Board of Trustees' Meeting
Department of State Treasurer
Friday, September 19, 2014
9:00 a.m. – 3:00 p.m.

1. Welcome	Janet Cowell, Chair
2. Conflict of Interest Statement	Janet Cowell, Chair
3. Review of Minutes ***(Requires Board Vote)***	Janet Cowell, Chair
A. August 1, 2014	
B. August 28, 2014	
4. Introduction of New Staff	
A. Dorothy Brown Smith, Global Benefits Communication Director	Melissa Waller
B. Katherine Keogh, Health Management and Promotion Manager	Nidu Menon
5. Value-Based Insurance Design: Changing the Health Care Cost Discussion from How Much to How Well	A. Mark Fendrick,MD University of Michigan Center for Value-Based Insurance Design
Break	
6. Benefit Design, Plan Options and Premiums	
A. 2016 Benefit Design Planning	Mona Moon
7. Member Experience and Communications	
A. Member Experience Update	Beth Horner

Lunch

8. Financial Report, Forecasting and Monitoring — Mark Collins

    A. July 2014 Financial Report

    B. CY 2014 2nd Quarter Actuarial Forecast Update

    C. State Health Plan Member Costs

9. Strategic Planning — Mona Moon

    A. Approval of Strategic Plan ***(Requires Board Vote)***

    B. Next Steps

10. Public Comment Period — Janet Cowell, Chair

11. Wrap-Up — Janet Cowell, Chair

Next Board of Trustees' Meeting: Thursday, November 20, 4-6 p.m. and Friday, November 21, 9 a.m. – 3 p.m.

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

SCHOOL OF PUBLIC HEALTH
CENTER FOR VALUE-BASED INSURANCE DESIGN
UNIVERSITY OF MICHIGAN

Value-Based Insurance Design: Changing the Health Care Cost Discussion from How Much to How Well

A. Mark Fendrick, MD

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Improving Care and Bending the Cost Curve

- **The past several decades have produced remarkable medical innovations resulting in impressive reductions in morbidity and mortality**
- **Regardless of these advances, cost growth remains the principle focus of health reform discussions**
- **Despite unequivocal evidence of clinical benefit, Americans systematically underuse high-value services across the care spectrum**
- **Attention should turn from *how much* to *how well* we spend our health care dollars**

Role of Consumer Cost-Sharing in Medical Spending

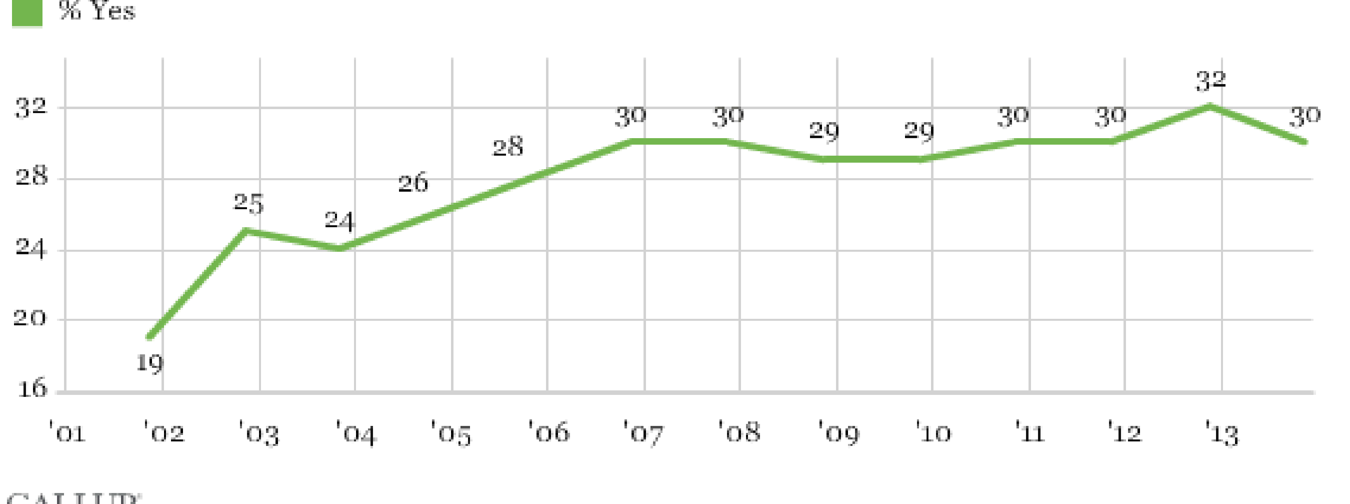
- **For today's discussion, our focus is on costs paid by the consumer, not the employer or insurance company**

Impact of Cost-Sharing on Health Care Utilization

- **Ideally, consumer cost-sharing levels would be set to encourage the clinically appropriate use of health care services**
- **The archaic "one-size-fits-all" approach to consumer cost-sharing fails to acknowledge the differences in clinical value among medical interventions**

Goldman D. *JAMA*. 2007;298(1):61–9.

Impact of Cost-Sharing on Health Care Utilization



A growing body of evidence concludes that increases in cost-sharing leads consumers to reduce the use of essential care, which in some cases, leads to greater overall costs

Goldman D. *JAMA*. 2007;298(1):61–9.

Inspiration

“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

Barbara Fendrick (my mother)

Cost-sharing Affects Mammography Use by Medicare Beneficiaries

Cost sharing
Full coverage

Screening Rate (%)
100
80
60
40
20
0

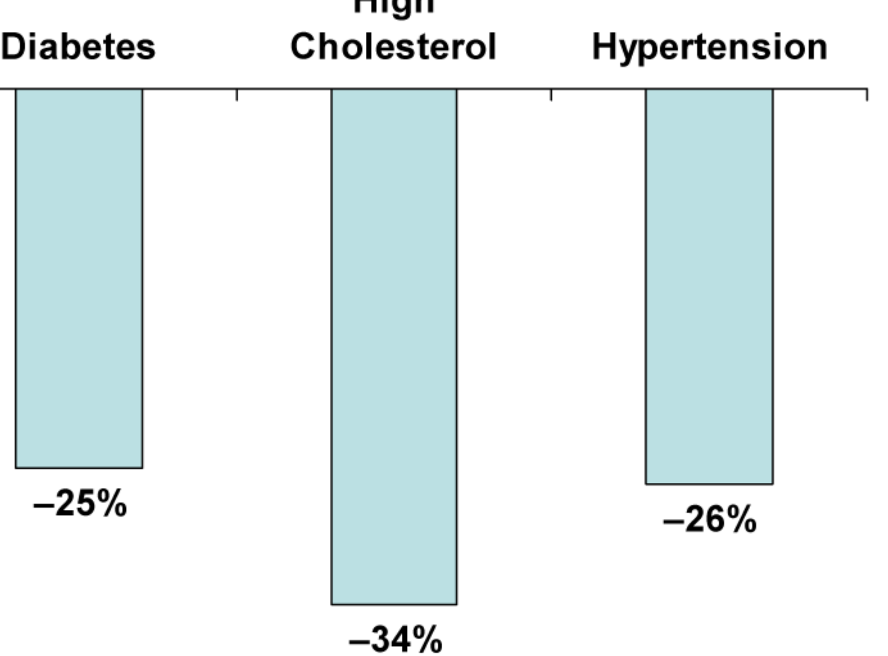
76.7
65.7
77.5
69.7
78.2
70.0

2002
2003
2004

Year

Trivedi A. *NEJM.* 2008;358:375-383

High Copays Reduce Adherence to Appropriate Medication Use



- When copays were doubled, patients took less medication in important classes. These reductions in medication levels were profound
- Reductions in medications supplied were also noted for:
  - NSAIDs 45%
  - Antihistamines 44%
  - Antiulcerants 33%
  - Antiasthmatics 32%
  - Antidepressants 26%
- For patients taking medications for asthma, diabetes, and gastric disorders, there was a 17% increase in annual ER visits and a 10% increase in hospital stays

ER = emergency room.

Goldman DP et al. *JAMA*. 2004;291:2344-2350.

Effects of Increased Copayments for Ambulatory Visits for Medicare Advantage Beneficiaries

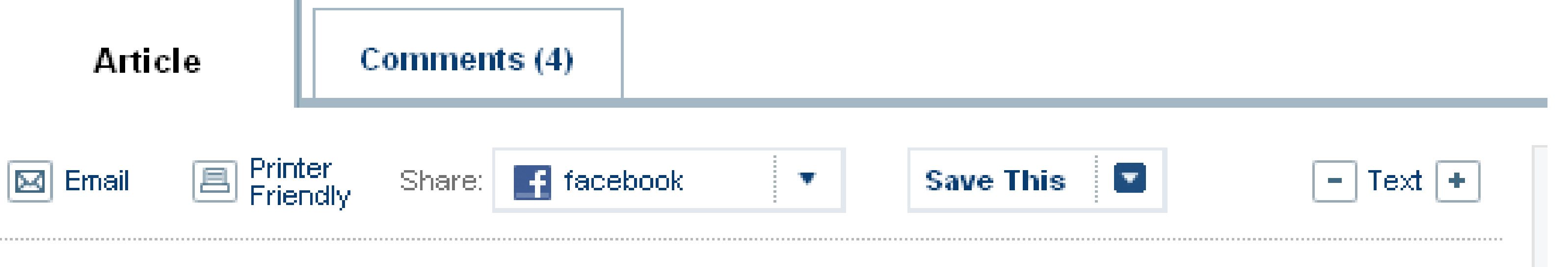
Copays increased:

- from $7.38 to $14.38 for primary care
- from $12.66 to $22.05 for specialty care
- remained unchanged at $8.33 and $11.38 in controls

In the year after copayment increases:

- 19.8 **fewer** annual outpatient visits per 100 enrollees
- 2.2 **additional** hospital admissions per 100 enrollees
- Effects worse in low-income individuals and beneficiaries with chronic illness

Trivedi A. *NEJM*. 2010;362(4):320-8..



BUSINESS | OCTOBER 29, 2009

IBM to Drop Co-Pay for Primary-Care Visits

Article | Comments (4)

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By WILLIAM M. BULKELEY

In an unusual bid to cut health-care costs, International Business Machines Corp. plans to stop requiring $20 co-payments by employees when they visit primary-care physicians.

The company said it believed the move would save costs by encouraging people to go to primary-care doctors faster, in order to get earlier diagnoses that could save on expensive visits to specialists and emergency rooms.

IBM said that the action applies to the 80% of its workers who are enrolled in plans in which the company self-insures—that is, programs in which it pays the health-care benefits, not insurers. The new policy doesn't cover IBM employees in health-maintenance organizations.

One of the nation's largest employers with 115,000 U.S. workers, IBM spends about $1.3 billion a year on U.S. health care. Its benefit practices are closely watched in the human-resources community, and its actions are sometimes trend-setters.

Impact of Cost-Sharing on Health Care Disparities

Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care

Michael Chernew, PhD[1] Teresa B. Gibson, PhD[2] Kristina Yu-Isenberg, PhD, RPh[3] Michael C. Sokol, MD, MS[4] Allison B. Rosen, MD, ScD[5], and A. Mark Fendrick, MD[5]

[1]Department of Health Care Policy, Harvard Medical School, Boston, MA, USA; [2]Thomson Healthcare, Ann Arbor, MI, USA; [3]Managed Markets Division, GlaxoSmithKline, Research Triangle Park, NC, USA; [4]Managed Markets Division, GlaxoSmithKline, Montvale, NJ, USA; [5]Departments of Internal Medicine and Health Management and Policy, Schools of Medicine and Public Health, University of Michigan, Ann Arbor, MI, USA.

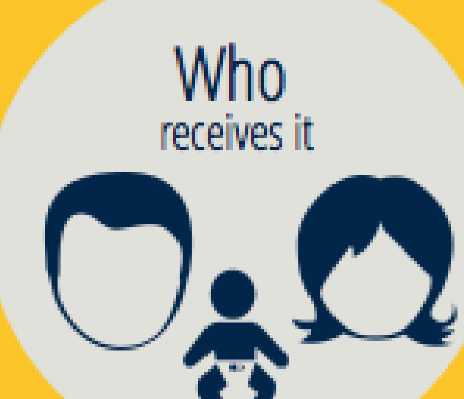
- **Rising copayments may worsen disparities and adversely affect health, particularly among patients living in low-income areas.**

Chernew M. J Gen Intern Med 23(8):1131–6.

A New Approach: Clinical Nuance

1. Services differ in clinical benefit produced

2. Clinical benefits from a specific service depend on:



Who
provides it

The Solution: Clinically-Nuanced Cost Sharing

Value-Based Insurance Design

- Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service
  - Reduce or eliminate financial barriers to high-value clinical services
- Successfully implemented by hundreds of public and private payers

THE WALL STREET JOURNAL ONLINE

WSJ.com

June 16, 2004

FOLLOW THE MONEY

From 'One Size Fits All' To Tailored Co-Payments

June 16, 2004

University of Michigan researchers say a patient's drug should depend on how much he or she will medication -- a move that would likely lower co

MI-FREEE: Better Quality Without Higher Costs

- **Assessed impact of free access to preventive medications for Aetna members with history of MI**
- **Random assignment by plan sponsor**
- **“Enhanced prescription coverage improved medication adherence and rates of first major vascular events and decreased patient spending without increasing overall health costs.”**

Choudhry NK, Avorn J, Glynn RJ, Antman EM, Schneeweiss S, Toscano M, et al. Full coverage for preventive medications after myocardial infarction. N Engl J Med. 2011 Dec 1;365(22):2088–97.

Emerging Best Practices in V-BID Implementation

A 2014 *Health Affairs* evaluation of 76 V-BID plans reported that programs that:

- **were more generous**
- **targeted high-risk individuals**
- **offered wellness programs**
- **avoided disease management**
- **used mail-order prescriptions**

had greater impact on adherence than plans without these features

WEB FIRST

By Niteesh K. Choudhry, Michael A. Fischer, Benjamin F. Smith, Gregory Brill, Charmaine Girdi
Olga S. Matlin, Troyen A. Brennan, Jerry Avorn, and William H. Shrank

Five Features Of Value-Based Insurance Design Plans Were Associated With Higher Rates Of Medication Adherence

ABSTRACT Value-based insurance design (VBID) plans selectively lower cost sharing to increase medication adherence. Existing plans have bee structured in a variety of ways, and these variations could influence the effectiveness of VBID plans. We evaluated seventy-six plans introduced b a large pharmacy benefit manager during 2007–10. We found that after we adjusted for the other features and baseline trends, VBID plans that were more generous, targeted high-risk patients, offered wellness programs, did not offer disease management programs, and made the benefit available only for medication ordered by mail had a significantly greater impact on adherence than plans without these features. The effects were as large as 4–5 percentage points. These findings can provide guidance for the structure of future VBID plans.

Copayments, coinsurance, deductibles, and other benefit structures are widely used to contain health care spending by encouraging patients to consider the costs of health services before deciding to purchase them. Cost sharing helps address the overconsumption that may result from generous insurance coverage (a type of "moral hazard," in economic terms).[1] However, it may also lead patients to reduce their use of high-value services.[2] Value-based insurance design (VBID) plans seek to avoid this problem by setting cost-sharing amounts in inverse relationship to the clinical benefit that an intervention offers.[3]

The peer-reviewed literature supports the ability of copay reductions to increase the use of essential medication and improve clinical outcomes without increasing overall health spending.[4–9] As a result, VBID plans have been adopted by many employers and health plans throughout the United States.[10] In addition, the Affordable Care Act calls for the creation of guidelines to facilitate the broader use of VBID plans

cations used to treat chronic disease. However, the plans differ in a number of important ways. Some plans target members who meet specific clinical criteria; others reduce copays for all members. Some plans eliminate cost sharing; others only reduce it. Some plans concurrently offer disease management and wellness programs; others do not.

We sought to understand the influence of these and other plan characteristics on how VBID plans affect medication adherence. Based on our results, we identify best practices for the future implementation of VBID plans.

Study Data And Methods

SETTING AND PLAN CHARACTERISTICS We identified VBID plans introduced by a large pharmacy benefit manager, CVS Caremark, on behalf of fifty-nine employer-based plan sponsors between 2007 and 2010. We classified plans according to whether or not they had

Choudhry. N. *Health Affairs*. 2014;33(3).

Evidence Supporting Value-Based Insurance Design: Improving Adherence Without Increasing Costs

- **Improved adherence**
- **Lower consumer out-of-pocket costs**
- **No significant increase in total spending**
- **Reduction in health care disparities**

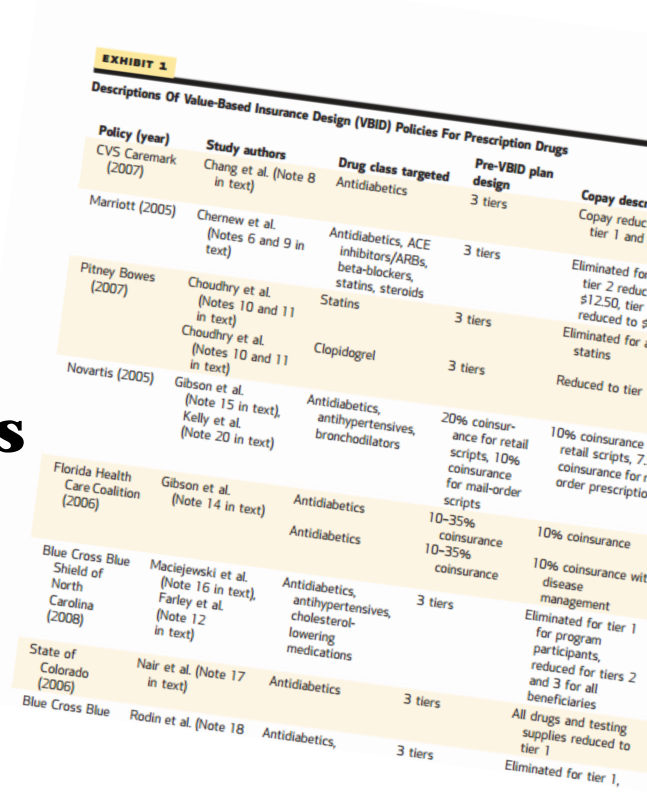


EXHIBIT 1

Descriptions Of Value-Based Insurance Design (VBID) Policies For Prescription Drugs

Policy (year)	Study authors	Drug class targeted	Pre-VBID plan design	Copay desc
CVS Caremark (2007)	Chang et al. (Note 8 in text)	Antidiabetics	3 tiers	Copay reduc tier 1 and
Marriott (2005)	Chernew et al. (Notes 6 and 9 in text)	Antidiabetics, ACE inhibitors/ARBs, beta-blockers, statins, steroids	3 tiers	Eliminated fo tier 2 reduc $12.50, tier reduced to
Pitney Bowes (2007)	Choudhry et al. (Notes 10 and 11 in text)	Statins	3 tiers	Eliminated for statins
	Choudhry et al. (Notes 10 and 11 in text)	Clopidogrel	3 tiers	Reduced to tier
Novartis (2005)	Gibson et al. (Note 15 in text), Kelly et al. (Note 20 in text)	Antidiabetics, antihypertensives, bronchodilators	20% coinsurance for retail scripts, 10% coinsurance for mail-order scripts	10% coinsurance retail scripts, 7. coinsurance for order prescriptio
Florida Health Care Coalition (2006)	Gibson et al. (Note 14 in text)	Antidiabetics	10–35% coinsurance	10% coinsurance
		Antidiabetics	10–35% coinsurance	10% coinsurance wit disease management
Blue Cross Blue Shield of North Carolina (2008)	Maciejewski et al. (Note 16 in text), Farley et al. (Note 12 in text)	Antidiabetics, antihypertensives, cholesterol-lowering medications	3 tiers	Eliminated for tier 1 for program participants, reduced for tiers 2 and 3 for all beneficiaries
State of Colorado (2006)	Nair et al. (Note 17 in text)	Antidiabetics	3 tiers	All drugs and testing supplies reduced to tier 1
Blue Cross Blue	Rodin et al. (Note 18	Antidiabetics,	3 tiers	Eliminated for tier 1,

Lee J. *Health Affairs*.. 2013;32(7):1251-1257

Evidence for Value-Based Insurance Design: Reducing Health Care Disparities

Full drug coverage:

- **Reduced rates of a post-MI vascular event or revascularization among patients who self-identified as being non-white**
- **Reduced total health care spending by 70 percent among patients who self-identified as being non-white**

DISPARITIES

By Niteesh K. Choudhry, Katsiaryna Bykov, William H. Shrank, Michele Toscano, Wayne S. Ra
Lonny Reisman, Troyen A. Brennan, and Jessica M. Franklin

Eliminating Medication Copayments Reduces Disparitie In Cardiovascular Care

ABSTRACT Substantial racial and ethnic disparities in cardiovascular ca persist in the United States. For example, African Americans and Hispanics with cardiovascular disease are 10–40 percent less likely than whites to receive secondary prevention therapies, such as aspirin and beta-blockers. Lowering copayments for these therapies improves outcomes among all patients who have had a myocardial infarction, but the impact of lower copayments on health disparities is unknown. Using self-reported race and ethnicity for participants in the Post-Myocardial Infarction Free Rx Event and Economic Evaluation (MI FREEE) trial, we found that rates of medication adherence were significantly lower and rates of adverse clinical outcomes were significantly higher for nonwhite patients than for white patients. Providing full drug coverage increased medication adherence in both groups. Among nonwhite patients, it also reduced the rates of major vascular events or revascularization by 35 percent and reduced total health care spending by 70 percent. Providing full coverage had no effect on clinical outcomes and costs for white patients. We conclude that lowering copayments for medications after myocardial infarctions may reduce racial and ethnic disparities for cardiovascular disease.

Health Aff (Millwood). 2014 May;33(5):863-70

Value-Based Insurance Design
"Clinically Nuanced, Fiscally Responsible"

- **To date, most V-BID programs have focused on removing barriers to high-value services**
- **V-BID programs that encourage conversations about the use of low-value services are being implemented**
  - **Choosing Wisely**
  - **MedInsight Health Waste Calculator**

Value Based Insurance Design
More than High-Value Prescription Drugs

- **Prevention/Screening**
- **Diagnostic tests/Monitoring**
- **Treatments**
- **Clinician visits**
- **Physician networks**
- **Hospitals**

Value-Based Insurance Design
Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- PhRMA
- AHIP
- NBCH

- National Governor's Assoc.
- Academy of Actuaries
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- US Chamber of Commerce

Lewin. *JAMA.* 2013;310(16):1669-1670

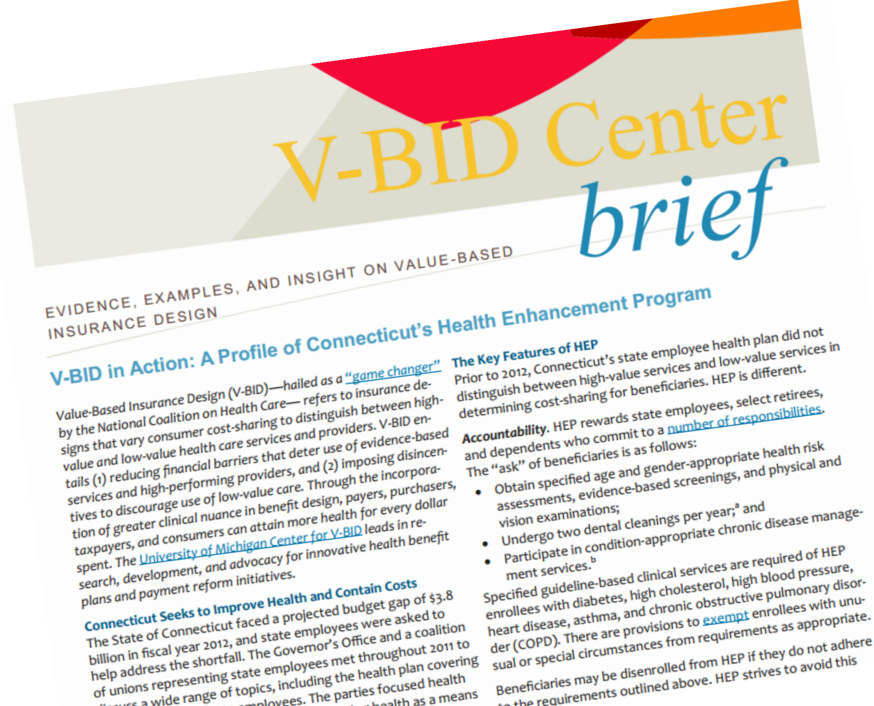
Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- **Receiving an A or B rating from the United States Preventive Services Taskforce (USPSTF)**
- **Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)**
- **Preventive care and screenings supported by the Health Resources and Services Administration (HRSA)**

Over 100 million Americans have received expanded coverage of preventive services

Value-Based Insurance Design
Growing Role in State Health Reform

- **State Employees Benefit Plans**
  - Connecticut
  - Oregon
  - Virginia
  - Minnesota
  - Maine
- **State Exchanges**
  - Maryland
  - California
- **CO-OPs**
- **Medicaid**



V-BID Center *brief*

EVIDENCE, EXAMPLES, AND INSIGHT ON VALUE-BASED INSURANCE DESIGN

V-BID in Action: A Profile of Connecticut's Health Enhancement Program

Value-Based Insurance Design (V-BID)—*hailed as a "game changer" by the National Coalition on Health Care*— refers to insurance designs that vary consumer cost-sharing to distinguish between high-value and low-value health care services and providers. V-BID entails (1) reducing financial barriers that deter use of evidence-based services and high-performing providers, and (2) imposing disincentives to discourage use of low-value care. Through the incorporation of greater clinical nuance in benefit design, payers, purchasers, taxpayers, and consumers can attain more health for every dollar spent. The University of Michigan Center for V-BID leads in research, development, and advocacy for innovative health benefit plans and payment reform initiatives.

Connecticut Seeks to Improve Health and Contain Costs
The State of Connecticut faced a projected budget gap of $3.8 billion in fiscal year 2012, and state employees were asked to help address the shortfall. The Governor's Office and a coalition of unions representing state employees met throughout 2011 to discuss a wide range of topics, including the health plan covering active and retired state employees. The parties focused health care discussions on possibilities for improving health as a means to control long-term costs. Discussions involving unions, the

The Key Features of HEP
Prior to 2012, Connecticut's state employee health plan did not distinguish between high-value services and low-value services in determining cost-sharing for beneficiaries. HEP is different.

Accountability. HEP rewards state employees, select retirees, and dependents who commit to a number of responsibilities. The "ask" of beneficiaries is as follows:

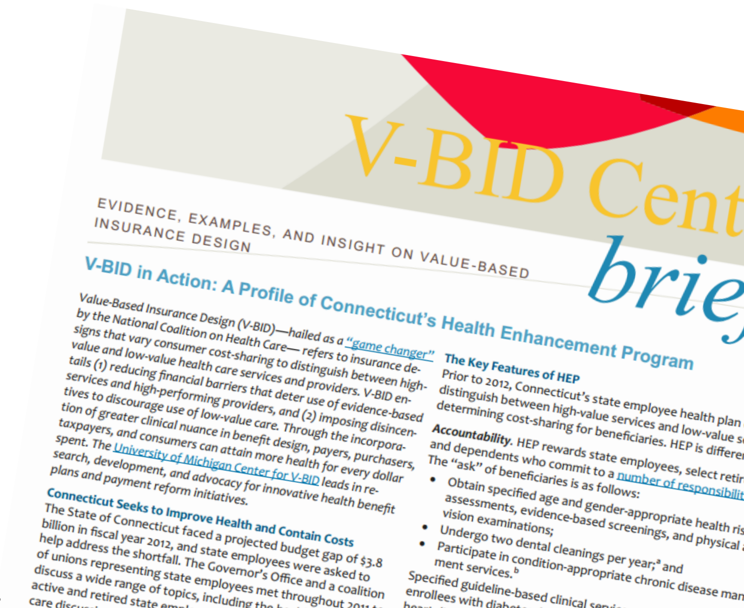
- Obtain specified age and gender-appropriate health risk assessments, evidence-based screenings, and physical and vision examinations;
- Undergo two dental cleanings per year;[a] and
- Participate in condition-appropriate chronic disease management services.[b]

Specified guideline-based clinical services are required of HEP enrollees with diabetes, high cholesterol, high blood pressure, heart disease, asthma, and chronic obstructive pulmonary disorder (COPD). There are provisions to exempt enrollees with unusual or special circumstances from requirements as appropriate.

Beneficiaries may be disenrolled from HEP if they do not adhere to the requirements outlined above. HEP strives to avoid this

Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

- **Participating employees receive a reprieve from higher premiums if they commit to:**
  - Yearly physicals, age-appropriate screenings/preventive care, two free dental cleanings
  - If employees have one of five chronic conditions, they must participate in disease management programs (which include free office visits and lower drug co-pays)
- **Early results:**
  - 99% of employees enrolled and 99% compliant
  - Decrease in ER and specialty care
  - Increase in primary care visits
  - Increase in chronic disease medication adherence


V-BID Cent
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enrollees with diabetes, high cholesterol,
heart disease, asthma

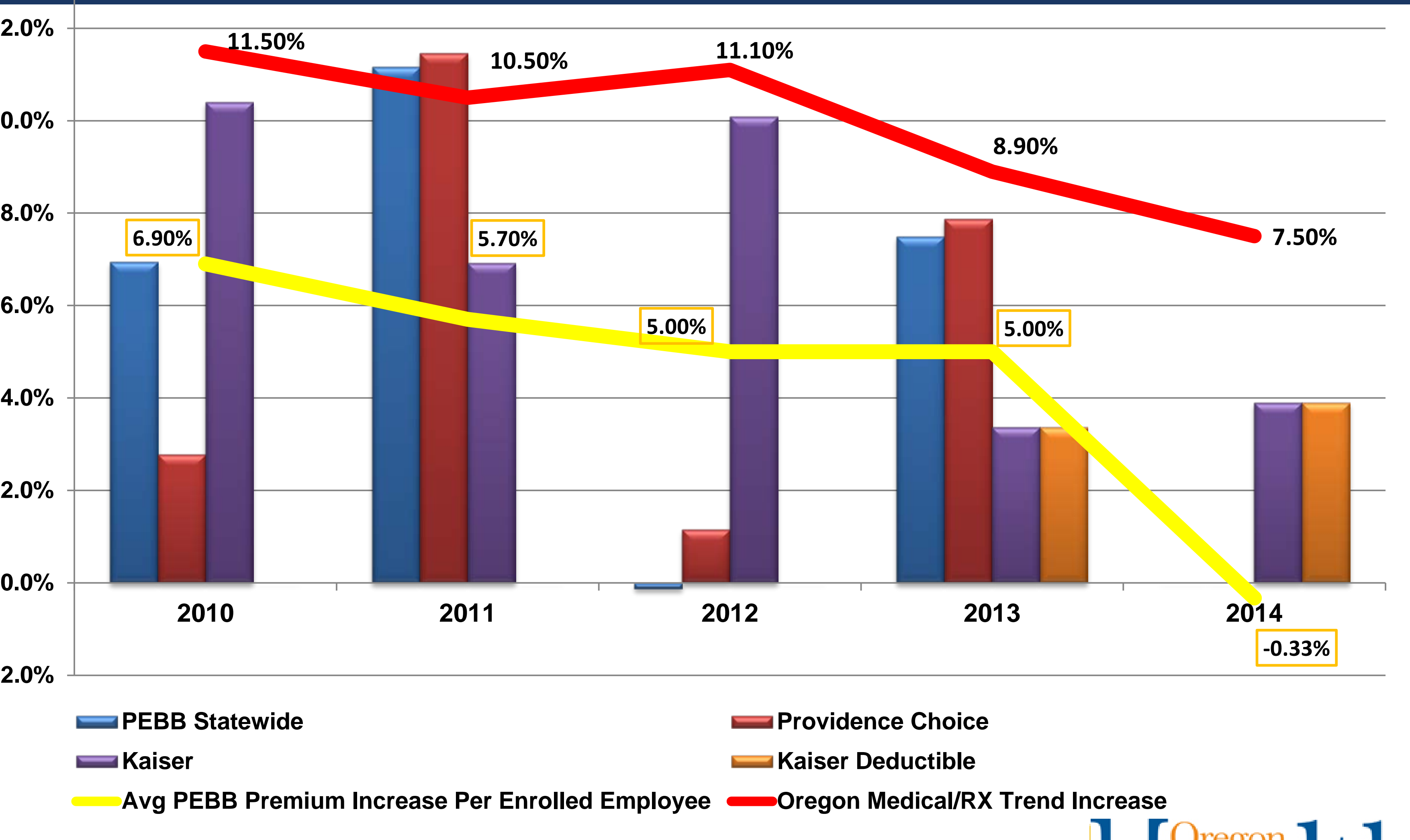
V-BID for State Employees: Oregon Educators and Public Employees

- **Prioritized list of services based on evidence**
- **No cost-sharing for participating members: Living Well with Chronic Disease, Diabetes Prevention Program**
  - **Complete a health assessment & take two actions**
- **Expand self management programs**
- **Promoted evidence based programs & wellness programs through grants and pilots**
  - **Participation 70% first year, 77% second year**

Oregon Educators and Public Employees Strategies With Financial Impact

- Quality based pay for performance
- Lower cost sharing and increase payments for certified primary care homes
- Higher cost sharing on certain imaging and sleep studies led to 15% - 30% decreased use; other procedures 5% -17%
- Data-driven 45% reduction in cardiac interventions
- Weight Watchers ROI in the first year

Oregon Educators and Public Employees PEBB Bending the Trend



NC State Health Plan Option: Enhanced 80/20

(For Active Employees and Non-Medicare Primary Retirees)

Plan Design Features	In-Network	Out-of-Network
Annual Deductible	$700 Individual $2,100 Family	$1,400 Individual $4,200 Family
Coinsurance	20% of eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge
Coinsurance Maximum (excludes deductible)	$3,210 Individual $9,630 Family	$6,420 Individual $19,260 Family
Out-of-Pocket Maximum (includes deductible)	Not Applicable	Not Applicable
Pharmacy Out-of-Pocket Maximum	$2500	$2500
Preventive Care	$0 (covered at 100%)	Not Applicable
Office Visits	$30 for primary doctor, $15 if you use PCP on ID card; $70 for specialist, $60 for Blue Options Designated Specialist	40% after deductible
Inpatient Hospital	$233 copay, then 20% after deductible; copay not applied if you use Blue Options Designated hospital	$233 copay, then 40% after deductible
Prescription Drugs		
Tier 1	$12 copay per 30-day supply	Applicable copay and the difference between the allowed amount and the charge
Tier 2	$40 copay per 30-day supply	
Tier 3	$64 copay per 30-day supply	
Tier 4	25% up to $100 per 30-day supply	
Tier 5	25% up to $125 per 30-day supply	
ACA Preventive Medications	$0 (covered at 100%)	$0 (covered at 100%)

NC State Health Plan Option: Traditional 70/30

(For Active Employees and Non-Medicare Primary Retirees)

Plan Design Features	In-Network	Out-of-Network
Annual Deductible	$933 Individual $2,799 Family	$1,866 Individual $5,598 Family
Coinsurance	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Coinsurance Maximum (excludes deductible)	$3,793 Individual $11,379 Family	$7,586 Individual $22,758 Family
Out-of-Pocket Maximum (includes deductible)	Not Applicable	Not Applicable
Pharmacy Out-of-Pocket Maximum	$2500	$2500
Preventive Care	$35 for primary doctor; $81 for specialist	Only certain services are covered
Office Visits	$35 for primary doctor; $81 for specialist	50% after deductible
Inpatient Hospital	$291 copay, then 30% after deductible	$291 copay, then 50% after deductible
Prescription Drugs		
Tier 1	$12 copay per 30-day supply	Applicable copay and the difference between the allowed amount and the charge
Tier 2	$40 copay per 30-day supply	
Tier 3	$64 copay per 30-day supply	
Tier 4	25% up to $100 per 30-day supply	
Tier 5	25% up to $125 per 30-day supply	
ACA Preventive Medications	Not applicable	Not applicable

NC State Health Plan Option: CDHP

(For Active Employees and Non-Medicare Primary Retirees)

Plan Design Features	In-Network	Out-of-Network
HRA Starting Balance	$500 Employee/Retiree $1000 Employee/Retiree + 1 $1,500 Employee/Retiree + 2 or more	
Annual Deductible	$1.500 Individual $4,500 Family	$3,000 Individual $9,000 Family
Coinsurance	15% of eligible expenses after deductible	35% of eligible expenses after deductible and the difference between the allowed amount and the charge
Coinsurance Maximum	Not Applicable	Not Applicable
Out-of-Pocket Maximum (includes deductible)	$3,000 Individual $9,000 Family	$6,000 Individual $18,000 Family
Pharmacy Out-of-Pocket Maximum	Included in total out-of-pocket maximum	Included in total out-of-pocket maximum
Preventive Care	$0 (covered at 100%)	Not Applicable
Office Visits	15% after deductible; $15 added to HRA if you use PCP on ID; $10 added to HRA if you use Blue Options Designated specialist	35% after deductible
Inpatient Hospital	15% after deductible; $50 added to HRA if you use Blue Options hospital	35% after deductible
Prescription Drugs		
Tier 1	15% after deductible	35% after deductible
Tier 2		
Tier 3		
Tier 4		
Tier 5		
ACA Preventive Medications	$0 (covered at 100%)	$0 (covered at 100%)
CDHP Preventive Medications	15%, no deductible	15%, no deductible

NC State Health Plan Wellness Premium Credits

Enhanced 80/20 Plan	Consumer-Directed Health Plan (CDHP) with HRA	Traditional 70/30 Plan
1) Health Assessment ($15) • Members will need to complete or update a Health Assessment through the Personal Health Portal. **2) Primary Care Provider ($15)** • Members will need to select a Primary Care Provider for themselves and any covered dependents. **3) Smoking Attestation ($20)** • Members and if applicable their spouse will need to attest to being a non-smoker or commit to a smoking cessation program by Jan. 1, 2015.	**1) Health Assessment ($10)** • Members will need to complete or update a Health Assessment through the Personal Health Portal. **2) Primary Care Provider ($10)** • Members will need to select a Primary Care Provider for themselves and any covered dependents. **3) Smoking Attestation ($20)** • Members and if applicable their spouse will need to attest to being a non-smoker or commit to a smoking cessation program by Jan. 1, 2015.	Premium Credits Are Not Available

V-BID in Medicare: Bipartisan Political Support

The Value-Based Insurance Design for Better Care Act of 2014

(Original Signature of Member)

113TH CONGRESS
2D SESSION

H. R. ____

To establish a demonstration program requiring the utilization of Value-Based Insurance Design to demonstrate that reducing the copayments or coinsurance charged to Medicare beneficiaries for selected high-value prescription medications and clinical services can increase their utilization and ultimately improve clinical outcomes and lower health care expenditures.

IN THE HOUSE OF REPRESENTATIVES

Mrs. BLACK (for herself and Mr. BLUMENAUER) introduced the following bill; which was referred to the Committee on ____

The Better Care, Lower Cost Act of 2014

Sponsored by:

U.S. Sen. Ron Wyden, D-Ore.

U.S. Sen. Johnny Isakson, R-Ga.

U.S. Rep. Erik Paulsen, R-Minn.

U.S. Rep. Peter Welch, D-Vt.

Value-Based Insurance Design: Key Initiatives

- **Applying V-BID to Specialty Medications**
- **Incorporating V-BID in HSA-qualified HDHPs**

Barriers to V-BID in HSA-qualified HDHPs

- **IRS guidance documents specifically exclude from the definition of preventive care those services or benefits meant to treat "an existing illness, injury or condition**
- **Confusion persists what services can and cannot be covered outside of the deductible**

April 2012

V-BID Center brief

EVIDENCE, EXAMPLES, AND INSIGHT ON VALUE-BASED INSURANCE DESIGN

Value-Based Insurance Design: Contributions to Consumer Health in Consumer-Directed Health Plans[1]

A consumer-directed health plan (CDHP) is an insurance product that offers lower premiums in exchange for higher patient deductibles than traditional plans. People who use CDHPs are responsible for paying for most of their routine care. The goal of CDHPs is to make customers more cost-conscious about the care they use, theoretically saving money on foregone services and lowering prices for consumers. In 2010, 18 million people were enrolled in a CDHP; in the same year nearly half of all employers reported that they planned to offer a CDHP to their employees within five years.[2]

ductibles in most CDHP plans.[3] V-BID is an innovative and widely implemented approach to providing health benefits that seeks to enhance patients' clinical outcomes and constrain health care cost growth. By reducing barriers to high-value, evidence-based services and providers (often through lower costs and other patient incentives) V-BID plans can achieve improved health outcomes at any level of health care expenditure. A V-BID waiver program would ensure that consumers are not deterred from receiving needed

Applying V-BID to Specialty Medications

- Impose no more than modest cost-sharing on high-value services
- Reduce cost-sharing in accordance with patient- or disease-specific characteristics
- Relieve patients from high cost-sharing after failure on a different medication
- Use cost-sharing to encourage patients to select high-performing providers and settings

Supporting Consumer Access to Specialty Medications Through Value-Based Insurance Design

A. Mark Fendrick, MD
Jason Buxbaum, MHSA
Kimberly Westrich, MA

Using Clinical Nuance to Align Payer and Consumer Incentives

Many "supply side" initiatives are restructuring provider incentives:

- **Payment reform**
  - **Global budgets**
  - **Pay-for-performance**
  - **Bundled payments**
  - **Accountable care**
- **Tiered networks**
- **Health information technology**

Using Clinical Nuance to Align Payer and Consumer Incentives

Unfortunately, “supply-side” initiatives have historically paid little attention to consumer decision-making or the “demand-side” of care-seeking behavior:

- **Benefit design**
- **Shared decision-making**
- **Literacy**

Recipe for Value: Aligning Quality, Transparency, Appropriateness and Incentives

- **Lack of quality and price transparency**
- **Significant price variation with no connection to quality**
- **Price transparency and anti-competitive behavior**
- **Lack of information about clinical necessity**

A Potent Recipe for Higher-Value Health Care

Aligning quality, price transparency, clinical appropriateness and consumer incentives

Elizabeth Q. Cliff
Center for Value-Based Insurance Design
University of Michigan

Kathryn Spangler
Center for Value-Based Insurance Design
University of Michigan

Suzanne Delbanco, *Catalyst for Payment Reform*

Nicole Perelman, *Catalyst for Payment Reform*

A. Mark Fendrick
Center for Value-Based Insurance Design
University of Michigan

September 2013

Role of V-BID in Multi-Payer Reform: Using Clinical Nuance to Align Payer and Consumer Incentives

- Adding clinical nuance into payment reform and consumer engagement initiatives can help states improve quality of care, enhance patient experience, and contain cost growth
- The alignment of supply- and demand-side incentives can improve quality and achieve savings more efficiently than either one alone

Improving Care and Bending the Cost Curve

- **The ultimate test of health reform will be whether it improves health <u>and</u> addresses rising costs**
- **V-BID should be part of the solution to enhance the efficiency of health care spending**

The New York Times

Business D

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ECONOMIC VIEW

When a Co-Pay Gets in the Way of Health

By SENDHIL MULLAINATHAN
Published: August 10, 2013

ECONOMISTS specialize in pointing out unpleasant trade-offs — a skill that is on full display in the health care debate.

Enlarge This Image

Minh Uong/The New York Times

We want patients to receive the best care available. We also want consumers to pay less. And we don't want to bankrupt the government or private insurers. Something must give.

The debate centers on how to make these trade-offs, and who gets to make them. The stakes are high, and the choices are at times unseemly. No matter how necessary, putting human suffering into dollars and cents is not attractive work. It's no surprise, then, that the conversation is so heated.

What is a surprise is that amid th

Mullainathan S. When a Co-Pay Gets in the Way of Health. The New York Times. 2013 Aug 10.

Discussion

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

2016 Benefit Design Planning

Board of Trustees Meeting

September 19, 2014

A Division of the Department of State Treasurer

Presentation Overview

- Purpose
- Board Approved Wellness Design Elements and Plan Options for 2014
- Considerations for Planning 2016 Benefit Design and Plan Options
- Next Steps

Purpose

Start organized discussion of the CY 2016 benefit development strategy for the State Health Plan that considers:

- Course Set in 2014
- How NC Compares to Other State Health Plans
- Desire/Need for Benefit Differentiation
- Next Phase of Wellness Premiums, Credits and Healthy Activities
- Strategic Priorities and Initiatives

Focus: Active Employees and Non-Medicare Retirees

Development of 2014 Plan Options

Overarching Themes, Goals and Initiatives

- Improve the health and wellness of Plan members
- Need to “bend” the health care cost curve to promote long term financial sustainability of the Plan and affordability for Plan members
- Increase member engagement and accountability
- Incent and reward healthy behaviors to provide members with opportunities to reduce their out-of-pocket expenses
- Increase choice and flexibility by offering more benefit options
- Increase reserve target
- Convert plan benefit year from State fiscal year to calendar year

2014 Wellness Benefit Design Elements

- 100% Coverage for Preventive Services
- Premium Strategy to Encourage Healthy Lifestyles
  - Complete healthy activities to reduce premiums
- Primary Care Providers/Patient Centered Medical Home
  - Premium credit for PCP selection
  - Copay reduction for utilizing PCP/PCMH
- Tiered Provider Networks
  - Promote high value/low cost providers
  - Incentives to use Blue Options Designated hospitals and specialists
- Consumer Directed Health Plan
  - Engage members in shopping for health care services
  - 85/15 coinsurance
  - Dependent premiums 10% < 70/30 Plan

Plan Options for 2014 & 2015

Active Employees and Non-Medicare Retirees

Enhanced 80/20 Plan	Consumer-Directed Health Plan (CDHP) with HRA	Traditional 70/30 Plan

• $0 ACA Preventive Services
• $0 ACA Preventive Medications
• Wellness Incentives
  ◦ Reduced medical copay opportunities
	• A high-deductible plan
	• A Health Reimbursement Account (HRA) to help offset the deductible
	• Maximum Out-of-Pocket includes medical and pharmacy
	• 85/15 Coinsurance
	• $0 ACA Preventive Services
	• $0 ACA Preventive Medications
	• CDHP Preventive Medication List ($0 deductible)
	• Wellness incentives
	  ◦ Additional HRA funds for visiting certain providers
		• No incentives available
		• No $0 ACA Preventive Services
		• No $0 ACA Preventive Medications

Wellness Premium Credits for 2014 & 2015

Enhanced 80/20 Plan	Consumer-Directed Health Plan (CDHP) with HRA	Traditional 70/30 Plan
1) **Health Assessment ($15)** Members complete or update a Health Assessment through the Personal Health Portal. **2) Primary Care Provider ($15)** Members select a Primary Care Provider for themselves and any covered dependents. **3) Smoking Attestation ($20)** Members and if applicable their spouse attest to being a non-smoker or commit to a smoking cessation program.	1) **Health Assessment ($10)** Members complete or update a Health Assessment through the Personal Health Portal. **2) Primary Care Provider ($10)** Members select a Primary Care Provider for themselves and any covered dependents. **3) Smoking Attestation ($20)** Members and if applicable their spouse attest to being a non-smoker or commit to a smoking cessation program.	Premium Credits Not Available

Additional Wellness Incentives for 2014 & 2015

Enhanced 80/20 Plan	Consumer-Directed Health Plan (CDHP) with HRA	Traditional 70/30 Plan
• Wellness incentives: • $15 copay reduction for utilizing the PCP (or someone in that practice) listed on the ID card • $10 specialist copay reduction for utilizing a Blue Options Designated Specialist • $0 inpatient hospital copay for utilizing a Blue Options Designated Hospital	• Wellness incentives: • $15 added to the HRA when the PCP (or someone in that practice) listed on the ID card is seen • $10 added to the HRA when a Blue Options Designated Specialist is seen • $50 added to the HRA when a Blue Options Designated Hospital is utilized for inpatient services	• Incentives Not Available

Beyond the Board Approved Benefit Options for 2014

Original Intent Regarding Future Changes

- To create a process of population health improvement:
  - Wellness premiums and credits increase over time
  - Healthy activities evolve and intensify over time
  - Modify for CY 2016
- Offer Traditional 70/30 Plan option on a premium free basis to Active Employees only through CY 2015
  - Apply subscriber wellness premiums and credits starting in CY 2016
  - At same levels in effect for the Enhanced 80/20 and CDHP Plan options

NC Plan Options Compared to Other States

Relative Plan Value
Excluding Premium Contributions

1.4000
1.2000
1.0000
0.8000
0.6000
0.4000
0.2000
-

70/30
80/20
CDHP

SC NC GA SC NC VA NC KY MI TN KY MI VA GA WI AZ MD TN MI MI OH AZ WI MD

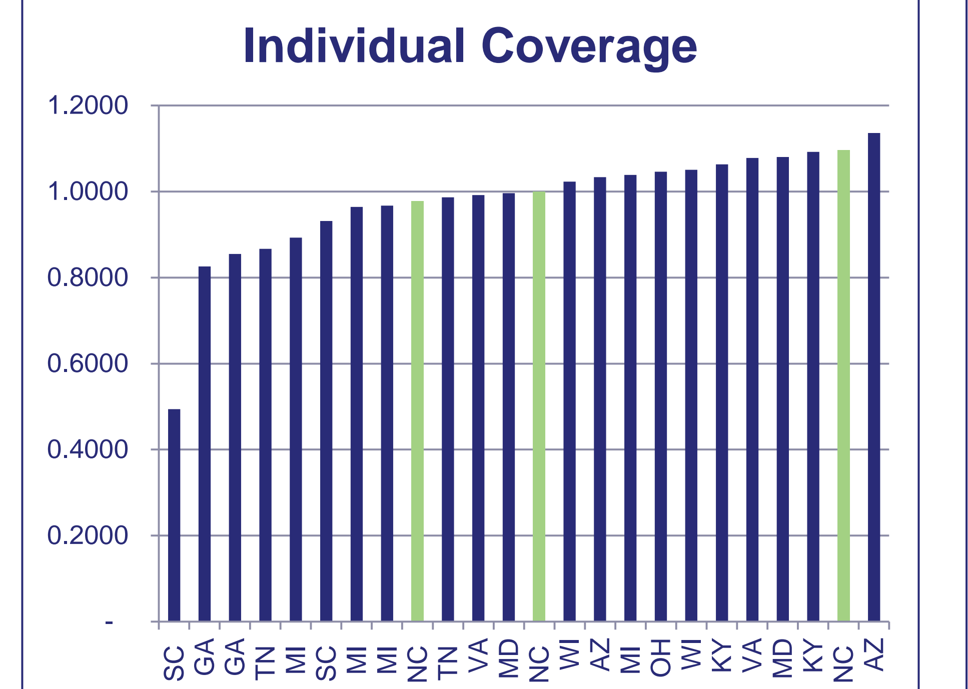
Segal Company – March 2014

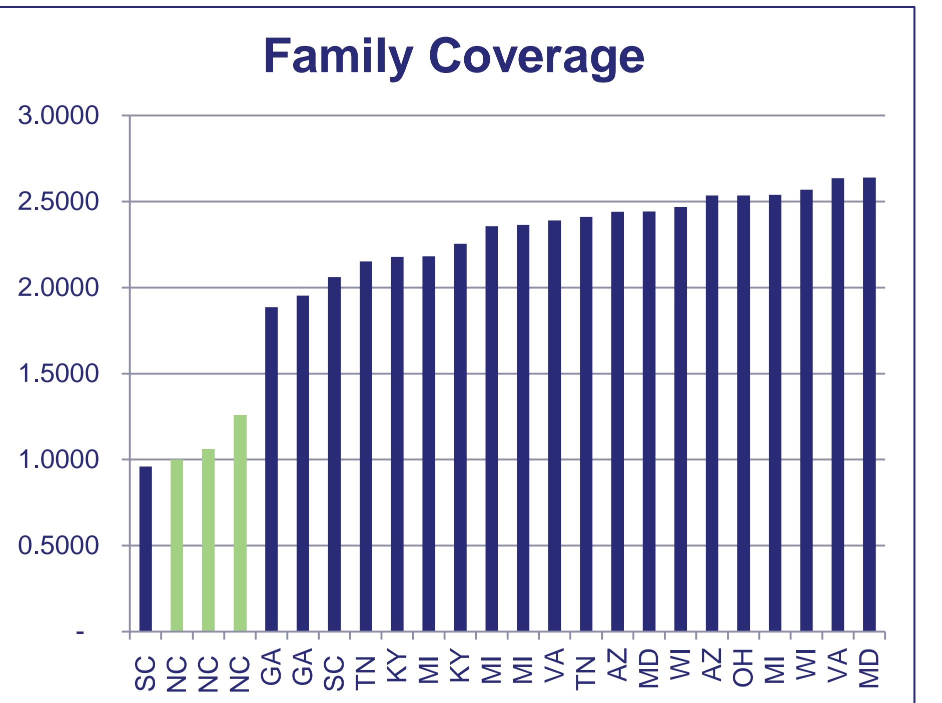
NC Options are:

- Similar in comparison to each other, and
- In the lower half of states in terms of relative plan value, *when premium contributions are not taken into account*

NC Plan Options Compared to Other States

Overall Relative Benefit Value Including Premium Contributions





When the analysis includes premium contributions, NC Options provide:

- A higher level of value than based solely on plan richness
- A broad range of value propositions for individuals, less so for family coverage

2014 Healthy Lifestyle Benefit Comparison Grid

	NC	GA	SC	KY	TN	VA	AZ	MD	MI	OH	WI
Smoking Credit	$20 monthly	$80	$40 monthly	$40 monthly	No	No	No	No	No	No	No
Health Assessment	$10 monthly	HRA ($)	No	Yes	Yes	$17 monthly	No	No	No	$50	No
PCP	$10 monthly	No	No	No	No	No	No	No	No	No	No
Biometric screening	No	HRA ($)	No	No	Yes	$17 monthly	No	No	No	$75	No
Activities / Coaching	No	HRA ($)	No	Yes	Yes	No	No	No	No	$200	No
Enrollment	No	No	No	Yes	Yes	No	No	No	No	No	No

Will Update for November Meeting

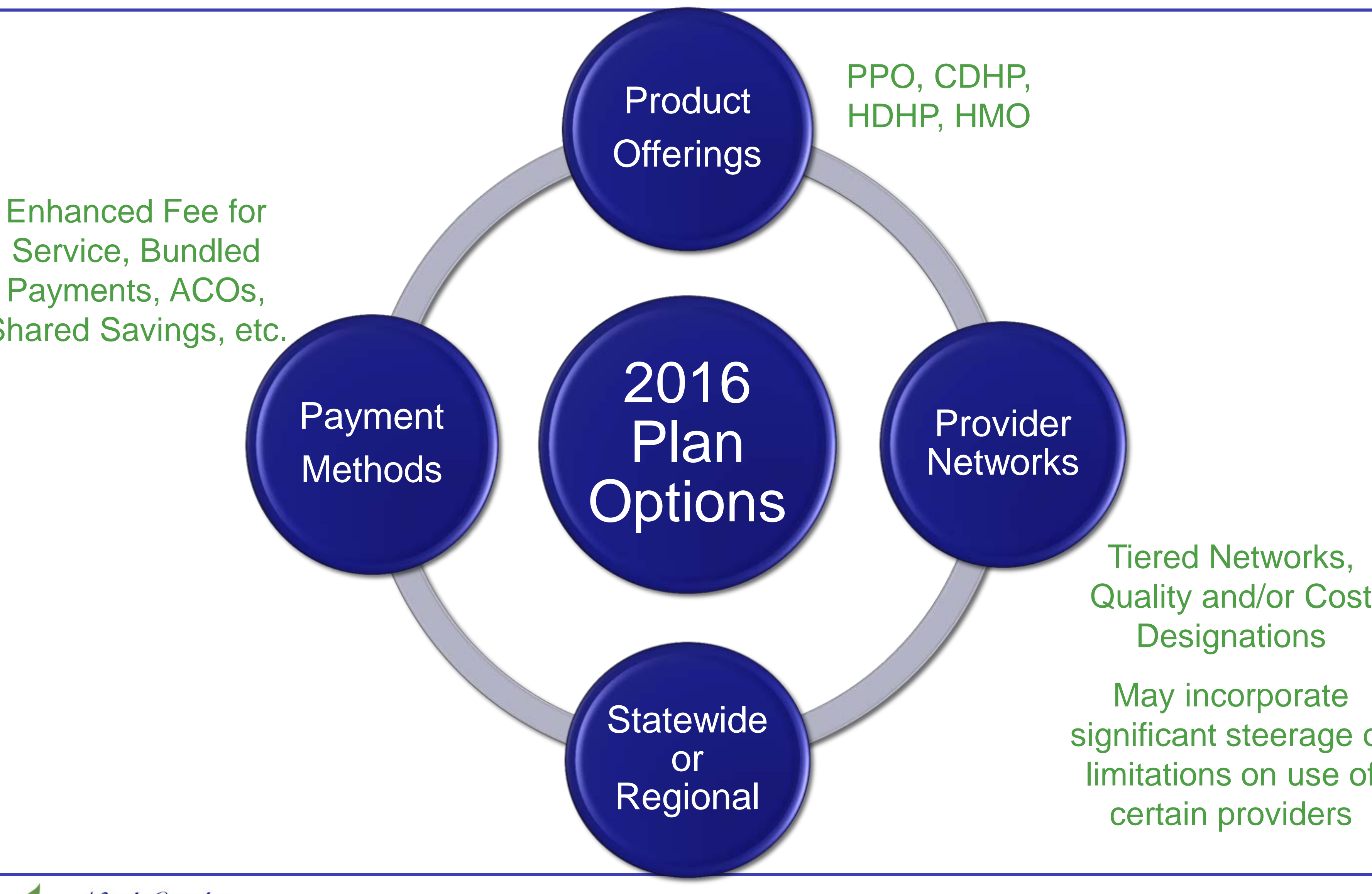
Why Consider Differentiating the SHP Options?

- Emerging trends include:
  - Differentiation and Steerage
  - Value-Based Design
  - Modifying Rx Benefit Design to establish a minimum and maximum copay approach
  - High Deductible Health Plans
  - Regional Offerings
- Segal analysis demonstrates similarity of NC options in terms of plan richness
  - Adding the Wellness Design to the 70/30 Plan will make the plan offerings more similar
  - When premiums are considered, individuals are provided greater choice, while families are provided very little meaningful choice
- Alignment with the Strategic Plan

Discussion Points on Benefit Differentiation

- Does differentiating the plans make sense?
- What strategies best match the Strategic Plan?
- What is the right amount of change?
- What can be implemented in CY 2016?

Elements for Differentiating Plan Options



Plan Differentiation Decision Tree

Should Plan consider modifying benefit designs and plan options to provide more meaningful choice?

- **Yes/Maybe**
  Plan should consider alternative benefit designs and options to promote differentiation of plan designs and value.

- **No**, the current offerings make sense for membership, and Plan should generally continue with previous vision for 2016 benefit design, and consider options for doing so.

Plan Differentiation Decision Tree

Yes/Maybe
Plan should consider alternative benefit designs and options to promote differentiation of plan designs and value. Sample strategies include:

Change Benefit Offerings:

1. Significantly Modify or Discontinue 70/30 Plan
2. Offer **High** Deductible Health Plan

New Provider Network Arrangement:

1. Offer Narrow or Limited Network Plans
2. Provide Managed Care Options

Change Medical and/or Rx Benefit Structure:

1. Steerage approach
2. Wellness design
3. Consumerism
4. Deductible & Copay Changes
5. New benefits
6. Differentiate Rx Designs

Wellness Premium & Credit Structure:

1. Differentiate credits across plans
2. Differentiate activities

Plan Differentiation Decision Tree

No, current offerings make sense. Plan should generally continue with previous vision for 2016 benefit design, and consider options for doing so. Sample strategies include:

Modify Member Cost Share:

1. Modify member out of pocket costs for services (deductible, copayments)
2. Increase employee only premiums to subsidize dependents

Wellness Premium Credit Structure:

1. Differentiate credits across plans
2. Differentiate activities

Sample Healthy Activities:

1. Change to Tobacco Cessation
2. Biometrics in HA
3. Member Contact Info
4. Healthy Lifestyle
5. Participation in DM/CM
6. Health Literacy, Use of Transparency Tools

Next Steps

Oct. & Nov. 2014
Develop Options for Consideration

- Staff Research
- Consultant/Vendor Input
- BOT Workgroups
- Begin Financial Modeling

Nov. 2014
BOT Consideration

- Staff Presents Options & Initial Recommendations to BOT

Jan. 2015
BOT Finalizes Benefit Design Changes

- State Budget Process
- Implementation by Vendors
- Member Communication

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Member Experience Update

Board of Trustees Meeting

September 19, 2014

A Division of the Department of State Treasurer

Presentation Overview

- Pre-65 Survey Results
- Member Satisfaction Survey
- Annual Enrollment Communications
- Medicare Outreach Meetings

Pre-65 Outreach Survey Results

- As a reminder, the Plan launched a campaign targeted at members turning 65 in the next year to educate them on their health plan options.
- 41 meetings were held in16 counties across the state with 1,065 members attending.
- A brief email survey was sent to everyone who registered, yielding 280 responses.

"The presenter was able to break down the information and explain it so clearly that I felt very comfortable listening. I help my father with his insurance and it was very helpful to me with understanding his insurance too. I would like to hear it all again because it is all so new to me but I am so grateful that the state provides insurance and someone to explain it to me."

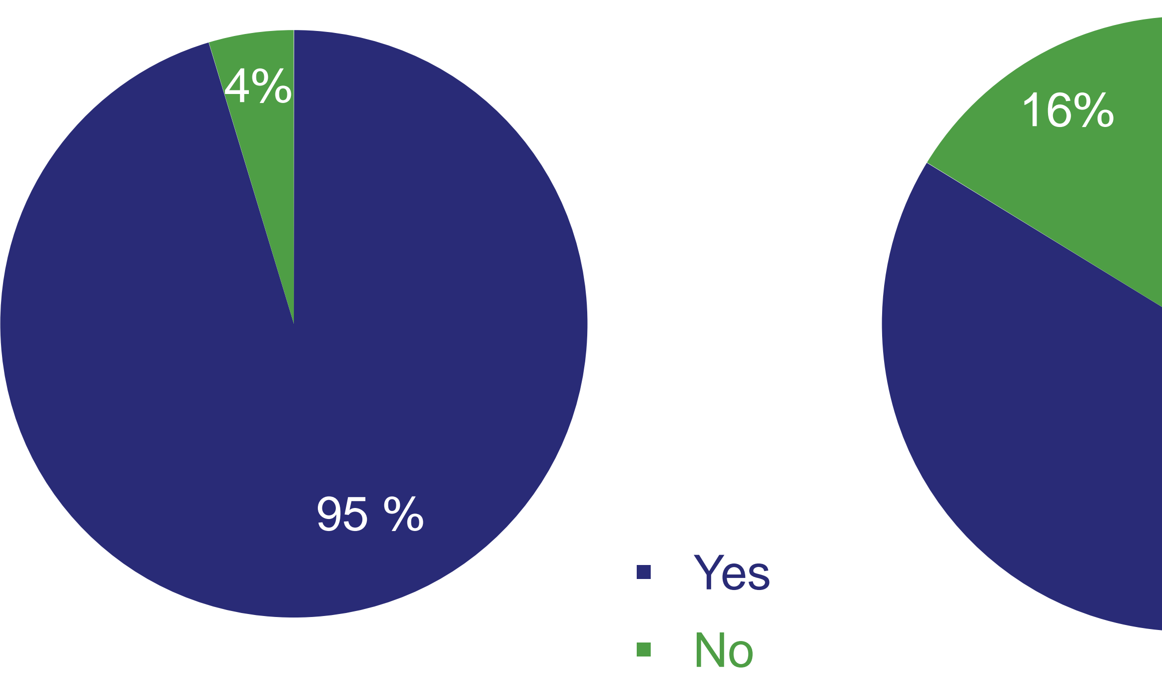
"The presenters were excellent and made what had seemed a very complicated process simple and very understandable."

"One of the best instructors I've had recently. Also the training room was pleasant and comfortable. Thank you for a wealth of information!"

Survey Results

Was this meeting helpful to you regarding your options at retirement for health plan benefits?

Do you feel the information in the presentation was easy to understand?



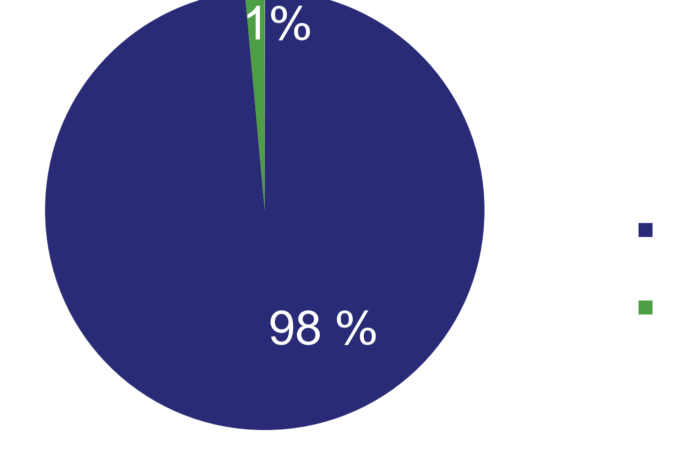
Membership Satisfaction Survey

- Survey conducted July 14 to Aug. 29, 2014
- Postcards were sent to members inviting them to participate
- 7,725 members completed the survey
- Results will be available in November

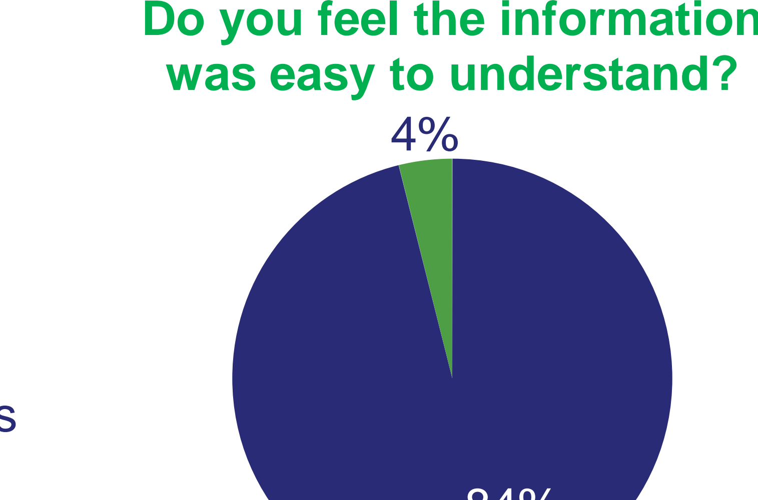
Annual Enrollment HBR Training

- Onsite and Webinar trainings were held in August for HBRs regarding Annual Enrollment.
- Approximately 500 HBRs attended
- A brief email survey was sent to everyone who registered, yielding 206 responses.

Was this meeting helpful to you regarding Annual Enrollment?



Do you feel the information was easy to understand?



Annual Enrollment Communications-*Actives/Non-Medicare Retirees*

- Decision Guides mailing out next week
- Reminder Postcard to be mailed in Oct.
- Member Webinars scheduled
- SHP Website
- Informational videos

2015 Annual Enrollment

YOUR STATE HEALTH PLAN DECISION GUIDE

Annual Enrollment Communications-*Medicare Retirees*

- Outreach Meeting Invite Mailer (Aug)
- Decision Guides mailing out next week
- Reminder Postcard to be mailed in Oct.
- SHP Website

YOUR STATE HEALTH PLAN
2015 Annual Enrollment Decision Guide

Annual Enrollment – *Medicare Outreach Meetings*

- 72 meetings in 42 counties have been scheduled
- 1,941 RSVP have been received
- 10 meetings have been held with 445 attending (*as of 9/16*)

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

July 2014 Financial Report

Board of Trustees Meeting

September 19, 2014

A Division of the Department of State Treasurer

Financial Results: Actual v. Budgeted Calendar Year to Date July 2014

Calendar Year 2014	Actual thru July 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Beginning Cash Balance	**$838.5 m**	**$695.0 m**	**$143.5 m**
Plan Revenue	**$1.742 b**	**$1.729 b**	**$13.0 m**
Net Claims Payments	$1.412 b	$1.495 b	($83.4 m)
Medicare Advantage Premiums	$91.5 m	$101.4 m	($9.9 m)
Net Administrative Expenses	$91.6 m	$106.0 m	($14.4 m)
Total Plan Expenses	**$1.595 b**	**$1.702 b**	**($107.7 m)**
Net Income/(Loss)	**$147.0 m**	**$26.3 m**	**$120.7 m**
Ending Cash Balance	**$985.5 m**	**$721.3 m**	**$264.2 m**

Note: Numbers might not sum to totals due to rounding

Adjusted Variance Report
Calendar Year to Date July 2014

Calendar Year 2014	Actual thru July 2014, As Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$1.768 b**	**$1.729 b**	**$38.8 m**
Net Claims Payments ^	$1.421 b	$1.495 b	($73.9 m)
Medicare Advantage Premiums	$91.5 m	$101.4 m	($9.9 m)
Net Administrative Expenses †	$83.1 m	$106.0 m	($22.9 m)
Total Plan Expenses	**$1.596 b**	**$1.702 b**	**($106.6 m)**
Net Income/(Loss)	**$171.7 m**	**$26.3 m**	**$145.4 m**

Note: Numbers might not sum to totals due to rounding

* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues and to remove the impact of a unanticipated pharmacy rebate true-up payments.
† Adjusted for timing issues.

Financial Results Actual v. Budgeted Calendar Year to Date July 2014

Per Member Per Month (PMPM) Analysis

Calendar Year 2014	Actual thru July 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue	**$366.89**	**$370.95**	**($4.06)**
Net Claims Payments	$297.83	$320.58	($22.75)
Medicare Advantage Premiums	$19.30	$21.74	($2.44)
Net Administrative Expenses	$19.32	$22.72	($3.40)
Total Plan Expenses	**$336.45**	**$365.04**	**($28.59)**
Net Income/(Loss)	**$30.44**	**$5.91**	**$24.53**

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

Adjusted Variance Report
Calendar Year to Date July 2014

Per Member Per Month (PMPM) Analysis

Calendar Year 2014	Actual thru July 2014, as Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$372.33**	**$370.95**	**$1.38**
Net Claims Payments ^	$299.85	$320.58	($20.73)
Medicare Advantage Premiums	$19.30	$21.74	($2.44)
Net Administrative Expenses †	$17.53	$22.72	($5.19)
Total Plan Expenses	**$336.68**	**$365.04**	**($28.36)**
Net Income/(Loss)	**$35.65**	**$5.91**	**$29.74**

* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues and to remove the impact of a larger-than-expected pharmacy rebate true-up payment.
† Adjusted for timing issues.

Plan Year to Date Expenditure Trend Per Member Per Month

Allocation of Claims Expenditures
Calendar Year to Date July 2014

Includes Medical, Blue Card & Pharmacy Payments

Source: BCBSNC Summary of Billed Charges

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Certified Budget
For the Month Ended July 2014

Calendar Year 2014

#		A	B	C	D	E	F	G	H
		Actual July 2014	Certified Budget July 2014	Monthly Variance Over/(Under) Certified Budget	Actual 2014 Calendar Year To Date	Certified Budget 2014 Calendar Year to Date	Calendar Year to Date Variance Over/(Under) Certified Budget	Calendar Year Certified Budget (Jan- Dec 2014)	Calendar Year to Date Variance Over/(Under) Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 257,559,061	$ 243,445,880	$ 14,113,181	$ 1,696,078,739	$ 1,705,933,523	$ (9,854,784)	$ 2,921,878,532	$ (1,225,799,793)
4	Premium Refunds/Retroactive Disenrollments	-	(124,095)	124,095	(22,385)	(869,571)	847,186	(1,489,408)	1,467,023
5	Medicare Part D (RDS) Subsidy	1,386,256	490,272	895,984	14,293,796	3,924,290	10,369,506	6,344,076	7,949,720
6	Medicare PDP (EGWP + Wrap) Subsidy	1,680,417	-	1,680,417	28,378,401	17,999,101	10,379,300	31,047,005	(2,668,604)
7	Medicare Advantage (MA) Subsidy	42,065	-	42,065	459,630	-	459,630	-	459,630
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
9	**Net Premium & Other Contributions**	**260,667,799**	**243,812,057**	**16,855,742**	**1,739,188,181**	**1,726,987,343**	**12,200,838**	**2,957,780,205**	**(1,218,592,024)**
10									
11	Investment Earnings	382,669	240,383	142,286	2,457,817	1,660,512	797,305	2,892,005	(434,188)
12	Miscellaneous Revenue	-	-	-	-	-	-	-	-
13	**Other Revenue**	**382,669**	**240,383**	**142,286**	**2,457,817**	**1,660,512**	**797,305**	**2,892,005**	**(434,188)**
14									
15	**Total Plan Revenue (excludes internal transfers)**	**261,050,468**	**244,052,440**	**16,998,028**	**1,741,645,998**	**1,728,647,855**	**12,998,143**	**2,960,672,210**	**(1,219,026,212)**
16									
17	**Plan Expenses:**								
18									
19	Medical Claim Payments	158,370,679	148,435,621	9,935,058	1,114,787,612	1,211,929,438	(97,141,826)	2,062,826,346	(948,038,734)
20	Medical Claim Refunds/Recoveries	(1,756,552)	(2,243,604)	487,052	(13,372,940)	(14,826,804)	1,453,864	(25,469,051)	12,096,111
21	**Net Medical Claims**	**156,614,127**	**146,192,017**	**10,422,110**	**1,101,414,672**	**1,197,102,634**	**(95,687,962)**	**2,037,357,295**	**(935,942,623)**
22									
23	Pharmacy Claim Payments	80,098,264	75,493,869	4,604,395	397,962,909	341,099,007	56,863,902	599,541,594	(201,578,685)
24	Pharmacy Claim Rebates	(28,537,461)	(11,457,732)	(17,079,729)	(88,001,925)	(43,238,232)	(44,763,693)	(54,794,623)	(33,207,302)
25	Pharmacy Claim Refunds/Recoveries	(6,990)	-	(6,990)	151,888	-	151,888	-	151,888
26	**Net Pharmacy Claims**	**51,553,813**	**64,036,137**	**(12,482,324)**	**310,112,872**	**297,860,775**	**12,252,097**	**544,746,971**	**(234,634,099)**
27									
28	**Net Claim Payments**	**208,167,940**	**210,228,154**	**(2,060,214)**	**1,411,527,544**	**1,494,963,409**	**(83,435,865)**	**2,582,104,266**	**(1,170,576,722)**
29									
30	**Medicare Advantage Premium Payments**	**12,950,142**	**14,519,520**	**(1,569,378)**	**91,488,989**	**101,384,264**	**(9,895,275)**	**174,162,733**	**(82,673,744)**
31									
32	**Net Administrative Expenses**	**12,999,565**	**14,790,500**	**(1,790,935)**	**91,585,741**	**105,938,830**	**(14,353,089)**	**179,815,010**	**(88,229,269)**
33									
34	**Total Plan Expenses (excludes internal transfers)**	**234,117,647**	**239,538,174**	**(5,420,527)**	**1,594,602,274**	**1,702,286,503**	**(107,684,229)**	**2,936,082,009**	**(1,341,479,735)**
35									
36	**Plan Income/(Loss)**	**26,932,821**	**4,514,266**	**22,418,555**	**147,043,724**	**26,361,352**	**120,682,372**	**24,590,201**	**122,453,523**
37									
38	**Cash Availability:**								
39									
40	Beginning Cash Balance/(Deficit)	958,558,040	716,822,219	241,735,821	838,447,137	694,975,133	143,472,004	694,975,133	143,472,004
41	**Ending Cash Balance/(Deficit)**	**985,490,861**	**721,336,485**	**264,154,376**	**985,490,861**	**721,336,485**	**264,154,376**	**719,565,334**	**265,925,527**
42									
43	Target Stabilization Reserve @ 12/31/14	234,282,695	234,282,695	-	234,282,695	234,282,695	-	234,282,695	-
44									
45	**Cash Balance Over/(Under) Reserve Target**	**$ 751,208,166**	**$ 487,053,790**	**$ 264,154,376**	**$ 751,208,166**	**$ 487,053,790**	**$ 264,154,376**	**$ 485,282,639**	**$ 265,925,527**

Comments:

a. Premium receivables totaled $145,937.31 as of July 31, 2014.
b. The average weekly medical claims cost net of claims refunds was $39,153,531.75 for the four scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included three bi-weekly invoice cycles averaging $26,699,421.33 per cycle.
d. The target stabilization reserve is 8.5% of the projected net claims and Medicare Advantage premiums for Calendar Year 2014.
e. Minor differences compared to other reports are due to rounding.

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Certified Budget
For the Month Ended July 2014
Fiscal Year 2014- 2015

#		A	B	C	D	E	F	G	H
		Actual July 2014	Certified Budget July 2014	Monthly Variance Over/(Under) Certified Budget	Actual Year to Date FY 2014-15	Certified Budget Year to Date FY 2014-15	Year to Date Variance Over/(Under) Certified Budget	Annual Certified Budget FY 2014-15	Year to Date Variance Over/(Under) Annual Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 257,559,061	$ 243,445,880	$ 14,113,181	$ 257,559,061	$ 243,445,880	$ 14,113,181	$ 2,951,350,285	$ (2,693,791,224)
4	Premium Refunds/Retroactive Disenrollments	-	(124,095)	124,095	-	(124,095)	124,095	(1,502,227)	1,502,227
5	Medicare Part D (RDS) Subsidy	1,386,256	490,272	895,984	1,386,256	490,272	895,984	6,498,606	(5,112,350)
6	Medicare PDP (EGWP + Wrap) Subsidy	1,680,417	-	1,680,417	1,680,417	-	1,680,417	13,047,904	(11,367,487)
7	Medicare Advantage (MA) Subsidy	42,065	-	42,065	42,065	-	42,065	-	42,065
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
9	**Net Premium & Other Contributions**	**260,667,799**	**243,812,057**	**16,855,742**	**260,667,799**	**243,812,057**	**16,855,742**	**2,969,394,568**	**(2,708,726,769)**
10									
11	Investment Earnings	382,669	240,383	142,286	382,669	240,383	142,286	2,836,015	(2,453,346)
12	Miscellaneous Revenue	-	-	-	-	-	-	-	-
13	**Other Revenue**	**382,669**	**240,383**	**142,286**	**382,669**	**240,383**	**142,286**	**2,836,015**	**(2,453,346)**
14									
15	**Total Plan Revenue (excludes internal transfers)**	**261,050,468**	**244,052,440**	**16,998,028**	**261,050,468**	**244,052,440**	**16,998,028**	**2,972,230,583**	**(2,711,180,115)**
16									
17	**Plan Expenses:**								
18									
19	Medical Claim Payments	158,370,679	148,435,621	9,935,058	158,370,679	148,435,621	9,935,058	2,123,045,570	(1,964,674,891)
20	Medical Claim Refunds/Recoveries	(1,756,552)	(2,243,604)	487,052	(1,756,552)	(2,243,604)	487,052	(26,482,043)	24,725,491
21	**Net Medical Claims**	**156,614,127**	**146,192,017**	**10,422,110**	**156,614,127**	**146,192,017**	**10,422,110**	**2,096,563,527**	**(1,939,949,400)**
22									
23	Pharmacy Claim Payments	80,098,264	75,493,869	4,604,395	80,098,264	75,493,869	4,604,395	592,629,603	(512,531,339)
24	Pharmacy Claim Rebates	(28,537,461)	(11,457,732)	(17,079,729)	(28,537,461)	(11,457,732)	(17,079,729)	(49,442,651)	20,905,190
25	Pharmacy Claim Refunds/Recoveries	(6,990)	-	(6,990)	(6,990)	-	(6,990)	-	(6,990)
26	**Net Pharmacy Claims**	**51,553,813**	**64,036,137**	**(12,482,324)**	**51,553,813**	**64,036,137**	**(12,482,324)**	**543,186,952**	**(491,633,139)**
27									
28	**Net Claim Payments**	**208,167,940**	**210,228,154**	**(2,060,214)**	**208,167,940**	**210,228,154**	**(2,060,214)**	**2,639,750,479**	**(2,431,582,539)**
29									
30	**Medicare Advantage Premium Payments**	**12,950,142**	**14,519,520**	**(1,569,378)**	**12,950,142**	**14,519,520**	**(1,569,378)**	**196,159,077**	**(183,208,935)**
31									
32	**Net Administrative Expenses**	**12,999,565**	**14,790,500**	**(1,790,935)**	**12,999,565**	**14,790,500**	**(1,790,935)**	**211,784,393**	**(198,784,828)**
33									
34	**Total Plan Expenses (excludes internal transfers)**	**234,117,647**	**239,538,174**	**(5,420,527)**	**234,117,647**	**239,538,174**	**(5,420,527)**	**3,047,693,949**	**(2,813,576,302)**
35									
36	**Plan Income/(Loss)**	**26,932,821**	**4,514,266**	**22,418,555**	**26,932,821**	**4,514,266**	**22,418,555**	**(75,463,366)**	**102,396,187**
37									
38	**Cash Availability:**								
39									
40	Beginning Cash Balance/(Deficit)	958,558,040	716,822,219	241,735,821	958,558,040	716,822,219	241,735,821	716,822,219	241,735,821
41	**Ending Cash Balance/(Deficit)**	**985,490,861**	**721,336,485**	**264,154,376**	**985,490,861**	**721,336,485**	**264,154,376**	**641,358,853**	**344,132,008**
42									
43	Target Stabilization Reserve @ 6/30/15	255,231,860	255,231,860	-	255,231,860	255,231,860	-	255,231,860	-
44									
45	**Cash Balance Over/(Under) Reserve Target**	**$ 730,259,001**	**$ 466,104,625**	**$ 264,154,376**	**$ 730,259,001**	**$ 466,104,625**	**$ 264,154,376**	**$ 386,126,993**	**$ 344,132,008**

Comments:
a. Premium receivables totaled $145,937.31 as of July 31, 2014.
b. The average weekly medical claims cost net of claims refunds was $39,153,531.75 for the four scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included three bi-weekly invoice cycles averaging $26,699,421.33 per cycle.
d. The target stabilization reserve is 9% of the projected net claims and Medicare Advantage premiums for Fiscal Year 2014-15.
e. Minor differences compared to other reports are due to rounding.

Actual vs Certified Budget (i.e. ***Original Budget*** per SL 2013-360 and Board Approved Design)
July 2014 - Fiscal Year

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Current Year Actual vs. Prior Year Actual
For the Month Ended July 2014
Fiscal Year 2014-2015

		A	B	C	D	E	F	G
		Current Year Actual July 2014	Prior Year Actual July 2013	Current Year to Date Actual FY 2014-15 thru July	Prior Year to Date Actual FY 2013-14 thru July	Current Year Certified Annual Budget FY 2014-15	Prior Year Annual Budget FY 2013-14	Prior Year Actual Results FY 2013-14
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 257,559,061	$ 247,712,470	$ 257,559,061	$ 247,712,470	$ 2,951,350,285	$ 2,902,567,015	$ 2,941,097,678
4	Premium Refunds/Retroactive Disenrollments	-	(3,887)	-	(3,887)	(1,502,227)	(1,466,766)	(299,923)
5	Medicare Part D (RDS) Subsidy	1,386,256	549,436	1,386,256	549,436	6,498,606	6,218,762	11,583,652
6	Medicare PDP (EGWP + Wrap) Subsidy	1,680,417	7,917,151	1,680,417	7,917,151	13,047,904	50,346,402	63,780,569
7	Medicare Advantage (MA) Subsidy	42,065	-	42,065	-	-	-	417,565
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-
9	**Net Premium & Other Contributions**	**260,667,799**	**256,175,170**	**260,667,799**	**256,175,170**	**2,969,394,568**	**2,957,665,413**	**3,016,579,541**
10								
11	Investment Earnings	382,669	268,810	382,669	268,810	2,836,015	2,868,131	3,861,263
12	Miscellaneous Revenue	-	-	-	-	-	-	54,972
13	**Other Revenue**	**382,669**	**268,810**	**382,669**	**268,810**	**2,836,015**	**2,868,131**	**3,916,235**
14								
15	**Total Plan Revenue (excludes internal transfers)**	**261,050,468**	**256,443,980**	**261,050,468**	**256,443,980**	**2,972,230,583**	**2,960,533,544**	**3,020,495,776**
16								
17	**Plan Expenses:**							
18								
19	Medical Claim Payments	158,370,679	187,337,017	158,370,679	187,337,017	2,123,045,570	2,107,493,114	1,989,574,333
20	Medical Claim Refunds/Recoveries	(1,756,552)	(2,199,898)	(1,756,552)	(2,199,898)	(26,482,043)	(24,643,884)	(22,450,766)
21	**Net Medical Claims**	**156,614,127**	**185,137,119**	**156,614,127**	**185,137,119**	**2,096,563,527**	**2,082,849,230**	**1,967,123,567**
22								
23	Pharmacy Claim Payments	80,098,264	95,318,946	80,098,264	95,318,946	592,629,603	699,653,578	743,680,114
24	Pharmacy Claim Rebates	(28,537,461)	(6,882,250)	(28,537,461)	(6,882,250)	(49,442,651)	(52,353,361)	(91,653,105)
25	Pharmacy Claim Refunds/Recoveries	(6,990)	(112,292)	(6,990)	(112,292)	-	-	(398,652)
26	**Net Pharmacy Claims**	**51,553,813**	**88,324,404**	**51,553,813**	**88,324,404**	**543,186,952**	**647,300,217**	**651,628,357**
27								
28	**Net Claim Payments**	**208,167,940**	**273,461,523**	**208,167,940**	**273,461,523**	**2,639,750,479**	**2,730,149,447**	**2,618,751,924**
29								
30	**Medicare Advantage Premium Payments**	**12,950,142**	-	**12,950,142**	-	**196,159,077**	**86,864,744**	**78,538,847**
31								
32	**Net Administrative Expenses**	**12,999,565**	**15,047,688**	**12,999,565**	**15,047,688**	**211,784,393**	**182,446,628**	**148,134,913**
33								
34	**Total Plan Expenses (excludes internal transfers)**	**234,117,647**	**288,509,211**	**234,117,647**	**288,509,211**	**3,047,693,949**	**2,999,460,819**	**2,845,425,684**
35								
36	**Plan Income/(Loss)**	**26,932,821**	**(32,065,231)**	**26,932,821**	**(32,065,231)**	**(75,463,366)**	**(38,927,275)**	**175,070,092**
37								
38	**Cash Availability:**							
39								
40	Beginning Cash Balance/(Deficit)	958,558,040	783,487,948	958,558,040	783,487,948	716,822,219	755,749,494	783,487,948
41	**Ending Cash Balance/(Deficit)**	**985,490,861**	**751,422,717**	**985,490,861**	**751,422,717**	**641,358,853**	**716,822,219**	**958,558,040**
42								
43	Target Stabilization Reserve @ 6/30/15	255,231,860	239,446,206	255,231,860	239,446,206	255,231,860	239,446,206	229,269,716
44								
45	**Cash Balance Over/(Under) Reserve Target**	**$ 730,259,001**	**$ 511,976,511**	**$ 730,259,001**	**$ 511,976,511**	**$ 386,126,993**	**$ 477,376,013**	**$ 729,288,324**

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

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended July 2014
Calendar Year 2014

#		A	B	C	D	E	F
		Actual Year to Date Calendar Year thru July	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Calendar Year to Date thru July	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 1,696,078,739	$ 34,794,945	$ 1,730,873,684	$ 1,705,933,523	$ 24,940,161	1.46%
4	Premium Refunds/Retroactive Disenrollments	(22,385)		(22,385)	(869,571)	847,186	-97.43%
5	Medicare Part D (RDS) Subsidy (Note 3)	14,293,796	(6,855,182)	7,438,614	3,924,290	3,514,324	89.55%
6	Medicare PDP (EGWP + Wrap) Subsidy (Note 4)	28,378,401	(1,680,417)	26,697,984	17,999,101	8,698,883	48.33%
7	Medicare Advantage (MA) Subsidy (Note 5)	459,630	(459,630)	-	-	-	
8	Federal Early Retiree Reinsurance Program (ERRP)	-		-	-	-	
9	**Net Premium & Other Contributions**	**1,739,188,181**	**25,799,717**	**1,764,987,898**	**1,726,987,343**	**38,000,555**	**2.20%**
10							
11	**Other Revenue**	**2,457,817**		**2,457,817**	**1,660,512**	**797,305**	**48.02%**
12							
13	**Total Plan Revenue (excludes internal transfers)**	**1,741,645,998**	**25,799,717**	**1,767,445,715**	**1,728,647,855**	**38,797,860**	**2.24%**
14							
15	**Plan Expenses:**						
16							
17	Net Medical Claims	1,101,414,672		1,101,414,672	1,197,102,634	(95,687,962)	-7.99%
18	Net Pharmacy Claims (Notes 6 and 7)	310,112,872	9,575,016	319,687,888	297,860,775	21,827,113	7.33%
19	**Net Claim Payments**	**1,411,527,544**	**9,575,016**	**1,421,102,560**	**1,494,963,409**	**(73,860,849)**	**-4.94%**
20							
21	**Medicare Advantage Premiums**	**91,488,989**		**91,488,989**	**101,384,264**	**(9,895,275)**	**-9.76%**
22							
23	**Net Administrative Expenses (Note 8)**	**91,585,741**	**(8,491,208)**	**83,094,533**	**105,938,830**	**(22,844,297)**	**-21.56%**
24							
25	**Total Plan Expenses (excludes internal transfers)**	**1,594,602,274**	**1,083,809**	**1,595,686,083**	**1,702,286,503**	**(106,600,421)**	**-6.26%**
26							
27	**Plan Income/(Loss)**	**147,043,724**	**24,715,908**	**171,759,632**	**26,361,352**	**145,398,280**	**551.56%**
28							
29	**Cash Availability:**						
30							
31	Beginning Cash Balance/(Deficit)	838,447,137		838,447,137	694,975,133	143,472,004	20.64%
32	**Ending Cash Balance/(Deficit)**	**985,490,861**	**24,715,908**	**1,010,206,769**	**721,336,485**	**288,870,284**	**40.05%**
33							
34	Target Stabilization Reserve @ 12/31/2014	234,282,695		234,282,695	234,282,695	-	
35							
36	**Cash Balance Over/(Under) Reserve Target**	**$ 751,208,166**	**$ 24,715,908**	**$ 775,924,074**	**$ 487,053,790**	**$ 288,870,284**	**59.31%**

Adjustment Notes:
1. Member premiums adjusted to include $60.8 million in prepaid January premiums received in December 2013.
2. Member premiums adjusted to exclude $26.0 million in prepaid August premiums received in July.
3. Medicare Part D subsidy adjusted to exclude an unbudgeted subsidy refund related to prior plan years.
4. EGWP subsidy adjusted to exclude unbudgeted subsidy payments received in July.
5. Medicare Advantage low income premium subsidies were not budgeted and therefore are excluded.
6. Pharmacy claims adjusted to exclude a $33.1 million claims payment that was budgeted for payment in December 2013 but was not paid until January 2014.
7. Pharmacy claims adjusted to remove unbudgeted rebate true-ups totaling $42.7 million.
8. Administrative expenses adjusted to reflect normal vendor payment schedules.

Adjusted Variance Report Based on Certified (Original) Budget
Calendar Year to Date Through July 2014

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended July 2014
Fiscal Year 2014-2015

#		A	B	C	D	E	F
		Actual Year to Date Fiscal Year thru July	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Fiscal Year to Date thru July	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 257,559,061	$ (10,018,869)	$ 247,540,192	$ 243,445,880	$ 4,094,312	1.68%
4	Premium Refunds/Retroactive Disenrollments	-		-	(124,095)	124,095	-100.00%
5	Medicare Part D (RDS) Subsidy	1,386,256		1,386,256	490,272	895,984	182.75%
6	Medicare PDP (EGWP + Wrap) Subsidy (Note 3)	1,680,417	(1,680,417)	-	-	-	
7	Medicare Advantage (MA) Subsidy (Note 4)	42,065	(42,065)	-	-	-	
8	Federal Early Retiree Reinsurance Program (ERRP)	-		-	-	-	
9	**Net Premium & Other Contributions**	**260,667,799**	**(11,741,351)**	**248,926,448**	**243,812,057**	**5,114,391**	**2.10%**
10							
11	**Other Revenue**	**382,669**		**382,669**	**240,383**	**142,286**	**59.19%**
12							
13	**Total Plan Revenue (excludes internal transfers)**	**261,050,468**	**(11,741,351)**	**249,309,117**	**244,052,440**	**5,256,677**	**2.15%**
14							
15	**Plan Expenses:**						
16							
17	Net Medical Claims	156,614,127		156,614,127	146,192,017	10,422,110	7.13%
18	Net Pharmacy Claims (Note 5)	51,553,813	16,852,591	68,406,404	64,036,137	4,370,267	6.82%
19	**Net Claim Payments**	**208,167,940**	**16,852,591**	**225,020,531**	**210,228,154**	**14,792,377**	**7.04%**
20							
21	**Medicare Advantage Premiums**	**12,950,142**		**12,950,142**	**14,519,520**	**(1,569,378)**	**-10.81%**
22							
23	**Net Administrative Expenses**	**12,999,565**		**12,999,565**	**14,790,500**	**(1,790,935)**	**-12.11%**
24							
25	**Total Plan Expenses (excludes internal transfers)**	**234,117,647**	**16,852,591**	**250,970,238**	**239,538,174**	**11,432,064**	**4.77%**
26							
27	**Plan Income/(Loss)**	**26,932,821**	**(28,593,942)**	**(1,661,121)**	**4,514,266**	**(6,175,387)**	**-136.80%**
28							
29	**Cash Availability:**						
30							
31	Beginning Cash Balance/(Deficit)	958,558,040		958,558,040	716,822,219	241,735,821	33.72%
32	**Ending Cash Balance/(Deficit)**	**985,490,861**	**(28,593,942)**	**956,896,919**	**721,336,485**	**235,560,434**	**32.66%**
33							
34	Target Stabilization Reserve @ 6/30/15	255,231,860		255,231,860	255,231,860	-	
35							
36	**Cash Balance Over/(Under) Reserve Target**	**$ 730,259,001**	**$ (28,593,942)**	**$ 701,665,059**	**$ 466,104,625**	**$ 235,560,434**	**50.54%**

Adjustment Notes:
1. Member premiums adjusted to include $16.0 million in prepaid July premiums received in June.
2. Member premiums adjusted to exclude $26.0 million in prepaid August premiums received in July.
3. EGWP subsidies were not budgeted and therefore are excluded.
4. Medicare Advantage low income premium subsidies were not budgeted and therefore are excluded.
5. Pharmacy claims adjusted to exclude a $16.9 million unbudgeted EGWP rebate true-up payment.

Adjusted Variance Report Based on Certified (Original) Budget
Fiscal Year to Date Through July 2014

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

CY 2014 2nd Quarter Actuarial Forecast Update
Authorized Budget

Board of Trustees Meeting

September 19, 2014

Forecast prepared by The Segal Company
Final version dated 9-9-14

A Division of the Department of State Treasurer

Presentation Overview

- Forecast Update Schedule
- Updated Assumptions: Certified Budget vs. CY 2014 2nd Quarter Projection
- Updated Forecast for CY 2014
- Summary Graphs
- Summary and Future Outlook

Actuarial Forecast Update Schedule

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

Forecast Assumptions Maintained in the Update Certified Budget vs. CY 2014 2nd Quarter Update

- Membership trends
  - 1% annual decrease in actives
  - 1% annual increase in retirees
- Pharmacy trend assumption of 8.5%
- New benefit design effective January 1, 2014
- 2014 revenues reflect 3.57% across the board premium increases effective January 1, 2014, and the wellness premium structure
- Wellness premium structure extended to the Traditional 70/30 Plan beginning in 2016

Forecast Assumptions Changed/Revised in the Update Certified Budget vs. CY 2014 2nd Quarter Update

Changes Always Included in Updates

- Membership based on actual June 2014 counts (instead of March 2013)
- Anticipated claims expenditures based on actual experience through June 2014 (instead of through March 2013)

Additional Changes Included in Earlier Updates

- Elimination of lifetime limits on ACA "Essential Health Benefits"
- Timing and amounts of pharmacy rebates and subsidies have been adjusted to reflect more recent estimates
- 100% coverage of preventive services and medications is assumed for Traditional 70/30 Plan beginning in 2016
- Target Stabilization Reserve balances to 9% of claims costs only; Certified Budget balanced to 9% of claims costs *plus* Medicare Advantage premium payments
- Projections extended to include Calendar Years 2018 and 2019

Forecast Assumptions Changed/Revised in the Update Certified Budget vs. CY 2014 2nd Quarter Update

New Changes in the CY 2014 2nd Quarter Update

- Medical trend assumption reduced to 7% annually
- Premium freeze for 2015 (Certified Budget assumed 2.14% increase)
- Medicare Advantage premium costs projected to increase with medical trend (7% annually) beginning in 2016
- Seasonality of claims costs reflects more recent experience
- Includes a $12.8 million increase in Fiscal Year 2014-15 administrative costs, as approved by the General Assembly
- Includes cost of Applied Behavior Analysis benefit beginning January 2015 (approved by Board in May 2014)
- Includes cost for 100% coverage of new ACA preventive medications for the Enhanced 80/20 Plan and CDHP beginning January 2015 (approved by Board in July 2014) and Traditional 70/30 Plan beginning January 2016
- Includes costs of adding three new local governments as employing units beginning January 2015 (S.L. 2014-75 and S.L. 2014-105)

Comparison of Models
Certified Budget vs. CY 2014 2nd Quarter Update

Calendar Year 2014	CY 2014 2nd Quarter Update (per Segal 9-9-14)	Certified Budget (per Segal 8-19-13)	Difference: Increase/ (Decrease) From Budget
Beginning Cash Balance	**$838.5 m**	**$695.0 m**	**$143.5 m**
Plan Revenue	**$2.957 b**	**$2.961 b**	**($3.4 m)**
Net Claims Payments	$2.492 b	$2.582 b	($89.8 m)
Medicare Advantage Premiums	$157.6 m	$174.2 m	($16.6 m)
Net Admin. Expenses	$173.7 m	$179.8 m	($6.1 m)
Total Plan Expenses	**$2.824 b**	**$2.936 b**	**($112.5 m)**
Net Income/(Loss)	**$133.7 m**	**$24.6 m**	**$109.1 m**
Ending Cash Balance	**$972.2 m**	**$719.6 m**	**$252.6 m**
2016 & 2017 Premium Increases	3.53%	8.22%	(4.69%)
2018 & 2019 Premium Increases	13.71%	*Not estimated*	--

Forecast Comparisons: Fiscal Year 2013-14 Claims

SPY = Short Plan Year

Forecast Comparisons: Calendar Year 2014 Claims

($ Millions)

	Medical Claims	Pharmacy Claims
Certified Budget	$2,037	$545
SPY Q1 Update	$1,993	$591
SPY Q2 Update	$1,974	$622
CY 2014 Q1 Update	$1,903	$587
CY 2014 Q2 Update	$1,913	$580

7% trend

SPY = Short Plan Year

Forecast Comparisons: Ending Cash Balances

SPY = Short Plan Year

Summary/Future Outlook

- Relative to the Certified Budget, the CY 2014 2nd Quarter Update projects lower medical claims costs and higher pharmacy claims costs in future years
- $972.1 million cash balance projected for the end of the biennium (June 30, 2015):
  - $252.6 million higher than the Certified Budget projection (despite the premium freeze for the 2015 plan year)
  - Exceeds the 9.0% target stabilization reserve amount by $744.0 million
  - Equates to more than 15 weeks of FY 2015-16 projected operating expenses
- Assuming no changes in benefits beyond the Board's current design, the CY 2014 2nd Quarter Update projects a 3.53% premium increase for January of 2016 and 2017. This is lower than the Certified Budget projection (8.22%)
- CY 2014 2nd Quarter Forecast Update will be used as the Authorized Budget for State Fiscal Year 2014-15 to benchmark against actual financial results

Certified Budget
(Segal 8-19-13)

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

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

Short Plan Year Q1 Update

(Segal 11-14-13)

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

	2012 - 2013 Biennium		2014 - 2015 Biennium				2016 - 2017 Biennium				
	Actual FY 2012	Actual FY 2013	Projection Short Plan Year Jul-Dec 2013	Projection Calendar 2014 Jan-June	Projection Calendar 2014 July-Dec	Projection Calendar 2015 Jan-Jun	Projection Calendar 2015 Jul-Dec	Projection Calendar 2016 Jan-June	Projection Calendar 2016 July-Dec	Projection Calendar 2017 Jan-Jun	Projection Calendar 2017 Jul-Dec
PLAN INCOME:											
Net Contribution Income	2,750,368,851	2,895,366,140	1,454,995,731	1,497,179,531	1,494,163,089	1,523,095,383	1,520,090,707	1,634,253,292	1,631,098,518	1,753,672,738	1,750,362,250
EGWP/PDP Spouse Premium Reduction		-	(1,231,103)	(14,552,685)	(14,625,268)	(14,698,212)	(14,771,520)	(14,845,194)	(14,919,235)	(14,993,646)	(15,068,428)
MA Spouse Premium Reduction				(5,856,638)	(5,885,849)	(5,915,205)	(5,944,707)	(5,974,357)	(6,004,154)	(6,034,100)	(6,064,196)
MA Buy-up Premium				11,144,450	11,200,034	15,391,702	15,468,469	20,077,844	20,177,983	25,245,260	25,371,173
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(613,406)	(748,590)	(747,082)	(761,548)	(760,045)	(817,127)	(815,549)	(876,836)	(875,181)
Premium Incentive			-	(15,132,835)	(15,102,346)	(14,099,776)	(14,071,961)	18,234,558	18,199,358	18,052,395	18,018,317
CDHP Premium Reduction			-	(3,486,444)	(3,479,420)	(4,693,593)	(4,684,333)	(5,878,790)	(5,867,442)	(7,042,406)	(7,029,111)
Medicare Part D	57,583,602	38,056,016	(2,045,274)	3,280,324	2,779,814	3,427,938	2,904,906	3,582,196	3,035,627	3,743,394	3,172,230
EGWP+Wrap											
Direct Subsidy	-	24,435,483	25,741,422	-	-	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	8,953,844	18,169,771	-	-	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	-	13,171,626	-	-	-	-	-
Total	-	24,435,483	34,695,267	18,169,771	-	13,171,626	-	-	-	-	-
Appropriations from State Reserve				-							
Investment Earnings	3,015,815	3,236,713	1,663,868	1,489,193	1,545,098	1,447,760	1,284,123	1,065,908	939,801	788,054	665,776
Total Plan Income	2,852,680,163	2,960,048,314	1,487,465,082	1,491,486,077	1,469,848,073	1,516,366,077	1,499,515,639	1,649,698,330	1,645,844,906	1,772,554,853	1,768,552,830
PLAN EXPENSE:											
Medical Claims Payment	1,849,410,105	1,858,096,405	1,004,924,154	1,087,845,343	1,014,877,297	1,175,569,905	1,106,736,822	1,270,823,703	1,191,944,159	1,370,832,602	1,285,284,566
Claim Refunds	(22,634,615)	(23,467,914)	(11,861,694)	(12,309,995)	(12,611,230)	(13,307,208)	(13,868,798)	(14,476,540)	(14,935,747)	(15,405,170)	(16,106,749)
Dental & MHSA Enhancement			1,424,066	3,370,351	3,144,282	3,642,138	3,428,880	3,937,253	3,692,869	4,247,099	3,982,055
Medicare Advantage Claims Reduction				(51,959,107)	(60,778,121)	(66,273,163)	(66,603,704)	(72,625,445)	(72,987,669)	(79,586,594)	(79,983,537)
Calendar Year Adjustments		-	33,053,694	(4,229,258)	14,039,329	(14,419,571)	18,822,423	(17,792,129)	20,205,328	(19,304,460)	21,922,781
Preventative at 100% in Standard Plan				9,572,332	13,420,058	15,191,448	14,674,949	16,376,496	15,789,284	17,649,201	17,009,684
Premium Incentive				(7,929,050)	(11,873,557)	(11,380,262)	(11,357,731)	(12,581,387)	(12,557,011)	(19,995,303)	(19,957,415)
CDHP Claims Reduction				(2,637,947)	(3,950,260)	(5,647,915)	(5,636,733)	(8,766,694)	(8,749,709)	(12,719,839)	(12,695,736)
Limited Network Savings				304,325	455,720	382,506	381,748	595,478	594,324	569,136	568,057
PCP Copay Waiver				4,337,145	6,494,768	(398,650)	(397,860)	(4,021,959)	(4,014,166)	(16,995,135)	(16,962,932)
Essential Health Benefits/MH Parity				1,411,202	1,898,981	2,198,838	2,070,089	2,390,068	2,241,718	2,593,674	2,431,814
Net Medical Claims	1,826,775,490	1,834,628,491	1,027,540,221	1,027,775,341	965,117,266	1,085,558,067	1,048,050,085	1,163,858,843	1,121,223,380	1,231,885,210	1,185,492,589
Medicare Advantage Premiums			-	88,480,183	88,921,483	110,744,961	111,297,308	135,281,658	135,956,384	162,309,415	163,118,944
Pharmacy Claims Payment	721,163,013	752,419,650	456,411,374	414,627,765	491,418,537	448,066,596	531,072,633	525,343,967	532,801,144	567,808,369	575,892,516
Rebates	(93,130,160)	(69,641,941)	(29,386,434)	(37,921,448)	(23,335,020)	(33,756,553)	(24,186,211)	(27,624,160)	(25,074,597)	(28,521,582)	(25,989,500)
Calendar Year Adjustments			4,259,545	(10,817,063)	12,155,834	(11,158,568)	13,136,856	(13,004,731)	13,460,008	(14,055,935)	14,548,727
Net Pharmacy Claims	628,032,853	682,777,709	431,284,485	365,889,254	480,239,351	403,151,475	520,023,278	484,715,076	521,186,555	525,230,852	564,451,743
MA-PDP Claims Reduction			-	(116,068,145)	(141,087,642)	(153,843,588)	(154,610,892)	(168,589,496)	(169,430,346)	(184,748,799)	(185,670,245)
EGWP+Wrap Reduction in Rebates		-	834,594	842,398	-	-	-	-	-	-	-
EGWP+Wrap Claim Increase		-	238,622	-	-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips		-	380,804	686,435	813,565	741,794	879,214	869,730	882,076	940,032	953,416
HB 675 - Pharmacy Audit Changes				100,000	104,614	95,386	113,056	111,837	113,424	120,876	122,597
Specialty Pharmacy Tier				(188,549)	(265,765)	(258,094)	(305,906)	(321,717)	(326,283)	(370,363)	(375,637)
Total Pharmacy Claims	628,032,853	682,777,709	432,738,506	251,261,393	339,804,124	249,886,974	366,098,750	316,785,430	352,425,425	341,172,598	379,481,875
Total Claims	2,454,808,343	2,517,406,200	1,460,278,726	1,367,516,917	1,393,842,873	1,446,190,002	1,525,446,144	1,615,925,931	1,609,605,189	1,735,367,224	1,728,093,407
Administrative Costs	165,480,561	161,401,639	83,826,787	91,261,895	88,664,163	88,487,385	91,322,160	91,143,934	93,697,029	93,518,151	96,141,860
ACA Reinsurance Fee				-	-	34,632,846	-	21,039,454	-	14,201,632	-
Extra EGWP+Wrap Administration	-	-	2,904,645	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,547,010,159	1,458,778,811	1,482,507,036	1,569,310,234	1,616,768,304	1,728,109,320	1,703,302,218	1,843,087,006	1,824,235,268
Plan Income (Loss)	232,391,259	281,240,475	(59,545,076)	32,707,266	(12,658,963)	(52,944,157)	(117,252,665)	(78,410,990)	(57,457,313)	(70,532,153)	(55,682,438)
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	723,942,870	756,650,136	743,991,173	691,047,016	573,794,351	495,383,360	437,926,048	367,393,895
Ending Cash Balance (Deficit)	502,247,471	783,487,946	723,942,870	756,650,136	743,991,173	691,047,016	573,794,351	495,383,360	437,926,048	367,393,895	311,711,457
Target Stabilization Reserve	184,110,626	201,392,496	116,822,298	240,362,630	234,715,582	255,602,959	267,447,253	282,723,487	290,297,801	301,047,517	311,711,457
	7.5%	8.0%	8.0%	8.5%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
Premium Increase:	7/1 Increase 5.3%	7/1 Increase 5.3%		1/1 Increase 3.57%		1/1 Increase 2.14%		1/1 Increase 7.72%		1/1 Increase 7.72%	

Short Plan Year Q2 Update

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North Carolina State Health Plan
Financial Projections - Dec 2013
Trends - 8.5% Medical & Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2012 - 2013 Biennium								
	Actual FY 2012	Actual FY 2013	Actual Short Plan Year Jul-Dec 2013	Projection Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019
PLAN INCOME:									
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	2,970,543,666	3,051,421,272	3,208,031,812	3,372,966,690	3,824,203,625	4,336,181,113
EGWP/PDP Spouse Premium Reduction		-	-	(28,758,859)	(29,046,448)	(29,336,913)	(29,630,282)	(29,926,584)	(30,225,850)
MA Spouse Premium Reduction				(11,584,206)	(11,700,048)	(11,817,049)	(11,935,219)	(12,054,571)	(12,175,117)
MA Buy-up Premium				22,174,902	30,658,726	40,019,308	50,341,322	50,844,735	51,353,182
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(1,485,272)	(1,525,711)	(1,604,016)	(1,686,483)	(1,912,102)	(2,168,091)
Premium Incentive			-	(30,069,702)	(28,000,094)	37,232,486	36,860,749	53,391,313	55,247,217
CDHP Premium Reduction			-	(6,988,511)	(9,406,300)	(11,779,904)	(14,110,059)	(14,083,447)	(14,057,443)
Medicare Part D	57,583,602	38,056,016	(1,323,888)	11,777,523	6,332,844	6,617,822	6,915,624	7,226,827	7,552,035
EGWP+Wrap									
Direct Subsidy	-	24,435,483	25,202,822	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,765	24,177,036	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	31,734,272	-	-	-	-
Total	-	24,435,483	37,082,587	24,177,036	31,734,272	-	-	-	-
Appropriations from State Reserve									
Investment Earnings	3,015,815	3,236,713	1,841,087	3,321,318	3,217,073	2,472,854	1,579,006	949,878	1,134,624
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	2,953,107,894	3,043,685,587	3,239,836,402	3,411,301,348	3,878,639,674	4,392,841,669
PLAN EXPENSE:									
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	2,083,673,638	2,261,596,481	2,440,333,727	2,631,827,805	2,897,278,791	3,072,605,012
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(24,973,844)	(26,929,550)	(29,144,515)	(31,223,916)	(33,784,572)	(36,623,068)
Dental & MHSA Enhancement			-	6,514,633	7,070,911	7,629,735	8,228,444	9,058,380	9,606,540
Medicare Advantage Claims Reduction				(112,463,601)	(132,498,969)	(145,198,995)	(159,116,318)	(174,367,618)	(191,080,754)
Calendar Year Adjustments		-	-	9,810,071	4,202,852	2,413,200	2,618,322	2,840,879	3,082,354
Preventative at 100%				22,773,966	29,585,221	49,841,453	55,369,746	60,984,799	64,519,766
Premium Incentive				(19,576,815)	(22,464,351)	(24,693,344)	(39,441,246)	(41,875,309)	(44,809,245)
CDHP Claims Reduction				(6,536,570)	(11,217,934)	(17,432,379)	(25,312,620)	(28,054,532)	(30,750,194)
Limited Network Savings				755,079	759,503	1,192,777	1,139,976	980,250	803,548
PCP Copay Waiver				10,761,897	(794,450)	(7,830,362)	(33,815,869)	(49,197,620)	(66,311,558)
Essential Health Benefits/MH Parity				3,310,240	4,268,927	4,631,786	5,025,488	5,532,368	5,867,154
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,974,048,693	2,113,578,641	2,281,743,083	2,415,299,812	2,649,395,817	2,786,909,556
Medicare Advantage Premiums			-	176,055,285	220,532,743	269,549,392	323,543,071	372,120,793	425,530,349
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	934,478,295	974,347,743	1,052,930,005	1,138,023,343	1,230,098,785	1,329,738,481
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(60,868,702)	(57,539,179)	(52,278,672)	(54,073,772)	(52,947,389)	(54,894,471)
Calendar Year Adjustments			-	1,940,054	1,968,345	452,762	490,050	530,460	574,256
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	875,549,647	918,776,908	1,001,104,094	1,084,439,621	1,177,681,856	1,275,418,266
MA-PDP Claims Reduction			-	(256,316,210)	(307,306,809)	(336,762,167)	(369,040,821)	(404,413,383)	(443,176,406)
EGWP+Wrap Reduction in Rebates		-	-	839,332	-	-	-	-	-
EGWP+Wrap Claim Increase		-	-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips		-	-	1,500,000	1,563,997	1,690,136	1,826,725	1,974,522	2,134,461
HB 675 - Pharmacy Audit Changes				204,615	208,438	225,248	243,452	263,149	284,465
Specialty Pharmacy Tier				(227,226)	(292,000)	(336,000)	(386,000)	(417,231)	(451,027)
Total Pharmacy Claims	628,032,853	682,777,709	393,069,298	621,550,158	612,950,534	665,921,311	717,082,978	775,088,914	834,209,759
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,771,654,136	2,947,061,919	3,217,213,786	3,455,925,861	3,796,605,524	4,046,649,664
Administrative Costs	165,480,561	161,401,639	69,548,737	188,437,262	179,809,574	184,837,642	189,649,805	192,119,934	192,119,934
ACA Reinsurance Fee				-	34,632,846	21,039,454	14,201,632	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,960,091,398	3,161,504,339	3,423,090,882	3,659,777,298	3,988,725,458	4,238,769,598
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	(6,983,504)	(117,818,752)	(183,254,480)	(248,475,950)	(110,085,784)	154,072,071
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	831,463,633	713,644,881	530,390,401	281,914,451	171,828,667
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	831,463,633	713,644,881	530,390,401	281,914,451	171,828,667	325,900,738
Target Stabilization Reserve	184,110,626	201,392,496	113,231,386	220,625,902	245,387,626	265,289,795	281,914,451	308,203,626	325,900,738
	7.5%	8.0%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase		1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	5.3%	5.3%		3.57%	2.14%	5.55%	5.55%	13.81%	13.81%

Short Plan Year Q2 Update

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North Carolina State Health Plan
Financial Projections - Dec 2013
Trends - 8.5% Medical & Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2010-2011 Biennium		2012 - 2013 Biennium		2014 - 2015 Biennium		2016 - 2017 Biennium		2018 - 2019 Biennium	
	Actual FY 2010	Actual FY 2011	Actual FY 2012	Actual FY 2013	Projection FY 2014	Projection FY2015	Projection FY2016	Projection FY2017	Projection FY2018	Projection FY2019
PLAN INCOME:										
Net Contribution Income	2,413,877,944	2,684,814,172	2,750,368,851	2,895,366,140	2,974,875,415	3,025,476,833	3,129,770,621	3,290,543,712	3,598,759,274	4,080,384,112
EGWP/PDP Spouse Premium Reduction				-	(14,343,660)	(28,902,296)	(29,191,319)	(29,483,232)	(29,778,065)	(30,075,845)
MA Spouse Premium Reduction					(5,777,695)	(11,641,983)	(11,758,403)	(11,875,987)	(11,994,747)	(12,114,694)
MA Buy-up Premium					11,059,870	26,406,262	35,327,375	45,167,477	50,592,402	51,098,326
Health care Reform ERRP	-	45,298,812	42,163,391	(558,219)	-	-	-	-	-	-
Retro Disenrollments	(1,310,146)	(1,281,584)	(451,496)	(487,819)	(1,013,687)	(1,512,738)	(1,564,885)	(1,645,272)	(1,799,380)	(2,040,192)
Premium Incentive					(15,050,145)	(29,033,551)	4,648,296	37,046,043	45,133,340	54,319,532
CDHP Premium Reduction					(3,497,810)	(8,198,537)	(10,594,160)	(12,945,967)	(14,096,677)	(14,070,368)
Medicare Part D	74,357,704	66,276,535	57,583,602	38,056,016	7,673,821	6,207,753	6,487,102	6,779,021	7,084,077	7,402,861
EGWP+Wrap										
Direct Subsidy	-	-	-	24,435,483	25,202,822	-	-	-	-	-
Coverage Gap Subsidy	-	-	-	-	36,056,800	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	-	31,734,272	-	-	-	-
Total	-	-	-	24,435,483	61,259,622	31,734,272	-	-	-	-
Appropriations from State Reserve										
Investment Earnings	3,532,448	2,861,085	3,015,815	3,236,713	3,458,328	3,374,214	2,870,577	2,060,786	1,170,721	942,963
Total Plan Income	2,490,457,950	2,797,969,020	2,852,680,163	2,960,048,314	3,018,644,061	3,013,910,229	3,125,995,203	3,325,646,582	3,645,070,948	4,135,846,695
PLAN EXPENSE:										
Medical Claims Payment	1,829,432,245	1,852,549,690	1,849,410,105	1,858,096,405	2,111,136,595	2,170,606,720	2,355,942,280	2,539,384,035	2,744,609,210	2,957,011,522
Claim Refunds	(31,916,831)	(24,723,681)	(22,634,615)	(23,467,914)	(23,311,025)	(25,683,840)	(28,087,779)	(30,064,154)	(32,703,421)	(35,022,891)
Dental & MHSA Enhancement					3,370,316	6,786,430	7,365,884	7,939,418	8,581,057	9,245,135
Medicare Advantage Claims Reduction					(51,858,331)	(126,689,953)	(138,833,186)	(152,140,346)	(166,722,999)	(182,703,398)
Calendar Year Adjustments				-	(4,229,258)	(380,241)	830,294	900,869	977,443	1,060,525
Preventative at 100%					9,478,438	28,342,109	39,151,144	53,420,904	57,681,930	62,081,319
Premium Incentive					(7,838,711)	(22,981,509)	(23,579,701)	(32,074,091)	(40,658,993)	(43,343,166)
CDHP Claims Reduction					(2,617,294)	(9,533,851)	(14,328,079)	(21,376,086)	(26,684,587)	(29,403,292)
Limited Network Savings					302,340	832,871	976,344	1,166,339	1,060,026	891,808
PCP Copay Waiver					4,309,148	6,055,127	(4,315,840)	(20,835,470)	(41,513,579)	(57,761,881)
Essential Health Benefits/MH Parity					1,411,238	4,097,858	4,460,159	4,835,394	5,240,844	5,646,428
Net Medical Claims	1,797,515,414	1,827,826,009	1,826,775,490	1,834,628,491	2,040,153,456	2,031,451,720	2,199,581,522	2,351,156,809	2,509,866,931	2,687,702,109
Medicare Advantage Premiums					87,808,667	198,238,694	244,980,101	296,479,075	347,771,512	398,759,141
Pharmacy Claims Payment	N/A	N/A	721,163,013	752,419,650	870,709,119	934,905,342	1,051,228,929	1,095,165,283	1,183,723,074	1,279,551,736
Rebates	N/A	N/A	(93,130,160)	(69,641,941)	(69,918,142)	(56,695,982)	(51,398,622)	(53,167,573)	(52,001,558)	(53,911,531)
Calendar Year Adjustments					(10,156,576)	992,565	131,662	(592,770)	(641,245)	(693,747)
Net Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	790,634,401	879,201,925	999,961,970	1,041,404,939	1,131,080,272	1,224,946,458
MA-PDP Claims Reduction					(115,753,515)	(293,833,875)	(321,997,852)	(352,861,346)	(386,683,106)	(423,746,682)
EGWP+Wrap Reduction in Rebates				-	839,332	-	-	-	-	-
EGWP+Wrap Claim Increase				-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips				-	715,027	1,500,685	1,687,405	1,757,931	1,900,081	2,053,903
HB 675 - Pharmacy Audit Changes					100,000	200,000	224,885	234,284	253,228	273,729
Specialty Pharmacy Tier					(94,304)	(266,546)	(325,193)	(360,820)	(401,501)	(434,004)
Total Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	676,440,941	586,802,189	679,551,215	690,174,988	746,148,975	803,093,403
Total Claims	2,394,225,189	2,483,694,744	2,454,808,343	2,517,406,200	2,804,403,064	2,816,492,603	3,124,112,838	3,337,810,872	3,603,787,417	3,889,554,653
Administrative Costs	164,649,780	165,902,094	165,480,561	161,401,639	169,321,052	177,151,548	182,466,094	187,208,490	192,195,802	192,119,934
ACA Reinsurance Fee					-	34,632,846	21,039,454	14,201,632	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,558,874,969	2,649,596,838	2,620,288,904	2,678,807,839	2,973,724,116	3,028,276,997	3,327,618,386	3,539,220,994	3,795,983,219	4,081,674,587
Plan Income (Loss)	(68,417,019)	148,372,182	232,391,259	281,240,475	44,919,945	(14,366,769)	(201,623,183)	(213,574,412)	(150,912,271)	54,172,108
Beginning Cash Balance (Deficit)	189,901,049	121,484,030	269,856,212	502,247,471	783,487,946	828,407,891	814,041,122	612,417,939	398,843,527	247,931,256
Ending Cash Balance (Deficit)	121,484,030	269,856,212	502,247,471	783,487,946	828,407,891	814,041,122	612,417,939	398,843,527	247,931,256	302,103,363
Target Stabilization Reserve	179,566,889	186,277,106	184,110,626	201,392,496	230,910,524	235,642,852	259,121,946	273,719,862	293,041,432	314,171,596
			7.5%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase	7/1 Increase	7/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	8.9%	8.9%	5.3%	5.3%	3.57%	2.14%	5.55%	5.55%	13.81%	13.81%

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North Carolina State Health Plan
Financial Projections - Mar 2014
Trends - 8.5% Medical & Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2012 - 2013 Biennium								
	Actual FY 2012	Actual FY 2013	Actual Short Plan Year Jul-Dec 2013	Projection Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019
PLAN INCOME:									
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	3,028,890,369	3,128,803,824	3,481,139,560	3,605,236,066	4,275,034,734	4,865,853,386
EGWP/PDP Spouse Premium Reduction		-	-	-	-	-	-	-	-
MA Spouse Premium Reduction				-	-	-	-	-	-
MA Buy-up Premium				-	-	-	-	-	-
Medicare Advantae Subsidy				152,149	-	-	-	-	-
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(1,147,610)	(1,564,402)	(1,740,570)	(1,802,618)	(2,137,517)	(2,432,927)
Wellness Credit			-	(86,126,636)	(115,224,546)	(336,693,892)	(333,629,435)	(486,724,546)	(486,445,952)
Premium Reduction due to Movement			-	-	(9,808,137)	(4,684,389)	(7,458,634)	(10,854,215)	(13,682,766)
Medicare Part D	57,583,602	38,056,016	(1,323,888)	14,528,165	6,332,844	6,617,822	6,915,624	7,226,827	7,552,035
EGWP+Wrap									
Direct Subsidy	-	24,435,483	25,202,822	572,152	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,765	23,747,921	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	31,734,272	-	-	-	-
Total	-	24,435,483	37,082,587	24,320,074	31,734,272	-	-	-	-
Investment Earnings	3,015,815	3,236,713	1,841,087	4,013,866	3,918,968	3,125,545	1,868,283	947,440	1,121,086
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	2,984,630,376	3,044,192,823	3,147,764,077	3,271,129,287	3,783,492,723	4,371,964,862
PLAN EXPENSE:									
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	1,998,101,810	2,237,889,787	2,414,753,829	2,604,241,245	2,866,910,701	3,040,400,426
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(23,670,288)	(26,647,267)	(28,839,018)	(30,896,629)	(33,430,454)	(36,239,211)
Dental & MHSA Enhancement			-	4,999,489	7,296,440	7,873,090	8,490,897	9,347,307	9,912,955
Medicare Advantage Claims Reduction				(78,444,877)	(115,388,404)	(126,448,382)	(138,568,460)	(151,850,247)	(166,405,093)
Calendar Year Adjustments		-	-	(4,650,956)	4,202,852	2,413,200	2,618,322	2,840,879	3,082,354
Preventative at 100% in Standard Plan				20,115,500	29,499,993	49,702,868	55,224,139	60,822,061	64,365,360
Wellness Comply Savings				(2,518,767)	(8,952,914)	(24,669,613)	(43,903,034)	(47,586,599)	(51,953,092)
Claims Reduction due to Movement				(22,567,495)	(30,328,293)	(14,443,883)	(19,442,907)	(28,102,594)	(36,731,934)
Limited Network Savings				705,306	924,795	1,517,412	1,396,118	1,252,501	1,076,509
PCP Copay Waiver				7,958,584	270,005	(10,422,866)	(32,068,571)	(55,361,216)	(80,571,041)
Essential Health Benefits/MH Parity				3,019,428	4,268,927	4,631,786	5,025,488	5,532,369	5,867,158
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,903,047,735	2,103,035,923	2,276,068,423	2,412,116,608	2,630,374,708	2,752,804,391
Medicare Advantage Premiums			-	158,450,497	193,034,335	232,276,427	275,487,271	316,071,947	360,688,456
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	845,130,445	937,199,494	1,012,785,871	1,094,635,194	1,183,200,557	1,279,041,944
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(95,427,102)	(58,014,645)	(52,771,544)	(54,584,611)	(53,476,984)	(55,443,564)
Calendar Year Adjustments				6,343,463	1,893,300	435,501	471,369	510,239	552,367
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	756,046,806	881,078,150	960,449,828	1,040,521,953	1,130,233,812	1,224,150,747
MA-PDP Claims Reduction			-	(170,590,776)	(251,548,637)	(275,659,573)	(302,081,544)	(331,036,060)	(362,765,866)
EGWP+Wrap Reduction in Rebates		-	-	-	-	-	-	-	-
EGWP+Wrap Claim Increase		-	-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips		-	-	1,193,853	1,663,411	1,797,567	1,942,839	2,100,032	2,270,138
HB 675 - Pharmacy Audit Changes				158,587	208,438	225,249	243,452	263,150	284,465
Specialty Pharmacy Tier				(202,159)	(292,000)	(336,000)	(386,000)	(417,231)	(451,027)
Total Pharmacy Claims	628,032,853	682,777,709	393,069,298	586,606,311	631,109,362	686,477,071	740,240,701	801,143,703	863,488,457
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,648,104,543	2,927,179,620	3,194,821,920	3,427,844,580	3,747,590,358	3,976,981,304
Administrative Costs	165,480,561	161,401,639	69,548,737	180,329,844	179,809,572	184,837,659	189,649,870	194,604,037	194,527,688
ACA Reinsurance Fee				-	34,632,846	21,039,454	14,201,632	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,828,434,388	3,141,622,038	3,400,699,034	3,631,696,082	3,942,194,395	4,171,508,992
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	156,195,988	(97,429,216)	(252,934,957)	(360,566,794)	(158,701,671)	200,455,870
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	994,643,125	897,213,909	644,278,952	283,712,158	125,010,486
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	994,643,125	897,213,909	644,278,952	283,712,158	125,010,486	325,466,356
Target Stabilization Reserve	184,110,626	201,392,496	113,231,386	211,620,594	246,073,076	266,629,094	283,712,158	308,836,657	325,466,356
	7.5%	8.0%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase		1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	5.3%	5.3%		3.57%	2.14%	4.47%	4.47%	16.11%	16.11%

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Segal Consulting

North Carolina State Health Plan
Financial Projections - Mar 2014
Trends - 8.5% Medical & Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2010-2011 Biennium		2012 - 2013 Biennium		2014 - 2015 Biennium		2016 - 2017 Biennium		2018 - 2019 Biennium	
	Actual FY 2010	Actual FY 2011	Actual FY 2012	Actual FY 2013	Projection FY 2014	Projection FY2015	Projection FY2016	Projection FY2017	Projection FY2018	Projection FY2019
PLAN INCOME:										
Net Contribution Income	2,413,877,944	2,684,814,172	2,750,368,851	2,895,366,140	2,994,394,148	3,103,079,247	3,305,254,358	3,543,210,326	3,940,507,313	4,570,671,983
EGWP/PDP Spouse Premium Reduction				-	-	-	-	-	-	-
MA Spouse Premium Reduction					-	-	-	-	-	-
MA Buy-up Premium					-	-	-	-	-	-
Medicare Advantae Subsidy					152,149	-	-	-	-	-
Health care Reform ERRP	-	45,298,812	42,163,391	(558,219)	-	-	-	-	-	-
Retro Disenrollments	(1,310,146)	(1,281,584)	(451,496)	(487,819)	(656,611)	(1,551,540)	(1,652,627)	(1,771,605)	(1,970,254)	(2,285,336)
Wellness Credit					(28,759,106)	(115,080,257)	(226,204,540)	(335,157,115)	(410,339,598)	(486,584,965)
Premium Reduction due to Movement					-	(4,919,289)	(7,237,917)	(6,074,468)	(9,158,848)	(12,271,619)
Medicare Part D	74,357,704	66,276,535	57,583,602	38,056,016	10,355,829	6,276,386	6,487,102	6,779,021	7,084,077	7,402,861
EGWP+Wrap										
Direct Subsidy	-	-	-	24,435,483	25,774,974	-	-	-	-	-
Coverage Gap Subsidy	-	-	-	-	35,627,686	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	-	31,734,272	-	-	-	-
Total	-	-	-	24,435,483	61,402,661	31,734,272	-	-	-	-
Investment Earnings	3,532,448	2,861,085	3,015,815	3,236,713	3,839,168	4,026,509	3,592,708	2,552,944	1,282,719	887,099
Total Plan Income	2,490,457,950	2,797,969,020	2,852,680,163	2,960,048,314	3,040,728,238	3,023,565,328	3,080,239,084	3,209,539,103	3,527,405,410	4,077,820,022
PLAN EXPENSE:										
Medical Claims Payment	1,829,432,245	1,852,549,690	1,849,410,105	1,858,096,405	2,036,106,807	2,147,853,708	2,331,246,792	2,512,766,161	2,715,840,904	2,926,017,901
Claim Refunds	(31,916,831)	(24,723,681)	(22,634,615)	(23,467,914)	(22,138,601)	(25,414,481)	(27,793,356)	(29,749,020)	(32,360,630)	(34,655,800)
Dental & MHSA Enhancement					1,754,883	7,002,886	7,600,823	8,192,650	8,854,757	9,540,021
Medicare Advantage Claims Reduction					(25,666,010)	(110,329,549)	(120,904,637)	(132,493,346)	(145,192,833)	(159,109,567)
Calendar Year Adjustments				-	(18,690,285)	(380,241)	830,294	900,869	977,443	1,060,525
Preventative at 100% in Standard Plan					6,854,749	28,259,422	39,036,399	53,276,346	57,532,424	61,929,190
Wellness Comply Savings					(828,478)	(6,107,341)	(16,704,734)	(34,154,969)	(45,720,880)	(49,740,728)
Claims Reduction due to Movement					(7,525,283)	(30,174,831)	(22,157,948)	(16,836,015)	(23,653,924)	(32,262,373)
Limited Network Savings					237,351	936,304	1,228,691	1,460,151	1,328,348	1,169,261
PCP Copay Waiver					2,631,058	5,519,195	(4,975,565)	(21,046,701)	(43,500,701)	(67,734,584)
Essential Health Benefits/MH Parity					1,059,857	4,158,427	4,460,159	4,835,394	5,240,845	5,646,430
Net Medical Claims	1,797,515,414	1,827,826,009	1,826,775,490	1,834,628,491	1,973,796,047	2,021,323,499	2,191,866,918	2,347,151,519	2,499,345,752	2,661,860,276
Medicare Advantage Premiums					79,548,716	175,178,855	212,606,572	253,828,104	295,729,130	338,324,708
Pharmacy Claims Payment	N/A	N/A	721,163,013	752,419,650	800,006,086	899,260,836	1,011,149,558	1,053,411,000	1,138,592,756	1,230,768,323
Rebates	N/A	N/A	(93,130,160)	(69,641,941)	(92,245,116)	(69,163,011)	(51,882,687)	(53,669,341)	(52,521,684)	(54,450,781)
Calendar Year Adjustments					(5,291,967)	954,722	126,642	(570,171)	(616,799)	(667,300)
Net Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	702,469,003	831,052,546	959,393,513	999,171,487	1,085,454,274	1,175,650,242
MA-PDP Claims Reduction					(55,531,971)	(240,520,250)	(263,574,116)	(288,837,695)	(316,522,788)	(346,861,498)
EGWP+Wrap Reduction in Rebates				-	-	-	-	-	-	-
EGWP+Wrap Claim Increase				-	-	-	-	-	-	-
Expand Coverage of Diabetic Test Strips				-	358,984	1,596,075	1,794,663	1,869,672	2,020,859	2,184,459
HB 675 - Pharmacy Audit Changes					53,972	200,000	224,885	234,284	253,229	273,729
Specialty Pharmacy Tier					(60,788)	(274,995)	(325,193)	(360,820)	(401,501)	(434,004)
Total Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	647,289,201	592,053,375	697,513,751	712,076,928	770,804,072	830,812,927
Total Claims	2,394,225,189	2,483,694,744	2,454,808,343	2,517,406,200	2,700,633,964	2,788,555,728	3,101,987,242	3,313,056,551	3,565,878,954	3,830,997,912
Administrative Costs	164,649,780	165,902,094	165,480,561	161,401,639	161,213,637	177,151,548	182,466,094	187,208,529	192,090,617	197,116,970
ACA Reinsurance Fee					-	34,632,846	21,039,454	14,201,632	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,558,874,969	2,649,596,838	2,620,288,904	2,678,807,839	2,861,847,600	3,000,340,123	3,305,492,790	3,514,466,711	3,757,969,570	4,028,114,882
Plan Income (Loss)	(68,417,019)	148,372,182	232,391,259	281,240,475	178,880,637	23,225,205	(225,253,707)	(304,927,609)	(230,564,161)	49,705,141
Beginning Cash Balance (Deficit)	189,901,049	121,484,030	269,856,212	502,247,471	783,487,946	962,368,583	985,593,789	760,340,082	455,412,473	224,848,313
Ending Cash Balance (Deficit)	121,484,030	269,856,212	502,247,471	783,487,946	962,368,583	985,593,789	760,340,082	455,412,473	224,848,313	274,553,453
Target Stabilization Reserve	179,566,889	186,277,106	184,110,626	201,392,496	222,792,246	235,203,919	260,044,260	275,330,560	294,313,484	314,340,588
			7.5%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase	7/1 Increase	7/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	8.9%	8.9%	5.3%	5.3%	3.57%	2.14%	4.47%	4.47%	16.11%	16.11%

Segal Consulting

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North Carolina State Health Plan
Financial Projections - Jun 2014
Trends - 7.0% Medical & 8.5% Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2012 - 2013 Biennium								
	Actual FY 2012	Actual FY 2013	Actual Short Plan Year Jul-Dec 2013	Projection Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019
PLAN INCOME:									
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	2,918,674,381	2,951,410,895	3,043,513,806	3,138,757,776	3,555,599,708	4,028,147,898
Additional Contribution/(Credit)		-	-	(9,273,308)	(18,200,330)	7,540,905	7,708,496	22,956,365	23,188,935
Medicare Advantae Subsidy				417,565	-	-	-	-	-
Health care Reform ERRP	42,163,391	(558,219)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(762,462)	(1,475,705)	(1,521,757)	(1,569,379)	(1,777,800)	(2,014,074)
Premium Change due to Movement			-	-	(2,069,875)	3,562,316	757,514	1,088,179	1,393,967
Medicare Part D	57,583,602	38,056,016	(1,323,888)	15,755,988	6,332,844	6,617,822	6,915,624	7,226,827	7,552,035
EGWP+Wrap									
Direct Subsidy	-	24,435,483	25,202,822	216,170	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,765	28,162,232	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	31,734,272	-	-	-	-
Total	-	24,435,483	37,082,587	28,378,402	31,734,272	-	-	-	-
Investment Earnings	3,015,815	3,236,713	1,841,087	4,037,042	3,795,447	2,968,598	1,760,825	919,811	1,067,149
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	2,957,227,608	2,971,527,548	3,062,681,690	3,154,330,856	3,586,013,091	4,059,335,910
PLAN EXPENSE:									
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	1,923,771,653	2,043,049,477	2,168,271,136	2,306,114,623	2,498,646,651	2,610,832,157
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(23,379,887)	(24,429,422)	(25,933,873)	(27,414,731)	(29,146,209)	(31,193,353)
Claims Adjustment for Changes				12,361,978	(533,548)	54,626,340	13,499,983	(12,249,983)	(43,217,635)
Cost of Autism				-	4,000,000	5,000,000	5,200,000	5,500,000	5,778,219
Cost of Add Towns				-	894,905	956,522	996,952	1,055,371	1,052,756
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,912,753,744	2,022,981,411	2,202,920,124	2,298,396,827	2,463,805,830	2,543,252,144
Medicare Advantage Premiums				157,598,589	168,862,661	181,496,934	194,973,718	209,526,378	225,241,621
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	679,332,594	714,742,901	769,323,996	829,338,691	894,087,930	963,950,031
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(99,777,740)	(58,107,239)	(52,742,044)	(54,414,583)	(56,160,834)	(57,969,685)
Claims Adjustment for Changes			-	-	-	-	-	-	-
Additional ACA Preventive Medicine			-	-	692,000	1,276,000	1,366,000	1,462,000	1,511,248
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	579,554,855	657,327,662	717,857,952	776,290,108	839,389,096	907,491,593
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,649,907,187	2,849,171,734	3,102,275,010	3,269,660,653	3,512,721,304	3,675,985,358
Administrative Costs	165,480,561	161,401,639	69,548,737	173,657,606	192,801,628	198,192,837	203,352,385	208,664,127	214,133,099
ACA Reinsurance Fee				-	34,019,697	20,569,718	13,884,560	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,823,564,794	3,075,993,058	3,321,037,565	3,486,897,598	3,721,385,432	3,890,118,457
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	133,662,815	(104,465,510)	(258,355,875)	(332,566,741)	(135,372,341)	169,217,453
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	972,109,951	867,644,441	609,288,566	276,721,824	141,349,483
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	972,109,951	867,644,441	609,288,566	276,721,824	141,349,483	310,566,936
Target Stabilization Reserve	184,110,626	201,392,496	113,231,386	211,846,231	241,227,817	262,870,027	276,721,824	297,287,543	310,566,936
	7.5%	8.0%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase		1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	5.3%	5.3%		3.57%	0.00%	3.53%	3.53%	13.71%	13.71%

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Segal Consulting

North Carolina State Health Plan
Financial Projections - Jun 2014
Trends - 7.0% Medical & 8.5% Pharmacy
Board Approved Wellness Incentives - Active 70/30 Unchanged thru 2015 only, Retirees 70/30 Unchanged
With MA & PDP, With Essential Health Benefits & MH Parity
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2010-2011 Biennium		2012 - 2013 Biennium		2014 - 2015 Biennium		2016 - 2017 Biennium		2018 - 2019 Biennium	
	Actual FY 2010	Actual FY 2011	Actual FY 2012	Actual FY 2013	Projection FY 2014	Projection FY2015	Projection FY2016	Projection FY2017	Projection FY2018	Projection FY2019
PLAN INCOME:										
Net Contribution Income	2,413,877,944	2,684,814,172	2,750,368,851	2,895,366,140	2,941,097,678	2,957,330,894	2,997,476,025	3,091,148,757	3,347,339,381	3,792,050,539
Additional Contribution/(Credit)				-	-	(18,389,215)	(5,299,800)	7,624,855	15,349,640	23,072,825
Medicare Advantae Subsidy					417,565	-	-	-	-	-
Health care Reform ERRP	-	45,298,812	42,163,391	(558,219)	-	-	-	-	-	-
Retro Disenrollments	(1,310,146)	(1,281,584)	(451,496)	(487,819)	(299,923)	(1,478,665)	(1,498,738)	(1,545,574)	(1,673,670)	(1,896,025)
0					-	-	-	-	-	-
Premium Change due to Movement					-	(1,034,938)	746,221	2,159,915	922,847	1,241,073
Medicare Part D	74,357,704	66,276,535	57,583,602	38,056,016	11,583,652	6,276,386	6,487,102	6,779,021	7,084,077	7,402,861
EGWP+Wrap										
Direct Subsidy	-	-	-	24,435,483	25,216,663	202,329	-	-	-	-
Coverage Gap Subsidy	-	-	-	-	38,563,909	1,478,088	-	-	-	-
Catastrophic Subsidy	-	-	-	-	-	31,734,272	-	-	-	-
Total	-	-	-	24,435,483	63,780,571	33,414,689	-	-	-	-
Investment Earnings	3,532,448	2,861,085	3,015,815	3,236,713	3,916,235	3,933,340	3,456,019	2,406,449	1,221,707	870,198
Total Plan Income	2,490,457,950	2,797,969,020	2,852,680,163	2,960,048,314	3,020,495,778	2,980,052,493	3,001,366,829	3,108,573,423	3,370,243,983	3,822,741,471
PLAN EXPENSE:										
Medical Claims Payment	1,829,432,245	1,852,549,690	1,849,410,105	1,858,096,405	1,989,574,333	1,981,132,627	2,104,367,930	2,236,473,423	2,378,323,219	2,527,382,130
Claim Refunds	(31,916,831)	(24,723,681)	(22,634,615)	(23,467,914)	(22,450,766)	(23,520,519)	(25,159,105)	(26,558,401)	(28,433,075)	(30,024,340)
Claims Adjustment for Changes					-	12,149,156	26,519,120	35,022,403	617,098	(27,583,637)
Cost of Autism						2,001,993	4,500,445	5,100,042	5,350,084	5,639,177
Cost of Add Towns						432,449	924,000	989,000	1,022,182	1,089,662
Net Medical Claims	1,797,515,414	1,827,826,009	1,826,775,490	1,834,628,491	1,967,123,567	1,972,195,706	2,111,152,391	2,251,026,467	2,356,879,507	2,476,502,992
Medicare Advantage Premiums					78,538,847	163,281,043	175,164,083	188,218,563	202,231,947	217,364,453
Pharmacy Claims Payment	N/A	N/A	721,163,013	752,419,650	743,281,462	686,597,084	769,269,941	798,947,229	861,298,346	928,570,652
Rebates	N/A	N/A	(93,130,160)	(69,641,941)	(91,653,105)	(74,166,940)	(51,914,121)	(53,570,874)	(55,279,945)	(57,057,201)
Claims Adjustment for Changes					-	-	-	-	-	-
Additional ACA Preventive Medicine						346,345	984,278	1,321,029	1,414,030	1,473,850
Net Pharmacy Claims	596,709,775	655,868,735	628,032,853	682,777,709	651,628,357	612,776,489	718,340,098	746,697,384	807,432,432	872,987,301
Total Claims	2,394,225,189	2,483,694,744	2,454,808,343	2,517,406,200	2,697,290,771	2,748,253,238	3,004,656,572	3,185,942,415	3,366,543,886	3,566,854,745
Administrative Costs	164,649,780	165,902,094	165,480,561	161,401,639	148,134,913	189,951,548	195,650,094	200,734,833	205,969,298	211,358,434
ACA Reinsurance Fee					-	34,019,697	20,569,718	13,884,560	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,558,874,969	2,649,596,838	2,620,288,904	2,678,807,839	2,845,425,684	2,972,224,483	3,220,876,384	3,400,561,808	3,572,513,183	3,778,213,179
Plan Income (Loss)	(68,417,019)	148,372,182	232,391,259	281,240,475	175,070,094	7,828,010	(219,509,556)	(291,988,384)	(202,269,200)	44,528,292
Beginning Cash Balance (Deficit)	189,901,049	121,484,030	269,856,212	502,247,471	783,487,946	958,558,040	966,386,050	746,876,494	454,888,110	252,618,909
Ending Cash Balance (Deficit)	121,484,030	269,856,212	502,247,471	783,487,946	958,558,040	966,386,050	746,876,494	454,888,110	252,618,909	297,147,201
Target Stabilization Reserve	179,566,889	186,277,106	184,110,626	201,392,496	222,593,914	232,647,498	254,654,324	269,795,147	284,788,074	301,454,126
			7.5%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%
	7/1 Increase	7/1 Increase	7/1 Increase	7/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	8.9%	8.9%	5.3%	5.3%	3.57%	0.00%	3.53%	3.53%	13.71%	13.71%

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

State Health Plan Member Costs

Board of Trustees Meeting

September 19, 2014

A Division of the Department of State Treasurer

Presentation Overview

- Member Premium Contributions
- Member Cost-Sharing
    - Medical Copays, Deductibles, and Coinsurance
    - Pharmacy Copays
- Summary
- 2016 Considerations

Employee/Retiree Premium Contributions

- In September 2011, a $21.62 employee/retiree contribution ($10 for Medicare primary subscribers) was added to the Standard 80/20 Plan and dependent premiums increased by 5.3%

- Premium increases since then:
  - 5.3% in July 2012
  - 3.6% in January 2014 (next increase no earlier than January 2016)

- Additional changes to member contributions effective January 2014
  - Consumer-Directed Health Plan (CDHP) with lower dependent premiums
  - Medicare Advantage-Prescription Drug Plans (MAPDPs) with lower dependent premiums and opportunity to buy-up to a richer MAPDP
  - Participation in wellness activities determines employee/retiree contribution in the 80/20 Plan
    - $40 added to the base monthly employee/retiree contribution with an opportunity to earn up to $50 in premium credits through participation in three wellness activities
  - Employee/retiree contribution for the CDHP is similar
    - $40 starting monthly premium with an opportunity to earn up to $40 in premium credits

Employee/Retiree Monthly Premiums: 2011 to 2015 Standard/Enhanced 80/20 Plan *(Non-Medicare Members)*

Full Participation in Wellness Activities in 2015

Coverage Tier	Sep 2011	Sep 2015	2011-2015 Change	2011-2015 % Change
Employee/Retiree Only	$21.62	$13.56	($8.06)	-37.3%
Employee/Retiree + Child(ren)	$271.80	$286.36	$14.56	5.4%
Employee/Retiree + Spouse	$598.04	$642.10	$44.06	7.4%
Employee/Retiree + Family	$632.74	$679.94	$47.20	7.5%

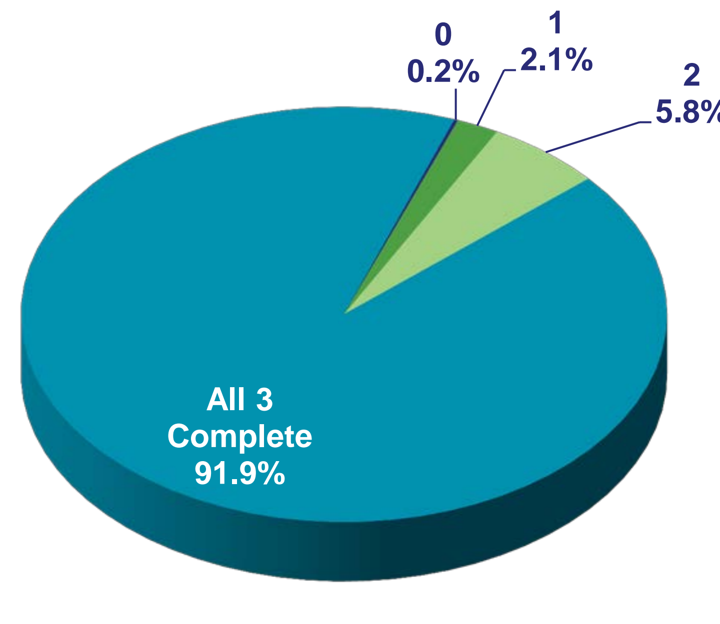
No Participation in Wellness Activities in 2015

Coverage Tier	Sep 2011	Sep 2015	2011-2015 Change	2011-2015 % Change
Employee/Retiree Only	$21.62	$63.56	$41.94	194.0%
Employee/Retiree + Child(ren)	$271.80	$336.36	$64.56	23.8%
Employee/Retiree + Spouse	$598.04	$692.10	$94.06	15.7%
Employee/Retiree + Family	$632.74	$729.94	$97.20	15.4%

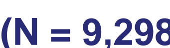
Strong Participation in 2014 Wellness Activities
Number of Wellness Activities Completed: April 2014

Enhanced 80/20 Plan

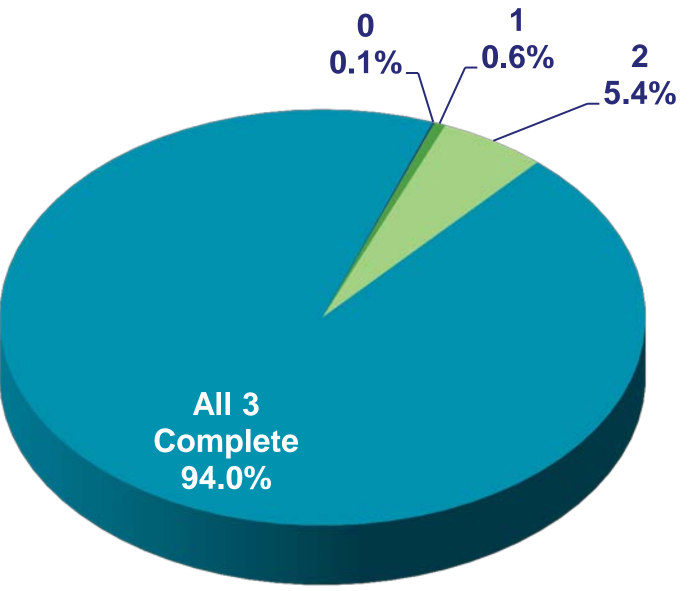
(N = 191,024)



Consumer-Directed Health Plan



(N = 9,298)



Source: BCBSNC

Employee/Retiree Monthly Premiums: 2011 to 2015 Basic/Traditional 70/30 Plan

Active Employees/Non-Medicare Retirees (No Medicare Primary Dependents)

Coverage Tier	Sep 2011	Sep 2015	2011-2015 Change	2011-2015 % Change
Employee/Retiree Only	$0.00	$0.00	$0.00	--
Employee/Retiree + Child(ren)	$188.12	$205.12	$17.00	9.0%
Employee/Retiree + Spouse	$484.70	$528.52	$43.82	9.0%
Employee/Retiree + Family	$516.26	$562.94	$46.68	9.0%

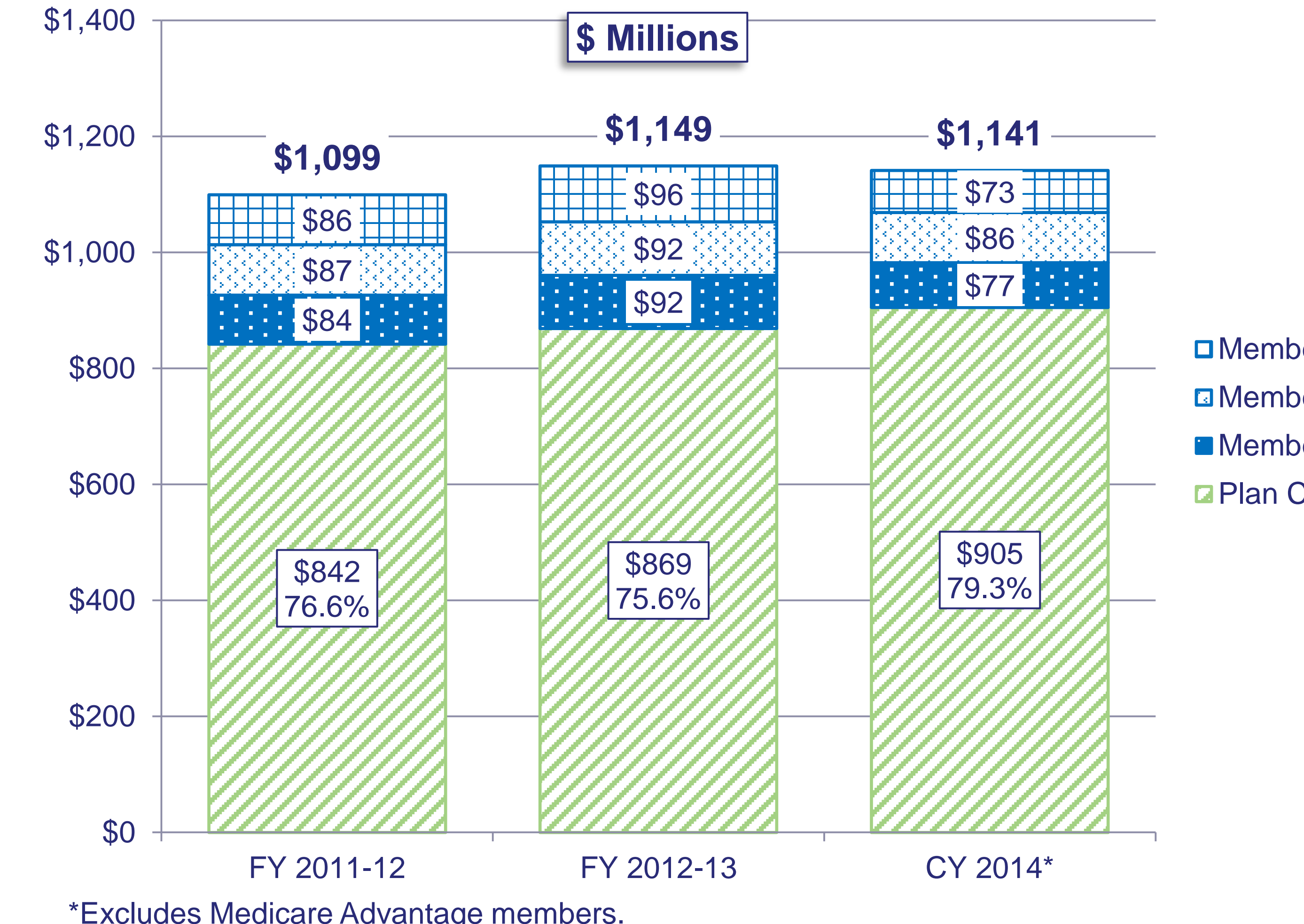
Medicare Retirees (with Medicare Primary Dependents)

Coverage Tier	Sep 2011	Sep 2015	2011-2015 Change	2011-2015 % Change
Employee/Retiree Only	$0.00	$0.00	$0.00	--
Employee/Retiree + Child(ren)	$133.84	$145.94	$12.10	9.0%
Employee/Retiree + Spouse	$351.90	$383.72	$31.82	9.0%
Employee/Retiree + Family	$383.44	$418.10	$34.66	9.0%

Member Cost-Sharing

- In 2011, member cost-sharing was increased. Some examples:
  - In-network deductibles increased from $800 to $933 in the 70/30 Plan and from $600 to $700 in the 80/20 Plan
  - Increased in-network urgent care copays from $75 to $87
  - Increased primary care copays by $5 ($30 to $35 in 70/30; $25 to $30 in 80/20)
  - Increased drug copays from $10 to $12 for generic drugs, $35 to $40 for preferred brand drugs, and $55 to $64 for non-preferred brand drugs
- Except for the addition of a 5th tier for specialty pharmacy copays in January 2014, member cost-sharing has not been increased since 2011
- Behavioral and Mental Health copays reduced as of July 1, 2013 to align with the copay for seeing a primary care provider
- Changes to member cost-sharing effective January 2014:
  - CDHP with 85% coinsurance and a Health Reimbursement Account (HRA) funded by the Plan
  - MAPDPs with lower copays and no deductibles
  - Enhanced 80/20 Plan and CDHP
    - Preventive care covered at 100%
    - Lower cost-sharing (or additional HRA funds) for using identified high-quality, low-cost providers

Paid Medical Claims: Member and Plan Costs First Two Quarters of Plan Years



*Excludes Medicare Advantage members.

Graph excludes Blue Card claims (i.e., out-of-state claims)

Source: BCBSNC

PMPM Member Cost-Sharing for Medical Benefits By Quarter

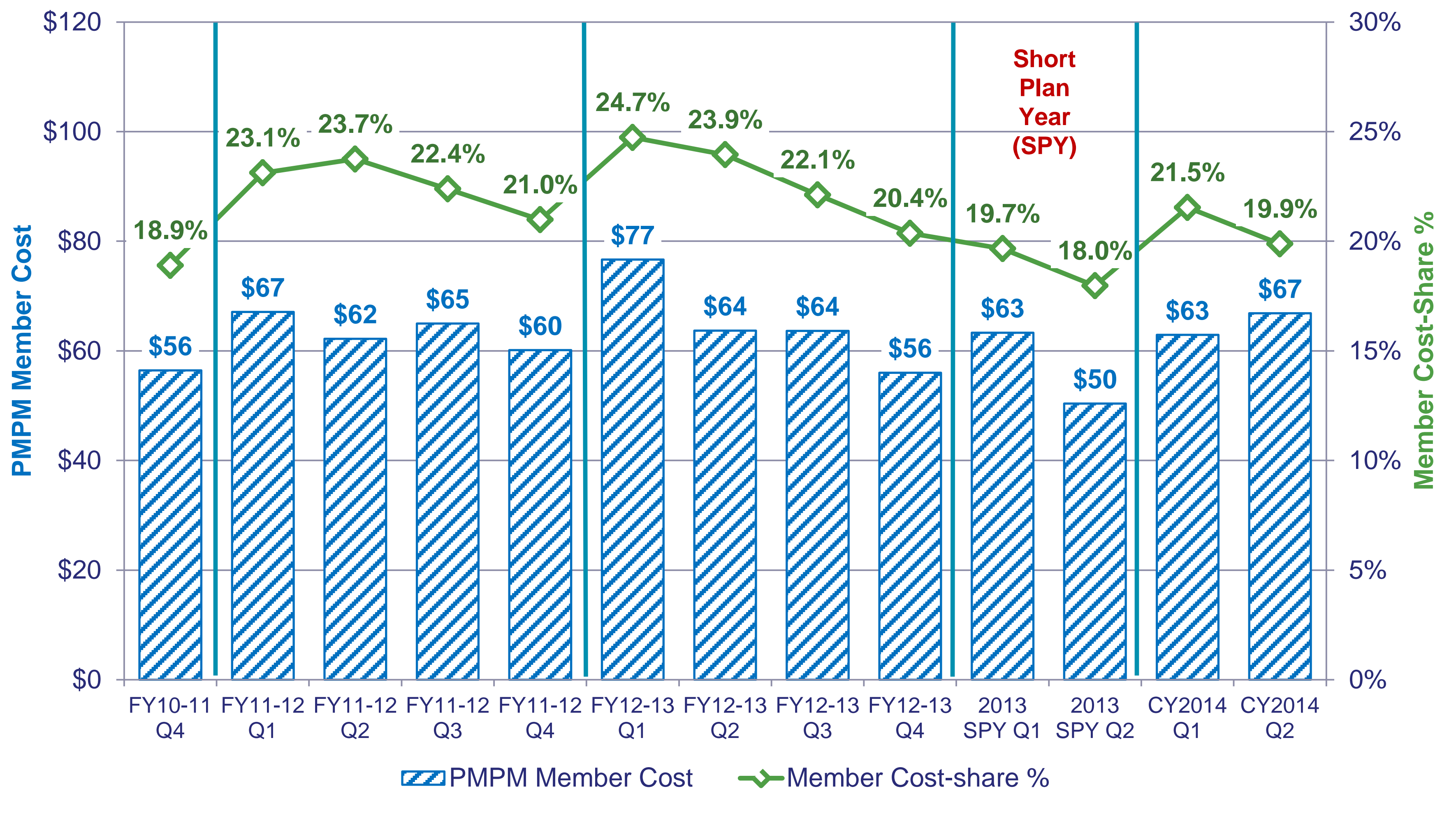
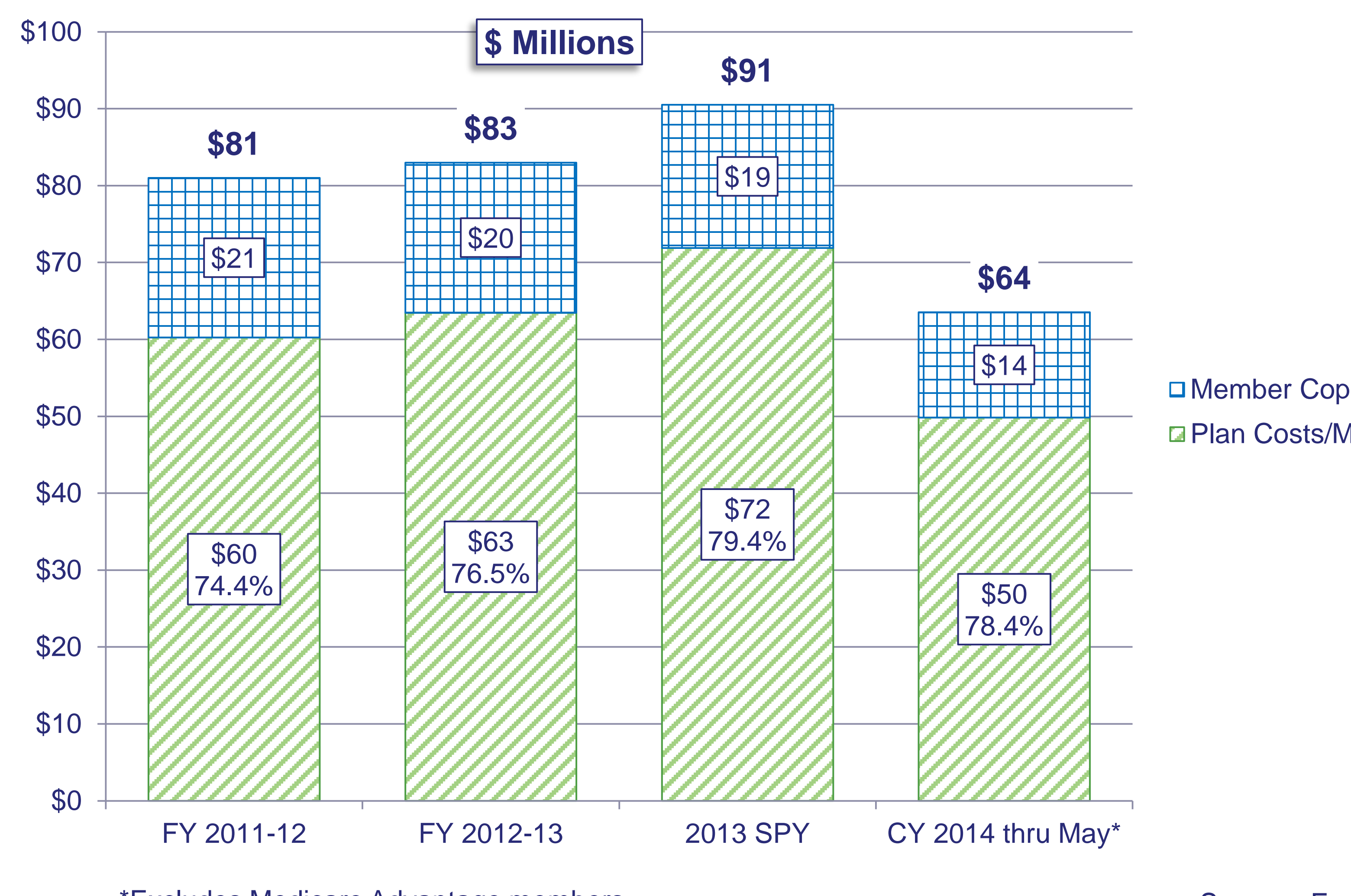


Chart excludes the 2014 Medicare Advantage members and Blue Card claims (i.e., out-of-state claims)

Source: BCBSNC

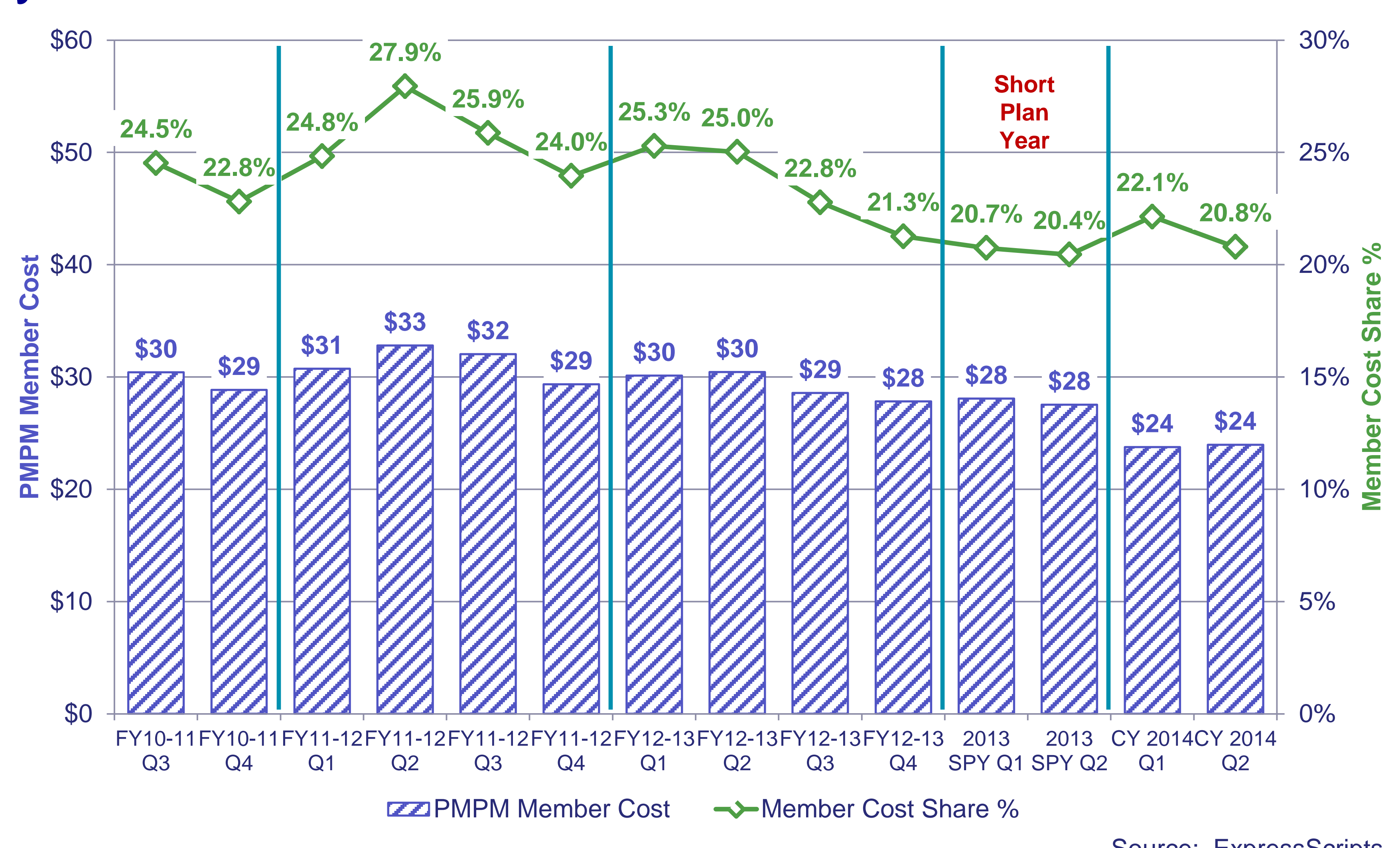
Paid Pharmacy Claims: Member and Plan Costs Monthly Costs by Plan Year



*Excludes Medicare Advantage members.

Source: ExpressScripts

PMPM Member Cost-Sharing for Pharmacy Benefits By Quarter



Source: ExpressScripts

Chart excludes the 2014 Medicare Advantage members

Summary

Member Premium Contributions

- Base premiums for the 70/30 and 80/20 plans have increased by 9% since September 2011 and will not increase again until January 2016

- Participation in three designated wellness activities can reduce the employee/retiree contribution for the Enhanced 80/20 Plan below the contributions that were required in 2012 and 2013
  - 91.9% of Enhanced 80/20 subscribers have completed all three wellness activities

- The CDHP and MAPDP options offer coverage with reduced dependent premiums relative to the Traditional 70/30 and Enhanced 80/20 plans

Member Cost-Sharing

- Member cost-sharing as a percent of total costs (Plan + member) for medical and pharmacy benefits has steadily decreased over the last couple years

- As expected, member cost-sharing was lower during the Short Plan Year

2016 Considerations

Member Premium Contributions

- Will the wellness premium structure be a feature of the Traditional 70/30 Plan in 2016?
- What new/enhanced wellness activities will be required to earn premium credits?
- What other changes to the premium structure are needed (e.g., lower dependent premiums, greater "employee only" contributions)? What would the changes mean for plan design? Could the changes be accomplished within the existing financial structure?

Member Cost-Sharing

- What level of member cost-sharing is expected? Desired?
- Current Plan offerings do not provide a very wide spread between the options. Is a greater spread desirable?
- Some features of the new 2014 plan designs use cost-sharing to steer members towards higher value services and facilities. How can the Plan build on this model in 2016? Which services/treatments should be encouraged? Which should be discouraged?

Board of Trustees

of the

State Health Plan for Teachers and State Employees

Strategic Plan
2014 – 2018

September 19, 2014

Adopted: ______________________________

Janet Cowell, Chair

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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 strategic plan for the years 2014 through 2018.

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*

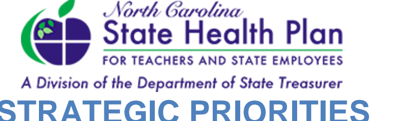
STRATEGIC PLAN GUIDING PRINCIPLES

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.

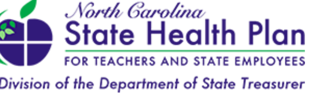
   "Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being."

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.



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	51% 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.



STRATEGIC INITIATIVES

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

Improve Members' Health	Maximize Patient Centered Medical Home (PCMH) Effectiveness	The Patient Centered Medical Home model is a way of organizing primary care that emphasizes care coordination (including appropriate setting) and communication to transform primary care to include population health management. Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.	• Support providers and practices in serving as PCMHs through data analytics, care management, and/or enhanced payment through the Population Health Management Services vendor to designated PCMH 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 serve as their primary care provider
				• At the heart of the PCMH are 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 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.	• 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	• 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%, hypertension is 57% and high cholesterol was 65%

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
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 treatment from high quality, cost effective providers	• Offer benefit designs that provide no-cost access for preventive care, encourage utilization of PCMHs 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, treatments and medications • Incent members to make long-term healthy lifestyle choices and more effectively manage chronic disease	• Access to high quality 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 Health*Smart* program, 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 Comprehensive Communication & Marketing Plan	Providing members with materials they can understand to help them effectively utilize their health benefits. Communicating regularly, not just at Annual Enrollment, to allow members the opportunity to maximize their experience 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 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	• 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	• 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

STRATEGIC MEASURES OF SUCCESS

Priority	Description	Metric	Rationale	Timeframe/Baseline
Improve Members' Health	PCMH utilization	Increase % of members receiving care from a NCQA recognized PCMH	PCMH 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.

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	2014		2015		2016		2017		2018	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
TPA / BCBSNC						12/31/16		12/31/17		12/31/18
TPA / MedCost LLC		10/1/14								
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				12/31/15		12/31/16				
PHMS / ActiveHealth Management		12/31/14		12/31/15						
COBRA & Billing / COBRAGuard						12/31/16		12/31/17		12/31/18
EES / Benefitfocus				Termination Expected by 12/31/15		12/31/16		12/31/17		12/31/18
EES / Aon-Hewitt		8/31/14								

New Contract   Option to Renew Contract   Contract Terminates

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.

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.					
PCMH	**PCMH Model:** Implementation of the PCMH model statewide. This will take place through the contract with the population health management vendor.	Contract Decision- PHMS				
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.					
High Prevalence Conditions	**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.					
High Prevalence Conditions	**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				
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.					
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.					
Worksite Wellness	**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.					

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.		◆			
	Medicare Primary Communication: Enhance current Medicare Primary learning module and develop additional outreach strategies.		◆	◆	◆	
	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.		◆	◆	◆	
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	◆			
	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.		◆	◆	◆	◆
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.	◆				
	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.			◆		
	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.				◆	

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.	➔	◆			
	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.	➔	◆			
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.	➔	◆			
	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.	◆				
Alternative Payment Models	**Alternative Payment Models:** Implement alternative payment models with 2 to 3 accountable care organizations (ACOs) and then expand.	◆		◆		
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.	◆	◆ ◆	◆ ◆	◆ ◆	◆ ◆
	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.	◆		◆	◆	◆

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
State Health Plan

Strategic Planning Process Recommendations

Phase I: Discovery Report

January 31, 2014
Final

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Executive Summary

The State Health Plan (SHP) has undergone many changes over the past 18-24 months, including the creation of a 10-member Board of Trustees that has the responsibility to develop and maintain a strategic plan. The State Treasurer, Board of Trustees (BOT) and SHP leadership recognize that an effective strategic planning process and plan will enable the SHP to better fulfill the SHP's mission in the future. This document outlines the key findings from an initial discovery phase of planning work and provides a set of recommendations for developing a strategic planning process and plan for the SHP that can be implemented and maintained by the State Treasurer, the current and future BOT and leaders of the SHP. The following is a summary of the key content and recommendations included in this report:

Strategic Planning Guiding Principles

The guiding principles will be used to create a level of consistency in the planning approaches and may be modified from time to time throughout the planning process. The principles included in this report have been developed based on the input of the members of the BOT and SHP leadership team gathered through interviews, a review of previous planning work and discussions at recent board and staff meetings.

Strategic Planning Framework

The recommended process framework will be used to structure the analysis, synthesis and output of the strategic plan. It is important to note that not all planning processes follow a linear path but this structure will help ensure consistent steps are taken to develop and continuously refresh the strategic plan.

Preliminary Strategic Questions to Address

This report identifies and organizes a set of strategic questions that have already been identified through the work of the BOT and SHP leadership. It is recommended that these issues be the starter list used to drive an initial wave of analysis, measurement and strategic prioritization.

Strategic Plan Governance & Management

The recommendations included in this section are intended to leverage existing strategic planning resources and tools, to create a level of cross-training for BOT and staff to ensure consistency during board term transition periods and specifically recommends that an appropriate level of SHP staffing be assigned to support the development of the strategic plan.

2014 Timeline

The timeline outlined in this report targets the first release of a strategic plan to be in late May or early June 2014. This timeline takes into consideration the time required to allocate and organize staff and resources and the need to better understand and assess the 2014 changes that have been implemented. This timeline can be adjusted as needed, but at a minimum provides the initial steps that can be taken to implement this strategic planning process.

In addition to what is outlined above, this report includes several concept charts, important contract dates and other information that will be useful references during the planning process.

I. Background & Purpose

The State Health Plan for Teachers and State Employees (SHP) provides health care coverage to more than 668,000 teachers, state employees, retirees, state university and community college personnel, and their dependents. The SHP has undergone a significant amount of change over the past 18-24 months.

Effective January 1, 2012 the SHP became a division of the North Carolina Department of State Treasurer. Previously the SHP reported to a legislative oversight committee within the General Assembly. As part of this change, in December of 2011 a new 10-member Board of Trustees (BOT) was appointed by the Governor (2), Senate (2), House (2) and State Treasurer (2) and includes the State Treasurer and State Budget Director. The BOT is made up of a diverse group of current and former teachers, state employees and other experts in medicine and health administration. The board is responsible for decisions regarding vendor contracts and the design of employee health benefits as well as the development of a strategic plan.

During this period of time, the SHP has evaluated and awarded new contracts for third party administrator services for its self-funded plan offerings, added a fully-insured Medicare Advantage offering and two additional payers to administer the offering, transitioned to a January 1 benefit plan year, added a new health engagement offering with incentives for healthy behaviors and undergone a change in SHP administrative leadership. The health care industry is also experiencing unprecedented levels of regulatory and market changes due to the Affordable Care Act (ACA). As the ACA becomes a reality, market and healthcare stakeholders, including employers, individuals, payers, regulators, providers and legislators, are continuously seeking to understand and assess its impact. It is prudent that the BOT and SHP leadership team build such external factors into the strategic planning process.

In an effort to ensure that the SHP continues to fulfill its mission amidst all of these changes, the SHP is undergoing an assessment of its strategic planning process. The purpose of this document is to outline the key findings from an initial discovery phase of work and provide a set of recommendations for developing a strategic planning process and plan for the SHP that can be implemented and maintained by the State Treasurer, the current and future BOT and leaders of the SHP.

II. Phase 1 Discovery Key Findings

As part of this discovery phase, a series of steps were taken to understand the current situation of the SHP strategic planning process and plan. Included in these steps were interviews with the active SHP BOT, including the North Carolina State Treasurer, key staff members of the Treasurer's Office, the SHP Executive Administrator and the SHP Executive Team. In addition, a review was conducted of available BOT minutes, presentations and relevant SHP strategic planning material, the new SHP plan offerings for the January 1, 2014 plan period, the March 2012 report of key findings from the Treasurer's and Board's state-wide tour and other information such as the North Carolina Statutes and a draft dashboard to monitor the quality and experience and the Treasurer's Office strategic priorities.

The following is a summary of key findings from the initial interviews that were conducted:

Progress To Date & What's Going Well

- A lot of positive energy, momentum and relationships
- Diverse, committed and knowledgeable staff and Board of Trustees
- Passion for the member, the member's health and being a model for North Carolina
- Significant change is already underway (a "new chassis")
- 3rd party vendors have been selected and contracts are in place
- Dashboard development is progressing
- Long term financial model (underway)
- ….others

Challenges & "Natural Tensions"

- Diverse, committed and knowledgeable staff and Board of Trustees: How do we leverage this?
- Significant change is already underway (a "new chassis"): How do we stabilize while we create new momentum for the future?
- Premiums & affordability: What is the value proposition to our members and to other stakeholders (legislature)?
- Ability to directly influence price, quality and efficiency: What can we control?
- The need for data & information: How do we learn about the market, the business, our members, etc.
- Leadership and Board turnover: How do we maintain continuity of purpose and plan?
- Prioritization: The many versus the few.

The following is an additional set of strategic planning process observations that were identified and considerations that are factored into the final recommendations:

Topic	Observation	Considerations
Mission Statement	The BOT and SHP Leadership Team are supportive of and are using the Mission Statement to guide their thinking and actions.	No action necessary. Revisit as needed.
Vision Statement	While there is a stated vision in place, there were several comments regarding the desire to move the SHP from an administrator of benefits and insurer to having a more active role in supporting the health outcomes and lifestyle choices of its members.	Consider the revision of a vision statement at an appropriate time during planning.
Guiding Principle Observations	There is a strong desire and a recognized need by both the BOT and SHP leadership to develop a set of strategic planning guiding principles as they relate to: ▪ The reaffirmation of the Mission Statement as the primary guide to decision making ▪ A general statement on and commitment to ensure the strategic plan becomes an active part of the actions and decisions made by the BOT and SHP ▪ Appropriately listening to and considering the differing needs of specific member constituents while balancing what is in the best interests of all members ▪ Member cost sharing, particularly for preventive services ▪ The use of industry benchmarks to measure quality, cost and member experience ▪ The appropriate engagement with and support from the General Assembly, specifically as it relates to reserves and funding approvals ▪ An acknowledgement for the need to stabilize and evaluate current plan design changes while continuing to update, modify, and improve plan offerings and incentives as well as develop new plan designs where appropriate	Develop an initial draft set of Guiding Principles and revisit as needed at appropriate times during the planning process.
Governance and Strategic Management	There is a need to address, as part of the process, the efficient and effective use of the SHP Executive Leadership Team and staff as well as BOT expertise. This includes but is not limited to: ▪ Freeing up time for or allocating dedicated staff time to enable the Executive Administrator to engage in more frequent strategic planning activities ▪ Effectively engaging more of the BOT in the activities of strategic planning, including the effective and appropriate use of the BOT formal board meetings ▪ Enabling the BOT to fulfill their fiduciary role and set the precedence of this being an "active" oversight board	Consider redesigning the use of the BOT meeting time, BOT workgroups and allocation of staff to support strategic planning activities.

III. Strategic Planning Guiding Principles

These guiding principles will be used to enable the BOT and SHP leadership team to develop a strategic plan. These are intended to create a level of consistency in planning approaches and may be modified from time to time during the strategic planning process.

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 desire of the BOT and SHP leadership team to develop a strategic planning process and plan that is **sustainable** beyond the current BOT members and SHP leadership team.

3. The development and execution of a strategic plan is viewed as a **joint responsibility** of the BOT and SHP leadership team, with the BOT approving strategic measures and strategic priorities while providing the support and guidance to the SHP leadership team to execute on the strategic plan.

4. The development of a strategic plan is considered **a process** to help understand what is relevant. The strategic plan will serve as a guide in prioritizing what is done, what is measured and how BOT and SHP staff time and resources are allocated.

5. It is the intent of the BOT and SHP leadership team to utilize all reasonable information sources to support the development of the strategic plan. When and where possible and appropriate, **industry or market benchmarks** and data will be used to develop strategic measures and establish strategic priorities for the SHP, with a specific emphasis on state employee health plans with similar characteristics and of comparable size.

6. The BOT and SHP leadership team acknowledges the need to integrate the SHP strategic plan into the strategic plan of North Carolina's **Department of State Treasurer**.

7. The adopted Strategic Plan should take into account the following factors:

   a. It is the intent of the BOT and SHP leadership team to ensure the **perspective of the member**, including experience and value, is factored into the strategic plan.

   b. It is the intent of the BOT and SHP 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 BOT and SHP leadership team will make every effort to work on behalf of the members and State of North Carolina to develop the most competitively priced offerings that **improve the health and well-being of its members**.

c. There needs to continue to be a **sense of urgency** to ensure the SHP remains financially stable to fulfill the mission of improving the health and health care of its members. That said the BOT and SHP 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.

d. It is the intent of the BOT and SHP leadership team to effectively manage premiums that members are required to pay for coverage and for out of pocket health care expenses. The BOT and SHP 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 healthcare services and improving the health of plan members. Ongoing communication and education will be critical.

e. The BOT and SHP 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 BOT and SHP leadership team will work collaboratively with that constituency to ensure the strategic plan fulfills the mission of the SHP.

f. Given the dependency on 3rd party vendors and business partners, the SHP, working in the best interests of the SHP members and State of North Carolina, will take a **partnership approach** with these stakeholders in developing and executing the strategic plan. This will include utilizing their areas of expertise and information to guide the decisions and actions of the BOT and SHP leadership team.

g. It is the intent of the BOT and SHP leadership team to act in a manner that is in **the best interests of all members** of the SHP and actively work toward **consensus** that will enable the fulfillment of the mission of the SHP.

IV. Strategic Planning Process Recommendations

A. Existing Process Steps and Tools to Build Upon

Over the past year and a half the BOT and SHP leadership team have developed or started to develop several strategic planning process steps and tools that can be leveraged to maintain the positive and constructive progress that has been made to date. Listed below are some examples along with a description of the opportunity to integrate into a more formalized strategic planning process:

Workgroups & "Active" Board

- Balance workgroups with strategic discussions & operational pre-Board meeting input
- Use workgroups to build relationships among BOT and SHP leadership team and staff
- Focus formal Board meetings on fiduciary responsibilities, formal Board votes and member experience

Dashboard

- Transition dashboard to a "balanced scorecard" for SHP
- Integrate strategic measures with operational and financial performance - one stop performance shopping
- Consider developing composite measures for quality and cost performance for strategic planning purposes

Financial Model

- A multi-year modeling tool provides a channel to capture key strategic or business assumptions as well as a tool to develop scenarios for strategic decisioning
- Continue to use the existing financial modeling tool to run scenarios on membership, pricing, medical expense, plan/ vendor admin expenses & reserve assumptions over a multi-year time horizon

Member Experience & Learnings From New Designs

- Integrate into regular Board meetings an update on member satisfaction, feedback from current designs and member engagement levels
- Focus a portion of the formal Board meetings on member experiences and input as this is critical information that will ensure commitment to the Mission Statement

B. Strategic Planning Framework

The following is a high level framework that can be used by the BOT and SHP leadership team to develop, monitor and manage a strategic plan for the SHP. The outer circles are the main components of a strategic plan. The "circle" image is intended to set the context that the planning process is ongoing and one component flows into the next.

An assessment of internal and external factors and trends. Examples:

- Demographics
- Regulatory changes (ACA)
- Disease and cost trends
- Medical science developments

The areas of focus or priorities and actions that leadership believes will have the greatest impact on the measures. Examples:

- Targeted expansion of NC Health Smart & incentives
- Provider engagement on quality
- Low cost benefit design options

Key strategic issues and conclusions that are identified based on leadership's review of the environmental analysis. Examples:

- Growth in incidence of disease
- Inconsistent quality of care
- Affordability / value are key drivers of satisfaction

A limited number of strategic measures used to establish direction and measure success. Examples:

- Financial stability (target reserves)
- Member engagement levels
- Quality of care
- Total cost of care

C. Preliminary Strategic Questions to Address

In an effort to leverage the strategic planning work that has been conducted to date, the following table includes a proposed set of strategic and business issues and questions that have been identified. These issues can be used to drive an initial wave of analysis, measurement and strategic prioritization. This will allow the BOT and SHP leadership team to continue to build on the momentum of actions already underway while at the same time informing the development of a more formal strategic planning process for the SHP.

Issue	Example Strategic & Business Questions

Affordability & Member Value	▪ What are reasonable premium and out of pocket costs for members?
	  o How does the SHP ensure out of pocket costs do not create dis-incentives to get needed care (e.g. meds for chronic conditions)?
	  o How can incentives be used to drive value to the member?
	▪ What is the SHPs premium strategy?
	  o What premiums and out of pocket costs are other similar states' health plans and private employers establishing? How does the SHP compare?
	▪ What are the top 10 drivers of medical costs? By demographic, region, provider, disease and health care services (hospitalizations, ER, Rx, etc)
	  o What are appropriate medical and pharmacy expense trends for the SHP? How can the SHP affect medical and pharmacy expense trends for its members?
	▪ Should the SHP attempt to factor in supplemental policies offered to members by other insurance carriers into its value story? If so, how?
	▪ How can the SHP assess the effectiveness of affordability and value initiatives?

Quality of Care & Access	▪ What are the most significant gaps in quality of or access to care for SHP members?
	  o How can the SHP drive the transition of provider reimbursement models to pay for outcomes (value)?
	  o How does the SHP measure quality of and access to care for SHP members? What industry standard measures exist?
	  o How can the SHP leverage existing measures or utilize the measures from 3rd party vendors?
	  o What measures of quality and access will have the greatest impact on cost and quality?
	  o How can the SHP assess the effectiveness of quality and access initiatives?
	▪ How can the SHP effectively improve provider engagement with the SHP?
	  o Which providers are best suited to work with SHP members to improve quality of care? Access to care? Which providers are seeing the highest volume of SHP members?
	  o What should the relationship be between SHP and providers?
	▪ What can the SHP do to drive the expansion of PCMH's and even integrate into accountable care organizations (ACOs)?
	▪ How can the SHP partner with the 3rd party vendors and providers to improve quality of care and access?

Financial Stability	▪ What additional actions should be taken to obtain legislative support over the long term?
	▪ How should financial stability be defined and evaluated?
	  o What level or percentage of healthcare cost trend is sustainable?
	  o What is a reasonable target reserve level to maintain for the next 3-5 years?
	  o What is a reasonable period of time to project and assess financials?
	▪ To what extent should benefit design be used to maintain financial stability?
	▪ To what degree is the SHP willing to spend more in the short term to achieve long term stability or savings?

Member Health Engagement	▪ What is the SHPs strategy for member communication and engagement?
	  o How can the SHP more effectively engage members, particularly those with chronic health conditions?
	  o How can the SHP partner with the various state agencies to promote healthy lifestyles?
	  o What are other large employers doing to increase member health engagement? What are examples of model worksite wellness programs?
	▪ How can the SHP service model (web and phone) assist in ensuring members know how to access providers and who are the most effective providers?
	  o How can health care cost and quality metrics become more transparent?
	▪ How will recent enrollment and new product challenges influence longer-term strategies to engage members around new health programs?
	  o How effective have the recent changes in benefit designs been in increasing member health engagement?
	  o How can the SHP assess the effectiveness of member engagement initiatives?

Future of SHP Offerings	▪ How much can and should the SHP drive new models of care delivery and / or provider payment models?
	  o With what strategic partners should the SHP be doing this?
	▪ How will future Federal-level policymaking impact the SHP?
	▪ How will future State-level policymaking impact the SHP?
	▪ What are the implications of ACA, exchanges, subsidies, Medicaid expansion etc. on future new product designs and SHP offerings?
	▪ Should the SHP consider defined contribution products, integration with Medicaid or any other significant changes to the operations or offerings of the SHP?
	  o How effective have the 3rd party vendors been and who are the best partners for the future?

D. Strategic Plan Governance and Management

The following recommendations are designed to ensure both the BOT and SHP leadership team are able to fulfill their responsibilities while leveraging the momentum, energy and knowledge of the BOT and SHP staff. These recommendations are also designed to create a level of cross-training for BOT and staff to ensure consistency during board term transition periods. These recommendations take into consideration the requirements of the North Carolina statutes. A more thorough review of these recommendations in context to SHP budgets, SHP staff operational priorities, BOT availability, BOT board meetings and other such dependencies will need to be considered over time.

Proposed BOT and SHP Leadership Team
Strategic Planning Governance & Management Structure
Year 1 (2014)

State Treasurer

BOT

BOT Workgroups

Strategic Planning Oversight & Integration

SHP Executive Administrator

SHP Leadership Team

Operational Workgroups

- Audit, Forecasting & Financing
- Member & Legislative Outreach
- Product & Provider Network Operations

Strategic Workgroups

- Affordability, Value, & Financial Stability
- Quality of Care & Access
- Health Engagement & SHP Offerings

SHP Director

Dashboard ("Balanced Scorecard")

Multi-year Financial Model

Indicates a change from current structures or a new structure

The following are some of the key points of consideration as the BOT and SHP leadership work to implement these recommendations:

1. **Leverage existing structures.** The intention is to leverage existing structures and components that are in place already or where there are efforts underway. For example, the workgroups have been effective to date and the model should be modified to support the strategic planning process. In addition, the dashboard can be further developed to provide the source for developing and monitoring key performance measures.

2. **Operational and strategic workgroups.** Creating a separate set of strategic workgroups focused on analyzing the strategic issues will ensure the more "short term" responsibilities are appropriately managed while protecting time for the "longer-term" planning work.

a. **New operational workgroup – Product and Provider Network Operations**
Focus this workgroup on more immediate provider network quality and access challenges, 3rd party vendor delivery for current product offerings and other current product offering issues and challenges that would require BOT input or expertise. Keep the other 2 operational workgroups as is.

b. **Strategic workgroups**
Assign the longer-term strategic questions and issues to each strategic workgroup, organized by the broad categories as outlined in section IV. C. of this report. SHP leadership and staff would conduct analysis and provide recommendations to SHP workgroups for input and guidance. That workgroup would then bring forward to the full BOT a summary of key findings and recommendations for integration into the strategic plan. This allows for a level of expertise to be developed among the BOT and staff around specific subjects, particularly given the broad range and volume of topics that could be explored.

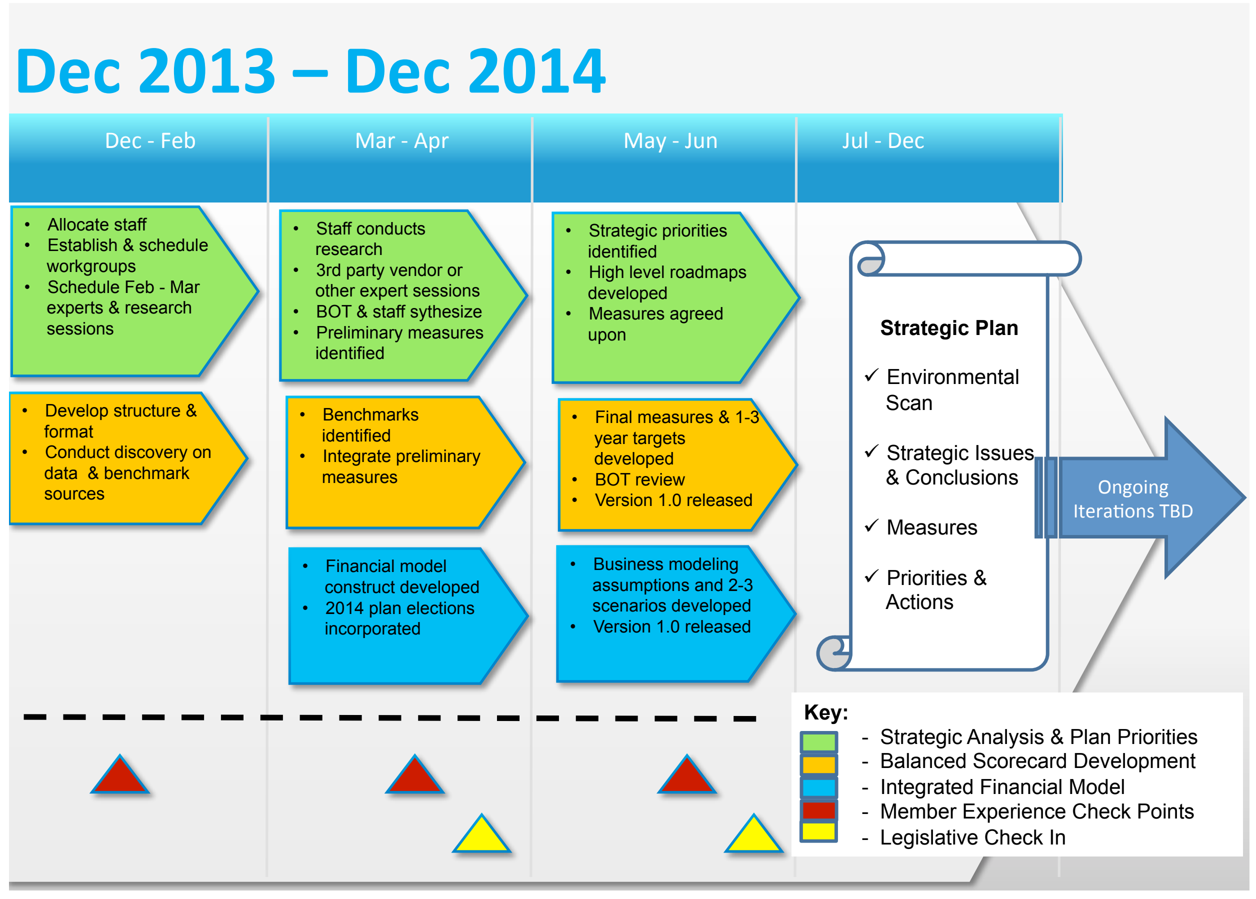
3. **Workgroup membership.** It is recommended that 3 BOT members be assigned to each operational workgroup and strategic workgroup with the BOT Chair (State Treasurer) participating as and where needed. In addition, if possible and with consideration of the expertise of BOT members, the membership of the operational and strategic workgroups will vary to enable all BOT members to work closely with each other. This will help ensure smoother transitions during scheduled BOT turnover and will also better leverage the diverse perspectives of the BOT and SHP staff members.

4. **SHP leadership staffing.** In order to effectively build an initial strategic plan, more dedicated SHP leadership resources will need to be allocated. The specific position (director-level) and responsibilities will need to be determined but generally, this will include a level of SHP leadership oversight for the administration of the strategic planning process and ongoing strategic plan management.

5. **Strategic Planning Oversight & Integration.** At this time, there is a Strategic Planning workgroup that can be repositioned. By establishing the strategic workgroups, all BOT will be able to participate in the development of the strategic plan. It is recommended that the Strategic Planning workgroup members initially function to ensure an appropriate level of oversight and integration is occurring but eventually that responsibility should transition to include the full BOT.

E. 2014 Timeline

This timeline assumes that the strategic plan development will be a process that will continue to evolve over time but that a reasonable first release of a more formalized strategic plan would be at the end of May or early June of 2014. This will allow time to set up the governance structure, complete the analysis of the strategic questions and ensure that the initial launch of the January 2014 offering is successful and member selections are understood.



REFERENCE MATERIALS

i. North Carolina General Statute 135-48.22. Board Powers and Duties.
ii. Macro-level Calendar of Dependencies
iii. Balanced Scorecard Concept
iv. Multi-year Financial Model

i. North Carolina General Statute 135-48.22. Board Powers and Duties.

The general statute information is included as a reference to document the authority and responsibility the Board of Trustees has to develop and maintain a strategic plan for the Plan. This also serves as a guide and reference in clarifying the role of the Board of Trustees as it relates to what requires Board approval.

§ 135-48.22. Board powers and duties.
The Board of Trustees shall have the following powers and duties:
(1) Approve benefit programs, as provided in G.S. 135-48.30(a)(2).
(2) Approve premium rates, co-pays, deductibles, and coinsurance percentages and maximums for the Plan, as provided in G.S. 135-48.30(a)(2).
(3) Oversee administrative reviews and appeals, as provided in G.S. 135-48.24.
(4) Approve large contracts, as provided in G.S. 135-48.33(a).
(5) Consult with and advise the State Treasurer as required by this Article and as requested by the State Treasurer.
(6) Develop and maintain a strategic plan for the Plan. (2011-85, s. 2.10; 2012-173, s. 4(a).)

ii. Macro-level Calendar of Dependencies.

The following calendar of dependencies highlights key externally or internally determined dates that should be considered as the strategic plan for the SHP is developed and maintained. This calendar is intended to be a reference point at this time and should not be considered approved or finalized by the BOT, SHP leadership, vendors or other stakeholders. These dates are subject to change and may be updated from time to time as part of the vendor contracting or strategic planning process.

Category		2014		2015		2016	
		Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Operational	Final Designs						
	Open Enrollment						
	BCBSNC						12/31/16
	Humana						12/31/16
	United						12/31/16
	Medco / Express Scripts				12/31/15		12/31/16
	Active Health		12/31/14		12/31/15		
	Cobra Guard						12/31/16
	Benefit Focus						12/31/16

- Internal or Plan deadline
- Vendor contract termination or renewal

Category		2014 Jan-Jun	2014 Jul-Dec	2015 Jan-Jun	2015 Jul-Dec	2016 Jan-Jun	2016 Jul-Dec
Legislative	Legislative Sessions						
	Budget Approvals						
	State Elections		2yr GA				2yr GA 4yr Gov, Trs

Category		2014 Jan-Jun	2014 Jul-Dec	2015 Jan-Jun	2015 Jul-Dec	2016 Jan-Jun	2016 Jul-Dec
BOT Terms	Initial 2.5 Year Terms	6/30/14	Hargett Johnson Medlin Rubin			6/30/16	TBD TBD TBD TBD
	Initial 3.5 Year Terms				Cunningham Huffstetler Moore Newton		Note: New 6/30/17

Category		2014 Jan-Jun	2014 Jul-Dec	2015 Jan-Jun	2015 Jul-Dec	2016 Jan-Jun	2016 Jul-Dec
"Wildcards"	ACA Employer Requirements			***TBD***			
	Other Regulatory Requirements			***TBD***			
	Market Trends			***TBD***			

iii. Balanced Scorecard Concept.

An important step in developing an effective strategic planning process and plan is to establish measures that will serve as a guide to setting priorities and monitoring progress. The concept is to establish a limited number of measures (10-15) whereby the SHP can monitor **trends** and establish longer term strategic **targets**. The diagram below is intended to build off of the work of the Dashboard and create a balanced scorecard that would enable the BOT and SHP leadership team to organize SHP measures into categories and identify strategic areas of focus and priorities. For purposes of this document, the following categories were used: **member experience & satisfaction**, **quality of care & access**, **financial stability & performance** and **operational excellence.** These measures would be revisited on a pre-determined basis, typically once per year and reviewed with the BOT and SHP leadership 1-2 times per year.

EXAMPLES FOR ILLUSTRATIVE PURPOSES ONLY

- **Member Experience & Engagement**
  - Medication Adherence
  - Tobacco Use Rates
  - Plan Satisfaction
  - Satisfaction with Providers
- **Quality of Care & Access**
  - Preventive Visit Rate
  - Clinical Quality Score
  - Re-admission Rates
  - Performance of PCMHs
- **Operational Excellence**
  - Enrollment Accuracy
  - Appeals Turnaround
  - Average Speed to Answer
  - Vendor Performance Management
- **Financial Stability & Performance**
  - Change in Reserves
  - Actual Results vs. Budgeted
  - Healthcare Trends and Utilization
  - Premium Rate Changes

iv. Multi-year Financial Model.

The BOT and SHP leadership have recognized the value of developing a multi-year, dynamic financial forecast that is maintained on a regular basis. Expanding the forecasting time horizon of the current model will enable the SHP to continue to capture critical business assumptions and conduct scenario planning beyond the immediate term as well as establish annual and multi-year goals. The financial model creates an opportunity to understand both internal and external factors that could impact the strategic plan and measures of success. The table below outlines major components of the model and examples of key assumptions.

Section	Description	Sample Assumptions & Factors
Membership	Number of enrolled members by product	• Current membership by coverage type: active employees, non-Medicare retirees and Medicare retirees • % of members electing coverage in a particular plan • Average family size (family coverage election) • Membership by product (MA, CDHP) • State and local employment outlook • Likely impact of plan design and premium strategies on plan selection
Premium Revenue	Projected total premium contributions	• Required across the board premium adjustments (%) • Premiums paid by employing units/retirement system • Base employee/retiree premiums • Premium surcharges • Impact of plan design changes on contribution revenues Note: Amount paid per enrollee varies by coverage tier and plan selection
Other Plan Revenue	Non premium revenue	• Retiree Drug Subsidy • EGWP Subsidy • ERRP Subsidy • Investment Earnings

Continued on Next Page

Medical Expense	Total cost of care	• Separate trend assumptions for medical and pharmacy expenses – assumption designed to take into account the following:
		    o Medical CPI trends
		    o Provider contracted rates
		    o Projected utilization of health services & incidence of diseases
		    o Generic prescription fill rates
		    o Growth in specialty pharmacy
		    o Growth in MAPDP fully insured premiums
		    o Savings associated with population health management services
		• Also considerations for the impact of the following:
		    o Proposed changes in plan design and member cost sharing assumptions
		    o Anticipated changes in payment models
		    o Impact associated with new TPA/PBM/MAPDP contracts

Administrative Expense	Expenses for SHP staff and vendor costs	• Projected vendor contract terms • Administrative staff assumptions
Net Income	Total revenue – total expense	• Formula driven field
Reserves	Cash balance	• Formula driven field, but required premium adjustments established to meet target reserve level • Target stabilization reserve levels or ranges • Dependent on premium pricing strategy and 3rd party vendor contracting effectiveness and risk sharing

The following chart outlines the current forecasting process that will be used to further develop the multi-year financial model:

Forecasting Process

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Expenditures
- Medical Claims
- Pharmacy Claims
- Admin Expenses

Revenues
- Medicare Part D Subsidy
- ERRP Subsidy
- Premiums
  - 1st = Based on Current Rates
  - 2nd = Post Benefit Changes

Target Stabilization Reserve
- 7.5% of Projected Claims

Projected Annual Premium Increase
- Across the Board

Account for Changes in Assumptions or Migration between Plan Options?
- Premium Increase
- Cost Sharing
- Other
  - Membership
  - Mandates
  - Contractual Changes

Baseline Projection

Benefit Changes

Final Forecast & Premium Rates