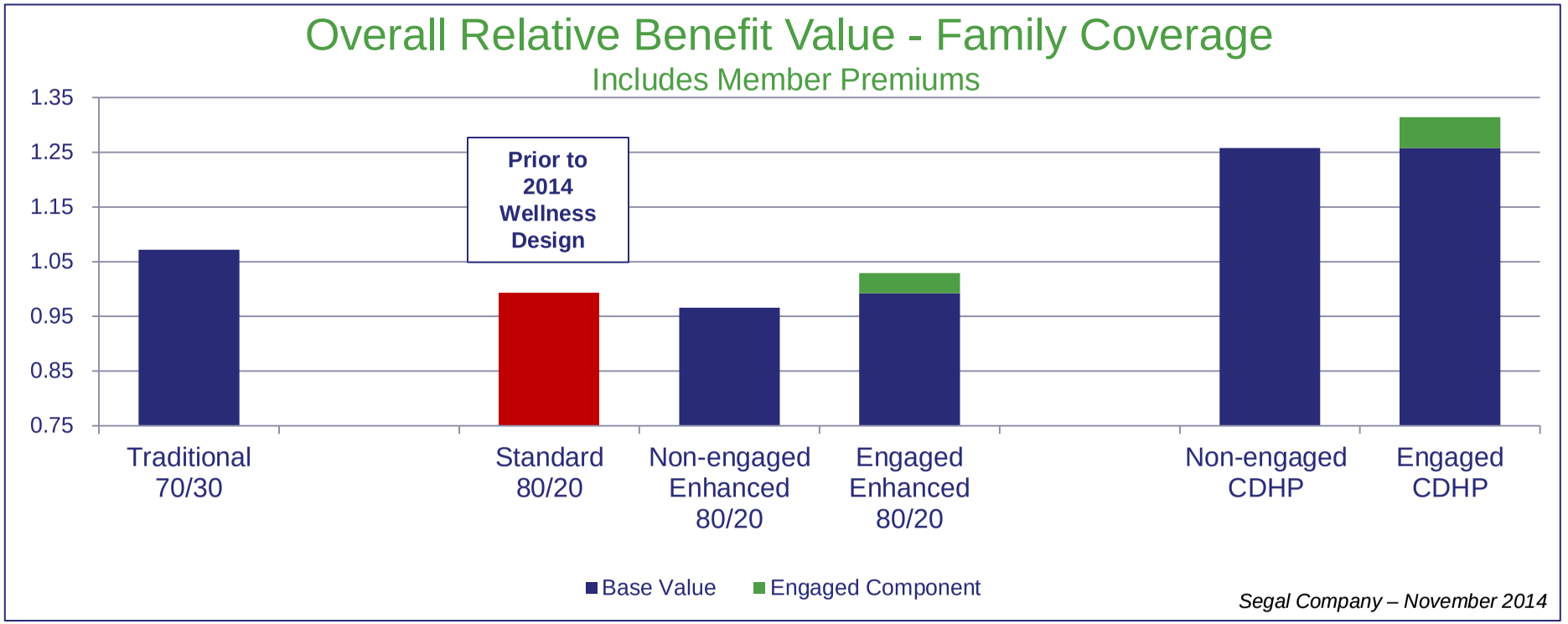
- 16% difference in relative value of richest plan (CDHP) and least rich plan (Traditional 70/30)
- Relative difference in value between 70/30 and non-engaged 80/20 is 5%
- Engaged 80/20 and CDHP members earn higher value coverage

Engaged Employees/Retirees Receive the Richest Overall Benefit



- Current benefit plans offer richer benefit options than the former Standard 80/20 plan
- Members have the opportunity to significantly increase the value of their benefit by completing healthy activities, earning premium credits and using their selected PCP and Blue Options Designated providers
- Taking wellness credits and incentives into account, an engaged CDHP member receives a 26% richer overall benefit than a non-engaged Enhanced 80/20 member
- For members who do not want to engage, the CDHP and Traditional 70/30 plans offer the best value

Engaged Families *May* Receive the Richest Overall Benefit



- Current benefit plans offer richer benefit options than the former Standard 80/20 plan
- Engaged employees/retirees and dependents have the opportunity to significantly increase the value of their benefit
- An engaged CDHP family receives a 36% richer overall benefit than a non-engaged Enhanced 80/20 family
- The Traditional 70/30 plan provides better overall value for families than the Enhanced 80/20 plan regardless of engagement level

Definitions

- Premium – The amount paid to the Plan for coverage under a benefit plan.
- Cost share or out-of-pocket costs – The portion of medical and pharmacy bills the member is responsible for when receiving care.
- Copays – A fixed dollar amount that is due and payable by the member at the time a covered service is provided.
- Deductible – The specified dollar amount that the member must incur for covered services each benefit period before the Plan will pay. The Deductible does not include copayments, coinsurance, charges in excess of the allowed amount, amounts exceeding any maximum, or expenses for non-covered services.
- Coinsurance – The sharing of charges by the Plan and the member for covered services received by a member after the deductible is met, usually stated as a percentage of the allowed amount.
- Consumer-Directed Health Plan – This plan covers Affordable Care Act (ACA) preventive services and medications at 100%. Generally a member must meet the deductible under the Plan before the Plan will pay its share of medical expense; however, for certain chronic disease medications the deductible is waived. This plan is paired with a health reimbursement account to assist members in paying costs. There are no copays with this plan. This is an 85/15 coinsurance plan.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Provider Engagement Initiatives

Board of Trustees Meeting

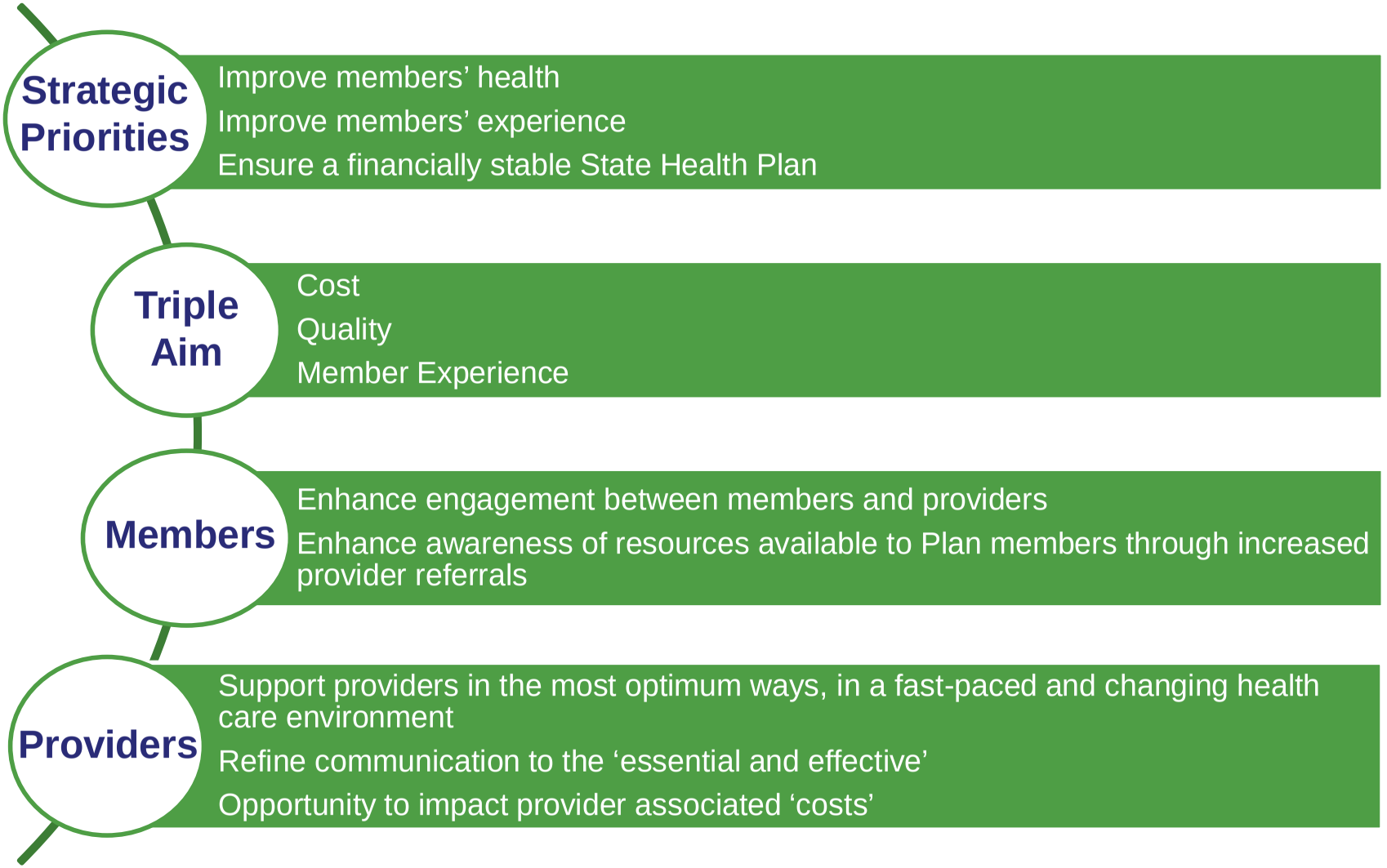
January 23, 2015

A Division of the Department of State Treasurer

Overview

- Purpose of Provider Engagement
- Provider Engagement through Vendor Partners
- Provider Engagement Strategies
  - PCMH Pilot
  - Wellness Wins Pilot (Jones, Greene, Lenoir Counties)
  - Advanced Primary Care Practice Demonstration
  - Wake Key Community Care-ACO Initiative

The Purpose of Provider Engagement



Provider Engagement through Vendor Partners

- Third Party Administrator (TPA) – Blue Cross Blue Shield of NC (BCBSNC)
  - Network of providers
  - Claims processing
  - Utilization management (UM)

- Population Health Management Vendor – Active Health Management (AHM)
    - Provider care considerations and alerts

Provider Engagement Strategies

- Patient Centered Medical Home (PCMH) Pilot - Novant Health Systems, Eagle Physicians & Associates, New Hanover Medical Group and CaroMont Medical Group

- Provider engagement arm of the pilot initiative in Greene, Jones, and Lenoir counties-“Wellness Wins”

- Advanced Primary Care Practice Demonstration with Community Care of North Carolina (7 rural communities)

- Leveraging Third Party Administrator Relationships with Accountable Care Organizations-Wake Key Community Care (WKCC)

Patient Center Medical Home Pilot with Active Health Management

PCMH Pilot with Active Health Management

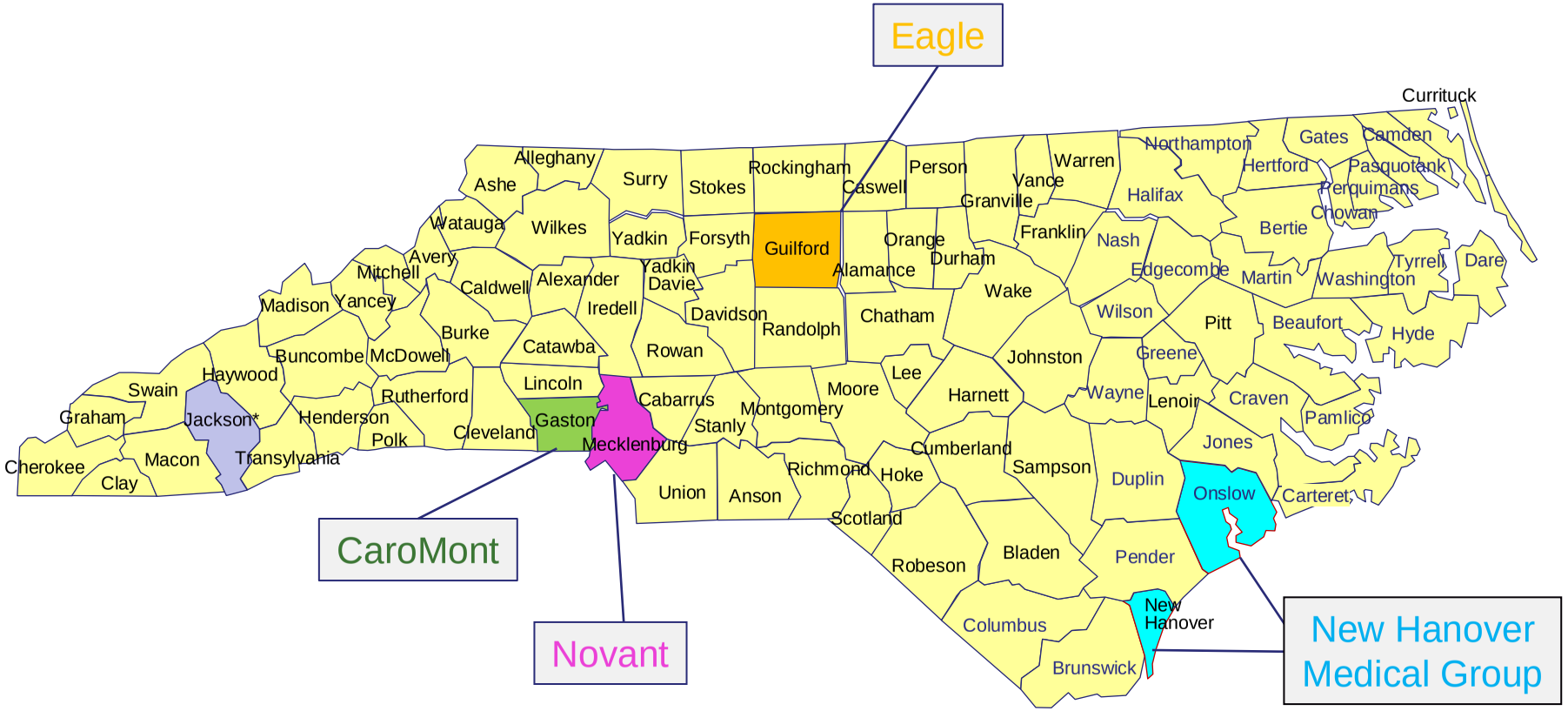
Objective: Engage physicians in the care of Plan members through *alternate payment strategy* as well as *data driven, coordinated supports* to achieve better health outcomes and to improve the member's and the provider's experience in a complex health care environment.

- Testing the model for the following:
  - Alternate payment strategy
  - Effective communication
  - Evolving role of the population health management vendor
  - Optimum utilization and sharing of data
  - Defining and measuring quality of care
  - Determining "total cost of care" in shared risks and savings

Practice Participation

Practice Group	Number of SHP Members
Eagle Physicians & Associates	4,532
Novant Health Systems	6,066
CaroMont Medical Group	1,410
New Hanover Medical Group	1,499
Totals	**13,507**

PCMH Pilot Practices and Locations



- Sylva Medical Practice in Jackson County
- Novant practices in Forsyth county are also being considered for the pilot

PCMH Overview

- Two-year pilot initiative for 2015-2016
- The State Health Plan will provide a per member per month (PMPM) payment on a quarterly basis based on attributed Plan members
- The PMPM will depend on a tier structure
  - Initial ‘onboarding’ tier determined by an objective scoring and assessment tool
  - Each practice will enter the model at a tier and will stay on that tier for a 12 month period
  - The practice may move up a tier or down depending on their achievement of targets in Year 1
  - Five to seven core quality metrics to be chosen for all practices
  - Five additional metrics to be selected in alignment with practice initiatives

PCMH Overview

- Quality metrics will be based on claims data as well as practice level EMR information (to be provided by the practice)
- Chosen quality metrics will be monitored quarterly by AHM and the Plan
- Targets are set based on baseline for each individual practice
- Active Health Management's role will vary with each practice depending on the tier of participation
- Practices will refer members who need disease management and other supports to AHM/SHP resources

Onboarding Tiers and Payment Strategy

Tier 1

$1.50 pmpm

- Strong interest/willingness to partner
- Demonstrated physician leadership
- Practice uses EMR and has IT infrastructure
- Practice uses EMR for patient care
- Willingness to coordinate with AHM/SHP services

Tier 2

$2.50 pmpm

- Strong interest/willingness to partner
- Demonstrated physician leadership
- Practice uses EMR and has IT infrastructure
- Practice uses EMR for patient care
- Willingness to coordinate with AHM/SHP services

- Internal QI process including QI committee
- Other PCMH relationships w/payers
- NCQA recognition minimum Level 1 PCMH recognition
- Historical performance on quality metrics meets or exceeds 50th - 75th percentile of regional performance (HSA regions)

Onboarding Tiers and Payment Strategy

Tier 3 — $3.50 pmpm

- Strong interest/willingness to partner
- Demonstrated physician leadership
- Practice uses EMR and has IT infrastructure
- Practice uses EMR for patient care
- Willingness to coordinate with AHM/SHP services

- Internal QI process including QI committee
- Other PCMH relationships with payers
- NCQA recognition minimum Level 1 PCMH recognition
- Historical performance on quality metrics meets or exceed 50th - 75th percentile of regional performance (HSA regions)

- Current partnerships with specialists and/or hospitals
- Has internal care coordination supports or is willing to hire a Care Coordinator
- Patient communication and engagement tools available

Tier 4 — $4.50 pmpm

- Strong interest/willingness to partner
- Demonstrated physician leadership
- Practice uses EMR and has IT infrastructure
- Practice uses EMR for patient care
- Willingness to coordinate with AHM/SHP services

- Internal QI process including QI committee
- Other PCMH relationships with payers
- NCQA recognition minimum Level 1 PCMH recognition
- Historical performance on quality metrics meets or exceed 50th - 75th percentile of regional performance (HSA regions)

- Current partnerships with specialists and/or hospitals
- Has internal care coordination supports or is willing to hire a Care Coordinator
- Patient communication and engagement tools available

- Member and provider satisfaction data available (12 month period)

Quality Improvement and Tier Movement (12 months)

Tier 1

$1.50 pmpm

- Contract signed and onboarding Tier 1 requirements met
- Over the next 12 months, meet targets on 70% of all decided upon quality metrics

Tier 2

$2.50 pmpm

- Contract signed and onboarding Tier 2 requirements met
- Over next 12 months meet target on 80% of all selected quality metrics
- Achieve 50% 'engagement' with members

Quality Improvement and Tier Movement (12 months)

Tier 3

$3.50 pmpm

- Contract signed and onboarding Tier 3 requirements met
- Over the next 12 months, meet target on 90% of all decided upon quality metrics and achieve 65% engagement with members

- Practice provides care coordination
- Practice can identify and target members for population health management based on clinical data available
- Practice provides analytics and reporting from EMR
- Increase to a minimum of NCQA Level 2

Tier 4

$4.50 pmpm

- Contract signed and onboarding Tier 4 requirements met
- Over the next 12 months, meet target on 100% of all decided upon quality metrics and achieve 85% engagement with members

- Practice provides care coordination
- Practice can identify and target members for population health management based on clinical data available
- Practice provides analytics and reporting from EMR
- Increase to a minimum of NCQA Level 3

- Member satisfaction is $\geq$ 90%
- Provider satisfaction is $\geq$ 90% (previous12 month period)

Core Quality Metrics

Clinical Measures

Diabetes Composite Measure

1. Members with diabetes meeting all 5 criteria below
    a. HBA1c test 2 per year
    b. LDL 1 per year
    c. Blood pressure every visit
    d. Tobacco assessment and referral
    e. Aspirin therapy

Asthma Management

1. Members with Persistent Asthma on ICS

Utilization Measures

1. Rate of ED visits per 1000
2. Rate of inpatient avoidable hospitalizations
3. Rate of all cause readmissions
4. Radiology costs/member per year

Optional Metrics (Examples)

1. Preventive Health

a. Influenza vaccine
b. Pneumococcal vaccine
c. Tobacco screening and intervention
d. Annual adult physical or preventive care visit
e. Adolescent well-care visit in last 12 months
f. Age appropriate cancer screenings
g. Mammogram
h. Colorectal cancer screening
i. Depression screening

2. Clinical Measures

a. CAD composite, persons with CAD meeting criteria below
Drug therapy for lowering LDL cholesterol
Ace inhibitor or ARB therapy for patients with CAD, diabetes or LVSD

b. Heart failure
Beta blocker therapy for LVSD

c. Hypertension
Members with hypertension whose BP is under control (140/90)

d. Diabetes
Members with diabetes whose HBA1c is under control (HBa1c< 8%)

Pharmacy

Adherence to preferred drugs
Patients with multiple comorbidities receiving medication reconciliation

Behavioral Health

Screening for depression

PCMH Pilot Status

Pilot is on target for implementation April 1, 2015

Current Activities

- Practices are reviewing draft contracts
- Review assessment tools from practices and assign to Tier Level

Next Steps

- Develop contract agreements with practices
- Select quality clinical metrics and targets jointly with practices
- Develop practice workflows and data exchange processes
- Develop reporting mechanism and frequency

‘Wellness Wins’ Pilot: Provider Engagement

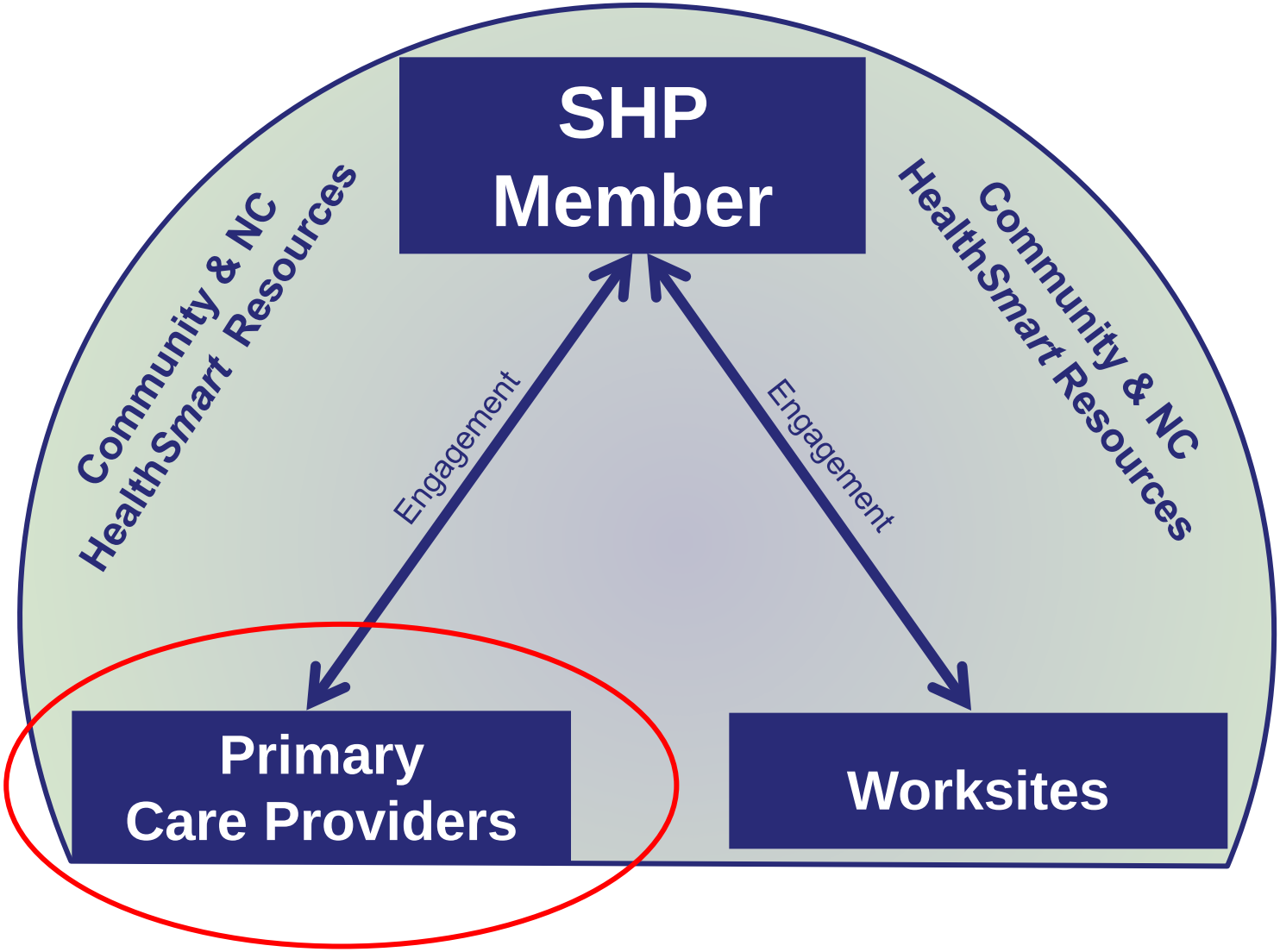
Wellness Wins Pilot Initiative: Overview

The Integrated Health Management (IHM) team proposes a two-year targeted pilot initiative for three eastern counties, utilizing a multipronged approach.

- Engage and support providers in delivering a higher level of care to our members
- Develop and strengthen wellness networks and worksite wellness initiatives
- Connect local leadership and resources to worksites
- Engage and empower members in their health care

Target counties: **Greene, Jones, and Lenoir** (Eastern NC)

Wellness Wins Pilot: Provider Engagement



Wellness Wins: Provider Engagement

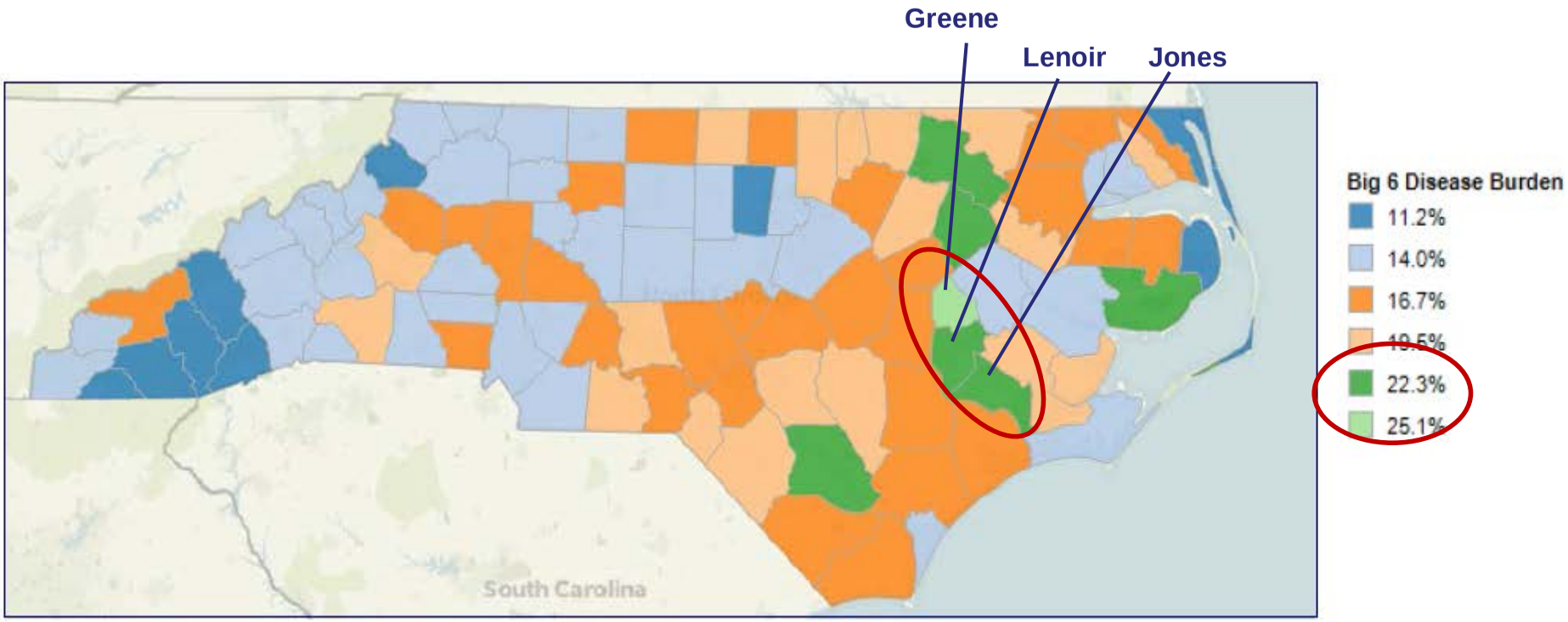
Objectives:

- Engage with local providers to deliver optimal care to Plan members
- Begin the conversation between the Plan and providers on how we can work together to meet common goals
- Practice supports to deliver optimal care to their patients
  - Practice management support
  - Care coordination
  - Referrals to NCHealth*Smart* resources

Wellness Wins: Greene, Jones, and Lenoir

Major Chronic Conditions

Disease Burden = Prevalence x Severity



Active Health Management, Heat Maps, 2014

Wellness Wins: Provider Support and Engagement Strategies

- Provider forum to understand practice needs
- “Hands on” quality improvement coaching and technical support to develop data driven improvements in clinic workflows, quality of care, and member experiences
- Care coordination and member engagement supports
- Collaborative networking and stakeholder meetings
- Continuing medical education opportunities:
  - Clinical updates for chronic disease management
  - Quality improvement tools and processes
  - Population health management

Wellness Wins: Provider Engagement Update

- Completed initial contact and conversations with the following:
  - Alber Arrigo-Delia, Director of Health Access, ECU
  - Lorrie Basnight, Pediatrician, Eastern AHEC
  - Skip Cummings, Pharmacy Dean, ECU
  - Jacqueline Halladay, MD, Professor of Medicine, UNC Chapel Hill
  - Angel Moore, QI Director, Eastern AHEC; ECU
  - Joan Templeton-Perry, Pediatrician
  - Greg Griggs, Executive VP, NC Academy of Family Physicians

Next Steps

- Conduct meetings with other community stakeholders and providers by February 2015

Advanced Primary Care Practice Demonstration

Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)

Objective: Federal demonstration project to evaluate outcomes using a PCMH model to deliver medical care to Medicare and commercial members between January 2013 to December 2014.

- Involves 7 rural counties and 47 Primary Care Practices
- Payer Participants: NC Medicaid, BCBSNC, NC SHP
- Community Care of NC (CCNC) Strategies**:**
  - Care managers embedded in each participating practice
    - Identified gaps in care
    - Worked with practice and members to close gaps
    - Practice supports provided by CCNC to achieve NCQA certification
    - Enhanced payment to providers

Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP) Outcomes

Timeframe: January 1 - June 30, 2014

Provider and Member Engagement

- Average 10,000-12,000 SHP members reached monthly
- 775 members engaged in care management
- 48 members received Transition Of Care (TOC) services when indicated within 30 days of hospital discharge
- 48 members received medication reconciliation services
- 100% of participating practices achieved National Committee for Quality Assurance (NCQA) Patient Centered Medical Home and Blue Quality Physician Program (BQPP) recognition

Health Outcomes (Baseline, July-December 2013)

- Decrease in Non-Emergent Emergency Room (ER) visits
- No change in total ER visits
- No change in breast cancer screening
- HbA1C testing compliance rate 76%*
- Lipid testing compliance rate 72%*

*Claims & EMR data. Comparison data unavailable.

Advanced Primary Care Practice Demonstration Outcomes (APCP)

- The Federal demonstration (MAPCP) ended in North Carolina as of December 2014.

- The Plan has decided to continue the initiative with CCNC for the 7 counties as the *Advanced Primary Care Practice Demonstration*.

Next Steps

- Contract with CCNC to continue model for 2015
- Does not include enhanced payment or PCMH recognition support
- Analyze and review outcomes from MAPCP efforts, 2014

State Health Plan Board Meeting: ACO Update and Move to Value

January 23, 2015

Susan Weaver, MD – Chief Medical Officer
Susan Jackson, Vice President, Health Delivery Redesign

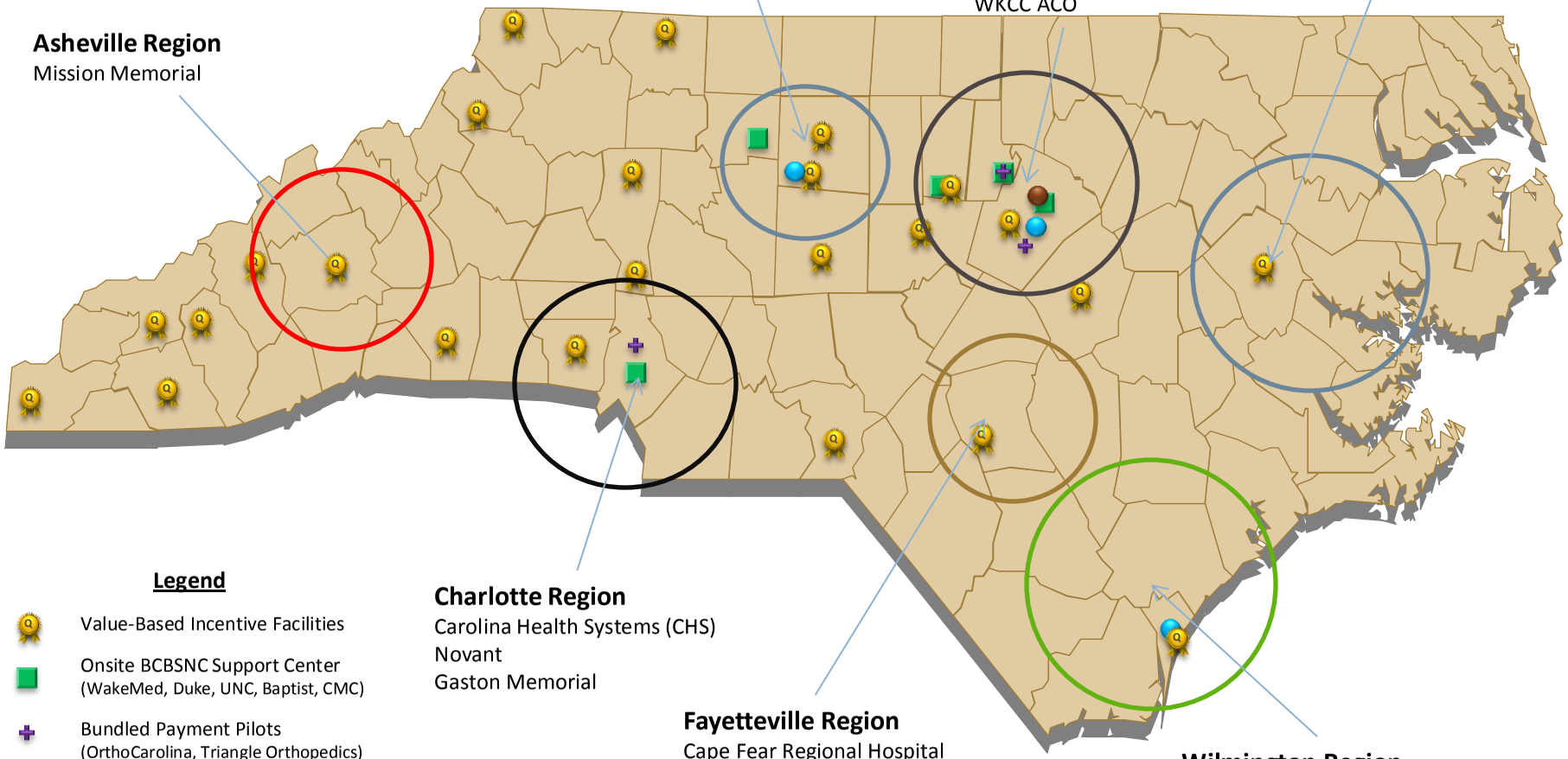
BlueCross BlueShield of North Carolina

Overview of ACOs and Value-based Partners

ACOs and Value-based Partnerships allow BCBSNC and providers to achieve high quality, more affordable care

- BCBSNC's goal is to invest in new capabilities and operational models with health care systems that will provide high quality, more affordable care and a better experience for our shared member/patient base
- BCBSNC's ongoing development of the ACO model and other Value-based Partnerships is providing us with strategic insight and knowledge resulting from the in-depth nature of the partnership between payer and provider

Regional Provider Partners



Triad Region
Baptist
Novant
Moses Cone – CHS
High Point Regional
Cornerstone ACO

Triangle Region
UNC
Duke
WakeMed
WKCC ACO

Eastern Region
Vidant

Asheville Region
Mission Memorial

Charlotte Region
Carolina Health Systems (CHS)
Novant
Gaston Memorial

Fayetteville Region
Cape Fear Regional Hospital

Wilmington Region
New Hanover Regional Medical Center
Wilmington Health / New Hanover RMC ACO

Legend

- Value-Based Incentive Facilities
- Onsite BCBSNC Support Center (WakeMed, Duke, UNC, Baptist, CMC)
- Bundled Payment Pilots (OrthoCarolina, Triangle Orthopedics)
- ACO: Cornerstone, WKCC, Wilmington Health/New Hanover RMC

Quality Measures

Current Quality Measures in ACO Portfolio

ACO Core Quality Measures					
Adult BMI Assessment	Cervical Cancer Screening	Appropriate Treatment for Children with URI (upper respiratory infection)	Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic	HbA1c Poor Control >9 (Lower score is better)	Antidepressant Medication Management
Weight Assessment for Children/ Adolescents	Colorectal Cancer Screening	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Warfarin Therapy inpatients with Atrial Fibrillation	Cholesterol LDL-C screening	Follow-up Care for Children Prescribed ADHD Medication
Childhood Immunizations	Chlamydia Screening in Women	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Annual Monitoring for Patients on Persistent Meds (ACE or ARB)	Diabetes Care Cholesterol LDL-C control <100	Follow-up After Hospitalization for Mental Illness – 7 days
Immunizations for Adolescents	Influenza Immunizations	Pharmacotherapy management of COPD Exacerbation	Diabetes Care Eye Exams	Diabetes Care Nephropathy Monitoring	High Risk Medications in the Elderly
Breast Cancer Screening	Tobacco Use Assessment and Cessation Intervention	Cholesterol Management for Patients with Cardiovascular Conditions	Diabetes Care Controlling High Blood Pressure <140/90	Use of Imaging Studies for Low Back Pain	Medication Reconciliation Post-Discharge
Appropriate Testing for Children with Pharyngitis	Controlling High Blood Pressure	HbA1c Testing	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Osteoporosis Management in Women Who Had a Fracture

WKCC Partnership

BlueCross BlueShield of North Carolina

Founding Principles

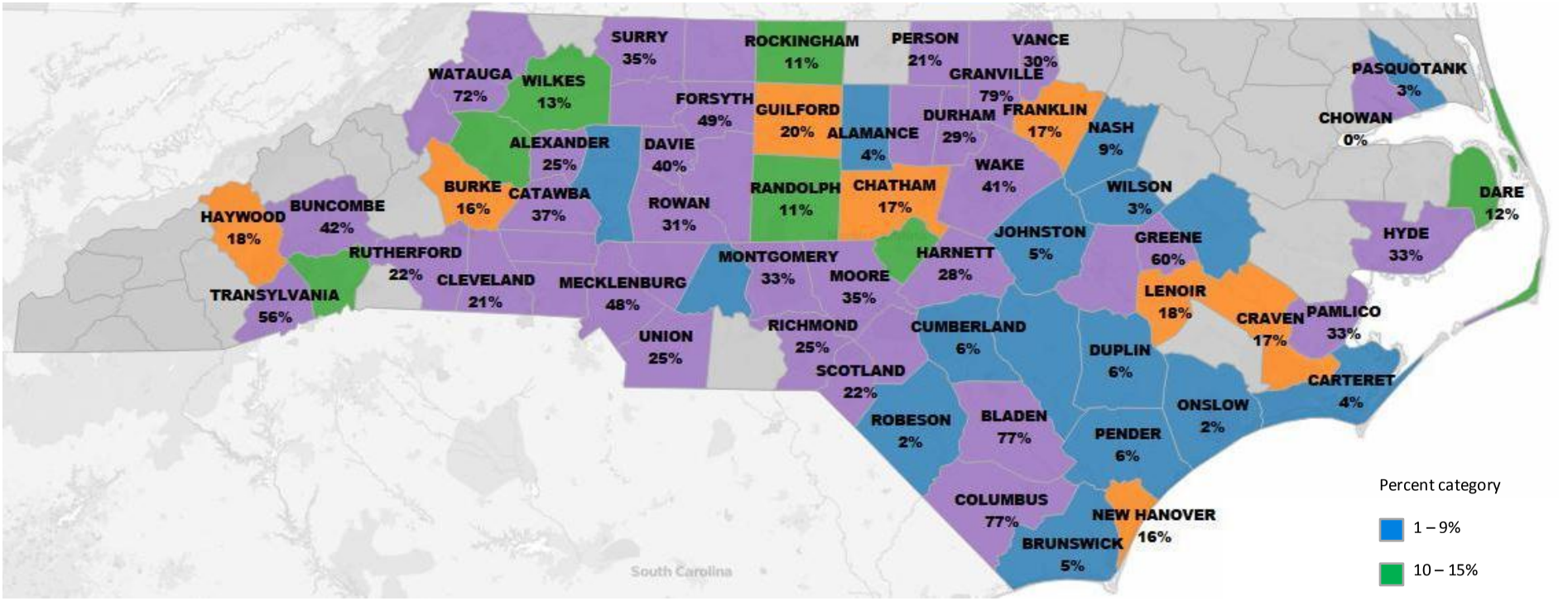
1. *Physician led*
   Physicians comprise 90% of governing board, each committee is chaired by a physician
2. *Maintain physician independence*
   No interest from either party in hospital acquiring individual physician practices
3. *Value through Payer Partnerships*
   MSSP as stepping stone to commercial ACO
4. *Data integration*
   Provide consolidated patient view of claims and clinical information, advanced analytics, workflow, and quality reporting

Enhanced Care Coordination

- BCBSNC and WKCC are collaborating on behalf of our members and patients to deliver high quality outcomes at a more affordable cost and enhance the overall experience for members
- WKCC, ActiveHealth, and BCBSNC work together to close gaps in care and provide patient education and assistance in all settings
- WKCC Clinical Navigator reaches out to patients on behalf of their physician
- WKCC helps to engage members with high-value, designated specialists, labs and imaging providers

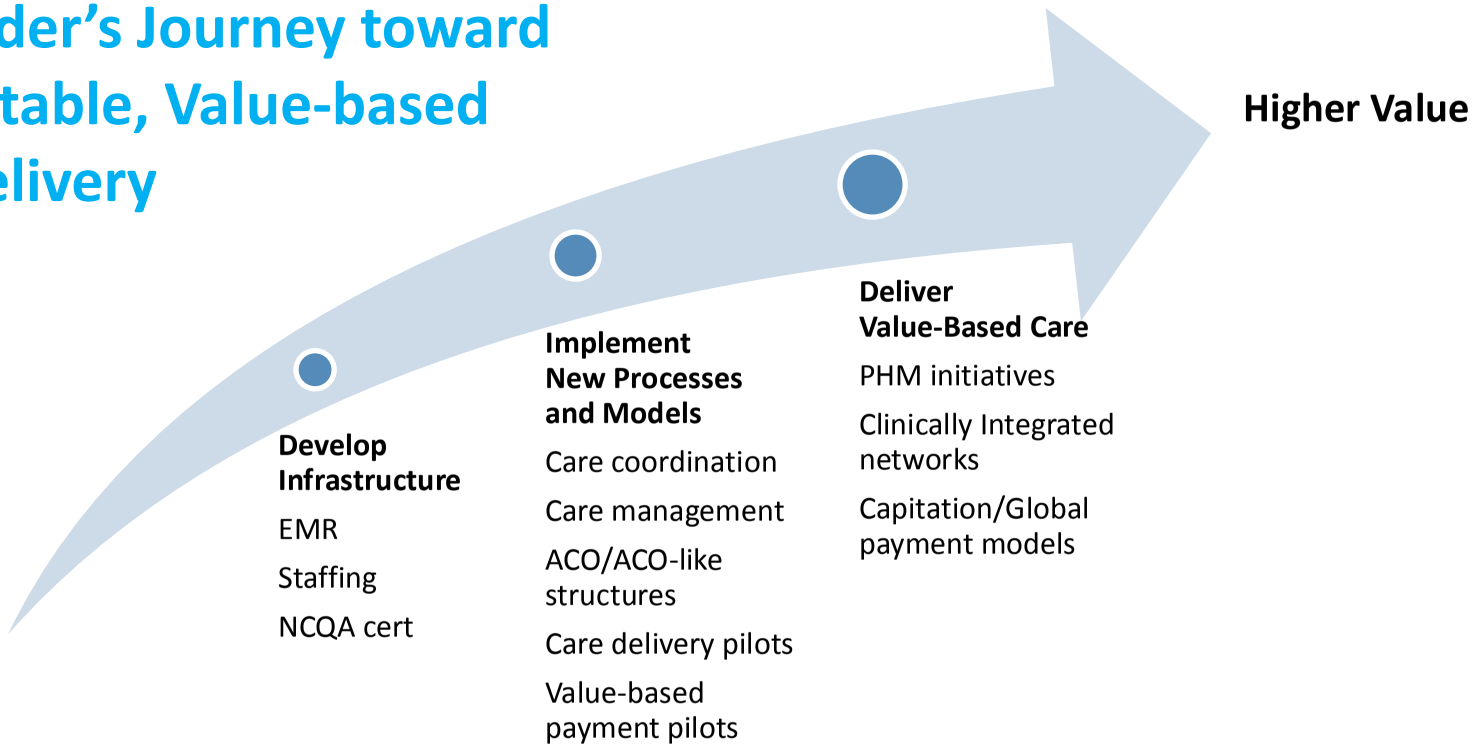
Patient-Centered Medical Homes (PCMH)

% of PCMH groups of overall Primary Care groups, per county (Source: NCQA)



- BCBSNC actively supports the development of PCMH's across the state.
- Many of the independent primary care groups also participate in BCBSNC's BQPP Program (Blue Quality Physician Program)
- BCBSNC views the emphasis on primary care as a critical component to maintaining the wellness of SHP membership

A Provider's Journey toward Accountable, Value-based Care Delivery



BCBSNC supports this journey by:

- Developing more collaborative, less transactional provider relationships emphasizing collaboration, trust, transparency, simplification and long-term commitment and focus on a common goal of greater accountability, robust quality and cost outcomes and integration among providers
- Helping providers build key capabilities to support value-based care delivery: analytics, data sharing, care coordination, consumer engagement, and reporting on quality metrics
- Designing and implementing new value-based payment mechanisms, incentive structures and products that focus on quality and population health management

Value Added by Hospital Quality in 2014

Effort → *Outcome*

Hospital Engagement

35
Number of hospitals engaged in 2014

65%
Growth

50%
Hospital network penetration expected in 2014

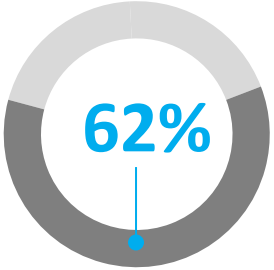
~30%
2013 hospital penetration

Financial Value…. Delivered

$1.67 Million
Savings realized on contracts ending 2014 YTD

Dollars Tied to Quality

$331 Million
Inpatient Paid contract dollars tied to quality for 12 months ending March 30, 2014



Percent of total contract dollars tied to quality in 2014 YTD

Care Value… Delivered

9%
Reduction in infection rate for central-line associated blood stream infections in participating hospitals (estimated savings of up to $40K per case)

39%
Reduction in infection rate for catheter associated UTIs in participating hospitals (estimated savings of up to $758 per case)

38%
Reduction in pre-term elective delivery rate in participating hospitals