North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Provider Reimbursement Strategies & Opportunities

Board of Trustees Meeting

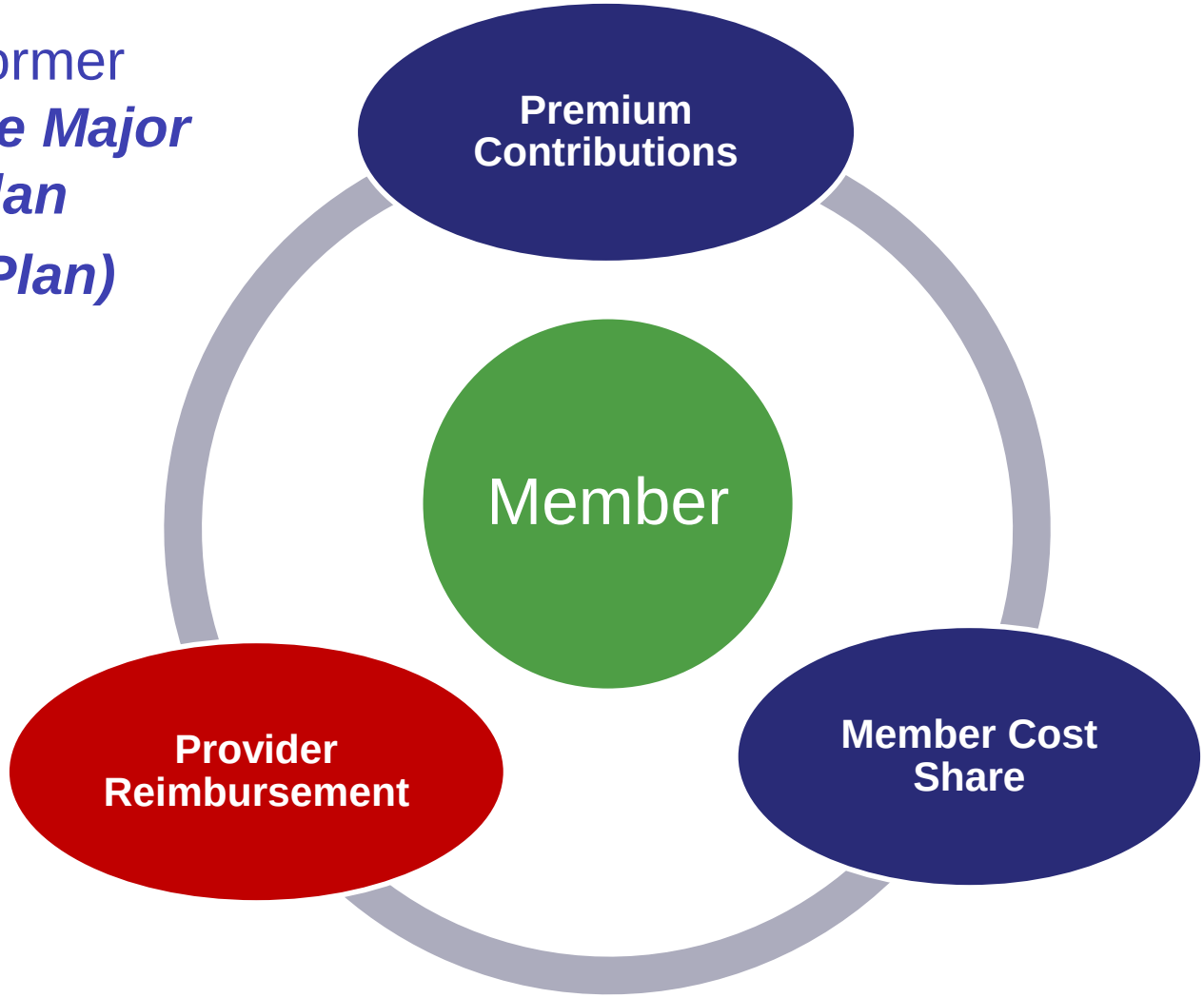
February 5, 2016

Presentation Overview

- Financing the Health Benefit & Bending the Cost Curve
- Methods to Address the Triple Aim/SHP Strategic Plan
- Provider Payment Methodologies
- Plan Payments under Fee for Service
- TPA & PBM Contracts
- Pilot Opportunities
- Next Steps

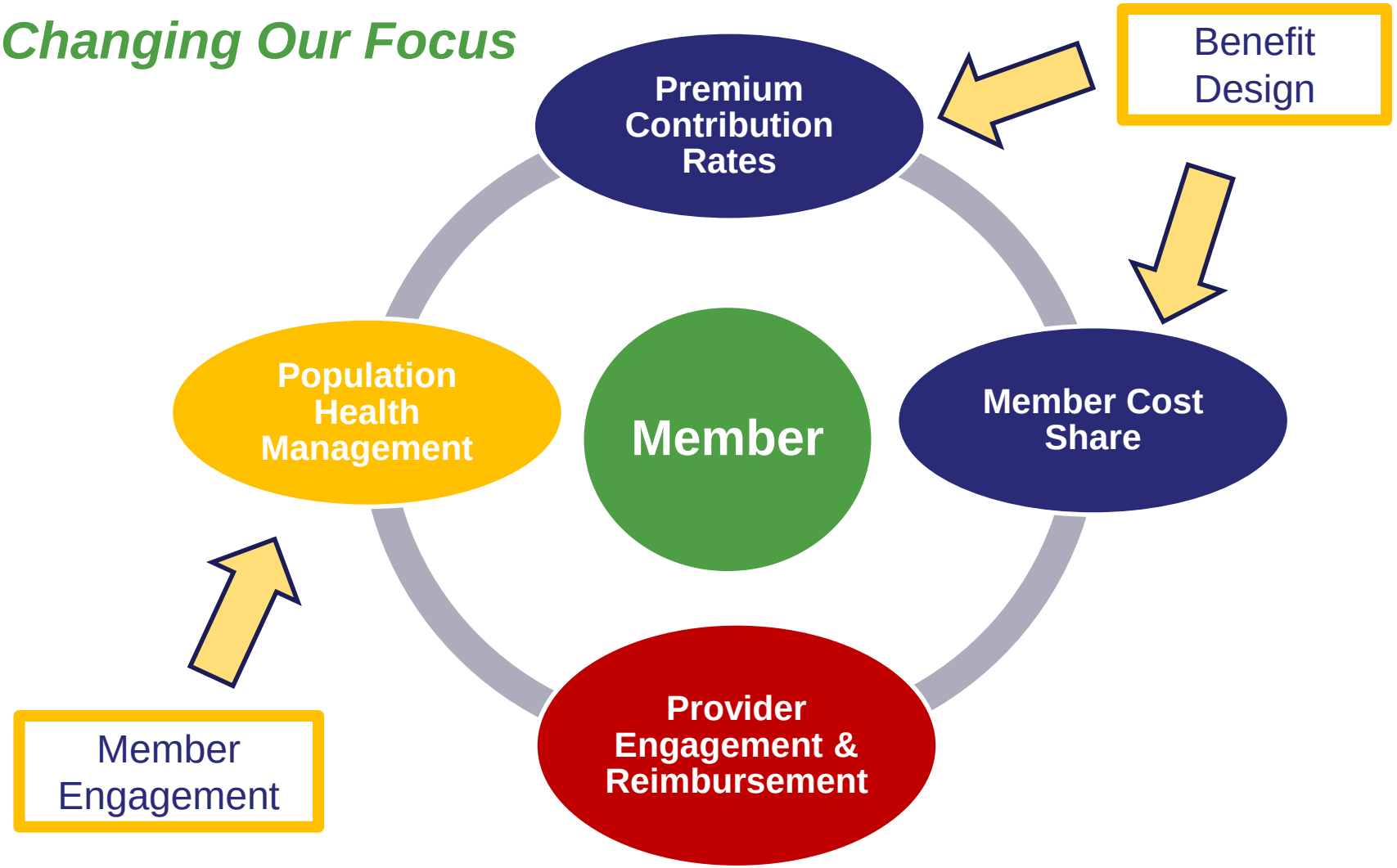
Financing the Health Benefit & Bending the Cost Curve

Under the former
Comprehensive Major Medical Plan
(Indemnity Plan)



Financing the Health Benefit & Bending the Cost Curve

Changing Our Focus



Methods to Address the Triple Aim & SHP Strategic Priorities

Plan's ability to directly impact services & costs based on current business model

Benefit Offerings & Programs
(PPOs, CDHPs, HRA/HSA, HMOs, Wellness Initiatives, Case and Disease Management)

Program Administration & Contracting
(Outsourcing vs. Self Administered, Self-Funded/Insured vs. Fully Insured, Single vs. Multiple TPA/Carriers, Statewide vs. Regionalized Approach)

Provider Network
(Limited Networks, Tiered Networks, Quality/Cost Designations)

Provider Payment Methods
(Enhanced FFS, Bundled Payments, ACOs, PCMH, P4P)

Triple Aim:

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

Source: Institute for Healthcare Improvement

SHP Strategic Priorities

1. **Improve members' health**
2. **Improve members' experience**
3. **Ensure financial stability**

Adopted: September 2014

Provider Payment Methodologies

January 2014 Presentation on Payment Methodologies

As part of the Strategic Planning process, the Strategic Planning Workgroup and Board of Trustees requested an environmental scan of emerging alternative provider payment methodologies and strategies that focus on quality, cost, and member experience

Key Findings

- Current model is a Fee for Service (FFS) approach which places almost all of the financial responsibility associated with members' health risk on the Plan while paying providers for volume (i.e. per service basis) rather than quality or outcomes
- Emerging provider payment strategies focus on sharing or spreading the financial risk among the payers of health care (SHP, our carriers, and our members) and those providing care
  - Providers have a greater incentive to provide cost-effective, high quality, outcome driven care if there are financial incentives and expectations
- The goal of alternative payment arrangements is to shift some or all of the risk to providers of care to incentivize the use of high quality, lower cost solutions to keep members healthier
- Emerging strategies enforce a **balance** of access and choice with affordability and quality/outcomes

State Health Plan Payment Model

Current Statewide Risk Model:

State Health Plan partners with one third party administrator (TPA), Blue Cross and Blue Shield of North Carolina, and two carriers, Humana and UnitedHealthcare, to provide members with broad access to care

- BCBSNC: State Health Plan assumes the financial/actuarial risk
- Humana/United: Carriers assume the financial/actuarial risk
  - **HOWEVER,** utilization under the Medicare Advantage plans is more tightly managed and there are significant financial subsidies at risk for plan performance, similar to many of the components to be discussed

Economies of Scale:

State Health Plan benefits from the additional membership available through our vendor partners in negotiating provider rates

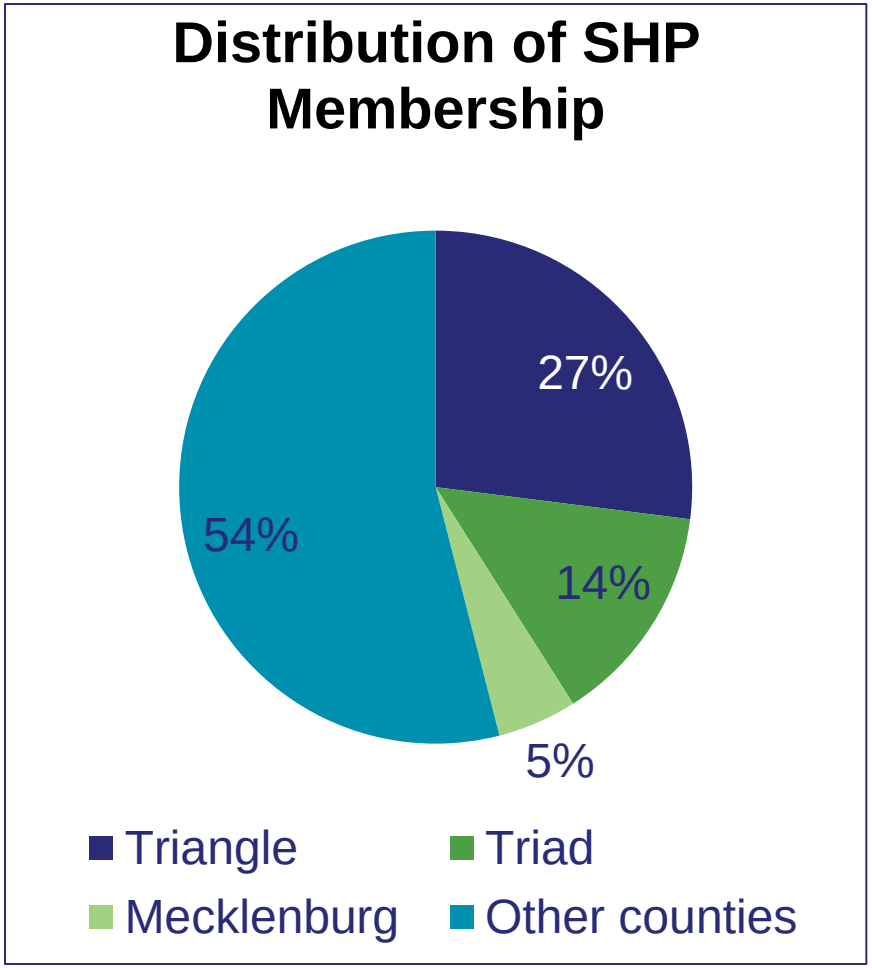
- Providers in Swain County (831 members) do not have access to the entire Plan membership but partnering with a TPA like BCBSNC increases our ability to negotiate lower rates (SHP members only represent approximately 17% of BCBSNC book of business in that area)

2013 Data

2013 State Health Plan Membership

Membership:

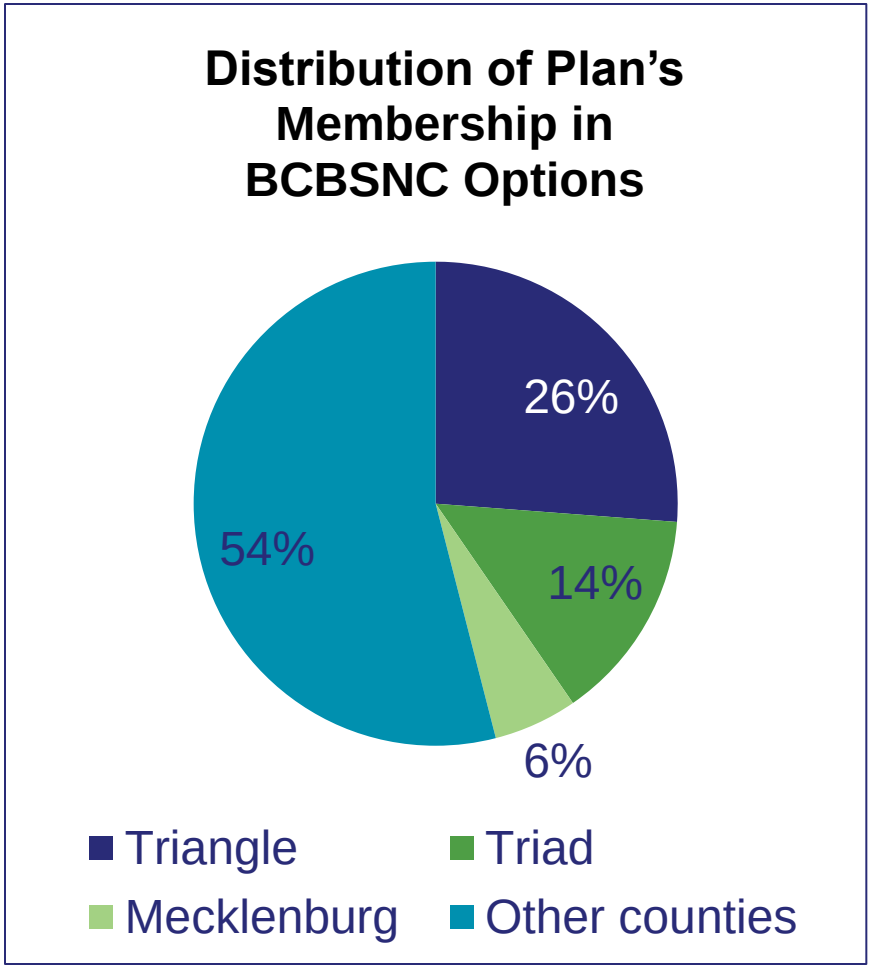
- Over 670,000 members located throughout North Carolina's 100 counties and out of State
- Despite the Plan's large size, the State Health Plan membership only made up about 27% of BCBSNC membership in 2013
- Significant number of counties with less than 1,000 SHP members
- Among "other counties" in the graph *no county represents more than 3% of SHP membership*



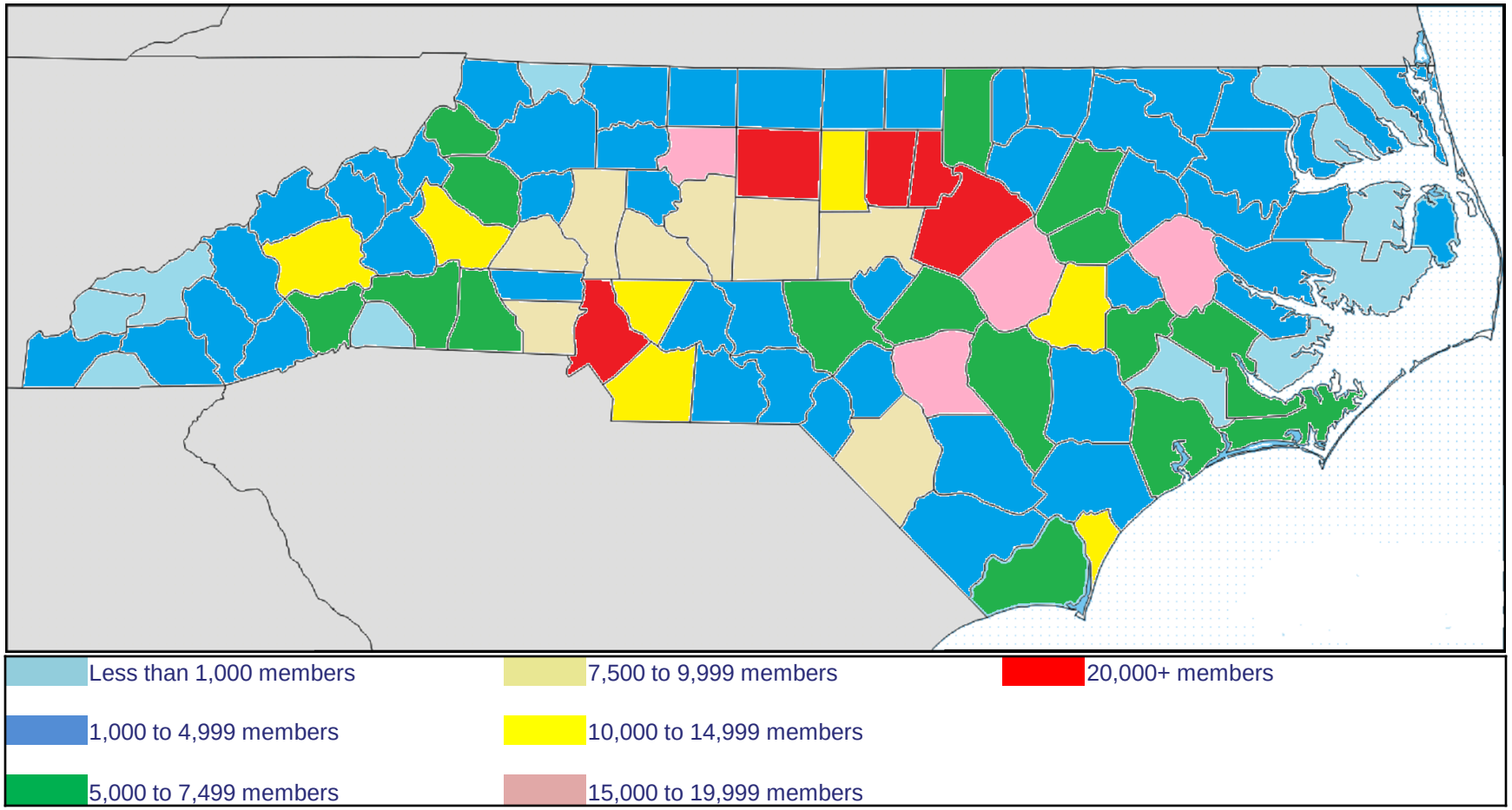
2015 State Health Plan Membership

Current Membership:

- Nearly 570,000 members located throughout North Carolina's 100 counties are on one of the BCBSNC plan options
- Still a number of NC counties with less than 1,000 SHP members in BCBSNC plans
- Among "other counties" in the graph, *only Pitt County (3.2%) represents more than 3% of Plan membership*

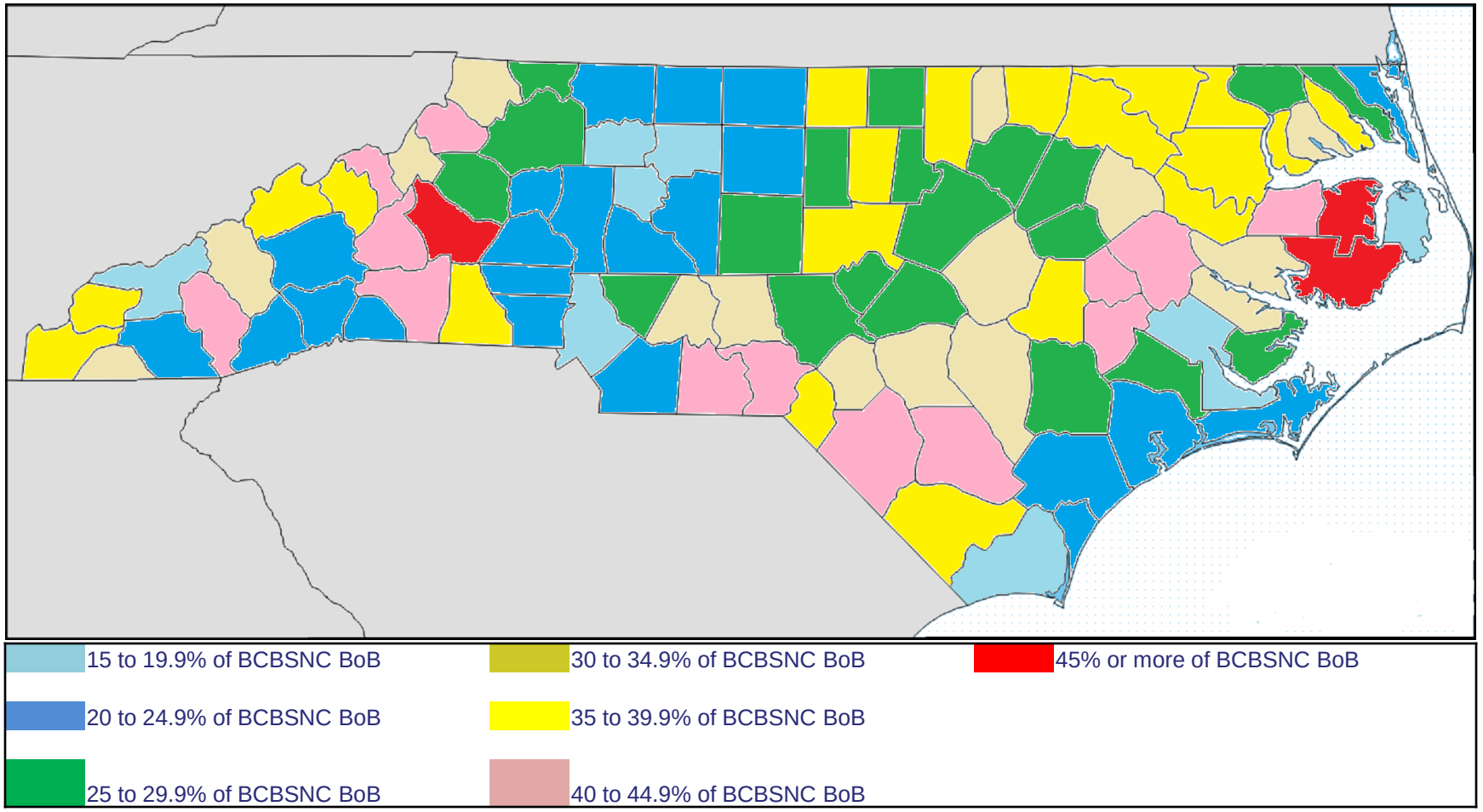


CY 2013 Average Distribution of SHP Membership



- Plan members live throughout the State and utilize multiple providers throughout the State

CY 2013 SHP Membership as a Percentage of BCBSNC's Book of Business



- In CY 2013 SHP membership accounted for 27% of BCBSNC's total membership
- Partnering with a TPA like BCBSNC improves the Plan's buying power

Spectrum of Potential Payment Methodologies

- The goal of many alternative provider payment arrangements is to shift from paying for productivity and each procedure (i.e. the FFS model) to paying for quality and outcomes
  - Additional benefits include better member experience and engagement as well as overall efficiency in the health care system
  - Currently, providers are not compensated if all their members are healthy
- The alternative payment models take various approaches to addressing quality but some key themes include:
  - Coordination of care
  - Enhanced focus on primary care
  - Incentives for reducing undesirable outcomes and bonuses for positive outcomes and use of appropriate settings of care
  - Payment withholds for lower quality care and/or redundant care

Summary of Findings

- Alternative payment opportunities are emerging in North Carolina in different parts of the State and at different levels based on the provider groups; SHP members have access to some of these
- Payment strategies that focus on quality and costs can have an impact on member choice and access – Need appropriate balance
- Alternative models require effective data analytics to monitor performance
- The size of the SHP member population offers opportunities when considering alternative payment methodologies and arrangements; however, the geographical dispersion of members throughout the State presents challenges

Next Steps and Recommendations

- Alternative payment opportunities are emerging in North Carolina in different parts of the State and at different levels based on the provider groups – *Do we promote utilization of these models?*
- A global, statewide strategy toward alternative payments does not appear to be possible in the short-term
- The State Health Plan should work with current and future TPAs/carriers to identify opportunities to incent quality of care and pay for outcomes while facilitating the development of successful evidence-based practices that are emerging in NC
- Investigate the use of alternative network arrangements and plan designs that can reward members for using higher quality and lower cost facilities
- Consider pursuing condition-based partnerships to reduce avoidable hospitalizations and help members manage conditions

Ensure a Financially Stable State Health Plan

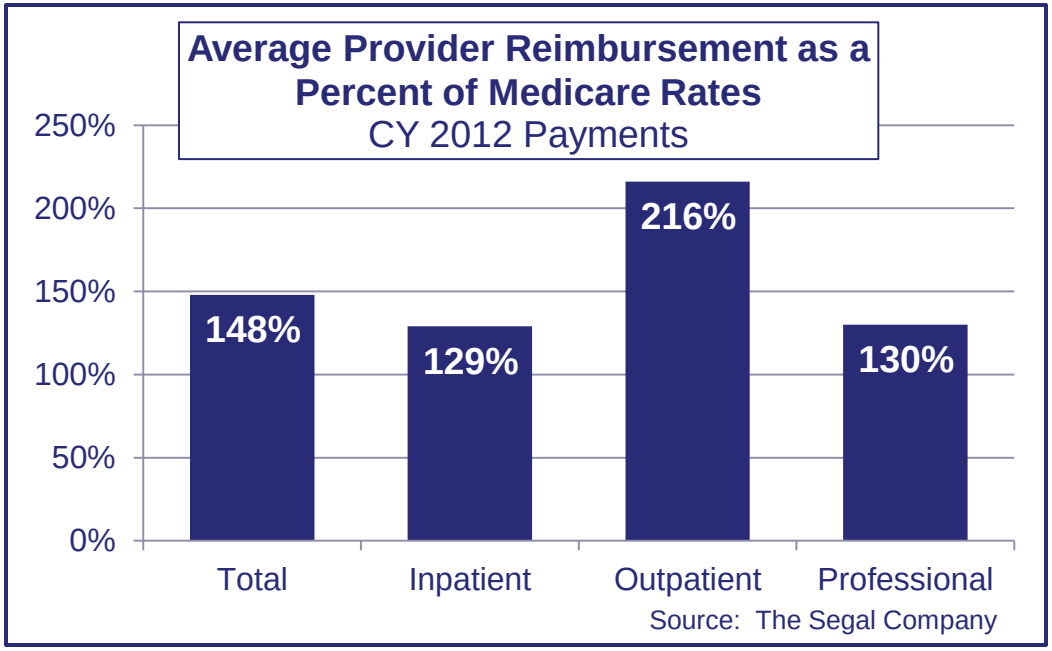
Strategic Initiative: Pursue Alternative Payment Models

What It Means	What We Will Do	Why It Is Important
• Shift away from the current pay for volume approach in health care to paying for outcomes based on evidence based metrics. • Utilize the spectrum of alternative payment strategies, ranging from PCMH to pure capitation, to more efficiently compensate providers to provide care in the most effective setting. • Take a long-term, prospective view to improve member health to manage cost growth versus only short-term price reductions.	• Partner with current and future third party administrators (TPA)/carriers to identify opportunities to incent quality of care and pay for outcomes while facilitating the development of successful evidence-based practices that are emerging in North Carolina • Partner with other payers, where appropriate, to implement consistent approaches to alternative payment strategies throughout North Carolina • Engage with providers who are able to work directly with the Plan on value based payments and metrics	• Moving away from pure fee for service provides an incentive to focus on better coordination and effective care • 15.6% of hospital admissions had a readmit within 30 days • Average inpatient cost per day has increased by 4.4% over the past year

SHP Payments under FFS

State Health Plan Payments under Fee for Service

- In 2013 Segal compared the Plan's average hospital and professional reimbursements from CY 2012 to Medicare reimbursement rates
- Combining professional and hospital rates, Segal concluded that, on average, the Plan pays providers at approximately 148% of Medicare rates
- Segal noted that a big reason for the higher reimbursement percentage on outpatient hospital payments is the deep discount that Medicare commands for those services
- This information was presented at the May 2013 Board meeting. Minutes from the meeting note that Segal "generally concluded that the Plan's provider rates are consistent with their expectations."



Reimbursing at Medicare Rates

- Tying provider reimbursement to a percentage of Medicare rates could generate savings, as Medicare rates are generally lower than commercial rates
- Plan must also consider network and access
- Unless the Plan establishes contracts with providers, either on its own or through a TPA, services would be “out-of-network” and providers could “balance bill” members for the difference between the Medicare rate and their billed charges
- The Plan would achieve significant savings but members could see significant cost growth, may be asked to pay up front, and access would likely be reduced

Medicare Rates and Balanced Billing

An Inpatient Example: Enhanced 80/20 Plan

Current Structure In-network	Amount
Provider Charge	$10,000
Allowed Amount	$6,500
Member Copay	$233
Plan Paid (In-Network 80%)	$5,013
Member Coinsurance	$1,254
Total Member Paid	**$1,487**

Medicare and Balanced Billing	Amount
Provider Charge	$10,000
Medicare Allowed	$5,200
Member Copay	$233
Plan Paid (Out-of-Network 60%)	$2,980
Member Coinsurance	$1,987
Balanced Billed to Member	$4,800
Total Member Share	**$7,020**

TPA & PBM Contracts:
Provider Networks, Reimbursements & Discounts

TPA Contract

- The Board and stakeholders are interested in potential savings associated with modifying provider networks and reimbursements.

Medical Networks and Reimbursement

- Based on the Plan's most recent TPA procurement (contractual services began July 2013), BCBSNC's network provided the highest aggregate discounts for the Plan
- Hospitals are resistant to changing their fee schedules/structure
  - Recent examples:
    - Effective February 1, Carteret is no longer in the BCBSNC network
    - Wayne Memorial contract negotiations, fall 2013
- Providers are looking for increases to fees as they are asked to better manage patients and participate in risk sharing arrangements

Alternative TPA Options & Procurement

- Historically, some national TPAs have not bid on the State Health Plan's contract due to the State's banking requirements, audit rights and/or other State required terms and conditions
- The Plan issued a Request for Information (RFI) and held a series of meetings with potential vendors prior to issuing the TPA Request for Proposals (RFP) in Feb 2012
  - CIGNA did not bid on the most recent TPA RFP
  - Aetna did not meet the minimum requirements
  - UnitedHealthcare met the requirements but was not awarded the contract

TPA Network Alternatives

Regional and Multiple Vendor Approach

- A 2011 analysis by Aon Hewitt determined that the Plan could save between $10M-$34M by breaking the state into multiple regions with multiple TPAs
  - A regional model has been discussed at various times with the Board and will be contemplated in the next TPA procurement
  - There is significant complexity in implementing a regional approach
    - Need to balance savings potential with administrative capabilities and potential member disruption/dissatisfaction
- Discounts, networks, and pricing have likely changed from the previous analysis but will be strongly considered as the Plan looks to achieve savings through its next competitive bid

PBM Contract

Pharmacy Networks, Discounts and Formulary

- The Plan conducted a market analysis of pharmacy discounts in the last 18 months
- Express Scripts (ESI) agreed to modify contractual guarantees as a result
- Opportunities to consider alternative pharmacy arrangements
  - Network – broad vs. narrow
  - Formulary – open vs. closed
  - Evaluating proposals in response to current RFP
  - Anticipate making award recommendation to the Board in March 2016

PBM Market Check

- In summer 2014, the Plan contracted with Segal to do a market check of the Plan's contract with Express Scripts. The final report was delivered September 2014
- The market check analyzed all components of ESI's pricing, including discount guarantees, dispensing fees, rebates, and administrative costs
- The Plan's contract was compared to the contracts of four other large public employers
- The analysis concluded that aggregate pricing among the comparison plans was somewhat better than the pricing in the Plan's contract
- The Plan used the findings to renegotiate its contract terms with ESI
- An analysis by Segal on the new pricing arrangements estimated savings of approximately 4.75% in 2015 and 4.86% in 2016
- The new pricing guarantees were effective January 1, 2015

Pilot Opportunities

Potential Network Related Pilots

- The Plan is investigating savings opportunities through narrow or tiered network arrangements, where available
  - BCBSNC has indicated that locally based narrow networks could be provided in CY 2018; on the Exchange the premium savings for using these networks is between 10% and 20%; however the Plan would project more conservative savings (3-7% for eligible members)
    - Triangle (excludes UNC Health)
    - Charlotte
  - The Plan is exploring pilot opportunities with UNC Healthcare and MedCost
- To be a cost saver for the Plan and members, members would have access to fewer in-network providers and providers would accept lower reimbursements in exchange for access to more patients
  - These opportunities are not available statewide. However, savings would be shared by the State and all members

Additional Pilot Opportunities

- Capitated Primary Model
  - Multiple vendors have proposed to capitate Primary Care Provider (PCP) services
  - There is some concern that members already have strong access to PCP services and are incented to use those services
  - The State could end up paying more under this approach in the aggregate; however, that is contingent on the services offered and how cost-sharing is covered
- Concierge Medical Services
  - For members with complex care the State could provide concierge services to help steer members to lower cost/higher quality providers
  - This might increase costs in the short-term but could help with the long-term cost curve

Next Steps

Next Steps and Decision Points

- Determine potential savings from PBM procurement
  - Decide on network and formulary arrangements
- Reassess strategic initiative to pursue alternative payment models if the primary goal is achieving reductions in FFS reimbursements
  - Provider network essential to preventing increased member cost
  - Establishing direct contracts with providers would require:
    - Change in the Plan's business model
    - Additional staff
  - Next TPA RFP development is getting under way
    - Need clear strategic direction