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

Board of Trustees Meeting
Tuesday, January 26, 2016, 6 p.m. - 8 p.m.

Dinner at 5:30 (for Board Members and Staff)

1.	Welcome	Janet Cowell, Chair
2.	Conflict of Interest Statement	Janet Cowell, Chair
3.	Review of Minutes ***(Requires Board Approval)***	Janet Cowell, Chair
	A. November 19 and 20, 2015	
4.	Introduction of New Staff *(5 minutes)*	Mona Moon
	A. Lauren Wides, Director of Contracting and Healthcare Compliance	
	B. Julie McManus, Operations Program Manager	
5.	Benefit Design, Plan Options and Premiums	
	A. Comparative Analysis of State Health Plans *(10 minutes)*	Tom Friedman
	B. Proposed 2017 Benefit Design Changes *(45 minutes)*	Tom Friedman
	C. Proposed Open Enrollment Strategy for 2017 Benefit Year *(10 minutes)*	Caroline Smart
	D. Transition Specialty Medications from Medical to Pharmacy Benefit *(10 minutes)*	Sandy Wolf
	E. Coverage for Clinical Trials *(10 minutes)*	Lotta Crabtree
6.	Member and Public Comment Period *(15 minutes)*	
7.	Adjourn	Janet Cowell, Chair

Next Regularly Scheduled Meeting: February 5, 3–5 p.m. (Vote on Benefits)

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.

Board of Trustees Meeting
Tuesday, January 26, 2016, 6 p.m. - 8 p.m.
Other Items of Interest

Because the meeting originally scheduled for January 22nd was rescheduled due to inclement weather, the Board of Trustees will hear an abbreviated agenda on Tuesday, January 26th. The following items will not be formally presented at the January 26th meeting. Some are being provided to the Board for informational purposes, and the staff will respond to any questions from the Board. Others will be postponed to a later date.

Information Only – Staff will respond to questions from the Board:

1. Financial Report, Forecasting and Monitoring
    A. November 2015 Financial Report — Mark Collins

2. Member Experience and Communications
    A. Communications Update — Beth Horner
    B. Annual Enrollment Exceptions — Caroline Smart

3. Clinical & Wellness Programs and Operations
    A. Specialty Medication Dispensing Update *(15 minutes)* — Sandy Wolf
    B. Pharmacy & Therapeutics Committee December Meeting *(10 minutes)* — David Boerner, Sandy Wolf

Postponed to a Later Date:

1. Executive Administrator Report
    A. Organizational Update
    B. Enrollment Stakeholder Council and Steering Committee

2. Clinical & Wellness Programs and Operations
    A. RivalHealth Wellness Program *(40 minutes)* — Christine Allison, Pete Durand, RivalHealth
    B. Member Tobacco Use and QuitlineNC *(15 minutes)* — Jessica Pyjas

3. Executive Session (for Board members only) — Janet Cowell, Chair
    Pursuant to: G.S. 143-318.11 and G.S. 132-1.2
    A. Lake Lawsuit (I. Beverly Lake et al. v. State Health Plan for Teachers and State Employees, et al.) *(G.S. §143.318.11(a)(3))* — Lotta Crabtree

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Comparative Analysis of State Health Plans

Board of Trustees Meeting

January 26, 2016

A Division of the Department of State Treasurer

Presentation Overview

- Executive Summary
- Selected States for Comparison
- Comparative Analysis Methodology
- Comparative Analysis
  - Comparator States
- States Incorporating Value Based and other Innovative Strategies
- Emerging Conclusions

Executive Summary

Purpose

- To update the previous environmental scan (last completed November 2014) of other state health plans and compare to the North Carolina State Health Plan

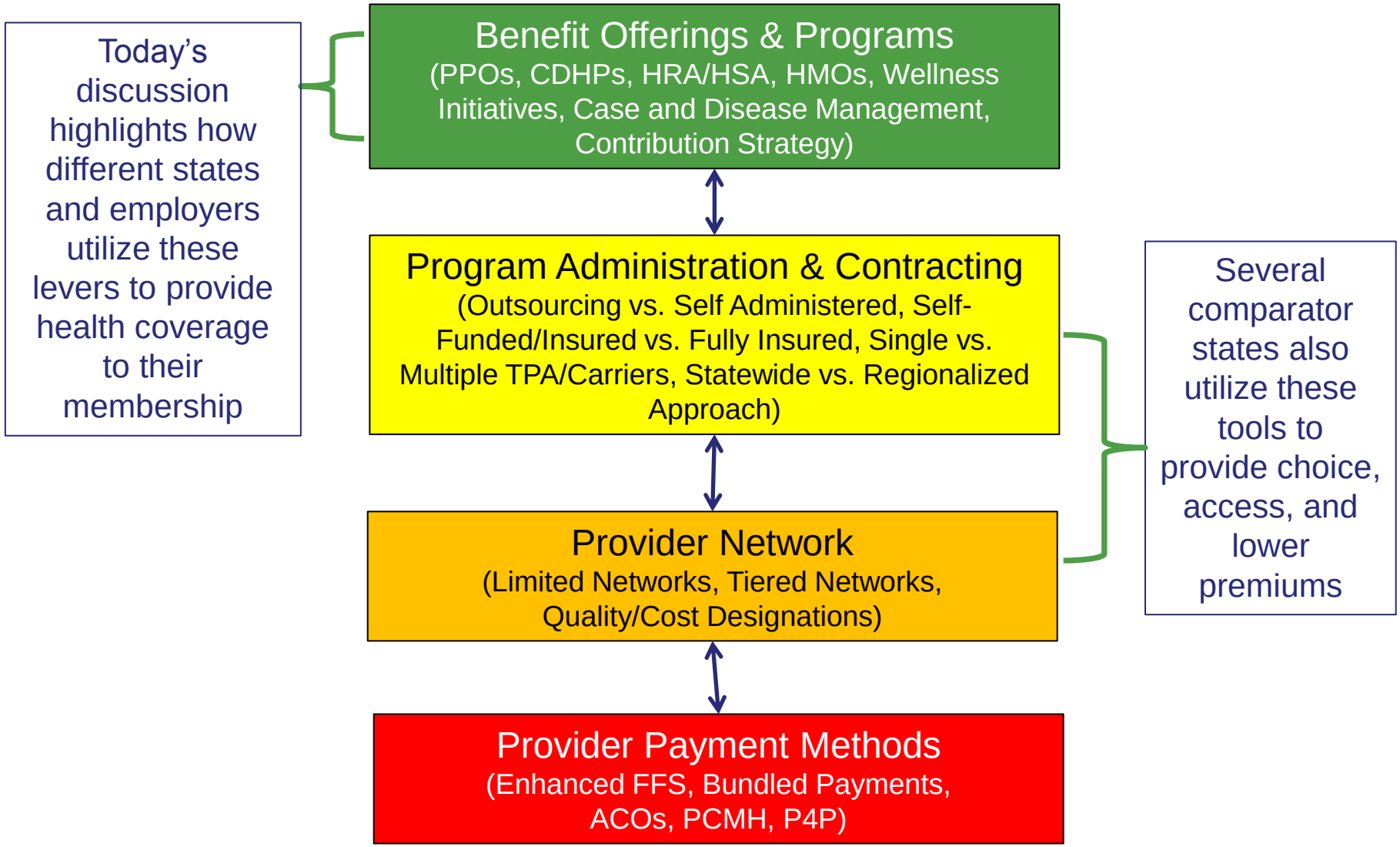
Approach

- The Plan investigated the following factors:
  - Plan richness (analysis by Segal)
  - Premium cost sharing (analysis by Segal)
  - Healthy lifestyle benefits
  - Number of coverage choices

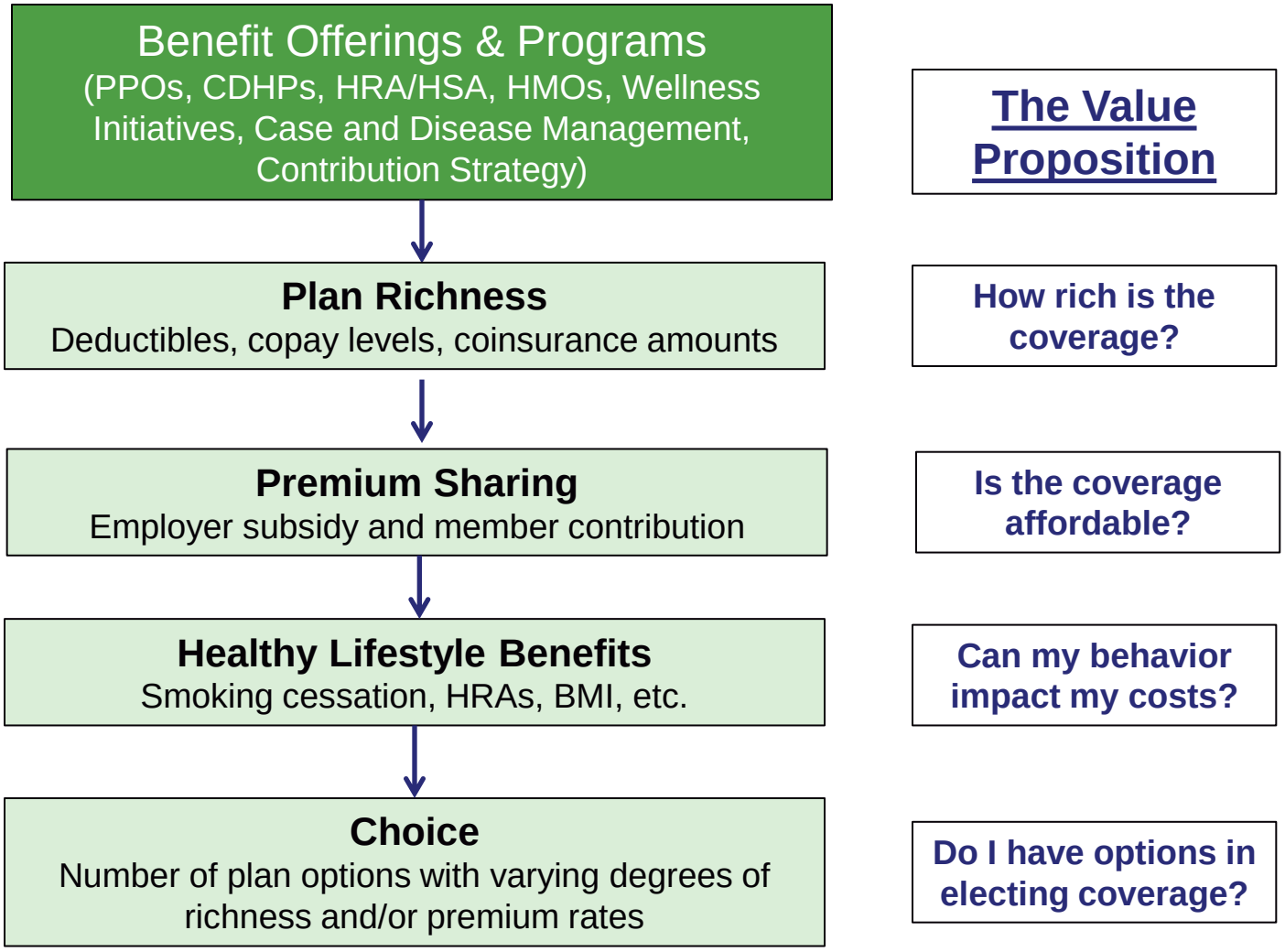
Key Findings (*related to other state health plans*)

- Comparatively, the Plan provides employees/retirees rich and affordable health benefits. However, coverage for dependents does not compare favorably
  - There does seem to be a slight reduction in other plans' subsidies
- Healthy lifestyle benefits continue to be used to manage costs and/or incent engagement
  - States are requiring more participation to receive credits
- States are continuing to incorporate VBID-like components into their designs
- States are using multiple approaches to manage cost growth

Methods to Address the Triple Aim & the Cost of Health Benefits



Value Proposition to Members and Points of Comparison



Selected Comparator States

Comparator States
(lowest and highest premium offerings)

Based on proximity to NC

- Georgia
- Kentucky
- Tennessee
- South Carolina
- Virginia

Based on size of state population and other factors

- Arizona
- Maryland
- Michigan
- Ohio
- Wisconsin

States with Promise Based Initiatives

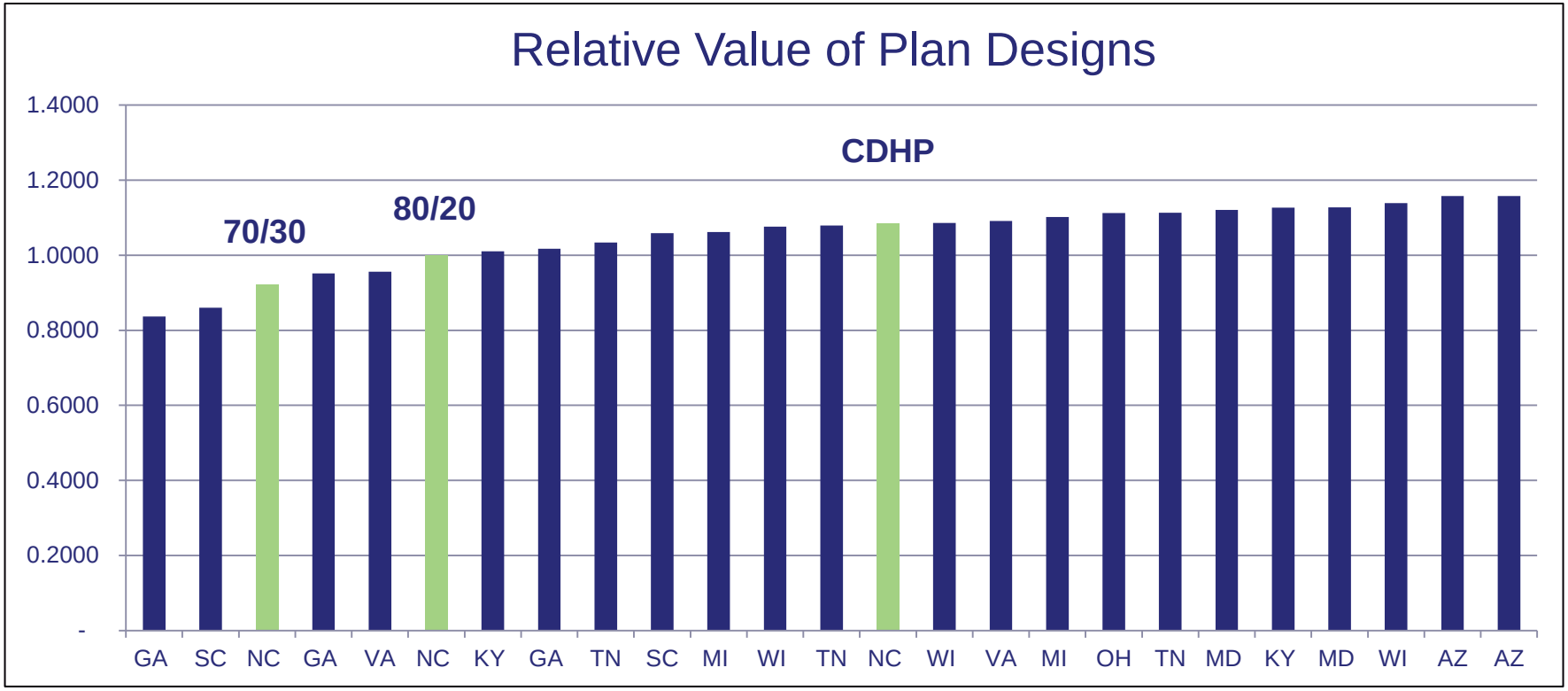
- Tennessee
- Kentucky
- Connecticut

Comparing Health Benefits – Plan Richness

Step One: How much does the average person pay out-of-pocket when they utilize their benefit?

- Comparing the actuarial value, or plan value, of each state's offerings provides a method to understand the average portion of claims a benefit design would pay for:
  - deductible,
  - coinsurance,
  - out-of-pocket maximums,
  - copays, and
  - out-of-network benefits (some states offer closed network plans)
- As many individuals make their benefit design election based on premium cost, we looked at the highest and lowest premium offerings available in the comparison states and benchmarked them against the 80/20 plan
- For NC the CDHP and 70/30 plans were included in the analysis

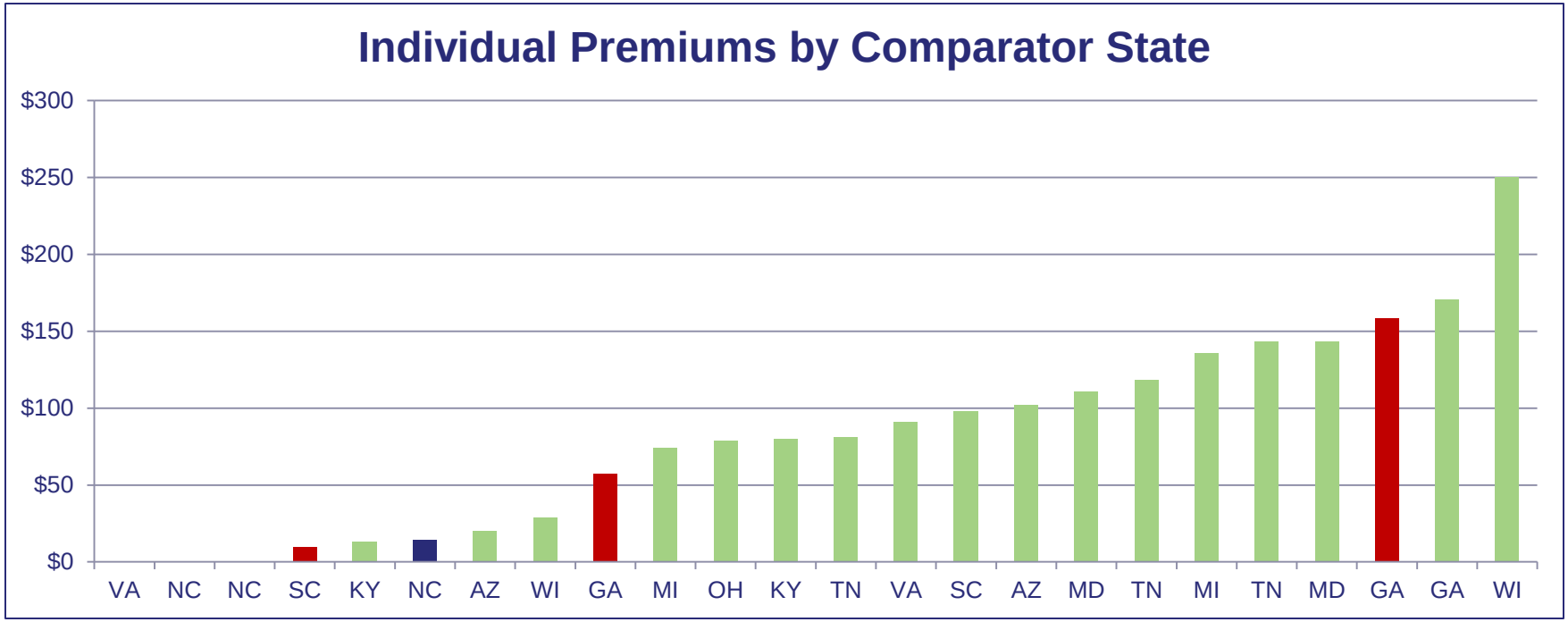
Relative Plan Richness Comparison (2016)



Segal Company – January 2016

- Excluding the CDHP, the State Health Plan's options are in the lower half of states in terms of relative plan value, which does not include premium contributions where SHP was among the lowest
- The premiums for the highest value plans range from $26 - $138 a month

Individual Premium Comparison



- The chart above shows the individual premiums members in various states pay for coverage
  - **Red** bars are less rich than the Enhanced 80/20 and the **green** bars are richer benefits
- Members in other states may receive richer benefits but pay significantly higher premiums in some cases

Financing Health Benefits

- Each state government finances health coverage for their membership differently
  - Most states provide direct subsidies for dependent coverage
    - Fixed subsidy by tier or dependent
    - Percentage of total premium
  - Some states have collective bargaining that impacts decision making

- NC's contribution strategy differs from most other states
  - Significant subsidies for employee and retiree only coverage
  - Employees and retirees pay full premium cost for dependents, but the State's contribution does provide an indirect subsidy

Comparing Health Benefits – Premium Sharing

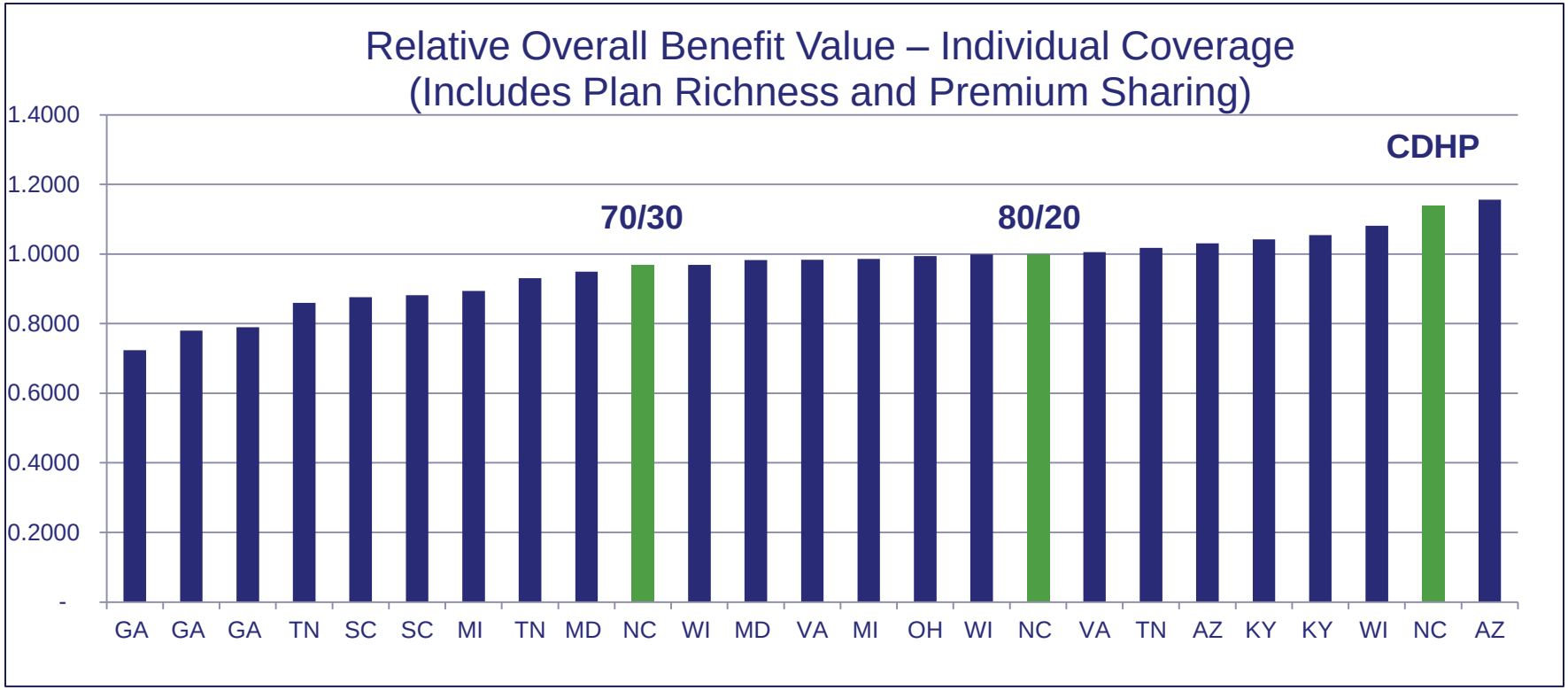
Step Two: How can employer subsidies and member premiums be incorporated?

- In addition to determining the value of the plan design, which represents the out-of-pocket exposure, the analysis included the individual's premium share to reflect average person's total cost exposure
  - The percentage of premium paid by each state for each plan combined with relative plan value determines the *Relative Overall Benefit Value* of the benefit offering

Caveat:

- Plan values are proxies for the anticipated average portion claims that the benefit would cover; the actual experience of low and high utilizers will create varying results

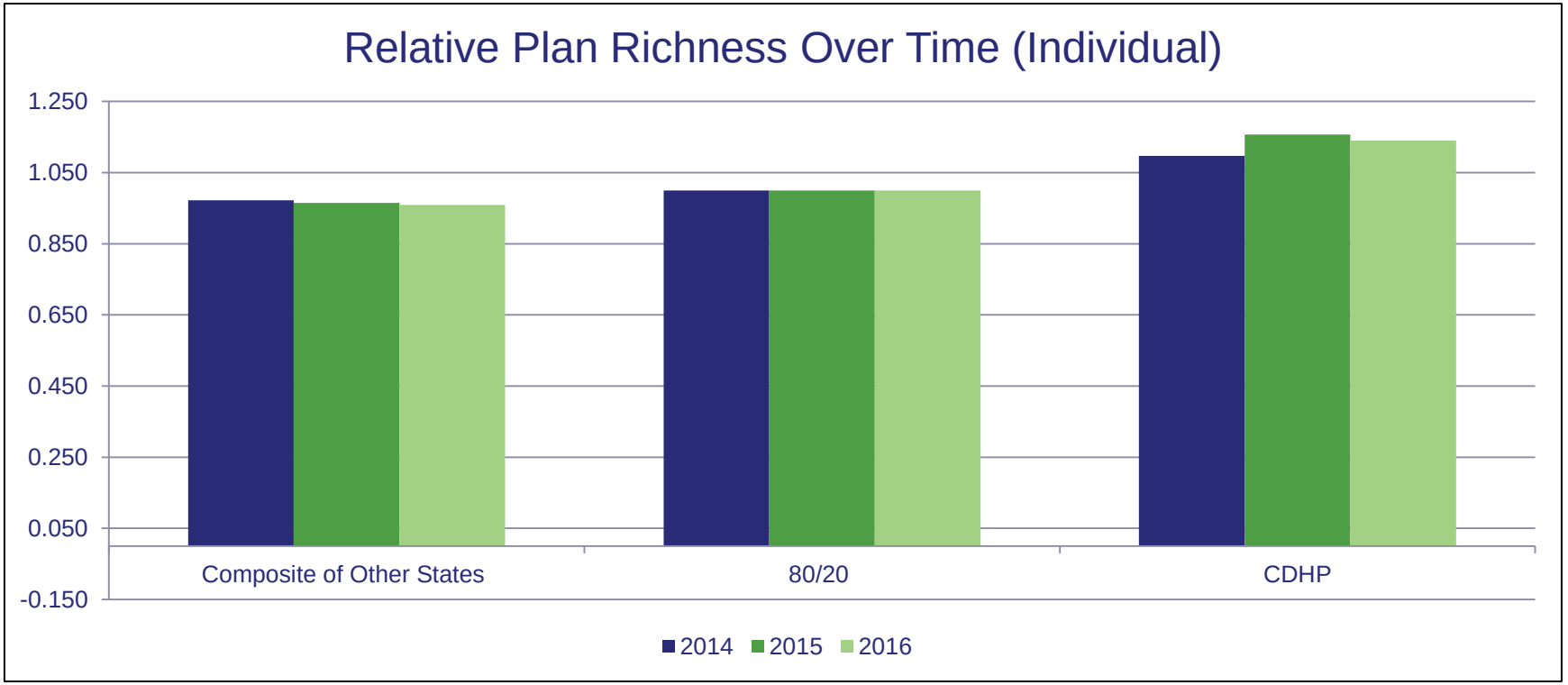
Relative Overall Benefit Value – Individual Coverage



Segal Company January 2016

- North Carolina's subsidy approach provides members with lower individual premiums; the state subsidy for individual coverage in other states is about 85% while in NC the minimum is 95%
- In terms of overall value, the CDHP is one of the richest plans available

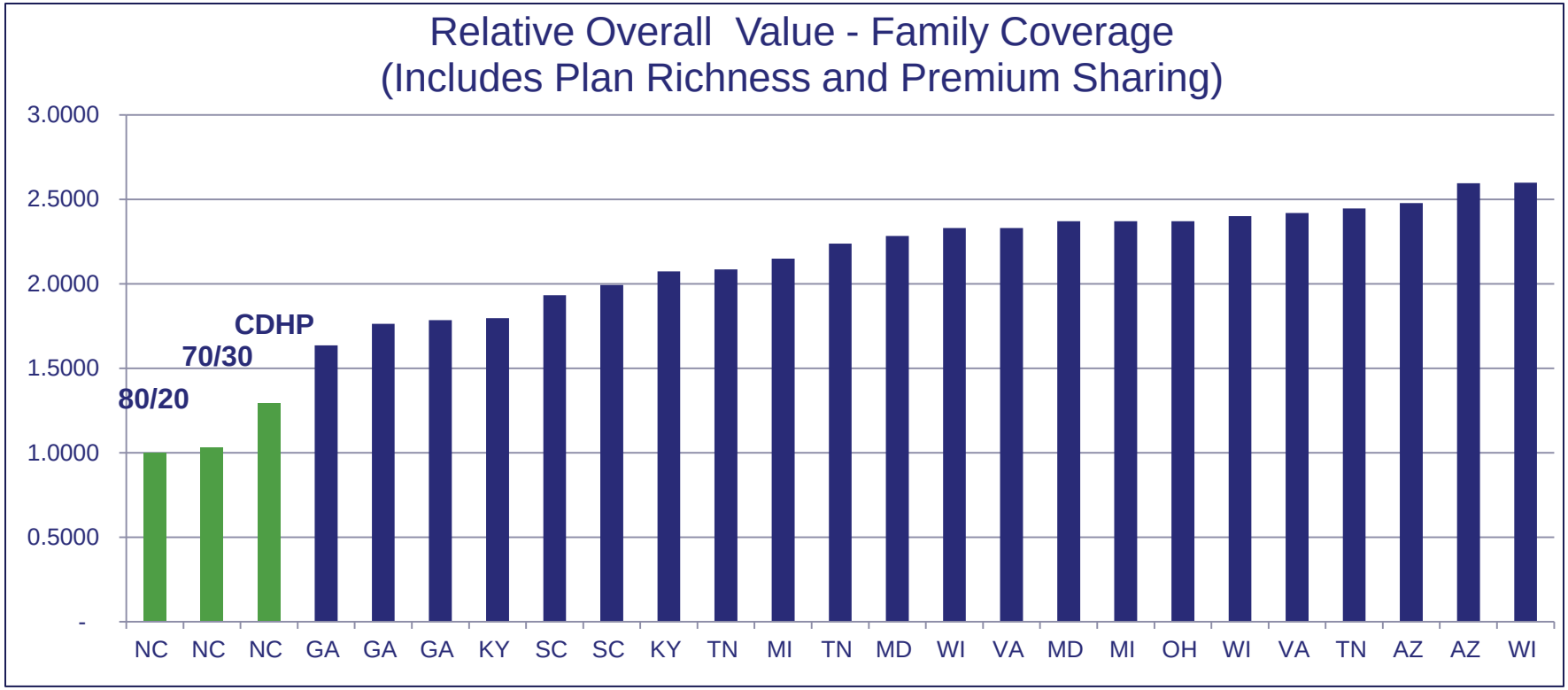
Value Changes Over Time (Individual)



Segal Company January 2016

- Compared to the Enhanced 80/20, other states are offering less rich individual plans over time
- The CDHP has increased in value over time

Relative Overall Benefit Value – Family Coverage

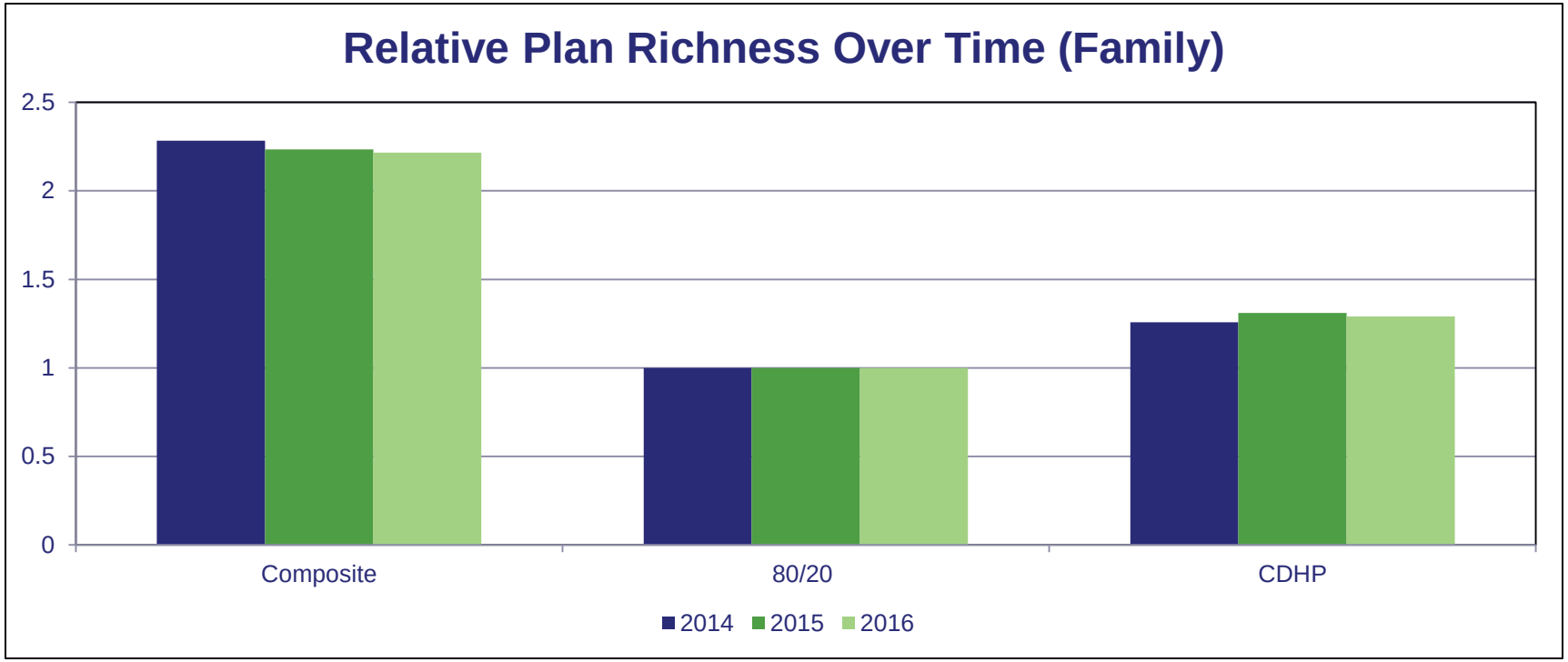


Segal Company January 2016

Historically, NC has not provided direct subsidies for dependent coverage while the median family subsidy of benchmarked states was 83% of total family premium (no change from previous analysis)

- NC contributes between 40% and 47% of the cost of family premiums (through the State's employer contribution)

Value Changes Over Time (Family)



Segal Company January 2016

- Compared to the Enhanced 80/20, other states are offering less rich family coverage over time; however, they remain substantially richer (driven by premium)
- The CDHP has increased in value over time

Trends in Comparative Analysis

Coverage Level	States ranked less favorable	States ranked more favorable
Individual	• Lower employer subsidy • Higher out-of-pocket costs • Higher coinsurance percentage for employees	• Lower deductibles • Use of closed networks • Out-of-pocket maximum versus coinsurance maximums • More favorable mail order differential in Rx (2x copay versus 3x copay)
Family	• Higher premiums • Less generous coverage	• **Dependent subsidies** • Lower deductibles • Use of closed networks • Out-of-pocket maximum versus coinsurance maximums • More favorable mail order differential in Rx (2x copay versus 3x copay)

Healthy Lifestyle Benefits Comparison

- State health plans continue to incorporate healthy lifestyle benefits into their plan design to address the growing costs of health care and to increase member engagement

- All but two of the comparator states include wellness incentives, either premium credits, cash, or HRA credit

- There has not been significant change in the number of steps or dollars associated with each state from the previous analysis

Healthy Lifestyle Benefit Grid (updated 2016)

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

Providing Meaningful Member Choice

- States take unique approaches to designing their health offerings.
- Approaches include:
  - Multiple vendors
    - Statewide or regional
      - 73% of comparator states utilize more than one TPA/carrier in their active population with many providing different rates based on the TPA/carrier provider network
        - This remains constant from the previous analysis
  - Number of offerings
    - The average state had four offerings for actives (up from three), with Georgia having the most with seven and Ohio having the least with one
    - Two increased their number of plan offerings
  - Differentiation in offerings
    - Members have unique coverage and price sensitivities

Employee Choice by State (2016)

State	Number of Offerings	Multiple TPA/Carriers	Regional Offerings or Rates
NC	Three	No	No
GA	Seven	Yes	Yes
SC	Two	No	No
KY	Four	No	No
TN	**Four***	Yes	Yes
VA	Four	Yes	Yes
AZ	Three	Yes	No
MD	Five	Yes	Yes
MI	Two	Yes	Yes
OH	One	Yes	No
WI	**Four***	Yes	Yes

**change from previous year*

Value-Based Initiatives in State Health Plans

- Staff examined three states that are incorporating different components of Value-Based Insurance Design (VBID)
  - There are several ways a plan can incent value
  - There does not appear to be a consistent model or approach for implementing value based design

- Value-driven design components include:
  - Tiered networks and benefits by network
  - Tying enrollment to participation in programs
  - Reducing or removing copays
  - Emphasizing Patient Centered Medical Home (PCMH)
  - End of life care

Innovative Plan Design Solutions: Tennessee

- Offers employees four plan offerings through two TPAs/carriers
- To enroll in the lower premium, more comprehensive offerings members must complete:
  - Well Being Assessment (WBA) within 3 months
  - Biometric screening within 6.5 months
  - Coaching calls, if identified
  - Keep contact information current
  - Failure to complete in the timeframe results in removal from the enhanced benefits
- Rules are modified for new hires to allow for some flexibility

Innovative Plan Design Solutions: Kentucky

- Offers employees four plan offerings
  - To enroll in the two most generous offerings members must complete a Health Assessment or a Biometric screening within the first half of the year
  - Failure to complete the activity makes a member ineligible for the richer benefits the following year
- Separate smoker credit for all four plans

Value-Based Incentives: Connecticut

- Connecticut's Health Enhancement Program (HEP) allows members the opportunity to:
  - Reduce deductibles for the year
  - Reduce monthly premiums
  - Receive lower/no cost care for select drugs and office visits
  - $100 payment for complying with all HEP requirements
- Participation Requirements:
  - Multi-year stair step approach
  - All age appropriate screenings and wellness exams
  - One dental cleaning
  - If a member has a chronic condition they must participate in education and counseling programs

Emerging Conclusions

- SHP is near the front of the curve in terms of integrating value based components which provide members the opportunity for richer benefits
- Plans are developing programs that give members broad choice in the type of plans they can select
- Plans are differentiating by:
  - Plan design
  - Wellness credits
  - Multiple TPAs
  - Narrow network options
- Plans are looking to incent certain behaviors and members can generate more value within benefit offerings by engaging
- Several states utilize multiple TPA/carriers to offer coverage; this trend is growing in the select states

Emerging Conclusions *continued*

- Based on relatively fixed funding, changing any aspect of a health plan will have a direct impact on other levers
  - Increasing benefit richness would increase member premiums
  - Reducing dependent premiums would increase individual premiums
- Legislative mandate to reduce premiums (i.e. the state's employer contribution) limits flexibility around improving all benefits

Next Steps/Questions

- Where should the Plan offerings be positioned in 2017? And as a foundation for 2018 and 2019?
- Where do we have opportunities in the market?
- Where should changes be considered to demonstrate different value proposition to members?
- Would changing the vendor arrangement provide the opportunity for greater flexibility?

Appendix

Out-of-Pocket Comparison

In-network Plan Benefits[1]	NC	GA	KY	SC	TN	VA
Deductible • Single • Family	$700 to 1,500 $2,100 to 4,500	$1,300 to 3,500 $2,600 to 6,450	$500 to 1,750 $1,000 to 3,500	$445 to 3,600 $890 to 7,200	$450 to 800 $1,150 to 2,050	$0 to 1,750 $0 to 3,500
Co-insurance	70% to 85%	70% to 85%	70% to 85%	80% to 85%	80% to 90%	80% to $100
Maximum[2] • Single • Family • Rx	$3,000 to 3,793 $9,000 to 11,379 Separate/Include	$4,000 to 6,450 $8,000 to 12,900 Include	$2,500 to 3,500 $5,000 to 7,000 Separate/Include	$2,540 to 6,000 $5,080 to 12,000 Included	$2,300 to 2,600 $4,600 to 5,200 Separate	$1,500 to 5,000 $3,000 to 10,000 Separate/Include
Office • PCP • SCP	$30 to ded/coin $70 to ded/coin	$35 to ded/coin $45 to ded/coin	$25 to ded/coin $45 to ded/coin	$12 to ded/coin $12 to ded/coin	$25 to 30 $45 to 50	$25 to ded/coin $40 to ded/coin
Inpatient Surgery	$233, ded/coin to ded/coin	$250 to ded/coin	Ded/coin	Ded/coin	Ded/coin	$300 to ded/coins
Rx • Tier 1 • Tier 2 • Tier 3	$12 to ded/coin $40 to ded/coin $64 to ded/coin	$20 to ded/coin $50 to ded/coin $90 to ded/coin	$10 to ded/coin $35 to ded/coin $55 to ded/coin	$9 to ded/coin $38 to ded/coin $63 to ded/coin	$5 to 10 $35 to 45 $85 to 95	$15 to ded/coin $25 to ded/coin $40 to ded/coin

1. Ded/coin = subject to deductible and coinsurance
2. NC uses coinsurance maximums on two plans, most other plans are out-of-pocket maximums

Out-of-Pocket Comparison- *continued*

In-network Plan Benefits[1]	NC	AZ	MD	MI	OH	WI
Deductible • Single • Family	 $700 to 1,500 $2,100 to 4,500	 $0 to 1,300 $1,000 to 2,500	 $0 $0	 $400 $800	 $200 $400	 $200 to 1,700 $400 to 3,400
Co-insurance	70% to 85%	90% to 100%	90% to100%	90% to 100%	80%	90%
Maximum[2] • Single • Family • Rx	 $3,000 to 3,793 $9,000 to 11,379 Separate/Include	 N/A to $2,000 N/A to $4,000 Include	 $1,500 to $2,000 $2,000 to $3,000 Separate	 N/A to $2,000 N/A to $4,000 Include	 $1,500 $3,000 Include	 $800 to 3,500 $1,600 to 7,000 Separate/Include
Office • PCP • SCP	 $30 to ded/coin $70 to ded/coin	 $15 to ded/coin $15 to ded/coin	 $15 $15 to $30	 $20 $20	 $20 $20	 Ded/coin Ded/coin
Inpatient Surgery	$233, ded/coin to ded/coin	$150 to ded/coin	$0 to ded/coin	$0 to ded/coin	Ded/coin	Ded/coin
Rx • Tier 1 • Tier 2 • Tier 3	 $12 to ded/coin $40 to ded/coin $64 to ded/coin	 $10 $20 $40	 $10 $15 $25	 $10 $30 $60	 $10 $25 $50	 $5 to ded/coin $15 to ded/coin $35to ded/coin

1. Ded/coin = subject to deductible and coinsurance
2. SHP uses coinsurance maximums on two plans, most other plans are out-of-pocket maximums

Comparative Analysis Methodology

Step one

- Plan staff and Segal discussed relevant states to use in comparative analysis
- Plan staff compiled benefit design components such as deductibles, copays, coinsurance for both individual/family coverage and in-network/out-of-network benefits
  - Premium contributions were also collected

Step two

- Segal ran the data inputs through their rate manual to develop expected costs of the benefit on PMPM basis
  - A rate manual is a tool that actuaries use to assign PMPMs based on underwriting guidelines and projected utilization
  - The expected costs are purely meant to compare benefit design values only and do not reflect expected utilization changes of different plan designs, geographic factors, age, etc.

Comparative Analysis Methodology

Step three

- The resulting PMPM costs were compared to the 80/20 plan to develop relative values
  - Benefit designs with a relative value greater than 1.0 are projected, on average, to pay for more covered services than the 80/20 plan; conversely plan designs with a relative value less than 1.0 are, on average, projected to pay less for covered services than the 80/20 plan
  - Example: Based on benefit design, the State of Arizona's PPO offering's relative value is 1.2142, or projected to be 21.142% more rich than the 80/20

Step four

- Employer share of premium was multiplied by relative value to create effective/adjusted relative value
  - The employer share of premium was calculated; employee share divided by total premium
  - Example: Arizona pays 83.246% of employee only premium; therefore the adjusted relative value is 1.0041 (.83246 x 1.2142)
    - Values may not equal due to rounding

Comparative Analysis Methodology

Step five

- Adjusted Relative Values were re-normalized to compare each plan's adjusted relative value to the Plan's 80/20 adjusted relative value
  - Example:
    - (Arizona PPO's Adjusted Value = 1.0041) divided by (80/20 Adjusted Value = 0.9714 (1.00 Relative Value x 97% Premium Share))
    - Arizona PPO's Adjusted Relative Value = 1.0337

North Carolina
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Proposed 2017 Benefit Design Changes

Board of Trustees Meeting

January 26, 2016

A Division of the Department of State Treasurer

Presentation Overview

- Results of Current Board Strategy (CY 2014 – CY 2016)
- Strategies to Meet Legislative Mandates
- Proposed Benefit Design Changes
- Implications on Retirees
  - Non-Medicare Retirees
  - Medicare Retirees
- Discussion

Results of Current Board Strategy

State Health Plan Board of Trustees Achievements

- Implementation of wellness/engagement model
- Low premium growth for members and state
  - Better results than multiple state and national trends
- Significant cash balance to offset future premium growth
- Increased member choice in plan options/offerings
- Retain broad view of the health care landscape in NC and nationally

Board-Approved Engagement Model: Financial Results and Developments

	CY 2014	CY 2015	CY 2016	CY 2017
Premium rate increase- Employer	3.57%	0.00%	3.45%	*3.47%*
Premium rate increase- Employee	3.57%	0.00%	2.83%	*3.47%*
Cash Balance- Beginning	$838.5M	$1.015B	*$1.00B*	*$772.4M*
Cash Balance- Ending	$1.015B	$1.00B	*$772.4M*	*$472.9M*
Other Key Developments & Legislation	• Move to CY benefit year • 9% TSR • Implement Strategic Plan	NCGA enacted: • "Sufficient" Measures • 20% Total Reserve	TBD	TBD

Projected in italics

Board-Approved Engagement Model: Benefit Changes and Program Implementations

	CY 2014	CY 2015	CY 2016	CY 2017

Benefit Changes	• Engagement Model
	• Consumer-Directed Health Plan (CDHP)
	• Wellness Premium Credits
	• Wellness incentives and value-based benefits in CDHP and Enhanced 80/20
	• Added Tier Five for Specialty Medications
	• MA-PDP products from United and Humana
		• Added Applied Behavioral Analysis (ABA) Benefit
		• HDHP for Newly Eligible Members non-permanent full-time employees
		• Additional ACA Preventive Services
			Traditional 70/30
			• Cost-sharing increases
			Enhanced 80/20:
			• Tier 5 copay increase
			CDHP
			• Increase in base HRA contribution
			• Increase value-based HRA credits
			• Increase in OOP maximum
			• Add Rx Debit Card
			• Wellness Premium Credits doubled
			• Health Engagement Program
			  • Chronic
			  • Healthy
			• Increase in Enhanced MA-PDP premiums and cost-sharing
				• Add Tobacco Attestation to Traditional 70/30

Current Approach Relative to the Strategic Plan: Strengths and Challenges

Strategic Priorities	Strengths	Remaining Challenges
Improve Members' Health	• Provides members the opportunity for richer benefits through engagement • Incentives/programs for members with chronic conditions • Case and Disease Management rates in line • PCP/PCMH model growth	• Significant members remain in 70/30 plan • Members still not engaging in Case and Disease Management • Low growth in Blue Options Designated provider utilization
Improve Members' Experience	• Increased member choice • Meaningful growth in transparency tools	• Enrollment vendor and platform challenges • Member resistance • Confusion re: premium credits and enrollment process
Ensure Financial Stability	• Low to no premium growth • Employer contribution increased more than forecast requirement • Significant excess cash reserves	• How to spend down cash balance without significant subsequent premium increase • Member out of pocket service costs is high compared to other states

CY 2018 and CY 2019 Under Current Strategy

- In CY 2018, the Board had planned to incent members to select engagement-based plans (CDHP and Enhanced 80/20) by:
  - Adding $20 base premium for Traditional 70/30
  - Additional increases in member cost-sharing to grandfathered limits
  - Providing premium credit for PCMH selection
  - Providing premium credit for provider reported biometrics
- The existing strategy involved increasing premium rates and the level of effort around premium credits each biennium
- The Board asked plan staff to identify opportunities to increase value-based benefits where possible
- Staff has recommended other approaches previously

Strategies to Meet Legislative Mandates

State Budget Impact on Planning Future Benefits

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

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

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

Financial Challenge - Defining "Sufficient Measures"

- While the General Assembly (GA) has not defined an amount that would constitute "sufficient measures," we have modeled the following scenarios:

2018 and 2019 Increases to Employer Contribution	Cumulative Savings Needed by end of 2019
7.4%*	$459 million
8.0%	$402 million
* 7.4% increases would represent a 50% reduction in the increases estimated in the Certified Budget projection (14.88%; 10-13-2015 Segal estimates)	

- The projected savings requirements are lower than previous estimates due to favorable experience and re-assessing projected savings needs

- If the GA determines the Plan has not taken "sufficient measures" to reduce growth in employer contribution for 2018 and 2019, member-paid premiums are projected to increase by ***37%*** to maintain the 20% legislative reserve requirement through June 30, 2017

Options for Consideration

1) Enhance current strategic direction with additional or stronger incentives to encourage engagement approach

   - Move to 2 plan options with required engagement component/significant premium for the higher valued plan
   - Offering a choice between a higher valued plan (e.g. CDHP) that requires engagement for participation and a lower valued plan (e.g. Traditional 70/30)

2) Request or recommend legislation to remove Spousal Coverage

3) Add a base premium for each active subscriber regardless of plan selection

4) Increase member cost share

Enhanced Engagement Model

- As we discussed in the state comparison presentation, other states are requiring engagement for members to be eligible for richer benefits at more favorable premiums
- The Enhanced Engagement Model also:
  - Provides significant opportunities to partner with members on improving their health
  - Provides meaningful opportunity to ensure financial stability by requiring engagement to stay in rich benefit
- Sample Engagement Criteria:
  - At enrollment:
    - Complete Health Assessment
    - Select PCP Selection
    - Participation agreement for CY 2018:
      - Participate in Case and Disease Management (if identified)

High Value Plan Engagement Criteria

	CY 2018	CY 2019	CY 2020
Engagement	• PCP Selection • Health Assessment • Agree to enroll in Case and Disease Management if identified	• PCP Selection • Health Assessment • Agree to enroll/continue in Case and Disease Management if identified • Agree to get/complete age appropriate preventive screenings	• PCP Selection • Health Assessment • Agree to enroll/continue in Case and Disease Management if identified • Agree to get/complete age appropriate preventive screenings
Participation During the Year	• Participate in Case and Disease Management if identified	• Participate/continue Case and Disease Management if identified • Complete preventive screenings	• Participate/continue Case and Disease Management if identified • Complete preventive screenings

Enhanced Engagement Model Concept Outline

	Low Plan (70/30)	High Plan (CDHP)
Premium Strategy	Base individual premium TBD (higher than CDHP)	Base individual premium TBD
Tobacco Cessation Program/Non-Tobacco User	Premium Credit	Premium Credit
Enhanced Engagement Component	No	• Health Assessment • PCP Selection • Agree to annual engagement steps
Provider Network (broad, narrow, tiered)	TBD	TBD
Preventive Coverage	100%	100%
Benefit Design	High Deductible, High Copay or HSA-eligible	CDHP, HRA Plan, Value-Based Copays
Plan Value	Bronze	Low Gold
Incentives for Health Engagement	None	HRA Credits

Enhance Current Strategy through Engagement

- The long-term Board strategy is to further differentiate the benefit offerings and incent engagement
  - Add a premium to the Traditional 70/30 in CY 2018
  - Increase Traditional 70/30 cost-sharing biannually
  - Increase intensity and financial incentives around premium credits
- This approach would retain and enhance those priorities

Strategic Initiatives	Improve Members' Health	Improve Members' Experience	Ensure Financial Stability
Strengths	• Stronger consequences for non-engagement • Long-term approach to healthier members	• Less options but more significant choice • Retains some familiar pieces	• Significant, growing long-term savings • **Savings: $180M for CYs 2018 & 2019**
Challenges	• Members in low plan have potential barriers to care	• Enrollment • Communications	• Must enforce engagement requirements

Pursue Legislation to Remove Spousal Eligibility

- In large part due to the traditional Plan funding model, the spouses covered by the Plan are among the highest utilizers of care
  - There is no direct subsidy for spouses, so many spouses who can achieve more affordable coverage elsewhere elect to do so
- The Affordable Care Act provides the opportunity for people to receive significant premium subsidies on the Exchange if they are not eligible for employer-sponsored coverage
- For families whose incomes fall below 300% of the Federal Poverty Level (FPL), there would be a significant opportunity for lower premiums on the Exchange (see handout)

Strategic Initiatives	Improve Members' Health	Improve Members' Experience	Ensure Financial Stability
Strengths	• Reduces the need for benefit reductions	• Small benefit to enrollment process	• Significant, growing long-term savings • **Savings: $100M to $125M annually**
Challenges	• Inconsistent with mission to improve health and care of employees, retirees ***and*** their dependents.	• Enrollment in Exchange • Communications • Optics	• Older and/or higher income members may pay more

Increase Member Premiums

- The Board could retain the current benefit offerings/premium credit structure but would need to implement substantial member premiums to achieve the legislative mandates
  - If the Board implemented base premiums in CY 2017, premiums would need to average between $36-$42 per subscriber per month and would still require annual increases
  - If the Board waits until CY 2018, the base premium increase would need to average between $56-$62 per subscriber per month and would still require annual increases
- Premium increases are the most certain way to achieve legislative mandates – guaranteed revenue

Strategic Initiatives	Improve Members' Health	Improve Members' Experience	Ensure Financial Stability
Strengths	• Reduces the need for benefit reductions • Could retain incentives in engagement plan	• Easier to understand than more nuanced approaches	• Significant, growing long-term savings • **Savings: up to $450M**
Challenges	• Members may buy down or reduce utilization of valued/medically necessary services	• Communications • Optics	• Does not bend cost curve driven by health status

Broad Increases in Member Cost-Sharing

- The Board could retain the current benefit premium structure but would need to implement substantial increases in member cost-sharing to achieve the legislative mandates
  - Would result in lower value benefit offerings
  - Would create significant barriers to care
  - Does not improve the long-term health of members

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

Staff Proposal

Staff Proposal

- Stay the course with the Strategic Plan and enhance the engagement model by moving to two-plan approach
  - Allows engaged members to retain richer benefits and lower premiums
    - 74% of members of Enhanced 80/20 and CDHP earn all credits
  - Assists members in improving their long-term health, which will help manage costs in a strategic manner
  - Members who refuse to engage would either pay significant premiums or move to lower valued plan
- Use CY 2017 as a bridge to mitigate some of the bigger changes from a financial and plan election perspective
  - Add base premium for active subscribers to mitigate larger premiums later
  - Increase cost-sharing on Traditional 70/30 and Enhanced 80/20 to steer toward CDHP
  - Increase Deductible and OOP Max on CDHP
  - Maintain same healthy activities as CY 2016 to earn premium credits
  - **CY 2017 savings/revenue from bridge approach = $140.3M**
    - Premium related revenue = $46.9m
    - Benefit related savings = 93.4M

Financial Impact of Staff Proposal

Projected Premium Increases and Reductions in State Contributions

	2018	2019	2020	2021
Premium Increases				
Baseline Model (Segal 11/24/15)	12.17%	12.17%	7.33%	7.33%
Staff Proposal Model (Segal 1/20/16)	8.93%	8.93%	5.84%	5.84%
Reductions in Employer Contributions/Staff Proposal	**$86.3 m**	**$190.2 m**	**$250.3 m**	**$317.2 m**

Rationale for Proposal

Rationale

- The two-plan engagement model is consistent with and enhances all areas of the Strategic Plan
  - The approach is a natural progression of the current Board-approved strategy while providing members with an opportunity to retain richer benefits by continuing engagement with the Plan

Sufficient measures

- The proposed reductions in benefits and larger premium increases are a function of the General Assembly's requirement and the lack of specificity around sufficient measures

Enhanced Engagement Model Concept Outline

	Low Plan (70/30)	High Plan (CDHP)
Premium Strategy	Base individual premium TBD (higher than CDHP)	Base individual premium TBD
Tobacco Cessation Program/Non-Tobacco User	Premium Credit	Premium Credit
Enhanced Engagement Component	No	• Health Assessment • PCP Selection • Agree to annual engagement steps
Provider Network (broad, narrow, tiered)	TBD	TBD
Preventive Coverage	100%	100%
Benefit Design	High Deductible, High Copay or HSA-eligible	CDHP, HRA Plan, Value-Based Copays
Plan Value	Bronze	Low Gold
Incentives for Health Engagement	None	HRA Credits

2017 Healthy Activities to Reduce Premiums

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

Previously Approved 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

2017 Healthy Activities to Reduce Premiums

To address concerns about members' enrollment experience and to recognize the lack of sufficient PCMH providers throughout North Carolina, staff proposes maintaining the 2016 healthy activities to earn premium credits for 2017:

Revised Proposal for CY 2017

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

Proposed Premium Strategy (Illustrative)

Plan Option	CY 2016 Premium (EE Only)	CY 2017 Premium (EE Only)	CY 2018 Premium (EE Only)	CY 2019 Premium (EE Only)
Enhanced 80/20	$14.20 ($24.20 Base)	$35.00 ($45.00 Base) Loss of Grandfather status	Not Offered	Not Offered
Traditional 70/30 (Low Plan)	**$0.00**	$20.00	$35.00	$50.00
CDHP (High Plan)	**$0.00**	**$10.00**	**$15.00**	**$20.00**

1. *Assumes all credits earned*
2. *Lowest premium in **BOLD***

Proposed Benefit Progression – CDHP (High Plan)

	CY 2016 CDHP Non-Grandfathered	CY 2017 CDHP Non-Grandfathered	CY 2018 CDHP Non-Grandfathered
Deductible HRA	$1,500 $600	**$1,750** $600	**$2,000** **$700**
Coinsurance Percentage	15%	15%	15%
Medical Coinsurance Rx Max OOP Max	N/A N/A $3,500	N/A N/A **$3,750**	N/A N/A **$4,250**
PCP	Ded/Coins. + $25 HRA credit if selected PCP	Ded/Coins. + $25 HRA credit if selected PCP	Ded/Coins. + $25 HRA credit if selected PCP
SCP	Ded/Coins. + $20 HRA credit if B.O.D	Ded/Coins. + $20 HRA credit if B.O.D	Ded/Coins. + $20 HRA credit if B.O.D
Inpatient B.O.D Non-B.O.D	Ded/Coins. + $200 HRA Credit Ded/Coins.	Ded/Coins. + $200 HRA Credit Ded/Coins.	Ded/Doins. + $200 HRA Credit Ded/Coins.
Outpatient Hospital	Ded/Coins.	Ded/Coins.	Ded/Coins.
Urgent Care	Ded/Coins.	Ded/Coins.	Ded/Coins.
ER Copay	Ded/Coins.	Ded/Coins.	Ded/Coins.
Drugs	Ded/Coins. CDHP Maintenance Medications are deductible exempt	Ded/Coins. CDHP Maintenance medications are deductible exempt	Ded/Coins. CDHP Maintenance medications are deductible exempt

Proposed Benefit Progression – Traditional 70/30 (Low Plan)

	CY 2016 Traditional 70/30 Grandfathered	CY 2017 Traditional 70/30 Grandfathered	CY 2018 Traditional 70/30 Non-Grandfathered
Deductible	$1,054	**$1,080**	**$4,500**
Coinsurance Percentage	30%	30%	30%
Preventive Coverage	Cost-Sharing Applies	Cost-Sharing Applies	**100%**
Medical Coinsurance Rx Max OOP Max	$4,282 $3,294 N/A	**$4,388** **$3,360** N/A	**N/A** **N/A** **$6,850**
PCP	$39	**$40**	**$65**
SCP	$92	**$94**	**$115**
Inpatient Hospital	$329, then Ded/Coins.	**$337, then Ded/Coins.**	**$500, then Ded/Coins.**
Outpatient Hospital	Ded/Coins.	Ded/Coins.	**$250, then Ded/Coins.**
Urgent Care	$98	**$100**	**$125, then Ded/Coins.**
ER Copay	$329, then Ded/Coins.	**$337, then Ded/Coins.**	**$500, then Ded/Coins.**
Drugs Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Tier 6	 $15 $46 $72 25% up to $100 25% up to $132 N/A	 **$16** **$47** **$74** **10% up to $100** **25% up to $103** **25% up to $133**	 **$20** **$50** **Ded/Coins.** **10% up to $150** **25% up to $200** **Ded/Coins.**

Proposed Benefit Progression – Enhanced 80/20

	CY 2016 Enhanced 80/20 Grandfathered	CY 2017 Enhanced 80/20 Non-Grandfathered	CY 2018 Enhanced 80/20 Non-Grandfathered
Deductible	$700	**$840**	**Not offered**
Coinsurance Percentage	20%	20%	**Not offered**
Medical Coinsurance Rx Max OOP Max	$3,210 $2,500 N/A	**$3,850** **$3,000** N/A	**Not offered**
Selected PCP PCP	$15 $30	$15 **$36**	**Not offered**
B.O.D SCP Non-B.O.D SCP	$60 $70	$60 **$84**	**Not offered**
Inpatient B.O.D Non-B.O.D	 $0, then Ded/Coins. $233, then Ded/Coins.	 $0, then Ded/Coins. **$280, then Ded/Coins.**	**Not offered**
Outpatient Hospital	Ded/Coins.	Ded/Coins.	**Not offered**
Urgent Care	$87	**$95**	**Not offered**
ER Copay	$233, then Ded/Coins.	**$280, then Ded/Coins.**	**Not offered**
Drugs **Tier 1** **Tier 2** **Tier 3** **Tier 4** **Tier 5** **Tier 6**	 $12 $40 $64 25% up to $100 25% up to $132 N/A	 **$14** **$45** **$70** **10% up to $100** **25% up to $103** **25% up to $133**	**Not offered**

B.O.D = Blue Options Designated

Proposed Changes to Pharmacy Tiers

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

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

Proposed Changes to Pharmacy Tiers

Traditional 70/30 Plan

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

Enhanced 80/20 Plan

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

CY 2017 Comparison of Proposed Benefit Options

	CDHP Non-Grandfathered	Enhanced 80/20 Non-Grandfathered	Traditional 70/30 Grandfathered
Deductible HRA	**$1,750** $600	**$840** N/A	**$1,080** N/A
Coinsurance Percentage	15%	20%	30%
Preventive Coverage	100%	100%	Cost-Sharing Applies
Medical Coinsurance Rx Max OOP Max	N/A N/A **$3,750**	**$3,850** **$3,000** N/A	**$4,388** **$3,360** N/A
Selected PCP PCP	Ded/Coins. + $25 HRA credit Ded/Coins.	$15 **$36**	**$40** **$40**
B.O.D SCP Non-B.O.D SCP	Ded/Coins. + $20 HRA credit Ded/Coins.	$60 **$84**	**$94** **$94**
Inpatient B.O.D Non-B.O.D	Ded/Coins. + $200 HRA Credit Ded/Coins.	$0, then Ded/Coins. **$280, then Ded/Coins.**	**$337, then Ded/Coins.** **$337, then Ded/Coins.**
Outpatient Hospital	Ded/Coins.	Ded/Coins.	Ded/Coins.
Urgent Care	Ded/Coins.	**$95**	**$100**
ER Copay	Ded/Coins.	**$280, then Ded/Coins.**	**$337, then Ded/Coins.**
Drugs **Tier 1** **Tier 2** **Tier 3** **Tier 4** **Tier 5** **Tier 6**	Ded/Coins. CDHP Maintenance medications are deductible exempt	 **$14** **$45** **$70** **10% up to $100** **25% up to $103** **25% up to $133**	 **$16** **$47** **$74** **10% up to $100** **25% up to $103** **25% up to $133**

CY 2018 Comparison of Proposed Benefit Options

	CDHP Non-Grandfathered	Traditional 70/30 Non-Grandfathered
Deductible HRA	**$2,000** **$700**	**$4,500** N/A
Coinsurance Percentage	15%	30%
Preventive Coverage	100%	**100%**
Medical Coinsurance Rx Max OOP Max	N/A N/A **$4,250**	**N/A** **N/A** **$6,850**
PCP	Ded/coins. + $25 HRA credit if selected PCP	**$65**
SCP	Ded/coins. + $20 HRA credit if B.O.D	**$115**
Inpatient B.O.D Non-B.O.D	Ded/Coins. + $200 HRA Credit Ded/Coins.	**$500, then Ded/Coins.** **$500, then Ded/Coins.**
Outpatient Hospital	Ded/Coins.	**$250, then Ded/Coins.**
Urgent Care	Ded/Coins.	**$125, then Ded/Coins.**
ER Copay	Ded/Coins.	**$500, then Ded/Coins.**
Drugs **Tier 1** **Tier 2** **Tier 3** **Tier 4** **Tier 5** **Tier 6**	Ded/Coins. CDHP Maintenance medications are deductible exempt	**$20** **$50** **Ded/Coins.** **10% up to $150** **25% up to $200** **Ded/Coins.**

Plan Options for Retirees

Base Premium Strategy for Retirees

- If the Board elects a strategy that is driven by adding a base premium, there would be different implications for retirees
  - G.S. 135-48.40(a) requires the Plan to offer a “noncontributory” or premium free plan to retirees
- **Non-Medicare Retirees:** The Traditional 70/30 would remain a premium free option for individual coverage
- **Medicare Retirees:** The Traditional 70/30 would remain a premium free option for individual coverage

Proposed Premium Strategy for Non-Medicare Retirees

Plan Option	CY 2016 Premium (EE Only)	CY 2017 Premium (EE Only)	CY 2018 Premium (EE Only)	CY 2019 Premium (EE Only)
Enhanced 80/20	$14.20 ($24.20 Base)	$35.00 ($45.00 Base) Loss of Grandfather status	Not Offered	Not Offered
Traditional 70/30 (Low Plan)	**$0.00**	**$0.00**	**$0.00**	**$0.00**
CDHP (High Plan)	**$0.00**	$15.00	$15.00	$20.00

- Pre-65 retirees would retain a premium free option in the Low plan
  - This would go against the enhancement model strategy

1. *Assumes all credits earned*
2. *Lowest premium in **BOLD***

Proposed Premium Strategy for Medicare Retirees

Plan Option	CY 2016 Premium (EE Only)	CY 2017 Premium (EE Only)	CY 2018 Premium (EE Only)	CY 2019 Premium (EE Only)
Base Medicare Advantage	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Traditional 70/30 (Low Plan)	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Medicare Advantage Buy-up	$66.00	TBD	TBD	TBD

- Medicare retirees would retain the Low plan as a premium free option
  - This would go against the enhancement model strategy, however, the Medicare Advantage plans are attractive options

1. *Lowest premium in **BOLD***

Proposed Benefit Progression – Traditional 70/30 (Low Plan)

	CY 2016 Traditional 70/30 Grandfathered	CY 2017 Traditional 70/30 Grandfathered	CY 2018 Traditional 70/30 Non-Grandfathered
Deductible	$1,054	**$1,080**	**$4,500**
Coinsurance Percentage	30%	30%	30%
Preventive Coverage	Cost-Sharing Applies	Cost-Sharing Applies	**100%**
Medical Coinsurance Rx Max OOP Max	$4,282 $3,294 N/A	**$4,388** **$3,360** N/A	**N/A** **N/A** **$6,850**
PCP	$39	**$40**	**$65**
SCP	$92	**$94**	**$115**
Inpatient Hospital	$329, then Ded/Coins.	**$337, then Ded/Coins.**	**$500, then Ded/Coins.**
Outpatient Hospital	Ded/Coins.	Ded/Coins.	**$250, then Ded/Coins.**
Urgent Care	$98	**$100**	**$125, then Ded/Coins.**
ER Copay	$329, then Ded/Coins.	**$337, then Ded/Coins.**	**$500, then Ded/Coins.**
Drugs Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Tier 6	 $15 $46 $72 25% up to $100 25% up to $132 N/A	 **$16** **$47** **$74** **10% up to $100** **25% up to $103** **25% up to $133**	 **$20** **$50** **Ded/Coins.** **10% up to $150** **25% up to $200** **Ded/Coins.**

Discussion and Next Steps

Other Efforts to Constrain Costs

- The Plan is evaluating proposals for a new PBM contract that could potentially generate savings in CY 2017; those opportunities will be discussed at future meetings
- The Plan is pursuing pilot opportunities with multiple partners to determine how narrowing of networks might impact long-term costs
  - The pilots will not be available statewide
- The Plan continues to partner with BCBSNC on initiatives to shift to alternative payment models that incent quality and move away from pure Fee-For-Service

Discussion Items

- Which approach feels best to the Board?
- Should the Plan pursue removal of spousal coverage?
- Would a savings strategy purely based in premiums that allows members to retain the current benefits be a better approach?

Next Steps

- Refine CY 2017 bridge strategy and approach for CY 2018 and CY 2019 approach based on Board feedback
- Determine total savings and reduction to employer contribution
- Board vote in February
- Communications strategy
- Vendor implementations
- Communicate changes
- Finalize engagement criteria and coordinate with states utilizing this approach
- Communicate changes

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Proposed Open Enrollment Strategy for 2017 Benefit Year

Board of Trustees Meeting

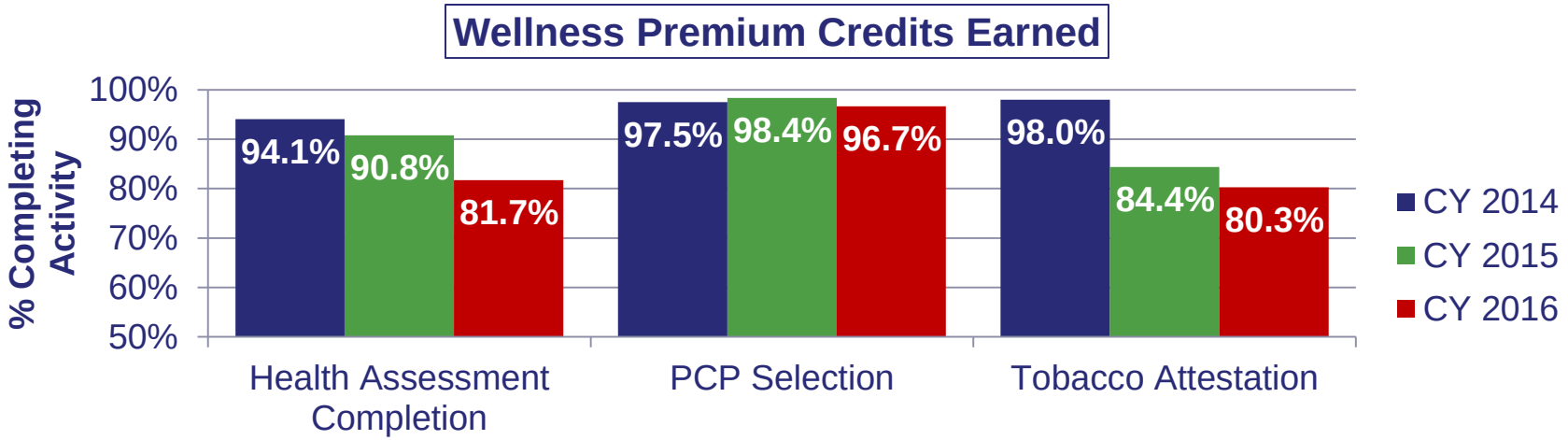
January 26, 2016

2017 Open Enrollment: Non-Medicare Primary Subscribers Default Strategy

The year that we introduced wellness premium credits into the enrollment strategy was the year that our members had the most success completing them.

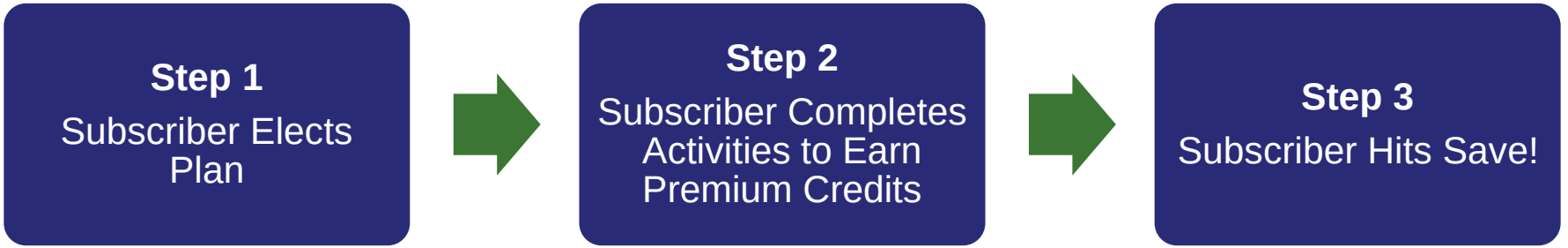
- **2014 Open Enrollment (OE)** – All members were moved to the Traditional 70/30 Plan and subscribers had to elect a higher value plan **and** complete healthy activities to earn premium credits

- **2015 & 2016 OE** – Members remained in the plan they elected for 2014 and if they did not want to change plans, only had to complete some of wellness premium credits during OE



2017 Open Enrollment: Non-Medicare Primary Subscribers Default Strategy

- Based on the first three years of experience, Plan staff believes the best strategy to engage members during OE is to move everyone back to the Traditional 70/30 as a starting point.
- Communicating that they **must take action** to elect the plan of their choice seems to resonate more with members. Like they did in year one, members will have to elect a higher value plan **and** complete the wellness premium credits.



- This strategy may have financial implications for employees beyond earning premium credits if a base premium is added to the Traditional 70/30 plan.

2017 Open Enrollment: Premium Credit Strategy

- Similar to the default enrollment strategy, Plan staff believes the best course of action for the wellness premium credits is to require subscribers to complete all three credits again during OE.
- By requiring subscribers to complete all three activities, there should be less confusion about what is required during OE. Subscribers will have to take action to enroll in the plan of their choice **and** to reduce their premiums.
  - **PCP Elections** – All subscribers will have to elect a PCP for themselves and any enrolled dependents during OE. **Even if they had elected a PCP for a previous plan year, they will have to re-elect a PCP during OE to earn the wellness premium credit for 2017**.
  - **Health Assessment –** All subscribers will have to complete a new Health Assessment to earn the credit for 2017. Their answers to the previous years' assessment will be removed, and they will need to complete the entire assessment. The time period for the completion will be shortened as well. Instead of allowing members to have a year from the last Annual Enrollment, members will have to complete the Health Assessment between March 1, 2016, and the end of OE.

2017 Open Enrollment: Premium Credit Strategy (continued)

- **Tobacco Attestation** – Instead of requiring the subscriber to attest that he or she and if applicable, his or her spouse, is not a tobacco user or is participating in a tobacco cessation program, Plan staff proposes streamlining it so that the subscriber only attests to his or her tobacco status:


Non-tobacco user or


Tobacco user who agrees to participate in the QuitelineNC or


Tobacco user

- Those who attest that they agree to participate in the QuitlineNC will have their enrollment in that program validated. They will not receive the credit unless they have enrolled.

2017 Open Enrollment: Premium Credit Strategy

- While the strategy for wellness premium credit completion is the same for both active and retired non-Medicare primary subscribers, only the active subscribers will have a tobacco attestation on the Traditional 70/30 plan.

2017 Wellness Premium Credits						
	Active Subscribers			Non-Medicare Prime Retirees		
Plan Option	Traditional 70/30	Enhanced 80/20	CDHP	Traditional 70/30	Enhanced 80/20	CDHP
Premium Credits	Tobacco Attestation	Tobacco Attestation	Tobacco Attestation		Tobacco Attestation	Tobacco Attestation
		Health Assessment	Health Assessment		Health Assessment	Health Assessment
		PCP Election	PCP Election		PCP Election	PCP Election

- Please note that some or all of the plan options may also include a base premium that will be due regardless of the completion of healthy activities and premium credits earned.

2017 Open Enrollment: Member Experience

In addition to moving to an enrollment strategy that we believe will be more straightforward, Plan staff is also working with Benefitfocus, other Plan vendors and Plan partners to improve the overall member experience during open enrollment.

Technical Improvements

- **Single-Sign-On (SSO)/Web Service with the Health Assessment (HA) –** There is already a project scheduled to re-implement the SSO & Web service between eEnroll and the HA so that the member can complete the HA as part of the enrollment workflow in eEnroll. This enhancement will also allow the HA credit to be applied to the members' eEnroll election immediately upon completion as long as the HA was accessed and completed from eEnroll. There will continue to be a delay in the application of the HA if a member completes it telephonically, but the delay should only be a couple of days, not a few weeks.

- **eEnroll Navigation –** The Plan has requested that Benefitfocus add additional messaging throughout the enrollment site to provide directions about where to go to complete specific activities and how to confirm their elections have been successfully completed. Other possible workflow enhancements are also under review.

2017 Open Enrollment: Member Experience

Partner Collaboration

- **Enrollment Stakeholder Council**– The Plan has also formed a stakeholder council with a steering committee composed of executives representing some of the employing units or groups of employing units. The intent is to share information with this group about the Board's benefit and enrollment strategy, update them on eEnroll's status including issues resolution and upcoming enhancements and receive feedback on proposed system and process changes. The council will also form workgroups as necessary to address technical and operational aspects of the enrollment process and experience.

- **Employing Unit User Council –** While we already hold HR round tables to discuss all aspects of the Plan's programs, we are forming more eligibility and enrollment focused groups to get feedback on defect resolution prioritization and desired enhancements.

- **HR Round Tables and Training –** We have expanded our HR round tables to include more representation from employing units and will continue to recruit more participants. Additionally we have committed to move to a quarterly meeting schedule to ensure they have opportunity to learn about plan and program changes as soon as possible and to provide feedback. As discussed in the communications update, we are also providing more enrollment training opportunities for HBRs.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Transition Specialty Medications from Medical to Pharmacy Benefit

Board of Trustees Meeting

January 26, 2016

Specialty Drugs from Medical to Pharmacy Benefit

Goal:

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

Reason:

- Manage Adherence
- Medical Stability
- Manage Drug Spend

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

Specialized Clinical Care Model

- The Plan wishes to utilize a specialized clinical care model:
  - Manage to lowest cost and effective dosing
  - Therapy management savings
  - Consistent clinical protocols
    - Improve and assess overall quality of care
    - Ongoing interaction and updates with providers
    - Ongoing measure of patient satisfaction
    - Ongoing assessment of the appropriate site of care
  - Utilization Management tools and specialization across members' conditions

Rationale for Transition

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

Phase 1 Example of Impacted Drugs

	Diagnosis	Drug Name
Self-Administered	Anemia	Aranesp
		Aranesp
		Procrit, Epogen
	Neutropenia	Leukine
		Zarxio
		Neulasta
		Neupogen
		Granix
	Thrombocytopenia	Promacta
		Neumega
		Nplate
		Actimmune
	Infertility	Follistim AQ
		Menopur
Rare Disease	Immune Globulins	Bivigam
		Carimune NF
		Flebogamma
		Gammaplex
	Hemophilia	Benefix
		Corifact
		Mononine

Phase 1 Medical Specialty Spend and Savings Opportunity

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

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

Comparison of Benefits Example

Enhanced 80/20 Plan								
		Medical Benefit				Pharmacy Benefit		
		Units	Cost	Member Cost	Plan Cost	Cost	Member Cost	Plan Cost
Neupogen	**OUTPATIENT**	480				N/A		
	Cost of Drug		$1,261.00	$262.00	$ 1,046.00			
	Treatment Room (admin fee)		$47.00					
	OFFICE VISIT	480			-			
	Cost of Drug		$915.00	$117.00	$915.00	$512.00	$128.00	$564.00
	Office Visit		$117.00			$182.00		
	HOME	480	$1,546.00	$309.00	$ 1,237.00			
	Cost of Drug					$512.00	$128.00	$599.00
	Admin Fee					$215.00		

Note: Excludes rebates.

Express Scripts, Inc. Medical Management Channel Model

- Express Scripts' (ESI) Medical Channel Management Team includes:
  - Specialty Pharmacist
  - Nurses trained to manage self-administered and rare disease therapy classes
  - Accredo, the Plan's Specialty Pharmacy, has 600 employed registered nurses who provide care in home, daycare, and other settings

- Member Onboarding Process includes:
  - Clinical (ex. Medication Reconciliation, dose optimization, and pain assessment
  - Assessment (ex. lab values)
  - Environmental factors (ex. home safety)
  - Nutrition Support

Communication Plan – Phase 1 (June 1, 2016)

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

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

Phase 2: Rare Diseases

- Infusion
- Rare Diseases for:
  - Alpha-1 Deficiency
  - Enzyme Deficiency
  - Pulmonary Hypertension
- Will involve evaluating claims to determine the providers/facilities
- Time Frame for phase 2: January 1, 2017

Phase 2 Medical Specialty Spend and Savings Opportunity

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

Phase 3: Physician Administered Drugs

- Physician administered for:
  - Asthma
  - Blood Cell Deficiency
  - Inflammatory Conditions
  - Miscellaneous Specialty Conditions
  - Ophthalmic Conditions
  - Oster-Arthritis
  - Respiratory Syncytial Virus
- Will involve evaluating claims to determine the providers/facilities
- Focus on the heavy hitters e.g. Osteo-Arthritis; Inflammatory Conditions, and Ophthalmic Conditions which represents 93% of the medications in the category
- Time Frame for phase 3: June 1, 2017

Phase 3: Physician Administered

Management Strategy	Therapy	Patients	Paid Amount	Therapy Management Savings	Utilization Management Savings	Total Savings
Physician Administered	Asthma	69	$1,152,779	$50,261	$115,393	$165,654
	Blood Deficiency	4	$50,123	$4,702	$4,215	$8,917
	Inflammatory Conditions	853	$22,830,278	$1,054,759	$1,310,458	$2,365,217
	Miscellaneous Specialty Conditions	79	$313,754	$13,178	$4,393	$17,570
	Opthalmic Conditions	324	$2,624,708	$299,742	$194,228	$493,970
	Osteo-Arthritis	1811	$1,827,693	$340,134	$227,548	$567,681
	Respiratory Syncytial Virus	56	$671,990	$17,136	$89,106	$106,242
	Incremental Rebates	N/A				$3,704,907
	Grand Total	3,196	$29,471,325	$1,779,910	$1,945,341	$7,430,158

Appendix

Current Comparison of Benefits

	Medical			Pharmacy	
Plan Type	**Office**	**Outpatient, Independent Clinic**	**Home**	**Office**	**Home**
CDHP (85/15)- No copays HDHP (50/50)- No copays	Deductible and Coinsurance applied until OOP max reached. Usually applied to each claim line.	Deductible and Coinsurance applied until OOP max reached. Usually applied to each claim line.	Deductible and Coinsurance applied until OOP max reached. Usually applied to each claim line.	Deductible and Coinsurance applied until OOP max reached. Usually applied to each claim line.	Deductible and Coinsurance applied until OOP max reached. Usually applied to each claim line.
Enhanced (80/20) Office Visit Copays: PCP $30 Specialist $70 Drug Copays: Tier 4 – 25% up to $ 100 Tier 5 – 25% up to $132	• No copay taken for drug or services to administer drug • If provider includes office visit code on claim then an office visit copay will be taken • Copay will vary depending on whether provider is PCP or specialist	Deductible and Coinsurance applied until OOP max reached. Usually applied to each claim line.	Deductible and Coinsurance applied until OOP max reached. Usually applied to each claim line.	• No copay taken for drug or services to administer drug • If provider includes office visit code on claim then an office visit copay will be taken • Copay will vary depending on whether provider is PCP or specialist	Copay for drug Coinsurance for Administration
Traditional (70/30) Office Visit Copays: PCP $35 Specialist $81 Drug Copays: Tier 4 – 25% up to $ 100 Tier 5 – 25% up to $132	• No copay taken for drug or services to administer drug • If provider includes office visit code on claim then an office visit copay will be taken • Copay will vary depending on whether provider is PCP or specialist	Deductible and Coinsurance applied until OOP max reached. Usually applied to each claim line. Can be applied to each claim line.	Deductible and Coinsurance applied until OOP max reached. Usually applied to each claim line.	• No copay taken for drug or services to administer drug • If provider includes office visit code on claim then an office visit copay will be taken • Copay will vary depending on whether provider is PCP or specialist	Copay for drug Coinsurance for Administration

Implementation Plan Highlights

	Task Description	Time
1	Medical Carrier to exclude provided J codes from coverage under medical benefit.	Beginning on implementation date
2	Review Medical Carriers' current process for drugs with unclassified or miscellaneous codes.	45-60 days before implementation
3	Determine places of service to be included/excluded in this initiative. Recommendation is to include physician office and other specialty vendor at a minimum. Health plan to confirm they can facilitate desired place of service coding	45-60 days before implementation
4	ESI to provide sample member and physician communications to Client for review	90-120 days before implementation date
5	Review the process and timing for ongoing updates to the drug list with the Medical Carriers.	30-45 days before implementation date
6	Client to confirm which letters they will be using.	60-90 days before implementation date
7	Update content on client's internal website or other communications vehicles.	45-60 days before implementation

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Coverage for Clinical Trials

Board of Trustees Meeting

January 26, 2016

ACA Coverage of Approved Clinical Trials

- Under the Affordable Care Act (ACA), group health plans and health insurance issuers offering individual or group health insurance products are required to provide coverage of **routine patient costs** associated with approved clinical trials.
- For plan years beginning on or after January 1, 2014, the plan or issuer is prohibited, under federal law, from doing any of the following:
    1. Denying the **qualified individual** participation in an approved clinical trial.
    2. Denying or limiting, or imposing additional conditions on, the coverage of routine patient costs for items or services furnished in connection with participation in the approved clinical trial.
    3. Discrimination against the individual on the basis of the individual's participation in the **approved clinical trial.**

ACA Coverage of Approved Clinical Trials

- **Qualified individual:** An individual who is enrolled or participating in a health plan or coverage and who is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. There must be a determination that the individual's participation in the approved clinical trial is appropriate to treat the disease or condition.

- **Routine patient costs:** Generally includes all items and services consistent with the coverage provided under the plan for a qualified individual who is not enrolled in a clinical trial. However, the following costs are not required to be covered:
    1. The cost of an investigational item, device, or service.
    2. The cost of items and services provided solely to satisfy data collection and analysis needs that are not used in direct clinical management.
    3. The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

ACA Coverage of Approved Clinical Trials

- **Approved clinical trial:** A phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:
    1. A federally funded or approved trial.
    2. A clinical trial conducted under an FDA investigational new drug application.
    3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Current Coverage under Grandfathered Plans

- Under the Traditional 70/30 Plan and Enhanced 80/20 Plan the following is covered:
  - Participation in clinical trials phases II, III, and IV.
  - Only covers medically necessary costs of health services associated with the trials and only to the extent costs are not funded by other resources.
  - Member must meet all protocol requirements and provide informed consent.
  - Must involve a life-threatening medical condition with services that are medically indicated and preferable for that member compared to non-investigational alternatives.

Current Coverage under Grandfathered Plans

- The clinical trial must:
  - Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical specialists.
  - Be approved by centers or groups funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veteran Affairs.
  - Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.
- Exclusions:
  - Non-health care services, such as services provided for data collection and analysis.
  - Investigational drugs and devices and services that are not for the direct clinical management of the patient.

Cost of Expanding Coverage to Phase I Trials

- The Segal Company has advised plans that the cost of covering clinical trials as required under the ACA is approximately 0.45% of total claims (i.e. medical and pharmacy combined), with phase I costs usually accounting for 10% or less of the projected costs of all phases.

- Since the Plan already covers participation in clinical trial phases II, III, and IV under the Traditional 70/30 and Enhanced 80/20 plans, the cost of expanding coverage to include phase I trials is estimated to be $1 million annually.

Recommendation

Plan staff recommends that the Board of Trustees approve the coverage of approved clinical trials consistent with ACA requirements for our grandfathered plans: Traditional 70/30 and Enhanced 80/20

If approved, this benefit change can be implemented for CY 2016 (effective January 1, 2016).

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

November 2015 Financial Report

Board of Trustees Meeting

Informational Report

January 26, 2016

A Division of the Department of State Treasurer

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

Calendar Year 2015	Actual thru Nov 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	**$2.788 b**	**$2.781 b**	**$6.9 m**
Net Claims Payments	$2.483 b	$2.521 b	($37.6 m)
Medicare Advantage Premiums	$157.7 m	$159.5 m	($1.8 m)
Net Administrative Expenses	$153.9 m	$221.4 m	($67.5 m)
Total Plan Expenses	**$2.795 b**	**$2.902 b**	**($106.9 m)**
Net Income/(Loss)	**($7.7 m)**	**($121.5 m)**	**$113.8 m**
Ending Cash Balance	**$1.007 b**	**$893.3 m**	**$113.8 m**

Adjusted Variance Report
Calendar Year to Date November 2015

Calendar Year 2015	Actual thru Nov 2015, As Adjusted	Authorized Budget (per Segal 4-28-15)	Variance Over/(Under) Budget
Plan Revenue *	**$2.788 b**	**$2.781 b**	**$7.0 m**
Net Claims Payments ^	$2.487 b	$2.521 b	($34.1 m)
Medicare Advantage Premiums	$157.7 m	$159.5 m	($1.8 m)
Net Administrative Expenses *	$162.8 m	$221.4 m	($58.6 m)
Total Plan Expenses	**$2.808 b**	**$2.902 b**	**($94.5 m)**
Net Income/(Loss)	**($20.0 m)**	**($121.5 m)**	**$101.5 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 November 2015

Per Member Per Month (PMPM) Analysis

Calendar Year 2015	Actual thru Nov 2015	Authorized Budget (per Segal 4-28-15)	Variance Over/(Under) Budget
Plan Revenue	**$369.40**	**$369.35**	**$0.05**
Net Claims Payments	$329.84	$335.13	($5.29)
Medicare Advantage Premiums	$20.94	$21.20	($0.26)
Net Administrative Expenses	$20.44	$29.44	($9.00)
Total Plan Expenses	**$371.22**	**$385.77**	**($14.55)**
Net Income/(Loss)	**($1.82)**	**($16.42)**	**$14.60**

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

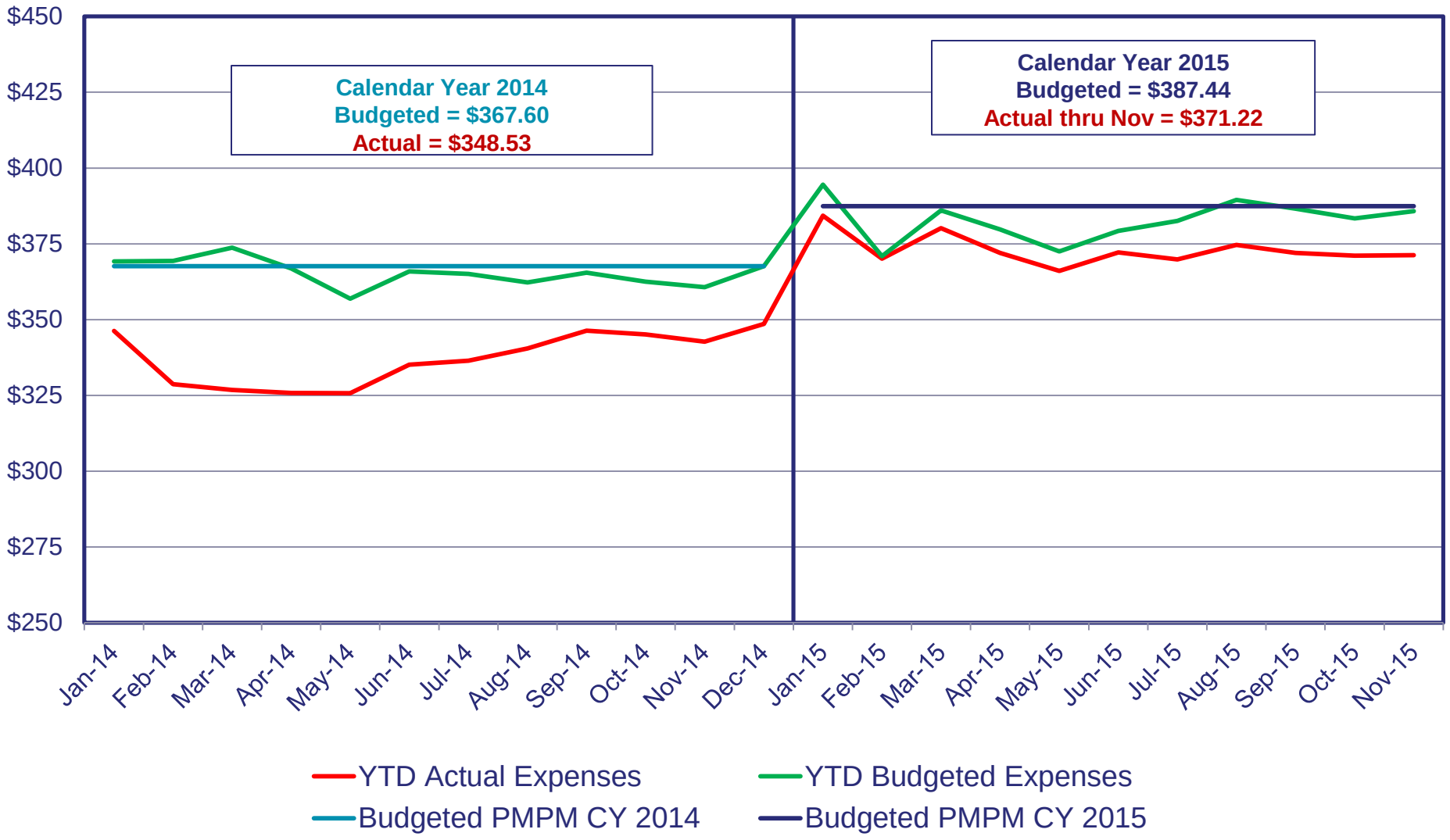
Adjusted Variance Report
Calendar Year to Date November 2015

Per Member Per Month (PMPM) Analysis

Calendar Year 2015	Actual thru Nov 2015, as Adjusted	Authorized Budget (per Segal 4-28-15)	Variance Over/(Under) Budget
Plan Revenue *	**$369.42**	**$369.35**	**$0.07**
Net Claims Payments ^	$330.30	$335.13	($4.83)
Medicare Advantage Premiums	$20.94	$21.20	($0.26)
Net Administrative Expenses *	$21.62	$29.44	($7.82)
Total Plan Expenses	**$372.86**	**$385.77**	**($12.91)**
Net Income/(Loss)	**($3.44)**	**($16.42)**	**$12.98**

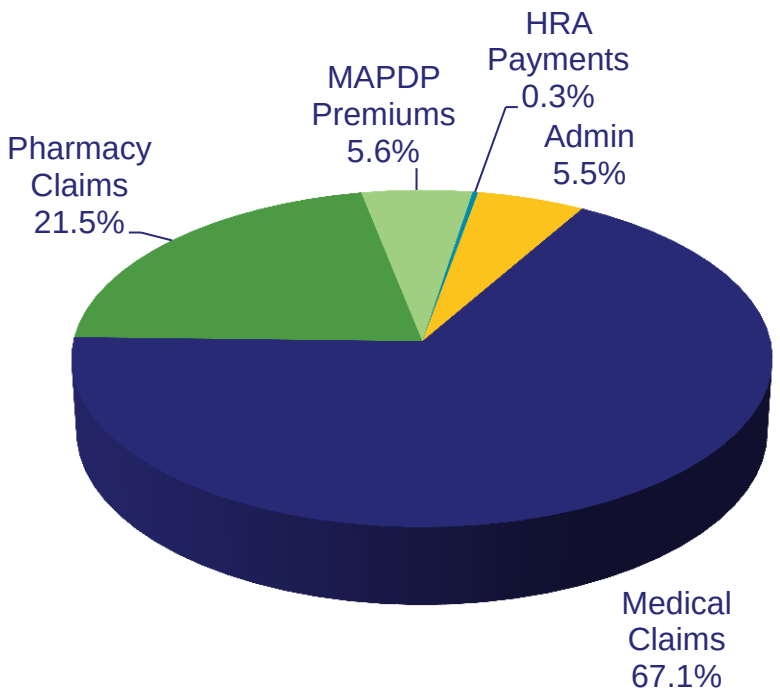
* Adjusted for timing issues.
^ Adjusted for timing issues on pharmacy rebates and to exclude unbudgeted credits against pharmacy claims.

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



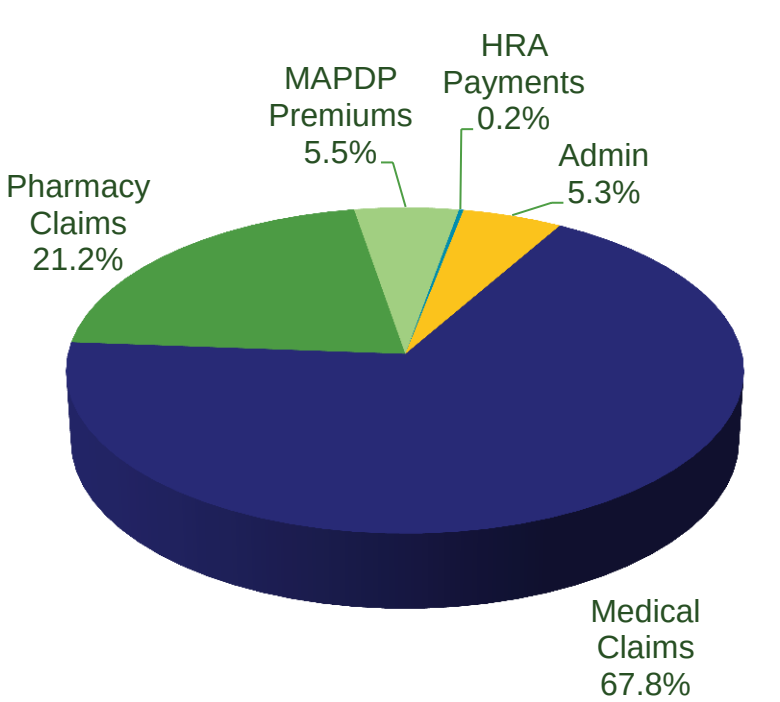
Allocation of Total Expenditures

Calendar Year To Date: Nov 2015



Total Expenses = $2.795 billion

Calendar Year 2014

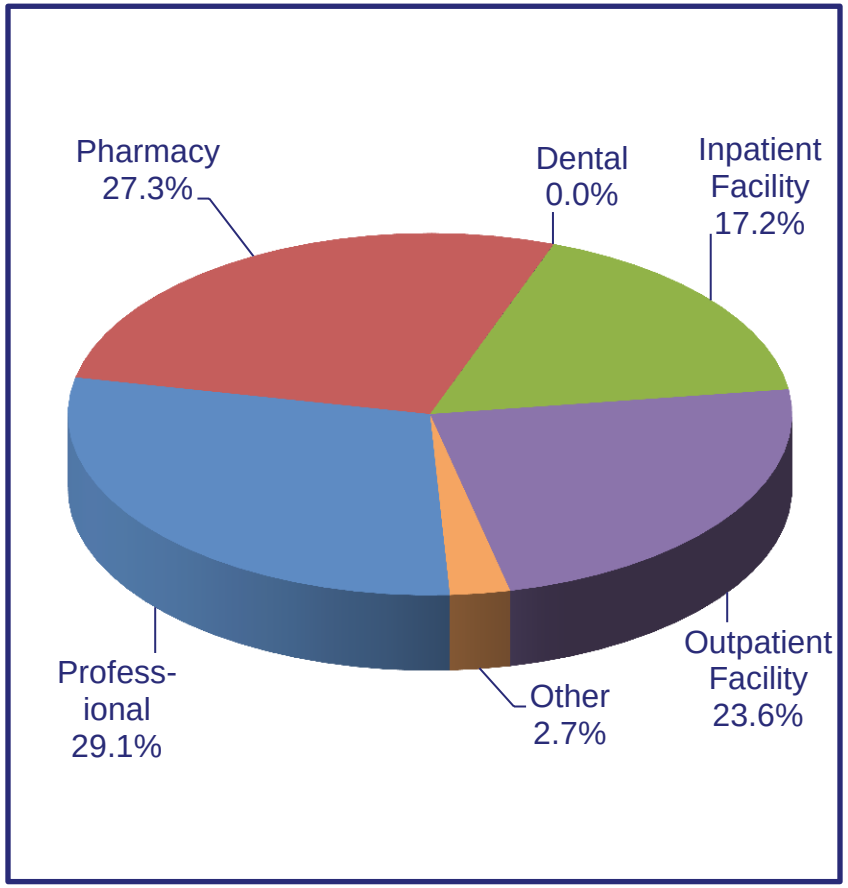


Total Expenses = $2.831 billion

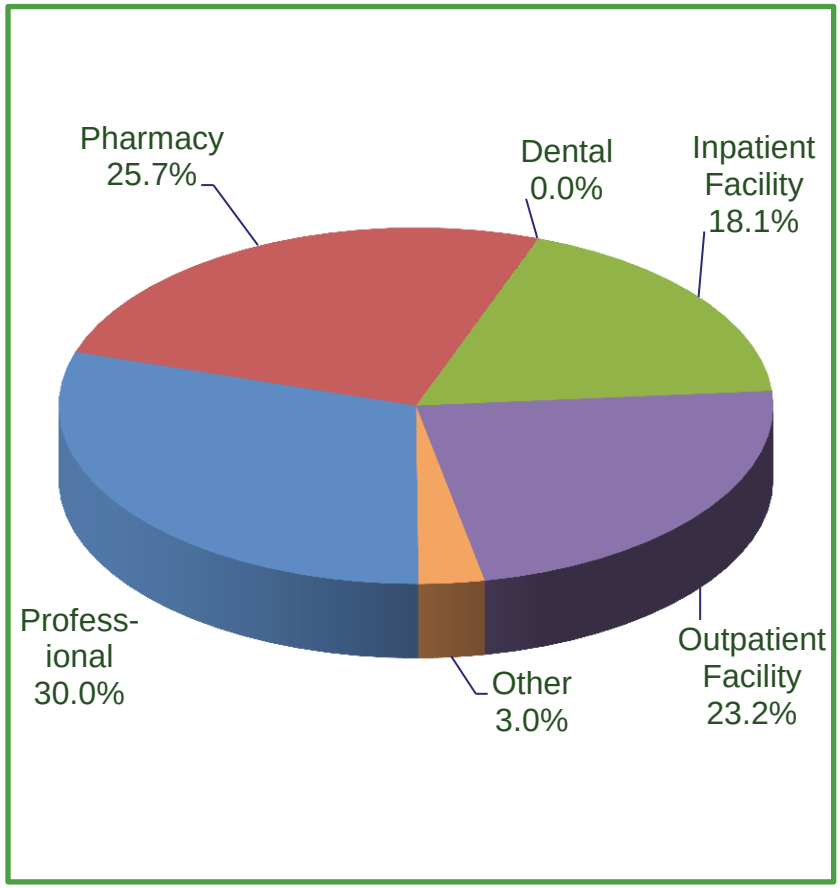
Sources: BCBSNC Net Disbursements reports; Financial Status Reports

Allocation of Claims Expenditures
Medical, Blue Card and Pharmacy Payments

Calendar Year to Date: Nov 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 November 2015
Calendar Year 2015

		A	B	C	D	E	F	G	H
		Actual November 2015	Authorized Budget November 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	$ 244,172,640	$ 248,321,115	$ (4,148,475)	$ 2,714,755,865	$ 2,715,697,149	$ (941,284)	$ 2,963,937,832	$ (249,181,967)
4	Premium Refunds/Retroactive Disenrollments	-	(124,550)	124,550	(5,343)	(1,362,148)	1,356,805	(1,486,657)	1,481,314
5	Medicare Part D (RDS) Subsidy	1,399,605	1,257,105	142,500	17,951,576	13,375,133	4,576,443	14,587,080	3,364,496
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	48,603,406	48,602,498	908	48,602,498	908
7	Medicare Advantage (MA) Subsidy	39,524	69,403	(29,879)	794,027	759,522	34,505	828,983	(34,956)
8	**Net Premium & Other Contributions**	**245,611,769**	**249,523,073**	**(3,911,304)**	**2,782,099,531**	**2,777,072,154**	**5,027,377**	**3,026,469,736**	**(244,370,205)**
9									
10	Investment Earnings	533,137	302,699	230,438	5,458,483	3,578,740	1,879,743	3,871,779	1,586,704
11	Miscellaneous Revenue	-	-	-	-	-	-	-	-
12	**Other Revenue**	**533,137**	**302,699**	**230,438**	**5,458,483**	**3,578,740**	**1,879,743**	**3,871,779**	**1,586,704**
13									
14	**Total Plan Revenue (excludes internal transfers)**	**246,144,906**	**249,825,772**	**(3,680,866)**	**2,787,558,014**	**2,780,650,894**	**6,907,120**	**3,030,341,515**	**(242,783,501)**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	183,912,430	199,569,916	(15,657,486)	1,903,685,405	1,966,896,938	(63,211,533)	2,128,799,496	(225,114,091)
19	Medical Claim Refunds/Recoveries	(2,078,717)	(2,114,615)	35,898	(21,689,979)	(23,013,958)	1,323,979	(25,072,202)	3,382,223
20	**Net Medical Claims**	**181,833,713**	**197,455,301**	**(15,621,588)**	**1,881,995,426**	**1,943,882,980**	**(61,887,554)**	**2,103,727,294**	**(221,731,868)**
21									
22	Pharmacy Claim Payments	92,268,089	55,818,357	36,449,732	703,129,774	634,365,467	68,764,307	718,955,282	(15,825,508)
23	Pharmacy Claim Rebates	(41,631,055)	(11,772,659)	(29,858,396)	(96,193,453)	(57,020,841)	(39,172,612)	(57,020,841)	(39,172,612)
24	Pharmacy Claim Refunds/Recoveries	(4,301)	-	(4,301)	(5,313,234)	-	(5,313,234)	-	(5,313,234)
25	**Net Pharmacy Claims**	**50,632,733**	**44,045,698**	**6,587,035**	**601,623,087**	**577,344,626**	**24,278,461**	**661,934,441**	**(60,311,354)**
26									
27	**Net Claim Payments**	**232,466,446**	**241,500,999**	**(9,034,553)**	**2,483,618,513**	**2,521,227,606**	**(37,609,093)**	**2,765,661,735**	**(282,043,222)**
28									
29	**Medicare Advantage Premium Payments**	**14,339,521**	**14,560,176**	**(220,655)**	**157,675,745**	**159,499,835**	**(1,824,090)**	**174,072,089**	**(16,396,344)**
30									
31	**Net Administrative Expenses**	**8,683,735**	**24,056,722**	**(15,372,987)**	**153,936,735**	**221,456,696**	**(67,519,961)**	**239,864,700**	**(85,927,965)**
32									
33	**Total Plan Expenses (excludes internal transfers)**	**255,489,702**	**280,117,897**	**(24,628,195)**	**2,795,230,993**	**2,902,184,137**	**(106,953,144)**	**3,179,598,524**	**(384,367,531)**
34									
35	**Plan Income/(Loss)**	**(9,344,796)**	**(30,292,125)**	**20,947,329**	**(7,672,979)**	**(121,533,243)**	**113,860,264**	**(149,257,009)**	**141,584,030**
36									
37	**Cash Availability:**								
38									
39	Beginning Cash Balance/(Deficit)	1,016,519,163	923,606,228	92,912,935	1,014,847,346	1,014,847,346	-	1,014,847,346	-
40	**Ending Cash Balance/(Deficit)**	**1,007,174,367**	**893,314,103**	**113,860,264**	**1,007,174,367**	**893,314,103**	**113,860,264**	**865,590,337**	**141,584,030**
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**	**$ 758,264,810**	**$ 644,404,546**	**$ 113,860,264**	**$ 758,264,810**	**$ 644,404,546**	**$ 113,860,264**	**$ 616,680,780**	**$ 141,584,030**

Comments:
a. Premium receivables totaled $1,277,639.56 as of November 30, 2015.
b. The average weekly medical claims cost net of claims refunds was $36,366,742.60 for the five scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included three bi-weekly invoice cycles averaging $30,756,029.67 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)
November - 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 November 2016
Fiscal Year 2015- 2016

		A	B	C	D	E	F	G	H
		Actual November 2016	Certified Budget November 2016	Monthly Variance Over/(Under) Certified Budget	Actual Year to Date FY 2015-16	10/13/2016 Certified Budget Year to Date FY 2015-16	Year to Date Variance Over/(Under) Certified Budget	10/13/2016 Annual Certified Budget FY 2015-16	Year to Date Variance Over/(Under) Annual Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 244,172,640	$ 248,463,191	$ (4,290,551)	$ 1,241,325,655	$ 1,243,119,935	$ (1,794,280)	$ 3,031,630,846	$ (1,790,305,191)
4	Premium Refunds/Retroactive Disenrollments	-	(124,589)	124,589	-	(623,348)	623,348	(1,523,909)	1,523,909
5	Medicare Part D (RDS) Subsidy	1,399,605	1,262,902	136,703	7,037,669	6,127,471	910,198	14,457,206	(7,419,537)
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	-	-	-	-	-
7	Medicare Advantage (MA) Subsidy	39,524	69,650	(30,126)	264,973	347,675	(82,702)	848,545	(583,572)
8	**Net Premium & Other Contributions**	**245,611,769**	**249,671,154**	**(4,059,385)**	**1,248,628,297**	**1,248,971,733**	**(343,436)**	**3,045,412,888**	**(1,796,784,391)**
9									
10	Investment Earnings	533,137	329,175	203,962	2,734,742	1,657,192	1,077,550	3,760,445	(1,025,703)
11	Miscellaneous Revenue	-	-	-	-	-	-	-	-
12	**Other Revenue**	**533,137**	**329,175**	**203,962**	**2,734,742**	**1,657,192**	**1,077,550**	**3,760,445**	**(1,025,703)**
13									
14	**Total Plan Revenue (excludes internal transfers)**	**246,144,906**	**250,000,329**	**(3,855,423)**	**1,251,363,038**	**1,250,628,925**	**734,114**	**3,049,173,333**	**(1,797,810,094)**
15									
16	**Plan Expenses:**								
17									
18	Medical Claim Payments	183,912,430	199,139,377	(15,226,947)	875,738,258	903,950,364	(28,212,106)	2,152,322,381	(1,276,584,123)
19	Medical Claim Refunds/Recoveries	(2,078,717)	(2,123,592)	44,875	(7,965,903)	(10,761,014)	2,795,111	(25,761,279)	17,795,376
20	**Net Medical Claims**	**181,833,713**	**197,015,786**	**(15,182,072)**	**867,772,355**	**893,189,350**	**(25,416,995)**	**2,126,561,102**	**(1,258,788,747)**
21									
22	Pharmacy Claim Payments	92,268,089	58,304,774	33,963,315	357,784,223	317,991,707	39,792,515	802,956,864	(445,172,641)
23	Pharmacy Claim Rebates	(41,631,055)	(11,688,039)	(29,943,016)	(84,377,483)	(77,646,286)	(6,731,197)	(104,118,976)	19,741,493
24	Pharmacy Claim Refunds/Recoveries	(4,301)	-	(4,301)	(1,645,077)	-	(1,645,077)	-	(1,645,077)
25	**Net Pharmacy Claims**	**50,632,733**	**46,616,736**	**4,016,998**	**271,761,663**	**240,345,421**	**31,416,242**	**698,837,888**	**(427,076,225)**
26									
27	**Net Claim Payments**	**232,466,446**	**243,632,520**	**(11,166,074)**	**1,139,534,018**	**1,133,534,771**	**5,999,247**	**2,825,398,990**	**(1,685,864,972)**
28									
29	**Medicare Advantage Premium Payments**	**14,338,521**	**14,326,270**	**13,251**	**72,234,454**	**71,512,706**	**721,748**	**181,076,580**	**(108,842,126)**
30									
31	**Net Administrative Expenses**	**8,683,735**	**24,056,661**	**(15,372,926)**	**56,539,823**	**97,772,087**	**(41,232,264)**	**244,252,193**	**(187,712,370)**
32									
33	**Total Plan Expenses (excludes internal transfers)**	**255,488,702**	**282,015,451**	**(26,526,748)**	**1,268,308,295**	**1,302,819,564**	**(34,511,268)**	**3,250,727,763**	**(1,982,419,468)**
34									
35	**Plan Income/(Loss)**	**(9,344,796)**	**(32,015,122)**	**22,670,326**	**(16,945,256)**	**(52,190,638)**	**35,245,383**	**(201,554,430)**	**184,608,374**
36									
37	**Cash Availability:**								
38									
39	Beginning Cash Balance/(Deficit)	1,016,519,163	1,003,944,106	12,575,057	1,024,119,623	1,024,119,623	-	1,024,119,623	-
40	**Ending Cash Balance/(Deficit)**	**1,007,174,367**	**971,928,984**	**35,245,383**	**1,007,174,367**	**971,928,984**	**35,245,383**	**822,684,993**	**184,608,374**
41									
42	Target Stabilization Reserve @ 6/30/16	254,285,909	254,285,909	-	254,285,909	254,285,909	-	254,285,909	-
43									
44	**Cash Balance Over/(Under) Reserve Target**	**$ 752,888,458**	**$ 717,643,075**	**$ 35,245,383**	**$ 752,888,458**	**$ 717,643,075**	**$ 35,245,383**	**$ 568,278,084**	**$ 184,608,374**

Comments:
a. Premium receivables totaled $1,277,639.56 as of November 30, 2015.
b. The average weekly medical claims cost net of claims refunds was $36,366,742.60 for the five scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included three bi-weekly invoice cycles averaging $30,756,029.67 per cycle.
d. The target stabilization reserve is 9% of the projected net claims for Fiscal Year 2015-16.
e. Minor differences compared to other reports are due to rounding.

Actual vs Certified Budget (per Segal 10-13-15 Projections)
November 2015 - Fiscal Year

North Carolina State Health Plan for Teachers and State Employees

Summary of Operations (Cash Basis)

Current Year Actual vs. Prior Year Actual

For the Month Ended November 2015

Calendar Year 2015

		A	B	C	D	E	F	G
		Current Year Actual November 2015	Prior Year Actual November 2014	Current Year to Date Actual CY 2015 thru November	Prior Year to Date Actual CY 2014 thru November	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	$ 244,172,640	$ 244,430,403	$ 2,714,755,865	$ 2,681,711,150	$ 2,963,937,832	$ 2,921,878,532	$ 2,952,592,141
4	Premium Refunds/Retroactive Disenrollments	-	-	(5,343)	(28,401)	(1,486,657)	(1,489,408)	(28,401)
5	Medicare Part D (RDS) Subsidy	1,399,605	2,321,961	17,951,576	20,326,396	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	39,524	76,717	794,027	649,586	828,983	-	721,773
8	Federal Early Retiree Reinsurance Program (ERRP)	-	(1,949)	-	(1,949)	-	-	(1,949)
9	**Net Premium & Other Contributions**	**245,611,769**	**246,827,132**	**2,782,099,531**	**2,731,035,183**	**3,026,469,736**	**2,957,780,205**	**3,003,246,369**
10								
11	Investment Earnings	533,137	413,715	5,458,483	3,974,718	3,871,779	2,892,005	4,417,142
12	Miscellaneous Revenue	-	-	-	-	-	-	-
13	**Other Revenue**	**533,137**	**413,715**	**5,458,483**	**3,974,718**	**3,871,779**	**2,892,005**	**4,417,142**
14								
15	**Total Plan Revenue (excludes internal transfers)**	**246,144,906**	**247,240,847**	**2,787,558,014**	**2,735,009,901**	**3,030,341,515**	**2,960,672,210**	**3,007,663,511**
16								
17	**Plan Expenses:**							
18								
19	Medical Claim Payments	183,912,430	150,895,281	1,903,685,405	1,777,879,533	2,128,799,496	2,062,826,346	1,949,838,964
20	Medical Claim Refunds/Recoveries	(2,078,717)	(2,037,534)	(21,689,979)	(21,123,612)	(25,072,202)	(25,469,051)	(22,731,740)
21	**Net Medical Claims**	**181,833,713**	**148,857,747**	**1,881,995,426**	**1,756,755,921**	**2,103,727,294**	**2,037,357,295**	**1,927,107,224**
22								
23	Pharmacy Claim Payments	92,268,089	54,036,740	703,129,774	613,312,862	718,955,282	599,541,594	698,129,098
24	Pharmacy Claim Rebates	(41,631,055)	(10,405,210)	(96,193,453)	(98,763,203)	(57,020,841)	(54,794,623)	(98,763,203)
25	Pharmacy Claim Refunds/Recoveries	(4,301)	(8,327)	(5,313,234)	91,788	-	-	(313,676)
26	**Net Pharmacy Claims**	**50,632,733**	**43,623,203**	**601,623,087**	**514,641,447**	**661,934,441**	**544,746,971**	**599,052,219**
27								
28	**Net Claim Payments**	**232,466,446**	**192,480,950**	**2,483,618,513**	**2,271,397,368**	**2,765,661,735**	**2,582,104,266**	**2,526,159,443**
29								
30	**Medicare Advantage Premium Payments**	**14,339,521**	**12,919,472**	**157,675,745**	**143,622,842**	**174,072,089**	**174,162,733**	**155,497,950**
31								
32	**Net Administrative Expenses**	**8,683,735**	**10,718,302**	**153,936,735**	**136,317,059**	**239,864,700**	**179,815,010**	**149,605,909**
33								
34	**Total Plan Expenses (excludes internal transfers)**	**255,489,702**	**216,118,724**	**2,795,230,993**	**2,551,337,269**	**3,179,598,524**	**2,936,082,009**	**2,831,263,302**
35								
36	**Plan Income/(Loss)**	**(9,344,796)**	**31,122,123**	**(7,672,979)**	**183,672,632**	**(149,257,009)**	**24,590,201**	**176,400,209**
37								
38	**Cash Availability:**							
39								
40	Beginning Cash Balance/(Deficit)	1,016,519,163	990,997,646	1,014,847,346	838,447,137	1,014,847,346	694,975,133	838,447,137
41	**Ending Cash Balance/(Deficit)**	**1,007,174,367**	**1,022,119,769**	**1,007,174,367**	**1,022,119,769**	**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**	**$ 758,264,810**	**$ 787,837,074**	**$ 758,264,810**	**$ 787,837,074**	**$ 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 November 2015
Fiscal Year 2015-2016

		A	B	C	D	E	F	G
		Current Year Actual November 2015	Prior Year Actual November 2014	Current Year to Date Actual FY 2015-16 thru November	Prior Year to Date Actual FY 2014-15 thru November	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	$ 244,172,640	$ 244,430,403	$ 1,241,325,655	$ 1,243,191,472	$ 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	1,399,605	2,321,961	7,037,669	7,418,856	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	39,524	76,717	264,973	232,021	848,545	-	833,262
8	Federal Early Retiree Reinsurance Program (ERRP)	-	(1,949)	-	(1,949)	-	-	(1,949)
9	**Net Premium & Other Contributions**	245,611,769	246,827,132	1,248,628,297	1,252,514,801	3,045,412,688	2,976,119,147	3,058,197,221
10								
11	Investment Earnings	533,137	413,715	2,734,742	1,899,570	3,760,445	3,933,340	5,065,735
12	Miscellaneous Revenue	-	-	-	-	-	-	-
13	**Other Revenue**	533,137	413,715	2,734,742	1,899,570	3,760,445	3,933,340	5,065,735
14								
15	**Total Plan Revenue (excludes internal transfers)**	246,144,906	247,240,847	1,251,363,039	1,254,414,371	3,049,173,133	2,980,052,487	3,063,262,956
16								
17	**Plan Expenses:**							
18								
19	Medical Claim Payments	183,912,430	150,895,281	875,738,258	821,462,600	2,152,322,381	1,995,716,227	2,021,369,178
20	Medical Claim Refunds/Recoveries	(2,078,717)	(2,037,534)	(7,965,903)	(9,507,224)	(25,761,279)	(23,520,519)	(24,839,428)
21	**Net Medical Claims**	181,833,713	148,857,747	867,772,355	811,955,376	2,126,561,102	1,972,195,708	1,996,529,750
22								
23	Pharmacy Claim Payments	92,268,089	54,036,740	357,784,223	295,448,217	802,956,864	686,943,428	725,610,004
24	Pharmacy Claim Rebates	(41,631,055)	(10,405,210)	(84,377,483)	(39,298,739)	(104,118,976)	(74,166,940)	(51,114,709)
25	Pharmacy Claim Refunds/Recoveries	(4,301)	(8,327)	(1,645,077)	(67,090)	-	-	(4,140,711)
26	**Net Pharmacy Claims**	50,632,733	43,623,203	271,761,663	256,082,388	698,837,888	612,776,488	670,354,584
27								
28	**Net Claim Payments**	232,466,446	192,480,950	1,139,534,018	1,068,037,764	2,825,398,990	2,584,972,196	2,666,884,334
29								
30	**Medicare Advantage Premium Payments**	14,339,521	12,919,472	72,234,454	65,083,995	181,076,580	163,281,044	162,400,394
31								
32	**Net Administrative Expenses**	8,683,735	10,718,302	56,539,823	57,730,883	244,252,193	223,971,245	168,416,645
33								
34	**Total Plan Expenses (excludes internal transfers)**	255,489,702	216,118,724	1,268,308,295	1,190,852,642	3,250,727,763	2,972,224,485	2,997,701,373
35								
36	Plan Income/(Loss)	(9,344,796)	31,122,123	(16,945,256)	63,561,729	(201,554,630)	7,828,002	65,561,583
37								
38	**Cash Availability:**							
39								
40	Beginning Cash Balance/(Deficit)	1,016,519,163	990,997,646	1,024,119,623	958,558,040	1,024,119,623	958,558,040	958,558,040
41	**Ending Cash Balance/(Deficit)**	1,007,174,367	1,022,119,769	1,007,174,367	1,022,119,769	822,564,993	966,386,042	1,024,119,623
42								
43	Target Stabilization Reserve @ 6/30	254,285,909	232,647,498	254,285,909	232,647,498	254,285,909	232,647,498	240,019,590
44								
45	**Cash Balance Over/(Under) Reserve Target**	$ 752,888,458	$ 789,472,271	$ 752,888,458	$ 789,472,271	$ 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 November 2015
Calendar Year 2015

		A	B	C	D	E	F
		Actual Year to Date Calendar Year thru November	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Authorized Budget Calendar Year to Date thru November	*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)	$ 2,714,755,865	$ 117,841	$ 2,714,873,706	$ 2,715,697,149	$ (823,443)	-0.03%
4	Premium Refunds/Retroactive Disenrollments	(5,343)		(5,343)	(1,362,148)	1,356,805	-99.61%
5	Medicare Part D (RDS) Subsidy	17,951,576		17,951,576	13,375,133	4,576,443	34.22%
6	Medicare PDP (EGWP + Wrap) Subsidy	48,603,406		48,603,406	48,602,498	908	0.00%
7	Medicare Advantage (MA) Subsidy	794,027		794,027	759,522	34,505	4.54%
8	**Net Premium & Other Contributions**	**2,782,099,531**	**117,841**	**2,782,217,372**	**2,777,072,154**	**5,145,218**	**0.19%**
9							
10	**Other Revenue**	**5,458,483**		**5,458,483**	**3,578,740**	**1,879,743**	**52.53%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**2,787,558,014**	**117,841**	**2,787,675,855**	**2,780,650,894**	**7,024,961**	**0.25%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	1,881,995,426		1,881,995,426	1,943,882,980	(61,887,554)	-3.18%
17	Net Pharmacy Claims (Notes 3 thru 5)	601,623,087	3,519,051	605,142,138	577,344,626	27,797,512	4.81%
18	**Net Claim Payments**	**2,483,618,513**	**3,519,051**	**2,487,137,564**	**2,521,227,606**	**(34,090,042)**	**-1.35%**
19							
20	**Medicare Advantage Premiums**	**157,675,745**		**157,675,745**	**159,499,835**	**(1,824,090)**	**-1.14%**
21							
22	**Net Administrative Expenses (Note 6)**	**153,936,735**	**8,882,861**	**162,819,596**	**221,456,696**	**(58,637,100)**	**-26.48%**
23							
24	**Total Plan Expenses (excludes internal transfers)**	**2,795,230,993**	**12,401,912**	**2,807,632,905**	**2,902,184,137**	**(94,551,232)**	**-3.26%**
25							
26	Plan Income/(Loss)	(7,672,979)	(12,284,071)	(19,957,050)	(121,533,243)	101,576,193	-83.58%
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)**	**1,007,174,367**	**(12,284,071)**	**994,890,296**	**893,314,103**	**101,576,193**	**11.37%**
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**	**$ 758,264,810**	**$ (12,284,071)**	**$ 745,980,739**	**$ 644,404,546**	**$ 101,576,193**	**15.76%**

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 $25.7 million in prepaid December premiums received in November.
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 $30.8 million to exclude a third November pharmacy invoice that was budgeted for payment in December.
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.
6. Administrative expenses adjusted to reflect normal invoice cycle.

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 November 2015
Fiscal Year 2015-2016

		A	B	C	D	E	F
		Actual Year to Date Fiscal Year thru November	Adjustments for Timing, Unusual & Onetime Events	***Adjusted*** *Actual Year to Date*	Certified Budget Fiscal Year to Date thru November	*Year to Date* ***Adjusted*** *Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 1,241,325,655	$ (4,248,079)	$ 1,237,077,576	$ 1,243,119,935	$ (6,042,359)	-0.49%
4	Premium Refunds/Retroactive Disenrollments	-		-	(623,348)	623,348	-100.00%
5	Medicare Part D (RDS) Subsidy	7,037,669		7,037,669	6,127,471	910,198	14.85%
6	Medicare PDP (EGWP + Wrap) Subsidy	-		-	-	-	
7	Medicare Advantage (MA) Subsidy	264,973		264,973	347,675	(82,702)	-23.79%
8	**Net Premium & Other Contributions**	**1,248,628,297**	**(4,248,079)**	**1,244,380,218**	**1,248,971,733**	**(4,591,515)**	**-0.37%**
9							
10	**Other Revenue**	**2,734,742**		**2,734,742**	**1,657,192**	**1,077,550**	**65.02%**
11							
12	**Total Plan Revenue (excludes internal transfers)**	**1,251,363,039**	**(4,248,079)**	**1,247,114,960**	**1,250,628,925**	**(3,513,965)**	**-0.28%**
13							
14	**Plan Expenses:**						
15							
16	Net Medical Claims	867,772,355		867,772,355	893,189,350	(25,416,995)	-2.85%
17	Net Pharmacy Claims (Notes 3 and 4)	271,761,663	(29,227,377)	242,534,286	240,345,421	2,188,865	0.91%
18	**Net Claim Payments**	**1,139,534,018**	**(29,227,377)**	**1,110,306,641**	**1,133,534,771**	**(23,228,130)**	**-2.05%**
19							
20	**Medicare Advantage Premiums**	**72,234,454**		**72,234,454**	**71,512,706**	**721,748**	**1.01%**
21							
22	**Net Administrative Expenses (Note 5)**	**56,539,823**	**8,882,861**	**65,422,684**	**97,772,087**	**(32,349,403)**	**-33.09%**
23							
24	**Total Plan Expenses (excludes internal transfers)**	**1,268,308,295**	**(20,344,516)**	**1,247,963,779**	**1,302,819,564**	**(54,855,785)**	**-4.21%**
25							
26	**Plan Income/(Loss)**	**(16,945,256)**	**16,096,436**	**(848,820)**	**(52,190,639)**	**51,341,819**	**-98.37%**
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)**	**1,007,174,367**	**16,096,436**	**1,023,270,803**	**971,928,984**	**51,341,819**	**5.28%**
32							
33	Target Stabilization Reserve @ 6/30/16	254,285,909		254,285,909	254,285,909	-	0.00%
34							
35	**Cash Balance Over/(Under) Reserve Target**	**$ 752,888,458**	**$ 16,096,436**	**$ 768,984,894**	**$ 717,643,075**	**$ 51,341,819**	**7.15%**

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 $25.7 million in prepaid December premiums received in November.
3. Net pharmacy claims exclude an unbudgeted $1.6 million recovery from a class action law suit.
4. Net pharmacy claims reduced by $30.8 million to exclude a third November pharmacy invoice that was budgeted for payment in December.
5. Administrative expenses adjusted to reflect normal invoice cycle.

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

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Communications Update

Board of Trustees Meeting

Informational Report

January 26, 2016

A Division of the Department of State Treasurer

Comprehensive Marketing & Communication Plan

Comprehensive Marketing & Communication Plan

- Buck Consultants has completed their initial audit of the State Health Plan's communication efforts.
- The next step, based on the audit results, is to implement a comprehensive marketing and communications campaign aimed at engaging members to be active consumers of health care by improving their understanding of their benefits and resources.
- This effort will also include the ongoing programs and initiatives the Plan is promoting such as:
  - Health Literacy
  - Pre-65 Outreach Promotion
  - Health Engagement Program
  - Diabetes Prevention Program
  - Annual Enrollment

Health Engagement Program

2016 Health Engagement Program

- For all Members (≥18 yrs.) in the Consumer-Directed Health Plan (CDHP)
- For Members with certain chronic conditions in the CDHP
- Incent health engagement, healthy behaviors, and high value medical care
- Program to be delivered by the Plan's Population Health Management Vendor, ActiveHealth Management (AHM), and incentives delivered in coordination with Third Party Administrator, Blue Cross and Blue Shield of NC (BCBSNC)
- Program will launch April 1, 2016

Health Engagement Program: Healthy Lifestyles Component

- Available to all CDHP members, 18 years and older
  - Members can enroll online anytime during the calendar year; activities are incented only after enrollment
  - Members encouraged to complete Health Assessment at enrollment
  - Enrolled members stay enrolled for the Plan benefit year
  - Members must complete activities within a calendar quarter to earn HRA incentive funds
- Incented activities include:
  - Engagement with Lifestyle Coach
  - Tracking physical activity and/or nutrition
    - Activities tracked on Personal Health Portal, through a free app, or with a wearable device

Healthy Lifestyles Tracking Activities

- **Lifestyle Coach**: Can have as many calls as needed, third call triggers incentive.

- **Physical Activity**: Track 30 minutes of activity (any kind of physical activity) or 5,000 steps a day for minimum of 46 days over a 13-week period (50% tracking required to earn incentive).
  - This allows members to track activity intermittently, rather than continuously, allowing flexibility for the member

- **Nutrition**: Track daily intake (calories) for a minimum of 46 days over a 13-week period (50% tracking required to earn incentive)
  - Unlike physical activity, a minimum or maximum has not been assigned for caloric intake
  - *Year 1 goal is to raise awareness and mindfulness of one's daily intake*

Health Lifestyles Incentives

Healthy Lifestyles Component for All Members	Participation in Lifestyle Coaching (3rd call is incentivized) Earn up to 1 per CY	Participation in Tracking Exercise AND/OR Nutrition Earn up to 1 per Quarter Total of 4 per CY	Potential Total Incentive Funds Earned Per CY
Incentive Amount	$25	$25	
Total Incentive Funds Available per Calendar Year (CY)	$25	$100 (max $75 for CY 2016)	$125 (max $100 for CY 2016)

Health Engagement Program: Chronic Condition Component

- Available to all CDHP members, 18 years and older
- Program is designed for members with high prevalence high cost chronic conditions (e.g. Diabetes, Asthma)
  - Members enroll by calling AHM at 800-817-7044
  - Members enroll on a rolling calendar year
  - Members must complete HA to enroll
- Diagnosis of one or more of following conditions:
  - Diabetes
  - Hypertension
  - COPD
  - Asthma
  - Coronary Artery Disease
  - Hyperlipidemia
  - Congestive Heart Failure

Chronic Condition Incentives

Incentive Amounts for Chronic Condition Component						
Disease/Condition	2 HC Calls[1] ($25 x2)	2 Primary Care Visits ($25 x 2)*	Labs	Education/ Treatment	Potential 'Earned Incentive'	Estimated Cost of Incentivized Services (includes Medications)
Incentive Amount per item	$25	$25	$30	$30		
Diabetes	$50	$50	$120	$30	$250	$1,399
COPD	$50	$50	$0	$30	$130	$1,383
Asthma	$50	$50	$0	$120	$220	$865
HTN	$50	$50	$30	$30	$160	$830
Hyperlipidemia	$50	$50	$30	$0	$130	$317
CHF	$50	$50	$60	$60	$220	$303
CAD	$50	$50	$60	$30	$190	$918
Multiple Comorbidities: Asthma + COPD	$50	$50	$0	$120	$220	$1,962
Multiple Comorbidities: DM+CAD+ Hyperlipidemia+CHF	$50	$50	$180	$120	$400	$2,183
Multiple Comorbidities DM + HTN+ Hyperlipidemia	$50	$50	$150	$60	$310	$2,053

*Members who go to their selected PCP will also receive an additional $25 in their HRA in 2016.

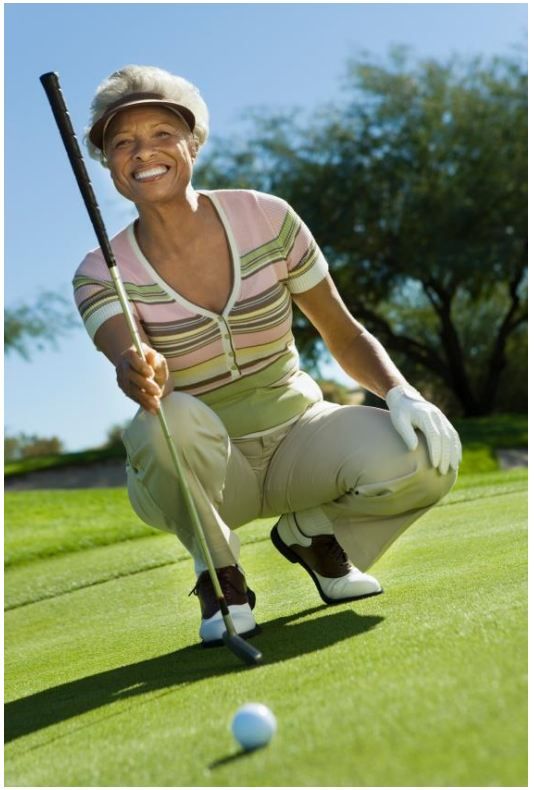
Health Engagement Program Communication

- Buck Consultants will be assisting the Plan with the marketing and communication strategy regarding this program
- ActiveHealth will also be assisting with the communication and promotion of this program
- Communication efforts will begin in March
- Communication efforts include:
  - Website
  - Social Media
  - E-communications
  - HBR education
  - Member webinars
  - Ongoing targeted letters to qualified members

Retiree Outreach

2016 Retiree Outreach

- The Plan will be launching “Navigating Your State Health Plan Benefits and Retirement: *Understanding How the State Health Plan, Medicare and Your Pension Work Together”* in 2016.
- This series of meetings will be aimed at assisting retiree members turning 65 in the next year.
- The NC Retirement Systems and the Social Security Administration will also be included and available to answer any retirement related questions.



North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Annual Enrollment Exceptions

Board of Trustees Meeting

January 26, 2016

Informational Report

A Division of the Department of State Treasurer

Annual Enrollment Exceptions – CY 2016

- Any requests for Annual Enrollment changes outside of the Annual Enrollment period are processed as exceptions.
- Active members are required to work with their HR department, which decides if an exception request is warranted.
- Non-Medicare retirees' and Medicare retirees' requests/calls are handled by State Health Plan staff

AE Exceptions Received To Date	**2,235**
Reviewed and Processed	**1,605**
To Be Reviewed	**630**

- The overwhelming majority of exception requests relate to the premium credits.
  - The primary root cause is members not saving their enrollment activity.
  - There are still some members who do not understand that the Health Assessment and the Tobacco-User attestation are two separate wellness premium credits.

Annual Enrollment Exceptions – Historical Information

- **Wellness Premium Credits Year 1 (CY 2014):**
  - The first year we introduced premium credits, exceptions did spike, but not because of the premium credits - 92% of subscribers successfully completed all of the activities to earn all three credits.
  - The primary driver of exceptions was the introduction of the Medicare Advantage Plans. The next largest exception driver was the inaccuracy of the enrollment elections taken over the phone.

- **Wellness Premium Credits Year 2 (CY 2015):**
  - In year two, the number of subscribers who successfully completed the healthy activities and earned all premium credits dropped substantially. We heard a lot of complaints that the Annual Enrollment materials did not clearly outline the steps required to complete the wellness premium credits and reduce the monthly employee/retiree only premium.
  - As a result, the Board asked to apply the non-smoker credit to all members who successfully completed the Health Assessment during Annual Enrollment. That brought the total number of subscribers who successfully completed the premium credits up to 82.2%.

More on Wellness Premium Credits for CY 2015

- Primary reasons given for not completing the healthy activities to earn premium credits for the 2015 plan year:
  - **Did not complete Annual Enrollment**– The primary reason given for not completing the smoker attestation is that they either forgot or did not understand the need to re-attest.
  - **Health Assessment** – Some members believed that by answering the smoker question within the Health Assessment, they had completed the non-smoker attestation.
  - **Navigation** – Although the non-smoker attestation was in the same place as the previous year, we heard that some members had trouble finding it.

All of our Annual Enrollment materials had the following language in **Bold**:

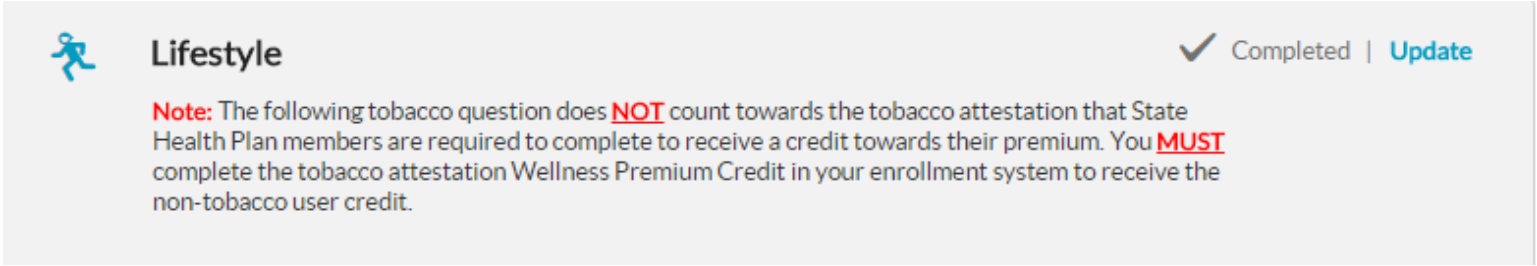
Even if you attested during last year's Annual Enrollment, you will need to re-attest. The smoker attestation can be completed only during Annual Enrollment.

- We also reminded members to print their confirmation statements because those statements not only confirmed enrollment but highlighted the wellness premium credits earned.

163,223 Subscribers enrolled in the Enhanced 80/20 and CDHP successfully attested to being a non-smoker.

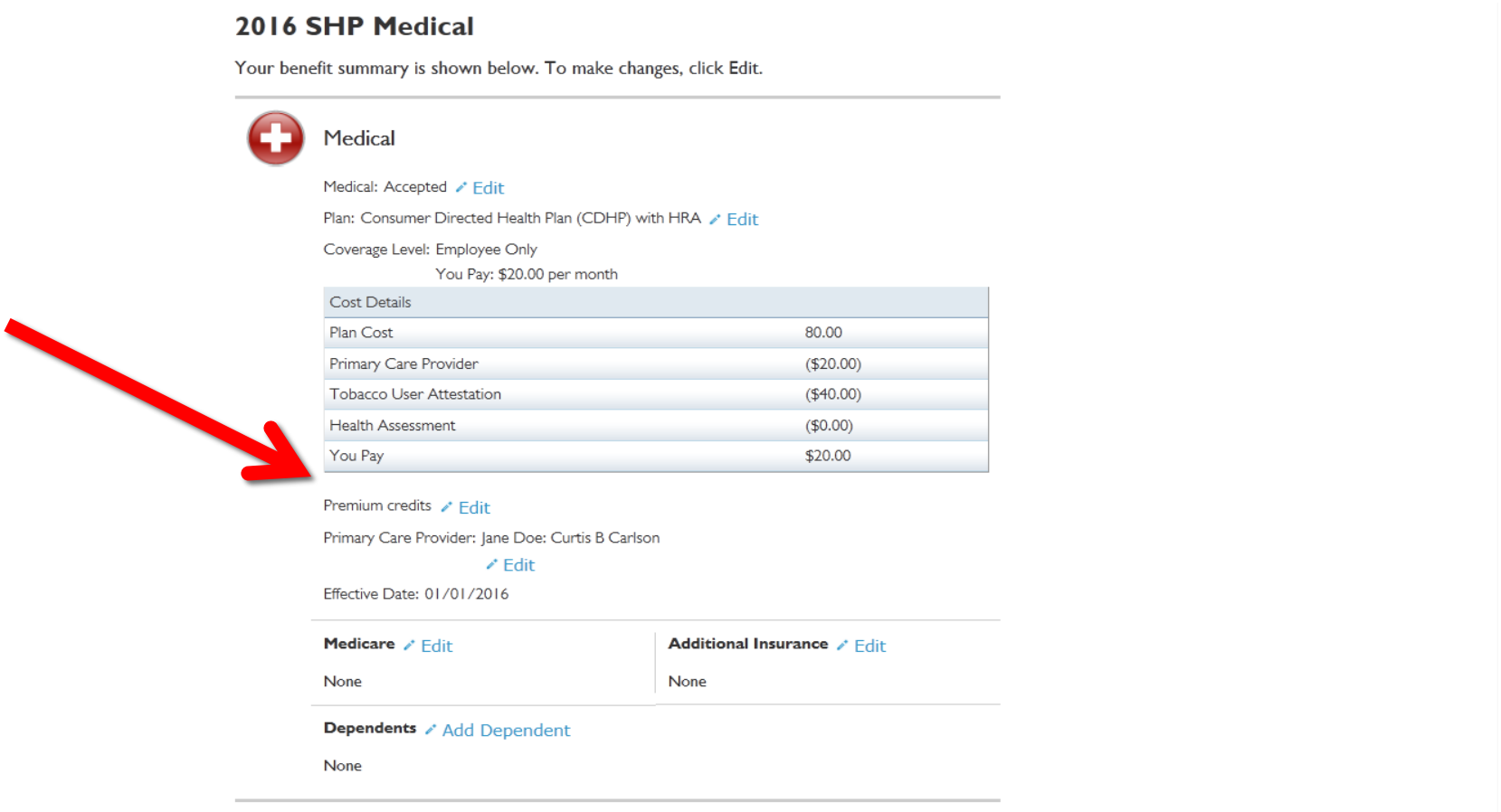
Annual Enrollment Exceptions – Current Year

- **Wellness Premium Credits Year 3 (CY 2016):**
  - The completion rate for earning all three premium credits dropped to 73.5%.
  - We are finding a lot of members that didn't take action last year are asking for an exception again this year. Overall, the reasons for the exceptions are very similar to last year. Some common themes we are hearing about barriers to successful completion of Annual Enrollment and healthy activities include:
  - **Health Assessment** –
    - **Single-Sign-On (SSO)** – Not having the SSO between the enrollment system and the Health Assessment was not only a huge dis-satisfier but very confusing for members. While we will be able to re-implement the SSO, we cannot eliminate the need for a second window to complete the attestation.
    - **Tobacco question** – There is a question about tobacco use in the Health Assessment that continues to confuse members. While we added a message to the Health Assessment advising members they needed to answer a different question about tobacco usage to earn the credit, many members say they did not understand this requirement:

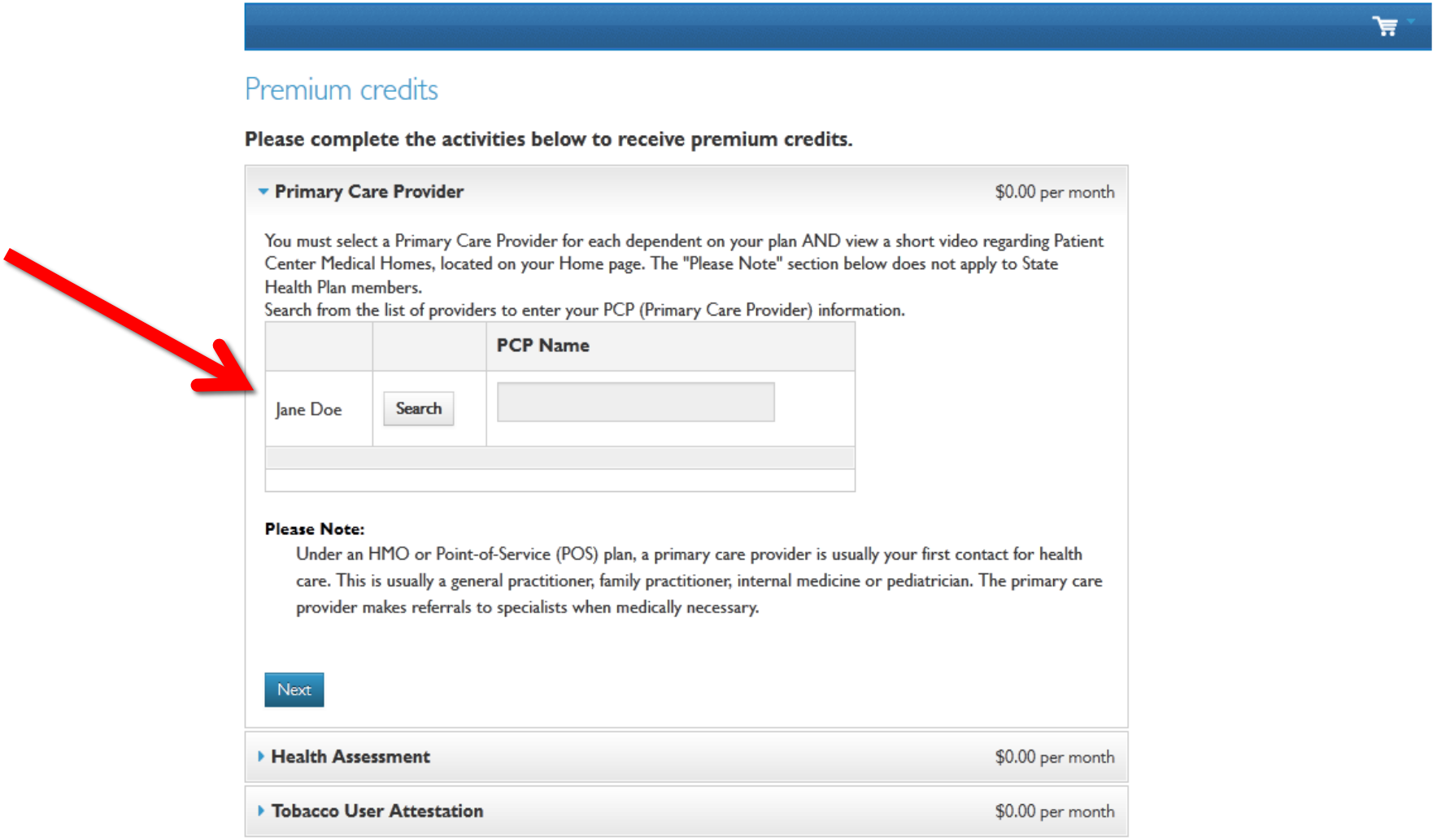


Annual Enrollment Exceptions – Current Year

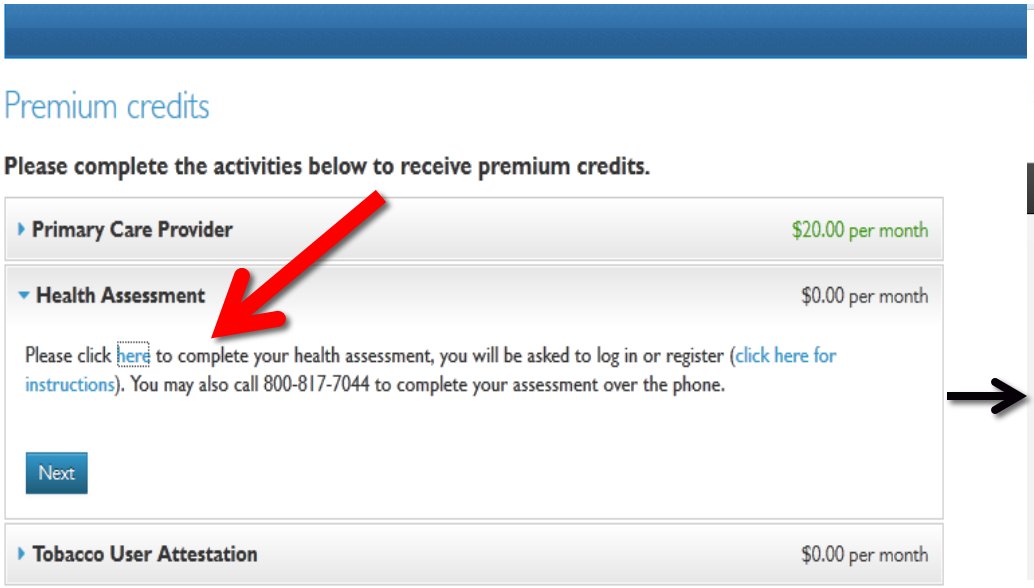
- **eEnroll Navigation –** The primary reason for not being able to successfully complete the healthy activities to earn wellness premium credits is that it is just too confusing. Some members are having a hard time finding and appropriately saving their enrollment elections. While we believe we can add additional messaging, the overall architecture of the system will not change.

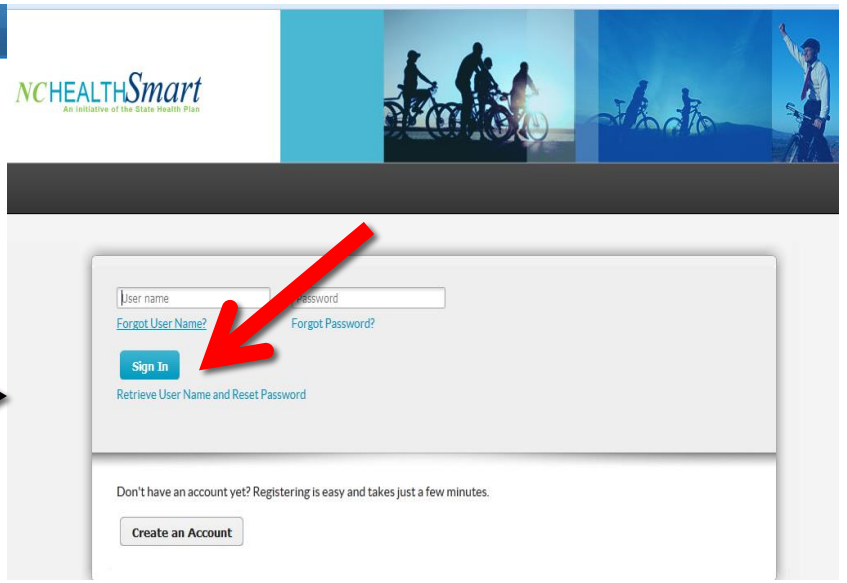


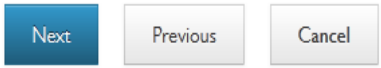
eEnroll Workflow: Electing a PCP

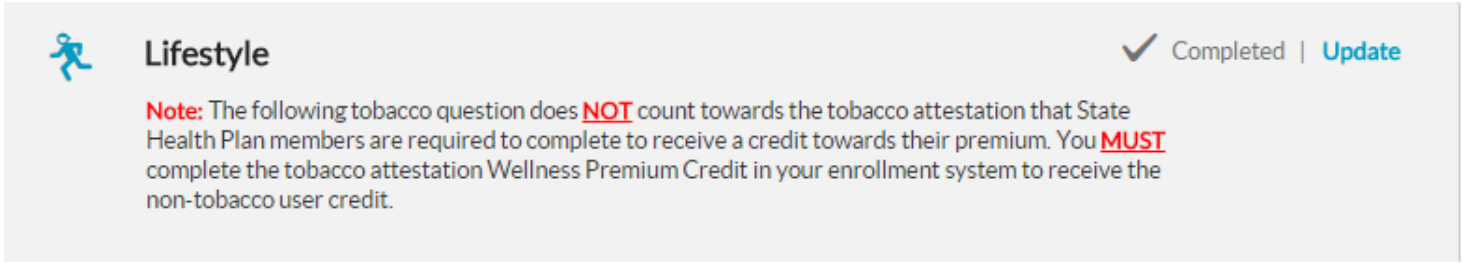


eEnroll Workflow: Completing the Health Assessment

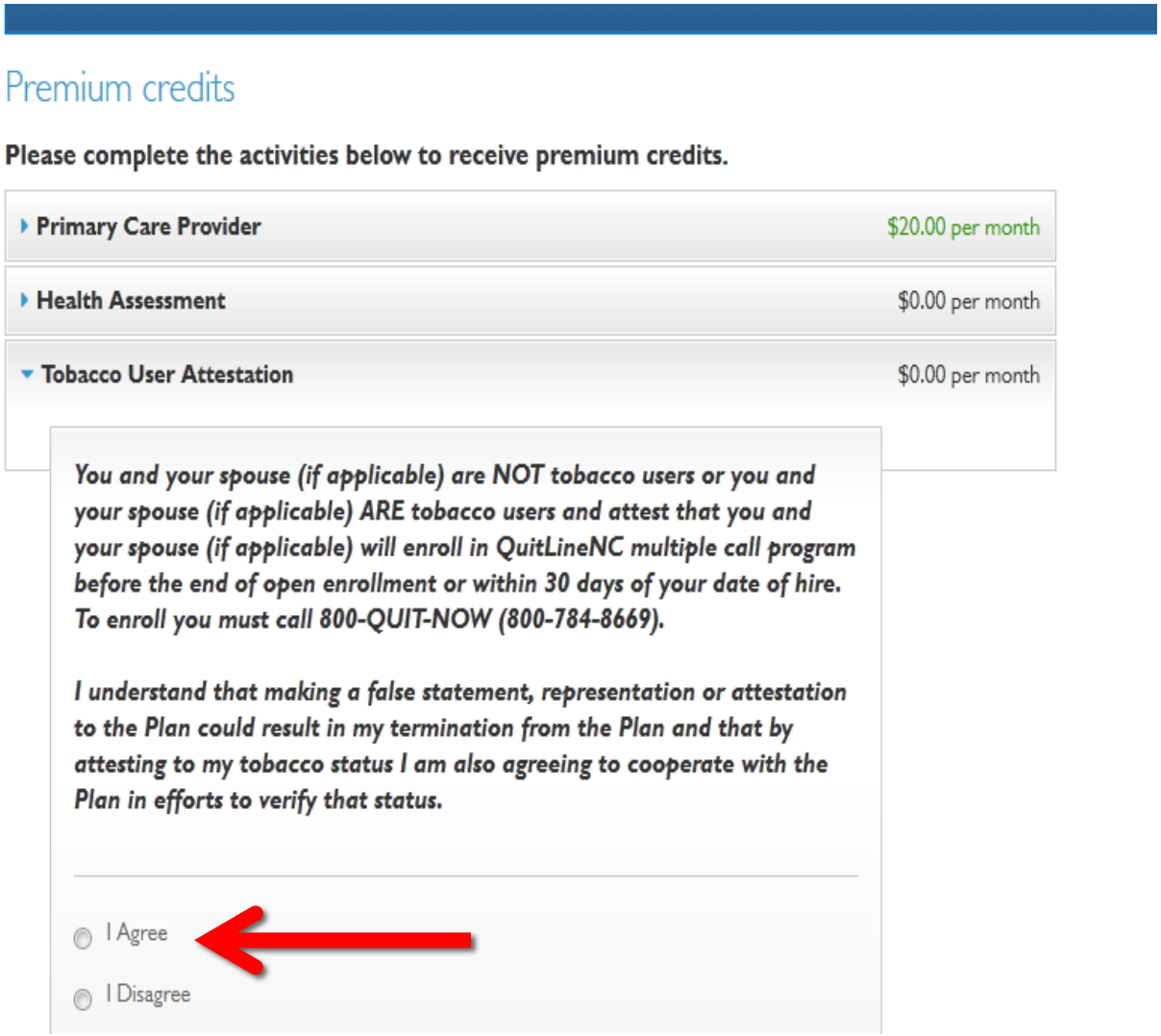




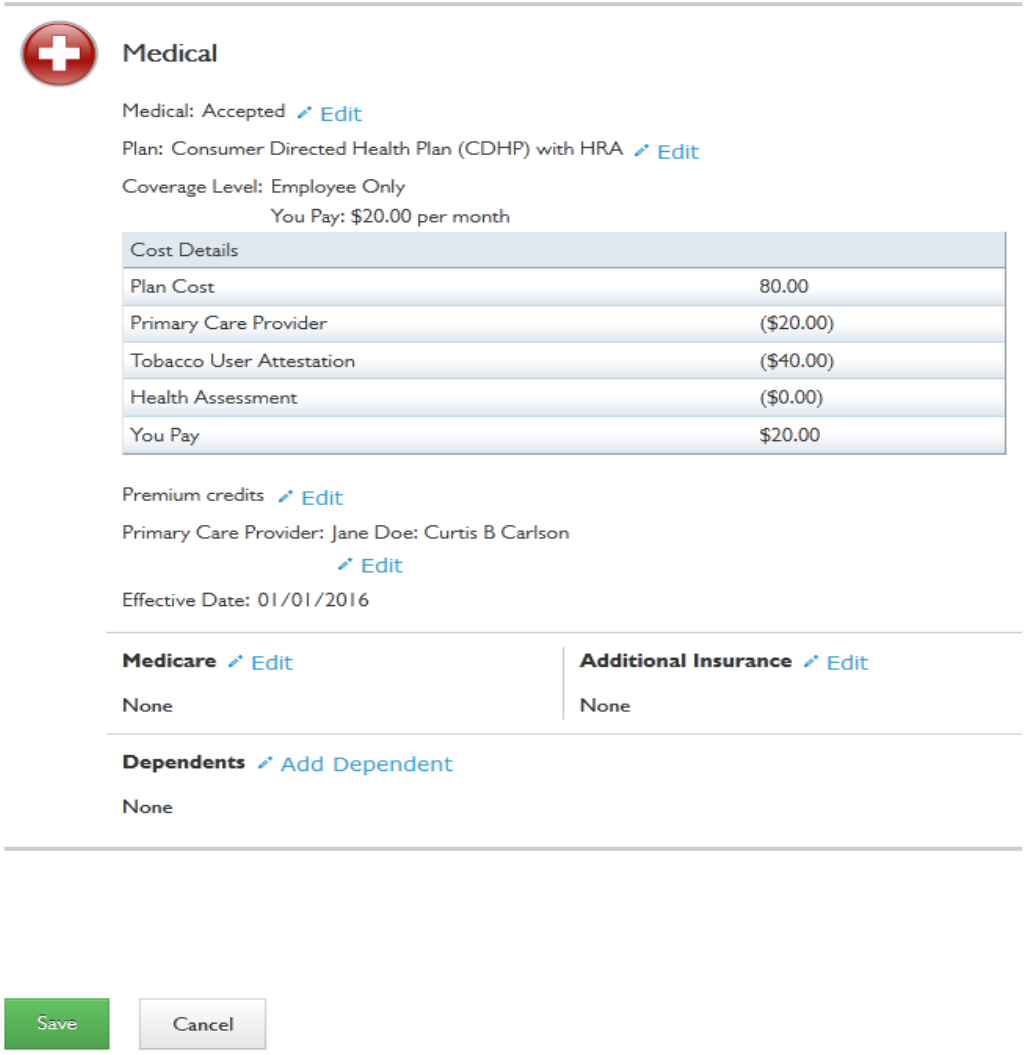




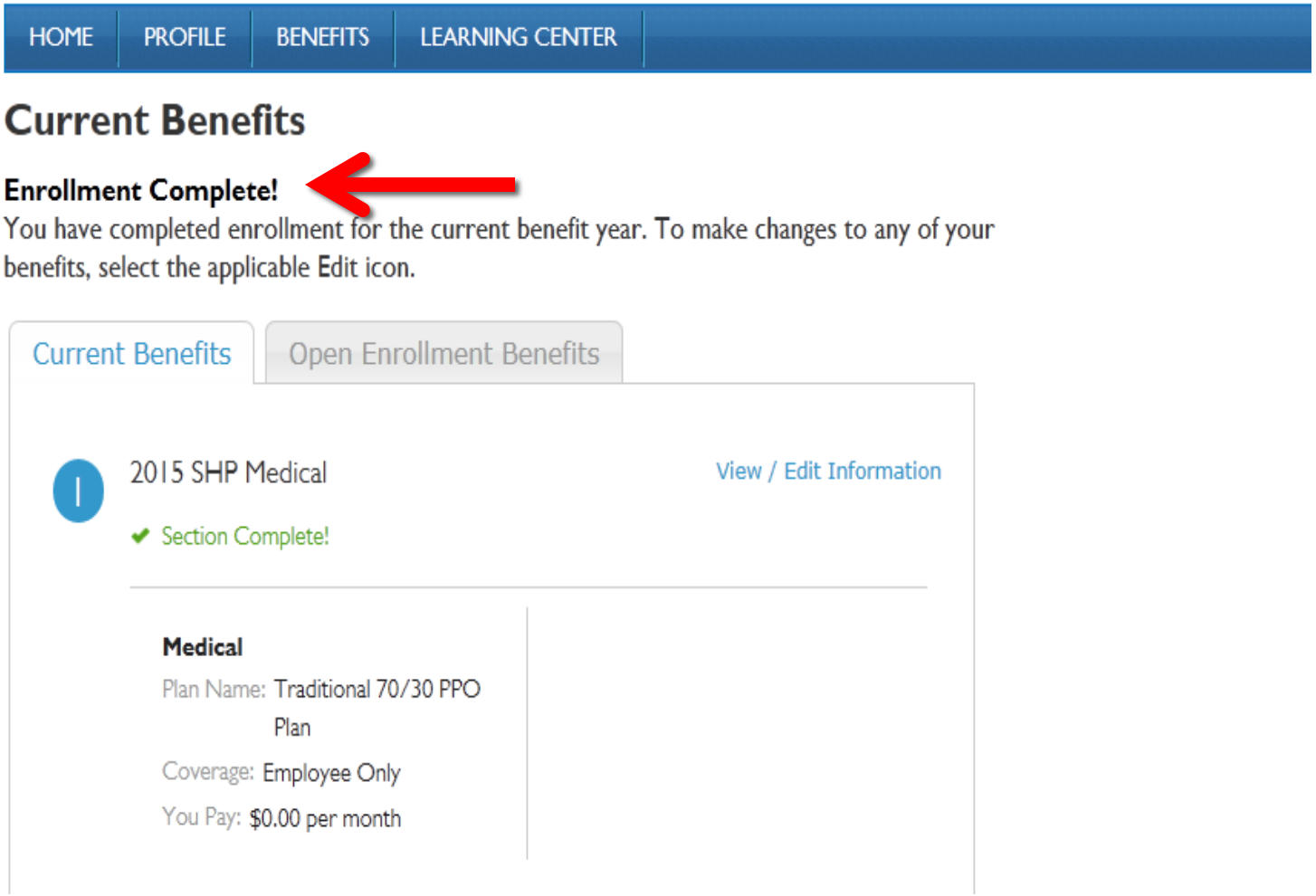
eEnroll Workflow: Tobacco Attestation



eEnroll Workflow: Saving Elections



eEnroll Workflow: Confirmation

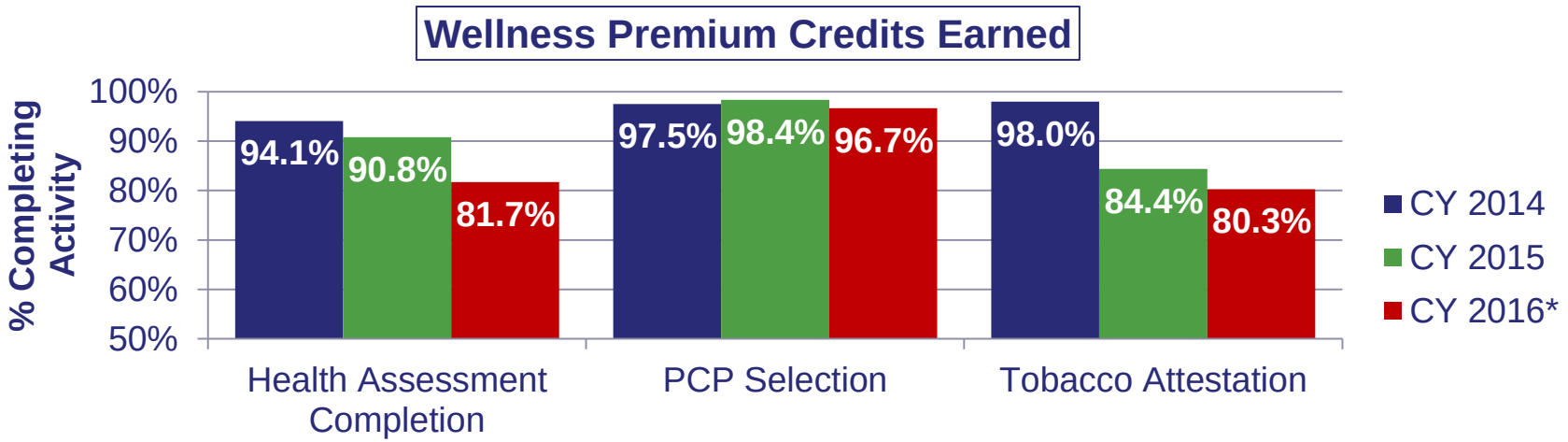


Annual Enrollment Trends

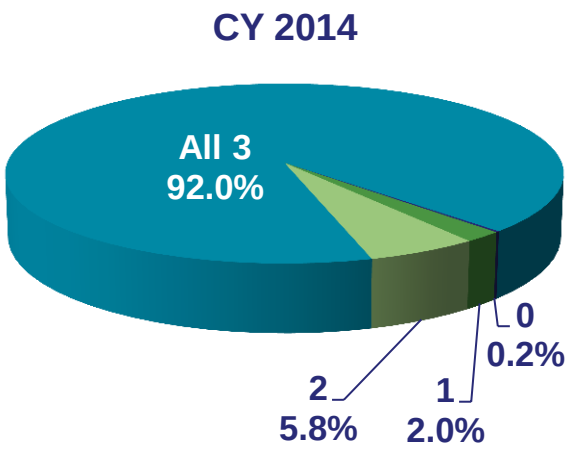
- The Plan held an HR Roundtable meeting on January 13th, where we spent the majority of the time discussing the barriers to successfully completing the wellness activities to earn premium credits.
- In addition to the navigation issues that we have discussed, they too were concerned with the number of people who simply did nothing and seemed to be unaware that any action was needed.
- In addition to the communications the Plan sends directly to members' homes, HBRs offer enrollment sessions, send their employees multiple emails about the requirements, and offer to assist their members with enrollment. While we have members who are not engaging with the process, it is important to note that the overwhelming majority are successfully completing the requirements.

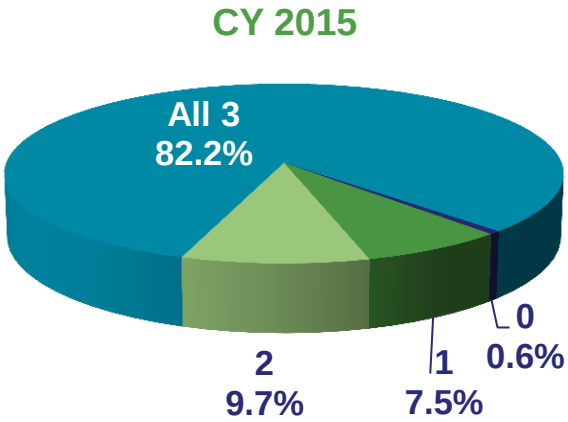
Credits Earned at Enrollment - CY 2016						
Completed Credit	PCP		Health Assessment		Tobacco Attestation	
	Subscribers	%	Subscribers	%	Subscribers	%
Yes	216,088	96.7%	182,435	81.7%	179,407	80.3%
No	7,299	3.3%	40,952	18.3%	43,980	19.7%
Total	223,387	100.0%	223,387	100.0%	223,387	100.0%

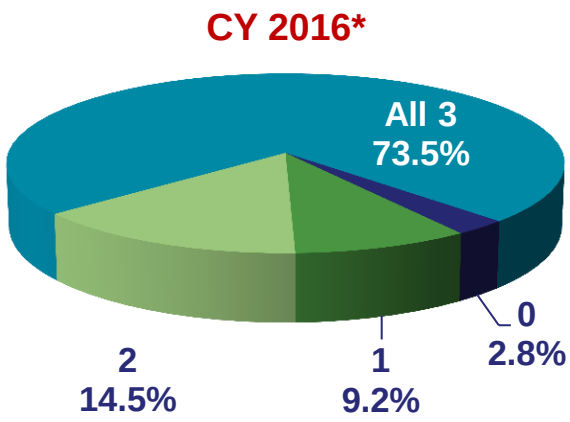
Completion of Healthy Activities by Year



Number of Healthy Activities Completed







*2016 numbers are prior to exceptions

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Specialty Medication Dispensing Update

Informational Report

Board of Trustees Meeting

January 26, 2016

A Division of the Department of State Treasurer

Specialty Medications and Dispensing

- Specialty medications are drugs used to treat complex conditions. They are FDA approved drugs including biosimilars that meet the following criteria:
  - Treat complex medical condition(s)
  - Require frequent clinical monitoring
  - Require special patient education
  - Require special handling
  - Generally prescribed by a specialist

- Currently, Specialty medications are often dispensed at a 90-day supply
- The State Health Plan is updating the Specialty dispensing policy to a 30-day initial refill

Specialty Medication Dispensing Update

- Making this change will help accomplish the following:
  - Ensure that a member's clinical progress is meeting expectations
  - Ensure that dosage or other therapeutic changes can be easily made
  - Manage side effects
  - Decrease cost
  - Reduce waste
  - Reduce possibility of member harm (multiple dosage of same drug)
  - Improve adherence

Specialty Medications – Extended Day Allowance

- Extended Day Supply Allowance on Certain Specialty Medications
  - Drugs packaged and administered in long-term quantities
  - Drugs exhibiting high adherence rates
  - Drugs requiring no dose stabilization
  - Drugs unlikely to be discontinued or contribute to pharmacy waste:
    - Kitabis Pak, packaged as 56 ampules with one inhaler, would not be limited to a shorter day supply
    - Ilaris, administered once every 8 weeks, would be allowed that greater day supply

Specialty Medications – 30-Day Allowance

- 30-Day Supply Allowance on Most Specialty Medications
  - Reinforcement of federal requirements, such as Risk Evaluation and Mitigation Strategies (REMS) programs requiring limited-day supplies.
  - Ongoing clinical monitoring ensures future use is safe and appropriate.
  - Ensures tolerance to the prescribed drug regimen.
  - Limits pharmacy waste from commonly discontinued medications.
    - Thalomid is associated with an FDA required REMS program limiting utilization to 30-day increments.
    - Arixtra, an anticoagulant medication, is recommended for administration in short treatment durations and the patient should be monitored for bleed risk.
    - Enbrel, an injectable medication, may not be well-tolerated by a patient new to therapy, and if discontinued due to intolerance produces pharmacy waste

Specialty Medications for New Patients

- New patients on a Specialty medication would receive an initial 30-day supply.
- If no clinical issues arise
  - 2nd refill 30-day supply
  - 3rd refill 30-day supply
  - 4th refill 90-day supply if a 90-day fill meets clinical guidelines
- If there is a gap of more than 120 days between refills, member will start with an initial 30-day supply

Specialty Medications for Existing Patients

- Existing patients on a Specialty medication will continue with 90-day supply
  - If therapy regimen began prior to the end of February 2016 and the drug is eligible for 90-day dispensing

- For patients new to a Specialty medication on or after March 1, 2016, the updated Specialty policy will apply
  - Members will be impacted < 90-day dispensing policy
    - Communication will be sent to impacted members
  - No financial impact to members on any plan
    - Traditional 70/30 and Enhanced 80/20 copayment is based on a 30-day fill
    - CDHP is a 15% coinsurance
    - HDHP is a 50% coinsurance

Financial Impact

- 2015 Data:
- 578 claims for impacted medications
  - 165 exceeded the 30-day maximum
- Claims cost total $1,703,579
  - 50 of the members did not refill the medication
- Potential savings: approximately $ 400,000

Specialty Dispensing Change Communications

- This update will be effective March 1, 2016

Members

- Website Specialty Drug list updated and expanded in February 2016
- Letters sent to members regarding drugs not eligible for a 90-day fill
- Letters sent to members new to Specialty medications

Prescribers

- Letter will be sent to all providers currently prescribing any Specialty medication

Vendor Partners

- Blue Cross and Blue Shield of North Carolina will be notified of change in dispensing policy

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Pharmacy & Therapeutics Committee
December 2015 Meeting Summary

Informational Report

Board of Trustees Meeting

January 26, 2016

A Division of the Department of State Treasurer

Updates to Utilization Management Programs

Program	Update
Testosterone Prior Authorization Policies	Separated old policy into two policies, Oral and Injectable AND Topical. Added requirement for two testosterone deficiency confirmatory tests. Removed anabolic steroids from the policy.
Hepatitis C Prior Authorization	**Harvoni**: Updated policy to align with national guidelines. Clarified treatment for HIV patients and those awaiting liver transplant.
Hepatitis C Prior Authorization	**Daklinza, Sovaldi, Vierkira Pak, and Olysio**: Updated policy to align with national guidelines.
Hepatitis C Prior Authorization	**Technivie**: Updated policy to require Harvoni prior to the use of Technivie.

Updates to Utilization Management Programs

Programs	Update
Ilaris Prior Authorization Policy	Updated to allow allergists/immunologists to prescribe. Extended PA approval to 3 years.
Arcalyst Prior Authorization Policy	Removal of requirement for FDA approved genotype testing, increased approval duration to 3 years, and added hairy cell leukemia to covered indications for Zelboraf.
Growth Hormone Prior Authorization Policy	Removed Tev-Tropin from policy (no longer marketed) and added Zomacton.

New Utilization Management Programs

Program	Description	Member Impact	Estimated Projected Savings	P&T Recommendation	Implementation
Seroquel Prior Authorization Policy	New policy to assess lower doses of quetiapine and quetiapine XR for appropriate use	131 members (letter in November)	$134,307 annually	Yes	January 1, 2016
Weight Loss Prior Authorization and Step Therapy Policy	Added requirement for generic phentermine prior to brand name weight loss products, excluding Xenical (Tier 2)	3,505 members (utilized brand name in last 90 days; current PA will continue until expiration date)	$1,719,517 annually	Yes	January 1, 2016

New Drugs for Formulary Consideration

Drug	Indication	Tier Placement
Stiolto™Respimat® (tiotropium bromide/olodaterol spray)	COPD	2
Incruse™ Ellipta® (umeclidinium 62.5 mcg inhalation powder)	COPD	3
Entresto™ (sacubitril and valsartan tablets)	Heart failure	3
Corlanor® (ivabradine tablets)	Heart failure	3
Rexulti™ (brexpiprazole tablets)	Major depressive disorder and schizophrenia	3
Prezcobix™ (darunavir/cobicistat tablets)	HIV	2
Aptensio XR™ (methylphenidate extended-release)	ADHD	3

Additional Topics

- High Cost Generics:
  - The following generics were moved from Tier 2 to Tier 1:
    - guanfacine (Intuniv)

New Drugs for Formulary Consideration

Drugs with PA need to be added to the specialty list prior to the next scheduled P&T committee meeting in February. These will be effective February 1st.

Drug Name	Tier	Criteria
Nucala	Tier 4 Specialty Drug	• First in class • Injection for uncontrolled asthma • Prior Authorization • Accredo exclusive • Reviewed by Dr. Boerner
Tagrisso	Tier 4 Specialty Drug	• Non small cell lung cancer • Prior Authorization, similar to 3 other drugs on class • Reviewed by Dr. Spiritos
Egrifta	Tier 4 Specialty Drug	• Complications due to HIV lipodystrophy • Prior Authorization • Accredo exclusive • Reviewed by Dr. Boerner