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
Friday, January 31, 2014
9:00 a.m. – 3:00 p.m.

AGENDA

1.	Welcome	Janet Cowell, Chair
2.	Conflict of Interest Statement	Janet Cowell, Chair
3.	Review of November 22, 2013 Minutes ***(Requires Board Vote)***	Janet Cowell, Chair
4.	2014 Benefits – Implementation Update *(30 minutes)* A. Open Enrollment Final Results B. Open Enrollment Exceptions	Caroline Smart
5.	Hearing Aid Benefit *(15 minutes)* A. Follow-up on ACA Essential Health Benefits Discussion B. Reimbursement Methodology	Caroline Smart Jack Kenley BCBSNC
6.	Pharmacy & Therapeutics Committee Meeting Summary *(20 minutes)*	Sally Morton
	Break *(10 minutes)*	
7.	Follow up – Benefit Change Requests *(20 minutes)*	Mona Moon Tom Friedman Mark Collins
8.	Financial Report *(30 minutes)* A. December 2013 Financial Report B. Analysis of Incurred Claims Trend and Loss Ratios	Mark Collins

9. Health Plan Dashboard *(45 minutes)*
    A. Update on Dashboard Development & Process — Tom Friedman
    B. Dashboard Report, Quarter Ending October 31, 2013 — Mark Collins

Lunch *(30 minutes)*

10. Provider Payment Methodologies & Strategies *(60 minutes)* — Tom Friedman

11. Strategic Planning *(60 minutes)* — Tom Gualtieri-Reed
    A. Phase I Discovery Report
    B. Phase II Updates, Discussion & Next Steps

Executive Session (for Board members only) *(30 minutes)* — Janet Cowell, Chair
Pursuant to: G.S. 143-318.11 and G.S. 132-1.2

12. Consultation with Legal Counsel – Contract Issue — Lotta Crabtree
    (G.S. §143.318.11(a)(3))

13. Wrap-Up *(5 minutes)* — 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
FOR TEACHERS AND STATE EMPLOYEES

Open Enrollment Final Results

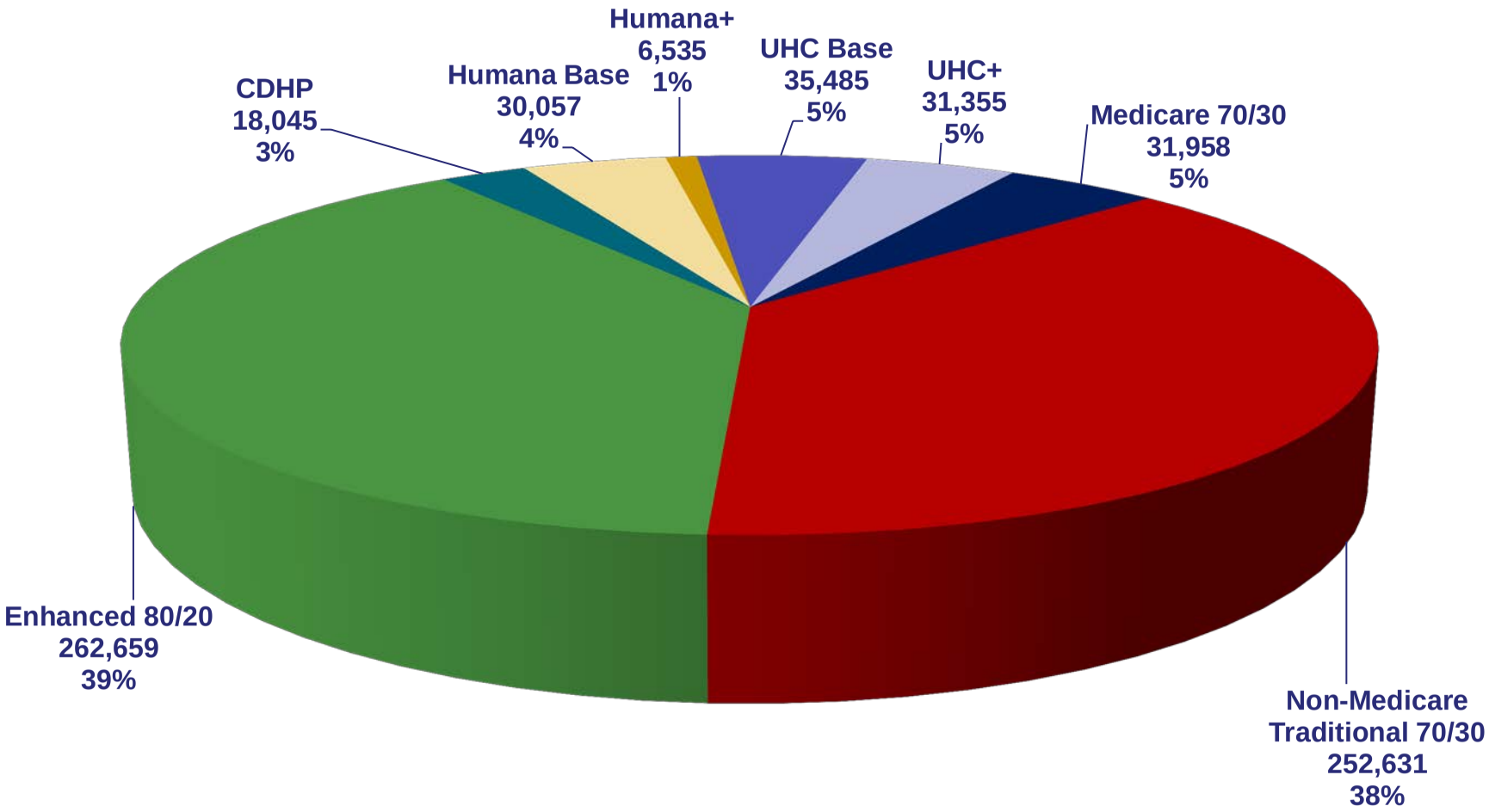
Board of Trustees Meeting

January 31, 2014

Open Enrollment – Final Results

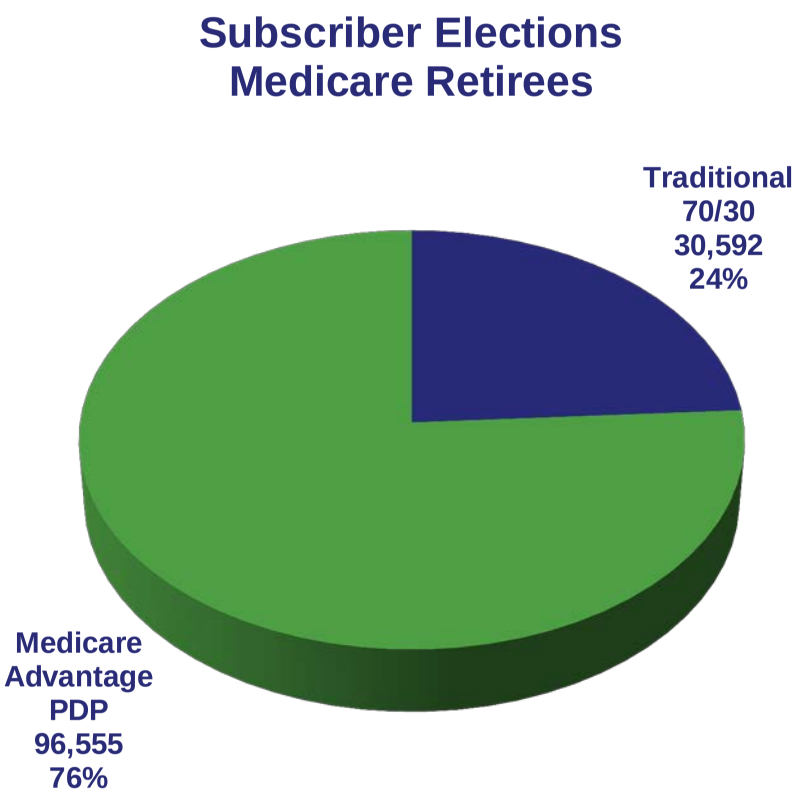
- Final Enrollment Counts
- Primary Care Provider (PCP) Elections
- Health Assessment Completions
- Personal Health Portal Registrations

Final Enrollment Counts – January 2014 Membership

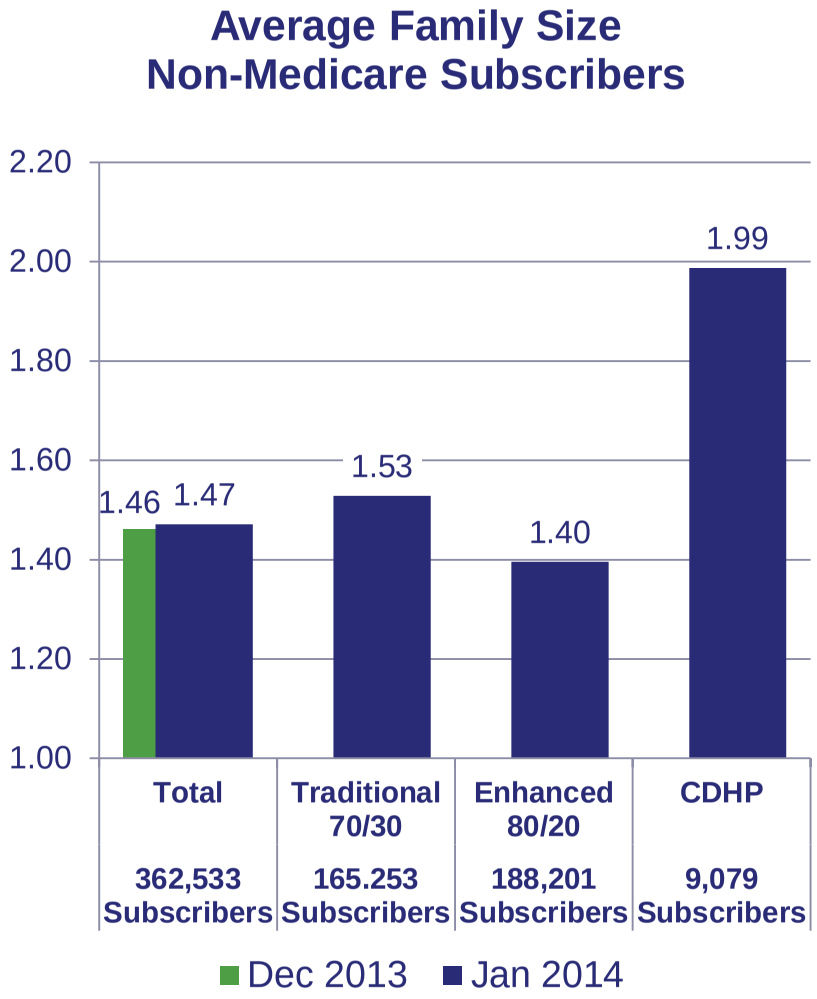


December 2013 Membership by Plan: 80/20 PPO = 64% 70/30 PPO = 36%

Final Enrollment Counts – January 2014 Subscribers



(Total Medicare Subscribers = 127,147)



Primary Care Provider (PCP) Election Update

PCP Specialty	Number of Members Selecting	Percentage of Total Selections
Family Medicine	156,870	51.17%
Internal Medicine	77,842	25.39%
Pediatrics	44,656	14.57%
OBGYN	16,157	5.27%
Nurse Practioner	7,390	2.41%
General Practice	3,552	1.16%
Physician Assistant	3	0.00%
*Unknown	73	0.02%
Total	306,543	

* BCBSNC researching “unknown” PCPs

Primary Care Provider (PCP) Visits

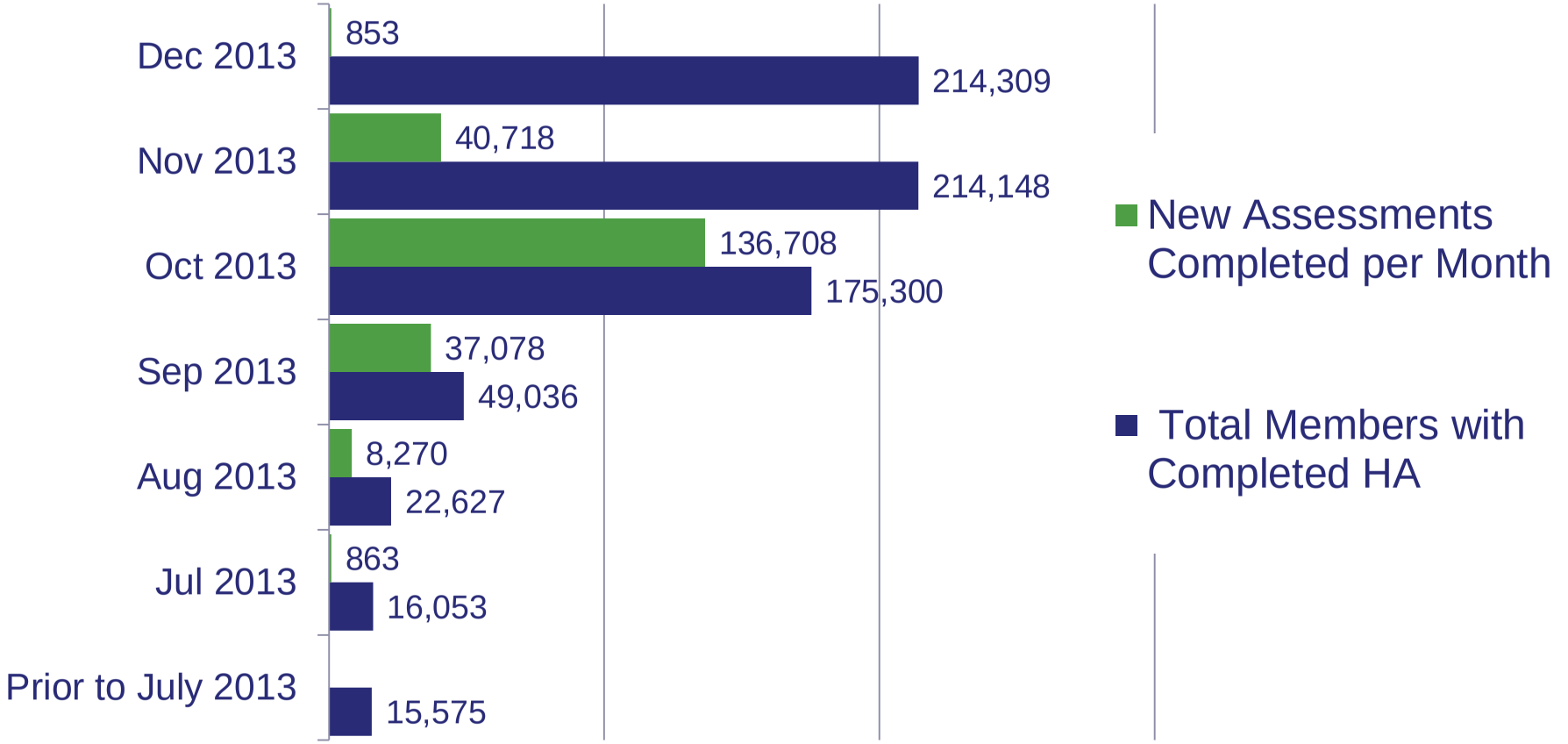
Measure	Percentage of All * Members
Percent of members who declared a PCP	45.41%
Percent of members who had any visit to the PCP they declared	0.01%
Percent of all office visits that were to member's declared PCP	0.00%
Percent of all PCP office visits that were to member's declared PCP	0.01%
Of members who declared a PCP, percent who had any visit to the PCP they declared	0.02%
Of members who declared a PCP, percent of all office visits that were to member's declared PCP	0.68%
Of members who declared a PCP, percent of all PCP office visits that were to member's declared PCP	1.14%

Claims Reporting Period Jul 1, 2013 – Oct 31, 2013: Paid through 12/31/13

** Includes non-Medicare and Medicare primary members*

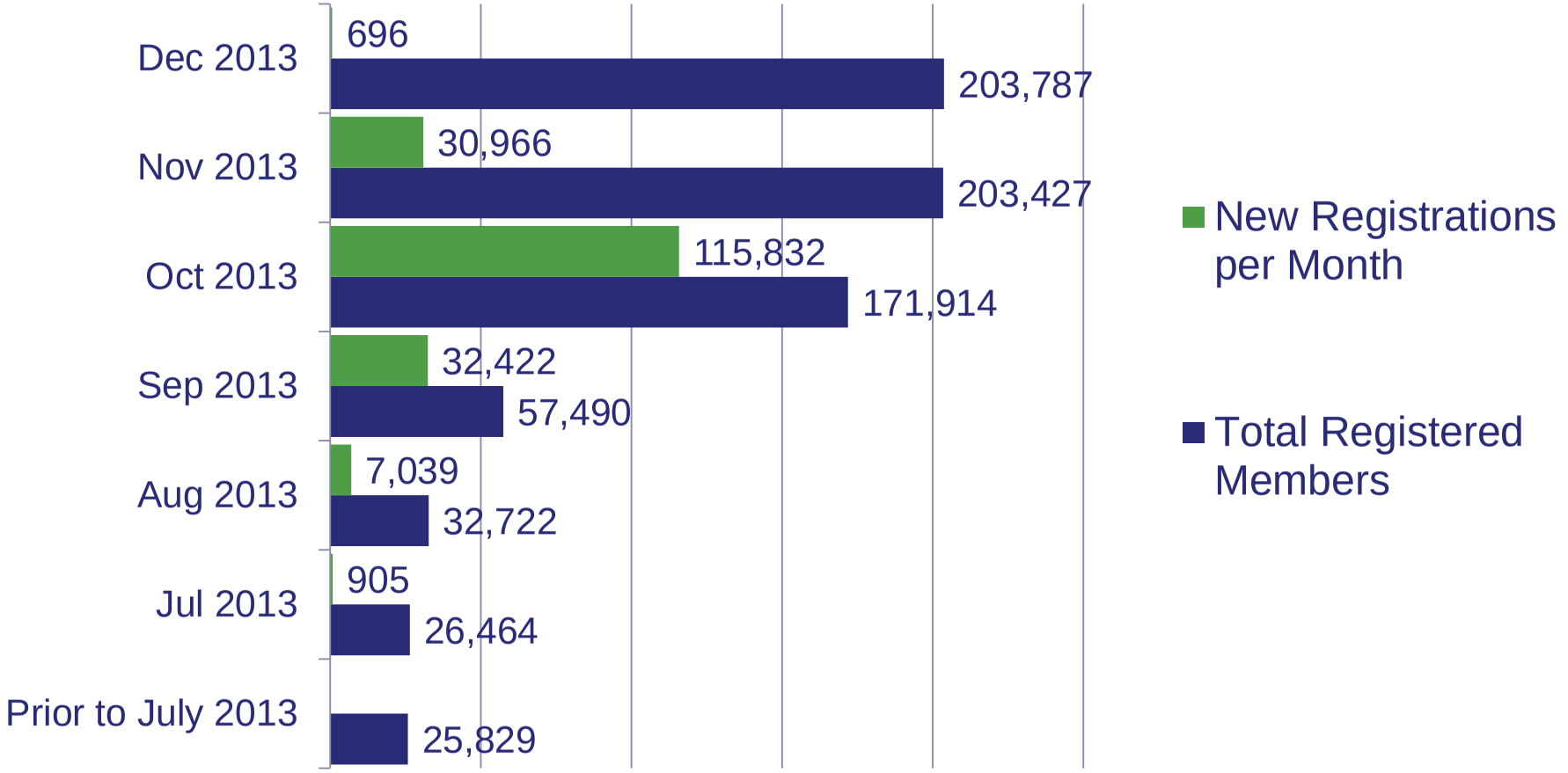
Health Assessment Completion Update

Health Assessment Completions	Total as of December 2013: 214,490



Personal Health Portal Usage Update

Personal Health Portal Registrations	Total as of December 2013: 203,787



North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Open Enrollment Exceptions

Board of Trustees Meeting

January 31, 2014

Exception Process

Submitting Exceptions

Active employees must submit exceptions through their Health Benefit Representative (HBR)

- The exception process has been communicated to all HBRs and is posted on the Plan's website.

Retirees submit their exceptions directly to the Plan

- Historically we have received very few retiree exceptions because retirees could enroll or drop coverage without a qualifying life event
- Effective January 1, 2014, a retiree's ability to change plan elections and add or drop coverage outside of open enrollment is subject to qualifying life events as defined by federal law, and for new retirees and retirees turning age 65, the MAPDP enrollment policy*

**See appendix for MAPDP enrollment policy*

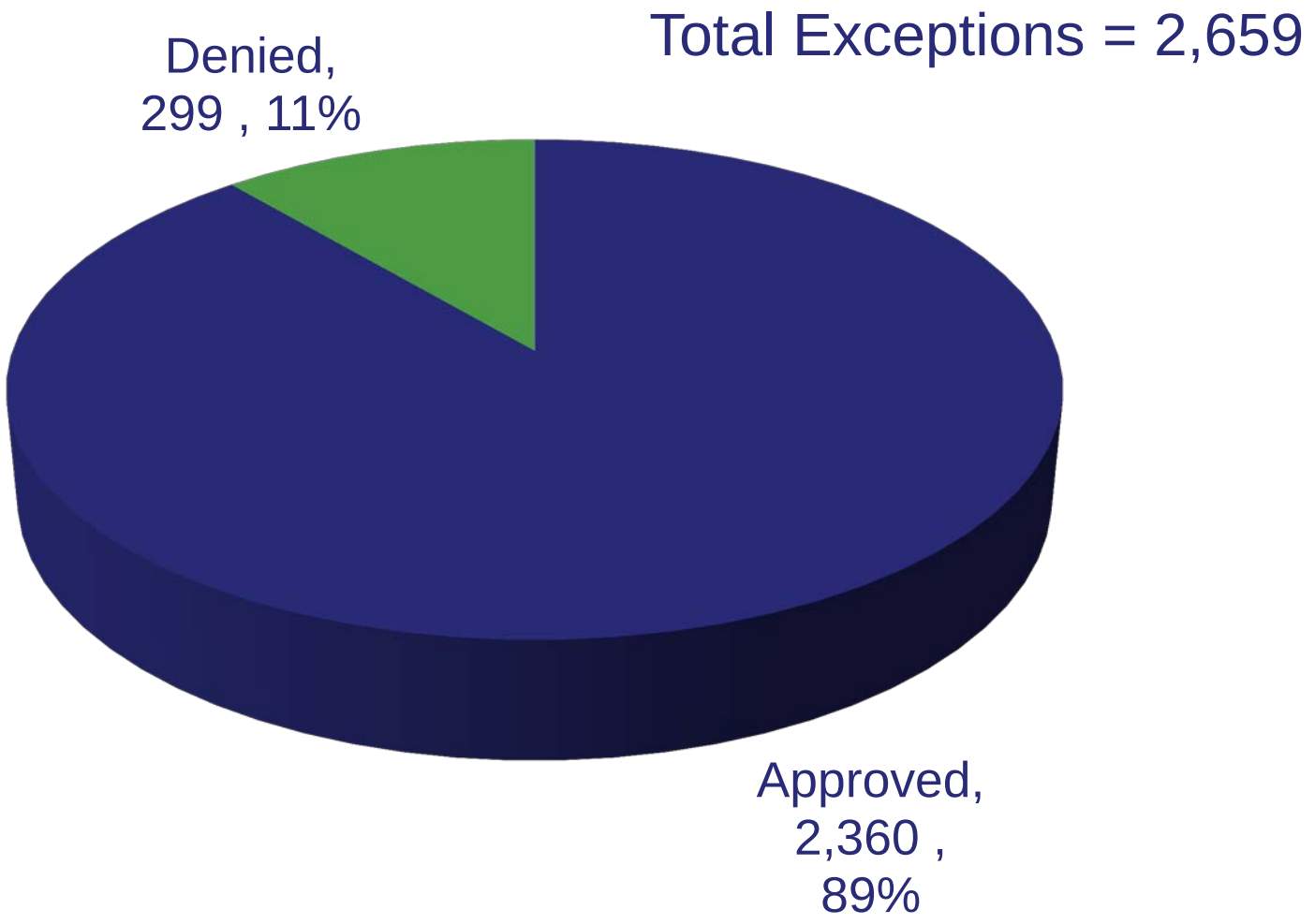
Exception Process

Reviewing Exceptions

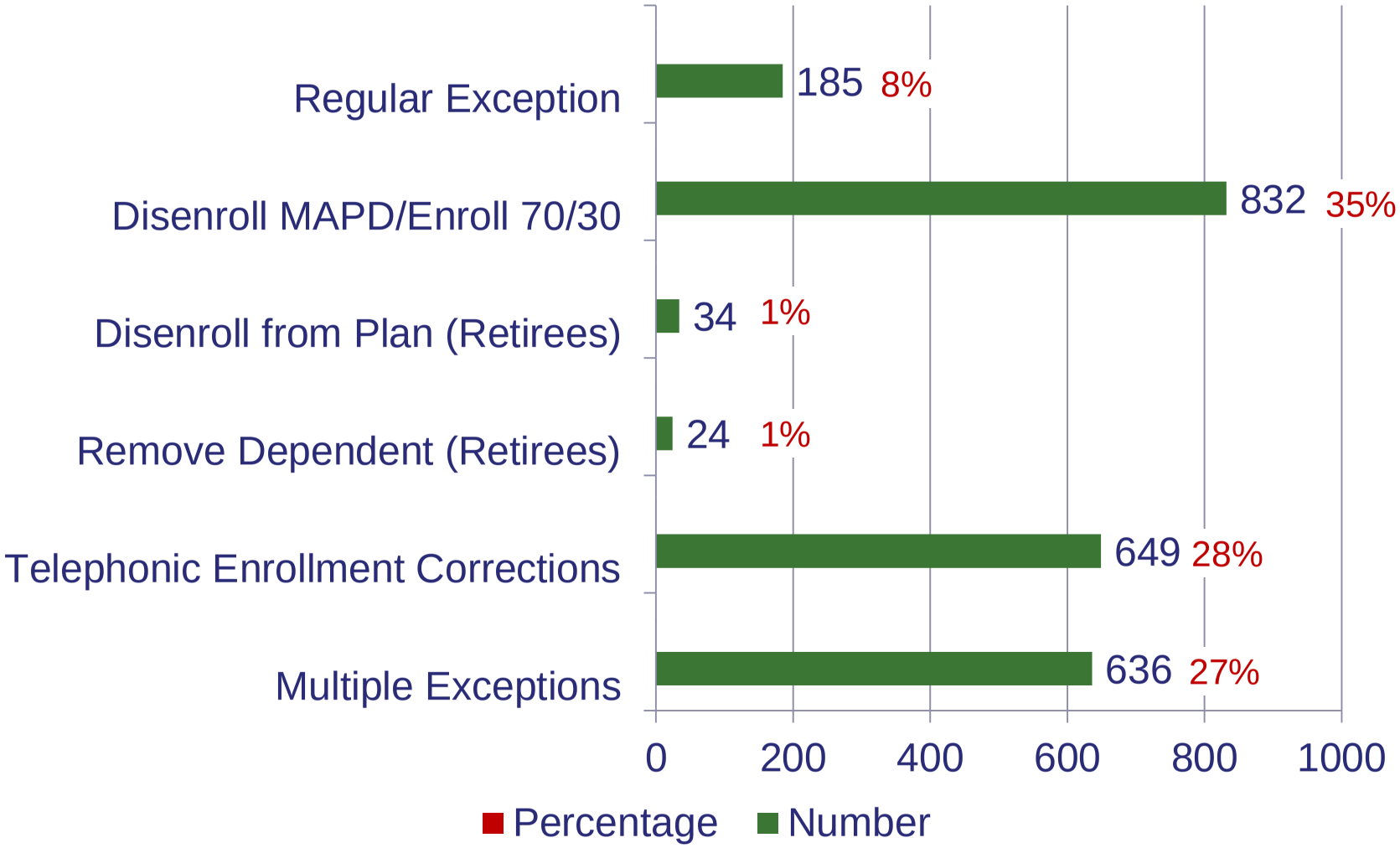
- The Plan follows the enrollment and eligibility requirements established in North Carolina General Statute and any applicable federal regulations
- Employees are held harmless by HBR errors
- Exceptions that require no additional information are generally resolved within three business days
- On average, the Plan receives approximately 40 exceptions each week

Open Enrollment Exceptions

November 18, 2013-January 14, 2014



Approved Open Enrollment Exceptions



Approved Open Enrollment Exceptions

- **"Regular" exceptions (185)** – exceptions we typically see during any OE.
  Some examples:
  - Newly hired/newly retired during the OE period
  - Misinformation from HBR
  - Dropped dependents or self in error (enrollment history captures subscriber OE enrollment)
  - Did not save online enrollment, but has a screen shots, enrollment history or other information to confirm enrollment activity
- **Dis-enrollments from assigned MAPDP and enrolled in Traditional 70/30 (832*)**
  - Took no action during OE
  - Change in plan selection allowed through February 14th per CMS regulations
- **Dis-enrollment from the Plan - Retirees (34)**
  - All of these members cited frustration with the process as a reason for the dis-enrollment
    - Call Center
    - Auto-enrollment
  - All stated they had other coverage

Does not include dis-enrollments handled telephonically by Benefitfocus

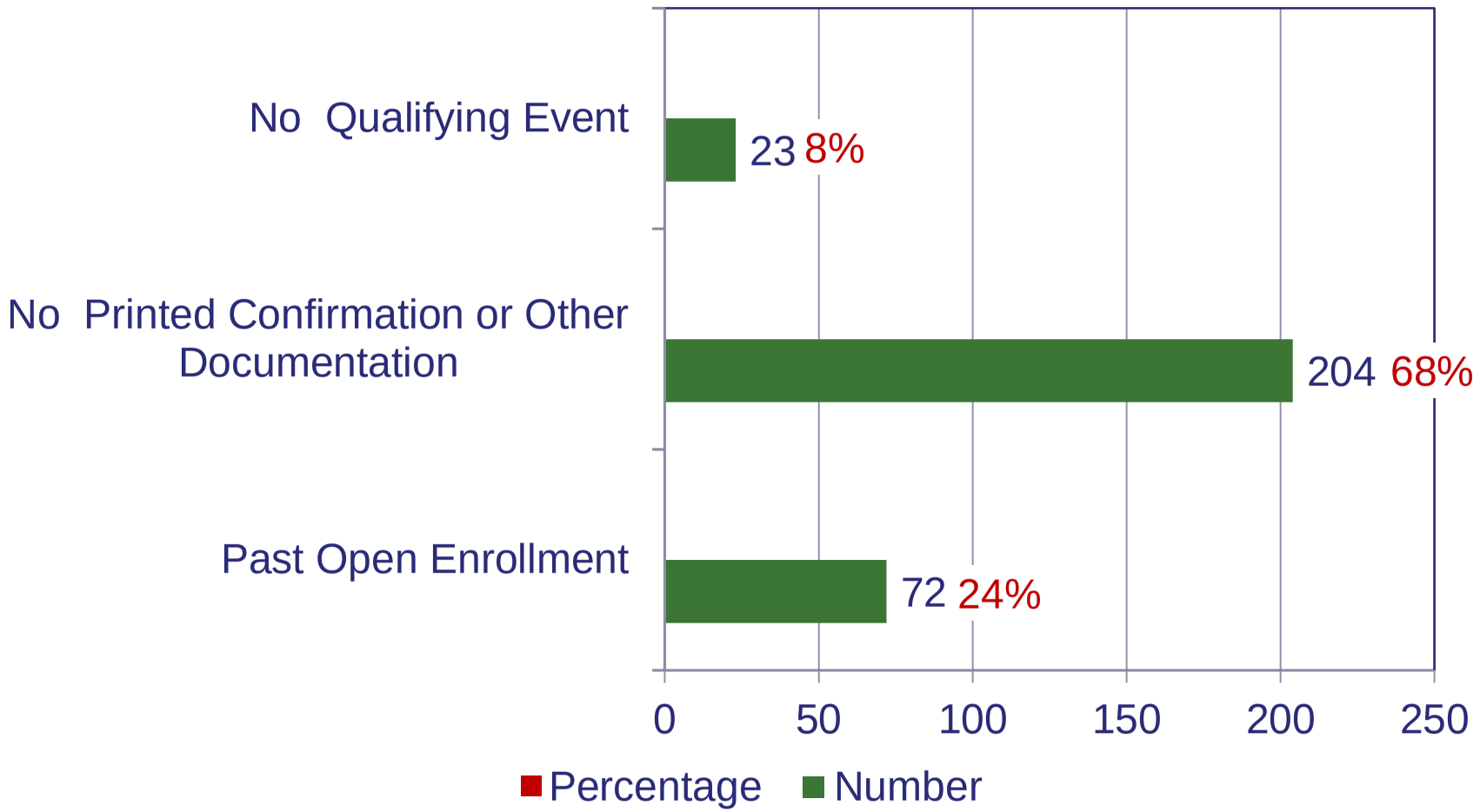
Approved Open Enrollment Exceptions

- **Dropped dependent – Retirees (24)**

- **Telephonic Corrections (649)**
  - Enrollment not processed correctly
  - Inaccurate information provided

- **Multiple Exceptions (636)** – Some members have called multiple times
  - Original exception not processed in a timely manner
  - Original exception not processed correctly
  - A subsequent change has over-written the original exception or change

Denied Open Enrollment Exceptions



Denied Open Enrollment Exceptions

- **No Qualifying Event (23**) – These members enrolled during OE and subsequently requested to drop a dependent. Active employee subscribers cannot drop a dependent without a qualifying life event.

- **No Printed Confirmation (204)** – These members stated they completed enrollment online, but they did not have a screen shot or confirmation statement, nor was there any available enrollment or "keystroke" history to confirm the enrollment. The Plan receives these types of exceptions following every open enrollment and always attempts to validate enrollment activity before denying the exception.

- **Past Open Enrollment (72)** – The member took no action during OE and now wants to make an enrollment election.

Open Enrollment Exceptions – Ongoing

While the exception request volume has decreased, several hundred exceptions have been processed since these results were gathered.

The Plan will continue to review the requests as they are received. Ensuring members are enrolled correctly is a priority.

Appendix

Retiree MAPDP Enrollment Policy
Originally Outlined in May 23, 2013 BOT Meeting

One of the most complex elements of the enrollment process is managing "split contracts," where one or more family members is eligible for SHP Primary benefits and other family members are eligible for Medicare Primary benefits.

Split Contract Enrollment Policy:

- When the retiree and dependents are both Medicare Primary or both SHP Primary, the dependents' enrollment will match the retiree's enrollment.
  - There is one exception: When all Medicare Primary retiree family members enroll in an MAPDP and CMS "dis-enrolls" one family member, the "dis-enrolled" family member will be enrolled in the Traditional 70/30 PPO Plan.

- When the retiree and dependents are split between Medicare Primary and SHP Primary, the Medicare Primary members will only be offered the Medicare Primary options. The SHP Primary members will only be offered the SHP Primary options. If there are multiple dependents on a separate contract from the retiree, all the dependents must elect the same option.
  - Example:
    - Retiree is Medicare Prime and is offered the 4 MAPDP options and the Traditional 70/30 plan – Retiree elects an Enhanced MAPDP
    - Dependents are SHP Prime and are offered the Enhanced 80/20 Plan, the CDHP, and the Traditional 70/30 PPO Plan - Dependents elect the CDHP

Retiree MAPDP Enrollment Policy
Originally Outlined in May 23, 2013 BOT Meeting

Auto-Enrollment Policy for Retirees Turning 65 or Entering the Retirement System at Age 65 or Older

Retirees/Dependents Turning 65 – No other family member is Medicare Primary:

- Auto-Enrolled in a base MAPDP 90 days prior to effective date and offered to elect any of the 5 options – Final election must be made 30 days before the effective date.

- **Retirees/Dependents Turning 65 –** Family member(s) already Medicare Primary:
  - Auto-Enrolled into the same plan as other Medicare Prime family members. Notified of the enrollment and advised of the options available at the next open enrollment.

- **Active Member or New Retiree coming into the Retirement System age 65 or older:**
  - **Retires with at least 60 days notice –** Auto-Enrolled in a base MAPDP and offered to elect any of the 5 options – Final election must be made 30 days before the effective date.
  - **Retires with less than 60 days notice –** Auto-Enrolled in the Traditional 70/30 PPO Plan and advised of the options available at the next open enrollment.

SHP Hearing Aid Benefit

The State Health Plan for Teachers and State Employees' Board of Trustees

January 31, 2014

North Carolina State Health Plan
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BlueCross BlueShield of North Carolina

Overview of Fee Schedule Solution

- Analyzed claims data to develop the best pricing approach across all lines of business
- Decided to use reference based pricing (fee schedule solution) to reimburse providers
  - Without dollar limits; a pronounced fee schedule helps us manage plan impact in addition to the time limits
- Built hierarchy similar to DME reimbursement to establish consistency and accuracy
  - Contract % of CMS allowable
  - Contract % of Optum RVU (Relative Value Unit)
  - Contract % of national average billed
  - Contract % of invoice

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Pharmacy and Therapeutics Committee
November 2013 Meeting Summary

Board of Trustees

January 31, 2014

Pharmacy Benefits

	Description	Traditional 70/30 Plan	Enhanced 80/20 Plan	Consumer-Directed Health Plan
Tier 1	Most cost-effective medications, which includes mostly generic drugs.	$12 per 30-day supply	$12 per 30-day supply	15% coinsurance after deductible (in-network) 35% coinsurance after deductible (out-of-network)
Tier 2	Preferred brand medications, including some high cost generic drugs and compound drugs.	$40 per 30-day supply	$40 per 30-day supply	
Tier 3	All other non-preferred brand drugs for which alternatives are available in lower tiers.	$64 per 30-day supply	$64 per 30-day supply	
Tier 4	Preferred Specialty medications which may include some Biosimilar specialty medications.	25% coinsurance up to $100 per 30-day supply	25% coinsurance up to $100 per 30-day supply	
Tier 5	Non-preferred Specialty medications which may include some Biosimilar specialty medications.	25% coinsurance up to $150 per 30-day supply	25% coinsurance up to $150 per 30-day supply	
ACA Preventive Medications	List of preventive medications required by the Affordable Care Act (ACA) to be covered at 100%.	N/A	$0 (covered at 100%)	$0 (covered at 100%)
CDHP Preventive Medications	List of preventive medications used to help prevent and manage certain chronic health conditions.	N/A	N/A	15%, no deductible

For 80/20 and 70/30 Plans, **brand name drugs with a generic equivalent** – Member pays the Tier 1 copay plus the difference between the Plan's cost of the brand name drug and the Plan's cost of the generic drug, not to exceed $100 per 30-day supply of the brand medication.

Pharmacy Utilization Management

- Pharmacy Utilization Management programs apply to **all** pharmacy benefit plans (Traditional 70/30, Enhanced 80/20 and CDHP)

- **Prior Authorization Programs** – patient specific therapeutic review to ensure patient receives the most clinically effective treatment and to ensure appropriate prescribing

- **Quantity Limit Programs** – defined initial benefit allowances and coverage review available for higher quantities

- **Step Therapy Programs** – ensures the Plan preferred medications are used first unless the member has experienced treatment failure or intolerance to preferred agents

Pharmacy and Therapeutics (P&T) Committee

- Advisory panel of practicing physicians and pharmacists independent of the Plan in multiple specialty areas.
- Current specialties represented include Dermatology, Psychiatry, Neurology, Internal Medicine, Ophthalmology, Rheumatology, Infectious Disease, Family Practice, Retail Pharmacy and Managed Care Pharmacy.
- Co-chaired by Plan Medical Director and Clinical Pharmacist.
- Plan Pharmacy and Medical staff also participate.
- Meets quarterly to review clinical information relating to the pharmacy formulary or preferred drug list and policies.

P&T Committee Purpose

- To develop and review the prescription drug formulary and to ensure the formulary is appropriately revised to adapt to the release of new drugs on the market. The Committee does this by reviewing drug products and clinical programs related to their specialty for use by the Plan, and its members.

- The P&T Committee makes recommendations regarding tier placement of drugs on formulary, reviews and approves pharmacy utilization management clinical criteria (e.g., prior approval and quantity limitations), and provides input on other pharmacy issues including addition and deletion of drugs from the preferred drug list.

Plan Formulary Management Process

Pharmacy Benefit Manager (PBM)	• Provides manufacturer contracting information • Provides clinical reviews & PBM's P&T committee recommendations
P&T Committee	• Reviews new medication clinical information for tier placement and provides recommendations • Reviews proposed new and revised coverage management programs and provides recommendations
State Health Plan	• Implements preferred drug list and coverage management programs based on P&T recommendations & PBM impact analysis

November P&T Meeting
Updates to Utilization Management Programs

Programs	Update
Multiple Sclerosis Prior Authorization	Removal of the step therapy requirement for the oral products
Melanoma Prior Authorization	Revision to current program due to the approval of new medications
Pulmonary Hypertension Prior Authorization	Removal of the step therapy requirement for Letairis
Rheumatoid Arthritis (Cimzia) Prior Authorization	Add coverage for newly approved indications
Psoriasis (Stelara) Prior Authorization	Add coverage for newly approved indications
Anti-emetic Quantity Limits	Decision to maintain current limits
Rheumatoid Arthritis (Actemra SQ) Prior Authorization	Include this SQ formulation in the Rheumatoid Arthritis prior authorization program

November P&T Meeting
New Utilization Management Programs Reviewed

Program	Indication	Description	Member Impact	Estimated Projected Savings	P&T Recommendation	Target Implementation Date
New melanoma specialty medications	Skin Cancer	Prior Authorization	Current members will be grand-fathered	N/A	Yes	January
Epinephrine auto-injector	Allergic Reactions	Step Therapy	30	$336,000	Yes	April
Inhaled corticosteroids	Asthma	Step Therapy	1,175	$375,000	Yes	April
Rapid and intermediate-acting Insulin	Diabetes	Step Therapy	7,000	$6 million	Yes	July

November P&T Meeting
New Drugs for Formulary Consideration

Drug	Indication	Tier Placement
Invokana (canaglifozin tablets)	Diabetes	3
Liptruzet (ezetimibe/atorvastatin tablets)	Hypercholesterolemia	3
Diclegis (doxylamine succinate and pyridoxine hydrochloride delayed-release tablets)	Pregnancy associated nausea and vomiting	3
Fulyzaq (crofelemer delayed-release tablets)	HIV non-infectious diarrhea	3
Uceris (budesonide extended-release tablets)	Ulcerative Colitis	2
Osphena (ospemifene tablets)	Dyspareunia (Painful intercourse)	Plan excludes coverage for sexual dysfunction drugs

Pharmacy and Therapeutics Committee
Meeting Summary
November 12, 2013

Dr. Derek Prentice welcomed the committee members, and the committee members introduced themselves to Lotta Crabtree. Sally Morton ensured there were no conflicts of interest for members with any of the items for discussion.

Dr. Sally Morton discussed the following changes to seven State Health Plan pharmacy coverage management rules for the Traditional pharmacy benefit.

- The committee and Dr. Konanc discussed the removal of the step therapy requirement of a trial of 2 injectable products for Multiple Sclerosis (MS) prior to the use of the newer oral medications – Tecfidera, Gilenya and Aubagio. The recommendation was to remove the step therapy requirement on the oral products to align with updated standards of care for the treatment of MS. Also since Betaseron and Extavia are the same generic product, the Plan will prefer Betaseron.
- With the approval of newer specialty medications for the treatment of melanoma, the Zelboraf (vemurafenib) prior authorization criteria will be revised to account for the use of these medications.
- The pulmonary hypertension step therapy program will be removed for Letairis due to the approval of newer medications for the treatment of pulmonary hypertension and updated package labeling for Letairis. The Plan will also move to the ESI standard criteria for all of the pulmonary hypertension medications.
- The Cimzia (certolizumab) prior authorization criteria were updated to allow coverage for the new approved FDA indications of psoriatic arthritis and active ankylosing spondylitis.
- The Stelara (ustekinumab) prior authorization criteria were updated to allow coverage for the new approved FDA indication of psoriatic arthritis.
- Upon further Plan review of the ESI standard criteria for the anti-emetic quantity limits, it was decided to keep the quantity limits program as is and not update to stricter limits as discussed at the August P&T meeting.
- Since Actemra (tocilizumab) is now available in a subcutaneous formulation, prior authorization criteria allowing coverage for approved indications will be implemented along with step therapy requiring the use of the Plan's preferred agents Humira and Enbrel first.

Several new prior authorization programs were reviewed and approved:

- It was recommended to add new melanoma specialty medications Mekinist (trametinib) and Tafinlar (dabrafenib) to the Plan's prior authorization program. Dr. Flynn and the committee agreed with the recommendation and the ESI criteria. The Plan will implement 1/1/14.
- With the availability of a new epinephrine auto-injector, Auvi-Q, the Plan has the opportunity to prefer Epipen and Epipen Jr. in a step therapy program. Also while reviewing utilization of the epinephrine auto-injectors it was identified that members may receive large quantities for one copay. It was recommended to also add a quantity limit of two syringes per copay. The committee agreed with the preferred step therapy program and quantity limits for the epinephrine auto-injectors. The Plan will implement in April 2014.

- The Plan currently has all six inhaled corticosteroids as preferred products. If the Plan continues with all products as preferred there will be a loss of manufacturer rebates. The Plan recommended implementing a preferred drug step therapy program with several agents preferred. Since all inhaled corticosteroids are equally effective, the committee recommended that the Plan consider the delivery methods, ease of use and member disruption for the step therapy program. The Plan's formulary management committee will review and choose the preferred products for the step therapy program. The Plan will implement April 1, 2014.
- The Plan currently has all brands of insulin as preferred products. If the Plan continues to have all brands of insulin as preferred there will be a loss of manufacturer rebates. The Plan recommended implementing a preferred drug step therapy program with one major rapid-acting, short-acting, and intermediate-acting insulin brand preferred. The committee agreed that clinically all brands are equivalent, except Novolog may be better to use in insulin pumps. The utilization for the two major brands is equal; therefore, the committee recommended the Plan to pursue the most cost-effective option for a step therapy program and preferred products on the formulary. The Plan's formulary management committee will review and choose the preferred products for the formulary and step therapy program. The Plan may implement in the summer of 2014.

The committee reviewed the following new drugs for formulary consideration:

- Invokana (canagliflozin tablets) – First in a new class of diabetes medications, SGLT2 inhibitors. Recommended May Add due to its safety and efficacy for lowering Hb_{A1C} in appropriately selected patients; however, its place in therapy is still evolving with more medications in this drug class expected to be approved soon. It will remain in Tier 3.
- Liptruzet (ezetimibe/atorvastatin tablets) – Recommended May Add due to its similar advantages to other preferred statins. Ezetimibe has not proven to decrease cardiovascular morbidity or mortality. It will remain in Tier 3.
- Diclegis (doxylamine succinate and pyridoxine hydrochloride delayed-release tablets) - Combination of ingredients which are both available over-the-counter and are recommended as first line therapy for nausea and vomiting with pregnancy by ACOG. Since the OTC medications may continue to be used as a more cost-effective alternative to the fixed combination it is recommended May Add, and it will remain in Tier 3.
- Uceris (budesonide extended-release tablets) – Due to its unique formulation with targeted delivery specifically to the colon for the treatment of mild-to-moderate ulcerative colitis, it has the advantage of being an oral glucocorticosteroid with an improved safety profile compared to conventional glucocorticosteroids. Recommended May Add, and it will be in Tier 2.
- Fulyzaq (crofelemer delayed-release tablets) – This is the only medication approved for HIV non-infectious diarrhea. It appears to have modest efficacy. Historically patients with non-infectious diarrhea have switched antiretroviral therapy or used supportive measures. Recommended May Add and will remain in Tier 3.
- Osphena (ospemifene tablets) – It is indicated for the treatment of moderate to severe dyspareunia, and only proven effective for dyspareunia. Since the Plan does not cover sexual dysfunction medications, the committee agreed that Osphena should not be covered by the Plan. Osphena will be removed from coverage and current members using Osphena will be notified.

North Carolina State Health Plan
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Pharmacy and Therapeutics Committee
Meeting Summary
August 20, 2013

Dr. Derek Prentice welcomed the committee members, and the committee members introduced themselves to Mona Moon. Sally Morton ensured there were no conflicts of interest for members with any of the items for discussion.

Dr. Sally Morton discussed the following changes to thirteen State Health Plan pharmacy coverage management rules for the Traditional pharmacy benefit.

- The new generic for Travatan (travoprost) was added as a preferred agent in the Glaucoma step therapy program to include all generics as preferred agents.
- A new branded generic product extended release Desvenlafaxine was added as a non-preferred agent to the Pristiq step therapy program to include all brand SNRIs as non-preferred products.
- The Xeljanz (tofacitinib) step therapy program now requires the use of two biologics first instead of just one since Xeljanz is a non-preferred product.
- The Simponi (golimumab) prior authorization criteria were updated to allow coverage for the new approved FDA indication of moderate to severe ulcerative colitis.
- Due to the integration of the ESI/Medco criteria, the Kineret (anakinra) step therapy program requires a 3 month trial of another biologic first for rheumatoid arthritis, and it must be prescribed by a rheumatologist.
- Generic Atacand (candesartan) was added as a preferred agent in the Angiotensin Receptor Blocker step therapy program and multisource brand Atacand was added to the non-preferred agents.
- Multisource brands, Fosamax and Boniva, were added as non-preferred agents to the Bisphosphonate step therapy program.
- In the Triptan step therapy and quantity limit program, the new product Zecuity (sumatriptan transdermal patch) was added as a non-preferred agent and quantity limits added. Generic zolmatriptan and rizatriptan were added as preferred agents, and brand Zomig and Maxalt are non-preferred agents.
- In order to include all CNS stimulants used for ADHD in the prior authorization criteria, Zenzedi (dextroamphetamine) and Quillivant XR (methylphenidate extended release oral suspension) were added to the program.
- Due to a manufacturer contracting opportunity, Axiron (testosterone topical solution) will be added as a preferred option in the Androgen step therapy program along with Androgel.
- The Antiemetic quantity limits will be revised 1/1/14 to limit coverage to FDA approved dosing.
- In the Interferon prior authorization program, coverage for Pegintron and Pegasys will be added for acute hepatitis C and recurrent hepatitis following liver transplant based on revised treatment guidelines. Also CD4 cell count requirements for the coverage of Intron-A were changed from 400 to > 200.
- In the Hepatitis agent prior authorization program, coverage will be allowed in the post liver transplant setting based on new supporting data.

The committee discussed Specialty pharmacy management under the pharmacy benefit:

- The addition of new prior authorization programs for high-cost specialty medications used for rare diseases was discussed. The recommended new prior authorization programs include Arcalyst (rilonacept SC injection), Chenodal (chenodial tablets), Ilaris (canakinumab SC injection), Korlym (mifepristone tablets), Kuvan (sapropterin tablets), Promacta (eltrombopag) and Xenazine (tetrabenazine) to ensure these high-cost specialty medications are prescribed for the approved indications and the members are followed by a specialist. The committee reviewed the proposed approval criteria and agreed these medications should require prior authorization since there is a risk of them being prescribed for off-label indications, and they should be prescribed by an appropriate specialist. Prior authorization programs will be implemented for these medications January 1, 2014, and current users will be grandfathered.
- The Board approved a Tier 5 for its Traditional pharmacy benefit to include non-preferred specialty medications which may include some Biosimilar specialty medications with a 25% coinsurance up to $150 max per 30 day supply. The committee discussed the implementation of Tier 5 on January 1, 2014. The Plan recommended that all specialty medications will remain in or be placed in the preferred specialty tier (Tier 4) unless they are non-preferred in a step therapy program, there is a generic available for the brand or a Biosimilar is available. All specialty step therapy programs will continue to be reviewed by the committee, and the Biosimilar opportunities will be reviewed when available. The committee agreed with the recommendation and to move the current non-preferred specialty medications (those in step therapy programs or brands that have a generic available) to Tier 5. Affected members will be notified prior to the increased member coinsurance.

The committee also discussed the implementation of placing high-cost generics in Tier 2 as approved by the Board. The Plan recommended that initially only new high-cost (>$150 per 30 day supply) and/or exclusive single source generics be placed in Tier 2 until they become multi-source (available from multiple manufacturers) and the price drops < $150 at which time they would move to Tier 1. The Plan may evaluate high-cost generics due to large inflation currently on the market at a later time for potential placement in Tier 2. The latter would require member notification and P&T review; therefore, the Plan may assess implementation at a later date. The committee agreed with this approach; however, strongly supported moving existing generics with large price increases to Tier 2. The first new high-cost generics will be placed in Tier 2 after October 1, 2013.

Several new prior authorization programs were reviewed and approved:

- Due to the availability of many generic topical acne products, the Plan recommended a generic first step therapy program for topical acne medications, cleansers and combination kits. Dr. Flynn and the committee agreed with the recommendation. The Plan will implement in first quarter 2014.
- Also due to the availability of many generic topical corticosteroids, the Plan recommended a generic first step therapy program for topical corticosteroids. Dr. Flynn and the committee agreed with the recommendation. The Plan will implement in first quarter 2014.

- With the review of another prescription omega-3 fatty acid product (Vascepa), the Plan recommended a prior authorization program for Lovaza and Vascepa to ensure the appropriate use in members with high triglycerides only if the member has tried or is currently receiving another product used for hypertriglyceridemia. The committee agreed with the recommendation since there are so many alternatives to prescription omega-3 fatty acid products. The Plan will implement January 1, 2014.

The committee reviewed the following new drugs for formulary consideration:

- Vascepa (icosapent ethyl capsules) – recommended May Add due to its safety and efficacy for lowering triglycerides; however, over-the-counter fish oil is an alternative. It will remain in Tier 3 and prior authorization criteria implemented.
- Eliquis (apixaban tablets) – recommended May Add due to its similar advantages to other preferred anticoagulants. It will remain in Tier 3.
- Nesina (alogliptin), Kazano (alogliptin/metformin) and Oseni (alogliptin/pioglitazone) – recommended May Add due to comparable efficacy to other DPP-4 inhibitors. They will remain in Tier 3 and non-preferred in the DPP-4 inhibitor step therapy program.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Follow up – Benefit Change Requests

Board of Trustees Meeting

January 31, 2014

A Division of the Department of State Treasurer

Presentation Overview

- The Board expressed interest in receiving additional information on some of the benefit change requests presented at the November meeting

- The requests to be discussed include:
  - Coverage of Applied Behavioral Analysis for Autism Spectrum Disorders
  - Reduced Copays for Chiropractic Services

Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder

- Requestor: Lorri Unumb, Autism Speaks
- Requested Change: Addition of treatment for autism spectrum disorders, including coverage for applied behavioral analysis
- Rationale: With appropriate treatment, including ABA therapy, children with autism can overcome disabling aspects of the condition. Autism Speaks referenced a study that estimates the lifetime cost savings associated with appropriate treatment is $1 million per child.

NC General Assembly Consideration of ABA

- House Bill 498 Autism Health Insurance Coverage
  - Requires insurers to provide $36k maximum annual ABA benefit for individuals age 23 and younger, who were diagnosed prior to age 8
  - Prohibits limitations on the number of visits
  - Coverage cannot be denied on the basis that treatments are educational or habilitative
  - Coverage cannot be subject to cost sharing requirements that are more restrictive than those applied to substantially all other medical services
  - Passed House and referred to Senate Committee on Insurance

ABA Benefit Design Development

- Plan staff seeking expertise to assist with benefit design development for consideration by the Board
  - TEACCH Autism Program, UNC-Chapel Hill
  - BCBSNC
  - ValueOptions (BCBSNC's behavioral health subcontractor)
  - Autism Speaks

Applied Behavioral Analysis for Autism Spectrum Disorder

- Considerations
  - Provider credentialing and diagnosis
  - Evidence based treatments/therapy
  - Development of medical policy and utilization management programs

- Financial Impact
  - HB 498 Actuarial Note projects Plan costs =
    - $3.3 to $5.1 million in FY 2014-15
    - $6.1 to $12.7 million annually in the long term
  - To be updated based on benefit design recommendation

Reduced Copays for Chiropractic Benefit

- Requestor: Dr. Joe Siragusa, NC Chiropractic Association
- Requested Change: Implement copay parity by reducing the current mid-level copay for chiropractic services to the same level as the office visit copay for primary care providers
  - Enhanced 80/20 plan from $52 to $30
  - Traditional 70/30 plan from $64 to $35
- Rationale: NCCA presented a study based on State Health Plan data that suggests a reduction in costs if parity is implemented.

NC General Assembly Consideration of Chiropractic Copays

- Senate Bill 561 Chiropractor Copay Parity
  - Prohibits health plans from establishing office visits copays for chiropractic services that are higher than the office visit copays for primary care physicians providing a comparable medically necessary treatment or service.
  - SB 561 Actuarial Note projects Plan costs =
    - $2.6 to 3.7 million in FY 2014-15
  - Referred to Senate Committee on Insurance

Studies of Chiropractic Services & Costs

- Follow up by Plan staff and Segal actuaries
  - Met with the authors of the NCCA study via conference call
  - Consulted with clinicians/researchers with the Sheps Center for Health Services Research, UNC-Chapel Hill
- Questions remain about study results and conclusions
  - Assumptions about impact of State law changes
  - Use of risk factors
  - Changes in utilization patterns with copay parity
  - No discussion of outcomes

Studies of Chiropractic Services & Costs

- Segal's Findings & Comments
  - Higher copays do present a barrier for some members
  - Cannot conclude that a reduction in the copay would result in savings to the Plan

- Potential Next Steps
  - Submit additional questions to the study authors
  - Request Segal to review chiropractic episodes over an extended period of time to better quantify long-term impact

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

December 2013 Financial Report

Board of Trustees Meeting

January 31, 2014

A Division of the Department of State Treasurer

Financial Results: Actual v. Budgeted
Year to Date December 2013

Short Plan Year July-December 2013	Actual thru Dec 2013	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Beginning Cash Balance	$783.5 m	$755.8 m	$27.7 m
Plan Revenue	$1.540 b	$1.476 b	$64.0 m
Net Claims Payments	$1.415 b	$1.445 b	($30.0 m)
Net Administrative Expenses	$69.5 m	$91.3 m	($21.8 m)
Total Plan Expenses	$1.485 b	$1.537 b	($51.8 m)
Net Income/(Loss)	$55.0 m	($60.8 m)	$115.8 m
Ending Cash Balance	$838.5 m	$695.0 m	$143.5 m

Adjusted Variance Report
Year to Date December 2013

Short Plan Year July-December 2013	Actual thru Dec 2013, As Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Beginning Cash Balance	$783.5 m	$755.8 m	$27.7 m
Plan Revenue *	$1.495 b	$1.476 b	$19.2 m
Net Claims Payments †	$1.454 b	$1.445 b	$8.9 m
Net Administrative Expenses ^	$78.0 m	$91.3 m	($13.3 m)
Total Plan Expenses	$1.532 b	$1.537 b	($4.4 m)
Net Income/(Loss)	($37.2 m)	($60.8 m)	$23.6 m
Ending Cash Balance	$746.3 m	$695.0 m	$51.3 m

* Adjusted for timing issues and to exclude non-budgeted revenue.
† Adjusted for timing issues and to exclude non-budgeted rebate payment earned in prior fiscal year.
^ Adjusted for timing issues.

Financial Results Actual v. Budgeted
Year to Date December 2013

Per Member Per Month (PMPM) Analysis

Short Plan Year July-December 2013	Actual thru Dec 2013	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue	$382.66	$368.67	$13.99
Net Claims Payments	$352.40	$360.79	($8.39)
Net Administrative Expenses	$17.31	$22.79	($5.48)
Total Plan Expenses	$369.71	$383.58	($13.87)
Net Income/(Loss)	$12.95	($14.91)	$27.86

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

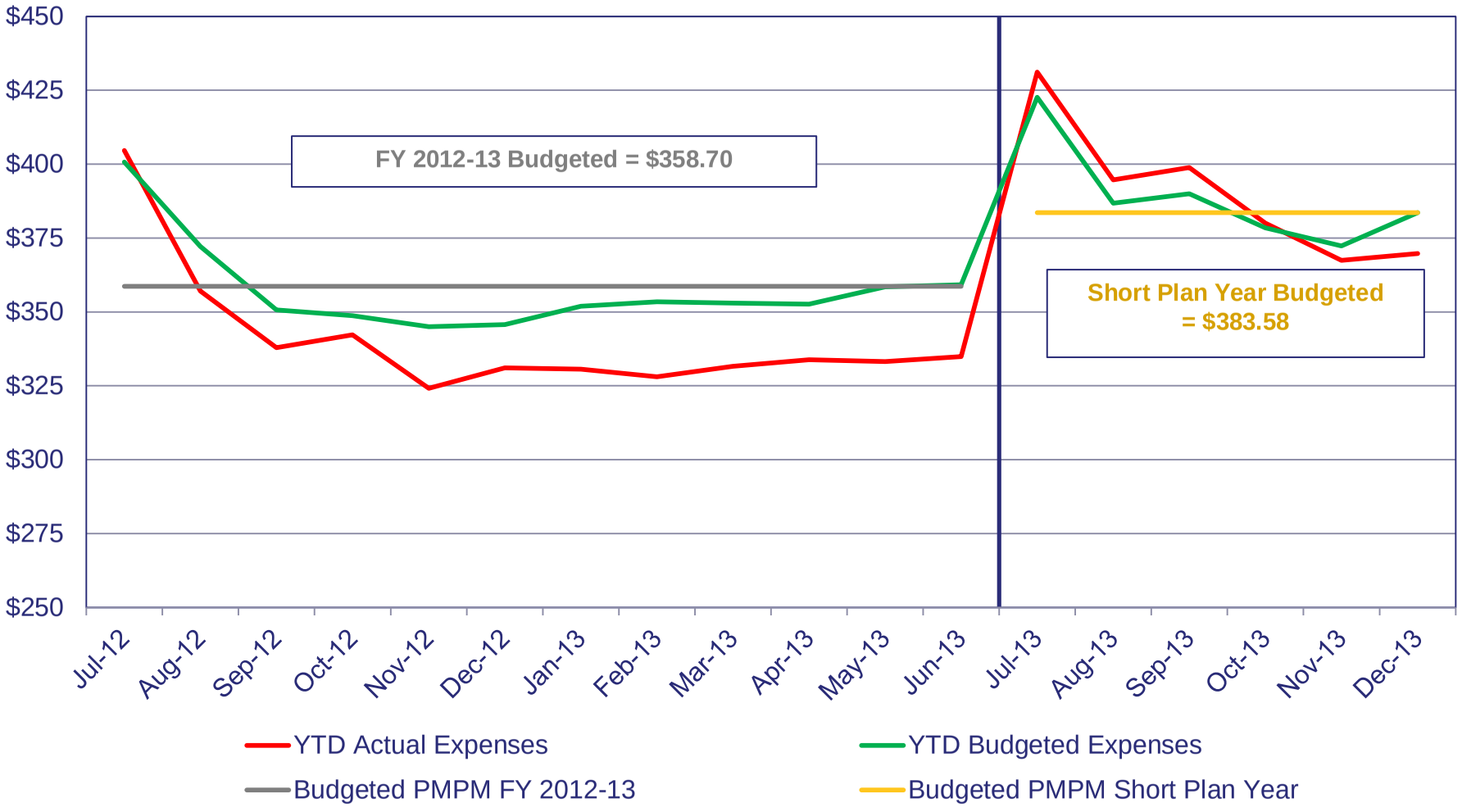
Adjusted Variance Report
Year to Date December 2013

Per Member Per Month (PMPM) Analysis

Short Plan Year July-December 2013	Actual thru Dec 2013, as Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	$371.53	$368.67	$2.86
Net Claims Payments †	$362.08	$360.79	$1.29
Net Administrative Expenses ^	$19.43	$22.79	($3.36)
Total Plan Expenses	$381.51	$383.58	($2.07)
Net Income/(Loss)	($9.98)	($14.91)	$4.93

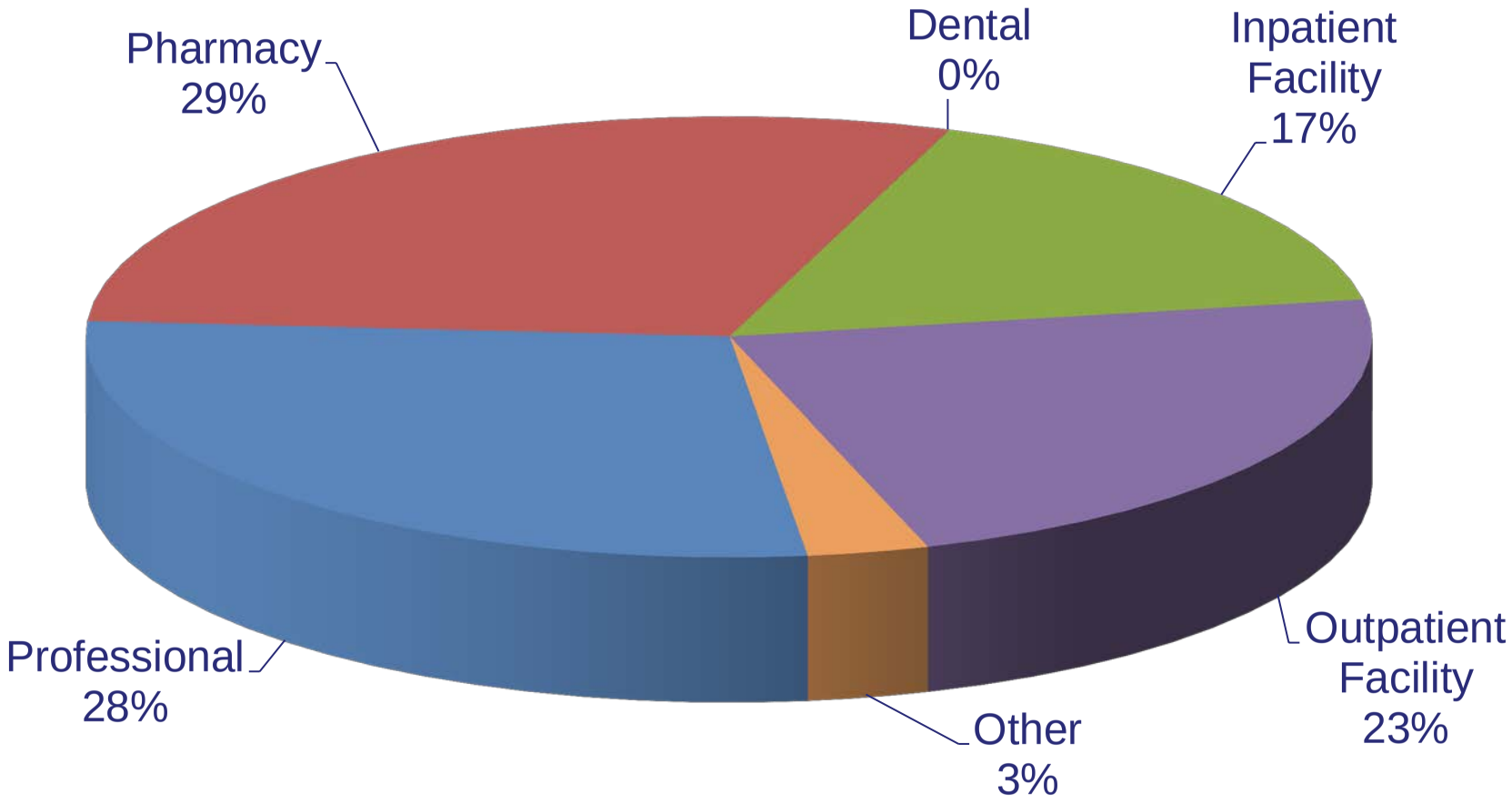
Adjusted for timing issues and to exclude non-budgeted revenue.
† Adjusted for timing issues and to exclude non-budgeted rebate payment earned in prior fiscal year.
^ Adjusted for timing issues.

Year to Date Expenditure Trend
Per Member Per Month



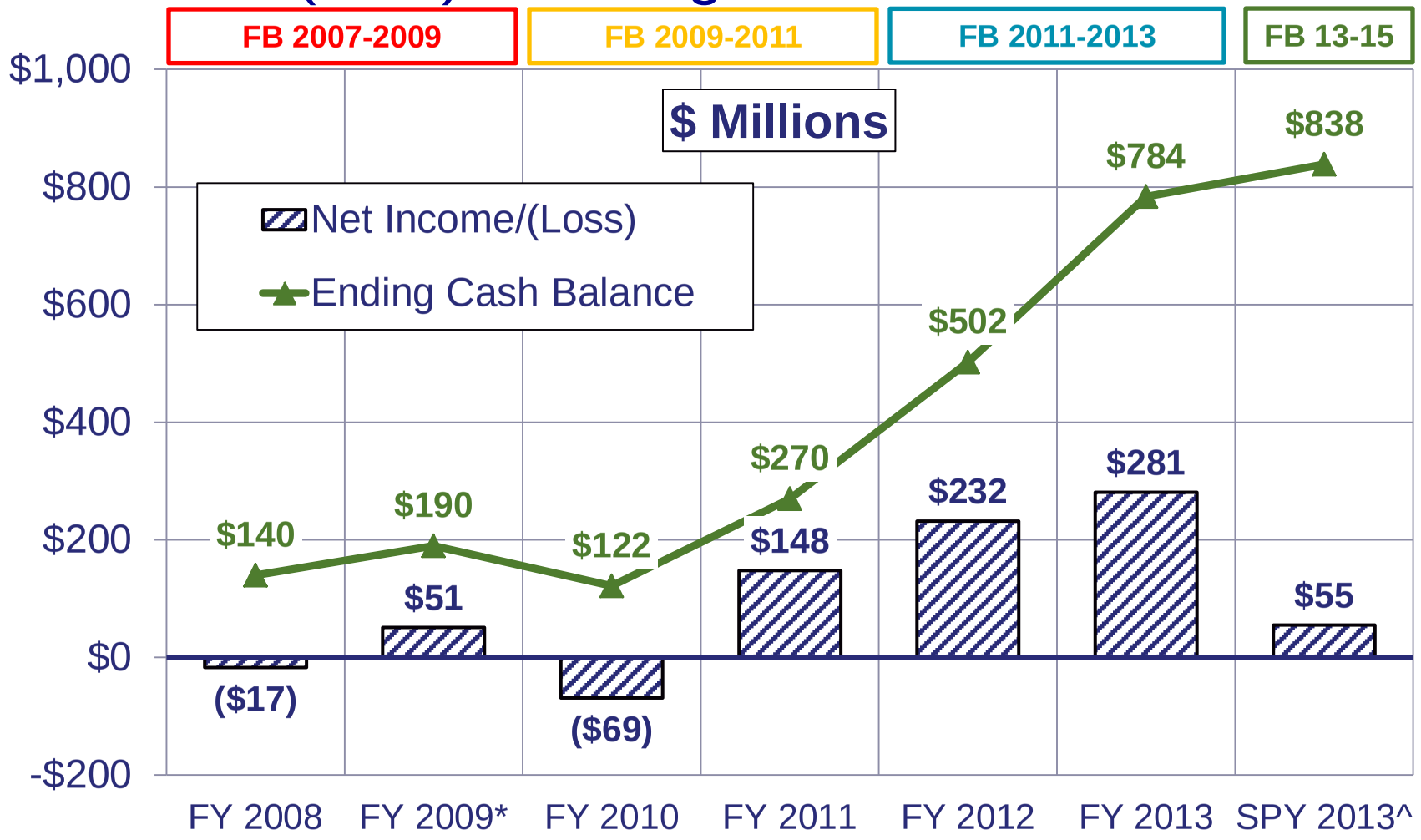
Allocation of Claims Expenditures

Includes Medical, Blue Card & Pharmacy Payments



Source: BCBSNC Summary of Billed Charges, year to date through December 2013

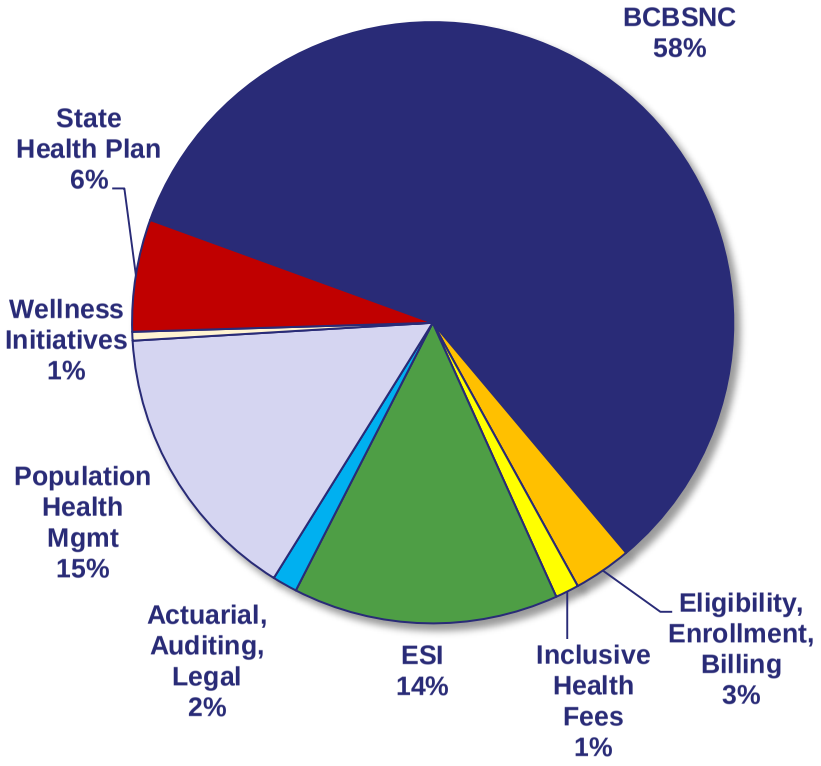
Historical Financial Results
Net Income/(Loss) & Ending Cash Balance



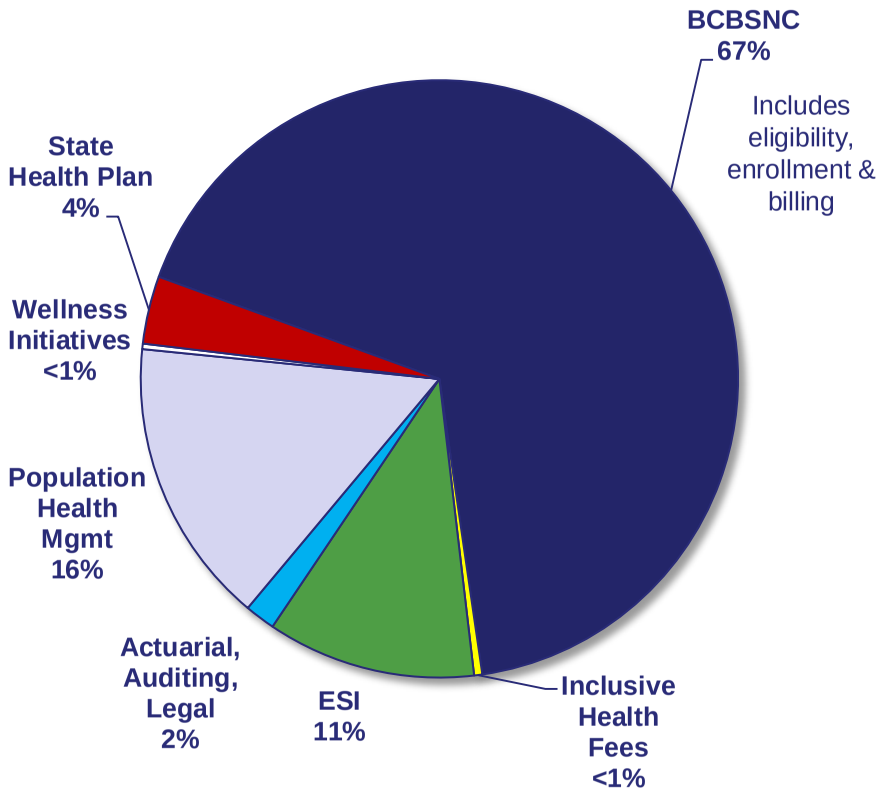
*The Plan received a $250 million general fund appropriation from the State in FY 2009.
^ Short Plan Year = six months from July to December 2013.

Short Plan Year (July – December 2013) Administrative Expenses

Short Plan Year ($69.5 Million)



FY 2012-13 Plan Year ($161.4 Million)



Short Plan Year (July – December 2013) Financial Performance Highlights

- Plan expenses (claims expenditures + administrative costs) were:
  1. $51.8 million (3.4%) less than projected in total dollars
     - FY 2012-13 Plan Year: Expenses were $173.6 million (6.1%) less than projected
  2. $13.87 (3.6%) less than projected per member per month
     - FY 2012-13: PMPM expenses were $24.26 (6.8%) less than projected
  3. After timing and other adjustments, Plan expenses were $4.4 million (0.3%) or $2.08 PMPM (0.5%) less than projected

- The Plan's $838.5 million ending cash balance for the short plan year:
  1. Is $55.0 million more than the beginning cash balance
  2. Is $115.8 million more than the Certified Budget projection
  3. Equates to approximately 15 weeks of projected CY 2014 expenses
  4. Exceeds the December 31, 2013 Target Stabilization Reserve by $619.0 million

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 December 2013

Short Plan Year (July - December 2013)

		A	B	C	D	E	F	G	H
		Actual December 2013	Certified Budget December 2013	Monthly Variance Over/(Under) Certified Budget	Actual Short Plan Year To Date	Certified Budget Short Plan Year to Date	Short Plan Year to Date Variance Over/(Under) Certified Budget	Short Plan Year Certified Budget (Jul - Dec 2013)	Short Plan Year to Date Variance Over/(Under) Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 267,504,683	$ 239,801,826	$ 27,702,857	$ 1,502,578,000	$ 1,440,079,372	$ 62,498,628	$ 1,440,079,372	$ 62,498,628
4	Premium Refunds/Retroactive Disenrollments	(785)	(120,110)	119,325	(277,538)	(721,290)	443,752	(721,290)	443,752
5	Medicare Part D (RDS) Subsidy	899,770	592,948	306,822	(1,323,888)	2,784,744	(4,108,632)	2,784,744	(4,108,632)
6	Medicare PDP (EGWP + Wrap) Subsidy	4,077,830	4,200,617	(122,787)	37,082,585	32,347,301	4,735,284	32,347,301	4,735,284
7	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
8	**Net Premium & Other Contributions**	**272,481,488**	**244,475,281**	**28,006,217**	**1,538,059,159**	**1,474,490,127**	**63,569,032**	**1,474,490,127**	**63,569,032**
9									
10	Investment Earnings	329,914	239,048	90,866	1,786,115	1,448,002	338,113	1,448,002	338,113
11	Miscellaneous Revenue	-	-	-	54,972	-	54,972	-	54,972
12	**Other Revenue**	**329,914**	**239,048**	**90,866**	**1,841,087**	**1,448,002**	**393,085**	**1,448,002**	**393,085**
13									
14	**Total Plan Revenue (exoludes internal transfers)**	**272,811,412**	**244,714,329**	**28,097,083**	**1,539,900,246**	**1,476,938,129**	**63,962,117**	**1,476,938,129**	**63,962,117**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	187,057,371	184,803,745	2,253,626	1,033,157,400	1,043,999,297	(10,841,897)	1,043,999,297	(10,841,897)
19	Medical Claim Refunds/Recoveries	(1,656,516)	(1,899,354)	242,838	(10,834,378)	(12,060,684)	1,226,306	(12,060,684)	1,226,306
20	**Net Medical Claims**	**185,400,855**	**182,904,391**	**2,496,464**	**1,022,323,022**	**1,031,938,613**	**(9,615,591)**	**1,031,938,613**	**(9,615,591)**
21									
22	Pharmacy Claim Payments	64,556,516	94,615,302	(30,058,786)	425,815,469	434,048,440	(8,232,971)	434,048,440	(8,232,971)
23	Pharmacy Claim Rebates	-	820,889	(820,889)	(32,188,641)	(20,572,861)	(11,615,780)	(20,572,861)	(11,615,780)
24	Pharmacy Claim Refunds/Recoveries	(14,210)	-	(14,210)	(557,530)	-	(557,530)	-	(557,530)
25	**Net Pharmacy Claims**	**64,542,306**	**95,436,191**	**(30,893,886)**	**393,069,298**	**413,475,579**	**(20,406,281)**	**413,475,579**	**(20,406,281)**
26									
27	**Net Claim Payments**	**249,943,161**	**278,340,582**	**(28,397,421)**	**1,415,392,320**	**1,446,414,192**	**(30,021,872)**	**1,445,414,192**	**(30,021,872)**
28									
29	**Net Administrative Expenses**	**5,860,906**	**16,205,907**	**(8,245,001)**	**69,548,737**	**91,288,288**	**(21,749,681)**	**91,288,288**	**(21,749,681)**
30									
31	**Total Plan Expenses (exoludes internal transfers)**	**255,804,067**	**293,548,489**	**(37,642,422)**	**1,484,941,057**	**1,538,712,480**	**(51,771,433)**	**1,538,712,480**	**(51,771,433)**
32									
33	**Plan Income/(Loss)**	**16,807,345**	**(48,832,160)**	**65,739,505**	**54,959,189**	**(80,774,351)**	**115,733,550**	**(80,774,351)**	**115,733,550**
34									
35	**Cash Availability:**								
36									
37	Beginning Cash Balance/(Deficit)	821,539,792	743,807,293	77,732,499	783,487,948	755,749,494	27,738,454	755,749,494	27,738,454
38	**Ending Cash Balance/(Deficit)**	**838,447,137**	**694,975,133**	**143,472,004**	**838,447,137**	**694,975,133**	**143,472,004**	**694,975,133**	**143,472,004**
39									
40	Target Stabilization Reserve @ 12/31/13	219,485,780	219,485,780	-	219,485,780	219,485,780	-	219,485,780	-
41									
42	**Cash Balance Over/(Under) Reserve Target**	**$ 618,961,357**	**$ 476,489,353**	**$ 143,472,004**	**$ 618,961,357**	**$ 476,489,353**	**$ 143,472,004**	**$ 476,489,353**	**$ 143,472,004**

Comments:

a. Premium receivables totaled $172,250.27 as of December 31, 2013.

b. The average weekly medical claims cost net of claims refunds was $37,080,171.00 for the five scheduled weekly claim cycles.

c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $32,278,258.00 per cycle.

d. The target stabilization reserve is 8% of the projected net claims for Calendar Year 2013.

e. Minor differences compared to other reports are due to rounding.

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Certified Budget
For the Month Ended December 2013
Fiscal Year 2013- 2014

		A	B	C	D	E	F	G	H
		Actual December 2013	Certified Budget December 2013	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	$ 267,504,683	$ 239,801,826	$ 27,702,857	$ 1,502,578,000	$ 1,440,079,372	$ 62,498,628	$ 2,902,567,015	$ (1,399,989,015)
4	Premium Refunds/Retroactive Disenrollments	(785)	(120,110)	119,325	(277,538)	(721,290)	443,752	(1,466,766)	1,189,228
5	Medicare Part D (RDS) Subsidy	899,770	592,948	306,822	(1,323,888)	2,784,744	(4,108,632)	6,218,762	(7,542,650)
6	Medicare PDP (EGWP + Wrap) Subsidy	4,077,830	4,200,617	(122,787)	37,082,585	32,347,301	4,735,284	50,346,402	(13,263,817)
7	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
8	**Net Premium & Other Contributions**	**272,481,498**	**244,476,281**	**28,008,217**	**1,538,058,159**	**1,474,490,127**	**63,568,032**	**2,957,665,413**	**(1,419,606,254)**
9									
10	Investment Earnings	329,914	239,048	90,866	1,786,115	1,448,002	338,113	2,868,131	(1,082,016)
11	Miscellaneous Revenue	-	-	-	54,972	-	54,972	-	54,972
12	**Other Revenue**	**329,914**	**239,048**	**90,866**	**1,841,087**	**1,448,002**	**393,085**	**2,868,131**	**(1,027,044)**
13									
14	**Total Plan Revenue (exoludes internal transfers)**	**272,811,412**	**244,714,329**	**28,097,083**	**1,539,900,248**	**1,475,938,129**	**63,962,117**	**2,960,533,544**	**(1,420,633,298)**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	187,057,371	184,803,745	2,253,626	1,033,157,400	1,043,999,297	(10,841,897)	2,107,493,114	(1,074,335,714)
19	Medical Claim Refunds/Recoveries	(1,656,516)	(1,899,354)	242,838	(10,834,378)	(12,060,684)	1,226,306	(24,643,884)	13,809,506
20	**Net Medical Claims**	**185,400,856**	**182,904,391**	**2,496,464**	**1,022,323,022**	**1,031,938,613**	**(9,615,591)**	**2,082,849,230**	**(1,060,526,208)**
21									
22	Pharmacy Claim Payments	64,556,516	94,615,302	(30,058,786)	425,815,469	434,048,440	(8,232,971)	699,653,578	(273,838,109)
23	Pharmacy Claim Rebates	-	820,889	(820,889)	(32,188,641)	(20,572,861)	(11,615,780)	(52,353,361)	20,164,720
24	Pharmacy Claim Refunds/Recoveries	(14,210)	-	(14,210)	(557,530)	-	(557,530)	-	(557,530)
25	**Net Pharmacy Claims**	**64,542,306**	**95,436,191**	**(30,893,885)**	**393,069,298**	**413,476,579**	**(20,406,281)**	**647,300,217**	**(254,230,919)**
26									
27	**Net Claim Payments**	**249,943,161**	**278,340,582**	**(28,397,421)**	**1,415,392,320**	**1,445,414,192**	**(30,021,872)**	**2,730,149,447**	**(1,314,757,127)**
28									
29	**Medicare Advantage Premiums**		-	-	-	-	-	**88,884,744**	**(88,884,744)**
30									
31	**Net Administrative Expenses**	**5,960,806**	**15,206,807**	**(9,245,001)**	**69,548,737**	**91,288,288**	**(21,748,561)**	**182,448,828**	**(112,887,891)**
32									
33	**Total Plan Expenses (exoludes internal transfers)**	**255,904,067**	**293,548,489**	**(37,642,422)**	**1,484,941,057**	**1,536,712,480**	**(51,771,433)**	**2,999,480,819**	**(1,514,619,762)**
34									
35	**Plan Income/(Loss)**	**16,907,345**	**(48,832,160)**	**65,739,505**	**54,959,189**	**(60,774,351)**	**115,733,550**	**(38,927,275)**	**93,886,464**
36									
37	**Cash Availability:**								
38									
39	Beginning Cash Balance/(Deficit)	821,539,792	743,807,293	77,732,499	783,487,948	755,749,494	27,738,454	755,749,494	27,738,454
40	**Ending Cash Balance/(Deficit)**	**838,447,137**	**694,976,133**	**143,472,004**	**838,447,137**	**694,976,133**	**143,472,004**	**716,822,219**	**121,624,918**
41									
42	Target Stabilization Reserve @ 6/30/14	239,446,206	239,446,206	-	239,446,206	239,446,206	-	239,446,206	-
43									
44	**Cash Balance Over/(Under) Reserve Target**	**$ 598,000,931**	**$ 455,528,927**	**$ 143,472,004**	**$ 598,000,931**	**$ 455,528,927**	**$ 143,472,004**	**$ 477,376,013**	**$ 121,624,918**

Comments:
a. Premium receivables totaled $172,250.27 as of December 31, 2013.
b. The average weekly medical claims cost net of claims refunds was $37,080,171.00 for the five scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $32,278,258.00 per cycle.
d. The target stabilization reserve is 8.5% of the projected net claims 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)
December 2013

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 December 2013
Fiscal Year 2013-2014

		A	B	C	D	E	F	G
		Current Year Actual December 2013	Prior Year Actual December 2012	Current Year to Date Actual FY 2013-14 thru December	Prior Year to Date Actual FY 2012-13 thru December	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	$ 267,504,683	$ 272,493,980	$ 1,502,578,000	$ 1,470,468,048	$ 2,902,567,015	$ 2,872,808,844	$ 2,895,366,140
4	Premium Refunds/Retroactive Disenrollments	(785)	(19,079)	(277,538)	(244,462)	(1,466,766)	(1,437,243)	(487,819)
5	Medicare Part D (RDS) Subsidy	899,770	5,042,821	(1,323,868)	25,570,898	6,218,762	39,519,892	38,056,016
6	Medicare PDP (EGWP + Wrap) Subsidy	4,077,830	-	37,082,585	-	50,346,402	19,759,856	24,435,483
7	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	(558,219)	-	-	(558,219)
8	**Net Premium & Other Contributions**	272,481,498	277,517,722	1,538,059,159	1,495,236,265	2,957,665,413	2,930,651,349	2,956,811,601
9								
10	Investment Earnings	329,914	268,390	1,786,115	1,403,080	2,868,131	5,658,262	3,117,666
11	Miscellaneous Revenue	-	-	54,972	8,159	-	-	119,047
12	**Other Revenue**	329,914	268,390	1,841,087	1,411,239	2,868,131	5,658,262	3,236,713
13								
14	**Total Plan Revenue (excludes internal transfers)**	272,811,412	277,786,112	1,539,900,246	1,496,647,504	2,960,533,544	2,936,309,611	2,960,048,314
15								
16	**Plan Expenses:**							
17								
18	Medical Claim Payments	187,057,371	176,886,869	1,033,157,400	919,071,986	2,107,493,114	2,003,583,417	1,858,096,405
19	Medical Claim Refunds/Recoveries	(1,656,516)	(1,330,645)	(10,834,378)	(12,293,069)	(24,643,884)	(31,216,928)	(23,467,914)
20	**Net Medical Claims**	185,400,855	175,556,224	1,022,323,022	906,778,917	2,082,849,230	1,972,366,489	1,834,628,491
21								
22	Pharmacy Claim Payments	64,556,516	55,266,783	425,815,469	358,901,155	699,653,578	743,853,418	755,896,440
23	Pharmacy Claim Rebates	-	-	(32,188,641)	(26,192,033)	(52,353,361)	(53,173,873)	(69,641,941)
24	Pharmacy Claim Refunds/Recoveries	(14,210)	(405,607)	(557,530)	(455,482)	-	-	(3,476,790)
25	**Net Pharmacy Claims**	64,542,306	54,861,176	393,069,298	332,253,640	647,300,217	690,679,545	682,777,709
26								
27	**Net Claim Payments**	249,943,161	230,417,400	1,415,392,320	1,239,032,557	2,730,149,447	2,663,046,034	2,517,406,200
28								
29	**Medicare Advantage Premiums**	-	-	-	-	86,864,744	-	-
30								
31	**Net Administrative Expenses**	5,960,906	13,505,079	69,548,737	79,894,819	182,446,628	189,387,392	161,401,639
32								
33	**Total Plan Expenses (excludes internal transfers)**	255,904,067	243,922,479	1,484,941,057	1,318,927,376	2,999,460,819	2,852,433,426	2,678,807,839
34								
35	**Plan Income/(Loss)**	16,907,345	33,863,633	54,959,189	177,720,128	(38,927,275)	83,876,185	281,240,475
36								
37	**Cash Availability:**							
38								
39	Beginning Cash Balance/(Deficit)	821,539,792	646,103,966	783,487,948	502,247,471	755,749,494	502,247,475	502,247,471
40	**Ending Cash Balance/(Deficit)**	838,447,137	679,967,599	838,447,137	679,967,599	716,822,219	586,123,660	783,487,946
41								
42	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
43								
44	**Cash Balance Over/(Under) Reserve Target**	$ 599,000,931	$ 480,239,146	$ 599,000,931	$ 480,239,146	$ 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 December 2013
Short Plan Year (July-December 2013)

		A	B	C	D	E	F
		Actual Year to Date Short Plan Year thru December	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Year to Date Short Plan Year thru December	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 1,502,578,000	$ (50,479,263)	$ 1,452,098,737	$ 1,440,079,372	$ 12,019,365	0.83%
4	Premium Refunds/Retroactive Disenrollments	(277,538)		(277,538)	(721,290)	443,752	-61.52%
5	Medicare Part D (RDS) Subsidy (Note 3)	(1,323,888)	5,717,385	4,393,497	2,784,744	1,608,753	57.77%
6	Medicare PDP (EGWP + Wrap) Subsidy	37,082,585		37,082,585	32,347,301	4,735,284	14.64%
7	Federal Early Retiree Reinsurance Program (ERRP)	-		-	-	-	
8	**Net Premium & Other Contributions**	**1,538,059,159**	**(44,761,878)**	**1,493,297,281**	**1,474,490,127**	**18,807,154**	**1.28%**
9							
10	**Other Revenue (Note 4)**	**1,841,087**	**(54,973)**	**1,786,114**	**1,448,002**	**338,112**	**23.35%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**1,539,900,246**	**(44,816,850)**	**1,495,083,396**	**1,475,938,129**	**19,145,267**	**1.30%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	1,022,323,022		1,022,323,022	1,031,938,613	(9,615,591)	-0.93%
17	Net Pharmacy Claims (Notes 5 and 6)	393,069,298	38,883,392	431,952,690	413,475,579	18,477,111	4.47%
18	**Net Claim Payments**	**1,415,392,320**	**38,883,392**	**1,454,275,712**	**1,445,414,192**	**8,861,520**	**0.61%**
19							
20	**Net Administrative Expenses (Note 7)**	**69,548,737**	**8,491,208**	**78,039,945**	**91,298,298**	**(13,258,353)**	**-14.52%**
21							
22	**Total Plan Expenses (excludes internal transfers)**	**1,484,941,057**	**47,374,600**	**1,532,315,657**	**1,536,712,490**	**(4,396,833)**	**-0.29%**
23							
24	**Plan Income/(Loss)**	**54,959,189**	**(92,191,450)**	**(37,232,261)**	**(60,774,361)**	**23,542,100**	**-38.74%**
25							
26	**Cash Availability:**						
27							
28	Beginning Cash Balance/(Deficit)	783,487,948		783,487,948	755,749,494	27,738,454	3.67%
29	**Ending Cash Balance/(Deficit)**	**838,447,137**	**(92,191,450)**	**746,255,687**	**694,975,133**	**51,280,554**	**7.38%**
30							
31	Target Stabilization Reserve @ 12/31/13	219,485,780		219,485,780	219,485,780	-	
32							
33	**Cash Balance Over/(Under) Reserve Target**	**$ 618,961,357**	**$ (92,191,450)**	**$ 526,769,907**	**$ 475,489,353**	**$ 51,280,554**	**10.78%**

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 $60.8 million in prepaid January 2014 premiums received in December 2013.
3. Medicare Part D Subsidy adjusted to remove the impact of an unbudgeted repayment of subsidy revenues from prior years.
4. Other revenue adjusted to exclude unbudgeted reimbursement of prior year expenditures.
5. Pharmacy claims adjusted to exclude a $5.8 million unbudgeted EGWP rebate earned last fiscal year but not received until October 2013.
6. Pharmacy clams adjusted to include a $33.1 million claims payment budgeted for December, but processed in January 2014.
7. Administrative expenses adjusted to include vendor payments that were not processed until January 2014.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Analysis of Incurred Claims Trend and Loss Ratios

Board of Trustees Meeting

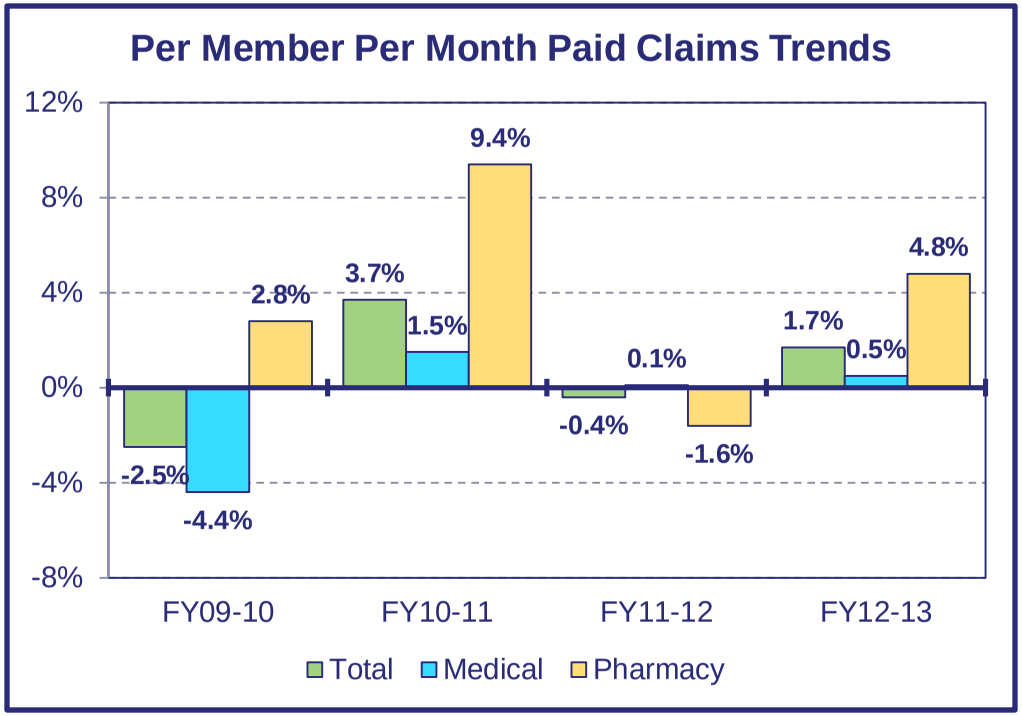
January 31, 2014

Presentation Overview

- Trends in Incurred Claims Paid through October 31, 2013
  - Plan Paid Claims
    - Per Member Per Month (PMPM)
    - By Service Category
  - PMPM Allowed Charges
- Fiscal Year 2012-13 Loss Ratios
  - By Employee Status
  - Subscribers vs. Dependents
  - By Family Tier
  - By Plan Option

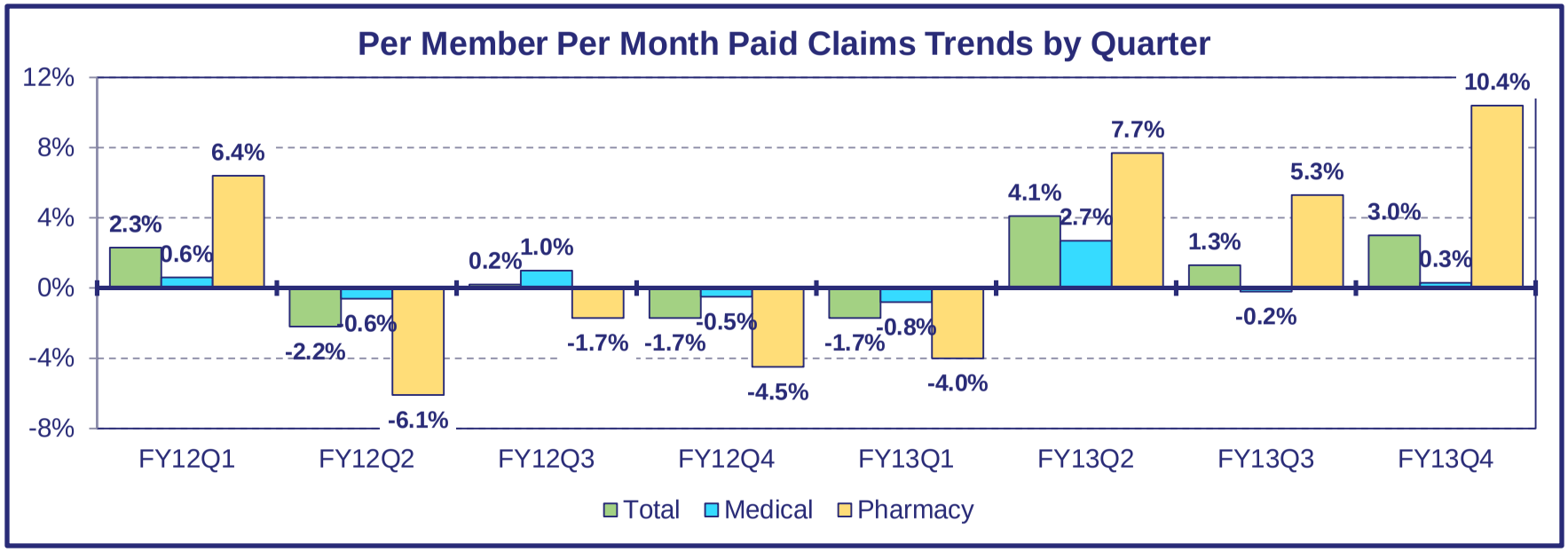
PMPM Annual Claims Trends
FY 2009-10 through FY 2012-13

- Using incurred claims data, Segal analyzed trends in claims costs paid through October 31, 2013
- Trends in PMPM claims paid by the Plan (medical and pharmacy combined) have been relatively low for the last four years. The highest year over year growth rate was 3.7% from FY 2009-10 to FY 2010-11
- Trends in PMPM medical claims costs have not exceeded 1.5% annual growth over the last four years
- PMPM pharmacy claims have trended upward in all years except FY 2011-12
- PMPM costs increased 1.7% from FY 2011-12 to FY 2012-13, including 4.8% growth in PMPM pharmacy costs



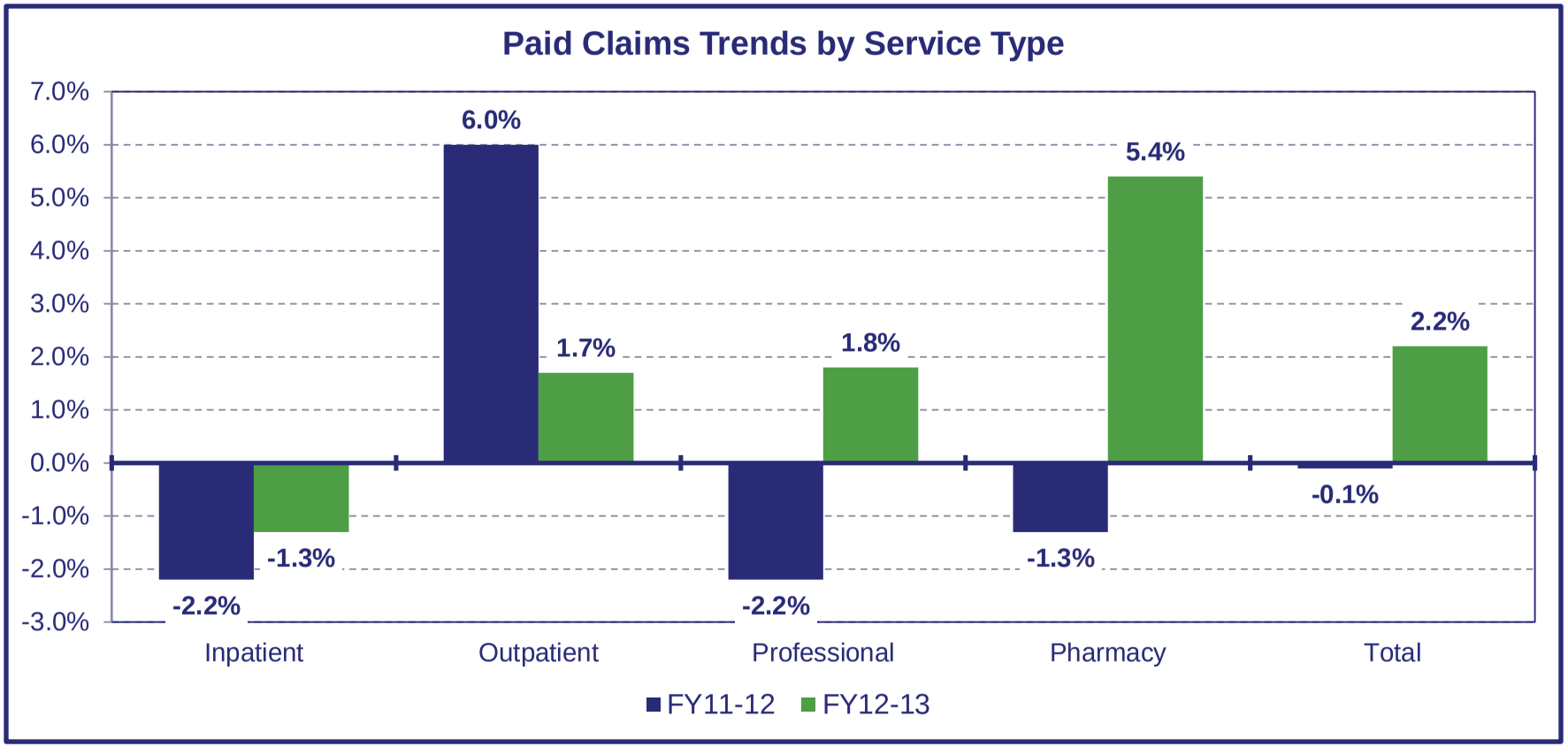
PMPM Quarterly Claims Trends
FY 2011-12 and FY 2012-13

- Quarterly claims trends compare Plan costs in each quarter with costs from the same quarter of the prior year
- Like the annual trends, quarterly PMPM cost trends are relatively modest for medical and pharmacy combined
- Pharmacy costs have been more volatile and began to show substantial trend during the last three quarters of FY 2012-13



Annual Claims Trends by Service Type FY 2011-12 and FY 2012-13

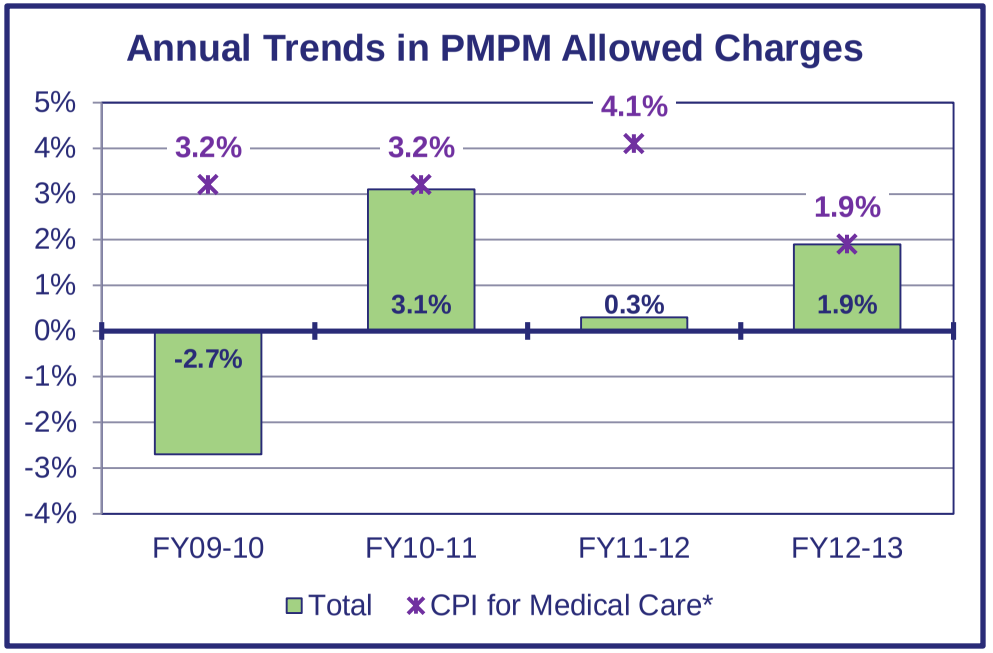
- Claims trends by category of service show some variation, but again, the overall trend is relatively modest



Note: Graph shows changes in total Plan costs and is not adjusted for changes in membership

Annual Trends in PMPM Allowed Charges FY 2009-10 through FY 2012-13

- Allowed charges reflect the total amount to be paid for claims, including the amounts paid by Medicare, by members, and by the Plan
- Examining PMPM trends in allowed charges controls for cost-shifting and gives a more complete picture of the overall claims experience
- Annual trends in allowed charges are relatively consistent with the paid claims trend
- Trend in allowed charges has been at or below the Consumer Price Index (CPI) for medical care in each of the last four years



*Source: Bureau of Labor Statistics; CPI Detailed Reports; July 2010-2013

Loss Ratios

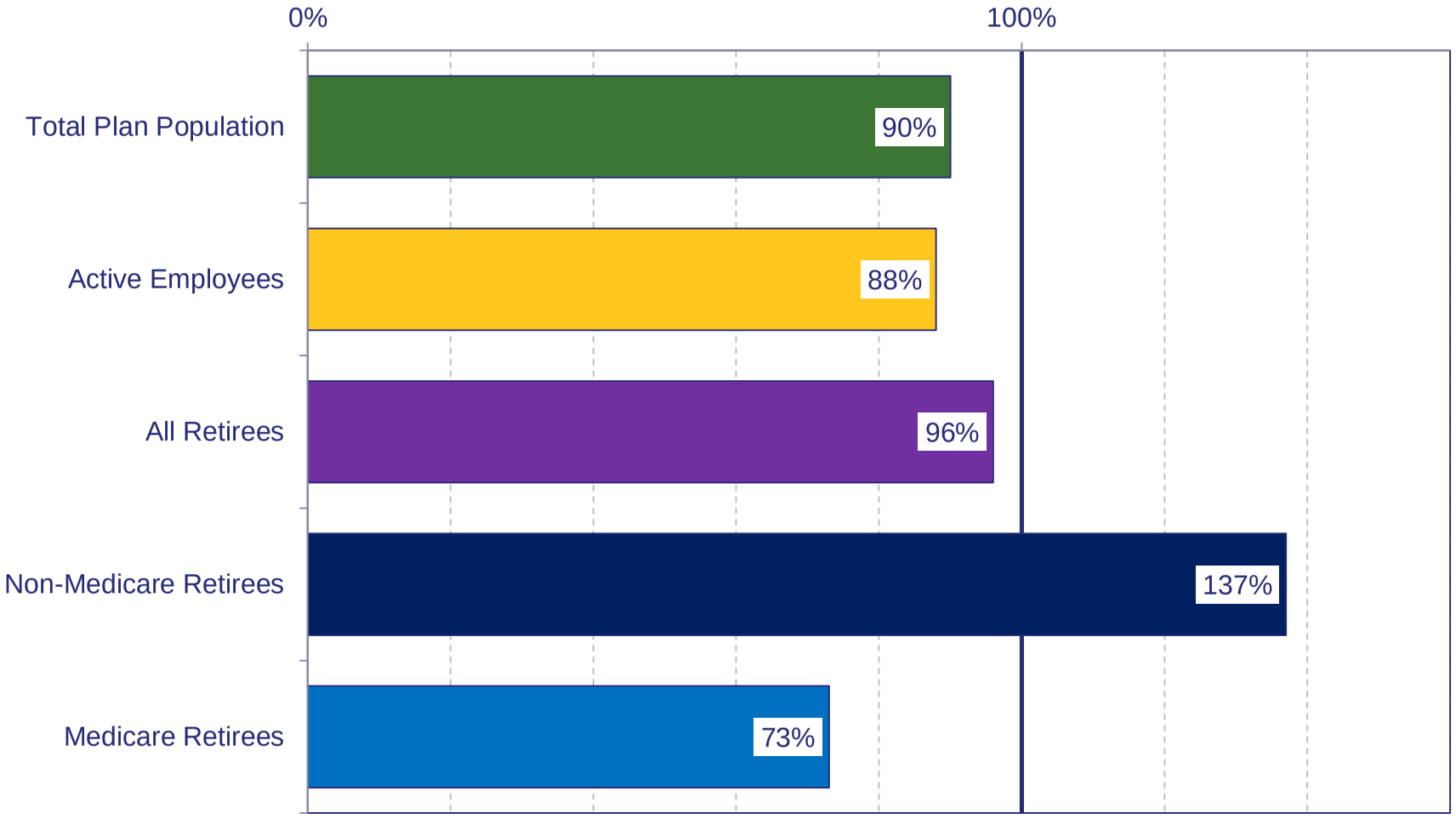
- Loss ratios relate member costs to the amount of funding received and are expressed as percentages

- A member subgroup that costs more than the premiums collected on its behalf has a loss ratio >100%
  - For example, a loss ratio of 120% means the group's actual costs exceeded the premiums collected by 20%.
    - For every $1 in premium collected, the Plan paid $1.20 in expenses

- A member subgroup that costs less than the premiums collected on its behalf has a loss ratio <100%
  - For example, a loss ratio of 90% means the group's actual costs were equal to 90% of the premiums collected
    - For every $1 in premium collected, the Plan paid $0.90 in expenses

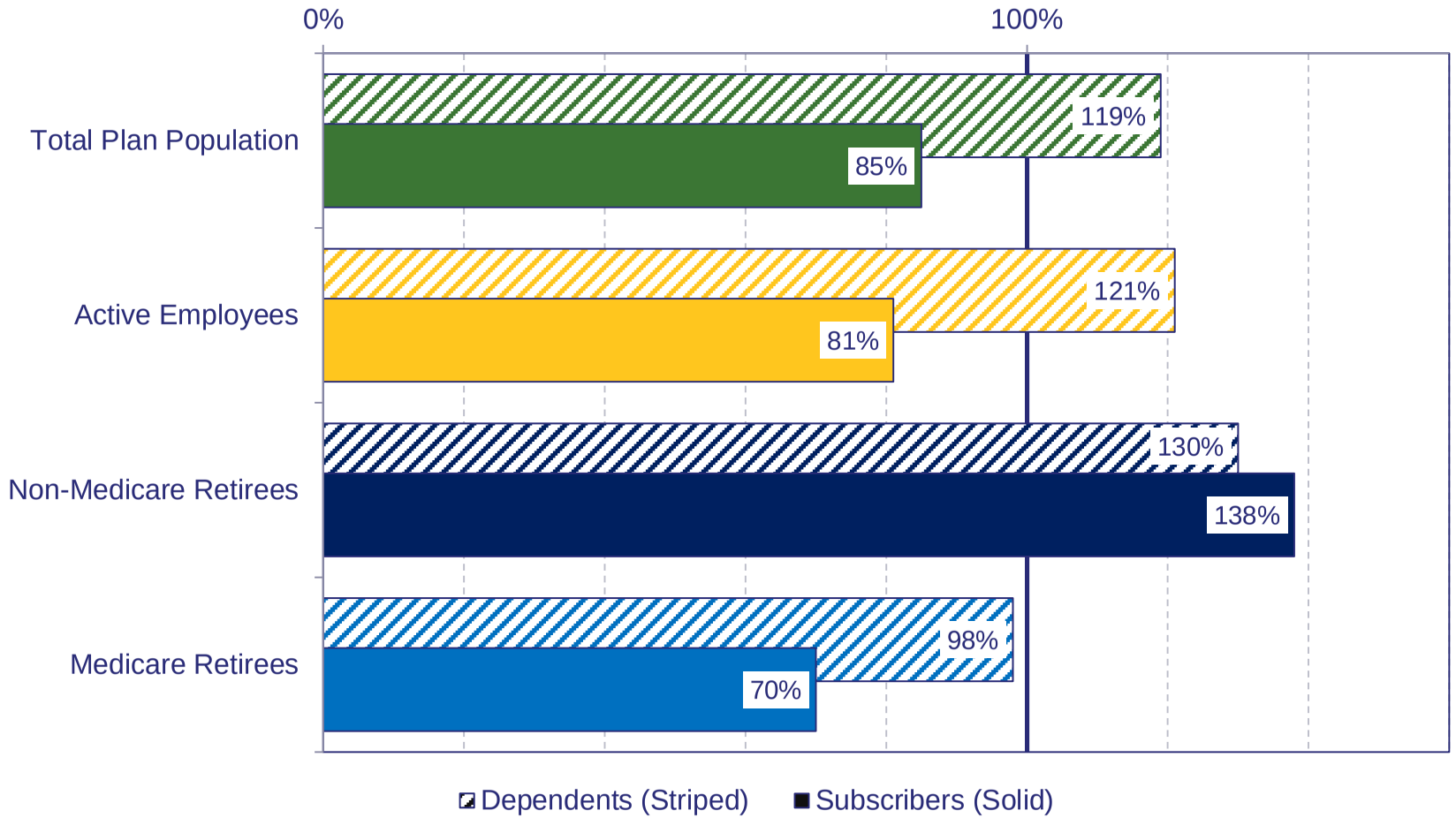
- Loss ratios incorporate Plan administrative costs and subsidies received by the Plan, but differences are primarily driven by claims experience in each subgroup

Loss Ratios by Employee Status
FY 2012-13



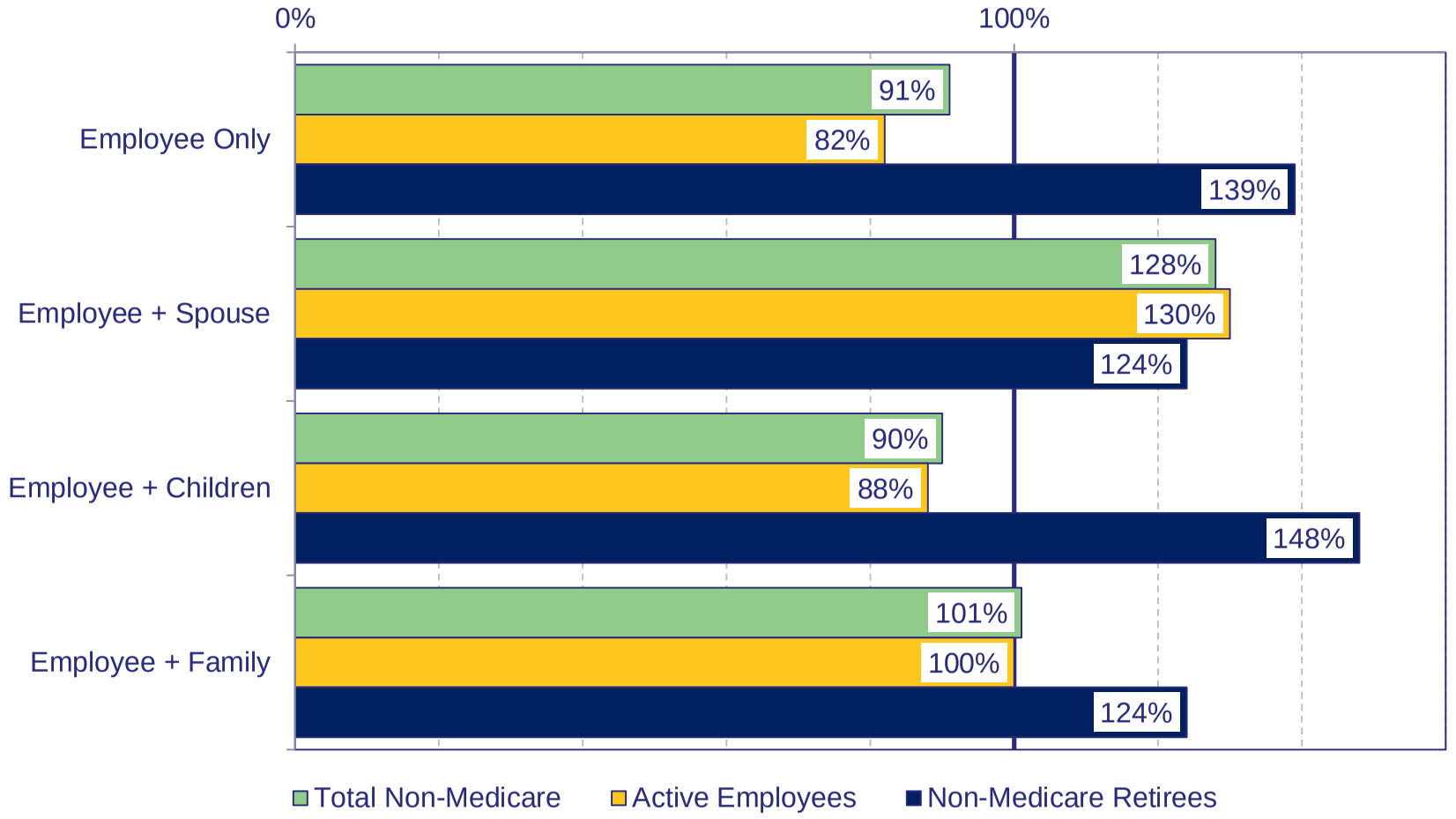
Note: Dependents are included within the subscriber's status

Loss Ratios for Subscribers/Dependents FY 2012-13

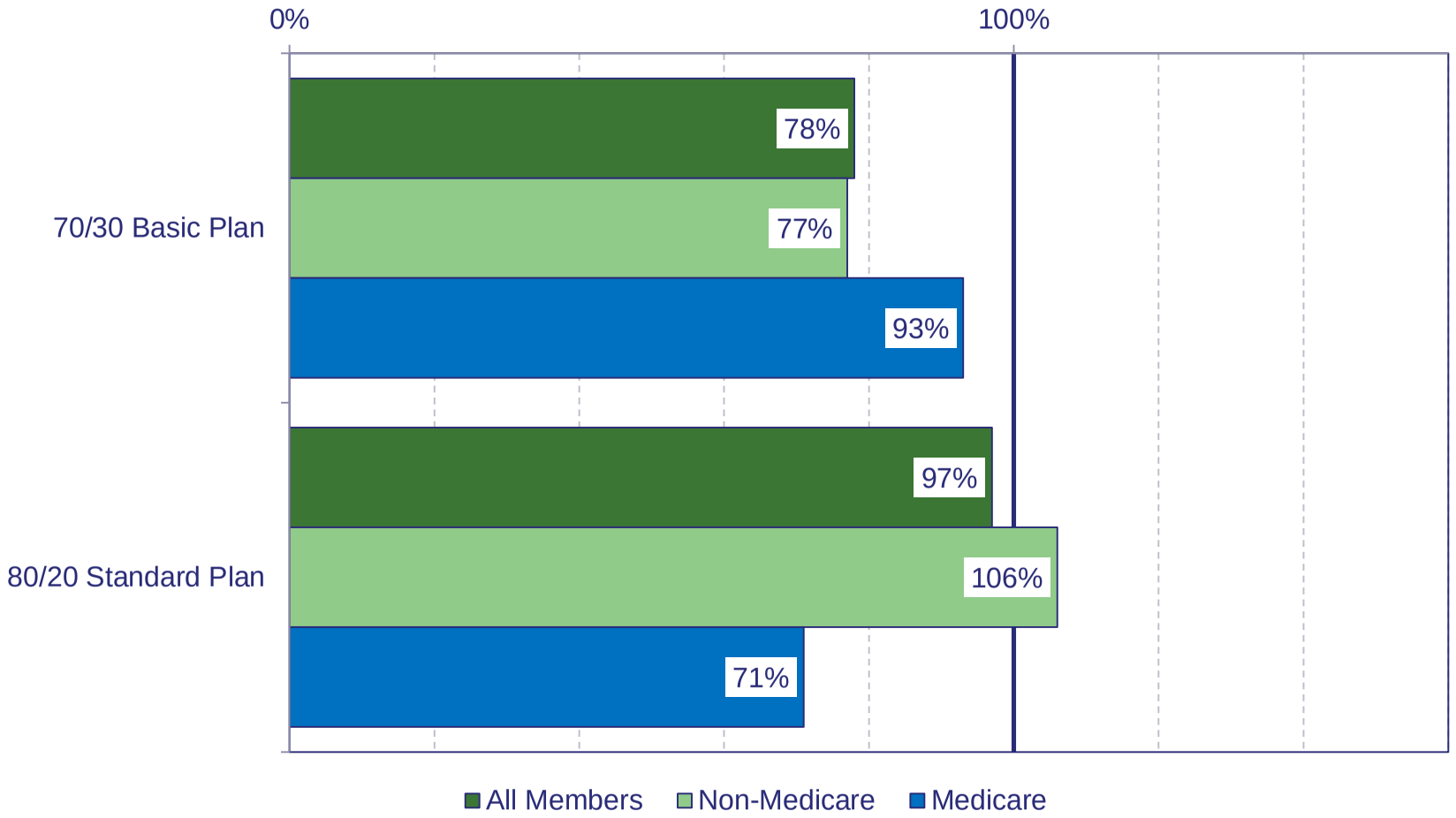


- Dependent costs are subsidized by the premiums collected on behalf of subscribers

Loss Ratios by Family Tier, Non-Medicare Members FY 2012-13



Loss Ratios by Plan Option
FY 2012-13



- With the exception of Medicare retirees, members in the 80/20 Standard Plan had higher loss ratios than members in the 70/30 Basic Plan

Loss Ratio Summary

- Overall, 90% of premiums collected by the Plan in FY 2012-13 were spent in support of claims and Plan administration
- The premiums collected for some member subgroups do not cover the associated costs; notably:
  - Non-Medicare Retirees (137% loss ratio; $117.1 million loss)
  - Dependents (119%; $81.4 million loss)
  - Non-Medicare Employee + Spouse Tier (128%; $39.7 million loss)

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Update on Dashboard Development & Process

Board of Trustees Meeting

January 31, 2014

A Division of the Department of State Treasurer

Presentation Overview

- Executive Summary
- Update on Dashboard Report
  - Work Process
  - Content
  - Presentations to Board
- Dashboard Purpose
- Areas of Focus
- Next Steps

Executive Summary

- Plan staff will begin taking a more active role in the development of quarterly dashboard reports and identifying key items and issues for discussion with the Board
- Plan staff will work with Segal to incorporate new metrics in future reports to support areas of focus and items of interest
  - For example, data on readmissions and specialty pharmacy utilization have been added to the dashboard
- Future dashboard presentations will include a comprehensive annual review of the entire dashboard and quarterly updates to highlight emerging trends and developments as well as “Spotlight” topics of interest

- Plan staff proposes two key areas of focus as starting points to guide development of the Strategic Plan, formulation of strategic objectives and initiatives, and evolution of the dashboard report and metrics
  1. Keep healthy members healthy
  2. Help members manage their chronic conditions

Update on Dashboard Report Work Process

- In the near term, Segal will continue to provide the data for the Dashboard Report
- Segal and Plan staff will discuss trends and key takeaways
- Plan staff will write the quarterly “Glance” section with a focus on shifts in the data and metrics the Plan can impact
- Quarterly “Spotlight” reports will highlight key challenges identified by Segal and Plan Staff, with Segal writing the analyses and supplying data for the “deeper dives”
  - Examples:
    - Members with multiple chronic conditions
    - The use of specialty medications
- As the Strategic Plan takes shape the dashboard will be revised to ensure appropriate metrics are captured to evaluate initiatives and determine progress

Update on Dashboard Report Content Changes

Data Elements

- Plan staff has identified additional metrics to include in future dashboards
  - Examples: readmissions, medication adherence, utilization of Tier One providers
  - Additional metrics will be added as necessary to help evaluate the 2014 benefit options and wellness incentives

Benchmarking

- Going forward, clinical quality measures will be compared against CY 2013 results to track progress towards improving members' health
- Benchmarks will incorporate a more diverse set of groupings depending on the measure
- Available data systems (e.g., Truven) will be used to provide additional perspective

Update on Dashboard Report Presentation to Board

- Plan staff will provide a comprehensive review of the Dashboard Report at least annually
- Dashboard panels and observations will be updated quarterly and emerging themes and trends will be discussed with the Board as warranted
- Focus of quarterly presentations will be the “Spotlight” reports, which will highlight measures that support strategic objectives established by the Board

Dashboard Purpose

- Help the Plan and the Board better understand the current environment
  - To identify areas of concern that need improvement
  - To identify areas of success that can be built upon
- Identify ***key metrics*** that the Plan and the Board expect to impact or maintain through programs, initiatives, and benefit designs
- Process may lead to a higher level “scorecard” with fewer measures to monitor key initiatives and areas of focus:
    - Provider engagement
    - Member engagement
    - Financial sustainability and affordability
- Set goals and track progress

1st Proposed Area of Focus
Keep Healthy Members Healthy

Context

- The Clinical Risk Grouper (CRG) report prepared by Segal categorized 48% of Plan members as healthy or with a history of acute conditions (*includes those with no claims*). These members accounted for 12% of FY 2012 claims expenditures.

Goal

- Provide ways to keep these members healthy and without chronic diseases

Supporting Initiatives

- Free preventive care
- PCP copay incentive
- Patient Centered Medical Home
- NC Health*Smart*

Potential Metrics

- Preventive care utilization
- PCP utilization
- Medication adherence
- Quitline utilization
- CRG report

Financials

- Are there results that demonstrate decreases in expenditures?

2nd Proposed Area of Focus
Help Members Manage their Chronic Conditions

Context

- The Clinical Risk Grouper (CRG) report prepared by Segal categorized 51% of members as having single or multiple chronic conditions. These members accounted for 78% of FY 2012 claims expenditures.

Goal

- Assist members in reducing current risk factors and manage chronic diseases

Supporting Initiatives

- Free preventive care
- PCP copay incentive
- Patient Centered Medical Home
- NC Health*Smart*

Potential Metrics

- PCP/preventive care utilization
- Disease management engagement rates
- Care management engagement rates among high utilizers
- ER utilization
- Medication adherence
- CRG report

Financials

- Are there results that demonstrate decreases in expenditures?

Next steps

Board of Trustees

- Provide feedback on approach and areas of focus

Plan Staff

- Finalize CY 2013 benchmarks/baselines
- Update reporting format
- Begin thinking about “Spotlight” topics for 2014
- Monitor results and contemplate CY 2016 Wellness programs

Appendix:
Potential Additions and Changes to the Dashboard Report

Panel #	Key Changes/Recommendations
2	Add Emergency Room claims costs (currently in "All Others" category)
3	Add readmission rate
4	Add congestive heart failure, mental illness, and substance abuse as conditions to track (need further discussion with Segal)
5	Highlight conditions the Plan can impact
6	Review measures for alignment with clinical guidelines; add a measure of medication adherence
7	Add specialty Rx paid amount; number of unique patients; percent of members utilizing benefit; percent of total Plan costs for pharmacy; total prescriptions
8	Consider reorganizing table to show information by indication rather than therapy class

Red = Added to current dashboard



USING THE DASHBOARD TO MONITOR THE HEALTH PROFILE OF THE POPULATION

Period Ending October 31, 2013

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

Segal Consulting

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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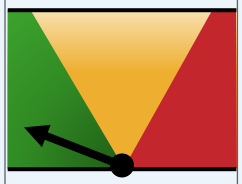
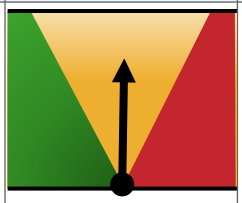
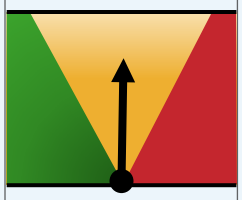
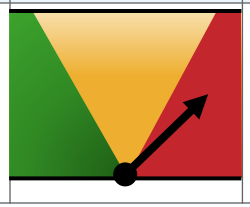
Healthcare Dashboard
Current Period: Nov 2012 – Oct 2013

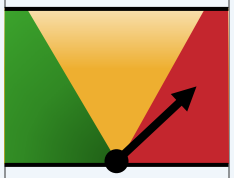
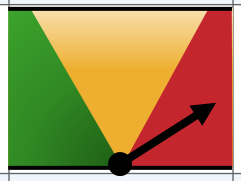
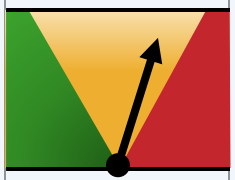
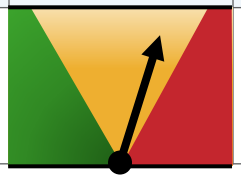
A Glance At The Dashboard

Panel	Alert	Observation	Recommendations
1) Principal Financial Trends		Allowed claims increased 1.9% PMPM, which is lower than projections and some national benchmarks. Spending on pharmacy claims is growing more rapidly than spending for medical claims.	Continue to monitor SHP performance to ensure rapid response to any troubling trends. In 2014, analyze costs by plan option and participation in wellness activities to understand differences in and impact on costs.
2) Paid Claims Summary		This quarter and the next are part of the short plan year as SHP transitions from a fiscal to calendar year basis, a critical consideration since deductibles and coinsurance maximums are halved for these periods. Total claims (medical and pharmacy) paid by the SHP increased 5.2%, while member-paid claims decreased by 8.5%. The difference is likely driven in part by the reduced deductibles and coinsurance maximums in the short plan year.	Analyze the impact of the short plan year on utilization and costs. Monitor impact on SHP costs of declining member cost share, particularly after the short plan year ends.
3) Key Performance Metrics		Office visits to physicians per 1,000 remain above Segal's book of business. There were no significant changes in patterns of utilization of Emergency rooms and hospitals.	The BoT has approved several new plan features that will impact this area in CY 2014. In addition to traditional markers, monitor: 1. Changes in preventive care visits 2. Changes in primary care utilization 3. Utilization of Tier One Hospitals and specialists Targeted Case Management of 'high utilizers' with specific diagnoses should be a strategy for SHP going forward.
4) Major Conditions		Diabetes, Asthma/COPD, and Hypertension continue to be the high cost, high prevalence chronic conditions among SHP members.	Population Health initiatives that address these conditions should be made a priority in the coming plan year. In addition to these conditions, SHP will begin to monitor prevalence and associated costs for Behavioral Health (MH/SA).

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

Healthcare Dashboard
Current Period: Nov 2012 – Oct 2013

A Glance At The Dashboard

Panel	Alert	Observation	Recommendations
5) High Risk High Cost		The number of high cost claimants increased by 371 members from the previous time frame; this relatively small increase reflected a corresponding increase in services that utilized an additional $16 million (see Panel 3).	Further analysis should be conducted on patterns of utilization of care among high cost members to identify and understand potential points for intervention to contain costs using medical management services. In 2014, pilot initiatives should be developed to focus on diverting members from ER and Inpatient facilities to PCP providers or other more appropriate level of care, such as urgent care facilities.
6) Clinical Quality Performance		Select clinical measures are above threshold while others fall below NCQA benchmarks. Baseline for clinical measures will be calendar year 2013.	Refine measures, establish appropriate benchmarks and baselines, and investigate initiatives to increase the delivery of care according to clinical standards.
7) Rx Summary		Specialty pharmacy and inflation are the primary drivers of pharmacy trend increases. With the high inflation rate, SHP is paying a larger portion of the cost of the drug compared to the member cost share. A significant portion of Medicare retirees are enrolled in the various Medicare Advantage products for 2014 and it will be critical to understand how this will impact trend.	Monitor overall pharmacy expenses highlighting specialty pharmacy under both the pharmacy and medical benefits. Monitor the impact of the pharmacy tier changes for generics and specialty by measuring member cost share. Track the impact on trend due to the movement of the Medicare eligible members.
8) Rx Top 10		Specialty pharmacy cost & utilization indicators are continuing to rise in the rankings of top 10 classes.	Monitor utilization and cost by top disease indications versus top therapy classes.

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Healthcare Dashboard
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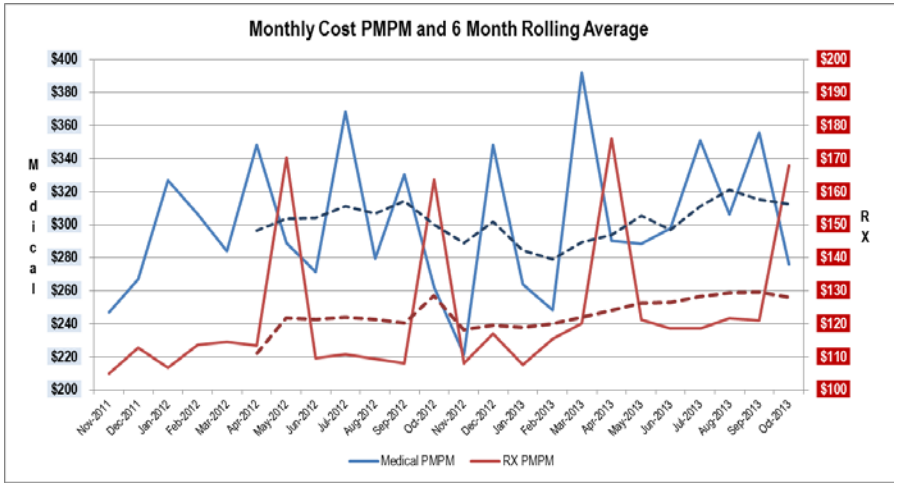
1 Principal Financial Trends – Claims Cost ALL Members



2 Paid Claims Summary – ALL Members

	Current Period			Prior Period			
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total PMPM	Total Paid Amount	Total Paid PMPM	% of Total PMPM	% Change in PMPM
Outpatient Hospital	$794,924,896	$99	23.0%	$787,797,321	$99	23.4%	0.4%
Inpatient Hospital	$603,840,613	$75	17.5%	$598,837,480	$75	17.8%	0.3%
Office	$664,946,810	$83	19.3%	$655,203,968	$82	19.5%	0.9%
Ambulatory Surgical Center	$53,557,029	$7	1.6%	$48,005,055	$6	1.4%	11.0%
Home	$57,091,534	$7	1.7%	$55,025,234	$7	1.6%	3.2%
All Others	$254,476,814	$32	7.4%	$231,678,101	$29	6.9%	9.3%
Total Medical	$2,428,837,696	$303	70.4%	$2,376,547,158	$298	70.6%	1.7%
Total Rx	$1,020,044,673	$127	29.6%	$989,493,737	$124	29.4%	2.5%
Total Paid	$3,448,882,369	$431	100.0%	$3,366,040,896	$423	100.0%	1.9%
Member Paid	$744,386,622	$93	21.6%	$809,081,737	$102	24.0%	-8.5%
Plan Paid	$2,704,495,747	$338	78.4%	$2,556,959,158	$321	76.0%	5.2%

3 Key Healthcare Performance Metrics – ALL Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	667,259	663,714	0.5%	N/A	N/A
High Cost Claimants	16,446	16,075	2.3%	N/A	N/A
High Cost Claimants Total Paid	$1,018,253,428	$1,002,333,851	1.6%	N/A	N/A
Inpatient Days Per Thousand	381	380	0.4%	365	4.5%
Average Inpatient Day Cost	$3,214	$3,115	3.2%	$3,090	4.0%
Total Admissions Per 1000	80	81	-0.7%	76	4.7%
Readmission Rate (30 Day)	15.5%	16.6%	-6.5%	N/A	N/A
Average Cost Per Admission	$15,307	$14,673	4.3%	$14,748	3.8%
ER Visits Per 1000	261	255	2.3%	262	-0.4%
Office Visits For Medical Care Per 1000	4,117	4,116	0.0%	3,515	17.1%
Office Visits for Preventive Care Per 1000	439	438	0.1%	401	9.4%
Rx Scripts Per 1000	17,235	18,006	-4.3%	16-18,000	0%
Average Cost Per Script	$89	$83	7.1%		

* Verisk BOB Norms; Segal Rx Norms

4 Major Conditions – Prevalence and Cost ALL Members with Conditions

Chronic Condition	Current Period		Prior Period		% Change in Members	% Change in Paid
	Members	Paid	Members	Paid		
1. Diabetes	96,481	$878,858,236	92,721	$839,037,016	4.1%	4.7%
2. Coronary Artery Disease (CAD)	47,481	$626,607,526	44,128	$594,462,047	7.6%	5.4%
3. Asthma	55,083	$374,634,256	45,397	$305,994,888	21.3%	22.4%
4. Chronic Obstructive Pulmonary Disease (COPD)	29,516	$380,659,894	25,859	$333,258,296	14.1%	14.2%
5. Hypertension	253,355	$1,880,082,706	240,961	$1,773,605,311	5.1%	6.0%
6. Breast Cancer	13,643	$193,070,757	12,666	$179,700,723	7.7%	7.4%
7. Colon Cancer	2,554	$57,671,300	2,290	$56,299,807	11.5%	2.4%
8. Prostate Cancer	8,008	$86,976,230	7,714	$89,920,969	3.8%	-3.3%
9. At Risk Birth	3,086	$38,194,592	3,172	$36,549,433	-2.7%	4.5%
10. Normal Delivery	3,050	$29,074,216	3,416	$30,746,308	-10.7%	-5.4%

Members with co-morbidities and their corresponding claims are combined in each applicable category.

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5 High Risk High Cost Analysis – ALL Members High Cost By Condition

Chronic Condition for High Cost Claimants*	Current Period		Prior Period		% Change in Members	% Change in PMPY
	Members	PMPY	Members	PMPY		
1. Diabetes	4,415	$68,526	4,461	$70,883	-1.0%	-3.3%
2. Coronary Artery Disease (CAD)	2,824	$71,749	3,071	$72,599	-8.0%	-1.2%
3. Asthma	2,322	$58,152	2,037	$62,120	14.0%	-6.4%
4. Chronic Obstructive Pulmonary Disease (COPD)	1,606	$74,995	1,599	$75,922	0.4%	-1.2%
5. Hypertension	9,741	$64,711	9,809	$65,330	-0.7%	-0.9%
6. Breast Cancer	1,312	$79,490	1,347	$77,447	-2.6%	2.6%
7. Colon Cancer	361	$100,325	368	$103,983	-1.9%	-3.5%
8. Prostate Cancer	409	$59,909	462	$62,341	-11.5%	-3.9%
9. Birth	233	$37,978	187	$39,669	24.6%	-4.2%

*High Cost Claimants are above $25,000

6 Clinical Quality Performance – Active and Non-Medicare Retiree Members

Chronic Condition	Clinical Compliance Metrics	Individuals			NCQA Quality Compass National Average*
		Population	Compliance Rate Prior Period	Compliance Rate Current Period	
Diabetes	• Patient(s) that had at least 2 hemoglobin A1C tests in last 12 reported months**	54,775	62.33%	60.31%	87.30%
	• Patient(s) that had an annual screening test for diabetic nephropathy	54,775	41.17%	38.86%	77.90%
	• Patient(s) that had an annual screening test for diabetic retinopathy	54,775	90.86%	83.49%	48.40%
Coronary Artery Disease	• Patient(s) currently taking an ACE-inhibitor	17,409	41.98%	41.39%	78.80%
	• Patient(s) currently taking a statin	17,409	71.74%	69.72%	Not Available
Hyperlipidemia	• Patient(s) with a LDL cholesterol test in last 12 reported months	292,038	94.72%	95.38%	83.6%***
	• Patient(s) with a total cholesterol test in last 12 reported months	292,038	94.72%	95.40%	Not Available
Preventive Screening	• Cervical cancer	318,825	64.93%	66.35%	74.40%
	• Breast cancer	221,925	61.50%	63.06%	66.80%
	• Colorectal cancer	280,478	40.06%	42.69%	55.20%
	• Prostate cancer	98,672	20.74%	22.80%	Not Available
COPD	• Patients with spirometry testing in the last 12 months	11,278	43.79%	40.73%	40.40%
Asthma	• Patient with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	42,526	67.99%	63.79%	91.70%

*Source: NCQA – State of Health Care Quality 2012 – Accredited Plans 2011 Commercial PPO Averages
**The NCQA HEDIS measure is based on one A1C test in the last 12 months whereas Segal measures two
***Represents cholesterol management for patients with cardiovascular conditions: LDL cholesterol screening

7 Summary of Prescription Drug Expenses – ALL Members

Category	Current Period	Prior Period	% Change	Norm*
Total Rx Paid Amount	$1,020,044,673	$989,493,737	3.1%	N/A
Prescriptions Written PMPY	17.2	18.0	-4.2%	
Total Rx Paid PMPY	$1,529	$1,491	2.6%	
Participant Cost Share	22.01%	25.47%	-13.6%	21% – 23%
Total Rx Plan Paid PMPY	$1,193	1,111	7.4%	
PBM Generic Dispensing Rate	79%	77%	3.3%	72% – 75%
PBM Mail Order Rx Scripts	3%	3%	-1.8%	10%
Specialty RX Paid Amount	$183,006,697	$163,486,302	11.9%	

* Segal Rx Norms

8 Prescription Drug Cost Management Analysis – ALL Members

Top 10 Rx Therapy Classes	Current Period		
	Total Paid Amount	% Generic by Count	PMPM
ANTIDEPRESSANTS	$52,007,172	87%	$6.50
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	$51,065,661	20%	$6.38
ANTINEOPLASTIC AGENTS	$47,621,505	89%	$5.95
INSULINS	$46,594,849	0%	$5.82
HMG-COA REDUCTASE INHIBITORS	$42,129,331	82%	$5.26
PROTON-PUMP INHIBITORS	$40,122,546	59%	$5.01
BIOLOGIC RESPONSE MODIFIERS	$36,989,806	0%	$4.62
ANGIOTENSIN II RECEPTOR ANTAGONISTS	$27,347,544	71%	$3.42
OPIATE AGONISTS	$20,591,114	95%	$2.57
ANTICONVULSANTS, MISCELLANEOUS	$20,486,724	85%	$2.56

First Quarter Comparison

The following two slides provide a comparison of the first quarter of the current and prior fiscal years (July through September).

Total paid claims for July 2013 – September 2013 increased 4.9% over the same period for the prior fiscal year. However, total plan payments increased 11.5%. This sharp increase in plan payments is partially attributable to the decrease in cost sharing percentages for plan members due to the half plan year.

Inpatient costs increased 2.6% but that was due to an increase in the cost per admission. Days per thousand decreased 4.2% but the average inpatient cost per day increased 8.3%. The decrease in inpatient hospital utilization is generating substantial savings for the plan.

Office visits for preventive care decreased 7.6% from the prior period. Increased preventive care may well be a positive indicator in utilization patterns. While utilization decreased almost across the board, the number of high cost claimants increased by 6.4%. This suggests that members may be more conservative with “discretionary” care which may then result in more costly episodes of care.

Total RX paid increased 9.8% which was almost entirely due to the 9.6% increase in the average cost of a prescription.

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2 Paid Claims Summary – ALL Members

Place of Service	Current Period Total Paid Amount	Current Period Total Paid PMPM	Current Period % of Total PMPM	Prior Period Total Paid Amount	Prior Period Total Paid PMPM	Prior Period % of Total PMPM	% Change in PMPM
Outpatient Hospital	$229,957,898	$115	25.0%	$214,210,479	$108	24.7%	6.3%
Inpatient Hospital	$170,493,637	$85	18.5%	$164,553,016	$83	19.0%	2.6%
Office	$176,835,197	$88	19.2%	$178,772,944	$90	20.6%	-2.1%
Ambulatory Surgical Center	$15,417,912	$8	1.7%	$13,213,975	$7	1.5%	15.5%
Home	$16,254,242	$8	1.8%	$14,950,474	$8	1.7%	7.6%
All Others	$68,535,657	$34	7.5%	$63,821,737	$32	7.4%	6.3%
Total Medical	**$677,494,543**	**$338**	**73.7%**	$649,522,626	$327	74.9%	3.3%
Total Rx	**$241,626,110**	**$120**	**26.3%**	$217,950,425	$110	25.1%	9.8%
Total Paid	**$919,120,653**	**$458**	**100.0%**	$867,473,051	$437	100.0%	4.9%
Member Paid	**$186,288,152**	**$93**	**20.3%**	$216,891,830	$109	25.0%	-15.0%
Plan Paid	**$732,832,501**	**$365**	**79.7%**	$650,581,221	$328	75.0%	11.5%

2 Paid Claims Summary – Active Members

Place of Service	Current Period Total Paid Amount	Current Period Total Paid PMPM	Current Period % of Total PMPM	Prior Period Total Paid Amount	Prior Period Total Paid PMPM	Prior Period % of Total PMPM	% Change in PMPM
Outpatient Hospital	$172,072,511	$121	27.8%	$159,045,122	$113	27.0%	7.2%
Inpatient Hospital	$128,931,236	$90	20.8%	$123,314,805	$87	20.9%	3.6%
Office	$134,088,064	$94	21.6%	$135,020,735	$96	22.9%	-1.6%
Ambulatory Surgical Center	$11,692,173	$8	1.9%	$9,814,007	$7	1.7%	18.1%
Home	$9,650,286	$7	1.6%	$9,006,442	$6	1.5%	6.2%
All Others	$50,930,528	$36	8.2%	$47,579,458	$34	8.1%	6.1%
Total Medical	**$507,364,797**	**$356**	**81.9%**	$483,780,569	$342	82.2%	4.0%
Total Rx	**$112,009,508**	**$79**	**18.1%**	$104,870,096	$74	17.8%	5.9%
Total Paid	**$619,374,305**	**$434**	**100.0%**	$588,650,665	$417	100.0%	4.3%
Member Paid	**$117,811,556**	**$83**	**19.0%**	$138,272,512	$98	23.5%	-15.5%
Plan Paid	**$501,562,749**	**$352**	**81.0%**	$450,378,153	$319	76.5%	10.4%

2 Paid Claims Summary – Non-Medicare Retiree Members

Place of Service	Current Period Total Paid Amount	Current Period Total Paid PMPM	Current Period % of Total PMPM	Prior Period Total Paid Amount	Prior Period Total Paid PMPM	Prior Period % of Total PMPM	% Change in PMPM
Outpatient Hospital	$43,785,699	$222	28.8%	$41,772,794	$211	28.9%	5.3%
Inpatient Hospital	$31,152,135	$158	20.5%	$29,779,692	$151	20.6%	5.1%
Office	$29,005,987	$147	19.1%	$29,577,037	$150	20.5%	-1.5%
Ambulatory Surgical Center	$2,559,201	$13	1.7%	$2,235,182	$11	1.5%	15.0%
Home	$2,378,581	$12	1.6%	$2,526,611	$13	1.7%	-5.4%
All Others	$8,932,396	$45	5.9%	$7,850,806	$40	5.4%	14.3%
Total Medical	**$117,813,998**	**$598**	**77.4%**	$113,742,121	$575	78.7%	4.1%
Total Rx	**$34,412,969**	**$175**	**22.6%**	$30,722,149	$155	21.3%	12.5%
Total Paid	**$152,226,968**	**$773**	**100.0%**	$144,464,270	$730	100.0%	5.9%
Member Paid	**$26,553,459**	**$135**	**17.4%**	$31,288,042	$158	21.7%	-14.7%
Plan Paid	**$125,673,509**	**$638**	**82.6%**	$113,176,228	$572	78.3%	11.5%

2 Paid Claims Summary – Medicare Retiree Members

Place of Service	Current Period Total Paid Amount	Current Period Total Paid PMPM	Current Period % of Total PMPM	Prior Period Total Paid Amount	Prior Period Total Paid PMPM	Prior Period % of Total PMPM	% Change in PMPM
Outpatient Hospital	$14,099,688	$37	9.6%	$13,392,563	$36	10.0%	3.4%
Inpatient Hospital	$10,410,266	$27	7.1%	$11,458,519	$31	8.5%	-10.8%
Office	$13,741,146	$36	9.3%	$14,175,172	$38	10.6%	-4.8%
Ambulatory Surgical Center	$1,166,538	$3	0.8%	$1,164,787	$3	0.9%	-1.7%
Home	$4,225,376	$11	2.9%	$3,417,421	$9	2.5%	21.4%
All Others	$8,672,734	$23	5.9%	$8,391,474	$22	6.2%	1.5%
Total Medical	**$52,315,747**	**$137**	**35.5%**	$51,999,936	$139	38.7%	-1.2%
Total Rx	**$95,203,633**	**$249**	**64.5%**	$82,358,180	$219	61.3%	13.5%
Total Paid	**$147,519,380**	**$386**	**100.0%**	$134,358,116	$358	100.0%	7.8%
Member Paid	**$41,923,137**	**$110**	**28.4%**	$47,331,276	$126	35.2%	-13.0%
Plan Paid	**$105,596,243**	**$276**	**71.6%**	$87,026,840	$232	64.8%	19.1%

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3 Key Healthcare Performance Metrics – ALL Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	668,223	662,038	0.9%	N/A	N/A
High Cost Claimants	3,759	3,534	6.4%	N/A	N/A
High Cost Claimants Total Paid	$193,425,412	$185,749,378	4.1%	N/A	N/A
Inpatient Days Per Thousand	408	426	-4.2%	365	11.8%
Average Inpatient Day Cost	$3,365	$3,108	8.3%	$3,090	8.9%
Total Admissions Per 1000	85	89	-4.6%	76	12.3%
Readmissions Per 1000 (30 Day)	12.2%	13.1%	-6.5%	N/A	N/A
Average Cost Per Admission	$16,089	$14,805	8.7%	$14,748	9.1%
ER Visits Per 1000	273	276	-1.1%	262	4.3%
Office Visits For Medical Care Per 1000	4,132	4,295	-3.8%	3,515	17.5%
Office Visits for Preventive Care Per 1000	521	564	-7.6%	401	30.0%
Rx Scripts Per 1000	15,725	15,694	0.2%	16-18,000	
Average Cost Per Script	$92	$84	9.6%		

3 Key Healthcare Performance Metrics – Active Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	475,184	471,013	0.9%	N/A	N/A
High Cost Claimants	2,749	2,563	7.3%	N/A	N/A
High Cost Claimants Total Paid	$139,201,726	$134,739,666	3.3%	N/A	N/A
Inpatient Days Per Thousand	252	255	-1.5%	250	0.8%
Average Inpatient Day Cost	$3,669	$3,396	8.0%	$3,672	-0.1%
Total Admissions Per 1000	60	61	-2.7%	61	-1.5%
Readmissions Per 1000 (30 Day)	6.4%	6.8%	-5.8%	N/A	N/A
Average Cost Per Admission	$15,491	$14,167	9.4%	$15,154	2.2%
ER Visits Per 1000	202	209	-3.6%	197	2.2%
Office Visits For Medical Care Per 1000	3,106	3,289	-5.6%	3,080	0.8%
Office Visits for Preventive Care Per 1000	639	693	-7.8%	383	67.0%
Rx Scripts Per 1000	10,039	10,504	-4.4%	9,853	
Average Cost Per Script	$94	$85	10.8%		

3 Key Healthcare Performance Metrics – Non-Medicare Retirees Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	65,648	65,946	-0.5%	N/A	N/A
High Cost Claimants	936	887	5.5%	N/A	N/A
High Cost Claimants Total Paid	$50,018,749	$46,026,249	8.7%	N/A	N/A
Inpatient Days Per Thousand	343	394	-13.0%	250	37.4%
Average Inpatient Day Cost	$4,822	$3,992	20.8%	$3,672	31.3%
Total Admissions Per 1000	69	74	-7.0%	61	13.9%
Readmissions Per 1000 (30 Day)	14.4%	11.2%	28.5%	N/A	N/A
Average Cost Per Admission	$24,018	$21,241	13.1%	$15,154	58.5%
ER Visits Per 1000	221	226	-2.2%	197	12.0%
Office Visits For Medical Care Per 1000	4,790	4,945	-3.1%	3,080	55.5%
Office Visits for Preventive Care Per 1000	561	587	-4.4%	383	46.6%
Rx Scripts Per 1000	21,178	20,593	2.8%	9,853	
Average Cost Per Script	$99	$90	9.4%		

3 Key Healthcare Performance Metrics – Medicare Retiree Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	127,392	125,080	1.8%	N/A	N/A
High Cost Claimants	41	27	51.9%	N/A	N/A
High Cost Claimants Total Paid	$2,441,099	$1,625,568	50.2%	N/A	N/A
Inpatient Days Per Thousand	1,026	1,085	-5.4%	1219	-15.8%
Average Inpatient Day Cost	$2,836	$2,684	5.7%	$1,843	53.9%
Total Admissions Per 1000	190	204	-6.7%	171	11.2%
Readmissions Per 1000 (30 Day)	16.4%	17.9%	-8.5%	N/A	N/A
Average Cost Per Admission	$15,306	$14,293	7.1%	$13,161	16.3%
ER Visits Per 1000	566	566	0.1%	274	106.7%
Office Visits For Medical Care Per 1000	7,618	7,892	-3.5%	6,163	23.6%
Office Visits for Preventive Care Per 1000	62	72	-14.3%	217	-71.6%
Rx Scripts Per 1000	8,531	8,163	4.5%	25,566	
Average Cost Per Script	$88	$81	8.6%		

* Verisk BOB Norms; Segal Rx Norms

SPOTLIGHT ON

Comorbidity - Asthma / Diabetes

	Members	Paid Prior	Paid Current	Prior Avg Paid Per Member	Current Avg Paid Per Member	Change in Avg Paid	Pct High Claimants (>25k)
Active + COBRA	2,590	$ 29,257,430	$ 35,450,587	$ 11,296	$ 13,687	21.2%	14.1%
Retiree - Non-Medicare	2,087	$ 39,671,869	$ 37,505,150	$ 19,009	$ 17,971	-5.5%	9.2%
Retiree - Medicare	2,910	$ 43,851,161	$ 45,973,453	$ 15,069	$ 15,798	4.8%	0.6%
TOTALS	**7,587**	**$ 112,780,460**	**$ 118,929,190**	**$ 14,865**	**$ 15,675**	**5.5%**	**7.6%**
TOTAL MEMBERSHIP	**669,007**	**$ 2,376,547,158**	**$ 2,428,837,696**	**$ 3,576**	**$ 3,636**	**1.7%**	**2.5%**

In an effort to identify candidates for focused medical management, we evaluated members who have been diagnosed with both asthma and diabetes. The group we looked at had claims in both the current and prior periods. They were diagnosed with their conditions prior to November 2011, so they were comorbid with these conditions for the entirety of the analysis periods. Only medical claims were considered, prescription drugs were not included in this analysis.

The average annual paid claims for this population is $15,675 which is 331% more than the total population's average of $3,640. While it is expected for a comorbid population to have substantially higher claims, the rate of increase in the active population warrants scrutiny. The average annual claims for this entire comorbid population increased 5.5% compared to 1.7% for the entire group. However, the active portion of this population increased 21.2% compared to 1.9% for the entire group. The sharp increase in paid claims for the active comorbid population is an indication that the plan will benefit from targeted management of this group.

Comorbid members are more likely to become high cost claimants than the rest of the population. Focusing management efforts on groups like this will help to control the trend in their paid claims as well as prevent some of them from becoming costly large claimants. Potential savings will be in avoidable E/R visits and hospital admissions.

With a large covered population, it is important to focus disease management efforts on members who are most likely to become costly in the future and have conditions that can be managed. The active members in this comorbid population meet that criteria. These findings should be discussed & coordinated with Active Health to monitor the effectiveness of their management of chronic conditions in these categories.

Healthcare Dashboard

Current Period: Nov 2012 – Oct 2013

SPOTLIGHT ON

Comorbidity - Asthma / Diabetes

	Total Members Current Period	<5K	5K-10K	10K-25K	25K-50K	50K-100K	100K-250K	250K-500K	500K+
Active + COBRA	2,590	1,453	364	409	222	98	37	6	1
Retiree - Non-Medicare	2,087	1,389	277	229	108	43	38	3	
Retiree - Medicare	2,910	2,516	251	126	11	4	2	-	
TOTALS	**7,587**	**5,358**	**892**	**764**	**341**	**145**	**77**	**9**	**1**

	Total Members Current Period	<5K	5K-10K	10K-25K	25K-50K	50K-100K	100K-250K	250K-500K	500K+
Active + COBRA	2,590	56.1%	14.1%	15.8%	8.6%	3.8%	1.4%	0.2%	0.0%
Retiree - Non-Medicare	2,087	66.6%	13.3%	11.0%	5.2%	2.1%	1.8%	0.1%	0.0%
Retiree - Medicare	2,910	86.5%	8.6%	4.3%	0.4%	0.1%	0.1%	0.0%	0.0%
TOTALS	**7,587**	**70.6%**	**11.8%**	**10.1%**	**4.5%**	**1.9%**	**1.0%**	**0.1%**	**0.0%**

The first table above shows the number of members by annual claim amount in the current period. The second table shows the percentage of members who fall into each claim amount category.

The active population has a significantly higher percentage of members in the larger claims categories. With their total claims increasing 21.2% over the prior period we can expect to see the number of large claimants, in this group, increase substantially. Closely monitoring and managing this group should yield significant savings. This should be a priority for Active Health in their ongoing efforts.

Appendix

Dashboard Overview

The purpose of this monthly dashboard is to:

- Highlight key metrics for the Board to monitor progress against strategic opportunities.
- Provide a mechanism to track:
  - **Claims and trends:** determine cost trend drivers plus analyze data on effective alternatives to manage those trends.
  - **Utilization metrics vs. benchmark:** compare the plan's utilization to benchmarks and desired targets.
  - **Population health status:** assess disease burden and recommend solutions to lessen future trend increases; Uncover opportunities for the plan to better control plan cost and improve the health of the covered population.

Methodology/Definitions

- Source of data includes eligibility as well as inpatient, outpatient and professional claims from SHPNC's SAS data warehouse. Pharmacy claims data was captured from Express Scripts.
- Generally, financial metrics are reported on a total cost basis (i.e., total cost includes plan paid and member cost sharing). This allows for tracking of population health status for improvement over time.
- Claims are reported on a paid basis for the periods November 1, 2012 – October 31, 2013 (current period) and November 1, 2011 – October 31, 2012 (prior period).

Norms / Benchmarks

- Where benchmarks are shown, we are using the book-of-business trends reported to us by our data warehouse partner, Verisk Health. Their database represents in excess of 10 million lives across plan types. Benchmark data was adjusted on a regional basis by actives/non-Medicare retirees vs. Medicare retirees.
- We also utilized Segal book of business benchmarks for pharmacy norms.
- In certain instances, we use NCQA HEDIS benchmarks for accredited commercial PPO plans, which are nationally recognized health care data standards.

Objective of Dashboard Panels

1. Principal Financial Trends

Objective: Provide the Board with a visual representation of how claims are trending over the short term.

- Seasonality in claims paid is expected with the highest monthly claims generally occurring in winter; 6-month rolling average is used to smooth the effect of seasonality.
- Monthly claims can fluctuate at the beginning and end of a plan year as members determine if their contribution to the out-of-pocket maximum warrants getting medical treatment in the current year or waiting until the next plan year.

2. Paid Claims Summary

Objective: Provide the Board with a comparative overview of claims based on treatment setting.

Place of Service can be helpful when investigating changes in utilization patterns or when trying to understand the impact of plan design changes. For example, outpatient experience and office visits may increase and inpatient hospital services decrease as participants are encouraged with copays waived under the PCMH outpatient setting.

Healthcare Dashboard
Objective of Dashboard Panels

3. Key Healthcare Performance Metrics

Objective: Provide the Board with some key comparative utilization metrics to track sources of claims increases

This table allows the plan to understand whether changes in cost are driven by price or change in utilization.

4. Major Chronic Conditions—Prevalence and Cost

Objective: Provide the Board metrics to monitor the cost and utilization of chronic conditions.

5. High Risk High Cost Analysis High Cost by Condition

Objective: Provide the Board with key metrics to monitor cost and utilization of high risk and high cost chronic conditions. Target high risk groups for medical management interventions

6. Clinical Quality Performance

Objective: Provide the Board with clinical metrics related to preventive screening, treatment compliance rates, and quality of care performance measures. This report enables the plan to determine the degree to which participants are receiving adequate care from an NCQA / HEDIS perspective.

Healthcare Dashboard
Objective of Dashboard Panels

7. Summary of Prescription Drug Expenses

Objective: Provide the Board with metrics to evaluate year-over-year growth in pharmacy spend, cost and utilization.

This report enables the plan to determine the degree to which a current drug benefit design is having in terms of cost and utilization. It showcases the degree to which cost-sharing options may be meeting expected targets or when cost sharing may be prohibitive.

8. Prescription Drug Cost Management Analysis

Objective: Provide the Board with a list of the top 10 therapeutic drug classes that are driving pharmacy claim expenses.

It enables the plan to determine what categories of drugs are driving utilization and cost over time. The plan can then determine if previous benefits design changes (i.e., cost sharing) have had their desired effect or if additional benefit changes within the pharmacy benefit plan are required.

Ongoing Use of the Dashboard

- View the current dashboard as a starting point
- Dashboard metrics can be added to be current with ongoing Board objectives
- Of key value will be to add performance metrics to monitor the progress vendors are making to support the strategic objectives of the SHP
- Provide insights into plan design alternatives that could be used to encourage behavioral change that will lower risk factors
- Monitor the effectiveness of efforts by vendors to support SHP participants in their efforts to improve their person health and lower health risk factors

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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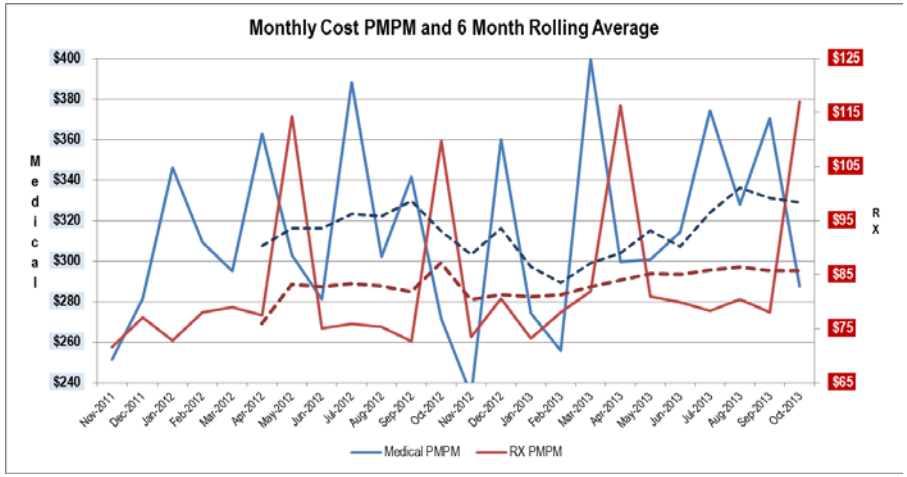
Dashboard – Active Members
Current Period: Nov 2012 – Oct 2013

1 Principal Financial Trends – Claims Cost
Active Members



2 Paid Claims Summary –
Active Members

	Current Period			Prior Period			
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total PMPM	Total Paid Amount	Total Paid PMPM	% of Total PMPM	% Change in PMPM
Outpatient Hospital	$585,630,073	$103	25.8%	$581,832,140	$102	25.9%	0.9%
Inpatient Hospital	$448,933,199	$79	19.7%	$449,976,238	$79	20.1%	0.0%
Office	$496,250,350	$87	21.8%	$490,248,989	$86	21.9%	1.4%
Ambulatory Surgical Center	$38,945,398	$7	1.7%	$35,058,283	$6	1.6%	11.3%
Home	$33,044,058	$6	1.5%	$33,087,150	$6	1.5%	0.1%
All Others	$190,744,831	$34	8.4%	$173,930,458	$30	7.8%	9.9%
Total Medical	$1,793,547,910	$315	78.9%	$1,764,133,258	$309	78.6%	1.9%
Total Rx	$480,665,185	$84	21.1%	$479,067,633	$84	21.4%	0.5%
Total Paid	$2,274,213,094	$400	100.0%	$2,243,200,891	$393	100.0%	1.6%
Member Paid	$467,374,251	$82	20.6%	$508,741,857	$89	22.7%	-7.9%
Plan Paid	$1,806,838,843	$317	79.4%	$1,734,459,034	$304	77.3%	4.4%

3 Key Healthcare Performance Metrics –
Active Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	474,288	475,304	-0.2%	N/A	N/A
High Cost Claimants	12,420	12,090	2.7%	N/A	N/A
High Cost Claimants Total Paid	$749,540,542	$736,822,657	1.7%	N/A	N/A
Inpatient Days Per Thousand	221	229	-3.6%	250	-11.4%
Average Inpatient Day Cost	$3,556	$3,418	4.0%	$3,672	-3.2%
Total Admissions Per 1000	54	55	-2.2%	61	-11.3%
Readmissions Per 1000 (30 Day)	7.7%	8.5%	-9.2%	N/A	N/A
Average Cost Per Admission	$14,650	$14,284	2.6%	$15,154	-3.3%
ER Visits Per 1000	197	194	1.3%	197	-0.2%
Office Visits For Medical Care Per 1000	3,210	3,223	-0.4%	3,080	4.2%
Office Visits for Preventive Care Per 1000	530	525	1.0%	383	38.6%
Rx Scripts Per 1000	11,594	12,238	-5.3%	9,853	0%
Average Cost Per Script	$87	$82	6.1%		

* Verisk BOB Norms; Segal Rx Norms

4 Major Conditions – Prevalence and Cost
Active Members with Conditions

Chronic Condition	Current Period		Prior Period		% Change in Members	% Change in Paid
	Members	Paid	Members	Paid		
1. Diabetes	39,481	$309,116,912	39,093	$302,861,054	1.0%	2.1%
2. Coronary Artery Disease (CAD)	11,370	$151,978,786	10,927	$155,345,263	4.1%	-2.2%
3. Asthma	36,767	$186,323,504	30,515	$157,393,597	20.5%	18.4%
4. Chronic Obstructive Pulmonary Disease (COPD)	7,849	$88,639,885	6,738	$79,607,495	16.5%	11.3%
5. Hypertension	111,855	$710,518,351	109,018	$691,002,571	2.6%	2.8%
6. Breast Cancer	4,367	$83,781,677	4,247	$82,651,458	2.8%	1.4%
7. Colon Cancer	732	$22,933,603	662	$23,085,152	10.6%	-0.7%
8. Prostate Cancer	1,712	$21,477,830	1,762	$22,589,907	-2.8%	-4.9%
9. At Risk Birth	3,069	$38,138,804	3,163	$36,495,104	-3.0%	4.5%
10. Normal Delivery	3,030	$28,986,404	3,390	$30,647,042	-10.6%	-5.4%

Members with co-morbidities and their corresponding claims are combined in each applicable category.

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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Dashboard – Active Members
Current Period: Nov 2012 – Oct 2013

5 High Risk High Cost Analysis – Active Members High Cost By Condition

Chronic Condition for High Cost Claimants*	Current Period		Prior Period		% Change in Members	% Change in PMPY
	Members	PMPY	Members	PMPY		
1. Diabetes	3,047	$66,621	3,100	$67,618	-1.7%	-1.5%
2. Coronary Artery Disease (CAD)	1,884	$70,315	2,028	$72,371	-7.1%	-2.8%
3. Asthma	1,755	$57,181	1,611	$60,895	8.9%	-6.1%
4. Chronic Obstructive Pulmonary Disease (COPD)	1,030	$74,776	1,030	$75,031	0.0%	-0.3%
5. Hypertension	6,872	$63,275	6,985	$64,036	-1.6%	-1.2%
6. Breast Cancer	935	$80,566	964	$79,984	-3.0%	0.7%
7. Colon Cancer	241	$100,254	246	$103,617	-2.0%	-3.2%
8. Prostate Cancer	286	$60,867	298	$63,166	-4.0%	-3.6%
9. Birth	232	$37,977	185	$39,735	25.4%	-4.4%

*High Cost Claimants are above $25,000

6 Clinical Quality Performance – Active Members

Chronic Condition	Clinical Compliance Metrics	Individuals			NCQA Quality Compass National Average*
		Population	Compliance Rate Prior Period	Compliance Rate Current Period	
Diabetes	• Patient(s) that had at least 2 hemoglobin A1C tests in last 12 reported months**	39,481	62.14%	60.00%	87.30%
	• Patient(s) that had an annual screening test for diabetic nephropathy	39,481	41.91%	39.38%	77.90%
	• Patient(s) that had an annual screening test for diabetic retinopathy	39,481	91.53%	83.57%	48.40%
Coronary Artery Disease	• Patient(s) currently taking an ACE-inhibitor	11,370	40.92%	40.57%	78.80%
	• Patient(s) currently taking a statin	11,370	68.12%	66.04%	Not Available
Hyperlipidemia	• Patient(s) with a LDL cholesterol test in last 12 reported months	231,816	95.10%	95.66%	83.6%***
	• Patient(s) with a total cholesterol test in last 12 reported months	231,816	95.11%	95.69%	Not Available
Preventive Screening	• Cervical cancer	243,059	71.92%	73.35%	74.40%
	• Breast cancer	148,701	67.82%	69.86%	66.80%
	• Colorectal cancer	134,919	53.28%	57.01%	55.20%
	• Prostate cancer	49,400	26.56%	29.40%	Not Available
COPD	• Patients with spirometry testing in the last 12 months	7,849	43.16%	39.47%	40.40%
Asthma	• Patient with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	36,767	66.20%	62.11%	91.70%

*Source: NCQA – State of Health Care Quality 2012 – Accredited Plans 2011 Commercial PPO Averages
**The NCQA HEDIS measure is based on one A1C test in the last 12 months whereas Segal measures two
***Represents cholesterol management for patients with cardiovascular conditions: LDL cholesterol screening

7 Summary of Prescription Drug Expenses – Active Members

Category	Current Period	Prior Period	% Change	Norm*
Total Rx Paid Amount	$480,665,185	$479,067,633	0.3%	N/A
Prescriptions Written PMPY	11.6	12.2	-5.3%	
Total Rx Paid PMPY	$1,013	$1,008	0.5%	
Participant Cost Share	22.89%	25.06%	-8.7%	21% – 23%
Total Rx Plan Paid PMPY	$781	755	3.5%	
PBM Generic Dispensing Rate	80%	78%	2.6%	72% – 75%
PBM Mail Order Rx Scripts	1%	1%	0.0%	10%
Specialty RX Paid Amount	$92,873,129	$87,834,545	5.7%	

* Segal Rx Norms

8 Prescription Drug Cost Management Analysis – Active Members

Top 10 Rx Therapy Classes	Current Period		
	Total Paid Amount	% Generic by Count	PMPM
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	$30,802,230	13%	$5.41
ANTIDEPRESSANTS	$28,889,612	88%	$5.08
BIOLOGIC RESPONSE MODIFIERS	$21,587,719	0%	$3.79
INSULINS	$19,513,735	0%	$3.43
PROTON-PUMP INHIBITORS	$16,809,987	58%	$2.95
ANTINEOPLASTIC AGENTS	$15,367,495	90%	$2.70
HMG-COA REDUCTASE INHIBITORS	$15,216,602	80%	$2.67
CONTRACEPTIVES	$13,692,071	84%	$2.41
ANTIRETROVIRALS	$12,660,147	5%	$2.22
ANGIOTENSIN II RECEPTOR ANTAGONISTS	$10,076,325	71%	$1.77

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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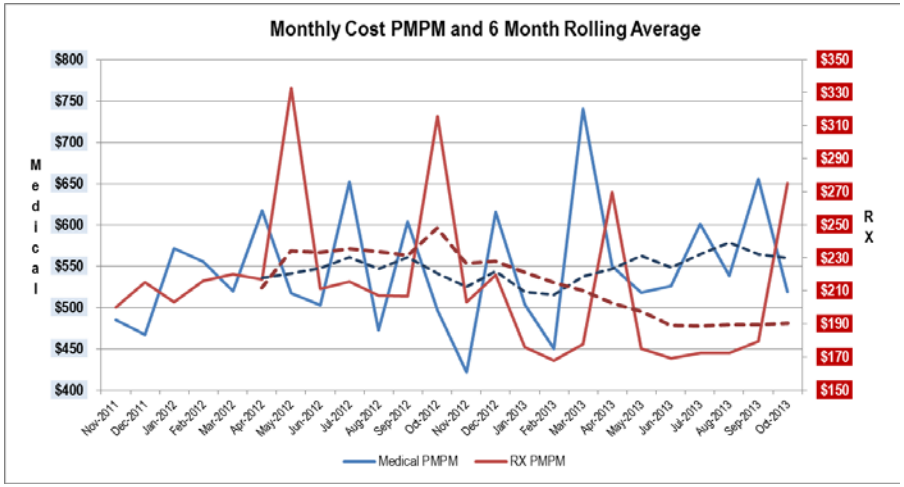
Dashboard – Non-Medicare Retirees
Current Period: Nov 2012 – Oct 2013

1 Principal Financial Trends – Claims Cost
Non-Medicare Retiree Members



2 Paid Claims Summary – Non-Medicare Retiree Members

	Current Period			Prior Period			
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total PMPM	Total Paid Amount	Total Paid PMPM	% of Total PMPM	% Change in PMPM
Outpatient Hospital	$158,693,996	$202	27.3%	$158,350,369	$201	28.2%	0.3%
Inpatient Hospital	$114,981,507	$146	19.8%	$110,428,585	$141	19.7%	4.2%
Office	$109,116,590	$139	18.8%	$107,900,379	$137	19.2%	1.2%
Ambulatory Surgical Center	$10,096,578	$13	1.7%	$8,709,439	$11	1.6%	16.0%
Home	$8,995,153	$11	1.5%	$8,861,132	$11	1.6%	1.6%
All Others	$32,410,284	$41	5.6%	$28,647,100	$36	5.1%	13.2%
Total Medical	$434,294,108	$553	74.7%	$422,897,004	$538	75.3%	2.7%
Total Rx	$146,961,011	$187	25.3%	$138,667,035	$176	24.7%	6.0%
Total Paid	$581,255,120	$740	100.0%	$561,564,039	$715	100.0%	3.6%
Member Paid	$105,056,177	$134	18.1%	$113,010,816	$144	20.1%	-7.0%
Plan Paid	$476,198,943	$606	81.9%	$448,553,223	$571	79.9%	6.2%

3 Key Healthcare Performance Metrics – Non-Medicare Retiree Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	65,456	65,488	0.0%	N/A	N/A
High Cost Claimants	3,633	3,579	1.5%	N/A	N/A
High Cost Claimants Total Paid	$242,341,689	$237,095,708	2.2%	N/A	N/A
Inpatient Days Per Thousand	352	365	-3.7%	250	40.9%
Average Inpatient Day Cost	$4,328	$3,988	8.5%	$3,672	17.9%
Total Admissions Per 1000	68	69	-1.8%	61	11.9%
Readmissions Per 1000 (30 Day)	15.4%	13.5%	14.0%	N/A	N/A
Average Cost Per Admission	$22,503	$21,140	6.4%	$15,154	48.5%
ER Visits Per 1000	208	203	2.3%	197	5.4%
Office Visits For Medical Care Per 1000	4,703	4,686	0.4%	3,080	52.7%
Office Visits for Preventive Care Per 1000	512	501	2.3%	383	33.8%
Rx Scripts Per 1000	23,347	23,753	-1.7%	9,853	0%
Average Cost Per Script	$96	$89	7.9%		

* Verisk BOB Norms; Segal Rx Norms

4 Major Conditions – Prevalence and Cost
Non-Medicare Retiree Members with Conditions

Chronic Condition	Current Period		Prior Period		% Change in Members	% Change in Paid
	Members	Paid	Members	Paid		
1. Diabetes	15,294	$129,957,255	16,877	$142,522,408	-9.4%	-8.8%
2. Coronary Artery Disease (CAD)	6,039	$76,929,950	7,025	$96,754,424	-14.0%	-20.5%
3. Asthma	5,759	$46,186,610	6,109	$44,962,395	-5.7%	2.7%
4. Chronic Obstructive Pulmonary Disease (COPD)	3,429	$44,042,419	4,006	$49,611,609	-14.4%	-11.2%
5. Hypertension	39,665	$275,459,216	44,722	$297,051,573	-11.3%	-7.3%
6. Breast Cancer	2,240	$32,803,999	2,447	$38,452,050	-8.5%	-14.7%
7. Colon Cancer	364	$10,472,618	414	$14,290,066	-12.1%	-26.7%
8. Prostate Cancer	1,009	$9,165,747	1,261	$14,845,484	-20.0%	-38.3%

Members with co-morbidities and their corresponding claims are combined in each applicable category.

North Carolina State Health Plan
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Dashboard – Non-Medicare Retirees
Current Period: Nov 2012 – Oct 2013

5 High Risk High Cost Analysis – Non-Medicare Retiree Members High Cost By Condition

Chronic Condition for High Cost Claimants*	Current Period		Prior Period		% Change in Members	% Change in PMPY
	Members	PMPY	Members	PMPY		
1. Diabetes	1,248	$75,286	1,249	$79,886	-0.1%	-5.8%
2. Coronary Artery Disease (CAD)	845	$77,985	956	$74,791	-11.6%	4.3%
3. Asthma	516	$63,088	400	$67,955	29.0%	-7.2%
4. Chronic Obstructive Pulmonary Disease (COPD)	481	$80,407	499	$80,230	-3.6%	0.2%
5. Hypertension	2,663	$69,392	2,657	$69,089	0.2%	0.4%
6. Breast Cancer	357	$78,849	368	$72,336	-3.0%	9.0%
7. Colon Cancer	108	$107,627	117	$107,512	-7.7%	0.1%
8. Prostate Cancer	111	$59,750	158	$61,806	-29.7%	-3.3%

*High Cost Claimants are above $25,000

6 Clinical Quality Performance – Non-Medicare Retiree Members

Chronic Condition	Clinical Compliance Metrics	Individuals			NCQA Quality Compass National Average*
		Population	Compliance Rate Prior Period	Compliance Rate Current Period	
Diabetes	• Patient(s) that had at least 2 hemoglobin A1C tests in last 12 reported months**	15,294	56.20%	61.10%	87.30%
	• Patient(s) that had an annual screening test for diabetic nephropathy	15,294	35.11%	37.52%	77.90%
	• Patient(s) that had an annual screening test for diabetic retinopathy	15,294	79.74%	83.31%	48.40%
Coronary Artery Disease	• Patient(s) currently taking an ACE-inhibitor	6,039	35.60%	42.94%	78.80%
	• Patient(s) currently taking a statin	6,039	63.63%	76.65%	Not Available
Hyperlipidemia	• Patient(s) with a LDL cholesterol test in last 12 reported months	60,222	82.92%	94.28%	83.6%***
	• Patient(s) with a total cholesterol test in last 12 reported months	60,222	82.91%	94.27%	Not Available
Preventive Screening	• Cervical cancer	42,364	72.61%	78.52%	74.40%
	• Breast cancer	39,922	85.39%	90.36%	66.80%
	• Colorectal cancer	58,771	64.32%	72.86%	55.20%
	• Prostate cancer	19,414	35.49%	41.05%	Not Available
COPD	• Patients with spirometry testing in the last 12 months	3,429	33.60%	43.60%	40.40%
Asthma	• Patient with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	5,759	60.52%	74.53%	91.70%

*Source: NCQA – State of Health Care Quality 2012 – Accredited Plans 2011 Commercial PPO Averages
**The NCQA HEDIS measure is based on one A1C test in the last 12 months whereas Segal measures two
***Represents cholesterol management for patients with cardiovascular conditions: LDL cholesterol screening

7 Summary of Prescription Drug Expenses – Non-Medicare Retiree Members

Category	Current Period	Prior Period	% Change	Norm*
Total Rx Paid Amount	$146,961,011	$138,667,035	6.0%	N/A
Prescriptions Written PMPY	23.3	23.8	-1.7%	
Total Rx Paid PMPY	$2,245	$2,117	6.0%	
Participant Cost Share	21.89%	24.74%	-11.5%	21% – 23%
Total Rx Plan Paid PMPY	$1,754	1,594	10.1%	
PBM Generic Dispensing Rate	77%	74%	4.1%	72% – 75%
PBM Mail Order Rx Scripts	5%	5%	0.0%	10%
Specialty RX Paid Amount	$26,549,651	$23,406,421	13.4%	

* Segal Rx Norms

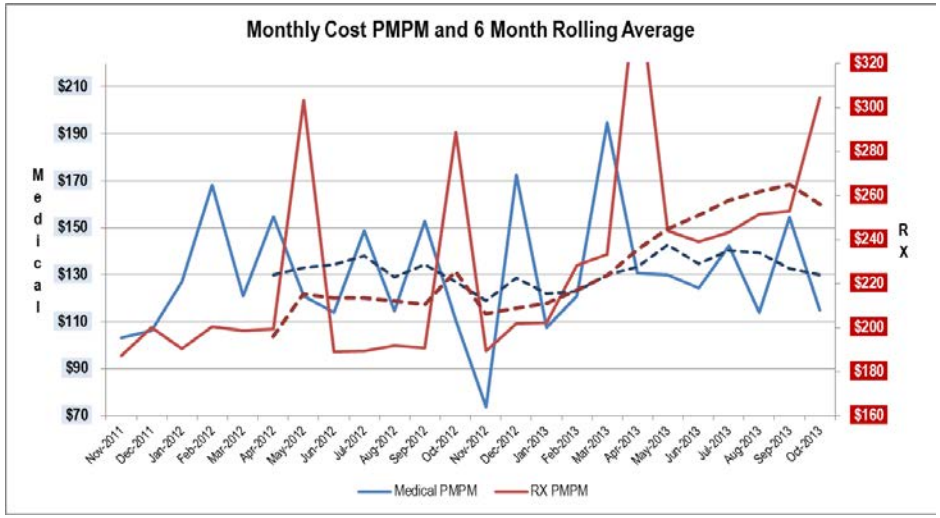
8 Prescription Drug Cost Management Analysis – Non-Medicare Retiree Members

Top 10 Rx Therapy Classes	Current Period		
	Total Paid Amount	% Generic by Count	PMPM
ANTIDEPRESSANTS	$8,245,577	85%	$10.50
HMG-COA REDUCTASE INHIBITORS	$7,482,439	79%	$9.53
INSULINS	$7,342,967	0%	$9.35
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	$7,111,154	24%	$9.05
ANTINEOPLASTIC AGENTS	$7,048,040	90%	$8.97
PROTON-PUMP INHIBITORS	$6,699,537	53%	$8.53
BIOLOGIC RESPONSE MODIFIERS	$6,049,185	0%	$7.70
ANGIOTENSIN II RECEPTOR ANTAGONISTS	$4,284,015	69%	$5.45
OPIATE AGONISTS	$3,561,841	94%	$4.53
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	$3,427,611	0%	$4.36

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

Dashboard – Medicare Retirees
Current Period: Nov 2012 – Oct 2013

1 Principal Financial Trends – Claims Cost
Medicare Retiree Members



2 Paid Claims Summary – Medicare Retiree Members

	Current Period			Prior Period			
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total PMPM	Total Paid Amount	Total Paid PMPM	% of Total PMPM	% Change in PMPM
Outpatient Hospital	$50,600,827	$33	8.5%	$47,614,812	$32	8.5%	2.7%
Inpatient Hospital	$39,925,906	$26	6.7%	$38,432,657	$26	6.8%	0.4%
Office	$59,579,871	$39	10.0%	$57,054,601	$39	10.2%	0.9%
Ambulatory Surgical Center	$4,515,052	$3	0.8%	$4,237,333	$3	0.8%	3.0%
Home	$15,052,324	$10	2.5%	$13,076,952	$9	2.3%	11.3%
All Others	$31,321,699	$21	5.3%	$29,100,542	$20	5.2%	4.0%
Total Medical	$200,995,678	$132	33.9%	$189,516,896	$128	33.8%	2.5%
Total Rx	$392,418,477	$257	66.1%	$371,759,068	$252	66.2%	2.0%
Total Paid	$593,414,155	$389	100.0%	$561,275,965	$381	100.0%	2.2%
Member Paid	$171,956,194	$113	29.0%	$187,329,064	$127	33.4%	-11.3%
Plan Paid	$421,457,961	$276	71.0%	$373,946,901	$254	66.6%	8.9%

3 Key Healthcare Performance Metrics – Medicare Retiree Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	127,178	122,921	3.5%	N/A	N/A
High Cost Claimants	255	221	15.4%	N/A	N/A
High Cost Claimants Total Paid	$15,356,575	$14,117,399	8.8%	N/A	N/A
Inpatient Days Per Thousand	994	968	2.6%	1219	-18.5%
Average Inpatient Day Cost	$2,727	$2,663	2.4%	$1,843	48.0%
Total Admissions Per 1000	185	186	-0.8%	171	8.1%
Readmissions Per 1000 (30 Day)	21.1%	23.0%	-8.0%	N/A	N/A
Average Cost Per Admission	$14,662	$13,842	5.9%	$13,161	11.4%
ER Visits Per 1000	527	516	2.1%	274	92.4%
Office Visits For Medical Care Per 1000	7,210	7,263	-0.7%	6,163	17.0%
Office Visits for Preventive Care Per 1000	62	69	-9.8%	217	-71.4%
Rx Scripts Per 1000	35,174	37,249	-5.6%	25,566	0%
Average Cost Per Script	$88	$81	8.0%		

* Verisk BOB Norms; Segal Rx Norms

4 Major Conditions – Prevalence and Cost Medicare Retiree Members with Conditions

Chronic Condition	Current Period		Prior Period		% Change in Members	% Change in Paid
	Members	Paid	Members	Paid		
1. Diabetes	41,706	$439,784,069	38,532	$405,466,762	8.2%	8.5%
2. Coronary Artery Disease (CAD)	30,072	$397,698,790	27,520	$364,131,441	9.3%	9.2%
3. Asthma	12,557	$142,124,142	10,251	$112,326,735	22.5%	26.5%
4. Chronic Obstructive Pulmonary Disease (COPD)	18,238	$247,977,590	16,145	$215,133,815	13.0%	15.3%
5. Hypertension	101,835	$894,105,139	93,464	$818,653,254	9.0%	9.2%
6. Breast Cancer	7,036	$76,485,081	6,276	$65,761,878	12.1%	16.3%
7. Colon Cancer	1,458	$24,265,079	1,296	$22,353,333	12.5%	8.6%
8. Prostate Cancer	5,287	$56,332,653	4,893	$55,334,591	8.1%	1.8%

Members with co-morbidities and their corresponding claims are combined in each applicable category.

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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Dashboard – Medicare Retirees
Current Period: Nov 2012 – Oct 2013

5 High Risk High Cost Analysis – Medicare Retiree Members High Cost By Condition

Chronic Condition for High Cost Claimants*	Current Period		Prior Period		% Change in Members	% Change in PMPY
	Members	PMPY	Members	PMPY		
1. Diabetes	120	$46,583	112	$60,840	7.1%	-23.4%
2. Coronary Artery Disease (CAD)	95	$44,721	87	$53,831	9.2%	-16.9%
3. Asthma	51	$41,633	26	$48,249	96.2%	-13.7%
4. Chronic Obstructive Pulmonary Disease (COPD)	95	$49,972	70	$58,316	35.7%	-14.3%
5. Hypertension	206	$52,119	167	$59,653	23.4%	-12.6%
6. Breast Cancer	20	$40,602	15	$39,777	33.3%	2.1%
7. Colon Cancer	12	$36,036	5	$39,424	140.0%	-8.6%
8. Prostate Cancer	12	$38,568	6	$35,497	100.0%	8.7%

*High Cost Claimants are above $25,000

6 Clinical Quality Performance – Medicare Retiree Members

Chronic Condition	Clinical Compliance Metrics	Individuals			NCQA Quality Compass National Average*
		Population	Compliance Rate Prior Period	Compliance Rate Current Period	
Diabetes	• Patient(s) that had at least 2 hemoglobin A1C tests in last 12 reported months**	41,706	25.37%	28.02%	87.30%
	• Patient(s) that had an annual screening test for diabetic nephropathy	41,706	22.41%	23.05%	77.90%
	• Patient(s) that had an annual screening test for diabetic retinopathy	41,706	87.64%	84.10%	48.40%
Coronary Artery Disease	• Patient(s) currently taking an ACE-inhibitor	30,072	44.34%	44.60%	78.80%
	• Patient(s) currently taking a statin	30,072	80.14%	80.45%	Not Available
Hyperlipidemia	• Patient(s) with a LDL cholesterol test in last 12 reported months	97,006	50.10%	58.25%	83.6%***
	• Patient(s) with a total cholesterol test in last 12 reported months	97,006	47.70%	56.03%	Not Available
Preventive Screening	• Cervical cancer	33,402	51.73%	65.18%	74.40%
	• Breast cancer	33,302	69.08%	83.82%	66.80%
	• Colorectal cancer	86,788	64.98%	75.18%	55.20%
	• Prostate cancer	29,858	18.62%	25.39%	Not Available
COPD	• Patients with spirometry testing in the last 12 months	18,238	42.13%	42.51%	40.40%
Asthma	• Patient with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	12,557	85.42%	81.33%	91.70%

*Source: NCQA – State of Health Care Quality 2012 – Accredited Plans 2011 Commercial PPO Averages
**The NCQA HEDIS measure is based on one A1C test in the last 12 months whereas Segal measures two
***Represents cholesterol management for patients with cardiovascular conditions: LDL cholesterol screening

7 Summary of Prescription Drug Expenses – Medicare Retiree Members

Category	Current Period	Prior Period	% Change	Norm*
Total Rx Paid Amount	$392,418,477	$371,759,068	5.6%	N/A
Prescriptions Written PMPY	35.2	37.2	-5.6%	
Total Rx Paid PMPY	$3,086	$3,024	2.0%	
Participant Cost Share	20.96%	26.25%	-20.1%	21% – 23%
Total Rx Plan Paid PMPY	$2,439	2,230	9.3%	
PBM Generic Dispensing Rate	79%	76%	3.9%	72% – 75%
PBM Mail Order Rx Scripts	5%	5%	0.0%	10%
Specialty RX Paid Amount	$63,583,916	$52,245,335	21.7%	

* Segal Rx Norms

8 Prescription Drug Cost Management Analysis – Medicare Retiree Members

Top 10 Rx Therapy Classes	Current Period		
	Total Paid Amount	% Generic by Count	PMPM
ANTINEOPLASTIC AGENTS	$25,205,970	89%	$16.52
INSULINS	$19,738,146	0%	$12.93
HMG-COA REDUCTASE INHIBITORS	$19,430,290	84%	$12.73
PROTON-PUMP INHIBITORS	$16,613,021	61%	$10.89
ANTIDEPRESSANTS	$14,871,983	87%	$9.74
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	$13,152,277	36%	$8.62
ANGIOTENSIN II RECEPTOR ANTAGONISTS	$12,987,204	72%	$8.51
BIOLOGIC RESPONSE MODIFIERS	$9,352,902	0%	$6.13
OPIATE AGONISTS	$8,843,481	95%	$5.79
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	$8,488,252	0%	$5.56

Healthcare Dashboard
Definitions

Data Dictionary/Definitions

1. Principal Financial Trends

Monthly Cost PMPM – total paid PMPM includes plan paid and member cost sharing; removed COB from Medicare Retirees

2. Paid Claims Summary

Total Paid Amount / Total Paid PMPM – financial metrics are reported on a total cost basis (i.e., total cost includes plan paid and member cost sharing); removed COB from Medicare Retirees

Outpatient – identified by using their claim type identifier (clmtyp='OUTP')

Inpatient – identified by using their claim type identifier (clmtyp='INPT')

Office – identified using Place of Service Code = 11

Ambulatory Surgical Center – identified using Place of Service Code = 24

Home – identified using Place of Service Code = 12

All Others – Total Medical Dollars minus (OutP+IP+Office+ASC+Home)

3. Key Healthcare Performance Metrics

Average membership – sum of the monthly membership for the 12 month period) divided by 12

High Cost Claimants – those that exceed $25,000 in total medical claims during the period. Rx is not included because we could not tie the RX and medical claims together due to eligibility insufficiency.

All "Per 1000" numbers use the average membership divided by 1000 as the denominator

Inpatient - includes POS code 21; excludes any claims when the total paid amount (member+plan) for the entire "stay" was less than $500 to eliminate low outliers.

Preventive visits – defined as Place of Service = 11 AND CPT Code included in ('99381', '99382', '99383', '99384', '99385', '99386', '99387', '99391', '99392', '99393', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99411', '99412')

ER visits – defined as Place of Service Code 23

Office Visits for Medical Care –defined as Place of Service 11 for all codes EXCEPT those defined above as Preventive

Healthcare Dashboard
Definitions

4. Major Chronic Conditions

Asthma – members who have ever had a claim with at least one occurrence of an ICD diagnosis code that begins with 493

Breast Cancer - members who have ever had a claim with at least one occurrence of any of the following ICD diagnosis codes (174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9)

Cervical Cancer - members who have ever had a claim with at least one occurrence of any of the following ICD diagnosis codes (180.0,180.1,180.8,180.9)

COPD - members who have ever had a claim with at least one occurrence of any of the following ICD diagnosis codes (491, 492, 493.2x, 494, 496)

Colon Cancer – members who have ever had a claim with at least one occurrence of any of the following ICD diagnosis codes (153.0, 153.1, 153.2, 153.3, 153.4, 153.6, 153.7, 153.8, 153.9)

Coronary Artery Disease - members who have ever had a claim with at least one occurrence of any of the following ICD diagnosis codes (410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82)

Diabetes - members who have ever had a claim with at least one occurrence of an ICD diagnosis code that begins with 250

Hyperlipidemia - members who have ever had a claim with at least one occurrence of any of the following ICD diagnosis codes (272.0, 272.1, 272.4) OR one occurrence of any of the following procedure codes (80061, 82172, 82465, 83715, 83716, 83718, 83719, 83721, 84478)

Hypertension - members who have ever had a claim with at least one occurrence of any of the following ICD diagnosis codes (401.0, 401.1, 401.9, V81.1)

Prostate Cancer - members who have ever had a claim with at least one occurrence of an ICD diagnosis code that begins with 185

4. Major Chronic Conditions (*continued*)

Live Birth – members who have ever had a claim with at least one occurrence of any of the following ICD diagnosis codes 650, V27.0, V27.2, V27.3, V27.5, V27.6, V30, V30.0, V30.00, V30.01, V30.1, V30.2, V31, V31.0, V31.00, V31.01, V31.1, V31.2, V33, V33.0, V33.00, V33.01, V33.1, V33.2, V34, V34.0, V34.00, V34.01, V34.1, V34.2, V37, V37.0, V37.00, V37.01, V37.1, V37.2, V39, V39.0, V39.00, V39.01, V39.1, V39.2

At Risk Birth – live birth meeting one of the following conditions (followed by the CPT and/or diagnosis codes used for classification) :

- Low birth weight (<2500 grams)
  - 76401, 76402, 76403, 76404, 76405, 76406, 76407, 76408, 76411, 76412, 76413, 76414, 76415, 76416, 76417, 76418, 76421, 76422, 76423, 76424, 76425, 76426, 76427, 76428, 76491, 76492, 76493, 76494, 76495, 76496, 76497, 76498, 76501, 76502, 76503, 76504, 76505, 76506, 76507, 76508, 76511, 76512, 76513, 76514, 76515, 76516, 76517, 76518, V2130, V2131, V2132, V2133, V2134, V2135
- Pre-existing hypertension causing complications
  - 6422, 6427, 64220, 64221, 64222, 64223, 64224, 64270, 64271, 64272, 64273, 64274
- Premature birth (<37 weeks)
  - 76521, 76522, 76523, 76524, 76525, 76526, 76527, 76528
- Pregnancy complications caused by obesity
  - 64910, 64911, 64912, 64913, 64914
- Pregnancy complications caused by tobacco
  - 64900, 64901, 64902, 64903, 64904
- Eclampsia
  - 6426, 64260, 64261, 64262, 64263, 64264

4. Major Chronic Conditions (*continued*)

At Risk Birth (*continued*) – live birth meeting one of the following conditions (followed by the CPT and/or diagnosis codes used for classification) :

- Preeclampsia
  - 6424, 64240, 64241, 64243, 64244, 6425, 64250
- Drug dependence during pregnancy
  - 64830, 64831, 64832, 64833, 64834
- Diabetes during pregnancy (gestational diabetes)
  - 6488, 6489, 64880, 64881, 64882, 64883, 64884, 64890, 64891
- Pregnancy with history of infertility and/or ART
  - V230, V2385, V2386

Healthcare Dashboard
Definitions

5. High Risk High Cost Analysis

High Cost Claimants – A high cost claim was any claim that exceeded 25K during the period. We could not tie a members medical and drug claims together, so the 25K is only looking at medical claims.

6. Clinical Quality Performance

Asthma (**Patient with inhaled corticosteroids or leukotriene inhibitors in the last 12 months**) – members who have at least one RX claim, during the 12 month period, for a drug with a Generic Product Indicator (GPI) beginning with 44 or 50

Breast Cancer (**Mammography Screening**) **–** members who have at least one claim record with one of the following procedure codes **(**77052, 77055, 77056, 77057, G0202, V761)

Cervical Cancer (**Screening**) – members who have at least one claim record with one of the following procedure codes (88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164, 88165, 88166, 88167, 88174, 88175, V7231, V7232, V762)

COPD (**Patients with spirometry testing in the last 12 months**) - members who have at least one claim record with one of the following procedure codes (94010, 94014, 94015, 94016, 94060, 94070, 94375, 94620)

Colon Cancer (**Screening**) – members who have at least one claim record with one of the following procedure codes during the period (44388, 44389, 44392, 44393, 44394, 45330, 45331, 45333, 45338, 45339, 45378, 45380, 45383, 45384, 45385, 82270, 82274, 88304, 88305, G0104, G0105, G0106, G0120, G0121, G0122, G0328, V160, V1851, V1859, V7641, V7650, V7651)

Diabetes (**Patient that had at least 2 hemoglobin A1C tests in last 12 reported months**) - members who have at least two occurrences of a claim record with one of the following procedure codes during the period (83036, 83037, 3044F, 3045F, 3046F, 3047F)

Diabetes (**Patient that had an annual screening test for diabetic nephropathy**) - members who have at least one claim record with one of the following procedure codes during the period (81000, 81001, 81002, 81003, 81005, 82042, 82043, 82044, 84156, 3062F, 3060F, 3061F)

Healthcare Dashboard
Definitions

6. Clinical Quality Performance (*continued*)

Diabetes (**Patient that had an annual screening test for diabetic retinopathy**) - members who have at least one claim record with one of the following procedure codes during the period (67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 99203, 99204, 99205, 92012, 92014, 92018, 92019, 99213, 99214, 99215, 92225, 92227, 92228, 92230, 92240, 92250, 92260, 99242, 99243, 99244, 99245, 92134, 92226, 92235, 2022F, 2024F, 2026F, 3072F, S0621, S0620, S0625, S3000)

Hyperlipidemia (**Patient with total cholesterol testing in last 12 reported months**) - members who have at least one claim record with one of the following procedure codes during the period (82465, 80061, 82172, 83715, 83716, 83719, 83721, 83718, 84478)

Hyperlipidemia (**Patient with an LDL cholesterol test in last 12 reported months**) - members who have at least one claim record with one of the following procedure codes during the period (82465, 80061, 82172, 83715, 83716, 83719, 83721, 83718, 8447

Prostate Cancer (**Screening**) – members who have at least one claim record with one of the following procedure codes (79093, 84152, 84153, 84154, G0102, G0103, V1642, V7644, V8403)

7. Summary of Prescription Drug Expense

Norms – We also utilized Segal book of business benchmarks for pharmacy norms

8. Prescription Drug Cost Management Analysis

High Cost Top Rx Therapy Classes – Based on American Hospital Therapy Class (AHFS) highest total plan paid (i.e., plan paid and member cost sharing)

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Provider Payment Methodologies and Strategies

Board of Trustees Meeting

January 31, 2014

A Division of the Department of State Treasurer

Presentation Overview

- Executive Summary
- Current Payment Model
- Environmental Scan of Payment Methodologies
- Next Steps and Recommendations

Executive Summary

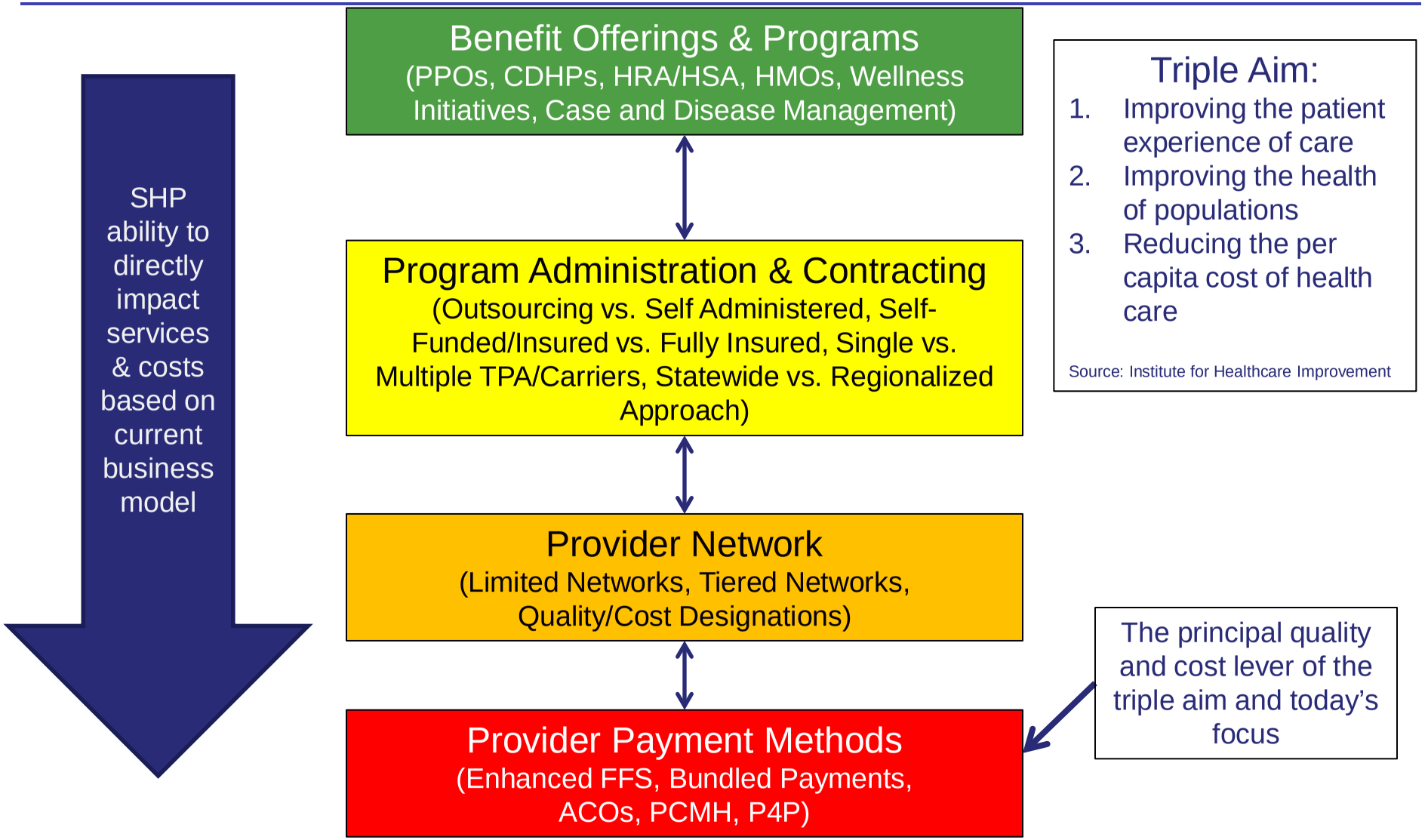
Purpose

- As part of the Strategic Planning process the Strategic Planning Workgroup and Board of Trustees requested an environmental scan of emerging alternative provider payment methodologies and strategies that focus on quality, cost, and member experience

Key findings

- The current SHP model is a Fee for Service (FFS) approach which places almost all of the financial responsibility associated with members' health risk on the Plan while paying providers for volume (i.e. per service basis) rather than quality or outcomes
- Emerging provider payment strategies focus on sharing or spreading the financial risk among the payers of health care (SHP, our carriers, and our members) and those providing care
  - Providers have a greater incentive to provide cost-effective, high quality, outcome driven care if there are financial incentives and expectations
- The goal of alternative payment arrangements is to shift some or all of the risk to providers of care to incentivize the use of high quality, lower cost solutions to keep members healthier
- Emerging strategies enforce a **balance** of access and choice with affordability and quality/outcomes

Methods to Address the Triple Aim & The Cost of Health Benefits



The 2014 SHP Service Model

	Active Employees & Pre-65 Retirees		Medicare Retirees 70/30		Medicare Retirees MAPDP	
	Responsible Vendor/Party	Payment Type & Basis	Responsible Vendor/Party	Payment Type & Basis	Responsible Vendor/Party	Payment Type & Basis
Eligibility & Enrollment Services	Benefitfocus	Admin Fee, PSPM	Benefitfocus	Admin Fee, PSPM	Benefitfocus	Admin Fee, PSPM
Medical Benefit Management Network Management and Discounts Claims Processing, COB Medical Policies, PA & UM Programs Customer Service	BCBSNC	Admin Fee, PSPM	BCBSNC	Admin Fee, PSPM	Humana or UHC	Fully Insured Premium, PMPM
Pharmacy Benefit Management Network Management and Discounts Claims Processing, COB Rx Policies, PA & UM Programs Customer Service	ESI	Admin Fee, Per Claim	ESI	Admin Fee, Per Claim	Humana or UHC	Fully Insured Premium, PMPM
Population Health Management Disease & Case Management Wellness Supports & Programs	ActiveHealth Management	Admin Fee, PMPM	Not Available		Humana or UHC	Fully Insured Premium, PMPM
Cost of Claims	Members	Applicable Copays, Deductible, Coninsurance	Members	Applicable Copays, Deductible, Coninsurance	Members	Applicable Copays, Deductible, Coninsurance
	SHP/Members	Plan Pays Allowed Charges Less Member Cost Share	SHP/Members	Plan Pays Allowed Charges Less Member Cost Share	Humana or UHC	Carriers Pay Medicare/Network Allowed Charges Less Member Cost Share
Financial Risk	Members	Limited to Cost Sharing Provisions of Benefit Design	Members	Limited to Cost Sharing Provisions of Benefit Design	Members	Limited to Cost Sharing Provisions of Benefit Design
	SHP	Limited by Network & Negotiated Rates, but Unlimited Regarding Health/Actuarial Risks	SHP	Limited by Network & Negotiated Rates, but Unlimited Regarding Health/Actuarial Risks	SHP	Limited to Premium Cost
					Humana or UHC	Managed by Network & Medicare Provisions, but Unlimited Regarding Health/Actuarial Risks

State Health Plan Payment Model

Current Statewide Risk Model:

- The State Health Plan partners with one third party administrator (TPA), Blue Cross and Blue Shield of North Carolina, and two carriers, Humana and United, to provide members with broad access to care
  - BCBSNC: State Health Plan assumes the financial/actuarial risk
  - Humana/United: Carriers assume the financial/actuarial risk
    - **HOWEVER,** utilization under Medicare Advantage plans is more tightly managed and there are significant financial subsidies at risk for plan performance, similar to many of the components to be discussed

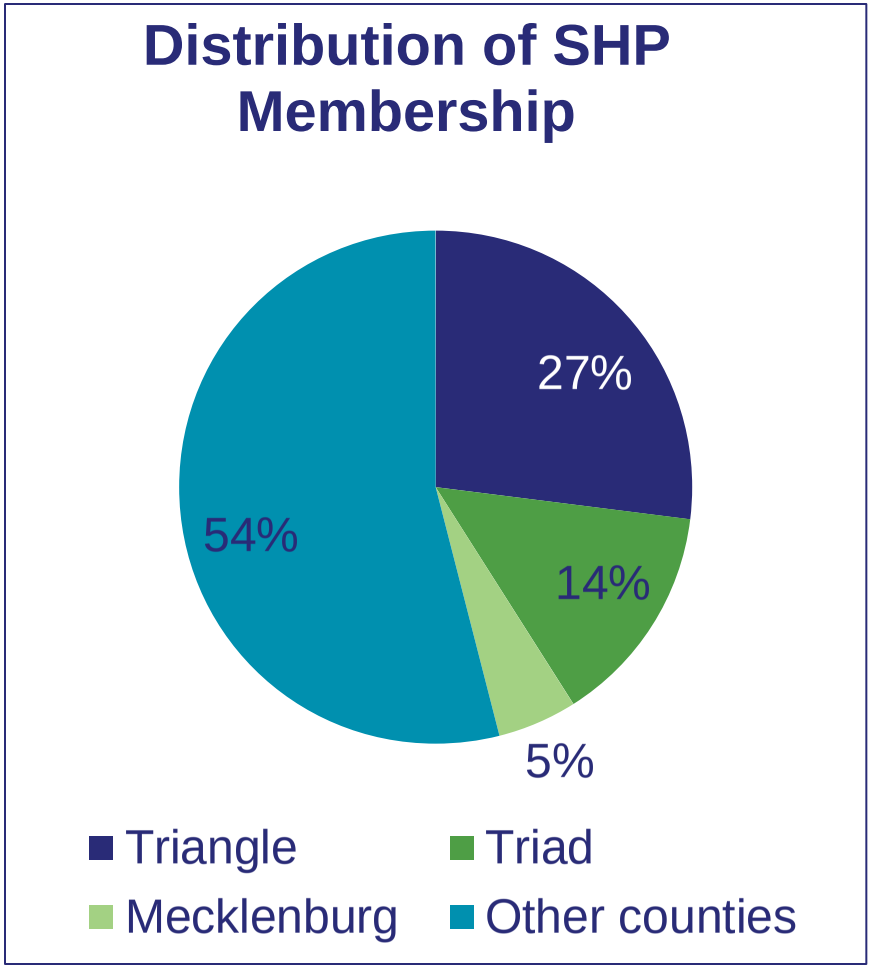
Economies of Scale:

- The State Health Plan benefits from the additional membership available through our vendor partners in negotiating provider rates
  - Providers in Swain County (831 members) do not have access to the entire Plan membership but partnering with a TPA like BCBSNC increases our ability to negotiate lower rates (SHP members only represent approximately 17% of BCBSNC book of business in that area)

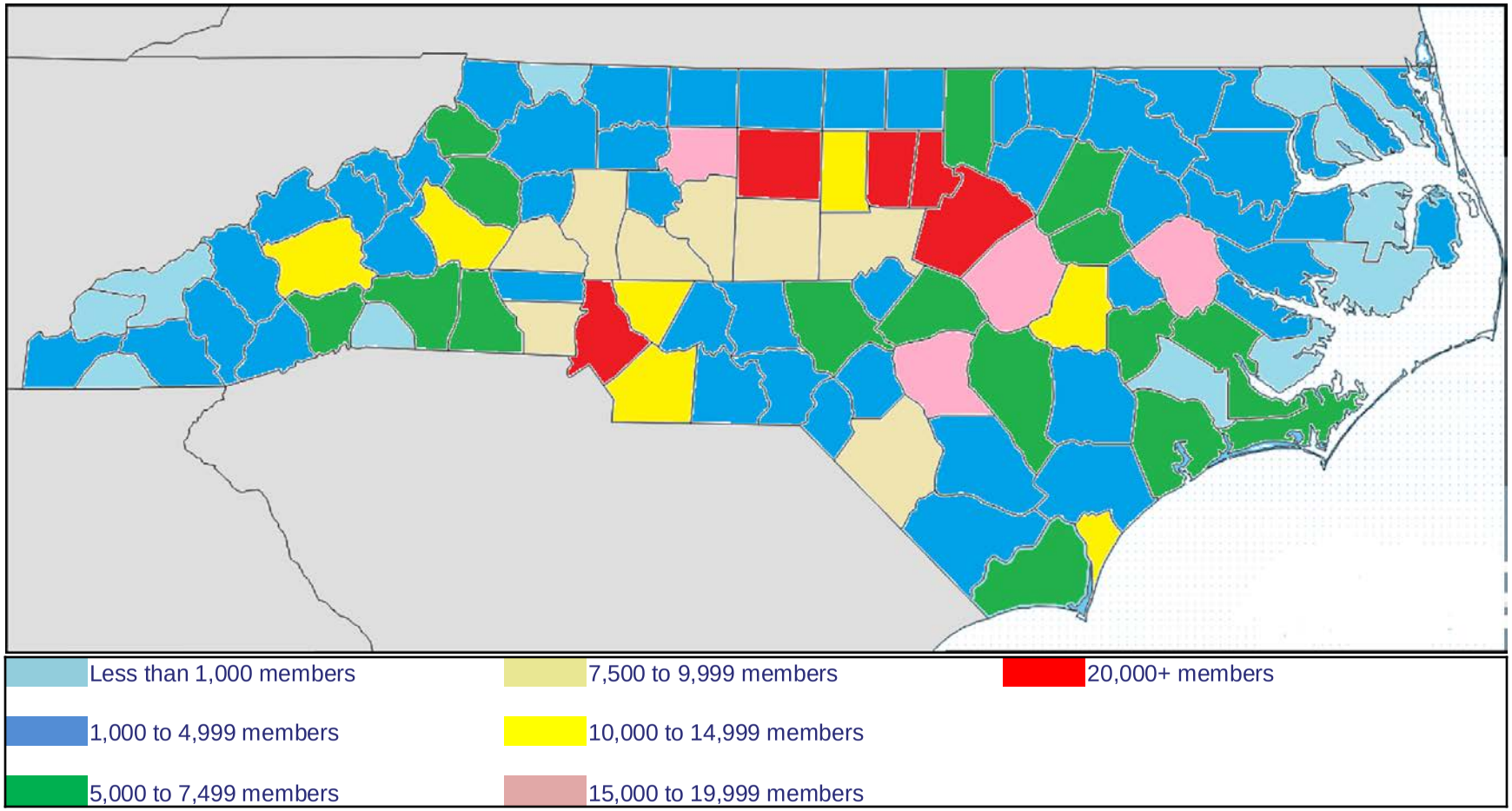
State Health Plan Membership

Current Membership:

- Over 670,000 members located throughout North Carolina's 100 counties and out of the State
- Despite the Plan's large size, the State Health Plan membership only made up about 27% of BCBSNC membership in 2013
- There are a significant number of counties with less than 1,000 SHP members
- Of the remaining counties not shown in the graph, *no county represents more than 3% of SHP membership*

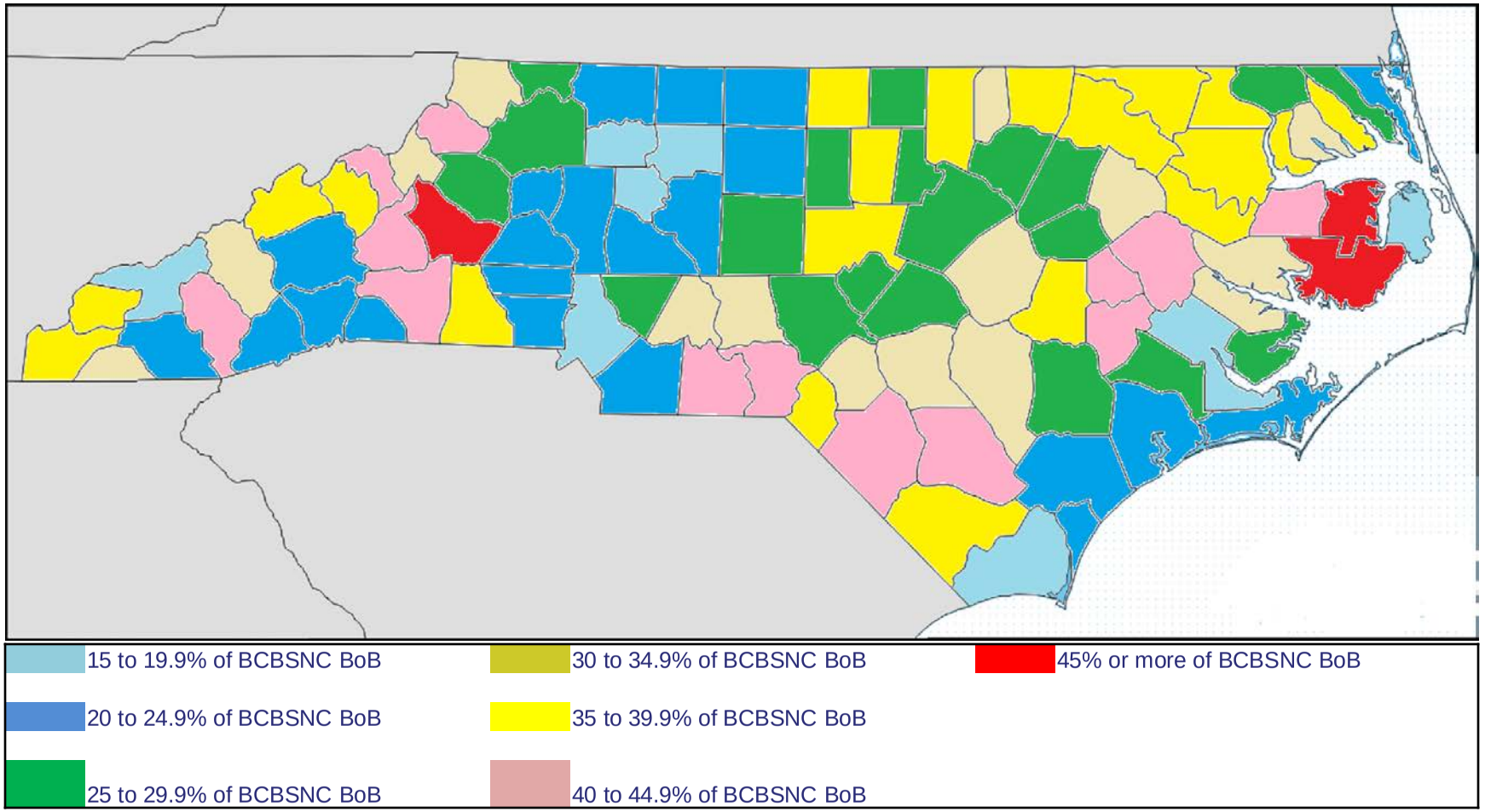


CY 2013 Average Distribution of SHP Membership



- Plan members live throughout the State and utilize multiple providers throughout the State

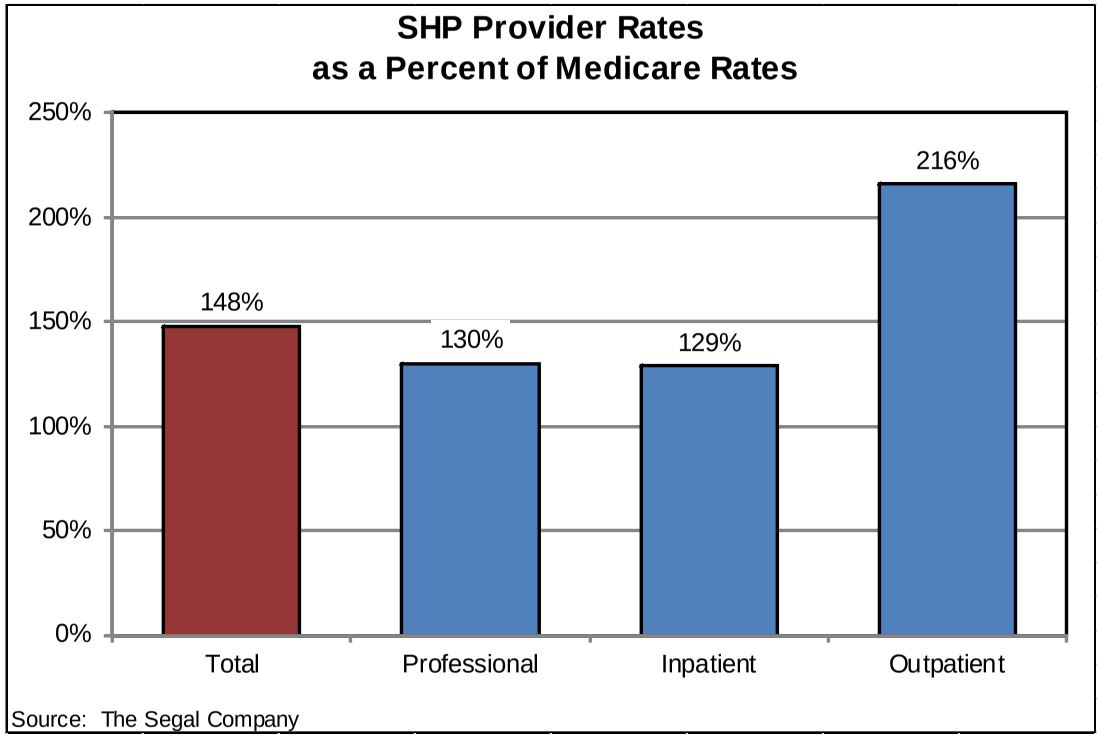
CY 2013 SHP Membership as a Percentage of BCBSNC's Book of Business



- In CY 2013 SHP membership accounted for 27% of BCBSNC's total membership
- Partnering with a TPA like BCBSNC improves the Plan's buying power

SHP Payments Under Fee for Service

- Combining professional and hospital rates, Segal concluded that, on average, the Plan pays providers at approximately 148% of Medicare rates; which is in line with expectations
- Medicaid pays approximately 90% of the Medicare provider rates; the Plan's rates would be about 164% of Medicaid rates



From May 2013 BOT Meeting

Current SHP Risk Sharing

Self – Funded
Currently, the State Health Plan (through BCBSNC) bears almost all of the financial & actuarial risk for our members' care.

MA Plans
Currently, our MA Carriers bear almost all of the financial & actuarial risk for our members' care. The Plan's financial exposure is limited, but premiums could increase in the future.

Spectrum of Potential Payment Methodologies

- The goal of many alternative provider payment arrangements is to shift from paying for productivity and each procedure (i.e. the FFS model) to paying for quality and outcomes
  - Additional benefits include better member experience and engagement as well as overall efficiency in the health care system
  - Currently, providers are not compensated if all their members are healthy
- The alternative payment models take various approaches to addressing quality but some key themes include:
  - Coordination of care
  - Enhanced focus on primary care
  - Incentives for reducing undesirable outcomes and bonuses for positive outcomes and use of appropriate settings of care
  - Payment withholds for lower quality care and/or redundant care

Capitation Risk Sharing Arrangement

Capitation Features:

- Fixed per capita payments to provide member care
- Tight networks
- Full risk on providers to manage and coordinate care

Payer of health care – 100% of risk

Provider of health care – 100% of risk

Traditional Capitation

- Capitation pays provider(s) a fixed fee for a designated period of time to provide all of a member's care
  - If a member has no services the provider still receives payment
- Popular in the US in the 1990s
  - Some models currently exist
- Concerns about providers being incented to withhold care or severely limit the amount of care provided
  - The opposite of the Fee For Service issue/concern
- Doesn't account for member acuity or complex care needs
- Significantly limits member choice of providers

ACO Risk Sharing Arrangement

ACO Features:

- Fixed capitated payments with the flexibility to adjust amounts to address acuity needs of populations
- Provider "stop loss"
- Bonuses and withholds depending on outcomes

Payer of health care – 100% of risk

Provider of health care – 100% of risk

Accountable Care Organizations (ACO)

- CMS defines an ACO as:

  Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors

  If savings are generated then they are shared throughout the system, If they are not then the responsibility for the cost is also shared

- Local and national marketplaces are using multiple approaches and methods for defining and establishing ACO-like entities
  - The market definition has significant variation

- ***ACOs need a captive population and tight integration to be effective***
- ***Based on geography and provider readiness it would be extremely difficult for the Plan to create an ACO***

How ACOs Differ From Traditional Capitation

- ACOs can address and compensate for acuity differences between populations
  - Per member payments can be based on member conditions versus a flat per patient fee – *Capitation payments are flat*
- ACOs can adjust for complex cases or higher needs populations by putting limits on risk to providers
  - Provider “stop loss” – *Capitation requires the Provider to take inappropriate risk*
- ACOs can include bonuses and penalties based on the quality of care provided
  - Reduces incentives to withhold care
  - Providers are compensated for keeping patients well
- ACOs combine elements of multiple payment models
  - Bundling, episodes of care
- ACOs can be designed for specific sets of care or a global payment
  - Primary Care
  - Acute Care +/- Primary Care
  - Post-Acute +/- Acute Care +/- Primary Care
  - Other combinations
- ACO systems greatly benefit from advances in Health Information Technology and data analytics

Bundled Payment/Episode of Care Risk Sharing Arrangement

Bundled Payment/Episode of Care Features:

- Providers and payers agree on a bundled rate of payments for either a condition or procedure
- Providers manage expenditures and appropriate care settings
- Providers are not compensated if quality care is not provided
- Allows for price adjustments

Payer of health care – 100% of risk

Provider of health care – 100% of risk

Episode of Care/Bundled Payments

- Under Bundled and Episode of Care payments, a single, aggregate payment is made to two or more providers, who otherwise are typically paid separately, for a single episode of care and/or a specific period of time
  - Bundled payment example: Knee Surgery
  - Episode of Care payment example: Cardiac Care and Rehabilitation
    - Medicare utilizes this approach for inpatient care
  - Providers are responsible for distributing payments amongst themselves for care rendered
    - Incents lower cost, higher quality care and utilization of appropriate care settings
    - Cannot easily be applied to all forms of care
- Currently, SHP makes DRG payments to several NC hospitals for inpatient care and bundled payment approaches are developing in certain NC hospitals

Fee for Service vs. Bundling vs. Episode of Care

Fee for Service

Providers	Payments
Primary Care Visits	Paid for each service
Specialist Visits	Paid for each service
Inpatient Care	Paid for each service
Rehabilitative Care	Paid for each service

Bundling

Providers	Payments
Primary Care Visits	Single Payment
Specialist Visits	
Inpatient Care	
Rehabilitative Care	Paid for each service

Episode of Care

Providers	Payments
Primary Care Visits	Single Payment
Specialist Visits	
Inpatient Care	
Rehabilitative Care	

Pay for Performance & Value Based Contracting Risk Sharing Arrangement

Pay for Performance Features:

- Payments may still be made on a fee for service basis
- Partial payment withholds may be used to provide additional funds to high performing providers
- Providers are at risk for payment withholds if they do not meet selected performance measures

Payer of health care – 100% of risk

Provider of health care – 100% of risk

Pay for Performance (P4P) & Value Based Contracting

- *"Pay for performance" is an umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care. These arrangements provide financial incentives to hospitals, physicians, and other health care providers to carry out such improvements and achieve optimal outcomes for patients*
- Popular in Medicare and some Medicaid programs; expanding in Medicare under the ACA
- Provides bonus payments to providers if they meet or exceed quality or performance measures
  - Specific to disease: reduction in hemoglobin A1c in diabetic patients
  - Annual markers: reduction in avoidable hospital readmissions
- Imposes financial withholds on providers that fail to achieve specified goals or cost savings
  - Specific to episode: no payment for preventable hospital infections
  - Annual markers: increases in avoidable hospital readmissions

Patient Centered Medical Home Risk Sharing Arrangement

Patient Centered Medical Home Features:

- PCMH exists in a fee for service model
- Primary care providers (PCPs), or other entry point caregivers, receive enhanced payments or PMPMs to coordinate care throughout the health care system
- May include outcome based bonuses

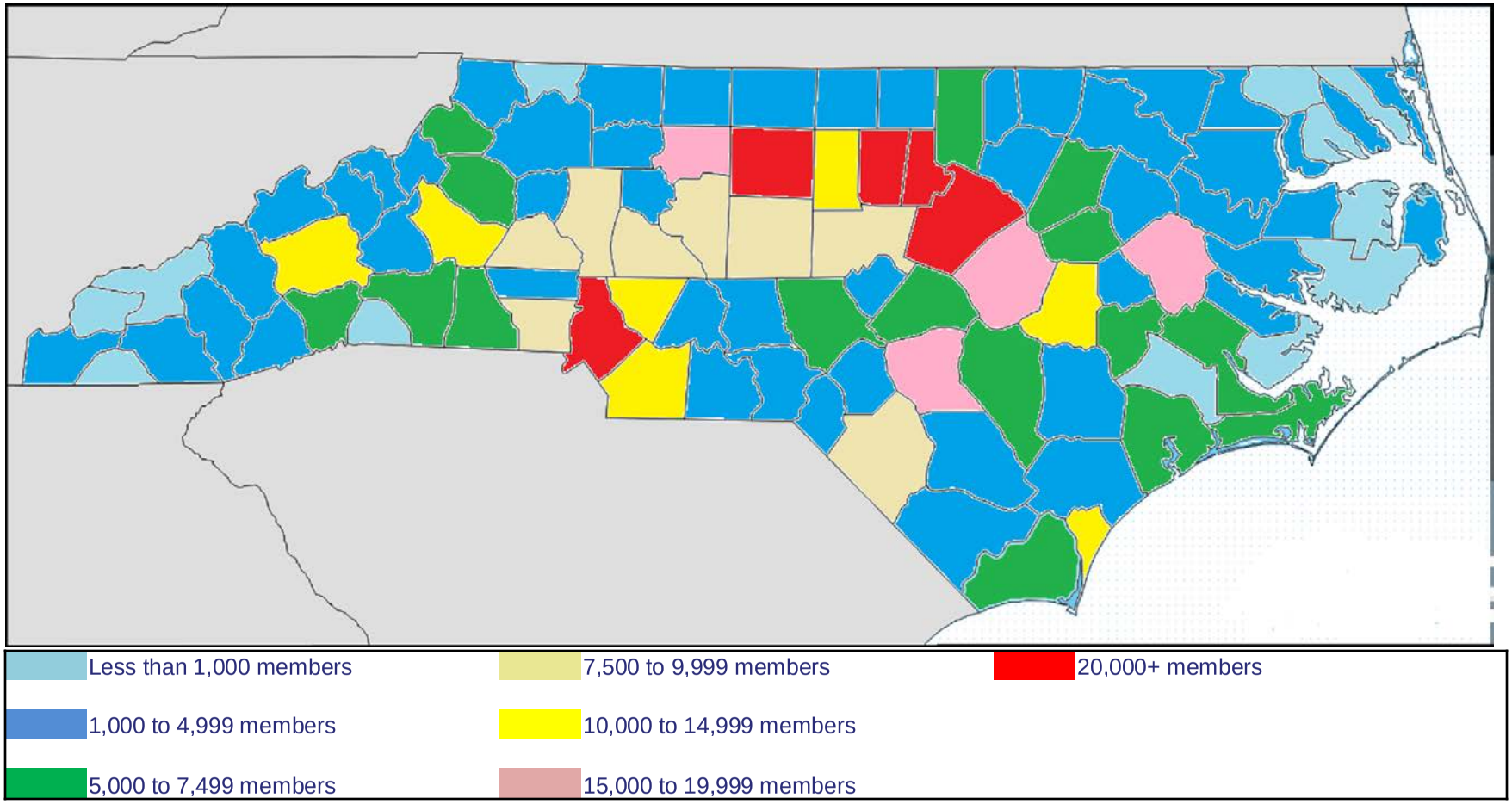
Payer of health care – 100% of risk

Provider of health care – 100% of risk

Patient Centered Medical Home (PCMH)

- The patient centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into “what patients want it to be.” Medical homes can lead to higher quality and lower costs, and can improve patients’ and providers’ experience of care
  - Fixed supplemental payments administered on a per member per month (PMPM) basis or enhanced fees for service to be used for care coordination and performing the functions of a medical home
  - Pay for performance bonus payments for meeting agreed upon medical home metrics (usually process measures, sometimes enhanced to include clinical outcomes measures)
- CCNC is the most recognizable model in North Carolina

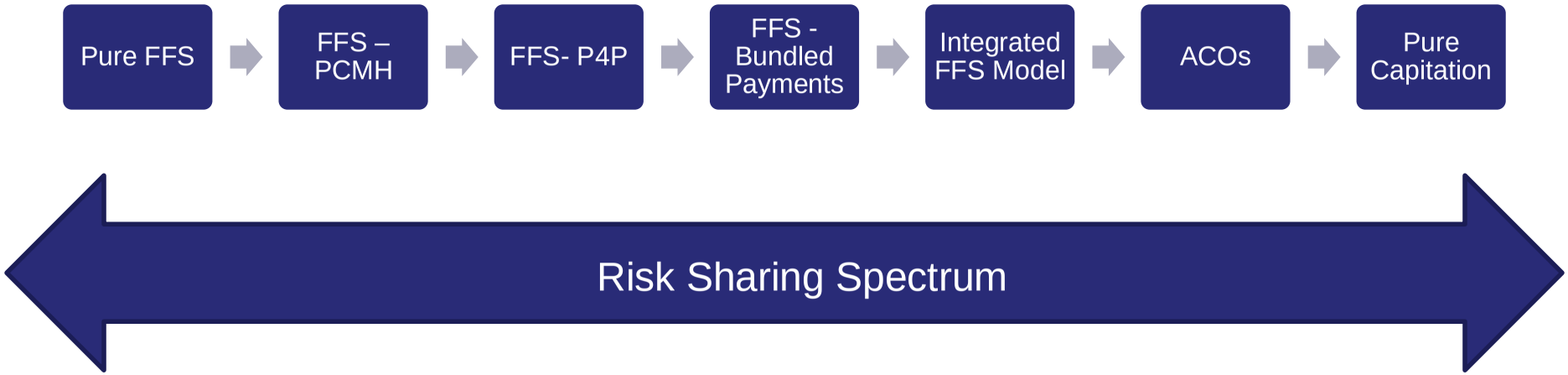
Consider Different Strategies for Different Areas of the State or Populations



Spectrum of Payment Methodologies: What is the Right Balance?

Current model is predominantly FFS

To what degree should the Plan move to the right?



Payer(s) of health care – 100% of insurance and performance risk

Provider of health care – 100% of insurance and performance risk

Summary of Findings

- Alternative payment opportunities are emerging in North Carolina in different parts of the State and at different levels based on the provider groups; SHP members have access to these
- Payment strategies that focus on quality and costs can have an impact on member choice and access – Need appropriate balance
- Alternative models require effective data analytics to monitor performance
- The size of the SHP member population offers opportunities when considering alternative payment methodologies and arrangements; however, the geographical dispersion of members throughout the State presents challenges

Next Steps and Recommendations

- Alternative payment opportunities are emerging in North Carolina in different parts of the State and at different levels based on the provider groups – *Do we promote utilization of these models?*
- A global, statewide strategy toward alternative payments does not appear to be possible in the short-term
- The State Health Plan should work with current and future 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 NC
- Investigate the use of alternative network arrangements and plan designs that can reward members for using higher quality and lower cost facilities
- Consider pursuing condition-based partnerships to reduce avoidable hospitalizations and help members manage conditions

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

Strategic Planning Update & Discussion Outline

January 31, 2014

I. Key Progress Updates

- Overall, moving forward in a positive direction using the **guiding principles** and process recommendations from the discovery phase work
- Discovery report has been completed and will incorporate any final comments received through this Board meeting
- SHP staff have initiated several **environmental scan** analyses
  - Example: Provider Payment Methodologies presentation
- Dashboard and scorecard development are underway
  - Staff has identified several **areas of focus** based on their synthesis
  - Staff is identifying and incorporating **benchmarks** where appropriate
  - Staff intends to use the dashboard to recommend **strategic measures** to the BOT
- BOT workgroup structure will be implemented over time
  - At this point, the focus is aligning staff time to support the analysis
  - As we move forward, the workgroup structure will be refined based on the needs and timing of BOT input and direction
- Key next step: SHP staff will be developing a work plan to manage the development of the strategic plan supporting analyses and BOT discussion topics

II. Final Discovery Report Highlights and Discussion

- Constructive and supportive input was received
- Examples of changes or additions:
  - Emphasis on the member and addressing affordability and competitive benefit offerings
  - Emphasis on the need to have ongoing measurement and monitoring processes in place
  - Reordering of the strategic and business questions to help prioritize and focus the analysis work

III. BOT Input – Environment Scan and Strategic Questions to Address

- Work that is underway based on staff availability and staff recommendations:
  - Provider **payment models/strategies** (presented at this Board meeting)
  - Assessment of **top conditions, utilization trends, medical cost drivers** (presented at this Board meeting through dashboard work)
    - Care opportunities
    - Quality of care compliance
    - Disease programs (asthma)
  - Research on **other state's** health plan offerings and models (of similar characteristics)
  - **Member engagement/worksite wellness** – research model employee wellness programs
  - Effectiveness of **3rd party vendors** (ongoing)
- In queue – ideas for discussion
  - New offerings – specifically for the newly eligible population as defined by the ACA
  - Provider engagement
  - Others…

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North Carolina
State Health Plan

Strategic Planning Process Recommendations

Phase I: Discovery Report

January 31, 2014
Final

Prepared by:
Tom Gualtieri-Reed, MBA
Lynn Spragens, MBA

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

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

Executive Summary

The State Health Plan (SHP) has undergone many changes over the past 18-24 months, including the creation of a 10-member Board of Trustees that has the responsibility to develop and maintain a strategic plan. The State Treasurer, Board of Trustees (BOT) and SHP leadership recognize that an effective strategic planning process and plan will enable the SHP to better fulfill the SHP's mission in the future. This document outlines the key findings from an initial discovery phase of planning work and provides a set of recommendations for developing a strategic planning process and plan for the SHP that can be implemented and maintained by the State Treasurer, the current and future BOT and leaders of the SHP. The following is a summary of the key content and recommendations included in this report:

Strategic Planning Guiding Principles

The guiding principles will be used to create a level of consistency in the planning approaches and may be modified from time to time throughout the planning process. The principles included in this report have been developed based on the input of the members of the BOT and SHP leadership team gathered through interviews, a review of previous planning work and discussions at recent board and staff meetings.

Strategic Planning Framework

The recommended process framework will be used to structure the analysis, synthesis and output of the strategic plan. It is important to note that not all planning processes follow a linear path but this structure will help ensure consistent steps are taken to develop and continuously refresh the strategic plan.

Preliminary Strategic Questions to Address

This report identifies and organizes a set of strategic questions that have already been identified through the work of the BOT and SHP leadership. It is recommended that these issues be the starter list used to drive an initial wave of analysis, measurement and strategic prioritization.

Strategic Plan Governance & Management

The recommendations included in this section are intended to leverage existing strategic planning resources and tools, to create a level of cross-training for BOT and staff to ensure consistency during board term transition periods and specifically recommends that an appropriate level of SHP staffing be assigned to support the development of the strategic plan.

2014 Timeline

The timeline outlined in this report targets the first release of a strategic plan to be in late May or early June 2014. This timeline takes into consideration the time required to allocate and organize staff and resources and the need to better understand and assess the 2014 changes that have been implemented. This timeline can be adjusted as needed, but at a minimum provides the initial steps that can be taken to implement this strategic planning process.

In addition to what is outlined above, this report includes several concept charts, important contract dates and other information that will be useful references during the planning process.

I. Background & Purpose

The State Health Plan for Teachers and State Employees (SHP) provides health care coverage to more than 668,000 teachers, state employees, retirees, state university and community college personnel, and their dependents. The SHP has undergone a significant amount of change over the past 18-24 months.

Effective January 1, 2012 the SHP became a division of the North Carolina Department of State Treasurer. Previously the SHP reported to a legislative oversight committee within the General Assembly. As part of this change, in December of 2011 a new 10-member Board of Trustees (BOT) was appointed by the Governor (2), Senate (2), House (2) and State Treasurer (2) and includes the State Treasurer and State Budget Director. The BOT is made up of a diverse group of current and former teachers, state employees and other experts in medicine and health administration. The board is responsible for decisions regarding vendor contracts and the design of employee health benefits as well as the development of a strategic plan.

During this period of time, the SHP has evaluated and awarded new contracts for third party administrator services for its self-funded plan offerings, added a fully-insured Medicare Advantage offering and two additional payers to administer the offering, transitioned to a January 1 benefit plan year, added a new health engagement offering with incentives for healthy behaviors and undergone a change in SHP administrative leadership. The health care industry is also experiencing unprecedented levels of regulatory and market changes due to the Affordable Care Act (ACA). As the ACA becomes a reality, market and healthcare stakeholders, including employers, individuals, payers, regulators, providers and legislators, are continuously seeking to understand and assess its impact. It is prudent that the BOT and SHP leadership team build such external factors into the strategic planning process.

In an effort to ensure that the SHP continues to fulfill its mission amidst all of these changes, the SHP is undergoing an assessment of its strategic planning process. The purpose of this document is to outline the key findings from an initial discovery phase of work and provide a set of recommendations for developing a strategic planning process and plan for the SHP that can be implemented and maintained by the State Treasurer, the current and future BOT and leaders of the SHP.

II. Phase 1 Discovery Key Findings

As part of this discovery phase, a series of steps were taken to understand the current situation of the SHP strategic planning process and plan. Included in these steps were interviews with the active SHP BOT, including the North Carolina State Treasurer, key staff members of the Treasurer's Office, the SHP Executive Administrator and the SHP Executive Team. In addition, a review was conducted of available BOT minutes, presentations and relevant SHP strategic planning material, the new SHP plan offerings for the January 1, 2014 plan period, the March 2012 report of key findings from the Treasurer's and Board's state-wide tour and other information such as the North Carolina Statutes and a draft dashboard to monitor the quality and experience and the Treasurer's Office strategic priorities.

The following is a summary of key findings from the initial interviews that were conducted:

Progress To Date & What's Going Well
❑ A lot of positive energy, momentum and relationships
❑ Diverse, committed and knowledgeable staff and Board of Trustees
❑ Passion for the member, the member's health and being a model for North Carolina
❑ Significant change is already underway (a "new chassis")
❑ 3rd party vendors have been selected and contracts are in place
❑ Dashboard development is progressing
❑ Long term financial model (underway)
❑ ….others

Challenges & "Natural Tensions"
❑ Diverse, committed and knowledgeable staff and Board of Trustees: How do we leverage this?
❑ Significant change is already underway (a "new chassis"): How do we stabilize while we create new momentum for the future?
❑ Premiums & affordability: What is the value proposition to our members and to other stakeholders (legislature)?
❑ Ability to directly influence price, quality and efficiency: What can we control?
❑ The need for data & information: How do we learn about the market, the business, our members, etc.
❑ Leadership and Board turnover: How do we maintain continuity of purpose and plan?
❑ Prioritization: The many versus the few.

The following is an additional set of strategic planning process observations that were identified and considerations that are factored into the final recommendations:

Topic	Observation	Considerations
Mission Statement	The BOT and SHP Leadership Team are supportive of and are using the Mission Statement to guide their thinking and actions.	No action necessary. Revisit as needed.
Vision Statement	While there is a stated vision in place, there were several comments regarding the desire to move the SHP from an administrator of benefits and insurer to having a more active role in supporting the health outcomes and lifestyle choices of its members.	Consider the revision of a vision statement at an appropriate time during planning.
Guiding Principle Observations	There is a strong desire and a recognized need by both the BOT and SHP leadership to develop a set of strategic planning guiding principles as they relate to: ▪ The reaffirmation of the Mission Statement as the primary guide to decision making ▪ A general statement on and commitment to ensure the strategic plan becomes an active part of the actions and decisions made by the BOT and SHP ▪ Appropriately listening to and considering the differing needs of specific member constituents while balancing what is in the best interests of all members ▪ Member cost sharing, particularly for preventive services ▪ The use of industry benchmarks to measure quality, cost and member experience ▪ The appropriate engagement with and support from the General Assembly, specifically as it relates to reserves and funding approvals ▪ An acknowledgement for the need to stabilize and evaluate current plan design changes while continuing to update, modify, and improve plan offerings and incentives as well as develop new plan designs where appropriate	Develop an initial draft set of Guiding Principles and revisit as needed at appropriate times during the planning process.
Governance and Strategic Management	There is a need to address, as part of the process, the efficient and effective use of the SHP Executive Leadership Team and staff as well as BOT expertise. This includes but is not limited to: ▪ Freeing up time for or allocating dedicated staff time to enable the Executive Administrator to engage in more frequent strategic planning activities ▪ Effectively engaging more of the BOT in the activities of strategic planning, including the effective and appropriate use of the BOT formal board meetings ▪ Enabling the BOT to fulfill their fiduciary role and set the precedence of this being an “active” oversight board	Consider redesigning the use of the BOT meeting time, BOT workgroups and allocation of staff to support strategic planning activities.

III. Strategic Planning Guiding Principles

These guiding principles will be used to enable the BOT and SHP leadership team to develop a strategic plan. These are intended to create a level of consistency in planning approaches and may be modified from time to time during the strategic planning process.

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 desire of the BOT and SHP leadership team to develop a strategic planning process and plan that is **sustainable** beyond the current BOT members and SHP leadership team.

3. The development and execution of a strategic plan is viewed as a **joint responsibility** of the BOT and SHP leadership team, with the BOT approving strategic measures and strategic priorities while providing the support and guidance to the SHP leadership team to execute on the strategic plan.

4. The development of a strategic plan is considered **a process** to help understand what is relevant. The strategic plan will serve as a guide in prioritizing what is done, what is measured and how BOT and SHP staff time and resources are allocated.

5. It is the intent of the BOT and SHP leadership team to utilize all reasonable information sources to support the development of the strategic plan. When and where possible and appropriate, **industry or market benchmarks** and data will be used to develop strategic measures and establish strategic priorities for the SHP, with a specific emphasis on state employee health plans with similar characteristics and of comparable size.

6. The BOT and SHP leadership team acknowledges the need to integrate the SHP strategic plan into the strategic plan of North Carolina's **Department of State Treasurer**.

7. The adopted Strategic Plan should take into account the following factors:

   a. 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.

   b. 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 most competitively priced offerings that **improve the health and well-being of its members**.

c. 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.

d. 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.

e. 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.

f. 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 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.

g. 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.

IV. Strategic Planning Process Recommendations

A. Existing Process Steps and Tools to Build Upon

Over the past year and a half the BOT and SHP leadership team have developed or started to develop several strategic planning process steps and tools that can be leveraged to maintain the positive and constructive progress that has been made to date. Listed below are some examples along with a description of the opportunity to integrate into a more formalized strategic planning process:

Workgroups & "Active" Board	• Balance workgroups with strategic discussions & operational pre-Board meeting input • Use workgroups to build relationships among BOT and SHP leadership team and staff • Focus formal Board meetings on fiduciary responsibilities, formal Board votes and member experience
Dashboard	• Transition dashboard to a "balanced scorecard" for SHP • Integrate strategic measures with operational and financial performance - one stop performance shopping • Consider developing composite measures for quality and cost performance for strategic planning purposes
Financial Model	• A multi-year modeling tool provides a channel to capture key strategic or business assumptions as well as a tool to develop scenarios for strategic decisioning • Continue to use the existing financial modeling tool to run scenarios on membership, pricing, medical expense, plan/ vendor admin expenses & reserve assumptions over a multi-year time horizon
Member Experience & Learnings From New Designs	• Integrate into regular Board meetings an update on member satisfaction, feedback from current designs and member engagement levels • Focus a portion of the formal Board meetings on member experiences and input as this is critical information that will ensure commitment to the Mission Statement

B. Strategic Planning Framework

The following is a high level framework that can be used by the BOT and SHP leadership team to develop, monitor and manage a strategic plan for the SHP. The outer circles are the main components of a strategic plan. The "circle" image is intended to set the context that the planning process is ongoing and one component flows into the next.

An assessment of internal and external factors and trends. Examples:
- Demographics
- Regulatory changes (ACA)
- Disease and cost trends
- Medical science developments

The areas of focus or priorities and actions that leadership believes will have the greatest impact on the measures. Examples:
- Targeted expansion of NC Health Smart & incentives
- Provider engagement on quality
- Low cost benefit design options

Key strategic issues and conclusions that are identified based on leadership's review of the environmental analysis. Examples:
- Growth in incidence of disease
- Inconsistent quality of care
- Affordability / value are key drivers of satisfaction

A limited number of strategic measures used to establish direction and measure success. Examples:
- Financial stability (target reserves)
- Member engagement levels
- Quality of care
- Total cost of care

C. Preliminary Strategic Questions to Address

In an effort to leverage the strategic planning work that has been conducted to date, the following table includes a proposed set of strategic and business issues and questions that have been identified. These issues can be used to drive an initial wave of analysis, measurement and strategic prioritization. This will allow the BOT and SHP leadership team to continue to build on the momentum of actions already underway while at the same time informing the development of a more formal strategic planning process for the SHP.

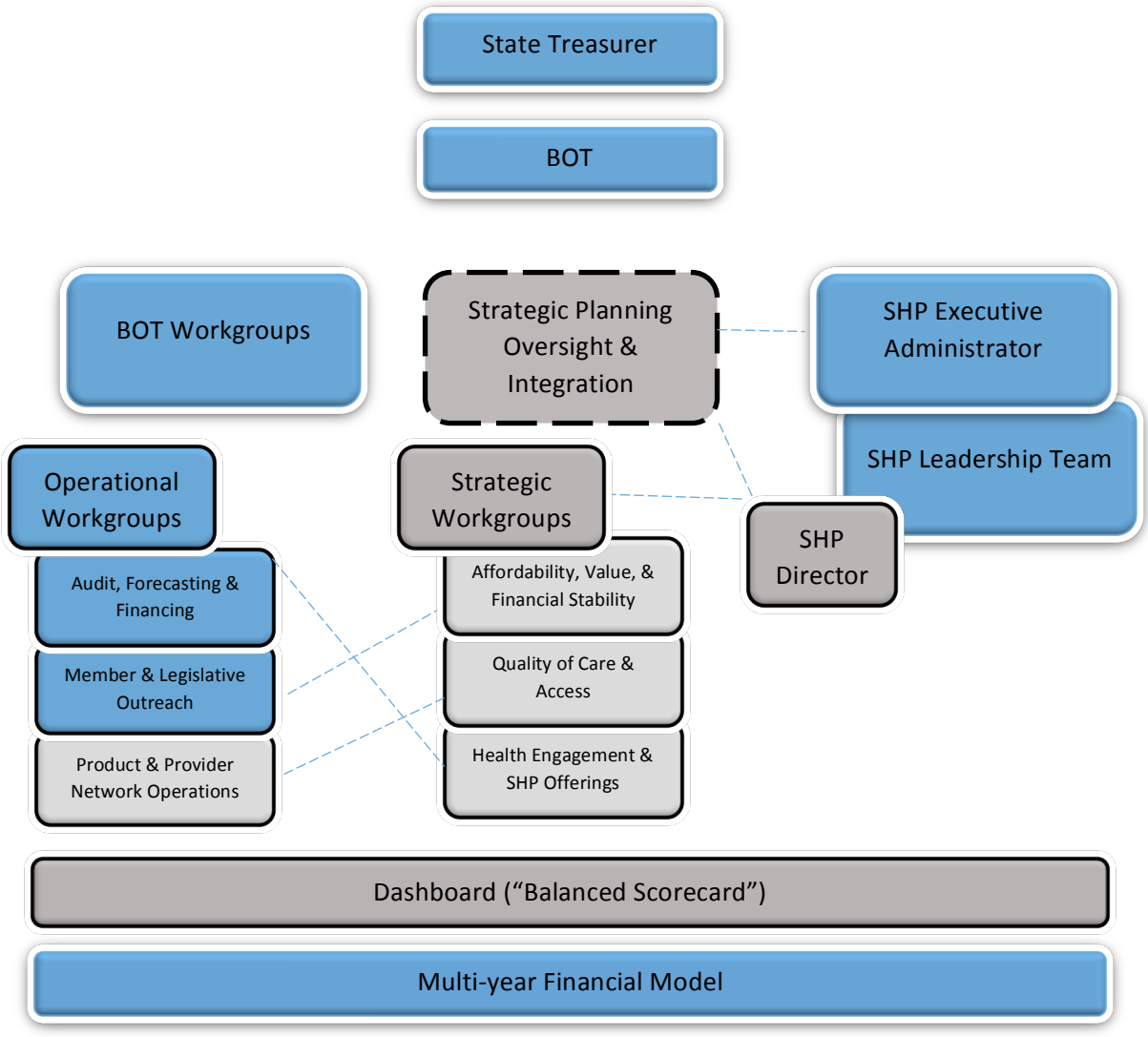
Issue	Example Strategic & Business Questions
Affordability & Member Value	▪ What are reasonable premium and out of pocket costs for members? o How does the SHP ensure out of pocket costs do not create dis-incentives to get needed care (e.g. meds for chronic conditions)? o How can incentives be used to drive value to the member? ▪ What is the SHPs premium strategy? o What premiums and out of pocket costs are other similar states' health plans and private employers establishing? How does the SHP compare? ▪ What are the top 10 drivers of medical costs? By demographic, region, provider, disease and health care services (hospitalizations, ER, Rx, etc) o What are appropriate medical and pharmacy expense trends for the SHP? How can the SHP affect medical and pharmacy expense trends for its members? ▪ Should the SHP attempt to factor in supplemental policies offered to members by other insurance carriers into its value story? If so, how? ▪ How can the SHP assess the effectiveness of affordability and value initiatives?
Quality of Care & Access	▪ What are the most significant gaps in quality of or access to care for SHP members? o How can the SHP drive the transition of provider reimbursement models to pay for outcomes (value)? o How does the SHP measure quality of and access to care for SHP members? What industry standard measures exist? o How can the SHP leverage existing measures or utilize the measures from 3rd party vendors? o What measures of quality and access will have the greatest impact on cost and quality? o How can the SHP assess the effectiveness of quality and access initiatives? ▪ How can the SHP effectively improve provider engagement with the SHP? o Which providers are best suited to work with SHP members to improve quality of care? Access to care? Which providers are seeing the highest volume of SHP members? o What should the relationship be between SHP and providers? ▪ What can the SHP do to drive the expansion of PCMH's and even integrate into accountable care organizations (ACOs)? ▪ How can the SHP partner with the 3rd party vendors and providers to improve quality of care and access?

Financial Stability	▪ What additional actions should be taken to obtain legislative support over the long term? ▪ How should financial stability be defined and evaluated? o What level or percentage of healthcare cost trend is sustainable? o What is a reasonable target reserve level to maintain for the next 3-5 years? o What is a reasonable period of time to project and assess financials? ▪ To what extent should benefit design be used to maintain financial stability? ▪ To what degree is the SHP willing to spend more in the short term to achieve long term stability or savings?
Member Health Engagement	▪ What is the SHPs strategy for member communication and engagement? o How can the SHP more effectively engage members, particularly those with chronic health conditions? o How can the SHP partner with the various state agencies to promote healthy lifestyles? o What are other large employers doing to increase member health engagement? What are examples of model worksite wellness programs? ▪ How can the SHP service model (web and phone) assist in ensuring members know how to access providers and who are the most effective providers? o How can health care cost and quality metrics become more transparent? ▪ How will recent enrollment and new product challenges influence longer-term strategies to engage members around new health programs? o How effective have the recent changes in benefit designs been in increasing member health engagement? o How can the SHP assess the effectiveness of member engagement initiatives?
Future of SHP Offerings	▪ How much can and should the SHP drive new models of care delivery and / or provider payment models? o With what strategic partners should the SHP be doing this? ▪ How will future Federal-level policymaking impact the SHP? ▪ How will future State-level policymaking impact the SHP? ▪ What are the implications of ACA, exchanges, subsidies, Medicaid expansion etc. on future new product designs and SHP offerings? ▪ Should the SHP consider defined contribution products, integration with Medicaid or any other significant changes to the operations or offerings of the SHP? o How effective have the 3rd party vendors been and who are the best partners for the future?

D. Strategic Plan Governance and Management

The following recommendations are designed to ensure both the BOT and SHP leadership team are able to fulfill their responsibilities while leveraging the momentum, energy and knowledge of the BOT and SHP staff. These recommendations are also designed to create a level of cross-training for BOT and staff to ensure consistency during board term transition periods. These recommendations take into consideration the requirements of the North Carolina statutes. A more thorough review of these recommendations in context to SHP budgets, SHP staff operational priorities, BOT availability, BOT board meetings and other such dependencies will need to be considered over time.

Proposed BOT and SHP Leadership Team
Strategic Planning Governance & Management Structure
Year 1 (2014)



The following are some of the key points of consideration as the BOT and SHP leadership work to implement these recommendations:

1. **Leverage existing structures.** The intention is to leverage existing structures and components that are in place already or where there are efforts underway. For example, the workgroups have been effective to date and the model should be modified to support the strategic planning process. In addition, the dashboard can be further developed to provide the source for developing and monitoring key performance measures.

2. **Operational and strategic workgroups.** Creating a separate set of strategic workgroups focused on analyzing the strategic issues will ensure the more "short term" responsibilities are appropriately managed while protecting time for the "longer-term" planning work.

a. **New operational workgroup – Product and Provider Network Operations**
Focus this workgroup on more immediate provider network quality and access challenges, 3rd party vendor delivery for current product offerings and other current product offering issues and challenges that would require BOT input or expertise. Keep the other 2 operational workgroups as is.

b. **Strategic workgroups**
Assign the longer-term strategic questions and issues to each strategic workgroup, organized by the broad categories as outlined in section IV. C. of this report. SHP leadership and staff would conduct analysis and provide recommendations to SHP workgroups for input and guidance. That workgroup would then bring forward to the full BOT a summary of key findings and recommendations for integration into the strategic plan. This allows for a level of expertise to be developed among the BOT and staff around specific subjects, particularly given the broad range and volume of topics that could be explored.

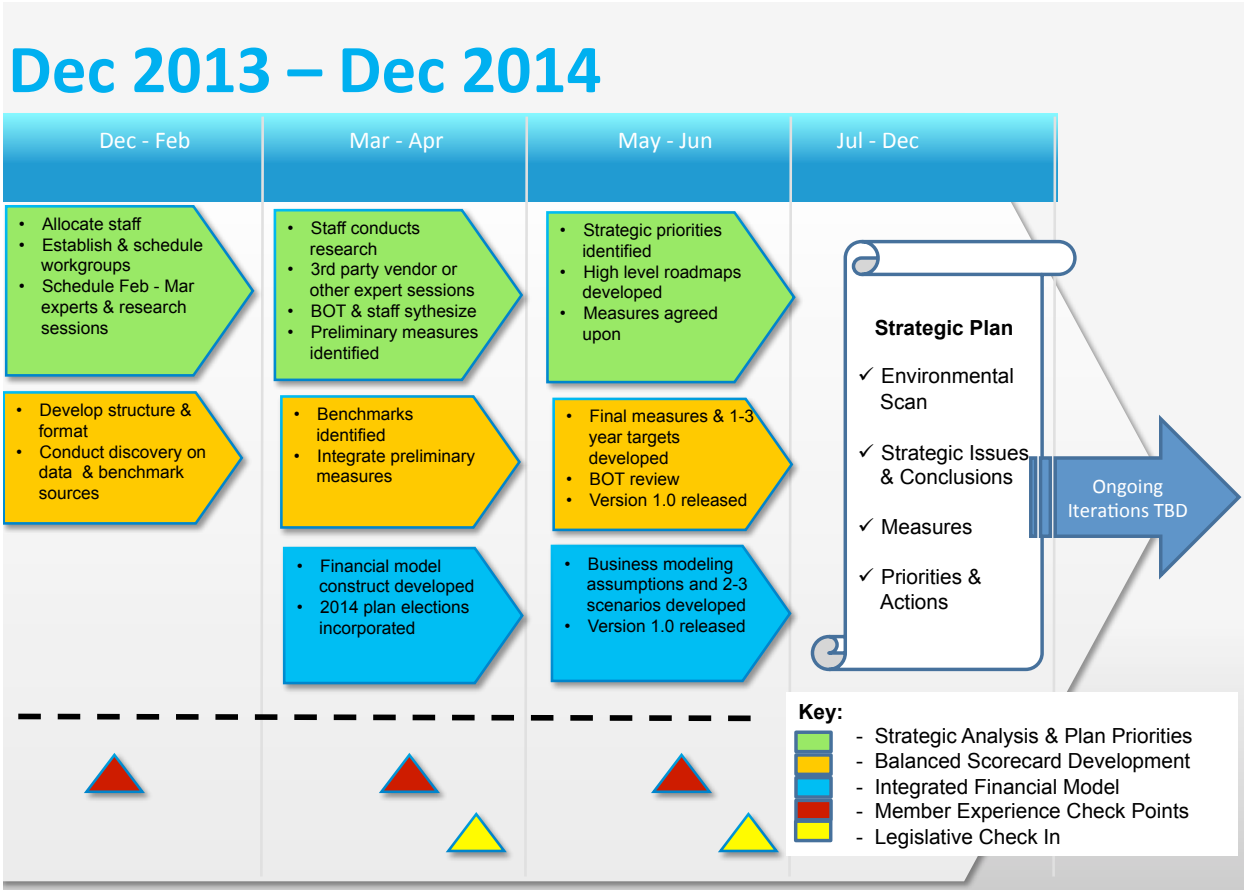
3. **Workgroup membership.** It is recommended that 3 BOT members be assigned to each operational workgroup and strategic workgroup with the BOT Chair (State Treasurer) participating as and where needed. In addition, if possible and with consideration of the expertise of BOT members, the membership of the operational and strategic workgroups will vary to enable all BOT members to work closely with each other. This will help ensure smoother transitions during scheduled BOT turnover and will also better leverage the diverse perspectives of the BOT and SHP staff members.

4. **SHP leadership staffing.** In order to effectively build an initial strategic plan, more dedicated SHP leadership resources will need to be allocated. The specific position (director-level) and responsibilities will need to be determined but generally, this will include a level of SHP leadership oversight for the administration of the strategic planning process and ongoing strategic plan management.

5. **Strategic Planning Oversight & Integration.** At this time, there is a Strategic Planning workgroup that can be repositioned. By establishing the strategic workgroups, all BOT will be able to participate in the development of the strategic plan. It is recommended that the Strategic Planning workgroup members initially function to ensure an appropriate level of oversight and integration is occurring but eventually that responsibility should transition to include the full BOT.

E. 2014 Timeline

This timeline assumes that the strategic plan development will be a process that will continue to evolve over time but that a reasonable first release of a more formalized strategic plan would be at the end of May or early June of 2014. This will allow time to set up the governance structure, complete the analysis of the strategic questions and ensure that the initial launch of the January 2014 offering is successful and member selections are understood.



REFERENCE MATERIALS

i. North Carolina General Statute 135-48.22. Board Powers and Duties.
ii. Macro-level Calendar of Dependencies
iii. Balanced Scorecard Concept
iv. Multi-year Financial Model

i. North Carolina General Statute 135-48.22. Board Powers and Duties.

The general statute information is included as a reference to document the authority and responsibility the Board of Trustees has to develop and maintain a strategic plan for the Plan. This also serves as a guide and reference in clarifying the role of the Board of Trustees as it relates to what requires Board approval.

§ 135-48.22. Board powers and duties.
The Board of Trustees shall have the following powers and duties:
(1) Approve benefit programs, as provided in G.S. 135-48.30(a)(2).
(2) Approve premium rates, co-pays, deductibles, and coinsurance percentages and maximums for the Plan, as provided in G.S. 135-48.30(a)(2).
(3) Oversee administrative reviews and appeals, as provided in G.S. 135-48.24.
(4) Approve large contracts, as provided in G.S. 135-48.33(a).
(5) Consult with and advise the State Treasurer as required by this Article and as requested by the State Treasurer.
(6) Develop and maintain a strategic plan for the Plan. (2011-85, s. 2.10; 2012-173, s. 4(a).)

ii. Macro-level Calendar of Dependencies.

The following calendar of dependencies highlights key externally or internally determined dates that should be considered as the strategic plan for the SHP is developed and maintained. This calendar is intended to be a reference point at this time and should not be considered approved or finalized by the BOT, SHP leadership, vendors or other stakeholders. These dates are subject to change and may be updated from time to time as part of the vendor contracting or strategic planning process.

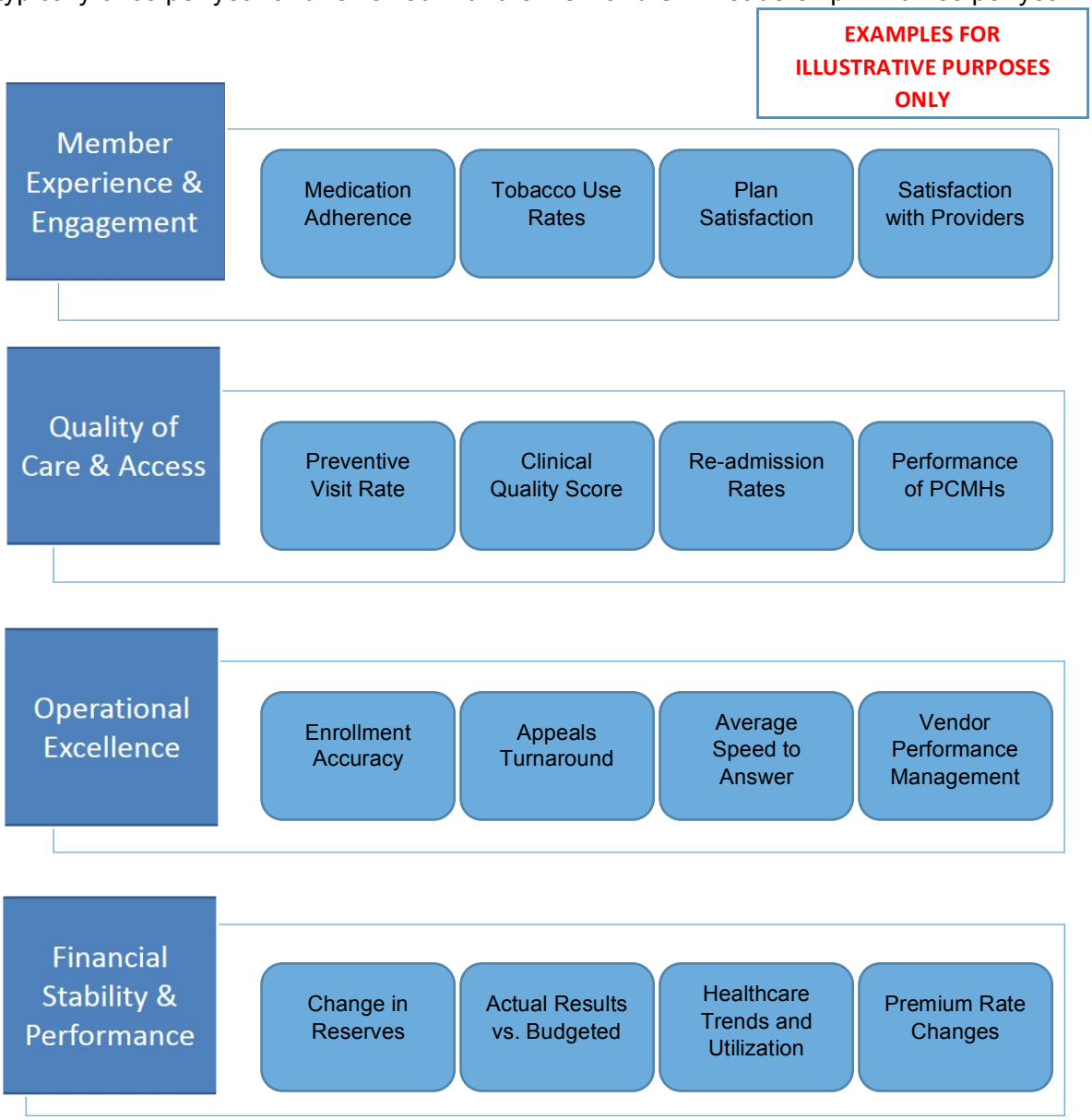
	Category	2014		2015		2016	
		Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Operational	Final Designs	△		△		△	
	Open Enrollment		⇨		⇨		⇨
	BCBSNC						▲ 12/31/16
	Humana						▲ 12/31/16
	United						▲ 12/31/16
	Medco / Express Scripts				▲ 12/31/15		▲ 12/31/16
	Active Health		▲ 12/31/14		▲ 12/31/15		
	Cobra Guard						▲ 12/31/16
	Benefit Focus						▲ 12/31/16

△ - Internal or Plan deadline
▲ - Vendor contract termination or renewal

Legislative	Legislative Sessions	▬		▬		▬	
	Budget Approvals	⇨		⇨		⇨	
	State Elections		△ 2yr GA				△ 2yr GA 4yr Gov, Trs
BOT Terms	Initial 2.5 Year Terms	6/30/14 △ Hargett Johnson Medlin Rubin				6/30/16 △ TBD TBD TBD TBD	
	Initial 3.5 Year Terms			△ Cunningham Huffstetler Moore Newton			Note: New 6/30/17 →
"Wildcards"	ACA Employer Requirements			***TBD***			
	Other Regulatory Requirements			***TBD***			
	Market Trends			***TBD***			

iii. Balanced Scorecard Concept.

An important step in developing an effective strategic planning process and plan is to establish measures that will serve as a guide to setting priorities and monitoring progress. The concept is to establish a limited number of measures (10-15) whereby the SHP can monitor **trends** and establish longer term strategic **targets**. The diagram below is intended to build off of the work of the Dashboard and create a balanced scorecard that would enable the BOT and SHP leadership team to organize SHP measures into categories and identify strategic areas of focus and priorities. For purposes of this document, the following categories were used: **member experience & satisfaction**, **quality of care & access**, **financial stability & performance** and **operational excellence.** These measures would be revisited on a pre-determined basis, typically once per year and reviewed with the BOT and SHP leadership 1-2 times per year.



iv. Multi-year Financial Model.

The BOT and SHP leadership have recognized the value of developing a multi-year, dynamic financial forecast that is maintained on a regular basis. Expanding the forecasting time horizon of the current model will enable the SHP to continue to capture critical business assumptions and conduct scenario planning beyond the immediate term as well as establish annual and multi-year goals. The financial model creates an opportunity to understand both internal and external factors that could impact the strategic plan and measures of success. The table below outlines major components of the model and examples of key assumptions.

Section	Description	Sample Assumptions & Factors
Membership	Number of enrolled members by product	• Current membership by coverage type: active employees, non-Medicare retirees and Medicare retirees • % of members electing coverage in a particular plan • Average family size (family coverage election) • Membership by product (MA, CDHP) • State and local employment outlook • Likely impact of plan design and premium strategies on plan selection
Premium Revenue	Projected total premium contributions	• Required across the board premium adjustments (%) • Premiums paid by employing units/retirement system • Base employee/retiree premiums • Premium surcharges • Impact of plan design changes on contribution revenues Note: Amount paid per enrollee varies by coverage tier and plan selection
Other Plan Revenue	Non premium revenue	• Retiree Drug Subsidy • EGWP Subsidy • ERRP Subsidy • Investment Earnings

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Medical Expense	Total cost of care	• Separate trend assumptions for medical and pharmacy expenses – assumption designed to take into account the following:
		  ○ Medical CPI trends
		  ○ Provider contracted rates
		  ○ Projected utilization of health services & incidence of diseases
		  ○ Generic prescription fill rates
		  ○ Growth in specialty pharmacy
		  ○ Growth in MAPDP fully insured premiums
		  ○ Savings associated with population health management services
		• Also considerations for the impact of the following:
		  ○ Proposed changes in plan design and member cost sharing assumptions
		  ○ Anticipated changes in payment models
		  ○ Impact associated with new TPA/PBM/MAPDP contracts

Administrative Expense	Expenses for SHP staff and vendor costs	• Projected vendor contract terms • Administrative staff assumptions
Net Income	Total revenue – total expense	• Formula driven field
Reserves	Cash balance	• Formula driven field, but required premium adjustments established to meet target reserve level • Target stabilization reserve levels or ranges • Dependent on premium pricing strategy and 3rd party vendor contracting effectiveness and risk sharing

The following chart outlines the current forecasting process that will be used to further develop the multi-year financial model: