Board of Trustees Meeting
Thursday, May 12, 2016

1.	Welcome	Andrew Holton, Chair
2.	Conflict of Interest Statement	Andrew Holton, Chair
3.	Review of Minutes ***(Requires Board Approval)***	Andrew Holton, Chair
	a. January 26, 2016	
	b. February 5, 2016	
	c. March 10, 2016	
	d. April 27, 2016	
4.	Clinical & Wellness Programs and Operations	
	a. Patient Centered Medical Home Practice Pilot *(90 minutes)*	
	i. Eagle Physicians & Associates	**Dr. Jim Osborne** Director of Contracting & Quality Improvement **Vicki Gregory** Chief Executive Officer
	ii. CaroMont Medical Group	**Lynda Hoyt** Director of Physician Contracting **Heather McConnell** Managed Care Quality Manager
	iii. New Hanover Medical Group	**John Wheeler** Practice Director **Marian Proctor, MSHI, BSN, RN, CCM** Care Coordination Manager **Deborah Musselwhite, RN** Corporate Clinical Supervisor **Diana Amedy BSN, RN** Quality and Performance Improvement Coordinator II
	iv. Novant Medical Group, Inc	**Marimartha Matthews** Senior Director Managed Care Contracting and Growth **Rea Buie, RN, BSN,** SANE-A-Manager Care Connections Program
	b. RivalHealth Wellness Program *(30 minutes)*	Christine Allison Pete Durand RivalHealth
5.	Adjourn	Andrew Holton, Chair

Board of Trustees Meeting
Friday, May 13, 2016

1.	Welcome	Andrew Holton, Chair
2.	Conflict of Interest Statement	Andrew Holton, Chair
3.	Financial Report, Forecasting and Monitoring *(30 minutes)*	Mark Collins
	a. Calendar Year 2015 Financial Report	
	b. March 2016 Financial Report	
4.	Legislative Update *(15 minutes)*	Matt Grabowski
5.	Benefit Design, Plan Options and Premiums	
	a. 2017 Benefit Design Changes ***(Requires Board Approval)*** *(60 minutes)*	Mona Moon

Break (10 minutes)

b. Modify Coverage of Specialty Medications ***(Requires Board Approval)*** *(15 minutes)*	Caroline Smart
c. Pharmacy Benefit Management Implementation *(30 minutes)*	Caroline Smart
d. Medicare Advantage Update *(5 minutes)*	Caroline Smart
e. Member and Public Comment on Proposed Changes	TBD
f. Board Action on Proposed Benefit Design Changes & Specialty Transition	

Lunch (30 minutes)

6.	Member Experience and Communications *(30 minutes)*	Beth Horner
	a. Communications & Marketing Strategy Update	
	b. Diabetes Prevent Program Launch	
	c. Online Enrollment Experience	
	d. 2017 Open Enrollment Communications	

7. Contracting and Vendor Partnerships
    a. Third Party Liability Recovery Services RFP *(5 minutes)* — Greg Moore
    b. Auditing Services Results
        i. Medical Claims *(10 minutes)* — Greg Moore
        ii. Pharmacy Claims & Financial Terms *(15 minutes)* — Natasha Davis

8. Clinical & Wellness Programs and Operations

    Pharmacy & Therapeutics Committee February Meeting *(15 minutes)* — David Boerner

Break (10 minutes)

9. Executive Session (for Board members only) *(30 minutes)* — Andrew Holton, Chair

    Pursuant to: G.S. 143-318.11 and G.S. 132-1.2

    Consultation Regarding Medicare Advantage Renewals (G.S. §143.318.11(a)(1)) — Caroline Smart, Mark Collins

6. Adjourn — Andrew Holton, Chair

Next Regularly Scheduled Meeting: August 4 and 5, 2016

Calendar Year 2015 Year-End Financial Report

Board of Trustees Meeting

May 12, 2016

A Division of the Department of State Treasurer

Financial Results: Actual v. Budgeted Calendar Year 2015

Calendar Year 2015	Actual thru Dec 2015	Authorized Budget (per Segal 4-28-15)	Variance Over/(Under) Budget
Beginning Cash Balance	**$1.015 b**	**$1.015 b**	**$0.0 m**
Plan Revenue	**$3.069 b**	**$3.030 b**	**$38.6 m**
Net Claims Payments	$2.709 b	$2.766 b	($57.0 m)
Medicare Advantage Premiums	$172.5 m	$174.1 m	($1.6 m)
Net Administrative Expenses	$187.4 m	$239.8 m	($52.4 m)
Total Plan Expenses	**$3.069 b**	**$3.180 b**	**($111.0 m)**
Net Income/(Loss)	**$0.4 m**	**($149.2 m)**	**$149.6 m**
Ending Cash Balance	**$1.015 b**	**$865.6 m**	**$149.6 m**

Adjusted Variance Report
Calendar Year 2015

Calendar Year 2015	Actual thru Dec 2015, As Adjusted	Authorized Budget (per Segal 4-28-15)	Variance Over/(Under) Budget
Plan Revenue *	**$3.041 b**	**$3.030 b**	**$11.0 m**
Net Claims Payments ^	$2.743 b	$2.766 b	($22.6 m)
Medicare Advantage Premiums	$172.5 m	$174.1 m	($1.6 m)
Net Administrative Expenses *	$178.3 m	$239.8 m	($61.5 m)
Total Plan Expenses	**$3.094 b**	**$3.180 b**	**$85.7 m**
Net Income/(Loss)	**($52.5 m)**	**($149.2 m)**	**$96.7 m**

* Adjusted for timing issues.
^ Adjusted to exclude unbudgeted rebates and recoveries.

Financial Results Actual v. Budgeted Calendar Year 2015

Per Member Per Month (PMPM) Analysis

Calendar Year 2015	Actual thru Dec 2015	Authorized Budget (per Segal 4-28-15)	Variance Over/(Under) Budget
Plan Revenue	**$372.60**	**$369.03**	**$3.57**
Net Claims Payments	$329.60	$337.00	($7.40)
Medicare Advantage Premiums	$20.99	$21.21	($0.22)
Net Administrative Expenses	$22.81	$29.23	($6.42)
Total Plan Expenses	**$373.40**	**$387.44**	**($14.04)**
Net Income/(Loss)	**($0.80)**	**($18.41)**	**$17.61**

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

Adjusted Variance Report
Calendar Year 2015

Per Member Per Month (PMPM) Analysis

Calendar Year 2015	Actual thru Dec 2015, as Adjusted	Authorized Budget (per Segal 4-28-15)	Variance Over/(Under) Budget
Plan Revenue *	**$369.25**	**$369.03**	**$0.22**
Net Claims Payments ^	$333.78	$337.00	($3.22)
Medicare Advantage Premiums	$20.99	$21.21	($0.22)
Net Administrative Expenses *	$21.70	$29.23	($7.53)
Total Plan Expenses	**$376.47**	**$387.44**	**($10.97)**
Net Income/(Loss)	**($7.22)**	**($18.41)**	**$11.19**

* Adjusted for timing issues.
^ Adjusted to exclude unbudgeted rebates and recoveries.

Calendar Year 2015 Expenditure Trend Per Member Per Month

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

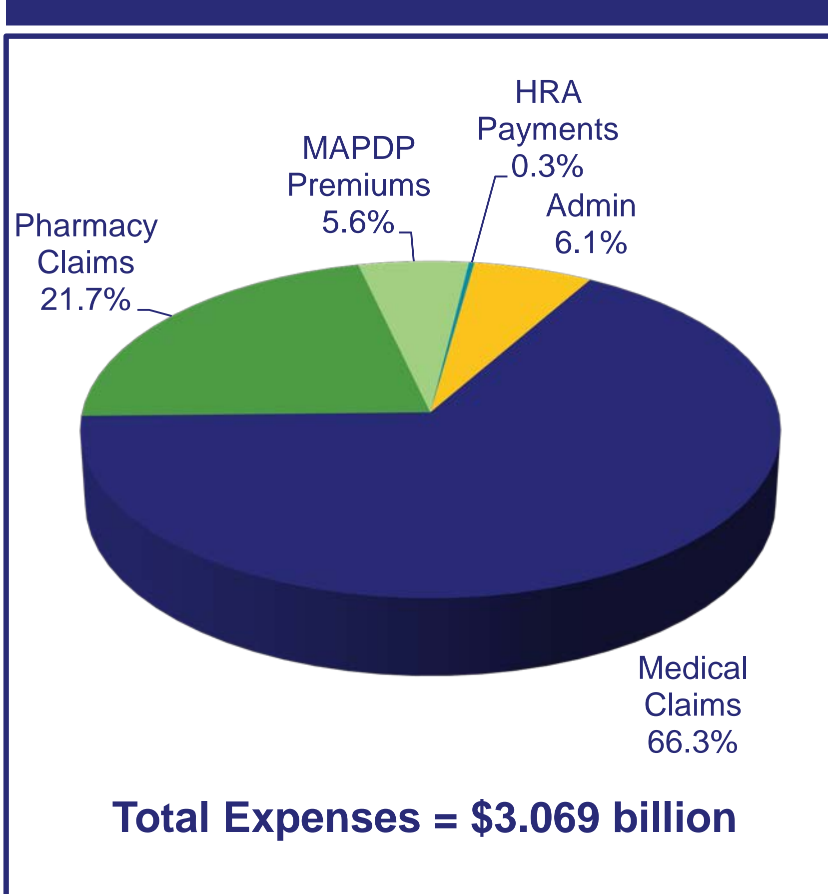
Calendar Year 2014 Budgeted = $367.60
Actual = $348.53

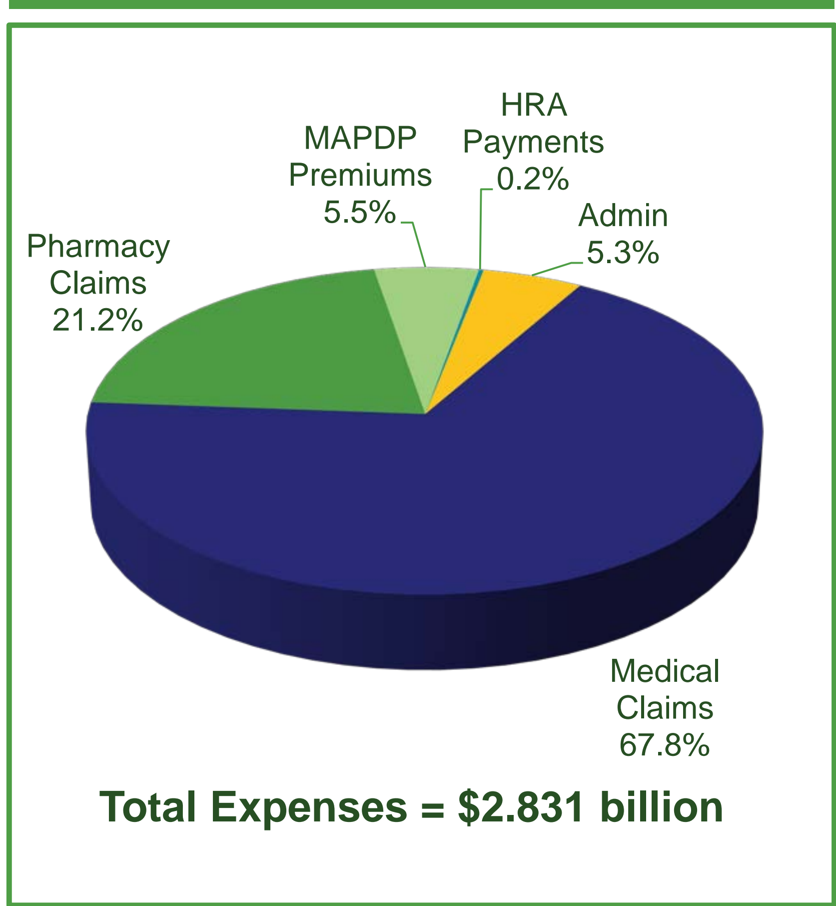
Calendar Year 2015 Budgeted = $387.44
Actual = $373.40

Jan-14 Feb-14 Mar-14 Apr-14 May-14 Jun-14 Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15

YTD Actual Expenses
YTD Budgeted Expenses
Budgeted PMPM CY 2014
Budgeted PMPM CY 2015

Allocation of Total Expenditures

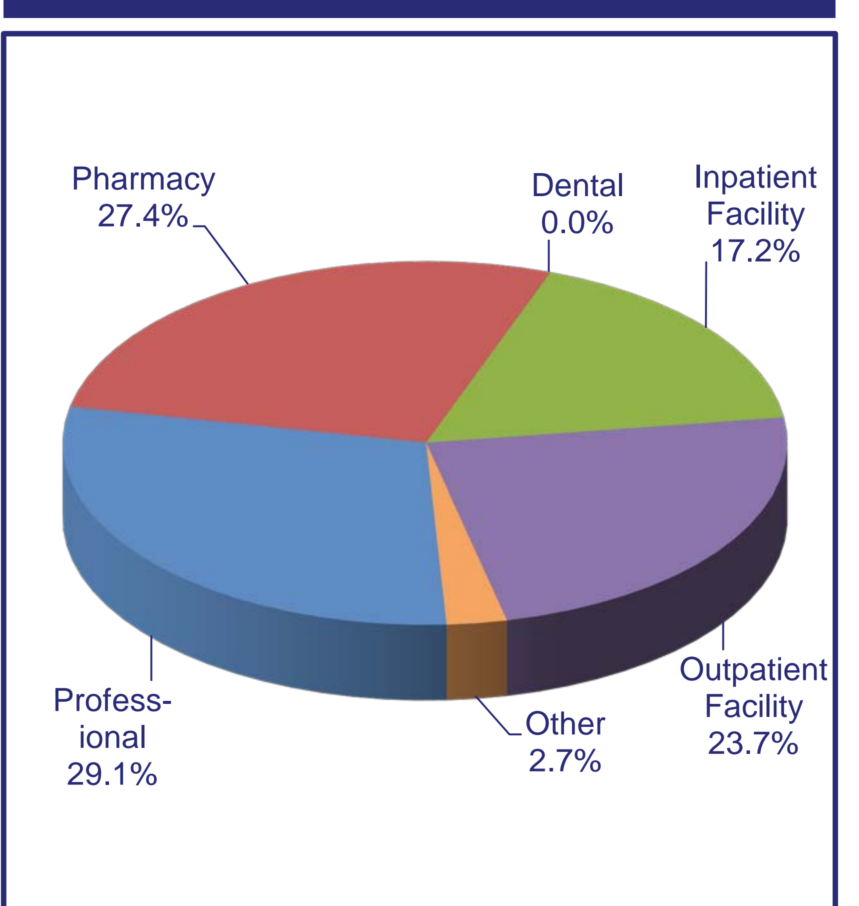




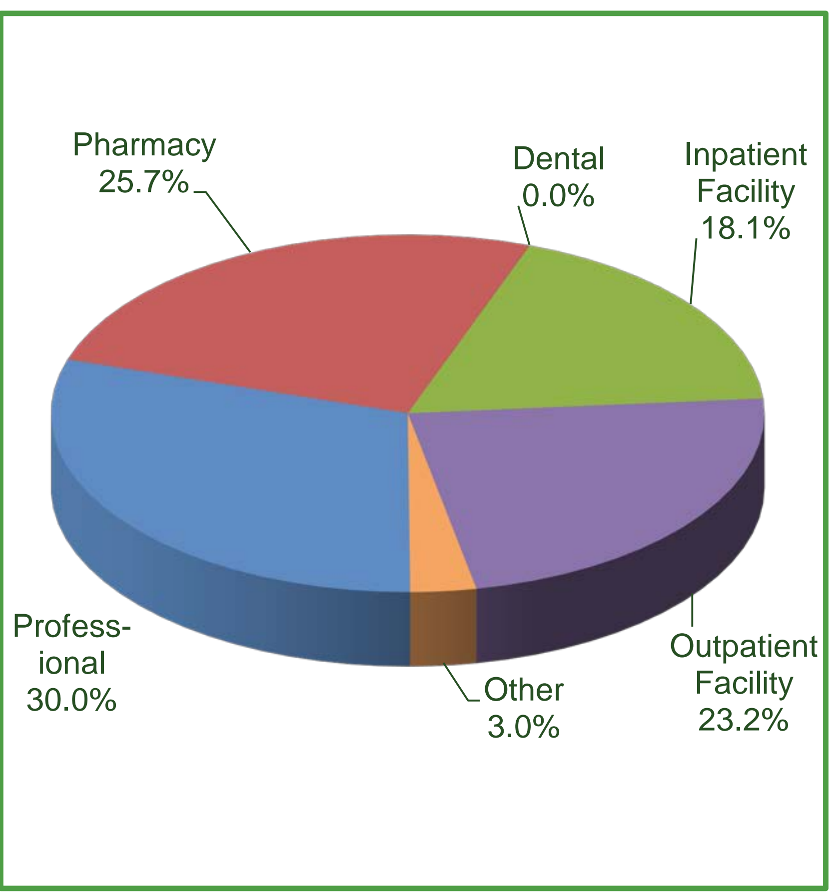
Sources: BCBSNC Net Disbursements reports; Financial Status Reports

Allocation of Claims Expenditures Medical, Blue Card and Pharmacy Payments

Calendar Year 2015



Calendar Year 2014



Source: BCBSNC Summary of Billed Charges

Recent Historical Financial Results
Revenues and Expenses

FB 2007-09 | FB 2009-11 | FB 2011-13 | FB 2013-15 | FB 15-17

$ Billions

	FY 2008	FY 2009*	FY 2010	FY 2011	FY 2012	FY 2013	CY 2014	CY 2015
Revenues	$2.273	$2.676	$2.490	$2.798	$2.852	$2.960	$3.007	$3.069
Expenses	$2.290	$2.625	$2.559	$2.650	$2.620	$2.679	$2.831	$3.069

Y-axis: $2.0, $2.2, $2.4, $2.6, $2.8, $3.0, $3.2

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

Note: The 2013 Short Plan Year is not shown in chart. In the six months from July to December 2013, Plan revenues totaled $1.540 Billion and Plan expenses were $1.485 Billion.

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

FB 2007-2009 | FB 2009-2011 | FB 2011-2013 | FB 2013-15 | FB 15-17

$ Millions

	FY 2008	FY 2009*	FY 2010	FY 2011	FY 2012	FY 2013	2013 SPY	CY 2014	CY 2015
Net Income/(Loss)	($17)	$51	($69)	$148	$232	$281	$55	$176	$0
Ending Cash Balance	$140	$190	$122	$270	$502	$784	$838	$1,015	$1,015

Axis: -$200, $0, $200, $400, $600, $800, $1,000, $1,200

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

SPY = Short Plan Year (Jul-Dec 2013)

Recent Historical Financial Results
Expenditures (Claims + Administrative) PMPM

	FB 2007-09		FB 2009-11		FB 2011-13		FB 2013-15		FB 15-17
	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	2013 SPY	CY 2014	CY 2015
Actual Expenses	$299	$331	$322	$333	$329	$335	$370	$349	$373
Budgeted Expenses	$290	$333	$317	$347	$362	$359	$384	$368	$387

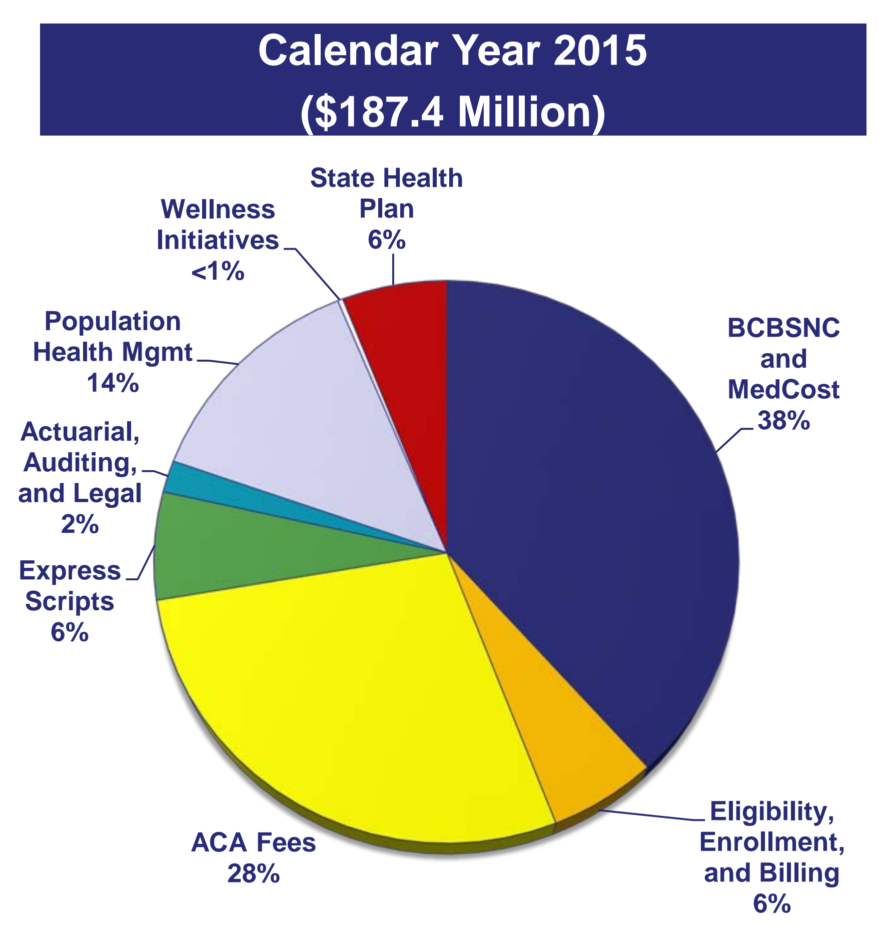
$400
$380
$360
$340
$320
$300
$280

Actual Expenses — Budgeted Expenses

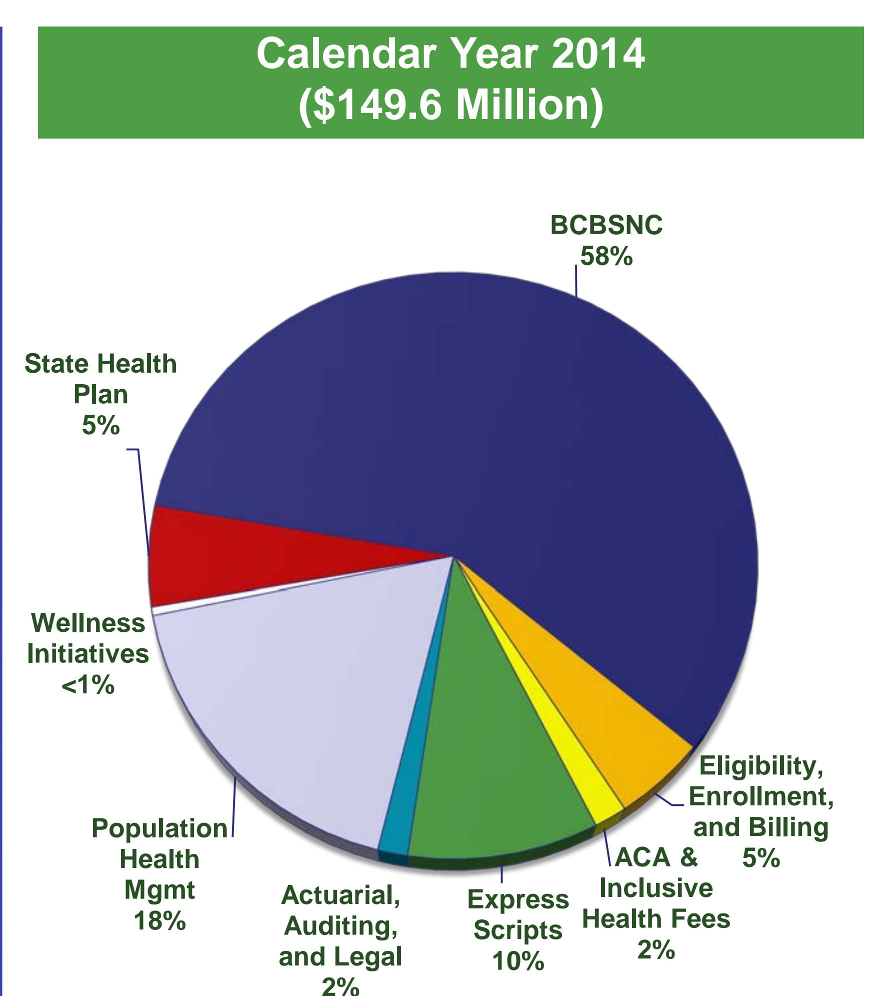
SPY = Short Plan Year (Jul-Dec 2013)

Calendar Year 2015 Administrative Expenses

Calendar Year 2015
($187.4 Million)



Calendar Year 2014
($149.6 Million)



Note: The charts show administrative fees that were paid in 2015 and 2014 and therefore reflect some inconsistencies in the timing of payments.

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Authorized Budget
For the Month Ended December 2015
Calendar Year 2015

		A	B	C	D	E	F	G	H
		Actual December 2015	Authorized Budget December 2015	Monthly Variance Over/(Under) Authorized Budget	Actual 2015 Calendar Year To Date	4/28/2015 Authorized Budget 2015 Calendar Year to Date	Calendar Year to Date Variance Over/(Under) Auth. Budget	4/28/2015 Calendar Year Authorized Budget (Jan-Dec 2015)	Calendar Year to Date Variance Over/(Under) Annual Auth. Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 279,135,908	$ 248,240,683	$ 30,895,225	$ 2,993,891,773	$ 2,963,937,832	$ 29,953,941	$ 2,963,937,832	$ 29,953,941
4	Premium Refunds/Retroactive Disenrollments	-	(124,509)	124,509	(5,343)	(1,486,657)	1,481,314	(1,486,657)	1,481,314
5	Medicare Part D (RDS) Subsidy	1,533,247	1,211,947	321,300	19,484,823	14,587,080	4,897,743	14,587,080	4,897,743
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	48,603,406	48,602,498	908	48,602,498	908
7	Medicare Advantage (MA) Subsidy	165,292	69,461	95,831	959,319	828,983	130,336	828,983	130,336
8	**Net Premium & Other Contributions**	**280,834,447**	**249,397,582**	**31,436,865**	**3,062,933,978**	**3,026,469,736**	**36,464,242**	**3,026,469,736**	**36,464,242**
9									
10	Investment Earnings	579,246	293,039	286,207	6,037,729	3,871,779	2,165,950	3,871,779	2,165,950
11	Miscellaneous Revenue	-	-	-	-	-	-	-	-
12	**Other Revenue**	**579,246**	**293,039**	**286,207**	**6,037,729**	**3,871,779**	**2,165,950**	**3,871,779**	**2,165,950**
13									
14	**Total Plan Revenue (excludes internal transfers)**	**281,413,693**	**249,690,621**	**31,723,072**	**3,068,971,707**	**3,030,341,515**	**38,630,192**	**3,030,341,515**	**38,630,192**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	163,409,879	161,902,558	1,507,321	2,067,095,284	2,128,799,496	(61,704,212)	2,128,799,496	(61,704,212)
19	Medical Claim Refunds/Recoveries	(2,019,328)	(2,058,244)	38,916	(23,709,307)	(25,072,202)	1,362,895	(25,072,202)	1,362,895
20	**Net Medical Claims**	**161,390,551**	**159,844,314**	**1,546,237**	**2,043,385,977**	**2,103,727,294**	**(60,341,317)**	**2,103,727,294**	**(60,341,317)**
21									
22	Pharmacy Claim Payments	63,688,729	84,589,815	(20,901,086)	766,818,503	718,955,282	47,863,221	718,955,282	47,863,221
23	Pharmacy Claim Rebates	-	-	-	(96,193,453)	(57,020,841)	(39,172,612)	(57,020,841)	(39,172,612)
24	Pharmacy Claim Refunds/Recoveries	(33,945)	-	(33,945)	(5,347,179)	-	(5,347,179)	-	(5,347,179)
25	**Net Pharmacy Claims**	**63,654,784**	**84,589,815**	**(20,935,031)**	**665,277,871**	**661,934,441**	**3,343,430**	**661,934,441**	**3,343,430**
26									
27	**Net Claim Payments**	**225,045,335**	**244,434,129**	**(19,388,794)**	**2,708,663,848**	**2,765,661,735**	**(56,997,887)**	**2,765,661,735**	**(56,997,887)**
28									
29	**Medicare Advantage Premium Payments**	**14,841,457**	**14,572,254**	**269,203**	**172,517,202**	**174,072,089**	**(1,554,887)**	**174,072,089**	**(1,554,887)**
30									
31	**Net Administrative Expenses**	**33,483,240**	**18,408,004**	**15,075,236**	**187,419,975**	**239,864,700**	**(52,444,725)**	**239,864,700**	**(52,444,725)**
32									
33	**Total Plan Expenses (excludes internal transfers)**	**273,370,032**	**277,414,387**	**(4,044,355)**	**3,068,601,025**	**3,179,598,524**	**(110,997,499)**	**3,179,598,524**	**(110,997,499)**
34									
35	**Plan Income/(Loss)**	**8,043,661**	**(27,723,766)**	**35,767,427**	**370,682**	**(149,257,009)**	**149,627,691**	**(149,257,009)**	**149,627,691**
36									
37	**Cash Availability:**								
38									
39	Beginning Cash Balance/(Deficit)	1,007,174,367	893,314,103	113,860,264	1,014,847,346	1,014,847,346	-	1,014,847,346	-
40	**Ending Cash Balance/(Deficit)**	**1,015,218,028**	**865,590,337**	**149,627,691**	**1,015,218,028**	**865,590,337**	**149,627,691**	**865,590,337**	**149,627,691**
41									
42	Target Stabilization Reserve @ 12/31/15	248,909,557	248,909,557	-	248,909,557	248,909,557	-	248,909,557	-
43									
44	**Cash Balance Over/(Under) Reserve Target**	**$ 766,308,471**	**$ 616,680,780**	**$ 149,627,691**	**$ 766,308,471**	**$ 616,680,780**	**$ 149,627,691**	**$ 616,680,780**	**$ 149,627,691**

Comments:

a. Premium receivables totaled $1,182,652.53 as of December 31, 2015.
b. The average weekly medical claims cost net of claims refunds was $40,347,637.75 for the four scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $31,844,364.50 per cycle.
d. The target stabilization reserve is 9% of the projected net claims for Calendar Year 2015.
e. Minor differences compared to other reports are due to rounding.

Actual vs Authorized Budget (i.e. ***Revised Budget*** per Segal 4-28-15 Projections)
December - 2015 Calendar Year

North Carolina State Health Plan for Teachers and State Employees

Summary of Operations (Cash Basis)

Current Year Actual vs. Prior Year Actual

For the Month Ended December 2015

Calendar Year 2015

#		A	B	C	D	E	F	G
		Current Year Actual December 2015	Prior Year Actual December 2014	Current Year to Date Actual CY 2015 thru December	Prior Year to Date Actual CY 2014 thru December	Current Year Authorized Annual Budget CY 2015	Prior Year Annual Budget CY 2014	Prior Year Actual Results CY 2014
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 279,135,908	$ 270,880,991	$ 2,993,891,773	$ 2,952,592,141	$ 2,963,937,832	$ 2,921,878,532	$ 2,952,592,141
4	Premium Refunds/Retroactive Disenrollments	-	-	(5,343)	(28,401)	(1,486,657)	(1,489,408)	(28,401)
5	Medicare Part D (RDS) Subsidy	1,533,247	1,258,008	19,484,823	21,584,404	14,587,080	6,344,076	21,584,404
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	48,603,406	28,378,401	48,602,498	31,047,005	28,378,401
7	Medicare Advantage (MA) Subsidy	165,292	72,187	959,319	721,773	828,983	-	721,773
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	(1,949)	-	-	(1,949)
9	**Net Premium & Other Contributions**	**280,834,447**	**272,211,186**	**3,062,933,978**	**3,003,246,369**	**3,026,469,736**	**2,957,780,205**	**3,003,246,369**
10								
11	Investment Earnings	579,246	442,424	6,037,729	4,417,142	3,871,779	2,892,005	4,417,142
12	Miscellaneous Revenue	-	-	-	-	-	-	-
13	**Other Revenue**	**579,246**	**442,424**	**6,037,729**	**4,417,142**	**3,871,779**	**2,892,005**	**4,417,142**
14								
15	**Total Plan Revenue (excludes internal transfers)**	**281,413,693**	**272,653,610**	**3,068,971,707**	**3,007,663,511**	**3,030,341,515**	**2,960,672,210**	**3,007,663,511**
16								
17	**Plan Expenses:**							
18								
19	Medical Claim Payments	163,409,879	171,959,431	2,067,095,284	1,949,838,964	2,128,799,496	2,062,826,346	1,949,838,964
20	Medical Claim Refunds/Recoveries	(2,019,328)	(1,608,128)	(23,709,307)	(22,731,740)	(25,072,202)	(25,469,051)	(22,731,740)
21	**Net Medical Claims**	**161,390,551**	**170,351,303**	**2,043,385,977**	**1,927,107,224**	**2,103,727,294**	**2,037,357,295**	**1,927,107,224**
22								
23	Pharmacy Claim Payments	63,688,729	84,816,236	766,818,503	698,129,098	718,955,282	599,541,594	698,129,098
24	Pharmacy Claim Rebates	-	-	(96,193,453)	(98,763,203)	(57,020,841)	(54,794,623)	(98,763,203)
25	Pharmacy Claim Refunds/Recoveries	(33,945)	(405,464)	(5,347,179)	(313,676)	-	-	(313,676)
26	**Net Pharmacy Claims**	**63,654,784**	**84,410,772**	**665,277,871**	**599,052,219**	**661,934,441**	**544,746,971**	**599,052,219**
27								
28	**Net Claim Payments**	**225,045,335**	**254,762,075**	**2,708,663,848**	**2,526,159,443**	**2,765,661,735**	**2,582,104,266**	**2,526,159,443**
29								
30	**Medicare Advantage Premium Payments**	**14,841,457**	**11,875,108**	**172,517,202**	**155,497,950**	**174,072,089**	**174,162,733**	**155,497,950**
31								
32	**Net Administrative Expenses**	**33,483,240**	**13,288,850**	**187,419,975**	**149,605,909**	**239,864,700**	**179,815,010**	**149,605,909**
33								
34	**Total Plan Expenses (excludes internal transfers)**	**273,370,032**	**279,926,033**	**3,068,601,025**	**2,831,263,302**	**3,179,598,524**	**2,936,082,009**	**2,831,263,302**
35								
36	**Plan Income/(Loss)**	**8,043,661**	**(7,272,423)**	**370,682**	**176,400,209**	**(149,257,009)**	**24,590,201**	**176,400,209**
37								
38	**Cash Availability:**							
39								
40	Beginning Cash Balance/(Deficit)	1,007,174,367	1,022,119,769	1,014,847,346	838,447,137	1,014,847,346	694,975,133	838,447,137
41	**Ending Cash Balance/(Deficit)**	**1,015,218,028**	**1,014,847,346**	**1,015,218,028**	**1,014,847,346**	**865,590,337**	**719,565,334**	**1,014,847,346**
42								
43	Target Stabilization Reserve @ 12/31	248,909,557	234,282,695	248,909,557	234,282,695	248,909,557	234,282,695	227,940,878
44								
45	**Cash Balance Over/(Under) Reserve Target**	**$ 766,308,471**	**$ 780,564,651**	**$ 766,308,471**	**$ 780,564,651**	**$ 616,680,780**	**$ 485,282,639**	**$ 786,906,468**

Comments:

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

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended December 2015

Calendar Year 2015

		A	B	C	D	E	F
		Actual Year to Date Calendar Year thru December	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Authorized Budget Calendar Year to Date thru December	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums **(Notes 1 and 2)**	$ 2,993,891,773	$ (27,658,638)	$ 2,966,233,135	$ 2,963,937,832	$ 2,295,303	0.08%
4	Premium Refunds/Retroactive Disenrollments	(5,343)		(5,343)	(1,486,657)	1,481,314	-99.64%
5	Medicare Part D (RDS) Subsidy	19,484,823		19,484,823	14,587,080	4,897,743	33.58%
6	Medicare PDP (EGWP + Wrap) Subsidy	48,603,406		48,603,406	48,602,498	908	0.00%
7	Medicare Advantage (MA) Subsidy	959,319		959,319	828,983	130,336	15.72%
8	**Net Premium & Other Contributions**	**3,062,933,978**	**(27,658,638)**	**3,035,275,340**	**3,026,469,736**	**8,805,604**	**0.29%**
9							
10	**Other Revenue**	**6,037,729**		**6,037,729**	**3,871,779**	**2,165,950**	**55.94%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**3,068,971,707**	**(27,658,638)**	**3,041,313,069**	**3,030,341,515**	**10,971,554**	**0.36%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	2,043,385,977		2,043,385,977	2,103,727,294	(60,341,317)	-2.87%
17	Net Pharmacy Claims **(Notes 3 and 4)**	665,277,871	34,358,433	699,636,304	661,934,441	37,701,863	5.70%
18	**Net Claim Payments**	**2,708,663,848**	**34,358,433**	**2,743,022,281**	**2,765,661,735**	**(22,639,454)**	**-0.82%**
19							
20	**Medicare Advantage Premiums**	**172,517,202**		**172,517,202**	**174,072,089**	**(1,554,887)**	**-0.89%**
21							
22	**Net Administrative Expenses (Notes 5 and 6)**	**187,419,975**	**(9,060,820)**	**178,359,155**	**239,864,700**	**(61,505,545)**	**-25.64%**
23							
24	**Total Plan Expenses (excludes internal transfers)**	**3,068,601,025**	**25,297,613**	**3,093,898,638**	**3,179,598,524**	**(85,699,886)**	**-2.70%**
25							
26	**Plan Income/(Loss)**	**370,682**	**(52,956,251)**	**(52,585,569)**	**(149,257,009)**	**96,671,440**	**-64.77%**
27							
28	**Cash Availability:**						
29							
30	Beginning Cash Balance/(Deficit)	1,014,847,346		1,014,847,346	1,014,847,346	-	0.00%
31	**Ending Cash Balance/(Deficit)**	**1,015,218,028**	**(52,956,251)**	**962,261,777**	**865,590,337**	**96,671,440**	**11.17%**
32							
33	Target Stabilization Reserve @ 12/31/2015	248,909,557		248,909,557	248,909,557	-	0.00%
34							
35	**Cash Balance Over/(Under) Reserve Target**	**$ 766,308,471**	**$ (52,956,251)**	**$ 713,352,220**	**$ 616,680,780**	**$ 96,671,440**	**15.68%**

Adjustment Notes:

1. Member premiums adjusted by $25.8 million to include prepaid January premiums received in December 2014 ($46.9 million) less a downward adjustment in the budget to account for the prepaid premiums ($21.1 million).
2. Member premiums adjusted to exclude $53.5 million in prepaid January premiums received in December.
3. Net pharmacy claims adjusted to exclude an unbudgeted $1.6 million recovery from a class action law suit.
4. Net pharmacy claims increased by $32.7 million to account for a rebate true-up payment received in excess of the budgeted true-up payment.
5. Administrative expenses increased by $8.7 million to assume payment of all normal monthly invoices in December.
6. Administrative expenses adjusted to exclude a $17.8 million federal fee payment that was not budgeted for payment until January 2016.

Adjusted Variance Report Based on Authorized (Revised) Calendar Year Budget
Calendar Year to Date Through December 2015

March 2016 Financial Report

Board of Trustees Meeting

May 13, 2016

Financial Results: Actual vs. Budgeted Calendar Year to Date March 2016

Calendar Year 2016	Actual thru Mar 2016	Certified Budget (per Segal 10-13-15)	Variance Over/(Under) Budget
Beginning Cash Balance	**$1.015 b**	**$941.3 m**	**$73.9 m**
Plan Revenue	**$793.9 m**	**$774.2 m**	**$19.7 m**
Net Claims Payments	$690.8 m	$693.8 m	($3.0 m)
Medicare Advantage Premiums	$47.9 m	$47.6 m	$0.3 m
Net Administrative Expenses	$42.7 m	$72.9 m	($30.2 m)
Total Plan Expenses	**$781.4 m**	**$814.3 m**	**($32.9 m)**
Net Income/(Loss)	**$12.5 m**	**($40.1 m)**	**$52.6 m**
Ending Cash Balance	**$1.028 b**	**$901.2 m**	**$126.5 m**

Adjusted Variance Report
Calendar Year to Date March 2016

Calendar Year 2016	Actual thru Mar 2016, As Adjusted	Authorized Budget (per Segal 10-13-15)	Variance Over/(Under) Budget
Plan Revenue *	**$798.7 m**	**$774.2 m**	**$24.5 m**
Net Claims Payments	$690.8 m	$693.8 m	($3.0 m)
Medicare Advantage Premiums	$47.9 m	$47.6 m	$0.3 m
Net Administrative Expenses ^	$57.1 m	$72.9 m	($15.8 m)
Total Plan Expenses	**$795.8 m**	**$814.3 m**	**($18.5 m)**
Net Income/(Loss)	**$2.9 m**	**($40.1 m)**	**$43.0 m**

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

Financial Results Actual vs. Budgeted
Calendar Year to Date March 2016

Per Member Per Month (PMPM) Analysis

Calendar Year 2016	Actual thru Mar 2016	Authorized Budget (per Segal 10-13-15)	Variance Over/(Under) Budget
Plan Revenue	**$376.89**	**$377.70**	**($0.81)**
Net Claims Payments	$332.12	$338.27	($6.15)
Medicare Advantage Premiums	$23.04	$23.18	($0.14)
Net Administrative Expenses	$20.55	$35.56	($15.01)
Total Plan Expenses	**$375.71**	**$397.01**	**($21.30)**
Net Income/(Loss)	**$1.18**	**($19.31)**	**$20.49**

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

Adjusted Variance Report
Calendar Year to Date March 2016

Per Member Per Month (PMPM) Analysis

Calendar Year 2016	Actual thru Mar 2016, as Adjusted	Authorized Budget (per Segal 10-13-15)	Variance Over/(Under) Budget
Plan Revenue *	**$379.17**	**$377.70**	**$1.47**
Net Claims Payments	$332.12	$338.27	($6.15)
Medicare Advantage Premiums	$23.04	$23.18	($0.14)
Net Administrative Expenses ^	$27.46	$35.56	($8.10)
Total Plan Expenses	**$382.62**	**$397.01**	**($14.39)**
Net Income/(Loss)	**($3.45)**	**($19.31)**	**$15.86**

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

Plan Year to Date (YTD) Expenditure Trend Per Member Per Month

Calendar Year 2014
Budgeted = $367.60
Actual = $348.53

Calendar Year 2015
Budgeted = $387.44
Actual = $373.39

Calendar Year 2016
Budgeted = $410.00
Actual thru Mar = $375.71

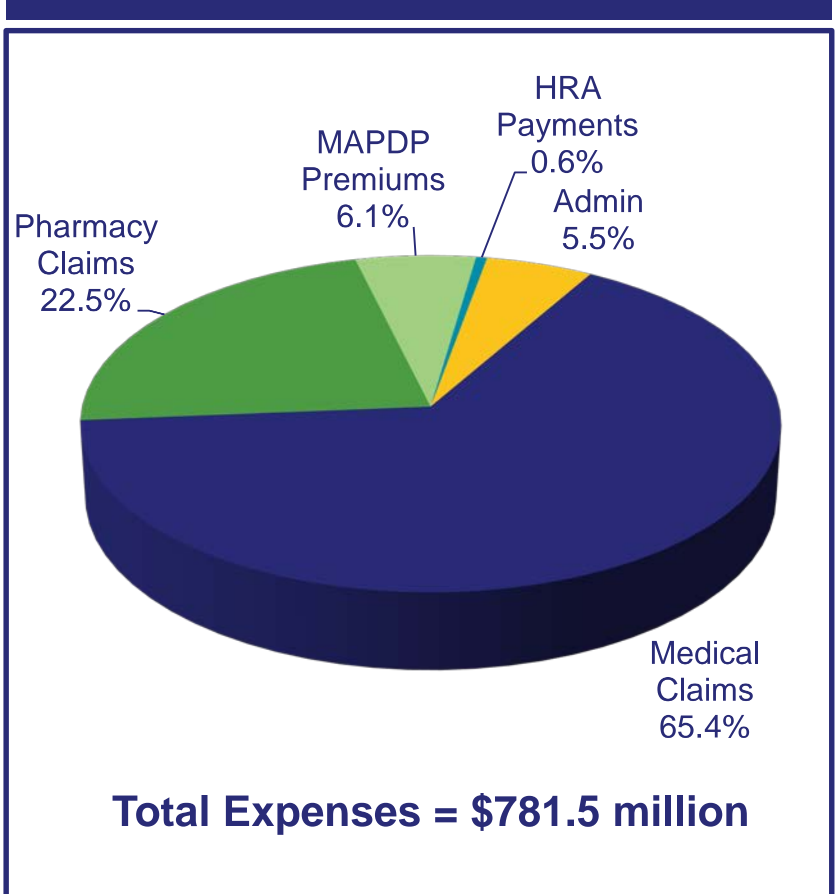
$450
$425
$400
$375
$350
$325
$300

Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16

YTD Actual Expenses
YTD Budgeted Expenses
Budgeted PMPM CY 2014
Budgeted PMPM CY 2015
Budgeted PMPM CY 2016

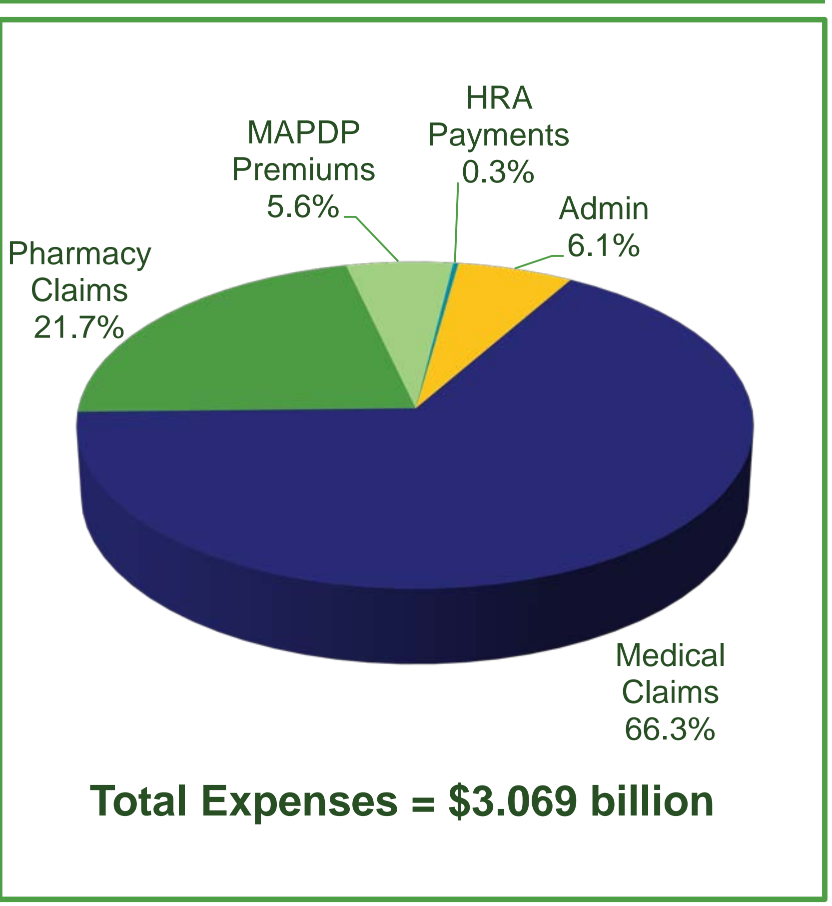
Allocation of Total Expenditures

Calendar Year To Date: Mar 2016



Total Expenses = $781.5 million

Calendar Year 2015

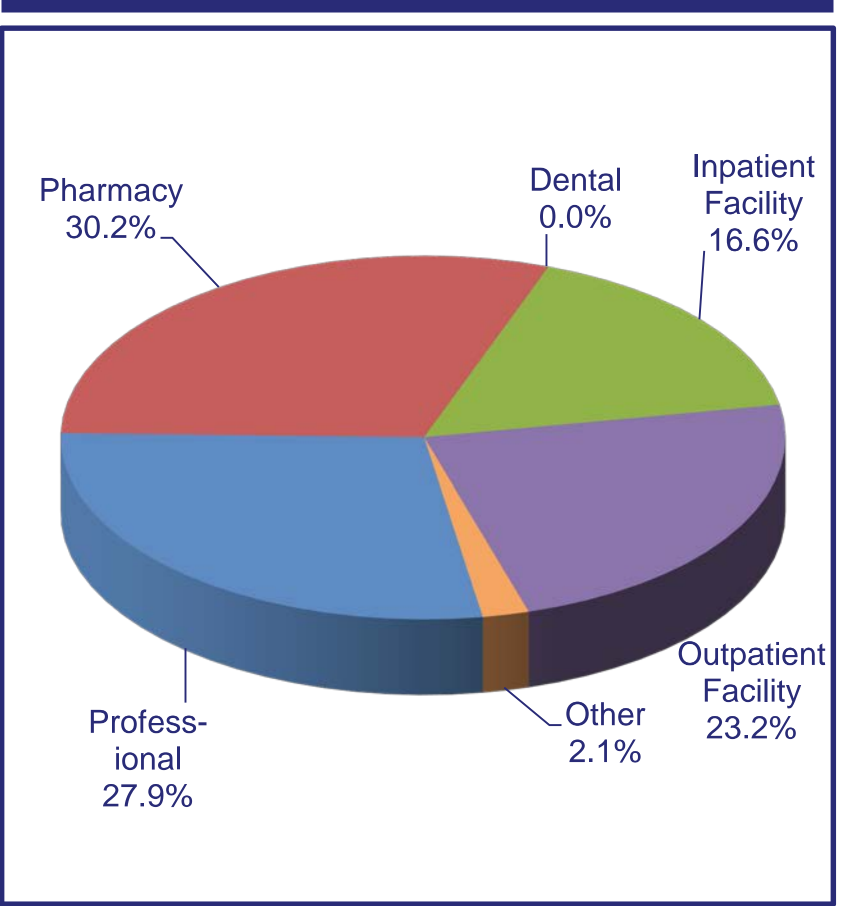


Total Expenses = $3.069 billion

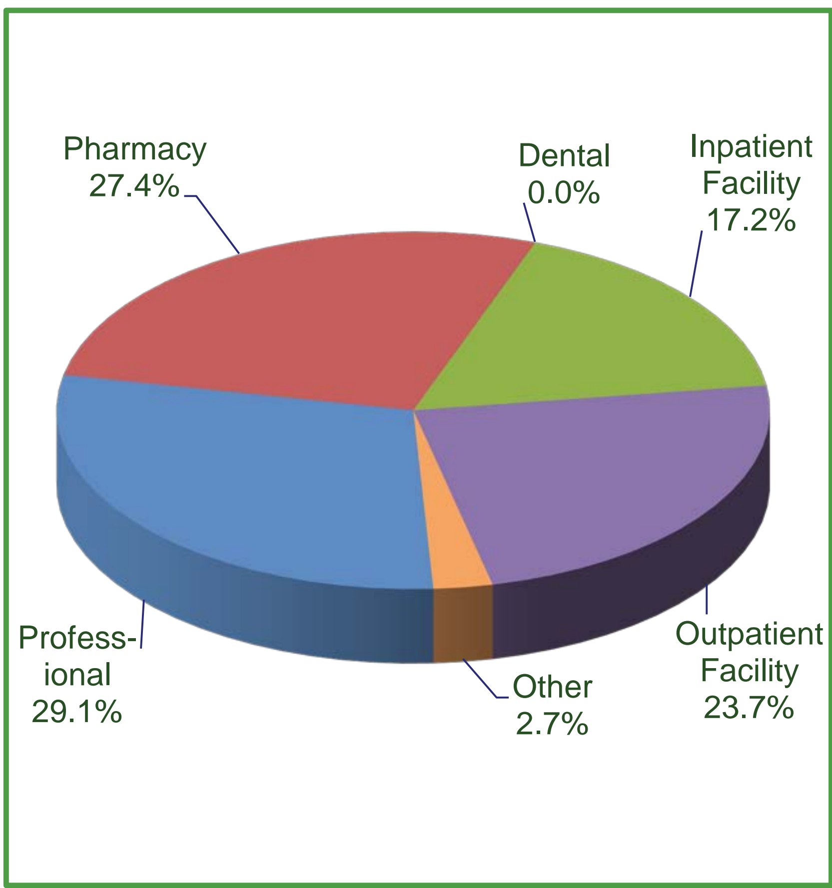
Sources: BCBSNC Net Disbursements reports; Financial Status Reports

Allocation of Claims Expenditures
Medical, Blue Card and Pharmacy Payments

Calendar Year to Date: Mar 2016



Calendar Year 2015



Source: BCBSNC Summary of Billed Charges

North Carolina State Health Plan for Teachers and State Employees

Summary of Operations (Cash Basis)

Consolidated Report, Actual vs. Certified Budget

For the Month Ended March 2016

Calendar Year 2016

#		A	B	C	D	E	F	G	H
		Actual March 2016	Certified Budget March 2016	Monthly Variance Over/(Under) Certified Budget	Actual Year to Date CY 2016	10/13/2015 Certified Budget Year to Date CY 2016	Year to Date Variance Over/(Under) Certified Budget	10/13/2015 Annual Certified Budget CY 2016 (Jan-Dec 2016)	Year to Date Variance Over/(Under) Annual Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 282,238,487	$ 256,729,557	$ 25,508,930	$ 786,994,578	$ 770,440,381	$ 16,554,197	$ 3,077,262,889	$ (2,290,268,311)
4	Premium Refunds/Retroactive Disenrollments	-	(129,356)	129,356	-	(388,193)	388,193	(1,550,543)	1,550,543
5	Medicare Part D (RDS) Subsidy	2,517,513	942,936	1,574,577	4,809,051	2,991,747	1,817,304	14,177,803	(9,368,752)
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	453	-	453	-	453
7	Medicare Advantage (MA) Subsidy	100,788	72,219	28,569	206,405	214,145	(7,740)	866,820	(660,415)
8	**Net Premium & Other Contributions**	**284,856,788**	**257,615,356**	**27,241,432**	**792,010,487**	**773,258,080**	**18,752,407**	**3,090,756,969**	**(2,298,746,482)**
9									
10	Investment Earnings	666,168	301,094	365,074	1,933,112	922,397	1,010,715	3,269,599	(1,336,487)
11	Miscellaneous Revenue	-	-	-	-	-	-	-	-
12	**Other Revenue**	**666,168**	**301,094**	**365,074**	**1,933,112**	**922,397**	**1,010,715**	**3,269,599**	**(1,336,487)**
13									
14	**Total Plan Revenue (excludes internal transfers)**	**285,522,956**	**257,916,450**	**27,606,506**	**793,943,599**	**774,180,477**	**19,763,122**	**3,094,026,568**	**(2,300,082,969)**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	154,265,563	167,014,240	(12,748,677)	520,913,321	529,436,591	(8,523,270)	2,191,757,976	(1,670,844,655)
19	Medical Claim Refunds/Recoveries	(1,331,950)	(2,131,505)	799,555	(5,625,004)	(6,297,028)	672,024	(26,876,079)	21,251,075
20	**Net Medical Claims**	**152,933,613**	**164,882,735**	**(11,949,122)**	**515,288,317**	**523,139,563**	**(7,851,246)**	**2,164,881,897**	**(1,649,593,580)**
21									
22	Pharmacy Claim Payments	65,135,165	62,246,182	2,888,983	189,207,211	182,461,477	6,745,734	803,327,996	(614,120,785)
23	Pharmacy Claim Rebates	-	-	-	(13,666,155)	(11,792,209)	(1,873,946)	(50,098,630)	36,432,475
24	Pharmacy Claim Refunds/Recoveries	(9,151)	-	(9,151)	(37,652)	-	(37,652)	-	(37,652)
25	**Net Pharmacy Claims**	**65,126,014**	**62,246,182**	**2,879,832**	**175,503,404**	**170,669,268**	**4,834,136**	**753,229,366**	**(577,725,962)**
26									
27	**Net Claim Payments**	**218,059,627**	**227,128,917**	**(9,069,290)**	**690,791,721**	**693,808,831**	**(3,017,110)**	**2,918,111,263**	**(2,227,319,542)**
28									
29	**Medicare Advantage Premium Payments**	**16,114,225**	**15,864,359**	**249,866**	**47,931,227**	**47,553,639**	**377,588**	**190,926,384**	**(142,995,157)**
30									
31	**Net Administrative Expenses**	**12,628,491**	**18,390,224**	**(5,761,733)**	**42,741,374**	**72,936,762**	**(30,195,388)**	**249,818,709**	**(207,077,335)**
32									
33	**Total Plan Expenses (excludes internal transfers)**	**246,802,343**	**261,383,500**	**(14,581,157)**	**781,464,322**	**814,299,232**	**(32,834,910)**	**3,358,856,356**	**(2,577,392,034)**
34									
35	**Plan Income/(Loss)**	**38,720,613**	**(3,467,050)**	**42,187,663**	**12,479,277**	**(40,118,755)**	**52,598,032**	**(264,829,788)**	**277,309,065**
36									
37	**Cash Availability:**								
38									
39	Beginning Cash Balance/(Deficit)	988,976,692	904,618,475	84,358,217	1,015,218,028	941,270,180	73,947,848	941,270,180	73,947,848
40	**Ending Cash Balance/(Deficit)**	**1,027,697,305**	**901,151,425**	**126,545,880**	**1,027,697,305**	**901,151,425**	**126,545,880**	**676,440,392**	**351,256,913**
41									
42	Target Stabilization Reserve @ 12/31/16	262,630,014	262,630,014	-	262,630,014	262,630,014	-	262,630,014	-
43									
44	**Cash Balance Over/(Under) Reserve Target**	**$ 765,067,291**	**$ 638,521,411**	**$ 126,545,880**	**$ 765,067,291**	**$ 638,521,411**	**$ 126,545,880**	**$ 413,810,378**	**$ 351,256,913**

Comments:

a. Premium receivables totaled $727,591.94 as of March 31, 2016.

b. The average weekly medical claims cost net of claims refunds was $38,233,403.25 for the four scheduled weekly claim cycles.

c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $32,567,582.50 per cycle.

d. The target stabilization reserve is 9% of the projected net claims for Calendar Year 2016.

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

Actual vs Certified Budget (Segal 10-13-15 Projections)
March - 2016 Calendar Year

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Certified Budget
For the Month Ended March 2016

Fiscal Year 2015- 2016

		A	B	C	D	E	F	G	H
		Actual March 2016	Certified Budget March 2016	Monthly Variance Over/(Under) Certified Budget	Actual Year to Date FY 2015-16	10/13/2015 Certified Budget Year to Date FY 2015-16	Year to Date Variance Over/(Under) Certified Budget	10/13/2015 Annual Certified Budget FY 2015-16	Year to Date Variance Over/(Under) Annual Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 282,238,487	$ 256,729,557	$ 25,508,930	$ 2,307,456,141	$ 2,261,943,455	$ 45,512,686	$ 3,031,630,846	$ (724,174,705)
4	Premium Refunds/Retroactive Disenrollments	-	(129,356)	129,356	-	(1,136,090)	1,136,090	(1,523,909)	1,523,909
5	Medicare Part D (RDS) Subsidy	2,517,513	942,936	1,574,577	13,379,967	10,337,654	3,042,313	14,457,206	(1,077,239)
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	453	-	453	-	453
7	Medicare Advantage (MA) Subsidy	100,788	72,219	28,569	636,670	631,528	5,142	848,545	(211,875)
8	**Net Premium & Other Contributions**	**284,856,788**	**257,615,356**	**27,241,432**	**2,321,473,231**	**2,271,776,547**	**49,696,684**	**3,045,412,688**	**(723,939,457)**
9									
10	Investment Earnings	666,168	301,094	365,074	5,247,100	2,898,327	2,348,773	3,760,445	1,486,655
11	Miscellaneous Revenue	-	-	-	-	-	-	-	-
12	**Other Revenue**	**666,168**	**301,094**	**365,074**	**5,247,100**	**2,898,327**	**2,348,773**	**3,760,445**	**1,486,655**
13									
14	**Total Plan Revenue (excludes internal transfers)**	**285,522,956**	**257,916,450**	**27,606,506**	**2,326,720,331**	**2,274,674,874**	**52,045,457**	**3,049,173,133**	**(722,452,802)**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	154,265,563	167,014,240	(12,748,677)	1,560,061,458	1,594,872,741	(34,811,283)	2,152,322,381	(592,260,923)
19	Medical Claim Refunds/Recoveries	(1,331,950)	(2,131,505)	799,555	(15,610,235)	(19,125,028)	3,514,793	(25,761,279)	10,151,044
20	**Net Medical Claims**	**152,933,613**	**164,882,735**	**(11,949,122)**	**1,544,451,223**	**1,575,747,713**	**(31,296,490)**	**2,126,561,102**	**(582,109,879)**
21									
22	Pharmacy Claim Payments	65,135,165	62,246,182	2,888,983	610,680,163	588,812,522	21,867,641	802,956,864	(192,276,701)
23	Pharmacy Claim Rebates	-	-	-	(98,043,638)	(89,438,495)	(8,605,143)	(104,118,976)	6,075,338
24	Pharmacy Claim Refunds/Recoveries	(9,151)	-	(9,151)	(1,716,674)	-	(1,716,674)	-	(1,716,674)
25	**Net Pharmacy Claims**	**65,126,014**	**62,246,182**	**2,879,832**	**510,919,851**	**499,374,027**	**11,545,824**	**698,837,888**	**(187,918,037)**
26									
27	**Net Claim Payments**	**218,059,627**	**227,128,917**	**(9,069,290)**	**2,055,371,074**	**2,075,121,740**	**(19,750,666)**	**2,825,398,990**	**(770,027,916)**
28									
29	**Medicare Advantage Premium Payments**	**16,114,225**	**15,864,359**	**249,866**	**135,007,138**	**133,404,499**	**1,602,639**	**181,076,580**	**(46,069,442)**
30									
31	**Net Administrative Expenses**	**12,628,491**	**18,390,224**	**(5,761,733)**	**132,764,437**	**189,116,833**	**(56,352,396)**	**244,252,193**	**(111,487,756)**
32									
33	**Total Plan Expenses (excludes internal transfers)**	**246,802,343**	**261,383,500**	**(14,581,157)**	**2,323,142,649**	**2,397,643,072**	**(74,500,423)**	**3,250,727,763**	**(927,585,114)**
34									
35	**Plan Income/(Loss)**	**38,720,613**	**(3,467,050)**	**42,187,663**	**3,577,682**	**(122,968,198)**	**126,545,880**	**(201,554,630)**	**205,132,312**
36									
37	**Cash Availability:**								
38									
39	Beginning Cash Balance/(Deficit)	988,976,692	904,618,475	84,358,217	1,024,119,623	1,024,119,623	-	1,024,119,623	-
40	**Ending Cash Balance/(Deficit)**	**1,027,697,305**	**901,151,425**	**126,545,880**	**1,027,697,305**	**901,151,425**	**126,545,880**	**822,564,993**	**205,132,312**
41									
42	Target Stabilization Reserve @ 6/30/16	254,285,909	254,285,909	-	254,285,909	254,285,909	-	254,285,909	-
43									
44	**Cash Balance Over/(Under) Reserve Target**	**$ 773,411,396**	**$ 646,865,516**	**$ 126,545,880**	**$ 773,411,396**	**$ 646,865,516**	**$ 126,545,880**	**$ 568,279,084**	**$ 205,132,312**

Comments:

a. Premium receivables totaled $727,591.94 as of March 31, 2016.
b. The average weekly medical claims cost net of claims refunds was $38,233,403.25 for the four scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $32,567,582.50 per cycle.
d. The target stabilization reserve is 9% of the projected net claims for Fiscal Year 2015-16.
e. Minor differences compared to other reports are due to rounding.

Actual vs Certified Budget (per Segal 10-13-15 Projections)
March 2016 - Fiscal Year

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Current Year Actual vs. Prior Year Actual
For the Month Ended March 2016
Fiscal Year 2015-2016

		A	B	C	D	E	F	G
		Current Year Actual March 2016	Prior Year Actual March 2015	Current Year to Date Actual FY 2015-16 thru March	Prior Year to Date Actual FY 2014-15 thru March	Current Year Certified Annual Budget FY 2015-16	Prior Year Annual Budget FY 2014-15	Prior Year Actual Results FY 2014-15
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 282,238,487	$ 258,490,811	$ 2,307,456,141	$ 2,253,426,582	$ 3,031,630,846	$ 2,937,906,736	$ 2,987,502,673
4	Premium Refunds/Retroactive Disenrollments	-	-	-	(6,016)	(1,523,909)	(1,478,664)	(11,359)
5	Medicare Part D (RDS) Subsidy	2,517,513	1,693,507	13,379,967	12,869,912	14,457,206	6,276,386	19,590,771
6	Medicare PDP (EGWP + Wrap) Subsidy	-	56	453	50,283,438	-	33,414,689	50,283,823
7	Medicare Advantage (MA) Subsidy	100,788	153,140	636,670	638,003	848,545	-	833,262
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	(1,949)	-	-	(1,949)
9	**Net Premium & Other Contributions**	**284,856,788**	**260,337,514**	**2,321,473,231**	**2,317,209,970**	**3,045,412,688**	**2,976,119,147**	**3,058,197,221**
10								
11	Investment Earnings	666,168	383,814	5,247,100	3,629,496	3,760,445	3,933,340	5,065,735
12	Miscellaneous Revenue	-	-	-	-	-	-	-
13	**Other Revenue**	**666,168**	**383,814**	**5,247,100**	**3,629,496**	**3,760,445**	**3,933,340**	**5,065,735**
14								
15	**Total Plan Revenue (excludes internal transfers)**	**285,522,956**	**260,721,328**	**2,326,720,331**	**2,320,839,466**	**3,049,173,133**	**2,980,052,487**	**3,063,262,956**
16								
17	**Plan Expenses:**							
18								
19	Medical Claim Payments	154,265,563	193,947,253	1,560,061,458	1,511,329,475	2,152,322,381	1,995,716,227	2,021,369,178
20	Medical Claim Refunds/Recoveries	(1,331,950)	(2,628,303)	(15,610,235)	(17,330,007)	(25,761,279)	(23,520,519)	(24,839,428)
21	**Net Medical Claims**	**152,933,613**	**191,318,950**	**1,544,451,223**	**1,493,999,468**	**2,126,561,102**	**1,972,195,708**	**1,996,529,750**
22								
23	Pharmacy Claim Payments	65,135,165	57,462,178	610,680,163	553,703,153	802,956,864	686,943,428	725,610,004
24	Pharmacy Claim Rebates	-	-	(98,043,638)	(51,114,709)	(104,118,976)	(74,166,940)	(51,114,709)
25	Pharmacy Claim Refunds/Recoveries	(9,151)	(150,603)	(1,716,674)	(644,870)	-	-	(4,140,711)
26	**Net Pharmacy Claims**	**65,126,014**	**57,311,575**	**510,919,851**	**501,943,574**	**698,837,888**	**612,776,488**	**670,354,584**
27								
28	**Net Claim Payments**	**218,059,627**	**248,630,525**	**2,055,371,074**	**1,995,943,042**	**2,825,398,990**	**2,584,972,196**	**2,666,884,334**
29								
30	**Medicare Advantage Premium Payments**	**16,114,225**	**14,212,589**	**135,007,138**	**119,518,953**	**181,076,580**	**163,281,044**	**162,400,394**
31								
32	**Net Administrative Expenses**	**12,628,491**	**11,529,425**	**132,764,437**	**133,530,223**	**244,252,193**	**223,971,245**	**168,416,645**
33								
34	**Total Plan Expenses (excludes internal transfers)**	**246,802,343**	**274,372,539**	**2,323,142,649**	**2,248,992,218**	**3,250,727,763**	**2,972,224,485**	**2,997,701,373**
35								
36	Plan Income/(Loss)	**38,720,613**	**(13,651,211)**	**3,577,682**	**71,847,248**	**(201,554,630)**	**7,828,002**	**65,561,583**
37								
38	**Cash Availability:**							
39								
40	Beginning Cash Balance/(Deficit)	988,976,692	1,044,056,499	1,024,119,623	958,558,040	1,024,119,623	958,558,040	958,558,040
41	Ending Cash Balance/(Deficit)	**1,027,697,305**	**1,030,405,288**	**1,027,697,305**	**1,030,405,288**	**822,564,993**	**966,386,042**	**1,024,119,623**
42								
43	Target Stabilization Reserve @ 6/30	254,285,909	232,647,498	254,285,909	232,647,498	254,285,909	232,647,498	240,019,590
44								
45	Cash Balance Over/(Under) Reserve Target	$ 773,411,396	$ 797,757,790	$ 773,411,396	$ 797,757,790	$ 568,279,084	$ 733,738,544	$ 784,100,033

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

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Current Year Actual vs. Prior Year Actual
For the Month Ended March 2016

Calendar Year 2016

#		A	B	C	D	E	F	G
		Current Year Actual March 2016	Prior Year Actual March 2015	Current Year to Date Actual CY 2016 thru March	Prior Year to Date Actual CY 2015 thru March	Current Year Certified Annual Budget CY 2016	Prior Year Annual Budget CY 2015	Prior Year Actual Results CY 2015
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 282,238,487	$ 258,490,811	$ 786,994,578	$ 739,354,119	$ 3,077,262,889	$ 2,963,937,832	$ 2,993,891,773
4	Premium Refunds/Retroactive Disenrollments	-	-	-	-	(1,550,543)	(1,486,657)	(5,343)
5	Medicare Part D (RDS) Subsidy	2,517,513	1,693,507	4,809,051	4,193,048	14,177,803	14,587,080	19,484,823
6	Medicare PDP (EGWP + Wrap) Subsidy	-	56	453	48,603,021	-	48,602,498	48,603,406
7	Medicare Advantage (MA) Subsidy	100,788	153,140	206,405	333,795	866,820	828,983	959,319
8	**Net Premium & Other Contributions**	**284,856,788**	**260,337,514**	**792,010,487**	**792,483,983**	**3,090,756,969**	**3,026,469,736**	**3,062,933,978**
9								
10	Investment Earnings	666,168	383,814	1,933,112	1,287,502	3,269,599	3,871,779	6,037,729
11	Miscellaneous Revenue	-	-	-	-	-	-	-
12	**Other Revenue**	**666,168**	**383,814**	**1,933,112**	**1,287,502**	**3,269,599**	**3,871,779**	**6,037,729**
13								
14	**Total Plan Revenue (excludes internal transfers)**	**285,522,956**	**260,721,328**	**793,943,599**	**793,771,485**	**3,094,026,568**	**3,030,341,515**	**3,068,971,707**
15								
16	**Plan Expenses:**							
17								
18	Medical Claim Payments	154,265,563	193,947,253	520,913,321	517,907,444	2,191,757,976	2,128,799,496	2,067,095,284
19	Medical Claim Refunds/Recoveries	(1,331,950)	(2,628,303)	(5,625,004)	(6,214,655)	(26,876,079)	(25,072,202)	(23,709,307)
20	**Net Medical Claims**	**152,933,613**	**191,318,950**	**515,288,317**	**511,692,789**	**2,164,881,897**	**2,103,727,294**	**2,043,385,977**
21								
22	Pharmacy Claim Payments	65,135,165	57,462,178	189,207,211	173,438,700	803,327,996	718,955,282	766,818,503
23	Pharmacy Claim Rebates	-	-	(13,666,155)	(11,815,970)	(50,098,630)	(57,020,841)	(96,193,453)
24	Pharmacy Claim Refunds/Recoveries	(9,151)	(150,603)	(37,652)	(172,316)	-	-	(5,347,179)
25	**Net Pharmacy Claims**	**65,126,014**	**57,311,575**	**175,503,404**	**161,450,414**	**753,229,366**	**661,934,441**	**665,277,871**
26								
27	**Net Claim Payments**	**218,059,627**	**248,630,525**	**690,791,721**	**673,143,203**	**2,918,111,263**	**2,765,661,735**	**2,708,663,848**
28								
29	**Medicare Advantage Premium Payments**	**16,114,225**	**14,212,589**	**47,931,227**	**42,559,850**	**190,926,384**	**174,072,089**	**172,517,202**
30								
31	**Net Administrative Expenses**	**12,628,491**	**11,529,425**	**42,741,374**	**62,510,490**	**249,818,709**	**239,864,700**	**187,419,975**
32								
33	**Total Plan Expenses (excludes internal transfers)**	**246,802,343**	**274,372,539**	**781,464,322**	**778,213,543**	**3,358,856,356**	**3,179,598,524**	**3,068,601,025**
34								
35	Plan Income/(Loss)	**38,720,613**	**(13,651,211)**	**12,479,277**	**15,557,942**	**(264,829,788)**	**(149,257,009)**	**370,682**
36								
37	**Cash Availability:**							
38								
39	Beginning Cash Balance/(Deficit)	988,976,692	1,044,056,499	1,015,218,028	1,014,847,346	941,270,180	1,014,847,346	1,014,847,346
40	Ending Cash Balance/(Deficit)	1,027,697,305	1,030,405,288	1,027,697,305	1,030,405,288	676,440,392	865,590,337	1,015,218,028
41								
42	Target Stabilization Reserve @ 12/31	262,630,014	248,909,557	262,630,014	248,909,557	262,630,014	248,909,557	243,779,746
43								
44	Cash Balance Over/(Under) Reserve Target	$ 765,067,291	$ 781,495,731	$ 765,067,291	$ 781,495,731	$ 413,810,378	$ 616,680,780	$ 771,438,282

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

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended March 2016
Calendar Year 2016

#		A	B	C	D	E	F
		Actual Year to Date Calendar Year thru March	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Calendar Year to Date thru March	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 786,994,578	$ 4,813,485	$ 791,808,063	$ 770,440,381	$ 21,367,682	2.77%
4	Premium Refunds/Retroactive Disenrollments	-		-	(388,193)	388,193	-100.00%
5	Medicare Part D (RDS) Subsidy	4,809,051		4,809,051	2,991,747	1,817,304	60.74%
6	Medicare PDP (EGWP + Wrap) Subsidy (Note 3)	453	(453)	-	-	-	
7	Medicare Advantage (MA) Subsidy	206,405		206,405	214,145	(7,740)	-3.61%
8	**Net Premium & Other Contributions**	**792,010,487**	**4,813,032**	**796,823,519**	**773,258,080**	**23,565,439**	**3.05%**
9							
10	**Other Revenue**	**1,933,112**		**1,933,112**	**922,397**	**1,010,715**	**109.57%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**793,943,599**	**4,813,032**	**798,756,631**	**774,180,477**	**24,576,154**	**3.17%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	515,288,317		515,288,317	523,139,563	(7,851,246)	-1.50%
17	Net Pharmacy Claims	175,503,404		175,503,404	170,669,268	4,834,136	2.83%
18	**Net Claim Payments**	**690,791,721**	-	**690,791,721**	**693,808,831**	**(3,017,110)**	-0.43%
19							
20	**Medicare Advantage Premiums**	**47,931,227**		**47,931,227**	**47,553,639**	**377,588**	0.79%
21							
22	**Net Administrative Expenses** (Notes 4 and 5)	**42,741,374**	**14,370,347**	**57,111,721**	**72,936,762**	**(15,825,041)**	**-21.70%**
23							
24	**Total Plan Expenses (excludes internal transfers)**	**781,464,322**	**14,370,347**	**795,834,669**	**814,299,232**	**(18,464,563)**	**-2.27%**
25							
26	**Plan Income/(Loss)**	**12,479,277**	**(9,557,315)**	**2,921,962**	**(40,118,755)**	**43,040,717**	**-107.28%**
27							
28	**Cash Availability:**						
29							
30	Beginning Cash Balance/(Deficit)	1,015,218,028		1,015,218,028	941,270,180	73,947,848	7.86%
31	**Ending Cash Balance/(Deficit)**	**1,027,697,305**	**(9,557,315)**	**1,018,139,990**	**901,151,425**	**116,988,565**	**12.98%**
32							
33	Target Stabilization Reserve @ 12/31/2016	262,630,014		262,630,014	262,630,014	-	0.00%
34							
35	**Cash Balance Over/(Under) Reserve Target**	**$ 765,067,291**	**$ (9,557,315)**	**$ 755,509,976**	**$ 638,521,411**	**$ 116,988,565**	**18.32%**

Adjustment Notes:

1. Member premiums adjusted to include $53.4 million in prepaid January premiums received in December 2015.
2. Member premiums adjusted to exclude $48.6 million in prepaid April premiums received in March.
3. EGWP subsidies were not budgeted and are therefore excluded.
4. Net administrative expenses adjusted to reflect the normal monthly invoice cycle (net of -$3.4 million).
5. Administrative expenses adjusted to include a $17.8 million federal fee payment that was budgeted for January 2016 but was actually made in December 2015.

Adjusted Variance Report Based on Certified Budget
Calendar Year to Date Through March 2016

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended March 2016

Fiscal Year 2015-2016

		A	B	C	D	E	F
		Actual Year to Date Fiscal Year thru March	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Fiscal Year to Date thru March	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums **(Notes 1 and 2)**	$ 2,307,456,141	$ (27,211,073)	$ 2,280,245,068	$ 2,261,943,455	$ 18,301,613	0.81%
4	Premium Refunds/Retroactive Disenrollments	-		-	(1,136,090)	1,136,090	-100.00%
5	Medicare Part D (RDS) Subsidy	13,379,967		13,379,967	10,337,654	3,042,313	29.43%
6	Medicare PDP (EGWP + Wrap) Subsidy **(Note 3)**	453	(453)	-	-	-	
7	Medicare Advantage (MA) Subsidy	636,670		636,670	631,528	5,142	0.81%
8	**Net Premium & Other Contributions**	**2,321,473,231**	**(27,211,526)**	**2,294,261,705**	**2,271,776,547**	**22,485,158**	**0.99%**
9							
10	**Other Revenue**	**5,247,100**		**5,247,100**	**2,898,327**	**2,348,773**	**81.04%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**2,326,720,331**	**(27,211,526)**	**2,299,508,805**	**2,274,674,874**	**24,833,931**	**1.09%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	1,544,451,223		1,544,451,223	1,575,747,713	(31,296,490)	-1.99%
17	Net Pharmacy Claims **(Note 4)**	510,919,851	1,612,006	512,531,857	499,374,027	13,157,830	2.63%
18	**Net Claim Payments**	**2,055,371,074**	**1,612,006**	**2,056,983,080**	**2,075,121,740**	**(18,138,660)**	**-0.87%**
19							
20	**Medicare Advantage Premiums**	**135,007,138**		**135,007,138**	**133,404,499**	**1,602,639**	**1.20%**
21							
22	**Net Administrative Expenses (Note 5)**	**132,764,437**	**4,133,000**	**136,897,437**	**189,116,833**	**(52,219,396)**	**-27.61%**
23							
24	**Total Plan Expenses (excludes internal transfers)**	**2,323,142,649**	**5,745,006**	**2,328,887,655**	**2,397,643,072**	**(68,755,417)**	**-2.87%**
25							
26	**Plan Income/(Loss)**	**3,577,682**	**(32,956,532)**	**(29,378,850)**	**(122,968,198)**	**93,589,348**	**-76.11%**
27							
28	**Cash Availability:**						
29							
30	Beginning Cash Balance/(Deficit)	1,024,119,623		1,024,119,623	1,024,119,623	-	0.00%
31	**Ending Cash Balance/(Deficit)**	**1,027,697,305**	**(32,956,532)**	**994,740,773**	**901,151,425**	**93,589,348**	**10.39%**
32							
33	Target Stabilization Reserve @ 6/30/16	254,285,909		254,285,909	254,285,909	-	0.00%
34							
35	**Cash Balance Over/(Under) Reserve Target**	**$ 773,411,396**	**$ (32,956,532)**	**$ 740,454,864**	**$ 646,865,516**	**$ 93,589,348**	**14.47%**

Adjustment Notes:

1. Member premiums adjusted to include $21.4 million in prepaid July 2015 premiums received in June 2015.
2. Member premiums adjusted to exclude $48.6 million in prepaid April premiums received in March.
3. EGWP subsidies were not budgeted and are therefore excluded.
4. Net pharmacy claims adjusted to exclude an unbudgeted $1.6 million recovery from a class action law suit.
5. Net Administrative Expenses adjusted to reflect normal monthly invoice cycle.

Adjusted Variance Report Based on Certified Budget
Fiscal Year to Date Through March 2016

Legislative Update

Board of Trustees Meeting

May 13, 2016

A Division of the Department of State Treasurer

Legislative Update Overview

- Budget Update
- Key Issues for Short Session
- Other Plan-Related Legislation
- Next Steps

Budget Update

- The Governor released his FY 2016-17 Recommended Budget Adjustments on April 27
  - Reallocated the $71 million held in reserve for the employer share of CY 2017 premium increases
  - Clarification from Office of State Budget and Management (OSBM) indicates that funds were allocated elsewhere because the Plan had not yet met the “sufficient measures” requirement outlined in the biennial budget (SL 2015-241)

- Plan Staff met with House Appropriations Chairs to discuss ongoing efforts on May 3

- Anticipate release of House budget recommendations in the next few weeks

State Health Plan Requested Legislation

- Plan Agency Bill filed in House and Senate on May 10
  - HB 1121 and SB 865 included provisions that address the following Plan issues:
    - Mandate contractor release of data to the Plan;
    - Clarify Plan's exemption from certain contracting rules;
    - Modify local government participation in the Plan;
    - Clarify ACA reporting responsibilities for State employers
  - SB 865 would increase the cap on local participation to 20,000 individuals; HB 1121 does not include this provision
  - We will continue to engage with the General Assembly as the bills move through the legislative process

HB1027 / SB808: 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
  - Options such as increased appropriations from the General Assembly, auto-enrollment into Medicare Advantage Plans, increasing retiree premiums and cost-share, etc.

- Status: House referred to Insurance Committee; Senate referred to Rules and Operations Committee

- Fiscal Impact: None

SB815: 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: To be determined

HB1048: Reduce Barriers to Improve NC Health & Safety

- Bill Summary:
  - Encourages the use of Abuse-Deterrent Opioids, when available
    - Limits the use of prior authorization and step therapy with regards to these drugs
  - Establishes explicit criteria for the use of step therapy by health plans
    - Requires that all step therapy protocols are based on clinical evidence and coupled with a comprehensive exceptions process

- *These requirements would not apply to the Plan*

- Status: Filed in the House

- Fiscal Impact: None

Next Steps

Budget Related

- Monitor the development of House and Senate budgets, with an emphasis on the availability of funds for employer premium contribution for 2017
- Having already met with House Appropriations leadership, the Plan will also seek to meet with Senate Appropriations leadership in the next few weeks

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

Board Action on Benefit Design, Plan Options & Premiums

Board of Trustees Meeting

May 13, 2016

A Division of the Department of State Treasurer

Board Action

1. 2017 Benefit Designs

   Plan staff recommends approval of the benefit designs and cost sharing changes outlined on slides 5-7 as well as the corresponding changes to family out of pocket maximums and out of network cost sharing outlined on slides 42-51 of the *2017 Benefit Design Changes* presentation, effective January 1, 2017.

2. Coverage of Specialty Medications

   Plan staff recommends the Board reverse its February 5, 2016 action authorizing transition of specialty medications from the medical to the pharmacy benefit to be reconsidered at a date in the future.

Board Action on Benefit Design, Plan Options & Premiums

Board of Trustees Meeting

May 13, 2016

A Division of the Department of State Treasurer

Board Action

1. 2017 Benefit Designs

   Plan staff recommends approval of the benefit designs and cost sharing changes outlined on slides 5-7 as well as the corresponding changes to family out-of-pocket maximums and out-of-network cost sharing outlined on slides 42-51 of the *2017 Benefit Design Changes* presentation, effective January 1, 2017.

2. Coverage of Specialty Medications

   Plan staff recommends the Board rescind its February 5, 2016 action authorizing transition of specialty medications from the medical to the pharmacy benefit.

Patient Centered Medical Home Practice Pilot

Board of Trustees Meeting

May 12, 2016

Patient Centered Medical Home Pilot: Year 1 Update

- The PCMH Pilot was initiated in May - August 2015 and includes the following four practices:
  - Eagle Physicians and Associates
  - CaroMont Health
  - NHRMC Physician Group
  - Novant Health
- Year 2 of the pilot was initiated on May 1, 2016
- The PCMH pilot has been a learning experience for the Plan and is allowing us to assess the provider relations strategy.

Report to SHP Board of Trustees

PCMH Pilot

Eagle Physicians and Associates

May 12, 2016

Year 0: Eagle Physicians and Associates, PA

- Greensboro and Guilford County
- 58 providers
  - 43 primary care providers
  - 8 primary care sites (IM, family medicine, pediatrics)
  - Also Walk-in Clinic, GI, endocrinology, OB-GYN, and sleep medicine
- Developed from the merger of several practices 20 years ago with some additions
- Value our site individuality
  - We don’t try to look the same
  - But what should be centralized?

Year 0: Participation in PCMH pilot

- Came at the right time in our development
  - We participate in a successful ACO, Triad HealthCare Network, but we needed more skills in our own practice
  - We recognized the need to develop further skills and processes in population health and care management
  - We needed financial resources to do so
- Ability to use resources that we developed for more than SHP patients – this was crucial
- Care coordinator visiting patients in the hospital – brilliant!

EAGLE PHYSICIANS

Year 1: Costs, processes, staff changes

- Implementation costs
  - Existing staff time (Dr. Osborne, Dr. Weissman, Vicki Gregory, Terri Jones)
  - Additional staff needed: Data Analyst, Patient Care Advocate
- Process changes
  - PCA: visiting patients, coordinating care management strategies (with AHM and other CM programs), gap closing
  - Data Analyst: tracking our population(s), producing gap lists
- Staffing changes
  - Reduced the need for sites to "garden" the list(s) and close gaps
  - Allowed site staff to concentrate on seeing patients

Year 1 Change drivers: Physician Engagement

- Highest level: Physician Leadership
  - Absolutely critical to have one or more physician champions
  - Dr. Osborne, Dr. Weissman, Dr. Fried (CMIO), Dr. Stoneking (President)
- Middle level: Physician participation in implementation
  - Quality Committee
  - Site physician leadership
- "Street level": Day to day buy-in
  - Make their lives easier, not harder

Added bonus:
Community member on Quality Committee

Year 1 Results: Did it work?

- Clinical Quality Metrics
  - Improvement in DM composite, Mammography rates, Nephropathy screening in DM, DM control, and colorectal cancer screening
  - No change in BP control
- Utilization Metrics
  - Increase in readmissions, ED visits and avoidable hospitalizations (but we were low to begin with!)
  - Drop in radiology costs
- Patient engagement – 85%!

Year 1 Results: Did it work?

- Patient satisfaction
  - Continuously measure six questions (facility, wait time, staff, treatment result, scheduling ease, and overall) – scale of 0 to 5
  - Scores 4.8-4.9, except wait time at 4.6
- Staff satisfaction
  - Overall staff are happy with the tools provided by the PCMH Pilot
  - We have identified continuing cultural issues in our sites
- Physician satisfaction
  - Work-life imbalance

EAGLE PHYSICIANS

Year 1 Results: Did it work?

- Applied similar processes to other populations
- Lessons learned
  - Data management
    - Using the insurance ID as the unique patient identifier
  - We need more help
    - Quality Manager
    - Another Patient Care Advocate
  - Difficulty of focusing on Quality and Utilization at the same time
    - They are really two different strategies

Year 2 and beyond: What is next?

- Looking forward to working with AHM and SHP for year 2
- Eagle is in this for the long haul
- The future of primary care medicine:
  - Value not volume
  - Population health: caring for people that are not in front of you

Primary care practices cannot finance the change they need to make (and you need them to make) in the volume based world!

Year 2 and beyond: What is next?

- Payer responsibility: to create opportunities for primary care to make the changes that our patients need and our health care system needs
- Payer risk
  - Every practice may not have the leadership needed to change
  - PCPs will "take the money and run"
- Our recommendation
  - Build on the lesson learned in the PCMH Pilot
  - Continue and expand incentives for practices to make changes toward population health

NC State Health Plan Board of Trustees Presentation

CaroMont Health

May 12, 2016

Partnership Opportunities

- PCMH-Patient centric Approach
- Care Coordination Fee Design
- Quality Centered Program
- Collaborate directly with the employer

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Year 1 Evolution

- Staffing Appropriation
- Process changes
    - Workflows
    - Patient tracking
    - Scheduling Efficiency
    - Member Outreach

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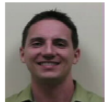
Physician Engagement/Leadership

- Physician-Led Medical Group
- Decision Makers
  - Attend JOC's
  - VP Chief Medical Officer (NEW)
- Clinic Operations
  - Unblinded scorecards
  - Quarterly Provider Meetings
- Monthly Newsletter

April 2016

Quality Improvement Updates



Pharmacy Prudence

New Opioid Guidelines Released

This month the CDC released the final version of its guidelines for prescribing opioids for chronic pain. The guidelines are intended for primary care clinicians who treat patients for chronic, non cancer pain of > 3 months not receiving palliative or end-of-life care.[1]

The pendulum of treating pain has swung. In the 1980s and 90s, patients were commonly found to be inadequately treated for pain. Calls from the Federation of State Medical Boards to adequately treat pain and the Joint Commission adopting pain as the fifth vital sign in 2000 led to more awareness and interventions for patients experiencing pain.[2] Drug manufacturers of prescription opioids strongly marketed opioids, and minimized risks of misuse and addiction.[3] Patient satisfaction surveys that included the assessment of pain became tied to physician performance and reimbursement.[2]

Today, there exists an opioid epidemic in the US. Nearly 20,000 deaths in 2014 resulted due to overdose of prescription opioids, and 2 million people met diagnostic criteria for substance use disorder involving prescription opioids, the highest in recorded history.[2] Despite a nearly 300% increase in prescription opioid sales since 1999, data suggest that there is no significant change in the amount of reported pain that patients in the US experience.[4]

There is well established short term opioid efficacy from RCTs of 12 weeks or less, with moderate pain relief and small benefits for functional outcomes. However, the CDC guidelines found no efficacy trials of opioid use for > 1 year vs placebo related to pain, function, or quality of life. Therefore, nonpharmacologic therapy such as exercise and cognitive behavioral therapy, along with nonopioid therapy is preferred for first line for chronic pain. This is due to lower risks with therapy and short term efficacy. Unfortunately, there are little data to support nonopioid therapy in long term pain relief.[1]

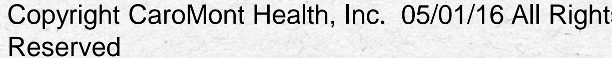
The quality of trials and data used to compose the CDC guidelines are moderately weak to weak. While not graded exactly the same as Beer's Criteria, the strength of the data is comparable. Most data on harms and adverse events are from cohort, case-control, and cross-sectional studies with notable limitations. No randomized controlled trials were found for harm and adverse events.[1]

Key points from the CDC to providers are to use nonopioid therapies for chronic pain, starting at the lowest possible effective dose (to avoid patients becoming addicted to opioids from acute pain, duration of 3 days is recommended). Start with immediate release formulations, never extended release. Close monitoring of the patient is essential, with the option of using validated instruments such as the PEG scale. Risk of overdose is dose dependent, and additional precautions should be implemented when a patient is put on opioid doses of 50 morphine milligram equivalents per day. Benzodiazepines should be avoided whenever possible, and muscle relaxers can also increase risk of opioid use.[1]

There are many other recommendations in the guidelines to assist in safety and efficacy in treating pain. While the guidelines do not address the art of treating chronic pain, they do outline the current science, which is limited.

Thomas Henry, PharmD BCPS

References:
1. CDC guideline for prescribing opioids for chronic pain – United States, 2016. MMWR Recomm Rep 2016;65(RR-1):1-49
2. Olsen Y. The CDC guideline on opioid prescribing: Rising to the challenge [editorial]. JAMA 2016.1910[Epub ahead of print].
3. Van Zee A. The promotion and marketing of oxycontin: commercial triumph, public health tragedy. Am J Public Health 2009;99:221-7.
4. New CDC Opioid Prescribing Guidelines: Improving the way opioids are prescribed for safer chronic pain treatment. CDC website. Available at: http://stacks.cdc.gov/view/cdc/36833. Assessed March 24, 2016.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Quality Improvement

- Alignment of measures within the Medical Group

Measure Name	Num.	Den.	Source	2014 Baseline	2015 Q2 Results	2015 Q3 Results	2015 Q4 Results	2015 Target
Diabetes Composite	158	236	AHM/EMR	66.40%	66.03%	63.33%	88.61%	72%
HBA1c Test 2x Year, LDL Screening, Blood Pressure every visit, Diabetes Tobacco Assessment, Aspirin Therapy								
Persistent Asthma on ICS	31	34	AHM	96.4%	100%	100%	91.2%	96.40%
Rate of ED Visits per 1000	N/A	N/A	AHM	95.3	98.7	95.4	103.6	90.8
Rate of Inpatient Avoidable Hospitalizations (Admits/per 1000)	N/A	N/A	AHM	0.80	1.30	2.30	1.90	1.1
Rate of Readmissions	53	61	AHM	8.8%	11.1%	9.5%	13.1%	8.3%
Radiology Costs PMPY	N/A	N/A	AHM	$146.17	$127.42	$142.77	$99.43	$137.50
Engagement	179	204	AHM	N/A	N/A	17.29%	87.74%	See Tiering PY2
Tobacco Screening	115	150	EMR	66.4%	73.4%	73.8%	76.6%	75%
Mammogram	552	635	AHM	84.3%	85.8%	88.2%	86.9%	86%
Colorectal Cancer	668	1,131	EMR	54.8%	63.6%	60.2%	59%	56.80%
BP Control (<140/90)	826	1,112	EMR	65.0%	77.2%	76.7%	74.2%	70.00%
Medical Attention for Nephropathy	199	230	AHM	79.3%	83.3%	85.9%	86.5%	87.50%

CaroMont Health
Performance 3rd Quarter Data

Healthier You Class

– Program Overview:
- 12 week program for patients with BMI >30 with co-morbidity
- Patients identified by the PCP, or the Care Navigator
- Pharmacist does lesson on weight loss meds and the pros and cons with them

- Outcome Measurements:
  1. Monitor BP, Weight & Waist Circumference
  2. Review Food Diaries weekly & discuss for tips
- Patient Goals:
  1. Identify Carbs, Fats & Sodium
  2. Label Reading Skills (Calorie King Book Given)
  3. Health Choices & Lifestyle changes
  4. Chair Exercise (Tension Bands given)
  5. Water Consumption (Water Bottles given)
  6. Document in Food Diary all meals

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Outcome Discussion

Healthy You Program

Member Case Study 1

Pre	Post
Weight=230 lbs	Weight=208 lbs
A1C=7.0	A1C=6.5
LDL=68	LDL=50
Trig=204	Trig=118
Waist Circumference=51	Waist Circumference=49.5
*Pt referred to the CaroMont Health and Fitness Center	

Member Case Study 2

Pre	Post
Weight=211.4 lbs	Weight=195.6 lbs
Waist Circumference=40.25	Waist Circumference=37.5
LDL=116	LDL=103

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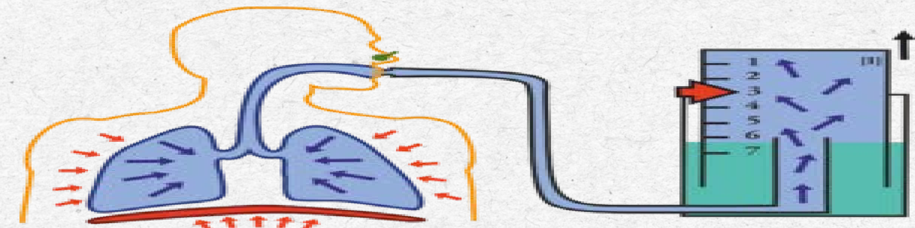
Patient Outcome

- Past Medical History: Diabetes, High Blood Pressure, and High Cholesterol
- Diabetes Education on November 2015
- Enrolled in Healthy You class on January 2016
- 4th week of class beneficiary expressed concern that they were having intermittent palpitations and tightness in their chest when they had increased their activity.
- Next day appt. with PCP for evaluation
- Scheduled stress test
- Abnormal stress. Heart catheterization completed.
- Noted CAD (Coronary Artery Disease)
- Patient was able to return back to class and complete 10 of the 12 weeks of class

Spirometry Training

- Background: CMG Care Coordination identified a barrier with Patients diagnosed with COPD not qualifying for Pulmonary Rehab due to lack of diagnosis by spirometry.
- Spirometry Training was provided to clinic staff
- Respiratory Therapist trained clinic staff:
  - Providing spirometry testing
  - Testing and calibrating the equipment
  - Screening Appropriate patients
  - Educating patients on the procedure to ensure accurate data



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Make the Right Call

- New Initiative at CaroMont to help patients "Make the Right Call" between using their PCP vs Urgent Care vs ED visits
- Roll out to clinics in 2016
- Plan is to educate the providers and clinic on giving the information out to all new patients and those with inappropriate use of the ED

Your guide to
Make the right call

When you're sick, it's sometimes hard to know who to call. Your Primary Care Provider is usually your best choice, but what if you need to go straight to the Emergency Department? Talk with your doctor before an emergency happens, using this chart as a guide for what to do in case of an emergency.

When do I call my Primary Care Provider (PCP)?
Your doctor treats a wide variety of mild to moderate injuries, illnesses and conditions during regular office hours, including:
- Allergic reactions, infections, rashes and bumps
- Burns, sprains and cuts
- Fever, flu and colds
- Diarrhea, vomiting, dehydration and indigestion
- Earaches, sore throats, strep throat, sinus and ear infections
- Chronic conditions, including high blood pressure, diabetes, COPD, arthritis, anxiety and depression

When do I visit an Urgent Care Center?
Urgent Care centers are a good option when your doctor's office is closed or you are unable to get a same-day appointment. Contact your doctor if you have questions before you go. Some injuries and illnesses treated at Urgent Care centers include:
- Diarrhea, vomiting, rashes, strep throat and infections
- Respiratory conditions including minor asthma and COPD
- Fractures and injuries to arms, legs, fingers and toes
- May offer x-ray and wound management care

Emergency Department - Call 911!
Call 911 or visit the nearest emergency department if you experience any of the following:

Heart Attack - Symptoms include chest tightness or pressure and/or pain in the chest, neck, jaw, arms or back and can differ in men and women. Men may experience shortness of breath, unusual fatigue, cold sweat and dizziness. Women may experience unusual fatigue, sleep disturbances, indigestion and anxiety.

Stroke - If you suspect that you or a loved one may be having a stroke, call 911 IMMEDIATELY! Symptoms come on suddenly and include numbness or weakness of the face, arm or leg, especially on one side of the body, confusion, trouble speaking or understanding speech, or trouble seeing in one or both eyes, trouble walking, dizziness or loss of balance and coordination.

Poisoning - Call 911 if there is a loss of consciousness. For suspected poisoning, call the 24/7 poison control center first at 1.800.222.1222 and ask for immediate home treatment. They will instruct you on what to do - some poison should be vomited and others should be diluted. You can also visit www.ncpoisoncenter.org for more information.

Trauma - Serious accidents or injuries should be seen in an emergency setting. Call 911 or visit the nearest emergency department for bleeding that does not stop after ten minutes of direct pressure, sudden and/or severe pain, and major injuries, such as head trauma, severe allergic reactions to insect bites or stings, or severe and/or persistent vomiting.

Fevers above 105°F should always be treated in the emergency department.

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Satisfaction

- Patient Satisfaction
  - Centralized Scheduling
  - Patient education programs offered in community
  - Nutrition Counseling offered in primary care office so member has no out of pocket
- Physician Satisfaction
  - Communication; newsletters and Ops Meetings
  - Embedded Nurse Navigators within Primary Care Offices

HealthStream-3rd party vendor satisfaction surveys

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Lessons Learned/Opportunities

- Lessons Learned
  - Patient readiness assessment
  - Optimizing Patient Outreach for this population

- Opportunities
  - Claims Data Sharing
  - Redefine a flexible engagement strategy
  - Motivate/Incentivize members to improve engagement and self management

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NC State Health Plan – PCMH

Board of Trustees Meeting

May 12, 2016

ROLL CALL / INTRODUCTIONS

Agenda

* Motivation for participating in pilot effort with NCSHP
* Evolution of practice during year 1
* Physician engagement and leadership
* Quality Improvement
* Sustaining change post pilot
* Practice recommendations-Quality care and outcomes

Motivation for Participation

* Form a collaborative relationship to manage the patient population
* Learn how to manage the population with access to payer and pharmacy data
* Pave the way for future efforts in managing patient populations

Evolution of Practice Year 1

- Implementation Costs:
  - Investment of time of management staff working through the processes was likely our greatest expense. In addition, staff time working with SHP patients.
- Internal Processes:
  - Created standing orders to expedite quality care and to allow clinical staff to work at the top of their license
  - Identification of State Health Plan members in Epic, viewable in Epic banner
  - Recognized need to change fragmented workflow and processes throughout the continuum of care
  - Continuous collaborative efforts between inpatient and community resources with focus on continuity of care
- Staffing changes:
  - Expanding Care Management Department staffing and capabilities

Physician Engagement & Leadership

* Role of physicians:
  * Act on identified Care Considerations
  * Support and adhere to the standard work that has been developed

* Physician Leadership:
  * Share the value of pilot participation:
    * Access to data to enhance patient care
    * Introduce patient population management
    * Prepare us for future reimbursement models

* Strategies to engage physicians:
  * Support from executive leadership, physician champions and practice as a whole
  * Ability to identify the patient population inside Epic
  * Present "future state" of alternate payment models highlighting NHMG State Health Plan pilot to primary care and specialty management staff (Presented by Network Leadership)

Quality Improvement

* Change in Quality Metrics:
  * Identification of patient population in Epic for population management
  * Best practice advisory point of care alerts impacted ability to close care gaps
  * Implemented standard work to expedite quality care and allow clinical staff to work at top of license
* Other Outcomes:
  * Discrete Data Capture
  * Analysis to Calculate Performance Metrics
* Patient and Physician Satisfaction:
  * Patients are appreciative of the outreach and communication regarding their care and disease
  * Standardized communication and collaboration between physician/clinical staff to enhance medical decision making resulting in improved patient outcomes and patient satisfaction
* Lessons Learned:
  * Validation to build and implement Healthy Planet dashboard
  * Best Practice Advisories at point of care are essential
  * Need to ensure statistical significance due to low case numbers (#'s)
  * Utilization of Epic data as source of truth for Diabetes Bundle. Accurate denominator

NHRMC Physician Group

Measure Name	Num.	Den.	Source	2014 Baseline	2015 Q2 Results	2015 Q3 Results	2015 Q4 Results	2016 Q1 Results	2015 Target	Region 5 Percentile
Diabetes Composite	126	158	EMR	70.51%	79.29%	77.42%	80.71%	79.75%	75%	N/A
HBA1c Test 2x Year, LDL Screening, Blood Pressure every visit, Diabetes Tobacco Assessment, Aspirin Therapy										
Persistent Asthma on ICS	18	19	AHM	95%	95%	90%	94.7%		93%	N/A
Rate of ED Visits per 1000	N/A	N/A	AHM	93.6	82.3	89.3%	86.3%		93.6	89
Rate of Inpatient Avoidable Hospitalizations (Admits/per 1000)	N/A	N/A	AHM	2.7	1.3	3.9	1.40		2.23	100
Rate of Readmissions	52	54	AHM	7.1%	3.6%	3.3%	3.7%		6.5%	92
Radiology Costs PMPY	N/A	N/A	AHM							
Influenza Vaccine	1003	1271	EMR	47.77%	63.84%	63.84%	57.78%	78.91%	53.3%	N/A
Tobacco Screening	1549	1572	EMR	90.34%	87.35%	82.67%	89.06%	89.28%	90%	N/A
Engagement	16	39	AHM	N/A	N/A	N/A	41.0%		See Tier PY2	N/A
Medical Attention for Nephropathy	171	172	AHM	87.6%	90.2%	92.7%	90.7%	99.42%	90%	82
Screening for Clinical Depression (PREV12)	1346	1696	EMR	58.09%	72.18%	63.60%	63.83%	79.36%	60%	N/A
Colorectal Cancer Screening	650	753	EMR	83.4%	84.92%	83.46%	85.36%	86.32%	72%	N/A

New Hanover Medical Group

NHRMC Physician Group

Sustaining Change Post Pilot

* Culture Shift towards population management
  * Expansion of the Care Management Department staffing and capabilities
  * Further development of standing orders to expedite quality care and to allow clinical staff to work at the top of their license

* Healthy Planet
  * Native to Epic
  * Care Gap Reports
  * High Risk Patient Identification
  * Outreach Tracking
  * Patient Outreach Encounter
  * Bulk Messaging/Orders

* Ongoing relationship and collaboration with ActiveHealth

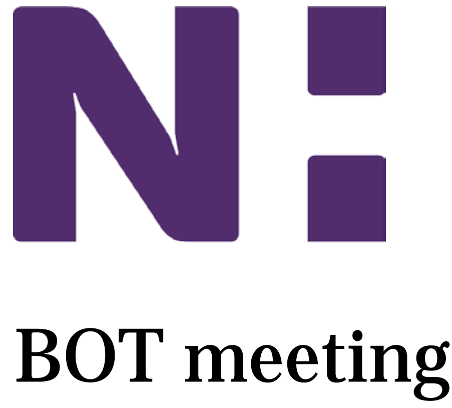
Practice Recommendations

* Use approved quality metrics for standardization amongst payers and reporting, which aligns with payment reform
* Utilization of USPTF clinical guidelines and recommendations

New Hanover Medical Group
NHRMC Physician Group

Questions/Comments/Feedback

NHRMC Physician Group



BOT meeting

May 12, 2016 4 to 6 p.m.

Motivation for participating in pilot effort with NCSHP

- Ability to work collaboratively with NCSHP to identify opportunities to improve the quality of care to our patients. This included coordinated efforts and resources between Novant Health, State Health Plan (SHP), and Active Health Management (AHM).
- Opportunity to receive and utilize attribution reports from SHP to identify this particular patient population.

Evolution of group during year 1

- Attributed population is approximately 12,000 patients between Winston-Salem and north Mecklenburg sub groups
- Novant Health achieved a 100 percent attribution match rate in Epic dashboard dedicated to the SHP population.
- Dedicated staff committed to SHP, including
  - 2 RN FTEs to work the transitions of care and referrals from SHP
  - 1 RN FTE to work quality measures from SHP and dashboard reporting
  - 1 pharmacist working medication alerts (adherence, high risk, etc.)
  - 1 value-based performance coordinator dedicated to the success of the contract

Physician engagement and leadership

- Novant Health has physician leadership dedicated to:

  Population health | Quality & HEDIS
  Information technology | RAF/HCC coding
  Pharmacy

- CMIO instrumental in setting up payor dashboards and reviewing metrics in program
- Communicate with care coordinators through Epic on care gaps, chronic conditions, pharmacy and social needs
- Novant Health providers have patient-level detail dashboard reports
- Medical group quality operations team comprised of MDs, CNO, population health, managed care representation to set goals

Program Successes

- 100 percent attribution match rate in Epic
- Improvement in A1c screen rates for diabetic population in both Winston-Salem and north Mecklenburg markets
- Patients express appreciation for the care coordination outreach, including help in “getting back on track” with preventive screenings
- Care coordinators express satisfaction in developing more in-depth relationships with patients

Quality improvement challenges

- **Engagement contractual requirement**: The two outreach connections by care coordinators and an office visit makes it difficult to determine patient engagement and reporting.

- **Quality metrics**: Contractual quality metrics vary greatly from dashboard metrics (e.g., diabetic composite), making it difficult to utilize Epic reporting for quarterly reporting to SHP.

- **Transitions of care reporting:** Care coordinators are required to complete weekly spreadsheets and return to SHP.

- **Data sharing**: Timing of reports and claims lag creates difficulty reconciling data between SHP and Novant Health

Making healthcare remarkable, one patient at a time

Meet Saundra: Female age 43, diagnosed with multiple sclerosis in 1999. Receiving infusions for MS, and is active in making appointments with her neurologist. She agreed to engaged with the RN care coordinator. One concern was her ability to attend holiday parties due to immunocompromised state and the need to wear a mask. The care coordinator suggested decorating mask, which delighted the patient.

Meet Catherine: Female patient, age 26, diagnosed with Hodgkin's Lymphoma during her pregnancy. Care coordinator called patient post hospital discharge to review discharge plan and ensure follow up appointments were in place. She connected patient with a cancer navigator and referred her back to the Active Health Management pregnancy program.

Recommendations and next steps

Recommendations

- Work with ActiveHealth to streamline the identification and risk stratification of members
- Explore better integration with existing Novant Health care coordination processes and workflows to address patient needs more holistically directly from our EHR platform.
- Novant Health assumes responsibility for the full process of care gap identification and resolution, which aligns with existing Novant Health quality improvement initiatives and our PCMH pilot contract metrics.
- Continue to identify opportunities to improve care gap closure and increase SHP member engagement utilizing EHR platform.

Next steps

- Plan for program year 2 with SHP and AHM
- Discuss process improvements, automation and operational efficiencies with AHM

RivalHealth Wellness Program

Board of Trustees Meeting

May 12, 2016

A Division of the Department of State Treasurer

Presentation Overview

- NC Health*Smart* and RivalHealth Introduction
- RivalHealth Presentation
- RivalHealth Wellness Program for State Health Plan Members

NC Health*Smart* and RivalHealth

- The State Health Plan offers a variety of health and wellness resources through NC Health*Smart.*

- The Plan has expanded the NC Health*Smart* suite of services to include the RivalHealth wellness program in order to:
  - Enhance opportunities for members to implement healthy behaviors
  - Provide programs that suit differing member needs
  - Incentivize organizations to support the health of their employees

RivalHealth is made available through the Plan's contract with BCBSNC.

RivalHealth

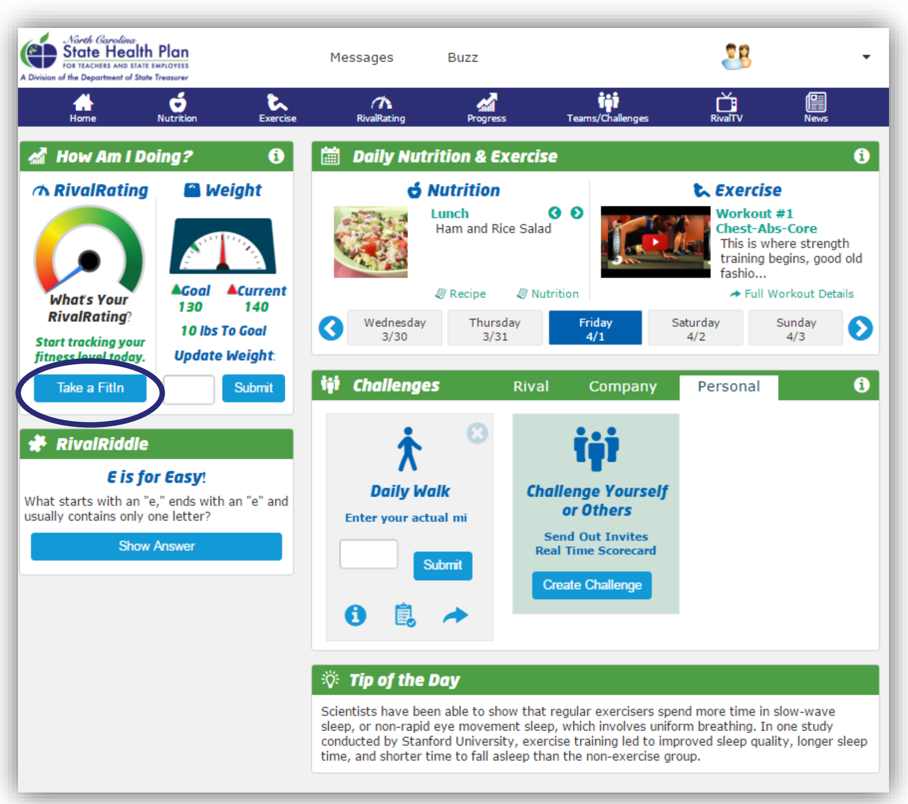
RivalHealth

- RivalHealth is a fitness-based wellness platform that engages members with daily exercise and nutrition activities and sustains engagement through social interaction, challenges, incentives and outcomes.
- RivalHealth has experience engaging employees in various worksite environments.
- This platform will provide members with an additional resource to enhance healthy behaviors related to physical activity and nutrition.

RivalHealth

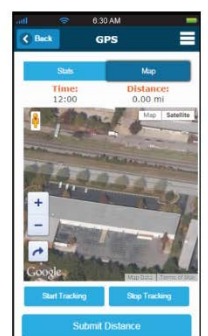
- It outlines what to do each day to reach goals
- It's personalized – members receive their own daily plan for exercise and healthy eating
- It encourages members to engage with teams and challenges to stay motivated
- It can be accessed anywhere through a friendly mobile app

Measure, Track, Improve

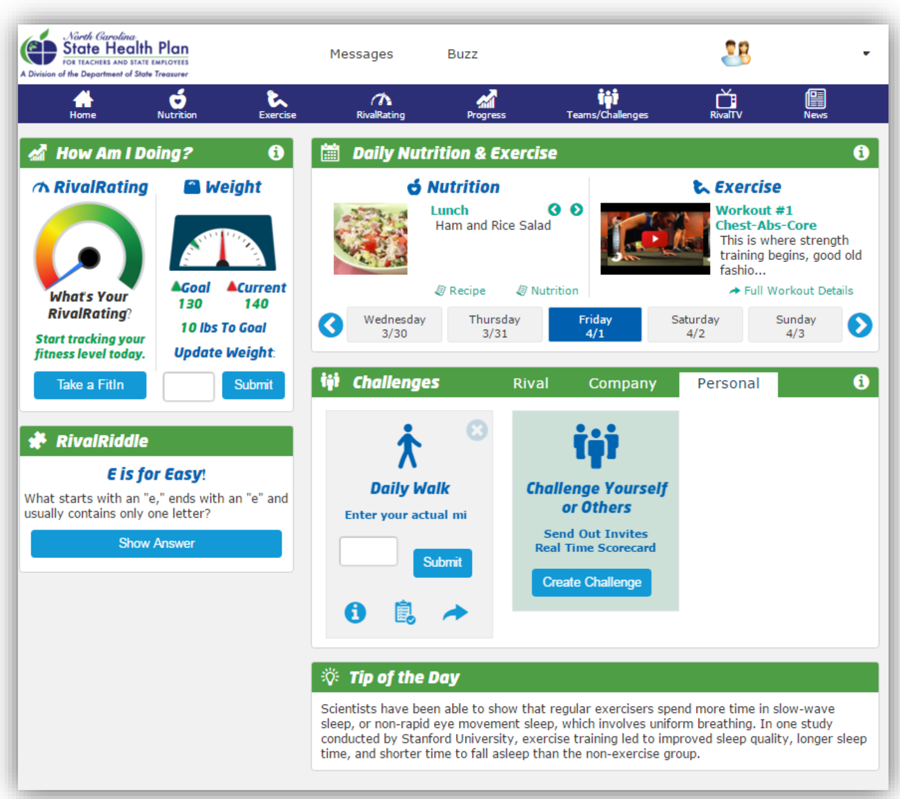


HOW CAN I MEASURE SUCCESS?

Our registration process determines someone's starting point and goals. The patent-pending RivalRating then serves as the standard measure of current fitness ***vs. others of the same age and gender***, allowing improvement to be tracked.

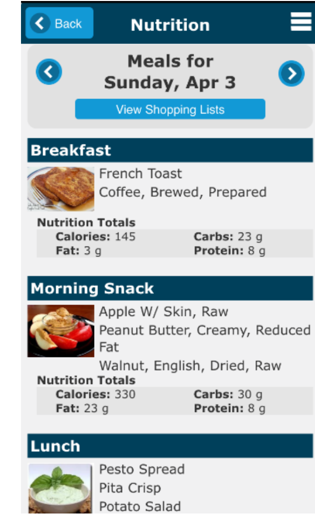


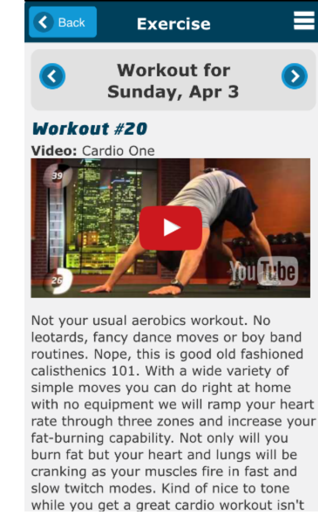
Engage and Coach



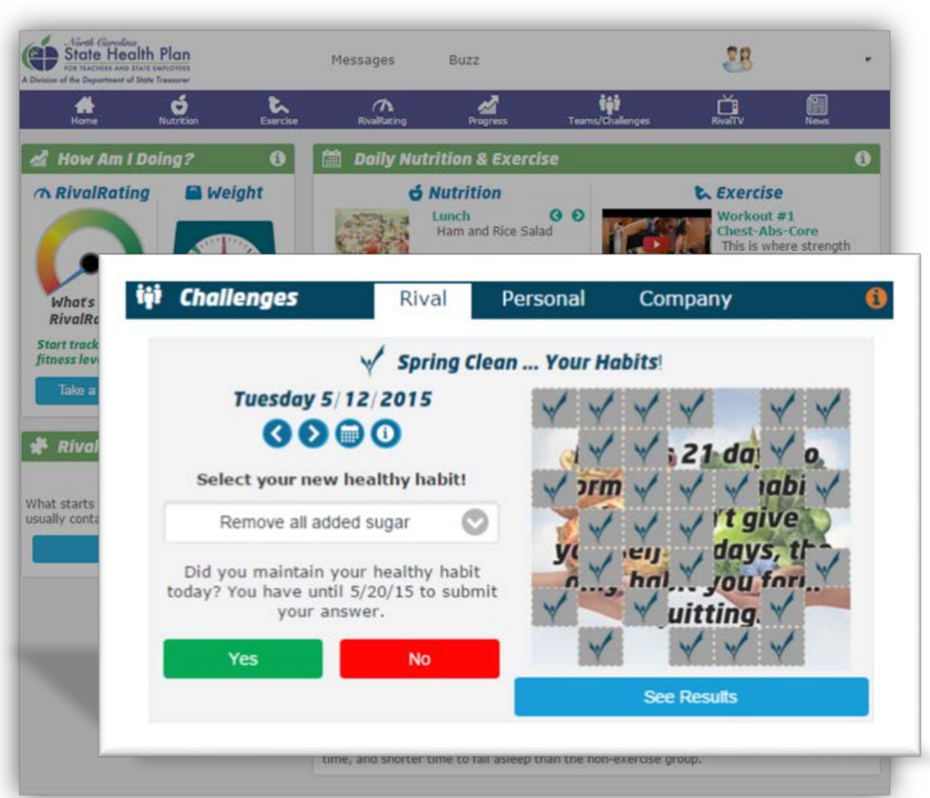
HOW DO I IMPROVE?

Personalized exercise and nutrition plans are generated daily, showing the member "what to do." These plans are created based on the original assessment, goals, and progress made.



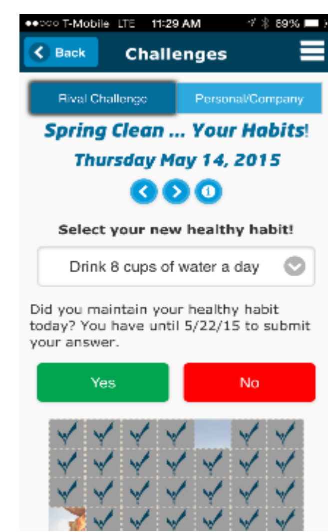


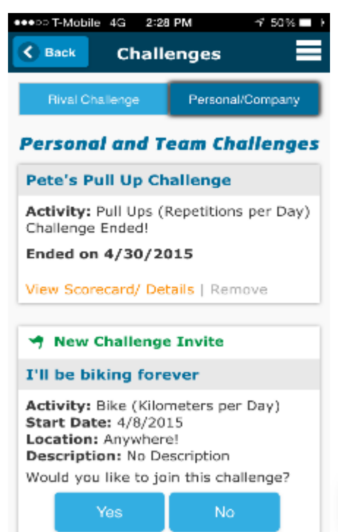
Maintain Engagement



HOW DO I ENGAGE WITH OTHERS?

Teamwork, competition, and social integrations fuel ongoing engagement not only between the members and the platform, but also between colleagues and family members, as well.





RivalHealth for Plan Members

Partnership for a Healthy Tomorrow

Beginning April 1, 2016, RivalHealth was made available to the following subset of the Plan's membership :

- **CDHP Subscribers and their Spouses**
- **Local Education Agencies (LEAs)/School Districts**
  - Schools are unique organizations and an alternate strategy is necessary to meet their needs and foster success
  - Healthy schools help create healthy students
  - All public school districts that demonstrate a willingness to promote staff wellness and meet pre-defined criteria
- **Wellness Champions Program**
  - The Plan's Wellness Champions Program is a network of wellness advocates that can earn incentives towards their worksite wellness program by completing various health activities
  - Wellness Champions who meet certain benchmarks that show a commitment to promoting workplace wellness

Wellness Champion Participation Criteria

- **To qualify for the RivalHealth offering a worksite agrees to:**
  - Have representatives in the Wellness Champions Program
  - Obtain written leadership support to:
    - Allow a wellness leader 4-6 hours a month to focus on staff wellness
    - Encourage staff to participate in wellness activities
  - Have an established wellness committee that meets at least quarterly
  - Agree to ongoing submissions of the quarterly questionnaire to report wellness activities completed

Partnership for a Healthy Tomorrow

School Staff:

- School superintendents and principals received a cobranded letter from DST and DPI on the importance of staff wellness and how RivalHealth can help schools accomplish staff wellness
- DPI included an additional promotion in their newsletter to all school staff on May 9

Wellness Champions:

- Two webinars were held for Wellness Champions to learn more about how RivalHealth could support their wellness program
- One-on-one meetings are being held with Wellness Champions who meet preliminary qualifications

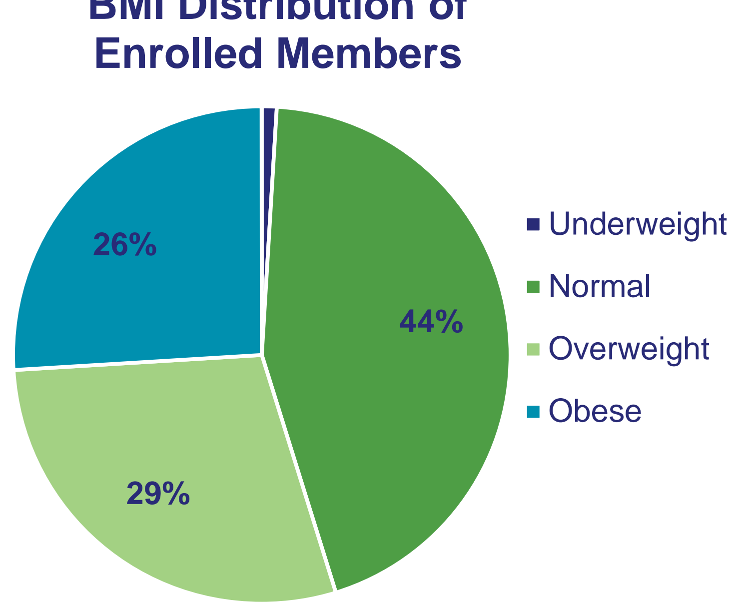
Consumer-Directed Health Plan Members

CDHP Members:

- CDHP members received information in the mail with details
- Three webinars were held on the new resources available for CDHP members in April
- Information is available on shpnc.org

Current Enrollment:

- 104 CDHP members enrolled
- Combined weight loss goal of 2,542 lbs.



Modify Coverage of Specialty Medications

Board of Trustees Meeting

May 13, 2016

A Division of the Department of State Treasurer

Coverage of Specialty Medications

At the February Board of Trustees meeting the Board approved the transition of specialty drugs (except oncology drugs) from the medical benefit to the pharmacy benefit in the following phases:

Timeframe		
Phase 1	Self Administered, Hemophilia, IVIG	June 1, 2016
Phase 2	Remaining Rare Diseases	January 1, 2017
Phase 3	Physician Administered	June 1, 2017

Specialty Medications Transition Update

With transition planning and implementation underway, two items have surfaced that have caused Plan staff to revisit the implementation timeline:

- **New PBM Contract** – Both Express Scripts and CVS offer programs to support the transition of drugs from the medical benefit to the PBM. The customer experience for members and providers is different under each PBM's model. Instead of rolling out the program to the first phase of members on June 1st, only to transition them again on January 1, 2017, Plan staff believes it would be better to delay the rollout until the new PBM contract is in place.
- **Medicare Part B Requirements** – The majority of specialty drugs targeted for transition are considered by Medicare to be "Part B," not "Part D" drugs. This means we have to introduce new claims processing rules at the PBM because the drugs currently covered by the PBM are only considered "Part D" drugs.
  - **Coordination of Benefits (COB)** – The PBM must coordinate benefits with Medicare at the point of sale for Medicare Primary Members
  - **"Phantom B" Processing** – The PBM must also follow special Medicare COB rules that are outlined in GS 135-48.38, which require the claim to be processed as if the member had Part B coverage even if they did not enroll in Part B. While both PBMs have standard Medicare COB processing functionality, neither Express Scripts nor CVS has ever processed claims using the "Phantom B" rules and may have to build functionality to support it.

Specialty Medications Transition Update

The impact of the Medicare COB requirements cannot be overstated:

- In addition to the fact that we consistently have a large number of Medicare Primary members eligible for this program, it is also important to note that we have hundreds of new members becoming Medicare Primary every month. Their Medicare Part A & B statuses can change monthly, which means we need to make sure the current electronic data interface (EDI) can provide the PBM with the information needed to process the claims appropriately.
  - More than 39,000 Medicare Primary members eligible for the program
  - Approximately 1,600 of these do not currently have Part B
- The original data that was reviewed did not include Medicare Primary members. The recent data refresh highlights the fact that Medicare Primary members make up over 40% of the eligible population in the self-administered category alone.
  - 420 Non-Medicare Primary members
  - 297 Medicare Primary members
- Plan staff believes more due diligence is required to review data for the Medicare population and determine next steps.

Coverage of Specialty Medications Recommendation

- To minimize member disruption and ensure CVS has time to implement the required Phantom B processing logic, the Board is asked to delay the transition.
- Plan staff will continue to work with CVS to develop an implementation plan to transition coverage at a later date and provide updates at the June and August Board meetings about target transition dates and phases.
- Plan staff recommends the Board rescind its February 5, 2016 action authorizing transition of specialty medications from the medical to the pharmacy benefit.

Pharmacy Benefit Management Implementation: 2017 Pharmacy Formulary and Program Considerations

Board of Trustees Meeting

May 13, 2016

A Division of the Department of State Treasurer

Presentation Overview

2017 Pharmacy Formulary and Program Considerations

- Medication Adherence Program
- Member-Pay-the-Difference
- Closed Formulary

Pharmacy Formulary and Program Considerations

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

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
   - Approximately10,000 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.*

Medication Adherence Program

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

Programs Already in Place and Available to All Members:

- **Generic Cholesterol-lowering Medications -** The copay for all generic cholesterol-lowering medications on the Traditional 70/30 or Enhanced 80/20 plans is $4 for a 1-month supply, or $10 for a 3 month supply The lower copays apply at any retail pharmacy or via home Delivery. The MAP copays are not applied under this 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

April 27, 2016 Proposed Plan Design Changes

- Enhanced 80/20 Plan – The 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	$14	$28	$42	**$35**
Proposed 2017	1	$5	$10	$15	NA
2016	2	$40	$80	$120	**$100**
Approved 2017	2	$45	$90	$135	**$112.50**
Proposed 2017	2	$25	$50	$75	NA

- If the proposed value based plan design is approved, there will not be a copay on Tier 3 so 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 web site 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.

Medication Adherence Program Proposal

The other important factor to consider when evaluating MAP is that the program 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 program.

- Based on the new plan options and plan design features that have been added since MAP was introduced as well as the ones currently under consideration, Plan staff believes discontinuing MAP effective 1/1/17 is the best course of action.
- Once evaluation of CVS's 90-Day Network is complete, we 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. This program was intended to encourage generic drug utilization and penalize members who elected to purchase a brand when a generic was available.
  - Tier 1 – Generics
  - Tier 2 – Preferred Brands
  - Tier 3 – Non-Preferred Brands
- 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 4 – Preferred Specialty
  - Tier 6 – Non-Preferred Specialty
- As we move to more value based benefits, the tiers will become even more blended. While we always want to encourage generic utilization, we also want to promote other value added medications. Therefore, we are currently evaluating whether there are any high costs brands that may need to move to Tier 1.

Member Pay the Difference Proposal

- Plan staff believes it is time to discontinue the "Member Pay the Difference" program.
- Strategies for steering members to more appropriate drugs have evolved over time.
- The member cost-sharing structure has also changed. We simply have more tools in the toolbox than we did when this was rolled out.
- This is also probably the most confusing program we have. It does not contribute to a positive member experience.

Closed Formulary

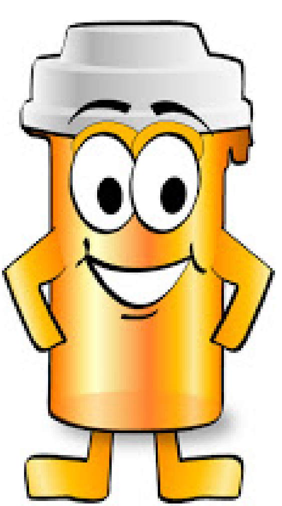
We have previously discussed that the Plan can realize additional savings by adopting a "Closed" Formulary. These savings come primarily through additional discounts and rebates that are available when only certain brands are included in the formulary.

- **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, CDHP 85/15, and Traditional 70/30 Plans.
- **Closed Formulary** – In a "closed" formulary, certain drugs are excluded. Plan members on the HDHP have ESI's standard formulary which is closed.
- **Member Disruption** – Plan staff is currently evaluating the member impacts, or disruption, of adopting the CVS exclusion list. We believe we will be able to move to some version of a closed formulary, but whether or not we adopt the entire exclusion list is still to be determined. While it will be impossible to avoid some disruption, we want to minimize it where possible and ensure it is clinically appropriate.

CVS Standard Closed Formulary

The Plan has completed an initial 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

- Plan staff believes the best course of action for the traditional plans is to move towards a closed, custom formulary.
- By closing the formulary, we will benefit from additional savings.
- By customizing it, we will not only be able to support the move to value based benefits, but also make any other changes we believe are in the best interest of the Plan and Plan members.
- We will use the current tier structure as the starting point of any changes.

Plan Staff continues to evaluate the best option for the HDHP.

Medicare Advantage Update

Board of Trustees Meeting

May 13, 2016

2017 Medicare Advantage Renewal Status

Medicare Advantage Contracts

- **Contracts** - The Medicare Advantage contracts were set up as three year contracts with the option of two, one year extensions. We are currently in year three of these contracts.
- **2017 Renewals** – The CMS call letter, which kicks off the Medicare Advantage renewal process, was issued the first week of April. The Plan received the initial renewal packages from Humana and UnitedHealthcare on Friday April 29th. After a couple of rounds of reviews, Plan staff is close to making a recommendation for 2017.
- **Next Steps** – Once the recommendation is finalized it will be shared with the Board and with stakeholders in preparation for a final vote at the June Board meeting.
  - May 20th - Stakeholder Roundtable
  - June 2nd or 3rd - Board Meeting

Member Experience and Communications Update

Board of Trustees Meeting

May 13, 2016

A Division of the Department of State Treasurer

Comprehensive Communications and Marketing Strategy Update

Buck Consulting

- The first two deliverables outlined in the contract with Buck Consulting included:
  - **Communications Audit**
    - The purpose of the audit was to provide a proactive and strategic analysis of where the State Health Plan's communications are, along with recommendations and action steps for improvement.
    - The assessment was designed to review communication materials for effectiveness, accessibility, readability, clarity and visual appeal.
  - **Comprehensive Communication and Marketing Strategy**
    - The goal of a comprehensive strategy is to improve member health and wellness, improve health literacy and inform and engage leadership, managers, HBRs, members and retirees in this transformation.

Communications Audit

Executive Summary

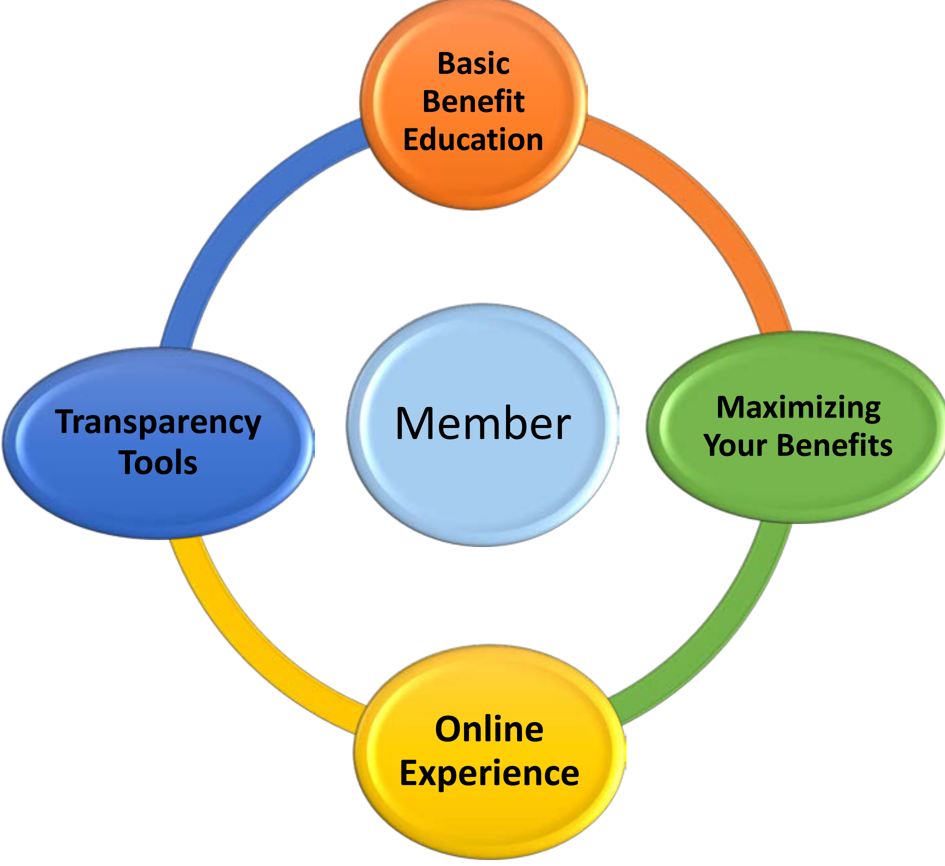
- "The State Health Plan offers its employees generous health and wellness benefits. The State also provides thorough benefit descriptions and information on how each plan works."
  - Ways to improve and enhance the Plan's current efforts:
    - Focus on a high-level health plan overview up front and then break down each plan separately
    - Develop a new brand and create a brand guide for all communication materials
    - Turn required communications into an opportunity
    - Educate employees about their plan throughout the year
    - Consolidate communications
    - Work to make communications more inviting

> "The Plan is by and large executing an effective communication strategy. The Plan leverages multiple media to help members receive the right information at the right time. For the most part the current strategy contains the components for impactful and successful communications."

Comprehensive Communication Strategy

Overall Goal

- To develop an integrated participant communication program and strategy that is focused on encouraging members to become engaged with the Plan to maximize their benefits and improve their health.



2016 At a Glance

Initiative	Audience	Timeline	Deliverables	Status
Establish Health Literacy Component in each SHP e-Newsletter	All members	January 2016	Create design element in each newsletter to highlight different monthly literacy topics	Complete
Enhance HBR Engagement Strategy for Training and Outreach	HBRs	January 2016	Establish monthly HBR webinars Establish quarterly HBR onsite training Work to offer online training modules	Complete
Navigating your State Health Plan Benefits and Medicare Meeting Series	Pre-65 members	March- August	Secure 40 locations and promote events to members, stakeholders and HBRs	Complete More than 3,400 members are registered to attend
Health Engagement Program	CDHP members	April	Program launch includes: website, direct mail, HBR and member webinars	Complete
Diabetes Prevention Program	At-risk members	May	Program launch includes: website, direct mail, HBR and member webinars	In progress
SHP 101 Webinar Series	All members	March-December	Develop a series of webinars and telephone town halls aimed at educating members on different literacy topics	In progress
CDHP Lunch-n-Learn Information Session Pilot	CDHP members	March-May	Finalize presentation	Finalize dates with DOT and DOR
2017 Open Enrollment Strategy	All members	August-October	Buck to develop project plan based off of brainstorm session held on 2/25/16	In progress
Wellness Champions (RivalHealth)	Wellness Champions	April-October	Program launch included in Health Engagement Program materials and targeted outreach to school personnel.	In progress
Alternative outreach and education avenues	All members	TBD	Research SHP modules in NCVIP, benefits apps, including financial lit. tools	In progress
Buck Consulting will be responsible for the main deliverables shaded in BLUE.				

Quarterly Communication Priorities

- To support our outreach and literacy objectives for 2016, the Plan's Customer Experience and Product Management teams along with Buck will work to increase health literacy among members through various communication methods.
- By increasing health literacy, our goal is to equip our members with the knowledge of how to be better health care consumers by maximizing their State Health Plan benefits.
- People learn and absorb complex information in different ways. This year, we hope to try different communication tactics that appeal to our members.

Quarter 1	Health Engagement Program Diabetes Prevention Program SHP 101 Webinar Series
Quarter 2	Navigating your State Health Plan Benefits and Medicare Meeting Series SHP 101 Webinar Series Wellness Champions/RivalHealth Launch
Quarter 3	Medicare Advantage Outreach Meetings HBR Open Enrollment Outreach Open Enrollment Telephone Town Halls
Quarter 4	Open Enrollment

Diabetes Prevention Program

Launched May 1, 2016

Diabetes Prevention Program

- The Plan is focusing on prevention to help members recognize their risk for developing diabetes and to connect members with the tools they need to prevent or delay the onset of diabetes by offering the Diabetes Prevention Program (DPP).
- DPP is a 12-month class series that covers subjects such as:
  - Nutrition
  - Physical activity
  - Stress
  - Motivation
  - Planning for continued success
- DPP is offered online or onsite, and consists of two phases:
  - Phase I: 16 classes spread out over 6 months
  - Phase II: 6 monthly classes

Diabetes Prevention Program

Eligible Members:

- All CDHP, 80/20, 70/30, and Medicare primary 70/30 members and their covered dependents over the age of 18 can participate in DPP
- Members must have prediabetes to qualify for participation by having:
  - A diagnosis of prediabetes by their physician with an A1c between 5.7% and 6.4% **OR**
  - Scored a 9 or above on the CDC Prediabetes Screening Test

  Note: Diabetic members are **NOT** eligible to participate

Enrollment Process:

- Members can visit www.diabetesfreenc.com to enroll in a DPP series
- At the time of enrollment, members can choose the particular class location where they would like to participate
- DPP costs only $25 for Plan members (a savings of $400)

Diabetes Prevention Program

Communication:

- All members will receive a mailer that:
  - Provides the CDC Prediabetes Screening Test and encourages members to understand their risk
  - Encourages members who score a 9 or above to visit their Primary Care Provider
  - Promotes those at risk to participate in DPP
- Identified providers will receive:
  - A letter announcing DPP as a covered benefit and encouraging them to provide information to their at-risk patients
  - Posters to hang in their office to promote DPP to patients
- Health Benefit Representatives will receive an announcement of the newly covered benefits and will learn more as part of a monthly webinar
- Information on DPP posted on shpnc.org

DIABETES: ARE YOU AT RISK?

Before a person develops type 2 diabetes, they usually have what's called prediabetes.
To find out if you're at risk, answer the questions on the next page and add up your score.

WHAT IS PREDIABETES?

Prediabetes means your blood glucose is higher than normal, but not yet high enough to be considered diabetes.

Here's the good news. With a little exercise and changes to your diet, you can reverse prediabetes and prevent or delay diabetes.

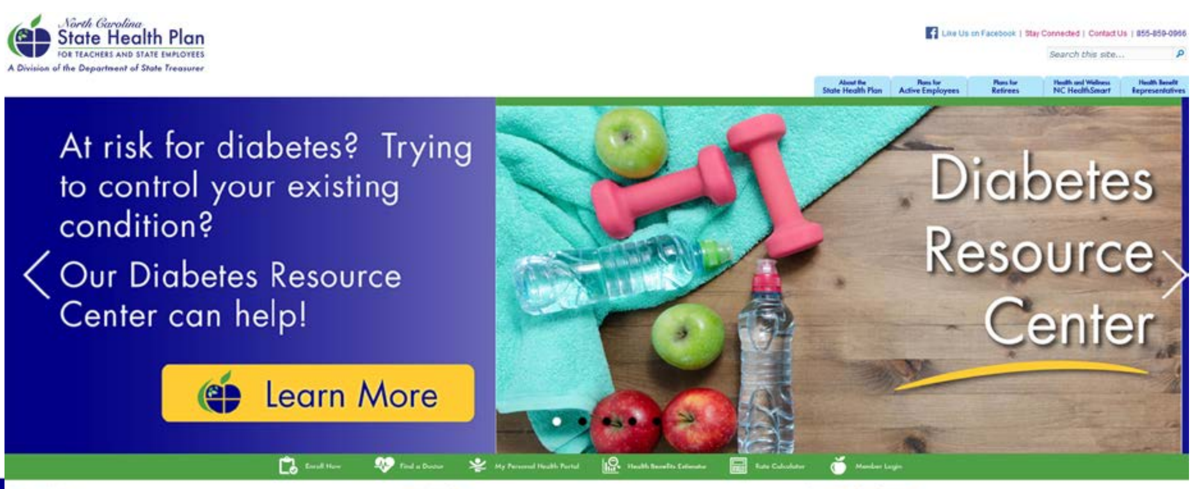
There are many factors that play a part in your risk for diabetes including weight, age and genetics.

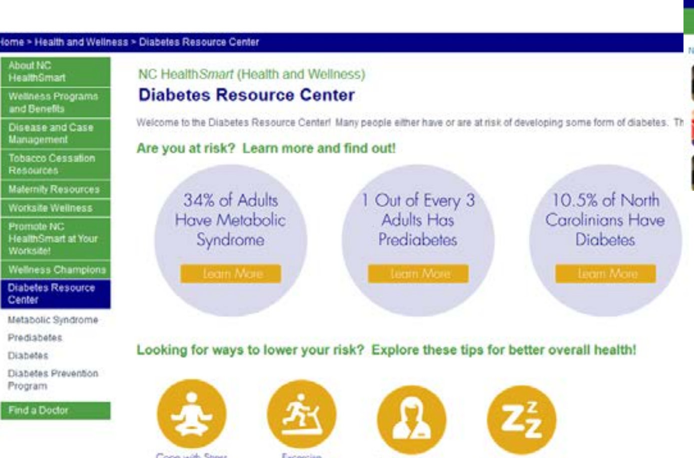
According to the Centers for Disease Control and Prevention (CDC), adults with type 2 diabetes have a higher risk of premature death and serious health issues including heart attack, stroke, kidney failure, blindness and amputation of toes, feet or legs.

Diabetes is expensive. People with diabetes spend more on hospitalization, prescription drugs and doctor visits than the general population.

Diabetes Resource Center

To supplement our ongoing efforts to educate members about their risk and how to manage diabetes, the Plan launched the Diabetes Resource Center on the website.





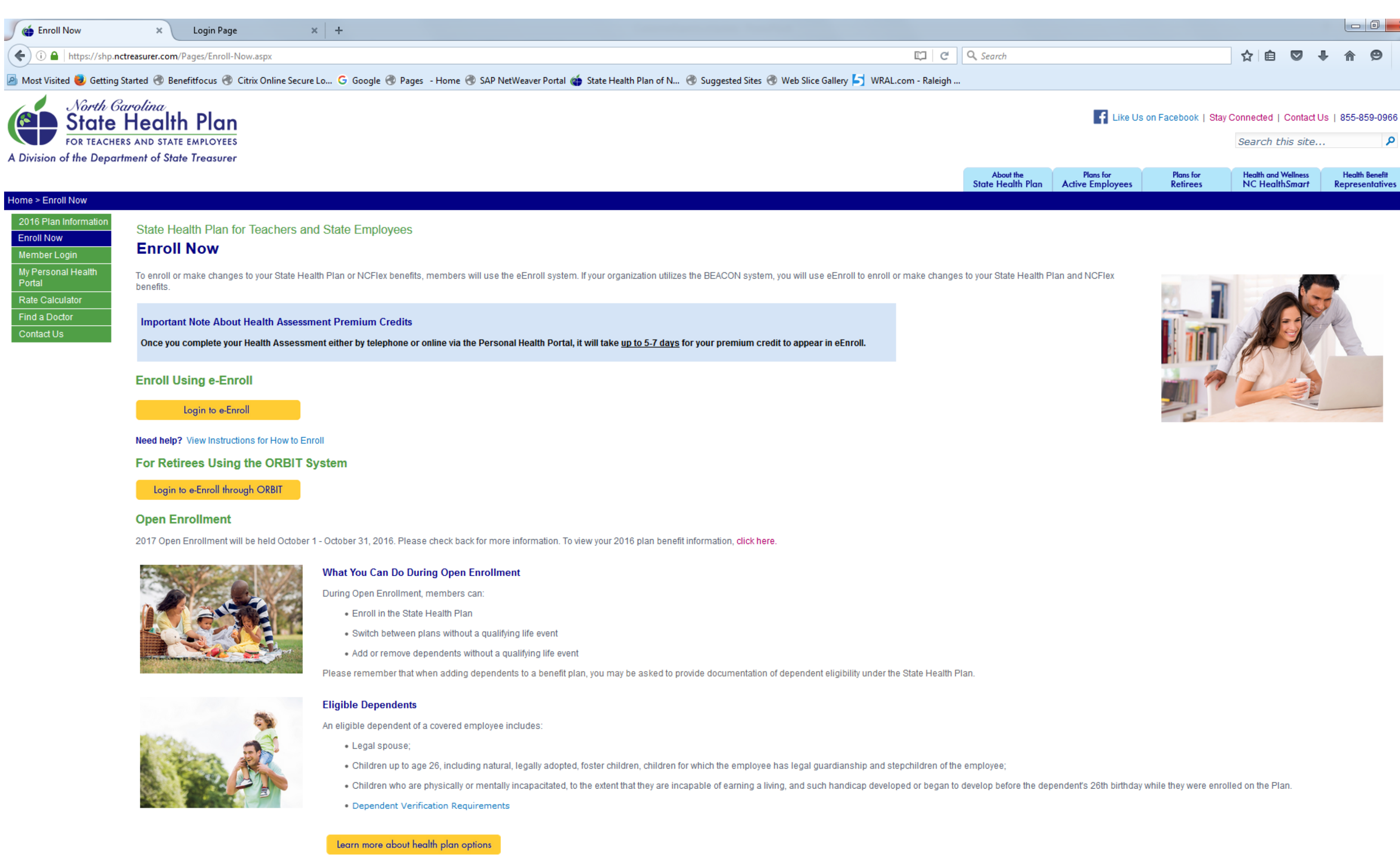
The State Health Plan website receives an average 50,000 views each month. We are hopeful this new tool creates more awareness around how to prevent, treat and manage diabetes.

Improving the Online Enrollment Experience

Benefitfocus User Experience Research

- **Phase I** – User Group Session
  - Informal group conversation focused on the 2015 enrollment experience
  - Intended to identify attitudes and user behaviors, gather feedback and identify key issues / difficulties
- **Phase 2** – Moderated Usability Study
  - Task-based, one-on-one usability interviews based on joint review of workflow
  - Intended to assess the intuitiveness and usability regarding:
    - the new Member Role initial enrollment configuration
    - passive enrollment configuration, with a particular focus on premium wellness credits
  - Nine separate sessions held over a two-day period

State Health Plan Website "Enroll Now"



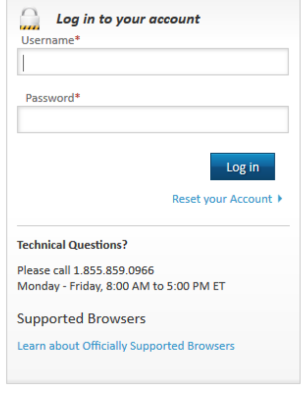
Login

Welcome to the North Carolina State Health Plan's eEnroll system!

If you are part of one of the groups below, please click the appropriate link.
If not, please login using your eEnroll username and password to the right.

State Retirement System (ORBIT)
UNC Chapel Hill and UNC General Administration
UNC Asheville
NC State University
BEACON (Click here if your agency uses BEACON)

eEnroll is used to enroll in your State Health Plan and NCFlex benefits.



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Get Started

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

- Home
- Dependents
- Language Preferences

MANAGE ACCOUNT

- Login Information
- Medicare
- Life Change
- Premium Wellness Credits

QUICK LINKS

- Learning Center

Important Actions for Completing Open Enrollment

Customizable Text

Open Enrollment October 1-31, 2016

All active and Non-Medicare retirees were moved to the Traditional 70/30 Plan. You have until October 31, 2016, to complete your enrollment selection and complete any

Open Enrollment takes place October 1-31, 2016. All active and Non-Medicare retirees were moved to the Traditional 70/30 Plan. You must take action! All three Wellness records. If you need assistance with navigating eEnroll you can view the Enrollment video or call the Support Center at 855-855-0966 M-F 8a.m.-10p.m and on Saturdays

Get started >

Ability to get straight to credit activities from this screen.

Important Messages for You

You have new benefits being offered to you:

You have 242 days to elect your Open Enrollment benefits.

A change has been made to your benefits. Please review the change

Completing Open Enrollment

$$$$$ custom page To begin Open Enrollment, please click "Get Started". Once you have completed your elections for 2017, please print a copy of the benefit detail report for Medicare retirees were moved to the Traditional 70/30 Plan. You must take action! All three Wellness Premium Credit activities must be completed by October 31, 2016. Detail Report for your records. If you need assistance with navigating eEnroll you can view the Enrollment video or call the Support Center at 855-855-0966 M-F 8a.m.-10p.m

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Ask a Question | Terms of Use | Privacy Statement

Edit Benefits

Checkmark Removed

✔ Profile ✔ Shop for benefits Confirm & Finish

Open Enrollment Benefits

1/14 Benefits Complete

Whether you want to change your benefits or keep them the same as last year, it's still important that you carefully complete each step in the enrollment process to make sure all of your benefits are covered for the upcoming plan year.

Current Benefits | **Open Enrollment Benefits**

Your benefits

Your 2016 Medical Coverage

You have selected the plan below! You have 242 to make changes to your coverage.

Traditional 70/30 PPO Plan 2017 — $578.86 Per month

Offered by: Blue Cross and Blue Shield of North Carolina
Effective date: 01/01/2017
Persons covered: Tester Five, Spouse Five, Child Tester

Edit plan | Show plan details | Decline benefit

Please review your enrollments

Verify that you have reviewed the information above by selecting the checkbox.

☐ I have reviewed the information above.

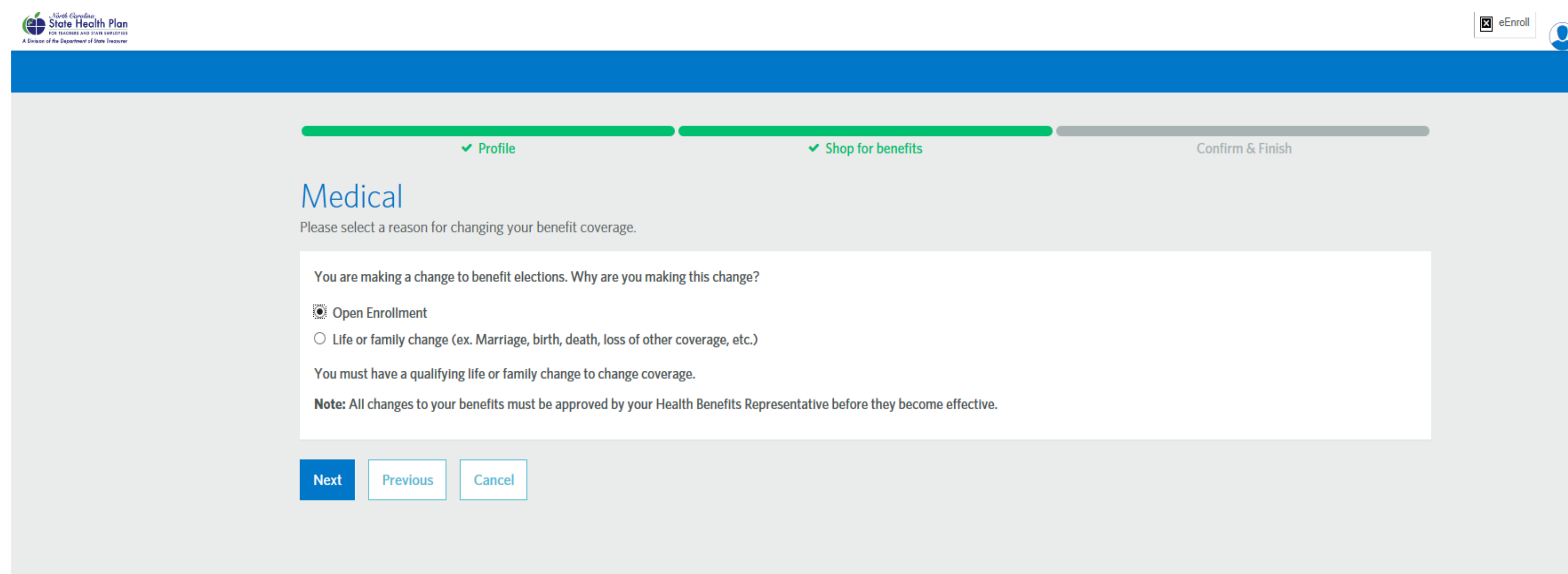
Choose your NCFlex Health FSA Coverage

You have 242 days to choose your coverage.

Begin enrollment | Decline benefit

Complete Enrollment | Return home

Open Enrollment Selection



Pop Up Reminder

Customizable Text

File Edit View Favorites Tools Help

Suggested Sites ▾ Web Slice Gallery ▾ Benefitfocus Citrix Online Secure Login Google Pages - Home SAP NetWeaver Portal State Health Plan of North... WRAL.com - Raleigh New...

Convert ▾ Selec

Page ▾ Safety ▾ Tools ▾

EENCQA4 Version 145274, 2016.1.rel-153, 2016-04-29 11:17

eEnroll Linda Forsberg

Profile Confirm & Finish

Choose your Medical

Please review your options and choose the plan th

Open Enrollment takes place October 1-31, 2016

Covered persons

- TERRY EDWARDS
- Debra Edwards

Add Dependent

2017 State Health Plan Comparison

- 2017 State Health Plan Comparison
- Traditional 70/30 PPO Plan
- Consumer-Directed Health Plan (CDHP)
- Enhanced 80/20 PPO Plan

Open Enrollment takes place October 1-31, 2016

All active and Non-Medicare retirees were moved to the Traditional 70/30 Plan. You must take action! All three Wellness Premium Credit activities must be completed by October 31, 2016. Remember to click SAVE when you have completed your enrollment and print your Benefit Detail Report for your records. If you need assistance with navigating eEnroll you can view the Enrollment video or call the Support Center at 855-855-0966 M-F 8a.m.-10p.m and on Saturdays from 8a.m.-3p.m.

- 70/30 Plan Details

Close

$543.46 *Monthly Cost*

Benefit Year Deductible	$1,054 Individual/$3,162 Family
Emergency Room Copay	$329 Copay, then 30% after deductible
Inpatient Hospital Copay	$329 Copay, then 30% after deductible
Office Visit Copay	$39 Copay
Preventive Care	$39 Copay
Specialist Visit Copay	$92 Copay

Currently Selected Plan details

FSA

Enhanced 80/20 PPO Plan 2017

$750.52 *Monthly Cost*

Benefit Year Deductible	$700 Individual/$2,100 Family
Emergency Room Copay	$233 Copay after deductible, then 20% after deductible
Inpatient Hospital Copay	$233 Copay after deductible, then 20% after deductible
Office Visit Copay	$30; $15 if you use PCP on ID card
Preventive Care	$0 Copay
Specialist Visit Copay	$70 Copay

Plan Selection

State Health Plan

eEnroll

Profile | Shop for benefits | Confirm & Finish

Choose your Medical plan.

Please review your options and choose the plan that best meets your needs.

Open Enrollment takes place October 1-31, 2016

Covered persons

+ Add Dependent

2017 State Health Plan Comparison

2017 State Health Plan Comparison
Traditional 70/30 PPO Plan
Consumer-Directed Health Plan (CDHP)
Enhanced 80/20 PPO Plan

FSA

Traditional 70/30 PPO Plan 2017

$543.46
Monthly Cost

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Currently Selected | Plan details

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Office Visit Copay	$30; $15 if you use PCP on ID card
Preventive Care	$0 Copay
Specialist Visit Copay	$70 Copay

Premium Wellness Credits

✔ Profile ✔ Shop for benefits Confirm & Finish

Premium credits

Tobacco User Attestation

$0.00 per month

You are NOT a tobacco user or you ARE a tobacco user and attest that you will enroll in QuitLineNC multiple call program before the end of open enrollment or within 30 days of your date of hire. To enroll you must call 800-QUIT-NOW (800-784-8669).

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

- I am not a tobacco user
- I am a tobacco user but agree to enroll in QuitLineNC multiple call program before the end of open enrollment or within 30 days of my date of hire
- I am a tobacco user

Next

Primary Care Provider

✔ $25.00 per month

Health Assessment

$0.00 per month

Next Previous Cancel

Medical Summary

State Health Plan

eEnroll

✔ Profile ✔ Shop for benefits Confirm & Finish

2017 SHP Medical Summary

Your 2017 SHP Medical benefit summary is shown below. To make changes, click Edit. Please note that your benefits have not been saved. You must click Save to complete the section.

Medical

$685.52 *per month*

Enhanced 80/20 PPO Plan 2017

Offered By: Blue Cross and Blue Shield of North Carolina

Effective Date: 01/01/2017

Persons Covered: TERRY M EDWARDS, Debra Honeycutt Edwards

Medicare Edit

1 policy on record

Show details >

Additional Insurance Edit

No policy on record

No additional insurance policy information on record

Edit plan | Plan details

Cart Summary

This is a summary of your OE benefit elections.

Benefit Elections

Monthly Cost

Eligible for Employer Contribution

Medical	$750.52
Subtotal	$750.52
Premium Wellness Credits	($65.00)
Monthly Total	**$685.52**

You Pay

Monthly Total:	**$685.52**

Save | Cancel

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Questions? Plea

Enrollment Confirmation

North Carolina State Health Plan

eEnroll | Linda Fors

Home
Profile
Benefits
Dependents
Language Preferences

MANAGE ACCOUNT

Login Information
Medicare
Life Change

Congratulations, TERRY! You have successfully completed your enrollment process.
Your confirmation number is: 172780505-b66f72. Please review and print your Benefit Detail Report for your records.
Print y[redacted]lment details

A note from your Health Benefits Representative

Customizable Text

*pre confirmation custom page Open Enrollment takes place October 1-31, 2016. All active and Non-Medicare retirees were moved to the Traditional 70/30 Plan. You must take action! All three Wellness Premium Credit activities mus completed by October 31, 2016. Remember to click SAVE when you have completed your enrollment and print your Benefit Detail Report for your records. If you need assistance with navigating eEnroll you can view the Enrollment videc Support Center at 855-855-0966 M-F 8a.m.-10p.m and on Saturdays from 8a.m.-3p.m.

Next

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Ask a Question | Terms of Use | Privacy Statement

Questions? Please call 85
Monday through Friday, 8:00 a.m. to 5

Open Enrollment

- Open Enrollment will be held Oct. 1-31, 2016
- The Eligibility and Enrollment Support Center will offer extended hours during Open Enrollment.
    - Monday-Friday, 8 a.m.-10 p.m.
    - Saturdays, 8 a.m.-3 p.m.
- Open Enrollment for the High Deductible Health Plan (HDHP) will also be held Oct. 1-31, 2016.
    - The Plan will not allow groups to conduct HDHP enrollment outside of this window.

2017 Open Enrollment Communications

Open Enrollment Communications Strategy

Members

Website

Direct Mail

HBRs

Email

Videos

Webinars

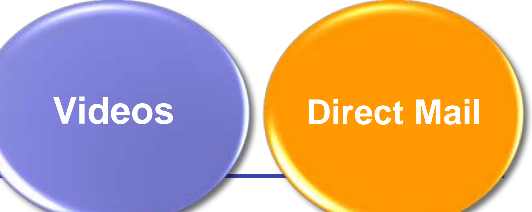
Educational Meetings

HBR Training and Outreach

HBR Outreach	Preview of 2017 Changes
HBR Update articles HBR Alerts Onsite Training Sessions Monthly Webinars	• Promote Open Enrollment early • How wellness plays a part in 2017 changes • Introduce Wellness Premium Credit changes

HBR Training sessions are currently scheduled for end of July. In order to produce materials for these trainings, benefits need to be finalized by June 6, 2016.

Member Communication Plans



Member Outreach – Phase I	Overview of 2017 Changes
What's New Mailer What's New Video	• Promote Open Enrollment early • How wellness plays a part in 2017 changes • Introduce Wellness Premium Credit changes
Member Outreach – Phase II	**Review 2017 Options and Resource Tools**
Online Learning Modules Whiteboard Video Webinars	• Plan details for each option • How to choose and how to enroll • Promote informational sessions
Member Outreach – Phase III	**Make a Decision That is Right for Your Family**
Decision Guide Onsite Meetings Statewide Invite to Telephone Town Halls Testimonial Video Reminder Postcard	• Enrollment Events • Enrollment has started, take action now • Option overview • Reference website and enrollment kit

In order to develop and produce "What's New" mailer and video, benefits need to be finalized by June 6, 2016.

Member Communication-*Medicare Retirees*

Videos

Member Outreach – Phase I	Overview of 2017 Changes
What's New Mailer What's New Video Outreach Meeting Invitation Booklet	• Promote Open Enrollment early • How wellness plays a part in 2017 changes
Member Outreach – Phase II	**Review 2017 Options and Resource Tools**
Outreach Meeting Invitation Booklet Decision Guide	• Enrollment Events • Plan details for each option • How to choose and how to enroll • Promote informational sessions
Member Outreach – Phase III	**Make a Decision That is Right for Your Family**
Outreach Meetings Statewide Invite to Telephone Town Halls Reminder Postcard	• Enrollment Events • Enrollment has started, take action now • Option overview

In order to develop and produce "What's New" mailer and video, benefits need to be finalized by June 6, 2016.

Concept to Mail: A Look at Direct Mail Timeline

Concept Draft (2 weeks)

Design Layout (2 weeks)

Route for Edits (2 weeks)

Revisions (1 week)

Final Approval (1 week)

Printing (2-3 weeks)

Mail Circulation (3-7 days)

Approximately 9-10 Weeks

MAIL

Appendix

1. Communications Audit: Employee Communication Assessment Report
2. 2016 Comprehensive Communication Strategy

North Carolina State Health Plan For Teachers and State Employees

Communications Audit: Employee Communication Assessment Report

December 22, 2015

buckconsultants

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Executive Summary 4

Key Findings and Recommendations 5

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- Accessibility 6
- Clarity 7
- Readability 8
- Visual Appeal 10
  - Current Examples of Communications 11
  - Examples of Visually Appealing Communications 12

Materials Inventory 15

Introduction

Buck Consultants conducted a communication audit for the North Carolina State Health Plan for Teachers and State Employees (“State Health Plan”) to provide a proactive and strategic analysis of where the organization’s communications are, along with recommendations and action steps for improvement.

Our assessment is designed to review employee communication materials for: effectiveness, accessibility, readability, clarity and visual appeal. Our key findings and recommendations are located on the following pages.

Executive Summary

The State Health Plan offers its employees generous health and wellness benefits. The State also provides thorough benefit descriptions and information on how each plan works. In the following pages, we provide more observations of your communications and recommendations for improvement. In summary, we recommend:

- ***Focusing on a high-level health plan overview up front and then breaking down each plan separately.*** Compare the attributes of each plan side-by-side so that an employee can easily see features, in addition to the cost. From there, link to each plan and give “real life” examples of the plans in action so an employee can visualize the “what’s in it for me” aspect. This will allow employees to see the big picture and select the right plan that meets their needs. Another way to accomplish this goal is to segment populations so that employees only see the information that is pertinent to them.
- ***Developing a new brand and creating a brand guide for all communication materials.*** Creating a new brand will help build awareness about the State’s benefit offering. The new brand should aid in the overall readability factor, especially when trying to emphasize important points through call-outs, infographics and charts. Consider increasing the amount of white space and selecting photography that has a similar overall feel. Consider creating a brand guideline that includes templates for emails, posters, postcards, etc. to ensure all communications are consistent and seamless regardless of whom creates them.
- ***Turning required communications into an opportunity.*** Capitalize on required communications, such as Summary Plan Descriptions (SPDs or Benefits Booklets) and Summary of Benefits Coverage (SBCs), to promote benefits and better educate participants on how the plans can work and how they can use them effectively. To accompany the branding aspect, update the current plan documents into brand-compliant and user-friendly reading materials.
- ***Educating employees about their plan throughout the year.*** Look for opportunities outside of Annual Enrollment, either through wellness initiatives, monthly e-bulletins, webinars, etc. to educate your employees. The State Health Plan offers a wealth of resources and vendor tools. Demonstrate to employees how to use those tools in conjunction with their plans.
- ***Consolidating communications.*** Today, plan communications are dispersed across a variety of different documents and pages. Consider consolidating main highlights in a brochure to provide employees with an “At a Glance” resource about each plan.
- ***Working to make communications more inviting.*** In general, the current communications on each page are a list of links to various documents and tools. Aim to include an introduction to the information and then compliment it with more visual elements such as descriptive headers, tables, infographics and callouts to emphasize key features and make documents easily understood.

Key Findings and Recommendations

The following section details findings and recommendations from our review.

Effectiveness

How effectively does communication help individuals understand their benefit offerings?

<table>
<tr><th>Key Findings</th><th>Recommendations</th></tr>
<tr><td>

- Online communications provide minimal descriptions of each plan. An overview or comparison of key highlights of each plan is missing.
  - No marketing of the plan — Why this plan may be a good choice for you
  - Missing the discussion about the differences and similarities between the plans
- Materials do not offer "real life" examples of each plan in action.
- The State Health Plan website provides both a 2016 Rate Calculator and a Health Benefits Cost Estimator that allows individuals to assess their costs per plan.
- Wellness incentives are geared to CDHP or 80/20 plans and aren't inclusive of all plans.
- Communications provide good, comprehensive information about the various wellness programs available to employees.
- The content on the 2016 Annual Enrollment page is dense — it displays materials for actives, retirees and COBRA participants.
- The website does not solicit employee feedback about the user experience.

</td><td>

- On the first level of the website, communicate a detailed description of each plan. Strengthen the main introductory section by providing context on the plan's purpose and "what's in it for me." This provides all-important context for readers before they encounter plan details.
  - Include a plan summary chart/plan comparison chart on the main introductory page.
  - Have a video about choosing your benefit plan on the home page. The "2016 Overview of Plans" video is a great start, but it focuses on enrollment (consider having a generic version up front after enrollment).
  - Provide links for specific information pertaining to each plan.
- For each plan option, consider including "real life" examples. This can help employees relate to how the plans work with their own personal situation.
- Images and infographics are important to catching a reader's eye. Consider replacing some of the images on the side with a helpful infographic. Also consider increasing white space.
- During benefit meetings and webinars, provide opportunities for action and suggest resources. For example, in a webinar, show participants how to calculate their own health benefit needs.
- Provide wellness incentives and activities for all plans.
- Consider segmenting populations so that people only see the information that is relevant to them — especially during Annual Enrollment. Users generally only want to see the information that directly applies to them so they can make an informed decision.
- The "What's New" section of the 2016 Annual Enrollment page is useful and effective. However, the entire page is dense, which lessens readability. It would be useful to distill the information into three distinct sections: What's New, How Do I Decide and Where Do I Enroll. (This is known as the "Learn, Plan, Do" approach to employee communications.)
- Conduct surveys or focus groups to gauge how employees view the website experience. Are they content or overwhelmed? Can they find the information they need, when they need it?

</td></tr>
</table>

Accessibility

How easy is the communication to access, and how diverse are the communication channels?

<table>
<tr><th>Key Findings</th><th>Recommendations</th></tr>
<tr><td>

- Users receive information through a variety of channels:
  - "Pull" channels, such as your website, My Personal Health Portal and vendor websites linked on your current website.
  - "Push" channels, such as flyers, videos, tools (calculators), testimonials, charts, meetings, webinars, brochures and posters.
- The My Personal Health Portal is difficult to find from the NC Health*Smart* home page; it's buried within the first bullet.
  - Comment on the Personal Health Portal YouTube page: "thanks for sharing the portal site. Not easy to find."
- Users must search for health plan information, as it is not located up front on the website. Users must look for the "Looking for 2016 Plan Information" on the scrolling bar in order to find details about their current plan and the plan they elected for the following year.
- There are many different types of communications and documents describing the plans and their features (brochures, videos, tools, etc.).
- Contact information is included on the sidebar and at the top of the website for easy access to a variety of resources.

</td><td>

- Confusion about which tab to click on can be prevented if the plans are housed in one area within the website. Right now, you can click on the top tab and only receive some of the information, whereas most of the information for each plan is housed under the "Looking for 2016 Plan Information" on the scrolling bar.
- Consider creating a single document that highlights "what's new" and the features and benefits of each plan.
- Treat benefits communication as an ongoing process rather than a single event. Benefits Enrollment is an annual event, but encourage employees to be engaged throughout the year by finding opportunities to communicate about health and wellness regularly.
- Consider new avenues to market benefit plans and educate members about the plans, such as social media, interactive videos, etc.
- Consider promoting the Personal Health Portal with higher visibility.
  - For example, employ an attractive ad-like banner on the wellness overview page so that users have easy access to the portal.

</td></tr>
</table>

Clarity

How clearly is the communication presented? What is the hierarchy of information?

Key Findings	Recommendations
• Overall, the communications do not feature a consistent use of headlines, subheads and white space. This can hamper a reader's ability to identify and focus on key messages. • Although videos and links are included throughout most pages, the information on the page is hard to follow because of how it is organized. • Naming conventions differ throughout the website. • Summary Plan Descriptions (SPDs) and Summary of Benefits Coverage (SBC) are up front on the website. • Communications are relatively clear, and there is obvious effort to draft content from the user's perspective (such as using leading questions). The copy is generally conversational and employs appropriate marketing techniques to help "sell" wellness programs and benefit materials to the employee. • There are effective use of landing pages (overview pages) • The website includes a variety of engaging headlines.	• For each main section, include a brief introductory description of what an employee will have access to and learn here. • First-, second- and third-level headings should differ in style and size depending on the communication deliverable (e.g., first heading should be largest). For example, a reader should be able to identify what's a second-level header, versus body text. • Some headlines are more descriptive than others; each headline should state or imply the main benefit of its contents. (For example: "Health Coaching" could be "Get One-on-One Health Support.") • Within landing pages, consider promoting each page link with stronger copy (short, strong words and compelling action/value messages). This creates a smoother and more intuitive user experience – Consider consistency when links are used as a list on a page. On some current pages, the links are bulleted, but on the same page, they are not. – Call out contact information and actionable information outside of the body copy. (You can also have that information concurrently in body copy.) • Add callouts, sidebars and infographics to highlight important information. Pulling small chunks of information out of longer sections helps users understand key points and action items. • Use a consistent naming convention when talking about specific pieces and ensure it is used within the communication, such as in the title. – 2016 CDHP Preventative Medications List ▪ Should be "Preventive" – 2015 vs. 2016 versions ▪ 2015 Uniform Summary of Coverage ▪ Newly Eligible Uniform Summary of Coverage – HDHP • Use consistent buttons on each page. – View the 2016 Rate Calculator (is a button on the Non-Medicare Retiree page), but on the HDHP page, it is a link only • SPDs and SBCs should be located in a legal documents section for further reading. – Currently SPDs are named "Benefit Booklet," which can be misleading • Limit the use of asterisks on web pages.

Readability

How engaging is the communication? Is it inviting?

Key Findings	Recommendations
• Generally, communications lack an introduction. When reviewing the website, content feels more like a list than a well-constructed communication. (The Health and Wellness NC Health*Smart* tab is an exception.) • Summary Plan Descriptions (SPDs or Benefits Booklets) and Summary of Benefits Coverage (SBCs) are written in legalese. These documents fulfill compliance requirements, but may miss an opportunity to promote benefits and educate participants. • While the communications are conversational, many sentences and paragraphs are written above the recommended sixth to eighth grade reading level. – Example: The following copy is written at a 12+ grade level: An important goal of the State Health Plan is to help members with a chronic disease or disease risk factors better manage their condition. Through NC HealthSmart, the Plan offers eligible members* comprehensive educational resources and access to one-on-one nurse coaching and specialty care. • The site contains many good communications: – Benefits Guide, whiteboard videos, etc.	• Improve readability and retention by ensuring materials are simply and clearly written, friendly and engaging. – The 2016 CDHP “Myths or Facts” Information Brochure is a good example of an attractive, clearly written communication. It is vibrant, easy to read, has images, consistency with color and fonts, charts and call-outs. ▪ Other pages within the Health and Wellness NC Health*Smart* tab contain a lot of copy. Consider using call-outs, charts and infographics to break up some of the paragraphs. – In general when creating communications, consider the following: ▪ Have an introduction to the section, but keep it short. Let the reader know the purpose of the communication. ▪ Include lists or bullet points to help break up long paragraphs. ▪ Avoid jargon and benefits-speak. If you need to use benefits-speak, ensure that the word is defined. ▪ Focus on benefits, not features. ▪ Use call-outs, charts and infographics ▪ Call out key points, actions and deadlines. • Use SPDs to fulfill compliance obligations not as the main vehicle for benefit communications. • Promote wellness throughout the year, and use it to educate about benefits. • Use more examples and illustrations to simplify complex concepts and help participants understand how the information applies to their own circumstances. When possible, point participants to personalized tools, such as the Rate Calculator and the Health Benefits Estimator. • Improve readability by ensuring that web copy is short, clear and engaging. Some guidelines to consider: – Wherever possible, use stronger Germanic words over their Latinate equivalents (e.g., use Germanic “help” instead of Latinate “assistance”). – Shorten sentences wherever possible; aim for 20 words or less. – Focus on “you” – instead of the “employee” or “member.” – For example, the following sentence can be re-written at a 7th grade level: ▪ *“An important goal of the State Health Plan is to help members with a chronic disease or disease risk factors better manage their condition. Through NC HealthSmart,*

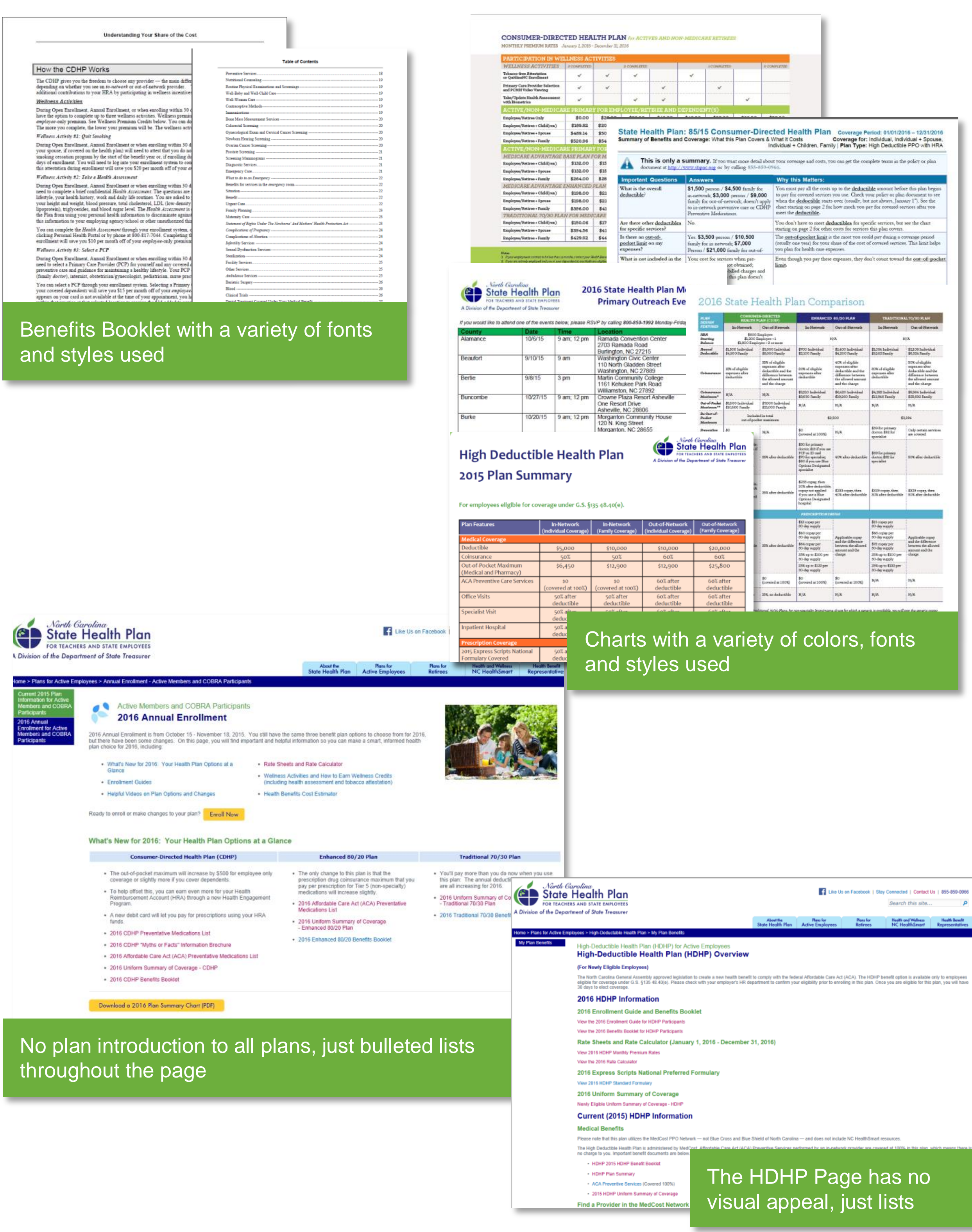
Key Findings	Recommendations
	the Plan offers eligible members comprehensive educational resources and access to one-on-one nurse coaching and specialty care."* ▪ ***7th grade level:*** *"One of our key goals is to help you better manage chronic disease or disease risk factors. Through NC HealthSmart, you get many resources to help you learn about your condition. You can even get one-on-one nurse coaching and specialty care."* – Consider trying to capture the tone and language used in the Benefits Guide and whiteboard video.

Visual Appeal

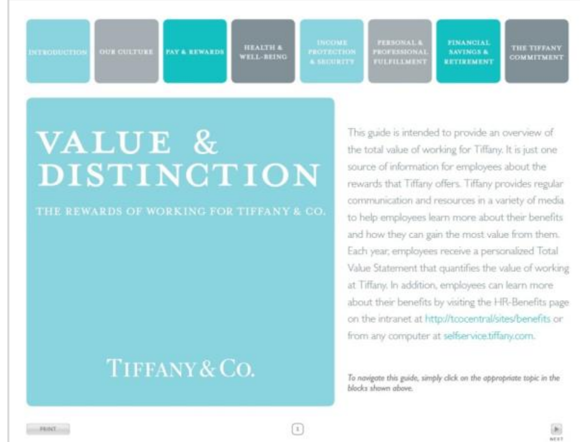
How engaging is the communication? Is it inviting?

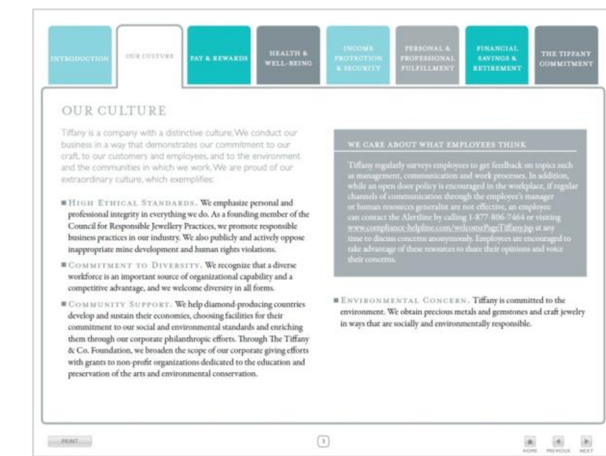
Key Findings	Recommendations
• Benefits communications use a variety of colors, fonts and styles, without a specific style guide and consistency. • Images on each website page are about the same size and placed off to either side. (Video icons are the exception.) – The HDHP page does not include visual elements. • Most pages on the website seem to be text-heavy; increased use of photos, infographics and charts/tables would enhance readability and effectiveness. • Communications combine straightforward text, stock images and graphical buttons throughout. • The rotating banners and megamenu are an effective way to organize the user's experience through the site.	• To strengthen the branding for the State Health Plan, a comprehensive style guide should be created and followed in all communications. This would supplement the current branding guidelines document. The brand guidelines should include: – **Overview** – an overview of the brand's history, personality and key values. – **Brand message or mission statement** – including examples of 'tone of voice – **Logo** – size of the logo and where to obtain the approved logo – **Fonts** – which fonts can be used and for what purpose – **Colors** – which colors are approved to be used, how to use multiple colors in one communication piece and when to use color versus black and white – **Font Styles** – when to use **bold**, *italics*, underline, ALL CAPS, etc. – **Headings** – How each heading should appear — on the website and within each communication piece — Level 1, Level 2, Level 3, etc. – **Bulleting/Numbering** – what bullet/numbering styles should be used – **Photography and Illustrations** – examples of image style and photographs that work with the brand • The State Health Plan can improve their overall visual appeal of its communications. On pages with a lot of written information, find ways to incorporate infographics, charts, graphs and imagery. • Develop templates for charts, posters, postcards, emails and Microsoft Word communications. These templates would ensure consistency and provide more graphic appeal. • Use interactive PDFs for Enrollment guides. This allows a reader to go to each page without having to read the sections that aren't applicable to them. • The bulk of the images on the website appear to be stock photos of people. Consider varying the design with attractive icons, images of objects, video thumbnails, etc. • Some sections are heavily bulleted; we recommend cutting down bullets to only the essentials.

Current Examples of Communications



Examples of Visually Appealing Communications

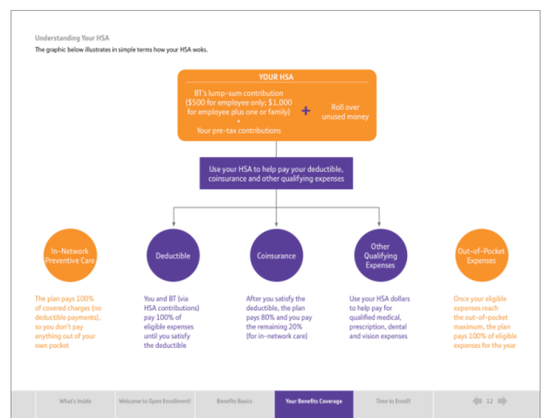




PeopleCare ...
Considers
march*09
sunday monday tuesday wednesday thursday friday saturday

people care
meeting needs, changing lives
2009
LabCorp

LESS
TIME
DISCOUNTS
DISCOVER


Understanding Your HSA
The graphic below illustrates in simple terms how your HSA works.
YOUR HSA
Roll over unused money
Your pre-tax contributions
Use your HSA to help pay your deductible, coinsurance and other qualifying expenses
In-Network Preventive Care
Deductible
Coinsurance
Other Qualifying Expenses
Out-of-Pocket Expenses

BT & ME
benefits
Benefits for a Healthier You
Your 2012 Enrollment Guide
Open Enrollment is February 21 – March 5
BT

PHC & Me
Create a Unique Experience
Why Is Total Rewards Important?

PHC & Me

create a unique experience

PHC & Me
what I need

PHC & Me
what I earn

PHC & Me
what I achieve

PHC & Me
what I choose

IT'S YOUR MONEY.
How Will You Spend It?
Get more. Go generic

IT'S YOUR MONEY.
How Will You Spend It?
DESIGNER RX $220
GENERIC RX $4
$55
$65
$95
Get more. Go generic

Materials Inventory

North Carolina State Health Plan for Teachers and State Employees website

Enrollment Guides

- 2016 Enrollment Guide for Non-Medicare Retirees
- 2016 Enrollment Guide for Medicare Retirees
- 2016 Enrollment Guide for HDHP Participants
- 2015 Enrolment Guide for HDHP Participants
- 2016 Enrollment Guide for Active Members
- 2016 Enrollment Guide for COBRA Participants
- 2016 Enrollment Guide for Active Members (Spanish Version)

Health Plan Comparison Chart

- 2016 Plan Summary Chart (Non-Medicare Retirees)
- Plan Comparison Chart for Medicare Primary Retiree Members

Wellness

- Wellness Activities and How to Earn Wellness Credits

Benefits Booklets

- 2016 CDHP Benefits Booklet
- 2016 Enhanced 80/20 Benefits Booklet
- 2016 Traditional 70/30 Benefits Booklet
- 2016 Benefits Booklet for HDHP Participants
- 2015 HDHP Benefit Booklet

Summary of Coverages

- 2016 Uniform Summary of Coverage – CDHP
- 2016 Uniform Summary of Coverage – Enhanced 80/20 Plan
- 2016 Uniform Summary of Coverage – Traditional 70/30 Plan
- Newly Eligible Uniform Summary of Coverage – HDHP
- HDHP Plan Summary
- 2015 HDHP Uniform Summary of Coverage

Preventive Medications and Services

- 2016 CDHP Preventative Medications List
- 2016 Affordable Care Act (ACA) Preventative Medications List
- ACA Preventive Services
- 2015 ACA Preventive Medication List

Brochures

- 2016 CDHP "Myths or Facts" Information Brochure

Rate Sheets and Calculator

- CDHP
  - Actives/Non-Medicare Retirees
  - Actives/Non-Medicare Retirees, 50% Contributory
  - Actives/Non-Medicare Retirees, 100% Contributory
  - Active Members
  - Active Members, 50% Contributory
  - Active Members and COBRA Participants, 100% Contributory
- Enhanced 80/20 Plan
  - Actives/Non-Medicare Retirees
  - Actives/Non-Medicare Retirees, 50% Contributory
  - Actives/Non-Medicare Retirees, 100% Contributory
  - Active Members
  - Active Members, 50% Contributory
  - Active Members and COBRA Participants, 100% Contributory
- Traditional 70/30 Plan
  - Actives/Non-Medicare Retirees
  - Actives/Non-Medicare Retirees, 50% Contributory
  - Actives/Non-Medicare Retirees, 100% Contributory
  - Active Members
  - Active Members, 50% Contributory
  - Active Members and COBRA Participants, 100% Contributory
- Medicare
  - Medicare Primary Members
  - Medicare Primary Members, 50% Contributory
  - Medicare Primary Members, 100% Contributory
- 2016 HDHP Monthly Premium Rates
- 2015 HDHP Rates
- 2016 Rate Calculator
- Health Benefits Cost Estimator

Prescription

- 2016 HDHP Standard Formulary
- 2015 Express Scripts' National Preferred Formulary

Videos

- 2016 Overview of Plans
- The Consumer-Directed Health Plan
- 2016 Annual Enrollment
- Choosing a 2016 Medical Plan
- 2015 NC Health*Smart* Overview Video
- NC Health*Smart* Testimonial Video
- NC Health*Smart* Personal Health Portal Video

Meetings and Presentations

- Medicare Outreach Meetings
- Medicare Outreach Meeting Presentation

*Health and Wellness: NC Health*Smart

- About NC Health*Smart*
  - Health Resources Available to You
- Wellness Programs and Benefits
  - Find a nutritionist near you
  - Preferred Prescription List
  - Health Resources Available to you
  - Health Coach Frequently Asked Questions
- Disease and Case Management
- Tobacco Cessation Resources
  - QuitlineNC
  - Printable Flyer
- Maternity Resources
  - Maternity Coaching
  - Stork Rewards Program
  - Free Tobacco Cessation Support for Moms to Be
  - Alcohol and Drug Abstinence Support
  - Adding Newborns to Your Health Plan
  - Journey through Pregnancy Checklist

- Worksite Wellness
  - Making the Case for Worksite Wellness
  - NC Health Smart Worksite Wellness Toolkit
  - NC Health Smart School Worksite Wellness Toolkit
  - Turnkey Programs for Worksite Wellness Toolkit
  - Strategies for Increasing Employee Participation
  - Guidelines for Selecting a Worksite Wellness Committee Chair
  - State of North Carolina Employees Wellness Program
  - Office of State Personnel Worksite Wellness Policy
  - CDC Healthier Worksite Initiative
  - Prevention Partners
  - Eat Smart Move More…NC
  - CDC: Nutrition for Everyone
  - Healthy Living: NCSU Plants for Human Health Institute
  - Nutrition.Gov
  - US Department of Agriculture
  - QuitlineNC
  - State Health Plan Tobacco Cessation Benefits for Members
  - Tobacco Prevention & Control Branch, NC Division of Public Health
  - Stress Management Posters/Fliers
  - Achieve Solutions Web Resource Flier
  - The President’s Challenge
- Promote NC Health*Smart* at your Worksite!
  - NC Health*Smart* Training Script for Presenters
  - NC Health Smart Onsite Session Promotional Poster
  - NC Health Smart Webinar Promotional Poster
  - NC Health Smart Resources Guide
  - Tobacco Cessation Resources Guide
  - Stress Management Posters/Fliers
  - Eat Smart Move More Weigh Less Website
  - Member Focus E-Newsletter Sign-Up
- Wellness Champions
  - About the Program
  - Activities and Points
  - Awards and Recognition
- Find a Doctor

North Carolina State Health Plan

2016 Comprehensive Communication Strategy

Revised April 8, 2016

buckconsultants

Current Situation

The State Health Plan wishes to:

- Improve participant engagement
- Maximize the participant experience
- Improve health and benefit literacy

Goal

- Have a health plan design that is economically sustainable for both employees and the State
- Improve participant health and wellness
- Improve health literacy
- Inform and engage leadership, managers, HBRs, participants, retirees and family participants in this transformation

Assessment of Current State

Our review of current SHP communications revealed that the Plan was by and large executing an effective communication strategy. The SHP leverages multiple media to help members receive the right information at the right time. This is especially important because SHP members represent multiple generations — from boomers to millennials — each with their own communication preferences. SHP also consistently engages with HBRs who assist with communicating to the larger population.

While most state health plans have similar content, the overall look and feel varies. When comparing the SHP website to other state websites, the SHP website is more engaging than those of other state sites such as Georgia, Virginia and Tennessee whose sites are more functional than attractive. The SHP does a good job at keeping the website relevant which is critical when reaching such a large audience. Website and banner ads are updated on a regular basis for open enrollment and other initiatives. The rotating banners and megamenu are effective in the organization of the user's experience through the site. Almost all the State websites rely too heavily on navigation lists which can make it difficult to find what you are looking for.

Home mailings are a proven, effective method for communicating to members, though at a population of 700,000 can be cost-prohibitive. The current strategy is mindful of cost and allows for the most critical information to be mailed - specifically deadline-oriented or legally-required communications.

For the most part the current strategy contains the components for impactful and successful communications. However, our audit revealed some areas that could be improved. Specifically we recommend:

- ***The addition of a high-level health plan overview on the website with a link to a deeper dive.*** Compare the attributes of each plan side-by-side so that members can easily see features, in addition to the cost. From there, link to each plan and give "real life" examples of the plans in action so a member can visualize the, "what's in it for me" aspect. This will allow members to see the big picture and select the right plan that meets their needs. Another way to accomplish this goal is to segment populations so that employees only see the information that is pertinent to them.
- ***Developing a new look and feel and creating a brand guide for all communication materials.*** Creating a new look will help build awareness about the

State's benefit offering and will aid in the overall readability factor, especially when trying to emphasize important points through call-outs, infographics and charts. Consider increasing the amount of white space and selecting photography that has a similar overall feel. Decreasing the amount of copy would aid in readability. Consider creating guidelines that includes templates for emails, posters, postcards, etc. to ensure all communications are consistent and seamless regardless of whom creates them.

- ***Turning required communications into an opportunity.*** Capitalize on required communications, such as Summary Plan Descriptions (SPDs or Benefits Booklets) and Summary of Benefits Coverage (SBCs), to promote benefits and better educate participants on how the plans can work and how they can use then effectively. To accompany the branding aspect, update the current plan documents into brand-compliant and user-friendly reading materials.
- ***Educating members about their plan throughout the year.*** Look for opportunities outside of Annual Enrollment, either through wellness initiatives, monthly e-bulletins, webinars, etc. to educate your employees. The State Health Plan offers a wealth of resources and vendor tools. Demonstrate to members how to use those tools in conjunction with their plans.
- ***Consolidating communications.*** Today, plan communications are dispersed across a variety of different documents and pages. Consider consolidating main highlights in a brochure to provide employees with an "At a Glance" resource about each plan.
- ***Working to make online communications more inviting.*** In general, communications on each page are a list of links to various documents and tools. Aim to include an introduction to the information and then compliment it with more visual elements such as descriptive headers, tables, infographics and callouts to emphasize key features and make documents easily digested. Consider shifting the orientation of online PDFs to landscape, instead of portrait to improve readability while still maintaining the ability to print on standard letter size paper. Leverage technology to engage viewers with voice over and sound effects similar to an emagazine.
- ***Developing/promoting mobile tools and resources.*** We recommend looking at additional ways to reach members via technology (i.e., through a SHP-specific benefits app or adapting current resources to be mobile-friendly.

In summary, the current strategy contains many of the right elements. With some reorganization and rebranding we can help you achieve your strategic goals.

2016 Communication Program and Strategy

The Plan seeks an integrated participant communication program and strategy that is focused on encouraging participants to become engaged with the Plan to maximize their benefits and improve their health.

To accomplish this goal, we followed the process outlined below in developing the strategy:

- Define the project scope and objectives to ensure that the campaign achieves measurable results and meets the Plan's goals and expectations
- Conduct a communication review to familiarize ourselves with the Plan's communication style and assess the effectiveness and environmental impact of these communications
- Review any past research and relevant data that provides insight into the behaviors and communication preferences of Plan participants and their dependents
- Engage in stakeholder facilitation, working with Plan's stakeholder workgroup to ensure understanding and agreement—this facilitation will take the form of both group meetings and conference calls, but could also include "break-out" sessions –
- Assess senior management (and other "influencer") support and readiness, through interviews or discussion groups, if desired, or alternative, more informal means

Our strategic communication plan includes the following:

- **Communication Audit** — documenting the compelling need underlying the communication effort and the barriers to change and acceptance.
- **Goals and objectives** — summarizing the goals and objectives established through the work group
- **Audience/stakeholder analysis and mapping** — identifying the various communication stakeholders and mapping each group's particular information needs to the elements that will be used to address those needs
- **Key messages** — detailing the key messages, including the compelling message (tagline) that will be used throughout all materials developed
- **Campaign elements** — describing each of the elements to be deployed during the campaign, including production specifications; also providing an outline of the content to appear within each element
- **Work plan** — detailing each step in the process of producing the various elements and assigning both responsibility and deadlines for each of those steps.

Communication Objectives

- **Improve participant engagement**
  - Participants will understand the resources available to assist them
  - Messaging and user experience will be consistent
  - Prepare leadership and HBRs to be champions of change

- **Maximize the participant experience**
  - Communications will be engaging
  - Tools will be easy to use
  - Participants will understand the resources available to assist them

- **Improve health and benefit literacy**
  - Understand what the State offers to support their well being
  - Provide education about benefit basics
  - Participants will understand how to be a smart health care consumer

Stakeholders/Audiences

- Executive leadership
- Managers/Front-line supervisors
- HBR
- Active employees
- Retirees – non-Medicare
- Retirees – Medicare
- LOA
- Dependents
- COBRA
- Surviving spouse
- New hires

Tactics

Refresh North Carolina State Health Plan to strengthen the connection between the State and participants and to:

- **Unify** – help attract and retain employees, provide a link between the State's values and perceptions, create a single voice for the Plan
- **Motivate** – ensure participants are focused on delivering the desired behaviors within a Total Well Being framework
- **Influence performance and results** – adapt to the evolving needs of the State while linking its vision, strategy, culture, people, leadership and systems to positively inspire and influence development

Key Messages By Stakeholder

Executive leadership, Managers/Front-line supervisors, HBR

- You are a critical partner in the success of this engagement. Your responsibility as leaders is to be a champion of change. To that end, we encourage you to engage in understanding this change and its impacts. To help you, we have developed a comprehensive communication plan to cascade information to you before it is shared with participants. We will share the elements of that campaign with you so you have a heads up on the timing.
- The State has worked to develop a plan design that will be affordable for participants today and in the future. We care about our participants and want them to be healthy. The consumer-directed health plan design is one way that participants have some "skin in the game" to take care of their health. They pay less when they are healthy. Wellness Premium Credits encourage employees to not use tobacco, have a relationship with their primary care physician (PCP) and complete the health assessment.

Employees, LOA, COBRA, Retirees (non-Medicare and Medicare), Dependents

- What's new
- Timing
- Why the change/improvement was made
- Available resources provided by the State
- What's not changing
- Decision support

HBRs

- What's my role
- The importance of your role
- What's new
- Timing
- Why the change/improvement was made

Employing Units (hospitals, state agencies, community colleges, charter schools, school districts)

- What's new
- Timing
- Why the change/improvement was made
- Available resources provided by the State
- What's not changing
- Decision support

Stakeholder/Association Partners (retiree associations)

- What's new
- Timing
- Why the change/improvement was made
- Available resources provided by the State
- What's not changing
- Decision support

New Hires

- How to enroll
- Benefit information
- Available resources provided by the State
- Decision support

Barriers To Success

- Large and varied audience (more than 700,000 employees and their dependents)
- Differences in:
  - Age/generation
  - Education level
  - Native language
  - Culture
  - Accessibility to email/internet
- Employees and dependents fundamentally do not understand health care
- Employees don't care an active role in their health
- Mail is preferred method of communication by retirees, however postage can be cost prohibitive

Keys To Success

- **Branding:** a consistent brand promise
- **Leader endorsed:** for credibility and role modeling
- **Multi-channel:** repetition, and because one size doesn't fit all
- **Personalized:** leveraging technology to make it real for ME and just-in-time
- **Behavioral economics:** to tap into human motivation; nudge
- **Social:** use social networking and support systems

Tactics (Media/Timing) November 2015 – December 2016

Workstreams

- Education and Outreach
- Health Plan Literacy

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
Strategy							
	Benefits Design Changes 2017/2018		SHP: Improve member experience	All members			
Education and Outreach							
	Comprehensive Communications Strategy	• Develop a member communication program and strategy that is focused on encouraging members to become engaged with the Plan in order to maximize their benefits and improve their health	SHP: Enhance member experience DST: Innovate and Modernize Operations	All members	In process	In process	On going in 2016
	Pre-65 Outreach Meetings	• Educate members turning 65 on their SHP options once they become Medicare primary	SHP: Improve member experience	Members turning 65 in the next year and those who are 65 and still actively working	Meeting in progress	Meetings scheduled and invites mailed	March - August

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
	Health Engagement Program	• To encourage all members to engage in healthy behaviors • Encourage members with chronic disease to obtain clinically recommended high value care appropriate to their health condition • Incentivize members who enroll and complete defined activities	SHP: Improve member health DST: Innovate and Modernize Operations	All members enrolled in the CDHP	• Established weekly meetings with IHM and Comm to work through the communication deliverables • Brochure mailed to CDHP members in early April • Letters mailed for chronic condition programs in April		March-April 2016
	Diabetes Prevention Program • Direct mailer • Poster	• Educate all members about diabetes prevention and encourage them to take a test to determine if they are at risk of having prediabetes	SHP: Improve member health DST: Provide Public Leadership in Finance, Fiscal and Health Policy	All SHP membership including Medicare Primary members who do not have diabetes but meet one of the following criteria: Score high enough on CDC paper test as being at risk for prediabetes, have A1C lab result indicating diabetes, diagnosed with diabetes	• Established weekly meetings with IHM and Comm to work through the communication deliverables • Poster and mailer under review		April 2016

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
	Diabetes Education Campaign	• Encourage members diagnosed with diabetes the importance of managing their condition	SHP: Improve member health DST: Provide Public Leadership in Finance, Fiscal and Health Policy	Any active/non-Medicare retiree with a diagnosis of diabetes can call and engage with an AHM Nurse Coach to obtain the Diabetes Education	• Established weekly meetings with IHM and Comm to work through the communication deliverables • NEXT: Work to include in upcoming newsletters and SHP website. • Launch Diabetes Resource Center on SHP website		January-April 2016
	HBR Outreach	• Establish tools and resources for existing and new HBRs to provide them the tools to be successful in their role.	SHP: Improve member experience DST: Innovate and Modernize Operations	HBRs (existing and new)	• Established a preliminary schedule of monthly HBR webinars and quarterly onsite training opportunities • NEXT: Rita working with BF and BCBSNC on tools, developing content for quarterly onsite meetings		Ongoing in 2016
	IHM Outreach Presentations	• Promote NCHS resources to members	SHP: Improve member experience DST: Innovate and Modernize Operations	All members (active/non-Medicare retirees)	• Ongoing • NEXT: Work to include health literacy topics into standard presentation.		Ongoing in 2016

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
	eEnroll Education	• Provide tools and guides to assist members with their online enrollment experience	SHP: Improve member experience DST: Innovate and Modernize Operations	All members	• TBD • NEXT: Develop channel and message.		Sept. 2016
	Wellness Wins	• Educate members with mailers and onsite presentations about certain conditions	SHP: Improve member health DST: Provide Public Leadership in Finance, Fiscal and Health Policy	SHP members residing in the Wellness Wins pilot region with one of the diagnosed chronic conditions: asthma, diabetes, heart disease	TBD NEXT: IHM working with ActiveHealth		April-September 2016
	Wellness Champions	• Provide support to worksite champions to promote healthier habits at home and work	SHP: Improve member health DST: Provide Public Leadership in Finance, Fiscal and Health Policy	Champions that have been nominated or registered to participate	Researching ways to provide group a way to connect online and re-evaluating the survey tool used quarterly		Ongoing in 2016
	Retirement Readiness Tour Participation	• Participate in DST's tour to provide onsite assistance regarding SHP benefits	SHP: Improve member experience	Active members	Initial meeting with SRD and Marquita on new approach for tour. Tour will be year-round not just in Oct.	Work with Marquita on schedule	Ongoing in 2016
	New Rx PBM Communication	• Educate members on new portals/etc. regarding new vendor	SHP: Improve member health DST: Provide Public Leadership in Finance, Fiscal and Health Policy	All active/Non-Medicare members	• TBD NEXT: Develop channel and message		Sept-Dec. 2016

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
	New Hire Resources	• Develop resources for new hires to assist them with their decision in selecting a health plan.	SHP: Improve member experience DST: Innovate and Modernize Operations	New hires	• Redesigned kit/working on Brainshark • NEXT: Kit is completed and posted to website • Brainshark completed and posted to website		Complete
Open Enrollment Strategy							
	OE website update	• Under “Plans for Active Employees” and “Plans for Retiree” reorganize information and change hierarchy of information • Develop a comprehensive guide that compares plans side-by-side • Provide real-life examples of how members are using the plans	SHP: Enhance member experience	All participants	Planning	Develop schedule	August
	OE website banner	• Design graphic to announce “OE is here”	SHP: Enhance member experience	All participants	Planning	Develop schedule	1st day of OE
	Vendor tools promotion	• Work with vendors understand any new tools and promote them on the website • Post all OE documents on website	SHP: Enhance member experience	All participants	Planning	Develop schedule	1st day of OE

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
	OE announcement postcard	• Announce OE dates • Announce tele-townhall sessions • List where to find information	SHP: Enhance member experience	Actives, Retirees, COBRA, LOA	Planning	Develop schedule	Mails one week before OE
	Videos	• Overview of Plans and Member scenarios • CDHP – Myth or Fact • Walk through of BenefitFocus enrollment	SHP: Enhance member experience	Actives, Retirees, COBRA, LOA	Planning	Develop schedule	Posted on website first day of OE
	OE What's New Mailed to homes	• Explain key changes • Provide timetable of communications • Promote website resources • First-time log-in instructions • OE dates • Emphasize what is NOT changing	SHP: Enhance member experience	Actives, Retirees, COBRA, LOA	Planning	Develop schedule	Mails one week before OE
	Benefit Guides Available online – clickable PDF OR E-magazine for active version only	• Align to new brand elements • Overview of all the plans Include info to earn Wellness Incentives in 2017, where applicable • Draft to be evergreen for all of 2017 (not OE-specific) • Medical comparison charts for the plans • Rate information for each plan	SHP: Enhance member experience	3 versions: Actives/COBRA/ New Hires Pre-Medicare Retirees Medicare-eligible Retirees	Planning	Develop schedule	Available 1st day of OE

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
	SBCs • Mail or post as required	• Summary of Benefits and Coverage	Legally required notices	Employees/ COBRA	Planning	Develop schedule	1st week of October 2016
	Reminder Postcard • Mail or post as required	• Postcard reminder of critical enrollment deadline and deadline to earn wellness credits • Description of wellness credits	SHP: Enhance member experience	All audiences not yet enrolled by date X	Planning	Develop schedule	Last week of October 2016
	Posters/Table Tents • Distributed at sites	• Distributed to sites • Also provide landscaped JPEG for flat panel monitors • Provide to employing units and stakeholder/ association partners	SHP: Enhance member experience	Employees	Planning	Develop schedule	Last week of September 2016
	OE Roadshows In person	• OE face-to-face presentations at key locations • Describe plan changes • Answer EE questions in real time	SHP: Enhance member experience	Participants	Planning	Develop schedule	September/ October
	HBR Training In person	• Face-to-face meetings and webinars • Describe plan changes • Answer HBR questions in real time	SHP: Enhance member experience by improving HBR education and training	HBRs	Planning	Develop schedule	September

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
	HBR Alert	• Describe plan changes • Describe role of HBR during OE	SHP: Enhance member experience by improving HBR education and training	HBRs	Planning	Develop schedule	1st week of October
	HBR Update	• Describe plan changes • Describe role of HBR during OE	SHP: Enhance member experience by improving HBR education and training	HBRs	Planning	Develop schedule	1st week of October
Health Plan Literacy							
Enrollment General Education							
	Online Benefits Calculator	• Provide members with online tool to estimate the cost of their health plan expenses	SHP: Improve member experience	All members	Lucy leading the research phases for possible vendors	Participate in demos from various vendors.	Q1 2016
	Benefits App	• Provide members with app to allow members to access information about the plan on their mobile device		Pilot to active members			
	CDHP education	• To educate and assist CDHP members with the understanding of the plan.	SHP: Improve member experience	CDHP Members	Brochures created and mailed	Completed	Feb. 2016
	ACA Preventive Health Services	• To educate members on what services and medications are considered preventative and covered at 100%.	SHP: Improve member experience				
	HDHP		SHP: Improve member experience	HDHP members			

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
Customer Experience							
	Health Literacy Corner in Newsletters	• Provide members with small doses of information regarding their benefits to assist them with their health plan literacy.	SHP: Improve member experience	All members	Lucy developing schedule of articles/topics to include: PCMH, PCP, BCBSNC Designation, Knee Bundle Payments, How to use Blue Connect Place a survey in Jan. MF to determine what topics members would like to learn more about to gage what topics we should concentrate on in 2016.		Ongoing in 2016
	Online Health Literacy Resource Center	• An area of the website that would provide members with a library of information including, recorded webinars, videos, a how to section.	SHP: Improve member experience	All members			Ongoing in 2016
	State Health Plan 101 Webinar Series	• Establish a monthly webinar series to educate members on their benefits and how best to maximize them.	SHP: Improve member experience	Active and Non-Medicare Retirees	Topics so far include: "A Q&A Conversation, Understanding your EOB, All about Preventative Services	Develop schedule.	Ongoing in 2016
	Telephone Town Halls	• Offer a town hall event per PPO Plan to assist members in learning more about how to understand and utilize their benefit.	SHP: Improve member experience	Actives/Non-Medicare Retirees	Not yet started	Work with Buck on their technology	Spring/Summer 2016

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
Integrated Health Management							
	Importance of having a PC Provider/PCMH/Low Cost Quality Providers		SHP: Improve member experience				
	Communicating with your Provider		SHP: Improve member experience				
	Designated Hospitals		SHP: Improve member experience				
	Blue Connect		SHP: Improve member experience				
	Provider Search Tools		SHP: Improve member experience				
	Know your Numbers/Health Assessment • Self-Mailer • Video, 3-2-1 FastDraw or similar (2.5 to 3 minutes long)	• Overview of wellness program, including deadlines and process • How to earn premium credits • Drive participants to video • Covers highlights and business case for wellness program • How to reduce premiums with wellness credits: • Health Assessment Wellness Premium Credit • Tobacco-Free Attestation Wellness Premium Credit	SHP: Improve member experience	All participants	Planning	Develop schedule	Mails August 2016

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
		• Primary Care Provider (PCP) and Patient-Centered Medical Home Video • Stresses privacy • Points participants to online to FAQs for more info (may even insert link to FAQs at end of video)					
	Wellness Champions						
	Choosing Wisely Campaign	• Promote various topics such as: questions to ask your Dr, appropriate antibiotic use, pap testing among women					
	Chronic condition letter (diabetes, COPD, asthma, hypertension, hyperlipidemia, CHF, and CAD)	• To encourage participants to enroll and complete activities to earn incentives • Educate participants about the program	SHP: Improve member experience	Eligible participants who have one more of the following chronic conditions: diabetes, COPD, asthma, hypertension, hyperlipidemia, CHF, and CAD.	Letter completed and mailed in April		In process
	Participant outreach	• Description of program and outline incentive tasks, call to action to enroll in program by calling AH	SHP: Improve member experience	Participant enrolled in CDHP with one of the identified conditions	Ongoing	Active Health	In process

Initiative	Tactic	Objective	Strategic Coordination	Audience	Progress and Next Steps	Status	Timeline
Pharmacy							
	CDHP Prescription Debit Card	• To educate CDHP members on how to use their new debit card	SHP: Improve member experience	CDHP Members			
	Medication Adherence		SHP: Improve member experience	All active/Non-Medicare members			
Post Enrollment Communication							
	Financial Wellness Assessment Tool	• On-line assessment that provides a heat map of employee financial health, provides suggestions for improvements and links to additional resources • Provide an incentive to view assessment	SHP: Improve member experience	Active participants	TBD	State to make determination	

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Third Party Liability Recovery Services RFP

Board of Trustees Meeting

May 13, 2016

Overview

NCGS Chapter 135- 48.37

- Provides the Plan's statutory right of subrogation "upon all of the Plan member's right to recover from a liable third party for payment made under the Plan, for all medical expenses, including provider, hospital, surgical, or prescription drug expenses, to the extent those payments are related to an injury caused by a liable third party."
- The Plan contracts with a third party liability recovery vendor, which is currently HMS.
- Vendors are paid a contingency fee based on actual recoveries.

Current Contract

- The current contract was awarded to HMS pursuant to a bid effective June 1, 2011, and ran through May 31, 2015.
  - The contract was renewed for one additional year through May 31, 2016.
  - The contract was extended for three months through August 31, 2016.

Current Contract

Total Subrogation Recoveries

Year	Total Recoveries
2012	$6,740,000.00
2013	$6,310,000.00
2014	$6,238,835.00
2015	$7,854,055.00

Current Contract

Total Fees Paid

Year	Total Fees Paid
2012	$982,086.00
2013	$914,259.00
2014	$904,617.28
2015	$1,138,838.35

New Third Party Liability Recovery Services RFP

- Posted on March 23, 2016.
- Closed on April 22, 2016.
- Currently under evaluation.
- The Plan's goal is to have a recommendation for the Board's vote at the June meeting.

Auditing Services Results

Board of Trustees Meeting

May 13, 2016

A Division of the Department of State Treasurer

Presentation Overview

- Audit Process
- Medical Claims Audits
- Pharmacy Audits

Why Do We Audit?

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

Audit Process

Audit Workflow

Audit Plan	Conduct Audit	Findings	Finalized Audit Report	Follow Up
• Determine objective and scope • Assessment of data needs • Establish timeframes	• Review data • Onsite fieldwork	• Document findings • Root cause analysis • Establish corrective action plan	• Review • Recommend changes or improvements • Sign off	• Monitor correction plan • Collect funds for missed performance guarantees

Medical Claims Audits

Medical Claims Audit Overview

- **Objectives:**
  - To determine if claims are processed and paid by the Third Party Administrator (TPA) in accordance with the contract
  - To determine whether the TPA met claims accuracy performance guarantees (an annual medical claims processing financial accuracy rate of 99%, payment accuracy rate of 99% and a process accuracy rate of 97% for the contract period ending December 31, 2015)
- **Auditor**:
  - Thomas & Gibbs CPAs, PLLC
- **Frequency**:
  - Quarterly, with an annual report delivered at the end of each fiscal year
- **Methodology**:
  - "Standard" and "focused" audits of statistically valid, random samples of medical claims are audited for processing and pricing accuracy
- **Status**:
  - Thomas & Gibbs has completed the FY 2014-15 reports

Medical Claims Audit Findings and Follow-up

July 2014 - December 2015								
	Performance Guarantee	**QE 9/30/14**	**QE 12/31/14**	**QE 3/31/15**	**QE 6/30/15**	**Fiscal Year 2014-15**	**QE 9/30/15**	**QE 12/31/15**
Standard Medical Claims Audit								
Process Accuracy Rate	97%	99.40%	100.00%	99.80%	100.00%	**99.80%**	100.00%	100.00%
Payment Accuracy Rate	99%	99.40%	100.00%	99.80%	100.00%	**99.80%**	100.00%	100.00%
Financial Accuracy Rate	99%	99.97%	100.00%	99.99%	100.00%	**99.99%**	100.00%	100.00%
"Focused Audit" CDHP Claims								
Process Accuracy Rate	N/A	N/A	N/A	100.00%	N/A			N/A
Payment Accuracy Rate	N/A	N/A	N/A	100.00%	N/A			
Financial Accuracy Rate	N/A	N/A	N/A	100.00%	N/A			

- **Processing error rate** is the total number of claims noted with claim payment errors divided by the total number of claims in the sample.
- **Payment error rate** is the total absolute dollar amount of overpayments or underpayments resulting from errors in the claims tested divided by the total dollar amount of claims in the sample.
- **Financial accuracy** is the total dollar amount in the audit sample processed accurately divided by the total dollar amount processed in the audit sample. Absolute dollar amounts are used so underpayments do not offset overpayments.
- **Follow-up:** Some audit errors uncover more systematic or process issues that need further review. When necessary, the Plan works with the TPA to develop a corrective action plan. Once developed, the Plan does a six month and an annual follow-up review with BCBSNC to monitor action plan results.

Medical Claims Audit - Quality Management Reviews

- The Plan's Quality Team performs additional TPA process quality checks throughout the year. During the 2014-15 fiscal year the following TPA processes were reviewed:
  - Debt Set Off
  - Enrollment Retro-Termination processing
  - Duplicate Claims
  - End-Stage Renal Disease claims processing

Pharmacy Audits

Audits Conducted on the Pharmacy Benefit Manager

- Pharmacy Financial Audit
- Pharmacy Claims Audit
- Pharmacy Plan Design Accuracy Audit

Pharmacy Financial Audit Overview

Objectives:

- To verify the Pharmacy Benefit Manager (PBM) (Express Scripts/ESI) has adjudicated pharmacy claims consistent with the pricing terms indicated in the contract
- To determine whether the PBM met the financial performance guarantees

Auditors:

- Segal Companies & TRICAST Inc.

Frequency:

- Quarterly with an annual report delivered after the contract year

Methodology:

- Detailed biweekly pharmacy claims files are analyzed for pricing and invoicing accuracy

Status:

- The Segal Company completed for October 1, 2013 – December 31, 2014
- TRICAST Inc. completed Contract year January 1, 2015 – December 31, 2015

Pharmacy Financial Audit Components

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

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

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

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

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

2013 - 2014 Results

Pharmacy Audit Components Results – The Segal Company

	QE 12/31/13	QE 3/31/14	QE 6/30/14	QE 9/30/14	QE 12/31/14	Contract Year
Invoice Reconciliation	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted
AWP	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted
Dispensing Fees	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted
Aggregate Achieved Discount	Small shortfall in discounts noted	Small shortfall in discounts noted	Small shortfall in discounts noted	Shortfall in aggregate discounts noted	Shortfall in aggregate discounts noted	Shortfall in aggregate discounts noted
Specialty Drug Discount	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted
Duplicate Claims	Potential duplicates identified for review by Plan	Potential duplicates identified for review by Plan	Potential duplicates identified for review by Plan	Potential duplicates identified for review by Plan	Potential duplicates identified for review by Plan	N/A

At the end of the contract year, the PBM is required to reconcile with the Plan any shortfall of financial guarantees. Following the end of the 15-month contract "year" (October 1, 2013 to December 31, 2014), ESI reimbursed the Plan $3.3 million for dispensing fee and discount guarantee shortfalls.

2015 Results

Pharmacy Audit Components Results – Tricast

	QE 03/31/15	QE 06/30/15	QE 09/30/15	QE 12/31/15
Invoice Reconciliation	No issues noted	No issues noted	No issues noted	No issues noted
AWP	Variance noted	Variance noted	Variance noted	Variance noted
Dispensing fee	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted
Aggregate achieved discount	Over performance in aggregate discount noted	Over performance in aggregate discount noted	Shortfall in aggregate discount noted	Shortfall in aggregate discount noted
Specialty drug discount	Variance noted	Variance noted	Variance noted	Variance noted
Duplicate Claims	No issues noted	No issues noted	No issues noted	No issues noted

At the end of the contract year, the PBM is required to reconcile with the Plan any shortfall of financial guarantees. The preliminary audit report issued by Tricast for CY 2015 finds ESI owes the plan approximately $8.6 million, net of a previous payment received, for dispensing fees and discount guarantee shortfalls.

Pharmacy Claims Audit Overview

- **Objectives:**
  - To determine if claims are processed and paid by the PBM in accordance with the contract
  - To determine whether the PBM met the claims accuracy performance guarantee (an annual medical claims processing error rate of no more than 0.5%)
- **Auditor:**
  - Thomas & Gibbs CPAs, PLLC
- **Frequency:**
  - Quarterly, with an annual report delivered at the end of each fiscal year
- **Methodology:**
  - Statistically valid, random samples of pharmacy claims are audited for processing and pricing accuracy
- **Status:**
  - Thomas & Gibbs has completed the FY 2013-14 reports

Pharmacy Claims Audit Findings

July 2013-December 2015								
	Performance Guarantee	QE 9/30/14	QE 12/31/14	QE 3/31/15	QE 6/30/15	Year End 14/15	QE 9/30/15	QE 12/31/15
Processing Error Rate	1.5% or less	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Payment Error Rate	1.5% or less	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Financial Accuracy	99% or higher	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- **Processing error rate** is the total number of claims noted with claim payment errors divided by the total number of claims in the sample.
- **Payment error rate** is the total absolute dollar amount of overpayments or underpayments resulting from errors in the claims tested divided by the total dollar amount of claims in the sample.
- **Financial accuracy** is the total dollar amount in the audit sample processed accurately divided by the total dollar amount processed in the audit sample. Absolute dollar amounts are used so underpayments do not offset overpayments.

Pharmacy Plan Design Accuracy Audit Overview

- **Objectives:**
  - To verify the Pharmacy Benefit Manager (PBM) (Express Scripts/ESI) has accurately administered benefit provisions consistent with the contract and approved plan design documentation
- **Auditor:**
  - TRICAST Inc.
- **Frequency:**
  - Plan Design Accuracy Audits are annual with an annual report delivered after the contract year
- **Methodology:**
  - Systematically re-adjudicating 100% of paid prescription drugs analyzing benefit plan parameters.
- **Status:**
  - Contract year January 1, 2014 – December 31, 2014 completed

Pharmacy Plan Design Accuracy Audit Components

- **Copayments/Coinsurance:** Represents the dollar amount required to be paid by the member when a prescription drug is purchased.
- **Exclusions:** Specifies the drugs and products that a plan did not or would not cover unless there is a Prior Authorization
- **Quantity Limits:** Included in plans to ensure safety and appropriate utilization.
- **Step Therapy:** Requires the trial and failure of one or more prerequisite drugs before the step therapy medication will be covered. It promotes the appropriate use of equally effective but lower cost drugs, most often generics, as first line therapy.
- **Prior Authorization:** Manages the use of certain medications that are high cost or have the potential for misuse. Drugs requiring prior approval have detailed criteria that must be met before the prior authorization can be granted.
- **Early Refill:** Describes the limitation of days and quantity allowed to be filled for specific medications.

Pharmacy Plan Design Accuracy Audit Components Results

	Traditional 70/30	Enhanced 80/20	Consumer-Directed Health Plan
Copayment	<0.2% Variance	<0.2% Variance	No issues noted
Exclusions	Variance noted	Variance noted	Variance noted
Quantity Limits	No issues noted	No issues noted	No issues noted
Step Therapy	No issues noted	No issues noted	No issues noted
Prior Authorization	No issues noted	No issues noted	No issues noted
Early Refill	No issues noted	No issues noted	No issues noted

Pharmacy & Therapeutics Committee February 2016 Meeting Summary

Board of Trustees Meeting

May 13, 2016

A Division of the Department of State Treasurer

Updates to Utilization Management Programs

Programs	Update
Juxtapid and Kynamro Prior Authorization Policies	New Injectable products for use in familial hypercholesterolemia, with PAs based upon FDA indications, including prior trial of PCSK9 drugs.
Orencia Prior Authorization	PA updated consistent with new FDA indications for use in Rheumatoid Arthritis, and exclusion for use in psoriasis.
Enbrel Prior Authorization	PA updated consistent with new FDA indications for use in un-differentiated spondyloarthropathies and reactive arthritis, with some new exclusions.
Humira Prior Authorization	PA updated consistent with new FDA indication for use in hidradenitis suppurativa and spondyloarthropathies, with exclusion in polymyalgia rheumatica.

Updates to Utilization Management Programs

Programs	Update
Odomzo and Erivedge Prior Authorization Policies	New PAs consistent with FDA indication for use in basal cell carcinoma of skin after all surgical and radiation therapies have been utilized.
Nucala Prior Authorization Policy	New PA consistent with FDA indication for use in severe persistent asthma with an eosinophilic phenotype on maximal maintenance therapy, with several specific exclusions.
Stivarga, Lonsurf, and Cotellic Prior Authorization Policies	New PAs for 3 new oncology medications, each with specific FDA approved indications.

Updates to Utilization Management Programs

Programs	Update
Keveyis Prior Authorization Policies	New PA consistent with FDA indications for use in primary hyperkalemic periodic paralysis and related variants.
Daraprim (pyrimethamine tablets) Prior Authorization Policy	New PA for drug indicated in the treatment of toxoplasmosis and malaria, in conjunction with other medications – due to recent dramatic price increase. Policy allows for up to a two-week supply to be dispensed prior to PA approval to avoid delay in therapy.

New Drugs for Formulary Consideration

Drug	Indication	Tier Placement
Synjardy (metformin and empagliflozin tablets)	Diabetes, Type 2	3
Tresiba (insulin degludec injection)	Diabetes	3
Viberzi (elluxadoline tablets)	Irritable Bowel Syndrome with diarrhea	2
Envarsus XR (tacrolimus extended release tablets)	Kidney transplant rejection prophylaxis	3
Vraylar (cariprazine capsules)	Atypical antipsychotic for the treatment of schizophrenia and the acute treatment of manic episodes associated with bipolar disorder	3
Tolak (fluorouracil 4% cream)	Actinic keratosis on the face, ears, or scalp	3

Additional Topics

- **New Specialty Generic Tier (Tier 4):**
  Traditional Tiers: 1 – preferred generics, 2 – preferred brand and high-cost generics, 3 – non-preferred brands
  Specialty Tiers: 4 – generic specialty, 5 – preferred brand specialty, 6 – non-preferred specialty

- **Specialty Medication Transition from Medical to Pharmacy Benefit:**
  Three phases planned with focus on patient safety, convenience, physician buy-in, and cost savings.