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

Board of Trustees Meeting
Friday, November 20, 2015
9:00 a.m. – 3:00 p.m.

1. Welcome — Janet Cowell, Chair

2. Conflict of Interest Statement — Janet Cowell, Chair

3. Legislative Report — Tom Friedman
   - A. Joint Legislative Program Evaluation Oversight Committee – Report Number 2015-05, Retiree Health
   - B. Local Government Participation in the State Health Plan
   - C. Final State Budget

4. Financial Report, Forecasting and Monitoring — Mark Collins, Tom Friedman
   - A. September 2015 Financial Report
   - B. CY 2015 3rd Quarter Actuarial Forecast Update
   - C. State Health Plan Trend Analysis

Break (10 minutes)

5. Member Experience and Communications — Caroline Smart, Beth Horner
   - A. 2015 Membership Satisfaction Results
   - B. 2016 Annual Enrollment
     - i. Telephone Town Hall Events
     - ii. Outreach and Results
   - C. 2016 Outreach and Education Strategy

6. Benefit Design, Plan Options and Premiums
   - A. Premium Contribution Rates
     - i. EA Action on 2016 Group Premiums — Mona Moon
     - ii. 2015 & 2016 COBRA Rates for HDHP ***(Requires Board Approval)*** — Mark Collins

B. Prescription Home Delivery Pilot Program	Sandy Wolf

Lunch (30 minutes)

C. Transition Specialty Medications from Medical to Pharmacy Benefit	Sandy Wolf
D. Potential Benefit Changes for CY 2017	Tom Friedman

7. Contracting and Vendor Partnerships

A. Pharmacy Benefit Manager (PBM) Request for Proposal	Sandy Wolf

8. Clinical & Program Operations

A. Pharmacy & Therapeutics Committee – August Meeting	Sandy Wolf Adam Root
B. Affordable Care Act Employer Reporting Requirements	Linda Forsberg

Break (10 minutes)

9. Strategic Planning — Tom Friedman
   - A. Future Planning
   - B. Strategic Plan Annual Update

10. Executive Session (for Board members only) — Janet Cowell, Chair
    Pursuant to: G.S. 143-318.11 and G.S. 132-1.2

A. Consultation with Legal Counsel – Contract Issue (Aon Hewitt) *(G.S. §143.318.11(a)(3) and G.S. § 132-1.2)*	Lotta Crabtree
B. Print and Mail Services, RFP #270-2015101601 Recommendation for Award ***(Requires Board Approval)***	Beth Horner

11. Adjourn — Janet Cowell, Chair

Next Regularly Scheduled Meeting: January 21, 4–6 p.m. and January 22, 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 well-being.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Joint Legislative Program Evaluation Oversight Committee
Retiree Health Report

Board of Trustees Meeting

November 20, 2015

A Division of the Department of State Treasurer

Program Evaluation Division Report

- At the direction of the Joint Legislative Program Evaluation Oversight Committee (Joint Committee), the General Assembly's Program Evaluation Division (PED) prepared a report on the unfunded liability for retiree health benefits

Unfunded Actuarial Liability for Retiree Health is Large, but State Could Save Up to $64 Million Annually by Shifting Costs to Medicare Advantage Plans

(July 2015)

http://www.ncleg.net/PED/Reports/2015/RetireeHealth.html

- Joint Committee met on October 7th to take action on the report

- Report recommends General Assembly "direct the State Treasurer and State Health Plan Board" to require Medicare retirees to be on Medicare Advantage plans
  - PED meeting on November 23rd, to review potential legislation

PED Report on Retiree Health Benefits

- The State has an unfunded actuarial liability for retiree health benefits of $25.5 billion
  - Board reviewed the 2015 OPEB report in August
- Governmental accounting standards will soon require states to report their unfunded liability on annual financial statements
  - North Carolina will have to report the liability in its Fiscal Year 2018 Comprehensive Annual Financial Report (CAFR)
- Like most states, North Carolina funds retiree health benefits on a “pay-as-you-go” basis
  - Therefore, unlike the method for supporting pension benefits, funds are not set aside to cover the future costs of benefits as they accrue
- A non-contributory benefit is available to a large proportion of state retirees
- North Carolina ranks poorly relative to other states on its retiree health benefit funded status

PED Report Options for Reducing the Unfunded Liability

1. Increase appropriations
2. Shift more costs to the federal government through Medicare Advantage
3. Transition to a defined contribution model
4. Reduce the number of retirees eligible for the benefit
5. Require active employees to contribute
6. Increase the amount retirees pay for the benefit through higher premiums or greater out-of-pocket costs

"To address the unfunded liability, the General Assembly:

- should direct the State Treasurer and State Health Plan Board of Trustees to shift costs to the federal government by requiring eligible retirees to be on Medicare Advantage plans, generating an estimated savings of up to $64 million annually, and
- could appoint a joint committee to determine which of the other options to pursue …."

Medicare Advantage Savings Estimate

- PED reports a potential savings of up to $64 million annually

- A Segal forecast* came to a similar conclusion with respect to potential expenditure reductions for Calendar Years 2016 and 2017, but
  - Does not account for the impact on revenues, and
  - Annual savings projected for future years decrease to $40-$50 million in CY 2018-19 and $30-$40 million in CY 2020-21

- Actual savings will depend on:
  - Number of Medicare retirees remaining in the Traditional 70/30 Plan; and
  - Future Medicare Advantage premiums

- Plan staff believes the overall annual savings from requiring Medicare members to enroll in an MA offering would be significant but somewhat lower than the $64 million referenced in the PED report

*The Segal forecast used for this analysis was not done with the specific intent of identifying savings from a mandated MA program.

Next Steps

- JLPEOC meets November 23rd to discuss potential legislation
- JLPEOC is considering a study to determine the financial impacts various legislative approaches may have on the unfunded liability
- SHP will update its savings estimate to reflect the results of the CY 2016 annual enrollment

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Local Government Participation in the State Health Plan

Board of Trustees Meeting

November 20, 2015

A Division of the Department of State Treasurer

Presentation Overview

- Review of Legislation
- Recurring Concerns from Local Governmental Units
- Process to Join the State Health Plan
- Engagement to Date
- Next Steps

Review of Legislation

- SL 2015-112 (HB 154) allows local governmental units with fewer than 1,000 members to enroll their active employees in the State Health Plan following the completion of:
  - Passing a local resolution, and
  - Signing a Memorandum of Understanding (MOU) with the Plan

- Key provisions:
  - Current and future retirees are ineligible for coverage
  - Local governmental units have to comply with all Plan policies and procedures
  - Enrollment is capped at 10,000 members total
    - Approximately 3,400 existing local government members are included in that cap

Recurring Concerns from Local Units

- Ability to cover retirees (current and future)
- Ability to modify premium payment amounts (higher/lower subsidies)
- Participation in wellness programs
- Annual Enrollment timing
- Ability to only offer Traditional 70/30
- Flexibility to opt out and shop for coverage

Participation Process

- Local Governmental Unit submits resolution expressing their intent to join the Plan
- Local Governmental Unit completes data sheet providing the Plan with information (contact person, current health coverage offering and enrollment, dependent eligibility, number of employee, etc.)
- Plan completes internal Requisition to Contract (RTC) for each unit
- Plan sends its standard MOU to the Unit for signature
- Once the signed MOU is received from the Unit, the Plan's EA executes the agreement
- Unit works with Plan's Operations Team on enrollment process

Current Signed MOUs and Members Eligible

	Local Gov't Members Currently Covered[1]	Estimated Eligible Members from Local Gov't Units[2]
Current Enrolled	3,400	
Local Units in MOU Process for 1/1/2016		5,112
Local Units seeking enrollment after 1/1/2016		2,353
Total Engaged with Plan		10,865
Cap		10,000

1. Enrollment is based on October BCBSNC data
2. Based on self-reported estimates by local units as of November 16, 2015

- Given amount of interest in joining the Plan, enrollment will likely exceed the cap authorized by statute
- Local governments continue to express interest in joining

Next Steps

- Enroll local units
  - Process begins after traditional Annual Enrollment
- Update Board and General Assembly actual enrollment
- Track utilization differences

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Final State Budget

Board of Trustees Meeting

November 20, 2015

Presentation Overview

- Final State Budget
  - Funding for Employer Contribution for State Health Plan Coverage
  - Special Provisions Impacting the State Health Plan
- Next Steps

SHP Budget Update

	Board Approved Plan Design (Feb 2015)	Governor's Budget	House Budget Proposal[1]	Senate Budget Proposal	Enacted State Budget[4]	Board Approved Plan Design Updated (Aug 2015)
Premium Increases						
CYs 2016 & 17 (January 1st)	3.37%	3.37%	3.75%	0.00%	3.46%	2.83%
General Fund Appropriations						
FY 2015-16	$34.0 m	$34.0 m	$38.2 m	$0[3]	$34.8 m	$28.4 m
FY 2016-17	$101.8 m	$101.8 m	$109.2 m[2]	TBD	$104.9 m	$85.8 m

1. House proposal includes funding for HB 56, Rehired Retiree Eligibility
2. House funding for FY 2016-17 contingent upon adoption of changes to reduce the required FB 17-19 increase in employer contributions
3. Senate requires Plan to maintain reserve of 20% of total expenses
4. Final budget includes both the House and Senate provisions but excludes Rehired Retiree funding

SHP Budget Final

- The Approved Budget includes a special provision mandating benefit changes to reduce the increase to the employer contribution for the 2017-19 biennium as a condition to fully fund the required employer contribution effective for CY 2017:
  - SECTION 30.26 (a). It is the intent of the General Assembly to make funds in the Reserve for Future Benefits Needs available for increasing employer contributions to the State Health Plan for Teachers and State Employees during the 2016-2017 fiscal year only if the General Assembly determines that the State Treasurer and the Board of Trustees established under G.S. 135-48.20 have adopted sufficient measures to limit projected employer contribution increases during the 2017-2019 fiscal biennium, in accordance with their powers and duties enumerated in Article 3B of Chapter 135 of the General Statutes.

SHP Budget Final

SECTION 30.26 (b-c).

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

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

Additional Budget Items Related to the State Health Plan

§ 135-48.40. (1a).

- Final Budget includes language that gives Employing units the authority to allow rehired retirees to enroll in plan options available to permanent full-time employees instead of the High Deductible Health Plan (HDHP).

§ 90-414.5. - 90-414.5.

- The State will be creating a new Health Information Exchange (HIE) that requires providers to send data for Medicaid and SHP members.
- Effective January 1, 2018 the Plan will begin receiving HIE data on Plan members.

Next Steps

- Legislative short session begins April 25, 2016
- Identify potential issues to bring to General Assembly
- Address state budget requirements

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

September 2015 Financial Report

Board of Trustees Meeting

November 20, 2015

A Division of the Department of State Treasurer

Financial Results: Actual vs. Budgeted
Calendar Year to Date September 2015

Calendar Year 2015	Actual thru Sept 2015	Authorized Budget (per Segal 4-28-15)	Variance Over/(Under) Budget
Beginning Cash Balance	**$1.015 b**	**$1.015 b**	**$0.0 m**
Plan Revenue	**$2.289 b**	**$2.281 b**	**$7.9 m**
Net Claims Payments	$2.029 b	$2.071 b	($41.4 m)
Medicare Advantage Premiums	$128.8 m	$130.4 m	($1.6 m)
Net Administrative Expenses	$133.4 m	$179.0 m	($45.6 m)
Total Plan Expenses	**$2.291 b**	**$2.380 b**	**($88.6 m)**
Net Income/(Loss)	**($2.5 m)**	**($99.0 m)**	**$96.5 m**
Ending Cash Balance	**$1.012 b**	**$915.9 m**	**$96.5 m**

Adjusted Variance Report
Calendar Year to Date September 2015

Calendar Year 2015	Actual thru Sept 2015, As Adjusted	Authorized Budget (per Segal 4-28-15)	Variance Over/(Under) Budget
Plan Revenue *	**$2.281 b**	**$2.281 b**	**$0.3 m**
Net Claims Payments ^	$2.040 b	$2.071 b	($30.3 m)
Medicare Advantage Premiums	$128.8 m	$130.4 m	($1.6 m)
Net Administrative Expenses	$133.4 m	$179.0 m	($45.6 m)
Total Plan Expenses	**$2.302 b**	**$2.380 b**	**($77.5 m)**
Net Income/(Loss)	**($21.2 m)**	**($99.0 m)**	**$77.8 m**

* Adjusted for timing issues.
^ Adjusted for timing issues on pharmacy rebates and to exclude unbudgeted credits against pharmacy claims.

Financial Results Actual vs. Budgeted
Calendar Year to Date September 2015

Per Member Per Month (PMPM) Analysis

Calendar Year 2015	Actual thru Sept 2015	Authorized Budget (per Segal 4-28-15)	Variance Over/(Under) Budget
Plan Revenue	**$371.06**	**$370.17**	**$0.89**
Net Claims Payments	$329.46	$336.37	($6.91)
Medicare Advantage Premiums	$20.91	$21.18	($0.27)
Net Administrative Expenses	$21.66	$29.08	($7.42)
Total Plan Expenses	**$372.03**	**$386.63**	**($14.60)**
Net Income/(Loss)	**($0.97)**	**($16.46)**	**$15.49**

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

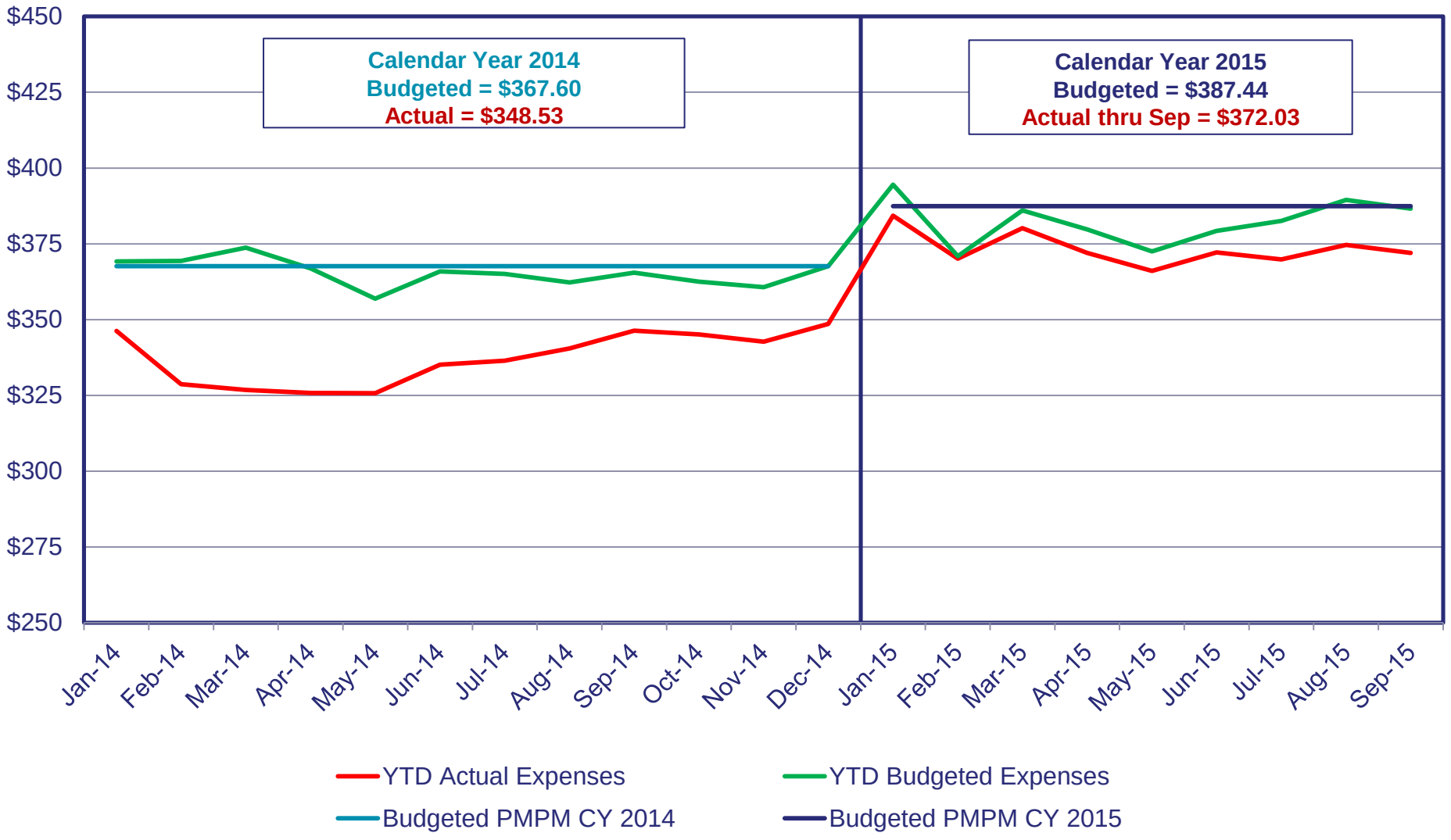
Adjusted Variance Report
Calendar Year to Date September 2015

Per Member Per Month (PMPM) Analysis

Calendar Year 2015	Actual thru Sept 2015, as Adjusted	Authorized Budget (per Segal 4-28-15)	Variance Over/(Under) Budget
Plan Revenue *	**$369.82**	**$370.17**	**($0.35)**
Net Claims Payments ^	$331.26	$336.37	($5.11)
Medicare Advantage Premiums	$20.91	$21.18	($0.27)
Net Administrative Expenses	$21.66	$29.08	($7.42)
Total Plan Expenses	**$373.83**	**$386.63**	**($12.80)**
Net Income/(Loss)	**($4.01)**	**($16.46)**	**$12.45**

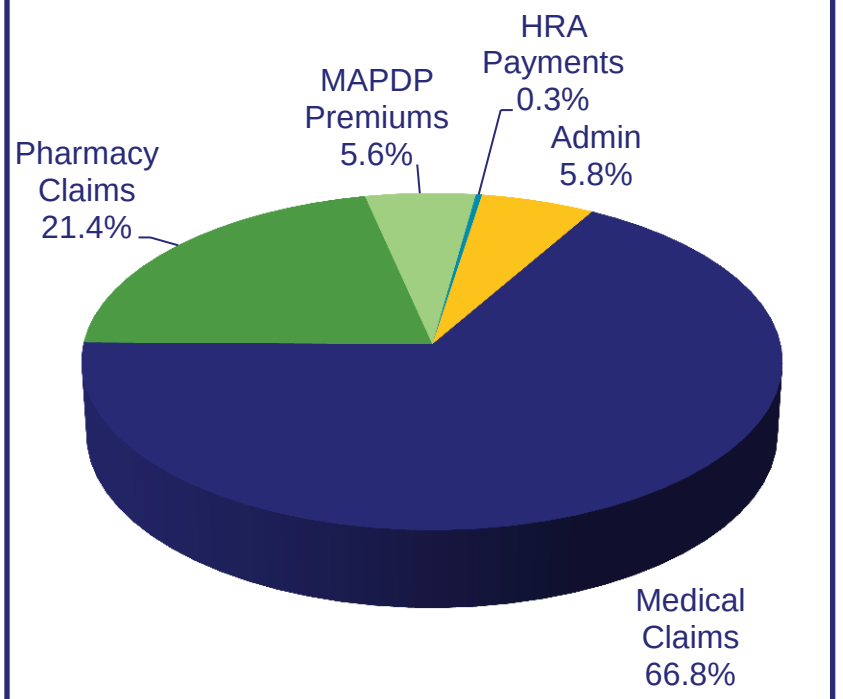
* Adjusted for timing issues.
^ Adjusted for timing issues on pharmacy rebates and to exclude unbudgeted credits against pharmacy claims.

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



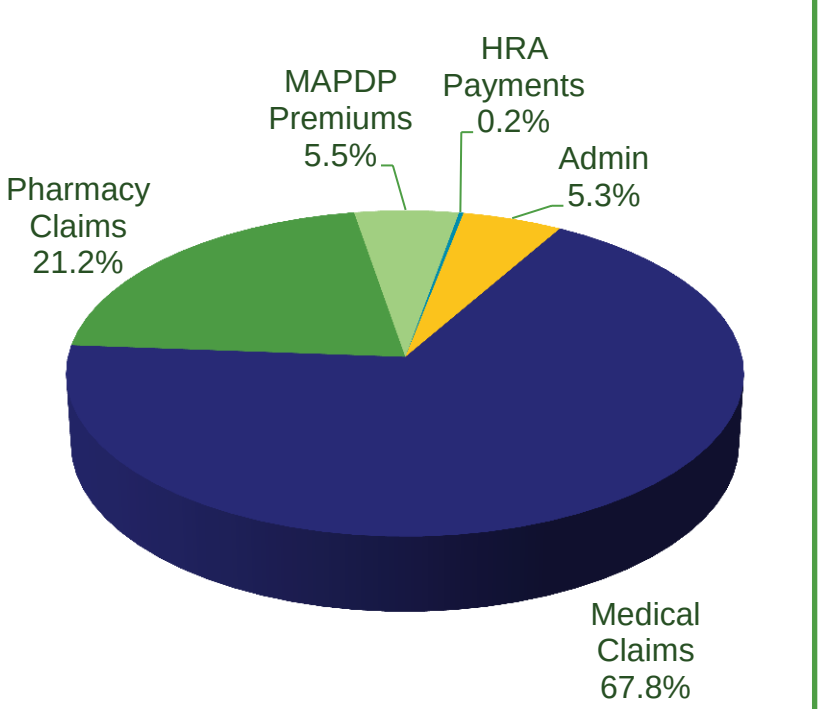
Allocation of Total Expenditures

Calendar Year To Date: Sep 2015



Total Expenses = $2.291 billion

Calendar Year 2014

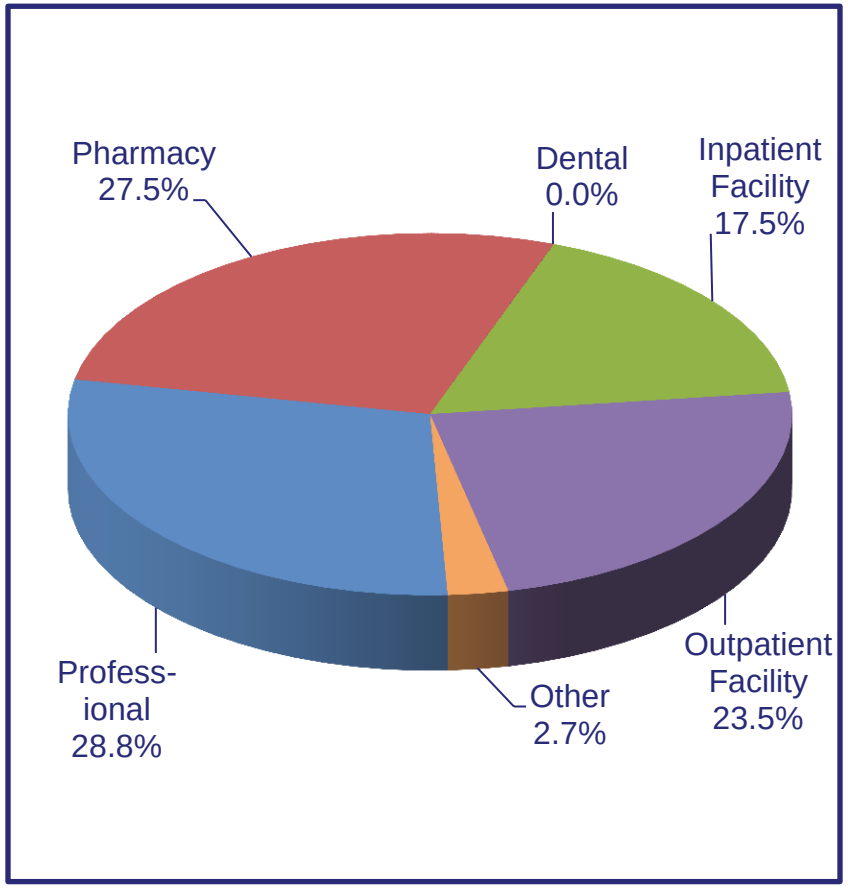


Total Expenses = $2.831 billion

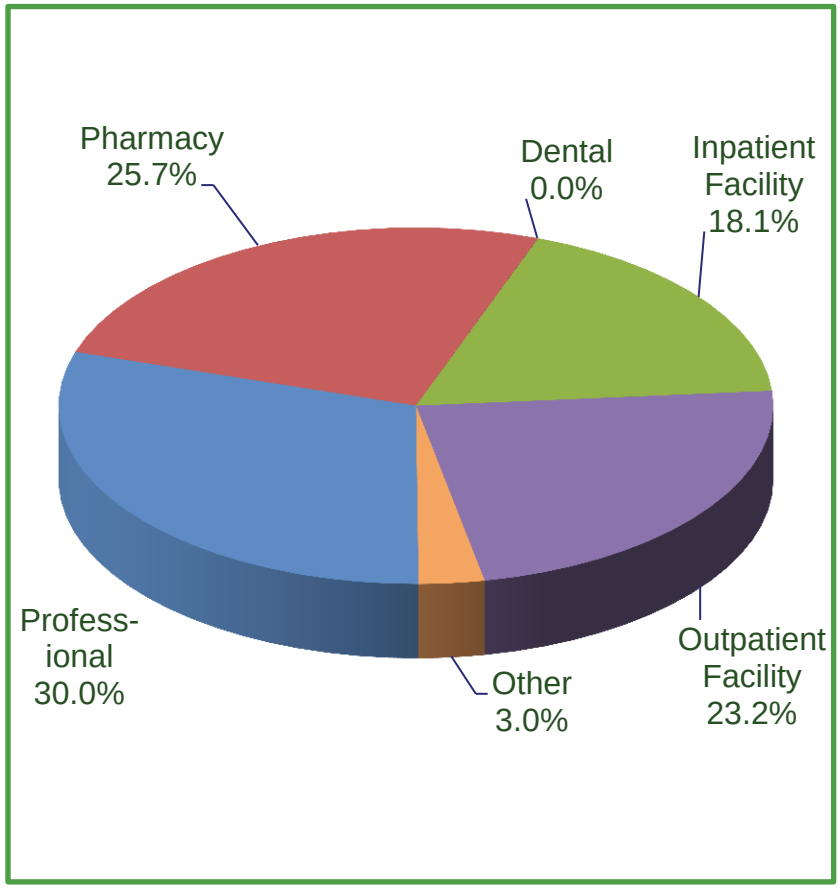
Sources: BCBSNC Net Disbursements reports; Financial Status Reports

Allocation of Claims Expenditures
Medical, Blue Card and Pharmacy Payments

Calendar Year to Date: Sep 2015



Calendar Year 2014



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. Authorized Budget
For the Month Ended September 2015
Calendar Year 2015

		A	B	C	D	E	F	G	H
		Actual September 2015	Authorized Budget September 2015	Monthly Variance Over/(Under) Authorized Budget	Actual 2015 Calendar Year To Date	4/28/2015 Authorized Budget 2015 Calendar Year to Date	Calendar Year to Date Variance Over/(Under) Auth. Budget	4/28/2015 Calendar Year Authorized Budget (Jan-Dec 2015)	Calendar Year to Date Variance Over/(Under) Annual Auth. Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 250,233,395	$ 248,482,497	$ 1,750,898	$ 2,220,931,575	$ 2,218,974,315	$ 1,957,260	$ 2,963,937,832	$ (743,006,257)
4	Premium Refunds/Retroactive Disenrollments	-	(124,631)	124,631	(5,343)	(1,113,007)	1,107,664	(1,486,657)	1,481,314
5	Medicare Part D (RDS) Subsidy	-	1,146,052	(1,146,052)	14,258,373	10,864,732	3,393,641	14,587,080	(328,707)
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	48,603,406	48,602,498	908	48,602,498	908
7	Medicare Advantage (MA) Subsidy	125,631	69,288	56,343	721,301	620,773	100,528	828,983	(107,682)
8	**Net Premium & Other Contributions**	**250,359,026**	**249,573,206**	**785,820**	**2,284,509,312**	**2,277,949,311**	**6,560,001**	**3,026,469,736**	**(741,960,424)**
9									
10	Investment Earnings	587,852	305,054	282,798	4,349,914	2,969,581	1,380,333	3,871,779	478,135
11	Miscellaneous Revenue	638	-	638	638	-	638	-	638
12	**Other Revenue**	**588,490**	**305,054**	**283,436**	**4,350,552**	**2,969,581**	**1,380,971**	**3,871,779**	**478,773**
13									
14	**Total Plan Revenue (excludes internal transfers)**	**250,947,516**	**249,878,260**	**1,069,256**	**2,288,859,864**	**2,280,918,892**	**7,940,972**	**3,030,341,515**	**(741,481,651)**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	150,682,321	163,364,382	(12,682,061)	1,556,468,644	1,611,418,555	(54,949,911)	2,128,799,496	(572,330,852)
19	Medical Claim Refunds/Recoveries	(1,370,107)	(2,370,497)	1,000,390	(18,192,194)	(18,714,803)	522,609	(25,072,202)	6,880,008
20	**Net Medical Claims**	**149,312,214**	**160,993,885**	**(11,681,671)**	**1,538,276,450**	**1,592,703,752**	**(54,427,302)**	**2,103,727,294**	**(565,450,844)**
21									
22	Pharmacy Claim Payments	58,860,196	55,103,799	3,756,397	550,679,131	523,060,682	27,618,449	718,955,282	(168,276,151)
23	Pharmacy Claim Rebates	-	-	-	(54,562,398)	(45,248,182)	(9,314,216)	(57,020,841)	2,458,443
24	Pharmacy Claim Refunds/Recoveries	(9,002)	-	(9,002)	(5,303,462)	-	(5,303,462)	-	(5,303,462)
25	**Net Pharmacy Claims**	**58,851,194**	**55,103,799**	**3,747,395**	**490,813,271**	**477,812,500**	**13,000,771**	**661,934,441**	**(171,121,170)**
26									
27	**Net Claim Payments**	**208,163,408**	**216,097,684**	**(7,934,276)**	**2,029,089,721**	**2,070,516,252**	**(41,426,531)**	**2,765,661,735**	**(736,572,014)**
28									
29	**Medicare Advantage Premium Payments**	**14,515,409**	**14,536,050**	**(20,641)**	**128,803,219**	**130,391,551**	**(1,588,332)**	**174,072,089**	**(45,268,870)**
30									
31	**Net Administrative Expenses**	**18,133,397**	**18,426,000**	**(292,603)**	**133,411,423**	**178,979,985**	**(45,568,562)**	**239,864,700**	**(106,453,277)**
32									
33	**Total Plan Expenses (excludes internal transfers)**	**240,812,214**	**249,059,734**	**(8,247,520)**	**2,291,304,363**	**2,379,887,788**	**(88,583,425)**	**3,179,598,524**	**(888,294,161)**
34									
35	**Plan Income/(Loss)**	**10,135,302**	**818,526**	**9,316,776**	**(2,444,499)**	**(98,968,896)**	**96,524,397**	**(149,257,009)**	**146,812,510**
36									
37	**Cash Availability:**								
38									
39	Beginning Cash Balance/(Deficit)	1,002,267,545	915,059,924	87,207,621	1,014,847,346	1,014,847,346	-	1,014,847,346	-
40	**Ending Cash Balance/(Deficit)**	**1,012,402,847**	**915,878,450**	**96,524,397**	**1,012,402,847**	**915,878,450**	**96,524,397**	**865,590,337**	**146,812,510**
41									
42	Target Stabilization Reserve @ 12/31/15	248,909,557	248,909,557	-	248,909,557	248,909,557	-	248,909,557	-
43									
44	**Cash Balance Over/(Under) Reserve Target**	$ 763,493,290	$ 666,968,893	$ 96,524,397	$ 763,493,290	$ 666,968,893	$ 96,524,397	$ 616,680,780	$ 146,812,510

Comments:
a. Premium receivables totaled $1,363,354.70 as of September 30, 2015.
b. The average weekly medical claims cost net of claims refunds was $37,328,053.50 for the four scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $29,430,098.00 per cycle.
d. The target stabilization reserve is 9% of the projected net claims for Calendar Year 2015.
e. Minor differences compared to other reports are due to rounding.

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

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Certified Budget
For the Month Ended September 2015
Fiscal Year 2015- 2016

		A	B	C	D	E	F	G	H
		Actual September 2015	Certified Budget September 2015	Monthly Variance Over/(Under) Certified Budget	Actual Year to Date FY 2015-16	10/13/2015 Certified Budget Year to Date FY 2015-16	Year to Date Variance Over/(Under) Certified Budget	10/13/2015 Annual Certified Budget FY 2015-16	Year to Date Variance Over/(Under) Annual Auth. Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 250,233,395	$ 248,623,814	$ 1,609,581	$ 747,501,365	$ 746,113,327	$ 1,388,038	$ 3,031,630,846	$ (2,284,129,481)
4	Premium Refunds/Retroactive Disenrollments	-	(124,669)	124,669	-	(374,130)	374,130	(1,523,909)	1,523,909
5	Medicare Part D (RDS) Subsidy	-	1,155,147	(1,155,147)	3,344,466	3,603,195	(258,729)	14,457,206	(11,112,740)
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	-	-	-	-	-
7	Medicare Advantage (MA) Subsidy	125,631	69,535	56,096	192,247	208,432	(16,185)	848,545	(656,298)
8	**Net Premium & Other Contributions**	**250,359,026**	**249,723,827**	**635,199**	**751,038,078**	**749,550,824**	**1,487,254**	**3,045,412,688**	**(2,294,374,610)**
9									
10	Investment Earnings	587,852	324,949	262,903	1,626,173	998,369	627,804	3,760,445	(2,134,272)
11	Miscellaneous Revenue	638	-	638	638	-	638	-	638
12	**Other Revenue**	**588,490**	**324,949**	**263,541**	**1,626,811**	**998,369**	**628,442**	**3,760,445**	**(2,133,634)**
13									
14	**Total Plan Revenue (excludes internal transfers)**	**250,947,516**	**250,048,776**	**898,740**	**752,664,889**	**750,549,193**	**2,115,696**	**3,049,173,133**	**(2,296,508,244)**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	150,682,321	162,948,555	(12,266,234)	528,521,497	549,315,170	(20,793,673)	2,152,322,381	(1,623,800,884)
19	Medical Claim Refunds/Recoveries	(1,370,107)	(2,313,134)	943,027	(4,468,118)	(6,443,612)	1,975,494	(25,761,279)	21,293,161
20	**Net Medical Claims**	**149,312,214**	**160,635,421**	**(11,323,207)**	**524,053,379**	**542,871,558**	**(18,818,179)**	**2,126,561,102**	**(1,602,507,723)**
21									
22	Pharmacy Claim Payments	58,860,196	57,558,132	1,302,064	205,333,580	201,729,000	3,604,580	802,956,864	(597,623,284)
23	Pharmacy Claim Rebates	-	-	-	(42,746,428)	(42,865,853)	119,425	(104,118,976)	61,372,548
24	Pharmacy Claim Refunds/Recoveries	(9,002)	-	(9,002)	(1,635,305)	-	(1,635,305)	-	(1,635,305)
25	**Net Pharmacy Claims**	**58,851,194**	**57,558,132**	**1,293,062**	**160,951,847**	**158,863,147**	**2,088,700**	**698,837,888**	**(537,886,041)**
26									
27	**Net Claim Payments**	**208,163,408**	**218,193,553**	**(10,030,145)**	**685,005,226**	**701,734,705**	**(16,729,479)**	**2,825,398,990**	**(2,140,393,764)**
28									
29	**Medicare Advantage Premium Payments**	**14,515,409**	**14,302,531**	**212,878**	**43,361,928**	**42,872,040**	**489,888**	**181,076,580**	**(137,714,652)**
30									
31	**Net Administrative Expenses**	**18,133,397**	**18,425,858**	**(292,461)**	**36,014,511**	**55,295,539**	**(19,281,028)**	**244,252,193**	**(208,237,682)**
32									
33	**Total Plan Expenses (excludes internal transfers)**	**240,812,214**	**250,921,942**	**(10,109,728)**	**764,381,665**	**799,902,284**	**(35,520,619)**	**3,250,727,763**	**(2,486,346,098)**
34									
35	**Plan Income/(Loss)**	**10,135,302**	**(873,166)**	**11,008,468**	**(11,716,776)**	**(49,353,091)**	**37,636,315**	**(201,554,630)**	**189,837,854**
36									
37	**Cash Availability:**								
38									
39	Beginning Cash Balance/(Deficit)	1,002,267,545	975,639,698	26,627,847	1,024,119,623	1,024,119,623	-	1,024,119,623	-
40	**Ending Cash Balance/(Deficit)**	**1,012,402,847**	**974,766,532**	**37,636,315**	**1,012,402,847**	**974,766,532**	**37,636,315**	**822,564,993**	**189,837,854**
41									
42	Target Stabilization Reserve @ 6/30/15	254,285,909	254,285,909	-	254,285,909	254,285,909	-	254,285,909	-
43									
44	**Cash Balance Over/(Under) Reserve Target**	**$ 758,116,938**	**$ 720,480,623**	**$ 37,636,315**	**$ 758,116,938**	**$ 720,480,623**	**$ 37,636,315**	**$ 568,279,084**	**$ 189,837,854**

Comments:
a. Premium receivables totaled $1,363,354.70 as of September 30, 2015.
b. The average weekly medical claims cost net of claims refunds was $37,328,053.50 for the four scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $29,430,098.00 per cycle.
d. The target stabilization reserve is 9% of the projected net claims for Fiscal Year 2015-16.
e. Minor differences compared to other reports are due to rounding.

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 September 2015
Calendar Year 2015

		A	B	C	D	E	F	G
		Current Year Actual September 2015	Prior Year Actual September 2014	Current Year to Date Actual CY 2015 thru September	Prior Year to Date Actual CY 2014 thru September	Current Year Authorized Annual Budget CY 2015	Prior Year Annual Budget CY 2014	Prior Year Actual Results CY 2014
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 250,233,395	$ 257,532,521	$ 2,220,931,575	$ 2,191,544,860	$ 2,963,937,832	$ 2,921,878,532	$ 2,952,592,141
4	Premium Refunds/Retroactive Disenrollments	-	-	(5,343)	(28,401)	(1,486,657)	(1,489,408)	(28,401)
5	Medicare Part D (RDS) Subsidy	-	2,369,310	14,258,373	18,004,435	14,587,080	6,344,076	21,584,404
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	48,603,406	28,378,401	48,602,498	31,047,005	28,378,401
7	Medicare Advantage (MA) Subsidy	125,631	38,742	721,301	536,077	828,983	-	721,773
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	(1,949)
9	**Net Premium & Other Contributions**	250,359,026	259,940,573	2,284,509,312	2,238,435,372	3,026,469,736	2,957,780,205	3,003,246,369
10								
11	Investment Earnings	587,852	353,651	4,349,914	3,232,497	3,871,779	2,892,005	4,417,142
12	Miscellaneous Revenue	638	-	638	-	-	-	-
13	**Other Revenue**	588,490	353,651	4,350,552	3,232,497	3,871,779	2,892,005	4,417,142
14								
15	**Total Plan Revenue (excludes internal transfers)**	250,947,516	260,294,224	2,288,859,864	2,241,667,869	3,030,341,515	2,960,672,210	3,007,663,511
16								
17	**Plan Expenses:**							
18								
19	Medical Claim Payments	150,682,321	189,082,882	1,556,468,644	1,478,419,240	2,128,799,496	2,062,826,346	1,949,838,964
20	Medical Claim Refunds/Recoveries	(1,370,107)	(1,861,670)	(18,192,194)	(17,050,328)	(25,072,202)	(25,469,051)	(22,731,740)
21	**Net Medical Claims**	149,312,214	187,221,212	1,538,276,450	1,461,368,912	2,103,727,294	2,037,357,295	1,927,107,224
22								
23	Pharmacy Claim Payments	58,860,196	53,062,418	550,679,131	504,763,477	718,955,282	599,541,594	698,126,200
24	Pharmacy Claim Rebates	-	-	(54,562,398)	(88,001,925)	(57,020,841)	(54,794,623)	(98,763,203)
25	Pharmacy Claim Refunds/Recoveries	(9,002)	(32,318)	(5,303,462)	110,669	-	-	(310,778)
26	**Net Pharmacy Claims**	58,851,194	53,030,100	490,813,271	416,872,221	661,934,441	544,746,971	599,052,219
27								
28	**Net Claim Payments**	208,163,408	240,251,312	2,029,089,721	1,878,241,133	2,765,661,735	2,582,104,266	2,526,159,443
29								
30	**Medicare Advantage Premium Payments**	14,515,409	13,163,912	128,803,219	117,713,027	174,072,089	174,162,733	155,497,950
31								
32	**Net Administrative Expenses**	18,133,397	12,345,540	133,411,423	114,223,530	239,864,700	179,815,010	149,605,909
33								
34	**Total Plan Expenses (excludes internal transfers)**	240,812,214	265,760,764	2,291,304,363	2,110,177,690	3,179,598,524	2,936,082,009	2,831,263,302
35								
36	**Plan Income/(Loss)**	10,135,302	(5,466,540)	(2,444,499)	131,490,179	(149,257,009)	24,590,201	176,400,209
37								
38	**Cash Availability:**							
39								
40	Beginning Cash Balance/(Deficit)	1,002,267,545	975,403,856	1,014,847,346	838,447,137	1,014,847,346	694,975,133	838,447,137
41	**Ending Cash Balance/(Deficit)**	1,012,402,847	969,937,316	1,012,402,847	969,937,316	865,590,337	719,565,334	1,014,847,346
42								
43	Target Stabilization Reserve @ 12/31	248,909,557	234,282,695	248,909,557	234,282,695	248,909,557	234,282,695	227,940,878
44								
45	**Cash Balance Over/(Under) Reserve Target**	$ 763,493,290	$ 735,654,621	$ 763,493,290	$ 735,654,621	$ 616,680,780	$ 485,282,639	$ 786,906,468

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

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

		A	B	C	D	E	F	G
		Current Year Actual September 2015	Prior Year Actual September 2013	Current Year to Date Actual FY 2015-16 thru September	Prior Year to Date Actual FY 2014-15 thru September	Current Year Certified Annual Budget FY 2015-16	Prior Year Annual Budget FY 2014-15	Prior Year Actual Results FY 2014-15
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 250,233,395	$ 257,532,521	$ 747,501,365	$ 753,025,182	$ 3,031,630,846	$ 2,937,906,736	$ 2,987,502,673
4	Premium Refunds/Retroactive Disenrollments	-	-	-	(6,016)	(1,523,909)	(1,478,664)	(11,359)
5	Medicare Part D (RDS) Subsidy	-	2,369,310	3,344,466	5,096,895	14,457,206	6,276,386	19,590,771
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	1,680,417	-	33,414,689	50,283,823
7	Medicare Advantage (MA) Subsidy	125,631	38,742	192,247	118,512	848,545	-	833,262
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	(1,949)
9	**Net Premium & Other Contributions**	250,359,026	259,940,573	751,038,078	759,914,990	3,045,412,688	2,976,119,147	3,058,197,221
10								
11	Investment Earnings	587,852	353,651	1,626,173	1,157,349	3,760,445	3,933,340	5,065,735
12	Miscellaneous Revenue	638	-	638	-	-	-	-
13	**Other Revenue**	588,490	353,651	1,626,811	1,157,349	3,760,445	3,933,340	5,065,735
14								
15	**Total Plan Revenue (excludes internal transfers)**	250,947,516	260,294,224	752,664,889	761,072,339	3,049,173,133	2,980,052,487	3,063,262,956
16								
17	**Plan Expenses:**							
18								
19	Medical Claim Payments	150,682,321	189,082,882	528,521,497	522,002,307	2,152,322,381	1,995,716,227	2,021,369,178
20	Medical Claim Refunds/Recoveries	(1,370,107)	(1,861,670)	(4,468,118)	(5,433,940)	(25,761,279)	(23,520,519)	(24,839,428)
21	**Net Medical Claims**	149,312,214	187,221,212	524,053,379	516,568,367	2,126,561,102	1,972,195,708	1,996,529,750
22								
23	Pharmacy Claim Payments	58,860,196	53,062,418	205,333,580	186,898,832	802,956,864	686,943,428	725,607,106
24	Pharmacy Claim Rebates	-	-	(42,746,428)	(28,537,461)	(104,118,976)	(74,166,940)	(51,114,709)
25	Pharmacy Claim Refunds/Recoveries	(9,002)	(32,318)	(1,635,305)	(48,209)	-	-	(4,137,813)
26	**Net Pharmacy Claims**	58,851,194	53,030,100	160,951,847	158,313,162	698,837,888	612,776,488	670,354,584
27								
28	**Net Claim Payments**	208,163,408	240,251,312	685,005,226	674,881,529	2,825,398,990	2,584,972,196	2,666,884,334
29								
30	**Medicare Advantage Premium Payments**	14,515,409	13,163,912	43,361,928	39,174,180	181,076,580	163,281,044	162,400,394
31								
32	**Net Administrative Expenses**	18,133,397	12,345,540	36,014,511	35,637,354	244,252,193	223,971,245	168,416,645
33								
34	**Total Plan Expenses (excludes internal transfers)**	240,812,214	265,760,764	764,381,665	749,693,063	3,250,727,763	2,972,224,485	2,997,701,373
35								
36	**Plan Income/(Loss)**	10,135,302	(5,466,540)	(11,716,776)	11,379,276	(201,554,630)	7,828,002	65,561,583
37								
38	**Cash Availability:**							
39								
40	Beginning Cash Balance/(Deficit)	1,002,267,545	975,403,856	1,024,119,623	958,558,040	1,024,119,623	958,558,040	958,558,040
41	**Ending Cash Balance/(Deficit)**	1,012,402,847	969,937,316	1,012,402,847	969,937,316	822,564,993	966,386,042	1,024,119,623
42								
43	Target Stabilization Reserve @ 6/30/15	254,285,909	232,647,498	254,285,909	232,647,498	254,285,909	232,647,498	240,019,590
44								
45	**Cash Balance Over/(Under) Reserve Target**	$ 758,116,938	$ 737,289,818	$ 758,116,938	$ 737,289,818	$ 568,279,084	$ 733,738,544	$ 784,100,033

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

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

		A	B	C	D	E	F
		Actual Year to Date Calendar Year thru September	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Authorized Budget Calendar Year to Date thru September	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 2,220,931,575	$ (7,656,420)	$ 2,213,275,155	$ 2,218,974,315	$ (5,699,160)	-0.26%
4	Premium Refunds/Retroactive Disenrollments	(5,343)		(5,343)	(1,113,007)	1,107,664	-99.52%
5	Medicare Part D (RDS) Subsidy	14,258,373		14,258,373	10,864,732	3,393,641	31.24%
6	Medicare PDP (EGWP + Wrap) Subsidy	48,603,406		48,603,406	48,602,498	908	0.00%
7	Medicare Advantage (MA) Subsidy	721,301		721,301	620,773	100,528	16.19%
8	**Net Premium & Other Contributions**	**2,284,509,312**	**(7,656,420)**	**2,276,852,892**	**2,277,949,311**	**(1,096,419)**	**-0.05%**
9							
10	**Other Revenue**	**4,350,552**		**4,350,552**	**2,969,581**	**1,380,971**	**46.50%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**2,288,859,864**	**(7,656,420)**	**2,281,203,444**	**2,280,918,892**	**284,552**	**0.01%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	1,538,276,450		1,538,276,450	1,592,703,752	(54,427,302)	-3.42%
17	Net Pharmacy Claims (Notes 3 thru 5)	490,813,271	11,098,753	501,912,024	477,812,500	24,099,524	5.04%
18	**Net Claim Payments**	**2,029,089,721**	**11,098,753**	**2,040,188,474**	**2,070,516,252**	**(30,327,778)**	**-1.46%**
19							
20	**Medicare Advantage Premiums**	**128,803,219**		**128,803,219**	**130,391,551**	**(1,588,332)**	**-1.22%**
21							
22	**Net Administrative Expenses**	**133,411,423**		**133,411,423**	**178,979,985**	**(45,568,562)**	**-25.46%**
23							
24	**Total Plan Expenses (excludes internal transfers)**	**2,291,304,363**	**11,098,753**	**2,302,403,116**	**2,379,887,788**	**(77,484,672)**	**-3.26%**
25							
26	**Plan Income/(Loss)**	**(2,444,499)**	**(18,755,173)**	**(21,199,672)**	**(98,968,896)**	**77,769,224**	**-78.58%**
27							
28	**Cash Availability:**						
29							
30	Beginning Cash Balance/(Deficit)	1,014,847,346		1,014,847,346	1,014,847,346	-	0.00%
31	**Ending Cash Balance/(Deficit)**	**1,012,402,847**	**(18,755,173)**	**993,647,674**	**915,878,450**	**77,769,224**	**8.49%**
32							
33	Target Stabilization Reserve @ 12/31/2015	248,909,557		248,909,557	248,909,557	-	0.00%
34							
35	**Cash Balance Over/(Under) Reserve Target**	**$ 763,493,290**	**$ (18,755,173)**	**$ 744,738,117**	**$ 666,968,893**	**$ 77,769,224**	**11.66%**

Adjustment Notes:

1. Member premiums adjusted by $25.8 million to include prepaid January premiums received in December 2014 ($46.9 million) less a downward adjustment in the budget to account for the prepaid premiums ($21.1 million).
2. Member premiums adjusted to exclude $33.5 million in prepaid October premiums received in September.
3. Net pharmacy claims adjusted to exclude an unbudgeted $1.6 million recovery from a class action law suit.
4. Net pharmacy claims reduced by $23.3 million to assume receipt of rebates that were budgeted but were not received by the end of September.
5. Net pharmacy claims increased by $32.7 million to account for a rebate true-up payment received in excess of the budgeted true-up payment.

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 September 2015
Fiscal Year 2015-2016

		A	B	C	D	E	F
		Actual Year to Date Fiscal Year thru September	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Fiscal Year to Date thru September	*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)	$ 747,501,365	$ (12,022,340)	$ 735,479,025	$ 746,113,327	$ (10,634,302)	-1.43%
4	Premium Refunds/Retroactive Disenrollments	-		-	(374,130)	374,130	-100.00%
5	Medicare Part D (RDS) Subsidy	3,344,466		3,344,466	3,603,195	(258,729)	-7.18%
6	Medicare PDP (EGWP + Wrap) Subsidy	-		-	-	-	
7	Medicare Advantage (MA) Subsidy	192,247		192,247	208,432	(16,185)	-7.77%
8	**Net Premium & Other Contributions**	**751,038,078**	**(12,022,340)**	**739,015,738**	**749,550,824**	**(10,535,086)**	**-1.41%**
9							
10	**Other Revenue**	**1,626,811**		**1,626,811**	**998,369**	**628,442**	**62.95%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**752,664,889**	**(12,022,340)**	**740,642,549**	**750,549,193**	**(9,906,644)**	**-1.32%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	524,053,379		524,053,379	542,871,558	(18,818,179)	-3.47%
17	Net Pharmacy Claims (Note 3)	160,951,847	1,612,006	162,563,853	158,863,147	3,700,706	2.33%
18	**Net Claim Payments**	**685,005,226**	**1,612,006**	**686,617,232**	**701,734,705**	**(15,117,473)**	**-2.15%**
19							
20	**Medicare Advantage Premiums**	**43,361,928**		**43,361,928**	**42,872,040**	**489,888**	**1.14%**
21							
22	**Net Administrative Expenses**	**36,014,511**		**36,014,511**	**55,295,539**	**(19,281,028)**	**-34.87%**
23							
24	**Total Plan Expenses (excludes internal transfers)**	**764,381,665**	**1,612,006**	**765,993,671**	**799,902,284**	**(33,908,613)**	**-4.24%**
25							
26	**Plan Income/(Loss)**	**(11,716,776)**	**(13,634,346)**	**(25,351,122)**	**(49,353,091)**	**24,001,970**	**-48.63%**
27							
28	**Cash Availability:**						
29							
30	Beginning Cash Balance/(Deficit)	1,024,119,623		1,024,119,623	1,024,119,623	-	0.00%
31	**Ending Cash Balance/(Deficit)**	**1,012,402,847**	**(13,634,346)**	**998,768,502**	**974,766,532**	**24,001,970**	**2.46%**
32							
33	Target Stabilization Reserve @ 6/30/15	254,285,909		254,285,909	254,285,909	-	0.00%
34							
35	**Cash Balance Over/(Under) Reserve Target**	**$ 758,116,938**	**$ (13,634,346)**	**$ 744,482,593**	**$ 720,480,623**	**$ 24,001,970**	**3.33%**

Adjustment Notes:
1. Member premiums adjusted to include $21.4 million in prepaid July 2015 premiums received in June 2015.
2. Member premiums adjusted to exclude $33.5 million in prepaid October premiums received in September.
3. Net pharmacy claims exclude an unbudgeted $1.6 million recovery from a class action law suit.

Adjusted Variance Report Based on Certified Budget
Fiscal Year to Date Through September 2015

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

CY 2015 3rd Quarter Actuarial Forecast Update

Board of Trustees Meeting

November 20, 2015

Forecast prepared by The Segal Company
Final version dated 11-6-15

Presentation Overview

- Forecast Update Schedule
- Updated Assumptions: Authorized CY 2015 Budget vs. CY 2015 3rd Quarter Forecast Update
- CY 2015 Forecast: Authorized CY 2015 Budget vs. CY 2015 3rd Quarter Forecast Update
- Summary Graphs
- Future Outlook
  - Relative to Authorized CY 2015 Budget
  - Relative to Certified 2015-2017 Fiscal Biennium (FB 2015-17) Budget

Actuarial Forecast Update Schedule

- The Plan's actuarial consultant updates the forecast quarterly and at the end of each calendar year and 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
Authorized CY15 Budget vs. CY15 3rd Quarter Update

- Membership trends
  - 1% annual decrease in actives
  - 1% annual increase in retirees

- Trend assumptions
  - 7% medical trend
  - 8.5% pharmacy trend

- Most components of the Board's new benefit design that will be effective January 1, 2016
  - Increase in wellness premiums and credits
  - Increased cost-sharing in Traditional 70/30 Plan
  - Enhancements to Consumer-Directed Health Plan (CDHP)
  - *Status Quo* in Enhanced 80/20 Plan, except Tier 5 pharmacy copay

- Increased administrative budget for 2015-17 Fiscal Biennium
  - 3% annual increases in administrative costs after Fiscal Year 2016-17

- Target Stabilization Reserve (TSR) equals 9% of projected claims costs in each year

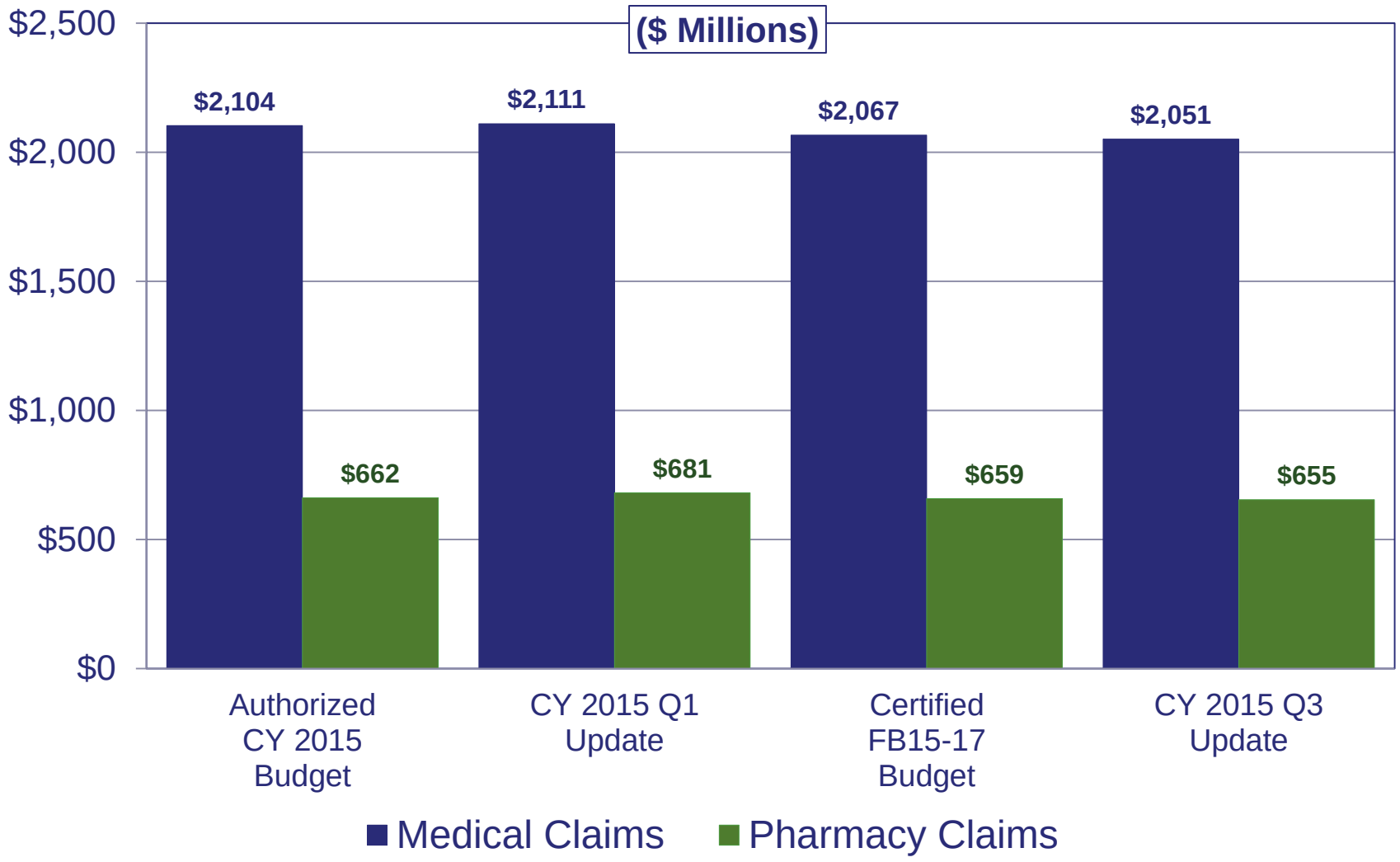
Forecast Assumptions Changed/Revised in the Update Authorized CY15 Budget vs. CY15 3rd Quarter Update

- Membership based on actual March 2015 enrollment data, with adjustments for known changes through May 2015, and then assumed to be stable through September (instead of using a December 2014 base)
- Anticipated claims expenditures based on actual experience through September 2015 (instead of through December 2014)
- Cash balance begins from actual total as of September 30, 2015 (rather than December 31, 2014)
- The impact of member migration in future years was adjusted to reflect more recent cost differentials among plan options
- Medicare Advantage (MA) premium costs reflect negotiations with carriers for 2016 rates
- Includes projected impact of additional local governments joining the Plan, as authorized in HB 154 (S.L. 2015-112)
- Includes actual 2014 rebate true-up payments received in July and August 2015 (total of $42.9 million)
- Assumes higher 2015 rebates to more accurately reflect recent rebate experience
- Includes actual rebates for first, second, and third quarters of CY 2015 in November 2015
- Delays the smoker attestation for the Traditional 70/30 Plan until 2017
- Includes impact of Board's decisions on premium rate increases
- Incorporates enacted State Budget; assumes increases in employer contributions in 2016 and 2017
- Re-balances to the Target Stabilization Reserve as of December 31, 2019 (rather than December 31, 2017)

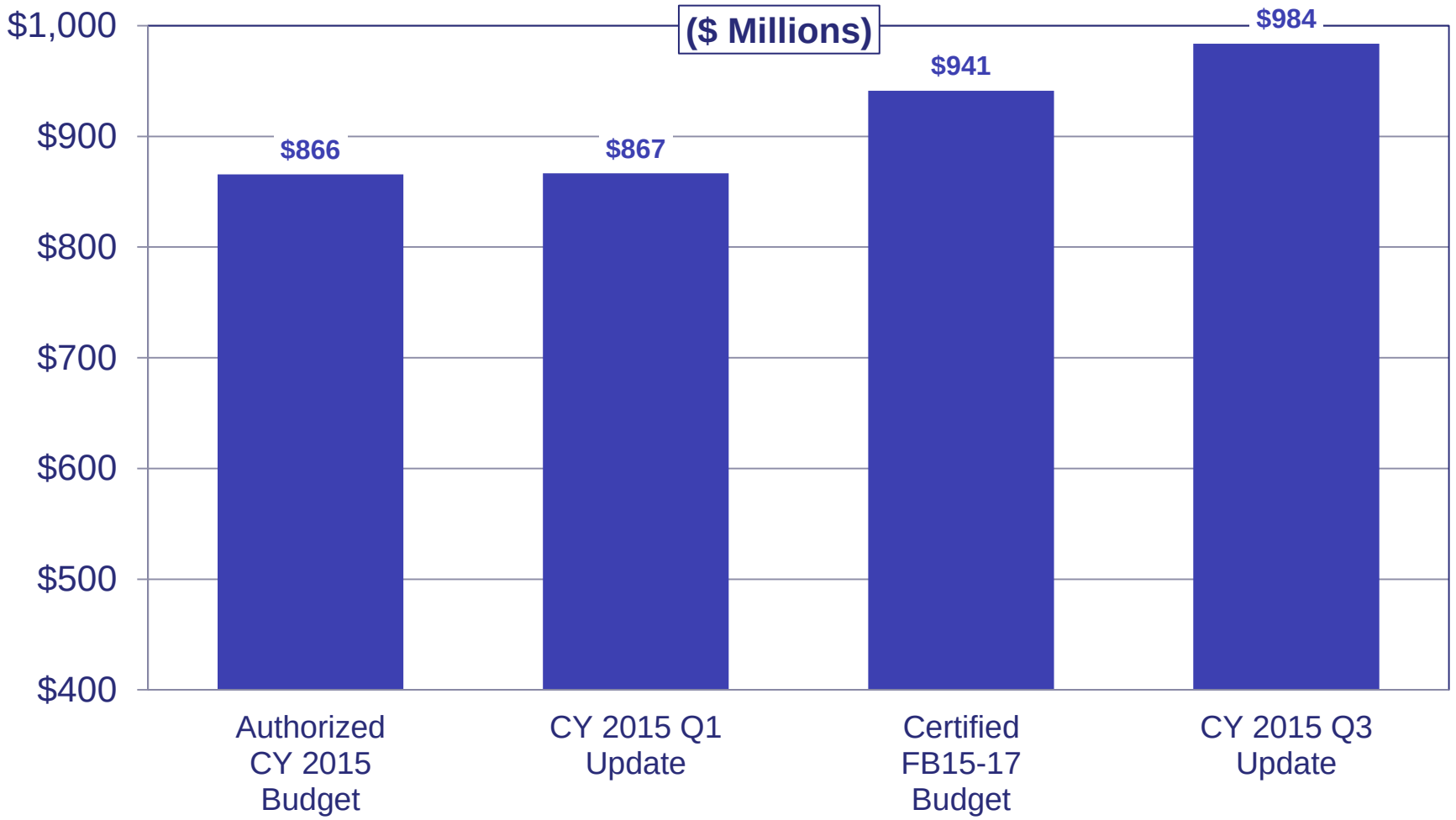
Comparison of Models
Authorized CY15 Budget vs. CY15 3rd Quarter Update

Calendar Year 2015	CY 2015 3rd Quarter Update (per Segal 11-6-15)	Authorized CY 2015 Budget (per Segal 4-28-15)	Difference: Increase/ (Decrease) From Budget
Beginning Cash Balance	**$1.015 b**	**$1.015 b**	**$0.0 m**
Plan Revenue	**$3.041 b**	**$3.030 b**	**$10.4 m**
Net Claims Payments	$2.706 b	$2.766 b	($59.6 m)
Medicare Advantage Premiums	$171.6 m	$174.1 m	($2.5 m)
Net Admin. Expenses	$194.3 m	$239.9 m	($45.6 m)
Total Plan Expenses	**$3.072 b**	**$3.179 b**	**($107.7 m)**
Net Income/(Loss)	**($31.1 m)**	**($149.2 m)**	**$118.1 m**
Ending Cash Balance	**$983.7 m**	**$865.6 m**	**$118.1 m**
2018 & 2019 Premium Increases	12.16%	15.21%	(3.05%)
2020 & 2021 Premium Increases	7.35%	4.34%	3.01%

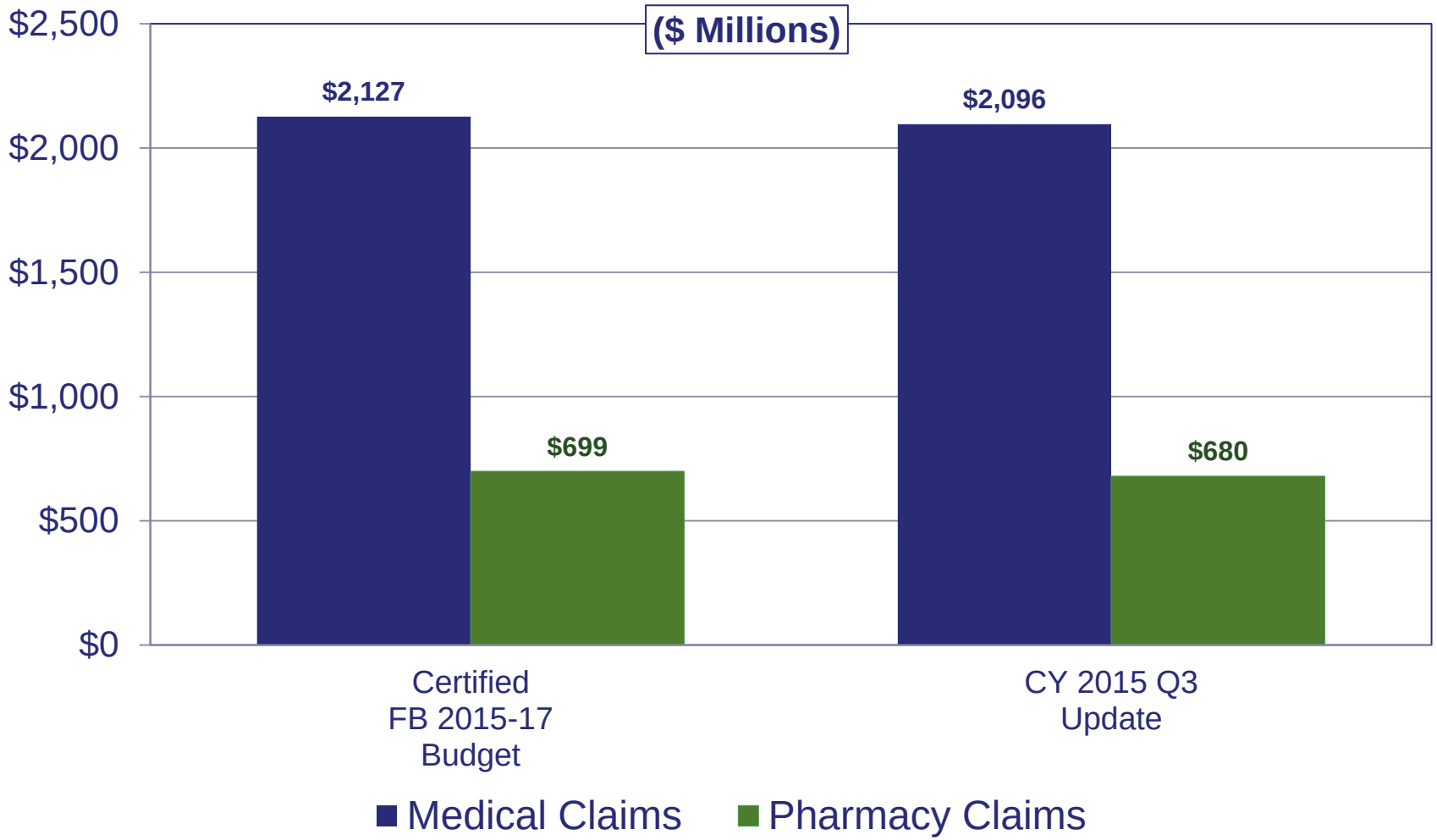
Forecast Comparisons: Calendar Year 2015 Claims



Forecast Comparisons: Ending Cash Balance December 31, 2015

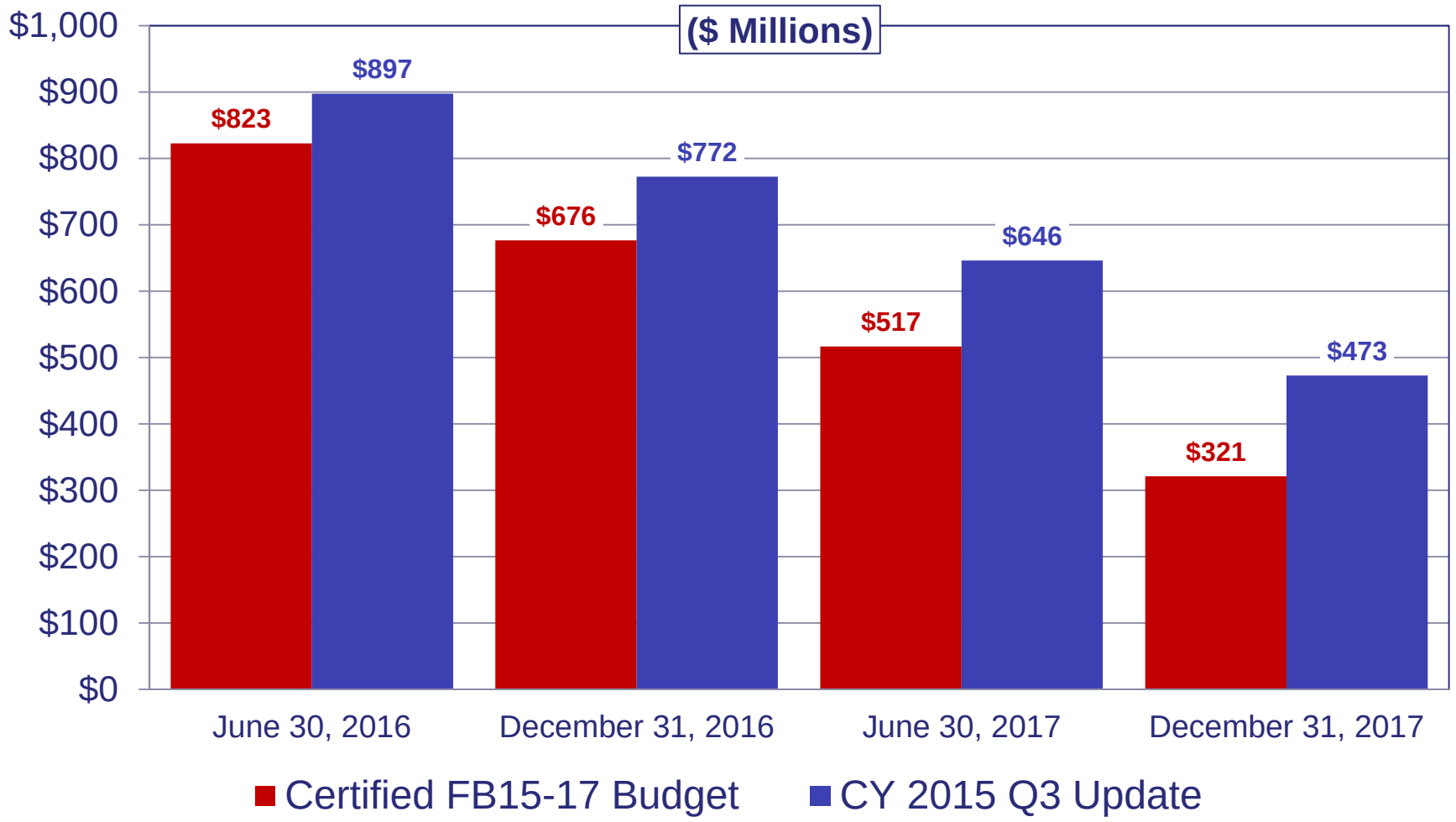


Forecast Comparisons: Fiscal Year 2015-16 Claims

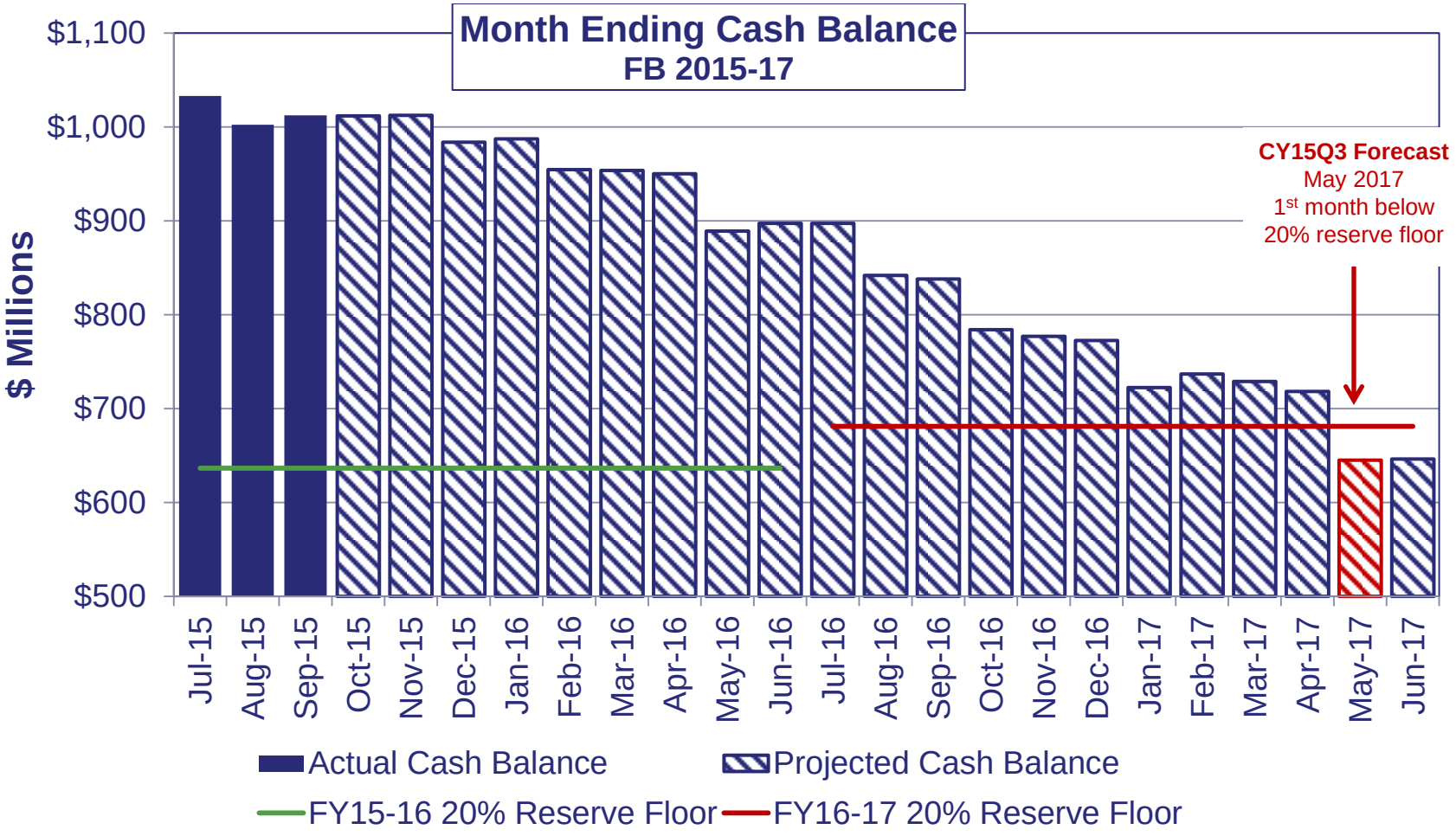


*Approximately $22 million in anticipated pharmacy rebates was not received by the end of the FY.

Forecast Comparisons: Ending Cash Balances in FB15-17



Projected Cash Balance/20% Legislative Reserve Floor CY 2015 3rd Quarter Update



Summary/Future Outlook
Based on CY 2015 3rd Quarter Update

Relative to the Authorized CY 2015 Budget, the CY 2015 3rd Quarter Update projects:

- **higher** cash balance at the end of 2015,
- **lower** medical claims costs,
- **higher** pharmacy rebates, and
- **higher** long-term pharmacy claims costs

Comparisons to the Certified FB 2015-17 Budget

- The **$646.2 million** cash balance projected for June 30, 2017:
  - Is $129.4 million **higher** than the Certified FB 2015-17 Budget projection
  - **Exceeds** the 9.0% target stabilization reserve amount by $379.7 million
  - Equates to **9.3 weeks** of projected FY 2017-18 operating expenses

- The CY 2015 3rd Quarter Update anticipates falling below the 20% Legislative Reserve Floor in May 2017, 6 months **later** than the Certified FB 2015-17 Budget projection (November 2016)

- The CY 2015 3rd Quarter Update projects the need for **12.16%** premium increases for January 2018 and 2019. This is **lower** than the Certified FB 2015-17 Budget (14.88%)

CY 2014 Q4 Update Authorized CY 2015 Budget

(Segal 9-9-14)

Segal Consulting

North Carolina State Health Plan
Financial Projections - Dec 2014
Trends - 7.0% Medical & 8.5% Pharmacy
No Wellness, No 100% Preventive, Increased Cost Sharing, Smoker Surchager ($40 for 2016 and 2017 and $60 for 2018 and 2019) and $20 Premium for Active on 70/30 Plan Starting 2018
With January 2015 Enrollment Updated
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	Actual Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019	Projection Calendar 2020	Projection Calendar 2021
PLAN INCOME:											
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	2,952,592,141	2,973,313,265	3,084,373,299	3,178,159,722	3,647,867,428	4,187,357,312	4,353,552,988	4,526,742,933
Additional Contribution/(Credit)		-	-	-	(11,254,466)	(1,037,235)	(813,056)	29,068,878	28,051,841	26,091,252	25,140,208
Medicare Advantae Subsidy			-	721,773	828,983	863,581	879,710	915,037	931,831	968,212	985,692
Health care Reform ERRP	42,163,391	(558,219)	-	(1,949)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(28,401)	(1,486,657)	(1,542,187)	(1,589,080)	(1,823,934)	(2,093,679)	(2,176,776)	(2,263,371)
Premium Change due to Movement			-	-	1,879,031	4,736,903	6,772,839	14,036,650	14,790,952	16,833,606	17,727,090
Medicare Part D	57,583,602	38,056,016	(1,323,888)	21,584,404	14,587,080	14,298,634	14,514,516	14,063,476	14,200,558	13,588,971	13,626,486
EGWP+Wrap											
Direct Subsidy	-	24,435,483	25,202,822	216,170	-	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,765	28,162,232	-	-	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	48,602,498	-	-	-	-	-	-
Total	-	24,435,483	37,082,587	28,378,402	48,602,498	-	-	-	-	-	-
Investment Earnings	3,015,815	3,236,713	1,841,087	4,417,142	3,871,780	3,014,101	1,815,911	890,582	1,054,034	1,559,559	1,603,266
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	3,007,663,512	3,030,341,513	3,104,707,096	3,199,740,563	3,705,018,118	4,244,292,849	4,410,417,812	4,583,562,303
PLAN EXPENSE:											
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	1,949,838,964	2,111,340,121	2,238,782,943	2,382,053,957	2,589,959,390	2,707,819,875	2,887,321,150	3,074,284,772
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(22,731,740)	(25,072,201)	(26,762,489)	(28,316,855)	(30,193,794)	(32,350,749)	(34,273,593)	(36,755,927)
Claims Adjustment for Changes				-	12,563,278	(34,775,189)	(48,204,121)	(20,681,815)	(41,590,816)	(53,892,086)	(44,591,961)
Cost of Autism				-	4,000,000	5,000,000	5,200,000	5,500,000	5,800,000	5,500,000	5,800,000
Cost of Add Towns				-	896,100	956,521	996,977	1,055,452	1,052,889	1,047,896	1,045,532
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,927,107,224	2,103,727,297	2,183,201,786	2,311,729,958	2,545,639,233	2,640,731,199	2,805,703,368	2,999,782,415
Medicare Advantage Premiums				155,497,950	174,072,089	193,223,905	208,833,714	231,478,810	250,300,181	277,319,722	299,996,296
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	697,815,422	718,263,283	767,803,395	827,727,508	892,381,574	962,143,775	1,037,984,755	1,119,319,325
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(98,763,203)	(57,020,841)	(50,441,480)	(51,470,131)	(52,183,288)	(53,239,165)	(53,941,763)	(55,015,158)
Claims Adjustment for Changes			-	-	-	-	-	-	-	-	-
Additional ACA Preventive Medicine			-	-	692,000	1,276,000	1,366,000	1,462,000	1,511,325	1,462,000	1,511,591
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	599,052,219	661,934,443	718,637,915	777,623,376	841,660,286	910,415,935	985,504,992	1,065,815,759
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,681,657,393	2,939,733,829	3,095,063,606	3,298,187,049	3,618,778,329	3,801,447,315	4,068,528,081	4,365,594,471
Administrative Costs	165,480,561	161,401,639	69,548,737	149,605,909	206,008,311	226,154,277	234,465,996	240,602,620	246,921,261	253,427,967	260,129,003
ACA Reinsurance Fee				-	33,856,390	23,696,015	14,429,245	-	-	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,831,263,302	3,179,598,530	3,344,913,898	3,547,082,290	3,859,380,949	4,048,368,576	4,321,956,048	4,625,723,474
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	176,400,210	(149,257,017)	(240,206,802)	(347,341,727)	(154,362,831)	195,924,273	88,461,764	(42,161,171)
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	1,014,847,346	865,590,329	625,383,527	278,041,800	123,678,969	319,603,242	408,065,006
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	1,014,847,346	865,590,329	625,383,527	278,041,800	123,678,969	319,603,242	408,065,006	365,903,836
Target Stabilization Reserve	184,110,626	201,392,496	113,231,386	214,723,553	248,909,557	261,165,573	278,041,800	304,856,957	319,603,242	341,208,752	365,903,836
	7.5%	8.0%	8.0%	8.5%	9.0%	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	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	5.3%	5.3%		3.57%	0.00%	3.43%	3.43%	15.21%	15.21%	4.34%	4.34%

Final Q4 Update

CY 2015 Q1 Update

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(Segal 5-14-15)

North Carolina State Health Plan
Financial Projections - Mar 2015
Trends - 7.0% Medical & 8.5% Pharmacy
No Wellness, No 100% Preventive, Increased Cost Sharing, Smoker Surchager ($40 for 2016 and 2017 and $60 for 2018 and 2019) and $20 Premium for Active on 70/30 Plan Starting 2018
With March 2015 Enrollment
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	Actual Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019	Projection Calendar 2020	Projection Calendar 2021
PLAN INCOME:											
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	2,952,592,141	2,983,580,339	3,099,319,091	3,208,868,439	3,666,157,555	4,188,978,109	4,371,109,270	4,561,561,364
Additional Contribution/(Credit)		-	-	-	(8,406,617)	(1,009,207)	(786,530)	29,069,329	28,053,975	26,096,405	25,147,101
Medicare Advantae Subsidy			-	721,773	958,017	865,285	881,481	916,996	933,860	970,437	987,990
Health care Reform ERRP	42,163,391	(558,219)	-	(1,949)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(28,401)	(1,122,113)	(1,549,660)	(1,604,434)	(1,833,079)	(2,094,489)	(2,185,555)	(2,280,781)
Premium Change due to Movement			-	-	1,351,700	6,078,505	8,881,746	22,062,895	27,043,263	32,739,747	36,367,818
Medicare Part D	57,583,602	38,056,016	(1,323,888)	21,584,404	14,329,561	12,825,874	13,075,320	12,630,645	12,816,638	12,224,303	12,329,139
EGWP+Wrap											
Direct Subsidy	-	24,435,483	25,202,822	216,170	56	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,766	28,162,232	-	-	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	48,602,965	-	-	-	-	-	-
Total	-	24,435,483	37,082,587	28,378,402	48,603,021	-	-	-	-	-	-
Investment Earnings	3,015,815	3,236,713	1,841,087	4,417,142	4,188,398	2,986,638	1,790,108	942,150	1,111,450	1,543,419	1,588,162
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	3,007,663,512	3,043,482,305	3,119,516,527	3,231,106,129	3,729,946,491	4,256,842,807	4,442,498,026	4,635,700,791
PLAN EXPENSE:											
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	1,949,838,964	2,130,042,184	2,285,239,688	2,409,660,789	2,620,955,586	2,739,402,020	2,921,951,842	3,106,548,653
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(22,731,740)	(25,643,812)	(27,079,502)	(28,644,927)	(30,555,252)	(32,727,927)	(34,684,538)	(37,148,878)
Claims Adjustment for Changes				-	2,961,798	(53,706,028)	(82,533,403)	(78,179,662)	(63,581,090)	(75,701,260)	(67,674,141)
Cost of Autism				-	2,999,456	5,000,000	5,200,000	5,500,000	5,800,000	5,500,000	5,800,000
Cost of Add Towns				-	679,300	956,521	996,993	1,055,503	1,052,974	1,048,016	1,045,685
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,927,107,224	2,111,038,926	2,190,410,678	2,304,679,452	2,518,776,175	2,649,945,977	2,818,114,059	3,008,571,319
Medicare Advantage Premiums				155,497,950	173,520,859	193,613,916	209,260,923	231,983,719	250,852,480	277,966,597	300,703,143
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	697,815,422	740,074,079	789,065,505	850,678,570	917,157,600	988,891,892	1,066,879,388	1,150,519,966
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(98,763,203)	(59,969,191)	(50,102,163)	(51,127,149)	(51,837,739)	(52,890,061)	(53,590,371)	(54,660,441)
Claims Adjustment for Changes			-	-	-	-	-	-	-	-	-
Additional ACA Preventive Medicine			-	-	518,906	1,276,000	1,366,000	1,462,000	1,522,939	1,637,794	1,749,271
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	599,052,219	680,623,794	740,239,341	800,917,422	866,781,861	937,524,770	1,014,926,811	1,097,608,796
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,681,657,393	2,965,183,579	3,124,263,935	3,314,857,796	3,617,541,755	3,838,323,227	4,111,007,467	4,406,883,258
Administrative Costs	165,480,561	161,401,639	69,548,737	149,605,909	220,789,282	226,154,228	234,469,803	240,614,327	246,941,340	253,456,913	260,167,335
ACA Reinsurance Fee				-	5,642,732	23,672,083	14,415,152	-	-	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,831,263,302	3,191,615,593	3,374,090,245	3,563,742,751	3,858,156,082	4,085,264,567	4,364,464,380	4,667,050,594
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	176,400,210	(148,133,288)	(254,573,718)	(332,636,622)	(128,209,591)	171,578,240	78,033,645	(31,349,802)
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	1,014,847,346	866,714,059	612,140,340	279,503,719	151,294,128	322,872,367	400,906,013
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	1,014,847,346	866,714,059	612,140,340	279,503,719	151,294,128	322,872,367	400,906,013	369,556,210
Target Stabilization Reserve	184,110,626	201,392,496	113,231,386	214,723,553	251,249,645	263,758,502	279,503,719	304,700,223	322,872,367	344,973,678	369,556,210
	7.5%	8.0%	8.0%	8.5%	9.0%	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	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
Premium Increase:	5.3%	5.3%		3.57%	0.00%	3.93%	3.93%	14.67%	14.67%	4.72%	4.72%

Certified FB 2015-17 Budget

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(Segal 10-13-15)

Segal Consulting

North Carolina State Health Plan
Financial Projections - Jun 2015
Trends - 7.0% Medical & 8.5% Pharmacy
No Wellness, No 100% Preventive, Increased Cost Sharing, Smoker Surchager ($40 for 2017 and $60 for 2018 and 2019) and $20 Premium for Active (Starting 2018) on 70/30 Plan
With March 2015 Enrollment
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit
3.47% Increase for Actives and NMRs and 3.45% Increase for MRs in ER Contribution and 2.83% Increase for EE Contribtuon in 2016, 3.43% Increase for ER and EE in 2017

	2012 - 2013 Biennium										
	Actual FY 2012	Actual FY 2013	Actual Short Plan Year Jul-Dec 2013	Actual Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019	Projection Calendar 2020	Projection Calendar 2021
PLAN INCOME:											
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	2,952,592,141	2,969,222,633	3,101,082,665	3,196,980,423	3,670,811,220	4,194,038,986	4,387,013,794	4,591,067,046
Wellness Surcharge/(Credit)		-	-	-	(5,579,400)	(12,235,376)	(244,681)	14,428,650	14,997,168	16,015,020	16,574,924
Medicare Advantae Subsidy			-	721,773	946,437	866,821	883,058	918,683	935,591	972,280	989,879
Health care Reform ERRP	42,163,391	(558,219)	-	(1,949)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(28,401)	(753,239)	(1,550,541)	(1,598,490)	(1,835,406)	(2,097,019)	(2,193,507)	(2,295,534)
Premium Change due to Movement			-	-	1,290,050	(11,584,401)	(8,449,897)	3,216,901	6,609,643	10,731,179	12,578,500
Medicare Part D	57,583,602	38,056,016	(1,323,888)	21,584,404	18,259,815	14,177,803	14,476,584	13,968,257	14,199,870	13,526,773	13,672,026
EGWP+Wrap											
Direct Subsidy	-	24,435,483	25,202,822	216,170	441	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,765	28,162,232	-	-	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	48,602,965	-	-	-	-	-	-
Total	-	24,435,483	37,082,587	28,378,402	48,603,406	-	-	-	-	-	-
Investment Earnings	3,015,815	3,236,713	1,841,087	4,417,142	4,699,673	3,269,599	2,005,537	1,069,547	1,152,773	1,529,812	1,573,273
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	3,007,663,512	3,036,689,374	3,094,026,568	3,204,052,534	3,702,577,852	4,229,837,012	4,427,595,351	4,634,160,114
PLAN EXPENSE:											
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	1,949,838,964	2,091,695,828	2,248,177,501	2,391,472,401	2,601,158,619	2,718,666,411	2,899,821,730	3,082,959,373
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(22,731,740)	(26,552,076)	(26,876,079)	(28,428,782)	(30,324,486)	(32,480,285)	(34,421,873)	(36,866,910)
Adjustment for Changes				-	1,687,469	(63,902,366)	(83,097,380)	(80,281,035)	(68,989,932)	(83,381,471)	(77,619,822)
				-	-	-	-	-	-	-	-
Cost of Add Locals				-	-	7,482,840	7,976,416	8,503,282	8,482,861	8,442,872	8,424,051
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,927,107,224	2,066,831,221	2,164,881,896	2,287,922,654	2,499,056,381	2,625,679,055	2,790,461,258	2,976,896,692
Medicare Advantage Premiums				155,497,950	171,292,151	190,926,383	207,663,919	231,607,844	251,851,659	280,568,061	305,023,745
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	697,815,422	747,682,663	802,051,996	864,669,485	932,231,424	1,005,133,318	1,084,389,407	1,169,389,293
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(98,763,203)	(89,462,256)	(50,098,631)	(51,122,325)	(51,830,700)	(52,881,526)	(53,579,327)	(54,647,657)
Claims Adjustment for Changes			-	-	-	-	-	-	-	-	-
Additional ACA Preventive Medicine			-	-	345,776	1,276,000	1,366,000	1,462,000	1,522,931	1,637,763	1,749,194
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	599,052,219	658,566,182	753,229,366	814,913,160	881,862,724	953,774,723	1,032,447,843	1,116,490,830
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,681,657,393	2,896,689,554	3,109,037,645	3,310,499,733	3,612,526,948	3,831,305,437	4,103,477,163	4,398,411,268
Administrative Costs	165,480,561	161,401,639	69,548,737	149,605,909	207,934,251	226,154,235	234,469,159	240,612,354	246,937,966	253,452,064	260,160,933
ACA Reinsurance Fee				-	5,642,732	23,664,475	14,405,357	-	-	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,831,263,302	3,110,266,537	3,358,856,354	3,559,374,250	3,853,139,302	4,078,243,404	4,356,929,227	4,658,572,201
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	176,400,210	(73,577,163)	(264,829,786)	(355,321,715)	(150,561,450)	151,593,608	70,666,124	(24,412,087)
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	1,014,847,346	941,270,183	676,440,397	321,118,681	170,557,232	322,150,840	392,816,964
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	1,014,847,346	941,270,183	676,440,397	321,118,681	170,557,232	322,150,840	392,816,964	368,404,877
Target Stabilization Reserve - CY (9%)	184,110,626	201,392,496	113,231,386	214,723,553	245,285,766	262,630,014	279,255,223	304,282,719	322,150,840	344,061,819	368,404,877
Legislative Target Reserve - CY (20%)					622,053,307	671,771,271					
Cash Balance Over CY TSR	318,136,845	582,095,450	725,215,751	800,123,793	695,984,417	413,810,383	41,863,458	(133,725,488)	0	48,755,145	0
Cash Balance Over CY LTR					319,216,876	4,669,126					
Target Stabilization Reserve %	7.5%	8.0%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
% of Expenses in Cash Reserve						20.1%	9.0%	4.4%	7.9%	9.0%	7.9%
	7/1 Increase	7/1 Increase		1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
ER Premium Increase:	5.3%	5.3%		0.00%	0.00%	3.47%	3.43%	14.88%	14.88%	5.03%	5.03%
EE Premium Increase:	5.3%	5.3%		0.00%	0.00%	2.83%	3.43%	14.88%	14.88%	5.03%	5.03%

Certified FB 2015-17 Budget

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(Segal 10-13-15)

Segal Consulting

North Carolina State Health Plan
Financial Projections - Jun 2015
Trends - 7.0% Medical & 8.5% Pharmacy
No Wellness, No 100% Preventive, Increased Cost Sharing, Smoker Surchager ($40 for 2017 and $60 for 2018 and 2019) and $20 Premium for Active (Starting 2018) on 70/30 Plan
With March 2015 Enrollment
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2012 - 2013 Biennium		2014 - 2015 Biennium		2016 - 2017 Biennium		2018 - 2019 Biennium		2020 - 2021 Biennium	
	Actual FY 2012	Actual FY 2013	Actual FY 2014	Actual FY2015	Projection FY2016	Projection FY2017	Projection FY2018	Projection FY2019	Projection FY2020	Projection FY2021
PLAN INCOME:										
Net Contribution Income	2,750,368,851	2,895,366,140	2,941,097,678	2,987,502,673	3,047,816,558	3,149,043,042	3,434,089,830	3,932,617,147	4,290,561,921	4,489,077,217
Wellness Surcharge/(Credit)		-	-	-	(11,707,747)	(6,225,252)	7,106,868	14,713,117	15,506,617	16,295,135
Medicare Advantae Subsidy			417,565	833,262	848,545	875,853	899,869	928,068	952,914	982,029
Health care Reform ERRP	42,163,391	(558,219)	-	(1,949)	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(299,923)	(11,359)	(1,523,908)	(1,574,522)	(1,717,045)	(1,966,309)	(2,145,281)	(2,244,539)
Premium Change due to Movement			-	-	(4,477,966)	(10,011,806)	(2,601,073)	4,918,367	8,676,356	11,658,104
Medicare Part D	57,583,602	38,056,016	11,583,652	19,590,771	14,457,206	14,230,850	14,333,822	13,977,434	13,988,152	13,481,389
EGWP+Wrap										
Direct Subsidy	-	24,435,483	25,216,663	202,770	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	38,563,909	1,478,088	-	-	-	-	-	-
Catastrophic Subsidy	-	-	-	48,602,965	-	-	-	-	-	-
Total	-	24,435,483	63,780,571	50,283,823	-	-	-	-	-	-
Investment Earnings	3,015,815	3,236,713	3,916,235	5,065,735	3,760,447	2,689,246	1,414,677	989,855	1,367,484	1,628,574
Total Plan Income	2,852,680,163	2,960,048,314	3,020,495,778	3,063,262,956	3,049,173,135	3,149,027,412	3,453,526,948	3,966,177,680	4,328,908,163	4,530,877,910
PLAN EXPENSE:										
Medical Claims Payment	1,849,410,105	1,858,096,405	1,989,574,333	2,021,369,178	2,178,449,449	2,319,076,194	2,471,229,778	2,631,415,335	2,862,799,493	2,989,707,862
Claim Refunds	(22,634,615)	(23,467,914)	(22,450,766)	(24,839,428)	(25,761,279)	(27,538,585)	(29,524,691)	(31,258,850)	(33,527,532)	(35,492,222)
Adjustment for Changes			-	-	(29,808,787)	(73,348,668)	(81,108,183)	(74,743,236)	(76,313,860)	(80,445,833)
				-	-	-	-	-	-	-
Cost of Add Locals				-	3,681,718	7,725,604	8,235,548	8,779,912	8,176,325	8,718,301
Net Medical Claims	1,826,775,490	1,834,628,491	1,967,123,567	1,996,529,750	2,126,561,101	2,225,914,544	2,368,832,452	2,534,193,161	2,761,134,427	2,882,488,107
Medicare Advantage Premiums			78,538,847	162,400,394	181,076,579	199,274,333	219,606,100	241,704,572	266,174,143	292,765,485
Pharmacy Claims Payment	721,163,013	752,419,650	743,281,462	721,469,293	801,972,479	832,959,448	898,016,897	968,213,916	1,044,840,766	1,126,360,411
Rebates	(93,130,160)	(69,641,941)	(91,653,105)	(51,114,709)	(104,118,977)	(50,534,232)	(51,558,326)	(52,269,924)	(53,319,911)	(54,019,906)
Claims Adjustment for Changes			-	-	-	-	-	-	-	-
Additional ACA Preventive Medicine				-	984,386	1,321,028	1,414,029	1,476,948	1,580,652	1,693,972
Net Pharmacy Claims	628,032,853	682,777,709	651,628,357	670,354,584	698,837,888	783,746,244	847,872,600	917,420,940	993,101,508	1,074,034,477
Total Claims	2,454,808,343	2,517,406,200	2,697,290,771	2,829,284,728	3,006,475,568	3,208,935,121	3,436,311,152	3,693,318,674	4,020,410,077	4,249,288,070
Administrative Costs	165,480,561	161,401,639	148,134,913	168,416,645	220,861,106	231,442,088	237,495,630	243,728,615	250,147,001	256,756,966
ACA Reinsurance Fee			-	-	23,391,088	14,452,627	5,868,849	-	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	2,845,425,684	2,997,701,373	3,250,727,762	3,454,829,836	3,679,675,631	3,937,047,289	4,270,557,079	4,506,045,035
Plan Income (Loss)	232,391,259	281,240,475	175,070,094	65,561,583	(201,554,627)	(305,802,424)	(226,148,683)	29,130,391	58,351,084	24,832,874
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	958,558,040	1,024,119,623	822,564,996	516,762,572	290,613,889	319,744,280	378,095,364
Ending Cash Balance (Deficit)	502,247,471	783,487,946	958,558,040	1,024,119,623	822,564,996	516,762,572	290,613,889	319,744,280	378,095,364	402,928,238
Target Stabilization Reserve - FY (9%)	184,110,626	201,392,496	222,593,914	240,019,590	254,285,909	270,869,471	289,503,455	310,645,269	337,881,234	356,087,033
Legislative Target Reserve - FY (20%)				599,540,275	650,145,552	690,965,967				
Cash Balance Over FY TSR				784,100,033	568,279,087	245,893,101	1,110,434	9,099,011	40,214,130	46,841,205
Cash Balance Over FY LTR				424,579,348	172,419,443	(174,203,395)				
Target Stabilization Reserve %	7.5%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
% of Expenses in Cash Reserve				34.2%	25.3%	15.0%	7.9%	8.1%	8.9%	8.9%
	7/1 Increase	7/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
ER Premium Increase:	5.3%	5.3%	0.00%	0.00%	3.47%	3.43%	14.88%	14.88%	5.03%	5.03%
EE Premium Increase:	5.3%	5.3%	0.00%	0.00%	2.83%	3.43%	14.88%	14.88%	5.03%	5.03%

CY 2015 Q3 Update

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(Segal 11-6-15)

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North Carolina State Health Plan
Financial Projections - Sep 2015
Trends - 7.0% Medical & 8.5% Pharmacy
No Wellness, No 100% Preventive, Increased Cost Sharing, Smoker Surchager ($40 for 2017 and $60 for 2018 and 2019) and $20 Premium for Active (Starting 2018) on 70/30 Plan
With March 2015 Enrollment
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit
3.47% Increase for Actives and NMRs and 3.45% Increase for MRs in ER Contribution and 2.83% Increase for EE Contribtuon in 2016, 3.43% Increase for ER and EE in 2017 , Adjust Rebates

	2012 - 2013 Biennium										
	Actual FY 2012	Actual FY 2013	Actual Short Plan Year Jul-Dec 2013	Actual Calendar 2014	Projection Calendar 2015	Projection Calendar 2016	Projection Calendar 2017	Projection Calendar 2018	Projection Calendar 2019	Projection Calendar 2020	Projection Calendar 2021
PLAN INCOME:											
Net Contribution Income	2,750,368,851	2,895,366,140	1,502,578,000	2,952,592,141	2,969,434,829	3,105,054,097	3,200,983,050	3,589,776,085	4,005,529,283	4,280,379,874	4,576,444,686
Wellness Surcharge/(Credit)		-	-	-	(2,793,778)	(12,263,431)	(233,288)	14,480,802	15,049,768	16,069,016	16,629,275
Medicare Advantae Subsidy			-	721,773	929,560	863,951	880,134	915,641	932,493	969,061	986,601
Health care Reform ERRP	42,163,391	(558,219)	-	(1,949)	-	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(277,538)	(28,401)	(379,595)	(1,552,527)	(1,600,492)	(1,794,888)	(2,002,765)	(2,140,190)	(2,288,222)
Premium Change due to Movement			-	-	646,082	(11,519,972)	(8,371,203)	2,848,087	5,561,674	10,110,963	12,592,164
Medicare Part D	57,583,602	38,056,016	(1,323,888)	21,584,404	18,952,795	14,774,755	15,094,295	14,555,087	14,805,491	14,093,417	14,254,775
EGWP+Wrap											
Direct Subsidy	-	24,435,483	25,202,822	216,170	441	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	11,879,765	28,162,232	-	-	-	-	-	-	-
Catastrophic Subsidy	-	-	-	-	48,602,965	-	-	-	-	-	-
Total	-	24,435,483	37,082,587	28,378,402	48,603,406	-	-	-	-	-	-
Investment Earnings	3,015,815	3,236,713	1,841,087	4,417,142	5,357,305	3,550,234	2,503,805	1,627,638	1,394,313	1,411,535	1,454,367
Total Plan Income	2,852,680,163	2,960,048,314	1,539,900,247	3,007,663,512	3,040,750,604	3,098,907,106	3,209,256,302	3,622,408,453	4,041,270,257	4,320,893,677	4,620,073,646
PLAN EXPENSE:											
Medical Claims Payment	1,849,410,105	1,858,096,405	1,033,157,400	1,949,838,964	2,074,977,584	2,217,519,782	2,358,765,720	2,564,269,898	2,679,997,515	2,858,455,874	3,038,929,464
Claim Refunds	(22,634,615)	(23,467,914)	(10,834,378)	(22,731,740)	(24,435,428)	(26,551,684)	(28,040,151)	(29,896,725)	(32,018,530)	(33,931,080)	(36,340,488)
Adjustment for Changes				-	834,617	(63,887,812)	(83,101,633)	(80,074,499)	(68,734,818)	(83,040,724)	(77,253,339)
Cost of Add Locals				-	-	7,482,839	7,976,186	8,502,793	8,482,130	8,441,894	8,422,830
Net Medical Claims	1,826,775,490	1,834,628,491	1,022,323,022	1,927,107,224	2,051,376,773	2,134,563,125	2,255,600,123	2,462,801,467	2,587,726,298	2,749,925,964	2,933,758,468
Medicare Advantage Premiums				155,497,950	171,639,724	190,294,172	206,976,285	230,840,925	251,017,707	279,639,021	304,013,725
Pharmacy Claims Payment	721,163,013	752,419,650	425,257,939	697,815,422	750,616,119	805,146,066	867,987,940	935,790,419	1,008,950,160	1,088,485,072	1,173,781,666
Rebates	(93,130,160)	(69,641,941)	(32,188,641)	(98,763,203)	(96,193,453)	(70,921,564)	(72,136,106)	(72,978,258)	(74,225,117)	(75,055,004)	(76,322,760)
Claims Adjustment for Changes			-	-	-	-	-	-	-	-	-
Additional ACA Preventive Medicine			-	-	172,925	1,276,000	1,366,000	1,462,000	1,522,886	1,637,595	1,748,784
Net Pharmacy Claims	628,032,853	682,777,709	393,069,298	599,052,219	654,595,591	735,500,501	797,217,834	864,274,160	936,247,929	1,015,067,663	1,099,207,689
Total Claims	2,454,808,343	2,517,406,200	1,415,392,320	2,681,657,393	2,877,612,088	3,060,357,798	3,259,794,242	3,557,916,552	3,774,991,934	4,044,632,648	4,336,979,883
Administrative Costs	165,480,561	161,401,639	69,548,737	149,605,909	188,653,615	226,154,671	234,465,773	240,601,941	246,920,108	253,426,322	260,126,849
ACA Reinsurance Fee				-	5,642,732	23,681,377	14,442,352	-	-	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	1,484,941,057	2,831,263,302	3,071,908,435	3,310,193,846	3,508,702,366	3,798,518,492	4,021,912,042	4,298,058,969	4,597,106,731
Plan Income (Loss)	232,391,259	281,240,475	54,959,190	176,400,210	(31,157,831)	(211,286,740)	(299,446,064)	(176,110,040)	19,358,215	22,834,708	22,966,915
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	838,447,136	1,014,847,346	983,689,515	772,402,775	472,956,711	296,846,672	316,204,887	339,039,594
Ending Cash Balance (Deficit)	502,247,471	783,487,946	838,447,136	1,014,847,346	983,689,515	772,402,775	472,956,711	296,846,672	316,204,887	339,039,594	362,006,509
Target Stabilization Reserve - CY (9%)	184,110,626	201,392,496	113,231,386	214,723,553	243,537,513	258,305,726	274,753,616	299,436,806	317,157,680	338,849,426	362,966,954
Legislative Target Reserve - CY (20%)					614,381,687	662,038,769					
Cash Balance Over CY TSR	318,136,845	582,095,450	725,215,751	800,123,793	740,152,002	514,097,049	198,203,095	(2,590,135)	(952,794)	190,168	(960,445)
Cash Balance Over CY LTR					369,307,828	110,364,006					
Target Stabilization Reserve	184,110,626	201,392,496	113,231,386	214,723,553	243,537,513	258,305,726	274,753,616	299,436,806	317,157,680	338,849,426	362,966,954
Target Stabilization Reserve %	7.5%	8.0%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
% of Expenses in Cash Reserve						23.3%	13.5%	7.8%	7.9%	7.9%	7.9%
	7/1 Increase	7/1 Increase		1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
ER Premium Increase:	5.3%	5.3%		0.00%	0.00%	3.47%	3.43%	12.16%	12.16%	7.35%	7.35%
EE Premium Increase:	5.3%	5.3%		0.00%	0.00%	2.83%	3.43%	12.16%	12.16%	7.35%	7.35%

Segal Consulting

(Segal 11-6-15)

North Carolina State Health Plan
Financial Projections - Sep 2015
Trends - 7.0% Medical & 8.5% Pharmacy
No Wellness, No 100% Preventive, Increased Cost Sharing, Smoker Surchager ($40 for 2017 and $60 for 2018 and 2019) and $20 Premium for Active (Starting 2018) on 70/30 Plan
With March 2015 Enrollment
Incentives start at $15/$15/$20 and increase $10/$10/$20 every 2-years, $10 Standard Premium Credit

	2012 - 2013 Biennium		2014 - 2015 Biennium		2016 - 2017 Biennium		2018 - 2019 Biennium		2020 - 2021 Biennium	
	Actual FY 2012	Actual FY 2013	Actual FY 2014	Actual FY2015	Projection FY2016	Projection FY2017	Projection FY2018	Projection FY2019	Projection FY2020	Projection FY2021
PLAN INCOME:										
Net Contribution Income	2,750,368,851	2,895,366,140	2,941,097,678	2,987,502,673	3,050,027,435	3,153,030,472	3,395,536,181	3,797,799,321	4,143,028,885	4,428,490,439
Wellness Surcharge/(Credit)		-	-	-	(8,936,204)	(6,233,533)	7,138,703	14,765,496	15,559,919	16,349,311
Medicare Advantae Subsidy			417,565	833,262	830,241	872,953	896,890	924,995	949,758	978,777
Health care Reform ERRP	42,163,391	(558,219)	-	(1,949)	-	-	-	-	-	-
Retro Disenrollments	(451,496)	(487,819)	(299,923)	(11,359)	(1,151,263)	(1,576,515)	(1,697,768)	(1,898,900)	(2,071,514)	(2,214,245)
Premium Change due to Movement			-	-	(5,089,766)	(9,940,232)	(2,746,640)	4,209,277	7,842,710	11,355,528
Medicare Part D	57,583,602	38,056,016	11,583,652	19,590,771	15,145,310	14,827,634	14,951,785	14,564,110	14,594,090	14,047,902
EGWP+Wrap										
Direct Subsidy	-	24,435,483	25,216,663	202,770	-	-	-	-	-	-
Coverage Gap Subsidy	-	-	38,563,909	1,478,088	-	-	-	-	-	-
Catastrophic Subsidy	-	-	-	48,602,965	-	-	-	-	-	-
Total	-	24,435,483	63,780,571	50,283,823	-	-	-	-	-	-
Investment Earnings	3,015,815	3,236,713	3,916,235	5,065,735	4,525,824	3,077,455	1,983,952	1,442,568	1,387,023	1,462,081
Total Plan Income	2,852,680,163	2,960,048,314	3,020,495,778	3,063,262,956	3,055,351,577	3,154,058,232	3,416,063,103	3,831,806,868	4,181,290,872	4,470,469,793
PLAN EXPENSE:										
Medical Claims Payment	1,849,410,105	1,858,096,405	1,989,574,333	2,021,369,178	2,146,535,686	2,287,405,014	2,436,793,675	2,594,043,546	2,822,021,392	2,947,034,629
Claim Refunds	(22,634,615)	(23,467,914)	(22,450,766)	(24,839,428)	(23,510,393)	(27,162,683)	(29,115,766)	(30,815,122)	(33,050,199)	(34,985,734)
Adjustment for Changes			-	-	(30,647,624)	(73,343,374)	(81,010,253)	(74,516,786)	(76,009,315)	(80,099,221)
				-	-	-	-	-	-	-
Cost of Add Locals				-	3,681,744	7,725,493	8,235,192	8,779,279	8,175,497	8,717,162
Net Medical Claims	1,826,775,490	1,834,628,491	1,967,123,567	1,996,529,750	2,096,059,412	2,194,624,449	2,334,902,848	2,497,490,917	2,721,137,376	2,840,666,835
Medicare Advantage Premiums			78,538,847	162,400,394	181,108,833	198,614,479	218,878,922	240,904,220	265,292,765	291,796,056
Pharmacy Claims Payment	721,163,013	752,419,650	743,281,462	721,469,293	806,435,407	836,164,450	901,454,272	971,900,389	1,048,797,720	1,130,602,793
Rebates	(93,130,160)	(69,641,941)	(91,653,105)	(51,114,709)	(127,247,043)	(71,438,765)	(72,653,831)	(73,499,843)	(74,745,767)	(75,578,303)
Claims Adjustment for Changes			-	-	-	-	-	-	-	-
Additional ACA Preventive Medicine				-	811,540	1,321,029	1,414,029	1,476,927	1,580,559	1,693,699
Net Pharmacy Claims	628,032,853	682,777,709	651,628,357	670,354,584	679,999,903	766,046,713	830,214,471	899,877,472	975,632,512	1,056,718,189
Total Claims	2,454,808,343	2,517,406,200	2,697,290,771	2,829,284,728	2,957,168,149	3,159,285,642	3,383,996,240	3,638,272,610	3,962,062,653	4,189,181,080
Administrative Costs	165,480,561	161,401,639	148,134,913	168,416,645	201,580,078	231,442,088	237,488,807	243,714,560	250,125,286	256,727,142
ACA Reinsurance Fee			-	-	23,403,765	14,478,775	5,883,921	-	-	-
Extra EGWP+Wrap Administration	-	-	-	-	-	-	-	-	-	-
Total Plan Expense	2,620,288,904	2,678,807,839	2,845,425,684	2,997,701,373	3,182,151,991	3,405,206,505	3,627,368,969	3,881,987,169	4,212,187,939	4,445,908,222
Plan Income (Loss)	232,391,259	281,240,475	175,070,094	65,561,583	(126,800,414)	(251,148,272)	(211,305,866)	(50,180,301)	(30,897,068)	24,561,571
Beginning Cash Balance (Deficit)	269,856,212	502,247,471	783,487,946	958,558,040	1,024,119,623	897,319,209	646,170,936	434,865,071	384,684,769	353,787,702
Ending Cash Balance (Deficit)	502,247,471	783,487,946	958,558,040	1,024,119,623	897,319,209	646,170,936	434,865,071	384,684,769	353,787,702	378,349,273
Target Stabilization Reserve - FY (9%)	184,110,626	201,392,496	222,593,914	240,019,590	249,845,338	266,460,405	284,860,559	305,763,155	332,709,290	350,764,652
Legislative Target Reserve - FY (20%)				599,540,275	636,430,398	681,041,301				
Cash Balance Over FY TSR				784,100,033	647,473,870	379,710,532	150,004,512	78,921,614	21,078,412	27,584,621
Cash Balance Over FY LTR				424,579,348	260,888,810	(34,870,365)				
Target Stabilization Reserve %	7.5%	8.0%	8.5%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
% of Expenses in Cash Reserve				34.2%	28.2%	19.0%	12.0%	9.9%	8.4%	8.5%
	7/1 Increase	7/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase	1/1 Increase
ER Premium Increase:	5.3%	5.3%	0.00%	0.00%	3.47%	3.43%	12.16%	12.16%	7.35%	7.35%
EE Premium Increase:	5.3%	5.3%	0.00%	0.00%	2.83%	3.43%	12.16%	12.16%	7.35%	7.35%

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

State Health Plan Trends

Board of Trustees Meeting

November 20, 2015

A Division of the Department of State Treasurer

Presentation Outline

- Trends for Non-Medicare Members (active employees and non-Medicare retirees)
- Components of Trend: FY 2012-13 to CY 2014
- Impact of Utilization v. Price Changes
- Trends in Paid Claims
- Comparison to Other BCBSNC Clients
- Trends in Member Health Status

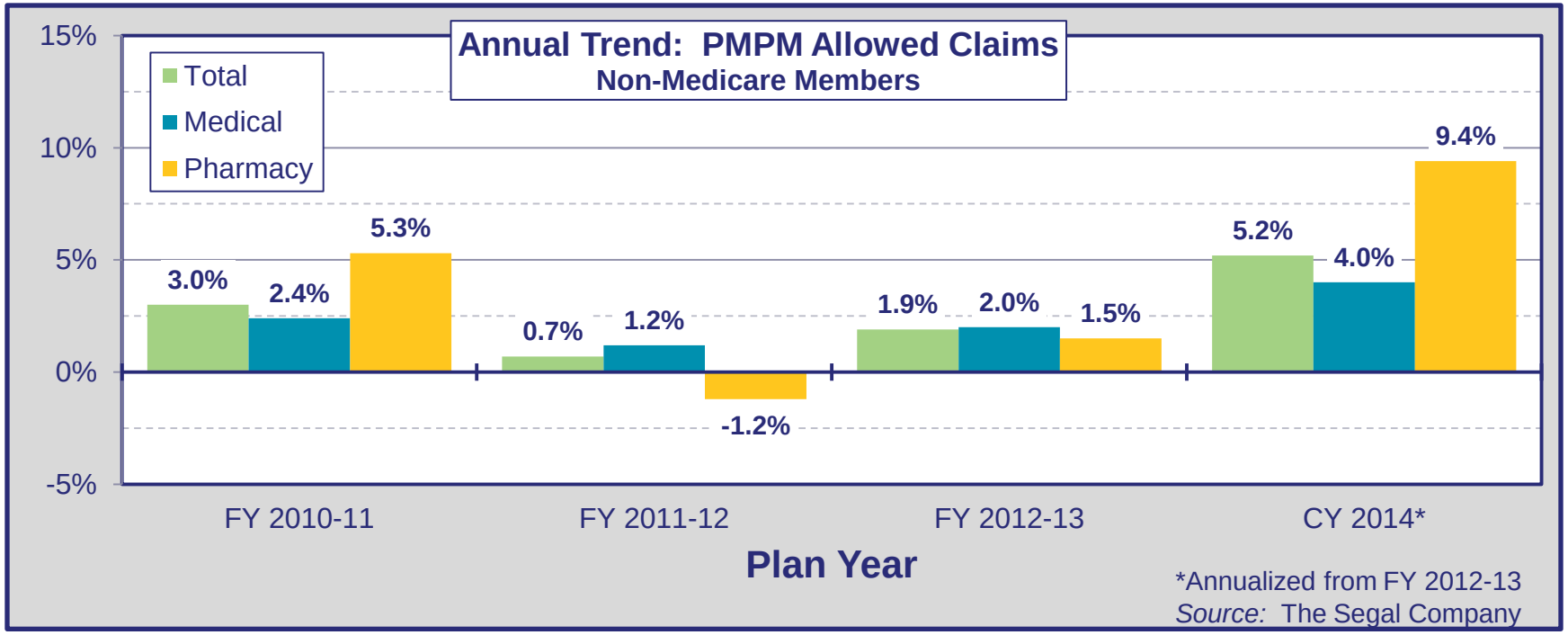
Strategic Planning: Why Examine Trends?

- **Strategic Goal: Ensure Financial Stability**
  - Monitor and understand what's happening with spending
  - Analysis by Segal showed that a 1% reduction in annual medical trend (excluding pharmacy) would:
    - Reduce Plan costs over the next four fiscal years by a total of $221.7 million
    - Reduce the required premium increase for 2018 and 2019 by nearly 3 percentage points (based on Certified Budget forecast)

- **Strategic Goal: Improve Members' Health**
  - Trends in member health status can also be tracked and monitored with risk grouping software
  - In addition to the obvious quality of life improvements for members, improving or maintaining member health – rather than accepting the natural progression towards declining health – has an impact on expense trends and financial sustainability
    - For example, progression from a single minor chronic condition to a dominant or moderate chronic condition increases medical costs by an average of 63% (*Source:* Segal Clinical Risk Grouper report)

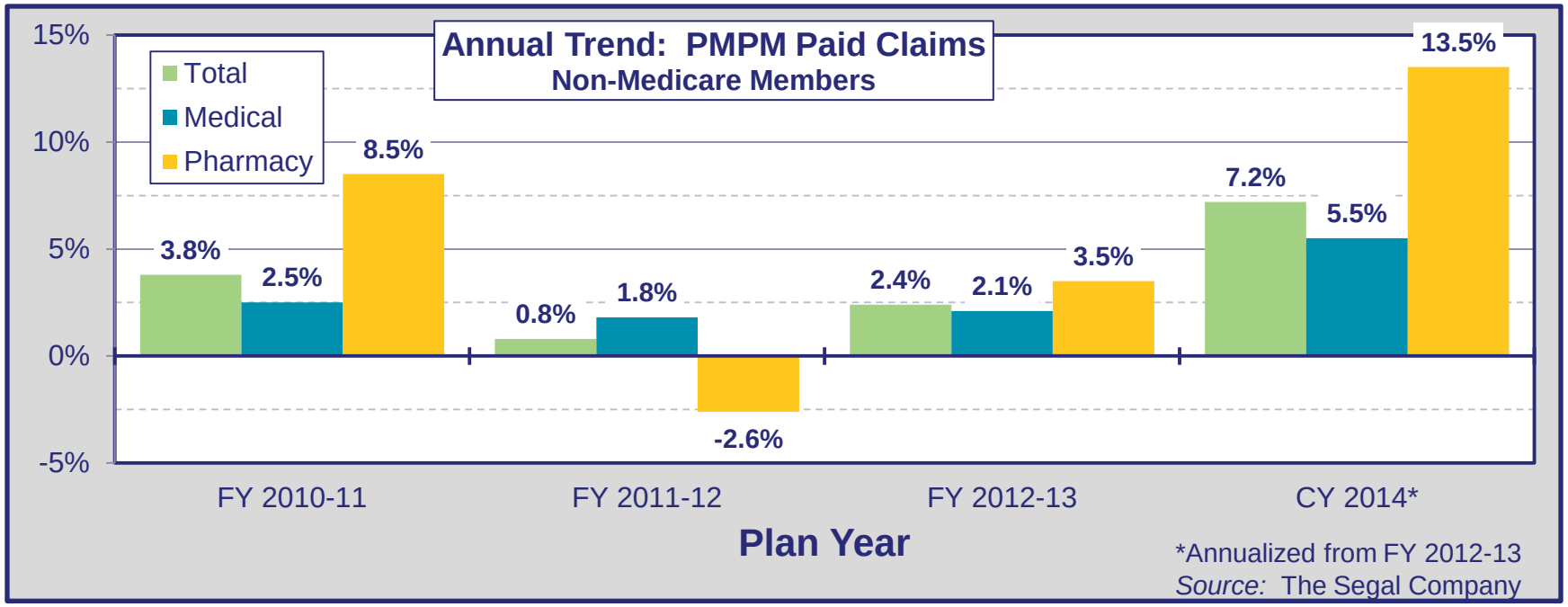
PMPM Annual Trends in Allowed Amounts Excluding Medicare Primary Members

- Using incurred claims data for claims paid by March 31, 2015, Segal analyzed trends in the Per Member Per Month (PMPM) claims for non-Medicare members
- Allowed amounts reflect the total authorized payment amounts for claims, including the Plan's share and member shares; examining PMPM trends in allowed amounts controls for cost-shifting
- Trends in total PMPM claims (green bars) have been relatively low, although both medical (blue) and pharmacy (yellow) trends ticked up in CY 2014



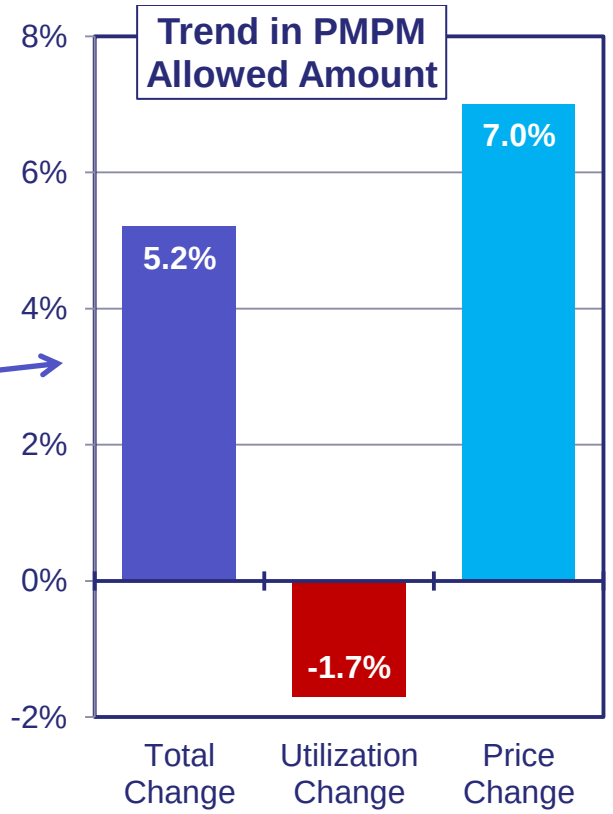
PMPM Annual Trends in Paid Claims Excluding Medicare Primary Members

- Paid Claims trends include only the share of claims costs paid by the Plan
- Trends in total paid PMPM claims (green bars) had been relatively low until 2014, when costs increased 7.2% -- 5.5% for medical costs (blue) and 13.5% for pharmacy costs (yellow)
- The Plan currently uses a trend assumption of 7% for medical costs and 8.5% for pharmacy costs in its forecasts. This translates to an overall trend in paid claims of approximately 7.4%
- In general, trends in paid amounts are slightly higher than trends in allowed amounts due to the increasing share of allowed costs being paid by the Plan



Components of PMPM Trend
Excluding Medicare Primary Members

	FY12-13	CY 2014	Average Annual % Change
Billed Charges	$834.44	$905.94	5.6%
Allowed Amount	$435.08	$469.32	**5.2%**
Plan Paid	$342.99	$380.72	7.2%
Member Share	$92.09	$88.58	-2.6%
Member % Share	21.2%	18.9%	

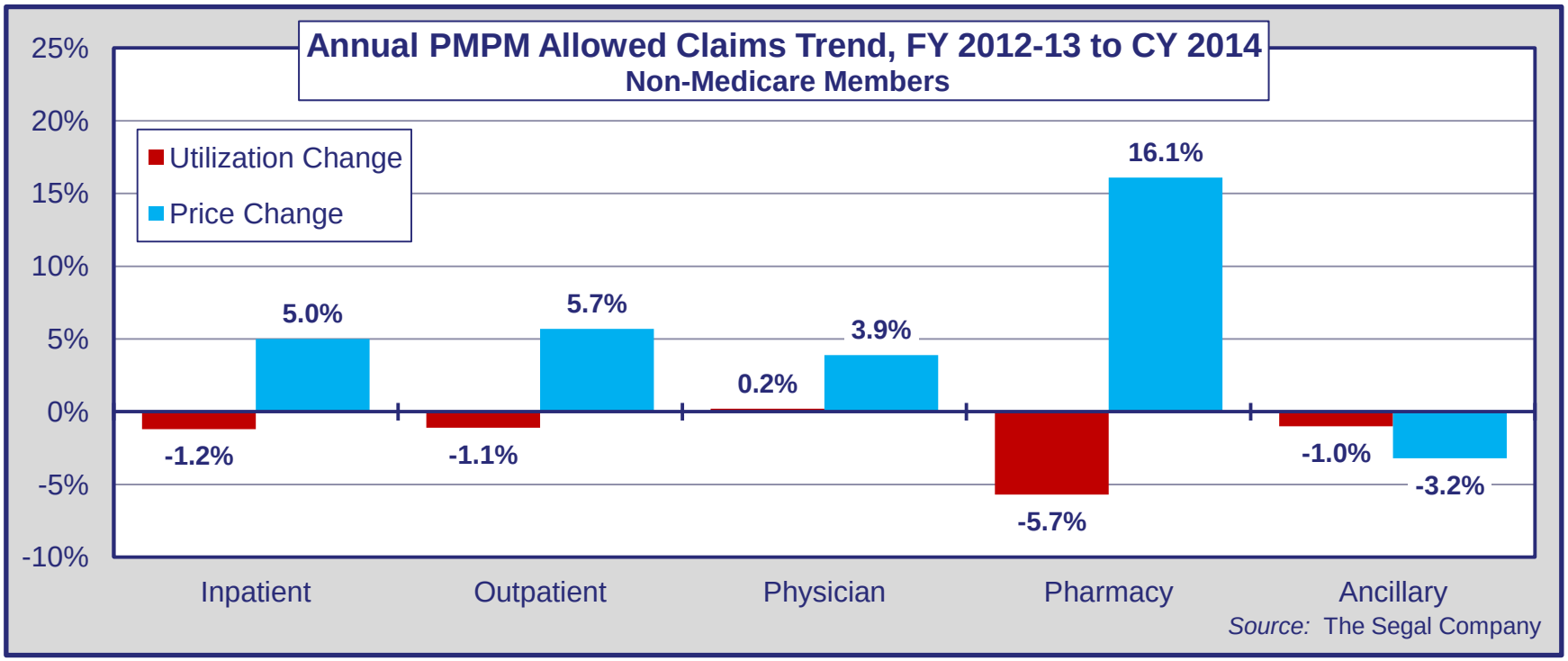


Source: The Segal Company

- Changes in utilization – including the frequency of use and the mix of services and drugs used – decreased PMPM costs by 1.7% annually from FY 2012-13 to CY 2014, but the decrease was offset by a 7.0% annual price increase

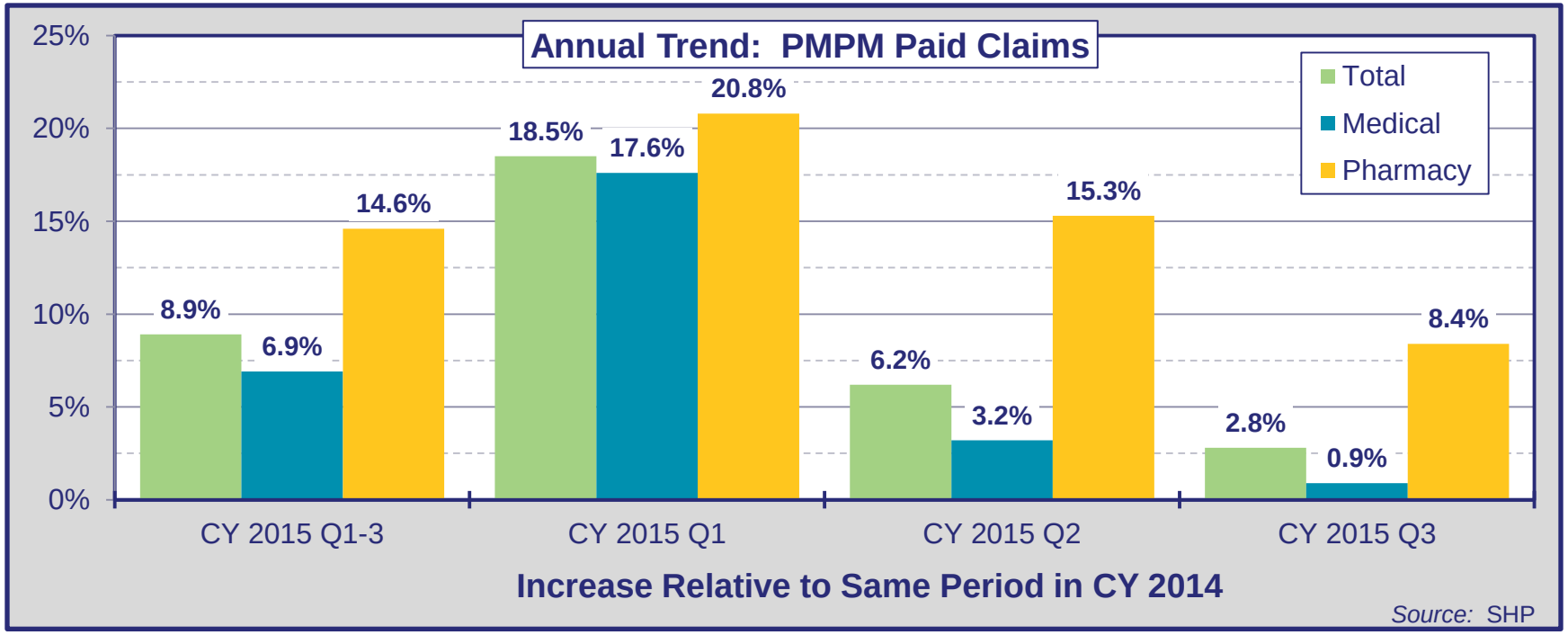
Annual Trends in PMPM Allowed Claims By Service Type (excluding Medicare primary members)

- Trends in allowed amounts are impacted by changes in utilization and price
- As demonstrated in the chart below, Plan trends have been impacted primarily by changes in price
- The utilization reductions in most service types help to mitigate growth in prices; the utilization decrease for pharmacy includes a transition from brand drugs to generic drugs and greater use of 90-day retail prescriptions



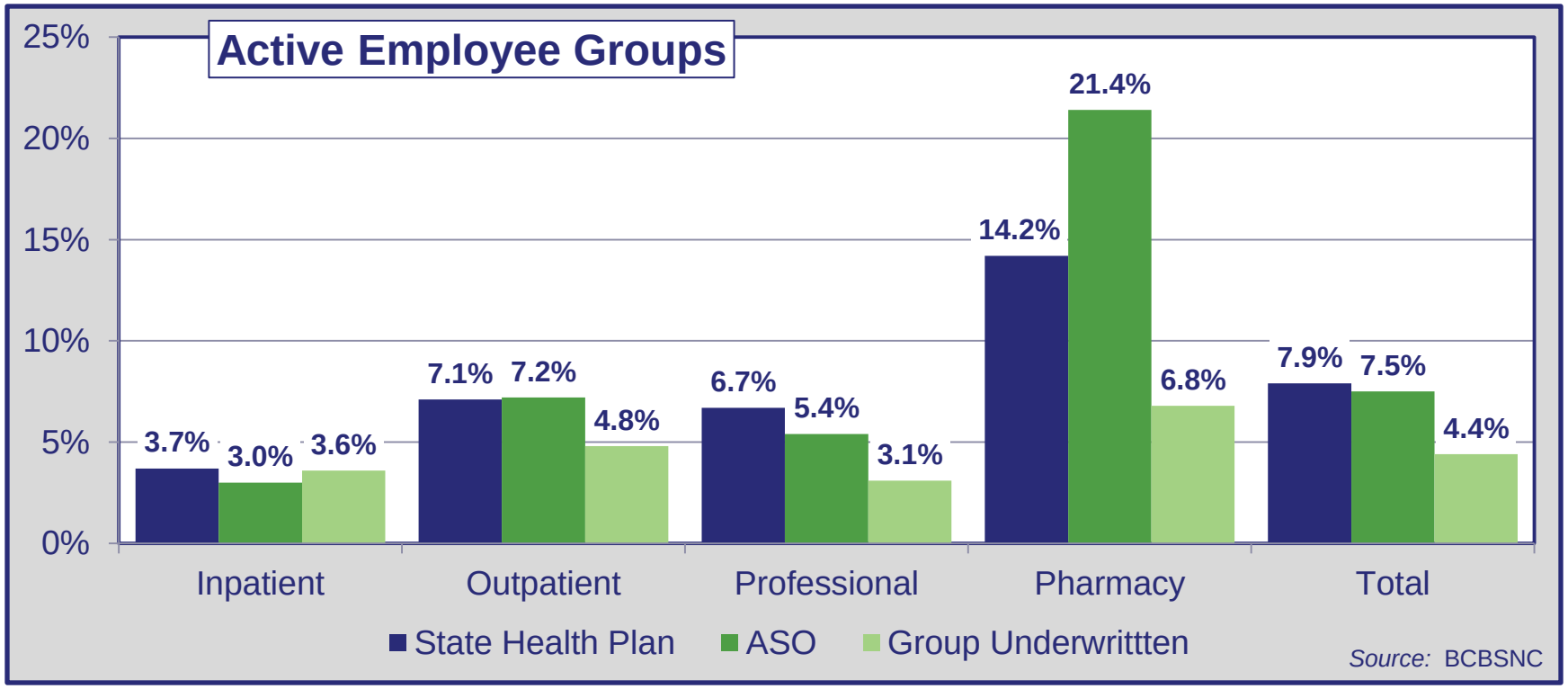
Calendar Year 2015 PMPM Trends Through September 2015

- These trends reflect claims paid (rather than incurred) by quarter, as reported in the monthly Financial Status Reports
  - All BCBSNC membership (including Medicare members) is used to develop PMPM figures
- The PMPM trends are adjusted to control for the impact of monthly claims and invoicing cycles
- Trend for CY 2015 through three quarters is relatively high, driven by very high trend in the first quarter of the year. Since Q1, overall trends have been below projections
- The high first quarter trends are due mostly to unusually low spending in Q1 of CY 2014



BCBSNC Trend Report
Allowed PMPM Claims Trends

- The trends are estimated incurred PMPM claims for the 12 months ending July 2015, paid through September 2015 with completion factors, and are compared to the 12 months ending July 2014
- In general, the Plan is performing about as well as BCBSNC's other administrative services only (ASO) contracts but not as well as its group underwritten clients
  - However, Plan trends for professional services are higher than other BCBSNC clients
- All BCBSNC clients are experiencing higher pharmacy trends than medical trends

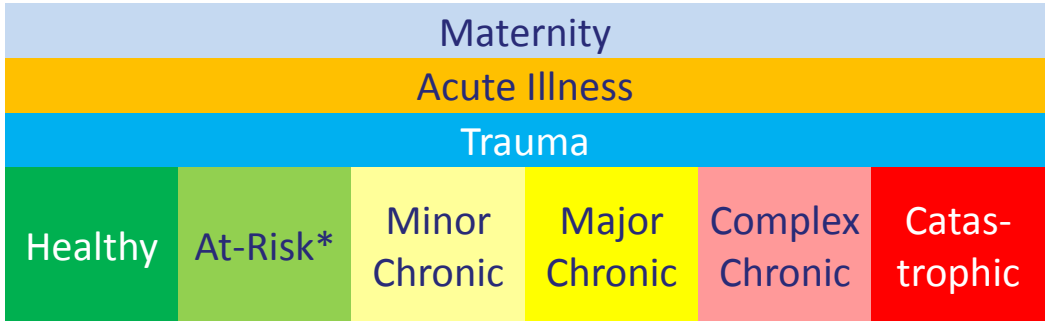


Member Health Trends

- One of the three priorities of the Strategic Plan is to improve members' health
- In addition to price and utilization trends, it is important to monitor the trends in health status of State Health Plan members
- Typically, members with fewer chronic conditions and/or better managed chronic conditions utilize less costly services
  - In particular, fewer hospital and ER admissions
- Plan design and member engagement can be key factors in helping to manage member health and slow declining health trends

Spectrum of Health

- The classification scheme involves assignment of each member to one of (five or) six health categories:
  - Healthy
  - Healthy At-Risk*
  - Minor Chronic Illness
  - Major Chronic Illness
  - Complex Chronic Illness
  - Catastrophic Illness



*The Healthy-at-Risk category is used when health assessment and biometric data are available.

Source: ActiveHealth Management

- In addition to the classification scheme above, there are three additional health conditions that can combine with these as concomitant episodes:
  - Maternity
  - Acute Illness
  - Trauma

The Chronic Episode Treatment Groups (ETGs)

The ETG classification system designates each ETG as representing a chronic or acute condition. The ETGs that are not designated as chronic conditions are mapped to either maternity, acute illness, trauma or other.

- **Minor Chronic Conditions** are those considered to have a **small or intermittent** impact on the health and well-being of the member and require simple and/or sporadic management. Examples of minor chronic illnesses include: cataracts, simple hypertension, and hyperlipidemia.
- **Major Chronic Conditions** are those considered to have **significant impact** on the member's health and well-being and require more regular and more intensive, active management. Examples of major chronic illnesses include: congestive heart failure, COPD, and uncomplicated diabetes.
- **Complex Chronic Conditions** are those where there are **multiple chronic illnesses being co-managed or where a single illness is associated with substantial co-morbidity and complication**. They require constant and intense management. Examples of complex chronic illnesses include: malignant neoplasm with active treatment, AIDS with complications, and organ transplants

Source: ActiveHealth Management

Spectrum of Health: Cohort Migration

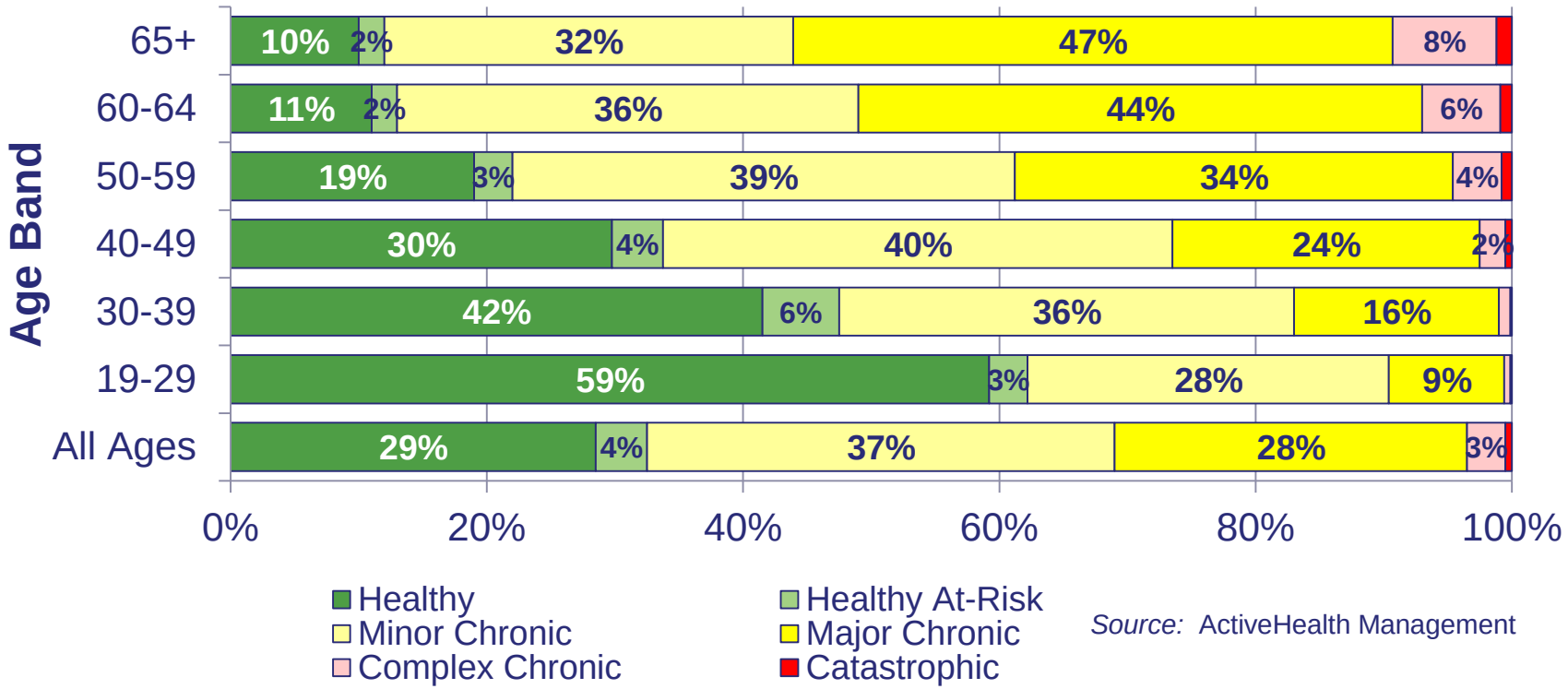
		CY 2014				
	Spectrum of Health Category	Healthy	Minor Chronic	Major Chronic	Complex Chronic	Catas-trophic
FY 2013	Healthy	76%	19%	5%	0.3%	0.1%
	Minor Chronic	12%	74%	14%	0.5%	0.2%
	Major Chronic	4%	13%	79%	3.8%	0.7%
	Complex Chronic	1%	2%	30%	63%	5%
	Catastrophic	0.4%	3%	27%	35%	35%

= stayed the same = became healthier = became less healthy

Source: ActiveHealth Management

- The table above shows 76% of the members classified as healthy in FY 2013 were also healthy in CY 2014. But 19% of the members who were healthy in FY 2013 became minor chronic in the CY 2014. Each row sums to 100%.
- Note the high rate of turnover in the Catastrophic group from year to year. ActiveHealth reports that 25% - 35% of Catastrophics persist from year to year.

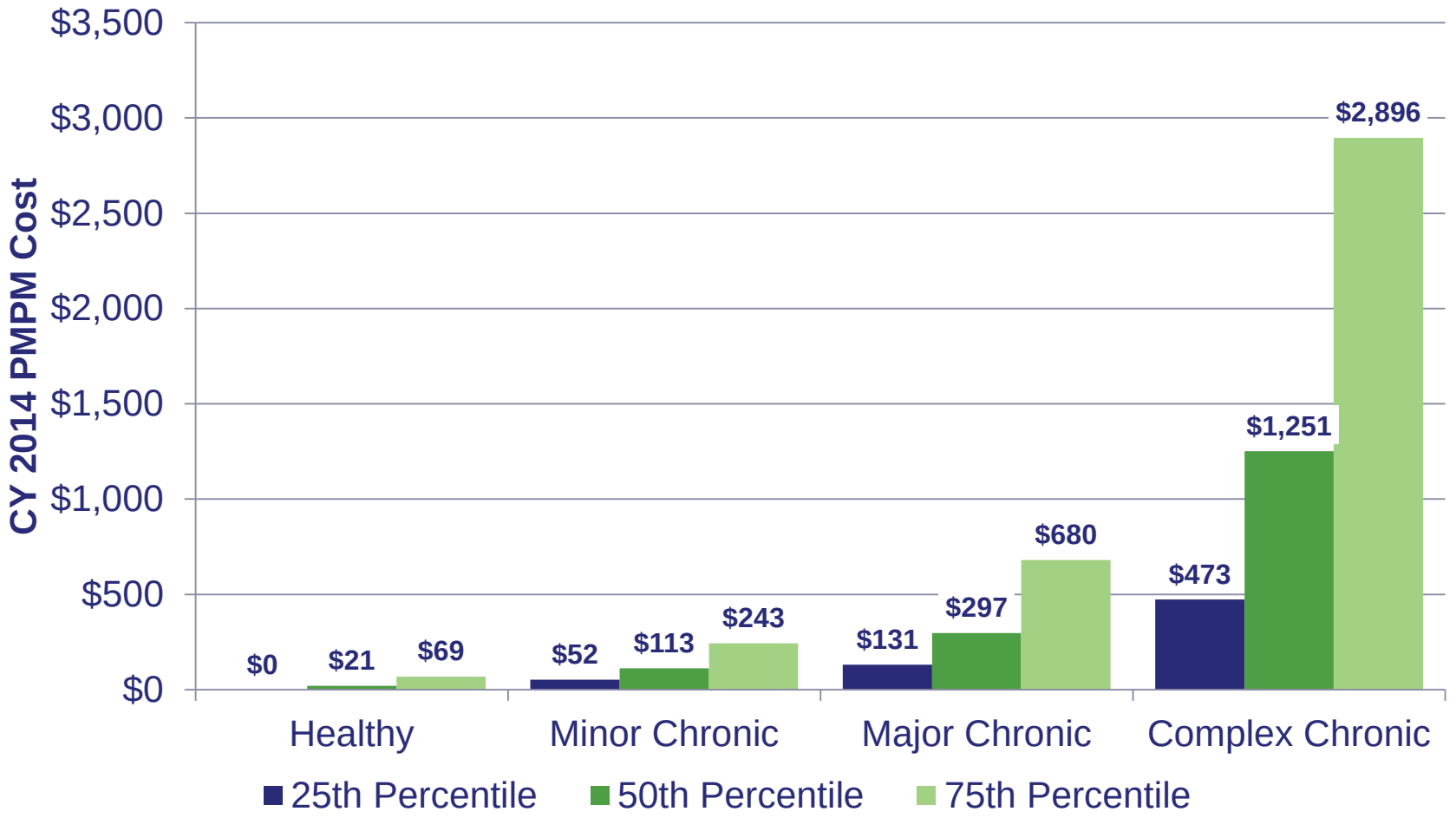
Spectrum of Health by Age Band



Source: ActiveHealth Management

- As would be expected, chronic disease prevalence and severity increases with age and this is reflected in the Spectrum of Health distributions by age band. Healthy prevalence declines from 62% to 12%, and Major Chronic prevalence increases from 9% in the youngest to nearly 47% in the oldest age band.

Paid PMPM Spending by Spectrum of Health Category



Source: ActiveHealth Management

Key Takeaways

Financial Trends

- Following several years of lower trends, claims spending accelerated in CY 2014 and so far in CY 2015
  - In particular, pharmacy trends have been high in recent years
- Changes in utilization among Plan members have helped to mitigate price inflation
  - However, reductions in member cost share have increased Plan costs
- Annual trends in claim payments for CY 2015 were very high in the first quarter of the year (January through March), but slowed in the next two quarters
- Plan trends are similar to other BCBSNC ASO clients

Health Trends

- As members age they are more likely to have chronic conditions and increased costs
- Management of chronic conditions can help control costs

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

2015 Membership Satisfaction Results

Board of Trustees Meeting

November 20, 2015

A Division of the Department of State Treasurer

2015 Survey Approaches

In 2015, the Plan conducted two member surveys in an effort to gauge our members' satisfaction on a variety of topics and services.

Survey 1: Health Management Survey

- This survey was mailed to a statistically valid random sampling of members with an incentive reward offered for completing an online or paper survey.

Survey 2: Annual Membership Satisfaction Survey

- This survey was offered to all members. All members received a postcard requesting them to complete an online survey.

The results were strikingly similar.

Survey 1: Health Management Survey Results

Methodology Reminder

- The Segal Company conducted a Health Management Survey with a randomized group of Active, Non-Medicare Retiree and Medicare Retiree State Health Plan members in April and May of 2015.
- The survey was available from April 20, 2015, through May 20, 2015.
- The survey's objective was to gather members' opinions about the service and care provided through the State Health Plan, with particular focus on members' interactions with their Primary Care Provider.
- 35,027 Actives and Non-Medicare Primary Retirees were invited to respond via an online version of the survey, using two postcard mailings to members' homes—an announcement and a reminder.
- 18,595 Medicare Primary members were invited to respond via a paper version of the survey, using two mailings to members' homes - the paper survey with an introductory letter and reminder.
- To encourage members to complete the survey, two types of incentives were offered:
  - **Actives and Non-Medicare Primary Retirees:** A one-night, free Redbox video rental, provided as a code by email or text message.
  - **Medicare Primary members:** A $5 Walmart gift card, provided by mail.

Executive Summary

- Despite providing an incentive, the overall response rate among Actives and Non-Medicare Primary Retirees was low: 6% and among them, less than half were Active members.
  - 10.6% male
  - 11.3% female
- 7,220 members responded:
  - 1,944 members (27%) responded online—these were almost exclusively Actives and Non-Medicare Primary Retirees. This represented a 6% (rounded) response rate. Of this group, 46% were Active members.
  - 5,276 members (73%) responded via paper—these were almost exclusively Medicare Primary Retirees. This represented a 28% (rounded) response rate.
- A majority of respondents have a Primary Care Provider, visit them regularly, have sufficient access to care, and are satisfied with the care received.
- While 60% of Actives/Non-Medicare Primary Retirees visit their PCP regularly, nearly 40% do not – potentially missing valuable preventive care.
- Most respondents select their plan based on the cost of coverage (the monthly premium).
- Two-thirds of respondents agree that they would use Plan resources to lower the amount they pay for their health plan.
- Most respondents are satisfied with the Plan communications they receive but would like more information about deductibles, copays, coinsurance, and out-of-pocket maximums.

Survey 2: Annual Member Satisfaction Survey Results

Methodology Reminder

- A total of approximately 496,000 postcards were mailed inviting subscribers and covered spouses to participate in the online survey that was posted on the home page of the State Health Plan's website.
- A total of 5,456 responses were collected from July 27 through September 1, 2015, resulting in a response rate of 1%. The survey length averaged 11 minutes.

2015		2014	
Active Employees/ Non-Medicare Retirees	Medicare Primary Retirees	Active Employees/ Non-Medicare Retirees	Medicare Primary Retirees
4,859 (89%)	597 (11%)	5,171 (67%)	2,554 (33%)

Active/Non-Medicare Retiree Respondent Profile

		2014 (A)	2015 (B)
GENDER	Male	24%B	22%
	Female	76%	78%A
WORK	University	12%	21%A
	Community College	5%B	3%
	State Agency	20%B	13%
	School System	33%B	30%
	UNC Healthcare	2%	2%
	Retired	27%	30%A
2014 PLAN[1]	Traditional 70/30 Plan	23%B	20%
	Enhanced 80/20 Plan	71%	75%A
	Consumer-Directed Health Plan	6%	5%
COVERAGE	Employee/Retiree only	77%	77%
	Employee/Retiree and child/children only	10%	10%
	Employee/Retiree and spouse only	6%	6%
	Family	8%	8%
HEALTH HABITS	I always wear my seatbelt	98%	98%
	I do not use tobacco products	93%	94%A
	I am mindful of my eating habits	86%	87%
	I work with my doctor and other health care professionals to improve my health	76%	77%
	I receive a flu shot every year	68%	69%
	I exercise on a regular basis	53%	54%
	I maintain a low level of stress	45%	48%A

Red letters represent statistically significant differences at the 95% level.

Medicare Primary Respondent Profile

		2014 (A)	2015 (B)
GENDER	Male	33%	33%
	Female	67%	67%
YEARS RETIRED	Less than 1 year	4%	7%A
	1-3	16%	18%
	4-6	20%	19%
	7-10	24%	24%
	11+	36%	31%
2014 PLAN[1]	Traditional 70/30 Plan	27%	83%A
	Humana (NET)	21%B	5%
	Humana Medicare Advantage Base Plan	14%B	4%
	Humana Medicare Advantage Enhanced Plan	7%B	2%
	UnitedHealthcare (NET)	52%B	12%
	UnitedHealthcare Medicare Advantage Base Plan	21%B	3%
	UnitedHealthcare Medicare Advantage Enhanced Plan	31%B	9%
COVERAGE	Employee/Retiree only	86%	85%
	Employee/Retiree and spouse only	13%	11%
	Family	1%	2%A
	Employee/Retiree and child/children only	0%	2%A
HEALTH HABITS	I always wear my seatbelt	98%	98%
	I do not use tobacco products	94%	92%
	I am mindful of my eating habits	90%	89%
	I work with my doctor and other health care professionals to improve my health	89%	87%
	I receive a flu shot every year	84%	82%
	I maintain a low level of stress	63%	61%
	I exercise on a regular basis	61%B	53%

Red letters represent statistically significant differences at the 95% level.

Executive Summary

- The cost of monthly premiums remains as the top reason behind Plan members' choice of health plans in 2015. However, the proportion of Medicare Primary Retirees who rate this as the number one reason increased significantly from 2014 to 2015. Other notable changes that occurred among Medicare Primary Retirees in 2015 include a decrease in the importance of maximums, copays and 100% coverage of preventive services, medications and/or prescriptions.
- The vast majority of Active Employees/Retirees had a primary care visit with the provider listed on their health benefits card in both 2014 and 2015. Significantly more of these members in 2015 than in the previous year also received/used preventive services, screenings and medications covered at 100%.
- Improvement occurred in 2015 with Active Employees/Retirees' level of satisfaction with the care and service they have received since January 1st.
  - In 2014, 59% gave the highest ratings (top 3 box) for the customer service they received when they called for assistance, whereas in 2015, 61% gave the same type of ratings.
  - 57% in 2014 gave the highest ratings for the prescription benefits offered through the State Health Plan, which increased to 61% in 2015.
  - 52% rated the information communicated about prescription benefits highly in 2014. This proportion increased to 55% in 2015.

Active Members - Drivers of Choice in Total

- What were your top reasons for choosing one design over another for the 2015 benefit year? Please rank the items on the list using numbers 1 through 8, where 1 means your top reason, 2 means your second reason, and so on, with 8 being the least important reason for choosing one plan over another.

#1

Reasons Ranked 1-8 *Base: AE 2014 Total (n=5171); AE 2015 Total (n=4859)*	Ranked #1		Ranked Top 2		Ranked Top 3		Average Ranking	
	2014 (A)	2015 (B)	2014 (C)	2015 (D)	2014 (E)	2015 (F)	2014 (G)	2015 (H)
Cost of monthly premiums	43%	43%	59%	59%	72%	73%	2.53	2.49
Copay or cost associated with each doctor visit or prescription	19%	19%	47%	46%	74%	75%	2.79	2.77
Having preventive services, medications, and/or prescriptions covered at 100%	13%	14%A	28%	29%	46%	46%	3.52	3.48
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	13%	13%	37%	37%	61%	61%	3.20	3.18
Presence or lack of wellness activities to lower monthly premiums	5%	5%	13%	14%	22%	23%E	4.82H	4.75
Cost of dependents	3%	2%	8%	7%	12%F	10%	6.17	6.23
Having a Health Reimbursement Account (HRA) to offset your out-of-pocket expenses	2%	2%	5%	4%	9%	8%	5.85	5.92G
Existence of other insurance such as TRICARE	2%	1%	3%D	2%	4%F	3%	7.12	7.18G

Red letters represent statistically significant differences at the 95% level. Groups compared include AB, CD, EF and GH.

Active Members - Drivers of Choice by Plan Type

- What were your top reasons for choosing one design over another for the 2015 benefit year? Please rank the items on the list using numbers 1 through 8, where 1 means your top reason, 2 means your second reason, and so on, with 8 being the least important reason for choosing one plan over another.

Reasons Ranked 1-8 *Bases: Traditional 70/30 (n=966)* *Enhanced 80/20 (n=3573)* *CDHP (n=229)*	**Ranked #1**			**Ranked Top 2**			**Ranked Top 3**			**Average Ranking**		
	Traditional (A)	Enhanced (B)	CDHP (C)	Traditional (D)	Enhanced (E)	CDHP (F)	Traditional (G)	Enhanced (H)	CDHP (I)	Traditional (J)	Enhanced (K)	CDHP (L)
Cost of monthly premiums	77%BC	34%	48%B	89%EF	50%	68%E	93%HI	67%	82%H	1.52	2.78JL	2.18J
Cost of dependents	5%B	2%	5%B	20%E	3%	18%E	25%H	5%	25%H	5.37	6.52JL	5.47
Copay or cost associated with each doctor visit or prescription	5%	24%AC	3%	28%F	53%DF	13%	66%I	80%GI	27%	3.21K	2.54	4.48JK
Existence of other insurance such as TRICARE	4%BC	1%	0%	6%EF	1%	0%	8%HI	2%	1%	6.90	7.23J	7.65JK
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	3%	16%A	12%A	31%	40%DF	26%	60%I	63%I	39%	3.35K	3.07	4.03JK
Having preventive services, medications, and/or prescriptions covered at 100%	3%	18%AC	9%A	15%	34%DF	22%D	28%	52%GI	45%G	4.19KL	3.25	3.87K
Presence or lack of wellness activities to lower monthly premiums	2%	6%A	4%A	7%	15%D	17%D	13%	26%G	25%G	5.45KL	4.54	4.90K
Having a Health Reimbursement Account (HRA) to offset your out-of-pocket expenses	1%	1%	18%AB	3%	3%	37%DE	7%	6%	57%GH	6.01L	6.06L	3.42

Red letters represent statistically significant differences at the 95% level. Groups compared include ABC, DEF, GHI and JKL.

Active Members - Drivers of Choice by Coverage

- What were your top reasons for choosing one design over another for the 2015 benefit year? Please rank the items on the list using numbers 1 through 8, where 1 means your top reason, 2 means your second reason, and so on, with 8 being the least important reason for choosing one plan over another.

Reasons Ranked 1-8 *Bases: Employee Only (n=3746)* *Employee + Children (n=465)* *Employee + Spouse (n=279)* *Family (n=369)*	**Ranked #1**				**Ranked Top 2**				**Ranked Top 3**				**Average Ranking**			
	Employee Only (A)	Employee + Children (B)	Employee + Spouse (C)	Family (D)	Employee Only (E)	Employee + Children (F)	Employee + Spouse (G)	Family (H)	Employee Only (I)	Employee + Children (J)	Employee + Spouse (K)	Family (L)	Employee Only (M)	Employee + Children (N)	Employee + Spouse (O)	Family (P)
Cost of monthly premiums	44% BC	38%	37%	43%	61% FG	54%	52%	56%	75% JKL	69%	64%	64%	2.38	2.70 M	2.95 M	2.95 M
Copay or cost associated with each doctor visit or prescription	19%	21% D	18%	15%	48% FH	41%	43%	37%	77% JKL	63%	71% JL	63%	2.69	3.06 M	2.85	3.13 MO
Having preventive services, medications, and/or prescriptions covered at 100%	15%	14%	14%	14%	30%	29%	29%	28%	47%	45%	48%	42%	3.41	3.67 M	3.64 M	3.80 M
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	13%	11%	15%	13%	39% FH	30%	37%	32%	63% JL	52%	59% J	56%	3.10	3.61 MO	3.18	3.44 MO
Presence or lack of wellness activities to lower monthly premiums	5% D	3%	5%	2%	15% FH	9%	14% F	11%	25% J	17%	21%	21%	4.62	5.35 MO	4.92 M	5.19 M
Cost of dependents	1%	8% A	6% A	8% A	2%	28% EG	16% E	28% EG	3%	39% IK	22% I	39% IK	6.80 NOP	3.98	5.13 NP	4.05
Having a Health Reimbursement Account (HRA) to offset your out-of-pocket expenses	1%	2% A	4% A	2%	4%	7% E	7% E	6%	7%	13% I	11% I	13% I	5.91	6.03	6.01	5.83
Existence of other insurance such as TRICARE	1%	2%	3% A	2%	2%	2%	3%	2%	3%	3%	4%	2%	7.08	7.59 MO	7.32 M	7.62 MO

Red letters represent statistically significant differences at the 95% level. Groups compared include ABCD, EFGH, IJKL and MNOP.

Medicare Members - Drivers of Choice

- What were your top reasons for choosing one design over another for the 2015 benefit year? Please rank the items on the list using numbers 1 through 6, where 1 means your top reason, 2 means your second reason, and so on, with 6 being the least important reason for choosing one plan over another.

Reasons Ranked 1-6 *Base: MP 2014 Total (n=2554); MP 2015 Total (n=597)*	Ranked #1		Ranked Top 2		Ranked Top 3		Average Ranking	
	2014 (A)	2015 (B)	2014 (C)	2015 (D)	2014 (E)	2015 (F)	2014 (G)	2015 (H)
Cost of monthly premiums	41%	53%A	57%	69%C	71%	78%E	2.46H	2.12
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	16%B	12%	48%D	43%	75%	72%	2.68	2.83G
Copay or cost associated with each doctor visit or prescription	18%B	11%	46%D	38%	79%F	75%	2.64	2.81G
Existence of other insurance such as an Individual Medicare Advantage Plan, an Individual Part D Plan or TRICARE	8%	11%A	13%	19%C	17%	23%E	4.68H	4.49
Having preventive services, medications, and/or prescriptions covered at 100%	14%B	10%	29%	26%	49%F	44%	3.24	3.43G
Cost of dependents	3%	3%	6%	5%	9%	8%	5.31	5.32

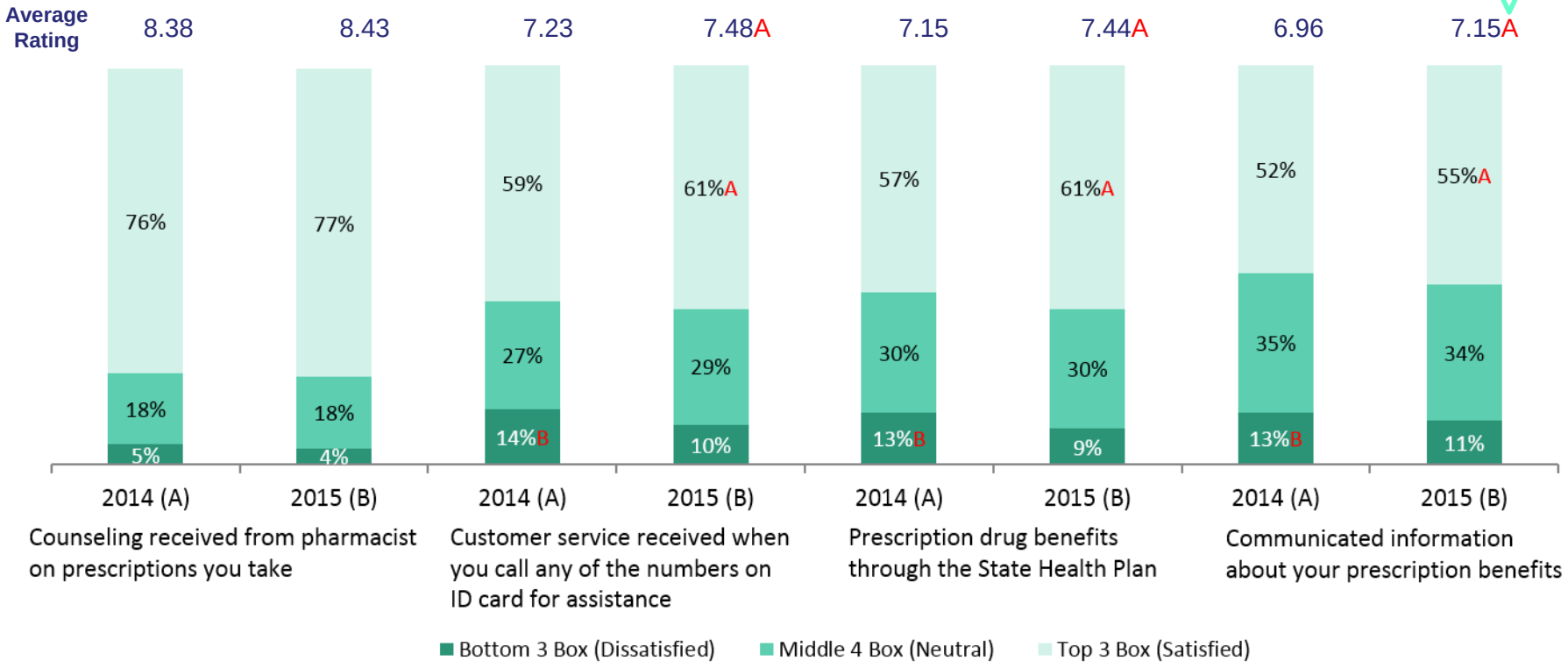
Red letters represent statistically significant differences at the 95% level. Groups compared include AB, CD, EF and GH.

Medicare Primary Respondents= 2,554

Active Members - Satisfaction

- An improvement in satisfaction levels occurred in 2015 among Active Employees/Retirees. More are satisfied with the customer service they received when calling for assistance, the prescription drug benefits offered through the State Health Plan and the communicated information about prescription benefits than in 2014.

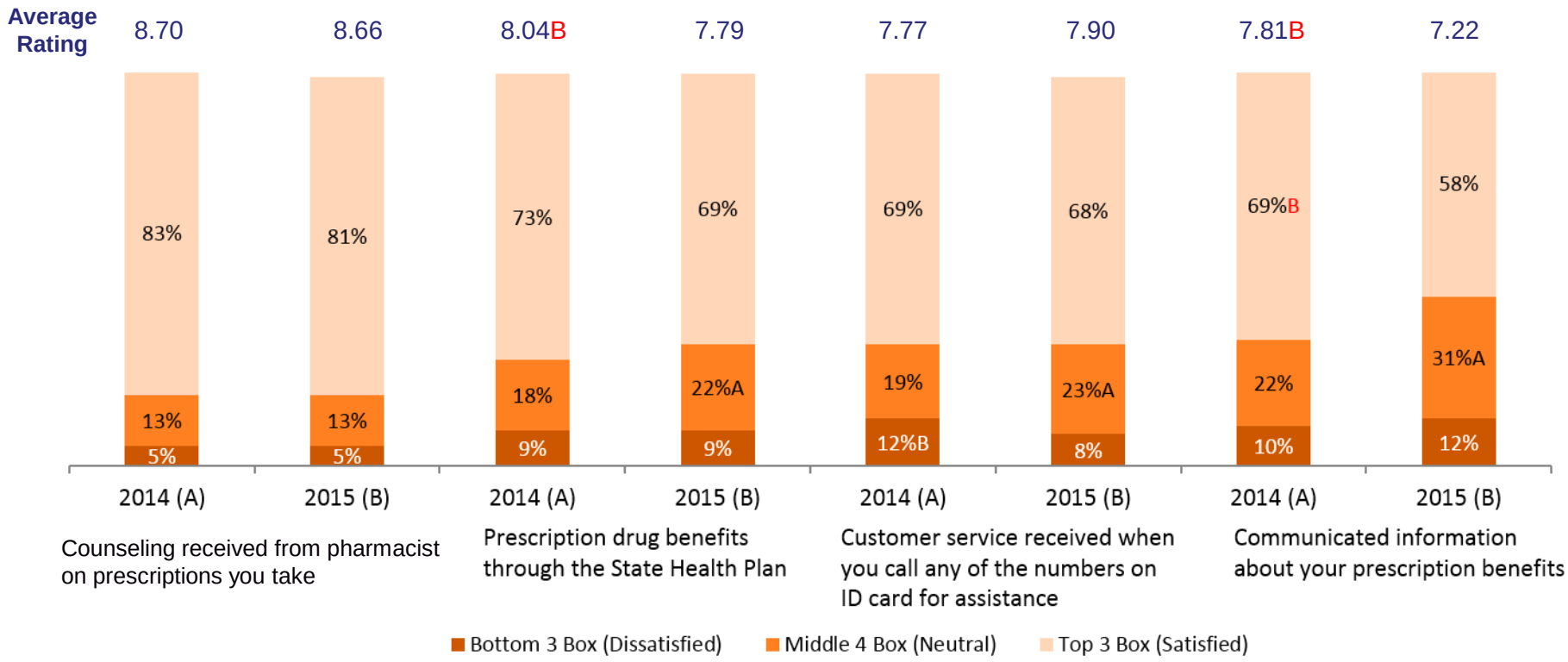
READ AS: This satisfaction measure in 2015 is statistically significantly higher than in 2014.



Red letters represent statistically significant differences at the 95% level.

Medicare Members - Satisfaction

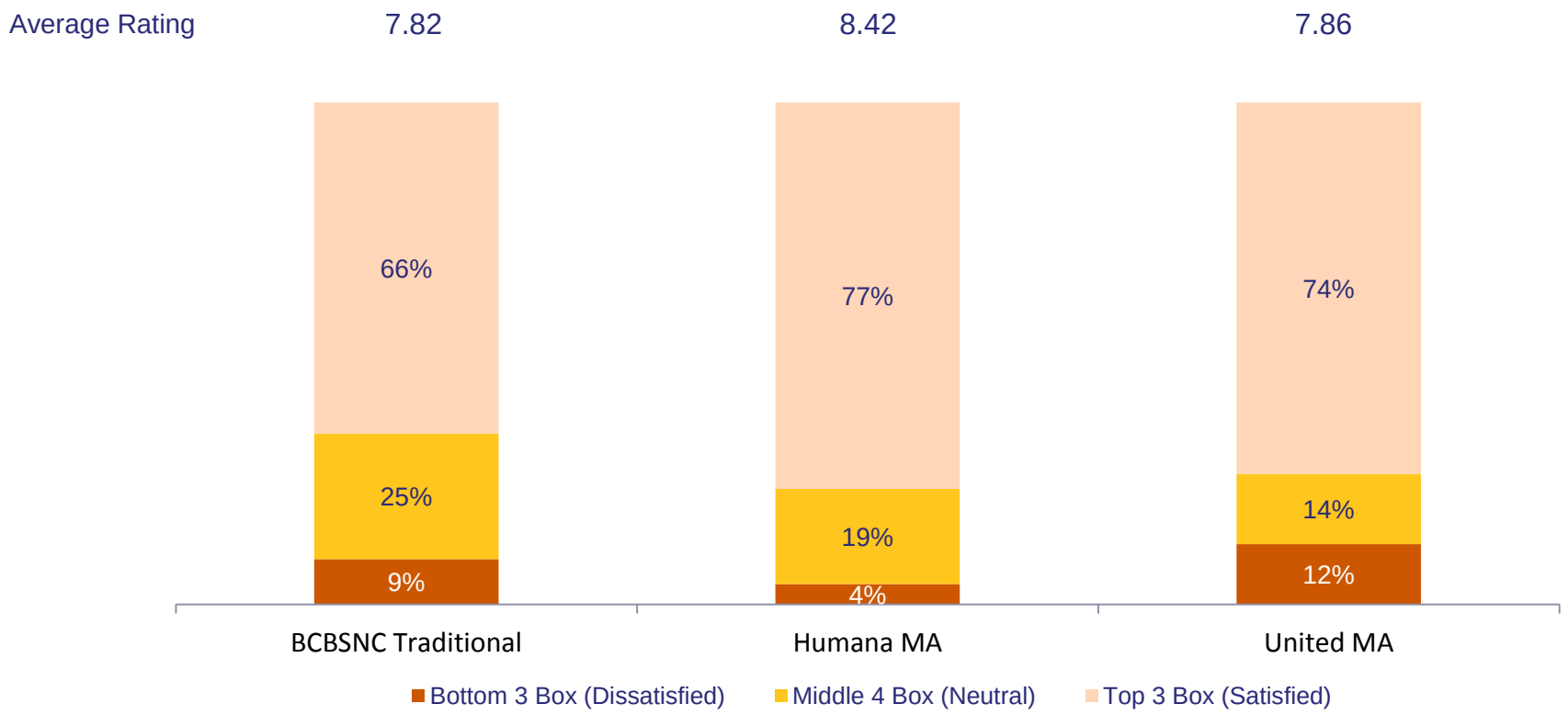
- The level of satisfaction with the counseling received from a pharmacist and the customer service received when calling for assistance did not change between the two years among Medicare Primary Retirees. Unfortunately, a drop did occur from 2014 to 2015 in their satisfaction with the prescription drug benefits offered through the State Health plan and the communicated information about prescription benefits.



Red letters represent statistically significant differences at the 95% level.

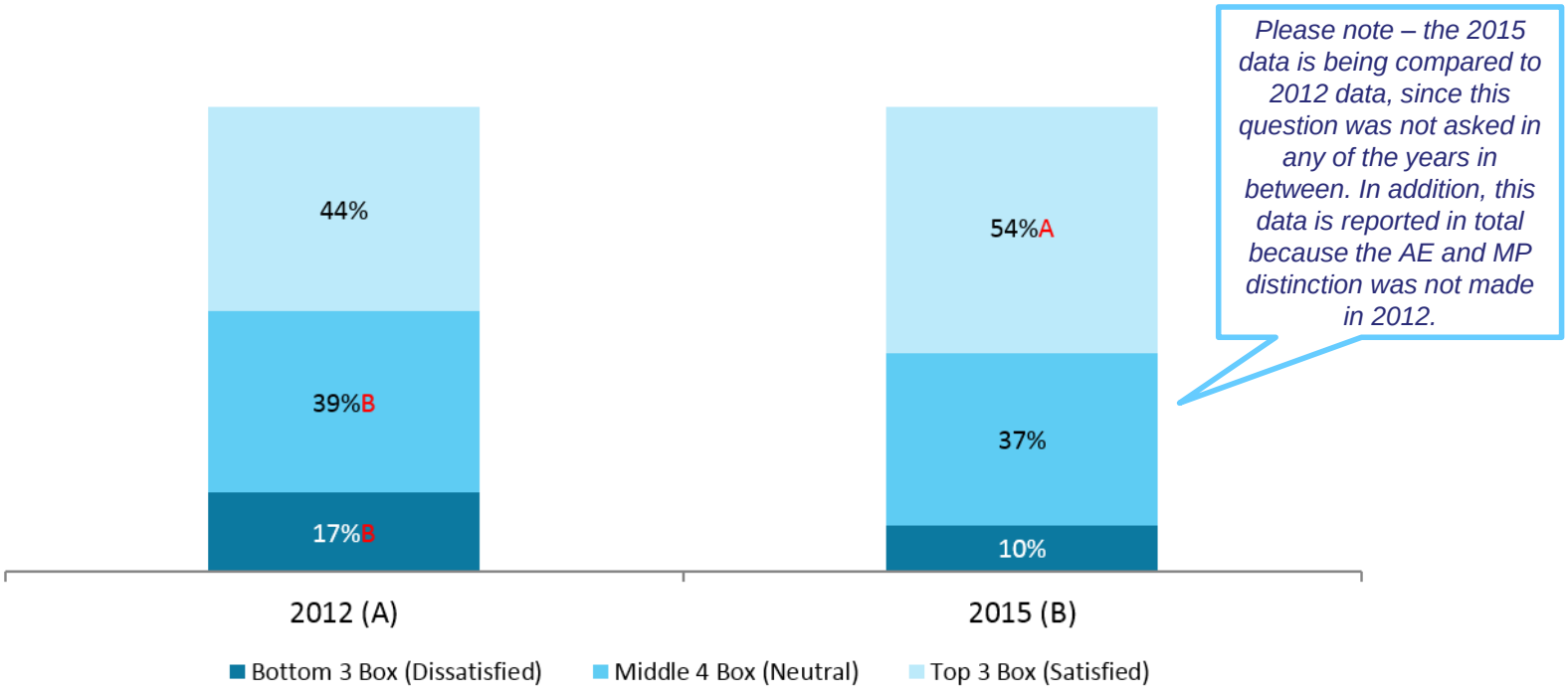
Medicare Members – Customer Service Satisfaction by Carrier

- The customer service you receive when you call any of the numbers on your ID for assistance.



State Health Plan Coverage Satisfaction

- Overall satisfaction with the current health plan coverage offered by the State Health Plan has improved in 2015 as compared to 2012.



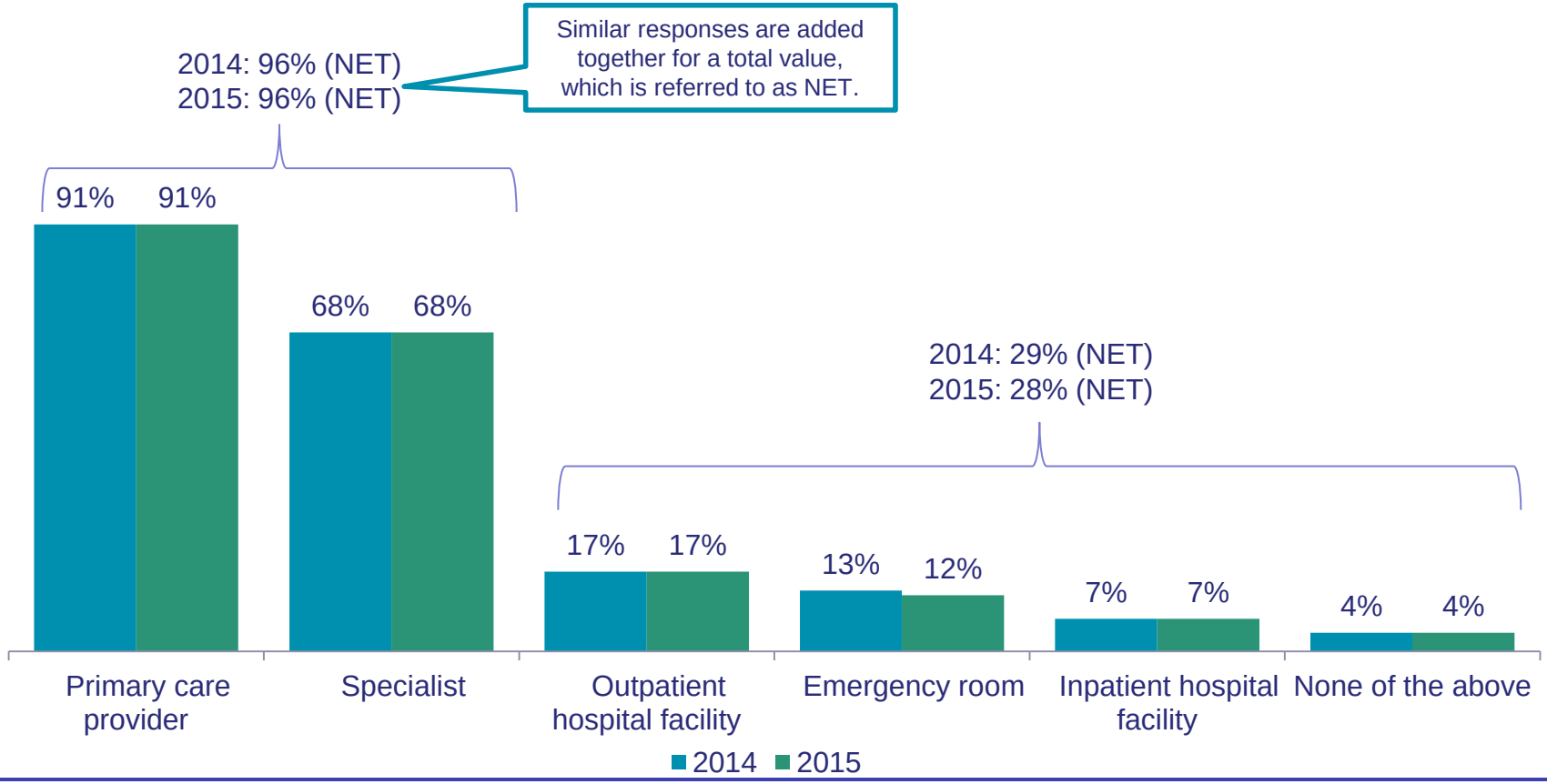
Please note – the 2015 data is being compared to 2012 data, since this question was not asked in any of the years in between. In addition, this data is reported in total because the AE and MP distinction was not made in 2012.

Base: 2012 Total excluding "n/a" (n=10453)
2015 Total (n=5456)

Red letters represent statistically significant differences at the 95% level.

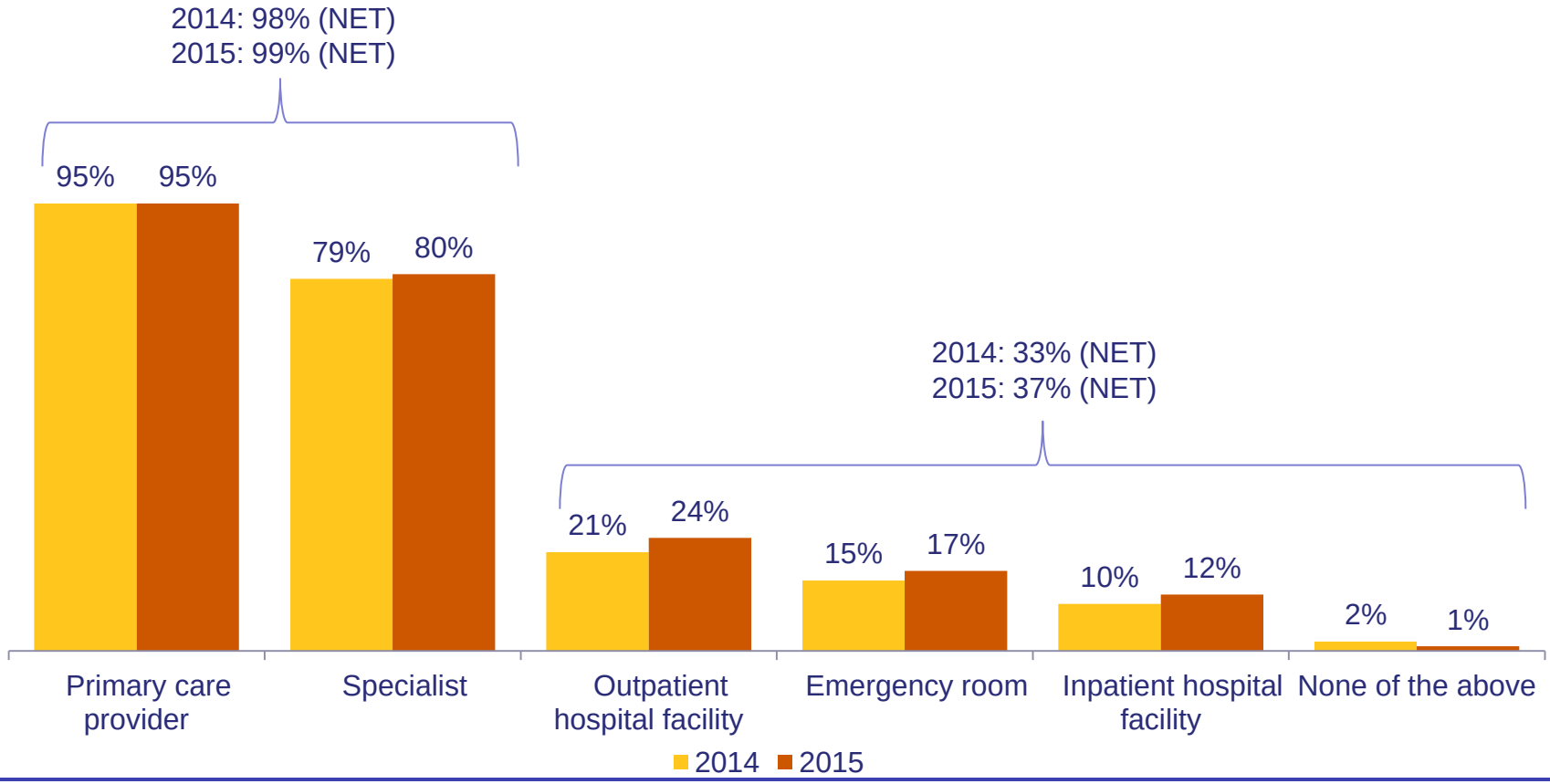
Active Members - Visits the Last 12 Months

- Which of the following have you visited within the past 12 months? Please check all that apply.
- Nearly all Active Employees/Retirees have visited a Primary Care Provider during the past 12 months. No significant changes occurred between 2014 and 2015.



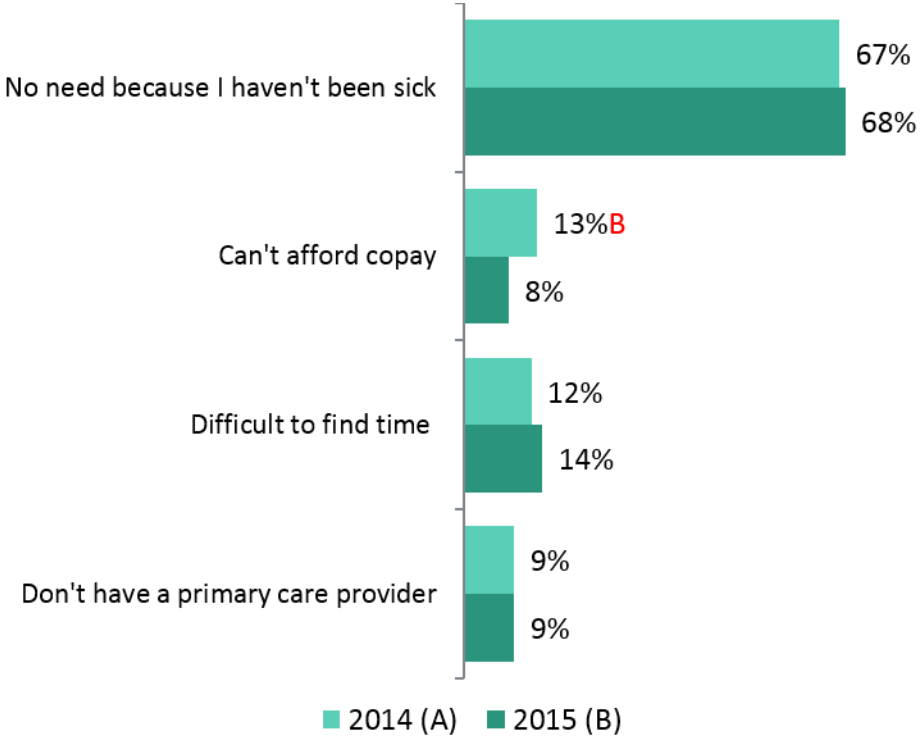
Medicare Members - Visits the Last 12 Months

- Which of the following have you visited within the past 12 months? Please check all that apply.
- Virtually all Medicare Primary Retirees visited a Primary Care Provider during the past 12 months. These proportions did not change significantly over time.



Active Members - Reasons for NOT Visiting PCP

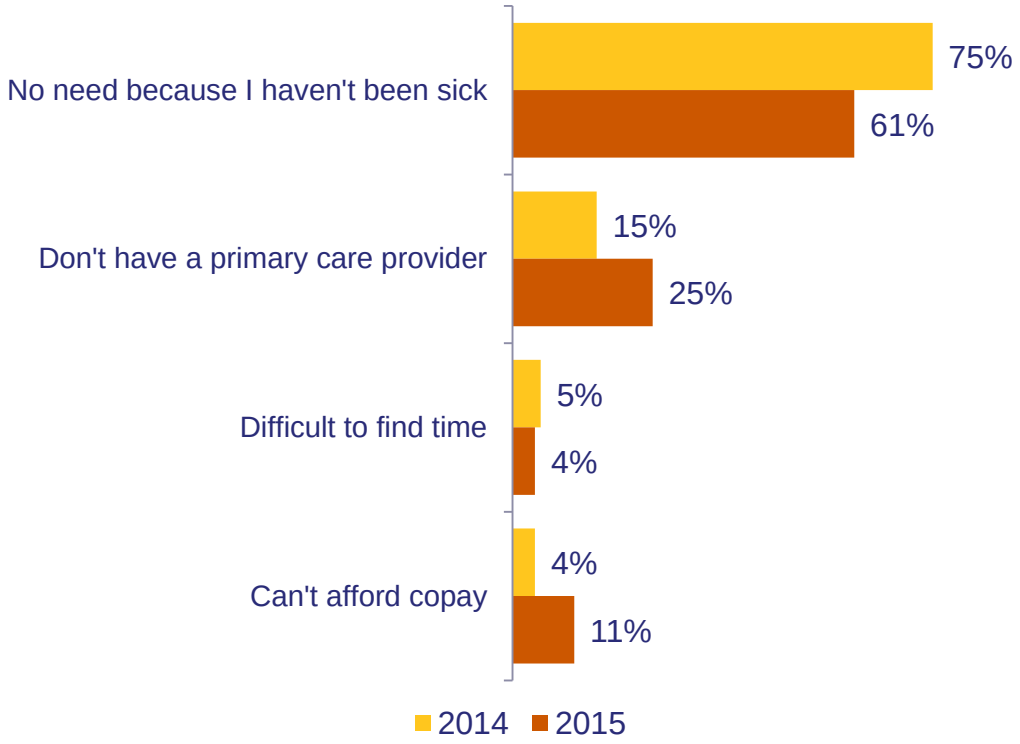
- What reason most closely matches why you have not visited a Primary Care Provider within the last 12 months?
- Of the Active Employees/Retirees who haven't visited a Primary Care Provider within the last 12 months, the majority didn't do so because they weren't sick, and therefore, didn't have a need. A similar proportion of these members gave the same response in 2014. In 2015, significantly fewer of these members didn't visit a PCP due to the cost of the copay than in the previous year.



Red letters represent statistically significant differences at the 95% level.

Medicare Members - Reasons for NOT Visiting PCP

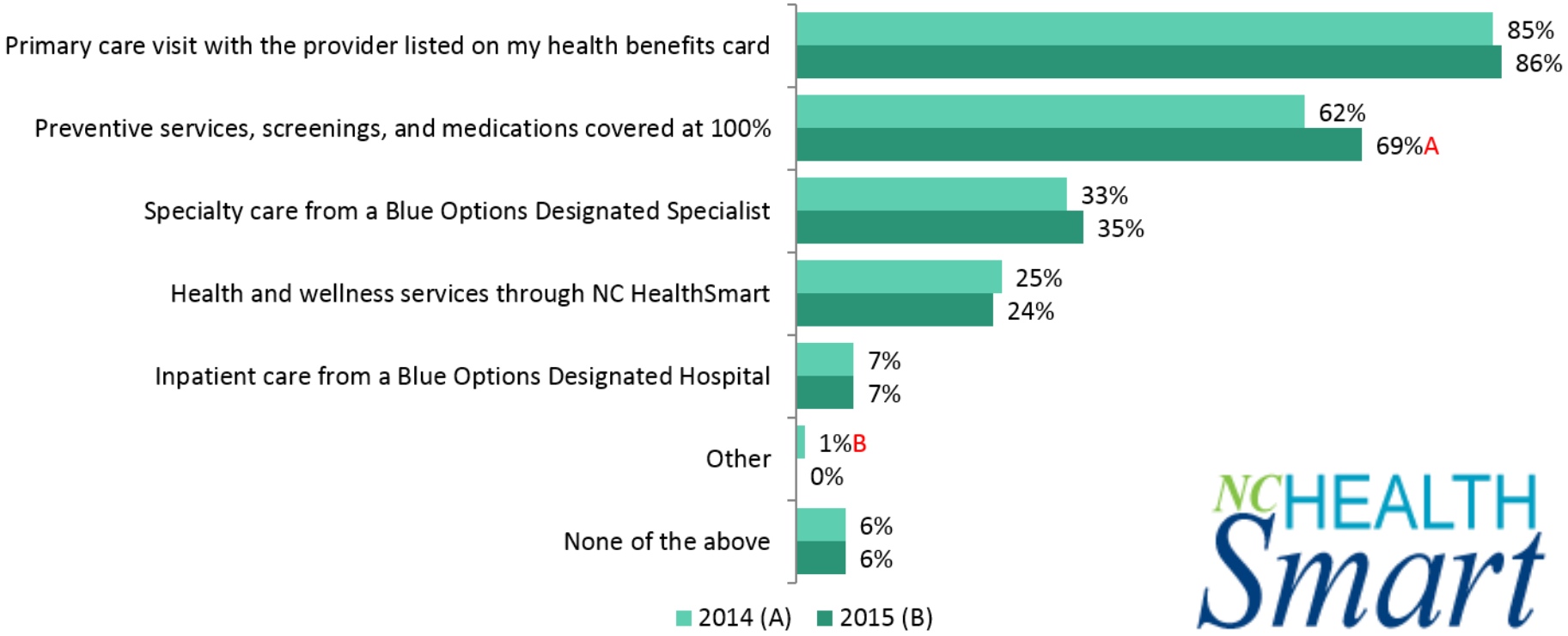
- What reason most closely matches why you have not visited a Primary Care Provider within the last 12 months?
- The majority of Medicare Primary Retirees didn't visit a Primary Care Provider in the past 12 months because they weren't sick, and therefore, didn't have a need to do so.



Red letters represent statistically significant differences at the 95% level.

Active Members - Services

- Which of the following services have you used since January 1, 2015?



Base: 2014 AE not on traditional 70/30 plan (n=4010)
2015 AE not on traditional 70/30 plan (n=3892)

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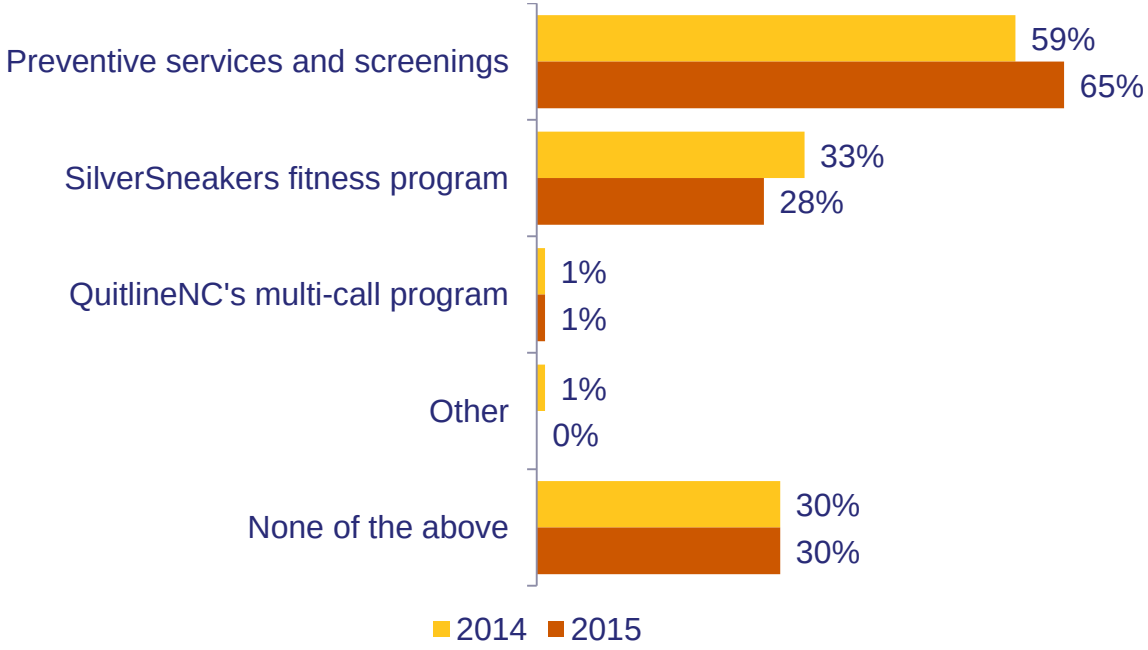
An initiative of the State Health Plan

Red letters represent statistically significant differences at the 95% level.

Medicare Members - Services

- Which of the following services have you used since January 1, 2015? Please select all that apply.

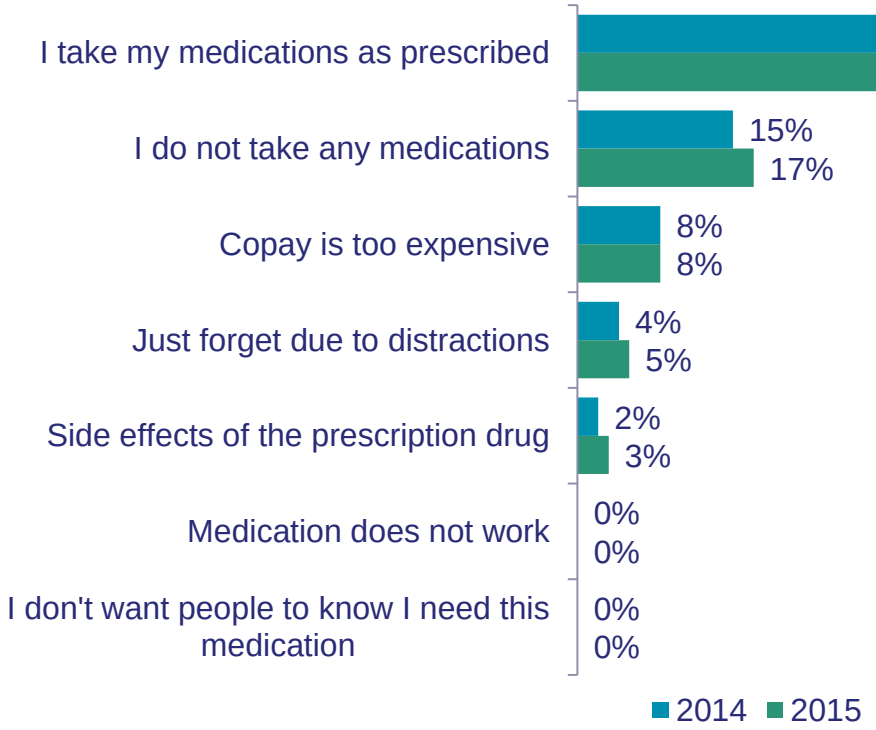


Base: 2014 MP not on traditional 70/30 plan (n=1894) 2015 MP not on traditional 70/30 plan (n=139)

Red letters represent statistically significant differences at the 95% level.

Active Members - Medication

- What prevents you from taking your medication(s) on a regular basis?
- Almost three-quarters of Active Employees/Retirees in both 2014 and 2015 take their medications as prescribed.



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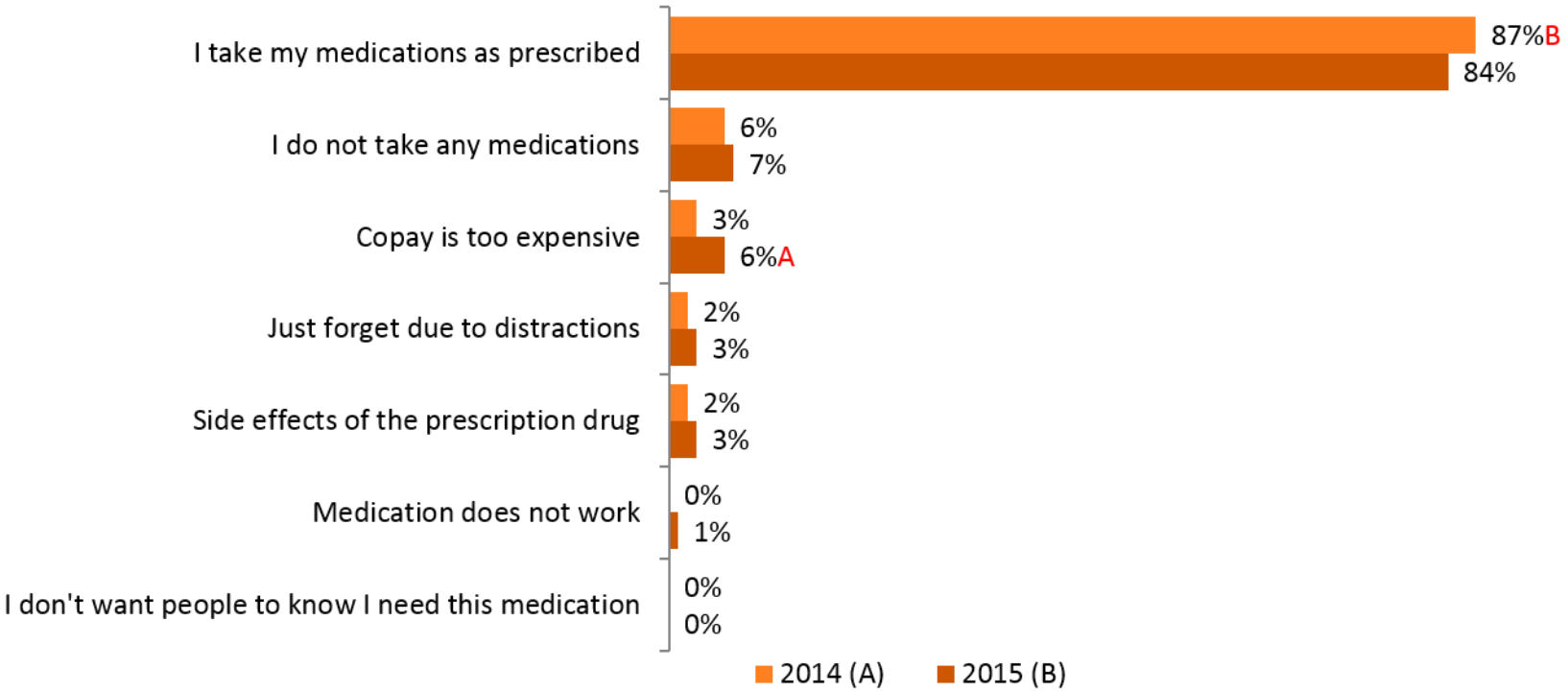
Medicare Members - Medication

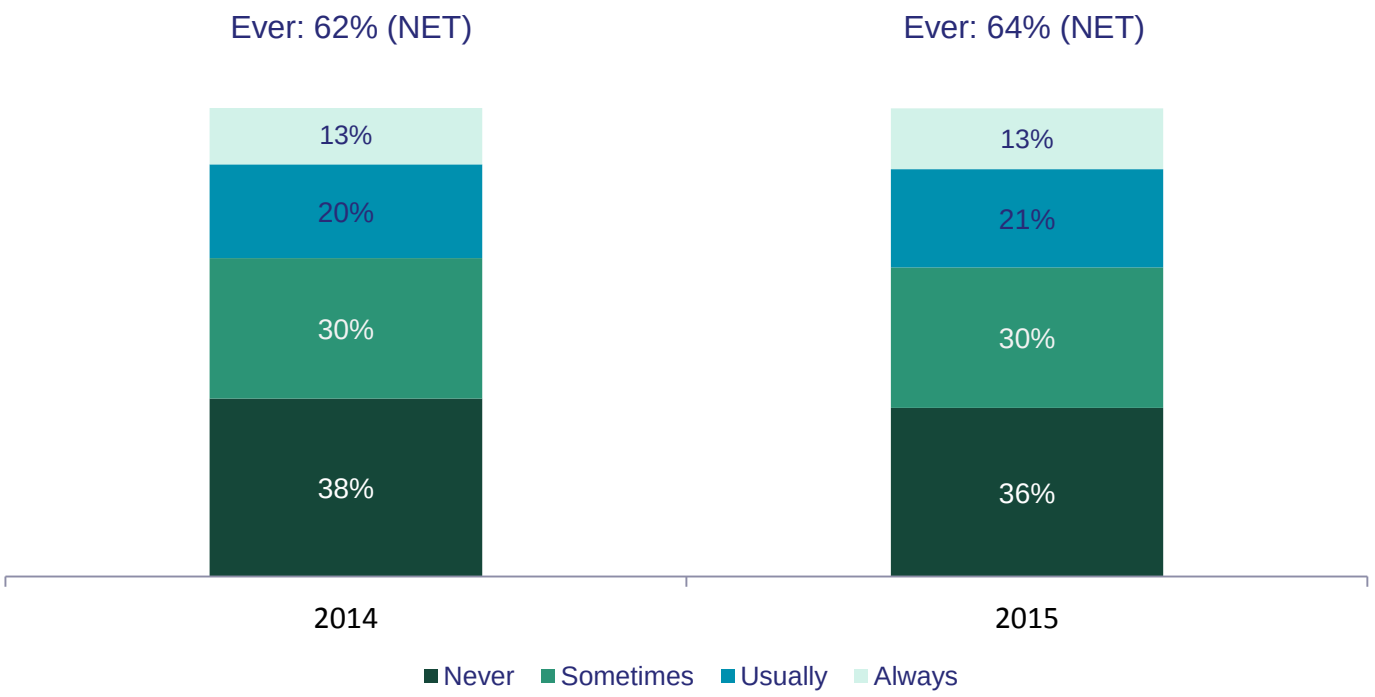
- What prevents you from taking your medication(s) on a regular basis?
- More Medicare Primary Retirees in 2014 than in 2015 took their medications as prescribed. This could be due to an increase in 2015 in the proportion of those who do not take their medications regularly because their copay is too expensive.



Red letters represent statistically significant differences at the 95% level.

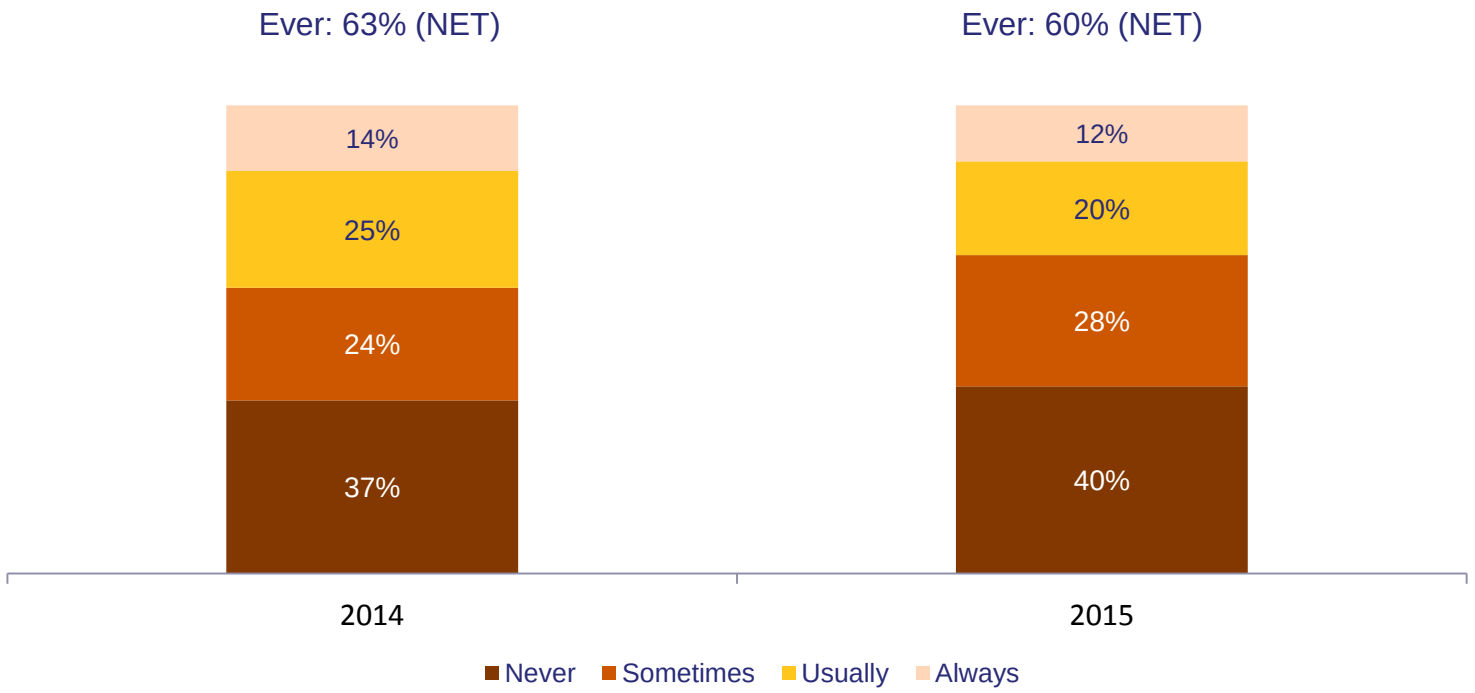
Active Members - Advance Notice of Cost

- In the last 12 months, how often were you able to find out in advance how much you would have to pay for health care services or equipment that you needed?
- Over the past 12 months, just over one third of Active Employees/Retirees say they have never been able to find out in advance how much they would have to pay for needed health care services/equipment. This proportion is similar to what was captured in 2014.



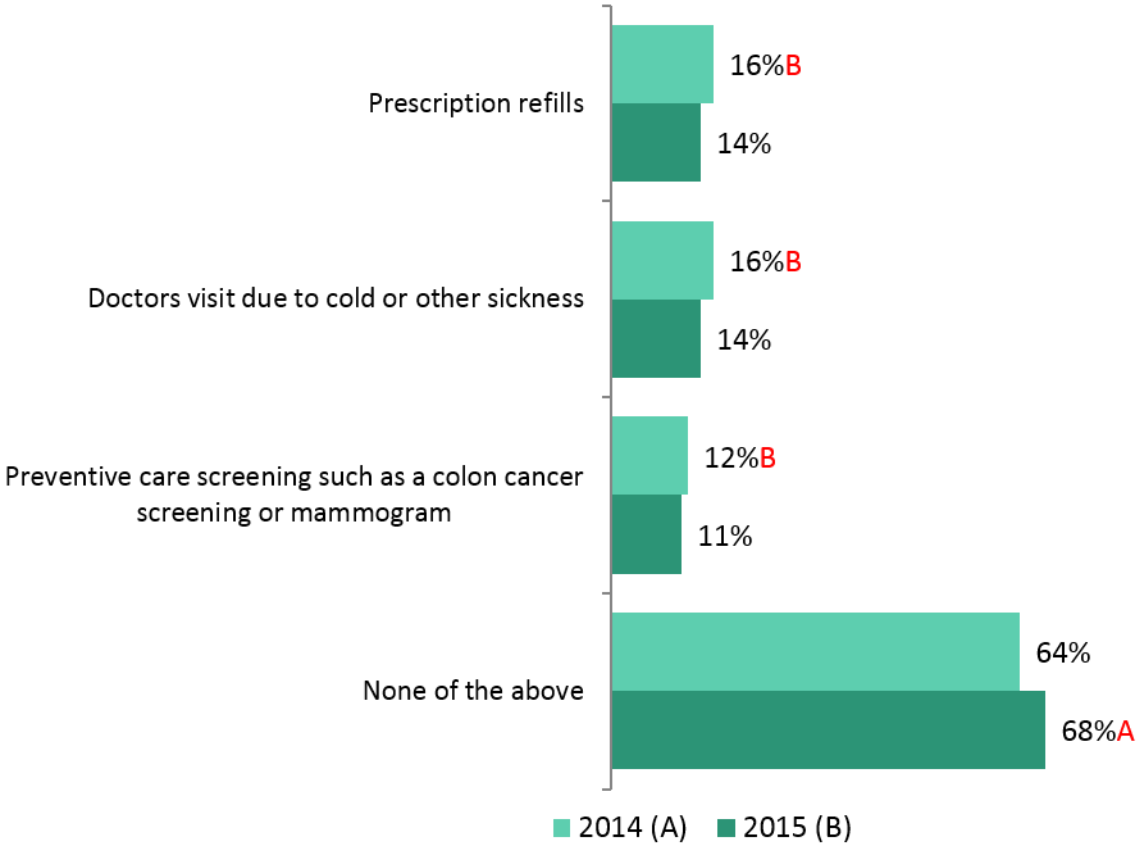
Medicare Members - Advance Notice of Cost

- In the last 12 months, how often were you able to find out in advance how much you would have to pay for health care services or equipment that you needed?
- Over the past 12 months, four out of ten Medicare Primary Retirees say they have never been able to find out in advance how much they would have to pay for needed health care services/equipment. This proportion did not change significantly from 2014.



Active Members – Cost as a Barrier

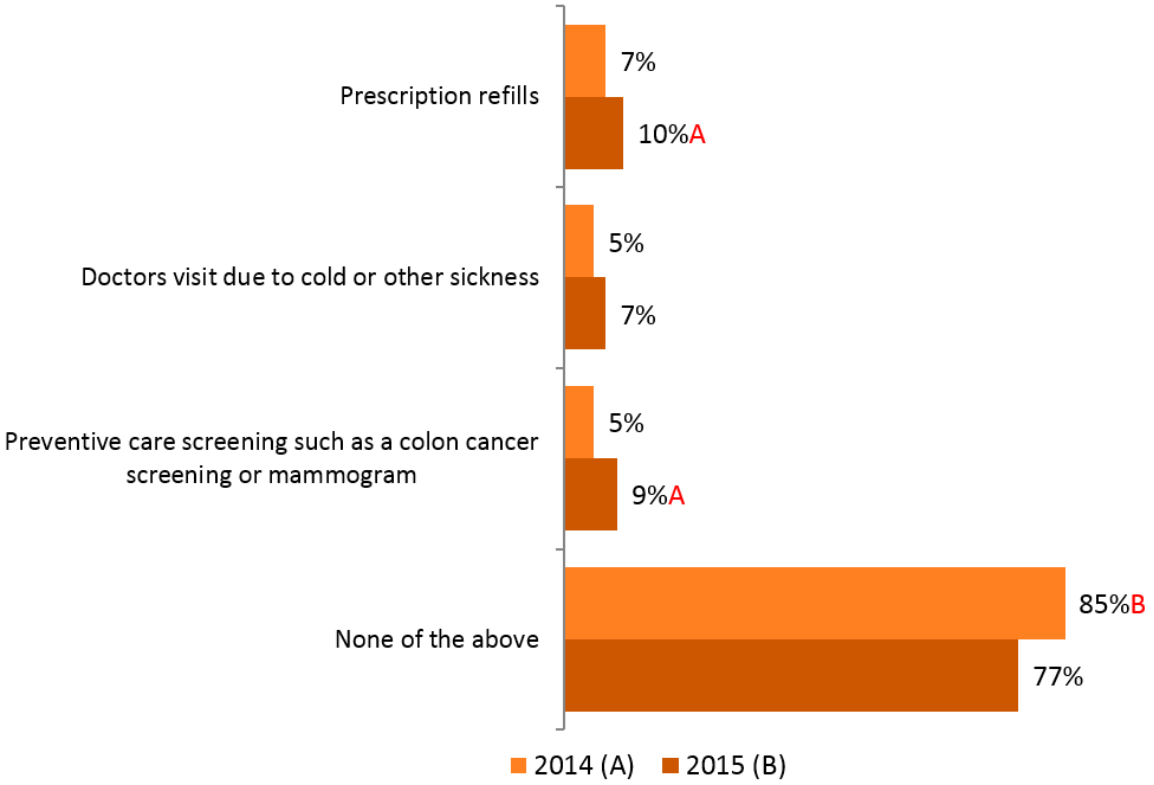
- In the last 12 months, did you delay or not get any of the following services because of the cost?
- 32% of Active Employees/Retirees say they were delayed in getting health care service or didn't receive it at all in the past 12 months because of cost. However, this is an improvement over 2014 where 36% said the same.



Red letters represent statistically significant differences at the 95% level.

Medicare Members - Cost as a Barrier

- In the last 12 months, did you delay or not get any of the following services because of the cost?
- Cost has become more of an issue for Medicare Primary Retirees in 2015, since 23% of these members say they were delayed in getting health care service or didn't receive it at all in the past 12 months for this reason, as compared to 15% in 2014. More specifically, more retirees in 2015 than in 2014 delayed or did not refill prescriptions and/or receive preventive care screenings because of the cost.



Red letters represent statistically significant differences at the 95% level.

Active Members – Communication Methods

- List your most preferred method or methods of receiving information from the State Health Plan. Please rank the items on the list using numbers 1 through 7, where 1 means your most preferred method, 2 means your second most preferred, and so on, with 7 being the least preferred method.
- Mailed printed materials and email communications are the top two most preferred methods of receiving information from the State Health Plan, among Active Employees/Retirees. However, more of these members in 2015 prefer mailed printed materials than in 2014. Other changes include fewer members in 2015 than in 2014 preferring the State Health Plan website and the Member Focus newsletter.

Method Preferences Ranked 1-7 *Base: AE 2014 Total (n=5171); AE 2015 Total (n=4859)*	**Ranked #1**		**Ranked Top 2**		**Ranked Top 3**		**Average Ranking**	
	2014 (A)	2015 (B)	2014 (C)	2015 (D)	2014 (E)	2015 (F)	2014 (G)	2015 (H)
Printed material mailed to my home	34%	39%A	52%	58%C	65%	71%E	2.78H	2.57
Email communications	35%	35%	63%	64%	80%	80%	2.36	2.35
State Health Plan website (shpnc.org)	16%B	14%	33%D	31%	56%F	52%	3.31	3.43G
Member Focus, monthly electronic State Health Plan newsletter	9%B	7%	31%D	26%	60%F	55%	3.33	3.49G
Through my Health Benefits Representative	3%	3%	8%	8%	15%	15%	5.26	5.26
Group meetings or presentations at my worksite	2%	2%	7%	7%	13%	13%	5.46	5.54G
Mobile application for my phone	2%	1%	6%	6%	12%	14%E	5.49H	5.36

Red letters represent statistically significant differences at the 95% level. Groups compared include AB, CD, EF and GH.

Medicare Members – Communication Methods

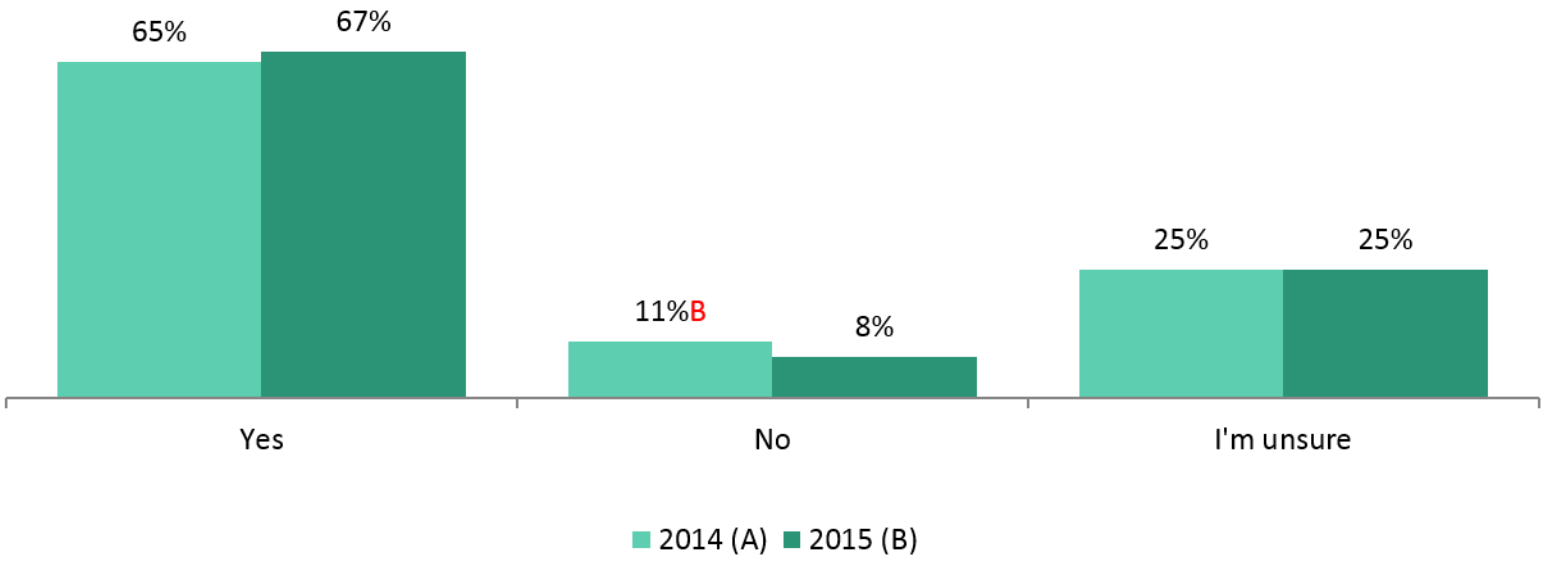
- List your most preferred method or methods of receiving information from the State Health Plan. Please rank the items on the list using numbers 1 through 7, where 1 means your most preferred method, 2 means your second most preferred, and so on, with 7 being the least preferred method.
- Mailed printed materials and email communications are the top two most preferred methods of receiving information from the State Health Plan, among Medicare Primary Retirees. However, more of these members in 2015 prefer mailed printed materials than in 2014.

Method Preferences Ranked 1-7 *Base: MP 2014 Total (n=2554); MP 2015 Total (n=597)*	**Ranked #1**		**Ranked Top 2**		**Ranked Top 3**		**Average Ranking**	
	2014 (A)	2015 (B)	2014 (C)	2015 (D)	2014 (E)	2015 (F)	2014 (G)	2015 (H)
Printed material mailed to my home	53%	58%A	68%	74%C	78%	82%E	2.14H	1.95
Email communications	25%	22%	56%	54%	75%	73%	2.60	2.71
State Health Plan website (shpnc.org)	11%	9%	31%	30%	58%	54%	3.25	3.38
Member Focus, monthly electronic State Health Plan newsletter	9%	7%	33%D	25%	66%F	57%	3.12	3.39G
Through my Health Benefits Representative	2%	3%	6%	9%C	11%	15%E	5.36	5.34
Group meetings or presentations at my worksite	0%	0%	3%	5%C	6%	11%E	5.86H	5.65
Mobile application for my phone	0%	1%	3%	3%	6%	8%	5.67	5.58

Red letters represent statistically significant differences at the 95% level. Groups compared include AB, CD, EF and GH.

Active Members – PCP & Specialist Communicating

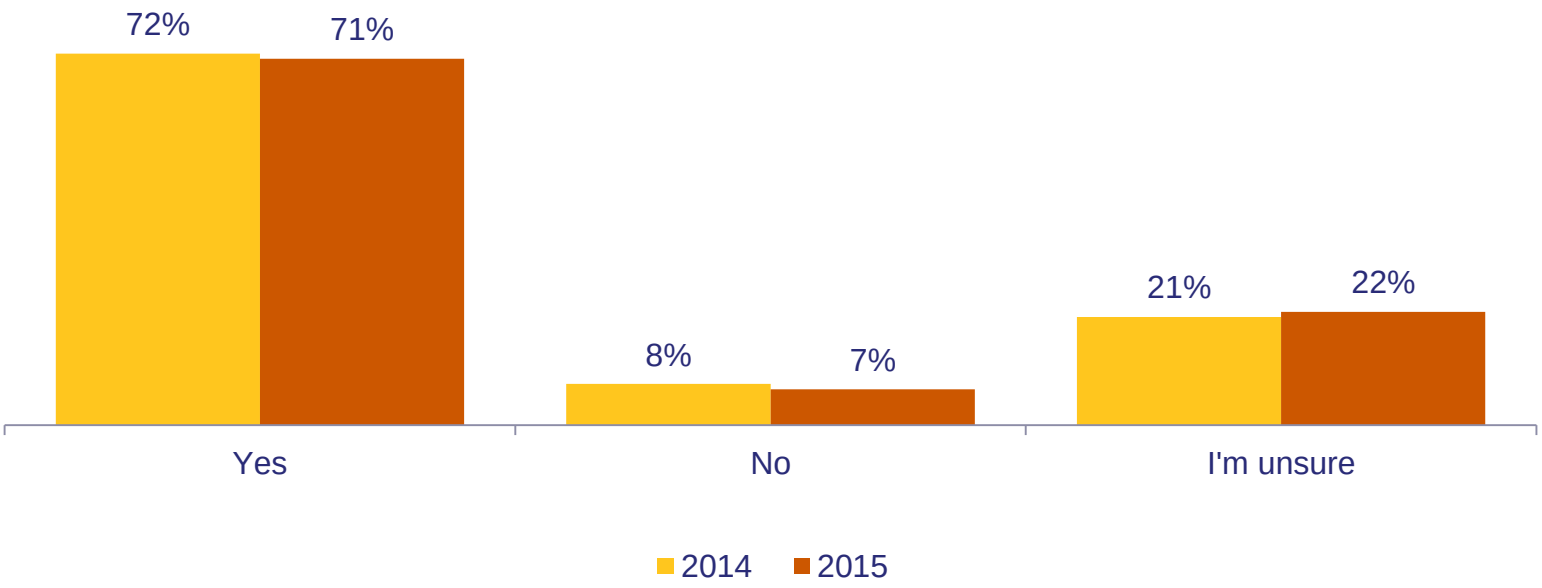
- Does your Primary Care Provider communicate with your specialist(s) to provide you with the highest level of care?
- In both 2014 and 2015, about two thirds of Active Employees/Retirees say their Primary Care Provider communicates with their specialist(s) to provide them with the highest level of care. The proportion of those who said their Primary Care Provider does not do this decreased from 2014 to 2015.



Red letters represent statistically significant differences at the 95% level.

Medicare Members – PCP & Specialist Communicating

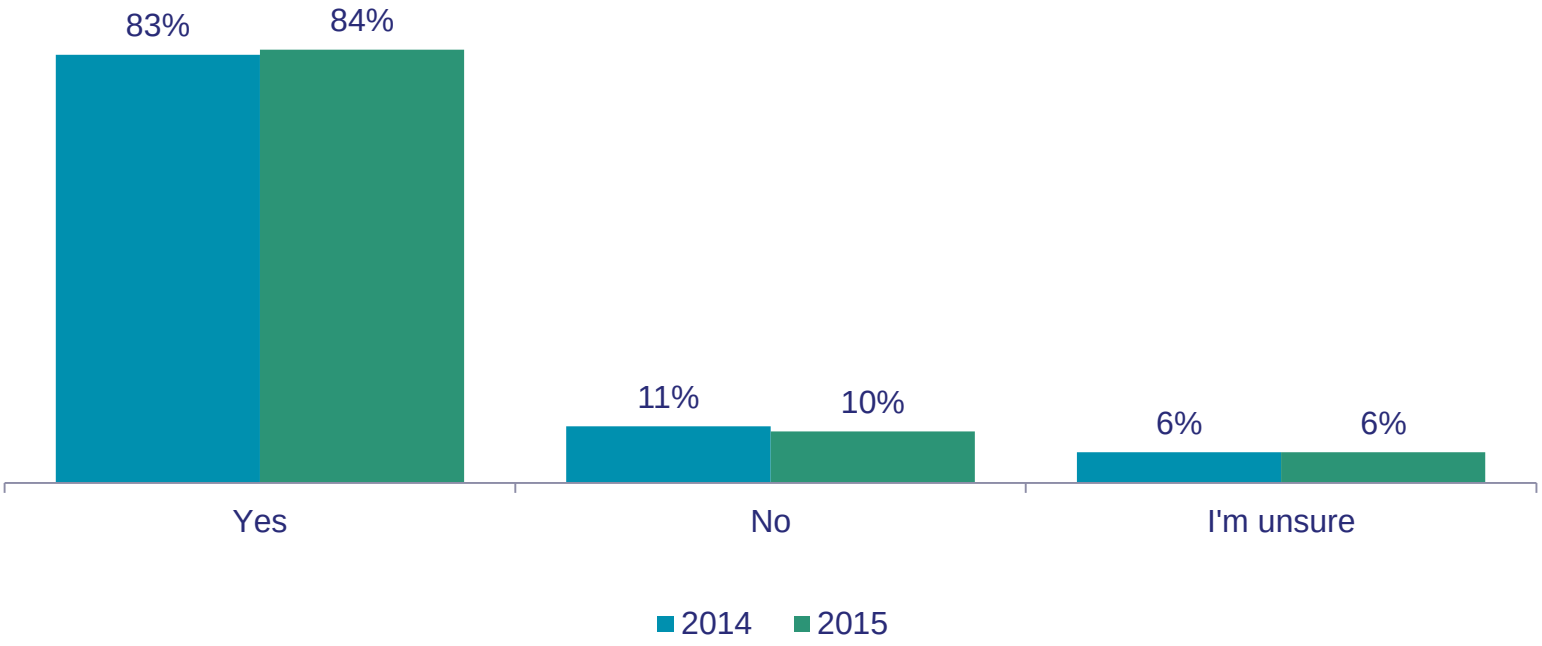
- Does your Primary Care Provider communicate with your specialist(s) to provide you with the highest level of care?
- In both 2014 and 2015, almost three quarters of Medicare Primary Retirees say their Primary Care Provider communicates with their specialist(s) to provide them with the highest level of care.



Red letters represent statistically significant differences at the 95% level.

Active Members – PCP Providing Resources

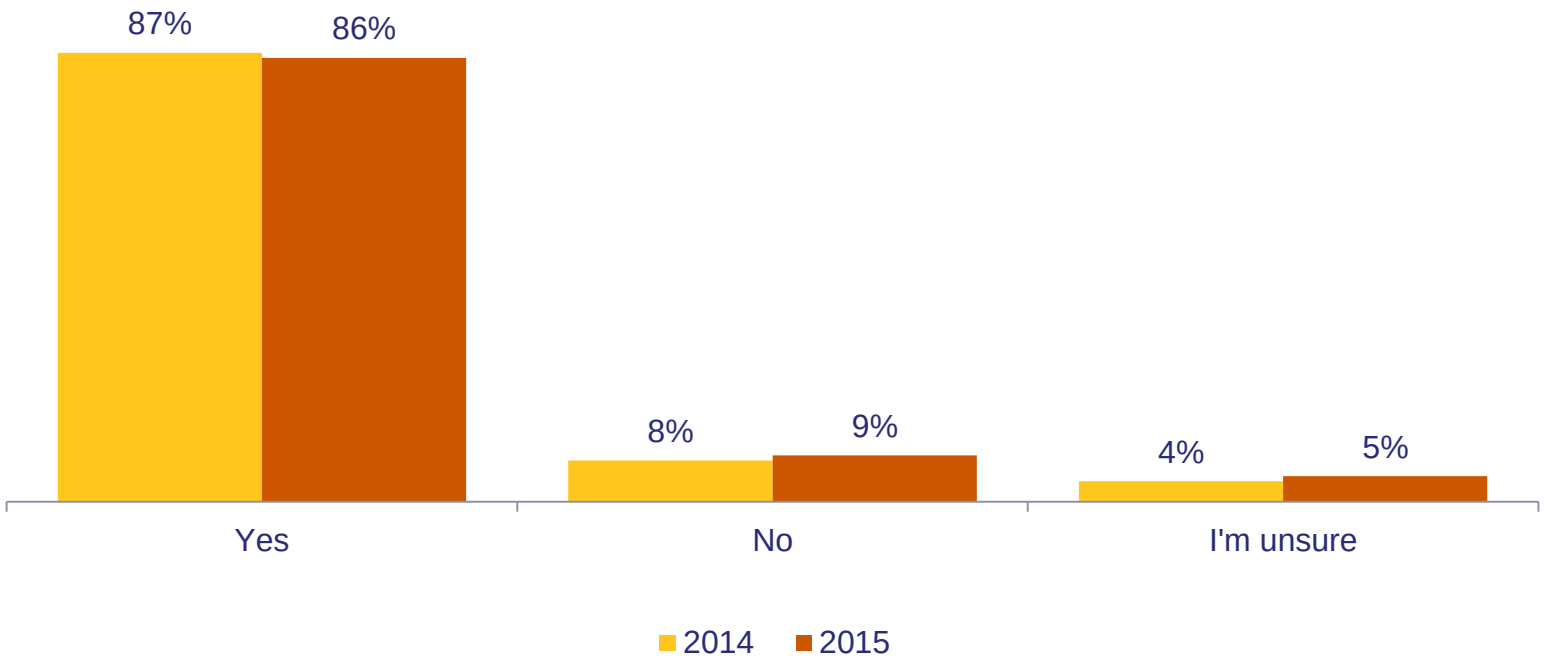
- Does your Primary Care Provider give you resources to help you understand and manage your health? For example, resources to help you manage your diabetes or maintain a healthy weight.
- About eight out of ten Active Employees/Retirees say their Primary Care Provider gives them resources to help them understand and manage their health. This proportion has remained stable over time.



Red letters represent statistically significant differences at the 95% level.

Medicare Members – PCP Providing Resources

- Does your Primary Care Provider give you resources to help you understand and manage your health? For example, resources to help you manage your diabetes or maintain a healthy weight.
- Almost nine out of ten Medicare Primary Retirees say their Primary Care Provider gives them resources to help them understand and manage their health. No significant changes occurred from 2014 to 2015.



Red letters represent statistically significant differences at the 95% level.

Survey Comparison

- Both surveys yielded similar low response rates even when an incentive was offered.
- Similar results regarding Primary Care Provider utilization.
- Similar opportunities to expand member's knowledge about the basics of their benefits to include in future outreach efforts.
- Preference in communication methods similar among Active and Medicare populations.

Appendix

1. 2015 Segal's Health Management Summary Report
2. 2015 Blue Cross and Blue Shield of NC Membership Satisfaction Survey Final Report

Segal Consulting

North Carolina State Health Plan

HEALTH MANAGEMENT SURVEY RESULTS
Board of Trustees Summary Report

August 28, 2015

THE SEGAL GROUP
Founded in 1939

Table of Contents

Background

- The Segal Company conducted a Health Management Survey with a randomized group of Active/Non-Medicare Retiree and Medicare Retiree North Carolina State Health Plan members in April and May of 2015.

- The survey was available from April 20, 2015 through May 20, 2015.

- The Survey's objective was to gather members' opinions about the service and care provided through the State Health Plan, with particular focus on members' interactions with their Primary Care Providers.

Survey Sampling

- 35,027 Actives and Non-Medicare Retiree members were invited to respond via an online version of the survey, using two postcard mailings to members' homes—an announcement and a reminder.
- 18,595 Medicare Retiree members were invited to respond via a paper version of the survey, using two mailings to members' homes - the paper survey with an introductory letter and reminder.
- The solicitation sampling design was intended to determine if there were any differences in responses by gender and by plan selection—an approach that was unique in contrast with previous member satisfaction surveys conducted by the State Health Plan.

Survey Incentive

- To encourage members to complete the survey, two types of incentives were offered:
  - **Actives and Non-Medicare Retiree members:** A one-night, free Redbox video rental, provided as a code by email or text message.
  - **Medicare Retiree members:** A $5 Walmart gift card, provided by mail.

Survey Response Rate

- The survey response rate was targeted at 10% for males and 16% for females, to reflect the State Health Plan's gender composition. The actual response rate by gender was as follows:
  - 10.6% male
  - 11.3% female

- 7,220 members responded:
  - 1,944 members (27%) responded online—these were almost exclusively Actives and Non-Medicare Retirees. This represented a 6% (rounded) response rate. Of this group, 46% were Active members.

  - 5,276 members (73%) responded via paper—these were almost exclusively Medicare Retirees. This represented a 28% (rounded) response rate.

Highlights of Results

Coverage Level

- Just over three-quarters of respondents have Employee/Retiree only coverage.

Reason for Current Coverage

- The answer to why they chose the health plan they have now, respondents ranked as #1 “The cost to have coverage (my monthly premium)”

Primary Care Provider Relationship

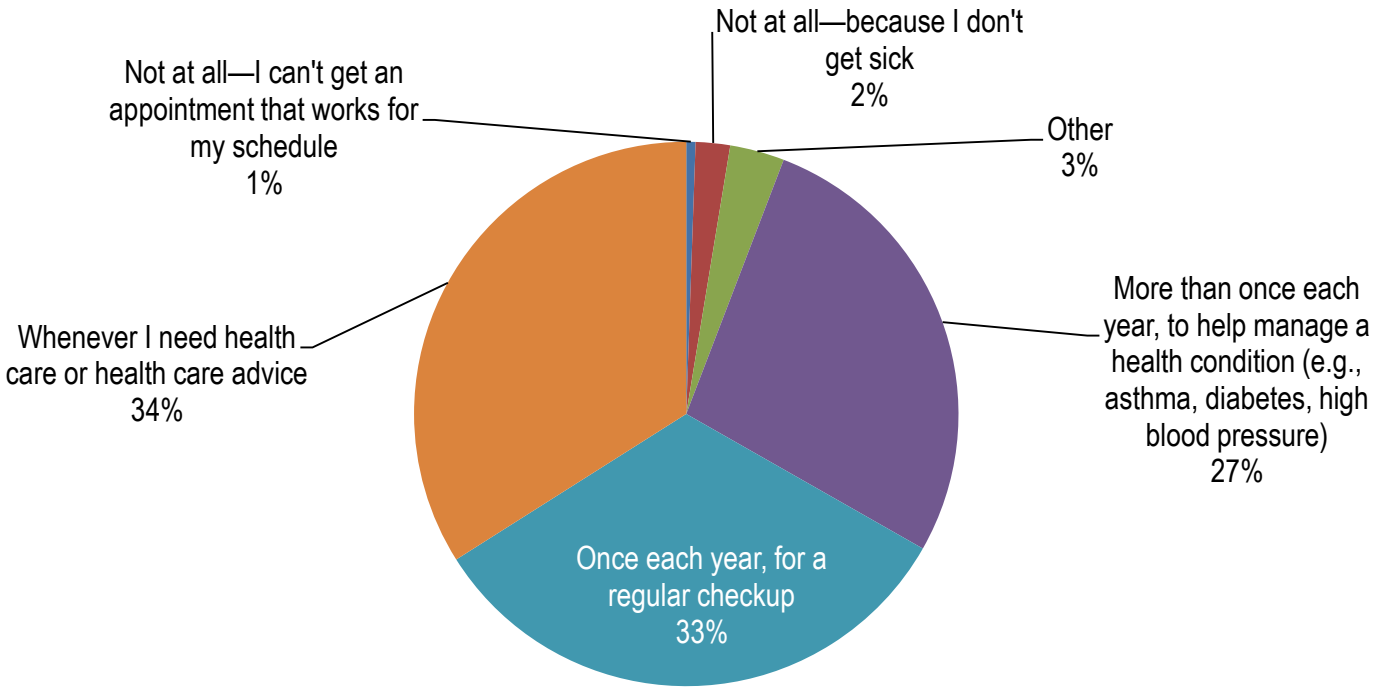
- The great majority (95%) of respondents have a Primary Care Provider
- Most respondents chose their PCP based on his/her location
  - While location convenience is an important practical factor in choosing a PCP, this may indicate an opportunity to educate members about the value of choosing a PCP that provides a clinical care advantage—that is, a PCP that is in a PCMH practice.

Highlights of Results *continued*

Primary Care Provider Relationship *continued*

- 60% of Actives/Non-Medicare Retiree respondents said they see their PCP for a regular check-up or see their PCP more than once each year to help manage a health condition.
  - This may indicate an opportunity to encourage the other 40% who may not see their PCP for a regular check-up to do so—and to provide education about the importance and value of receiving preventive care.

Actives/Non-Medicare Retirees

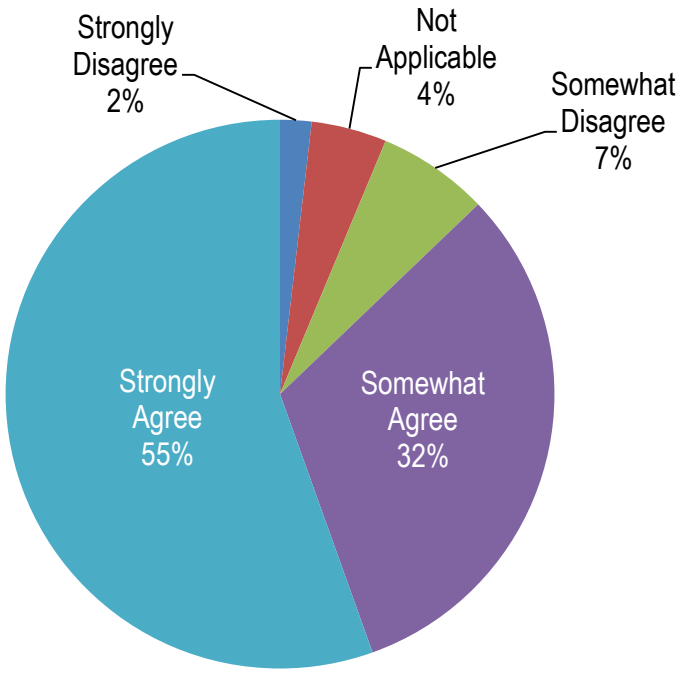


Highlights of Results *continued*

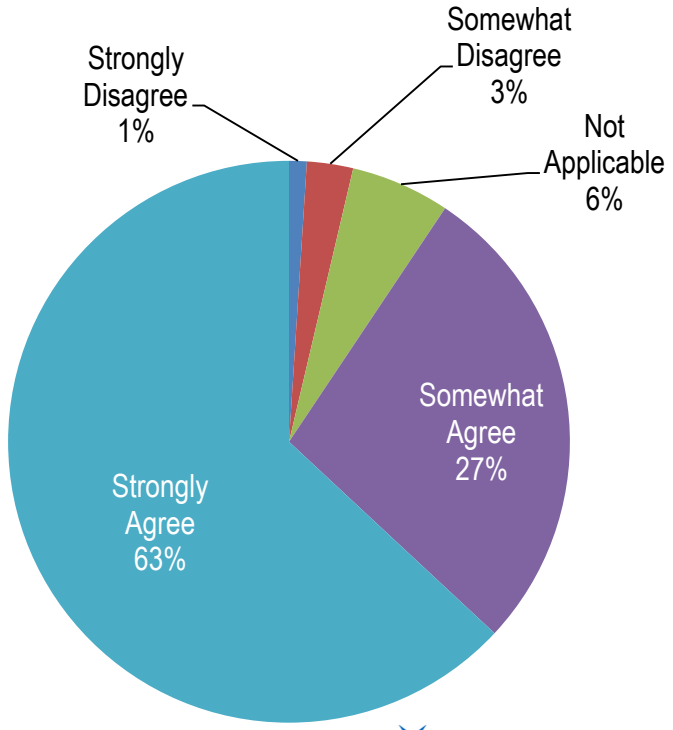
Primary Care Provider Relationship *continued*

- The large majority (87%) of Actives/Non-Medicare Retirees and Medicare Retirees (90%) respondents strongly agree or somewhat agree that it's easy for them to get a PCP appointment as soon as they need one.
  - This indicates that PCP access is not an issue for most respondents in receiving the primary medical care they need.

Actives/Non-Medicare Retirees



Medicare Retirees

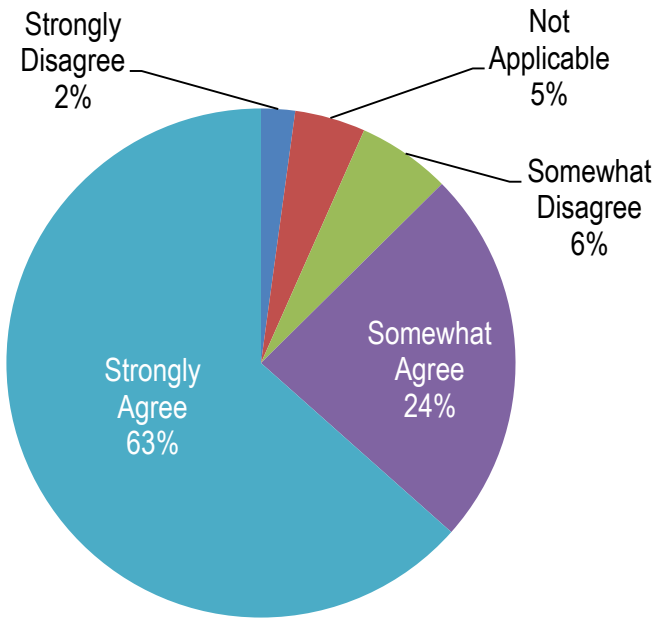


Highlights of Results *continued*

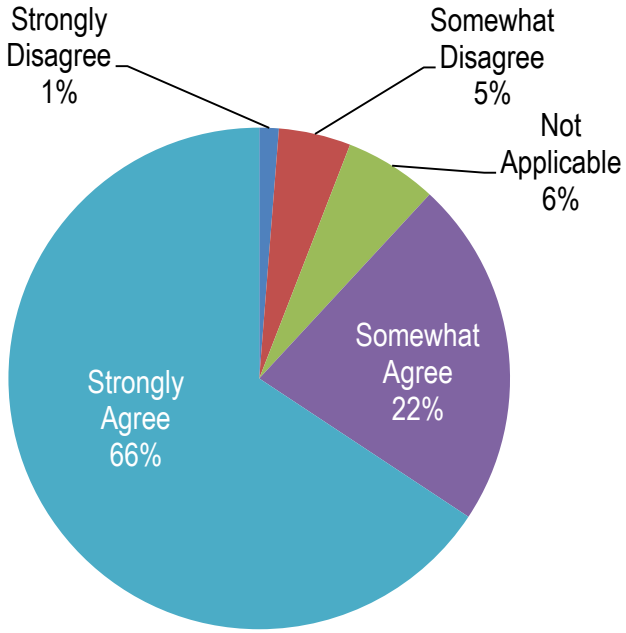
Primary Care Provider Relationship *continued*

- 63% of Actives/Non-Medicare Retirees and 66% of Medicare Retiree respondents strongly agree that when they need health care, they visit their primary care provider before seeing a specialist.
  - While many respondents are appropriately visiting PCPs before specialists, these results indicate there may be an opportunity to reinforce the importance of and value in seeing a PCP before seeing a specialist among all members.

Actives/Non-Medicare Retirees



Medicare Retirees

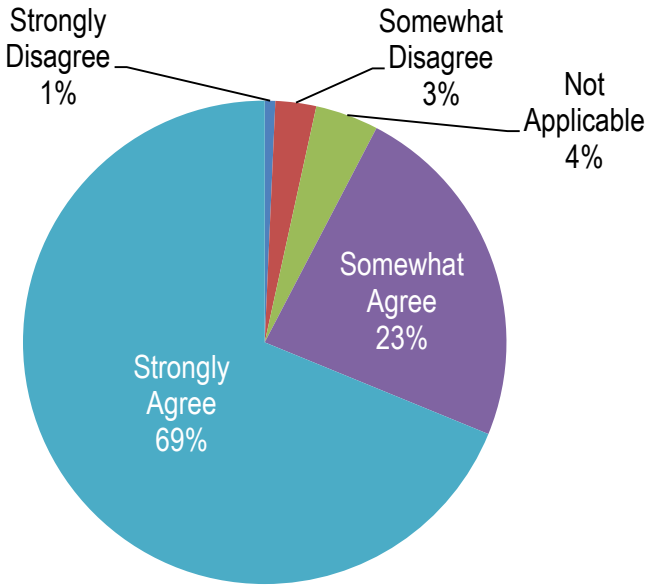


Highlights of Results *continued*

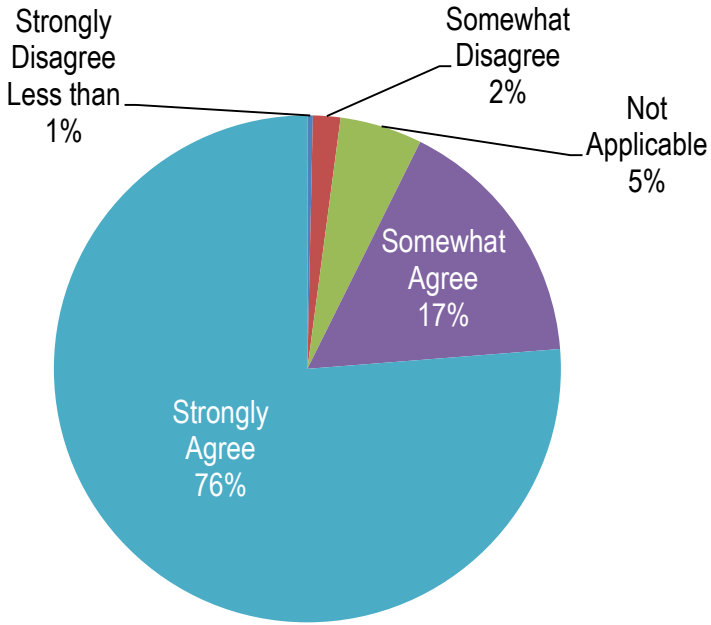
Primary Care Provider Relationship *continued*

- 69% of Actives/Non-Medicare Retirees and 76% of Medicare Retiree respondents strongly agree that they are satisfied with the care they receive from their PCP.
  - This may indicate that while a majority of respondents are satisfied with their care, there may be an opportunity to learn why a substantial portion of members respondents do not strongly agree with this statement.

Actives/Non-Medicare Retirees



Medicare Retirees

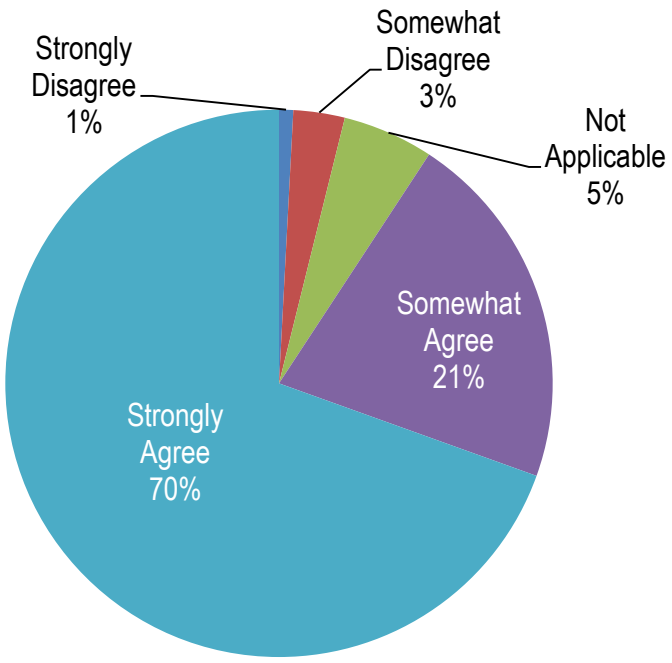


Highlights of Results *continued*

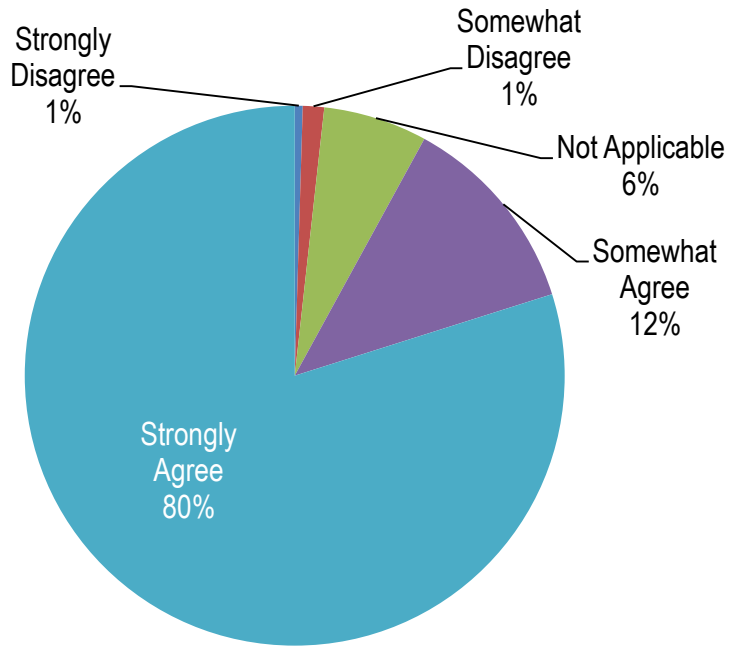
Primary Care Provider Relationship *continued*

- 70% of Actives/Non-Medicare Retirees and 80% of Medicare Retiree respondents strongly agree that their PCP tells them the preventive care screening, tests, and immunizations they need. However, 25% of Actives/Non-Medicare Retiree respondents do not strongly agree that their PCP provides this advice.
  - This indicates that an opportunity remains to educate all members—but especially Actives and Non-Medicare Retirees—about the preventive care screenings, tests, and immunizations they should ask their PCP about.

Actives/Non-Medicare Retirees



Medicare Retirees

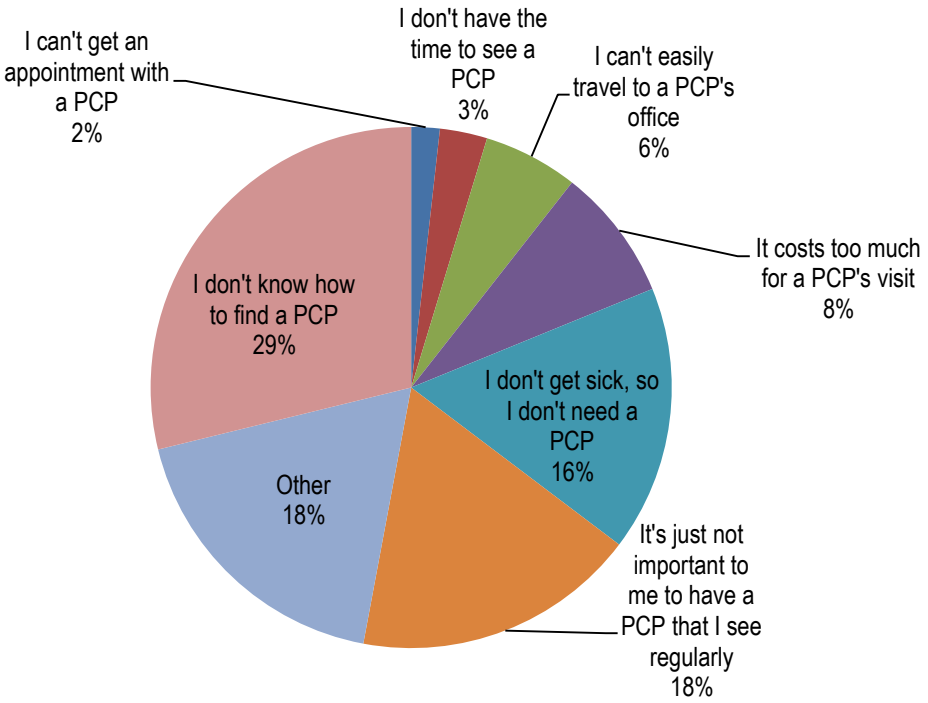


Highlights of Results *continued*

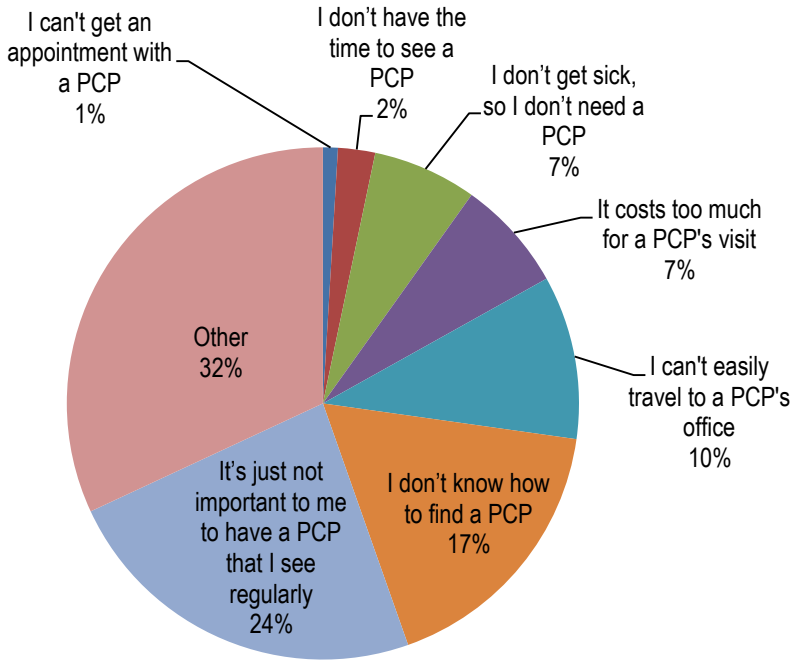
Primary Care Provider Relationship *continued*

- Only 6% of Actives/Non-Medicare Retirees and 4% of Medicare Retirees indicate they don't have a PCP. Actives/Non-Medicare Retirees cite “not knowing how to find a PCP” as the main reason. Retirees cite “other” or “it’s just not important”.
- The relatively small number of respondents who said they don't have a PCP indicates that this may not be a core medical care access issue or cost driver.

Actives/Non-Medicare Retirees



Medicare Retirees

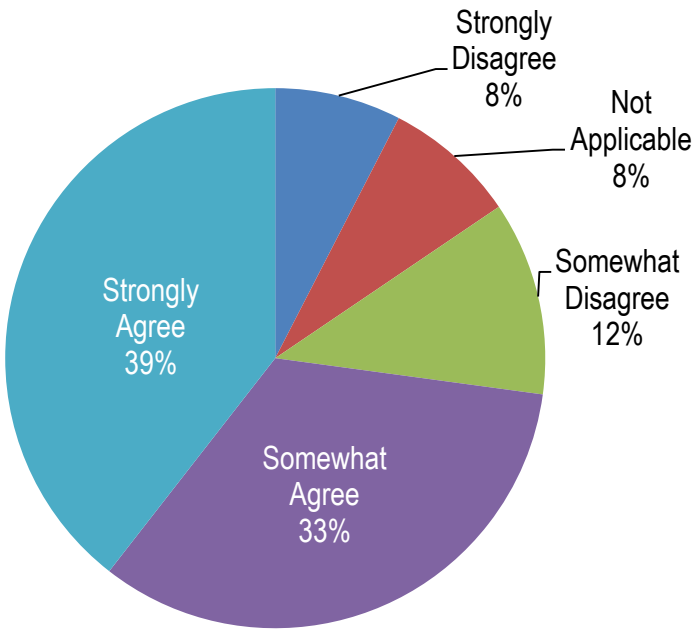


Highlights of Results *continued*

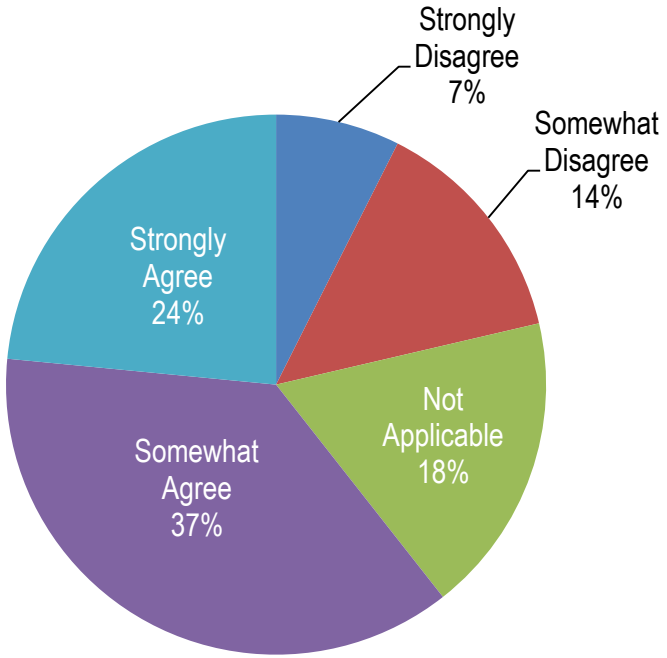
State Health Plan Resources

- 72% of Actives/Non-Medicare Retirees and just under 61% of Medicare Retiree respondents agree that they would use State Health Plan resources to lower the amount they pay for their health plan.
  - This indicates an opportunity to promote the availability of telephonic health coaching and case management for a health condition to all members, through the SHP's new Health Engagement Program.

Actives/Non-Medicare Retirees



Medicare Retirees

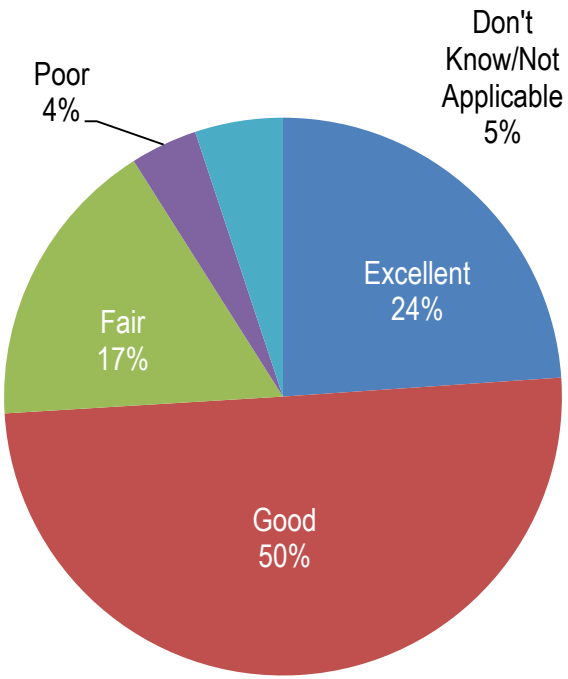


Highlights of Results *continued*

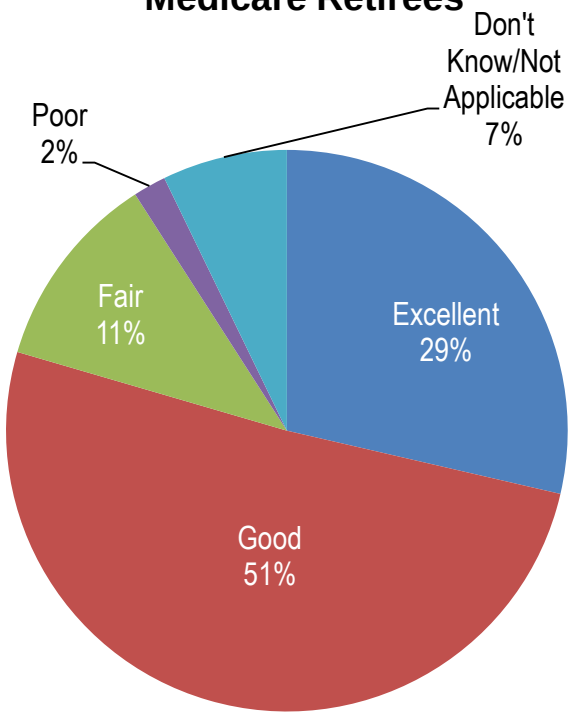
State Health Plan Resources *continued*

- 74%) of Actives/Non-Medicare Retirees and 80% of Medicare Retiree respondents rate the overall effectiveness of mailings they receive from the State Health Plan as excellent or good.

Actives/Non-Medicare Retirees



Medicare Retirees



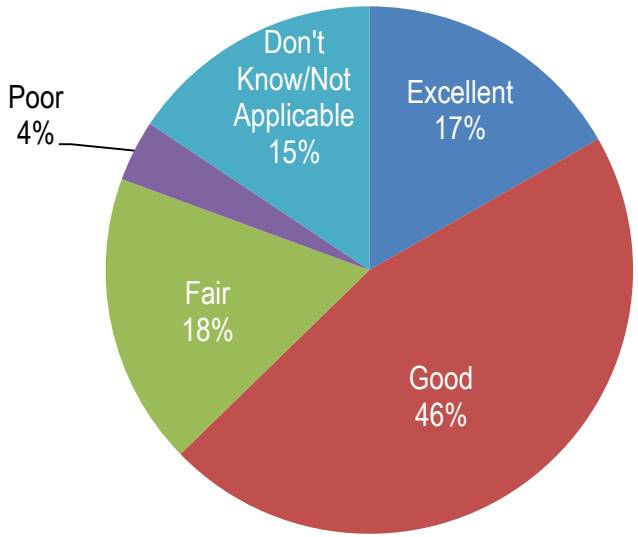
- Actives/Non-Medicare Retiree respondents would like to get information about their health plan benefits through home mailings, by email, and on the State Health Plan's website, while Medicare Retirees primarily prefer home mailings.

Highlights of Results *continued*

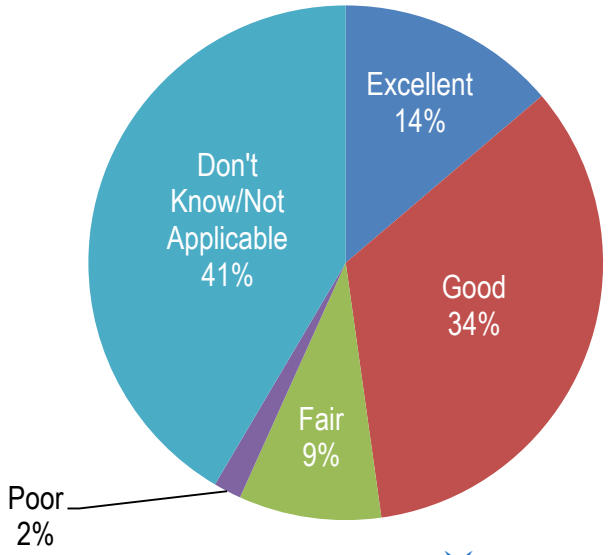
State Health Plan Resources *continued*

- 63%) of Actives/Non-Medicare respondents and almost half (48%) of Medicare Retiree respondents rate the effectiveness of the State Health Plan website as excellent or good. However, 41% of Medicare Retiree respondents say they don't know about the effectiveness of the website or that the question doesn't apply to them.
  - Note: Since the survey was distributed, a new website has been launched. However, an opportunity exists.

Actives/Non-Medicare Retirees



Medicare Retirees

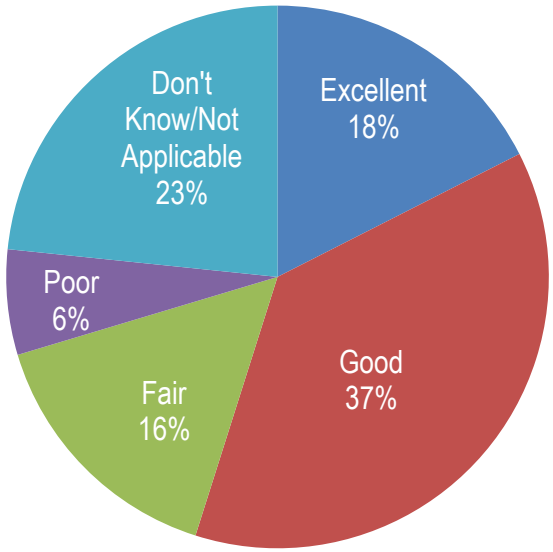


Highlights of Results *continued*

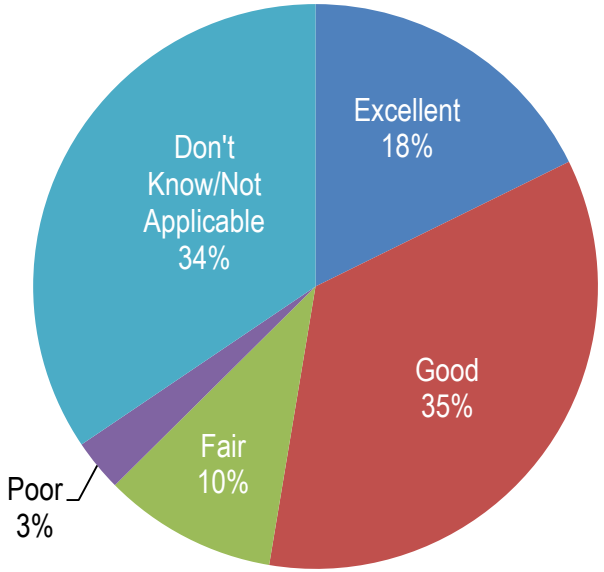
State Health Plan Resources *continued*

- Just over half (55%) of Actives/Medicare Retirees and just over half (53%) of Medicare Retiree respondents rate the overall effectiveness of their Benefits/Human Resources representative/the State's Retirement Systems as excellent or good.
  - This indicates an opportunity to share these findings with HBRs to encourage continued engagement with members and to continue to provide benefits training for HBRs so they can provide the highest level of support possible to members.

Actives/Non-Medicare Retirees



Medicare Retirees

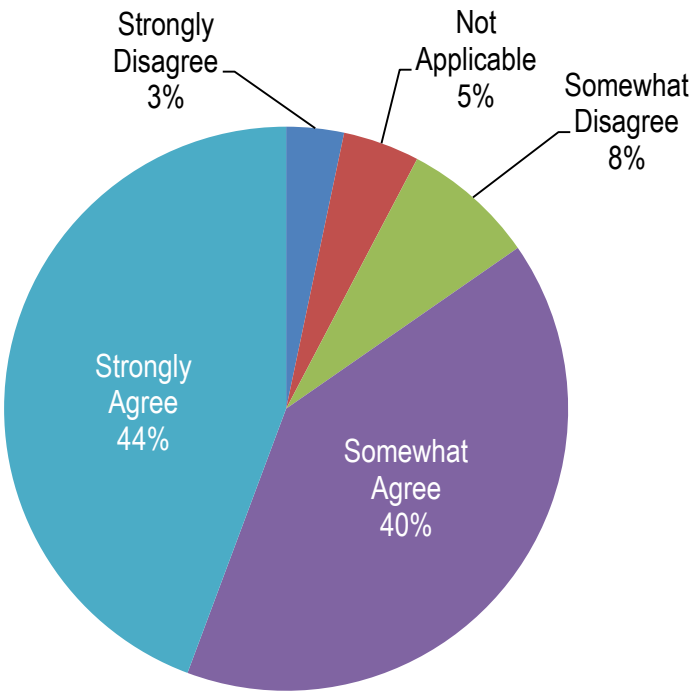


Highlights of Results *continued*

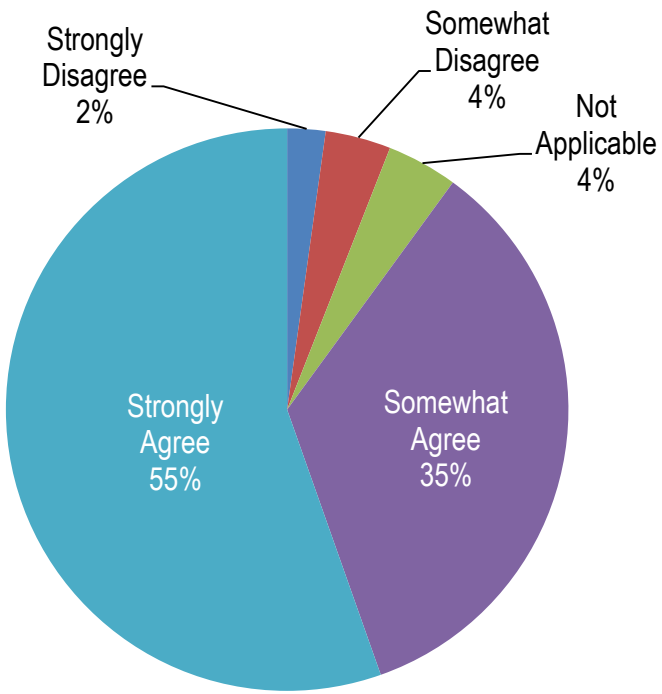
Claims Services

- A large majority (84%) of Actives/Non-Medicare Retirees and an even larger majority (90%) of Medicare Retiree respondents strongly agree or somewhat agree that they are satisfied with the claims services their health plan provides.

Actives/Non-Medicare Retirees



Medicare Retirees

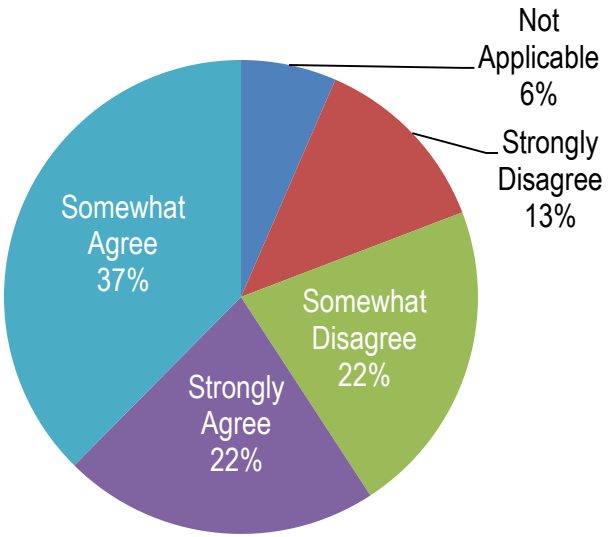


Highlights of Results *continued*

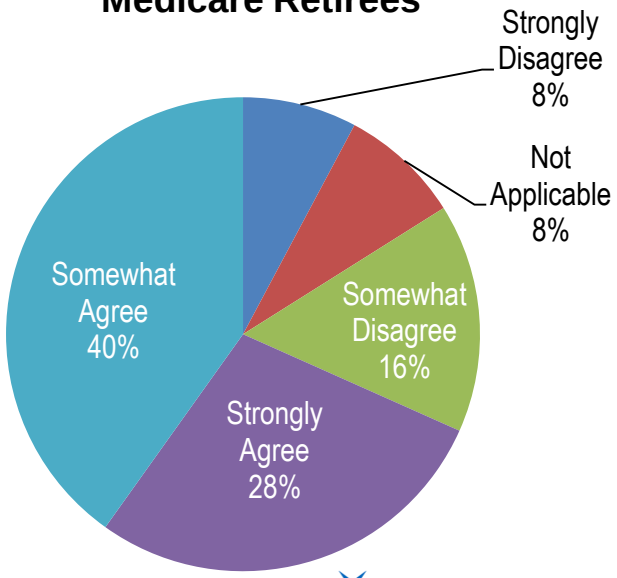
Opportunities to Learn More

- Actives/Non-Medicare Retirees and Medicare Retiree respondents both selected "deductibles, copays, coinsurance, and out-of-pocket maximums" as the subjects they would most like to learn more about.
- Only 22%) of Actives/Non-Medicare Retirees and 28% of Medicare Retiree respondents indicate that they know how to find the cost of a medical service or supply they need.
  - This indicates an opportunity to provide members with an objective source of health care cost and quality information and to educate members on how to use that information to make well-informed health care purchasing decisions.

Actives/Non-Medicare Retirees



Medicare Retirees



About Demographic Differences

Survey results were also analyzed by respondent group: Actives/Non-Medicare Retirees, Medicare Retirees gender, and the plan selection.

The following pages list responses that differed among Plan groups. There was only one question that showed a significant difference in response based on gender.

- Responses where the spread was 10 percentage points or more higher are noted in green text
- Responses where the spread was 10 percentage points or more lower are noted in red text

  - In many cases, for Actives/Non-Medicare Retirees, the least positive response sentiments were from CDHP members. This may indicate a lack of understanding about how the CDHP works or a lack of satisfaction with plan coverage.

  - In most cases, for Medicare Retirees the most positive response sentiment is from members covered under the Humana Medicare Advantage Enhanced Plan. This may indicate a high degree of satisfaction with and understanding of this plan compared to the other available health plan options.

Demographic Differences: Actives/Non-Medicare Retirees

Q10—I do/do not have a Primary Care Provider (PCP)—I do:

- 96% Enhanced 80/20 Plan
- 96% Consumer-Directed Health Plan
- 86% Traditional 70/30 Plan

Q15—When I need health care, I visit my Primary Care Provider before seeing a specialist. [Strongly Agree]

- 65% Enhanced 80/20 Plan
- 60% Traditional 70/30 Plan
- 53% Consumer-Directed Health Plan

Q16—I am confident that my Primary Care Provider is providing/can provide the care I need. [Strongly Agree]

- 71% Enhanced 80/20 Plan
- 60% Traditional 70/30 Plan
- 57% Consumer-Directed Health Plan

Demographic Differences: Actives/Non-Medicare Retirees *continued*

Q17—I am satisfied with the care I receive from my Primary Care Provider. [Strongly Agree]

- 73% Enhanced 80/20 Plan
- 60% Consumer-Directed Health Plan
- 59% Traditional 70/30 Plan

Q18—My Primary Care Provider tells me the preventive care screenings, tests, and immunizations I need. [Strongly Agree—*by gender*]

- More females than males strongly agree (+11 points)

Q18—My Primary Care Provider tells me the preventive care screenings, tests, and immunizations I need. [Strongly *Agree—by plan*]

- 74% Enhanced 80/20 Plan
- 59% Traditional 70/30 Plan
- 57% Consumer-Directed Health Plan

Demographic Differences: Actives/Non-Medicare Retirees *continued*

Q19—My Primary Care Provider explains the results of my blood tests, X-rays, and other tests in plain language that I can understand. [Strongly Agree]

- 75% Enhanced 80/20 Plan
- 63% Traditional 70/30 Plan
- 60% Consumer-Directed Health Plan

Q20—My Primary Care Provider explains the medication he/she prescribes, in plain language that I can understand. [Strongly Agree]

- 76% Enhanced 80/20 Plan
- 64% Traditional 70/30 Plan
- 61% Consumer-Directed Health Plan

Demographic Differences: Actives/Non-Medicare Retirees *continued*

Q21—My Primary Care Provider helps me understand and manage my health conditions. [Strongly Agree]

- 68% Enhanced 80/20 Plan
- 58% Traditional 70/30 Plan
- 46% Consumer-Directed Health Plan

Q22—I am confident that my Primary Care Provider and/or their office can help me coordinate the care/testing I may need. [Strongly Agree]

- 71% Enhanced 80/20 Plan
- 62% Traditional 70/30 Plan
- 60% Consumer-Directed Health Plan

Demographic Differences: Actives/Non-Medicare Retirees *continued*

Q29—How would you rate the overall effectiveness of mailings you receive from the State Health Plan? [Excellent or Good]

- 77% Enhanced 80/20 Plan
- 76% Traditional 70/30 Plan
- 65% Consumer-Directed Health Plan

Q30—How would you rate the overall effectiveness of your Benefits/Human Resources representative/the State's Retirement Systems? [Excellent or Good]

- 58% Enhanced 80/20 Plan
- 57% Traditional 70/30 Plan
- 47% Consumer-Directed Health Plan

Demographic Differences: Actives/Non-Medicare Retirees *continued*

Q31—My main source of information about the State Health Plan is: [The State Health Plan website]

- 43% Consumer-Directed Health Plan
- 39% Enhanced 80/20 Plan
- 29% Traditional 70/30 Plan

Demographic Differences: Medicare Retirees

Q10—I do/do not have a Primary Care Provider (PCP)—I do:

- 96% Humana Medicare Advantage Enhanced Plan
- 93% UnitedHealthcare Medicare Advantage Base Plan
- 89% UnitedHealthcare Medicare Advantage Enhanced Plan
- 88% Humana Medicare Advantage Base Plan
- 85% Traditional 70/30 Plan

Q14: It's easy for me to get a Primary Care Provider's (PCP's) appointment as soon as I need one [Strongly Agree]

- 71% Humana Medicare Advantage Enhanced Plan
- 63% UnitedHealthcare Medicare Advantage Enhanced Plan
- 62% Traditional 70/30 Plan
- 61% UnitedHealthcare Medicare Advantage Base Plan
- 54%Humana Medicare Advantage Base Plan

Demographic Differences: Medicare Retirees *continued*

Q15—When I need health care, I visit my Primary Care Provider before seeing a specialist. [Strongly Agree]

- 71% Humana Medicare Advantage Enhanced Plan
- 71% UnitedHealthcare Medicare Advantage Base Plan
- 64% Humana Medicare Advantage Base Plan
- 59% Traditional 70/30 Plan
- 58% UnitedHealthcare Medicare Advantage Enhanced Plan

Q18—My Primary Care Provider tells me the preventive care screenings, tests, and immunizations I need. [Strongly Agree]

- 84% UnitedHealthcare Medicare Advantage Enhanced Plan
- 79% Humana Medicare Advantage Enhanced Plan
- 73% UnitedHealthcare Medicare Advantage Base Plan
- 70% Humana Medicare Advantage Base Plan
- 68% Traditional 70/30 Plan

Demographic Differences: Medicare Retirees *continued*

Q19—My Primary Care Provider explains the results of my blood tests, X-rays, and other tests in plain language that I can understand. [Strongly Agree]

- 88% Humana Medicare Advantage Enhanced Plan
- 78% Humana Medicare Advantage Base Plan
- 76% UnitedHealthcare Medicare Advantage Enhanced Plan
- 75% UnitedHealthcare Medicare Advantage Base Plan
- 73% Traditional 70/30 Plan

Q21—My Primary Care Provider helps me understand and manage my health conditions (e.g., overweight, diabetes, high blood pressure). [Strongly Agree]

- 83% Humana Medicare Advantage Enhanced Plan
- 75% UnitedHealthcare Medicare Advantage Enhanced Plan
- 71% Traditional 70/30 Plan
- 68% Humana Medicare Advantage Base Plan
- 64% UnitedHealthcare Medicare Advantage Base Plan

Demographic Differences: Medicare Retirees *continued*

Q22—I am confident that my Primary Care Provider and/or their office can help me coordinate the care/testing I may need. [Strongly Agree]

- 88% Humana Medicare Advantage Enhanced Plan
- 76% UnitedHealthcare Medicare Advantage Base Plan
- 75% UnitedHealthcare Medicare Advantage Enhanced Plan
- 74% Humana Medicare Advantage Base Plan
- 72% Traditional 70/30 Plan

Q23—I would use State Health Plan resources to lower the amount I pay for my health plan.

- 42% UnitedHealthcare Medicare Advantage Base Plan
- 41% Humana Medicare Advantage Enhanced Plan
- 30% UnitedHealthcare Medicare Advantage Enhanced Plan
- 28% Traditional 70/30 Plan
- 26% Humana Medicare Advantage Base Plan

Demographic Differences: Medicare Retirees *continued*

Q25—I am satisfied with the claims services my health plan provides. [Strongly Agree]

- 54% Humana Medicare Advantage Enhanced Plan
- 54% Humana Medicare Advantage Base Plan
- 53% UnitedHealthcare Medicare Advantage Enhanced Plan
- 47% UnitedHealthcare Medicare Advantage Base Plan
- 40% Traditional 70/30 Plan

Q27—How would you rate the overall effectiveness of the State Health Plan website (shpnc.org)? [Excellent or Good]

- 67% Humana Medicare Advantage Enhanced Plan
- 51% UnitedHealthcare Medicare Advantage Base Plan
- 51% Traditional 70/30 Plan
- 44% UnitedHealthcare Medicare Advantage Enhanced Plan
- 44% Humana Medicare Advantage Base Plan

Demographic Differences: Medicare Retirees *continued*

Q29—How would you rate the overall effectiveness of mailings you receive from the State Health Plan. [Excellent or Good]

- 96% Humana Medicare Advantage Enhanced Plan
- 90% Humana Medicare Advantage Base Plan
- 79% Traditional 70/30 Plan
- 78% UnitedHealthcare Medicare Advantage Base Plan
- 77% UnitedHealthcare Medicare Advantage Enhanced Plan

Q30—How would you rate the overall effectiveness of your Benefits/ Human Resources representative/the State's Retirement Systems?

- 79% Humana Medicare Advantage Enhanced Plan
- 72% Humana Medicare Advantage Base Plan
- 61% UnitedHealthcare Medicare Advantage Base Plan
- 55% UnitedHealthcare Medicare Advantage Enhanced Plan
- 55% Traditional 70/30 Plan

Conclusions

- Despite providing an incentive, the overall response rate among Actives/Non-Medicare Retirees was low: 6% and among them, less than half were Actives
- A majority of respondents have a Primary Care Provider, visit them regularly, have sufficient access to care, and are satisfied with the care received
- While 60% of Actives/Non-Medicare Retiree respondents visit their PCP regularly, nearly 40 % do not – potentially missing valuable preventive care
- Most respondents select their plan based on the cost to have coverage (the monthly premium)
- Two-thirds of respondent agree that they would use Plan resources to lower the amount they pay for their health plan
- Most respondents are satisfied with the Plan communications they receive but would like more information about deductibles, copays, coinsurance, and out-of-pocket maximums

BlueCross BlueShield of North Carolina

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

Research Report
October 6, 2015

Table of Contents

Research Objectives

The research objectives for 2015 are:

1. Trends. Compare the 2015 results to those in 2014 in order to uncover data trends.
2. Focus. Member communication, customer service and plan design
3. Purpose. Solicit member feedback to support customer experience improvements, plan design changes and new offerings.

Furthermore, the questionnaire was designed with these objectives in mind:

- To learn the reasons behind members' choice of health plan design
- To identify wellness benefit usage
- To assess satisfaction with key elements of the pharmacy benefits
- To explore access to and usage of care services

Methodology

- FGI research conducted an online survey of SHP subscribers, both active and retired, and covered spouses. It was a census survey, meaning everyone in this population had a chance to take the survey.
- A total of approximately 496,000 postcards were mailed inviting subscribers and covered spouses to participate in the survey that was posted on the main page of the SHP website.
- A total of 5,456 responses were collected from July 27 through September 1, 2015, resulting in a response rate of 1%. The survey length averaged 11 minutes.
- This report includes 2014 and 2015 data for both Active Employees/Retirees (AE) and Medicare Primary Retirees (MP). Within each of these subscriber groups, the two years were compared for statistically significant differences at the 95% confidence level, which are notated by a letter. Counts for each group are included below.
- In addition, some questions provide additional breakouts by plan type, coverage, and/or provider. Statistically significant differences at the 95% level between the subgroups are noted with a red letter. Sample sizes for subgroups are provided on individual slides.

Active Employees/Retirees		Medicare Primary Retirees	
2014	2015	2014	2015
n=5171	n=4859	n=2554	n=597

Executive Summary

1. The cost of monthly premiums remains as the top reason behind SHP members' choice of health plans in 2015. However, the proportion of Medicare Primary Retirees who rate this as the number one reason increased significantly from 2014 to 2015. Other notable changes that occurred among Medicare Primary Retirees in 2015 include a decrease in the importance of maximums, copays and 100% coverage of preventive services, medications and/or prescriptions.
2. There are some noteworthy differences by plan type and coverage for Active Employees/Retirees:
   - Unlike those on the Traditional or CDHP plans, those on the Enhanced plan rank, on average, copays as more important than monthly premiums.
   - To those with employee only coverage, monthly premiums, 100% coverage of preventive services, medications and/or prescriptions, the presence or lack of wellness activities and the existence of other insurance are more important than they are to those who cover additional members of their family (spouse and/or children).
3. In 2015, the cost of services had slightly less of an impact on Active Employees/Retirees' decision to seek health care. 36% of these members in 2014 delayed or did not receive health care services during that year due to concerns about the cost, but this proportion decreased to 32% in 2015. In addition, being unable to afford the copay was a bigger reason for not visiting a Primary Care Provider in 2014 than in 2015.
4. On the other hand, cost played a more important role this year in Medicare Primary Retirees' decision to seek care, despite no change in cost for 2015. Last year just 15% of these members delayed or did not receive health care services. This year it increased to 23%. More specifically, Medicare Primary Retirees more frequently delayed or didn't refill prescriptions and/or receive preventive care screenings. Not surprisingly then, more of these members in 2015 than in 2014 did not take their prescribed medications regularly because they couldn't afford the copay.
5. Improvement occurred in 2015 with Active Employees/Retirees' level of satisfaction with the care and service they have received since January 1st.
   - In 2014, 59% gave the highest ratings (top 3 box) for the customer service they received when they called for assistance, whereas in 2015, 61% gave the same type of ratings.
   - 57% in 2014 gave the highest ratings for the prescription benefits offered through the State Health Plan, which increased to 61% in 2015.
   - 52% rated the information communicated about prescription benefits highly in 2014. This proportion increased to 55% in 2015.

Executive Summary

6. While satisfaction improved for Active Employees/Retirees, it declined in some areas for Medicare Primary Retirees.
   - In 2014, Medicare Primary Retirees rated their level of satisfaction with the prescription benefits offered through the State Health Plan as an 8 out of 10, on average. In 2015, the average decreased to 7.8.
   - Medicare Primary Retirees rated their level of satisfaction with the information communicated about prescription benefits as a 7.8 out of 10 in 2014, on average, but in 2015, this value dropped to 7.2.
7. Improvement also occurred in members' overall satisfaction with the current health plan coverage offered by the State Health Plan. 54% are highly satisfied (top 3 box) with the plan in 2015, while just 45% were in 2012.
8. The vast majority of Active Employees/Retirees had a primary care visit with the provider listed on their health benefits card in both 2014 and 2015. Significantly more of these members in 2015 than in the previous year also received/used preventive services, screenings and medications covered at 100%.
9. No change occurred in the proportion of those who have taken advantage of NC Health*Smart* – about one quarter did so in either year.
10. Similar to 2014, almost two thirds of Medicare Primary Retirees have used preventive services and screenings in 2015, only about one third have taken advantage of the Silver Sneakers fitness program, and just 1% have used QuitlineNC's free tobacco cessation services hotline.
11. In the last 12 months, more than one third of SHP members were unable to find out in advance how much health care services or equipment would cost. A similar proportion said the same in 2014.
12. In 2015, the most preferred method of receiving information from the State Health Plan is by mailed printed materials. Preference for this type of communication method increased significantly from the previous year. Preference *decreased* this year among Active Employees/Retirees for receiving information from the State Health Plan website and the Member Focus newsletter.

Recommendations

1. Although satisfaction increased among Active Employees/Retirees, there's still room for improvement. There is a sizable number in this group who have neutral feelings about the service areas that were surveyed and are vulnerable to becoming more negative.

2. For Medicare Primary Retirees, satisfaction dipped in 2015. Therefore, SHP should explore this more deeply among these members and work to resolve any issues they are facing.

3. Overall satisfaction with the current health plan coverage offered by SHP isn't extremely strong – almost half have neutral or negative feelings about it. Thus, SHP should examine what these members' expectations are and how to meet them.

4. Participation in the Health*Smart* and SilverSneakers programs remains low. SHP should work to increase awareness of these programs or uncover how to make them appealing enough to boost participation among members who are not on a traditional plan.

5. Continue communicating with SHP members via printed material mailed to their home and/or email.

Drivers of Plan Choice

Drivers of Choice — AE in Total

The cost of monthly premiums remained the top reason for choosing one design over another in 2015. As in 2014, copays are the second reason. Slightly more Active Employees/Retirees rank 100% coverage of preventive services, medication and/or prescriptions as third than in 2014.

The lower the ranking, the more important the reason.

#1

Reasons Ranked 1-8 *Base: AE 2014 Total (n=5171); AE 2015 Total (n=4859)*	Ranked #1		Ranked Top 2		Ranked Top 3		Average Ranking	
	2014 (A)	2015 (B)	2014 (C)	2015 (D)	2014 (E)	2015 (F)	2014 (G)	2015 (H)
Cost of monthly premiums	43%	43%	59%	59%	72%	73%	2.53	2.49
Copay or cost associated with each doctor visit or prescription	19%	19%	47%	46%	74%	75%	2.79	2.77
Having preventive services, medications, and/or prescriptions covered at 100%	13%	14%A	28%	29%	46%	46%	3.52	3.48
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	13%	13%	37%	37%	61%	61%	3.20	3.18
Presence or lack of wellness activities to lower monthly premiums	5%	5%	13%	14%	22%	23%E	4.82H	4.75
Cost of dependents	3%	2%	8%	7%	12%F	10%	6.17	6.23
Having a Health Reimbursement Account (HRA) to offset your out-of-pocket expenses	2%	2%	5%	4%	9%	8%	5.85	5.92G
Existence of other insurance such as TRICARE	2%	1%	3%D	2%	4%F	3%	7.12	7.18G

Red letters represent statistically significant differences at the 95% level. Groups compared include AB, CD, EF and GH.

Q4a. What were your top reasons for choosing one design over another for the 2015 benefit year? Please rank the items on the list using numbers 1 through 8, where 1 means your top reason, 2, means your second reason, and so on, with 8 being the least important reason for choosing one plan over another.

Drivers of Choice — AE by Plan Type

AE

The cost of monthly premiums is by far the leading driver of plan choice among those who have the Traditional plan. In fact, all plan types had more customers select monthly premiums than anything else as the #1 most important reason. However, when looking at average rankings, copays ranked slightly more important than monthly premiums for members on the Enhanced plan. Other significant differences between the plan types are notated below.

Reminder, the lower the ranking, the more important the reason.

Reasons Ranked 1-8 *Bases: Traditional 70/30 (n=966)* *Enhanced 80/20 (n=3573)* *CDHP (n=229)*	Ranked #1			Ranked Top 2			Ranked Top 3			Average Ranking		
	Traditional (A)	Enhanced (B)	CDHP (C)	Traditional (D)	Enhanced (E)	CDHP (F)	Traditional (G)	Enhanced (H)	CDHP (I)	Traditional (J)	Enhanced (K)	CDHP (L)
Cost of monthly premiums	77%BC	34%	48%B	89%EF	50%	68%E	93%HI	67%	82%H	1.52	2.78JL	2.18J
Cost of dependents	5%B	2%	5%B	20%E	3%	18%E	25%H	5%	25%H	5.37	6.52JL	5.47
Copay or cost associated with each doctor visit or prescription	5%	24%AC	3%	28%F	53%DF	13%	66%I	80%GI	27%	3.21K	2.54	4.48JK
Existence of other insurance such as TRICARE	4%BC	1%	0%	6%EF	1%	0%	8%HI	2%	1%	6.90	7.23J	7.65JK
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	3%	16%A	12%A	31%	40%DF	26%	60%I	63%I	39%	3.35K	3.07	4.03JK
Having preventive services, medications, and/or prescriptions covered at 100%	3%	18%AC	9%A	15%	34%DF	22%D	28%	52%GI	45%G	4.19KL	3.25	3.87K
Presence or lack of wellness activities to lower monthly premiums	2%	6%A	4%A	7%	15%D	17%D	13%	26%G	25%G	5.45KL	4.54	4.90K
Having a Health Reimbursement Account (HRA) to offset your out-of-pocket expenses	1%	1%	18%AB	3%	3%	37%DE	7%	6%	57%GH	6.01L	6.06L	3.42

Red letters represent statistically significant differences at the 95% level. Groups compared include ABC, DEF, GHI and JKL.

Q4a. What were your top reasons for choosing one design over another for the 2015 benefit year? Please rank the items on the list using numbers 1 through 8, where 1 means your top reason, 2, means your second reason, and so on, with 8 being the least important reason for choosing one plan over another.

Drivers of Choice — AE by Coverage

Based on average scores, the cost of monthly premiums, 100% coverage, wellness activities and the existence of other insurance are more important to Active Employees/Retirees with employee only coverage than to those with other coverage levels. And, it's no surprise that the cost of dependents is much less important for those with employee only coverage. The full list of differences by coverage level can be found in the table below.

Reminder, the lower the ranking, the more important the reason.

Reasons Ranked 1-8 *Bases: Employee Only (n=3746)* *Employee + Children (n=465)* *Employee + Spouse (n=279)* *Family (n=369)*	**Ranked #1**				**Ranked Top 2**				**Ranked Top 3**				**Average Ranking**			
	Employee Only (A)	Employee + Children (B)	Employee + Spouse (C)	Family (D)	Employee Only (E)	Employee + Children (F)	Employee + Spouse (G)	Family (H)	Employee Only (I)	Employee + Children (J)	Employee + Spouse (K)	Family (L)	Employee Only (M)	Employee + Children (N)	Employee + Spouse (O)	Family (P)
Cost of monthly premiums	44% BC	38%	37%	43%	61%FG	54%	52%	56%	75%JKL	69%	64%	64%	2.38	2.70 M	2.95 M	2.95 M
Copay or cost associated with each doctor visit or prescription	19%	21% D	18%	15%	48%FH	41%	43%	37%	77%JKL	63%	71%JL	63%	2.69	3.06 M	2.85	3.13 MO
Having preventive services, medications, and/or prescriptions covered at 100%	15%	14%	14%	14%	30%	29%	29%	28%	47%	45%	48%	42%	3.41	3.67 M	3.64 M	3.80 M
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	13%	11%	15%	13%	39%FH	30%	37%	32%	63%JL	52%	59%J	56%	3.10	3.61 MO	3.18	3.44 MO
Presence or lack of wellness activities to lower monthly premiums	5%D	3%	5%	2%	15%FH	9%	14%F	11%	25%J	17%	21%	21%	4.62	5.35 MO	4.92 M	5.19 M
Cost of dependents	1%	8%A	6%A	8%A	2%	28%EG	16%E	28%EG	3%	39%IK	22%I	39%IK	6.80 NOP	3.98	5.13 NP	4.05
Having a Health Reimbursement Account (HRA) to offset your out-of-pocket expenses	1%	2%A	4%A	2%	4%	7%E	7%E	6%	7%	13%I	11%I	13%I	5.91	6.03	6.01	5.83
Existence of other insurance such as TRICARE	1%	2%	3%A	2%	2%	2%	3%	2%	3%	3%	4%	2%	7.08	7.59 MO	7.32 M	7.62 MO

Red letters represent statistically significant differences at the 95% level. Groups compared include ABCD, EFGH, IJKL and MNOP.

Drivers of Choice — MP Plan

In both years, Medicare Primary Retirees ranked the cost of monthly premiums as the top reason for choosing one design over another, however, more did so in 2015 than in 2014. Other changes that occurred in 2015 include fewer Medicare Primary Retirees placing importance on copays, maximums and 100% coverage. Conversely, slightly more retirees place importance on the existence of other insurance in 2015 than in 2014.

The lower the ranking, the more important the reason.

Reasons Ranked 1-6 *Base: MP 2014 Total (n=2554); MP 2015 Total (n=597)*	Ranked #1		Ranked Top 2		Ranked Top 3		Average Ranking	
	2014 (A)	2015 (B)	2014 (C)	2015 (D)	2014 (E)	2015 (F)	2014 (G)	2015 (H)
#1 → Cost of monthly premiums	41%	53%A	57%	69%C	71%	78%E	2.46H	2.12
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	16%B	12%	48%D	43%	75%	72%	2.68	2.83G
Copay or cost associated with each doctor visit or prescription	18%B	11%	46%D	38%	79%F	75%	2.64	2.81G
Existence of other insurance such as an Individual Medicare Advantage Plan, an Individual Part D Plan or TRICARE	8%	11%A	13%	19%C	17%	23%E	4.68H	4.49
Having preventive services, medications, and/or prescriptions covered at 100%	14%B	10%	29%	26%	49%F	44%	3.24	3.43G
Cost of dependents	3%	3%	6%	5%	9%	8%	5.31	5.32

Red letters represent statistically significant differences at the 95% level. Groups compared include AB, CD, EF and GH.

Q4b. What were your top reasons for choosing one design over another for the 2015 benefit year? Please rank the items on the list using numbers 1 through 6, where 1 means your top reason, 2, means your second reason, and so on, with 6 being the least important reason for choosing one plan over another.

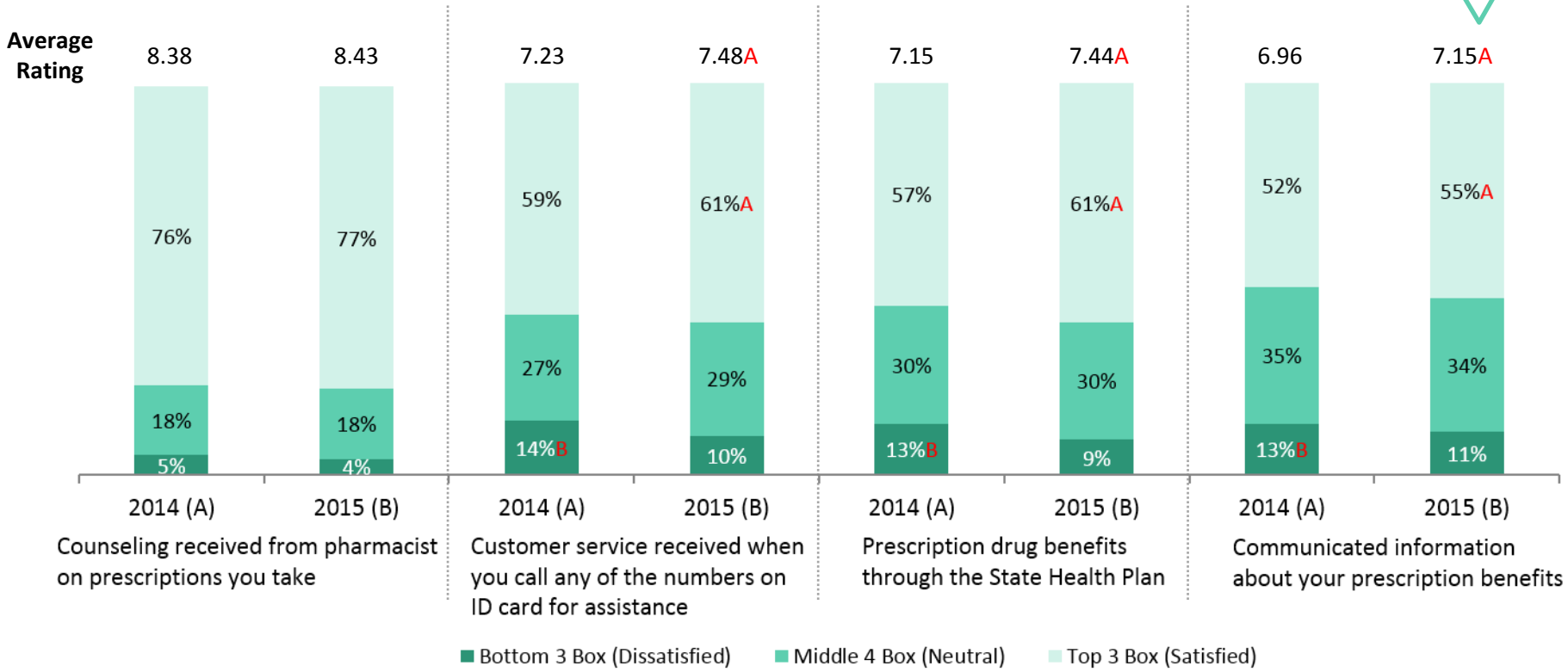
Usage & Satisfaction

Satisfaction – AE

Base: AE Total excluding "n/a" (base varies)

An improvement in satisfaction levels occurred in 2015 among Active Employees/Retirees. More are satisfied with the customer service they received when calling for assistance, the prescription drug benefits offered through the State Health Plan and the communicated information about prescription benefits than in 2014.

READ AS: This satisfaction measure in 2015 is statistically significantly higher than in 2014.



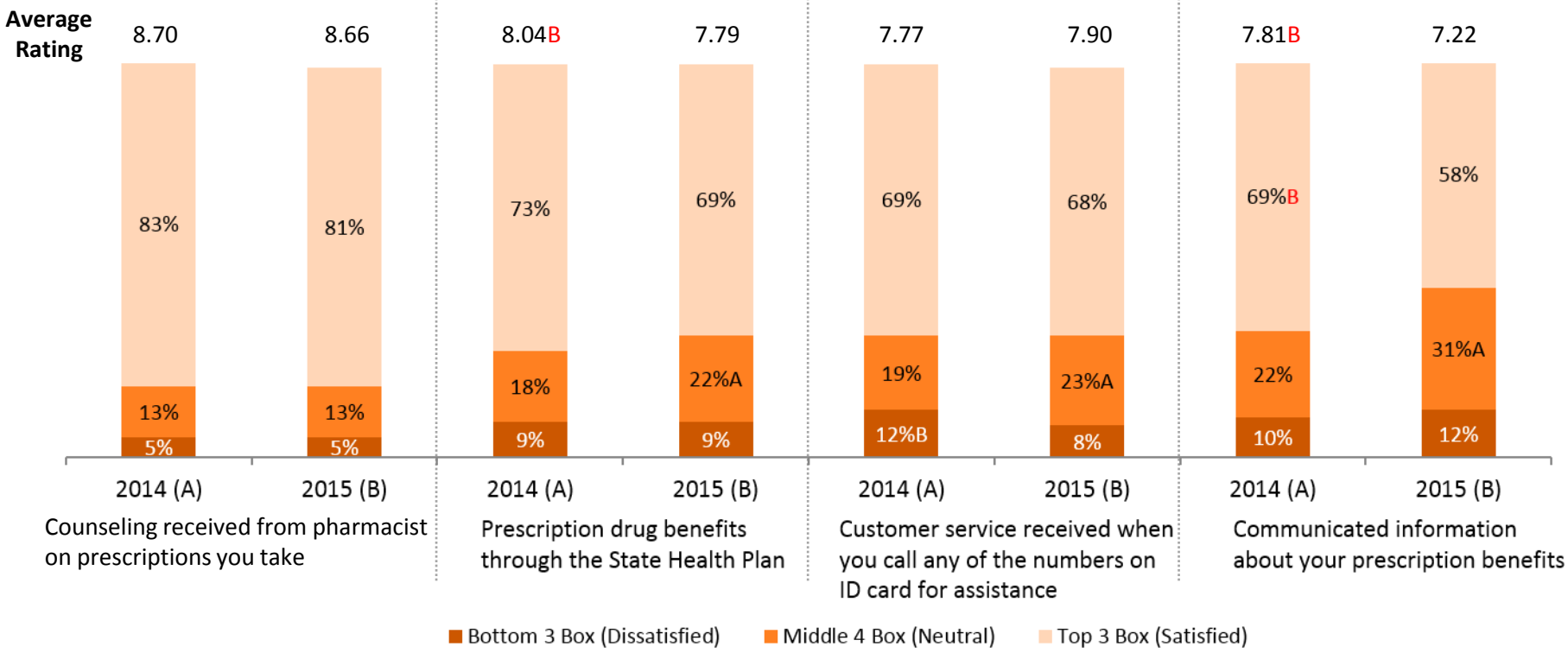
Red letters represent statistically significant differences at the 95% level.

Q7. Using a scale of 1-10, where a "10" means completely satisfied and "1" means completely dissatisfied, how satisfied or dissatisfied are you with the following since January 1, 2015?

Satisfaction – MP

The level of satisfaction with the counseling received from a pharmacist and the customer service received when calling for assistance did not change between the two years among Medicare Primary Retirees. Unfortunately, a drop did occur from 2014 to 2015 in their satisfaction with the prescription drug benefits offered through the State Health plan and the communicated information about prescription benefits.

Base: MP Total excluding "n/a" (base varies)



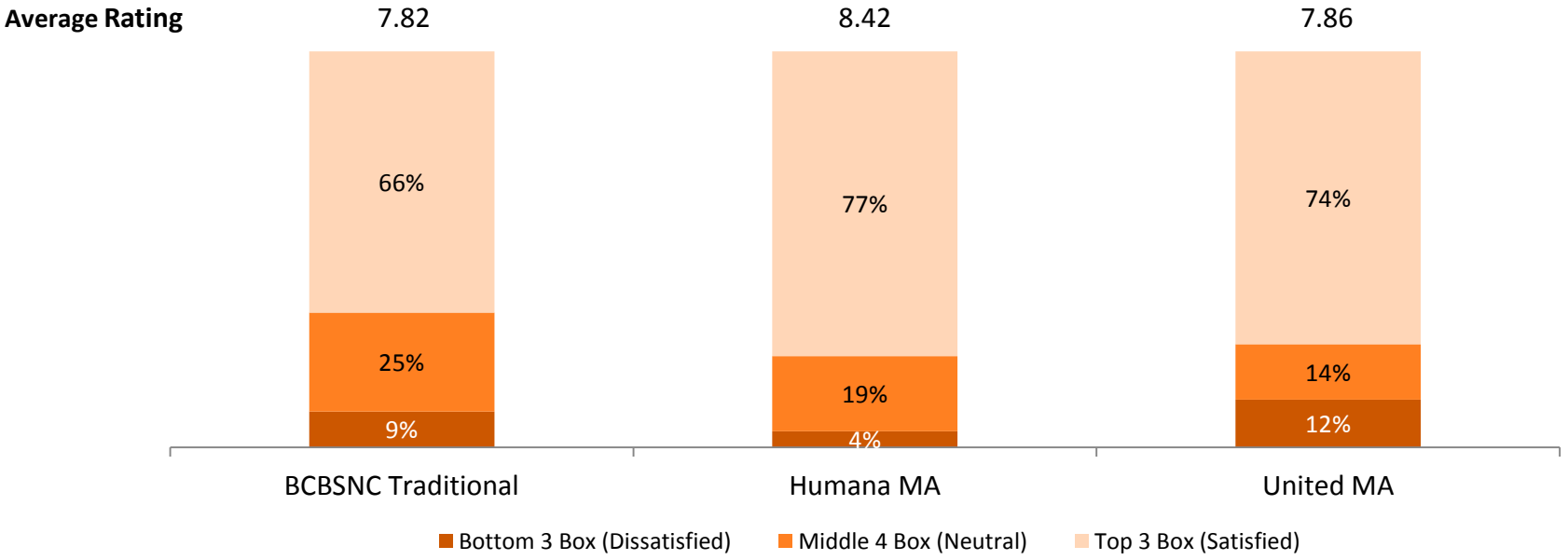
Letters represent statistically significant differences at the 95% level.

Customer Service Satisfaction by MP Carrier

Due to small base sizes, this data should be interpreted with extreme caution. BCBSNC, Humana and UnitedHealthcare are currently satisfying the needs of their customers, when they call in for assistance.

Bases exclude "n/a"
BCBSNC Traditional 70/30 Plan (n=371)
Humana Medicare Advantage (n=26) [Extremely small base size – not eligible for significance testing]
UnitedHealthcare Medicare Advantage (n=57) [Small base size]

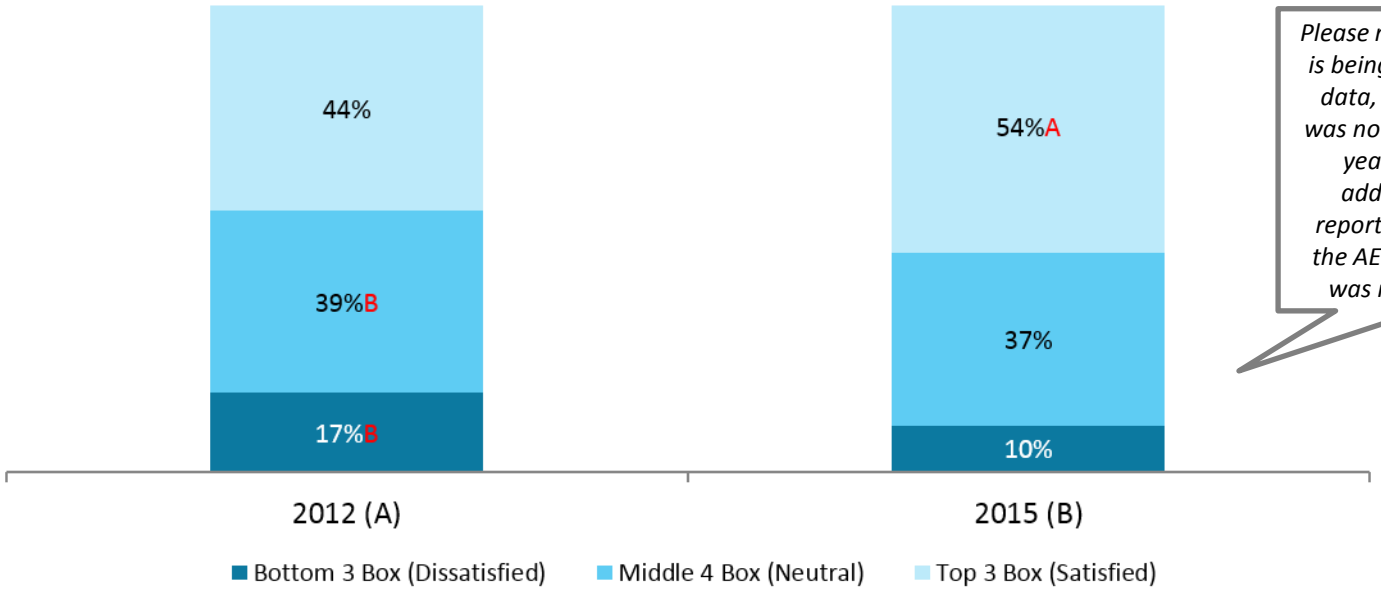
The customer service you receive when you call any of the numbers on your ID card for assistance



Q7. Using a scale of 1-10, where a "10" means completely satisfied and "1" means completely dissatisfied, how satisfied or dissatisfied are you with the following since January 1, 2015?

State Health Plan Coverage Satisfaction

Overall satisfaction with the current health plan coverage offered by the State Health Plan has improved in 2015 as compared to 2012.



Please note – the 2015 data is being compared to 2012 data, since this question was not asked in any of the years in between. In addition, this data is reported in total because the AE and MP distinction was not made in 2012.

Base: 2012 Total excluding "n/a" (n=10453)
2015 Total (n=5456)

Red letters represent statistically significant differences at the 95% level.

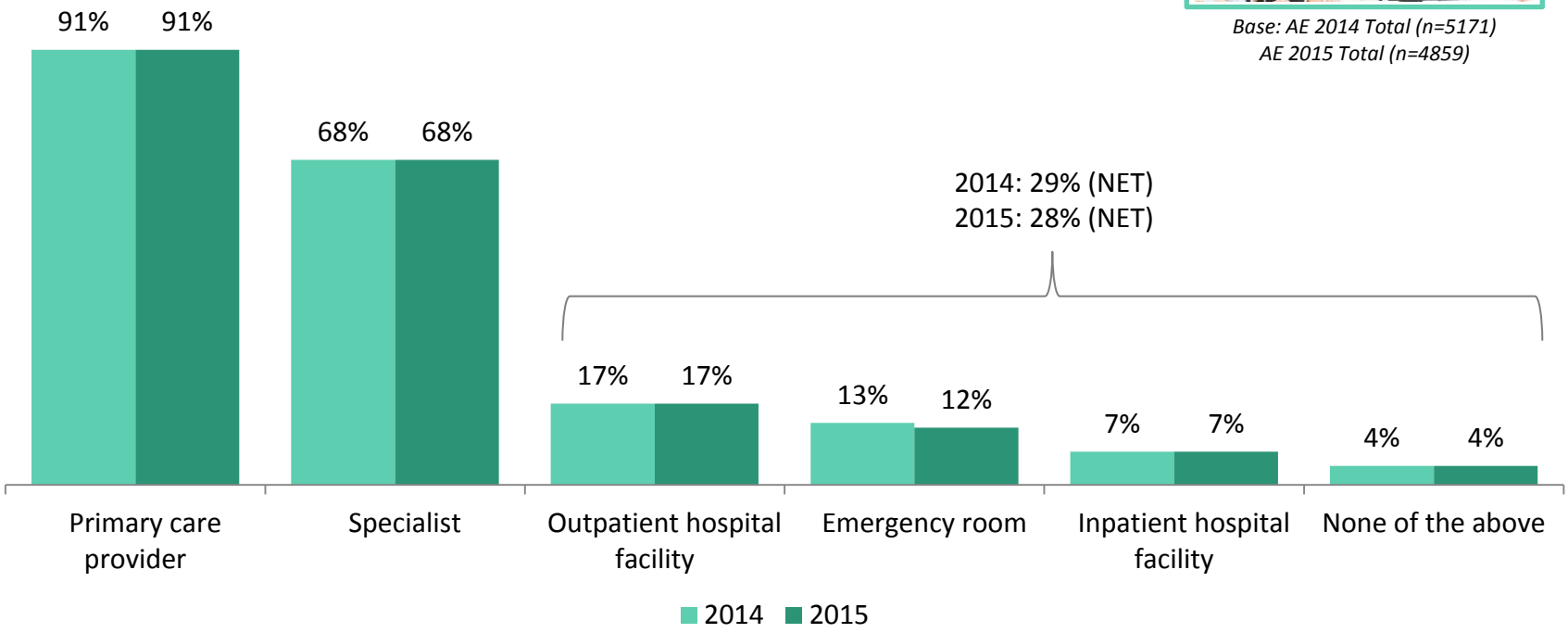
Visits in Past 12 Months – AE

Nearly all Active Employees/Retirees have visited a primary care provider during the past 12 months. No significant changes occurred between 2014 and 2015.

2014: 96% (NET)
2015: 96% (NET)

Similar responses are added together for a total value, which is referred to as NET.

Base: AE 2014 Total (n=5171)
AE 2015 Total (n=4859)



Q11. Which of the following have you visited within the past 12 months? Please check all that apply.

Visits in Past 12 Months – MP

Virtually all Medicare Primary Retirees visited a primary care provider during the past 12 months. These proportions did not change significantly over time.

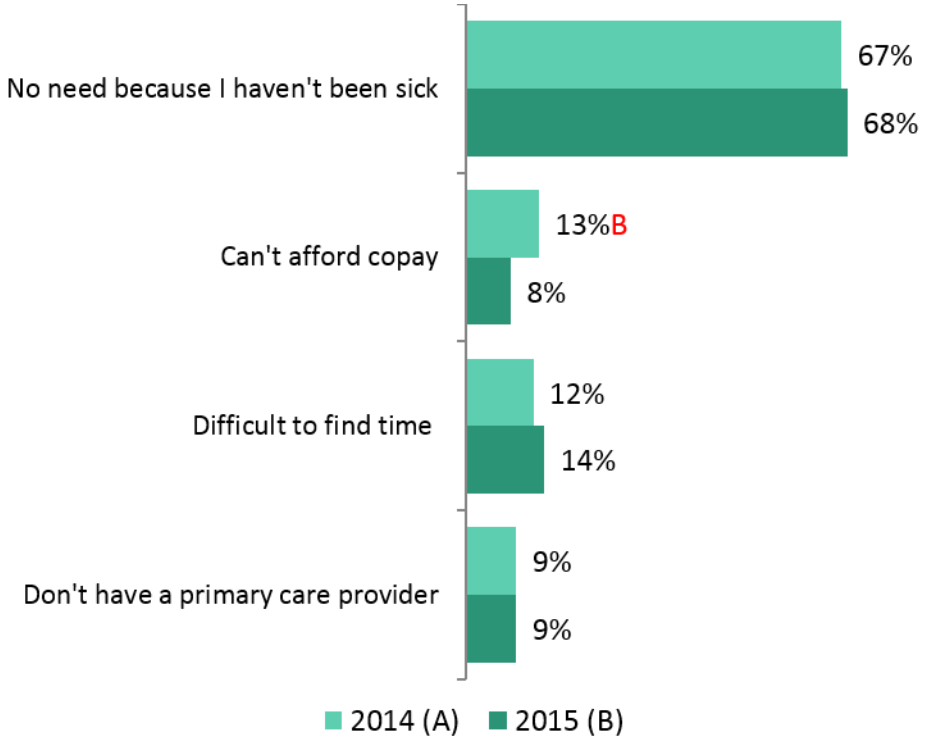
Base: MP 2014 Total (n=2554)
MP 2015 Total (n=597)

Q11. Which of the following have you visited within the past 12 months? Please check all that apply.

Reasons for NOT Visiting PCP – AE

Of the Active Employees/Retirees who haven't visited a Primary Care Provider within the last 12 months, the majority didn't do so because they weren't sick, and therefore, didn't have a need. A similar proportion of these members gave the same response in 2014. In 2015, significantly fewer of these members didn't visit a PCP due to the cost of the copay than in the previous year.

Base: 2014 AE who have not visited PCP past 12 months (n=464)
2015 AE who have not visited PCP past 12 months (n=444)

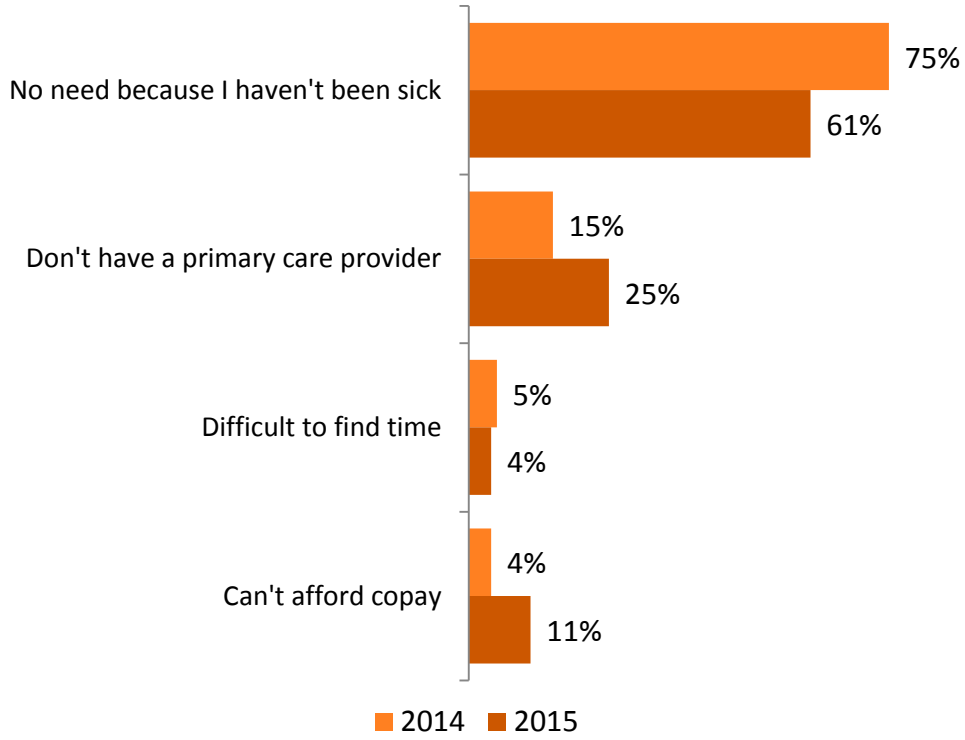


Red letters represent statistically significant differences at the 95% level.

Q14. What reason most closely matches why you have not visited a Primary Care Provider within the last 12 months?

Reasons for NOT Visiting PCP – MP

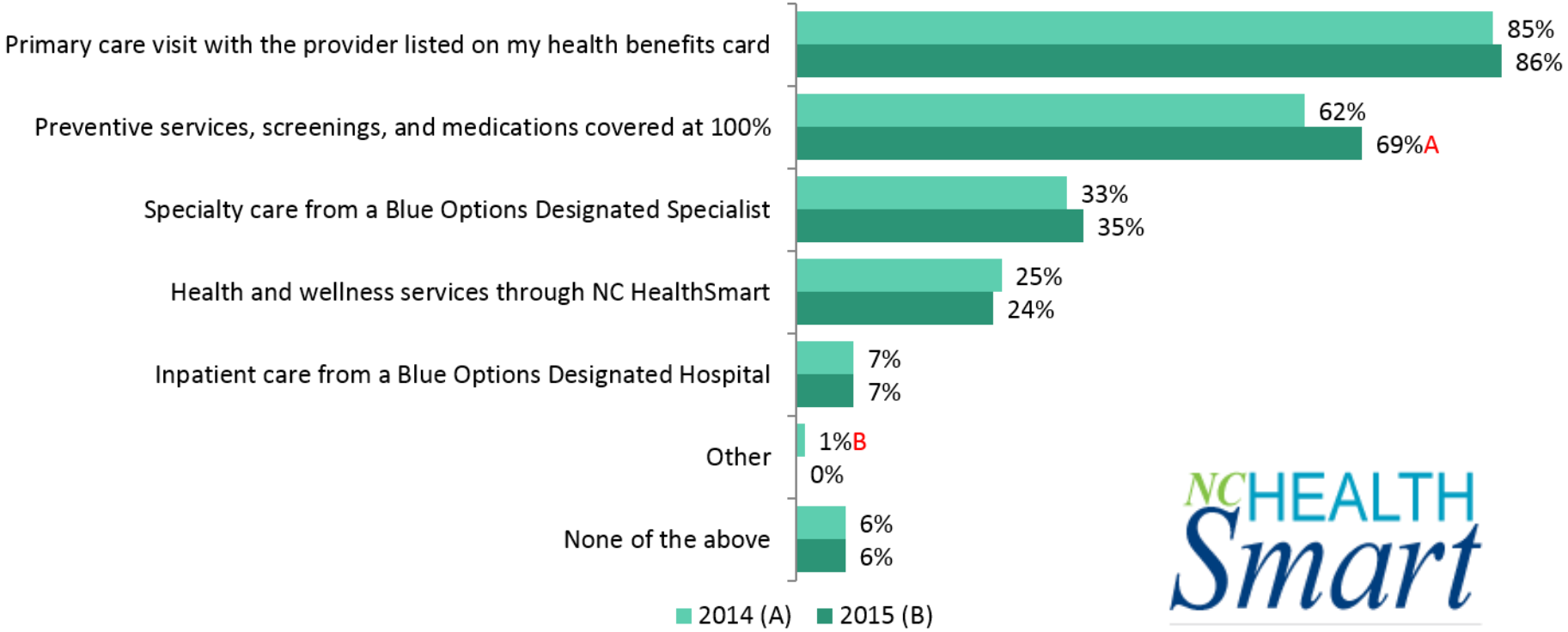
The majority of Medicare Primary Retirees didn't visit a Primary Care Provider in the past 12 months because they weren't sick, and therefore, didn't have a need to do so.



Base: 2014 MP who have not visited PCP past 12 months (n=136)
2015 MP who have not visited PCP past 12 months (n=28) [Extremely small base size – not eligible for significance testing]

AE Services

In both 2014 and 2015, a visit with a primary care provider was the service utilized by most Active Employees/Retirees. However, more of these members in 2015 than in 2014 used preventive services, screenings and medications. Only about one-quarter in either year have taken advantage of NC Health*Smart*.



NC HEALTH Smart
An initiative of the State Health Plan

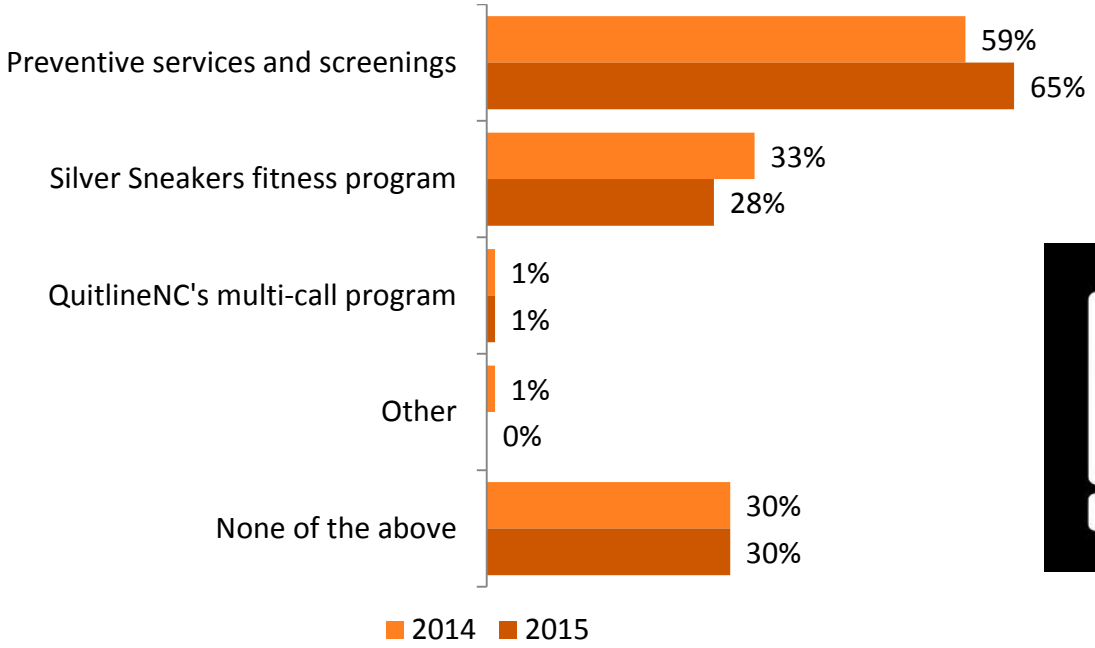
Base: 2014 AE not on traditional 70/30 plan (n=4010)
2015 AE not on traditional 70/30 plan (n=3892)

Red letters represent statistically significant differences at the 95% level.

Q5b. Which of the following services have you used since January 1, 2015? Please select all that apply.

MP Services

Preventive services and screenings were utilized most often by Medicare Primary Retirees in both 2014 and 2015. About one third, in either year, have taken advantage of the fitness program Silver Sneakers. QuitlineNC was used by only 1% in both years.



Base: 2014 MP not on traditional 70/30 plan (n=1894)
2015 MP not on traditional 70/30 plan (n=139)

QuitlineNC.com
1-800-QUIT-NOW

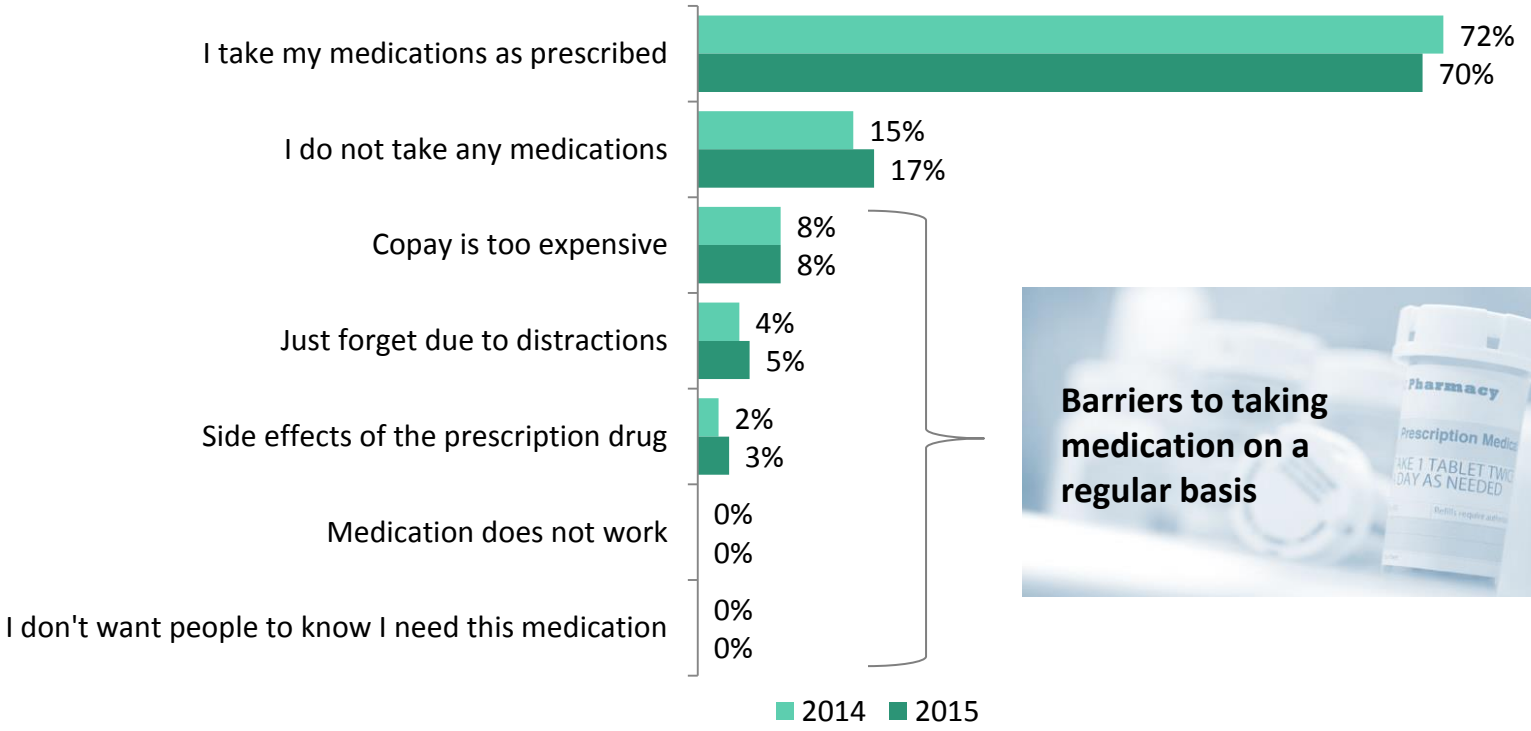
HEALTHWAYS SilverSneakers FITNESS

Q5a. Which of the following services have you used since January 1, 2015? Please select all that apply.

Medication – AE

Almost three quarters of Active Employees/Retirees in both 2014 and 2015 take their medications as prescribed.

Base: AE 2014 Total (n=5171)
AE 2015 Total (n=4859)

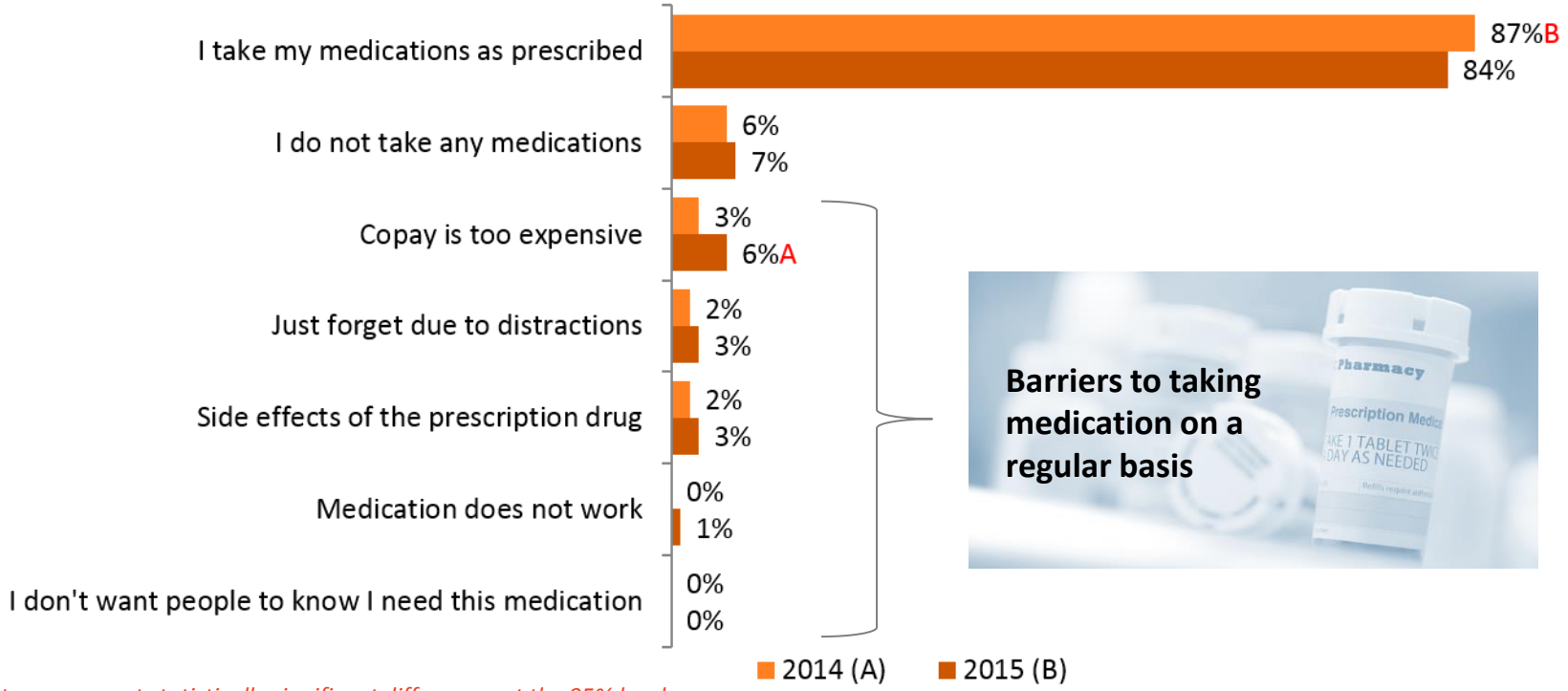


Q8. What prevents you from taking your medication(s) on a regular basis?

Medication – MP

More Medicare Primary Retirees in 2014 than in 2015 took their medications as prescribed. This could be due to an increase in 2015 in the proportion of those who do not take their medications regularly because their copay is too expensive.

Base: MP 2014 Total (n= 2554)
MP 2015 Total (n=597)



Red letters represent statistically significant differences at the 95% level.

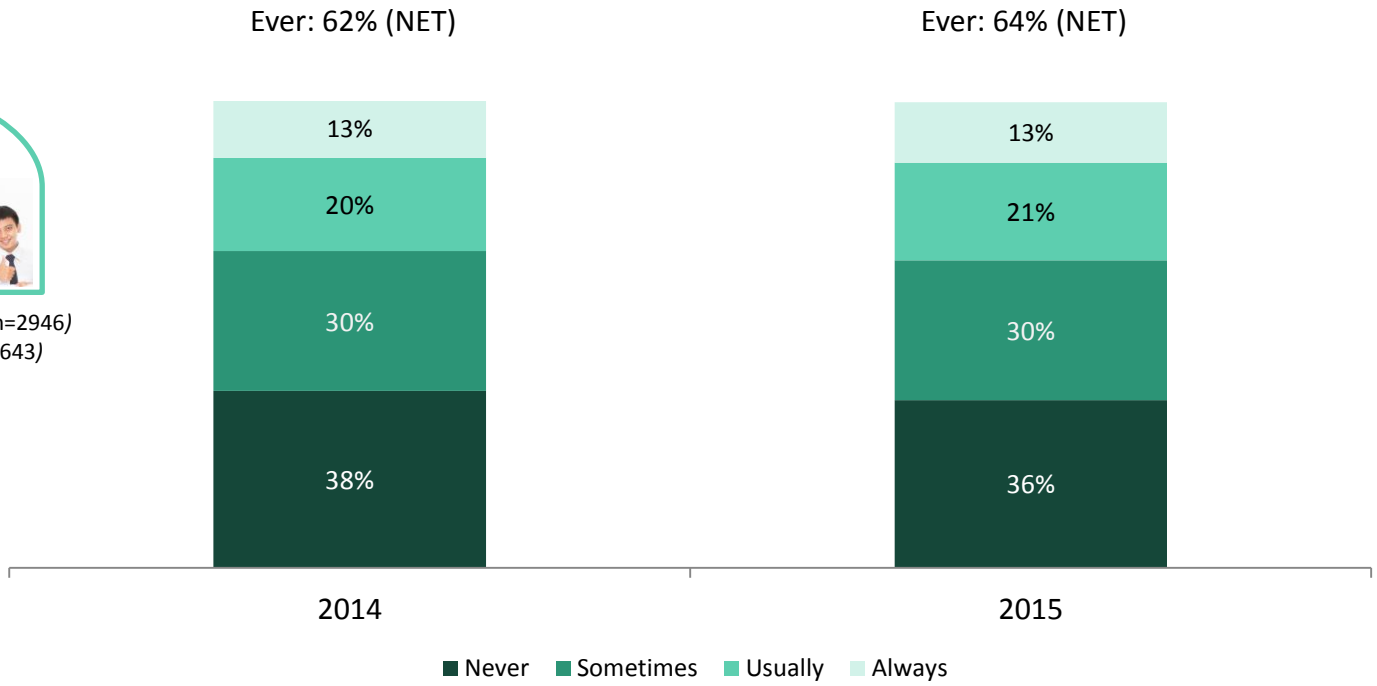
Q8. What prevents you from taking your medication(s) on a regular basis?

Attitudes toward Cost

Advanced Notice of Cost – AE

Over the past 12 months, just over one third of Active Employees/Retirees say they have never been able to find out in advance how much they would have to pay for needed health care services/equipment. This proportion is similar to what was captured in 2014.

*Base: AE 2014 Total excluding n/a (*n=2946*)*
*AE 2015 Total excluding n/a (*n=2643*)*

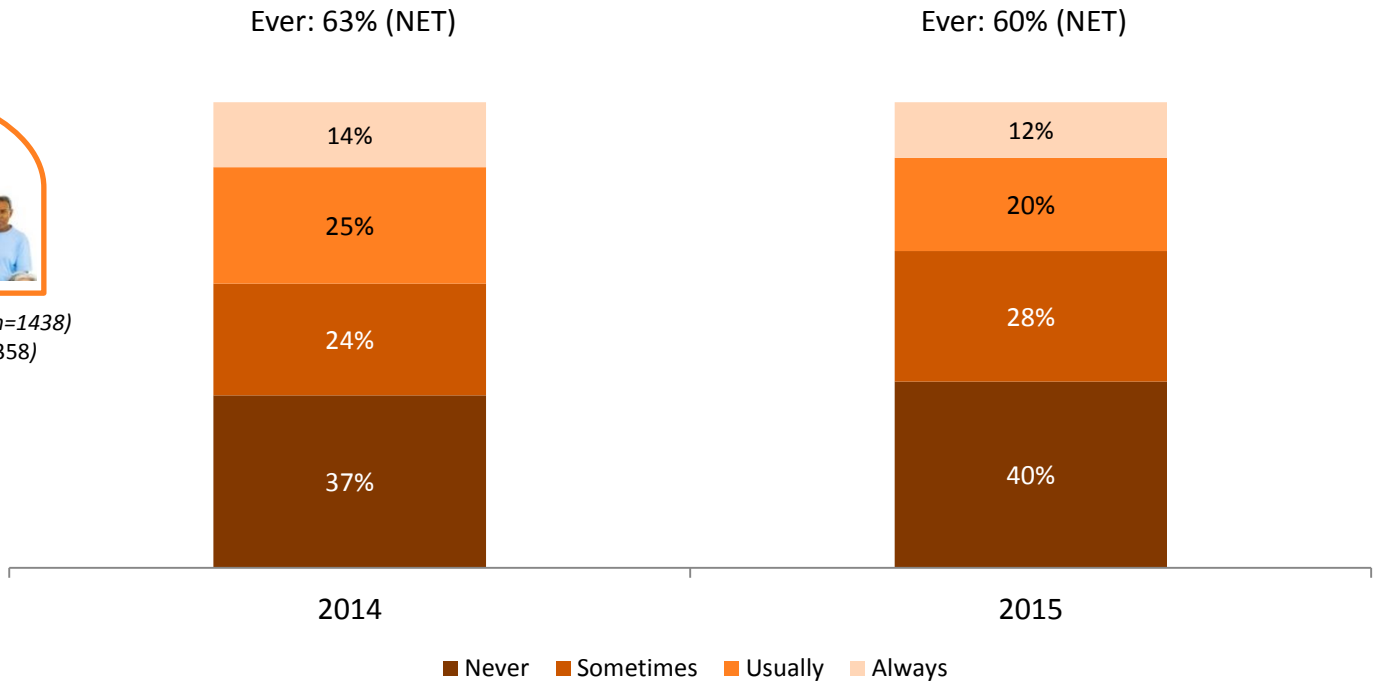


Q9. In the last 12 months, how often were you able to find out in advance how much you would have to pay for health care services or equipment that you needed?

Advanced Notice of Cost – MP

Over the past 12 months, four out of ten Medicare Primary Retirees say they have never been able to find out in advance how much they would have to pay for needed health care services/equipment. This proportion did not change significantly from 2014.

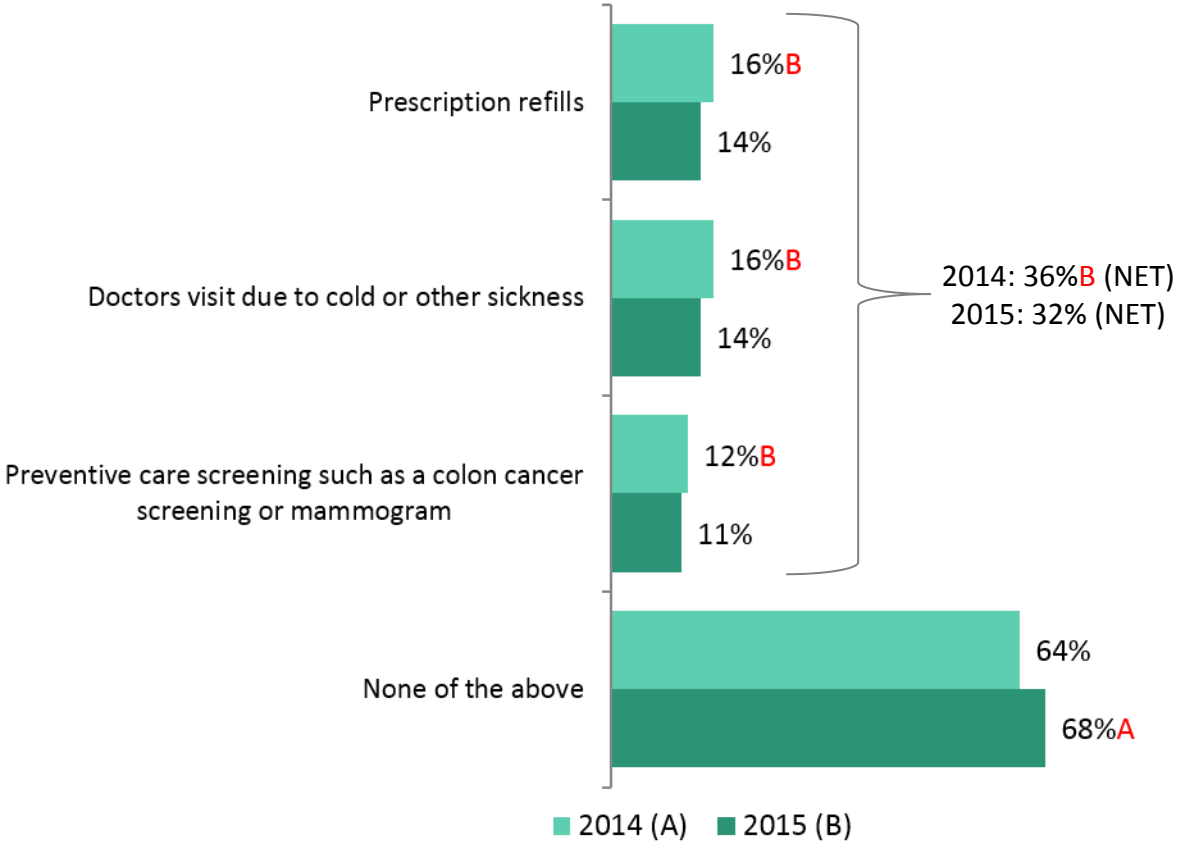
Base: MP 2014 Total excluding n/a (n=1438)
MP 2015 Total excluding n/a (n=358)



Q9. In the last 12 months, how often were you able to find out in advance how much you would have to pay for health care services or equipment that you needed?

Cost as a Barrier – AE

32% of Active Employees/Retirees say they were delayed in getting health care service or didn't receive it at all in the past 12 months because of cost. However, this is an improvement over 2014 where 36% said the same.



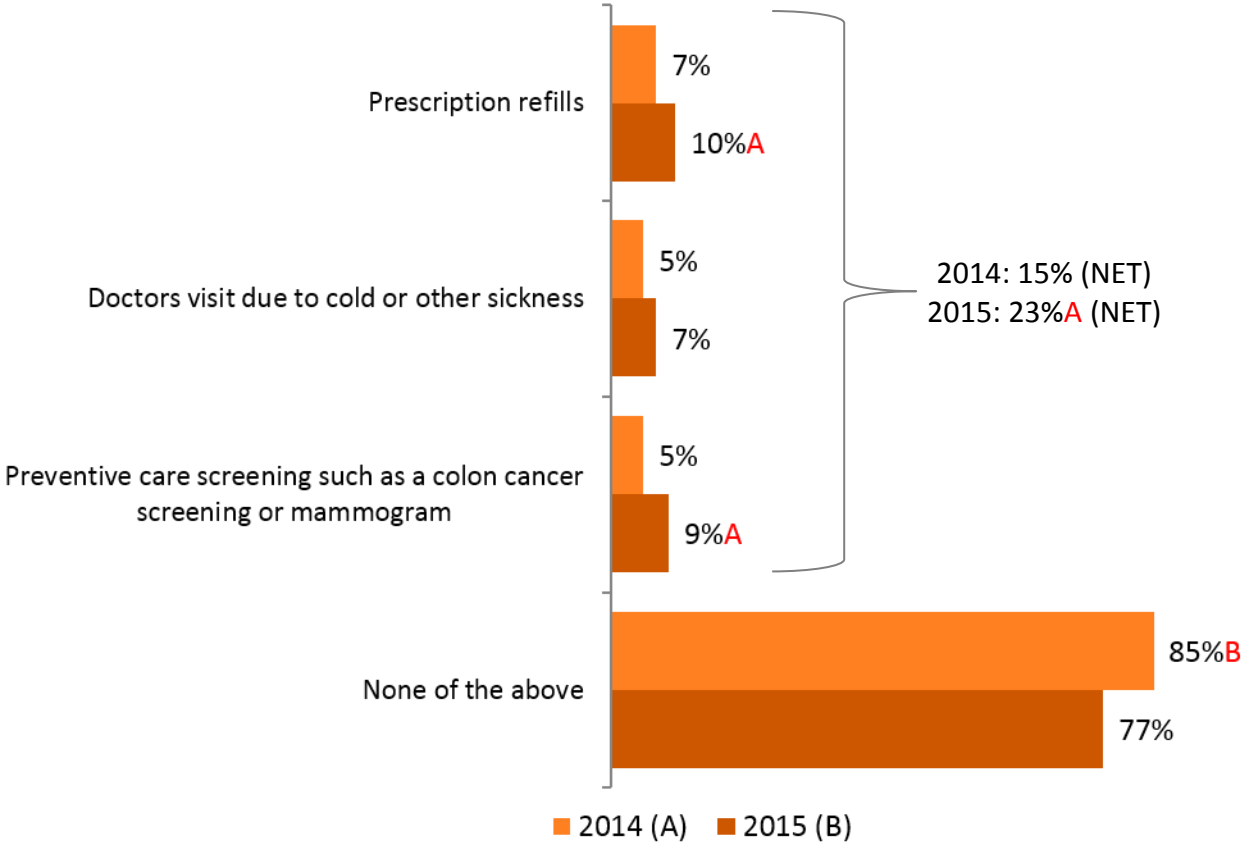
Base: AE 2014 Total (n=5171)
AE 2015 Total (n=4852)

Red letters represent statistically significant differences at the 95% level.

Q10. In the last 12 months, did you delay or not get any of the following services because of the cost?

Cost as a Barrier – MP

Cost has become more of an issue for Medicare Primary Retirees in 2015, since 23% of these members say they were delayed in getting health care service or didn't receive it at all in the past 12 months for this reason, as compared to 15% in 2014. More specifically, more retirees in 2015 than in 2014 delayed or did not refill prescriptions and/or receive preventive care screenings because of the cost.



Base: MP 2014 Total (n=2552)
MP 2015 Total (n=596)

Red letters represent statistically significant differences at the 95% level.

Q10. In the last 12 months, did you delay or not get any of the following services because of the cost?

Communication & Resources

Communication Methods – AE

AE

Mailed printed materials and email communications are the top two most preferred methods of receiving information from the State Health Plan, among Active Employees/Retirees. However, more of these members in 2015 prefer mailed printed materials than in 2014. Other changes include fewer members in 2015 than in 2014 preferring the State Health Plan website and the Member Focus newsletter.

The lower the ranking, the more preferred the method.

Method Preferences Ranked 1-7 *Base: AE 2014 Total (n=5171); AE 2015 Total (n=4859)*	Ranked #1		Ranked Top 2		Ranked Top 3		Average Ranking	
	2014 (A)	2015 (B)	2014 (C)	2015 (D)	2014 (E)	2015 (F)	2014 (G)	2015 (H)
Printed material mailed to my home	34%	39%A	52%	58%C	65%	71%E	2.78H	2.57
Email communications	35%	35%	63%	64%	80%	80%	2.36	2.35
State Health Plan website (shpnc.org)	16%B	14%	33%D	31%	56%F	52%	3.31	3.43G
Member Focus, monthly electronic State Health Plan newsletter	9%B	7%	31%D	26%	60%F	55%	3.33	3.49G
Through my Health Benefits Representative	3%	3%	8%	8%	15%	15%	5.26	5.26
Group meetings or presentations at my worksite	2%	2%	7%	7%	13%	13%	5.46	5.54G
Mobile application for my phone	2%	1%	6%	6%	12%	14%E	5.49H	5.36

Red letters represent statistically significant differences at the 95% level. Groups compared include AB, CD, EF and GH.

Communication Methods – MP

Mailed printed materials and email communications are the top two most preferred methods of receiving information from the State Health Plan, among Medicare Primary Retirees. However, more of these members in 2015 prefer mailed printed materials than in 2014.

The lower the ranking, the more preferred the method.

Method Preferences Ranked 1-7 *Base: MP 2014 Total (n=2554); MP 2015 Total (n=597)*	Ranked #1		Ranked Top 2		Ranked Top 3		Average Ranking	
	2014 (A)	2015 (B)	2014 (C)	2015 (D)	2014 (E)	2015 (F)	2014 (G)	2015 (H)
Printed material mailed to my home	53%	58%A	68%	74%C	78%	82%E	2.14H	1.95
Email communications	25%	22%	56%	54%	75%	73%	2.60	2.71
State Health Plan website (shpnc.org)	11%	9%	31%	30%	58%	54%	3.25	3.38
Member Focus, monthly electronic State Health Plan newsletter	9%	7%	33%D	25%	66%F	57%	3.12	3.39G
Through my Health Benefits Representative	2%	3%	6%	9%C	11%	15%E	5.36	5.34
Group meetings or presentations at my worksite	0%	0%	3%	5%C	6%	11%E	5.86H	5.65
Mobile application for my phone	0%	1%	3%	3%	6%	8%	5.67	5.58

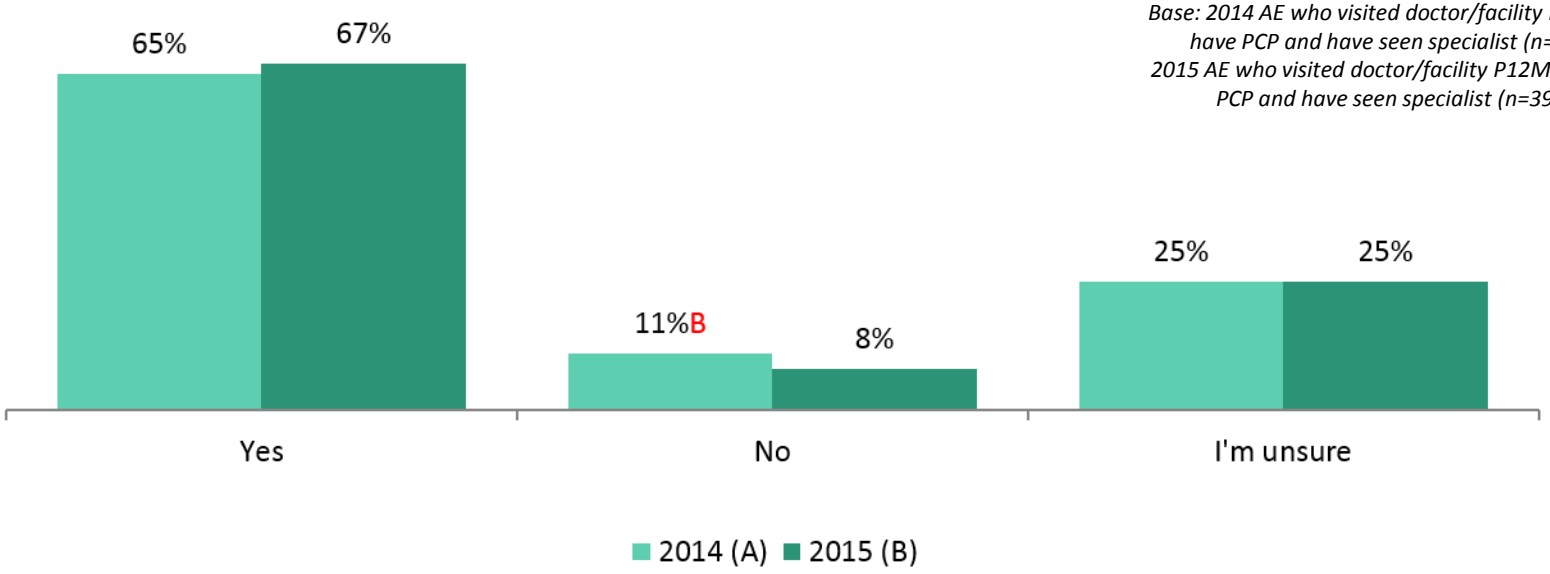
Red letters represent statistically significant differences at the 95% level. Groups compared include AB, CD, EF and GH.

Q6. List your most preferred method or methods of receiving information from the State Health Plan. Please rank the items on the list using numbers 1 through 7, where 1 means your most preferred method, 2 means your second most preferred, and so on, with 7 being the least preferred method.

PCP & Specialist Communicating – AE

In both 2014 and 2015, about two thirds of Active Employees/Retirees say their Primary Care Provider communicates with their specialist(s) to provide them with the highest level of care. The proportion of those who said their Primary Care Provider does <u>not</u> do this decreased from 2014 to 2015.

Base: 2014 AE who visited doctor/facility P12M who have PCP and have seen specialist (n=4198)
2015 AE who visited doctor/facility P12M who have PCP and have seen specialist (n=3963)

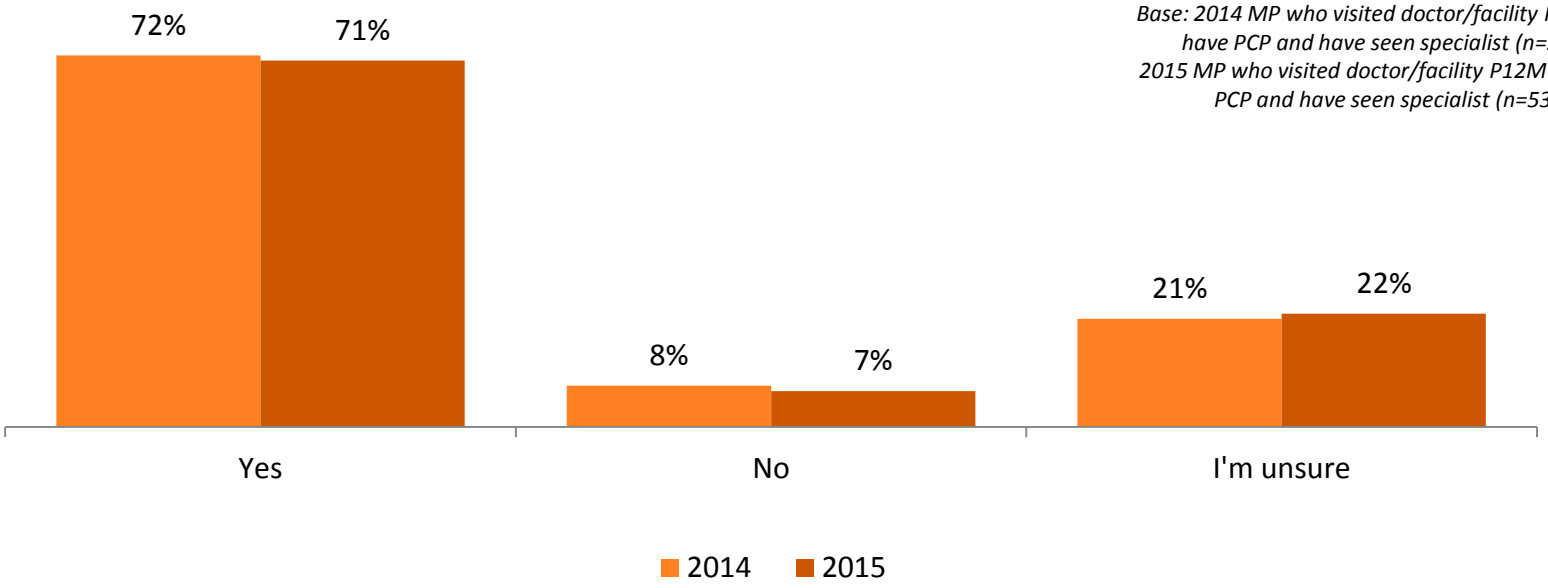


Red letters represent statistically significant differences at the 95% level.

PCP & Specialist Communicating – MP

In both 2014 and 2015, almost three quarters of Medicare Primary Retirees say their Primary Care Provider communicates with their specialist(s) to provide them with the highest level of care.

Base: 2014 MP who visited doctor/facility P12M who have PCP and have seen specialist (n=2223)
2015 MP who visited doctor/facility P12M who have PCP and have seen specialist (n=539)

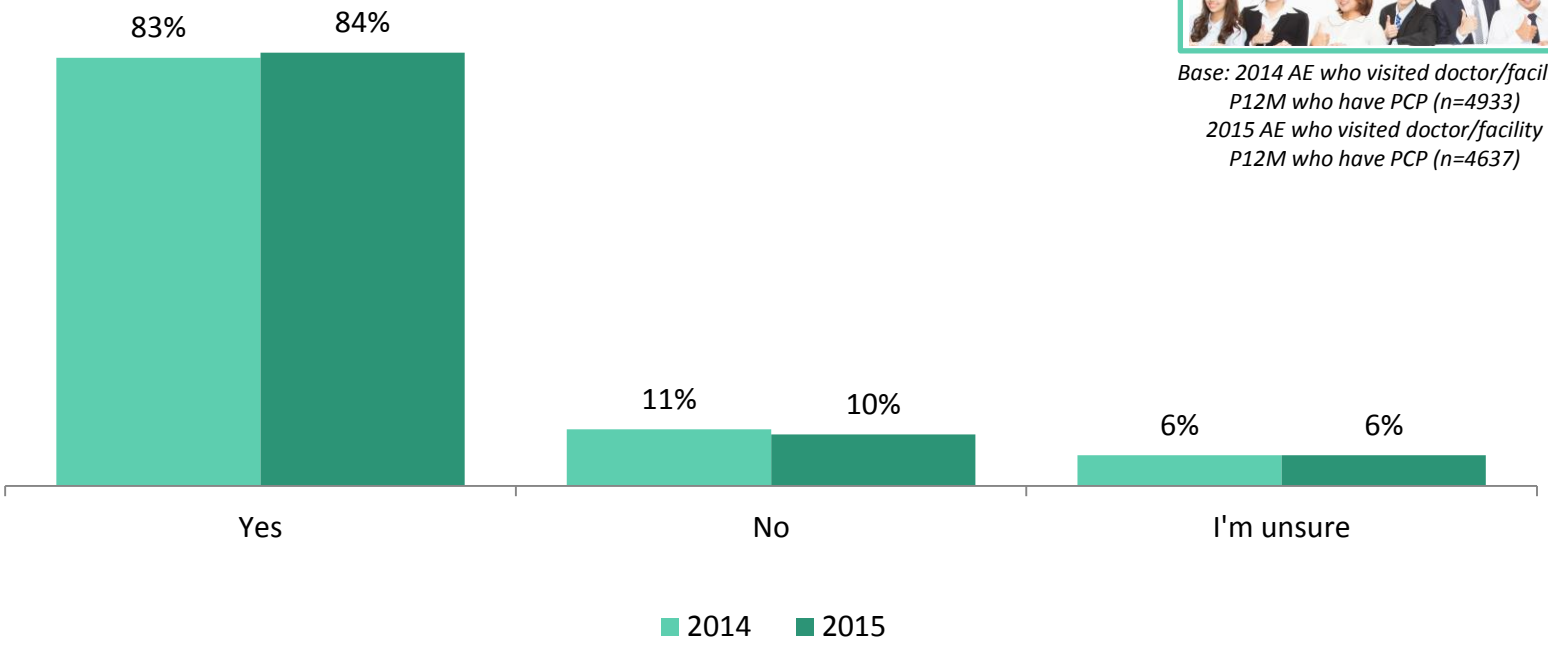


Q13. Does your Primary Care Provider communicate with your specialist(s) to provide you with the highest level of care?

PCP Providing Resources – AE

About eight out of ten Active Employees/Retirees say their primary care provider gives them resources to help them understand and manage their health. This proportion has remained stable over time.

Base: 2014 AE who visited doctor/facility P12M who have PCP (n=4933)
2015 AE who visited doctor/facility P12M who have PCP (n=4637)

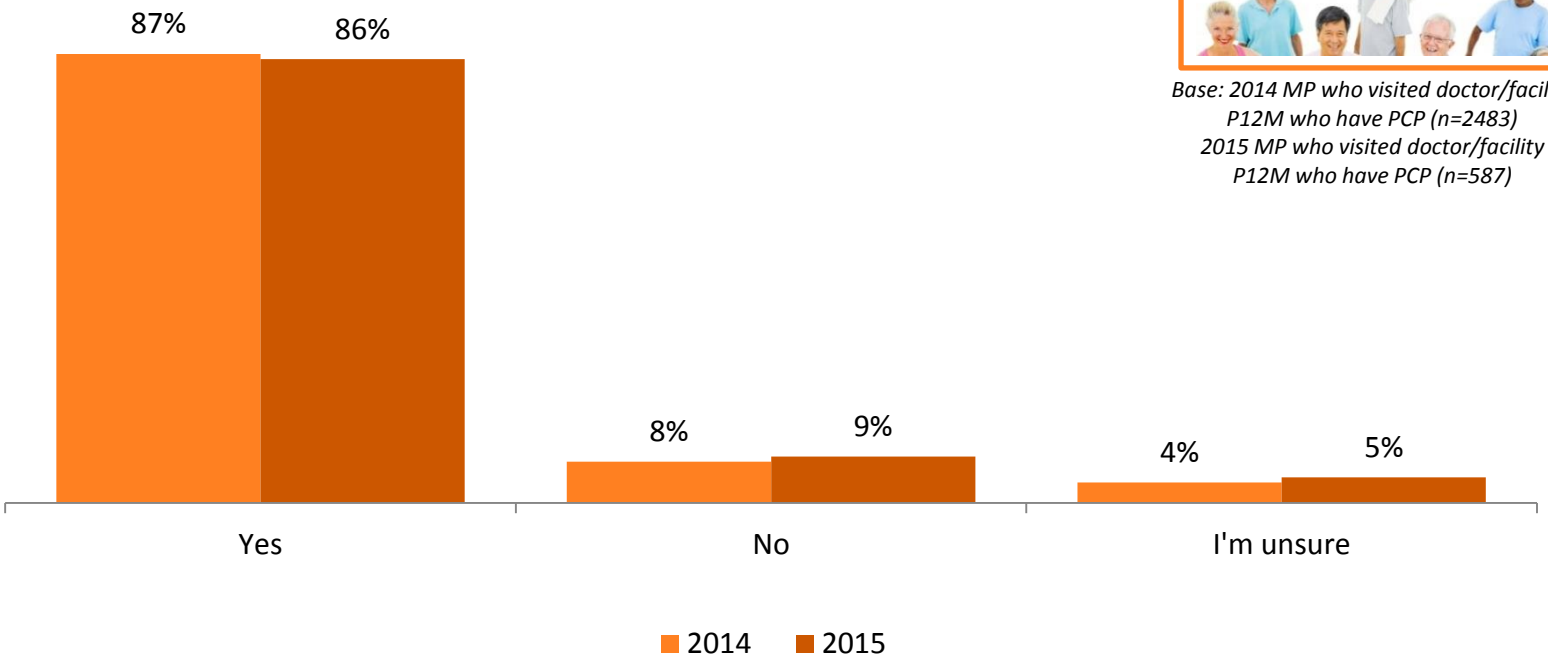


Q12. Does your Primary Care Provider give you resources to help you understand and manage your health? For example, resources to help you manage your diabetes or maintain a healthy weight.

PCP Providing Resources – MP

Almost nine out of ten Medicare Primary Retirees say their primary care provider gives them resources to help them understand and manage their health. No significant changes occurred from 2014 to 2015.

Base: 2014 MP who visited doctor/facility P12M who have PCP (n=2483)
2015 MP who visited doctor/facility P12M who have PCP (n=587)



Q12. Does your Primary Care Provider give you resources to help you understand and manage your health? For example, resources to help you manage your diabetes or maintain a healthy weight.

Respondent Profile

AE Respondent Profile

		2014 (A)	2015 (B)
GENDER	Male	24%B	22%
	Female	76%	78%A
WORK	University	12%	21%A
	Community College	5%B	3%
	State Agency	20%B	13%
	School System	33%B	30%
	UNC Healthcare	2%	2%
	Retired	27%	30%A
2014 PLAN[1]	Traditional 70/30 Plan	23%B	20%
	Enhanced 80/20 Plan	71%	75%A
	Consumer-Directed Health Plan	6%	5%
COVERAGE	Employee/Retiree only	77%	77%
	Employee/Retiree and child/children only	10%	10%
	Employee/Retiree and spouse only	6%	6%
	Family	8%	8%
HEALTH HABITS	I always wear my seatbelt	98%	98%
	I do not use tobacco products	93%	94%A
	I am mindful of my eating habits	86%	87%
	I work with my doctor and other health care professionals to improve my health	76%	77%
	I receive a flu shot every year	68%	69%
	I exercise on a regular basis	53%	54%
	I maintain a low level of stress	45%	48%A

Red letters represent statistically significant differences at the 95% level.

Base: AE 2014 Total (n=5171); AE 2015 Total (n=4859)

[1]Excludes those who were not sure

MP Respondent Profile

		2014 (A)	2015 (B)
GENDER	Male	33%	33%
	Female	67%	67%
YEARS RETIRED	Less than 1 year	4%	7%A
	1-3	16%	18%
	4-6	20%	19%
	7-10	24%	24%
	11+	36%	31%
2014 PLAN[1]	Traditional 70/30 Plan	27%	83%A
	Humana (NET)	21%B	5%
	Humana Medicare Advantage Base Plan	14%B	4%
	Humana Medicare Advantage Enhanced Plan	7%B	2%
	UnitedHealthcare (NET)	52%B	12%
	UnitedHealthcare Medicare Advantage Base Plan	21%B	3%
	UnitedHealthcare Medicare Advantage Enhanced Plan	31%B	9%
COVERAGE	Employee/Retiree only	86%	85%
	Employee/Retiree and spouse only	13%	11%
	Family	1%	2%A
	Employee/Retiree and child/children only	0%	2%A
HEALTH HABITS	I always wear my seatbelt	98%	98%
	I do not use tobacco products	94%	92%
	I am mindful of my eating habits	90%	89%
	I work with my doctor and other health care professionals to improve my health	89%	87%
	I receive a flu shot every year	84%	82%
	I maintain a low level of stress	63%	61%
	I exercise on a regular basis	61%B	53%

Red letters represent statistically significant differences at the 95% level.

Base: MP 2014 Total (n=2554); MP 2015 Total (n=597)

[1]Excludes those who were not sure

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

2016 Annual Enrollment Telephone Town Hall Events

Board of Trustees Meeting

November 20, 2015

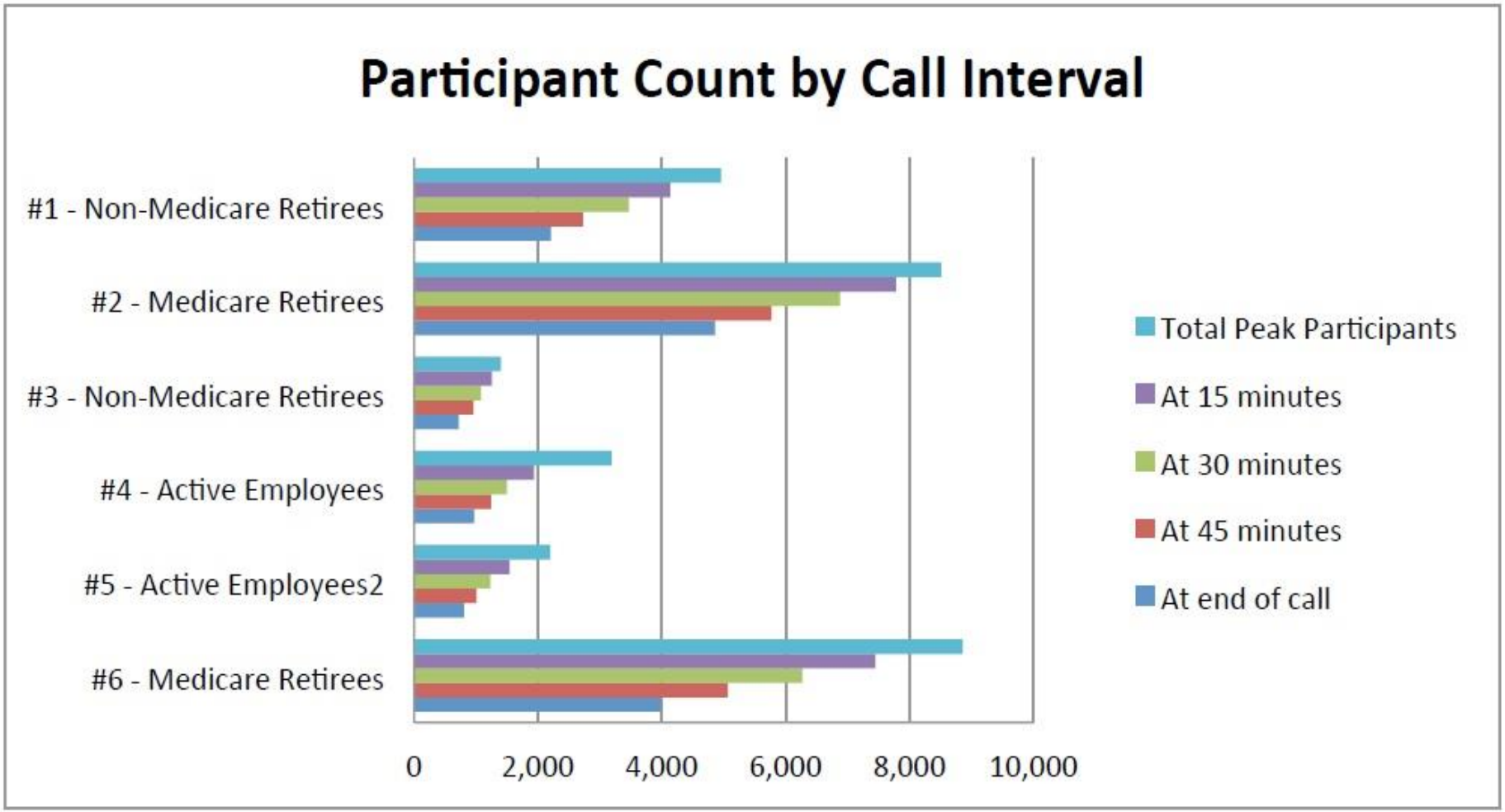
Overview

- The six Telephone Town Hall events were held between September 15 and October 8, yielding an unprecedented level of participation and engagement.
- Listeners joined and remained on the calls at extremely high rates.
- Medicare Retirees and Non-Medicare Retirees stayed on the calls for significantly longer than Active Employees.
- Industry standard yields 5% of participants staying on until the end of the call.
  - Our events averaged between 13% and 33% of all participants staying on the call until the end.
- Over 93% of call participants joined via the outbound dial, 6% by inbound dial, and less than 1% by web listener interface.

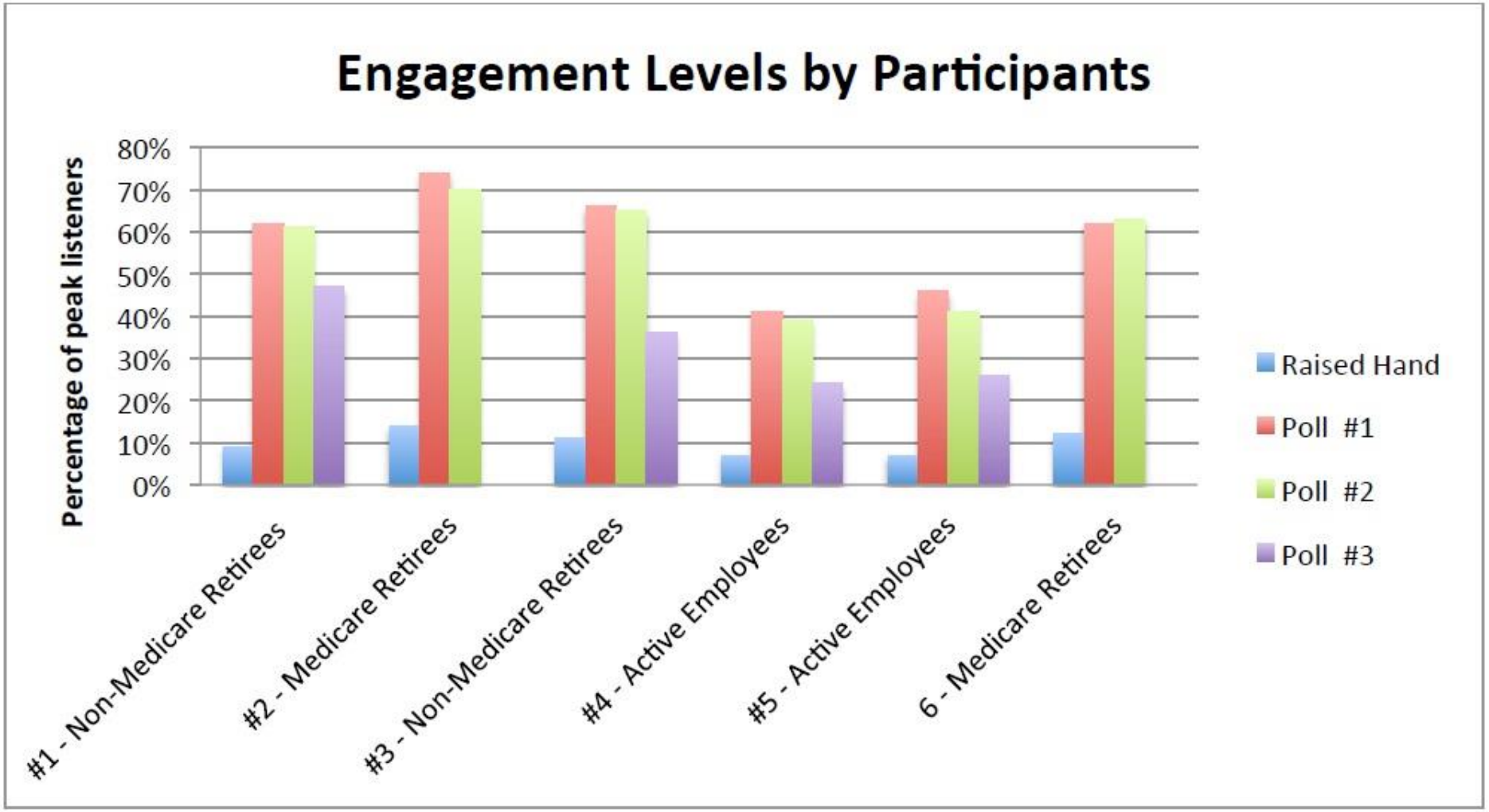
Overview-*Continued*

- Listeners participated in the events at very high rates through poll questions and live questions.
- Medicare Retirees most frequently raised their hands to ask questions.
- Active Employees were the least likely to participate in poll questions.
- The types of phone numbers varied widely across universes, which affected the overall participation levels for the events.
  - 53% of the Active Employee outbound universe were composed of cell phones, while 25% of Non-Medicare Retiree and 15% of the Medicare Retiree phones were cell numbers.
- Medicare Retirees were the most likely to opt out of receiving future calls about the Telephone Town Halls after the pre-event robocall.

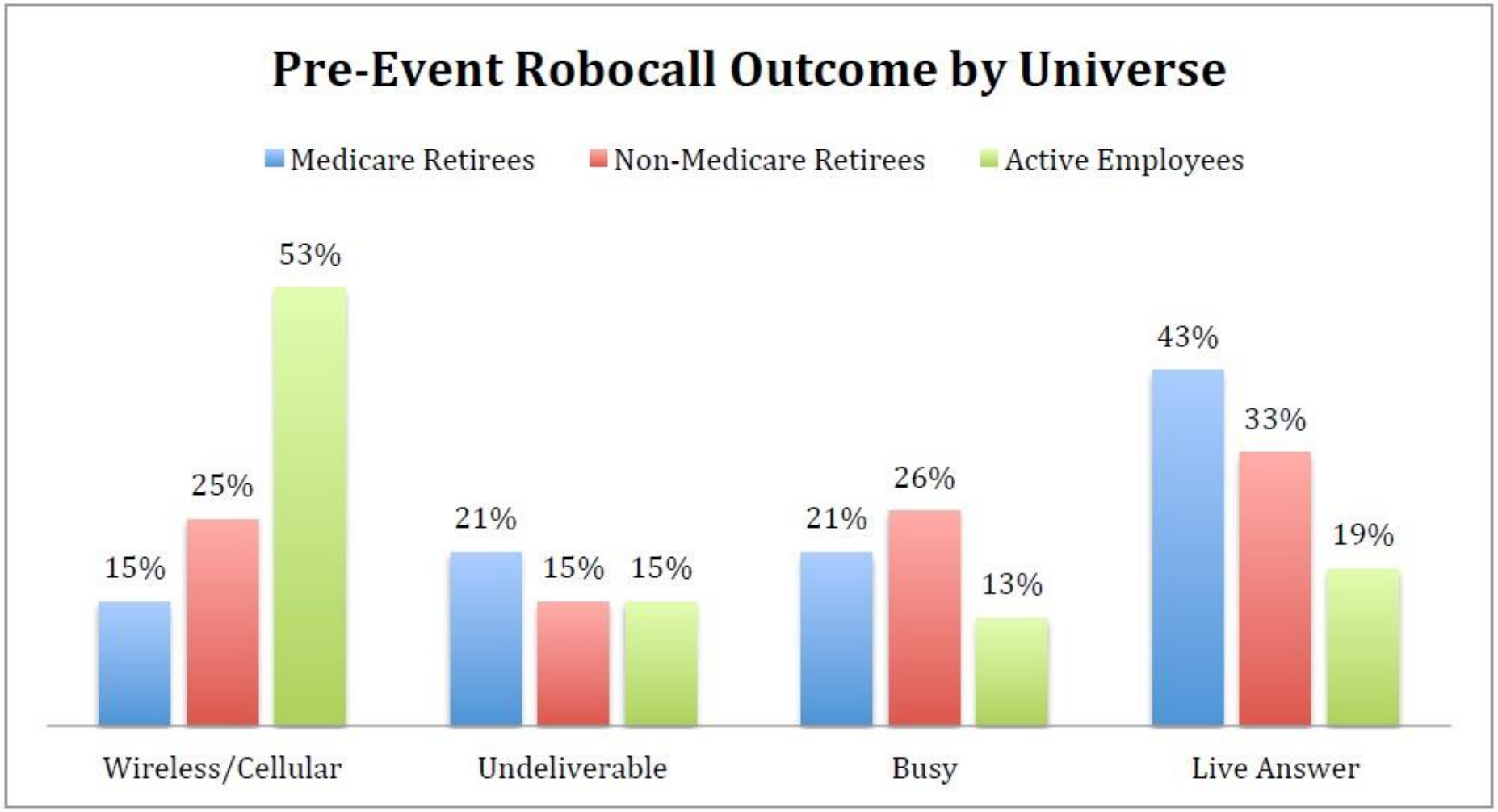
Total Participants



Engagement Levels by Participants

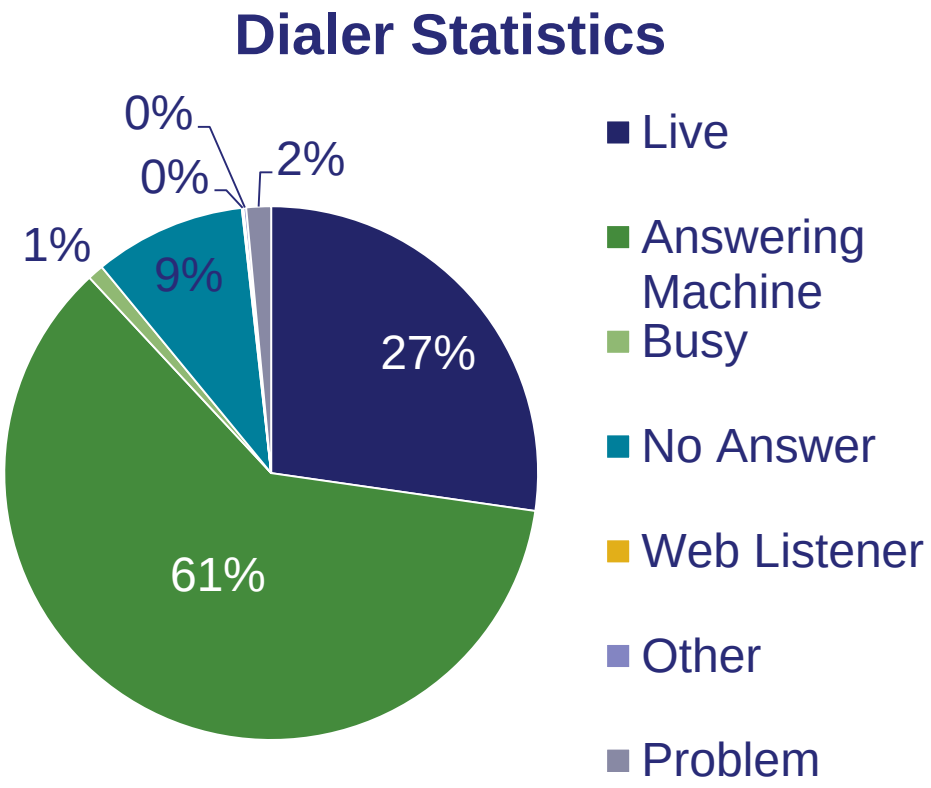


Member Phone Number Outcomes



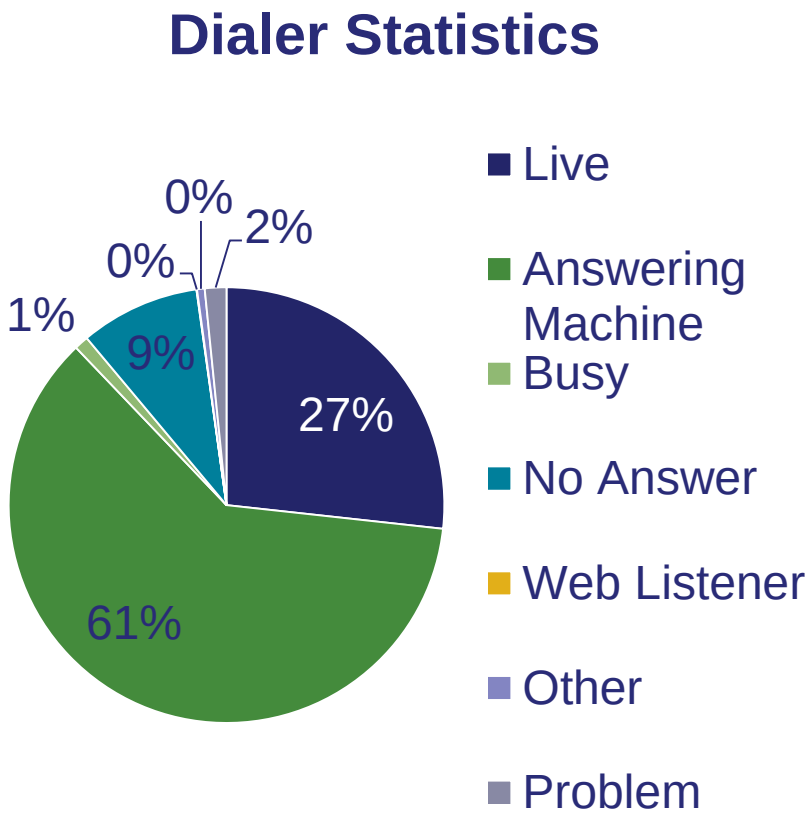
Active Dial Statistics-9/22/15

Category	Count	Percent
Live	10,976	27.27%
Answering Machine	24,476	60.81%
Busy	391	0.97%
No Answer	3,700	9.19%
Web Listener	42	0.1%
Other	64	0.16%
Problem	602	1.5%
Total	40,251	100%



Active Dial Statistics-9/24/15

Category	Count	Percent
Live	10,986	26.74%
Answering Machine	25,116	61.12%
Busy	431	1.05%
No Answer	3,651	8.89%
Web Listener	17	0.04%
Other	232	0.56%
Problem	657	1.6%
Total	41,090	100%



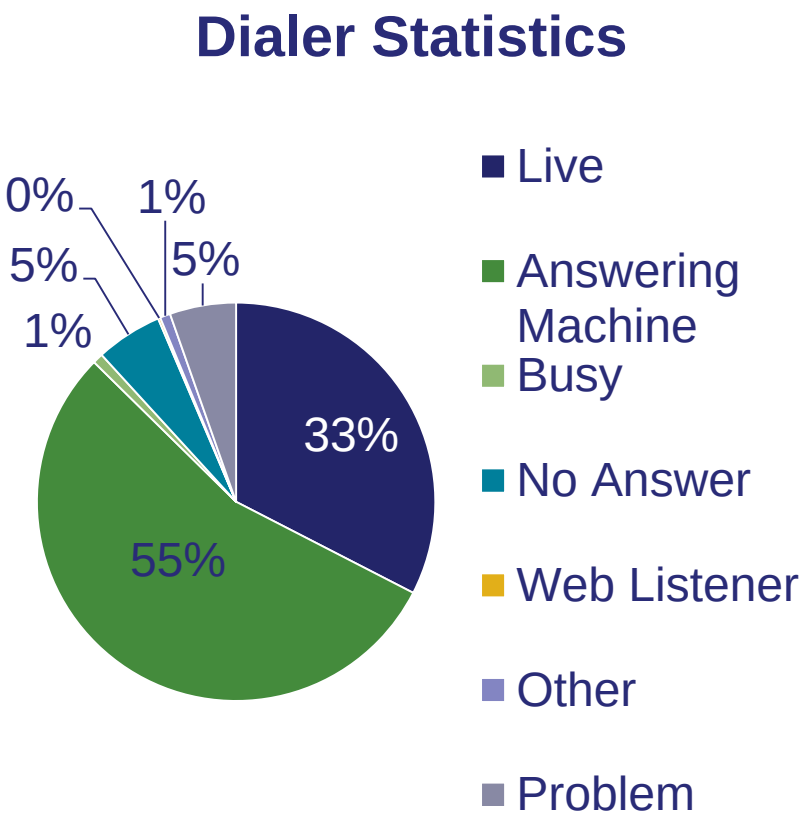
Active Employees Event Call Data

Listener Data for Active Event- 9/22/15	
Live Participants	7,370
Peak Listeners	3,181
Peak Inbound Listeners	329
Peak Outbound Listeners	3,000
Hands Raised	232
Screened	193
On Deck	16
Live	15
Poll Votes	3274
Question Statistics	
Total Hands Raised	232
Total Calls Screened	193
Total Questions Accepted	75
Total Questions Removed	91
Total Questions Hung Up On	27
Total Questions Live	15

Listener Data for Active Event- 9/24/15	
Live Participants	4,072
Peak Listeners	2,191
Peak Inbound Listeners	247
Peak Outbound Listeners	2,079
Hands Raised	163
Screened	153
On Deck	18
Live	18
Poll Votes	2481
Question Statistics	
Total Hands Raised	163
Total Calls Screened	153
Total Questions Accepted	65
Total Questions Removed	80
Total Questions Hung Up On	8
Total Questions Live	18

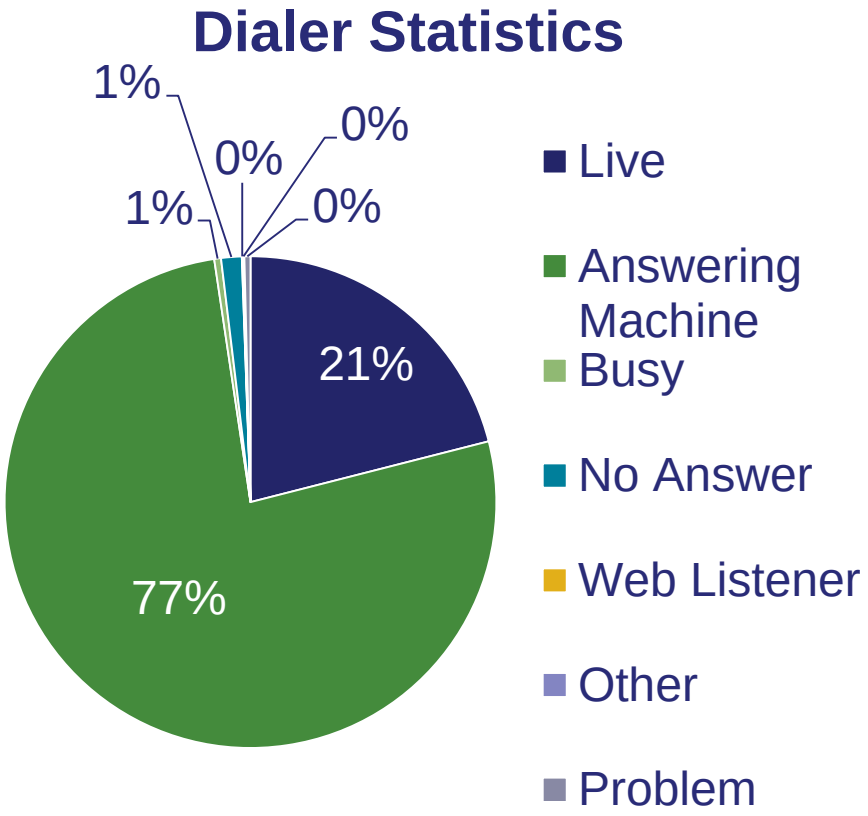
Non-Medicare Dial Statistics 9/15/15

Category	Count	Percent
Live	9,580	32.56%
Answering Machine	16,125	54.8%
Busy	248	0.84%
No Answer	1,586	5.39%
Web Listener	55	0.19%
Other	246	0.84%
Problem	1,584	5.38%
Total	29,424	100%



Dial Statistics: Non-Medicare 9/17/15

Category	Count	Percent
Live	3,588	21.02%
Answering Machine	13,076	76.62%
Busy	76	0.45%
No Answer	231	1.35%
Web Listener	8	0.05%
Other	20	0.12%
Problem	68	0.4%
Total	17,067	100%



Non-Medicare Listener Call Data

Listener Data for Non-Medicare Event-9/15/15	
Live Participants	7,666
Peak Listeners	4,952
Peak Inbound Listeners	505
Peak Outbound Listeners	4,574
Hands Raised	428
Screened	161
On Deck	15
Live	16
Poll Votes	8,421
Average Call Duration	7.63 m

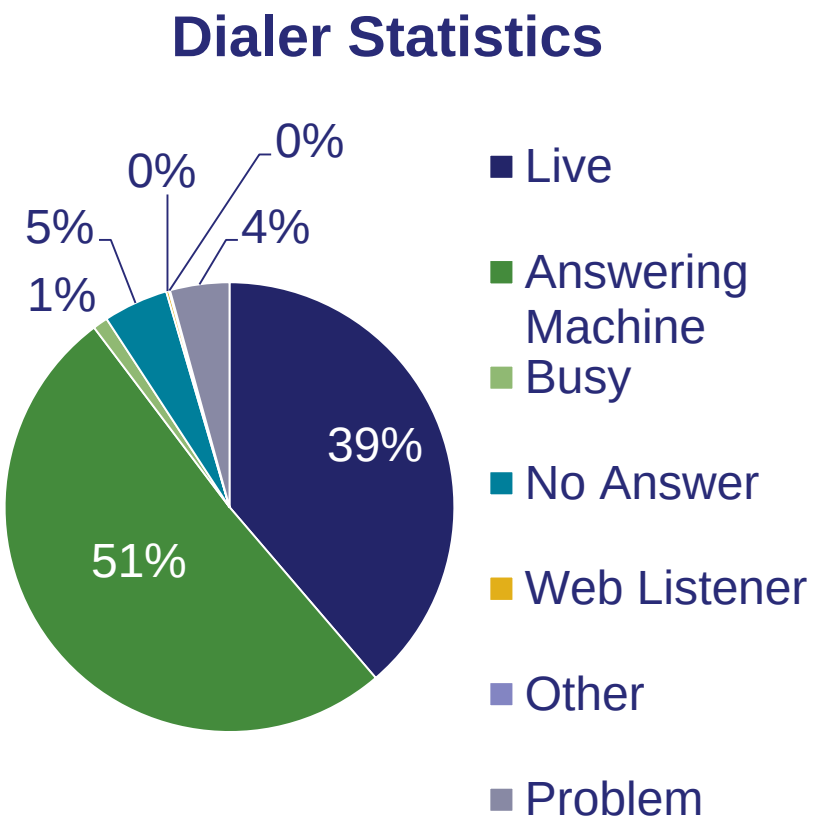
Question Statistics	
Total Hands Raised	428
Total Calls Screened	161
Total Questions Accepted	77
Total Questions Removed	77
Total Questions Hung Up On	7
Total Questions Live	16

Listener Data for Non-Medicare Event-9/17/15	
Live Participants	2,724
Peak Listeners	1,403
Peak Inbound Listeners	386
Peak Outbound Listeners	1,203
Hands Raised	158
Screened	148
On Deck	19
Live	18
Poll Votes	2,343
Average Call Duration	4.64 m

Question Statistics	
Total Hands Raised	158
Total Calls Screened	148
Total Questions Accepted	100
Total Questions Removed	45
Total Questions Hung Up On	3
Total Questions Live	18

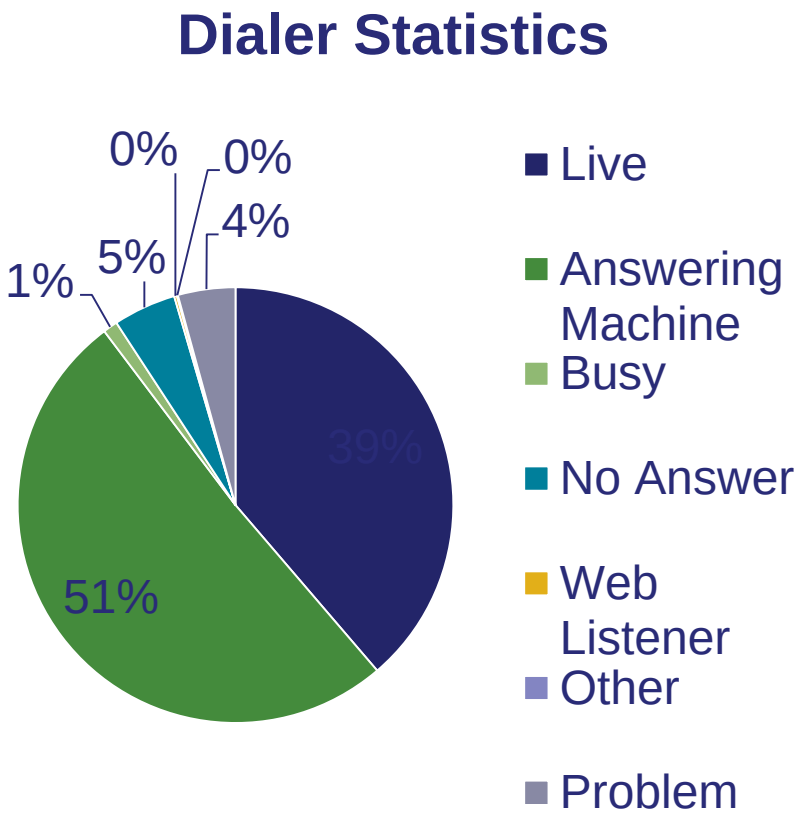
Medicare Dial Statistics 9/16/15

Category	Count	Percent
Live	17,614	38.73%
Answering Machine	23,188	50.98%
Busy	491	1.08%
No Answer	2,121	4.66%
Web Listener	91	0.2%
Other	36	0.08%
Problem	1,940	4.27%
Total	45,481	100%



Medicare Dial Statistics-10/8/15

Category	Count	Percent
Live	17,552	39.27%
Answering Machine	23,517	52.61%
Busy	522	1.17%
No Answer	2,506	5.61%
Web Listener	46	0.1%
Other	48	0.11%
Problem	510	1.14%
Total	44,701	100%



Medicare Listener Data

Listener Data Medicare Event-9/16/15	
Live Participants	14,786
Peak Listeners	8,509
Peak Inbound Listeners	969
Peak Outbound Listeners	7,859
Hands Raised	1,233
Screened	211
On Deck	21
Live	19
Poll Votes	12,230
Average Call Duration	9.64 m

Listener Data Medicare Event-10/8/15	
Live Participants	14,945
Peak Listeners	8,541
Peak Inbound Listeners	911
Peak Outbound Listeners	7,941
Hands Raised	1,080
Screened	312
On Deck	15
Live	14
Poll Votes	11,084
Average Call Duration	9.09 m

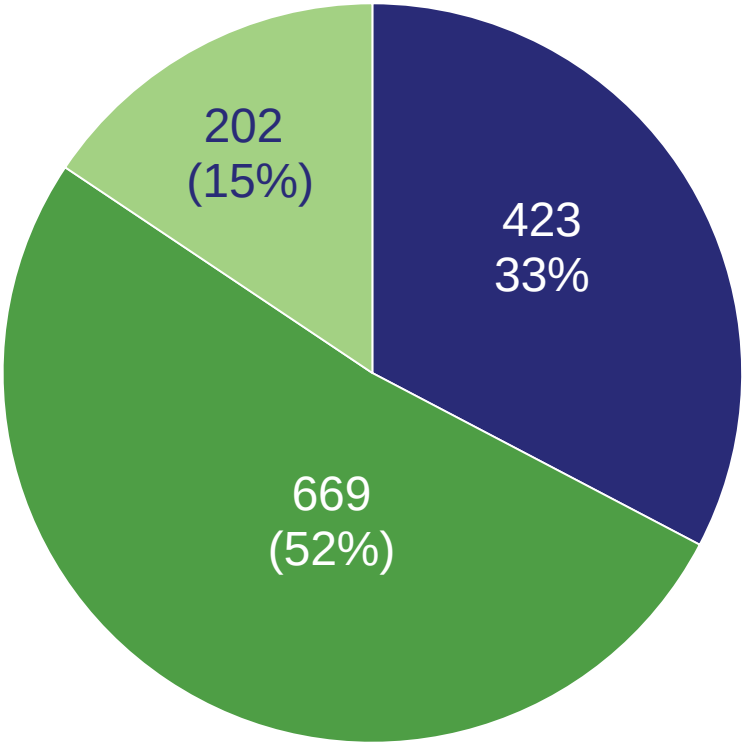
Question Statistics	
Total Hands Raised	1,233
Total Calls Screened	211
Total Questions Accepted	96
Total Questions Removed	105
Total Questions Hung Up On	10
Total Questions Live	19

Question Statistics	
Total Hands Raised	1,080
Total Calls Screened	312
Total Questions Accepted	143
Total Questions Removed	142
Total Questions Hung Up On	27
Total Questions Live	14

Appendix

Active Poll Question #1- *9/22/15*

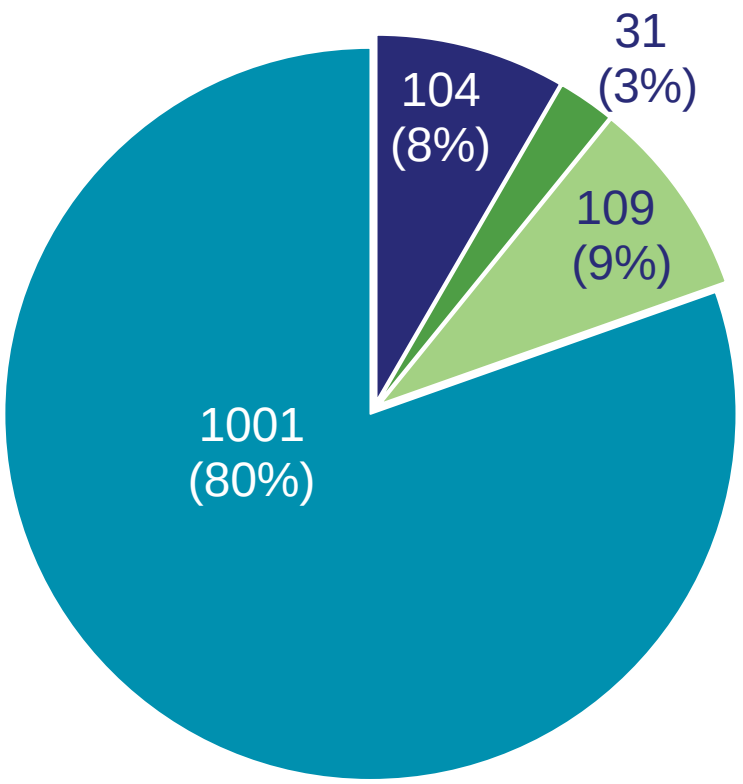
- Poll #1 - We want to know what you are most interested in hearing on this call.



- Press 1 if you're interested in learning how to save money on your monthly premium by taking simple steps.
- Press 2 if you want to learn more about how to decide which health plan is right for you and whether you should consider changing plans.
- Press 3 if you're interested in learning how you may be able to save even more money if you enroll in the CDHP.

Active Poll Question #2- *9/22/15*

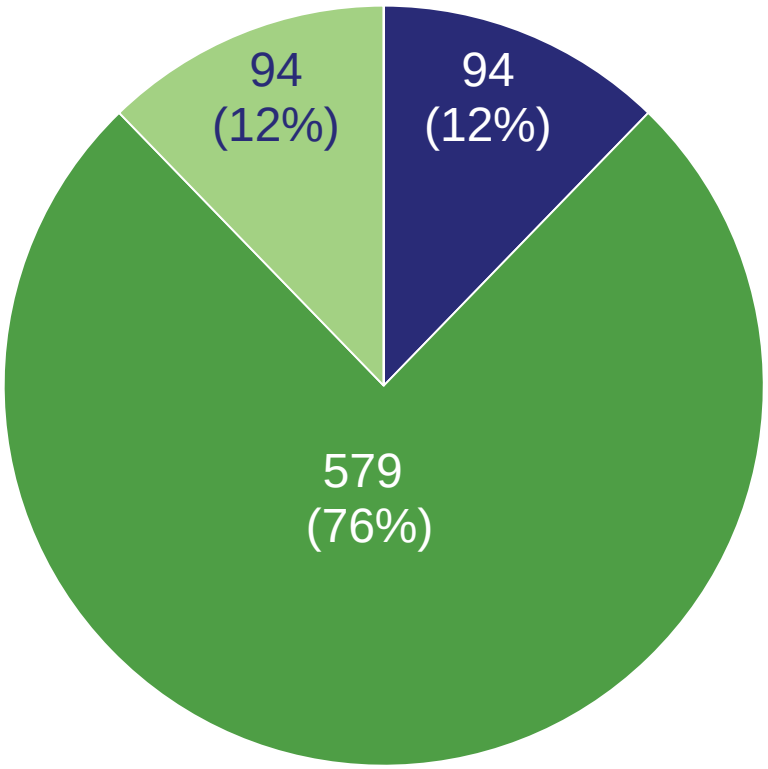
- Poll #2 - Please tell us which wellness activity you think you'll do.



- Press 1 if you'll attest – or confirm – at enrollment that you and your enrolled spouse are non-tobacco users.
- Press 2 if you'll choose a Primary Care Provider if you don't have one now, and if you'll watch a video about PCMH.
- Press 3 if you'll take or update your Health Assessment, if you haven't done so since October 31, 2014.
- Press 4 if you think you'll do all three activities.

Active Poll Question #3-*9/22/15*

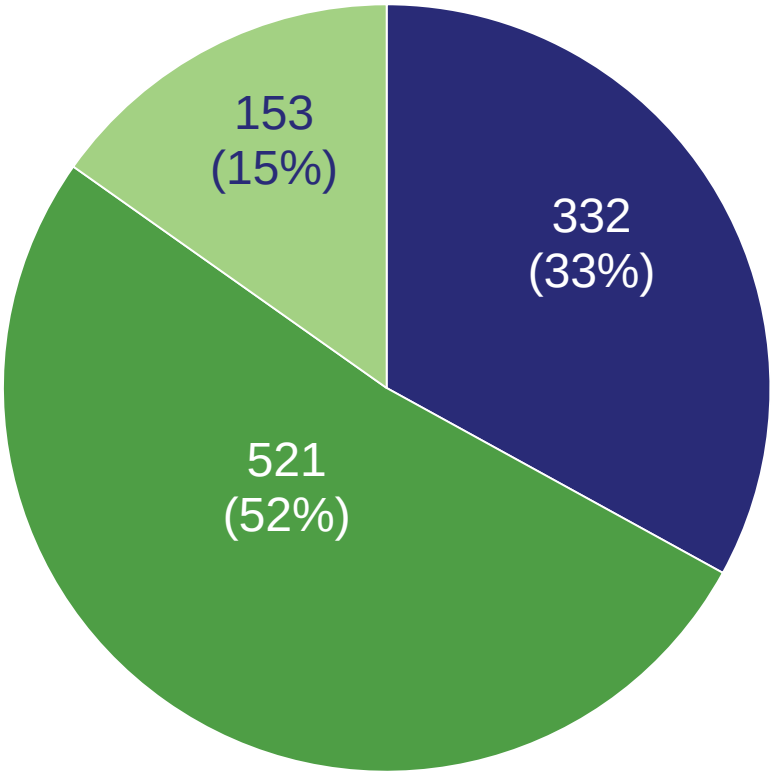
- Poll # 3 - What plan do you think you'll choose for 2016 health coverage?



- Press 1 if you think you'll choose the Consumer-Directed Health Plan.
- Press 2 if you think you'll choose the Enhanced 80/20 Plan.
- Press 3 if you think you'll choose the Traditional 70/30 Plan.

Active Poll Question #1-*9/24/15*

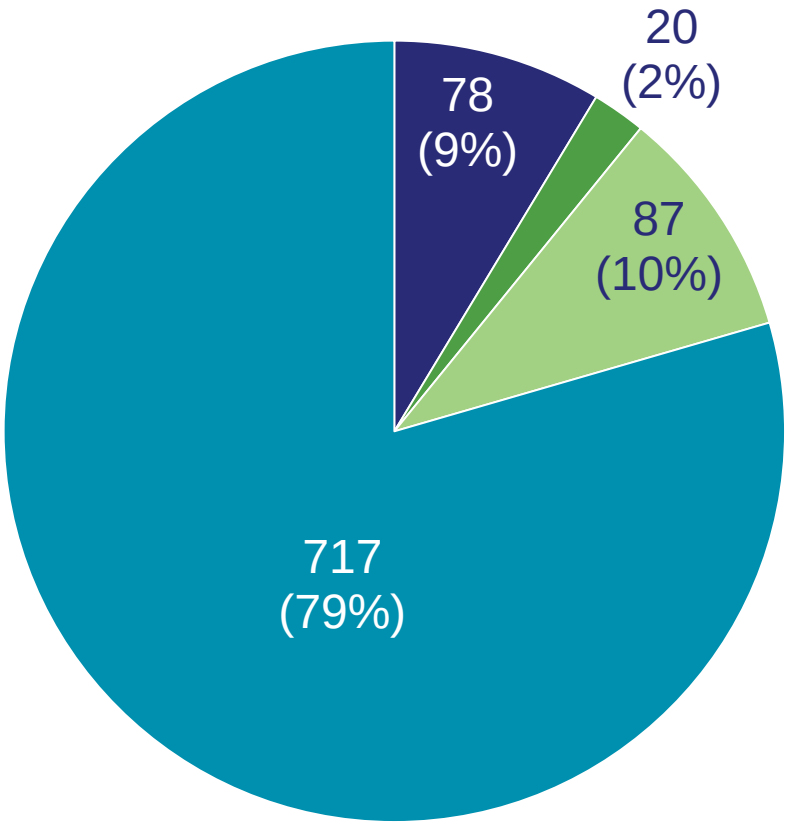
- Poll #1 - We want to know what you are most interested in hearing on this call.



- Press 1 if you're interested in learning how to save money on your monthly premium by taking simple steps.
- Press 2 if you want to learn more about how to decide which health plan is right for you and whether you should consider changing plans.
- Press 3 if you're interested in learning how you may be able to save even more money if you enroll in the CDHP.

Active Poll Question #2-*9/24/15*

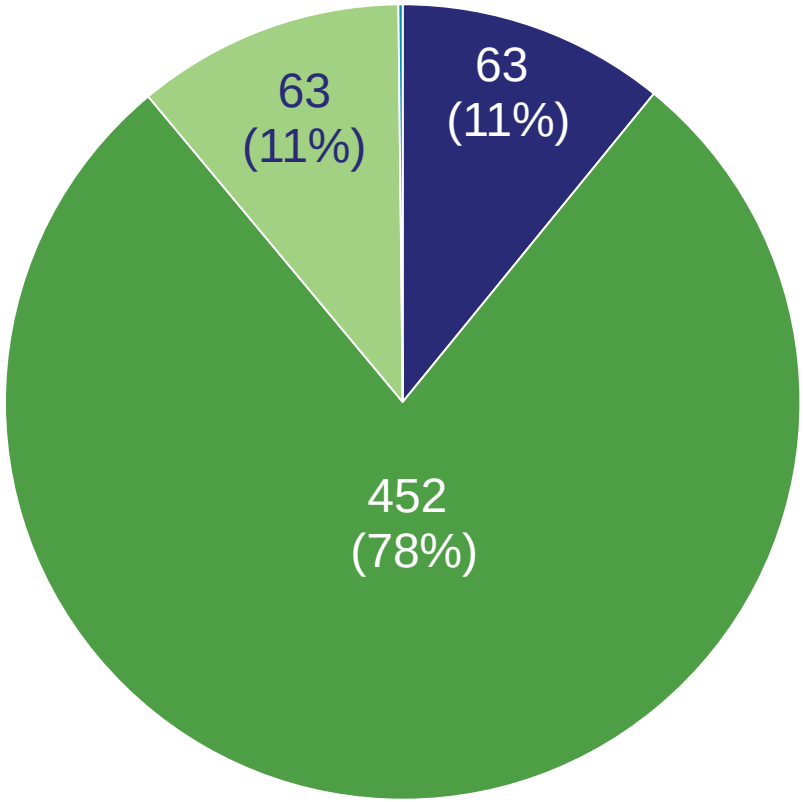
- Poll #2 - Please tell us which wellness activity you think you'll do.



- Press 1 if you'll attest – or confirm – at enrollment that you and your enrolled spouse are non-tobacco users.
- Press 2 if you'll choose a Primary Care Provider if you don't have one now, and if you'll watch a video about PCMH.
- Press 3 if you'll take or update your Health Assessment, if you haven't done so since October 31, 2014.
- Press 4 if you think you'll do all three activities.

Active Poll Question #3-*9/24/15*

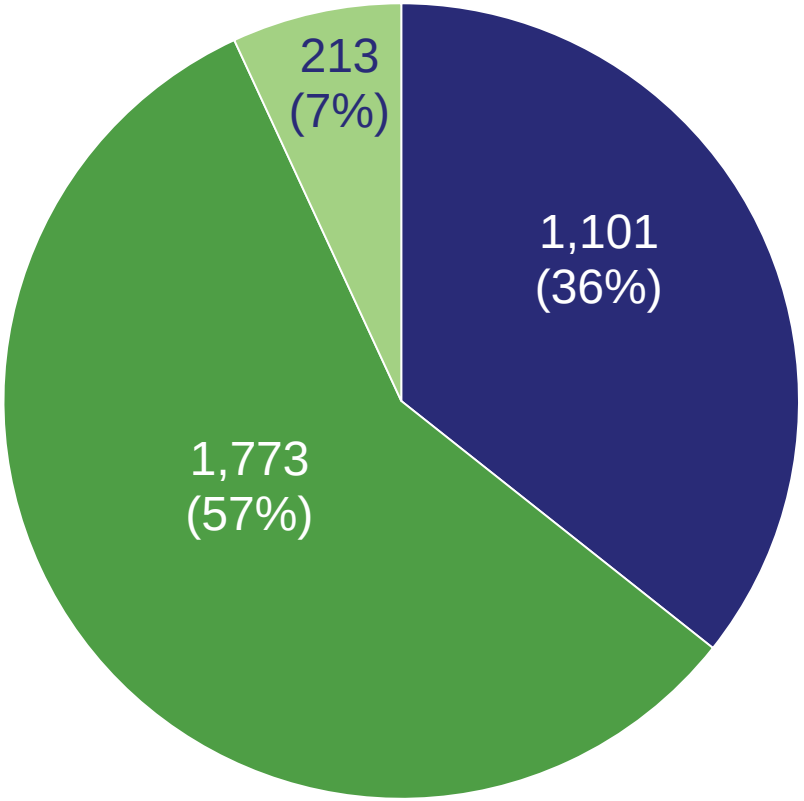
- Poll #3 – What plan do you think you'll choose for 2016 health coverage?



- Press 1 if you think you'll choose the Consumer-Directed Health Plan.
- Press 2 if you think you'll choose the Enhanced 80/20 Plan.
- Press 3 if you think you'll choose the Traditional 70/30 Plan.
- Press 4 if you think you'll decline coverage because you have other coverage—for example, under your spouse's employer.

Non-Medicare Poll Question #1-*9/15/15*

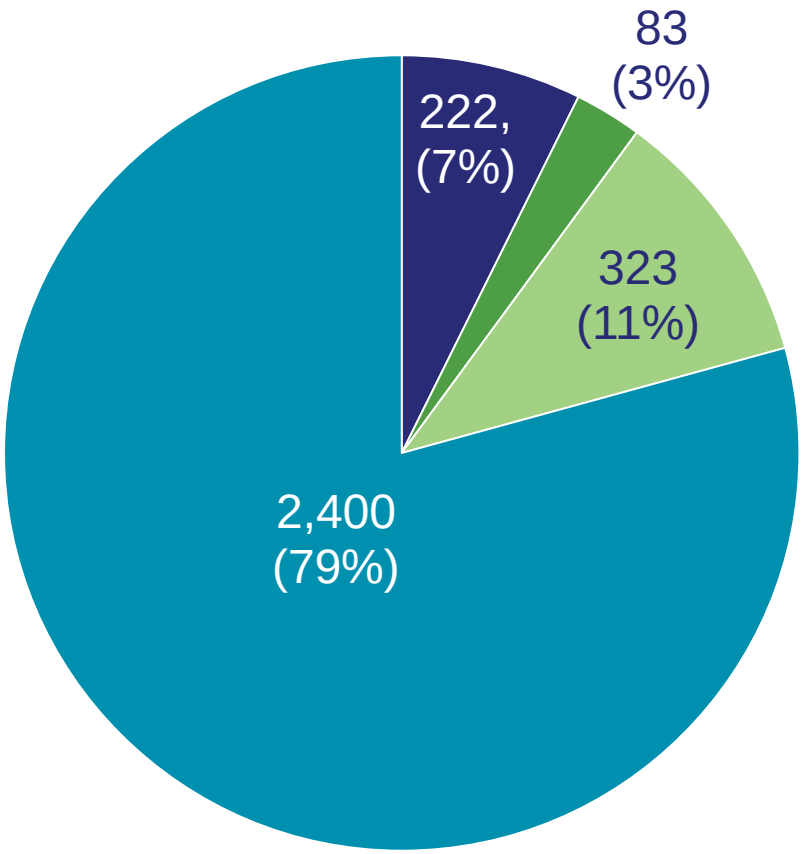
- Poll #1 – We want to know what you are most interested in hearing on this call.



- If you're interested in learning how to save money on your monthly premium by taking simple steps.
- If you want to learn more about how to decide which health plan is right for you and whether you should consider changing plans.
- If you're interested in learning how you may be able to save even more money if you enroll in the CDHP.

Non-Medicare Poll Question #2-9/15/15

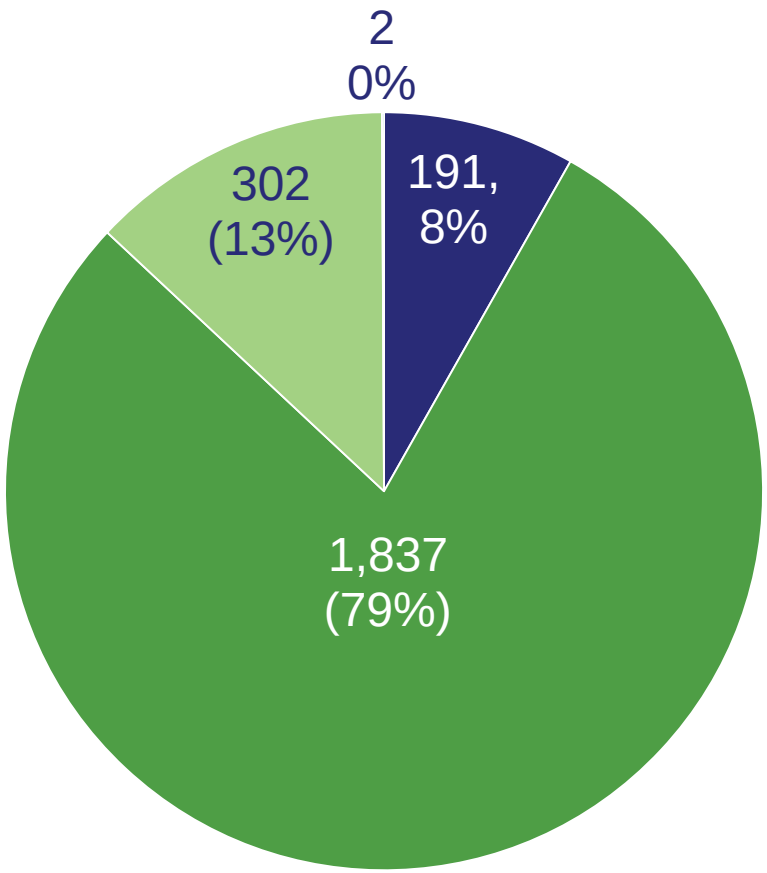
- Poll #2 – Please tell us which wellness activity you think you'll do.



- You'll attest – or confirm – at enrollment that you and your enrolled spouse are non-tobacco users.
- You'll choose a Primary Care Provider if you don't have one now, and if you'll watch video on PCMH.
- You'll take or update your Health Assessment, if you haven't done so since October 31, 2014.
- You think you'll do all three activities.

Non-Medicare Poll Question #3-*9/15/15*

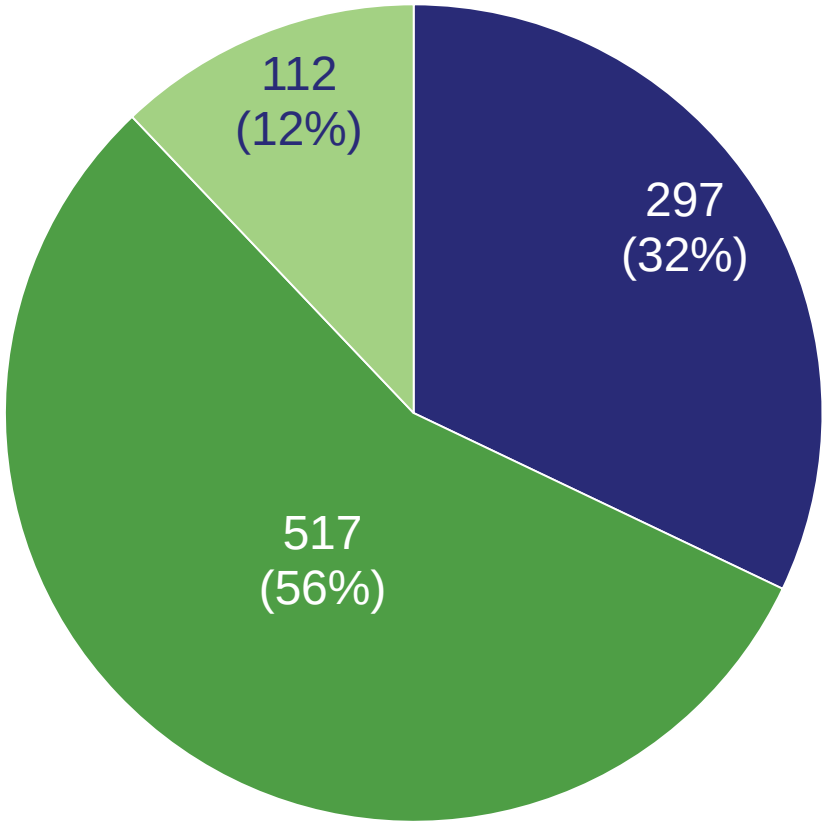
- Poll #3 – What plan do you think you'll choose for 2016 health coverage?



- You'll choose the Consumer-Directed Health Plan.
- You'll choose the Enhanced 80/20 Plan.
- You'll choose the Traditional 70/30 Plan.
- You'll decline coverage because you have other coverage—for example, under your spouse's employer.

Non-Medicare Poll Question #1-*9/17/15*

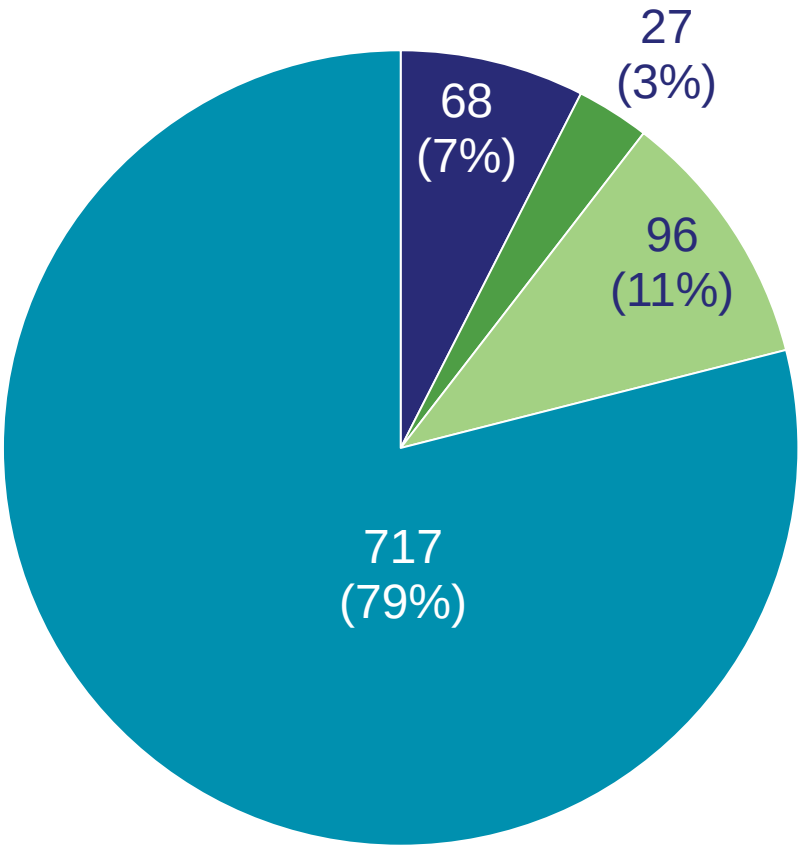
- Poll #1– What are you most interested in hearing on this call?



- Press 1 if you're interested in learning how to save money on your monthly premium by taking simple steps.
- Press 2 if you want to learn more about how to decide which health plan is right for you and whether you should consider changing plans.
- Press 3 if you're interested in learning how you may be able to save even more money if you enroll in the CDHP.

Non-Medicare Poll Question #2-9/17/15

- Poll #2 – Please tell us which wellness activity you think you'll do.



- Press 1 if you'll attest – or confirm – at enrollment that you and your enrolled spouse are non-tobacco users.
- Press 2 if you'll choose a Primary Care Provider if you don't have one now, and if you'll watch a video about PCMH.
- Press 3 if you'll take or update your Health Assessment, if you haven't done so since October 31, 2014.
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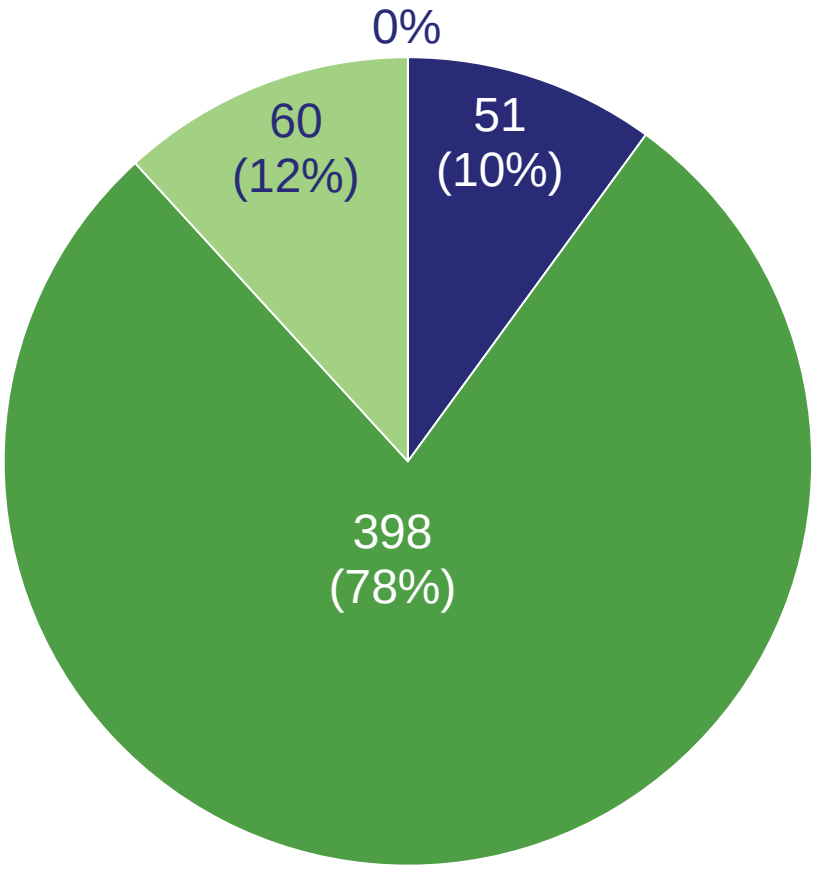
Non-Medicare Poll Question #3-*9/17/15*

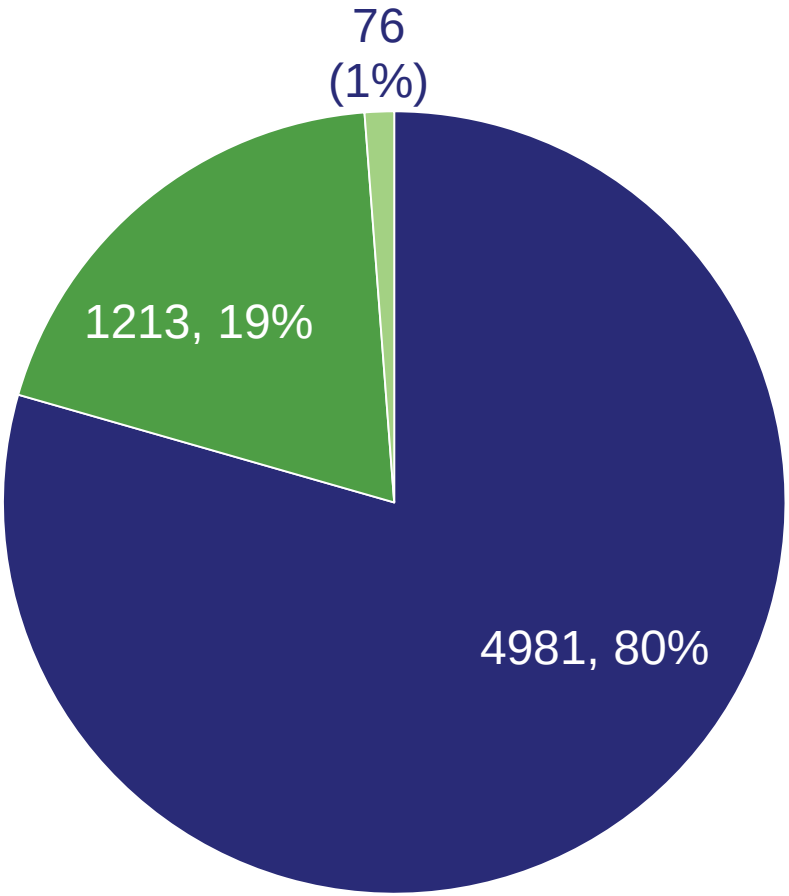
- Poll #3 – What plan do you think you'll choose for 2016 health coverage?



- Press 1 if you think you'll choose the Consumer-Directed Health Plan.
- Press 2 if you think you'll choose the Enhanced 80/20 Plan.
- Press 3 if you think you'll choose the Traditional 70/30 Plan.
- Press 4 if you think you'll decline coverage because you have other coverage—for example, under your spouse's employer.

Medicare Poll Question #1-*9/16/15*

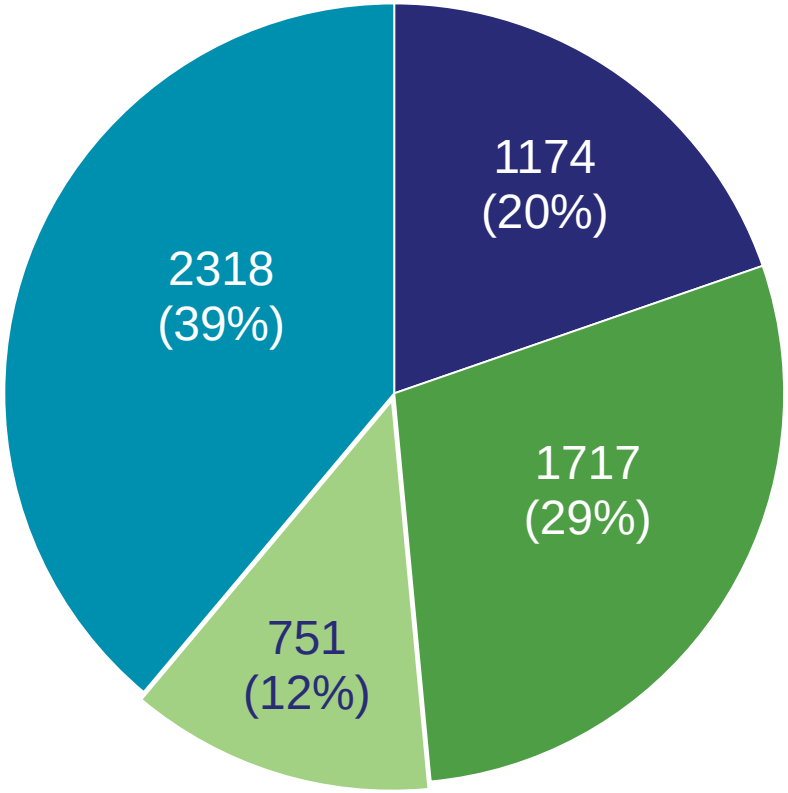
- Poll #1 – We want to know how you are joining this Telephone Town Hall today.



- Press 1 if you are listening from home and you are the only person on the call at your household.
- Press 2 if you are listening from home and you are joined by at least one other person.
- Press 3 if you are listening from a cell phone outside of your home.

Medicare Poll Question #2-*9/16/15*

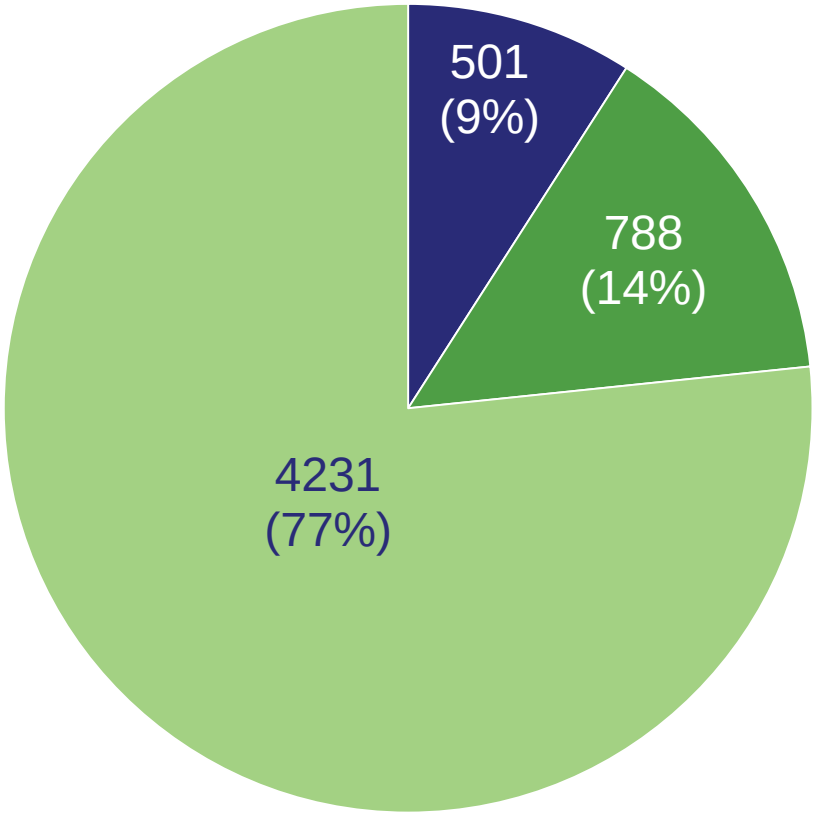
- Poll #2 – Tell us what type of plan you are most likely to enroll in for 2016.



- Press 1 if you're most likely to enroll in a Medicare Advantage Base Plan.
- Press 2 if you're leaning toward choosing a Medicare Advantage Enhanced Plan.
- Press 3 if you are likely to select the Traditional 70/30 Plan.
- Press 4 if you're not sure which plan you'll choose.

Medicare Poll Question #1-*10/08/15*

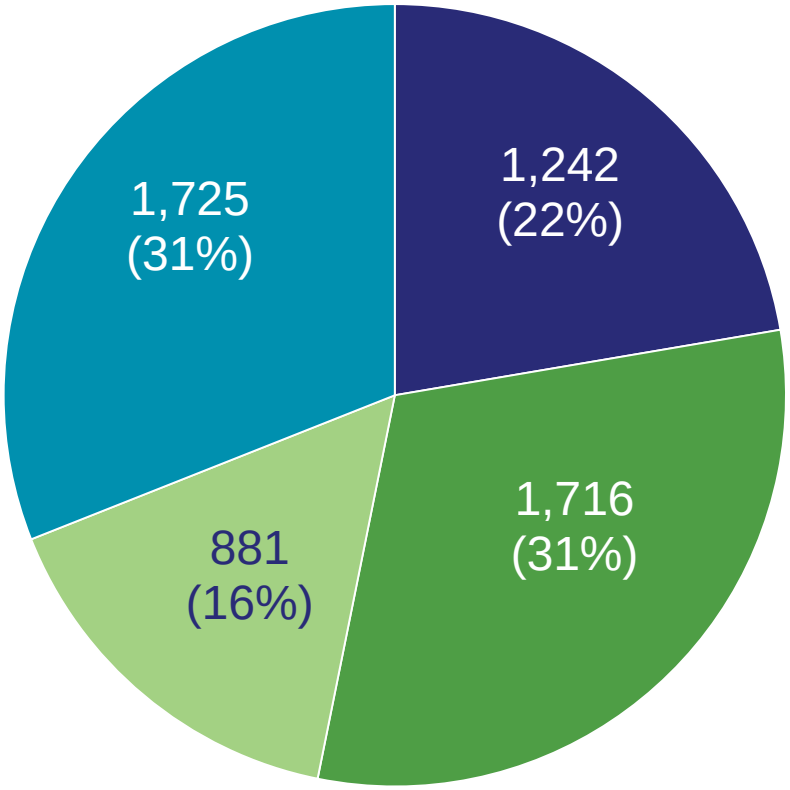
- Poll #1 – Have attended or plan to attend an in-person Medicare Outreach Event.



- Press 1 if you have already attended one the Medicare Outreach Events.
- Press 2 if you have RSVP'd to attend a future Medicare Outreach Event.
- Press 3 if you do not plan to attend a Medicare Outreach Event.

Medicare Poll Question #2-*10/08/15*

- Poll #2 – Tell us what type of plan you are most likely to enroll in for 2016.



- Press 1 if you're most likely to enroll in a Medicare Advantage Base Plan.
- Press 2 if you're leaning toward choosing a Medicare Advantage Enhanced Plan.
- Press 3 if you are likely to select the Traditional 70/30 Plan.
- Press 4 if you're not sure which plan you'll choose.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

2016 Annual Enrollment Outreach & Results

Board of Trustees Meeting

November 20, 2015

A Division of the Department of State Treasurer

Annual Enrollment Preparation

Annual Enrollment: HBR Training Efforts

- HBRs were very engaged with the Plan as we rolled into Annual Enrollment. Not only were we preparing for Annual Enrollment but we were also transitioning back to Benefitfocus, which required a great deal of effort from the HBRs.
- HBR trainings were held at locations across the state and via webinars.
  - The Plan partnered with NCFlex for 8 onsite trainings with 450 HBRs attending
  - 45 onsite trainings were held with 572 HBRs attending
  - 4 webinars were held with 242 HBRs attending

Annual Enrollment: Member Outreach

- Direct Mail Campaign
  - Medicare Invitation to Outreach Meetings
  - Enrollment Decision Guides
  - How Does the CDHP Work? Brochure
  - Reminder Postcards
- 5 Active/Non-Medicare Member Webinars were held with 331 members attending.
- 74 Medicare Primary Outreach Events in 38 counties
- 6 Telephone Town Hall Events
- State Health Plan Website
  - Videos
  - Premium Rate Calculator/Health Benefits Estimator

Annual Enrollment: Medicare Primary Retiree Outreach Events

- 74 Medicare Primary Outreach Events were conducted in 38 counties.
- Received 13,053 RSVPs
- 12,920 individuals attended Outreach Events
- 4,494 of attendees completed a survey
  - 96% were pleased that the State Health Plan has multiple choices for Medicare primary retirees.
  - 96% agreed that the information presented was helpful and easy to understand.
  - 98% agreed that the presenters were clear and knowledgeable.
  - 94% agreed that the location was convenient.
  - 85% heard about Annual Enrollment through the Plan's mailer this year; 10% through email, 8% through the Plan's website and 7% through other means.
  - Of those enrolled in a Medicare Advantage Plan, 51% are very satisfied with their current plan, 16% are somewhat satisfied, 1% are unsatisfied and 3% are neutral.

Annual Enrollment: eEnroll Readiness

- As a reminder, the reimplementation of Benefitfocus will take place in three phases:
  - **Phase I: Go-Live ✓**
  - **Phase II: Annual Enrollment ✓**
  - **Phase III:** Includes separate projects to be kicked off after Annual Enrollment which will address outstanding deficiencies and features that could not be re-implemented in phase II. While not having all of these items did not prevent a member from completing Annual Enrollment, the lack of several of these made it a very "clunky" experience:

- **Single-Sign-Ons (SSO) –** Instead of linking seamlessly from the eEnroll portal to the Active Health portal, members had to sign in separately at Active Health to complete the Health Assessment (HA). The lack of SSOs also impacted BEACON members who had to log in at BEACON and again in eEnroll.

- **WebService –** The second piece missing from the HA was a web service between Active Health and Benefitfocus. This was tied to the SSO and without this web service, the completion of the Health Assessment was not automatically displayed on the members' enrollment screens. A daily file of HA completions was sent from Active Health to Benefitfocus, but there were additional delays before both the credit and the appropriate employee premiums were displayed in eEnroll.

- In addition to the functionality scheduled for phase III, there was one other item we chose to move forward with, even though it could not be integrated prior to Annual Enrollment: the Patient-Centered Medical Home (PCMH) video. The video was placed at the beginning of the enrollment process. If members chose not to watch it, they still received the credit. Again, a bit clunky, but we believed there was value in presenting the video.

Annual Enrollment: eEnroll Readiness

BEACON/NCFlex Enrollment: As a reminder, under our prior contract with Benefitfocus, BEACON members enrolled through BEACON. Therefore, BEACON NCFlex enrollment data was not stored in Benefitfocus. That model changed when we moved to Aon Hewitt and all BEACON enrollment took place in the Aon Hewitt platform. When we transitioned back to Benefitfocus, we agreed that the best model was to have BEACON enroll through Benefitfocus. Unfortunately, none of the BEACON NCFlex enrollment data was housed in Benefitfocus.

Benefitfocus BEACON/NCFlex Data Transition Recommendation: Instead of attempting a data transition, Benefitfocus recommended an active enrollment for all BEACON members wishing to elect NCFlex for 2016.

BEACON/NCFlex Data Transition Solution: The NCFlex team felt strongly that a positive enrollment approach would negatively impact NCFlex enrollment and the program overall so the Plan worked with Benefitfocus and the NCFlex vendors to find a data transition solution for BEACON/NCFlex which was completed shortly before Annual Enrollment began.

Annual Enrollment
October 15, 2015 – November 18, 2015

Annual Enrollment: eEnroll Challenges

- BEACON Members Only
  - **Account Set-Up/Registration** – There were some configuration problems on the first day of AE that impacted BEACON members' ability to self-register; therefore, they had to call the service center. This was corrected by early afternoon.
  - **NCFlex –** As noted earlier, the loading of the BEACON/NCFlex data was not finalized until just before AE started and there were some unanticipated consequences. Primarily, BEACON members were not able to easily access any of their 2016 NCFlex enrollment options. There were workarounds, but they were not optimal. Benefitfocus was able to make a change by the end of day two that alleviated the initial problem. Similar, intermittent problems continued throughout AE. We encouraged all members who could not complete their enrollment online to call the support center.
  - **EOI** – Members are being asked to complete an Evidence of Insurability (EOI) form for guaranteed issued coverage.

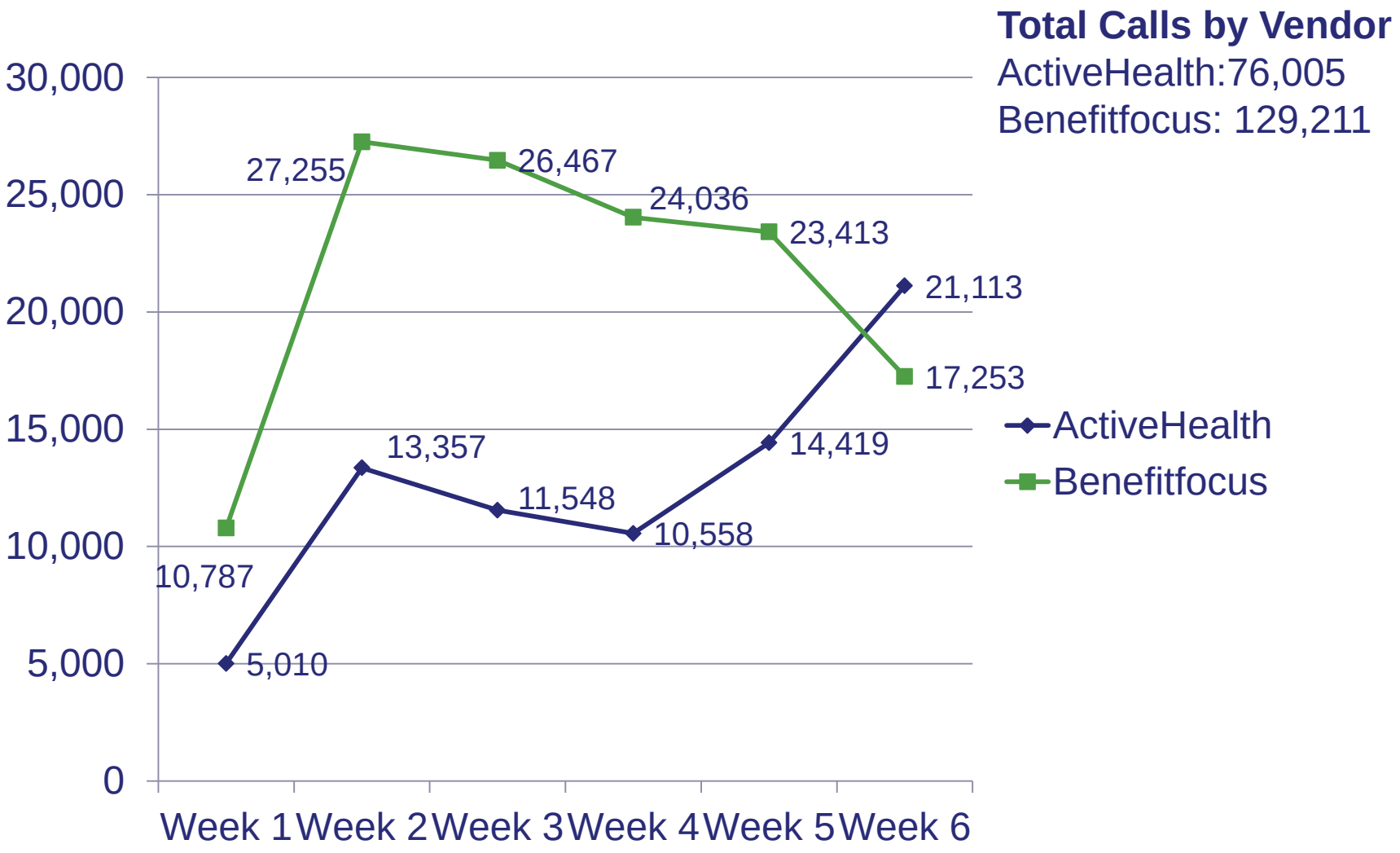
- All Members
  - **Rates –** BF did not load all the rates correctly. During the opening days of AE, some members electing the Enhanced 80/20 plan appeared to have a $0 premium. There were also rate issues on some of the NCFlex plans. The employer rates had to be corrected as well. Even after the rates were corrected in the platform, intermittent rate display issues lingered throughout AE.
  - **Health Assessment (HA) –** The HA itself was working throughout AE, but the need to log in separately to complete the HA coupled with the delayed application of the HA credits led to a great deal of member frustration.
  - **PCMH Video –** There have been some intermittent complaints that either the video didn't play or wouldn't stop playing. This item was difficult to re-create and appeared to be related to the individual members' computer, operating system, pop-up blockers and/or preferences.

Annual Enrollment: eEnroll Challenges

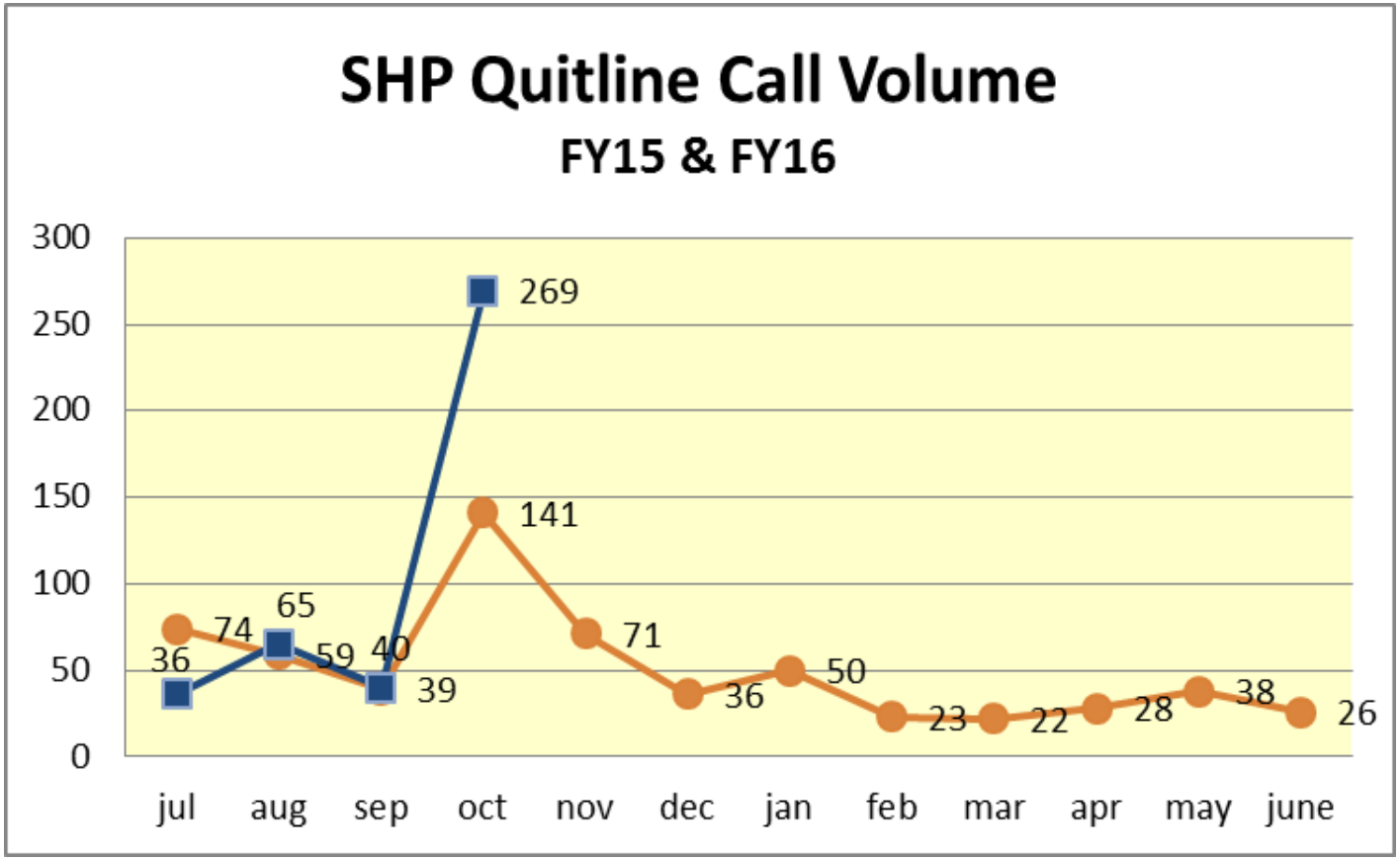
- <u>All Members (con't.)</u>
  - **NCFlex/Health FSA** - The maximum deduction for Health FSA accounts displayed the incorrect amount when AE opened. The issue was fixed that morning.
  - **NCFlex** - Similar to BEACON/NCFlex members, other members with NCFlex sometimes experienced issues where certain NCFlex benefits were "greyed out" and could not be updated which prevented the member from completing enrollment.
  - **Confirmation Statements –** During the first week of AE, the option to print a confirmation statement went away for some members. This was corrected during the second week of AE. Members who called did not receive a confirmation statement. Benefitfocus will not be able to support this requirement until their enhancement is deployed.

- <u>Some Members</u>
  - **Missing Benefit Options**- On opening day, two groups were missing one of the NCFlex options: 1) 2016 Allstate Cancer for Two Rivers Community School, 2) 2016 TriCare Supp plan for UNC Greensboro. Both were corrected on day one.
  - **Error/Unable to Enroll** - UNC Pembroke was unable to enroll online for about a week (2nd week of AE).
  - **Unable to elect Enhanced 80/20** – During the first week of AE, Charlotte-Mecklenburg School members were unable to select the Enhanced 80/20 Plan from the Traditional 70/30 Plan.
  - **Phased Retirees** - Appalachian State is not able to enroll Phased Retirees for 2016 NCFlex benefits

Weekly Call Volume by Vendor



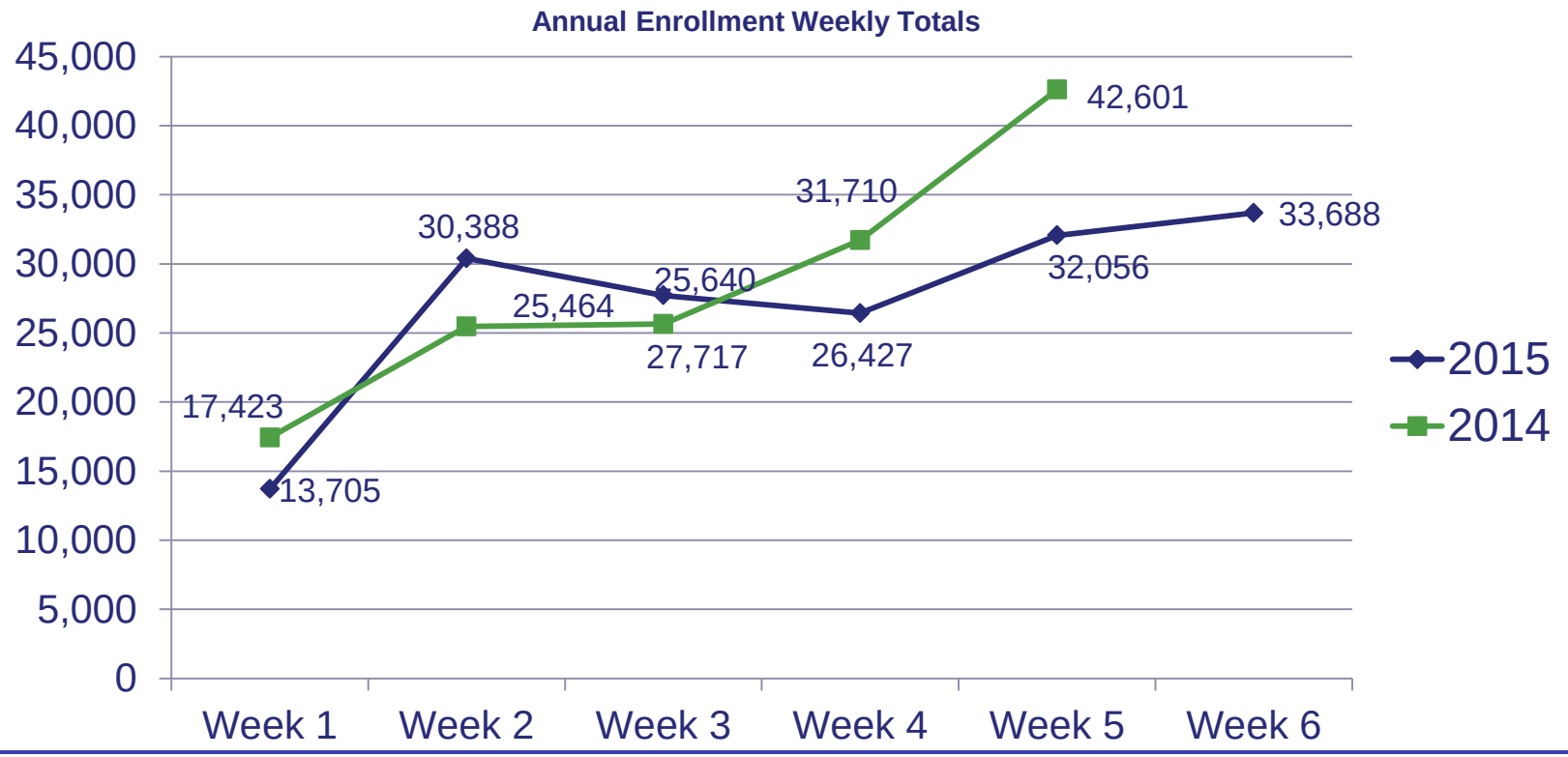
QuitlineNC Call Volume



- October 2014 Multi-call Program Enrollment= 93
- October 2015 Multi-call Program Enrollment = 175

Total Health Assessments

Health Assessment Completions	2015	2014
During Annual Enrollment	163,981	142,838
Carry Over from Previous Completions	36,402	90,530
TOTAL	**200,383**	**233,368**



SHP Website Statistics: August 1 – Nov. 18, 2015

Type of Data	Number
Page Views	3,959,059
Sessions	1,022,352
Visitors	657,334
New Users (visitors that had not previously viewed the site from June 2015 until August 1, 2015)	413,119

SHP Website Page Statistics: August 1 – Nov. 18, 2015

Page	Page Views
Enroll Now	662,698
Annual Enrollment	407,628
Member Login	277,742
Health Assessment	135,437
Find a Doctor	47,505
Upcoming Events	6,981

SHP Website Statistics: Annual Enrollment Period Comparison

Page	2016 AE Data (Oct. 15 – Nov. 18, 2015)	2015 AE Data (Oct. 1–31, 2014*)
SHPNC.org	505,003 Visitors (2,879,413 Page Views)	<250,000 Visitors
State Health Plan Home Page	923,026 Page Views	<240,000 Page Views
Annual Enrollment – Actives	215,601 Page Views	<6,000 Page Views [1]
Annual Enrollment Page	318,679 Page Views	N/A (new page for 2015)
Annual Enrollment – Non-Medicare Retirees	38,732 Page Views	N/A (new page for 2015)
Annual Enrollment – Medicare Retirees	22,962 Page Views	N/A (new page for 2015)

* 2014 data derived from 2014 SHP Analytics Report. [1] Equivalent page on prior SHPNC.org website.

SHP Website Statistics: Annual Enrollment Period Comparison

Site/Page	2015 AE Data (Oct. 15 – Nov. 18, 2015)	2014 AE Data (Oct. 1–31, 2014*)
Member Login	211,217 Page Views	N/A (new page for 2015)
Health Assessment	117,775 Page Views	N/A (new page for 2015)
Find a Doctor	31,994 Page Views	<15,000 Page Views
Upcoming Events	2,449 Page Views	N/A (new page for 2015)
Annual Enrollment Audio/Video Landing Page (Videos and Podcasts)	7,762 Page Views	N/A (new page for 2015)

* 2014 data derived from 2014 SHP Analytics Report.

SHP Website Statistics:
Site Traffic During the Final Three Days of 2016 Annual Enrollment

Page	Visitors	New Users	Page Views
Monday, November 16	39,371	18,923	204,764
Tuesday, November 17	41,278	19,589	218,370
Wednesday, November 18	39,190	18,551	218,988
Totals	**119,839**	**57,063**	**642,122**

2015 Web Statistics via WebTrends

Website Activity: Videos and Tools

Activity	Dates	Number of Clicks
2016 Plan Overview Video	Sept. 18-Nov. 18	15,965
How Does the CDHP Work? Video	Sept. 18-Nov. 18	7,592
2016 Plan Overview (Self-directed) Module	Sept. 18-Nov. 18	16,808
2016 Member Scenario Video	Oct. 28-Nov. 18	1,046
Health Benefits Estimator Tool	Oct. 9-Nov. 18	32,853
Patient-Centered Medical Home Video	Oct. 15-Nov.18	219,382

Active/Non-Medicare Retirees **Net** Subscriber Plan Changes by Week

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Total
CDHP	247	500	506	657	935	1,038	3,883
Enhanced 80/20	(17)	1,422	1,660	1,137	1,742	2,446	8,390
Traditional 70/30	(378)	(1,271)	(1,505)	(1,746)	(1,962)	(2,438)	(9,300)

We will not know the total membership shift until the January membership reports are available in early February 2015.

Medicare Primary Retirees **Net** Subscriber Plan Changes by Week

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Total
Humana Base	(349)	(1,087)	(843)	(46)	(254)	(222)	(2,801)
Humana Enhanced	584	1,270	993	594	473	418	4,332
UHC Base	(2,048)	(4,145)	(3,365)	(1,543)	(1,432)	(794)	(13,327)
UNC Enhanced	2,105	4,763	4,047	2,457	1,967	1,273	16,612
Traditional 70/30	(397)	(880)	(818)	(753)	(726)	(708)	(4,282)

We will not know the total membership shift until the January membership reports are available in early February 2015

2016 Annual Enrollment Engagement

- Our overall Annual Enrollment engagement was much higher during the 2016 Annual Enrollment period than it was during 2015. We answered more calls and more members completed their enrollments.

Overall Enrollment Engagement			
	2015 AE	2016 AE	Percent Increase
Total Calls Handled by Enrollment Call Centers	80,884	129,211	60%
Total Distinct AE Participants	197,467	223,658	13%

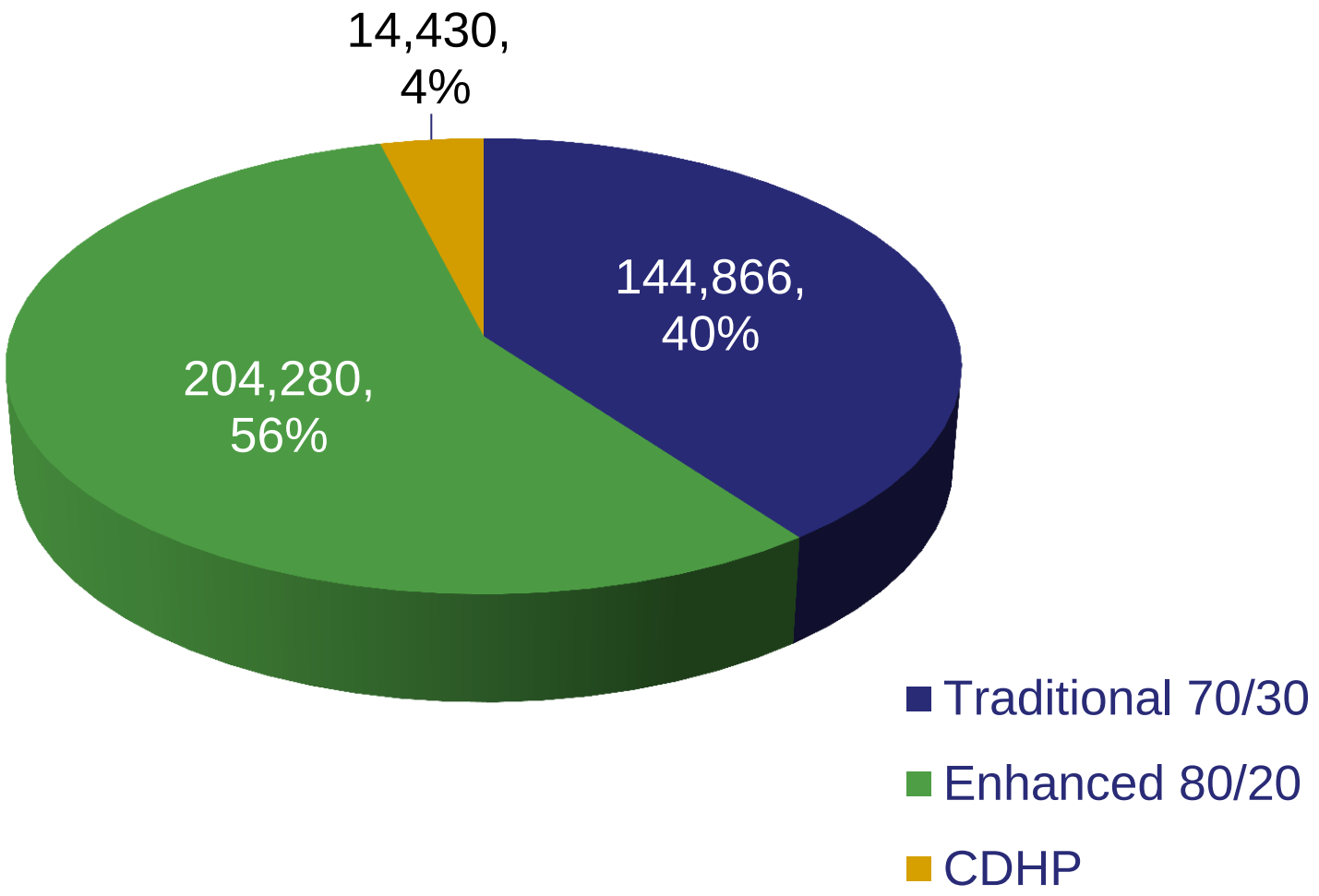
2016 Annual Enrollment Engagement

- Another trend that continued, but more than doubled this year, is the number of members who waited to take action until the last few days of Annual Enrollment.

Enrollments Updated During the Last 3 Days of Annual Enrollment			
	2015 AE	2015 AE	Percent Increase
Third from last day	9,708	18,683	92%
Second from last day	11,677	20,227	73%
Last Day	11,971	20,214	69%

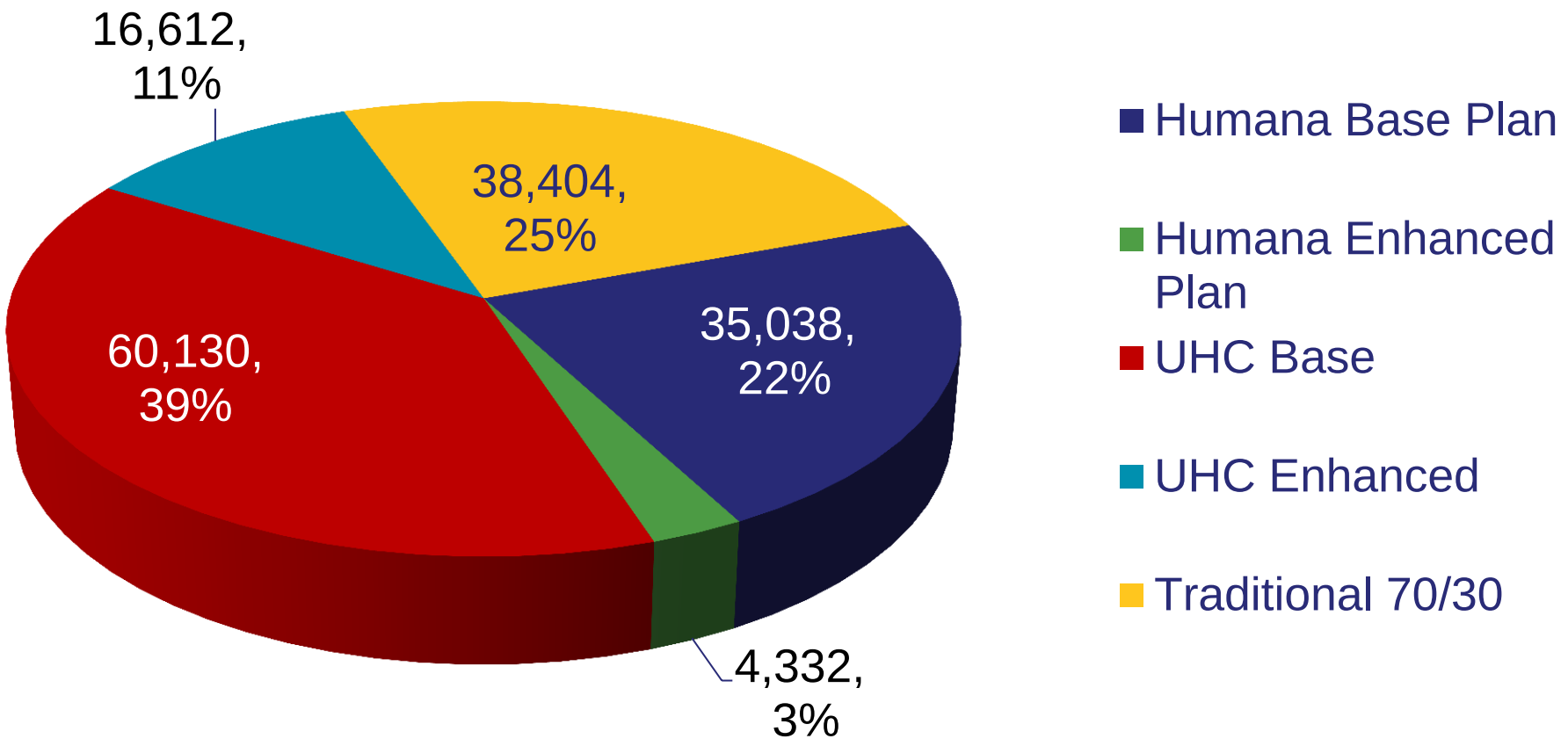
Final Results and Next Steps

Plan Distribution Post Enrollment-Active/Non-Medicare Retirees



These are subscriber only counts.

Plan Distribution Post Enrollment-Medicare Primary Retirees



Traditional 70/30 results do not include dependent counts. Dependents are included in the MAPDP results.

Annual Enrollment – Next Steps

Exception Requests –

- Typically after Annual Enrollment, we see a spike in Exception requests and expect the same this year given the navigation challenges with online enrollment.

ID Cards –

- Based on the current schedule, members who took action during Annual Enrollment should have ID cards by January 1.

Medicare Advantage Disenrollment Period –

- **Medicare Advantage members** have the option to disenroll from a Medicare Advantage Plan and enroll in the Traditional 70/30 Plan from Jan. 1 until Feb. 14, 2016.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

2016 Outreach and Education Strategy

Board of Trustees Meeting

November 20, 2015

A Division of the Department of State Treasurer

2016 Outreach and Education Strategy

- With assistance from Buck Consulting, our communications and marketing firm, we plan to tackle several key areas of engagement during 2016.
  - Members enrolled in the CDHP:
    - Understanding the CDHP and your benefits
    - Promotion of the Health Engagement Program
  - Focus on our Non-Medicare Retirees
    - Pre-65 Outreach meeting and education
    - Introduce monthly webinar series
  - Focus on Active Employees
    - Introduce State Health Plan 101 webinar series

2016 Outreach and Education Strategy

- New Tools and Tactics for Engagement
  - Given the success of the Plan's Telephone Town Hall events for Annual Enrollment, we will be looking into using that method for additional outreach opportunities in 2016.
  - The Plan will research new online tools and estimators to assist members with their health plan and health care decisions.
- Health Benefit Representative Education
  - In an effort to equip HBRs with the tools to make them successful, the Plan will concentrate on providing new training, training guides and modules in 2016 to encourage them to be active partners with the Plan in assisting our members with understanding their benefits.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Premium Contribution Rates

Board Trustees Meeting

November 20, 2015

A Division of the Department of State Treasurer

Presentation Overview

- Executive Administrator Action on 2016 Group Premiums
- COBRA Rates for High Deductible Health Plan
  - *Requires Board Approval*

2016 Group Premiums

Board Action on 2016 Premium Contribution Rates

Excerpt from August 2015 Meeting

Staff Recommendations:

1. Approve 2.83% member premium rate increases on the self-funded benefit options administered by BCBSNC for January 1, 2016, as shown on pages 9-13 of the presentation.
2. Approve increases in member Medicare Advantage rates to reflect 2016 MA renewal rates, as shown on pages 8, 9, and 13 of the presentation.
3. Approve increases in the "other member groups," as described on page 14 of the presentation. [COBRA, 100%, 50%, National Guard, etc.]
4. Approve a 2.83% increase in the total monthly premium rate for HDHP, with increases for employers and employees as shown on page 17 of the presentation.
5. Authorize the Executive Administrator to alter group billing rates effective January 1, 2016 to reflect any increase in the maximum employer contribution enacted by the General Assembly for fiscal year 2015-16 when it becomes law, except rates for "other member groups" will remain the same as described on page 14 of the presentation.

Approved

State Budget: Funding for Employer Contributions

- General Assembly passed a budget with sufficient funding to increase the State's employer contribution by nearly 3.5% beginning January 1, 2016

Maximum Annual Employer Contributions	FY 2015-16
Non-Medicare Members	$5,471
Medicare Members	$4,251

- Governor signed the bill into law on September 18, 2015
- Executive Administrator established for following employer contributions for CY 2016

Monthly Employer Contributions	CY 2015	CY 2016	% Increase
Non-Medicare Members	$448.12	$463.68	3.47%
Medicare Members	$348.24	$360.24	3.45%

COBRA Rates for High Deductible Health Plan

Background and Recommendation

- The Board approved rates for the 2015 High Deductible Health Plan (HDHP) at the August 2014 meeting and approved rates for the 2016 HDHP at the August 2015 meeting
- Although COBRA rates have been approved for all other Plan options, no COBRA rates have ever been set for the HDHP
  - Therefore, COBRA rates need to be established for 2015 *and* 2016
- Federal law allows for up to a 2% administrative fee for COBRA coverage
- In August, the Board approved COBRA rates for other 2016 Plan options
  - The approved rates do *not* charge any additional fee to 2016 COBRA members
- **To be consistent, Plan staff recommends that former employees not be charged an additional administrative fee for HDHP COBRA coverage**
  - **COBRA members would simply pay the total premium (employee and employer share) for HDHP coverage (see page 8)**
- 2015 monthly enrollment in the HDHP has been approximately 175 to 250 subscribers

Recommended Monthly HDHP COBRA Rates

Approved *2015* Monthly HDHP Premium Rates

Coverage Tier	Employee Share	Employer Share	Total Premium	Recommended COBRA Rates
Employee Only	$92.38	$117.62	$210.00	$210.00
+Child(ren)	$262.16	$117.62	$379.78	$379.78
+Spouse	$468.94	$117.62	$586.56	$586.56
+Family	$562.94	$117.62	$680.56	$680.56

Approved *2016* Monthly HDHP Premium Rates

Coverage Tier	Employee Share	Employer Share	Total Premium	Recommended COBRA Rates
Employee Only	$93.16	$122.78	$215.94	$215.94
+Child(ren)	$267.74	$122.78	$390.52	$390.52
+Spouse	$480.38	$122.78	$603.16	$603.16
+Family	$577.04	$122.78	$699.82	$699.82

HDHP COBRA Rate Recommendation

Vote Required:

Plan staff recommends approval of the HDHP COBRA premium contribution rates for calendar years 2015 and 2016 shown on Page 8

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Prescription Home Delivery Pilot Program

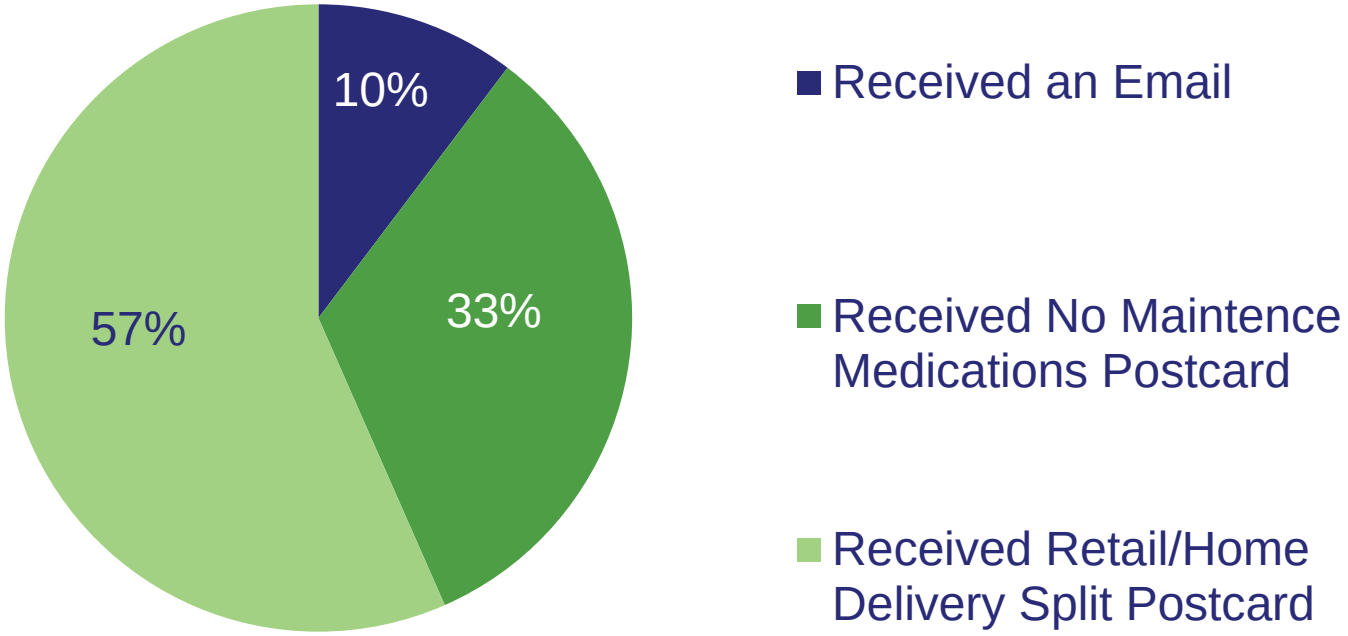
Board of Trustees Meeting

November 20, 2015

A Division of the Department of State Treasurer

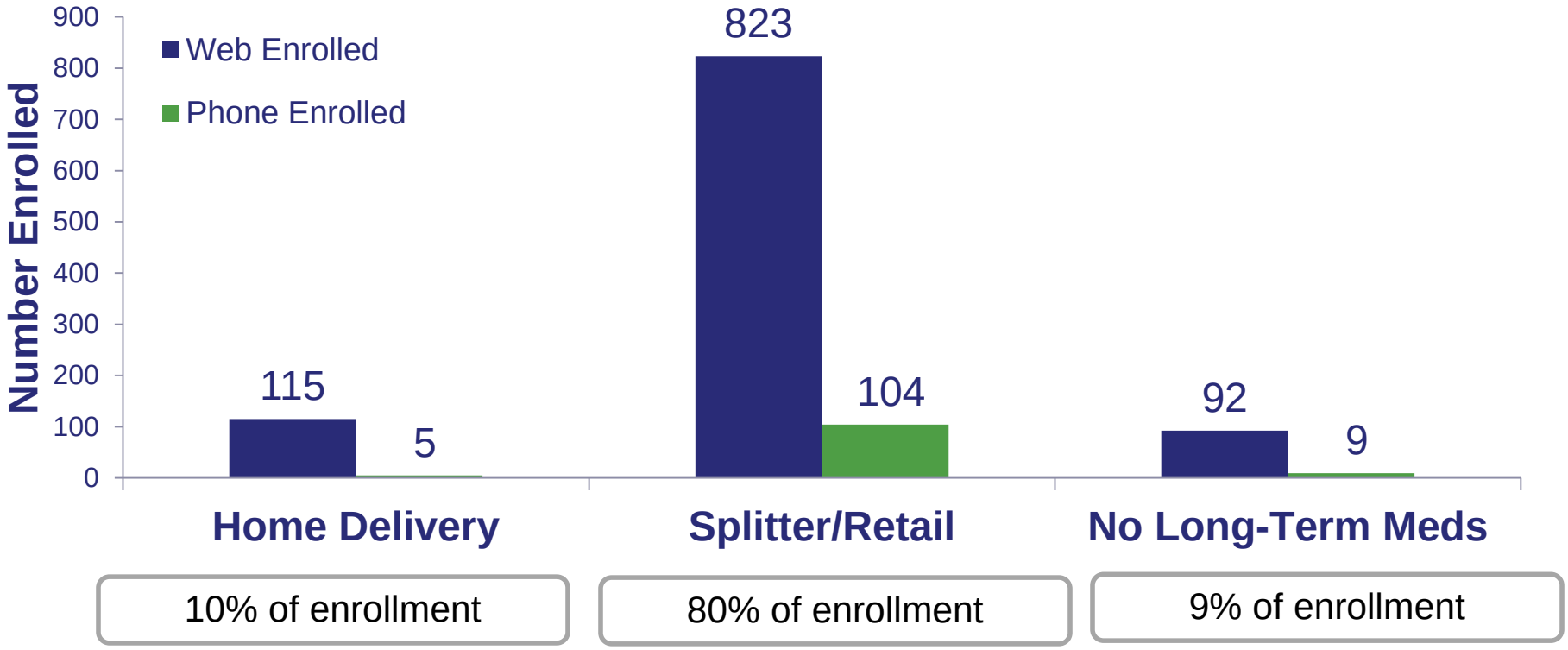
Home Delivery Pilot Program Communication

- Postcards and emails were sent to members in August 2015 announcing the program. Of the members who enrolled, the following communication methods were identified as how learned of the program.



Home Delivery Pilot Enrollment

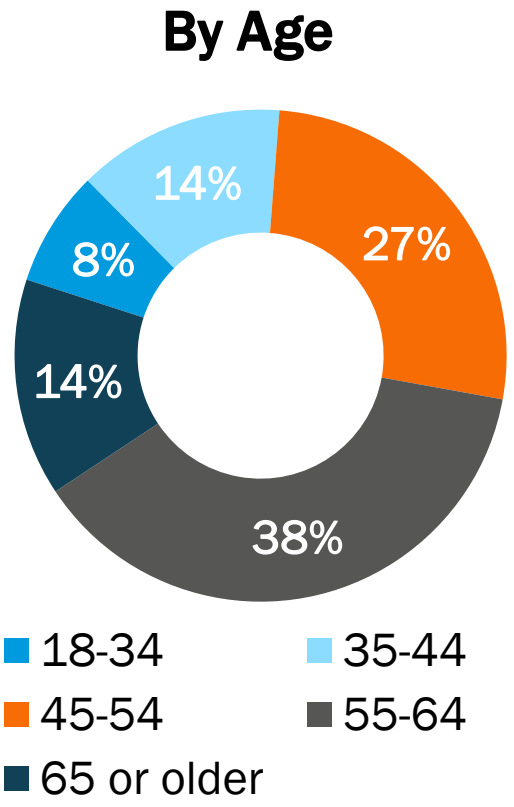
- Enrollment was most successful among those already using the Express Scripts Pharmacy for long-term medications.
- 0.25% of the Plan's membership has enrolled in this program.

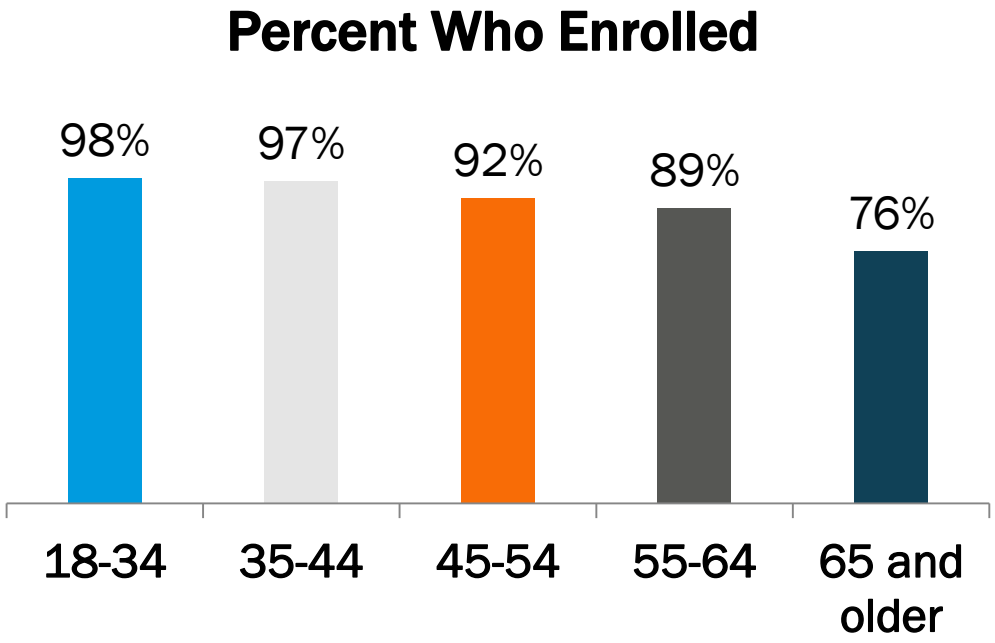


Home Delivery Pilot Demographics

Two-thirds (65%) of members enrolled were between 45 and 64 years old.

- Of those younger than 65, more than 90% were enrolled online
- Among those 65 and older, more than 75% were enrolled online





Home Delivery Pilot Next Steps

- Express Scripts will monitor prescription refills
  - 1St Retail fill- member will be reminded that their prescription could be filled at home delivery
  - 2nd Retail fill- Express Scripts will request prescription from physician and notify member

- Results of prescription refills moved to home delivery from October 2015 to December 2015 will be presented at next Board of Trustees meeting.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Transition Specialty Medications from Medical to Pharmacy Benefit

Board of Trustees Meeting

November 20, 2015

Specialty Medications: Self-Injectables

- Review Current Plan Specialty Medication Administration
- Potential Savings from moving Self-Injectable to pharmacy benefits
- Next Steps

Specialty Medications: Medical Benefit

- Currently, most specialty medications under the CDHP, Enhanced 80/20, and Traditional 70/30 are administered under the medical benefit, not through the pharmacy benefit.

- The HDHP plan, which began in 2015, and is administered by MedCost, follows a slightly different approach and all non-cancer specialty medications are administered through the pharmacy benefit.

- Blue Cross Blue Shield of NC has recently proposed moving self-administered and IV hemophilia drugs to the pharmacy benefit. Plan staff is reviewing options to move **all** specialty medications, other than cancer drugs, to the pharmacy benefit.

Potential Savings: Self-Administered and Infusion Transition to Rx Benefit

	Management Strategy	Therapy	Patients	Paid	Therapy Management Savings	Utilization Management Savings	Total Savings
	Self-administered	BLOOD CELL DEFICIENCY	404	$5,027,73	$471,601	$422,832	$894,434
		INFERTILITY	16	$3,18	$258	$276	$534
		Total	**420**	**$5,030,92**	**$471,860**	**$423,108**	**$894,968**
INFUSION	**Rare disease**	ALPHA-1 DEFICIENCY	4	$435,62	$0	$10,847	$10,847
		ENZYME DEFICIENCY	10	$2,507,32	$18,805	$35,102	$53,907
		HEMOPHILIA	7	$963,35	$24,084	$0	$24,084
		IMMUNE DEFICIENCY	94	$4,432,28	$121,001	$173,746	$294,747
		PULMONARY HYPERTENSION	10	$316,66	$6,523	$15,580	$22,103
		Total	**125**	**$8,655,24**	**$170,413**	**$235,275**	**$405,688**
	Clinician-administered	ASTHMA	69	$1,152,77	$50,261	$115,393	$165,654
		BLOOD CELL DEFICIENCY	4	$50,12	$4,702	$4,215	$8,917
		INFLAMMATORY CONDITIONS	853	$22,830,27	$1,054,759	$1,310,458	$2,365,217
		MISCELLANEOUS SPECIALTY CONDITIONS	79	$313,75	$13,178	$4,393	$17,570
		OPHTHALMIC CONDITIONS	324	$2,624,70	$299,742	$194,228	$493,970
		OSTEO-ARTHRITIS	1,811	$1,827,69	$340,134	$227,548	$567,681
		RESPIRATORY SYNCYTIAL VIRUS	56	$671,99	$17,136	$89,106	$106,242
		Total	**3,196**	**$29,471,32**	**$1,779,910**	**$1,945,341**	**$3,725,251**
		Incremental Pharmacy Rebates	**n/a**				**$3,761,467**
		Grand Total	**3,741**	**$43,157,49**	**$2,422,183**	**$2,603,724**	**$8,787,374**

(Based on medical claims paid between 8/2014 and 7/2015)

Specialty Medications: Next Steps

- Review member impacts
  - Cost-share
  - Disruption and service delivery
- Review provider impacts
- Complete financial analysis
- Work with Plan Vendors on possible implementation plan
- Develop member and provider communication plan
- Develop recommendation for the Board of Trustees

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Potential Benefit Changes for CY 2017

Board of Trustees Meeting

November 20, 2015

Presentation Overview

- Modifications to Healthy Activities
- Primary Care Provider Incentives
- Traditional 70/30 Changes
- Next Steps

2017 Healthy Activities to Reduce Premiums

In February 2015, the Board approved the following Healthy Activities to earn premium credits for CY 2017

Healthy Activity	CDHP	Enhanced 80/20	Traditional 70/30
Non-Tobacco User or QuitlineNC Enrollment	$40	$40	$40
Patient-Centered Medical Home Selection	$20	$25	N/A
Health Assessment Completion with Provider-Reported Biometrics	$20	$25	N/A
Total Credits Available	$80	$90	$40

To address concerns about members' enrollment experience and to recognize the lack of sufficient PCMH providers throughout North Carolina, the Board may want to consider modifying the healthy activities to earn premium credits for 2017.

Potential Modification #1: Selection of PCMH

- A strategic priority for the Plan is maximize the efficiency of the Patient Centered Medical Home (PCMH) model
- The Board approved a premium credit for members who select a PCMH accredited provider (members would no longer receive credit for selecting a PCP)
  - According to Blue Cross and Blue Shield of NC, approximately 40% of Plan members currently utilize a PCMH Primary Care Provider (PCP)
- There appears to be uneven growth of PCMH accredited providers in the State, raising concerns about whether there is sufficient access to PCMHs for the Plan to use this as a healthy activity to reduce premiums.

Potential Modification #1 *Continued*: Replace PCMH Selection with Education on Age Appropriate Screenings

- The Board may want to consider tying future premium credits to ensuring members receive age/gender appropriate screenings (such as mammograms or cholesterol testing) through claims-based adjudication
- This approach would require members to engage their PCP annually to make sure they are receiving the appropriate care
- A future strategy such as this will require significant communication and education to ensure members are aware of and understand their responsibility
  - Having members complete an education module on age/gender appropriate screenings to reduce their 2017 premiums presents an opportunity to educate members as an initial step

Potential Modification #2: Health Assessment and Provider-Reported Biometrics

- There have been significant challenges to the members' experience during CY 2016 Enrollment process
  - One major area of concern has been requiring the member to complete a Health Assessment on the ActiveHealth platform requiring multiple sign-ons
- There is also concern that having providers sign-off on or submit biometric data *in addition to members completing a Health Assessment* would create further difficulties and complexities within the enrollment process

Potential Modification #2 *Continued*: Health Assessment and Provider-Reported Biometrics

- In order to improve the member experience and provide the Plan with relevant information, while still encouraging members to engage with their PCP, the Board may want to consider discontinuing the premium credit for completion of the health assessment in 2017, and instead of requiring provider-reported biometrics, require members to enter the biometric data through the enrollment platform
  - Data would need to be current within the last twelve months
  - Members could contact their provider's office for information or schedule an appointment if data is not current
  - Plan will need to initiate a communication campaign in early 2016 to help members understand the requirement and where to go to get the data

Summary of Approved and Proposed Healthy Activities

Board Approved 2017 Healthy Activities	CDHP	Enhanced 80/20	Traditional 70/30
Non-Tobacco User or QuitlineNC Enrollment	$40	$40	$40
PCMH Selection	$20	$25	N/A
Health Assessment with Provider-Reported Biometrics	$20	$25	N/A
Total Credits Available	$80	$90	$40

Proposed Modified Healthy Activities	CDHP	Enhanced 80/20	Traditional 70/30
Non-Tobacco User or QuitlineNC Enrollment	$40	$40	$40
Education module on Age/Gender Screenings	$20	$25	N/A
Member Entered Biometrics	$20	$25	N/A
Total Credits Available	$80	$90	$40

Modification #3: PCP Copay Reduction

- Rewarding members who select a PCP at the time of enrollment with a copay reduction in the Enhanced 80/20 or HRA credit in the Consumer Directed Health Plan remains a value-based approach to helping members offset cost barriers to care
- The Board may want to consider providing an additional reduction for members who select a PCMH as additional benefit to incent high quality care

Potential 2017 PCP Cost Sharing Modification

Proposed PCP Incentive Strategy	CDHP	Enhanced 80/20
Selection of PCP at time of Enrollment	Required for Copay Reduction	Required for Copay Reduction
Non-Selected PCP Copay	Deductible/Coinsurance	$30
Selected PCP Visit	Deductible/Coinsurance ($25 HRA Credit)	$15
Selected PCMH Visit	Deductible/Coinsurance ($30 HRA Credit)	$10

Modification #4: Move to Annual Cost Sharing Increases in the Traditional 70/30 beginning with CY 2017

- The Board approved a strategy that will increase the cost sharing in the Traditional 70/30 plan every two years to incent enrollment in the Enhanced 80/20 and CDHP
- The strategy appears to be working as preliminary enrollment data for 2016 indicates more members are enrolling in the two wellness plans or the Medicare Advantage plans
- Reducing the value of the Traditional 70/30 plan would also assist the Plan in reaching the savings target required in the State Budget

Next Steps

- Discuss strategy priorities and broader benefit strategy
- Board feedback and workgroups
- Solicit feedback from stakeholders
- Formal benefit recommendations in January
- Vote on CY 2017 benefits
- Communicate benefit changes to members

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Pharmacy Benefit Manager (PBM) Request for Proposal

Board of Trustees Meeting

November 20, 2015

A Division of the Department of State Treasurer

Pharmacy RFP Milestones

Milestone	Time Frames
Pharmacy RFP Released	October 1, 2015
RFP Responses Due to Plan	December 7, 2015
Evaluation Period	December 7, 2015 – January 22, 2016
Finalist Oral Presentations	January 25-29, 2016
Site Visits	February 1–12, 2016
Recommendation to Plan BOT	February 2016
Award of Contract	March 2016

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Pharmacy & Therapeutics Committee
August 2015 Meeting Summary

Board of Trustees Meeting

November 20, 2015

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Updates to Utilization Management Programs

Program	Update
Hepatitis C Prior Authorization	**Viekira Pak:** Removal of requirement for ribavirin to be used in genotype 1b patients with cirrhosis due to results from TURQUOISE-III study
Hepatitis C Prior Authorization	**Daklinza:** New drug for: Genotype 3 hepatitis C in combination with Sovaldi
Hepatitis C Prior Authorization	**Technivie**: New drug for: Genotype 4 hepatitis C-not to be used in patients with CTP score > B
Hepatitis C Prior Authorization	**Sovaldi**: Added combination use with Daklinza for genotype 3 and recurrent HCV-post liver transplantation in genotype 3 patients. Added Technivie to list of medication excluded for combination use. Added retreatment exclusion for patients failing Harvoni, Viekira Pak, and Technivie.

Updates to Utilization Management Programs

Program	Update
Serotonin and Norepinephrine Reuptake Inhibitors (SNRI) Step Therapy Policy	Added new SNRI, Irenka, as a Step 2 product.
Mekinist, Zelboraf, and **Tafinlar** Prior Authorization Policies	Removal of requirement for FDA approved genotype testing, increased approval duration to 3 years, and added hairy cell leukemia to covered indications for Zelboraf.
Antifungal Agents for Onychomycosis Prior Authorization Policy	Added trial of two oral agents or topical ciclopirox solution prior to approval of Jublia and Kerydin. Removed Terbinex, Lamisil, Sporanox, and Onmel from the policy.
Migraine Agents Step Therapy/ Quantity Limit Policy	Added generic almotriptan and dihydroergotamine nasal spray to step 1 product listing. Removed Migranal from step 1 and placed as a step 2 product

Updates to Utilization Management Programs

Program	Update
Revlimid, Thalomid Prior Authorization Policy	Updated approval duration to three years—consistent with other oncology policies.
Promacta Prior Authorization Policy	Removed age requirement for Chronic Immune (Idiopathic) Thrombocytopenia Purpura (ITP)
Pegylated Interferons Prior Authorization Policy	Updated policy to reflect national guidelines and new therapies
Xyrem Prior Authorization	Updated to ESI format and changed name of the current Risk Management Program known as the XYREM Success Program® to the Risk Evaluation and Mitigation Strategy (REMS) Program for XYREM® effective 8/24/15

Updates to Utilization Management Programs

Program	Update
Bisphosphonates Step Therapy Policy	Generics to Actonel in strengths of 5, 30 and 35 mg tablets added to Step 1. Generics to Atelvia (risedronate 35 mg delayed-release tablets) added to Step 1. Criteria removed regarding exceptions for Actonel in patients with Paget's disease who have already started therapy with Actonel tablets.
Copaxone Prior Authorization Policy	Added new drug, Glatopa, to the policy Added Lemtrada® (alemtuzumab injection for intravenous use) and Plegridy™ (peginterferon beta-1a injection) to the list of medications that should not be given concomitantly with Copaxone or Glatopa.
Betaseron/Extavia Prior Authorization Policy	Updated policy to add Glatopa as a Step 1 product

New Utilization Management Programs

Program	Description	Member Impact	Estimated Projected Savings	P&T Recommendation	Implementation
Oral Oncology Drugs (Pharmaco-genomics) Prior Authoriz-ation Policies	New policies for: Afinitor, Bosulif, Gilotrif, Gleevec, Iclusig, Revlimid, Sprycel, Stivarga, Tarceva, Tasigna, Thalomid, Tykerb, Xalkori and Zykadia	0 (Current utilizers grandfath-ered)	$1,730,514	Yes	October 1, 2015
Entresto Prior Authorization Policy	A new drug approved for the treatment of heart failure	5 members grandfath-ered for two months	New drug	Yes	September 11, 2015

New Drugs for Formulary Consideration

Drug	Indication	Tier Placement
Hysingla™ ER (hydrocodone bitartrate ER tablets)	Long-acting pain medication	3
Saxenda® (liraglutide [rDNA] injection)	Adjunct to diet and increased physical activity for chronic weight management	3
Rytary™ (carbidopa and levodopa extended-release capsules)	Parkinson's Disease	3
Soolantra® (ivermectin cream, 1%)	Rosacea	3
Toujeo® (insulin glargine injection U-300)	Diabetes Mellitus	3
Trulicity™ (dulaglutide for subcutaneous injection)	Type 2 Diabetes Mellitus	3
Glyxambi® (empagliflozin/linagliptin)	Type 2 Diabetes Mellitus	3

New Drugs for Formulary Consideration

Drug	Indication	Tier Placement
Xigduo™ XR (dapagliflozin / metformin ER)	Type 2 Diabetes Mellitus	3
Movantik® (naloxegol tablets)	Opioid-induced constipation	2
Savaysa™ (edoxaban tablets)	Faxtor Xa inhibitor to reduce risk of stroke/embolism and treat deep vein thrombosis and pulmonary embolism	3
Cresemba® (isavuconazonium sulfate)	Oral antifungal	2
Tybost® (cobicistat tablets)	Human immunodeficiency virus (HIV)	2

New Drugs for Formulary Consideration

Drug	Indication	Tier Placement
Evotaz™ (atazanavir and cobicistat)	Human immunodeficiency virus (HIV)	2
Vitekta® (elvitegravir tablets)	Human immunodeficiency virus (HIV)	3
Belsomra® (suvorexant tablets)	Insomnia	3

Additional Topics

- High Cost Generics:
  - The following generics were future coded for Tier 2 placement due to anticipated generic cost:
    - rabeprazole sprinkles (Aciphex Sprinkles), dutasteride (Avodart), derifenacin (Enablex), tamsulosin (Jalyn), armodafinil (Nuvigil), clindamycin/tretinoin (Ziana), rivastigmine tartrate patch (Exelon)
  - The following generics were moved from Tier 2 to Tier 1:
    - rabeprazole (Aciphex), celecoxib (Celebrex)

- ADDYI indicated for the treatment of hypoactive sexual desire disorder in premenopausal women was excluded from pharmacy benefit coverage
  - Drugs for sexual dysfunction are not covered by the Plan, per NCGS §135-48.52(7);

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Affordable Care Act Employer Reporting Requirements

Board of Trustees Meeting

November 20, 2015

ACA Employer Reporting Requirements

- The Patient Protection and Affordable Care Act (ACA) enacted IRS Sections 6055 and 6056—each of which requires various information to be reported to the IRS and provided to certain individuals.

- Section 6055 requires all "plan sponsors" to file a yearly report to the IRS that identifies the months that any individual (employee, former employee, dependent, etc.) were enrolled at least one day in Minimum Essential Coverage (MEC) provided by the plan sponsor. A report will be furnished to each "responsible individual" as well.

- Section 6056 requires every applicable large employer (ALE) to file a yearly report regarding coverage offered each month (if any), and the scope of coverage offered, to any employee of the ALE who was full time (as defined by Code Section 4980H) at least one month during the year.

ACA Requirements: 6055 / 6056 Reporting

6055 Reporting

- The purpose of the reporting is to assist with the individual minimum essential coverage mandate. For self-insured plans (like the State Health Plan) this responsibility falls on the “plan sponsor” (see next slide).

6056 Reporting

- The purpose of this reporting is to administer the employer shared responsibility provisions of Section 4980H of the IRS code and the Code Section 36B premium tax credit for Exchange coverage. This obligation falls on each ALE regardless of whether the plan through which any coverage is offered was fully insured or self-insured.

6055 Reporting Obligations - Plan Sponsor

- The rules define the plan sponsor of a self-insured plan, such as the SHP, as any entity in the following categories:
  - #1: Each participating employer in a plan established or maintained by more than one employer;
  - #2: The joint board of trustees, association or committee of a multi-employer plan (plan maintained by a union and employers pursuant to a CBA);
  - #3: The employee organization if plan is maintained by an employee organization;
  - #4: If not described above, then the entity identified in the documentation that maintains the plan.

- After detailed analysis, discussion with outside counsel, and informal comments with IRS (conducted by outside counsel), we believe that the Plan is in Category #1 above.
  - All employing units will report employees, former employees (last employed by the unit) and their dependents enrolled in the SHP

ACA Requirements: Forms 1094 & 1095

Compliance reporting is accomplished via IRS Forms 1094 and 1095

- **Form 1095** is delivered to each Responsible Individual or Full-time Employee. This form is also filed with the IRS for each individual.
  - Responsible individual is an individual (other than an employee who was full time at least one month) who has the enrollment right or who should otherwise receive a 1095 (based on facts)
- **Form 1094** is a transmittal form that is filed with the IRS along with the 1095s. The process is analogous to W3/W2 filings.

B and C Versions

- **B Version** is designed for coverage providers to satisfy their 6055 reporting obligations
  - Generally not applicable to ALEs (such as most of the employing units)
- **C Version** is designed for applicable large employers (ALE) to satisfy both 6055 and/or 6056 obligations.

ACA Requirements: Self-Insured Reporting

- Self-insured employers who are ALEs must comply with both Section 6055 and 6056.

- ALEs that participate in the SHP may use the C version exclusively to the extent that they have Social Security numbers for all "Responsible Individuals."
  - B-Series must be used by non-ALE employing units whose employees/former employees participated in the Plan or
  - Employing unit does not have SSN of responsible individual

- **C Version** contains a section where enrollment data may be reported and a check box to indicate self-insured.

ACA Requirements: Data

- **No one entity has all of the data needed to complete the forms.**
- **State Health Plan** – Some information resides within the Plan's eligibility and enrollment services vendors' systems
- **Retirement Systems** – Some information resides within the Retirement Systems
- **Employing Unit** – Some information resides within the employing units' payroll systems

- When the Plan transitioned to Aon Hewitt earlier in the year, a project was deployed to aggregate Benefitfocus and Aon Hewitt data to support the employer reporting requirements. Because of the transition back to Benefitfocus, the original solution was never rolled out to the employing units.

ACA Requirements: Reporting Support Options

- **In late September, after a new support plan was in place with Benefitfocus, the Plan announced two reporting support options:**
  - **Full Service:** Includes data file generation, form 1095 and 1094-C forms and IRS filing, printing, mailing and call center support.
  - **Data Only:** Includes data file generation for all employees and dependents in the Benefitfocus system, retirees, COBRA and HDHP members.

- **In mid-October, at the request of several employing units who had already contracted for a reporting solution, the Plan developed at third option:**
  - **Retiree Only Data:** Includes data file generation for retirees and a list of COBRA and HDHP members.

- The cost of the full-service option is $6 per 1095 plus postage.
- The cost of the data-only options are $4 per 1095.
- When the options were first announced, the Plan agreed to cover $2 per 1095 for each option.
- Because the options and costs were rolled out to the employing units so late in the year, the Plan determined the best course of action was to cover the full cost of the 1095s for this reporting period.The employing units will cover the cost of the postage.
- The Plan will revisit the solution and the funding for the solution before the next reporting period.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Future Planning

Board of Trustees Meeting

November 20, 2015

A Division of the Department of State Treasurer

Presentation Overview

- State Budget, SL 2015-241
  - Special Provisions
  - Short-term vs. Long-term approaches
    - Starting in 2017 vs. waiting until 2018
- Levers for Reducing Cost Growth
  - Member cost-sharing
    - Premiums
    - Cost-Share
  - Provider Payments
  - Improve Health
  - Member Health

State Budget Impact on Planning Future Benefits

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

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

Implications of Budget Provisions

- SL 2015-241, Section 30.26 (a) and Section 30.26 (b) directly and indirectly mandate the Plan to reduce costs to the employer contribution and use fewer reserve dollars in the short term. The implications are that future dollars will need to come from sources other than the State General Fund in coming fiscal bienniums, which will require cost-shifting measures or reductions in spend

Timeframe	Mechanism to Reduce Employer Increase	Certainty in Cost Saving
Short Term	Member Cost-Sharing Increases Provider Networks	Higher Short Term
Midterm	Provider Reimbursement	Unlikely in Short Term TBD in the Long Term
Long Term	Improve Member Health	Potential Cost in Short Term Long Term savings likely

Opportunities to Reduce Cost Growth

Members

- Premium based
  - Across the Board Premium Increase
  - Increases through Premium Credits
  - *Removal of Spousal Coverage*
- Cost-Sharing based
  - Across the board increases
  - 70/30 strategy moves to annual basis
  - Value-based increases
    - ER
    - Reference price labs
    - Rx tiering

Members and Providers

- Premium based
  - Narrow network offerings
    - Medical
    - Pharmacy
  - *Mandatory Wellness*
- Cost-sharing based
  - Tiering based on quality and price
  - Bundled Payments
  - ACOs

Providers

- Premium and Cost-sharing
  - Cut reimbursements
  - Move to downside risk arrangements where possible

Items in italics would require legislative changes

Opportunities to Reduce Cost Growth that Can Improve Members Health in the Long Term

Members

- Premium based
  - Across the Board Premium Increase
  - **Targeted Increases through Premium Credits**
  - Removal of Spousal Coverage
- Cost Sharing based
  - Across the board increases
  - **70/30 strategy moves to annual basis**
  - **Value-based increases**
    - **ER**
    - **Reference price labs**
    - **Rx tiering**

Members and Providers

- Premium based
  - **Narrow network offerings**
    - **Medical**
    - **Pharmacy**
  - **Mandatory Wellness**
- Cost-sharing based
  - **Tiering based on quality and price**
  - **Bundled Payments**
  - **ACOs**

Providers

- Premium and Cost-sharing
  - Cut reimbursements
  - **Move to downside risk arrangements where possible**

Quantifying Opportunities

- Segal provided estimates of savings opportunities at a recent Board meeting that began to quantify multiple opportunities to reduce cost growth
- Based on our most recent forecast to reduce premium growth to about 6% annually *and* maintain a 20% reserve through the biennium, the Plan will need to generate approximately $850m in savings
  - The General Assembly has not indicated whether 6% cost growth would be sufficient
- Changes could be implemented for CY 2017 and CY 2018 benefits
  - Recently, more significant changes have been made in even-numbered years
  - By holding off changes until CY 2018, we run the risk of having to make larger reductions, not meeting the 20% reserve threshold, and/or putting CY 2017 employer contributions at risk

Timeline for Implementing Benefit Changes

2016

- Benefit designs are set for CY 2016
- Approve changes for CY 2017
- NCGA determines if changes are sufficient for release of FY 2016-17 increase
- Award PBM contract for CY 2017
- Monitor reserves and forecast results

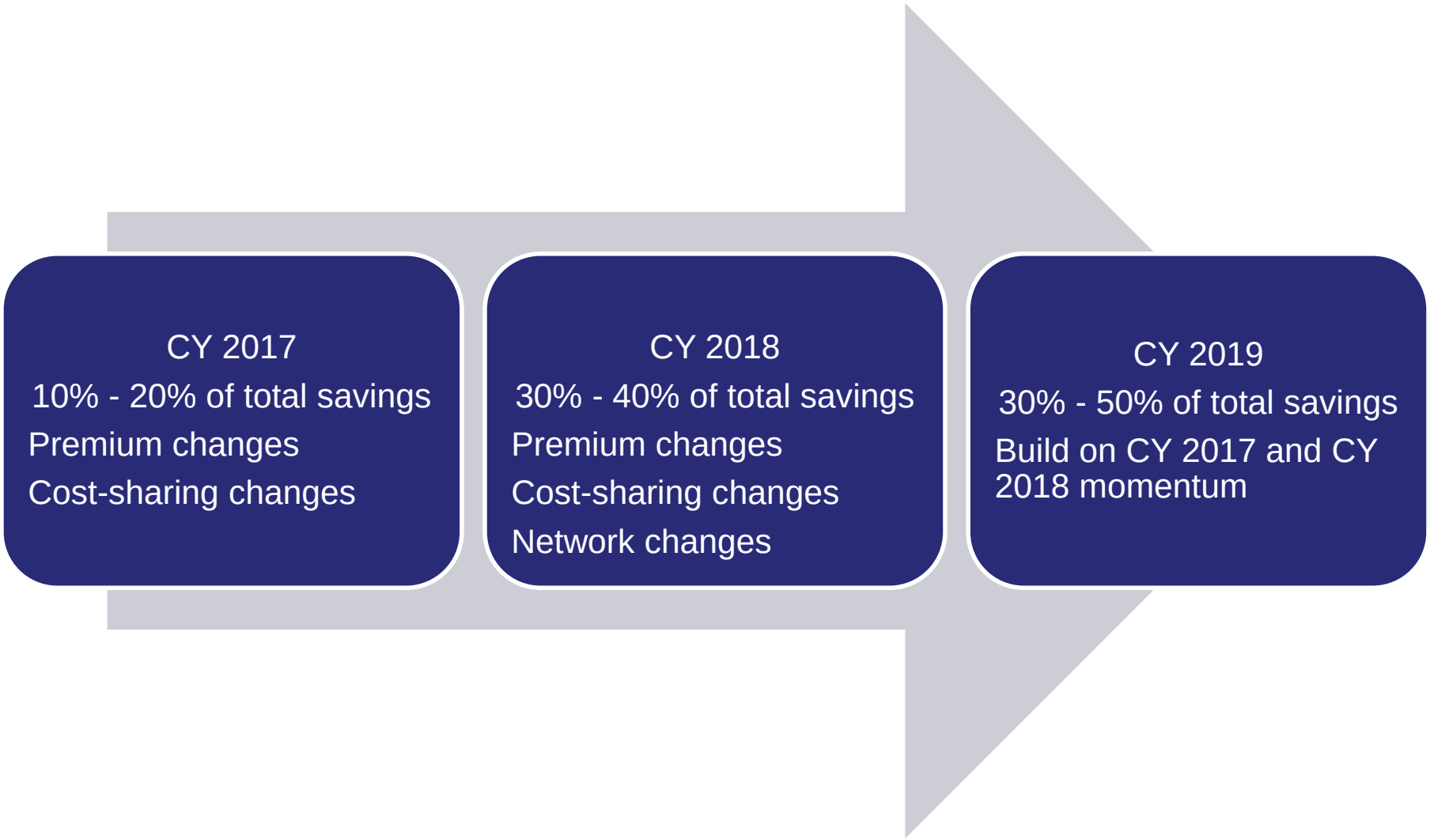
2017

- Approve benefit designs for CY 2018 and CY 2019
- Work with NCGA on CY 2018 and CY 2019 premium increases
- Monitor reserves
- Track impact of benefit changes on CY 2018 forecast

2018 *and beyond*

- Third Party Administrator RFP
- Potential network changes
- Evaluate provider payment strategies and opportunities
- Identify potential large scale partnerships

Breakdown of Annual Savings Goals by Benefit Year



Overview of Network-Based Approach

- **Strengths:**
  - Providers agree to charge less for services
  - Networks inclusion can be tied to discounts and quality
  - Likely to generate meaningful savings; however, not the full amount needed
- **Challenges:**
  - Members have less choice in providers and likely to disrupt some members' care
  - Not actionable uniformly throughout North Carolina
  - Provider pushback

Overview of Cost-Sharing Based Approach

- **Strengths:**
  - Can be done in a value-based manner that could mitigate impact on engaged members
  - Can steer members to higher quality providers that could lead to healthier members
  - Likely to generate meaningful savings; however, not the full amount needed
  - Across-the-board approach would generate meaningful long-term savings
- **Challenges:**
  - Members have been slow to embrace “carrot” approach on hospitals, specialists, and/or PCPs
  - Unengaged members may pay more for care or not access care
  - Current cost-sharing does not compare favorably to other states

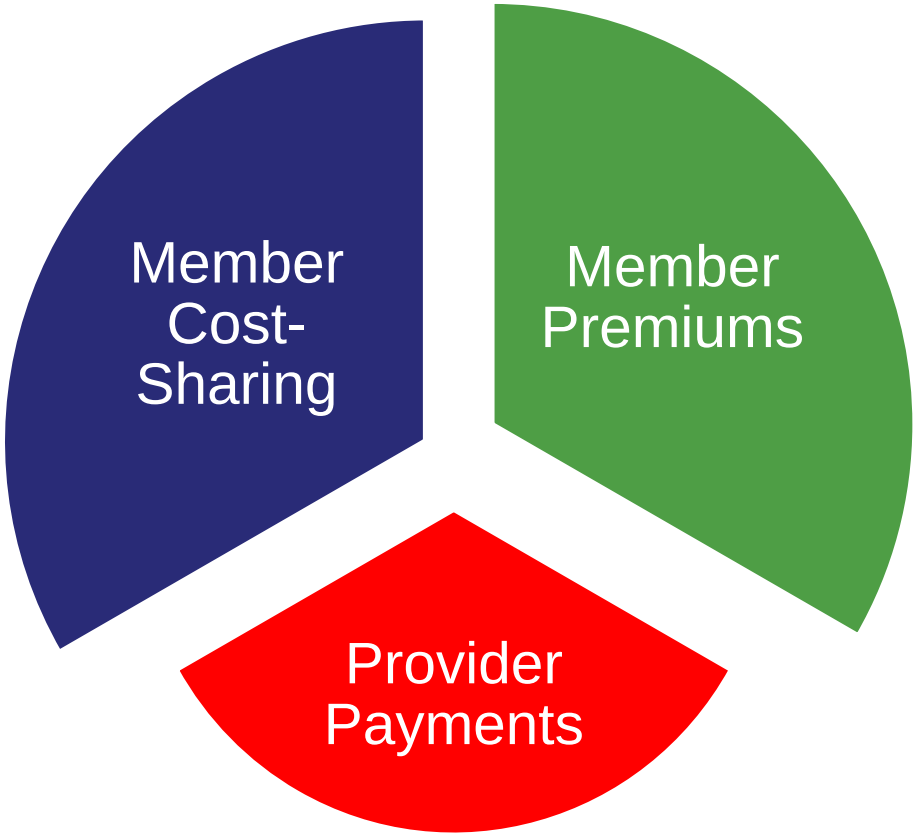
Overview of Premium-Based Approach

- **Strengths:**
  - Most predictable approach to generate significant savings
  - Could be centered around wellness and engagement to offset member impact
  - Individual coverage is on the lower end of costs compared to other states
- **Challenges:**
  - Would further decrease dependent coverage affordability
  - Unengaged members may pay more for care or not access care

Benefits Change Discussion

- **Options to consider:**
  - Changes to premium structure – *Most likely to reduce employer increase*
  - Changes to cost-sharing structure – *Likely to reduce employer increase; however, depending on magnitude, likely to adversely impact member health*
  - Implement new benefit (such as HDHP) – *Likely to reduce employer increase; however, likely to adversely impact member health*
  - Long-term provider strategy – *Longer term strategy*
    - Opportunity in short term is more around Pharmacy Benefit
  - Do nothing and forgo CY 2017 increase to employer contribution – *Forces large employee increases going forward*

Areas to Generate Savings in the Short Term



Next Steps

- Board feedback on potential benefit changes
- Plan staff develops recommended benefit design for January Board meeting
- Plan staff works with BCBSNC on cost-savings opportunities
- Board votes on design in February
- Monitor budget and member utilization
- Identify opportunities to reduce employer contribution

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Strategic Plan Annual Update

Board of Trustees

November 19, 2015

Presentation Overview

- Review of Current Strategic Plan
  - Improve Members' Health
  - Improve Members' Experience
  - Ensure Financial Stability
- Progress Report of Priorities and Initiatives
- Why Refresh the Strategic Plan?
- Strategic Planning Updates and Evaluation
- Staff Observations of Strategic Plan
- Timing to Update Strategic Plan

Layout of the Strategic Plan

- Strategic Priorities
  - 3 broad goals
  - Each includes 3 to 4 Initiatives per priority
- Strategic Initiatives
  - What We Will Do
  - Each Initiative contains 1 to 3 Projects and/or Programs
- Projects and Programs Roadmap
- Strategic Metrics
  - Review in April with complete CY 2015 data

Strategic Plan Priority Areas

Strategic Priority	Key Initiatives
Improve Members' Health	• Maximize Patient Centered Medical Home (PCMH) Effectiveness • Assist Members to Effectively Manage High Cost High Prevalence Chronic Conditions • Offer Health-Promoting and Value-Based Benefit Designs • Promote Worksite Wellness
Improve Members' Experience	• Create Comprehensive Communication & Marketing Plan • Improve the Member Enrollment Experience • Promote Health Literacy
Ensure Financial Stability	• Target Acute Care and Specialist Medical Expense • Target Pharmacy Expense • Pursue Alternative Payment Models • Ensure Adequate, Stable Funding from the State of North Carolina

Strategic Plan Updates and Evaluation

Strategic Plan Tracking

- Staff prepares a quarterly status report to highlight progress/challenges on each of the key initiatives in the Strategic Plan
  - Typically produced a month after the end of each calendar quarter H
  - Highlights key topics to discuss with the Board
  - Executive team uses the document to assess overall progress and guide operational priorities

Strategic Plan Evaluation

- Staff developed a scorecard to evaluate how well the Strategic Plan initiatives are being addressed
  - Scorecard metrics are a calendar year basis
  - CY 2015 results should be available in April 2016 to allow proper claims run out

Review of Improve Members' Health Initiatives, Programs, and Projects (CY 2015)

Successes	Ongoing Project	Revising Approach	Future Project	Potential to Reconsider
• PCMH Pilot with 4 practices up and running • Transition of Care Program Implemented • Chronic HEP designed for CY 2016 • Wellness Champions Implemented • Wellness Wins Implemented	• PCMH Pilot • Transition of Care Program • HEP Programs in CY 2016 • Wellness Champions	• High Utilizer Program • PCMH Pilot Year 2	• Chronic Pain Pilot • Identifying areas for value based design integration • Further opportunities for provider partnerships	• Focus on PCMH versus broadly on high quality providers

Challenges to Success – Improve Members' Health (CY 2015)

- Maximize PCMH Effectiveness:
  - *Highly successful in implementing in CY 2015*
  - Challenge: There has yet to be broad statewide adoption of PCMH accreditation despite North Carolina being one of the most engaged states
  - Challenge: Identifying practices with the right level of engagement and mutual capacity
  - ***Potential Solution: Broaden PCMH to include more forms of high quality providers in a transparent and consistent manner***

- High Prevalence Chronic Conditions
  - *Key Success: Design of Health Engagement Program for members with chronic conditions for CY 2016*
  - Challenge: Communication and member uptake for high utilizers
  - Challenge: Member Plan election remains high in Traditional 70/30
  - Challenge: Staff capacity to implement and appropriately manage multiple initiatives

Challenges to Success – Improve Members' Health (CY 2015)

- Value-based Benefit Design:
  - *Key Success: Implementation of Health Engagement Program for CY 2016*
  - Challenge: General Assembly pressure to reduce cost growth limits flexibility to invest in health
  - Challenge: Member plan election
  - Challenge: Vendor capabilities and benefit integration
  - ***Potential Solution: Identify approaches to incorporate Enhanced 80/20***

- Worksite Wellness:
  - *Highly successful in CY 2015*
  - Challenge: Difficulty in being able to design and implement a worksite program that is able to attract and retain enough interest
  - Challenge: Lack of broad statewide policy to incorporate in a manner that can be duplicated

Review of Improve Members' Experience Initiatives, Programs, and Projects (CY2015)

Successes	Ongoing Project	Revising approach	Future Project	Potential to Reconsider
• BCBSNC transparency deployed • HEP Programs in place for CY 2016 • Re-implemented Benefitfocus and completed AE despite challenges • Awarded Communication & Marketing Services Contract • Communicated with more members through Telephone Town Hall meetings	• Improving the member enrollment experience and stabilizing the enrollment platform • HEP Programs in CY 2016 • Continuing to improve customer satisfaction • Meet regularly with provider community • Develop non-Medicare primary health literacy campaign	• Searching for a new benefits calculator tool • Improve member contact information	• Enhance Medicare Primary learning opportunities • Develop learning modules for all members • Implement a communications and marketing campaign	

Challenges to Success – Improve Members' Experience (CY 2015)

- Overarching Challenges:
  - Director of Global Benefits Communications Director position vacant
  - Enrollment and Eligibility Vendor Transition
    - Consumed staff resources and capacity
    - Issues with data transfer and file setup
    - Members are vendor transition weary
  - New programs and/or enhancements require technology development and vendor integration which must be prioritized and resourced by the vendors
    - Leads to longer implementation timelines

Review of Ensure Financial Stability Initiatives, Programs, and Projects (CY 2015)

Successes	Ongoing Project	Revising approach	Future Project	Potential to Reconsider
• Implement alternative payment models with 2 to 3 ACOs • Communication with State Gov't Leadership • Legislative Agenda • Identify opportunities to incent quality of care • Direct provider engagement • Act in an open and transparent manner • Ensure adequate funding • Partner with stakeholders	• Incent members to utilize appropriate providers • Communication with State Gov't Leadership • Legislative Agenda • Reduce Avoidable admissions • Partner to identify opportunities to incent quality of care • Direct provider engagement	• Communication with State Gov't Leadership • Reduce Avoidable admissions • Partner to identify opportunities to incent quality of care • Direct provider engagement • Proactively work with State Gov't to protect Plan's reserves and ensure adequate funding	• Specialty Rx programs • Enhanced Fraud, Waste, and Abuse • Partner to identify opportunities to incent quality of care • Direct provider engagement	• Implement a telehealth option

Challenges to Success – Ensure Financial Stability (CY 2015)

- Acute and Specialist Care:
  - Challenge: Opportunities are not emerging uniformly around the State
  - Challenge: Incorporating into benefit design and communicating benefit changes

- Target Pharmacy Expense:
  - Challenge: Specialty drug trends continue to drive overall trend
  - Challenge: Staff turnover, recruitment and onboarding

Challenges to Success – Ensure Financial Stability (CY 2015)

- Pursue Alternative Payment Models:
  - Challenge: Opportunities are not emerging uniformly around the State
  - Challenge: Incorporating into benefit design and communicating benefit changes

- Ensure Adequate, Stable Funding from the State of North Carolina
  - Challenge: General Assembly asking for short-term savings or cost-shifting at the expense of long-term planning
  - Challenge: Reserve for low employer contribution growth

Why Refresh the Strategic Plan?

- The Strategic Plan is designed to be a living document that reflects the priorities of the Board, the health care environment in North Carolina, and administrative capabilities of our current vendor partners
  - Reviewing the status of these factors annually:
    - Helps maintain relevancy of the Strategic Plan
    - Provides a useful tool to guide Plan staff and operational priorities
- Multiple lessons learned and Board feedback from the past year to incorporate that will enhance the Strategic Plan
- The healthcare space is rapidly changing
- Vendor and provider capabilities are changing at different rates

Next Steps

- Discussion following Friday's meeting
- Revise the Plan based on Board feedback
- Update metrics in April