Board of Trustees' Meeting
Department of State Treasurer
Thursday, March 27, 2014
4:00 p.m. – 6:00 p.m.

Item	Presenter
1. Welcome	Janet Cowell, Chair
2. Conflict of Interest Statement	Janet Cowell, Chair
3. Review of Minutes ***(Requires Board Vote)***	Janet Cowell, Chair
A. January 31, 2014 – Regular Meeting	
B. March 12, 2014 – Teleconference	
4. Strategic Planning Progress Update	Tom Gualtieri-Reed
5. Organizational and Legislative Update	Mona Moon
6. Pharmacy Report	
A. Non-Preferred Specialty Pharmacy Tier *(**Requires Board Vote**)*	Tracy Stephenson
B. Pharmacy & Therapeutics Committee Meeting Summary	Sally Morton, PharmD
7. Potential Autism Spectrum Disorder Benefit	Lotta Crabtree
8. Communications Report	
A. New Medicare Primary Outreach Program	Caroline Smart
9. Financial Report	Mark Collins
A. January 2014 Financial Report	
B. 2nd Quarter Actuarial Forecast Update	

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

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

B. Lake Lawsuit (I. Beverly Lake et al. v. State Health Plan for Teachers and State Employees, et al.) (G.S. §143.318.11(a)(3) Lotta Crabtree

11. Wrap-Up Janet Cowell, Chair

Board of Trustees' Meeting
Department of State Treasurer
Friday, March 28, 2014
9:00 a.m. – 3:00 p.m.

AGENDA

1. Welcome	Janet Cowell, Chair
2. Conflict of Interest Statement	Janet Cowell, Chair
3. Affordable Care Act	
A. How ACA is Changing Employer Health Benefits and the Marketplace	Rick Johnson, Senior VP *Segal Consulting*
B. Joint Study Committee on the ACA – March 18, 2014	Mona Moon
4. Follow-up - Provider Payment Methodologies & Strategies	
A. Blue Cross and Blue Shield of North Carolina	Jack Kenley, VP *Sales and Marketing* *State Health Plan Executive* Lisa Cade, VP *Network Management* Susan Weaver, VP *Health Delivery Redesign*
Break	
B. Humana	Glen Champlin *MSO Director, SE Region* Tim Moorhead, Market VP *North Carolina* *Senior Products* Anup Sharma, MD *Regional Medical Director* *Senior Products* *Southeast Region* Keith Peele *Director* *Provider Contracting*

C. UnitedHealthcare — John Rennick, MD, *Medical Director*, *North and South Carolina*

Garland Scott, *Chief Executive Officer*, *North and South Carolina Georgia*

Stephen Daniels, VP, *Network Management*, *North and South Carolina*

Lunch

5. Integrated Health Management Report
   A. Engaging Members in Worksite Wellness — Nidu Menon
   B. Patient Centered Medical Homes: SHP Program Design and Approach — Nidu Menon; Scott Money, *Business Projects Program Manager-Active Health Management*

Break

6. Comparative Analysis of State Health Plans — Tom Friedman

7. Multi-Year Financial Model — Mark Collins

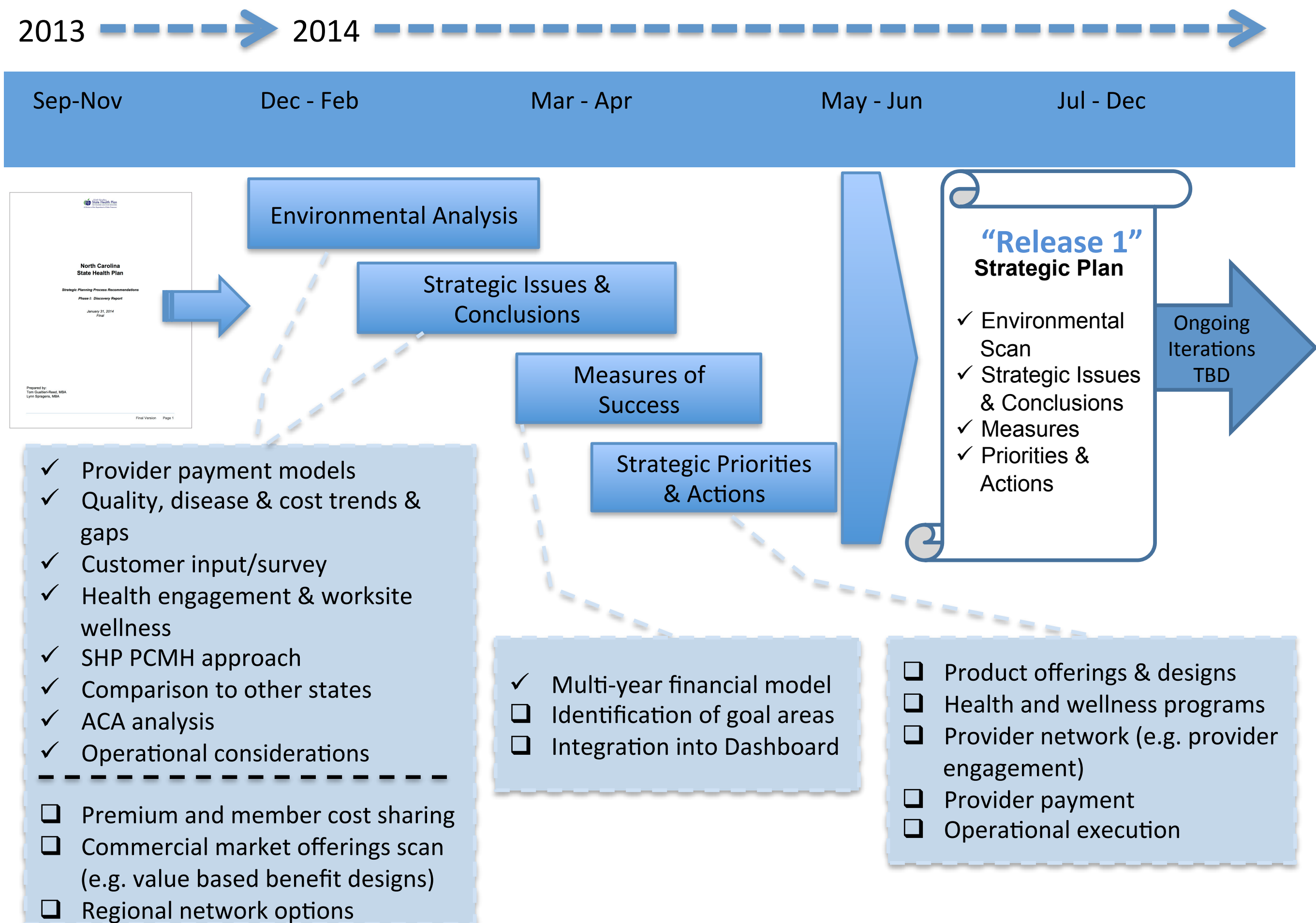
8. Member and Public Input Period
   A. State Employees Association of North Carolina — Ardis Watkins
   B. NC Retired School Personnel — Lacy Presnell
   C. Autism Speaks — Patrick Ballantine

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

Strategic Plan Development Briefing
State Health Plan Board of Trustees
March 27-28, 2014

I. Overall progress

- Good progress on environmental scans & emerging conclusions
- Still developing best model for engaging with the BOT between Board meetings
- SHP leadership and staff's time is continuing to be shifted to focus more on strategic work.
  - Challenge: Ongoing operational issues and priorities
  - Challenge: Prioritizing all of the input, advice and voices that are seeking information and action
- Good progress in engaging 3rd party vendors and development of customer input processes
- Concerns remain related to timing of decisions for 2015 benefit year and ability to move forward on specific initiatives prior to completing strategic plan development ("no regret actions")



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

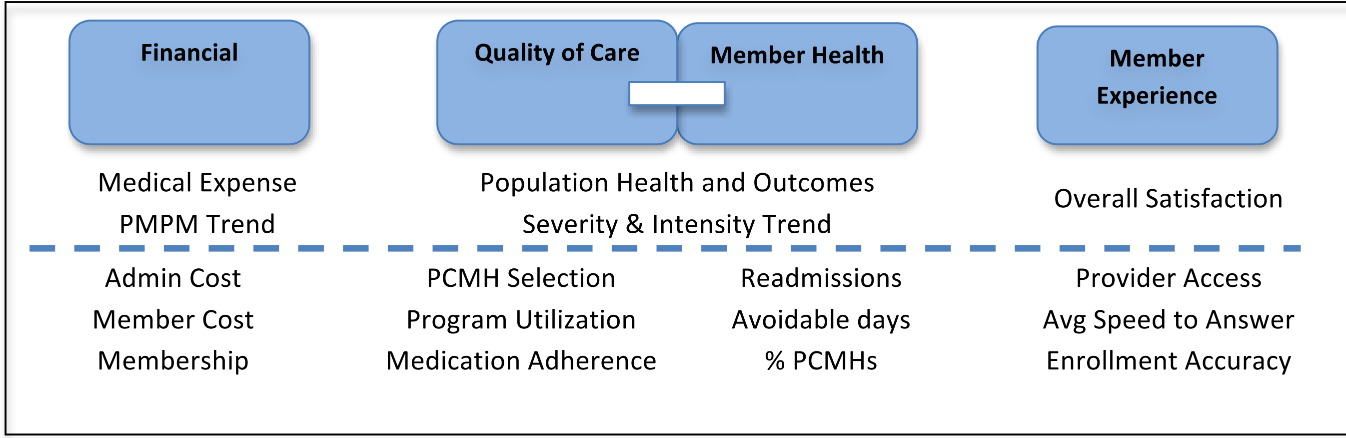
For discussion purposes only.

II. Strategic Plan Measures of Success & Priorities - DRAFT Framework

Based on findings to date, there are 4 primary goals that the SHP desires to address over the next 5-10 years. There are expected to be both short term (e.g. 3 year) and longer-term milestones based on the area of measurement and feasibility considerations. The SHP then intends to focus its efforts and resources to support the goals in the specific areas.

Why?
What does the SHP need to accomplish?

EXAMPLES:
Macro-level broader goals vs. targeted tactical goals



What?
What does the SHP need to do?

Product Offerings & Benefit Designs
- Provider cost and quality transparency
- Targeted benefit enhancements (stabilize product offerings)

Health & Wellness Programs
- Worksite wellness partnerships with state agencies

Provider Network
- Provider quality programs

Provider Payment
- Value and quality based payment model demonstrations

Operational Execution
- Enrollment capability stabilization

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Organizational Update

Board of Trustees Meeting

March 27, 2014

A Division of the Department of State Treasurer

Organizational Update

Recruitment and Staffing

1. Medical Director
2. SHP Global Communications Director
3. Director of Policy, Planning and Analysis

Other Resources

1. Data and Analytics
   - Independent assessment of Healthcare Business Intelligence Strategy and resource needs

2. Health Plan Operations
   - Project management assistance
   - Temporary staffing
   - Assessment of permanent staffing needs

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Non-Preferred Specialty Pharmacy Tier

Board of Trustees

March 27, 2014

A Division of the Department of State Treasurer

Non-Preferred Specialty Pharmacy Tier

Timeline:

- January 2013: The Board of Trustees approved the creation of a non-preferred specialty pharmacy tier (Tier 5) on the Preferred Drug List for the Traditional 70/30 and Enhanced 80/20 PPO Plans
  - Tier 5 was created to prepare for the release of Biosimilar medications
- July 2013: The Board of Trustees approved member cost sharing for the new non-preferred specialty pharmacy tier
  - 25% coinsurance, up to $150 maximum per 30-day supply
- January 2014: Tier 5 implemented as part of pharmacy benefit

Non-Preferred Specialty Pharmacy Tier

- Traditional 70/30 and Enhanced 80/20 Plans are "Grandfathered" plans under Patient Protection and Affordable Care Act (ACA)
- To remain grandfathered the Plan can not increase the coinsurance maximums in effect March 23, 2010, by more than 15 percent plus medical inflation

Original Coinsurance Max	$100
Medical Inflation	10.6%
Medical Inflation Plus 15%	25.6%
Maximum Amount of Increase Allowed	$25.57
Coinsurance Max Allowed as a Grandfathered Plan	$125.00

- The $50 increase per 30-day supply for non-preferred specialty tier is more than is allowed by ACA

Non-Preferred Specialty Tier Financial Impact

	Prior to 1/1/14	Current	Proposed	Difference
Preferred Specialty Tier Coinsurance Max	$100 max	$100 max	$100 max	-
Non-preferred Specialty Tier Coinsurance Max	N/A	$150 max	$125 max	($25)
FY 2012-13 Specialty Member Cost Share (est.)	$3.8 M	$4.2 M	$4.0 M	($200,000)
Projected Annual Plan Savings vs. Current (est.)*				
CY 2014	-	$490,000	$254,000	($236,000)
CY 2015	-	$564,000	$292,000	($272,000)
CY 2016	-	$648,000	$336,000	($312,000)
CY 2017	-	$746,000	$386,000	($360,000)
Member Cost Share at Average Specialty Cost ($4,000)	2.50%	3.75%	3.125%	(0.625%)

*Modeled with very few current non-preferred specialty medications. Non-preferred specialty tier in preparation for release of future Biosimilar medications. Modeling performed by Express Scripts and Segal and assumes 15% annual trend. This does not apply to CDHP or Medicare Advantage. Only applies to Traditional 70/30 and Enhanced 80/20 Plans.

Non-Preferred Specialty Pharmacy Tier

Plan staff recommends lowering the coinsurance maximum from $150 to $125 per 30-day supply for Tier 5 non-preferred specialty medications for the Traditional 70/30 and Enhanced 80/20 Plans, effective January 2014, to maintain Grandfather status under the ACA.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Pharmacy and Therapeutics Committee February 2014 Meeting Summary

Board of Trustees

March 27, 2014

A Division of the Department of State Treasurer

February P&T Meeting
Updates to Utilization Management Programs

Programs	Update
Melanoma Medication Prior Authorization	Allow coverage of combination of Mekinist and Tafinlar
Antifungal (Noxafil) Prior Authorization	Include new delayed-release tablet formulation
Pulmonary Hypertension Prior Authorization	Add new medications Opsumit and Adempas to program
Psoriasis (Stelara) Prior Authorization	Add step therapy requiring use of preferred agents first
Proton Pump Inhibitors Step Therapy	Add new medication Esomeprazole strontium and new generic Aciphex (rabeprazole)
Hepatitis C Prior Authorization	Add new medications Sovaldi and Olysio
Angiotensin Receptor Blocker Step Therapy	Add new generic Micardis (telmisartan)

February P&T Meeting
New/Revised Utilization Management Programs Reviewed

Program	Indication	Description	Member Impact	Estimated Projected Savings	P&T Recommendation	Target Implementation Date
Growth Hormones	Growth related disorders	Step Therapy	20	$329,000-$411,000	Yes	TBD
Tetracyclines	Acne	Step Therapy	665	$645,000	Yes	August
Buprenorphine, Buprenorphine/ Naloxone sublingual	Opioid Dependence	Prior Authorization	400	$122,000	Yes	August
Proton Pump Inhibitors	Ulcers GERD	Quantity limits	TBD	TBD	Delete Quantity limits	TBD - will recommend comprehensive PPI coverage strategy at later date

February P&T Meeting
New Drugs for Formulary Consideration

Drug	Indication	Tier Placement
Zubsolv (buprenorphine/naloxone sublingual tablets)	Opioid Dependence	3
Brisdelle (paroxetine capsules)	Menopause associated vasomotor symptoms	3
Khedezla (venlafaxine extended-release tablets)	Major Depressive Disorder	3
Mirvaso (brimonidine topical gel)	Erythema of rosacea	2
Breo Ellipta (fluticasone furoate and vilanterol inhalation powder)	Chronic Obstructive Pulmonary Disease	2

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer
4901 Glenwood Avenue, Suite 300 • Raleigh, NC 27612 • Phone: 919-881-2300 • Fax: 919-881-2308 • www.shpnc.org

Pharmacy and Therapeutics Committee
Meeting Summary
February 19, 2014

Tracy Stephenson welcomed the committee members and reviewed the fiscal year 2012-13 vs. 2011-12 pharmacy utilization and financial reports. She also reviewed the 2014 benefit plan breakouts for the Plan membership. Sally Morton ensured there were no conflicts of interest for members with any of the items for discussion.

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

- The Melanoma medication prior authorization program will allow coverage for the combination use of Mekinist (trametinib) and Tafinlar (dabrafenib) per new FDA approval for combination use.
- The Noxafil (posaconazole) prior authorization program now includes the new delayed-release tablet formulation in order to include all dosage formulations in the program. There will also be quantity limits placed on the Noxafil tablets.
- New medications, Opsumit (macitentan) and Adempas (riociguat), were added to the Pulmonary Hypertension prior authorization program in order to include all medications in the program.
- Step therapy requirements were added to the Stelara (ustekinumab) prior authorization program to prefer Enbrel or Humira first line.
- 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.
- The Proton Pump Inhibitor step therapy program now includes the new medication esomeprazole strontium as a non-preferred agent and generic Aciphex (rabeprazole) as a preferred agent. Generic rabeprazole is a Tier 2 generic.
- New specialty medications Sovaldi (sofosbuvir) and Olysio (simeprevir) were added to the Hepatitis C prior authorization program. Dr. Patel and colleagues from his practice reviewed the criteria.
- Generic Micardis (telmisartan) was added as a preferred agent to the Angiotensin Receptor Blocker step therapy program and brand Micardis was moved to a non-preferred agent.

Several new and revised prior authorization programs were reviewed and approved:

- It was recommended to further limit the preferred Growth Hormones in the Growth Hormone step therapy program to two preferred agents instead of three. There are no clinical differences among the products and product choice appears to be based on the delivery device and manufacturer support programs. The committee agreed with the recommendation to limit the preferred agents in this class if it provided financial savings to the Plan. The Plan's formulary management committee will choose the preferred products for the step therapy program. The Plan will implement late summer.
- Based on a local neurologist's feedback on the Anti-narcoleptic agent prior authorization criteria, Dr. Konanc and the committee reviewed the coverage for Multiple Sclerosis related fatigue once again. The committee agreed that coverage should be allowed for Provigil (modafanil) and Nuvigil (armodafanil) for MS related fatigue since fatigue is so common in MS and there are not many other effective treatment options. This coverage allowance will be added immediately.
- The Plan currently has a step therapy program for brand Solodyn and Oracea oral tetracycline products used for acne. The Plan recommended including additional brand and generic extended-release tetracycline products such as Doryx, Monodox and Morgidox in the step therapy program too. Dr. Flynn and the committee agreed with the recommendation. The additions to the program will be implemented in late summer.
- Currently the Plan has a quantity and duration limit for prescription Proton Pump Inhibitors (PPIs) limiting the use to 90 days in 180 days (without an approval) which was implemented in 2004 when there was a question about the long term safety of PPIs. Dr. Patel and the committee reviewed the criteria and agreed that there are many indications that require chronic daily use of a PPI and this policy may not be necessary any longer. The Plan may incorporate the recommendation to discontinue the prescription quantity limits in a comprehensive PPI coverage strategy for 2014/15 factoring in the release of over-the-counter and generic Nexium expected this year.
- With increased concern over prescription drug abuse, the Plan recommended the implementation of a sublingual buprenorphine and buprenorphine/naloxone prior authorization program with quantity limits ensuring appropriate prescribing for opioid dependence. Dr. Bentsen, Dr. Grigg and the committee reviewed possible authorization criteria and agreed that prior authorization was appropriate for these medications to avoid use for chronic pain. The Plan will implement the prior authorization program in August 2014.

The committee reviewed the following new drugs for formulary consideration:

- Zubsolv (buprenorphine/naloxone sublingual tablets) – New formulation of buprenorphine/naloxone. Recommended May Add due to its similar safety and efficacy for treating opioid dependence; however, Suboxone films may be a safer agent to use due to its individual packaging, and it already has the majority of the utilization. Zubsolv will remain in Tier 3 and Suboxone films will move to Tier 2 when the prior authorization program is implemented in order to have a brand product in Tier 2.
- Brisdelle (paroxetine 7.5mg capsules) – First labeled medication for the vasomotor symptoms associated with menopause. Recommended May Add due to its similar efficacy to other pharmacologic alternatives to hormone therapy; however, hormone therapy is the most effective therapy. It will remain in Tier 3.
- Khedezla (desvenlafaxine extended-release tablets) – Third desvenlafaxine product on the market with no apparent advantages over generic products such as venlafaxine or duloxetine and is only approved for Major Depressive Disorder. It is recommended May Add, and it will remain in Tier 3. It will be added as a non-preferred agent in the Serotonin and Norepinephrine reuptake inhibitors (SNRIs) step therapy program.

- Mirvaso (brimonidine 0.33% topical gel) – It has a unique mechanism of action and is the only medication specifically indicated for the reduction of erythema in patients with rosacea. It has a direct effect on erythema and works faster than other agents. Recommended May Add, and it will be in Tier 2.
- Breo Ellipta (fluticasone furoate and vilanterol inhalation powder) – Combination corticosteroid and long-acting beta agonist effective and safe for the treatment of COPD. It is not indicated for asthma. The breath activated device is simple to use and dosed once daily. Recommended May Add and will be in Tier 2.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Potential Autism Spectrum Disorder Benefit

Board of Trustees

March 27, 2014

A Division of the Department of State Treasurer

Presentation Summary

- Recap of BOT interest
- Update on Autism Spectrum Disorder (ASD) Benefit Design Development
- Comparison of Proposed Benefit and HB 498
- Status with BCBSNC and ValueOptions
- Next Steps

Summary of BOT Interest in Autism Benefit

- In the November BOT meeting, stakeholder groups were allowed to present potential benefit changes to the Board
- Autism Speaks proposed the Board increase coverage for ASD to include Applied Behavioral Analysis (ABA) therapy that mirrored HB 498
  - The Board requested Plan staff develop a benefit design for consideration that includes ABA therapy

Autism Benefit Development

- BCBSNC does not currently cover ABA therapy, therefore, the Plan is working with BCBSNC to evaluate the network and design a benefit
- Plan staff has met with local experts to better understand ASD, ABA, the roles of different service providers, and benefit considerations
- Actuarial note for HB 498 projects annual cost of new benefit ranging from $2.5 to $5.1 million in FY 2014-15 with an annual benefit of $36k
  - Within five to six years, the annual cost is expected to be $6.1 to $12.7 million

Benefit Goal

Provide members with a benefit that covers treatment for ASD that will assist in maximizing independence and improving quality of life.

Current Draft of Proposed Benefit Design v. HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Age requirements	Diagnosis: Prior to Age 8 Treatment: Age 23 **(§ 58-3-192.b)**	Diagnosis and Treatment: Age 26	Age changed to match dependent eligibility
Utilization management	An insurer shall have the right to request a review of that treatment not more than once annually, unless the insurer and the individual's licensed physician or the individual's licensed psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to a particular insured being treated for an autism spectrum disorder and shall not apply to all individuals being treated for an autism spectrum disorder by a physician or psychologist. The cost of obtaining any review shall be borne by the insurer. **(§ 58-3-192.h)**	Consistent with SHP utilization management policies through BCBSNC and ValueOptions. **ABA Exclusions:** • With medical conditions or impairments that would prevent beneficial utilization of services • Requiring 24 hour medical/nursing monitoring or procedures provided in a hospital setting	Exclusions appropriate if underlying issues would prevent effective treatment; important to retain rights regarding medical necessity review

Current Draft of Proposed Benefit Design v. HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Diagnosis of Care	"Diagnosed with autism spectrum disorder by a licensed physician, or a licensed psychologist who determines the care to be medically necessary" **(§ 58-3-192.a.10)**	Same	No difference
Providers of Treatment	Provided or supervised by: (i) a Board Certified Behavior Analyst or (ii) a licensed psychologist or licensed psychological associate, so long as the services performed are commensurate with the psychologist's training and experience **(§ 58-3-192.a.3(b))**	Behavioral health treatment, including applied behavioral analysis (ABA), when provided by: • a licensed psychologist, • licensed psychiatrist, • medical doctor specializing in autism disorders, • licensed social worker, • licensed counselor, or • a Board Certified Behavior Analyst working under the supervision of a licensed psychologist.	Expanded to be more inclusive and to make sure practitioners not licensed by NC have oversight by NC licensed providers

Current Draft of Proposed Benefit Design v. HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Board Certified Behavior Analysts	Does not prevent a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA) from offering services within the scope of practice authorized by the Behavior Analyst Certification Board, including behavior analysis and therapy, in accordance with professional standards of the BCBA or BCaBA's certification, if both of the following are true: (1) The BCBA or BCaBA is properly certified and in good standing with the Behavior Analyst Certification Board; and (2) does not hold him/herself out to be a licensed psychologist. **(G.S. 90-270.4 f1)**	BCBA must be supervised by a psychologist. BCaBA must be supervised by a BCBA who is supervised by a licensed psychologist	Currently, there is no NC licensure for BCBAs or BCaBAs. To ensure appropriate medically necessary treatment is being administered, SHP would require these providers to be supervised by a licensed psychologist. Additionally, BCBA's and BCaBA's are not currently in network.

Current Draft of Proposed Benefit Design v. HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Therapeutic Care	Therapeutic care. – Direct or consultative services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or licensed clinical social worker. **(§ 58-3-192.a.9)**	ABA treatment will not be certified for the following services: • Speech therapy • Occupational therapy • Vocational rehabilitation • Supportive respite care • Recreational therapy • Orientation and mobility • Respite Care • Equine therapy • Hippo therapy • Dolphin therapy • Other educational services	Recognizes ABA treatment as distinct from other therapies. Exclusions based on analysis of other states and best practices while remaining consistent with SHP benefit policies.
Annual benefit maximum	$36,000 annual maximum **(§ 58-3-192.g)**	$36,000 annual maximum	No difference

Status of Implementing Benefit through BCBSNC

- BCBSNC will be administering the benefit for our members as our TPA
- BCBSNC does not cover a similar benefit for their book of business
- BCBSNC and their behavioral health subcontractor, ValueOptions, are providing assistance with the development of Medical Policy
- BCBSNC will be preparing the required system updates to ensure the appropriate billing codes are available
- BCBSNC contracts with providers on behalf of the Plan and is assessing the availability of providers in the State based on current draft design and definition of who is eligible to provide treatment

Next Steps

- Finalize Benefit Design and Medical Policy
- Update the Financial Impact Analysis
- Discuss with Relevant Stakeholders
- Present Final Benefit Proposal to BOT in May for Consideration

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

New Medicare Primary Outreach Program

Board of Trustees Meeting

March 27, 2014

A Division of the Department of State Treasurer

Overview

- Medicare Primary Education – Lessons Learned
- Medicare Primary Education Outreach Programs
  - Members
  - Partners
  - HBRs

Medicare Primary Education – Lessons Learned

Lessons learned from Open Enrollment

1. **Face to Face Meetings –** There is no substitute for face to face meetings with plenty of time for questions and answers.

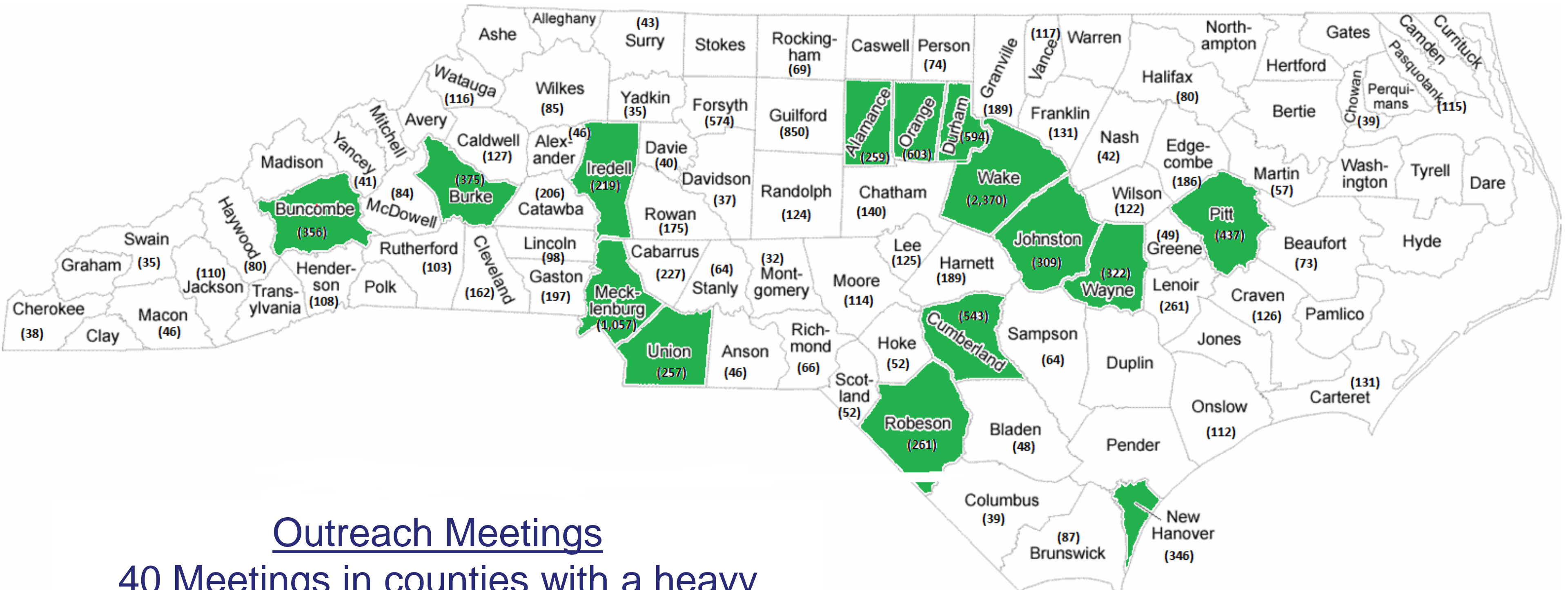
2. **Partner Education –** It's not just the retirees that need to be educated. Our partners such as the Retirement Systems, SHIIP and the HBRs need to be fully trained.

3. **Printed Materials –** Everyone needs to have the same documentation with a consistent message.

Education Outreach Programs

- Plan staff is providing additional training to:
  - Retirement System's Call Center/Membership Team
  - SHIIP Call Center and State-wide Coordinators
- Engagement of members turning 65 in the next 12 months:
  - Outreach meetings across the state
  - New Collateral

Members Turning 65 in the Next 12 Months



<u>Outreach Meetings</u>

40 Meetings in counties with a heavy population of members turning 65 in the next 12 months.

Medicare Primary Education: New Retirees

Retirement approved at least 60 days prior to effective date of retiree *health coverage*

Active Employee 65 or older

Retirement Papers must be approved 60 + days prior to the SHP benefit effective date*

Member notified of auto-enrollment into Medicare Advantage Base Plan

May elect any of the Medicare Primary options until 30 days before benefit effective date*

If no election, auto-enrollment completed 30 days before benefit effective date*

**The SHP benefit effective date is the first of the month following the retirement effective date. For example: If the retirement date is January 1, the SHP benefit effective date is February 1.*

Medicare Primary Education: New Retirees

Retirement approved less than 60 days prior to effective date of retiree *health coverage*

Active employee 65 or older

Retirement papers processed and approved 59 days or less prior to retiree health coverage effective date.

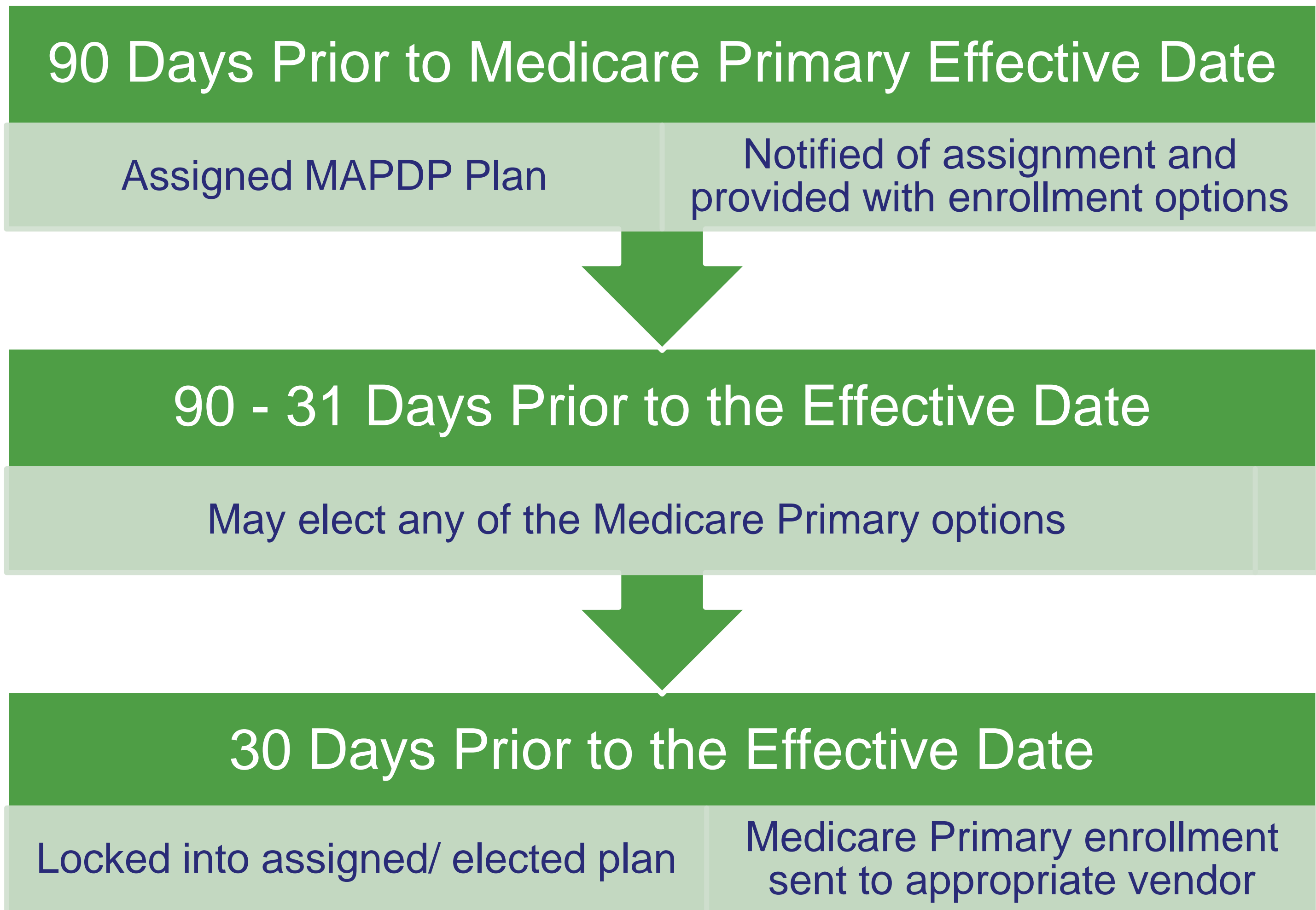
Medicare Advantage Options Not Available

Will be auto-enrolled into the Traditional 70/30 plan 30 days before effective date.

Next Open Enrollment

Will have access to all Medicare Advantage options during the next Open Enrollment Period.

Medicare Primary Education: Retirees/Dependents turning 65



Education Outreach-*HBRs*

- Ongoing communication through Newsletters and email Alerts
- Provide collateral for potential retirees for their employees
- HBR webinars
- Outreach meetings (invite HBRs along with members)

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

January 2014 Financial Report

Board of Trustees Meeting

March 27, 2014

A Division of the Department of State Treasurer

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

Calendar Year 2014	Actual thru Jan 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Beginning Cash Balance	$838.5 m	$695.0 m	$143.5 m
Plan Revenue	**$228.9 m**	**$253.2 m**	**($24.3 m)**
Net Claims Payments	$196.4 m	$216.5 m	($20.1 m)
Medicare Advantage Premiums	$12.9 m	$14.5 m	($1.6 m)
Net Administrative Expenses	$23.4 m	$15.2 m	$8.2 m
Total Plan Expenses	**$232.7 m**	**$246.2 m**	**($13.5 m)**
Net Income/(Loss)	**($3.8 m)**	**$7.0 m**	**($10.8 m)**
Ending Cash Balance	$834.7 m	$702.0 m	$132.7 m

Adjusted Variance Report
Calendar Year to Date January 2014

Calendar Year 2014	Actual thru Jan 2014, As Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$257.8 m**	**$253.2 m**	**$4.6 m**
Net Claims Payments ^	$157.7 m	$216.5 m	($58.8 m)
Medicare Advantage Premiums	$12.9 m	$14.5 m	($1.6 m)
Net Administrative Expenses ^	$14.9 m	$15.2 m	($0.3 m)
Total Plan Expenses	**$185.5 m**	**$246.2 m**	**($60.7 m)**
Net Income/(Loss)	**$72.3 m**	**$7.0 m**	**$65.3 m**

* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues.

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

Per Member Per Month (PMPM) Analysis

Calendar Year 2014	Actual thru Jan 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue	**$338.20**	**$379.96**	**($41.76)**
Net Claims Payments	$292.21	$324.69	($32.48)
Medicare Advantage Premiums	$19.21	$21.66	($2.45)
Net Administrative Expenses	$34.86	$22.80	$12.06
Total Plan Expenses	**$346.28**	**$369.15**	**($22.87)**
Net Income/(Loss)	**($8.08)**	**$10.81**	**($18.89)**

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

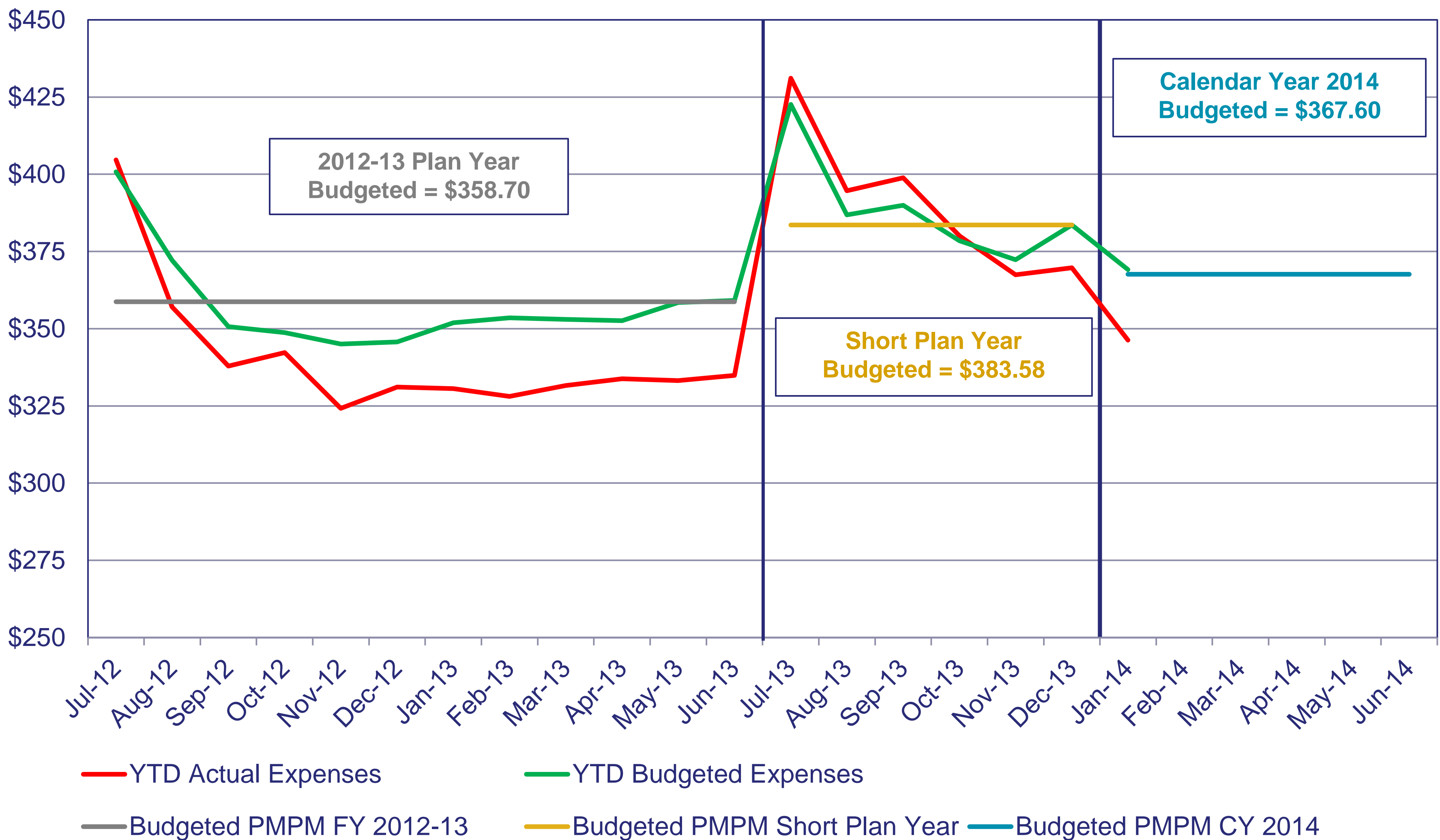
Adjusted Variance Report
Calendar Year to Date January 2014

Per Member Per Month (PMPM) Analysis

Calendar Year 2014	Actual thru Jan 2014, as Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$380.91**	**$379.96**	**$0.95**
Net Claims Payments ^	$234.69	$324.69	($90.00)
Medicare Advantage Premiums	$19.21	$21.66	($2.45)
Net Administrative Expenses ^	$22.22	$22.80	($0.58)
Total Plan Expenses	**$276.12**	**$369.15**	**($93.03)**
Net Income/(Loss)	**$104.79**	**$10.81**	**$93.98**

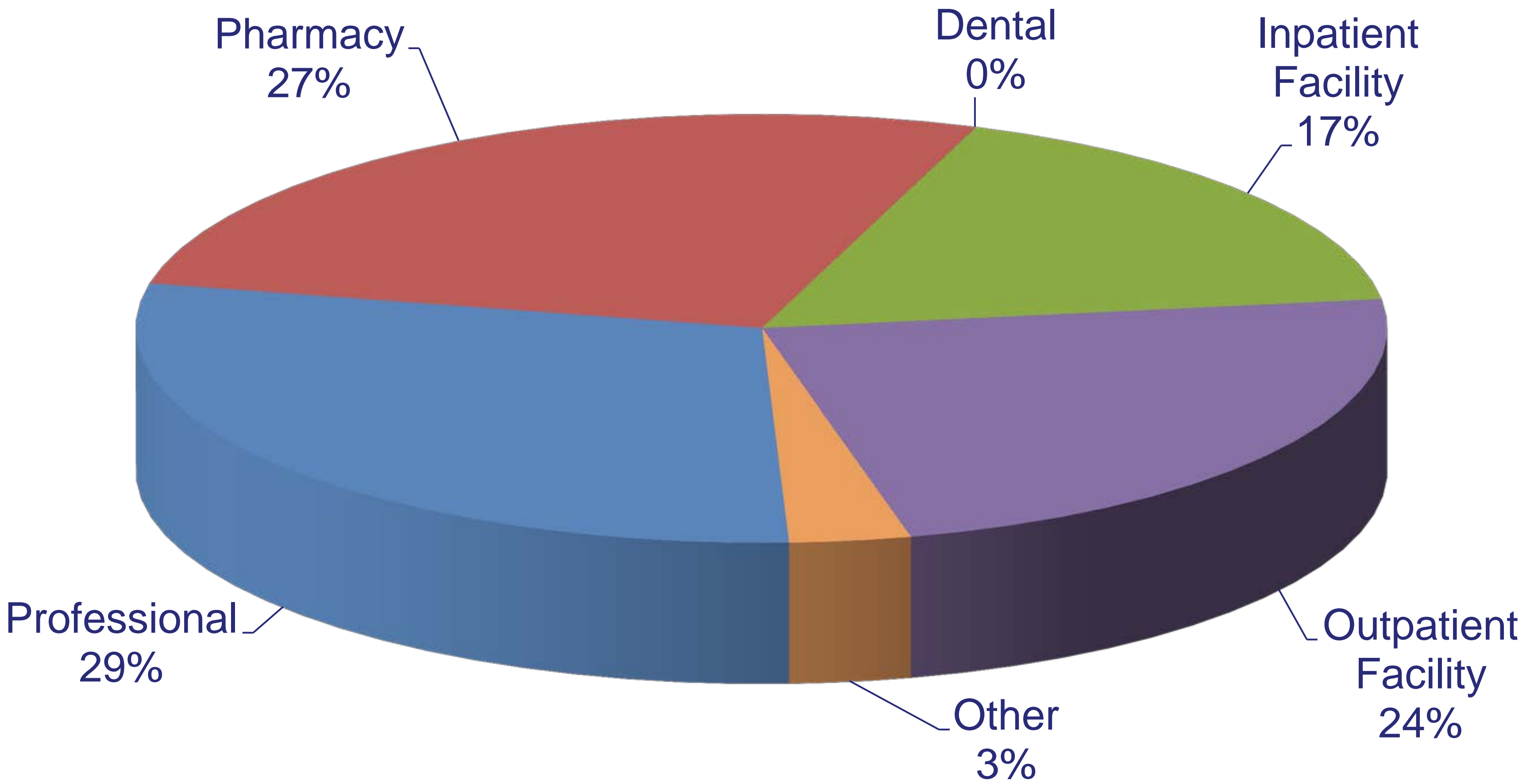
* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues.

Plan Year to Date Expenditure Trend Per Member Per Month



Allocation of Claims Expenditures
Fiscal Year to Date

Includes Medical, Blue Card & Pharmacy Payments



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

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

#		A	B	C	D	E	F	G	H
		Actual January 2014	Certified Budget January 2014	Monthly Variance Over/(Under) Certified Budget	Actual 2014 Calendar Year To Date	Certified Budget 2014 Calendar Year to Date	Calendar Year to Date Variance Over/(Under) Certified Budget	Calendar Year Certified Budget (Jan- Dec 2014)	Calendar Year to Date Variance Over/(Under) Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 215,624,797	$ 243,964,546	$ (28,339,749)	$ 215,624,797	$ 243,964,546	$ (28,339,749)	$ 2,921,878,532	$ (2,706,253,735)
4	Premium Refunds/Retroactive Disenrollments	1,918	(124,354)	126,272	1,918	(124,354)	126,272	(1,489,408)	1,491,326
5	Medicare Part D (RDS) Subsidy	865,445	603,039	262,406	865,445	603,039	262,406	6,344,076	(5,478,631)
6	Medicare PDP (EGWP + Wrap) Subsidy	12,080,189	8,534,636	3,545,553	12,080,189	8,534,636	3,545,553	31,047,005	(18,966,816)
7	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
8	**Net Premium & Other Contributions**	**228,572,349**	**252,977,867**	**(24,405,518)**	**228,572,349**	**252,977,867**	**(24,405,518)**	**2,957,780,205**	**(2,729,207,856)**
9									
10	Investment Earnings	369,150	232,080	137,070	369,150	232,080	137,070	2,892,005	(2,522,855)
11	Miscellaneous Revenue	-	-	-	-	-	-	-	-
12	**Other Revenue**	**369,150**	**232,080**	**137,070**	**369,150**	**232,080**	**137,070**	**2,892,005**	**(2,522,855)**
13									
14	**Total Plan Revenue (excludes internal transfers)**	**228,941,499**	**253,209,947**	**(24,268,448)**	**228,941,499**	**253,209,947**	**(24,268,448)**	**2,960,672,210**	**(2,731,730,711)**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	122,660,199	172,999,479	(50,339,280)	122,660,199	172,999,479	(50,339,280)	2,062,826,346	(1,940,166,147)
19	Medical Claim Refunds/Recoveries	(1,967,807)	(1,883,217)	(84,590)	(1,967,807)	(1,883,217)	(84,590)	(25,469,051)	23,501,244
20	**Net Medical Claims**	**120,692,392**	**171,116,262**	**(50,423,870)**	**120,692,392**	**171,116,262**	**(50,423,870)**	**2,037,357,295**	**(1,916,664,903)**
21									
22	Pharmacy Claim Payments	82,399,014	56,670,333	25,728,681	82,399,014	56,670,333	25,728,681	599,541,594	(517,142,580)
23	Pharmacy Claim Rebates	(6,534,968)	(11,255,379)	4,720,411	(6,534,968)	(11,255,379)	4,720,411	(54,794,623)	48,259,655
24	Pharmacy Claim Refunds/Recoveries	(174,738)	-	(174,738)	(174,738)	-	(174,738)	-	(174,738)
25	**Net Pharmacy Claims**	**75,689,308**	**45,414,954**	**30,274,354**	**75,689,308**	**45,414,954**	**30,274,354**	**544,746,971**	**(469,057,663)**
26									
27	**Net Claim Payments**	**196,381,700**	**216,531,216**	**(20,149,516)**	**196,381,700**	**216,531,216**	**(20,149,516)**	**2,582,104,266**	**(2,385,722,566)**
28									
29	**Medicare Advantage Premiums**	**12,907,634**	**14,447,462**	**(1,539,828)**	**12,907,634**	**14,447,462**	**(1,539,828)**	**174,162,733**	**(161,255,099)**
30									
31	**Net Administrative Expenses**	**23,427,097**	**15,201,741**	**8,225,356**	**23,427,097**	**15,201,741**	**8,225,356**	**179,815,010**	**(156,387,913)**
32									
33	**Total Plan Expenses (excludes internal transfers)**	**232,716,431**	**246,180,419**	**(13,463,988)**	**232,716,431**	**246,180,419**	**(13,463,988)**	**2,936,082,009**	**(2,703,365,578)**
34									
35	**Plan Income/(Loss)**	**(3,774,932)**	**7,029,528**	**(10,804,460)**	**(3,774,932)**	**7,029,528**	**(10,804,460)**	**24,590,201**	**(28,365,133)**
36									
37	**Cash Availability:**								
38									
39	Beginning 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
40	**Ending Cash Balance/(Deficit)**	**834,672,205**	**702,004,661**	**132,667,544**	**834,672,205**	**702,004,661**	**132,667,544**	**719,565,334**	**115,106,871**
41									
42	Target Stabilization Reserve @ 12/31/14	234,282,695	234,282,695	-	234,282,695	234,282,695	-	234,282,695	-
43									
44	**Cash Balance Over/(Under) Reserve Target**	$ 600,389,510	$ 467,721,966	$ 132,667,544	$ 600,389,510	$ 467,721,966	$ 132,667,544	$ 485,282,639	$ 115,106,871

Comments:
a. Premium receivables totaled $138,061.46 as of January 31, 2014.
b. The average weekly medical claims cost net of claims refunds was $30,173,098.00 for the four scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included three bi-weekly invoice cycles averaging $27,466,338.00 per cycle.
d. The target stabilization reserve is 8.5% of the projected net claims and Medicare Advantage premiums for Calendar Year 2014.
e. Minor differences compared to other reports are due to rounding.

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

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

#		A Actual January 2014	B Certified Budget January 2014	C Monthly Variance Over/(Under) Certified Budget	D Actual Year to Date FY 2013-14	E Certified Budget Year to Date FY 2013-14	F Year to Date Variance Over/(Under) Certified Budget	G Annual Certified Budget FY 2013-14	H Year to Date Variance Over/(Under) Annual Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 215,624,797	$ 243,964,546	$ (28,339,749)	$ 1,718,202,797	$ 1,684,043,918	$ 34,158,879	$ 2,902,567,015	$ (1,184,364,218)
4	Premium Refunds/Retroactive Disenrollments	1,918	(124,354)	126,272	(275,620)	(845,644)	570,024	(1,466,766)	1,191,146
5	Medicare Part D (RDS) Subsidy	865,445	603,039	262,406	(458,443)	3,387,783	(3,846,226)	6,218,762	(6,677,205)
6	Medicare PDP (EGWP + Wrap) Subsidy	12,080,189	8,534,636	3,545,553	49,162,774	40,881,937	8,280,837	50,346,402	(1,183,628)
7	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
8	**Net Premium & Other Contributions**	**228,572,349**	**252,977,867**	**(24,405,518)**	**1,766,631,508**	**1,727,467,994**	**39,163,514**	**2,957,665,413**	**(1,191,033,905)**
9									
10	Investment Earnings	369,150	232,080	137,070	2,155,265	1,680,082	475,183	2,868,131	(712,866)
11	Miscellaneous Revenue	-	-	-	54,972	-	54,972	-	54,972
12	**Other Revenue**	**369,150**	**232,080**	**137,070**	**2,210,237**	**1,680,082**	**530,155**	**2,868,131**	**(657,894)**
13									
14	**Total Plan Revenue (excludes internal transfers)**	**228,941,499**	**253,209,947**	**(24,268,448)**	**1,768,841,745**	**1,729,148,076**	**39,693,669**	**2,960,533,544**	**(1,191,691,799)**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	122,660,199	172,999,479	(50,339,280)	1,155,817,599	1,216,998,776	(61,181,177)	2,107,493,114	(951,675,515)
19	Medical Claim Refunds/Recoveries	(1,967,807)	(1,883,217)	(84,590)	(12,802,185)	(13,943,901)	1,141,716	(24,643,884)	11,841,699
20	**Net Medical Claims**	**120,692,392**	**171,116,262**	**(50,423,870)**	**1,143,015,414**	**1,203,054,875**	**(60,039,461)**	**2,082,849,230**	**(939,833,816)**
21									
22	Pharmacy Claim Payments	82,399,014	56,670,333	25,728,681	508,214,483	490,718,773	17,495,710	699,653,578	(191,439,095)
23	Pharmacy Claim Rebates	(6,534,968)	(11,255,379)	4,720,411	(38,723,609)	(31,828,240)	(6,895,369)	(52,353,361)	13,629,752
24	Pharmacy Claim Refunds/Recoveries	(174,738)	-	(174,738)	(732,268)	-	(732,268)	-	(732,268)
25	**Net Pharmacy Claims**	**75,689,308**	**45,414,954**	**30,274,354**	**468,758,606**	**458,890,533**	**9,868,073**	**647,300,217**	**(178,541,611)**
26									
27	**Net Claim Payments**	**196,381,700**	**216,531,216**	**(20,149,516)**	**1,611,774,020**	**1,661,945,408**	**(50,171,388)**	**2,730,149,447**	**(1,118,375,427)**
28									
29	**Medicare Advantage Premiums**	**12,907,634**	**14,447,462**	**(1,539,828)**	**12,907,634**	**14,447,462**	**(1,539,828)**	**86,864,744**	**(73,957,110)**
30									
31	**Net Administrative Expenses**	**23,427,097**	**15,201,741**	**8,225,356**	**92,975,834**	**106,500,039**	**(13,524,205)**	**182,446,628**	**(89,470,794)**
32									
33	**Total Plan Expenses (excludes internal transfers)**	**232,716,431**	**246,180,419**	**(13,463,988)**	**1,717,657,488**	**1,782,892,909**	**(65,235,421)**	**2,999,460,819**	**(1,281,803,331)**
34									
35	**Plan Income/(Loss)**	**(3,774,932)**	**7,029,528**	**(10,804,460)**	**51,184,257**	**(53,744,833)**	**104,929,090**	**(38,927,275)**	**90,111,532**
36									
37	**Cash Availability:**								
38									
39	Beginning Cash Balance/(Deficit)	838,447,137	694,975,133	143,472,004	783,487,948	755,749,494	27,738,454	755,749,494	27,738,454
40	**Ending Cash Balance/(Deficit)**	**834,672,205**	**702,004,661**	**132,667,544**	**834,672,205**	**702,004,661**	**132,667,544**	**716,822,219**	**117,849,986**
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**	**$ 595,225,999**	**$ 462,558,455**	**$ 132,667,544**	**$ 595,225,999**	**$ 462,558,455**	**$ 132,667,544**	**$ 477,376,013**	**$ 117,849,986**

Comments:

a. Premium receivables totaled $138,061.46 as of January 31, 2014.
b. The average weekly medical claims cost net of claims refunds was $30,173,098.00 for the four scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included three bi-weekly invoice cycles averaging $27,466,338.00 per cycle.
d. The target stabilization reserve is 8.5% of the projected net claims and Medicare Advantage premiums for Fiscal Year 2013-14.
e. Minor differences compared to other reports are due to rounding.

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 January 2014
Fiscal Year 2013-2014

		A	B	C	D	E	F	G
		Current Year Actual January 2014	Prior Year Actual January 2013	Current Year to Date Actual FY 2013-14 thru January	Prior Year to Date Actual FY 2012-13 thru January	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	$ 215,624,797	$ 217,336,501	$ 1,718,202,797	$ 1,687,804,549	$ 2,902,567,015	$ 2,872,808,844	$ 2,895,366,140
4	Premium Refunds/Retroactive Disenrollments	1,918	(33,965)	(275,620)	(278,427)	(1,466,766)	(1,437,243)	(487,819)
5	Medicare Part D (RDS) Subsidy	865,445	-	(458,443)	25,570,898	6,218,762	39,519,892	38,056,016
6	Medicare PDP (EGWP + Wrap) Subsidy	12,080,189	3,879,515	49,162,774	3,879,515	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**	**228,572,349**	**221,182,051**	**1,766,631,508**	**1,716,418,316**	**2,957,665,413**	**2,930,651,349**	**2,956,811,601**
9								
10	Investment Earnings	369,150	266,690	2,155,265	1,669,770	2,868,131	5,658,262	3,117,666
11	Miscellaneous Revenue	-	-	54,972	8,159	-	-	119,047
12	**Other Revenue**	**369,150**	**266,690**	**2,210,237**	**1,677,929**	**2,868,131**	**5,658,262**	**3,236,713**
13								
14	**Total Plan Revenue (excludes internal transfers)**	**228,941,499**	**221,448,741**	**1,768,841,745**	**1,718,096,245**	**2,960,533,544**	**2,936,309,611**	**2,960,048,314**
15								
16	**Plan Expenses:**							
17								
18	Medical Claim Payments	122,660,199	137,118,189	1,155,817,599	1,056,190,175	2,107,493,114	2,003,583,417	1,858,096,405
19	Medical Claim Refunds/Recoveries	(1,967,807)	(2,361,986)	(12,802,185)	(14,655,055)	(24,643,884)	(31,216,928)	(23,467,914)
20	**Net Medical Claims**	**120,692,392**	**134,756,203**	**1,143,015,414**	**1,041,535,120**	**2,082,849,230**	**1,972,366,489**	**1,834,628,491**
21								
22	Pharmacy Claim Payments	82,399,014	84,034,775	508,214,483	442,935,930	699,653,578	743,853,418	755,896,440
23	Pharmacy Claim Rebates	(6,534,968)	(10,854,294)	(38,723,609)	(37,046,327)	(52,353,361)	(53,173,873)	(69,641,941)
24	Pharmacy Claim Refunds/Recoveries	(174,738)	(651)	(732,268)	(456,133)	-	-	(3,476,790)
25	**Net Pharmacy Claims**	**75,689,308**	**73,179,830**	**468,758,606**	**405,433,470**	**647,300,217**	**690,679,545**	**682,777,709**
26								
27	**Net Claim Payments**	**196,381,700**	**207,936,033**	**1,611,774,020**	**1,446,968,590**	**2,730,149,447**	**2,663,046,034**	**2,517,406,200**
28								
29	**Medicare Advantage Premiums**	**12,907,634**	-	12,907,634	-	**86,864,744**	-	-
30								
31	**Net Administrative Expenses**	**23,427,097**	**11,491,663**	**92,975,834**	**91,386,482**	**182,446,628**	**189,387,392**	**161,401,639**
32								
33	**Total Plan Expenses (excludes internal transfers)**	**232,716,431**	**219,427,696**	**1,717,657,488**	**1,538,355,072**	**2,999,460,819**	**2,852,433,426**	**2,678,807,839**
34								
35	**Plan Income/(Loss)**	**(3,774,932)**	**2,021,045**	**51,184,257**	**179,741,173**	**(38,927,275)**	**83,876,185**	**281,240,475**
36								
37	**Cash Availability:**							
38								
39	Beginning Cash Balance/(Deficit)	838,447,137	679,967,599	783,487,948	502,247,471	755,749,494	502,247,475	502,247,471
40	**Ending Cash Balance/(Deficit)**	**834,672,205**	**681,988,644**	**834,672,205**	**681,988,644**	**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**	$ 595,225,999	$ 482,260,191	$ 595,225,999	$ 482,260,191	$ 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 January 2014

Calendar Year 2014

#		A	B	C	D	E	F
		Actual Year to Date Calendar Year thru January	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Calendar Year to Date thru January	*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)	$ 215,624,797	$ 29,484,769	$ 245,109,566	$ 243,964,546	$ 1,145,020	0.47%
4	Premium Refunds/Retroactive Disenrollments	1,918		1,918	(124,354)	126,272	-101.54%
5	Medicare Part D (RDS) Subsidy	865,445		865,445	603,039	262,406	43.51%
6	Medicare PDP (EGWP + Wrap) Subsidy (Note 3)	12,080,189	(572,152)	11,508,037	8,534,636	2,973,401	34.84%
7	Federal Early Retiree Reinsurance Program (ERRP)	-		-	-	-	
8	**Net Premium & Other Contributions**	**228,572,349**	**28,912,617**	**257,484,966**	**252,977,867**	**4,507,099**	**1.78%**
9							
10	**Other Revenue**	**369,150**		**369,150**	**232,080**	**137,070**	**59.06%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**228,941,499**	**28,912,617**	**257,854,116**	**253,209,947**	**4,644,169**	**1.83%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	120,692,392		120,692,392	171,116,262	(50,423,870)	-29.47%
17	Net Pharmacy Claims (Notes 4 and 5)	75,689,308	(38,657,674)	37,031,634	45,414,954	(8,383,320)	-18.46%
18	**Net Claim Payments**	**196,381,700**	**(38,657,674)**	**157,724,026**	**216,531,216**	**(58,807,190)**	**-27.16%**
19							
20	**Medicare Advantage Premiums**	**12,907,634**		**12,907,634**	**14,447,462**	**(1,539,828)**	**-10.66%**
21							
22	**Net Administrative Expenses (Note 6)**	**23,427,097**	**(8,491,208)**	**14,935,889**	**15,201,741**	**(265,852)**	**-1.75%**
23							
24	**Total Plan Expenses (excludes internal transfers)**	**232,716,431**	**(47,148,881)**	**185,567,550**	**246,180,419**	**(60,612,869)**	**-24.62%**
25							
26	**Plan Income/(Loss)**	**(3,774,932)**	**76,061,498**	**72,286,566**	**7,029,528**	**65,257,038**	**928.33%**
27							
28	**Cash Availability:**						
29							
30	Beginning Cash Balance/(Deficit)	838,447,137		838,447,137	694,975,133	143,472,004	20.64%
31	**Ending Cash Balance/(Deficit)**	**834,672,205**	**76,061,498**	**910,733,703**	**702,004,661**	**208,729,042**	**29.73%**
32							
33	Target Stabilization Reserve @ 12/31/2014	234,282,695		234,282,695	234,282,695	-	
34							
35	Cash Balance Over/(Under) Reserve Target	**$ 600,389,510**	**$ 76,061,498**	**$ 676,451,008**	**$ 467,721,966**	**$ 208,729,042**	**44.63%**

Adjustment Notes:

1. Member premiums adjusted to include $60.8 million in prepaid January premiums received in December 2013.
2. Member premiums adjusted to exclude $31.3 million in prepaid February premiums received in January.
3. EGWP Subsidies adjusted to exclude an unbudgeted Direct Subsidy.
4. Pharmacy claims adjusted to exclude a $33.1 million claims payment that was budgeted for payment in December 2013 but was not paid until January.
5. Pharmacy clams adjusted to include $5.6 million in EGWP rebates budgeted for January and received in February.
6. Administrative expenses adjusted to exclude December 2013 vendor invoices that were not processed until January 2014.

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

		A	B	C	D	E	F
		Actual Year to Date Fiscal Year thru January	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Fiscal Year to Date thru January	*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)	$ 1,718,202,797	$ (20,994,494)	$ 1,697,208,303	$ 1,684,043,918	$ 13,164,385	0.78%
4	Premium Refunds/Retroactive Disenrollments	(275,620)		(275,620)	(845,644)	570,024	-67.41%
5	Medicare Part D (RDS) Subsidy (Note 3)	(458,443)	5,717,385	5,258,942	3,387,783	1,871,159	55.23%
6	Medicare PDP (EGWP + Wrap) Subsidy (Note 4)	49,162,774	(572,152)	48,590,622	40,881,937	7,708,685	18.86%
7	Federal Early Retiree Reinsurance Program (ERRP)	-		-	-	-	
8	**Net Premium & Other Contributions**	**1,766,631,508**	**(15,849,261)**	**1,750,782,247**	**1,727,467,994**	**23,314,253**	**1.35%**
9							
10	**Other Revenue (Note 5)**	**2,210,237**	**(54,973)**	**2,155,264**	**1,680,082**	**475,182**	**28.28%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**1,768,841,745**	**(15,904,233)**	**1,752,937,512**	**1,729,148,076**	**23,789,436**	**1.38%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	1,143,015,414		1,143,015,414	1,203,054,875	(60,039,461)	-4.99%
17	Net Pharmacy Claims (Notes 6 and 7)	468,758,606	225,718	468,984,324	458,890,533	10,093,791	2.20%
18	**Net Claim Payments**	**1,611,774,020**	**225,718**	**1,611,999,738**	**1,661,945,408**	**(49,945,670)**	**-3.01%**
19							
20	**Medicare Advantage Premiums**	**12,907,634**		**12,907,634**	**14,447,462**	**(1,539,828)**	**-10.66%**
21							
22	**Net Administrative Expenses**	**92,975,834**		**92,975,834**	**106,500,039**	**(13,524,205)**	**-12.70%**
23							
24	**Total Plan Expenses (excludes internal transfers)**	**1,717,657,488**	**225,718**	**1,717,883,206**	**1,782,892,909**	**(65,009,703)**	**-3.65%**
25							
26	**Plan Income/(Loss)**	**51,184,257**	**(16,129,951)**	**35,054,306**	**(53,744,833)**	**88,799,139**	**-165.22%**
27							
28	**Cash Availability:**						
29							
30	Beginning Cash Balance/(Deficit)	783,487,948		783,487,948	755,749,494	27,738,454	3.67%
31	**Ending Cash Balance/(Deficit)**	**834,672,205**	**(16,129,951)**	**818,542,254**	**702,004,661**	**116,537,593**	**16.60%**
32							
33	Target Stabilization Reserve @ 6/30/14	239,446,206		239,446,206	239,446,206	-	
34							
35	**Cash Balance Over/(Under) Reserve Target**	**$ 595,225,999**	**$ (16,129,951)**	**$ 579,096,048**	**$ 462,558,455**	**$ 116,537,593**	**25.19%**

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 $31.3 million in prepaid February premiums received in January.
3. Medicare Part D Subsidy adjusted to remove the impact of an unbudgeted repayment of subsidy revenues from prior years.
4. EGWP Subsidies adjusted to exclude an unbudgeted Direct Subsidy received in January.
5. Other revenue adjusted to exclude unbudgeted reimbursement of prior year expenditures.
6. Pharmacy claims adjusted to exclude $5.8 million in unbudgeted EGWP rebates earned last fiscal year but not received until October 2013.
7. Pharmacy clams adjusted to include $5.6 million in EGWP rebates budgeted for January and received in February.

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

2nd Quarter Actuarial Forecast Update

Board of Trustees Meeting

March 27, 2014

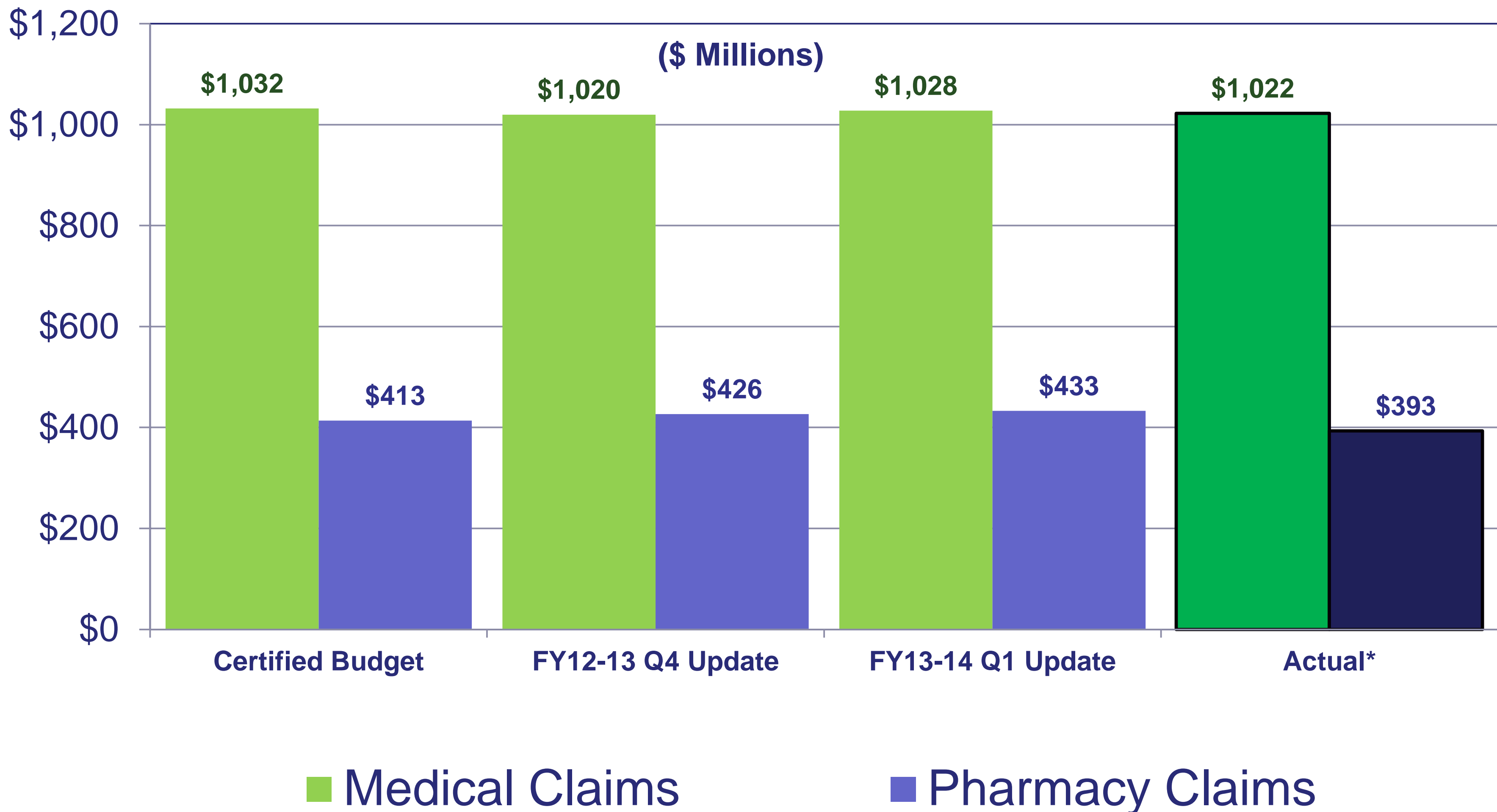
Forecast prepared by The Segal Company
Final version dated 3-20-14

A Division of the Department of State Treasurer

Presentation Overview

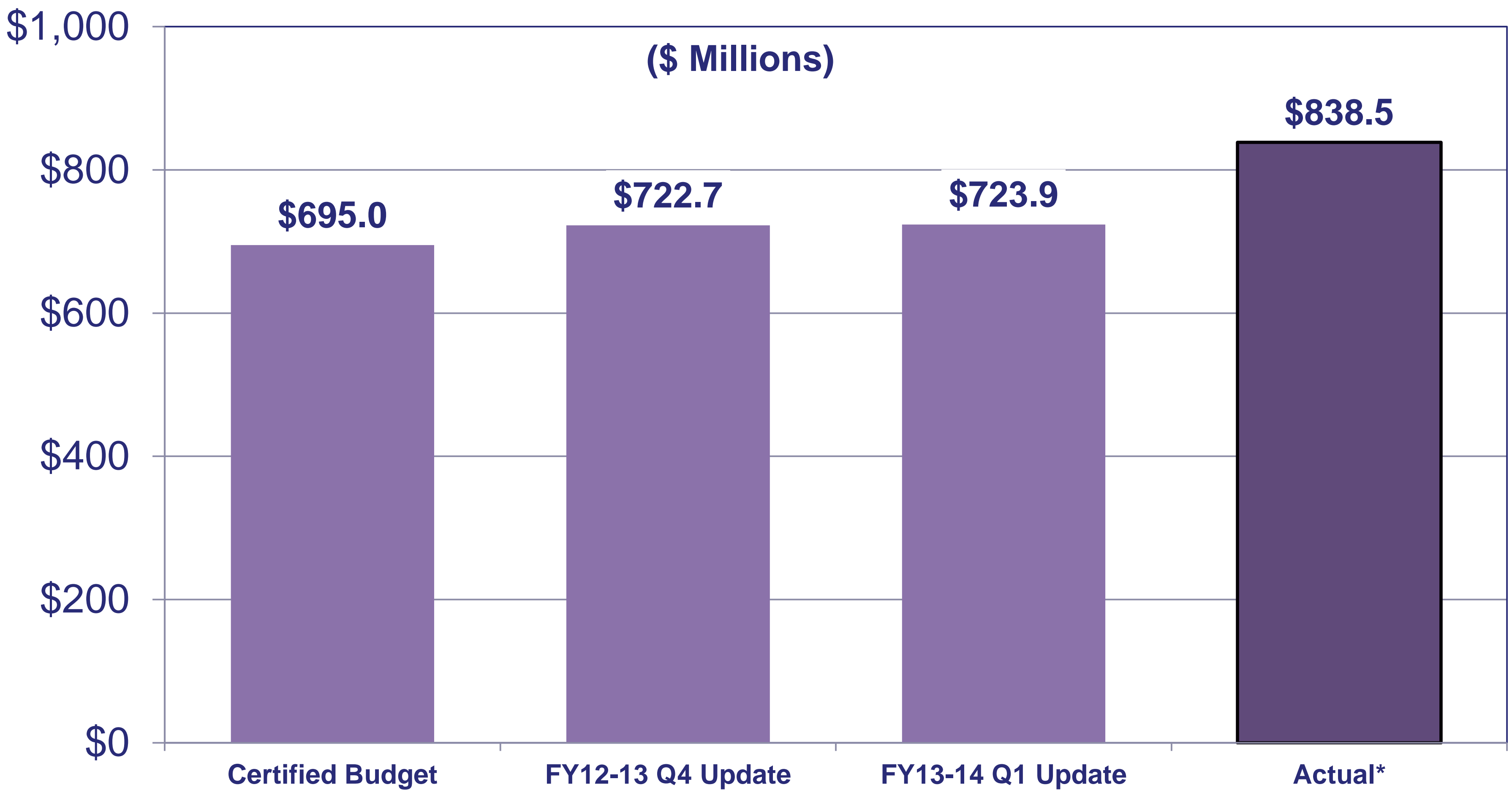
- Final Short Plan Year Summary
- Forecast Update Schedule
- Updated Assumptions: Certified Budget vs. 2nd Quarter Forecast
- Updated Forecast for 2014 Plan Year
- Summary Graphs
- Future Outlook

Forecast Comparisons: Short Plan Year Claims



*An additional pharmacy claims payment was expected in December but was not made until January 2014. The payment was $33.1 million.

Forecast Comparisons: December 31, 2013 Ending Cash



*The actual December 31st cash balance included $50.5 million in prepaid premium revenue not anticipated in previous estimates of the cash balance and $41.6 million in unpaid expenses that had been anticipated in previous estimates.

Actuarial Forecast Update Schedule

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

Forecast Assumptions Maintained in the Update
Certified Budget vs. 2nd Quarter Update

- Overall trend assumption of 8.5%
- Membership trends
  - 1% annual decrease in actives
  - 1% annual increase in retirees
- New benefit design effective January 1, 2014
- 2014 revenues reflect 3.57% across the board premium increases effective January 1, 2014 and the wellness premium structure
- 2015 revenues assume 2.14% across the board premium increases effective January 1, 2015 as authorized by the General Assembly and continuation of the 2014 wellness premium structure
- Future bienniums assume escalating wellness premium surcharges/credits and extension of the wellness premium structure to the Traditional 70/30 Plan

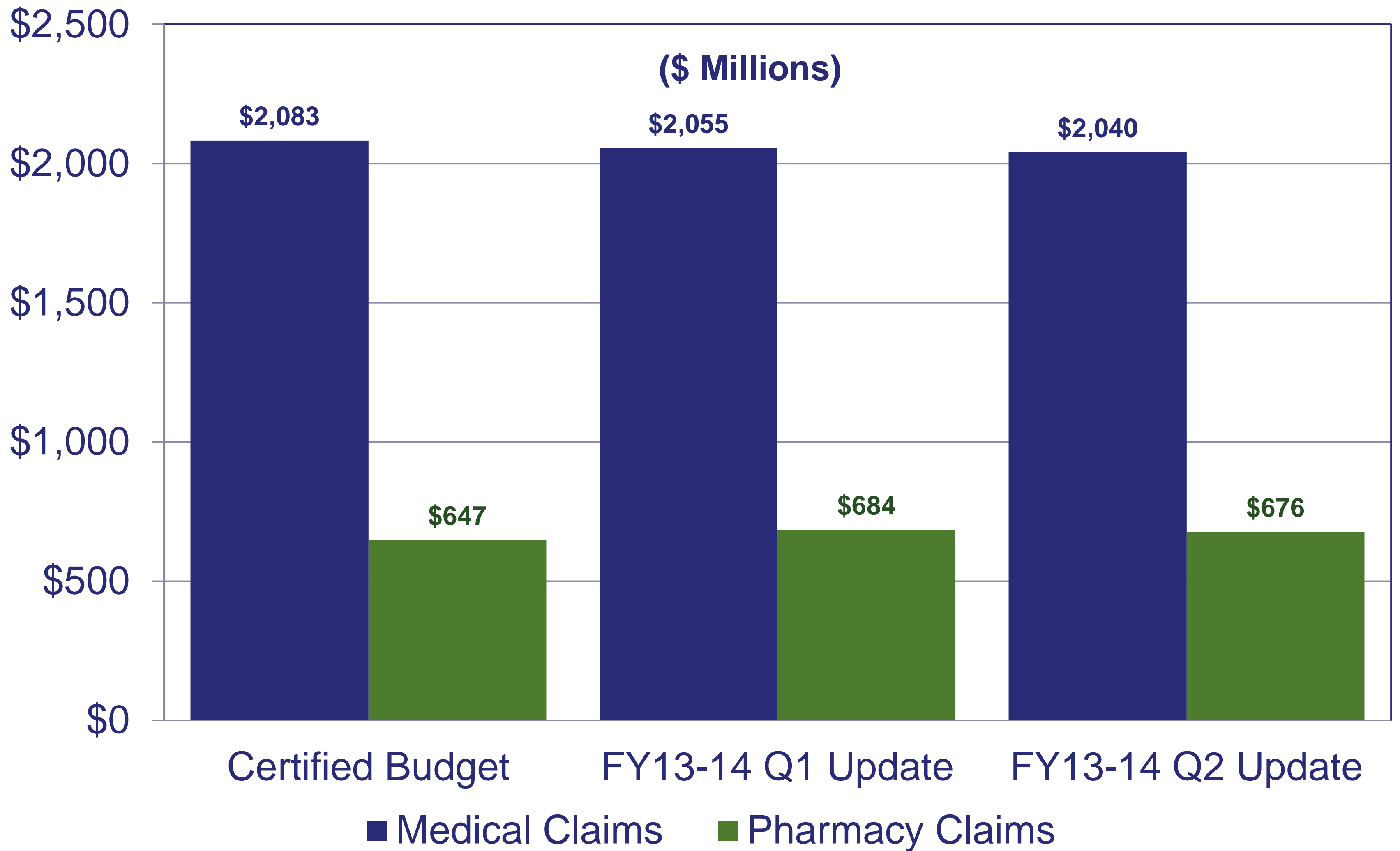
Forecast Assumptions Changed/Revised in the Update Certified Budget vs. 2nd Quarter Update

- Membership based on actual December 2013 counts (instead of March 2013)
- Anticipated claims expenditures based on actual experience through December 2013 (instead of through March 2013)
- Baseline pharmacy claims amount increased to reflect experience from the last six months (rather than the last 12 months) due to increasing pharmacy trends
- Elimination of lifetime limits on ACA "Essential Health Benefits"
- Decrease in the coinsurance maximum for Tier 5 non-preferred specialty medications to $125
- Timing and amounts of pharmacy rebates have been adjusted
- Timing of EGWP catastrophic subsidy revenue was moved from November 2014 to January 2015
- Projections of remaining EGWP subsidies (coverage gap and catastrophic) were increased to more closely reflect estimates from Express Scripts
- 100% coverage of preventive treatment is assumed for Traditional 70/30 Plan beginning in 2016
- Target Stabilization Reserve balances to 9% of claims costs only; Certified Budget balanced to 9% of claims costs *plus* Medicare Advantage premium payments
- Projections extended through 2019

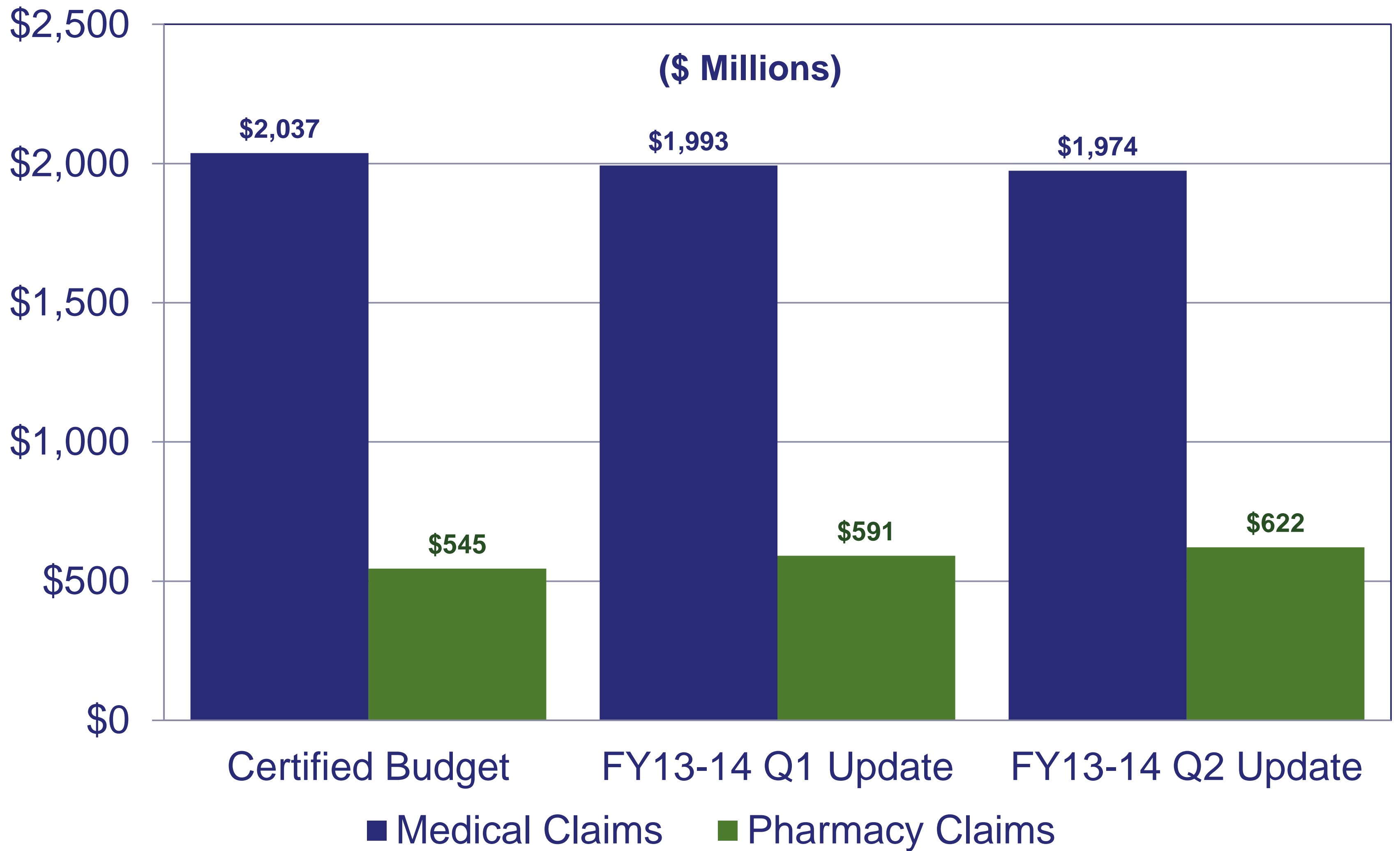
Comparison of Models for Short Plan Year Certified Budget vs. 2nd Quarter Update

Calendar Year 2014	2nd Quarter Update (per Segal 03-20-14)	Certified Budget (per Segal 8-19-13)	Difference: Increase/ (Decrease) From Budget
Beginning Cash Balance	$838.5 m	$695.0 m	$143.5 m
Plan Revenue	**$2.953 b**	**$2.961 b**	**($7.6 m)**
Net Claims Payments	$2.596 b	$2.582 b	$13.5 m
Medicare Advantage Premiums	$176.1 m	$174.2 m	$1.9 m
Net Admin. Expenses	$188.4 m	$179.8 m	$8.6 m
Total Plan Expenses	**$2.960 b**	**$2.936 b**	**$24.0 m**
Net Income/(Loss)	**($7.0 m)**	**$24.6 m**	**($31.6 m)**
Ending Cash Balance	$831.5 m	$719.6 m	$111.9 m
2016 & 2017 Premium Increases	5.55%	8.22%	(2.67%)
2018 & 2019 Premium Increases	13.81%	--	--

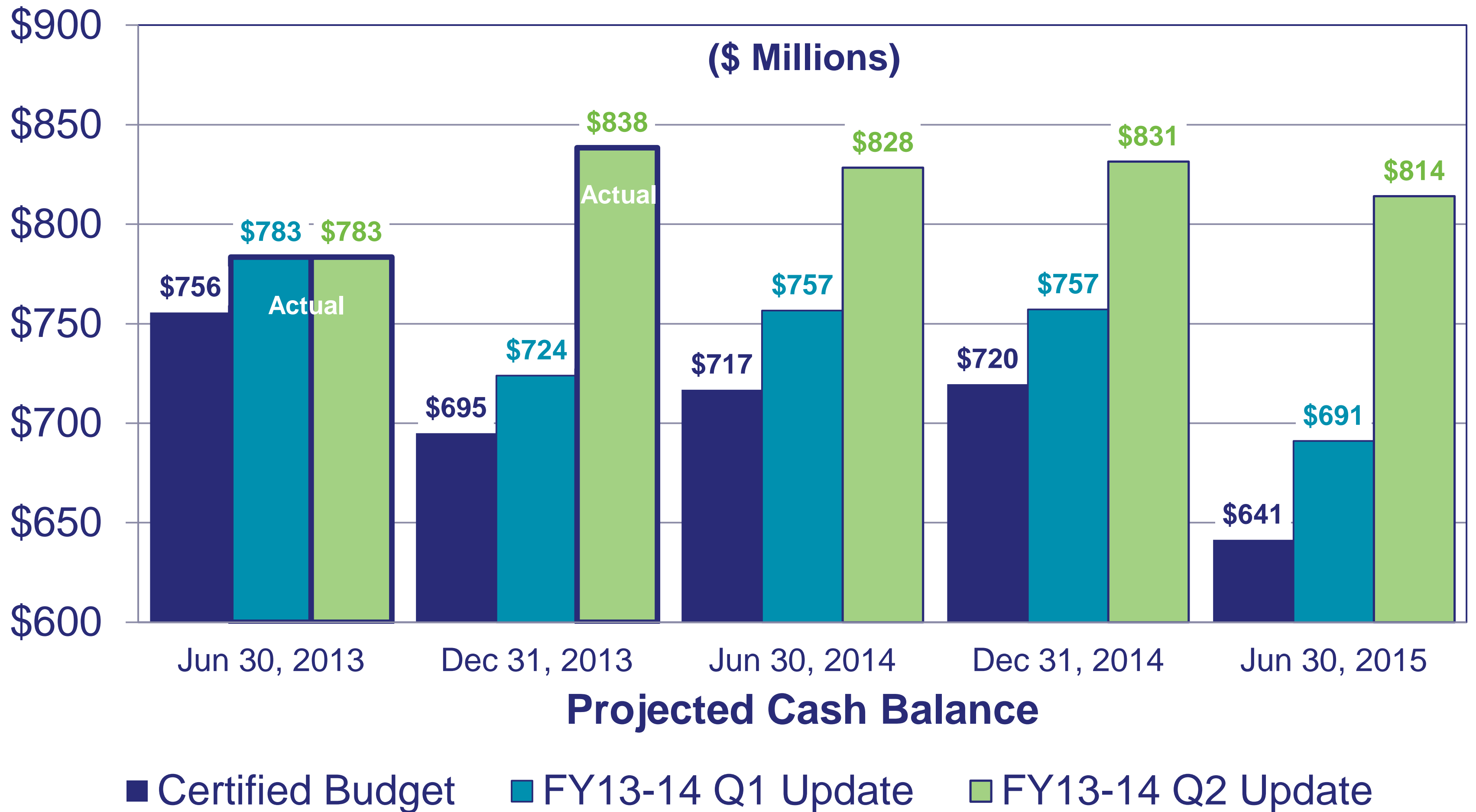
Forecast Comparisons: Fiscal Year 2013-14 Claims



Forecast Comparisons: Calendar Year 2014 Claims



Forecast Comparisons: Ending Cash Balances



Future Outlook

- Current Fiscal Biennium (2013-2015)
  - Relative to the Certified Budget, the 2nd Quarter Update projects lower medical claims costs and higher pharmacy claims costs for the biennium
  - $814.0 million cash balance projected for the end of the biennium:
    - $172.7 million higher than the Certified Budget
    - About 2/3 of the higher projected cash balance can be attributed to greater revenue attainment than previously projected; 1/3 is due to reduced expenditures
    - Exceeds the 9.0% target reserve amount by $578.4 million
    - Equates to almost 13 weeks of FY 2015-16 projected operating expenses
- Assuming no changes in benefits beyond the Board's current design (except extension of the wellness benefit design to the Traditional 70/30 Plan beginning in 2016), the 2nd Quarter Update projects a 5.55% premium increase for January 1 of each year of the 2015-17 biennium. This is lower than the Certified Budget projection (8.22%)

Certified Budget
(Segal 8-19-13)

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

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

FY 2013-13 Q1 Update
(Segal 11-14-13)

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

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

FY 2013-14 Q2 Update

Page 1

(Segal 3-20-14)

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

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

FY 2013-14 Q2 Update
Page 2
(Segal 3-20-14)

SEGAL

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

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

North Carolina State Health Plan

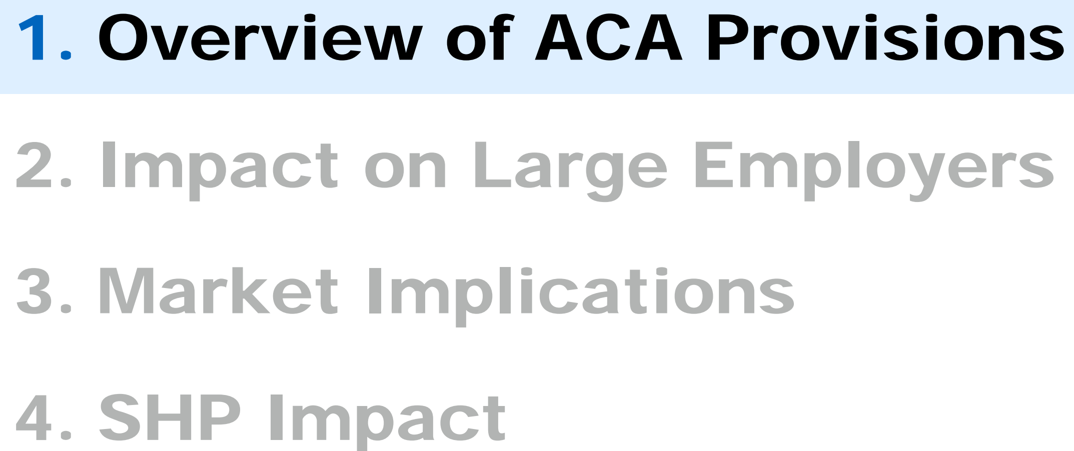
How ACA is Changing Employer Health Benefits and the Marketplace

Presented by:

J. Richard Johnson
Senior Vice President,
Public Sector Health Practice Leader
rjohnson@segalco.com

March 28, 2014

Copyright © 2014 by The Segal Group, Inc. All rights reserved.



1. **Overview of ACA Provisions**
2. Impact on Large Employers
3. Market Implications
4. SHP Impact

Copyright © 2014 by The Segal Group, Inc. All rights reserved.

ACA Mandates a FLOOR for Health Insurance

- **Extends access** to health insurance coverage to all citizens by imposing mandates:
  - **Individual Mandate**: have health coverage with minimum essential benefits or pay a tax penalty
  - **Employer Shared Responsibility**: provide a minimum level of affordable health care for full-time employees or pay tax penalties
  - **Insurers**: Fully insured policies must have no pre-existing conditions; limits on carrier profit margins
- **Expands Medicaid** eligibility
  - To individuals under 65 with income under 133% of Federal Poverty Level (FPL)
  - Increases Medicaid funding to states that expand coverage
- Expands certain **Medicare** benefits
- **Creates new virtual marketplaces** (exchanges) to buy coverage
  - Provides subsidies for low-income individuals to buy Exchange coverage

ACA Mandates and Requirements Since 2010

- Dependent coverage to age 26
- No annual or lifetime dollar limits
- No preexisting condition exclusions
- No waiting period over 90 days
- Coverage of preventive care benefits
- Increased wellness program incentive allowances
- Medical Loss Ratios for insured and Medicare plans (85%)
- Uniform information disclosure
- Summary of Benefits and Coverage
- Comparative Effectiveness Research Fees
- W-2 Reporting of health benefit costs
- Employer Exchange-Related Notices

Individual Mandate - 2014

The Individual

- Must be covered under *minimum essential* health coverage (including employer-sponsored or Medicare coverage) OR pay a penalty
  - Penalty is *the greater of:*
    - 2014: **$95 per adult or 1% of income**
    - 2015: **$325 per adult or 2% of income**
    - 2016: **$695 per adult or 2.5% of income** (indexed after 2016)
  - No penalty if:
    - Cost of coverage exceeds 8% of household income
    - Coverage lapses of 3 months or less
    - Income is below income tax filing threshold
    - Native American
- Individual penalty accounted for as an additional amount of federal tax owed

Employer Shared Responsibility Penalty - 2015

- Applies to ***large employers*** - 50 or more full-time employee equivalents
- Full time = 30 or more ***hours of service*** per week (130 hours per month)
- Penalty triggered when a full-time employee receives a federal subsidy in a state Exchange
- Cannot retaliate against employees for subsidies
- Employees must have ***access*** to at least one plan of health benefit coverage for themselves and dependent children that is both
  - **Minimum actuarial value**
    - Provides at least a value of 60% of the cost of services
  - **Affordable**
    - Plan of minimum essential actuarial value must be at an affordable price for self only coverage (9.5% of gross taxable wages)

The 4980H(a) and (b) Penalties – The Details

(a) If a large employer **does not** offer “minimum essential coverage” to at least **95%*** of its full-time employees (and dependent children under age 26) and if one full-time employee receives subsidized coverage on the Exchange:

➢ *Penalty is **$2,000** (annualized) times the **total #** of full-time employees (minus first 30 workers)*

(b) If a large employer **does** offer coverage to 95% of its full-time employees (and their dependent children under 26), but the coverage is either:

- **Not affordable** (premium for self-only coverage is 9.5% or more of household income), or
- **Not of minimum value** (actuarial value is less than 60%)

and one full-time employee receives federally subsidized coverage in the Exchange

➢ *Penalty is **$3,000** (annualized) times the **# of full-time employees getting a tax credit** in an Exchange (subject to a penalty maximum)*

*Under a 2/10/14 transition rule, large employers (100 or more employees) must offer coverage to least 70% of employees for 2015, then 95% of employees for 2016 and after.

Mandates on Insurance Companies

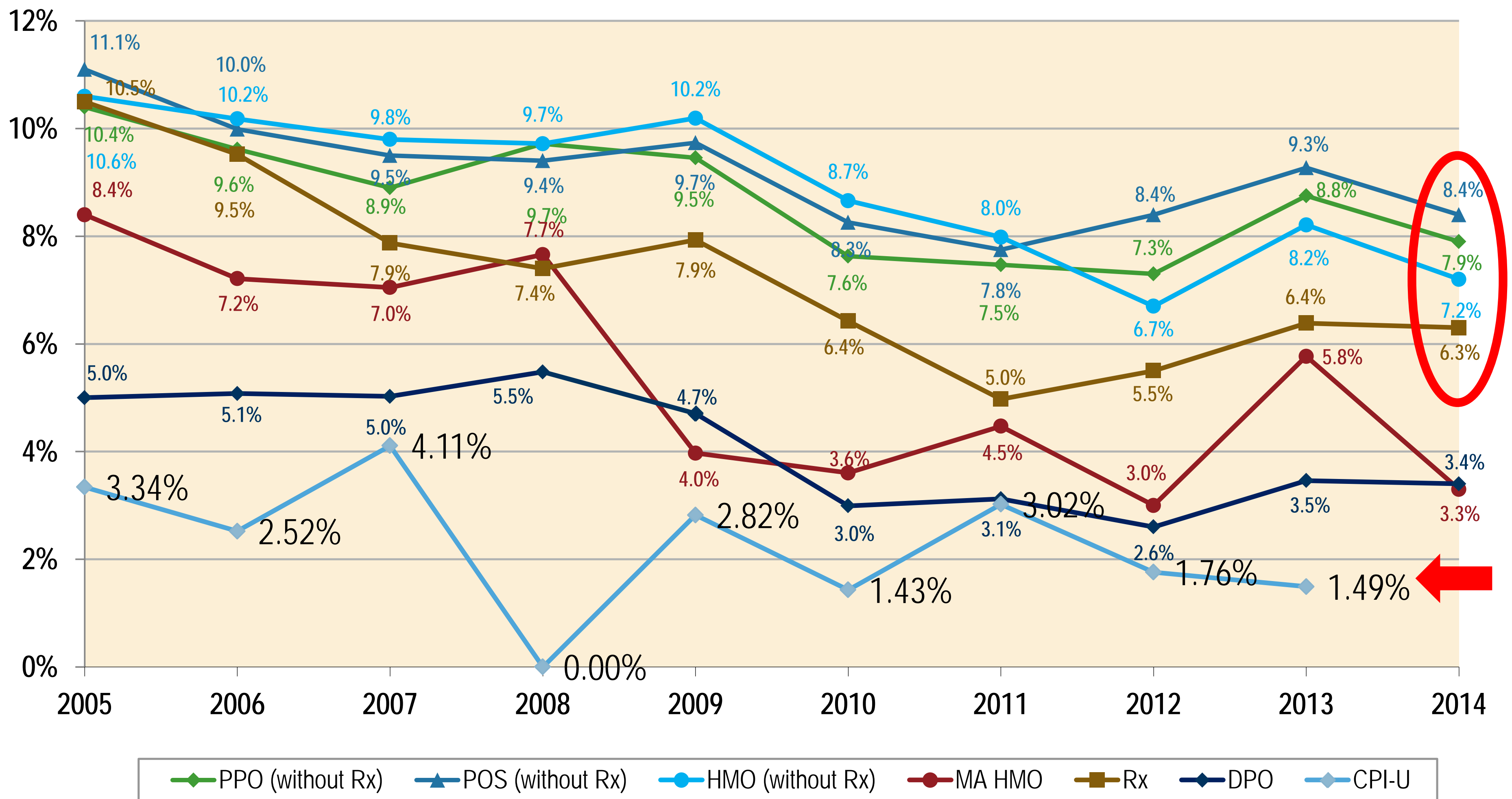
- Pay premium tax on premium income proportionate to total health insurance share of market (1.5% - 3.5% estimate. Not for profit is 50% of for profit companies)
- Pay comparative effectiveness fees and reinsurance fee to subsidize Exchange
- Fees estimated to add 3.5%-4% to the renewal rates for 2014
- Charge the same rate to individuals as it does through the Exchange, if it offers coverage inside the Exchange and outside the Exchange
- Eliminate all exclusions due to pre-existing conditions
- Establish rates through the Exchange based on certain factors:
  - Coverage tier (single, two party, family)
  - Geography
  - Age (maximum rate difference of 3 to 1)
  - Smoker versus non-smoker (maximum of 150% of non-smoker)
- Range of rates from youngest to oldest applicant cannot exceed a factor of 3
- Guarantee the renewal of the insurance policy

ACA Imposes a CEILING on Tax Free Benefits

40% Excise Tax on High Cost Health Plans *(2018)*

- Threshold $10,200/$27,500 indexed to the CPI-U
  - Based on total cost of coverage – Employer + Employee cost
  - No regional adjustment for cost of medical care
- Increased thresholds **($11,850/$30,950)** for high-risk professions and **retirees**
  - Includes public safety, construction, etc.
- Appears to exclude most dental and vision;
- Includes health FSAs and HRAs
- Tax payable by plan administrator
- No guidance yet!

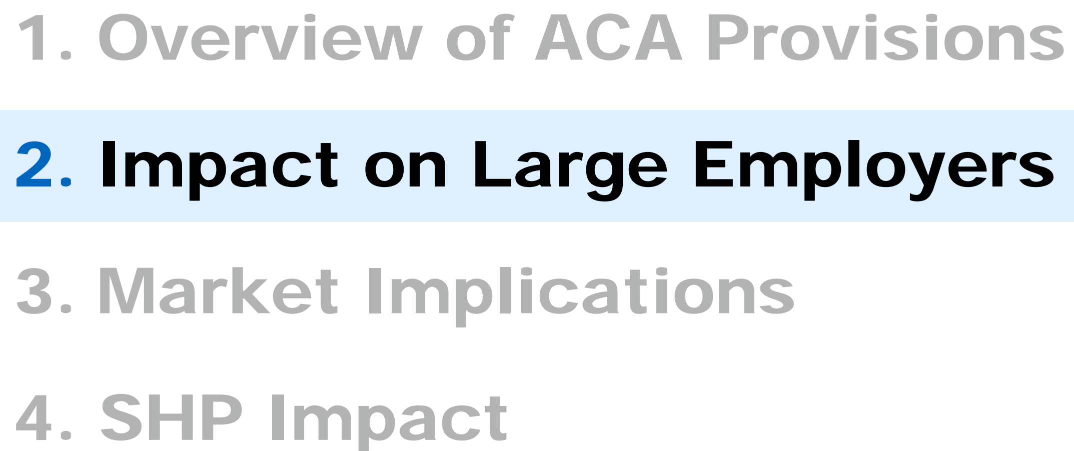
Ten-Year Summary of Selected Medical, Prescription Drug Carve-Out and Dental Trends: 2005 – 2012 Actual and 2013 and 2014 Projected[1]



Source: 2014 *Segal Health Plan Cost Trend Survey*

[1] All trends are illustrated for actives and retirees under age 65, except for MA HMOs.

[2] Prescription drug trend data for 2005 – 2007 only reflects retail. For 2008 – 2014, prescription drug retail and mail order delivery channels are combined.



1. Overview of ACA Provisions

2. Impact on Large Employers

3. Market Implications

4. SHP Impact

Copyright © 2014 by The Segal Group, Inc. All rights reserved.

Rethinking Plan Eligibility

- Redefining eligibility
  - Seasonal and part-time employees with multiple part-time positions
  - Adjunct faculty working full-time but not previously benefit eligible
- New Federal ACA penalty rules create a change of perspective in managing health benefit plan eligibility
  - Previous eligibility definitions may no longer work under the ACA "full-time" employee rules
  - Manage to "the rule" of no part-timer over 29 hours?
  - Allow coverage in existing plans – but how to fund the employer subsidy?
  - Create separate minimum benefit plans for these employees – but what about equity among "full-time" employees?

How Long Do We Try to Remain Grandfathered?

- **Purpose** is to preserve existing coverage; **Advantage** is plan does not have to comply with certain coverage mandates
- Limits on changes – Cannot have:
  - Elimination of all or substantially all benefits to diagnose or treat a particular condition
  - Any increase in percentage cost-sharing requirement (i.e., coinsurance)
  - Increase in deductible or out-of-pocket maximum by an amount that exceeds medical inflation + 15 percentage points
  - Increase in copays by an amount that exceeds medical inflation +15 percentage points (or, if greater, $5 + medical inflation)
  - Decrease in employer's contribution rate by more than 5 percentage points (and related increase in employee's contribution rate)
  - Imposition of annual limits on the dollar value of benefits below certain amounts
- Only about 20% of plans in place in March 2010 remain grandfathered today
- Medical cost inflation keeps increasing employer's share of cost. At some point the additional design and pricing flexibility outweighs the additional preventive benefits and other requirements

What Options For Retiree Coverage?

- Retirees are still subject to the individual mandate – but not to the employer shared responsibility penalty
- Retirees not yet eligible for Medicare may:
  - Purchase coverage on the state exchanges even if eligible for employer plan coverage
  - Qualify for Medicaid and/or federal exchange subsidies due to limited (retirement benefit) income
- Potential options:
  - Carve out retirees to their own plans and trusts
  - Push non-Medicare retirees to the Exchange to capture the Federal and Medicaid subsidies
  - Implement private exchanges for Medicare retirees
  - Move to defined contribution employer subsidies

How Should We Integrate Exchange Benefits?

Add the SHOP Exchange as a plan option

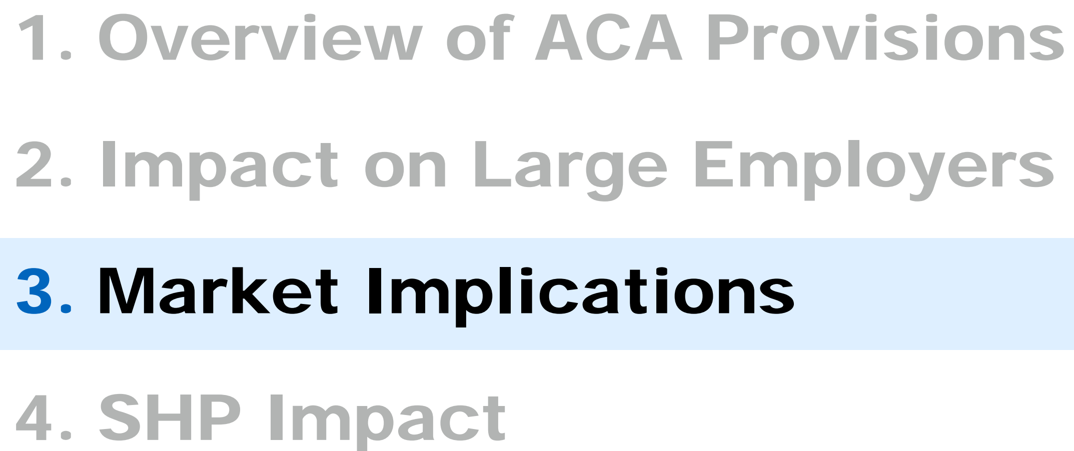
- Keep existing group plan
- Add a Metal Color option
  - Participant may select any plan available at Gold Level OR
  - Employer subsidizes specific plan in the Gold level
- Employer collects employee contributions and pays total premium to exchange, including its subsidy

Offer only Exchange options

- Employer will pay a defined contribution premium subsidy amount to exchange for a selected metal level.
- Participant may select up or down from subsidized plan, but pays the difference (or gets a reduced premium) to the exchange

Rethinking Total Compensation Philosophy

- What is the employer’s responsibility to provide and/or subsidize health insurance benefits beyond compliance with the law?
- What role will health benefits play in attracting and retaining talent?
- With limited budgets, what is the tipping point between benefits subsidy and infrastructure repair?
- Redefinition of “full-time benefits eligible” will drive significant changes to workforce composition
- Potential reduction or removal of pre-tax status for health benefit premiums
- What is the tipping point between group health plan cost and state exchange policy cost?



1. Overview of ACA Provisions
2. Impact on Large Employers
3. **Market Implications**
4. SHP Impact

Copyright © 2014 by The Segal Group, Inc. All rights reserved.

Affordable Care Organizations

What are ACOs and how do they work?

- Networks formed by groups of doctors, hospitals and other health care providers to receive financial incentives for coordinating care for people with Medicare and disabilities
- Delivery system ties predetermined quality of care and outcome measures to reimbursement for care. If successful in improving efficiency, patient care and health, the ACO keeps extra Medicare and Medicaid reimbursements
- Puts doctors' groups and hospitals at additional risk to prove what they are doing makes a difference

North Carolina ACOs

- Currently 14 or more formed and approved
- 360+ now approved nationally

Potential Impact

- Hold down medical trend increases
- Redefine traditional networks

Medicaid Expansion

- Expansion to 133% of Federal Poverty Level
  - Puts pressure on state budgets
  - But also brings in more Federal revenue
  - Forces reconsideration of Medicaid models (managed care growth)
- Even if state doesn't expand, more citizens likely will be determined as eligible for Medicaid benefits who never applied directly in the past
- Now must consider how Medicaid coordinates with
  - Employer provided benefits
  - Medicare
  - Federal exchange subsidies
- No clear-cut best solution

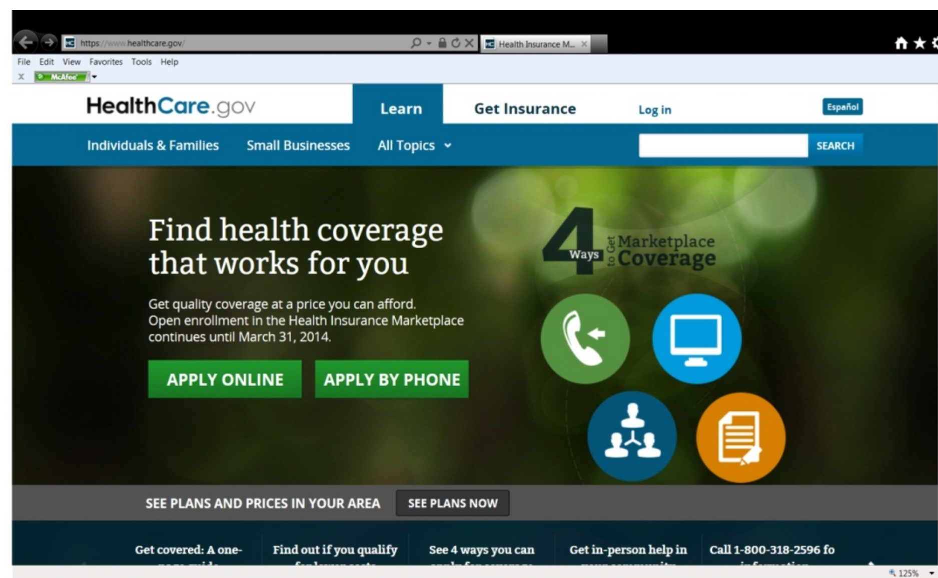
Income Eligibility for Subsidized Coverage–
Between 100% & 400% FPL

Persons in Family	100% FPL	133% FPL	250% FPL	400% FPL
1	$11,490	$15,282	$28,725	$45,960
2	$15,510	$20,628	$38,775	$62,040
3	$19,530	$25,975	$48,825	$78,120
4	$23,550	$31,322	$58,875	$94,200
5	$27,570	$36,668	$68,925	$110,280
6	$31,590	$42,015	$78,975	$126,360
7	$35,610	$47,361	$89,025	$142,440
8	$39,630	$52,708	$99,075	$158,520

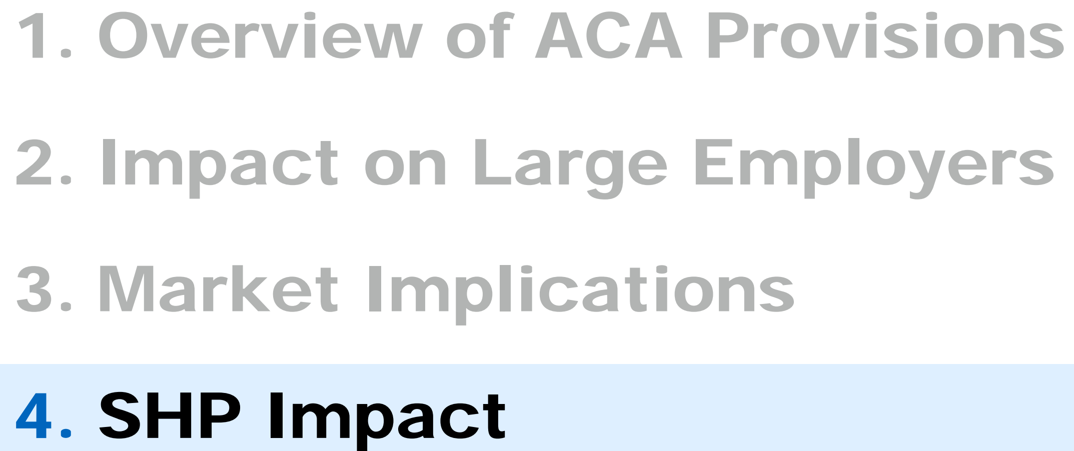
2013 Federal Poverty Line guidelines for the 48 contiguous states

Health Exchange Implications

- Exchange becomes the standard against which all other plans are measured
  - Metal levels drive plan design corridors
  - Skinnier provider networks on some exchange options may limit patient options, but also help hold down costs
  - More options against which the SHP will ultimately compete
  - Will also influence employer subsidy levels in the future
- NC Health Exchange
  - 200,000 enrolled (March 1, 2014)
  - 18.7% of estimated potential enrollees
  - Potentially more than 50% of U.S. households could qualify for exchange subsidies (based on Bureau of Labor Statistics (BLS) estimates)



1. Overview of ACA Provisions
2. Impact on Large Employers
3. Market Implications
4. **SHP Impact**



Copyright © 2014 by The Segal Group, Inc. All rights reserved.

The Playing Field Has Changed!

Why it's different now and for the future

1. Health Care Reform places new and increasingly more stringent requirements onto public sector health plans
2. The Federal Government is now a player in every state and local jurisdiction health plan.
3. Medicaid will now impact more employees and dependents
4. State and local government's traditional role in providing "hire to grave" health benefits for active and retired employees is changing
5. Public employers will have to make possibly significant changes to their health plan eligibility and/or workforce composition
6. Public plans have a developing new competitor (*state health insurance exchanges*) that may eventually be more cost effective for some groups

And Don't Forget the Environmental Factors

- The population is aging (Older = Sicker = Costlier)
- The cost of health care keeps rising faster than inflation
- Private employers will likely continue to cut or curtail employer sponsored and subsidized health benefits, making public employers even more attractive
- Public employees are likely to work longer just to keep subsidized health benefits (impact on budgets and retirement plan costs?)

Key Takeaways for SHP

- Expect an influx of new eligibles and possible pressure to offer a minimum benefit plan option
- The 70/30 and 80/20 plans will eventually lose grandfathered status
- There will be increased emphasis on Patient Centered Medical Home and Accountable Care Organization delivery networks as the market evolves

- Increased emphasis on wellness based premiums is possible
- Over time, there may be pressure to provide selected member groups an option to elect Plan subsidized coverage on the exchange
- Eventually, pressure may build to allow incoming employees to continue their previous exchange participation instead of joining the SHP
- While not imminent, eventually the 40% excise tax will force plan design changes

Health Reform Resources

On the Segal Website:

SEGAL

Segal | Segal Select Insurance | Segal Rogerscasey | Sibson Consulting | Contact Us
Segal Canada | Segal Rogerscasey Canada | Sibson Canada | Log in | Register

ABOUT US | WHO WE HELP | SERVICES | PUBLICATIONS AND RESOURCES | NEWS AND EVENTS | SEARCH

- Multiemployer Publications
- Public Sector Publications
- Health Care Reform Guide
  - Health Care Reform In the News
  - Health Care Reform Speaking Engagements
- *Stat! Health Reform News*
- Archived Presentations & Webinars
- Articles by Segal Experts
- Links

Home > Publications and Resources > *Health Care Reform Guide*

Health Care Reform Guide

After discussing, debating and analyzing for over a year, Congress passed health care reform legislation in March 2010. Throughout the process, Segal has provided timely updates on the latest developments and guidance on how health care reform will affect your health plan.

Below, we have gathered the resources that we are producing to help you as you move forward in making your plan compliant with the new law.

Learn more about our health care reform services for Multiemployer and Public Sector plans.

Health Care Reform Timeline for Calendar-Year Group Health Plans

Segal Publications

- February 8, 2013 *Capital Checkup*, "Affordable Care Act's Employer Notice of Exchange Coverage Delayed" (for Public Sector plans)
- February 8, 2013 *Capital Checkup*, "Affordable Care Act's Employer Notice of Exchange Coverage Delayed" (for Multiemployer staff plans subject to the rules of single-employer plans)
- January 25, 2013 *Capital Checkup*, "Proposed Rule on the Affordable Care Act's Employer Penalty Addresses Application to Multiemployer Plans" (for Multiemployer plans)
- January 25, 2013 *Capital Checkup*, "IRS Proposes Rule on Employer Penalty Under the Affordable Care Act" (for Public Sector plans)
- January 25, 2013 *Capital Checkup*, "IRS Proposes Rule on Employer Penalty Under the Affordable Care Act" (for Multiemployer staff plans subject to the rules of single-employer plans)

Connect With Us

Related Content

- What Health Exchanges Mean to Plan Sponsors and Plan Participants
- 4th Quarter 2012 *TRENDS*
- 4th Quarter 2012 *TRENDS*
- Multiemployer Plans and the Health Insurance Exchanges - What Trustees Need to Know
- 2013 *Segal Health Plan Cost Trend Survey*

Our Web sites

Explore other Segal Company Web sites:

- Segal Rogerscasey
- Segal Canada
- Sibson Consulting

Rick Johnson
Senior Vice President
rjohnson@segalco.com
212.833.6470
www.segalco.com

- Health Care Reform Timeline
- *Health Care Reform Insights*
- *Stat!*
- *Bulletins*
- *Public Sector Letters*
- Webinar recordings and slides

Health Reform Resources: www.segalco.com/health-care-reform/

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Impact of the Affordable Care Act (ACA) on the State Health Plan

Joint Study Committee on the Affordable Care Act and Implementation Issues

March 18, 2014

Mona M Moon, Executive Administrator

A Division of the Department of State Treasurer

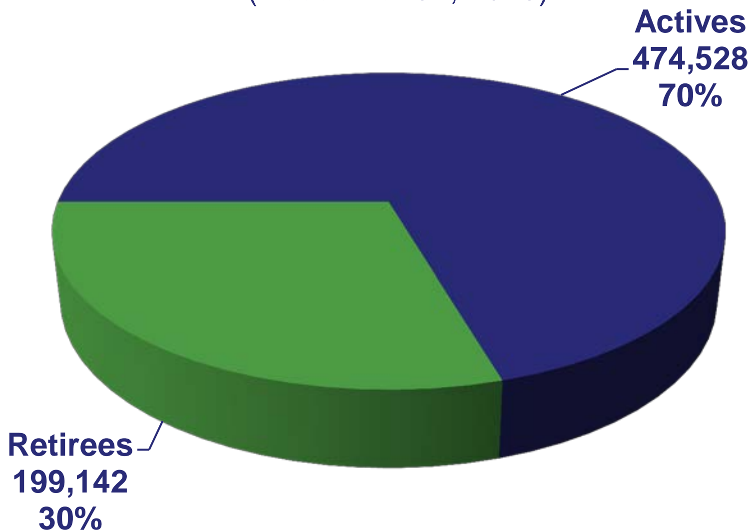
Presentation Outline

- Background Information
- Financial Impact of ACA
- Other Changes Due to ACA
- Future Considerations
- Conclusions

State Health Plan Membership

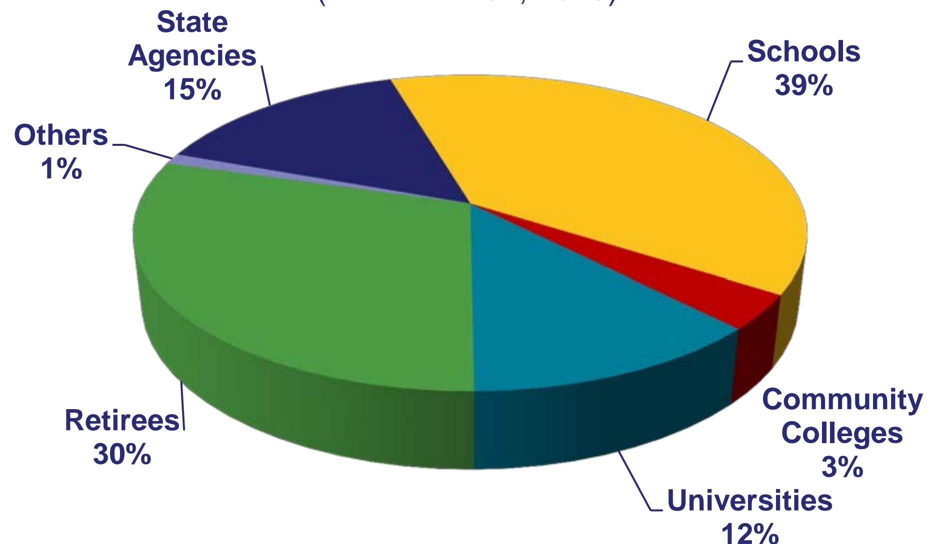
- The State Health Plan covers more than 673,600 active and former employees and their dependents
- The schools are the largest employing entity in the Plan, with 39% of members

Membership by Subscriber Status
(December 31, 2013)



Notes: Dependents are included with respective subscriber group. COBRA and direct bill members are included with Actives.

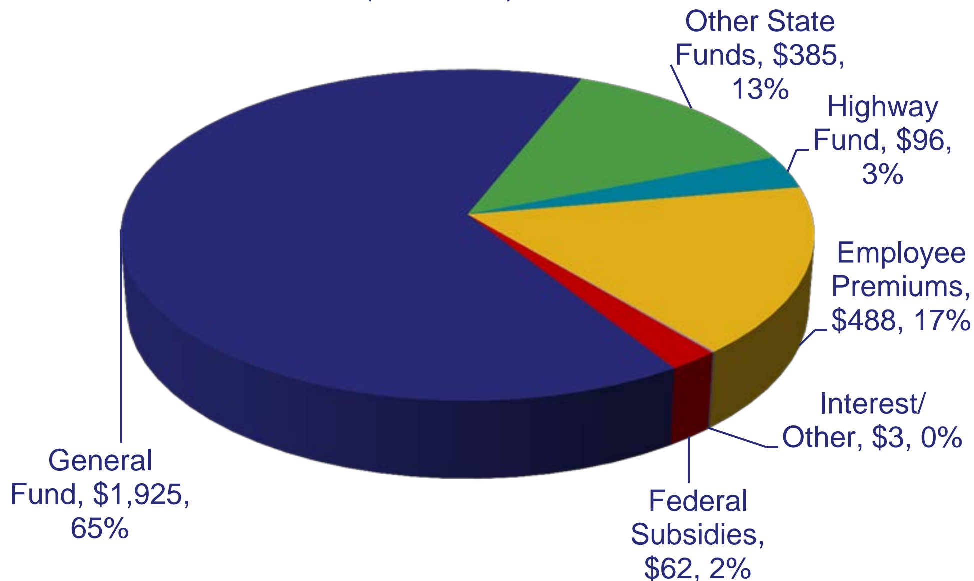
Membership by Entity
(December 31, 2013)

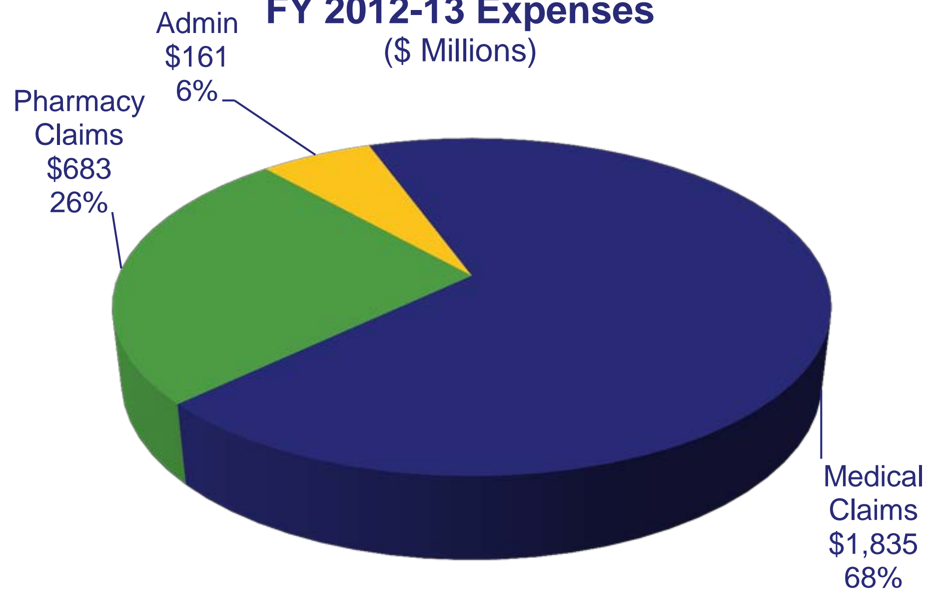


Notes: Dependents are included with respective subscriber entity. Schools include charter schools and traditional public schools.

State Health Plan Finances FY 2012-13

- State Health Plan Revenues come primarily from employer contributions
- Most of the State Health Plan's $2.679 billion expenditures are for claims



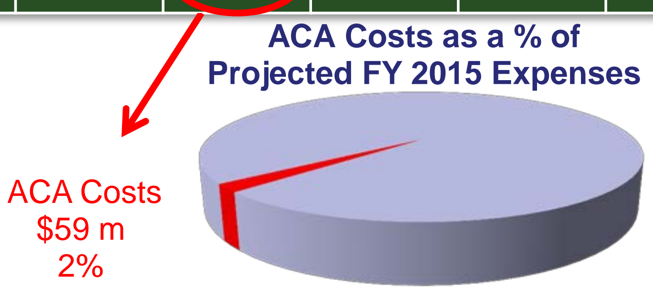


Total State Employer Contributions = $2.4 billion, 81% of total funding.

Financial Impact of Affordable Care Act

($ Millions)	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	7-Year Total
Revenue from ACA								
Early Retiree Reinsurance	$45.3	$42.2	($0.6)	$0.0	$0.0	$0.0	$0.0	$86.9
Increased Expenditures due to ACA (Estimated)								
Cover Dependents to Age 26		($15.6)	($15.6)	($16.9)	($18.3)	($19.9)	($21.6)	($107.9)
Reinsurance Fee					($34.6)	($21.0)	($14.2)	($69.9)
PCORI Fee					($0.6)	($1.2)	($1.3)	($3.1)
Preventive in CDHP				($1.5)	($2.5)	($3.1)	($4.1)	($11.2)
Essential Health Benefits				($1.3)	($2.9)	($3.1)	($3.4)	($10.8)
Net Financial Impact on Plan	**$45.3**	**$26.6**	**($16.1)**	**($19.8)**	**($59.0)**	**($48.4)**	**($44.5)**	**($116.0)**

For FY 2015 ACA costs represent a small percentage of total Plan costs



Early Retiree Reinsurance Program (ERRP)

- Incentive for employers to continue coverage for early retirees
- Early retirees are defined as former employees who are retired, do not have Medicare, and are between the ages of 55 and 65
- Reimbursed employers 80% of incurred claims between $15,000 and $90,000 per benefit year
- $5 billion in total Federal funding available June 1, 2010 through Dec 31, 2013 or when funding runs out
  - Plan received notice in February 2012 that funds are depleted
  - Plan has approximately $22 million in outstanding claims and is on a waiting list should additional funds become available
- State Health Plan received $86.9 million in ERRP funds
  - Federal Centers for Medicare and Medicaid Services (CMS) currently conducting an audit of the Plan eligibility and use of ERRP funds

Coverage for Dependents

- Effective July 1, 2011, the Plan extended eligibility for dependent coverage to age 26, regardless of student or marital status, or whether the dependent resides with the subscriber
  - The initial requirement provided that if the dependent or dependent spouse was eligible for health coverage under a group health policy, they were not eligible for coverage as a dependent under the State Health Plan until 2014 or when the Plan is no longer "grandfathered," whichever is sooner.

Transitional Reinsurance Program Fees

- Supplemental payments to insurers with high risk pools in individual and group markets
- Funding: Plan Sponsors will pay per member per month (PMPM) fee for their active and non-Medicare primary covered lives

Three year program with declining PMPM fee, effective 2014 calendar year (CY)

Due	Targeted Federal Assistance	PMPM *(estimated)*	Projected Cost
FY 2015	$10 billion	$5.25	$34.6 million
FY 2016	$6 billion	$3.15	$21.0 million
FY 2017	$4 billion	$2.10	$14.2 million

Patient-Centered Outcome Research Institute (PCORI) Fees

- Formerly the Comparative Effectiveness Research Fee
- Used to fund a portion of the Patient-Centered Outcome Research Institute Trust Fund
  - The research evaluates and compares health outcomes and the clinical effectiveness, risks, and benefits of medical treatments and/or services
- Increasing per member per year fee through program expiration in 2019
  - Year 1: $1 per covered life
  - Year 2: $2 per covered life
  - Year 3 + : Annual amount indexed to national health expenditures
- The Plan pays the fee for members enrolled in the 80/20, 70/30, and CDHP plans, while the Medicare Advantage carriers are responsible for the fee associated with members enrolled in one of the MAPDP offerings

Grandfathering Requirements under ACA

From a group coverage perspective, "grandfathered plans" are plans that were in existence when Health Care Reform was passed in March 2010. "Grandfathered status" exempts plans from certain ACA requirements .

- Requirements not applicable to grandfathered plans include:
  - 100% coverage of preventive medical services and prescription drugs
  - New appeals and claims requirements
  - Coverage for routine costs associated with approved clinical trials
- To maintain grandfather status, must limit benefit changes:
  - Any increase in coinsurance
  - An increase in the deductible or out-of-pocket maximum greater than 15% + medical inflation
  - An increase in a copayment equal to $5 (adjusted for medical inflation) or medical inflation + 15%, whichever is greater
  - Decrease in employer contribution by more than 5% below the contribution rate (as of 3/23/2010)

80/20 and 70/30 PPO Plans are Grandfathered

Consumer Directed Health Plan (CDHP)

- New 2014 benefit option for active employees and early retirees
- As a new option, the CDHP is not a grandfathered plan
- Provides 100% or first dollar coverage for preventive medical services and prescription drugs as required by the ACA

Note: Effective January 2014, the 80/20 PPO plan includes 100% coverage for preventive care, but the change was approved by the Board of Trustees as a benefit enhancement and is not related to the ACA.

Essential Health Benefits

- Essential Health Benefits (EHB)– The ACA requires that health plans offered in the individual and small group markets offer a comprehensive package of items and services.

- 10 categories of services comprising EHB:
  1) ambulatory patient services;
  2) emergency services;
  3) hospitalization;
  4) maternity and newborn care;
  5) mental health and substance use disorder services, including behavioral health treatment;
  6) prescription drugs;
  7) rehabilitative and habilitative services and devices;
  8) laboratory services;
  9) preventive and wellness services and chronic disease management; and
  10) pediatric services, including oral and vision care.

Essential Health Benefits

- For 2014 and 2015, USDHHS has defined EHB by reference to a "benchmark plan" that each state will select.
- The benchmark plan for North Carolina is the BCBSNC Blue Options PPO Plan. However, as a self-funded benefit plan, SHP may choose any benchmark plan to follow.
- Large employer plans, including the State Health Plan, are not required to cover EHB; however, for any EHB covered by their plan, the large employer cannot impose annual or lifetime dollar limits. Actuarially equivalent treatment or service limits may be applied.
- Board of Trustees eliminated annual dollar and lifetime limits on several EHBs, effective January 1, 2014:
  - Cranial Bands
  - Hearing Aids
  - Infertility and Sexual Dysfunction

Other Changes Due to ACA

- Waiting periods for pre-existing conditions
  - Effective July 1, 2011, eliminated the pre-existing condition exclusion for members under age 19
  - Effective January 1, 2014 eliminated the pre-existing condition exclusion for all members

- Retroactive dis-enrollments
  - Members cannot be retroactively dis-enrolled from the Plan except in cases of intentional misrepresentation or fraud

Future Considerations and Potential Impacts

Newly Eligible Employees:

- ACA requires large employers to offer coverage to employees who work *30 hours* or more, or pay a penalty
  - Costs will increase for employing units (State agencies, universities, school systems, colleges, etc.) that use non-permanent employees working 30+ hours/week
  - This may increase Plan membership but will not directly impact net Plan finances, as a monthly premium will be received for each newly eligible enrolled
  - Federal government is not applying the penalty in 2014 and recently adjusted the penalty provisions for 2015 to reduce the impact on employers
- The State Health Plan is working with the Office of State Human Resources, the University and Community College systems and the Department of Public Instruction to develop a potential benefit option for the newly eligible employees

Future Considerations and Potential Impacts

- Individual Mandate
  - Will previously uninsured dependents join the Plan?
- Health Insurance Exchanges/Marketplaces
  - State Health Plan dependents are not eligible for exchange subsidies
    - Will exchange prices for individual coverage drive more dependents into the Plan?

      OR
    - Will the accessibility of other health insurance options result in fewer dependents on the Plan?
- Reduced Funding for Medicare Advantage Plans
  - Future federal subsidies for Medicare Advantage providers may be constrained by ACA
  - This may result in a more rapid increase in premium costs for the Plan's Medicare Advantage products

Future Considerations and Potential Impacts

- Loss of Grandfather Status
  - Adding 100% preventive care to the Traditional 70/30 Plan would cost an estimated $20-25 million annually
  - Enhanced 80/20 Plan would be prohibited from eliminating 100% preventive care; current budget assumes $24-30 million annually for 80/20 members
  - Cost associated with coverage for clinical trials is unknown

- 40% Excise Tax on “High Cost” Plans begins in 2018
  - Plan is currently under the projected 2018 “high cost” threshold of $10,200 annually for individual coverage or $27,500 annually for family coverage
  - The threshold will increase with the Consumer Price Index-All Urban Consumers (CPI-U), but medical inflation usually exceeds growth in CPI-U

Summary and Conclusions

- ACA has required the Plan to make changes and to monitor federal regulations more closely; *however*
  - Changes have been manageable to date, and
  - Have not prevented the Plan from implementing the Board's vision

- ACA has and will increase Plan costs; *however*
  - The increase does not account for a significant proportion of Plan costs

- As a large self-insured plan that already provided comprehensive benefits to members, the impact of ACA on the Plan has been relatively minor; *however*
  - The law will continue to affect the healthcare landscape well into the future, and many of the long-term effects are unknown

- ACA is likely to continue to have an impact on the Plan and the State:
  - *The cost of compliance for state and local employing units whose work forces include large numbers of newly eligible employees may be significant*
  - Future effects are difficult to predict

Appendix

- Statutory Authority, Governance & Oversight
- Board of Trustees
- Legislative Directives
- 2014 Plan Options

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

www.shpnc.org

www.nctreasurer.com

Statutory Authority, Governance & Oversight

- Statutory authority set out in Article 3B of Chapter 135, N.C.G.S.
- Effective January 1, 2012, the Plan became a division of the Department of the State Treasurer
  - Historically the Plan reported directly to the General Assembly via a legislative oversight committee
- Executive Administrator is appointed by the Treasurer to oversee the day to day operations of the Plan
- State Treasurer has broad authority to administer the Plan and may delegate powers and duties to the Executive Administrator, Board of Trustees or Plan staff, but ultimately maintains responsibility for the performance of those powers and duties and the Plan

State Health Plan Board of Trustees

Fiduciary board with statutory duty to:

1. Approve benefit programs, as provided in G.S. 135-48.30(2)
2. Approve premium rates, co-pays, deductibles and coinsurance maximums, as provided in G.S. 135-48.30(2)
3. Oversee administrative reviews and appeals, as provided in G.S. 135-48.24
4. Approve contracts in excess of $500,000, as provided in G.S. 135-48.33(a)
5. Consult with and advise the State Treasurer
6. Develop and maintain a strategic plan

10 Members, 2 Ex Officio and 8 Appointed

- State Treasurer (votes only in the event of a tie)
- Director of the Office of State Budget and Management (non-voting)
- Governor, State Treasurer, House of Representatives and Senate each appoint 2 members
  - Active employee and teacher, retired employee and teacher
  - Experts in actuarial science, health economics, benefits and administration, and policy and law

Legislative Directives & Guidance

SB 323 [State Health Plan Changes SL 2011-96] and HB 578 [State Health Plan Changes SL 2011-96] set out certain requirements and authority for the Plan:

- ❑ Examine the issue, costs and mechanics of moving to a **calendar year**
- ❑ **Find savings** through wellness programs, Medicare Advantage plans, alternative plan designs, or other resources
- ❑ Any savings and available cash reserves may be used to **offer a premium-free plan** option to employees for FYs 2012 & 2013. Premium free option required no later than July 1, 2013
- ❑ Strive to **keep all premiums low** by finding savings through wellness programs, Medicare Advantage plans, alternative plan designs, or other resources

- ✓ Conversion will begin July 1, 2013; operate on **Calendar Year basis in 2014**
- ✓ Board approved benefit design includes wellness programs & incentives, Medicare Advantage options, and a new Consumer Directed Health Plan **expected to save in excess of $400 million over the next four years**
- ✓ **Basic 70/30 PPO option** offered to active employees on premium free basis since June 1, 2011 and will continue to be available through calendar year 2015
- ✓ Board approved benefit design will **lower the average annual premium increases** for employees & retirees and the State over the next four years

Health Plan Options for 2014

Active Employees/Non-Medicare Retirees

Enhanced 80/20 Plan

- $0 ACA Preventive Services
- $0 ACA Preventive Medications
- Offer reduction in employee-only premium for the completion of specific wellness activities:
  - ✓ Attest to being a non-smoker or to participating in a smoking cessation program
  - ✓ Select a primary care provider (PCP)
  - ✓ Complete a health assessment
- Opportunities to reduce medical copayments

NEW: Consumer-Directed Health Plan (CDHP) with HRA

- A high-deductible medical plan
- A Health Reimbursement Account (HRA) to help offset the deductible
- $0 ACA Preventive Services
- $0 ACA Preventive Medications
- CDHP Preventive Medication List ($0 deductible)
- Offer reduction in employee-only premium for the completion of specific wellness activities:
  - ✓ Attest to being a non-smoker or to participating in a smoking cessation program
  - ✓ Select a primary care provider (PCP)
  - ✓ Complete a health assessment
- Opportunities to increase HRA

Traditional 70/30 Plan

- Basic 70/30 Plan with a new name
- No $0 ACA Preventive Services
- No $0 ACA Preventive Medications
- No wellness incentives available

Health Plan Options for 2014

Medicare Primary Retirees

Medicare Advantage Base	Medicare Advantage Enhanced	Traditional 70/30 Plan
• Offered by Two Carriers: 1. Humana 2. UnitedHealthcare • Benefits are the same for each carrier • Fully insured medical plan with integrated pharmacy • Enhanced Benefits: • No deductibles • Wellness programs & disease and case management services • SilverSneakers®	• Offered by Two Carriers: 1. Humana 2. UnitedHealthcare • Benefits vary by carrier • Fully insured medical plan with integrated pharmacy • Enhanced Benefits: • No deductibles • Wellness programs & disease and case management services • SilverSneakers®	• Basic 70/30 Plan with a new name

State Health Plan Board Meeting: Provider Payment Methodologies

March 28, 2014

Lisa Cade – Vice President, Network Management

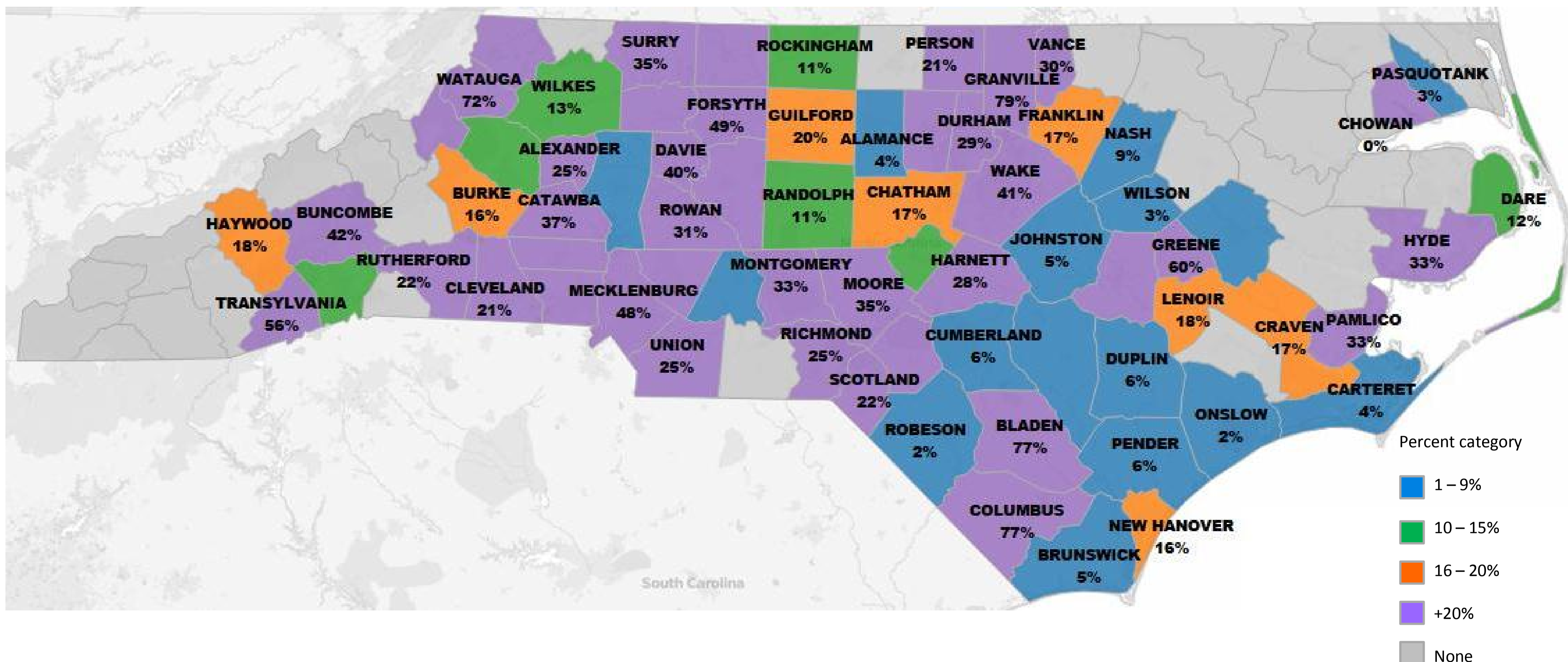
Susan Weaver, MD – Vice President, Healthcare Delivery Redesign

Overview

- BCBSNC has actively been embracing the shift from Fee for Service (FFS) to a reimbursement approach focused on value, outcomes and provider accountability.
- Many of the payment models that were inquired upon in the SHP survey have been actively pursued by BCBSNC with pilot programs and subsequent institutionalization across its provider base
- BCBSNC views the SHP goals around more involvement around new payment methodologies, provider partnership programs and other initiatives as an opportunity to better collaborate with the SHP and improve the health of its member base

Primary Care Medical Homes (PCMH)

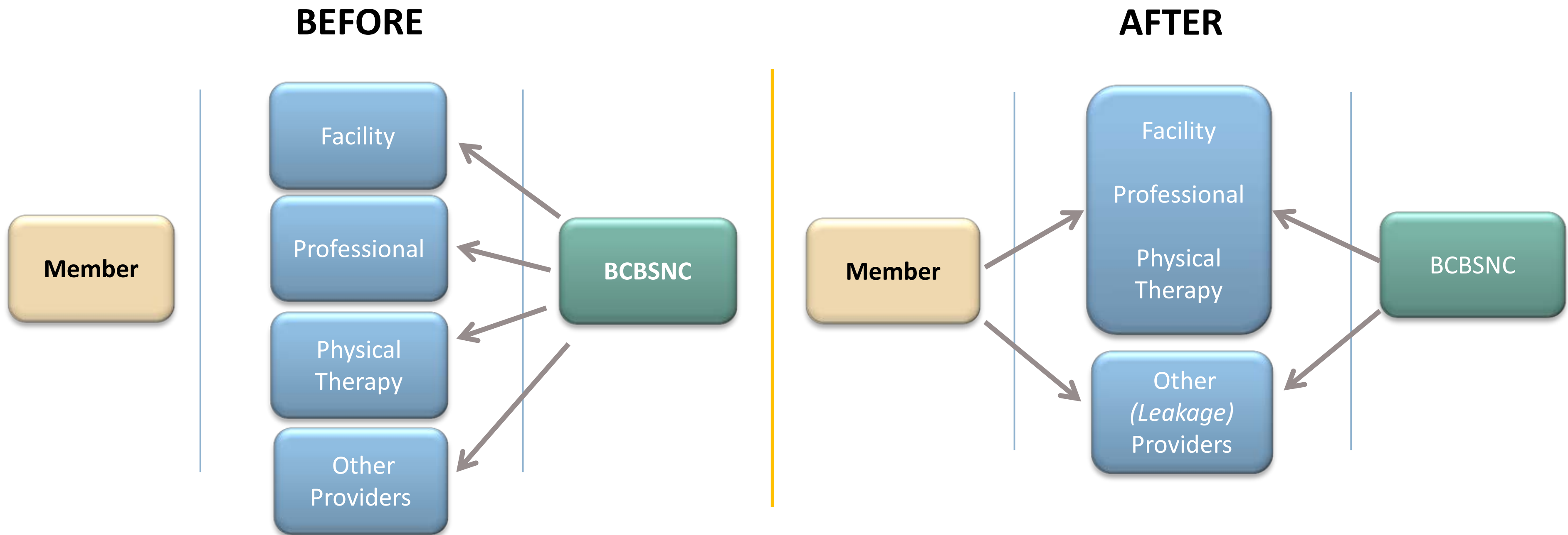
% of PCMH groups of overall Primary Care groups, per county (Source: NCQA)



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

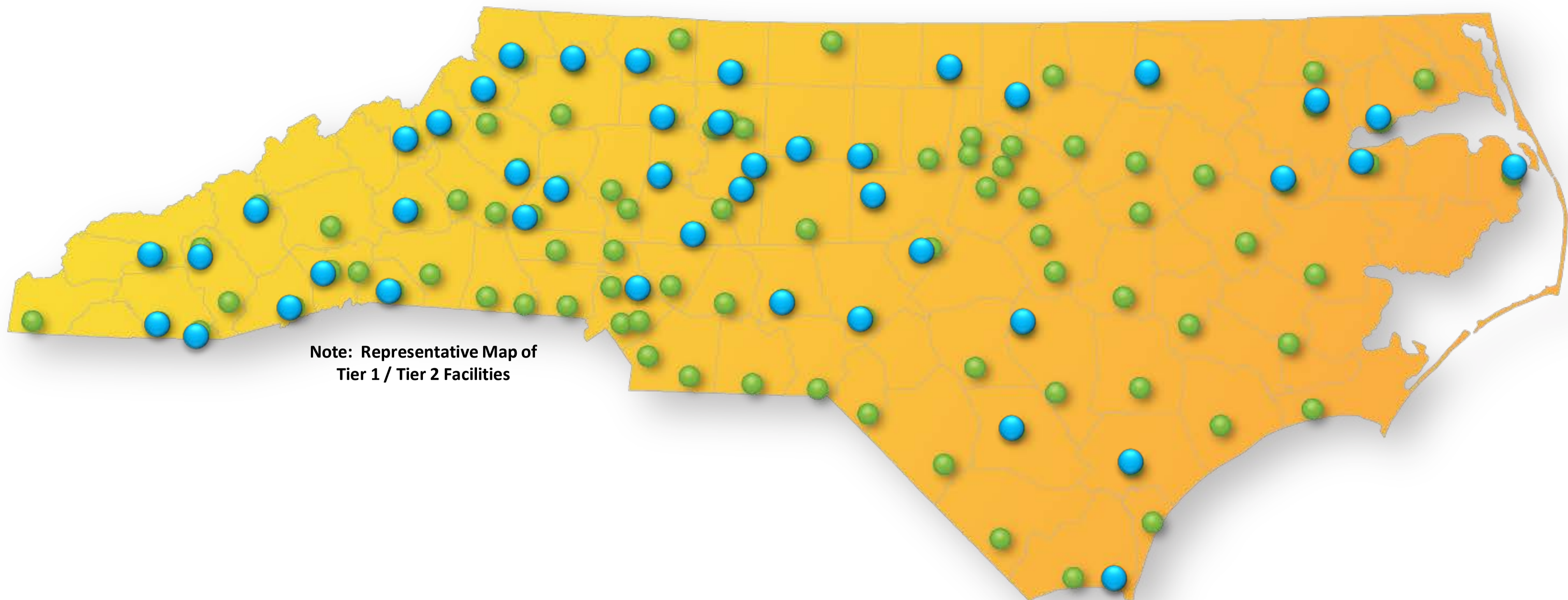
Bundled Payments

BCBSNC has been a leader in the development and implementation of bundled payments



- BCBSNC has been an early adopter in the rollout of bundled payment options for our member base
- By combining disparate services into a fixed rate, members benefit from more predictable and lower service prices
- SHP membership has been able to benefit from some of the current bundled arrangements in place today

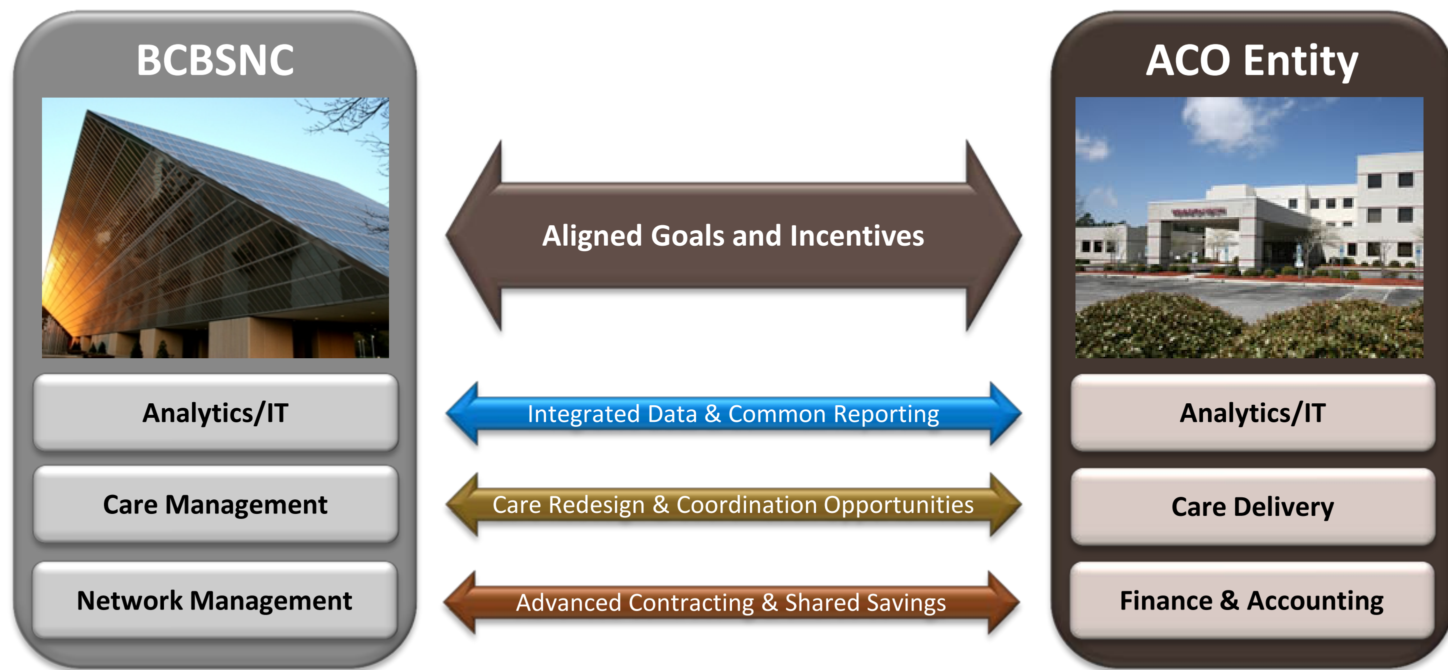
Facility and Specialist Tiering



- Over the last three years, BCSBNC has enabled consumer-driven demand for information related to provider performance by measuring facilities and select specialties on quality and efficiency-based metrics
- Last year the SHP was able to take advantage of some of these metrics and incorporate them into some initial benefit-driven steerage opportunities
- BCBSNC is currently in the process of exploring more specialties to add to the current set of tiered specialties (Orthopedics, Cardiology, GI, General Surgery, OB/GYN, Neurology)

ACO Overview

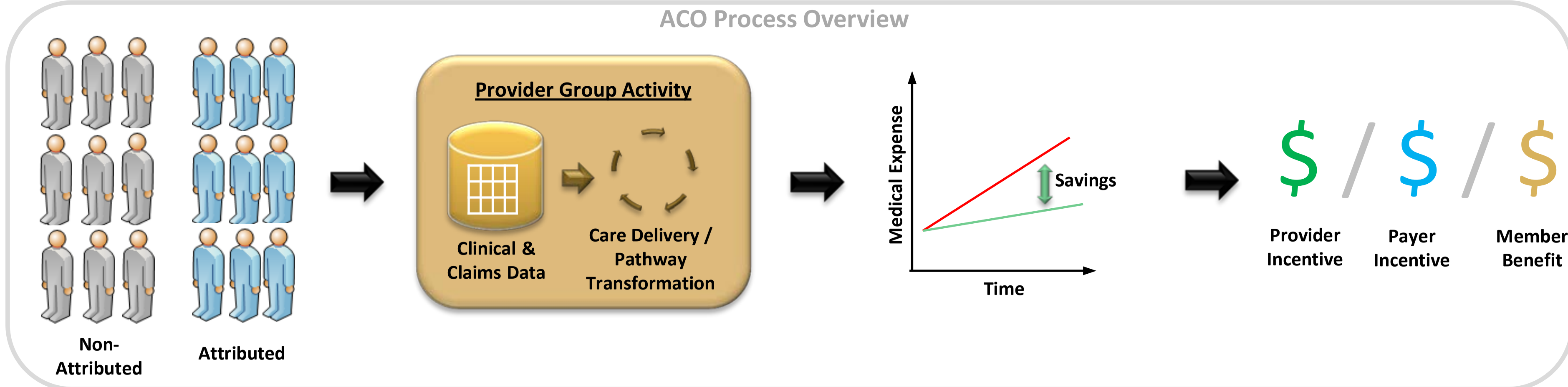
ACOs allow BCBSNC and providers to integrate to achieve high quality, more affordable care



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

ACO Overview – Payment Model

Brief contextual detail on what ACOs are intended to accomplish



Step 1: Define a patient population for a provider group

Step 2: Implement care transformation & improvements

Step 3: Create medical expense savings, improve quality & patient experience

Step 4: Distribute savings between provider group, payer and members

- At the highest level, ACOs provide an opportunity to represent the latest innovation in reimbursement and/or incentive arrangement between payers and providers to achieve the "Triple Aim": Lower Expense, Improved Quality and Patient Experience
- Beyond payment, ACOs are ways for payers and providers to integrate operations between their two organizations for improved outcomes

Statewide Focus – Active Initiatives

BCBSNC's reach allows for a statewide approach to the implementation of payment innovations and partnerships

- Currently BCBSNC has several key provider partnerships active in areas with high levels of SHP membership
- However, BCBSNC is able to reach not just the urban markets, but also has the ability to implement new payment innovations and partnerships across the state, as the next slide highlights

BCBSNC initiatives that are **making health care better** all across North Carolina

BCBSNC initiatives and collaborations, statewide = **301 in 76 counties***

Network providers in all **100** counties

Key

Accountable Care Organizations
4 provider groups
BCBSNC has teamed up with leading health care providers to focus on common goals, shared data, cost-effective care, and better-quality outcomes for our members.

BCBSNC On-site Support Teams
13 health care facilities
BCBSNC currently has more than 40 on-site service and claims professionals working to resolve issues quickly and maintain a member-focused relationship with hospitals.

Blue Distinction® Centers
25 hospitals
This initiative gives patients and their doctors an objective look at medical facilities within six specialty areas. Designation is a rigorous process based on input from expert physicians and medical organizations. There are two designations: Blue Distinction® Centers and Blue Distinction® Centers+℠.

Blue Quality Physicians Program
106 practices
This program recognizes and rewards physicians who demonstrate a strong commitment to patient-centered care, clinical quality, administrative efficiency, and cost efficiency.

Bundled Payment Initiatives
4 programs
This model is proven to reduce potentially avoidable complications, improve patient outcomes and reduce cost.

Carolina Advanced Health
This innovative collaboration with UNC Health Care is a prototype for a new model in primary care, enhancing efficiency and quality of care by coordinating a patient's doctors, nutritionist, pharmacist and other clinical team members in a single location.

FastMed℠ Urgent Care Centers
38 locations – and growing
On average, a visit to an urgent care clinic costs 90 percent less than going to the ER* – a major reason BCBSNC made an investment in FastMed℠ Urgent Care Centers.

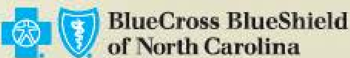
Program to Advance Technology for Health
80 practices
Also known as NC PATH, this collaboration is bringing electronic health records to practices and free clinics statewide. BCBSNC and NC PATH subsidize 85% of the cost over a 5-year term.

Retail Stores
6 locations
As they continue to open across the state, BCBSNC's retail stores provide another resource for navigating health care reform and give customers a place to seek face-to-face help with questions about plans or benefits.

Value-Based Incentive Facilities
24 providers
These providers have incentives that reward them for performance-based quality.

* Source: BCBSNC internal data, 2013

An independent licensee of the Blue Cross and Blue Shield Association. U9139c, 10/13



Closing Remarks

- Payment innovations and provider partnerships are some of the key opportunities available to the BCBSNC/SHP partnership to control costs, improve member health and achieve better outcomes.

- BCBSNC currently has many of the leading innovations in reimbursement already in place or under development, and these savings levers can be implemented to meet strategic goals of the SHP from both a statewide and regional perspective.

- BCBSNC's Network Management and Healthcare Delivery Redesign teams look forward to continued collaborative opportunities with the SHP to find new ways to leverage these innovations/partnerships to meet our common objectives.

Humana Physician Quality Rewards Program 2014

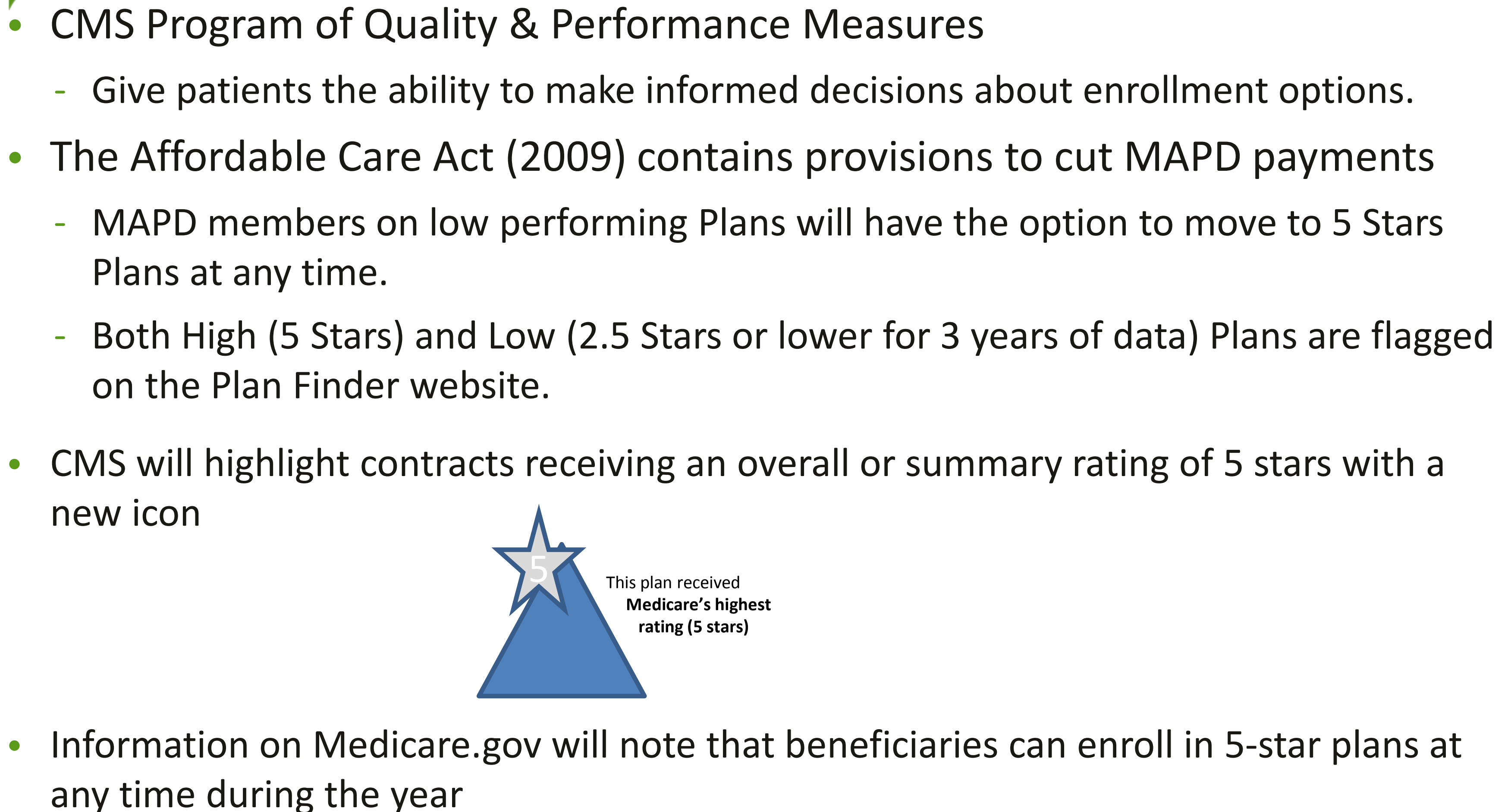
Medicare

Glen Champlin
MSO Director

March 28, 2014

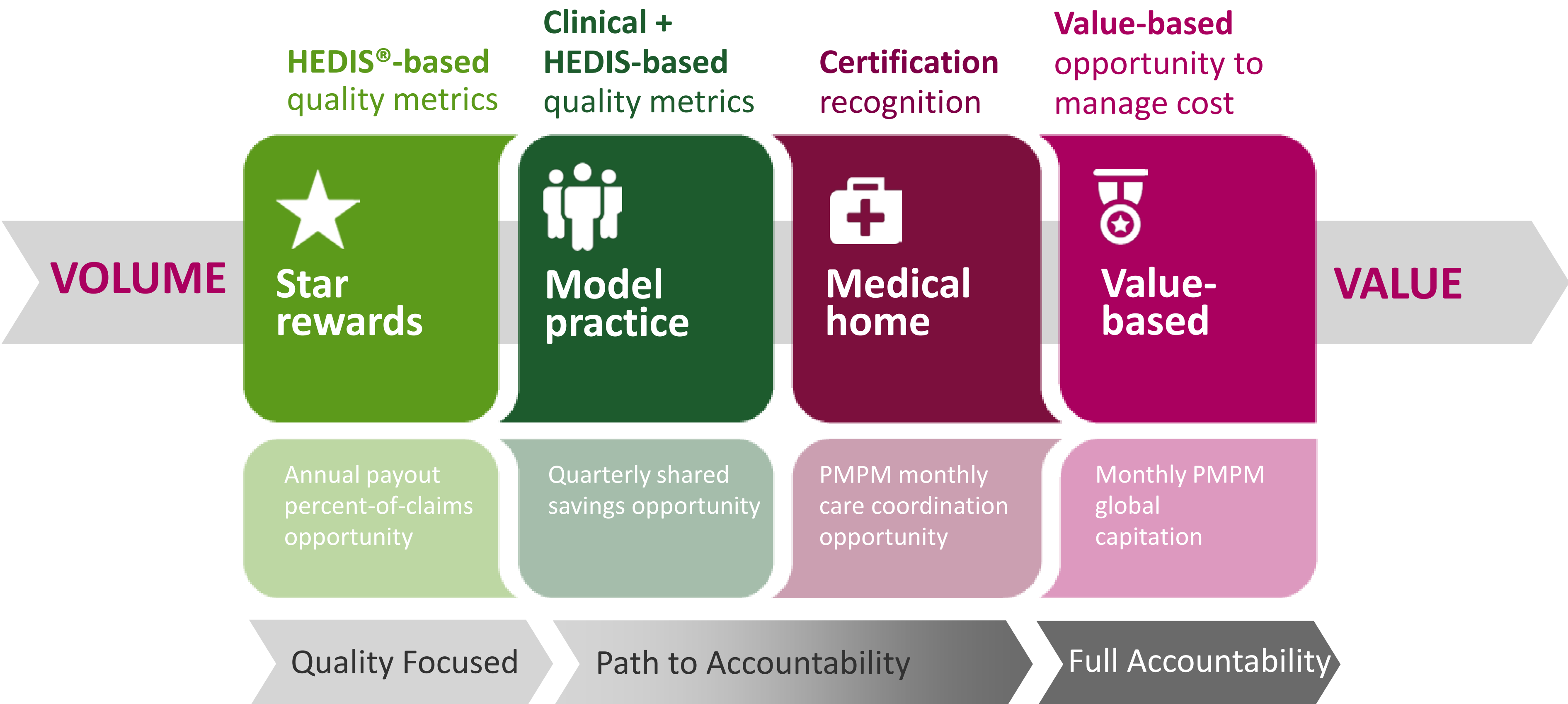
Humana

1430ALL0114-B


What is CMS Stars and Why Should Providers Be Concerned?
CMS Program of Quality & Performance Measures
Give patients the ability to make informed decisions about enrollment options.
The Affordable Care Act (2009) contains provisions to cut MAPD payments
MAPD members on low performing Plans will have the option to move to 5 Stars Plans at any time.
Both High (5 Stars) and Low (2.5 Stars or lower for 3 years of data) Plans are flagged on the Plan Finder website.
CMS will highlight contracts receiving an overall or summary rating of 5 stars with a new icon
5
This plan received
Medicare's highest
rating (5 stars)
Information on Medicare.gov will note that beneficiaries can enroll in 5-star plans at any time during the year
Humana
2

Humana's Accountable Care Continuum

Provider Quality Rewards



Humana's Accountable Care Continuum

From Pay for Production **to** Pay for Value

HEDIS-based
quality metrics

VOLUME

Star rewards

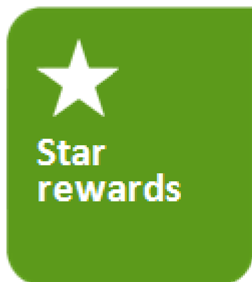
Annual payout percent-of-claims opportunity

Providers are rewarded annually for meeting 2/3 of NCQA HEDIS metrics

VALUE

Quality Focused → Path to Accountability → Full Accountability

Star Rewards Program



Quality-only Reward

National Committee for Quality Assurance (NCQA)
Healthcare Effectiveness Data and Information Set (HEDIS) Measures

Star Rewards Program

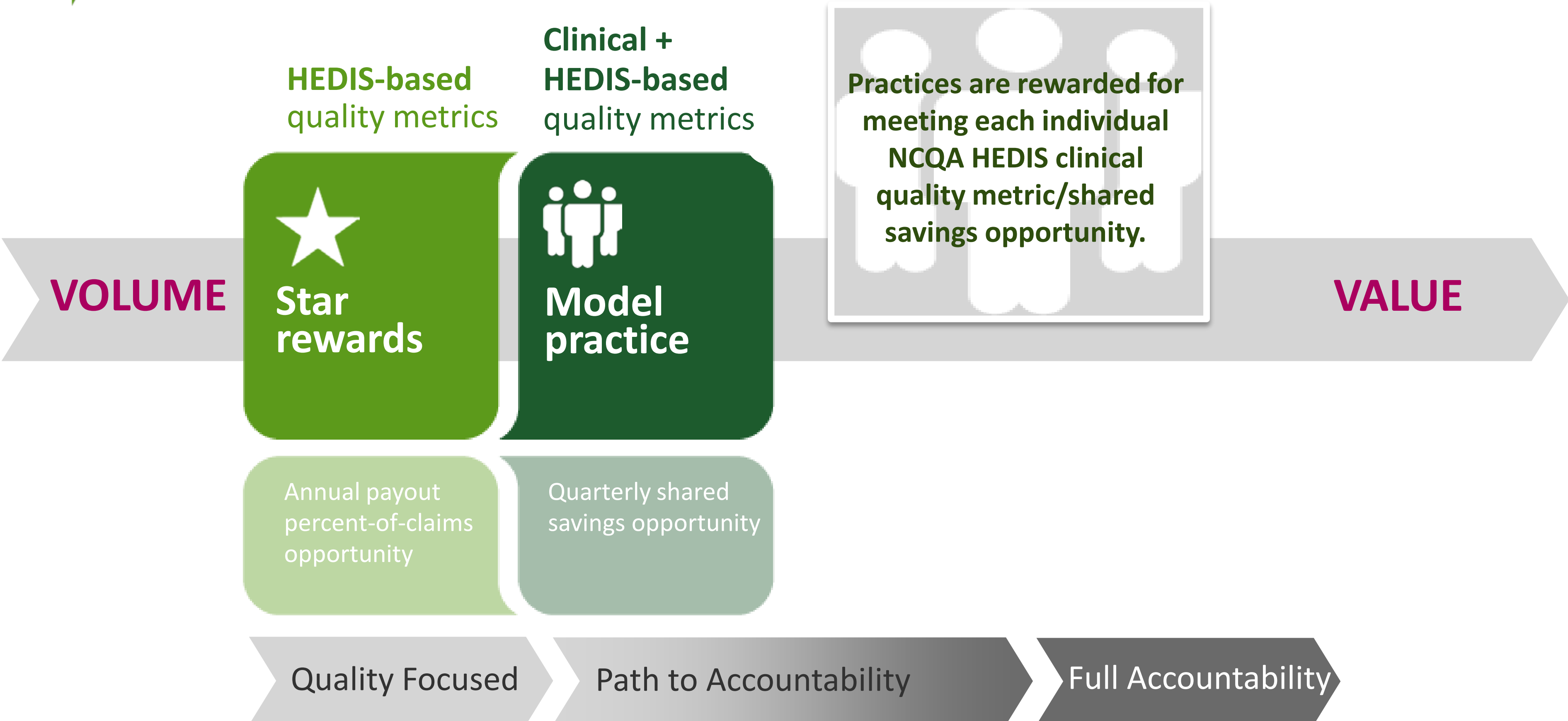
Quality-only Reward

- Humana-covered patients attributed/assigned to a physician's practice for MA PPO, MA HMO-FFS and MA PFFS
- Practice goal to meet is two-thirds of the six NCQA HEDIS measures at the CMS 5-star Level
- Rewards payments are paid on an annual basis
- Practices can participate in one program at a time
- Measures may be adjusted based on CMS priorities

*Limited to Humana participating providers

Humana's Accountable Care Continuum

From Pay for Production **to** Pay for Value



Model Practice Program

Path-to-Accountability Rewards

NCQA HEDIS Measures and Clinical /Strategic Initiatives

Reward payments for each individual measure met at CMS 5-star level

HEDIS Measures
- Generally the most relevant measures
- Example: Diabetic Management

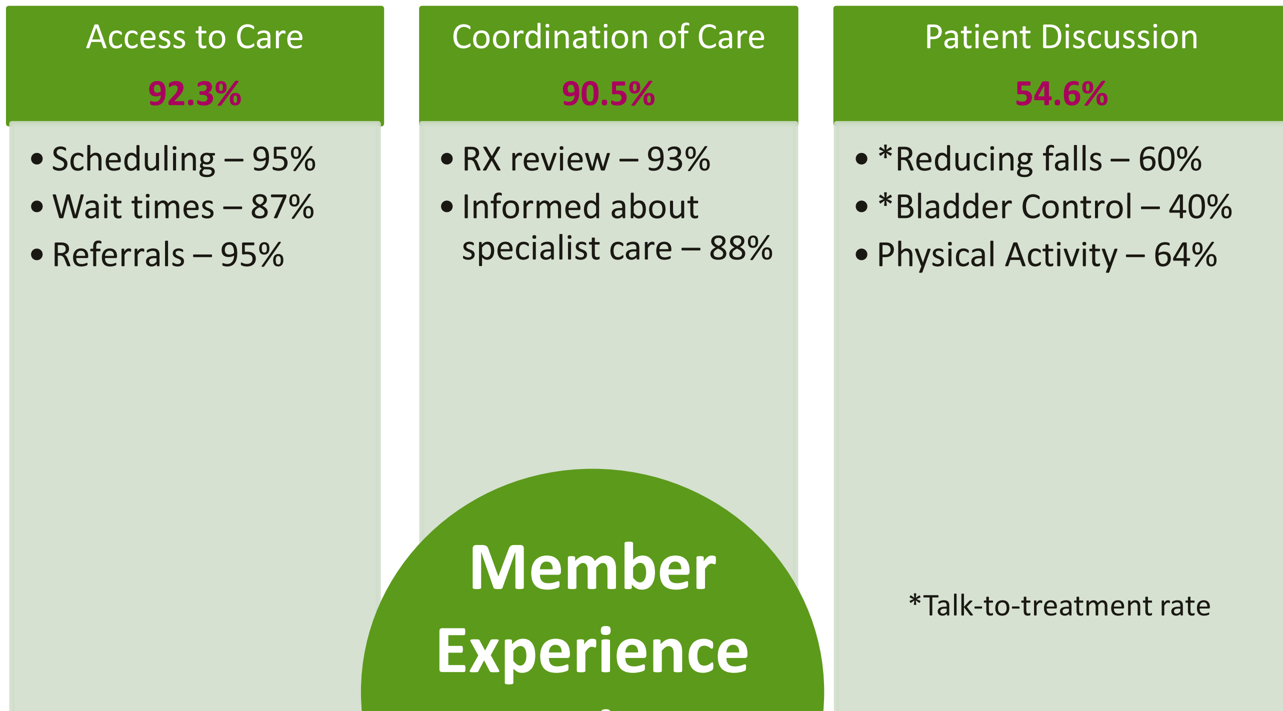
Clinical and Strategic Initiatives
- Example: 30 day Readmission

Humana "CAHPS/HOS" VAT Survey – Annual Kicker

New in 2014: Modeled after CMS surveys

The measure will be based on the categories shown here with an aggregated annual target of 80%.

Member surveys are made by outbound VAT calls similar to the CMS CAHPS/HOS survey patient experience program.



Humana

*Health Outcomes Survey (HOS) is done each spring as a random sample of Medicare beneficiaries drawn from each participating MA Organization.
*Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a series of patient surveys rating health care experiences in the U.S.

Model Practice Program

Path-to-Accountability Rewards*

- Includes HEDIS measures like the Star Rewards Program, but also includes additional clinical measures recommended by Humana's Quality Organization.
- Unlike Star Rewards, rewards for Model Practice are paid for meeting each individual measure achieved .
- For Humana-covered patients attributed/assigned to a physician's practice for MA PPO, MA HMO-FFS and MA PFFS.
- Reward payments are paid quarterly.
- Practices can participate in one program at a time.

*Limited to Humana participating providers

Humana's Accountable Care Continuum

From Pay for Production **to** Pay for Value

Providers must meet HEDIS and clinical quality metrics/payments based on care coordination opportunities depending on level of certification.

VOLUME → VALUE

HEDIS-based quality metrics	**Clinical + HEDIS-based** quality metrics	**Certification** recognition
Star rewards	**Model practice**	**Medical home**
Annual payout percent-of-claims opportunity	Quarterly shared savings opportunity	Shared savings/ PMPM monthly care coordination opportunity

Quality Focused → Path to Accountability → Full Accountability

Medical Home

Path-to-Accountability Rewards

- Targets higher functioning practices:
  - Infrastructure well defined with evidence of team functioning and access to care
  - Health information technology, such as electronic health record (EHR) and electronic prescribing (eRx) systems
- Medical Home measures are the same as the Model Practice measures with additional measures focusing on the full spectrum of patient care.
- Monthly care coordination payment covers physician cost of Medical Home certification, additional resources required for utilization measures and overall practice enhancements.
- To be eligible for the care coordination payment, practices must meet measure target goals on the same quarterly basis as they would for the Model Practice program.

Third-Party Industry Organizations

- Humana's Physician Quality Rewards Program includes industry-standard measures and has been introduced to these health care industry organizations:
  - Medical Group Management Association (MGMA)
  - American College of Physicians (ACP)
  - American Medical Association (AMA)
  - American Academy of Family Physicians (AAFP)
- In 2013, Humana paid $60 million in reward payments to provider practices across the country as part of our Provider Quality Reward Program.

Questions?

Humana

ACCOUNTABLE CARE PLATFORM

Delivering distinctive value to those we serve

North Carolina State Health Plan

March 28, 2014

UnitedHealthcare®

Network Strategy | Delivering Distinctive Value

Paying for Value

We are paying for value through outcome-based payment models that reward care providers for improvements in quality and cost-efficiency

Transforming the Delivery System

We are transforming the delivery system to be more accountable for cost, quality and experience outcomes, helping make health care more affordable

WE ARE TRANSFORMING HOW WE PAY FOR HEALTH CARE AND HOW HEALTH CARE IS DELIVERED

Aligning Incentives

We are aligning incentives across employers, consumers and care providers to achieve the Triple Aim of better health, better care and lower costs

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Health System Transformation | Accountable Care Platform

WE ARE TRANSFORMING HOW HEALTH CARE IS PAID FOR, DELIVERED AND REWARDED.

UnitedHealthcare's Accountable Care Platform

We are transitioning physicians from fee-for-service to outcome-based payment models and aligning those payment models with our product and network offerings (e.g., tiered benefits plans, wellness programs, networks).

- Today, **more than $29 billion** of UnitedHealthcare's reimbursements to hospitals, physicians and ancillary care are tied to accountable care programs, centers of excellence and performance-based programs.
- Today, we have **9 million members** in value-based contacts – **2 million** of which are in **accountable care/coordinated care models**.
- By 2018, our accountable care contracts are expected to **total $65 billion**, half of our annual network spend.

MORE THAN 740 HOSPITALS, 1,150 MEDICAL GROUPS AND 80,000 PHYSICIANS ARE PARTICIPATING IN OUR ACCOUNTABLE CARE PLATFORM.

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

Accountable Care Platform | Definition & Goals

UnitedHealthcare's definition and objective

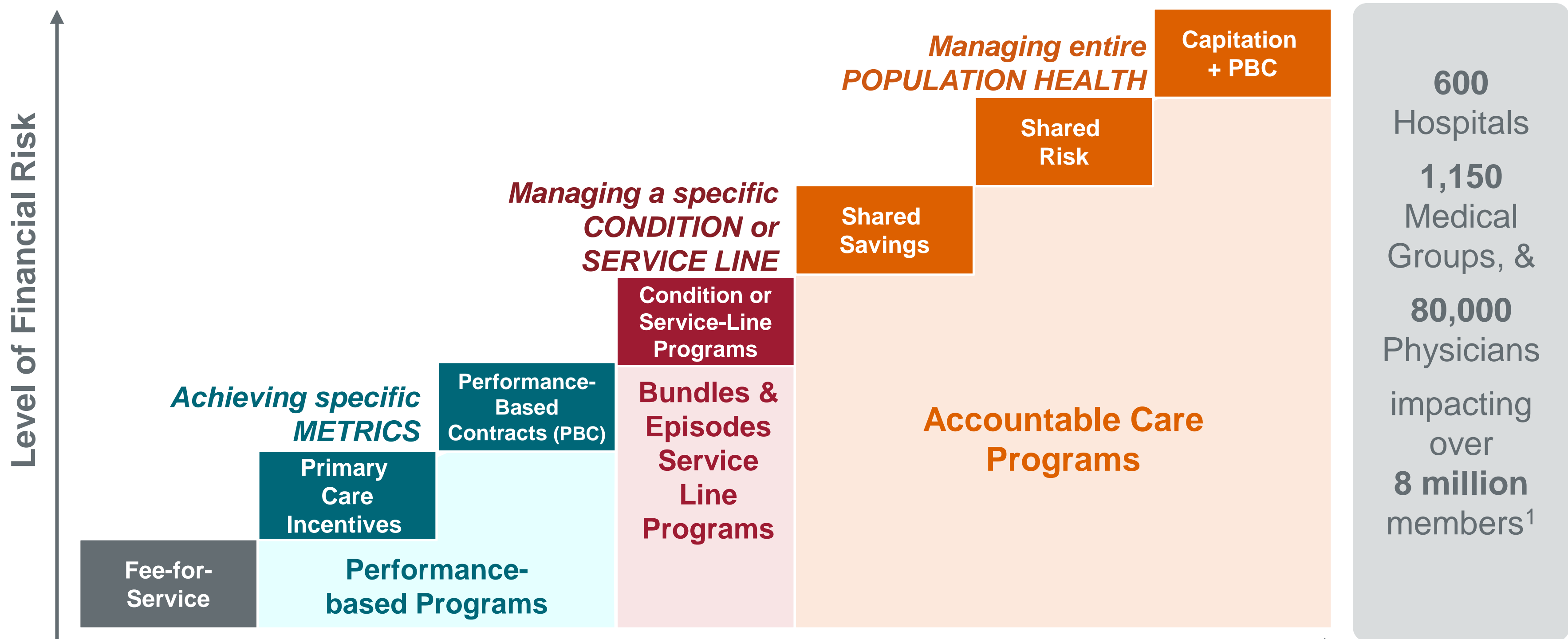
- **Accountable Care Organizations (ACOs) are clinically integrated, coordinated health care organizations that accept responsibility for managing and improving the health of a defined population in addition to reducing the total costs of health care services.**
- **A successful ACO partnership will foster and change the nature of relationships among healthcare providers and the community, resulting in achievement of the Triple Aim:**
  - **Improved Quality Outcomes**
    - Demonstrated through improvement of a robust set of metrics that encompass care across the continuum: physician, hospital, long-term care and home-health care metrics.
  - **Reduced Cost**
    - Consumer: Reflected in lower premiums and out-of-pocket expenses
    - Provider: Realized in the form of increased efficiency and payments that are tied to value
    - Payer: Reduced total cost of care realized through increased provider efficiency
  - **Better care**
    - Improved patient experience of care
    - Improved coordination of health care
    - Reflects that consumers need to be central in the healthcare discussion

MEANINGFUL

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

Accountable Care Platform | Accountability Continuum



600 Hospitals
1,150 Medical Groups, &
80,000 Physicians
impacting over
8 million members[1]

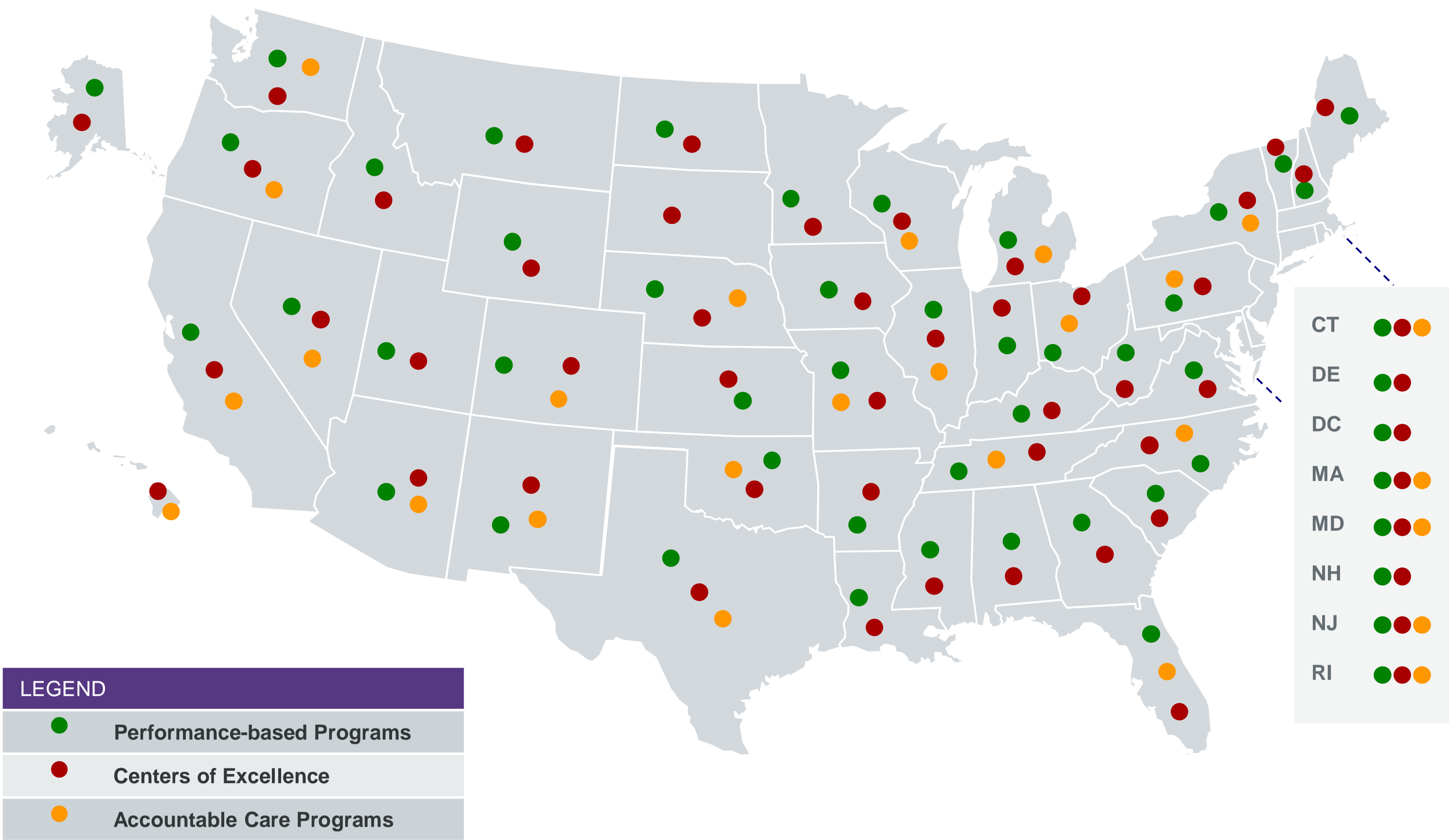
[1] Deployment statistics for executed contracts as of July 2013, net of program overlap; Member data as of November 2013

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Accountable Care Platform | Deployment Map

UnitedHealthcare®

DELIVERING DISTINCTIVE VALUE ACROSS THE COUNTRY



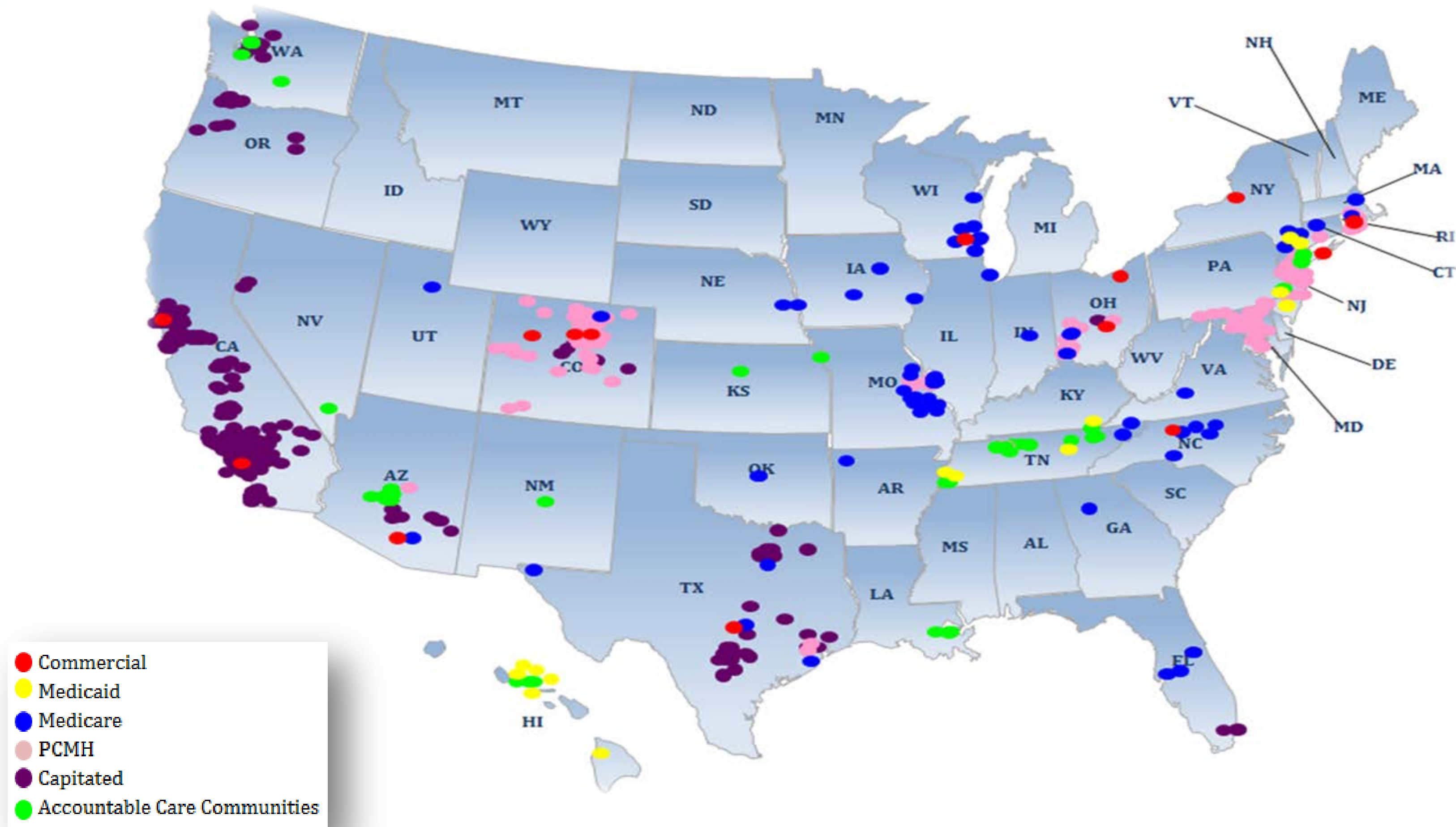
LEGEND
Performance-based Programs
Centers of Excellence
Accountable Care Programs

Location of icon within state is for illustrative purposes only and is not indicative of program's actual geographic locations within the state – many programs are state-wide. Deployment as of December 2013.

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

Accountable Care Programs | All Lines of Business



550 Medical Groups

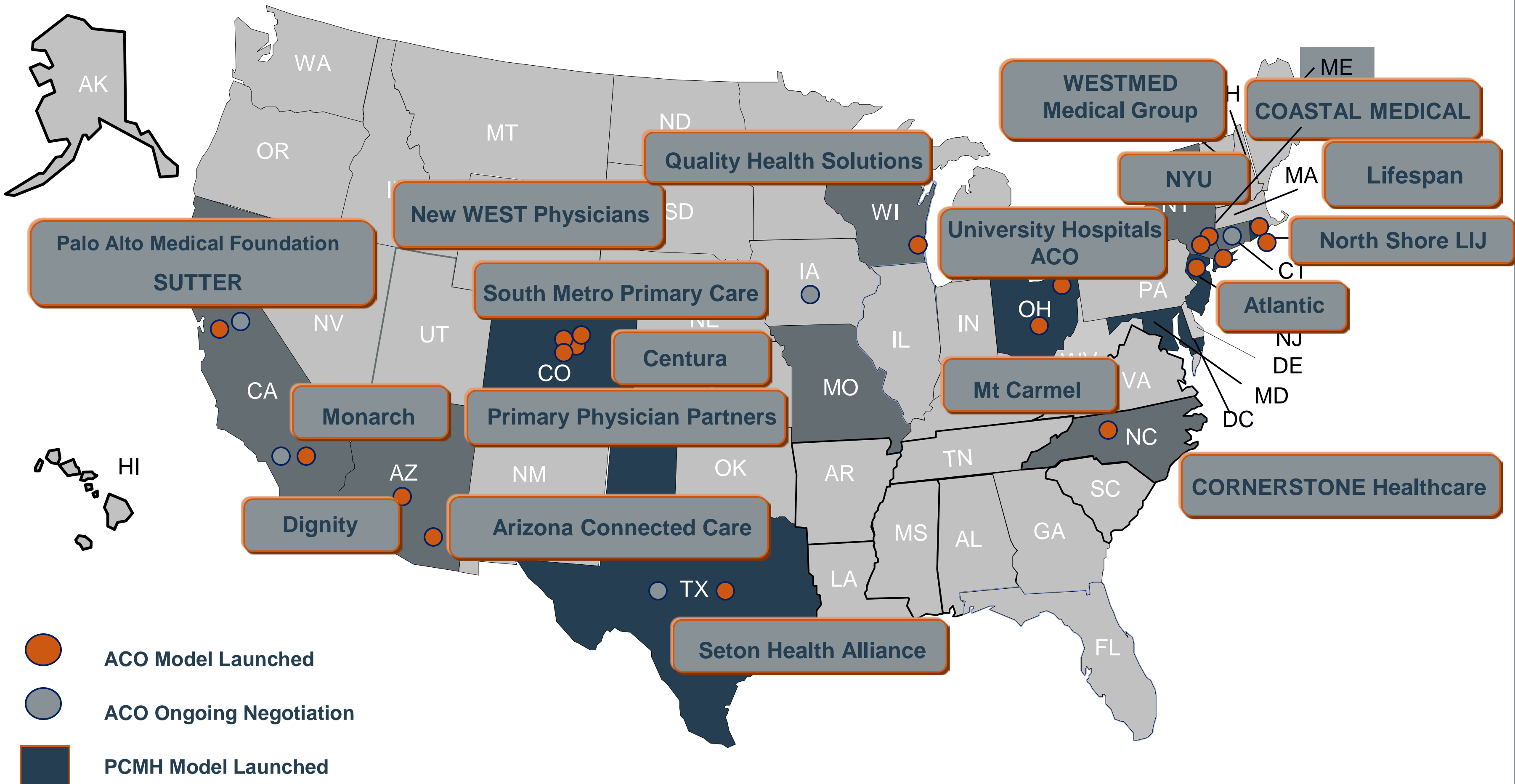
Confidential Property of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

Accountable Care Platform | Commercial Business

As of 2/26/14

ACCOUNTABLE CARE ORGANIZATIONS (ACO) & PATIENT-CENTERED MEDICAL HOMES (PCMH)



Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

Accountable Care Platform | Managing Population Health

ACCOUNTABLE CARE ORGANIZATIONS (ACO)

Improve Population Health and Patient Experience

Reduce Medical Costs/ Trend

Deliver Best Possible Quality Outcomes

Our ACO model incorporates proactive population health management strategies

The objectives of our ACO model are to:

- Improve population health and patient experience
- Deliver the best possible quality outcomes
- Reduce medical cost and medical trend

19 ACO agreements signed supporting commercial business:

- ACO model executed with 19 Accountable Care Organizations
- Participating in Dartmouth-Brookings ACO collaborative in Arizona
- Ongoing negotiations with ACOs in Phoenix, New York and other markets.
- See map for ACO locations.

Medicare and Medicaid Accountable Care programs launched in several states

THIS MATTERS | We are introducing Optum capabilities to our ACO partners to provide them with the analytics and decision support solutions to manage risk and improve quality outcomes.

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

ACO Partnerships | Finding the Right Partner

- We do not have a prescribed formula or a template or a set profile that we look for in developing an ACO relationship
  - One size does not fit all
  - Successful ACO's will have similar characteristics, but the organization structures will vary depending on the geography but more importantly they will vary by the people that we serve

- We identify potential ACO partners through a bottoms-up process
  - We rely on our local Market and Health Plan Leaders to identify ACO Candidates using both subjective and objective criteria:
    - Do we share common visions?
    - How strong and deep is the current relationship?
    - How well do the teams work together day to day and when there are problems?
    - Have we worked on other pilots with this organization previously?
    - What's the degree of clinical integration and does the organization already have tools and programs in place to manage risk and populations?
    - What is the ACO's relative financial strength and position?

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

Accountable Care Platform | Supporting Care Providers

SUPPORTING CARE PROVIDERS IN MANAGING POPULATION RISK

Requirements for Accountable Care Program Partnerships

- Physician leadership with clear governance
- Robust end-to-end clinical programs
- Ability to coordinate care across all care settings
- Effective Health Information Technology
- Disciplined financial accounting and systems
- Mechanisms to appropriately distribute funds
- Ability to manage and willingness to accept risk
- Tools for patient activation and engagement

These are key success factors critical to achieving the Triple Aim

How We Support Accountable Care Program Partners

- Membership
- Contracting evolution based on provider risk readiness
- Comprehensive performance measurement and reporting
- Member empowerment strategies
- Clinical consultation
- Robust suite of tools offered by Optum
- Mechanism to administer incentive programs
- Physician/patient portals and transparency tools
- Option to apply model to provider’s employee lives
- Innovative care management programs

Our partners are accountable for managing patients across the care continuum

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

Accountable Care Platform | Measuring Success

WE ARE DRIVING ACCOUNTABILITY THROUGH A SHARED RISK ENVIRONMENT FOCUSED ON QUALITY, COST AND PATIENT EXPERIENCE OUTCOMES

Achievement of quality and efficiency measures results in improved quality and reduced medical cost:

- HEDIS Basic and HEDIS Extended Quality Measures
- Quality Defects
- Intermediate Outcomes—HAC/HAI
- Optimal/Tier 1 Prescription Drugs
- Efficient Lab Use
- Specialist Usage
- Risk adjusted ER and Admission Rates
- Readmission Rates/Avg Lengths of Stay
- Potentially Avoidable Hospitalizations
- Total Cost of Care Targets

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

SELECT RESULTS & FINDINGS

UnitedHealthcare®

Demonstrated Results | ACOs

- Double-digit reduction in readmissions for high-risk patient population
- Reduction in acute hospital admissions
- Reduction in ER visits per 1,000
- NCQA recognition
- Improvement in HEDIS measures
- Significant number of metrics at or above 90th percentile of Quality[1] Compass
- 3% reduction in total medical cost
- Improvement in generic Rx prescribing rate
- The network's market share increased by 5% in the first six months of operation
- ~$1M bonus to physicians

"This program will increase patient engagement and ensure patients are receiving appropriate care and screenings. Our goal is to achieve better health outcomes and to prevent more costly treatments or hospitalizations for our patients."

Grace Terrell, M.D., President & CEO, Cornerstone Health Care

*"We are committed to providing best-in-class care to our patients so when we joined together with UnitedHealthcare and Optum, we were optimistic…that we would improve care, while reducing costs…**Our initial results exceeded our expectations.**"*
Simeon Schwartz, M.D., President & CEO of WESTMED

"We're on the front lines of implementing technology and solutions from Optum, such as advanced analytics and care coordination workflow enablement, that are helping our providers across the system stay connected."
Susan Willis, President, Innovative Practices, Arizona Connected Care

[1] Based on UnitedHealthcare's calculation of claims data of members receiving care through WESTMED compared to national Quality Compass ratings, UnitedHealthcare reported that the ACO is performing above the 90th percentile of National Committee for Quality Assurance (NCQA) Quality Compass for providing the highest level of coordinated care for breast cancer and cervical cancer screenings.

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

Demonstrated Results | All Programs

	SPECIFIC RESULTS
Performance-based Programs	•**$50M** savings in last 12 months •**3.6%** readmit reduction •**9%** reduction in inpatient length of stay •Reduction in the use of non-participating laboratory services •Reduction in the use of non-Tier 1 prescriptions

Centers of Excellence	• **25%** decrease in the average length of hospital stays for transplants
	• Improved transplant survival rates at Centers of Excellence
	  • **3%** reduction in one-year mortality for liver transplants
	  • **5%** reduction in one-year mortality for heart transplants
	• **16%** reduction in the incidence of transplants through application of evidence-based appropriateness criteria

Accountable Care Programs[1]	**Patient Centered Medical Home** •**1.5%-3.5%** lower medical cost trend than expected •**4:1 ROI** **Westmed ACO** •**3%** reduction in medical cost •**5%** reduction in acute hospital admissions •Significant number of metrics at or above **90th percentile** of Quality Compass[2]

[1]Patient Centered Medical Home results based on 4 states and 1 Commercial ACO.

[2] Based on UnitedHealthcare's calculation of claims data of members receiving care through WESTMED compared to national Quality Compass ratings, UnitedHealthcare reported that the ACO is performing above the 90th percentile of National Committee for Quality Assurance (NCQA) Quality Compass for providing the highest level of coordinated care for breast cancer and cervical cancer screenings.

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare

UHC & Optum | Creating Value & Transforming Markets

- Value-Based Contracts
- High Performance Networks
- Value-Based Benefits
- Care Management Programs
- Cost & Quality Transparency

- Population Health Analytics
- Population Risk Analytics
- Patient Engagement
- Targeted Care Coordination Programs
- Financial Performance Management

Intentional Integration Nationally & Enabling Providers Locally

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

Accountable Care Platform | Our Difference

THE UNITEDHEALTHCARE DIFFERENCE

Our Accountable Care Platform drives optimal value through **delivery system transformation;** with our modular suite of value-based programs, we can **customize** our accountable care approach according to a care provider's risk readiness

Our **broad national network** of more than 750,000 doctors and health professionals, 64,000 pharmacies, 5,600 hospitals and 1,500 convenient care clinics gives us the ability to deploy our platform in **many markets** with **many types of care providers**

We are an **industry leader** not only for private, commercial insurance, but also for Medicare Advantage and Medicaid programs. We have the opportunity to partner with care providers in proactively managing the health of a **variety of populations**

We offer comprehensive data and reporting, innovative mechanisms to distribute funds based on performance and access to cutting edge health information technology. We are **supporting care providers** by supplying them with the tools they need to be successful

THIS MATTERS | Our strategy uniquely maximizes value by aligning incentives across consumers, employers and care providers to achieve the Triple Aim of better health, better care and lower costs.

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

2014 UnitedHealth Premium® Designation Physicians

25 SPECIALTIES COVERING >80% OF MEDICAL SPEND

Primary Care

- Family Medicine
- Internal Medicine
- Obstetrics & Gynecology
- Pediatrics

Specialists

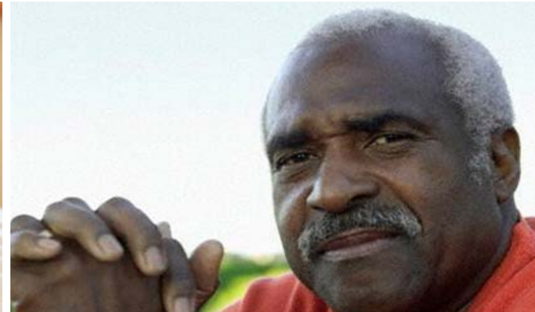
- Allergy
- Cardiology
  - Electrophysiology
  - Interventional
- Endocrinology
- General Surgery
- Colon/Rectal
- Infectious Disease
- Nephrology
- Neurology
- Neurosurgery-Spine
- Ophthalmology
- Orthopaedics
  - General
  - Foot/Ankle
  - Hand
  - Hip/Knee
  - Shoulder/Elbow
  - Spine
  - Sports Medicine
- Pulmonology
- Rheumatology
- Urology

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Clinical Resources

The broadest portfolio of integrated services in the industry, leveraging the eSync Platform^{SM} for holistic care management

eSync synchronizes health care management for optimal wellness, based on current health status

Staying Healthy	Getting Healthy	Living with a Condition
		
Wellness Tools and Resources: • eSync Health Portal (Health Assessment, Personal Health Record, interactive coaching, health tools/trackers, personal messaging, cost estimators, Online Nurse Chat • Telephonic Wellness Coaching • Publications and reminders • Healthy Pregnancy Program • Onsite Wellness (Know Your Numbers, on-site consultant)	• 24/7 urgent needs support • Condition education and health advocacy • Treatment Decision Support • Provider quality and efficiency information • HealtheNotes • Integrated clinical delivery management • Holistic care management, including medical and behavioral health integration • Broadest chiropractic network in the nation	• Personal Health Support (50+ conditions) • Disease Management (asthma, COPD, CAD, heart failure, diabetes) • Centers of Excellence/ • Specialty case management (Transplantation, cancer, kidney, neonatal, bariatric, congenital heart disease, infertility)
Self Help	**Support**	**Intervention**

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

Engagement Resources

myuhc.com®

PROVIDES MEMBERS WITH EASY ACCESS TO RELEVANT AND PERSONAL INFORMATION

- Intuitive navigation
- Find a physician by location
- myHealthcare Cost Estimator
- Improved hospital search
- Enhanced Personal Health Record

THIS MATTERS Easy access to information and resources helps keep members engaged in their health care decisions.

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

UnitedHealthcare®

Accountable Care Platform | Questions?

PAYING FOR VALUE • TRANSFORMING THE DELIVERY SYSTEM • ALIGNING INCENTIVES

MORE ACCOUNTABILITY

MORE HEALTH IMPROVEMENT

MORE ENGAGEMENT

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Engaging Members in Worksite Wellness

Board of Trustees Meeting

March 28, 2014

A Division of the Department of State Treasurer

Providing Context

- As part of the strategic planning process, and in researching opportunities to improve member health, the following questions were raised:

  - What are examples of *model worksite wellness* programs*?*
  - What are other large employers doing to *increase member health engagement*?
  - What is SHP's *strategy for member communication and engagement*?
  - How can *SHP partner* with other State agencies to *promote healthy lifestyles?*

- The presentation covers information gathered through a brief environmental scan and is intended to help address these questions.

Presentation Overview

- Worksite wellness: what & why
- Dimensions of successful worksite wellness initiatives
- Successful models of worksite wellness initiatives
- State Health Plan experience
- Emerging conclusions and recommendations

Worksite wellness contributes to addressing the 'Triple Aim'

Triple Aim*:

1. Improving the health of populations
2. Reducing the per capita cost of health care
3. Improving the patient experience of care

Worksite wellness can be integrated across the core components of the SHP business model

1. Benefit offerings and programs
2. Program administration and contracting
3. Provider network

4. Provider payment methods

- *Source: Institute for Healthcare Improvement*

What are Worksite Wellness Programs?

- Any ***employment based activity or employer sponsored benefit*** aimed at promoting healthy behaviors (primary or secondary prevention)

- Typically include a wide spectrum of services ranging from health information, free or discounted gym memberships to, comprehensive counseling and active lifestyle management to policy and environmental changes

Information, awareness& education

Discounted memberships/services

HRA, lifestyle & disease management

Policy & environmental changes (culture of health)

Why Offer Worksite Based Wellness Initiatives?

Challenge

- Burden of chronic disease is growing
  - 1 in 2 adults in US have a diagnosed chronic condition (CDC, 2010)
- Rising rates of obesity and physical inactivity
  - 25.7% obesity, 51% meeting recommended physical activity (CDC, 2010)
- Burden is shifting to younger ages.
  - 28.7% under 18 yrs. meeting physical activity recommendation; 13% obesity among youth (CDC, 2010)
- Resulting in high medical care costs and loss of productivity
  - Chronic diseases account for $3 of every $4 spent on health care. That's nearly $7,900 for every American with a chronic disease. (CDC 2007)

Response

- Employers have adopted health promotion, wellness, disease management strategies to counter these trends
  - Access to audience at a younger age
  - Focus on primary prevention
  - Influencing health behaviors and impacting the trajectory

Worksite Wellness Programs

- 85% of large employers (>500 members) and 81% of small employers have a wellness program in place.

Employee/Member Benefits

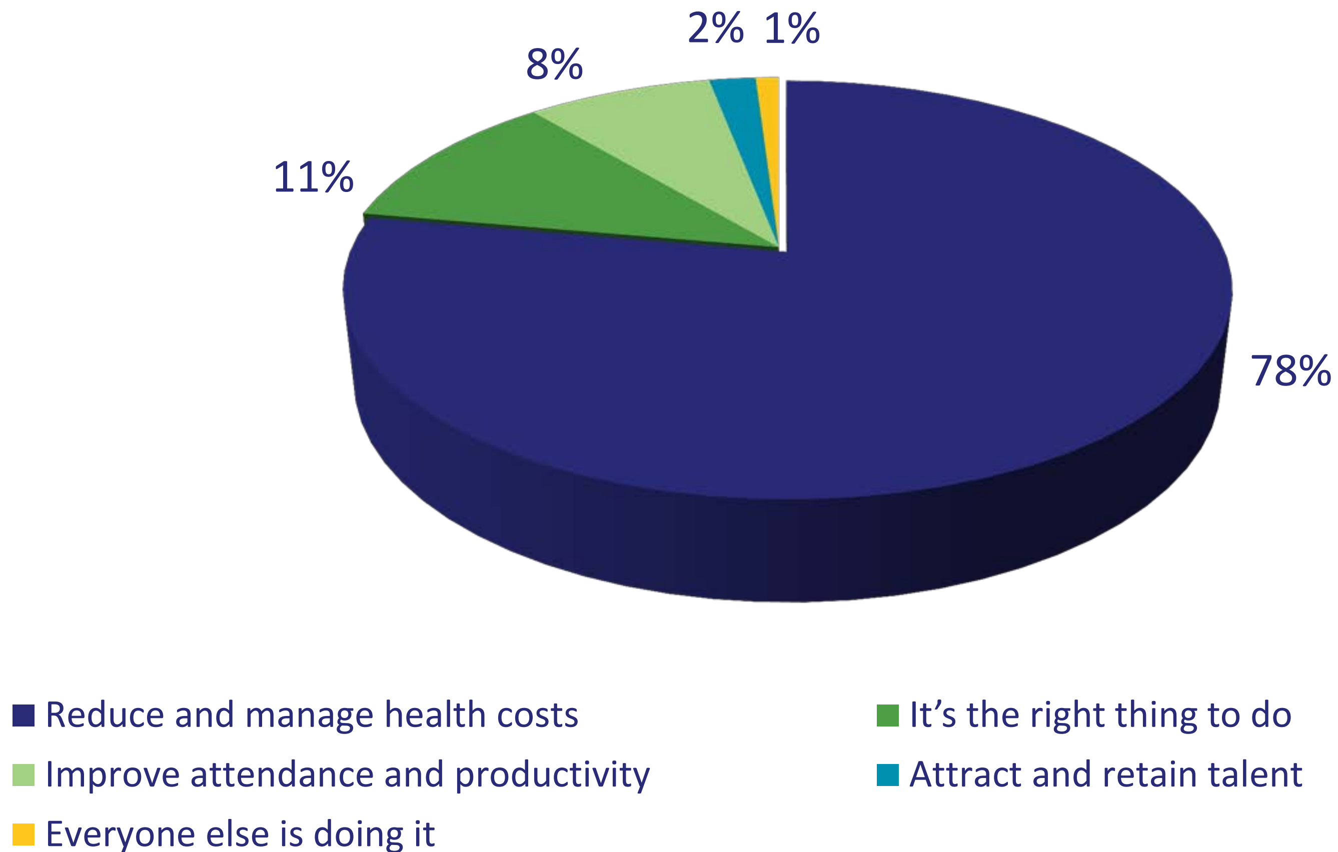
- 62% believe wellness activities are successful in improving health and reducing health risks
- 51% say they work harder and perform better
- 59% say they have more energy and are more productive
- 45% say health related programs encourage them to stay in their current position
- 43% say they miss fewer days of work as a result of wellness programs

Employer Benefits

- Healthier workforce
- $5.81 return on every dollar invested
- Sick leave absenteeism reduced by 26.8%
- Health care costs reduced by 26%
- Workers compensation and disability management reduced by 32%

Source: Principal Financial Well-being Index for American Workers, 2012; Wellness Council of America, 2012

Why Large Employers Invest in Wellness Programs



Source: 2013 Wellness and Benefits Administration benchmarking study

The Reality: Employee Resistance

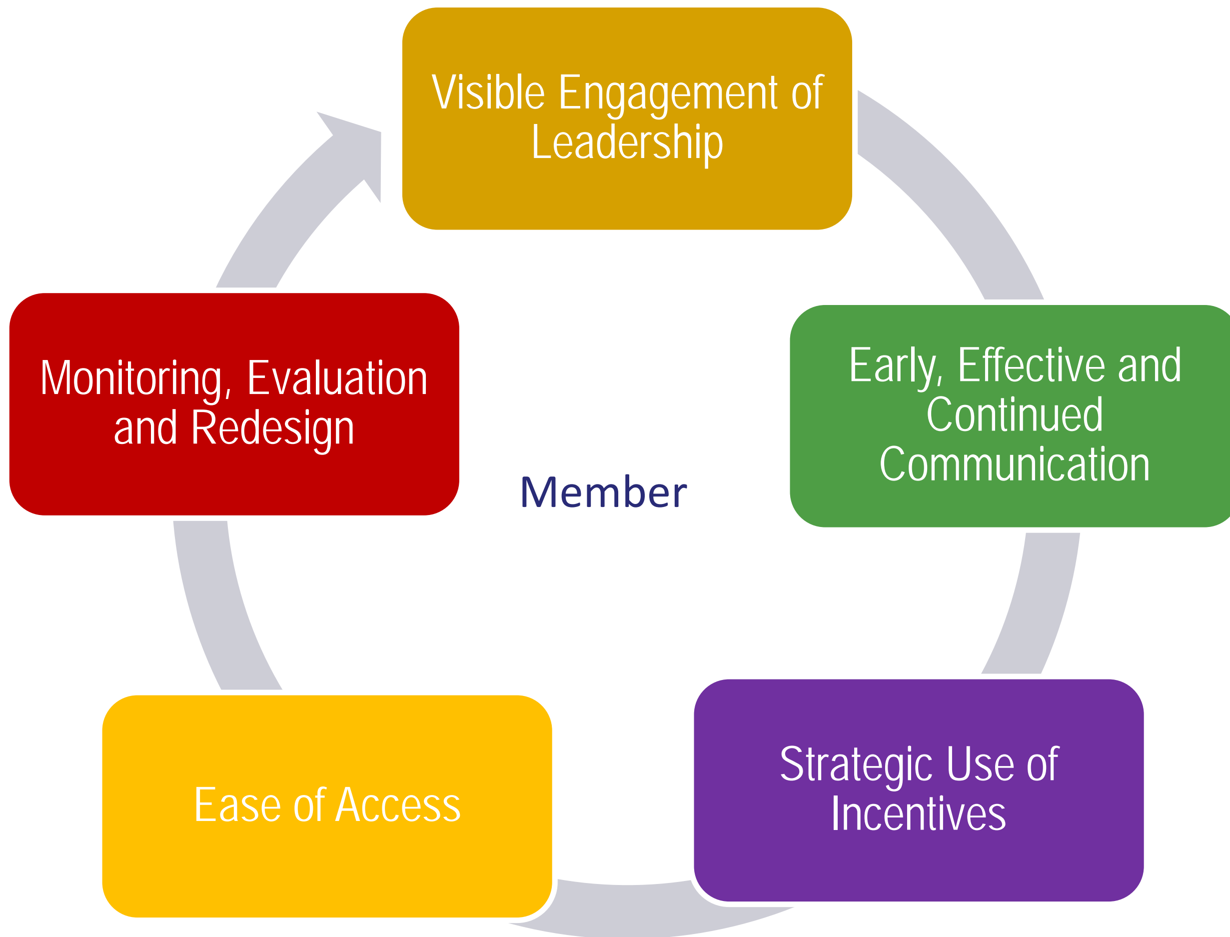
- While prevalence of such initiatives is common and people who participate value them, there remains resistance.
- There is no nationally representative data but typically fewer than **20%** of eligible employees participate in any wellness initiative
- **34%** consistently refuse to participate in employee sponsored wellness programs

Source: Rand Corporation, A review of the US workplace Wellness Market, US Dept. of Labor and US Dept. of Health and Human Services, 2012

Why Employees do not Participate in Wellness Initiatives

- **Trust**: Lack of trust in the employer's motivation, employers trying to save money
- **Personal information**: Do not believe Health Assessments are reported in the aggregate
- **Lack of interest**: Not interested in changing select health behaviors (know that smoking is unhealthy but not ready to make a change)
- **Inconsistent messages**: Company sends mixed messages (encourages participation in wellness but does not change high fat junk options in cafeteria or vending machines; does not allow employees time during work day to exercise)
- **Lack of leadership**: Company leaders don't participate, so employees don't think it's important
- **Benefit:** Employees believe the employer saves money and do not see that profit being translated to them

Dimensions of a Comprehensive Program



Effective Marketing & Communication

- **Early, multimodal, broad outreach and clear messaging**
  - Letter or email from leadership
  - Brochures with clear details, email blasts, fliers
  - Mail to home address
  - Have a large and entertaining kick off
  - Help people see perceived value, e.g.: a ticket given to each person showing time and value, “Value $75”
  - Create expectation that everyone will participate

Visible Engagement with Leadership

- **Strong commitment at all levels of the organization**
- **Leadership engagement vs. incentives**
  - 50% participation with a $40 incentive and strong commitment; while with lower levels of management commitment incentive has to be up to $120 to gain similar participation*.

- **Senior Management Support**
  - Senior leaders serving as role models
  - Visible participation

- **Empowerment of middle managers**
  - Advisory teams, wellness committees, resources
  - Standard training on wellness to ensure conformity
  - Company wide policies and procedures for wellness participation

*Source: *Taitel, V.H and Heck, D. Incentives and other factors associated with employee participation in health risk assessments. Journal of Occupational and Environmental Medicine, 2008.50(8)pp-863-872*

Ease of Access-*Removing Roadblocks*

- **Ability to access the program (s) with ease**
  - Flexibility of when to access services (first thing in the morning, extended lunch times)
  - Build in small attainable goals to obtain interest and generate continued participation

- **Policy changes**
  - Allow members time during work day to participate
  - Access to terminals if program requires use of a computer

- **Data confidentiality**
  - Set policy on confidentiality and communicate the policy to participants prior to initiation and continue to make policy available to members.

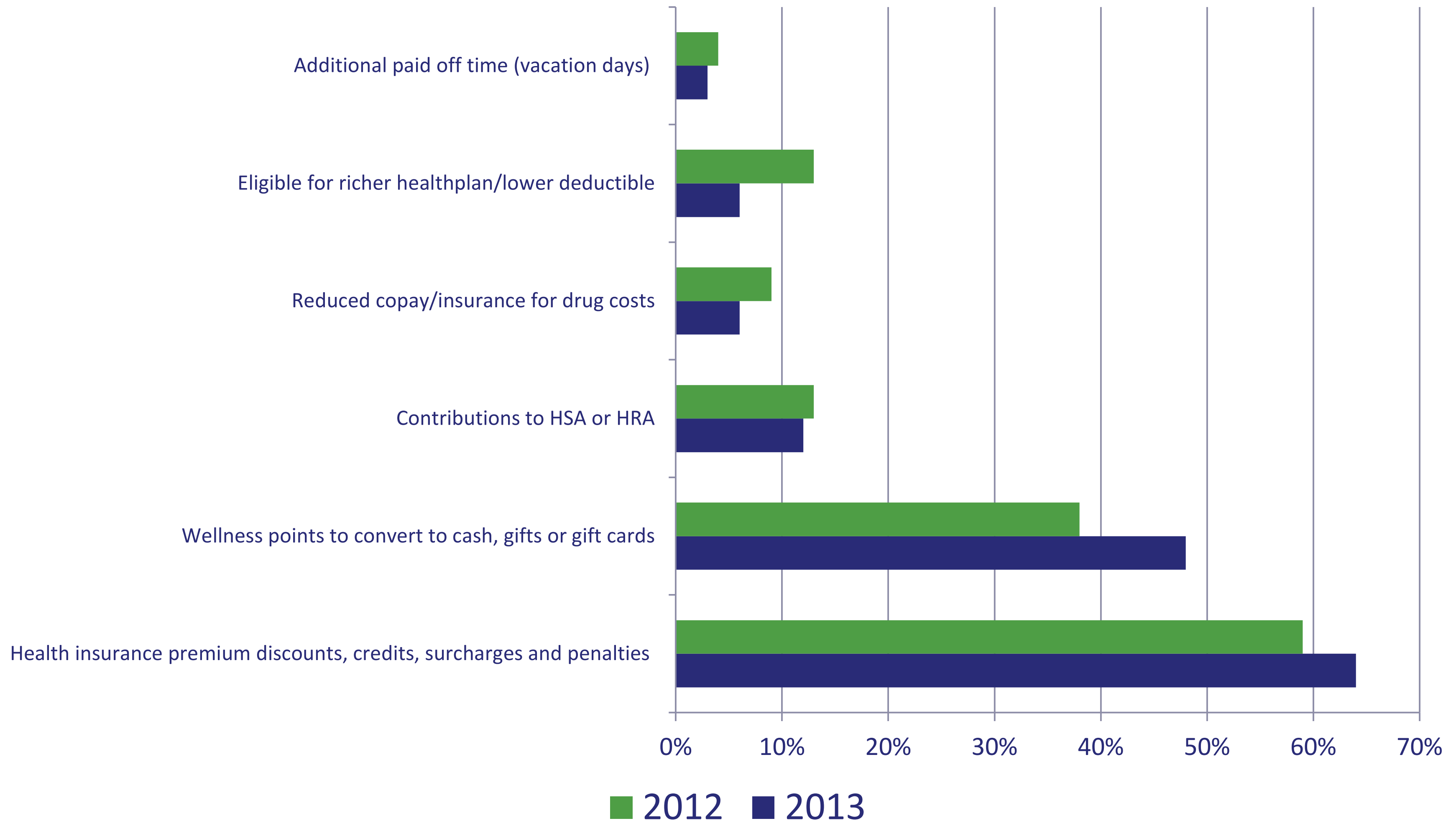
Use of Incentives

- **Rewarding or penalizing members** has become a popular approach to obtain participation
  - Building body of evidence that targeted incentives can influence health behaviors that are normally difficult to alter

- **Types of incentives**
  - A variety: cash, gift cards, merchandise, time off, recognition, raffles, lotteries, reduced premiums, contributions to HSA/HRA

- **Incentive triggers**
  - Incentive triggered by various levels of engagement (signing up vs. attending a class)
  - Tying an incentive to an outcome (giving contact information, becoming tobacco free, achieving BP control or lowering HBA1c)

Types of Wellness Incentives Used in the U.S. Marketplace



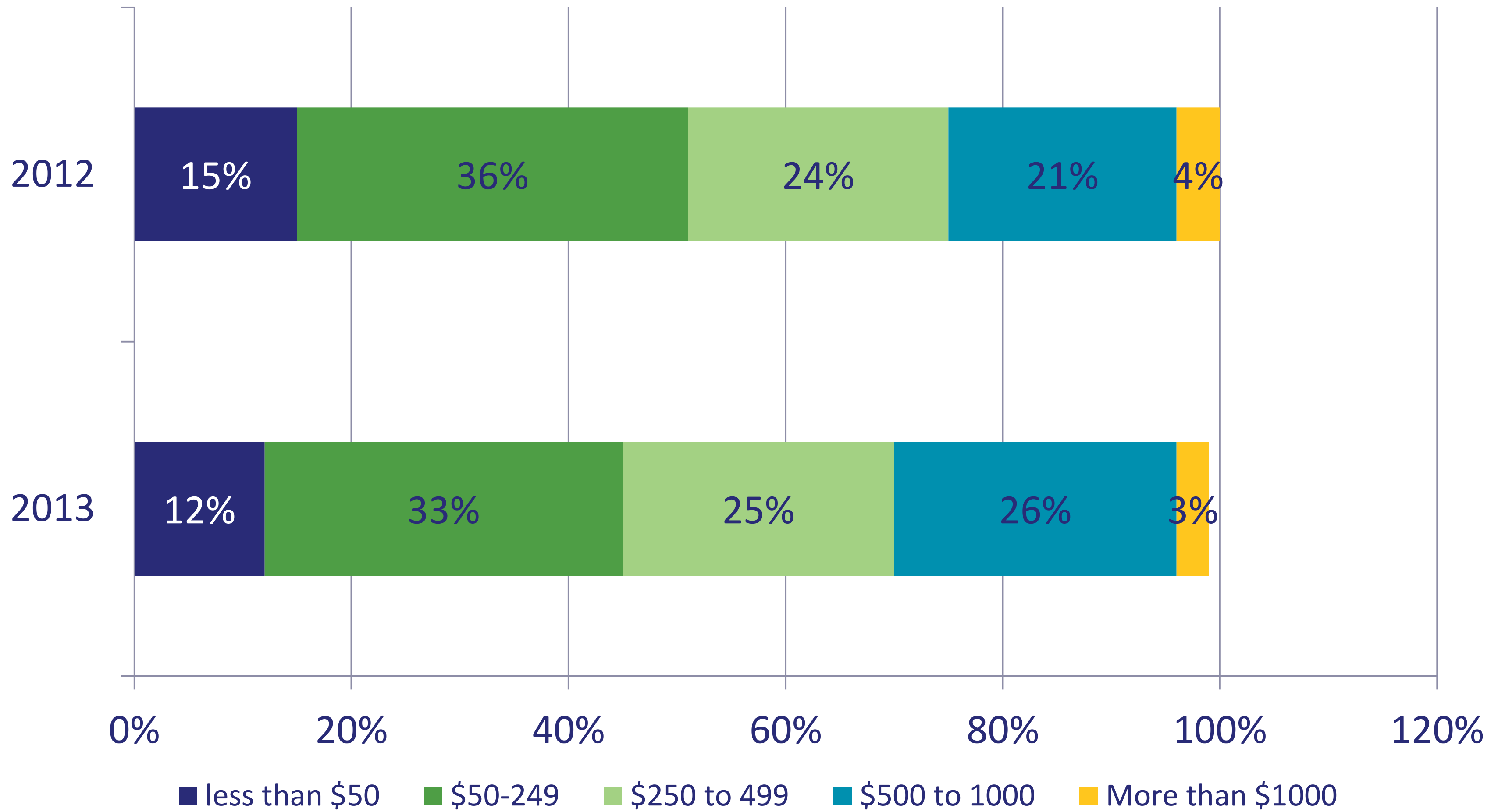
Incenting Participation

- More than three-fourths (78%) of large companies (>500) offered incentives in 2013, holding steady from 2012 (76%)
- Small employers (50-500 employees) offering incentives grew from 52% to 69%

What is the norm for the **annual dollar amount per employee** for wellness incentives?

- In 2013, 54% of large employers offered annual incentives above $250, up from 49% in 2012
- 12% offered less than $50 in 2013, compared to 15% in 2012

Average Annual Spend per Employee for Incentives



Monitoring, Evaluation and Redesign

- **Needs assessment and environment scans**
  - Assessing worker interests and preferences as well as organizational policies and resources
- **Data based design**
  - Utilizing the information gathered as well as profile reports in tailoring programs to an organization
- **Performance measurement**
  - Measures of participation, retention. Not just depending on health outcomes, costs and utilization
- **Information sharing with participants**
  - Periodic sharing of information and inviting qualitative feedback
- **Implementing changes to program based on evaluation**
  - Making midway course corrections

State of Nebraska

- **Components of program**
  - Champion network
  - Senior leadership support including involvement of the Governor
  - Health Risk Assessment
  - Health Coaching
  - Biometrics
  - Web resources
  - Disease management for CAD, HF, DM, Back Pain, Asthma, COPD, Depression and Healthy Pregnancy
  - Recognition program

- **Incentive**
  - Low-premium PPO plan

- **Measurement of success**
  - $4.2 million in savings ($934 claims savings for program participants)
  - ROI of 2.70:1
  - 8% reduction in medical cost vs. overall State

- **Participation rate**
  - 30% of eligible members enrolled in low-premium wellness PPO plan (employee and enrolled spouse)
  - 42% of members on wellness PPO plan participated (roughly 5,800 members)

Dell Inc.

- **Components of program**
  - Annual onsite health screenings
  - Health Risk Assessment & Health Coaching
  - Onsite support with additional resources for remote employees
  - Resources available on BP, Weight, Nutrition, and Physical Activity
  - 24 hour nurse line that coordinates with other resources
  - Condition management program
  - Wellness teams
  - Extensive communication
  - Wellness incorporated in goals and culture of business
- **Incentive**
  - "Pay for performance" model contributed to salary
  - Premium reduction ranges from $845-$1690
- **Measurement of success**
  - ROI 1.8 in 2009, 2.11 in 2011
  - Low-risk group increased by 7%
  - 50% reduction in smokers
  - Program has been active for 8 years
- **Participation rate**
  - HA completion rates 50-73% for employees, 34-48% of spouses/partners

North Carolina Landscape: SAS

- **Components of program**
  - Onsite Health Care Center for employees and dependents
  - Culture of wellness
  - Onsite recreation and fitness center
  - Subsidized onsite child care

- **Incentive**
  - Health education and physical activity campaigns/programs with awards or prizes
  - Resources are available to members and spouses for no cost

- **Measurement of success**
  - $7M saved by health insurance costs and employee time saved
  - 4% turnover rate (industry norm 22%)

- **Participation rate**
  - Approximately 70% of employees use the onsite Health Care Center as their medical home
  - 90-95% of employees use the onsite recreation center in one way or another

State Health Plan Strategy: NC Health*Smart*

NC Health*Smart* is the Plan's population health initiative that aims to:

- Empower healthy members to stay healthy;
- Help those with chronic disease or disease risk factors to better manage their health;
- Offer integrated, cutting-edge resources and programs to members at work, at home, and through their health care provider

NC Health*Smart* Components

- Currently offers a spectrum of wellness initiatives through NC Health*Smart* suite of resources/services:
  - Health Promotion & Education (toolkits)
  - Health Coaching (Telephonic)
  - Tobacco Cessation (Quitline NC)
  - Weight Loss Programs (ESMMWL)
  - Health Assessment/Health Record/Web Tools
  - Disease Management
  - Physician Support/Clinical Gap Identification
  - Intensive Case Management
  - High Risk Maternity/NICU
  - ESKD/CKD Care Management

NCSHP Experience: Wellness Pilots

- Consistent with national experience SHP participation has been generally low, even when high interest was generated in the first year.

Sample Pilot Initiatives	Year 1 Participation	Year 2 Participation
Murdoch Developmental Center	49% (1,036/2130 eligible members)	7% (134/1,938 eligible members)
DHHS Expansion	32% (803/2,532 eligible members)	13% (333/2,603 eligible members)
Charlotte Mecklenburg Schools	9% (1,847/21,421 eligible members)	7% (1,590/21,968 eligible members)

Biometric testing, incentive based pilot project ($15 reduced copay for PCP visits)

Why SHP Members do not Participate

- **CWI:** The past Comprehensive Wellness Initiative (CWI) has made members wary of how their *Health Assessment* data will be used (will they lose the plan benefits if they say they have diabetes?)

- **Health Information:** Concerned about the security of their health data moving between different vendors

- **No Access**: Some members do not have access to a computer at work and/or at home

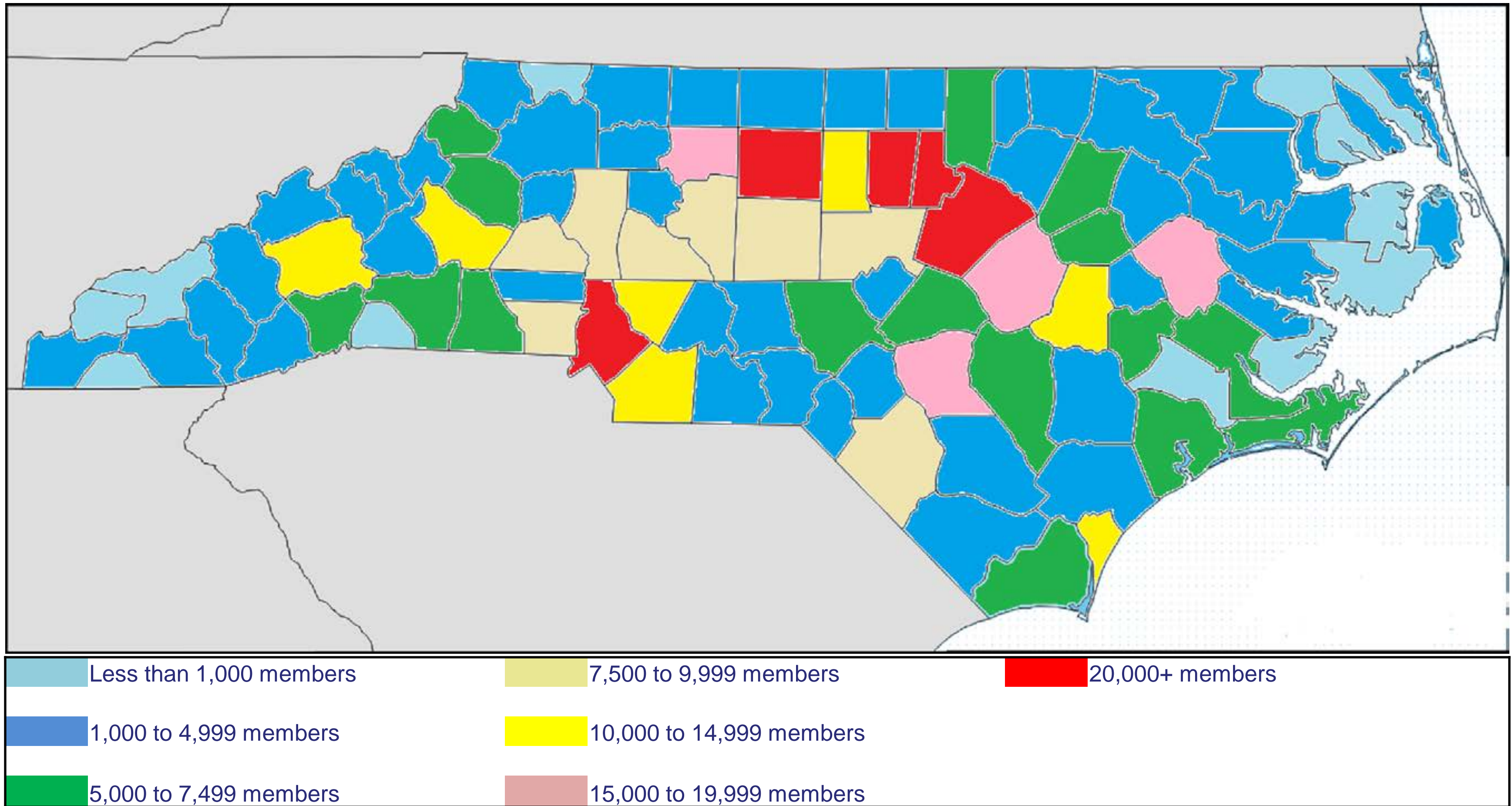
- **Nature of their job:** keeps them from being able to do wellness activities at work (such as the guards working for DOC or nurses working at 24-hour facilities like Central Regional Hospital)

- **Leadership:** Even if top leaders are engaged, lower-level management may not be engaged and that may keep members from participating

- **Policy and environmental issues:** Lack of any consistent policy across agencies; lack of ability to change policy or environment

- **Being Healthy:** Members feel they don’t need these programs if they are without chronic conditions

State Health Plan Members are in All 100 Counties



Plan members live throughout the State with pockets of high concentration

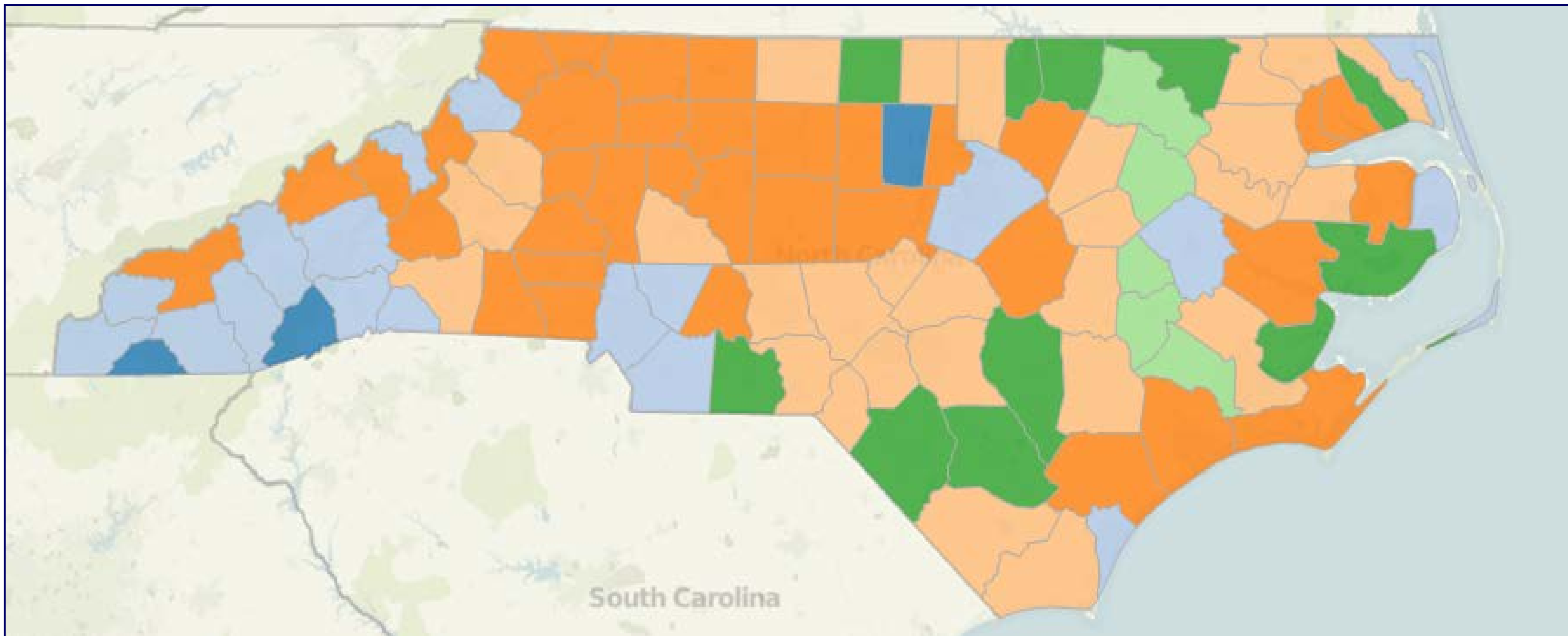
Member Density and Profiles Vary by Agency

Agency/Worksite	Members	PMPY	Relative Cost	Risk Factor
Community College System	23,325	$5025	0.990	0.987
Department of Corrections (DOC)	26346	$5235	1.031	1.039
Health and Human Services (DHHS)	24,224	$5233	1.031	1.054
Department of Transportation (DOT)	17,722	$4515	0.889	0.954
North Carolina Public Schools	258,201	$4441	0.875	0.875
University of North Carolina (Health care & NC system)	80,830	$4469	0.880	0.862
All Other Groups	46,290	$4908	0.967	0.953
Total (Actives only)	476,937	$4607	0.907	0.907

Reviewing department specific risk factors and profiles will identify specific opportunities to tailor wellness programs and boost participation.

Major Chronic Conditions

Asthma, CAD, CVD, CHF, COPD, Diabetes



Big 6 condition Prevalence
- 9.5%
- 11.9%
- 14.2%
- 16.6%
- 19.0%
- 21.3%

Planning for Worksite Wellness

- The average state employee stays in their job for 11 years (longevity is high, turnover is low) – it is a long term engagement (attrition 9.5%, typical 6%)
- As seen from map, members are dispersed over all100 counties
- Agencies are diverse in nature, with different risk profiles, with different categories of employees with disparate resource availability
- Geographic variation in prevalence of chronic conditions
- Meeting the needs and influencing impact is challenging

Emerging Recommendations

Visible Engagement of Leadership	Use agency and state leaders to promote initiatives, show leadership by participation. Empower middle management to be supportive of the initiative. There has to be agency partnership, sponsorship and sharing of resources
Effective Communication	Broad communication and multi-layered marketing strategy; leverage local resources to maximize awareness and engagement
Strategic Use of Incentives	Incentives need not be cash; incentives should be tied to action and should have significant value; strategically build incentives to sustain interest
Ease of Access	Partner with agencies that can influence policy change. Policy changes should remove road blocks: flexibility of time; access to computer terminals; environmental changes that make the healthy choice the easier choice
Monitoring Evaluation and Redesign	Data and information should form the foundation for any programmatic design, ongoing monitoring of program and redesign as needed is critical

Overall Conclusions

- SHP should continue to pursue and expand worksite wellness initiatives, these programs support the mission of the Plan and help achieve the triple aim
- Delivering a comprehensive yet tailored program suited to the different strata of the membership is challenging
- Though engagement is low, there are strategic steps that can be taken to increase engagement and showcase value to members
- Partnership with agencies that can influence environmental and policy changes is critical
- Continued and consistent support of worksite wellness initiatives that are valued by members can and will lead to culture change

Appendix

L.L. Bean Inc.

- **Components of program**
  - Health, safety, and wellness committees
  - Onsite fitness rooms are various locations open to employees and spouses/partners
    - Health education and fitness classes
    - Remote employees are eligible for a subsidy for gym membership
  - Health Risk Assessment
  - Telephonic coaching based on health risk level (1 call for low risk, 4 calls for moderate, and unlimited for high risk)
  - Target health risks such as obesity, physical activity, heart health, diabetes, and mental health programming.
    - Allowed to participate on work time
  - Monthly wellness themes with photo submissions from employees
- **Incentive**
  - Up to $2,900 annual reduction in premiums
  - Overall culture of well being
- **Measurement of success**
  - Smoking rates decreased to 5.6%
  - Medical claims significantly lower than average for state
  - From 2007-2010 a net savings of more than $2 M for medical claims, and $3 M net considering absenteeism and presenteeism
- **Participation rate**
  - 85% of eligible members completed HRA
  - Nearly 100% participation with health coaching

University of Michigan

- **Components of program**
  - Targeted physical activity, nutrition, flu vaccines, etc.
  - Disease management with targeted interventions
  - Free annual/biannual wellness screening and health risk assessment with follow-up coaching
  - Wellness champion network of roughly 346 employees
    - Champions can earn badges for completing program steps such as blogging, and sharing ideas
  - Health workplace culture survey administered regularly
  - Health and wellness campaigns either to entire population or targeted group or department
    - Campaigns were open to spouses and students at a cost
  - Quizzes on various health subjects
  - Smoke free campus
- **Incentive**
  - Screenings and assessments earned employees $100 contribution to paycheck (before taxes) and an entry into a grand prize drawing up to $750
  - For campaigns: T-shirts, $50 Amazon gift card, cash contribution, additional prizes not specified
- **Measurement of success**
  - Increase in low risk employees from 35.06% in 2009 to 40.7% in 2012; reduction in medium risk from 54.86% to 52.02%; decrease in high risk from 10.08% to 7.28%
  - Decrease in number of members with cholesterol over 204 mg/dL (9.4% in 2009 vs 4.7% 2012) and BP over 140/90 (12.5% in 2009 vs. 4.2% in 2012)
- **Participation rate**
  - 17,640 members completed both screening and health assessment; 581 engaged in health coaching; 248 engaged in tobacco cessation services

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Patient Centered Medical Homes: State Health Plan Program Design and Approach

Board of Trustees

March 28, 2014

A Division of the Department of State Treasurer

Presentation Overview

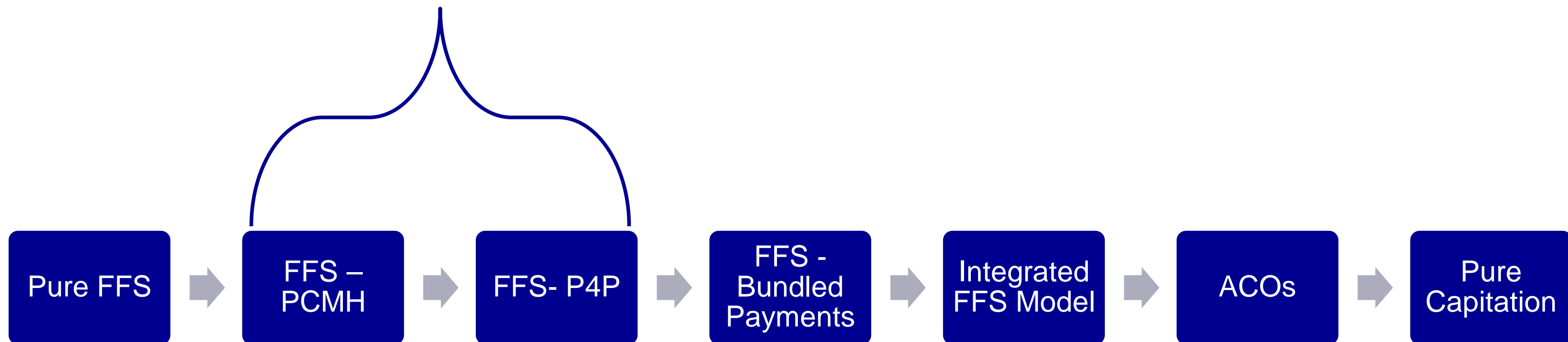
State Health Plan

- Defining a Patient Centered Medical Home (PCMH)
- Value of National Committee for Quality Assurance (NCQA) Recognition
- Member and provider expectations of a PCMH
- State Health Plan’s history with PCMH
- State Health Plan PCMH program purpose

ActiveHealth Management

- 2014-15 PCMH pilot initiative

January 2014 BOT Presentation



At the January BOT meeting the discussion centered on payment models and strategies. Payment is a component of an overall strategy to attain the goals of access, quality, experience and health outcomes.

The Patient Centered Medical Home (PCMH) is part of the clinical strategy of the Plan to achieve the triple aim.

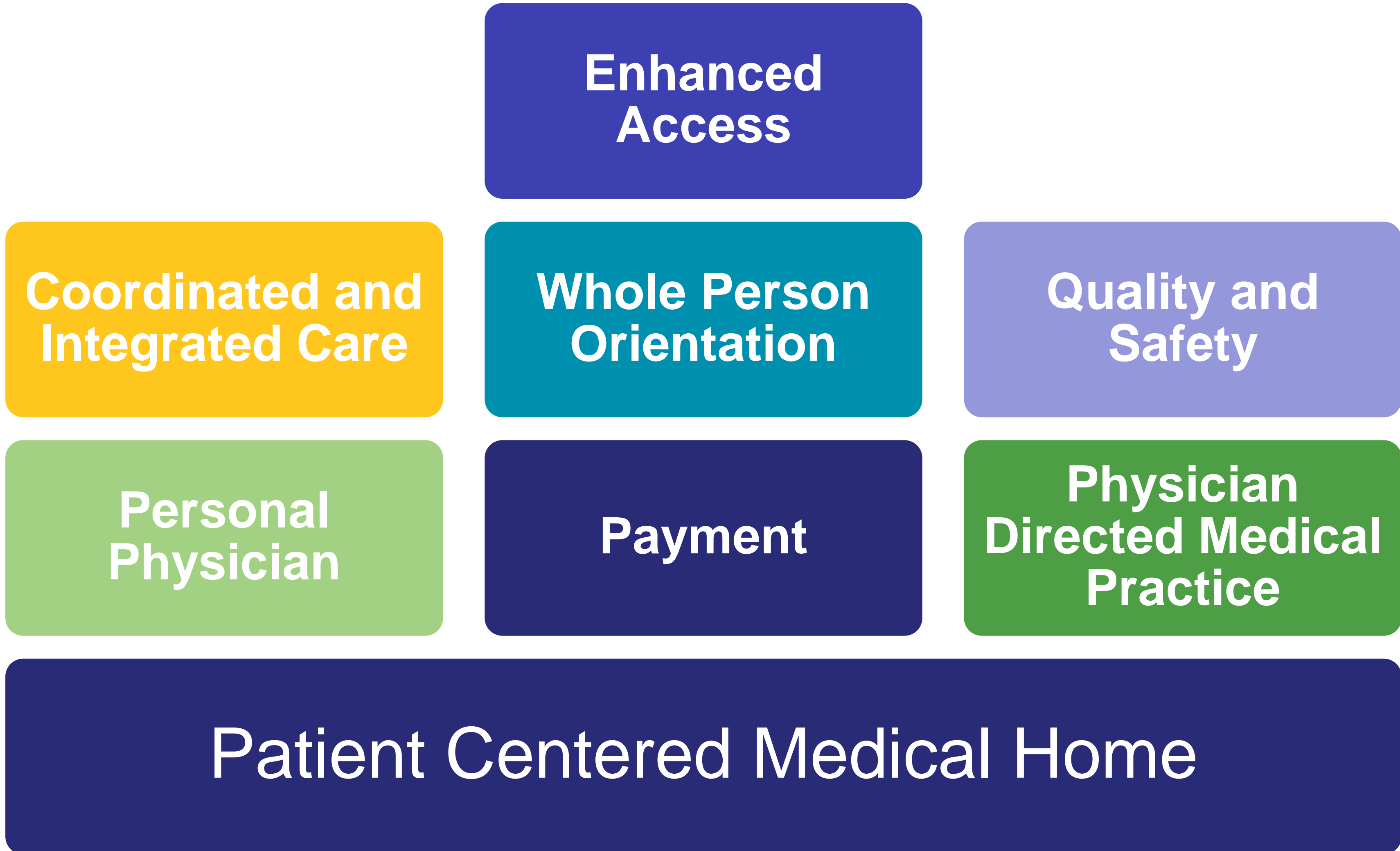
FFS: Fee for Service, PCMH: Patient Centered Medical Home, P4P: Pay for Performance, ACO: Accountable Care Organizations

Patient Centered Medical Home (PCMH)

There are many definitions of a PCMH, but for purposes of the SHP, this is the definition we will use:

A model of care that strengthens the **patient-physician relationship** by replacing ***episodic care*** with ***coordinated care*** and a long-term relationship.

Building Blocks of a PCMH



Expected Outcomes from a PCMH

High level of accessibility to care (Access)

- Open scheduling
- Expanded hours
- 24/7 telephonic access

Timely care within appropriate settings (Quality)

- Timely preventive care
- Avoidance of ER
- Preventable hospital admissions

Excellent timely communication (Experience)

- Comprehensive health assessments
- Established plan (goals) of care
- Transition of care

Access to latest technology (Health Outcomes)

- E-prescription
- Medication reconciliation
- Obtain clinical support
- Timely sharing of information
- Track results

NCQA PCMH Recognition

National Committee for Quality Assurance (NCQA) developed a recognition process, as the concept of PCMH evolved, to standardize and operationalize the model:

- NCQA PCMH recognition process supports and guides physicians in achieving levels of competency to enhance quality of care through systematic processes and use of information technology
- NCQA PCMH recognition demonstrates that systems and processes are in place to meet nationally recognized standards for delivering high quality of care enabling providers to take advantage of *financial incentives* offered by payers, employers and health plans

What does it mean to be part of a PCMH?

Member	Provider
I know who to call if I need help or have questions, anytime of the day or night.	I am the first point of contact for my patients when there is a health concern. I make access to care easy for my patient through flexible scheduling.
I am comfortable asking questions and discussing my goals and preferences with my medical home team.	I create an environment where a patient can openly ask questions and discuss their concerns regarding their health care.
I have a primary care provider and his team who know my needs and help me navigate my care with specialists.	I coordinate care between specialists for my patients when appropriate.
My important health information is available to me and I have help understanding what it means.	I communicate effectively with my patients and help them become informed consumers of healthcare.
My medical home helps make sure everything is in place when I get out of the hospital.	I have information technology available to give my team access to real-time data so I can assist in the transition of care of my patient.

What does it mean to be part of a PCMH?

Member	Provider
I have help with my medications and understand how and when to take them.	My clinical team will help manage the medications of my patients through periodic medication review and management, especially during transitions of care.
When I have a change in my health, my medical home team provides me with support.	I deliver care in the most appropriate setting for my patients. My team will monitor the care of my patients to identify gaps in care.
I have access to my personal health portal and can grant my provider access to it as well.	I have technological supports that are needed to appropriately monitor the care of my patients.
I know what a medical home team is and I am a part of mine.	I create and lead the medical home for my patients.

Partially sourced from NORTH CAROLINA STATE DEMONSTRATION TO INTEGRATE CARE FOR DUAL ELIGIBLE INDIVIDUALS, Submitted to CENTER FOR MEDICARE AND MEDICAID INNOVATION, Contract Number: HHSM-500-2011-00037C

State Health Plan History with PCMH

January 2012

- ActiveHealth (AHM) launches PCMH Model with Community Care of North Carolina (CCNC)
- Multi-payer (MAPCP) demonstration project through CCNC includes 7 of 10 counties first launched

December 2013

- AHM live with PCMH in 54 counties
- Contract concluded between AHM and CCNC
- No impact on any outcomes of interest

January 2014

- AHM launches PCMH Practice Support model
- SHP continues participation in MAPCP project through direct contract with CCNC

Sept/Dec 2014

- AHM continues with PCMH Practice Support Model
- MAPCP project ends in Sept. 2014, with possibility of a federal extension till December with evaluation in 2015

State Health Plan's PCMH Program Purpose

Engage & collaborate with physicians to enhance the delivery of comprehensive, high quality, multi-disciplinary, patient-centered medical care within a primary care setting utilizing timely data; measured through quality, efficiency and member satisfaction.

2014 NC PCMH Practice Support Pilot

Scott Money

2014 PCMH Practice Support Model

Evolving Model Design

Integrated, Member-Centric Care Management Model, with Physician Leadership

Enhance provider engagement with SHP members to support PCMH program across the state to improve member experience, health outcomes and reduce costs

- Explore various PCMH Fee for Service (FFS) and Pay for Performance (P4P) payment models that support the PCMH clinical model and service features
- Explore integrated practice/care management workflows
- Assist practices with transformation and PCMH recognition
- Develop case management model with embedded care managers
- Develop performance measures for care management services
- Target 'Triple Aim'

2014 PCMH Practice Support Model

PCMH Collaboration Model

NC State Health Plan PCMH Program

ActiveHealth

- Member Stratification/ Identification
- Onsite Care Management
- Onsite Health Coaching
- Data Integration
- Provider Integration
- Data Analysis
- Program Evaluation

Participating Practices

- Patient Referrals/ Engagement
- Coordination of Care
- Quality Measures/ Care Alerts
- Care Plan Follow Up

Collaboration

BCBSNC ESI Quest/Solstas Labcorp NCHA Value Options Fresenius ESMMWL BenefitFocus BEACON

2014 PCMH Practice Support Model

Practice Identification Criteria

- **Population Demographics**
  - Attributed Members in County/Region
  - Attributed Members in Practice
- **Practice Demographics**
  - NCQA PCMH Recognition
  - Rural and Urban locations
  - Connection to Health System
  - Use of Electronic Medical Records (EMR) and Health Information Exchanges (HIE)
- **Clinical Demographics**
  - % of Attributed Members Targeted for Programs
  - Top Conditions
  - High Cost Utilizers
  - Care Alerts and QMs Attributed to Practice
  - Admissions/30 Day Re-admissions/ER Visits
  - Polypharmacy
  - Healthcare Costs

PCMH Practices & Locations

ActiveHealth (AHM) has spoken with all practices

Practices SHP and AHM have met with already

PCMH Practice Model

Practice Analysis – Practice Considerations

Information	Practice		
	Sylva Medical Center	Vidant Health	CaroMont Health
Practice National Provider Identifier (NPI)	1982831574	Multiple	Multiple
Health System	YES	YES	YES
NCQA PCMH	NO	NO	YES
Region	West	East	West
State Health Plan Patients attributed	549	3538	1781
% SHP Members in County	15.80%	19.99%	3.98%
Disease Mgmt Targeted/% of Total Pop	256 / 46.60%	1548 / 43.75%	644 / 36.16%
Case Mgmt Targeted/% of Total Pop	5 / .90%	53 / 1.49%	13 / 0.73%
Lifestyle Coaching Targeted/% of Total Pop	170 / 30.96%	1027 / 29.02%	431 / 24.20%
Average Cost per member	$3,140.46	$3,309.35	$2,839.63
Average Cost per member (medical and rx)	$4,119.62	$4,339.66	$3,670.78

Information	Practice		
	Eagle Family Physicians	New Hanover Medical Group	Physicians East
Practice National Provider Identifier (NPI)	Multiple	Multiple	1598761967
Health System	YES	YES	YES
NCQA PCMH	NO	YES	NO
Region	West	East	East
State Health Plan Patients attributed	5056	1506	3700
% SHP Members in County	19.62%	13.61%	20.90%
Disease Mgmt Targeted/% of Total Pop	1794 / 35.48%	636 / 42.23%	1834 / 49.57%
Case Mgmt Targeted/% of Total Pop	88 / 1.74%	19 / 1.26%	75 / 2.02%
Lifestyle Coaching Targeted/% of Total Pop	1067 / 21.10%	452 / 30.01%	1189 / 32.13%
Average Cost per member	$2,535.60	$3,336.93	$4,149.82
Average Cost per member (medical and rx)	$3,419.91	$4,343.43	$5,477.62

PCMH Practice Model

Practice Analysis – Practice Considerations (continued)

Information	Practice		
	Wilmington Health Associates	Cornerstone Health System	Novant Health (Forsyth Only)
Practice National Provider Identifier (NPI)	Multiple	Multiple	Multiple
Health System	YES	YES	YES
NCQA PCMH	NO	YES	YES
Region	East	West	West
State Health Plan Patients attributed	3599	2685	8031
% SHP Members in County	32.52%	0.75%	51.76%
Disease Mgmt Targeted/% of Total Pop	1249 / 34.70%	735 / 27.37%	2439 / 30.37%
Case Mgmt Targeted/% of Total Pop	49 / 1.36%	30 / 1.11%	82 / 1.02%
Lifestyle Coaching Targeted/% of Total Pop	876 / 24.34%	468 / 17.43%	1377 / 17.15%
Average Cost per member	$2,935.14	$2,697.97	$2,999.69
Average Cost per member (medical and rx)	$3,980.30	$3,493.15	$3,790.05

ActiveHealth MANAGEMENT.

PCMH Practice Model

Initial Understanding of Practice Payment Models

	Pure FFS	FFS – PCMH	FFS- P4P	FFS - Bundled Payments	Integrated FFS Model	ACOs	Pure Capitation
Meetings Held with SHP	Sylva Medical Center; Eagle Family Physicians	Vidant Health	CaroMont Health				
Meetings To Be Held		New Hanover Medical Group; Physicians East				Cornerstone Health	

ActiveHealth (AHM) has spoken with all 9 practices

Sylva Medical Center

Practice Accomplishments

- Live with integrated workflows 1/1/2014
- Care Manager embedded in practice
- Mailed postcard announcement to SHP members in Sylva
- Physician referrals into NC Health*Smart* programs
- Sharing patient care plans between Embedded Care Manager and physicians
- Weekly huddles with practice staff to close care gaps and address quality measures
- Partnering with Eat Smart, Move More, Weigh Less (ESMMWL) to offer onsite course(s) for Sylva members

2014 PCMH Practice Support Model

Data Enhancements

NC Hospital Association (NCHA)

- 100% of NC Hospitals Connected
  - Standard admission/discharge data in daily flat file
  - Enhancements to HL7* format on NCHA roadmap
- Data is real-time
  - NCHA uses state ER/Hospital surveillance systems
  - Ability to transmit in real-time, or 1-3 times daily
  - ActiveHealth to receive via file transfer protocol (FTP) once daily for Transition of Care efforts

NC HIEs

- Building relationships with State Health Information Exchanges (HIEs)
  - We will pursue more connectivity via NC HIEs once HIE connectivity is established with physician electronic medical records (EMRs)

***Health Level 7** is an international community of healthcare subject matter experts and information scientists collaborating to create standards for the exchange, management and integration of electronic healthcare information.

2014 PCMH Practice Support Model

AHRQ Evaluation Methodology: Triple Aim

Component*	Services
Experience	▪ Combine AHM member and provider surveys with CAHPS survey ▪ Administer new PCMH/CAHPS survey to members and providers
Quality	▪ Determine care management and practice operational measures to measure quality of care, i.e. use of ACTS, care alerts ▪ Determine PCMH specific clinical outcomes to measure against HEDIS standards
Cost	▪ Determine specific utilization measures that drive cost, i.e., inpatient admits/readmits and ER Visits ▪ Study cost trends for PCMH eligible population vs. non PCMH eligible population

* Based on Agency on Healthcare Research and Quality (AHRQ) Recommendations

PCMH Practice Model

Evaluation Methodology

- Modeled After the Agency for Healthcare Research and Quality (AHRQ) Guidelines
  - Evaluations of the medical home should measure three outcomes:
    - Quality, cost, and experience
- Study Design
  - Propensity matched comparison study
    - Individual matching practices will be selected based on specialty, practice size, patient volume, and demographics for comparison to each participating practice
  - Pre-post evaluation
    - A comparison of various measures will be conducted from baseline to follow-up
- Potential Measures
  - 2014 clinical measures
  - Utilization measures
  - Member and provider satisfaction
  - Operational measures
- Validation
  - Exploring validation of evaluation methodology by 3rd party

PCMH Practice Model Metrics

Clinical Measures

- Asthma
  - Use of Appropriate Medications
  - Medication Management for People with Asthma
- Congestive Heart Failure
  - Readmission Rate
  - Use of ACEi/ARB
  - Use of β-blocker
- Chronic Obstructive Pulmonary Disease
  - Use of Spirometry
  - Pharmacology of Exacerbation – Systemic Steroids
  - Pharmacology of Exacerbation - Bronchodilator
- Diabetes
  - HbA1c Monitoring
  - LDL Monitoring
  - Nephropathy Monitoring/Treatment
- Cancer Screening
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Colorectal Cancer Screening
- Well Care
  - Preventive or ambulatory care visit during reporting period (≥ 20 yrs of age)

Utilization Measures

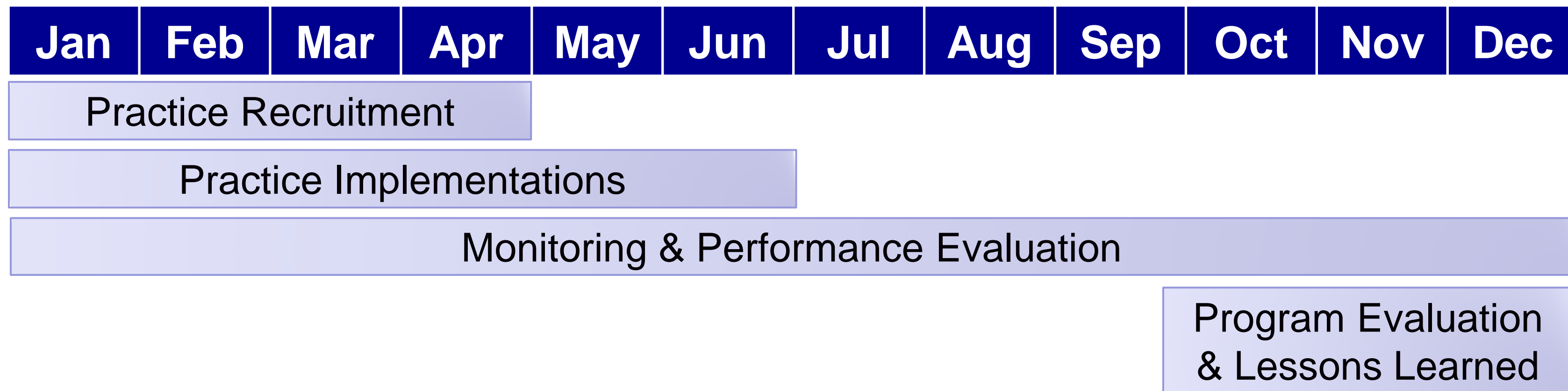
- All Cause Readmissions
- All Cause Admissions
- IP Admissions/1000
- ER Visits/1000
- PCP Preventive Care Visits/1000
- PCP Medical Care Visits/1000

Performance Metrics

- Engagement
- Transition of Care
  - Medication Reconciliation
  - Post Discharge Planning
  - Facility based planning
- Member Satisfaction
- Provider Satisfaction

2014 PCMH Practice Support Model

Timeline



In Conclusion

- Patient Centered Medical Homes continue to be the most appropriate strategy, in the short term, to influence quality, experience and cost
  - Considerable evidence on success of PCMH in delivering outcomes
- 2014-2015 are exploratory years as the Plan defines and develops the role of the payer in supporting PCMH practices
  - Data and quality improvement support
  - Care coordination and management support
  - Ancillary services such as Quitline (tobacco cessation) and ESMMWL (weight loss program)
  - Alternate payment strategies including pay for performance
- The Plan is taking a staged approach identifying practices of varying levels of capacity and experience

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Comparative Analysis of State Health Plans

Board of Trustees Meeting

March 28, 2014

A Division of the Department of State Treasurer

Presentation Overview

- Executive Summary
- Selected States for Comparison
- Comparative Analysis Methodology
- Comparative Analysis
- Key Initiatives in Other States
- Emerging Conclusions

Executive Summary

Purpose

- As part of the Strategic Planning process, the Strategic Planning Workgroup and Board of Trustees requested an environmental scan of state health plans in other states to compare the North Carolina State Health Plan

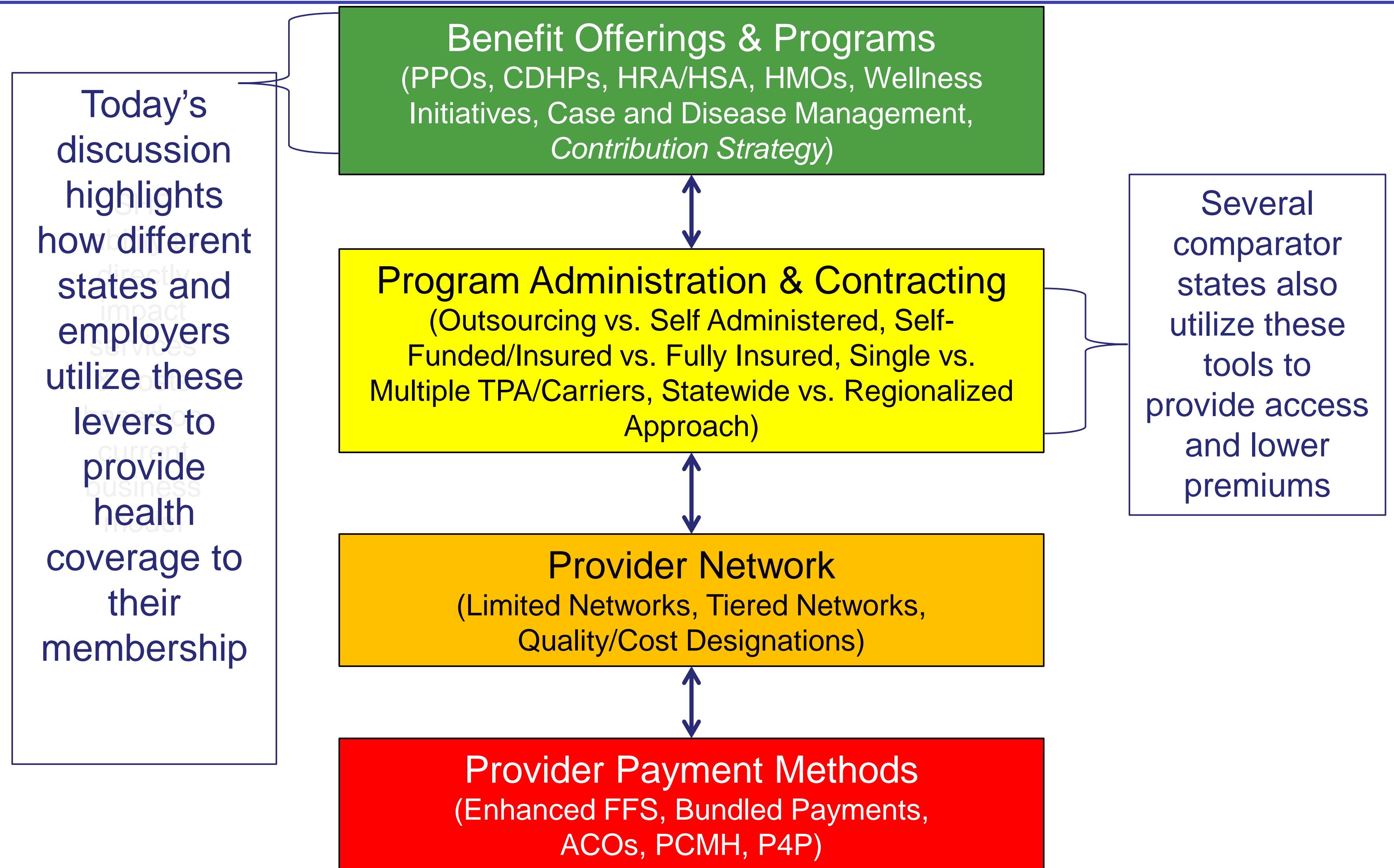
Approach

- The Plan investigated the following factors:
  - Plan richness (analysis by Segal)
  - Premium cost sharing (analysis by Segal)
  - Healthy lifestyle benefits
  - Number of coverage choices

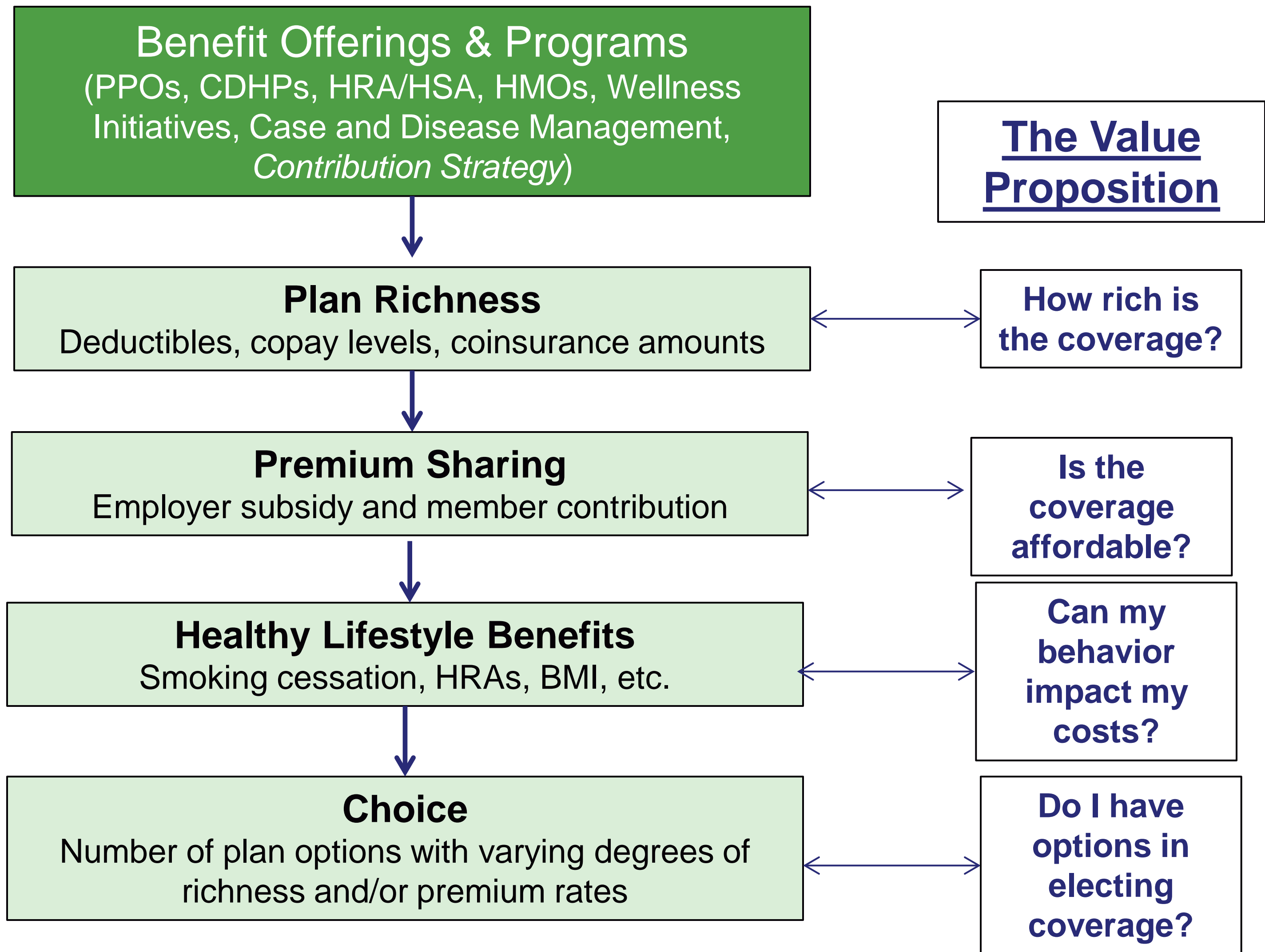
Key Findings (*related to other state health plans*)

- Comparatively, the Plan provides employees/retirees generous and affordable health benefits. However, coverage for dependents does not compare favorably
- Healthy lifestyle benefits are becoming more common among state health plans
  - The $40/$50 monthly premium credit is in the middle in terms of amounts at stake
  - Tobacco cessation benefits are the most popular among state plans who utilize healthy lifestyle credits
- Most states provide health coverage to their members in at least one significantly different manner than the Plan but there isn't uniformity in the differences
  - Dependents are directly subsidized

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



Value Proposition to Members and Points of Comparison



Selected Comparator States

Comparator States
(lowest and highest premium offerings)

Based on proximity to NC
- Georgia
- Kentucky
- Tennessee
- South Carolina
- Virginia

Based on size of state population and other factors
- Arizona
- Maryland
- Michigan
  - Included pre and post 2010 designs
- Ohio
- Wisconsin

Case studies

Financing premiums
- Illinois
- Wisconsin

Plan design
- Tennessee
- Kentucky

Healthy lifestyle benefits
- Connecticut
- Utah

Comparing Health Benefits

- **Step One: How much does the average person pay out-of-pocket when they utilize their benefit?**
  - Comparing the actuarial value, or plan value, of each state's offerings provides a method to understand the average portion of claims a benefit design would pay for:
    - deductible,
    - coinsurance,
    - out-of-pocket maximums,
    - copays, and
    - out-of-network benefits (some states offer closed network plans)
  - As many individuals make their benefit design election based on premium cost, we looked at the highest and lowest premium offerings available in the comparison states and benchmarked them against the 80/20 plan
  - For NC the CDHP and 70/30 plans were included in the analysis

Out-of-Pocket Comparison

In-network Plan Benefits[1]	NC	GA	KY	SC	TN	VA
Deductible • Single • Family	$700 to 1,500 $2,100 to 4,500	$1,500 to 2,500 $3,000 to 5,000	$500 to 1,750 $2,500 to 3,500	$250 to 3,600 $500 to 7,200	$450 to 800 $1,150 to 2,050	$225 to 1,750 $450 to 3,500
Co-insurance	70% to 85%	75% to 80%	70% to 80%	80% to 85%	80% to 90%	80%
Maximum[2] • Single • Family • Rx	$3,000 to 3,793 $9,000 to 11,379 Separate/Include	$4,000 to 6,000 $8,000 to 12,000 Include	$2,500 to 3,500 $5,000 to 7,000 Separate/Include	$2,000 to 6,000 $4,000 to 12,000 Included	$1,550 to 1,900 $4,000 to 5,000 Separate	$1,500 to 5,000 $3,000 to 10,000 Separate/Include
Office • PCP • SCP	$30 to ded/coin $70 to ded/coin	Ded/coin Ded/coin	$25 to ded/coin $45 to ded/coin	$15 to ded/coin $45 to ded/coin	$25 to 30 $45 to 50	$25 to ded/coin $40 to ded/coin
Inpatient Surgery	$233, ded/coin to ded/coin	Ded/coin	Ded/coin	$200 to ded/coin	Ded/coin	$300 to ded/coins
Rx • Tier 1 • Tier 2 • Tier 3	$12 to ded/coin $40 to ded/coin $64 to ded/coin	Ded/coin Ded/coin Ded/coin	$10 to ded/coin $35 to ded/coin $55 to ded/coin	$4 to ded/coin $40 to ded/coin $80 to ded/coin	$5 to 10 $35 to 45 $85 to 95	$15 to ded/coin $25 to ded/coin $50 to ded/coin

1. Ded/coin = subject to deductible and coinsurance
2. NC uses coinsurance maximums on two plans, all other plans are out-of-pocket maximums

Out-of-Pocket Comparison (*continued*)

In-network Plan Benefits[1]	NC	AZ	MD	MI	OH	WI
Deductible • Single • Family	 $700 to 1,500 $2,100 to 4,500	 $500 to 1,250 $1,000 to 2,500	 $0 $0	 $0 to 400 $0 to 800	 $200 $400	 $0 to 200 $0 to 400
Co-insurance	70% to 85%	90% to 100%	100%	90% to 100%	80%	90%
Maximum[2] • Single • Family • Rx	 $3,000 to 3,793 $9,000 to 11,379 Separate/Include	 $1,000 to 2,000 $2,000 to 4,000 Include	 $1,000 $2,000 Separate	 N/A to $1,500 N/A to $3,000 Include	 $1,500 $3,000 Include	 $500 to 800 $1,000 to 1,600 Separate/Include
Office • PCP • SCP	 $30 to ded/coin $70 to ded/coin	 $15 to Ded/coin $15 to Ded/coin	 $15 $25	 $10 to 20 $10 to 20	 $20 $20	 Ded/coin Ded/coin
Inpatient Surgery	$233, ded/coin to ded/coin	$150	$0	$0 to ded/coin	Ded/coin	Ded/coin
Rx • Tier 1 • Tier 2 • Tier 3	 $12 to ded/coin $40 to ded/coin $64 to ded/coin	 $10 $20 $40	 $5 $15 $25	 $5 to 10 $10 to 30 $10 to 60	 $10 $25 $50	 $5 $15 $50

1. Ded/coin = subject to deductible and coinsurance
2. SHP uses coinsurance maximums on two plans, all other plans are out-of-pocket maximums

Relative Values of the Benefits

State Name	Value of Plan Relative to 80/20
SC	0.9312
NC (70/30)	**0.9499**
GA	0.9655
SC	0.9796
NC (80/20)	**1.0000**
VA	1.0472
NC (CDHP)	**1.0652**
Kentucky	1.0825
TN	1.0995
Kentucky	1.1053
VA	1.1261
GA	1.1292
TN	1.1685

- The higher the relative value, the richer the benefit package as compared to the 80/20 plan for the average person utilizing the benefit
  - Generally, higher value plans have lower deductibles, lower copays/coinsurance, lower out-of-pocket maximums, etc.
  - Values are based on multiple scenarios and should not be construed to reflect every person's medical experience
    - Particularly true for very low and very high utilizing members

Relative Plan Richness Comparison

Relative Plan Value

Segal Company – March 2014

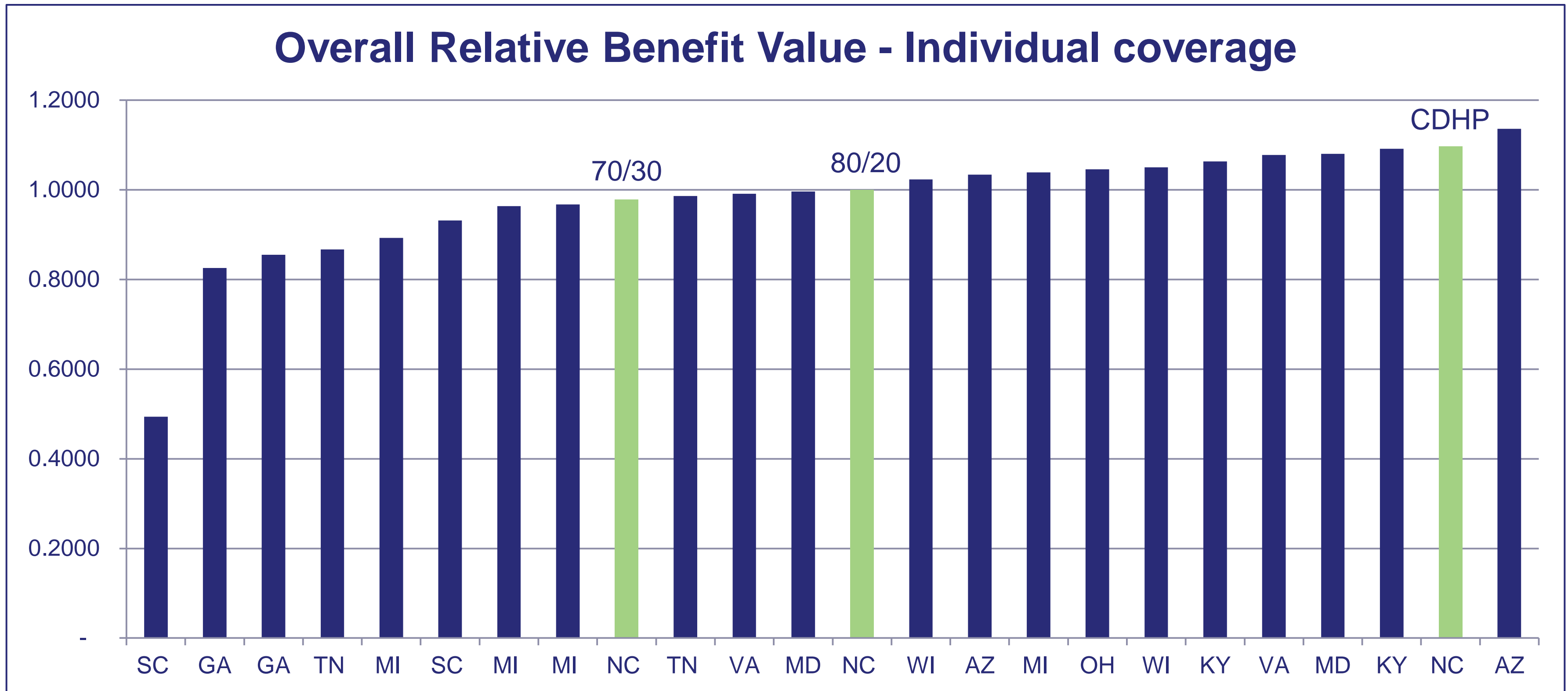
The State Health Plan's options are in the lower half of states in terms of relative plan value, which does not include premium contributions

Incorporating Member Premiums

- **Step Two: How do you incorporate member premiums?**
  - In addition to determining the value of the benefit, which represents the out-of-pocket exposure, the analysis included the individual's premium share to reflect average person's total cost exposure
    - The percentage of premium paid for by each state for each plan combined with relative plan value determined the overall relative value of the benefit offering

- **Caveat:**
  - Plan values are proxies for the anticipated average portion claims that the benefit would cover; the actual experience of low and high utilizers will create varying results

Plan Richness and Premium Cost Comparison – Individual Coverage



Segal Company – March 2014

When the analysis includes premium contributions, the State Health Plan's offerings provide a higher level of value than based solely on plan richness

- NC provides 100% of employee only premiums for two plans and a comparatively low premium for the 80/20
- CDHP moves near the top in terms of overall value, and the 80/20 and 70/30 plans move toward the middle

Plan Richness and Premium Cost Comparison – Family Coverage

Segal Company – March 2014

Historically, NC has not provided direct subsidies for dependent coverage while the median family subsidy of benchmarked states was 81% of total family premium

- NC contributes between 40% and 47% of the cost of family premiums (through the State's employer contribution)

Trends in Comparative Analysis

Coverage Level	States ranked less favorable	States ranked more favorable
Individual	• Lower employer subsidy • Higher out-of-pocket costs • Higher coinsurance percentage for employees	• Lower deductibles • Use of closed networks • Out-of-pocket maximum versus coinsurance maximums • More favorable mail order differential in Rx (2x copay versus 3x copay)
Family	• Higher premiums • Less generous coverage	• **Dependent subsidies** • Lower deductibles • Use of closed networks • Out-of-pocket maximum versus coinsurance maximums • More favorable mail order differential in Rx (2x copay versus 3x copay)

Financing Health Benefits

- Each state government finances health coverage for their membership differently
  - Most states provide direct subsidies for dependent coverage
    - Fixed subsidy by tier or dependent
    - Percentage of premium
  - Some states have collective bargaining that impacts decision making

- NC's contribution strategy differs from most other states
  - Significant changes could potentially impact expected Plan costs and the long-term sustainability of the Plan
    - Positively or negatively

Healthy Lifestyle Benefits Comparison

- State health plans are beginning to incorporate healthy life benefits into their plan design to address the growing cost of health care and to increase member engagement
- 60% of comparator states had at least one healthy living benefit in place
  - Two states (KY and TN) require healthy action steps to enroll in the most generous benefit offerings
  - 50% of states utilize Health Assessments (HA) or Well Being Assessments (WBA) as part of their healthy lifestyle benefit
  - Healthy lifestyle benefits range from $17 to $80 per month
  - Georgia provides up to $480 in Health Reimbursement Account (HRA) contributions for completing all healthy action steps

Healthy Lifestyle Benefit Grid

	NC	GA	SC	KY	TN	VA	AZ	MD	MI	OH	WI
Smoking Credit	$20 monthly	$80	$40 monthly	$40 monthly	No	No	No	No	No	No	No
HA/WBA	$10 monthly	HRA ($)	No	Yes	Yes	$17 monthly	No	No	No	$50	No
PCP	$10 monthly	No	No	No	No	No	No	No	No	No	No
Biometric screening	No	HRA ($)	No	No	Yes	$17 monthly	No	No	No	$75	No
Activities/ Coaching	No	HRA ($)	No	Yes	Yes	No	No	No	No	$200	No
Enrollment	No	No	No	Yes	Yes	No	No	No	No	No	No

Providing Member Choice

- States take unique approaches to designing their health offerings. Approaches include:
  - Multiple vendors
    - Statewide or regional
      - 60% of comparator states utilize more than one TPA/carrier in their active population
  - Number of offerings
    - The average state had three offerings for actives, with Maryland having the most with eight and Ohio having the least with one
  - Differentiation in offerings
    - Members have unique coverage and price sensitivities

Employee Choice by State

State	Number of Offerings	Multiple TPA/Carriers	Regional Offerings or Rates
NC	Three	No	No
GA	Three	No	No
SC	Three	No	No
KY	Four	No	No
TN	Three	Yes	Yes
VA	Four	Yes	No
AZ	Three	Yes	No
MD	Eight	Yes	No
MI	Two	Yes	Yes
OH	One	Yes	No
WI	Two	Yes	Yes

Innovative Health Care Financing Solutions: Illinois

- Premiums vary by employee salary (dependent premiums do not):

Annual Salary	Employee Monthly Health Contributions	
$30,200 & below	Managed Care: $68.00	Quality Care: $93.00
$30,201 - $45,600	Managed Care: $86.00	Quality Care: $111.00
$45,601 - $60,700	Managed Care: $103.00	Quality Care: $127.00
$60,701 - $75,900	Managed Care: $119.00	Quality Care: $144.00
$75,901 - $100,000	Managed Care: $137.00	Quality Care: $162.00
$100,001 & above	Managed Care: $186.00	Quality Care: $211.00

- Deductibles vary by employee salary:

Employee's Annual Salary	Member Plan Year Deductible	Family Plan Year Deductible Cap
$60,700 or less	$350	$875
$60,701 - $75,900	$450	$1,125
$75,901 and above	$500	$1,250

Innovative Health Care Financing Solutions: Wisconsin

Tier	Individual Premium	Family Premium
Tier One	$88.00	$219.00
Tier Two	$129.00	$324.00
Tier Three	$239.00	$596.00

- Wisconsin utilizes regional HMO offerings and one plan option that is available throughout the state
- In theory, plans are tiered based on their efficiency and quality of care
  - In practice, all HMOs are in tier one and the statewide plan is tier three

Innovative Plan Design Solutions: Tennessee and Kentucky

Tennessee

- Offers employees two plan offerings through two TPAs/carriers with regional rates
- To enroll in the lower premium, more comprehensive offering members must complete Well Being Assessment (WBA) and a biometric screening
  - In coming years members will have additional action steps in place

Kentucky

- Offers employees four plan offerings
- To enroll in the two most generous offerings members must complete a Health Assessment, keep contact information current, and complete healthy activities
- Separate smoker credit for all four plans

Innovative Healthy Lifestyle Programs: Connecticut

- The State of Connecticut provides members with a Health Enhancement Program (HEP)
  - Members who participate receive:
    - Reduced monthly premiums
    - Eliminated in-network deductible
    - If members have one of five chronic conditions they additionally receive
      - Waived copays for visits related to the condition
      - Reduced copays for related drugs
      - Mandatory disease education and counseling programs
  - Members enrolled in HEP must participate in age appropriate wellness and diagnostic screenings and receive one dental cleaning per year

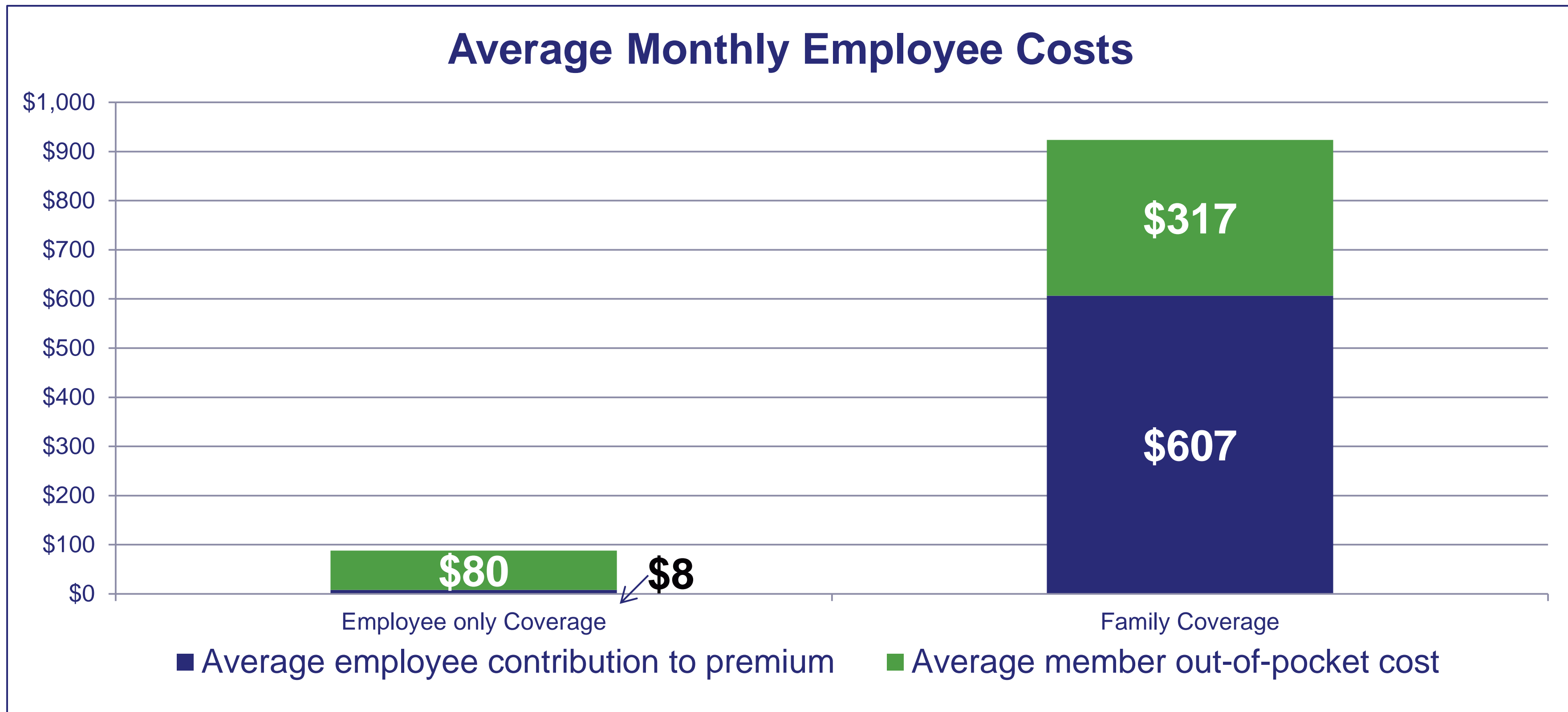
Innovative Healthy Lifestyle Programs: Utah

- The Utah State Employee Health Plan provides employees the opportunity to earn rebates for the completion of wellness activities and working to improve their chronic conditions
- Employees can earn rebates for:
  - Biometric screening
  - Blood pressure improvement
  - BMI improvement
  - Diabetes management
  - Health assessment
  - Lipid management

Emerging Conclusions

- If you've seen one state health plan, you've seen one state health plan
- States are addressing the four value propositions differently but some key themes include:
  - Direct subsidies for dependents but higher individual premiums
  - Moving toward utilization of healthy lifestyle credits
  - States are adding consumer directed offerings or higher deductible offerings
- Several states utilize multiple TPA/carriers to offer coverage, however, Georgia just reduced their partners to one
- Based on relatively fixed funding, changing any aspect of a health plan will have a direct impact on other levers
  - Increasing benefit richness would increase member premiums
  - Reducing dependent premiums would increase individual premiums

The Current Structure of SHP Benefits



1. Average employee premium based on January 2014 enrollment in all plans and actual wellness credits completed for actives only
2. Average family premium based on CY 2013 Segal Dashboard and active family size of 3.96 members (January 2014 enrollment figure) for actives only

Manipulating the Levers of SHP Contribution Structure

Assuming the annual subsidy strategy from the General Assembly doesn't change

- Increasing plan richness
  - Reduces OOP cost sharing
  - Increases employee contributions
- Reducing plan richness
  - Increases OOP cost sharing
  - Reduces employee contributions
- Using employee only dollars on dependent coverage
  - Increases employee only premiums
  - Creates budget uncertainty in near-term
- Increasing healthy lifestyle credits
  - Reduces employee premiums for some members
  - Increases employee premiums for some members

Next Steps/Questions

- Where should the Plan be positioned in three years? Five years?
- Where should changes be considered to improve the value proposition to members?
- In the likely absence of new funds from the General Assembly what can be impacted?
  - Based on state budget constraints it is not realistic to expect a fundamental change in how the Plan is funded
    - Competing interests for General Fund dollars
    - Any requests and changes would have to be part of a longer-term, multiple step approach
    - Employee only contributions would need to increase to subsidize dependent coverage tiers
  - Does it make sense to reduce individual benefits to increase dependent subsidies?
- How can alternative payment strategies be incorporated to free up additional resources for increasing the value proposition?
- How does moving toward a PCMH approach that focuses on improving member health fit in with these strategic questions?

Appendix

Comparative Analysis Methodology

Step one

- Plan staff and Segal discussed relevant states to use in comparative analysis
- Plan staff compiled benefit design components such as deductibles, copays, coinsurance for both individual/family coverage and in-network/out-of-network benefits
  - Premium contributions were also collected

Step two

- Segal ran the data inputs through their rate manual to develop expected costs of the benefit on PMPM basis
  - A rate manual is a tool that actuaries use to assign PMPMs based on underwriting guidelines and projected utilization
  - The expected costs are purely meant to compare benefit design values only and do not reflect expected utilization changes of different plan designs, geographic factors, age, etc.

Comparative Analysis Methodology

Step three

- The resulting PMPM costs were compared to the 80/20 plan to develop relative values
  - Benefit designs with a relative value greater than 1.0 are projected, on average, to pay for more covered services than the 80/20 plan; conversely plan designs with a relative value less than 1.0 are, on average, projected to pay less for covered services than the 80/20 plan
  - Example: Based on benefit design, the State of Arizona's PPO offering's relative value is 1.2142, or projected to be 21.142% more rich than the 80/20

Step four

- Employer share of premium was multiplied by relative value to create effective/adjusted relative value
  - The employer share of premium was calculated; employee share divided by total premium
  - Example: Arizona pays 83.246% of employee only premium; therefore the adjusted relative value is 1.0041 (.83246 x 1.2142)
    - Values may not equal due to rounding

Comparative Analysis Methodology

Step five

- Adjusted Relative Value were re-normalized to compare each plan's adjusted relative value to the Plan's 80/20 adjusted relative value
  - Example:
    - (Arizona PPO's Adjusted Value = 1.0041) divided by (80/20 Adjusted Value = 0.9714 (1.00 Relative Value x 97% Premium Share))
    - Arizona PPO's Adjusted Relative Value = 1.0337

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Multi-Year Financial Model

Board of Trustees Meeting

March 28, 2014

A Division of the Department of State Treasurer

Presentation Overview

Background

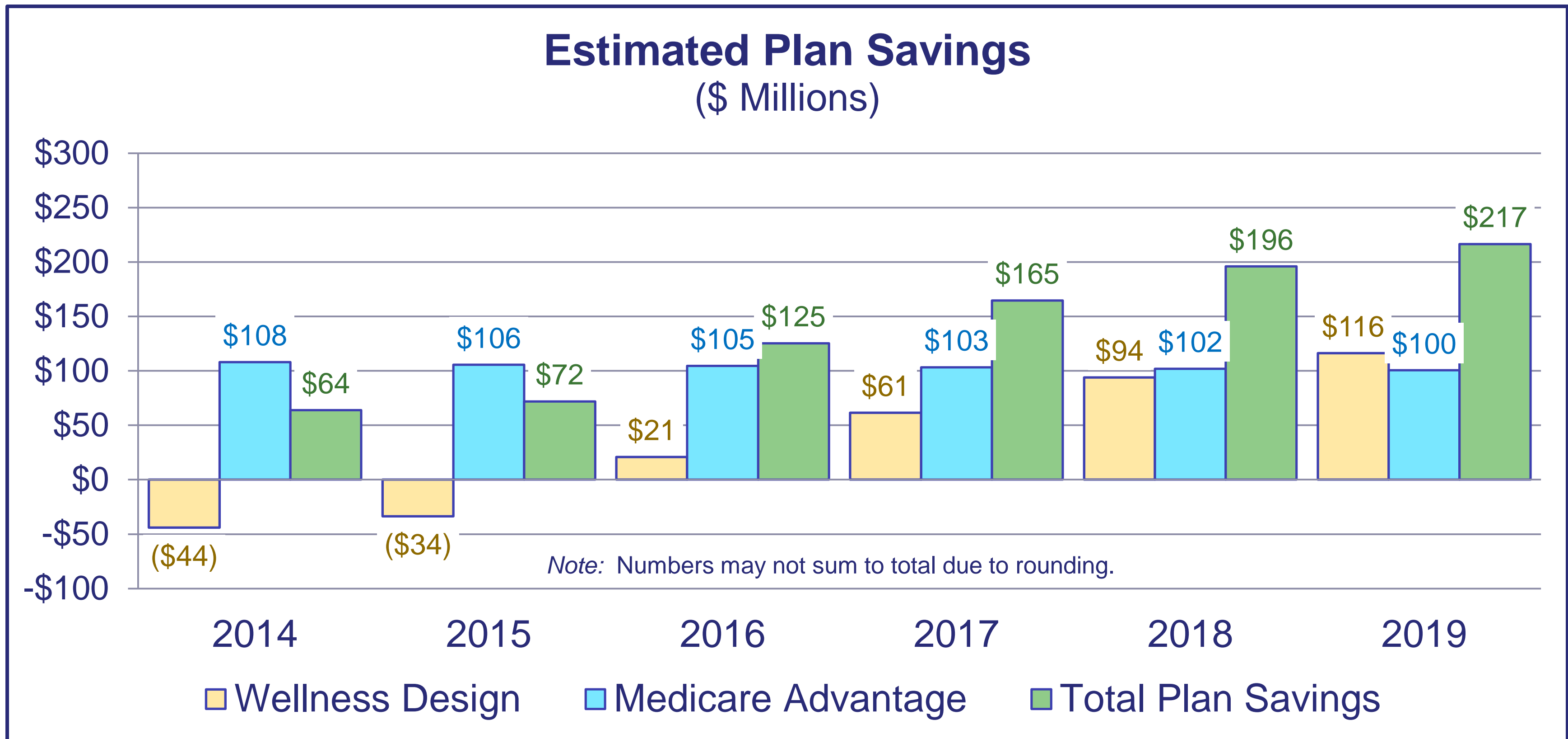
The multi-year financial model will be used as a scenario planning tool in support of the strategic plan development, specifically to support the development of goals.

Agenda

- Progress to Date/Current Status
- Scenario Modeling
  - Review Updated Forecast Based on 2014 Benefit Changes
  - Scenario 1: Smoothed Premium Increases
  - Scenario 2: Reduce Base Premium Increases
  - Scenario 3: Reduce Long-Term Trend

Progress to Date: Impact of 2014 Benefit Options

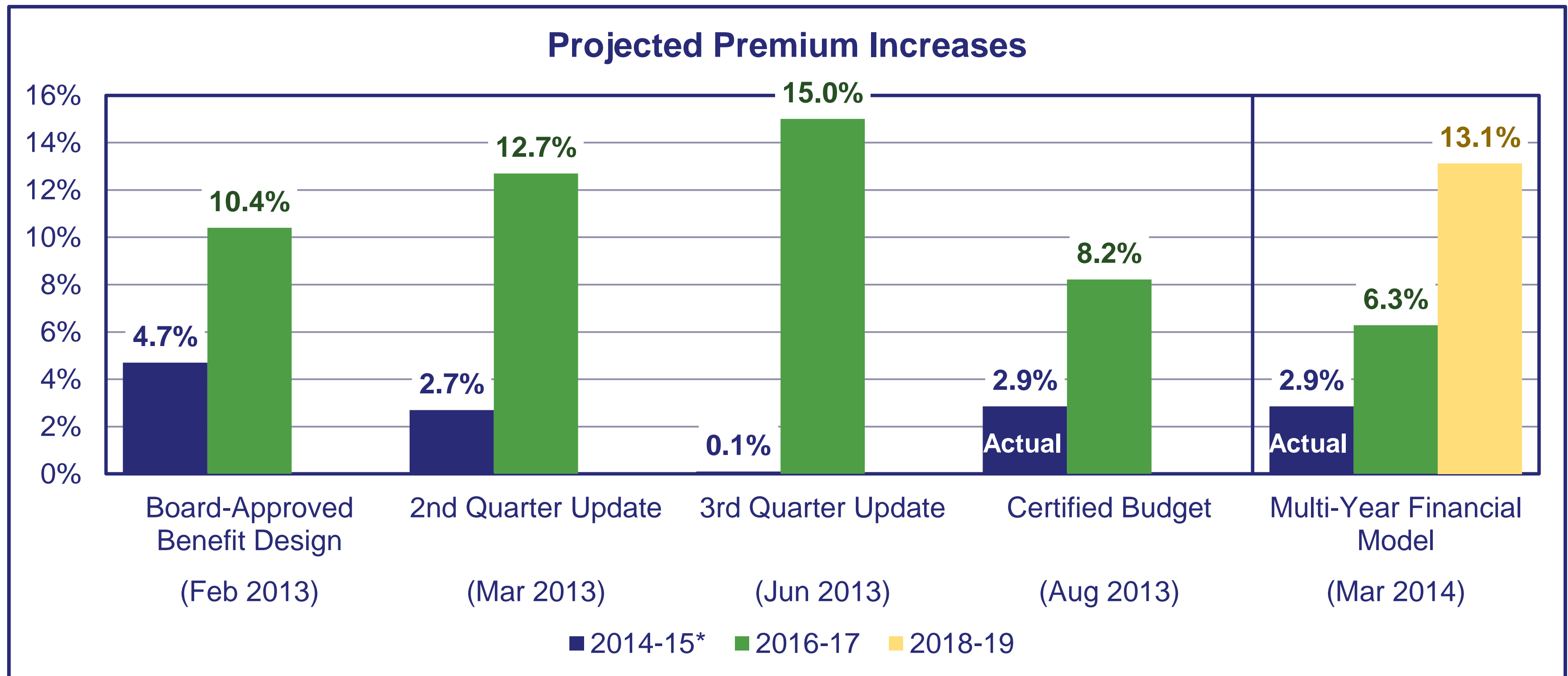
- Implementing 2014 benefit options and wellness initiatives is expected to result in a net savings to the Plan of approximately $839 million from 2014 to 2019



Savings estimates based on Multi-Year Financial Model produced by Segal. The model incorporates results from the Fall 2013 open enrollment into the 2nd quarter update.

Progress to Date: Premium Increases

- The Plan has outperformed projections in recent years, resulting in a higher cash balance and reduced estimates of premium increases in the near-term
- Based on current modeling assumptions, premium increases are estimated at 6.3% for 2016 and 2017 and 13.1% for 2018 and 2019



*2.9% premium increases in Certified Budget and Multi-Year Financial Model represent average increases for January 2014 (3.57%) and 2015 (2.14%).

Current Status: Forecast Through 2019

	Estimates for CY 2014-2015		Estimates for CY 2016-2017		Estimates for CY 2018-2019	
Forecast Model	**PMPM Spending**	**12/31/15 Cash Balance**	**Annual Premium Increases**	**PMPM Spending**	**Annual Premium Increases**	**PMPM Spending**
Certified Budget	$383.94	$527 m	8.22%	$447.34	Not Estimated	Not Estimated
2nd Quarter Update	$380.22	$714 m	5.55%	$443.41	13.81%	$518.97
Multi-Year Model: Q2 Update with Open Enrollment Results	$381.35	$687 m	6.28%	$444.49	13.12%	$519.56

Scenario Planning

Building scenarios through the Multi-Year Financial Model will guide the Board and SHP leadership team in answering the following ***Key Questions:***

- Should the SHP establish financial goals as part of the strategic plan? Establish financial guardrails or parameters?
- If yes, what should be the SHP's primary financial goal?
  - Maintain stability in annual premium increases
  - Constrain annual increases in premiums
  - Constrain PMPM expense trends
  - Something else/other
- Who is the targeted beneficiary of the financial goal?
  - State/taxpayers
  - State Health Plan
  - Members

These questions will not be answered today but should be kept in mind as the scenarios are reviewed.

Scenario 1: Stabilize Premium Rate Increases

	Estimates for CY 2014-2015		Estimates for CY 2016-2017		Estimates for CY 2018-2019	
Forecast Model	**PMPM Spending**	**12/31/15 Cash Balance**	**Annual Premium Increases**	**PMPM Spending**	**Annual Premium Increases**	**PMPM Spending**
Multi-Year Financial Model	$381.35	$687 m	6.28%	$444.49	13.12%	$519.56
Scenario 1: Smoothed Premium Increases	$381.35	$687 m	**8.40%**	$444.49	**8.40%**	$519.56

- Scenario 1 requires annual premium increases of 8.4% each January from 2016 to 2019 to balance to the Target Stabilization Reserve by December 2019
- Near-term premium increases would be higher and long-term premium increases would be lower
- Smoothing out premium increases does **not** affect the Plan's PMPM spending (i.e. estimated medical/pharmacy claims or administrative costs)

Potential Consideration/Action: Work with Legislature to secure additional employer funds for the short-term – and approve higher short-term premium rates – in order to maintain a cash balance that can be spent down over a longer timeline

Scenario 2: Reduce Premium Rate Increases

	Estimates for CY 2016-2017			Estimates for CY 2018-2019		
Forecast Model	**Annual Premium Increases**	**2016 PMPM Spending**	**2017 PMPM Spending**	**Annual Premium Increases**	**2018 PMPM Spending**	**2019 PMPM Spending**
Scenario 1	8.40%	$429.20	$459.84	8.40%	$502.91	$536.27
Scenario 2: Reduce Base Premium Rate Increases	**7.40%**	$424.92	$451.25	**7.40%**	$489.98	$518.96

- Scenario 2 reduces the four-year base premium increase of 8.4% by 1 percentage point
- Reducing annual premium increases would require the Plan to decrease spending (modeled in PMPM Spending numbers above)
  - ***or*** bring in additional revenue from sources not tied to base premium increases

Potential Consideration/Action: A decrease of $342.4 million in total projected Plan spending would need to be achieved between now and the start of 2020 to achieve the reduction in premium rate increases. Initiatives and programs that will result in reduced costs would have to be implemented to achieve the goal.

Scenario 3: Reduce Long-Term Trend

	Estimates for CY 2016-2017			Estimates for CY 2018-2019		
Forecast Model	**Annual Premium Increases**	**2016 PMPM Spending**	**2017 PMPM Spending**	**Annual Premium Increases**	**2018 PMPM Spending**	**2019 PMPM Spending**
Scenario 1	8.40%	$429.20	$459.84	8.40%	$502.91	$536.27
Scenario 3: Reduce Long-Term Trend	7.98%	$429.20	$459.84	7.98%	**$498.06**	**$523.36**

- Scenario 3 reduces trend from 8.5% to 7.5% in 2018 and to 7.0% in 2019
- With the reduced trend assumptions, annual premium increases decrease to 7.98%
- Successfully reducing trend has the potential for significant long-term savings

Potential Consideration/Action: Reduce projected spending by $38.7 million in 2018 and by $102.1 million in 2019. Initiatives and programs that will result in reduced costs would have to be implemented to achieve the goal.

Next Steps: Potential Actions to Achieve the Goal

Key Questions

- Should the Plan establish financial goals as part of the strategic plan?
- If yes, what is the primary financial goal?
- Who is the targeted financial beneficiary of the financial goal?

Knowing the goal will help to determine the strategies

- Alternative provider payment methods
- Targeted disease and case management
- Medical management/specialty pharmacy management
- Member cost-sharing/cost-shifting
- Member incentives
- Limited network/formulary
- Premium structure/wellness premiums/incentives
- Premium pricing
- Spending cash reserves

Considerations

- How will the strategy drive change?
- Who is impacted?
- What are the risks?
- How quickly will the strategy affect change?
- What is the expected magnitude of the change?