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

Board of Trustees Meeting
Wednesday, April 27, 2016
1:00 p.m. to 4:00 p.m.

1.	Welcome	Janet Cowell, Chair
2.	Conflict of Interest Statement	Janet Cowell, Chair
3.	Introduction of New Board Members	Janet Cowell, Chair
	a. Elizabeth Poole	
	b. Neal Alexander	
4.	Introduction of New Staff	Mona Moon
	a. Matt Grabowski, Health Policy Analyst/Legislative Liaison	
5.	Review of Minutes ***(Requires Board Approval)***	Janet Cowell, Chair
	a. January 26, 2016	
	b. February 5, 2016	
	c. March 10, 2016 Teleconference	
6.	Strategic Planning	
	a. 2015 Scorecard Results	Tom Friedman
	b. Updating the Plan for 2016-2020	Tom Friedman
	c. Provider Reimbursement Strategies	Mona Moon
7.	2016 Short Session Legislative Agenda	Matt Grabowski

8. Benefit Design, Plan Options and Premiums

a.	State Health Plan Myths vs. Facts	Mona Moon
b.	Rationale and Alignment of Benefit Changes with the Strategic Plan and Legislative Requirements	Mona Moon
c.	Proposed Benefit Design Changes for 2017	Tom Friedman
d.	Benefit Planning for 2018 and Beyond	Tom Friedman
e.	Update on Transition of Specialty Medications from Medical to Pharmacy Benefit	Caroline Smart

9. Member and Public Comment Period — TBD

10. Adjourn — Janet Cowell, Chair

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

Next Regularly Scheduled Meeting: May 12, 4-6 p.m. and May 13, 9 a.m.-3 p.m., 2016

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

2015 Strategic Plan Scorecard Results

Board of Trustees Meeting

April 27, 2016

A Division of the Department of State Treasurer

Executive Summary

For 2015:

- The Plan scored a “Met” in all the categories of the Strategic Planning Scorecard
- The Plan fell below the established threshold goal for 2 specific metrics

Next Steps:

- At a later date, Plan staff will be proposing a few modifications to address changes in the health care environment as well as the strategic initiatives and roadmap
- Plan staff also has a better understanding of areas that the Board/Plan can influence

Review of Approved Strategic Plan Metrics

- The Board-approved Strategic Plan includes a series of metrics to evaluate State Health Plan progress in achieving the goals set forth in the Strategic Plan
- The goal of the scorecard is to measure strategic intent and monitor overall progress
- The approved metrics aim to measure how well the Plan is:
  - Improving members' health,
  - Improving members' experience, and
  - Ensuring a financially sustainable State Health Plan

2015 Actual Results

Summary Score Card – 2015 Actual Results

Strategic Priority	Description	Below Threshold	Met or Exceeded Threshold	Met or Exceeded Target	Met or Exceeded Stretch	Annual Result (Unmet or Met)
Improve Members' Health	PCMH Utilization				X	Met
	Quality of Care			X		
	Worksite Wellness				X	
Improve Members' Experience	Customer Satisfaction	X				Met
	Annual Enrollment Service Level Agreements			X		
	Member Engagement				X	
Ensure a Financially Stable State Health Plan	Net income/loss		X			Met
	PMPM Claims Expenditures		X			
	Member Cost-Sharing		X			

CY 2015 Improve Members' Health Results

		Benchmark Period	CY 2015				CY 2017
Description	Metric	CY 2014 Actual	Actual Results	Goals – Met or Exceeded			Threshold
				Threshold	Target	Stretch	
PCMH Utilization	Increase % of members receiving care from a NCQA recognized PCMH	Level 1: 0.9% Level 2: 3.1% Level 3: 25.8% Total: 29.8% N= 177,165	**36.1%**	33.0%	34.0%	35.0%	55% of active and non-Medicare members
Quality of Care	Percent of members with diabetes meeting clinical care standards of care	30.7%	**27.6%**	31.5%	33.0%	35.0%	45.0%
	Percent of members with persistent asthma that meet clinical care standards of care	63.2%	**66.8%**	64.0%	67.0%	69.0%	75.0%
	Asthma related ED	7.7%	**4.9%**	7.7%	7.0%	6.7%	6.5%
	Asthma related IP admissions	15.3%	**13.9%**	15.3%	15.0%	14.5%	14.0%
Worksite Wellness	Increase the number of worksites with active worksite wellness	N/A	**170**	92	111	125	110 worksites

CY 2015 Improve Members' Experience Results

		Benchmark Periods	CY 2015				CY 2017
Description	Metric	CY 2014 Actual	Actual Results	Goals – Met or Exceeded			Goal
				Threshold	Target	Stretch	Threshold
Customer Satisfaction	Maintain or improve overall Customer Satisfaction score	Moderately pleased (new questions - composite score)	54%	55%	60%	65%	65%
Annual Enrollment Service Level Agreements	Improve Annual Enrollment customer service SLAs. *(metric changed to reflect BF contract)*	85% (100% for weeks 1 -3)	72%	70%	75%	80%	80%
Member Engagement	1. Increase in the # of unique member registered users on TPA site per month 2. Increase in the average monthly usage of TPA's provider search and transparency tools 3. Increase in attendance at educational roadshows	1. 10,005 2. 1,210 3. 6,080	**1. 24,061** **2. 2,126** **3. 40,510**	1. 10,005 2. 1,210 3. 6,080	1. 10,105 2. 1,225 3. 6,688	1. 10,305 2. 1,237 3. 7,355	1. 10,305 2. 1,237 3. 7,355

CY 2015 - Ensure a Financially Stable Plan

		Benchmark Periods	CY 2015				CY 2017
Strategic Initiative	Goal Description	CY 2014 Actual	Actual Results	Goal – Met or Exceeded			Goal
				Threshold	Target	Stretch	Threshold
Net Income/Loss	Net income/loss actual or above certified or authorized budget for plan year	+ $151M variance	+ 149M variance	**Projected loss: $148M Actual gain: $370K**			**Projected loss: $333M**
PMPM Claims Expenditures	PMPM claims expense at or below certified or authorized budget (as forecasted by actuaries) for plan year	5% lower ($348.53 actual vs. $367.00 projected)	2% lower ($391.18 actual vs. $399.31 projected	2% above – 8% below	1% above – 7% below	0% above – 6% below	0% above – 6% below
Member Cost-Sharing	% of total claims cost paid by members through copays, deductibles and coinsurance at or below benchmark	**Three Plan Options** Silver (77%) Gold (83%) Platinum (91%)	**Three Plan Options** Gold (81%) Gold (83%) Gold (89%)	**Three Plan Options** Silver (77%) Gold (83%) Platinum (91%)	**Three Plan Options** Silver (76%) Gold (84%) Platinum (92%)	**Three Plan Options** Silver (76%) Gold (85%) Platinum (92.5%)	**Three Plan Options** Silver (72%) Gold (85%) Platinum (91.0%)

Next Steps

- Discuss CY 2017 goals
- Determine how State Budget will impact goals
- Measure progress annually and adjust, as necessary
  - Many goals have significant external variables
- Identify areas of focus to achieve strategic goals

Appendix

Approved Metrics – Improve Members' Health

Priority	Description	Goal Description
Improve Members' Health	PCMH Utilization	Increase % of members receiving care from a NCQA recognized PCMH
	Quality of Care	Increase % of members with targeted high prevalence conditions receiving care according to national clinical standards
	Worksite Wellness	Increase number of worksites offering worksite wellness

These metrics reflect areas of focus for the Plan. Initiatives aimed at meeting the goals and future targets will help lead to:

- Healthier and more engaged members,
- Better managed chronic disease, and
- Members receiving high quality, coordinated care.

Approved Metrics – Improve Members' Experience

Priority	Description	Goal Description
Improve Members' Experience	Customer Satisfaction	Maintain or improve overall Customer Satisfaction score
	Annual Enrollment Service Level Agreements	Improve Annual Enrollment customer service SLAs
	Member Engagement	1. Increase in the # of active members registered as users on TPA site 2. Increase in the usage of TPA's provider search and transparency tools 3. Increase in attendance at educational roadshows

These metrics reflect areas of focus for the Plan. Initiatives aimed at meeting the goals and future targets will help lead to:

- Increased member engagement,
- Higher level of trust, and
- More informed members who are empowered in their decision making.

Approved Metrics – Ensure a Financially Stable State Health Plan

Priority	Description	Goal Description
Ensure a Financially Stable State Health Plan	Net Income/Loss	Net income/loss actual or above certified or authorized budget for plan year
	PMPM Claims Expenditures	PMPM claims expense at or below certified or authorized budget (as forecasted by actuaries) for plan year
	Member Cost-Sharing	Percent of total claims cost paid by members through copays, deductibles and coinsurance at or below benchmark

These metrics reflect areas of focus for the Plan. Initiatives aimed at meeting the goals and future targets will help lead to:

- Reduced costs for members and the Plan
- Reduced fraud, waste, abuse and overuse
- Delivery of appropriate care in the appropriate setting
- Payment for quality and value rather than quantity

Summary of Methodology

- Each of the strategic measures was chosen to illustrate the progress the Plan is making (or not making) in achieving the Strategic Plan
  - Additionally, they are items that can be measured
- Where appropriate, the two benchmark periods will be FY 2012-13 and CY 2014 to reflect the last two full plan years *(Note: the Strategic Plan adopted by the Board assumes CY 2013 as the benchmark period)*
  - This serves to reflect (directionally) the trends related to each metric
- Beginning in CY 2015, each measure will have a threshold, target, and stretch goal
  - *In addition, initial threshold goals have been identified for CY 2017 for discussion purposes*
- The scorecard will be a high level summary of detailed analyses that is easy to digest
- Success (i.e. Met Goal) in a particular category will be measured by meeting at least two of three priority groupings, minimizing those below threshold, and identifying targets to achieve the stretch measures

Appendix: Description of Measures

- **PCMH Measure**: Provided by BCBSNC, the number of members who either selected a PCP (Enhanced 80/20 and CDHP) with PCMH recognition or can be attributed to a PCP through BCBSNC attribution model (Traditional 70/30)
- **Quality of Care -** Internal data mining:
  - Diabetes: Members meeting clinical standards of care (appendix for services)
  - Persistent Asthma: Using claims data for persistent asthma, will change with ICD-10 (appendix for definition)
  - Asthma ED Admissions: Based on site of service and primary diagnosis in claims data
  - Asthma IP Admissions: Based on site of service and primary diagnosis in claims data
- **Wellness Champions**: Program established in CY 2015 to increase worksite wellness and recruit dedicated champions

Appendix: Quality of Care Metrics

- **Diabetes**
  - Members identified using the HEDIS definition of diabetes
  - To be considered as receiving clinical standards of care, members must have received 4 different nationally recognized best practice clinical services
- **Persistent Asthma**
  - Members identified using the HEDIS definition of persistent asthma
  - To be considered as receiving clinical standards of care, members with persistent asthma must have received appropriate medication (HEDIS) and regular doctor visits in the past 12 months

Appendix: Quality of Care Metrics, con't.

- **Asthma**
  - Members are identified using a weakening of the HEDIS definition of persistent asthma.
    - Every member identified with persistent asthma will also fit the definition of asthma
    - Criteria developed in consultation with SHP clinical staff
  - A member is included in the population if s/he satisfies at least one of the following during the measurement year.
    - At least one ED visit with a primary diagnosis of asthma
    - At least one acute inpatient encounter with a primary diagnosis of asthma
    - At least two outpatient visits or observation visits on different dates of service with any diagnosis of asthma and at least one asthma medication dispensing event. Visit type need not be the same for the two visits.
    - At least two asthma medication dispensing events. A member identified as having asthma because of at least two asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed that year, must also have at least one diagnosis of asthma during the same year as the leukotriene modifier.
  - Use rate is [# of visits w/primary dx of asthma]/[# of visits] for IP and ER

Appendix: Description of Measures

- **Net Income/Loss:** For the past few years the Plan has exceeded net income/loss projections by accruing more cash. In CY 2015 and the coming biennium the Plan will spend cash reserves down in lieu of premium increases; therefore, the strategic goal reflects a net loss in each of the next three years.
- **PMPM Claims Expenditures:** Claims expenditures drive a significant portion of Plan costs. Effectively forecasting these costs assists in maintaining benefits and addressing member needs.
- **Member Cost-Share:** The 2016 Board-approved plan design makes significant cost-share changes to the Traditional 70/30 and smaller changes to the CDHP. Additionally, members in the Enhanced 80/20 and CDHP have options to reduce their out-of-pocket costs through Plan engagement.

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Board of Trustees
of the
State Health Plan for Teachers and State Employees

Strategic Plan
2014 – 2018

Adopted September 19, 2014

Potential Revisions for Consideration April 27, 2016*

** The potential revisions represent initial changes to the strategic plan for discussion purposes. Once the Board has finalized revisions to the strategic initiatives, Plan staff will propose revisions to the Strategic Roadmap to outline anticipated projects and programs for 2016 – 2020.*

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EXECUTIVE SUMMARY

The State Health Plan for Teachers and State Employees (Plan) was created by statute to make available comprehensive health benefits for eligible teachers, employees, retirees and their eligible dependents. The Plan is governed by the State Treasurer, Board of Trustees (Board) and the Executive Administrator, who carry out their duties and responsibilities as fiduciaries for the Plan. The Board is responsible, by statutory mandate, for developing and maintaining a strategic plan for the Plan. This document outlines the current strategic plan ~~for the years 2014 through 2018~~ and will be updated periodically to reflect the changing healthcare landscape and priorities of the Board.

The strategic plan is organized by first identifying the Plan's mission, vision and values followed by "guiding principles" that describe the intent and motivation behind the Plan's actions. Next, the Board has identified three strategic priorities ~~for 2014-2018~~: 1) Improve members' health; 2) Improve members' experience; and 3) Ensure a financially stable State Health Plan. A description of what each means, what will be done, and why it is important, is also included. Specific initiatives designed to achieve each strategic priority are then identified and described again in terms of what each means, what will be done, and why it is important. Finally, a roadmap is provided that identifies major projects and programs within each initiative along with key decision points regarding contracts or benefits, launch dates, and an indication of the magnitude relative to members impacted or resources needed.

This strategic plan is designed to align the mission and vision of the State Health Plan with the programs and services provided to its members, and along with the values expressed, will serve as a guide over the period identified. This document is considered a "living document." That is, specific projects and programs are expected to be modified on a frequent basis, as appropriate, with the priorities, initiatives and measures being revisited on an annual basis as agreed upon by the Board.

Ongoing performance monitoring, detailed project plans and other progress updates will be provided on a regularly scheduled or as needed basis. Background information, including environmental scans and other supporting analyses and conclusions used by the Board in the development of this strategic plan, are available on the Plan's website at www.shpnc.org under the Board of Trustees quick link.

MISSION

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

VISION

Our vision is to be a health plan that is a leader in North Carolina in providing access to cost-effective, quality health care and wellness programs on behalf of our membership.

VALUES

***Member Focus** – Keeping the member at the forefront of our actions*

***Collaboration** – Partnering with individuals and other stakeholders on behalf of our members*

***Transparency** – Acting in an open manner with the highest possible degree of integrity in all we do*

***Quality** – Striving for the best quality of care and service for our members*

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STRATEGIC PLAN GUIDING PRINCIPLES

The following guiding principles were used in developing the strategic priorities and measures of success for the State Health Plan's strategic plan:

1. The State Health Plan's **Mission Statement** will serve as the primary guide in the development of a strategic plan.

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

2. It is the intent of the Board and Plan leadership team to ensure that the **perspective of the member**, including experience and value, is factored into the strategic plan.
3. It is the intent of the Board and Plan leadership team to support the development of benefit offerings that are **affordable** to state employees, retirees and their dependents and the State of North Carolina. Therefore the Board and Plan leadership team will make every effort to work on behalf of the members and State of North Carolina to develop the competitively priced offerings that **improve the health and well-being of its members**.
4. The Board and Plan leadership team recognize the responsibility to work to ensure that members have **access to quality care** and that their **patient experience is continuously improved**.
5. Given the Plan's responsibility to serve members across the state, the Board and Plan leadership team recognize the need to develop benefit offerings and programs that **balance cost and access to quality care**. Access includes addressing issues such as distance to providers, cost and length of time to schedule an appointment.
6. There needs to continue to be a **sense of urgency** to ensure the Plan remains financially stable to fulfill the mission of improving the health and health care of its members. That said, the Board and Plan leadership team acknowledge that the ability to make operational changes requires time and resources. Therefore, it is prudent to have **a reasonable period of stabilization** to manage recent member and operational impacts and to have time to measure the results of recent changes. Continuous measurement and monitoring will be an integral part of the strategic planning process.
7. The Board and Plan leadership team recognize the opportunity to develop benefit offerings and programs that will require longer time horizons to determine measurable results. Therefore, it is the intent of the Board and Plan leadership team to **develop a balanced portfolio of both near and long term strategic initiatives**.
8. It is the intent of the Board and Plan leadership team to effectively manage premiums that members are required to pay for coverage and for out-of-pocket health care expenses. The Board and Plan leadership team **support the development of programs and benefit offerings that encourage healthy lifestyles** and the appropriate use of incentives and cost sharing as levers in influencing the use of health care services and improving the health of plan members. Ongoing communication and education will be critical.
9. The Board and Plan leadership team acknowledge that there will be a dependency on the **support of the North Carolina General Assembly** to fund or operationally execute on the strategic plan. The Board and Plan leadership team will work collaboratively with that constituency to ensure the strategic plan fulfills the mission of the Plan.
10. Given the dependency on 3rd party vendors, business partners, providers and other stakeholders the Plan, working in the best interests of the Plan members and State of North Carolina, will take a **collaborative** and **partnership approach** with all stakeholders in developing and executing on the strategic plan. This will include utilizing others' areas of expertise and information to guide the decisions and actions of the Board and Plan leadership team.
11. The Board and Plan leadership team recognize their **fiduciary responsibility** first and foremost to the members of the Plan but also to the State of North Carolina and its citizens.
12. It is the intent of the Board and Plan leadership team to act in a manner that is in **the best interests of all members** of the Plan and actively work toward **consensus** that will enable the fulfillment of the mission of the Plan.

North Carolina State Health Plan
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STRATEGIC PRIORITIES

Priority	What It Means	What We Will Do	Why It Is Important
Improve Members' Health	Population health management is a model for managing all aspects of member health from wellness to chronic disease with a focus both on engaging members in their health and improving the quality and coordination of care within the health care system. The goal is maintaining or improving the health of members and lowering medical claims cost for members and the Plan.	• Maintain or improve member health as appropriate including the support of members with chronic conditions • Engage health care providers in improving the quality and coordination of care • Identify and address gaps in access to quality care or in the care itself • Promote a culture of wellness	About ~~51~~50% of members have at least one chronic condition and account for 76% of claims expenditures. Duplication of services and the provision of services in higher cost settings significantly contribute to the cost of care. Better coordination of care and better health of the population can improve member well-being and lower costs for both members and the Plan. In addition, offering programs and products that attract membership for all stages of health ensures a more stable Plan.
Improve Members' Experience	The member experience includes the relationship members have with the Plan including enrollment, access to information, benefit designs, and affordability of coverage; services and programs provided by the Plan and its vendor partners; and access to providers and quality care through effective relationships with the Plan's network providers. The Plan also seeks to foster and improve the direct relationship between the member and the provider including the provider's practice and staff.	• Improve communication with members about benefit design, enrollment, and eligibility to promote health literacy • Increase transparency of the cost of care and the quality of network providers • Provide reliable, quality services for enrollment, claims processing, and population health management • Address member concerns regarding Plan operations, benefit design, coverage, and costs • Develop partnerships and benefit designs that improve members' experience with providers and practices	Members who are informed and satisfied with their service experience are more likely to engage with the Plan and participate in benefit designs and programs aimed at improving their health, leading to improved health and well-being for the member and lower health care costs for the both the Plan and the member.
Ensure a Financially Stable State Health Plan	The Plan must address the cost of health care, the delivery of health care, and the utilization of benefits in order to minimize State and member premium contributions, provide a cost-effective and sustainable benefit and optimize the benefits offered to members within the financial resources available.	• Manage the cost of medical claims • Manage the cost of pharmacy claims with a specific focus on specialty pharmacy management • Encourage members to use benefits appropriately and to be informed consumers of medical services • Develop programs focused on reducing fraud, waste, abuse and overuse • Collaborate with the General Assembly and Office of State Budget and Management to help ensure predictable funding for health benefits	Financial stability and cost management protect the State and members from large premium increases. Maintaining a strong reserve balance enables the Plan to invest in initiatives to improve health and experience while managing future cost increases and cash flow. The Plan's expense trend has been at or below the medical Consumer Price Index for the last four fiscal years and reserves at the end of FY 2014 were approximately four times the targeted amount. Recent experience has allowed the Plan to offer more options and enhanced benefits for 2014 and forgo premium increases for the State and members in 2015.

North Carolina State Health Plan
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STRATEGIC INITIATIVES

Priority	Initiative	What It Means	What We Will Do	Why It Is Important

Improve Members' Health	Maximize ~~Patient Centered Medical Home (PCMH)~~ Medical Home Effectiveness	The ~~Patient Centered Medical Home~~Medical Home model is a way of organizing primary care that emphasizes care coordination (including appropriate setting), reduction in duplication in ~~and~~services and communication to transform primary care to include population health management. Medical homes are an example that can lead to higher quality and lower costs, and can improve patients' and providers' experience of care. Multiple practices are abandoning PCMH accreditation in favor of alternative approaches such as ACOs; the Plan would like to leverage multiple models of care coordination.	• Support providers and practices in serving as ~~PCMHs~~ Medical Homes through data analytics, care management, and/or enhanced payment through the Population Health Management Services vendor to designated ~~PCMH~~ Medical Home groups
			• Groups will be identified for support/ partnership (directly or through vendor partners) based on willingness to engage and opportunity for improved patient outcomes based on review of available clinical measures
			• Develop metrics and benchmarks to demonstrate the impact of improved care delivery and coordination such as medication adherence, reduced ED use, hospital readmissions and nationally benchmarked HEDIS measures
			• Design and communicate incentives and other benefit designs that encourage members to have designated ~~PCMHs~~ Medical Homes serve as their primary care provider
				• At the heart of ~~the~~ ~~PCMH~~ Medical Home ~~are~~ is the patient and the primary care physician who serves as the key to better coordination of care and patient engagement
				• For 2014, 98% of members in the 80/20 and 99% of members in the CDHP plans selected a primary care provider
				• Increasing the number of primary care providers that are ~~PCMHs~~ Medical Homes will help ensure timely access to care and increase the focus on quality of care indicators such as:
				  • Diabetes HbA1c testing rate is 88.9% while the national benchmark at the 75th percentile is 91% and at the 90th percentile is 94%
				  • Cholesterol LDL-C testing rate is 81.3% while the national benchmark at the 75th percentile is 87% and at the 90th percentile is 89%

	Assist Members to Effectively Manage High Cost, High Prevalence Chronic Conditions	Focused programs designed to assist members and their providers to effectively manage a member's chronic condition(s). The targeted chronic conditions include asthma, COPD, cardiovascular diseases & diabetes. This includes a focus on members with multiple and complex chronic conditions. Additional programs will focus on high cost members or "super utilizers" that could	• Develop chronic care management programs focused on high volume and high cost conditions where there is opportunity to collaborate with providers to improve both quality of care and member engagement • Collaborate with other state entities and stakeholders, including the NC Department of Health and Human Services, on addressing how to improve these conditions across the state • Identify super utilizers and assist those members in seeking more appropriate sites of service. • Utilize programs such as Transitions of	• Members with at least one chronic condition account for 76% of total cost of care (Non-Medicare) • Prevalence of high cost chronic conditions (for actives): Hypertension 25%, Asthma/COPD – 10%, Diabetes – 9%, CAD – 3% • Members with one or more chronic conditions utilize $7,664 of services while healthy members (those without a chronic disease related claim) utilize about $1,283, roughly 1/6th the cost of those with a chronic condition • 2013 medication adherence rates for active members with diabetes was 46%,

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
		be better managed.	Care, the SHP High Utilizers Program, and Telehealth	hypertension is 57% and high cholesterol was 65%
Improve Members' Health	Offer Health-Promoting and Value-Based Benefit Designs	Benefit designs that reduce barriers to care and are directed at sustaining long-term health and managing chronic disease and incent members to seek high value and appropriate treatment from high quality, cost effective providers	• Offer benefit designs that provide no-cost access for preventive care, encourage utilization of ~~PCMHs~~ PPHMs and use of high quality primary care providers, encourage healthy behaviors and engage members • Consider additional value-based benefit designs that offer quality and cost options around ~~providers,~~providers, appropriate treatments and medications • Incent members to make long-term healthy lifestyle choices and more effectively manage chronic disease	• Access to high quality, appropriate care at cost effective settings helps sustain health and allow for management of chronic disease • When offered a premium credit, 84% of active members selecting the CDHP and 80/20 plan options completed a health assessment, chose a PCP and attested they did not smoke or were enrolled in a smoking cessation program
	Promote Worksite Wellness	Any employment based activity or employer sponsored benefit aimed at promoting healthy behaviors (primary or secondary prevention). These are programs that require longer time horizons by which to measure results and impacts.	• ~~Using the NC HealthSmart program, partner~~ Partner with state agencies to influence environmental and workplace policies and tailor programs suited to the different strata of membership across the state • Develop programs and approaches that ensure the continuous engagement of members throughout the year • Create a culture of wellness to include participation and support from employing units and agency leadership	• National data suggests that worksite wellness programs help employees feel more valued • 45% of employees say these programs encourage them to stay with their employer

Priority	Initiative	What It Means	What We Will Do	Why It Is Important

Improve Members' Experience	Create and Implement a Comprehensive Communication & Marketing Plan	Providing members with materials ~~they can understand~~through multiple mediums to help them effectively utilize their health benefits. Communicating regularly, not just at Annual Enrollment, to allow members the opportunity to maximize their experience, reduce their costs, and improve their access to the health care services available to them.	• Develop a comprehensive and continuous communication strategy, including print, email, web-based and mobile applications and media, regarding benefit plan options, how to get the most value out of the benefit programs and explain the value of the benefits that are offered, including:
			  ○ Improve member contact information
			  ○ Develop a branding campaign in coordination with the Department of State Treasurer
			  ○ Regularly meet with provider community to distinguish Plan services from BCBSNC services
			• Demonstrate the value of and promote Plan offerings
				• Health benefits are utilized throughout the year and therefore, regular benefits communications will assist members with benefit questions and managing their care
				• There are opportunities to increase the use of online communication channels because fewer than 1% of members now access NCHealth*Smart* resources online
				• Over 80% of retired members prefer written materials while active members prefer online communications. This demonstrates the need for a variety of communication channels

	Improve the Member Enrollment Experience	Members are able to enroll in and access the benefits they choose and their premium credits are accurately reflected. Enrollment tools meet current technology standards. Streamline customer service calls and online access.	• Develop a consistent and stable platform for members' enrollment experience • Provide a customer service call center to provide members with timely and accurate enrollment and benefit information • Ensure that enrollment data is accurately collected, maintained and transmitted in a timely manner • Where possible, provide single sign-on from the originating secure site to other sites to eliminate the need for multiple passwords and user IDs	• Enrollment is the gateway to the provision of benefits and it is imperative that the member's enrollment experience is as simple as possible and that enrollment information is accurately captured, displayed and transmitted to ensure access to appropriate benefits and to improve the trust of members • Having multiple contact numbers and login IDs can be a barrier to access and timeliness of service • Improving member experience can enable increased engagement
	Promote Health Literacy	Provide access to tools and resources designed to assist members in understanding costs, treatment and provider options to support members in communicating with their provider and engaging in their health care decisions.	• Develop and market tools and resources, particularly web-based and mobile applications, that provide cost and quality transparency metrics and assist members in making informed choices on appropriate treatment options, cost, provider selections, and site of service	• Providing tools to access high quality, site appropriate, and low cost care encourages improved health outcomes, raises member satisfaction, and reduces Plan cost growth • Only 0.2% of members access the provider portal, which houses the current transparency tools • Web-based and mobile platforms improve accessibility to information

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
Ensure a Financially Stable State Health Plan	Target Acute Care and Specialist Medical Expense	The management of specific categories/ treatments of care that exceed the Plan forecast and/or medical expense trends. The management of member out-of-pocket costs in high cost services and care settings such as hospitalizations and specialized medical care. The management of fraud, waste, abuse and overuse of medical services.	• Develop and implement targeted programs or benefit designs that specifically address the following: ○ Appropriate use of emergency rooms and urgent care centers ○ Avoidable inpatient admissions, readmissions, duplicative care ○ Use, costs and/or site of service for specialty medical services ○ Implement targeted programs focused on reducing fraud, waste, abuse and overuse of medical services. ○ Reinforce payment for necessary care only and minimize payment for unnecessary, duplicative care (e.g., preventable patient safety incidents otherwise known as “never events”)	• Hospital inpatient costs averaged $3,266 per day in 2013 and represented $612 million in spending (17.5% of total) • The average cost of a hospital stay for Plan members was $15,553 in 2013 • Emergency room costs represent another $146 million in medical costs (4.2%)
	Target Pharmacy Expense	The management of specialty medications across the medical and pharmacy benefits as well as fraud, waste, abuse and overuse of pharmaceuticals	• Implement targeted programs or benefit designs that manage the cost, use, and/or site of service of specialty medications. • Implement targeted programs focused on reducing fraud, waste, abuse and overuse of pharmaceuticals. • Develop a scorecard to evaluate prescribers and pharmacies.	• Pharmacy costs are 29% of total plan medical costs • 2.6% of non-Medicare membership uses specialty medications under the medical benefit which accounts for 6.7% of total plan (non-Medicare) medical payments • Medical specialty pharmacy trend is 11.3% • <2 % of members use specialty medications under the pharmacy benefit which accounts for 22% of plan pharmacy cost. This is projected to be 50% by 2018. • Specialty pharmacy (pharmacy benefit) trend is currently 16%

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
Ensure a Financially Stable State Health Plan	Pursue Alternative Payment Models	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 through both claims and other sources	• 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
	Ensure Adequate, Stable Funding from the State of North Carolina	Work to secure the necessary stable funding sources by maintaining stakeholder confidence in and support for the Plan.	• Act in an open and transparent manner as appropriate in all interactions with the Governor, Office of State Budget and Management (OSBM), General Assembly, Fiscal Research Division (FRD), state agencies and the public • Use all reasonable tools, processes and assumptions to accurately forecast revenues, expenses, and required premium contributions • Proactively work with the Governor, OSBM, General Assembly, and FRD to protect the Plan's reserves and ensure adequate funding is appropriated each year to enable the Plan to achieve its mission • Partner with employee and retiree stakeholder groups to support the Plan's funding and legislative requests	• Maintaining the confidence in and support for the Plan by key stakeholders in a time of fiscal challenges and competing priorities will help ensure adequate funding is available over the long term, thereby producing a stable financial environment to support the mission of the Plan • Maintaining stable funding helps prevent against benefit erosion and allows the Plan to offer and evaluate the cost-effectiveness of alternative benefit designs, incentives and pilot programs as well as invest in programs and initiatives to improve the member experience and access to quality care

North Carolina State Health Plan
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STRATEGIC MEASURES OF SUCCESS

Priority	Description	Metric	Rationale	Timeframe/Baseline
Improve Members' Health	~~PCMH~~ ~~MeH~~Medical Home utilization	Increase % of members receiving care from a ~~NCQA recognized PCMH~~~~MeH~~Medical Home	~~PCMH~~ ~~MeH~~Medical Home practices provide an opportunity to improve care and care coordination for members	Annual comparison to year-end 2013
	Quality of care measure	Increase % of members with targeted high prevalence conditions receiving care according to national clinical standards	Monitoring delivery of clinical quality of care standards ensures Plan members are receiving quality health care	Annual comparison to year-end 2013
	Worksite wellness	Increase number of worksites offering worksite wellness initiatives	The number of worksites offering onsite wellness initiatives are a proxy for measuring a culture of wellness across State agencies	Annual comparison to year-end 2013
Improve Members' Experience	Customer satisfaction	Maintain or improve overall customer satisfaction score	Overall customer satisfaction is a proxy to monitor the overall Plan's effectiveness	Annual comparison to year-end 2012
	Annual Enrollment service level agreements (SLA)	Improve Annual Enrollment customer service SLAs	Enrollment is the gateway to the provision of benefits and an opportunity to instill trust in the member	Annual comparison to year-end 2013 (from October 2013 enrollment period)
	Member engagement	• Increase in the number of active members registered as users on TPA's website • Increase in the usage of TPA's provider search and transparency tools by active members • Increase in attendance at educational roadshows	Measuring members engaged in communication and health literacy efforts is a proxy for measuring the Plan's effectiveness at targeted member outreach	Annual comparison to year-end 2013
Ensure a Financially Stable State Health Plan	Net income/loss	Net income/loss actual at or above certified or authorized budget (as forecasted by actuaries) for plan year	Provides a comprehensive measure of Plan finances	Annual comparison
	PMPM claims expenditures	PMPM claims expense at or below certified or authorized budget (as forecasted by actuaries) for plan year	Claims expense is the main variable driving financial performance	Annual comparison
	Member cost-sharing	% of total claims cost paid by members through copays, deductibles and coinsurance at or below benchmark	Member cost-sharing is an important component in member affordability	Annual comparison to year-end benchmark

Note: All years are based on the calendar year ending in December, unless specifically noted as fiscal year (FY). Measures will be reported as part of the Plan scorecard and updates will be provided according to the financial reporting schedule.

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VENDOR CONTRACT DEPENDENCIES

The following chart outlines the anticipated effective dates of new contracts as well as the optional renewal and termination dates for existing contracts that are important to the strategic plan. The timing of contract terminations and the length of time required to procure new vendors may impact the strategic initiatives as well as the sequence and timing of the initiatives. The estimated length of time to change vendors or make significant changes to existing contracts can take between 18 and 24 months including development, procurement and implementation. The Board is required to approve all contracts with a value of $500,000 or more.

Vendor dependencies and contract requirements will be continuously assessed as the details of the deliverables of specific projects and programs are developed. Depending on the final detailed design of each initiative as well as other contracting or vendor selection or negotiation issues, the vendor contract reference chart and the timelines associated with each initiative outlined in the roadmap on the following pages could be modified. In addition, the chart below only reflects active contracts. Additional vendor contracts may be required in order to implement the initiatives, and Board approvals will be acquired as needed.

Vendor Contract Reference Chart

Category / Contractor	2016		2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jan-Jun	Jul-Dec	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
TPA / BCBSNC		12/31/16		12/31/17		12/31/18				
TPA / MedCost LLC				12/31/17						
MA / Humana		12/31/16		12/31/17		12/31/18				
MA / UnitedHealthcare		12/31/16		12/31/17		12/31/18				
PBM / Express Scripts		12/31/16								
PBM/ New Contract			1/1/17					12/31/19		12/31/20
PHMS / ActiveHealth Management		12/31/16		12/31/17						
COBRA & Billing / COBRAGuard		12/31/16		12/31/17		12/31/18				
EES / Benefitfocus								12/31/19		12/31/20

New Contract Option to Renew Contract Contract Terminates

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Vendor Contract Reference Chart

Category / Contractor	2016		2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jan-Jun	Jul-Dec	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
TPA / BCBSNC		12/31/16		12/31/17		12/31/16		12/31/17		12/31/18
TPA / MedCost LLC										
MA / Humana		12/31/16			12/31/16	12/31/16		12/31/17		12/31/18
MA / UnitedHealthcare		12/31/16			12/31/16	12/31/16		12/31/17		12/31/18
PBM / Express Scripts		12/31/16			12/31/16	12/31/16				
PBM/ New Contract										
PHMS / ActiveHealth Management										
COBRA & Billing / COBRAGuard		12/31/16			12/31/16	12/31/16		12/31/17		12/31/18
EES / Benefitfocus		12/31/16			12/31/16	12/31/16		12/31/17		12/31/18

New Contract Option to Renew Contract Contract Terminates

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STRATEGIC ROADMAP

July 2014 – December 2018

Background and Definitions

The charts on the following pages outline the high level roadmap for each of the strategic initiatives included in the strategic plan. Each chart includes a brief description of the project or program, any associated contract decisions and/or benefit approvals, an estimated launch date, and an indication of the magnitude of impact relative to the membership. Although not necessarily described in the charts, each of the projects or programs include planning (discovery interviews, market research, synthesis, and gaining consensus), building (developing detailed designs, acquiring necessary approvals, contracts, staff, and training), and implementation (communication, launch, and ongoing monitoring and management). Details on specific programs or benefit designs will be communicated as proposals are developed. The purpose is to organize the major work streams and key milestones, particularly those that will require Board approval. The Plan leadership team will provide updates to the Board proactively on progress as appropriate and as needed.

In addition, the estimated milestones take into consideration the dependencies on vendor contracts based on what is known at the time of planning. The dates on the charts that follow are **not intended to communicate actual contract dates or otherwise indicate that Board approval will be required for every contract decision.** As a planning document, the charts are intended to indicate the possibility of vendor contracts or Board action and final decisions and actions will depend on the details of each initiative.

The following reference table outlines the elements of the work and timelines included in the charts:

Term or Key Indicator	Definition
Projects & Programs	Short description of the major work efforts that will be delivered in support of the initiative
	Possible Board benefit approval point. The need for any approvals will depend on the final detailed design of any new project or program.
	Possible contract decision point – reflects the anticipated point in time when a decision regarding contract extensions or amendments or Board approval of a new contract is required. Contract decisions may or may not require Board action. The need for any approvals will depend on whether it is a new contract with a value of $500,000 or more.
	Indicates the estimated launch date for small or moderately sized projects or programs. For example, pilots, regional programs or projects impacting a relatively small number of Plan members.
	Indicates the estimated launch date for large, statewide projects or programs. For example new products or a disease management program available statewide that impacts a large number of members.

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Strategic Priority: Improve Members' Health

	Projects & Programs	Jul – Dec 2014	2015	2016	2017	2018
PCMH	**PCMH Pilot:** PCMH pilots established with at least 4 health care systems or provider groups. The goal of the pilot is to identify a statewide standard for the PCMH model, to inform the next iteration of the Plan's contract with its population health management vendor and to assess the readiness of these health care systems for alternative payment methods.	Implemented and Ongoing				
	PCMH Model: Implementation of the PCMH model statewide. This will take place through the contract with the population health management vendor.	Contract Decision- PHMS		Delayed		
High Prevalence Conditions	**High Prevalence High Cost Care Management:** Develop and implement a high utilizer care management/coordination plan for members with a diagnosis of diabetes, asthma/COPD, hypertension or CAD in partnership with the Plan's population health management vendor. The intent of the initiative is to promote the delivery of appropriate and timely care within appropriate settings.	Implemented and Ongoing				
	Chronic Pain Pilot: Implement a new program designed to identify and address prescription abuse, improve the safety of members who are taking narcotics and identify care management options.		Delayed			
	Transition of Care Program: Target high priority members who are transitioning out of the hospital for care management to assist in reconciling prescriptions post discharge (Medication Therapy Management – MTM), coordinating follow-up appointments as necessary and to providing education and information on conditions. This will be accomplished through the contract with the population health management vendor.	Contract Decision - ADT feeds Implemented and Ongoing				
Value-Based Benefits	**Value Based Benefit Design:** Implement the next generation of wellness activities, premium credits, and incentives to increase member engagement and accountability, improve medication adherence, reduce waste and encourage the use of quality providers.	In Progress				
Worksite Wellness	**Wellness Champions Pilot:** Develop a network of wellness champions within worksites to lead employees in worksite wellness initiatives. The Plan will provide incentives that reward those worksites with high levels of participation as well as support worksite with resources like speakers and toolkits.	Implemented and Ongoing				
	Multipronged Three County Pilot: A three pronged, two year pilot in Greene, Jones and Lenoir counties aimed at addressing the high prevalence, high cost chronic conditions of diabetes, asthma, COPD, hypertension, CAD, and stroke. The Plan and its vendors would help develop capacity to implement wellness initiatives within worksites in three counties, develop provider engagement with Plan membership and empower members in seeking appropriate health care and leveraging community resources.	Implemented and Ongoing				

Strategic Priority: Improve Members' Experience

	Projects & Programs	Jul – Dec 2014	2015	2016	2017	2018
Communication & Marketing	**Coordinated Communication Campaign:** Implement a communication approach for Retiree Health Benefits that is coordinated with the Retirement System and the Department of State Treasurer.	Implemented and Ongoing				
	Medicare Primary Communication: Enhance current Medicare Primary learning module and develop additional outreach strategies.	Implemented and Ongoing				
	Active and Non-Medicare Primary Communication: Develop learning module for Active and non-Medicare Primary members to enhance their health literacy and understanding of Plan Benefits.	Implemented and Ongoing				
Enrollment Experience	**New Eligibility and Enrollment vendor:** Transition all eligibility and enrollment services to a new vendor no later than July 1, 2015. In order to launch the new services all testing must be completed by March 31, 2015, and the communication plan with members, vendors and other stakeholders completed by December 31, 2014.	Contract Decision Implemented and Ongoing				
	Annual Enrollment and Benefit Design Communication: Implement a comprehensive communication and marketing campaign each year regarding Annual Enrollment and benefit designs. Focus campaigns to emphasize the healthy activities required to earn premium wellness credits and value-based designs.	Implemented and Ongoing				
Health Literacy	**BlueConnect Launch:** BCBSNC is implementing a new member web portal in January 2015. Partner with BCBSNC to develop a communication strategy to increase engagement and utilization with the new functionality**.**	Implemented and Ongoing				
	Transparency & Literacy Tools Program: Implement programs that promote and incentivize members to utilize web-based transparency tools for identifying high quality, cost effective providers; calculate their best plan options based on expected utilization; and identify resources to assist with chronic conditions.	Implemented and Ongoing				
	Incentive Rewards Program: Implement a program that rewards members for healthy lifestyles, use of preventive benefits, and benefit engagement. An example of a potential reward is a Fitbit® for participating in a walking program or engaging with a health coach.	Implemented and Ongoing				

Strategic Priority: Ensure a Financially Stable State Health Plan

	Projects & Programs	Jul – Dec 2014	2015	2016	2017	2018
Acute Care and Specialists	**Avoidable Admissions and Emergency Department Visits:** Implement a telehealth option to provide a less costly alternative to an ED visit but that also provides the member with direct and immediate access to a physician.			Delayed		
	Place of Service: Incent members through benefit design to utilize the appropriate provider in the most cost effective setting for health care services. For example, incent members to choose a location without an associated facility fee.	In Progress				
Pharmacy	**Specialty Pharmacy Management:** Implement programs that encourage the cost effective use of specialty pharmacy drugs including member and provider incentives regarding drug infusion site of care, equity in member cost share across pharmacy and medical benefits, and utilization management.			Delayed		
	Enhanced Fraud Waste & Abuse Program: Replace the high utilization program, which restricts a member to one pharmacy due to the high utilization of targeted drugs (controlled substances and muscle relaxants) with a comprehensive Enhanced Fraud, Waste and Abuse Program. The Enhanced Program includes a review of both medical and pharmacy claims to accurately identify members who meet the robust criteria for restriction to one pharmacy and up to two prescribers for controlled substances and other drugs of abuse. The goal is to decrease fraud, waste and abuse (which includes improper use) of controlled substances and other drugs of abuse.		Delayed			
Alternative Payment Models	**Alternative Payment Models:** Implement alternative payment models with 2 to 3 accountable care organizations (ACOs) and then expand.		Implemented and Ongoing			
Adequate, Stable Funding	**Communication with State Government Leadership:** Provide the Governor, General Assembly and other key stakeholders with regular updates and targeted communications on the Plan's strategic plan and financial results as well as policy and programmatic priorities through contact with the Office of the Governor, committees and individual members of the General Assembly, leadership staff, OSBM, FRD and state agencies.		Ongoing			
	Legislative Agenda: Develop and communicate funding requirements and requests for statutory changes for the long and short sessions to address the Plan's administrative, financial and policy needs and provide information, actuarial notes, and educational sessions as needed and requested.		Ongoing			

LIST OF ACRONYMS

ACO	Accountable Care Organization
ADT	Admissions, Discharge and Transfer
BCBSNC	Blue Cross Blue Shield of North Carolina
CAD	Coronary Artery Disease
CDHP	Consumer-Directed Health Plan
COPD	Chronic Obstructive Pulmonary Disease
ED	Emergency Department
EES	Eligibility and Enrollment Services
FRD	Fiscal Research Division
HEDIS	Healthcare Effectiveness Data and Information Set
MA	Medicare Advantage
MTM	Medication Therapy Management
NCQA	National Committee on Quality Assurance
OSBM	Office of State Budget and Management
PBM	Pharmacy Benefit Manager
PCHM	Patient Centered Medical Home
PCP	Primary Care Provider
PHMS	Population Health Management Services
SLA	Service Level Agreement
TPA	Third Party Administrator

North Carolina
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Provider Reimbursement Strategies

Board of Trustees Meeting

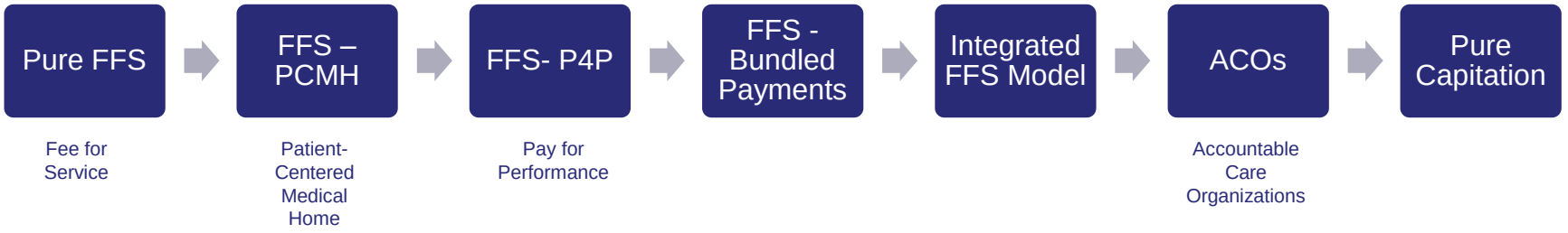
April 27, 2016

Presentation Overview

- January 2014 Board Presentation on Provider Payment Methodologies and Strategies
- Board Approved Strategic Initiative to Pursue Alternative Payment Models
- Blue Cross and Blue Shield of NC Provider Reimbursement Savings Initiatives
- Considerations and Decision Points

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; Plan 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 Plan 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

PROVIDER REIMBURSEMENT SAVINGS INITIATIVES

BlueCross BlueShield of North Carolina

REIMBURSEMENT SAVINGS INITIATIVES

Initiative	Comments/Description	Annual Savings Projection
Out-of-network Lab	Implemented reimbursement change in 2015	$8 million
Reimbursement policy changes	e.g., Incidental services edits; assistant surgeon, residential treatment centers, and out of network professional reimbursement changes; implemented in late-2015 to early-2016	$3.6 + million
Bundled payment arrangements	Knee and hip replacements	Average savings per knee: $1,000-$2,000 Average savings per hip: $4,200-$4,800 Apr 2014-Mar 2015 total savings: $142,000.
Blue Local	Currently available in Triangle (Duke and WakeMed) and in Charlotte (Carolinas HealthCare System)	6-8% savings in Blue Local markets, assuming total replacement offer; approximately 118,000 Plan members would have access to current Blue Local arrangements
ACO arrangements	Plan currently participates with WakeMed / Key Physicians (WKCC) ACO	TBD based on ACO performance
Aligning outlier reimbursement	e.g., Wayne Memorial , Carteret Health Care	As example, ~5% savings on facility rates per initiative. Varies by facility.
Large health system renewal strategy	Value-based contracting strategy, ongoing at contract renewal	Varies by health system; projected annual savings of $10.8 million off run rate
Benchmark-driven professional reimbursement update	Benchmarking to industry-standard methodology	TBD based on benchmarking results
Sleep study management	Implementing mid-2016	$2 million
Hospital and high volume specialist designation program	Designation based on cost and quality; more than 40% of inpatient admissions are to designated facilities; in place since 2014	$4 million (based on historical Plan data); net savings of $2.4 million, after incentives
Blue Distinction Center (BDC) Program	BDCs for joint replacement, spine surgery, bariatric surgery, cardiac care, complex and rare cancers, transplants, and maternity; BDCs are designated based on cost and quality	Savings range from 5-20% for total episode of care, depending on procedure and based on BDC facilities versus relevant comparison facilities
Recruitment of ABA therapy providers	Upon the addition of ABA therapy to Plan benefits, BCBSNC contracted with additional providers to join the network	Approximate savings for 2015: $40,000 Savings will increase as utilization increases

LONGER TERM COST MANAGEMENT STRATEGY

- BCBSNC continuously evaluates the total cost of care to ensure savings for clients and members and to ensure a competitive advantage in the market
- BCBSNC has executed on a number of initiatives that are already generating savings
- Over the next 2-4 years and ongoing, BCBSNC will execute on medical expense strategies to further improve its competitive advantage, starting with professional reimbursement (currently benchmarking), followed by facility outpatient and inpatient
- In addition to reimbursement advantage, BCBSNC is evaluating savings opportunities related to medical policy and reimbursement policy
- Quality and access will be important components of any reimbursement or policy initiative
- Long term cost management will result from the totality of these efforts, not from reimbursement alone

Considerations and Decision Points

- If the primary goal is achieving reductions in FFS reimbursements, the Board needs to reassess the strategic initiative to pursue alternative payment models
- If the Plan sets “allowed” amounts or specifies maximum reimbursement rates without also establishing a network of contracted providers, members may experience access issues and balanced billing
- Development of next TPA RFP is under way – need clear strategic direction
- Key focus of upcoming discussions regarding changes/updates to the strategic plan

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

2016 Short Session Legislative Agenda

Board of Trustees Meeting

April 27, 2016

A Division of the Department of State Treasurer

Priorities for Short Session

- 2016 Legislative Session began on April 25
- Bill Filing Deadline is May 10
- State Health Plan Priorities
  - Release Funds Reserved for Increase in Employer Contribution
  - Clarify ACA Reporting Responsibilities
  - Modify Local Government Participation
  - Clarify Contracting Exemption
  - Mandate Contractor Release of Data
  - Authorize Flexibility Regarding the State's Banking Requirements

Release Funds for Increased Employer Contribution

Issue:

- 2015 Appropriations Act, House Bill 97, SL 2015-241 includes funds for an increase in the State's employer contribution for health benefits during FY 2016-17, but the funds are reserved until release by the General Assembly.
- Funds will be made available only if the General Assembly determines that the State Treasurer and the Board of Trustees have adopted sufficient measures to limit projected employer contribution increases during the 2017-2019 fiscal biennium.
- The Plan will have difficulty complying with the legislative requirement to maintain cash reserves equal to 20% of annual costs without an increase in the employer contribution.

Legislative Request:

- Pending approval of benefit design changes by the Board for calendar year 2017, the Plan is requesting the release of funds in the Reserve for Future Benefits Needs.

Clarify ACA Reporting Responsibilities for Employers

Issue:

- The Affordable Care Act (ACA) requires large employers report to the Internal Revenue Service (IRS) annually regarding the offer of health insurance coverage to full-time employees and retirees (6056) and the coverage provided (6055).
- The ACA reporting requirements are the responsibility of the employer, meaning that each employing unit participating in the Plan is responsible for meeting the requirement.
- In some cases, such as when an employee cannot be linked back to an employer, the Plan is responsible for meeting reporting requirements. In addition, the Plan could be considered the sponsor of retiree coverage and therefore could assume the responsibility for reporting on retirees.

Legislative Request:

- To avoid continued confusion regarding the responsibilities between the Plan and employing units, the Plan is requesting legislation that places the responsibility for retiree reporting on the Plan, but clarifies that reporting for all other employees and plan participants falls to the employing units.

Modify Local Government Participation in the Plan

Issue:

- Legislation adopted by the General Assembly in 2015 allowed local government units to join the State Health Plan upon meeting certain requirements.
- Total participation by local governments is limited to 10,000 employees – a cap which was recently reached with a total of 80 local governments currently enrolled.
- While local government units may participate in the Plan, current law allows them to determine what portion of the premiums employees will pay. Employee premium contributions that differ from those the Board has approved creates administrative difficulties and potentially frustrates the strategic plan.

Legislative Request:

- The Plan does not oppose local government participation in the health plan offerings, but cannot be responsible for the risks and administrative burden associated with local flexibility. The Plan is seeking a statutory change to ensure that local governments do not deviate from Board strategies related to plan premiums and benefit design.

Clarify Plan's Contracting Exemption

Issue:

- The Plan has an exemption from Department of Administration, Purchase and Contract (P&C) rules regarding its third-party administrator contracts and the design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under those plans.
- The Plan considers most of its contracts to be service contracts and not IT contracts. However, with improvements in technology the contracts contain more and more of an IT component.
- The Plan does not have an exemption from Department of Information Technology (DIT) procurement rules and believes clarification of its exemption is important in reducing risks to the Plan from both a compliance and efficiency standpoint.

Legislative Request:

- The Plan is requesting a specific exemption from both P&C and DIT.

Mandate Contractor Release of Data to the Plan

Issue:

- To date, the Plan's ability to conduct provider-specific data analyses has been limited due to the inability to link claims data (cost) with provider identification.
- The Plan currently has access to claims data from Blue Cross and Blue Shield of NC (BCBSNC), but that data is delivered with scrambled provider identification – meaning the Plan cannot use the data in any efforts to measure provider performance without going directly to BCBSNC.

Legislative Request:

- The Plan is requesting authority to require third-party administrators to supply the Plan with data that includes both provider identifiers and cost so that data can be used in a wider range of analytics.
- The legislation would apply to future contracts and the Plan will continue to be obligated to protect proprietary and confidential information provided by vendors.

Authorize Flexibility Regarding State Banking Requirements

Issue:

- The Plan's third-party administrators (TPAs) for medical and pharmacy benefits are required to adhere to the State's banking requirements, which require contractors to establish and manage depository and disbursing accounts in the name of the State Treasurer.
- In many cases, however, potential TPA bidders have reported that these banking and financial requirements are burdensome or cost prohibitive to the point that they have declined to bid.

Legislative Request:

- The Plan is working with the Office of the State Controller and the Financial Operations Division of the Department of State Treasurer to develop legislation authorizing the State Treasurer and State Controller to approve exceptions to the state's banking requirements to provide flexibility to agencies in certain circumstances while continuing to protect the State's interest.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

State Health Plan Myths vs. Facts

Board of Trustees Meeting

April 27, 2016

Myth vs. Fact #1:
Myth: The Plan Offers Bronze or Catastrophic Coverage

Fact:

- In 2013 the Plan's actuarial firm, the Segal Company, conducted a minimum value certification and concluded that all three "plans are closest to Gold as defined by the Affordable Care Act" for CY 2014.
- The table below highlights the actual percentage of claims paid by the Plan for actives, COBRA, and non-Medicare retirees in CY 2014 and CY 2015 and the ACA medal level associated with that level of plan payment
  - Medicare retirees in the Traditional 70/30 were excluded because Medicare is the primary payer

Plan Name	CY 2014	CY 2015
Traditional 70/30	77% (Silver)	80% (Gold)
Enhanced 80/20	83% (Gold)	84% (Gold)
CDHP	91% (Platinum)	89% (Gold)

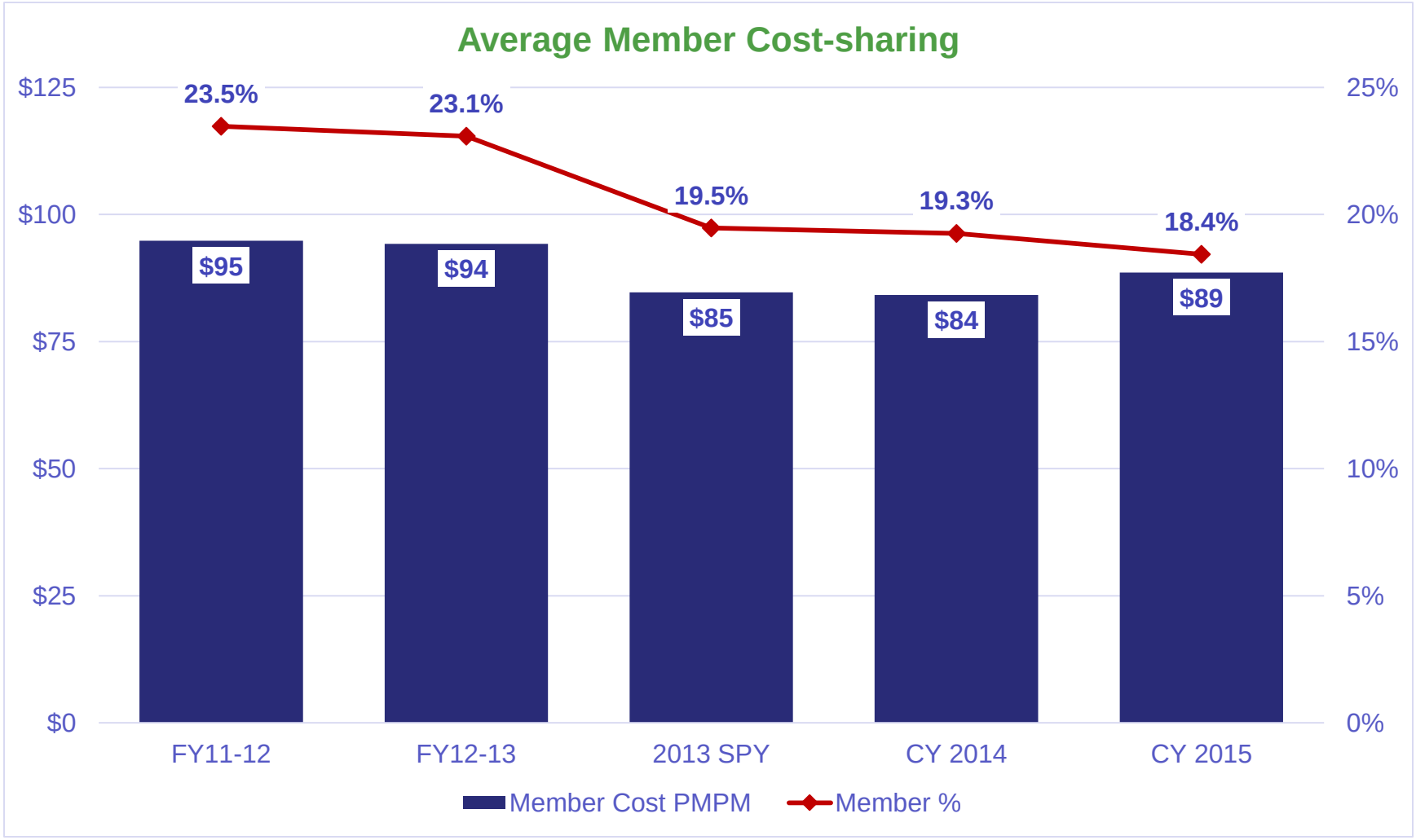
Myth vs. Fact #2:
Myth: Plan Members' Out-of-Pocket Costs Rise Every Year

Fact:

- Other than the creation of new pharmacy tier for non-preferred specialty medications in 2013, prior to CY 2016 there have been no increases in member cost-sharing since the Plan was moved to the Department of State Treasurer with the new Board of Trustees and governance structure in 2012
  - There have been decreases in member cost-sharing in the Enhanced 80/20
    - 100% coverage of ACA preventive services
    - Reduced copays for behavioral health services
  - The CDHP which offers the lowest out-of-pocket exposure of the three plan offerings was established in 2014
- Because the Traditional 70/30 and Enhanced 80/20 plans are copay based plans and copays have been held constant, the percentage of total out-of-pocket cost members paid has actually gone down since FY 11-12
- On average, member out-of-pocket cost on per member per month basis has decreased since FY 11-12

Myth vs. Fact #2:
Myth: Plan Members Out-of-Pocket Costs Rise Every Year

Fact:



Myth vs. Fact #3:

Myth: Wellness Premiums are Punitive and Adversely Impact the Membership

Fact:

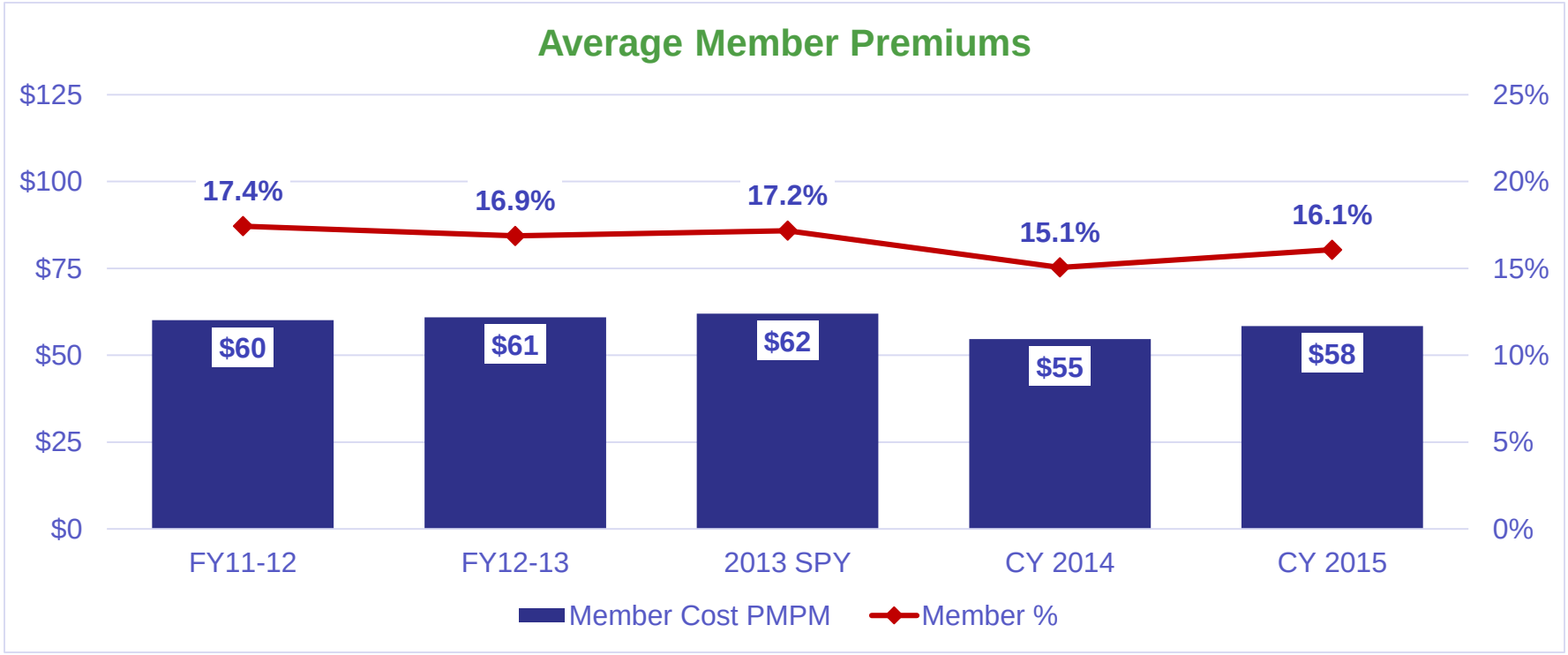
- The 80/20 Wellness Premiums Credits *reduced* member premiums by an estimated $19.0 million in CY 2014 and by an estimated $12.5 million in CY 2015.
- The average monthly premium *reduction* associated with the Wellness Premium Credit structure was $8.31 in 2014 ($100 annual savings) and $5.22 in 2015 ($63 annual savings).
  - Initial analyses for CY 2016 indicate that members may be paying slightly more (less than $1 per month or about $10 per year) due to the Wellness Premium structure.

Myth vs. Fact #3:

Myth: Wellness Premiums are Punitive and Adversely Impact the Membership

Fact:

- Wellness Premium Credits have successfully reduced premium cost growth for a large percentage of the membership
  - The average member paid monthly premium is lower than FY 11-12
    - Members are also paying a smaller share of the total premium/contribution cost



Myth vs. Fact #4:
Myth: Provider Rates Paid by the Plan are High

Fact:

- The Plan competitively bid the third party administrative services contract in 2012 with services effective 7/1/2013
- Blue Cross and Blue Shield of NC won the contract and on a statewide basis offered the best provider reimbursement rates in the market
- The Plan could pay lower provider reimbursement rates but that would shrink the network of available providers
- By contracting with CVS/Caremark the Plan is projected to save between $300m - $500m over the initial term of the contract
  - Savings range is contingent on the Plan's formulary choice.
  - A closed formulary would generate the highest savings

Myth vs. Fact #5:

Myth: The Prison System Negotiated Lower Rates than the Plan Pays

Fact:

- The Department of Public Safety (DPS) operates its own hospital and health care facilities for inmates and uses other facilities only when necessary.
- The General Assembly established provider reimbursement rates for inmate medical services that occur outside DPS facilities:
  - SECTION 16C.4.(a) of SL 2013-360, as amended provides, "The Department of Public Safety shall reimburse those providers and facilities providing approved inmate medical services outside the correctional facility *the lesser amount of either a rate of seventy percent (70%) of the provider's then-current prevailing charge or two times the then-current Medicaid rate for any given service*. The Department shall have the right to audit any given provider to determine the actual prevailing charge to ensure compliance with this provision."
- The Plan currently pays less than these rates and using the DPS reimbursement methodology would dramatically *increase* costs
  - Under the current TPA contract, the Plan's aggregate discounts range from 46% to 50% of charges.
  - In CY 2013 the Plan paid about 165% of Medicaid rates

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Rationale and Alignment of Benefit Changes with the Strategic Plan and Legislative Requirements

Board of Trustees Meeting

April 27, 2016

Rationale for Proposed Benefit Changes

Why Are Benefit Changes Being Proposed?

- Comply with legislative mandates
- Achieve objectives of the Strategic Plan

These are not opposing goals.

State Budget Impact on Benefits Decision

2015 Appropriations Act, House Bill 97, SL 2015-241

SECTION 30.26.(a) It is the intent of the General Assembly to make funds in the Reserve for Future Benefits Needs available for increasing employer contributions to the State Health Plan for Teachers and State Employees during the 2016-2017 fiscal year only if the General Assembly determines that the State Treasurer and the Board of Trustees established under G.S. 135-48.20 **have adopted sufficient measures to limit projected employer contribution** increases during the 2017-2019 fiscal biennium, in accordance with their powers and duties enumerated in Article 3B of Chapter 135 of the General Statutes.

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

SECTION 30.26.(c) On and after January 1, 2016, if the State Health Plan for Teachers and State Employees projects a cash reserve of less than the minimum cash reserve required by this section at any time during the remainder of the 2015-2017 fiscal biennium, or the Fiscal Research Division of the General Assembly notifies the Plan that it projects such a deficiency, the Department of State Treasurer shall report to the Joint Legislative Commission on Governmental Operations within 60 days of that projection or notification on actions the Department plans to take in order to maintain that required minimum cash reserve.

Strategic Direction of Revised Benefit Proposal

- The Board's Strategic Plan and benefit strategy emphasizes three strategic priorities:
  - Improve Members' Health
  - Improve Members' Experience
  - Ensure Financial Stability

- Where possible the revised proposal focuses on these priorities by creating stronger incentives to utilize value-based services and promoting awareness around the actual cost of care and choice of services/providers

Recent Results and Achievements

State Health Plan Achievements

- Increased member choice in plan options, enhanced benefit designs
- Implemented and continue to expand wellness/engagement model
- Low premium growth for members and the State
  - Better results than multiple state and national trends
  - Low and infrequent premium increases
    - 7/1/2012 = 5.3%
    - 1/1/2014 = 3.5%
    - 1/1/2016 = 2.8% employee/dependent premiums, 3.4% employer contribution
- Limited increases in member cost sharing (out-of-pocket costs) since 2011
  - 9/1/2011 – Increases set by NCGA
  - 1/1/2014 – New Tier 5 non-preferred specialty medications tier
  - 1/1/2016 –
    - 70/30 across-the-board increases (no engagement required)
    - CDHP increased out-of-pocket max, but increased HRA contribution too
    - 80/20 Tier 5 pharmacy copay (small amount)
- Significant cash balance to offset future premium growth

Board-Approved Wellness/Engagement Model: Benefit Changes and Program Implementations

	CY 2014	CY 2015	CY 2016	CY 2017

Benefit Changes	• New Consumer-Directed Health Plan (CDHP 85/15) offering
	• Wellness and Engagement Model for Enhanced 80/20 & CDHP 85/15
	  • Premium credits (reduced premiums for completing healthy activities
	  • Wellness incentives and value-based benefits
	  • ACA preventive services
	• Added Tier Five for specialty medications
	• Four new MAPDP products from United and Humana (two premium free options)
		• Added Applied Behavioral Analysis (ABA) benefit
		• New bronze level High Deductible Health Plan (HDHP) for non-permanent full-time employees
		• Additional ACA preventive services
			Traditional 70/30
			• Cost-sharing increases
			Enhanced 80/20:
			• Tier 5 copay increase
			CDHP
			• Increase base Health Reimbursement Account (HRA) contribution
			• Increase value-based HRA credits
			• Increase in out-of-pocket (OOP) maximum
			• Add Rx Debit Card
			• Health Engagement Program – HRA funds
			  • Positive Pursuits (chronic)
			  • Healthy Lifestyles
			• Increase in Enhanced MA-PDP premiums and cost-sharing
				• Add Tobacco Attestation and wellness premium credit to Traditional 70/30

Consider the General Assembly's Perspective

- Added a new richer plan option in 2014 – Consumer-Directed Health Plan (CDHP 85/15) has:
  - $0 employee/retiree premium if three (relatively simple) healthy activities are completed
  - Lowest dependent premiums of any option
- Reduced premiums for the Enhanced 80/20 Plan by offering a $10 credit against the employee premium for completion of three (relatively simple) healthy activities
- Extended 100% coverage of preventive services and medications to members in the Enhanced 80/20 Plan, while maintaining grandfather status under ACA
- Added four new Medicare Advantage Prescription Drug Plan (MAPDP) options.
  - $0 retiree premium for the two base plan options, which are similar in value to the 80/20 Plan, which included a monthly retiree premium for Medicare primary retirees in 2013
- Until 2016, members did not pay for these enhancements with any significant increases in member cost-sharing
- In 2014 and 2016 the General Assembly appropriated more funding for the employer contribution than the forecasts required

Alignment with the Strategic Plan

Alignment with Strategic Plan

Revised proposal aligns with the following strategic priorities and initiatives set out by the Board:

- Improve members' experience
- Ensure financial stability
- Increase and incent utilization of:
  - primary care
  - high quality, lower cost providers
  - high value, lower cost medications
- Address high costs and increasing specialty medications trend

Strategic Alignment: Improve Members' Experience

- Members of the Board and stakeholders:
  - Expressed significant concern about the elimination of the Enhanced 80/20, discussed in January
  - Expressed significant concern about across-the-board cost-sharing increases in the Enhanced 80/20, proposed in February
  - Desire benefit designs aimed at reducing barriers to care, specifically in medications and that retain a copay based structure

- The proposed changes to the Enhanced 80/20 plan design are intended to address these concerns, while offering some benefit enhancements and complying with legislative mandates

Strategic Alignment: Ensure Financial Stability

- The Board of Trustees has a fiduciary responsibility to all the members of the State Health Plan and to manage cost growth for the State
- Managed premium cost growth below national/state benchmarks without reducing benefits until CY 2015
  - Extended periods with no premium increase and on average members are paying less in premium dollars than in CY 2012
  - Extended periods with no benefit reduction or cost sharing increase, and on average members are paying less in out-of-pocket costs than in CY 2012
- The proposed changes to the Enhanced 80/20 plan will help continue these trends for the State while incenting members to engage more to help manage their cost growth and in some cases reduce their expenditures

Strategic Alignment:
Increase and Incent the Utilization of Primary Care

- Effective CY 2014, the Plan provided a premium credit for selection of a primacy care physician/practice (PCP) and a copay reduction/HRA credit for utilization of the selected PCP
  - Enhanced 80/20 PCP copay was reduced 50% from $30 to $15

- The proposed Enhanced 80/20 plan design creates richer incentives in the Enhanced 80/20 for PCP utilization (reduced copays)

Strategic Alignment: Steerage to High Quality, Lower Cost Providers

- Effective CY 2014, the Plan provided a copay reduction/HRA credit for utilization of Blue Options Designated (B.O.D) providers for inpatient and specialist services
  - Designated based on meeting certain quality and cost thresholds and on balance provide higher quality care and a lower average reimbursement
  - Enhanced 80/20 inpatient copay reduced 100% from $233 to $0
  - Enhanced 80/20 specialist copay was reduced about 15% from $70 to $60
  - CDHP 85/15 members receive HRA contributions for using B.O.D providers

- The Board and stakeholders have expressed interest in looking at alternative provider networks that emphasize higher quality providers and use steerage to drive steeper provider discounts
- Some of these arrangements may be more restrictive to members and impact access

- The proposed Enhanced 80/20 plan design creates stronger incentives to utilize Blue Options Designated providers to incent higher quality, lower cost care

Strategic Alignment: Increase and Incent the Utilization of High Value, Lower Cost Medications

- Stakeholders and Board members have indicated that the current cost-sharing on prescription medications can be a barrier to care
- This may result in members with chronic conditions not utilizing key maintenance medications

- The proposed Enhanced 80/20 plan design significantly reduces copays on Tier 1 (generic) and Tier 2 (preferred brand and high cost generic) medications
- Tier 3 drugs would significantly increase in price but these are medications that have multiple alternatives in Tiers 1 and 2

Strategic Alignment: Address High Costs and Specialty Medications Trend

- The prescription drug benefit in the Traditional 70/30 and Enhanced 80/20 plans has three specialty tiers to attempt to drive members to the lower cost options when appropriate
- Specialty medication is the Plan's largest cost driver and members are currently paying less than 5% of the cost of these medications

- The proposed Enhanced 80/20 plan design significantly increases copays on Tier 5 and Tier 6 drugs while still paying for over 90% of the average specialty drug cost
- This will promote financial transparency and member engagement

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Proposed Benefit Design Changes for 2017

Board of Trustees Meeting

April 27, 2016

A Division of the Department of State Treasurer

Presentation Overview

- Review Board Actions to Date
- Proposed Benefit Design Changes for 2017
- Impact on Actuarial Forecast

Summary February 5th Board Actions – CY 2017

Approved Items

1. Maintain same healthy activities to earn premium credits as previous year
   - Apply tobacco attestation credit to Subscribers only
   - PCP selection instead of PCMH
   - Complete HA which includes biometric questions instead of seeking provider reported biometrics
2. Add low-cost generic specialty medications tier
   - Reflects some increases in cost sharing on pharmacy tiers in Traditional 70/30 and Enhanced 80/20

Delayed Items (until May 1st)

1. Increases in cost sharing on Traditional 70/30 and Enhanced 80/20 options
2. Modify base premium strategy
   - Increase base premium for Enhanced 80/20 to $35 (currently $24.20)
   - Establish base premium on other options:
     - $10 CDHP
     - $15 Traditional 70/30

Items in red can no longer be implemented for CY 2017

CY 2017 Healthy Activities & Premium Credits

Healthy Activity	CDHP 85/15	Enhanced 80/20	Traditional 70/30
Non-Tobacco User or QuitlineNC Enrollment *(applies to subscriber only, attestation regarding spousal tobacco use not required)*	$40	$40	$40
Primary Care Provider Selection *(applies to subscriber and enrolled dependents)*	$20	$25	N/A
Health Assessment Completion *(applies to subscriber only)*	$20	$25	N/A
Total Credits Available	**$80**	**$90**	**$40**

Board Approved Feb 5, 2016

Changes to Pharmacy Tiers

- In CY 2017 and beyond, generic/lower cost versions of specialty medications will be entering the market
  - There will be two to three drugs entering in CY 2016

- Beginning in CY 2017, Plan staff recommends incenting members to utilize these lower cost medications by adding a new Tier Four which would incorporate these lower cost drugs
  - The current Tier Four would shift to Tier Five
  - The current Tier Five would shift to Tier Six

Board Approved Feb 5, 2016

Changes to Pharmacy Tiers

Traditional 70/30 Plan

CY 2016		CY 2017	
Tiers	Member Cost Share	Tiers	Member Cost Share
Tier 1 Tier 2 Tier 3 Tier 4 (Preferred Specialty) Tier 5 (Non-preferred Specialty) Tier 6	$15 $46 $72 25% up to $100 25% up to $132 N/A	Tier 1 Tier 2 Tier 3 **Tier 4 (Low-cost/Generic Specialty)** **Tier 5 (Preferred Specialty)** **Tier 6 (Non-preferred Specialty)**	**$16** **$47** **$74** **10% up to $100** **25% up to $103** **25% up to $133**

Enhanced 80/20 Plan

CY 2016		CY 2017	
Tiers	Member Cost Share	Tiers	Member Cost Share
Tier 1 Tier 2 Tier 3 Tier 4 (Preferred Specialty) Tier 5 (Non-preferred Specialty) Tier 6	$12 $40 $64 25% up to $100 25% up to $132 N/A	Tier 1 Tier 2 Tier 3 **Tier 4 (Low-cost/Generic Specialty)** **Tier 5 (Preferred Specialty)** **Tier 6 (Non-preferred Specialty)**	**$14** **$45** **$70** **10% up to $100** **25% up to $103** **25% up to $133**

Board Approved Feb 5, 2016

Proposed Benefit Design Changes for 2017

Proposed Benefit Design – CDHP 85/15 *(no change)*

	Current CY 2016 Non-Grandfathered	Proposed CY 2017 Non-Grandfathered
Deductible HRA	$1,500 $600	$1,500 $600
Coinsurance Percentage	15%	15%
ACA Preventive Services	Covered at 100%	Covered at 100%
Medical Coinsurance Max Pharmacy Max Out of Pocket Max *(Includes Deductible)*	N/A N/A $3,500	N/A N/A $3,500
Selected PCP Non-selected PCP	Ded/Coins. +$25 HRA credit Ded/Coins.	Ded/Coins. + $25 HRA credit Ded/Coins.
B.O.D. Specialist. Non-B.O.D. Specialist	Ded/Coins. + $20 HRA credit Ded/Coins.	Ded/Coins. + $20 HRA credit Ded/Coins.
Inpatient Hospital B.O.D Non-B.O.D.	Ded/Coins. + $200 HRA Credit Ded/Coins.	Ded/Coins. + $200 HRA Credit Ded/Coins.
Outpatient Hospital	Ded/Coins.	Ded/Coins.
Urgent Care	Ded/Coins.	Ded/Coins.
ER Copay	Ded/Coins.	Ded/Coins.
Drugs	Ded/Coins. CDHP Maintenance Medications are deductible exempt	Ded/Coins. CDHP Maintenance Medications are deductible exempt

B.O.D = Blue Options Designated Provider

Proposed Benefit Design – Enhanced 80/20

	Current CY 2016 Grandfathered	Proposed Feb 5, 2016 BOT Meeting CY 2017 Non-Grandfathered	Proposed Value Based Design CY 2017 Non-Grandfather
Deductible	$700	**$840**	**$1,250**
Coinsurance Percentage	20%	20%	20%
ACA Preventive Coverage	Covered at 100%	Covered at 100%	Covered at 100%
Medical Coinsurance Max Pharmacy Max Out of Pocket Max *(Includes Deductible)*	$3,210 $2,500 N/A	**$3,850** **$3,000** N/A	N/A N/A **$6,400**
Selected PCP Non-selected PCP	$15 $30	$15 **$36**	**$10** **$25**
B.O.D. Specialist. Non-B.O.D. Specialist	$60 $70	$60 **$84**	**$45** **$85**
Inpatient Hospital B.O.D Non-B.O.D.	 $0, then Ded/Coins. $233, then Ded/Coins.	 $0, then Ded/Coins. **$280, then Ded/Coins.**	 $0, then Ded/Coins. **$450, then Ded/Coins.**
Outpatient Hospital	Ded/Coins.	Ded/Coins.	Ded/Coins.
Urgent Care	$87	**$95**	**$70**
ER *(Copay waived w/ admission or observation stay)*	$233, then Ded/Coins.	**$280 then Ded/Coins.**	**$300, then Ded/Coins.**
Drugs Tier 1 (Generic) Tier 2 (Preferred Brand & High-cost Generic) Tier 3 (Non-preferred Brand) Tier 4 (Low-cost/Generic Specialty) Tier 5 (Preferred Specialty) Tier 6 (Non-preferred Specialty)	 $12 $40 $64 N/A 25% up to $100 25% up to $132	***Approved 2-5-16*** **$14** **$45** **$70** **10% up to $100** **25% up to $103** **25% up to $133**	 **$5** **$25** **Deductible/Coinsurance** **$100** **$250** **Deductible/Coinsurance**

B.O.D = Blue Options Designated Provider

Summary of Revisions to Enhanced 80/20 Plan Valued Based Design

- In the last few weeks, Plan staff reviewed the proposed benefit changes including an alternative design for the Enhanced 80/20 plan with Board members and stakeholder groups.
- In response to feedback received through these meetings, the proposed value based design elements in the Enhanced 80/20 plan outlined on the previous page were revised as follows:

  - Reduced deductible from $2,000 to $1,250
  - Reduced out of pocket maximum from $6,850 to $6,400
  - Reduced emergency room copay from $500 to $300

Proposed Benefit Design – Traditional 70/30 Plan

	Current CY 2016 Grandfathered	Proposed CY 2017 Grandfathered
Deductible	$1,054	**$1,080**
Coinsurance Percentage	30%	30%
ACA Preventive Services	Cost-Sharing Applies	Cost-Sharing Applies
Medical Coinsurance Max Pharmacy Max Out of Pocket Max *(Includes Deductible)*	$4,282 $3,294 N/A	**$4,388** **$3,360** N/A
PCP Copay	$39	**$40**
Specialist Copay	$92	**$94**
Inpatient Hospital	$329, then Ded/Coins.	**$337, then Ded/Coins.**
Outpatient Hospital	Ded/Coins.	Ded/Coins.
Urgent Care	$98	**$100**
ER *(Copay waived w/ admission or observation stay)*	$329, then Ded/Coins.	**$337, then Ded/Coins.** ***Approved 2-5-16***
Drugs Tier 1 (Generic) Tier 2 (Preferred Brand & High-cost Generic) Tier 3 (Non-preferred Brand) Tier 4 (Low-cost/Generic Specialty) Tier 5 (Preferred Specialty) Tier 6 (Non-preferred Specialty)	 $15 $46 $72 N/A 25% up to $100 25% up to $132	 **$16** **$47** **$74** **10% up to $100** **25% up to $103** **25% up to $133**

Impact on Actuarial Forecast

Baseline Forecast

	Baseline Forecast (assumes no additional changes)		New PBM Contract * Open Formulary (current arrangement)		New PBM Contract * Closed Formulary	
	ER	EE	ER	EE	ER	EE
CY 2017 Projected Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Max Amount Short of 20% Reserve (1st Month short)	$115.6 M (March 2017)		$83.1 M (April 2017)		$72.0 M (May 2017)	
CY 2018 Projected Increase	15.21%	15.21%	12.71%	12.71%	11.91%	11.91%
CY 2019 Projected Increase	15.21%	15.21%	12.71%	12.71%	11.91%	11.91%
CY 2020 Projected Increase	4.82%	4.82%	6.02%	6.02%	6.45%	6.45%
CY 2021 Projected Increase	4.82%	4.82%	6.02%	6.02%	6.45%	6.45%

ER = employer contribution, EE = employee premium

*Assumes 100% of the projected savings for discount guarantees and 50% of the projected savings for pharmacy rebates; savings begin to accrue one month after 1/1/2017 start of contract

Forecast Scenarios: Open Formulary & Benefit Changes

	New PBM Contract * Open Formulary (current arrangement)		With Proposed Benefit Changes		With Proposed Benefit Changes & Increased Contributions	
	ER	EE	ER	EE	ER	EE
CY 2017 Projected Increase	0.00%	0.00%	0.0%	0.00%	3.43%	3.43%
Max Amount Short of 20% Reserve (1st Month short)	$83.1 M (April 2017)		$51.8 M (May 2017)		$7.4 M (May 2017) *End FY above threshold*	
CY 2018 Projected Increase	12.71%	12.71%	9.75%	9.75%	6.27%	6.27%
CY 2019 Projected Increase	12.71%	12.71%	9.75%	9.75%	6.27%	6.27%
CY 2020 Projected Increase	6.02%	6.02%	7.84%	7.84%	10.05%	10.05%
CY 2021 Projected Increase	6.02%	6.02%	7.84%	7.84%	10.05%	10.05%

ER = employer contribution, EE = employee premium

*Assumes 100% of the projected savings for discount guarantees and 50% of the projected savings for pharmacy rebates; savings begin to accrue one month after 1/1/2017 start of contract

Forecast Scenarios: Closed Formulary & Benefit Changes

	New PBM Contract * Closed Formulary		With Proposed Benefit Changes		With Proposed Benefit Changes & Increased Contributions	
	ER	EE	ER	EE	ER	EE
CY 2017 Projected Increase	0.00%	0.00%	0.0%	0.00%	3.43%	3.43%
Max Amount Short of 20% Reserve (1st Month short)	$72.0 M (May 2017)		$42.4 M (May 2017)		$0	
CY 2018 Projected Increase	11.91%	11.91%	8.94%	8.94%	5.47%	5.47%
CY 2019 Projected Increase	11.91%	11.91%	8.94%	8.94%	5.47%	5.47%
CY 2020 Projected Increase	6.45%	6.45%	8.30%	8.30%	10.54%	10.54%
CY 2021 Projected Increase	6.45%	6.45%	8.30%	8.30%	10.54%	10.54%

ER = employer contribution, EE = employee premium

*Assumes 100% of the projected savings for discount guarantees and 50% of the projected savings for pharmacy rebates; savings begin to accrue one month after 1/1/2017 start of contract

Discussion

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Benefit Planning for 2018 and Beyond

Board of Trustees Meeting

April 27, 2016

A Division of the Department of State Treasurer

Presentation Overview

Benefit Progression Strategy

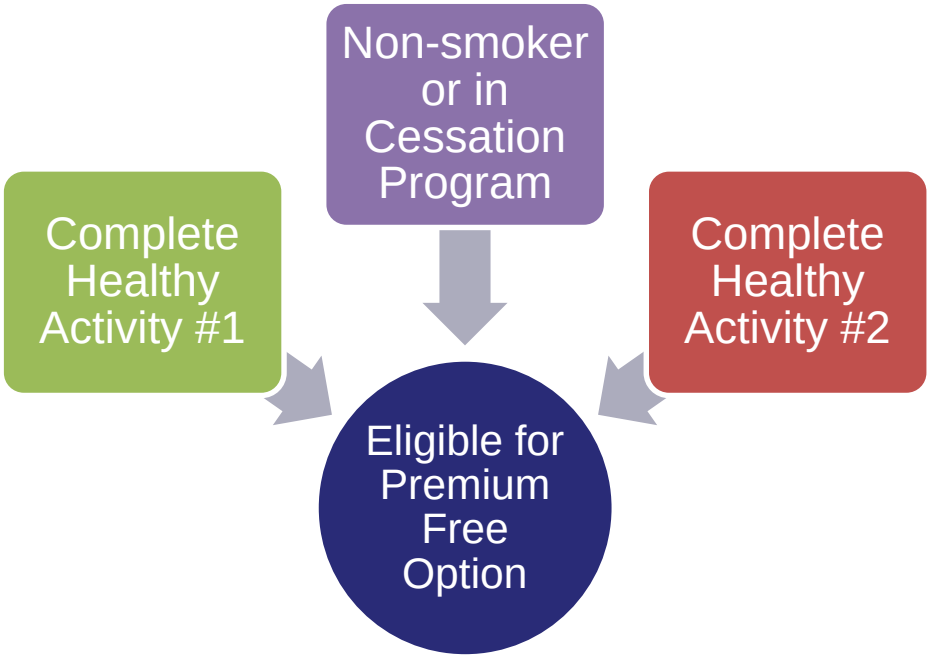
- Healthy Activities and Wellness Premium Credits
- Engagement Incentives
- Value-based Benefits Enhancements
- Base Premium Strategy
- Provider Network Strategy

Incenting Healthy Behaviors

Wellness premiums were established in 2014 to encourage engagement in wellness programs and healthy activities

- Subscriber premium credits earned for completing healthy activities

Reward engagement and healthy activities with reduced premium



Premium free plan can be achieved through premium credits

Healthy activities originally intended to evolve/increase from year to year to create a process of population health improvement

Healthy Activities and Wellness Premium Credits

Recent Experience

- Administrative challenges
- Enrollment work flow has varied from year to year – “clunky”
  - Has been different for eEnroll vs. BEACON agencies
  - Single sign-on/web interface capability
- Member education and communications challenges
- Post Open Enrollment exceptions
- Healthy activities have not progressed as expected
- Member “engagement” is questionable

Healthy Activities and Wellness Premium Credits

- In an effort to improve and simplify members' enrollment experience and build in more opportunities for year round engagement/incentives consider moving away from three premium credits in CY 2018
- Maintain tobacco attestation as a premium credit
  - Tobacco utilizers are demonstratively more expensive and a significant number of states and large employers have premium differentials for tobacco users
  - Tobacco attestation should apply to all three plans and would continued to be completed at the time of enrollment to earn the premium credit/reduction

Healthy Activities and Wellness Premium Credits

2014 & 2015

Healthy Activity	CDHP 85/15	Enhanced 80/20	Traditional 70/30
Non-Smoker Attestation	$20	$20	N/A
PCP Selection	$10	$15	N/A
Health Assessment	$10	$15	N/A
Total Credits Available	$40	$50	$0

2016 & 2017

Healthy Activity	CDHP 85/15	Enhanced 80/20	2016 Traditional 70/30	2017 Traditional 70/30
Non-Tobacco User or QuitlineNC Enrollment	$40	$40	N/A	$40
PCPSelection	$20	$25	N/A	N/A
Health Assessment	$20	$25	N/A	N/A
Total Credits Available	$80	$90	$0	$40

Suggested 2018 & 2019

Healthy Activity	CDHP 85/15	Enhanced 80/20	Traditional 70/30
Non-Tobacco User or QuitlineNC Enrollment	TBD	TBD	TBD
Total Credits Available	$0	$0	$0

- *The premium credit for the tobacco attestation would increase to at least $60 in 2018, and consideration may be given to a higher amount.*

Engagement Incentives

Recent Experience

- Wellness premiums and credits for completing healthy activities
- Copay reductions or Health Reimbursement Account (HRA) contributions for use of selected PCP and Blue Options Designated providers for members enrolled in Enhanced 80/20 and CDHP 85/15
- New Health Engagement Program for members enrolled in CDHP 85/15
  - Healthy Lifestyles – HRA contributions for tracking activity and/or calories
  - Positive Pursuits – HRA contributions for managing chronic conditions
- Opportunities to expand incentives are somewhat limited under copay based plan design of Enhanced 80/20
- Members prefer rewards to penalties

Options for Increasing/Rewarding Engagement

- Expand HRA contribution rewards for CDHP 85/15
- Establish an HRA for Enhanced 80/20 to allow members to earn contributions/rewards throughout the year to help offset deductible and coinsurance amounts
- Members could earn HRA contributions by:
  - Participating in the Health Engagement Program
    - Currently only offered to CDHP 85/15 members
    - Healthy Lifestyles
    - Positive Pursuits
  - Participating in Case and Disease Management, if identified
  - Completing age/gender appropriate screenings
    - Visits are general preventive with no out-of-pocket costs
    - Members would earn HRA dollars to offset future costs

HRA Incentives under Enhanced 80/20

- One of the primary purposes of the Positive Pursuits program is to help members offset deductible costs that might serve as a barrier to managing their chronic conditions
  - Not as big an issue in the Enhanced 80/20 plan as such services are typically subject to low to moderate copays that also include lab services
  - Lab services are a large driver of cost in the CDHP 85/15

- HRA incentives will likely be smaller in the Enhanced 80/20 plan; however, contributions will need to be sufficient to incent members to change their behavior and help to offset their other costs
  - Such as medications, deductible, coinsurance

Value-based Benefit Design Enhancements

Health Engagement Program 2.0

- Consider expanding the Positive Pursuits program in CY 2018 to address additional chronic conditions:
  - Depression
  - Obesity

- Consider including outcomes based incentives
  - In year three of the program rewarding members who are maintaining/improving their health, effectively managing their conditions and demonstrating clinical outcomes represents a value-based progression
  - Would apply to both Healthy Lifestyles and Positive Pursuits

Alternatives to Increasing Member Cost-Sharing

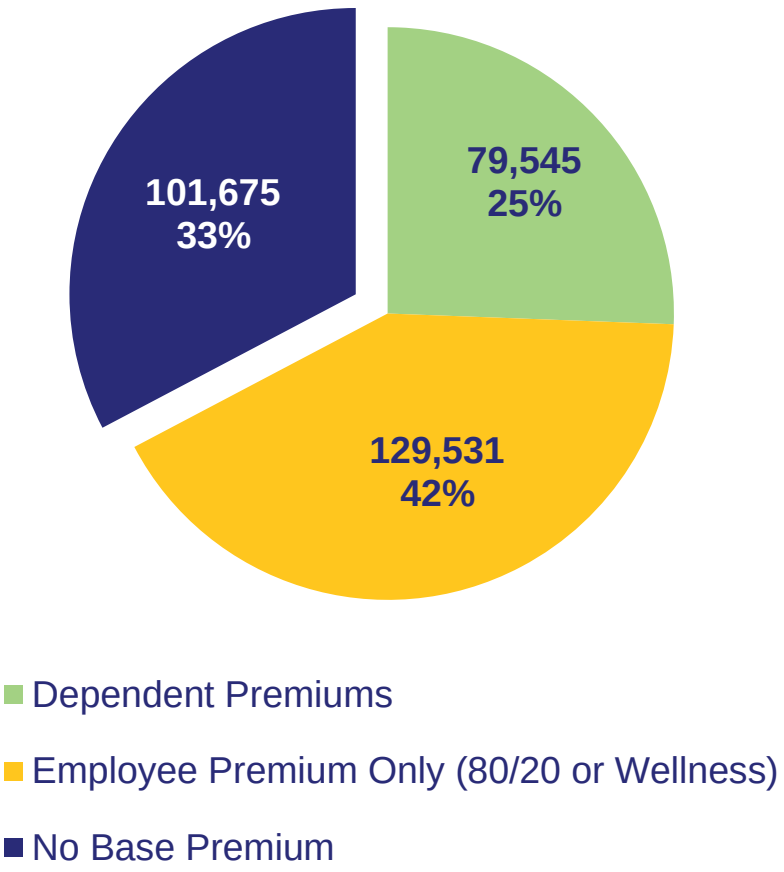
- Given increases in member cost-sharing in CY 2016 and the proposed increases for CY 2017, need to consider alternatives for CY 2018 and beyond
- Increasing member-cost share:
  - Results in lower value benefit offerings
  - Creates/increases financial barriers to care
  - Does not improve the long-term health of members, and may in fact adversely impact member health

Strategic Initiatives	Improve Members' Health	Improve Members' Experience	Ensure Financial Stability
Strengths of Increasing member out-of-pocket costs	• None	• Easier to understand than more nuanced approaches	• Can provide significant, growing long-term savings • Savings: contingent upon level of increase in cost sharing
Challenges of Increasing member out-of-pocket costs	• Members may buy down or utilize less service • Limited unless strong steerage is implemented	• Communications • Optics	• Does not bend cost curve driven by health status

Current Employee Premium Structure

- Currently almost one-third of active employees pay no premium for their coverage
- Another 42% pay only employee premiums for the Enhanced 80/20 Plan and/or Wellness Premiums
- Just over one-quarter of active employees pay dependent premiums
  - *These employees are impacted the most by large across-the-board increases to existing premiums*

Number of Active Employees Paying Premiums
December 2015



Rationale for Adding Base Premiums for Employees

- Employee premiums spread the impact of required savings over the entire population of active employees
- Other savings options include increased member cost-sharing or increases to the existing member-paid premiums, but those do not impact members equally
  - Increasing cost-sharing disproportionately impacts members who need/use more services
  - Increasing the existing member-paid premiums disproportionately impacts members who carry dependents on the plans
- A balanced approach should be used to spread a portion of future costs over the entire population of employees
  - The addition of employee premiums for all plans will minimize the negative impact on dependent premiums and the Plan's less healthy members
- States that provide higher subsidies for dependent coverage have significantly higher employee premiums

Provider Network Strategy

- Opportunities to expand steerage to better value providers
  - Increase differentials and/or incentives to use Blue Options Designated providers
    - If possible identify additional classes of providers to include
  - Develop strategy for outpatient facilities
  - Consider procedure based incentives

- Identify opportunities and impacts of narrowing networks
- Member steerage through copay differentials and HRA contributions in CY 2017 helps set the stage for tiered or narrow networks where available
  - Determine the provider savings available by reducing network size
  - Determine impacts to member access

Discussion

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Update on Transition of Specialty Medications from Medical to Pharmacy Benefit

Board of Trustees Meeting

April 27, 2016

Specialty Drugs Transition Update

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 Drugs Transition Update

While the transition efforts have continued, 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 Drugs 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

Next Steps

- Plan staff proposes delaying implementation of the transition of specialty medications from the medical to the pharmacy benefit to allow for:
  - Sufficient due diligence to review impacts and implications related to the Medicare population and determine next steps
  - A single transition for members under the new PBM contract

- Since the Board previously approved this benefit change with Phase 1 effective June 1, 2016, the Board will be asked to vote to delay implementation at the May Board meeting.

Appendix
Feb 5, 2016 Board Presentation

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Transition Specialty Medications from Medical to Pharmacy Benefit

Board of Trustees Meeting

February 5, 2016

Specialty Drugs from Medical to Pharmacy Benefit

Goal:

Transition specialty drugs (except Oncology drugs) from the medical benefit to the pharmacy benefit in staged phases.

Reason:

- Manage Adherence
- Medical Stability
- Manage Drug Spend

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

Rationale for Transition

- Provide the Plan with:
  - Ability to manage spending, trend, and utilization
  - Consistent clinical protocol
  - Consistent benefit design
  - Consistent member cost share
  - Real-time adjudication
  - NDC-level claims
- Impact magnified by specialty drugs in pipeline
  - Add new generics and biosimilar drugs when available and appropriate
  - Add clinical policies including step therapy when appropriate

Phase 1 Medical Specialty Spend and Savings Opportunity

Management Strategy	Therapy	Patients	Paid Amount	Therapy Management Savings	Utilization Management Savings	Total Savings
Self-Administered	Blood Cell Deficiency	404	$5,027,734	$471,601	$422,832	$894,434
	Infertility	16	$3,186	$258	$276	$534
	Incremental Rebates	n/a				$56,560
	Total	**420**	**$5,030,920**	**$471,859**	**$423,108**	**$894,968**
Rare Disease	Hemophilia	7	$963,356	$24,084	$0	$24,084
	Immune Deficiency	94	$4,432,286	$121,001	$173,746	$294,747
	Incremental Rebates					N/A
	Total	**101**	**$5,395,642**	**$145,085**	**$173,746**	**$318,831**
	Grand Total	**521**	**$10,426,562**	**$616,944**	**$596,854**	**$1,213,799**

Data based on medical claims from 8/2014 -7/2015.

Phase 2 Medical Specialty Spend and Savings Opportunity

Management Strategy	Therapy	Patients	Paid Amount	Therapy Management Savings	Utilization Management Savings	Total Savings
Rare Diseases	ALPHA - 1 Deficiency	4	$435,623	$0	$10,847	$10,847
	Enzyme Deficiency	10	$2,507,320	$18,805	$35,102	$53,907
	Pulmonary Hypertension	10	$316,661	$6,523	$15,580	$22,103
	Incremental Rebates					N/A
	Grand Total	24	$3,259,604	$25,328	$61,529	$86,857

Phase 1 & 2 Member and Provider Financial Impact

- **Members**

  In aggregate, member copays* will be reduced approximately $215,000

- **Providers**

  Shift in cost from outpatient providers and office visits to the Pharmacy Benefit Manager and home settings will result in approximately $7,074,873 in savings to the Plan and a potential revenue loss for providers.

  Because the Plan does not have access to the specific rebates the providers may receive on these drugs, we cannot provide an accurate estimate of total provider impact.

* *Copays apply to the Traditional 70/30 and Enhanced 80/20 PPO plans*.

Communication Plan – Phase 1 (June 1, 2016)

- **Communication to Members**
  - ESI to send notification regarding the change to all impacted members
  - ESI will also make outbound calls by a home health nurse to set an appointment and meet with the member
  - SHP will feature this change in Member Focus article and update website accordingly

- **Communication to Prescribers**
  - ESI to send notification regarding the change to all prescribers who have prescribed self-administered immunoglobulin and hemophilia Specialty drugs
  - Any prescriber who has prescribed these drugs in 2014 and 2015
  - ESI will also make outbound calls by Medical Channel Specialty Pharmacist to prescribers and discuss all the prescribers' patients impacted by the change

Specialty Drug Transition Recommendation

To ensure high quality of care for Plan members while reducing overall member and Plan costs, Plan staff recommends the Board approve moving specialty drugs identified for Phases 1 and 2 from the medical benefit to the pharmacy benefit effective June 1, 2016 and January 1, 2017 respectively.

Plan staff will gather additional information on physician administered drugs and request Board approval for Phase 3 at a later date.