



**Board of Trustees' Meeting**  
**Department of State Treasurer**  
**Friday, May 24, 2013**  
**9:00 a.m. – 9:30 a.m. (Executive Session)**  
**9:30 a.m. – 3:00 p.m. (Public Meeting)**

**AGENDA**

1. Welcome Janet Cowell, Chair
2. Conflict of Interest Statement Janet Cowell, Chair
3. **Executive Session (for Board members only) (9:00 – 9:30)** Janet Cowell, Chair  
*Pursuant to: G.S.§143-318.11 and G.S. 132-1.2*
  - A. Lake Lawsuit Update Marc Bernstein  
Attorney General's Office
  - B. Medical Claims Audit and Third Party Liability Recovery Services RFP Caroline Smart
4. Review of Minutes – March 22 (**Requires Board Vote**) Janet Cowell, Chair
5. Legislative Update (9:30 – 9:55) Thomas Friedman
  - A. Update on Legislative Budget
  - B. State Health Plan Related Legislation – Update on Bills
  - C. Follow-up March BOT Meeting
6. Financial Report (9:55 – 10:35) Mark Collins
  - A. March 2013 Financial Report
  - B. Analysis of Incurred Claims Trend and Provider Payments
  - C. Follow-up March BOT Meeting: Financial Impact of the Enhanced Blood Glucose Test Strip Benefit
  - D. Proposed Premium Rate Structure for 2014 (**Requires Board Vote**)

**Break (10 minutes)**

7. Implementation Update *(10:45 – 1:00, includes lunch)* Caroline Smart
- A. 2014 Final Plan Design Details
    - i. Medicare Advantage Plan Designs **(Requires Board Vote)**
    - ii. Consumer Directed Health Plan (CDHP) with Health Reimbursement Account (HRA) Plan Features **(Requires Board Vote)**
    - iii. Tiered Network Incentives **(Requires Board Vote)**
  - B. Preview of the Enrollment Workflow of the Benefitfocus Platform
  - C. Communications Update

**Lunch – approximately at 12:00**

8. Pharmacy Report *(1:00 – 1:30)* Sally Morton, PharmD
- A. Specialty Pharmacy Management
  - B. Pharmacy & Therapeutics Committee Meeting Summary
9. Integrated Health Management Report *(1:30 – 2:00)* Lotta Crabtree  
Kenisha Riley
- A. Stork Rewards Year One Outcomes
  - B. Tobacco Cessation Support through NC Quitline
  - C. Worksite Wellness Pilot Changes
10. Process Discussion *(2:00 – 2:15)* Mona Moon
- A. Requests to Consider Benefit Changes or Enhancements
11. Strategic Planning Update *(2:15 – 3:00)* Strategic Planning  
Workgroup
12. Wrap-Up Janet Cowell, Chair

**Next Board Meeting: July 25 and 26, 2013**

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



# *North Carolina* State Health Plan

FOR TEACHERS AND STATE EMPLOYEES



## Legislative Update *Board of Trustee's Meeting*

May 24, 2013

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A Division of the Department of State Treasurer

# Legislative Update

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- Budget
- House and Senate Bills

# Budget Requirements for State Health Plan

	Governor's Budget (Segal 02-01-13)	2Q Updated Projection (Segal 03-14-13)	Senate Budget
<b>Premium Increases Fiscal Biennium 2013-15</b>			
Jan 1 <sup>st</sup> 2014	4.7%	2.7%	3.6%^
Jan 1 <sup>st</sup> 2015	4.7%	2.7%	0.8%^
<b>General Fund Appropriations</b>			
FY 2013-14	\$44.8 m	\$25.9 m	\$34.0 m
FY 2014-15	\$136.2 m	\$78.2 m	\$77.0 m
<b>Total</b>	<b>\$181.0 m</b>	<b>\$104.1 m</b>	<b>\$111.0 m</b>

- The proposed Senate increase is lower than the Governor's Budget, but is projected to be sufficient to cover plan expenses in the coming biennium
- The Senate linked their proposed increase to CPI, which historically is much lower than health care trends

# House and Senate Bills Update

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- In addition to the budget proposals there are several health care related bills that successfully “crossed over” that would impact the State Health Plan
- The following slides highlight:
  - Legislation that has become law
  - Summary of crossed over legislation
  - Potential fiscal impact of legislation

# Legislative Update

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## Legislation Signed by the Governor

# SB 98: Expands the Newborn Screening Program

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- Bill Summary:
  1. Adds Pulse Oximetry screening requirements to all newborn screenings
  2. Requires follow-up protocols for newborns identified as having congenital heart defects
- Bill Status: Signed by Governor (S.L. 2013-45)
- Projected Fiscal Impact = Negligible



# Legislative Update

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## Summary of Key Crossed Over Legislation

# HB 232: State Health Plan Agency Bill

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- **Bill Summary:**
  1. Clarifying language on population health management
    - Removed in House Rules Committee
  2. Redefines and broadens eligibility rules based on ACA
  3. Clarifies the period in which retirees can enroll (similar to legislation enacted last year for active employees)
  4. Repeals the requirement to collect of certain penalties/interest
- **Bill Status:** Passed the House, referred to Senate Committee on Pension & Retirement and Aging
- **Fiscal Impact:** Negligible

# HB 498: Mandate Autism Coverage

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- Bill Summary:
  1. Requires the Plan to provide annual coverage of \$36,000 for autism behavioral treatment benefits (some benefits not covered currently)
  2. Coverage is for individuals age 23 and under
- Bill Status: Passed the House, referred to Senate Committee on Insurance
- Projected Biennium Fiscal Impact = \$4.1M to \$9.7M increase in expenses
  - Fiscal impact is based on \$75,000 benefit cap with no age limitation and will need to be updated to reflect the impact of the bill as it passed the House

# HB 675:Amend Pharmacy Laws

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- Bill Summary:
  1. Restricts the right to recoup from pharmacists in the event of audit findings
  2. Restricts the amount that may be recouped in the event of audit findings
- Bill Status: Passed the House, referred to Senate Committee on Rules
- Projected Biennium Fiscal Impact = \$3.2M to \$3.4M revenue loss
  - Projected Fiscal Impact is based on older version of bill and financial impact may be revised

# SB 477: Non-Covered Vision Services

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- **Bill Summary:**

Prohibits Insurers and Health Benefit Plans from limiting or fixing the fees an Optometrist may charge patients for services or materials unless the services or materials are covered by reimbursement under the Plan or insurer contract with the Optometrist, and to require Optometrists to provide a written disclosure to patients.

  - Currently, BCBSNC provides vision discounts through their discount program available to individuals covered by BCBSNC, including State Health Plan members
- **Bill Status:** Passed the Senate, referred to Senate Committee on Insurance
- **Projected Biennium Fiscal Impact:** None

# SB 473: Health Care Cost Reduction and Transparency

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- Bill Summary (as it relates to SHP):
  1. Inpatient: Effective at the end of March 2014, for each of the top 100 DRGs each hospital will report:
    - Total payments from SHP
  2. Outpatient/Ambulatory Surgery Centers (ASC): Effective at the end of June 2014, for each of the top 20 most common surgery and imaging procedures each hospital/ASC will report:
    - Total payments from SHP
- Bill Status: Passed the Senate, referred to House Committee on Health and Human Services
- Projected Biennium Fiscal Impact: None

# SB 336 and HB 459: Chronic Conditions Collaboration Bill (HB 459) & Collaboration Among State Diabetes Programs (SB 336)

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- **Bill Summary:**
  1. Requires the Division of Medical Assistance of the Department of Health and Human Services, the Division of Public Health of the Department of Health and Human Services, and the Department of the State Treasurer to identify goals and benchmarks while also developing individual entity plans to reduce the incidence of chronic conditions in North Carolina, improve care, and control complications
    - a) HB 459 addresses chronic conditions broadly,
    - b) SB 336 specifically addresses diabetes
  2. Provide reports to Joint Legislative committees on progress
- **Bill Status:** Passed the Senate and House, respectively
- **Projected Biennium Fiscal Impact:** Negligible

# Legislative Update

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## Financial Impacts of Legislation



# Crossed Over Bills that impact State Health Plan

Bill Number	Bill Description	Biennium Fiscal Impact <sup>1</sup>
HB 232	State Health Plan Agency Bill	Negligible
HB 498	Mandate Autism Benefits	\$4.1M to \$9.7M <sup>2</sup>
HB 675	Amend Pharmacy Laws	\$3.2M - \$3.4M <sup>2</sup>
HB 176	Allows Corvian Committee School to enroll in SHP	No fiscal note
HB 459 and SB 336	Two separate bills that require SHP to work with State Agencies on care coordination - HB 459 = broadly covers chronic disease - SB 336 = specific to diabetes	Negligible
SB 473	Health Care Transparency Bill	No fiscal note
SB 477	Removes discounts on non-covered vision services	Not to SHP
<b>Total Fiscal Impact</b>		<b>\$7.3M to \$13.1M</b>

1. Fiscal impact projections from Segal and Hartman Associates (Fiscal Research's Actuary); reflect both losses in revenues and increases in costs
2. Projection will need to be updated to reflect amended bill language

# Bills that Did Not Crossover (not all bills included)

Bill Number	Bill Description	Status	Fiscal Impact <sup>1</sup>
HB 651	Disclosure of premium increase related to ACA	Not read in committee	No fiscal note
HB 740	Right to choose athletic trainer	Not read in committee	Negligible
SB 248	Right to choose hearing aid specialist	Referred to Senate Insurance	Negligible
SB 531	Require the Plan to offer HSA	Not read in committee	No fiscal note
SB 561	Chiropractor Copay Parity	Not read in committee	\$3.6M to \$5.2M
SB 657	New Prescription requirements	Not read in committee	Negligible

1. Fiscal impact projections from Segal and Hartman Associates (Fiscal Research's Actuary); reflect both losses in revenues and increases in costs



*North Carolina*  
**State Health Plan**  
FOR TEACHERS AND STATE EMPLOYEES



# March 2013 Financial Report

**Board of Trustees Meeting**

**May 24, 2013**

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**A Division of the Department of State Treasurer**

# Financial Results: Actual v. Budgeted Year to Date March 2013

Fiscal Year 2012-2013	Actual thru Mar 2013	Authorized Budget (per Segal 9-18-12)	Variance Over/(Under) Budget
Beginning Cash Balance	\$502.2 m	\$502.2 m	\$0.0 m
Plan Revenue	\$2.221 b	\$2.205 b	\$15.8 m
Net Claims Payments	\$1.874 b	\$1.962 b	(\$88.5 m)
Net Administrative Expenses	\$112.4 m	\$140.7 m	(\$28.3 m)
Total Plan Expenses	\$1.986 b	\$2.103 b	(\$116.8 m)
Net Income/(Loss)	\$234.7 m	\$102.1 m	\$132.6 m
Ending Cash Balance	\$736.9 m	\$604.3 m	\$132.6 m

# Adjusted Variance Report Year to Date March 2013

Fiscal Year 2012-2013	Actual thru Mar 2013, As Adjusted	Authorized Budget (per Segal 9-18-12)	Variance Over/(Under) Budget
Beginning Cash Balance	\$502.2 m	\$502.2 m	\$0.0 m
Plan Revenue *	\$2.219 b	\$2.205 b	\$13.6 m
Net Claims Payments ^	\$1.871 b	\$1.962 b	(\$91.6 m)
Net Administrative Expenses ^	\$121.9 m	\$140.7 m	(\$18.8 m)
Total Plan Expenses	\$1.993 b	\$2.103 b	(\$110.4 m)
Net Income/(Loss)	\$226.1 m	\$102.1 m	\$124.0 m
Ending Cash Balance	\$728.3 m	\$604.3 m	\$124.0 m

\* Adjusted for timing issues and to remove the impact of unbudgeted revenues.

^ Adjusted to for end-of-month timing issues.

# Financial Results Actual v. Budgeted Year to Date March 2013

Per Member Per Month (PMPM) Analysis

Fiscal Year 2012-2013	Actual thru Mar 2013	Authorized Budget (per Segal 9-18-12)	Variance Over/(Under) Budget
Plan Revenue	\$370.06	\$369.81	\$0.25
Net Claims Payments	\$312.80	\$329.42	(\$16.62)
Net Administrative Expenses	\$18.76	\$23.61	(\$4.85)
Total Plan Expenses	\$331.56	\$353.03	(\$21.47)
Net Income/(Loss)	\$38.50	\$16.78	\$21.72

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

# Adjusted Variance Report Year to Date March 2013

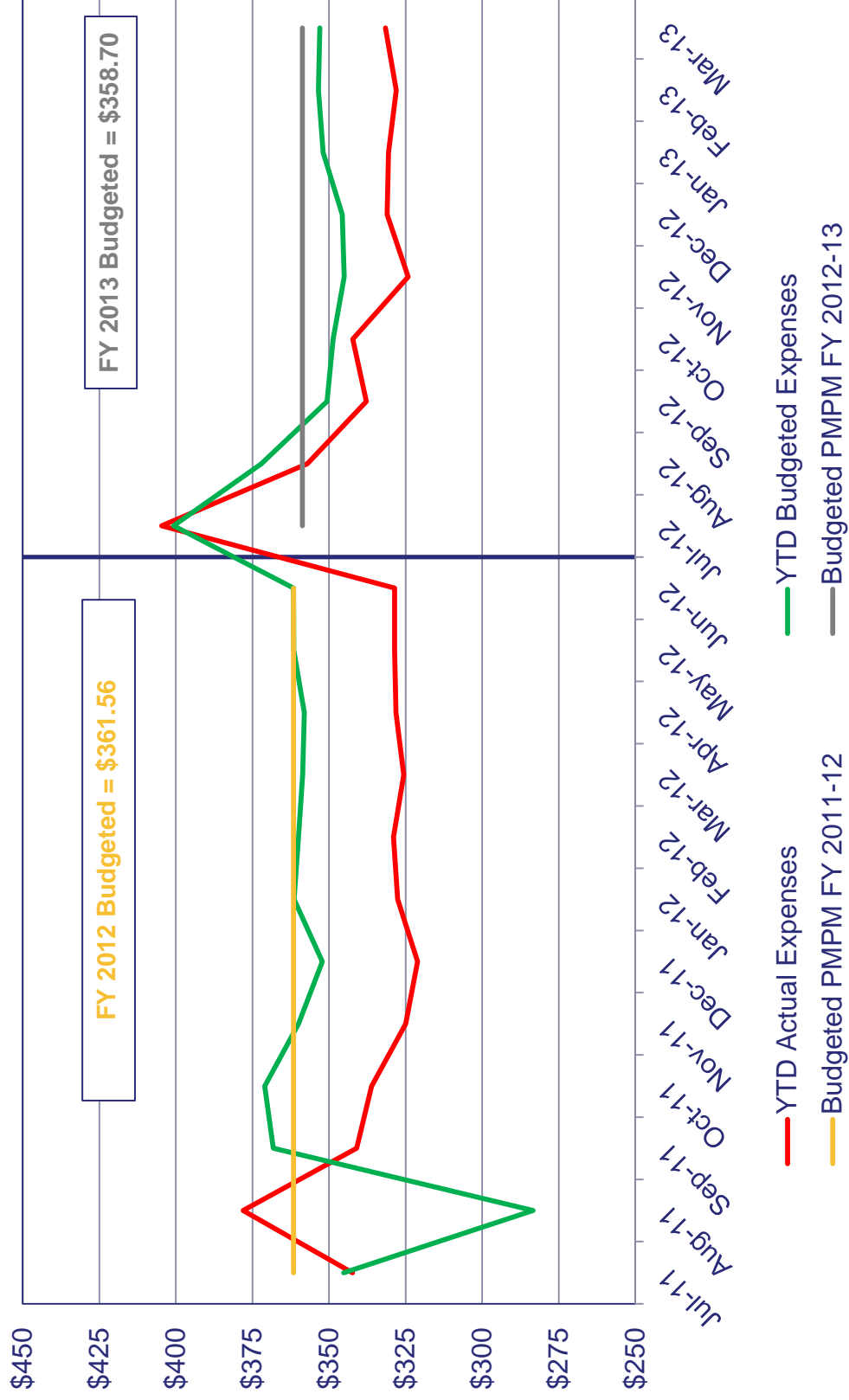
## Per Member Per Month (PMPM) Analysis

Fiscal Year 2012-2013	Actual thru Mar 2013, as Adjusted	Authorized Budget (per Segal 9-18-12)	Variance Over/(Under) Budget
Plan Revenue *	\$369.69	\$369.81	(\$0.12)
Net Claims Payments ^	\$312.29	\$329.42	(\$17.13)
Net Administrative Expenses ^	\$20.34	\$23.61	(\$3.27)
Total Plan Expenses	\$332.63	\$353.03	(\$20.40)
Net Income/(Loss)	\$37.06	\$16.78	\$20.28

\* Adjusted for timing issues and to remove the impact of unbudgeted revenues.

^ Adjusted to for end-of-month timing issues.

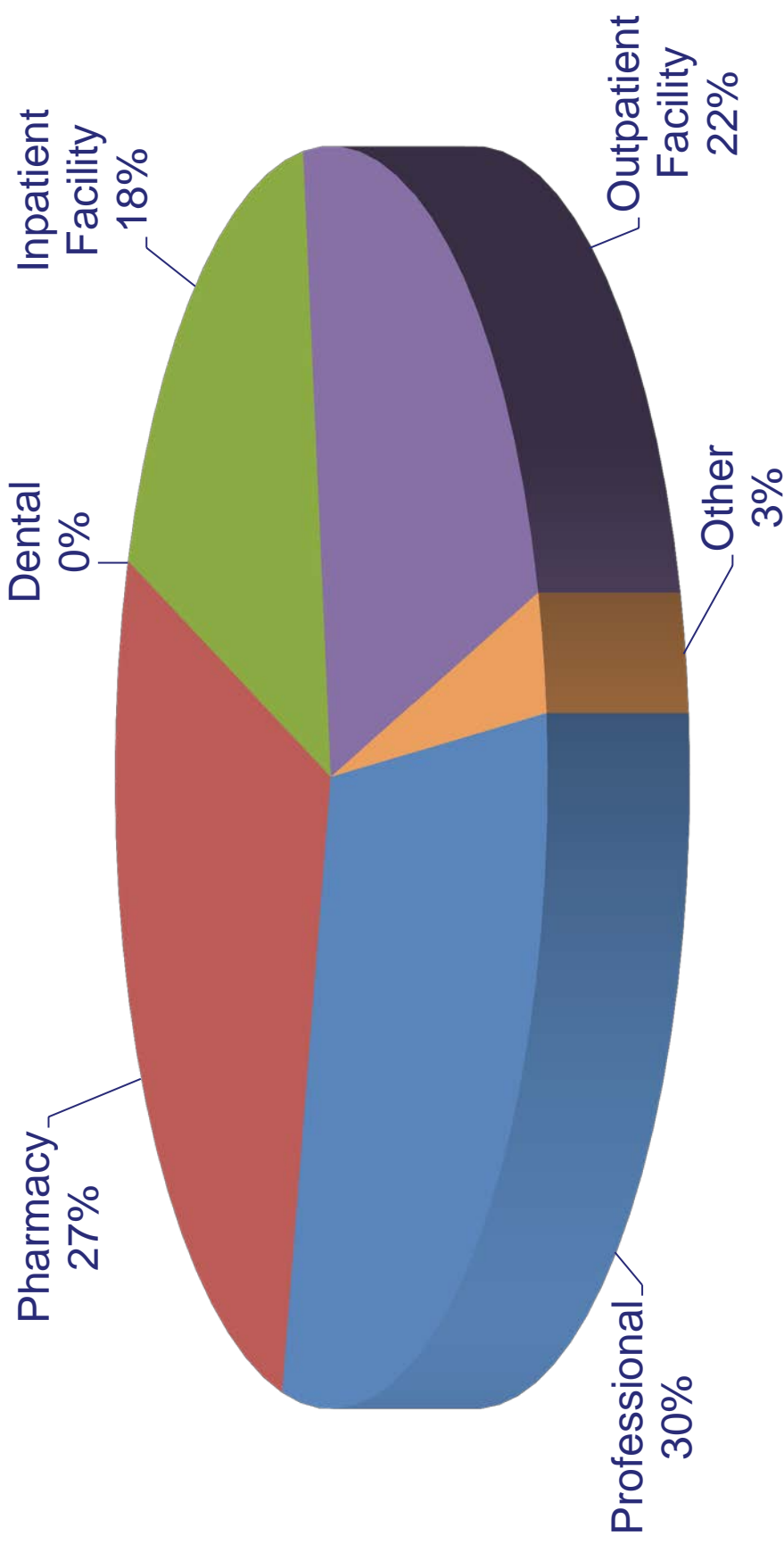
# Year to Date Expenditure Trend Per Member Per Month





# Allocation of Claims Expenditures

## Includes Medical, Blue Card & Pharmacy Payments



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

**North Carolina State Health Plan for Teachers and State Employees**

**Summary of Operations (Cash Basis)**  
 Consolidated Report, Actual vs. Authorized Budget  
 For the Month Ended March 2013  
 Fiscal Year 2012- 2013

	A	B	C	D	E	F	G	H
	Actual March 2013	Authorized Budget March 2013	Monthly Variance Over/(Under) Authorized Budget	Actual Year to Date FY 2012-13	Authorized Budget Year to Date FY 2012-13	Year to Date Variance Over/(Under) Authorized Budget	Authorized Annual Budget FY 2012-13	Year to Date Variance Over/(Under) Annual Authorized Budget
1 <b>Plan Revenue:</b>								
2 Member Premiums	\$ 244,770,880	\$ 239,046,428	\$ 5,724,452	\$ 2,173,329,667	\$ 2,156,181,250	\$ 17,148,417	\$ 2,872,808,844	\$ (699,479,177)
3 Premium Refunds/Retroactive Disenrollments	(54,563)	(119,663)	65,100	(353,511)	(1,078,509)	724,998	(1,437,243)	1,083,732
4 Medicare Part D (RDS) Subsidy	4,789,476	563,496	4,225,980	33,730,286	37,981,597	(4,251,311)	39,519,892	(5,789,606)
5 Medicare PDP (EGWP + Wrap) Subsidy	3,952,331	3,948,693	3,638	12,479,240	7,894,113	4,585,127	19,759,856	(7,280,616)
6 Federal Early Retiree Reinsurance Program (ERRP)				(558,219)	-	(558,219)	-	(558,219)
7 Net Premium & Other Contributions	253,458,124	243,438,954	10,019,170	2,218,627,463	2,200,978,451	17,649,012	2,930,651,349	(712,023,886)
9 Investment Earnings	254,811	496,471	(241,660)	2,209,143	4,165,893	(1,956,750)	5,658,262	(3,449,119)
11 Miscellaneous Revenue	110,888	-	110,888	119,047	-	119,047	-	119,047
12 Other Revenue	365,699	496,471	(130,772)	2,328,190	4,165,893	(1,837,703)	5,658,262	(3,330,072)
13 Total Plan Revenue (excludes internal transfers)	253,823,823	243,935,425	9,888,398	2,220,955,653	2,205,144,344	15,811,309	2,936,309,611	(715,353,958)
15 <b>Plan Expenses:</b>								
16 Medical Claim Payments	173,909,720	162,025,257	11,884,463	1,363,295,214	1,463,364,529	(100,069,315)	2,003,583,417	(640,288,203)
18 Medical Claim Refunds/Recoveries	(1,582,718)	(2,684,541)	1,101,823	(17,902,078)	(22,857,523)	4,955,445	(31,216,928)	13,314,850
19 Net Medical Claims	172,327,002	159,340,716	12,986,286	1,345,393,136	1,440,507,006	(95,113,870)	1,972,366,489	(626,973,353)
21 Pharmacy Claim Payments	63,103,130	58,955,773	4,147,357	566,053,110	562,968,046	3,085,064	743,853,418	(177,800,308)
22 Pharmacy Claim Rebates	-	(3,082,747)	3,082,747	(37,046,327)	(41,053,952)	4,007,625	(53,173,873)	16,127,546
23 Pharmacy Claim Refunds/Recoveries	(14,189)	-	(14,189)	(484,867)	-	(484,867)	-	(484,867)
24 Net Pharmacy Claims	63,088,941	55,873,026	7,215,915	528,521,916	521,914,094	6,607,822	690,679,545	(162,157,629)
25 Net Claim Payments	235,415,943	215,213,742	20,202,201	1,873,915,052	1,962,421,100	(88,506,048)	2,663,046,034	(789,130,982)
26 Net Administrative Expenses	4,831,784	16,250,111	(11,418,327)	112,382,795	140,664,857	(28,282,072)	189,387,392	(77,004,607)
28 Total Plan Expenses (excludes internal transfers)	240,247,727	231,463,853	8,783,874	1,986,297,837	2,103,085,957	(116,788,120)	2,852,433,426	(866,135,589)
30 <b>Plan Income/(Loss)</b>	13,576,096	12,471,572	1,104,524	234,657,816	102,058,387	132,599,429	83,876,185	150,781,631
32 <b>Cash Availability:</b>								
34 Beginning Cash Balance/(Deficit)	723,329,191	591,834,290	131,494,901	502,247,471	502,247,475	(4)	502,247,475	(4)
35 Ending Cash Balance/(Deficit)	736,905,287	604,305,862	132,599,425	736,905,287	604,305,862	132,599,425	586,123,660	150,781,627
36 Target Stabilization Reserve @ 6/30/13	199,728,453	199,728,453	-	199,728,453	199,728,453	-	199,728,453	-
37 Cash Balance Over/(Under) Reserve Target	\$ 537,176,834	\$ 404,577,409	\$ 132,599,425	\$ 537,176,834	\$ 404,577,409	\$ 132,599,425	\$ 386,395,207	\$ 150,781,627

Comments:  
 a. Premium receivables totaled \$ 228,837.33 as of March 31, 2013.  
 b. The average weekly medical claims cost net of claims refunds was \$43,081,750.50 for the four scheduled weekly claim cycles  
 c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging \$31,551,565.00 per cycle.  
 d. The target stabilization reserve is 7.5% of the projected net claims for Fiscal Year 2012-13.  
 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 March 2013  
Fiscal Year 2012-2013

G

F

E

D

C

B

A

	A	B	C	D	E	F	G
	Current Year Actual March 2013	Prior Year Actual March 2012	Current Year to Date Actual FY 2012-13 thru March	Prior Year to Date Actual FY 2011-12 thru March	Current Year Authorized Annual Budget FY 2012-13	Prior Year Annual Budget FY 2011-12	Prior Year Actual Results FY 2011-12
1 <b>Plan Revenue:</b>							
2							
3 Member Premiums	\$ 244,770,880	\$ 228,651,269	\$ 2,173,329,667	\$ 2,054,788,166	\$ 2,872,808,844	\$ 2,772,587,259	\$ 2,750,368,851
4 Premium Refunds/Retroactive Disenrollments	(54,563)	(34,242)	(353,511)	(364,526)	(1,437,243)	(2,672,292)	(451,496)
5 Medicare Part D (RDS) Subsidy	4,789,476	5,106,550	33,730,286	37,108,709	39,519,892	60,058,789	57,583,602
6 Medicare PDP (EGWP + Wrap) Subsidy	3,952,331	-	12,479,240	-	19,759,856	-	-
7 Federal Early Retiree Reinsurance Program (ERRP)	-	-	(558,219)	42,163,391	-	25,583,136	42,163,391
8 <b>Net Premium &amp; Other Contributions</b>	<b>253,458,124</b>	<b>233,723,577</b>	<b>2,218,627,463</b>	<b>2,133,695,740</b>	<b>2,930,651,349</b>	<b>2,855,556,892</b>	<b>2,849,664,348</b>
9							
10 Investment Earnings	254,811	247,172	2,209,143	2,348,242	5,658,262	2,245,712	3,015,819
11 Miscellaneous Revenue	110,888	-	119,047	-	-	-	-
12 Other Revenue	365,699	247,172	2,328,190	2,348,242	5,658,262	2,245,712	3,015,819
13							
14 <b>Total Plan Revenue (excludes internal transfers)</b>	<b>253,823,823</b>	<b>233,970,749</b>	<b>2,220,955,653</b>	<b>2,136,043,982</b>	<b>2,936,309,611</b>	<b>2,857,802,604</b>	<b>2,852,680,167</b>
15							
16 <b>Plan Expenses:</b>							
17							
18 Medical Claim Payments	173,909,720	147,796,790	1,363,295,214	1,370,241,037	2,003,583,417	2,078,924,788	1,849,410,105
19 Medical Claim Refunds/Recoveries	(1,582,718)	(3,027,501)	(17,902,078)	(21,517,985)	(31,216,928)	(33,175,196)	(22,634,615)
20 <b>Net Medical Claims</b>	<b>172,327,002</b>	<b>144,769,289</b>	<b>1,345,393,136</b>	<b>1,348,723,052</b>	<b>1,972,366,489</b>	<b>2,045,749,592</b>	<b>1,826,775,490</b>
21							
22 Pharmacy Claim Payments	63,103,130	57,049,844	566,053,110	550,456,534	743,853,418	706,459,465	721,644,990
23 Pharmacy Claim Rebates	-	(16,812,290)	(37,046,327)	(77,675,064)	(53,173,873)	(66,582,530)	(93,130,160)
24 Pharmacy Claim Refunds/Recoveries	(14,189)	(5,804)	(484,867)	(69,113)	-	-	(481,977)
25 <b>Net Pharmacy Claims</b>	<b>63,088,941</b>	<b>40,231,750</b>	<b>528,521,916</b>	<b>472,712,357</b>	<b>690,679,545</b>	<b>639,876,935</b>	<b>628,032,853</b>
26							
27 <b>Net Claim Payments</b>	<b>235,415,943</b>	<b>185,001,039</b>	<b>1,873,915,052</b>	<b>1,821,435,409</b>	<b>2,663,046,034</b>	<b>2,685,626,527</b>	<b>2,454,808,343</b>
28							
29 <b>Net Administrative Expenses</b>	<b>4,831,784</b>	<b>14,038,844</b>	<b>112,382,785</b>	<b>125,184,890</b>	<b>189,387,392</b>	<b>180,464,149</b>	<b>165,480,561</b>
30							
31 <b>Total Plan Expenses (excludes internal transfers)</b>	<b>240,247,727</b>	<b>199,039,883</b>	<b>1,986,297,837</b>	<b>1,946,620,299</b>	<b>2,852,433,426</b>	<b>2,866,090,676</b>	<b>2,620,288,904</b>
32							
33 <b>Plan Income/(Loss)</b>	<b>13,576,096</b>	<b>34,930,866</b>	<b>234,657,816</b>	<b>189,423,683</b>	<b>83,876,185</b>	<b>(8,288,072)</b>	<b>232,391,263</b>
34							
35 <b>Cash Availability:</b>							
36							
37 Beginning Cash Balance/(Deficit)	723,329,191	424,349,029	502,247,471	269,856,212	502,247,475	226,838,352	269,856,212
38 Ending Cash Balance/(Deficit)	736,905,287	459,279,895	736,905,287	459,279,895	586,123,660	218,550,280	502,247,475
39							
40 Target Stabilization Reserve @ 6/30/13	199,728,453	201,421,989	199,728,453	201,421,989	199,728,453	201,421,989	201,421,989
41							
42 <b>Cash Balance Over/(Under) Reserve Target</b>	<b>\$ 537,176,834</b>	<b>\$ 257,857,906</b>	<b>\$ 537,176,834</b>	<b>\$ 257,857,906</b>	<b>\$ 386,395,207</b>	<b>\$ 17,128,291</b>	<b>\$ 300,825,486</b>

Comments:

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

North Carolina State Health Plan for Teachers and State Employees  
Summary of Operations (Cash Basis, as adjusted)

Consolidated Report, Actual vs. Budgeted  
For the Month Ended March 2013  
Fiscal Year 2012-13

	A	B	C	D	E	F
	Actual Year to Date FY 2012-13 thru March	Adjustments for Timing, Unusual & Overtime Events	Adjusted Actual Year to Date	Authorized Budget Year to Date FY 2012-13 thru March	Year to Date Adjusted Over/(Under) Budget	Adjusted Variance as Percentage of Budget
1 <b>Plan Revenue:</b>						
2	\$ 2,173,329,667	\$ (74,137)	\$ 2,173,255,530	\$ 2,156,181,250	\$ 17,074,280	0.79%
3	(353,511)		(353,511)	(1,078,509)	724,998	-67.22%
4	33,730,286	1,165,935	34,896,221	37,981,597	(3,085,376)	-8.12%
5	12,479,240	(3,879,515)	8,599,725	7,894,113	705,612	8.94%
6	(558,219)	558,219	-	-	-	-
7	2,218,627,463	(2,229,498)	2,216,397,965	2,200,978,451	15,419,514	0.70%
8						
9	2,328,190		2,328,190	4,165,893	(1,837,703)	-44.11%
10						
11	2,220,955,653	(2,229,498)	2,218,726,155	2,205,144,344	13,581,811	0.62%
12						
13						
14 <b>Plan Expenses:</b>						
15	1,345,393,136		1,345,393,136	1,440,507,006	(95,113,870)	-6.60%
16	528,521,916	(3,082,747)	525,439,169	521,914,094	3,525,075	0.68%
17	1,873,915,052	(3,082,747)	1,870,832,305	1,962,421,100	(91,588,795)	-4.67%
18						
19	112,382,785	9,457,721	121,840,506	140,664,857	(18,824,351)	-13.38%
20						
21	1,986,297,837	6,374,974	1,992,672,811	2,103,085,957	(110,413,146)	-5.25%
22						
23	234,657,816	(8,604,472)	226,053,344	102,058,387	123,994,957	121.49%
24						
25						
26 <b>Cash Availability:</b>						
27						
28	502,247,471		502,247,471	502,247,475	(4)	0.00%
29	736,905,287	(8,604,472)	728,300,815	604,305,862	123,994,953	20.52%
30						
31	199,728,453		199,728,453	199,728,453	-	-
32						
33	\$ 537,176,834	\$ (8,604,472)	\$ 528,572,362	\$ 404,577,409	\$ 123,994,953	30.65%

**Adjustment Notes:**

1. Member premiums adjusted for timing issues.
2. Medicare RDS subsidy revenues decreased to remove impact of unbudgeted prior year reconciliation receipt (\$482,857).
3. Medicare RDS subsidy revenues increased to adjust for RDS subsidy budgeted in March but received in April (\$1.6 million).
4. Medicare EGWP subsidy revenues decreased to remove impact of an unbudgeted January subsidy payment (\$3.9 million).
5. Revenues adjusted to remove impact of unbudgeted reimbursement to CMS for FY 2012 ERRP overpayment (\$558,219).
6. Net pharmacy claims decreased to account for the annual rebate true-up amount that was budgeted for March but had not been received by the end of the month.
7. Administrative expenses increased to include the March administrative payment to Blue Cross Blue Shield that was not disbursed until April (\$9.5 million).



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FOR TEACHERS AND STATE EMPLOYEES



## **Analysis of Incurred Claims Trend and Provider Payments**

*Board of Trustees Meeting*

May 24, 2013

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A Division of the Department of State Treasurer

# Presentation Overview

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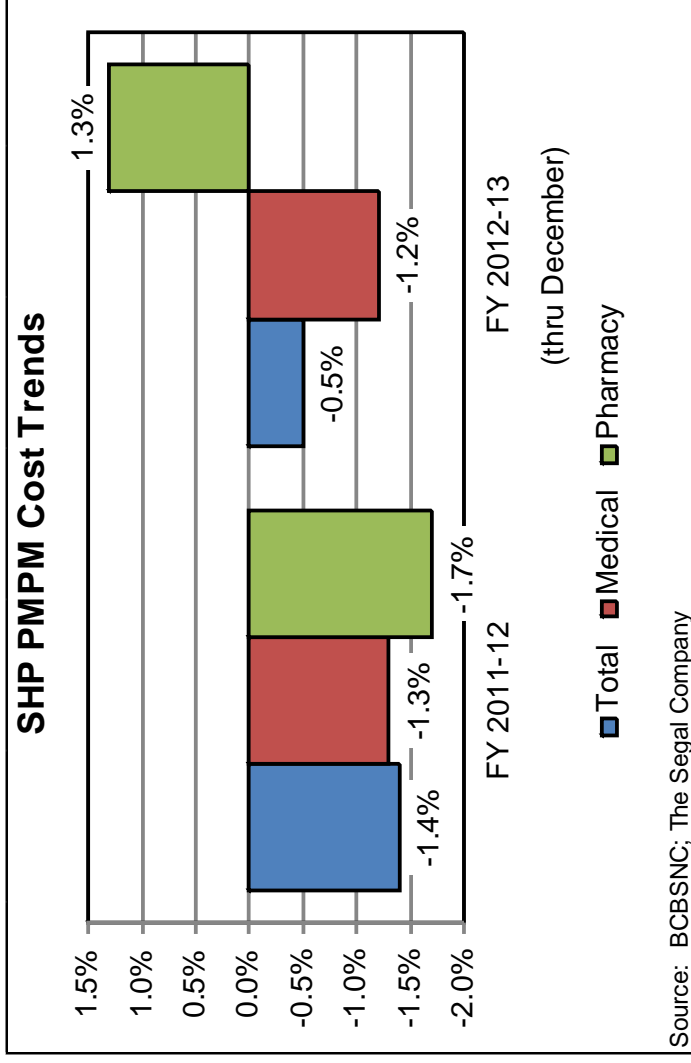
- Trends in Incurred Claims Paid through March 31, 2013
  - Per Member Per Month (PMPM)
  - By Service Category
- State Health Plan Provider Rates
  - Comparison to Medicare Provider Rates
  - Comparison of Medicare and Medicaid Provider Rates

# Per Member Per Month (PMPM) Claims Trends

- Using incurred claims data from BCBSNC, Segal analyzed trends in the Plan's claims costs paid through March 31, 2013
- PMPM claims costs were down 1.4% from FY 2010-2011 to FY 2011-12, including negative trends for medical and pharmacy claims

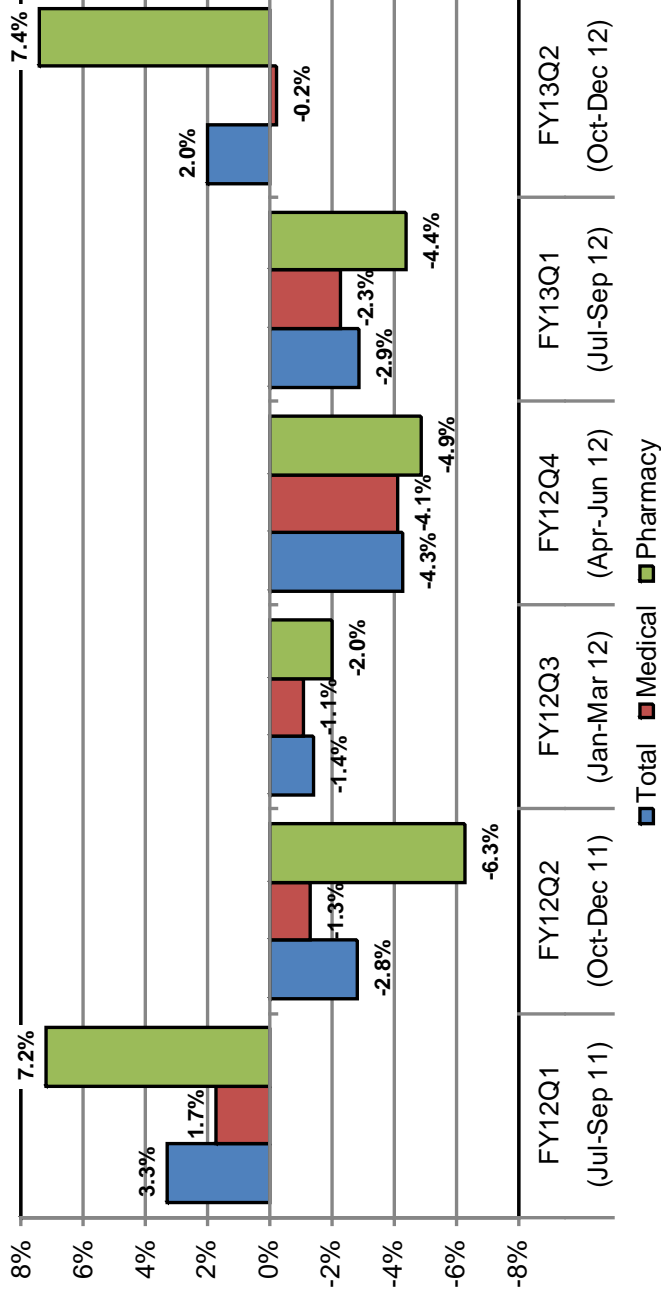
- PMPM claims were down 0.5% from the first six months of FY 2011-12 to the first six months of FY 2012-13

- A 1.2% decrease in PMPM medical claims was partially offset by a 1.3% increase in pharmacy claims



# PMPM Claims by Quarter

- Quarterly claims trends compare Plan costs in each quarter with costs from the same quarter of the prior year
- Quarterly claims show mostly negative trend over the last 18 months

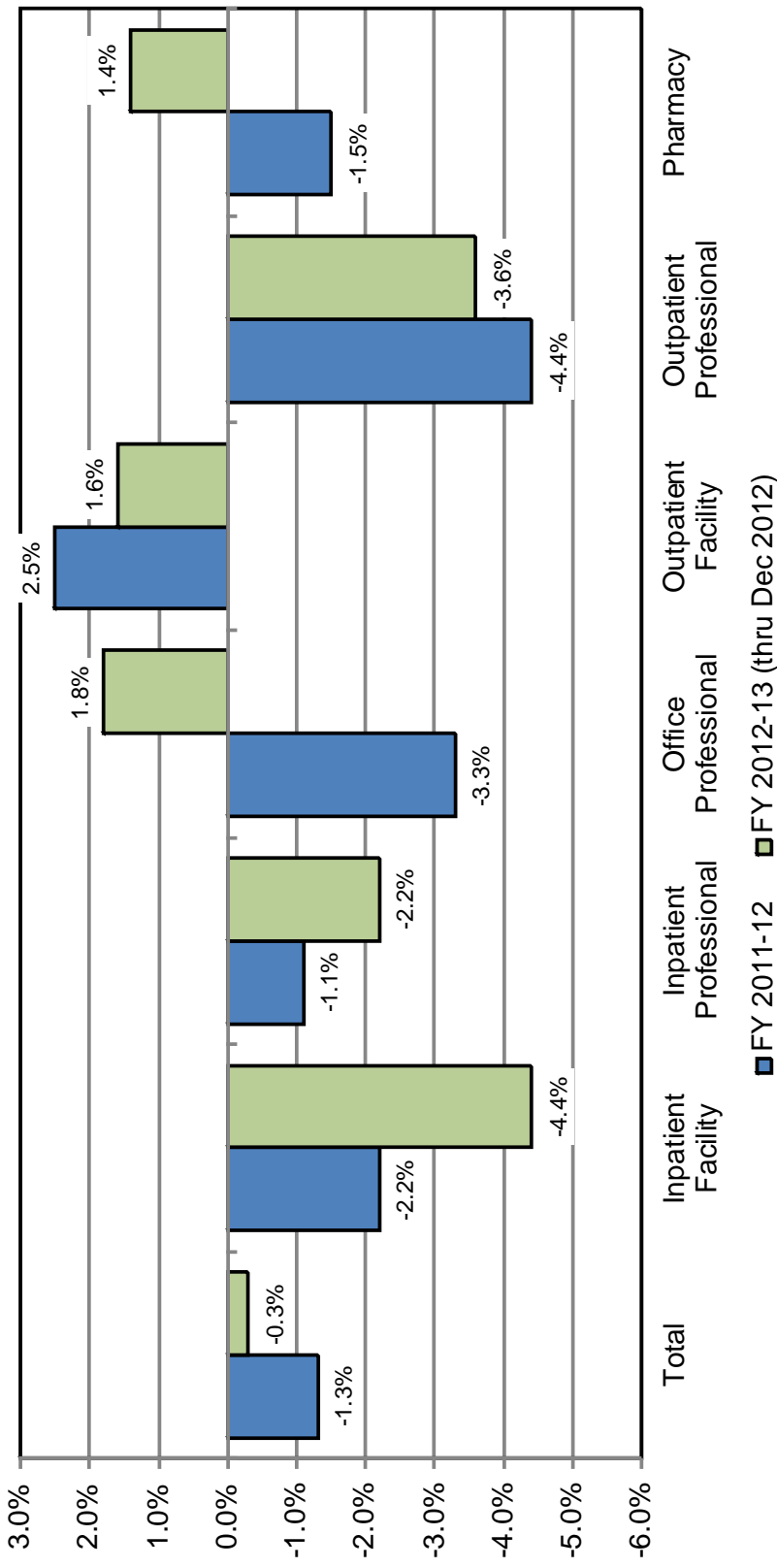


Source: BCBSNC; The Segal Company



# Total Claims Cost Trends by Service

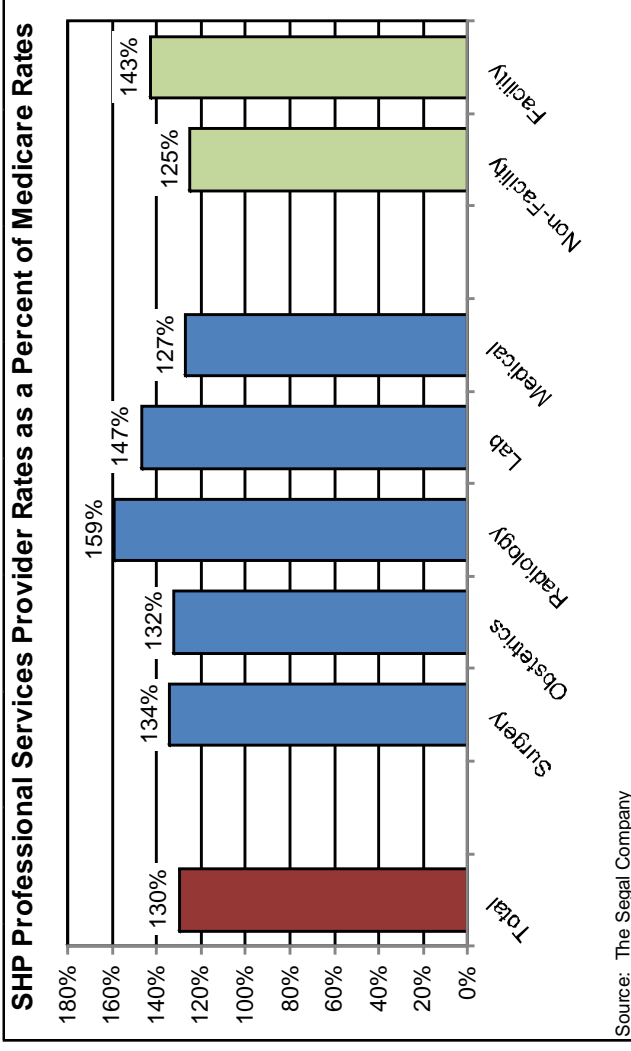
- Claims trends by category of service show some variation, but again, most of trends are negative



Source: BCBSNC; The Segal Company

# Plan and Medicare Provider Rates: Professional Services

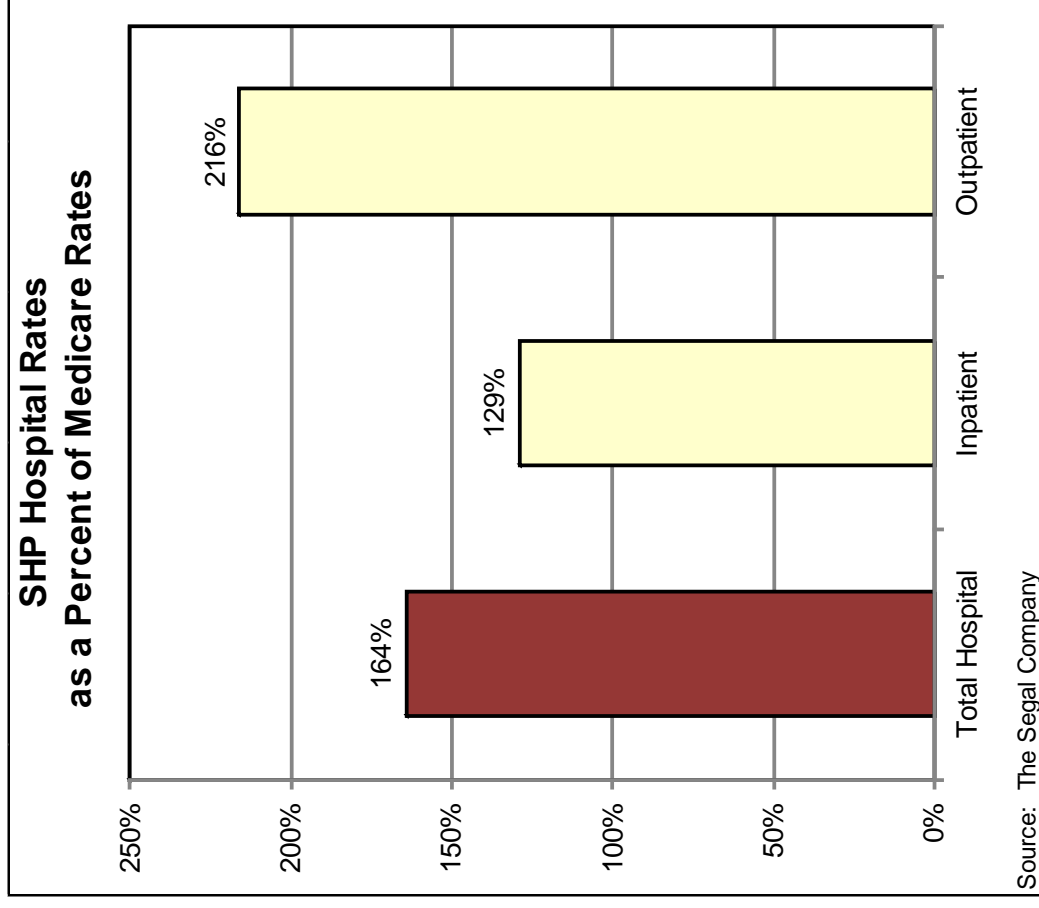
- Using data from BCBSNC, Segal analyzed 2012 Plan and Medicare provider rates for specific professional procedure codes
- Professional services were divided into five categories with Plan rates ranging from 127% to 159% of the corresponding Medicare provider rates



- Professional fees also differ based on the location of the professional service being provided. The Plan pays:
  - 143% of Medicare rates for professional services provided in facilities (generally-speaking, hospitals), and
  - 125% of Medicare rates for professional services provided in other settings (non-facilities)
- In total, Segal concluded that **the Plan pays 130% of Medicare** for professional services

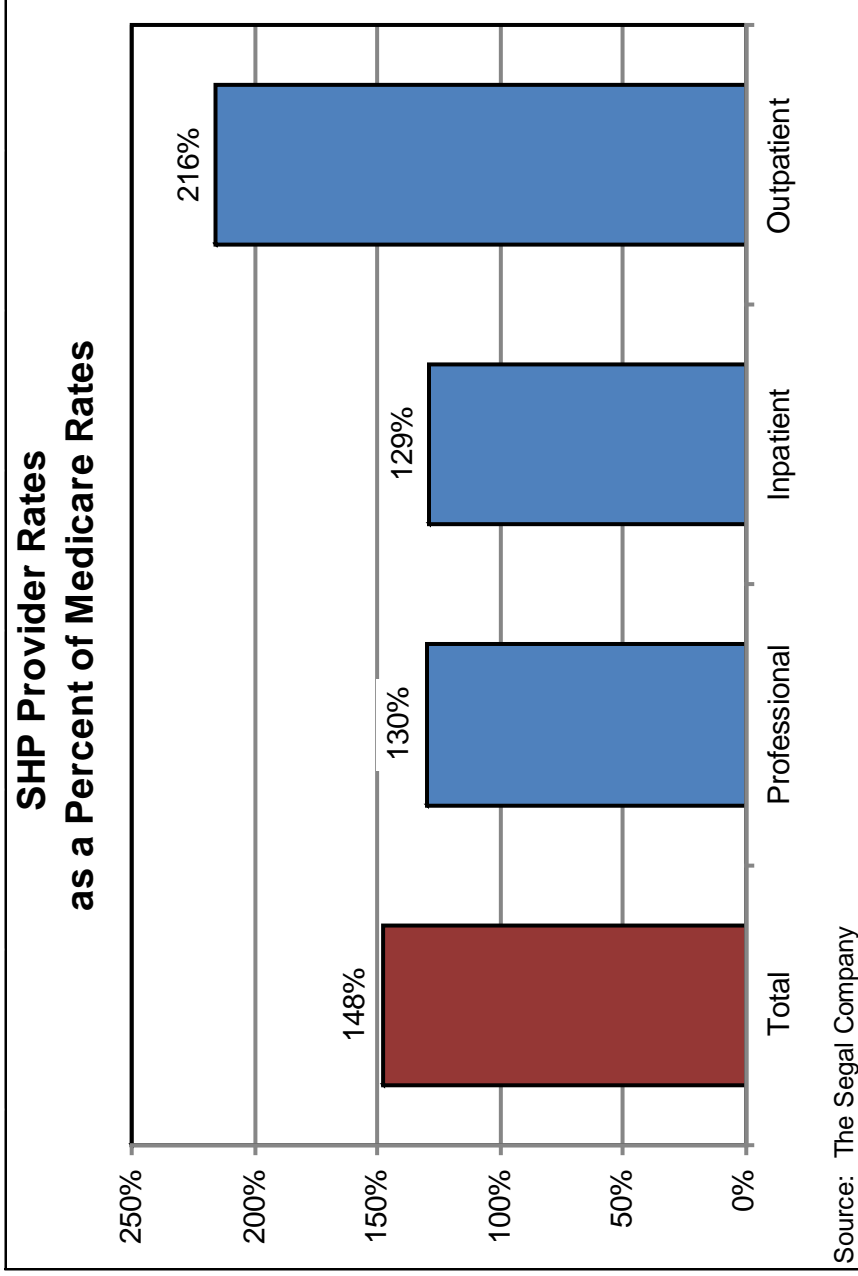
# Plan and Medicare Provider Rates: Hospital Services

- Segal also compared Plan provider rates for inpatient and outpatient hospital services using data from BCBSNC and the Healthcare Cost Report Information System (HCRIS)
- The Plan pays 129% of Medicare for inpatient care
- Because Medicare pays for outpatient services at a significant discount, the Plan pays 216% of the Medicare rates
- Overall, Segal found that **the Plan pays 164% of Medicare rates for hospital services**



# Plan and Medicare Provider Rates: Medical Services

- Combining professional and hospital rates, Segal concluded that the Plan pays providers at approximately 148% of Medicare rates



# Comparing NC Medicare and Medicaid Provider Rates

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- Physicians
  - Medicaid pays 100% of Medicare rates for primary care physicians (PCPs) in 2013-14
  - For specialists, Medicaid pays 95% of Medicare rates for office visits and 86% of Medicare rates for procedures
  - After 2014, PCPs will be reimbursed at the same percentages (95%/86%) as specialists
- Inpatient Hospital
  - Medicaid has its own hospital rates that, in theory, pay 100% of Medicare rates after including supplemental payments
  - However, these supplemental payments are funded through the imposition of hospital assessments that increase hospital costs
  - The net effect of rates, supplemental payments, and assessments is that hospitals receive on average 75% to 95% of Medicare rates
- Outpatient Hospital
  - Medicaid reimburses hospitals at 80% of cost, as reported by each hospital
  - A later “true up” payment, funded with hospital assessments, gets the hospitals up to 100% of cost
  - In general, Medicaid pays more than Medicare

*Note:* This slide was prepared with the assistance of the Fiscal Research Division of the North Carolina General Assembly.

# Comparison of Provider Rates Relative to Medicare

Category	Medicaid	Medicare	Plan
Physician/Professional	86% - 100%	100%	130%
Inpatient	75% - 95%	100%	129%
Outpatient	>100%	100%	216%
<b>Total</b>	<b>Est. 90%</b>	<b>100%</b>	<b>148%</b>

- If we estimate that, in total, Medicaid pays approximately 90% of the Medicare provider rates, the Plan's rates would be about 164% of Medicaid rates



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**Follow-up March BOT Meeting: Financial Impact of  
the Enhanced Blood Glucose Test Strip Benefit**

*Board of Trustees Meeting*

May 24, 2013

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A Division of the Department of State Treasurer

# Review of Diabetic Test Strip Enhancement

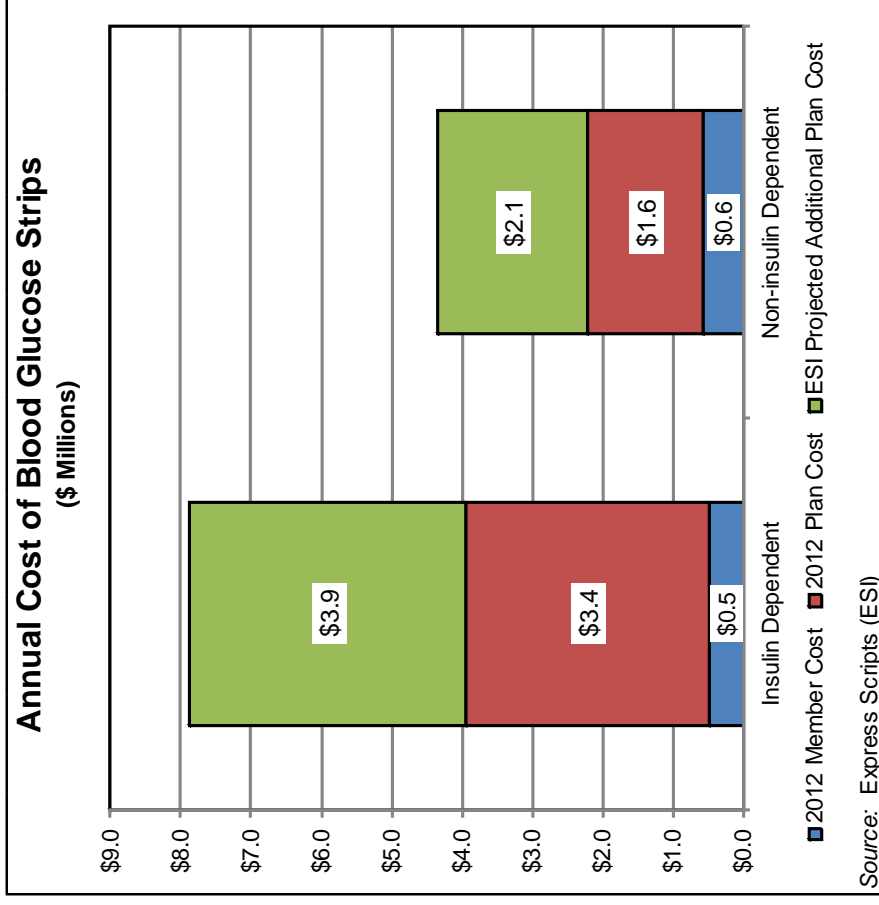
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- On March 22, 2013 the Board approved an increase in the number of blood glucose test strips available by prescription to plan members with diabetes
  - For **insulin dependent members**, the limit was increased from **153 to 204 strips/30 days**
  - For **non-insulin dependent members** with diabetes, the limit was increased from **51 to 102 strips/30 days**
- The Board was presented initial estimates of the financial impact on the Plan, which calculated the impact if **all test strip users** increased to the new maximum
  - **\$3.9 million** for insulin dependent members
  - **\$2.1 million** for non-insulin dependent members
- Plan staff reported in March that a refined analysis would be conducted with the Plan's actuaries (Segal) to estimate the financial impact of the enhancement



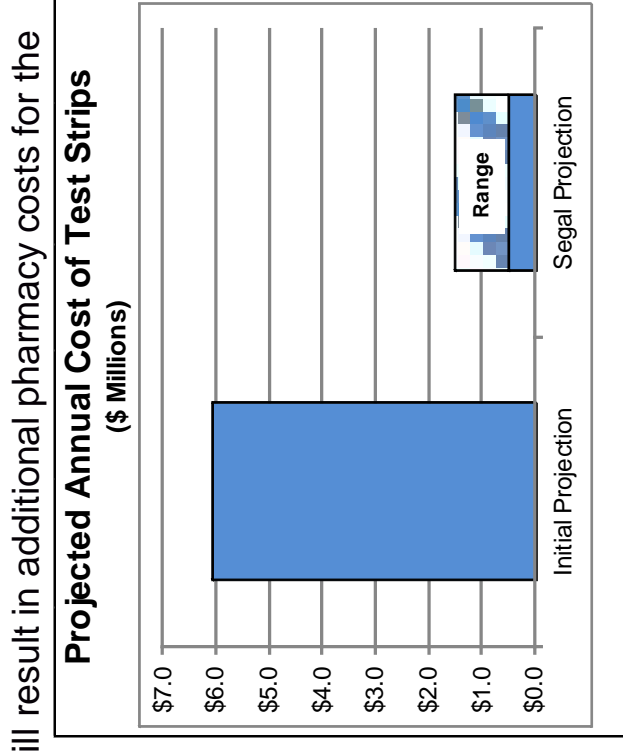
# 2012 Blood Glucose Test Strip Costs

- Express Scripts (ESI) provided data on prescriptions for blood glucose test strips during calendar 2012
- 2012 costs:
  - Gross costs for nearly 7,000 insulin dependent test strip users averaged \$570 PMPY
  - Gross costs for non-insulin dependent test strip users averaged \$185 PMPY
- ESI's initial estimate would represent a doubling of the 2012 cost of prescription test strips for Plan members



# Conclusion

- After reviewing the initial estimates, Segal suggested a cost estimation model focused on test strip users at or near the previous limits (those in place prior to March 22, 2013 Board meeting)
- A review of the 2012 data suggests that no more than 10-15% of test strip users were at or above 80% of the previous test strip maximum
- Segal also noted that the data set suggests that some members may have been exceeding the prior limits due to a discrepancy in the way the test strips were prescribed and the way the prescriptions were filled
- Segal concluded that the new test strip maximums will result in additional pharmacy costs for the Plan of **\$500,000 to \$1,500,000**
- Although some members may currently be using medical benefits to purchase test strips (subject to deductible and coinsurance), Segal does not anticipate a measurable reduction in medical claims with the enhancement to the pharmacy benefit
- To be conservative, Segal will use an estimated increase in pharmacy costs of **\$1.5 million** in Plan projections





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## Proposed Premium Rate Structure for 2014

*Board of Trustees Meeting*

May 24, 2013

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A Division of the Department of State Treasurer

# Presentation Overview

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- Current premium rates/rate structure
- January 2014 plan design changes require a review of rate structure
- Features of current structure retained in proposal
- Proposed structure
- Summary

# Current Rates



## Monthly Premium Rates for Twelve-Month Active Employees July 1, 2012 - December 31, 2013

Coverage Types	EMPLOYEE MONTHLY PREMIUM RATES									
	70/30 Basic Plan				80/20 Standard Plan				State Monthly Contribution	
Non-Medicare for Both Active Employee and Dependent(s)	Employee Monthly Premium	Dependent Monthly Premium	Total Monthly Premium	Employee Monthly Premium	Dependent Monthly Premium	Total Monthly Premium	Employee Monthly Premium	Dependent Monthly Premium	Total Monthly Premium	State Monthly Contribution
Employee	\$0.00	N/A	\$0.00	\$22.76	N/A	\$22.76	\$22.76	N/A	\$22.76	\$432.66
Employee+ Child(ren)	\$0.00	\$198.06	\$198.06	\$22.76	\$263.40	\$286.16	\$22.76	\$263.40	\$286.16	\$432.66
Employee + Spouse	\$0.00	\$510.32	\$510.32	\$22.76	\$606.88	\$629.64	\$22.76	\$606.88	\$629.64	\$432.66
Employee+ Family	\$0.00	\$543.54	\$543.54	\$22.76	\$643.42	\$666.18	\$22.76	\$643.42	\$666.18	\$432.66
<b>Medicare Primary for Active Employee Only</b>										
Employee	\$0.00	N/A	\$0.00	\$10.52	N/A	\$10.52	\$10.52	N/A	\$10.52	\$336.25
Employee + Child(ren)	\$0.00	\$198.06	\$198.06	\$10.52	\$263.40	\$273.92	\$10.52	\$263.40	\$273.92	\$336.25
Employee + Spouse	\$0.00	\$510.32	\$510.32	\$10.52	\$606.88	\$617.40	\$10.52	\$606.88	\$617.40	\$336.25
Employee + Family	\$0.00	\$543.54	\$543.54	\$10.52	\$643.42	\$653.94	\$10.52	\$643.42	\$653.94	\$336.25
<b>Medicare Primary for Dependent(s) Only</b>										
Employee	\$0.00	N/A	\$0.00	\$22.76	N/A	\$22.76	\$22.76	N/A	\$22.76	\$432.66
Employee + Child(ren)	\$0.00	\$140.92	\$140.92	\$22.76	\$200.50	\$223.26	\$22.76	\$200.50	\$223.26	\$432.66
Employee + Spouse	\$0.00	\$370.50	\$370.50	\$22.76	\$453.06	\$475.82	\$22.76	\$453.06	\$475.82	\$432.66
Employee + Family	\$0.00	\$403.70	\$403.70	\$22.76	\$489.62	\$512.38	\$22.76	\$489.62	\$512.38	\$432.66
<b>Medicare Primary for Both Active Employee and Dependent(s)</b>										
Employee	\$0.00	N/A	\$0.00	\$10.52	N/A	\$10.52	\$10.52	N/A	\$10.52	\$336.25
Employee + Child(ren)	\$0.00	\$140.92	\$140.92	\$10.52	\$200.50	\$211.02	\$10.52	\$200.50	\$211.02	\$336.25
Employee + Spouse	\$0.00	\$370.50	\$370.50	\$10.52	\$453.06	\$463.58	\$10.52	\$453.06	\$463.58	\$336.25
Employee + Family	\$0.00	\$403.70	\$403.70	\$10.52	\$489.62	\$500.14	\$10.52	\$489.62	\$500.14	\$336.25



# Additional Complexity in Premium Rates

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- New plan options
  - *CDHP*: Dependent premiums set 10% below rates for the 70/30 Plan
  - *MA-PDP Base Plans*: Rates set to cover the carrier premium for the plan (\$112 per month) + a share of SHP administrative expenses (\$2-3 per month)
  - *MA-PDP Buy-up Plans*: An additional \$33 is added to the base plan monthly premium
- Split Contracts: Different plan options for the Medicare and non-Medicare populations
- Wellness surcharges and credits
  - *80/20 Plan*: \$40 is added to the base monthly employee premium contribution; the rate can be reduced by as much as \$50 by completing healthy action steps
  - *CDHP*: The monthly employee premium starts at \$40 but can be reduced to \$0 by completing healthy action steps

# Features Maintained from Current Structure

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- “Free” options for employee/retiree coverage
  - Non-Medicare: 70/30 basic plan; CDHP can be reduced to \$0 with surcharge credits
  - Medicare: MA-PDP base plans; 70/30 basic plan
- Family tier structure
  - Employee/retiree only
  - Employee/retiree + child(ren)
  - Employee/retiree + spouse
  - Employee/retiree + family
- Employer (state) contribution pays the premium for the employee or retiree only
- Rates for 80/20 standard plan and 70/30 basic plan will be set from the current rates
- Employer and employee contributions are higher for non-Medicare members and lower for Medicare prime members

# Proposed Rate Structure

Employee/Retiree Premiums						
Active Employees and Non-Medicare Retirees						
	Wellness Activities	All Three	Two Activities Completed	One Activity Completed	None	
	Smoking Attestation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
	PCP Selection	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
	HA Completion	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Employee/Retiree Share						
Employer Share		\$12.76	\$27.76	\$27.76	\$42.76	\$47.76
80/20 Standard Plan		\$432.66	\$27.76	\$27.76	\$42.76	\$47.76
Consumer-Directed Health Plan		\$432.66	\$10.00	\$10.00	\$20.00	\$30.00

	Employee/Retiree Share
Alternate Plan	\$0.00
70/30 Basic Plan	\$0.00
<b>Medicare Retirees</b>	
<i>Medicare Advantage Plans</i>	
MA-PDP Base Plan	\$0.00
MA-PDP Buy-up Plan	\$33.00
Alternate Plan	\$0.00
70/30 Basic Plan	\$0.00

**Total Employee/Retiree Contribution =**  
 Employee/Retiree Share  
 of the Employee/Retiree Premium  
 +  
 Dependent Premium

*Red lettering* indicates a new offering from the State Health Plan.  
 Note: With the exception of the MA-PDP products, the premium rates shown are prior to the application of any premium increase approved by the Board and the General Assembly.

Dependent Premiums			
Dependent Group	All Dependents are Non-Medicare		One or More Medicare Dependents
	80/20	CDHP	70/30
Employee/Retiree + Child(ren)	\$263.40	\$178.25	\$140.92
Employee/Retiree + Spouse	\$606.88	\$459.29	\$370.50
Employee/Retiree + Family	\$643.42	\$489.19	\$403.70
			MA-PDP Buy-up
			\$114.50
			\$147.50
			\$114.50
			\$147.50
			\$229.00
			\$295.00



# Proposed Rate Table (Example)

## Monthly Premium Rates for 80/20 Standard Plan Subscribers

Wellness Activities	Participation in Activities			
	All 3	Two Activities Completed	One Activity Complete	None
Smoking Attestation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
PCP Selection	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
HA Completion	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

### Non-Medicare for Employee/Retiree and Dependent(s)

Employee/Retiree Only	\$12.76	\$27.76	\$27.76	\$32.76	\$42.76	\$47.76	\$62.76
Employee/Retiree + Child(ren)	\$276.16	\$291.16	\$291.16	\$296.16	\$306.16	\$311.16	\$326.16
Employee/Retiree + Spouse	\$619.64	\$634.64	\$634.64	\$639.64	\$649.64	\$654.64	\$669.64
Employee/Retiree + Family	\$656.18	\$671.18	\$671.18	\$676.18	\$686.18	\$691.18	\$706.18

### Medicare Primary for One or More Dependent(s)

<i>MA Base Plan for Medicare Dependents</i>							
Employee/Retiree + Child(ren)	\$127.26	\$142.26	\$142.26	\$147.26	\$157.26	\$162.26	\$177.26
Employee/Retiree + Spouse	\$127.26	\$142.26	\$142.26	\$147.26	\$157.26	\$162.26	\$177.26
Employee/Retiree + Family	\$241.76	\$256.76	\$256.76	\$261.76	\$271.76	\$276.76	\$291.76
<i>MA Buy-up Plan for Medicare Dependents</i>							
Employee/Retiree + Child(ren)	\$160.26	\$175.26	\$175.26	\$180.26	\$190.26	\$195.26	\$210.26
Employee/Retiree + Spouse	\$160.26	\$175.26	\$175.26	\$180.26	\$190.26	\$195.26	\$210.26
Employee/Retiree + Family	\$307.76	\$322.76	\$322.76	\$327.76	\$337.76	\$342.76	\$357.76
<i>70/30 Basic Plan for Medicare Dependents</i>							
Employee/Retiree + Child(ren)	\$153.68	\$168.68	\$168.68	\$173.68	\$183.68	\$188.68	\$203.68
Employee/Retiree + Spouse	\$383.26	\$398.26	\$398.26	\$403.26	\$413.26	\$418.26	\$433.26
Employee/Retiree + Family	\$416.46	\$431.46	\$431.46	\$436.46	\$446.46	\$451.46	\$466.46

Note: The premium rates shown are prior to the application of any premium increases approved by the Board and the General Assembly.

# Summary

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- January 2014 plan design changes add new complexity to the premium rate structure
- The proposed structure maintains the current family tiers as the basis for new rates
- Proposed structure designed so that rates within the family tiers will be the same or less under the proposal than they would be under the current plans after applying any across the board premium increases
- Dependent rates for Medicare retirees choosing an MA-PDP plan will be more favorable than the rates currently available to these members
- Future 2014 premium rate discussions will include rates for other member groups:
  - Direct bill and 50% contributory subscribers
  - COBRA
  - National Guard, Fire Department, and Emergency Medical Services (North Carolina G.S. § 135 – 38.48)

# Proposed Premium Rate Structure for 2014

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Plan staff recommends the Board of Trustees approve the proposed premium rate structure for 2014, which maintains the current tier structure.

Note: Recommended premium contribution rates for 2014 will be presented for Board approval after the General Assembly sets the employer contribution rates for the 2013-15 fiscal biennium.



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## 2014 Final Plan Design Details

*Board of Trustees Meeting*

May 24, 2013

# Plan Design Details – 2014 Benefits

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- Medicare Advantage Plan Design Details
- Consumer Directed Health Plan (CDHP) with Health Reimbursement Account (HRA) Plan Features
- Tiered Network Incentive Rewards

# Medicare Advantage & Prescription Drug Plans (MA-PDP)

# Medicare Advantage Plan Design Options

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- There will be four Medicare Advantage Plan Design Options
  - Two Identical Base Plan Designs – One from each carrier
  - Both plans will have the same copays, deductibles and coinsurances
  - Each plan will offer slightly different Rx formularies
  - Wrap-around services will vary by carrier
- Two Enhanced Plan Designs – One from each carrier
  - Some copays and deductibles are the same
  - Medicare Primary members will have to review the plan design features to determine which plan offers the best value to meet their individual needs

Both Base Plans offer the same office visit copays and overall out-of-pockets. Each Enhanced Plan offers a reduced copay – the amount of the reduction varies by carrier.

North Carolina State Health Plan Proposed Medicare Advantage & Prescription Drug Plans					
	Proposed MA-PDP Base Plans		Proposed MA-PDP Enhanced Plans		
	Humana Base Plan	UHC Base Plan	Humana Enhanced Plan	UHC Enhanced Plan	UHC Enhanced Plan
<b>*Proposed Monthly Carrier Rate</b>	\$112.00	\$112.00	\$145 (\$33 differential)	\$145 (\$33 differential)	\$145 (\$33 differential)
<b>Medical Coverage</b>					
Covered Services					
Deductibles	\$0	\$0	\$0	\$0	\$0
OOP Maximum (co-pays, ded/coins included)	\$4,000	\$4,000	\$2,600	\$2,600	\$2,600
<b>Physician Services</b>					
Primary Care Physician	\$20 co-pay	\$20 co-pay	\$10 co-pay	\$10 co-pay	\$10 co-pay
Specialist Office	\$40 co-pay	\$40 co-pay	\$30 co-pay	\$35 co-pay	\$35 co-pay
Diagnostic Procedures & Testing (Doctor's office visit applies)	\$0 (dr. office visit co-pay applies)	\$0 (dr. office visit co-pay applies)	\$0 (dr. office visit co-pay applies)	\$0 (dr. office visit co-pay applies)	\$0 (dr. office visit co-pay applies)
Preventive Care (Annual Wellness Exam)	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay

\* Premium rate charged to the Plan by the carrier. Actual contribution rates paid by the Retirement System and Members will be slightly higher to account for the Plan's administrative cost.



While the hospital service copays are similar for each Enhanced Plan, there are some variations.

		North Carolina State Health Plan Proposed Medicare Advantage & Prescription Drug Plans			
		Proposed MA-PDP Base Plans		Proposed MA-PDP Enhanced Plans	
		Humana Base Plan	UHC Base Plan	Humana Enhanced Plan	UHC Enhanced Plan
Hospital Services					
Inpatient Hospital Services		\$160/day (Days 1-10) \$0/day thereafter	\$160/day (Days 1-10) \$0/day thereafter	\$150/day (Days 1-10) \$0/day thereafter	\$150/day (Days 1-8) \$0/day thereafter
Outpatient Hospital Services (Includes observation & medical care)		\$125 co-pay	\$125 co-pay	\$75 co-pay	\$50 co-pay
Outpatient Surgery		\$250 co-pay	\$250 co-pay	\$150 co-pay	\$100 co-pay
Outpatient Lab & X-Ray		\$40 co-pay	\$40 co-pay	\$25 co-pay	\$20 co-pay (Lab) \$25 co-pay (X-Ray)
Complex Diagnostic Procedures & Testing (MRI, CT, MRA and PET Scans)		\$100 co-pay	\$100 co-pay	\$100 co-pay	\$50 co-pay
Emergency Room Co-pay (Waived if admitted)		\$65 co-pay	\$65 co-pay	\$50 co-pay	\$50 co-pay
Behavioral Health					
Inpatient Hospital Services		\$140/day (Days 1-10) \$0/day thereafter	\$140/day (Days 1-10) \$0/day thereafter	\$140/day (Days 1-10) \$0/day thereafter	\$140/day (Days 1-10) \$0/day thereafter
Outpatient Visits		\$20 co-pay	\$20 co-pay	\$10 co-pay	\$10 co-pay

# There is more copay variance by carrier on the Enhanced Plans for therapies and other services.

North Carolina State Health Plan Proposed Medicare Advantage & Prescription Drug Plans			
	Proposed MA-PDP Base Plans		Proposed MA-PDP Enhanced Plans
	Humana Base Plan	UHC Base Plan	Humana Enhanced Plan UHC Enhanced Plan
Other Coverage			
Skilled Nursing Facility	\$0/day (Days 1-20) \$50/day (Days 21-100)	\$0/day (Days 1-20) \$50/day (Days 21-100)	\$0/day (Days 1-20) \$50/day (Days 21-100)
Hospice	\$0 co-pay	\$0 co-pay	\$0 co-pay
Home Health Care Services	\$0 co-pay	\$0 co-pay	\$0 co-pay
Outpatient Acute Short-Term Rehab			
Physical Therapy	\$20 co-pay	\$20 co-pay	\$10 co-pay
Speech Therapy	\$20 co-pay	\$20 co-pay	\$10 co-pay
Occupational Therapy	\$20 co-pay	\$20 co-pay	\$10 co-pay
Cardiac Therapy	\$20 co-pay	\$20 co-pay	\$10 co-pay
Pulmonary Therapy	\$20 co-pay	\$20 co-pay	\$10 co-pay
Chiropractic Visit	\$20 co-pay	\$20 co-pay	\$20 co-pay
Kidney Dialysis	20% co-insurance	20% co-insurance	20% co-insurance
Blood	\$0	\$0	\$0
DME	20% co-insurance	20% co-insurance	20% co-insurance
Orthotics & Prosthetics	20% co-insurance	20% co-insurance	20% co-insurance
Medical Supplies	20% co-insurance	20% co-insurance	20% co-insurance
Diabetes Monitoring Supplies	20% co-insurance	20% co-insurance	20% co-insurance
Fitness	Silver Sneakers	Silver Sneakers	Silver Sneakers
Podiatry Visit (Medicare-covered)	\$40 co-pay	\$40 co-pay	\$35 co-pay
Eye Exam (Medicare-covered)	\$40 co-pay	\$40 co-pay	\$35 co-pay
Hearing Exam (Medicare-covered)	\$40 co-pay	\$40 co-pay	\$35 co-pay
Dental Services (Medicare-covered)	\$40 co-pay	\$40 co-pay	\$35 co-pay
Urgent Care	\$50 co-pay	\$50 co-pay	\$35 co-pay
Ambulance Services	\$75 co-pay	\$75 co-pay	\$40 co-pay

# The Enhanced Plans offer significant copay reductions and variation by carrier for retail Pharmacy copays.

North Carolina State Health Plan Proposed Medicare Advantage & Prescription Drug Plans			
	Proposed MA-PDP Base Plans		Proposed MA-PDP Enhanced Plans
	Humana Base Plan	UHC Base Plan	Humana Enhanced Plan / UHC Enhanced Plan
Part B Drugs			
Immunosuppressive, Oral Chemotherapy, Anti-nausea, Inhalation Solutions, Hemophilia Clotting Factors, Antigenes, OP Injectable Medications Administered in a Physician's Office	\$50 co-pay	\$50 co-pay	\$50 co-pay
<b>Prescription Drug Coverage</b>			
Part D Gap Coverage Formulary Name	Full Coverage Custom	Full Coverage Custom	Full Coverage Custom
Part D Retail (up to a 31 day supply)			
Tier 1	\$10 co-pay	\$10 co-pay	\$5 co-pay
Tier 2	\$40 co-pay	\$40 co-pay	\$30 co-pay
Tier 3	\$64 co-pay	\$64 co-pay	\$40 co-pay
Tier 4	25% co-insurance (\$100 Max)	25% co-insurance (\$100 Max)	25% co-insurance (\$95 Max)
Maintenance Drugs (up to a 90 day supply)			
Tier 1	\$24 co-pay	\$24 co-pay	\$10 co-pay
Tier 2	\$80 co-pay	\$80 co-pay	\$60 co-pay
Tier 3	\$128 co-pay	\$128 co-pay	\$80 co-pay
Tier 4	25% co-insurance (\$300 Max)	25% co-insurance (\$300 Max)	25% co-insurance (\$200 Max)
Prescription Drug Annual OOP Max	\$2,500	\$2,500	\$2,500
Diabetic Testing Supplies (Part B Cove	20% co-insurance	20% co-insurance	20% co-insurance

The best way to compare the MA-PDP to the Traditional Plan Design is to compare the Pharmacy copays.

Medicare Care Primary High Level Plan Design Comparison					
		Proposed MA-PDP Base Plans		Proposed MA-PDP Enhanced Plans	
Traditional 70/30 PPO		Humana Base Plan	UHC Base Plan	Humana Enhanced Plan	UHC Enhanced Plan
BCBSNC/ESI					
Physician Services					
Primary Care Physician	\$35 co-pay*	\$20 co-pay	\$20 co-pay	\$10 co-pay	\$10 co-pay
Specialist	\$81 co-pay*	\$40 co-pay	\$40 co-pay	\$30 co-pay	\$35 co-pay
Preventive Care	\$35 co-pay*	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Annual Deductible	\$933/\$2799*	\$0	\$0	\$0	\$0
Coinsurance Max/OOP	\$3,793/(\$11,379 (Coins Max))	\$4000 (Out-of-Pocket Max)	\$4000 (Out-of-Pocket Max)	\$2600 (Out-of-Pocket Max)	\$2600 (Out-of-Pocket Max)
<b>Prescriptions Drug Coverage</b>					
Part D Gap Coverage	Full Coverage Custom	Full Coverage Custom	Full Coverage Custom	Full Coverage Custom	Full Coverage Custom
Formulary Name					
Part D Retail (up to a 31 day supply)					
Tier 1	\$12 co-pay	<b>\$10 co-pay</b>	<b>\$10 co-pay</b>	\$7 co-pay	\$5 co-pay
Tier 2	\$40 co-pay	\$40 co-pay	\$40 co-pay	\$35 co-pay	\$30 co-pay
Tier 3	\$64 co-pay	\$64 co-pay	\$64 co-pay	\$50 co-pay	\$40 co-pay
Tier 4	25% co-insurance (\$100 Max)	25% co-insurance (\$100 Max)	25% co-insurance (\$100 Max)	25% co-insurance (\$95 Max)	25% co-insurance (\$95 Max)
Maintenance Drugs (up to a 90 day supply)					
Tier 1	\$36 (61 - 90 days)	<b>\$24 co-pay</b>	<b>\$24 co-pay</b>	\$14 co-pay	\$10 co-pay
Tier 2	\$120 (61 - 90 days)	<b>\$80 co-pay</b>	<b>\$80 co-pay</b>	\$70 co-pay	\$60 co-pay
Tier 3	\$192 (61 - 90 days)	<b>\$128 co-pay</b>	<b>\$128 co-pay</b>	\$100 co-pay	\$80 co-pay
Tier 4		25% co-insurance (\$300 Max)	25% co-insurance (\$300 Max)	25% co-insurance (\$190 Max)	25% co-insurance (\$200 Max)
Prescription Drug Annual OOP Max	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500
<b>*Actual Cost Share paid by member may vary - State Health Plan is secondary for medical services.</b>					

# Medicare Advantage Plan Design Confirmation

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Plan staff recommends the Board of Trustees approve the MA-PDP plan designs as presented.

# Consumer Directed Health Plan

# Consumer Directed Health Plan (CDHP): Plan Design Features

---

**The CDHP has two primary features:**  
High Deductible Health Plan (HDHP)  
Health Reimbursement Account (HRA)

**HDHP**

- \$1500/\$4500 Deductible
- \$3000/\$9000 Out-of-Pocket Maximum
- 100% Preventive Benefits
- Integrated Pharmacy Benefit

**HRA**

- \$500 Employee Only
- \$1000 Employee+1
- \$1500 Employee+2 or more
- Additional Incentive Funds
  - \$15/Visit to PCP on ID Card
  - \$10/Visit to Tier 1 Specialist
  - \$50/Inpatient Stay at Tier 1 Facility

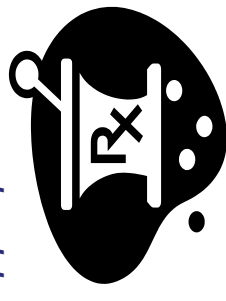
## Consumer Directed Health Plan (CDHP): High Deductible Health Plan

---

### **A High Deductible Health Plan is exactly what it says – A plan with a high front-end deductible.**

- ❖ Instead of copays, members will have to meet a deductible and pay a 15% coinsurance on all in-network medical and retail pharmacy benefits except preventive care which is covered at 100%.
- ❖ Because the pharmacy benefit is “integrated” with the medical benefit, the pharmacy and medical deductible and out-of-pockets are shared.

*To keep the pharmacy and medical deductibles and out-of-pockets (OOP) synchronized, a project is under way to share claims data between ESI and BCBSNC. By sharing individual member deductible and coinsurance accumulations, deductible and OOP balances can be maintained at both BCBSNC and ESI; therefore, both the pharmacy and the medical provider will know when a member reaches their deductible or OOP and will apply the appropriate member cost share.*





# Consumer Directed Health Plan (CDHP): Pharmacy Benefits



## The Deductible Does Not Apply to Every Medication

- ❖ Under the Affordable Care Act, most preventive drugs must be paid at 100%
- ❖ The Plan recommends that certain other drugs be paid at 85% with no deductible

Proposed Preventive Medication List	
Coverage	Description
100% - No Deductible	Preventive Drugs from the Affordable Care Act
85% - No Deductible	Preventive Drugs used to treat anemia in children, cavities, heart disease or stroke, obesity, pregnancy, smoking-cessation therapy, vaccines and low levels of vitamins
85% - No Deductible	Preventive drugs sometimes used to treat asthma, bone disease and fractures, breast cancer recurrence, side effects from cancer treatment, colonoscopy preparation, estrogen replacement and other hormones, gout, gum disease, heart disease and stroke, infection, kidney disease, nausea and dizziness, ulcer disease, and low levels of vitamins or minerals
85% - No Deductible	Medications used to treat the complications of diabetes (insulin and hypoglycemic drugs)

# Consumer Directed Health Plan (CDHP): The HRA

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**HRA funding is based on the size of the subscriber’s family**

- Subscriber-only accounts will be funded with \$500
- Subscribers with one dependent will be funded with \$1000
- Subscribers with two dependents will be funded with \$1500

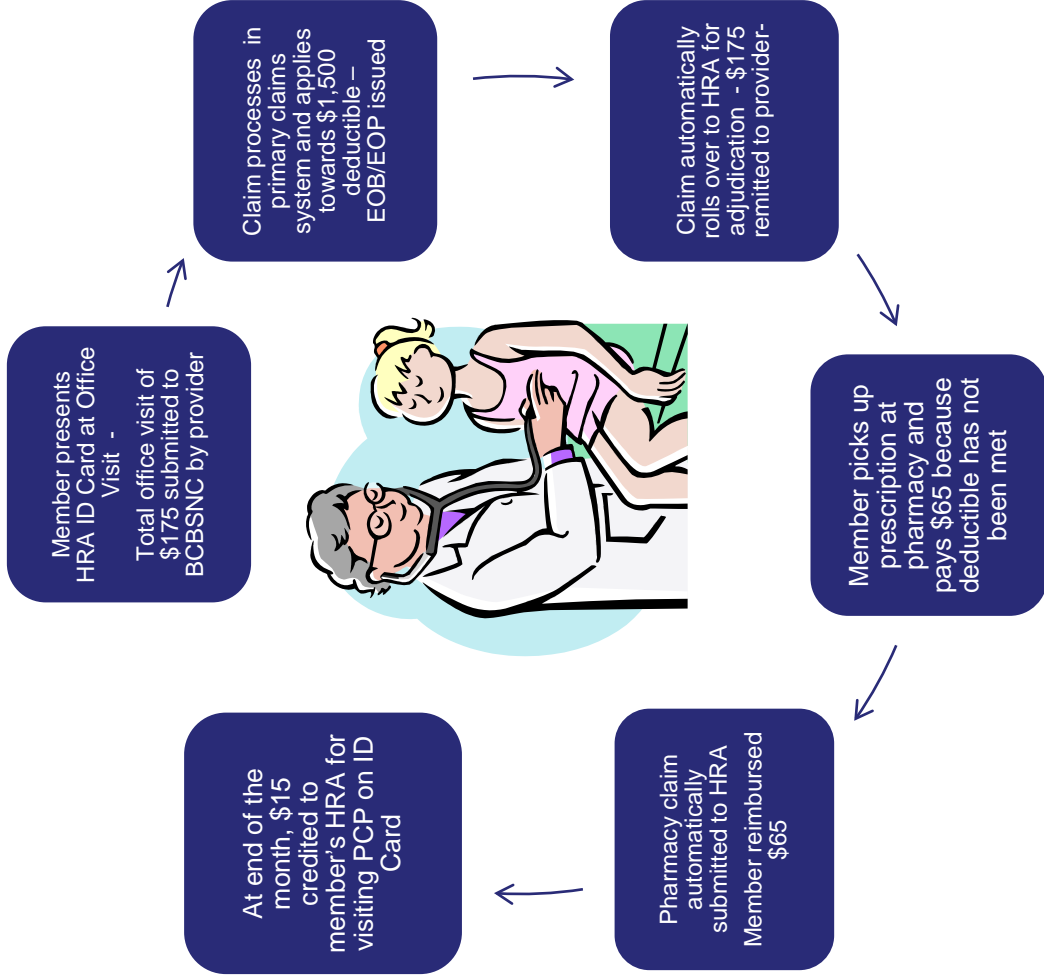
**All members are eligible to earn incentive reward HRA contributions.**

**Members electing the CDHP mid-year will receive a prorated HRA**

Example: New hire with one dependent elects the CDHP on July 1, 2014. Instead of an HRA account with \$1000, the HRA will be funded with \$500, or 50% of the annual amount.

**Unused HRA balances will be “rolled-over” and available for use the following plan year. HRA balances are not portable.**

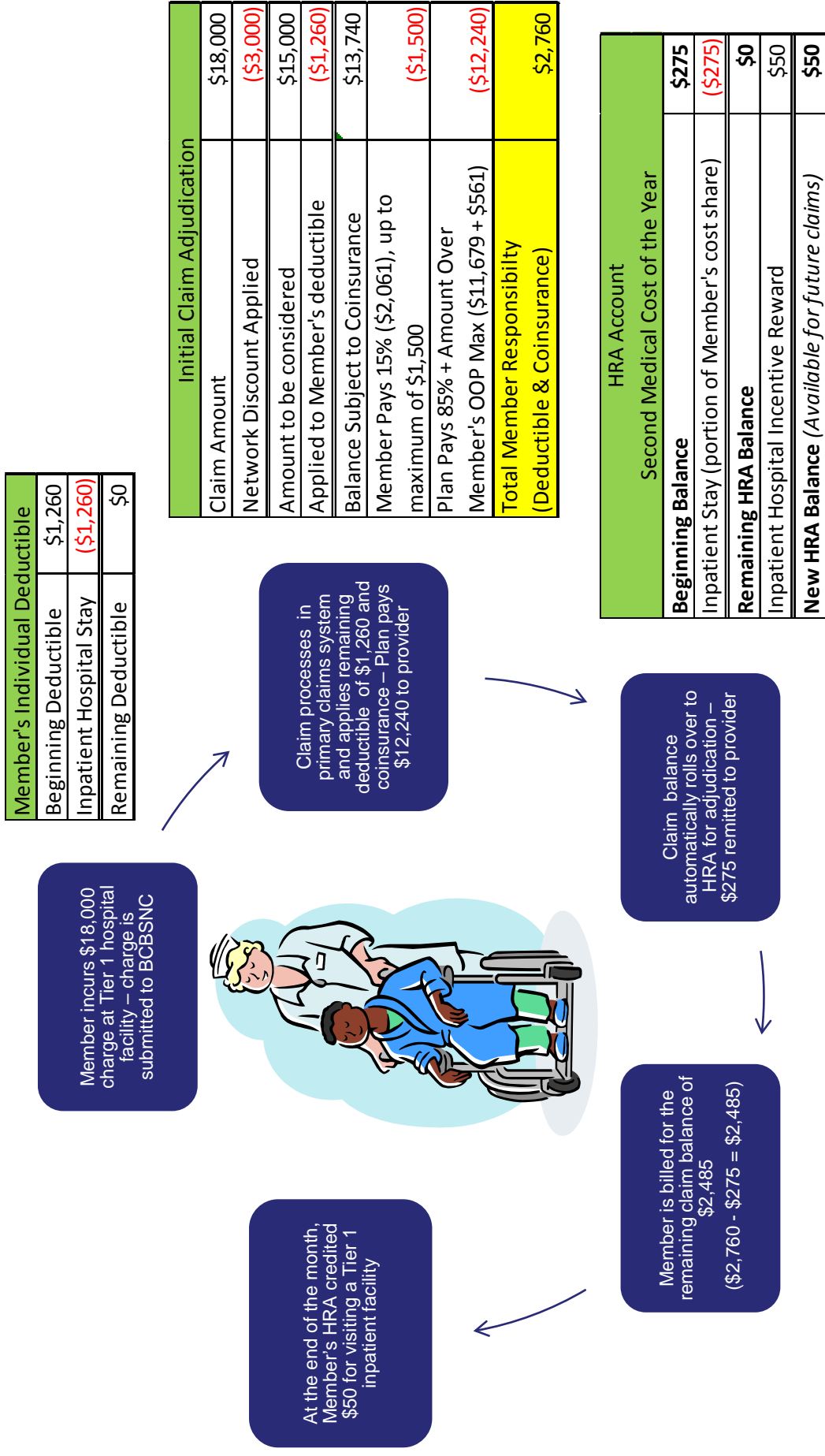
# Consumer Directed Health Plan (CDHP): How It Works



Member's Individual Deductible	
Beginning Deductible	\$1,500
Office Visit	(\$175)
Rx	(\$65)
Remaining Deductible	\$1,260

HRA Account	
First Medical Cost of the Year	
Beginning Balance	\$500
Office Visit	(\$175)
Rx	(\$65)
Remaining HRA Balance	\$260
PCP Incentive Reward	\$15
New HRA Balance	\$275

# Consumer Directed Health Plan (CDHP): How It Works



# Consumer Directed Health Plan (CDHP): Provider Experience

---

## **How will the provider know a member's cost share?**

- ID Cards will indicate the member's deductible and coinsurance as well as the fact that there is an HRA
- Blue e will also be enhanced to support HRA; although, specific member HRA balances will not be available via Blue e in 2014
- Providers will be able to determine a specific member's deductible and out-of-pocket accumulations via Blue e

## **Explanation of Payments (EOPs)**

- Two separate EOPs will be issued
  - One from BCBSNC
  - One from Health Equity, BCBSNC's HRA Vendor\*

*\* Members will not receive an Explanation of Benefits in the mail – HRA balance and claims information will be available online*

# Consumer Directed Health Plan (CDHP) Summary Grids

Proposed CDHP Plan Design						
HRA			HDHP/Rx			
Initial HRA Contributions	HRA Incentive Reward Contributions	HRA Rollover	Annual Deductible	Annual Out-of-Pockets	Preventive (ACA)	Coinsurance
<b>\$500</b> Employee Only Account <b>\$1000</b> Employee + 1 Account <b>\$1500</b> Employee + Family Account (New members added after January 1 will receive a prorated account)	<b>\$15</b> for each visit to the PCP on ID Card <b>\$10</b> for each visit to a Tier 1 Specialist <b>\$50</b> for each stay at a Tier 1 facility	Funds not used during the plan year will "rollover" to the next plan year	<b>\$1500</b> Individual <b>\$4500</b> Family (Non-Network is 2X network)	<b>\$3000</b> Individual <b>\$9000</b> Family (Non-Network is 2X network)	<b>100%</b> (No Deductible)	<b>85%</b> In-network <b>65%</b> Non-Network

Proposed Preventive Medication List	
Coverage	Description
100% - No Deductible	Preventive Drugs from the Affordable Care Act
85% - No Deductible	Preventive Drugs used to treat anemia in children, cavities, heart disease or stroke, obesity, pregnancy, smoking-cessation therapy, vaccines and low levels of vitamins
85% - No Deductible	Preventive drugs sometimes used to treat asthma, bone disease and fractures, breast cancer recurrence, side effects from cancer treatment, colonoscopy preparation, estrogen replacement and other hormones, gout, gum disease, heart disease and stroke, infection, kidney disease, nausea and dizziness, ulcer disease, and low levels of vitamins or minerals
85% - No Deductible	Medications used to treat the complications of diabetes (insulin and hypoglycemic drugs)

# Consumer Directed Health Plan (CDHP) Plan Design Confirmation

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Plan staff recommends the Board of Trustees approve the CDHP plan designs as presented.

# Tiered Network Incentive Rewards



# Incentive Rewards: Blue Options Network

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- We previously proposed incentive rewards for members who accessed a Blue Select specialist or had an inpatient stay in a Blue Select facility. Upon further review, we have determined the best approach for Plan members will be to utilize the Blue Options network. Similar to the Blue Select approach, Blue Options providers will be designated based on quality and costs.
- Hospitals designation criteria:
  - Quality outcomes
  - Cost efficiency
  - Accessibility
- Specialist types designated:
  - General Surgery
  - Ob-Gyn
  - Gastroenterology
  - Orthopedics
  - Cardiology
  - Neurology (*new for 2014*)

## Three Possible Designations

### *“Cost and Quality”*

For providers who meet both the quality and cost benchmarks

### *“Quality”*

For providers who meet the

quality but not the cost benchmark

### *“Critical Access Hospitals”*

For hospitals classified as Critical

Access Hospitals by CMS

# Incentive Rewards: Blue Options Network

## Designated Hospitals

ALLEGHANY COUNTY MEMORIAL HOSPITAL  
ANGEL MEDICAL CENTER  
ASHE MEMORIAL HOSPITAL  
BERTIE MEMORIAL HOSPITAL  
BLADEN COUNTY HOSPITAL  
BLOWING ROCK HOSPITAL  
CHARLES A CANNON JR MEMORIAL HOSP  
CHATHAM HOSPITAL  
DAVIE COUNTY HOSPITAL  
DOSHER MEMORIAL HOSPITAL  
FIRSTHEALTH MONTGOMERY MEM HOSP  
HIGHLANDS CASHIERS HOSPITAL  
OUR COMMUNITY HOSPITAL  
PENDER MEMORIAL HOSPITAL  
PIONEER COMMUNITY HOSP OF STOKE  
PUNGO DISTRICT HOSPITAL  
ST LUKES HOSPITAL  
SWAIN COUNTY HOSPITAL  
THE OUTER BANKS HOSPITAL INC  
TRANSYLVANIA COMMUNITY HOSPITAL  
VIDANT CHOWAN HOSPITAL  
WASHINGTON COUNTY HOSPITAL  
YADKIN VALLEY COMMUNITY HOSPITAL

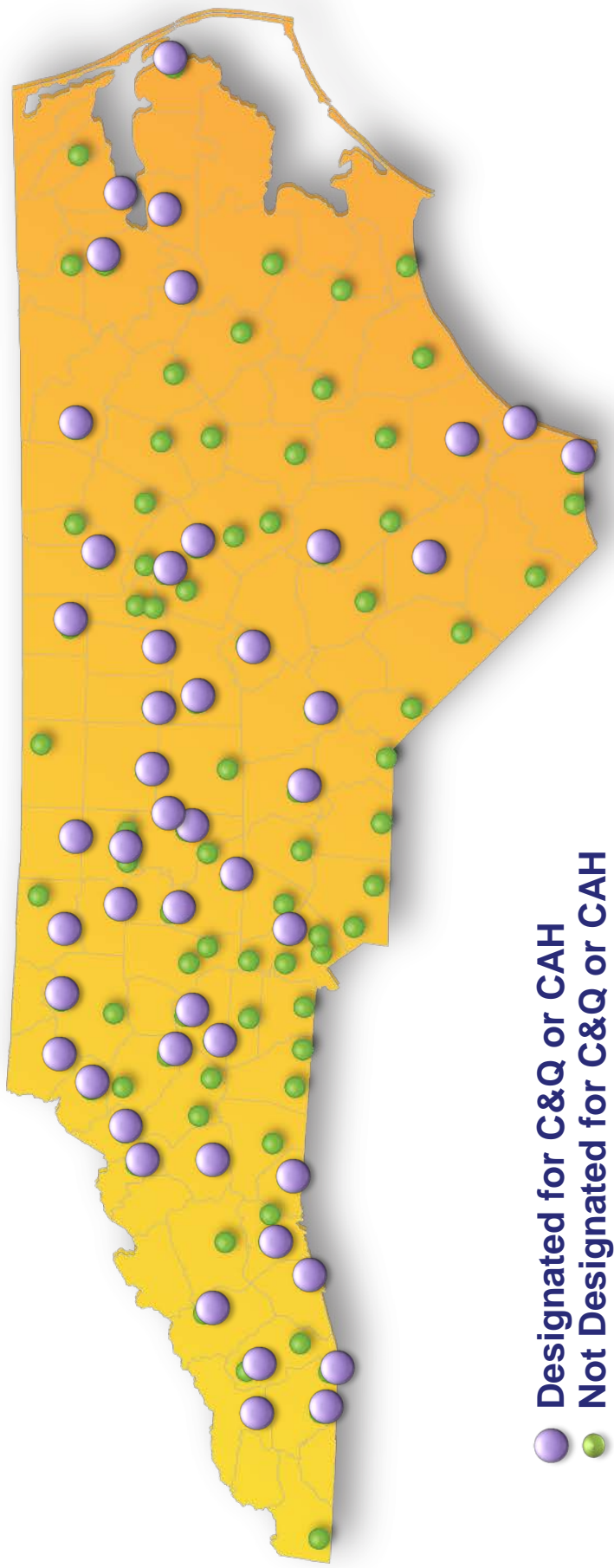
## Critical Access Hospitals

ALAMANCE REGIONAL MEDICAL CENTER  
BLUE RIDGE REGIONAL HOSPITAL  
CALDWELL MEMORIAL HOSPITAL  
CAROLINAS MEDICAL CENTER UNIVERSITY  
CATAWBA VALLEY MED CTR  
CENTRAL CAROLINA HOSPITAL  
D L P PERSON MEMORIAL HOSPITAL LLC  
FIRSTHEALTH MOORE REGIONAL  
FRYE REGIONAL MEDICAL CTR  
GRANVILLE MEDICAL CENTER  
HARRIS REGIONAL HOSPITAL  
HAYWOOD REGIONAL MEDICAL CENTER  
HIGH POINT REGIONAL HOSPITAL  
HUGH CHATHAM MEMORIAL HOSPITAL  
LEXINGTON MEMORIAL HOSPITAL  
MARG R PARDEE MEMORIAL HOSPITAL  
MARTIN GENERAL HOSPITAL  
MOSES H CONE MEMORIAL HOSPITAL  
NEW HANOVER REGIONAL MEDICAL CENTER  
NORTH CAROLINA BAPTIST HOSPITAL  
REX HOSPITAL  
SAMPSON REGIONAL MED CTR  
ROWAN REGIONAL MEDICAL CENTER INC  
THE MCDOWELL HOSPITAL  
UNC HOSPITALS  
WAKEMED RALEIGH CAMPUS

## Cost & Quality Designated Hospitals

# Incentive Rewards: Blue Options Network

## PPO Provider Network - Hospitals



# Incentive Rewards: Blue Options Network

---

- The intent of these incentives is to reward members for choosing a high quality provider. Unlike some plan designs that penalize members for not selecting the designated network provider, the Plan is rewarding members who have made a choice to select a quality provider.
- Members who just happen to access these providers will be rewarded as well. Members who visit Blue Options providers who are not designated will still receive in-network benefits.

Enhanced 80/20 PPO Plan		
Blue Options Network	Specialist Copay	Inpatient Hospital Copay
Designated	\$60 Copay	\$0 Copay
Not Designated	\$70 Copay	\$233 Copay
CDHP*		
Blue Options Network	Specialist Visit	Inpatient Hospital Stay
Designated	\$10 Added HRA	\$50 Added to HRA

\* There are no copays on a CDHP

# Tiered Network Incentive Rewards: Confirmation

---

Plan staff recommends the Board of Trustees approve the incentive rewards for designated Blue Options hospitals and specialists as presented.



*North Carolina*  
**State Health Plan**

FOR TEACHERS AND STATE EMPLOYEES



## Preview of the Enrollment Workflow of the Benefitfocus Platform

*Board of Trustees Meeting*

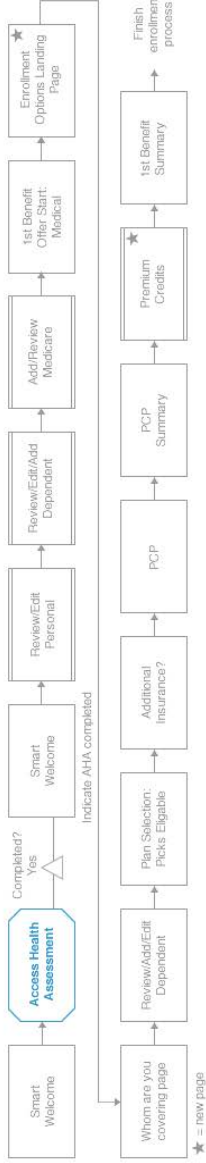
May 24, 2013


# Enrollment Workflow: Active/SHP Prime Retirees

---

Work is currently under way to integrate the premium incentives into the enrollment workflow. While the member experience will be slightly different on each platform (Benefitfocus and BEACON), both will offer the same options.

- Primary Care Provider (PCP) Election
- The option to select a PCP will be presented during the enrollment workflow – once elected, the appropriate premium credit will be applied
- If PCP(s) selected prior to enrollment, the appropriate premium credit will be applied
- Health Assessment (HA)
- The option to take the HA will be on the welcome page and within the enrollment workflow
- If the HA was completed in the appropriate timeframe prior to enrollment, the appropriate premium credit will be applied and the HA will not appear in the enrollment workflow
- Smoker Attestations
- Smoker attestations will be included in the enrollment workflow and the appropriate premium credit will be applied if the attestation is affirmative






**North Carolina State Health Plan**  
FOR TEACHERS AND STATE EMPLOYEES  
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[HOME](#)
[MY BASIC INFO](#)
[MY BENEFITS](#)

✔ Success! Your Health Assessment has been completed!



Welcome, John!

You have new benefits being offered to you:

- You have **0 days** to elect your Current Enrollment benefits.
- You have **22 days** to elect your Open Enrollment benefits.

Get Started

You have new benefits being offered to you:

- You have **22 days** to elect your Open Enrollment benefits.


An Important Note for You

Before beginning the enrollment process please make sure that you have the following information:

- The Social Security Number for any dependent that you may want to cover.
- Information regarding any other health insurance plan that you are covered, including the name of the insurance carrier, policy number and effective date of coverage.
- If you participate in Medicare, please have your Medicare number and effective date.


My Basic Information

View and edit personal information




My Benefits

View and edit benefit information




My Login Information

Edit Password




My Language Preferences

Edit your language preferences




Summary of your Benefits

View a summary of your benefits



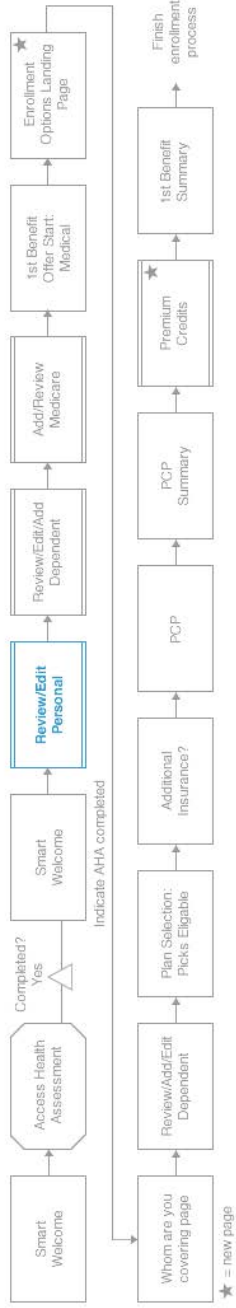
My Beneficiary Form


View your beneficiary form



Let's get started!







**HOME MY BASIC INFO MY BENEFITS**

1 Profile 2 Shop for benefits 3 Review elections 4 Confirmation

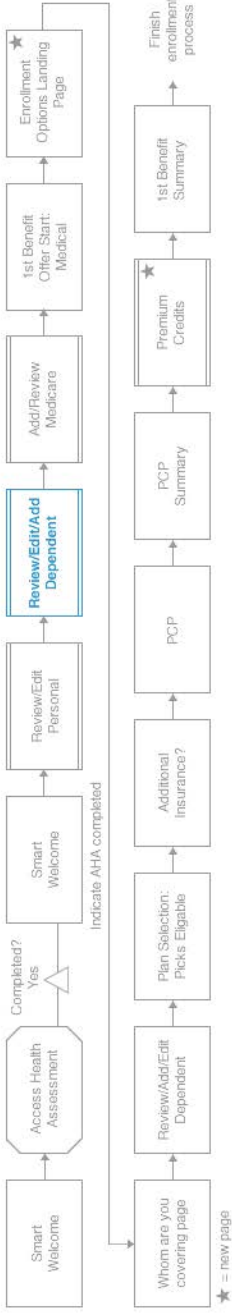
## Tell us about yourself


Please provide us with your profile information.

**Personal and contact information**

First name *	<input type="text" value="John"/>	Middle name	<input type="text"/>	Last name *	<input type="text" value="Smith"/>
Date of birth *	<input type="text" value="mm/dd/yyyy"/>	Gender *	<input checked="" type="radio"/> Male   <input type="radio"/> Female	Social security number	<input type="text" value="XXX-XX-1234"/>
Address line 1 *	<input type="text" value="123 Main St."/>				
Address line 2	<input type="text"/>				
City *	<input type="text" value="Lorem ipsum"/>	State / province *	<input type="text" value="SC"/>		
Country *	<input type="text" value="USA"/>	Zip / postal code *	<input type="text" value="28414"/>		

Next
Save
Cancel





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HOME MY BASIC INFO MY BENEFITS

1 Profile 2 Shop for benefits 3 Review elections 4 Confirmation

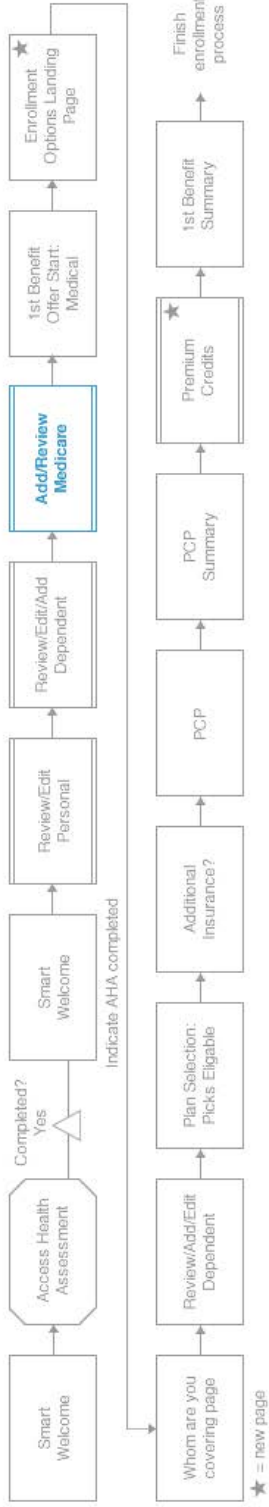
## Tell us about your dependents

Please fill out the information on anyone you wish to cover for any benefits. Once you start shopping for benefits, you can add or remove your dependents based on what coverage you would like them to have.

**Dependent information**

First name *	Middle name	Last name *	Social security number
Jessie		Smith	XXX-XX-1234
Date of birth *	Gender *		
mm/dd/yyyy	<input type="radio"/> Male   <input checked="" type="radio"/> Female		
Address line 1 *	Address line 2		
123 Main St.			
City *	State / province *		
Lorem ipsum	SC		
Country *	Zip / postal code *		
USA	28414		

Next
Save
Cancel



## Medicare

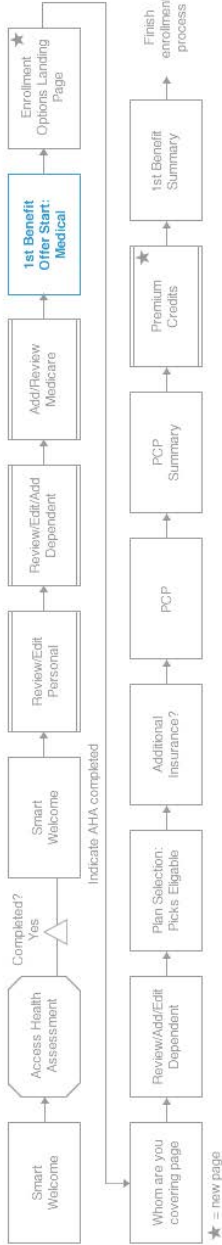
Please provide Medicare information if applicable.


**Medicare information** ?

Are you or any of your dependents covered by Medicare?

No  
 Yes

Next
Save
Cancel





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FOR TEACHERS AND STATE EMPLOYEES  
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HOME
MY BASIC INFO
MY BENEFITS

1 Profile
2 Shop for benefits
3 Review elections
4 Confirmation

## Welcome to Open Enrollment!

Please click Start section to complete your Medical Offer section.

My Current Benefits
My Open Enrollment Benefits

1

**Medical Offer**

Section Incomplete - Please complete by 10/31/2013

**You are being offered the following options**

Medical

Start section

2

**Dental Offer**

Section Incomplete - Please complete by 10/31/2013

**You are being offered the following options**

Dental

3

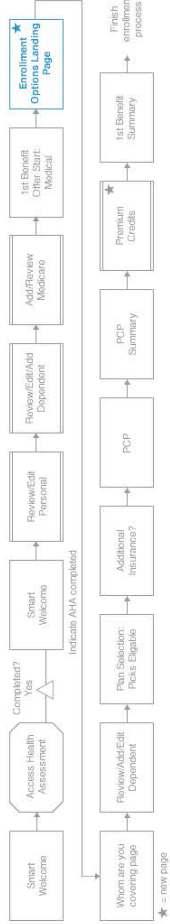
**Life Offer**

Section Incomplete - Please complete by 10/31/2013

**You are being offered the following options**

Life  
AD&D

Log out



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HOME MY BASIC INFO MY BENEFITS Shop for benefits 3 Review elections 4 Confirmation

## Health plan comparison

Compare state health plan options for active and non-Medicare primary retirees below.

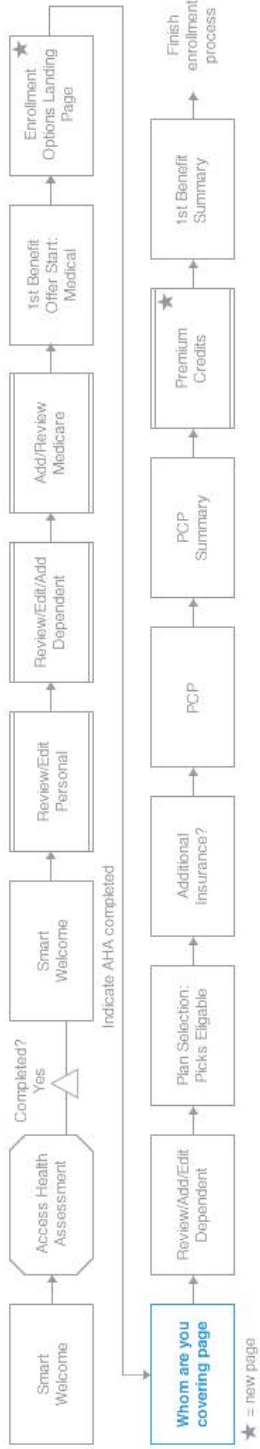
Premium	Traditional 70/30 plan	Enhanced 80/20 plan	Consumer directed health plan (CDHP)*
Employee only premium base	\$0	\$25	\$0
Employee only premium surcharge	\$0	\$40	\$40
Total employee only premium	\$0	\$65	\$40
<b>Wellness premium credits</b>			
Employee (and spouse, if covered on plan) attest to not smoking	N/A	\$20	\$20
Each family member selects a primary care provider at time of enrollment	N/A	\$15	\$10
Employee completes health assessment	N/A	\$15	\$10
Premium total credits	N/A	\$50	\$40
<b>Total premium with credits applied</b>			
Employee only	\$0	\$15	\$0

### Wellness incentives

PCP Office Visit	\$35 copay (employees do not apply to this plan)	\$30 copay or \$15 copay when using PCP listed on their ID card**	\$15 credit into HRA fund account when using PCP listed on ID card**
Specialist Office Visit	\$81 copay (employees do not apply to this plan)	\$70 copay when a Blue Options designated provider is utilized	\$10 credit when using a Blue Options designated provider
Inpatient Hospital Stay	\$291 30% after deductible (employees do not apply to this plan)	\$233 copay after deductible or \$0 copay when a Blue Options designated hospital is utilized	\$50 credit into a HRA fund account when using a Blue Options designated provider

\*The Consumer Directed Health Plan (CDHP) is a High Deductible Health Plan (HDHP) in which copays do not apply. Each employee in the CDHP will receive \$500 in a Health Reimbursement Arrangement (HRA) fund account. Employees in the CDHP must select a primary care provider (PCP) at the time of enrollment. New members who elect the CDHP with an effective date after January 1, 2014 will receive a prorated amount in their HRA. HRA funds will automatically be used to offset the member's out-of-pocket expenses. Once the HRA reaches a \$0 balance, deductibles and coinsurance will apply.

\*\*A Primary Care Provider (PCP) must be selected by the end of annual enrollment, initial enrollment, or during a qualifying event enrollment to meet requirements for the copay reduction. Members electing a PCP for the first time after these periods will not be eligible for the copay reduction until the next plan year.



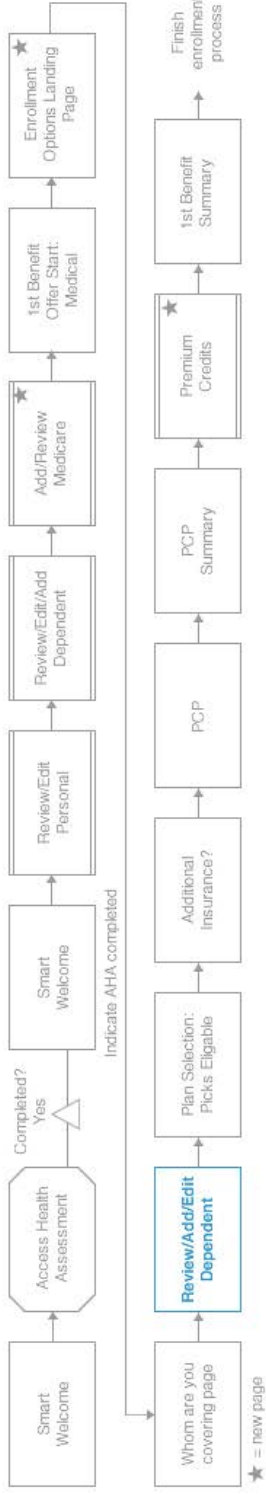
## Medical: Whom do you want to cover?

Choose from your list of dependents below.

Name	Relationship	Date of birth	Gender
John Smith	Subscriber	01/25/1975	Male
<input checked="" type="checkbox"/> Jessie Smith	Child	10/21/1981	Female <a href="#">Edit</a>
<input checked="" type="checkbox"/> Johnny Smith	Child	01/02/2011	Male <a href="#">Edit</a>

[+ Add dependent](#)

[Next](#) [Save](#) [Cancel](#)



## Review requirements to add this dependent

Additional information is needed about this dependent

Name	Relationship	Date of birth	Gender
Johnny Smith	Child	10 / 26 / 2012	Male

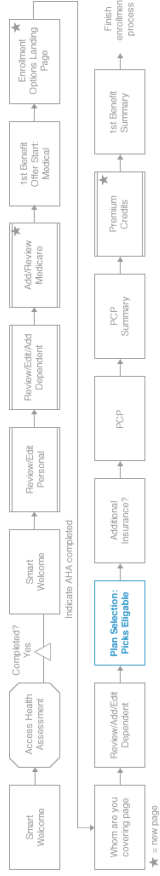
**In order to be covered, a child or student must meet both of the following requirements:**

- Be a naturally, legally adopted or foster child for whom you are a court appointed guardian
- Not eligible for their own employer sponsored health coverage

**Are the above requirements met?**

- No, this dependent does not meet the above requirements.
- Yes, this dependent meets the above requirements.

**Next** Save Cancel



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The State's Health Insurance Program  
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**Medical**

Please select your plan.

Costs based on John Smith, Jessie Smith, Johnny

<b>Traditional 70/30 PPO Plan</b>	
Preventive Care	\$35 Copay
Office Visit Copay	\$35 Copay
Specialist Visit Copay	\$81 Copay
Benefit Year Deductible	\$933 Individual/\$2,799 Family
Inpatient Service Copay	\$291 copay, then 30% after deductible
Emergency Room Copay	\$291 copay, then 30% after deductible
Q. Plan details	Plan documents
<b>Enhanced 80/20 PPO Plan</b>	
Preventive Care	\$0 Copay
Office Visit Copay	\$30; \$15 if you use PCP on ID card
Q. Plan details	Plan documents

**Uniform Summary of Coverage**

Summary of Benefits and Coverage. It is to be used as a reference document for your plan.

per month

\$207.37

Rate does not reflect wellness premium credits

Select plan

per month

\$186.63

Rate does not reflect wellness premium credits

Select plan

per month

\$70

Rate does not reflect wellness premium credits

Select plan

**Consumer Directed Health Plan**

Preventive Care

Benefit Year Deductible

\$186.63

Rate does not reflect wellness premium credits

Select plan

**Consumer Directed Health Plan**

Preventive Care

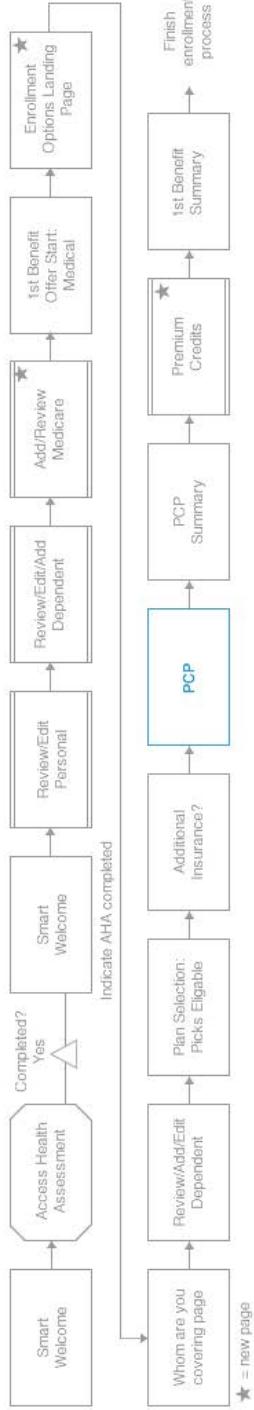
Benefit Year Deductible


\$186.63

Rate does not reflect wellness premium credits

Select plan







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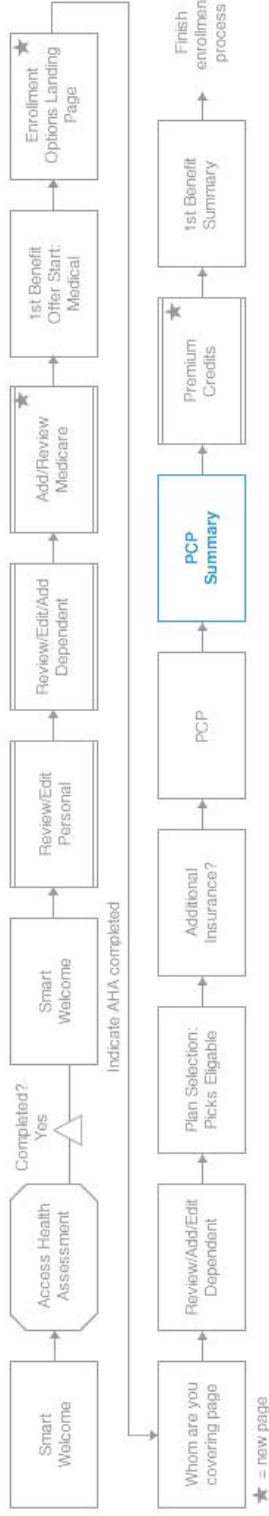
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## Medical: PCP

Search from the list of providers to enter your PCP Code.

*PCP Code	PCP Name	
John Smith *	<input type="text" value="John Smith"/>	<input type="button" value="Search"/>
<p style="color: #0070c0; font-weight: bold;">Do you and your dependents use the same provider?</p> <p>No <input type="button" value="No"/></p>		
Johnny Smith *	<input type="text" value="Johnny Smith"/>	<input type="button" value="Search"/>
Jessie Smith *	<input type="text" value="Jessie Smith"/>	<input type="button" value="Search"/>



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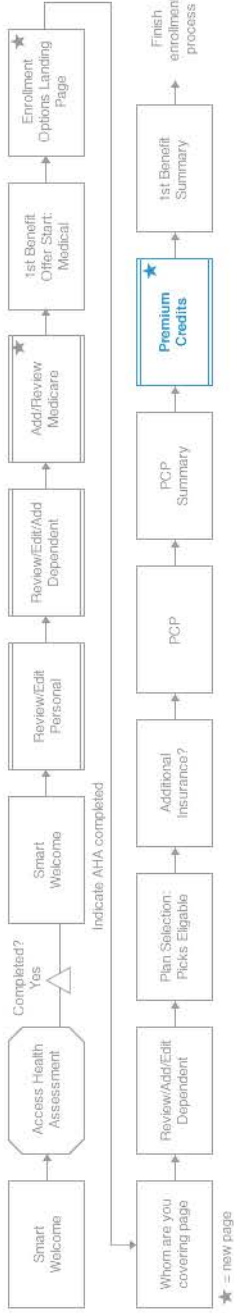
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## Medical: PCP

Provider summary

PCP Code	PCP Name	Last Effective Date
310NCB2	Joseph Bruckert	N/A
310NCB2	Joseph Bruckert	N/A
310NCB2	Joseph Bruckert	N/A

Next Save Cancel





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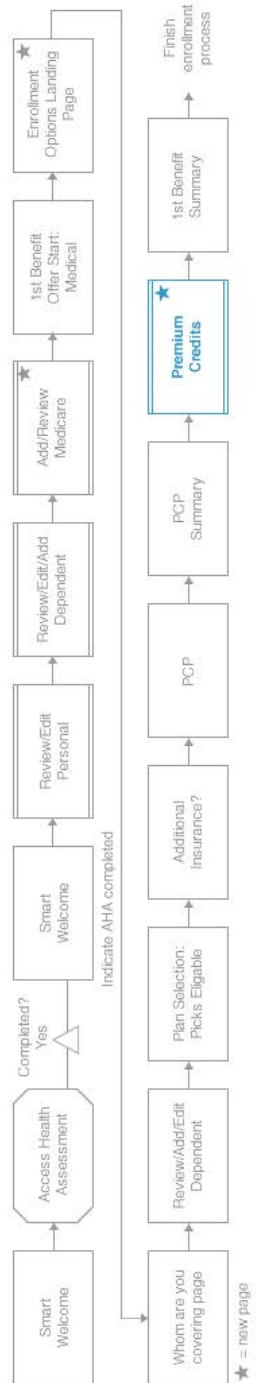
## Premium credits


Please complete the activities below to receive premium credits.

<b>Primary Care Provider</b>	Credit amount <b>\$15.00</b> ✓
<b>Health Assessment</b>	Credit amount <b>\$15.00</b> ✓
<b>Smoker Attestation</b>	?

I and, if applicable, my spouse are not tobacco smokers or promise to participate in a tobacco smoking cessation program, during this benefit year.

I understand that making a false statement, representation or attestation to the Plan could result in my termination from the Plan and that by attesting to my tobacco status I am also agreeing to cooperate with the Plan in any efforts to verify that status.





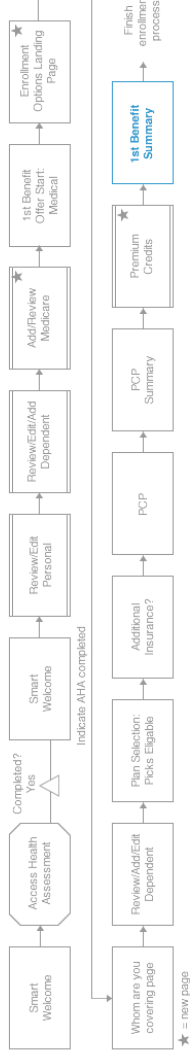
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## Premium credits

Please complete the activities below to receive premium credits.

▶ <b>Primary Care Provider</b>	Credit amount <b>\$15.00</b> ✓
▶ <b>Health Assessment</b>	Credit amount <b>\$15.00</b> ✓
▶ <b>Smoker Attestation</b>	Credit amount <b>\$20.00</b> ✓
<p><b>Congratulations, your credit has been applied!</b></p> <p>I and, if applicable, my spouse are not tobacco smokers or promise to participate in a tobacco smoking cessation program, during this benefit year.</p> <p>I understand that making a false statement, representation or attestation to the Plan could result in my termination from the Plan and that by attesting to my tobacco status I am also agreeing to cooperate with the Plan in any efforts to verify that status.</p> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <input type="button" value="I Agree"/> <input type="button" value="I Disagree"/> </div>	





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## SHP Medical

### Medical summary

Your SHP Medical benefit summary is shown below. To make changes, click [Edit](#).  
Please note that your benefits have not been saved. You must click **Save** to complete the section.

Important Note

**Medical**

Medical: [Accepted](#) [Edit](#)

Plan: [Enhanced 80/20 PPO Plan](#)

[Edit](#)

Coverage Level: Employee and Children

Your Cost: \$25.78 per pay period
Primary Care Provider \$15.00 <span style="color: green;">✔</span>
Health Assessment \$15.00 <span style="color: green;">✔</span>
Smoker Attestation \$20.00 <span style="color: green;">✔</span>

Primary Care Provider: [John Smith; Joseph Bruckert, Code 310NCB2\\_19281\\_01](#)

Johny Smith; Joseph Bruckert, Code 310NCB2\_19281\_01

Jessie Smith; Joseph Bruckert, Code 310NCB2\_19281\_01 [Edit](#)

Effective Date: 01/01/2014 [Edit](#)

**Additional Insurance** [Edit](#)

None None **Medicare** [Edit](#)

**Dependents** [Edit](#)

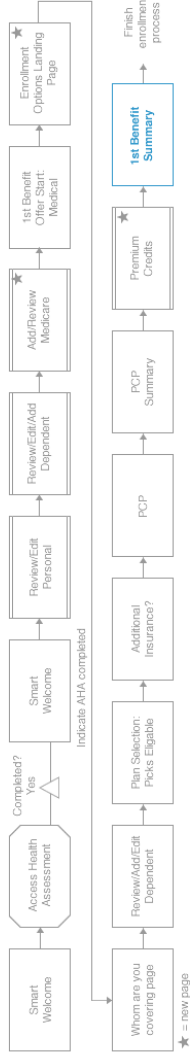
Name	Relationship	Status
Johny Smith	Child	
Jessie Smith	Child	

To edit a person's Name or SSN, click the person's name.

Save

Log out

Cancel



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## SHP Medical

### Medical summary

Your SHP Medical benefit summary is shown below. To make changes, click Edit. Please note that your benefits have not been saved. You must click Save to complete.

**Important Note**

**Medical**

Medical: Accepted [Edit](#)

Plan: Enhanced 80/20 PPO Plan

Coverage Level: Employee and Children

Your Cost: \$225.78 per pay period	
Primary Care Provider \$15.00	✓
Health Assessment \$15.00	✓
Smoker Attestation \$20.00	✓

Primary Care Provider: John Smith; Joseph Bruckert, Code 310NCB2\_1928|\_01  
 Johnny Smith; Joseph Bruckert, Code 310NCB2\_1928|\_01  
 Jessie Smith; Joseph Bruckert, Code 310NCB2\_1928|\_01 [Edit](#)  
 Effective Date: 01/01/2014 [Edit](#)

**Recurring Deductions (monthly)**

Medical	\$275.78
Primary Care Provider	-\$15.00
Health Assessment	-\$15.00
Smoker Attestation	-\$20.00
Dental	\$20
Life	\$10
AD & D	\$1
<b>Recurring Deductions</b>	<b>\$256.78</b>

**Additional Insurance** [Edit](#)

None None

**Dependents** [Edit](#)

Name	Relationship	Status
Johnny Smith	Child	
Jessie Smith	Child	

To edit a person's Name or SSN, click the person's name.

Save

Log out

Cancel

# Enrollment Preview: Split Contracts

---

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

## **Split Contract Enrollment Rules:**

- When the retiree and dependents are both Medicare Primary or both SHP Primary, the dependents’ enrollments will match the retiree’s enrollment. There is one exception to this rule. When all Medicare Primary retiree family members enroll in an MA-PDP plan and CMS “dis-enrolls” one family member, the “dis-enrolled” family member will be enrolled in the Traditional 70/30 PPO Plan.
- When the retiree and dependents are split between Medicare Primary and SHP Primary, the Medicare Primary members will only be offered the Medicare Primary options. The SHP primary members will only be offered the SHP Primary options. If there are multiple dependents on a separate contract from the retiree, all the dependents must elect the same option.
  - Example:
    - Retiree is Med Prime and is offered the 4 MA-PDP plans and the Traditional 70/30 plan – Retiree elects the Enhanced MA-PDP Plan
    - Dependents are SHP Prime and are offered the Enhanced 80/20 Plan, the CDHP and the Traditional 70/30 PPO Plan - Dependents elect the CDHP

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

- **Retirees/Dependents Turning 65** – No other family member Medicare Primary
  - Auto-Enrolled in a base MA-PDP 90 days prior to effective date and offered to elect any of the 5 available options – Final election must be made 30 days before the effective date.
- **Retirees/Dependents Turning 65** – Family member(s) already Medicare Primary
  - Auto-Enrolled into the same plan as other Medicare Prime family members. Notified of the enrollment and advised of the options available at the next open enrollment.
- **Active Member or New Retiree coming into the Retirement System 65 or older**
  - **Retirees with at least 60 days notice** – Auto-Enrolled in a base MA-PDP and offered to elect any of the 5 options – Final election must be made 30 days before the effective date.
  - **Retirees with less than 60 days notice** – Auto-Enrolled in the Traditional 70/30 PPO Plan and advised of the options available at the next open enrollment.



# Next Steps: Plan Designs and Enrollment

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## Multiple workgroups and work-streams in progress

- Wellness Incentive Enrollment front-end web requirements
- Medicare Primary Enrollment front-end web requirements
- Health Assessment Connectivity between ActiveHealth Management, BEACON and Benefitfocus
- In- and outbound file enhancement or new implementations between Benefitfocus and
  - BCBSNC
  - Humana
  - UHC
  - COBRAGuard
  - Retirement System
- Inbound file transfers from BEACON to Benefitfocus
- HRA Integration
- ESI/BCBSNC Integration for CDHP
- Enhanced ID Cards to reflect Wellness Incentives and Blue Options Rewards
- New Billing Process in development to support Medicare Advantage
- Payroll requirements and testing for Benefitfocus groups with eLinks for Community Colleges, UNC University System, Charlotte Mecklenburg Schools, NC Housing & Finance
- Implementation of the Total Compensation Tool – Approximately 75 Benefitfocus groups



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## Communications Update

*Board of Trustees Meeting*

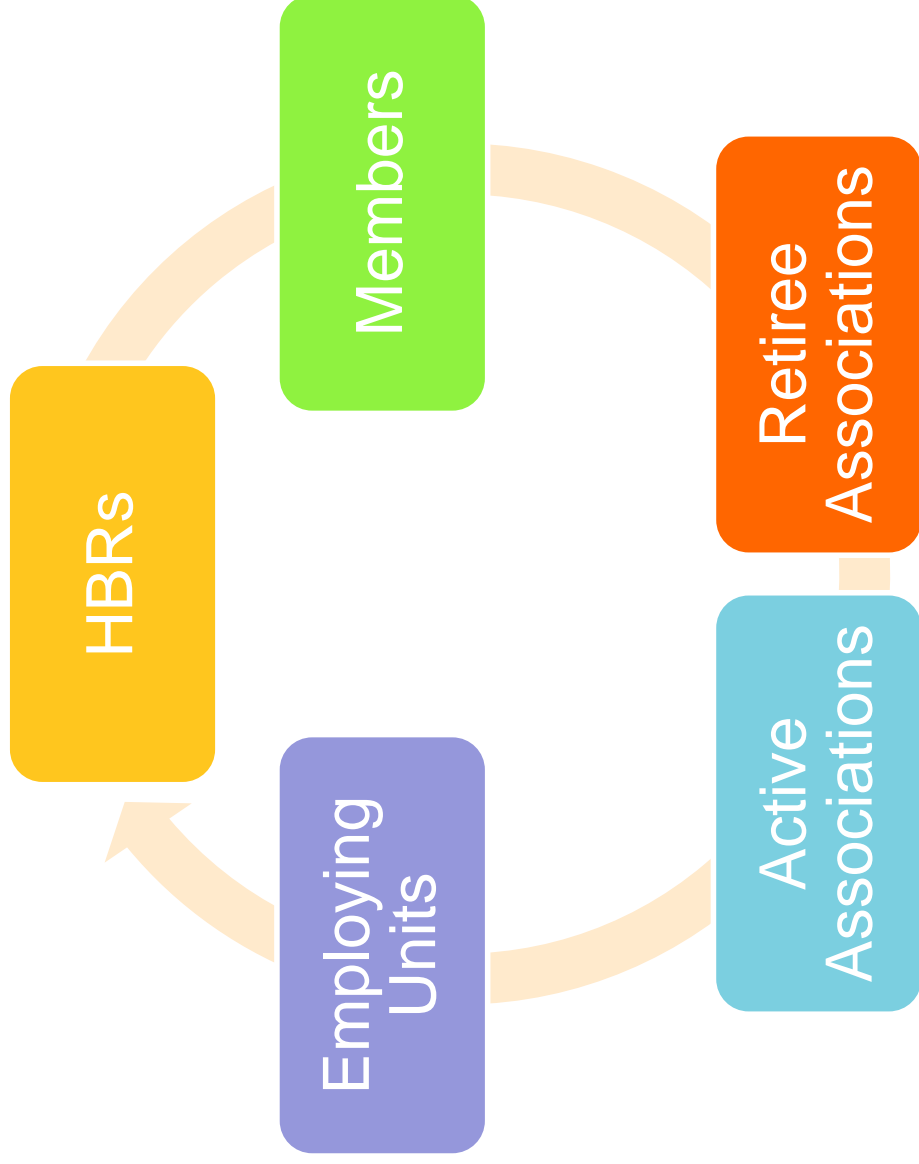
May 24, 2013

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# Communications Strategy

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# Ongoing Communication Efforts

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- NC Retired School Personnel Association
  - Presented at 3 district meetings (~200 retirees)
- North Carolina Retired Governmental Employees' Association
  - Presented at 6 district meetings (~1,100 retirees)
- Annual Enrollment HBR Trainings
  - Conducted 11 trainings in April (~600 HBRs)
  - Community College Finance Meeting (~400 Finance/HR)
- Cross Promotion with State Retirement Systems
- NC Medical Society
- Seniors' Health Insurance Information Program
- Join us on Facebook!



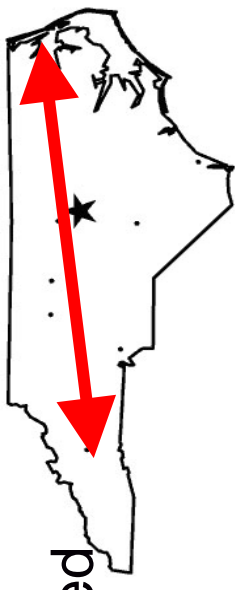
# HBR Training Progress Report

Employing  
Units

HBRs

## Activities:

- 57 training locations have been secured
- 1-800 number goes live July 1, 2013
- Training materials currently being developed



## Upcoming Milestones

- SHP announces training dates June 3, 2013
- Training sessions begin on July 8, 2013

# Member Outreach-Actives and Non-Medicare Progress Report

Members

## Activities:

- September will feature “Member Information Sessions”
  - 7 locations, 2 webinars secured
- October will feature an “Enrollment Tour”
  - 14 locations secured

## Upcoming Milestones

- Member video production begins in June
- Initial mailers finalized in June

Video	Content
Video #1: Overview	Intro w/State Treasurer for “Overview of New Plans”
Video #2: Comparing Plans	Self-directed “Comparing Plan Options”
Video #3: All about CDHP	How the Consumer-Directed Health Plan Works
Video #4: Enrollment	Self-directed “What You Need to Know to Enroll”

# Member Outreach-Medicare Retirees Progress Report

## Activities:

- UHC is in the process of securing 122 locations in NC, VA, SC and FL.
- Humana will be setting up a 1-800 line for retirees to RSVP

## Upcoming Milestones

- Materials development finalized in June





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## Specialty Pharmacy Management

*Board of Trustees Meeting*

May 24, 2013

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# Presentation Overview

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- What are specialty drugs?
- Marketplace trends and projections
- Current benefits and financial summary
- Current specialty drug benefit management strategies
- Future strategies

# What are Specialty Drugs?

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## **State Health Plan Definition:**

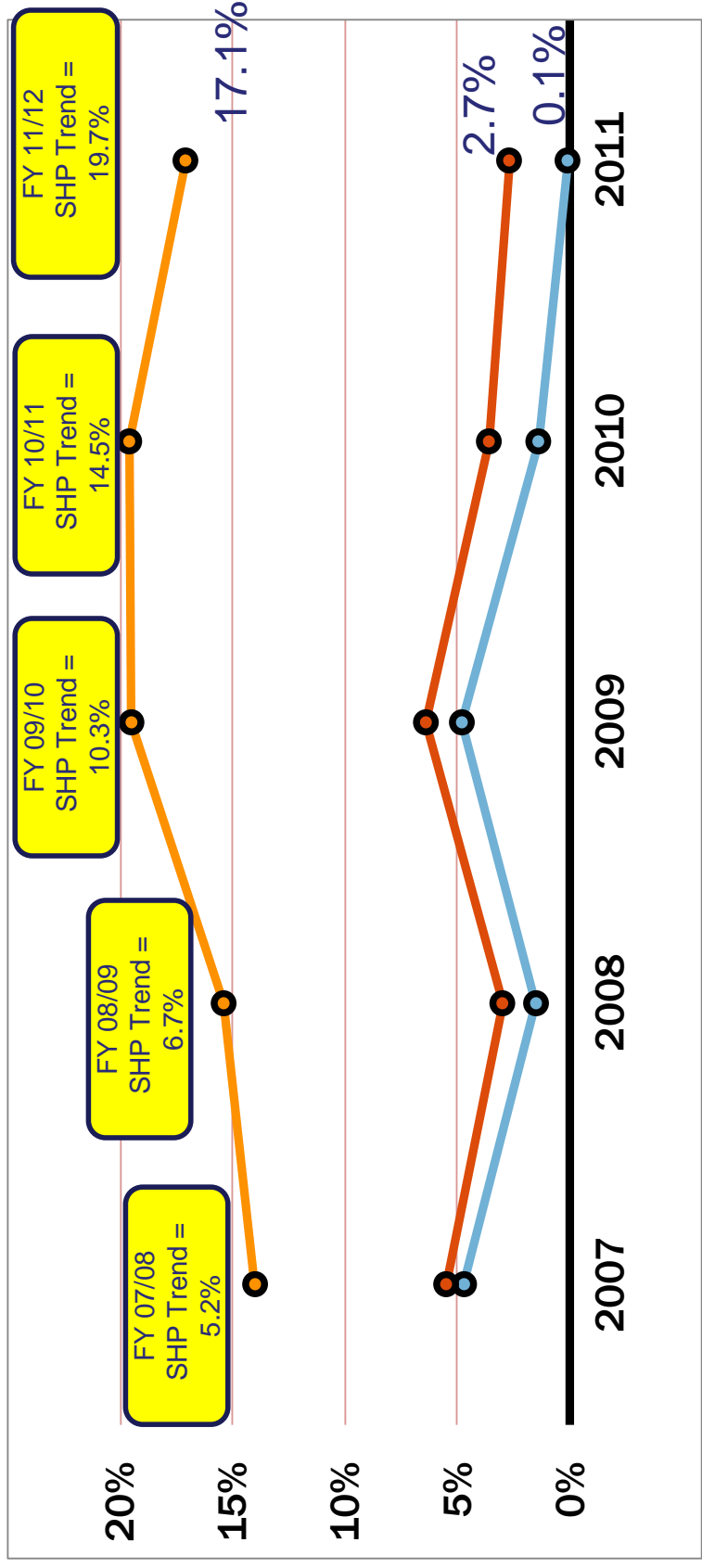
- Covered biotech and biosimilar medications
- Have unique uses for the treatment of complex diseases (Multiple Sclerosis, Rheumatoid Arthritis, Hepatitis)
- Require special dosing or administration
- Require special handling
- Typically prescribed by a specialist provider
- Exceed \$400 cost to the Plan

Specialty drugs are in the midst of a tremendous boom, with an annual yearly cost trend of 17%. Currently that is expected to grow to 22% by 2014.

Industry experts have predicted that specialty drugs will represent 45% of pharmaceutical sales by 2017.

Specialty drugs are billed under the pharmacy and medical benefit, and at multiple places of service under the medical benefit.

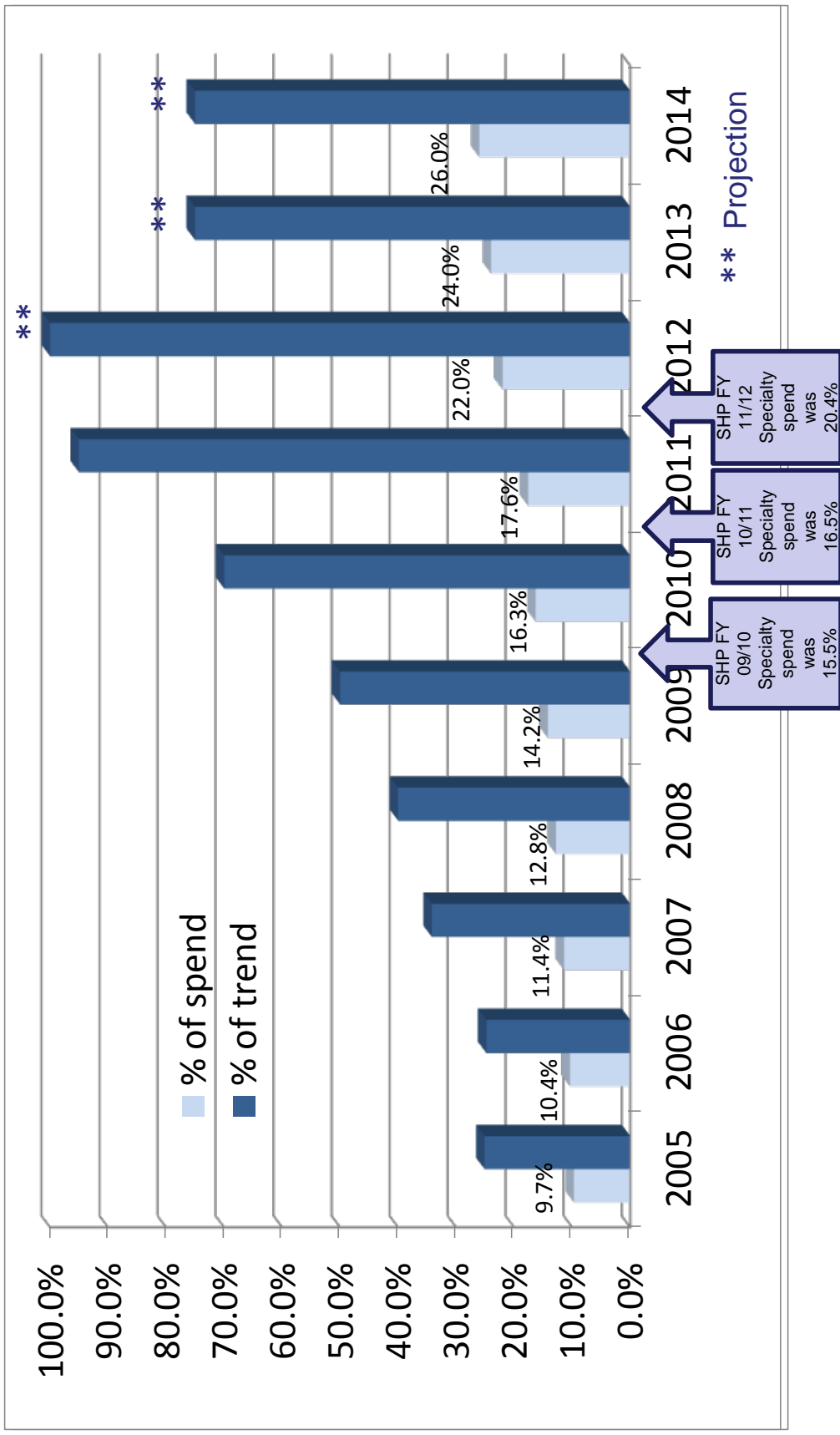
# 2011 Express Scripts Drug Trend as Compared to State Health Plan



- Express Scripts Specialty Trend: 17.1%
- Express Scripts Overall Drug Trend: 2.7%
- Express Scripts Traditional Trend: 0.1%

# Specialty Pharmacy Trend Projections

As a percent of Express Scripts book of business plan spend and percent of trend:



# Current Specialty Drug Benefit

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- All non-acute specialty medications covered under the pharmacy benefit must be obtained through Accredo, except for oncology medications.
- Pharmacy co-insurance of 25% up to \$100 max per 30 day supply.
- Most infused specialty medications are covered under the medical benefit managed by BCBSNC.
- When biosimilars become available the Plan may impose a higher specialty copay for non-preferred specialty medications. The maximum copay for the non-preferred specialty medications could be set higher than the preferred per 30-day supply.

# Financial Summary\*

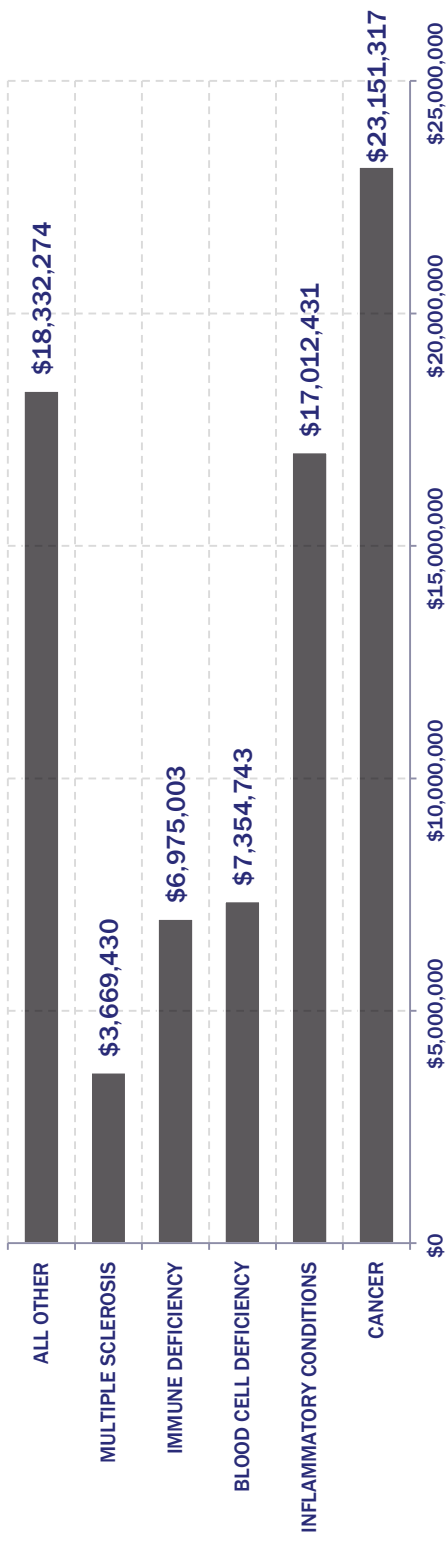
	7/11-3/12	7/12-3/13
Specialty Rx Plan Cost	\$108,233,392	\$120,662,841
Total PBM Plan Cost	\$535,473,480	\$550,265,155
Specialty Rx % of Plan Cost	20.2%	21.9%
Specialty Plan Cost PMPM	\$18.05	\$20.13
Members using specialty medication	8897	8896

\*Pharmacy Benefit only

- Average cost of specialty drug = \$3989/30 days
- Inflation is the top driver of trend – some drugs have double digit inflation rates

# Medical Specialty Claims

## Top 5 Therapy Classes

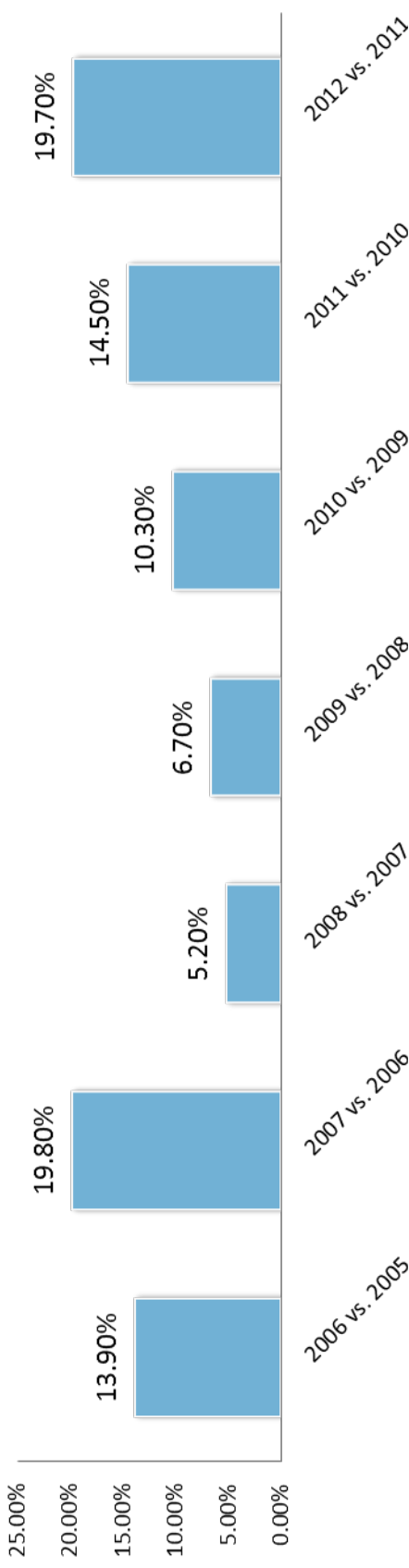


Rank	Therapy Class	Amount Allowed	Claims
1	CANCER	\$23,151,317	25,034
2	INFLAMMATORY CONDITIONS	\$17,012,431	7,494
3	BLOOD CELL DEFICIENCY	\$7,354,743	9,708
4	IMMUNE DEFICIENCY	\$6,975,003	1,749
5	MULTIPLE SCLEROSIS	\$3,669,430	1,253
	ALL OTHER	\$18,332,274	33,033
<b>TOTAL SPEND</b>		<b>\$76,495,199</b>	<b>78,271</b>

Based on spend from September 2011 through August 2012

# Strategies Implemented and the Affect on Trend

NCSHP Specialty PMPM trend



## Timeline of Specialty Management Strategies Enacted

**2012:** Fertility PTPA and Fertility Pureplay lock on 4/1/12. Medical/Pharmacy coverage delineation on 7/1/12. Hep-C PTPA to be implemented on 10/1/12, along with PA rules for IVIG, Acthar, and Firazyr.

**2011:** PA for PAH Drugs and Accredo Clinical Days Supply. Step Therapy for RA drugs implemented 11/1/11.

**2010:** Forteo Step Therapy implemented 4/1/10; **Note:** Pharmacy trend for Specialty is artificially lower in 2010 due to movement of IVIG to medical on 3/1/10 and Synagis to medical on 7/1/10.

**2009:** All chronic Specialty medications to be filled at Accredo and implemented Specialty Coinsurance Tier on 7/1/09.

**2008:** Implemented PA for MS Agents, Revlimid/Thalomid and Psoriasis Agents on 11/1/08. Main impact of the 11/1/07 Out of State Specialty provider removal was realized during 2008.

**2007:** Out of State Specialty providers removed from network on 11/1/07. Impact seen in 2008.

**2006:** No Specialty Strategies were implemented during this time.





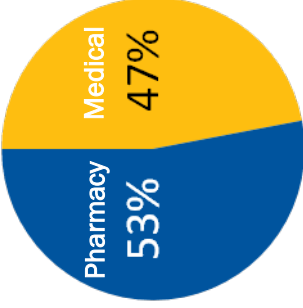

# Management Strategies

	2011-2012	2013-2014	2015 →
<b>Unit Cost (AWP)</b>	<ul style="list-style-type: none"> <li>Improve pricing with current vendor</li> </ul>	<ul style="list-style-type: none"> <li>Re-evaluate pricing with annual market check</li> </ul>	<ul style="list-style-type: none"> <li>Bid for specialty pharmacy vendor</li> </ul>
<b>Network</b>	<ul style="list-style-type: none"> <li>Pharmacy - one vendor</li> <li>Medical - Limited vendors</li> </ul>	<ul style="list-style-type: none"> <li>Oncology limited network</li> <li>Home infusion preferred network</li> </ul>	<ul style="list-style-type: none"> <li>Exclusive network (1-2) for pharmacy and medical</li> <li>New CPC Vendor</li> </ul>
<b>Utilization Management</b>	<ul style="list-style-type: none"> <li>Additional prior authorization rules to include quantity limits and step therapy</li> </ul>	<ul style="list-style-type: none"> <li>Additional prior authorization rules to include quantity limits and step therapy</li> </ul>	<ul style="list-style-type: none"> <li>Incorporate genomic testing into UM rules</li> </ul>
<b>Formulary/Specialty List</b>	<ul style="list-style-type: none"> <li>Expand list to include HIV &amp; Transplant</li> <li>Increase rebates with preferred specialty products</li> <li>Coordination and referrals between Accredo and Active Health</li> </ul>	<ul style="list-style-type: none"> <li>Include oncology</li> <li>Increase rebates earned under pharmacy and medical benefit</li> <li>Include CCNC in care management</li> <li>Improve medication</li> </ul>	<ul style="list-style-type: none"> <li>Exclusive Rebates</li> </ul>
<b>Care Management</b>	<ul style="list-style-type: none"> <li>Align reimbursement with specialty discount rates &amp; remove prescribing reimbursement incentives</li> </ul>	<ul style="list-style-type: none"> <li>Eliminate specific drugs and TCs</li> </ul>	<ul style="list-style-type: none"> <li>Integrated care management and data with all vendors</li> </ul>
<b>Buy and Bill/ Provider Reimbursement</b>	<ul style="list-style-type: none"> <li>25% up to \$100 for pharmacy benefit</li> </ul>	<ul style="list-style-type: none"> <li>Develop Biosimilar/preferred specialty tier</li> <li>Copay parity all channels</li> </ul>	<ul style="list-style-type: none"> <li>Manage/limit buy and bill (exc. ONC)</li> </ul>
<b>Benefit Design</b>	<ul style="list-style-type: none"> <li>Clearly delineate medical vs. pharmacy benefit</li> <li>Address self-administrable/rare disease</li> </ul>	<ul style="list-style-type: none"> <li>Include oncology</li> <li>Home infusion preferred network</li> </ul>	<ul style="list-style-type: none"> <li>Place of service copay tiers and incentives to cost-effective channels</li> <li>Incent cost-effective channels for office-administered medications</li> </ul>
<b>Channel Management</b>	<ul style="list-style-type: none"> <li>J-Code</li> </ul>	<ul style="list-style-type: none"> <li>J-Code + NDC crosswalk</li> </ul>	<ul style="list-style-type: none"> <li>J-Code + NDC crosswalk</li> </ul>
<b>Claims Adjudication</b>	<ul style="list-style-type: none"> <li>BCBSNC cost management program</li> <li>Active Health referrals to Accredo</li> </ul>	<ul style="list-style-type: none"> <li>Limit Retail Network</li> <li>Medical Channel Mgmt (Anemia, self-inj)</li> <li>Clinical coverage rules</li> </ul>	<ul style="list-style-type: none"> <li>Pharmacogenomic testing</li> </ul>
<b>Oncology Management</b>	<ul style="list-style-type: none"> <li>(5%)</li> </ul>	<ul style="list-style-type: none"> <li>(5-10%)</li> </ul>	<ul style="list-style-type: none"> <li>(15+%)</li> </ul>
<b>Total Savings Range</b>			

5/11 spm

Denotes priorities

# Key Trends in Specialty

Specialty Pipeline <sup>1</sup>	Biosimilars <sup>2</sup>	Medical Spend <sup>3</sup>	Bioethics
 <ul style="list-style-type: none"> <li>■ 600+ drugs in the pipeline over the next 5-8 years</li> <li>■ Oncology represents about 45% of the pipeline</li> <li>■ 35% of oncology and 64% of non-oncology may be self-administered</li> </ul>	 <ul style="list-style-type: none"> <li>■ 46 biotech products with patent expirations through 2020*</li> <li>■ \$31.5 billion biosimilar opportunity</li> <li>■ Interchangeable alternatives will greatly affect management options and cost</li> </ul>	 <ul style="list-style-type: none"> <li>■ Significant amount of specialty drug spend is on the medical benefit</li> <li>■ Frequently administered in high cost places of treatment</li> <li>■ Limited ability to apply critical health and safety checks</li> </ul>	 <ul style="list-style-type: none"> <li>■ Specialty pipeline will continue to produce high-cost drugs</li> <li>■ Growing impact on the viability of Benefit Plans</li> <li>■ Question of coverage for a small number of high cost patients vs. the whole patient population</li> </ul>

<sup>1</sup> Accredo Pipeline Database, Promising Phase II and Higher. Extracted October 4, 2011.

<sup>2</sup> U.S. Drug spend estimates are based on IMS Health data for 2009 (if available), manufacturer reported U.S. sales or a percent of manufacturer reported worldwide annual sales of the drug. Market availability of biosimilars based on expected patent expiration dates current as of November 2010 plus two years. Changes may occur due to litigation, patent challenges, or other factors. \* Includes all drugs with patent expirations through 2011.

<sup>3</sup> Express Scripts 2011 Drug Trend Report

# Near-term Pipeline Highlights

<p>Cystic fibrosis</p> <p><i>Bronchito</i><sup>™</sup> Levofloxacin Inh</p>	<p>Cushing's syndrome</p> <p>Pasireotide</p>	<p>Gaucher disease</p> <p>Eliglustat</p>	<p>Ocular</p> <p><i>Cystaran</i><sup>™</sup> Voclosporin</p>
<p>Clotting factors/ hematology</p> <p>rFXIII Semuloparin</p>	<p>Fabry disease</p> <p><i>Amigal</i><sup>®</sup></p>	<p>Growth hormone</p> <p>LBO3002 (sustained release)</p>	<p>Pulmonary arterial hypertension</p> <p>QT 1571 Macitentan</p>
<p><b>Cancer</b> ~45% of pipeline</p>	<p>Familial amyloid polyneuropathy</p> <p>Tafamidis</p> <p>Familial Hypercholesterolemia</p>	<p>Multiple sclerosis</p> <p>Teriflunomide BG-12 <i>Lemtrada</i><sup>™</sup> Daclizumab</p>	<p>Rheumatoid arthritis</p> <p>Tofacitinib Fostamatinib Sarilumab Secukinumab</p>
<p><i>Clearazide</i><sup>®</sup> carfilzomib <i>Marqibo</i><sup>®</sup> <i>Zaltrap</i><sup>™</sup> bosutinib cabozantinib enzalutamide <i>Omapro</i><sup>™</sup> trastuzumab-DM-1 perifosine <i>Allovecitin-7</i><sup>®</sup></p>	<p>Lomitapide <i>Kynamro</i><sup>®</sup></p>		

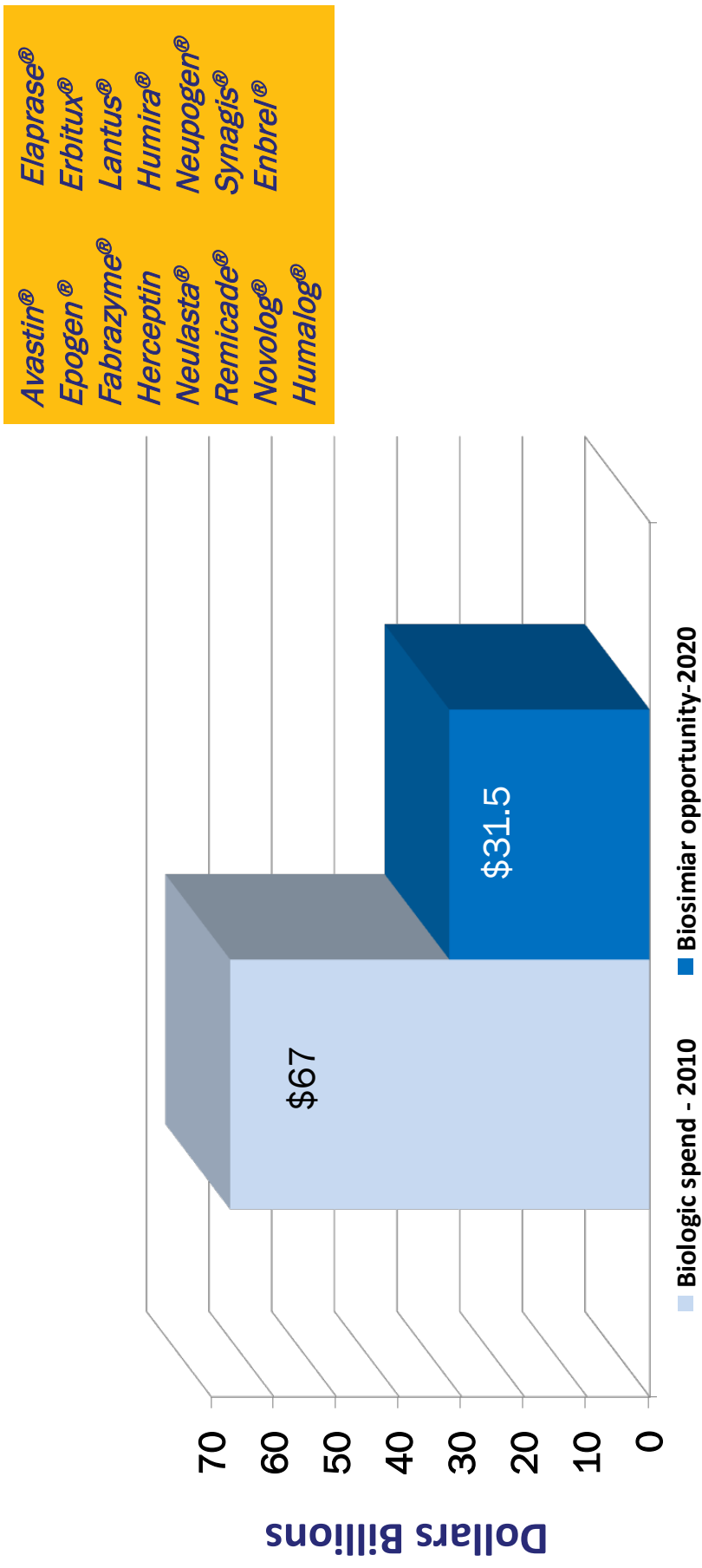
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# Examples of New Drugs 2012-2013

Drug	Route	Indication	Estimated annual cost*	Prevalence/comments
Tafamidis	Oral	Transthyretin Familial Amyloid Polyneuropathy (TTR-FAP)	\$75,000	8000 worldwide
Terifunomide	Oral	Multiple Sclerosis	\$45,000	350,000-400,000 Active metabolite of leflunomide
Tofacitinib	Oral	Rheumatoid arthritis	\$30,000	≈ 1.3 million Oral once or twice daily JAK-3 inhibitor
Dimethyl fumerate (BG-12)	Oral	Multiple Sclerosis	\$45,000	350,000-400,000 Oral drug given 3x daily
Gattex™ (teduglutide)	SC	Reduce need for IV feeding in patients with short bowel syndrome	\$20,000	10,000-15,000 SBS patients on home TPN for SBS Daily SC injection
Metreleptin	SC	Diabetes and/or hypertriglyceridemia in patients with rare forms of lipodystrophy	\$75,000	~2000 patients worldwide Analog of the human hormone leptin
Pasireotide	SC	Cushing syndrome/Acromegaly	\$30,000	3,000-5,000/15,000 – Very rare disorders; Somastatin analog (like lanreotide) with twice daily dosing

# Biosimilars Opportunity

Biosimilars in development with possible patent expiration for reference product by 2020



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Source: IMS institute of healthcare informatics, IPD analytics biologics tracker Medtrack sales screener

# Future Potential Strategies

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- 1) **Benefit design**
  - Biosimilar/Preferred Specialty tier – coinsurance
  - Copay parity under pharmacy and medical channels
  
- 2) **Medical management**
  - Reimbursement methods – medication and cognitive services
  - Site of care management - preferred home infusion network
  
- 3) **Utilization management**
  - Additional prior authorization rules
  - Incorporate genomic testing
  
- 4) **Oncology management**
  - Limited retail network
  - Care management programs
  - Utilization management



**Pharmacy and Therapeutics Committee  
Meeting Summary  
May 14, 2013**

Derek Prentice welcomed the committee members, and announced the appointment of Mona Moon as the new Executive Administrator. Sally Morton ensured there were no conflicts of interest for members with any of the items for discussion. Dr. Rig Patel disclosed that he is a consultant with Forest.

Dr. Sally Morton discussed the following changes to fourteen State Health Plan pharmacy coverage management rules, many due to the integration of Medco and Express Scripts (ESI) coverage criteria. The Plan will review all criteria integration to ensure they meet the Plan's needs.

- The Orencia SQ step therapy program now only requires the use of Enbrel OR Humira prior to coverage approval in the step therapy program. ESI recommended adding many off-label indications to the coverage for Enbrel and Humira. The committee recommended to maintain the current criteria which only approves for labeled indications and off-label items should be handled on appeal.
- The Topical Diclofenac step therapy program now requires the trial of 2 different NSAIDs and considerations for age and NSAID associated risk factors were added.
- The Difucid (fidaxomicin) prior authorization program now allows coverage for patients treated for C.Difficile associated diarrhea for the first time, if the patient has tried metronidazole or oral vancomycin.
- The new medication Onmel (itraconazole) was added to the Antifungal agent prior authorization program to include all medications indicated for onchomycosis.
- The step therapy program for Oracea (doxycycline) used to treat acne now requires the use of one generically available immediate-release or delayed release doxycycline product.
- Due to the generic availability of the majority of SSRIs used for depression, it was recommended to discontinue the SSRI step therapy program requiring the use of generics first prior to the brand.
- A new medication Rescula (unoprostone) was added to the Glaucoma step therapy program as a non-preferred agent and multisource brands will now be targeted.
- Multisource brands (Flonase and Nasacort AQ) will be added as non-preferred targets in the Nasal Steroid step therapy program.
- Due to the generic and over-the-counter availability of most non-sedating antihistamines (NSA) and Singulair, it was recommended to discontinue the NSA and Singulair step therapy program.
- The Growth Hormone prior authorization criteria have been revised to include many changes to the conditions listed within the covered indications.
- The COX II (Celebrex) prior authorization program added coverage allowances for decreased platelet counts or other coagulation disorders, hypersensitivity to aspirin or NSAIDs and aspirin or NSAID induced asthma. Exclusions were added for use in bariatric surgery and preoperatively, perioperatively or postoperatively.
- The Solodyn (minocycline) step therapy requires the use of one minocycline product first.

- The new Multiple Sclerosis (MS) oral medication Tecfidera was added to the MS prior authorization program. The oral agents used in the treatment of MS (Aubagio, Gilenya and Tecfidera) require the use of 2 interferons first.
- The anti-emetic quantity limits were revised to allow for one year of coverage for all indications.

The committee discussed the Plan's available tobacco cessation resources to help members qualify for premium credits in 2014 for the Enhanced 80/20 PPO Plan and Consumer Directed Health Plan (CDHP) for members. To qualify for the premium credit members must attest to being a non-smoker or participation in a smoking cessation program. The committee agreed with the recommendation to focus on supports offered through the Quitline since there was counseling and nicotine replacement therapy available which has proven to be the most beneficial for sustained smoking cessation rates. Due to the safety concerns with prescription Chantix it was not recommended to reduce the copay on prescription products any further than Tier 2. However, the Plan is clarifying the smoking cessation intervention mandates in the Affordable Care Act (ACA) that must be available in 2014 for the 80/20 and CDHP plans. Since the Plan offers the resources through the Quitline at no charge to members that may satisfy the ACA requirements without having to offer prescription products at no charge as well.

The committee reviewed the following new drugs for formulary consideration:

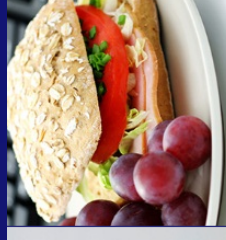
- Ultresa (pancrealipase delayed-release capsules) – recommended May Add due to similar efficacy to currently preferred products. It will remain in Tier 3.
- Viokace (pancrealipase tablets) – recommended Must Add due to it being the only available non-enteric coated product. It will be in Tier 2.
- Prepopik (Sodium picosulfate, magnesium oxide, and anhydrous citric acid oral solution) – recommended May Add due to the equivalent efficacy to other agents; however, has the advantage of better taste and tolerability due to the low volume required. It will remain in Tier 3.
- Linzess (linaclotide capsules) – recommended May Add due to its efficacy in reducing abdominal pain and increasing bowel movements in irritable bowel syndrome with constipation. However, it should be reserved for patients with chronic constipation who have tried other options. It will remain in Tier 3 until a step therapy/prior authorization program can be implemented.
- Rayos (prednisone delayed-release tablets) – recommended Must Not Add since it does not offer any advantages to regular prednisone and should be reserved for adjunctive therapy only if failing DMARD. It will remain in Tier 3.
- Qsymia (phentermine and topiramate extended-release capsules) – recommended May Add due to concerns about long term safety. Effective agent for weight management only if used in combination with diet and exercise. It will remain in Tier 3 with the prior authorization program.
- Tudorza Pressair (aclidinium bromide inhalation powder) – recommended May Add due to its effectiveness in decreasing the moderate to severe exacerbations of COPD. It will be in Tier 2.
- Binosto (alendronate effervescent tablets) – recommended May Add due to similar efficacy and safety to other products. It will remain in Tier 3 and non-preferred agent in the bisphosphonates step therapy program.
- Qnasl (beclomethasone dipropionate nasal aerosol) – recommended a May Add due to similar efficacy to other products. It will remain in Tier 3 and non-preferred agent in the nasal steroid step therapy program.





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## Stork Rewards Year One Outcomes

May 24, 2013

*Board of Trustee's Meeting*



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# Why are we doing this?

## Pre-term Birth Statistics

### In the United States:

- Immense need exists to produce better health outcomes in the treatment of pregnant women and their unborn children with prenatal and antenatal care
- In 2012, the number of babies born too soon exceeded 517K with 11.7% of births preterm
- Preterm birth is the No. 1 obstetrical complication and leading cause of neonatal\* death
- Received a grade of “C” from the March of Dimes for the 2012 Premature Birth Report Card
- Annual economic cost associated with preterm births is >\$26B or \$51,600 per infant born preterm
- 25-40% of total health plan expenses are maternity related driven by preterm births and NICU days



### In North Carolina:

- In 1988, NC had the highest infant mortality rate in the nation
- In 2011, NC's infant mortality rate was 2<sup>nd</sup> lowest in the state's history; 7.2 babies died /1,000 live births
- In 2012, 12.6% of births were preterm; higher than national statistic
- Received a grade of “C” from the March of Dimes for 2012 Premature Birth Report Card
- In an average week in NC, 299 babies are born preterm

### In State Health Plan:

- From October 2011 through September 2012, there were 229 unique preterm newborns
- Preterm and low birth weight newborns' cost to the Plan was: **\$65,520** from Oct. 2009-Sept. 2010 and **\$61,373** from Oct. 2010- Sept. 2011

Source: March of Dimes and Infant Mortality Reduction Coalition – Forsyth County [http://www.helpourbabies.org/causes.aspx](http://www.marchofdimes.com/peristats/pdf/iib/998/NC.pdf)

\* Affecting the newborn during the first month after birth

# Stork Rewards

## Objectives & Strategy

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- **Objectives**
  - Help the pregnant member achieve a healthy full-term delivery through education, behavior change, improved coordination and communication regarding adherence to her physician's prenatal care plan
  - Engage members to reduce adverse events
  - Improve outcomes (antenatal complications, preterm and low birth weight rates)
  - Reduce costs
  
- **Strategy**
  - Introduce incentives to improve engagement and encourage 1<sup>st</sup> trimester engagement
  - Present program through multiple communication channels to subscribers and covered spouses of child bearing age



# Executive Summary

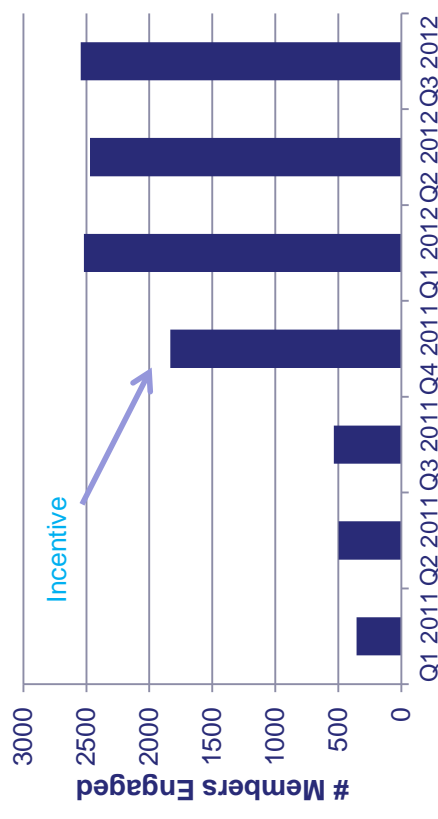
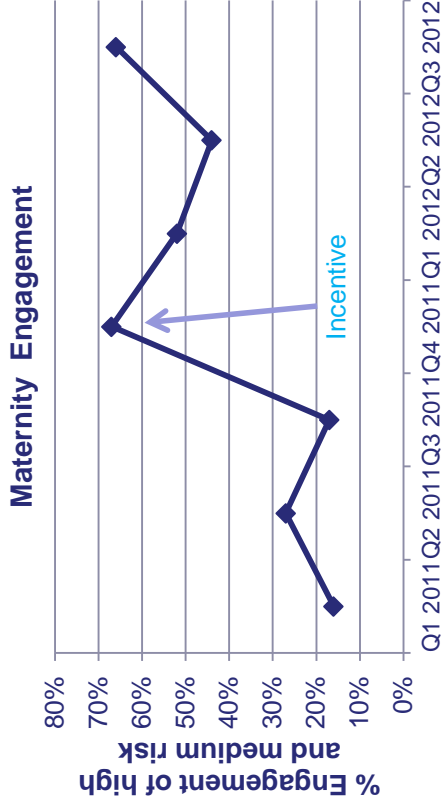
Outcome	Baseline	PY1	Comment
Eligible Deliveries	6,374	6,200	Declined 2.7%
Admits for Antenatal Complications (per 100 deliveries)	3.95	3.73	p = 0.26**
LBW/preterm births (per 100 deliveries)	8.10	8.69	p = 0.13**
NICU Admissions (per 100 deliveries)	7.49	8.02	P = 0.15**

\*\*Major outcomes not statistically significant

# Engagement

## Did the incentive improve engagement?

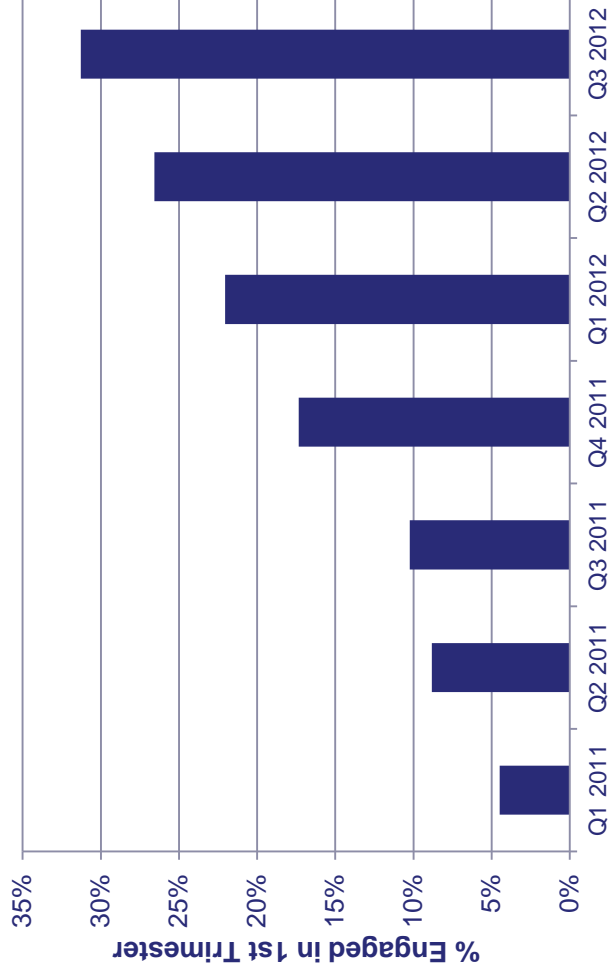
- Engagement of medium and high risk pregnant women increased from an average of 20% pre-incentive to 57% post-incentive
- Average # of members engaged per quarter increased 400% after incentive



# Engagement

## *Are we engaging pregnant women early enough?*

- % of pregnant women engaged in first trimester is steadily increasing; currently only represents 31% of engaged members
- Pregnant women ideally should be engaged during first trimester so there is sufficient time to impact antenatal complications and birth outcomes



# Findings and Recommendations

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- Findings
  - Member engagement increased to 96% with Stork Rewards program
  - Analysis did not show a statistically significant difference between baseline period and PY1 with respect to hospitalizations for antenatal complications, LBW and preterm rates and NICU utilization
  - Cost of incentive to the Plan was \$353,874 for 1st year of program
  - **Many women enrolled in Stork Rewards in PY1 have not yet delivered; therefore more time is needed to fully assess program impact**
- Recommendations by ActiveHealth
  - Continue Stork Rewards incentive program through 2014
  - Place greater communication emphasis on first trimester enrollment





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## Tobacco Cessation Support through NC Quitline

*Board of Trustee's Meeting*

May 24, 2013

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# Current Tobacco Cessation Supports and Benefits

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## QuitlineNC Supports

- FREE one-on-one support from a Quit Coach® by telephone
  - 24 hours a day, 7 days a week
  - English/Spanish
- FREE web coaching at [www.QuitlineNC.com](http://www.QuitlineNC.com)
- FREE Quit Kit (self-help manual and educational materials)
- FREE nicotine replacement patches available to members enrolled in the multi-call program
  - Nicotine Replacement Patches: Habitrol (generic) - 7, 14, 21 mg
  - Maximum four, 4-week shipments of NRT patches per year
  - \$48per shipment, up to \$192 per year

## Medical and Pharmacy Benefits

- In-person counseling with a doctor or behavioral therapist
- Prescription coverage for generic over-the-counter nicotine patches--\$5\*/30 day supply
- Preferred formulary coverage for all tobacco cessation prescription medications
  - Bupropion (generic for Zyban)--\$12 (Tier 1)
  - Nicotine Nasal Spray and Nicotine Inhaler--\$40 (Tier 2)
  - Varenicline (Chantix)--\$40 (Tier 2)

*\*Requires a prescription*

# Expansion of Tobacco Cessation Supports

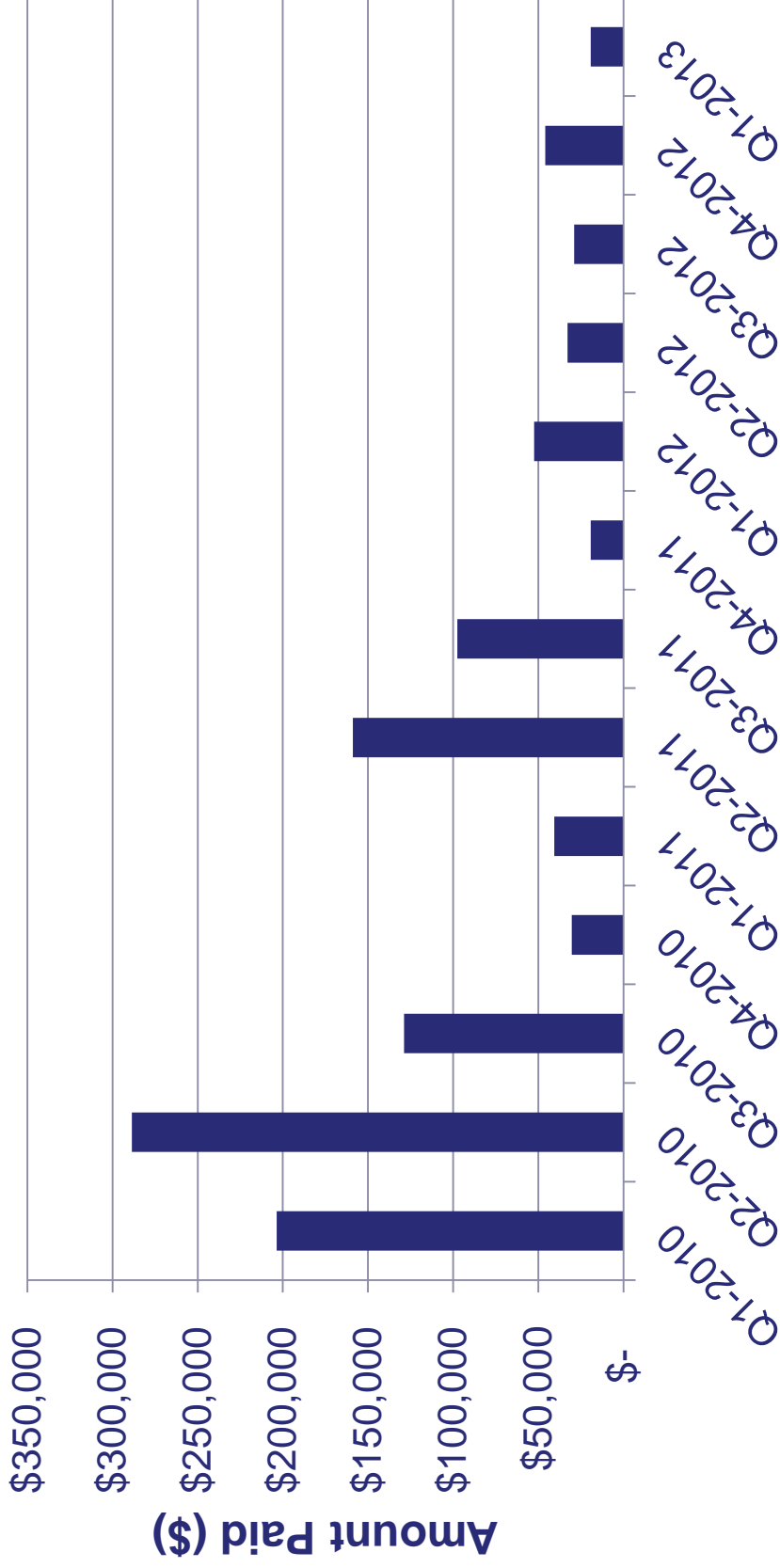
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- Add nicotine gum as a single-use NRT option
- Offer combination NRT (patch plus gum) to members who smoke 9+ cigarettes per day
- All NRT options will remain free for the member
- NRTs will be sent in two, 4 week shipments

Quitline NRT Option	Shipment #1 4 weeks	Shipment #2 4 weeks
Patches only	28 patches	28 patches
Gum only	3 boxes (110 pieces per box)	1 box (110 pieces per box)
Combo NRT (patch + gum)	28 patches + 1 box of gum	28 patches (no gum)

- Eligible members may re-enroll in multi-call program to receive up to two 8-week NRT courses per Plan year

# Cost Trends for QuitlineNC

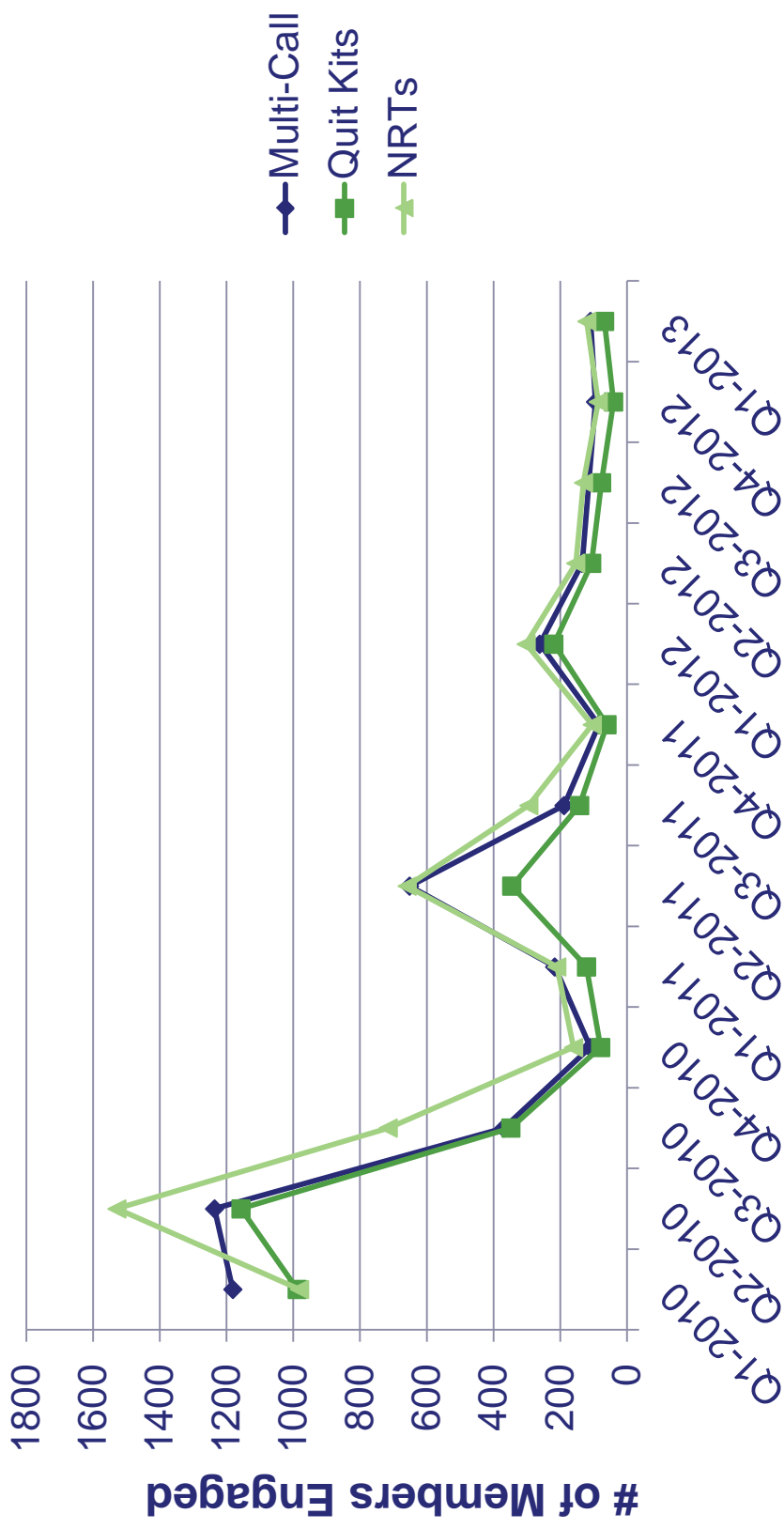


## Quitline Services Paid per Calendar Quarter

- **2012 per member per year cost = \$182.85**

Source: Data includes services provided between 10/01/10 and 03/31/2013 as reported by the NC DHHS – Division of Public Health.

# Engagement of SHP Members in Quitline Services

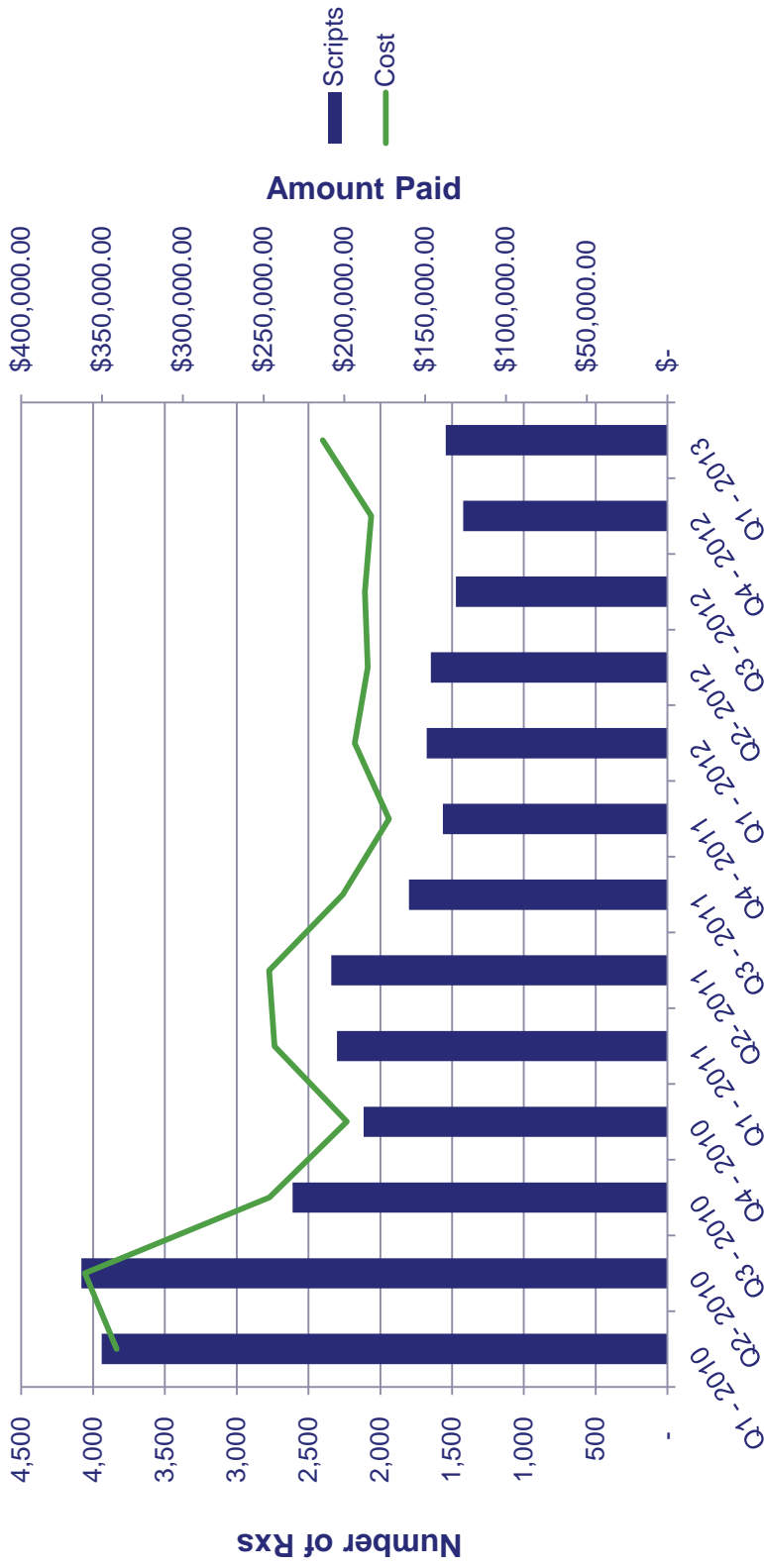


Quitline Services provided per Calendar Quarter

- 2010-2011 SHP Quit Rate = 41.8%; All NC Quitline Quit Rate = 23.1%

Source: Data includes services provided between 01/01/10 and 03/31/2013 as reported by the DHHS – Division of Public Health.

# Cost Trends for Rx Benefit



SHP Utilization Paid per Calendar Quarter

Claims Data 03/01/2010 - 03/31/2013 \*Source: Express Scripts' Expert

# Supporting Evidence

## ➤ **U.S. Public Health Service Clinical Guideline (2008)**

Certain combinations of first-line medications have been shown to be effective smoking cessation treatments. Therefore, clinicians should consider using these combinations of medications with their patients who are willing to quit.<sup>1</sup>

Effective combination medications for long-term (>14 weeks) are:

- Nicotine patch + other Nicotine Replacement Therapy (gum or spray)<sup>1</sup>

## ➤ **Wisconsin study - Enhancing Tobacco Quitline Effectiveness: Identifying a**

### **Superior Pharmacotherapy Adjuvant (2012)**

Compared clinical effectiveness of different Quitline enhancements (n=987):

- Combination NRT (Nicotine patch only vs. patch plus nicotine gum)
- Longer duration of NRT (2 vs. 6 weeks)<sup>2</sup>

### **Clinical Results:**

- 6 weeks of combination NRT yielded the highest 6-month abstinence rate (51.6%) vs. 6 weeks of the patch alone (46.2%)
- 2 weeks of combination NRT (48.2%) vs. 2 weeks of the patch (38.4%)<sup>2</sup>

### **Recommendation:** Combination NRT (nicotine patch plus gum) for 6+ weeks<sup>2</sup>

<sup>1</sup> *Treating Tobacco Use and Dependence: 2008 Update. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service; 2008 May. p.118*

<sup>2</sup> Smith, S. S., Keller, P. A., Koblinsky, K. H., Baker, T. B., Fraser, D. L., Bush, T. et al. (2012). Nicotine & Tobacco Research, 3, 718-2

NRT Options	Plan Cost per Member per Year (2014)	5% of Smokers
Current Patches through QuitlineNC	\$193.00	\$919,286
Combo NRT: Patch + Gum through QuitlineNC	\$204.71	\$970,676
Single NRT with Options: Patch or Gum through QuitlineNC	\$209.00	\$948,140
All-Inclusive NRT: Combo OR Patch OR Gum through QuitlineNC	\$214.00	\$984,050
OTC Gum	\$428.60	\$1,714,400

**KEY:**

- Cost for all members (99,750 SHP members use tobacco)
- Cost for actives and early retirees ONLY (80,000 SHP members use tobacco)



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**Worksite Wellness Pilot Changes**  
*Board of Trustee's Meeting*

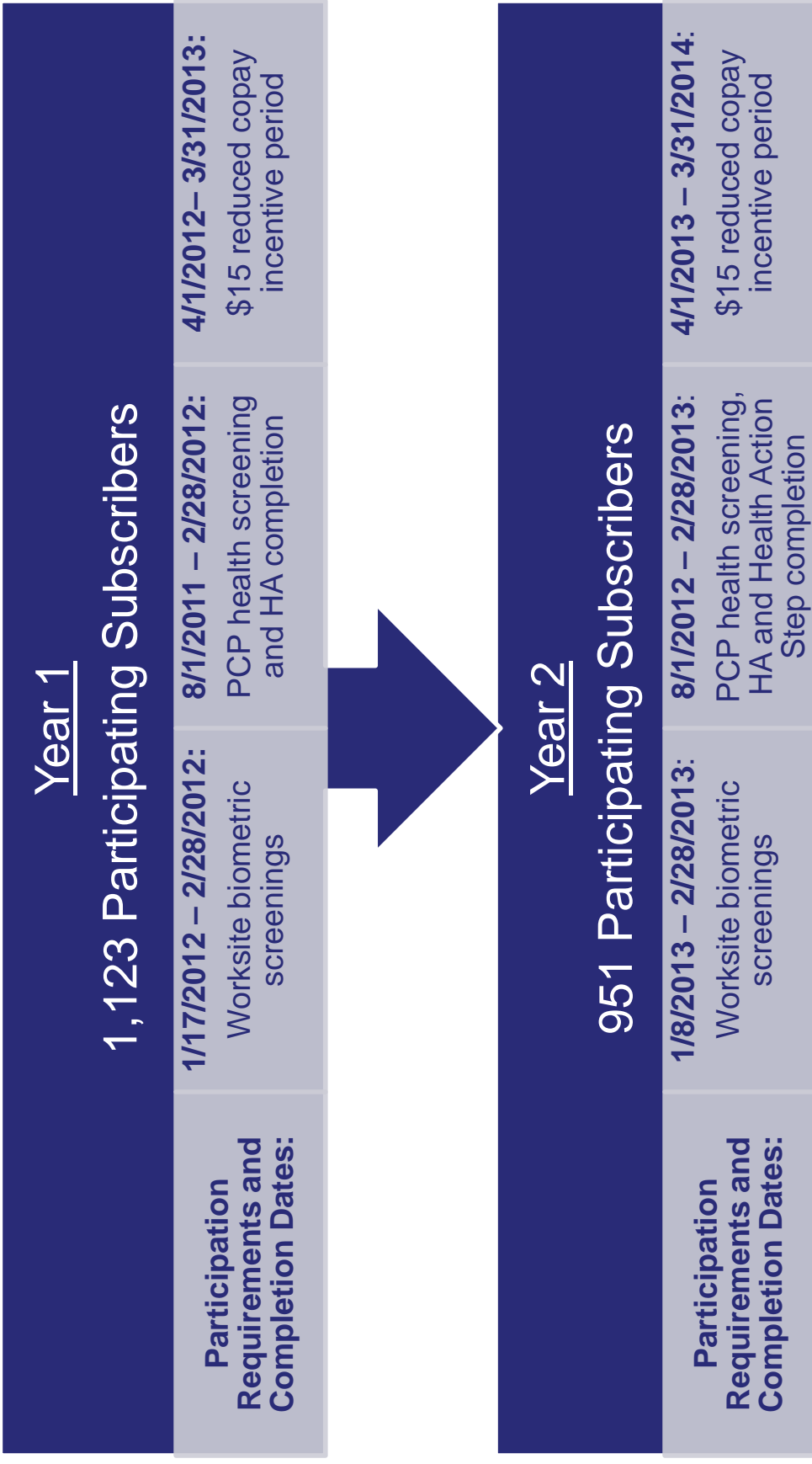
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# CMS Wellness Wins Pilot Snapshot



# Incentive Modification to Align with 2014 Benefit Change

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<b>Project Component</b>	<b>Modification</b>
Incentive Period	04/01/2013 -12/31/2013
Incentive offering	Participating members (n = 951) will receive a refund check for the \$15 copay reduction reflecting the sum total for each PCP visit from 1/1/2014 – 3/31/2014.
Communication	In August 2013, participating subscribers will be notified of the program change by email and formal letter.