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STATE HEALTH PLAN UPDATE

MONA M MOON
CFO/INTERIM DEPUTY EXECUTIVE ADMINISTRATOR

OSC Financial Conference

December 12, 2012

Presentation Overview

- State Health Plan Governance
- Member Feedback
- Benefit Design Planning
- OPEB Valuation

State Health Plan Update

Governance & Oversight

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Changes to Plan Governance and Oversight
State Treasurer

- Historically the State Health Plan reported directly to the NC General Assembly via a legislative oversight committee
- January 1, 2012, the Plan became a division of the Department of the State Treasurer
- Plan's Executive Administrator appointed by the Treasurer
- State Treasurer may delegate powers and duties to the Executive Administrator, Board of Trustees or Plan staff, but ultimately maintains responsibility for the performance of those powers and duties and the Plan

Changes to Plan Governance and Oversight
Board of Trustees

- The composition, authority and governance of the Plan's Board of Trustees changed
  - The Governor, State Treasurer, House of Representatives and Senate each appoint two members
  - The Board transitioned from being a mostly "consultative-type" board to a "fiduciary board" with responsibility for the following:
    1. Approve benefit programs
    2. Approve premium rates, co-pays, deductibles and coinsurance maximums
    3. Oversee administrative reviews and appeals
    4. Approve large contracts
    5. Consult with and advise the State Treasurer
    6. Develop and maintain a strategic plan

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Member Feedback

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Outreach Efforts – Listening Tour

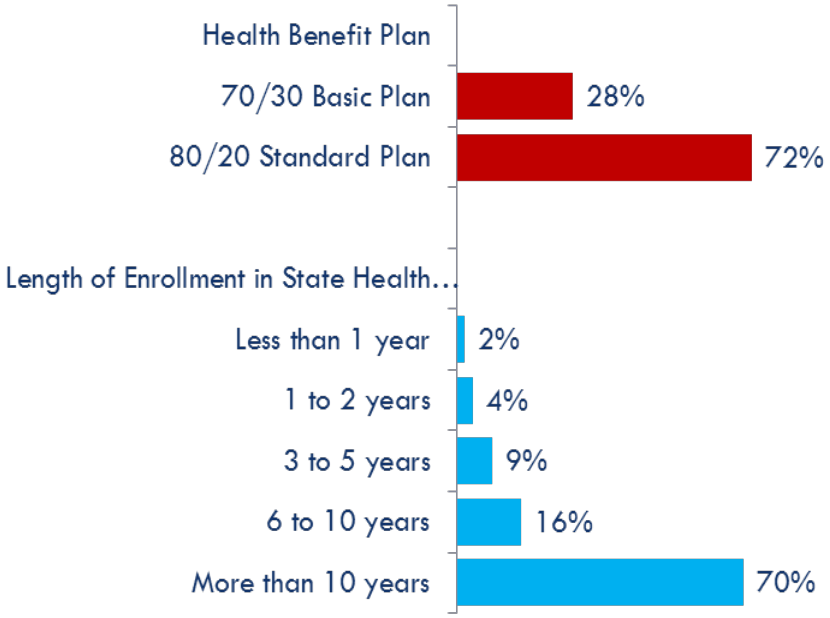
- Treasurer and board members participated in a six-stop "listening" tour across the state
  - Visits to Wilmington, Greenville, Raleigh, Greensboro, Charlotte, and Lenoir
  - Approximately 650 members attended
- As part of the tour, Department created a web version of the Plan's official 2011 survey to give members an opportunity to provide feedback
  - Approximately 500 members responded

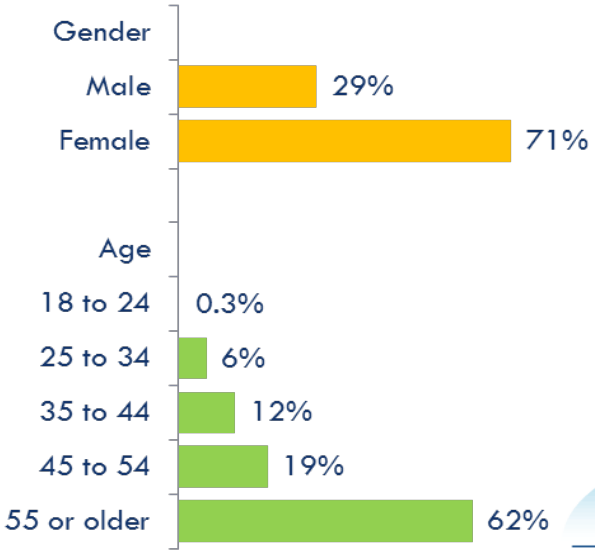
Outreach Efforts – Focus Groups

- 8 Focus Groups conducted in the Triangle area
  - 2 State Agencies, 4 Schools, 2 Universities
  - Each group composed of 8-12 people
  - 60% Women, 40% Men

Outreach Efforts – Annual Survey

Employment Status	Percent
Insured through the State Health Plan as an Active Employee (or Covered Spouse)	56%
Insured through the State Health Plan as a Medicare Primary Retired Employee (or Covered Spouse)	44%
Insured through the State Health Plan through COBRA, RIF, Survivor benefits, or as a SHP Primary Retiree (or Covered Spouse)	<1%





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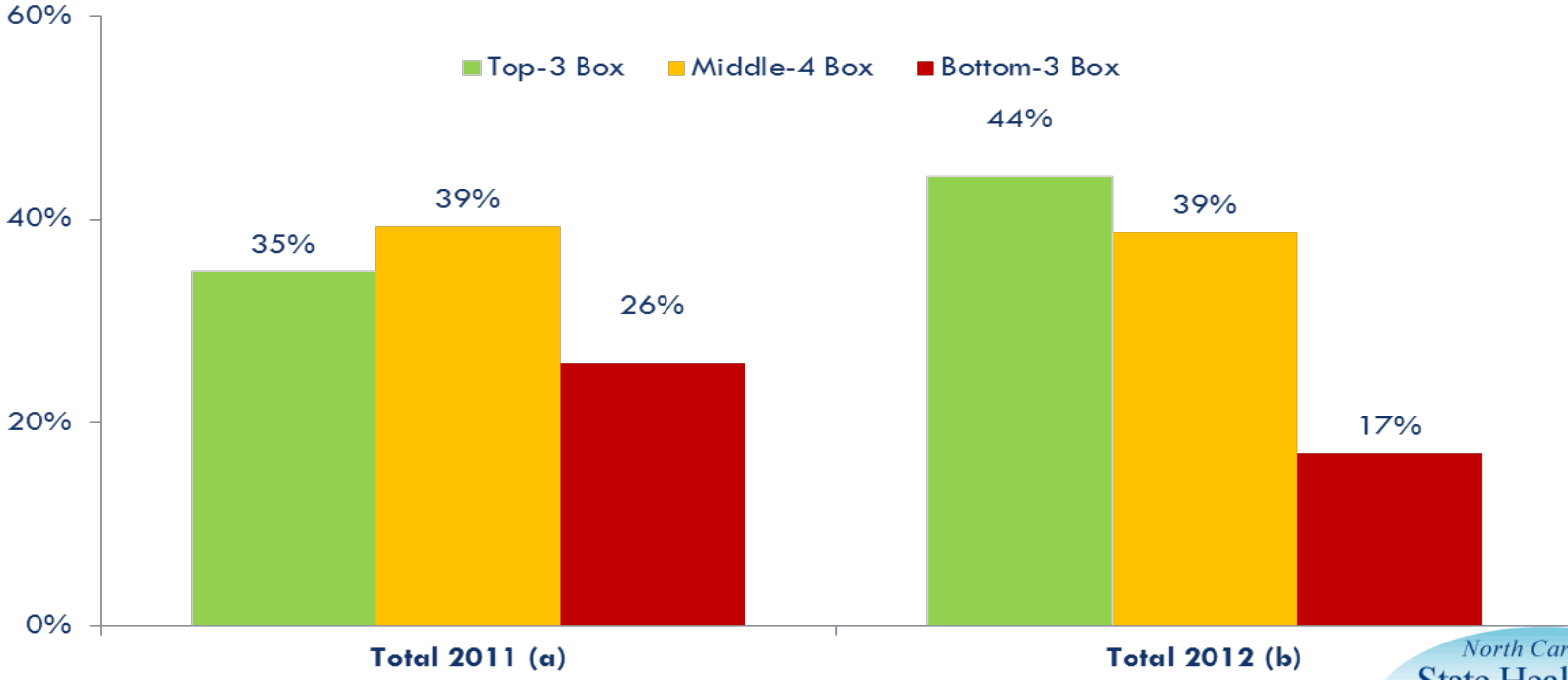
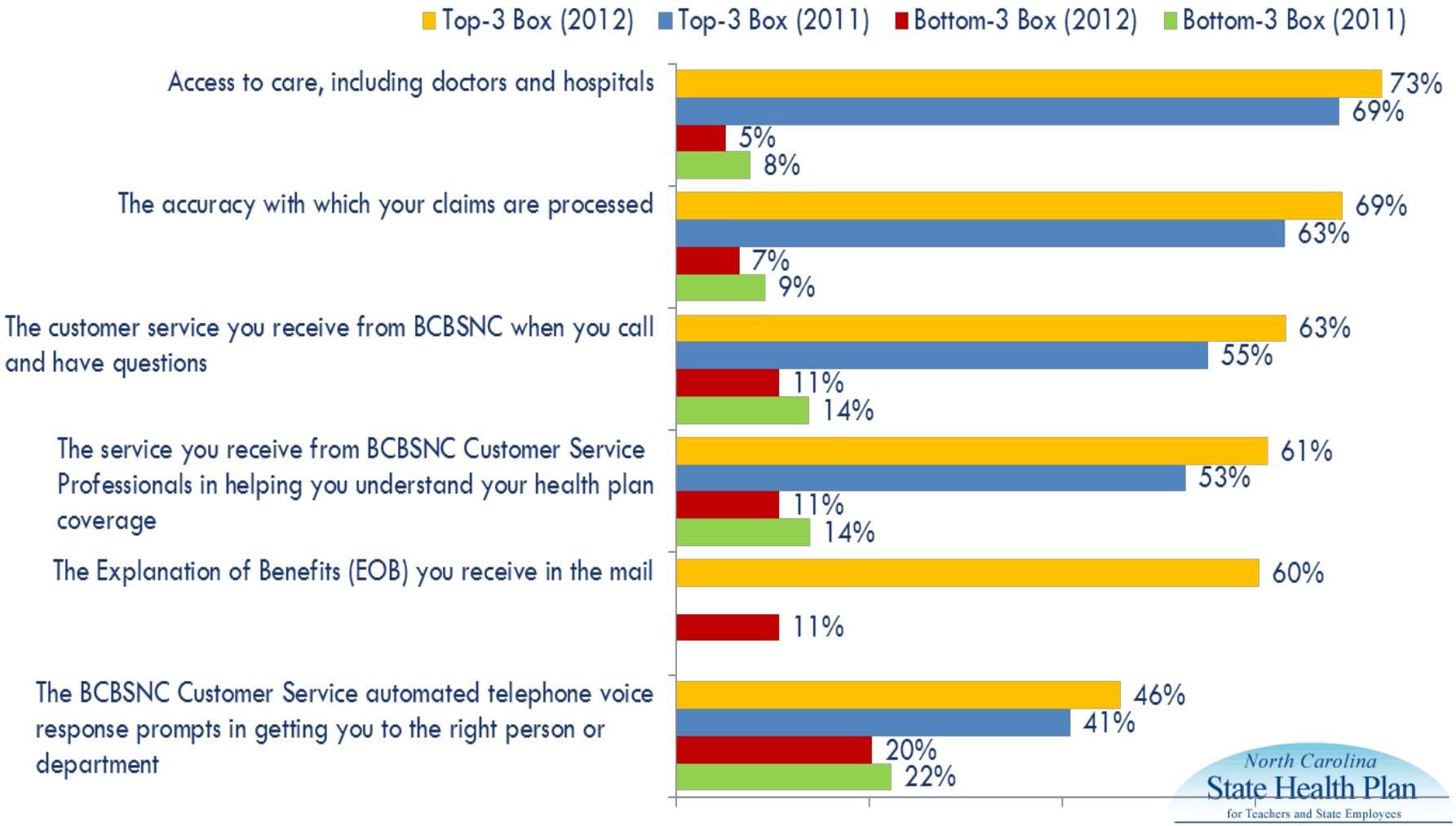
Overall Satisfaction With the Plan

More than 40% of the respondents are satisfied with the health plan coverage offered by the State Health Plan as measured by the top 3 box percentage – overall satisfaction increased by 9 percentage points from last year (35%). Alternatively, the proportion of dissatisfied respondents decreased by 9 percentage points from 26% last year to 17% this year.

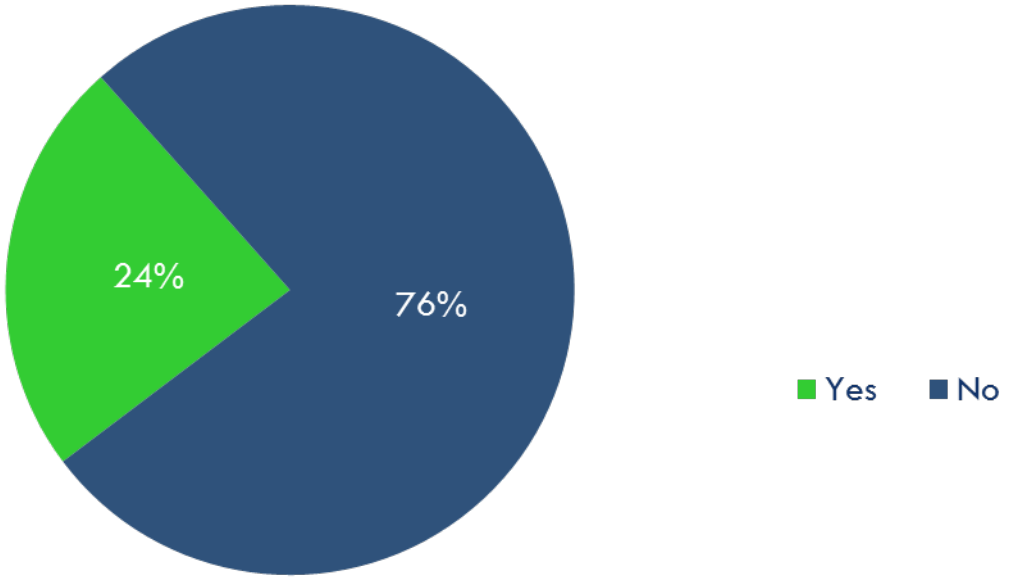


Satisfaction with Services



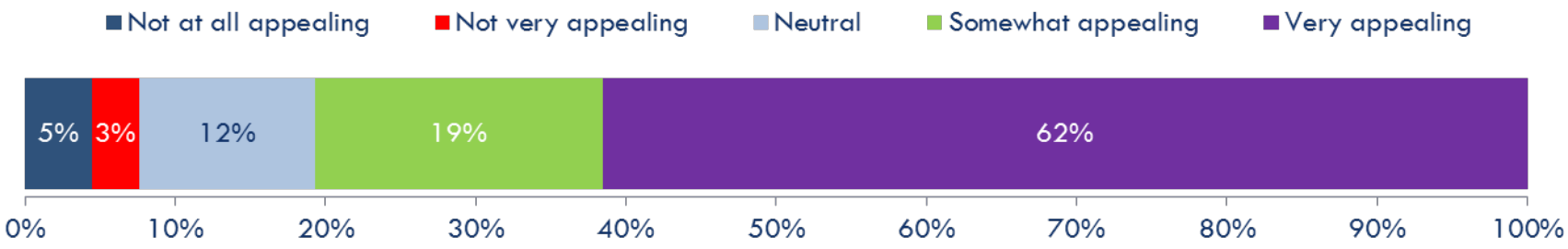
Willingness to Pay More in Monthly Premiums

Nearly a quarter of the respondents said they would be willing to pay more in monthly premiums in order to have lower copays, coinsurance and deductibles. The other three-fourths are not willing to pay more in premiums.



Lower Premiums for Healthy Lifestyles

- Slightly more than 80% of the respondents found a health plan that offers a lower monthly premium because of healthy lifestyle choice appealing – 62% of them found such a plan very appealing.
- Less than one in ten respondents did not find this type of plan appealing – 5% said such a plan is not at all appealing to them.



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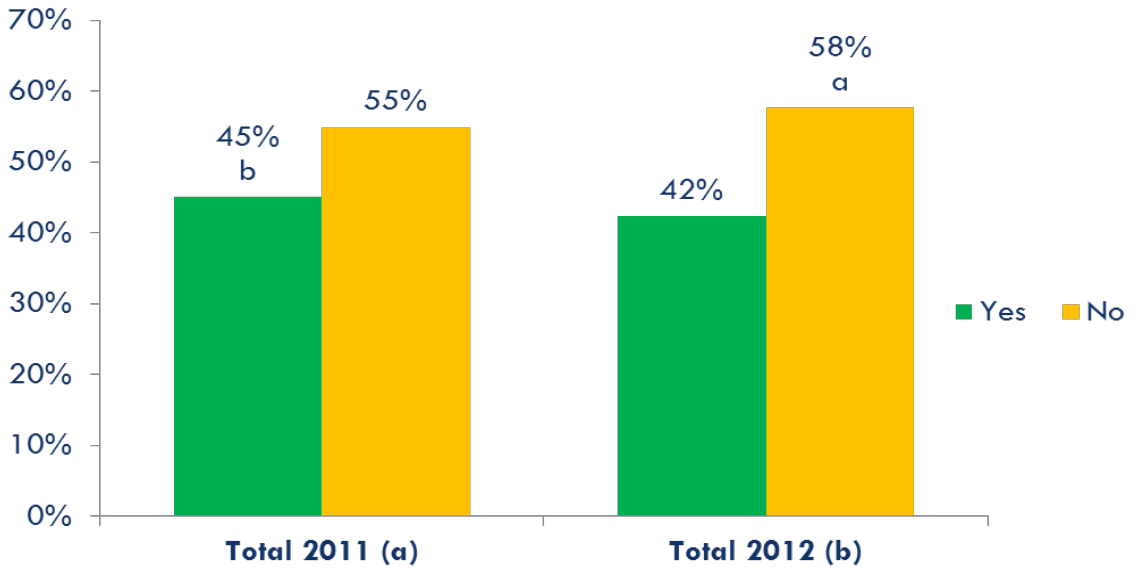
No Treatment or Medication Due to Cost

- Over the past six months, 42% of the respondents have chosen not to seek treatment or fill a medication due to cost – a decline of 3 percentage points from last year.
- Active employees (55%) are more likely not to seek treatment or fill a prescription than Medicare-primary retired employees (26%) and COBRA, RIF, Survivor or SHP Primary Retirees (36%).



Results of Outreach Efforts

- Overall satisfied with access to care, processing of claims and customer service
  - Satisfaction increased from last year
- Automated telephone voice response system has least number of satisfied respondents
  - Satisfaction increased from last year
- The various contact points can be confusing

  "There are too many websites, publications, and phone numbers"

Member Costs are Too High

- Premiums and co-pays were regular targets
- Cost of dependent coverage is a common concern
- Overall participants agreed that at some point in the last year they had not sought treatment or refilled a medication due to cost

> "It is a sad, sad day when people opt to go without care even though they have purchased expensive coverage and still face high deductibles."

Benefit Design Realities are Confusing

- Federal Affordable Care Act confuses the landscape
- Members do not understand difference between the Plan and the TPA (contracted vendors)
- The Plan's scope and risk pooling structure does not resonate with many

  "My husband works for a company that covers 30 people. The State covers 600,000; why do I pay more?"

Members Want but Underutilize Preventive Services

- Large numbers of members do not know about or do not use preventive services
- Members regularly cite specific programs or incentives that they say they want or would use

  "Need some coverage for wellness promotion-regular exercise programs. Why wait until I have a heart attack?"
- Most expressed support for employees taking ownership of their health
  - Non-smoking popular, BMI was not
  - Health Risk Assessment received mixed reviews

Desire Greater Choice and Flexibility

- There is a sense that more vendors might lead to better rates
  - "BCBS has no competition."
- Members do not understand why higher coverage options aren't available
  - "Why can't we have a 90/10 option?"
- There is a desire for more plans options even if some options aren't suited for a particular employee or their family
- Calendar year would be a positive change and would help in planning for flex benefits spending

State Health Plan Update

Benefit Design Changes & Planning for 2013-15 Biennium

Projected financial impacts are preliminary for information purposes only and subject to change pending final design decisions

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What's New for 2013?

1. Medicare Prescription Drug Plan (PDP) for Medicare-eligible retirees
   - Federally regulated and subsidized Employer Group Waiver (EGWP) plus wrap around services to maintain or improve current benefit
   - Premium reduction for eligible spouses/dependents

Effective January 1, 2013
Projected Savings = $20 million annually (incurred basis)
Positive cash flow impact by 2015

What's New for 2013?

2. Lower copay for Behavioral Health Services from Mid-tier to Primary Care Level
   - Will bring Plan into compliance with federal mental health parity requirements

3. Remove certain exclusions for Dental Services
   - Provide coverage for accidental injuries, congenital deformity, and diseases due to tumor or infection

Effective July 1, 2013
Projected Cost = $6.5 million annually

Considerations for 2014

Board reviewed financial modeling of potential benefit changes in September

Considerations for 2014

1. Change plan benefit year from fiscal year to calendar year
   - Align the health benefit with other programs
   - Facilitate annual enrollment process
   - Convert via short plan year from July 1, 2013 to December 31, 2013
     - ½ annual deductible and out of pocket maximum

Projected Conversion Cost FY 2014 = $38.2 million

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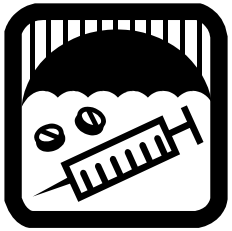
Considerations for 2014

2. Offer Medicare Advantage Plan
   - Fully insured product offering
   - Enhanced benefits relative to current coverage
   - Medicare-eligible members
   - Premium reduction for eligible spouses/dependents
   - Contracts with Humana and United Health Care
     - Considering standard plan and buy-up options



Projected Net Savings CY 2014 = $32 million (medical only)

Considerations for 2014

3. Enhance Preventive Benefit

- Provide 1st dollar coverage for preventive services
- No copays or deductibles

Projected Cost CY 2014 = $30 to $60 million

4. Increase Reserves

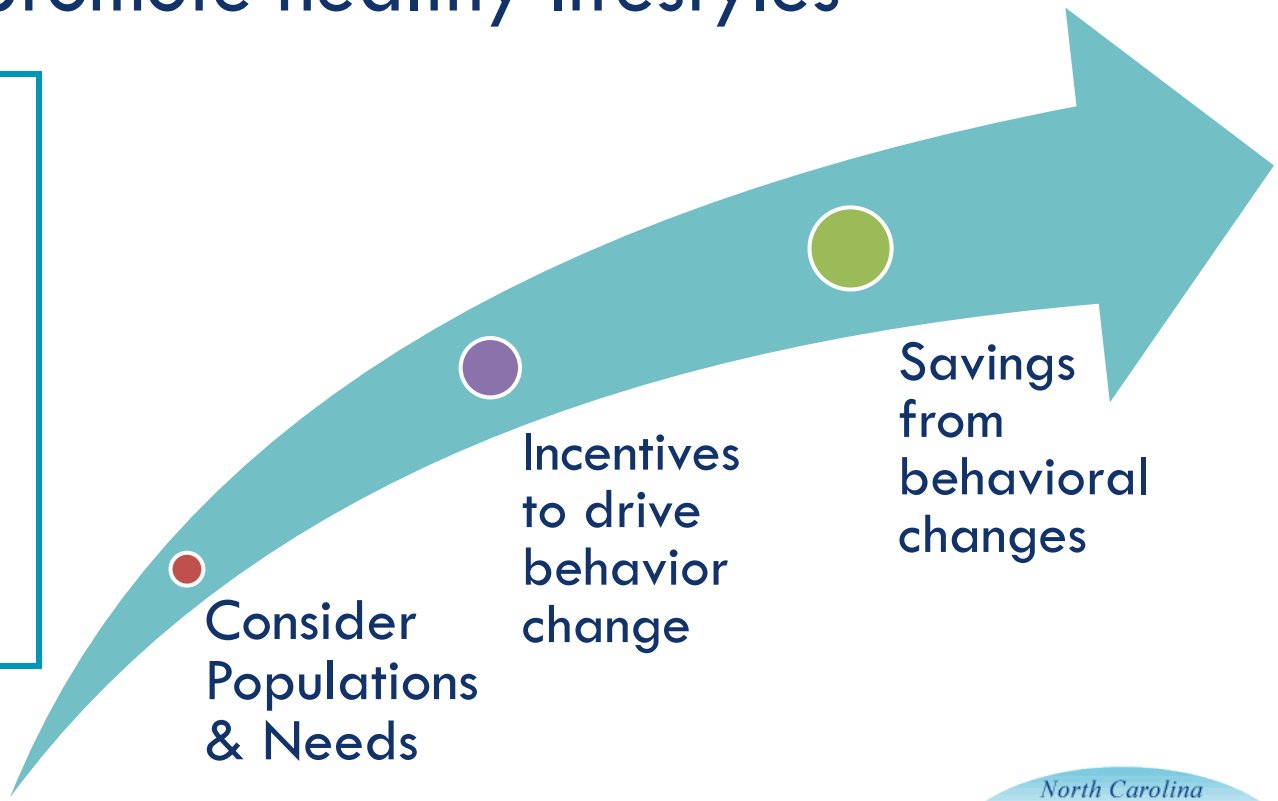
- Cushion to address adverse claims experience
- More closely approximate year end claims liability
- Stabilize premium increases

Projected Cost = $45 million based on projected claims

Other Benefit Design Considerations

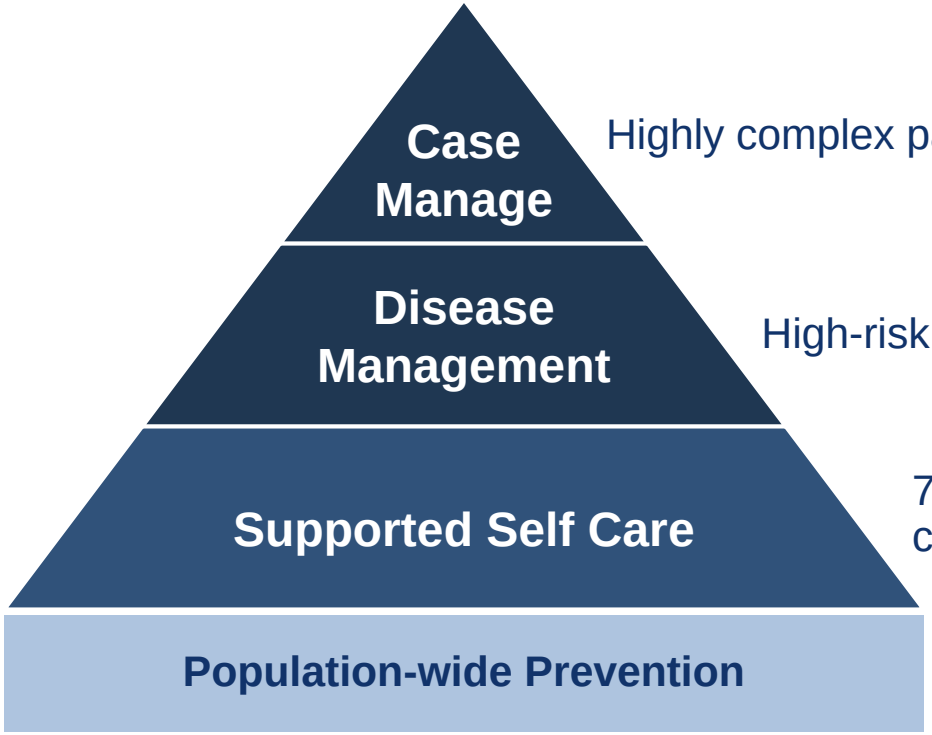
In November the Board reviewed design elements to promote healthy lifestyles

How can benefit design elements be used to lower trend and slow the increases in future funding requirements?



Different Populations-Different Needs

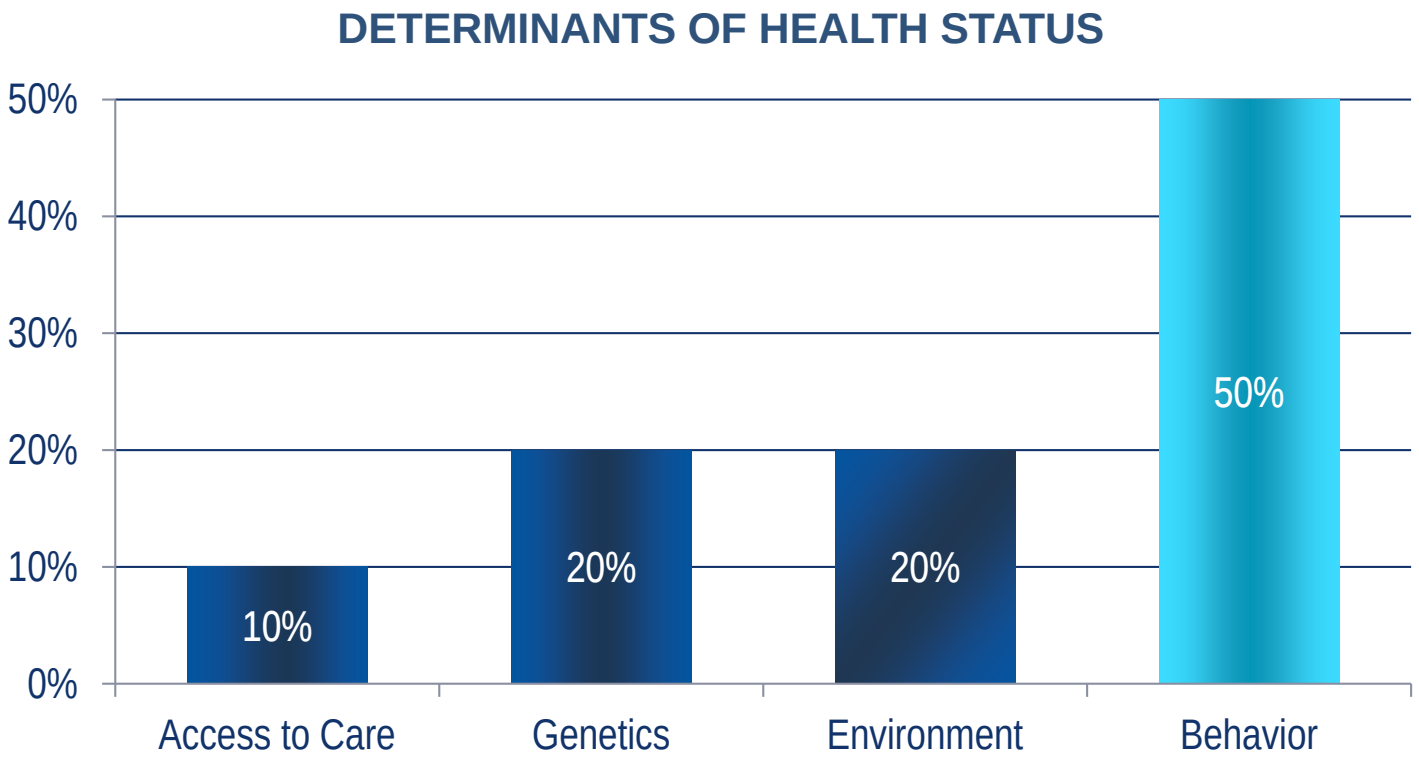
Four key groups must be addressed in any design:



Programs need to be structured to support the wide range of population needs.

Incentives Drive Behavior Change

Behavior drives consumption and influences health status



Source: IFTF, Center for Disease Control and Prevention

Savings from Behavioral Change

Behavior Change in Three Areas

Value Purchasing

- Ask price of service
- Consider alternatives
- Research doctor and hospital quality
- Use generic Rx
- Urgent care vs. ER
- Outpatient vs. inpatient
- Online consultation
- Retail health clinics

Improved Health

- Use preventive benefits
- Complete health assessment
- Reduce weight
- Stop smoking
- Manage stress
- Get biometric screenings
- Use online health coach

Manage Chronic

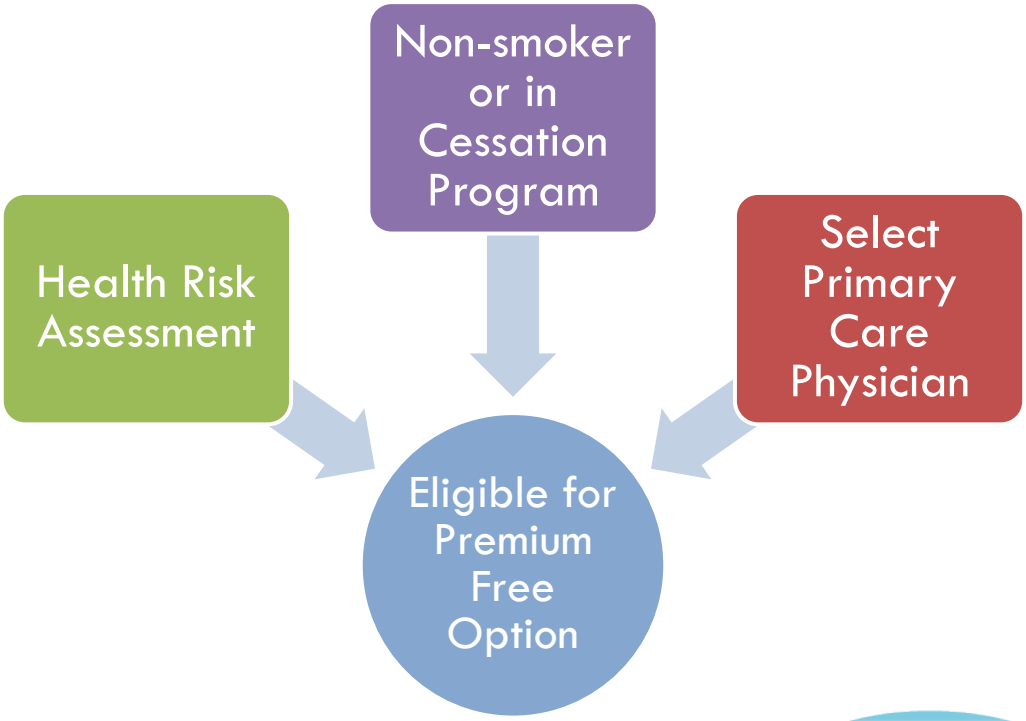
- Use disease management program
- Follow evidence based guidelines
- Use a premium doctor
- Maintain personal medical record

Incenting Healthy Activities

May add premium rewards for healthy activity

- Member receives premium credits for completing healthy activities

Free plan can be achieved through premium credits



Healthy Activities Will Evolve Year to Year to Create a Process of Population Health Improvement

Promoting High Quality Provider Networks

- May implement a procedure-based distinctive provider network
  - Bariatric surgery, heart bypass surgery, knee and hip replacement
  - Members receive reduced copayments or deductibles for using preferred physicians/hospitals
- Considering use of Blue Cross Blue Shield of North Carolina tiered network option
  - Hospitals and/or specialists

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Incenting Use of Patient Centered Medical Homes (PCMH)

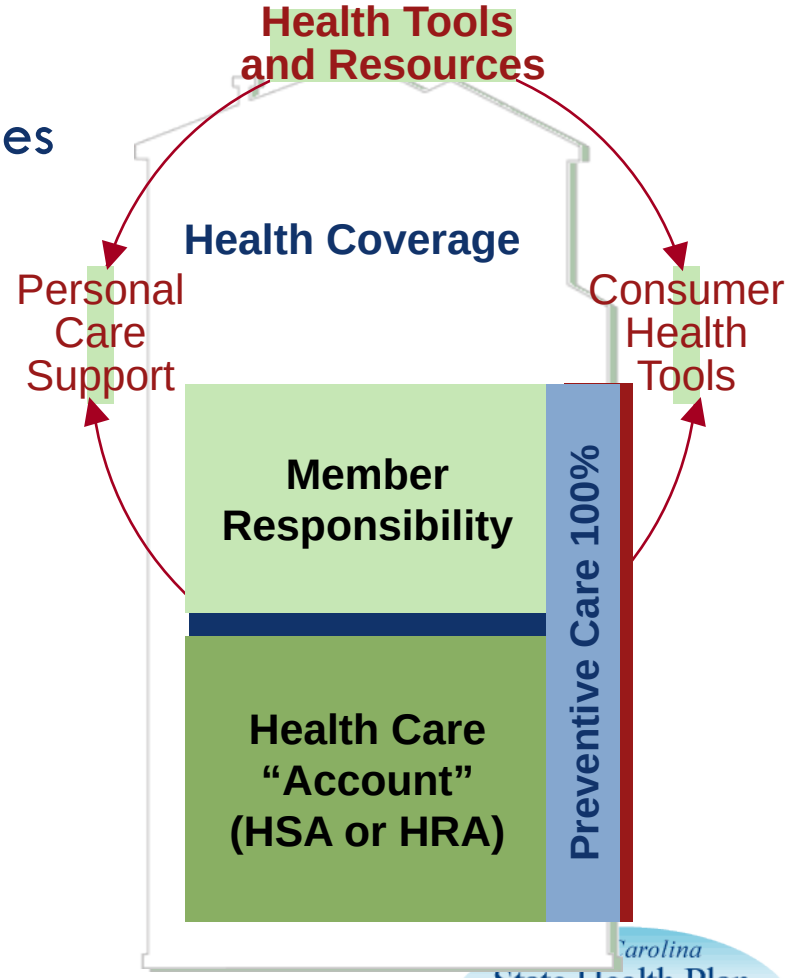
- Incent high-risk members to select a primary care physician (PCP) or medical home
- Offer copay reduction for utilizing PCP/PCMH
- Offer reduced drug copays for participating in disease management

Consumer Directed Health Plan (CDHP)

- Engage member in shopping for health care services
- May offer CDHP as a third option along with the Basic (70/30) and Standard (80/20) plans
  - Combine with health savings account (HSA) or health reimbursement account (HRA)
  - Includes 1st dollar coverage for preventive benefits
- May offer premium credits for healthy activities, and incentives for PCP/PCMH use and disease management participation

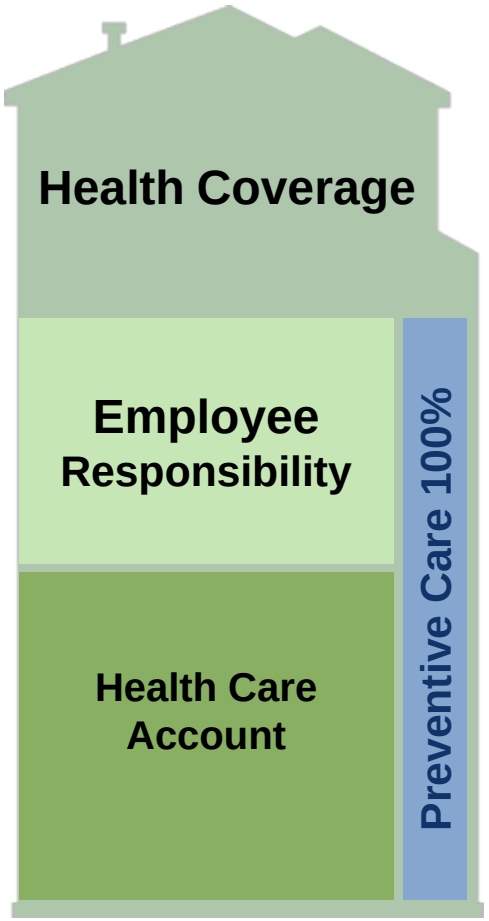
How Does a CDHP Work?

- Preventive Care covered 100%
  - Based on age and gender guidelines
  - No need to use Account
- Health Care Account
- Typically Deductible & Coinsurance Only, no Copays
- Member Responsibility
- Health Coverage
- Resources and Tools



Health Coverage Overlays the Health Care Account and Deductible

- Employer contributes to health care account (HSA or HRA)
- Employee is responsible for the full deductible, with offset by Account on first dollar coverage
- Traditional health insurance coverage overlays Account when employee responsibility is exceeded
- In-network and out-of-network coinsurance applies
- Health coverage would be similar to current PPO plans in place



How Will Incentives Impact Costs?

- The Segal Company, the Plan's consulting actuary is preparing financial projections that incorporate the various design elements
- The projections will be presented to the Board in January 2013
- Preliminary estimates indicate 1st year savings of $24 million, growing to $150 million by CY 2017
  - Conservatively equates to 10% cost reduction in 2017 (compared to baseline)

Projected financial impacts are preliminary for information purposes only and subject to change pending final design decisions

State Health Plan Update

OPEB Valuation

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OPEB Valuation

- GASB Statements 43 and 45
  - Require the State to disclose information in the CAFR regarding the liability associated with **O**ther (i.e. non-pension) **P**ost **E**mployment **B**enefits
    - **Retiree health coverage**
    - Disability income benefits (if not paid from pension)
    - Dental, vision, or hearing benefits
    - Long term care

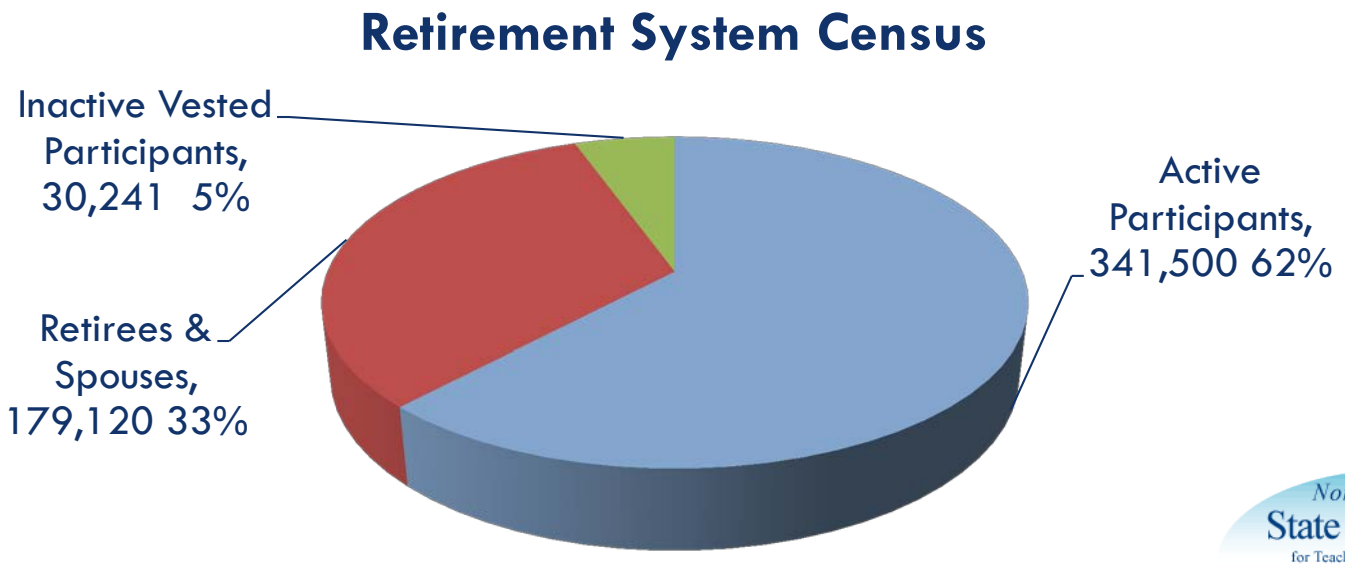
Committee on Actuarial Valuation of Retired Employees' Health Benefits

- General Assembly established a committee to oversee the annual valuation process (G.S. 135-48.12):
  - State Budget Officer, chair
  - State Auditor
  - State Controller
  - State Treasurer
  - Executive Administrator of the State Health Plan
- Responsible for:

Selecting an Actuary	Assumptions
Data Collection	Results

Valuation Results

- OPEB valuation reports, in today's dollars, the State's unfunded liability associated with retiree health benefits earned by:
  - Current retirees
  - Active employees
  - Former employees with a vested retiree health benefit



Unfunded Actuarial Accrued Liability (UAAL)

Liability associated with benefits earned in past years

Valuation of Retired Employees' Health Benefits	Segal	Aon Hewitt		
	Dec 31, 2011	Dec 31, 2010	Dec 31, 2009	Dec 31, 2008
UAAL	$29.6 b	$32.8 b	$32.7 b	$27.8 b

- Implementation of EGWP prescription drug benefit effective Jan 1, 2013 reduces the accrued liability by $4.9 billion
- If Plan implements fully insured Medicare Advantage benefit in 2014 it will impact 2012 valuation

Annual Required Contribution (ARC)

ARC = amortization of unfunded liability + normal costs

- If the State were to reduce or amortize the UAAL over a 30 year period, the annual payment = $1.093 b
- Liability associated with future benefits earned in the current (valuation) year is the "Normal Cost" = $1,386 b

Valuation of Retired Employees' Health Benefits	Dec 31, 2011	Dec 31, 2010	Dec 31, 2009	Dec 31, 2008
Amortization of Unfunded Liability	$1.1 b	$1.2 b	$1.2 b	$1.0 b
Normal Cost	$1.4 b	$1.7 b	$1.8 b	$1.7 b
ARC	**$2.5 b**	**$2.9 b**	**$3.0 b**	**$2.7 b**
As % of Payroll	16.7%	19.3%	19.9%	17.5%

For More Information

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