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

**Board of Trustees' Meeting**
**Department of State Treasurer**
**Thursday, May 29, 2014**
**4:00 – 6:00 p.m.**

| | | |
|---|---|---|
| 1. | Welcome | Janet Cowell, Chair |
| 2. | Conflict of Interest Statement | Janet Cowell, Chair |
| 3. | Strategic Planning | Tom Gualtieri-Reed |
| 4. | 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 wellbeing.*

North Carolina State Health Plan
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**Board of Trustees' Meeting**
**Department of State Treasurer**
**Friday, May 30, 2014**
**9:00 a.m. – 3:00 p.m.**

| | |
|---|---|
| 1. Welcome | Janet Cowell, Chair |
| 2. Conflict of Interest Statement | Janet Cowell, Chair |
| 3. Review of Minutes – March 27 and 28, 2014 ***(Requires Board Vote)*** | Janet Cowell, Chair |
| 4. Executive Administrator Update *(15 minutes)* | Mona Moon |
| 5. Legislative Update *(15 minutes)* | Tom Friedman |
| 6. Financial Report, Forecasting and Monitoring *(45 minutes)* | Mark Collins |
| A. March 2014 Financial Report | |
| B. CY 2014 1st Quarter Actuarial Forecast Update | |
| i. Baseline Scenario | |
| ii. Modified Trend Scenario | |
| C. Member Migration Analysis: FY 2012-13 to CY 2014 | |

**Break (10 minutes)**

| | |
|---|---|
| 7. Benefit Design and Plan Options | |
| A. Coverage for Applied Behavior Analysis ***(Requires Board Vote)*** *(60 minutes)* | Lotta Crabtree |
| B. Comment on Proposed ABA Benefit *(15 minutes – 5 minutes each)* | |
| i. Autism Speaks | Lorri Unumb, VP<br>*State Government Affairs* |
| ii. TEACCH Autism Program | Dr. Laura Klinger<br>*Executive Director* |
| iii. North Carolina Psychological Association | Dr. Vickie Shea<br>*Past President* |

C. 2015 Enrollment Rules & Medicare Advantage Plan Renewals ***(Requires Board Vote)*** *(20 minutes)* — Caroline Smart

**Lunch (30 minutes)**

D. Potential Benefit Option for Newly Eligibles *(15 minutes)* — Mona Moon

8. Member Experience and Communications *(35 minutes)*
   A. Medicare Primary and Open Enrollment Outreach — Caroline Smart
   B. 2014 Member Satisfaction Survey — Caroline Smart
   C. Member Contact Information Contest — Nidu Menon

9. Contracting and Vendor Partnerships *(20 minutes)*
   A. Eligibility and Enrollment Services — Mona Moon, Caroline Smart
   B. ADT Data from NC Hospital Association — Nidu Menon

10. Pharmacy & Therapeutics Committee Meeting Summary *(10 minutes)* — Sally Morton

**Break (10 minutes)**

11. Strategic Planning *(60 minutes)* — Tom Gualtieri-Reed

12. Wrap-Up — Janet Cowell, Chair

Next Board of Trustees' Meeting: Thursday, July 31, 4-6 p.m. and Friday, August 1, 9 a.m. – 3 p.m.

North Carolina State Health Plan
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# North Carolina
# State Health Plan

## *Strategic Plan*
## *2014 – 20XX*

*May 20, 2014*
*DRAFT*

*For Discussion Purposes Only*

Note: This document will serve as the foundation for the State Health Plan's strategic plan. Background, environmental scan conclusions and other supporting analyses will be included in the final version of the strategic plan.

North Carolina State Health Plan
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# STRATEGIC PLAN GUIDING PRINCIPLES

The following guiding principles were used in developing the strategic priorities and measures of success for the SHP's strategic plan:

1. The State Health Plan's **Mission Statement** will serve as the primary guide in the development of a strategic plan.

   *"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."*

2. It is the intent of the BOT and SHP leadership team to ensure the **perspective of the member**, including experience and value, is factored into the strategic plan.
3. It is the intent of the BOT and SHP leadership team to support the development of benefit offerings that are **affordable** to state employees, retirees and their dependents and the State of North Carolina. Therefore the BOT and SHP leadership team will make every effort to work on behalf of the members and State of North Carolina to develop the competitively priced offerings that **improve the health and well-being of its members**.
4. The BOT and SHP leadership team recognize the responsibility to ensure that members have **access to quality care** and that their **patient experience is positive**.
5. Given the Plan's responsibility to serve members across the state, the BOT and SHP leadership team recognize the need to develop benefit offerings and programs that **balance cost and access to quality care**.
6. There needs to continue to be a **sense of urgency** to ensure the SHP remains financially stable to fulfill the mission of improving the health and health care of its members. That said the BOT and SHP leadership team acknowledge that the ability to make operational changes requires time and resources. Therefore, it is prudent to have **a reasonable period of stabilization** to manage recent member and operational impacts and to have time to measure the results of recent changes. Continuous measurement and monitoring will be an integral part of the strategic planning process.
7. The BOT and SHP leadership team recognize the opportunity to develop benefit offerings and programs that will require longer time horizons to determine measurable results. Therefore, it is the intent of the BOT and SHP leadership team to **develop a balanced portfolio of both near and long term strategic initiatives**.
8. It is the intent of the BOT and SHP leadership team to effectively manage premiums that members are required to pay for coverage and for out of pocket health care expenses. The BOT and SHP leadership team **support the development of programs and benefit offerings that encourage healthy lifestyles** and the appropriate use of incentives and cost sharing as levers in influencing the use of healthcare services and improving the health of plan members. Ongoing communication and education will be critical.
9. The BOT and SHP leadership team acknowledge that there will be a dependency on the **support of the North Carolina General Assembly** to fund or operationally execute on the strategic plan. The BOT and SHP leadership team will work collaboratively with that constituency to ensure the strategic plan fulfills the mission of the SHP.
10. Given the dependency on 3rd party vendors and business partners, the SHP, working in the best interests of the SHP members and State of North Carolina, will take a **partnership approach** with these stakeholders in developing and executing on the strategic plan. This will include utilizing their areas of expertise and information to guide the decisions and actions of the BOT and SHP leadership team.
11. It is the intent of the BOT and SHP leadership team to act in a manner that is in **the best interests of all members** of the SHP and actively work toward **consensus** that will enable the fulfillment of the mission of the SHP.

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# DRAFT SHP Strategic Plan
# 2014 – 20XX

## 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.*

## VISION

**Proposed Statement for Consideration**

*Our vision is to be a health plan that is a leader in North Carolina for partnering with organizations and individuals from across the state to provide access to cost-effective, quality health care and wellness programs on behalf of our membership.*

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## STRATEGIC PRIORITIES

| Priority | What It Means | What We Will Do | Why It Is Important |
|---|---|---|---|
| **Manage the health of the population** | Population health management is a model for managing all aspects of member health from wellness to chronic disease with a focus both on engaging members in their health and improving the quality and coordination of care within the health care system. The goal is maintaining or improving the health of members and lowering medical claims cost for members and the Plan. | • Maintain or improve member health as appropriate including the support of members with chronic conditions<br>• Engage healthcare providers in improving the quality and coordination of care<br>• Promote a culture of wellness | 51% of members have at least one chronic condition and account for 78% of claims expenditures. Duplication of services and the provision of services in higher cost settings significantly contribute to the cost of care. Better coordination of care and better health of the population can improve member's well-being and lower costs for both members and the Plan. |
| **Improve member's experience** | The member experience includes the relationship members have with the Plan including enrollment, access to information, benefit designs, and affordability of coverage; services and programs provided by the Plan and its vendor partners; and access to providers and quality care through effective relationships with the Plan's network providers. The Plan also seeks to foster and improve the direct relationship between the member and the provider. | • Improve communication with members about benefit design, enrollment, and eligibility to promote health literacy<br>• Increase transparency of the cost of care and the quality of network providers<br>• Provide reliable, quality services for enrollment, claims processing, and population health management<br>• Address member concerns regarding Plan operations, benefit design, coverage, and costs<br>• Develop partnerships and benefit designs that improve the member's experience with providers | Members who are informed and satisfied with service experience are more likely to engage with the Plan and participate in benefit designs and programs aimed at improving their health, leading to improved health and well-being for the member and lower health care costs for the both the Plan and the member. |
| **Ensure a financially stable State Health Plan** | The Plan must address the cost of healthcare, the delivery of healthcare, and the utilization of benefits in order to keep the Plan sustainable and ensure that costs do not exceed resources or result in the diminishment of benefits. | • Manage the cost of medical claims<br>• Manage the cost of pharmacy claims with a specific focus on specialty pharmacy management<br>• Encourage members to use benefits appropriately and to be informed consumers of medical services.<br>• Develop programs focused on fraud, waste, abuse and overuse<br>• Collaborate with the General Assembly and Office of State Budget and Management to help ensure predictable funding for health benefits | Financial stability and management of costs protect the State and members from large premium increases. Maintaining a strong reserve balance enables the Plan to invest in initiatives to improve health and experience while managing future cost increases.<br>The Plan's expense trend has been at or below medical CPI for the last four fiscal years, and the Plan holds reserves equal to approximately 16 weeks of projected Plan spending. Recent experience has allowed the Plan to offer more options and enhanced benefits for 2014. |

## STRATEGIC INITIATIVES

| Priority | Initiative | What It Means | What We Will Do | Why It Is Important |
|---|---|---|---|---|
| **Manage the health of the population** | Maximize Patient Centered Medical Home (PCMH) Effectiveness | The Patient Centered Medical Home model is a way of organizing primary care that emphasizes care coordination (including appropriate setting) and communication to transform primary care to include population health management. Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care | • Support providers in serving as PCMHs through data analytics, care management, and/or enhanced payment through the Population Health Management Services vendor to designated PCMH groups.<br>• Groups will be identified for support/partnership (directly or through a vendor partner) based on willingness to engage and opportunity for improved patient outcomes based on review of available clinical measures.<br>• Develop metrics and benchmarks to demonstrate the impact of improved care and coordination such as medication adherence, cost-effective settings of care and HEDIS measure testing and compliance measures<br>• Design and communicate incentives and other benefit designs that encourage members to have designated PCMH's serve as their primary care provider | • At the heart of the PCMH are the patient and the primary care physician who serves as the key to better coordination of care and patient engagement.<br>• For 2014, 98% of members in the 80/20 and 99% of members in the CDHP plans selected a primary care provider<br>• Increasing the number of primary care providers that are PCMHs will increase the focus on quality of care indicators such as:<br>  ◦ Diabetes HbA1c testing rate is 12% below the national average<br>  ◦ Cholesterol LDL-C screening is 29% below the national average |
| | Engage Members with High Cost High Prevalence Chronic Conditions | Focused programs designed to engage members and their providers to effectively manage a member's chronic condition(s). The targeted chronic conditions include asthma, COPD, cardiovascular diseases & diabetes. | • Develop chronic care management programs focused on high volume and high cost conditions where there is opportunity to collaborate with providers to improve both quality of care and member engagement<br>• Collaborate with other state entities and stakeholders, including the NC Department of Health and Human Services, on addressing how to improve these conditions across the state | • Members with at least one chronic condition account for 76% of total cost of care (Non-Medicare)<br>• Prevalence of high cost chronic conditions (for actives):<br>  ◦ Hypertension - 25%<br>  ◦ Asthma/COPD – 10%<br>  ◦ Diabetes – 9%<br>  ◦ CAD – 3%<br>• In 2013, members with managed chronic conditions utilized $5,198 of services; members without chronic conditions utilized about $1,283. Members with unmanaged chronic conditions utilized $19,899 of services, almost 4 times the cost of members with managed conditions. |

| Priority | Initiative | What It Means | What We Will Do | Why It Is Important |
|---|---|---|---|---|
| | | | | • Medication adherence rates for diabetes is 66%, hypertension is 75% and high cholesterol is 66% |
| **Manage the health of the population** | Offer Health-Promoting and Value-Based Benefit Designs | Benefit designs that reduce barriers to care and are directed at sustaining long-term health and managing chronic disease and incent members to seek treatment from high quality, cost effective providers | • Offer benefit designs that provide no cost access for preventive care, encourage utilization of PCMHs and use of high quality primary care providers, encourage healthy behaviors and engage members.<br>• Consider additional value-based benefit designs that offer quality and cost options around providers, treatments and medications<br>• Incent members to make long-term healthy lifestyle choices maintenance and more effectively manage chronic disease | • Access to high quality care at cost effective settings helps sustain health and allow for management of chronic disease<br>• When offered a premium credit, 84% of active members selecting the CDHP and 80/20 plan options completed a health assessment, chose a PCP and attested they did not smoke or were enrolled in a smoking cession program |
| | Promote Worksite Wellness | Any employment based activity or employer sponsored benefit aimed at promoting healthy behaviors (primary or secondary prevention). These are programs that require longer time horizons by which to measure results and impacts. | • Using the NC Health*Smart* program, partner with state agencies to influence environmental and workplace policies and tailor programs suited to the different strata of membership across the state<br>• Develop programs and approaches that ensure the continuous engagement of members throughout the year | • Creating a culture of wellness requires the participation and support of the employer.<br>• National data suggests that worksite wellness programs help employees feel more valued<br>• 45% of employees say these programs encourage them to stay with their employer |

| Priority | Initiative | What It Means | What We Will Do | Why It Is Important |
|---|---|---|---|---|
| **Improve member's experience** | Create Comprehensive Communication & Marketing Plan | Providing members with materials they can understand to help them effectively utilize their health benefits. Communicating regularly, not just at open enrollment, to allow members the opportunity to maximize their experience and improve health literacy. | • Develop a comprehensive and continuous communication strategy, including print, email, web-based and mobile applications and media, regarding benefit plan options, how to get the most value out of the benefit programs and explain the value of the benefits that are offered, including:<br>  ○ Improve member contact information<br>  ○ Develop a branding campaign in coordination with the Department of State Treasurer<br>  ○ Regularly meet with provider community to distinguish SHP services from BCBSNC services<br>• Influence the perception of the value of SHP offerings | • Health benefits are utilized throughout the year and therefore, regular benefits communications will assist members with benefit questions and managing their care.<br>• There are opportunities to use online communication channels as less than 1% of members access Health*Smart* resources online.<br>• Over 80% of retired members prefer written materials while active members prefer online communications. This demonstrates the need for a variety of communication channels. |
| | Improve the Member Enrollment Experience | Members are able to enroll in the benefits they choose and their premium credits are accurately reflected. Enrollment tools meet current technology standards. Streamline customer service calls and online access | • Develop a consistent and stable platform for member's enrollment experience<br>• Provide a superior customer service call center to provide members with timely and accurate enrollment and benefit information<br>• Ensure that enrollment data is accurately and timely collected, maintained and transmitted<br>• Where possible, provide single sign-on from the originating secure site to other sites to eliminate the need for multiple passwords and user IDs. | • Enrollment is the gateway to the provision of benefits and it is imperative that the member's enrollment experience is as simple as possible and that enrollment information is accurately captured, displayed and transmitted to ensure access to appropriate benefits and to improve the trust of members.<br>• Having multiple contact numbers and login IDs can be a barrier to access and timeliness of service.<br>• Improving member experience can enable increased engagement. |
| | Promote Health Literacy | Provide access to tools and resources designed to assist members in understanding costs, treatment and provider options to support members in communicating with their provider and engaging in their health care decisions. | • Develop and market tools and resources, particularly web-based and mobile applications that provide cost and quality transparency metrics and assist members in making informed choices on treatment options, cost, provider selections, and site of service. | • Providing tools to access high quality, site appropriate, and low cost care encourages improved health outcomes, raises member satisfaction, and reduces Plan cost growth<br>• Only 0.2% of members access the provider portal, which houses the current transparency tools.<br>• Web-based and mobile platforms improve accessibility to information |

| Priority | Initiative | What It Means | What We Will Do | Why It Is Important |
|---|---|---|---|---|
| Ensure a financially stable State Health Plan | Target Hospital and Specialist Medical Expense | The management of specific categories/ treatments of care that exceed the Plan forecast and/or medical expense trends. The management of member out-of-pocket costs in high cost services and care settings such as hospitalizations and specialized medical care. The management of fraud, waste, abuse and overuse of medical services. | • Develop and implement targeted programs or benefit designs that specifically address the following:<br>○ Appropriate use of emergency rooms and urgent care centers<br>○ Avoidable inpatient admissions, readmissions, duplicative care<br>○ Use, costs and/or site of service for specialty medical services<br>○ Implement targeted programs focused on reducing fraud, waste, abuse and overuse of medical services. | • Hospital inpatient costs averaged $3,266 per day in 2013 and represented $612 million in spending (17.5% of total).<br>• The average cost of a hospital stay for Plan members was $15,553 in 2013<br>• Emergency room costs represent another $146 million in medical costs (4.2%). |
| | Target Pharmacy Expense | The management of specialty medications across medical and pharmacy spend as well as fraud, waste, abuse and overuse of pharmaceuticals | • Implement targeted programs or benefit designs that manage the cost, use, and/or site of service of specialty medications.<br>• Implement targeted programs focused on reducing fraud, waste, abuse and overuse of pharmaceuticals. | • Pharmacy costs are 29% of total plan medical costs<br>• 2.6% of non-Medicare membership uses specialty medications under the medical benefit which accounts for 6.7% of total plan (non-Medicare) medical payments<br>• Medical specialty pharmacy trend is 11.3%<br>• <2 % of members use specialty medications under the pharmacy benefit which accounts for 22% of plan pharmacy cost. This is projected to be 50% by 2018.<br>• Specialty pharmacy (pharmacy benefit) trend is currently 16%. |
| | Pursue Alternative Payment Models | Shift away from the current pay for volume approach in health care to paying for outcomes based on evidence based metrics. Utilize the spectrum of alternative payment strategies, ranging from PCMH to pure capitation, to more efficiently compensate providers to provide care in the most effective setting. Take a long-term, prospective view to improve member health to manage cost growth versus only short-term price reductions | • Partner with current and future third party administrators (TPAs)/carriers to identify opportunities to incent quality of care and pay for outcomes while facilitating the development of successful evidence-based practices that are emerging in North Carolina<br>• Partner with other payers, where appropriate, to implement consistent approaches to alternative payment strategies throughout North Carolina<br>• Engage with providers who are able to work directly with the Plan on value based payments and metrics | • Moving away from pure fee for service provides an incentive to focus on better coordination and effective care<br>• 15.6% of hospital admissions had a readmit within 30 days<br>• Average inpatient cost per day has increased by 4.4% over the past year |

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## STRATEGIC MEASURES OF SUCCESS

**EXAMPLE FOR DISCUSSION PURPOSES ONLY**

| Measure | Manage the health of the population | Improve member's experience[1] | Ensure a financially stable State Health Plan |
|---|---|---|---|
| **Description** | Measure the % of members that are classified as healthy or having experienced a significant acute encounter | Utilize a variety of survey tools and feedback sources to evaluate the impact of specific initiatives | Meet or exceed annual financial forecasts |
| **Metric** | Average of 48% over the measurement timeframe | Varies by Initiative | Medical expense trend forecast and cash balance |
| **Baseline Year[2]** | 2013 | Varies by Initiative | 2014 |
| **Measurement Timeframe[2]** | 2014 – 20xx | Varies by Initiative | Each Calendar Year and Each Fiscal Year |
| **Measurement Source** | Clinical Risk Grouping (CRG) classification using a 3rd party vendor | Varies by Initiative | 3rd party developed annual forecast |

1 SHP Executive Committee and Board of Trustees will establish appropriate evaluation criteria based on the timing and details of specific member experience initiatives

2 All years are based on the calendar year ending in December, unless specifically noted as fiscal year

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# HIGH-LEVEL ROADMAP

**FRAMEWORK TO BE DETERMINED**

| | 2014-2015 | 2016-2017 | 2018-2019 | 2020-2021 |
|---|---|---|---|---|
| **Benefit Offerings & Programs** | | | | |
| **Program Administration & Contracting** | | | | |
| **Provider Network** | | | | |
| **Provider Payment Methods** | | | | |
| | | | | |
| **General Assembly Engagement** | | | | |
| **Member Communication** | | | | |

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

# Legislative Update

***Board of Trustees***

**May 30, 2014**

# Legislative Update Overview

- Budget Update
- Summary of SHP-related Legislation
- Next Steps

# SHP Budget Update

- Last week the State Treasurer, in consultation with the Board, recommended foregoing scheduled increases in employer and employee premiums in CY 2015
  - The Appropriations Act of 2013, (the budget enacted by SL 2013-360) includes funding in FY 2014-15 to increase the employer contribution for health benefits by 2.14% in January 2015
  - Forgoing the premium increase will save $22 million in General Fund and $1.05 million in Highway Fund Appropriations
- The Governor's Recommended Budget (SB 842) and the proposed Senate Budget (SB 744) include the savings associated with foregoing the premium increase

# SHP Budget Update

| | Enacted Budget (SL 2013-360) | Governor's Recommended Budget | Senate Budget Proposal | House Budget Proposal | Revised Budget |
|---|---|---|---|---|---|
| Premium Increase | | | | | |
| FY 2014-15 | 2.14% Jan 1, 2015 | 0.00% | 0.00% | TBD | TBD |
| General Fund Appropriations | | | | | |
| FY 2014-15 | $89.0 m | $67.0 m | $67.0 m | TBD | TBD |
| Change | N/A | ($22.0 m) | ($22.0 m) | TBD | TBD |
| Highway Fund Appropriations | | | | | |
| FY 2014-15 | $4.5 m | $3.45 m | $3.45 m | TBD | TBD |
| Change | N/A | ($1.05 m) | ($1.05 m) | TBD | TBD |

# Reallocation of Funds Appropriated for Premium Increase

| Governor's Recommended Budget: | |
|---|---|
| One NC Fund investments in Job Creating Businesses: | $10,000,000 |
| Severance Reserve: | $2,000,000 |
| Rural Infrastructure Grants: | $2,000,000 |
| Research Triangle Institute Funding: | $500,000 |
| UNC Game Changing Research: | $2,000,000 |
| Medical Examiner Training & Certification: | $1,000,000 |
| NC Symphony Challenge Grant: | $500,000 |
| Distinguished Leadership in Practice: | $500,000 |
| Housing Finance Agency Low-Income Housing Loan Program: | $2,000,000 |
| Economic Development Fund/OSBM-Special Appropriation: | $1,000,000 |
| ABC Underage Drinking Program: | $500,000 |
| DOT General Maintenance Reserve (Highway Funds): | $1,050,000 |

The Senate Budget does not specifically cite the use of the $23 million

# Additional Budget Items Related to the State Health Plan

The Senate Budget also includes the following items:

- Increases the Plan's administrative budget by $12.8 million to reflect revised estimates of contractual and agency administrative costs

- Section 35.16 Alternative Health Benefit Coverage for Nonpermanent Full-time State Employees
  - Creates a new eligibility category for nonpermanent full-time employees to comply with the Affordable Care Act
  - Directs the Treasurer and Board to determine the coverage and contributions for these "newly eligible" employees as follows:
    - Minimum essential coverage, no greater than "Bronze" level, minimize employer contribution
  - Allows the UNC system the discretion to provide their own coverage to this group of employees
  - More details:  Potential Benefit Option for Newly Eligibles agenda item

# Next Steps

- Review House Budget Proposal and Conference Report
- Track SHP-related legislation
- Determine and communicate Plan's position on SHP related legislation
- Update the Board on final Revised Budget

# HB 498: Autism Health Insurance Coverage

- Bill Summary:
  - Requires the Plan to provide annual coverage of $36,000 for autism behavioral treatment benefits (some benefits not covered currently)
  - Coverage is for individuals age 23 and under
  - Exempts Board Certified Behavior Analysts (BcBAs) from the Psychology Practice Act to enable them to treat patients within the scope of their national certification, so long as they do not represent themselves to be psychologists
- Status: Passed the House, referred to Senate Committee on Insurance
- Fiscal Impact: Increase Plan costs by
  - $3.3 to $5.1 million in FY 2014-15
  - $6.1 to $12.7 million annually in the long term
  - Based on legislative actuarial note

# SB 783: Establish Chiropractor Co-pay Parity

- Bill Summary:
  - Similar in scope to SB 561 introduced in the 2013 long session
  - Requires the Plan to cover chiropractic care at the PCP copay level
  - Removes covered limits on visits to chiropractor
- Status: Referred to Senate Committee on Insurance
- Fiscal Impact:  Increase Plan costs by
  - $1.0 to $1.5 million 1st year
  - $2.6 to $3.7 million 2nd year
  - Based on the legislative actuarial note for SB 561

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# March 2014 Financial Report

***Board of Trustees Meeting***

**May 30, 2014**

A Division of the Department of State Treasurer

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

| Calendar Year 2014 | Actual thru Mar 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** | **$744.6 m** | **$742.3 m** | **$2.3 m** |
| Net Claims Payments | $583.3 m | $658.4 m | ($75.1 m) |
| Medicare Advantage Premiums | $40.3 m | $43.4 m | ($3.1 m) |
| Net Administrative Expenses | $37.4 m | $45.6 m | ($8.2 m) |
| **Total Plan Expenses** | **$661.0 m** | **$747.4 m** | **($86.4 m)** |
| **Net Income/(Loss)** | **$83.6 m** | **($5.1 m)** | **$88.7 m** |
| Ending Cash Balance | $922.1 m | $689.9 m | $232.2 m |

# Adjusted Variance Report
# Calendar Year to Date March 2014

| Calendar Year 2014 | Actual thru Mar 2014, As Adjusted | Certified Budget (per Segal 8-19-13) | Variance Over/(Under) Budget |
|---|---|---|---|
| **Plan Revenue *** | **$755.6 m** | **$742.3 m** | **$13.3 m** |
| Net Claims Payments ^ | $576.0 m | $658.4 m | ($82.4 m) |
| Medicare Advantage Premiums | $40.3 m | $43.4 m | ($3.1 m) |
| Net Administrative Expenses † | $37.2 m | $45.6 m | ($8.4 m) |
| **Total Plan Expenses** | **$653.5 m** | **$747.4 m** | **($93.9 m)** |
| **Net Income/(Loss)** | **$102.1 m** | **($5.1 m)** | **$107.2 m** |

* 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.

# Financial Results Actual v. Budgeted
# Calendar Year to Date March 2014

## *Per Member Per Month (PMPM) Analysis*

| Calendar Year 2014 | Actual thru Mar 2014 | Certified Budget (per Segal 8-19-13) | Variance Over/(Under) Budget |
|---|---|---|---|
| **Plan Revenue** | **$365.86** | **$371.42** | **($5.56)** |
| Net Claims Payments | $288.41 | $329.23 | ($40.82) |
| Medicare Advantage Premiums | $19.90 | $21.69 | ($1.79) |
| Net Administrative Expenses | $18.48 | $22.80 | ($4.32) |
| **Total Plan Expenses** | **$326.79** | **$373.72** | **($46.93)** |
| **Net Income/(Loss)** | **$39.07** | **($2.30)** | **$41.37** |

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

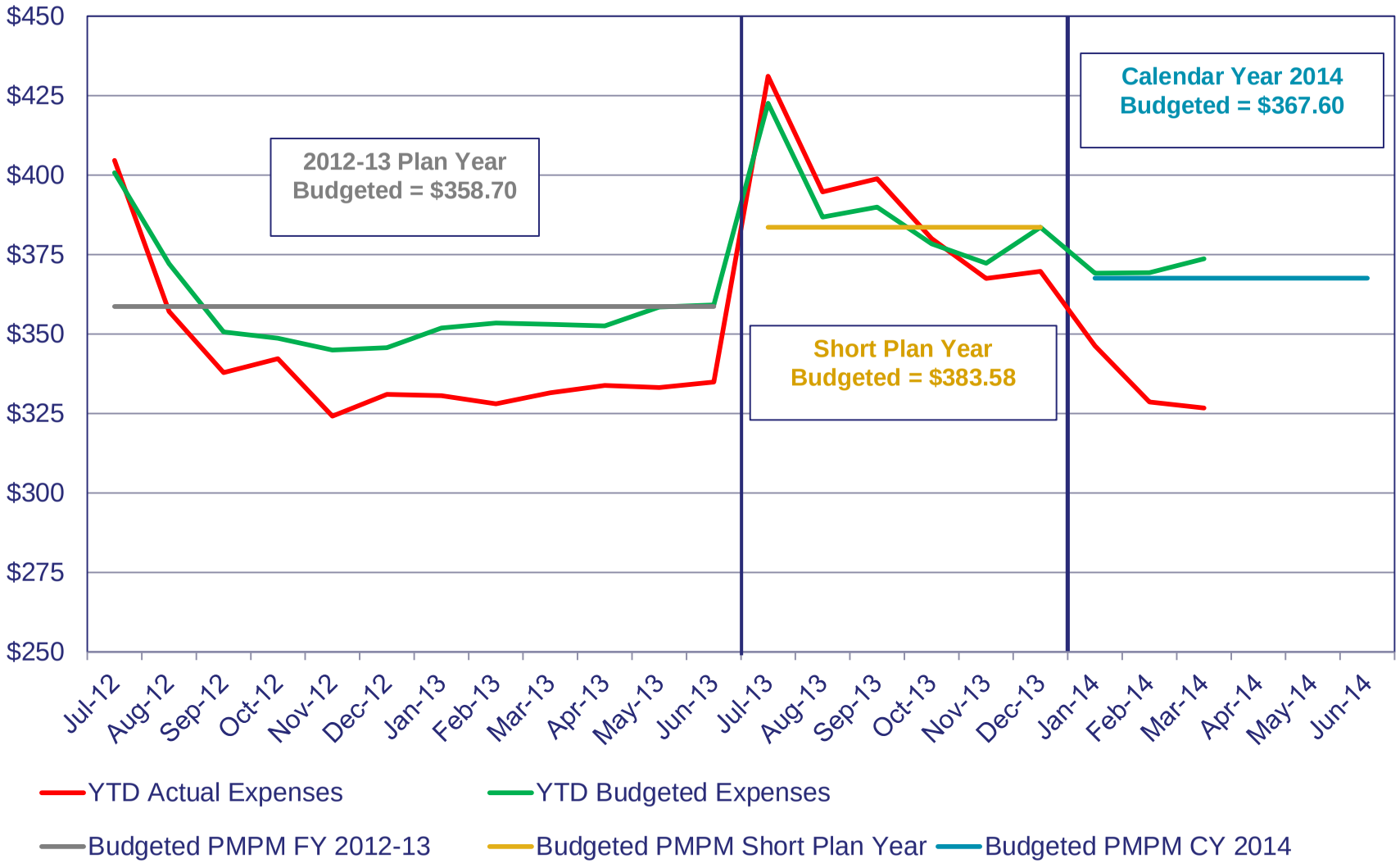
# Adjusted Variance Report
# Calendar Year to Date March 2014

## *Per Member Per Month (PMPM) Analysis*

| Calendar Year 2014 | Actual thru Mar 2014, as Adjusted | Certified Budget (per Segal 8-19-13) | Variance Over/(Under) Budget |
|---|---|---|---|
| **Plan Revenue *** | **$371.26** | **$371.42** | **($0.16)** |
| Net Claims Payments ^ | $284.81 | $329.23 | ($44.42) |
| Medicare Advantage Premiums | $19.90 | $21.69 | ($1.79) |
| Net Administrative Expenses † | $18.42 | $22.80 | ($4.38) |
| **Total Plan Expenses** | **$323.13** | **$373.72** | **($50.59)** |
| **Net Income/(Loss)** | **$48.13** | **($2.30)** | **$50.43** |

* 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.

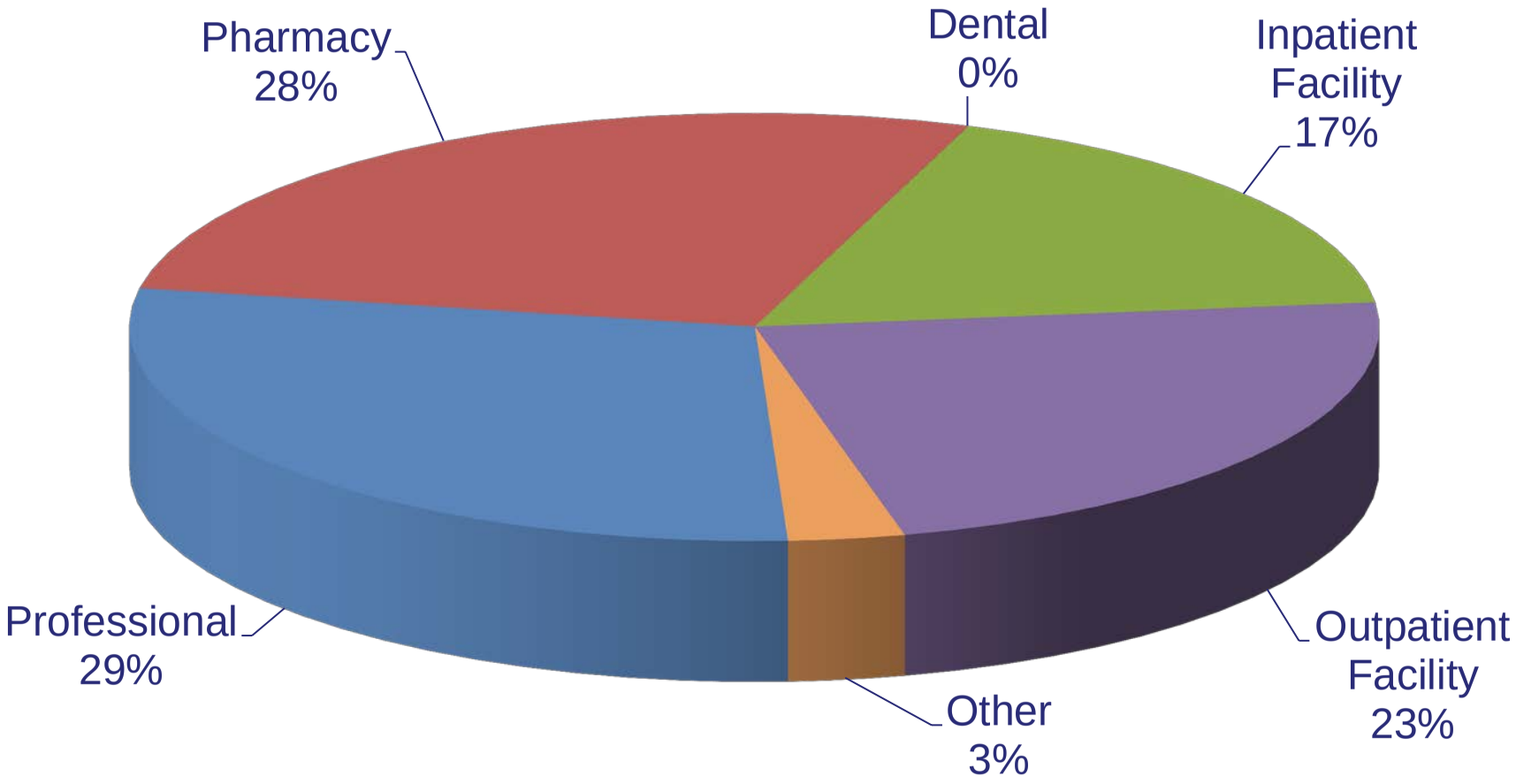
# Plan Year to Date Expenditure Trend
# Per Member Per Month



# Allocation of Claims Expenditures

## Fiscal Year to Date

**Includes Medical, Blue Card & Pharmacy Payments**




Source: BCBSNC Summary of Billed Charges, fiscal year to date through March 2014

**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 March 2014**
**Calendar Year 2014**

| | | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|---|
| | | Actual March 2014 | Certified Budget March 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 | $ 261,081,536 | $ 243,790,979 | $ 17,290,557 | $ 722,074,811 | $ 731,633,202 | $ (9,558,391) | $ 2,921,878,532 | $ (2,199,803,721) |
| 4 | Premium Refunds/Retroactive Disenrollments | 947 | (124,268) | 125,215 | 5,798 | (372,933) | 378,731 | (1,489,408) | 1,495,206 |
| 5 | Medicare Part D (RDS) Subsidy | 7,711,178 | 598,158 | 7,113,020 | 9,258,550 | 1,797,558 | 7,460,992 | 6,344,076 | 2,914,474 |
| 6 | Medicare PDP (EGWP + Wrap) Subsidy | - | - | - | 12,080,189 | 8,534,636 | 3,545,553 | 31,047,005 | (18,966,816) |
| 7 | Medicare Advantage (MA) Subsidy | 115,656 | - | 115,656 | 152,149 | - | 152,149 | - | 152,149 |
| 8 | Federal Early Retiree Reinsurance Program (ERRP) | - | - | - | - | - | - | - | - |
| 9 | **Net Premium & Other Contributions** | 268,909,317 | 244,264,869 | 24,644,448 | 743,571,497 | 741,592,463 | 1,979,034 | 2,957,780,205 | (2,214,208,708) |
| 10 | | | | | | | | | |
| 11 | Investment Earnings | 315,044 | 232,354 | 82,690 | 1,038,278 | 698,812 | 339,466 | 2,892,005 | (1,853,727) |
| 12 | Miscellaneous Revenue | - | - | - | - | - | - | - | - |
| 13 | **Other Revenue** | 315,044 | 232,354 | 82,690 | 1,038,278 | 698,812 | 339,466 | 2,892,005 | (1,853,727) |
| 14 | | | | | | | | | |
| 15 | **Total Plan Revenue (excludes internal transfers)** | 269,224,361 | 244,497,223 | 24,727,138 | 744,609,775 | 742,291,275 | 2,318,500 | 2,960,672,210 | (2,216,062,435) |
| 16 | | | | | | | | | |
| 17 | **Plan Expenses:** | | | | | | | | |
| 18 | | | | | | | | | |
| 19 | Medical Claim Payments | 184,877,202 | 195,828,352 | (10,951,150) | 464,709,526 | 545,892,357 | (81,182,831) | 2,062,826,346 | (1,598,116,820) |
| 20 | Medical Claim Refunds/Recoveries | (1,748,825) | (2,057,679) | 308,854 | (5,339,692) | (5,920,987) | 581,295 | (25,469,051) | 20,129,359 |
| 21 | **Net Medical Claims** | 183,128,377 | 193,770,673 | (10,642,296) | 459,369,834 | 539,971,370 | (80,601,536) | 2,037,357,295 | (1,577,987,461) |
| 22 | | | | | | | | | |
| 23 | Pharmacy Claim Payments | 46,912,582 | 40,602,073 | 6,310,509 | 173,037,518 | 138,892,269 | 34,145,249 | 599,541,594 | (426,504,076) |
| 24 | Pharmacy Claim Rebates | (36,441,085) | (9,172,982) | (27,268,103) | (48,528,784) | (20,428,361) | (28,100,423) | (54,794,623) | 6,265,839 |
| 25 | Pharmacy Claim Refunds/Recoveries | (25,997) | - | (25,997) | (548,335) | - | (548,335) | - | (548,335) |
| 26 | **Net Pharmacy Claims** | 10,445,500 | 31,429,091 | (20,983,591) | 123,960,399 | 118,463,908 | 5,496,491 | 544,746,971 | (420,786,572) |
| 27 | | | | | | | | | |
| 28 | **Net Claim Payments** | 193,573,877 | 225,199,764 | (31,625,887) | 583,330,233 | 658,435,278 | (75,105,045) | 2,582,104,266 | (1,998,774,033) |
| 29 | | | | | | | | | |
| 30 | **Medicare Advantage Premium Payments** | 13,802,453 | 14,471,442 | (668,989) | 40,244,787 | 43,378,351 | (3,133,564) | 174,162,733 | (133,917,946) |
| 31 | | | | | | | | | |
| 32 | **Net Administrative Expenses** | 11,295,074 | 15,193,441 | (3,898,367) | 37,387,246 | 45,592,768 | (8,205,522) | 179,815,010 | (142,427,764) |
| 33 | | | | | | | | | |
| 34 | **Total Plan Expenses (excludes internal transfers)** | 218,671,404 | 254,864,647 | (36,193,243) | 660,962,266 | 747,406,397 | (86,444,131) | 2,936,082,009 | (2,275,119,743) |
| 35 | | | | | | | | | |
| 36 | **Plan Income/(Loss)** | 50,552,957 | (10,367,424) | 60,920,381 | 83,647,509 | (5,115,122) | 88,762,631 | 24,590,201 | 59,057,308 |
| 37 | | | | | | | | | |
| 38 | **Cash Availability:** | | | | | | | | |
| 39 | | | | | | | | | |
| 40 | Beginning Cash Balance/(Deficit) | 871,541,689 | 700,227,435 | 171,314,254 | 838,447,137 | 694,975,133 | 143,472,004 | 694,975,133 | 143,472,004 |
| 41 | **Ending Cash Balance/(Deficit)** | 922,094,646 | 689,860,011 | 232,234,635 | 922,094,646 | 689,860,011 | 232,234,635 | 719,565,334 | 202,529,312 |
| 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** | $ 687,811,951 | $ 455,577,316 | $ 232,234,635 | $ 687,811,951 | $ 455,577,316 | $ 232,234,635 | $ 485,282,639 | $ 202,529,312 |

**Comments:**
a. Premium receivables totaled $568,863.04 as of March 31, 2014.
b. The average weekly medical claims cost net of claims refunds was $36,625,675.40 for the five scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $23,456,291.00 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)
March - 2014 Calendar Year

**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 March 2014**
**Fiscal Year 2013- 2014**

| | | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|---|
| | | Actual March 2014 | Certified Budget March 2014 | Monthly Variance Over/(Under) Certified Budget | Actual Year to Date FY 2013-14 | Certified Budget Year to Date FY 2013-14 | Year to Date Variance Over/(Under) Certified Budget | Annual Certified Budget FY 2013-14 | Year to Date Variance Over/(Under) Annual Certified Budget |
| 1 | **Plan Revenue:** | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | Member Premiums | $ 261,081,536 | $ 243,790,979 | $ 17,290,557 | $ 2,224,652,811 | $ 2,171,712,574 | $ 52,940,237 | $ 2,902,567,015 | $ (677,914,204) |
| 4 | Premium Refunds/Retroactive Disenrollments | 947 | (124,268) | 125,215 | (271,740) | (1,094,223) | 822,483 | (1,466,766) | 1,195,026 |
| 5 | Medicare Part D (RDS) Subsidy | 7,711,178 | 598,158 | 7,113,020 | 7,934,662 | 4,582,302 | 3,352,360 | 6,218,762 | 1,715,900 |
| 6 | Medicare PDP (EGWP + Wrap) Subsidy | - | - | - | 49,162,774 | 40,881,937 | 8,280,837 | 50,346,402 | (1,183,628) |
| 7 | Medicare Advantage (MA) Subsidy | 115,656 | - | 115,656 | 152,149 | - | 152,149 | - | 152,149 |
| 8 | Federal Early Retiree Reinsurance Program (ERRP) | - | - | - | - | - | - | - | - |
| 9 | **Net Premium & Other Contributions** | 268,909,317 | 244,264,869 | 24,644,448 | 2,281,630,656 | 2,216,082,590 | 65,548,066 | 2,957,665,413 | (676,034,757) |
| 10 | | | | | | | | | |
| 11 | Investment Earnings | 315,044 | 232,354 | 82,690 | 2,824,393 | 2,146,814 | 677,579 | 2,868,131 | (43,738) |
| 12 | Miscellaneous Revenue | - | - | - | 54,972 | - | 54,972 | - | 54,972 |
| 13 | **Other Revenue** | 315,044 | 232,354 | 82,690 | 2,879,365 | 2,146,814 | 732,551 | 2,868,131 | 11,234 |
| 14 | | | | | | | | | |
| 15 | **Total Plan Revenue (excludes internal transfers)** | 269,224,361 | 244,497,223 | 24,727,138 | 2,284,510,021 | 2,218,229,404 | 66,280,617 | 2,960,533,544 | (676,023,523) |
| 16 | | | | | | | | | |
| 17 | **Plan Expenses:** | | | | | | | | |
| 18 | | | | | | | | | |
| 19 | Medical Claim Payments | 184,877,202 | 195,828,352 | (10,951,150) | 1,497,866,926 | 1,589,891,654 | (92,024,728) | 2,107,493,114 | (609,626,188) |
| 20 | Medical Claim Refunds/Recoveries | (1,748,825) | (2,057,679) | 308,854 | (16,174,070) | (17,981,671) | 1,807,601 | (24,643,884) | 8,469,814 |
| 21 | **Net Medical Claims** | 183,128,377 | 193,770,673 | (10,642,296) | 1,481,692,856 | 1,571,909,983 | (90,217,127) | 2,082,849,230 | (601,156,374) |
| 22 | | | | | | | | | |
| 23 | Pharmacy Claim Payments | 46,912,582 | 40,602,073 | 6,310,509 | 598,852,987 | 572,940,709 | 25,912,278 | 699,653,578 | (100,800,591) |
| 24 | Pharmacy Claim Rebates | (36,441,085) | (9,172,982) | (27,268,103) | (80,717,425) | (41,001,222) | (39,716,203) | (52,353,361) | (28,364,064) |
| 25 | Pharmacy Claim Refunds/Recoveries | (25,997) | - | (25,997) | (1,105,865) | - | (1,105,865) | - | (1,105,865) |
| 26 | **Net Pharmacy Claims** | 10,445,500 | 31,429,091 | (20,983,591) | 517,029,697 | 531,939,487 | (14,909,790) | 647,300,217 | (130,270,520) |
| 27 | | | | | | | | | |
| 28 | **Net Claim Payments** | 193,573,877 | 225,199,764 | (31,625,887) | 1,998,722,553 | 2,103,849,470 | (105,126,917) | 2,730,149,447 | (731,426,894) |
| 29 | | | | | | | | | |
| 30 | **Medicare Advantage Premium Payments** | 13,802,453 | 14,471,442 | (668,989) | 40,244,787 | 43,378,351 | (3,133,564) | 86,864,744 | (46,619,957) |
| 31 | | | | | | | | | |
| 32 | **Net Administrative Expenses** | 11,295,074 | 15,193,441 | (3,898,367) | 106,935,983 | 136,891,066 | (29,955,083) | 182,446,628 | (75,510,645) |
| 33 | | | | | | | | | |
| 34 | **Total Plan Expenses (excludes internal transfers)** | 218,671,404 | 254,864,647 | (36,193,243) | 2,145,903,323 | 2,284,118,887 | (138,215,564) | 2,999,460,819 | (853,557,496) |
| 35 | | | | | | | | | |
| 36 | Plan Income/(Loss) | 50,552,957 | (10,367,424) | 60,920,381 | 138,606,698 | (65,889,483) | 204,496,181 | (38,927,275) | 177,533,973 |
| 37 | | | | | | | | | |
| 38 | **Cash Availability:** | | | | | | | | |
| 39 | | | | | | | | | |
| 40 | Beginning Cash Balance/(Deficit) | 871,541,689 | 700,227,435 | 171,314,254 | 783,487,948 | 755,749,494 | 27,738,454 | 755,749,494 | 27,738,454 |
| 41 | **Ending Cash Balance/(Deficit)** | 922,094,646 | 689,860,011 | 232,234,635 | 922,094,646 | 689,860,011 | 232,234,635 | 716,822,219 | 205,272,427 |
| 42 | | | | | | | | | |
| 43 | Target Stabilization Reserve @ 6/30/14 | 239,446,206 | 239,446,206 | - | 239,446,206 | 239,446,206 | - | 239,446,206 | - |
| 44 | | | | | | | | | |
| 45 | **Cash Balance Over/(Under) Reserve Target** | $ 682,648,440 | $ 450,413,805 | $ 232,234,635 | $ 682,648,440 | $ 450,413,805 | $ 232,234,635 | $ 477,376,013 | $ 205,272,427 |

**Comments:**
a. Premium receivables totaled $568,863.04 as of March 31, 2014.
b. The average weekly medical claims cost net of claims refunds was $36,625,675.40 for the five scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $23,456,291.00 per cycle.
d. The target stabilization reserve is 8.5% of the projected net claims and Medicare Advantage premiums for Fiscal Year 2013-14.
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)
March 2014 - Fiscal Year

**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 March 2014
Fiscal Year 2013-2014

| | | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|---|
| | | Current Year Actual March 2014 | Prior Year Actual March 2013 | Current Year to Date Actual FY 2013-14 thru March | Prior Year to Date Actual FY 2012-13 thru March | Current Year Certified Annual Budget FY 2013-14 | Prior Year Annual Budget FY 2012-13 | Prior Year Actual Results FY 2012-13 |
| 1 | **Plan Revenue:** | | | | | | | |
| 2 | | | | | | | | |
| 3 | Member Premiums | $ 261,081,536 | $ 244,770,880 | $ 2,224,652,811 | $ 2,173,329,667 | $ 2,902,567,015 | $ 2,872,808,844 | $ 2,895,366,140 |
| 4 | Premium Refunds/Retroactive Disenrollments | 947 | (54,563) | (271,740) | (353,511) | (1,466,766) | (1,437,243) | (487,819) |
| 5 | Medicare Part D (RDS) Subsidy | 7,711,178 | 4,789,476 | 7,934,662 | 33,730,286 | 6,218,762 | 39,519,892 | 38,056,016 |
| 6 | Medicare PDP (EGWP + Wrap) Subsidy | - | 3,952,331 | 49,162,774 | 12,479,240 | 50,346,402 | 19,759,856 | 24,435,483 |
| 7 | Medicare Advantage (MA) Subsidy | 115,656 | - | 152,149 | - | - | - | - |
| 8 | Federal Early Retiree Reinsurance Program (ERRP) | - | - | - | (558,219) | - | - | (558,219) |
| 9 | **Net Premium & Other Contributions** | 268,909,317 | 253,458,124 | 2,281,630,656 | 2,218,627,463 | 2,957,665,413 | 2,930,651,349 | 2,956,811,601 |
| 10 | | | | | | | | |
| 11 | Investment Earnings | 315,044 | 254,811 | 2,824,393 | 2,209,143 | 2,868,131 | 5,658,262 | 3,117,666 |
| 12 | Miscellaneous Revenue | - | 110,888 | 54,972 | 119,047 | - | - | 119,047 |
| 13 | **Other Revenue** | 315,044 | 365,699 | 2,879,365 | 2,328,190 | 2,868,131 | 5,658,262 | 3,236,713 |
| 14 | | | | | | | | |
| 15 | **Total Plan Revenue (excludes internal transfers)** | 269,224,361 | 253,823,823 | 2,284,510,021 | 2,220,955,653 | 2,960,533,544 | 2,936,309,611 | 2,960,048,314 |
| 16 | | | | | | | | |
| 17 | **Plan Expenses:** | | | | | | | |
| 18 | | | | | | | | |
| 19 | Medical Claim Payments | 184,877,202 | 173,909,720 | 1,497,866,926 | 1,363,295,214 | 2,107,493,114 | 2,003,583,417 | 1,858,096,405 |
| 20 | Medical Claim Refunds/Recoveries | (1,748,825) | (1,582,718) | (16,174,070) | (17,902,078) | (24,643,884) | (31,216,928) | (23,467,914) |
| 21 | **Net Medical Claims** | 183,128,377 | 172,327,002 | 1,481,692,856 | 1,345,393,136 | 2,082,849,230 | 1,972,366,489 | 1,834,628,491 |
| 22 | | | | | | | | |
| 23 | Pharmacy Claim Payments | 46,912,582 | 63,103,130 | 598,852,987 | 566,053,110 | 699,653,578 | 743,853,418 | 755,896,440 |
| 24 | Pharmacy Claim Rebates | (36,441,085) | - | (80,717,425) | (37,046,327) | (52,353,361) | (53,173,873) | (69,641,941) |
| 25 | Pharmacy Claim Refunds/Recoveries | (25,997) | (14,189) | (1,105,865) | (484,867) | - | - | (3,476,790) |
| 26 | **Net Pharmacy Claims** | 10,445,500 | 63,088,941 | 517,029,697 | 528,521,916 | 647,300,217 | 690,679,545 | 682,777,709 |
| 27 | | | | | | | | |
| 28 | **Net Claim Payments** | 193,573,877 | 235,415,943 | 1,998,722,553 | 1,873,915,052 | 2,730,149,447 | 2,663,046,034 | 2,517,406,200 |
| 29 | | | | | | | | |
| 30 | **Medicare Advantage Premium Payments** | 13,802,453 | - | 40,244,787 | - | 86,864,744 | - | - |
| 31 | | | | | | | | |
| 32 | **Net Administrative Expenses** | 11,295,074 | 4,831,784 | 106,935,983 | 112,382,785 | 182,446,628 | 189,387,392 | 161,401,639 |
| 33 | | | | | | | | |
| 34 | **Total Plan Expenses (excludes internal transfers)** | 218,671,404 | 240,247,727 | 2,145,903,323 | 1,986,297,837 | 2,999,460,819 | 2,852,433,426 | 2,678,807,839 |
| 35 | | | | | | | | |
| 36 | **Plan Income/(Loss)** | 50,552,957 | 13,576,096 | 138,606,698 | 234,657,816 | (38,927,275) | 83,876,185 | 281,240,475 |
| 37 | | | | | | | | |
| 38 | **Cash Availability:** | | | | | | | |
| 39 | | | | | | | | |
| 40 | Beginning Cash Balance/(Deficit) | 871,541,689 | 723,329,191 | 783,487,948 | 502,247,471 | 755,749,494 | 502,247,475 | 502,247,471 |
| 41 | **Ending Cash Balance/(Deficit)** | 922,094,646 | 736,905,287 | 922,094,646 | 736,905,287 | 716,822,219 | 586,123,660 | 783,487,946 |
| 42 | | | | | | | | |
| 43 | Target Stabilization Reserve @ 6/30/14 | 239,446,206 | 199,728,453 | 239,446,206 | 199,728,453 | 239,446,206 | 199,728,453 | 188,805,465 |
| 44 | | | | | | | | |
| 45 | **Cash Balance Over/(Under) Reserve Target** | $ 682,648,440 | $ 537,176,834 | $ 682,648,440 | $ 537,176,834 | $ 477,376,013 | $ 386,395,207 | $ 594,682,481 |

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 March 2014**
**Calendar Year 2014**

| | | A | B | C | D | E | F |
|---|---|---|---|---|---|---|---|
| | | Actual Year to Date Calendar Year thru March | Adjustments for Timing, Unusual & Onetime Events | *Adjusted Actual Year to Date* | Certified Budget Calendar Year to Date thru March | *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) | $ 722,074,811 | $ 18,571,987 | $ 740,646,798 | $ 731,633,202 | $ 9,013,596 | 1.23% |
| 4 | Premium Refunds/Retroactive Disenrollments | 5,798 | | 5,798 | (372,933) | 378,731 | -101.55% |
| 5 | Medicare Part D (RDS) Subsidy (Note 3) | 9,258,550 | (6,855,182) | 2,403,368 | 1,797,558 | 605,810 | 33.70% |
| 6 | Medicare PDP (EGWP + Wrap) Subsidy (Note 4) | 12,080,189 | (572,152) | 11,508,037 | 8,534,636 | 2,973,401 | 34.84% |
| 7 | Medicare Advantage (MA) Subsidy (Note 5) | 152,149 | (152,149) | - | - | - | |
| 8 | Federal Early Retiree Reinsurance Program (ERRP) | - | | - | - | - | |
| 9 | **Net Premium & Other Contributions** | **743,571,497** | **10,992,504** | **754,564,001** | **741,592,463** | **12,971,538** | **1.75%** |
| 10 | | | | | | | |
| 11 | **Other Revenue** | **1,038,278** | | **1,038,278** | **698,812** | **339,466** | **48.58%** |
| 12 | | | | | | | |
| 13 | **Total Plan Revenue (excludes internal transfers)** | **744,609,775** | **10,992,504** | **755,602,279** | **742,291,275** | **13,311,004** | **1.79%** |
| 14 | | | | | | | |
| 15 | **Plan Expenses:** | | | | | | |
| 16 | | | | | | | |
| 17 | Net Medical Claims | 459,369,834 | | 459,369,834 | 539,971,370 | (80,601,536) | -14.93% |
| 18 | Net Pharmacy Claims (Notes 6 and 7) | 123,960,399 | (7,277,575) | 116,682,824 | 118,463,908 | (1,781,084) | -1.50% |
| 19 | **Net Claim Payments** | **583,330,233** | **(7,277,575)** | **576,052,658** | **658,435,278** | **(82,382,620)** | **-12.51%** |
| 20 | | | | | | | |
| 21 | **Medicare Advantage Premiums** | **40,244,787** | | **40,244,787** | **43,378,351** | **(3,133,564)** | **-7.22%** |
| 22 | | | | | | | |
| 23 | **Net Administrative Expenses (Note 8)** | **37,387,246** | **(140,286)** | **37,246,960** | **45,592,768** | **(8,345,808)** | **-18.31%** |
| 24 | | | | | | | |
| 25 | **Total Plan Expenses (excludes internal transfers)** | **660,962,266** | **(7,417,861)** | **653,544,405** | **747,406,397** | **(93,861,992)** | **-12.56%** |
| 26 | | | | | | | |
| 27 | Plan Income/(Loss) | **83,647,509** | **18,410,364** | **102,057,873** | **(5,115,122)** | **107,172,995** | **-2095.22%** |
| 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)** | **922,094,646** | **18,410,364** | **940,505,010** | **689,860,011** | **250,644,999** | **36.33%** |
| 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** | **$ 687,811,951** | **$ 18,410,364** | **$ 706,222,315** | **$ 455,577,316** | **$ 250,644,999** | **55.02%** |

**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 $42.2 million in prepaid April premiums received in March.
3. Medicare Part D subsidy adjusted to exclude an unbudgeted subsidy refund related to prior plan years.
4. EGWP subsidy adjusted to exclude an unbudgeted Direct Subsidy.
5. Medicare Advantage low income premium subsidies were not budgeted and therefore are excluded.
6. 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.
7. Pharmacy claims adjusted to remove the unbudgeted portion of a rebate true-up payment that was $25.8 million more than anticipated.
8. Administrative expenses adjusted to reflect normal vendor payment schedules.

**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 March 2014**
**Fiscal Year 2013-2014**

| | | A | B | C | D | E | F |
|---|---|---|---|---|---|---|---|
| | | Actual Year to Date Fiscal Year thru March | Adjustments for Timing, Unusual & Onetime Events | *Adjusted Actual Year to Date* | Certified Budget Fiscal Year to Date thru March | *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) | $ 2,224,652,811 | $ (31,907,277) | $ 2,192,745,534 | $ 2,171,712,574 | $ 21,032,960 | 0.97% |
| 4 | Premium Refunds/Retroactive Disenrollments | (271,740) | | (271,740) | (1,094,223) | 822,483 | -75.17% |
| 5 | Medicare Part D (RDS) Subsidy | 7,934,662 | | 7,934,662 | 4,582,302 | 3,352,360 | 73.16% |
| 6 | Medicare PDP (EGWP + Wrap) Subsidy (Note 3) | 49,162,774 | (572,152) | 48,590,622 | 40,881,937 | 7,708,685 | 18.86% |
| 7 | Medicare Advantage (MA) Subsidy (Note 4) | 152,149 | (152,149) | - | - | - | |
| 8 | Federal Early Retiree Reinsurance Program (ERRP) | - | | - | - | - | |
| 9 | **Net Premium & Other Contributions** | **2,281,630,656** | **(32,631,578)** | **2,248,999,078** | **2,216,082,590** | **32,916,488** | **1.49%** |
| 10 | | | | | | | |
| 11 | **Other Revenue** (Note 5) | **2,879,365** | **(54,973)** | **2,824,392** | **2,146,814** | **677,578** | **31.56%** |
| 12 | | | | | | | |
| 13 | **Total Plan Revenue (excludes internal transfers)** | **2,284,510,021** | **(32,686,551)** | **2,251,823,470** | **2,218,229,404** | **33,594,066** | **1.51%** |
| 14 | | | | | | | |
| 15 | **Plan Expenses:** | | | | | | |
| 16 | | | | | | | |
| 17 | Net Medical Claims | 1,481,692,856 | | 1,481,692,856 | 1,571,909,983 | (90,217,127) | -5.74% |
| 18 | Net Pharmacy Claims (Notes 6 and 7) | 517,029,697 | 31,605,817 | 548,635,514 | 531,939,487 | 16,696,027 | 3.14% |
| 19 | **Net Claim Payments** | **1,998,722,553** | **31,605,817** | **2,030,328,370** | **2,103,849,470** | **(73,521,100)** | **-3.49%** |
| 20 | | | | | | | |
| 21 | **Medicare Advantage Premiums** | **40,244,787** | | **40,244,787** | **43,378,351** | **(3,133,564)** | **-7.22%** |
| 22 | | | | | | | |
| 23 | **Net Administrative Expenses** (Note 8) | **106,935,983** | **8,350,922** | **115,286,905** | **136,891,066** | **(21,604,161)** | **-15.78%** |
| 24 | | | | | | | |
| 25 | **Total Plan Expenses (excludes internal transfers)** | **2,145,903,323** | **39,956,739** | **2,185,860,062** | **2,284,118,887** | **(98,258,825)** | **-4.30%** |
| 26 | | | | | | | |
| 27 | **Plan Income/(Loss)** | **138,606,698** | **(72,643,289)** | **65,963,409** | **(65,889,483)** | **131,852,892** | **-200.11%** |
| 28 | | | | | | | |
| 29 | **Cash Availability:** | | | | | | |
| 30 | | | | | | | |
| 31 | Beginning Cash Balance/(Deficit) | 783,487,948 | | 783,487,948 | 755,749,494 | 27,738,454 | 3.67% |
| 32 | **Ending Cash Balance/(Deficit)** | **922,094,646** | **(72,643,289)** | **849,451,357** | **689,860,011** | **159,591,346** | **23.13%** |
| 33 | | | | | | | |
| 34 | Target Stabilization Reserve @ 6/30/14 | 239,446,206 | | 239,446,206 | 239,446,206 | - | |
| 35 | | | | | | | |
| 36 | **Cash Balance Over/(Under) Reserve Target** | **$ 682,648,440** | **$ (72,643,289)** | **$ 610,005,151** | **$ 450,413,805** | **$ 159,591,346** | **35.43%** |

**Adjustment Notes:**
1. Member premiums adjusted to include $10.3 million in prepaid July premiums received in June 2013.
2. Member premiums adjusted to exclude $42.2 million in prepaid April premiums received in March.
3. EGWP subsidy adjusted to exclude an unbudgeted Direct Subsidy received in January.
4. Medicare Advantage low income premium subsidies were not budgeted and therefore are excluded.
5. Other revenue adjusted to exclude unbudgeted reimbursement of prior year expenditures.
6. Pharmacy claims adjusted to exclude $5.8 million in unbudgeted EGWP rebates earned last fiscal year but not received until October 2013.
7. Pharmacy claims adjusted to remove the unbudgeted portion of a rebate true-up payment that was $25.8 million more than anticipated.
8. Administrative expenses adjusted to reflect normal vendor payment schedules.

Adjusted Variance Report Based on Certified (Original) Budget
**Fiscal Year** to Date Through March 2014

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

# CY 2014 1st Quarter Actuarial Forecast Update
# Baseline Scenario

***Board of Trustees Meeting***

**May 30, 2014**

Forecast prepared by The Segal Company
Final version dated 5-16-14

# Presentation Overview

- Forecast Update Schedule
- Updated Assumptions:  Certified Budget vs. CY 2014 1st Quarter Projection
- Updated Forecast for CY 2014
- Summary Graphs
- Summary and Outlook for 2015-2017 Fiscal Biennium

# Actuarial Forecast Update Schedule

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

# Forecast Assumptions Maintained in the Update
# Certified Budget vs. CY 2014 1st Quarter Update

- Overall trend assumption of 8.5%
- Membership trends
  - 1% annual decrease in actives
  - 1% annual increase in retirees
- 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
- 2015 revenues assume 2.14% across the board premium increases effective January 1, 2015, as authorized by the General Assembly and continuation of the 2014 wellness premium structure
- Future bienniums assume escalating wellness premium surcharges/credits and extension of the wellness premium structure to the Traditional 70/30 Plan

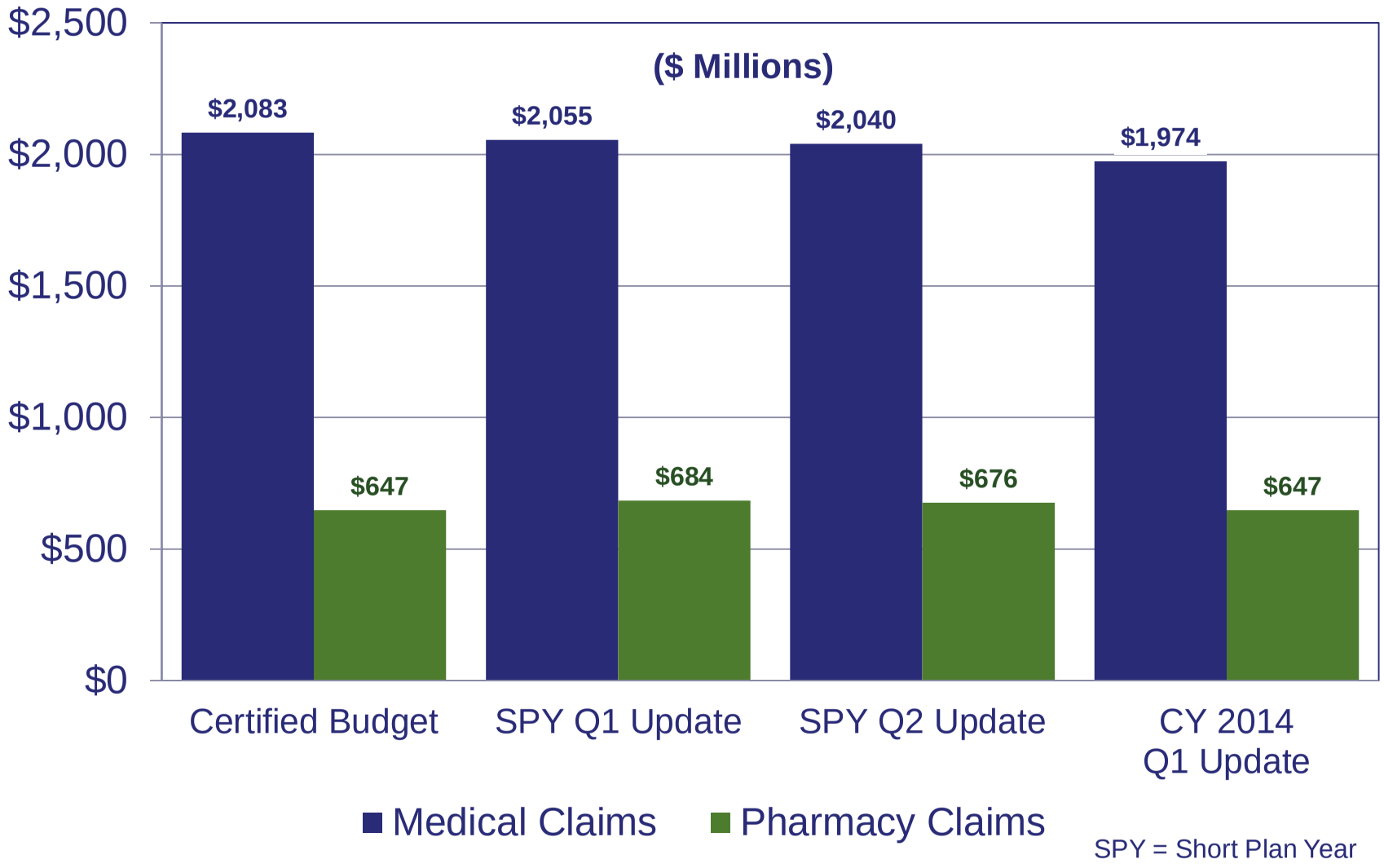
# Forecast Assumptions Changed/Revised in the Update Certified Budget vs. CY 2014 1st Quarter Update

- Membership based on actual March 2014 counts (instead of March 2013)
- Anticipated claims expenditures based on actual experience through March 2014 (instead of through March 2013)
- Baseline pharmacy claims amount increased to reflect experience from the last six months (rather than the last 12 months)
- Elimination of lifetime limits on ACA "Essential Health Benefits"
- Decrease in the coinsurance maximum for Tier 5 non-preferred specialty medications to $125
- Timing and amounts of pharmacy rebates and subsidies have been adjusted to reflect more recent estimates
- 100% coverage of preventive treatment is assumed for Traditional 70/30 Plan beginning in 2016
- Target Stabilization Reserve balances to 9% of claims costs only; Certified Budget balanced to 9% of claims costs *plus* Medicare Advantage premium payments
- Projections extended to include Fiscal Biennium 2017-19

# Comparison of Models
# Certified Budget vs. CY 2014 1st Quarter Update

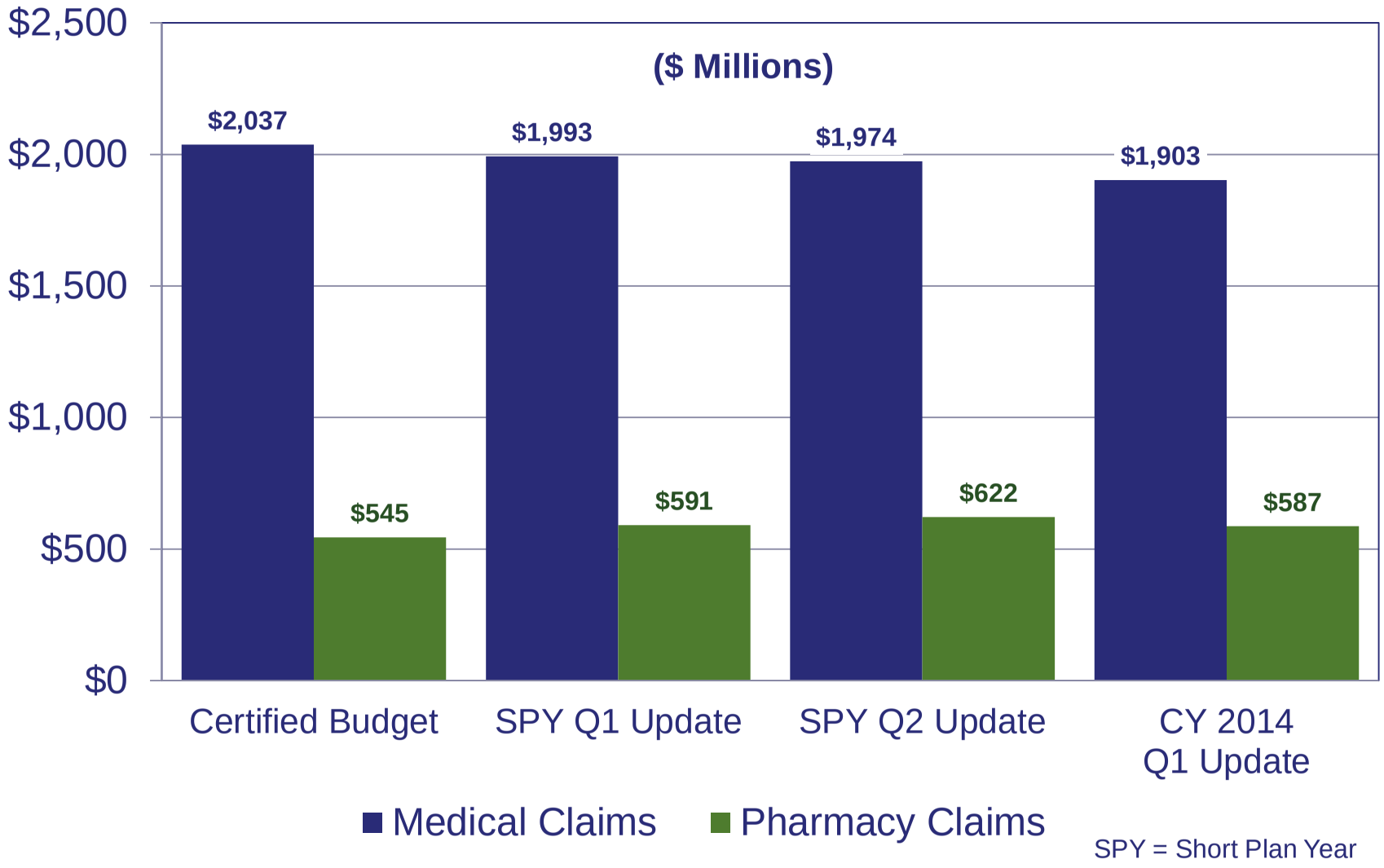
| Calendar Year 2014 | CY 2014 1st Quarter Update (per Segal 05-16-14) | Certified Budget (per Segal 8-19-13) | Difference: Increase/ (Decrease) From Budget |
|---|---|---|---|
| Beginning Cash Balance | $838.5 m | $695.0 m | $143.5 m |
| **Plan Revenue** | **$2.985 b** | **$2.961 b** | **$24.0 m** |
| Net Claims Payments | $2.489 b | $2.582 b | ($92.5 m) |
| Medicare Advantage Premiums | $158.5 m | $174.2 m | ($15.7 m) |
| Net Admin. Expenses | $180.3 m | $179.8 m | $0.5 m |
| **Total Plan Expenses** | **$2.828 b** | **$2.936 b** | **($107.6 m)** |
| **Net Income/(Loss)** | **$156.2 m** | **$24.6 m** | **$131.6 m** |
| Ending Cash Balance | $994.7 m | $719.6 m | $275.1 m |
| FB 2015-17 Premium Increases | 4.47% | 8.22% | (3.75%) |
| FB 2017-19 Premium Increases | 16.11% | -- | -- |

# Forecast Comparisons: Fiscal Year 2013-14 Claims



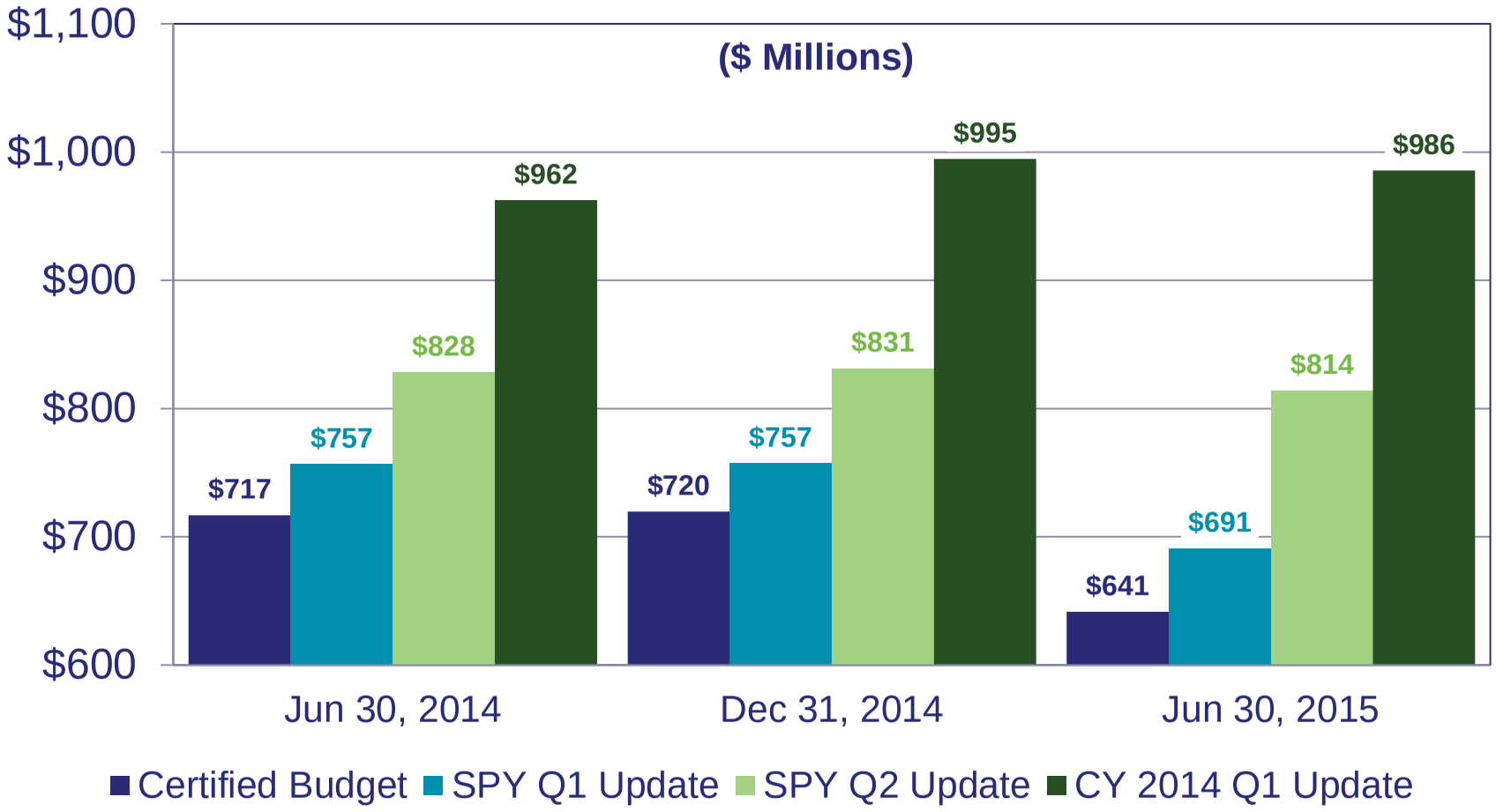

SPY = Short Plan Year

# Forecast Comparisons: Calendar Year 2014 Claims




SPY = Short Plan Year

# Forecast Comparisons: Ending Cash Balances




SPY = Short Plan Year

# Summary/Impact on State Budget

- Current Fiscal Biennium (2013-2015)
  - Relative to the Certified Budget, the CY 2014 1st Quarter Update projects lower medical claims costs and higher pharmacy claims costs for the biennium
  - $985.6 million cash balance projected for the end of the biennium (June 30, 2015):
    - $344.2 million higher than the Certified Budget projection
    - More than half (53.7%) of the higher projected cash balance can be attributed to lower projected expenses, 38.2% is due to higher projected revenues, and 8.1% is due to a higher starting balance than anticipated in the Certified Budget
    - Exceeds the 9.0% target reserve amount by $750.4 million
    - Equates to more than 15 weeks of FY 2015-16 projected operating expenses
- Assuming no changes in benefits beyond the Board's current design, the 1st Quarter Update projects a 4.47% premium increase for January 1 of each year of the 2015-17 biennium. This is lower than the Certified Budget projection (8.22%)

# 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

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(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

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(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

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(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

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(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% |

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

# CY 2014 1st Quarter Actuarial Forecast Update
# Modified Trend Scenario

***Board of Trustees Meeting***

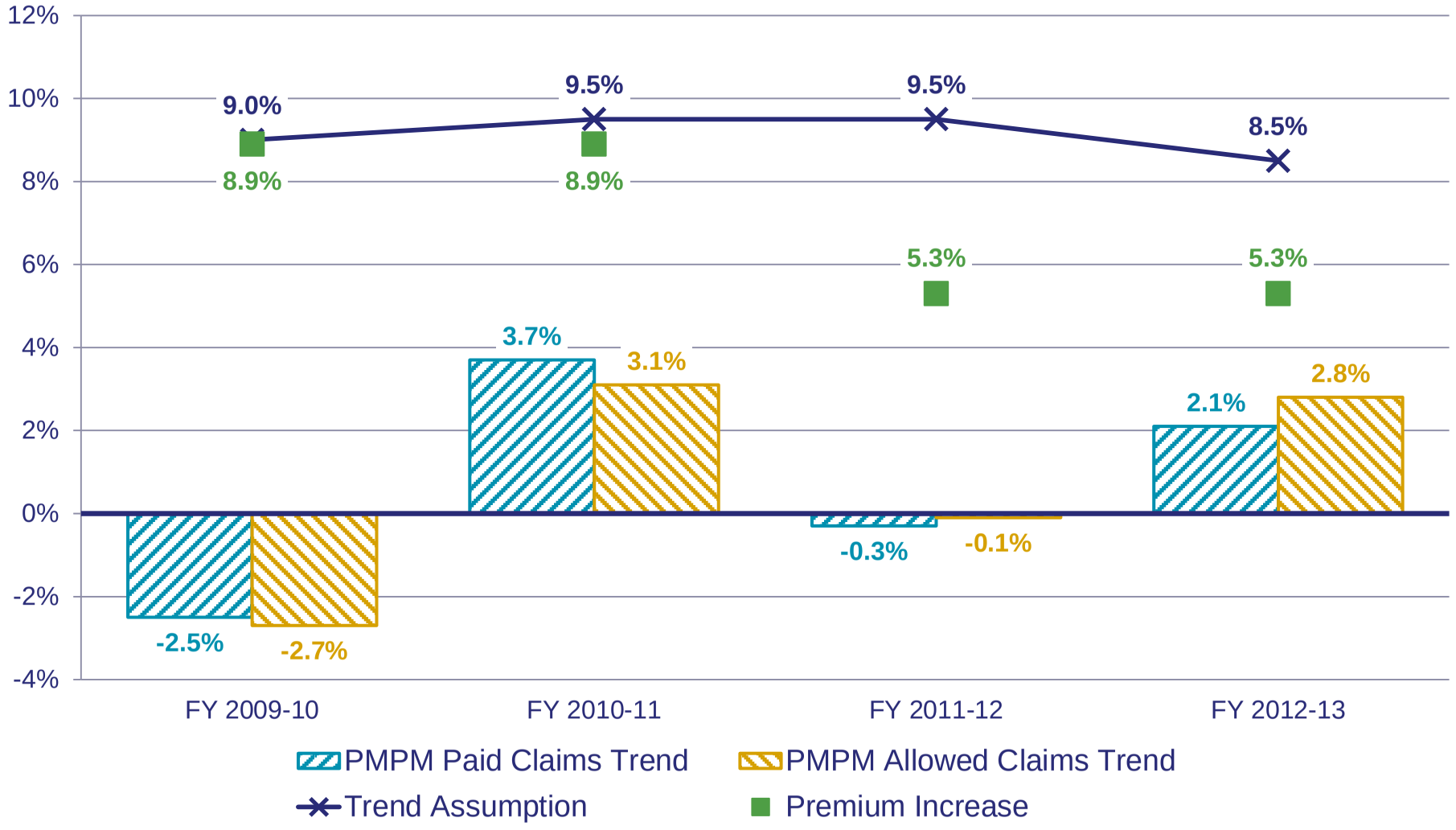
**May 30, 2014**

Forecast prepared by The Segal Company
Final versions dated 5-16-14

# Presentation Overview

- Comparison of the Plan's Trend Assumption to Actual Experience
  - Findings and Conclusion
- Updated Forecast for CY 2014 Using Revised Trend Assumption
- Summary Graphs
- Proposed Premium Freeze for 2015
  - Summary Graphs
- Summary and Outlook for 2015-2017 Fiscal Biennium

# Plan Results for FY 2009-10 to FY 2012-13



# PMPM Trend Factors:
# Active Employees and Non-Medicare Retirees

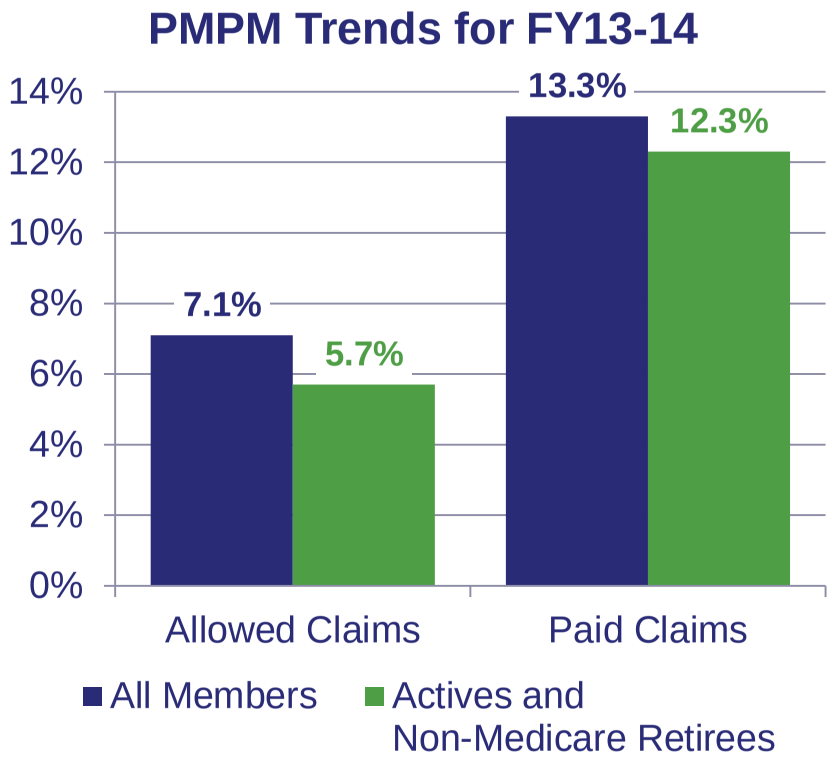
| Trend Factor | Change from FY 2011-12 to FY 2012-13 | Change from CY 2012 to CY 2013 |
|---|---|---|
| Utilization | -4.3% | -4.0% |
| Price | 6.5% | 7.9% |
| **Allowed Claims Costs** | **1.9%** | **3.5%** |
| Cost Share | 0.3% | 3.7% |
| **Paid Claims Costs** | **2.2%** | **7.2%** |

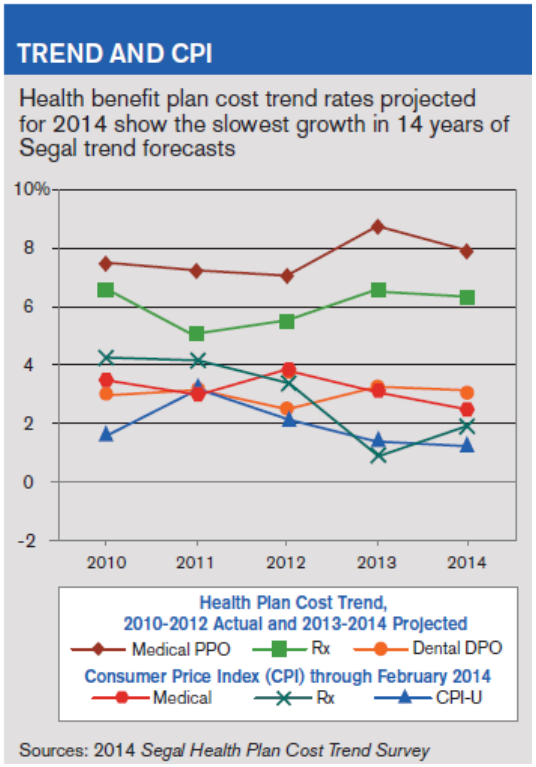
Source: The Segal Company

- Reductions in utilization have helped to reduce trends in allowed and paid claims.
- The trend due to cost share is high in CY 2013 because it included the second half of the FY 2012-13 Plan Year, when deductibles and out-of-pocket (OOP) maximums are more likely to have been met, and the Short Plan Year, when deductibles and OOP maximums were halve.
- The paid claims trends were below the 8.5% trend assumption in both time periods reviewed.

# FY 2013-14 Trends Through December 2013

- Experience through December 2013 suggests higher trends for the current fiscal year
- Increases in paid claims are attributable to the Short Plan Year




- The 2014 *Segal Health Plan Cost Trend Survey* projects Medical cost increases of 8% and Pharmacy cost increases of just over 6%
- Segal's actuaries note that the trend survey tends to be conservative

# Trend Review Findings and Conclusion

## Findings:

- Trends in Plan paid costs for the four years prior to FY 2013-14 were very low and suggest a trend well below the current trend assumption of 8.5%
- Over the last 18-24 months, a decrease in utilization has offset growth in prices and reduced member cost sharing and has helped to constrain increases in Plan costs
- Trends in PMPM allowed claims have increased in the first half of FY 2013-14 from trends in prior fiscal years but are still less than 8.5%
- A conservative estimate of 2014 trend by insurance companies (the Segal survey) projects 8% for medical costs and just over 6% for pharmacy costs
- Risks to reducing the trend assumption:
  - Reductions in utilization may be unsustainable; prices have increased during recent measurement periods
  - PMPM claims trends have increased in the first half of FY 2013-14
  - There has been very little experience with new benefit designs and plan offerings
  - The economy, which is assumed to be one of the main causes for reduced medical expense trends, is improving

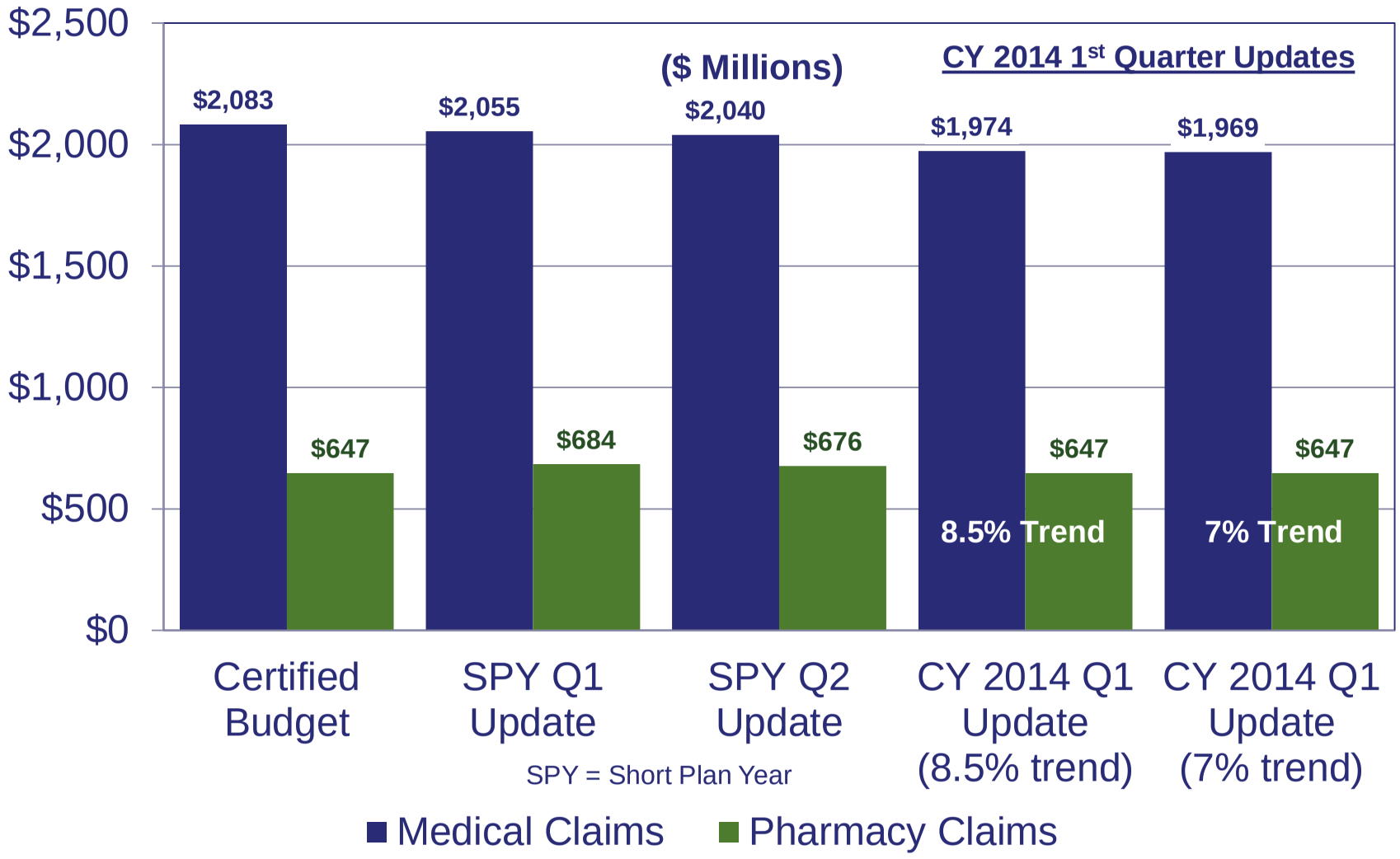
## Conclusion:

- Despite risks, recent experience supports a decrease in the trend assumption used in the forecasts
- **Decision:** Reduce the trend assumption to 7%

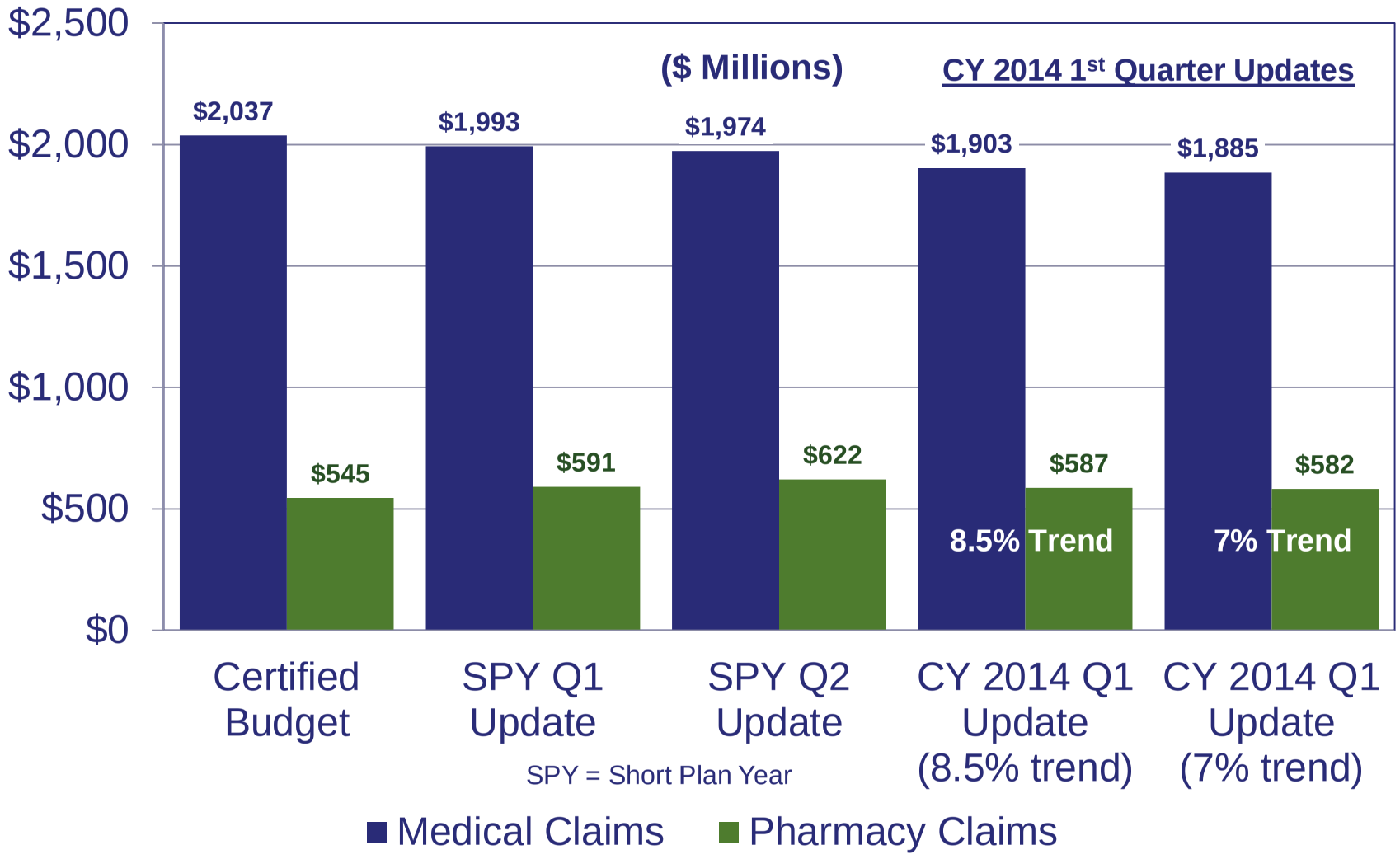
# Comparison of Models:
# Certified Budget vs. CY 2014 1st Quarter Update (7% trend)

| Calendar Year 2014 | 7% Trend CY 2014 Q1 Update (per Segal 05-16-14) | 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** | **$2.985 b** | **$2.961 b** | **$24.0 m** |
| Net Claims Payments | $2.467 b | $2.582 b | ($115.0 m) |
| Medicare Advantage Premiums | $158.5 m | $174.2 m | ($15.7 m) |
| Net Admin. Expenses | $180.3 m | $179.8 m | $0.5 m |
| **Total Plan Expenses** | **$2.804 b** | **$2.936 b** | **($130.2 m)** |
| **Net Income/(Loss)** | **$178.8 m** | **$24.6 m** | **$154.2 m** |
| **Ending Cash Balance** | **$1.017 b** | **$719.6 m** | **$297.6 m** |
| 2016 & 2017 Premium Increases | 0.00% | 8.22% | (8.22%) |
| 2018 & 2019 Premium Increases | 16.86% | -- | -- |

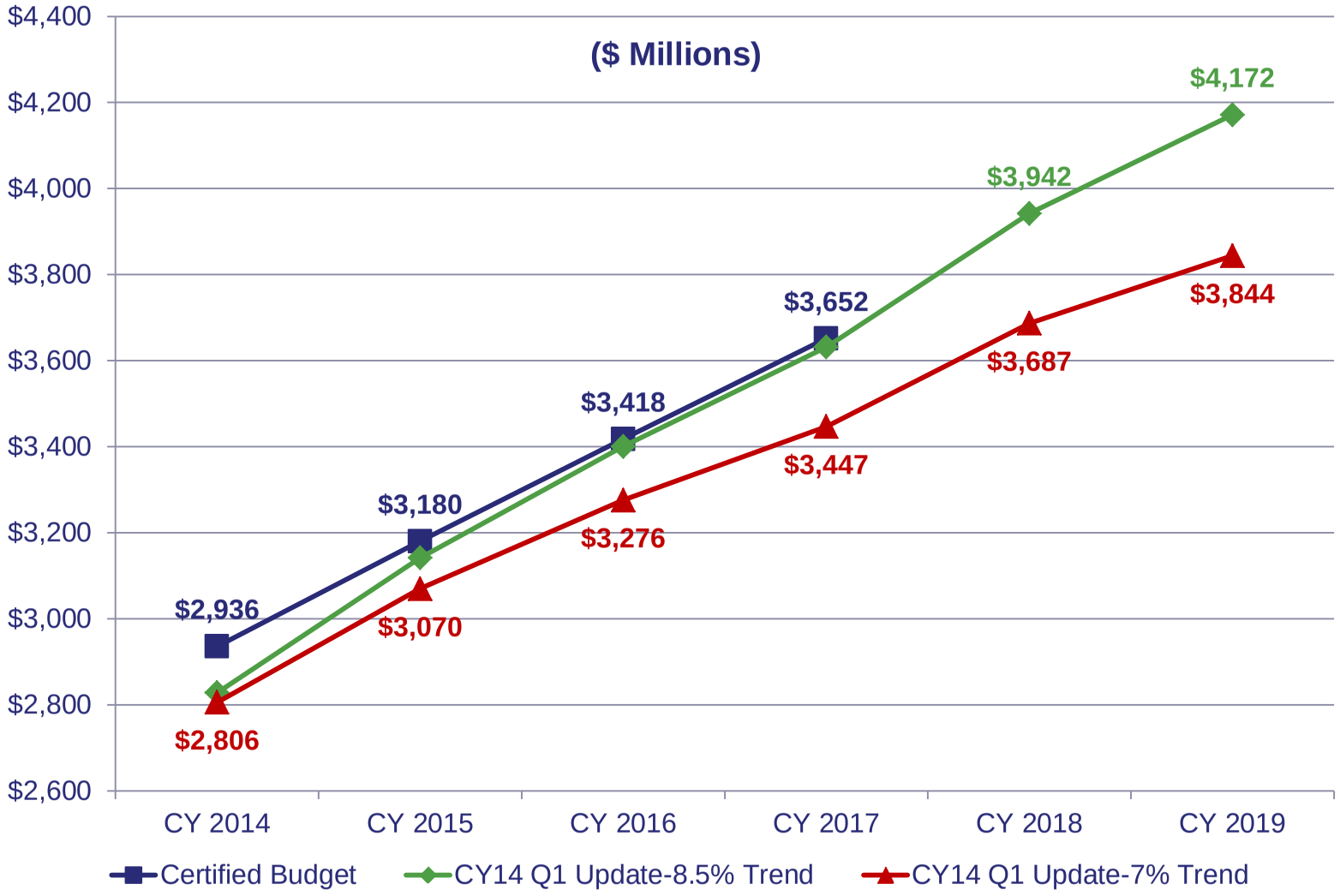
# Forecast Comparisons: Fiscal Year 2013-14 Claims



# Forecast Comparisons: Calendar Year 2014 Claims



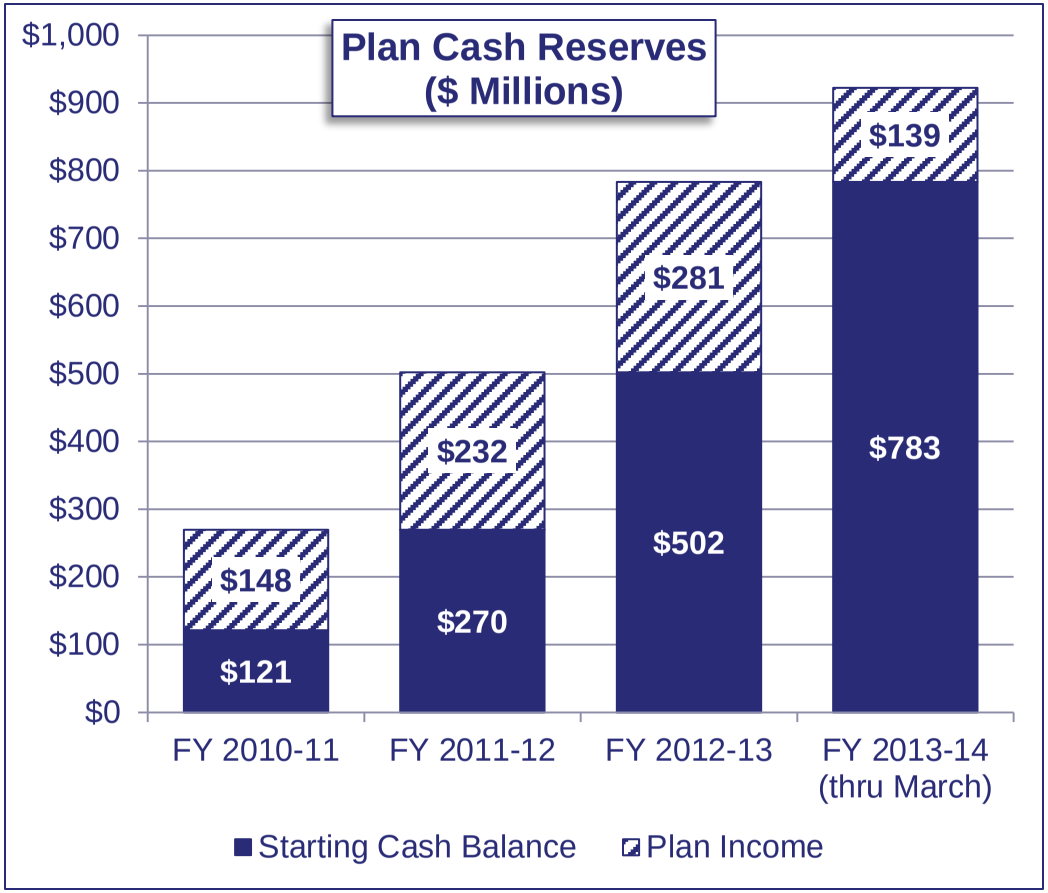
# Forecast Comparisons: Projected Plan Spending Certified Budget vs. CY 2014 1st Quarter Updates



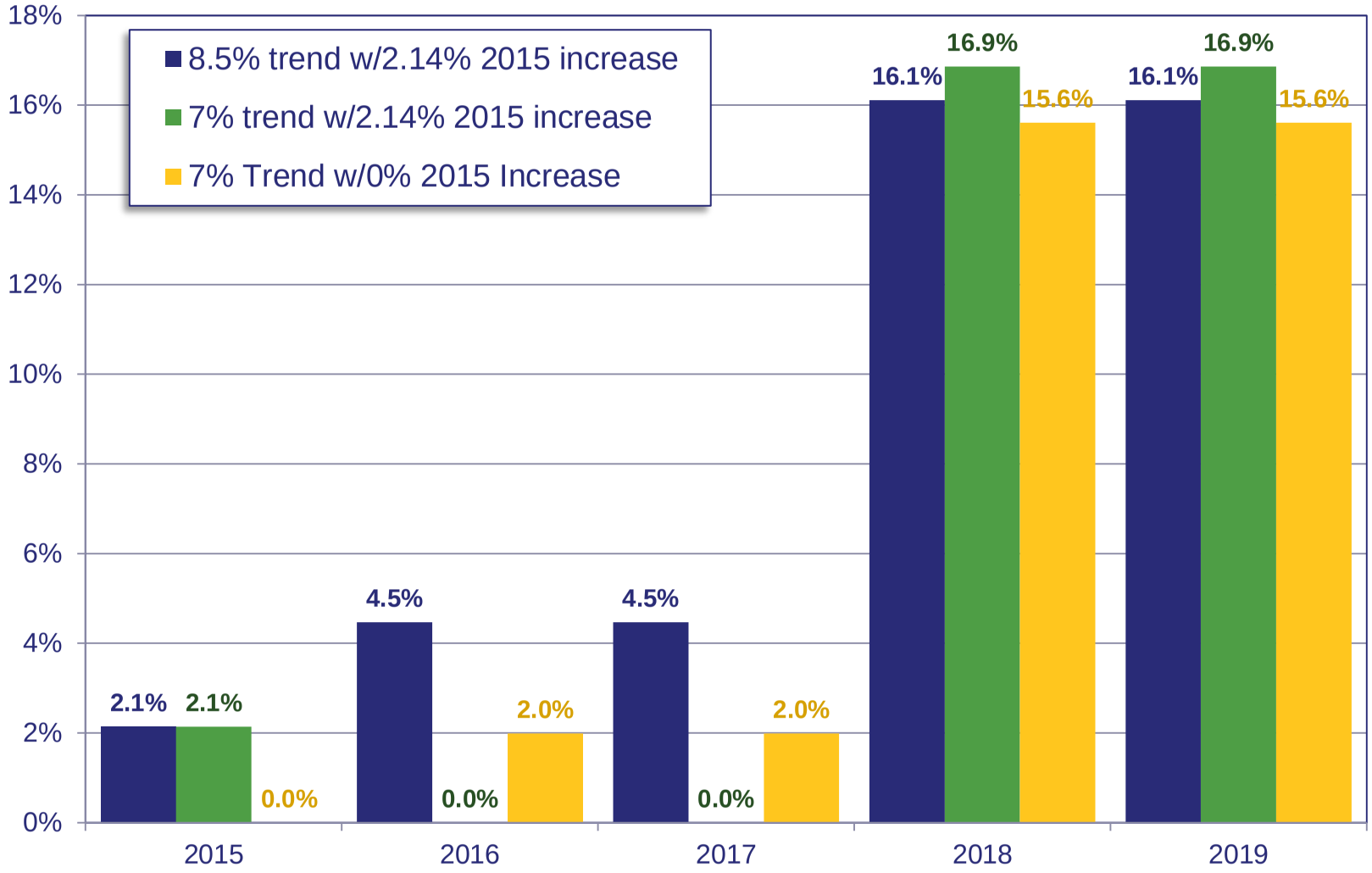
# Proposed 2015 Premium Freeze

- On May 19th, the Treasurer sent a letter to General Assembly's Presiding Officers to inform them that she and the Board recommend forgoing the scheduled 2015 premium increase of 2.14%

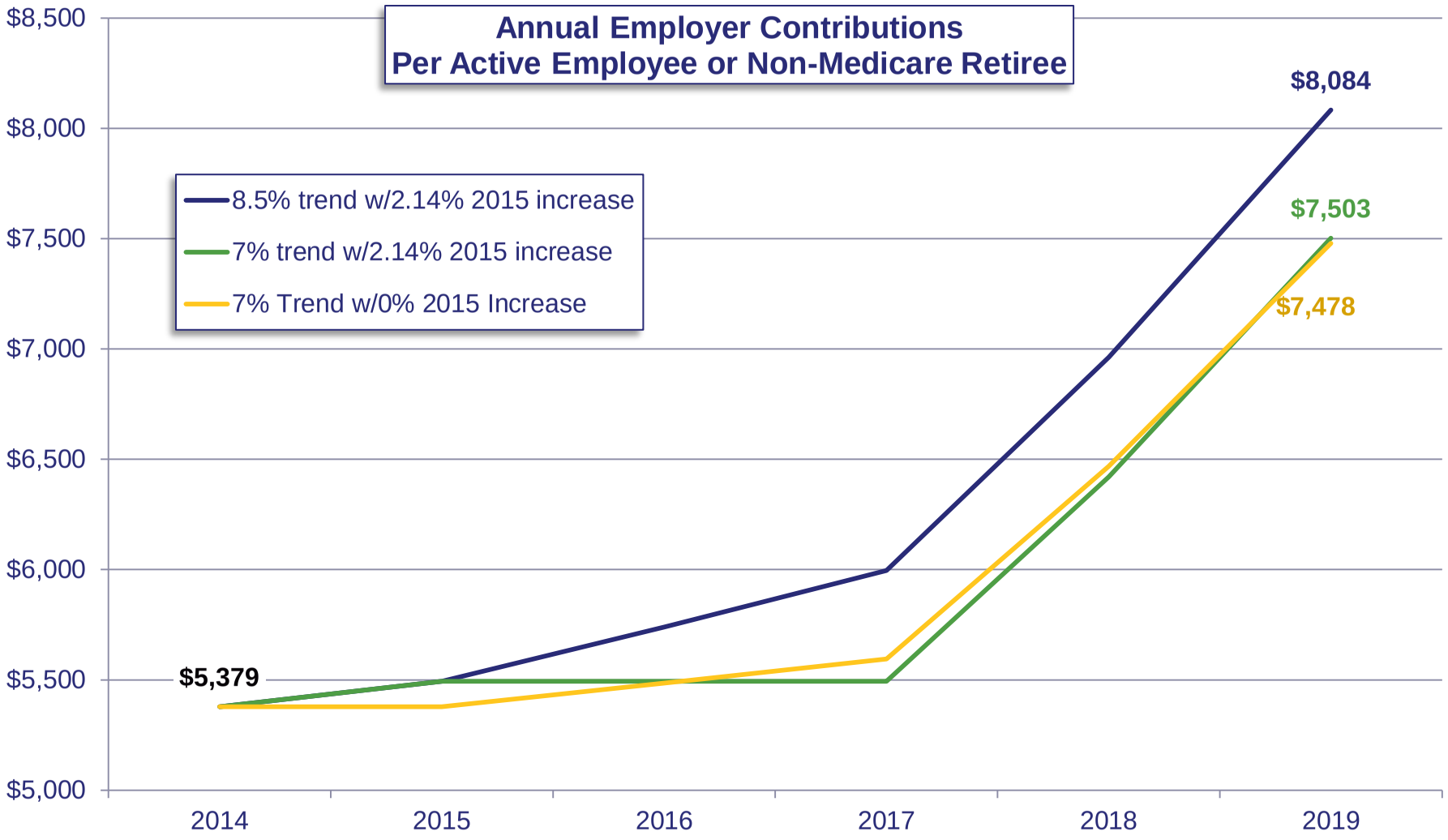
- Reasons for the freeze:
  - Plan is on pace to spend $250 less per member than budgeted for FY 2013-14
  - Projected Plan income for FY 2013-14 is about $180 million
  - Plan and Segal have mutually agreed to reduce the trend assumption used in the forecast from 8.5% to 7%
  - Even with no increase in premiums for 2015, premium increases for 2016 and 2017 are expected to be less than 3% with the new trend assumption



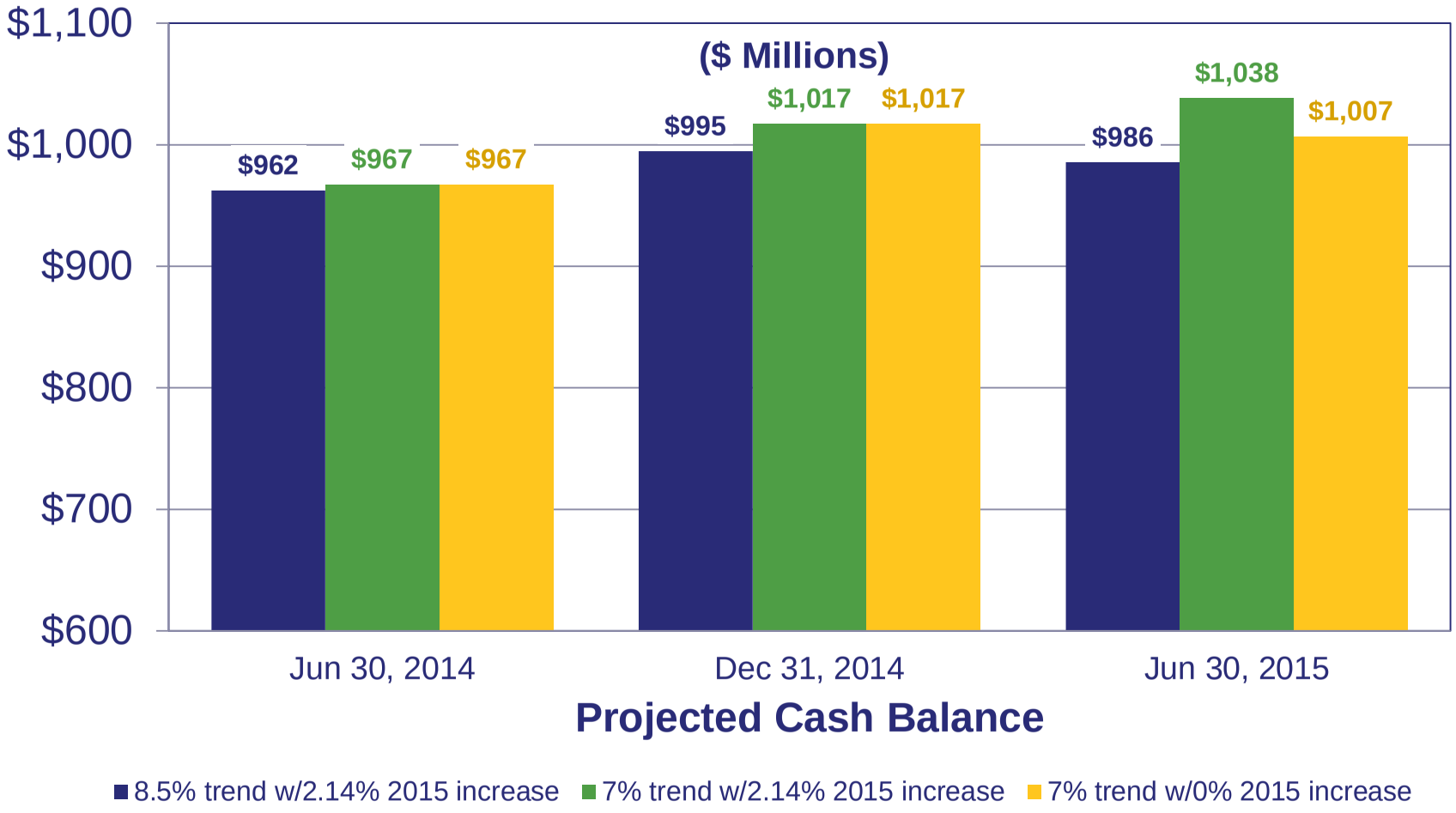
# Projected Premium Increases: CY 2014 1st Quarter Update Scenarios



# Estimated Employer Contributions: CY 2014 1st Quarter Update Scenarios



# Ending Cash Balances:
# CY 2014 1st Quarter Update Scenarios



# Summary/Impact on State Budget

- Current Fiscal Biennium (2013-2015)
  - Relative to the Certified Budget, the CY 2014 1st Quarter Update with 7% trend projects lower medical claims costs and higher pharmacy claims costs for the biennium
  - With or without a 2015 increase in premiums, cash balance is projected to be more than $1 billion by the end of the biennium (June 30, 2015).
    - More than $350 million higher than the Certified Budget
    - Exceeds the 9.0% target reserve amount by about $800 million
    - Equates to more than 16 weeks of FY 2015-16 projected operating expenses
- *Assuming no increase in premiums for 2015* and no changes in the current benefit design, the CY 2014 1st Quarter Update projects a 1.99% premium increase for January 1 of each year of the 2015-17 biennium. This is lower than the Certified Budget projection (8.22%)

# Key Takeaways

- After reviewing the relevant data, Plan staff and Segal actuaries made a decision to lower the trend assumption used in the forecast to 7%
- Noting increasing reserves and continued good experience, the Treasurer has recommended that the General Assembly re-allocate $23 million in State funds designated for the Plan to other purposes
- Premium increases for 2016 and 2017 look to be relatively low
- The Board will need to continue its pursuit of long-term cost reduction strategies to keep premium increases down for 2018 and 2019

# 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% | |

# CY 2014 Q1 Update
# 8.5% Trend
## Page 1
## (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
# 8.5% Trend
## Page 2
## (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 Q1 Update 7% Trend 2015 Premium Increase

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(Segal 5-16-14)

**North Carolina State Health Plan**
**Financial Projections - Mar 2014**
**Trends - 7.0% 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 | 3,347,179,776 | 3,332,384,098 | 3,981,723,320 | 4,552,511,955 |
| 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) | (1,673,590) | (1,666,192) | (1,990,862) | (2,276,256) |
| 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 | 4,041,748 | 4,137,497 | 3,471,636 | 2,022,452 | 844,859 | 962,454 |
| **Total Plan Income** | 2,852,680,163 | 2,960,048,314 | 1,539,900,247 | 2,984,658,258 | 3,044,411,352 | 3,014,217,363 | 2,998,567,914 | 3,490,225,384 | 4,058,621,469 |
| **PLAN EXPENSE:** | | | | | | | | | |
| Medical Claims Payment | 1,849,410,105 | 1,858,096,405 | 1,033,157,400 | 1,979,602,158 | 2,184,208,528 | 2,324,429,826 | 2,472,275,309 | 2,683,773,310 | 2,806,548,981 |
| Claim Refunds | (22,634,615) | (23,467,914) | (10,834,378) | (23,512,811) | (26,063,669) | (27,817,870) | (29,390,896) | (31,362,323) | (33,526,926) |
| Dental & MHSA Enhancement | | | - | 4,985,330 | 7,187,968 | 7,649,419 | 8,135,961 | 8,831,976 | 9,236,016 |
| Medicare Advantage Claims Reduction | | | | (77,883,672) | (112,977,782) | (122,095,089) | (131,948,163) | (142,596,380) | (154,103,907) |
| Calendar Year Adjustments | | - | - | (4,650,956) | 4,202,852 | 2,532,821 | 2,710,118 | 2,899,826 | 3,102,814 |
| Preventative at 100% in Standard Plan | | | | 19,866,393 | 28,788,927 | 47,829,125 | 52,422,093 | 56,932,443 | 59,409,530 |
| 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 | | | | 697,475 | 921,683 | 1,535,379 | 1,448,328 | 1,352,580 | 1,241,340 |
| PCP Copay Waiver | | | | 7,981,392 | 507,478 | (9,792,633) | (30,422,187) | (52,310,237) | (75,668,503) |
| Essential Health Benefits/MH Parity | | | | 3,010,876 | 4,209,910 | 4,504,603 | 4,819,926 | 5,232,260 | 5,471,622 |
| Net Medical Claims | 1,826,775,490 | 1,834,628,491 | 1,022,323,022 | 1,885,009,924 | 2,051,704,688 | 2,189,662,085 | 2,286,704,549 | 2,457,064,262 | 2,533,025,941 |
| Medicare Advantage Premiums | | | - | 158,450,497 | 186,791,195 | 218,708,064 | 253,369,052 | 285,527,073 | 320,397,357 |
| Pharmacy Claims Payment | 721,163,013 | 752,419,650 | 425,257,939 | 839,182,293 | 917,539,888 | 978,010,226 | 1,042,435,439 | 1,111,199,721 | 1,184,602,221 |
| 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 | | | - | 6,228,977 | 1,756,690 | 322,600 | 344,490 | 367,901 | 392,941 |
| Net Pharmacy Claims | 628,032,853 | 682,777,709 | 393,069,298 | 749,984,168 | 861,281,933 | 925,561,282 | 988,195,319 | 1,058,090,638 | 1,129,551,599 |
| MA-PDP Claims Reduction | | | - | (169,024,224) | (245,794,445) | (265,630,057) | (287,066,403) | (310,232,661) | (335,268,437) |
| EGWP+Wrap Reduction in Rebates | | - | - | - | - | - | - | - | - |
| EGWP+Wrap Claim Increase | | - | - | - | - | - | - | - | - |
| Expand Coverage of Diabetic Test Strips | | - | - | 1,191,683 | 1,640,061 | 1,748,149 | 1,863,306 | 1,986,219 | 2,117,422 |
| HB 675 - Pharmacy Audit Changes | | | | 158,806 | 206,898 | 220,533 | 235,061 | 250,566 | 267,118 |
| Specialty Pharmacy Tier | | | | (201,792) | (292,000) | (336,000) | (386,000) | (411,463) | (438,642) |
| Total Pharmacy Claims | 628,032,853 | 682,777,709 | 393,069,298 | 582,108,641 | 617,042,446 | 661,563,907 | 702,841,283 | 749,683,299 | 796,229,059 |
| Total Claims | 2,454,808,343 | 2,517,406,200 | 1,415,392,320 | 2,625,569,062 | 2,855,538,329 | 3,069,934,056 | 3,242,914,885 | 3,492,274,635 | 3,649,652,357 |
| 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 | 2,805,898,907 | 3,069,980,747 | 3,275,811,170 | 3,446,766,386 | 3,686,878,671 | 3,844,180,045 |
| Plan Income (Loss) | 232,391,259 | 281,240,475 | 54,959,190 | 178,759,352 | (25,569,395) | (261,593,807) | (448,198,472) | (196,653,288) | 214,441,424 |
| Beginning Cash Balance (Deficit) | 269,856,212 | 502,247,471 | 783,487,946 | 838,447,136 | 1,017,206,488 | 991,637,093 | 730,043,286 | 281,844,814 | 85,191,526 |
| Ending Cash Balance (Deficit) | 502,247,471 | 783,487,946 | 838,447,136 | 1,017,206,488 | 991,637,093 | 730,043,286 | 281,844,814 | 85,191,526 | 299,632,950 |
| Target Stabilization Reserve | 184,110,626 | 201,392,496 | 113,231,386 | 209,705,078 | 240,187,242 | 256,610,339 | 269,059,125 | 288,607,281 | 299,632,950 |
| | 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% | 0.00% | 0.00% | 16.86% | 16.86% |

# CY 2014 Q1 Update 7% Trend 2015 Premium Increase

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(Segal 5-16-14)

**North Carolina State Health Plan**
**Financial Projections - Mar 2014**
**Trends - 7.0% 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 | 3,238,209,159 | 3,339,739,649 | 3,657,419,018 | 4,267,339,617 |
| 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) | (1,619,105) | (1,669,870) | (1,828,710) | (2,133,670) |
| 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 | 3,841,399 | 4,125,046 | 3,914,998 | 2,842,413 | 1,285,591 | 728,433 |
| **Total Plan Income** | 2,490,457,950 | 2,797,969,020 | 2,852,680,163 | 2,960,048,314 | 3,040,730,468 | 3,023,663,865 | 3,013,549,698 | 3,006,459,631 | 3,244,461,531 | 3,774,480,657 |
| **PLAN EXPENSE:** | | | | | | | | | | |
| Medical Claims Payment | 1,829,432,245 | 1,852,549,690 | 1,849,410,105 | 1,858,096,405 | 2,031,399,679 | 2,110,125,213 | 2,258,871,190 | 2,401,194,294 | 2,559,461,067 | 2,719,469,947 |
| Claim Refunds | (31,916,831) | (24,723,681) | (22,634,615) | (23,467,914) | (22,122,851) | (25,031,060) | (26,996,014) | (28,496,836) | (30,569,315) | (32,284,772) |
| Dental & MHSA Enhancement | | | | | 1,755,792 | 6,944,169 | 7,433,674 | 7,902,042 | 8,422,879 | 8,949,449 |
| Medicare Advantage Claims Reduction | | | | | (25,482,995) | (108,749,048) | (117,525,096) | (127,009,371) | (137,259,027) | (148,335,831) |
| Calendar Year Adjustments | | | | - | (18,690,285) | (380,241) | 1,229,251 | 1,315,299 | 1,407,370 | 1,505,885 |
| Preventative at 100% in Standard Plan | | | | | 6,791,651 | 27,757,947 | 37,790,909 | 50,912,121 | 54,221,153 | 57,559,180 |
| 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 | | | | | 234,352 | 928,583 | 1,233,896 | 1,493,754 | 1,402,670 | 1,299,491 |
| PCP Copay Waiver | | | | | 2,639,241 | 5,633,674 | (4,563,789) | (19,954,086) | (41,203,466) | (63,815,910) |
| Essential Health Benefits/MH Parity | | | | | 1,060,406 | 4,126,087 | 4,366,463 | 4,668,285 | 4,989,902 | 5,301,854 |
| Net Medical Claims | 1,797,515,414 | 1,827,826,009 | 1,826,775,490 | 1,834,628,491 | 1,969,231,229 | 1,985,073,152 | 2,122,977,802 | 2,241,034,517 | 2,351,498,427 | 2,467,646,193 |
| Medicare Advantage Premiums | | | | | 79,548,716 | 172,065,050 | 202,709,932 | 235,995,447 | 269,408,065 | 302,918,843 |
| Pharmacy Claims Payment | N/A | N/A | 721,163,013 | 752,419,650 | 798,951,591 | 886,950,308 | 983,315,106 | 1,010,095,422 | 1,076,680,795 | 1,147,754,108 |
| 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 | | | | | (5,266,655) | 1,001,134 | 191,276 | (471,571) | (503,150) | (536,892) |
| Net Pharmacy Claims | 596,709,775 | 655,868,735 | 628,032,853 | 682,777,709 | 701,439,820 | 818,788,431 | 931,623,696 | 955,954,510 | 1,023,655,961 | 1,092,766,434 |
| MA-PDP Claims Reduction | | | | | (55,021,320) | (236,594,411) | (255,687,580) | (276,321,568) | (298,620,718) | (322,719,410) |
| EGWP+Wrap Reduction in Rebates | | | | - | - | - | - | - | - | - |
| EGWP+Wrap Claim Increase | | | | - | - | - | - | - | - | - |
| Expand Coverage of Diabetic Test Strips | | | | - | 359,644 | 1,585,383 | 1,757,631 | 1,805,499 | 1,924,518 | 2,051,558 |
| HB 675 - Pharmacy Audit Changes | | | | | 53,842 | 200,000 | 221,729 | 227,768 | 242,783 | 258,809 |
| Specialty Pharmacy Tier | | | | | (60,900) | (275,019) | (325,266) | (360,906) | (398,681) | (424,998) |
| Total Pharmacy Claims | 596,709,775 | 655,868,735 | 628,032,853 | 682,777,709 | 646,771,087 | 583,704,384 | 677,590,211 | 681,305,305 | 726,803,863 | 771,932,393 |
| Total Claims | 2,394,225,189 | 2,483,694,744 | 2,454,808,343 | 2,517,406,200 | 2,695,551,032 | 2,740,842,586 | 3,003,277,945 | 3,158,335,269 | 3,347,710,355 | 3,542,497,429 |
| 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 | 2,856,764,669 | 2,952,626,981 | 3,206,783,493 | 3,359,745,430 | 3,539,800,972 | 3,739,614,400 |
| Plan Income (Loss) | (68,417,019) | 148,372,182 | 232,391,259 | 281,240,475 | 183,965,799 | 71,036,885 | (193,233,796) | (353,285,799) | (295,339,441) | 34,866,257 |
| Beginning Cash Balance (Deficit) | 189,901,049 | 121,484,030 | 269,856,212 | 502,247,471 | 783,487,946 | 967,453,745 | 1,038,490,630 | 845,256,835 | 491,971,036 | 196,631,595 |
| Ending Cash Balance (Deficit) | 121,484,030 | 269,856,212 | 502,247,471 | 783,487,946 | 967,453,745 | 1,038,490,630 | 845,256,835 | 491,971,036 | 196,631,595 | 231,497,852 |
| Target Stabilization Reserve | 179,566,889 | 186,277,106 | 184,110,626 | 201,392,496 | 222,360,197 | 231,189,978 | 252,051,121 | 263,010,584 | 277,047,206 | 291,562,073 |
| | | | 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% | 0.00% | 0.00% | 16.86% | 16.86% |

# CY 2014 Q1 Update 7% Trend
# No 2015 Premium Increase
## Page 1
## (Segal 5-16-14)

**North Carolina State Health Plan**
**Financial Projections - Mar 2014**
**Trends - 7.0% 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 | 3,065,755,502 | 3,342,864,001 | 3,387,505,313 | 4,007,862,016 | 4,539,137,541 |
| 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) | (1,532,878) | (1,671,432) | (1,693,753) | (2,003,931) | (2,269,569) |
| 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 | 4,041,748 | 4,011,227 | 3,209,957 | 1,861,473 | 845,969 | 989,132 |
| **Total Plan Income** | 2,852,680,163 | 2,960,048,314 | 1,539,900,247 | 2,984,658,258 | 2,981,268,284 | 3,009,642,068 | 3,053,500,588 | 3,516,352,121 | 4,045,280,421 |
| **PLAN EXPENSE:** | | | | | | | | | |
| Medical Claims Payment | 1,849,410,105 | 1,858,096,405 | 1,033,157,400 | 1,979,602,158 | 2,184,208,528 | 2,324,429,826 | 2,472,275,309 | 2,683,773,310 | 2,806,548,981 |
| Claim Refunds | (22,634,615) | (23,467,914) | (10,834,378) | (23,512,811) | (26,063,669) | (27,817,870) | (29,390,896) | (31,362,323) | (33,526,926) |
| Dental & MHSA Enhancement | | | - | 4,985,330 | 7,187,968 | 7,649,419 | 8,135,961 | 8,831,976 | 9,236,016 |
| Medicare Advantage Claims Reduction | | | | (77,883,672) | (112,977,782) | (122,095,089) | (131,948,163) | (142,596,380) | (154,103,907) |
| Calendar Year Adjustments | | - | - | (4,650,956) | 4,202,852 | 2,532,821 | 2,710,118 | 2,899,826 | 3,102,814 |
| Preventative at 100% in Standard Plan | | | | 19,866,393 | 28,788,927 | 47,829,125 | 52,422,093 | 56,932,443 | 59,409,530 |
| 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 | | | | 697,475 | 921,683 | 1,535,379 | 1,448,328 | 1,352,580 | 1,241,340 |
| PCP Copay Waiver | | | | 7,981,392 | 507,478 | (9,792,633) | (30,422,187) | (52,310,237) | (75,668,503) |
| Essential Health Benefits/MH Parity | | | | 3,010,876 | 4,209,910 | 4,504,603 | 4,819,926 | 5,232,260 | 5,471,622 |
| Net Medical Claims | 1,826,775,490 | 1,834,628,491 | 1,022,323,022 | 1,885,009,924 | 2,051,704,688 | 2,189,662,085 | 2,286,704,549 | 2,457,064,262 | 2,533,025,941 |
| Medicare Advantage Premiums | | | - | 158,450,497 | 186,791,195 | 218,708,064 | 253,369,052 | 285,527,073 | 320,397,357 |
| Pharmacy Claims Payment | 721,163,013 | 752,419,650 | 425,257,939 | 839,182,293 | 917,539,888 | 978,010,226 | 1,042,435,439 | 1,111,199,721 | 1,184,602,221 |
| 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 | | | - | 6,228,977 | 1,756,690 | 322,600 | 344,490 | 367,901 | 392,941 |
| Net Pharmacy Claims | 628,032,853 | 682,777,709 | 393,069,298 | 749,984,168 | 861,281,933 | 925,561,282 | 988,195,319 | 1,058,090,638 | 1,129,551,599 |
| MA-PDP Claims Reduction | | | - | (169,024,224) | (245,794,445) | (265,630,057) | (287,066,403) | (310,232,661) | (335,268,437) |
| EGWP+Wrap Reduction in Rebates | | - | - | - | - | - | - | - | - |
| EGWP+Wrap Claim Increase | | - | - | - | - | - | - | - | - |
| Expand Coverage of Diabetic Test Strips | | - | - | 1,191,683 | 1,640,061 | 1,748,149 | 1,863,306 | 1,986,219 | 2,117,422 |
| HB 675 - Pharmacy Audit Changes | | | | 158,806 | 206,898 | 220,533 | 235,061 | 250,566 | 267,118 |
| Specialty Pharmacy Tier | | | | (201,792) | (292,000) | (336,000) | (386,000) | (411,463) | (438,642) |
| Total Pharmacy Claims | 628,032,853 | 682,777,709 | 393,069,298 | 582,108,641 | 617,042,446 | 661,563,907 | 702,841,283 | 749,683,299 | 796,229,059 |
| Total Claims | 2,454,808,343 | 2,517,406,200 | 1,415,392,320 | 2,625,569,062 | 2,855,538,329 | 3,069,934,056 | 3,242,914,885 | 3,492,274,635 | 3,649,652,357 |
| 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 | 2,805,898,907 | 3,069,980,747 | 3,275,811,170 | 3,446,766,386 | 3,686,878,671 | 3,844,180,045 |
| Plan Income (Loss) | 232,391,259 | 281,240,475 | 54,959,190 | 178,759,352 | (88,712,463) | (266,169,102) | (393,265,798) | (170,526,550) | 201,100,376 |
| Beginning Cash Balance (Deficit) | 269,856,212 | 502,247,471 | 783,487,946 | 838,447,136 | 1,017,206,488 | 928,494,025 | 662,324,923 | 269,059,125 | 98,532,574 |
| Ending Cash Balance (Deficit) | 502,247,471 | 783,487,946 | 838,447,136 | 1,017,206,488 | 928,494,025 | 662,324,923 | 269,059,125 | 98,532,574 | 299,632,950 |
| Target Stabilization Reserve | 184,110,626 | 201,392,496 | 113,231,386 | 209,705,078 | 240,187,242 | 256,610,339 | 269,059,125 | 288,607,281 | 299,632,950 |
| | 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% | 1.99% | 1.99% | 15.61% | 15.61% |

# CY 2014 Q1 Update 7% Trend
# No 2015 Premium Increase
## Page 2
## (Segal 5-16-14)

**North Carolina State Health Plan**
**Financial Projections - Mar 2014**
**Trends - 7.0% 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 | 3,071,523,682 | 3,204,556,411 | 3,365,170,757 | 3,698,034,873 | 4,273,703,486 |
| 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) | (1,535,762) | (1,602,278) | (1,682,585) | (1,849,017) | (2,136,852) |
| 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 | 3,841,399 | 4,093,477 | 3,691,745 | 2,601,335 | 1,220,057 | 762,058 |
| **Total Plan Income** | 2,490,457,950 | 2,797,969,020 | 2,852,680,163 | 2,960,048,314 | 3,040,730,468 | 2,992,092,509 | 2,979,690,522 | 3,031,636,945 | 3,284,991,544 | 3,780,874,969 |
| **PLAN EXPENSE:** | | | | | | | | | | |
| Medical Claims Payment | 1,829,432,245 | 1,852,549,690 | 1,849,410,105 | 1,858,096,405 | 2,031,399,679 | 2,110,125,213 | 2,258,871,190 | 2,401,194,294 | 2,559,461,067 | 2,719,469,947 |
| Claim Refunds | (31,916,831) | (24,723,681) | (22,634,615) | (23,467,914) | (22,122,851) | (25,031,060) | (26,996,014) | (28,466,836) | (30,569,315) | (32,284,772) |
| Dental & MHSA Enhancement | | | | | 1,755,792 | 6,944,169 | 7,433,674 | 7,902,042 | 8,422,879 | 8,949,449 |
| Medicare Advantage Claims Reduction | | | | | (25,482,995) | (108,749,048) | (117,525,096) | (127,009,371) | (137,259,027) | (148,335,831) |
| Calendar Year Adjustments | | | | - | (18,690,285) | (380,241) | 1,229,251 | 1,315,299 | 1,407,370 | 1,505,885 |
| Preventative at 100% in Standard Plan | | | | | 6,791,651 | 27,757,947 | 37,790,909 | 50,912,121 | 54,221,153 | 57,559,180 |
| 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 | | | | | 234,352 | 928,583 | 1,233,896 | 1,493,754 | 1,402,670 | 1,299,491 |
| PCP Copay Waiver | | | | | 2,639,241 | 5,633,674 | (4,563,789) | (19,954,086) | (41,203,466) | (63,815,910) |
| Essential Health Benefits/MH Parity | | | | | 1,060,406 | 4,126,087 | 4,366,463 | 4,668,285 | 4,989,902 | 5,301,854 |
| Net Medical Claims | 1,797,515,414 | 1,827,826,009 | 1,826,775,490 | 1,834,628,491 | 1,969,231,229 | 1,985,073,152 | 2,122,977,802 | 2,241,034,517 | 2,351,498,427 | 2,467,646,193 |
| Medicare Advantage Premiums | | | | | 79,548,716 | 172,065,050 | 202,709,932 | 235,995,447 | 269,408,065 | 302,918,843 |
| Pharmacy Claims Payment | N/A | N/A | 721,163,013 | 752,419,650 | 798,951,591 | 886,950,308 | 983,315,106 | 1,010,095,422 | 1,076,680,795 | 1,147,754,108 |
| 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 | | | | | (5,266,655) | 1,001,134 | 191,276 | (471,571) | (503,150) | (536,892) |
| Net Pharmacy Claims | 596,709,775 | 655,868,735 | 628,032,853 | 682,777,709 | 701,439,820 | 818,788,431 | 931,623,696 | 955,954,510 | 1,023,655,961 | 1,092,766,434 |
| MA-PDP Claims Reduction | | | | | (55,021,320) | (236,594,411) | (255,687,580) | (276,321,568) | (298,620,718) | (322,719,410) |
| EGWP+Wrap Reduction in Rebates | | | | - | - | - | - | - | - | - |
| EGWP+Wrap Claim Increase | | | | - | - | - | - | - | - | - |
| Expand Coverage of Diabetic Test Strips | | | | - | 359,644 | 1,585,383 | 1,757,631 | 1,805,499 | 1,924,518 | 2,051,558 |
| HB 675 - Pharmacy Audit Changes | | | | | 53,842 | 200,000 | 221,729 | 227,768 | 242,783 | 258,809 |
| Specialty Pharmacy Tier | | | | | (60,900) | (275,019) | (325,266) | (360,906) | (398,681) | (424,998) |
| Total Pharmacy Claims | 596,709,775 | 655,868,735 | 628,032,853 | 682,777,709 | 646,771,087 | 583,704,384 | 677,590,211 | 681,305,305 | 726,803,863 | 771,932,393 |
| Total Claims | 2,394,225,189 | 2,483,694,744 | 2,454,808,343 | 2,517,406,200 | 2,695,551,032 | 2,740,842,586 | 3,003,277,945 | 3,158,335,269 | 3,347,710,355 | 3,542,497,429 |
| 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 | 2,856,764,669 | 2,952,626,981 | 3,206,783,493 | 3,359,745,430 | 3,539,800,972 | 3,739,614,400 |
| Plan Income (Loss) | (68,417,019) | 148,372,182 | 232,391,259 | 281,240,475 | 183,965,799 | 39,465,529 | (227,092,971) | (328,108,484) | (254,809,428) | 41,260,569 |
| Beginning Cash Balance (Deficit) | 189,901,049 | 121,484,030 | 269,856,212 | 502,247,471 | 783,487,946 | 967,453,745 | 1,006,919,274 | 779,826,303 | 451,717,819 | 196,908,391 |
| Ending Cash Balance (Deficit) | 121,484,030 | 269,856,212 | 502,247,471 | 783,487,946 | 967,453,745 | 1,006,919,274 | 779,826,303 | 451,717,819 | 196,908,391 | 238,168,960 |
| Target Stabilization Reserve | 179,566,889 | 186,277,106 | 184,110,626 | 201,392,496 | 222,360,197 | 231,189,978 | 252,051,121 | 263,010,584 | 277,047,206 | 291,562,073 |
| | | | 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% | 1.99% | 1.99% | 15.61% | 15.61% |

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

# Migration Analysis: FY 2012-13 to CY 2014

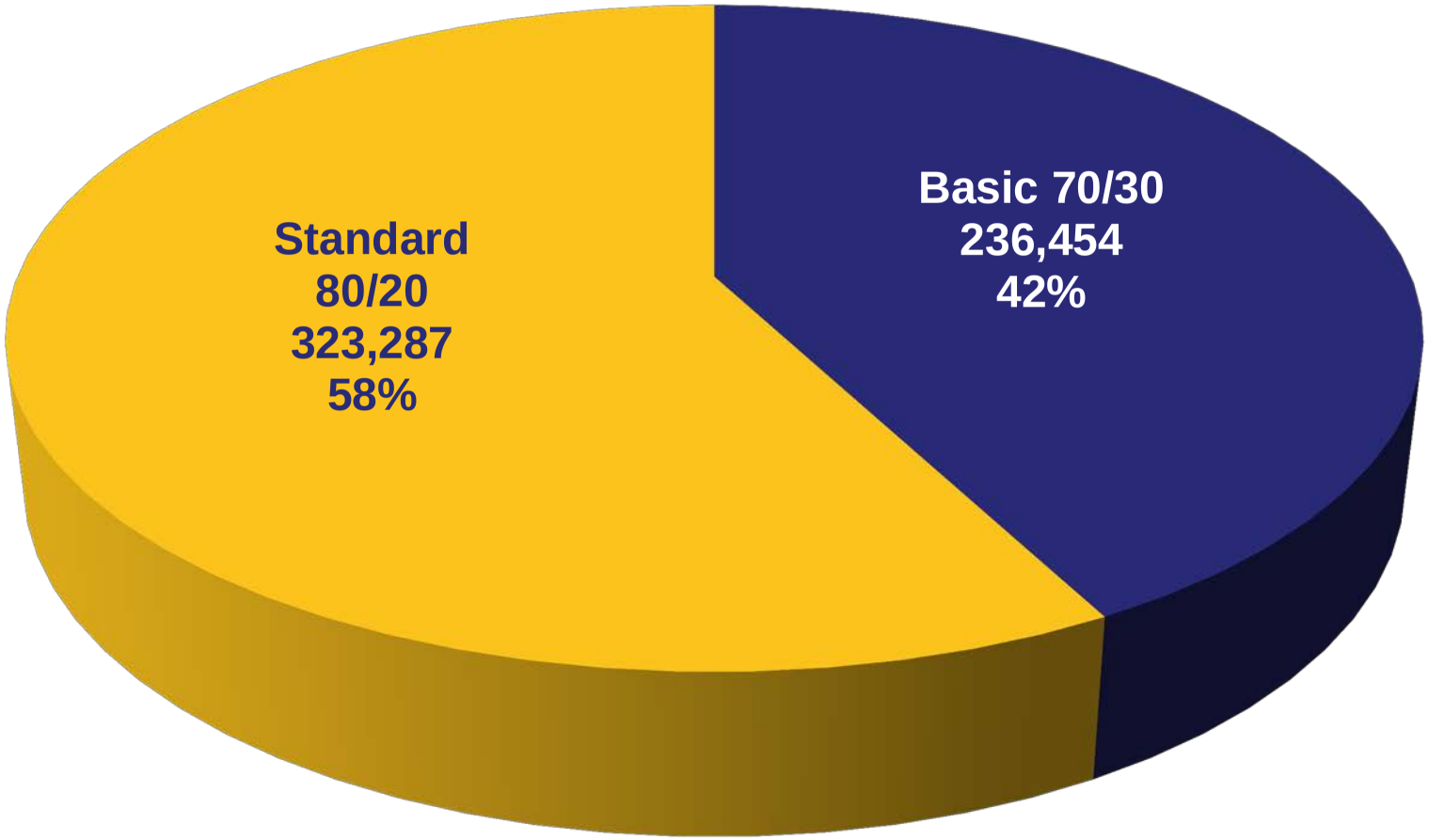
***Board of Trustees Meeting***

**May 30, 2014**

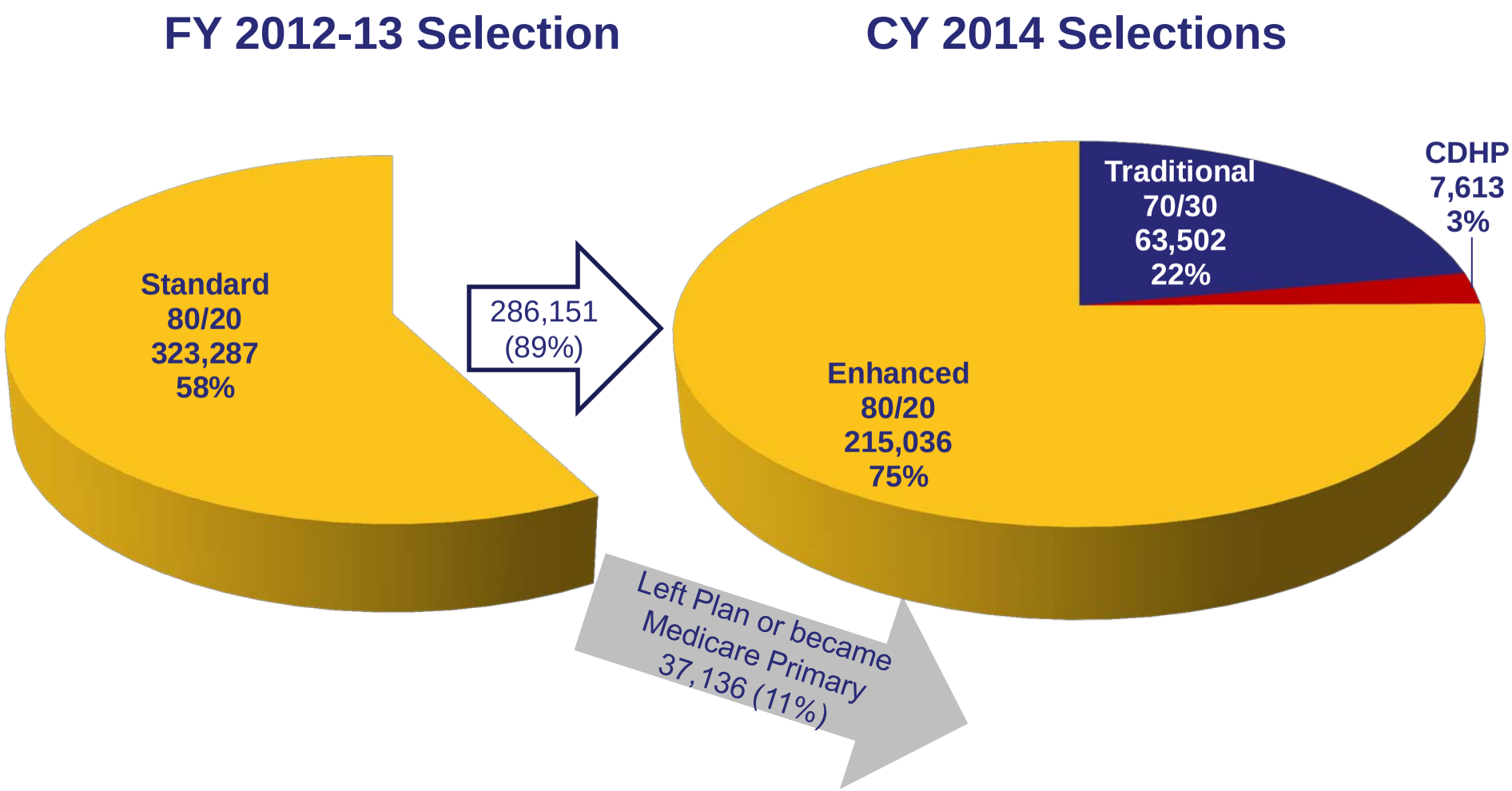
# Presentation Outline

- Migration of Active Employees and Non-Medicare Retirees
- Migration of Medicare Primary Employees and Retirees
- Summary

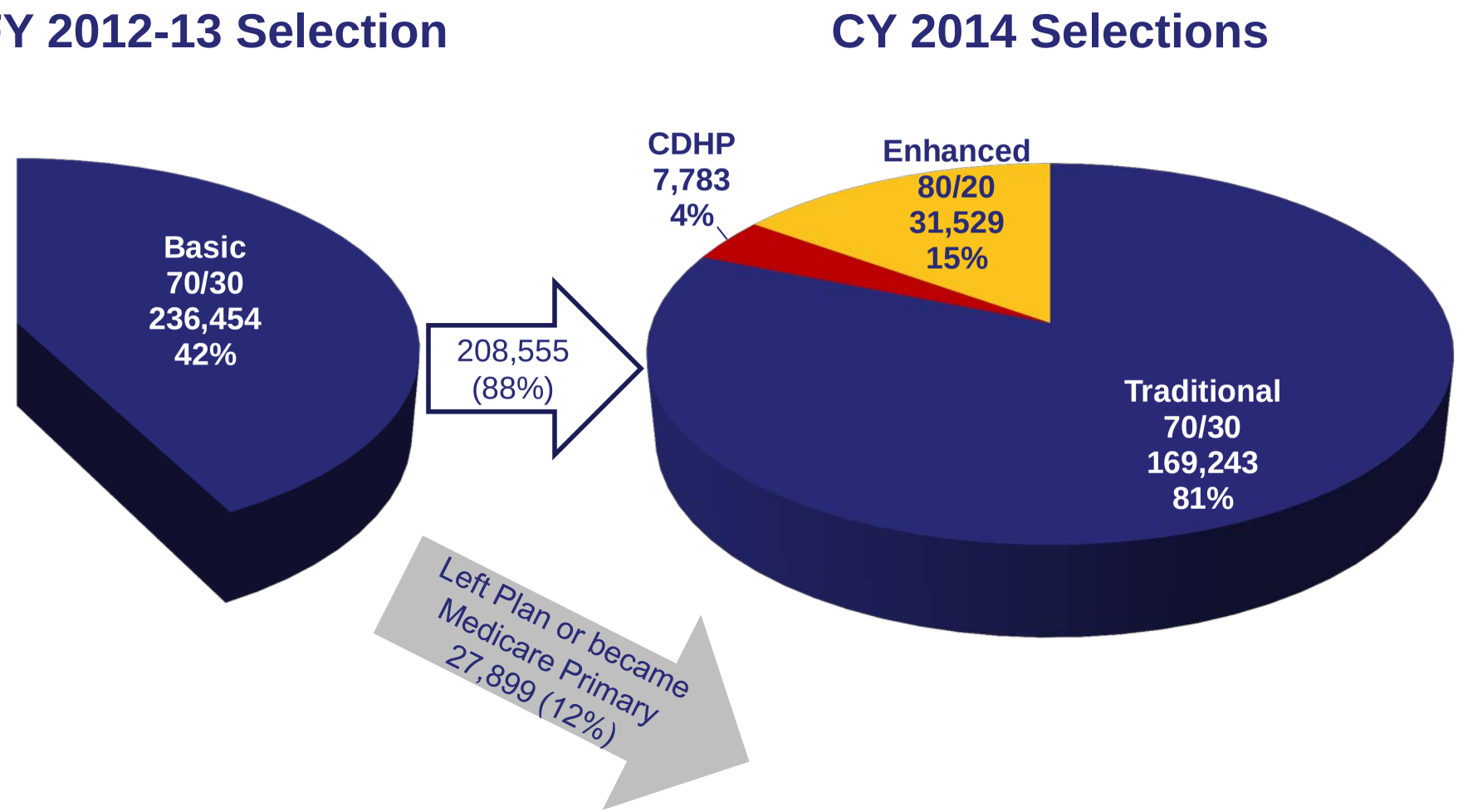
# Fiscal Year 2012-13 Plan Selections:
## Active Employees and Non-Medicare Retirees



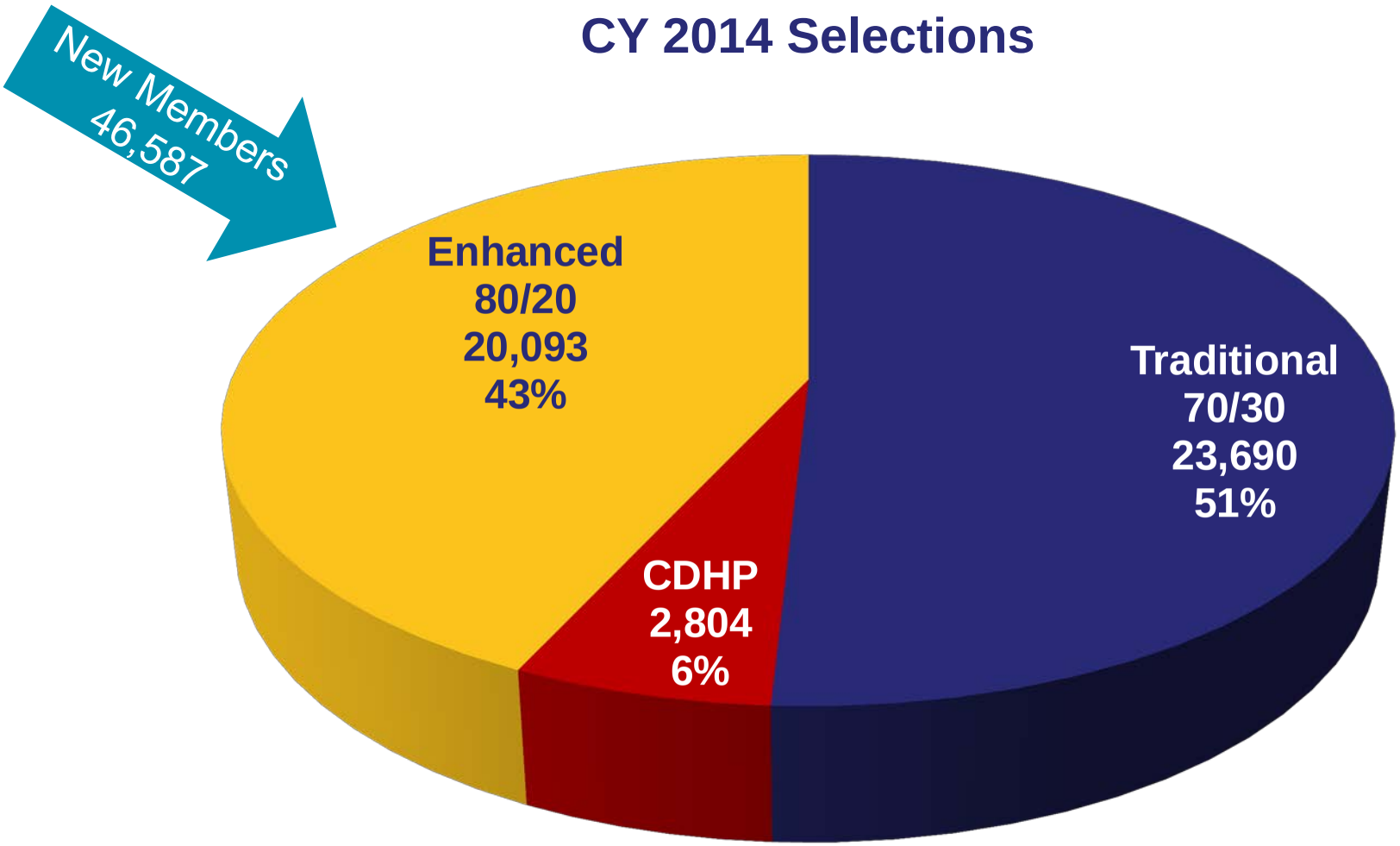
# Migration from the 80/20 Standard Plan:
## Active Employees and Non-Medicare Retirees



# Migration from the 70/30 Basic Plan:
## Active Employees and Non-Medicare Retirees

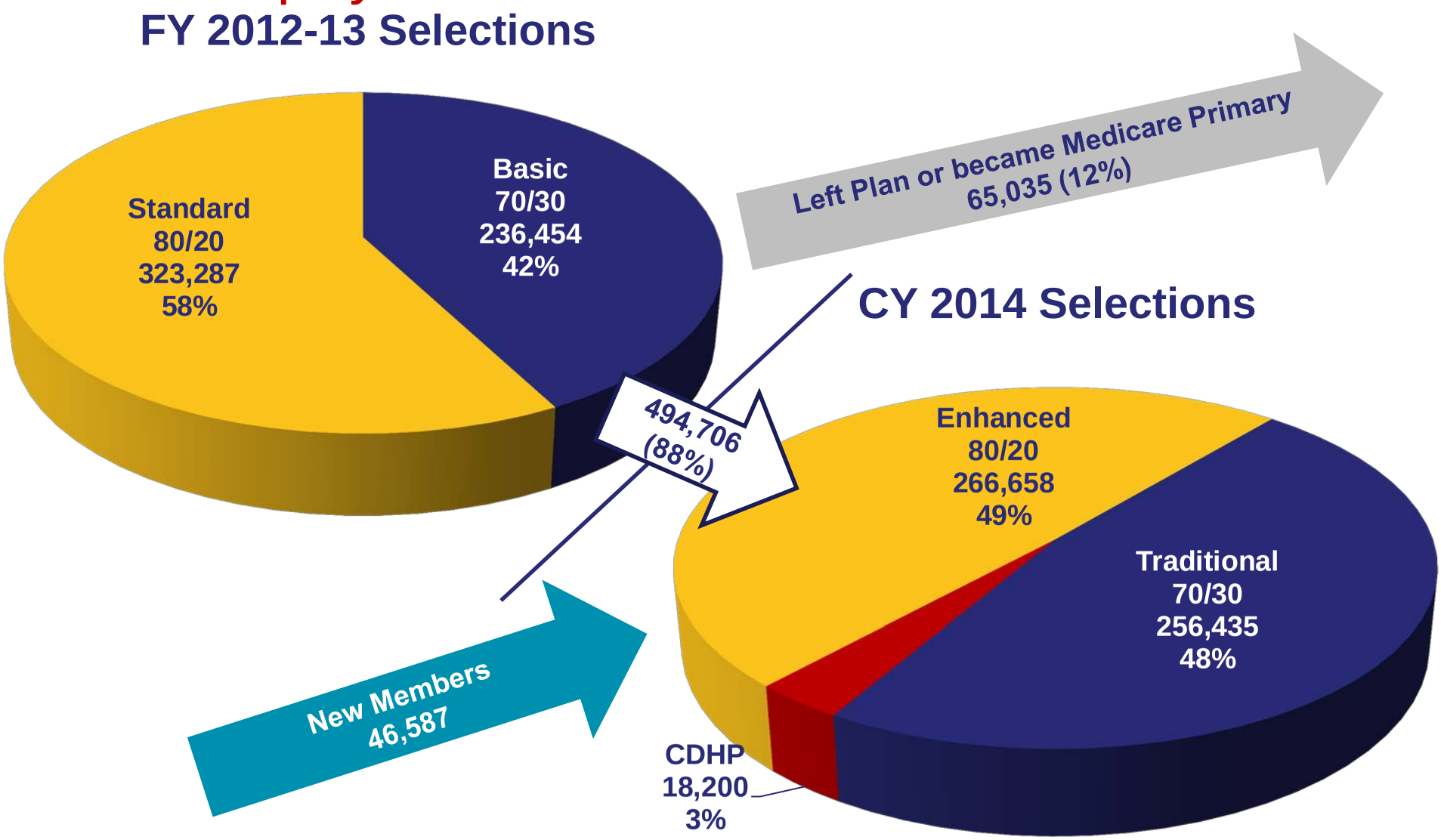


# Plan Selections Among New Members:
## Active Employees and Non-Medicare Retirees



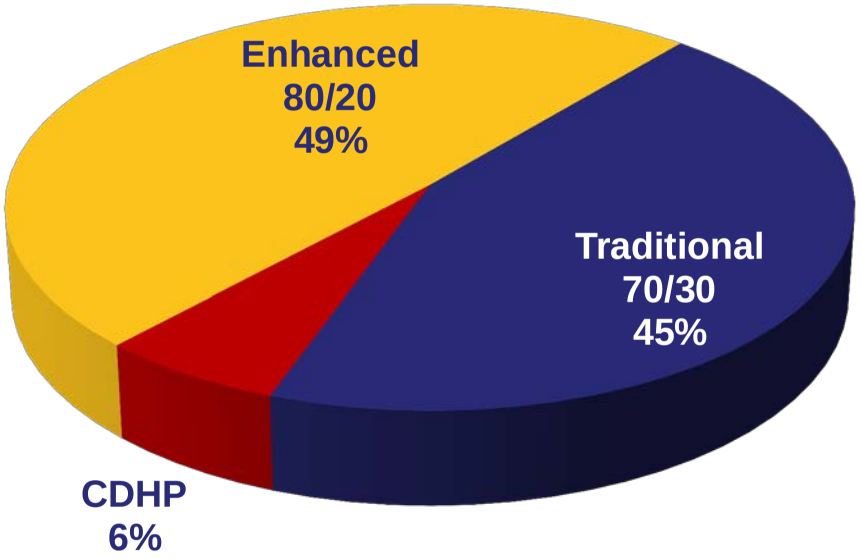
# Member Movement:

## Active Employees and Non-Medicare Retirees

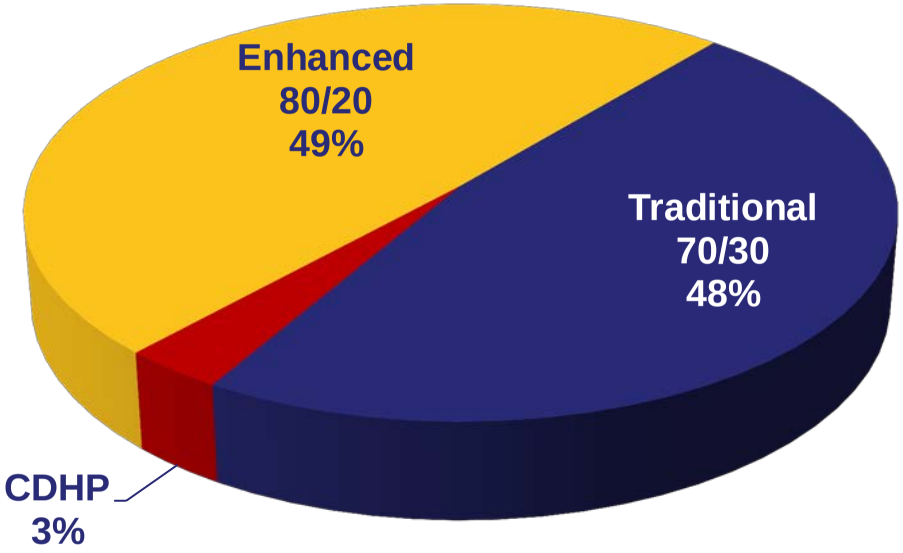


# Comparison to Forecast:
## Active Employees and Non-Medicare Retirees

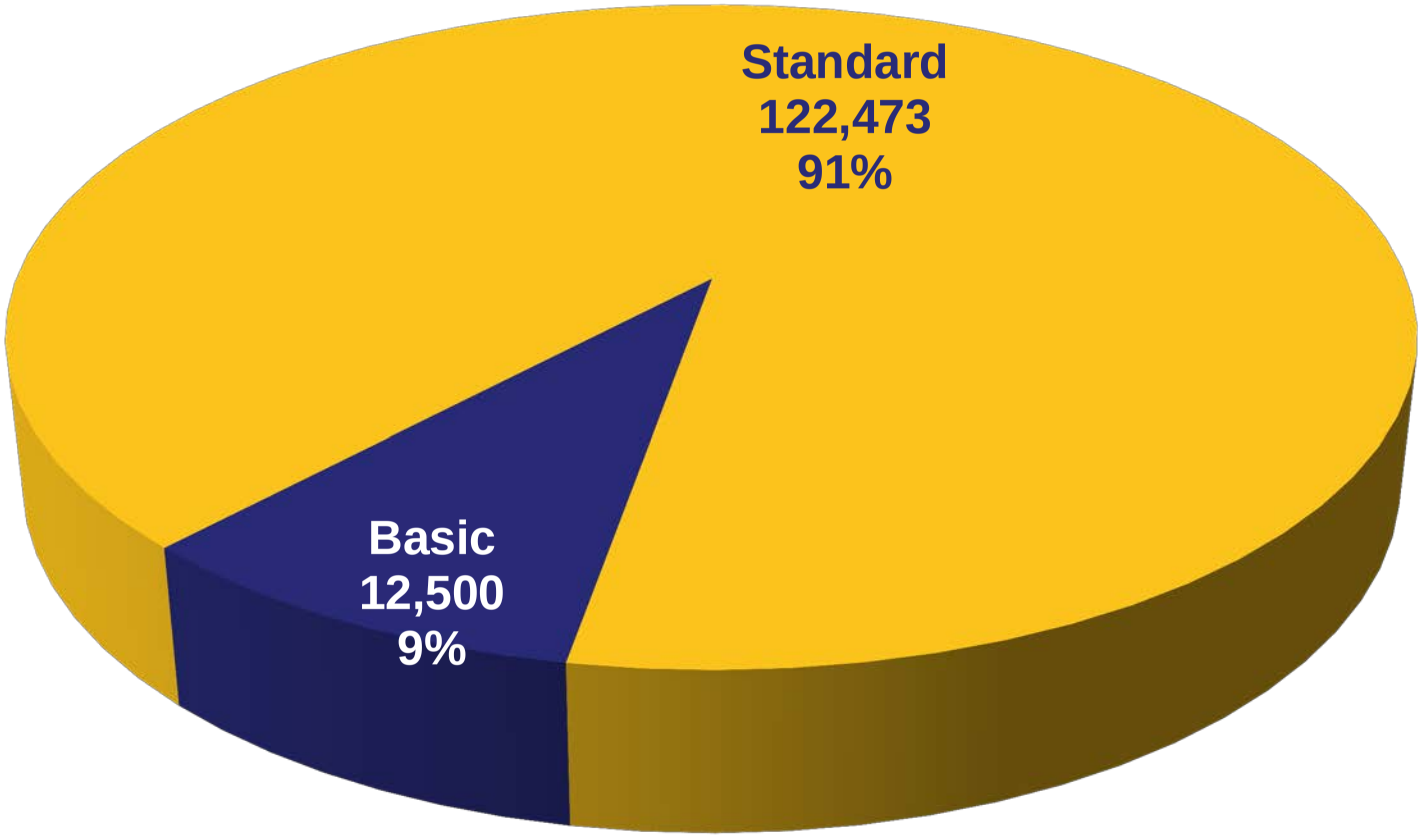
**Forecasted**
**CY 2014 Selections**



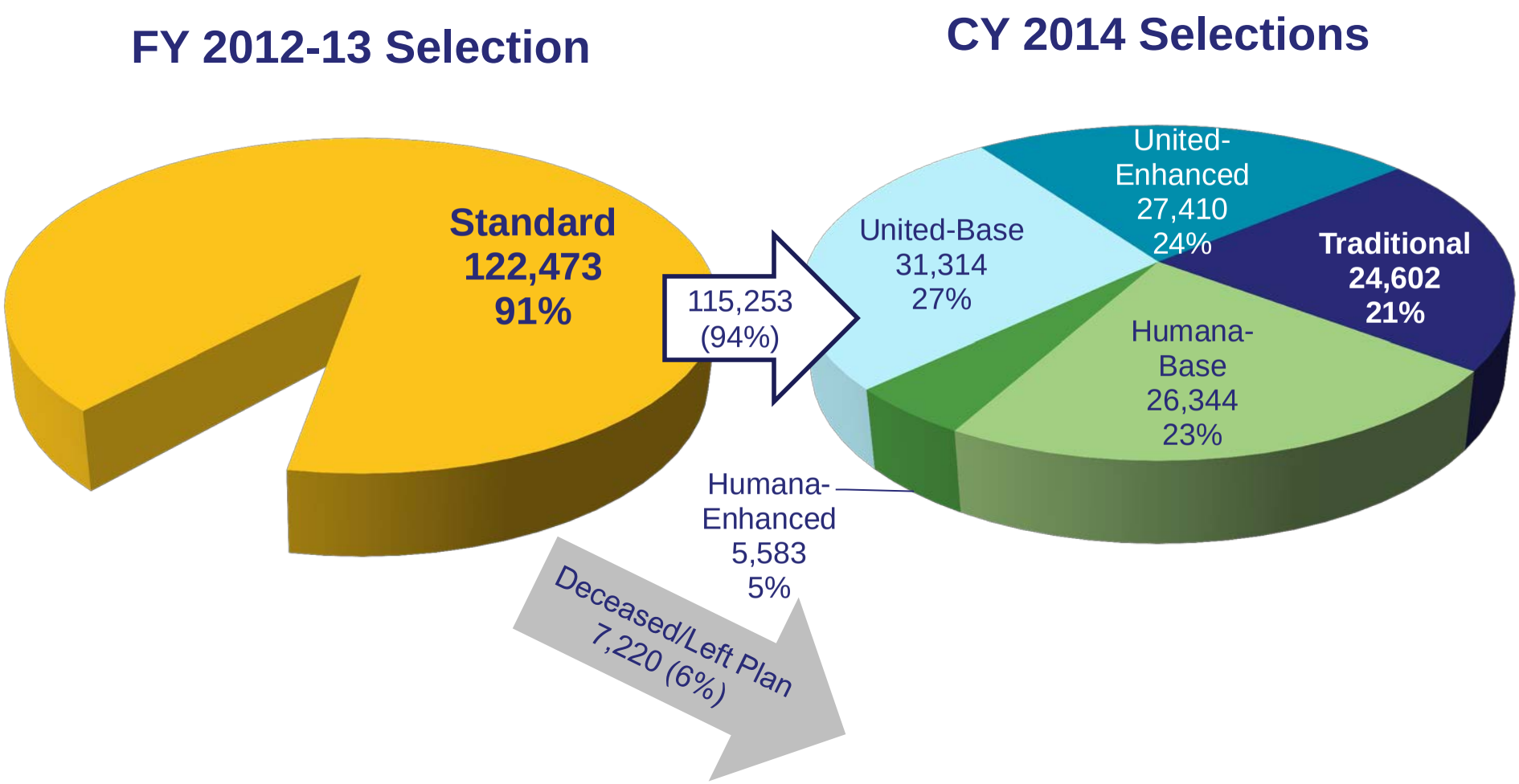

**Actual**
**CY 2014 Selections**



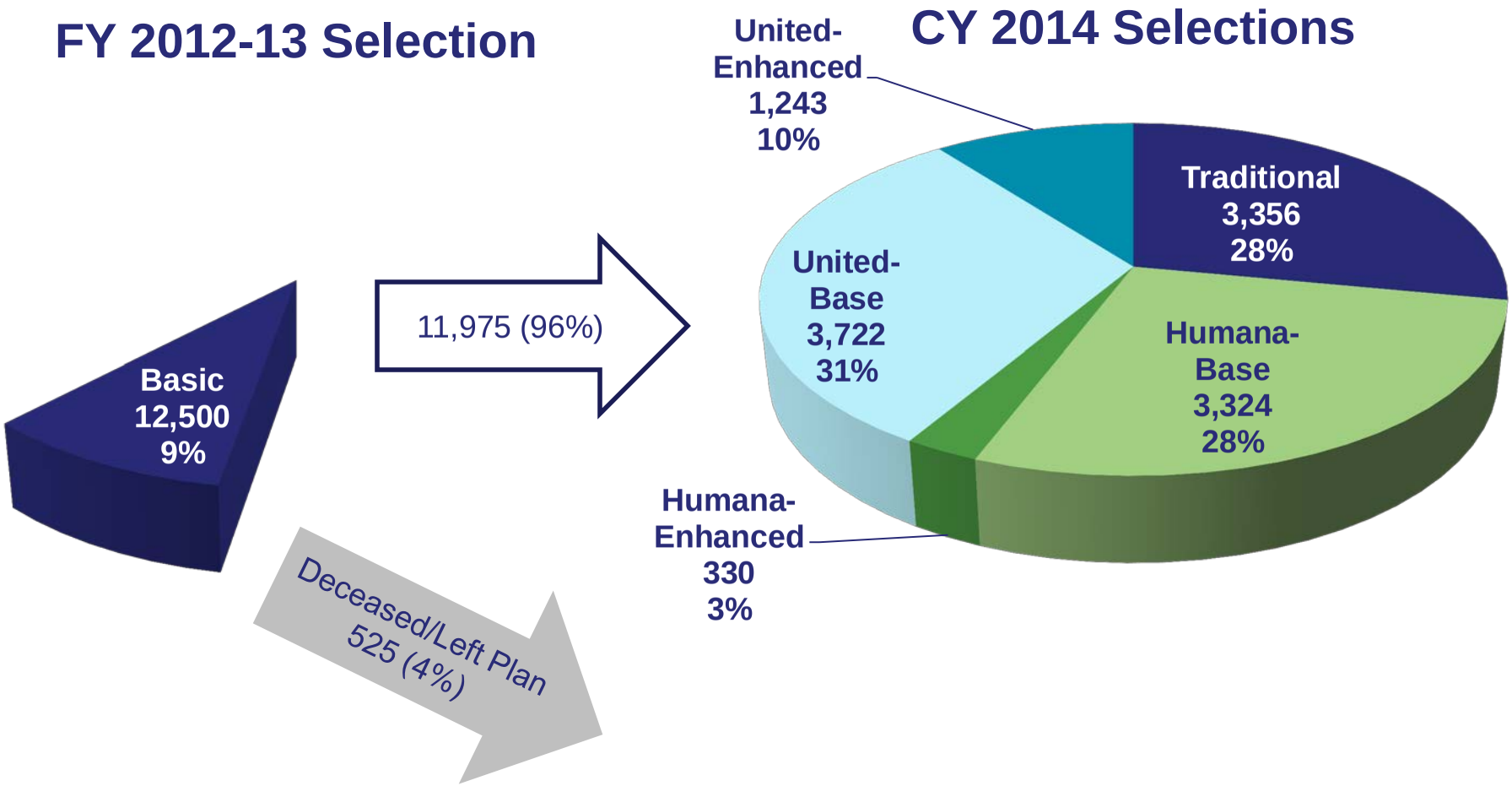
# Fiscal Year 2012-13 Plan Selections:
## Medicare Primary Members



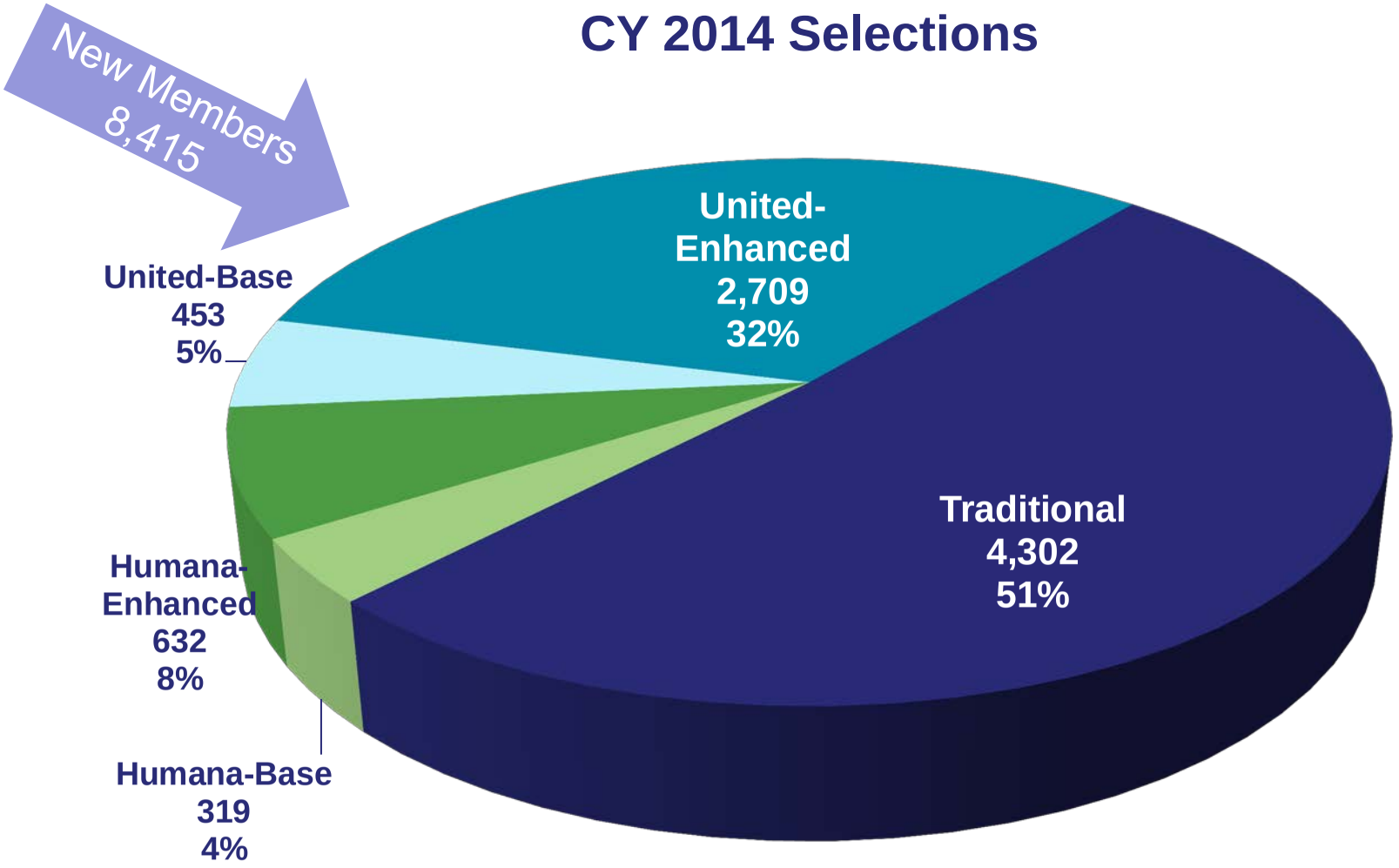
# Migration from the 80/20 Standard Plan:
## Medicare Primary Members



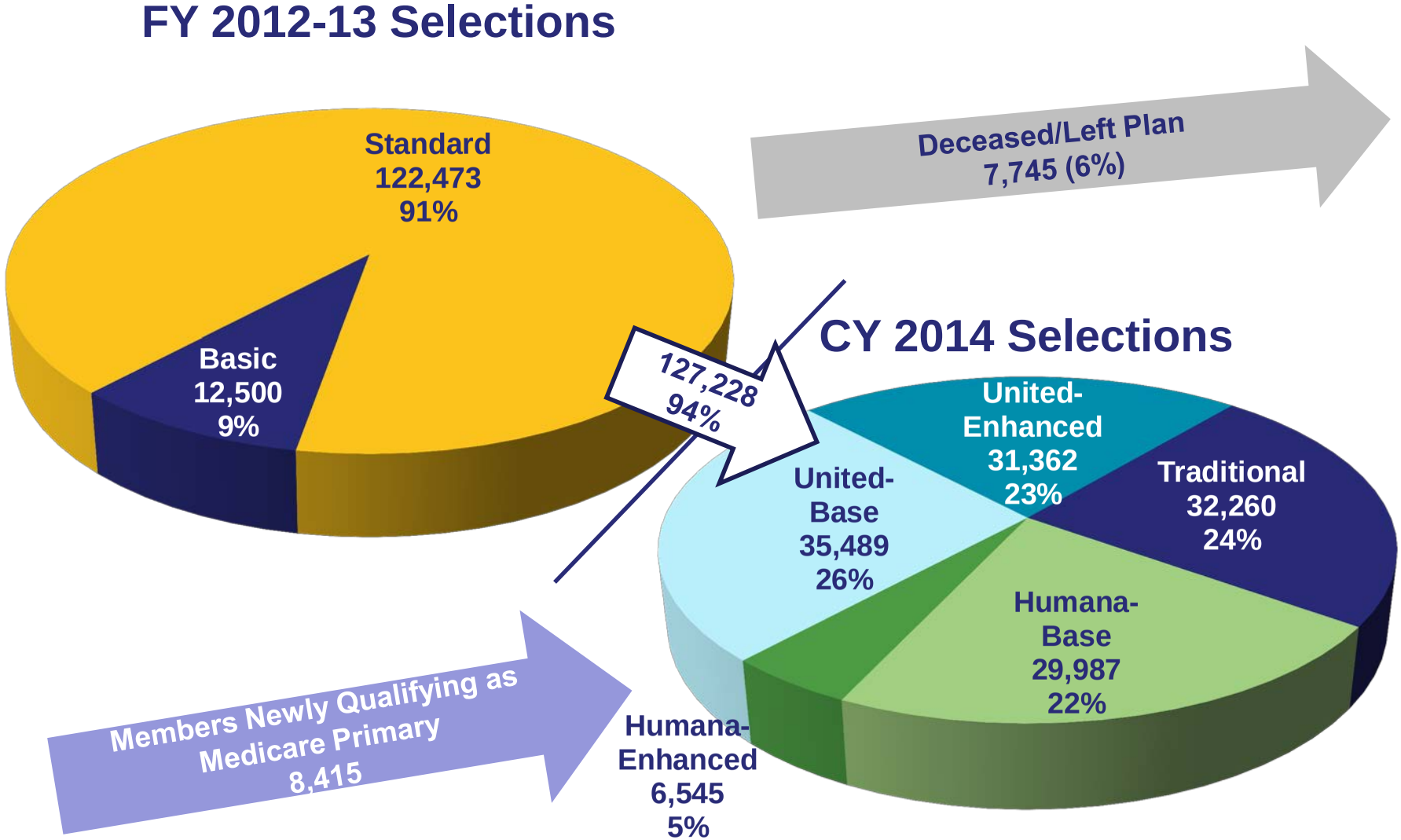
# Migration from the 70/30 Basic Plan:
## Medicare Primary Members



# Plan Selections of Newly Medicare Prime Members:
## Medicare Primary Members

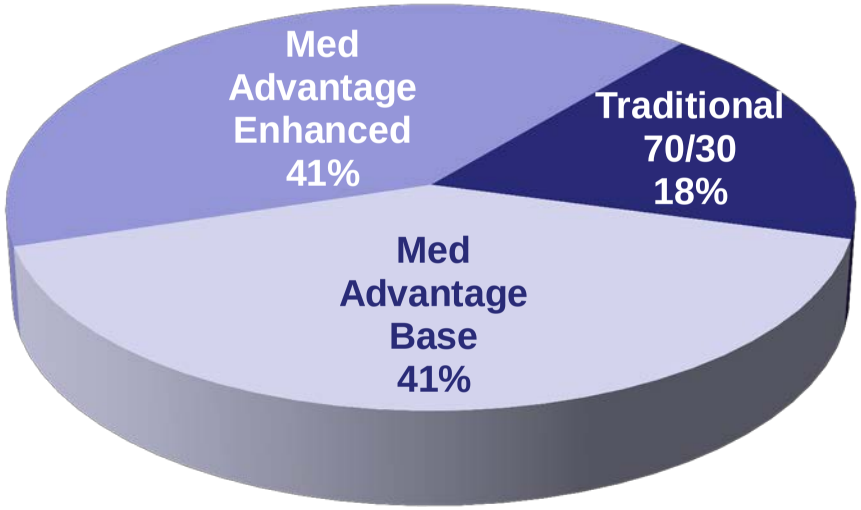


# Member Movement:
## Medicare Primary Members

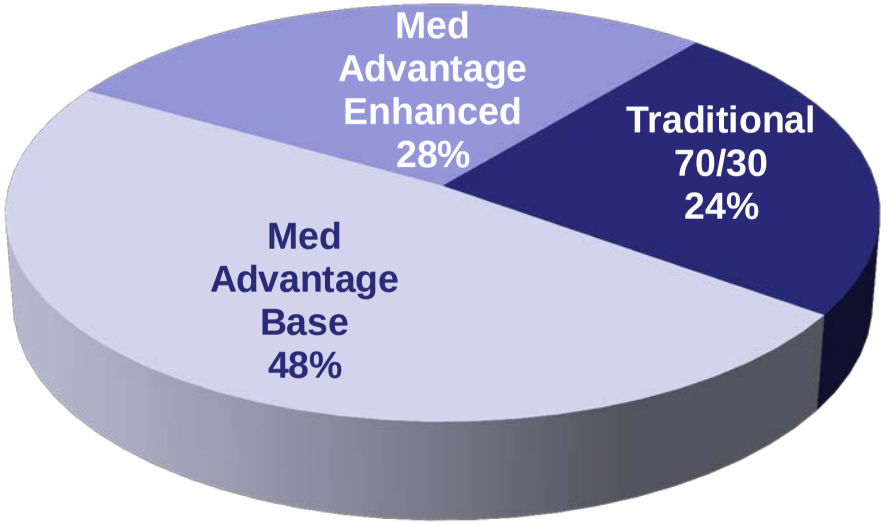


# Comparison to Forecast:
## Medicare Primary Members

**Forecasted**
**CY 2014 Selections**




**Actual**
**CY 2014 Selections**



# Migration Summary

## Active Employees and Non-Medicare Retirees

- Most active employees and non-Medicare retirees opted to stick with their FY 2012-13 plans in 2014
  - 75% of those who were in the 80/20 Standard Plan in 2012-13
  - 81% of those who were in the 70/30 Basic Plan in 2012-13
- Only 3% of active employees and non-Medicare retirees who were in the Plan in FY 2012-13 elected the Consumer-Directed Health Plan (CDHP) for 2014 coverage; however, 6% of new members chose the CDHP
- Actual results were close to forecasted results, with a slightly lower percentage of members selecting the CDHP than anticipated

# Migration Summary

## Medicare Primary Members

- 91% of Medicare primary members were in the 80/20 Standard Plan in the 2012-13 Plan Year
  - Most of them (79%) moved to a Medicare Advantage-Prescription Drug Program (MA-PDP) for 2014
  - 29% “bought up” to one of the enhanced MA-PDPs
- Just 9% of Medicare primary members were in the 70/30 Basic Plan in 2012-13
  - 72% moved to a Medicare Advantage plan for 2014; 13% “bought up” to an enhanced MA-PDP
  - Less than 3,400 stayed in the 70/30 Plan, meaning nearly all Medicare primary members (97%) moved to a new plan from 2012-13 to 2014
- The Humana Enhanced MA-PDP drew 5% of Medicare primary members in 2014; the remaining 95% of Medicare members are split fairly evenly between the other four options: Traditional 70/30 Plan, Humana Base MA-PDP, UnitedHealthcare Base MA-PDP, and UnitedHealthcare Enhanced MA-PDP
- Enrollment in the Traditional 70/30 Plan among Medicare primary members was greater than anticipated; fewer members than expected “bought up” to the enhanced MA-PDP plans

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

# Coverage for Applied Behavior Analysis

***Board of Trustees Meeting***

**May 30, 2014**

A Division of the Department of State Treasurer

# Overview of the Recommendation Process

- Request to consider coverage for Applied Behavior Analysis (ABA) from Autism Speaks
- Directive from SHP BOT to SHP staff to explore coverage for ABA
- Development of Proposed Benefit
  - Review of HB 498
  - Review of Current Coverage for Autism Spectrum Disorder (ASD)
  - Review of Value Options clinical criteria for coverage of ABA
  - Discussions with representatives from: TEACCH, BCBSNC, Value Options, Autism Speaks, NC Psychology Association, Fiscal Research Division of the General Assembly
  - Review of NC law as it relates to the provision of ABA
  - Review of Value Options ABA credentialing criteria (BCBA and BCaBA)
  - Drafting of proposed benefit
  - Actuarial analysis of financial impact to SHP for ABA coverage
- Recommendation to SHP BOT to cover ABA

# Contents of Information Packet

- Power Point Presentation dated 5/30/14
- HB 498
- Proposed Benefit language for Benefit Booklet
- Value Options Clinical Criteria for ABA
- Applied Behavior Analyst Credentialing Criteria (Applies only if required by State where treatment is given.)
- Applicable Billing Codes (AMA, and BCBSNJ)
- Bibliography of Reviews of the Evidence for Early Intensive Behavioral Intervention
- Analysis of the Evidence Base for ABA and EIBI for Autism
- Actuarial Note from Segal
- ASD Screening Tools

# ASD and ABA at a Glance

- CDC reports 1 in 68 children were identified with ASD in 2010; that is 30% higher than the 1 in 88 estimate for 2008
- Currently 37 other states have legislation requiring coverage of ABA
- ASD can cause significant social, communication and behavioral challenges
- There are no medications that can cure or even treat ASD
- Evidence suggests that early intervention programs are beneficial for children with Autism
- ABA encourages positive behaviors and discourages negative behaviors and includes:  Discrete Trial Training (DTT), Early Intensive Behavioral Intervention (EIBI), Pivotal Response Training (PRT) and Verbal Behavior Intervention (VBI)

# Autism Spectrum Disorder

- Any of the autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems. (source: HB 498)
- ASD includes:  autistic disorder, pervasive developmental disorder not otherwise specified, and Asperger syndrome (source:  CDC, DSM V)

# Current Coverage for Autism Spectrum Disorder

Coverage for Autism Spectrum Disorder (ASD) is consistent with coverage for other medical conditions or mental health disorders meaning that we cover medically necessary treatment as described in the benefit booklet. Relevant State Health Plan (SHP) coverage includes:

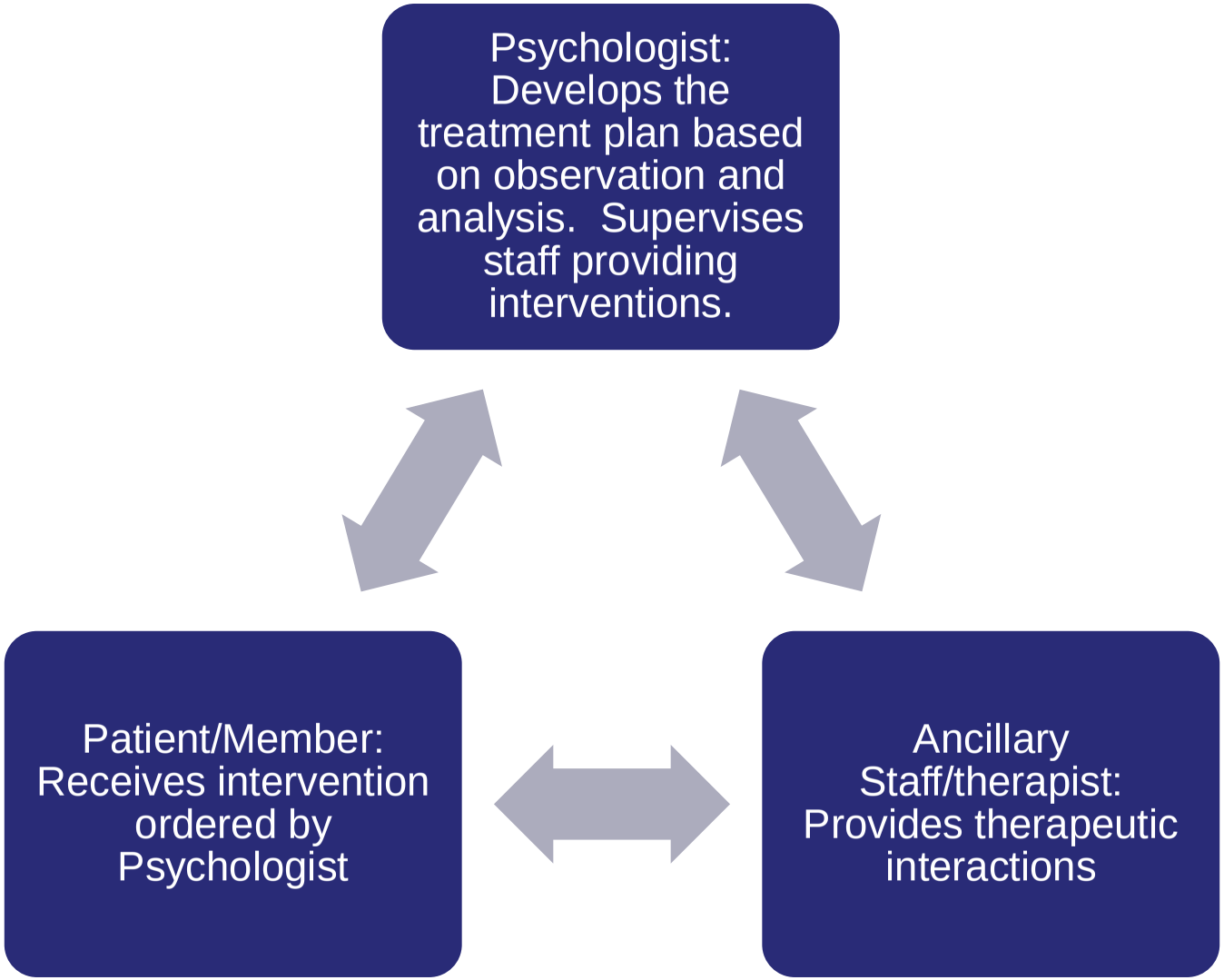
- Speech therapy
- Occupational therapy
- Medical evaluation and treatment
- Mental health evaluation and treatment

Limitations and exclusions to coverage may apply and are listed in the benefit booklet. Currently, Applied Behavior Analysis (ABA) is excluded from coverage.

# Applied Behavior Analysis

- ABA is a systematic and structured strategy for addressing challenging behavior problems often found in individuals with ASD.
- Such challenging behavioral problems are culturally abnormal behaviors of such an intensity, frequency or duration that the physical safety of the individual or others is likely threatened, or,
- Behavior which is likely to seriously limit the ability to participate in common social activities such as the educational system and in addition the individual may be denied access to, ordinary community facilities.
- The ABA approach relies on applying experimentally derived principles of behaviorism to modify behavior.

# ABA in practice = Analysis + Intervention



# Who can provide ABA in North Carolina?

- The Practice of Psychology: The observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods, and procedures for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior or enhancing interpersonal relationship, work and life adjustment, personal effectiveness, behavior health, or mental health. The practice of psychology includes, but is not limited to: psychological testing and the evaluation or assessment of personal characteristics such as intelligence, personality, abilities, interests, aptitudes, and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy…*NCGS §90-270.2*
- Board Certified Behavior Analysts and Board Certified Assistant Behavior Analysts are not licensed or otherwise authorized in North Carolina to provide ABA.

# Supervision of Ancillary staff by a Psychologist

- "Psychologist" includes licensed psychologists (provisional and permanent) and licensed psychological associates, or temporary licensees
- A psychologist may employ or supervise unlicensed individuals to provide ancillary services; the psychologist retains full professional responsibility for ancillary services rendered
- The psychologist is required to have face to face contact with all recipients of services provided by unlicensed ancillary staff
- Failure of any psychologist to train ancillary services personnel, to ensure training has occurred, or to supervise ancillary services personnel may subject that psychologist to disciplinary action

*21 NCAC 54.2801*

# Proposed Benefit Design for ABA

Coverage will be provided for Applied Behavior Analysis when:

- The member is younger than age 26, and
- Diagnosed with ASD by a licensed physician (MD or DO) or a licensed doctoral level clinical psychologist (PsyD or PhD) utilizing results from a face-to-face evaluation and a clinically recognized, validated tool accepted by the Mental Health Care Manager, and
- Treatment is determined by the Mental Health Care Manager to be medically necessary.

Coverage for ABA is limited to a maximum of $36,000 per benefit year and is only available in-network.

Coverage is subject to copay, deductible and coinsurance as applicable (depends on ABA component and place of service).

# Applied Behavior Analysis Exclusions

Treatment for the following is not covered:

- Members with medical conditions or impairments that would prevent beneficial utilization of services
- Members requiring 24 hour medical/nursing monitoring or procedures in a hospital setting

ABA will not be certified for the following services:

- Speech therapy
- Occupational therapy
- Vocational rehabilitation
- Supportive respite care
- Recreational therapy
- Orientation and mobility
- Respite Care
- Equine therapy/Hippotherapy
- Dolphin therapy
- Service Animals
- Other educational services

# Medical Necessity Criteria – Initial Approval

All of the following criteria must be met:

- Verified diagnosis of ASD
- Display of a “severe challenging behavior” that either 1) presents a health or safety risk to self or others or 2) significantly interferes with socially acceptable activities in the home or community due to the objectionable nature of the behavior.
- Less intensive forms of behavioral treatment or therapy have not been sufficient or are not appropriate to reduce the interfering behaviors, increase pro-social behaviors, or to maintain desired behaviors.
- There is a reasonable expectation of the part of the treating provider that the behavior will improve or the individual will receive maximum benefit through the use of ABA.
- Parent/caregiver training and support is included in the treatment plan with documented plans that skills transfer to the parent/caregiver will occur.

# Medical Necessity Criteria - Initial Approval

- The treatment plan must be individualized with measurable objectives. Interventions emphasize generalization of skill and focus on the development of spontaneous social communication, adaptive skills and appropriate behaviors and include a focus that:
  - Is child centered, strengths based, family inclusive, community based, culturally competent, and provided in the least restrictive setting
  - Targets specific behaviors (including frequency, rate, symptom intensity, duration)
  - Incorporates objective baseline and quantifiable progress measures
  - Describes detailed behavioral interventions, reinforcers, strategies for generalization of skills beyond the ABA sessions
  - Coordinates ancillary services and transition plans

# Medical Necessity Criteria - Continuing Treatment

- The individual's condition continues to meet admission criteria for ABA, either due to continuation of presenting problems, or appearance of new problems or symptoms.
- There is reasonable expectation that the individual will benefit from the continuation of ABA services.
- Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. The treatment plan is updated based on treatment progress including the addition of new target behaviors.
- All services and treatment interventions are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Expected benefit from all relevant modalities is documented.

# Medical Necessity Criteria - Continuing Treatment

- Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms or there are clear benefits to treatment, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.
- There is documented skills transfer to the individual and treatment transition planning from the beginning of treatment.
- There is a documented attempt at coordination of care with relevant providers/caretakers, etc., when appropriate. If coordination is not successful, the reasons are documented.
- Unless contraindicated, family and/or significant other are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.

# Discharge Criteria

- The individual has achieved adequate stabilization of the challenging behavior and less-intensive modes of treatment are appropriate and indicated.
- The individual no longer meets admission criteria, or meets criteria for a less or more intensive services.
- Treatment is making symptoms persistently worse.
- The individual is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement or stabilization of challenging behavior and there is no reasonable expectation of progress.

# Network Considerations

Plan staff recommends coverage be available in-network only.

- If the benefit is approved, BCBSNC will work on developing a network of ABA providers. This will include:
  - Credentialing and contracting with qualified providers who are not already in the network
  - Amending current contracts with qualified providers to include fee schedules for ABA billing codes

# Other considerations

- Billing Codes have not yet been finalized by the American Medical Association (AMA). Until finalized, temporary codes published by AMA will be utilized.
- Treatment limitations on ABA will result in loss of mental health parity and the Plan will have to exercise the opt-out that is allowed under federal law.

# Estimated Cost for ABA Coverage

| Plan Design | Projected Cost Impact (in Millions) each Calendar Year | | | | |
|---|---|---|---|---|---|
| | 2015 | 2016 | 2017 | 2018 | 2019 |
| $36,000 annual maximum | $4.0 | $5.0 | $5.2 | $5.5 | $5.8 |

# Recommendation for Coverage of ABA

Plan staff recommends coverage of ABA for the treatment of Autism Spectrum Disorder as described on slide 11 and as set forth in the draft benefit booklet excerpt for Mental Health and Chemical Dependency Benefits.

# Appendix

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Age requirements | Diagnosis: Prior to Age 8<br>Treatment: Age 23<br>(G.S. 58-3-192.b) | Diagnosis and Treatment up to Age 26 | Age changed to match dependent eligibility |
| Utilization management | An insurer shall have the right to request a review of that treatment not more than once annually, unless the insurer and the individual's licensed physician or the individual's licensed psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to a particular insured being treated for an autism spectrum disorder and shall not apply to all individuals being treated for an autism spectrum disorder by a physician or psychologist. The cost of obtaining any review shall be borne by the insurer.<br>(G.S. 58-3-192.h) | Consistent with SHP utilization management policies through BCBSNC and Value Options. Prior authorization will be required for the initial treatment plan as well as all continuing treatment. | Prior authorization for both initial and continuing treatment is necessary to ensure that therapy is appropriate for the individual and that progress toward treatment goal is being made. This includes review of the diagnosis. |

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Diagnosis | "Diagnosed with autism spectrum disorder by a licensed physician, or a licensed psychologist who determines the care to be medically necessary" (G.S. 58-3-192.a.10) | Diagnosis and referral for ABA will only be accepted from an MD, DO, Doctor of Psychology (Psy.D.), or a PhD Psychologist. | Limits diagnosis to licensed physician, Doctor of Psychology or PhD Psychologist. |
| Providers of Treatment | ABA Provided or supervised by: (i) a Board Certified Behavior Analyst or (ii) a licensed psychologist or licensed psychological associate, so long as the services performed are commensurate with the psychologist's training and experience (G.S. 58-3-192.a.3(b)) | Care that the provider cannot legally provide or legally charge or is outside the scope of license or certification is not covered. ABA rendered by a Psychologist with interventions provided by ancillary staff, including paraprofessionals, supervised by the psychologist is covered. | Does not recognize the provision of ABA by BCBAs. ABA falls within the scope of practice of a psychologist and BCBAs are not licensed to provide ABA in North Carolina. |

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Board Certified Behavior Analysts | Does not prevent a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA) from offering services within the scope of practice authorized by the Behavior Analyst Certification Board, including behavior analysis and therapy, in accordance with professional standards of the BCBA or BCaBA's certification, if both of the following are true:<br>(1) The BCBA or BCaBA is properly certified and in good standing with the Behavior Analyst Certification Board; and (2) does not hold him/herself out to be a licensed psychologist.<br>(G.S. 90-270.4 f1) | Will only cover ABA provided by licensed providers for whom ABA is within their scope of practice. | Compliant with currently existing NC law. |

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Behavioral Health Treatment | Counseling and treatment programs, including applied behavior analysis, that are (a) necessary to i) increase appropriate or adaptive behaviors, ii) decrease maladaptive behaviors, or iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual, and (b) provided or supervised by i) BCBSA or ii) a licensed psychologist or licensed psychological associate, so long as the services performed are commensurate with the psychologist's training and experience. (G.S. 53-3-192) | Expands SHP coverage to include ABA so long as clinical criteria are met. See Value Options clinical criteria for 2.60 Outpatient Services, 2.605 Applied Behavior Analysis. Provider must be licensed and performing within their scope of practice. | Requires additional clinical criteria be met including that certain behaviors are present and less intensive treatment is not sufficient or has been unsuccessful. |

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Exclusions | None listed | ABA for individuals:<br>• With medical conditions or impairments that would prevent beneficial utilization of services<br>• Requiring 24 hour medical/nursing monitoring or procedures provided in a hospital setting<br><br>ABA treatment will not be certified for the following services:<br>• Speech therapy<br>• Occupational therapy<br>• Vocational rehabilitation<br>• Supportive respite care<br>• Recreational therapy<br>• Orientation and mobility<br>• Respite Care<br>• Equine therapy<br>• Hippo therapy<br>• Dolphin therapy<br>• Service Animals<br>• Other educational services | ABA excluded for individuals with an underlying medical condition that would interfere with effectiveness of treatment. Therapies and services that are not evidence based are excluded. |

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Therapeutic Care | Therapeutic care. – Direct or consultative services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or licensed clinical social worker. (G.S. 58-3-192.a.9) | The Plan currently covers therapeutic care. | ABA therapy is recognized as being distinct from other therapies and therefore, therapeutic care provided during ABA therapy is not covered. |
| Annual benefit maximum | $36,000 annual maximum (G.S. 58-3-192.g) | $36,000 annual maximum | No Change |

**GENERAL ASSEMBLY OF NORTH CAROLINA**
**SESSION 2013**

**H** **4**

# HOUSE BILL 498

**Committee Substitute Favorable 5/14/13**
**Committee Substitute #2 Favorable 5/15/13**
**Fourth Edition Engrossed 5/15/13**

Short Title: Autism Health Insurance Coverage. (Public)

Sponsors:

Referred to:

April 3, 2013

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS, INCLUDING THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES, TO PROVIDE COVERAGE FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS.

The General Assembly of North Carolina enacts:

**SECTION 1.** Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read as follows:

"**§ 58-3-192. Coverage for autism spectrum disorders.**

(a) As used in this section, the following definitions apply:

(1) Applied behavior analysis. – The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) Autism spectrum disorder. – Any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems.

(3) Behavioral health treatment. – Counseling and treatment programs, including applied behavior analysis, that are both of the following:

a. Necessary to (i) increase appropriate or adaptive behaviors, (ii) decrease maladaptive behaviors, or (iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

b. Provided or supervised by (i) a Board Certified Behavior Analyst or (ii) a licensed psychologist or licensed psychological associate, so long as the services performed are commensurate with the psychologist's training and experience.

(4) Diagnosis of autism spectrum disorder. – Any medically necessary assessments, evaluations, or tests to diagnose whether an individual has autism spectrum disorder.

(5) Health benefit plan. – As defined in G.S. 58-3-167, and including the State Health Plan for Teachers and State Employees established under Article 3B of Chapter 135 of the General Statutes.

(6) Pharmacy care. – Medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need for or effectiveness of the medications.

(7) Psychiatric care. – Direct or consultative services provided by a licensed psychiatrist.

(8) Psychological care. – Direct or consultative services provided by a licensed psychologist or licensed psychological associate.

(9) Therapeutic care. – Direct or consultative services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or licensed clinical social worker.

(10) Treatment for autism spectrum disorders. – Any of the following care or related equipment ordered for an individual diagnosed with autism spectrum disorder by a licensed physician, or a licensed psychologist who determines the care to be medically necessary:

a. Behavioral health treatment.

b. Pharmacy care.

c. Psychiatric care.

d. Psychological care.

e. Therapeutic care.

(b) Every health benefit plan shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder for individuals 23 years of age or younger. No insurer shall terminate coverage or refuse to issue, amend, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Individuals must have received a diagnosis of autism spectrum disorder prior to the age of eight to qualify for required coverage under this section.

(c) Coverage under this section may not be subject to any limits on the number of visits an individual may have for treatment of autism spectrum disorder.

(d) Coverage under this section may not be denied on the basis that the treatments are habilitative or educational in nature.

(e) Coverage under this section may be subject to co-payment, deductible, and coinsurance provisions of a health benefit plan that are not less favorable than the co-payment, deductible, and coinsurance provisions that apply to substantially all other medical services covered by the health benefit plan.

(f) This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

(g) Coverage for behavioral health treatment under this section may be subject to a maximum benefit of up to thirty-six thousand dollars ($36,000) per year.

(h) Except for inpatient services, if an individual is receiving treatment for autism spectrum disorder, an insurer shall have the right to request a review of that treatment not more than once annually, unless the insurer and the individual's licensed physician or the individual's licensed psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to a particular insured being treated for an autism spectrum disorder and shall not apply to all individuals being treated for an autism spectrum disorder by a physician or psychologist. The cost of obtaining any review shall be borne by the insurer.

(i) This section shall not apply to plans that are certified as qualified health plans, as defined in 45 C.F.R. § 155.20, if the requirements of this section are determined by the federal government to require the State to make payments for a state-required benefit that is in excess of the essential health benefits, pursuant to 45 C.F.R. § 155.170(a)(3). Nothing in this subsection shall nullify the application of this section to plans that are not certified as qualified health plans.

(j) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

(k) The Commissioner of Insurance shall grant a health benefit plan issuer a waiver from the provisions of this section for a health benefit plan if the issuer demonstrates to the Commissioner, by actual claims experience over any consecutive 12-month period, that compliance with this section has increased the cost of the health benefit plan by an amount of one percent (1%) or greater in the premium rate charged under the health benefit plan over the most recent calendar year."

**SECTION 2.** G.S. 90-270.4 is amended by adding a new subsection to read as follows:

"(f1) Nothing in this Article shall be construed to prevent a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA) from offering services within the scope of practice authorized by the Behavior Analyst Certification Board, including behavior analysis and therapy, in accordance with professional standards of the BCBA or BCaBA's certification, if both of the following are true:

(1) The BCBA or BCaBA is properly certified and in good standing with the Behavior Analyst Certification Board.

(2) The BCBA or BCaBA does not hold himself or herself out to the public by any title or description stating or implying that the BCBA or BCaBA is a psychologist or is licensed, certified, or registered to practice psychology in this State."

**SECTION 3.(a)** G.S. 135-48.51 reads as rewritten:

"**§ 135-48.51. Coverage and operational mandates related to Chapter 58 of the General Statutes.**

The following provisions of Chapter 58 of the General Statutes apply to the State Health Plan:

(1) G.S. 58-3-191, Managed care reporting and disclosure requirements.

(2) G.S. 58-3-192, Coverage for autism spectrum disorders.

~~(2)~~(3) G.S. 58-3-221, Access to nonformulary and restricted access prescription drugs.

~~(3)~~(4) G.S. 58-3-223, Managed care access to specialist care.

~~(4)~~(5) G.S. 58-3-225, Prompt claim payments under health benefit plans.

~~(5)~~(6) G.S. 58-3-235, Selection of specialist as primary care provider.

~~(6)~~(7) G.S. 58-3-240, Direct access to pediatrician for minors.

~~(7)~~(8) G.S. 58-3-245, Provider directories.

~~(8)~~(9) G.S. 58-3-250, Payment obligations for covered services.

~~(9)~~(10) G.S. 58-3-265, Payment obligations for covered services.

~~(10)~~(11) G.S. 58-3-280, Coverage for the diagnosis and treatment of lymphedema.

~~(11)~~(12) G.S. 58-3-285, Coverage for hearing aids.

~~(12)~~(13) G.S. 58-50-30, Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, physical therapist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant.

~~(13)~~(14) G.S. 58-67-88, Continuity of care."

**SECTION 3.(b)** No later than March 1, 2015, and every March 1st thereafter, the Department of the State Treasurer shall submit a report to the General Assembly regarding the

implementation of coverage under the State Health Plan for Teachers and State Employees required under this section. The report shall include the following information:

(1) The total number of insureds diagnosed with autism spectrum disorder.

(2) The total costs of all claims paid out in the prior fiscal year for coverage required by this section.

(3) The cost of coverage required under this section per insured per month.

(4) The average cost per insured for coverage of any treatment involving applied behavior analysis.

**SECTION 4.** Section 1 of this act becomes effective October 1, 2013, and applies to insurance contracts issued, renewed, or amended on or after that date. Section 3 of this act becomes effective January 1, 2014. The remainder of this act is effective when it becomes law.

## CPT® Category III Codes

The following CPT codes are an excerpt of the CPT Category III code set, a temporary set of codes for emerging technologies, services, and procedures.

For more information on the criteria for CPT Category I, II and III codes, see Applying for Codes.

To assist users in reporting the most recently approved Category III codes, the AMA's CPT Web site features updates of the CPT Editorial Panel actions and early release of the Category III codes in July and January in a given CPT cycle. This was approved by the CPT Editorial Panel as a part of the 1998-2000 CPT-5 projects. These dates for early release correspond with the three annual CPT Editorial Panel meetings for each CPT cycle (June, October, and February). Although publication of Category III codes through early release to the CPT web site allows for expedient dispersal of the code and descriptor, early availability does not imply that these codes are immediately reportable before the posted implementation date.

Publication of the Category III codes to this Web site takes place on a semiannual basis when the codes have been approved by the CPT Editorial Panel. The full set of temporary Category III codes for emerging technology, procedures and services are published annually in the code set for each CPT publication cycle.

As with CPT Category I codes, inclusion of a descriptor and its associated code number does not represent endorsement by the AMA of any particular diagnostic or therapeutic procedure or service. Inclusion or exclusion of a procedure or service does not imply any health insurance coverage or reimbursement policy.

**Background information for Category III codes**
CPT Category III codes are a set of temporary codes that allow data collection for emerging technology, services, and procedures. These codes are intended to be used for data collection to substantiate widespread usage or to provide documentation for the Food and Drug Administration (FDA) approval process. The CPT Category III codes may not conform to the following CPT Category I code requirements:

- All devices and drugs necessary for performance of the procedure or service have received FDA clearance or approval when such is required for performance of the procedure or service.
- The procedure or service is performed by many physicians or other qualified health care professionals across the United States.
- The procedure or service is performed with frequency consistent with the intended clinical use (ie, a service for a common condition should have high volume, whereas a service commonly performed for a rare condition may have low volume).
- The procedure or service is consistent with current medical practice.
- The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code change application.

These codes have an alpha character as the 5th character in the string preceded by four digits (e.g., 1234T) and are located in a separate section of the CPT codebook, following the Medicine section. The introductory language for this code section explains the purpose of these codes

CPT Category III codes are intended to be used for data collection purposes to substantiate widespread usage or to provide documentation for the FDA approval process. Category III codes are not developed as a result of Panel review of an incomplete proposal, the need for more information, or a lack of CPT

Advisory Committee support of a code change application.

CPT Category III codes are not referred to the AMA-Specialty RVS Update Committee (RUC) for valuation because no relative value units (RVUs) are assigned to these codes. Payment for these services or procedures is based on the policies of payers and not on a yearly fee schedule.

In general, a given Category III code will be archived five years from the date of initial publication or extension unless a modification of the archival date is specifically noted at the time of a revision or change to a code (eg, addition of parenthetical instructions, reinstatement).

**Category III codes for CPT 2015**

It is important to note that, because future CPT Editorial Panel or Executive Committee actions may affect these items, codes and descriptor language may differ at the time of publication. Also, future Panel actions may result in gaps in code number sequencing. A cross-reference will appear in the Category III section of the CPT codebook to direct users to the newly established CPT Category I code.

Unless otherwise indicated, the symbol ● indicates new procedure codes that will be added to the CPT codebook in 2015.

**Category III codes**

The following section contains a set of temporary codes for emerging technology, services, and procedures. Category III codes allow data collection for these services or procedures. Use of unlisted codes does not offer the opportunity for the collection of specific data. If a Category III code is available, this code must be reported instead of a Category I unlisted code. This is an activity that is critically important in the evaluation of health care delivery and the formation of public and private policy. The use of the codes in this section allows physicians and other qualified health care professionals, insurers, health services researchers, and health policy experts to identify emerging technology, services, and procedures for clinical efficacy, utilization, and outcomes.

The inclusion of a service or procedure in this section neither implies nor endorses clinical efficacy, safety, or the applicability to clinical practice. The codes in this section may not conform to the usual requirements for CPT Category I codes established by the Editorial Panel. The nature of emerging technology, services, and procedures is such that the requirements for the Category I criteria may not be met. For these reasons, temporary codes for emerging technology, services, and procedures have been placed in a separate section of the CPT codebook, and the codes are differentiated from CPT Category I codes by the use of the alphanumeric characters.

Services/procedures described in this section make use of alphanumeric characters. These codes have an alpha character as the 5th character in the string (ie, four digits followed by the letter T). The digits are not intended to reflect the placement of the code in the Category I section of CPT nomenclature. Codes in this section may or may not eventually receive a Category I CPT code. In either case, in general, a given Category III code will be archived five years from the date of initial publication or extension unless a modification of the archival date is specifically noted at the time of a revision or change to a code (eg, addition of parenthetical instructions, reinstatement).
Services/procedures described by Category III codes which have been archived after five years, without conversion, must be reported using the Category I unlisted code unless another specific cross reference is established at the time of archiving.
New codes or revised codes are released semi-annually via the AMA/CPT internet site, to expedite dissemination for reporting. The full set of temporary codes for emerging technology, services, and procedures are published annually in the CPT codebook. Go to www.ama-assn.org/go/cpt for the most current listing.

| | | | |
|---|---|---|---|
| **Category III codes 0340T- 0346T were accepted at the May 2013 CPT Editorial Panel meeting for the 2015 CPT production cycle. Therefore, these codes do not appear in the 2014 CPT codebook. However, due to the Category III code early release policy, these codes are effective on January 1, 2014, following the six- month implementation period which began on July 1, 2013. Shaded text refers to additional refinements accepted at the October 2013 CPT Editorial Panel meeting for the 2015 CPT production cycle.** | | | |
| ⊙●0340T | Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, includes imaging guidance | Released<br>July 1, 2013<br>Implemented<br>January 1, 2014<br>Moderate Sedation symbol ⊙ added October 2013 | ***CPT 2015*** |
| | (Do not report code 0340T in conjunction with 76940, 77013, 77022) | | |
| ●0341T | Quantitative pupillometry with interpretation and report, unilateral or bilateral | Released<br>July 1, 2013<br>Implemented<br>January 1, 2014 | ***CPT 2015*** |
| ●0342T | Therapeutic apheresis with selective HDL delipidation and plasma reinfusion | Released<br>July 1, 2013<br>Implemented<br>January 1, 2014 | ***CPT 2015*** |
| ●0343T | Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; initial prosthesis | Released<br>July 1, 2013<br>Implemented<br>January 1, 2014 | ***CPT 2015*** |
| ●0344T | additional prosthesis (es) during same session (List separately in addition to code for primary procedure) | Released<br>July 1, 2013<br>Implemented<br>January 1, 2014 | ***CPT 2015*** |
| | (Use 0343T in conjunction with 0344T) | | |
| ●0345T | Transcatheter mitral valve repair percutaneous approach via the coronary sinus | Released<br>July 1, 2013<br>Implemented<br>January 1, 2014 | ***CPT 2015*** |
| | (0343T is applicable for initial prosthesis placed during a session even when patient has an existing mitral valve prosthesis in place) | | |

| | | | |
|---|---|---|---|
| | (Do not report 0343T, 0344T, 0345T in conjunction with 93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461for diagnostic left and right heart catheterization procedures intrinsic to the valve repair procedure) | | |
| | (Do not report 0345T in conjunction with 93453, 93454 for coronary angiography intrinsic to the valve repair procedure) | | |
| ●0346T | Ultrasound, elastography (List separately in addition to code for primary procedure) | Released<br>July 1, 2013<br>Implemented<br>January 1, 2014 | ***CPT 2015*** |
| | (Use 0346T in conjunction with 76536, 76604, 76645, 76700, 76705, 76770, 76775, 76830, 76856, 76857, 76870, 76872, 76881, 76882) | | |
| | (For elastography without ultrasound imaging, use an unlisted code) | Refinement approved<br>October 2013 | |
| **Category III codes were accepted at the October 2013 CPT Editorial Panel meeting for the 2015 CPT production cycle. However, due to the Category III code early release policy, these codes are effective on July 1, 2014, following the six-month implementation period which begins January 1, 2014.** | | | |
| ●0347T | Placement of interstitial device(s) in bone for radiostereometric analysis (RSA) | Released<br>January 1, 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |
| ●0348T | Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic and lumbosacral, when performed) | Released<br>January 1, 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |
| ●0349T | upper extremity(ies), (includes shoulder, elbow and wrist, when performed) | Released<br>January 1, 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |

| | | | |
|---|---|---|---|
| ●0350T | lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed) | Released January 1, 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| ●0351T | Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative | Released January 1, 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| ●0352T | interpretation and report, real time or referred | Released January 1, 2014 Implemented July 1, 2014 | |
| | (Do not report 0352T in conjunction with 0351T when performed by the same physician) | | |
| ●0353T | Optical coherence tomography of breast, surgical cavity; real time intraoperative | Released January 1, 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| | (Report 0353T once per session) | | |
| ●0354T | interpretation and report, real time or referred | Released January 1, 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| | (Do not report 0354T in conjunction with 0353T when performed by the same physician) | | |
| ●0355T | Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report | Released January 1, 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| | (Use 0355T for imaging of distal ileum, when performed) | | |
| | (Do not report 0355T in conjunction with 91110, 91111) | | |
| ●0356T | Insertion of drug-eluting implant (including punctual dilation and implant removal when performed) into lacrimal canaliculus, each | Released January 1, 2014 Implemented July 1, 2014 | ***CPT 2015*** |

| | | | |
|---|---|---|---|
| ●0358T | Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report | Released<br>January 1, 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |
| **Adaptive Behavior Assessments**<br><br>***Behavior identification assessment (0359T)*** conducted by the physician or other qualified health care professional, includes a detailed behavioral history, patient observation, administration of standardized and non-standardized tests and structured guardian/caregiver interview to identify and describe deficient adaptive or maladaptive behaviors (eg, impaired social skills and communication deficits, destructive behaviors, and additional functional limitations secondary to maladaptive behaviors). 0359T also includes the physician's or other qualified health care professional's interpretation of results and development of plan of care, which may include further observational or exposure behavioral follow-up assessment(s) (0360T, 0361T, 0362T, 0363T), discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.<br><br>***Observational behavioral follow-up assessment (0360T, 0361T)*** is administered by a technician under the direction of a physician or other qualified health care professional. The physician or other qualified health care professional may or may not be on-site during the face-to-face assessment process. Codes 0360T, 0361T include the physician's or other qualified health care professional's interpretation of results, discussion of findings and recommendations with the primary caregiver(s), and preparation of report.<br><br>Codes 0360T, 0361T describe services provided to patients who present with specific destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction) or behavioral problems secondary to repetitive behaviors or deficits in communication or social relatedness. These assessments include use of structured observation and/or standardized and non-standardized tests to determine levels of adaptive behavior. Areas assessed may include cooperation, motivation, visual understanding, receptive and expressive language, imitation, requests, labeling, play and leisure and social interactions. Specific destructive behavior(s) assessments include structured observational testing to examine events, cues, responses, and consequences associated with the behavior(s). | | ***CPT 2015*** |

| | | |
|---|---|---|
| ***Exposure behavioral follow-up assessment (0362T, 0363T)*** is administered by the physician or other qualified health care professional with the assistance of one or more technicians. Codes 0362T, 0363T include the physician's or other qualified health care professional's interpretation of results, discussion of findings and recommendations with the primary caregiver(s), and preparation of report.<br><br>The typical patients for 0362T, 0363T include patients with one or more specific severe destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction). Specific severe destructive behavior(s) are assessed using structured testing to examine events, cues, responses, and consequences associated with the behavior(s). | | |
| Codes 0362T, 0363T include exposing the patient to a series of social and environmental conditions associated with the destructive behavior(s). Assessment methods include using testing methods designed to examine triggers, events, cues, responses, and consequences, associated with the before mentioned maladaptive behavior(s). This assessment is completed in a structured, safe environment.<br><br>Codes 0360T, 0361T, 0362T, 0363T are reported following 0359T based on the time that the patient is face-to-face with one or more technician(s). Only count the time of one technician when two or more are present. Codes 0360T, 0361T, 0362T, 0363T are reported per the CPT Time Rule (eg, a unit of time is attained when the mid-point is passed). See Table 1. The time reported with 0360T, 0361T, 0362T, 0363T is over a single day and is not cumulative over a longer period.<br><br>Do not report 0359T, 0360T, 0361T, 0362T, 0363T in conjunction with 90785-90899, 96101-96125, 96150, 96151, 96152, 96153, 96154, 96155 on the same date.<br><br>(For psychiatric diagnostic evaluation, see 90791, 90792)<br><br>(For speech evaluations, use 92506)<br><br>(For occupational therapy evaluation, see 97003, 97004)<br><br>(For medical team conference, see 99366, 99367, 99368)<br><br>(For health and behavior assessment/intervention, see 96150, 96151, 96152, 96153, 96154, 96155)<br>(For neurobehavioral status exam, use 96116)<br>(For neuropsychological testing, use 96118) | | |

**Table1**
**Reporting of 0360T, 0361T, 0362T, 0363T per CPT Time Rule**
**Utilizing Face-to-Face Technician Time**

| | |
|---|---|
| Less than 16 min | Not reportable |
| 16 – 45 min | 0360T or<br>0362T |
| 46 – 75 min | 0360T and 0361T,<br>or 0362T and 0363T |
| Each additional increment up to 30 min | Additional 0361T or 0363T |

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|---|---|---|---|
| ●0359T | Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report | Released<br>January 1, 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |
| ●0360T | Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient | Released<br>January 1, 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |
| +●0361T | each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service) | Released<br>January 1, 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |
| | (Use 0361T in conjunction with 0360T) | | |
| ●0362T | Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient | Released<br>January 1, 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |

| | | |
|---|---|---|
| +●0363T each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure) | Released<br>January 1, 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |
| (Use 0363T in conjunction with 0362T ) | | |
| (0362T, 0363T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians) | | |
| Do not report 0359T, 0360T, 0361T, 0362T, 0363T in conjunction with 90785-90899, 96101-96125, 96150, 96151, 96152, 96153, 96154, 96155) | | |
| **Coding Tip**<br><br>If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be included as part of the required technician time to meet the elements of the code. | | |
| **Adaptive Behavior Treatment**<br>Adaptive behavior treatment codes 0364T-0374T describe services provided to patients, presenting with deficient adaptive or maladaptive behaviors (eg, impaired social skills and communication, destructive behaviors, or additional functional limitations secondary to maladaptive behaviors). Specific target problems and treatment goals are based on results of previous assessments (see 0359T-0363T). | Released<br>March 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |
| **Adaptive behavior treatment by protocol and group adaptive behavior treatment by protocol** are administered by a technician face-to-face with one patient (0364T, 0365T), or two or more patients (0366T, 0367T) under the direction of a physician or other qualified health care professional, utilizing a behavior intervention protocol designed in advance by the physician or other qualified health care professional who may or may not provide direct supervision during the face-to-face therapy. Do not report 0366T, 0367T if the group is larger than 8 patients. | | |

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|---|---|---|
| **Adaptive behavior treatment with protocol modification** (0368T, 0369T) is administered by a physician or other qualified health care professional face-to-face with a single patient The physician or other qualified health care professional resolves one or more problems with the protocol and may simultaneously instruct a technician and/or guardian(s)/caregiver(s) in administering the modified protocol. Physician or other qualified health care professional instruction of the technician without the patient present is not reported separately. | | |
| **Family adaptive behavior treatment guidance and multiple-family group adaptive behavior treatment guidance** are administered by a physician or other qualified health care professional face-to-face with guardian(s)/caregiver(s), without the presence of a patient, and involves identifying problem behaviors and deficits and teaching guardian(s)/caregiver(s) of one patient (0370T) or multiple patients (0371T) to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits. Do not report 0371T if the group is larger than 8 patients. | | |
| **Adaptive behavior treatment social skills group** (0372T) is administered by a physician or other qualified health care professional face-to-face with multiple patients, focusing on social skills training and identifying and targeting individual patient social deficits and problem behaviors. The physician or other qualified health care professional monitors the needs of individual patients and adjusts the therapeutic techniques during the group, as needed. Services to increase target social skills may include modeling, rehearsing, corrective feedback, and homework assignments. In contrast to adaptive behavior treatment by protocol techniques (0364T-0367T), adjustments required in social skills group setting are made in real time rather than for a subsequent service. Do not report 0372T if the group is larger than 8 patients. | | |
| Codes 0364T-0369T, 0372T may include services involving patient interaction with other individuals, including other patients. Report group services (0366T, 0367T, 0372T) only for patients who are participating in the interaction in order to meet their own individual treatment goals. | | |
| **Coding Tips**<br><br>If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be reported as technician time. Each minute is only counted once whether 1 or more than one treating individual is present | | |

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|---|---|---|---|
| ●0364T | **Adaptive behavior treatment by protocol**, administered by technician, face-to-face with one patient; first 30 minutes of technician time | Released March 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| ✚●0365T | each additional 30 minutes of technician time (List separately in addition to code for primary procedure) | Released March 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| | (Use 0365T in conjunction with 0364T) | | |
| | (Do not report 0364T, 0365T in conjunction with 90785-90899, 92507, 96101-96155, 97532) | | |
| ●0366T | Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time | Released March 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| ✚●0367T | each additional 30 minutes of technician time (List separately in addition to code for primary procedure) | Released March 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| | (Use 0367T in conjunction with 0366T) | | |
| | (Do not report 0366T, 0367T if the group is larger than 8 patients) | | |
| | (Do not report 0366T, 0367T in conjunction with 90785-90899, 92508, 96101-96155, 97150) | | |
| ●0368T | Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time | Released March 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| ●0369T | each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure) | Released March 2014 Implemented July 1, 2014 | ***CPT 2015*** |

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|---|---|---|---|
| | (Use 0369T in conjunction with 0368T) | | |
| | (Do not report 0368T, 0369T in conjunction with 90791, 90792, 90846, 90847, 90887, 92507, 97532) | | |
| ●0370T | Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) | Released March 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| ●0371T | Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) | Released March 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| | (Do not report 0371T when the families of more than 8 patients are participants) | | |
| | (Do not report 0370T, 0371T in conjunction with 90791, 90792, 90846, 90847, 90887) | | |
| ●0372T | Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients | Released March 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| | (Do not report 0372T if the group is larger than 8) | | |
| | (Do not report 0372T in conjunction with 90853, 92508, 97150) | | |

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|---|---|---|---|
| **Exposure Adaptive Behavior Treatment With Protocol Modification**<br><br>Codes 0373T, 0374T describe services provided to patients with one or more specific severe destructive behaviors (eg, self-injurious behavior, aggression, property destruction), with direct supervision by a physician or other qualified health care professional which requires two or more technicians face-to-face with the patient for safe treatment. Technicians elicit behavioral effects of exposing the patient to specific environmental conditions and treatments. Technicians record all occurrences of targeted behaviors. The physician or other qualified health care professional reviews and analyzes data and refines the therapy using single-case designs; ineffective components are modified or replaced until discharge goals are achieved (eg, reducing destructive behavior by at least 90%, generalizing the treatment effects across caregivers and settings, or maintaining the treatment effects over time). The therapy is conducted in a structured, safe environment. Precautions may include environmental modifications and/or protective equipment for the safety of the patient or the technicians. | | Released<br>March 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |
| ●0373T | Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient | Released<br>March 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |
| +●0374T | each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure) | Released<br>March 2014<br>Implemented<br>July 1, 2014 | ***CPT 2015*** |
| | (Use 0374T in conjunction with 0373T) | | |
| | (0373T, 0374T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians) | | |
| | (Do not report 0373T, 0374T in conjunction with 90785-90899, 96101-96155) | | |

| HCPC | BSBS NJ Definition | VO Definition | VO Codes | AMA Interim Codes | AMA Interim Codes Definition |
|---|---|---|---|---|---|
| **H2019** | Therapeutic Behavioral Services ABA Follow-up per 15 min | Therapeutic Behavioral Services (direct care), 15 min | **H2019–** HM | 0364T<br>+0365T | - Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time<br>- each additional 30 minutes of technician time (List separately in addition to code for primary procedure) |
| | | | **H2019-** HP, HO HN AH | 0368T<br>+0369T | - Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time<br>- each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure) |
| | | | NA | 0373T<br>+0374T | - Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient<br>- each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure) |
| **H2014** | NA | Skills training and Development (Social skills group), 15 min | **H2014-** HP HO HN AH | 0372T | - Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients |
| | | | **H2014-** HM | 0366T<br>+0367T | - Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time<br>- each additional 30 minutes of technician time (List separately in addition to code for primary procedure) |
| **H0031** | Mental Health Assessment by non-physician ABA Reassessment per 15 min | Mental health assessment by non-physician per hr | **H0031-** HP HO HN AH | ***0359T*** | *Behavior identification assessment conducted by physician or other qualified health care professional* |
| **H0032** | Mental health service plan by non-physician ABA Initial Assessment and Plan Development per hr | Mental health service plan development by non-physician, per hr | **NA** | ***0360T***<br>***+0361T*** | *Observational behavioral follow-up assessment by technician under direction of physician/QHCP (16 – 45 min)*<br>*Observational behavioral follow-up assessment by technician under direction of physician/QHCP (46 – 75 min w **0361T**)* |
| | | | **H0032-** HP HO HN AH | ***0362T***<br>***+0363T*** | *Exposure behavioral follow-up assessment by physician or other qualified health care professional (16 – 45 min)*<br>*Exposure behavioral follow-up assessment by physician or other qualified health care professional (46 – 75 min w **0361T*** |
| **S5110** | NA | Home care training, family, 15 min | **S5110-** HP HO HN AH | 0370T | Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) |
| | | | NA | 0371T | Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) |
| **H0046** | Mental health services, NOS (Supervision of ABA follow-up per 15 min | **NA** | NA | NA | NA |

| | | | | | |
|---|---|---|---|---|---|
| **G9012** | NA | Other specified case management services not elsewhere classified (case consultation with larger care team) | **G9012-**<br>HP<br>HO<br>HN<br>AH | NA | NA |
| **S5108** | NA | Home care training to home care client (supervision of direct care provider - Higher Level Supervisor), 15 min | **S5108-**<br>HP<br>HO<br>HN<br>AH | NA | NA |

***Behavior identification assessment (0359T)*** conducted by the physician or other qualified health care professional, includes a detailed behavioral history, patient observation, administration of standardized and non-standardized tests and structured guardian/caregiver interview to identify and describe deficient adaptive or maladaptive behaviors (eg, impaired social skills and communication deficits, destructive behaviors, and additional functional limitations secondary to maladaptive behaviors). 0359T also includes the physician's or other qualified health care professional's interpretation of results and development of plan of care, which may include further observational or exposure behavioral follow-up assessment(s) (0360T, 0361T, 0362T, 0363T), discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.

***Observational behavioral follow-up assessment (0360T, 0361T)*** is administered by a technician under the direction of a physician or other qualified health care professional. The physician or other qualified health care professional may or may not be on-site during the face-to-face assessment process. Codes 0360T, 0361T include the physician's or other qualified health care professional's interpretation of results, discussion of findings and recommendations with the primary caregiver(s), and preparation of report.
Codes 0360T, 0361T describe services provided to patients who present with specific destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction) or behavioral problems secondary to repetitive behaviors or deficits in communication or social relatedness. These assessments include use of structured observation and/or standardized and non-standardized tests to determine levels of adaptive behavior. Areas assessed may include cooperation, motivation, visual understanding, receptive and expressive language, imitation, requests, labeling, play and leisure and social interactions. Specific destructive behavior(s) assessments include structured observational testing to examine events, cues, responses, and consequences associated with the behavior(s).

***Exposure behavioral follow-up assessment (0362T, 0363T)*** is administered by the physician or other qualified health care professional with the assistance of one or more technicians. Codes 0362T, 0363T include the physician's or other qualified health care professional's interpretation of results, discussion of findings and recommendations with the primary caregiver(s), and preparation of report.
The typical patients for 0362T, 0363T include patients with one or more specific severe destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction). Specific severe destructive behavior(s) are assessed using structured testing to examine events, cues, responses, and consequences associated with the behavior(s).

Codes 0362T, 0363T include exposing the patient to a series of social and environmental conditions associated with the destructive behavior(s). Assessment methods include using testing methods designed to examine triggers, events, cues, responses, and consequences, associated with the before mentioned maladaptive behavior(s). This assessment is completed in a structured, safe environment.
Codes 0360T, 0361T, 0362T, 0363T are reported following 0359T based on the time that the patient is face-to-face with one or more technician(s). Only count the time of one technician when two or more are present. Codes 0360T, 0361T, 0362T, 0363T are reported per the CPT Time Rule (eg, a unit of time is attained when the mid-point is passed). See Table 1. The time reported with 0360T, 0361T, 0362T, 0363T is over a single day and is not cumulative over a longer period.

| | |
|---|---|
| Less than 16 min | Not reportable |
| 16-45 min | 0360T or 0362T |
| 46-75 min | 0360T and 0361T; or 0362T and 0363T |
| Each additional increment up to 30 min | Additional 0361T or 0363T |

| | | |
|---|---|---|
| 0359T Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report | Released January 1, 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| ●0360T Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient | Released January 1, 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| ✚●0361T each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service) | Released January 1, 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| (Use 0361T in conjunction with 0360T) | | |
| ●0362T Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient | Released January 1, 2014 Implemented July 1, 2014 | ***CPT 2015*** |

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|---|---|---|
| ✚●0363T each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure) | Released January 1, 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| (Use 0363T in conjunction with 0362T ) | | |
| (0362T, 0363T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians) | | |
| Do not report 0359T, 0360T, 0361T, 0362T, 0363T in conjunction with 90785-90899, 96101-96125, 96150, 96151, 96152, 96153, 96154, 96155) | | |
| **Coding Tip**<br>If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be included as part of the required technician time to meet the elements of the code. | | |

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|---|---|---|
| **Adaptive Behavior Treatment**<br>Adaptive behavior treatment codes 0364T-0374T describe services provided to patients, presenting with deficient adaptive or maladaptive behaviors (eg, impaired social skills and communication, destructive behaviors, or additional functional limitations secondary to maladaptive behaviors). Specific target problems and treatment goals are based on results of previous assessments (see 0359T-0363T). | Released March 2014<br>Implemented July 1, 2014 | ***CPT 2015*** |
| **Adaptive behavior treatment by protocol and group adaptive behavior treatment by protocol** are administered by a technician face-to-face with one patient (0364T, 0365T), or two or more patients (0366T, 0367T) under the direction of a physician or other qualified health care professional, utilizing a behavior intervention protocol designed in advance by the physician or other qualified health care professional who may or may not provide direct supervision during the face-to-face therapy. Do not report 0366T, 0367T if the group is larger than 8 patients. | | |
| **Adaptive behavior treatment with protocol modification** (0368T, 0369T) is administered by a physician or other qualified health care professional face-to-face with a single patient The physician or other qualified health care professional resolves one or more problems with the protocol and may simultaneously instruct a technician and/or guardian(s)/caregiver(s) in administering the modified protocol. Physician or other qualified health care professional instruction of the technician without the patient present is not reported separately. | | |
| **Family adaptive behavior treatment guidance and multiple-family group adaptive behavior treatment guidance** are administered by a physician or other qualified health care professional face-to-face with guardian(s)/caregiver(s), without the presence of a patient, and involves identifying problem behaviors and deficits and teaching guardian(s)/caregiver(s) of one patient (0370T) or multiple patients (0371T) to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits. Do not report 0371T if the group is larger than 8 patients. | | |
| **Adaptive behavior treatment social skills group** (0372T) is administered by a physician or other qualified health care professional face-to-face with multiple patients, focusing on social skills training and identifying and targeting individual patient social deficits and problem behaviors. The physician or other qualified health care professional monitors the needs of individual patients and adjusts the therapeutic techniques during the group, as needed. Services to increase target social skills may include modeling, rehearsing, corrective feedback, and homework assignments. In contrast to adaptive behavior treatment by protocol techniques (0364T-0367T), adjustments required in social skills group setting are made in real time rather than for a subsequent service. Do not report 0372T if the group is larger than 8 patients. | | |
| Codes 0364T-0369T, 0372T may include services involving patient interaction with other individuals, including other patients. Report group services (0366T, 0367T, 0372T) only for patients who are participating in the interaction in order to meet their own individual treatment goals. | | |
| **Coding Tips**<br>If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be reported as technician time. Each minute is only counted once whether 1 or more than one treating individual is present | | |
| ●0364T **Adaptive behavior treatment by protocol**, administered by technician, face-to-face with one patient; first 30 minutes of technician time | Released March 2014<br>Implemented July 1, 2014 | ***CPT 2015*** |
| ✚●0365T each additional 30 minutes of technician time (List separately in addition to code for primary procedure) | Released March 2014<br>Implemented July 1, 2014 | ***CPT 2015*** |
| (Use 0365T in conjunction with 0364T) | | |

| | | |
|---|---|---|
| (Do not report 0364T, 0365T in conjunction with 90785-90899, 92507, 96101-96155, 97532) | | |
| ●0366T Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time | Released March 2014<br>Implemented July 1, 2014 | ***CPT 2015*** |
| ✚●0367T each additional 30 minutes of technician time (List separately in addition to code for primary procedure) | Released March 2014<br>Implemented July 1, 2014 | ***CPT 2015*** |
| (Use 0367T in conjunction with 0366T) | | |
| (Do not report 0366T, 0367T if the group is larger than 8 patients) | | |
| (Do not report 0366T, 0367T in conjunction with 90785-90899, 92508, 96101-96155, 97150) | | |
| ●0368T Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time | Released March 2014<br>Implemented July 1, 2014 | ***CPT 2015*** |
| ●0369T each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure) | Released March 2014<br>Implemented July 1, 2014 | ***CPT 2015*** |
| (Use 0369T in conjunction with 0368T) | | |
| (Do not report 0368T, 0369T in conjunction with 90791, 90792, 90846, 90847, 90887, 92507, 97532) | | |
| ●0370T Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) | Released March 2014<br>Implemented July 1, 2014 | ***CPT 2015*** |
| ●0371T Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) | Released March 2014<br>Implemented July 1, 2014 | ***CPT 2015*** |
| (Do not report 0371T when the families of more than 8 patients are participants) | | |
| (Do not report 0370T, 0371T in conjunction with 90791, 90792, 90846, 90847, 90887) | | |
| ●0372T Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients | Released March 2014<br>Implemented July 1, 2014 | ***CPT 2015*** |
| (Do not report 0372T if the group is larger than 8) | | |
| (Do not report 0372T in conjunction with 90853, 92508, 97150) | | |
| **Exposure Adaptive Behavior Treatment With Protocol Modification**<br>Codes 0373T, 0374T describe services provided to patients with one or more specific severe destructive behaviors (eg, self-injurious behavior, aggression, property destruction), with direct supervision by a physician or other qualified health care professional which requires two or more technicians face-to-face with the patient for safe treatment. Technicians elicit behavioral effects of exposing the patient to specific environmental conditions and treatments. Technicians record all occurrences of targeted behaviors. The physician or other qualified health care professional reviews and analyzes data and refines the therapy using single-case designs; ineffective components are modified or replaced until discharge goals are achieved (eg, reducing destructive behavior by at least 90%, generalizing the treatment effects across caregivers and settings, or maintaining the treatment effects over time). The therapy is conducted in a structured, safe environment. Precautions may include environmental modifications and/or protective | Released March 2014<br>Implemented July 1, 2014 | ***CPT 2015*** |

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| equipment for the safety of the patient or the technicians. | | |
| ●0373T Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient | Released March 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| ✚●0374T each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure) | Released March 2014 Implemented July 1, 2014 | ***CPT 2015*** |
| (Use 0374T in conjunction with 0373T) | | |
| (0373T, 0374T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians) | | |
| (Do not report 0373T, 0374T in conjunction with 90785-90899, 96101-96155) | | |

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# Analysis of the Evidence Base for ABA and EIBI for Autism

Eric V. Larsson, Ph.D., L.P., B.C.B.A.-D. (2012)

A misimpression stands that the treatment of autism lacks evidence-based approaches. However, in actuality, Applied Behavior Analysis (ABA) and Early Intensive Behavioral Intervention (EIBI) are possibly the best examples of evidence-based behavioral health care. In contrast to the folklore that one hears, independent reviews consistently agree that ABA and EIBI treatments for autism are effective, and that the extensive body of research meets high standards of evidence.

Two such independent reviews are highlighted here.

One well-known review was conducted for Division 53 of the American Psychological Association (the Society for Clinical Child and Adolescent Psychology). The following was concluded:

> *"Randomized controlled trials have demonstrated positive effects in both short-term and longer term studies. The evidence suggests that early intervention programs are indeed beneficial for children with autism, often improving developmental functioning and decreasing maladaptive behaviors and symptom severity at the level of group analysis." (Page 8).*
>
> *"Lovaas's treatment meet Chambless and colleague's (Chambless et al., 1998; Chambless et al., 1996) criteria for 'well-established'" (Page 8).*
>
> *"Across all the studies we cited, improvements in language, communication, and IQ, and reduction in severity of autism symptoms indicate that the core symptoms of autism appear malleable in early childhood"* (page 30).
>
> Rogers, S.J., & Vismara, L.A. (2008). Evidence-based comprehensive treatments for early autism. *Journal of Clinical Child and Adolescent Psychology*. 37, 8-38.

In another review, the state of Hawaii convened a Department of Health Task Force to identify evidence-based treatments in children's mental health. The overarching goals of the task force were to broaden and update the summary of scientific information used to guide decisions about children's care. The report provides an extensive review of the major randomized, controlled research findings for psychosocial treatments for children. The committee grouped its findings into "treatment families" of similar treatments for given disorders and represented these on a "Blue Menu" summary.

Regarding the treatment of autism, the "Hawaii Blue Menu" report stated:

> *"Two treatment families demonstrated Best Support. Intensive Behavioral Treatment was successful in three (3) studies, beating alternative treatments in two (2) of those, and beating a no-treatment control in one (1). Likewise, Intensive Communication Training was*

*also successful in three (3) studies, beating alternative treatments in two (2) of those, and beating a no-treatment control in one (1) study." (Page 16).*

*"These results are quite promising in terms of effect size, although it should be noted that the outcome variables for these studies mainly involved reductions in the frequency of —autistic behaviors or increases in social communication or other forms of social exchange (e.g., turn taking). None of these studies claimed that children were —autism free following the intervention programs. Nevertheless, these findings represent an extraordinary improvement over the evidence base for interventions for autistic spectrum disorders in the previous Biennial Report." (Page 18).*

*"The shape of the profile suggests that all successful treatments for autistic spectrum disorders involve teaching communication skills and modeling of appropriate communication or other behaviors. Other strategies include training in non-verbal communication (social skills), teaching parents and teachers to praise desired behaviors, and the setting of goals paired with the intensive rehearsal and reinforcement of behaviors consistent with those goals (i.e., discrete trial training)." (Page 19).*

Chorpita, B.F. & Daleiden, E.L. (2007). *2007 Biennial report: Effective psychosocial interventions for youth with behavioral and emotional needs.* Child and Adolescent Mental Health Division, Honolulu: Hawaii Department of Health.

Here are two other statements from recent objective scientific reviews of EIBI.

*"Recovery in children with ASD through behavioral and educational interventions seems possible in a significant minority of cases."* (page 360).

Helt, M., Kelley, E., Kinsbourne, M., Pandey, J., Boorstein, H., Herbert, M., & Fein, D. (2008). Can children with autism recover? If so, how? *Neuropsychology Review*. 18, 339-366. (The authors are psychologists and pediatricians at the University of Connecticut, Queen's University, the New School, Children's Hospital of Philadelphia, and Massachusetts General Hospital).

*"The weight of currently available scientific evidence, however, indicates that ABA should be viewed as the optimal, comprehensive treatment approach in young children with ASD."*

Barbaresi, W.J., Katusic, S.K., & Voigt, R.G. (2006). Autism: A review of the state of the science for pediatric primary health care clinicians. *Archives of Pediatric and Adolescent Medicine*, 160. 1167-1175. (The authors are pediatricians at the Mayo Clinic and at Harvard University).

Forty-five such independent, meta-analysis, and peer reviews are listed in a bibliography below. In none of these do the authors systematically refute the published evidence for ABA treatments of autism. The reviews are critical evaluations – in many cases, other non-ABA treatments are assigned to categories such as "insufficient evidence," "unproven," or even "potentially harmful."

Yet every review cites the obvious positive results of ABA and EIBI and accepts them as proven. The most "negative" conclusions that are offered are:

1) ABA does not cure all children of autism
2) ABA is not the only established treatment, nor is it clearly the best treatment
3) There are not well-established means to identify the best candidates for treatment

It should be noted that the above conclusions can be drawn about any medical treatment that already enjoys full coverage, so they should not be cause for denying coverage for ABA.

However, the lay impression persists that there are "negative" reviews in the literature. But let's look at what the "negative" reviews do say. The following is the *most skeptical* recent publication in the scientific literature. But see one of their concluding statements.

> *"There is little question now that early intensive behavioral intervention is highly effective for some children. However, gains are not universal, and some children make only modest progress while others show little or no change, sometimes after extremely lengthy periods in treatment."* (page 36).

Howlin, P., Magiati, I., & Charman, T. (2009). Systematic review of early intensive behavioral interventions for children with autism. *American Journal on Intellectual and Developmental Disabilities*. 114. 23-41. (The authors are professors at the Institute of Psychiatry, King's College (London, UK) and University College, London, Institute of Child Health).

Other "negative" reviews may exclude the majority of ABA research, by applying highly restrictive criteria for what qualifies as evidence.

For example, there is the Comparative Effectiveness Review published by the AHRQ in 2011. But, while this report has also been cited as "negative," see their main conclusions regarding ABA and EIBI interventions.

> *"Evidence supports early intensive behavioral and developmental intervention, including the University of California, Los Angeles (UCLA)/Lovaas model and Early Start Denver Model (ESDM) for improving cognitive performance, language skills, and adaptive behavior in some groups of children."* (page vi).

> *"Evidence suggests that interventions focusing on providing parent training and cognitive behavioral therapy (CBT) for bolstering social skills and managing challenging behaviors may be useful for children with ASDs to improve social communication, language use, and potentially, symptom severity.* (page vi).

The "negative" qualifiers of these conclusions are stated as:

> *"All of these studies need to be replicated, and specific focus is needed to characterize which children are most likely to benefit."* (page vi).

> *"Information is lacking on modifiers of effectiveness, generalization of effects outside the treatment context, components of multicomponent therapies that drive effectiveness, and predictors of treatment success."* (page vi).

In comparison to the above comments, these are the clearly negative conclusions about traditional biomedical treatments that are currently widely covered by insurance policies:

> *"No current medical interventions demonstrate clear benefit for social or communication symptoms in ASDs."* (page vi).

> *"Little evidence is available to assess other behavioral interventions, allied health therapies, or complementary and alternative medicine."* (page vi).

Warren, Z., Veenstra-VanderWeele, J., Stone, W., Bruzek, J.L., Nahmias, A.S., Foss-Feig, J.H., Jerome, R.N., Krishnaswami, S., Sathe, N.A., Glasser, A.M., Surawicz, T., & McPheeters, M.L. (April, 2011). Therapies for Children With Autism Spectrum Disorders. *Comparative Effectiveness Review No. 26*. (Prepared by the Vanderbilt Evidence-based Practice Center under Contract No.290-2007-10065-I.) AHRQ Publication No. 11-EHC029-EF. Rockville, MD:Agency for Healthcare Research and Quality. Available at: www.effectivehealthcare.ahrq.gov/reports/final.cfm.

The AHRQ report reached these positive conclusions about ABA and EIBI despite excluding a large number of studies, including all studies published prior to 2000. Yet the AHRQ report still found 78 studies of behavioral interventions, which included 34 studies of EIBI that met their criteria for inclusion.

Other "negative" reviews cited are typically proprietary reports published privately. For example, the Kaiser Blue Cross report did not offer positive statements (Rothenberg & Samson, 2009). However in their methodology, they limited their analysis to only 16 studies, out of the hundreds available, and concluded that more research needs to be done. Interestingly, unlike the AHRQ review, this report did not comment on the comparable lack of data for psychotropic medications, yet insurance companies readily cover such treatment.

Three other areas of research, that were not addressed by the AHRQ report or the proprietary reports, are the following: cost-benefit analyses, meta-analyses of effect magnitude, and direct analyses of significant behavior improvement. Here are some sample conclusions from these fields of research.

Cost-Benefit Analyses

> *"Under our model parameters, expansion of IBI to all eligible children represents a cost-saving policy whereby total costs of care for autistic individuals are lower and gains in dependency-free life years are higher.* (page 136).
>
> Motiwala, S.S., Gupta, S., Lilly, M.D., Ungar, W.J., & Coyte, P.C. (2006). The cost-effectiveness of expanding intensive behavioural intervention to all autistic children in Ontario. *Healthcare Policy*, 1, 135-151.. (The authors are members of the Department of Health Policy, Management and Evaluation of the University of Toronto, ON).

Meta-Analyses of Magnitude of Effect

> *"Results suggested that long-term, comprehensive ABA intervention leads to (positive) medium to large effects in terms of intellectual functioning, language development, acquisition of daily living skills and social functioning in children with autism. Although favorable effects were apparent across all outcomes, language-related outcomes (IQ, receptive and expressive language, communication) were superior to non-verbal IQ, social functioning and daily living skills, with effect sizes approaching 1.5 for receptive and expressive language and communication skills. Dose-dependant effect sizes were apparent by levels of total treatment hours for language and adaptation composite scores."* (page 387).
>
> Virues-Ortega, J. (2010). Applied behavior analytic intervention for autism in early childhood: Meta-analysis, meta-regression and dose–response meta-analysis of multiple outcomes. *Clinical Psychology Review*. 30, 387-399. (The author is a professor of psychology at the University of Manitoba).

Analyses of the Direct Effect of ABA on Clinically Significant Behavior Disorders

> *"The available intervention technology is reasonably effective at reducing problem behaviors performed by people with developmental disabilities, including autism. Reductions of 80% or greater were reported in half to two thirds of the comparisons. Reductions of 90% or greater were reported for all classes of problem behavior, and with individuals with all diagnostic labels."* (page 429).
>
> Horner, R.H., Carr, E.G., Strain, P.S., Todd, A.W., & Reed, H.K. (2002). Problem behavior interventions for young children with autism: A research synthesis. *Journal of Autism and Developmental Disorders*. 32, 423-446. (The authors are professors at the University of Oregon, the State University of New York at Stony Brook, and the University of Colorado).

> *"Within the last 8 years, 66 studies with strong or acceptable methodological rigor have been conducted and published. These studies have been conducted using over 500 participants, and have evaluated interventions with different delivery agents, methods, target skills, and settings. Collectively, the results of this synthesis show there is much supporting evidence for the treatment of social deficits in autism."* (page 161).
>
> Reichow, B. & Volkmar, F.R. (2010). Social Skills Interventions for Individuals with Autism: Evaluation for Evidence-Based Practices within a Best Evidence Synthesis Framework. *Journal of Autism and Developmental Disorders*. 40, 149-166. (The authors are professors at the Yale University Child Study Center, New Haven, CT).

*Earnest researchers and clinicians welcome the challenge to even further extend the effectiveness of ABA to more children, and are continuing to innovate to do so. But it is clear that all professional circles now agree that there is generous and sufficient evidence to endorse public and private coverage of accountable ABA treatment and Early Intensive Behavioral Intervention.*

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# NORTH CAROLINA STATE HEALTH PLAN
# FOR TEACHERS AND STATE EMPLOYEES

## POTENTIAL AUTISM SPECTRUM DISORDER BENEFIT

**Prepared by:**

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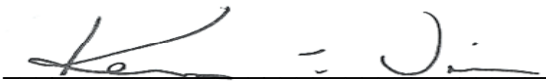
**May 2014**

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that The Segal Company prepare an Actuarial Note in response to a draft proposal to Provide Coverage for a Potential Autism Spectrum Disorder Benefit.

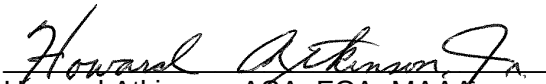
This Actuarial Note was prepared according to generally accepted actuarial principles and practices. The Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.



Kenneth C. Vieira, FSA, FCA, MAAA
Senior Vice President

May 28, 2014
Date



Howard Atkinson, ASA, FCA, MAAA
Vice President and Health Actuary

May 28, 2014
Date

## POTENTIAL AUTISM SPECTRUM DISORDER BENEFIT

### PLAN CHANGES

The State Health Plan Board of Trustees is considering providing coverage for the treatment of autism spectrum disorders.

The full text of the potential benefit is attached to this actuarial note.

### PROJECTED COSTS

| Option | Plan Design Change | Projected Cost Impact (in Millions) Calendar Year | | | | |
|---|---|---|---|---|---|---|
| | | 2015 | 2016 | 2017 | 2018 | 2019 |
| 1 | Coverage for Autism Spectrum Disorders – $36,000 annual maximum | $4.0 | $5.0 | $5.2 | $5.5 | $5.8 |
| 2 | Coverage for Autism Spectrum Disorders – no annual maximum | $5.7 | $7.8 | $8.6 | $9.8 | $10.9 |

### PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- In total, 32 states have autism mandates in place as of January 2013.

- According to the Centers for Disease Control (CDC) Autism and Developmental Disabilities Monitoring (ADDM) Network, the prevalence of autism spectrum disorders in 2010 was one in 68 children at the age of eight. The CDC states that most individuals are diagnosed with an autism disorder by this age. This number has been increasing over time as diagnosis become more common and practice patterns evolve.

| Year | Prevalence Per 1,000 | 1 in x Children |
|---|---|---|
| 2000 | 6.7 | 1 in 150 |
| 2002 | 6.6 | 1 in 150 |
| 2004 | 8.0 | 1 in 125 |
| 2006 | 9.0 | 1 in 110 |
| 2008 | 11.3 | 1 in 88 |
| 2010 | 14.7 | 1 in 68 |

Over the 8 year period the prevalence has grown from 6.7% to 14.7%, or approximately 10% per year. Due to large increase the last two years, we have assumed a slower growth of 5% per year.

- Very little mature insured data exists for use in developing credible utilization and unit cost estimates for Applied Behavioral Analysis (ABA). While the ultimate cost of covering ABA benefits is uncertain, our analysis reflects the likely behavior of consumers and providers of ABA services in developing the assumptions underlying the cost estimates.

- ABA may include 30-40 hours of therapy a week, though it is unlikely many programs would utilize that level of resources.

- ABA programs require a significant commitment from affected children, as well as their families. It is likely that a significant number of ASD children will not have an ABA program regardless of the availability of a provider.

- The North Carolina State Health Plan (the Plan) currently covers medical benefits for autism spectrum disorder, including medical visits, physical therapy, occupational therapy, speech therapy and psychological testing. ABA and other behavioral therapies are typically considered "educational therapy" and presently not a component of the Plan's medical benefit. ABA is defined as "the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior".

- A Blue Cross and Blue Shield of North Carolina (BCBSNC) report was provided showing the number of members diagnosed with autism spectrum disorders and other pervasive developmental disorders as well as each member's claim expenditures for the Plan for the Fiscal Years 2010, 2011, 2012 and through March Fiscal Year 2013. Based on reported autism diagnosis codes, the BCBSNC report identified 728 plan members, 619 members under age 21, with paid claims in Fiscal Year 2013. These member counts by age are shown below.

**Number of Members Diagnosed with Autistic Spectrum Disorder in Plan**

| | |
|---|---|
| Under 6 | 80 |
| 6 | 26 |
| 7 | 37 |
| 8 | 34 |
| 9 | 44 |
| 10 | 55 |
| 11 | 45 |
| 12 | 50 |
| 13 to 20 | 248 |
| 21 and Over | 109 |
| Total | 728 |

- In Minnesota, a state that is widely regarded as having some of the most extensive ABA coverage and services in the nation, provider data indicates ABA utilization of approximately 20% of diagnosed three to six year olds (taken from a March 2012 Oliver Wyman report in discussion with Dr. Eric Larsson Executive Director, Clinical Services, The Lavaas Institute for Early Intervention. Midwest Headquarters regarding ABA utilization research in Minnesota. February 2009.)

- According to the Wyman study, in addition to the likelihood of starting a program, program continuance assumptions have a very significant impact on overall ABA utilization and cost estimates. ABA programs are generally geared towards addressing deficits in younger children and are not intended to be continued indefinitely. For this reason, we have assumed that no programs would terminate prior to school age, that a large percentage of ABA programs would terminate at ages six and seven, when an autistic child could be expected to enter elementary school, and annually thereafter a large percentage of remaining programs would terminate until only a very small percentage of children have ABA programs by the time they reach their teenage years. From the Wyman study, the assumed percentage of children diagnosed with ASD that have an ABA program by age is shown in the table below:

**% of Diagnosed Children with Autistic Disorder with ABA**

| | |
|---|---|
| Under 6 | 65.0% |
| 6 | 48.8% |
| 7 | 32.5% |
| 8 | 21.7% |
| 9 | 14.4% |
| 10 | 9.6% |
| 11 | 6.4% |
| 12 | 4.3% |
| 13 to 21 | 3.3% |

We have assumed the ABA prevalence for those ages 21-26 would also remain at the 3.3% level.

- In developing the assumed annual ABA program hours, we discussed typical ABA programming with ABA providers, and received benefit materials from one of the large self-insured employers who offers ABA benefits (Autism Therapy Reference – Microsoft Corporation (administered by Premera Blue Cross))

**Average Annual ABA Program Hours for a Child with Autism Disorder**

| | |
|---|---|
| Ages Under 8 | 1500 |
| Ages 8 to 12 | 671 |
| Ages 13 to 21 | 401 |

We have assumed the ABA programs hours would remain for 401 for those at 21-26.

- Based on information reported by the Families for Early Autism Treatment (FEAT) of North Carolina, treatment cost ranges from $25 - $60 per hour. We assume $60 per hour in our analysis.

- Assuming a $30 copay applies to each three-hour session (3 hours @ $60/hour = $180), we reduced the developed cost by approximately 17% to account for this design feature.

- We do not make any adjustment to the utilization data to account for therapies and services that are deemed to be excluded because they are not evidence based.

**Fiscal Impact**

- Utilizing the assumptions above we expect 132 members to utilize ABA services in Calendar 2015. This is expected to grow to 161 by Calendar Year 2019.

- Based on the expected utilization and associated ABA cost figures, we estimate the fiscal impact of adding ABA services to the Plan to be approximately $4.0 million for calendar year 2015 assuming a January 1, 2015 effective date, a two-month claims payment lag and a $36,000 annual maximum. This amount grows to $5.7 million for calendar year 2015 if the annual maximum is eliminated.

- A 25% margin was added to the unlimited benefit option to cover the uncertainty and open-ended nature of the benefit.

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Age requirements | Diagnosis: Prior to Age 8<br>Treatment: Age 23<br>(G.S. 58-3-192.b) | Diagnosis and<br>Treatment up to Age 26 | Age changed to match dependent eligibility |
| Utilization management | An insurer shall have the right to request a review of that treatment not more than once annually, unless the insurer and the individual's licensed physician or the individual's licensed psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to a particular insured being treated for an autism spectrum disorder and shall not apply to all individuals being treated for an autism spectrum disorder by a physician or psychologist. The cost of obtaining any review shall be borne by the insurer.<br>(G.S. 58-3-192.h) | Consistent with SHP utilization management policies through BCBSNC and Value Options. Prior authorization will be required for the initial treatment plan as well as all continuing treatment. | Prior authorization for both initial and continuing treatment is necessary to ensure that therapy is appropriate for the individual and that progress toward treatment goal is being made. This includes review of the diagnosis. |

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Diagnosis | "Diagnosed with autism spectrum disorder by a licensed physician, or a licensed psychologist who determines the care to be medically necessary" (G.S. 58-3-192.a.10) | Diagnosis and referral for ABA will only be accepted from an MD, DO, Doctor of Psychology (Psy.D.), or a PhD Psychologist. | Limits diagnosis to licensed physician, Doctor of Psychology or PhD Psychologist. |
| Providers of Treatment | ABA Provided or supervised by:<br>(i) a Board Certified Behavior Analyst or<br>(ii) a licensed psychologist or licensed psychological associate, so long as the services performed are commensurate with the psychologist's training and experience (G.S. 58-3-192.a.3(b)) | Care that the provider cannot legally provide or legally charge or is outside the scope of license or certification is not covered. ABA rendered by a Psychologist with interventions provided by ancillary staff, including paraprofessionals, supervised by the psychologist is covered. | Does not recognize the provision of ABA by BCBAs. ABA falls within the scope of practice of a psychologist and BCBAs are not licensed to provide ABA in North Carolina. |

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Board Certified Behavior Analysts | Does not prevent a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA) from offering services within the scope of practice authorized by the Behavior Analyst Certification Board, including behavior analysis and therapy, in accordance with professional standards of the BCBA or BCaBA's certification, if both of the following are true: (1) The BCBA or BCaBA is properly certified and in good standing with the Behavior Analyst Certification Board; and (2) does not hold him/herself out to be a licensed psychologist. (G.S. 90-270.4 f1) | Will only cover ABA provided by licensed providers for whom ABA is within their scope of practice. | Compliant with currently existing NC law. |

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Behavioral Health Treatment | Counseling and treatment programs, including applied behavior analysis, that are (a) necessary to i) increase appropriate or adaptive behaviors, ii) decrease maladaptive behaviors, or iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual, and (b) provided or supervised by i) BCBSA or ii) a licensed psychologist or licensed psychological associate, so long as the services performed are commensurate with the psychologist's training and experience. (G.S. 53-3-192) | Expands SHP coverage to include ABA so long as clinical criteria are met. See Value Options clinical criteria for 2.60 Outpatient Services, 2.605 Applied Behavior Analysis. Provider must be licensed and performing within their scope of practice. | Requires additional clinical criteria be met including that certain behaviors are present and less intensive treatment is not sufficient or has been unsuccessful. |

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Exclusions | None listed | ABA for individuals:<br>• With medical conditions or impairments that would prevent beneficial utilization of services<br>• Requiring 24 hour medical/nursing monitoring or procedures provided in a hospital setting<br><br>ABA treatment will not be certified for the following services:<br>• Speech therapy<br>• Occupational therapy<br>• Vocational rehabilitation<br>• Supportive respite care<br>• Recreational therapy<br>• Orientation and mobility<br>• Respite Care<br>• Equine therapy<br>• Hippo therapy<br>• Dolphin therapy<br>• Service Animals<br>• Other educational services | ABA excluded for individuals with an underlying medical condition that would interfere with effectiveness of treatment. Therapies and services that are not evidence based are excluded. |

# Comparison of Benefit Design to HB 498

| Benefit Component | HB 498 | SHP Considered Benefit | Explanation of Difference |
|---|---|---|---|
| Therapeutic Care | Therapeutic care. – Direct or consultative services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or licensed clinical social worker. (G.S. 58-3-192.a.9) | The Plan currently covers therapeutic care. | ABA therapy is recognized as being distinct from other therapies and therefore, therapeutic care provided during ABA therapy is not covered. |
| Annual Benefit Maximum | $36,000 annual maximum (G.S. 58-3-192.g) | $36,000 annual maximum | No Change |

# Applied Behavior Analyst (ABA)
# Credentialing Criteria

**Board Certified Behavior Analyst Doctoral (BCBA-D)***

a) Doctoral degree, conferred at least ten (10) years prior to applying with a specialty of behavior analysis, psychology, education or another related field **and**

b) A minimum of 10 years post-doctoral experience in behavior analysis **and**

c) Certified as a Board Certified Behavior Analyst – Doctoral (BCBA-D) by the Behavior Analyst Certification Board.

d) State Licensed to practice at the highest level of independent practice in the state where practice is to occur (if applicable).

e) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent.

**Board Certified Behavior Analyst (BCBA)***

a) Master's degree or higher from a graduate school with a specialty of behavior analysis, psychology, special education or related field **and**

b) A minimum of 12 credit hours of graduate level course work in behavioral analysis; courses must have focus on application of behavior analysis, rather than more generic topics in the discipline for which the graduate degree was awarded. The courses should address the following issues in applied behavior analysis; family dynamics, ethical considerations, definition and characteristics, principles, processes and concepts; behavioral assessment and the selection of intervention strategies and outcomes; experimental evaluation of interventions; measurement of behavior and displaying/interpreting behavioral data; behavioral change procedures and systems support (Adapted from the Behavior Analyst Certification Board) **and**

c) A minimum of six months full-time supervised employment (or internship/Practicum in behavior analysis under the supervision of a behavior analysis)

d) Certified as a Behavior Analyst **(BCBA**) by the Behavior Analyst Certification Board.

e) State Licensed to practice at the highest level of independent practice in the state where practice is to occur (if applicable).

f) All provider applicants must have a minimum of one (1) year post certification experience providing direct patient care

g) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent.

# Applied Behavior Analyst (ABA)
# Credentialing Criteria

**Board Certified Assistant/Associate Behavior Analyst (BCaBA)***

a) Bachelor's degree or higher with coursework in behavior analysis, including ethical considerations, definition and characteristics, principles, processes and concepts; behavioral assessment and the selection of intervention strategies and outcomes; experimental evaluation of interventions; measurement of behavior and displaying/interpreting behavioral data; behavioral change procedures and systems support. (Adapted from the Behavior
Analyst Certification Board)

b) A minimum of 1000 hours of Supervised Independent Fieldwork in behavior analysis conducting assessment activities related to the need for behavioral interventions, Designing, implementing, and monitoring behavior analysis programs for clients, and Overseeing the implementation of behavior analysis programs by others. (Adapted from the Behavior Analyst Certification Board)

c) Certified as an Assistant Behavior Analyst **(BCaBA**) by the Behavior Analyst Certification Board.

d) May only provide patient care services under the direction and supervision of a Master's level Certified Behavior Analyst (BCBA). Must report the name of their BCBA supervisor(s) and provide documentation of that supervision as requested.

e) All provider applicants must have a minimum of one (1) year post certification experience providing direct patient care.

f) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent.

**(Applies Only to States/Client Accounts where required by regulation or benefit plan)*

# 2.60 OUTPATIENT SERVICES

## 2.605 Applied Behavioral Analysis (ABA)

Description of Services:

When covered by the benefit plan or state mandate, ValueOptions provides utilization care management for Applied Behavioral Analysis (ABA) which may be classified as an educational rehabilitation service, a medical benefit, or a behavioral benefit depending on the benefit plan. ABA is a systematic and structured strategy for addressing challenging behavior problems often found in individuals with Autism Spectrum Disorders (ASD). Such challenging behavioral problems are culturally abnormal behaviors of such an intensity, frequency or duration that the physical safety of the individual or others is likely threatened, or, behavior which is likely to seriously limit the ability to participate in common social activities such as the educational system and in addition the individual may be denied access to, ordinary community facilities. The ABA approach relies on applying experimentally derived principles of behaviorism to modify behavior.

ABA begins with an initial behavioral assessment of the individual with ASD in order to determine skills that are either present or absent in the individual's behavioral repertoire. Selection of treatment goals follows using data from the initial assessment. The treatment plan includes skills in all domains (acquiring learning skills, communication, social, academic, self-care, motor, play and leisure, etc.). The treatment program itself entails using intensive teaching techniques carefully designed to reinforce appropriate social behaviors in children with ASD. Typically, the ABA program consists of discrete trials where the "therapist" issues a directive to the patient, receives a response from the patient, and then there is a reaction from the "therapist" in order to either positively or negatively reinforce the patient's behavioral response.

The individual ABA treatment plan is developed by a professional with advanced formal training and certification in behavioral analysis, and this level of professional directs the program. The actual 1:1 sessions are typically provided by behavioral technicians or paraprofessionals for up to 40 hours of patient contact per week in a variety of settings (school; home; community). The technician is supervised by the ABA certified professional.

ABA is an extremely intensive treatment program. It can occur in any number of settings, including school, home, agencies, hospitals, etc. It is imperative that the interventions be applied systematically and uniformly, and that behavioral data is gathered, maintained and analyzed in order to evaluate the effectiveness of both the treatment plan and the interventions. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information

| Criteria | |
|---|---|
| **Admission Criteria** | ***All** of the following criteria are necessary for admission*:<br>1. The individual demonstrates behavioral symptoms consistent with a DSM-IV-TR (or most current DSM), (Axes I-V) diagnosis falling within the range of Autism Spectrum Disorders (299.00, 299.10, 299.80)<br>2. The individual displays a "severe challenging behavior" that either 1) presents a health or safety risk to self or others (e.g., self-injury, aggressive behaviors, destruction of property severe disruptive behaviors) or 2) significantly interferes with socially acceptable activities in the home or community due to the objectionable nature of the |

| | |
|---|---|
| | behavior,<br>3. Less intensive forms of behavioral treatment or therapy have not been sufficient or are not appropriate to reduce the interfering behaviors, increase pro-social behaviors, or to maintain desired behaviors.<br>4. There is a reasonable expectation on the part of a qualified treating health professional who has evaluated the individual that the behavior will improve or the individual will receive maximum benefit through the use of Applied Behavioral Analysis.<br>5. The treatment plan is individualized: objectives are measurable and tailored to the individual. Interventions emphasize generalization of skill and focus on the development of spontaneous social communication, adaptive skills and appropriate behaviors and include a focus that:<br>• Is child centered, strengths based, family inclusive, community based, culturally competent, and provided in the least restrictive setting<br>• Targets specific behaviors (including frequency, rate, symptom intensity, duration).<br>• Incorporates objective baseline and quantifiable progress measures.<br>• Describes detailed behavioral interventions, reinforcers, strategies for generalization of skills beyond the ABA sessions.<br>• Coordinates ancillary services and transition plans.<br>6. Parent/caregiver training and support is included into the treatment plan with documented plans that skills transfer to the parent/caregiver will occur. |
| **Psychosocial, Occupational, and Cultural and Linguistic Factors** | *These factors, as detailed in the Introduction, may change the risk assessment and should be considered when making level of care decisions.* |
| **Exclusion Criteria** | ***Any** of the following criteria are sufficient for exclusion from this level of care*:<br>1. The individual has medical conditions or impairments that would prevent beneficial utilization of services.<br>2. The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting.<br>3. ABA treatment will not be certified for the following services:<br>a. Speech therapy<br>b. Occupational therapy<br>c. Vocational rehabilitation<br>d. Supportive respite care<br>e. Recreational therapy<br>f. Orientation and mobility<br>g. Respite care<br>h. Equine therapy |

| | |
|---|---|
| | i. Hippo therapy<br>j. Dolphin therapy<br>k. Other educational services |
| **Continuing Stay Criteria** | ***All*** *of the following criteria are necessary for continuing treatment at this level of care*:<br>1. The individual's condition continues to meet admission criteria for Applied Behavioral Analysis, either due to continuation of presenting problems, or appearance of new problems or symptoms.<br>2. There is reasonable expectation that the individual will benefit from the continuation of ABA services.<br>3. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. The treatment plan is updated based on treatment progress including the addition of new target behaviors.<br>4. All services and treatment interventions are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Expected benefit from all relevant modalities is documented.<br>5. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms or there are clear benefits to treatment, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.<br>6. There is documented skills transfer to the individual and treatment transition planning from the beginning of treatment.<br>7. There is a documented active attempt at coordination of care with relevant providers/caretakers, etc., when appropriate. If coordination is not successful, the reason(s) are documented<br>8. Unless contraindicated, family and/or significant other are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them. |
| **Discharge Criteria** | ***Any*** *of the following criteria are sufficient for discharge from this level of care*:<br>1. The individual has achieved adequate stabilization of the challenging behavior and less-intensive modes of treatment are appropriate and indicated.<br>2. The individual no longer meets admission criteria, or meets criteria for a less or more intensive services.<br>3. Treatment is making the symptoms persistently worse.<br>4. The individual is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement or stabilization of challenging behavior and there is no reasonable expectation of progress. |

## SCREENING for AUTISM SPECTRUM DISORDER:
## (American Academy of Pediatrics)

The American Academy of Pediatrics (AAP) recommends that developmental surveillance should be done at every well – child appointment using an **A.L.A.R.M.** approach:

**A**utism is prevalent.
**L**isten to parents about developmental concerns.
**A**ct early with the use of screening.
**R**efer to appropriate professionals, organizations and programs such as Early Intervention.
**M**onitor incoming information and the child and family.

During these well-child visits, the primary care clinician should;

- elicit a developmental history,
- listen to parental concerns,
- observe the child directly,
- use developmental checklists to record milestones, and
- decide whether a developmental screening might need to be performed due to developmental concerns about language, social and pretend-play skills.

**Note that while parental concerns are often present in the first years of life, the *lack* of parental concern does not imply that a child's development is typical.**

Detecting developmental delays early is challenging because children develop and acquire skills asynchronously.

**Screening Tools**: It is imperative to use screening tools with good reliability, sensitivity, and specificity. Current screening tools may **not** identify children with milder variants of autism, those without mental retardation or language delay, those with Asperger's disorder, or ASD in older children, adolescents, and young adults. Primary care physicians should be familiar with at least one of these tools to be used with children suspected to have an ASD. Recommended screening tools include:

**Summary of Selected Assessment Instruments for Autism Spectrum Disorder*** **From AACAP 2014**

| Scale (see legend) | Uses | Age Range | Method of Administration | Population Studied | Scale characteristics | Reference |
|---|---|---|---|---|---|---|
| ABC | screening | children | parent rated | AD | 57 items, scale 1-4 | Krug et al., 198043 |
| CARS | screening | children | clinician rated | AD | 15 items, scale 1-4 | Schopler et al., 198044 |
| M-CHAT | screening | toddlers | parent rated | AD | 23 items, yes/no | Robins et al., 200145 |
| CSBS-DP-IT-Checklist | screening | toddlers | parent rated | AD | 24 items | Wetherby et al., 200846 |
| ASQ | screening | child/adult | parent rated | AD/AspD | 40 items, yes/no | Berument et al., 199947 |
| AQ | screening | child/adult | self or parent rated | AspD | 50 items, scale 0-3 | Baron-Cohen et al., 200148 |
| CAST | screening | 4-11 years | parent rated | AspD | 37 items, yes/no | Scott et al., 200249 |
| ASDS | screening | 5-18 years | parent or teacher rated | AspD | 50 items, yes/no | Myles et al., 200050 |
| GADS | screening | 3-22 years | parent or teacher rated | AspD | 32 items, scale 0-3 | Gilliam, 200151 |
| ASDI | screening | child/adult | interview + clinician rated | AspD | 50 items, yes/no | Gillberg et al., 200152 |
| SRS | screening | 4-18 years | parent or teacher rated | AspD | 65 items, scale 1-4 | Constantino et al., 200353 |
| ADI | diagnostic | child/adult | interview + clinician rated | AD/AspD | see text | Lord et al., 200354 |
| DISCO | diagnostic | child/adult | interview + clinician rated | AD/AspD | see text | Wing et al., 200255 |
| ADOS | diagnostic | child/adult | semi-structured interactive session | AD/AspD | see text | Lord et al., 199456 |

Note:
ABC = Autism Behavior Checklist;
AD = autism disorder;
ADI = Autism Diagnostic Interview Revised **(See Attachment 1 for a summary of components.)**
ADOS = Autism Diagnostic Observation Schedule;
AQ = Autism Quotient;
ASDI = Asperger Syndrome Diagnostic Interview;
ASDS = Asperger Syndrome Diagnostic Scale;
AspD = Asperger's disorder;
ASQ = Autism Screening Questionnaire;
CARS = Childhood Autism Rating Scale;
AST = Childhood Autism Screening Test;
M-CHAT = Checklist for Autism in Toddlers;
CSBS-DP-IT-Checklist = Communication and Symbolic Behavior Scales Developmental Profile Infant-Toddler Checklist;
DISCO = Diagnostic Interview for Social and Communication Disorders;
GADS = Gilliam Asperger's Disorder Scale;
Parent = primary caregiver;
SRS = Social Responsiveness Scales.

*Note that these instruments may need to be revised to provide evidence of validity for DSM-5 ASD and supplement but DO NOT REPLACE clinical diagnosis. (See Attachment 2 for DSM-5 ASD criteria.)

**ATTACHMENT 1:**

**Autism Diagnostic Interview™, Revised (ADI™-R)**

By Michael Rutter, MD, FRS, Ann LeCouteur, MBBS, et al.

http://www.wpspublish.com/store/p/2645/autism-diagnostic-interview-revised-adi-r

Summary of components of the Autism Diagnostic Interview – Revised (ADI-R). *This standardized interview requires extensive training to administer, but is considered the "gold standard" of accuracy in autism screening, so the following summary is provided to allow clinicians to incorporate elements of this instrument into their clinical evaluation.* The questions in the ADI-R are asked of parents/caregivers.

Qualitative Impairment in Social Interactions

- Direct gaze: *Does the child look at you directly in the face while talking to you*?
- Social smiling: *Does the child smile in meeting? In response to others*?
- Showing and directing attention: *Does the child show/bring things*?
- Offering to share: *Food, toys, favorite objects*?
- Seeking to share enjoyment with others: *Does the child direct attention to things (he) likes?*
- Offer comfort: *Spontaneously?*
- Quality of social overtures: *Coordinated eye gaze – pointing*?
- Range of facial expressions used to communicate: *Full range*?
- Inappropriate facial expression: *Related to context*?
- Appropriateness of social responses: *Responses to the approaches of others*?
- Imaginative play: *Pretend games*?
- Imaginative social play: *Initiates and responds to simple social games*?
- Interest in other children: *Interested in children (he) doesn't know*?
- Response to approaches of other children: *Responsive?*
- Group play with peers: *Actively seeks and plays cooperatively*?
- Friendships: *Does (he) have a particular friends or a best friend*?

Qualitative Impairment in Communication

- Use of another's body to communicate: *Uses others as a tool*?
- Age of first single words: *Under 24 months; phrases under 33 months*
- Social vocalizations/chat: *Small talk*?
- Stereotyped utterances and delayed echolalia: *Saying the same thing over and over.*
- Reciprocal conversation: *Able to carry on a conversation*?
- Inappropriate questions or statements: *Seems to lack the understanding of the social impact of questions or statements*?
- Pronomial reversals: *Mixing up you/I/he/she and inappropriate inflection*.
- Neologisms/idiosyncratic language: *Made up words*.
- Verbal rituals: *Insisting on saying or others saying the same thing the same way*
- Spontaneous imitation
- Pointing to express interest: *Uses conventional/instrumental gestures*?
- Nodding: *Nodding to mean yes or shaking head to mean no*.

Restricted, Repetitive and Stereotyped Patterns of Behavior, Interests and Activities

- Circumscribed interests: Unusual in intensity and causing social impairment
- Unusual preoccupations: E.g. metal objects, traffic lights, street signs, toilets. etc.
- Repetitive use of objects or interest in parts of objects: E.g. spinning wheels, lines
- Compulsions/ rituals: Fixed sequence of activities, intrude on family life
- Unusual sensory interests: Sight, touch, sound, taste, smell.
- Hand and finger mannerisms: Flicking, waving, flapping, etc.
- Other complex mannerisms or stereotyped body movements: spinning, bouncing, running in circles, body rocking.

**ATTACHMENT 2:**
**DSM-5 Criteria for Autism Spectrum Disorder**

## Autism Spectrum Disorder 299.00 (F84.0)

Diagnostic Criteria

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative paly or in making friends; to absence of interest in peers.

*Specify* current severity:

**Severity is based on social communication impairments and restricted repetitive patterns of behavior** (see Table 2).

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g, strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

*Specify* current severity:

**Severity is based on social communication impairments and restricted, repetitive patterns of behavior** (see Table 2).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

**Note:** Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

*Specify* if:

**With or without accompanying intellectual impairment**

**With or without accompanying language impairment**

**Associated with a known medical or genetic condition or environmental factor**

(**Coding note:** Use additional code to identify the associated medical or genetic condition.)

Associated with another neurodevelopmental, mental, or behavioral disorder

(**Coding note:** Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].)

**With catatonia** (refer to the criteria for catatonia associated with another mental disorder, pp. 119-120, for definition) (**Coding note:** Use additional code 293.89 [F06.1] catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

Table 2 - Severity levels for autism spectrum disorder

| Severity level | Social communication | Restricted, repetitive behaviors |
|---|---|---|
| Level 3<br>"Requiring very substantial support" | Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches | Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action. |
| Level 2<br>"Requiring substantial support" | Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication. | Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action. |
| Level 1<br>"Requiring support" | Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions– e.g., a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful. | Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence |

**Benefit Booklet language for ABA**

## ***Mental Health and Chemical Dependency Benefits***

The Plan provides benefits for the treatment of mental illness and *chemical dependency* by a *hospital, doctor* or other provider.

Coverage for *in-network inpatient* and outpatient services is coordinated through your Mental Health Case Manager. The Plan delegates administration of these benefits to the Mental Health Case Manager. To understand more about when you need to contact the Mental Health Case Manager, see "How to Access Mental Health and *Chemical Dependency* Services."

### *Office Visit Services*

The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- Medically necessary biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

### *Outpatient Services*

Covered outpatient treatment services when provided in a mental health or *chemical dependency* treatment facility include:

- Each service listed in the section under office visit services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).
- Certain *in-network* outpatient services, such as partial hospitalization and intensive therapy, require prior review and *certification* or services will not be covered. Visit the State Health Plan website at www.shpnc.org or call the Mental Health Case Manager for a detailed list of these services. The list of services that require prior review may change from time to time.

### *Inpatient Services*

Covered *inpatient* treatment services also include:

- Each service listed under office visit services
- Semi-private room and board
- Detoxification to treat *chemical dependency*.

Prior review must be requested and *certification* must be obtained in advance for *in-network inpatient* services or services will not be covered, except for *emergencies*.

### *Applied Behavior Analysis*

Coverage is provided for *Applied Behavior Analysis* when all of the following conditions are met:

- The *member* is younger than age 26, and
- Diagnosed with Autism Spectrum Disorder by a licensed physician (MD or DO) or a licensed doctoral level clinical psychologist (PhD or PsyD) utilizing results from a face-to-face evaluation and a clinically recognized, validated tool accepted by the Mental Health Case Manager, and
- Treatment is determined by the Mental Health Case Manager to be medically necessary

Coverage for *Applied Behavior Analysis* is limited to a maximum of $36,000 per benefit year and is only available in-network.

***Applied Behavior Analysis Exclusions***

Treatment for the following is not covered:

- *Members* with medical conditions or impairments that would prevent beneficial utilization of services
- *Members* requiring 24 hour medical/nursing monitoring or procedures provided in a hospital setting

ABA treatment will not be certified for the following services:

- Speech therapy
- Occupational therapy
- Vocational rehabilitation
- Supportive respite care
- Recreational therapy
- Orientation and mobility
- Respite Care
- Equine therapy/Hippotherapy
- Dolphin therapy
- Service Animals
- Other educational services

## *How to Access Mental Health and Chemical Dependency Services*

Prior review by the Mental Health Case Manager is not required for any office visit or for out-of-network *inpatient* or outpatient services. Although prior review is not required for *emergency* situations, please notify the Mental Health Case Manager of your *inpatient* stay as soon as reasonably possible.

When you need *inpatient* or outpatient services that require prior review and *certification*, call the Mental Health Case Manager at the number listed in "Who Do I Call?" The Mental Health Case Manager can also help you find an appropriate *in-network provider* and give you information about prior review and *certification* requirements.

### ***Timeframe Requirements for Prior Review and Treatment Certification of Covered Services***

| **Covered Service** | **Within Two (2) Business Days of Admission** | **Prior to Admission to the Program** | **Continuing Treatment Certifications*** |
|---|---|---|---|
| **Crisis Evaluation & Stabilization** | **X** | | **X** |
| **Psychiatric Inpatient Hospital** | **X** | | **X** |
| **Chemical Dependency Inpatient Hospital** | **X** | | **X** |

| | | | |
|---|---|---|---|
| **Inpatient Medical Detoxification** | **X** | | **X** |
| **Psychiatric**<br>**Residential Treatment Center** | | **X** | **X** |
| **Chemical Dependency Residential Treatment Center** | | **X** | **X** |
| **Psychiatric**<br>**Partial Hospitalization Program** | | **X** | **X** |
| **Chemical Dependency Partial Hospitalization Program** | | **X** | **X** |
| **Psychiatric**<br>**Intensive Outpatient Program** | | **X** | **X** |
| **Chemical Dependency Intensive Outpatient Program** | | **X** | **X** |

**Continuing treatment certifications must be requested by the last date of any previously certified period. Otherwise, certification decisions by the* Mental Health Case Manager *are effective as of the date the request for certification is received by the* Mental Health Case Manager.

***Mental Health and Chemical Dependency Services Exclusions***

- Care for conditions not classified as psychiatric, emotional, or substance abuse illnesses
- Psychoanalysis
- Counseling with relatives about a patient with mental illness, alcoholism, drug addiction or substance abuse
- *Inpatient* confinements that are primarily intended as a change of environment
- Mental health services received in residential treatment facilities when age 18 or older. Residential treatment facilities are covered for *chemical dependency*.
- Marriage Counseling
- *Inpatient* psychiatric care rendered in a *hospital* not accredited by JCAHO
- *Inpatient chemical dependency* care rendered in a facility which is not currently accredited by a national health care organization approved by the Mental Health Case Manager
- *Inpatient hospital* care for medical detoxification rendered in a facility which is not licensed as a *hospital* and accredited by a national health care organization approved by the Mental Health Case Manager
- Outdoor components of a residential *chemical dependency* treatment program, when such program is licensed as a *chemical dependency* treatment program in the state in which services are provided, are covered only if facility based services are available as a part of the same program
- Primary treatment of a psychiatric disorder in a residential treatment center (RTC) unless the RTC is licensed as a psychiatric RTC
- Primary treatment of a *chemical dependency* or substance abuse disorder in a residential treatment center (RTC) unless the RTC is licensed as a *chemical dependency* or substance abuse RTC
- Services by providers not currently licensed in the state in which services are provided
- Psychotherapy as part of artificial means of conception

- Psychological assessment and psychotherapy treatment in conjunction with proposed gender transformation
- Psychological testing for those persons with a *chemical dependency* diagnosis until 30 consecutive days of abstinence are obtained.
- Therapeutic boarding schools as a psychiatric residential treatment center (RTC) unless the program is licensed for psychiatric RTC in the state in which services are provided, has registered nurses who are present on-site 24-hours per day, and holds current national accreditation by a national health care accrediting body approved by the Mental Health Case Manager
- Therapeutic boarding schools as a *chemical dependency* or substance abuse residential treatment center (RTC) unless the program is licensed as a *chemical dependency* RTC in the state in which services are provided and has licensed supervision of all residents 24 hours per day, seven days per week
- Wilderness camps, wilderness "step-down" components of a residential program, and stand-alone outdoor treatment programs or outdoor "step-down" components of a residential program are not covered as a psychiatric RTC unless the program is licensed for psychiatric residential treatment in the state in which services are provided, has registered nurses who are present on-site 24-hours per day, and holds current national accreditation by a national health care accrediting body approved by the Mental Health Case Manager
- Wilderness camps and stand-along outdoor treatment programs are not covered as *chemical dependency* or substance abuse RTC programs
- Academic education during residential treatment when charged separately
- Administrative psychiatric services (e.g., expert testimony, report writing, medical records review and maintenance, case management or case coordination, chart review, etc.)
- Consultation with a mental health professional for adjudication of marital, child support, and custody cases
- Evaluations, consultations, testing or therapy for educational, professional training, or for investigation purposes relating to employment, insurance, judicial or administrative proceedings
- Training analysis
- Treatment for personal or professional growth, development, training or professional *certification*
- Aversive Treatment
- Treatment programs based solely on the 12-step Model
- Erhard Seminar Training (EST) or similar motivational services
- Bioenergetic, carbon dioxide, confrontational, hyperbaric or normobaric oxygen, marathon, megavitamin, orthomolecular, primal, rebirthing, or sleep therapies
- Expressive therapies (art, poetry, movement, psychodrama), guided imagery, or stress and relaxation therapy when billed separately
- Telephonic crisis management as a separate charge
- Sedative action, electro stimulation therapy
- Z therapy, also known as "holding therapy"
- Narcotherapy with LSD
- Environmental ecology treatments
- Hemodialysis for schizophrenia
- Rolfing
- Sensitivity training
- Room and Board costs for patients admitted to a partial *hospital* or intensive outpatient program are not covered.

- Intensive in-home services less than two hours per day
- Private duty nursing
- Therapeutic family, foster or home care
- L-tryptophan and vitamins, except thiamine injections on admission for alcoholism when there is a diagnosed nutritional deficiency
- Travel time necessary for service delivery

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

# 2015 Enrollment Rules

***Board of Trustees Meeting***

**May 30, 2014**

# Proposed 2015 Enrollment Rules

- Premium Wellness Credits
- Open Enrollment
  - Active and Non-Medicare
  - Medicare Primary
- ACA New Hire Automatic Enrollment*

**Final guidance has not been provided – The ACA requirement to auto-enroll all new hires could be postponed again.*

# 2014 Premium Wellness Credits

| 2014 Premium Wellness Credits | | |
|---|---|---|
| **Traditional 70/30 PPO** | **Enhanced 80/20 PPO** | **Consumer Driven Health Plan** |
| NA | Smoker Surcharge<br>Applies to Subscriber & Spouse<br>$20 | Smoker Surcharge<br>Applies to Subscriber & Spouse<br>$20 |
| NA | PCP Election<br>Each family member must elect a PCP<br>$15 | PCP Election<br>Each family member must elect a PCP<br>$10 |
| NA | Health Assessment (HA)<br>Subscriber must complete HA<br>$15 | Health Assessment (HA)<br>Subscriber must complete HA<br>$10 |

- Smoker Attestation had to be completed during OE.
- PCPs could be elected prior or during to OE.
- HA had to be completed between November 1, 2012 and the end of OE.

# Premium Wellness Activity – Smoker Attestation Recommendation

| 2015 Premium Wellness Credits | | |
|---|---|---|
| **Traditional 70/30 PPO** | **Enhanced 80/20 PPO** | **Consumer Driven Health Plan** |
| NA | Smoker Surcharge<br>Applies to Subscriber & Spouse<br>$20 | Smoker Surcharge<br>Applies to Subscriber & Spouse<br>$20 |

Plan staff recommends that the subscriber, and if applicable, the spouse must re-attest to not smoking or to participating in a smoking cessation program during the 2015 Open Enrollment to receive the smoking credit.

# Premium Wellness Activity – PCP Selection Recommendation

| 2015 Premium Wellness Credits | | |
|---|---|---|
| **Traditional 70/30 PPO** | **Enhanced 80/20 PPO** | **Consumer Driven Health Plan** |
| NA | PCP Election<br>Each family member must elect a PCP<br>$15 | PCP Election<br>Each family member must elect a PCP<br>$10 |

Plan staff recommends that subscribers who have selected a valid PCP for each participating family member prior to the 2015 open enrollment do not need to change or update their PCP to receive the PCP Premium Credit for the 2015 Plan Year.

# Premium Wellness Activity – HA Recommendation

| 2015 Premium Wellness Credits | | |
|---|---|---|
| **Traditional 70/30 PPO** | **Enhanced 80/20 PPO** | **Consumer Driven Health Plan** |
| **NA** | **Health Assessment (HA)**<br>**Subscriber must complete HA**<br>**$15** | **Health Assessment (HA)**<br>**Subscriber must complete HA**<br>**$10** |

Plan staff recommends that any subscriber who has updated their HA or taken it for the first time between November 2013 and the end of the 2015 Open Enrollment will receive the HA credit.

# Active & Non-Medicare Enrollment

| 2015 Plan Design Options for Actives & Non-Medicare Primary Members | | | |
|---|---|---|---|
| | Traditional 70/30 PPO | Enhanced 80/20 PPO | Consumer Driven Health Plan |
| Premium Wellness Credits Apply | No | Yes | Yes |

Plan staff recommends a passive enrollment for existing Active and Non-Medicare Primary members. When a subscriber logs in to view their 2015 Open Enrollment options, the 2014 benefit election will display with the premium wellness credits earned for 2015. The subscriber may

- Complete wellness credits *and/or*
- Elect a new plan design *and/or*
- *Make no change and remain in their 2014 election

**If no changes are made during OE, the member will remain in the plan that was elected in 2014 with the premium credits earned through the end of the 2015 OE.*

# Medicare Primary Enrollment

- Plan staff prefers a passive enrollment for existing Medicare Primary Retirees, Dependents and Surviving Dependents who have already made a Medicare Primary election.
- However, the Plan is in the process of discussing renewal pricing (i.e. the fully insured premium rates applicable for 2015) with the Medicare Advantage Carriers.
- Depending on the results of those discussions, Plan staff may recommend changes to the auto-enrollment and contribution strategies and will present a final recommendation at a later date.

| Preferred Medicare Primary Enrollment Approach | |
|---|---|
| **Member Type** | **Open Enrollment Type** |
| **Existing Medicare Primary Retirees, Dependents and Surviving Dependents** | **Passive** - Unless they make a new election during Open Enrollment, they will remain in the Medicare Primary Plan they had previously elected |
| **New Medicare Primary Enrollees** (New Medicare Primary Retirees or Members who will age into Medicare primacy in November, December, January) | **Active** - Member will be auto-enrolled into a Medicare Advantage Base Plan and have the option to elect any of the other three Medicare Advantage Plans or the Traditional 70/30 Plan |

# January 1, 2015 – New Hires

As a reminder, we may also have new ACA enrollment requirements for January 2015 related to new hires: New Hire Auto-Enrollment.

If this moves forward, Plan staff recommends enrolling New Hires into the Traditional 70/30 if they have not made an election by the end of their thirty (30) day initial enrollment period, which means these members will not have the opportunity to make a plan change until the next open enrollment period.

# Appendix: Premium Wellness Credit Scenarios

# Premium Wellness Activity – PCP Selection Scenarios

| PCP Enrollment Scenarios | | | | |
|---|---|---|---|---|
| Scenario | PCP action taken at OE | PCP action taken after OE - Prior to 1/1/15 | PCP action taken after 1/1/15 | Qualified for PCP Premium Credit |
| Sub/Family have elected PCP prior to OE | None | None | None | Yes |
| Sub/Family have not elected PCP prior to OE | All family members elect PCP | None | None | Yes |
| Sub/Family have not elected PCP prior to OE | Only subscriber elects PCP | None | None | No |
| Sub/Family have not elected PCP prior to OE | Only subscriber elects PCP | None | Rest of the family elects PCPs | No |
| Sub/Family have not elected PCP prior to OE | Some family members elect PCPs | None | None | No |
| Sub/Family have elected PCP prior to OE | None | Sub changes PCP | Family members change PCP | Yes |
| Sub/Family have not elected PCP prior to OE | None | All family members elect PCP | None | No |
| Sub/Family have not elected PCP prior to OE | None | None | All family members elect PCP | No |
| Sub/Family have not elected PCP prior to OE | None | None | Sub elects PCP | No |
| Sub/Family have not elected PCP prior to OE | All family members elect PCP | None | One or all family members change PCP to "none selected" | Yes |
| Sub/Family have not elected PCP prior to OE | All family members elect PCP | None | New family member is added who does not add a PCP | Yes |
| Sub/Family have not elected PCP prior to OE | All family members elect PCP | Baby born after OE and PCP added | None | Yes |
| Sub/Family have not elected PCP prior to OE | All family members elect PCP | Dependent added with QE - no PCP elected | None | Yes |

# Premium Wellness Activity – Health Assessment Scenarios

| Open Enrollment Health Assessment Scenarios | | | | |
|---|---|---|---|---|
| **Subscriber HA takes between 11/16/13 and start of OE** | **Subscriber HA taken During OE** | **Subscriber takes HA for the first time after OE and before 1/1/15** | **Subscriber takes HA for the first time after 1/1/15** | **Qualifies for HA Credit** |
| Yes | | | | Yes |
| | Yes | | | Yes |
| | | Yes | | No |
| | | | Yes | No |
| **Subscriber enrolls as a new hire or Qualifying Event after Open Enrollment** | | | | |
| **Subscriber completes HA during 30 day enrolment window** | **Subscriber completes HA after 30 day enrollment window** | | | **Qualifies for HA Credit** |
| Yes | | | | Yes |
| | No | | | No |

# Premium Wellness Activity – Smoker Attestation Scenarios

| Open Enrollment Scenarios | | | |
|---|---|---|---|
| **Subscriber completes Smoker Attestation during OE** | **Subscriber completes smoker attestation for the first time after OE and before 1/1/15** | **Subscriber completes smoker attestation for the first time after 1/1/15** | **Qualifies for Non-Smoker Credit** |
| X | | | Yes |
| | X | | No |
| | | X | No |

North Carolina
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# Potential Benefit Option for Newly Eligibles

***Board of Trustees Meeting***

**May 30, 2014**

# Presentation Overview

- Summary of ACA Requirements
- Potential Enrollees
- Options for Compliance
- Potential Plan Designs
- Potential Premiums
- Decision Points

# ACA Requirements – Who is Eligible for Coverage?

- The Affordable Care Act (ACA) and section 4980H of the Internal Revenue Code (the Code) prescribe updated definitions of full-time employees and requirements to determine which employees are required to be offered employer-sponsored health care.
- Employees are determined to be full-time, and thus required to be offered employer-sponsored health care, if they are reasonably expected to work 30 hours per week.
  - Employers have flexibility in their measurement and stability periods on determining eligibility.
  - This includes all non-permanent full-time employees. Non-permanent full-time employees are currently not offered coverage through the State Health Plan.
- Employers are penalized for not meeting Employer Responsibility requirements.

# ACA Requirements – What are the Coverage Rules?

To avoid Employer Shared Responsibility penalties, full-time employees must have access to a plan that meets the definition of Minimum Essential Coverage:

- At least **Minimum Actuarial Value:** Provides at least a value of 60% of the cost of services (Bronze level on the Exchange)
  - The Plan had Segal design a minimum value high deductible health plan and a slightly more generous Bronze level plan

- **Affordable:** Costs an employee no more than 9.5% of gross taxable wages for self-only coverage
  - An employer contribution *will be needed* for low-wage employees in order to maintain affordability and ensure the avoidance of penalties
  - A decision is needed on the approach to set the employee and employer contributions

# ACA Plan Requirements
# What are the Penalties for Non-Compliance?

| "Sledge Hammer" Penalty | "Tack Hammer" Penalty |
|---|---|
| If employing units do not offer "minimum essential coverage" to at least 70% of full-time employees (and dependent children under age 26) and if one full-time employee receives subsidized coverage on the Exchange:<br>• Penalty is $2,000 (annualized) times the **total # of full-time employees** (minus first 30 workers) | If employing units do offer coverage to 95% of full-time employees (and their dependent children under 26), but the coverage is either not affordable or not of minimum value and one full-time employee receives federally subsidized coverage in the Exchange<br>• Penalty is $3,000 (annualized) times the # of full-time employees getting a tax credit in an Exchange (subject to a penalty maximum) |

# Potential Enrollees

- In December, Plan staff solicited a survey from the Office of State Human Resources, Department of Public Instruction, the University of North Carolina (UNC) system, and the Community College system to determine the number of potentially eligible employees.
  - Based on the number hours worked, approximately 24,000 people could become eligible under the 2015 rule; however, several entities indicated that they will be changing HR policies to potentially reduce the number of newly eligible employees.
    - The IRS has also issued newer guidance for schools and universities on determining eligibility

# Options for Compliance

- Under current State law, effective January 1, 2015 non-permanent full-time employees (newly eligibles) will be eligible to enroll in the benefit plan options currently offered by the State Health Plan.
  - Employing units and newly eligible employees will be subject to the same employer and employee contributions as apply to the CDHP, Enhanced 80/20 and Traditional 70/30 plans.
- All employing units have expressed interest in creating a lower cost option to offer these employees that would include an employee premium.
- Plan staff has been exploring options to offer an alternate health benefit plan to newly eligibles if legislation is enacted by the General Assembly.

# Options for Compliance

- The UNC system has expressed interest in creating their own plan because their potential newly eligibles are significantly younger than the average of other employing units and it would reduce the cost to the UNC system.
  - This would, in turn increase the cost for the remainder of the employing units covered through the Plan's option.
- Segal has priced benefit options with and without UNC's participation and two levels of benefit.
  - A minimum value plan and a slightly enhanced Bronze Plan.
  - Both offerings would provide significant savings to employing units when compared to the current SHP offerings.
  - Savings are reduced by both offering a more generous benefit and by excluding UNC.

# Potential Alternate Plan Designs Compared to Traditional 70/30

| Plan Design Components | Traditional 70/30 Plan | Minimum Creditable Coverage (MCC) (60% Actuarial Value) | Bronze Level Plan (66% Actuarial Value) |
|---|---|---|---|
| **Deductible** | $933 | $5,000 | $1,400 |
| **Health Saving Account Compatible** | No | Yes | Yes |
| **Coinsurance** | 70% | 50% | 50% |
| **Medical Coinsurance Maximum** | $3,793 | N/A | N/A |
| **Out-of-Pocket Maximum** | N/A | $6,450 | $6,450 |
| **Medical Copays** | | | |
| **Preventive Care** | $35 or $81 | $0 | $0 |
| **Primary Care Provider** | $35 | Deductible, then coinsurance | Deductible, then coinsurance |
| **Specialist Visit** | $81 | Deductible, then coinsurance | Deductible, then coinsurance |
| **Inpatient Hospital** | $291 | Deductible, then coinsurance | Deductible, then coinsurance |
| **Emergency Room Services** | $291 | Deductible, then coinsurance | Deductible, then coinsurance |
| **Pharmacy Copays** | | | |
| **Generic** | $12 | Deductible, then coinsurance | Deductible, then coinsurance |
| **Preferred Brand Drugs** | $40 | Deductible, then coinsurance | Deductible, then coinsurance |
| **Non-Preferred Brand Drugs** | $64 | Deductible, then coinsurance | Deductible, then coinsurance |
| **Specialty High-Cost Drugs** | 75% coinsurance | Deductible, then coinsurance | Deductible, then coinsurance |
| **Out-of-Pocket Maximum** | $2,500 | Included in total Out-of-Pocket | Included in total Out-of-Pocket |

# Sample Premium Sharing (MCC Plan): Employee/Employer Contributions in Four Pay Bands

| | Employee Share | *Including UNC* Employer Share | *Excluding UNC* Employer Share |
|---|---|---|---|
| **Non-Permanent Employees in Pay Band 1** | | | |
| Employee Only | $90.00 | $111.00 | $133.00 |
| Employee + Child(ren) | $263.00 | $111.00 | $133.00 |
| Employee + Spouse[1] | $467.00/$507.00 | $111.00 | $133.00 |
| Employee + Family | $564.00 | $111.00 | $133.00 |
| **Non-Permanent Employees in Pay Band 2** | | | |
| Employee Only | $124.00 | $77.00 | $99.00 |
| Employee + Child(ren) | $297.00 | $77.00 | $99.00 |
| Employee + Spouse[1] | $501.00/$541.00 | $77.00 | $99.00 |
| Employee + Family | $598.00 | $77.00 | $99.00 |
| **Non-Permanent Employees in Pay Band 3** | | | |
| Employee Only | $161.00 | $40.00 | $62.00 |
| Employee + Child(ren) | $334.00 | $40.00 | $62.00 |
| Employee + Spouse[1] | $538.00/$578.00 | $40.00 | $62.00 |
| Employee + Family | $635.00 | $40.00 | $62.00 |
| **Non-Permanent Employees in Pay Band 4** | | | |
| Employee Only | $201.00 | $0.00 | $22.00 |
| Employee + Child(ren) | $374.00 | $0.00 | $22.00 |
| Employee + Spouse[1] | $578.00/$618.00 | $0.00 | $22.00 |
| Employee + Family | $675.00 | $0.00 | $22.00 |

| **Pay Band 1** | | |
|---|---|---|
| **Pay Unit** | | **to** |
| Hourly | up to | $10.00/hour |
| Monthly | up to | $1,300.00/month |
| Annual | up to | $15,600.00/year |

| **Pay Band 2** | | |
|---|---|---|
| **Pay Unit** | **from** | **to** |
| Hourly | $10.01 | $13.00/hour |
| Monthly | $1,300.01 | $1,690.00/month |
| Annual | $15,600.01 | $20,280.00/year |

| **Pay Band 3** | | |
|---|---|---|
| **Pay Unit** | **from** | **to** |
| Hourly | $13.01 | $16.25/hour |
| Monthly | $1,690.01 | $2,113.00/month |
| Annual | $20,280.01 | $25,350.00/year |

| **Pay Band 4** | | |
|---|---|---|
| **Pay Unit** | **from** | |
| Hourly | $16.26/hour | or more |
| Monthly | $2,113.01/month | or more |
| Annual | $25,350.01/year | or more |

1. Segal has estimated that the total premium in the employee + spouse tier would disproportionally higher due to selection

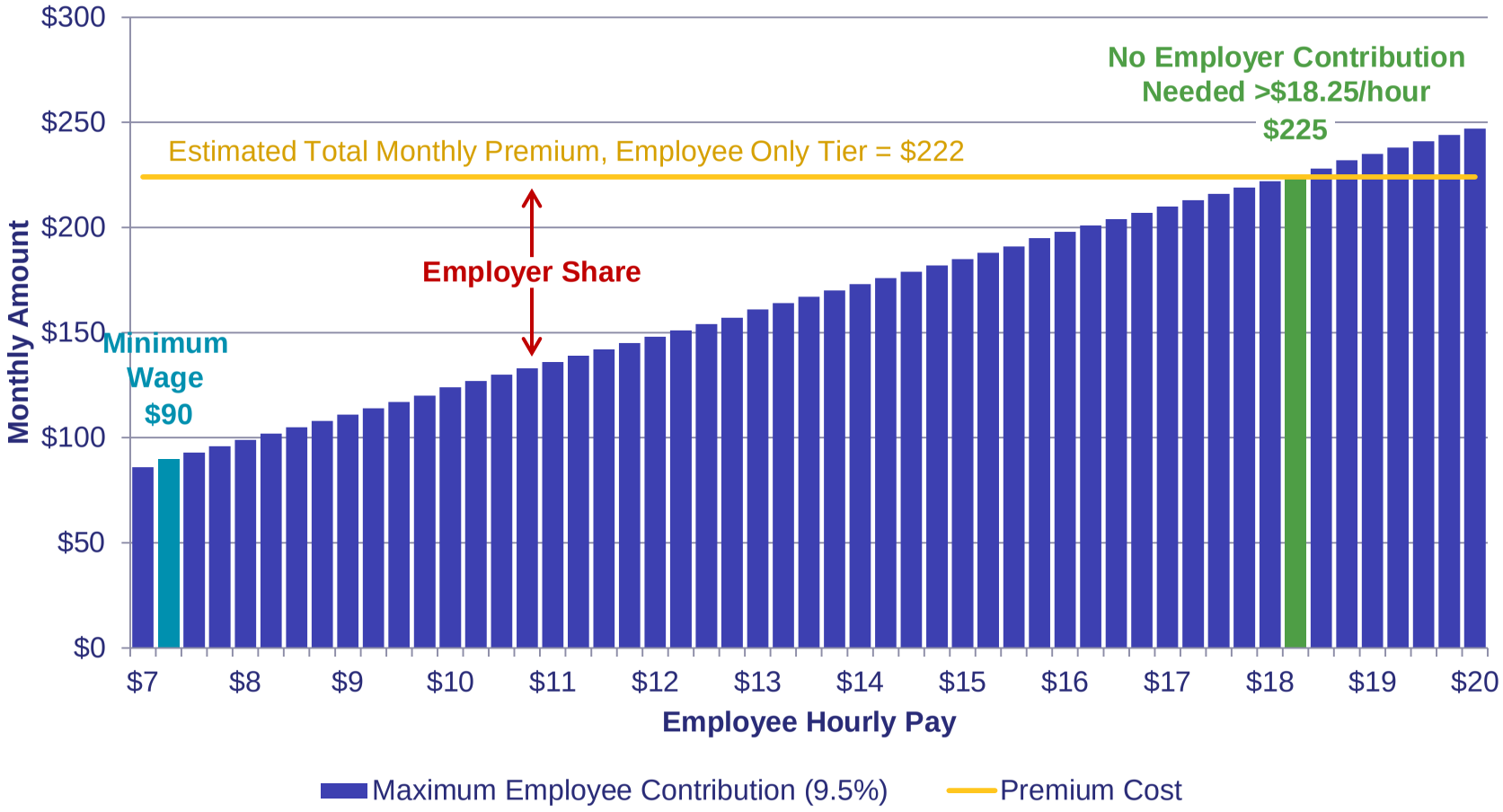
# Sample Premium Sharing (Bronze Plan): Employee/Employer Contributions in Four Pay Bands

| Pay Band | Employee Share | *Including UNC* Employer Share | *Excluding UNC* Employer Share |
|---|---|---|---|
| **Non-Permanent Employees in Pay Band 1** | | | |
| Employee Only | $90.00 | $132.00 | $156.00 |
| Employee + Child(ren) | $280.00 | $132.00 | $156.00 |
| Employee + Spouse[1] | $505.00/$549.00 | $132.00 | $156.00 |
| Employee + Family | $611.00 | $132.00 | $156.00 |
| **Non-Permanent Employees in Pay Band 2** | | | |
| Employee Only | $124.00 | $98.00 | $122.00 |
| Employee + Child(ren) | $314.00 | $98.00 | $122.00 |
| Employee + Spouse[1] | $539.00/$583.00 | $98.00 | $122.00 |
| Employee + Family | $645.00 | $98.00 | $122.00 |
| **Non-Permanent Employees in Pay Band 3** | | | |
| Employee Only | $173.00 | $49.00 | $73.00 |
| Employee + Child(ren) | $363.00 | $49.00 | $73.00 |
| Employee + Spouse[1] | $588.00/$633.00 | $49.00 | $73.00 |
| Employee + Family | $694.00 | $49.00 | $73.00 |
| **Non-Permanent Employees in Pay Band 4** | | | |
| Employee Only | $222.00 | $0.00 | $24.00 |
| Employee + Child(ren) | $412.00 | $0.00 | $24.00 |
| Employee + Spouse[1] | $637.00/$681.00 | $0.00 | $24.00 |
| Employee + Family | $743.00 | $0.00 | $24.00 |

| Pay Bands | | |
|---|---|---|
| **Pay Band 1** | | |
| **Pay Unit** | | **to** |
| Hourly | up to | $10.00/hour |
| Monthly | up to | $1,300.00/month |
| Annual | up to | $15,600.00/year |
| **Pay Band 2** | | |
| **Pay Unit** | **from** | **to** |
| Hourly | $10.01 | $14.00/hour |
| Monthly | $1,300.01 | $1,820.00/month |
| Annual | $15,600.01 | $21,840.00/year |
| **Pay Band 3** | | |
| **Pay Unit** | **from** | **to** |
| Hourly | $14.01 | $18.00/hour |
| Monthly | $1,820.01 | $2,340.00/month |
| Annual | $21,840.01 | $28,470.00/year |
| **Pay Band 4** | | |
| **Pay Unit** | **from** | |
| Hourly | $18.01/hour | or more |
| Monthly | $2,340.01/month | or more |
| Annual | $28,470.01/year | or more |

1. Segal has estimated that the total premium in the employee + spouse tier would disproportionally higher due to selection

# Affordability: Employee and Employer Shares (Bronze Plan with UNC included)




- A minimum wage ($7.25/hour) employee working 30 hours/week could be required to contribute $90/month
- A 30-hour per week employee making over $18.25/hour could pay the entire $222 projected monthly premium with 9.5% of pay

# Decision Points: What Plan to Offer and Who is Included?

- The General Assembly determines eligibility for State Health Plan benefits and has provided some indication that they would like to offer newly eligible employees something different than the current Plan offerings.
- OSHR is working with legislative staff on statutory language to allow the Plan to provide these employees a different, more affordable benefit offering.
  - The Plan provided input regarding the statutory change and is monitoring the process to ensure that we can administer what is enacted.
  - The authorizing language will likely be included in the budget.
- The UNC system has expressed interest in offering their own plan due to their more favorable risk pool.
  - Allowing individual employing units to opt out of SHP coverage may have adverse implications to other employees and the Plan's authority.

# Decision Point:
# Setting Employee and Employer Contributions

## Statutory language will likely provide guidance on the premium contribution structure

- Considered options include:
  - **Option 1:** Set employee contribution at 9.5% of expected income; employer pays the remaining amount
    - Pros: Minimizes employer contribution
    - Cons: Administratively difficult
  - **Option 2:** Set employee contribution at 9.5% of lowest-paid employee (approx. $90/month); employer pays the remaining amount
    - Pros: Establishes a set employer contribution (approx. $134/month); simplifies administration
    - Cons: Higher employer costs
  - **Option 3:** Set several (2-5) pay bands with employee contributions equal to 9.5% of lowest-paid employee within each pay band; employer pays the remaining amount
    - Pros: Reduces administrative burden and employer contribution
    - Cons: Fairness issues for pay rates just above or just below a cut point for a higher employee share

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

# Medicare Primary and Open Enrollment Outreach

***Board of Trustees Meeting***

**May 30, 2014**

# Medicare Advantage Member Outreach Efforts

# Humana Member Outreach Efforts

| Jan | Feb | March | April | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|

- ❖ Welcome Calls / Humana Health Assessment to New Members and Ongoing Follow-Up Calls
- ❖ Guidance Center HAO Walking Program – Greensboro, Raleigh
- ❖ Events Page Live on Humana's Dedicated NCSHP Landing Page
- ❖ New Member Orientation Events with Silver Sneakers
  - ❖ Locations Finalized
- ❖ BH2U Meetings
  - ❖ Locations Finalized
- ❖ AE Meetings
  - ❖ Tent. Dates: 9/8-10/24
- ❖ NCRGEA District Meetings
  - ❖ April 22-25; Charlotte, Gastonia, Concord
- ❖ Humana Vitality / WellBeing Tour
  - ❖ Locations TBD
- ❖ NCRGEA District Meetings
  - ❖ October 2014; Wilkesboro, Boone, Hickory, Statesville, Cullowhee, Asheville, Hendersonville

# Humana Member Outreach Efforts

- Welcome Calls/Humana Health Assessments
  - 40% participation rate with Health Assessments
  - 54% of participants have been referred to clinical programs
- SilverSneakers Participation
  - More than 2,000 members have enrolled
- Invalid Phone Number Communication Piece
- In-Home Assessment Co-Branded Letters
- Humana Vitality Packets

Humana Vitality®

# Humana Member Outreach Efforts

*New Member Orientation Events: March 31 – May 28*

**Purpose:** To educate members on their Humana benefits, give them an opportunity to ask questions about their plan, and highlight the SilverSneakers' program

- Total number of events: 48
- Main locations: Asheville, Charlotte, Winston-Salem, Greensboro, Raleigh, and other towns around the state
- Invitations were sent to all NC resident addresses; RSVPs are required
- Shared invitation with key partners:
  - Provider partners will help promote events at their offices
  - NCRGEA posted invitation on its website as another way to promote events

# Humana Member Outreach Efforts

*New Member Orientation Events: March 31 – May 28*

- Anticipate meeting with **more than 1,000 retirees**
- Frequent questions:
  - Do I still have Medicare?
  - Is Original Medicare billed as primary?
  - How does the Medicare Advantage plan work?
  - Why do I only have one ID card?
  - Does Tricare coordinate with my benefits?
  - Do I have international coverage?
  - Am I responsible for initiating prior authorizations?
  - What is the difference between copays and coinsurance?

# Humana Member Outreach Efforts

*Bringing Humana to U: June/July*

**Purpose:** To educate members on their Humana benefits, value-added services, and showcase the SilverSneakers' program

- Proposed number of planned events: 18-20
- Proposed timeframe: June/July 2014
- Target areas include more rural locations; 20 mile radius
- BH2U events are typically hosted at SilverSneakers' facilities
- Members are given a tour of the facility and encouraged to sign up on-site

# UnitedHealthcare Outreach Efforts

| Programs | Timeline |
|---|---|
| HouseCalls | Ongoing |
| Health Risk Assessment | Ongoing |
| Solutions for Caregivers | Spring Mailer |
| Annual Wellness Direct Mail and Emails | April 2014 |
| Benefits U Healthfair | March 2014 |
| New Medical EOB Mailer | March 2014 |
| Diabetes Opt In and Birthday Blast Emails | March 2014 – Ongoing |
| hiHealthInnovations Mailer | Feb 2014 |
| Positivity Kit | Feb 2014 |

# UnitedHealthcare Outreach Efforts

*Benefits U - Member Engagement*

- An opportunity for new North Carolina State Health Plan members to get more value out of their health benefits by attending a healthfair. The events were designed to facilitate engagement with retirees. Healthfairs were held on March 17 in Greensboro and March 18 in Raleigh.
  - Members spoke with Customer Service Reps to ask questions about their claims or benefits.
  - Members spoke with onsite pharmacists to:
    - Review prescription and over-the-counter medications and answer question
    - **Discuss high risk medications**
      - **Address clinical concerns and formulary alternatives**
    - Look for safety issues
    - Discuss medication adherence
  - Members spoke to representatives from HouseCalls and hiHealthInnovations to learn more about their programs.

# UnitedHealthcare Outreach Efforts

*Benefits U - Member Engagement*

- Members received preventive screenings
  - 67 Screenings performed (Fasting was required to ensure most accurate results)
  - More than 130 screening appointments were made but due to an ice storm that hit Guilford and Wake Counties, many were unable to attend

- Benefits U Survey Results: (50 participated)
  - How helpful would you say Benefits U was?
    Not helpful: 0 Somewhat helpful: 8=16% Very helpful: 42=84%
  - Did you learn anything today that will help you take better care of your health?
    No: 4=8% Yes: 46=92%
  - As a result of attending Benefits U today, how do you feel about your UnitedHealthcare medical benefits plan?
    Worse: 1=2% About the same: 13=26% Better: 36=72%

# UnitedHealthcare Outreach Efforts

*HouseCalls: Uniquely Impactful*

| Member Engagement | Status | Description |
|---|---|---|
| 2,241 | Completed | Had HouseCalls Visit |
| 483 | Scheduled | Scheduled for a Visit |
| 3,652 | Attempted | Called member, unable to reach or schedule a visit |
| 2,692 | Refused | Called, refused visit |
| 11,863 | Cancelled* | Visit cancelled via member or provider; Or made max call attempt to reach member; Or no valid phone number avail |
| 3,249 | Open | Scheduled for a call |

# UnitedHealthcare Outreach Efforts

*HRA (High Risk Assessment)*

- 2014 Health Risk Assessment (Health Survey)--a CMS requirement for the Plan--within 90 days of new members enrolling in an MA plan. Members are **not** required to participate in the survey.

| Number of Completed Assessment | Number of Refusal to Participate |
|---|---|
| 30,343 | 21,570 |

# Pre-65 Outreach Campaign Update

# Pre-65 Outreach Sessions Update


- More than 500members have registered to attend.
- To date,14 of the 39 meetings have been held in the following counties:
  - Buncombe
  - Burke
  - Iredell
  - Wake
  - Durham
  - Wayne
- 378 members have been in attendance

Red =Events completed
Green =Events scheduled

# 2015 Open Enrollment Outreach Plan

# Active/Non-Medicare Primary Member Outreach

| **HBR Trainings** | |
|---|---|
| Webinars | August |
| Face-to-Face Sessions | August |
| NC Flex HBR Meetings (State Agencies) | September |
| **Member Direct Mailings** | |
| Decision Guide | September |
| Reminder Postcard | October |
| **Member Outreach Meetings** | |
| Webinars | September-October |
| **Partner Outreach** | |
| Ongoing Communication | September-October |

# Retiree/Medicare Primary Outreach

| **Direct Mailings** | |
|---|---|
| Outreach Meeting Invitation | August |
| Decision Guide | September |
| Reminder Postcard | October |
| **Outreach Meetings** | |
| More than 80 meetings statewide | September-October |
| Retirement Association Partnerships | September-October |

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FOR TEACHERS AND STATE EMPLOYEES

# 2014 Member Satisfaction Survey

***Board of Trustees Meeting***

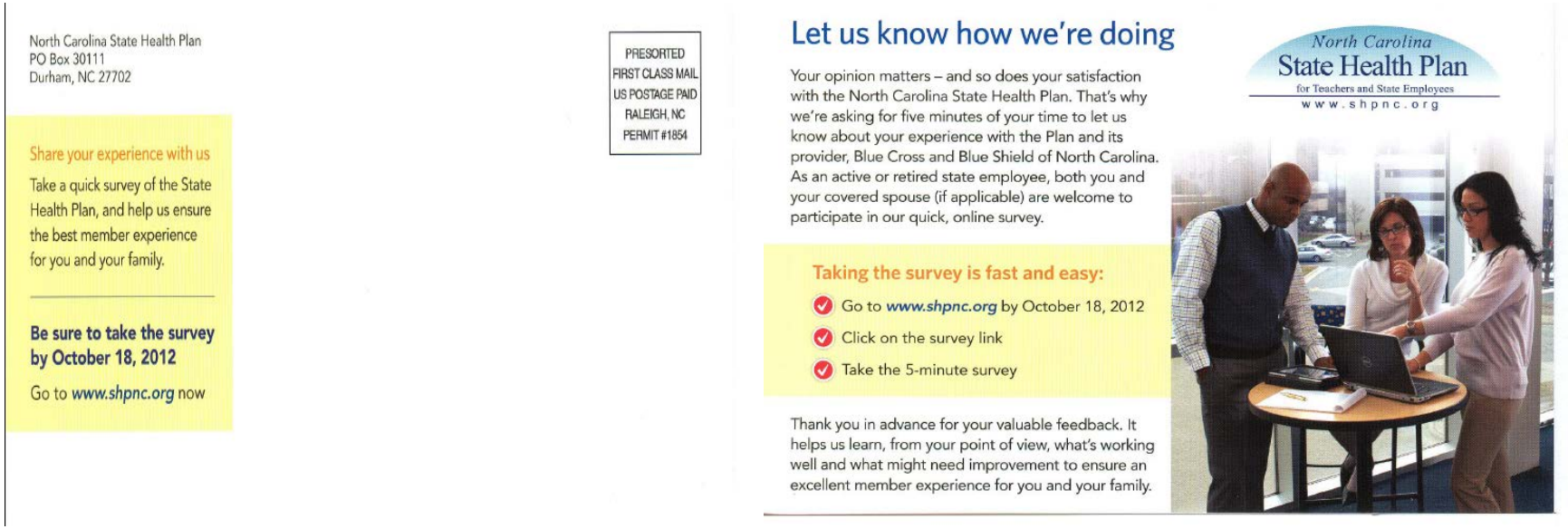
**May 30, 2014**

A Division of the Department of State Treasurer

# Membership Satisfaction Survey: *2011 & 2012*

- **Focus** - Member communication, customer service and plan design
- **Purpose** – Solicit member feedback to support customer experience improvements, plan design changes and new offerings.
- **Process** – All members received a postcard inviting them to participate in the online survey. Survey was also promoted via the SHP website and newsletters.

## 2011 Member Postcard



# Membership Satisfaction Survey*: 2011 & 2012*

- In 2011, the online survey received 4,766 respondents.
  - Results found that Plan members were generally satisfied with some of the service and communications attributes, but there were certain areas that needed improvement.
    - 35% of Plan members were very happy with the current plan offered by the Plan
    - 26% were not very happy at all
    - 39% were in between

- In 2012, the online survey received 10,468 respondents.
  - Results found that members were more satisfied with the various services/features associated with the Plan than the previous year.
    - 54% of active members and 36% of retirees were interested in High Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs)
    - 44% of the respondents were satisfied with the Plan – an increase of 9 percentage points from the last year. The number of respondents dissatisfied with the plan decreased by the same percentage points from 2011 to 2012.

# 2014 Membership Satisfaction Survey Approach

- Per conversations with the BOT, SHP staff is researching two ways to solicit feedback from members.
  - *All Member Survey*
    - **Focus**: Customer Experience, Overall Satisfaction
    - **Approach**: Similar to more recent surveys
      - Survey all members utilizing online tool through BCBSNC
      - Communicate survey via member mailing, newsletters and website
    - **Status:**
      - Verbiage reviewed by Plan Staff,  BOT Comm Group, DST Comm
      - Ready to move forward with a summer implementation
  - *Patient Experience Survey*
    - **Focus:**  Information gathered through this survey will set the baseline on member experience and concerns as the Plan implements PCMH model of care and payment reforms intended to influence the member experience, quality and cost of care.
    - **Approach:** Longer, more in-depth survey administered to a randomly selected, representative sample group with roughly 3,500 responses.
    - **Status:** This survey is still in the discovery phase.
      - Vendor options are under review
      - Anticipate a first quarter 2015 implementation

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# Member Experience and Satisfaction Survey

Follow the numbering for either MP, Medicare-Primary, or AE, Active Employee/Retiree.

## Confirmation of 2014 State Health Plan Election

**1 MP & AE. What level of plan coverage do you have with the State Health Plan?**

- ☐ Employee/Retiree only
- ☐ Employee/Retiree and child/children only
- ☐ Employee/Retiree and spouse only
- ☐ Family
- ☐ No State Health Plan coverage → Prompt: "Thank you for your feedback. We have no additional questions for you at this time." [Redirect to SHPNC.org]

**2 MP & AE. Do you have Medicare as your primary coverage due to age or disability?**

- ☐ Yes →Prompt #3 MP
- ☐ No → Prompt #3 AE

**3 MP. As a Medicare-primary State Health Plan member, which plan design did you choose for the 2014 benefit year?**

- ☐ Traditional 70/30 Plan
- ☐ Humana Medicare Advantage Base Plan
- ☐ Humana Medicare Advantage Enhanced Plan
- ☐ UnitedHealthcare Medicare Advantage Base Plan
- ☐ UnitedHealthcare Medicare Advantage Enhanced Plan
- ☐ I am not sure which plan I have for the 2014 benefit year

**3 AE. As a State Health Plan member, which plan design did you choose for the 2014 benefit year?**

- ☐ Traditional 70/30 Plan
- ☐ Enhanced 80/20 Plan
- ☐ Consumer-Directed Health Plan (CDHP)
- ☐ I am not sure which plan I have for the 2014 benefit year

**4 AE. What were your top reasons for choosing one plan design over another for the 2014 benefit year? (Select up to three)**

- ☐ The cost of monthly premiums
- ☐ The annual out-of-pocket or coinsurance maximums on medical and pharmacy services
- ☐ The copay or cost associated with each doctor visit or prescription
- ☐ Having preventive services, medications, and/or prescriptions covered at 100%
- ☐ The cost of dependents
- ☐ Having a Health Reimbursement Account (HRA) to offset your out-of-pocket expenses
- ☐ The presence or lack of wellness activities to lower monthly premiums
- ☐ The existence of other insurance such as Tricare

MP= Medicare Primary Retiree
AE=Active Employee/Retiree

**4 MP. What were your top reasons for choosing one plan design over another for the 2014 benefit year? (Select up to three)**

- ☐ The cost of monthly premiums
- ☐ The annual out-of-pocket or coinsurance maximums on medical and pharmacy services
- ☐ The copay or cost associated with each doctor visit or prescription
- ☐ Having preventive services, medications, and/or prescriptions covered at 100%
- ☐ The cost of dependents
- ☐ The existence of other insurance such as an Individual Medicare Advantage Plan, an Individual Part D Plan or Tricare

## Wellness Benefit Use

**5 MP.** IF SELECTED 70/30 PLAN, SKIP TO #6 MP & AE: **Which of the following services have you used since January 1, 2014? Please select all that apply.**

- ☐ Silver Sneakers fitness program
- ☐ Preventive services and screenings
- ☐ QuitlineNC's multi-call program
- ☐ None of the above
- ☐ Other (please specify):_____

**5 AE.** IF SELECTED 70/30 PLAN, SKIP TO #:6 MP & AE. **Which of the following services have you used since January 1, 2014? Please select all that apply.**

- ☐ Primary care visit with the provider listed on my health benefits card
- ☐ Preventive services, screenings, and medications covered at 100%
- ☐ Health and wellness services through NC Health*Smart*
- ☐ Specialty care from a Blue Options Designated Specialist
- ☐ Inpatient care from a Blue Options Designated Hospital
- ☐ None of the above
- ☐ Other (please specify):_____

**6 MP&AE. List your most preferred method or methods of receiving information from the State Health Plan. (Select up to three)**

- ☐ State Health Plan website (shpnc.org)
- ☐ Member Focus, the monthly electronic State Health Plan newsletter
- ☐ Email communications
- ☐ Printed material mailed to my home
- ☐ Mobile application for my phone
- ☐ Group meetings or presentations at my worksite
- ☐ Through my Health Benefits Representative



MP= Medicare Primary Retiree
AE=Active Employee/Retiree

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## Pharmacy Benefits

**7 MP&AE. Using a scale of 1-10, where a "10" means completely satisfied and "1" means completely dissatisfied, how satisfied or dissatisfied are you with the following since January 1, 2014:**

| | Completely Satisfied | | | | | | | | | Completely Dissatisfied | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | N/A |
| A. Your prescription drug benefits through the State Health Plan | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| B. The communicated information about your prescription benefits | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| C. The counseling you receive from your pharmacist on the prescriptions you take | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| D. The customer service I receive when I call any of the numbers on my ID card for assistance | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**8 MP&AE. What prevents you from taking your medication(s) on a regular basis?**

- ☐ I take my medications as prescribed
- ☐ Copay is too expensive
- ☐ Side effects of the prescription drug
- ☐ Just forget due to distractions
- ☐ Medication does not work
- ☐ I don't want people to know I need this medication
- ☐ I do not take any medications

## Access and Care

**9 MP & AE. In the last 12 months, how often were you able to find out how much you would have to pay for health care services or equipment that you needed? For example, equipment could include a hearing aid or a glucose meter.**

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**10 MP & AE. In the last 12 months, did you delay or not get any of the following services because of the cost? Please select all that apply.** (Trend 2005 Q16, 2007 Q11 modified, 2010 Q10a modified)

- ☐ Preventive care screening(s) such as a colon cancer screening or mammogram
- ☐ Doctors visit due to cold or other sickness
- ☐ Prescription refills
- ☐ Other (please specify):_____

MP= Medicare Primary Retiree
AE=Active Employee/Retiree

**11 MP & AE. Which of the following have you visited within the past 12 months? Please check all that apply.**

- ☐ Primary care provider
- ☐ Specialist
- ☐ Emergency room
- ☐ Inpatient hospital facility
- ☐ Outpatient hospital facility
- ☐ None of the above → Skip to question #14

**12 MP & AE. Does your Primary Care Provider give you resources to help you understand and manage your health? For example, resources to help you manage your diabetes or maintain a healthy weight.**

- ☐ Yes
- ☐ No
- ☐ Unsure

**13 MP & AE. Does your Primary Care Provider communicate with your specialist(s) to provide you with the highest level of care?**

- ☐ Yes
- ☐ No
- ☐ I'm unsure

→ All responses skip to #15 MP & AE

**14 MP & AE. What reason most closely matches why you have not visited a Primary Care Provider within the last 12 months?**

- ☐ I have no need because I have not been sick
- ☐ I do not have a primary care provider
- ☐ It is difficult to find time to go see a provider
- ☐ I cannot afford the copay to see a primary care provider

## Member Information

**15 MP & AE. Are you male or female?**

- ☐ Male
- ☐ Female

**16 AE. How would you best classify where you work?**

- ☐ University
- ☐ Community College
- ☐ State Agency
- ☐ School System
- ☐ UNC Healthcare
- ☐ Retired



MP= Medicare Primary Retiree
AE=Active Employee/Retiree

**16 MP. How many years have you been retired from the State?**

- ☐ Less than 1 year
- ☐ 1-3
- ☐ 4-6
- ☐ 7-10
- ☐ 11+

**17 MP & AE. Which of the following statements describes your health habits? (Select all that apply.)**

- ☐ I am mindful of my eating habits
- ☐ I exercise on a regular basis (4 or more days a week)
- ☐ I always wear my seatbelt
- ☐ I do not use tobacco products
- ☐ I maintain a low level of stress
- ☐ I receive a flu shot every year
- ☐ I work with my doctor and other health care professionals to improve my health
- ☐ None of the above
- ☐ Other (please specify): _____

## Additional Feedback

**Please include any comments or ideas you would like the State Health Plan to consider regarding the following areas.**

| | |
|---|---|
| Plan options available for 2014 | |
| Resources to help you maintain a healthy lifestyle | |
| Pharmacy benefits | |
| Access and services from primary care providers, specialist, hospitals, and the State Health Plan | |
| Communications from the State Health Plan | |
| Additional comments | |

MP= Medicare Primary Retiree
AE=Active Employee/Retiree

**AE. END OF SURVEY**

"Thank you for your time and participation. Your feedback will help the State Health Plan continue to offer the highest quality of service for its members.

For additional information on benefits offered to you through NC Health*Smart*, the State Health Plan's healthy living initiative, click HERE."

**MP. END OF SURVEY**

"Thank you for your time and participation. Your feedback will help the State Health Plan continue to offer the highest quality of service for its members.

For more information about your benefits, please visit the State Health Plan's website by clicking HERE."



MP= Medicare Primary Retiree
AE=Active Employee/Retiree

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

# Eligibility and Enrollment Services (EES) Contract

***Board of Trustees Meeting***

**May 30, 2014**

# Eligibility and Enrollment Services Contract Update

Over the last several months, the Plan has been exploring alternative arrangements for Eligibility and Enrollment Services (EES)

## Exploratory Steps

- Developed/Updated RFP
- Identified and Met with Potential Vendors
- Detailed Requirement Review Sessions with Potential Vendors and SHP Partners

## Legal Analysis

- Authority to Sole Source EES Contract
- Advisory Letter from Department of Justice/Attorney General

## Contract with Aon Hewitt

- Drafting Letter of Intent
- Drafting Contract

## Project Management & Implementation

- Additional Project Management Resources
- Benefitfocus Transition Support

# Eligibility and Enrollment Services Contract

- The groundwork for next week's implementation "kick-off" meeting was laid during vendor discovery sessions conducted in late March.
- It was during these sessions that the Plan determined that Aon Hewitt is the only vendor that currently provides all of the services the contract requires.
- The Plan is developing an implementation path to facilitate a full transition to the Aon Hewitt platform by July 1, 2015.

# Eligibility and Enrollment Services Contract Timeline

## Next Steps

- **Today - Communicate EES Change to Employing Units**
  - HBR Alert
  - Letter to each Employing Unit
- **Next Week – Planning Session**
  - State Health Plan, Aon Hewitt and SHP Partners, including TPAs, BEACON, Retirement System
  - Develop an implementation management approach
- **June & July – Engage Employing Units**
  - Form workgroups
  - Establish ongoing communication/feedback process
- **June, July, August –Finalize Contract**
  - Early implementation work will be handled through a letter of intent (LOI) with Aon-Hewitt
  - Final contract expected for BOT approval by the end of August 2014

# Eligibility and Enrollment Services Contract Implementation

- It is important to note that the 2015 Open Enrollment will be conducted on the Benefitfocus platform.
- At this time we do not anticipate moving any employing units to the Aon Hewitt platform prior to 2015.
- The goal is to have everyone transitioned to the Aon Hewitt platform by July 2015 to allow several months of normal enrollment activity/maintenance prior to the 2016 Open Enrollment.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

# Opportunity for Improved Care Coordination: Admissions, Discharge and Transfer Data from NC Hospital Association

***Board of Trustees Meeting***

**May 30, 2014**

# Background

- North Carolina hospitals participating in the North Carolina Hospital Emergency Surveillance System- Investigative Monitoring Capability (NCHESS-IMC) have technology in place to capture real time admission, discharge and transfer (ADT) information.
- North Carolina Hospital Enterprises (NCHE), which is hospital owned, participates in the administration of the NCHESS-IMC program, and can facilitate the sharing of ADT feeds with the Plan.
- 61 hospitals currently have this technology and NCHE captures admission, discharge and transfer data from these facilities.
- These 61 hospitals will cover approximately 70% of hospital admissions for Plan members.
- It is anticipated that this capability could reach over 100 hospitals in the near future.
- Medicaid uses this type of data to manage its population.

# Background Continued

- Hospital sharing of data with the Plan is voluntary and hospitals will have to sign the requisite agreements, allowing NCHA/contractors to collect and send the data to the Plan.
- NCHA Board is committed to this initiative and has passed a resolution in support.
- This data will support the Plan's strategic plan for population health management.

# Population Health Management Strategy

**Receipt of this data can assist the Plan with its goal to reduce avoidable hospitalizations, hospital readmissions and emergency department utilization:**

- In 2013, the hospital admission rate for active members was 54/1000 with an all cause readmission rate of 7.9/1000. The average cost of admission was $14,806.
- The hospital admission rate for Pre-Medicare Retirees was 69/1000 with an all cause readmission rate of 15.7/1000. The average cost of admission was $22,782.
- Emergency department costs represent $146 million in annual medical costs (4.2% of spend).
- The data will provide useful information to address:
  a. Transition of care
  b. Medication Therapy Management (MTM)/medication reconciliation/medication adherence

# Value to the Plan

- Helps the Plan improve care management and care coordination.
- Provides the Plan and hospitals with information that can used to potentially prevent avoidable and costly hospital readmission.
- Creates better collaboration within the continuum of health care services.
- Data will be used by the Plan's population health management vendor, ActiveHealth Management to:
  - Develop criteria for high priority members who will benefit from care transition.
  - Deliver care transition services including medication reconciliation, follow up appointments and visits.
  - Evaluate cost-benefit by year three of implementation.

# Estimated Timeline

| | |
|---|---|
| August 2014 | • SHP and NCHA to execute contract for data sharing<br>• Execute contracts and DUAs with GDAC/SAS and Active Health Management<br>• GDAC will receive data 60-90 days from execution of participation agreement between SHP and NCHA |
| October 2014 | • ActiveHealth Management to complete system changes |
| December 2014 | • NCHA will be responsible for having hospital participation agreements executed in all 61 hospitals<br>• Development of care coordination program complete |
| 2015 | • Full implementation complete<br>• The data will be delivered by NCHA contractor 'Truven Health Analytics' to 'Government Data Analytic Center (GDAC)' three times daily |

# Appendix: *Data Elements*

a. *State Employee Health plan Group Number*
b. *Hospital patient ID*
c. *Patient Name*
d. *Patient DOB*
e. *Patient Gender*
f. *Patient Address*
g. *Patient Phone*
h. *ED/Inpatient facility*
i. *DOA*
j. *Chief complaint*
k. *ICD 9 and CPT codes*
l. *ED disposition*
m. *Discharge date*
n. *Caregiver names ( Attending, Consulting and Admitting)*

North Carolina
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FOR TEACHERS AND STATE EMPLOYEES

# Pharmacy and Therapeutics Committee
# May 13, 2014, Meeting Summary

***Board of Trustees***

**May 30, 2014**

# Updates to Utilization Management Programs

| Programs | Update |
|---|---|
| Hepatitis C Agents Prior Authorization | Allow coverage to follow updated guidelines from the American Association for the Study of Liver Diseases |
| Immunomodulator (Revlimid) Prior Authorization | Include coverage for all FDA approved indications and clarify medication regimens according to the National Comprehensive Cancer Network (NCCN) |
| Rheumatoid Arthritis Prior Authorization | Add double step therapy requirement to Actemra, Xeljanz and Kineret policies |
| Psoriasis Prior Authorization | Add double step therapy and add criteria for new psoriatic arthritis medication, Otezla |
| Nasal Steroids Step Therapy | Allow Nasacort OTC as a step 1 product |
| Cystic Fibrosis (Kalydeco) Prior Authorization | Add additional FDA approved indications for coverage |
| Topical Pain Reliever (Diclofenac) Prior Authorization | Add new generic products as targeted products |
| Cholesterol lowering (Omega 3 Fatty Acids) Prior Authorization | Add new generics and brand product Omtryg as targeted products |
| Asthma (Xolair) Prior Authorization | Allow coverage for new indication of chronic idiopathic urticaria |
| Sedative Hypnotic Step Therapy | Include generic Lunesta as a preferred product |
| Pulmonary Hypertension Prior Authorization | Add new product, Orenitram, to the program |

# New/Revised Utilization Management Programs Reviewed

| Program | Indication | Description | Member Impact | Estimated Projected Savings | P&T Recommendation | Target Implementation Date |
|---|---|---|---|---|---|---|
| Hetlioz (tasimelton) | Non-24-Hour Sleep-Wake Disorder | Prior Authorization | (no current utilization) | Product cost-$8,400/month/ eligible member | Yes | October |
| Oral Brand Long-Acting Opioids | Pain | Step Therapy | 1,817 | $1,255,827 | Yes | November |
| Oral Generic and Brand Long-Acting Opioids | Pain | Quantity Limits | 375 | $405,474 | Yes | November |

# New Drugs for Formulary Consideration

| Drug | Indication | Tier Placement |
|---|---|---|
| **Quartette** (ethinyl estradiol/levonorgestrel tablets) | Pregnancy Prevention | 3 |
| **Prolensa** (bromfenac 0.07% ophthalmic solution) | Ophthalmic pain and inflammation | 2 |
| **Simbrinza** (brinzolamide 1%/brimonidine 0.2% ophthalmic suspension) | Glaucoma | 3 |
| **Trokendi XR** (topiramate extended-release capsules) | Epilepsy | 3 |
| **Esomeprazole strontium** | Acid-Peptic Disorders | 3 |
| **Tivicay** (dolutegravir tablets) | HIV | 2 |
| **Fetzima** (levomilnacipran extended-release capsules) | Major Depressive Disorder | 3 |
| **Brintellix** (vortioxetine tablets) | Major Depressive Disorder | 3 |
| **Namenda XR** ( memantine extended-release capsules) | Alzheimer's Disease | 2 |

# Nexium 24HR Over-the-Counter Coverage

- The Plan currently covers all generic and brand over-the-counter Proton Pump Inhibitors (PPIs) used to treat heartburn for a $5 copay for 42-day supply (70/30 and 80/20 plans). CDHP members are responsible for their deductible and 15% coinsurance.
- **June 1, 2014 Nexium 24HR will be added to this coverage.**
- Members must obtain a prescription for Nexium 24HR in order to receive prescription coverage.
- Members currently using prescription Nexium will save over $700 per year by switching to the OTC product.
- This coverage does not apply to Medicare Advantage plans.

North Carolina State Health Plan
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**Pharmacy and Therapeutics Committee**
**Meeting Summary**
**May 13, 2014**

Tracy Stephenson welcomed the committee members and notified the committee that the State Health Plan should have a new medical director by the next meeting. She also informed the committee that the Plan will be presenting its Strategic Plan at the May Board of Trustees meeting, and that the Strategic Plan will be shared at an upcoming P&T meeting. Dr. Sally Morton ensured there were no conflicts of interest for members with any of the discussion items.

Sally Morton discussed the following updates to 11 State Health Plan pharmacy coverage management rules for the Traditional pharmacy benefit.

- The Hepatitis C agents prior authorization program will allow coverage for the combination use of Sovaldi and Olysio in interferon ineligible treatment-naïve/relapse patients or in prior non-responders per updated guidelines from the American Association for the Study of Liver Diseases.
- The Revlimid (lenalidomide) prior authorization program now allows coverage for mantle cell lymphoma to include coverage for all FDA approved indications and clarifies medication regimens according to the National Comprehensive Cancer Network (NCCN).
- The double step therapy requiring the use of preferred agents Humira and Enbrel first was added to the Rheumatoid Arthritis prior authorization program for Actemra (tocilizumab), Xeljanz (tofacitinib) and Kineret (Anakinra).
- The double step therapy requiring the use of preferred agents Humira and Enbrel first was added to the Psoriasis prior authorization program for Stelara (ustekinumab). Also new medication Otezla (apremilast) indicated for psoriatic arthritis was added to the prior authorization program.
- Nasacort OTC was added as a step one product in the Nasal Steroids step therapy program.
- Additional FDA approved indications were added to coverage for Kalydeco (ivacaftor) for cystic fibrosis.
- In the Topical Diclofenac prior authorization program, generic diclofenac epolamine patch (Flector) and generic diclofenac sodium topical solution (Pennsaid) will be added as targeted products.
- The Omega 3-Fatty Acids prior authorization program will include generic omega 3-acid ethyl esters (Lovaza) and new brand product Omtryg.
- Coverage for new indication of chronic idiopathic urticara is added to the Xolair (omalizumab) prior authorization program to include all FDA approved indications.
- Generic eszopiclone (Lunesta) is added to the Sedative Hypnotic step therapy program as a preferred product.
- New oral prostacyclin vasodilator Orenitram (treprostinil) is added to the pulmonary arterial hypertension prior authorization program.

Several new prior authorization programs were reviewed and approved:

- Hetlioz, a melatonin receptor agonist, is indicated for the treatment of Non-24-Hour Sleep-Wake Disorder and studies establishing its efficacy included patients who were totally blind and reported no light perception. It is a highly advertised and a very expensive specialty medication. A prior authorization program was recommended for Hetlioz coverage because of the specialized skills required for evaluation and diagnosis of patients with Non-24, and treatment should be limited to patients who are totally blind with no perception of light. The committee agreed with the recommendation for the prior authorization requirement and also quantity limits of 30 capsules per month. This program will be implemented this Fall.
- The Plan is focusing on programs to target fraud, waste and inappropriate use of controlled substances. One potential program to decrease the use of high cost, highly abused brand name long-acting opioids is to require the use of a generic long-acting opioid product prior to the use of a brand name long-acting opioid product. The step therapy program would require the use of generic first unless the member is unable to tolerate or has a drug allergy noted with morphine sulfate, or if they are pregnant or have renal insufficiency. In addition to the step therapy program it was recommended to implement quantity limits per 30 days on the long-acting generic and brand opioids. Additional quantities for Avinza, Embeda, Exalgo, Kadian, MS Contin, Oramorph SR, Nucynta ER (50mg, 100mg, 150mg), Opana ER, Oxycontin, Zohydro ER and applicable generics can be approved if the provider indicates the member has intractable pain from a chronic condition. The committee agreed with the step therapy and quantity limit program recommendations; however, they noted that these programs should be a part of a comprehensive approach to chronic pain management for members, which should also include disease and case management. These programs will be implemented this Fall.

The committee reviewed the following new drugs for formulary consideration:

- Quartette (ethinyl estradiol/levonorgestrel) – Quartette is an extended-cycle oral contraceptive similar to Seasonale, Seasonique and LoSeasonique. It differs in that it is a four phasic therapy with ascending doses of ethinyl estradiol designed to decrease days of unscheduled bleeding. It appears to be similar in efficacy to other extended-cycle oral contraceptives. Whether it causes fewer days of unscheduled bleeding and spotting remains to be established. Recommended May Add due to the similar efficacy to the other extended-cycle products. It will remain Tier 3 for the 70/30 Plan, and will be included in the ACA preventive drug list contraceptive coverage.
- Prolensa (bromfenac 0.07% ophthalmic solution) – Prolensa is a once daily ophthalmic nonsteroidal anti-inflammatory indicated for the management of pain in the postoperative setting. There is no comparative data to the other once daily products. Currently only have generics as preferred on PDL (Bromfenac is once daily generic available). Recommended May Add, and it will be placed in Tier 2.
- Simbrinza (brinzolamide 1%/brimonidine tartrate 0.2% ophthalmic suspension) – Simbrinza is a unique combination of carbonic anhydrase inhibitor brinzolamide and alpha-2 agonist brimonidine used for glaucoma. It may be used first-line, but must be dosed three times a day. It is an attractive combination product since it does not include timolol and appears effective in lowering intraocular pressure. Recommended May Add, and it will be placed in Tier 3.

- Trokendi XR (topiramate extended-release tablets) – Trokendi XR is an extended-release topiramate indicated for epilepsy that was approved on existing data from Topamax. It may be helpful to have a once daily product, but it cannot be crushed or used in a G-tube. There is no increased tolerability or side effects over the regular release product. It is recommended May Add, and it will remain in Tier 3.
- Esomeprazole strontium delayed-release capsules – It is another esomeprazole product used for acid-peptic disorders with no different release mechanism or other nuance. There is also no comparative data to other proton pump inhibitors. Recommended May Add, and it will remain in Tier 3.
- Tivicay (dolutegravir tablets) – One of 3 integrase strand-transfer inhibitors (INSTI) used to treat HIV. It is non-inferior to other drugs, well-tolerated and can be given once daily unless resistant. It is included as a first line drug in latest HIV treatment recommendations. Recommended Must Add and will be placed in Tier 2.
- Fetzima (levomilnacipran extended-release capsules) – Fetzima is a serotonin and norepinephrine reuptake inhibitor (SNRI) only indicated for major depressive disorder. It is a more potent inhibitor of NE than SE reuptake which the clinical significance is unknown. There is nothing superior about Fetzima. It is recommended May Add, and it will remain in Tier 3. It will also remain a non-preferred product in the SNRI step therapy program.
- Brintellix (vortioxetine tablets) – Brintellix is a serotonin reuptake inhibitor and 5-$HT_3$ receptor antagonist indicated for major depressive disorder. This multimodal serotonergic activity has not demonstrated any clinical advantages. It is well tolerated and effective with a low incidence of sexual dysfunction and no effect on weight. Recommended May Add, and it will remain in Tier 3.

Other Topics –

- Due to the discontinuation of regular release Namenda (memantine tablets) prior to the release of the generic product in 2015, it was recommended to move the extended-release capsules Namenda XR to Tier 2. Namenda XR will be placed in Tier 2.
- The Plan currently covers all over-the-counter (OTC) proton pump inhibitor medications for only $5 for a 42-day supply in the 70/30 and 80/20 plans. Members in the Consumer-Directed Health Plan (CDHP) are responsible for their deductible and 15% coinsurance. June 1, 2014, the OTC version of Nexium (esomeprazole) 20mg capsules will also be covered with a written prescription. This coverage does not apply to Medicare Advantage plans.