Board of Trustees Meeting
Thursday, June 2, 2016, 4:00 – 6:00 p.m.

1. Welcome — Melissa Waller, Chair

2. Conflict of Interest Statement — Melissa Waller, Chair

3. Review of Minutes ***(Requires Board Approval)*** — Melissa Waller, Chair
   a. May 12-13, 2016

4. Benefit Design, Plan Options and Premiums — Caroline Smart
   a. Medicare Advantage Prescription Drugs Plan Options and Open Enrollment Strategy
   b. Pharmacy Formulary and Benefit Design Changes

5. Member and Public Comment — TBD

6. Financial Report, Forecasting and Monitoring
   a. April 2016 Financial Report — Mark Collins

7. Strategic Planning Update — Tom Friedman

8. Adjourn — Melissa Waller, Chair

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

Board of Trustees Meeting
Friday, June 3, 2016, 9:00 a.m. – noon

1. Welcome	Melissa Waller, Chair
2. Conflict of Interest Statement	Melissa Waller, Chair
3. Benefit Design, Plan Options and Premiums	
a. Medicare Advantage Prescription Drugs Plan Options and Open Enrollment Strategy ***(Requires Board Approval)***	Caroline Smart
b. Pharmacy Formulary and Benefit Design Changes ***(Requires Board Approval)***	Caroline Smart
c. Segal Consulting 2017 Formulary Considerations	Kautook Vyas The Segal Company
4. Initiatives and Directions Among State Employee Health Plans	Rick Johnson The Segal Company
5. Analysis of State Health Plan Utilization and Costs by Region	Tom Friedman
6. Legislative Update	Matthew Grabowski

Lunch

7. Executive Session **(for Board members only)** *Pursuant to: G.S. 143-318.11 and G.S. 132-1.2*	Melissa Waller, Chair
a. Third Party Liability Services Contract ***(Requires Board Approval)*** (G.S. §143.318.11(a)(1))	Lauren Wides Greg Moore
b. Lake Lawsuit Update (I. Beverly Lake et al. v. State Health Plan for Teachers and State Employees, et al.) *(G.S. §143.318.11(a)(3))*	Marc Bernstein Office of Attorney General
8. Adjourn	Melissa Waller, Chair

Next Regularly Scheduled Meeting: August 4 and 5, 2016

North Carolina

State Health Plan

FOR TEACHERS AND STATE EMPLOYEES

Strategic Planning Update

Board of Trustees Meeting

June 3, 2016

A Division of the Department of State Treasurer

Presentation Overview

- Strategic Planning Update Timeline and Activities
- Board Workgroups and Future Planning

Strategic Planning Update Timeline

- Presented CY 2015 scorecard results and suggested revisions to the Strategic Plan in April
- 1-1 phone calls scheduled with all Board members to discuss updates to the Strategic Plan and review a draft roadmap through CY 2020
- Based on Board feedback staff will make additional revisions to the Strategic Plan
- Staff will present updates to scorecard in August
- Board will be asked to vote on changes to the Strategic Plan in August

Revised Board Workgroups

- Currently, the Board has two categories of workgroups:
  - Operational and Strategic
  - There are three workgroups under each area
- Due to various reasons, the current workgroup structure has not been effective
- Staff proposes reducing the number of workgroups to three
- The workgroups would cover:
  - Member and Stakeholder Outreach and Engagement
  - Provider Network, Quality, and Access
  - Benefit Design Development
- The workgroups will meet on a more regular basis to plan for CY 2018 benefits
  - 1-2 meetings prior to the August Board Meeting

Board Workgroup Structure

Member and Stakeholder Outreach and Engagement	Provider Network, Quality, and Access	Benefit Design Development
Neal Alexander Paul Cunningham Charles Johnson David Rubin	Aaron McKethan Bill Medlin Warren Newton Elizabeth Poole Drew Heath, ex officio	Janet Cowell, ex officio Neal Alexander Paul Cunningham Aaron McKethan Bill Medlin

- Workgroups are limited to four voting members
- Ex officio, non-voting members (Treasurer and Director OSBM) also assigned workgroups
- Benefit Design Development workgroup includes two members from each of the other two workgroups

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Proposed 2017 Medicare Advantage Prescription Drug Plan Options and Open Enrollment Strategy

Board of Trustees Meeting

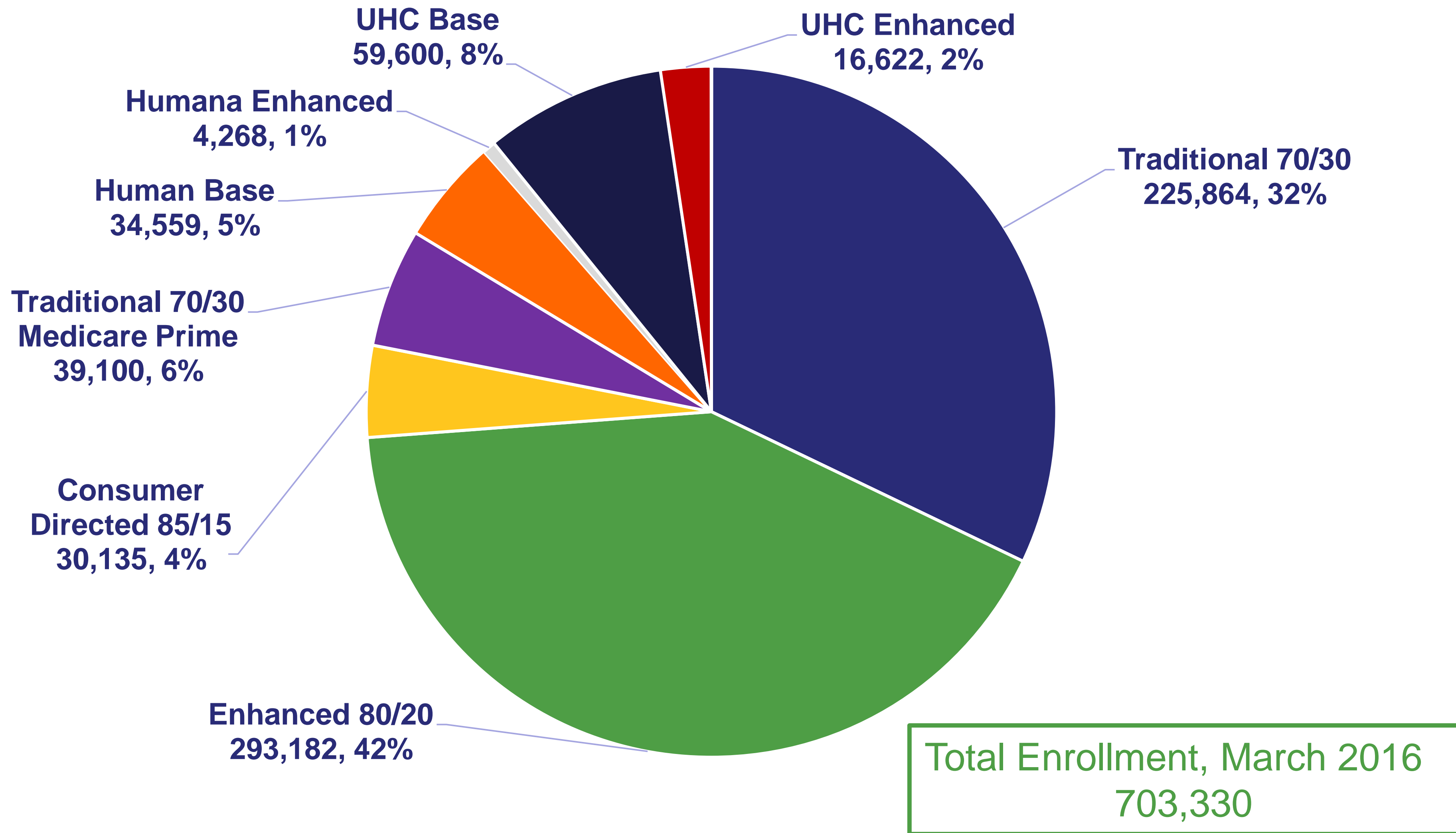
June 2-3, 2016

A Division of the Department of State Treasurer

Presentation Overview

- Membership Summary
- Review CY 2016 Retiree Medicare Primary Plan Options
- CY 2017 Retiree Medicare Primary Plan Options
  - Recommendation for Medicare Advantage Offerings
- CY 2017 Open Enrollment Strategy for Medicare Retirees
- Questions & Discussion
- Board Action (Friday Meeting)

Membership by Plan Option



CY 2016 Medicare Primary Plan Options

- Medicare Primary Retirees currently have five plan options:
  - Traditional 70/30 PPO Plan (BCBSNC-administered)
  - Base Medicare Advantage Plan (Humana)
  - Base Medicare Advantage Plan (UHC)
  - Enhanced Medicare Advantage Plan (Humana)
  - Enhanced Medicare Advantage Plan (UHC)

- Both the Traditional 70/30 PPO Plan and the Base Medicare Advantage Plan designs are premium free for retiree-only coverage.
- The Enhanced Medicare Advantage Plan is available for an additional $66 per month for retiree-only coverage.

Proposed CY 2017 Medicare Primary Plan Options

- For CY 2017, Plan staff recommends moving to one Medicare Advantage carrier, UnitedHealthcare (UHC) and providing three plan options for Medicare retirees:
  - Traditional 70/30 PPO Plan (BCBSNC-administered)
  - Base Medicare Advantage Plan (UHC)
  - Enhanced Medicare Advantage Plan (UHC)

- No plan design changes are proposed for the UHC Medicare Advantage plan options, only changes to the formulary.
  - Board approved changes to the Traditional 70/30 PPO Plan on May 13, 2016.
- Both the Traditional 70/30 PPO Plan and the Base Medicare Advantage Plan options will remain premium free for retirees.
- The Enhanced Medicare Advantage Plan will be available for an additional $64 a month, which is $2 less than the 2016 Enhanced Plans.

Recommendation for Medicare Advantage Offerings

Advantages of UHC single carrier offering:

- Reduced Costs
  - $44.5 million in Plan savings and $7 million in member savings over next two years (includes formulary changes)
    - Reduced premium rate for CY 2017
    - Agreed upon maximum premium rate increase for CY 2018
- Added Stability & Improved Predictability
  - Ensuring a sustainable premium for CY 2018 provides stability and predictability for the Plan and MAPDP members in terms of costs and benefits.
  - An additional renewal option will allow the Plan to explore rates for CY 2019 early enough to determine whether to competitively bid the contract.
    - Mitigates operational concerns about timing of MAPDP RFP process relative to other planned procurements
  - Multi-year agreement with UHC provides unique opportunity to reduce risks given uncertainty in MA environment

UHC Proposed CY 2017 Formulary Changes

- In addition to the normal year over year formulary changes where prior authorizations, step therapies and tier placements are reviewed and updated, UHC proposed two additional cost saving measures for consideration by the Plan:
    - Preferred Insulin
    - Additional High Cost Generic Tiering

UHC Proposed CY 2017 Formulary Changes

Preferred Insulin

- Lilly and Novo products are covered in the Preferred Brand (Tier 2)
- For additional savings, UHC offered preference for Lilly insulin products and exclusion of Novo insulin products.

Brand	Utilizers (CY 2015)
Lilly	1181
Novo	1751

- No clinical reason to select one product over the other, but there are additional savings by limiting the number of preferred choices.

UHC Proposed CY 2017 Formulary Changes

High Cost Generics

- All covered generics are currently in Tier 1 unless the drug qualifies for a specialty tier.
- To qualify for the specialty tier, the average 31-day ingredient cost must be > $600 for a 31-day supply. The $600 threshold is set by CMS.
- In 2017, the threshold for moving a high cost generic drug to the specialty tier is increasing > $670/31-day supply.

- To earn additional savings in CY 2017, UHC offered to move high cost generics with an average ingredient cost of greater than $150 but less than $670 to Tier 3 (copays = $64 Base Plan and $50 Enhanced Plan).

Proposed CY 2017 Medicare Primary Plan Options

		Traditional 70/30 Plan	2016 UHC Base Plan	2016 UHC Enhanced Plan
Annual Deductible		$1,080	$0	$0
Physician Services				
	Primary Care Physician	$40	$20 copay	$15 copay
	Preventive Care	$40	$0 copay	$0 copay
	Specialist	$94	$40 copay	$35 copay
	Urgent Care	$100	$50 copay	$40 copay
Outpatient Lab/Xray		$0 copay (after PCP or Specialist copay)	$40 copay	$20/$25 copay
Emergency Room		$337 copay/Ded/Coins	$65 copay	$65 copay
Physical, Speech, Occupational Therapy		$72	$20 copay	$20 copay
Chiropractic Visits		$72	$20 copay	$20 copay
Durable Medical Equipment		Deductible/Coinsurance	20% Coinsurance	20% Coinsurance
Ambulance		Deductible/Coinsurance	$75	$75
Outpatient Hospital Services		Deductible/Coinsurance	$125 copay	$100 copay
Diagnostic(CT, MRI, PET scans)		Deductible/Coinsurance	$100 copay	$100 copay
Outpatient Surgery		Deductible/Coinsurance	$250 copay	$250 copay
Inpatient Hospital Confinement		$337 copay/Ded/Coins	$160/day (Days 1 - 10) Zero after that	$150/day (Days 1 - 10) Zero after that
Coinsurance Max/OOP		$4,388 Individual Max	$4,000 OOP	$3,300 OOP
		$13,164 Family Max	(No Family Max)	(No Family Max)
Fitness		Not Covered	Silver Sneakers	Silver Sneakers

No changes to MAPDP Benefit Design; Traditional 70/30 Plan changes approved by Board, May 13, 2016

Proposed CY 2017 Medicare Primary Plan Options

Prescriptions Drug Coverage		Traditional 70/30 Plan		2016 UHC Base Plan		2016 UHC Enhanced Plan
Part D Gap Coverage		Full Coverage		Full Coverage		Full Coverage
Formulary Name		Custom		Custom		Custom
Part D Retail (up to a 31 day supply)						
	Tier 1	$16		$10 copay		$10 copay
	Tier 2	$47		$40 copay		$35 copay
	Tier 3	$74		$64 copay		$50 copay
	Tier 4	10% Coinsurance Max (Up to $100)		25% Coinsurance ($100 Max)		25% Coinsurance ($100 Max)
	Tier 5	25% Coinsurance Max (Up to $103)		N/A		N/A
	Tier 6	25% Coinsurance Max (Up to $133)		N/A		N/A
Maintenance Drugs (up to a 90 day supply)						
	Tier 1	$48 (61-90 days)		$24 co-pay		$20 co-pay
	Tier 2	$141 (61-90 days)		$80 co-pay		$70 co-pay
	Tier 3	$222 (61-90 days)		$128 co-pay		$100 co-pay
	Tier 4	10% Coinsurance Max (Up to $300) (61-90 days)		25% Coinsurance ($300 Max)		25% Coinsurance ($200 Max)
	Tier 5	25% Coinsurance Max (Up to $309) (61-90 days)		N/A		N/A
	Tier 6	25% Coinsurance Max (Up to $399) (61-90 days)		N/A		N/A
Prescription Drug Annual OOP Max		$3,360 Individual/$10,080 Family		$2,500		$2,500

No changes to MAPDP Benefit Design; Traditional 70/30 Plan changes approved by Board, May 13, 2016

Proposed CY 2017 Medicare Advantage Enrollment Strategy

- Members enrolled in a **Humana** Medicare Advantage Plan for 2016 will have to take action during Open Enrollment to ensure they are enrolled in the plan of their choice for 2017.
- Plan staff recommends assigning all **Humana** members to the **UHC** Base Plan for Open Enrollment. Members who take no action will remain in the **UHC** Base Plan for 2017.
- Because there are no plan design changes in the UHC options, Plan staff recommends leaving **UHC** members in their 2016 election for the start of Open Enrollment. Members who take no action will remain in their 2016 election for 2017.
- Plan staff also recommends leaving Traditional 70/30 members in their 2016 election for the start of Open Enrollment. Members who take no action will remain in their 2016 election for 2017.

Recommended 2017 Retiree Medicare Primary Enrollment Strategy	
2016 Enrollment	**2017 Open Enrollment Assignment**
Humana Base MAPDP	UHC Base MAPDP
Humana Enhanced MAPDP	UHC Base MAPDP
UHC MAPDP	UHC Base MAPDP
UHC Enhanced MAPDP	UHC Enhanced MAPDP
Traditional 70/30 PPO Plan	Traditional 70/30 PPO Plan

Questions & Discussion

Board Action (Friday Meeting)

1. Medicare Advantage Plan Options

   Plan staff recommends approval of one carrier, UnitedHealthcare, offering Base and Enhanced Medicare Advantage Plan options effective January 1, 2017. There will be no benefit design changes to either UHC MAPDP offering. As outlined on slide 5, Medicare Retirees will have three plan options in CY 2017:

   - Traditional 70/30 PPO Plan (BCBSNC-administered)
   - Base Medicare Advantage Plan (UHC)
   - Enhanced Medicare Advantage Plan (UHC)

2. Medicare Primary Open Enrollment Strategy

   Plan staff recommends approval of the enrollment strategy outlined on slide 12, which assigns all Humana members (Base and Enhanced) to the UHC Base Plan for Open Enrollment. UHC and Traditional 70/30 Plan members will remain in their 2016 plan selection for Open Enrollment.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Proposed 2017 Pharmacy Formulary and Benefit Design Changes

Board of Trustees Meeting

June 2-3, 2016

A Division of the Department of State Treasurer

Presentation Overview

- Traditional Plans (Traditional 70/30, Enhanced 80/20 & CDHP 85/15)
  - Pharmacy Benefit Programs under PBM Contract
  - Formulary Review
  - Custom Pharmacy Programs
- High Deductible Health Plan (HDHP for non-permanent full-time employees)
- Questions & Discussion
- Board Action (Friday Meeting)

Traditional Plans
(Traditional 70/30, Enhanced 80/20, CDHP 85/15)
2017 Pharmacy Benefit Programs

Pharmacy Benefit Management Contract Program Overview

- Clinical, safety and savings programs are core components of any PBM contract.
- While some of the programs offered through the new contract with CVS are consistent with the programs offered under the current ESI contract, some of the programs will be brand new to our members.
- In the following pages we will review the program highlights.

Pharmacy Benefit Contract: Clinical, Safety & Savings Programs

Program Name	Current ESI Program	Category of Service		
		Safety	Clinical	Savings
Point of Sale Safety Review/Drug Utilization Review (DUR)	Concurrent DUR	X	X	
Retrospective Safety Review	Plan Opted Out	X	X	
Safety and Monitoring Solution	FWA Program	X		
POS Utilization Management	UM Programs		X	X
Lowest Cost Drugs @ Mail and Retail	NA			X
Targeted Generic Alternative Mailing	NA			X
Pharmacy Advisor Support*	Plan Opted Out		X	
Pharmacy Audit	Pharmacy Audit			X
Diabetic Meter program	NA		X	X
Extracare Health Card	NA			X
Enhanced Safety and Monitoring Solutions	Similar Program	X		X
Specialty Guideline Management	Accredo Therapy Management		X	X

* Coordinate with Population Health Management Vendor

Pharmacy Benefit Contract: Clinical, Safety & Savings Programs

Program Name	Program Description
Point of Sale (POS) Drug Utilization Review (DUR) – aka POS Safety Review	Flags potential medication safety concerns at point of sale
Retrospective Safety Review	Reviews claims within 72 hours to identify potential medication safety concerns
Safety and Monitoring Solution	Reduces instances of fraud, waste and abuse through regular monitoring and timely interventions
POS Utilization Management	Dose Optimization, Quantity Limits and Step Therapy
Lowest Cost Drugs @ Mail and Retail	Dispense as written (DAW) solutions at mail and/or retail; outreach to prescriber and/or member to suggest an alternative medication for future fill
Targeted Generic Alternative Mailing	Direct to member communication to inform about generic alternatives for select single source, non-preferred drugs

Pharmacy Benefit Contract: Clinical, Safety & Savings Programs

Program Name	Program Description
Pharmacy Advisor Support	Promotes optimal adherence for members with chronic conditions; closes gap in evidence based medication therapy
Enhanced Safety and Monitoring Solutions	Enhanced safety and fraud monitoring with consultative course of action, investigation and continued monitoring
Pharmacy Audit	Daily review of all Rx claims and onsite audit of select network pharmacies.
Diabetic Meter program	Provides members with no-cost diabetes blood glucose meter every 365 days
ExtraCare Health Card	ExtraCare Card holders receive a 20% discount on regular, non-sale priced CVS brand health related items
Specialty Guideline Management	Promotes safe and appropriate utilization of specialty drugs by applying evidence-based guidelines throughout course of therapy

Traditional Plans
(Traditional 70/30, Enhanced 80/20, CDHP 85/15)
2017 Pharmacy Benefit Formulary Review

Closed Formulary Review

We have previously discussed that the Plan can realize additional savings by adopting a "Closed" Formulary. These savings come primarily through additional discounts and rebates that are available when only certain brands are included in the formulary.

- **Open Formulary** – In an "open" formulary, all drugs are included, subject to any benefit exclusions. The Plan currently utilizes an "open" formulary for the Enhanced 80/20, Consumer-Directed Health Plan (CDHP) 85/15, and Traditional 70/30 Plans.
- **Closed Formulary** – In a "closed" formulary, certain drugs are excluded. Plan members on the High Deductible Health Plan (HDHP) have ESI's standard formulary, which is closed.
- **Member Disruption** – Moving to a closed formulary will create some disruption for members who will no longer be able to purchase certain drugs. In all instances, there will be a generic and/or brand alternative on the formulary, and in most cases there will be multiple options.

Closed Formulary Review: Utilization Impact

	Number of Utilizers	Number of Scripts	Current Drug Tier	Member Cost Share	Alternative Drug Tier
Enhanced 80/20 Plan					
	11	12	1	$5	1,2 or 3
	9,811	33,361	2	$25	1,2 or 3
	5,936	16,622	3	Ded/Coins	1,2 or 3
	286	782	4*	$100	5 and 6
	286	826	5	$250	4 and 5
			6	Ded/Coins	6
Totals	**16,330**	**51,603**			
Traditional 70/30 Plan					
	5	6	1	$16	1,2 or 3
	8,496	27,896	2	$47	1,2 or 3
	4,587	12,464	3	$74	1,2 or 3
	249	804	4*	10% up to$100	5 and 6
	169	490	5	25% up to$103	4 and 5
			6	25% up to$133	6
Totals	**13,506**	**41,660**			
CDHP 85/15 Plan					
*Deductible waived for CDHP Preventive medications	-	-	1	Ded/Coins*	1,2 or 3
	303	778	2	Ded/Coins*	1,2 or 3
	226	515	3	Ded/Coins*	1,2 or 3
	17	54	4*	Ded/Coins*	5 and 6
	12	39	5	Ded/Coins*	4 and 5
			6	Ded/Coins*	6
Totals	**558**	**1,386**			
Total All Plans	**30,394**	**94,649**			

**** Tier 4 new for 2017***

For tiers 1 – 3, there is always an alternative in an equal or better class on the 80/20 & 70/30.

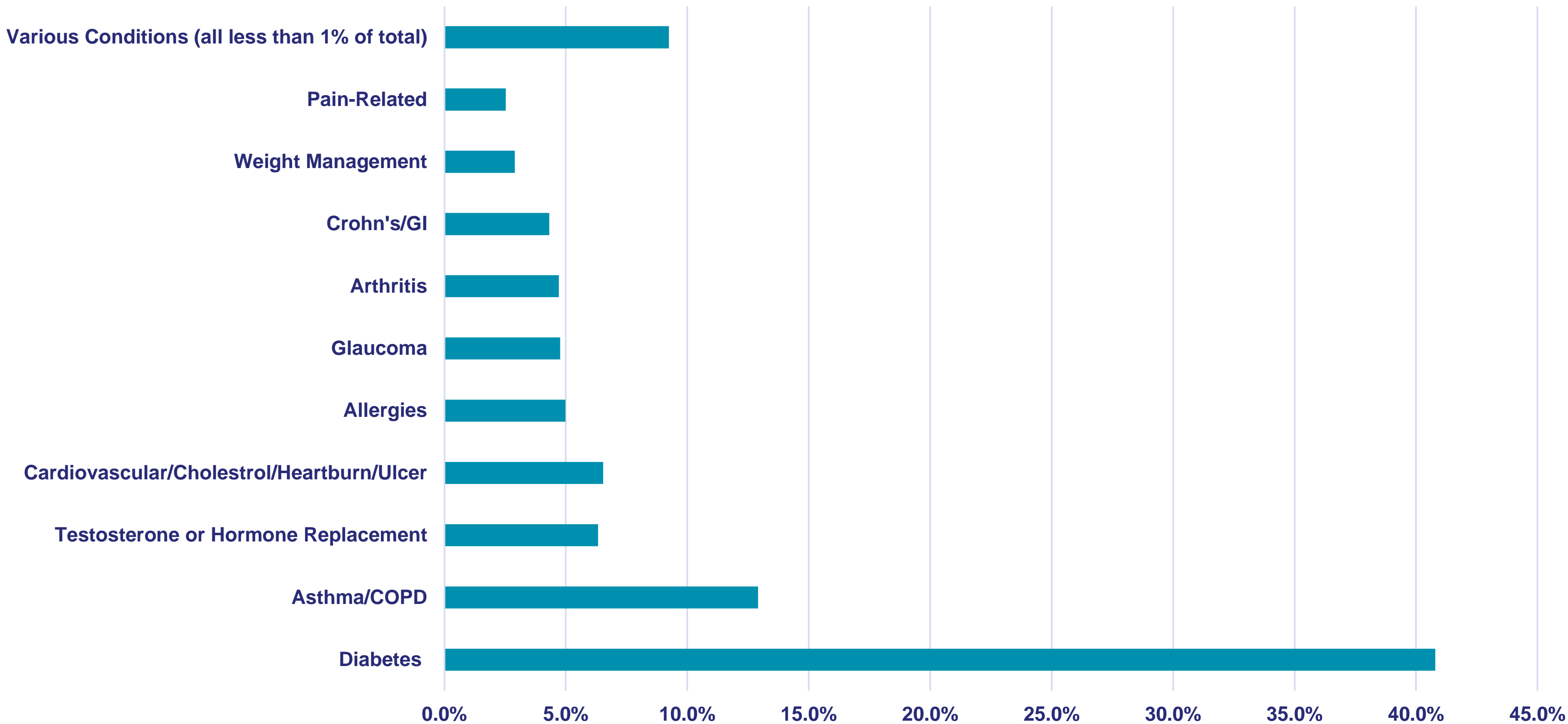
The results are mixed for Tiers 4*-6 on the 80/20 and 70/30. The alternative drug may be in a higher tier.

There are no tiers on the CDHP, but some drugs are deductible exempt.

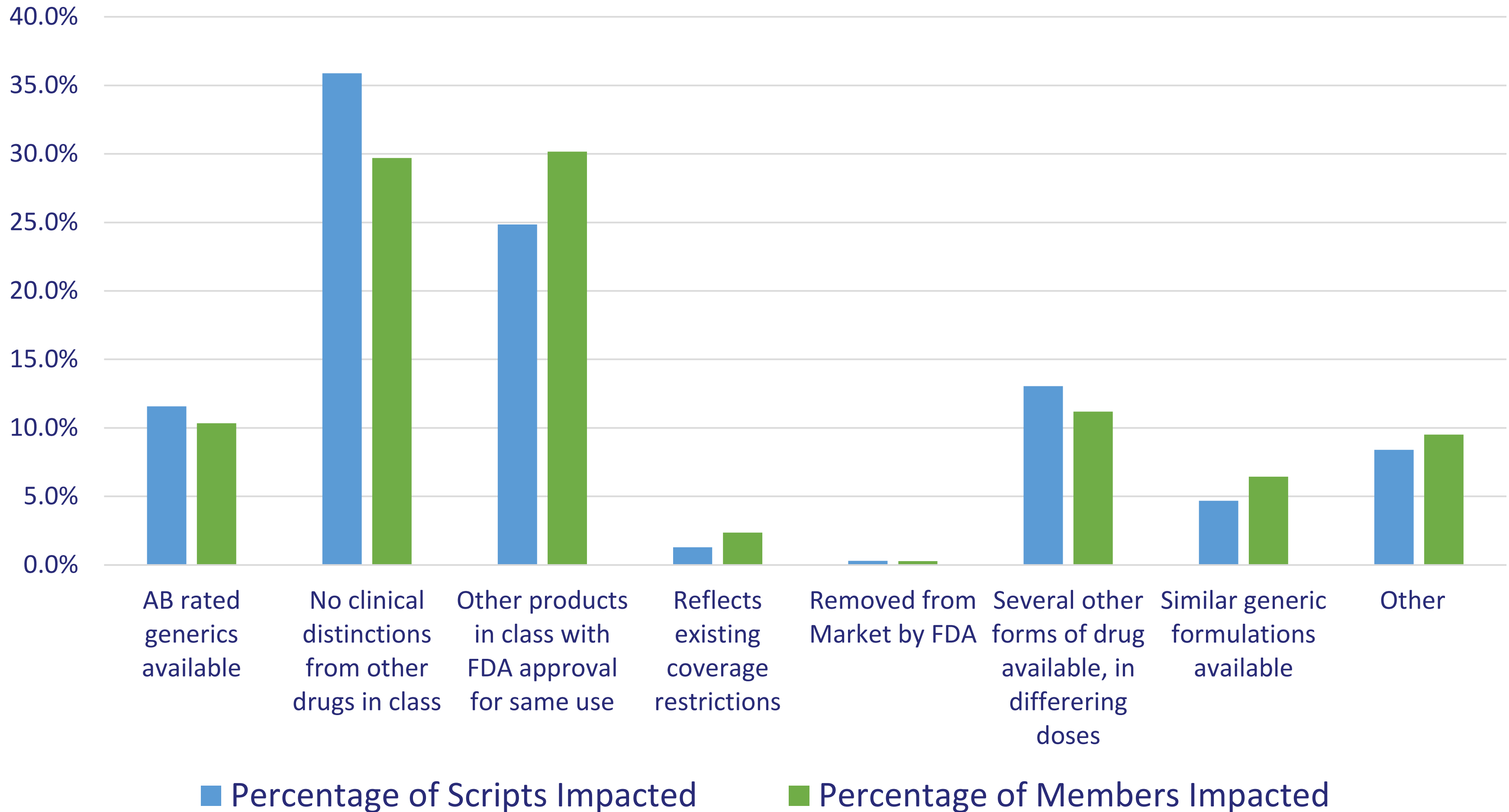
Closed Formulary Utilization Impact Review: Exclusions

- There is no avoiding the fact that some members will have to change medications when we move to a closed formulary, but the impact varies depending on the drug and the tier.
  - **Acute Medications** – Some of the drugs on the CVS closed formulary list are for acute conditions. In other words, these medications are used to treat a time-limited condition. There should be little to no impact to excluding some acute drugs.
  - **Diabetic Supplies** – Some brands of diabetic supplies are excluded. There should be no impact to changing diabetic supply brands.
  - **Maintenance Medications** – These medications are taken on an on-going basis and are used to maintain one's health. While there would be little to no impact on changing most of these medications, there are some conditions and medications that might warrant an exception.
- There will be an exception process available to providers who believe that, based on medical necessity, it is in the members' best interest to remain on the excluded drug(s).

Closed Formulary Utilization Impact Review



Closed Formulary Utilization Impact Review

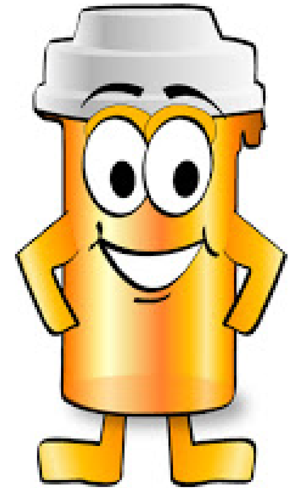


Closed Formulary Communications Plan

- **Communications Plan** - A key component of the overall Pharmacy Benefit communications plan will be the closed formulary.
  - **Providers** will receive communications about the exclusions that will outline the timelines for making the change as well as a process for requesting exceptions.
  - **Members**
    - All members will receive communications about the new pharmacy benefits manager including information about the closed formulary.
    - Members who are currently taking a medication that is on the exclusion list will receive a direct communication that describes the impacts of the closed formulary, the steps required to change medications, and the exception process.

CVS Standard Closed Formulary

- The Plan has completed an evaluation of the tier structure included in CVS's closed formulary.
  - Traditional Tier structure with all generics in Tier 1
  - Adoption would require changes to preferred and non-preferred drugs
  - No value based elements



Closed Formulary Proposal

For CY 2017, Plan staff recommends a closed, custom formulary for the Traditional 70/30, Enhanced 80/20 and CDHP 85/15 plan options.

- By closing the formulary, the Plan and members will benefit from additional savings.
- By customizing it, the Plan will be able to support the move to value based benefits and make any other changes that are in the best interest of the Plan and Plan members.
- The current tier structure will serve as the starting point of any changes.
- The Plan's P&T Committee will advise the Plan on utilization management, including tier placement and exclusions.

Traditional Plans
(Traditional 70/30, Enhanced 80/20, CDHP 85/15)
2017 Custom Pharmacy Programs

Custom Programs

The Plan currently offers programs that were originally implemented to complement the formulary and copay structures that were in place at the time these programs were introduced.

1. **Medication Adherence Program (MAP)**
   - Available to **retirees** and applies to diabetes and cardiovascular medications
   - Intended to increase adherence by removing cost barriers
   - Retirees can receive a 90-day supply from ***participating pharmacies**** for 2 ½ times the copay
   - Approximately 10,000 scripts are filled each month under this program

2. **Member-Pay-the-Difference Program**
   - Applies to non-specialty brand name drugs with a generic equivalent
   - Members who elect to purchase the brand drug must pay the Tier 1 copay plus the difference between the Plan's cost of the brand name drug and the Plan's cost of the generic drug, not to exceed $100 per 30 day supply

**Any pharmacy that agrees to the fee schedule can participate.*

Custom Programs

3. **Diabetic Testing Supplies**
   - Diabetic testing supplies are covered under the medical and pharmacy benefit
   - Program implemented to ensure these maintenance supplies were available at an affordable cost
   - Members are able to receive a 30-, 60- or 90-day supply of a specific diabetic supply for a set copay on the Enhanced 80/20 and Traditional 70/30 plans
   - Additional test strips are covered under the medical benefit and are subject to the deductible and coinsurance.

4. **Low Cost Generic Cholesterol-lowering Medications**
   - Implemented to support the Plan's cholesterol-lowering medication adherence program
     - $4 copay for a 1-month supply of generic cholesterol-lowering medication
     - $10 copay for a 3-month supply of generic cholesterol-lowering medication
   - Available at any in-network retail pharmacy

Medication Adherence Program

Since we rolled out MAP in 2011, we have either already made or are proposing plan design changes that have lessened the need for this program.

- **MAPDP Options** – MAP was introduced prior to the rollout of the Medicare Advantage Plans. Over 100,000 retirees are now enrolled in an MAPDP and no longer have access to the MAP program.

- **CDHP Preventive Medications** – The MAP program does not apply to the CDHP because there are no pharmacy copays. Instead, the CDHP deductible is waived on drugs that can help members prevent serious health conditions. The drugs included in this list are more inclusive that those included in MAP:

  - Anti-Infectives
  - Cardiovascular Medications
  - Diabetic Medications
  - Diabetic Supplies
  - Gout Prevention
  - Nutrition
  - Obesity
  - Obstetrical & Gynecological
  - Respiratory
  - Tobacco Cessation

Medication Adherence Program

- Enhanced 80/20 Plan – The 2017 value-based plan design lowers the Tier 1 & 2 copays, which reduces members' cost-share more than MAP and **MAP is only available for retirees.**

Year	Tier	30-Day Supply	60-Day Supply	90-Day Supply	90-Day Supply with MAP
2016	**1**	$12	$24	$36	$30
Approved 2017	**1**	$5	$10	$15	N/A
2016	**2**	$40	$80	$120	$100
Approved 2017	**2**	$25	$50	$75	N/A

- Because there is no longer a copay on Tier 3, MAP would not apply.

Medication Adherence Program

Other Considerations:

- **MAP 90-Day Network**
  - Current 90-Day Network that supports this program is open to any pharmacy that agrees to the reduced fee scheduled.
  - The list of participating pharmacies is posted on the Plan's website and changes periodically.
  - Not every pharmacy in a chain is included. Members must not only check to determine if a particular chain is participating, but also that the specific pharmacy is participating.
- **CVS 90-Day Network**
  - As part of the CVS implementation, Plan staff will be evaluating the CVS 90-Day Network. It is possible that this network could be used to support a program similar to MAP or some other value-based program and made available to a larger population.

Medication Adherence Program Proposal

Plan staff recommends discontinuing MAP effective January 1, 2017.

- Once evaluation of CVS's 90-Day Network is complete, the Plan will reconsider options for value added programs that could be supported by a limited pharmacy network.

Member-Pay-the-Difference

- The **"Member Pay the Difference"** program was originally implemented when the tier structure was more restrictive and generics were always the lowest cost drugs.
    - Tier 1 – Generics
    - Tier 2 – Preferred Brands
    - Tier 3 – Non-Preferred Brands
- This program was intended to encourage generic drug utilization and penalize members who elected to purchase a brand when a generic was available.
- The payment cap ($100 for 30-day supply) limits the financial impact and may not serve as a strong deterrent in some cases.

Member-Pay-the-Difference

- Over time the contents of the tiers have changed.
  - Tier 1 - Generics
  - Tier 2 – **Preferred Brands, High-Cost Generics, HIV Medications**
  - Tier 3 – Non-Preferred Brands
  - Tier 4 - Low Cost/Generic Specialty
  - Tier 5 – Preferred Specialty
  - Tier 6 – Non-Preferred Specialty
- As the Plan continues to move to more value based benefits, the tiers will become even more blended.
- While the Plan wants to encourage generic utilization, we also want to promote other value added medications and are currently evaluating whether there are any high cost brands that may need to move to Tier 1.

Member-Pay-the-Difference Proposal

Plan recommends discontinuing the Member Pay the Difference program effective January 1, 2017.

- The member cost-sharing structure and strategies for steering members to more appropriate drugs have evolved over time and the Plan has more tools in the toolbox than when this program was rolled out.
- This is one of the Plan's most confusing programs and does not contribute to a positive member experience.

Current Diabetic Testing Supplies Cost Share Structure

- The current cost share structure offers reduced copays for supplies, but no differentiation between the Enhanced 80/20 and the Traditional 70/30.
- CDHP members are subject to deductible and coinsurance.

Enhanced 80/20 and Traditional 70/30 Diabetic Testing Supplies Copays*			
Brand	**Up to 30-day Supply**	**31-60 day Supply**	**61-90 day Supply**
Preferred Brand	$10	$20	$30
Non-preferred Brand	$25	$50	$75
CDHP Members	After meeting the deductible, the member pays a 15% coinsurance on all in-network medical and pharmacy benefits and 35% coinsurance on all out-of-network medical and pharmacy benefits. CDHP Maintenance Medications are deductible exempt.		

**Insulin dependent members receive 204 test strips and non-insulin dependent members receive 102 test strips per 30-day supply. Additional test strips are covered under the medical benefit.*

Diabetic Testing Supplies Cost Sharing Proposal

Plan staff recommends maintaining customized cost sharing for diabetic supplies, but differentiating across the plan options effective

January 1, 2017 as follows:

- Enhanced 80/20 Preferred Diabetic Tier copay will equal the Tier 1 copay
- Traditional 70/30 Preferred Diabetic Tier copay will remain at $10 (Tier 1 is $16)

- Differentiation is consistent with other cost sharing changes approved by the Board and aligns with the value based benefits strategic initiative.

Drugs	Traditional 70/30 Plan	Enhanced 80/20 Plan	Consumer-Directed Health Plan
Tier 1 (Generic)	$16	$5	Preferred brands fall under CDHP Preventive List – deductible is waived
Tier 2 (Preferred Brand & High-cost Generic)	$47	$30	
Tier 3 (Non-preferred Brand)	$74	Deductible/Coinsurance	
Tier 4 (Low-cost/Generic Specialty)	10% up to $100	$100	
Tier 5 (Preferred Specialty)	25% up to $103	$250	
Tier 6 (Non-preferred Specialty)	25% up to $133	Deductible/Coinsurance	
Preferred Diabetic Supplies* (e.g. Test Strips, Lancets, Syringes, Needles)	$10	$5	

**Non-preferred Diabetic Supplies will be priced at Tier 3*

Low Cost Generic Cholesterol-lowering Medications

- The low cost generic cholesterol-lowering medications program was implemented prior to the introduction of the 2014 plan designs and the more recent move to a more value based plan design.
- With these more recent offerings the Plan has:
  - Lowered the Tier 1 (generic) copay on the 80/20 from $12 to $5 (CY 2017)
  - Rolled out a CDHP with an HRA that provides first dollar coverage and a preventive drug list that waives the deductible for these medications
  - Offered a health engagement program on the CDHP that allows members with chronic conditions who engage with a health coach and complete required screening activities to earn extra HRA dollars
  - Enrolled over 100,000 retirees into Medicare Advantage Plans that offer different programs for these medications
- Additionally, as part of the ongoing review of the formulary and engagement strategy, Plan staff will continue to evaluate options for offering more value based care at a lower member cost share.

Low Cost Generic Cholesterol-Lowering Medications Proposal

Plan recommends discontinuing the Low Cost Generic Cholesterol-Lowering Medication Program effective January 1, 2017.

- In CY 2017, Members on the Enhanced 80/20 Plan will have a much lower Tier 1 (generic) copay than was in place when this program was implemented.
- Members can still purchase these medications for $4 at pharmacies that offer reduced copays for certain medications (not a State Health Plan program, but a program offered by the pharmacy).

HDHP
(For non-permanent full-time employees)
2017 Pharmacy Benefit Programs & Formulary Review

High Deductible Health Plan (HDHP)

- The HDHP is offered to qualified non-permanent employees and currently utilizes Express Scripts' National preferred formulary, which is a closed formulary. The plan was developed to meet the ACA minimum value standard.
- **Plan Design –** There are no copays, and therefore, no pharmacy tiers on this plan. It is a high deductible health plan with combined medical and pharmacy deductibles and out of pockets.
- **Current Membership –** The membership on this plan is very low – usually around 350 members a month.

Benefit Design	Individual Coverage	Family Coverage
Deductible	$5,000	$10,000
Out-of-Pocket Maximum	$6,450	$12,900
Coinsurance	50%	50%
ACA Preventive Medical	Covered at 100%	
ACA Preventive Pharmacy	Covered at 100%	
Non-network benefits will be paid at 40%. The non-network deductible and out-of-pocket maximum are 2 times the in-network amounts.		

HDHP Pharmacy Programs and Formulary

The HDHP pharmacy benefit currently has a closed formulary and is subject to Express Scripts' Comprehensive Standard Utilization Management Package:

- Pre-defined package with a broad offering that focuses on managing trend through programs targeting inappropriate use and promoting clinically appropriate cost-effective therapies
- Includes prior authorization, step therapy and drug quantity programs for both traditional and specialty drugs
- Express Scripts is responsible for processing coverage exceptions and pharmacy appeals.
- The Plan's P&T Committee does not make recommendations regarding the formulary or utilization management programs.

HDHP Programs and Formulary Proposal

For CY 2017, Plan staff recommends continuing to offer the PBM's closed formulary for the HDHP – the CVS Standard Closed Formulary.

- The Plan will continue to benefit from savings associated with a closed formulary.
- This is a small population that will experience minimal disruption with the transition to a program similar to the one in place today.

Questions & Discussion

Board Action (Friday Meeting)

Traditional 70/30, Enhanced 80/20 and CDHP 85/15 Plan Options

1. **Closed, Custom Formulary**
   Plan staff recommends a closed, custom formulary for the Traditional 70/30, Enhanced 80/20 and CDHP 85/15 plan options, effective January 1, 2017 *(see slides 8-16).*

2. **Medication Adherence Program**
   Plan staff recommends discontinuing the Medication Adherence Program (MAP) effective January 1, 2017 *(see slides 18, 20-23).*

3. **Member Pay the Difference Program**
   Plan staff recommends discontinuing the Member Pay the Difference program effective January 1, 2017 *(see slides 18, 24-26).*

4. **Diabetic Testing Supplies Cost Share Structure**
   Plan staff recommends member cost share for Preferred Diabetic Testing Supplies be set at $5 on the Enhanced 80/20 Plan and $10 on the Traditional 70/30 Plan effective January 1, 2017 *(see slides 19, 27-28).*

5. **Low Cost Generic Cholesterol-lowering Medication Program**
   Plan staff recommends discontinuing the Low Cost Generic Cholesterol-Lowering Medication Program effective January 1, 2017 *(see slides 19, 29-30).*

Board Action (Friday Meeting)

High Deductible Health Plan Option

6. **Pharmacy Programs and Formulary**

   Plan staff recommends the CVS Standard Closed Formulary for the HDHP plan effective January 1, 2017 *(see slides 31-34).*

Pharmacy Benefit Management Implementation

2017 Pharmacy Formulary Considerations

Board of Trustees

North Carolina State Health Plan

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2017 Formulary Exclusions

Summary of Findings

- Segal National Pharmacy Benefits Practice reviewed the medications that would be removed if North Carolina State Health Plan (NC SHP) decide to move to a closed formulary.
- The value of moving into a smart formulary management, is to control costs and sustain the pharmacy benefit while protecting member health.
- After review of the exclusions, we find that the formulary will still offer access to safe and effective medications in all therapy classes , which was determined by an independent group of expert health professionals.
- We have prepared a comprehensive review in the following slides detailing what the excluded drugs are used for and the patient impact and whether the drug would typically be identified as acute or chronic
- Communications will be issued to members who attempt to fill a non-covered medication.
- There is also a medical exception criteria that would allow exceptions when medically necessary.
- There may be some areas where you may want to consider grandfathering, like Cancer and/or other sensitive categories.

2017 Formulary Exclusions

Cardiovascular

- **Blood Pressure**
  - **Edarbi, Edarbyclor, Teveten** (chronic)
    - Clinical rationale: Okay to exclude because there are other available drugs within the same class that have similar clinical efficacy
    - *Edarbi 83 utilizers; Edarbyclor 160 utilizers*
- **High Cholesterol**—various drug classes to treat high cholesterol
  - **Advicor** (chronic)
    - Clinical rationale: Okay to exclude because this drug has been removed from the market by FDA
    - *86 utilizers*
  - **Altoprev (extended release Lovastatin)** (chronic)
    - Clinical rationale: Okay to exclude because lovastatin is available generically; same drug
    - *20 utilizers*
  - **Liptruzet (Ezetimibe and Atorvastatin)** (chronic)
    - Atorvastatin is available generically; Zetia (ezetimibe) is also available;
    - *No utilizers*
  - **Livalo** (chronic) – Clinical rationale: Okay to exclude because there are many alternative generic drugs and preferred brands that are less costly and have equal efficacy.
    - *972 utilizers*

2017 Formulary Exclusions

Cardiovascular *continued*

- **Heterozygous familial hypercholesterolemia**
  - **Praluent** (PCSK-9 inhibitor)—injectable (chronic)
    - Clinical rationale: Okay to exclude because Repatha has similar clinical efficacy. This is a recent deletion to CVS formulary
    - *7 utilizers*

Diabetes

- **Short acting insulin (injectable) to treat type 1 and type 2 diabetes**
  - **Apidra** (chronic)
    - Clinical rationale: Okay to exclude because Novo Nordisc makes equivalent short acting insulin, Novolog.
    - *121 utilizers; NC SHP has a step therapy on this drug*
  - **Humalog and Humulin products** (chronic)
    - Clinical rationale: Okay to exclude because Novo Nordisc makes equivalent products; NC SHP has step therapy to use Novo Nordisc
    - *Humalog products—199 utilizers*
    - *Humulin—66 utilizers*

2017 Formulary Exclusions

Diabetes *continued*

- **Injectable for type 2 diabetes (chronic)**
  - **Bydureon, Byetta**
    - Clinical rationale: Okay to exclude because all products are FDA approved for the same indications and work in the body in the same manner
    - Bydureon 313 *utilizers; Byetta 282 utilizers*
- **Oral for type 2 diabetes (various oral drug classes to treat diabetes) (chronic)**
  - **Fortamet, Glumetza, Riomet** (chronic)
    - Clinical rationale: Okay to exclude because all these products are same drug, metformin, just slightly different dosage forms.
    - *Fortamet 5 utilizers; Glumetza 315 utilizers; Riomet 7 utilizers*
  - **Kazano, Kombiglyze XR, Oseni** (chronic)
    - Kazano (combo Alogliptin-metformin) both available generically
    - Kombliglyze (combo Saxagliptin-metformin)—Okay to exclude because other drugs in same class have same clinical efficacy
    - *Kazano 15 utilizers; Kombliglyze 942 utilizers; Oseni 152 utilizers*

2017 Formulary Exclusions

Diabetes *continued*

- **Oral for type 2 diabetes (various oral drug classes to treat diabetes)**
  - **Nesina, Onglyza** (chronic)
    - Clinical rationale: Okay to exclude because other drugs in same class have same clinical efficacy
    - *Onglyze 1056 utilizers*
    - *Nesina 11 utilizers ; NC SHP currently has step therapy on Nesina*
  - **Invokana, Invokamet** (chronic)
    - Clinical rationale: Okay to exclude because there is no clinical difference among the drugs in this class. They all work the same, lower blood sugar by the same percent and have the same side effects
    - *Invokamet 454 utilizers*
    - *Invokana 3129 utilizers*

2017 Formulary Exclusions

Diabetes *continued*

- **Diabetic Supplies (strips and tests)—Various brands excluded (chronic)**
  - Clinical rationale: Okay to exclude because all blood glucose test strips measure blood sugar in the same manner. **One Touch Lifescan products** are preferred for CVS Health
    - *Accu-chek products (4891 utilizers); Contour Bayer (2419 utilizers), Freestyle products (1905 utilizers)*
    - *Truetest products (241 utilizers); Unitstrip1 (221 utilizers); Bayer products (219 utilizers); Truetrack (163 utilizers); Relion products (110 utilizers); Embrace (94 utilizers); Prodigy products (70 utilizers); Advocate products (59 utilizers); Solus v2 product (43 utilizers); Fora products (42 utilizers); Precision XT products (41 utilizers)*
    - *Various diabetic products utilized by 30 utilizers or less for each product*

2017 Formulary Exclusions

Asthma/COPD

- **Aerospan, Alvesco** (Asthma) (chronic)
  - Clinical rationale: Okay to exclude because all corticosteroid inhalers carry the same FDA indication for asthma. No generics in this class
  - NCSHP has step therapy in place for this class
  - *Aerospan—11 utilizers; Alvesco—62 utilizers*
- **Symbicort (Asthma/COPD) (chronic)**
  - Clinical rationale: Okay to exclude because Inhaled Corticosteroid/beta agonist product. There are now a few like products on the market, with same indications and clinical effectiveness
  - *3080 utilizers*
- **Incruse Ellipta, Tudorza (COPD) (chronic)**
  - Clinical rationale: Okay to exclude because there are multiple “me too” drugs (anticholinergics). All products are FDA approved for the same indications and work the same way.
  - *Incruse Ellipta 15 utilizers; Tudorza 78 utilizers*

2017 Formulary Exclusions

Asthma/COPD *continued*

- **Ventolin HFA Proventil HFA, Xoponex HFA (Asthma) (acute for typical treatment)**
  - Clinical rationale: Okay to exclude because Ventolin HFA, Proventil HFA and Proair HFA are all an inhaled version of the same drug, albuterol.
  - *Xoponex 606 utilizers*

Hepatitis C

- **Viekira Pak (acute for typical treatment)**
  - Clinical rationale: Okay to exclude because there are now around 5 products with same cure rate and side effects. CVS Health prefers Harvoni and Sovaldi (Gilead products). These products can also be dosed once a day; Viekira pak is multiple daily dosing.
  - *No utilizers*
- **Pegasys** (chronic)
  - Clinical rationale: Okay to exclude because PegIntron (peginterferon alpha-2b); Sovaldi are alternatives. American Association for the Study of Liver Disease (AASLD) does include peginterferon (+Sovaldi + ribavirin) as an alternative regimen option for treatment-naïve patients with HCV genotype 3, 4 and 6 infections. Peginterferon is recommended (+Sovaldi + ribavirin) for treatment-naïve patients with HCV genotype 5 and as an alternate regimen (+ribavirin) for genotype 5.
  - *13 utilizers*

2017 Formulary Exclusions

Erectile Dysfunction

- **Viagra, Levitra** (acute)
  - Clinical rationale: Okay to exclude because NC SHP does not cover ED medications, with the exception of Cialis 5mg for BPH
  - *Viagra 35 utilizers; Levitra 9 utilizers*

Overactive bladder

- **Toviaz (festoterodine)** (chronic)
  - Clinical rationale: Okay to exclude because there are other alternatives with same clinical efficacy
  - *No utilizers*

2017 Formulary Exclusions

Multiple Sclerosis (Specialty)

- **Avonex, Extavia, Plegridy** (chronic)
  - Clinical rationale: Okay to exclude because formulary alternatives are the same exact drug as the excluded drugs; however the alternatives will have different formulations with different dosing schedules but same drug.
  - *Plegridy—5 utilizers; Avonex—92 utilizers; Extavia—1 utilizer*

Osteoarthritis injections

- **Euflexxa,Monovisc,Orthovisc** (acute i.e. Euflexxa once a week shots up to 3)
  - Clinical rationale: Okay to exclude because there are 6 manufacturers of these osteoarthritis medications all containing the SAME drug, hyaluronic acid.
  - *Monovisc 1 utilizer*

2017 Formulary Exclusions

Testosterone replacement

- **Androgel (testosterone gel), Fortesta, Natesto, Testim, Testosterone Gel 1%, Vogelxo** (acute)
  - Clinical rationale: Okay to exclude because there are other topical testosterone containing products that are covered under the formulary. There are many different topical forms of testosterone available on the market; gels, solutions patches. All forms contain the same drug, testosterone.
  - *Androgel 1839 utilizers; Natesto 1 utilizer; Testim 44 utilizers*

Growth Hormone (Specialty)

- **Tev-Tropin, Nutropin AQ, Omnitrope, Saizen** (chronic for FDA approved indication i.e. inadequate growth hormone)
  - Clinical rationale: Okay to exclude because all growth hormone products contain the same drug, Somatropin. NC SHP has step therapy in this class currently. Genotropin is an preferred product. CVS Health's preferred products are Humatrope or Norditropin
  - *Genotropin 26 utilizers; Norditropin 56 utilizers*

2017 Formulary Exclusions

Transplant (Specialty)

- **Hecoria** (chronic)
  - Clinical rationale: Okay to exclude because this medication has been discontinued by the manufacturer
  - *No utilizers*
- **Prograf** (chronic) Okay to exclude because tacrolimus is an AB rated generic equivalent for brand Prograf.
  - *252 utilizers*

Opioid Induced constipation

- **Relistor** (acute)
  - Clinical rationale: Okay to exclude because they work in the same way in the body. There is no clinical difference between these two products to treat Opioid Induced constipation
  - *Relistor 13 utilizers*

Irritable Bowel Disease – Constipation predominant

- **Amitiza** (acute)
  - Clinical rationale: Okay to exclude because Linzess is a formulary alternative that is less expensive brand alternative for same indication.
  - *Amitiza 776 utilizers*

2017 Formulary Exclusions

Kidney disease

- **Fosrenol** (chronic)
  - Clinical rationale: Okay to exclude because there are generic products available to remove phosphate from the body when someone has kidney disease. Fosrenol is a "me too" drug in this class. Fosrenol is FDA approved for same indications as generics in this class. It is available as a chewable tablet, but is much more expensive than generics.
  - *26 utilizers*

Arthritis

- **Pennsaid** (acute)
  - Clinical rationale: Okay to exclude because Pennsaid is a topical solution form of a drug called diclofenac. Diclofenac is an anti-inflammatory available generically as an oral tablet and topically as a gel. NC SHP currently has a prior authorization on Pennsaid.
  - *Pennsaid 666 utilizers*

2017 Formulary Exclusions

Muscle Relaxer

- **Amrix** (acute)
  - Clinical rationale: Okay to exclude because Amrix is an extended release form of a generic formulary product, cyclobenzaprine. Amrix is dosed once a day; generic cyclobenzaprine is dosed one to three times a day. However, this is not a maintenance medication and should not be taken for longer than 2-3 weeks, so adherence to this product is not paramount.
  - *193 utilizers 193*

Allergies

➢ **Allergic reactions**

- **Adrenaclick** (acute)
  - Clinical rationale: Okay to exclude because there are several different products on the market to treat allergic reactions. All products contain the same active ingredient, epinephrine, which come in the same strengths.
  - *No utilizers*

2017 Formulary Exclusions

Allergies *continued*

- **Nasal Steroids/ Combinations**
  - **Dymista, Qnasl, Beconase AQ, Omnaris, Veramyst; Zetonna** (acute and/or seasonally chronic)
    - Clinical rationale: Okay to exclude because all nasal steroid products are FDA approved for the same indication. CVS Health prefers use of generics in this class and has excluded these high cost brands. *Generic alternatives include Flunisolide nasal spray; Fluticasone spray. Less expensive brand alternative is Nasonex.*
    - *Qnasl—398 utilizers; Dymista—720 utilizers; NC SHP has a step therapy on Dymista and Qnasl*
    - *Omnaris—66 utilizers; Veramyst—129 utilizers; Zetonna 31 utilizers*
- **Allergic Conjunctavitis (Opthalmic)**
  - **Lastacaft** (acute)
    - Clinical rationale: Okay to exclude because there are generically available products and preferred brand products that work the same way in the body to control eye allergies.
    - *172 utilizers*

2017 Formulary Exclusions

Dermatology

- **Skin Inflammation and Hives**
  - **Apexicon E, Olux-E** (acute)
    - Clinical rationale: Okay to exclude because Apexicon E and Olux-E are new formulations of the generically available products, which are available as a cream, too. The base or cream in which the drug is incorporated is the only difference between Apexican E and Olux E and the formulary generics.
    - *Apexicon 16 utilizers; Olux-E 3 utilizers*
- **Rosacea**
  - **Noritate** (acute)
    - Clinical rationale: Okay to exclude because Noritate is the cream form of a drug called metronidazole. It is available as a 1% cream. There is a generic metronidazole 0.75% cream or 1% gel.
    - *48 utilizers*
- **Actinic keratosis**
  - **Carac,flourouracil cream** 1% (acute)
    - Clinical rationale: Okay to exclude because there are many flourouracil products on the market- various strengths of creams, solutions. All are applied topically and have the same FDA approved indications.
    - *Carac 120 utilizers*

2017 Formulary Exclusions

Dermatology *continued*

- **Anti-inflammatory**
  - **Clobex Spray, Clobetasol Spray** (acute)
    - Clinical rationale: Okay to exclude because drug is clobetasol, which is available as a cream, ointment, gel, solution, lotion, foam or spray to treat inflammation of the skin. The spray products are the most expensive. Members would still be able to use clobetasol, just another formulation
    - *Clobex—26 utilizers*

- **Corticosteroid**
  - **Rayos** (acute)
    - Clinical rationale: Okay to exclude because Rayos is the extended release dosage form of a drug called prednisone. It is the same drug.
    - *20 utilizers*

Ulcerative colitis or Inflammatory Bowel Disease

- **Asacol HD, Delzicol** (acute)
  - Clincal rational: Okay to exclude because there are other effective mesalamine products available. It is the same drug.
  - *Asacol 342 utilizers; Delzicol 166 utilizers*

2017 Formulary Exclusions

Sleep

- **Intermezzo** (acute)
  - Clinical rationale: Okay to exclude because the only difference between Intermezzo and generic is that the brand drug is an orally disintegrating tablet. The drug is zolpidem, which is available generically.
  - *11 utilizers*
- **Rozerem** (acute)
  - Clinical rationale: Okay to exclude because there are generics that are less costly to help a member sleep
  - *45 utilizers; NC SHP has step therapy on Rozerem*

Depression/Sleep

- **Oleptro** (chronic)
  - Clinical rationale: Okay to exclude because Oleptro is the extended release version of a generically available drug, trazodone.
  - *Oleptro—2 utilizers*

2017 Formulary Exclusions

Analgesic Combination (pain and inflammation)

- **Duexis, Vimovo** (acute)
  - Duexis Clinical rationale: Okay to exclude because this is a combination drug that contains both famotidine and ibuprofen, which are available generically as individual drugs.
  - Vimovo Clinical rationale: Okay to exclude because this is a combination drug that contains both esomeprazole and naproxen, which are available generically as individual drugs.
  - *Duexis 33 utilizers; Vimovo 486 utilizers*

Weight Loss

- **Qsymia** (acute)
  - Clinical rationale: Okay to exclude because there are other weight loss agents available that are less costly with similar clinical efficacy.
  - *863 utilizers*

2017 Formulary Exclusions

Glaucoma

- **Lumigan** (chronic)
  - Clinical rationale: Okay to exclude because there are 5 other drugs in the same class to treat glaucoma. All drugs in this class are clinically equal in their eye pressure lowering abilities and side effects.
  - *1421 utilizers*

Rheumatoid Arthritis and other inflammatory conditions (Specialty)

- **Actemra; Kineret; Orencia; Cimzia; Remicade; Simponi; Xeljanz** (chronic)
  - Clinical rationale: Okay to exclude because alternative brand name drugs Enbrel and Humira remain the most highly utilized biologic products on the market. Both products come in multiple injection forms to offer flexibility in dosing and administration. Alternative brands provide cost savings.
  - *Kineret 5 utilizers; Actemra 34 utilizers; Orencia 83 utilizers; Cimzia 79 utilizers; Remicade 2 utilizers; Simponi 57 utilizers*

Pulmonary Arterial Hypertension (Specialty)

- **Adcirca; Revatio,Opsumit** (chronic)
  - Revatio and Adcirca Clinical rationale: Okay to exclude because the alternative that is available is sildenafil which is an AB rated generic equilavent for Revatio; for Opsumit preferred brand alternatives are Letairis and Tracleer.
  - *Adcirca 29 utilizers; Revatio 7 utilizers; Opsumit 15 utilizers*

2017 Formulary Exclusions

Various Conditions

Clinical rationale: Okay to exclude because all of these below medications have **AB rated generics** available as well as other generics within their classes. Generic equivalents are the formulary alternatives. Below is the impact:

- *Abilify (727 utilizers) for bipolar or major depression (chronic)*
- *Actos (7 utilizers) for diabetes (chronic)*
- *Aderall XR (152 utilizers) for ADHD (chronic)*
- *Arthrotec (29 utlizers) for pain (acute)*
- *Exforge (178 utilizers) Atacand (16 utilizers) Cardizem (28 utilizers) Detrol (25 utilizers) Diovan (243 utilizers) Intuniv (48 utilizers) Norvasc (48 utilizers) for hypertension (chronic)*
- *Cymbalta (149 utilizers) for depression (chronic)*
- *Prevacid (507 utilizers); Prevacid (253 utilizers) Protonix (13 utilizers) for ulcer (acute)*
- *Jalyn (106 utilizers) for BPH (chronic)*
- *Lescol (49 utilizers); Lipitor (254 utilizers) Tricor (30 utilizers) for high cholesterol (chronic)*
- *Lunesta (29 utilizers) for sleep (acute)*
- *Naprelan (41 utilizers) for pain (acute)*
- *Oxytrol (18 utilizers); Tovias (138 utilizers) for overactive bladder (chronic)*
- *Plavix (24 utilizers) for stroke (chronic)*
- *Rhinocort (9 utilizers) for allergies (acute)*
- *Valcyte (20 utilizers) for CMV retinitis (chronic)*
- *Valtrex (29 utilizers) for herpes (acute)*
- *Matzim (No utilizers) for hypertension (chronic)*

2017 Formulary Exclusions

Fertility (Specialty)

- **Bravelle**—(acute) Clinical rationale: Okay to exclude because based on data from a few clinical studies there does not appear to be a significant difference between Menopur or Repronex and Follistim for efficacy or safety. Bravelle is only available in powder form which requires mixing prior to injection and may be more cumbersome for patients.
  - *4 utilizers*
- **Gonal F**—(acute) Clinical rationale: Okay to exclude because based on data from a few clinical studies, there does not appear to be a significant difference between Menopur or Repronex and Follistim for either efficacy or safety.
  - *13 utilizers*

Psoriatic Arthritis; Plaque Psoriasis (Specialty)

- **Otezla, Stelara**—(chronic) Clinical rationale: Okay to exclude because alternative brand name drugs Enbrel and Humira remain the most highly utilized biologic products on the market. Both products come in multiple injection forms to offer flexibility in dosing and administration. Alternative brands provide cost savings.
  - *Otezla141 utilizers*
  - *Stelara138 utilizers*

2017 Formulary Exclusions

Anemia (Specialty)

- **Procrit**—(chronic) Clinical rationale: Okay to exclude because alternative drugs available with similar efficacy. The National Kidney Foundation's Clinical Practice Guidelines and Clinical Practice Recommendations for Anemia in Chronic Kidney Disease recommends either darbepoetin or epoetin for the treatment of anemia in chronic kidney disease when erythropoietin stimulating agents are indicated
  - *13 utilizers*

Cancer (Specialty)

- **Tasigna**—(chronic) Clinical rationale: Okay to exclude because Gleevec (imatinib) 400mg once daily is recommended first-line therapy for newly diagnosed CP-CML (leukemia) patients. Based on the FDA approval of Tasigna (nilotinib) and Sprycel (dasatinib), the guidelines also recommend these as first-line therapy options for newly diagnosed patients. Gleevec is now available generically as imatinib.
  - *26 utilizers*
- **Xtandi**—(chronic) Clinical rationale: Okay to exclude because the National Comprehensive Cancer Network (NCCN) Prostate Cancer Practice Guidelines released in 2015 recommend abiraterone and enzalutamide as first-line therapy for patients with asymptomatic, chemotherapy-naïve, metastatic castration-resistant prostate cancer.
  - *36 utilizers*

2017 Formulary Exclusions

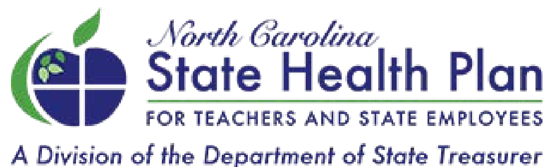
Opioid Dependence Agents

- **Zubsolv**—(acute) Clinical rationale: Okay to exclude because Zubsolv is a brand name for combination of buprenorphine and naloxone. There are less expensive alternatives. Generic alternative is buprenorphine-naloxone sub-lingual tablet. Brand alternative is Suboxone Film - also a combination of the same drugs - buprenorphine and naloxone.
  - *16 utilizers*

INITIATIVES AND DIRECTIONS AMONG STATE EMPLOYEE HEALTH PLANS

Presentation to State Health Plan Board

June 3, 2016



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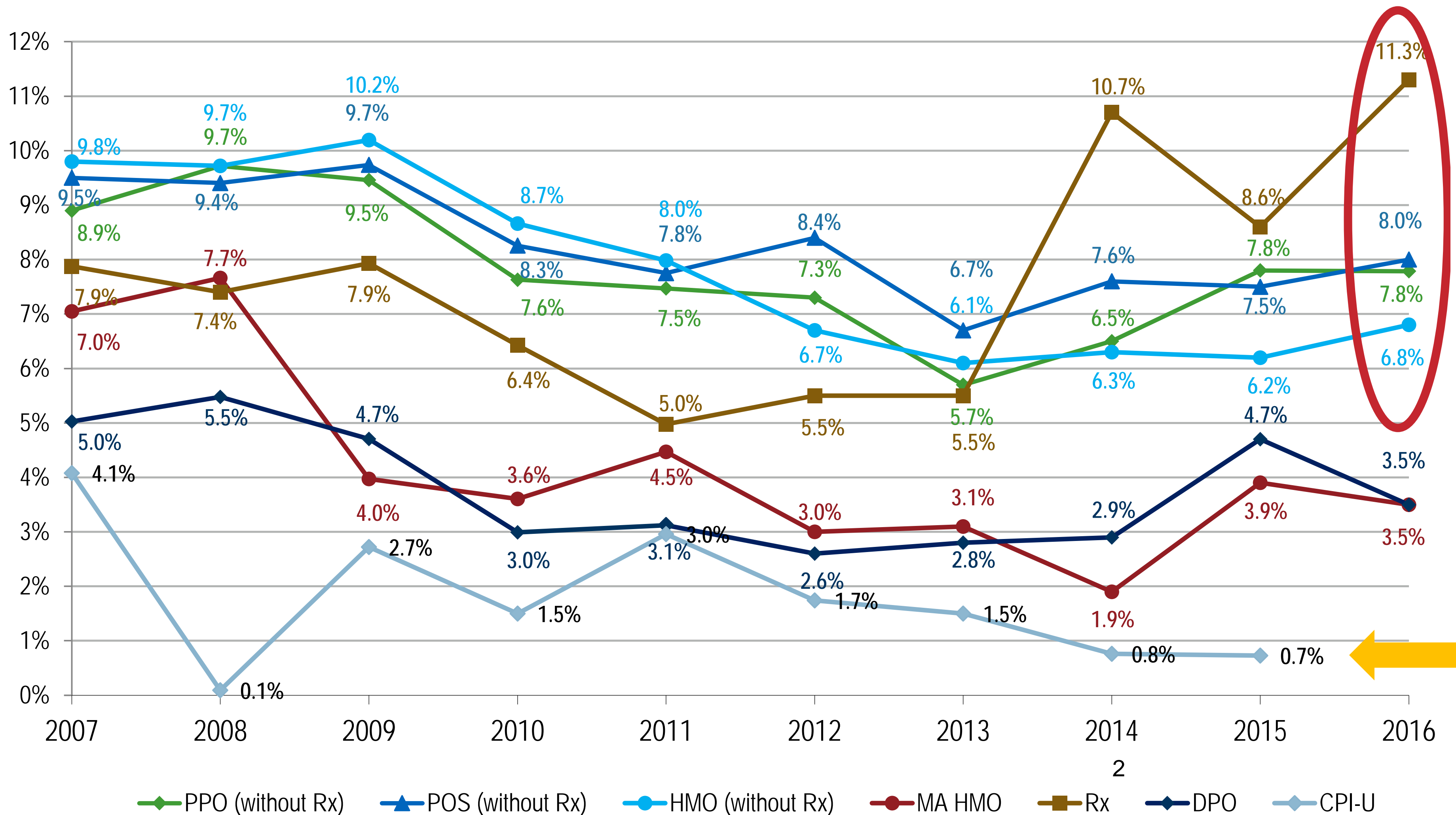
State Employee Health Plans
Lay of the Land

- All state health plans are facing budget and funding issues, some more directly than others
- Health benefit plan costs keep going up faster than state employee compensation
  - Each year more of the employee's pay must go to pay for health benefits or the state must pick up an increasing share of the costs
- Plans are continually looking for innovative ways to control and contain the increase of health plan costs and keep member premiums affordable
- The Affordable Care Act requires minimum levels of coverage, some of which have driven up plan costs
- Starting in 2018 (now delayed to at least 2020) plans will have a ceiling on the nontaxable value of benefits they can provide to employees and retirees
  - 40% Excise Tax (known as Cadillac Tax) will apply for **total** plan costs over fixed dollar thresholds
  - To stay under the Excise Tax threshold, plans will eventually have to shift more out-of-pocket costs to participants or change how care is provided
  - Can't just charge participants more premium, since tax is based on total cost

Ten-Year Summary of Selected Medical, Prescription Drug Carve-Out and Dental Trends: 2007 – 2014 Actual and 2015 and 2016 Projected[1]



Source: 2016 *Segal Health Plan Cost Trend Survey*

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

[2] Prescription drug trend data for 2007 only reflects retail. For 2008 – 2016, prescription drug retail and mail order delivery channels are combined.

State Plan Initiatives:

1. **Benefit Plan Design and Program Changes**
2. Provider Network Contracting
3. Premium Subsidy Approaches
4. Retiree Health Benefit Programs
5. Other Interesting Developments

State Employee Health Plan Offerings

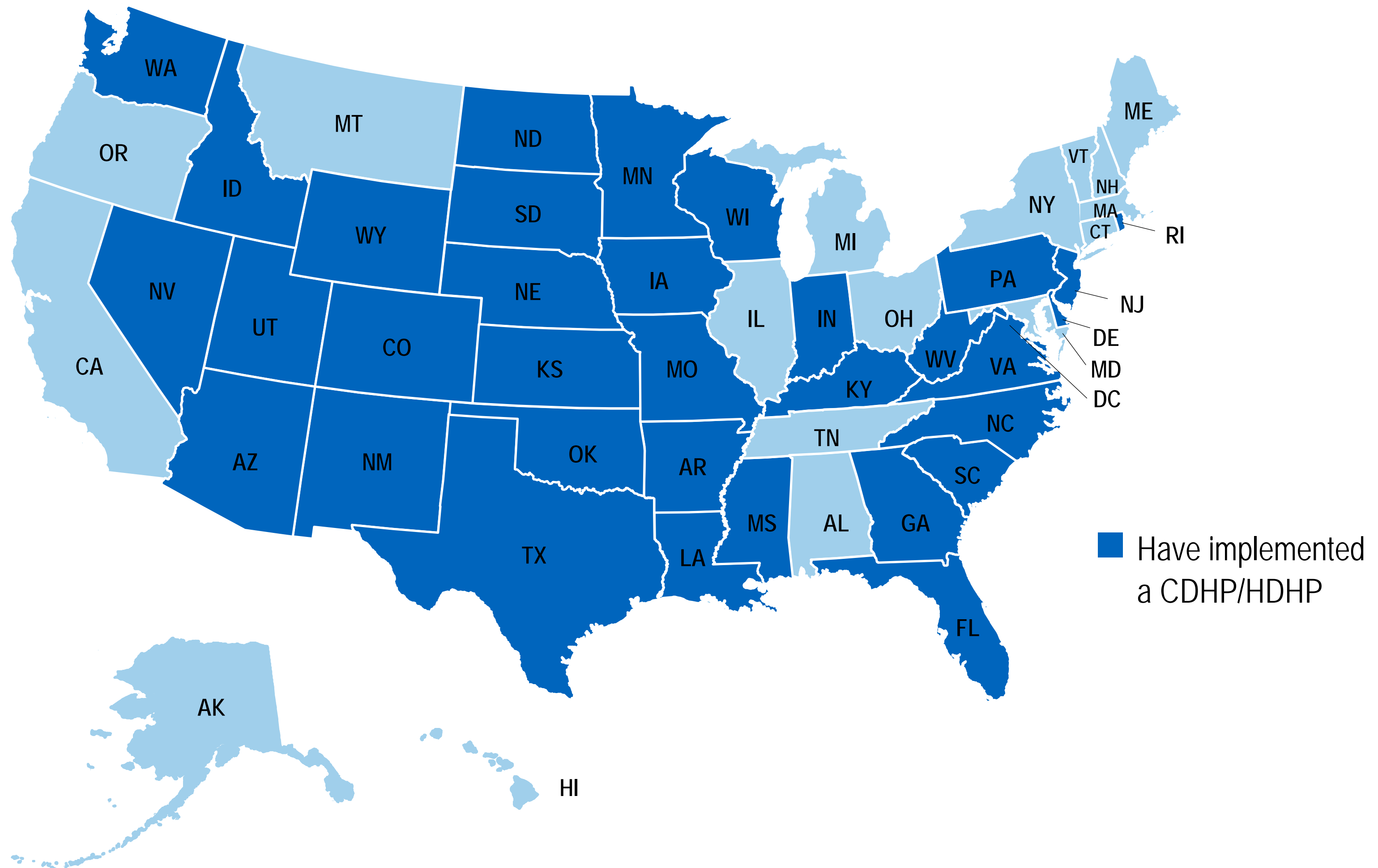
- Stability and progressive migration:
  - States have moved progressively from Indemnity to PPO to CDHP
  - Changes tend to be incremental
    - Introduce new plan types then phase out older ones over a few years
- Majority of enrollment is currently in PPO type plans
- CDHP has grown rapidly in the last four years

Plan Type	1999 Segal Survey	Percent of States	2014 Segal Survey	Percent of States
Indemnity Plans	43	84%	7	14%
PPO/POS	26	51%	47	92%
HMO/EPO	43	84%	29	57%
CDHP/HDHP	0	0%	30 *(now 33)*	59% *(65%)*

Source: Segal State Health Plan Survey 1999 and Segal State Study 2014

Consumer Directed Health Plans

As consumerism plays a larger role in plan features, the majority of states (33) have implemented Consumer Directed Health Plans (CDHP) or High Deductible Health Plans (HDHP)



How States Encourage CDHP Participation
Preferential Premium Structure

Indiana

- Three CDHP options plus one PPO
- Wellness CDHP is only available to members that meet the wellness participation requirement
- Significant differences in employee premium for different plans

State of Indiana Plan Options	Monthly Premium Employee Only
Wellness CDHP	$30
CDHP – 1	$57
CDHP – 2	$222
70/30 PPO	$635

How States Encourage CDHP Participation

Preferential Premium Structure continued

- **Arizona** and **Georgia** also offer a preferential premium structure to encourage CDHP enrollment:

State of Arizona Plan Options	Monthly Premium Employee Only
PPO	$102
EPO	$40
HSA	$20

State of Georgia Plan Options	Monthly Premium Employee Only
UHC HMO	$170
BCBS HMO	$130
Kaiser HMO	$140
BCBS Gold HRA	$159
BCBS Silver HRA	$105
BCBS Bronze HRA	$66
UHC HDHP	$57

- **North Carolina State Health Plan** allows members to earn down their CDHP premiums for completion of designated wellness activities

How States Encourage CDHP Participation *continued*

HSA/HRA Contribution Incentives

- A number of states offer increased HSA/HRA contributions for CDHP/HDHP members tied to participation in a wellness and/or disease management programs

Attractive HSA/HRA Contribution Levels

- Employees selecting these plans can recoup a significant portion of the deductible through HSA/HRA credits
- **Kansas** has experienced promising enrollment in their CDHP, likely a result of the rich State contributions to HSAs that offset the plan's design:
  - $1,500 for single
  - $2,250 for family
- **Indiana** contributes between $600 to $1,250 for single and $1,200 to $2,500 for family based on the CDHP plan selected

Wellness Plan Design

- A majority of states offer wellness programs designed to promote healthy behaviors
- Programs range from cash reduction of premiums, to point systems for incentives, to required activities to avoid surcharges

Georgia	Rhode Island	Connecticut
• Up to $480 to offset plan expenses. • $240 for completing a well-being assessment and having a biometric screening. • $240 earned by participating in phone coaching or the completing online well-being activities.	• Up to $500 for completing certain activities. • Each activity is allocated a dollar amount and paid as a credit to employee premium cost share on their paycheck deductions.	• Requires age-related activities. • All family members must participate • $100 monthly premium reductions and waived medical deductibles. • Chronic care management are eligible for reduced copays on PCP visits and treatment specific prescriptions.

Wellness Plan Design *continued*

- Many states already offer **free health resources**, such as:
  - Health coaching or on-line apps to:
    - Track health habits
    - Help participants quit smoking, eat better, get more physical activity, sleep better or manage stress
  - Group-based activities organized through onsite wellness coordinators
- An increasing number of states are exploring how to leverage **social media** and **smart phone apps** to encourage a healthy lifestyle:
  - **Using Twitter, Facebook, Instagram,** and other apps to push the message of wellness, and to communicate how participation in these programs can improve quality of life through positive behavior change.
  - **Ongoing personal reminders** supporting the activities featured in the wellness program
  - **Fitness tracking** tied to competitive groups
  - **Articles and videos** to broaden employee perspective on maintaining health
  - **Fun and health features,** e.g., coordinating with a local onsite farmers market to publish healthy recipes based on the market's available produce

Worksite Wellness Initiatives

- Best Practice Programs are:
  - Integrated among state / agency / local coordinators to offer local programs
  - Balanced between incentive-based programs and other resources
  - Branded to state (not health plans)
  - Available to all employees, retirees and dependents

CommonHealth of Virginia

- Created in 1986, more than 500 agency locations now participate
- Nine regional coordinators help support local programs
- "Start a Fitness Class at Work" and similar toolkits offered

Work Well Texas!

- State legislation requires agencies to support wellness, including:
  - Development of an agency wellness council
  - Allowing employees 30 minutes during normal working hours for physical activity three times per week
  - Providing eight hours of additional leave time each year for completing a health risk assessment/physical examination
- State provides guidance, model programs and policies to support local wellness initiatives

Worksite Wellness Initiatives

Work Well (Minnesota)

- Promotes worksite wellness programs within state agencies
- Agency wellness committees meet to plan activities and environmental changes that promote good health
- Best practices shared through statewide interagency Wellness Champions team

LiveWell Vermont

- Promotes employee /retiree health through:
  - Onsite biometric screenings
  - Telephonic wellness coaching
  - Quarterly wellness challenges
  - State employee Healthy Recipe Book
- Health & wellness workshops/classes—both **onsite** and **online**

Washington Wellness

- Supports local wellness coordinators at participating employers
- "Build Your Wellness Program" roadmap for agencies to secure leadership support, promote activities, evaluate results
- Specific resources for local wellness leaders to help promote "physical activity", "healthy eating", "living tobacco free", etc.

Plan Design Tiered Structure

- Different state health plans use different tiered plan designs to incent plan members to utilize high-quality, efficient facilities and providers
  - **Illinois'** Quality Care Health Plan (QCHP) provides three deductible levels that are determined by the employee's salary, and includes enhanced benefits for receiving care from a designated QCHP provider
  - **West Virginia** maintains a Comprehensive Care Partnership (CCP) program in which enrolled members receive reduced plan cost share for services rendered at a CCP provider. These services include primary care, coordination of care, and where available specialty care
  - **Massachusetts** tiers the plan cost share for specialty physician office visits and inpatient hospital medical care. Three tiers are used to provide improved member cost-sharing for utilizing more cost effective and/or higher quality facilities
- Some states have implemented salary-based tiered plan designs
  - **West Virginia** tiers both deductibles and out-of-pocket maximums for three of its plan offerings; each plan has a range dependent upon the employee's salary. (WV also applies different premiums based on that same ten-tier salary band structure)

1. Benefit Plan Design and Program Changes
2. **Provider Network Contracting**
3. Premium Subsidy Approaches
4. Retiree Health Benefit Programs
5. Other Interesting Developments

Health Provider Network Contracting

- The majority of state plans contract with medical carriers (BCBS, UHC, Aetna, etc.) to access hospital and physician networks and the accompanying discount arrangements:
  - Usually discounts and network guarantees are negotiated as part of the third party administration contracting process
  - Generally, the best discounts overall are available through the larger medical carriers
  - Once contracted, states typically have limited ability to change or realign network provider reimbursement except through systemic renegotiations
- While more prevalent in the private sector, some states are exploring alternative provider contract arrangements including:
  - Directly contracting with selected providers and facilities
  - Regional contracting through local HMO or local physician practice groups
  - Tiering physician groups based on risk adjusted experience
  - Global or reference-based payments for certain episodes of care
  - Bifurcated Networks
  - Value-Based Shared Savings Arrangements

Regional Contracting Arrangements

Some states contract provider networks geographically

- **Tennessee** divides the state into three regions:
  - Each region contracts with two medical administrators for its plan offerings
  - Both primary networks are available in many locations.
- **Alaska** participates in a coalition, including five union groups and other non-public health plans:
  - Coalition negotiates and contracts directly with the hospital network in Anchorage for improved discounts over those that can be obtained through Premera Blue Cross
- **Wisconsin** contracts with 17 fully insured HMOs:
  - Each HMO offers its plan in counties where it determines it can compete best
- Additional states offering multiple plan network options by geography include:
  - **California**
  - **Florida**
  - **Illinois**
  - **Iowa**
  - **New York**
  - **Massachusetts**
  - **Oregon**

Alternative Contracting Arrangements

States also differentiate among providers within the network and/or negotiate directly with major provider groups

- **Minnesota** employs a tiered provider network approach
  - Physician groups are placed within one of four tiers based on risk-adjusted historical cost
  - Member cost share for benefits is keyed to the provider's tier—higher tiered providers have higher copays
  - Physician groups are allowed to negotiate more deeply discounted contracts with the three plan administrators (BCBSMN, HealthPartners, PreferredOne) to move into a lower provider tier
- **Delaware** is beginning to negotiate directly with its four key hospitals
  - Goal is to leverage the plan's utilization to obtain preferential pricing with their major hospitals

To manage alternative provider contracts successfully, the state must establish and monitor data metrics that are highly correlated with quality and health improvement.

Centers of Excellence

Centers of Excellence are hospitals or physicians that are highly proficient in specific episodes of care, such as cancer treatment, bariatric surgery, or transplants. These centers typically demonstrate higher quality outcomes often at a lower cost

- **California** (CalPERS) contracts directly with high performing hospitals for specific surgeries and provides a set payment (reference based pricing) against the total cost
  - Due to success with knee and hip replacement surgery, California has expanded these arrangements to other surgical procedures
  - Also, more hospitals have agreed to meet the reference pricing and be added to the direct network
- **Virginia**, **Wisconsin**, and **Minnesota** contract with selected hospitals and physician groups for specific procedures like Bariatric surgery and transplants at a discounted rate for state employee members
- **Vermont** covers transplants at 100% when services are rendered at designated facilities
- **Alaska** is contracting directly with providers not in the Blue Cross network to eliminate balance billing on end stage renal disease

Bifurcated Network Contracting

Bifurcated networks allow plan sponsors to split medical networks based on separate provider contracting arrangements

- **New York** contracts with separate medical plan administrators to provide their physician services and hospital facility services
  - United Healthcare currently provides the physician network and administers physician claims for all participants
  - Empire BCBS provides the hospital facility network and administers hospital claims
- **Maryland** is an all-payer state for hospital costs
  - The state regulates all inpatient and outpatient hospital charges through an all-payer rate regulation system
  - Health plans and network administrators are limited on their ability to negotiate hospital discount arrangements
  - However, health plans and network administrators are generally open to negotiate discounts with non-hospital providers as most of these services do not fall under the all-payer regulations
- **Kansas** contracts separately with Quest Diagnostics and Stormont-Vail/Cotton-O'Neil to provide outpatient and non-emergency laboratory testing
  - Members that utilizes these facilities can receive services with no member cost share, or discounted pricing terms dependent on the participant's plan election

Value-Based and Shared Savings Contracting

Value-based and shared savings network arrangements share gains with the network providers, the plan and the members

- These arrangements foster a partnership among all parties
  - Plan members are encouraged to engage through the use of incentives and disincentives
  - Medical administrators and network providers are rewarded/penalized on their ability to manage the health risk of the population
  - The plan sponsor benefits through higher quality care and lower overall claims costs
  - Requires clear communication on the guidelines, measurements, and reasons for the program
- **Maryland** has a value-based shared savings arrangement with all three of its medical administrators (CareFirst, UHC, and Kaiser)
  - Administrators are measured on their ability to improve certain provider quality metrics over the contract duration
  - Each administrator receives points for meeting annual targets and based on the total point accumulation receives a payment incentive or pays a penalty
- Some states are beginning to look at episode of care/reference-based pricing and global provider network budgets as another form of a value-based approach

State Plan Initiatives:

1. Benefit Plan Design and Program Changes
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Percentage Based Employee Cost Share

- Majority of states require employees to pay a certain percentage of the total premium
- Most use same or similar percentage for dependent coverage as for employee only coverage
- State plans typically do not offer flex credits or tie premiums to other cafeteria benefit plan options

2014 Median State Premium Subsidy

Plan Type	Coverage Tier	Employer Share	Employee Share
PPO/POS Plans	Employee Only	85%	15%
	Family	81%	19%
HMO/EPOs	Employee Only	88%	12%
	Family	84%	16%
HDHP/CDHPs	Employee Only	95%	5%
	Family	81%	19%

Source: Segal State Health Plan Study, 2014

Flat Dollar and Pegged Premiums

Flat Dollar (Employee's share is defined)

- **Minnesota** employees pays a flat dollar amount across all tiers

Pegged Premium (Employer's share is defined)

- The **Federal Employee Health Benefit Program (FEHBP)** provides a base premium payment for all available plans based on a calculated pegged subsidy
  - Federal subsidy is 72% of the average of the lowest cost national PPO plans
  - Flat dollar amount applies to any plan purchased by a federal employee
    - If employee chooses more expensive plan, employee pays the difference
    - If employee chooses less expensive plan, employee's cost is reduced dollar for dollar
- **General Motors** has historically pegged its employer contribution to the health plan that demonstrates the highest quality metric in that region
  - The pegged contribution is fixed for all available plans
  - Employee selecting lesser quality plan pays the difference in cost

Tiered Premium Structure

Pay-Based Tiers

- Employee premium share is based on compensation from the employer, with higher paid employees paying a larger percentage share of the premium cost:
  - This approach is attractive where a large portion of the workforce has low family income
  - While member premiums will be more constant as a percent of their pay, some employees view this as discriminatory against those who make median and higher pay
- **Illinois** sets the employee premium share based on 6 salary bands
- **West Virginia** includes 10 salary bands in their premium tier structure
- **Rhode Island** sets premiums based on 2 salary tiers, with employee premium share ranging from 20% – 25%. The family coverage level includes three tiers with employee premium share ranging from 15% – 25%

Plan-Based Tiers

- Employee premium is based on the overall cost of the **plan**, with the state providing a fixed amount:
  - Tiers may be based on overall plan cost, quality metrics or a combination of factors
- **Wisconsin** tiers employee premiums based on the tier in which the plan is assigned:
  - Tier 1 (lower cost) plans have lower employee premiums than Tier 2 or Tier 3 plans

Premium Credits

- The majority of state plans offer wellness programs that provide premium incentives for participation:
  - In partnership with HealthQuest, **Kansas** offers a point-based wellness program:
    - Participants are required to complete a health assessment, but then can accumulate points for completing different activities
    - Point allocation differs depending on the healthy activity
    - Employees can receive up to $240 in annual premium credits for accumulating 30 points
    - Premium incentives are applied to the following plan year
  - **Connecticut** offers a monthly premium reduction of $100 for all family units that complete the age-related preventive care requirements
- Medical Opt-Out Payment
  - **Oregon** offers employees with other medical coverage $233 per month for opting out of the state plan
  - **Wisconsin** offers employees up to $2,000 per year to opt out of the plan if covered elsewhere

Premium Surcharges

- A number of states apply a tobacco surcharge:
  - At the time of Segal's 2014 State Health Plan Study, 14 states included premium changes as a result of tobacco use:

Northeast	South	Midwest	West	Total
0	7 (AL, GA, KY, NC, SC, TX & WV)	4 (IN, KS, MO & SD)	3 (MT, OR, & WA)	14

  - **Indiana** builds a tobacco surcharge into the premium:
    - To receive the non-tobacco rate, employees must identify at enrollment as non-tobacco users and submit to tobacco testing throughout the year
    - Those that sign the agreement and later fail a tobacco test will be subject to termination of employment
  - **Alabama** includes a $60 surcharge for tobacco use:
    - Surcharge is applied separately to both the employee and their enrolled spouse (maximum of $120)
    - Premium discount of $25 per month is available for employees that participate in the wellness program
- Spousal Premium Surcharge
  - **Alabama** and **Oregon** include a $50 premium surcharge for all employee and retiree spouses that are eligible for other health insurance coverage

State Plan Initiatives:

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Retirees Included in Active Employee Plans

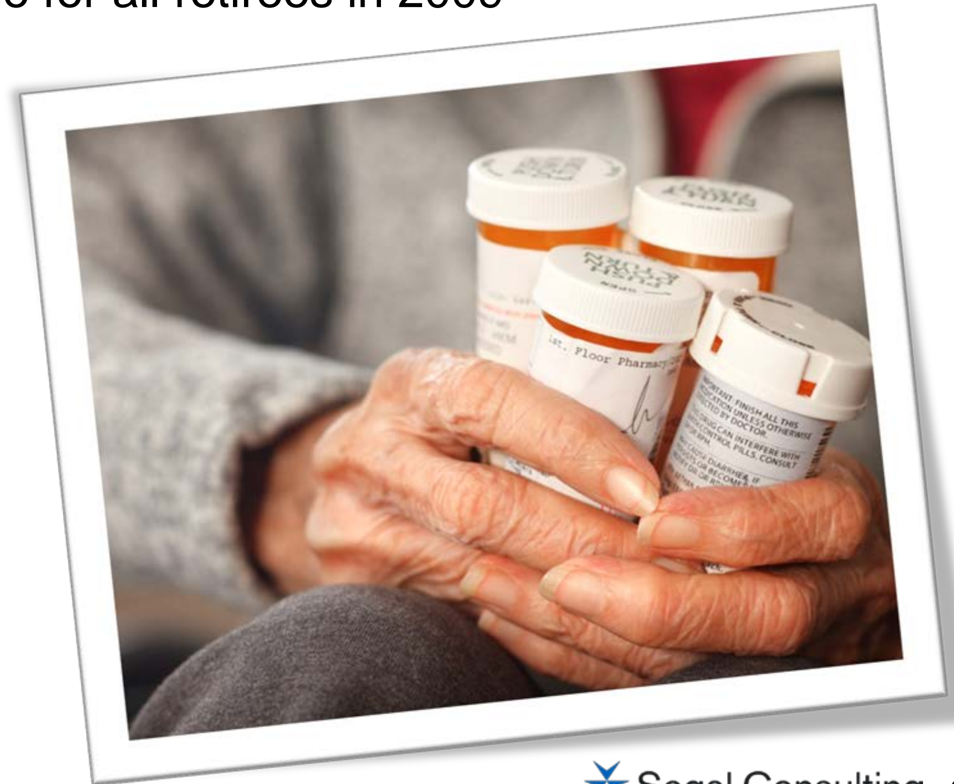
Most states include both Medicare and Non-Medicare eligible retirees in the same plans covering their active employees

- Usually the same employer subsidy as actives, reduced for Medicare eligible retirees
- Rates are reduced for Medicare primary retirees
- Rate setting uses the entire member group including both actives and retirees
- Implicit subsidy for early retirees, sometimes for Medicare retirees

Medicare Advantage Plans

A number of states offer Medicare Advantage Plans for Medicare eligible retirees

- MAPD carve-out may be optional or mandatory
- **Illinois** requires retirees and survivors who become eligible for Medicare to enroll in one of the HMO or PPO Medicare Advantage programs or opt out of coverage
- **Idaho** implemented Medicare Advantage for all retirees in 2009
- **Pennsylvania** mandated Medicare Advantage Prescription Drug plans for all Medicare eligible retirees in 2010
- **Arizona** offers a Medicare Advantage HMO alongside a traditional Medicare Supplemental Plan



Medicare Retiree Exchanges

States are beginning to look at outsourcing their retiree health insurance to an exchange

Outsource to a Private Exchange

Ohio Public Employee Retirement System (OPERS) outsourced all 145,000 of its retirees to a contracted private exchange vendor effective 1/1/2016:

- Vendor provides Medicare Advantage and Medicare supplement options for Medicare eligible retirees
- Vendor also counsels non-Medicare retirees to purchase exchange
- Fixed Health Reimbursement Arrangement amounts from OPERS, retiree pays the difference
- Phasing spousal coverage subsidy out by 2018
- Many early retirees qualify for federal exchange subsidy better than OPERS' fixed contribution
- Significant reduction in plan staff, since most work is done by the private exchange vendor

Medicare Retiree Exchanges *continued*

Build a Self-Administered Exchange

Pennsylvania Public School Employees' Retirement System (PSERS) provides a voluntary, retiree-pay-all, health benefit program for Medicare eligible retirees who lose health coverage from their local school districts:

- Now over 100,000 members and growing by 6,000 per year
- Health Options Program offers a variety of choices in an exchange environment:
  - Two self-insured Medicare supplement plans
  - Three self-insured Medicare Prescription Drug Plans (through a direct EGWP contract with CMS)
  - Dental benefits
  - Five fully insured Managed Care Organizations each offering a competitive Medicare Advantage group plan, and competing regionally where they are approved by CMS
- Third-party administrator handles eligibility and customer service, plus member counseling and premium administration

Defined Contribution Retiree Subsidy Strategies

More states are moving toward a defined contribution subsidy for retiree health benefits

Flat Dollar Contributions

- **New Hampshire** has begun to explore defined contribution alternatives to their current subsidy structure where Medicare eligible retirees receive a 100% subsidy, to address budget pressure
- **Michigan** is phasing in a flat dollar subsidy amount for all new retirees that is dependent upon the years of service with the State. Some current retirees are under a collectively bargained arrangement
- **Kansas** is exploring removing all subsides for retirees

Using Accumulated Sick Leave

- **Wisconsin** retirees are allowed to use their accumulated sick leave at retirement to pay health plan premiums
  - On average the sick leave accounts for approximately two years' worth of premium payment
  - Once sick leave runs out, retirees are responsible for 100% of the retiree premiums

Removal of Rx Coverage

- **Maryland** is currently scheduled to cease providing prescription drug coverage for Medicare retirees in 2020 with the closure of the Part D doughnut hole. Retirees would have to purchase their own Medicare Part D coverage outside the state health plan

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Telemedicine/Tele-Health Services

More states are looking at Tele-Health services as a low cost option for basic health treatments

- **Georgia** implemented a Telemedicine and Virtual Visit program effective in 2016
  - Members are charged the physician copay for each session
- **Delaware** provides Telemedicine services through its bundled carrier contracts
- **Minnesota** provides members with access to Doctor on Demand through BCBSMN
  - Participants are charged a $10 copay for access to a health care provider via the internet
- **Kentucky** offers live face-to-face sessions through mobile devices or computer webcams
  - For common health concerns such as colds, fevers, rashes, and allergies
  - These sessions are currently offered at no cost to the employee
- **Virginia** has recently conducted a pilot Telemedicine program for remote and hard to access areas of the State

Onsite Clinics and Concierge Care

Onsite clinics can save cost and promote smart plan utilization, particularly where large groups of employees are concentrated

- **Tennessee** inherited clinics from the State Department of Health and now utilizes these as onsite clinics for employees in select locations around the state
- **South Dakota** is in the process of identifying a vendor to administer an onsite clinic
- **Arizona** has contracted with a local care center located within a mile of their Capitol building. The center provides acute care, minor injuries, immunization/vaccinations, lab services, and includes an onsite pharmacy

Concierge care coordination can provide a higher perception of plan service while encouraging preventive medicine

- **New Jersey** implemented a concierge service that allows participants to pick a primary doctor and choose a direct primary care-style practice that gives around-the-clock access to preventive and primary care services

340B Prescription Drug Pricing

340B prescription drug contracts are available through hospital pharmacies and may provide better pricing on certain drugs than available through a pharmacy benefit manager

- **University of Virginia** utilizes its on-site UVa Medical Center pharmacy for access by University health plan members:
  - Encourages member access by offering prescription pick-up and delivery of scripts at various locations on campus
  - Offered a mobile pharmacy (van) for non-restricted prescription delivery
  - Member acceptance has been somewhat slow, since many prefer to use neighborhood pharmacies near their residence rather than be seen picking up prescriptions on the University campus

Integration of Initiatives

To be most effective, initiatives need to be well-reasoned and integrated

- Keep goals clearly in mind:
  - Cost containment
  - Premium and cost sharing equity
  - Population health improvement
  - Access
  - High quality and cost efficient care
- What is the objective for each program and how does it fit into the overall strategic plan?
- A single initiative may have only a small overall effect, while carefully coordinated sets of initiatives can have major impact
- Important to involve providers and carriers as well as participants
- Member satisfaction is important, but so are health management and the long-term affordability of the plan

Impact of Initiatives

It is important to determine how initiatives affect different program concerns and how they work together

Initiative	Plan Costs	Out-of-Pocket Costs	Participant Contributions	How Care Is Provided	What Care Is Required
Plan Design	✓	✓	✓		
Wellness	✓				✓
Provider Contracting	✓			✓	
Premium Subsidies	✓		✓		
Retiree Health Strategies	✓		✓	✓	
Telemedicine	✓			✓	
Onsite Clinics	✓	✓		✓	
340B Drug Pricing	✓	✓		✓	

Thank you!

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North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Analysis of State Health Plan Utilization and Costs by Region

Board of Trustees Meeting

June 3, 2016

A Division of the Department of State Treasurer

Presentation Overview

- Study Approach and Demographics
- Analysis by Region
  - Spending
  - Utilization
  - Per Member Annual Costs

Review of Approach

- The State Health Plan and The Segal Company, the Plan's actuarial firm, broke the State into 16 regions based on the ACA Exchange for CY 2014 and CY 2015
  - Members were assigned to a region based on their address in the Plan's eligibility file
  - Active and *non-Medicare Advantage* retiree claims were included

- The Plan compared the regions by:
  - Utilization of services
  - Cost per unit
  - Per Member Per Year (PMPY) Cost

North Carolina Regions

Region	Major City/Town	Region	Major City/Town	Region	Major City/Town
1	Asheville	6	Winston-Salem	12	Elizabeth City
2	Hickory	7	Greensboro	13	Raleigh
3	Boone	8	Southern Pines	14	Greenville
4	Charlotte	9	Fayetteville	15	Wilmington
5	Gastonia	10	Henderson	16	New Bern
		11	Durham		

Statewide Demographics

- Demographics for CY 2015
  - Most State Health Plan members are female, 61.8%; 38.2% are male
  - Among Plan members who live in NC and are in a BCBSNC-administered plan (i.e., Traditional 70/30, Enhanced 80/20, CDHP 85/15):
    - 19% are younger than 20
    - 19% are 20-35
    - 22% are 36-49
    - 31% are 50-64
    - 9% are 65 or older
  - 30.6% of members are dependents on the Plan with either a parent or spouse as the subscriber
  - Demographics were consistent in CY 2014
- Statewide Average Cost: Allowed PMPY was **$5,466** ($455.50 PMPM) in CY 2015; up 4.1% from CY 2014
  - Resulted in a loss ratio of 103% for the Plan's share of costs for members enrolled in the BCBSNC-administered plan options
    - CY 2014 loss ratio was also 103%
    - Dependents and non-Medicare retirees have the highest loss ratio

Analysis by Region

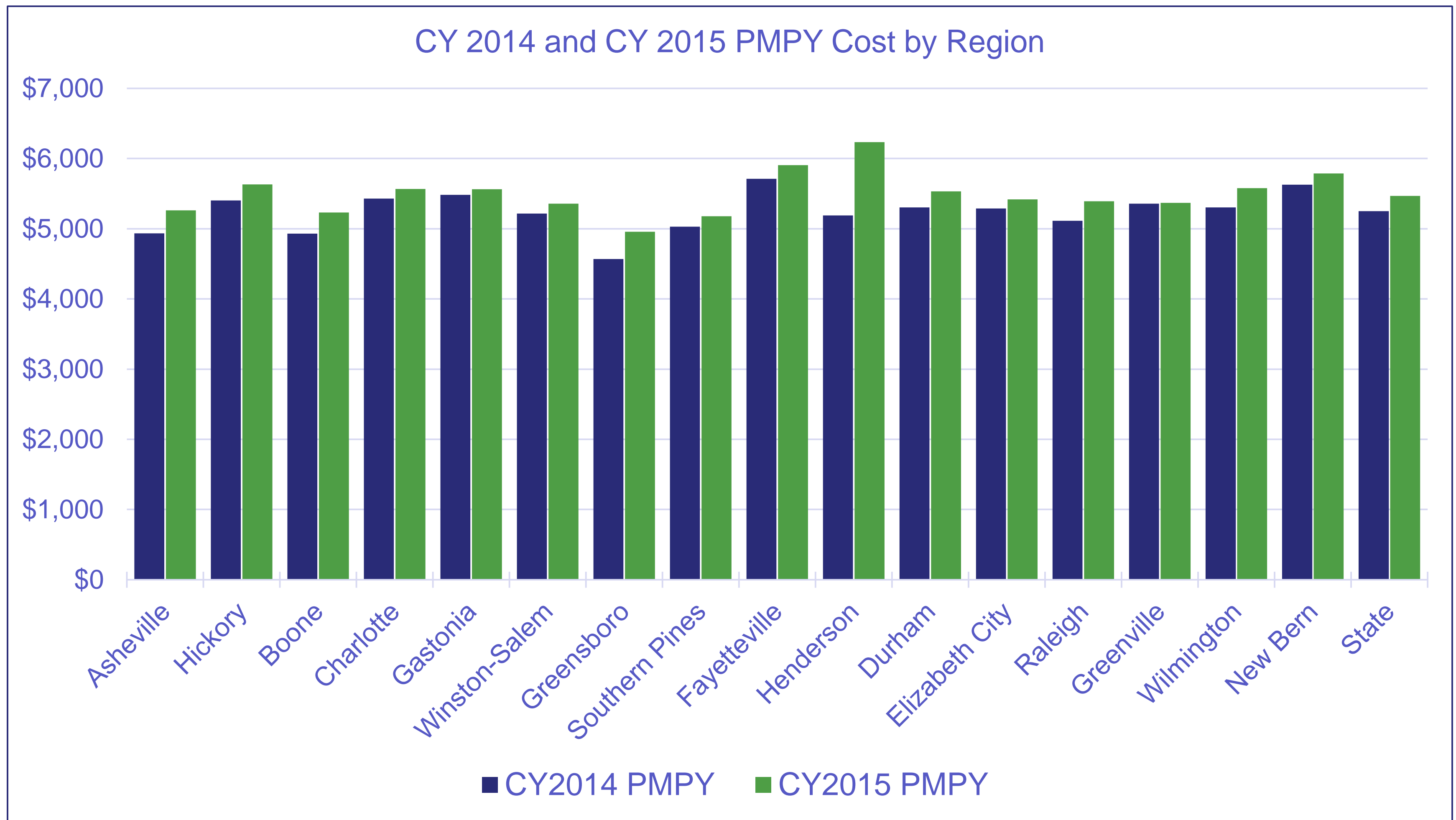
Why Are Costs Higher in Some Places?

Common Theories

- Prices
  - Negotiated discounts from billed charge amount are not as good: **False.**
  - Unit prices are higher: **True.**

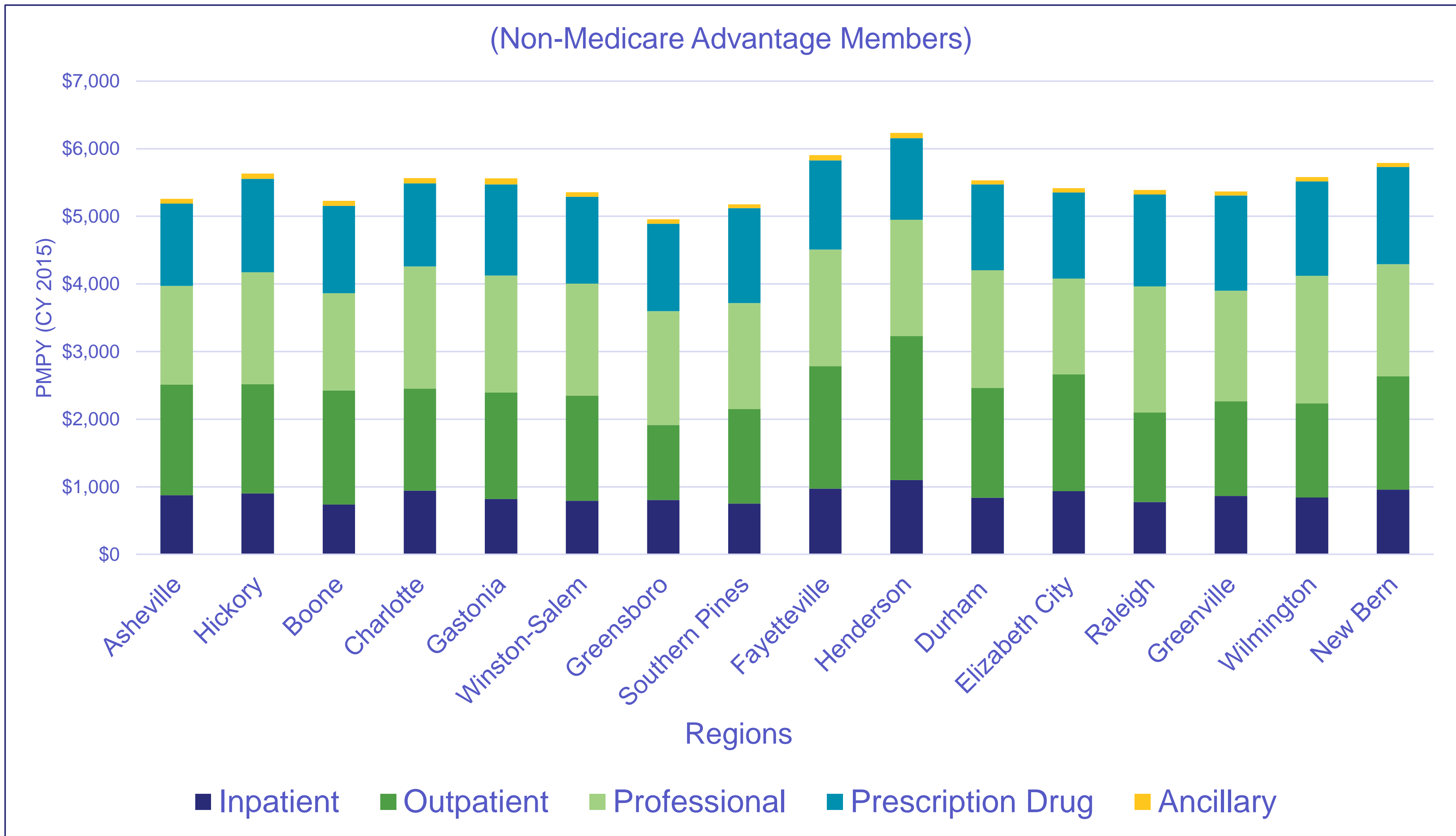
- Utilization
  - Less healthy membership in a region *leads to* higher utilization of services *which leads to* higher costs: **Mostly True.**
  - Higher utilization of costly, low-value services (e.g., emergency room, ambulance): **Mostly False.**

PMPY Spending by Region*



** Regions identified by major city/town. See page 4 for map of regions and counties included.*

CY 2015 PMPY Spending by Service Category



Regional Variance CY 2015

Region	PMPY (rank 1= lowest))	Overall Utilization	Cost Per Unit
Asheville	$5,260 (4)	Low	Average
Hickory	$5,632 (13)	High	Average
Boone	$5,231 (3)	Average	Low
Charlotte	$5,566 (11)	Average	High
Gastonia	$5,563 (10)	Average	High
Winston-Salem	$5,356 (5)	Average	Mixed
Greensboro	$4,956 (1)	Average	Low
Southern Pines	$5,178 (2)	Average	Mixed
Fayetteville	$5,905 (15)	High	High
Henderson	$6,233 (16)	Mixed	Mixed
Durham	$5,532 (9)	Mixed	Mixed
Elizabeth City	$5,417 (8)	Low	Mixed
Raleigh	$5,392 (7)	Mixed	Mixed
Greenville	$5,367 (6)	Average	Mixed
Wilmington	$5,579 (12)	High	Average
New Bern	$5,789 (14)	Average	Mixed

Unit Costs and Utilization by Region and PMPM

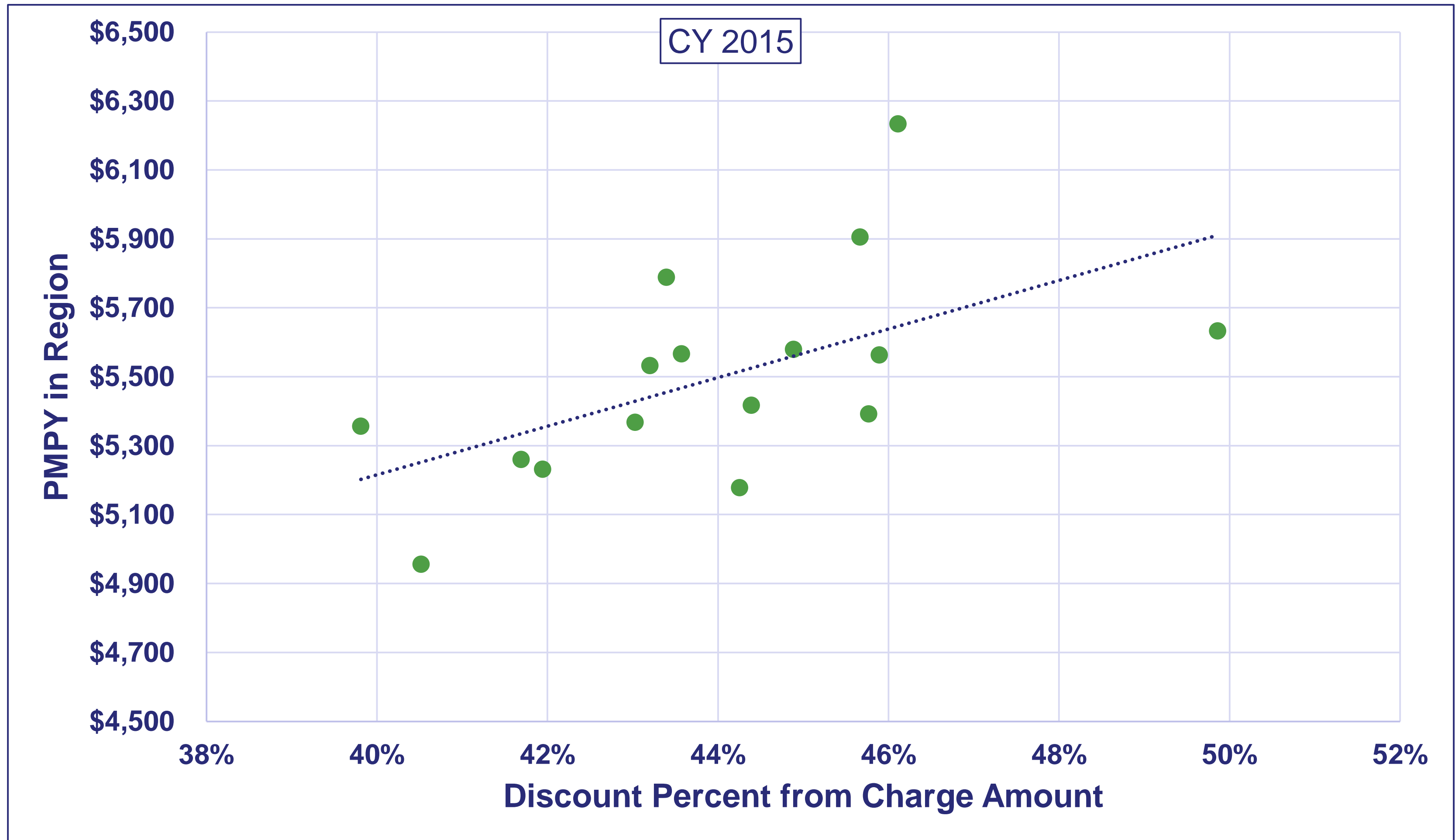
(PMPM/Rank)

Rank: lowest = 1; highest =16

		Utilization		
		High	Average/Mixed	Low
Unit Costs	High	Fayetteville ($492/15)	Charlotte ($464/11) Gastonia ($464/10)	
	Average/ Mixed	Hickory ($469/13) Wilmington ($465/12)	Henderson ($519/16) New Bern ($482/14) Durham ($461/9) Raleigh ($449/7) Greenville ($447/6) Winston-Salem ($446/5) So. Pines ($431/2)	Elizabeth City ($451/8) Asheville ($438/4)
	Low		Boone ($436/3) Greensboro ($413/1)	

- Utilization of hospital-based services is probably a better predictor of cost than overall utilization
  - For example, Henderson has very low utilization of office visits and prescription drugs but very high hospitalization rates

Aggregate Discount versus PMPY



- Better discounts do not necessarily lead to lower costs

Key Takeaways

- In general, the PMPY costs were consistent year over year
  - Henderson had the largest cost increase that is mainly driven by a large increase in hospitalizations
- PMPY costs are rising at various rates throughout the state but they are rising everywhere with the exception of Greenville
- Fayetteville is one of the highest cost markets, while Greensboro has been the lowest cost market in both CY 2014 and CY 2015
  - Fayetteville has high unit costs and high utilization
  - Greensboro is low in both

Key Takeaways

- The State Health Plan serves a very diverse set of members and providers
- Steep discounts don't necessarily lead to lower per member expenditures
- Inpatient costs are an important cost driver and unit cost is higher in the metropolitan areas where there is more competition
- Unit cost varies throughout the state on hospitalizations but there also appears to be variation in services like prescription drugs and ancillary services
- To control cost growth the state will need multiple strategies
  - Strategies to consider:
    - Quality-based payments
    - Unit cost
    - Discounts
    - Utilization

Next Steps

- Review CY 2016 data; look to see which patterns hold with another year of data
- Have discussions with BCBSNC regarding regions and where it appears we might have opportunity to reduce certain costs (inpatient, professional, etc.)
- Look for pilot project opportunities in areas where:
  - Member health is poor
  - Utilization patterns are not what we expect or want
    - ER too high
    - Preventive, PCP, and immunization too low

Appendix: The 16 State Regions

Region 1: Asheville/Western NC

- Demographics
  - Higher percentage of males (41.3%) than average; about average age
  - Average proportion of dependents
- Cost: Allowed PMPY is **$5,260**, 4th lowest among 16 regions
  - Cost growth: 6.6%, 3rd highest among 16 regions
  - Overall utilization is **low**
    - Low on: Inpatient Hospital; Physician; Pharmacy
    - High on: Outpatient Hospital; Ancillary
  - Cost per unit is **average**
    - Low on: Ancillary; Physician Services
    - High on: Inpatient Hospital

Region 2: Hickory

- Demographics
  - Average percentage of females (61.6%), average age
  - Above average proportion of dependents
- Cost: Allowed PMPY is **$5,632**, 4th highest among 16 regions
- Cost growth: 4.2%, 8th highest among 16 regions
  - Overall utilization is **high**
    - Low on: Nothing
    - High on: Prescription Drugs
  - Cost per unit is **average**
    - Low on: Physician Services
    - High on: Ambulance and Anesthesia

Region 3: Boone

- Demographics
  - Highest percentage of males (44.3%), average age
  - Highest proportion of dependent members among regions
- Cost: Allowed PMPY is **$5,231**, 3rd lowest among 16 regions
- Cost growth: 6.1%, 4th highest among 16 regions
  - Overall utilization is **average**
    - Low on: Inpatient Hospital; Physician
    - High on: Outpatient Hospital; Ancillary Services
  - Cost per unit is **low**
    - Low on: Inpatient Hospital; Outpatient Hospital; Physician Services
    - High on: Nothing

Region 4: Charlotte

- Demographics
  - Smallest percentage of males (35.8%) and probably the youngest group on average with 41.5% under 36
  - Average proportion of dependent members
- Cost: Allowed PMPY is **$5,566**, 6th highest among 16 regions
- Cost growth: 2.5%, 4th lowest among 16 regions
  - Overall utilization is **average**
    - Low on: Hospital Outpatient; Prescription Drugs
    - High on: Physician Services
  - Cost per unit is **high**
    - Low on: Nothing
    - High on: Inpatient Hospital; Outpatient Hospital; Physician; Ancillary; Prescription Drugs

Region 5: Gastonia

- Demographics
  - Above average percentage of females (64.0%); slightly younger than average
  - Slightly above average proportion of dependents
- Cost: Allowed PMPY is **$5,563**, 7th highest among 16 regions
- Cost growth: 1.5%, 2nd lowest among 16 regions
  - Overall utilization is **average**
    - Low on: Inpatient Hospital; Outpatient Hospital
    - High on: Physician Services; Prescription Drugs; Ancillary Services
  - Cost per unit is **high**
    - Low on: Physician Services
    - High on: Outpatient Hospital; Ancillary Services

Region 6: Winston-Salem

- Demographics
  - Below average percentage of males (36.8%); about average age
  - Average proportion of dependents
- Cost: Allowed PMPY is **$5,356**, 5th lowest among 16 regions
- Cost growth: 2.7%, 5th lowest among 16 regions
  - Overall utilization is **average**
    - Low on: Inpatient Hospital; Physician Services
    - High on: Outpatient Hospital
  - Cost per unit is **mixed**
    - Low on: Outpatient Hospital; Ancillary Services
    - High on: Physician Services

Region 7: Greensboro

- Demographics
  - Above average percentage of females (64.3%); a little younger than average
  - Slightly below average proportion of dependents
- Cost: Allowed PMPY is **$4,956**, lowest among 16 regions
- Cost growth: 8.4%, 2nd highest among 16 regions
  - Overall utilization is **average**
    - Low on: Outpatient Hospital; Prescription Drugs
    - High on: Inpatient Hospital
  - Cost per unit is **low**
    - Low on: Inpatient Hospital; Outpatient Hospital
    - High on: Nothing

Region 8: Southern Pines

- Demographics
  - Above average percentage of males (40.8%); above average age
  - Average proportion of dependents
- Cost: Allowed PMPY is **$5,178**, 2nd lowest among 16 regions
- Cost Growth: 3.0%, 10th highest among 16 regions
  - Overall utilization is **average**
    - Low on: Inpatient Hospital; Ancillary Services
    - High on: Outpatient Hospital
  - Cost per unit is **mixed**
    - Low on: Physician Services
    - High on: Ancillary Services

Region 9: Fayetteville

- Demographics
  - Above average percentage of females (63.2%); above average age
  - Low proportion of dependents
  - Highest percentage of high cost claimants (0.21%)
- Cost: Allowed PMPY is **$5,905**, 2nd highest among 16 regions
- Cost Growth: 3.4%, 9th highest among 16 regions
  - Overall utilization is **high**
    - Low on: Nothing
    - High on: Inpatient Hospital; Outpatient Hospital; Physician Services; Prescription Drugs; Ancillary Services
  - Cost per unit is **high**
    - Low on: Prescription Drugs
    - High on: Inpatient Hospital; Ancillary Services

Region 10: Henderson

- Demographics
  - Average percentage of males (38.2%); older members, low percentage of members under 36 years old
  - Lowest proportion of dependents in 16 regions
  - High proportion of high cost claimants
- Cost: Allowed PMPY is **$6,233**, the highest among 16 regions
- Cost Growth: 20.1%, highest among 16 regions
  - Overall utilization is **mixed** (high for hospitalization, low for physician)
    - Low on: Physicians Services
    - High on: Inpatient Hospital; Outpatient Hospital; Ancillary Services
  - Cost per unit is **mixed**
    - Low on: Prescription Drugs
    - High on: Physician Services

Region 11: Durham

- Demographics
  - Slightly above average percentage of males (39.5%); younger members, high percentage of members under 36 years old
  - Above average proportion of dependents
- Cost: Allowed PMPY is **$5,532**, the 8th highest among 16 regions
- Cost Growth: 4.3%, 7th highest among 16 regions
  - Overall utilization is **mixed**
    - Low on: Prescription Drugs
    - High on: Outpatient Hospital
  - Cost per unit is **mixed**
    - Low on: Inpatient Hospital; Outpatient Hospital
    - High on: Prescription Drugs; Physician Services

Region 12: Elizabeth City

- Demographics
  - Slightly above average percentage of males (39.5%); older members
  - Low proportion of dependents
- Cost: Allowed PMPY is **$5,417**, the 8th lowest among 16 regions
- Cost Growth: 2.4%, 3rd lowest among 16 regions
  - Overall utilization is **low**
    - Low on: Physician Services
    - High on: Outpatient Hospital
  - Cost per unit is **mixed**
    - Low on: Outpatient Hospital
    - High on: Inpatient Hospital

Region 13: Raleigh

- Demographics
  - Average percentage of females (61.1%); slightly younger members
  - Above average proportion of dependents
- Cost: Allowed PMPY is **$5,392**, the 7th lowest among 16 regions
- Cost Growth: 5.9%, 12th highest among the 16 regions
  - Overall utilization is **mixed**
    - Low on: Outpatient Hospital; Prescription Drugs
    - High on: Physician Services
  - Cost per unit is **mixed**
    - Low on: Inpatient Hospital
    - High on: Prescription Drugs

Region 14: Greenville

- Demographics
  - Average percentage of males (37.6%); average age
  - Average proportion of dependents
- Cost: Allowed PMPY is **$5,367**, the 6th lowest among 16 regions
- Cost Growth: 0.2%, the lowest among 16 regions
  - Overall utilization is **average**
    - Low on: Outpatient Hospital
    - High on: Nothing
  - Cost per unit is **mixed**
    - Low on: Ancillary Services
    - High on: Outpatient Hospital

Region 15: Wilmington

- Demographics
  - Average percentage of females (61.4%) and slightly older than average
  - Average proportion of dependents
- Cost: Allowed PMPY is **$5,579**, the 5th highest among 16 regions
- Cost Growth: 5.2%, 11th highest among 16 regions
  - Overall utilization is **high**
    - Low on: Outpatient Hospital; Ancillary Services
    - High on: Physician Services
  - Cost per unit is **average**
    - Low on: Inpatient Hospital
    - High on: Prescription Drugs

Region 16: New Bern

- Demographics
  - Slightly above average percentage of males (39.1%); slightly older membership
  - Slightly low proportion of dependents
  - 3rd highest percentage of high cost claimants (0.20%)
- Cost: Allowed PMPY is **$5,789**, the 3rd highest among 16 regions
- Cost Growth: 2.9%, 6th lowest among 16 regions
  - Overall utilization is **average**
    - Low on: Ancillary Services
    - High on: Physician Services
  - Cost per unit is **mixed** (high for hospitalization, low for physician)
    - Low on: Physician Services
    - High on: Inpatient Hospital; Outpatient Hospital

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Legislative Update

Board of Trustees Meeting

June 3, 2016

A Division of the Department of State Treasurer

Legislative Update Overview

- Budget Update
- Plan-Requested Legislation
- Other Plan-Related Legislation
- Next Steps

Governor's Budget HB 1140 & SB 885, 1st Editions

- The Governor released his FY 2016-17 Recommended Budget Adjustments on April 27th
  - Introduced as HB 1140 and SB 885 on May 23, 2016

- Reallocates $71 million held in reserve for the employer share of CY 2017 premium increases due to inaction by the State Health Plan Board

- Section 6.13(a) of HB 1140 and SB 885 appropriates funds in the Medicaid Contingency Reserve established in Section 12H.38(a) of SL 2015-241 to a statewide reserve for various purposes, including:
  - $71 million for the State Health Plan if the General Assembly deems that the Plan has met the requirements of Section 30.26 of SL 2015-241

- Section 25.6(c) sets the FY 2016-17 maximum annual employer contribution for health plan coverage at the same amounts as allowed for FY 2015-16

House Budget HB 1030, 4th Edition

- House budget passed May 19th
- Eliminates the General Fund *Reserve for Future Benefits Needs*, redirecting the $71 million state agency budgets to pay for increased employer contributions to the State Health Plan in FY 2016-17.
- Section 30.20 sets the FY 2016-17 maximum annual employer contributions for health plan coverage and reflects a 3.43% increase over the FY 2015-16 amounts.
- Section 36.24 replaces the 2015 special provision with a new one that:
  - Finds the Treasurer and Board adopted sufficient measures for CY 2017 to limit projected increases in the employer contribution
  - Directs the Treasurer and Board to adopt additional measures for CYs 2018 and 2019 to limit increases in FB 2017-19
  - Eliminates language requiring maintenance of 20% cash reserve (Section 30.26(b) of SL 2015-241)

House Budget HB 1030, 4th Edition

State Health Plan Cost Controlling Measures

SECTION 36.24.(a) The General Assembly finds that the State Treasurer and the Board of Trustees of the State Health Plan for Teachers and State Employees (Board of Trustees) have adopted sufficient measures for the 2017 calendar year to limit projected employer contribution increases. **The State Treasurer and the Board of Trustees shall adopt additional measures applicable to the 2018 and 2019 calendar years to limit projected employer contribution increases during the 2017-2019 fiscal biennium.**

SECTION 36.24.(b) Section 30.26 of S.L. 2015-241 is repealed.

Senate Budget, HB 1030, 6th Edition

- Senate budget passed June 3rd
- Does not release funds held in the *Reserve for Future Benefits Needs* to pay for increased employer contributions to the State Health Plan in FY 2016-17
- Section 36.20 sets the FY 2016-17 maximum annual employer contribution for health plan coverage at the same amounts as allowed for FY 2015-16
  - But also authorizes a 3.43% increase in the FY 2016-17 employer contribution if the Director of the Budget (i.e. the Governor or OSBM or other designee) reallocates the *Reserve for Future Benefits Needs* as provided in Section 36.24.
- Section 36.24
  - Directs the Treasurer and Board to adopt measures for CYs 2017, 2018 and/or 2019 to limit increases in the employer contribution.
  - Authorizes the Director of the Budget to release the *Reserve for Future Benefits Needs* if measures adopted by the Plan are sufficient to reduce the projected increase in employer contributions to 4% or less for CYs 2018 and 2019, assuming the release of *Reserve* funds
  - Modifies 2015 special provision (Section 30.26(b) of SL 2015-241) to reduce the required cash reserve threshold from 20% of annual costs to 12% (Section 30.26(b) of SL 2015-241)

Senate Budget, HB 1030, 6th Edition

State Health Plan Cost-Controlling Measures and Reallocation of Reserve for Future Benefit Needs

SECTION 36.24.(a) The State Treasurer and the Board of Trustees shall adopt measures applicable to any or all of the 2017, 2018, or 2019 calendar years to limit projected employer contribution increases.

SECTION 36.24.(b) **If the Director of the Budget determines that the additional cost-controlling measures adopted by the Board of Trustees and the State Treasurer as directed in subsection (a) of this section are sufficient to reduce the projected employer premium increases to four percent (4%) or less in both the 2018 and 2019 plan years, then the Director of the Budget is authorized to reallocate funds in the Reserve** for Future Benefit Needs to individual State agency budgets. The projected employer premium increases should be calculated assuming the Reserve for Future Benefit Needs is reallocated.

SECTION 36.24.(c) SECTION 36.24.(c) Section 30.26(b) of S.L. 2015-241 reads as rewritten: "SECTION 30.26.(b) **During the 2015-2017 fiscal biennium, the State Health Plan for Teachers and State Employees shall maintain a cash reserve of at least ~~twenty~~ twelve percent ~~(20%)~~ (12%) of its annual costs.** For purposes of this section, the term "cash reserve" means the total balance in the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund established in G.S. 135-48.5 plus the Plan's administrative account, and the term "annual costs" means the total of all medical claims, pharmacy claims, administrative costs, fees, and premium payments for coverage outside of the Plan."

State Health Plan Budget Update

Funding for Increase in the Employer Contribution for Health Plan Coverage

	April 2015 Forecast	Governor's Recommended Budget	House Budget Proposal	Senate Budget Proposal	Final State Budget
Premium Increase					
FY 2016-17	3.43% Jan 1, 2017	0.00%[1]	3.43%	0.00% or 3.43%[2]	TBD
General Fund Appropriations					
FY 2016-17	$70.2 m	$0 m	$71.0 m	$0 m or $71.0 m[2]	TBD

1. Governor's proposed budget would require a decrease in the employer contribution due to the Plan's move to calendar year impacting when premiums are adjusted. Based on the recommended annual funding level, the Plan would need to reduce the employer contribution by 3.35% for CY 2017.
2. If the Director of the Budget determines that additional cost-controlling measures adopted by the Treasurer and Board are sufficient to reduce the projected employer premium increases to 4%, then the Director is authorized to reallocate funds for FY 2016-17.

HB 1121/SB 865 State Health Plan Admin Changes/Local Govts

- Filed in House and Senate on May 10th
  - HB 1121 and SB 865 include provisions that address the following State Health Plan issues:
    - Mandate contractor release of data to the Plan;
    - Seek to clarify Plan's exemption from certain contracting rules;
    - Modify local government participation in the Plan; and
    - Clarify ACA reporting responsibilities for State employers;
  - SB 865 increases the cap on local government participation in the Plan to 20,000 individuals; HB 1121 does not include this provision
  - HB 1121 referred to House Committee on State Personnel
  - SB 865 referred to Senate Committee on Insurance

HB 1121/SB 865 State Health Plan Admin Changes/Local Govts

- The language requested by the Plan to require local governments to follow the premium structure approved by the Board with respect to employee premiums was not included in either the House or Senate versions of the bill
  - As drafted, local governments retain authority to charge lower premiums
    - The bills do prohibit local governments from charging more
  - The Plan is engaging sponsors to revise the language in this section to address Plan concerns and honor the Board's premium strategy

HB 1027/SB 808: Study Unfunded Liability of Retiree Health Benefit

- Bill Summary:
  - Establishes a Joint Legislative Committee to study options aimed at reducing the long-term, unfunded liability of the Retiree Health Benefit Fund
    - Treasurer, Executive Administrator, and Board of Trustees member would serve on an *Ex Officio* basis
  - Options such as increased appropriations from the General Assembly, auto-enrollment into Medicare Advantage Plans, increasing retiree premiums and cost-share, etc.

- Status: *Passed by the House on May 24th* ; Senate referred to Committee on Pensions & Retirement and Aging

- Fiscal Impact: None, due to study bill

SB 815: Charter School in the State Health Plan

- Bill Summary:
  - Allows active employees (and their dependents) of Longleaf School of the Arts to enroll in the State Health Plan
    - Does not allow retirees to enroll in the Plan

- Status: Referred to Senate Insurance Committee

- Fiscal Impact: TBD

Next Steps

Budget Related

- Continue to monitor the budget bill as it moves through the legislative process, with an emphasis on the availability of funds for an increase in the employer premium contribution for 2017

Substantive Legislation

- Track Plan-related legislation and work to move Plan-supported bills through the committee processes
- Determine and communicate Plan's position on any additional legislation of interest