Board of Trustees' Meeting
Department of State Treasurer
Friday, September 27, 2013
9:00 a.m. – 3:00 p.m.

AGENDA

1. Welcome	Janet Cowell, Chair
2. Conflict of Interest Statement	Janet Cowell, Chair
3. Introduction of New Plan Staff Nidu Menon, Director of Integrated Health Management	 Mona Moon
4. Review of Minutes ***(Requires Board Vote)*** A. July 26, 2013 – Regular Meeting B. September 5, 2013 – Teleconference	Janet Cowell, Chair
5. Financial Report *(40 minutes)* A. FY 2012-13 Final Financial Results B. 4th Quarter Forecast Update C. July 2013 Financial Report	Mark Collins
6. Additional 2014 Coverage Changes – Essential Health Benefits ***(Requires Board Vote)*** *(20 minutes)*	Lotta Crabtree
7. Board Process Discussion Follow-up – Requests to Consider Benefit Changes ***(Requires Board Vote)*** *(15 minutes)*	Lotta Crabtree Andrew Holton

Break *(10 minutes)*

8. Implementation Update A. Communications Update *(30 minutes)*	 Caroline Smart

Agenda Item	Presenter
B. Member Questions Regarding Network Coverage *(10 minutes)*	Caroline Smart
i. Blue Options Designated Providers *(10 minutes)*	Jack Kenley *Vice President* *Sales & Marketing,* *State Health Plan Executive* *Blue Cross Blue Shield of NC*
ii. Humana Medicare Advantage Providers *(10 minutes)*	Christa Klein *Group Medicare Business Executive* *Humana*
iii. UnitedHealthcare Medicare Advantage Providers *(10 minutes)*	John Thompson *Vice President, Client Development* *UnitedHealthcare Retiree Solutions* *UnitedHealthcare*
C. HBR Implementation Satisfaction Survey Results *(15 minutes)*	Caroline Smart
Lunch *(30 minutes)*	
9. Express Scripts, Inc. FY 2012-13 Pharmacy Report *(15 minutes)*	Tracy Stephenson Jeff Scott *Senior Director* *Express Scripts, Inc.*
10. State Health Plan Audits *(30 minutes)*	
A. Audit Process	Tracy Stephenson
B. Medical Claims	Caroline Smart
C. BCBSNC Administrative Costs	Mark Collins
D. ActiveHealth ROI Validation	Mark Collins
E. Pharmacy	Tracy Stephenson
F. Early Retiree Reinsurance Program	Linda Forsberg
11. Strategic Planning	
A. Facilitator Report *(30 minutes)*	Lynn Spragens Tom Gualtieri-Reed *Spragens & Associates, LLC*
B. Segal Dashboard *(20 minutes)*	Mona Moon
C. Workgroup Discussion (30 minutes)	Strategic Planning Workgroup
12. Wrap-Up (10 minutes)	Janet Cowell, Chair

Next Board Meeting: November 21-22, 2013

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

Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
September 27, 2013

The meeting of the Board of Trustees of the North Carolina State Health Plan for Teachers and State Employees was called to order at approximately 9:00 a.m. on Friday, September 27, 2013, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

Members Present:
Chair Janet Cowell
Paul Cunningham, MD
V. Kim Hargett
Bill Medlin
Vice-Chair Genell Moore
Warren Newton, MD
Charles Johnson
Barbara Baldwin attending for Art Pope

Members Absent:
Noah Huffstetler
Art Pope

State Health Plan Staff: Mona Moon, Glenda Adams, Mark Collins, Lotta Crabtree, Thomas Friedman, Nidu Menon, Sally Morton, Lorraine Munk, Derek Prentice, MD, Tracy Stephenson

Department of State Treasurer Staff: Andrew Holton, Joan Fontes

Guests: Ginger Austin, Barbara Baldwin, Janelle Cain, Charlotte Craver, Pam Deardorff, Carol Durrell, Pam Deardorff, Larry Earle, Marge Foreman, Bob Fronius, Charla Katz, Jack Kenley, Mike Laraway, Rich Lomax, Jackie Matis, Lanier McRee, Tim Moorhead, Wadida Murib-Holmes, Keith Peele, Lacey Presnell, Tom Gualtieri-Reed, Ed Regan, Joe Sheehan, Lynn Spragens, Chuck Stone, John Thompson, Kim Turk, Mark Werner

Welcome
Treasurer Janet Cowell, Chair, welcomed Board members, State Health Plan and Department of State Treasurer staff to the meeting.

Agenda Item - Conflict of Interest Statement
In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, Chair Cowell read the "Conflict of Interest Statement" requesting members who have either an actual or perceived conflict of interest to identify the conflict and refrain from discussion and voting in those matters as appropriate. No disclosures were made and no conflicts identified.

Agenda Item – Introduction of New Staff

Ms. Moon introduced Nidu Menon, Ph.D., Director of Integrated Health Management. Dr. Menon joined the Plan on September 3, 2013.

Agenda Item – Review of Minutes – July 27 and September 5, 2013 (Attachment 1)
Presented by Janet Cowell, Chair

Following a motion by Warren Newton and seconded by Paul Cunningham, the Board voted unanimously to approve the July 27, 2013 regular meeting minutes as written.

Following a motion by Bill Medlin and seconded by Warren Newton, the Board voted unanimously to approve the September 5, 2013 teleconference meeting minutes with correction of typographical errors to page 2.

Agenda Item – Financial Report (Attachment 2)
Presented by Mark Collins, Financial Analyst

FY 2012-13 Final Financial Results
The year-end Plan revenue was $2.96 billion, an increase of approximately $24 million over the authorized budget amount. Total plan expenses were $173.6 million less than budgeted and the ending cash balance was $783.4 million, $197.3 million more than budgeted. The adjusted variance report results were similar, with revenue $29 million over the authorized budget amount and total Plan expenses $158.5 million under budget. With adjustments, the ending cash balance was $773.6 million, approximately $187 million more than budgeted.

The per member per month (PMPM) adjusted variance analysis demonstrated savings on the medical claims side, as well as for administrative expenses. The net income of $33.46 PMPM was significantly better than the budgeted amount of $10.35 PMPM. The year-to-date expenditure trend and the allocation of claims expenditures followed a similar pattern to what the Plan has experienced over the past year.

The financial performance highlights for Fiscal Year 2012-13 included Plan expenses that were 6.1% lower than the projected amount. The PMPM expenses were 6.8% less than projected. The year-end ending cash balance of $783.5 million equates to approximately 15 weeks of operating expenses and exceeds the 9% targeted reserve benchmark established by the Board. In comparison, the 2011-12 ending cash balance of $502.2 million equated to approximately 9 weeks of operating expenses. The net income and ending cash balance have both increased steadily since Fiscal Year 2009-10, when Plan expenses exceeded revenue for the year.

In response to a question by the Board regarding member cost sharing, Ms. Moon stated that the contribution rate from members has been between 15-18% on the premium side. The Plan can produce a report that provides a general idea of out of pocket member costs. She stated that in FY 2009, the Plan made no benefit changes and that $250 million was appropriated to the Plan from the General Assembly. The members did not bear the cost of the shortfall that year. However, there were significant changes to the benefit structure, including increases in member cost sharing and premiums in FY 2010 and again in FY 2012. The Plan will provide a report to the Board on the historical cost structure, including member cost sharing information.

In comparing the cost sharing of Plan members to other insurance companies, Ms. Moon stated that the Plan tended to be on the higher side several years ago but assumes that gap has closed over the past year or two given there have been no additional increases in copays, deductibles and coinsurance maximums since September 2011 and none are currently planned for this biennium . With the economy improving, members may be able to seek more care and Plan expenses may increase, although medical costs and member behavior are hard to accurately predict.

From a financial standpoint, the Plan is doing well and a healthy cash balance is important if utilization increases. From a healthcare outcomes perspective, however, the Plan is concerned that members are not using services and seeking appropriate care. For example, some members categorized as "healthy" have no claims experience and that could be a concern.

4th Quarter Forecast Update

For Fiscal Year 2012-13, pharmacy and medical claims expenditures were fairly close to the projections from the 3rd quarter actuarial forecast. Projections of the fiscal year ending cash balance have steadily increased over the past year of forecast updates, and the actual fiscal year ending cash balance was nearly $30 million higher than projected in the 3rd quarter update.

Many forecast assumptions were maintained from the 3rd quarter update to the 4th quarter update, including the trend and membership assumptions. Changes and revisions in the 4th quarter update included a rebasing of the pharmacy claims to use the past six months, rather than the past 12 months, due to an increase in the pharmacy trend in more recent months. The projected pharmacy rebate amounts also increased.

Mr. Collins provided a comparison of the 3rd and 4th quarter updates for the short plan year. Projections of revenue and claims expenses increased slightly in the 4th quarter update. The net income and ending cash balance remained the same between the forecasts. Relative to the 3rd quarter forecast, projected medical claims expenses for the short plan year decreased by about $12 million and projected pharmacy claims increased by about $12 million.

Looking at the 2013-15 Fiscal Biennium, the 4th quarter forecast projects that the cash balance will decrease during the short plan year, increase slightly in 2014 and decrease in the first half of 2015. Unlike recent years when revenues have exceeded expenses, the Plan would use cash on hand to pay a portion of Plan costs, reducing the cash balance over the biennium.

The 2015-17 Fiscal Biennium outlook projects a starting cash balance of approximately $689 million, which exceeds the 9% target reserve amount and equates to approximately 11 weeks of projected Fiscal Year 2015-16 operating expenses. The 4th quarter update projects 7.64% premium increases in January 2016 and 2017, which is lower than the previous projection of 8.22%.

July 2013 Financial Report

Mr. Collins stated that the 3rd quarter forecast update will be used as the certified budget. This decision, made in consultation with Fiscal Research, recognizes that the General Assembly had access to and used the 3rd quarter update when it made final funding decisions for the Plan in July 2013.

July revenue was $10 million above the budgeted amount and claims expenditures were $6.3 million more than projected through July. Administrative expenses were $0.2 million less than budgeted. The Plan's ending cash balance for July was $751.4 million. Year-to-date allocation of claims expenditures for July was as follows: Pharmacy 26%; Inpatient facility 17%; Outpatient facility 25%; Professional 29%; and other 3%.

Noting that claims expenses exceeded projections in July, Ms. Moon reminded the Board that the coinsurance maximum and deductibles were cut in half in the short plan year and members will reach those levels more quickly. Utilization patterns, therefore, could change during the short plan year. The Plan will continue to closely monitor pharmacy and medical claims to see if spending levels remain above projections.

Agenda Item - Additional 2014 Coverage Changes – Essential Health Benefits (Attachment 3)
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance

Under the Affordable Care Act (ACA), individual and small group health plans are required to offer a comprehensive package of services – Essential Health Benefits (EHB). As a large employer plan, the State Health Plan is not required to cover EHB but if they do, annual or lifetime dollar limits cannot be imposed. Actuarially equivalent treatment or service limits, however, may be applied.

Each state selects a "benchmark plan" which in North Carolina is the Blue Cross Blue Shield Blue Options PPO plan. As a self-funded benefit plan, the Plan doesn't have to follow the NC benchmark plan and can choose another plan to follow.

In July, Plan staff recommended removing dollar limits on essential health benefits however the Board had concerns about the ability to control costs especially around hearing aids. Following discussions with BCBSNC, Plan staff recommended that the dollar limits be removed and replaced with the previously proposed quantity limits. In addition, reimbursement for hearing aids can be limited to the usual, customary and reasonable (UCR) amounts with the balance billed to members.

Plan staff continues to recommend removing the dollar limit on cranial bands and replacing it with a quantity limit of one per lifetime. In addition, the Plan recommended removing the combined lifetime dollar limit for infertility and sexual dysfunction and establishing an infertility lifetime quantity limit of three ovulation induction cycles and associated services; coverage for sexual dysfunction would be unlimited.

The total estimated annual cost for all proposed coverage changes would be approximately $2.7 million.

The options were to change the coverage on EHB as proposed, eliminate or drop current coverage (and risk losing Grandfather status for the 80/20 and 70/30 plans), or to choose a benchmark plan that does not include coverage of some or all of these services.

In response to a question about the low cost associated with the sexual dysfunction change, Ms. Crabtree stated that the Plan doesn't cover sexual dysfunction drugs.

The Plan recommends that the Board approve the proposed coverage changes to eliminate dollar limits on EHB, effective January 2014.

Following a motion by Paul Cunningham and seconded by Genell Moore, the Board voted unanimously to approve the proposed coverage changes.

Agenda Item - Board Process Discussion Follow-up – Requests to Consider Benefit changes (Attachment 4)
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance and Andrew Holton, Deputy Chief of Staff and Legal Counsel

At the July meeting, Board members discussed a process by which groups and individuals could address the Board to propose benefit coverage changes. The Board requested that Plan staff simplify Step 2 of the original process recommendation.

The requestor would complete a form including name, requested change, rationale, effective date, supporting documentation and contact information and send it via email to the Board/Plan. The Plan would provide the forms to the board as they are received. The November 2013 Board meeting will be used to review requested changes. It was suggested that beginning in 2014, requests would be reviewed annually at the July Board meetings.

Persons requesting to address the Board may be allowed to speak or present at the discretion of the Treasurer with input from Plan staff. The Treasurer could also invite persons requesting changes to speak at the annual meeting. Ms. Crabtree presented proposed additions to the bylaws.

The Plan also frequently receives requests from vendors to meet with Plan staff. An informal process is currently in place but a more formalized process could be instituted. Both processes could be added to the Plan's website.

Changes brought to the Board in November 2013 and July 2014 would not be effective until 2015 since the benefit structure is already set for the upcoming plan year.

Following a motion by Dr. Newton and seconded by Dr. Cunningham, the Board voted unanimously to approve the process for requests to consider benefit changes.

Following the vote, it was suggested that the word "individuals" replace "people" under the *Proposed Board of Trustees Policy* on page 2 of the presentation.

Agenda Item – Implementation Update (Attachment 5)

Communications Update
Presented by Caroline Smart, Director of Health Plan Operations

Health Benefit Representative (HBR) training sessions were completed this summer with over 1,500 participating in fifty-three counties and two webinars. Of those who attended more than 85% completed a survey and 80% either agreed or strongly agreed that the training was helpful.

Newsletters and Decision Guides were mailed to active and non-Medicare retiree members in August and mid-September. Approximately 20,000 health assessments have been completed, a 45% increase since July. Over 34,000 unique visitors clicked on the Open Enrollment web page and the first member video received more than 15,000 clicks. Forty-five information sessions and enrollment tours are scheduled across the state, in addition to 12 member webinars.

Decision guides and newsletters were also mailed to Medicare primary retirees and more than 7,000 attended outreach events. Twenty-eight percent of those attending completed a survey and comments indicate a positive response to the Medicare Advantage options being offered. Approximately 134 Medicare retiree outreach events are scheduled across the state and in Virginia, South Carolina and Florida during September and October.

A question was asked regarding a contingency plan for those members who miss the October 31 enrollment deadline. Ms. Smart responded that she wasn't prepared to address an exception process at this point but stated that a cut-off date would be established.

Member Questions Regarding Network Coverage
Presented by Caroline Smart, Director of Health Plan Operations

Two questions most consistently asked by members relate to network coverage and provider accessibility. Active and non-Medicare primary members have expressed concern regarding the lack of Blue Options designated facilities in the eastern part of the state and whether or not members can only use the designated facilities. Medicare primary member questions center around whether or not their provider is in the Humana or UnitedHealthcare network. They have also expressed concern about whether their provider will accept Medicare Advantage and file their claims.

Representatives from Blue Cross Blue Shield of NC, Humana and UnitedHealthcare addressed concerns.

Blue Options Designated Providers (Blue Cross Blue Shield of North Carolina
Presented by Jack Kenley, Vice President Sales and Marketing, State Health Plan Executive

Members in the Enhanced plan and CDHP can reduce their costs if they use a Blue Options designated provider. The criteria used to determine whether a hospital is designated are quality outcomes, cost efficiency and accessibility. Designated specialists are in the areas of general surgery, OB-GYN, gastroenterology, orthopedics, cardiology and neurology. Members are incented to use designated providers through reduced copays or health reimbursement account (HRA) credits. They may, however, choose to use non-designated providers but will not receive copay reductions or HRA credits.

Designated providers go through an annual review to determine if the measures are still being met. The Centers for Medicare and Medicaid Services (CMS) has eleven quality core measures and a hospital's quality score is based on these measures. If they are below the 66th percentile, they will not be chosen as a designated provider. Following the quality evaluation, BCBSNC reviews cost efficiency through claims data. Providers must score at or below 40%. A cluster analysis is also conducted that includes bed size, utilization volume, and diversity of services. There are 6 peer groups and they do not look just at region. Outside of the annual review, providers can request to meet with BCBSNC network staff to discuss opportunities to have their designation changed.

A question was asked regarding the accuracy of the specialty area of the providers on the designated list. BCBSNC stated that a provider may end up as designated when they're not in one of the six specialties and that they are working on a process to minimize those errors. In addition, some providers may be double boarded; when a misclassification is brought to BCBSNC's attention, it is corrected.

Humana Medicare Advantage Providers
Presented by Tim Moorhead, Market Vice President, North Carolina, Senior Products and Keith Peele, Director of Contracting, North Carolina

Humana continues to reach out to providers not in their network via telephone, onsite visits and through community forums throughout the state. Meetings with the major health systems have occurred and anticipated contracts with new hospital systems may be finalized soon. In person visits to interested providers are occurring to ensure that plan benefits are well understood and whether or not they are willing to accept Plan members. Humana is visiting offices of providers who processed member claims in the past year but who are not in the network.

Humana will be up and running on January 1 and have staff available to address potential issues. Staff will be on the ground in Greenville on January 2.

UnitedHealthcare Medicare Advantage Providers

Provided by John Thompson, Vice President, Client Development, UHC Retiree Solutions

In addition to attending retiree meetings, UnitedHealthcare (UHC) reviewed the last twelve months of claims data and reached out to providers who processed Plan member claims. UHC reached out to 117 hospitals and currently have contracts with 76 of them. They are conducting in-person meetings with providers and have eight offices in North Carolina. All provider representatives are located in the state and a customer service center is located in Greensboro.

UHC has focused on educating provider staff and members to the fact that the Plan members are in a group UHC product. To alleviate the burden on retirees, UHC is calling providers on their behalf and then reaching back out to the member regarding questions about the network.

Mr. Chuck Stone, State Employees Association of NC, stated that it would be helpful for the Medicare Advantage vendors to have a communication system in place between provider offices and the Plan to address urgent issues. Mr. Thompson responded that a dedicated team in the customer service center in Greensboro could address urgent issues and that they also have a tracking system for member satisfaction.

HBR Implementation Satisfaction Survey Results

Presented by Caroline Smart, Director of Health Plan Operations

The Plan conducted an HBR satisfaction survey and 50 out of 492 training participants responded. The majority (87.5%) found the implementation of the newsletter helpful while 48% answered "no" to the engagement of the Account Manager (Benefitfocus). The Plan is working to resolve some outstanding issues with NC Flex implementation and Ms. Smart will be at Benefitfocus during the first week of October to assist with calls and outstanding issues.

Communicating with retirees has been a primary focus since most of the questions are coming from that segment of the population. Reaching out to retirees to ensure they understand the process for enrolling and the need to make a choice has been a primary focus for the Plan. Suggestions for further communication with retirees including local newspapers, television and other news outlets were discussed.

Agenda Item – Express Scripts, Inc. FY 2012-13 Pharmacy Report (Attachment 6)

Presented by Tracy Stephenson, Director of Pharmacy Benefits and
Jeff Scott, Senior Director, Express Scripts, Inc.

Mr. Scott presented the historical performance of key metrics by quarter and stated that the PMPM costs have been stable over the past few years. The Plan's generic prescription fill rate is 80% and several new generics coming out in 2014 could increase the generic prescription rate. The Plan's generic fill rate is a value driver for the Plan; a 1-2% difference in generic fill rates drive savings. It was noted that a 1% change in the generic rate is equivalent to approximately $17 million and for every 1% increase, the savings are approximately 2.5% of total Plan cost. The member cost share would be reduced 6%.

The Plan PMPM cost trend on specialty drugs is 12.1% compared to a 2.5% trend on non-specialty drugs. Brand inflation is the largest cost driver of the PMPM costs and discounts are the largest cost saver of the Plan PMPM cost. The Plan achieved an additional $12.1 million in savings in pharmacy clinical programs over the previous fiscal year.

Future challenges include the management of specialty medications, inflation on brand drugs, high cost generics and coupon cards.

Agenda Item – State Health Plan Audits (Attachment 7)

Audit Process
Presented by Tracy Stephenson, Director of Pharmacy Benefits

The Plan conducts audits to ensure contractual compliance, identify pricing errors, assess vendors' internal controls, validate that the benefits are being administered correctly, validate vendor performance guarantees and comply with State laws and regulations. Ms. Stephenson discussed the audit workflow from the audit plan, including the scope and assessment of data needs to post audit follow up, which can include the monitoring of a correction plan and fund collection for miss performance guarantees.

Medical Claims
Presented by Caroline Smart, Director of Health Plan Operations

The objective of the medical claims audit is to ensure that claims are accurately processed and paid by the Third Party Administrator (TPA). Thomas & Gibbs, PLLC performs quarterly audits of random samples of medical claims and provides an annual report at the end of each year. In the 2012-13 fiscal year, no errors were noted in the first quarter and for the year, the financial accuracy rate was 99.8%. Most of the errors noted related to Medicare coordination of benefits claims. When errors are found, the Plan works with the TPA to develop a corrective action plan and performs several follow-up reviews throughout the year.

The quality management team's review of the TPA was redesigned and the following processes were reviewed during the past fiscal year: financial processing services - check deposit, appeals, debt set off, Medicare claims processing accuracy, and enrollment retro-termination processing. The most significant process improvement was the verification of Medicare primary members. The Plan is working with HBRs to assist in providing information on terminated members.

BCBSNC Administrative Costs
Presented by Mark Collins, Financial Analyst

The purpose of the annual audit is to determine the validity of BCBSNC's administrative charges and to ensure that the Plan hasn't been charged for unallowed costs.

In 2011-2012, the Plan's auditor reviewed 80 separate transactions totaling approximately $10 million in costs. BCBCNC's incurred costs exceeded the cost plus cap for 2011-12 and administrative fees charged by BCBSNC equaled the cap of $115.2 million.

Unallowed costs identified in the 2011-12 audit included a portion of BCBS lobbying activities that may have been charged to the Plan and sponsorship costs. BCBSNC modified the accounting process for unallowed items; however, there was no reimbursement to the Plan because BCBSNC administrative costs exceeded the cost cap under the contract. The final audit of the cost plus contract with BCBSNC, which ended June 30, 2013, will be conducted this fall.

ActiveHealth ROI Validation
Presented by Mark Collins, Financial Analyst

The purpose of the annual audit is to validate the return on investment (ROI). Actual claims costs are compared to projected costs and the difference is compared to ActiveHealth Management (AHM) fees to produce the ROI. The audit results for calendar year 2012 were submitted to the Plan in July 2013. The results indicated a savings of $142.7 million and the calculated ROI was 5.74:1, exceeding the targeted ROI of 3:1.

Pharmacy
Presented by Tracy Stephenson, Director of Pharmacy Benefits

Ms. Stephenson reported that there are three types of audits conducted on the PBM, the pharmacy financial audit, pharmacy rebate audit and the pharmacy claims audit.

The purpose of the pharmacy financial quarterly audit is to verify appropriate adjudication of pharmacy claims by the pharmacy benefit manager (PBM), ExpressScripts, Inc. (ESI) and to determine if financial performance guarantees are met. The Plan's actuarial consultant, Segal, performs a biweekly analysis of claims to determine the accuracy of pricing and invoicing. The Fiscal Year 4th quarter audit is due at the end of September. For previous quarters, there were no findings in three of the five audit components: invoice reconciliation, claims average wholesale price (AWP) and dispensing fees. ESI paid the Plan $2.5 million for a shortfall in financial discounts.

The purpose of the pharmacy rebate audit is to verify that the PBM has met its contractual requirements surrounding rebates. Segal will review the contracts between the PBM and major pharmaceutical manufacturers to ensure that 100% of the rebates are passed back to the Plan as required in the contract. The Plan is finalizing the contract with Segal and anticipates completing the rebate audit by early 2014.

The purpose Pharmacy claims audit is to determine if claims are appropriately processed and paid by the PBM and whether the claims processing error rate of no more than 1.5% is met. The audit is conducted by Thomas & Gibbs, CPAs, LLC. Approximately 200 claims are reviewed annually and no findings have been reported since 2002.

Early Retiree Reinsurance Program
Presented by Linda Forsberg, Program Manager

The Early Retiree Reinsurance Program (ERRP) was one of the components of health care reform. The Plan received approximately $87 million in reimbursement from the Federal government for early retirees with incurred claims of $15,000 or greater in 2010 and 2011. The Centers for Medicare and Medicaid Services (CMS) are conducting an audit to ensure that the Plan met the program requirements and received appropriate reimbursements.

The program requirements audit was completed in 2012 and the claims audit is scheduled to be conducted in October 2013. To date, no findings have been reported.

In response to a question regarding whether or not the Plan changes auditors on a regular basis, Ms. Moon stated that the current contract terminates at the end of 2014. Typically, this procurement area produces a low number of bidders.

Agenda Item - Strategic Planning (Attachment 8)

Facilitator Report
Presented by Lynn Spragens and Tom Gualtieri-Reed, Spragens & Associates

Ms. Spragens and Mr. Gualtieri-Reed met with members of the Board and Plan staff to begin the process of developing and implementing the strategic plan. The strategic plan should be sustainable through Board turnover and environmental changes. Board members recognize that strategic planning is ongoing and that principles, by which the strategic plan is developed, should be created.

Segal Dashboard
Presented by Mona Moon, Executive Administrator

The Healthcare Dashboard developed by Segal is nearly finalized and was been presented to Plan staff and the Board work groups to solicit feedback and suggestions. Eight panels within the report will be incorporated into the strategic plan. The goal is not to depend solely on the dashboard management report but to manage the data in-house. The Plan will develop a timeline and the frequency in which the Dashboard Report will be presented to the Board in the future. Ms. Moon stated that while the Board is working on its strategic plan, the Department of State Treasurer also has a strategic plan within which the Plan is working.

Board members commented that it's important to review Plan data and develop priorities to incorporate in the strategic plan. It was also mentioned that the primary focus has been on cost and that quality and member experience have been overlooked. The quality of care for members should be a priority.

The Dashboard report included a spotlight on asthma. Three years of claims data was used in the analysis. A steady increase in the incidence of newly diagnosed members is cause for concern. Patient medication compliance for members with asthma is well below the norm. They also use the emergency room at double the rate of the total population. Priorities will change over time and the Board suggested a regular review of the Dashboard report and focusing on one area each year where gaps in care occur.

Workgroup Discussion
Presented by the Strategic Planning Workgroup

The workgroup determined that priorities need to be established and the immediate focus should be on quality of care and member experience.

The Communications work group discussed some of the issues regarding the upcoming enrollment process. They also reviewed the satisfaction survey results and discussed whether or not the survey might provide an opportunity to establish a baseline of the information the Board wants to collect.

The Legislative committee did not meet in September.

The Forecasting and Financial workgroup discussed the frequency and content of audit report presentations to the Board. Ms. Moon stated that the Board should determine the level of detail they want and that it would ultimately be up to the Treasurer to determine what is brought to the Board. Several Board members stated that the summaries provided at the meeting were adequate and that more detail wasn't needed. The Plan will continue to provide summaries to the Board.

Agenda Item – Wrap Up

A resolution acknowledging Michele Shaw's participation on the Board was read. Upon a motion by Ms. Hargett and seconded by Mr. Medlin, the Board voted unanimously to approve the resolution.

Upon a motion by Ms. Hargett and seconded by Bill Medlin the Board voted unanimously to adjourn the meeting.

The meeting was adjourned at approximately 2:00 p.m.

Janet Cowell, Chair

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Financial Report
Fiscal Year Ending June 30, 2013

FY 2012-13 Final Financial Results

Board of Trustees Meeting

September 27,2013

A Division of the Department of State Treasurer

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

Fiscal Year 2012-2013	Actual thru June 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	$2.960 b	$2.936 b	$23.7 m
Net Claims Payments	$2.517 b	$2.663 b	($145.6 m)
Net Administrative Expenses	$161.4 m	$189.4 m	($28.0 m)
Total Plan Expenses	$2.679 b	$2.852 b	($173.6 m)
Net Income/(Loss)	$281.2 m	$83.9 m	$197.3 m
Ending Cash Balance	$783.4 m	$586.1 m	$197.3 m

Adjusted Variance Report
Year to Date June 2013

Fiscal Year 2012-2013	Actual thru June 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 *	$2.965 b	$2.936 b	$29.0 m
Net Claims Payments ^	$2.533 b	$2.663 b	($130.5 m)
Net Administrative Expenses	$161.4 m	$189.4 m	($28.0 m)
Total Plan Expenses	$2.694 b	$2.852 b	($158.5 m)
Net Income/(Loss)	$271.4 m	$83.9 m	$187.5 m
Ending Cash Balance	$773.6 m	$586.1 m	$187.5 m

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

^Adjusted to remove the impact of a larger-than-expected pharmacy rebate true-up payment and to include a rebate payment that had not been credited by the end of the fiscal year.

Financial Results Actual v. Budgeted Year to Date June 2013

Per Member Per Month (PMPM) Analysis

Fiscal Year 2012-2013	Actual thru June 2013	Authorized Budget (per Segal 9-18-12)	Variance Over/(Under) Budget
Plan Revenue	$369.60	$369.52	$0.08
Net Claims Payments	$314.72	$335.32	($20.60)
Net Administrative Expenses	$20.18	$23.85	($3.67)
Total Plan Expenses	$334.90	$359.17	($24.27)
Net Income/(Loss)	$34.70	$10.35	$24.35

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

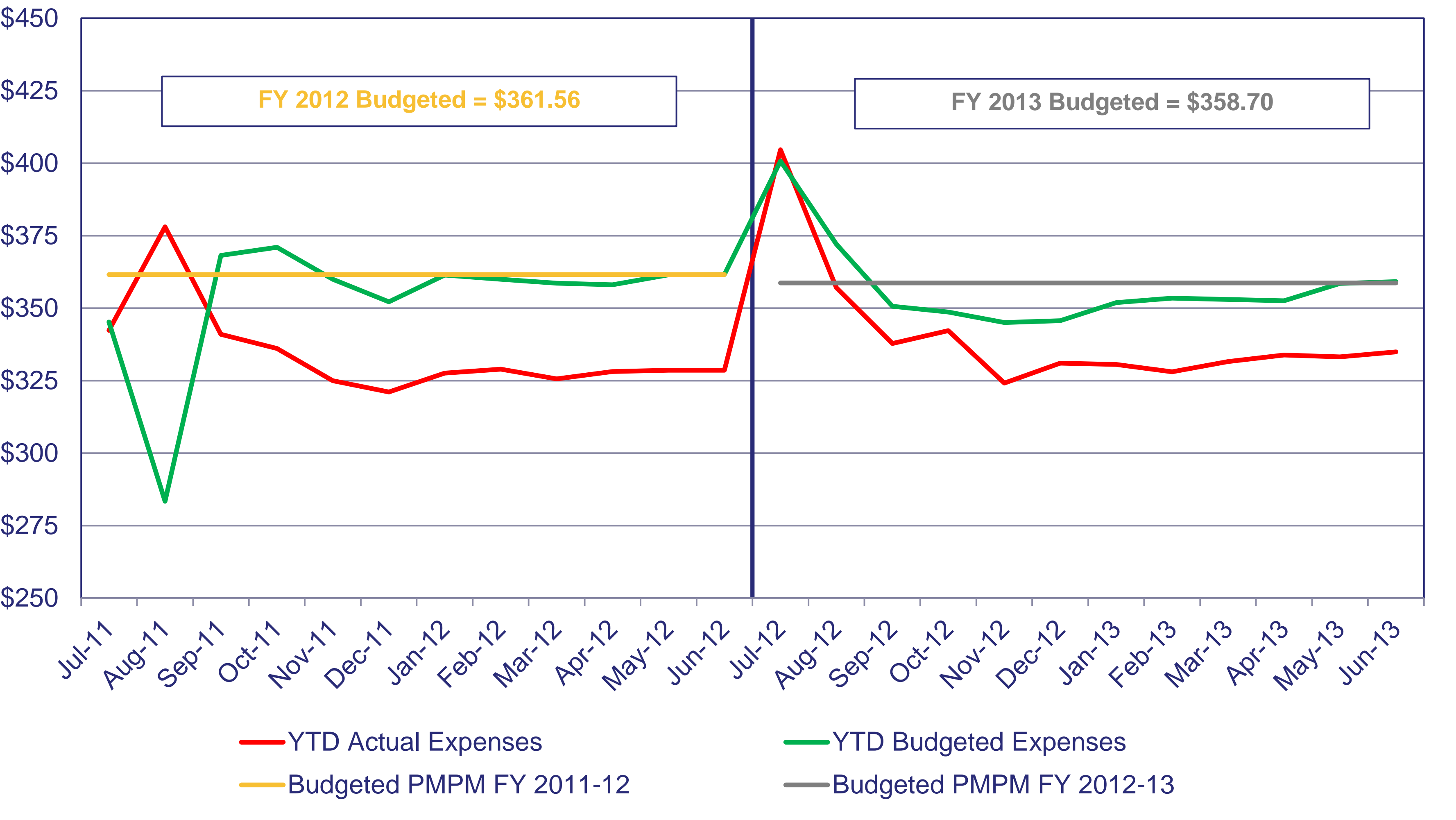
Adjusted Variance Report
Year to Date June 2013

Per Member Per Month (PMPM) Analysis

Fiscal Year 2012-2013	Actual thru June 2013, as Adjusted	Authorized Budget (per Segal 9-18-12)	Variance Over/(Under) Budget
Plan Revenue *	$370.25	$369.52	$0.73
Net Claims Payments ^	$316.61	$335.32	($18.71)
Net Administrative Expenses	$20.18	$23.85	($3.67)
Total Plan Expenses	$336.79	$359.17	($22.38)
Net Income/(Loss)	$33.46	$10.35	$23.11

*Adjusted for timing issues and to remove the impact of unbudgeted revenues.
^Adjusted to remove the impact of a larger-than-expected pharmacy rebate true-up payment and to include a rebate payment that had not been credited by the end of the fiscal year.

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 June 2013

Fiscal Year 2012-13
Financial Performance Highlights

- Plan expenses (claims expenditures + administrative costs) were:
  1. $173.6 million (6.1%) less than projected in total dollars
     - FY 2011-12: Expenses were $245.8 million (8.6%) less than projected
  2. $24.26 (6.8%) less than projected per member per month
     - FY 2011-12: PMPM expenses were $32.96 (9.1%) less than projected

- The Plan's $783.5 million ending cash balance for FY 2012-13:
  1. Is $281.3 million more than the beginning cash balance
  2. Is $197.4 million more than the Authorized Budget projection
  3. Equates to approximately 15 weeks of operating expenses
     - The Plan's FY 2011-12 ending cash balance was $502.2 million, approximately 9 weeks of operating expenses
  4. Is 31% of the net claims expense for the year, far exceeding the new target stabilization reserve benchmark of 9%

Recent Historical Financial Results
Revenues and Expenses

FB 2007-2009 | FB 2009-2011 | FB 2011-2013

$ Billions

	FY 2008	FY 2009*	FY 2010	FY 2011	FY 2012	FY 2013
Revenues	$2.273	$2.676	$2.490	$2.798	$2.852	$2.960
Expenses	$2.290	$2.625	$2.559	$2.650	$2.620	$2.679

*FY 2009 revenues include a $250 million general fund appropriation from the State.

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

*The Plan received a $250 million general fund appropriation from the State in FY 2009.

Recent Historical Financial Results
Expenditures (Claims + Administrative) PMPM

FB 2007-2009
FB 2009-2011
FB 2011-2013

PMPM Expenditures

$380
$360
$340
$320
$300
$280

$298.84
$290.00
$333.48
$330.91
$321.93
$317.36
$347.49
$332.85
$361.56
$328.60
$358.70
$334.90

Actual Expenses
Budgeted Expenses

FY 2008
FY 2009
FY 2010
FY 2011
FY 2012
FY 2013

Administrative Expenses FY 2012-13

Wellness Initiatives $478,328 <1%

State Health Plan $5,914,398 4%

Population Health Mgmt $25,028,302 16%

Actuarial, Auditing, Legal $2,665,470 2%

Medco $18,228,715 11%

Inclusive Health Fees $712,406 <1%

BCBSNC $108,374,018 67%

- Fiscal Year 2012-13 administrative expenses totaled $161.4 million, $4.1 million (2.5%) less than the previous fiscal year.

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Authorized Budget
For the Month Ended June 2013
Fiscal Year 2012- 2013

#		A	B	C	D	E	F	G	H
		Actual June 2013	Authorized Budget June 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	**Plan Revenue:**								
2									
3	Member Premiums	$ 231,487,077	$ 238,790,749	$ (7,303,672)	$ 2,895,366,140	$ 2,872,808,844	$ 22,557,296	$ 2,872,808,844	$ 22,557,296
4	Premium Refunds/Retroactive Disenrollments	(51,743)	(119,535)	67,792	(487,819)	(1,437,243)	949,424	(1,437,243)	949,424
5	Medicare Part D (RDS) Subsidy	540,586	489,942	50,644	38,056,016	39,519,892	(1,463,876)	39,519,892	(1,463,876)
6	Medicare PDP (EGWP + Wrap) Subsidy	3,989,104	3,958,528	30,576	24,435,483	19,759,856	4,675,627	19,759,856	4,675,627
7	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	(558,219)	-	(558,219)	-	(558,219)
8	**Net Premium & Other Contributions**	**235,965,024**	**243,119,684**	**(7,154,660)**	**2,956,811,601**	**2,930,651,349**	**26,160,252**	**2,930,651,349**	**26,160,252**
9									
10	Investment Earnings	295,603	486,090	(190,487)	3,117,666	5,658,262	(2,540,596)	5,658,262	(2,540,596)
11	Miscellaneous Revenue	-	-	-	119,047	-	119,047	-	119,047
12	**Other Revenue**	**295,603**	**486,090**	**(190,487)**	**3,236,713**	**5,658,262**	**(2,421,549)**	**5,658,262**	**(2,421,549)**
13									
14	**Total Plan Revenue (excludes internal transfers)**	**236,260,627**	**243,605,774**	**(7,345,147)**	**2,960,048,314**	**2,936,309,611**	**23,738,703**	**2,936,309,611**	**23,738,703**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	160,836,063	167,484,574	(6,648,511)	1,858,096,405	2,003,583,417	(145,487,012)	2,003,583,417	(145,487,012)
19	Medical Claim Refunds/Recoveries	(1,594,137)	(2,852,051)	1,257,914	(23,467,914)	(31,216,928)	7,749,014	(31,216,928)	7,749,014
20	**Net Medical Claims**	**159,241,926**	**164,632,523**	**(5,390,597)**	**1,834,628,491**	**1,972,366,489**	**(137,737,998)**	**1,972,366,489**	**(137,737,998)**
21									
22	Pharmacy Claim Payments	64,053,421	60,874,413	3,179,008	755,896,440	743,853,418	12,043,022	743,853,418	12,043,022
23	Pharmacy Claim Rebates	-	766,594	(766,594)	(69,641,941)	(53,173,873)	(16,468,068)	(53,173,873)	(16,468,068)
24	Pharmacy Claim Refunds/Recoveries	(24,328)	-	(24,328)	(3,476,790)	-	(3,476,790)	-	(3,476,790)
25	**Net Pharmacy Claims**	**64,029,093**	**61,641,007**	**2,388,086**	**682,777,709**	**690,679,545**	**(7,901,836)**	**690,679,545**	**(7,901,836)**
26									
27	**Net Claim Payments**	**223,271,019**	**226,273,530**	**(3,002,511)**	**2,517,406,200**	**2,663,046,034**	**(145,639,834)**	**2,663,046,034**	**(145,639,834)**
28									
29	**Net Administrative Expenses**	**13,364,005**	**16,236,224**	**(2,872,219)**	**161,401,639**	**189,387,392**	**(27,985,753)**	**189,387,392**	**(27,985,753)**
30									
31	**Total Plan Expenses (excludes internal transfers)**	**236,635,024**	**242,509,754**	**(5,874,730)**	**2,678,807,839**	**2,852,433,426**	**(173,625,587)**	**2,852,433,426**	**(173,625,587)**
32									
33	**Plan Income/(Loss)**	**(374,397)**	**1,096,020**	**(1,470,417)**	**281,240,475**	**83,876,185**	**197,364,290**	**83,876,185**	**197,364,290**
34									
35	**Cash Availability:**								
36									
37	Beginning Cash Balance/(Deficit)	783,862,343	585,027,640	198,834,703	502,247,471	502,247,475	(4)	502,247,475	(4)
38	**Ending Cash Balance/(Deficit)**	**783,487,946**	**586,123,660**	**197,364,286**	**783,487,946**	**586,123,660**	**197,364,286**	**586,123,660**	**197,364,286**
39									
40	Target Stabilization Reserve @ 6/30/13	199,728,453	199,728,453	-	199,728,453	199,728,453	-	199,728,453	-
41									
42	**Cash Balance Over/(Under) Reserve Target**	**$ 583,759,493**	**$ 386,395,207**	**$ 197,364,286**	**$ 583,759,493**	**$ 386,395,207**	**$ 197,364,286**	**$ 386,395,207**	**$ 197,364,286**

Comments:
a. Premium receivables totaled $ 1,064,641.56 as of June 30, 2013.
b. The average weekly medical claims cost net of claims refunds was $39,810,481.50 for the four scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $32,026,710.50 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.

Actual vs Authorized Budget (i.e. ***Revised Budget*** per Segal 09-18-12 projection)
June 2013

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Current Year Actual vs. Prior Year Actual
For the Month Ended June 2013
Fiscal Year 2012-2013

#		A	B	C	D	E	F	G
		Current Year Actual June 2013	Prior Year Actual June 2012	Current Year to Date Actual FY 2012-13 thru June	Prior Year to Date Actual FY 2011-12 thru June	Current Year Authorized Annual Budget FY 2012-13	Prior Year Annual Budget FY 2011-12	Prior Year Actual Results FY 2011-12
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 231,487,077	$ 233,039,709	$ 2,895,366,140	$ 2,750,368,851	$ 2,872,808,844	$ 2,772,587,259	$ 2,750,368,851
4	Premium Refunds/Retroactive Disenrollments	(51,743)	(36,176)	(487,819)	(451,496)	(1,437,243)	(2,672,292)	(451,496)
5	Medicare Part D (RDS) Subsidy	540,586	4,293,347	38,056,016	57,583,602	39,519,892	60,058,789	57,583,602
6	Medicare PDP (EGWP + Wrap) Subsidy	3,989,104	-	24,435,483	-	19,759,856	-	-
7	Federal Early Retiree Reinsurance Program (ERRP)	-	-	(558,219)	42,163,391	-	25,583,136	42,163,391
8	**Net Premium & Other Contributions**	**235,965,024**	**237,296,880**	**2,956,811,601**	**2,849,664,348**	**2,930,651,349**	**2,855,556,892**	**2,849,664,348**
9								
10	Investment Earnings	295,603	243,757	3,117,666	3,015,819	5,658,262	2,245,712	3,015,819
11	Miscellaneous Revenue	-	-	119,047	-	-	-	-
12	**Other Revenue**	**295,603**	**243,757**	**3,236,713**	**3,015,819**	**5,658,262**	**2,245,712**	**3,015,819**
13								
14	**Total Plan Revenue (excludes internal transfers)**	**236,260,627**	**237,540,637**	**2,960,048,314**	**2,852,680,167**	**2,936,309,611**	**2,857,802,604**	**2,852,680,167**
15								
16	**Plan Expenses:**							
17								
18	Medical Claim Payments	160,836,063	144,683,709	1,858,096,405	1,849,410,105	2,003,583,417	2,078,924,788	1,849,410,105
19	Medical Claim Refunds/Recoveries	(1,594,137)	4,105,941	(23,467,914)	(22,634,615)	(31,216,928)	(33,175,196)	(22,634,615)
20	**Net Medical Claims**	**159,241,926**	**148,789,650**	**1,834,628,491**	**1,826,775,490**	**1,972,366,489**	**2,045,749,592**	**1,826,775,490**
21								
22	Pharmacy Claim Payments	64,053,421	56,236,591	755,896,440	721,644,990	743,853,418	706,459,465	721,644,990
23	Pharmacy Claim Rebates	-	-	(69,641,941)	(93,130,160)	(53,173,873)	(66,582,530)	(93,130,160)
24	Pharmacy Claim Refunds/Recoveries	(24,328)	(396,564)	(3,476,790)	(481,977)	-	-	(481,977)
25	**Net Pharmacy Claims**	**64,029,093**	**55,840,027**	**682,777,709**	**628,032,853**	**690,679,545**	**639,876,935**	**628,032,853**
26								
27	**Net Claim Payments**	**223,271,019**	**204,629,677**	**2,517,406,200**	**2,454,808,343**	**2,663,046,034**	**2,685,626,527**	**2,454,808,343**
28								
29	**Net Administrative Expenses**	**13,364,005**	**13,722,974**	**161,401,639**	**165,480,561**	**189,387,392**	**180,464,149**	**165,480,561**
30								
31	**Total Plan Expenses (excludes internal transfers)**	**236,635,024**	**218,352,651**	**2,678,807,839**	**2,620,288,904**	**2,852,433,426**	**2,866,090,676**	**2,620,288,904**
32								
33	**Plan Income/(Loss)**	**(374,397)**	**19,187,986**	**281,240,475**	**232,391,263**	**83,876,185**	**(8,288,072)**	**232,391,263**
34								
35	**Cash Availability:**							
36								
37	Beginning Cash Balance/(Deficit)	783,862,343	483,059,489	502,247,471	269,856,212	502,247,475	226,838,352	269,856,212
38	**Ending Cash Balance/(Deficit)**	**783,487,946**	**502,247,475**	**783,487,946**	**502,247,475**	**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	**Cash Balance Over/(Under) Reserve Target**	**$ 583,759,493**	**$ 300,825,486**	**$ 583,759,493**	**$ 300,825,486**	**$ 386,395,207**	**$ 17,128,291**	**$ 300,825,486**

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 June 2013
Fiscal Year 2012-13

#		A	B	C	D	E	F
		Actual Year to Date FY 2012-13 thru June	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Authorized Budget Year to Date FY 2012-13 thru June	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Note 1)	$ 2,895,366,140	$ 9,063,419	$ 2,904,429,559	$ 2,872,808,844	$ 31,620,715	1.10%
4	Premium Refunds/Retroactive Disenrollments	(487,819)		(487,819)	(1,437,243)	949,424	-66.06%
5	Medicare Part D (RDS) Subsidy (Note 2)	38,056,016	(482,857)	37,573,159	39,519,892	(1,946,733)	-4.93%
6	Medicare PDP (EGWP + Wrap) Subsidy (Note 3)	24,435,483	(3,879,515)	20,555,968	19,759,856	796,112	4.03%
7	Federal Early Retiree Reinsurance Program (ERRP) (Note 4)	(558,219)	558,219	-	-	-	
8	**Net Premium & Other Contributions**	**2,956,811,601**	**5,259,266**	**2,962,070,867**	**2,930,651,349**	**31,419,518**	**1.07%**
9							
10	**Other Revenue**	**3,236,713**		**3,236,713**	**5,658,262**	**(2,421,549)**	**-42.80%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**2,960,048,314**	**5,259,266**	**2,965,307,580**	**2,936,309,611**	**28,997,969**	**0.99%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	1,834,628,491		1,834,628,491	1,972,366,489	(137,737,998)	-6.98%
17	Net Pharmacy Claims (Notes 5 and 6)	682,777,709	15,151,710	697,929,419	690,679,545	7,249,874	1.05%
18	**Net Claim Payments**	**2,517,406,200**	**15,151,710**	**2,532,557,910**	**2,663,046,034**	**(130,488,124)**	**-4.90%**
19							
20	**Net Administrative Expenses**	**161,401,639**		**161,401,639**	**189,387,392**	**(27,985,753)**	**-14.78%**
21							
22	**Total Plan Expenses (excludes internal transfers)**	**2,678,807,839**	**15,151,710**	**2,693,959,549**	**2,852,433,426**	**(158,473,877)**	**-5.56%**
23							
24	Plan Income/(Loss)	**281,240,475**	**(9,892,444)**	**271,348,031**	**83,876,185**	**187,471,846**	**223.51%**
25							
26	**Cash Availability:**						
27							
28	Beginning Cash Balance/(Deficit)	502,247,471		502,247,471	502,247,475	(4)	0.00%
29	**Ending Cash Balance/(Deficit)**	**783,487,946**	**(9,892,444)**	**773,595,502**	**586,123,660**	**187,471,842**	**31.99%**
30							
31	Target Stabilization Reserve @ 6/30/13	199,728,453		199,728,453	199,728,453	-	
32							
33	**Cash Balance Over/(Under) Reserve Target**	**$ 583,759,493**	**$ (9,892,444)**	**$ 573,867,049**	**$ 386,395,207**	**$ 187,471,842**	**48.52%**

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 EGWP subsidy revenues decreased to remove impact of an unbudgeted January subsidy payment ($3.9 million).
4. Revenues adjusted to remove impact of unbudgeted reimbursement to CMS for FY 2012 ERRP overpayment ($558,219).
5. Net pharmacy claims adjusted to remove the impact of a rebate true-up payment that was larger than anticipated.
6. Net pharmacy claims adjusted to include estimated EGWP rebates that were budgeted for FY 2013 but will not be received until FY 2014 ($5.8 million).

Adjusted Variance Report Based on Authorized (Revised) Budget
Year to Date Through June 2013

4th Quarter Actuarial Forecast Update

Board of Trustees Meeting

September 27, 2013

Forecast prepared by The Segal Company
Final version dated 9-17-13

A Division of the Department of State Treasurer

Presentation Overview

- Final Fiscal Year 2012-13 Charts
- Forecast update schedule
- Updated assumptions: 3rd Quarter vs. 4th Quarter Projection
- Updated forecast for Short Plan Year (July-December 2013)
- Summary and Long-Term Outlook

Forecast Comparisons: FY 2012-13 Claims

($ Millions)

	Medical Claims FY 2013	Pharmacy Claims FY 2013
Certified Budget	$2,181	$672
Nov 2011 Update	$2,117	$681
Jan 2012 Update	$2,100	$671
Apr 2012 Update	$2,068	$692
Authorized Budget	$1,972	$690
Sep 2012 Update	$1,930	$697
Dec 2012 Update	$1,899	$680
Mar 2013 Update	$1,859	$678
Actual	$1,835	$683

Forecast Comparisons: FY 2012-13 Ending Cash

($ Millions)

	Certified Budget	Nov 2011 Update	Jan 2012 Update	Apr 2012 Update	Authorized Budget	Sep 2012 Update	Dec 2012 Update	Mar 2013 Update	Actual
Ending Cash	$170.0	$318.1	$369.9	$421.1	$586.1	$627.8	$699.6	$755.8	$783.5

Actuarial Forecast Update Schedule

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

Forecast Assumptions Maintained in the Update
3rd Quarter Update vs. 4th Quarter Update

- Overall trend assumption of 8.5%
- Membership trends
  - 1% annual decrease in actives
  - 1% annual increase in retirees
- Short plan year, July-December 2013
- New plan offerings as of January 1, 2014
- Includes impact of:
  - SL 2013-360, Appropriations Act, SB 402 funding to increase employer contributions for health plan coverage during the 2013-15 biennium
  - SL 2013-379, Amend Pharmacy Laws, HB 675 pertaining to audits
  - Coverage changes approved by Board in July to comply with Federal Mental Health Parity Act

Forecast Assumptions Changed/Revised in the Update
3rd Quarter Update vs. 4th Quarter Update

- Membership based on actual June 2013 counts (instead of March 2013)
- Anticipated claims expenditures based on actual experience through June 2013 (instead of through March 2013)
- Baseline pharmacy claims amount increased to reflect experience from the last six months (rather than the last 12 months) due to increasing pharmacy trends
- Projected pharmacy rebate amounts increased to reflect more recent expectations

Comparison of Models for Short Plan Year (Jul-Dec 2013) 3rd Quarter Update vs. 4th Quarter Update

Short Plan Year July – December 2013	3rd Quarter Update (Final Version per Segal 8-19-13)	4th Quarter Update (per Segal 9-17-13)	Difference Increase/ (Decrease)
Beginning Cash Balance	$755.8 m	$783.5 m	$27.7 m
Plan Revenue	$1.476 b	$1.477 b	$0.8 m
Net Claims Payments	$1.445 b	$1.446 b	$0.8 m
Net Admin. Expenses	$91.3 m	$91.3 m	$0.0 m
Total Plan Expenses	$1.537 b	$1.538 b	$0.8 m
Net Income/(Loss)	($60.8 m)	($60.8 m)	$0.0 m
Ending Cash Balance	$695.0 m	$722.7 m	$27.7 m

Forecast Comparisons: Short Plan Year and Fiscal Year 2013-14

($ Millions)

	Medical Claims	Pharmacy Claims
Short Plan Year – 3rd Quarter Update	$1,032	$414
Short Plan Year – 4th Quarter Update	$1,020	$426
FY 2013-14 – 3rd Quarter Update	$2,083	$647
FY 2013-14 – 4th Quarter Update	$2,057	$665

Forecast Comparisons: Ending Cash Balances

($ Millions)

	Jun 30, 2013	Dec 31, 2013	Jun 30, 2014	Dec 31, 2014	Jun 30, 2015
3rd Quarter Update	$756	$695	$717	$720	$641
4th Quarter Update	$784	$723	$754	$756	$689

Summary/FB 2015-17 Outlook

Final Fiscal Year 2012-13 results:

- Actual medical claims ended $25 million below the 3rd Quarter Update
- Actual pharmacy claims ended $5 million above the 3rd Quarter Update

Current Fiscal Biennium: 2013-2015

- Relative to the 3rd Quarter Update, the 4th Quarter Update projects slightly lower medical claims costs and slightly higher pharmacy claims costs

Fiscal Biennium 2015-17 Outlook

- Cash balance to start the 2015-17 Fiscal Biennium:
  - $689.1 million
  - $47.8 million higher than the 3rd Quarter Update (mostly due to higher starting balance – actual FY 2013 ending cash higher than 3rd Quarter projection)
  - Exceeds the 9.0% target reserve amount by $434.7 million
  - Equates to approximately 11 weeks of FY 2015-16 projected operating expenses
- Assuming no changes in benefits beyond the Board's current design, the 4th Quarter Update projects a 7.64% premium increase for January 1st of each year of the 2015-17 biennium. This is lower than the previous projection (of 8.22%)
- Caveat: While the 4th Quarter Update indicates we can expect our cash balance to continue to exceed projections (slide 10) – an indication claims experience is likely to continue to be less than projected – actual claims payments in the 1st quarter of FY 2013-14 are close to or exceeding projections.

Q3 Update
(Final Version
Segal 8-19-2013)

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

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

Q4 Update
(Segal 9-17-13)

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

	2011 - 2013 Biennium		2013 - 2015 Biennium				2015 - 2017 Biennium				
	Actual FY 2012	Actual FY 2013	Projection Short Plan Year Jul-Dec 2013	Projection Calendar 2014 Jan-June	Projection Calendar 2014 July-Dec	Projection Calendar 2015 Jan-Jun	Projection Calendar 2015 Jul-Dec	Projection Calendar 2016 Jan-June	Projection Calendar 2016 July-Dec	Projection Calendar 2017 Jan-Jun	Projection Calendar 2017 Jul-Dec
PLAN INCOME:											
Net Contribution Income	2,750,368,851	2,895,366,140	1,442,174,466	1,490,547,441	1,487,472,109	1,516,200,908	1,513,135,765	1,625,450,041	1,622,232,251	1,742,717,907	1,739,341,677
EGWP/PDP Spouse Premium Reduction		-	(2,487,307)	(14,619,077)	(14,691,991)	(14,765,268)	(14,838,911)	(14,912,921)	(14,987,300)	(15,062,050)	(15,137,173)
MA Spouse Premium Reduction				(5,915,367)	(5,944,871)	(5,974,521)	(6,004,319)	(6,034,266)	(6,064,363)	(6,094,609)	(6,125,006)
MA Buy-up Premium				11,086,677	11,141,972	15,329,232	15,405,688	20,010,236	20,110,038	25,172,031	25,297,578
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(721,087)	(745,274)	(743,736)	(758,100)	(756,568)	(812,725)	(811,116)	(871,359)	(869,671)
Premium Incentive			-	(15,191,659)	(15,160,315)	(14,132,995)	(14,121,033)	18,418,359	18,381,897	18,234,380	18,199,054
CDHP Premium Reduction			-	(3,511,855)	(3,504,610)	(4,728,115)	(4,724,113)	(5,927,555)	(5,915,821)	(7,102,205)	(7,088,445)
Medicare Part D	57,583,602	38,056,016	3,480,930	4,292,522	3,637,572	4,485,686	3,801,263	4,687,542	3,972,320	4,898,481	4,151,074
EGWP+Wrap											
Direct Subsidy	-	24,435,483	25,486,468	-	-	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	7,246,510	18,126,022	-	-	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	13,139,911	-	-	-	-	-	-
Total	-	24,435,483	32,732,978	18,126,022	13,139,911	-	-	-	-	-	-
				-							
Appropriations from State Reserve											
Investment Earnings	3,015,815	3,236,713	1,499,854	1,484,750	1,545,368	1,449,429	1,282,970	1,125,880	999,600	846,301	721,467
Total Plan Income	2,852,680,163	2,960,048,314	1,476,679,834	1,485,554,180	1,476,891,411	1,497,106,256	1,493,180,742	1,642,004,590	1,637,917,507	1,762,738,876	1,758,490,555
PLAN EXPENSE:											
Medical Claims Payment	1,849,410,105	1,858,096,405	985,190,847	1,097,790,133	1,024,105,824	1,186,201,329	1,116,692,340	1,282,191,803	1,202,548,316	1,382,959,214	1,296,591,064
Claim Refunds	(22,634,615)	(23,467,914)	(11,856,867)	(12,427,126)	(12,726,122)	(13,427,769)	(14,184,290)	(14,606,266)	(15,068,865)	(15,541,687)	(16,248,702)
Dental & MHSA Enhancement			1,965,773	3,370,429	3,144,204	3,641,869	3,428,463	3,936,578	3,692,057	4,245,954	3,980,787
Medicare Advantage Claims Reduction				(51,968,249)	(60,761,863)	(66,255,435)	(66,585,888)	(72,606,018)	(72,968,145)	(79,565,305)	(79,962,142)
Calendar Year Adjustments		-	44,524,878	(4,229,258)	14,039,329	(14,419,571)	18,622,423	(17,792,129)	20,205,328	(19,304,460)	21,922,781
Preventative at 100% in Standard Plan				9,667,771	13,547,862	15,338,830	14,810,139	16,534,080	15,936,126	17,817,328	17,166,254
Premium Incentive				(7,870,811)	(11,785,870)	(11,278,934)	(11,262,371)	(12,267,698)	(12,243,326)	(19,636,512)	(19,598,330)
CDHP Claims Reduction				(2,677,783)	(4,009,753)	(5,714,828)	(5,706,435)	(8,856,958)	(8,839,362)	(12,834,027)	(12,809,073)
Limited Network Savings				306,831	459,453	385,508	384,942	597,628	596,440	571,179	570,069
PCP Copay Waiver				4,374,516	6,550,465	(400,206)	(399,618)	(4,095,020)	(4,086,884)	(17,120,631)	(17,087,342)
Mental Health Enhancements				451,937	608,123	704,182	662,918	765,424	717,880	830,629	778,755
Net Medical Claims	1,826,775,490	1,834,628,491	1,019,824,631	1,036,788,388	973,171,653	1,094,774,976	1,056,462,623	1,173,801,425	1,130,489,565	1,242,421,682	1,195,304,122
Medicare Advantage Premiums			-	88,021,495	88,460,508	110,212,713	110,762,406	134,668,503	135,340,171	161,607,300	162,413,326
Pharmacy Claims Payment	721,163,013	752,419,650	439,471,366	400,667,190	474,851,078	432,941,019	513,121,759	507,563,056	514,744,662	548,539,882	556,324,465
Rebates	(93,130,160)	(69,641,941)	(22,231,618)	(37,631,175)	(23,038,391)	(33,453,422)	(23,876,429)	(27,307,574)	(24,751,103)	(28,190,866)	(25,651,553)
Calendar Year Adjustments			6,396,219	(10,452,836)	11,745,894	(10,781,873)	12,692,680	(12,564,560)	13,003,743	(13,578,939)	14,054,262
Net Pharmacy Claims	628,032,853	682,777,709	423,635,967	352,583,179	463,558,581	388,705,724	501,938,011	467,690,921	502,997,303	506,770,077	544,727,174
MA-PDP Claims Reduction			-	(115,393,569)	(140,344,687)	(153,033,461)	(153,796,725)	(167,701,719)	(168,538,141)	(183,775,928)	(184,692,522)
EGWP+Wrap Reduction in Rebates		-	1,647,855	838,031	-	-	-	-	-	-	-
EGWP+Wrap Claim Increase		-	468,869	-	-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips		-	591,761	686,451	813,549	741,745	879,117	869,593	881,897	939,797	953,135
HB 675 - Pharmacy Audit Changes				100,000	104,617	95,383	113,048	111,824	113,406	120,851	122,566
Specialty Pharmacy Tier				(188,553)	(265,759)	(258,100)	(305,900)	(321,724)	(326,276)	(370,372)	(375,628)
Total Pharmacy Claims	628,032,853	682,777,709	426,344,452	238,625,540	323,866,300	236,251,291	348,827,551	300,648,895	335,128,189	323,684,426	360,734,725
Total Claims	2,454,808,343	2,517,406,200	1,446,169,083	1,363,435,424	1,385,498,461	1,441,238,980	1,516,052,580	1,609,118,824	1,600,957,925	1,727,713,408	1,718,452,173
Administrative Costs	165,480,561	161,401,639	85,503,942	91,148,672	88,666,322	88,485,226	91,324,401	91,141,693	93,690,104	93,506,610	96,125,220
ACA Reinsurance Fee				-	-	34,632,846	-	21,039,454	-	14,201,632	-
Extra EGWP+Wrap Administration	-	-	5,794,014	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,537,467,039	1,454,584,096	1,474,164,783	1,564,357,052	1,607,376,981	1,721,299,971	1,694,648,029	1,835,421,650	1,814,577,393
Plan Income (Loss)	232,391,259	281,240,475	(60,787,205)	30,970,084	2,726,628	(67,250,796)	(114,196,240)	(79,295,381)	(56,730,522)	(72,682,774)	(56,086,837)
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	722,700,741	753,670,825	756,397,453	689,146,657	574,950,417	495,655,036	438,924,513	366,241,740
Ending Cash Balance (Deficit)	502,247,471	783,487,946	722,700,741	753,670,825	756,397,453	689,146,657	574,950,417	495,655,036	438,924,513	366,241,740	310,154,902
Target Stabilization Reserve	184,110,626	201,392,496	115,693,527	238,816,383	233,659,380	254,406,370	266,156,240	281,265,426	288,906,907	299,580,420	310,154,902
	7.5%	8.0%	8.0%	8.5%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase		1/1 Increase		1/1 Increase		1/1 Increase		1/1 Increase	
Premium Increase:	5.3%	5.3%		3.57%		2.14%		7.64%		7.64%	

July 2013 Financial Report

Board of Trustees Meeting

September 27, 2013

A Division of the Department of State Treasurer

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

Short Plan Year July-December 2013	Actual thru July 2013	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Beginning Cash Balance	$783.5 m	$755.8 m	$27.7 m
Plan Revenue	$256.4 m	$246.4 m	$10.0 m
Net Claims Payments	$273.5 m	$267.2 m	$6.3 m
Net Administrative Expenses	$15.0 m	$15.2 m	($0.2 m)
Total Plan Expenses	$288.5 m	$282.4 m	$6.1 m
Net Income/(Loss)	($32.1 m)	($36.0 m)	$3.9 m
Ending Cash Balance	$751.4 m	$719.8 m	$31.6 m

Adjusted Variance Report
Year to Date July 2013

Short Plan Year July-December 2013	Actual thru July 2013, As Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Beginning Cash Balance	$783.5 m	$755.8 m	$27.7 m
Plan Revenue *	$248.2 m	$246.4 m	$1.8 m
Net Claims Payments *	$268.1 m	$267.2 m	$0.9 m
Net Administrative Expenses	$15.0 m	$15.2 m	($0.2 m)
Total Plan Expenses	$283.1 m	$282.4 m	$0.7 m
Net Income/(Loss)	($34.9 m)	($36.0 m)	$1.1 m
Ending Cash Balance	$748.6 m	$719.8 m	$28.8 m

* Adjusted for timing issues.

A Division of the Department of State Treasurer

Financial Results Actual v. Budgeted Year to Date July 2013

Per Member Per Month (PMPM) Analysis

Short Plan Year July-December 2013	Actual thru July 2013	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue	$383.99	$369.10	$14.89
Net Claims Payments	$408.64	$399.85	$8.79
Net Administrative Expenses	$22.49	$22.78	($0.29)
Total Plan Expenses	$431.13	$422.63	$8.50
Net Income/(Loss)	($47.14)	($53.53)	$6.39

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 July 2013

Per Member Per Month (PMPM) Analysis

Short Plan Year July-December 2013	Actual thru July 2013, as Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	$371.74	$369.10	$2.64
Net Claims Payments *	$400.57	$399.85	$0.72
Net Administrative Expenses	$22.49	$22.78	($0.29)
Total Plan Expenses	$423.06	$422.63	$0.43
Net Income/(Loss)	($51.32)	($53.53)	$2.21

* Adjusted for timing issues.

Year to Date Expenditure Trend Per Member Per Month

$450
$425
$400
$375
$350
$325
$300
$275
$250

FY 2012-13 Budgeted = $358.70

Short Plan Year Budgeted = $383.58

Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13 Feb-13 Mar-13 Apr-13 May-13 Jun-13 Jul-13 Aug-13 Sep-13 Oct-13 Nov-13 Dec-13

YTD Actual Expenses
YTD Budgeted Expenses
Budgeted PMPM FY 2012-13
Budgeted PMPM Short Plan Year

Allocation of Claims Expenditures

Includes Medical, Blue Card & Pharmacy Payments

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

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

#		A	B	C	D	E	F	G	H
		Actual July 2013	Certified Budget July 2013	Monthly Variance Over/(Under) Certified Budget	Actual Short Plan Year To Date	Certified Budget Short Plan Year to Date	Short Plan Year to Date Variance Over/(Under) Certified Budget	Short Plan Year Certified Budget (Jul - Dec 2013)	Short Plan Year to Date Variance Over/(Under) Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 247,712,470	$ 240,225,187	$ 7,487,283	$ 247,712,470	$ 240,225,187	$ 7,487,283	$ 1,440,079,372	$ (1,192,366,902)
4	Premium Refunds/Retroactive Disenrollments	(3,887)	(120,320)	116,433	(3,887)	(120,320)	116,433	(721,290)	717,403
5	Medicare Part D (RDS) Subsidy	549,436	469,160	80,276	549,436	469,160	80,276	2,784,744	(2,235,308)
6	Medicare PDP (EGWP + Wrap) Subsidy	7,917,151	5,669,732	2,247,419	7,917,151	5,669,732	2,247,419	32,347,301	(24,430,150)
7	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
8	**Net Premium & Other Contributions**	**256,175,170**	**246,243,759**	**9,931,411**	**256,175,170**	**246,243,759**	**9,931,411**	**1,474,490,127**	**(1,218,314,957)**
9									
10	Investment Earnings	268,810	244,949	23,861	268,810	244,949	23,861	1,448,002	(1,179,192)
11	Miscellaneous Revenue	-	-	-	-	-	-	-	-
12	**Other Revenue**	**268,810**	**244,949**	**23,861**	**268,810**	**244,949**	**23,861**	**1,448,002**	**(1,179,192)**
13									
14	**Total Plan Revenue (excludes internal transfers)**	**256,443,980**	**246,488,708**	**9,955,272**	**256,443,980**	**246,488,708**	**9,955,272**	**1,475,938,129**	**(1,219,494,149)**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	187,337,017	188,919,238	(1,582,221)	187,337,017	188,919,238	(1,582,221)	1,043,999,297	(856,662,280)
19	Medical Claim Refunds/Recoveries	(2,199,898)	(2,078,616)	(121,282)	(2,199,898)	(2,078,616)	(121,282)	(12,060,684)	9,860,786
20	**Net Medical Claims**	**185,137,119**	**186,840,622**	**(1,703,503)**	**185,137,119**	**186,840,622**	**(1,703,503)**	**1,031,938,613**	**(846,801,494)**
21									
22	Pharmacy Claim Payments	95,318,946	91,432,944	3,886,002	95,318,946	91,432,944	3,886,002	434,048,440	(338,729,494)
23	Pharmacy Claim Rebates	(6,882,250)	(11,056,828)	4,174,578	(6,882,250)	(11,056,828)	4,174,578	(20,572,861)	13,690,611
24	Pharmacy Claim Refunds/Recoveries	(112,292)	-	(112,292)	(112,292)	-	(112,292)	-	(112,292)
25	**Net Pharmacy Claims**	**88,324,404**	**80,376,116**	**7,948,288**	**88,324,404**	**80,376,116**	**7,948,288**	**413,475,579**	**(325,151,175)**
26									
27	**Net Claim Payments**	**273,461,523**	**267,216,738**	**6,244,785**	**273,461,523**	**267,216,738**	**6,244,785**	**1,445,414,192**	**(1,171,952,669)**
28									
29	**Net Administrative Expenses**	**15,047,688**	**15,226,894**	**(179,206)**	**15,047,688**	**15,226,894**	**(179,206)**	**91,298,298**	**(76,250,610)**
30									
31	**Total Plan Expenses (excludes internal transfers)**	**288,509,211**	**282,443,632**	**6,065,579**	**288,509,211**	**282,443,632**	**6,065,579**	**1,536,712,490**	**(1,248,203,279)**
32									
33	**Plan Income/(Loss)**	**(32,065,231)**	**(35,954,924)**	**3,889,693**	**(32,065,231)**	**(35,954,924)**	**3,889,693**	**(60,774,361)**	**28,709,130**
34									
35	**Cash Availability:**								
36									
37	Beginning Cash Balance/(Deficit)	783,487,948	755,749,494	27,738,454	783,487,948	755,749,494	27,738,454	755,749,494	27,738,454
38	**Ending Cash Balance/(Deficit)**	**751,422,717**	**719,794,570**	**31,628,147**	**751,422,717**	**719,794,570**	**31,628,147**	**694,975,133**	**56,447,584**
39									
40	Target Stabilization Reserve @ 12/31/13	219,485,780	219,485,780	-	219,485,780	219,485,780	-	219,485,780	-
41									
42	**Cash Balance Over/(Under) Reserve Target**	**$ 531,936,937**	**$ 500,308,790**	**$ 31,628,147**	**$ 531,936,937**	**$ 500,308,790**	**$ 31,628,147**	**$ 475,489,353**	**$ 56,447,584**

Comments:
a. Premium receivables totaled $ 2,316,483.37 as of July 31, 2013.
b. The average weekly medical claims cost net of claims refunds was $37,027,423.80 for the five scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included three bi-weekly invoice cycles averaging $31,772,982.00 per cycle.
d. The target stabilization reserve is 8% of the projected net claims for Calendar Year 2013.
e. Minor differences compared to other reports are due to rounding.

Actual vs Certified Budget (i.e. ***Original Budget*** per SL 2013-360 and Board Approved Design thru July 2013)
July 2013-Short Plan Year

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Current Year Actual vs. Prior Year Actual
For the Month Ended July 2013
Fiscal Year 2013-2014

#		A	B	C	D	E	F	G
		Current Year Actual July 2013	Prior Year Actual July 2012	Current Year to Date Actual FY 2013-14 thru July	Prior Year to Date Actual FY 2012-13 thru July	Current Year Certified Annual Budget FY 2013-14	Prior Year Annual Budget FY 2012-13	Prior Year Actual Results FY 2012-13
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 247,712,470	$ 238,141,727	$ 247,712,470	$ 238,141,727	$ 2,902,567,015	$ 2,872,808,844	$ 2,895,366,140
4	Premium Refunds/Retroactive Disenrollments	(3,887)	(27,686)	(3,887)	(27,686)	(1,466,766)	(1,437,243)	(487,819)
5	Medicare Part D (RDS) Subsidy	549,436	4,002,360	549,436	4,002,360	6,218,762	39,519,892	38,056,016
6	Medicare PDP (EGWP + Wrap) Subsidy	7,917,151	-	7,917,151	-	50,346,402	19,759,856	24,435,483
7	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	(558,219)
8	**Net Premium & Other Contributions**	**256,175,170**	**242,116,401**	**256,175,170**	**242,116,401**	**2,957,665,413**	**2,930,651,349**	**2,956,811,601**
9								
10	Investment Earnings	268,810	255,103	268,810	255,103	2,868,131	5,658,262	3,117,666
11	Miscellaneous Revenue	-	-	-	-	-	-	119,047
12	**Other Revenue**	**268,810**	**255,103**	**268,810**	**255,103**	**2,868,131**	**5,658,262**	**3,236,713**
13								
14	**Total Plan Revenue (excludes internal transfers)**	**256,443,980**	**242,371,504**	**256,443,980**	**242,371,504**	**2,960,533,544**	**2,936,309,611**	**2,960,048,314**
15								
16	**Plan Expenses:**							
17								
18	Medical Claim Payments	187,337,017	188,992,659	187,337,017	188,992,659	2,107,493,114	2,003,583,417	1,858,096,405
19	Medical Claim Refunds/Recoveries	(2,199,898)	(1,985,632)	(2,199,898)	(1,985,632)	(24,643,884)	(31,216,928)	(23,467,914)
20	**Net Medical Claims**	**185,137,119**	**187,007,027**	**185,137,119**	**187,007,027**	**2,082,849,230**	**1,972,366,489**	**1,834,628,491**
21								
22	Pharmacy Claim Payments	95,318,946	83,193,670	95,318,946	83,193,670	699,653,578	743,853,418	755,896,440
23	Pharmacy Claim Rebates	(6,882,250)	(12,543,432)	(6,882,250)	(12,543,432)	(52,353,361)	(53,173,873)	(69,641,941)
24	Pharmacy Claim Refunds/Recoveries	(112,292)	(12,410)	(112,292)	(12,410)	-	-	(3,476,790)
25	**Net Pharmacy Claims**	**88,324,404**	**70,637,828**	**88,324,404**	**70,637,828**	**647,300,217**	**690,679,545**	**682,777,709**
26								
27	**Net Claim Payments**	**273,461,523**	**257,644,855**	**273,461,523**	**257,644,855**	**2,730,149,447**	**2,663,046,034**	**2,517,406,200**
28								
29	**Medicare Advantage Premiums**	-	-		-	**86,864,744**	-	-
30								
31	**Net Administrative Expenses**	**15,047,688**	**11,110,634**	**15,047,688**	**11,110,634**	**182,446,628**	**189,387,392**	**161,401,639**
32								
33	**Total Plan Expenses (excludes internal transfers)**	**288,509,211**	**268,755,489**	**288,509,211**	**268,755,489**	**2,999,460,819**	**2,852,433,426**	**2,678,807,839**
34								
35	**Plan Income/(Loss)**	**(32,065,231)**	**(26,383,985)**	**(32,065,231)**	**(26,383,985)**	**(38,927,275)**	**83,876,185**	**281,240,475**
36								
37	**Cash Availability:**							
38								
39	Beginning Cash Balance/(Deficit)	783,487,948	502,247,471	783,487,948	502,247,471	755,749,494	502,247,475	502,247,471
40	**Ending Cash Balance/(Deficit)**	**751,422,717**	**475,863,486**	**751,422,717**	**475,863,486**	**716,822,219**	**586,123,660**	**783,487,946**
41								
42	Target Stabilization Reserve @ 6/30/14	239,446,206	199,728,453	239,446,206	199,728,453	239,446,206	199,728,453	188,805,465
43								
44	**Cash Balance Over/(Under) Reserve Target**	$ 511,976,511	$ 276,135,033	$ 511,976,511	$ 276,135,033	$ 477,376,013	$ 386,395,207	$ 594,682,481

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

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

Consolidated Report, Actual vs. Budgeted
For the Month Ended July 2013
Short Plan Year (July-December 2013)

#		A	B	C	D	E	F
		Actual Year to Date Short Plan Year thru July	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Year to Date Short Plan Year thru July	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 247,712,470	$ (8,175,162)	$ 239,537,308	$ 240,225,187	$ (687,879)	-0.29%
4	Premium Refunds/Retroactive Disenrollments	(3,887)		(3,887)	(120,320)	116,433	-96.77%
5	Medicare Part D (RDS) Subsidy	549,436		549,436	469,160	80,276	17.11%
6	Medicare PDP (EGWP + Wrap) Subsidy	7,917,151		7,917,151	5,669,732	2,247,419	39.64%
7	Federal Early Retiree Reinsurance Program (ERRP)	-		-	-	-	
8	**Net Premium & Other Contributions**	**256,175,170**	**(8,175,162)**	**248,000,008**	**246,243,759**	**1,756,249**	**0.71%**
9							
10	**Other Revenue**	**268,810**		**268,810**	**244,949**	**23,861**	**9.74%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**256,443,980**	**(8,175,162)**	**248,268,818**	**246,488,708**	**1,780,110**	**0.72%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	185,137,119		185,137,119	186,840,622	(1,703,503)	-0.91%
17	Net Pharmacy Claims (Note 3)	88,324,404	(5,400,000)	82,924,404	80,376,116	2,548,288	3.17%
18	**Net Claim Payments**	**273,461,523**	**(5,400,000)**	**268,061,523**	**267,216,738**	**844,785**	**0.32%**
19							
20	**Net Administrative Expenses**	**15,047,688**		**15,047,688**	**15,226,894**	**(179,206)**	**-1.18%**
21							
22	**Total Plan Expenses (excludes internal transfers)**	**288,509,211**	**(5,400,000)**	**283,109,211**	**282,443,632**	**665,579**	**0.24%**
23							
24	**Plan Income/(Loss)**	**(32,065,231)**	**(2,775,162)**	**(34,840,393)**	**(35,954,924)**	**1,114,531**	**-3.10%**
25							
26	**Cash Availability:**						
27							
28	Beginning Cash Balance/(Deficit)	783,487,948		783,487,948	755,749,494	27,738,454	3.67%
29	**Ending Cash Balance/(Deficit)**	**751,422,717**	**(2,775,162)**	**748,647,555**	**719,794,570**	**28,852,985**	**4.01%**
30							
31	Target Stabilization Reserve @ 12/31/2013	219,485,780		219,485,780	219,485,780	-	
32							
33	**Cash Balance Over/(Under) Reserve Target**	**$ 531,936,937**	**$ (2,775,162)**	**$ 529,161,775**	**$ 500,308,790**	**$ 28,852,985**	**5.77%**

Adjustment Notes:
1. Member premiums adjusted to include $10.3 million in prepaid premiums from June 2013.
2. Member premiums adjusted to exclude $18.5 million in prepaid premiums received in July 2013.
3. Pharmacy claims adjusted to include an EGWP rebate budgeted for July that will not be received until October.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Additional 2014 Coverage Changes– Essential Health Benefits

Board of Trustees Meeting

September 27, 2013

A Division of the Department of State Treasurer

Statutory Authority

Pursuant to NCGS §135-48.30 the State Treasurer sets benefits subject to the approval of the Board of Trustees.

Compliance Review Concerns

- Discussion initiated at July 2013 Board Meeting
- Essential Health Benefits
  - Cranial Bands - $600 lifetime limit
  - Hearing Aids - $2,500 per ear, per 3 year period, up to age 22
  - Infertility and Sexual Dysfunction - $5,000 lifetime limit

Essential Health Benefits

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

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

Essential Health Benefits

- For 2014 and 2015, USDHHS has defined EHB by reference to a “benchmark plan” that each state will select.
- The benchmark plan for North Carolina is the BCBSNC Blue Options PPO Plan. However, as a self-funded benefit plan, SHP may choose any benchmark plan to follow.

- Note: Large employer plans (e.g. NC State Health Plan) are not required to cover EHB; however, for any EHB covered by their plan, the large employer cannot impose annual or lifetime dollar limits. However, actuarially equivalent treatment or service limits may be applied.

Essential Health Benefits – Coverage Comparison

Current Coverage

- Cranial Bands – $600 lifetime limit
- Hearing Aids - $2,500 limit per ear per 3 year period, up to age 22
- Infertility and Sexual Dysfunction - $5,000 lifetime limit

Proposed Compliant Coverage

- Cranial Bands – quantity limit of one per lifetime
- Hearing Aids – quantity limit of one hearing aid per hearing impaired ear every 3 years, up to age 22
  - Reimbursement can be limited to the usual, customary, and reasonable amount (UCR), but members may be balanced billed
- Remove combined lifetime dollar limit for Infertility and Sexual Dysfunction:
  - Establish an Infertility lifetime quantity limit of three ovulation induction cycles and associated services
  - Unlimited coverage for sexual dysfunction

Cost of Compliance – Essential Health Benefits

Proposed Compliant Coverage	Estimated Additional Annual Cost
• Cranial Bands	$54,667
• Hearing Aids	$240,878
• Infertility	$2,290,950
• Sexual Dysfunction	$88,000
Total:	**$2,674,495**

Options – Essential Health Benefits

Options:

- Change coverage as proposed (page 6) to eliminate dollar limits on EHB
- Eliminate or drop current coverage – this would result in loss of Grandfather status for the 70/30 and 80/20 plans
- Choose a benchmark plan that does not include coverage for some or all of the services listed

Recommendation – Essential Health Benefits

Plan staff recommends the Board of Trustees approve the proposed coverage changes (page 6) eliminating dollar limits on EHB, effective January 2014.

Process Discussion Follow-up: Requests to Consider Benefit Changes

Board of Trustees Meeting

September 27, 2013

A Division of the Department of State Treasurer

Proposed Policy

- Pursuant to 135-48.30 the State Treasurer sets benefits subject to the approval of the Board of Trustees.

- Proposed Board of Trustees Policy:

  In fulfilling its mission to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, it is the policy of the Board of Trustees to provide a forum for people or groups wishing to propose changes in benefit coverage.

Process – Step 1

- Requestor completes a "*Request Form for BOT Consideration of a Change to SHP Benefits*" and submits to BOT/Plan by email, etc.

- The following information is provided in the Form:
  - Name of Requestor
  - Requested Change
  - Rationale for Request
  - Proposed Effective Date
  - Supporting Documentation
  - Contact Information

Process – Step 2

- Requests will be provided to the BOT as received.
- For Calendar Year 2013, the November BOT meeting will be used to review requested changes.
- Thereafter, requests will be reviewed at the July BOT meetings.
- Persons requesting to address the Board at the annual meeting may be allowed to speak or present at the discretion of the Treasurer. The Treasurer may also invite persons requesting changes to speak at the annual meeting.

Proposed Additions to the Bylaws:

- Article IV, Meetings, revised to add:
  Annual Meeting to Consider Changes to SHP Benefits: One meeting per year will be used to review requests made by parties outside of the Plan for changes in coverage under the health benefit plans.

- Article V, Operations, revised to add:
  Appearance Before the Board at the Annual Meeting to Consider Changes to SHP Benefits: Individuals or who wish to appear before the Board shall make their request in writing to the Chairperson at least two (2) weeks in advance of the Annual Meeting. The written request shall include a *Request Form for BOT Consideration of a Change to SHP Benefits* if not previously submitted. The chairperson, at his or her discretion, may approve the request and allot a reasonable time for presentation. The Chairperson shall limit presentation as necessary to maintain the timely conduct of business by the Board.

Current Bylaws Provide:

- Appearance Before the Board: Individuals or groups who wish to appear before the Board shall make their request in writing to the Chairperson at least seven (7) days in advance of the next regularly scheduled meeting. The Chairperson, at his or her discretion, may approve the request and allot a reasonable time for presentation. The Chairperson shall limit presentation as necessary to maintain the timely conduct of business by the Board.

Next Steps

- Revise bylaws.
- Develop external procedure.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

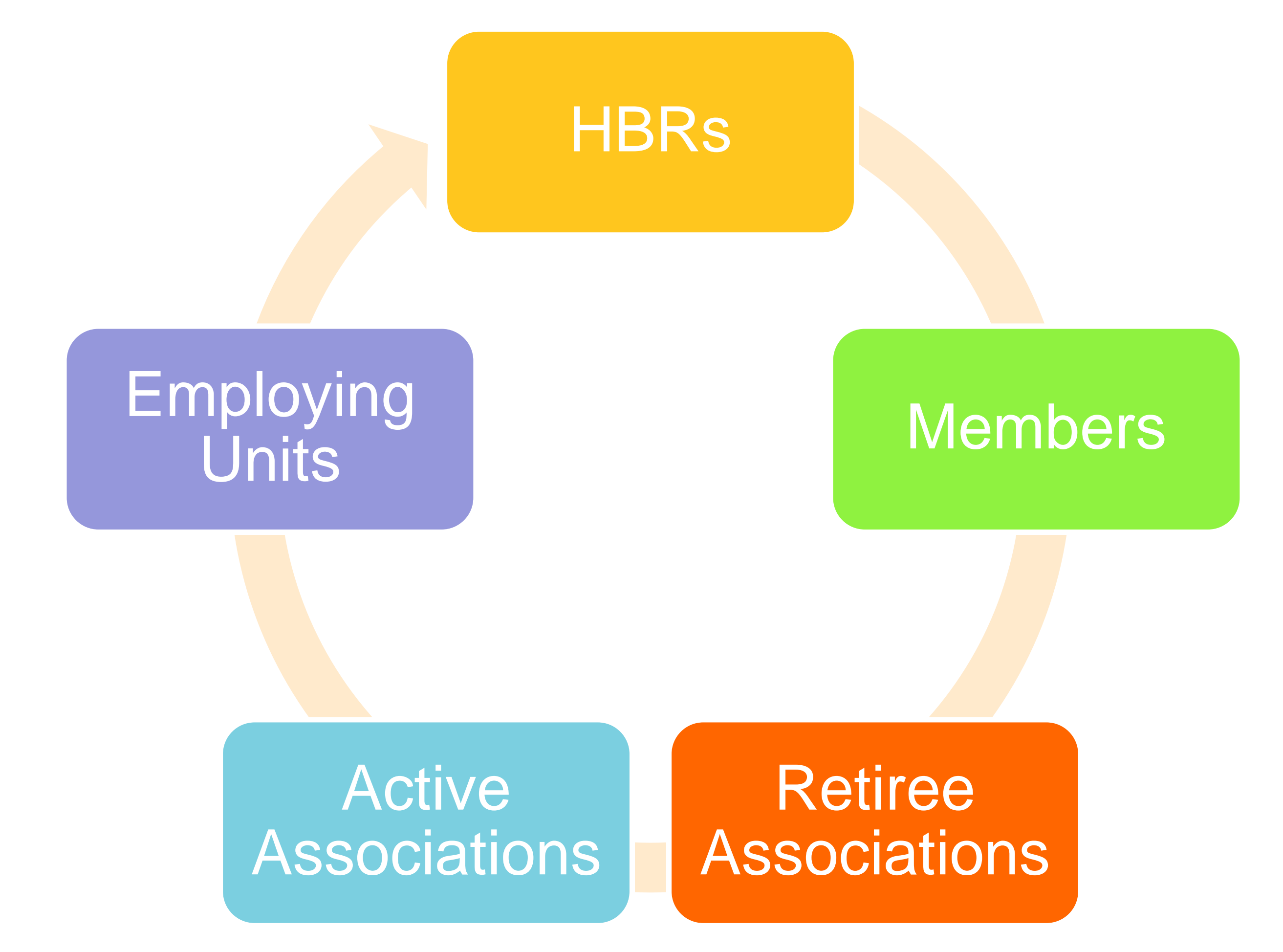
Communications Update

Board of Trustees Meeting

September 27, 2013

A Division of the Department of State Treasurer

Communications Strategy



HBR Training in Summary

- 72 sessions were completed across 53 counties in 30 days, including 2 webinars.
- 1,556 HBRs have attended training sessions.
- 90% of those who attended RSVP'd.
- 85.7% of those attended completed a survey.
- 80% of those surveyed either agreed or strongly agreed training was helpful.
- 4,449 clicks to HBR web page for the month of August.

HBRs – *The Next 90+ Days*

HBRs

Employing Units

	SEP	OCTOBER				NOVEMBER				DECEMBER			
	9/30	10/7	10/14	10/21	10/28	11/4	11/11	11/18	11/25	12/9	12/16	12/23	12/30
Internal SHP Training													
Stakeholder / Association Outreach	■	■	■	■	■	■	■	■	■	■	■	■	■
HBR Training													
Website	■	■	■	■	■	■	■	■	■	■	■	■	■
HBR PPT													
Secure Training Locations													
Promote Training via eBlast													
Open Enrollment Communication	■	☒	■	☒	☒								
Training Materials													
HBR Hotline	■	■	■	■	■								
Polling													

Legend	
HBRs	■
Indicates Mail / eMail Drop Week	☒
Indicates completed	(blue)

Active / Non-Medicare Primary Retirees

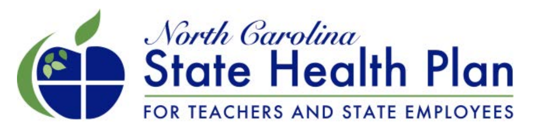
Members

- Newsletters were mailed week of Aug. 12.
- Decision Guides mailed week of Sept. 16.
- Health Assessment (HA) postcard mailed Aug. 23.
- Smoking Resource postcard mailed Sept. 23.
- Nearly 20,000 HAs have been completed since Aug. 16, an increase of 45% from July.
- As of Sept. 20, more than 1,800 members have attended sessions, 28% of those who attended completed a survey.
- Of those surveyed, 88% have stated that they are "…*most likely to participate in Wellness Premium Credits to reduce premium*."
- During Aug., SHP website received 52,462 clicks to 2014 Open Enrollment web page. Of those, 34,190 were unique visitors.
- As of Sept. 19, the first member video received 15,136 clicks.

Active / Non-Medicare Retirees – *The Next 90+ Days*

	SEP	OCTOBER				NOVEMBER				DECEMBER			
	9/30	10/7	10/14	10/21	10/28	11/4	11/11	11/18	11/25	12/9	12/16	12/23	12/30
Active / Non-Medicare Primary Retiree Members													
Website (Actives)													
Rate Tool													
Active Member Videos	2	3		4									
Member Newsletter													
Health Assessment Postcard													
Actives Facebook Messaging													
Enrollment Guides													
Smoking Resource Postcard													
Member Reminder Postcard													
Member Non-Responder Postcard													
Enrollment Tour													
Active Polling during Info Sessions													

Legend	
Actives / Non-Medicare Primary Retirees	
Indicates Mail / eMail Drop Week	
Indicates completed	



Active / Non-Medicare Primary Retirees

Members

Meeting Locations

Ashe, Alleghany, Surry, Stokes, Rockingham, Caswell, Person, Granville, Vance, Warren, Northampton, Gates, Hertford, Camden, Currituck, Pasquotank, Perquimans, Chowan, Watauga, Wilkes, Yadkin, Forsyth, Guilford, Alamance, Orange, Durham, Franklin, Halifax, Bertie, Mitchell, Avery, Yancey, Madison, Caldwell, Alexander, Iredell, Davie, Davidson, Randolph, Chatham, Wake, Nash, Edgecombe, Martin, Washington, Tyrrell, Dare, Mcdowell, Burke, Catawba, Rowan, Wilson, Pitt, Beaufort, Hyde, Haywood, Buncombe, Swain, Graham, Rutherford, Lincoln, Cabarrus, Lee, Johnston, Greene, Henderson, Jackson, Polk, Cleveland, Gaston, Mecklenburg, Stanly, Montgomery, Moore, Harnett, Wayne, Lenoir, Craven, Pamlico, Cherokee, Macon, Clay, Transylvania, Union, Anson, Richmond, Hoke, Cumberland, Sampson, Duplin, Jones, Scotland, Robeson, Bladen, Pender, Onslow, Carteret, Columbus, New Hanover, Brunswick

Month of September

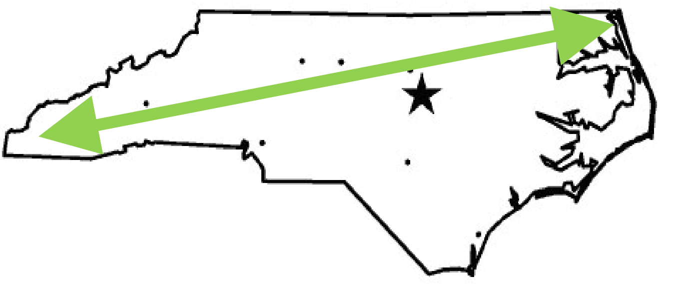
Month of October

A Division of the Department of State Treasurer

Active / Non-Medicare Primary Retirees

Information Session and Enrollment Tours Outreach

45 Meetings



Number of Sessions / County

Wake = 17
Durham, Mecklenburg, and Wayne = 2 each
Buncombe = 4

One meeting each for Beaufort, Burke, Columbus, Craven Cumberland, Edgecombe, Forsyth, Harnett, Moore, New Hanover, Pasquotank, Pitt, Randolph, Robeson, Rutherford, and Watauga counties

12 member webinars

Medicare Primary Retirees

- Newsletters were mailed week of Aug. 12.
- Decision Guides and MAPDP Enrollment kits were mailed week of Sept. 16.
- As of Sept. 20, 7,317 have attended Outreach Events.
- Of those in attendance, 28% completed surveys.
- Of those surveyed, 57.5% agree and strongly agree that SHP is offering more choices, while 27% stayed neutral.
- Of those surveyed, 38.5% agreed or strongly agreed that *"…the MAPDPs offer an opportunity to save money*," while 47.5% stayed neutral.
- Of those surveyed, 66.5% agreed and strongly agreed that the presentation held their attention.
- Of those surveyed, 61.5% agreed and strongly agreed that they now have a better understanding after having attended an Outreach Event.
- During Aug., SHP website received 11,034 clicks to the 2014 Medicare Primary Open Enrollment webpage. Of those, 7,565 were unique visitors.

Medicare Primary Retirees – *The Next 90+ Days*

	SEP	OCTOBER				NOVEMBER				DECEMBER			
	9/30	10/7	10/14	10/21	10/28	11/4	11/11	11/18	11/25	12/9	12/16	12/23	12/30
Medicare Primary Retiree Members													
Website (Retirees)													
Member Newsletter													
Retirees Facebook Messaging													
Enrollment Guides													
Retiree Reminder Postcard													
Retiree Non-Responder Postcard													
Outreach Events													
Retiree Polling during Info Sessions													
Robo Outbound Calls													

Legend	
Medicare Primary Retirees	
Indicates Mail / eMail Drop Week	
Indicates completed	

Medicare Primary Retirees

Members

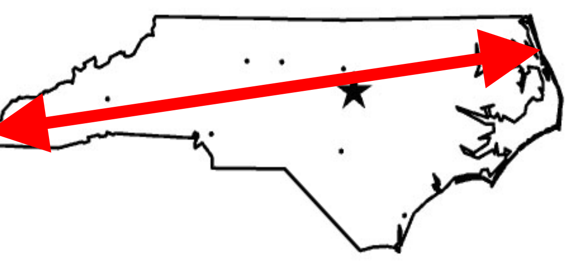
Meeting Locations

- Month of September
- Month of October

Medicare Primary Retirees

Medicare Primary Outreach Events

134 Meetings



Number of Sessions / County

Wake = 24
Mecklenburg and Orange = 6 each
Forsyth and Guilford = 4 each
Alamance, Cumberland, Harnett, Johnston, Lenoir, New Hanover, Rockingham = 3 each
Beaufort, Brunswick, Buncombe, Burke, Cabarrus, Carteret, Catawba, Cleveland, Craven, Davidson, Gaston, Granville, Haywood, Henderson, Horry (SC), Nash, Onslow, Pasquotank, Pitt, Pittsylvania (SC), Randolph, Robeson, Rowan, Rutherford, Sampson, Surry, Union, and Wayne counties = 2 each

One meeting each for
Bertie, Brevard (FL), Dare, Duplin, Halifax, Jackson, Lake (FL), Moore, Orange (FL), Pender, Pinellas (FL), Watauga, and York (SC).

Medicare Primary Retirees

- As of Sept. 20, more than 15,000 RSVP’d for Outreach Events.
- As of Sept. 20, 7,317 have attended Outreach Events.

2013 Timeline

Members

Ongoing Communication Activities
- ✓ Facebook Posts
- ✓ Electronic Newsletters
- ✓ Posters
- ✓ Website

The **BIG** Picture

	AUGUST				SEPTEMBER					OCTOBER				NOVEMBER				DECEMBER			
	8/5	8/12	8/19	8/26	9/2	9/9	9/16	9/23	9/30	10/7	10/14	10/21	10/28	11/4	11/11	11/18	11/25	12/9	12/16	12/23	12/30
Internal SHP Training																					
Stakeholder / Association Outreach																					
HBR Training																					
Website	LAUNCH																				
HBR PPT																					
Secure Training Locations																					
Promote Training via eBlast																					
Open Enrollment Communication																					
Training Materials																					
HBR Hotline																					
Polling																					

	AUGUST				SEPTEMBER					OCTOBER				NOVEMBER				DECEMBER			
	8/5	8/12	8/19	8/26	9/2	9/9	9/16	9/23	9/30	10/7	10/14	10/21	10/28	11/4	11/11	11/18	11/25	12/9	12/16	12/23	12/30
Active / Non-Medicare Primary Retiree Members																					
Website		LAUNCH																			
Rate Tool																					
Active / Non-Medicare Primary Retiree Videos	1								2	3		4									
Member Newsletter																					
Health Assessment Postcard																					
Actives / Non-Medicare Primary Retiree Facebook Messaging																					
Enrollment Guides																					
Smoking Resource Postcard																					
Member Reminder Postcard																					
Member Non-Responder Postcard																					
Enrollment Tour																					
Active / Non-Medicare Retirees Polling during Info Sessions																					

	AUGUST				SEPTEMBER					OCTOBER				NOVEMBER				DECEMBER			
	8/5	8/12	8/19	8/26	9/2	9/9	9/16	9/23	9/30	10/7	10/14	10/21	10/28	11/4	11/11	11/18	11/25	12/9	12/16	12/23	12/30
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Legend	
HBRs	
Active / Non-Medicare Primary Retirees	
Medicare Primary Retirees	
Indicates Mail / eMail Drop Week	
Indicates completed	

Open Enrollment Materials

Members

YOUR HEALTH?
Assess your assets!
NC HEALTH Smart

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer
2014 OPEN ENROLLMENT
YOUR STATE HEALTH PLAN
OCTOBER 1 – 31, 2013

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer
2014 OPEN ENROLLMENT
YOUR STATE HEALTH PLAN DECISION GUIDE
OPEN IMMEDIATELY: IMPORTANT INFORMATION ABOUT CHANGES TO YOUR STATE HEALTH PLAN BENEFITS
OCTOBER 1 – 31, 2013

To see the second member video, go to:
http://elearning.shpnc.org/2014-open-enrollment/

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Member Questions Regarding Network Coverage

Board of Trustees Meeting

September 27, 2013

A Division of the Department of State Treasurer

Most Frequently Asked Questions

While there have been many interesting questions posed throughout the HBR and Member meetings, the most consistently expressed questions and concerns relate to network coverage and provider accessibility

Actives/Non-Medicare Primary

- Concern with the lack of Blue Options Designated facilities in the eastern portion of the state
- Misconception that members can *only* use Blue Options Designated facilities

Medicare Primary

- Concern that their provider is not in either the Humana or UHC network
- Lack of understanding regarding Passive PPO Network
- Lack of clarity regarding whether their provider will accept Medicare and file claims for SHP members

Network Coverage Concerns

We have asked representatives from BCBSNC, Humana and UHC to address these concerns.

Blue Options Designated Providers

- BCBSNC: Jack Kenley, Vice President Sales & Marketing, SHP Executive

Medicare Advantage Networks

- Humana: Christa Klein, Group Medicare Business Executive
- UHC: John Thompson, Vice President, Client Development, UHC Retiree Solutions

Blue Options Designated Providers

Wellness Incentives

Members enrolled in the Enhanced 80/20 Plan and CDHP can reduce their out of pocket costs when visiting a Blue Options Designated Provider:

Designated Specialists

- General Surgery
- Ob-Gyn
- Gastroenterology
- Orthopedics
- Cardiology
- Neurology

Designated Hospitals

- Quality Outcomes
- Cost Efficiency
- Accessibility

State Health Plan Designated Facility Listing - 2014

Designated for Cost & Quality	Designated for Critical Access
ALAMANCE REGIONAL MEDICAL CENTER	ALLEGHANY COUNTY MEMORIAL HOSPITAL
BLUE RIDGE REGIONAL HOSPITAL	ANGEL MEDICAL CENTER
CALDWELL MEMORIAL HOSPITAL	ASHE MEMORIAL HOSPITAL
CMC - UNIVERSITY	BERTIE MEMORIAL HOSPITAL
CATAWBA VALLEY MED CTR	BLADEN COUNTY HOSPITAL
CENTRAL CAROLINA HOSPITAL	BLOWING ROCK HOSPITAL
D L P PERSON MEMORIAL HOSPITAL LLC	CHARLES A CANNON JR MEMORIAL HOSP
FIRSTHEALTH MOORE REGIONAL	CHATHAM HOSPITAL
FRYE REGIONAL MEDICAL CTR	DAVIE COUNTY HOSPITAL
GRANVILLE MEDICAL CENTER	DOSHER MEMORIAL HOSPITAL
HARRIS REGIONAL HOSPITAL	FIRSTHEALTH MONTGOMERY MEM HOSP
HAYWOOD REGIONAL MEDICAL CENTER	HIGHLANDS CASHIERS HOSPITAL
HIGH POINT REGIONAL HOSPITAL	OUR COMMUNITY HOSPITAL
HUGH CHATHAM MEMORIAL HOSPITAL	PENDER MEMORIAL HOSPITAL
LEXINGTON MEMORIAL HOSPITAL	PIONEER COMMUNITY HOSP OF STOKE
MARG R PARDEE MEMORIAL HOSPITAL	PUNGO DISTRICT HOSPITAL
MARTIN GENERAL HOSPITAL	ST LUKES HOSPITAL
MOSES H CONE MEMORIAL HOSPITAL	SWAIN COUNTY HOSPITAL
NEW HANOVER REGIONAL MEDICAL CTR	THE OUTER BANKS HOSPITAL INC
NORTH CAROLINA BAPTIST HOSPITAL	TRANSYLVANIA COMMUNITY HOSPITAL
REX HOSPITAL	VIDANT CHOWAN HOSPITAL
SAMPSON REGIONAL MED CTR	WASHINGTON COUNTY HOSPITAL
ROWAN REGIONAL MEDICAL CENTER INC	YADKIN VALLEY COMMUNITY HOSPITAL
THE MCDOWELL HOSPITAL	
UNC HOSPITALS	
WAKEMED RALEIGH CAMPUS	

These are the hospitals where:

- your Inpatient Admission Co-Pay will be waived *(80/20 Enhanced plan)*

or

- you will receive a $50 HRA deposit *(85/15 CDHP Plan)*

These are NOT the only in-network hospitals.

State Health Plan Non-Designated Facility Listing - 2014

ALBEMARLE HOSPITAL	MARIA PARHAM HOSPITAL
ANSON COMMUNITY HOSPITAL	MEDICAL PARK HOSPITAL
BETSY JOHNSON REGIONAL HOSPITAL	MEMORIAL MISSION HOSPITAL
BRUNSWICK NOVANT MEDICAL CTR	MOREHEAD MEMORIAL HOSPITAL
CAPE FEAR VALLEY MEDICAL CENTER	MURPHY MEDICAL CENTER
CAROLINAEAST HEALTH SYSTEM	NASH GENERAL HOSPITAL
CARTERET COUNTY GENERAL HOSPITAL	NORTHERN HOSPITAL OF SURRY COUNTY
CLEVELAND REGIONAL MEDICAL CENTER	ONSLOW MEMORIAL HOSPITAL
CMC - CAROLINAS MEDICAL CENTER	PARK RIDGE HEALTH
CMC - LINCOLN	PRESBYTERIAN HOSPITAL
CMC - MERCY	PRESBYTERIAN HOSPITAL HUNTERSVILLE
CMC - NORTHEAST	PRESBYTERIAN HOSPTIAL MATTHEWS
CMC - PINEVILLE	RANDOLPH HOSPITAL
CMC - UNION	RUTHERFORD HOSPITAL INC
CMC - BLUE RIDGE MORGANTON	SANDHILLS REGIONAL MEDICAL CENTER
COLUMBUS REGIONAL HEALTHCARE	SCOTLAND MEMORIAL HOSPITAL
DAVIS REGIONAL MEDICAL CENTER	SOUTHEASTERN REGIONAL MEDICAL CTR
DUKE HEALTH RALEIGH HOSPITAL	STANLY REGIONAL MEDICAL CENTER
DUKE UNIVERSITY HOSPITAL	THOMASVILLE MEDICAL CENTER
DURHAM REGIONAL HOSPITAL	VALDESE GENERAL HOSPITAL
FORSYTH MEMORIAL HOSPITAL	VIDANT BEAUFORT HOSPITAL
FRANKLIN REGIONAL MEDICAL CENTER	VIDANT DUPLIN HOSPITAL
GASTON MEMORIAL HOSPITAL	VIDANT EDGECOMBE HOSPITAL
HALIFAX REGIONAL MEDICAL CENTER	VIDANT MEDICAL CENTER
IREDELL MEMORIAL HOSPITAL	VIDANT ROANOKE-CHOWAN HOSPITAL
JOHNSTON MEMORIAL HOSPITAL	WAKEMED CARY HOSPITAL
KINGS MOUNTAIN HOSPITAL	WATAUGA MEDICAL CENTER
LAKE NORMAN REGIONAL MEDICAL CTR	WAYNE MEMORIAL HOSPITAL
LENOIR MEMORIAL HOSPITAL	WILKES REGIONAL MEDICAL CENTER
	WILSON MEDICAL CENTER

These hospitals are all **in-network** with BCBSNC and your State Health Plan, but they not designated.

You will still receive in-network benefits when you receive care at these hospitals.

BlueOptions℠

PPO Provider Network - Hospitals

Designated for C&Q or CAH

Not Designated for C&Q or CAH

Follow-up for BCBSNC

Blue Options Designated Providers

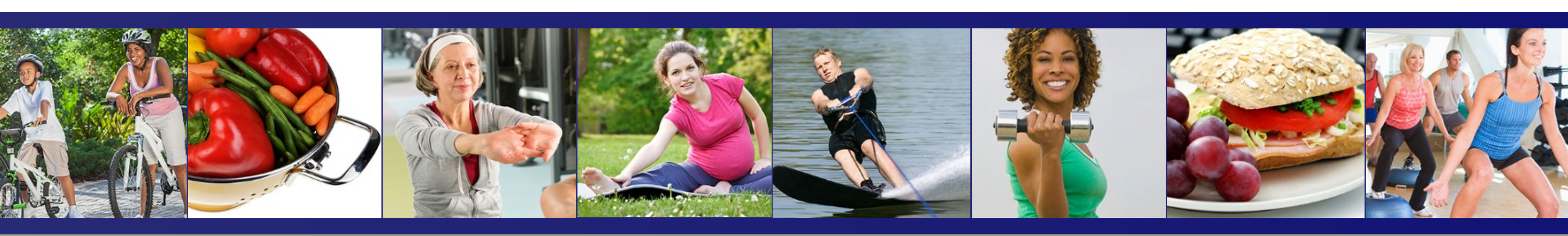
- Review the criteria for designation
  - Quality
  - Cost
  - When determined and how often evaluated
- Discuss relationship to Blue Select Network
- What steps can be taken to expand the list of Blue Options Designated hospital facilities?

Questions for Humana & UHC

Medicare Advantage Networks

- What steps have been taken to increase the MA provider network since the contract was awarded?
- What steps have been taken to increase the number of providers who will accept the MAPDP options and file claims on behalf of SHP members?
- How are network changes being communicated *within* provider organizations and practices to ensure SHP members receive accurate responses to questions about network participation and Medicare acceptance?
- What assistance will be available to SHP members after January 1st to address issues and questions?

Board Discussion



www.shpnc.org

www.nctreasurer.com

HBR Implementation Satisfaction Survey Results

Board of Trustees Meeting

September 27, 2013

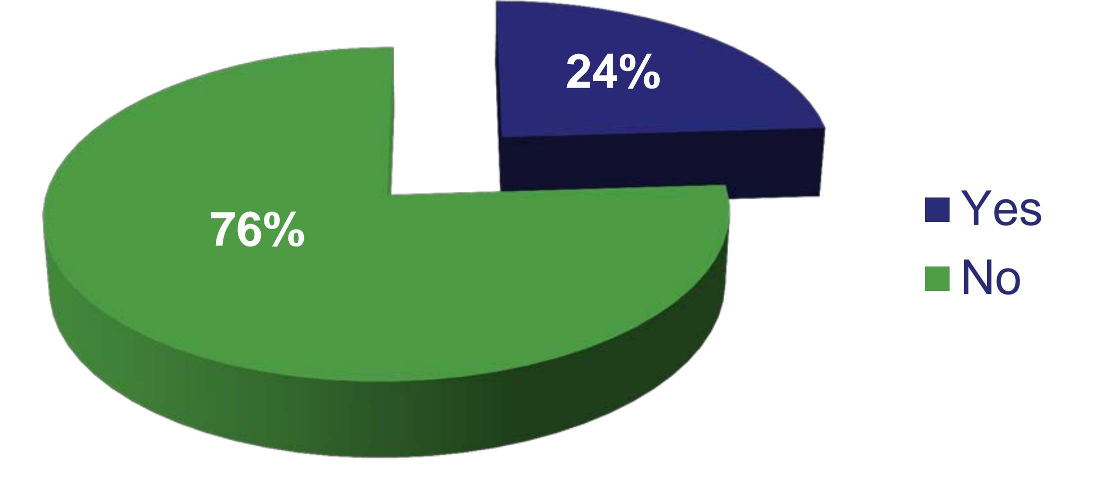
A Division of the Department of State Treasurer

HBR Survey Results Summary

- Out of approximately 200 implemented agencies, 492 HBRs were surveyed, 50 responded
- Received 10% response rate
- Eight questions were asked
- Seven were "yes/no" – one was open-ended
- Not all questions answered
- Of those answered, "*Implementation newsletter helpful*" scored best with 87.5% (#5) stating "*Yes*"
- Of those answered, "*Account Manager engagement during process*" (#3) performed worst with approximately 48% indicating "*No*"
- Least responded question was open-ended question

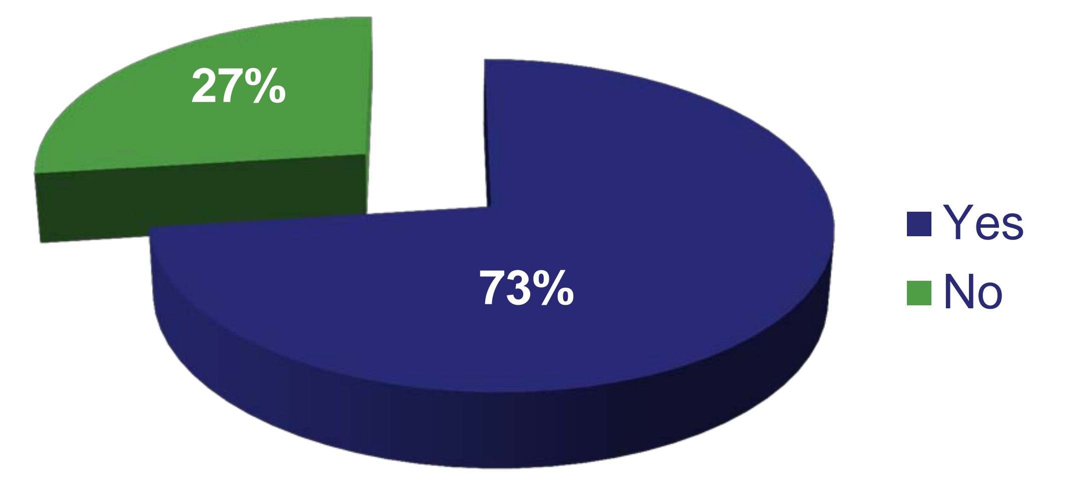
Question #1

- **Does your employing unit have any outstanding issues relating to implementation that still need to be addressed?**
  - **24% answered "*Yes*"**
  - **76% answered "*No*"**



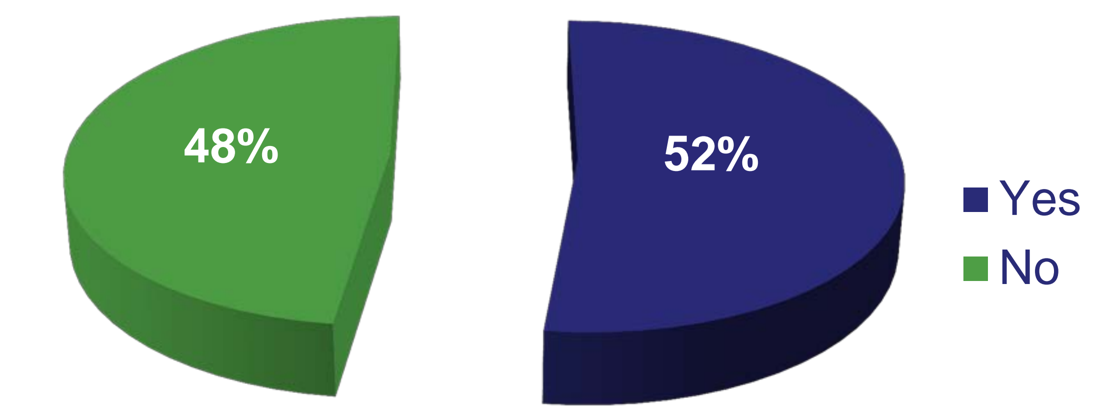
Question #2

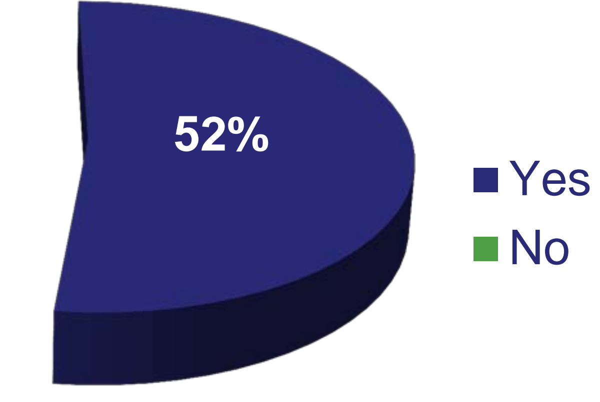
- **Was your eEnroll Account Manager helpful during this process?**
  - **73% answered “ *Yes*”**
  - **27% answered “*No*”**



Question #3

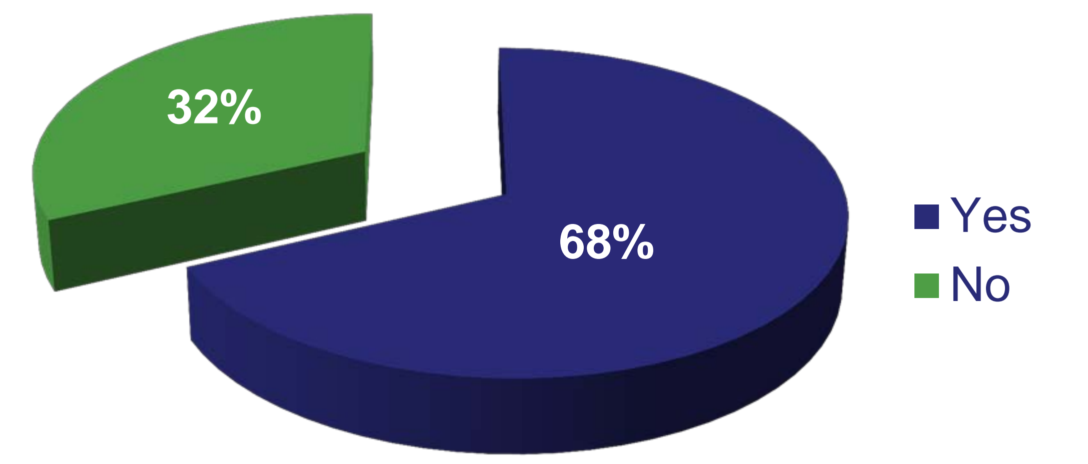
- **Did your eEnroll Account Manager engage you and your unit during this process?**
  - **52% answered “*Yes*”**
  - **48% answered “*No*”**





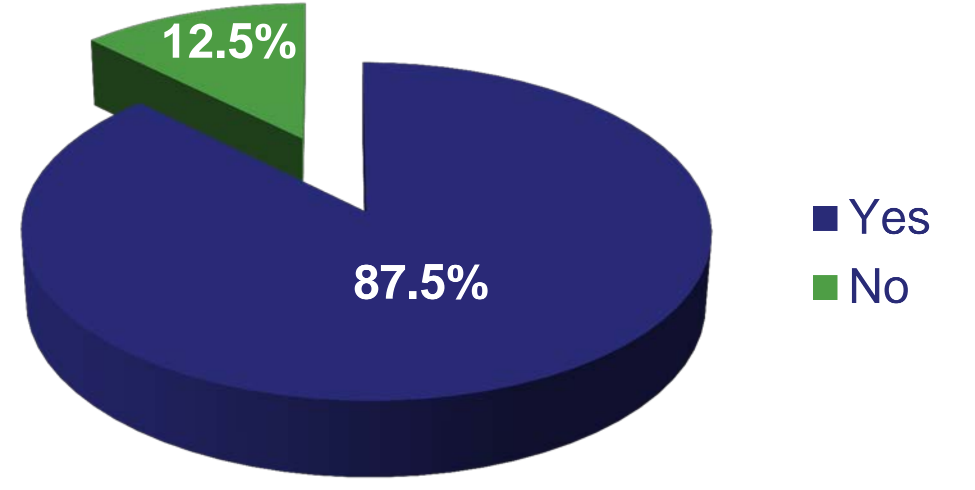
Question #4

- **Do you feel the communication during the implementation process was sufficient?**
  - **68% answered “*Yes*”**
  - **32% answered “*No*”**



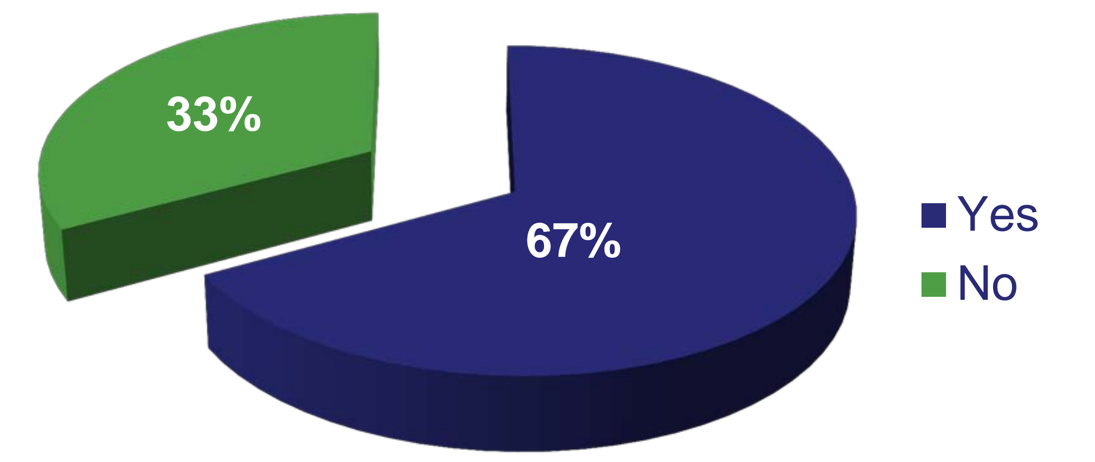
Question #5

- **Did you find the Implementation Update newsletters helpful?**
  - **87.5% answered “*Yes*”**
  - **12.5% answered “*No*”**



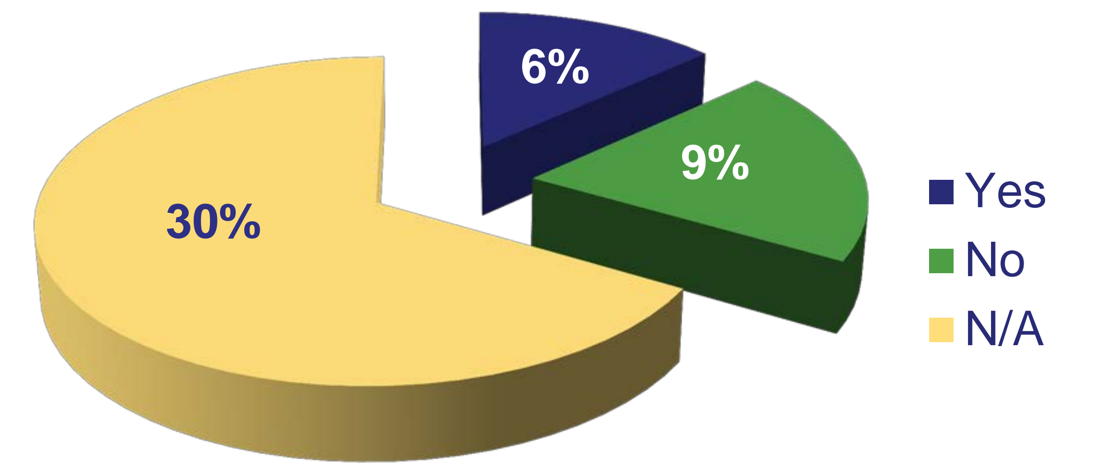
Question #7

- **Do you feel your eEnroll Account Manager responded to your questions or concerns in a timely manner?**
  - **67% answered "*Yes*"**
  - **33% answered "*No*"**



Question #8

- **If your agency offers NCFlex benefits, does your employing unit have any outstanding issues relating to the NCFlex implementation that still need to be addressed?**
  - **6% answered “*Yes*”**
  - **9% answered “*No*”**
  - **30% answered “*N/A*”**



North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

HBR Implementation Survey Results Appendix

A Division of the Department of State Treasurer

Question #6 (Open Ended)

- **Do you have any other comments regarding how this implementation was conducted?**
  - **Nine people responded averaging about 20% of total surveyed**
    - *"As an employer, we used to have a contact at BCBS that could help us with problems. We no longer have that and have to email everything. We need an individual contact when we have problems. We have a contact with eBenefits, and I can contact her with eBenefits and she is awesome. … If you call the number, you get transferred over and over…"*
    - *"Well done."*
    - *"Need more information sent early to employees."*

Question #6 (Open Ended) *continued*

- *"In reference to question #5, are you talking about HBR Alert or was there something else? BenefitFocus did not seem to have an implementation and testing plan for my university and as a result, our resources did most of the testing and facilitating of implementation. I don't feel that BenefitFocus had the appropriate resources dedicated to this project. NCFlex did not actively participate in this process. Overall, lack of communication and engagement of all parties involved. My account manager never seemed to know where the SHP was on certain issues, and as mentioned, NCFlex was non-existent and that should have been raised with senior leadership at State level. And BenefitFocus …found it difficult to communicate timelines, testing procedures, file deadlines, etc. to us. I still feel that our eEnroll account manager is spread to thin."*
- *"We should not have had a balance forward from the June invoice due to the over/shortage report making it balance. This made balancing our first invoice difficult because we had a balance forward and also a retro credit."*

Question #6 (Open Ended) *continued*

- *"The implementation was handled in a hurry of a fashion. More time was needed for testing to insure the change was smooth and that minor details were worked out. It felt like little guidance was given to eBN regarding expectations and knowing the product they were representing. Our account manager was great when you could reach her, but she wasn't likely to return calls from a voice mail request."*
- *"Too little information, too late in the process, everything felt incredibly rushed."*
- *"Never spoke to my eEnroll Account Manager."*
- *"There are agencies other than the State enrolled in this plan. There are items that are not applicable to them. It would be very refreshing to have communications that deal with those agencies."*

A presentation to

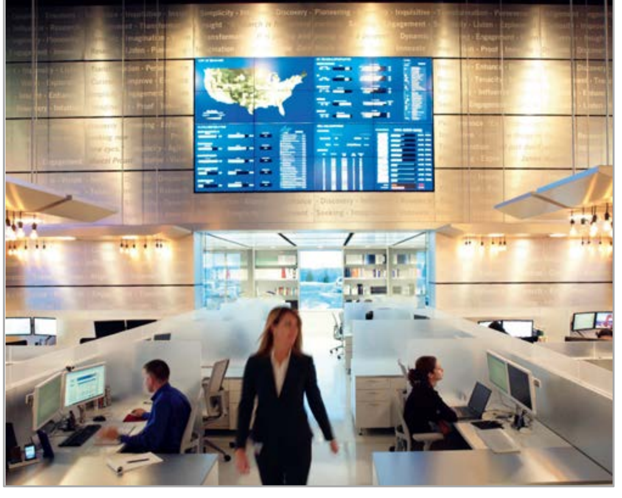
North Carolina State Health Plan Board of Trustees

September 27, 2013

We Are Express Scripts

National healthcare leader

- Best-in-class pharmacy benefit manager caring for nearly one in three Americans
- Industry-leading home delivery and specialty pharmacy services
- Pioneering research, analytics, and innovation



Independent business model, aligned with clients

Focus on driving better decisions and healthier outcomes through our unique approach: Health Decision Science℠

Solutions for greater care and cost control

Historical Performance

Plan Performance

- Gross cost increased 2.0% to $988M.
- Member contributions decreased $15M to $233M.
- Low Income Subsidy and Coverage Gap Discount reduced plan cost by an additional $15M in 1st Half 2013.

Plan Performance			
	7-12 - 6-13	7-11 - 6-12	Change %
AWP	$1,823,315,217	$1,657,936,632	10.0%
Network & Mail Discount Savings (includes dispensing fees)	-$835,755,565	-$690,025,230	21.1%
Tax	$17,963	$67,215	-73.3%
Gross Cost	$987,577,615	$967,978,617	2.0%
Member Cost	-$233,089,343	-$247,946,610	-6.0%
Plan Cost*	$754,456,964	$719,964,378	4.8%
Low Income Subsidy	$2,385,375	$0	N/A
Coverage Gap Discount	$13,069,212	$0	N/A
Adjusted Plan Cost*	$739,002,377	$719,964,378	2.6%

* Financial results have not been audited

Top Line Performance Metrics

- Plan Cost PMPM is $94.25, a 4.5% trend over the previous period
- Generic Fill Rate (GFR) increased 3.5 percentage points to 79.6%
- Specialty Plan Cost PMPM is $20.79, a 12.1% trend over the previous period

	State of NC			Government Advisory Panel (GAP)	
Description	7-12 - 6-13	7-11 - 6-12	Change	7-12 - 6-13	Change
Avg Members per Month	667,085	665,256	0.3%		
Number of Unique Patients	576,640	565,121	2.0%		
Pct Members Utilizing Benefit	86.4%	84.9%	1.5		
Total Plan Cost	$754,456,964	$719,964,378	4.8%		
Total Rxs	11,910,462	11,821,792	0.8%		
Average Member Age	46.9	45.5	3.1%	44.2	
Plan Cost PMPM	$94.25	$90.19	4.5%	$101.13	0.9%
Plan Cost per Rx	$63.34	$60.90	4.0%	$86.68	1.9%
Nbr Rxs PMPM	1.49	1.48	0.5%	1.21	2.4%
Generic Fill Rate	79.6%	76.1%	3.5	78.1%	3.5
Home Delivery Utilization	7.9%	7.9%	0.0	25.8%	-1.1
Member Cost %	23.6%	25.6%	-2.0	16.1%	-1.7
Specialty Percent of Plan Cost	22.1%	20.6%	1.5	21.3%	1.9
Specialty Plan Cost PMPM	$20.79	$18.54	12.1%	$21.58	10.9%
Formulary Compliance Rate	93.8%	92.9%	1.0	93.8%	1.0

Key Statistics: Specialty vs. Non-Specialty

- Plan Cost PMPM trend on specialty drugs is 12.1%, compared to a 2.5% Plan Cost PMPM trend on non-specialty drugs
- There are 10,443 unique specialty patients, an increase of 81 specialty patients over the previous period

State of NC						
	Non-Specialty			Specialty		
Description	7-12 - 6-13	7-11 - 6-12	Change	7-12 - 6-13	7-11 - 6-12	Change
Avg Members per Month	667,085	665,256	0.3%	667,085	665,256	0.3%
Number of Unique Patients	576,435	564,924	2.0%	10,443	10,362	0.8%
Pct Members Utilizing Benefit	86.4%	84.9%	1.5	1.6%	1.6%	0.0
Total Plan Cost	$588,042,621	$571,954,211	2.8%	$166,414,343	$148,010,168	12.4%
Percent of Total Plan Cost	77.9%	79.4%	-1.5	22.1%	20.6%	1.5
Total Rxs	11,869,232	11,781,205	0.7%	41,230	40,587	1.6%
Percent of Total Rxs	99.65%	99.66%	0.0	0.35%	0.34%	0.0
Plan Cost PMPM	$73.46	$71.65	2.5%	$20.79	$18.54	12.1%
Plan Cost per Rx	$49.54	$48.55	2.1%	$4,036.24	$3,646.74	10.7%
Nbr Rxs PMPM	1.48	1.48	0.0%	0.005	0.005	0.0%
Generic Fill Rate	79.8%	76.3%	3.5	14.0%	14.6%	-0.5
Member Cost %	27.9%	29.8%	-1.9	3.0%	3.5%	-0.4

Specialty Government Advisory Panel (GAP)	
1st H 2013	Change
$21.58	10.9%
$3,148.68	-0.3%
0.01	11.2%
32.4%	5.5
2.2%	0.0

Trend Components

- Non-specialty Plan Cost PMPM trend is 2.5% while specialty is at 12.1%
- Inflation is the largest cost driver of Plan Cost PMPM
- Discount is the largest cost saver of Plan Cost PMPM

	Overall		Non-Specialty		Specialty	
Previous Plan Cost PMPM	**$90.19**		**$71.65**		**$18.54**	
Utilization	$1.31	1.5%	$1.02	1.4%	$0.35	1.9%
Inflation	$6.18	6.9%	$4.36	6.1%	$2.48	13.4%
Drug Mix	$1.13	1.3%	$1.29	1.8%	-$0.68	-3.7%
Discount	-$7.04	-7.8%	-$6.74	-9.4%	$0.01	0.1%
Cost Share	$2.48	2.8%	$1.89	2.6%	$0.09	0.5%
Change in Plan Cost PMPM	**$4.06**	**4.5%**	**$1.81**	**2.5%**	**$2.25**	**12.1%**
Current Plan Cost PMPM	**$94.25**		**$73.46**		**$20.79**	

Date Range 7-12 - 6-13 versus 7-11 - 6-12

Utilization based on change in days PMPM

Inflation based on change in AWP/quantity at a drug level

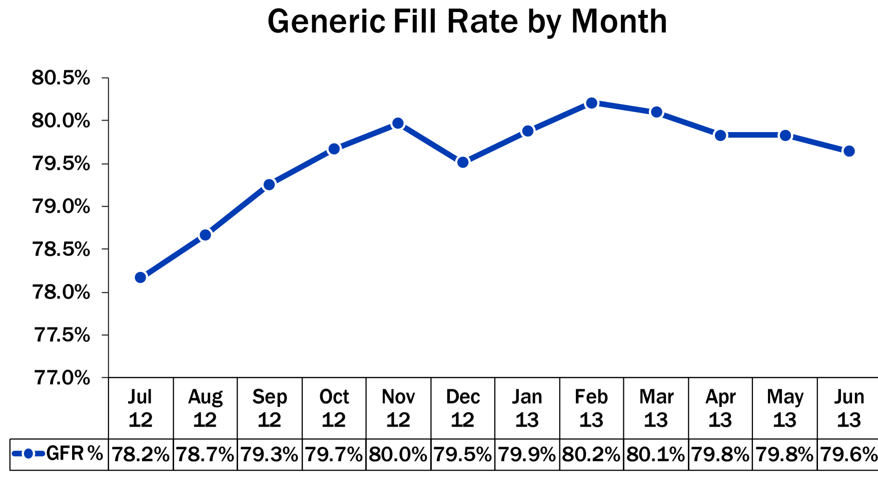
Drug Mix based on changes in therapy, addition of new therapies and the blend of brand/generics

Discount based on change in aggregate AWP discount

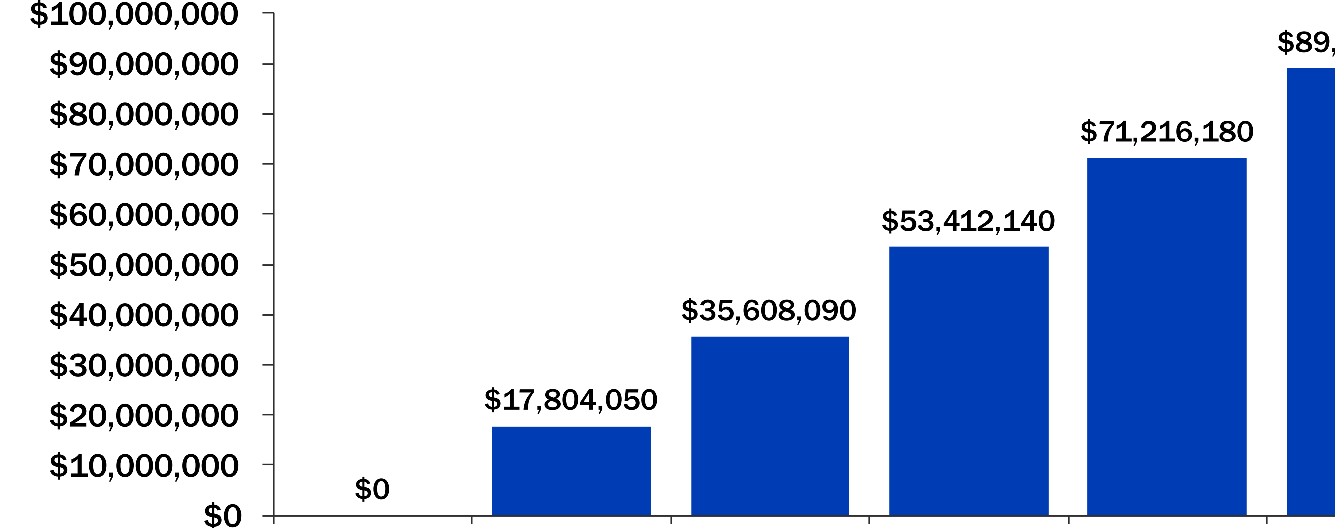
Cost share based on change in aggregate member share

Generic Dispensing

- Generic Fill Rate increases will continue to save the plan money year after year
- For every 1% increase in GFR the plan could save approximately 2.4% of total plan cost



	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13	Apr 13	May 13	Jun 13
GFR %	78.2%	78.7%	79.3%	79.7%	80.0%	79.5%	79.9%	80.2%	80.1%	79.8%	79.8%	79.6%



Top 10 Indications

- The largest trend is in Cancer, at 26.5%
- The largest negative trend is in High Blood Cholesterol, at -16.1%

Represent 59.7% of your total Plan Cost

Top Indications by Plan Cost

			7-12 - 6-13					7-11 - 6-12					% Change
Rank	Peer Rank	Indication	Rxs	Patients	Plan Cost	Generic Fill Rate	Plan Cost PMPM	Rank	Rxs	Patients	Generic Fill Rate	Plan Cost PMPM	Plan Cost PMPM
1	1	DIABETES	749,383	69,628	$89,490,634	47.6%	$11.18	1	742,335	67,445	44.3%	$9.58	16.7%
2	2	HIGH BLOOD CHOLESTEROL	957,311	146,968	$59,169,263	70.9%	$7.39	2	984,043	145,238	61.1%	$8.81	-16.1%
3	5	INFLAMMATORY CONDITIONS	34,805	6,028	$57,275,398	23.7%	$7.15	3	33,462	5,816	23.7%	$6.14	16.5%
4	6	CANCER	72,691	12,206	$45,251,930	90.2%	$5.65	5	70,731	11,635	91.3%	$4.47	26.5%
5	3	HIGH BLOOD PRESS/HEART DISEASE	1,826,375	202,847	$39,625,054	90.5%	$4.95	4	1,835,303	196,252	87.9%	$4.73	4.6%
6	9	DEPRESSION	745,317	112,983	$37,696,313	86.1%	$4.71	6	738,011	110,355	81.9%	$4.09	15.0%
7	8	MULTIPLE SCLEROSIS	5,802	962	$36,368,914	0.0%	$4.54	8	5,737	959	0.0%	$3.82	18.9%
8	4	ULCER DISEASE	528,643	103,784	$30,456,702	62.7%	$3.80	10	519,031	101,286	60.3%	$3.50	8.7%
9	7	ASTHMA	286,352	73,384	$30,158,391	35.4%	$3.77	7	266,712	64,678	9.2%	$3.95	-4.6%
10	10	MENTAL/NEURO DISORDERS	144,338	18,898	$24,789,942	63.7%	$3.10	9	140,496	18,108	52.7%	$3.57	-13.2%
		Total Top 10:	**5,351,017**		**$450,282,541**	**73.4%**	**$56.25**		**5,335,861**		**68.1%**	**$52.66**	**6.8%**
		Differences Between Periods:	**15,156**		**$29,916,604**	**5.3%**	**$3.59**						

Peer = Express Scripts Peer 'Commercial Division (CD) with EGWP' market segment

NCSHP Clinical Program Results

Clinical Program	Total Clinical Program Savings (7/1/11 – 6/30/12)	Total Clinical Program Savings (7/1/12 - 6/3/13)
Concurrent Drug Utilization Review	$94,236,830	$105,265,022
Prior Authorization, Step Therapy, Quantity Limits	$38,112,327	$42,667,556
Preferred Drug Step Therapy (does not include increased rebates)	$7,489,069	$5,409,207
RationalMed	$11,276,059	$9,948,394
Total Clinical Program Savings	$151,114,285	$163,290,179

NCSHP achieved an additional $12,175,894 million in savings over the previous fiscal year.

Future Challenges Facing Pharmacy Benefits

- Specialty medications
- Inflation on brand drugs
- High cost generics
- Coupon cards

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

State Health Plan Audits

Board of Trustees Meeting

September 27, 2013

A Division of the Department of State Treasurer

Presentation Overview

- Audit Process
- Medical Claims Audits
- BCBSNC Administrative Costs
- ActiveHealth Management Return on Investment
- Pharmacy Audits
- ERRP Audit

Why Do We Conduct Audits?

- To ensure contractual compliance
- To identify pricing errors
- To assess vendors' internal controls
- To validate benefit design is administered correctly
- To validate vendor performance guarantees
- To comply with State laws/regulations

Audit Process

Audit Workflow

Audit Plan
- Determine objective and scope
- Assessment of data needs
- Establish timeframes

Conduct Audit
- Review data
- Onsite fieldwork

Findings
- Document findings
- Root cause analysis
- Establish corrective action plan

Finalized Audit Report
- Review
- Recommend changes or improvements
- Sign off

Follow Up
- Monitor correction plan
- Collect funds for missed performance guarantees

Medical Claims Audits

Medical Claims Audit Overview

- Objectives:
  - To determine if claims are processed and paid by the Third Party Administrator (TPA) in accordance with the contract
  - To determine whether the TPA met claims accuracy performance guarantees (an annual medical claims processing error rate of no more than 3% and an annual payment error rate of no more than 2% for the contract ended June 30, 2013)
- Auditor: Thomas & Gibbs CPAs, PLLC
- Frequency: Quarterly, with an annual report delivered at the end of each fiscal year
- Methodology: “Standard” and “focused” audits of statistically valid, random samples of medical claims are audited for processing and pricing accuracy
- Status: Thomas & Gibbs has completed the FY 2012-13 reports

Medical Claims Audit Findings and Follow-up

Medical Claims Audit Findings						
July 2012 - June 2013						
	Performance Guarantee	QE 9/30/12	QE 12/31/12	QE 3/31/13	QE 6/30/13	Fiscal Year 2012-13
Standard Medical Claims Audit						
Processing error rate	3% or less	0.00%	0.52%	1.05%	2.08%	0.88%
Payment error rate	2% or less	0.00%	0.00%	0.008%	0.49%	0.12%
Financial accuracy	NA	100.00%	100.00%	99.99%	99.51%	99.88%
"Focused Audit" Duplicate Claims						
Processing error rate	NA	0.00%	0.00%	6.67%	2.67%	
Payment error rate	NA	0.00%	0.00%	0.78%	0.22%	N/A
Financial accuracy	NA	100.00%	100.00%	99.24%	99.78%	
"Focused Audit" Coordination of Benefits						
Processing error rate	NA	0.00%	1.20%	2.38%	4.82%	
Payment error rate	NA	0.00%	0.49%	0.13%	4.15%	N/A
Financial accuracy	NA	100.00%	99.51%	99.87%	95.85%	

Processing error rate is the total number of claims noted with claim payment errors divided by the total number of claims in the sample.

Payment error rate is the total absolute dollar amount of overpayments or underpayments resulting from errors in the claims tested divided by the total dollar amount of claims in the sample.

Financial accuracy is the total dollar amount in the audit sample processed accurately divided by the total dollar amount processed in the audit sample. Absolute dollar amounts are used so underpayments do not offset overpayments.

- Follow-up: Some audit errors uncover more systematic or process issues that need further review. When necessary, the Plan works with the TPA to develop a corrective action plan. Once developed, the Plan does three-month, six-month and annual follow-up reviews with BCBSNC to monitor action plan results.

Medical Claims Audit - Quality Management Reviews

The Plan's Quality Team performs additional TPA process quality checks throughout the year. Last year the following TPA processes were reviewed:

- Financial Processing Services Check Deposit
- Appeals
- Debt Set Off
- Medicare Claims Processing Accuracy
- Enrollment Retro-Termination Processing

BCBSNC Administrative Costs

BCBSNC Administrative Costs

- Purpose:
  - To determine the validity of BCBSNC's administrative charges, including both direct and indirect charges
  - To ensure that the Plan has not reimbursed BCBSNC for unallowed costs
- Auditor: Thomas & Gibbs CPAs, PLLC
- Frequency: Annual, following the end of each fiscal year
- Methodology: For the Fiscal Year 2011-12 audit, auditors reviewed supporting documentation for 80 transactions totaling approximately $10 million in costs
- Status: Final audit under the "cost plus" contract with BCBSNC will be conducted this fall (the cost plus contract ended June 30, 2013)
  - Most recent audit was from Fiscal Year 2011-12

BCBSNC Administrative Costs Findings and Follow-up

- Findings (from FY 2011-12 report)
  - Because BCBSNC's incurred costs exceeded the cost plus cap established for FY 2011-12, administrative fees charged by BCBSNC on a PMPM basis equaled the cost-plus cap and totaled $115.2 million for the fiscal year
  - Unallowed costs:
    - A portion of BCBS Association lobbying activities may have been allocated to the Plan
    - A small portion of BCBSNC sponsorship costs were allocated to the Plan
- Follow-Up/Outcome:
  - BCBSNC agreed to modify its accounting process to exclude the unallowed items, as required by the Contract
  - Because BCBSNC incurred costs above the cost-plus cap that easily exceeded the excluded items, no adjustments were made to the amount BCBSNC charged the Plan

Validation of ActiveHealth Management Return on Investment Calculation

ActiveHealth Management Return on Investment Audit

- Objective:
  - To validate the return on investment (ROI) of the Plan's contract with ActiveHealth Management
  - To determine whether ActiveHealth has met its performance guarantee of a 3:1 ROI
- Auditor: The Segal Company
- Frequency: Annual, based on calendar year ROI calculation
- Methodology: Actual claims costs are compared to projected costs. The difference between projected and actual costs are compared to ActiveHealth fees in order to produce an ROI ratio
- Status: Segal submitted the results of their ROI validation for Calendar Year 2012 in July 2013

ActiveHealth Management Return on Investment Audit Findings and Follow-up

- Important Findings from the Calendar Year 2012 measurement
  - Per the agreed-upon methodology for calculating an expected spending trend, ActiveHealth's relationship with the Plan resulted in savings of $142.7 million relative to program fees of $24.9 million
  - The resulting ROI was calculated at 5.74:1
  - Segal's measurement of the savings generated by ActiveHealth were somewhat lower than the savings calculated by ActiveHealth
  - ActiveHealth easily exceeded the target ROI of 3:1
- Follow-Up/Outcome: Segal, the Plan, and ActiveHealth agree that ActiveHealth has successfully met its performance guarantee

Pharmacy Audits

Audits conducted on the Pharmacy Benefit Manager

- Pharmacy Financial Audit
- Pharmacy Benefit Manager Rebate Audit
- Pharmacy Claims Audit

Pharmacy Financial Audit Overview

- Objective:
  - To verify the PBM (ExpressScripts/ESI) has adjudicated pharmacy claims consistent with the pricing terms indicated in the contract
  - To determine whether the PBM met the financial performance guarantees
- Auditor: The Segal Company
- Frequency: Quarterly with an annual report delivered after the contract year
- Methodology: Detailed biweekly pharmacy claims files are analyzed for pricing and invoicing accuracy
- Status: Contract year October 1, 2011- September 30, 2012 completed
  4th Quarterly audit for FY 2012-13 due at the end of September

Pharmacy Audit Components

- **Invoice reconciliation:** A claims data file covering the period of review is received from ESI and compared to invoice records obtained from ESI and also matched to the SHP's paid PBM invoice report.

- **Claims Average Wholesale Price (AWP):** The AWP reported for each claim by ESI is examined and compared to the AWP independently obtained from Medi-Span, using an 11-digit national drug code (NDC) and actual dispensing date for each claim.

- **Dispensing Fees:** Test of dispensing fee guarantees involved aggregating total dispensing fees paid for all non-member resubmitted claims filled at mail and retail pharmacies and comparing the actual dispensing fee changed to the amount expected based on the contractual guarantee.

- **Discount guarantees:** Claims are aggregated according to terms of the agreement. Claims excluded from discount guarantees are identified and separated from all other claims. The contract terms state that the discount and dispensing fee guarantees are guaranteed on a dollar-for-dollar basis. ESI may not offset a shortfall generated in one guarantee category (retail/mail, brand/generic) with a surplus generated in another.

- **Duplicate Claims:** Criteria is applied to identify duplicate claims, including same member ID, same date of service, and same national drug code (NDC).

Pharmacy Audit Components Results

	*QE 12/31/11	*QE 3/31/12	QE 6/30/12	QE 9/30/12	Contract Year
Invoice Reconciliation	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted
AWP	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted
Dispensing fee	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted
Aggregate achieved discount	Shortfall in aggregate discount noted	Shortfall in aggregate discount noted	Shortfall in aggregate discount noted	Shortfall in aggregate discount noted	Shortfall in aggregate discount noted
Specialty drug discount	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted
Duplicate Claims	No issues noted	No issues noted	Potential duplicate claims identified	Potential duplicate claims identified	960 potential duplicate claims identified

At the end of the contract year, the PBM is required to reconcile with the Plan any shortfall of financial guarantees. For contract year ending September 30, 2012, the PBM paid the Plan $2.5 million to account for a shortfall in financial discounts for achieved discounts and dispensing fees. Potential duplicate claims are analyzed, if an adjustment of the claim occurred within the period after it is not deemed a duplicate claim.

* Identifies audits conducted by Plan's previous consultant AON Hewitt

Pharmacy Rebate Audit Overview

- Objective: To verify that contractual requirements between the Plan and PBM have been met and that payments provided under the Plan’s rebate payment agreement validate rebate history
- Auditor: The Segal Company
- Frequency: As needed
- Methodology: Auditor will select six to ten major pharmaceutical manufacturers working with the PBM and review PBM’s contracts with the manufacturers to ensure that all manufacturer rebates are passed back to the Plan as required by the contract
- Status: The Plan is finalizing contract arrangements with Segal in order to complete the audit by early 2014

Pharmacy Claims Audit Overview

- Objectives:
  - To determine if claims are processed and paid by the PBM in accordance with the contract
  - To determine whether the PBM met the claims accuracy performance guarantee (an annual pharmacy claims processing error rate of no more than 1.5%)
- Auditor: Thomas & Gibbs CPAs, PLLC
- Frequency: Quarterly, with an annual report delivered at the end of each fiscal year
- Methodology: Statistically valid, random samples of pharmacy claims are audited for processing and pricing accuracy
- Status: Thomas & Gibbs has completed the FY 2012-13 reports

Pharmacy Claims Audit Findings

Pharmacy Claims Audit Findings					
July 2012 - June 2013					
	Performance Guarantee	QE 9/30/12	QE 12/31/12	QE 3/31/13	QE 6/30/13
Processing error rate	1.5% or less	0.00%	0.00%	0.00%	0.00%
Payment error rate	1.5% or less	0.00%	0.00%	0.00%	0.00%
Financial accuracy	99% or higher	100.00%	100.00%	100.00%	100.00%

Processing error rate is the total number of claims noted with claim payment errors divided by the total number of claims in the sample.

Payment error rate is the total absolute dollar amount of overpayments or underpayments resulting from errors in the claims tested divided by the total dollar amount of claims in the sample.

Financial accuracy is the total dollar amount in the audit sample processed accurately divided by the total dollar amount processed in the audit sample. Absolute dollar amounts are used so underpayments do not offset overpayments.

Early Retiree Reinsurance Program (ERRP) Audit

Early Retiree Reinsurance Program Audit

- Background:
  - ERRP was one of the components of health care reform.
  - The Plan received $87 million in reimbursement from the Federal Government for early retirees with incurred claims greater than $15,000 in a plan year between June 2010 and December 2011.
- Objective:
  - To ensure that the Plan met ERRP program requirements and that reimbursements received were for claims incurred by early retirees
- Auditor: Centers for Medicare and Medicaid Services (CMS)
- Frequency: One time audit

ERRP Audit
Status, Findings, and Follow-Up

- Status:
  - Program requirements portion was completed in 2012
  - Claims audit (both medical and pharmacy) to be conducted in October 2013
- Findings: None reported to date
- Follow-up: Potential for claims resubmission and/or repayment of funds pending results of claims audit component and final audit report

USING THE DASHBOARD TO MONITOR THE HEALTH PROFILE OF THE POPULATION

September 23, 2013

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

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Healthcare Dashboard

Current Period: July 2012 – June 2013

A Glance At The Dashboard

Panel	Alert	Observation	Recommendations
1) Principal Financial Trends		Claims have been trending lower than expectations for the last two years. This is consistent with the results of the most recent financial projections. Note that in the last 6 months the trends are starting to creep back up and follow a moderate slope. The occasional "blips" in the monthly cost figures are timing of payments related and not material, i.e. Nov. 2012.	More review needs to be done to determine what portion of the lower medical trend has been influenced by short-term economic forces, ACA or successful use of medical management and wellness initiatives. Monitor impact of short plan year and new 2014 plans.
2) Paid Claims Summary		On a PMPM basis, claims trended at only 1.7%. As discussed in (1) above, this is lower than expected. Note that member cost sharing has surprisingly decreased 1.2%, even though more people moved to the Basic Plan. Plan selection has likely caused utilization patterns to change, shifting the member cost relationship . Hospital claims have decreased while professional claims have increased slightly.	Research the anomaly resulting from the shift to the Basic Plan in conjunction with the drop in member cost share. Analyze utilization by plan option after the value-based plan goes into effect to see if engagement in medical management and wellness initiatives impacts health status.
3) Key Performance Metrics		Medical and Preventive Office visit utilization rates were 18.3% and 9.3% above industry norms, respectively. Admissions per 1,000 were above the industry norms of 6.1%. The combination of the above would either indicate a much sicker population or ineffectiveness of the visits.	Evaluate the effectiveness of better health management when initiated through the PCP. Develop a methodology for evaluating the success of Tier 1 providers that incorporates cost and quality metrics.
4) Major Conditions		Costs have increased for nearly every disease group. Note that diabetes and hypertension are components in nearly half the claims. Chronic conditions are both preventable and manageable with appropriate medical attention and member education. Preventive screening, medication adherence, and treatment compliance should improve with the value based plan design and the health activity requirements.	Monitor and analyze re-admission rates for key conditions; as well as hospital admissions and ER visits. Determine if appropriate treatment setting protocols are consistent by plan.

Healthcare Dashboard

Current Period: July 2012 – June 2013

A Glance At The Dashboard

Panel	Alert	Observation	Recommendations
5) High Risk High Cost		The prevalence of high-cost members with asthma and COPD has increased significantly over the prior period and is higher than typical plan levels. Asthma is especially manageable, thus high asthma claims should be avoidable with proper use of medication.	Analyze the highest-cost diagnosed cases with asthma and COPD to assess compliance with medication and treatment.
6) Clinical Quality Performance		The best way to control chronic condition claims will be through member awareness (disease management), treatment compliance and medication adherence. Compliance rates for diabetes, CAD and asthma have decreased from the prior period. Preventive screening rates are below desired levels and the value-based plan incentives should improve these rates.	Establish medication compliance targets for key chronic conditions and monitor medication adherence. Work with vendors to measure consistently.
7) Rx Summary		The generic dispensing rate increased over the prior period and is above typical plan levels. This has helped keep overall trends at 2.2%. Due to the above, the member cost sharing % has dropped, moving closer to the industry norms. A drop in cost share leverages the plan cost trends to 4.9%. Although both the plan and member save from generic substitution, the financial effect on members appears to be greater.	The continued upswing in generic dispensing rates based on brands losing patent protection is likely to begin leveling off. In addition, the plan should monitor specialty drug cost increases as utilization surges.
8) Rx Top 10		Opiate Agonists appears in the top 10 therapeutic drug classes (ranked 9th by total amount paid). This class is predominantly generic and the SHPNC data shows 95% generic by count which is consistent with what is expected with this class.	Research Opiate drug utilization to determine if there are indications of utilization for non-medical purposes. Take steps with the support of the PBM to reduce non-medical use of these drugs.

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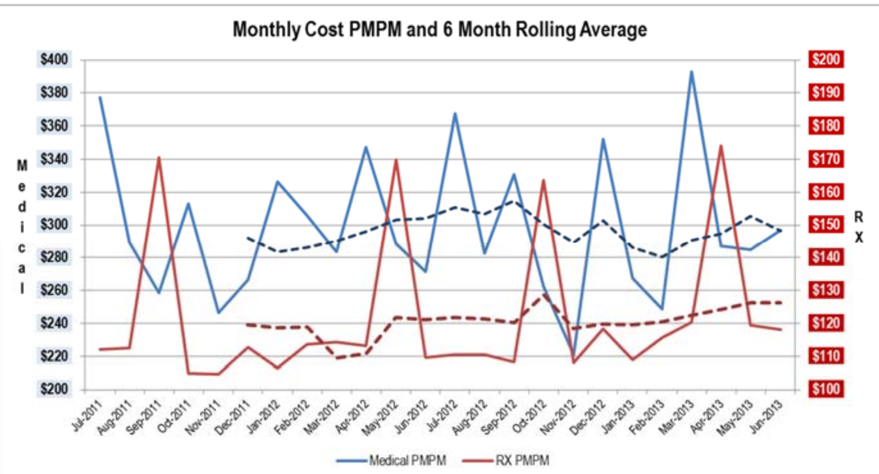
Healthcare Dashboard

Current Period: July 2012 – June 2013

1 Principal Financial Trends – Claims Cost
ALL Members



2 Paid Claims Summary –
ALL Members

Place of Service	Current Period Total Paid Amount	Current Period Total Paid PMPM	Current Period % of Total PMPM	Prior Period Total Paid Amount	Prior Period Total Paid PMPM	Prior Period % of Total PMPM	% Change in PMPM
Outpatient Hospital	$ 775,422,905	$ 97	23%	$ 791,542,149	$ 99	24%	-2.3%
Inpatient Hospital	$ 596,669,640	$ 75	18%	$ 603,474,466	$ 76	18%	-1.4%
Office	$ 664,417,000	$ 83	20%	$ 649,662,104	$ 82	19%	2.0%
Ambulatory Surgical Center	$ 51,049,333	$ 6	2%	$ 48,090,131	$ 6	1%	5.8%
Home	$ 56,287,712	$ 7	2%	$ 55,482,551	$ 7	2%	1.2%
All Others	$ 247,707,118	$ 31	7%	$ 224,507,133	$ 28	7%	10.0%
Total Medical	**$ 2,391,553,707**	**$ 299**	**71%**	$ 2,372,758,534	$ 298	71%	0.5%
Total Rx	**$ 982,867,757**	**$ 123**	**29%**	$ 959,236,978	$ 120	29%	2.2%
Total Paid	**$ 3,374,421,464**	**$ 423**	**100%**	$ 3,331,995,512	$ 418	100%	1.0%
Member Paid	**$ 785,721,965**	**$ 98**	**23%**	$ 792,601,970	$ 100	24%	-1.2%
Plan Paid	**$ 2,588,699,499**	**$ 324**	**77%**	$ 2,539,393,542	$ 319	76%	1.7%

3 Key Healthcare Performance Metrics –
ALL Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	665,442	663,539	0.3%	N/A	N/A
High Cost Claimants	16,078	15,715	2.3%	N/A	N/A
High Cost Claimants Total Paid	$987,660,418	$979,866,934	0.8%	N/A	N/A
Inpatient Days Per Thousand	385	379	1.6%	365	5.6%
Average Inpatient Day Cost	$3,144	$3,143	0.0%	$3,090	1.7%
Total Admissions Per 1000	81	81	0.3%	76	6.1%
Average Cost Per Admission	$14,945	$14,736	1.4%	$14,748	1.3%
ER Visits Per 1000	262	258	1.7%	262	0.1%
Office Visits For Medical Care Per 1000	4,157	4,196	-0.9%	3,515	18.3%
Office Visits for Preventive Care Per 1000	438	437	0.2%	401	9.3%
Rx Scripts Per 1000	17,379	17,394	-0.1%	16-18,000	0%
Average Cost Per Script	$86	$83	3.0%		

* Verisk BOB Norms; Segal Rx Norms

4 Major Conditions – Prevalence and Cost
ALL Members with Conditions

Chronic Condition	Current Period Members	Current Period Paid	Prior Period Members	Prior Period Paid	% Change in Members	% Change in Paid
1. Diabetes	97,286	$852,274,185	90,623	$817,973,976	7.4%	4.2%
2. Coronary Artery Disease (CAD)	47,739	$621,594,759	41,788	$562,845,424	14.2%	10.4%
3. Asthma	54,790	$351,644,302	41,759	$278,575,371	31.2%	26.2%
4. Chronic Obstructive Pulmonary Disease (COPD)	29,614	$368,088,715	23,980	$311,502,383	23.5%	18.2%
5. Hypertension	255,159	$1,839,628,231	232,540	$1,680,613,988	9.7%	9.5%
6. Breast Cancer	13,692	$187,748,013	12,075	$172,891,824	13.4%	8.6%
7. Colon Cancer	2,557	$58,085,496	2,175	$53,037,714	17.6%	9.5%
8. Prostate Cancer	8,073	$89,459,262	7,482	$83,252,248	7.9%	7.5%
9. At Risk Birth	1,360	$6,033,820	1,477	$6,760,260	-7.9%	-10.7%
10. Normal Delivery	8,560	$75,467,324	8,485	$78,325,672	0.9%	-3.6%

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

Healthcare Dashboard
Current Period: July 2012 – June 2013

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

Chronic Condition for High Cost Claimants*	Current Period		Prior Period		% Change in Members	% Change in PMPY
	Members	PMPY	Members	PMPY		
1. Diabetes	4,406	$68,642	4,371	$71,359	0.8%	-3.8%
2. Coronary Artery Disease (CAD)	3,048	$70,314	2,917	$72,393	4.5%	-2.9%
3. Asthma	2,302	$57,959	1,927	$60,745	19.5%	-4.6%
4. Chronic Obstructive Pulmonary Disease (COPD)	1,723	$74,922	1,513	$75,509	13.9%	-0.8%
5. Hypertension	9,870	$64,245	9,491	$65,005	4.0%	-1.2%
6. Breast Cancer	1,379	$76,680	1,341	$77,068	2.8%	-0.5%
7. Colon Cancer	396	$100,003	364	$101,095	8.8%	-1.1%
8. Prostate Cancer	444	$61,212	440	$63,031	0.9%	-2.9%
9. Birth	530	$52,262	493	$60,280	7.5%	-13.3%

6 Clinical Quality Performance – ALL Members

Disease Condition	Clinical Compliance Metrics	Individuals			NCQA Quality Compass National Average*
		Population	Compliance Rate Prior Period	Compliance Rate Current Period	
Diabetes	• Patient(s) that had at least 2 hemoglobin A1C tests in last 12 reported months**	97,286	47.22%	46.48%	87.30%
	• Patient(s) that had an annual screening test for diabetic nephropathy	97,286	33.84%	32.22%	77.90%
	• Patient(s) that had an annual screening test for diabetic retinopathy	97,286	92.64%	84.52%	48.40%
Coronary Artery Disease	• Patient(s) currently taking an ACE-inhibitor	47,739	42.86%	42.77%	78.80%
	• Patient(s) currently taking a statin	47,739	76.71%	75.86%	Not Available
Hyperlipidemia	• Patient(s) with a LDL cholesterol test in last 12 reported months	391,602	84.33%	86.00%	83.6%***
	• Patient(s) with a total cholesterol test in last 12 reported months	391,602	83.83%	85.46%	Not Available
Preventive Screening	• Cervical cancer	317,515	67.67%	74.72%	74.40%
	• Breast cancer	222,054	67.49%	75.77%	66.80%
	• Colorectal cancer	281,219	53.87%	65.27%	55.20%
	• Prostate cancer	99,040	23.69%	29.91%	Not Available
COPD	• Patients with spirometry testing in the last 12 months	29,614	42.19%	41.88%	40.40%
Asthma	• Patient with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	54,790	72.54%	67.28%	91.70%

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

7 Summary of Prescription Drug Expenses – ALL Members

Category	Current Period	Prior Period	% Change	Norm*
Total Rx Paid Amount	$982,867,757	$959,236,978	2.5%	N/A
Prescriptions Written PMPY	17.4	17.4	-0.2%	
Total Rx Paid PMPY	$1,478	$1,446	2.2%	
Participant Cost Share	23.51%	25.48%	-7.7%	21% – 23%
Total Rx Plan Paid PMPY	$1,130	1,077	4.9%	
PBM Generic Dispensing Rate	79%	75%	5.8%	72% – 75%
PBM Mail Order Rx Scripts	3%	3%	-0.6%	10%

* Segal Rx Norms

8 Prescription Drug Cost Management Analysis – ALL Members

Top 10 Rx Therapy Classes	Current Period		
	Total Paid Amount	% Generic by Count	PMPM
ANTIDEPRESSANTS	$53,917,167	87%	$6.75
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	$51,208,929	21%	$6.42
ANTINEOPLASTIC AGENTS	$46,819,546	89%	$5.87
INSULINS	$46,325,775	0%	$5.80
HMG-COA REDUCTASE INHIBITORS	$44,118,317	82%	$5.53
PROTON-PUMP INHIBITORS	$41,547,564	58%	$5.21
BIOLOGIC RESPONSE MODIFIERS	$37,688,066	0%	$4.72
ANGIOTENSIN II RECEPTOR ANTAGONISTS	$28,937,579	68%	$3.63
OPIATE AGONISTS	$21,870,740	95%	$2.74
ANTICONVULSANTS, MISCELLANEOUS	$21,125,554	84%	$2.65

SPOTLIGHT ON

Asthma

Chronic Condition	Current Period		Prior Period		% Change in Members	% Change in Paid
	Members	Paid	Members	Paid		
3. Asthma	54,790	$351,644,302	41,759	$278,575,371	31.2%	26.2%

When Segal identifies a member as an asthmatic, the member is classified as an asthmatic in perpetuity (i.e. once an asthmatic, always an asthmatic). We are using three fiscal years in our analysis. In fiscal year 2011 (the first full year we have experience) 27,000+ members had their first asthma diagnosis. In fiscal year 2012, approximately 14,000 members were newly diagnosed. In the current fiscal year, approximately 13,000 members were newly diagnosed.

The precipitous drop from fiscal year 2011 to fiscal year 2012 is in line with expectations. However, the relatively steady incidence of newly diagnosed members from fiscal year 2012 to fiscal year 2013 is a concern. While the total incidence of asthma in the SHPNC population is currently consistent with the national average (approximately eight percent), the steady diagnosis of new patients over the last twenty four months is an indication that the total incidence of asthma in the SHPNC population is at risk of exceeding the norm in the near future.

Disease Condition	Clinical Compliance Metrics	Individuals			NCQA Quality Compass National Average
		Population	Compliance Rate Prior Period	Compliance Rate Current Period	
Asthma	• Patient with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	54,790	72.54%	67.28%	91.70%

While asthma is generally not a preventable condition, it is manageable. Patient medication compliance is well below the norm. Given the trend in asthma incidence within the SHPNC population, it would be prudent to aggressively pursue strategies to increase patient compliance in an effort to avoid significant unnecessary future claims costs.

SPOTLIGHT ON

Asthma

CURRENT PERIOD						
Claim Range	Total Paid Claims	Total Paid Asthma Claims	Members	ER Visits Per 1,000	Pediatric Incidence	Pediatric % of Total Cost
$0 - $5K	$ 50,293,939	$ 5,886,450	41,115	244	24.4%	17.2%
$5K - $25K	$ 120,385,148	$ 16,978,227	11,373	998	6.9%	6.6%
$25K - $50K	$ 73,197,431	$ 10,193,864	1,495	1,769	3.0%	2.9%
$50K - $100K	$ 58,990,867	$ 5,172,988	601	2,503	1.7%	1.6%
$100K - $200K	$ 32,843,734	$ 1,779,807	168	2,996	1.6%	1.7%
$200K - $500K	$ 14,806,741	$ 422,216	37	3,582	5.5%	6.6%
$500K+	$ 1,126,443	$ 120	1	-	50.0%	49.2%
TOTALS	**$ 351,644,302**	**$ 40,433,670**	**54,790**	**518**	**19.4%**	**5.9%**

Members with an asthma diagnosis use the emergency room at double the rate of the total covered population. Those with total claims less than $5,000 use the emergency room at a rate similar to the overall population. An education campaign, on appropriate use of the emergency room, directed specifically at the asthma population could yield significant savings.

Asthma members with claims over $5K (13,675 members) account for 9% of total paid claims.

11.5% of the total paid claims of this group contained an asthma diagnosis code which is not surprising given that asthma is often associated with various comorbidities.

Pediatric claimants make up 19.4% of the plan's asthma population. However, only 5.9% of the total claim dollars are from pediatric claimants so they are not significant drivers of the cost of this population. This is likely a result of the lower number of dependents enrolled in the program.

Appendix

- Dashboard Overview
- Objective of Dashboard Panels
- Ongoing Use of Dashboard
- Dashboard - Active Members
- Dashboard - Non-Medicare Retirees
- Dashboard - Medicare Retirees

Dashboard Overview

The purpose of this monthly dashboard is to:

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

Methodology/Definitions

- Source of data includes eligibility as well as inpatient, outpatient and professional claims from SHPNC's SAS data warehouse. Pharmacy claims data was captured from Express Scripts.
- Generally, financial metrics are reported on a total cost basis (i.e., total cost includes plan paid and member cost sharing). This allows for tracking of population health status for improvement over time.
- Claims are reported on a paid basis for the periods July 1, 2012 – June 30, 2013 (current period) and July 1, 2011 – June 30, 2012 (prior period).

Norms / Benchmarks

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

Objective of Dashboard Panels

1. Principal Financial Trends

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

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

2. Paid Claims Summary

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

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

3. Key Healthcare Performance Metrics

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

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

4. Major Chronic Conditions—Prevalence and Cost

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

5. High Risk High Cost Analysis High Cost by Condition

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

6. Clinical Quality Performance

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

7. Summary of Prescription Drug Expenses

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

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

8. Prescription Drug Cost Management Analysis

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

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

Ongoing Use of the Dashboard

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

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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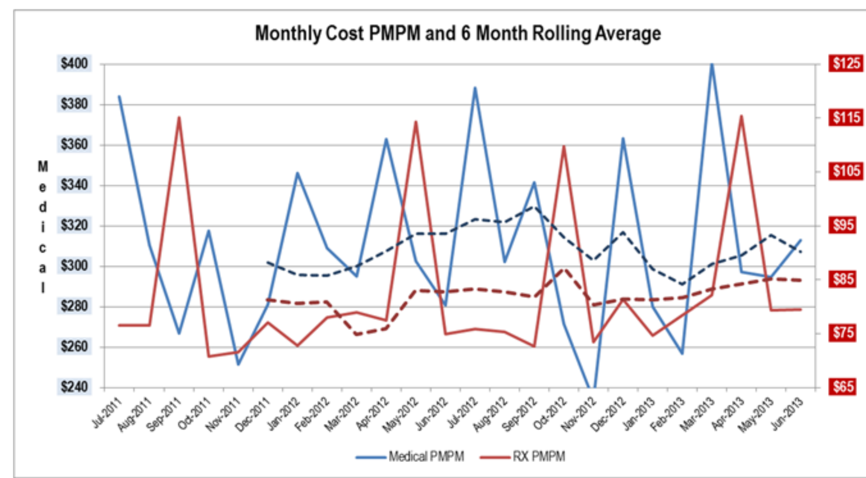
Healthcare Dashboard

Current Period: July 2012 – June 2013

1 Principal Financial Trends – Claims Cost
Active Members



2 Paid Claims Summary –
Active Members

Place of Service	Current Period Total Paid Amount	Current Period Total Paid PMPM	Current Period % of Total PMPM	Prior Period Total Paid Amount	Prior Period Total Paid PMPM	Prior Period % of Total PMPM	% Change in PMPM
Outpatient Hospital	$ 569,801,292	$ 100	26%	$ 585,440,829	$ 102	26%	-1.7%
Inpatient Hospital	$ 442,132,094	$ 78	20%	$ 454,315,544	$ 79	20%	-1.8%
Office	$ 495,050,476	$ 87	22%	$ 485,627,128	$ 85	22%	2.9%
Ambulatory Surgical Center	$ 36,904,908	$ 7	2%	$ 35,009,501	$ 6	2%	6.4%
Home	$ 32,706,708	$ 6	1%	$ 32,949,077	$ 6	1%	0.2%
All Others	$ 185,662,635	$ 33	8%	$ 167,743,803	$ 29	8%	11.7%
Total Medical	**$ 1,762,258,111**	**$ 310**	**79%**	$ 1,761,085,883	$ 307	79%	1.0%
Total Rx	**$ 470,086,260**	**$ 83**	**21%**	$ 467,172,027	$ 82	21%	1.6%
Total Paid	**$ 2,232,344,371**	**$ 393**	**100%**	$ 2,228,257,910	$ 389	100%	1.1%
Member Paid	**$ 494,862,184**	**$ 87**	**22%**	$ 500,237,244	$ 87	22%	-0.1%
Plan Paid	**$ 1,737,482,187**	**$ 306**	**78%**	$ 1,728,020,666	$ 302	78%	1.5%

3 Key Healthcare Performance Metrics –
Active Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	473,067	477,588	-0.9%	N/A	N/A
High Cost Claimants	12,099	11,756	2.9%	N/A	N/A
High Cost Claimants Total Paid	$723,330,350	$717,840,910	0.8%	N/A	N/A
Inpatient Days Per Thousand	222	234	-5.0%	250	-10.9%
Average Inpatient Day Cost	$3,471	$3,379	2.7%	$3,672	-5.5%
Total Admissions Per 1000	54	56	-2.9%	61	-10.6%
Average Cost Per Admission	$14,274	$14,204	0.5%	$15,154	-5.8%
ER Visits Per 1000	199	193	3.2%	197	1.0%
Office Visits For Medical Care Per 1000	3,263	3,200	2.0%	3,080	5.9%
Office Visits for Preventive Care Per 1000	529	521	1.6%	383	38.3%
Rx Scripts Per 1000	11,743	11,855	-0.9%	9,853	0%
Average Cost Per Script	$85	$82	3.1%		

* Verisk BOB Norms; Segal Rx Norms

4 Major Conditions – Prevalence and Cost
Active Members with Conditions

Chronic Condition	Current Period Members	Current Period Paid	Prior Period Members	Prior Period Paid	% Change in Members	% Change in Paid
1. Diabetes	40,985	$300,448,933	39,116	$296,645,836	4.8%	1.3%
2. Coronary Artery Disease (CAD)	11,864	$153,212,507	10,598	$147,759,331	11.9%	3.7%
3. Asthma	37,164	$177,117,935	28,359	$143,574,329	31.0%	23.4%
4. Chronic Obstructive Pulmonary Disease (COPD)	8,060	$85,468,667	6,236	$72,967,757	29.2%	17.1%
5. Hypertension	116,031	$695,523,957	107,158	$657,322,748	8.3%	5.8%
6. Breast Cancer	4,577	$83,303,883	4,201	$80,716,887	9.0%	3.2%
7. Colon Cancer	749	$22,936,829	654	$22,716,538	14.5%	1.0%
8. Prostate Cancer	1,819	$21,610,223	1,770	$21,890,148	2.8%	-1.3%
9. At Risk Birth	1,354	6,033,788	1,472	6,758,758	-8.0%	-10.7%
10. Normal Delivery	8,528	75,322,373	8,443	76,444,809	1.0%	-1.5%

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

Healthcare Dashboard

Current Period: July 2012 – June 2013

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

Chronic Condition for High Cost Claimants*	Current Period		Prior Period		% Change in Members	% Change in PMPY
	Members	PMPY	Members	PMPY		
1. Diabetes	3,069	$66,299	2,993	$68,777	2.5%	-3.6%
2. Coronary Artery Disease (CAD)	1,995	$70,012	1,944	$71,478	2.6%	-2.1%
3. Asthma	1,749	$56,918	1,517	$60,231	15.3%	-5.5%
4. Chronic Obstructive Pulmonary Disease (COPD)	1,104	$74,375	975	$74,032	13.2%	0.5%
5. Hypertension	6,966	$62,734	6,716	$64,228	3.7%	-2.3%
6. Breast Cancer	969	$78,939	953	$78,965	1.7%	0.0%
7. Colon Cancer	258	$97,708	248	$102,275	4.0%	-4.5%
8. Prostate Cancer	299	$63,220	288	$63,488	3.8%	-0.4%
9. Birth	529	$52,306	489	$60,514	8.2%	-13.6%

6 Clinical Quality Performance – Active Members

Disease Condition	Clinical Compliance Metrics	Individuals			NCQA Quality Compass National Average*
		Population	Compliance Rate Prior Period	Compliance Rate Current Period	
Diabetes	• Patient(s) that had at least 2 hemoglobin A1C tests in last 12 reported months**	40,985	62.74%	60.53%	87.30%
	• Patient(s) that had an annual screening test for diabetic nephropathy	40,985	42.57%	39.78%	77.90%
	• Patient(s) that had an annual screening test for diabetic retinopathy	40,985	95.54%	84.90%	48.40%
Coronary Artery Disease	• Patient(s) currently taking an ACE-inhibitor	11,864	40.47%	40.01%	78.80%
	• Patient(s) currently taking a statin	11,864	68.55%	65.69%	Not Available
Hyperlipidemia	• Patient(s) with a LDL cholesterol test in last 12 reported months	239,153	94.68%	95.57%	83.6%***
	• Patient(s) with a total cholesterol test in last 12 reported months	239,153	94.68%	95.60%	Not Available
Preventive Screening	• Cervical cancer	245,769	69.59%	75.41%	74.40%
	• Breast cancer	152,761	63.65%	70.48%	66.80%
	• Colorectal cancer	141,011	47.71%	56.63%	55.20%
	• Prostate cancer	51,232	23.85%	29.11%	Not Available
COPD	• Patients with spirometry testing in the last 12 months	8,060	43.47%	40.05%	40.40%
Asthma	• Patient with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	37,164	66.71%	61.81%	91.70%

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

7 Summary of Prescription Drug Expenses – Active Members

Category	Current Period	Prior Period	% Change	Norm*
Total Rx Paid Amount	$470,086,260	$467,172,027	0.6%	N/A
Prescriptions Written PMPY	11.8	11.9	-1.0%	
Total Rx Paid PMPY	$994	$978	1.6%	
Participant Cost Share	23.80%	25.10%	-5.2%	21% – 23%
Total Rx Plan Paid PMPY	$757	733	3.3%	
PBM Generic Dispensing Rate	80%	76%	5.3%	72% – 75%
PBM Mail Order Rx Scripts	1%	1%	0.0%	10%

* Segal Rx Norms

8 Prescription Drug Cost Management Analysis – Active Members

Top 10 Rx Therapy Classes	Current Period		
	Total Paid Amount	% Generic by Count	PMPM
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	$30,816,486	14%	$5.43
ANTIDEPRESSANTS	$30,370,825	88%	$5.35
BIOLOGIC RESPONSE MODIFIERS	$22,216,867	0%	$3.91
INSULINS	$19,639,469	0%	$3.46
PROTON-PUMP INHIBITORS	$17,703,013	58%	$3.12
HMG-COA REDUCTASE INHIBITORS	$16,071,733	80%	$2.83
ANTINEOPLASTIC AGENTS	$15,436,924	90%	$2.72
CONTRACEPTIVES	$15,051,692	83%	$2.65
ANTIRETROVIRALS	$13,166,003	5%	$2.32
ANGIOTENSIN II RECEPTOR ANTAGONISTS	$10,810,987	68%	$1.90

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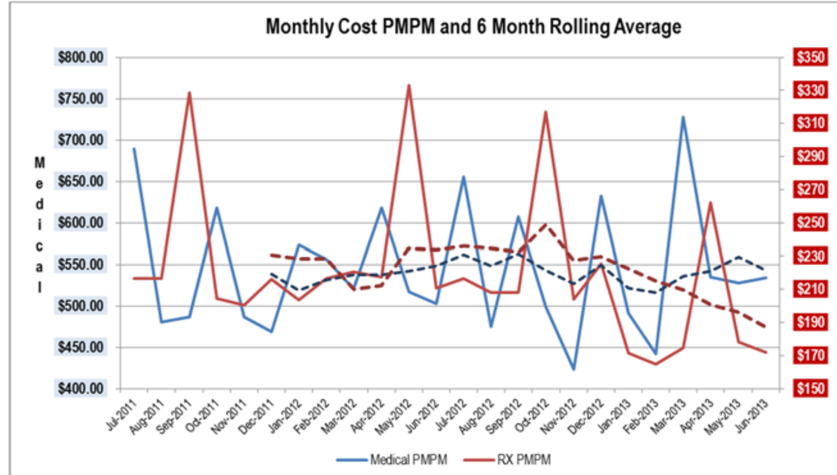
Healthcare Dashboard
Current Period: July 2012 – June 2013

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



2 Paid Claims Summary –
Non-Medicare Retiree Members

Place of Service	Current Period Total Paid Amount	Current Period Total Paid PMPM	Current Period % of Total PMPM	Prior Period Total Paid Amount	Prior Period Total Paid PMPM	Prior Period % of Total PMPM	% Change in PMPM
Outpatient Hospital	$ 156,302,648	$ 198	26%	$ 160,545,753	$ 204	26%	-3.1%
Inpatient Hospital	$ 113,568,965	$ 144	19%	$ 112,166,964	$ 143	18%	0.8%
Office	$ 109,454,881	$ 139	18%	$ 107,049,518	$ 136	18%	1.7%
Ambulatory Surgical Center	$ 9,644,654	$ 12	2%	$ 8,889,634	$ 11	1%	8.0%
Home	$ 9,201,483	$ 12	2%	$ 8,583,665	$ 11	1%	6.7%
All Others	$ 31,128,370	$ 39	5%	$ 28,281,137	$ 36	5%	9.5%
Total Medical	**$ 429,301,001**	**$ 544**	**72%**	$ 425,516,671	$ 542	70%	0.4%
Total Rx	**$ 164,152,112**	**$ 208**	**28%**	$ 182,039,077	$ 232	30%	-10.3%
Total Paid	**$ 593,453,112**	**$ 752**	**100%**	$ 607,555,748	$ 774	100%	-2.8%
Member Paid	**$ 115,085,068**	**$ 146**	**19%**	$ 120,144,305	$ 153	20%	-4.7%
Plan Paid	**$ 478,368,044**	**$ 606**	**81%**	$ 487,411,443	$ 621	80%	-2.3%

3 Key Healthcare Performance Metrics –
Non-Medicare Retiree Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	65,761	65,440	0.5%	N/A	N/A
High Cost Claimants	3,601	3,563	1.1%	N/A	N/A
High Cost Claimants Total Paid	$237,217,348	$234,726,820	1.1%	N/A	N/A
Inpatient Days Per Thousand	365	384	-4.8%	250	46.4%
Average Inpatient Day Cost	$4,088	$3,866	5.7%	$3,672	11.4%
Total Admissions Per 1000	69	70	-2.7%	61	13.4%
Average Cost Per Admission	$21,787	$21,060	3.5%	$15,154	43.8%
ER Visits Per 1000	209	201	4.0%	197	5.9%
Office Visits For Medical Care Per 1000	4,715	4,691	0.5%	3,080	53.1%
Office Visits for Preventive Care Per 1000	507	495	2.3%	383	32.4%
Rx Scripts Per 1000	25,687	29,303	-12.3%	9,853	0%
Average Cost Per Script	$96	$95	0.8%		

* Verisk BOB Norms; Segal Rx Norms

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

Chronic Condition	Current Period Members	Current Period Paid	Prior Period Members	Prior Period Paid	% Change in Members	% Change in Paid
1. Diabetes	15,282	$126,752,413	16,576	$143,566,567	-7.8%	-11.7%
2. Coronary Artery Disease (CAD)	6,048	$75,551,484	6,691	$95,015,663	-9.6%	-20.5%
3. Asthma	5,447	$42,424,878	5,450	$41,044,713	-0.1%	3.4%
4. Chronic Obstructive Pulmonary Disease (COPD)	3,396	$42,705,384	3,661	$46,621,792	-7.2%	-8.4%
5. Hypertension	39,291	$270,382,828	43,487	$288,860,321	-9.6%	-6.4%
6. Breast Cancer	2,215	$32,007,793	2,342	$39,547,206	-5.4%	-19.1%
7. Colon Cancer	367	$11,082,227	410	$13,116,411	-10.5%	-15.5%
8. Prostate Cancer	1,038	$10,258,128	1,243	$14,896,209	-16.5%	-31.1%
1. Diabetes	15,282	$126,752,413	16,576	$143,566,567	-7.8%	-11.7%
2. Coronary Artery Disease (CAD)	6,048	$75,551,484	6,691	$95,015,663	-9.6%	-20.5%

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

Healthcare Dashboard

Current Period: July 2012 – June 2013

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

Chronic Condition for High Cost Claimants*	Current Period		Prior Period		% Change in Members	% Change in PMPY
	Members	PMPY	Members	PMPY		
1. Diabetes	1,221	$75,240	1,259	$79,463	-3.0%	-5.3%
2. Coronary Artery Disease (CAD)	942	$73,418	896	$76,347	5.1%	-3.8%
3. Asthma	511	$62,302	383	$63,889	33.4%	-2.5%
4. Chronic Obstructive Pulmonary Disease (COPD)	525	$78,413	463	$81,273	13.4%	-3.5%
5. Hypertension	2,708	$68,322	2,606	$67,709	3.9%	0.9%
6. Breast Cancer	389	$72,968	371	$73,866	4.9%	-1.2%
7. Colon Cancer	124	$112,362	107	$103,189	15.9%	8.9%
8. Prostate Cancer	131	$59,134	148	$62,859	-11.5%	-5.9%

6 Clinical Quality Performance – Non-Medicare Retiree Members

Disease Condition	Clinical Compliance Metrics	Individuals			NCQA Quality Compass National Average*
		Population	Compliance Rate Prior Period	Compliance Rate Current Period	
Diabetes	• Patient(s) that had at least 2 hemoglobin A1C tests in last 12 reported months**	15,282	55.43%	61.16%	87.30%
	• Patient(s) that had an annual screening test for diabetic nephropathy	15,282	35.02%	37.53%	77.90%
	• Patient(s) that had an annual screening test for diabetic retinopathy	15,282	80.66%	84.11%	48.40%
Coronary Artery Disease	• Patient(s) currently taking an ACE-inhibitor	6,048	34.49%	42.48%	78.80%
	• Patient(s) currently taking a statin	6,048	61.84%	76.64%	Not Available
Hyperlipidemia	• Patient(s) with a LDL cholesterol test in last 12 reported months	59,225	78.41%	94.01%	83.6%***
	• Patient(s) with a total cholesterol test in last 12 reported months	59,225	78.39%	93.99%	Not Available
Preventive Screening	• Cervical cancer	41,140	69.05%	77.96%	74.40%
	• Breast cancer	38,774	82.38%	90.52%	66.80%
	• Colorectal cancer	57,427	59.50%	72.35%	55.20%
	• Prostate cancer	19,181	32.81%	40.51%	Not Available
COPD	• Patients with spirometry testing in the last 12 months	3,396	33.16%	44.20%	40.40%
Asthma	• Patient with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	5,447	60.39%	74.68%	91.70%

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

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

Category	Current Period	Prior Period	% Change	Norm*
Total Rx Paid Amount	$164,152,112	$182,039,077	-9.8%	N/A
Prescriptions Written PMPY	26.1	29.4	-11.2%	
Total Rx Paid PMPY	$2,496	$2,782	-10.3%	
Participant Cost Share	22.10%	23.00%	-3.9%	21% – 23%
Total Rx Plan Paid PMPY	$1,945	2,142	-9.2%	
PBM Generic Dispensing Rate	77%	73%	5.5%	72% – 75%
PBM Mail Order Rx Scripts	5%	5%	0.0%	10%

* Segal Rx Norms

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

Top 10 Rx Therapy Classes	Current Period		
	Total Paid Amount	% Generic by Count	PMPM
ANTIDEPRESSANTS	$9,676,310	84%	$12.29
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	$8,446,447	0%	$10.73
ANTINEOPLASTIC AGENTS	$8,313,093	79%	$10.56
INSULINS	$8,176,640	89%	$10.39
HMG-COA REDUCTASE INHIBITORS	$8,046,565	25%	$10.22
PROTON-PUMP INHIBITORS	$7,807,732	0%	$9.92
BIOLOGIC RESPONSE MODIFIERS	$7,608,661	53%	$9.66
ANGIOTENSIN II RECEPTOR ANTAGONISTS	$5,152,607	93%	$6.54
OPIATE AGONISTS	$4,819,722	66%	$6.12
ANTICONVULSANTS, MISCELLANEOUS	$3,931,995	82%	$4.99

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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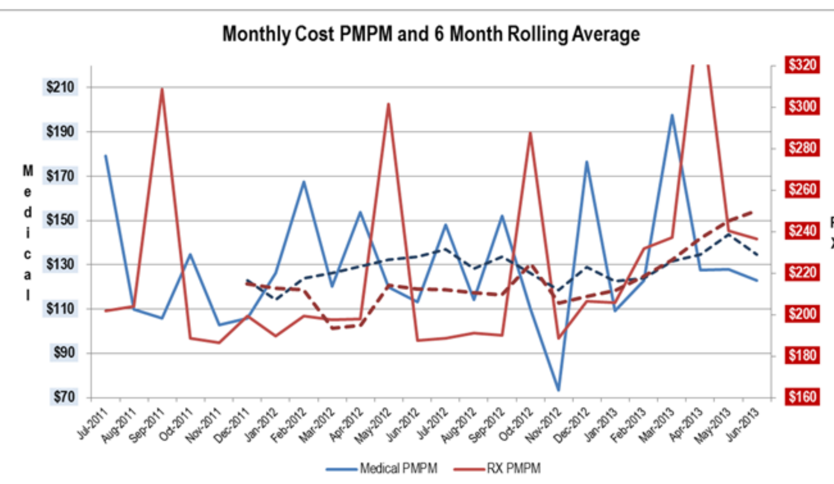
Healthcare Dashboard

Current Period: July 2012 – June 2013

1 Principal Financial Trends – Claims Cost
Medicare Retiree Members



2 Paid Claims Summary –
Medicare Retiree Members

Place of Service	Current Period			Prior Period			
	Total Paid Amount	Total Paid PMPM	% of Total PMPM	Total Paid Amount	Total Paid PMPM	% of Total PMPM	% Change in PMPM
Outpatient Hospital	$ 49,318,966	$ 33	9%	$ 45,555,568	$ 32	9%	3.3%
Inpatient Hospital	$ 40,968,582	$ 27	7%	$ 36,991,958	$ 26	7%	5.7%
Office	$ 59,911,643	$ 40	11%	$ 56,985,458	$ 39	11%	0.3%
Ambulatory Surgical Center	$ 4,499,770	$ 3	1%	$ 4,190,996	$ 3	1%	2.5%
Home	$ 14,379,521	$ 9	3%	$ 13,949,808	$ 10	3%	-1.6%
All Others	$ 30,916,113	$ 20	6%	$ 28,482,193	$ 20	6%	3.6%
Total Medical	**$ 199,994,595**	**$ 132**	**36%**	$ 186,155,981	$ 129	38%	2.5%
Total Rx	**$ 348,629,385**	**$ 230**	**64%**	$ 310,025,874	$ 214	62%	7.3%
Total Paid	**$ 548,623,980**	**$ 362**	**100%**	$ 496,181,854	$ 343	100%	5.5%
Member Paid	**$ 175,774,712**	**$ 116**	**32%**	$ 172,220,420	$ 119	35%	-2.6%
Plan Paid	**$ 372,849,269**	**$ 246**	**68%**	$ 323,961,434	$ 224	65%	9.8%

3 Key Healthcare Performance Metrics –
Medicare Retiree Members

Category	Current Period	Prior Period	% Change	Norm*	Comparison to Norm
Average Membership Per Month	126,275	120,512	4.8%	N/A	N/A
High Cost Claimants	233	216	7.9%	N/A	N/A
High Cost Claimants Total Paid	$15,638,427	$12,943,574	20.8%	N/A	N/A
Inpatient Days Per Thousand	1,006	950	5.9%	1219	-17.5%
Average Inpatient Day Cost	$2,694	$2,753	-2.1%	$1,843	46.2%
Total Admissions Per 1000	189	186	1.4%	171	10.3%
Average Cost Per Admission	$14,371	$14,066	2.2%	$13,161	9.2%
ER Visits Per 1000	526	545	-3.4%	274	91.9%
Office Visits For Medical Care Per 1000	7,226	7,875	-8.2%	6,163	17.2%
Office Visits for Preventive Care Per 1000	64	77	-15.8%	217	-70.3%
Rx Scripts Per 1000	34,211	32,881	4.0%	25,566	0%
Average Cost Per Script	$82	$78	5.4%		

* Verisk BOB Norms; Segal Rx Norms

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

Chronic Condition	Current Period		Prior Period		% Change in Members	% Change in Paid
	Members	Paid	Members	Paid		
1. Diabetes	41,019	$425,072,839	36,979	$392,174,672	10.9%	8.4%
2. Coronary Artery Disease (CAD)	29,827	$392,830,767	25,936	$343,670,836	15.0%	14.3%
3. Asthma	12,179	$132,101,490	9,352	$102,379,867	30.2%	29.0%
4. Chronic Obstructive Pulmonary Disease (COPD)	18,158	$239,914,664	15,083	$203,425,321	20.4%	17.9%
5. Hypertension	99,837	$873,721,446	89,123	$772,433,752	12.0%	13.1%
6. Breast Cancer	6,900	$72,436,337	5,868	$60,815,603	17.6%	19.1%
7. Colon Cancer	1,441	$24,066,440	1,206	$20,331,578	19.5%	18.4%
8. Prostate Cancer	5,216	$57,590,911	4,691	$49,799,181	11.2%	15.6%
1. Diabetes	41,019	$425,072,839	36,979	$392,174,672	10.9%	8.4%
2. Coronary Artery Disease (CAD)	29,827	$392,830,767	25,936	$343,670,836	15.0%	14.3%

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

Healthcare Dashboard

Current Period: July 2012 – June 2013

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

Chronic Condition for High Cost Claimants*	Current Period		Prior Period		% Change in Members	% Change in PMPY
	Members	PMPY	Members	PMPY		
1. Diabetes	116	$61,196	119	$50,573	-2.5%	21.0%
2. Coronary Artery Disease (CAD)	111	$49,418	77	$49,467	44.2%	-0.1%
3. Asthma	42	$48,479	27	$45,072	55.6%	7.6%
4. Chronic Obstructive Pulmonary Disease (COPD)	94	$61,856	75	$59,119	25.3%	4.6%
5. Hypertension	196	$61,647	169	$54,216	16.0%	13.7%
6. Breast Cancer	21	$41,198	17	$40,630	23.5%	1.4%
7. Colon Cancer	14	$32,836	9	$43,672	55.6%	-24.8%
8. Prostate Cancer	14	$37,777	4	$36,514	250.0%	3.5%

6 Clinical Quality Performance – Medicare Retiree Members

Disease Condition	Clinical Compliance Metrics	Individuals			NCQA Quality Compass National Average*
		Population	Compliance Rate Prior Period	Compliance Rate Current Period	
Diabetes	• Patient(s) that had at least 2 hemoglobin A1C tests in last 12 reported months**	41,019	24.51%	26.98%	87.30%
	• Patient(s) that had an annual screening test for diabetic nephropathy	41,019	22.20%	22.70%	77.90%
	• Patient(s) that had an annual screening test for diabetic retinopathy	41,019	89.81%	84.28%	48.40%
Coronary Artery Disease	• Patient(s) currently taking an ACE-inhibitor	29,827	43.62%	43.93%	78.80%
	• Patient(s) currently taking a statin	29,827	79.63%	79.74%	Not Available
Hyperlipidemia	• Patient(s) with a LDL cholesterol test in last 12 reported months	93,224	48.01%	56.39%	83.6%***
	• Patient(s) with a total cholesterol test in last 12 reported months	93,224	45.71%	54.05%	Not Available
Preventive Screening	• Cervical cancer	30,606	49.08%	64.87%	74.40%
	• Breast cancer	30,519	67.77%	83.50%	66.80%
	• Colorectal cancer	82,781	60.97%	75.07%	55.20%
	• Prostate cancer	28,627	16.70%	24.25%	Not Available
COPD	• Patients with spirometry testing in the last 12 months	18,158	41.05%	42.26%	40.40%
Asthma	• Patient with inhaled corticosteroids or leukotriene inhibitors in the last 12 months	12,179	86.42%	80.68%	91.70%

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

7 Summary of Prescription Drug Expenses – Medicare Retiree Members

Category	Current Period	Prior Period	% Change	Norm*
Total Rx Paid Amount	$348,629,385	$310,025,874	12.5%	N/A
Prescriptions Written PMPY	33.8	32.8	3.0%	
Total Rx Paid PMPY	$2,761	$2,573	7.3%	
Participant Cost Share	23.78%	27.50%	-13.5%	21% – 23%
Total Rx Plan Paid PMPY	$2,104	1,865	12.8%	
PBM Generic Dispensing Rate	79%	74%	6.8%	72% – 75%
PBM Mail Order Rx Scripts	5%	5%	0.0%	10%

* Segal Rx Norms

8 Prescription Drug Cost Management Analysis – Medicare Retiree Members

Top 10 Rx Therapy Classes	Current Period		
	Total Paid Amount	% Generic by Count	PMPM
ANTINEOPLASTIC AGENTS	$23,205,981	88.9%	$15.29
HMG-COA REDUCTASE INHIBITORS	$19,733,490	83.8%	$13.00
INSULINS	$18,239,859	0.0%	$12.02
PROTON-PUMP INHIBITORS	$16,235,891	59.6%	$10.70
ANTIDEPRESSANTS	$13,870,033	87.5%	$9.14
ANGIOTENSIN II RECEPTOR ANTAGONISTS	$13,306,870	68.7%	$8.77
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	$12,345,878	35.7%	$8.13
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	$8,317,168	0.0%	$5.48
OPIATE AGONISTS	$7,933,452	95.2%	$5.23
BIOLOGIC RESPONSE MODIFIERS	$7,663,467	0.0%	$5.05