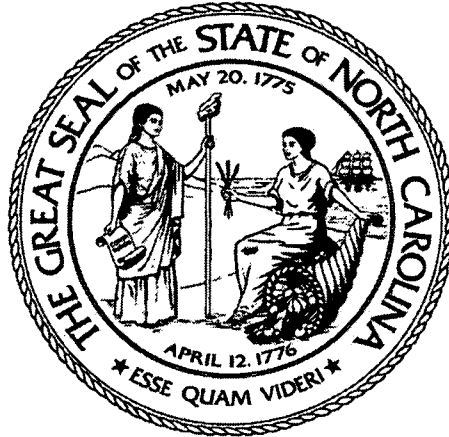


2009-2010

**BLUE RIBBON TASK
FORCE ON THE STATE
HEALTH PLAN**

MINUTES

NORTH CAROLINA GENERAL ASSEMBLY



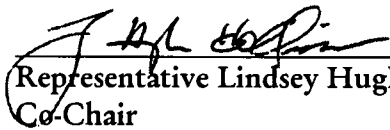
BLUE RIBBON TASK FORCE ON THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

REPORT TO THE 2011 SESSION of the GENERAL ASSEMBLY

NOVEMBER, 2010

TRANSMITTAL LETTER

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees was established by S.L. 2009-16, Part Seven, as amended by S.L. 2009-571. The Task Force respectfully submits the following report.



Representative Lindsey Hugh Holliman
Co-Chair



Senator Daniel T. Blue, Jr.
Co-Chair

TASK FORCE MEMBERSHIP

Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

Co-Chairs

Rep. Lindsey Hugh Holliman (Co-Chair)	House Appointment
Sen. Daniel T. Blue, Jr. (Co-Chair)	Senate Appointment

Legislative Members

Rep. R. Van Braxton	House Appointment
Rep. Dale R. Folwell	House Appointment
Sen. Thomas M. Apodaca	Senate Appointment
Sen. Linda Dew Garrou	Senate Appointment

Ex Officio Members

Hon. George Wayne Goodwin	Ex Officio
Mr. Andrew M. Perkins, Jr.	Ex Officio

Public Members

Ms. Gale Brown Adcock, RN	Governor's Appointment
Mr. Allen Feezor	House Appointment
Dr. William C. Harrison	Senate Appointment
Dr. Dan A. Myers, MD	Senate Appointment
Ms. Sharnese Ransome	Senate Appointment
Ms. Victoria Leigh Simmons	House Appointment
Mr. Charles Stone	House Appointment

TASK FORCE PROCEEDINGS

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees met three times from August 12, 2010 until November 16, 2010. The information below provides an overview of presentations received and issues discussed by the Task Force. Detailed minutes and copies of handouts from each meeting are on file in the Legislative Library or are available for a period of time at the Task Force website: <http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=114>.

August 12, 2010

The Task Force was presented recommendations on changing the governance of the State Health Plan by two separate entities with a relationship to the Plan.

First, Navigant Consulting, a consulting firm to the State Health Plan, presented recommendations regarding the State Health Plan's governance arrangement. Navigant evaluated the Plan's governance and claims processing function under a General Assembly mandated audit. Representatives for Navigant Consulting recommended that the Plan be organizationally located under the Governor, but functionally responsible to an independent board. This independent board should be tasked with the direct authority to manage the Plan's operations. Representatives of Navigant Consulting noted that in most states, an independent board or executive branch agency or department houses the function of a public employer health benefit plan.

The second recommendation was from the State Health Plan's Board of Trustees. Dr. John Hammond, a member of the State Health Plan's current Board of Trustees, presented a recommendation to require that oversight of the Plan's day-to-day operations and appointment of the Plan's Executive Administrator fall under the responsibility of an executive agency with a reporting relationship to the Governor. The Board of Trustees also recommended that the Plan's Board of Trustees be given the responsibility to formulate policies implemented by the Plan, to conduct rule-making, and to make final agency decisions.

The balance of the meeting was devoted to discussion about the information presented to Task Force members regarding State Health Plan governance changes and ways to move forward with developing a Task Force recommendation.

September 21, 2010

At the request of the co-chairs in an effort to guide the Task Force discussion on governance options, Mark Trogon, staff fiscal analyst, presented a broad overview of issues related to governance of the State Health Plan. Mr. Trogon mentioned the following three primary areas the Task Force might wish to consider as they discuss governance options: organizational location within an Executive Branch of State

Government; the authority to appoint and remove the Plan's Executive Administrator; and the distribution of powers and duties relative to the Plan.

Mr. Trogdon reviewed the following location options for organizational placement of the State Health Plan: Office of the Governor, Cabinet agency, Council of State agency, or other location. Mr. Trogdon pointed out that Navigant Consulting, Inc. had provided the Task Force an *Assessment of Compatibility of Selected State Departments, Agencies and Entities with the State Health Plan* which recommended placement of the State Health Plan in the Office of the Governor. Mr. Trogdon also reminded the Task Force that during their prior meeting they received a report from the Board of Trustees recommending placement of the State Health Plan in an executive agency, but not specifying whether it should be a Cabinet or Council of State agency.

Next Mr. Trogdon reviewed a list of potential authorities to appoint or remove the Executive Administrator of the State Health Plan. The list of authorities included: the Governor; an appointed Cabinet Secretary or elected Council of State Officer; an appointed governing board; or a shared appointment/removal process.

The third area suggested for consideration by the Task Force was the powers and duties that provide the fundamental authority for operation and oversight. This summary list included the authority to: enhance or reduce benefit options; set co-pay, annual deductible and co-insurance maximum amounts; set premiums and contribution rates; negotiate and enter into contracts; fiduciary responsibility; and other broad elements key to the Plan's mission of providing health benefits to State employees and teachers. Mr. Trogdon pointed out that to operate the Plan on a daily basis, the assignment of those powers and duties must be given directly to an executive administrator, to an agency head that carries out the power and duties or delegates them, or to a governing board or authority that carries out the power and duties or delegates them.

The Task Force asked for a reminder of the State Health Plan's current organizational placement. Mr. Trogdon explained that the State Health Plan is currently placed under the executive branch but operates as an independent entity. The Plan does have a Board of Trustees vested with some powers and duties and limited governing authority. Currently, most of the powers and duties are assigned to the Plan's Executive Administrator.

Upon request, Mr. Trogdon reported that research for prior reports received by the Task Force noted that 25 states place the health plan within an executive agency, 15 states place the health plan within an executive agency with a governing advisory board, there are 8 states where the health plan operates as an independent agency with a governing board, and a couple of states where they were not able to determine placement. It was noted that a decision on organizational placement of North Carolina's State Health Plan is complex because the Plan covers employees of both Cabinet and Council of State agency employees, legislative and judicial branch employees, employees of local school systems, employees of community colleges, and

university employees. Since the Task Force had heard from the Commissioner of Insurance, the Task Force suggested that the Auditor, Commissioner of Labor, and Treasurer be asked to comment on organizational placement of the State Health Plan under their agency.

The balance of the meeting was devoted to Task Force discussion of the organizational location of the State Health Plan within an Executive Branch of State Government; the authority to appoint and remove the Plan's Executive Administrator; and the distribution of powers and duties relative to the Plan.

November 16, 2010

The Task Force was presented a draft report to the 2011 Session of the North Carolina General Assembly. Task Force members discussed changes to the report and approved the amended report.

FINDINGS AND RECOMMENDATIONS

FINDINGS:

During the 2010 Interim, the Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees examined issues related to governance of the State Health Plan. Discussions of the Task Force yielded the observations below.

- Responsibility for broad oversight of the State Health Plan should not primarily reside with the General Assembly.
- Compatibility with the mission of existing State agencies and the range of employees covered by the State Health Plan present challenges in finding a logical organizational fit of the State Health Plan within an existing State agency.
- A strong governing board may be a logical entity to provide oversight of the State Health Plan. Membership of a strong governing board shall include persons with experience in, but not limited to: health benefit financing, managing large group employer-sponsored health benefits plans, care quality, prevention and health promotion, and utilization management. The governing board shall also include representation from employee and retiree groups.
- The operation of the State Health Plan includes the following:
 - Authority to enhance or reduce benefits.
 - Authority to set co-pays, deductibles, and co-insurance maximums.
 - Authority to set premiums.
 - Authority to negotiate and execute contracts.
 - Authority to act as fiduciaries to the Plan.
 - Authority to create rules.
 - Authority to adjudicate members' appeals.
 - Authority to conduct strategic planning.
 - Authority to create and implement medical policy.
- The current appointment and removal process for the Plan's Executive Administrator is unclear.
- The current plan year structure makes it difficult for employees and retirees to focus on their health and not their health care.

The Task Force acknowledges that oversight of the State Health Plan is complex because coverage includes: executive, judicial, and legislative branch employees; local school system employees; community college employees; and university employees. Additionally, similar to most health insurance providers, the State Health Plan must respond to the challenges of an older and less physically active population, increasing health care costs, and compliance with Federal law. The Task Force finds that

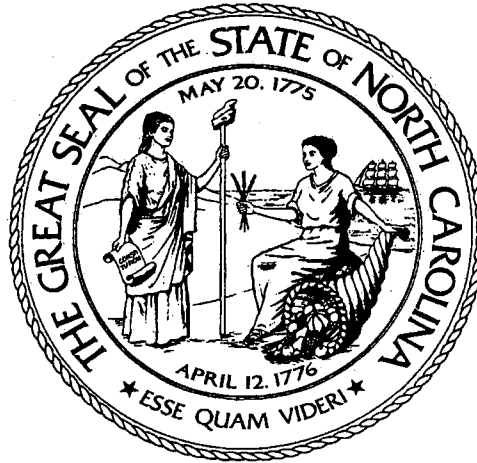
governance of the State Health Plan is a serious and substantial undertaking and must be clarified in order to effectively meet current challenges.

RECOMMENDATIONS:

The Task Force recommends that oversight of the State Health Plan be provided by the executive branch and a strong and independent governing board with broad policy making authority and also recommends that appointment and removal of the Executive Administrator be one of the duties of the governing board.

The Task Force recommends putting the State Health Plan's plan year on a calendar year basis.

NORTH CAROLINA GENERAL ASSEMBLY



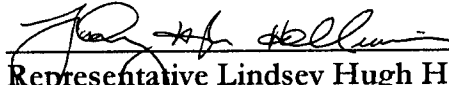
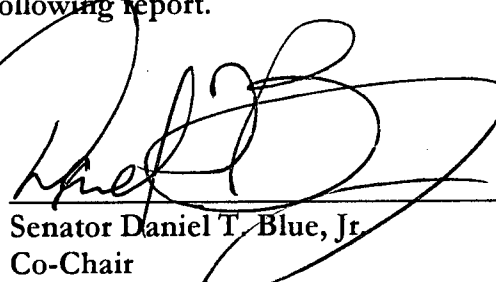
BLUE RIBBON TASK FORCE ON THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

REPORT TO THE
2010 SESSION
of the
2009 GENERAL ASSEMBLY

APRIL, 2010

TRANSMITTAL LETTER

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees was established by S.L. 2009-16, Part Seven, as amended by S.L. 2009-571. The Task Force respectfully submits the following report.


Representative Lindsey Hugh Holliman
Co-Chair
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Ms. Victoria Leigh Simmons

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Mr. Charles Stone

House Appointment

TASK FORCE PROCEEDINGS

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees met six times from November 11, 2009 until April 22, 2010. The Task Force heard from the individuals listed below during the specified meeting dates. Detailed minutes and copies of handouts from each meeting are on file in the Legislative Library.

November 18, 2009

- Gann Watson, staff attorney, presented to the Task Force a summary of Session Law 2009-16 (SB 287), which made significant changes to the laws governing the operation of the State Health Plan for Teachers and State Employees (State Health Plan). Ms. Watson's presentation covered the key components of the enacted legislation including additional funding appropriated to the State Health Plan, annual premium increases authorized over the 2009-11 biennium, benefit changes affecting out-of-pocket requirements for Plan members, the establishment of a Comprehensive Wellness Initiative, a directive for an operational audit of the State Health Plan's medical and drug claims processing vendors, and the authorizing language for the Blue Ribbon Task Force on the State Health Plan.
- Mark Trogon, staff fiscal analyst, made a presentation to the Task Force entitled "Overview of the State Health Plan." Mr. Trogon's presentation covered the State Health Plan's statutory authorization and creation, its size based on enrollment, total claims, and total revenues, benefit design, funding basis, administrative structure, Plan member eligibility guidelines, enrollment demographics, etc. His presentation also provided a financial summary of the State Health Plan including the financial impact of Session Law 2009-16, a historical summary of the State Health Plan's claims growth over time, and the State Health Plan's per capita medical costs by age bands and the percent of Plan members in each of those bands.

December 2, 2009

- Theresa Matula, staff legislative analyst, presented a document listing priorities developed from input provided by Task Force members during the November 18, 2009 meeting.
- Dr. Jack Walker, Executive Administrator, State Health Plan, presented an overview of the State Health Plan and the Comprehensive Wellness Initiative. The presentation included demographic data on Plan membership, statistics concerning the rationale for choosing tobacco use and body mass index (BMI) as targets for the Wellness Initiative, and information on the Comprehensive Wellness Initiative. Comprehensive Wellness Initiative information covered the following topics: employee privacy, employee benefits and support, and desired outcomes for the State Health Plan.

January 21, 2010

- Ann Rogers, Director of Integrated Health Management, State Health Plan, provided information on tobacco use testing for Plan members. Her presentation included information on the development of the Request for Proposal for a vendor to administer off-site tobacco use testing to members and to verify members' enrollment in smoking cessation programs. Ms. Rogers also reviewed the testing process, explained how members' attestation to tobacco use status will drive initial State Health Plan qualifications, and reviewed member consequences for falsifying tobacco use status.
- Dr. Jack Walker, Executive Administrator, State Health Plan, reviewed the financial requirements for the State Health Plan for the next five years. He presented information on current and projected State Health Plan revenues, member cost-sharing, projected annual increases in health costs and utilization, and State Health Plan efforts to detect and prevent fraudulent claims. Dr. Walker's presentation emphasized the importance of improving the health status of active Plan members through behavior management, case management, and disease management, in order to achieve savings and lower the cost trend.
- Lacey Barnes, Deputy Executive Administrator, State Health Plan, provided follow-up information on select inquiries by Task Force Members which included the reduction in cost savings if individual members, rather than entire family units, are moved to the 70/30 State Health Plan; and reasons Plan members are electing to terminate dependent coverage under the State Health Plan.
- Carol Durrell, Director of Product Development, State Health Plan, provided an outline, timeline, and costs for planned actuarial studies to be performed by Aon Consulting in 2010 to address Task Force requests, responses to questions from the Legislative Oversight Committee and constituents, and State Health Plan requirements. Ms. Durrell discussed the Cost Comparison study of State Health Plan benefit options in Georgia, Virginia and Tennessee (which should be available in mid February) and the study concerning Other Post-Employment Benefits like retiree benefits.

February 25, 2010

- Carol Durrell, Director of Product Development, State Health Plan, presented details of our State Health Plan in comparison to the state health plans of Georgia, Virginia, and Tennessee. Ms. Durrell highlighted differences and similarities in state health plan benefits, premium costs, subsidization of dependent care premiums, and other aspects of operations.
- Ann Rogers, Director of Integrated Health Management, State Health Plan, discussed the extension of a nutritional visit benefit to all Plan members (previously available only to Plan members with diabetes). She noted that for provision of this benefit the State Health Plan has contracted for participation in the Eat Smart, Move More, Weigh Less program.
- Dr. Derek Prentice, Consulting Medical Director, State Health Plan, discussed a range of issues related to medications prescribed to members participating in State Health Plan weight loss programs.

March 25, 2010

- Chris Schoffner, Managing Partner, White Bear Group, an employee benefit consulting firm, discussed methods of changing member behavior to create savings for the State Health Plan. Mr. Schoffner presented information on the success of the Ashville Project. In the Ashville Project, diabetic employees received support and guidance from counselors, physicians, and pharmacists all working together, and employees received preventive care without any out-of-pocket costs. Mr. Schoffner recommended the following main steps:
 1. Identify employees with needs via Health Fairs.
 2. Engage beyond the chronically ill; remove barriers to treatment.
 3. Educate through face to face coaching.
 4. Communicate at all steps to allow all to get information.
- Mark Ruby, Vice President for Business Development, BioSignia, a healthcare risk assessment company located in Research Triangle Park., presented information on BioSignia's "Know You Number" product. BioSignia uses data analysis of large populations and individual test results to help participants better understand their personal health risks. According to Mr. Ruby, the State Health Plan could save \$124 million over five years by screening 300,000 Plan members twice a year for five years.
- Victoria Simmons, Task Force member, provided copies of pay slips for several Guilford County School employees and discussed the importance of the "promise" of affordable health care from the State to its employees. The Task Force discussed the "promise" of health care at no cost and whether employees would be willing to pay a member contribution based on a percentage of their salaries.
- Representative Folwell, Task Force member, advocated the use of a calendar year, rather than State's fiscal year, for the State Health Plan. He cited broad support for the change among various State employee organizations and the use of a calendar year by 24 other states. Although there would be a one-time cost of \$25 millions and a six month moratorium on rate increases, Rep. Folwell requested that the Task Force endorse the idea in order to facilitate health insurance planning by families with non-State Health Plan options.

April 22, 2010

- Jack Walker, Executive Administrator, State Health Plan, presented information concerning the impact on the State Health Plan of the following federal health reform Acts: Patient Protection and Affordable Care Act (HR 3590), and the Health Care and Education Affordability Act of 2010 (HR 4872).
- The Task Force received a draft report to be presented to the 2010 General Assembly, the Governor, and the Committee on Employee Hospital and Medical Benefits. The Task Force approved the report.

FINDINGS AND RECOMMENDATIONS

FINDINGS:

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees met six times prior to the convening of the 2010 short session. During these meetings Task Force members received an overview of the State Health Plan, the State Health Plan's Comprehensive Wellness Initiative, and information on issues that will impact the State Health Plan in the future. Members were also apprised of the study issues identified in the legislation creating the Task Force and prioritized the study of these issues. The Task Force explored a number of concerns regarding the State Health Plan and found there is a good bit of information that, although not immediately available, will be forthcoming during the tenure of the Task Force and following adjournment of the 2010 short session. In the coming months, the Task Force anticipates receiving the following reports: Consumer Directed Health Care, Medicare Products and Strategy, Dependent Subsidy including Salary Based Premium Structure, and an Audit of the State Health Plan.

RECOMMENDATION:

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees recommends that the General Assembly continue addressing State Health Plan issues during the 2010 Session and that the Task Force resume its work after adjournment of the 2010 Session and develop a report to the 2011 General Assembly.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009**

**SESSION LAW 2009-16
SENATE BILL 287**

**AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS
AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE
STATE HEALTH PLAN.**

Whereas, the General Assembly must act quickly and prudently to maintain a financially stable State Health Plan to ensure that all members of the Plan have affordable access to medically necessary health benefits and services within available resources; and

Whereas, in order to meet current fiscal obligations, the General Assembly must appropriate \$250,000,000 for the 2008-2009 fiscal year to cover the current year shortfall in funds; and

Whereas, estimates indicate that a substantially larger appropriation will be necessary to maintain the fiscal integrity of the Plan in the next and ensuing fiscal periods; and

Whereas, in order to ensure continued access to medically necessary health care to Plan members, the Plan must implement measures to contain costs through premium increases, benefit changes, and healthy lifestyle programs that not only reduce costs but improve member health; and

Whereas, the Plan estimates that over 70,000 Plan members use tobacco, resulting in a cost to the Plan of \$2,000 per member per year more than the cost of providing coverage for nonusers of tobacco; and

Whereas, cessation of tobacco use has been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation incentives and initiatives with mechanisms to verify member compliance with smoking cessation requirements; and

Whereas, over 60% of North Carolina adults are obese or overweight; and

Whereas, obesity is linked to an over 37% increase in health care spending at a cost of \$2,445 per member per year; and

Whereas, weight management and cessation of tobacco use have been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation and weight management incentives and initiatives with mechanisms to verify member compliance with smoking cessation and weight management requirements; Now, therefore,

The General Assembly of North Carolina enacts:

PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE.

SECTION 1.(a) Appropriation for 2008-2009 Fiscal Year. – There is appropriated from the Savings Reserve Account established in G.S. 143C-4-2 to the Health Benefit Reserve Fund established in G.S. 135-44.5 the sum of two hundred fifty million dollars (\$250,000,000) for the 2008-2009 fiscal year. These funds shall be used to address the shortfall in funds available for the payment of health care and administrative costs under the State Health Plan for Teachers and State Employees ("Plan") for the 2008-2009 fiscal year.

SECTION 1.(b) General Fund Appropriation for 2009-2011 Fiscal Biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of one hundred thirty-two million two hundred fourteen thousand seven hundred fifty-two dollars (\$132,214,752) for the 2009-2010 fiscal year and the sum of two hundred seventy-six million one hundred seventy-nine thousand seven hundred nine dollars (\$276,179,709) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.



SECTION 1.(c) Highway Fund Appropriation for the 2009-2011 Fiscal Biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of six million one hundred seventy thousand twenty-two dollars (\$6,170,022) for the 2009-2010 fiscal year and the sum of twelve million eight hundred eighty-eight thousand three hundred eighty-six dollars (\$12,888,386) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(d) All other agency funds required to fund the premium increase enacted in this act, other than funds appropriated in subsections (b) and (c) of this section, are appropriated for the 2009-2011 fiscal biennium.

SECTION 1.(e) Definitions. – As used in this act unless the context clearly requires otherwise:

- (1) "Plan." – The State Health Plan for Teachers and State Employees.
- (2) "Basic Plan." – The Plan's PPO option providing for 70/30 in-network coverage after deductibles and co-payments.
- (3) "Smoking" or "Smoking cessation." – Includes cessation of the use of all tobacco products.
- (4) "Standard Plan." – The Plan's PPO option providing for 80/20 in-network coverage after deductibles and co-payments.

SECTION 1.(f) Scope. – In the event of a conflict between the provisions of this act and Article 3A of Chapter 135 of the General Statutes, this act prevails.

PART TWO: HEALTH BENEFIT CHANGES.

SECTION 2.(a) Eliminate PPO Plus Option. – Effective July 1, 2009, the PPO Plus option (90/10 in-network coverage) under the State Health Plan for Teachers and State Employees ("Plan") is eliminated. The Executive Administrator shall provide notice to all members of the Plan that this option will no longer be available as of July 1, 2009. Employees enrolled in the Plan's Plus option shall have the choice of enrolling in the Basic or Standard Plan options for the 2009-2010 benefit year.

SECTION 2.(b) Implement Comprehensive Wellness Initiative.

- (1) Program development. – The Plan shall develop a Comprehensive Wellness Initiative that includes a focus on smoking cessation and weight management and that is designed to be implemented effective July 1, 2010, for smoking cessation and July 1, 2011, for weight management. Benefit levels shall be determined by the Plan based upon tobacco use or the inability of the member to meet national, evidence-based healthy weight clinical guidelines. For purposes of the Comprehensive Wellness Initiative, "member" includes all State Health Plan primary subscribers and their covered dependents. The Plan shall develop a process whereby a Plan member may appeal the Plan's basis for action it takes due to the member's failure or refusal to comply with the Plan's smoking cessation or weight management requirements.
- (2) Smoking cessation. – Effective July 1, 2010, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO unless the subscriber can attest that the subscriber or any qualifying dependent does not smoke or otherwise use tobacco products. The Plan shall develop a mechanism for verifying that the member does not smoke or use other tobacco products. Tobacco use will be reassessed annually at the time of Plan enrollment. All subscribers who have attested that neither they nor their dependents use tobacco, or whose physician certifies in writing that the member is participating in a smoking cessation program, shall have the choice of remaining in the Basic Plan option or enrolling in the Standard Plan option. For purposes of the smoking cessation initiative, "member" includes all members covered under the Plan. As used in this section, "smoking cessation program" means active participation in a Plan-approved cessation program to include counseling or use of tobacco cessation medications.
- (3) Weight management. – Effective July 1, 2011, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO Plan unless the subscriber attests that the

weight and height ratio of the member is within a range determined by the Plan based on evidence-based healthy weight clinical guidelines, or unless the member's physician certifies in writing that the member has a medical condition that prevents the attainment of the specified weight range or that the member is actively participating in a Plan-approved weight management program. In either case, the member shall have the option to enroll in the Basic or Standard Plan.

Not later than October 1, 2009, the Executive Administrator shall inform Plan members of the healthy lifestyle initiatives, requirements for compliance, and consequences of noncompliance. The Executive Administrator shall provide to members education and training to assist members in complying with healthy lifestyle initiatives. The Executive Administrator may implement incentive initiatives to further encourage member achievement in smoking cessation, weight management, and other integrated health management programs.

The Executive Administrator shall report to the Committee on Employee Hospital and Medical Benefits recommendations the Plan may have for additional sanctions that may be imposed when the Executive Administrator finds that a member intentionally makes a false statement on a Plan document.

SECTION 2.(c) Prescription Drug Co-Payments. – G.S. 135-45.6(b) reads as rewritten:

"(b) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility shall be as determined by the Plan's Executive Administrator and Board of Trustees, which determinations are not subject to appeal under Article 3 of Chapter 150B of the General Statutes. Co-payments and other allowable charges or coverage for prescription drugs shall be as follows:

- (1) The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars (\$10.00) for each generic prescription, ~~thirty dollars (\$30.00)~~ thirty-five dollars (\$35.00) for each preferred branded prescription without a generic equivalent, ~~and forty dollars (\$40.00) for each preferred branded prescription with a generic equivalent drug,~~ and ~~fifty dollars (\$50.00)~~ fifty-five dollars (\$55.00) for each nonpreferred branded or generic prescription. For each branded prescription drug with a generic equivalent drug, the member shall pay the generic co-payment plus the difference between the Plan's gross allowed cost for the generic prescription and the Plan's cost for the branded prescription drug.
- (2) The Plan shall provide coverage of nonacute specialty medications, excluding cancer medications, under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the Plan. The Plan may transfer coverage of specified specialty disease medications covered under the Plan's medical benefit to the contracted specialty pharmacy vendor. Specialty medications are covered biotech medications and other medications designated and classified by the Plan as specialty medications that are significantly more expensive than alternative drugs or therapies. Medications classified by the Plan as specialty medications shall meet all of the following conditions:
 - a. Have unique uses for the treatment of complex diseases.
 - b. Require special dosing or administration.
 - c. Require special handling.
 - d. Are typically prescribed by a specialist provider.
 - e. Exceed four hundred dollars (\$400.00) cost to the Plan per prescription.

The Plan shall impose a co-payment in the amount of twenty-five percent (25%) of the Plan's gross allowed cost of the specialty drug not to exceed one hundred dollars (\$100.00) per prescription per 30-day supply.

- (3) The Plan may exclude coverage of drugs that have therapeutic equivalents, as defined by the U.S. Food and Drug Administration, that are available over the counter. Before excluding coverage under this subdivision, the Plan shall consult with the Plan's Pharmacy and Therapeutics Committee.

These co-payments apply to all optional alternative plans available under the Plan.

- (4) Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a ~~34-day~~ 30-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. ~~The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for sexual dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinum toxin without approval in advance by the pharmacy benefit manager. The Plan may adopt utilization management procedures for certain drugs, but in no event shall the Plan provide coverage for sexual dysfunction or hair growth drugs or nonmedically necessary drugs used for cosmetic purposes. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars (\$2,500) per person per fiscal year in copayments required by this subsection. The Plan's Pharmacy Benefit Manager, or any pharmacy or vendor participating in the Plan shall charge the Plan for any prescription legend drug dispensed under the Plan's pharmacy benefit based upon the original National Drug Code (NDC) as established by the manufacturer of the prescription legend drug and published by the United States Food and Drug Administration.~~

Co-payments and other allowable charges under this subsection shall be the lesser of the Plan's discounted cost of the drug or the co-payment amount or allowable charge and apply to all optional alternative plans available under the Plan."

SECTION 2.(d) Routine Eye Examinations Not Covered. – Effective January 1, 2010, G.S. 135-45.8(13) reads as rewritten:

"§ 135-45.8. General limitations and exclusions.

The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-45.6 through G.S. 135-45.11 be payable for:

- (13) Charges for routine eye examinations, eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons) and hearing aids or examinations for the prescription or fitting thereof."

SECTION 2.(e) Deductible and Co-Payment Changes. – Effective July 1, 2009, the Executive Administrator shall make the following changes to deductibles, coinsurance maximums, and co-payments under the Basic and Standard PPO Plans:

- (1) Basic plan (70/30):
- a. Increase the in-network annual deductible to eight hundred dollars (\$800.00) for member-only coverage and to one thousand six hundred dollars (\$1,600) for the out-of-network annual deductible for member-only coverage.
The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.
 - b. Increase the in-network coinsurance maximum to three thousand two hundred fifty dollars (\$3,250) for member-only coverage and to six

thousand five hundred dollars (\$6,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

- c. Increase the in-network primary care co-payment to thirty dollars (\$30.00) per covered individual.
 - d. Increase the in-network specialist co-payment to seventy dollars (\$70.00) per covered individual, except that for mental health and substance abuse services, chiropractic services, and physical therapy, occupational therapy, and speech therapy services, the in-network specialist co-payment shall be fifty-five dollars (\$55.00) per covered individual.
 - e. Increase the in-network and out-of-network inpatient co-payment to two hundred fifty dollars (\$250.00) per covered individual.
 - f. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.
 - g. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.
- (2) Standard Plan (80/20):
- a. Increase the in-network annual deductible to six hundred dollars (\$600.00) for member-only coverage and to one thousand two hundred dollars (\$1,200) for the member-only out-of-network annual deductible.
The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.
 - b. Increase the in-network coinsurance maximum to two thousand seven hundred fifty dollars (\$2,750) for member-only coverage and to five thousand five hundred dollars (\$5,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.
 - c. Increase the in-network urgent care co-payment to seventy-five dollars (\$75.00) per covered individual.
 - d. Increase the in-network primary care co-payment to twenty-five dollars (\$25.00) per covered individual.
 - e. Increase the in-network specialist co-payment to sixty dollars (\$60.00) per covered individual, except that for mental health and substance abuse services, chiropractic services, and physical therapy, occupational therapy, and speech therapy services, the in-network specialist co-payment shall be forty-five dollars (\$45.00) per covered individual.
 - f. Increase the in-network and out-of-network inpatient co-payment to two hundred dollars (\$200.00) per covered individual.
 - g. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.
 - h. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

SECTION 2.(f) Limitation on Authority to Change Benefits. – G.S. 135-45(g)

reads as rewritten:

"(g) The Executive Administrator and Board of Trustees shall not change the Plan's comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums in effect on July 1, 2008, July 1, 2009, or a later act of the General Assembly, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members as a whole unless and until the proposed changes are directed to be made in an act of the General Assembly."

SECTION 2.(g) Premium Increases. – Premium rates for contributory coverage established in accordance with G.S. 135-44.6 shall be increased to eight and nine-tenths percent (8.9%) for contributory coverage for the 2009-2010 fiscal year and shall be increased by an additional eight and nine-tenths percent (8.9%) over the premium rate for contributory coverage for the 2010-2011 fiscal year.

SECTION 2.(h) Pharmacy Benefit Savings. – The Plan shall direct its pharmacy benefit manager (PBM), within the terms of the Plan's PBM contract, to achieve the sum of eighteen million dollars (\$18,000,000) in savings in pharmacy benefit costs in the 2009-2010 fiscal year, and the sum of twenty million dollars (\$20,000,000) in savings in pharmacy benefit costs in the 2010-2011 fiscal year through reduced reimbursements paid to pharmacies for prescription drugs. If the savings achieved in each six-month period of the fiscal year do not exceed one hundred five percent (105%) of the savings amount specified in this section for that fiscal year, there shall be no further adjustment to reimbursements paid to pharmacies for that six-month period. If the total savings achieved, by fiscal year, exceeds one hundred five percent (105%) of the specified savings amount in each six-month period of the fiscal year, the Plan shall adjust pharmacy reimbursement reductions accordingly. The Plan shall review savings achieved twice annually to ensure compliance with this section. The Plan shall calculate the savings to be achieved based on Plan enrollment and estimated cost and utilization trends incorporated in the Plan's Financial Projections as of March 20, 2009. The total savings by fiscal year achieved in this section may be increased or decreased without adjustment based on a change in total enrollment provided that the rate of savings achieved on a per-member per-month basis remains constant. Not later than 60 days immediately following each six-month period, the Plan shall report the amount of savings achieved and any adjustments made for that period to the Committee on Employee Hospital and Medical Benefits.

PART THREE: ELIGIBILITY CLARIFICATION.

SECTION 3.(a) Dependent Child Clarifications. – G.S. 135-45.1(10) reads as rewritten:

"(10) Dependent child. – A natural, legally adopted, or foster child or children of the employee and or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent child also includes a stepchild of the member who is married to the stepchild's natural parent. To be eligible, the stepchild must have his or her primary residence with the member. Dependent child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday. Dependent children of firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions as are other dependent children covered by this subdivision. Eligibility of dependent children is subject to the requirements of G.S. 135-45.2(d). The Plan may require documentation from the member confirming a child's eligibility to be covered as the member's dependent."

SECTION 3.(b) Eligibility of Full-Time Students. – G.S. 135-45.2(d) reads as rewritten:

"(d) A foster child is covered as a dependent child (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the claims processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of the child, are not eligible participants.

Coverage of a dependent child may be extended beyond the 19th birthday under the following conditions:

- (1) If the dependent is a full-time student, ~~aged 19 years and one month through the end of the month following the student's 26th birthday,~~ As used in this section, a full-time student is a student who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction. In accordance with applicable federal law, coverage of a full-time student that loses full-time status due to illness may be extended for one year from the effective date of the loss of full-time status provided that the student was enrolled at the time of the onset of the illness.
- (2) The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-45.2(5)a."

SECTION 3.(c) Waiting Periods Subject to Federal Law. – G.S. 135-45.3(b) reads as rewritten:

"(b) ~~Newly~~ Except as otherwise required by applicable federal law, newly acquired dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not be subject to the 12-month waiting period for preexisting conditions. A dependent can become qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a dependent child or the death of the spouse of a dependent child, and at the beginning of each legislative session (applies only to enrolled legislators). Effective date for newly acquired dependents if application was made within the 30 days can be the first day of the following month. Effective date for an adopted child can be date of adoption, or date of placement in the adoptive parents' home, or the first of the month following the date of adoption or placement. Firefighters, rescue squad workers, and members of the national guard, and their eligible dependents, are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll."

SECTION 3.(d) G.S. 135-45.4(b)(5) reads as rewritten:

- "(5) To administer the 12-month waiting period for preexisting conditions under this that Article, the Plan must give credit against the 12-month period for the time a person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 63 days before the effective date of coverage. As used in this subdivision, a "previous plan" means any policy, certificate, contract, or any other arrangement provided by any accident and health insurer, any hospital or medical service corporation, any health maintenance organization, any preferred provider organization, any multiple employer welfare arrangement, any self-insured health benefit arrangement, any governmental health benefit or health care plan or program, or any other health benefit arrangement. Waiting periods for preexisting conditions administered under this Article are subject to applicable federal law."

SECTION 3.(e) Eligibility Audit. – The Executive Administrator shall provide for an audit of dependent eligibility under the Plan. The audit shall be designed to determine whether all dependents currently covered under the Plan are eligible for coverage under current law. Upon identification of an individual who is enrolled as a dependent but not eligible, the Plan shall disenroll the ineligible dependent effective within 10 days of sending written termination notice to the employee. The notice shall state the date upon which disenrollment will become effective and the basis on which the determination of dependent ineligibility is made. Notwithstanding any other provision of law, the Executive Administrator may waive requirements to collect from the member reimbursement for claims paid for the ineligible covered individual.

SECTION 3.(f) Cessation of Coverage of Ineligible Individuals. – G.S. 135-45.12 is amended by adding the following new subdivision to read:

- "(8) The last day of the month in which a covered individual is found to be ineligible for coverage."

SECTION 3.(g) Documentation of Dependent Eligibility. – G.S. 135-45.3 is amended by adding the following new subsection to read:

"(c) When an eligible or enrolled member applies to enroll the member's eligible dependent child or spouse, the member shall provide the documentation required by the Plan to verify the dependent's eligibility for coverage."

PART FOUR: NC HEALTH CHOICE CHANGES.

SECTION 4.(a) Over-the-Counter Medications. – Coverage of over-the-counter medication authorized under G.S. 108A-70.21(d) for the NC Health Choice Program shall become effective on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration and processing of claims under the NC Health Choice Program.

SECTION 4.(b) Subrogation. – For the period authorized under subsection (a) of this section, the right of subrogation under G.S. 108A-57 applies to the State Health Plan for payments made by the Plan under the NC Health Choice Program. This subsection expires on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration, processing, and payment of claims under the NC Health Choice Program.

SECTION 4.(c) DHHS Subrogation Under NC Health Choice. – G.S. 108A-57 is amended by adding the following new subsection to read:

"(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article."

SECTION 4.(d) G.S. 108A-70.21(g) reads as rewritten:

"(g) Purchase of Extended Coverage. – An enrollee in the Program who loses eligibility due to an increase in family income above two hundred ~~fifty percent (250%)~~ percent (200%) of the federal poverty level and up to and including two hundred ~~seventy-five percent (275%)~~ twenty-five percent (225%) of the federal poverty level may purchase at full premium cost continued coverage under the Program for a period not to exceed one year beginning on the date the enrollee becomes ineligible under the income requirements for the Program. The benefits, copayments, and other conditions of enrollment under the Program applicable to extended coverage purchased under this subsection shall be the same as those applicable to an NC Kids' Care enrollee whose family income equals two hundred ~~fifty percent (250%)~~ percent (200%) of the federal poverty level."

PART FIVE: OTHER CHANGES.

SECTION 5.(a) G.S. 135-45.4(b)(2) reads as rewritten:

"(2) Employees not enrolling or not adding dependents when first eligible may enroll later on the first of any following month, but will be subject to a twelve-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section. The waiting period under this subdivision is subject to applicable federal law."

SECTION 5.(b) Powers and Duties of Executive Administrator. – G.S. 135-44.4 is amended by adding the following new subdivisions to read:

"(13a) The Plan and its pharmacy benefit manager may implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.

... (29) For transplant and bariatric medical procedures, the Plan may restrict coverage to certain in-network providers that are designated by the Plan's Claims Processing Contractor.

(30) The Executive Administrator shall ensure provisions in contracts between the Plan and the Plan's Claims Processing Contractor that call for the Plan to contract with an independent auditor, selected by the Plan, to review the Claims Processing Contractor's administrative costs and services to the Plan by the Claim's Processing Contractor.

(31) The Plan shall conduct a monthly review of Plan costs as compared to the same month in the immediately preceding year and a comparison of projected costs and savings to actual costs and savings. The Plan shall report the results of the review to the Committee on Employee Hospital and Medical Benefits and the State Health Plan Blue Ribbon Task Force at least semiannually."

SECTION 5.(c) G.S. 135-44.1(b) reads as rewritten:

"(b) ~~Six~~ A majority of the members of the Board of Trustees in office shall constitute a quorum. Decisions of the Board of Trustees shall be made by a majority vote of the Trustees present, except as otherwise provided in this Part."

SECTION 5.(d) G.S. 135-45.9(b) reads as rewritten:

"(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered as provided in this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment:

(1) For mental illness treatment:

- a. Licensed psychiatric ~~hospitals;~~
hospitals or State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
- b. Licensed psychiatric beds in licensed general hospitals;
- c. Licensed residential treatment facilities that have 24-hour on-site care provided by a registered nurse who is physically located at the facility at all times and that hold current accreditation by a national accrediting body approved by the Plan's mental health case manager;
- d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
- e. Licensed intensive outpatient treatment programs; and
- f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:

- a. Licensed chemical dependency units in licensed psychiatric ~~hospitals;~~ hospitals or in State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
- b. Licensed chemical dependency hospitals;
- c. Licensed chemical dependency treatment facilities;
- d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
- e. Licensed intensive outpatient treatment programs;
- f. Licensed partial hospitalization programs; and
- g. Medical detoxification facilities or units."

SECTION 5.(e) Section 28.22A(k) of S.L. 2007-323 reads as rewritten:

"**SECTION 28.22A.(k)** Subsection (j) of this section expires ~~June 30, 2009.~~ June 30, 2011."

SECTION 5.(f) G.S. 135-43(b) reads as rewritten:

"(b) Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees may contract with providers of institutional and professional medical care and services to establish preferred provider networks.

~~The terms pertaining to reimbursement rates or other terms of consideration of any contract between hospitals, hospital authorities, doctors, or other medical providers, or a pharmacy benefit manager and the Plan, or contracts pertaining to the provision of any medical benefit offered under the Plan, including its optional alternative comprehensive benefit plans, and programs available under the optional alternative plans, shall not be a public record under Chapter 132 of the General Statutes for a period of 30 months after the date of the expiration of the contract. The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record except that the terms in those contracts that contain trade secrets or proprietary or competitive information are not a public record under Chapter 132 of the General Statutes, and any such proprietary or competitive information and trade secrets contained in the contract shall be redacted by the Plan prior to making it available to the public. Provided, however, nothing in this subsection shall be deemed to~~ This subsection shall not be construed to prevent or restrict the release of any information made not a public record under this subsection to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, ~~the Department of Health and Human Services solely for the purpose of implementing the transition of NC~~

~~Health Choice from the Plan to the Department of Health and Human Services, and the Committee on Employee Hospital and Medical Benefits solely and exclusively for their use in the furtherance of their duties and responsibilities-responsibilities, and to the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services.~~ The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-45 are not subject to the requirements of Article 3 of Chapter 143 of the General Statutes. The Executive Administrator and Board of Trustees shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits."

SECTION 5.(g) The Executive Administrator of the Plan shall include in the development of its Request for Proposal (RFP) for an independent audit of the Plan, an audit of claims paid by the State Health Plan for Teachers and State Employees. One purpose of the audit is to determine whether savings to the Plan and to Plan members could be achieved if claims payments and processing were more efficiently and effectively administered. The audit shall encompass Plan years beginning in 2005, or earlier, through 2008 and shall look at claims administration and payment under the former Indemnity Plan as compared to the present PPO Plan. In developing the RFP, the Executive Administrator shall consult with the Fiscal Research Division staff and the Director of the Program Evaluation Division of the General Assembly to ensure that all of the following are addressed by the independent audit.

- (1) Estimated or actual savings that could be achieved if changes recommended by the independent auditor were enacted by the General Assembly, and how those savings should be allocated to the benefit of Plan members.
- (2) The governance structure of the Plan and whether it should be under the supervision and oversight of the Governor or a State agency.
- (3) The extent to which the failure or inability to share confidential or otherwise protected information with the Board of Directors and the General Assembly contributes to financial weaknesses in the Plan, and how such data sharing should be strengthened.
- (4) The role of the Board of Directors of the Plan and whether the role should be strengthened or otherwise changed.
- (5) Past, present, and potential areas of overpayments, overutilization, underutilization, or abuse that contributes to increasing costs of Plan benefits, including deductibles, co-payments, dependent premiums, and co-insurance maximums.
- (6) Safeguards to ensure the prompt reporting of claims data and trends to the actuaries under contract with the Plan and the General Assembly.
- (7) Any other matters the Executive Administrator, Fiscal Research Division Staff, the Director of the Program Evaluation Division, or the contracting entity believe would be useful in helping to strengthen the financial integrity of the Plan and Plan benefits.

It is the intent of the General Assembly that savings identified by the independent audit and realized through enactment by the General Assembly, and overpayments identified by the audit or by the Plan, will be allocated by the General Assembly to minimize benefit reductions and maintain affordable contributions, deductibles, and co-payments by Plan members and to maintain the fiscal integrity of the Plan itself.

The Executive Administrator shall provide the RFP developed in accordance with this section to the Division of Purchase and Contract not later than July 1, 2009. A copy of the audit report submitted to the Plan by the contracting entity shall be provided to the Committee on Employee Hospital and Medical Benefits.

SECTION 5.(h) G.S. 135-45(d) reads as rewritten:

"(d) The Plan benefits shall be provided under contracts between the Plan and the claims processors selected by the Plan. The Executive Administrator may contract with a pharmacy benefits manager to administer pharmacy benefits under the Plan. Such contracts shall include the applicable provisions of G.S. 135-45.1 through G.S. 135-45.15 and the description of the Plan in the request for proposal, and shall be administered by the respective claims processor or Pharmacy Benefits Manager, which will determine benefits and other questions arising

thereunder. The contracts necessarily will conform to applicable State law. If any of the provisions of G.S. 135-45.1 through G.S. 135-45.15 and the request for proposals must be modified for inclusion in the contract because of State law, such modification shall be made. The Executive Administrator shall ensure that the terms of the contract between the Plan and the Plan's Claims Processing Contractor, the Pharmacy Benefit Manager, and the Disease Management Contractor require the contractor to provide the following:

- (1) Detailed billing by each entity showing itemized cost information, including individual administrative services provided;
- (2) Transactional data; and
- (3) The cost to the Plan for each administrative function performed by the contractor."

PART SIX: SALARY-RELATED CONTRIBUTIONS.

SECTION 6.(a) Effective for the 2009-2011 fiscal biennium, required employer salary-related contributions for employees whose salaries are paid from department, office, institution, or agency receipts shall be paid from the same source as the source of the employees' salary. If an employee's salary is paid in part from the General Fund or Highway Fund and in part from department, office, institution, or agency receipts, required employer salary-related contributions may be paid from the General Fund or Highway Fund only to the extent of the proportionate part paid from the General Fund or Highway Fund in support of the salary of the employee, and the remainder of the employer's requirements shall be paid from the source that supplies the remainder of the employee's salary. The requirements of this section as to source of payment are also applicable to payments on behalf of the employee for hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave, workers' compensation, severance pay, separation allowances, and applicable disability income benefits.

Notwithstanding any other provision of law, an employing unit that is subject to Part 3A of Article 3A of Chapter 135 of the General Statutes and that hires or has hired as an employee a retiree that is in receipt of monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State shall enroll the retiree in the active group and pay the cost for the hospital-medical benefits if that retiree is employed in a position that would require the employer to pay hospital-medical benefits if the individual had not been retired.

SECTION 6.(b) Effective July 1, 2009, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2009-2010 fiscal year are: (i) eight and fifty-four hundredths percent (8.54%) – Teachers and State Employees; (ii) thirteen and fifty-four hundredths percent (13.54%) – State Law Enforcement Officers; (iii) eleven and eighty-six hundredths percent (11.86%) – University Employees' Optional Retirement System; (iv) eleven and eighty-six hundredths percent (11.86%) – Community College Optional Retirement Program; (v) seventeen and seventy-one hundredths percent (17.71%) – Consolidated Judicial Retirement System; and (vi) four and fifty hundredths percent (4.50%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and fifty hundredths percent (4.50%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(c) Effective July 1, 2010, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2010-2011 fiscal year are: (i) eight and ninety-four hundredths percent (8.94%) – Teachers and State Employees; (ii) thirteen and ninety-four hundredths percent (13.94%) – State Law Enforcement Officers; (iii) twelve and twenty-six hundredths percent (12.26%) – University Employees' Optional Retirement System; (iv) twelve and twenty-six hundredths percent (12.26%) – Community College Optional Retirement Program; (v) eighteen and eleven hundredths percent (18.11%) – Consolidated Judicial Retirement System; and (vi) four and ninety hundredths percent (4.90%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and ninety hundredths percent (4.90%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College

Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(d) Effective July 1, 2009, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand four hundred forty-seven dollars (\$3,447) and (ii) non-Medicare-eligible employees and retirees – four thousand five hundred twenty-seven dollars (\$4,527).

SECTION 6.(e) Effective July 1, 2010, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand seven hundred fifty-three dollars (\$3,753) and (ii) non-Medicare-eligible employees and retirees – four thousand nine hundred twenty-nine dollars (\$4,929).

PART SEVEN: STATE HEALTH PLAN BLUE RIBBON TASK FORCE.

SECTION 7.(a) State Health Plan Blue Ribbon Task Force. – There is established the Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees (Task Force). The purpose of the Task Force is to review the governance of the State Health Plan for Teachers and State Employees (Plan) and to make recommendations for changes that will ensure the ongoing financial stability of the Plan, increase and maintain high participation rates for dependent coverage under the Plan, study and compare coverage and costs of the Plan to coverage and costs of other State health plans in the region, and address issues of cost, quality, and access to health care coverage under the Plan. In conducting its review of the Plan the Task Force shall consider all of the following:

- (1) The feasibility of transferring the ongoing day-to-day oversight of the Plan to an independent board or to a State agency.
- (2) Tiered premium rates for member-only coverage for employees and future retirees based on income or ability to pay.
- (3) Ways to increase participation in dependent coverage including supplements from the State or other methods for reducing dependent premiums.
- (4) The benefits of implementing a closed prescription drug formulary.
- (5) Whether it is advisable to move the Plan to a calendar year, the costs involved in the move, and the benefits that accrue to the Plan and the members as a result of moving to a calendar year.
- (6) Any other matters the Task Force considers relevant to its purpose.

SECTION 7.(b) The Task Force shall consist of 15 members, appointed as follows:

- (1) Six members by the General Assembly upon the recommendation of the Speaker of the House of Representatives, three of whom shall be members of the House of Representatives, one shall be a public schoolteacher, one shall be a State or covered local government retiree other than a retired public schoolteacher, and one at-large. Of the three legislators appointed to the Task Force, one shall be a member of the minority party.
- (2) Six members by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, three of whom shall be members of the Senate, one shall be a State employee who is not a public schoolteacher, one shall be a retired State public school employee, and one at-large. Of the three legislators appointed to the Task Force, one shall be a member of the minority party.
- (3) One member by the Governor with expertise in the business of health insurance or in administering health care services other than an insurance company or third-party administrator or contractor of the Plan.
- (4) The chair of the Board of Directors of the State Health Plan.
- (5) The Commissioner of Insurance or the Commissioner's designee.

SECTION 7.(c) The cochairs of the Task Force shall convene the first meeting as soon as possible after appointments have been made. The Task Force may engage the services

of a consultant to provide independent analysis of Plan costs and recommendations on how to strengthen the Plan's financial stability, benefit structure and coverage, and the most effective and efficient location for Plan administration.

SECTION 7.(d) Upon the convening of each session of the General Assembly, the Task Force shall report its findings and recommendations to the General Assembly, the Governor, and the Committee on Employee Hospital and Medical Benefits.

SECTION 7.(e) A majority of the Task Force members shall constitute a quorum for the transaction of business. The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall each appoint one Task Force member as chair. Appointments shall be made as soon as possible after this act becomes law. Task Force members shall receive no compensation for their service but shall be paid per diem, subsistence, and travel expenses in accordance with G.S. 120-3.1, G.S. 138-5, and G.S. 138-6, as applicable.

SECTION 7.(f) The Legislative Services Officer shall allocate from a portion of the funds appropriated to the General Assembly for each fiscal year for expenses of the Task Force.

PART EIGHT: EFFECTIVE DATE.

SECTION 8. Sections 1(b), 1(c), 1(d), 2(c), 2(f), 2(h) of this act become effective July 1, 2009. Section 4(d) of this act applies to applications for the purchase of extended coverage made on and after July 1, 2008. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 22nd day of April, 2009.

s/ Walter H. Dalton
President of the Senate

s/ William L. Wainwright
Speaker Pro Tempore of the House of Representatives

s/ Beverly E. Perdue
Governor

Approved 8:17 a.m. this 23rd day of April, 2009

Blue Ribbon Task Force on the State Health Plan For Teachers and State Employees

MEMBERSHIP

Co-Chairs:

The Honorable Hugh Holliman, Co-Chair
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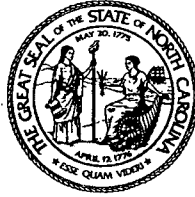
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Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

[illegible]



NORTH CAROLINA GENERAL ASSEMBLY

16 West Jones Street
LEGISLATIVE BUILDING
RALEIGH NC 27601

October 22, 2009

MEMORANDUM

TO: Members, State Health Plan Blue Ribbon Task Force

FROM: Rep. Hugh Holliman, Co-Chair
Sen. Tony Rand, Co-Chair

SUBJECT: Committee Meeting Notice

The State Health Plan Blue Ribbon Task Force Committee will meet on the following date:

DAY: Wednesday
DATE: November 18, 2009
TIME: 9:00 am
LOCATION: Room 1228 Legislative Building

If you have any questions concerning this meeting or you cannot attend, please contact Carol Bowers, Committee Clerk at 919-715-0873 or Hollimanla@ncleg.net.

Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

**Wednesday, November 18, 2009
9:00 a.m.**

Legislative Building, Room 1228

I. Welcome, Introductions, and Remarks

*Representative Hugh Holliman, Co-Chair
Senator Tony Rand, Co-Chair*

II. Overview of S.L. 2009-16 (SB 287)

Gann Watson, Attorney, Bill Drafting Division, NCGA

III. Overview of the State Health Plan

Mark Trogon, Fiscal Analyst, Fiscal Research Division, NCGA

IV. Task Force Discussion

V. Future Meeting Dates

VISITOR REGISTRATION SHEET

State Health Plan

Name of Committee

11/18/09

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cam Coker	B PM H L
Larry Presnell, Jr.	North Carolina Retired School Personnel
Bo Heath	McGuire Woods
John Bowditch	AstraZeneca
Mona Moon	Health Plan
Lacey Barnes	Health Plan
Jack W Walker	Health Plan
Carl Dean	OSP
DANIEL BAUM	K + L GATES
Anne Rogers	Health Plan
Linda McQuinn	State Health Plan

VISITOR REGISTRATION SHEET

State Health Plan

Name of Committee

11/18/09

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Williams	HR Benefits NC State University Campus Box 7215 Raleigh NC 27695-7215
Yvette Griffin Director of Benefits	NC State University Campus Box 7215 Raleigh, NC 27587
Chris Shoffner	White Bear Group PO Box 7529 Raleigh NC
Joey Nichols	Cap. Results
Brian Lewis	NC A E
Katherine Joyce	NCA SA
Missy O'Neal	IBM RTP
Meg Ryan O'Connell	Capital Results
Kevin Fitzgerald	UNC
Ed Regan	NC RGEA

VISITOR REGISTRATION SHEET

State Health Plan

Name of Committee

11/18/09

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Andy Ellen	NCEMHA
Harrison Gilbert	Office of the Governor
ANN LUKER	DUKE
Christopher Jones	NC DST
Jean Holliday	WCDOT
Rose Williams	NC DOT
TED Hamby	NC DOT
Amy Whited	NC medical Society
BILL STOCKARD	OSBM
Anthony S. Uhl	P. Chord & Assoc.

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

DAVID BARNES	Payan Spink
Adam Linker	NC Justice Center
Elizabeth Robinson	Nickmat
Jack Gzart	Womble
Pita Harris	NC Commerce
Emilyn Jacobson	ETOR
HUGH TILSON	NCHA

VISITOR REGISTRATION SHEET

State Health Plan

Name of Committee

11/18/09

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Tracy Stephenson	State Health Plan
JEFF SCOTT	MEDCO
ANTHONY ALLEN	NCAC
Patricia Buff	Nelson Mullins
Harmon Chmura	
Richard Jit	BeBOWE
Ken Melton	KMA

HOUSE PAGES

Rm 1228

NAME OF COMMITTEE State Health Plan DATE 11/18/09

1. Name: _____

County: _____

Sponsor: _____

2. Name: _____

County: _____

Sponsor: _____

3. Name: _____

County: _____

Sponsor: _____

4. Name: _____

County: _____

Sponsor: _____

5. Name: _____

County: _____

Sponsor: _____

SGT-AT-ARM

House
1. Name: David Shearon

2. Name: Tom Wilder

3. Name: _____

4. Name: _____

SENATE

WADE ANDERS

CECIL DOWD

STAN JOHNSON

JON FITCHETT

MINUTES

BLUE RIBBON TASK FORCE ON THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

**Wednesday, November 18, 2009 9 AM
Room 1228, Legislative Building**

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees held its first meeting on November 18, 2009 in Room 1228 of the Legislative Building. Senator Tony Rand, Co-Chair presided. (*See Attachment: Members Present.*) Senator Rand asked the members of the Task Force and staff to introduce themselves. Following those introductions, Senator Rand set a tone by saying the State Health Plan spends about \$50 million dollars per week thus was of significant importance to the General Assembly and the employees covered by the plan. Rep Holliman urged all Task Force members to be involved in the work of the group and assured the members there were no preconceived notions concerning the scope to be covered.

PRESENTATIONS

Overview of S.L. 2009-16 (SB 287)

Gann Watson, Attorney with the Bill Drafting Division of the General Assembly outlined the law which provided for Good Health Initiatives in the State Health Plan, set up premium increases, benefit changes, appropriated \$250 million to the Plan to cover a shortfall, etc. SB 287 also created the Blue Ribbon Task Force. (*SEE ATTACHMENT: SB 287.*)

The Task Force is at liberty to consider a variety of issues, including, but not limited to an independent board to administer the State Health Plan or operation by a state agency, creation of tiered rates for members, methods to increase participation for dependents, a closed prescription system, and changing the SHP to operate on a calendar year basis. The over-riding purpose is to see that the Plan maintains financial stability, reasonable costs, quality member care and the governance mechanism to achieve such goals. The Task Force will report to each Session of the General Assembly and will cease to operate on December 31, 2010.

An 8.9% premium increase for each year of the biennium is in the appropriations act separate from SB287.

In addition, SB 287 eliminated the 90/10 PPO coverage, increased certain co-pay rates for members and dependent coverage. There were other issues modified such as duties of the executive director, accreditation of state hospitals that provide mental health and chemical dependency treatment, and made various contractual health plan actions public record and requires an independent audit.

Wellness Initiatives are part of the act, in the form of weight reduction and smoking cessation programs. The smoking cessation initiative goes into effect July 1, 2010. The 80/20 plan will be available to employees and their dependents who are non-smokers. If the employee or a dependent proves to be a smoker or uses other tobacco products they will be taken out of the 80/20 plan and re-enrolled in the 70/30 plan. There will be random testing of members to see if they are indeed following the guidelines and if a coverage change should result.

The weight reduction initiative goes into effect July, 2011 and all members must fit into certain criteria set up by the Plan, unless the member is covered by Medicare, or has a physician's written exemption.

Rep. Folwell asked if dependent adherence to the wellness guidelines was required for both the smoking and weight loss programs. Ann Rogers from the SHP said that only the smoking program required dependent adherence. There followed further discussion of dependent adherence. Senator Apodaca was told that policy coverage would change one month after a family member might fail a random smoking test. Rep. Braxton questioned the justification for moving an entire family to the 70/30 plan if only one member smoked or failed a smoking test after the member had certified all the family members were non-smokers. Senator Rand said the main reason was cost.

Mr. Stone termed as a 'penalty' the rate difference when a single family member failed a random test. Senator Rand said it was not a penalty, only that the family would fall under the 70/30 rather than the 80/20 plan. As for the issue that one member could affect the entire family, Ann Rogers from the SHP said that the enrollment was made for a family as a unit, not individual members. Data collected by the Plan show a smoker costs the Plan an additional \$2054 per member month.

Commissioner Goodwin asked if obesity might be considered a pre-existing condition given the federal health insurance debate on pre-existing conditions. Ms. Rogers said the Plan would consider that concern and provide information later. Senator Rand said that obesity may be under the individual's control, whereas asthma for example of a pre-existing condition is not considered to be under a person's control.

Mr. Stone returned to the dependent adherence issue asking if family members could seek individual coverage if one person was founding smoking. It was pointed out that the General Assembly can change the enrollment system, but there could be a cost issue that is not clear at this time.

Senator Apodaca asked the age at which the Plan considered the additional smoker cost would kick in. Ms. Rogers said the statistics did not figure age as a factor in the excessive cost for smokers.

Overview of the State Health Plan

Mark Trogon, Fiscal Analyst for the General Assembly's Fiscal Research Division provided members with the overview including authorization, benefit design, administration and eligibility. *(SEE ATTACHMENT: Overview-this includes the Quarterly Report presented to the Joint Committee on Employee Hospital and Medical Benefits on November 12, 2009))*

The Plan began in 1982 as a self-financed indemnity plan, but is a PPO plan now. There are 661,000 members spread across North Carolina's 100 counties, some of the other contiguous states and a few foreign countries. The statewide coverage has a major impact in setting up provider networks due to shortage of medical personnel in some rural counties.

Mr. Trogon pointed out the statutory home of the Plan and said the Plan is a receipt-supported operation. And he noted the emergency \$250 million appropriation made to the Plan in the 2009 Session of the General Assembly.

The *Financial Summary* begins on page 12 of the Attachment. On page 13, line 17 is the reflection in the Net Plan Income that is an anomaly. The Plan received a pre-payment in June of \$52 million from the State Retirement System that was actually budgeted to be received in July-the next fiscal year. This pre-payment causes a skew in the figures.

Mr. Trogon pointed to a higher than expected increase in claims in June, due in part to members anticipating premium increases which came in July.

Through the rest of the presentation Mr. Trogon tracked historical data that showed a steady trend of increases in health care costs at approximately 8% each year. The Plan and the General Assembly have taken steps to equalize this, but it is a difficult level to hold.

Demographic effects can be plotted through the Summary.

There was a further explanation of SB287 (*SEE ATTCHMENT: SB 287 and Actuarial Note.*) As stated above, the Session Law eliminated the Plan's 90/10 plan which had been losing about \$150 million per year. Other Plan changes such as benefit reductions, premium and co-pay increases and pharmacy discount may be tracked in the attachment. .

Ms. Adcock asked about increased costs for specialty drugs. Mr. Trogon said this involved bio-tech drugs, but not cancer drugs. Mr. Feezor asked if the specialty drugs included genetically tailored drugs. Ms. Stephenson said the definition cover drugs which were not biologically created, not synthetically created, not used for chronic conditions and had only limited distribution. These drugs are channeled through a single vendor as a way to be more cost effective.

Representative Braxton asked why administrative costs had risen when claims had declined. Mr. Trogon explained that the projections for claims took into account various factors such as the trend for the cost of care, out of pocket expenses and benefits changes. Ms Mona Moon, Chief Financial Officer for the State Health Plan explained that another factor in the change shown on page 13 of the Summary was the settling up of the cost-plus contract with Blue Cross-Blue Shield. At the end of FY 2007-2009, BCBS paid a refund of \$17 million to the Plan. She said the Plan was making quarterly settling actions in that FY, but now the settling up was done monthly and no refunds this high should be expected. Further, Senator Rand said that this would be subject to extensive audit. Ms. Moon said the audit done by Thomas and Gibbs should be available in late January.

Mr. Stone asked if employee receipts paid for about 20% of the Plan. Mr. Trogon said the figure was closer to 17%. Mr. Stone also asked who validated the certification that the SHP prescription plan was equal to or better than Medicare Part D. Ms. Stephenson of SHP said the AON consulting firm made this validation.

Mr. Feezor asked if there was data available concerning impact on the Plan based on geography or job category. Ms. Rogers from the SHP said there was information on the Plan's website concerning pilots which had been conducted showing types of disease by government agency or utilization of benefits.

Mr. Feezor also asked about information on the use of mail order versus retail stores for prescription drugs. Mr. Trogdon said there is no incentive in the Plan to prompt the use of mail order. Dr. Jack Walker, Plan Administrator said mail order prescription use was less than 2% of the total.

Task Force Discussion

Co-Chair Representative Holliman asked the members to express their ideas for issues to be considered by the Task Force.

Representative Braxton wants more younger family members covered by the Plan, consideration of an HSA Plan, cost differences between brand drugs and generics.

Ms. Ransome expressed interest in incentives for use of mail order for drugs, and the impact on the family of wellness initiatives.

Ms. Simmons wants a price break for teacher assistants who are in a low salary range.

Mr. Stone is concerned with dependent coverage and younger members, the role of trustees and governance, prescription drugs vis a vis brand name when generics bring on adverse reactions, and he would like to see more coverage options.

Dr. Myers, in his second term on the Board of Trustees, believes there was a Covenant made in 1982 when the Plan began to provide adequate coverage in a sound financial basis for employees. Since then we have an aging population and use of increased services and he said such changes bring difficult decisions to be made in order to continue to keep a viable Plan and the covenant.

Mr. Feezor said the Task Force should look at such things as the 8-11% cost of care increase in a long range view. He spoke of incentives to make coverage more affordable for families, considering the cost of premiums versus similar costs to corporate employees. He also urged consideration of governance and the trend of costs rising more than gross domestic product.

From the viewpoint of the current Chairman of the Board of Trustees, Steve Beam said the Board has done a report concerning oversight and the role of the Trustees. (*SEE ATTACHMENT: State Health Plan Board Structure.*) He said members may have to look at private health care plans and realize that these members of the SHP may have to pay for coverage.

Ms. Adcock is interested in lower administrative costs, increasing younger members in the Plan and disease prevention considerations.

Commissioner Goodwin is most concerned with the coverage, solvency and the oversight and governance of the Plan.

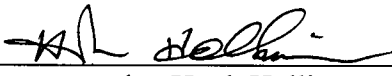
Senator Garrou also wants a longer view taken of the operation of the Plan.

Representative Folwell primarily wants a change to a calendar year. He believes the Plan punishes younger people and should have more attention paid to older members with chronic conditions. His term is a focus on 'health and not health care'.

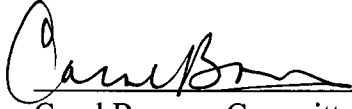
Co-Chair Representative Holliman announced the next meeting of the Task Force for December 2.

The meeting adjourned at 10:25 am.

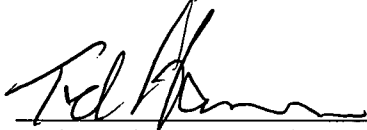
Senator Tony Rand, Co-Chair Presiding



Representative Hugh Holliman, Co-Chair



Carol Bowers, Committee Clerk



Ted Harrison, Committee Assistant

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009**

**SESSION LAW 2009-16
SENATE BILL 287**

**AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS
AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE
STATE HEALTH PLAN.**

Whereas, the General Assembly must act quickly and prudently to maintain a financially stable State Health Plan to ensure that all members of the Plan have affordable access to medically necessary health benefits and services within available resources; and

Whereas, in order to meet current fiscal obligations, the General Assembly must appropriate \$250,000,000 for the 2008-2009 fiscal year to cover the current year shortfall in funds; and

Whereas, estimates indicate that a substantially larger appropriation will be necessary to maintain the fiscal integrity of the Plan in the next and ensuing fiscal periods; and

Whereas, in order to ensure continued access to medically necessary health care to Plan members, the Plan must implement measures to contain costs through premium increases, benefit changes, and healthy lifestyle programs that not only reduce costs but improve member health; and

Whereas, the Plan estimates that over 70,000 Plan members use tobacco, resulting in a cost to the Plan of \$2,000 per member per year more than the cost of providing coverage for nonusers of tobacco; and

Whereas, cessation of tobacco use has been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation incentives and initiatives with mechanisms to verify member compliance with smoking cessation requirements; and

Whereas, over 60% of North Carolina adults are obese or overweight; and

Whereas, obesity is linked to an over 37% increase in health care spending at a cost of \$2,445 per member per year; and

Whereas, weight management and cessation of tobacco use have been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation and weight management incentives and initiatives with mechanisms to verify member compliance with smoking cessation and weight management requirements; Now, therefore,

The General Assembly of North Carolina enacts:

PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE.

SECTION 1.(a) Appropriation for 2008-2009 Fiscal Year. – There is appropriated from the Savings Reserve Account established in G.S. 143C-4-2 to the Health Benefit Reserve Fund established in G.S. 135-44.5 the sum of two hundred fifty million dollars (\$250,000,000) for the 2008-2009 fiscal year. These funds shall be used to address the shortfall in funds available for the payment of health care and administrative costs under the State Health Plan for Teachers and State Employees ("Plan") for the 2008-2009 fiscal year.

SECTION 1.(b) General Fund Appropriation for 2009-2011 Fiscal Biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of one hundred thirty-two million two hundred fourteen thousand seven hundred fifty-two dollars (\$132,214,752) for the 2009-2010 fiscal year and the sum of two hundred seventy-six million one hundred seventy-nine thousand seven hundred nine dollars (\$276,179,709) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.



SECTION 1.(c) Highway Fund Appropriation for the 2009-2011 Fiscal Biennium. – Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve for the State Health Plan in the Office of State Budget and Management the sum of six million one hundred seventy thousand twenty-two dollars (\$6,170,022) for the 2009-2010 fiscal year and the sum of twelve million eight hundred eighty-eight thousand three hundred eighty-six dollars (\$12,888,386) for the 2010-2011 fiscal year. These funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011 fiscal biennium.

SECTION 1.(d) All other agency funds required to fund the premium increase enacted in this act, other than funds appropriated in subsections (b) and (c) of this section, are appropriated for the 2009-2011 fiscal biennium.

SECTION 1.(e) Definitions. – As used in this act unless the context clearly requires otherwise:

- (1) "Plan." – The State Health Plan for Teachers and State Employees.
- (2) "Basic Plan." – The Plan's PPO option providing for 70/30 in-network coverage after deductibles and co-payments.
- (3) "Smoking" or "Smoking cessation." – Includes cessation of the use of all tobacco products.
- (4) "Standard Plan." – The Plan's PPO option providing for 80/20 in-network coverage after deductibles and co-payments.

SECTION 1.(f) Scope. – In the event of a conflict between the provisions of this act and Article 3A of Chapter 135 of the General Statutes, this act prevails.

PART TWO: HEALTH BENEFIT CHANGES.

SECTION 2.(a) Eliminate PPO Plus Option. – Effective July 1, 2009, the PPO Plus option (90/10 in-network coverage) under the State Health Plan for Teachers and State Employees ("Plan") is eliminated. The Executive Administrator shall provide notice to all members of the Plan that this option will no longer be available as of July 1, 2009. Employees enrolled in the Plan's Plus option shall have the choice of enrolling in the Basic or Standard Plan options for the 2009-2010 benefit year.

SECTION 2.(b) Implement Comprehensive Wellness Initiative.

- (1) Program development. – The Plan shall develop a Comprehensive Wellness Initiative that includes a focus on smoking cessation and weight management and that is designed to be implemented effective July 1, 2010, for smoking cessation and July 1, 2011, for weight management. Benefit levels shall be determined by the Plan based upon tobacco use or the inability of the member to meet national, evidence-based healthy weight clinical guidelines. For purposes of the Comprehensive Wellness Initiative, "member" includes all State Health Plan primary subscribers and their covered dependents. The Plan shall develop a process whereby a Plan member may appeal the Plan's basis for action it takes due to the member's failure or refusal to comply with the Plan's smoking cessation or weight management requirements.
- (2) Smoking cessation. – Effective July 1, 2010, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO unless the subscriber can attest that the subscriber or any qualifying dependent does not smoke or otherwise use tobacco products. The Plan shall develop a mechanism for verifying that the member does not smoke or use other tobacco products. Tobacco use will be reassessed annually at the time of Plan enrollment. All subscribers who have attested that neither they nor their dependents use tobacco, or whose physician certifies in writing that the member is participating in a smoking cessation program, shall have the choice of remaining in the Basic Plan option or enrolling in the Standard Plan option. For purposes of the smoking cessation initiative, "member" includes all members covered under the Plan. As used in this section, "smoking cessation program" means active participation in a Plan-approved cessation program to include counseling or use of tobacco cessation medications.
- (3) Weight management. – Effective July 1, 2011, all members of the Plan who do not have Medicare as their primary coverage shall be enrolled in the Basic Plan under the Plan's PPO Plan unless the subscriber attests that the

weight and height ratio of the member is within a range determined by the Plan based on evidence-based healthy weight clinical guidelines, or unless the member's physician certifies in writing that the member has a medical condition that prevents the attainment of the specified weight range or that the member is actively participating in a Plan-approved weight management program. In either case, the member shall have the option to enroll in the Basic or Standard Plan.

Not later than October 1, 2009, the Executive Administrator shall inform Plan members of the healthy lifestyle initiatives, requirements for compliance, and consequences of noncompliance. The Executive Administrator shall provide to members education and training to assist members in complying with healthy lifestyle initiatives. The Executive Administrator may implement incentive initiatives to further encourage member achievement in smoking cessation, weight management, and other integrated health management programs.

The Executive Administrator shall report to the Committee on Employee Hospital and Medical Benefits recommendations the Plan may have for additional sanctions that may be imposed when the Executive Administrator finds that a member intentionally makes a false statement on a Plan document.

SECTION 2.(c) Prescription Drug Co-Payments. – G.S. 135-45.6(b) reads as rewritten:

"(b) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility shall be as determined by the Plan's Executive Administrator and Board of Trustees, which determinations are not subject to appeal under Article 3 of Chapter 150B of the General Statutes. Co-payments and other allowable charges or coverage for prescription drugs shall be as follows:

- (1) The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars (\$10.00) for each generic prescription, ~~thirty dollars (\$30.00)~~ thirty-five dollars (\$35.00) for each preferred branded prescription without a generic equivalent, and ~~forty dollars (\$40.00)~~ for each preferred branded prescription with a generic equivalent drug, and ~~fifty dollars (\$50.00)~~ fifty-five dollars (\$55.00) for each nonpreferred branded ~~or generic~~ prescription. For each branded prescription drug with a generic equivalent drug, the member shall pay the generic co-payment plus the difference between the Plan's gross allowed cost for the generic prescription and the Plan's cost for the branded prescription drug.
- (2) The Plan shall provide coverage of nonacute specialty medications, excluding cancer medications, under the Plan's pharmacy benefit through a specialty pharmacy vendor under contract with the Plan. The Plan may transfer coverage of specified specialty disease medications covered under the Plan's medical benefit to the contracted specialty pharmacy vendor. Specialty medications are covered biotech medications and other medications designated and classified by the Plan as specialty medications that are significantly more expensive than alternative drugs or therapies. Medications classified by the Plan as specialty medications shall meet all of the following conditions:
 - a. Have unique uses for the treatment of complex diseases.
 - b. Require special dosing or administration.
 - c. Require special handling.
 - d. Are typically prescribed by a specialist provider.
 - e. Exceed four hundred dollars (\$400.00) cost to the Plan per prescription.

The Plan shall impose a co-payment in the amount of twenty-five percent (25%) of the Plan's gross allowed cost of the specialty drug not to exceed one hundred dollars (\$100.00) per prescription per 30-day supply.

- (3) The Plan may exclude coverage of drugs that have therapeutic equivalents, as defined by the U.S. Food and Drug Administration, that are available over the counter. Before excluding coverage under this subdivision, the Plan shall consult with the Plan's Pharmacy and Therapeutics Committee.

~~These co-payments apply to all optional alternative plans available under the Plan.~~

- (4) Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a ~~34-day~~30-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription." Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though a prescription is not required. ~~The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for sexual dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinum toxin without approval in advance by the pharmacy benefit manager.~~ The Plan may adopt utilization management procedures for certain drugs, but in no event shall the Plan provide coverage for sexual dysfunction or hair growth drugs or nonmedically necessary drugs used for cosmetic purposes. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars (\$2,500) per person per fiscal year in copayments required by this subsection. The Plan's Pharmacy Benefit Manager, or any pharmacy or vendor participating in the Plan shall charge the Plan for any prescription legend drug dispensed under the Plan's pharmacy benefit based upon the original National Drug Code (NDC) as established by the manufacturer of the prescription legend drug and published by the United States Food and Drug Administration.

Co-payments and other allowable charges under this subsection shall be the lesser of the Plan's discounted cost of the drug or the co-payment amount or allowable charge and apply to all optional alternative plans available under the Plan."

SECTION 2.(d) Routine Eye Examinations Not Covered. – Effective January 1, 2010, G.S. 135-45.8(13) reads as rewritten:

"§ 135-45.8. General limitations and exclusions.

The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-45.6 through G.S. 135-45.11 be payable for:

- ...
- (13) Charges for routine eye examinations, eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons) and hearing aids or examinations for the prescription or fitting thereof."

SECTION 2.(e) Deductible and Co-Payment Changes. – Effective July 1, 2009, the Executive Administrator shall make the following changes to deductibles, coinsurance maximums, and co-payments under the Basic and Standard PPO Plans:

- (1) Basic plan (70/30):
- a. Increase the in-network annual deductible to eight hundred dollars (\$800.00) for member-only coverage and to one thousand six hundred dollars (\$1,600) for the out-of-network annual deductible for member-only coverage.
The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.
 - b. Increase the in-network coinsurance maximum to three thousand two hundred fifty dollars (\$3,250) for member-only coverage and to six

thousand five hundred dollars (\$6,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.

- c. Increase the in-network primary care co-payment to thirty dollars (\$30.00) per covered individual.
 - d. Increase the in-network specialist co-payment to seventy dollars (\$70.00) per covered individual, except that for mental health and substance abuse services, chiropractic services, and physical therapy, occupational therapy, and speech therapy services, the in-network specialist co-payment shall be fifty-five dollars (\$55.00) per covered individual.
 - e. Increase the in-network and out-of-network inpatient co-payment to two hundred fifty dollars (\$250.00) per covered individual.
 - f. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.
 - g. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.
- (2) Standard Plan (80/20):
- a. Increase the in-network annual deductible to six hundred dollars (\$600.00) for member-only coverage and to one thousand two hundred dollars (\$1,200) for the member-only out-of-network annual deductible.
The aggregate maximum annual deductible for employee-child and employee-family coverage shall be three times the member-only annual deductibles.
 - b. Increase the in-network coinsurance maximum to two thousand seven hundred fifty dollars (\$2,750) for member-only coverage and to five thousand five hundred dollars (\$5,500) for member-only out-of-network maximum coinsurance. The aggregate maximum coinsurance for employee-child and employee-family coverage shall be three times the member-only coinsurance maximums.
 - c. Increase the in-network urgent care co-payment to seventy-five dollars (\$75.00) per covered individual.
 - d. Increase the in-network primary care co-payment to twenty-five dollars (\$25.00) per covered individual.
 - e. Increase the in-network specialist co-payment to sixty dollars (\$60.00) per covered individual, except that for mental health and substance abuse services, chiropractic services, and physical therapy, occupational therapy, and speech therapy services, the in-network specialist co-payment shall be forty-five dollars (\$45.00) per covered individual.
 - f. Increase the in-network and out-of-network inpatient co-payment to two hundred dollars (\$200.00) per covered individual.
 - g. Increase prescription drug co-pays as required under G.S. 135-45.6(b) as enacted by this act.
 - h. Except as otherwise provided in this act, co-payments and coinsurance for coverage not otherwise listed in this subdivision shall remain as applicable in the 2008-2009 benefit year.

SECTION 2.(f) Limitation on Authority to Change Benefits. – G.S. 135-45(g) reads as rewritten:

"(g) The Executive Administrator and Board of Trustees shall not change the Plan's comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums in effect on July 1, 2008, July 1, 2009, or a later act of the General Assembly, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members as a whole unless and until the proposed changes are directed to be made in an act of the General Assembly."

SECTION 2.(g) Premium Increases. – Premium rates for contributory coverage established in accordance with G.S. 135-44.6 shall be increased to eight and nine-tenths percent (8.9%) for contributory coverage for the 2009-2010 fiscal year and shall be increased by an additional eight and nine-tenths percent (8.9%) over the premium rate for contributory coverage for the 2010-2011 fiscal year.

SECTION 2.(h) Pharmacy Benefit Savings. – The Plan shall direct its pharmacy benefit manager (PBM), within the terms of the Plan's PBM contract, to achieve the sum of eighteen million dollars (\$18,000,000) in savings in pharmacy benefit costs in the 2009-2010 fiscal year, and the sum of twenty million dollars (\$20,000,000) in savings in pharmacy benefit costs in the 2010-2011 fiscal year through reduced reimbursements paid to pharmacies for prescription drugs. If the savings achieved in each six-month period of the fiscal year do not exceed one hundred five percent (105%) of the savings amount specified in this section for that fiscal year, there shall be no further adjustment to reimbursements paid to pharmacies for that six-month period. If the total savings achieved, by fiscal year, exceeds one hundred five percent (105%) of the specified savings amount in each six-month period of the fiscal year, the Plan shall adjust pharmacy reimbursement reductions accordingly. The Plan shall review savings achieved twice annually to ensure compliance with this section. The Plan shall calculate the savings to be achieved based on Plan enrollment and estimated cost and utilization trends incorporated in the Plan's Financial Projections as of March 20, 2009. The total savings by fiscal year achieved in this section may be increased or decreased without adjustment based on a change in total enrollment provided that the rate of savings achieved on a per-member per-month basis remains constant. Not later than 60 days immediately following each six-month period, the Plan shall report the amount of savings achieved and any adjustments made for that period to the Committee on Employee Hospital and Medical Benefits.

PART THREE: ELIGIBILITY CLARIFICATION.

SECTION 3.(a) Dependent Child Clarifications. – G.S. 135-45.1(10) reads as rewritten:

- "(10) Dependent child. – A natural, legally adopted, or foster child or children of the employee and or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent child also includes a stepchild of the member who is married to the stepchild's natural parent. To be eligible, the stepchild must have his or her primary residence with the member. Dependent child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday. Dependent children of firefighters, rescue squad workers, and members of the national guard are subject to the same terms and conditions as are other dependent children covered by this subdivision. Eligibility of dependent children is subject to the requirements of G.S. 135-45.2(d). The Plan may require documentation from the member confirming a child's eligibility to be covered as the member's dependent."

SECTION 3.(b) Eligibility of Full-Time Students. – G.S. 135-45.2(d) reads as rewritten:

"(d) A foster child is covered as a dependent child (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the claims processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of the child, are not eligible participants.

Coverage of a dependent child may be extended beyond the 19th birthday under the following conditions:

- (1) If the dependent is a full-time student, ~~aged 19 years and one month through the end of the month following the student's 26th birthday,~~ birthday. As used in this section, a full-time student is a student who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction. In accordance with applicable federal law, coverage of a full-time student that loses full-time status due to illness may be extended for one year from the effective date of the loss of full-time status provided that the student was enrolled at the time of the onset of the illness.
- (2) The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-45.2(5)a."

SECTION 3.(c) Waiting Periods Subject to Federal Law. – G.S. 135-45.3(b) reads as rewritten:

"(b) ~~Newly~~ Except as otherwise required by applicable federal law, newly acquired dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not be subject to the 12-month waiting period for preexisting conditions. A dependent can become qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a dependent child or the death of the spouse of a dependent child, and at the beginning of each legislative session (applies only to enrolled legislators). Effective date for newly acquired dependents if application was made within the 30 days can be the first day of the following month. Effective date for an adopted child can be date of adoption, or date of placement in the adoptive parents' home, or the first of the month following the date of adoption or placement. Firefighters, rescue squad workers, and members of the national guard, and their eligible dependents, are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll."

SECTION 3.(d) G.S. 135-45.4(b)(5) reads as rewritten:

- "(5) To administer the 12-month waiting period for preexisting conditions under this that Article, the Plan must give credit against the 12-month period for the time a person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 63 days before the effective date of coverage. As used in this subdivision, a "previous plan" means any policy, certificate, contract, or any other arrangement provided by any accident and health insurer, any hospital or medical service corporation, any health maintenance organization, any preferred provider organization, any multiple employer welfare arrangement, any self-insured health benefit arrangement, any governmental health benefit or health care plan or program, or any other health benefit arrangement. Waiting periods for preexisting conditions administered under this Article are subject to applicable federal law."

SECTION 3.(e) Eligibility Audit. – The Executive Administrator shall provide for an audit of dependent eligibility under the Plan. The audit shall be designed to determine whether all dependents currently covered under the Plan are eligible for coverage under current law. Upon identification of an individual who is enrolled as a dependent but not eligible, the Plan shall disenroll the ineligible dependent effective within 10 days of sending written termination notice to the employee. The notice shall state the date upon which disenrollment will become effective and the basis on which the determination of dependent ineligibility is made. Notwithstanding any other provision of law, the Executive Administrator may waive requirements to collect from the member reimbursement for claims paid for the ineligible covered individual.

SECTION 3.(f) Cessation of Coverage of Ineligible Individuals. – G.S. 135-45.12 is amended by adding the following new subdivision to read:

- "(8) The last day of the month in which a covered individual is found to be ineligible for coverage."

SECTION 3.(g) Documentation of Dependent Eligibility. – G.S. 135-45.3 is amended by adding the following new subsection to read:

"(c) When an eligible or enrolled member applies to enroll the member's eligible dependent child or spouse, the member shall provide the documentation required by the Plan to verify the dependent's eligibility for coverage."

PART FOUR: NC HEALTH CHOICE CHANGES.

SECTION 4.(a) Over-the-Counter Medications. – Coverage of over-the-counter medication authorized under G.S. 108A-70.21(d) for the NC Health Choice Program shall become effective on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration and processing of claims under the NC Health Choice Program.

SECTION 4.(b) Subrogation. – For the period authorized under subsection (a) of this section, the right of subrogation under G.S. 108A-57 applies to the State Health Plan for payments made by the Plan under the NC Health Choice Program. This subsection expires on the later of July 1, 2010, or the date upon which the Department of Health and Human Services assumes full responsibility for administration, processing, and payment of claims under the NC Health Choice Program.

SECTION 4.(c) DHHS Subrogation Under NC Health Choice. – G.S. 108A-57 is amended by adding the following new subsection to read:

"(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article."

SECTION 4.(d) G.S. 108A-70.21(g) reads as rewritten:

"(g) Purchase of Extended Coverage. – An enrollee in the Program who loses eligibility due to an increase in family income above two hundred ~~fifty percent (250%)~~percent (200%) of the federal poverty level and up to and including two hundred ~~seventy-five percent (275%)~~ twenty-five percent (225%) of the federal poverty level may purchase at full premium cost continued coverage under the Program for a period not to exceed one year beginning on the date the enrollee becomes ineligible under the income requirements for the Program. The benefits, copayments, and other conditions of enrollment under the Program applicable to extended coverage purchased under this subsection shall be the same as those applicable to an NC Kids' Care enrollee whose family income equals two hundred ~~fifty percent (250%)~~percent (200%) of the federal poverty level."

PART FIVE: OTHER CHANGES.

SECTION 5.(a) G.S. 135-45.4(b)(2) reads as rewritten:

"(2) Employees not enrolling or not adding dependents when first eligible may enroll later on the first of any following month, but will be subject to a twelve-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section. The waiting period under this subdivision is subject to applicable federal law."

SECTION 5.(b) Powers and Duties of Executive Administrator. – G.S. 135-44.4 is amended by adding the following new subdivisions to read:

"(13a) The Plan and its pharmacy benefit manager may implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.

...

(29) For transplant and bariatric medical procedures, the Plan may restrict coverage to certain in-network providers that are designated by the Plan's Claims Processing Contractor.

(30) The Executive Administrator shall ensure provisions in contracts between the Plan and the Plan's Claims Processing Contractor that call for the Plan to contract with an independent auditor, selected by the Plan, to review the Claims Processing Contractor's administrative costs and services to the Plan by the Claim's Processing Contractor.

(31) The Plan shall conduct a monthly review of Plan costs as compared to the same month in the immediately preceding year and a comparison of projected costs and savings to actual costs and savings. The Plan shall report the results of the review to the Committee on Employee Hospital and Medical Benefits and the State Health Plan Blue Ribbon Task Force at least semiannually."

SECTION 5.(c) G.S. 135-44.1(b) reads as rewritten:

"(b) ~~Six~~ A majority of the members of the Board of Trustees in office shall constitute a quorum. Decisions of the Board of Trustees shall be made by a majority vote of the Trustees present, except as otherwise provided in this Part."

SECTION 5.(d) G.S. 135-45.9(b) reads as rewritten:

"(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered as provided in this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment:

(1) For mental illness treatment:

- a. ~~Licensed psychiatric hospitals;~~
hospitals or State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
- b. Licensed psychiatric beds in licensed general hospitals;
- c. Licensed residential treatment facilities that have 24-hour on-site care provided by a registered nurse who is physically located at the facility at all times and that hold current accreditation by a national accrediting body approved by the Plan's mental health case manager;
- d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
- e. Licensed intensive outpatient treatment programs; and
- f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:

- a. ~~Licensed chemical dependency units in licensed psychiatric hospitals; hospitals or in State psychiatric hospitals accredited by the Joint Commission on the Accreditation of Healthcare Organizations;~~
- b. Licensed chemical dependency hospitals;
- c. Licensed chemical dependency treatment facilities;
- d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities or County Programs in accordance with G.S. 122C-141;
- e. Licensed intensive outpatient treatment programs;
- f. Licensed partial hospitalization programs; and
- g. Medical detoxification facilities or units."

SECTION 5.(e) Section 28.22A(k) of S.L. 2007-323 reads as rewritten:

"SECTION 28.22A.(k) Subsection (j) of this section expires ~~June 30, 2009.~~ June 30, 2011."

SECTION 5.(f) G.S. 135-43(b) reads as rewritten:

"(b) Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees may contract with providers of institutional and professional medical care and services to establish preferred provider networks.

~~The terms pertaining to reimbursement rates or other terms of consideration of any contract between hospitals, hospital authorities, doctors, or other medical providers, or a pharmacy benefit manager and the Plan, or contracts pertaining to the provision of any medical benefit offered under the Plan, including its optional alternative comprehensive benefit plans, and programs available under the optional alternative plans, shall not be a public record under Chapter 132 of the General Statutes for a period of 30 months after the date of the expiration of the contract. The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record except that the terms in those contracts that contain trade secrets or proprietary or competitive information are not a public record under Chapter 132 of the General Statutes, and any such proprietary or competitive information and trade secrets contained in the contract shall be redacted by the Plan prior to making it available to the public. Provided, however, nothing in this subsection shall be deemed to~~ This subsection shall not be construed to prevent or restrict the release of any information made not a public record under this subsection to the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, ~~the Department of Health and Human Services solely for the purpose of implementing the transition of NC~~

~~Health Choice from the Plan to the Department of Health and Human Services, and the Committee on Employee Hospital and Medical Benefits solely and exclusively for their use in the furtherance of their duties and responsibilities, and to the Department of Health and Human Services solely for the purpose of implementing the transition of NC Health Choice from the Plan to the Department of Health and Human Services.~~ The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-45 are not subject to the requirements of Article 3 of Chapter 143 of the General Statutes. The Executive Administrator and Board of Trustees shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits."

SECTION 5.(g) The Executive Administrator of the Plan shall include in the development of its Request for Proposal (RFP) for an independent audit of the Plan, an audit of claims paid by the State Health Plan for Teachers and State Employees. One purpose of the audit is to determine whether savings to the Plan and to Plan members could be achieved if claims payments and processing were more efficiently and effectively administered. The audit shall encompass Plan years beginning in 2005, or earlier, through 2008 and shall look at claims administration and payment under the former Indemnity Plan as compared to the present PPO Plan. In developing the RFP, the Executive Administrator shall consult with the Fiscal Research Division staff and the Director of the Program Evaluation Division of the General Assembly to ensure that all of the following are addressed by the independent audit.

- (1) Estimated or actual savings that could be achieved if changes recommended by the independent auditor were enacted by the General Assembly, and how those savings should be allocated to the benefit of Plan members.
- (2) The governance structure of the Plan and whether it should be under the supervision and oversight of the Governor or a State agency.
- (3) The extent to which the failure or inability to share confidential or otherwise protected information with the Board of Directors and the General Assembly contributes to financial weaknesses in the Plan, and how such data sharing should be strengthened.
- (4) The role of the Board of Directors of the Plan and whether the role should be strengthened or otherwise changed.
- (5) Past, present, and potential areas of overpayments, overutilization, underutilization, or abuse that contributes to increasing costs of Plan benefits, including deductibles, co-payments, dependent premiums, and co-insurance maximums.
- (6) Safeguards to ensure the prompt reporting of claims data and trends to the actuaries under contract with the Plan and the General Assembly.
- (7) Any other matters the Executive Administrator, Fiscal Research Division Staff, the Director of the Program Evaluation Division, or the contracting entity believe would be useful in helping to strengthen the financial integrity of the Plan and Plan benefits.

It is the intent of the General Assembly that savings identified by the independent audit and realized through enactment by the General Assembly, and overpayments identified by the audit or by the Plan, will be allocated by the General Assembly to minimize benefit reductions and maintain affordable contributions, deductibles, and co-payments by Plan members and to maintain the fiscal integrity of the Plan itself.

The Executive Administrator shall provide the RFP developed in accordance with this section to the Division of Purchase and Contract not later than July 1, 2009. A copy of the audit report submitted to the Plan by the contracting entity shall be provided to the Committee on Employee Hospital and Medical Benefits.

SECTION 5.(h) G.S. 135-45(d) reads as rewritten:

"(d) The Plan benefits shall be provided under contracts between the Plan and the claims processors selected by the Plan. The Executive Administrator may contract with a pharmacy benefits manager to administer pharmacy benefits under the Plan. Such contracts shall include the applicable provisions of G.S. 135-45.1 through G.S. 135-45.15 and the description of the Plan in the request for proposal, and shall be administered by the respective claims processor or Pharmacy Benefits Manager, which will determine benefits and other questions arising

thereunder. The contracts necessarily will conform to applicable State law. If any of the provisions of G.S. 135-45.1 through G.S. 135-45.15 and the request for proposals must be modified for inclusion in the contract because of State law, such modification shall be made. The Executive Administrator shall ensure that the terms of the contract between the Plan and the Plan's Claims Processing Contractor, the Pharmacy Benefit Manager, and the Disease Management Contractor require the contractor to provide the following:

- (1) Detailed billing by each entity showing itemized cost information, including individual administrative services provided;
- (2) Transactional data; and
- (3) The cost to the Plan for each administrative function performed by the contractor."

PART SIX: SALARY-RELATED CONTRIBUTIONS.

SECTION 6.(a) Effective for the 2009-2011 fiscal biennium, required employer salary-related contributions for employees whose salaries are paid from department, office, institution, or agency receipts shall be paid from the same source as the source of the employees' salary. If an employee's salary is paid in part from the General Fund or Highway Fund and in part from department, office, institution, or agency receipts, required employer salary-related contributions may be paid from the General Fund or Highway Fund only to the extent of the proportionate part paid from the General Fund or Highway Fund in support of the salary of the employee, and the remainder of the employer's requirements shall be paid from the source that supplies the remainder of the employee's salary. The requirements of this section as to source of payment are also applicable to payments on behalf of the employee for hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave, workers' compensation, severance pay, separation allowances, and applicable disability income benefits.

Notwithstanding any other provision of law, an employing unit that is subject to Part 3A of Article 3A of Chapter 135 of the General Statutes and that hires or has hired as an employee a retiree that is in receipt of monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State shall enroll the retiree in the active group and pay the cost for the hospital-medical benefits if that retiree is employed in a position that would require the employer to pay hospital-medical benefits if the individual had not been retired.

SECTION 6.(b) Effective July 1, 2009, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2009-2010 fiscal year are: (i) eight and fifty-four hundredths percent (8.54%) – Teachers and State Employees; (ii) thirteen and fifty-four hundredths percent (13.54%) – State Law Enforcement Officers; (iii) eleven and eighty-six hundredths percent (11.86%) – University Employees' Optional Retirement System; (iv) eleven and eighty-six hundredths percent (11.86%) – Community College Optional Retirement Program; (v) seventeen and seventy-one hundredths percent (17.71%) – Consolidated Judicial Retirement System; and (vi) four and fifty hundredths percent (4.50%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and fifty hundredths percent (4.50%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(c) Effective July 1, 2010, the State's employer contribution rates budgeted for retirement and related benefits as percentage of covered salaries for the 2010-2011 fiscal year are: (i) eight and ninety-four hundredths percent (8.94%) – Teachers and State Employees; (ii) thirteen and ninety-four hundredths percent (13.94%) – State Law Enforcement Officers; (iii) twelve and twenty-six hundredths percent (12.26%) – University Employees' Optional Retirement System; (iv) twelve and twenty-six hundredths percent (12.26%) – Community College Optional Retirement Program; (v) eighteen and eleven hundredths percent (18.11%) – Consolidated Judicial Retirement System; and (vi) four and ninety hundredths percent (4.90%) – Legislative Retirement System. Each of the foregoing contribution rates includes four and ninety hundredths percent (4.90%) for hospital and medical benefits. The rate for Teachers and State Employees, State Law Enforcement Officers, Community College

Optional Retirement Program, and for the University Employees' Optional Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

SECTION 6.(d) Effective July 1, 2009, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand four hundred forty-seven dollars (\$3,447) and (ii) non-Medicare-eligible employees and retirees – four thousand five hundred twenty-seven dollars (\$4,527).

SECTION 6.(e) Effective July 1, 2010, the maximum annual employer contributions, payable monthly, by the State for each covered employee or retiree for the 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i) Medicare-eligible employees and retirees – three thousand seven hundred fifty-three dollars (\$3,753) and (ii) non-Medicare-eligible employees and retirees – four thousand nine hundred twenty-nine dollars (\$4,929).

PART SEVEN: STATE HEALTH PLAN BLUE RIBBON TASK FORCE.

SECTION 7.(a) State Health Plan Blue Ribbon Task Force. – There is established the Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees (Task Force). The purpose of the Task Force is to review the governance of the State Health Plan for Teachers and State Employees (Plan) and to make recommendations for changes that will ensure the ongoing financial stability of the Plan, increase and maintain high participation rates for dependent coverage under the Plan, study and compare coverage and costs of the Plan to coverage and costs of other State health plans in the region, and address issues of cost, quality, and access to health care coverage under the Plan. In conducting its review of the Plan the Task Force shall consider all of the following:

- (1) The feasibility of transferring the ongoing day-to-day oversight of the Plan to an independent board or to a State agency.
- (2) Tiered premium rates for member-only coverage for employees and future retirees based on income or ability to pay.
- (3) Ways to increase participation in dependent coverage including supplements from the State or other methods for reducing dependent premiums.
- (4) The benefits of implementing a closed prescription drug formulary.
- (5) Whether it is advisable to move the Plan to a calendar year, the costs involved in the move, and the benefits that accrue to the Plan and the members as a result of moving to a calendar year.
- (6) Any other matters the Task Force considers relevant to its purpose.

SECTION 7.(b) The Task Force shall consist of 15 members, appointed as follows:

- (1) Six members by the General Assembly upon the recommendation of the Speaker of the House of Representatives, three of whom shall be members of the House of Representatives, one shall be a public schoolteacher, one shall be a State or covered local government retiree other than a retired public schoolteacher, and one at-large. Of the three legislators appointed to the Task Force, one shall be a member of the minority party.
- (2) Six members by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, three of whom shall be members of the Senate, one shall be a State employee who is not a public schoolteacher, one shall be a retired State public school employee, and one at-large. Of the three legislators appointed to the Task Force, one shall be a member of the minority party.
- (3) One member by the Governor with expertise in the business of health insurance or in administering health care services other than an insurance company or third-party administrator or contractor of the Plan.
- (4) The chair of the Board of Directors of the State Health Plan.
- (5) The Commissioner of Insurance or the Commissioner's designee.

SECTION 7.(c) The cochair of the Task Force shall convene the first meeting as soon as possible after appointments have been made. The Task Force may engage the services

of a consultant to provide independent analysis of Plan costs and recommendations on how to strengthen the Plan's financial stability, benefit structure and coverage, and the most effective and efficient location for Plan administration.

SECTION 7.(d) Upon the convening of each session of the General Assembly, the Task Force shall report its findings and recommendations to the General Assembly, the Governor, and the Committee on Employee Hospital and Medical Benefits.

SECTION 7.(e) A majority of the Task Force members shall constitute a quorum for the transaction of business. The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall each appoint one Task Force member as chair. Appointments shall be made as soon as possible after this act becomes law. Task Force members shall receive no compensation for their service but shall be paid per diem, subsistence, and travel expenses in accordance with G.S. 120-3.1, G.S. 138-5, and G.S. 138-6, as applicable.

SECTION 7.(f) The Legislative Services Officer shall allocate from a portion of the funds appropriated to the General Assembly for each fiscal year for expenses of the Task Force.

PART EIGHT: EFFECTIVE DATE.

SECTION 8. Sections 1(b), 1(c), 1(d), 2(c), 2(f), 2(h) of this act become effective July 1, 2009. Section 4(d) of this act applies to applications for the purchase of extended coverage made on and after July 1, 2008. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 22nd day of April, 2009.

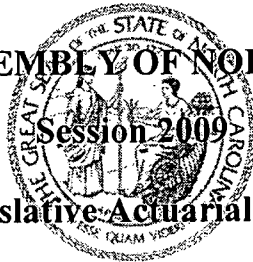
s/ Walter H. Dalton
President of the Senate

s/ William L. Wainwright
Speaker Pro Tempore of the House of Representatives

s/ Beverly E. Perdue
Governor

Approved 8:17 a.m. this 23rd day of April, 2009

GENERAL ASSEMBLY OF NORTH CAROLINA



Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Senate Bill 287 (Ratified Bill)

SHORT TITLE: State Health Plan\$/Good Health Initiatives.

SPONSOR(S):

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY: Senate Bill 287 (Ratified) appropriates funds from various sources, authorizes annual premium rate increases, makes various benefit and provider related changes to achieve financial savings, and directs other various changes to the Plan. The bill also generally establishes a Blue Ribbon Task Force to conduct a comprehensive review of the Plan

EFFECTIVE DATE: Sections 1(b), 1(c), 1(d), 2(c), 2(f), 2(h) become effective July 1, 2009. Section 4(d) (as relates to NC Health Choice) applies to applications for the purchase of extended coverage made on and after July 1, 2008. The remainder of the act is effective when it becomes law or as specified in a particular section of the act.

ESTIMATED IMPACT ON STATE:

Current FY 2008-2009

Appropriated Funds

Section 1(a) appropriates the sum of \$250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. These funds are to be used to finance a shortfall in funds available to pay health care benefits, administrative costs, and adequately fund the Plan's beginning cash balance on July 1, 2009.

2009-2011 Biennium

Increased Premium Contributions

Appropriated Funds

Sections 1(b), (c), and (d) appropriate the estimated required funds to support increased employer contributions to continue non-contributory benefit coverage for eligible employees and retired employees enrolled in the Plan for the 2009-2011 Biennium. These appropriations correspond to an annual 8.9%

premium increase in non-contributory premium rates for the fiscal year beginning July 1, 2009, and an additional annual premium increase of 8.9% for the fiscal year beginning July 1, 2010. Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium; however, the premium increases in the bill change that methodology to an annual increase at the beginning of each fiscal year of a biennium. The table below reflects the allocation of appropriated funds by fund source:

Additional Employer Contributions Appropriated Funds			
Fund Source	FY 2009-10	FY 2010-11	Biennium
General Fund	\$132,214,752	\$276,179,709	\$408,394,461
Highway Fund	\$6,170,022	\$12,888,386	\$19,058,408
Other Funds	\$27,276,062	\$56,976,206	\$84,252,268
Total	\$165,660,836	\$346,044,301	\$511,705,137

Employee Funds

Section 2(g) of the bill authorizes an annual 8.9% premium increase in contributory premium rates for the fiscal year beginning July 1, 2009, and an additional annual premium increase of 8.9% for the fiscal year beginning July 1, 2010. The estimated additional premium contributions from this change are listed below:

Additional Employee Contributions For Contributory Dependent Coverage			
Fund Source	FY 2009-10	FY 2010-11	Biennium
Employee Contributions	\$33,915,132	\$70,844,373	\$104,759,505

Total Increased Premium Contributions From Appropriated and Employee Funds

The table below reflects the total additional premium contributions projected to be received by the Plan over the 2009-2011 Biennium as a result of the authorized premium rate increase:

Total Additional Premium Contributions From Appropriated and Employee Funds			
Fund Source	FY 2009-10	FY 2010-11	Biennium
<u>Appropriated</u>			
General Fund	\$132,214,752	\$276,179,709	\$408,394,461
Highway Fund	\$6,170,022	\$12,888,386	\$19,058,408
Other Funds	\$27,276,062	\$56,976,206	\$84,252,268
Sub-total	\$165,660,836	\$346,044,301	\$511,705,137
Employee Contributions	\$33,915,132	\$70,844,373	\$104,759,505
Total	\$199,575,968	\$416,888,674	\$616,464,642

Financial Savings for the 2009 Biennium

Per the requirements of Senate Rule 42.2, House Rule 36.2, and G.S. 120-114 actuarial analyses have been prepared with respect to the bill's authorized benefit and other changes that are estimated to affect the financial condition of the Plan. A summary of the authorized changes are described below including the estimated actuarial impact of these changes.

Sections 2(c), (d), and (e) of the bill authorizes various benefit changes to include increased annual deductibles, annual co-insurance maximums, increased office visit co-pays, increased outpatient prescription drug co-pays, a new mid-tier co-pay for chiropractor, mental health, substance abuse and physical, occupational, and speech therapies, a new specialty drug co-pay and utilization of a specialty drug vendor. Effective January 1, 2010, the bill also eliminates the current in-network routine eye examination benefit offered under the Plan.

A summary of the out-of-pocket changes for medical benefit related services are summarized in the table below:

Medical Benefits Plan Member Co-pays (per visit)	PPO Basic		PPO Standard	
	Current	New Co-pay	Current	New Co-pay
Primary Care	\$25	\$30	\$20	\$25
Specialty Care	\$50	\$70	\$40	\$60
Urgent Care	\$75	\$75	\$50	\$75
Inpatient Hospital	\$200	\$250	\$150	\$200
New mid-tier Co-pay for Chiropractor, Physical-Occupational-Speech Therapy, and Mental Health/Substance Abuse	\$50	\$55	\$40	\$45
Annual Deductible				
In-network	\$600	\$800	\$300	\$600
Out-of-network	\$1,200	\$1,600	\$600	\$1,200
Coinsurance Maximum				
In-network	\$2,500	\$3,250	\$1,750	\$2,750
Out-of-network	\$5,000	\$6,500	\$3,500	\$5,500

For acute and maintenance prescription drugs, the co-pay for brand drugs increases from \$30 per script to \$35 per script, brand drugs with a generic equivalent from \$40 per script to \$10 plus the difference in the Plan's gross allowed cost of the brand drug and the Plan's cost of the generic equivalent drug, and from \$50 per script to \$55 per script for non-preferred brand drugs.

The bill authorizes a new co-pay tier for specialty prescription drugs determined to be "biotech" medications or other select costly medications that cost the Plan in excess of \$400 per prescription. The new per script co-pay will be equal to 25% of the Plan's cost for the drug or a maximum of \$100. The current co-pays for specialty drugs range from \$30 to \$50 per script. The bill also authorizes the Plan to contract with a specialty drug vendor through which to channel plan member purchases of specialty drugs on an outpatient basis or in a professional office or institution setting.

Aon Consulting, the consulting actuary for the State Health Plan for Teachers and State Employees, estimates that implementation of the benefit changes included in the bill will yield the following projected savings:

Aon Consulting Projected Financial Savings Benefit and Provider Related Changes			
Category	FY 2009-10	FY 2010-11	Biennium
Medical Benefits	\$110,464,129	\$129,971,359	\$240,435,488
Outpatient Prescription Drugs (acute drugs)	\$22,162,147	\$24,092,234	\$46,254,381
Specialty Drugs	\$3,086,315	\$3,396,887	\$6,483,202
Total	\$135,712,591	\$157,460,480	\$293,173,071

Hartman & Associates, the consulting actuary for the General Assembly's Fiscal Research Division, estimates that implementation of the benefit changes included in the bill will yield the following projected savings:

Hartman & Associates Projected Financial Savings Benefit and Provider Related Changes			
Category	FY 2009-10	FY 2010-11	Biennium
Medical Benefits	\$111,266,000	\$135,041,000	\$246,307,000
Outpatient Prescription Drugs (acute drugs)	\$24,015,000	\$24,225,000	\$48,240,000
Specialty Drugs	\$3,026,000	\$3,292,000	\$6,318,000
Total	\$138,307,000	\$162,558,000	\$300,865,000

Provided below is a comparison table reflecting the specific results of each consulting actuary by the type of benefit and provider change included in the bill:

Projected Financial Savings by Type						
Category	Aon Consulting (Plan)			Hartman & Assoc. (General Assembly)		
	FY 2009-10	FY 2010-11	Biennium	FY 2009-10	FY 2010-11	Biennium
Medical Benefits						
Primary Care Co-pay (Increase)	\$8,518,038	\$9,571,177	\$18,089,215	\$8,116,000	\$9,257,000	\$17,373,000
Specialist Co-pay (Increase)	\$29,077,025	\$32,672,003	\$61,749,028	\$27,125,000	\$31,713,000	\$58,838,000
Urgent Care Co-pay (Increase)	\$739,560	\$830,997	\$1,570,557	\$854,000	\$994,000	\$1,848,000
Inpatient Co-pay (Increase)	\$2,158,037	\$2,424,849	\$4,582,886	\$1,970,000	\$2,247,000	\$4,217,000
Routine Eye Exam (Eliminate Benefit) (Eff. 1/2010)	\$2,158,693	\$7,193,591	\$9,352,284	\$2,540,000	\$7,039,000	\$9,579,000
Deductible and Coinsurance Max (Increase)	\$76,215,565	\$86,849,600	\$163,065,165	\$78,079,000	\$92,463,000	\$170,542,000
Mid-tier Specialty Co-pay (New co-pay)	(\$8,402,789)	(\$9,570,858)	(\$17,973,647)	(\$7,418,000)	(\$8,672,000)	(\$16,090,000)
Sub-total	\$110,464,129	\$129,971,359	\$240,435,488	\$111,266,000	\$135,041,000	\$246,307,000
Outpatient Prescription Drugs (acute drugs)						
Brand Drug Co-pay (Increase)	\$11,734,884	\$12,173,684	\$23,908,568	\$12,010,000	\$11,741,000	\$23,751,000
Brand Drug with Generic Equivalent (Increase)	\$4,632,720	\$5,644,491	\$10,277,211	\$6,285,000	\$6,536,000	\$12,821,000
Non-Preferred Brand Drug Co-pay (Increase)	\$3,089,092	\$3,204,602	\$6,293,694	\$3,530,000	\$3,671,000	\$7,201,000
Reduce from 34-Day supply to 30-Day Supply	\$2,705,451	\$3,069,457	\$5,774,908	\$2,190,000	\$2,277,000	\$4,467,000
Sub-total	\$22,162,147	\$24,092,234	\$46,254,381	\$24,015,000	\$24,225,000	\$48,240,000
Specialty Drugs						
Establish a Specialty Drug vendor	\$1,682,177	\$1,835,102	\$3,517,279	\$1,555,000	\$1,762,000	\$3,317,000
Specialty Drug Copay (Establish)	\$1,404,138	\$1,561,785	\$2,965,923	\$1,471,000	\$1,530,000	\$3,001,000
Sub-total	\$3,086,315	\$3,396,887	\$6,483,202	\$3,026,000	\$3,292,000	\$6,318,000
Grand Total	\$135,712,591	\$157,460,480	\$293,173,071	\$138,307,000	\$162,558,000	\$300,865,000

Other Changes Affecting the Plan

Section 2(a) of the bill eliminates the PPO Plus benefit alternative for plan members effective July 1, 2009. Employees currently in this plan will be provided the option to enroll in the remaining PPO Basic or PPO Standard plans. The PPO Plus alternative currently offers 90/10 coverage for an additional premium charge paid by the plan member.

Section 2(b) of the bill implements a "Comprehensive Wellness Initiative" to focus on smoking cessation and weight management efforts.

The smoking cessation program will commence July 1, 2010 and will require all non-Medicare plan members to be enrolled in the PPO Basic plan unless the subscribing employee or retired employee can attest that they or any enrolled dependent do not smoke or otherwise use tobacco products. For eligible employees or retired employees who have attested that neither they nor their enrolled dependents use tobacco products, or if their medical provider certifies that a plan member is in a smoking cessation program, they will have the option to enroll in the PPO Standard plan.

Aon Consulting, consulting actuary for the Plan, estimates the smoking cessation program will save approximately \$3.4 million in claims cost for the FY 2010-11. However, the administrative costs to begin implementation are estimated by Aon to offset any first year savings. Aon consulting noted that until further administrative costs and program implementation issues are determined, estimating future savings to the Plan is not possible at this time. Hartman and Associates, consulting actuary for the General Assembly's Fiscal Research Division, does not project any financial impact to the Plan from the smoking cessation program. According to Hartman and Associates, the lack of program parameters and specific administrative costs prevents any reasonable analysis to be conducted.

The weight management program authorized in the bill will begin effective July 1, 2011. Under this program all non-Medicare plan members will be enrolled in the PPO Basic plan unless the subscribing employee or retired employee attests that the ratio of weight and height of the employee or retired employee, or for any of their enrolled dependents, meets certain evidence-based healthy weight clinical

guidelines. A plan member who cannot meet the Plan's weight and height ratio guidelines will remain in the PPO Basic plan unless a medical provider certifies the plan member has a medical condition that prevents them from attaining a specified ration of weight and height, or if the member is actively participating in a Plan-approved weight management program.

Neither the Plan's consulting actuary, Aon Consulting, nor the General Assembly's consulting actuary, Hartman and Associates, have estimated any financial impact due to the weight management program. The July 1, 2011 implementation date and yet to be developed administrative costs and program implementation requirements do not allow for any reliable financial projection at this time.

Section 2(h) of the bill directs the Plan to achieve a reduction of \$18 million in FY 2009-10 and \$20 million in FY 2010-11 in pharmacy provider costs through its existing contract authority with the Plan's Pharmacy Benefit Manager. These savings are based on the Plan's actuarial projection dated March 20, 2009 which makes specific assumptions about enrollment, estimated costs and utilization trends. Total savings under this authority may increase or decrease without adjustment based on a change in total enrollment provided that the rate of savings achieved on a per member per month basis remains constant. Adjustments to total savings may be made within 60-days after each six-month period of a fiscal year if savings exceed 105% of the specified savings.

Reconciliation of Plan's Financial Requirements

According to available information from the Executive Administrator of the Plan, the Plan needs an immediate appropriation of \$250 million for the current 2008-2009 fiscal year to operate through June 30, 2009, and to provide for an adequate beginning cash balance to begin operations for the new fiscal year commencing July 1, 2009. In addition, for the new biennium beginning July 1, 2009 the Plan is estimated to require over \$1.2 billion in additional financial support to remain solvent and maintain minimum claim stabilization reserves for the 2009-2011 biennium. If the Plan were to maintain current benefit levels and assuming a 9% per capita claims trend, the Plan would require an estimated 30.8% premium increase for the biennium (effective October 1, 2009).

The bill addresses the projected shortfall by authorizing the following changes:

1. Authorizing a 8.9% annual premium increase on July 1 of each fiscal year of the biennium for non-contributory and contributory premium rates; this change moves the historical date to increase premium rates from October 1 in the first year of a biennium, and moves to an annual premium increase;
2. Eliminating the current PPO Plus option benefit alternative;
3. Increase plan member out-of-pocket requirements for certain medical and prescription drug benefits; and
4. Directing the Plan to achieve a reduction of \$18 million in FY 2009-10 and \$20 million in FY 2010-11 in pharmacy provider costs through its existing contract authority with the Plan's Pharmacy Benefit Manager.

A financial summary table provided below provides a projected reconciliation of the financial related changes authorized under the bill assuming the Plan's consulting actuary's estimate of projected financial need for the 2009-2011 biennium, their projected financial savings due to benefit and other provider related changes, and their estimate of additional premium contributions:

State Health Plan
Summary of Financial Changes
Amendment to Senate Bill 287 (~~2009-10~~ (Ratified))
(\$ Million)

	FY 2009-10	FY 2010-11	Biennium
1) Projected Financial Support Required Before Any Adjustments	\$528.1	\$704.2	\$1,232.3
2) Adjust for Proposed FY 2008-09 Special Appropriation of \$250M	(\$107.1)	(\$142.9)	(\$250.0)
3) Adjust for Elimination of PPO Plus (Net Adjustment)	(\$14.4)	(\$24.4)	(\$38.8)
4) Adjusted Financial Support Required for the 2009-11 Biennium	\$406.6	\$536.9	\$943.5
5) Benefit Reductions Effective July 1, 2009			
Medical			
Primary Care Co-pay (Increase)	(\$8.5)	(\$9.6)	(\$18.1)
Specialist Co-pay (Increase)	(\$29.1)	(\$32.7)	(\$61.8)
Mid-tier Specialist Co-pay (New)	\$8.5	\$9.6	\$18.1
Urgent Care Co-pay (Increase)	(\$0.7)	(\$0.8)	(\$1.5)
Inpatient Co-pay (Increase)	(\$2.2)	(\$2.4)	(\$4.6)
Deductible and Coinsurance Maximum (Increase)	(\$76.2)	(\$86.9)	(\$163.1)
Routine Eye Exam (Eliminate Benefit) (Effective January 1, 2010)	(\$2.2)	(\$7.2)	(\$9.4)
Sub-total	(\$110.4)	(\$130.0)	(\$240.4)
Outpatient Acute and Specialty Prescription Drugs			
Brand Drug Co-pay (Increase)	(\$11.8)	(\$12.2)	(\$24.0)
Brand Drug with Generic Equivalent (Increase)	(\$4.6)	(\$5.6)	(\$10.2)
Non-Preferred Brand Drug Co-pay (Increase)	(\$3.1)	(\$3.2)	(\$6.3)
Reduce from 34-Day supply to 30-Day Supply per script	(\$2.7)	(\$3.1)	(\$5.8)
Specialty Drug Copay (Establish)	(\$1.4)	(\$1.6)	(\$3.0)
Establish a Specialty Drug vendor	(\$1.7)	(\$1.8)	(\$3.5)
Sub-total	(\$25.3)	(\$27.5)	(\$52.8)
Total -- Benefit Reductions	(\$135.7)	(\$157.5)	(\$293.2)
6) Additional Pharmacy Discounts to be Implemented by the Plan	(\$18.0)	(\$20.0)	(\$38.0)
7) Appropriations by the General Assembly			
Premium increase for Employing Agencies (July 1, 2009 = 8.9%, July 1, 2010 = 8.9%)			
General Fund	(\$132.2)	(\$276.1)	(\$408.3)
Highway Fund	(\$6.2)	(\$12.9)	(\$19.1)
Other Employer Funds	(\$27.3)	(\$57.0)	(\$84.3)
Total Employer Funds	(\$165.7)	(\$346.0)	(\$511.7)
8) Premium increases for Dependent Coverage (July 1, 2009 = 8.9%, July 1, 2010 = 8.9%) Paid by Employees and Retirees for Enrolled Spouses and Dependent Children			
Total Employee Funds	(\$33.9)	(\$70.9)	(\$104.8)
9) Plan's Other Operating Adjustments	\$0.1	\$6.1	\$6.2
10) Balance	\$53.4	(\$51.4)	\$2.0

Note: The \$2.0 balance remaining at the end of the biennium is a product of rounding error and a difference in projected ending cash balances between financial projections estimating total financial requirements and final requirements after the authorized premium increases, benefit changes, and other program changes. This difference is not expected to have an adverse effect on the Plan's finances.

ASSUMPTIONS AND METHODOLOGY:

The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be \$2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

- 1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;
- 2) The "Standard" 80/20 plan; and
- 3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

Employees and retired employees electing coverage under the Plus alternative must make a partially contributory premium contribution for their own coverage. The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under all plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of \$139.8 million. Receipts for the year are projected to be \$2.3 billion from premium collections, \$53.9 million from Medicare Part D subsidies, and \$2.7 million from investment earnings, for a total of slightly over \$2.3 billion in receipt income for the year. Projected disbursements from the Plan are expected to be \$2.4 billion in claim-payment expenses and \$168.7 million in administration and claims-processing expenses for projected total expenses of nearly \$2.6 billion for FY 2008-09. The Plan's net operating loss is projected to be approximately \$264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses are expected to deplete the Plan's cash balance of \$139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year. It is currently estimated by the Plan's Executive Administrator that the Plan will not be able to pay claims on a timely basis by March 31, 2009.

Consequently, the reforecast of Plan finances now indicates that the Plan will require up to \$300 million in additional resources to operate for the balance of the 2008-09 fiscal year. This amount represents the estimated funds necessary to pay claims and administrative expenses through June 30, 2009, plus funding a minimum stabilization reserve equal to 7.5% of projected claims, and assuming a future premium rate increase effective October 1, 2009.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
<u>Actives</u>					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
<u>Retired</u>					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
<u>Former Employees with Continuation Coverage</u>					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
<u>Firefighters, Rescue Squad & National Guard</u>					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
<u>Local Governments</u>					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
<u>Total</u>					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	35,254	533,204	98,351	666,809	100%
Percent of Total	5.3%	80.0%	14.7%	100.0%	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	13,481	401,253	66,319	481,053
Percent Enrollment by Contract				
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	100.0%	100.0%	100.0%	100.0%

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	35,254	533,204	98,351	666,809

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	100.0%	100.0%	100.0%	100.0%

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	35,254	533,204	98,351	666,809

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	100.0%	100.0%	100.0%	100.0%

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	146,774	19,528	166,302

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	100.0%	100.0%	100.0%

SOURCES OF DATA:

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, October 10, 2008.

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, July 2009 & 2010 Rate Increases, \$250 Million Grant, No Plus Option – July 2009, Benefit Option, Pharmacy Initiatives, March 20, 2009.

Aon Consulting, North Carolina State Health Plan, Financial Projections – October 2008, Total For All Plans – 9% Trend, July 2009 & 2010 Rate Increases, \$250 Million Grant, No Plus Option – July 2009, Benefit Option, Pharmacy Initiatives, Chiro PT/OT/ST MH/CD Middle Tier April 21, 2009.

Medco Health Solutions, various outpatient acute, specialty, and maintenance drug data and discount assumptions, March 2009.

State Health Plan, various summarized claims reports for medical claims by category and purpose and time period, December 2008, January 2009.

-Actuarial Note, Hartman & Associates, "Senate Bill 287 Proposed Conference Committee Substitute (S287-PCCS35293-LN-3): An Act to Appropriate Funds for the State Health Plan and to Make Other Changes to the State Health Plan", April 22, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "Senate Bill 287 Proposed Conference Committee Substitute, S287-PCCS35293-LN-3, State Health Plan \$/Good Health Initiatives", April 22, 2009, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogon

APPROVED BY:

Marilyn Chism, Director
Fiscal Research Division

DATE: April 24, 2009

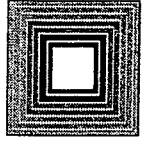


Signed Copy Located in the NCGA Principal Clerk's Offices

**NC General Assembly
Blue Ribbon Task Force on the
State Health Plan for
Teachers and State Employees**

Overview of the State Health Plan

November 2009



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Authorization

- Authorized under Article 3A of Chapter 135 of the General Statutes as the State Health Plan for Teachers and State Employees
- Began in October 1982 as a self-funded Indemnity plan; currently utilizes a self-funded Preferred Provider Option (PPO) benefit design
- Currently provides employer sponsored group health benefit coverage for nearly 661,000 plan members in all 100 counties of the State, most other U.S. states and some foreign locales

PPO Benefit Design

The Plan's PPO benefit design includes two benefit alternatives:

- a "Basic" 70/30 plan that offers higher out-of-pocket requirements in return for lower fully contributory dependent premium rates; and
- A "Standard" 80/20 plan which provides lower out-of-pocket requirements for plan members but higher dependent premium rates

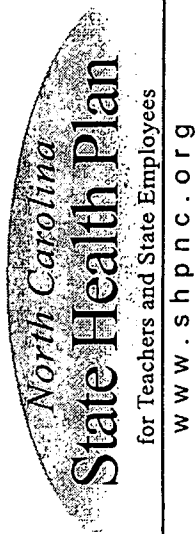


Administration

- The Plan operates as a receipt supported “enterprise” type agency
- Based on its governmental status and purpose, the Plan is not subject to federal ERISA oversight
- Plan medical claims are administered through a third-party administrator (BCBSNC) and pharmacy claims through a pharmacy benefit manager (Medco)

Premium Contribution Design

- Employing agencies pay 100% of the premium cost for eligible active employees
- Retirement Systems Division of the Department of State Treasurer pays 100% of the premium cost for eligible retired employees
- Active Employees and Retired Employees pay 100% of the premium cost to cover eligible family members (dependents)



Monthly Contribution Rates for Twelve-Month Employees/Retirees for Benefit Year 2009-2010 Effective July 1, 2009

EMPLOYEE / RETIREE MONTHLY CONTRIBUTION RATES	
Coverage Types	
Non-Medicare Active Employee / Retiree	
Employee / Retiree	\$ - \$ - \$ 377.22
Employee / Retiree + Child(ren)	\$ 164.08 \$ 218.20 \$ 377.22
Employee / Retiree + Spouse	\$ 422.74 \$ 502.74 \$ 377.22
Employee / Retiree + Family	\$ 450.26 \$ 533.00 \$ 377.22
Medicare Primary for Only Employee / Retiree	
Employee / Retiree	\$ - \$ - \$ 287.20
Employee / Retiree + Child(ren)	\$ 172.26 \$ 218.20 \$ 287.20
Employee / Retiree + Spouse	\$ 430.92 \$ 502.74 \$ 287.20
Employee / Retiree + Family	\$ 458.46 \$ 533.00 \$ 287.20
Medicare Primary for Only Dependent(s)	
Employee / Retiree	\$ - \$ - \$ 377.22
Employee / Retiree + Child(ren)	\$ 116.72 \$ 166.10 \$ 377.22
Employee / Retiree + Spouse	\$ 306.92 \$ 375.32 \$ 377.22
Employee / Retiree + Family	\$ 334.44 \$ 405.60 \$ 377.22
Medicare Primary for Both Employee / Retiree and Dependent(s)	
Employee / Retiree	\$ - \$ - \$ 287.20
Employee / Retiree + Child(ren)	\$ 124.92 \$ 166.10 \$ 287.20
Employee / Retiree + Spouse	\$ 315.10 \$ 375.32 \$ 287.20
Employee / Retiree + Family	\$ 342.62 \$ 405.60 \$ 287.20

Notes:

- 1) If your employment contract is for less than 12 months, contact your Health Benefits Representative or benefits office for monthly rates.
- 2) If you are actively employed and you or your dependent(s) are Medicare eligible, the State Health Plan is the primary insurer and the Non-Medicare rates apply. An exception to this would be if you or your dependent(s) are Medicare eligible due to end stage renal disease (ESRD).

Primary Groups Eligible for Coverage

State Employees: Eligible active employees from employing units of State agencies, departments and universities

Local Education Employees: Eligible active employees of local public school systems and local community college institutions

Retired Employees: Eligible former state and local education employees eligible to participate in the Plan based upon commencement of retirement benefits from a State administered retirement system

Dependents: Family members of active and retired employees are authorized to participate in the Plan provided they meet certain eligibility requirements



General Eligibility Requirements

State paid non-contributory coverage:

Active Employees – permanent employees working at least 30 hours per week

Retired Employees – with five years of contributory State service

Employee paid full contributory coverage:

Active Employees – permanent employees working between 20 and 30 hours per week

Dependents – spouses and unmarried children of Active and Retired Employees

General Eligibility Exception

For Employees first hired on or after October 1, 2006, eligibility for State paid benefit coverage as a retired employee is as follows:

<u>Years of Service</u>	<u>State Contribution</u>
20 or more years of service	100%
10 up to 20 years of service	50%
5 to 10 years of service	0%
Less than 5 years of service	Ineligible

Enrollment by Employer Type¹

<u>Employer Type</u>	<u>Employees</u>	<u>Dependents</u>	<u>Total</u>
State Agencies	75,880	34,893	110,773
UNC System ²	50,169	29,687	79,856
Local Public Schools	181,318	88,365	269,683
Local Community College	14,646	7,532	22,178
Local Governments	1,943	954	2,897
Other ³	3,126	791	3,917
Sub-total	327,082	162,222	489,304
Retirement Systems	152,454	19,495	171,949
Grand Total	479,536	181,717	661,253

¹As of September 30, 2009

²Includes enrollment of the UNC Health Care System

³Includes Former Plan Members eligible for COBRA, and 8 plan members of the National Guard/Fire-Rescue group

Enrollment by Plan & Age Band

Enrollment by Age	PPO Basic	PPO Standard	Total
19 & Under	17,289	96,162	113,451
20 to 29	3,236	57,451	60,687
30 to 44	9,530	120,952	130,482
45 to 54	6,349	109,028	115,377
55 to 64	3,977	128,344	132,321
65 & Over	1,512	107,423	108,935
Total	41,893	619,360	661,253

Percent Enrollment by Age	PPO Basic	PPO Standard	Total
19 & Under	41.3%	15.5%	17.2%
20 to 29	7.7%	9.3%	9.2%
30 to 44	22.7%	19.5%	19.7%
45 to 54	15.2%	17.6%	17.4%
55 to 64	9.5%	20.7%	20.0%
65 & Over	3.6%	17.3%	16.5%
Total	100.0%	100.0%	100.0%

¹As of September 30, 2009

Financial Summary

- For the fiscal year ending June 30, 2010 (FY 2009-2010) the Plan is projected to pay approximately \$2.38 Billion in medical and pharmacy claims¹
- Of that amount an estimated \$1.79 Billion is projected for medical claims and \$589.6 million in pharmacy related claims
- Administrative costs for the Plan are expected to be \$181.7 million for the fiscal year

¹ Aon Consulting, October 12, 2009, Revised Financial Projection

Financial Summary¹

1	State Health Plan	FY 2008-09	FY 2009-10
2	Financial Category	Actual	Projected
3		Year-end June 30, 2009	Revised (October 2009)
4	Beginning Cash Balance	\$139,744,498	\$189,901,049
5	Plan Revenues/Receipts		
6	Net Premium Collections ²	\$2,371,309,259	\$2,420,483,546
7	Special Appropriation	\$250,000,000	\$0
8	Medicare Part D	\$49,361,397	\$70,878,017
9	Investment Earnings	\$4,905,055	\$6,178,502
10	Net Plan Income	\$2,675,575,711	\$2,497,540,065
11	Plan Expenses		
12	Net Medical Claims	\$1,843,667,288	\$1,788,130,637
13	Net Pharmacy Claims	\$615,912,029	\$589,620,460
14	Administration	\$165,839,843	\$181,649,186
15	Net Plan Expenses	\$2,625,419,160	\$2,559,400,283
16			
17	Net Plan Income(Loss)	\$50,156,551	(\$61,860,218)
18	Ending Cash Balance	\$189,901,049	\$128,040,831
19	Enrollment (Actual)	665,779	661,253
20	Enrollment (Average)	660,087	661,166

¹Aon Consulting, October 12, 2009, Revised Financial Projection

²An estimated \$52 million in premiums budgeted for receipt in July 2009 were pre-paid to the Plan in June 2009

Financial Summary

State Health Plan Historical Claims Paid

Fiscal Year	Claims Paid by Plan	Average Membership	Average Claims per Member
1998-99	\$712,606,088	406,119	\$1,755
1999-00	\$839,179,757	425,363	\$1,973
2000-01	\$1,062,637,450	491,448	\$2,162
2001-02	\$1,214,701,705	538,467	\$2,256
2002-03	\$1,325,397,189	554,928	\$2,388
2003-04	\$1,437,673,914	564,298	\$2,548
2004-05	\$1,650,404,404	573,866	\$2,876
2005-06	\$1,746,227,347	586,644	\$2,977
2006-07	\$1,967,829,627	608,705	\$3,233
2007-08	\$2,150,297,897	638,729	\$3,367
2008-09	\$2,459,579,317	661,156	\$3,720
Avg. Annual Growth Rate		5.1%	7.9%

Claims Experience Example

Claims Experience by Age ^{1,2}

FY 2008-2009

Incurred Medical Claims Only

Per Member Per Month Basis (PMPM)

Average Monthly Enrollment	Members	% Total	PMPM
19 & Under	113,949	17.2%	\$102.27
20 to 29	63,667	9.6%	\$149.47
30 to 44	131,247	19.9%	\$222.72
45 to 54	117,162	17.7%	\$307.66
55 to 64	129,279	19.6%	\$414.17
65 & Over	105,439	16.0%	\$115.66
Total	660,743	100.0%	\$230.33

¹ Excludes Pharmacy Claims

² Report 12 ClaimsExp_by_AgeSex_Incurred_FY09, State Health Plan

Session Law 2009-16 (SB 287)

- Significant financial measures were enacted by the 2009 General Assembly to fund the Plan for 2009-11 Biennium
- Special Appropriation of \$250 million from the State's "Rainy Day Fund" for the Plan to finance a shortfall in the Plan's FY 2008-2009 funding
- Eliminated PPO Plus (90/10 Option) benefit plan

Session Law 2009-16 (SB 287)

- Authorized annual premium increases of 8.9% for each fiscal year of the 2009-11 Biennium at a cost of \$511.7 million in additional State Contributions
- Increased employee contributions for coverage of dependents by \$104.8 million
- Made benefit reductions of \$293.2 million over the 2009-11 Biennium by increasing plan member out-of-pocket requirements
- Increased discounts from Pharmacists by \$38 million



Session Law 2009-16 (SB 287)

Benefit Changes (Medical Only)	PPO Basic		PPO Standard	
	Prior Year Out-of-Pocket Limits	Out-of-Pocket limits eff. July 1, 2009	Prior Year Out-of-Pocket Limits	Out-of-Pocket limits eff. July 1, 2009
Out-of-Pocket Categories				
Office Visit Co-pays				
Primary Care	\$25	\$30	\$20	\$25
Specialty Care	\$50	\$70	\$40	\$60
Urgent Care	\$75	\$75	\$50	\$75
Inpatient Hospital	\$200	\$250	\$150	\$200
New mid-tier Co-pay for Chiropractor, Physical-Occupational-Speech Therapy, and Mental Health/Substance Abuse	\$50	\$55	\$40	\$45
Annual Deductible				
In-network	\$600	\$800	\$300	\$600
Out-of-network	\$1,200	\$1,600	\$600	\$1,200
Coinurance Maximum				
In-network	\$2,500	\$3,250	\$1,750	\$2,750
Out-of-network	\$5,000	\$6,500	\$3,500	\$5,500

Session Law 2009-16 (SB 287)

Acute and Maintenance Prescription Drugs

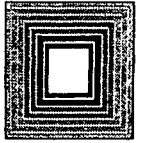
Plan Member Co-pay Changes (30-day Supply)

(Effective July 1, 2009)

- Brand drugs increased from \$30 per script to \$35 per script
- Brand drugs with a generic equivalent increased from \$40 per script to \$10 plus the difference in the Plan's gross allowed cost of the brand drug and the Plan's cost of the generic equivalent drug
- Non-preferred drugs increased from \$50 per script to \$55 per script
- Specialty Drugs increased from \$50 per script to a new co-pay equal to 25% of the Plan's cost for the drug or a maximum of \$100.
- Authorized the Plan to contract with a specialty drug vendor through which to channel most plan member purchases of specialty drugs

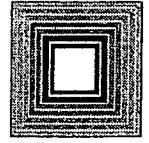


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Appendix



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The North Carolina State Health Plan for Teachers and State Employees Plan Comparisons

Plan Design Feature	Basic (70/30)		Standard (80/20)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Benefit Year Deductible	\$800 Individual \$2,400 Family	\$1,600 Individual \$4,800 Family	\$600 Individual \$1,800 Family	\$1,200 Individual \$3,600 Family
Plan Coinsurance	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge	20% of eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge
Coinsurance Maximum (does not include deductible)	\$3,250 Individual \$9,750 Family	\$6,500 Individual \$19,500 Family	\$2,750 Individual \$8,250 Family	\$5,500 Individual \$16,500 Family
Office Visits	\$30 ¹ copay primary care \$70 ¹ copay specialist	50% coinsurance after deductible	\$25 ¹ copay primary care \$60 ¹ copay specialist	40% coinsurance after deductible
Urgent Care	\$75 copay	Same as in-network benefit	\$75 copay	Same as in-network benefit
Emergency Room	\$250 copay plus 30% coinsurance after deductible	Same as in-network benefit	\$200 copay plus 20% coinsurance after deductible	Same as in-network benefit
Inpatient	\$250 copay plus 30% coinsurance after deductible	\$250 copay then 50% coinsurance after deductible	\$200 copay plus 20% coinsurance after deductible	\$200 copay then 40% coinsurance after deductible
Outpatient Hospital and Ambulatory Surgical Center	30% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Preventive Care	\$30 ¹ copay primary care \$70 ¹ copay specialist	Not covered ²	\$25 ¹ copay primary care \$60 ¹ copay specialist	Not covered ²
Short Term Therapies Physical/Occupational/Speech (PT/OT/ST)	\$55 ¹ copay - office services 30% coinsurance after deductible - outpatient hospital	50% coinsurance after deductible	\$45 ¹ copay - office services 20% coinsurance after deductible - outpatient hospital	40% coinsurance after deductible
Chiropractic (Chiro)	\$55 ¹ copay - 30 visit limit per benefit period	50% coinsurance after deductible	\$45 ¹ copay - 30 visit limit per benefit period	40% coinsurance after deductible
Routine Eye Exam ³	\$30 copay	Not covered	\$25 copay	Not covered
Mental Health/Substance Abuse (MH/SA)				
Office Services	\$55 ¹ copay	50% coinsurance	\$45 ¹ copay	40% coinsurance
Outpatient Services	30% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Inpatient Services	\$250 copay then 30% coinsurance after deductible	\$250 copay then 50% coinsurance after deductible	\$200 copay then 20% coinsurance after deductible	\$200 copay then 40% coinsurance after deductible
	Prior authorization is required after 26-combined in and out-of-network office visits		Prior authorization is required after 26-combined in and out-of-network office visits	
Generic Rx	\$10 copay for 30 day supply		\$10 copay for 30 day supply	
Preferred Brand Rx (no generic equivalent)	\$35 copay for 30 day supply		\$35 copay for 30 day supply	
Non-Preferred Brand Rx (no generic equivalent)	\$55 copay for 30 day supply		\$55 copay for 30 day supply	
For brand name drugs with an available generic, members will be required to pay the generic copay, plus the difference between the Plan's cost of the brand name drug and the Plan's cost of the generic drug.				
Specialty Rx ⁴	25% coinsurance up to \$100 for each 30 day supply		25% coinsurance up to \$100 for each 30 day supply	
Medical Supplies ⁵	\$10 copay for preferred brand for 30 day supply \$25 copay for non-preferred brand for 30 day supply		\$10 copay for preferred brand for 30 day supply \$25 copay for non-preferred brand for 30 day supply	

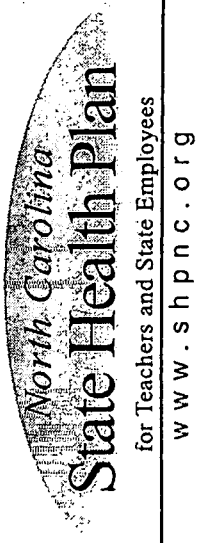
1. In-network: hospital owned or operated practices may be subject to deductible and coinsurance. Please call your physician or see the Provider Directory to determine if your physician's practice is hospital owned or operated.

2. The following preventive care benefits are available both in and out-of-network: gynecological exams, cervical cancer screenings, ovarian cancer screening, screening mammograms, colorectal screening and prostate specific antigen tests

3. Routine eye exams as of January 1, 2010 will no longer be covered. Check with your Health Benefits Representative about your benefit options for vision.

4. All non-acute specialty drugs, excluding cancer medications, must be obtained through the Accredited specialty pharmacy.

5. For a single copay, insulin dependent members will receive 100 test strips and non-insulin dependent members receive 300 test strips per 30 day supply. Additional test strips needed are covered under the medical supply benefit.



Monthly Contribution Rates for Twelve-Month Employees/Retirees for Benefit Year 2009-2010 Effective July 1, 2009

		EMPLOYEE / RETIREE MONTHLY CONTRIBUTION RATES			
	Coverage Types	Basic Plan 70/30	Standard Plan 80/20	State Monthly Contribution	
Non-Medicare Active Employee / Retiree					
	Employee / Retiree	\$ -	\$ -	\$ 377.22	
	Employee / Retiree + Child(ren)	\$ 164.08	\$ 218.20	\$ 377.22	
	Employee / Retiree + Spouse	\$ 422.74	\$ 502.74	\$ 377.22	
	Employee / Retiree + Family	\$ 450.26	\$ 533.00	\$ 377.22	
Medicare Primary for Only Employee / Retiree					
	Employee / Retiree	\$ -	\$ -	\$ 287.20	
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	Employee / Retiree + Child(ren)	\$ 124.92	\$ 166.10	\$ 287.20	
	Employee / Retiree + Spouse	\$ 315.10	\$ 375.32	\$ 287.20	
	Employee / Retiree + Family	\$ 342.62	\$ 405.60	\$ 287.20	

Notes:

- 1) If your employment contract is for less than 12 months, contact your Health Benefits Representative or benefits office for monthly rates.
- 2) If you are actively employed and you or your dependent(s) are Medicare eligible, the State Health Plan is the primary insurer and the Non-Medicare rates apply. An exception to this would be if you or your dependent(s) are Medicare eligible due to end stage renal disease (ESRD).



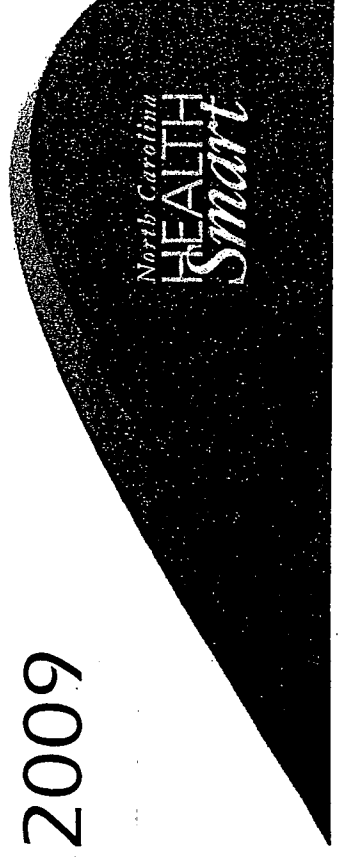
Quarterly Report

1st Quarter FY 2009-10

(July 2009 to September 2009)

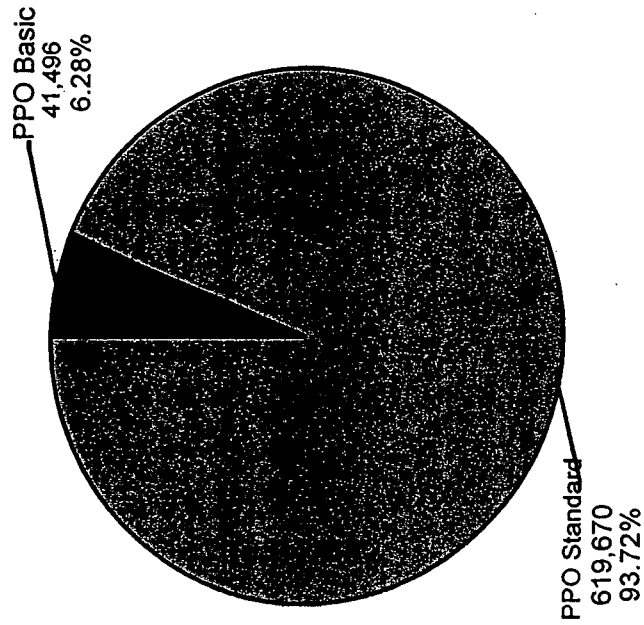
**Presentation to Committee on Employee
Hospital and Medical Benefits**

November 12, 2009



Membership by Plan 1st Quarter FY 2009-10

Average Membership by Plan
(July thru September 2009)



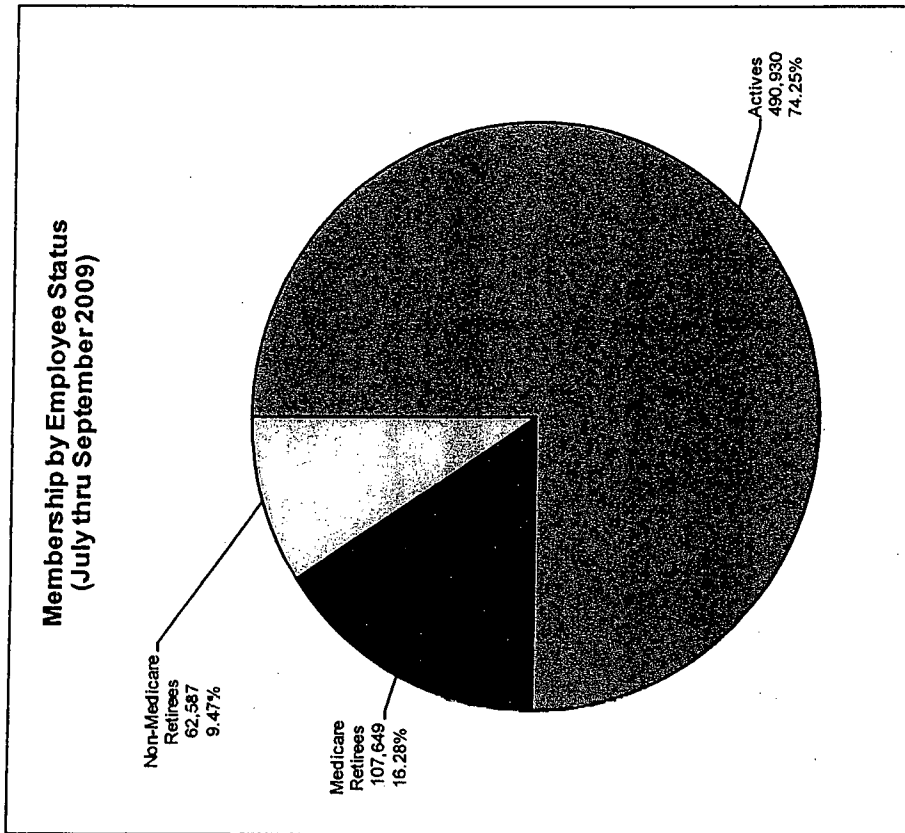
July 2009				
	Employees	Dependents	Total	% of SHP Mbrship
PPO Basic	15,551	25,735	41,286	6.24%
PPO Standard	463,999	156,721	620,720	93.76%
Totals	479,550	182,456	662,006	100%
				1.38

August 2009				
	Employees	Dependents	Total	% of SHP Mbrship
PPO Basic	15,589	25,720	41,309	6.26%
PPO Standard	462,810	156,119	618,929	93.74%
Totals	478,399	181,839	660,238	100%
				1.38

September 2009				
	Employees	Dependents	Total	% of SHP Mbrship
PPO Basic	15,838	26,055	41,893	6.34%
PPO Standard	463,698	155,662	619,360	93.66%
Totals	479,536	181,717	661,253	100%
				1.38

Average Membership (July thru September 2009)				
	Employees	Dependents	Total	% of SHP Mbrship
PPO Basic	15,659	25,837	41,496	6.28%
PPO Standard	463,502	156,167	619,670	93.72%
Totals	479,162	182,004	661,166	100%
				1.38

Membership by Employee Status 1st Quarter FY 2009-10



	Employees	Dependents	Total	Average Contract Size
Actives	330,719	163,502	494,221	1.49
Medicare Retirees	99,754	7,446	107,200	1.07
Non-Medicare Retirees	49,078	11,507	60,585	1.23
	479,551	182,455	662,006	1.38

	Employees	Dependents	Total	Average Contract Size
Actives	326,873	162,392	489,265	1.50
Medicare Retirees	100,159	7,478	107,637	1.07
Non-Medicare Retirees	51,368	11,968	63,336	1.23
	478,400	181,838	660,238	1.38

	Employees	Dependents	Total	Average Contract Size
Actives	327,083	162,221	489,304	1.50
Medicare Retirees	100,614	7,495	108,109	1.07
Non-Medicare Retirees	51,840	12,000	63,840	1.23
	479,537	181,716	661,253	1.38

	Employees	Dependents	Total	Average Contract Size
Actives	328,225	162,705	490,930	1.50
Medicare Retirees	100,176	7,473	107,649	1.07
Non-Medicare Retirees	50,762	11,825	62,587	1.23
	479,163	182,003	661,166	1.38

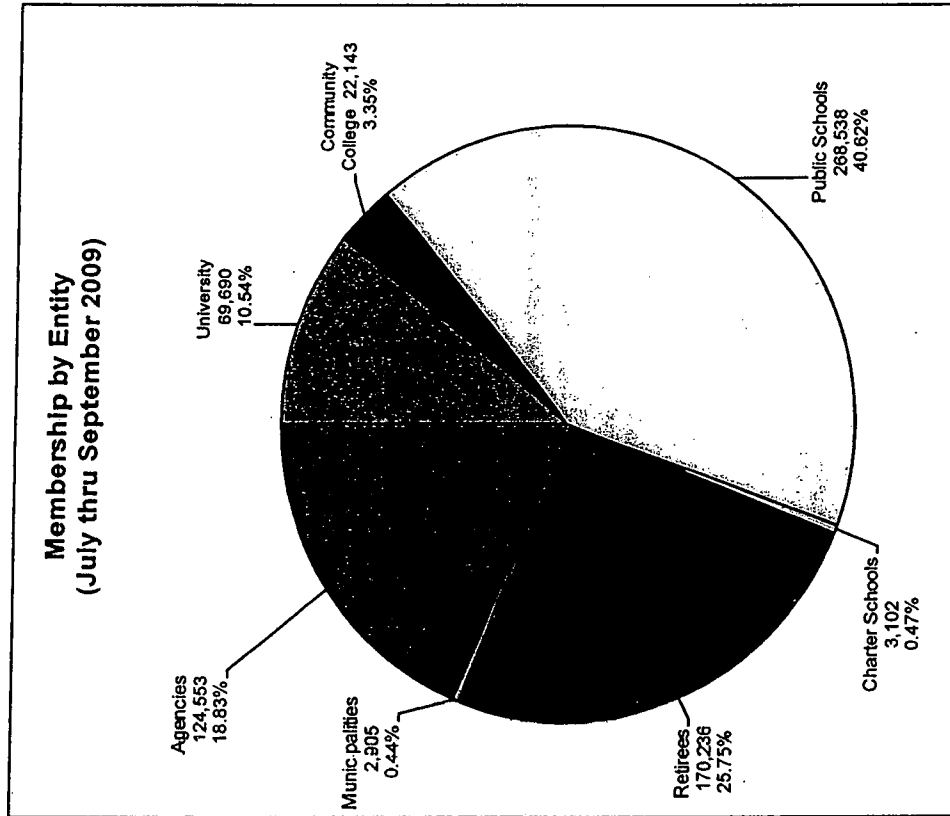
Membership by Entity 1st Quarter FY 2009-10

July 2009			
	Employees	Dependents	Total
University	44,046	25,812	69,858
Community College	14,721	7,508	22,229
Public Schools	183,316	88,568	271,884
Charter Schools	1,856	1,148	3,004
Retirees	148,832	18,953	167,785
Municipalities	1,955	962	2,917
Agencies	84,825	39,504	124,329
Total	479,551	182,455	662,006
			1.38

August 2009			
	Employees	Dependents	Total
University	43,752	25,781	69,533
Community College	14,558	7,464	22,022
Public Schools	179,749	87,574	267,323
Charter Schools	1,866	1,159	3,025
Retirees	151,527	19,446	170,973
Municipalities	1,947	953	2,900
Agencies	85,001	39,461	124,462
Total	478,400	181,838	660,238
			1.38

September 2009			
	Employees	Dependents	Total
University	43,801	25,877	69,678
Community College	14,846	7,532	22,378
Public Schools	179,273	87,133	266,406
Charter Schools	2,045	1,232	3,277
Retirees	152,454	19,495	171,949
Municipalities	1,943	954	2,897
Agencies	85,375	39,493	124,868
Total	479,537	181,716	661,253
			1.38

Average Membership (July thru September 2009)			
	Employees	Dependents	Total
University	43,866	25,823	69,690
Community College	14,642	7,501	22,143
Public Schools	180,779	87,758	268,538
Charter Schools	1,922	1,180	3,102
Retirees	150,938	19,298	170,236
Municipalities	1,948	956	2,905
Agencies	85,067	39,486	124,553
Total	479,163	182,003	661,166
			1.38



Financial Report

September 2009

Actual vs. Budgeted

	Actual September 2009	Certified Budget (per SL 2009-16)	Variance Over/(Under) Budget
Beginning Cash Balance	\$126.3 m	\$150.7 m	(\$24.4 m)
Plan Revenue	\$203.7 m	\$206.2 m	(\$2.5 m)
Net Claims Payment	\$180.6 m	\$188.1 m	(\$7.5 m)
Net Admin. Expenses	<u>\$15.0 m</u>	<u>\$15.5 m</u>	<u>(\$0.5 m)</u>
Total Plan Expense	\$195.6 m	\$203.6 m	(\$8.0 m)
Net Income/(Loss)	\$8.1 m	\$2.6 m	\$5.5 m
Ending Cash Balance	\$134.4 m	\$153.3 m	(\$18.9 m)

Financial Report

Year to Date thru September 2009

Actual vs. Budgeted

	Actual thru September 2009	Certified Budget (per SL 2009-16)	Variance Over/(Under) Budget
Beginning Cash Balance *	\$189.9 m	\$146.8 m	\$43.1 m
Plan Revenue *	\$586.7 m	\$628.3 m	(\$41.6 m)
Net Claims Payment	\$599.9 m	\$575.4 m	\$24.5 m
Net Admin. Expenses	<u>\$42.3 m</u>	<u>\$46.4 m</u>	(\$4.1 m)
Total Plan Expense	\$642.2 m	\$621.8 m	\$20.4 m
Net Income/(Loss) *	(\$55.5 m)	\$6.5 m	(\$62.0 m)
Ending Cash Balance	\$134.4 m	\$153.3 m	(\$18.9 m)

* Approximately \$52 million in premiums budgeted for receipt in July were paid by the Retirement System in June. The prepayment contributes to the variances in beginning cash, revenue and net income/(loss).

Financial Report

Year to Date thru September 2009

Per Member Per Month (PMPM) Analysis

	Actual YTD	Certified Budget (per SL 2009-16)	Variance Over/(Under) Budget
Plan Revenue *	\$321.98	\$320.78	\$1.20
Claims Payment	\$300.63	\$293.81	\$6.82
Net Admin. Expenses	<u>\$21.19</u>	<u>\$23.68</u>	<u>(\$2.49)</u>
Total Plan Expense	\$321.82	\$317.49	\$4.33
Net Income/(Loss)	\$0.16	\$3.29	(\$3.13)

* Adjusted for \$52 million in premiums for July coverage received in June (i.e. receipt of the \$52 million is budgeted in FY 2009-10 and for the purposes of this analysis the prepaid premiums are reflected in the actual Plan Revenue PMPM amount)

North Carolina State Health Plan for Teachers and State Employees

Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Budgeted
For the Month Ended September 2009
Fiscal Year 2009-2010

	A	B	C	D	E	F	G	H
	Actual September 2009	Budget September 2009	Monthly Variance Over/(Under) Budget	Actual Year to Date FY 2009-10	Budget Year to Date FY 2009-10	Year to Date Variance Over/(Under) Budget	Annual Budget FY 2009-10	Year to Date Variance Over/(Under) Annual Budget
Plan Revenue								
1 Member Premiums	\$ 202,045,078	\$ 203,769,105	\$ (1,724,027)	\$ 566,384,237	\$ 611,307,315	\$ (44,923,078)	\$ 2,445,229,263	\$ (1,878,845,026)
2 Premium Refunds/Retroactive Disenrollments	(66,221)	(697,742)	631,521	(211,803)	(2,093,226)	1,881,425	(8,372,898)	8,161,097
3 Medicare Part D Subsidy	1,437,147	2,520,590	(1,083,443)	19,582,570	17,290,022	2,292,548	56,262,519	(36,679,949)
4 Net Premium & Other Contributions	203,416,004	205,591,953	(2,175,949)	585,155,006	626,504,111	(40,749,105)	2,493,118,884	(1,907,363,878)
5 Investment Earnings	288,128	619,785	(331,657)	894,602	1,774,494	(879,892)	7,945,058	(7,050,456)
6 Miscellaneous Revenue	(2,376)		2,376	3,640		3,640		3,640
7 Other Revenue	290,504	619,785	(329,281)	898,242	1,774,494	(876,252)	7,945,058	(7,046,816)
8 Total Plan Revenue (excludes internal transfers)	203,706,508	206,211,738	(2,505,230)	586,553,248	628,278,605	(41,625,357)	2,501,063,942	(1,914,410,694)
Plan Expenses								
9 Net Medical Claims	130,456,443	118,673,768	11,782,675	480,050,806	422,560,609	57,490,197	1,719,379,474	(1,259,328,668)
10 Net Pharmacy Claims	50,216,941	69,447,193	(19,230,252)	139,813,065	152,887,101	(13,074,036)	581,325,349	(441,512,284)
11 Net Claim Payments	180,645,384	188,120,961	(7,475,577)	599,863,871	575,447,710	24,416,161	2,300,704,823	(1,700,840,952)
12 Net Administrative Expenses	14,958,541	15,470,235	(501,694)	42,272,671	46,373,311	(4,100,640)	185,605,422	(143,332,751)
13 Total Plan Expenses (excludes internal transfers)	195,631,925	203,591,961	(7,977,271)	642,136,542	621,821,021	20,315,521	2,486,310,245	(1,844,173,703)
14 Plan Income/(Loss)	8,074,583	2,620,542	5,454,041	(55,583,294)	6,457,584	(61,940,878)	14,753,697	(70,236,991)
Cash Availability								
15 Beginning Cash Balance/(Deficit)	126,325,172	150,683,438	(24,358,266)	189,901,049	146,846,396	43,054,653	146,846,396	43,054,653
16 Ending Cash Balance/(Deficit)	134,417,755	153,303,980	(18,886,225)	134,417,755	153,303,980	(18,886,225)	161,600,093	(27,182,338)
17 Target Stabilization Reserve @ 6/30/10	172,552,862	172,552,862		172,552,862	172,552,862		172,552,862	
18 Cash Balance Over/(Under) Reserve Target	\$ (38,135,107)	\$ (19,248,882)	\$ (18,886,225)	\$ (38,135,107)	\$ (19,248,882)	\$ (18,886,225)	\$ (10,952,769)	\$ (27,182,338)

Comments:

- The delinquent receivables totaled \$1,014,297.50 as of September 30, 2009.
- The average weekly medical claims cost net of claims refunds was \$32,607.116.75 for the four weekly claim disbursements.
- Pharmacy claims include three bi-weekly invoice cycles and averaged \$16,738,980.34 per cycle.
- Stabilization reserve is 7.5% of the funding projection of net claims for Fiscal Year 2009-2010 or \$172,552,862.
- Approximately \$52 million in member premiums for the month of July were paid by the Retirement System in June 2009. Because these receipts are budgeted in FY 2009-10, the \$52 million prepayment will contribute to both the revenue and net income/(loss) variances throughout the 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 September 2009
Fiscal Year 2009-2010

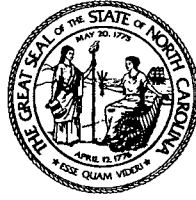
	A	B	C	D	E	F	G
	Current Year Actual September 2009	Prior Year Actual September 2008	Current Year to Date Actual FY 2009-10 thru September	Prior Year to Date Actual FY 2008-09 thru September	Current Year Annual Budget FY 2009-10	Prior Year Annual Budget FY 2008-09	Prior Year Annual Actual FY 2008-09
1 Plan Revenue:							
2							
3 Member Premiums	\$ 202,945,078	\$ 192,477,811	\$ 566,384,237	\$ 569,673,964	\$ 2,445,229,263	\$ 2,281,595,143	\$ 2,373,596,994
4 Premium Refunds/Retroactive Disenrollments	(66,221)	(316,316)	(211,801)	(1,146,972)	(8,372,898)	(7,812,586)	(2,287,735)
5 Medicare Part D Subsidy	1,437,147	1,046,708	19,582,570	18,535,327	56,262,519	53,886,565	49,361,396
6 Appropriation from Savings Reserve Account							250,000,000
7 Net Premium & Other Contributions	203,416,004	193,208,203	585,755,006	587,062,319	2,493,118,884	2,327,669,122	2,670,670,655
8							
9 Investment Earnings	288,128	522,069	894,602	1,653,090	7,945,058	2,711,451	4,902,987
10 Miscellaneous Revenue	2,376		3,640				2,058
11 Other Revenue	290,504	522,069	898,242	1,653,097	7,945,058	2,711,451	4,905,055
12							
13 Total Plan Revenue (excludes internal transfers)	203,706,508	193,730,272	585,653,248	588,715,416	2,501,063,942	2,330,380,573	2,675,575,710
14							
15 Plan Expenses:							
16							
17 Net Medical Claims	130,428,443	157,941,270	460,050,806	465,818,347	1,719,379,474	1,806,608,733	1,843,667,288
18 Net Pharmacy Claims	50,216,941	70,461,628	139,813,065	175,932,744	581,325,349	619,498,743	615,912,029
19							
20 Net Claim Payments	180,645,384	228,402,898	599,863,871	642,751,091	2,300,704,823	2,426,107,476	2,459,579,317
21							
22 Net Administrative Expenses	14,988,541	11,408,090	42,272,671	35,786,897	185,605,422	188,696,844	165,839,843
23							
24 Total Plan Expenses (excludes internal transfers)	195,613,925	239,810,988	642,136,542	678,537,988	2,486,310,245	2,594,804,120	2,625,419,160
25							
26 Plan Income/(Loss)	8,092,583	(46,080,716)	(55,483,294)	(89,822,572)	14,753,697	(264,423,547)	50,156,550
27							
28 Cash Availability:							
29							
30 Beginning Cash Balance/(Deficit)	126,325,172	96,002,643	189,901,049	139,744,498	146,846,396	139,744,497	139,744,498
31 Ending Cash Balance/(Deficit)	134,417,755	49,921,927	134,417,755	49,921,926	161,600,093	(124,679,050)	189,901,048
32							
33 Target Stabilization Reserve @ 6/30/10	172,552,862	181,958,061	172,552,862	181,958,061	172,552,862	181,958,061	181,958,061
34							
35 Cash Balance Over/(Under) Reserve Target	\$ (38,135,107)	\$ (132,036,134)	\$ (38,135,107)	\$ (132,036,135)	\$ (10,952,769)	\$ (306,637,111)	\$ 7,942,987

a. Minor differences compared to other reports due to rounding

b. Approximately \$52 million in member premiums for the month of July were paid by the Retirement System in June 2009.

Because these receipts are budgeted in FY 2009-10, the \$52 million prepayment will contribute to both the revenue and net income/(loss) variances throughout the fiscal year.

Consolidated Current Year v Prior Year
September 2009



NORTH CAROLINA GENERAL ASSEMBLY

16 West Jones Street
LEGISLATIVE BUILDING
RALEIGH NC 27601

October 22, 2009

MEMORANDUM

TO: Members, State Health Plan Blue Ribbon Task Force

FROM: Rep. Hugh Holliman, Co-Chair
Sen. Tony Rand, Co-Chair

SUBJECT: Committee Meeting Notice

The State Health Plan Blue Ribbon Task Force Committee will meet on the following date:

DAY: Wednesday
DATE: November 18, 2009
TIME: 9:00 am
LOCATION: Room 1228 Legislative Building

If you have any questions concerning this meeting or you cannot attend, please contact Carol Bowers, Committee Clerk at 919-715-0873 or Hollimanla@ncleg.net.

Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

**Wednesday, November 18, 2009
9:00 a.m.**

Legislative Building, Room 1228

I. Welcome, Introductions, and Remarks

*Representative Hugh Holliman, Co-Chair
Senator Tony Rand, Co-Chair*

II. Overview of S.L. 2009-16 (SB 287)

Gann Watson, Attorney, Bill Drafting Division, NCGA

III. Overview of the State Health Plan

Mark Trogon, Fiscal Analyst, Fiscal Research Division, NCGA

IV. Task Force Discussion

V. Future Meeting Dates



NORTH CAROLINA GENERAL ASSEMBLY

16 West Jones Street
LEGISLATIVE BUILDING
RALEIGH NC 27601

November 18, 2009

MEMORANDUM

TO: Members of the State Health Plan Blue Ribbon Task Force Committee

FROM: Rep. Hugh Holliman, Co-Chair
Sen. Tony Rand, Co-Chair

SUBJECT: Committee Meeting Notice

The State Health Plan Blue Ribbon Task Force Committee will meet on the following date:

DAY: Wednesday
DATE: December 2, 2009
TIME: 9:00 am
LOCATION: Room 1228 Legislative Building

If you have any questions concerning this meeting or you cannot attend, please contact Carol Bowers, Committee Clerk at 919-715-0873 or Hollimanla@ncleg.net.

**Blue Ribbon Task Force
on the State Health Plan
for Teachers and State Employees**

**Wednesday, December 2, 2009
9:00 a.m.**

Legislative Building, Room 1228/1327

I. Welcome

*Representative Hugh Holliman, Co-Chair
Senator Tony Rand, Co-Chair*

II. Approve Minutes

III. Prioritizing the Work of the Task Force

IV. Wellness and Disease Prevention Promotion Efforts

Jack Walker, Executive Administrator, State Health Plan

V. Task Force Discussion

VI. Next Meeting Date

HOUSE PAGES

NAME OF COMMITTEE SHP DATE 12-2-09

1. Name: _____

County: _____

Sponsor: _____

2. Name: _____

County: _____

Sponsor: _____

3. Name: _____

County: _____

Sponsor: _____

4. Name: _____

County: _____

Sponsor: _____

5. Name: _____

County: _____

Sponsor: _____

SGT-AT-ARM

1. Name: Tom Willey George Robinson

2. Name: Martha Parnell CHESTER WHITE

3. Name: _____ CHARLES HARPER

4. Name: _____

VISITOR REGISTRATION SHEET

Health Plan

Name of Committee

12/2/09

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Casey Herget	State Health Plan
Tracy Stephenson	State Health Plan
Carol Durrell	State Health Plan
Mona Moon	SHIP
Lorraine Munk	SHIP
Wendy L. Greene	SHIP
Jim Thornton	Ethicon Endo Surgery
Cam Coker	BPMHL
Ed Turling	

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Linda Forsberg	State Health Plan
John Hammond	Board of Trustees SHP
John Bowditch	AstraZeneca
DAVID BARNES	Poyner Spruill
HUGH TILSON	NCHH
Evin Schuettgen	UNC-GA
Brian Lewis	NCAE
El Regier	NCRGEA
Sandy Sachs	WCSR

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Erica Baldwin

SEANC, Raleigh

Katherine Joyce

NCASA

Mr. Smith

Citizen

Ben Niolet

N+O

Adam Linker

NC Division Center

Louis Belo

NCDOI

Ronnie Cordrey

DOI

Rose Williams

NCDOI

Jean Holliday

NCDOI

Ted Hamby

NCDOI

Carl Dean

OSP

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME _____

FIRM OR AGENCY AND ADDRESS

Bo Heath

Melaine Wood

Daniel Baum

V+L GATES

Emily Doyle

NCPAPA

Enoch Ramon

NCMA

Amy White d

NC Med Society

Harrison Gilbert

Governor's Office

MINUTES

BLUE RIBBON TASK FORCE ON THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES Wednesday, December 2, 2009 9:00 a.m.

Legislative Building, Room 1228/1327

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees met Wednesday, December 2 at 9 a.m. in Room 1228/1327 of the Legislative Building

Representative Hugh Holliman, Co-Chairman presided. Upon motion of Senator Apodaca and second by Ms. Adcock the minutes of the meeting of November 18, 2009 were approved. (***ATTACHMENT: MEMBERS PRESENT.***) Representative Holliman called attention to the summary of priorities developed from members' comments made at the November 18th meeting. Representative Folwell suggested some attention should be paid to fraudulent use of the State Health Plan. There was no immediate indication of where that might fall in the Task Force work, but the idea was taken under advisement.

PRESENTATIONS

Prioritizing the Work of the Task Force

Theresa Matula of the Legislative Research Division explained the priorities list was developed from the discussion as mentioned above. At that previous meeting, Gann Watson of the Research Staff presented an explanation of the legislation which created the Task Force and the areas the Task Force could consider, from oversight to benefits etc. Research Staff grouped the points made during the discussion into broad categories and sub-groups. The prioritizing was done by the Co-Chair, Representative Holliman. (***ATTACHMENT: PRIORITIZING THE WORK OF THE BLUE RIBBON TASK FORCE.***)

Representative Braxton was concerned that the list would 'handcuff' the Task Force. Representative Holliman said items could be added based on the will of the group.

Chuck Stone said based on discussions with state employees, he would like to see a comparative analysis with other state health plans and review of best practices in health insurance.

Ms. Adcock would like to see early intervention considered.

The Co-Chairman was amenable to the members' suggestions.

Wellness and Disease Prevention Promotion Efforts

Dr. Jack Walker, Executive Administrator for the State Health Plan began his presentation with a brief history of the Plan as created and the goals of the Plan.

(ATTACHMENT: STATE HEALTH PLAN OVERVIEW.)

He said the two major causes of preventable deaths in North Carolina were tobacco use and lack of diet/physical activity. Yet, he pointed out, automobile accident deaths occupied more attention from media.

He provided demographic data concerning plan membership, type of plan, average of members etc. Membership by gender shows nearly 70% of the members are women.

Approximately 50% of the members of the plan have some sort of chronic condition. Responding to Mr. Stone's question of chronic versus acute/catastrophic, Walker said an acute condition lasts less than a year while chronic was ongoing and catastrophic was an acute condition with either ultimate improvement or death.

Mr. Walker explained that some of data in his report was provided from the Behavioral Risk Factor Surveillance Survey. Ms. Adcock asked how the figures might match up with data from the Centers for Disease Control. Casey Herget with the State Health Plan explained that the data provided here was specific to North Carolina and the State Health Plan.

Over 2004 and 2005 the State Health Plan began working to slow down the increased costs for members with chronic disease. The vehicle for this is called Health Smart run by a company called Health Dialog. The program involves coaching through contact with members to see if they will change their behavior thus change their risk scores thereby costing the Plan less money. Dr. Walker provided anecdotal information about the program. Representative Braxton asked the cost for the Plan to use Health Dialog and the extent of the company's work. Health Dialog is paid @ \$28 million per year. The Plan clears expenses and receives @ \$18 million on top of that. Dr. Walker said an incentive program will be started through the HealthSmart in January to encourage members to be involved in case management with gift cards for those who complete the program.

In response to a question from Mr. Stone, Dr. Walker said less than 5% of the Plan members had completed a health risk assessment.

This was followed by statistics concerning the rationale for choosing tobacco use and weight issues as the target of the wellness initiative.

Mr. Stone asked about cost factors if only the smoker in a family was assigned to the 70/30 plan and not the entire family. Dr. Walker said he had no figure, but he said the challenge that would be faced, if a tier system such as Mr. Stone suggested, would involve changing the various payroll systems used in state government. He estimated it could take as long as five years to adjust payroll withholding etc. across the various agencies. Dr. Walker noted that while claims systems were based individually, the enrollment system with premiums is based on the enrolled unit and collected through the variety of payroll operations.

In another service provided by Health Dialog, data is developed to analyze lifestyle factors and sociodemographic profiles to allow messages to be tailored to various member-segments of the adult population. During this part of the presentation, Dr Walker

urged the group to remember the importance of keeping the healthy members in the Plan at a healthy level. And as he put it, "if one member gains a pound, then another member better lose a pound" so that the level does not climb overall. Keeping the people who are at the low level of weight at that low level will save health care costs. Dr. Walker said keeping healthy people in a healthy state would save more in costs than trying to "bend" the lifestyles of other members.

Dr. Walker explained further sections of the data showing such factors as emergency room use, in-patient use, socioeconomic status, education and clinical factors.

The State Health Plan smoking cessation begins July 1, 2010 with all members on the 70/30 plan, unless they check the application as a non-user of tobacco or are enrolled in a smoking cessation plan. The weight control initiative begins in 2011 with the target of a body mass index of 40. The Session law requires verification of the tobacco usage restrictions, but no verification on weight.

Mr. Stone expressed concern that many low income members did not have access to computers so that they could participate in the Health Risk Assessment to allow the Plan to address their needs. He suggested that all members should be required to take the assessment.

Representative Braxton asked what programs would be offered to members who were affected by the weight management component.

(At this point, Senator Apodaca needed to attend another meeting. He left saying the State Health Plan did a great job identifying where the money goes, but needed to do a better job in bringing money in, specifically younger members in the plan.)

To that end, Dr. Walker said to get dependent coverage increased would require the Plan to subsidize the coverage by 70% to 75% to bring in "nearly all the people on the Plan that you would desire to have on the Plan."

Dr. Walker said some agencies have work site health capability to work with wellness programs and other facets of employee health.

In the tobacco cessation program, he said participants would be given free nicotine patches, there would be access to the Quitline and FDA approved smoking cessation medications are covered by the Plan.

Ms. Adcock raised the point of cost of cessation drugs. She said providing free drugs to those who wish to stop using tobacco would bring savings that would outweigh the costs. Dr. Walker said the Plan would look at that.

Concerning weight-loss drugs such as Meridia and Xenical, Dr. Walker said people tend not to stay on them because they are not a long-term fix. He said they are effective, but difficult to tolerate. Ms. Adcock suggested increasing the nutrition visits per year for people who are obese and wish to lose weight.

In further discussion, Dr. Walker said there were some state agencies which showed they do a poor job encouraging healthy lifestyles for employees because those workers have very high health care costs. He suggested that the Department of Correction was in this category. He wants to set up a community clinic in the Butner area because the members there don't go to the doctor unless it is absolutely necessary and then it is emergency room or urgent care offices.

Mr. Stone compared State Health Plan with general population saying that higher educational levels usually meant better health conditions.

Representative Braxton asked if the state could hire a physician for some areas. Dr. Walker said that state law prohibits competition with private business. So he said the Plan has approached the provider community with the idea of contracting personnel and services.

Ms. Ransome brought up the Community Care Network as providing some of the support. Dr. Walker said the major barrier was the cost of the co-pays with the State Health Plan.

Ms Adcock said that providing services on-site or closer to members was a point to consider. Further she said if state law prohibited competition with private enterprise preventing the hiring of a physician then perhaps the law should be changed.

Dr. Walker provided insight into various wellness programs and sites that members could use. He said the challenge is getting members to engage in the programs. His opinion is that the mechanism must be brought to the work place. Dr. Walker said that the State Health Plan could only provide the various wellness services, other than the upcoming tobacco cessation and weight loss initiatives, to state agencies. The agencies can decide not to participate in some programs.

He also spoke of the question of various incentives for participation, i. e. should the Plan use more incentives such as t-shirts, tote bags and the like? He said such a decision would need guidance from the legislature.

In summary, Dr. Walker said the overall effort is aimed at saving money for members and taxpayers, strengthening the Plan through optimal health for members and lower out of pocket costs.

Representative Folwell asked about a previously referenced statistic that 35% of members did not take medications as prescribed. Tracy Stephenson from the State Health Plan explained that the figure related to chronic disease patients who tended not to adhere to the prescription protocol longer than six months. She noted that there had been some lowering of co-pays and the Plan was starting a pilot program to improve the adherence rate.

Representative Folwell also asked about the discovery that in one state agency 18% of the males above a certain age suffered from chronic conditions such as diabetes, pre-diabetes, hypertension—but had not been diagnosed. Dr. Walker said the discovery came during a health fair when a “shocking number” of males above a certain age did indeed have those previously undiagnosed conditions.

Representative Folwell said he was concerned with the future of primary care physicians as a part of the health care picture. He also said there should be some sort of consequence for members who used the Plan fraudulently.

Mr. Feezor said the various parts of government needed to be re-engaged with the Plan and take a more involved role. He suggested that units of government could use employee profiles to make the unit aware of the per-member cost of the agency.

Mr. Feezor also asked about feedback that might come after a health coach deals with a patient. Dr. Walker said the feedback is given to the primary care provider about what the coach is doing, but there was not a Current Procedure Terminology (CPT) code to allow a physician to charge for the service. In some instances, he said this means that the patient himself is the manager of his own health care, not a physician. He said there were motions toward better compensation for primary care physicians in these instances.

Dr. Walker said he believes there should be better availability for acute care at the work site and the use of nurse practitioners in place of the primary care physician who is not being compensated financially. He told the members that while better health would produce savings that the major benefit would be from greater productivity from a healthier work force.

Mr. Feezor asked if the Plan could provide agencies with risk factor assessment information. Dr. Walker said that information could be provided. Mr. Feezor went on to say that agency heads could see how their employees fit in the health scheme of things and thus into productivity. Ms. Adcock said departments should embrace the idea of work-site health opportunities as a measurable way to gain productivity.

Ms. Simmons who teaches in the Guilford County Schools spoke of two cases of teacher assistants, one of whom has a gross monthly just over \$1000, is paying \$500 per month for her husband's coverage that he has not used, the other assistant continued to work despite an ankle injury because she couldn't afford to take a day off to seek medical attention. Ms. Simmons referred to these women as the people who are behind the numbers that may be associated with the Plan.

Mr. Stone asked if there was comparative data to match North Carolina with another state plan with similar demographics. He said that when the benefits are calculated, who the plan members are must also be factored. Dr. Walker said the information for 48 states is available on line. Co-Chair Representative Holliman asked if a set of comparative data could be made available.

Mr. Stone said that often state employees with low incomes would be leaving one job each day and going directly to another with little food choice other than fast food with the inherent contribution to obesity. He believes a multi-faceted approach including nutrition is necessary. He also wanted to know if food preparation and actual food preparation demonstrations would be provided. Dr. Walker said he would have to look into that. He went further to say that the State Health Plan can't solve these issues by itself, that agency buy-in is necessary.

Representative Braxton asked Mr. Stone if SEANC was doing things to make members aware of health issues. Mr. Stone said that Health Plan articles were made available in news letters and presentations. He said the problem is how to structure the wellness initiative so that the programs (tobacco cessation and weight loss) are not punitive and considered to better for the individual's own health.

Representative Folwell asked for clarification on the exodus from the plan of young, healthy families. Dr. Walker cautioned that the exodus could not be considered necessarily as 'young' families, since he did not have that information. He did say that the Plan was insuring fewer people due in part to lay-offs, etc. He said the number of people seeking COBRA coverage had doubled. (Consolidated Omnibus Budget Reconciliation Act allows employees who are laid off to purchase group rate coverage for certain periods of time.) He said he would get further demographic information about the members who have been leaving the Plan.

Dr. Walker went on to say that a member could be healthy at 60 or not so healthy at 60 and that the goal was to make people healthy at any age. He said the need was to ingrain the idea of good health into peoples' lives. He added that schools needed to be involved in the goal of good health.

After Dr. Walker's presentation, Representative Folwell praised the information as putting a face on the problem. He reiterated his support for putting the Plan on a calendar year basis. He said his experience had been that those members who have been leaving the Plan are young, healthy families. Part of the problem he said is that members do not know how much their coverage will cost until the General Assembly passes the budget. As he put it, "We have no opportunity to compete for the business." Co-Chair Representative Holliman said that issue would be addressed.

Representative Holliman said the Task Force would meet again in January.

The Committee adjourned at 10:33 a.m.



Representative Hugh Holliman
Co-Chair, Presiding.



Carol Bowers, Commission Clerk



Ted Harrison, Minutes



State Health Plan and CWI Overview

Blue Ribbon Task Force

December 2, 2009



Objectives

- To provide key health statistics and background information about the State Health Plan membership
- To clarify the goals of the Comprehensive Wellness Initiative (CWI) and describe how it works
- To provide information on healthy living resources and benefits
- To answer questions and address concerns about the initiative

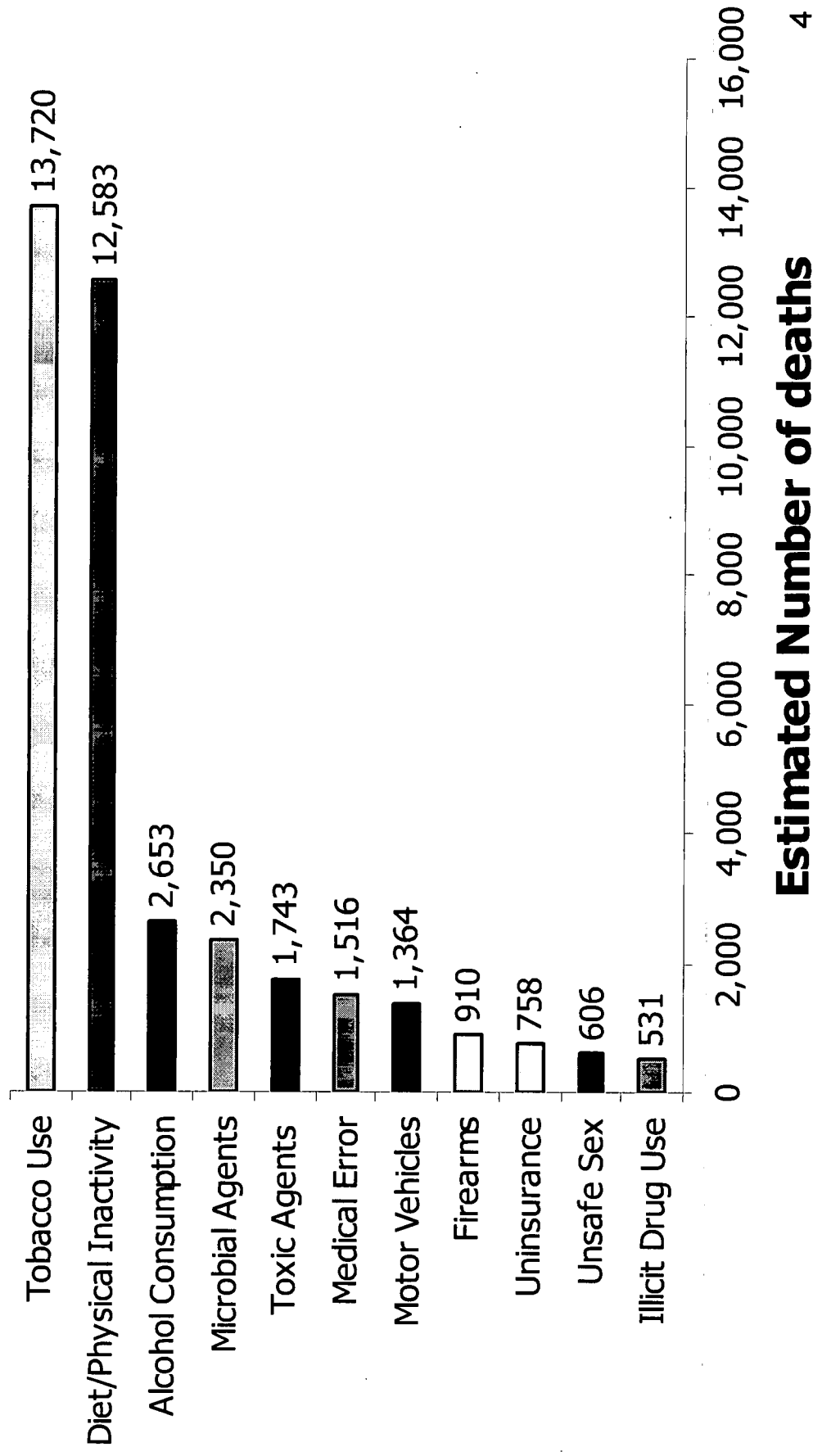
National Statistics

- 70% of deaths in the U.S. are related to chronic disease*
- Treating patients with chronic diseases accounts for 75% of health care spending**

* <http://www.cdc.gov/nccdphp>

**<http://www.fightchronicdisease.org>

Preventable Causes of Death in North Carolina (2007)



Snapshot of State Health Plan Membership:

- 661,000 members
- Average age is 46.41 years
- 79.1% Enroll in Employee Only
- 80/20 Plan Predominant
- Employee/Children Plan: Children per Employee = 1.74
- Family Plan: Dependents per Employee = 2.84

Snapshot of Membership

Actives, Non-Medicare Retirees and Dependents

Demographics Health/Wellness Stats

- 69% female • 12% use tobacco*
- 13.2% under 30 • 32% are obese**
- 18.3% 30 to 39 • 50% have a chronic
- 68.5% 40 or over or catastrophic illness***

* BRFSS - State Health Plan has ~12% of members who use tobacco

** Dr. Eric Finkelstein, Research Triangle Institute Obesity Cost Calculator, 2009

*** Aon: Clinical risk analysis, Dec 2008

Plan Statistics

- NC HealthSmart chronic disease management programs show results:
 - Slowed down the rise in cost among members with chronic disease*
 - \$18 million saved in 2007*
 - 2:1 return on investment to date**
- Plan continues to focus on wellness, disease management and prevention

* State of Member Health Report 2009

**Aon: Clinical risk analysis, Dec 2008

Why Tobacco and Weight?

- Tobacco use and unhealthy diet/physical inactivity are leading causes of preventable deaths in North Carolina.*
- Plan estimates 54,000 - 67,000 members use tobacco products**
- Plan estimates 25,000 members have a Body Mass Index of 40 or more ***

* North Carolina State Center for Health Statistics, 2002; NC Medical Journal, July/August 2002, Vol.63, #4, Makdad, 2004 & NC Mortality 2006

** Behavioral Risk Factor Surveillance Survey (BRFSS) (2008) -- State Health Plan has 12% - 15% of members who use tobacco

*** Dr. Eric Finkelstein, Research Triangle Institute Obesity Cost Calculator, 2009

Costs

- Plan estimates an average excess cost of
 - \$2,660 per member/year for those using tobacco
 - \$1,000 per member/year for those with a Body Mass Index (BMI) of 35 or more.
- Plan Actuary estimates that CWI will save the Plan \$13 million in 2010/2011 through increased cost sharing related to tobacco use
- Tobacco users in the 70/30 plan will pay on average \$40 per month more in cost sharing than they would have in the 80/20 plan

Body Mass Index (BMI)

Examples:

1. a person who is 5'5" tall and weighs
 - 145 lbs has a BMI of 24.1
 - 175 lbs has a BMI of 29.1
 - 225 lbs has a BMI of 37.4
 - 250 lbs has a BMI of 41.6
2. a person who is 6'2" tall and weighs
 - 175 lbs has a BMI of 22.5
 - 225 lbs has a BMI of 28.9
 - 300 lbs has a BMI of 38.5
 - 325 lbs has a BMI of 41.7

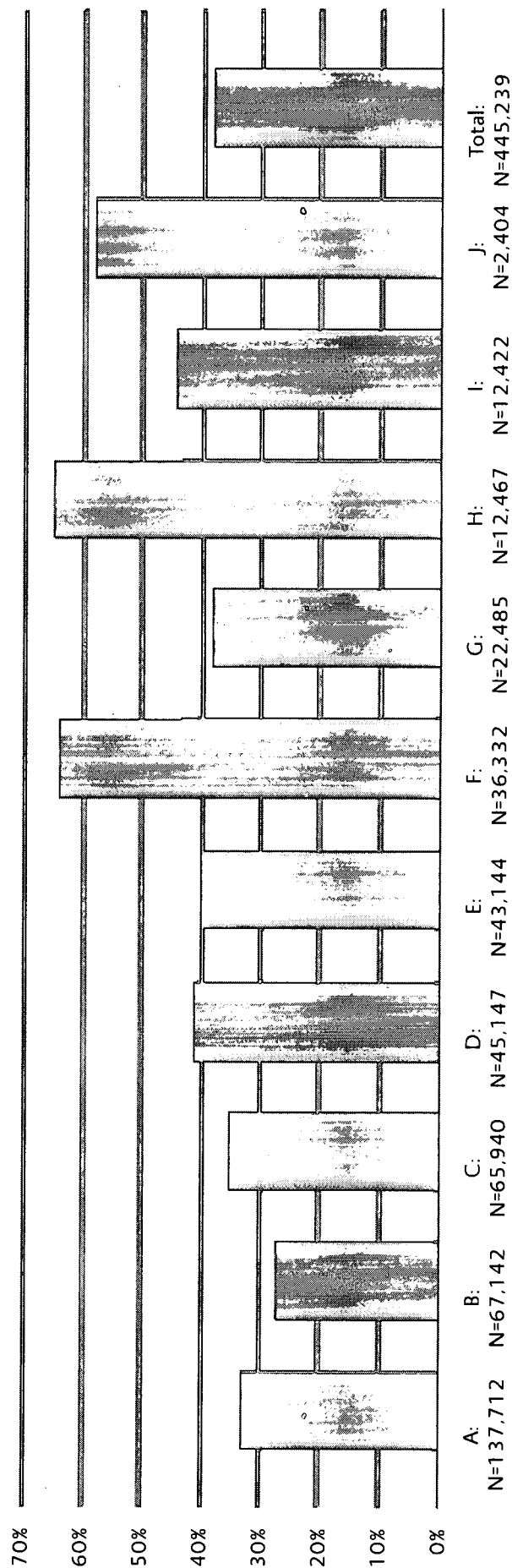
Source: National Heart, Lung and Blood Institute, www.nhlbiupport.com/bmi

Lifestyle Profile

High Likelihood of Obesity Comparison

Analysis shows that obesity can lead to the development of chronic conditions.

High Likelihood of Obesity Distribution by Community Cluster



All members included in analysis are over age 18 and have a non-Medicare status (August 2009).

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Group F

Sociodemographic Profile

The majority of members in this group are over the age of 55, with an exceedingly high rate of diabetes. Members are characterized by below average income, average rate of home ownership, poor diets of convenience foods, and a penchant for sweets. Inactive lifestyles likely contributes to high medical costs; while a higher than average rural index may mean less access to specialist care.

Group F: N=36,332				
Sociodemographics	Stats	Index	Sociodemographics	Stats
Average Age	55	1.20	% Without High School Diploma	22%
% Age 18-34	3%	0.13	% With High School Diploma	29%
% Age 35-54	39%	0.83	% Greater than High School Diploma	49%
% Age 55-64	54%	1.93	Average Median Household Income	\$ 42,634
% Age 65+	4%	2.00	% Household Income Less than \$25K	29%
% Age Less than 18	24%	1.00	% Household Income Greater than \$75K	19%
% Female	54%	0.83	% Household Owner	75%
Average Members per Household	1.48	0.86	Rural Area Indicator	13%
				1.18

Group H

Sociodemographic Profile

The majority of members in this group are older than Group F, with higher prevalence rates of asthma, CHD, heart failure, COPD, back pain, joint pain, depression, and hypertension. Members are characterized by high rates of PCP visits and exceedingly high rates of specialist and emergency room visits. Very high rates of inpatient admissions likely contribute to high total medical costs.

Group H: N=12,467

Sociodemographics	Stats	Index	Sociodemographics	Stats	Index
Average Age	57	1.26	% Without High School Diploma	21%	1.11
% Age 18-34	1%	0.04	% With High School Diploma	28%	1.04
% Age 35-54	28%	0.60	% Greater than High School Diploma	50%	0.93
% Age 55-64	64%	2.29	Average Median Household Income	\$ 43,766	0.95
% Age 65+	7%	3.50	% Household Income Less than \$25K	29%	1.07
% Age Less than 18	24%	1.00	% Household Income Greater than \$75K	20%	0.91
% Female	55%	0.85	% Household Owner	75%	1.01
Average Members per Household	1.43	0.83	Rural Area Indicator	12%	1.09

Group J

Sociodemographic Profile

The majority of members in this group are female, with an average age of 47. Members are characterized by having the highest predicted medical costs, along with the highest rates of emergency room visits and inpatient admissions. Struggles with both physical and mental health likely contribute to the overwhelming feeling little can be done to improve their situation.

Group J: N=2,404				
Sociodemographics	Stats	Index	Sociodemographics	Stats
Average Age	47	1.03	% Without High School Diploma	23%
% Age 18-34	19%	0.83	% With High School Diploma	29%
% Age 35-54	48%	1.02	% Greater than High School Diploma	47%
% Age 55-64	29%	1.04	Average Median Household Income	\$ 39,963
% Age 65+	4%	2.00	% Household Income Less than \$25K	32%
% Age Less than 18	24%	1.00	% Household Income Greater than \$75K	17%
% Female	66%	1.02	% Household Owner	69%
Average Members per Household	1.48	0.86	Rural Area Indicator	12%
				1.09

Clinical Profile

Condition Comparison

Clinical Factor	Group F: N = 36,332	Group H: N = 12,467	Group J: N = 2,404
	Index	Index	Index
% with Chronic Condition	6.60	6.67	3.93
% Asthma	3.20	5.80	3.60
% Coronary Heart Disease	5.33	12.33	7.00
% Heart Failure	4.41	19.87	15.45
% Diabetes	8.11	7.67	4.11
% Chronic Obstructive Pulmonary Disease	4.00	13.00	8.00
% Back/Lumbar Pain	1.00	2.44	3.33
% Joint Pain	1.18	2.73	3.36
% Depression	1.00	1.86	3.57
% Hypertension	2.71	3.21	2.71

Clinical Profile

Risk and Utilization Comparison

Clinical Factor	Group F: N = 36,332		Group H: N = 12,467		Group J: N = 2,404	
	Stats	Index	Stats	Index	Stats	Index
% High Risk for Tobacco Use	n/a	1.00	n/a	1.06	n/a	1.94
% High Risk for Obesity	n/a	1.68	n/a	1.71	n/a	1.53
Average Annual PCP Visits	n/a	1.66	n/a	2.34	n/a	2.74
Average Annual Specialist Visits	n/a	0.82	n/a	5.20	n/a	4.00
Average Annual Emergency Room Visits	n/a	0.70	n/a	2.85	n/a	30.60
Average Annual Inpatient Admissions	n/a	1.25	n/a	7.50	n/a	27.75
Average Annual Inpatient Admission Days	n/a	1.00	n/a	7.90	n/a	33.70
Average Annual Prescription Drug Cost	\$ 1,689	2.07	\$ 3,624	4.44	\$ 2,738	3.35
Average Total Cost (Past 12 Months)	\$ 4,945	1.28	\$ 20,613	5.32	\$ 37,349	9.64
Average Predicted Cost (Next 12 Months)	\$ 5,504	1.69	\$ 14,584	4.49	\$ 17,467	5.38

Comprehensive Wellness Initiative

- State Health Plan will implement the CWI as legislated by Senate Bill 287 (Session Law 2009-16)*
- Developed to help members succeed in quitting tobacco use, achieve and maintain a healthy weight and to lower the costs associated with the treatment of health conditions caused or complicated by smoking and obesity
 - Tobacco cessation component starts July 1, 2010
 - Weight management component starts July 1, 2011 (with BMI value of 40 or greater)

CWI does **not** include members who have Medicare as primary coverage

*<http://www.ncleg.net/Sessions/2009/Bills/Senate/PDF/S287v8.pdf>

Comprehensive Wellness Initiative

- All members will be enrolled in the 70/30 Plan
- Members can qualify for the 80/20 Plan if they and their dependents for Plan years beginning in 2010 and going forward:
 - Don't use tobacco
 - Are actively trying to quit tobacco and for Plan years beginning in 2011:
 - Have a healthy weight, as defined by BMI
 - Are actively trying to lose weight
 - Have a medical condition that prevents them from attaining the specified weight range as certified by their physician
- Members must self-report during annual enrollment if they want to apply for 80/20 Plan. Session law requires a verification process for tobacco use.

Important Points

- Premium discounting was not an option for the Legislature because State employees do not contribute to their premium
- All members, regardless of their tobacco use and BMI status may access the 80/20 Plan by engaging in tobacco cessation and/or weight management activities
- On average, Plan members who are enrolled in the 70/30 Plan will pay about 9% more than members on the 80/20 Plan. Dependent premiums are lower, but copays and deductibles are higher

Employee Privacy

- Member privacy is an important focus for the Plan.
- The Plan and the North Carolina Attorney General's Office have reviewed and addressed the federal and state laws applicable to the CWI.
- The Plan's CWI complies with all state and federal laws and does not discriminate.
- The Plan has ensured that all CWI processes and procedures are HIPAA-compliant.

CWI Benefits & Supports

- Tobacco Cessation
 - NC Tobacco Use Quitline
 - Coaching & free patches
 - Provider Counseling & Medications
- Weight Management Benefits
- NC HealthSmart Health Coaches
- NC HealthSmart Personal Health Portal
- Blue 365 Discounts
- Worksite Wellness

Tobacco Cessation Supports

- **NC Tobacco Use Quitline – 1-800-QUIT-NOW**

Open 8:00 am – 3:00 am, 7 days a week in English/Spanish

Partners: NC Division of Public Health & Health and Wellness Trust Fund (HWTF)

- **Telephonic tobacco cessation program**

- Combining counseling & medication increases quit success.
- Quit Coaches® help members who smoke or use other tobacco products set goals, understand medication, etc.
- Plan covers two 8-wk multiple call programs/member/lifetime

- **Free over the counter, generic nicotine replacement patches (NRP) available January 2010**

- **NEW:** Members can have 4 months of patches per Plan year for a max of 2 years without a prescription
- Coach determines dosage; those with medical conditions need physician permission; NRP mailed to home

Tobacco Cessation Medical & Pharmacy Benefits

- Tobacco cessation counseling by a primary care or behavioral health provider is covered.
- FDA-approved tobacco cessation medications are already covered, including:
 - Bupropion (*generic for Zyban*)
 - Nicotrol Nasal Spray
 - Nicotrol Inhaler
 - Varenicline (*Chantix*)
 - Nicotine Patches with prescription:
 - \$10 generic copay
 - \$5 over the counter generic copay
- Branded medications will move from the Preferred Pharmacy Tier (\$55) to Non-preferred Tier (\$35) January 1.

Weight Management Medical & Pharmacy Benefits

- All Plan members and dependents will receive 4 covered nutrition visits at a primary care copay per Plan benefit year.
- Previously, only members with a diagnosis of diabetes received 6 covered nutrition visits at zero copay. This benefit will not change.
- FDA-approved weight-loss medications are a covered pharmacy benefit *currently* with prior authorization. Beginning January 1, 2010 the Plan will remove prior authorization from the following weight-loss medications:
 - benzphetamine (*Didrex®*)
 - diethylpropion (*Tenuate®*; *Tenuate Dospan®*)
 - phendimetrazine (*Bontril®*; *Various*)
 - phentermine (*Ionamin®*; *Various*)
 - sibutramine (*Meridia®*)
 - orlistat (*Xenical®*)
- Brand name weight-loss medications Meridia and Xenical, have moved from the Preferred Pharmacy Tier (\$55) to Non-preferred Tier (\$35)

CWI Supports for Members

NC HealthSmart Health Coaches

- Specially trained professionals, such as nurses, respiratory therapists or dietitians, who are available to answer questions concerning the health of members or their family.
- Health Coaches are available at no cost, 24 hours a day, 7 days a week.
- They provide members with education, support and guidance in making important decisions about their health.

CWI Supports for Members

NC HealthSmart Personal Health Portal

- Offers timely information and support on lifestyle issues such as nutrition, weight management, smoking cessation, and stress management.
- Provides support for chronic condition management (e.g., asthma, diabetes, back pain), and other health issues.
- Includes a Personal Health Assessment (PHA) and a Personal Action Plan: members gain a better understanding of factors influencing their health, both positive and negative, and are provided strategies for improvement.

CWI Supports for Members

Personal Health Portal - Windows Internet Explorer

https://www2.thorlogcenter.com/cgi-local/index.cgi

File Edit View Favorites Tools Help

Personal Health Portal



Quick links

Health news

Contact a health coach

Bookmark your health coach

Healthwise Knowledge base

Healthwise Spanish health guide

Healthwise family research

Research measures

Even if you're not a doctor, you can get a health coach to help you learn more about your health, symptoms, and how to take care of them.

Update

Welcome

Welcome to the North Carolina HealthSmart Personal Health portal — a resource to help you make the best health care decisions for you and your family.

Your NC HealthSmart Personal Health Portal offers timely information and support on health issues such as nutrition, weight management, smoking cessation, stress management, chronic condition management (e.g., asthma, diabetes, back pain), and much more!

NC HealthSmart Personal Health Assessment
Take the PHA and get your Personal Action Plan today! It will tell you the changes you can make to have the greatest impact on your health. Click here to get started now.

Health Coach
Tools for partnering with a Health Coach, secure message center, and Health Coach bookshelf.

Health Information
Healthwise® KnowledgeBase medical encyclopedia (English) and Spanish/Español), medical decision-support resources, and personal bookmarks.

Health tools
Personal Health Assessment, interactive tools, medication list, and symptom diaries.

Resources
Recommended additional health and health care resources.

My profile
Your personal settings and preferences.

About us
Site features, philosophy and purpose.

Stroke Signs and Prevention
Everyone should know how to spot the symptoms of a stroke, and know what to do if symptoms develop. To help you make sure you keep your blood pressure under control, avoid cigarettes and alcohol, and get regular physical activity.

27

100% Internet

Worksite Wellness Initiatives

Eat Smart Move More Weigh Less (ESMMWL):

- ESMMWL partnership with Division of Public Health and NC Cooperative Extension in (5) counties having the most dense population of state employees (Wake, Pitt, Orange, Guilford and Mecklenburg).
- ESMMWL is designed to be delivered in group settings and is an ideal curriculum for worksites. ESMMWL groups meet once a week for 15 weeks for a 45- to 60-minute educational/motivational program and personal goal assessment.
- Preliminary evaluation of a previous ESMMWL program reveals 440 participants (25 counties) achieved an average weight loss of 9 pounds over the course of the program.

Worksite Wellness Initiatives

Worksite Wellness Toolkit:

- The Plan, in conjunction with the Division of Public Health, Physical Activity & Nutrition Branch, provides worksite wellness committees with valuable resources. Below are links to six (6) turnkey programs that provide an overview, step-by-step instructions and ready-made supporting materials to assist with wellness and healthy living activities. These include:

Solving the Puzzle of Moving More
Stress Less Challenge
Scavenger Hunt

Smart Fuel
Ten Minute Challenge
Smart Moves

- These modules include things such as

Newsletters
Program completion certificates
Promotional posters

Tracking logs
Sign-up sheets

Blue365 – Diet Discounts & Online Resources

E-Diets

Offers more than 20 different diet plans to choose from. Plus, Blue365 members enjoy special exclusive discounts: 25% off any online diet or 15% off the eDiets Meal Delivery program.

Kronos

Lose Weight - Gain Control. More motivation, more energy, more confidence. Kronos Weight Management helps members take control and learn to make choices that create lasting control. Members save \$40.

Nutrisystem

Members save an extra 12% on any 28-day program order and get an extra week of food.

Online Resources

- Daily calorie counter
- Nutrition resources and links geared to individuals and groups

Blue365 – Fitness Discounts

- **Cardiovascular Workout – 3 Days per Week Cardiovascular Program**
- **Curves Discount** - Curves is giving Blue365 members an exclusive offer on their workout that works your arms, legs, heart and your whole body – burning up to 500 calories in 30 minutes. Members can join the club of their choice for 15% off monthly club dues and 60% off the initial service fee.
- **SNAP Fitness** - Snap Fitness, with convenient locations near home, work and worldwide, offers members a 50% enrollment fee discount, plus 5% off monthly dues, 10% off personal training and many other FREE bonus perks. More than \$300 in value! Members enjoy a better experience and better results – at a better price!

Get Active With these activities and virtual exercise aids

- **12-Week Cardiovascular Workout - 3 Days per Week Cardiovascular Program**
This program helps burn more calories by providing a periodized workout plan with personalized target heart rate recommendations. This particular option is for individuals who exercise 3 times per week.
- **12-Week Cardiovascular Workout – 5 Days per Week Cardiovascular Program**
This program helps burn more calories by providing a periodized workout plan with personalized target heart rate recommendations. This particular option is for individuals who exercise 5 times per week.

Desired Outcomes

- The Plan, members and taxpayers realize cost savings
- Health status is improved so that the Plan is strengthened long-term
- Members and their families succeed in reaching optimal health
- Out of pocket costs for all Plan members are reduced

What's Next...

- I welcome your questions and concerns.
- Also, please encourage your employees to visit our Web site @ www.shpnc.org for CWI content, FAQs and, if desired, to provide feedback via the Home Page.
- Thank you, on behalf of the State Health Plan.



NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE BUILDING
RALEIGH NC 27601

December 28, 2009

MEMORANDUM

TO: Members, State Health Plan Blue Ribbon Task Force

FROM: Rep. Hugh Holliman, Co-Chair
Sen. Tony Rand, Co-Chair

SUBJECT: Meeting Notice

The State Health Plan Blue Ribbon Task Force Committee will meet on the following date:

DAY: Thursday
DATE: January 21, 2010
TIME: 9:00 am
LOCATION: Room 1228 Legislative Building

If you have any questions concerning this meeting or can not attend, please contact Carol Bowers at 919-715-0873 or Hollimanla@ncleg.net

Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

Thursday, January 21, 2010

9:00 a.m.

Legislative Building, Room 1228/1327

- I. Welcome, Introductions, and Remarks**
Representative Hugh Holliman, Co-Chair
- II. Approval of Minutes**
- III. Testing for Tobacco Usage by Plan Members**
Committee Discussion
- IV. Five -year Projection of Plan's Financial Requirements
Assuming Current Benefit Levels**
*Jack Walker, Executive Administrator
State Health Plan*
- V. Select Follow-up Items Requested by Task Force Members**
*Lacey Barnes, Deputy Executive Administrator
State Health Plan*
 - A. Reduce Cost Savings to the State Health Plan if only Individual Plan
Members Affected by the Tobacco Cessation and Weight Management
Requirements are Moved to the PPO Basic 70/30 Plan as Opposed to all
Family Members**
 - B. Analysis of "Exodus" of Dependents from the State Health Plan**
- VI. An Overview of Actuarial Studies Being Conducted by the
State Health Plan Based on the Priorities of the Task Force**
*Carol Durrell, Director of Product Development
State Health Plan*
- VII. Task Force Discussion**
- VIII. Future Meeting Dates**

HOUSE PAGES

State Health Plan

NAME OF COMMITTEE _____

DATE

1/21/10

1. Name: _____

County: _____

Sponsor: _____

2. Name: _____

County: _____

Sponsor: _____

3. Name: _____

County: _____

Sponsor: _____

4. Name: _____

County: _____

Sponsor: _____

5. Name: _____

County: _____

Sponsor: _____

HOUSE

SGT-AT-ARM

SENATE

1. Name: MARVIN LEE

JOY ZICHETT

2. Name: CARLTON HARRIS

3. Name: _____

4. Name: _____

VISITOR REGISTRATION SHEET

State Health Plan
Name of Committee

1.21.2020
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

<i>Erica Baldwin</i>	<i>SEANC</i>
<i>Wendy L. Greene</i>	<i>SHP</i>
<i>John Hammond</i>	<i>Board of Trustees SHP</i>
<i>Chris Shoffner</i>	<i>Citizen</i>
<i>Margaret V. Freeman</i>	<i>NCAE</i>
<i>Cecil Banks</i>	<i>NCAE</i>
<i>Kathryn Joyce</i>	<i>NCAEA</i>
<i>Matt Farrell</i>	<i>TPG</i>
<i>Jim Nichols</i>	<i>Q-Results</i>
<i>Lillian Robinson</i>	<i>NCEMA</i>
<i>Patricia Buff</i>	<i>Nelson Mullins</i>

VISITOR REGISTRATION SHEET

State Health Plan

Name of Committee

1. 21. 2010

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

DAVID BARNES	Poyner Spruill
Meg R. D.	Capital Realty
Andy Ellen	NCKump
DANIEL BAUM	TROUTMAN SANDERS
Mark Fleming	BCBSNC
Erin Schoellpely	UNC-GA
Bob Jackson	AARP
Bob Heath	McGuire Wood
Ed Imhofe	Brooks Bremer
Harry Lyda	MWC

VISITOR REGISTRATION SHEET

State Health Plan

Name of Committee

1.21.2010

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Larry Presnell	NC Retired School Personnel
Ken Melton	K.M.A.
Ken Wright	B.C.B.S.
Amy White	NC Med Society
Joel Maynard	GRM'S ASSOC
Kevin Fitzgerald	UNC

MINUTES

BLUE RIBBON TASK FORCE ON THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

Thursday, January 21, 2010

9:00 a.m.

Room 1228/1327 Legislative Building

The Blue Ribbon Task on the State Health Plan for Teachers and State Employees met Thursday, January 21, 2010 at 9 a.m. in room 1228/1327 of the Legislative Building. Co-Chair Representative Hugh Holliman presided. On motion of Senator Garrou the minutes of the December 2, 2009 meeting were approved.

PRESENTATIONS

Testing for Tobacco Use by Plan Members

Dr. Jack Walker, Executive Administrator for the State Health Plan introduced, Ann Rogers, Director of Integrated Health Management for the SHP who is in charge of testing.

Ms. Rogers said the request for proposal is being developed for a testing vendor. The vendor will be administering the statewide testing and collecting the physician verification for members who are in smoking cessation programs. The RFP seeks a vendor to provide testing at sites within 15 miles or 30 minutes travel time of the member's home. Members of the SHP had been concerned about earlier consideration for testing at the work site, so the SHP staff opted for testing away from the work place. The RFP will be released in February with the contract to be let in April.

The sample will consist of members and spouses not covered by Medicare selected after enrollment. There will be a saliva test for the presence of cotinine, and a secondary test will be offered at that time if the test is positive for the substance. (Cotinine is a metabolite of nicotine and is an anagram of nicotine.)

Once the vendor is in place members will be provided information about the testing process.

Senator Garrou asked how many members could be considered as tobacco users. Ms. Rogers said the Plan was using a figure of 15% of the membership based on the Behavioral Risk Factor Surveillance Survey of the membership. The overall statewide percentage of users is about 20%. Ms. Rogers said the lower membership figure could be due to the large number of public school teachers and others who work in smoke-free schools.

Co-Chair Representative Holliman asked what would happen if there was no testing. Ms. Rogers said Indiana does testing and has found that members were not necessarily truthful about their testing. Indiana has increased its testing and implemented

consequences for those who falsified their status. Indiana found twice as many tobacco users after they increase their testing. Co-Chair Holliman asked about the effects of a member's positive test on the rest of the family covered by the SHP. Ms. Rogers said that since the SHP uses a unit enrollment system the subscriber's tobacco use status drives the plan qualification. At initial enrollment all non-Medicare members will be enrolled in the 70/30 plan unless they attest to qualifying for the 80/20 plan. If a member/family is moved to the 70/30 plan due to failing the tobacco test that change would be in effect for the remainder of the benefit year and the next benefit year. Ms. Rogers said that while some states terminate employees who falsify their status, North Carolina opted for a more moderate consequence. She said that the minimum testing would involve 2400 members, but that the RFP is seeking cost estimates for as high as 10,000 tests. The 2400 number is about ½ of 1% of the SHP membership.

Mr. Stone asked if the off-site testing would be considered work time. Ms. Rogers said this issue was discussed in a meeting with state agency Human Resource directors. The SHP would like to get a sense of what the various employing agencies feel about this.

Lacey Barnes, Deputy Executive Director of the SHP said that the Office of State Personnel position is that the testing could be done on state time insofar as members who are covered under that Office. However she noted that teachers who fall under the various school systems do not come under the OSP. Mr. Stone also asked what the total cost would be after adding employee time, travel and testing expenses. Ms. Barnes said that since the SHP would not be paying for time and travel there was not way to calculate the total cost as he asked. Ms. Rogers said that testing hours could be from 5 a.m. until 10 p.m. Actual site mileage will be refined. Member addresses on files are home addresses and not work addresses so the current 15 mile radius is based on those the home locations.

Representative Braxton asked how long a person would have to stop smoking ahead of time so as to pass the test. Ms. Rogers said she would hesitate to answer lest people would try to beat the test. She said the SHP was looking for the most reliable most sensitive test. There will also be a secondary test available.

Ms. Simmons asked a similar question about the time between smoking and testing. She also asked that the SHP website be updated. Ms. Rogers said there was a deadline to get the testing information corrected on the website. Again Ms. Rogers stressed that the testing would be for SHP members and covered spouses. The attestation forms for non-smokers will be part of the information in the spring enrollment package. The test has varying levels of sensitivity; the SHP test will be set for a regular smoker which would eliminate second hand smoke as a factor.

Dr. Walker said if someone stopped smoking on or by June 30, 2010 and was tested in August; the person would register as a non-smoker.

Senator Garrou asked how the cost evaluation would be made. Dr. Walker said the first year anticipated cost is less than a half million dollars, and the total savings are estimated to be \$13 million, net of the testing cost.

Mr. Stone asked about smokers who enter smoking cessation programs and quit, but start again. Ms. Rogers said the attestation program will allow non-smokers and those in a smoking cessation program to report that status. The testing pool will be those who attest to being a non-user of tobacco.

Ms. Simmons asked if the test was for any other substances. Ms. Rogers said the nicotine derivative cotinine is the only substance being measured. The test will be certified by CLIA (Clinical Laboratory Improvement Amendment.) Ms. Rogers said she could see no problems if those tested wished to take the used swabs with them after the test.

Representative Braxton asked about the SHP financial support for the smoking cessation programs. Ms. Rogers said the Plan would pay for the programs for members. In addition various support information will be available: the SHP will work with the smoking QUITLINE, provide free nicotine cessation patches over the counter and reduced co-pays for tobacco cessation drugs.

Mr. Stone asked if the member didn't pass the first test and took the blood test and did not pass what the appeal process might be. He also asked about samples being maintained. Ms. Rogers said that the appeal process would be explained at time of testing. **NOTE: A follow-up test can be either a blood test or another saliva test.**

Co-Chairman Holliman asked what would be the process for the weight management initiative. Ms. Rogers said there was no testing planned, but a sample taken of members who say they are in management programs. Representative Holliman asked about the appearance that the stand on smoking was stronger than that on weight control. Ms. Rogers said there were some legal questions concerning weight testing and that the Plan's intention was to support a healthy life style. Dr. Walker said that the law concerning the wellness initiative did not require testing in the weight portion.

Five Year Financial Requirements for the State Health Plan

Dr. Jack Walker, Plan Executive Administrator said the Plan was preparing an overview of the Plan that is being called Health Plan 101. The idea was to provide a comprehensive look at the entire structure and activity of the State Health Plan. Such a "course" could be ready as early as March. Senator Garrou said such a presentation would be a good idea.

Prior to beginning the explanation of the 5-Year Plan, Representative Braxton said he hope that current benefit levels would not be the basis. He said he felt the Task Force should be moving to make the plan financially sound and that might not mean current benefit levels for five years. Dr. Walker said he hoped his presentation would provide information that would answer Representative Braxton's questions. **(SEE ATTACHMENT: State Health Plan Strategy 2011 and Beyond.)**

Dr. Walker began by saying that maintaining current benefits through the next two biennia, with premiums increasing at the current 8% to 9%, the Plan would need almost two billion dollars in general fund revenue. He said that this was one of the reasons the Task Force was created as Representative Braxton had said. Co-Chair Holliman asked about the premium increase percentages. Dr. Walker said for large employers it was between 8 and 10 percent and for small employers there were double digit increases.

Currently the Plan collects about \$2.4 billion annually from agencies and members. That is expected to be about \$3.8 billion by 2015.

Dr. Walker said he expects the health cost and utilization to increase at least 9% per year and most likely 9.5 per cent.

Ms. Ransome asked about efforts to detect and prevent fraud. Dr. Walker said the providers were involved already in audit procedures. The Plan has recently hired someone to investigate member abuse. The Plan is looking for such things as high number of emergency room visits, use of several different hospitals to obtain drugs, use of multiple pharmacies and using more time on member review.

Mr. Stone asked about the percentage of premiums provided by members and what is paid by the state. Dr. Walker said that information was in the Health Plan 101, but could not recall it right now. Mark Trogon of the Fiscal Research Staff provided information that in the current year employees paid \$381 million in premiums or about 17% of the total. In response to a question about seeking more federal money, Mr. Trogon said most of the federal stimulus money which came to the state came to the Medicaid program with a small amount to COBRA. There was no direct money to programs per se.

Co-Chair Holliman said there was a potential for federal money if a national health plan is passed, but that is a big question mark.

Ms Ransome and Mr. Trogon discussed the point that when there is a state position that is fund by a combination of state and other funds, the benefit costs are also shared on the same ratio.

Dr. Walker told the Task Force there are no significant incentives to participate in anything. In terms of cost sharing the level is between 20% and 30% per employee, or the member is paying that percentage out of pocket. He believes that getting into the 30% area means that people will forego medical services. He said that even at the 20% level some lower income people will pick and choose which services they choose to get. He termed the idea of future increases in cost sharing as "treacherous".

Mr. Feezor said that the provider delivery side doesn't should be included. He said that keeping provider institutions on point and having them improve has to be part of any solution.

Mrs. Adcock asked if the Plan could tell the members what to do, but if Blue Cross was the only one who negotiated with the providers. Dr. Walker said that was the case. Mr. Feezor said that Blue Cross Blue Shield was some plans in the works that could even provide its own provider network.

Dr. Walker said that the percentage of healthy members had been decreasing among active members, dependents and non-Medicare retirees. The projection is that this decrease will continue. The percentage of healthy members varies greatly from agency to agency. The principle health problems in some of the agencies with fewer healthy members: 1. diabetes, 2. hypertension.

The plan wants to lower the cost trend by increasing participation in healthy behavior management, lower barriers to health care at the primary care level and subsidizing dependent premiums. Dr. Walker said the first point in the strategy to lower costs was to keep the low risk members at low risk. To change the trend of doing the same thing repeatedly would require incentives for healthy people to remain healthy.

Members should have a personal health assessment. Dr. Walker stressed the need for leadership within agencies to do those things which the Plan can not do to reduce costs. Mr. Feezor said that agency cost accounting should reflect the link of expense of unhealthy employees. He went further to say that perhaps agencies should present such information to Appropriations Committees. Co-Chair Holliman agreed.

Dr. Walker noted that 82% of members during a year survey period had a primary care visit. Even so a Health Fair provided information that a large group of the population surveyed, mostly males between 41 and 50 were hypertensive or prehypertensive and over 50% pre-diabetic, undiagnosed diabetic or diabetic.

Dr. Walker said there is very little coordination being done in health today. A member visits a physician for a specific situation, is treated and very little is available for other health concerns. Case management under the SHP is aimed at coordinating and integrating the health care needs.

Ms. Adcock asked how savings were recognized in case management. Dr. Walker said it was primarily in proper medications and future hospitalizations. She also asked how to determine the difference in participation in case management and partial participation. Full participation is when a member completes the full case management protocol. Partial participation is when a member who starts a management protocol does not complete it.

Representative Braxton asked how case management was carried out. Ms. Rogers said the primary method was by telephone, but that method was not always the best. A request for proposals is being prepared for a more integrated approach involving case management, disease management and the medical home. Dr. Walker said the move was to use the telephone plus patient and provider face to face.

Using the example of lower co-pay for a generic lipid-reducing medication, Dr. Walker said purchases increased. He said, "Dollars change behavior." He said there would be further tracking to see if the members continued to take the generic medication.

Dr. Walker said the Plan would discuss incentives with the Legislature-
"Without incentives, without provider participation, we are not going to bend the (cost) curve."

Senator Garrou asked if members who got flu shots had been tracked. Ms. Rogers said that this year had not been tracked. There is the ability to compare this year with last year.

Select Follow-up Items Requested by Task Force Members

Lacey Barnes, Deputy Executive Administrator of the State Health Plan provided the members with information on:

- A. Reduce Cost Savings if individual member is moved to the 70/30 plan rather than all family members

The plan estimates that the savings reduction would be minimal, about 10%. The family is enrolled as a unit and payroll systems withhold premiums per the plan the member has selected. Claims are figured on the unit. The SHP would have to have revamp costs in and of itself. Also, the matter of customizing the various payroll systems within state agencies is a large task, further complicated by the systems of school systems etc.

Responding to questions, Ms. Barnes said the Plan knew of no state or other large system that followed such a split out. Ms. Rogers said many other states that have a similar premium situation for employees are imposing a surcharge.

B. "Exodus" of Dependents

The Plan examined reasons for termination from the Plan of dependent coverage between June and September. Spouses in the under 55 group changed due to the employee leaving employment or a change to other insurance. Those over 55 changed due to retirement, change in marital status, or enrolled in Medicare.

The under 18 members left primarily because the member left employment.

Thus reduction in force due to budget problems and the pending eligibility audit for dependents seem to be the main reason for the departure of over three thousand members during the period.

Co-Chairman Holliman asked the status of the dependent eligibility audit. Ms. Barnes said the vendor has been chosen. The audit will be not be started until after annual enrollment.

(SEE ATTACHMENT: Blue Ribbon Task Force Follow Up Items.)

Mr. Stone asked what if an attestation form from a Medicare eligible member is lost in the mail. Ms. Barnes said that Medicare primary members would not be moved at all.

Ms. Barnes said if a member attests to being a non-smoker and then fails the test and is moved to the 70/30 plan all deductibles paid to that time will be lost and the deductibles will be re-set to zero. When Co-Chair Holliman asked why this was the case, Ms. Barnes said that during the creation of the statute legislative members thought the consequences should be significant. Ms. Barnes said the Executive Administrator (Dr. Walker) chose to be guided the input of the legislators concerning any variance in the consequences.

State Health Plan Actuarial Studies

Carol Durrell, Director of Product Development for the State Health Plan provided the outline of studies which will be performed by Aon Consulting. ***(SEE ATTACHMENT: 2010 Planned Actuarial Studies.)*** The studies are being done to support requests of the Task Force, respond to questions from the Legislative Oversight Committee and constituents, and reflect needs of the Plan.

The Cost Comparison will look at Georgia, Virginia and Tennessee which have various benefit options. That study will be available in mid February. The schedule for the remaining studies is on the provided handout.

Mr. Feezor asked about including examination of length of employment in the first study with the other three states. Ms. Durrell agreed to take note of that.

On the 4th study concerning Other Post-Employment Benefits, Mr. Feezor asked if the liability for retiree benefits was a liability for the Plan for the State. It was agreed that the liability was to the state.

Ms. Simmons asked the feasibility of adding South Carolina to the state by state comparison. Ms. Durrell said that South Carolina was a smaller state and that the population of Georgia was much closer to that of North Carolina and made a better fit. Aon already has access to existing data for the 3 states designated.

Mr. Stone asked if public school teachers in Virginia were covered under that state's health plan. Ms. Durrell said she thought the teachers were not covered, but would provide the answer.

Co-Chair Holliman said the studies would be shared with the Task Force as the studies became available.

Rep. Preventative Folwell asked the overall cost of the studies. Ms. Durrell said the range was between \$190 thousand and \$220 thousand for all. The cost per study will be provided to the members.

Co-Chair Holliman announced the next three meeting dates:

February 25

March 25

April 22

Mr. Feezor asked if the projected cost increase was higher than historic data was due to the "unhealthy" condition of members of the Plan. Dr. Walker said previous trends included cost sharing and the projections reflected a freeze in cost sharing. Ms. Adcock asked for a goal the Plan would like to see. Dr. Walker said the goal is 6%. He said the projection was a decade of work.

Mr. Feezor said that as the work of the Task Force went forward toward recommendations that attention should be paid to premium costs, cost to the state, cost to employees, cost to dependants and underlying health care costs as a way of "stratifying" the approach.

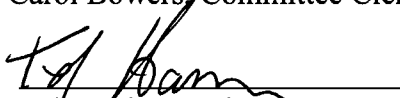
Dr. Myers divided issues facing the Task Force into three categories:

1. Costs that can be controlled
2. Costs that can be controlled partially
3. Costs that can not be controlled.

Co-Chair Holliman said if and when there is a national health plan there will be a presentation of how that impacts the State Health Plan.

Ms. Simmons advised that a Guilford County school employee's family, members of the State Health Plan, would be featured in the television program Extreme Home Makeover on January 31st.


Representative Hugh Holliman, Co-Chair
Presiding.


Carol Bowers, Committee Clerk

Ted Harrison, Minutes



State Health Plan Strategy 2011 and Beyond

By
Jack W. Walker, PhD
Executive Administrator

Updated January 20, 2010



Additional General Fund Requirements

Fiscal Year 2012 – 2015*
(Cumulative)

\$1.8 - \$1.9 Billion

With annual premium increases of between 8.1% and 9.8%

** Using FY 2011 as a base for State Health Plan and no benefit changes and NO federal health care reform.*

**North Carolina State Health Plan
Financial Projections - January 2010
Total For All Plans - 9% Trend**

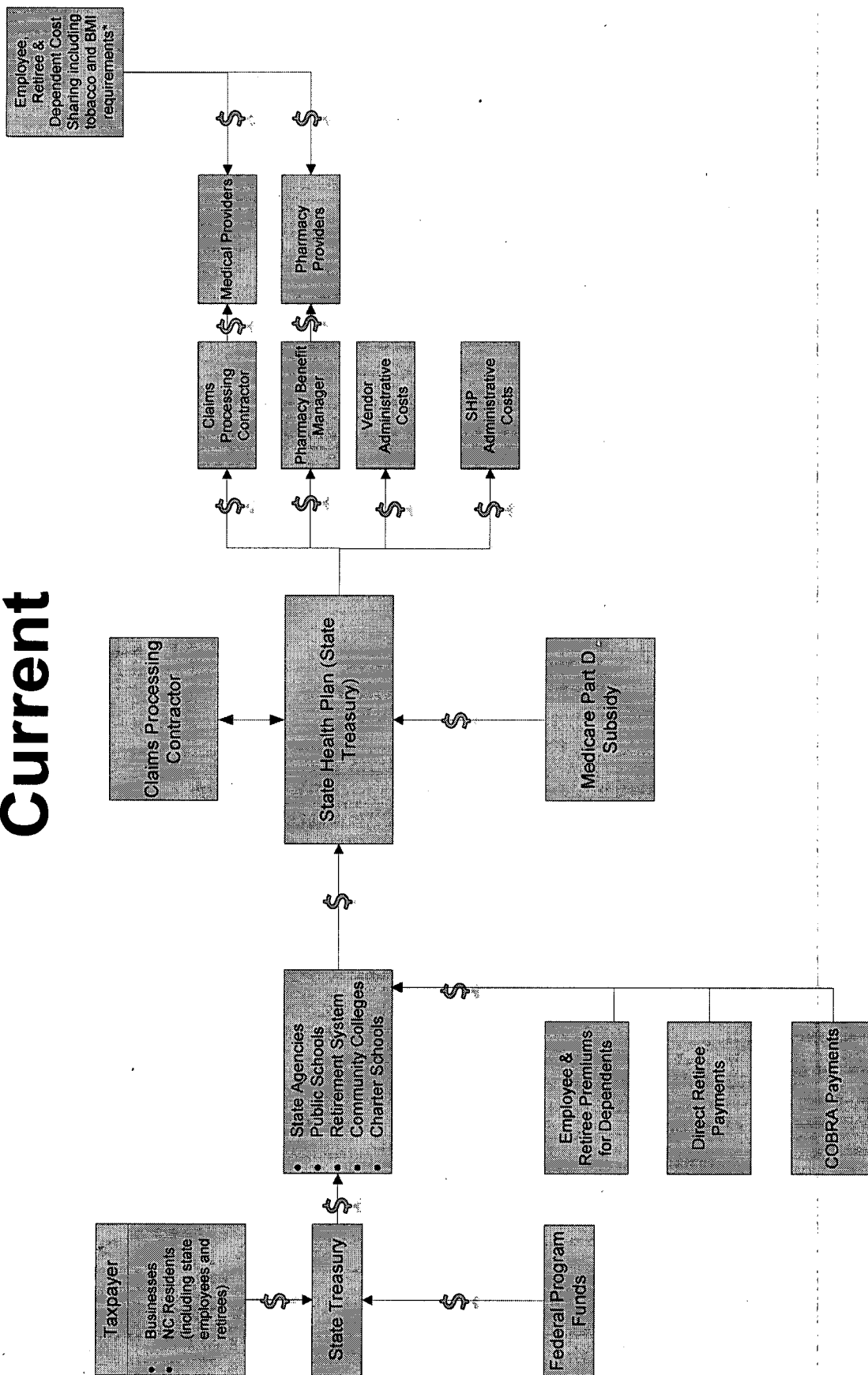
	2007 - 2009 Biennium		2009 - 2011 Biennium		2011 - 2013 Biennium		2013 - 2015 Biennium	
	Actual FY 2008	Actual FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
PLAN INCOME:								
Net Contribution Income	2,230,388,650	2,373,586,984	2,420,688,108	2,691,049,276	2,941,848,515	3,216,021,833	3,486,917,244	3,780,631,245
Retro Disenrollments	(7,637,274)	(2,287,735)	(1,839,493)	(2,593,704)	(2,835,431)	(3,089,888)	(3,380,782)	(3,643,871)
Medicare Part D*	41,828,388	49,361,397	75,718,280	56,545,474	58,217,839	59,840,374	61,714,585	63,542,022
Appropriation from State Reserve		250,000,000						
Investment Earnings	8,816,484	4,805,055	4,393,279	4,984,092	5,504,059	6,674,865	7,946,938	8,240,237
Total Plan Income	2,273,407,268	2,875,575,711	2,498,971,176	2,749,985,139	3,002,734,982	3,278,536,986	3,553,217,985	3,846,769,633
PLAN EXPENSE:								
Medical Claims Payment	1,651,870,238	1,874,012,846	1,869,037,528	2,057,366,220	2,242,427,913	2,444,246,428	2,664,228,804	2,894,039,178
Health Dialog Savings	-	-	(2,554,594)	(5,109,187)	(5,109,187)	(5,109,187)	(5,109,187)	(5,109,187)
Medical Benefit Changes	-	-	(80,841,413)	(126,971,359)	(134,340,500)	(138,864,215)	(143,548,316)	(148,388,849)
Claim Refunds	(25,683,281)	(30,345,358)	(29,680,987)	(32,444,887)	(35,363,285)	(38,545,980)	(42,015,119)	(45,798,479)
Medical Initiatives	-	-	-	(13,421,379)	(22,234,767)	(35,289,155)	(38,719,195)	(42,470,639)
Net Medical Claims	1,625,986,977	1,843,667,288	1,775,980,532	1,876,419,428	2,045,380,175	2,228,437,888	2,434,836,787	2,662,234,024
Pharmacy Claims Payment	524,310,920	615,912,029	585,344,431	674,502,211	737,102,264	805,413,280	879,952,309	961,283,185
Medico Rebate Savings	-	-	-	(4,000,000)	(4,000,000)	(4,000,000)	(4,000,000)	(4,000,000)
Pharmacy Initiatives	-	-	-	-	-	-	-	-
Pharmacy Benefit Changes	-	-	-	-	-	-	-	-
Net Pharmacy Claims	524,310,920	615,912,029	585,344,431	670,502,211	733,102,264	801,413,280	875,952,309	957,283,185
Projected Claims	2,150,297,897	2,459,579,317	2,371,304,963	2,548,921,639	2,778,482,439	3,027,851,149	3,310,789,096	3,618,517,209
Total Administrative Costs	140,070,316	165,839,843	176,856,468	191,731,806	197,483,780	203,408,273	209,510,521	215,795,837
Total Plan Expense	2,290,368,213	2,625,419,160	2,548,161,429	2,738,653,445	2,975,966,199	3,231,259,422	3,520,299,617	3,835,313,046
Plan Income (Loss)	(16,960,945)	50,156,550	(48,180,253)	11,331,693	26,768,783	48,277,564	32,918,368	11,450,587
Beginning Cash Balance (Deficit)	156,705,443	139,744,498	189,901,049	140,710,785	152,042,489	178,811,272	227,088,836	280,007,204
Ending Cash Balance (Deficit)	139,744,498	189,901,049	140,710,785	152,042,489	178,811,272	227,088,836	280,007,204	271,463,791
Target Stabilization Reserve	181,272,342	184,468,449	177,847,872	191,019,123	208,386,183	227,088,836	248,309,182	271,463,791
Premium Increase	11.2% PPO		7/1 Increase 8.9%		Projected Annual Increase 9.3%		Projected Annual Increase 8.4%	

**North Carolina State Health Plan
Financial Projections - January 2010
Total For All Plans - 9.5% Trend**

	2007 - 2009 Biennium		2009 - 2011 Biennium		2011 - 2013 Biennium		2013 - 2015 Biennium	
	Actual FY 2008	Actual FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
PLAN INCOME:								
Net Contribution Income	2,230,388,650	2,373,596,984	2,420,688,109	2,691,049,276	2,970,009,098	3,277,888,477	3,559,793,634	3,885,945,573
Retro Disenrollments	(7,037,274)	(2,287,735)	(1,839,493)	(2,593,704)	(2,862,573)	(3,159,313)	(3,431,022)	(3,728,100)
Medicare Part D*	41,829,388	49,361,397	75,718,280	50,545,474	58,217,839	59,940,374	61,714,585	63,542,022
Appropriation from State Reserve		250,000,000						
Investment Earnings	8,810,494	4,906,055	4,388,388	4,787,287	5,129,712	8,585,918	8,215,796	5,828,571
Total Plan Income	2,273,407,268	2,875,575,711	2,498,984,285	2,749,788,334	3,030,494,074	3,341,233,456	3,628,292,993	3,931,591,088
PLAN EXPENSE:								
Medical Claims Payment	1,651,670,238	1,874,012,646	1,869,989,158	2,066,486,453	2,262,685,334	2,477,651,391	2,713,028,273	2,970,765,959
Health Dialog Savings	-	-	(2,554,594)	(5,109,187)	(5,109,187)	(5,109,187)	(5,109,187)	(5,109,187)
Medical Benefit Changes	-	-	(60,848,545)	(129,971,359)	(134,340,500)	(138,884,215)	(143,548,316)	(148,388,849)
Claim Refunds	(25,683,281)	(30,345,358)	(29,687,587)	(32,563,852)	(35,655,525)	(39,042,800)	(42,751,886)	(46,813,293)
Medical Initiatives	-	-	-	(13,421,379)	(22,234,787)	(35,289,155)	(38,719,195)	(42,470,639)
Net Medical Claims	1,625,986,957	1,843,667,288	1,770,897,451	1,885,430,676	2,085,355,355	2,259,346,034	2,482,899,709	2,727,973,990
Pharmacy Claims Payment	524,310,920	615,912,029	595,788,275	677,921,875	744,411,109	817,301,547	897,204,744	984,790,491
Medco Rebate Savings	-	-	-	(4,000,000)	(4,000,000)	(4,000,000)	(4,000,000)	(4,000,000)
Pharmacy Initiatives	-	-	-	-	-	-	-	-
Pharmacy Benefit Changes	-	-	-	-	-	-	-	-
Net Pharmacy Claims	524,310,920	615,912,029	595,788,275	673,921,875	740,411,109	813,301,547	893,204,744	980,790,491
Projected Claims	2,150,297,897	2,459,579,317	2,372,885,727	2,558,352,551	2,805,768,494	3,072,647,581	3,376,104,453	3,708,764,481
Total Administrative Costs	140,070,316	165,839,843	176,858,466	191,731,806	197,483,780	203,408,273	209,510,521	215,795,837
Total Plan Expense	2,290,368,213	2,625,419,160	2,549,542,193	2,751,084,357	3,003,252,225	3,276,055,854	3,585,614,974	3,924,560,318
Plan Income (Loss)	(16,960,945)	50,156,550	(50,577,908)	(1,296,023)	27,243,850	65,177,601	40,678,019	7,030,748
Beginning Cash Balance (Deficit)	156,705,443	139,744,498	189,901,049	139,323,141	138,027,118	165,270,988	230,448,589	271,126,588
Ending Cash Balance (Deficit)	139,744,498	189,901,049	139,323,141	138,027,118	165,270,988	230,448,589	271,126,588	278,157,336
Target Stabilization Reserve	181,272,342	184,468,449	177,951,430	191,951,441	210,432,485	230,448,569	253,207,834	278,157,336
Premium Increase	11.2% PPO		7/1 Increase 8.9%	7/1 Increase 8.9%	Projected Annual Increase 10.4%	Projected Annual Increase 10.4%	Projected Annual Increase 8.6%	Projected Annual Increase 8.6%

State Health Plan Financing

Current

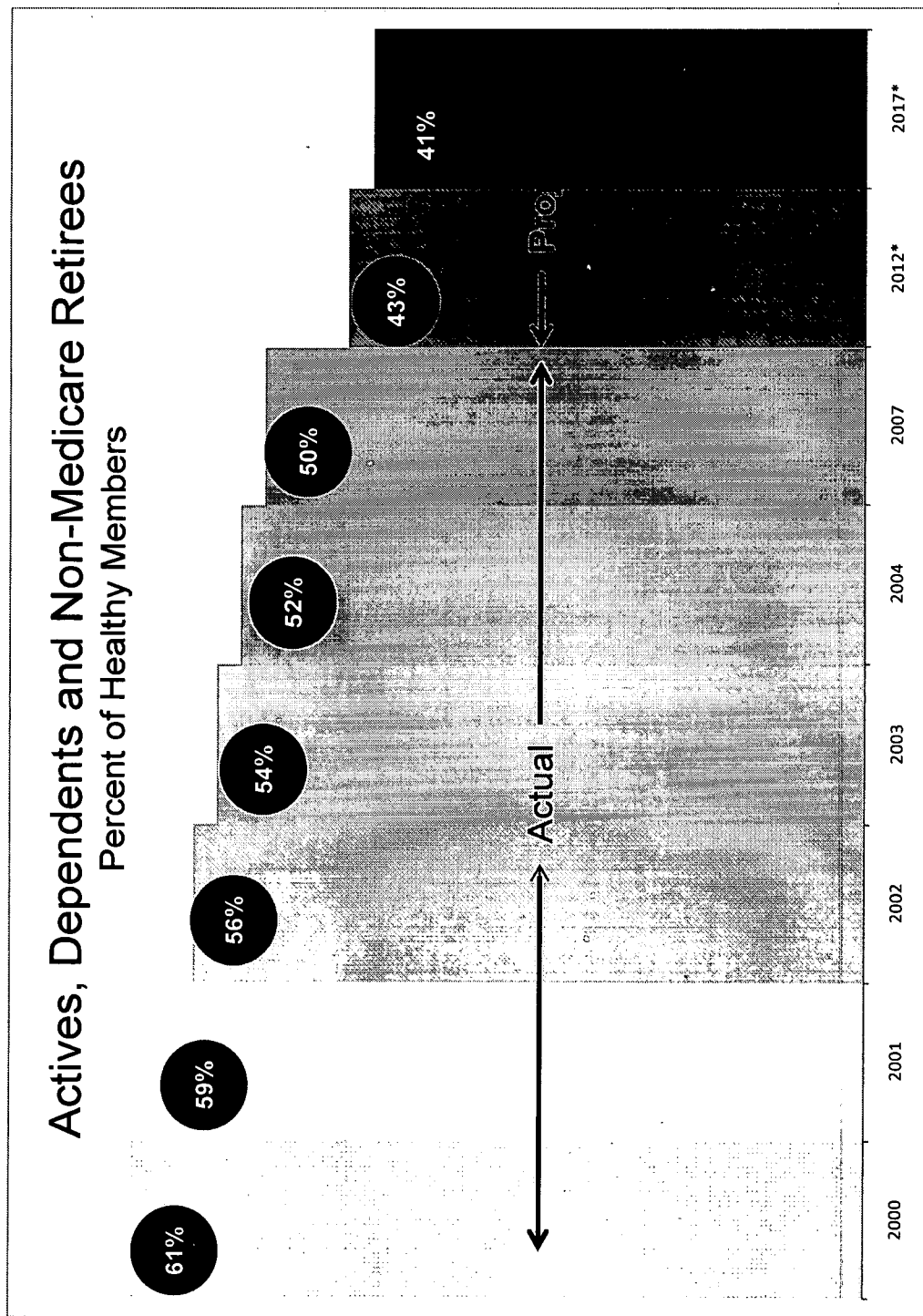


*Cost Sharing is represented by payments of deductible, coinsurance and copayments. There are some limitations set by state regulations.

Cost Increase Current

- Raise premiums
- Raise cost sharing
- Requirements related to tobacco usage and weight
- No significant incentives or participation requirements for disease or case management, selection of a primary care physician, adherence to prescribed drug therapy, completion of a health risk assessment, or development of a health improvement plan

NC HealthSmart Projection of Healthy Members*



* With NO incentives or participation requirements

Objective: Lower health care cost trend from projected 9.0 – 9.5% per year trend

- A. Maximize participation in healthy behavior engagement**
 - 1. Weight management, smoking cessation, moderation of alcohol usage and safe driving habits
 - 2. Completion of a personal health assessment, creation of a health improvement work plan and adherence to that plan
 - 3. Participation in Plan programs for disease and case management
- B. Lower barriers to health care access at the primary care level**
 - 1. Consider cost sharing related to income
 - 2. Worksite acute care centers at minimal cost sharing
- C. Subsidize dependent premiums to minimize current adverse selection**

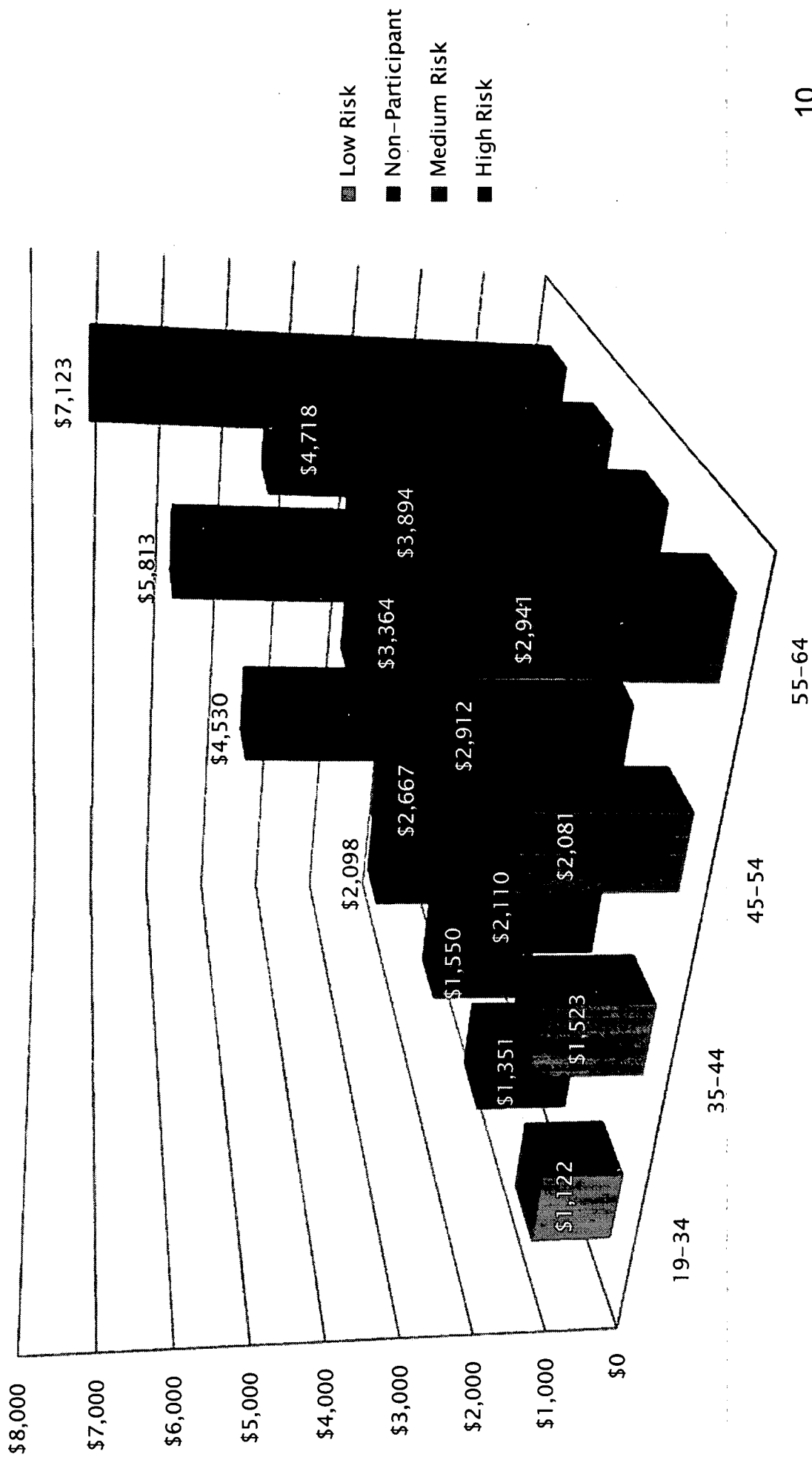
Strategy

- A. Focus on maintaining low risk members at low risk.
- B. Encourage medium and high risk members participation in case management and disease management.
- C. Promote worksite wellness, personal health assessments and medical homes. Improve access to appropriate health care.
- D. Lower barriers to appropriate health care.
 - 1. Worksite acute health care delivery (pending review)
 - 2. Lower cost sharing for lower income employees
- E. Promote employer leadership¹

¹ Agencies, schools, community colleges, universities and retirement system.

Costs Associated with Risks

Medical Paid Amount x Age x Risk



Risk Measurements

- Smoker
- BMI ≥ 27.5
- Cholesterol > 239 mg/dl
- HDL Cholesterol < 35 mg/dl
- Blood Pressure: > 139 systolic
> 89 diastolic
- Existing Health Conditions –
Heart, Cancer, Diabetes &
Stroke
- Illness > 5 days in past 12
months
- Perception of Health: Fair or
Poor
- Perception of Stress: High
- Life Satisfaction: Not Satisfied
- Use of seat belt < 100%
- Physical Activity < One
time/week

Low Risk	0 - 2 of above factors
Medium Risk	3 – 4 of above factors
High Risk	5 or more of above factors

**Percent of Employees Who Have One
or More Primary Care Visits in a
12 month Period**

82%*

** BCBSNC 1/19/2010 data request, FY 2009*

Health Fair Example*

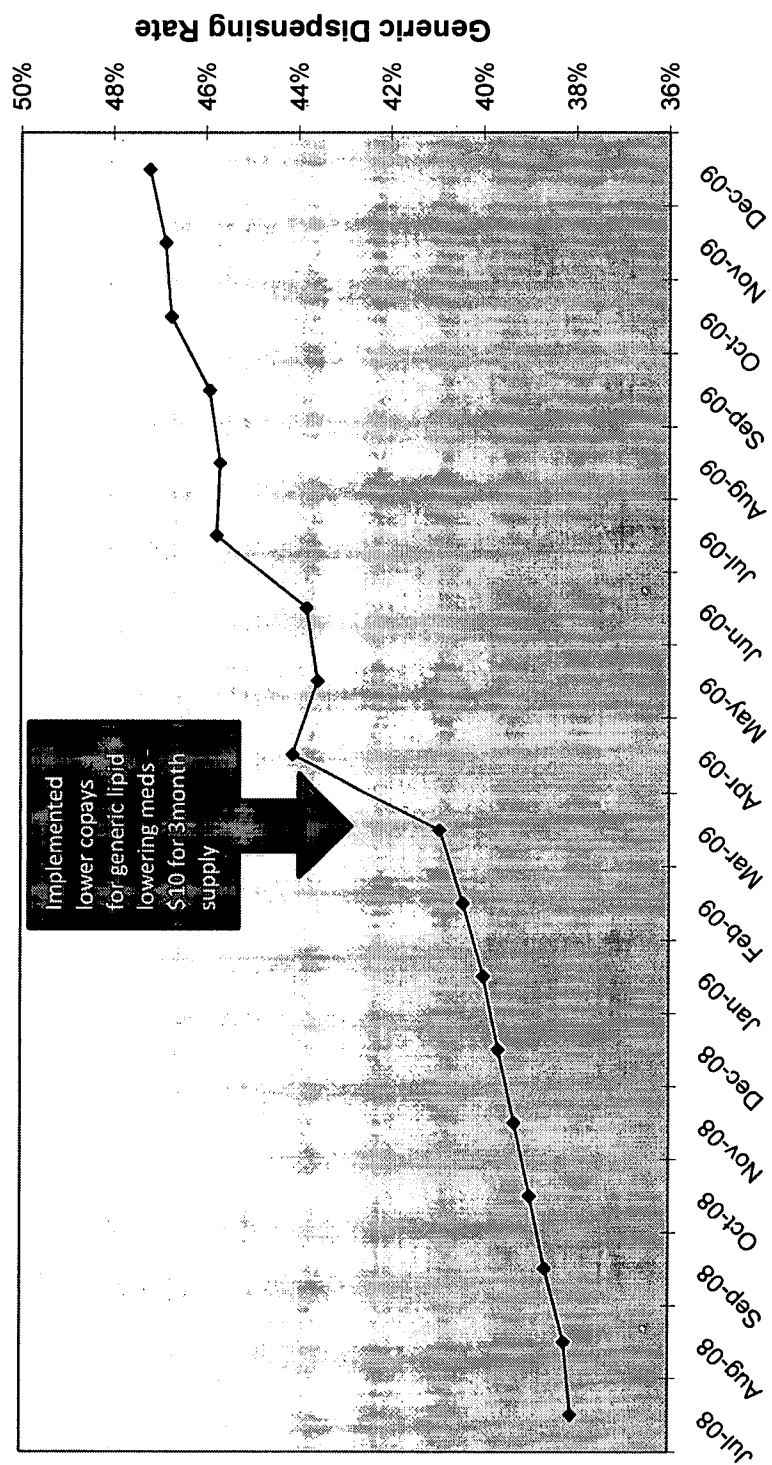
	Percent of Population	On Medication
Pre-hypertensive	39.5%	
Hypertensive	<u>52.1%</u>	
Total	91.6%	24.6%
High Cholesterol	36.4%	16.5%
Pre-diabetic	31.4%	
Undiagnosed Diabetic	19.6%	
Diabetic	<u>9.4%</u>	
Total	60.4%	Not Measured

* 86.6% male, median age 41 - 50

Need CM and DM Engagement & Savings

Those Needing Case Management	Those Participating Partially	Those Participating Fully
19,055	4,338	1,071
Additional Net Savings if all participated		
\$38 - \$44 million/year		
Those Needing Disease Management	Those Participating	
92,081	42,479	
Additional Net Annual Savings if all participated		
\$25 - \$50 million/year		

State Health Plan Lipid Lowering Drugs

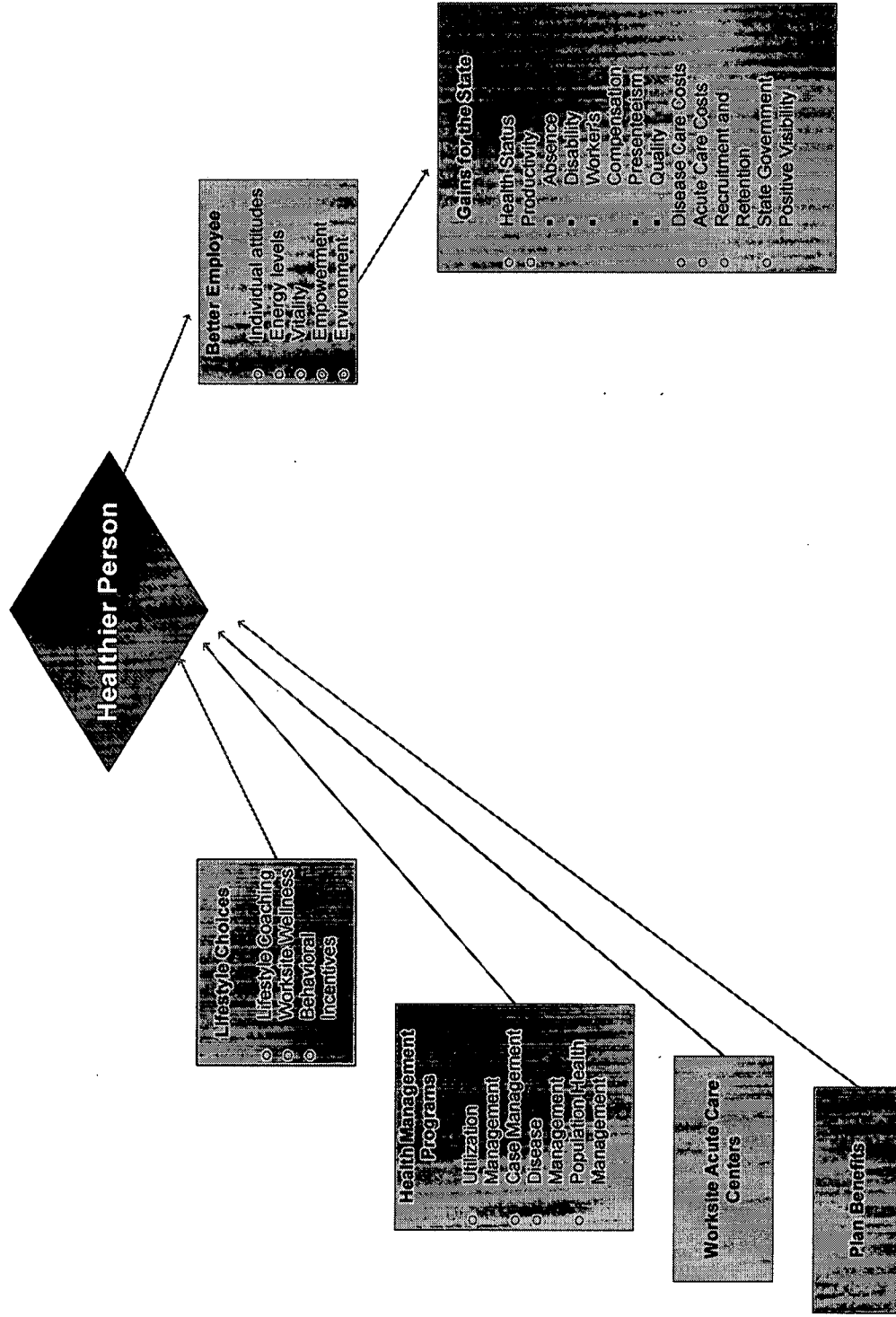


Population Health Management Action Steps

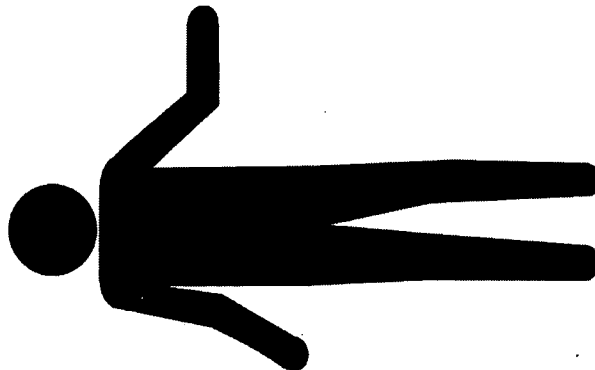
- A. Select a Population Health Management vendor and implement
- B. Create and implement incentives which encourage*
 - Maintenance of low health risk behavior
 - Completion of a Personal Health Assessment
 - Participation in disease and case management
 - Adoption of worksite wellness activities and participation
- C. Determine the validity of worksite acute care health delivery
- D. Minimize health care silo mentality

** Needs to be \$300 - \$600/year per subscriber to get high participation and to have a significant impact upon cost trends. These incentives may need to be funded directly to the Plan and employers.*

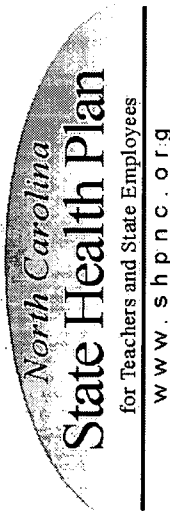
Population Health Management



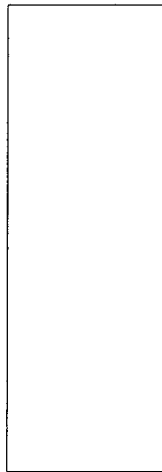
Formula for Success



+



+



Member
Engagement =
Healthy
Behaviors and
Well Being

Population
Health
Management

State of North
Carolina
Leadership

APPENDIX

Federal Health Care Reform

Potential Impact on State Health Plan

Description	Senate	House	Impact
Require employers to cover 72.5% of premium cost of single coverage	N	Y	None
Require employers to cover 65% of the premium cost of lowest cost family coverage	N	Y	Significant
Provide a set of benefits which cover a percentage of health service expenses with additional limits on cost sharing	65% Max. cost sharing \$5,950 (S) \$11,900 (F)	70% Max. cost sharing \$5,000 (S) \$10,000 (F)	Significant
Reinsurance for retirees age 55 – 64 (80% for claims between \$15,000 - \$90,000/year/retiree)	Y	Y	Positive (But for a limited period)
Excise tax on business with aggregate values in excess of \$8,000 (S) and \$21,000 (F)	Y	N	None
Conform definitions of HRA, FSA and other medical savings accounts	Y	N	None
Require employers to automatically enroll all employees in an "offered" health plan	Y	Y	None
Limit contributions to FSA to \$2,500/year	Y	N	None
Require health plans to report expenditures on items other than medical care	Y	N	None
Provide premium credits to lower income individuals and families	Y	Y	Uncertain
Restrict payments to Medicare Advantage Plans	Y	Y (but different than Senate)	Uncertain
Adopt standard rules for eligibility, claims status, claims payment and electronic transfer of funds	Y	N	Uncertain
Create a national QI strategy	Y	Y (but different than Senate)	Uncertain
Enhanced data collection on race, ethnicity and language	Y	Y (but different than Senate)	Uncertain
No cost sharing for preventive services	Y	Y (but only for Medicare and Medicaid)	Small
			20



Cost Increase Future*

- Limited ability to increase cost sharing
- Focus on member health engagement with participation incentives and requirements**

** Assuming some form of federal health care reform*

*** Subject to federal health care reform regulations/ limitations*

Employee Costs

1. Wages and productivity
2. Absenteeism
3. Worker's Compensation
4. STD & LTD
5. Health care Costs

Blue Ribbon Task Force Follow Up Items

1/21/2010

Lacey Barnes

The Plan was asked to respond to two of the issues that were raised by committee members in the last BRTF meeting in December.

The first question has to do with ineligibility for the 80/20 plan if one member of the family uses tobacco or has a BMI of 40 or more. You will recall that the Comprehensive Wellness Initiative goes into effect in July of this year. All non-Medicare members will be moved to the 70/30 Plan, and can then select the 80/20 Plan if they qualify. As the Plan enrolls families in units, with the employee as the subscriber and family members enrolled as dependents, if one member of the family cannot qualify for the 80/20 Plan, that is they cannot attest that no one smokes or they are unwilling to participate in a cessation plan, certified by their medical provider, then the family unit will remain in the 70/30 plan. Some felt that it may be unfair to enroll all family members in the Basic Plan when only one family member was obese or a tobacco user. The Plan was asked to estimate the impact on projected savings from the Comprehensive Wellness Initiative if family members could separately enroll in the plan for which each of them was eligible.

- The Plan estimates that the savings reduction if we did not move the family together would be minimal, about 10%. The decision to move families as units was driven by systems issues more than by savings for each individual in the family unit.
- The limiting factor remains financial, however, in terms of the costs to customize systems to accommodate individual status. As I said before, the Plan is offered to employees and their eligible dependents. Payroll systems withhold premium contributions based on plan selection and type of dependent coverage. Claims systems accumulate out of pocket maximums for the family based on the family unit. All of these systems are built around the subscriber/dependent model. To revamp that process would be complex and unique to the Plan. The State would incur costs to reprogram and retool the membership accounting, eligibility, coordination of benefits and a long list of other sub-programs associated with claims processing. Likewise, payroll systems used by state agencies, schools and other participating groups would need to change to capture this information and adjust the premium collection processes.
- As you probably know, there are a variety of laws and statutes that regulate the health insurance industry as well as tax laws that apply to the deduction of premium payments etc. While these laws do not specifically prohibit such a change, they do tie many requirements to the subscriber/dependent relationship. The Plan would need to conduct detailed analysis to ensure that by altering these relationships and uncoupling these dependencies, it did not inadvertently create a legal or regulatory problem for the state or for our members.

For all these reasons, the Plan cannot advise adjusting this provision of the CWI implementation plan.

Questions?

Exodus of dependents

In addition, the Plan was asked to provide information about the loss or "exodus" of dependents from the Plan in recent months. The concern is that the Plan's younger, healthier members were leaving due to the increased cost sharing provisions in the current benefit structure. The Plan has conducted analysis of the reasons for terminations that occurred between June and September 2009. The changes in dependent enrollment appear to be driven, in large part, by the changes in employees.

Spouses

The primary reasons for changing enrollment in the under 55 years dependent spouse group were:

- The employee left employment
- The spouse moved to other insurance

For the over 55 years group they were:

- Employee retired
- Change in marital status
- Became enrolled in Medicare

Dependent Children

The primary reasons for changing in the under 18 group:

- Employee left employment—by far the largest proportion

Over age 18 group:

- Dependent is over age and/or no longer a student
- Employee left employment and/or retired

So, in summary, there was a net change of 3,430 dependents between June and September 2009. The data indicates that most of these enrollment changes can be linked to 2 significant events: reductions in force due to budgetary constraints and the announcement prior to annual enrollment of the dependent eligibility audit. That having been said, some of these changes may have been related to the premium and benefit changes, but that does not appear to have been the primary driver.

State Health Plan - Comprehensive Wellness Initiative (CWI) Verification Process

A third party vendor will be hired by the State Health Plan to conduct the tobacco verification process, the exemption certification process and appeals. The CWI tobacco program starts July 1, 2010.

Tobacco Use Verification

Senate Bill 287 (session Law 2009-16) requires the State Health Plan to verify if members who attest to not using tobacco are eligible for the 80/20 plan. A sample of members will be selected using a stratified random methodology for tobacco use testing.

1. An initial saliva test will be used to determine tobacco use.
2. A secondary test will be offered immediately if test results are positive.
3. Testing will not be conducted at the worksite to reduce member privacy concerns.
4. Non-Medicare primary subscribers and their spouses may be selected for tobacco testing.
5. Testing sites will be within 15 miles and 30 minutes drive time from the member's home.

Tobacco Program Certification Process

Members may qualify for the 80/20 plan if they are actively trying to quit using tobacco. A random sample of members who attest to participating in a cessation program may be required to submit a physician signed form certifying that the member is enrolled in a cessation program.

Consequences of Non-Compliance for 2010/2011

Members who refuse testing, test positive for tobacco use or fail to submit a physician certification form within the required timeframe and their covered dependents will be moved from the 80/20 plan to the 70/30 plan for the remainder of the 2010/2011 benefit year. Members will forfeit any coinsurance and deductibles already paid under the 80/20 Plan during the 2010/2011 benefit year. Members and their covered dependents will be eligible to enroll **only** in the 70/30 plan for the 2011/2012 benefit year.

Appeals

Members may appeal testing results and administrative errors. Members who refuse testing may not appeal.

*Effective July 1, 2011, the weight management component of the CWI will start. The process around Body Mass Index (BMI) verification has not been determined, however, the certification process, including consequences and appeals, does apply. A random sample of members who attest to being in a weight management program or to having a medical condition that prevents the attainment of the specific weight range may be required to submit a physician certification form.

Other State Program Examples:

Indiana Tobacco

- Members sign a waiver at enrollment
- \$20/month/premium discount for non-users
- Test employees with saliva test
- Number of employees reporting tobacco use increased as penalties became more severe
- 2010 Penalty: Termination of Job

Alabama Weight

- Members sign a waiver at enrollment
- \$25/month surcharge
- Members in wellness program, at low risk, under physician care or engaging in self-management may receive \$25/m discount
- Must participate in annual health screening
- Penalty is surcharge

North Carolina
State Health Plan

for Teachers and State Employees
www.shpnc.org

2010 Planned Actuarial Studies

Due Date

1. Limited State by State Benefit Comparison/Cost

2/15/10

This study will compare the North Carolina State Health Plan's Membership demographics, premium structure, benefits and loss ratios to those of three key southeastern states (Georgia, Virginia and Tennessee) that offer multiple benefit options.

2. Consumer Directed Health Care

4/30/10

(also referred to as "Consumer-Focused Health Care")
Study will review the potential for Health Reimbursement Account (HRAs) or Health Savings Account (HSAs) arrangements.

3. Medicare Products and Strategy

5/14/10

This study will review how the current PPO plans work in relation to Medicare, and study other types of plans currently available to employer groups and individual Medicare recipients, such as Medicare Advantage and Medicare Supplement type plans.

4. OPEB or "Other Post-Employment Benefits" Reduction Strategy

6/30/10

This study will be conducted in tandem with the Medicare Strategy Study. It involves the development of a strategy to reduce state liability for retiree health benefits. Accounting rules require the state to report the liability annually in its financial statement.

5. Dependent Subsidy, including Salary Based Premium Structure

9/24/10

This study will look at the current dependent population and the level of subsidy needed to increase the number of dependents in the Plan; it will also review the potential for a salary-based premium structure.



NORTH CAROLINA GENERAL ASSEMBLY

**LEGISLATIVE BUILDING
RALEIGH NC 27601**

February 5, 2010

MEMORANDUM

TO: Members of the State Health Plan Blue Ribbon Task Force Committee

FROM: Rep. Hugh Holliman, Co-Chair
Sen. Dan Blue Co-Chair

SUBJECT: Meeting Notice

The State Health Plan Blue Ribbon Task Force Committee will meet on the following date:

DAY:	Thursday
DATE:	February 25, 2010
TIME:	9:00 am
LOCATION:	Room 1228 Legislative Building

If you have any questions concerning this meeting or can not attend, please contact Carol Bowers at 919-715-0873 or Hollimanla@ncleg.net

AGENDA

Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

Thursday, February 25, 2010

9:00 a.m.

Legislative Building, Room 1228/1327

I. Welcome, Introductions, and Remarks

Representative Hugh Holliman, Co-Chair
Senator Dan Blue, Co-Chair

II. Approval of Minutes

III. State Health Plan as Compared to Other State-Operated Governmental Health Benefit Plans in Georgia, Tennessee & Virginia

✓ *Carol Durrell, Director of Product Development*
State Health Plan for Teachers and State Employees

IV. Select Follow-up Items Requested by Task Force Members

Cost-sharing and other policy issues related to plan member access
to nutritional visits and weight-loss drugs under the Comprehensive
Wellness Initiative

Ann Rogers, Director of Integrated Health Management,
State Health Plan for Teachers and State Employees

Dr. Derek Prentice, Consulting Medical Director
State Health Plan for Teachers and State Employees

V. Closing Remarks & Adjournment

next mtg Mar. 25

HOUSE PAGES

NAME OF COMMITTEE BRTF - SHP DATE 2-25-10

1. Name: _____

County: _____

Sponsor: _____

2. Name: _____

County: _____

Sponsor: _____

3. Name: _____

County: _____

Sponsor: _____

4. Name: _____

County: _____

Sponsor: _____

5. Name: _____

County: _____

Sponsor: _____

SGT. AT-ARM

1. Name: Martha Perin

2. Name: Lorissant Arent

3. Name: Jon Fitchett

4. Name: Stan Johnson

VISITOR REGISTRATION SHEET

2-25-10

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

JOHN LUTTER	MERCK
DAVID BARNES	Popper Spauld
Rae Presnell	NC Retired School Personnel
Wally Franken	NCHAE
Fudbur	Born Assoc
Ed Regan	NCRGEA
LOR Ann Hines	LATHA
SANDY SPANGL	WCSR
Chris Minard	NC State Bd of Ed

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Mona Meun	State Health Plan
BILL STOCKARD	STATE BUDGET
Chris Shoffner	Citizen
● Pam Deardorff	NC Retired School Personnel
Math Arnold	TPG
Carl Dean	DSP
Cam Crook	BP and
Adam Linker	NC Justice Center
Daniel Baum	TROUTMAN SANDERS
Conor Brockett	Medical Society
● Joey Nichols	CR

VISITOR REGISTRATION SHEET

Blue Ribbon State Health

Name of Committee

2-25-10

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

*Emily Willbourne**TPG**Elizabeth W. Robinson**Nelma**Patricia Buffin**WRF**Bo Heath**McGuire Woods**Sim Stegall**U.C.P.S.**Match Leonard**SEANC**Joel Magwood**GRM : ASBOL**Evelyn Shawcross**EHOR**Brian Scoburn**TGG*

MINUTES

BLUE RIBBON TASK FORCE ON THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

Thursday, February 25, 2010

9:00 a.m.

Legislative Building Room 1228/1327

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees met Thursday, February 25, 2010 at 9 a.m. in Room 1228/1327 of the Legislative Building. Co-Chair Representative Holliman presided. *(SEE ATTACHMENT: Members and Guests Present.)* On motion of Ms. Adcock the minutes were approved as presented.

The meeting was devoted to providing Task Force Members with information requested during previous meetings.

Presentations

Carol Durrell, Director of Product Development for the State Health Plan presented the SHP in Comparison with several other states. *(SEE ATTACHMENT: Comparative Study to Georgia, Virginia and Tennessee State Health Plans.)*

Senate Bill 287 directs the SHP to make such a comparison which was conducted for the Plan by Aon Consulting. Ms. Durrell said that the average insurance coverage time in large industries was 6 to 7 years, while state government employees tended to work for the state throughout their work career and be covered after retirement. Many industries do not offer retiree coverage at all.

Only North Carolina covers community college and university employees. Virginia also excludes coverage for public school employees. North Carolina does not contribute to dependent coverage, whereas the other three states do make such contributions. North Carolina members tend not to opt for dependent coverage if there is only one dependent.

The highest cost members are the non-Medicare retirees. For Medicare retirees the SHP is the secondary plan.

In a comparison which takes the North Carolina demographics and normalizes the costs, North Carolina's cost is lowest among the four states. When considering the average claims cost per member per month the North Carolina cost is lower perhaps because of:

1. better contracted rates
2. more in network utilization
3. better health risk
4. better health management.

The plan options for active employee/ non Medicare retiree members vary among the four states with North Carolina having the two: basic and standard, while there are

four options in Georgia and three in both Virginia and Tennessee. Thus the other states must contract with more separate administrators.

In North Carolina, the state funds a little more than 41% of the family coverage. While other states pay between 77% and 89% of the family coverage.

Ms. Durrell said that if there members were charged a premium it could prompt younger, healthier members to the plan which might prevent reductions in benefits.

In addition to some of the earlier notations, there were these conclusions:

- N. C. is the only one with free coverage for retiree only and employee only
- Va., Tenn. And Ga. have employee-only premiums to subsidize dependent coverage
- Only Tenn. has two-tier premiums for actives and retirees

In the discussion, Representative Braxton asked how the family coverage rates were derived. Ms. Durrell said experience, age, sex and trends in overall costs go into the formula. SHP Plan Administrator, Dr. Jack Walker said to arrive at a future rate, the current family rate is multiplied by the same factor as the single member rate then take that total premium and subtract the total member rate at a 100%, what is left over is the dependent rate. Representative Braxton then asked if North Carolina was using the dependent rate to subsidize the active coverage. Dr. Walker said that actually employee coverage was being used as a slight subsidy for dependent coverage. The margin on employee only coverage is slightly larger than employee cost and a little bit of that margin is being used for dependent coverage. Further, Dr. Walker said the Plan loses money on employee/spouse coverage. He said younger people with younger children are cheaper for the plan that "people my age."

Co-Chair Representative Holliman asked if other states which charge for employee coverage use those funds to subsidize dependent coverage. Dr. Walker said if a state charged \$100/month per member it would raise a lot of revenue to provide dependent coverage.

In response to a question from Representative Braxton about other state experience with high risk case management, Ms. Durrell said Georgia does, but she was not sure of other states.

Mr. Feezor asked if there was a comparison of cost of care with other states. Ms. Durrell said that was not part of this study. Responding to another of Mr. Feezor's questions, Ms. Durrell said the community college and university employees tended to be healthier, therefore less expensive for the Plan. Mr. Feezor also asked if there was a way to anticipate what the new, younger State employees might be looking for in a plan. And he asked how the factor that State employees tended to stay employed longer with the state figured. Dr. Walker said the average age a member in the SHP was 9 years older than the average private sector worker. Mr. Feezor said the worker competition for the State tended to be the private sector rather than other states.

Mr. Stone asked if there were any figures to see what the SHP might have to do to subsidize dependent coverage like other states do. Ms. Durrell said that is under review. and that will be considered as the Plan focuses directly on dependent coverage. She said

that the review would consider what the dollar amounts an employee might pay to provide dependent coverage.

Representative Folwell asked if any of the \$140 million in federal Medicare money that came to Sate would wind up in the SHP. Tracy Stephenson, SHP Director of Pharmacy said the Plan was not eligible to receive any of these Medicare Part D subsidy funds. Ms. Ransome noted that the fund credit received reflected some stimulus money and part of a fallback in the Medicaid program.

Representative Folwell said the treasurer's audit noted some errors concerning employee premiums, he asked if that was caused by people who were incorrectly covered by the Plan. Ms. Durrell said that information would be provided.

Representative Folwell asked what incentive there is for a 58-year old retiree to be on any plan other than the 80/20 plan. Ms. Durrell said there was no such incentive. Representative Folwell also asked if the Medicare enrollment age was changed to 66 would the state be accountable for the additional year's coverage. The answer was yes, and a cost estimate would be provided.

Representative Folwell asked if other Medicare supplement information would require a shift to the calendar year for the SHP to match up. Dr. Walker said that shift would not be necessary.

Representative Folwell asked if the SHP had any answer to the question of why the largest purchaser of health care coverage in North Carolina could not provide that coverage better and cheaper. Ms. Durrell said the point raised a good question. Further she said that was the reason for the Blue Ribbon Task Force. Co-Chair Holliman asked for a clarification on the term "better and cheaper", if that mean in comparison with other states. Representative Folwell said he doubted that the average prison employee or school teacher could interpret some of the terms in the report. He said those employees want to know why they can't afford family health coverage through their employer. Ms. Durrell said the report would suggest one approach could be to charge an employee premium to subsidize dependent coverage. Representative Folwell said the conclusion could be drawn that the plan is having financial troubles and is structured to force away the younger healthier potential members who could boost the Plan efficiency. When he asked what the Plan, via Ms. Durrell, could suggest, she said that the report points to subsidizing dependent coverage as a way of increasing the membership base.

Senator Garrou said she wondered if Representative Folwell had an idea of what should be done. The Representative responded saying that he could not go to his state employee constituents and explain why the largest purchaser of the health care insurance in the State can not provide coverage better and cheaper than anyone else. He said the SHP does not have an answer, either. He said all we've got is "data and reports, not one solution." He said he would love to have a solution. Senator Garrou said that she thought that was what the Task Force was to do: gather information and come up with a solution. The Senator said that Task Force was to come up with recommendations to the General Assembly, but Representative Folwell said that could not happen until 2012 or 2013.

Mr. Feezor said Representative Folwell was on target that the Plan was able to purchase care at a cheaper rate, but that was offset by the accumulated risk of an older membership. He said the failure to recruit younger healthier members was an historical

situation that would not be changed "anytime soon." Noting his own work experience, he said that pursuing lower costs without being cognizant of risks was not a good way of doing business.

Mr. Stone said the issue of provider reimbursement rate has not been addressed and what plans there were to address that. Ms. Durrell said the allowed costs were a part of the reimbursement rates. Further Mr. Stone said that provider reimbursement rates were a major part of the nationwide debate on rising health care costs.

Ms. Simmons said the fact that health care insurance is provided free to individual employees and retirees is considered as a benefit to some and as insurance to some. Her view is that it is a benefit. So she asked how it was viewed by the members. Co-Chair Holliman said it is a benefit, just as in the private market. Ms. Adcock said she considered it as a part of the total compensation package.

Ms. Adcock continued by saying the Task Force needed all the information available to grasp the entire issue/ She said there is a difference between what is being paid for coverage and what that coverage costs. She said she felt that we were not doing the best job to get the best product. She said the administrative part needed to be examined.

Representative Braxton asked if the family coverage price was lowered would the Plan be able to attract many more of the state employees in the \$30,000 to \$40,000 per year salary range, if the dependent coverage was not subsidized. His opinion was "no". Dr. Walker said unless the cost was less than \$200 those employees would not. He said further the subsidy for dependent coverage had to be at least 80% of the premium to make dependent coverage attractive. Mr. Stone said the idea of the total compensation package involves affordability and the North Carolina employee salary ranges compared to other states.

Ms. Adcock asked if health care costs in the other three states compare with the experience in North Carolina. Ms. Durrell said she would revisit that.

Mr. Feezor asked if the state is making a contribution for the Governmental Accounting Standards Board (GASB) retired employee obligation. (The Board directs government to treat all post-retirement benefits be accounted for on an annual basis, not pay as you go.) Mark Trogon, Fiscal Research, said the current unfunded liability for the retired employee costs is \$28 billion projected over the 30-year period. That is funded from percentages of the contributions from the various state agencies. The money is held in a trust fund by the State Treasurer, the premium for a current retiree comes from that trust fund. No prefunding is being done. The trust is approximately \$500 million now. Representative Folwell noted that as the cost for retirees goes up and the number of retirees also increases there will be a convergence which would require an annual appropriation to the Plan of approximately \$1.4 billion per year. Mr. Trogon responded to Co-Chair Representative Holliman's question about state who are prefunding this obligation say that two states were pre-funding others are considering reduced benefits or bonds.

Ms. Simmons noted a teacher assistant who pays \$603 per month in Plan coverage for her husband with a gross salary of \$575 per month. Ms. Simmons said she did not want to go back to tell the woman that not only was the Plan going up 8.9%, but that there maybe another \$100/month increase. Ms. Durrell said such an increase would not

necessarily be the case, since employee premiums was an item of discussion, but not a foregone conclusion. Co-Chair Representative Holliman said such an increase would come to pass if health care costs are going to be higher-the question was who pays it.

Representative Folwell, who sponsored a bill which requires the Office of State Personnel to provide workers with a present value of future obligations that each worker, asked the Plan had been contacted by any agencies about such information. Dr. Walker said "no".

Ann Rogers, Director of Integrated Health Management said the nutritional visit benefit had been extended to all members. Previously this benefit had been available only to diabetic members. She said since other plans did not see much member involvement even with zero dollars co-pay. The SHP has contracted for participation in the Eat Smart, Move More, Weigh Less program. **(SEE ATTACHMENT: February 2010 Update.)** She presented testimonial videos for the members to view.

Dr. Derek Prentice, Consulting Medical Director for the State Health Plan discussed medication for weight loss programs for members. **(SEE ATTACHMENT: Weight Loss Medication Coverage Recommendations.)** He said the history is that members tend to stay on weight loss drugs only 71 days on average. One of the drugs, Meridia is no longer offered in Europe and the US requires a notice that it is contraindicated for patients with cardio-vascular disease. The recommendation is for the drugs continue for coverage by the Plan, but the co-pays should not be lowered. Mr. Stone asked if the SHP would be watching for correlations between people who did take these drugs and any adverse side effects-particularly coronary problems. Ms. Rogers said that some anomalies would be noted, but this was intended to take the barriers away, but not to recommend the medications. Dr. Prentice noted that the SHP was not a provider of the medications. Mr. Stone said he was asking that the Plan have an awareness of any instances of serious adverse effects cause by the drugs. Dr. Prentice said the pharmacies have programs in place, but the first point of awareness came when the prescription was written. Mr. Stone said his primary concern was for coronary incidents that could result from the drugs.

The meeting adjourned at 10:32 a.m.

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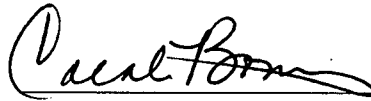
Ann Rogers, Director of Integrated Health Management said the nutritional visit benefit had been extended to all members. Previously this benefit had been available only to diabetic members. She said since other plans did not see much member involvement even with zero dollars co-pay. The SHP has contracted for participation in the Eat Smart, Move More, Weigh Less program. **(SEE ATTACHMENT: February 2010 Update.)** She presented testimonial videos for the members to view.

Dr. Derek Prentice, Consulting Medical Director for the State Health Plan discussed medication for weight loss programs for members. **(SEE ATTACHMENT: Weight Loss Medication Coverage Recommendations.)** He said the history is that members tend to stay on weight loss drugs only 71 days on average. One of the drugs Meridia is no longer offered in Europe and the US requires a notice that it is contra-indicated for patients with cardio-vascular disease. The recommendation is for the drugs continue for coverage by the Plan, but the co-pays should not be lowered. Mr. Stone asked if the SHP would be watching for correlations between people who did take these drugs and any adverse side effects-particularly coronary problems. Ms. Rogers said that some anomalies would be noted, but this was intended to take the barriers away, but not to recommend the medications. Dr. Prentice noted that the SHP was not a provider of the medications. Mr. Stone said he was asking that the Plan have an awareness of any instances of serious adverse effects cause by the drugs. Dr. Prentice said the pharmacies have programs in place, but the first point of awareness came when the prescription was written. Mr. Stone said his primary concern was for coronary incidents that could result from the drugs.

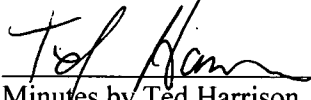
The meeting adjourned at 10:32 a.m.



Representative Hugh Holliman, Co-Chair
Presiding



Carol Bowers, Clerk



Minutes by Ted Harrison

Senator Dan Blue, Co-Chair

North Carolina State Health Plan

Comparative Study to Georgia, Virginia and
Tennessee State Health Plans

February 25, 2010

AON CONSULTING

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Objective

- S287 (SL2009-16) directs the State Health Plan to conduct a health benefit study of other southeastern states
- Aon conducted the study to compare coverage and costs of North Carolina State Health Plan to coverage and costs of other State health plans in the region.
- The study includes information from the State health plans of Georgia, Virginia and Tennessee

Groups Covered

	NC	GA	VA	TN
State Agencies	✓	✓	✓	✓
Public School Employees	✓	✓		✓*
Universities & Community Colleges	✓			

*Covers Public School Employees that elect to join the plan with 40% State funding and flexible contributions (virtually all)

Total Enrollment

	NC	GA	VA	TN
Contracts	479,992	331,605	124,064	169,196
Members	664,882	657,386	227,110	296,631
	NC	GA	VA	TN
Members/ Contracts	1.385	1.982	1.831	1.753
Members/ Child Contracts	2.760	2.530	1.999	N/A
Members/ Family Contracts	3.862	3.324	3.820	3.018

*Fiscal Year 2009

N/A = non-applicable

Enrollment by Status*

Contracts	NC	GA	VA	TN
Active	69.2%	74.6%	69.9%	76.3%
Non-MC Retiree	10.1%	10.8%	6.8%	7.7%
MC Retiree	20.7%	14.7%	23.3%	15.9%
Members	NC	GA	VA	TN
Active	74.9%	81.9%	82.5%	85.0%
Non-MC Retiree	9.0%	8.5%	4.8%	5.9%
MC Retiree	16.1%	9.6%	12.8%	9.1%

*Fiscal Year 2009

Enrollment by Tier (Contracts)* Active Employees

	NC	GA	VA	TN
Employee Only	74.7%	44.1%	41.8%	53.9%
Employee/ Spouse	3.6%	14.2%	19.2%	N/A
Employee/ Child(ren)	14.6%	10.6%	7.3%	N/A
Employee/ Family	7.0%	31.2%	31.7%	46.1%

*Fiscal Year 2009

Enrollment by Tier (Contracts)* Non-Medicare Retirees

	NC	GA	VA	TN
Employee Only	84.8%	54.6%	75.5%	72.7%
Employee/ Spouse	9.9%	N/A	20.4%	N/A
Employee/ Child(ren)	3.1%	N/A	1.5%	N/A
Employee/ Family	2.2%	45.4%	2.6%	27.3%

*Fiscal Year 2009

Enrollment by Tier (Contracts)* Medicare Retirees

	NC	GA	VA	TN
Employee Only	91.0%	69.8%	100.0%	100.0%
Employee/ Spouse	8.0%	N/A	N/A	N/A
Employee/ Child(ren)	0.6%	N/A	N/A	N/A
Employee/ Family	0.4%	30.2%	N/A	N/A

*Fiscal Year 2009

Membership Distribution By Gender

Male	NC	GA	VA	TN*
Active	38.6%	43.1%	47.0%	44.4%
Non-MC Retiree	37.0%	37.7%	40.7%	41.2%
MC Retiree	34.1%	36.4%	43.1%	No Data
All Males	37.7%	42.0%	46.2%	44.2%
Female	NC	GA	VA	TN*
Active	61.4%	56.9%	53.0%	55.6%
Non-MC Retiree	63.0%	62.3%	59.3%	58.8%
MC Retiree	65.9%	63.6%	56.9%	No Data
All Females	62.3%	58.0%	53.8%	55.8%

*Tennessee totals do not include Medicare retirees

Average Membership Age (By Gender)

Male	NC	GA	VA	TN*
Active	34.68	32.79	35.70	35.79
Non-MC Retiree	55.54	54.89	56.88	58.41
MC Retiree	72.66	73.69	72.64	No Data
All Males	42.05	37.9	40.98	37.32
Female	NC	GA	VA	TN*
Active	37.98	35.10	36.37	37.46
Non-MC Retiree	57.37	56.26	57.34	57.36
MC Retiree	73.20	74.26	72.94	No Data
All Females	45.75	41.17	42.41	38.97

*Tennessee totals do not include Medicare retirees

Average Membership Age (Total)

	NC	GA	VA	TN*
Active	36.70	34.10	36.06	36.72
Non-MC Retiree	56.70	55.74	57.15	57.79
MC Retiree	73.02	74.06	72.81	No Data
All Members	44.35	39.79	41.75	38.24

	NC	GA	VA	TN
Percentage of Membership Age 50-64	29.1%	25.6%	27.7%	31.7%

*Tennessee totals do not include Medicare retirees

Net State Payments¹ Per Member Per Month

Active Employees and Dependents

	North Carolina	Georgia	Virginia	Tennessee
Allowed Cost				
Cost Share ²	\$355.10	\$360.35	\$372.56	\$412.97
Employee Paid Premiums	\$61.21	\$57.36	\$49.53	\$39.60
	\$57.57	\$75.79	\$43.93	\$74.00
Net State Payments	\$236.32	\$227.21	\$279.11	\$299.37
Net as Percentage of Allowed	66.6%	63.1%	74.9%	72.5%

Non-Medicare Retirees and Dependents

	North Carolina	Georgia	Virginia	Tennessee
Allowed Cost				
Cost Share ²	\$646.38	\$699.43	\$718.31	\$696.21
Employee Paid Premiums	\$100.00	\$112.12	\$76.42	\$75.63
	\$57.67	\$95.47	\$43.93	\$91.92
Net State Payments	\$488.71	\$491.83	\$597.97	\$528.66
Net as Percentage of Allowed	75.6%	70.3%	83.2%	75.9%

¹FY 2009

²Cost Share is sum of deductibles, coinsurance and copayments

Allowed and Normalized Cost Comparison¹ Per Member Per Month

Active Employees and Dependents

	North Carolina	Georgia	Virginia	Tennessee
Allowed Cost	\$355.10	\$360.35	\$372.56	\$412.97
Normalized Allowed Cost ²	\$355.10	\$385.92	\$378.35	\$409.32
Percent Variance		8.7%	6.5%	15.3%

Non-Medicare Retirees and Dependents

	North Carolina	Georgia	Virginia	Tennessee
Allowed Cost	\$646.38	\$699.43	\$718.31	\$696.21
Normalized Allowed Cost ²	\$646.38	\$713.79	\$709.85	\$697.77
Percent Variance		10.4%	9.8%	8.0%

¹FY 2009

²Adjusted for age, gender and benefits of North Carolina

Observation on Claims Cost

- ➔ North Carolina had the lowest average allowed claims cost PMPM for active employees and non-Medicare retirees
- ➔ North Carolina's average allowed claims cost PMPM is lower than all other states when normalized for NC's age/sex risk and plan design
- ➔ This could be a result of a combination of factors including:
 - better contracted rates
 - more in-network utilization
 - better health risk
 - better health management

● Active Employees and ● Non-Medicare Retirees

- Non-Medicare retirees are eligible for the same plans as active employees in all 4 states
- Non-Medicare retirees pay the same contributions as active employees in all 4 states

Active Employee/Non-Medicare Retiree

Plan Options for 2009

- ➔ North Carolina
 - 3 PPO plans (Basic, Standard and Plus)
- ➔ Georgia
 - HMO
 - PPO
 - HDHP(HSA) with Employee owned portable account
 - CDHP(HRA) with Employer owned account
 - Kaiser HMO (fully-insured)
- ➔ Virginia
 - Base HMO plan with buy-up options (including OON coverage, Expanded Dental, Vision & Hearing)
 - HDHP
 - Kaiser HMO (fully-insured)
- ➔ Tennessee
 - PPO
 - POS
 - HMO

● Active Employee/Non-Medicare ● Retiree Plan Options for 2010

➔ North Carolina

- 2 PPO plans

➔ Georgia

- HMO
- PPO
- HDHP(HSA) with Employee owned portable account
- CDHP(HRA) with Employer owned account

➔ Virginia

- Base HMO plan with buy-up options (including OON coverage, Expanded Dental, Vision & Hearing)
- HDHP
- Kaiser HMO plan (fully-insured)

➔ Tennessee

- PPO
- POS
- HMO plans

Dominant Plans - based on Membership

- North Carolina
 - 80% of all members were in the Standard plan in 2009
- Georgia
 - 81% of all members were split almost evenly between the HMO and PPO plans in 2009
- Virginia
 - 85% of all members were in the HMO/PPO plan in 2009
- Tennessee
 - 46% of all members were in the POS plan in 2009 with the remaining members split between other plans

2010 Employer Funding for Dominant Active Employee/Non-Medicare Retiree Plans

North Carolina PPO-Standard	Total Premium	Employer Contribution	Employer % Paid	Employee Contribution	Employee % Paid
Employee Only	\$377.16	\$377.16	100.0%	\$0.00	0.0%
Family	\$910.10	\$377.16	41.4%	\$532.94	58.6%

Georgia HMO	Total Premium	Employer Contribution	Employer % Paid	Employee Contribution	Employee % Paid
Employee Only	\$398.82	\$298.62	74.9%	\$100.20	25.1%
Family	\$1,116.70	\$871.30	78.0%	\$245.40	22.0%

Georgia PPO	Total Premium	Employer Contribution	Employer % Paid	Employee Contribution	Employee % Paid
Employee Only	\$450.87	\$356.17	79.0%	\$94.70	21.0%
Family	\$1,262.43	\$973.33	77.1%	\$289.10	22.9%

Virginia HMO/PPO	Total Premium	Employer Contribution	Employer % Paid	Employee Contribution	Employee % Paid
Employee Only	\$485.00	\$444.00	91.5%	\$41.00	8.5%
Family	\$1,313.00	\$1,169.00	89.0%	\$144.00	11.0%

Tennessee POS	Total Premium	Employer Contribution	Employer % Paid	Employee Contribution	Employee % Paid
Employee Only	\$516.11	\$430.47	83.4%	\$85.64	16.6%
Family	\$1,288.61	\$1,074.75	83.4%	\$213.86	16.6%

Medicare Retirees

→ Medicare retiree plans differ in each of the 4 states

Medicare Retiree Plan Options for 2010

- ➔ North Carolina
 - Same 2 PPO plans offered to active employees and non-Medicare retirees
- ➔ Georgia
 - 2 Medicare Advantage + Part D plans
- ➔ Virginia
 - Medicare coordinating medical plan with buy-up to include an enhanced Part D plan
- ➔ Tennessee
 - Medicare Supplement (Medigap Plan D) for medical and no coverage for Rx

North Carolina Retirees

- ➔ Medicare retirees are eligible for the same PPO plans as active employees
 - For medical benefits, SHP is secondary payer to Medicare with “carveout” coordination of benefits (COB) - example on following page
 - For pharmacy benefits, SHP is primary payer
- ➔ Retiree Drug Subsidy is received by SHP for Medicare-eligible Rx coverage
- ➔ Retiree pays 100% contribution for dependent coverage
- ➔ Retiree pays 0% contribution for retiree coverage if hired prior to 10/1/2006
- ➔ Retiree pays 50%-100% of retiree coverage with less than 20 years of service if hired on or after 10/1/06

Carveout Coordination of Benefits (COB) Example

- ➔ \$15,000 Hospital Bill (20 days) to Medicare
- ➔ - \$1,100 (Part A Deductible)
- ➔ \$13,900 Paid by Medicare

- ➔ \$1,100 to SHP
- ➔ - \$600 (Individual Deductible paid by Retiree)
- ➔ - \$200 (Inpatient Copay paid by Retiree)
- ➔ \$300
- ➔ x 0.8
- ➔ \$240 Paid by SHP
- ➔ \$300
- ➔ x 0.2
- ➔ \$60 Paid by Retiree

- ➔ \$860 Paid by Retiree (\$15,000 - \$13,900 - \$240) OR
- ➔ \$860 = (\$600 Deductible + \$200 Inpatient Copay + \$60 (20%))

Georgia Retirees

- Starting 2010, Medicare Retirees are eligible for 2 Medicare Advantage (Med) + Part D (Rx) plans
- Retiree pays contribution

Virginia Retirees

- Medicare retirees are eligible for a retiree plan designed to pay medical amounts not paid by Medicare with minimal cost sharing with an option to buy-up a Part D (Rx) plan
- Retiree pays full premium less amounts credited for more than 15 years of service (\$4 per ^{month} ~~year~~ of service) (after 15 yrs.)

Tennessee Retirees

- ➔ Medicare retirees are eligible for a self-insured Group Medicare Supplement plan (Medigap Plan D) with no Rx coverage
- ➔ Retiree pays full premium less amounts credited for more than 15 years of service (on a sliding scale up to 41% subsidized)

2010 Employer Funding for Medicare Retiree Plans

North Carolina PPO-Standard	Total Premium	Employer Contribution	Employer % Paid	Employee Contribution	Employee % Paid
Employee Only	\$263.72	\$263.72	100.0%	\$0.00	0.0%
Family	\$636.16	\$263.72	41.5%	\$372.44	58.5%

Georgia MAPD Standard	Total Premium	Employer Contribution	Employer % Paid	Employee Contribution	Employee % Paid
Employee Only	\$185.00	\$165.70	89.6%	\$19.30	10.4%
Family	\$370.00	\$331.40	89.6%	\$38.60	10.4%

Virginia Advantage 65	Total Premium	Employer Contribution	Employer % Paid	Employee Contribution	Employee % Paid
Employee Only	\$258.00	\$0.00	0.0%	\$258.00	100.0%
Family	N/A	N/A	N/A	N/A	N/A

Tennessee Medigap Plan D	Total Premium	Employer Contribution	Employer % Paid	Employee Contribution	Employee % Paid
Employee Only	\$121.00	\$0.00	0.0%	\$121.00	100.0%
Family	N/A	N/A	N/A	N/A	N/A

Key Observations

- ➔ North Carolina is the only state (of the four states) that covers Universities and Community Colleges.
- ➔ North Carolina is the only state (of the four states) that provides employee-only and retiree-only coverage free of charge.
- ➔ Virginia, Tennessee and Georgia all charge a premium for employee-only and retiree-only coverage, and in turn, directly subsidize dependent coverage.
- ➔ Tennessee is the only state that offers a two-tier premium structure for both actives and retirees.

Key Observations, Cont'd

- ➔ North Carolina has the lowest overall member/contract ratio at 1.385. The member/contract ratios in the other three states range from 1.753 in Tennessee to 1.982 in Georgia.
- ➔ North Carolina has the highest percentage of employee-only coverage (74.7%) in its active population with only 25.3% of contracts including dependent coverage.
- ➔ Active contracts that include dependent coverage in the other three states represent a much higher percentage ranging from 46.1% in Tennessee to 58.2% in Virginia.
- ➔ In contrast, North Carolina has the highest active member/contract ratios for both the Employee&Child(ren) and Family tiers. This may indicate employees are less inclined to purchase dependent coverage through SHP if they only have one child.

Key Observations, Cont'd

- ➔ North Carolina has the highest percentage of females (across all categories) than in the other three states.
- ➔ North Carolina had the lowest average allowed claims costs PMPM for active employees and non-Medicare retirees, and the PMPM cost is lower than other states when normalized for NC's age/sex and plan design. This could be a result of a combination of factors including:
 - Better contracted rates
 - More in-network utilization
 - Better health risk
 - Better health management
- ➔ Because North Carolina does not charge the employee a premium contribution, the only alternative to address increased costs is to cost shift to members who utilize the Plan.

Summary

- The purpose of this presentation has been to take a more detailed look at key southeastern states to determine where North Carolina membership and costs are in relation to those states.
- This information will lay the foundation for more detailed discussion on potential approaches to plan design and premium strategy going forward

Appendix

- ➔ Exhibit A – Membership by Tier
- ➔ Exhibit B – Membership by Age/Sex
- ➔ Exhibit C – Financial Experience by State 2009
- ➔ Exhibit D – Financial Experience by Dominant Plan 2009
- ➔ Exhibit E – 2010 Benefit Design Comparison (Active Employee/Non-Medicare Retiree Plans)
- ➔ Exhibit F – 2010 Benefit Design Comparison (Medicare Retiree Plans)
- ➔ Exhibit G – Types of Health Plans – PPO
- ➔ Exhibit H – Types of Health Plans – HMO
- ➔ Exhibit I – Types of Health Plans – POS
- ➔ Exhibit J – Types of Health Plans – HDHP(HSA)
- ➔ Exhibit K – Types of Health Plans – CDHP(HRA)

Exhibit A Membership by Tier

Actives Coverage Type	North Carolina						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	248,144	-	248,144	1.000	74.7%	0.0%	49.8%
Employee & Spouse	11,976	11,982	23,958	2.001	3.6%	7.2%	4.8%
Employee & Child(ren)	48,544	86,206	134,750	2.776	14.6%	52.0%	27.1%
Family	23,325	67,645	90,970	3.900	7.0%	40.8%	18.3%
Total	331,989	165,833	497,822	1.500			

% of Total	69.2%	89.7%	74.9%

Actives Coverage Type	Georgia						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	109,077	-	109,077	1.000	44.1%	0.0%	20.3%
Employee & Spouse	35,029	34,901	69,930	1.996	14.2%	12.0%	13.0%
Employee & Child(ren)	26,142	40,004	66,146	2.530	10.6%	13.8%	12.3%
Family	77,031	215,948	292,979	3.803	31.2%	74.2%	54.4%
Total	247,279	290,853	538,132	2.176			

% of Total	74.6%	89.3%	81.9%

Actives Coverage Type	Virginia						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	36,199	0	36,199	1.000	41.8%	0.0%	19.3%
Employee & Spouse	16,611	16,611	33,222	2.000	19.2%	16.5%	17.7%
Employee & Child(ren)	6,366	6,361	12,727	1.999	7.3%	6.3%	6.8%
Family	27,519	77,682	105,201	3.823	31.7%	77.2%	56.2%
Total	86,696	100,654	187,349	2.161			

% of Total	69.9%	97.7%	82.5%

Actives Coverage Type	Tennessee						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	69,601	-	69,601	1.000	53.9%	0.0%	27.6%
Employee & Spouse							
Employee & Child(ren)							
Family	59,578	123,001	182,580	3.065	46.1%	100.0%	72.4%
Total	129,180	123,001	252,181	1.952			

% of Total	76.3%	96.5%	85.0%

Exhibit A Membership by Tier

Non-Medicare Retirees Coverage Type	North Carolina						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	41,182	-	41,182	1.000	84.8%	0.0%	68.5%
Employee & Spouse	4,813	5,756	10,569	2.196	9.9%	49.9%	17.6%
Employee & Child(ren)	1,495	2,729	4,224	2.825	3.1%	23.7%	7.0%
Family	1,080	3,044	4,124	3.819	2.2%	26.4%	6.9%
Total	48,570	11,529	60,099	1.237			

% of Total	10.1%	6.2%	9.0%

Non-Medicare Retirees Coverage Type	Georgia						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	19,520	-	19,520	1.000	54.6%	0.0%	34.9%
Employee & Spouse	-	-	-				
Employee & Child(ren)	-	-	-				
Family	16,225	20,183	36,408	2.244	45.4%	100.0%	65.1%
Total	35,745	20,183	55,928	1.565			

% of Total	10.8%	6.2%	8.5%

Non-Medicare Retirees Coverage Type	Virginia						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	6,340	-	6,340	1.000	75.5%	0.0%	58.7%
Employee & Spouse	1,711	1,711	3,423	2.000	20.4%	71.5%	31.7%
Employee & Child(ren)	130	130	260	2.000	1.5%	5.4%	2.4%
Family	221	551	771	3.497	2.6%	23.0%	7.1%
Total	8,402	2,392	10,794	1.285			

% of Total	6.8%	2.3%	4.8%

Non-Medicare Retirees Coverage Type	Tennessee						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	9,499	-	9,499	1.000	72.7%	0.0%	54.3%
Employee & Spouse							
Employee & Child(ren)							
Family	3,560	4,433	7,993	2.245	27.3%	100.0%	45.7%
Total	13,059	4,433	17,493	1.339			

% of Total	7.7%	3.5%	5.9%

Exhibit A Membership by Tier

Medicare Retirees Coverage Type	North Carolina						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	90,508	-	90,508	1.000	91.0%	0.0%	84.6%
Employee & Spouse	7,929	6,993	14,922	1.882	8.0%	92.9%	14.0%
Employee & Child(ren)	575	161	736	1.280	0.6%	2.1%	0.7%
Family	421	374	795	1.888	0.4%	5.0%	0.7%
Total	99,433	7,528	106,961	1.076			

% of Total	20.7%	4.1%	16.1%

Medicare Retirees Coverage Type	Georgia						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	33,907	-	33,907	1.000	69.8%	0.0%	53.5%
Employee & Spouse	-	-	-				
Employee & Child(ren)	-	-	-				
Family	14,674	14,745	29,419	2.005	30.2%	100.0%	46.5%
Total	48,581	14,745	63,326	1.304			

% of Total	14.7%	4.5%	9.6%

Medicare Retirees Coverage Type	Virginia						
	Contracts	Dependents	Members*	Members /Contract	Contract %	Dependent %	Member %
Employee Only	28,967	-	28,967	1.000	100.0%	0.0%	100.0%
Employee & Spouse	-	-	-				
Employee & Child(ren)	-	-	-				
Family	-	-	-				
Total	28,967	-	28,967	1.000			

% of Total	23.3%	0.0%	12.8%

* Each member is a separate contract

Medicare Retirees Coverage Type	Tennessee						
	Contracts	Dependents	Members*	Members /Contract	Contract %	Dependent %	Member %
Employee Only	26,957	-	26,957	1.000	100.0%	0.0%	100.0%
Employee & Spouse							
Employee & Child(ren)							
Family	-	-	-				
Total	26,957	-	26,957	1.000			

% of Total	15.9%	0.0%	9.1%

* Each member is a separate contract

Exhibit A Membership by Tier

Total Coverage Type	North Carolina						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	379,834	-	379,834	1.000	79.1%	0.0%	57.1%
Employee & Spouse	24,718	24,731	49,449	2.001	5.1%	13.4%	7.4%
Employee & Child(ren)	50,614	89,096	139,710	2.760	10.5%	48.2%	21.0%
Family	24,826	71,063	95,889	3.862	5.2%	38.4%	14.4%
Total	479,992	184,890	664,882	1.385			

Total Coverage Type	Georgia						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	162,504	-	162,504	1.000	49.0%	0.0%	24.7%
Employee & Spouse	35,029	34,901	69,930	1.996	10.6%	10.7%	10.6%
Employee & Child(ren)	26,142	40,004	66,146	2.530	7.9%	12.3%	10.1%
Family	107,930	250,876	358,806	3.324	32.5%	77.0%	54.6%
Total	331,605	325,781	657,386	1.982			

Total Coverage Type	Virginia						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	71,506	0	71,506	1.000	57.6%	0.0%	31.5%
Employee & Spouse	18,322	18,322	36,645	2.000	14.8%	17.8%	16.1%
Employee & Child(ren)	6,496	6,491	12,987	1.999	5.2%	6.3%	5.7%
Family	27,740	78,232	105,972	3.820	22.4%	75.9%	46.7%
Total	124,064	103,046	227,110	1.831			

Total Coverage Type	Tennessee						
	Contracts	Dependents	Members	Members /Contract	Contract %	Dependent %	Member %
Employee Only	106,058	-	106,058	1.000	62.7%	0.0%	35.8%
Employee & Spouse							
Employee & Child(ren)							
Family	63,139	127,435	190,573	3.018	37.3%	100.0%	64.2%
Total	169,196	127,435	296,631	1.753			

Exhibit B

Membership by Age/Sex

Actives Age Range	North Carolina			Georgia			Virginia			Tennessee		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
<1	0.5%	0.5%	0.9%	0.6%	0.5%	1.1%	0.5%	0.4%	0.9%	0.5%	0.4%	0.9%
1-4	2.0%	1.9%	3.9%	2.5%	2.4%	4.9%	2.3%	2.2%	4.5%	2.2%	2.1%	4.4%
5-9	2.8%	2.7%	5.4%	3.8%	3.6%	7.4%	3.2%	3.1%	6.2%	3.1%	3.0%	6.1%
10-14	3.1%	3.0%	6.0%	4.3%	4.2%	8.5%	3.6%	3.5%	7.1%	3.5%	3.3%	6.8%
15-19	3.2%	3.2%	6.4%	4.2%	4.1%	8.4%	4.3%	4.1%	8.4%	3.8%	3.6%	7.4%
20-24	2.2%	3.2%	5.4%	1.9%	2.6%	4.5%	3.0%	3.3%	6.3%	2.3%	2.8%	5.1%
25-29	2.0%	4.8%	6.7%	1.9%	4.0%	5.8%	1.9%	2.7%	4.6%	1.9%	3.4%	5.3%
30-34	2.3%	5.1%	7.4%	2.6%	4.6%	7.2%	2.5%	3.3%	5.9%	2.7%	4.1%	6.8%
35-39	3.1%	6.1%	9.2%	3.5%	5.5%	9.0%	3.4%	4.2%	7.5%	3.4%	4.8%	8.2%
40-44	3.3%	6.3%	9.6%	3.7%	5.5%	9.1%	3.9%	4.8%	8.7%	3.5%	4.9%	8.4%
45-49	3.6%	7.0%	10.7%	3.8%	5.8%	9.6%	4.4%	5.8%	10.3%	4.0%	5.9%	9.8%
50-54	3.8%	7.3%	11.1%	3.7%	5.7%	9.4%	4.8%	6.2%	11.0%	4.5%	6.5%	11.0%
55-59	3.6%	6.3%	9.9%	3.2%	4.8%	8.0%	4.6%	5.2%	9.8%	4.4%	5.9%	10.2%
60-64	2.4%	3.3%	5.7%	2.2%	2.5%	4.7%	3.2%	3.1%	6.3%	3.1%	3.5%	6.6%
65-74	0.7%	0.8%	1.5%	1.1%	0.9%	1.9%	1.4%	0.9%	2.4%	1.5%	1.2%	2.7%
75+	0.0%	0.0%	0.1%	0.2%	0.2%	0.3%	0.1%	0.0%	0.1%	0.1%	0.1%	0.2%
Total	38.6%	61.4%	497,822	43.1%	56.9%	538,132	47.0%	53.0%	187,349	44.4%	55.6%	252,181
Avg Age	34.68	37.98	36.70	32.79	35.10	34.10	35.70	36.37	36.06	35.79	37.46	36.72
Age/Sex	0.713	0.831	0.785	0.680	0.774	0.733	0.744	0.731	0.773	0.750	0.825	0.792

Exhibit B

Membership by Age/Sex

Non-Medicare Retirees Age Range	North Carolina			Georgia			Virginia			Tennessee		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
<1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1-4	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.2%
5-9	0.2%	0.1%	0.3%	0.2%	0.2%	0.4%	0.2%	0.2%	0.4%	0.2%	0.2%	0.4%
10-14	0.4%	0.4%	0.7%	0.6%	0.7%	1.3%	0.4%	0.4%	0.8%	0.4%	0.5%	0.9%
15-19	1.3%	1.2%	2.4%	1.6%	1.7%	3.3%	0.9%	1.0%	1.9%	1.1%	1.0%	2.1%
20-24	1.7%	1.6%	3.3%	1.5%	1.7%	3.2%	0.8%	1.1%	1.9%	1.3%	1.3%	2.6%
25-29	0.2%	0.2%	0.4%	0.1%	0.1%	0.2%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%
30-34	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%
35-39	0.1%	0.2%	0.3%	0.1%	0.2%	0.2%	0.1%	0.3%	0.4%	0.1%	0.2%	0.3%
40-44	0.2%	0.3%	0.5%	0.2%	0.5%	0.7%	0.3%	0.5%	0.7%	0.2%	0.4%	0.6%
45-49	0.5%	0.8%	1.3%	0.9%	1.4%	2.3%	0.6%	1.3%	1.9%	0.5%	1.4%	1.8%
50-54	3.3%	5.8%	9.2%	3.1%	6.3%	9.4%	4.0%	5.8%	9.8%	2.3%	5.2%	7.5%
55-59	9.6%	18.6%	28.2%	10.3%	18.5%	28.8%	11.4%	17.7%	29.0%	9.7%	17.3%	27.0%
60-64	18.7%	32.9%	51.6%	19.0%	30.9%	49.9%	21.8%	30.8%	52.6%	18.4%	29.2%	47.5%
65-74	0.5%	0.6%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.1%	1.3%	7.4%
75+	0.1%	0.2%	0.3%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.7%	0.5%	1.2%
Total	37.0%	63.0%	60,099	37.7%	62.3%	55,928	40.7%	59.3%	10,794	41.2%	58.8%	17,493

Avg Age	55.54	57.37	56.70	54.89	56.26	55.74	56.88	57.34	57.15	58.41	57.36	57.79

Age/Sex	1.382	1.318	1.342	1.361	1.287	1.315	1.421	1.426	1.358	1.486	1.316	1.386

Exhibit B

Membership by Age/Sex

Medicare Retirees Age Range	North Carolina			Georgia			Virginia			Tennessee*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
<1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A
1-4	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A
5-9	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A
10-14	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A
15-19	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A
20-24	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A
25-29	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A
30-34	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A
35-39	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A
40-44	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A
45-49	0.2%	0.3%	0.5%	0.0%	0.0%	0.0%	0.1%	0.1%	0.3%	N/A	N/A	N/A
50-54	0.4%	0.7%	1.1%	0.0%	0.0%	0.0%	0.5%	0.8%	1.3%	N/A	N/A	N/A
55-59	0.7%	1.4%	2.1%	0.0%	0.0%	0.0%	1.0%	1.5%	2.4%	N/A	N/A	N/A
60-64	1.3%	2.1%	3.4%	0.0%	0.0%	0.0%	1.8%	2.2%	4.0%	N/A	N/A	N/A
65-74	18.8%	34.2%	53.0%	23.0%	36.5%	59.4%	23.5%	28.9%	52.3%	N/A	N/A	N/A
75+	12.5%	27.1%	39.6%	13.4%	27.1%	40.6%	16.0%	23.0%	39.0%	N/A	N/A	N/A
Total	34.1%	65.9%	106,961	36.4%	63.6%	63,326	43.1%	56.9%	26,967	N/A	N/A	26,957
Avg Age	72.66	73.20	73.02	73.69	74.26	74.06	72.64	72.94	72.81	N/A	N/A	N/A
Age/Sex	2,017	1,748	1,840	2,057	1,777	1,879	2,017	2,031	1,860	N/A	N/A	N/A

* Tennessee Age/Sex information not available for Medicare retirees.

Exhibit B

Membership by Age/Sex

Total Age Range	North Carolina			Georgia			Virginia			Tennessee*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
<1	0.4%	0.3%	0.7%	0.5%	0.4%	0.9%	0.4%	0.4%	0.8%	0.4%	0.4%	0.8%
1-4	1.5%	1.4%	2.9%	2.1%	2.0%	4.0%	1.9%	1.8%	3.7%	2.1%	2.0%	4.1%
5-9	2.1%	2.0%	4.1%	3.1%	3.0%	6.1%	2.6%	2.5%	5.2%	2.9%	2.8%	5.7%
10-14	2.3%	2.2%	4.6%	3.6%	3.5%	7.1%	3.0%	2.9%	5.9%	3.3%	3.1%	6.4%
15-19	2.5%	2.5%	5.0%	3.6%	3.5%	7.1%	3.6%	3.5%	7.0%	3.6%	3.4%	7.0%
20-24	1.8%	2.5%	4.4%	1.7%	2.3%	4.0%	2.5%	2.8%	5.3%	2.2%	2.7%	4.9%
25-29	1.5%	3.6%	5.1%	1.5%	3.2%	4.8%	1.6%	2.3%	3.8%	1.8%	3.1%	4.9%
30-34	1.8%	3.8%	5.6%	2.2%	3.8%	5.9%	2.1%	2.8%	4.8%	2.5%	3.8%	6.3%
35-39	2.3%	4.6%	6.9%	2.9%	4.5%	7.4%	2.8%	3.5%	6.2%	3.1%	4.5%	7.6%
40-44	2.5%	4.8%	7.3%	3.0%	4.5%	7.5%	3.2%	4.0%	7.2%	3.3%	4.6%	7.8%
45-49	2.8%	5.4%	8.2%	3.2%	4.9%	8.1%	3.7%	4.9%	8.6%	3.7%	5.5%	9.2%
50-54	3.2%	6.1%	9.3%	3.3%	5.2%	8.5%	4.2%	5.5%	9.7%	4.3%	6.4%	10.7%
55-59	3.7%	6.6%	10.3%	3.5%	5.5%	9.0%	4.5%	5.3%	9.8%	4.8%	6.7%	11.5%
60-64	3.7%	5.8%	9.5%	3.4%	4.7%	8.1%	3.9%	4.3%	8.2%	4.2%	5.3%	9.5%
65-74	3.6%	6.1%	9.7%	3.1%	4.2%	7.3%	4.2%	4.5%	8.6%	1.8%	1.2%	3.0%
75+	2.1%	4.4%	6.5%	1.4%	2.7%	4.2%	2.1%	3.0%	5.1%	0.2%	0.1%	0.3%
Total	37.7%	62.3%	664,882	42.0%	58.0%	657,386	46.2%	53.8%	227,110	44.2%	55.8%	296,631

Avg Age	42.05	45.75	44.35	37.90	41.17	39.79	40.98	42.41	41.75	37.32	38.97	38.24

Age/Sex	0.962	1.032	1.005	0.847	0.927	0.893	0.924	0.943	0.940	0.800	0.862	0.835

* Tennessee Age/Sex total does not include Medicare retirees.

Exhibit C
Financial Comparison PMPM
Experience by State
Fiscal Year 2009

Actual	North Carolina		Georgia		Virginia		Tennessee	
	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees
Allowed	\$355.10	\$646.38	\$360.35	\$699.43	\$372.56	\$718.31	\$412.97	\$696.21
Cost Share	\$61.21	\$100.00	\$57.36	\$112.12	\$49.53	\$76.42	\$39.60	\$75.63
Cost Share %	17%	15%	16%	16%	13%	11%	10%	11%
State Paid	\$293.88	\$546.38	\$303.00	\$587.30	\$323.04	\$641.89	\$373.38	\$620.58
Contribution	\$57.57	\$57.67	\$75.79	\$95.47	\$43.93	\$43.93	\$74.00	\$91.92
Contribution %	20%	11%	25%	16%	14%	7%	20%	15%
Net Cost	\$236.32	\$488.71	\$227.21	\$491.83	\$279.11	\$597.97	\$299.37	\$528.66
State Paid Benefit	67%	76%	63%	70%	75%	83%	72%	76%

Normalized	North Carolina		Georgia		Virginia		Tennessee	
	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees
Allowed	\$355.10	\$646.38	\$360.35	\$699.43	\$372.56	\$718.31	\$412.97	\$696.21
Age/Sex Factor	0.785	1.342	0.733	1.315	0.773	1.358	0.792	1.339
Normalized Allowed	\$355.10	\$646.38	\$385.92	\$713.79	\$378.35	\$709.85	\$409.32	\$697.77
Cost Share	\$61.21	\$100.00	\$66.52	\$110.43	\$65.22	\$109.82	\$70.56	\$107.95
Cost Share %	17%	15%	17%	15%	17%	15%	17%	15%
State Paid	\$293.88	\$546.38	\$319.39	\$603.36	\$313.13	\$600.03	\$338.76	\$589.82
Difference from NC			9%	10%	7%	10%	15%	8%

Exhibit D
Financial Comparison PMPM
Experience by Dominant Plans
Fiscal Year 2009

Actual	North Carolina Standard PPO		Georgia HMO		Georgia PPO		Virginia HMO/PPO		Tennessee POS	
	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees
Allowed	\$328.22	\$588.50	\$323.74	\$662.94	\$431.87	\$715.99	\$373.91	\$723.85	\$381.12	\$677.32
Cost Share	\$60.84	\$98.35	\$45.35	\$89.43	\$75.91	\$125.26	\$49.57	\$76.53	\$29.97	\$52.92
Cost Share %	19%	17%	14%	13%	18%	17%	13%	11%	8%	8%
State Paid	\$267.38	\$490.14	\$278.39	\$573.52	\$355.97	\$590.73	\$324.34	\$647.32	\$351.14	\$624.40
Contribution	\$48.37	\$48.12	\$72.16	\$90.67	\$86.71	\$99.31	\$44.15	\$47.24	\$67.83	\$81.22
Contribution %	18%	10%	26%	16%	24%	17%	14%	7%	19%	13%
Net Cost	\$219.01	\$442.03	\$206.23	\$482.85	\$269.26	\$491.42	\$280.18	\$600.08	\$283.31	\$543.18
State Paid Benefit	67%	75%	64%	73%	62%	69%	75%	83%	74%	80%

Normalized	North Carolina Standard PPO		Georgia HMO		Georgia PPO		Virginia HMO/PPO		Tennessee POS	
	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees	Active Employees	Non-MC Retirees
Allowed	\$328.22	\$588.50	\$323.74	\$662.94	\$431.87	\$715.99	\$373.91	\$723.85	\$381.12	\$677.32
Age/Sex Factor	0.793	1.346	0.691	1.278	0.815	1.329	0.775	1.359	0.727	1.329
Normalized Allowed	\$328.22	\$588.50	\$371.53	\$698.22	\$420.22	\$725.15	\$382.59	\$716.92	\$415.71	\$685.98
Cost Share	\$60.84	\$98.35	\$88.87	\$116.69	\$77.90	\$121.19	\$70.92	\$119.82	\$77.06	\$114.85
Cost Share %	19%	17%	19%	17%	19%	17%	19%	17%	19%	17%
State Paid	\$267.38	\$490.14	\$302.65	\$581.53	\$342.32	\$603.96	\$311.67	\$597.10	\$338.65	\$571.33
Difference from NC			13%	19%	28%	23%	17%	22%	27%	17%

Exhibit E
2010 Benefit Design Comparison
Active Employee/Non-Medicare Retiree Plans

Benefit Plan	NC - 1		NC - 2		GA - 1		GA - 2		GA - 3		GA - 4	
	North Carolina		North Carolina		Georgia		Georgia		Georgia		Georgia	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
1 Deductible												
2 Individual	\$800	\$1,600	\$800	\$1,200	\$600	\$1,200	\$1,200	\$2,400	\$1,200	\$2,400	\$1,100	\$1,100
3 Family	\$2,400	\$4,800	\$1,800	\$3,600	\$1,800	\$3,600	\$2,400	\$4,800	\$2,400	\$4,800	\$2,750	\$2,750
4 Per Admission Deductible	\$250	N/A	\$200	N/A	N/A	\$250	N/A	N/A	N/A	N/A	N/A	N/A
5 Maximum Out of Pocket	Does Not Include Ded	Does Not Include Ded	Does Not Include Ded	Does Not Include Ded	Includes Ded	Includes Ded	Includes Ded	Includes Ded	Includes Ded	Includes Ded	Includes Ded	Includes Ded
6 Individual	\$3,250	\$6,500	\$2,750	\$5,500	\$2,000	\$4,000	\$4,000	\$4,000	\$1,800	\$4,000	\$2,500	\$2,500
7 Family	\$9,750	\$19,500	\$8,250	\$16,500	\$4,000	\$8,000	\$8,000	\$7,400	\$3,100	\$7,400	\$5,700	\$5,700
8 HRA Credits												
9 Individual	None	None	None	None	None	None	None	None	None	None	\$500	\$500
10 Family	None	None	None	None	None	None	None	None	None	None	\$1,500	\$1,500
11 Coinsurance	70%	50%	80%	60%	80%	60%	60%	60%	90%	60%	85%	60%
12 Physician Office Visit												
13 Primary Care Office Visit	\$30 copay	50%	\$25 copay	60%	\$35 copay	60%	60%	60%	90%	60%	85%	60%
14 Specialist Office Visit	\$70 copay	50%	\$60 copay	60%	\$35 copay	60%	60%	60%	90%	60%	85%	60%
15 Emergency Room Services												
16 ER for Emergency Care	\$250 copay, 70% after deductible		\$200 copay, 80% after deductible		\$150 copay		90%				85%	60%
17 OON Services												
18 Coinsurance for OON (buy-up)												
19 PHARMACY												
20 Copay: Retail												
21 Generic	\$10	N/A	\$10	N/A	\$15	N/A	N/A	N/A	20% after deductible; \$10 min-\$100 max	N/A	15% after deductible	40% after deductible
22 Preferred Brand	\$35	N/A	\$35	N/A	\$40	N/A	N/A	N/A	20% after deductible; \$10 min-\$100 max	N/A	25% after deductible	40% after deductible
23 Non-Preferred Brand	\$55	N/A	\$55	N/A	\$75	N/A	N/A	N/A	20% after deductible; \$10 min-\$100 max	N/A	25% after deductible	40% after deductible
24 Copay: Mail Order												
25 Generic	\$30	N/A	\$30	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
26 Preferred Brand	\$105	N/A	\$105	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27 Non-Preferred Brand	\$165	N/A	\$165	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
28 Pharmacy Copay Annual Maximum	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
29 Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
30 Employee Contributions:												
31 Employee Only	\$0.00	\$0.00	\$0.00	\$0.00	\$100.20	\$94.70	\$94.70	\$54.40	\$54.40	\$62.50	\$62.50	\$62.50
32 Employee & Child(ren)	\$164.07	\$218.17	\$218.17	\$218.17	\$227.60	\$268.10	\$268.10	\$171.40	\$171.40	\$185.30	\$185.30	\$185.30
33 Employee & Spouse	\$422.68	\$502.67	\$502.67	\$502.67	\$236.50	\$278.50	\$278.50	\$176.50	\$176.50	\$191.00	\$191.00	\$191.00
34 Employee + 1												
35 Family	\$450.21	\$532.94	\$532.94	\$532.94	\$245.40	\$289.10	\$289.10	\$181.60	\$181.60	\$196.60	\$196.60	\$196.60
36 Employer Contributions:												
37 Employee Only	\$377.16	\$377.16	\$377.16	\$377.16	\$298.62	\$356.17	\$356.17	\$284.41	\$284.41	\$327.22	\$327.22	\$327.22
38 Employee & Child(ren)	\$377.16	\$377.16	\$377.16	\$377.16	\$490.28	\$543.46	\$543.46	\$438.46	\$438.46	\$516.20	\$516.20	\$516.20
39 Employee & Spouse	\$377.16	\$377.16	\$377.16	\$377.16	\$680.79	\$758.50	\$758.50	\$602.77	\$602.77	\$705.36	\$705.36	\$705.36
40 Employee + 1												
41 Family	\$377.16	\$377.16	\$377.16	\$377.16	\$871.30	\$973.33	\$973.33	\$767.08	\$767.08	\$894.62	\$894.62	\$894.62
42 Total Premium												
43 Employee Only	\$377.16	\$377.16	\$377.16	\$377.16	\$398.82	\$450.87	\$450.87	\$338.81	\$338.81	\$389.72	\$389.72	\$389.72
44 Employee & Child(ren)	\$541.23	\$595.33	\$595.33	\$595.33	\$717.88	\$811.56	\$811.56	\$609.86	\$609.86	\$701.50	\$701.50	\$701.50
45 Employee & Spouse	\$799.84	\$879.83	\$879.83	\$879.83	\$917.29	\$1,037.00	\$1,037.00	\$779.27	\$779.27	\$896.36	\$896.36	\$896.36
46 Employee + 1												
47 Family	\$827.37	\$910.10	\$910.10	\$910.10	\$1,116.70	\$1,262.43	\$1,262.43	\$948.68	\$948.68	\$1,091.22	\$1,091.22	\$1,091.22

Exhibit E
2010 Benefit Design Comparison
Active Employee/Non-Medicare Retiree Plans

Benefit Plan	North Carolina		North Carolina		North Carolina		Virginia		Virginia		Virginia	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	Pro-Base	Pro-Standard	Pro-Base	Pro-Standard	Pro-Base	Pro-Standard
1 Deductible												
2 Individual	\$800	\$1,600	\$600	\$1,200								
3 Family	\$2,400	\$4,800	\$1,800	\$3,600								
4 Per Admission Deductible	\$250	N/A	\$200	N/A								
5 Maximum Out of Pocket												
6 Individual	\$3,250	\$6,500	\$2,750	\$5,500								
7 Family	\$9,750	\$19,500	\$7,250	\$14,500								
8 HRA Credits												
9 Individual	None	None	None	None								
10 Family	None	None	None	None								
11 Coinsurance	70%	50%	80%	60%								
12 Physician Office Visit												
13 Primary Care Office Visit	\$30 copay	50%	\$25 copay	60%								
14 Specialist Office Visit	\$70 copay	50%	\$60 copay	60%								
15 Emergency Room Services												
16 ER for Emergency Care	\$250 copay, 70% after deductible		\$200 copay, 80% after deductible									
17 OON Services												
18 Coinsurance for OON (buy-up)												
19 PHARMACY												
20 Copay, Retail												
21 Generic	\$10	N/A	\$10	N/A								
22 Preferred Brand	\$35	N/A	\$35	N/A								
23 Non-Preferred Brand	\$55	N/A	\$55	N/A								
24 Copay, Mail Order												
25 Generic	\$30	N/A	\$30	N/A								
26 Preferred Brand	\$105	N/A	\$105	N/A								
27 Non-Preferred Brand	\$165	N/A	\$165	N/A								
28 Pharmacy Copay Annual Maximum	N/A	N/A	N/A	N/A								
29 Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited								
30 Employee Contributions:												
31 Employee Only	\$0.00	\$0.00	\$0.00	\$0.00								
32 Employee & Child(ren)	\$164.07	\$218.17	\$164.07	\$218.17								
33 Employee & Spouse	\$422.68	\$502.67	\$422.68	\$502.67								
34 Employee + 1												
35 Family	\$450.21	\$532.94	\$450.21	\$532.94								
36 Employer Contributions:												
37 Employee Only	\$377.16	\$377.16	\$377.16	\$377.16								
38 Employee & Child(ren)	\$377.16	\$377.16	\$377.16	\$377.16								
39 Employee & Spouse	\$377.16	\$377.16	\$377.16	\$377.16								
40 Employee + 1												
41 Family	\$377.16	\$377.16	\$377.16	\$377.16								
42 Total Premium												
43 Employee Only	\$377.16	\$377.16	\$377.16	\$377.16								
44 Employee & Child(ren)	\$541.23	\$595.33	\$541.23	\$595.33								
45 Employee & Spouse	\$799.84	\$879.83	\$799.84	\$879.83								
46 Employee + 1												
47 Family	\$827.37	\$910.10	\$827.37	\$910.10								

Exhibit E
2010 Benefit Design Comparison
Active Employee/Non-Medicare Retiree Plans

Benefit Plan	NC - 1 North Carolina		NC - 2 North Carolina		TN - 1 Tennessee		TN - 2 Tennessee		TN - 3 Tennessee	
	PPO-Base		PPO-Standard		PPO		POS		HMO	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
1 Deductible	\$800	\$1,600	\$600	\$1,200	\$350	\$350	\$0	\$300	\$0	\$0
2 Individual	\$2,400	\$4,800	\$1,800	\$3,600	\$875	\$875	\$0	\$750	\$0	\$0
3 Family	\$250	N/A	\$200	N/A	N/A	N/A	\$100	\$300	\$100	\$100
4 Per Admission Deductible	Does Not Include Deductible	Does Not Include Deductible	Does Not Include Deductible	Does Not Include Deductible	Includes Deductible	Includes Deductible				
5 Maximum Out of Pocket	\$3,250	\$6,500	\$2,750	\$5,500	\$1,350	\$4,050	None	None	None	None
6 Individual	\$9,750	\$19,500	\$8,250	\$16,500	\$2,700	\$8,100	None	None	None	None
7 Family										
8 HRA Credits	None	None	None	None	None	None	None	None	None	None
9 Individual	None	None	None	None	None	None	None	None	None	None
10 Family	None	None	None	None	None	None	None	None	None	None
11 Coinsurance	70%	50%	80%	60%	90%	70%	100%	70%	100%	100%
12 Physician Office Visit	\$30 copay	50%	\$25 copay	60%	90%	70%	\$25 copay	70%	\$20 copay	\$20 copay
13 Primary Care Office Visit	\$70 copay	50%	\$60 copay	60%	90%	70%	\$30 copay	70%	\$25 copay	\$25 copay
14 Specialist Office Visit										
15 Emergency Room Services										
16 ER for Emergency Care	\$250 copay, 70% after deductible		\$200 copay, 80% after deductible		\$75 copay	\$75 copay	\$75 copay		\$75 copay	\$75 copay
17 OON Services										
18 Coinsurance for OON (buy-up)										
19 PHARMACY										
20 Copay, Retail										
21 Generic	\$10	N/A	\$10	N/A	\$5	\$5 + cost above in-network rates	\$5	70%	\$5	\$5
22 Preferred Brand	\$35	N/A	\$35	N/A	\$25	\$25 + cost above in-network rates	\$25	70%	\$25	\$25
23 Non-Preferred Brand	\$55	N/A	\$55	N/A	\$75	\$75 + cost above in-network rates	\$75	70%	\$75	\$75
24 Copay, Mail Order										
25 Generic	\$30	N/A	\$30	N/A	\$10	\$10	\$10	70%	\$10	\$10
26 Preferred Brand	\$105	N/A	\$105	N/A	\$50	\$50	\$50	70%	\$50	\$50
27 Non-Preferred Brand	\$165	N/A	\$165	N/A	\$100	\$100	\$100	70%	\$100	\$100
28 Pharmacy Copay Annual Maximum	N/A	N/A	N/A	N/A	\$1,620	\$1,620	N/A	N/A	N/A	N/A
29 Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
30 Employee Contributions:										
31 Employee Only	\$0.00		\$0.00		\$107.62		\$85.64		\$78.76	
32 Employee & Child(ren)	\$164.07		\$218.17							
33 Employee & Spouse	\$422.68		\$502.67							
34 Employee + 1										
35 Family	\$450.21		\$532.94		\$268.69		\$213.86		\$195.06	
36 Employer Contributions:										
37 Employee Only	\$377.16		\$377.16		\$430.48		\$430.47		\$430.47	
38 Employee & Child(ren)	\$377.16		\$377.16							
39 Employee & Spouse	\$377.16		\$377.16							
40 Employee + 1					\$1,074.75		\$1,074.75		\$1,074.76	
41 Family	\$377.16		\$377.16							
42 Total Premium										
43 Employee Only	\$377.16		\$377.16		\$538.10		\$516.11		\$509.23	
44 Employee & Child(ren)	\$541.23		\$595.33							
45 Employee & Spouse	\$799.84		\$879.83							
46 Employee + 1					\$1,343.44		\$1,288.61		\$1,269.82	
47 Family	\$627.37		\$810.10							

Exhibit F
2010 Benefit Design Comparison
Medicare Retiree Plans

Benefit Plan	NC - 1		NC - 2		GA - 1		GA - 2		VA - 1		TN - 1	
	North Carolina		North Carolina		Georgia		Georgia		Virginia		Tennessee	
	In-Network	Out of Network	In-Network	Out of Network	MAPD Standard	MAPD Premium	MAPD Standard	MAPD Premium	Rockledge 65	Rockledge 65	Medigap Plan D	Medigap Plan D
1 Deductible												
2 Individual	\$800	\$1,600	\$600	\$1,200	\$0	\$0	\$0	\$0	\$100 Part A; \$155 Part B; \$310 Brand Rx	\$0	\$155 Part B	\$0
3 Family	\$2,400	\$4,800	\$1,800	\$3,600	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4 Per Admission Deductible		N/A			\$190 per day/days 1-4	\$100 per day/days 1-3						
5 Maximum Out of Pocket												
6 Individual	Does Not Include Ded	Does Not Include Ded	Does Not Include Ded	Does Not Include Ded	\$1,000	\$500			None	None	None	None
7 Family	\$3,250	\$6,500	\$2,750	\$5,500	N/A	N/A			None	None	None	None
8 HRA Credits	\$9,750	\$19,500	\$8,250	\$16,500								
9 Individual	None	None	None	None	None	None			None	None	None	None
10 Family	None	None	None	None	None	None			None	None	None	None
11 Coinsurance	70%	50%	80%	60%	90%/100%	90%/100%			100%	100%	100%	100%
12 Physician Office Visit												
13 Primary Care Office Visit	\$30 copay	50%	\$25 copay	60%	\$20 copay	\$10 copay			\$0 copay	\$0 copay	\$0 copay	\$0 copay
14 Specialist Office Visit	\$70 copay	50%	\$60 copay	60%	\$25 copay	\$20 copay			\$0 copay	\$0 copay	\$0 copay	\$0 copay
15 Emergency Room Services												
16 ER for Emergency Care	\$250 copay, 70% after deductible		\$200 copay, 80% after deductible		\$50 copay	\$50 copay			\$0 copay	\$0 copay	\$0 copay	\$0 copay
17 OON Services												
18 Coinsurance for OON (buy-up)												
19 PHARMACY												
20 Copay: Retail												
21 Generic	\$10	N/A	\$10	N/A	\$10	\$10			\$7	N/A	N/A	N/A
22 Preferred Brand	\$35	N/A	\$35	N/A	\$25	25% up to max of \$25			\$25	N/A	N/A	N/A
23 Non-Preferred Brand	\$55	N/A	\$55	N/A	\$50	25% up to max of \$50			75% Non-Preferred / 25% Specialty	N/A	N/A	N/A
24 Copay: Mail Order												
25 Generic	\$30	N/A	\$30	N/A	\$20	\$20			\$7	N/A	N/A	N/A
26 Preferred Brand	\$105	N/A	\$105	N/A	\$50	25% up to max of \$50			\$50	N/A	N/A	N/A
27 Non-Preferred Brand	\$165	N/A	\$165	N/A	\$100	25% up to max of \$100			75% Non-Preferred / 25% Specialty	N/A	N/A	N/A
28 Pharmacy Copay Annual Maximum	N/A	N/A	N/A	N/A	N/A	N/A			\$4,550	N/A	N/A	N/A
29 Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited			Unlimited	Unlimited	Unlimited	Unlimited
30 Employee Contributions:												
31 Employee Only	\$0.00		\$0.00		\$19.30	\$59.30			\$258.00	\$121.00		
32 Employee & Child(ren)	\$114.70		\$152.52		\$38.60	\$118.60						
33 Employee & Spouse	\$289.34		\$344.64		\$38.60	\$118.60						
34 Employee + 1												
35 Family	\$314.62		\$372.44		\$38.60	\$118.60						
36 Employer Contributions:												
37 Employer Only	\$263.72		\$263.72		\$165.70	\$150.70			\$0.00	\$0.00		
38 Employee & Child(ren)	\$263.72		\$263.72		\$331.40	\$301.40						
39 Employee & Spouse	\$263.72		\$263.72		\$331.40	\$301.40						
40 Employee + 1												
41 Family	\$263.72		\$263.72		\$331.40	\$301.40						
42 Total Premium												
43 Employee Only	\$263.72		\$263.72		\$185.00	\$210.00			\$258.00	\$121.00		
44 Employee & Child(ren)	\$378.42		\$416.24		\$370.00	\$420.00						
45 Employee & Spouse	\$553.06		\$608.36		\$370.00	\$420.00						
46 Employee + 1												
47 Family	\$578.34		\$636.16		\$370.00	\$420.00						

Exhibit G

Types of Health Plans—PPO

- ➔ PPO's or Preferred Provider Organizations offer a network of preferred credentialed providers who accept a plan's payment based on a negotiated discount, but these types of plans also allow members to seek services out of network.
- Members pay less out of pocket if they seek services in-network.
- NC, Georgia, and Tennessee all offer PPO plans; Virginia's out of network option is similar to a PPO plan.

Types of Health Plans—HMO's

- HMO's or Health Maintenance Organizations offer services through an exclusive network that its membership is required to utilize.
- An integral part of an HMO is to manage patient care through the patient's primary care provider, and typically, the member is required to select a primary care provider (PCP) under these products
 - Although there are many different HMO models, there are two distinctive types of HMO's
 - A Gatekeeper HMO typically requires a member to seek any specialty services through his or her PCP, and a referral to a specialist is required.
 - In an open-access HMO, members are still restricted to services rendered by a participating provider. However, they may access specialty services without a referral.

Exhibit I

Types of Health Plans—POS

- POS or Point of Service plans, often look a lot like PPO's. Some companies no longer offer these plans side-by-side with PPO's because they are so similar.
 - In the past, the in-network component of a POS product was an HMO; under this model, members could go through their PCP to obtain referrals to specialists in-network at a much lower rate, or seek services out of network without the same referral requirements, but higher cost-sharing.
 - With the advent of 'open access' to specialists, many PPO and POS products look virtually the same.

Types of Health Plans—HDHP (HSA)

- High Deductible Health Plans (HDHPs) with a tax deductible Health Savings Account (HSA) are plans with limits defined by law (e.g. \$1,200 deductible for 2010)
 - Both employers and employees can contribute to the HSA
 - The HSA can be used to pay deductibles, coinsurances or other eligible expenses
 - The concept is that if most services require a percentage of cost-sharing rather than copays, members will become more effective shoppers for their own health care services.
 - This type of plan can also be integrated with strong wellness incentives, low cost annual physicals, and very strong disease and case management programs
 - The HSA is the employee's account, and it goes with the employee if they should leave employment

Exhibit K

Types of Health Plans—CDHP (HRA)

- A Consumer Driven Health Plan (CDHP) with a Health Reimbursement Account (HRA) employs the same techniques as an HDHP, but design is not limited to federal requirements, and the HRA is funded by the employer in a manner similar to funding other benefits
 - The money doesn't have to be 'set aside' in a separate account; employers can provide reimbursements out of the health plan fund.
 - Any dollars provided via an HRA stays with the employer if the member should leave employment.

Eat Smart, Move More, Weigh Less for NC Teachers and State Employees

February 2010 Update

Eat Smart, Move More, Weigh Less (ESMM WL) is a 15-week weight management program that uses strategies proven to work for weight loss/maintenance. The NC State Health Plan entered into a 2-½ year contract (July 2009 – December 2011) with NC Cooperative Extension and NC Division of Public Health. The contract provides funding to hire instructors to offer ESMM WL to state employees at their worksites in the five counties, i.e. Guilford, Mecklenburg, Orange, Pitt, and Wake, with a the high concentration of state employees.

A minimum of 250 classes will be offered between July 2009 and June 2011 at state worksites including public schools. Cost to the Plan, per participant, is \$160 for an average class size of 20 employees.

The protocol for the contract dictates participants pay a \$30 entry. Participants who complete at least 10 of the 15 sessions receive a \$25 refund.

Summary of progress made since July 2009:

- Hired two 0.5 FTE program coordinators to manage all contract activities
- Completed a statewide survey of existing instructors to assess their interest in working with state worksites
- Hired and trained eight program instructors
- Hired a lead instructor with primary responsibility of teaching classes as well as observing other instructors and providing performance appraisals
- Convened an evaluation team retreat and updated the evaluation instrument
- Developed on-line training modules and webinar presentation for training new instructors on an ongoing schedule
- Revised curriculum and program magazine to include new physical activity guidelines and other content updates
- Completed 22 classes during August 2009 – December 2009
- **Enrolled 440 participants in the 2009 series. Nearly 70% completed the program and achieved an average weight loss of 6 lbs.**
- **Forty-seven (47) classes in progress for January 2010 – April 2010 increasing the total number of participants to 860.**
- Developed and launched program Website – www.ESMMWeighLess.com
- Encouraging use of the Worksite Wellness ToolKit training modules for ongoing participant support

State Health Plan Weight Loss Medication Coverage Recommendations

Blue Ribbon Task Force Meeting - February 2010

Current Formulary Status – As of January 1, 2010, the Plan in consultation with the Pharmacy and Therapeutics committee, removed access barriers to weight loss drugs by moving brand products to the Preferred copay tier and removing the prior authorization requirements.

2009	2010
Generics (Phentermine, Diethylpropion, Phendimetrazine, Benzphetamine) - \$10	Generics - \$10
Non-Preferred Brands (Meridia®, Xenical®) - \$55	Preferred Brands (Meridia®, Xenical®) - \$35
Prior authorization required for all generic and brand weight loss medications initial prescriptions and renewals.	No prior authorization required for any weight loss medication initial prescriptions or renewals.

2009 Utilization statistics:

Total prescription users – 1,267 (56% generic users and 44% Brand users)

Total prescriptions – 3,060 (57% generics and 43% Brands)

Average Days supply per user – 71

Weight Loss Medication Clinical Information:

- Primary Care guidelines on the management of obesity recommend that pharmacologic therapy can be offered to obese patients who have failed to achieve their weight loss goals through diet and exercise alone. However, there needs to be a doctor-patient discussion of the drugs' side effects, the lack of long-term safety data, and the temporary nature of the weight loss achieved with medications before initiating therapy.
- All of the medications have side effects.
- Long-term safety and efficacy (>12 months) data are not available.
- The amount of extra weight loss attributable to weight loss medications is modest (< 10 lbs at 1 year).
- On January 21, the FDA requested the manufacturer of Meridia to add a new contraindication for the package labeling stating that Meridia is not to be used in patients with a history of cardiovascular disease. In Europe, Meridia has been recommended for withdrawal from the market due to the increased risk of cardiovascular events seen in clinical studies.
- Since 1997, 5 drugs have been removed from the US and International markets because of efficacy and safety concerns.
- There is no data to determine whether one drug is more efficacious than another, and there is no evidence for increased weight loss with combination therapy.
- There is no data about weight regain after medications are withdrawn, highlighting the need for sustained lifestyle and behavioral modifications.

Recommendation:

Because of the Comprehensive Wellness Initiative it is appropriate to remove authorization and large financial obstacles for these medications; however, the Plan should not lower copays any further for weight loss medications and promote these products due to safety and efficacy concerns.



NORTH CAROLINA GENERAL ASSEMBLY
16 West Jones Street
LEGISLATIVE BUILDING
RALEIGH NC 27601

March 1, 2010

MEMORANDUM

TO: Members, State Health Plan Blue Ribbon Task Force

FROM: Rep. Hugh Holliman, Co-Chair
Sen. Dan Blue, Co-Chair

SUBJECT: Committee Meeting Notice

The State Health Plan Blue Ribbon Task Force Committee will meet on the following date:

DAY: Thursday
DATE: March 25, 2010
TIME: 9:00 am
LOCATION: Room 1228 Legislative Building

If you have any questions concerning this meeting or you cannot attend, please contact Carol Bowers, Committee Clerk at 919-715-0873 or Hollimanla@ncleg.net.

Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

Thursday, March 25, 2010

9:00 a.m.

Legislative Building, Room 1228/1327

I. Welcome, Introductions, and Remarks

Representative Hugh Holliman, Co-Chair
Senator Dan Blue, Co-Chair

II. Approval of Minutes *see Sharnese Ransome's note*

III. "Creating the Environment for Success"



Chris M. Shoffner, Managing Partner
White Bear Group

info from coming

IV. "Know Your Number® Promoting Healthier Lives and Saving Smillions for North Carolina"



Mark Ruby, VP for Business Development
BioSignia

V. Discussion Time Requested Task Force Members:



Victoria Simmons
Rep. Folwell

VI. Closing Remarks & Adjournment

HOUSE PAGES

NAME OF COMMITTEE Blue Ribbon Task Force State Health Plan DATE 3/25/10

1. Name: _____

County: _____

Sponsor: _____

2. Name: _____

County: _____

Sponsor: _____

3. Name: _____

County: _____

Sponsor: _____

4. Name: _____

County: _____

Sponsor: _____

5. Name: _____

County: _____

Sponsor: _____

SGT-AT-ARM

1. Name: Earl Coker (House) SENATE
2. Name: Charles Harper (Senate) CHESTER WHITE
3. Name: Martha Madison (House) CHARLES HARPER
4. Name: _____

VISITOR REGISTRATION SHEET

Blue Ribbon Task - State Health 4/25/10
 Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Julia Leggett	The Arc of NC
Fred Bone	Bone & Assoc.
Meag O'Donnell	ON
2nd Baggett	Smith Moore Leatherwood
Lori Ann Harris	NAHSA
Ashley Enaul	NMSS - NC
Erin Schuetz	UNC-GA
Michael Horser	NC Dept of Revenue

VISITOR REGISTRATION SHEET

Blue Ribbon Task - State Health ³/_{25/10}
 Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Ken Melton	K. M. A.
Phyllis Trone	NCAEC
Bill Rustin	AD
Bo Hatt	McGuire Wood
Jeff Drozda	UNITED HEALTH GROUP
Maria Minceloh	Paynet Small
Pam Heardory	NC Retired School Personnel
Carl Dean	OSP
Larry Presnell, Jr.	NCRSP
Tina Harrison	WCPSS
DANIEL BAUM	TROUTMAN SAUNDERS

VISITOR REGISTRATION SHEET

Blue Ribbon Task Force, State Health 3/25/10
 Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
<u>Mark Hall</u>	<u>TPG</u>
<u>Kathy Eller</u>	<u>NRN</u>
<u>Cari Brockett</u>	<u>NCMS</u>
<u>Brandon James</u>	<u>OSBM</u>
<u>Carm Cover</u>	<u>BPR & C</u>
<u>Jim Stegall</u>	<u>U.C.P.S</u>
<u>Peter Hans</u>	<u>Nelson Mullins</u>
<u>Jonny Nichols</u>	<u>CR</u>
<u>Robert Brath</u>	<u>CR</u>
<u>Candice Tucker</u>	<u>MedCO</u>

VISITOR REGISTRATION SHEET

State Health Plan

Name of Committee

3/25/10
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

J.W. Walker	State Health Plan
Anne Rogers	State Health Plan
Mona Moon	SHP
Sally Morton	SHP
Tracy Stephenson	SHP
TERESA Gutierrez	White Bear Group
Laura Cook	Roche Diagnostics
ANTONIO GUTIERREZ	WHITE BEAR GROUP
Allen Cobb	MAGNUS HEALTH PORTAL
Chas Scarantino	Magnus Health Portal
Lorraine Munk	State Health Plan

VISITOR REGISTRATION SHEET

Name of Committee

Date

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NAME

FIRM OR AGENCY AND ADDRESS

Ron Condrey	NC DOI
Jean Holliday	NC DOI
Rose Williams	NC DOI
Sam & Sarah	WCSR
Cheryl Best	NEMS
John Bowditch	AstraZeneca
K. Wright	BARBAR
Mark Frey	BCBSNC

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME _____

FIRM OR AGENCY AND ADDRESS

LINDA MCCRUDDEN

State Health Plan

MINUTES
Blue Ribbon Task Force on the State Health Plan
For Teachers and State Employees

Thursday, March 25, 2010
9:00 a.m.
Legislative Building, Room 1228/1327

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees met Thursday, March 25, 2010 at 9:00 a.m. in Room 1228/1327 of the Legislative Building. Co-Chair Representative Hugh Holliman presided. (*SEE ATTACHMENT: Members and Guests Attending.*)

Presentations

The early part of the meeting was given over to information regarding wellness programs. Co-Chair Holliman introduced Chris Shoffner, Managing Partner of the White Bear Group, an employee benefit consulting firm. (*SEE ATTACHMENT: "Creating the Environment for Success etc."*)

Mr. Shoffner's opening premise was that the only way to reduce the cost of the SHP was to get members healthier by modifying their behavior.

The example the Asheville Project; which employs value based benefit design. He promised to provide members of the Task Force with a paper which will be presented in Washington, D. C. on March 30, 2010 to a group convening to examine health care costs and benefits.

Mr. Shoffner quoted from the SHPS State Health Practices Study of 2007, "companies that spend less on healthcare focus on improving the health of their employees, while those that spend more, focus on the administrative aspects of healthcare, such as procurement." The SHPS study shows that best practice employers manage the care of their chronically ill employees, providing cash incentives to be healthier, along with a consistent communication objective.

Mr. Shoffner offered examples of several companies which have instituted health plans following these principles and experienced deep reductions in health care costs. Ordnance Systems Inc. and Safeway both used health reimbursement accounts.

In another portion of the presentation, using an excerpt from the American Academy of Actuaries, Mr. Shoffner pointed out that CIGNA used a consumer driven health care approach and classified nearly 250 drugs as preventive drugs and thus free under the CIGNA plan.

The Asheville Project approach to preventive health began in the mid 1990s with the idea of working with diabetic employees working for the City of Asheville. The startup began with the UNC School of Pharmacy and the North Carolina Association of Pharmacists. The diabetic patients received all the care associated with diabetes free. Out of this experience came the Ten City Challenge funded by Glaxo Smith Kline to try the approach on a larger scale and with a greater geographic spread. The model continued to produce the same results: lower health care costs, increased productivity, etc. Now the model has been expanded into other health problem areas: COPD, asthma, depression etc.

The City of Fayetteville has just completed the first year using this model. The results have been better than average.

To move the Asheville Project today Mr. Shoffner said requires four keys:

- Identify those with needs via Health Fairs etc.
- Engage beyond the chronically ill; remove barriers

- Educate through face to face coaching
- Communicate at all steps to allow all to get information

Mr. Shoffner believes the plan can make primary care profitable.

In the discussion that followed, Senator Apodaca asked how active primary care physicians were in the Asheville Project. Mr. Shoffner said a primary care physician and a pharmacist were required in the collaboration.

Representative Braxton asked how the results could be known, guaranteed in effect to prevent certain health problems. Mr. Shoffner said there was ten years of clinical information on the N. C. Pharmacists website. Representative Braxton also wanted to know if any entire states had tried this approach. Mr. Shoffner said he did not know if any states had implemented the plan on a full scale. He said a pilot had been done in Louisiana and the City of Rocky Mount had implemented it—but the results had been the same where ever it was used.

Dr. Myers said the data seemed to show the most benefits in the first year, but wondered about the savings beyond that time. Mr. Shoffner again referred to the N. C. Pharmacists website. He said the CIGNA figures showed the same savings the second year of the plan as the first. He also said that the report to be made in Washington on March 30th would quantify the results.

Mr. Feezor asked how Health Savings Accounts and Health Reimbursement Accounts figured into such a model as the Asheville Project. Mr. Shoffner said he favored the HRA because they offered more flexibility.

Mr. Stone asked if there was data regarding Medicare eligible participants. Mr. Shoffner said the Community Care Network and Medicaid has been running a hybrid of the model. Since the care is already free there is a lack of an incentive, but that an incentive could be laid over the model: with a gas card, phone card or some other type of cash value for the member.

Mr. Shoffner said that the coaching method used in the Asheville project was one on one. He did say that his primary care physician's opinion was that the introductory message for diabetics, for example, could be given to a group—after that whether the coaching was one on one or in a group would depend on preference.

When asked about using the Asheville Project as a pilot in the State Health Plan community, Mr. Shoffner said since there was ten years of data available why not implement the plan across the entire membership.

Mr. Feezor noted that the Community Care Network working in New Hanover County had used the group education method in its work.

Senator Apadoca asked the average age in the Asheville Project and if retirees were participating. Mr. Shoffner said retirees did participate in the Fayetteville and said the average employee age in the Asheville Project was about 40. Retirees' participation in other locations varied.

Representative Braxton asked the percentage of first year costs increased for the Asheville Project. Mr. Shoffner said he could not give a percentage, but the first cost for the Asheville Project was \$600 per member.

Mr. Stone asked if the analytical tool used to assess the membership was based on 30 cents per member per month across the board and the personal health record cost of 85 cents per member per month was based on those participants who were involved in the coaching aspects. Mr. Shoffner concurred.

Co-Chair Representative Holliman introduced Mark Ruby, Vice President for Business Development for BioSignia, a healthcare risk assessment company located in the Research Triangle Park. *(SEE ATTACHMENT: Promoting Healthier Lives and Saving etc.)*

Again the approach is to focus on disease prevention rather than "treating the sick". The company proposes health screening to 300,000 State Health Plan members twice each year

during a five year period. BioSignia believes this will have an impact on 70,000 plus diabetic and pre-diabetic SHP members. The company figures a \$124 million saving in health costs over the 5-year period.

BioSignia uses a system called Know Your Number which develops a confidential profile of the participant which identifies potential diseases and then an individual health plan which maps out the steps to improvement.

BioSignia has worked with the State Health Plan on various grant-funded projects and with several North Carolina agencies. The company is beginning to work with the N. C. Department of Correction and Kerr Drug in a coaching type situation like the Asheville Project.

The Know Your Number mechanism is such that the potential disease burden can be projected. For instance, the mechanism can project that the State Health Plan will have over 11,000 new cases of Type II diabetes in the next five years. As it stands now, that 5 years could bring the SHP 7500 new cases of heart disease and 5000 case of stroke. The Centers for Disease Control believes that 80% of heart disease, stroke and Type II diabetes is preventable. Theoretically, the SHP is facing \$600 million dollars in costs for new cases of heart disease, stroke and Type II diabetes over the next 5 years; people who have not shown up yet as having those risks.

According to Mr. Ruby, the current wellness approach involves old technology. The Know Your Number system shows the individual the knowledge to lower the risks and how to obtain that knowledge and use it in the individual cases.

In the discussion, Mr. Ruby told Mr. Stone that the Know Your Number system had not been applied to a group of Medicare eligible individuals. Also any face to face discussion of the health risk assessment would be up to the coaching group. The SHP has the informational breakdown of the pilot projects done with the state agencies using the KYN system.

While Mr. Ruby offered to do an assessment for members of the Task Force, but Dr. Walker, Executive Administarto of the SHP reminded the group that the members should not receive a gift from a vendor.

Ms. Simmons and Representative Folwell had requested time to speak to their fellow Task Force members.

Ms. Simmons provided a handout of including redacted pay slips for several employees from the Guilford County School system. (*SEE ATTACHMENT: Guilford County Schools etc.*) She termed this as "awareness time" in terms of costs to various members of the SHP and the needs of these members. Representative Braxton asked Ms Simmons if she had any feedback from people she spoke with concerning possible cost to members of approximately \$100 per month for themselves and \$250 per month to obtain coverage for families. She said the people believe that the SHP was a promise of affordable health coverage and these people believe that promise is for the employee's health care be paid for. She remembered the Task Force's first meeting when there was discussion of the impact of members paying \$10 per month, at another meeting the figure was \$25 per month and now the example was \$100 per month. She wondered if that figure would be \$200/month at the next meeting. As she said, "Where will it end?"

Dr. Harrison asked the percentage of SHP members who have member only coverage. Dr. Walker said that was 80%.

Mr. Stone said that employees and retirees had said to him that the State made a promise to provide employee coverage at no cost. Co-Chair Representative Holliman asked where the promise came from. Mr. Stone said this was contained in information provided at the time of employment. It is not clear if this is a promise in perpetuity.

Mr. Feezor asked Ms. Simmons if a member contribution was based on salary would be more suitable to the people she has spoken with. She said the effect of percentage increases did have a great impact and that a contribution based on salary would be better.

Although the term "promise" was used in further discussion there was no source or statute cited, only that the practice of employer-paid coverage for the employee had been in place for some time.

Next, Representative Folwell spoke to the Task Force regarding a change for the SHP to a calendar year. (*SEE ATTCHMENT: House Bill 348 etc.*) The bill to make that change, sponsored by Representative Folwell, Co-Chair Representative Holliman, Representative Blackwell and Senator Blue (when he was a member of the House) is in the House Appropriations Subcommittee on Health and Human Services. Representative Folwell said the bill has been endorsed by the North Carolina Association of Educators, the State Employees Association, the North Carolina Retired Governmental Employees Association and the North Carolina Retired School Personnel Association. In addition, he said that 24 states use the calendar year for their respective health plans.

He asked the Task Force to endorse the change. Ms. Adcock said the idea seemed so logical and she wondered about opposition. Representative Folwell said the change would cost approximately \$25 million. Such a change, he said would mean no ability to increase premiums for six months. He pointed out that the state agencies were the largest payer of premiums, not the individuals.

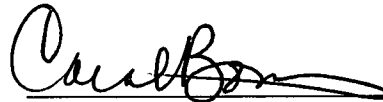
Mr. Stone reiterated the support for the change by the SEANC. He also pointed out that every other year when the General Assembly was considering the budget, SHP members were being asked to sign the open enrollment forms without knowing what the premiums or benefits would be until the budget was passed. He said the change would also benefit Medicare recipients and members planning health savings account. He predicted that federal health care reform plans would be on a calendar year.

The meeting was adjourned at 11:56 a.m.

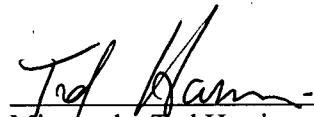


Representative Hugh Holliman, Co-Chair
Presiding

Senator Dan Blue, Co-Chair



Carol Bowers, Clerk



Minutes by Ted Harrison

Creating the Environment for Success

Chris M. Shoffner

Creating the Environment for Success

- Define Value Based Benefit Design
- Explain Financial Impact of Best Practices
- Explore Three Specific Examples
- Asheville 2010

Value Based Benefit Design

- **Value-based insurance design** is a strategy that minimizes or eliminates out-of-pocket costs for high-value services in defined patient populations.
- High value services are identified through evidence-based analysis.
- The more clinically beneficial and cost-effective the therapy is for a patient group, the lower the out-of-pocket costs.

Financial Impact of Best Practices

- companies that spend less on healthcare focus on improving the health of their employees, while those that spend more focus on the administrative aspects of healthcare, such as procurement.*

*2007 SHPS Health Practices Study: What Every Self-Insured Employer Should Know.

Specific Examples

- Ordnance Systems Inc./Safeway
- CIGNA Choice Fund/American Academy of Actuaries May 2009 Report
- "The Asheville Project"

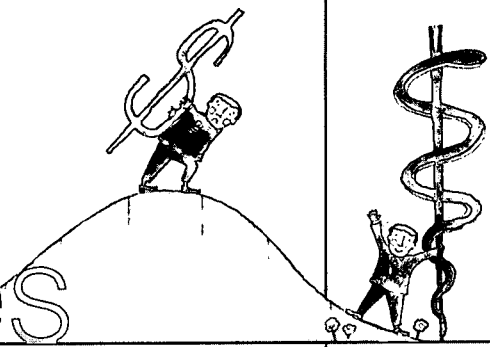
Asheville 2010

- Identify – Health Fair, Analytics
- Engage – Value Based Plan Design
- Educate – Face to Face Coaching towards Measurable Goals
- Communicate – Enrollment Process, Coaching, PHR

Asheville 2010

- Analytic Tool – 30 cents pm/pm
- Portable PHR – 85 cents pp/pm
- Face to Face Coaching - \$250 pp/pyr
- Happier, Healthier more Productive Employees – PRICELESS!!

100% SHPS
Health Practices
What Every Self-Insured Employer Should Know
Study



2007 SHPS Health Practices Study

What Every Self-Insured Employer Should Know

Introduction from Rishabh Mehrotra SHPS President & CEO

What can we learn about healthcare from a steel company, or a bank, or a soft-drink bottler? Quite a bit as it turns out.

For all practical purposes, every self-insured employer manages its own unique health plan. It underwrites the cost of healthcare and owns the financial risk associated with the health of their employees. Yet, not all employers are equally adept at managing their health plan. Several recent studies by leading health actuarial firms have noted the same observation: there is a widening gap in the cost of healthcare between employers that cannot be explained by differences in workforce demographics, location or coverage. Some employers have experienced double-digit increases in healthcare costs for several years in a row. But there are also employers who are effectively administering many of the most-efficient health plans that exist in our nation today.

The premise behind the *2007 SHPS Health Practices Study* is to understand why some employers are so much more efficient in delivering health benefits to their employees than others. Which strategies and tactics work? Do some benefits policies lead to higher costs? At the most basic level, the study revealed an interesting dichotomy – companies that spend less on healthcare focus on improving the health of their employees, while those that spend more focus on the administrative aspects of healthcare, such as procurement.

The results of the *2007 SHPS Health Practices Study* offer clear direction for self-insured employers. To manage healthcare costs, employers need to take a sharply focused, outcome-oriented and *relentless* approach to measuring and managing the prevalent clinical risks within their covered population. Employers need objective health analytics combined with administrative, clinical and financial programs that support a culture of health. Sometimes, this means confronting employees directly with the need to change personal habits and health behaviors. However, the results of our study show that employers already navigating this path have reaped an enormous competitive advantage through improved health and productivity at lower cost. In companies where employee health is valued, the employer and employee both benefit.

Not all of the study findings reflect well on our industry. Some challenge traditional benefits practices, some make good intuitive sense and others go against the grain of conventional thinking.

I hope you will find the results of our inaugural health practices study illuminating – and worthy of discussion on how we can create a better, more practical financial model to deliver healthcare – for all involved.

Wishing you good health,


Rishabh Mehrotra



Why Do Some Companies Pay More For Health Benefits Than Others?

The 2007 SHPS Health Practices Study began with a simple observation. While most employers experience year-over-year increases in healthcare costs averaging three to five times the rate of inflation, SHPS observed that a handful of its clients consistently managed their healthcare costs down to the rate of inflation without cutting health coverage or shifting costs.

What made this observation especially puzzling was that none of the clients appeared to have much in common. They represent diverse industries, possess distinctive workforce demographics and corporate cultures, offer dissimilar health plans, and are located in different parts of the country. For unexplained reasons, they consistently outperform other employers in managing healthcare costs. An informal investigation of these clients revealed a framework for effective healthcare practices. This framework is documented in our 2006 publication titled *Making Consumerism Work: A Practical Guide for Transforming Healthcare*.

So, why do some self-insured employers pay more for healthcare than others? SHPS designed the study to answer this question. One hundred and fifteen companies representing almost four million covered lives completed a 230-item survey.

Classic benefits benchmark studies focus on forecasting actuarial trends and allow companies to compare health benefits against their peers. In contrast, this unique survey considered a much broader range of practices – health benefits strategies, plan design, vendor procurement, health analytics, care management programs, provider quality, network discounts, administration and communication. After factoring out differences in location and workforce composition, SHPS then correlated these practices with total healthcare

expenditures per employee. This study is not designed to specifically report on the health practices in use by employers, but instead focuses on which practices have a positive or negative impact on healthcare costs.

A National Trend

Recent studies by leading health consultants noted substantial differences in per employee healthcare costs – on the order of \$1,200 to \$2,500 or more per benefit-eligible employee per year. For a company with 20,000 employees, this cost differential could yield an enormous competitive advantage – \$24 million to \$50 million per year in discretionary dollars that could be invested elsewhere or passed on to shareholders.

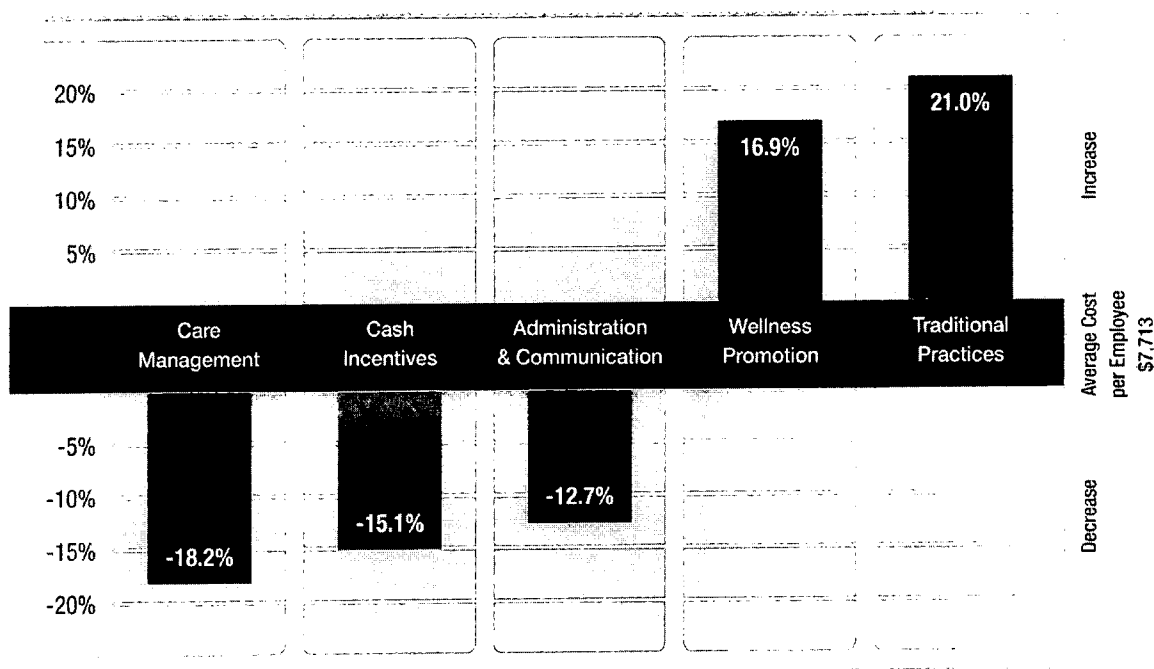
The results of the 2007 SHPS *Health Practices Study* challenge many traditional practices. Based on the survey data collected, the average employer spent \$7,713 in healthcare costs per benefit-eligible employee. The study shows that the use of certain practices in healthcare management could explain enormous differences in per employee costs – as much as 30 to 50 percent between two otherwise comparable employers (see Exhibit 1). The charts on the following pages summarize the findings.

It is important to note that best practice employers did not achieve their healthcare cost savings overnight. The best practices identified in this study typically require several years to reach their full potential. Employers who are only now starting to develop effective health practices will need patience and perseverance to achieve parity with companies who have had programs in place for at least three years.

Study Methodology

SHPS' study findings are based upon a statistical regression model and do not prove strict causality. However, they do demonstrate that certain employer health practices have a strong positive or negative correlation to the cost of healthcare. In reality, these practices will co-exist rather than stand alone as reported in this study. The model estimates the savings (or increases) in healthcare cost per benefit-eligible employee that would result for a typical company who adopted that practice. Actual savings (or increases) will vary based upon employer-specific factors and would be observed over a multi-year period. Some practices described in this study might not be appropriate for all employers. SHPS recommends that employers obtain guidance from an independent, third-party health benefits professional to determine the right approach for their company.

Exhibit 1: Impact on employer annual healthcare cost*



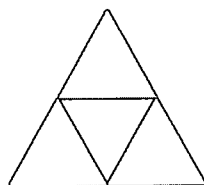
* Impact on annual healthcare costs is based on a regression analysis of the correlation of specific benefits practices with total healthcare costs. The study did not factor in the length of time practices had been in place. It is important to note that impact will vary by employer.

A PUBLIC POLICY MONOGRAPH

Emerging Data on Consumer-Driven Health Plans

May 2009

American Academy of Actuaries
Consumer-Driven Health Plans Work Group



AMERICAN ACADEMY *of* ACTUARIES

Because exact values could not be established from some of the studies, it is difficult to definitively state the absolute cost savings for CDH product introductions. However, the evidence from the various studies suggests that first-year cost savings expected from traditional actuarial models is being realized to varying degrees. The magnitude of results in some studies may actually be somewhat greater than what we would expect. However, some of this difference may be due to differences in plan design, health risk, or other factors that may not be entirely evident from the limited data and description available in the studies.

The savings in the first year of adopting a CDH plan ranged from a year-over-year reduction in costs of 4 percent (Cigna) to as much as a 10 to 15 percent reduction in costs (Aetna, Uniprise). These results are before comparison to the traditional plan trend, which may be an increase in costs of as much as 7 percent to 9 percent (Uniprise, Cigna). When the relative costs are compared, the total cost savings for members moving to a CDH plan could range from a 12 percent reduction in cost (Cigna) to as much as a 17 to 21 percent reduction in cost (Aetna, Uniprise) in the first year of experience. These results are summarized in Table 1 below.

Table 1: Summary of First-Year CDH versus Traditional Plan Trend Results

Study	CDH Trend	Traditional Trend	% Difference (1)
CIGNA	-4%	9%	-12%
Aetna	-10%	8%	-17%
Uniprise	-15%	7%	-21%
Reden & Anders	N/A	N/A	N/A

(1): % Difference is calculated as $[(1 + \text{CDH trend}) / (1 + \text{traditional trend}) - 1] \times 100\%$

Results for continuing cost-savings experience with CDH designs are often difficult to interpret, but the studies do seem to indicate that there may be a favorable effect on ongoing cost trends as well. Some studies have combined multiple years of results together and indicated that the overall trend over a two-year period has been less than the corresponding traditional product trend over the same time period. The Cigna study specifically identified the trend for the second year of CDH plan experience and compared it to the corresponding traditional plan trend. It found that the second-year trend in the CDH plan was nearly 5 percent lower than the traditional plan trend. The Uniprise study measured trend savings over a four-year period and suggests that the trend for the CDH plan is about 3 percent lower per year on average over the four-year period.

If this favorable trend effect can be further established as significant (e.g., 3 percent to 4 percent or more per year) and persistent over a multiyear period, this would be a strong argument for the further adoption of these plans. There are few other alternatives available to employers that demonstrate this degree of ongoing savings and trend reduction. It is possible that the favorable trend effects currently being observed are merely due to residual risk-selection effects or other factors that may cause this apparent trend to erode or disappear over time as larger data sets become available. It is also possible that this apparent trend-dampening feature of higher cost-sharing plans is a consistent element of all plans (similar to the first-year effect which has been well-measured), but one that has not been measured historically because the differences in cost-sharing levels for traditional plans is relatively small.

In summary, while there continues to be difficulty in establishing a consensus value for the cost-savings impact of CDH designs, there is much evidence that the plans do offer some degree of savings compared to traditional plan options over both the short- and longer-term time horizons. As more data becomes available for these plan designs, we hope that carriers would continue to publish and present their findings so that more accurate conclusions might be drawn in the future.

● Preventive Drug List

Preventive care benefits are an integral part of a comprehensive health care plan that includes preventive drug therapies. Under some plans, you may not be required to pay a copayment, coinsurance and/or deductible for preventive medications.

Preventive medications are those prescribed to prevent the occurrence of a disease or condition for those individuals with risk factors, or to prevent the recurrence of a disease or condition for those who have recovered, and do not include drugs used to treat an existing illness, injury or condition.

Preventive medications are those used for the prevention of conditions such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke, and prenatal nutrient deficiency.

Below is a list of brand-name preventive medications with their generic equivalents (where available). You can also check the Drug List on myCIGNA.com for more information and new updates to this list. Preventive medications on the Drug List are indicated with a "PM" after the drug name. Refer to your plan materials to determine if your plan includes a preventive medication benefit feature.

Asthma Related

Accolate
Accuneb (albuterol sulfate)
Advair
Advair HFA
Aerobid
Aerobid-M
Alupent
Aminophylline Tablet (aminophylline)
Asmanex
Atrovent (ipratropium bromide)
(nebulizer solution only)
Atrovent
Atrovent HFA
Azmacort
Beclonvent
Brethine (terbutaline sulfate)
Bricanyl (terbutaline sulfate)
Broncap
Broncodur
Broncomar-1
Brovana
Cafcit (caffeine citrated)
Difil-G
Dilex-G 400
Dilor-G (guaifenesin/dyphylline)
Dyflex
Dyflex-G (guaifenesin/dyphylline)
Dyphylline-GG
Ed-Bron G (guaifenesin/theophylline)
Elixophyllin GG
Elixophylline (theophylline anhydrous)
Elixophylline Sr
(theophylline anhydrous)

Asthma Related (continued)

Flovent
Flovent Diskus
Flovent HFA
Foradil
Intal (aerosol)
Isoetharine HCL (isoetharine hcl)
KIE
Lufyllin (dyphylline)
Lufyllin-400
Lufyllin-GG (guaifenesin/dyphylline)
Maxair
Maxair Autohaler
Metaproterenol Sulfate
(metaproterenol sulfate)
Panfil G (guaifenesin/dyphylline)
ProAir HFA (albuterol sulfate)
Proventil (albuterol sulfate)
Proventil HFA
Pulmicort
Quibron
Quibron-T
Quibron-300
Quibron T/SR
(theophylline anhydrous)
Qvar
S-2
Serevent
Serevent Diskus
Singulair
Slo-Bid 50
Slo-Bid 75
Slo-Phyllin GG
(guaifenesin/theophylline)
Spiriva
Symbicort
Theo-24
Theobid
TheoCap (theophylline anhydrous)
Theochron (theophylline anhydrous)
Theo-Dur (theophylline anhydrous)
Theolair
Theolate (guaifenesin/theophylline)
Theomar GG
(guaifenesin/theophylline)
Theophylline
T-Phyl (theophylline anhydrous)

Asthma Related (continued)

Uniphyll (theophylline anhydrous)
Ventolin (albuterol sulfate)
Ventolin HFA
Vospire ER (albuterol sulfate)
Xolair
Xopenex
Xopenex HFA
Zyflo CR

Blood Thinner

Aggrenox
Coumadin (warfarin)
Persantine (dipyridamole)
Plavix
Pletal (cilostazol)
Ticlid (ticlopidine hcl)

Cholesterol Related

Advicor
Altoprev
Antara
Crestor
Lescol
Lescol XL
Lipitor
Lofibra (fenofibrate)
Lofibra (fenofibrate, micronized)
Lopid (gemfibrozil)
Lovaza
Mevacor (lovastatin)
Niacor
Niaspan
Pravachol (pravastatin sodium)
Tricor
Triglide
Vytorin
Zetia
Zocor (simvastatin)

Diabetes Related

Actoplus Met
Actos
Amaryl (glimepiride)
Apidra
Avandamet
Avandaryl
Avandia
Byetta

Diabetes Related (continued)

Diabeta (glyburide)
Diabinese (chlorpropamide)
Duetact
Dymelor (acetohexamide)
Fortamet
Glucophage (metformin hcl)
Glucophage XR (metformin hcl)
Glucotrol (glipizide)
Glucotrol XL (glipizide)
Glucovance (glyburide/metformin)
Glumetza
Glycron
Glynase (glyburide micronized)
Glyset
Humalog
Humalog Mix 50/50
Humalog Mix 75/25
Humulin 50/50
Humulin 70/30
Humulin L
Humulin N
Humulin R
Humulin U
Iletin II Pork Lente (insulin zinc pork purified)
Janumet
Januvia
Lantus
Lantus solostar
Levemir
Metaglip (glipizide/metformin hcl)
Micronase (glyburide)
Novolin N
Novolin R
Novolin 70/30
Novolin 70/30 Innolet
Novolog
Novolog Mix 70/30
Prandin
Precose
Riomet
Starlix
Symlin
Orinase (tolbutamide)
Velosulin Human BR



Hypertension Related

Accupril (quinapril)
 Accuretic (quinapril hcl/hctz)
 Aceon
 Adalat CC (nifedipine)
 Aldactazide (spironolactone/hctz)
 Aldactone (spironolactone)
 Aldoclor-250
 Aldomet (methyldopa)
 Altace
 Apresazide (hydralazine/hctz)
 Atacand
 Atacand HCT
 Avalide
 Avapro
 Benicar
 Benicar HCT
 Betapace (sotalol hcl)
 Betapace AF (sotalol hcl)
 Blocadren (timolol maleate)
 Bumex (bumetanide)
 Calan (verapamil)
 Calan SR (verapamil)
 Capoten (captopril)
 Capozide (captopril/
 hydrochlorothiazide)
 Cardene (nicardipine hcl)
 Cardene SR
 Cardizem (diltiazem)
 Cardizem CD (diltiazem)
 Cardizem LA
 Cardura (doxazosin mesylate)
 Cardura XL
 Catapres (clonidine hcl)
 Catapres-TTS 1
 Catapres-TTS 2
 Catapres-TTS 3
 Clorpres
 Coreg (carvedilol)
 Coreg CR
 Corgard (nadolol)
 Corzide (bendroflumethiazide/
 nadolol)
 Covera-HS
 Cozaar
 Demadex (torsemide)
 Demser
 Diamox (acetazolamide)
 Diamox Sequels
 Dibenzyline

Hypertension Related (continued)

Dilacor XR (diltiazem)
 Diltiazem HCL (diltiazem)
 Diovan
 Diovan HCT
 Diuretic Ap-ES (hydralazine/
 reserpine/hctz)
 Diuril (chlorothiazide)
 Diutensen-R
 Dyazide (triamterene/hctz)
 Dynacirc CR (isradipine)
 Dyrenium
 Edocrin
 Enduron
 Enduronyl
 Enduronyl Forte
 Esimil
 Flumezide (rauwolfia serpentina/
 bfmtz)
 Furosemide (Solution)
 Hydralazine HCL (hydralazine hcl)
 Hydrodiuril (hydrochlorothiazide)
 Hydroplus-50 (reserpine/
 hydrochlorothiazide)
 Hygroton (chlorthalidone)
 Hytrin (terazosin hcl)
 Hyzaar
 Indapamide (indapamide)
 Inderal (propranolol hcl)
 Inderal LA (propranolol hcl)
 Inderide (propranolol/hctz)
 Inderide LA
 Innopran XL
 Inspra
 Inversine
 Kerlone (betaxolol hcl)
 Lasix (furosemide)
 Levatol
 Loniten (minoxidil)
 Lopressor (metoprolol tartrate)
 Lopressor HCT (metoprolol/hctz)
 Lotensin (benazepril hcl)
 Lotensin HCT (benazepril hcl/hctz)
 Lotrel (benazepril hcl/amlodipine bs)
 Losol (indapamide)
 Mavik (trandolapril)
 Maxzide (triamterene/hctz)
 Methyldopa (methyldopa)
 Micardis
 Micardis HCT

Hypertension Related (continued)

Microzide (hydrochlorothiazide)
 Midamor (amiloride hcl)
 Minipress (prazosin hcl)
 Minizide 1
 Minizide 2
 Minizide 5
 Moduretic (hydrochlorothiazide/
 amilor hcl)
 Monopril (fosinopril sodium)
 Monopril HCT (fosinopril sodium/hctz)
 Mykrox
 Naturetin-5
 Neptazane (methazolamide)
 Nimotop (nimodipine)
 Normodyne (labetalol hcl)
 Norvasc (amlodipine besylate)
 Plendil (felodipine)
 Prinivil (lisinopril)
 Prinzide (lisinopril/
 hydrochlorothiazide)
 Procardia (nifedipine)
 Procardia XL (nifedipine)
 Propranolol HCL (propranolol hcl)
 Propranolol HCTZ (propranolol/hctz)
 Renese-R
 Reserpine
 Saluron (hydroflumethiazide)
 Salutensin
 Salutensin Demi (reserpine/
 hydrochlorothiazide)
 Sectral (acebutolol hcl)
 Sular
 Tarka
 Tekturna
 Tenex (guanfacine hcl)
 Tenoretic 100 (chlorthalidone/
 atenolol)
 Tenoretic 50 (chlorthalidone/atenolol)
 Tenormin (atenolol)
 Terazosin HCL
 Teveten
 Teveten HCT
 Thaltone
 Tiazac (diltiazem)
 Timolide
 Toprol XL (metoprolol succinate)
 Triamterene W/HCTZ (triamterene/
 hctz)
 Uniretic (moexipril hcl/hctz)

Hypertension Related (continued)

Univasc (moexipril hcl)
 Vaseretic (enalapril maleate/hctz)
 Vasotec (enalapril maleate)
 Verelan (verapamil)
 Verelan PM (verapamil)
 Viskin (pindolol)
 Wytensin (guanabenz acetate)
 Zaroxolyn (metolazone)
 Zebeta (bisoprolol fumarate)
 Zestoretic (lisinopril/
 hydrochlorothiazide)
 Zestril (lisinopril)
 Ziac (bisoprolol/hctz)

Osteoporosis Related

Actonel
 Actonel with Calcium
 Boniva
 Didronel (etidronate disodium)
 Evista
 Forteo
 Fosamax
 Fosamax Plus D
 Miacalcin ((Fortical) calcitonin-salmon)
 Miacalcin (calcitonin-salmon)
 Skelid

Representative Prenatal Vitamins

*All prescription strength prenatal
 vitamins qualify as preventive
 medications*

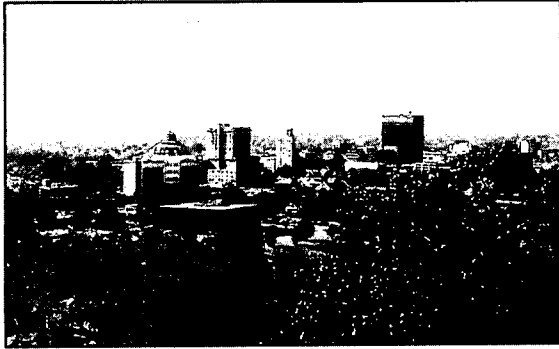
Duet
 Duet DHA EC StuartNatal
 Duet DHA StuartNatal
 Duet StuartNatal
 Materna
 Maternal Plus 90
 Natachew
 Natafort
 OB Complete
 OB Complete DHA
 Precare
 Precare Conceive
 Precare Premier
 Prenatal Vitamin
 Stuart Prenatal
 StuartNatal Plus
 StuartNatal Plus 3

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The Asheville Project



Frequency/Severity Matrix

		Severity 	
 Frequency	High Frequency	High Frequency	
	Low Severity	High Severity	
Frequency	Low Frequency	Low Frequency	
	Low Severity	High Severity	

It's the System That Needs Care

- ✧ Over half of all healthcare via managed care
- ✧ Largest increase in 6 years in costs
- ✧ It's evolution not revolution
- ✧ Giving patients the resources to be well
- ✧ Buy VALUE
- ✧ Taiwanese healthcare system

UN-Managing Care

- ✧ "Kaiser physicians know what things need to be done for diabetic patients, but due to the constraints of modern medical practice they seldom have the time to do them...."
Managed Care News 1999 Apr.
- ✧ "Ultimately, all care is managed by patients."
Dan Garrett, Exec. Dir. NCAP

Diabetes-Related Comorbidities

- * 2–4 times greater risk of heart disease
- * 60–65% have hypertension
- * 2–4 times greater risk of stroke
- * 60–70% have some degree of nervous system damage
- * Leading cause of adult blindness
- * Leading cause of ESRD (40% new cases)
- * >50% lower limb amputations

In the Beginning

- * “Partnering” with hospital system, NCAPH, NCCPC, UNC School of Pharmacy
- * Invitation to all pharmacists in community
- * Responses of independents vs. chains
- * Two weekends (32 hours) of training by physicians and diabetes educators
- * Compensation after results
- * Fee schedule
- * \$2,400 first year, ongoing average of \$48.02 per monthly visit through 2002.

Diabetes-Related Indirect Costs

- * 8.3 sick-leave days annually
- * 1.7 sick-leave days for employees without diabetes
- * \$47 billion in productivity forgone due to disability, absence, and premature mortality

Patient Incentives and Care Model

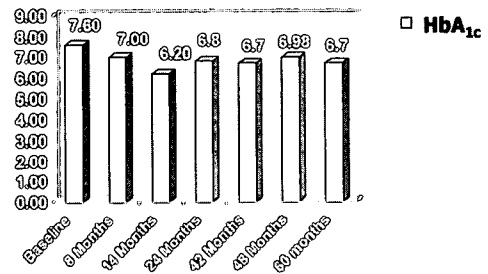
- * Patient selection / recruitment
- * Patient education — Mission + St. Joseph’s Diabetes Center
- * Matching patients to pharmacists
- * Incentives:
 - PBM co-pay waivers
 - Labs without co-pays
 - Glucose meters
- * The operative word in pharmaceutical care is “care” (Madge testimonial)

How They Do It

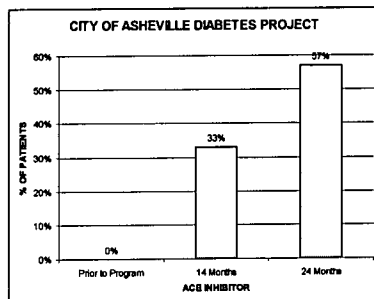


"Patient making better food choice. Blood glucose much improved. 2 x 1.5 cm wound RLE. Referred to physician for evaluation and therapy."

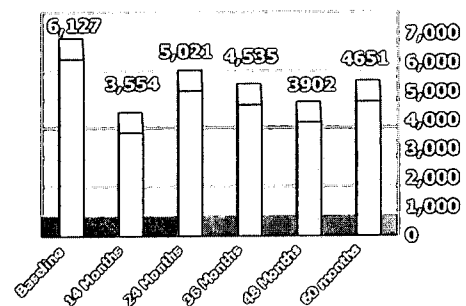
Clinical Outcomes: Avg. Glycosylated Hemoglobin

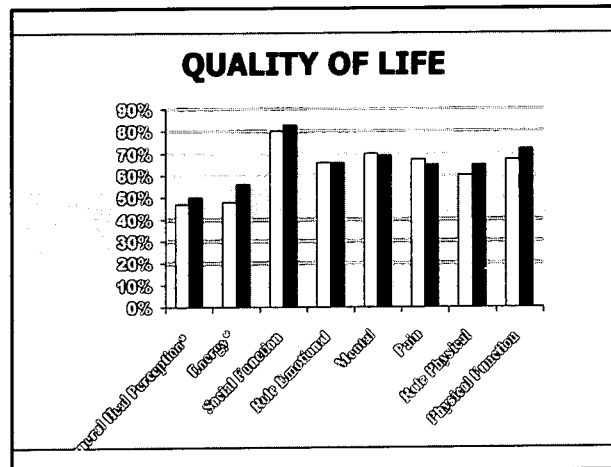
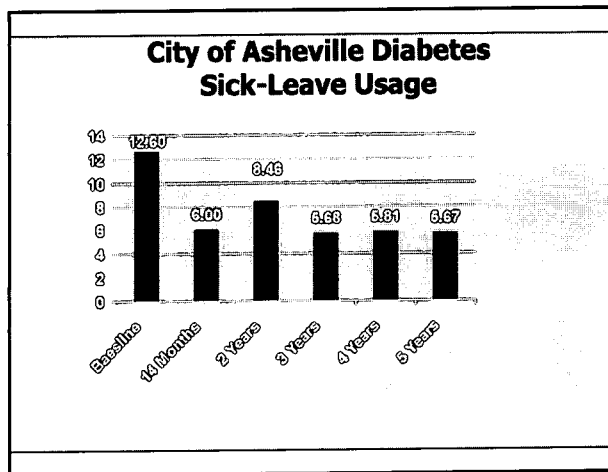
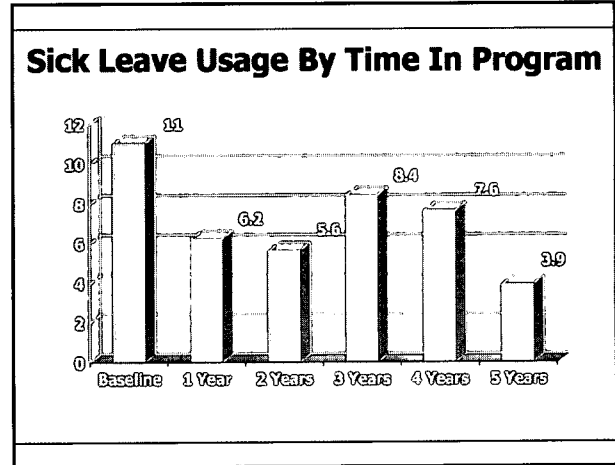
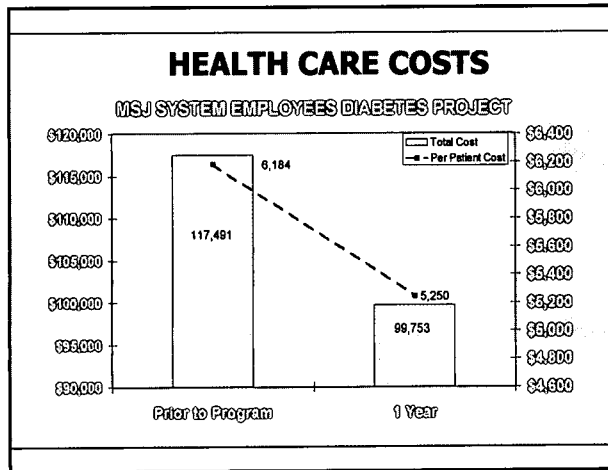


APPROPRIATE MEDICATION



City of Asheville Medical Costs





Conclusions

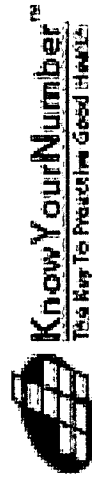
- ⌘ Pharmacists have had the opportunity to serve on the frontline of patient care, and have made a difference.
- ⌘ Physicians with patients in the program have recognized the positive impact on care.
- ⌘ Collaboration plus innovation leads to reduced healthcare costs.
- ⌘ Employers benefit by lowering or eliminating barriers to care.

Other Materials

<http://www.ncpharmacists.org>

Look for Asheville Project Tab

Promoting Healthier Lives And Saving
\$Millions For North Carolina
March 25, 2010





Biosignia, Inc.

- **North Carolina Based**
- **Profile/Technologies**
 - Science driven company focused on providing “embedded” predictive solutions to the health care and life insurance industries.
 - Know Your Number® a personalized disease specific risk assessment that provides a roadmap outlining ways to reduce risk and improve health
 - Know Your Number® is used in employer wellness & medical management

Examples of National Clients

- **Abbott Laboratories**
(Albertsons, Toyal, China, Latin America)
- **Life Line Screening**
(1.5 million people screened/year)
- **GE Healthcare**
(Centricity EMR)
- **NBC Biggest Loser Show**
(BL KYN consumer home kit version)

Examples of North Carolina Clients

- **NC State Health Plan**
- **Doctors Direct Healthcare**
(50 self-funded employers, Cape Fear Valley, PepsiCo Bottling)
- **Kerr Drug**
- **ECU & UNC Chapel Hill**
- **Duke University**
(Academic collaborations)



State Health Plan/BioSignia Collaborations

Future (Summer 2010)

- Fayetteville State University
- Fayetteville Technical Community College

Current (March, 2010 start)

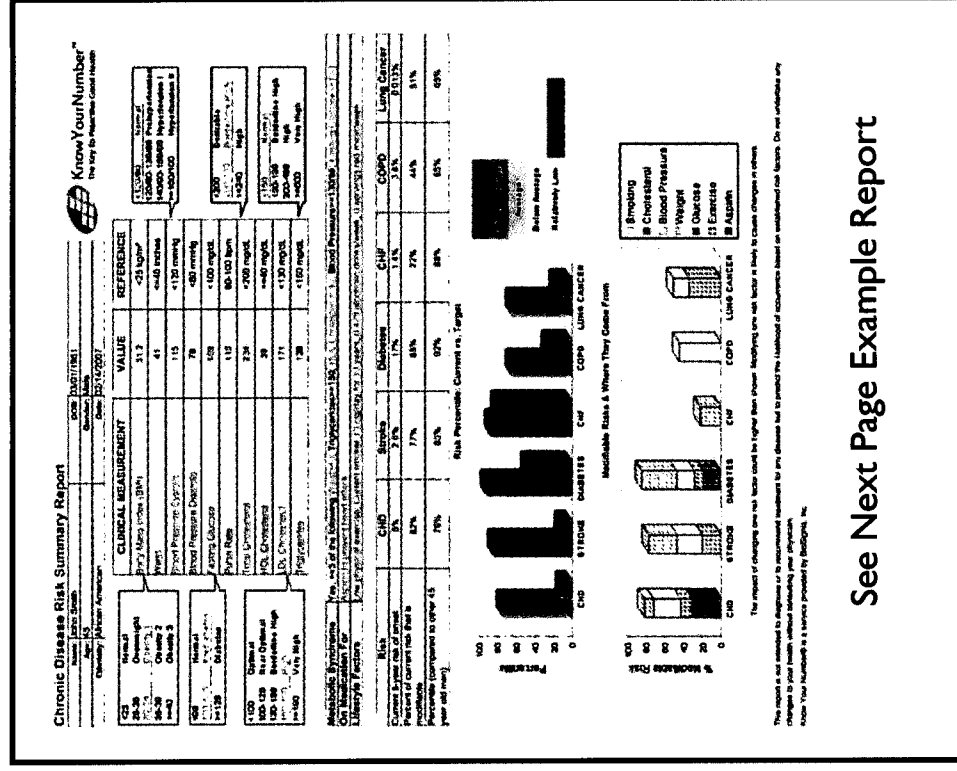
- Department of Corrections (Men's & Women's Central Prison Employees)
 - With Kerr Drug, using the Ashville Project Health Coaching approach

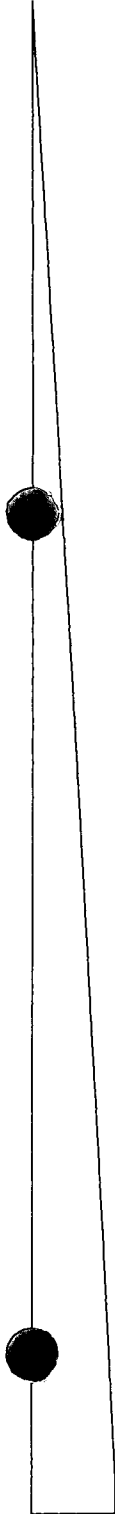
Past

- State Health Plan's own employees screened with KYN in February 2009
- Teachers (Stars)
 - 14% reduction in aggregate disease risk
 - 13% decrease in projected 5-year disease cost burden
- Cumberland County Wellness Pilot
 - State data on Cumberland County Wellness Pilot shows that KYN can save up to \$500/person/year in program
- State Highway Patrol
- NCDOT

Know Your Number Disease Risk Report

- Each screened employee will receive a Know Your Number® report (confidential) that tells them their risk by disease, engages “window into their internal health”, and provides a personalized “roadmap” outlining what changes they can make in their lives to improve their health.

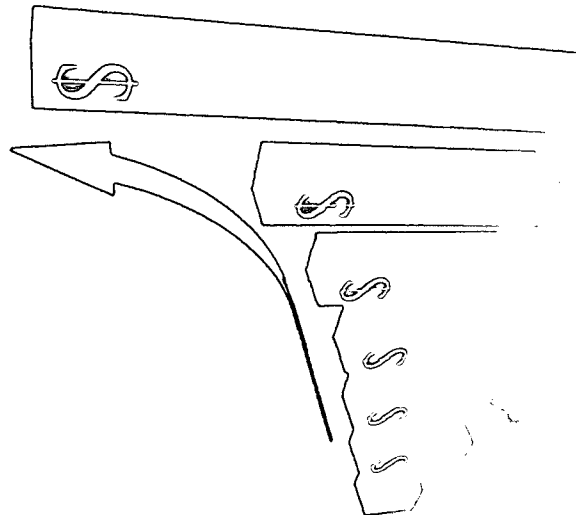




The Underlying Problem

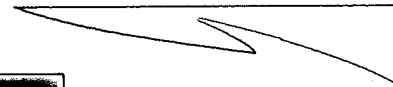
State Health Plan Costs

Estimated Five-Year Future New Disease Load
(Incidence in 300,000 active state government/teacher employees)



Disease	New Cases	Avoidable Cases	New Cost	Avoidable Cost
Type 2 Diabetes	11,398	9,411	\$283 Million	\$234 Million
CHD	7,554	5,132	\$185 Million	\$125 Million
Stroke	4,975	3,586	\$141 Million	\$101 Million
Total	23,927	18,129	\$609 Million	\$460 Million

•According to the CDC, approximately 80% of heart disease, stroke, and type 2 diabetes is preventable





Beneath the Problem

(As an example)

A Diabetes Pandemic In The Making



Health Plan Employee Members

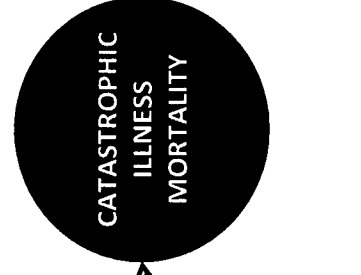
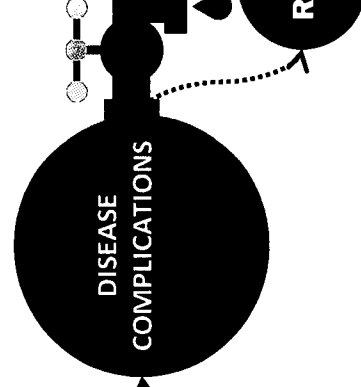
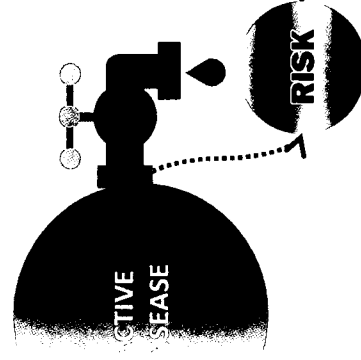
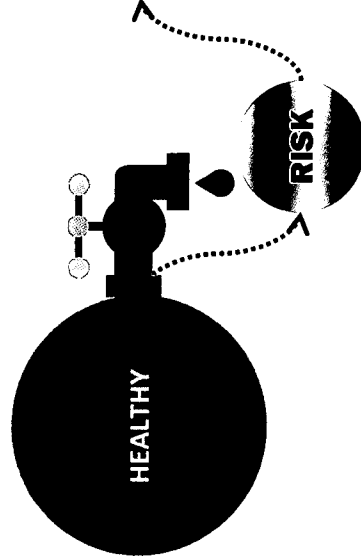
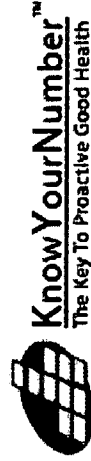
- 24% of employee members are in a diabetic or pre-diabetic state
- **50,000+ employee members are pre-diabetic**
- Pre-diabetic population drives 48% of future 5-year disease burden for diabetes, CHD & stroke (\$294 million)
- Group represent 48% of employees who have obesity (BMI > 30)





The Solution is Pro-active Prevention

The Continuous Flow of Preventable Disease



Screen with BioSignia's Know Your Number® "next generation" disease risk assessment to:

- Build awareness of disease risk, approximately 40% of adults don't have a primary physician of record
- Gain engagement and motivation, provides personalized roadmap on how to reduce health risks
- Produce results and document outcomes to monitor success of wellness program





- Each screened employee will receive a Know Your Number® report (confidential) that tells them their risk by disease, engages “window into their internal health”, and provides a personalized “roadmap” outlining what changes they can make in their lives to improve their health.



Participant Results:

Results for Biometric Screenings

1. Complete Lipid Panel
2. Glucose
3. CRP (if available)
4. Blood pressure
5. BMI
6. Waist circumference

Red indicates out of range
Green indicates normal range

CLINICAL MEASUREMENT	VALUE	REFERENCE
Body Mass Index (BMI)	37.3	<25 kg/m ²
Waist	42	<=40 Inches
Blood Pressure Systolic	115	<120 mmHg
Blood Pressure Diastolic	81	<80 mmHg
Blood Glucose	109	<100 mg/dL
Pulse Rate	110	60-100 bpm
Total Cholesterol	234	<200 mg/dL
HDL Cholesterol	38	>=40 mg/dL
LDL Cholesterol	171	<130 mg/dL
Triglycerides	126	<150 mg/dL

<25	Normal
25-29.9	Overweight
30-34.9	Obesity 1
35-39.9	Obesity 2
>=40	Obesity 3

<100	Normal
100-126	Prediabetes
>=126	Diabetes

<100	Optimal
100-129	Near Optimal
130-159	Borderline High
160-189	High
>=190	Very High

<120/80	Normal
120/80-130/89	Prehypertension
140/90-159/99	Hypertension I
>=160/100	Hypertension II

<200	Desirable
200-230	Borderline High
>=240	High

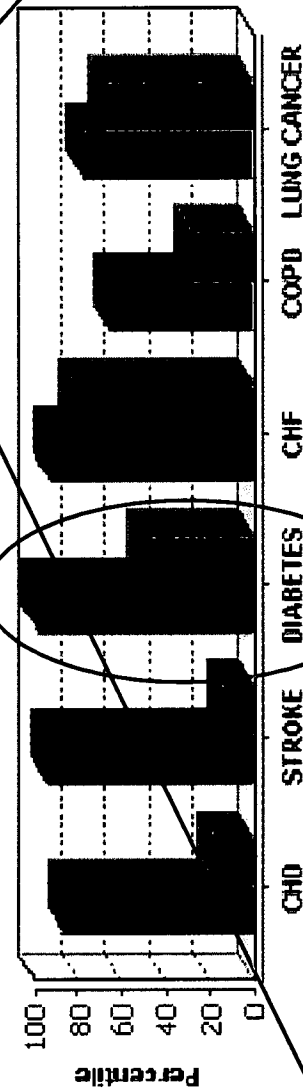
<150	Normal
150-199	Borderline High
200-499	High
>=500	Very High

Risk of Onset, Modifiable Risk and Risk Comparison for a 45 male participant

He has an 36% chance of developing type 2 diabetes in the next 5 years

Risk	CHD	Stroke	Diabetes	CHF	COPD	Lung Cancer
Current 5-year risk of onset	7%	4.1%	36%	1.8%	3.9%	0.039%
Percent of current risk that is modifiable	84%	86%	92%	40%	44%	59%
Percentile (compared to other 45 year old American men)	86%	94%	98%	93%	86%	78%

Risk Percentile: Current vs. Target



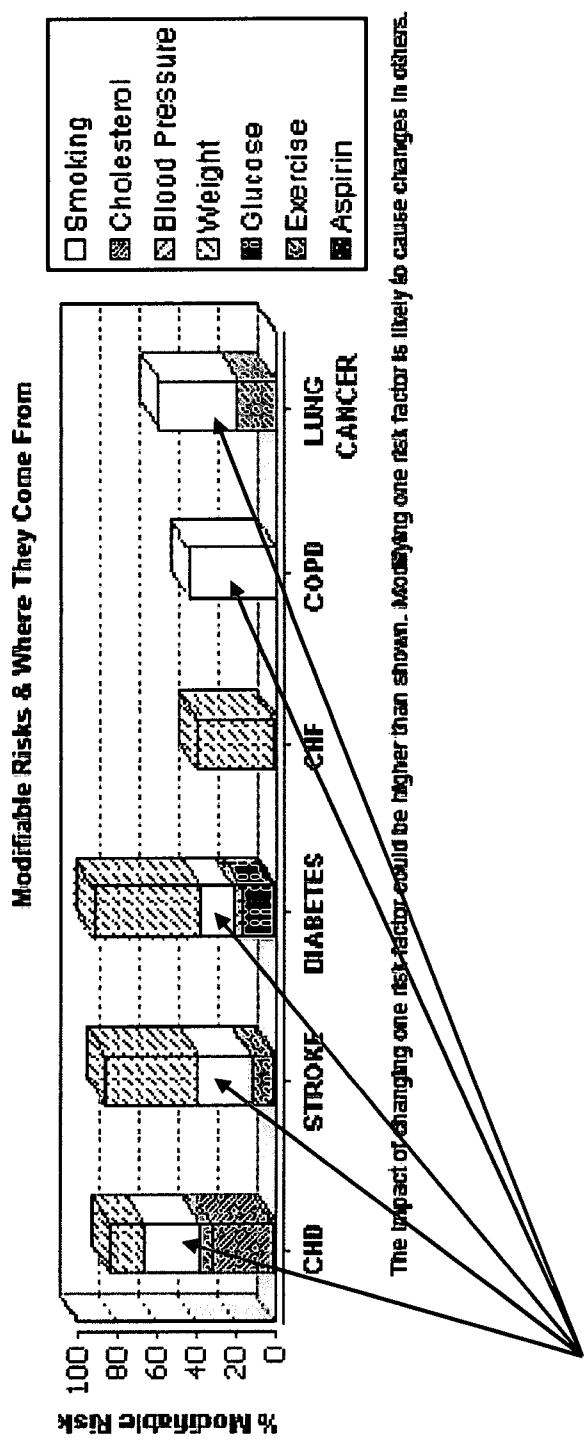
Compared to other 45 yr old men, 98% have a lower risk of diabetes than he does

Being in the 98% percentile (compared to his peers) puts his diabetes risk in the Relatively High category



92% of his diabetes risk is in his control (modifiable)

Risk Factors with the Most Impact to Reduce Disease Risk



Smoking is a major risk factor that is contributing a majority of his disease risk. By modifying just this one risk factor, he would decrease his risk of onset for several conditions significantly.

Provides the participant with an Action Plan!





5. Be Prepared for Releases

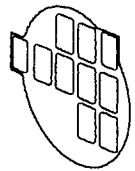
Most relapses occur within the first 3 months after quitting. Don't be discouraged if you start smoking again. Remember, most people try several times before they finally quit. Here are some difficult situations to watch for:

- **Alcohol.** Avoid drinking alcohol. Drinking lowers your chances of success.
- **Other Smokers.** Being around smoking can make you want to smoke.
- **Weight Gain.** Many smokers will gain weight when they quit, usually less than 10 pounds. Eat a healthy diet and stay active. Don't let weight gain distract you from your main goal—quitting smoking. Some quit-smoking medications may help delay weight gain.
- **Bad Mood or Depression.** There are a lot of ways to improve your mood other than smoking. If you are having problems with any of these situations, talk to your doctor or other health care provider.

Summary

In the end, we would like to say congratulations again because by enrolling in the KYN program and reading this letter about your risks for major chronic diseases, you just started a journey to better control your future health. For that reason alone, you are already ahead of most Americans. We hope you find this letter helpful and start to take action to reduce your risks so that you can enjoy a healthy life in the future. Should you have any further questions, please contact your doctor for more assistance.



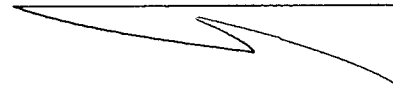
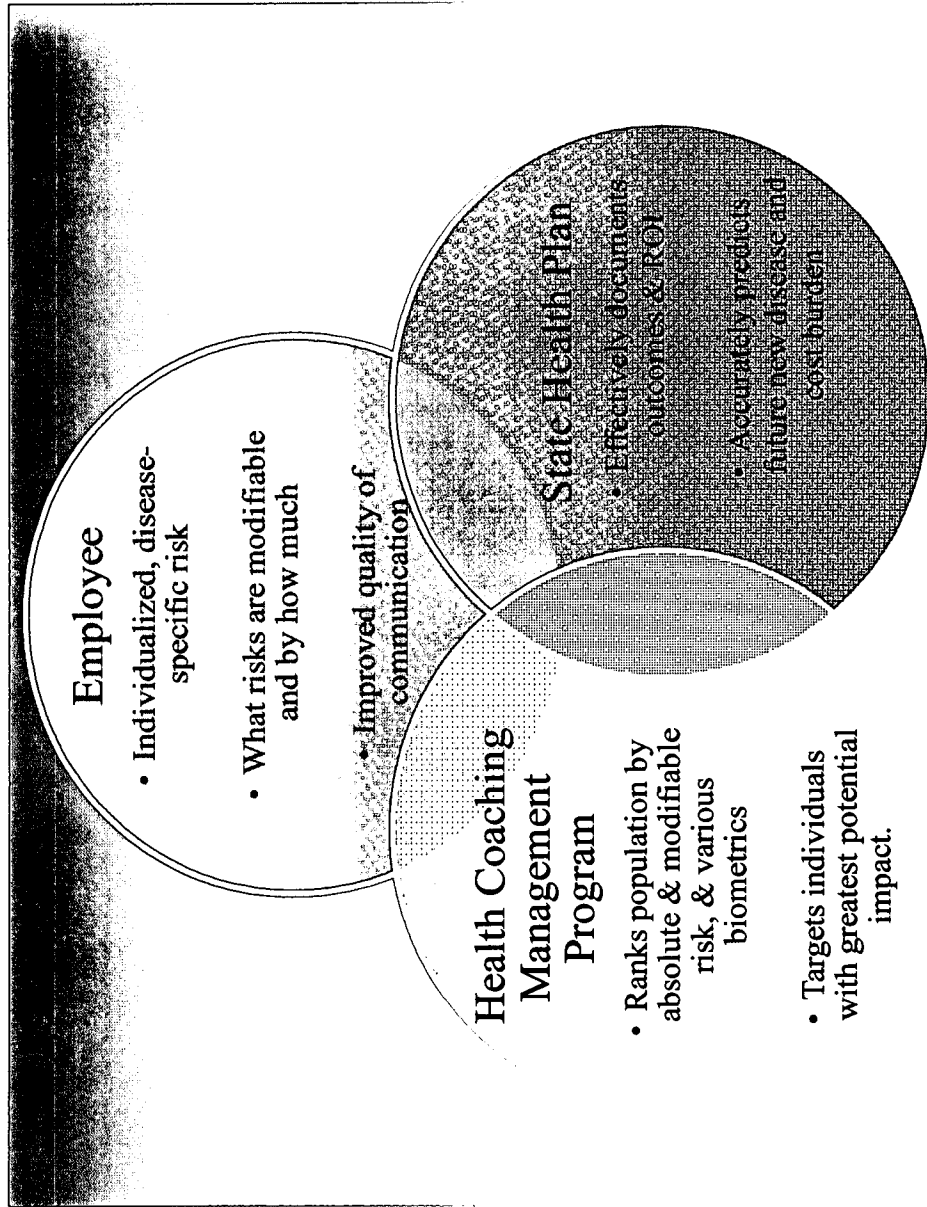


Know Your Number™

The Key To Proactive Good Health



Know Your Number™ Provides “Richer and Actionable Knowledge” to all stakeholders





Next Steps

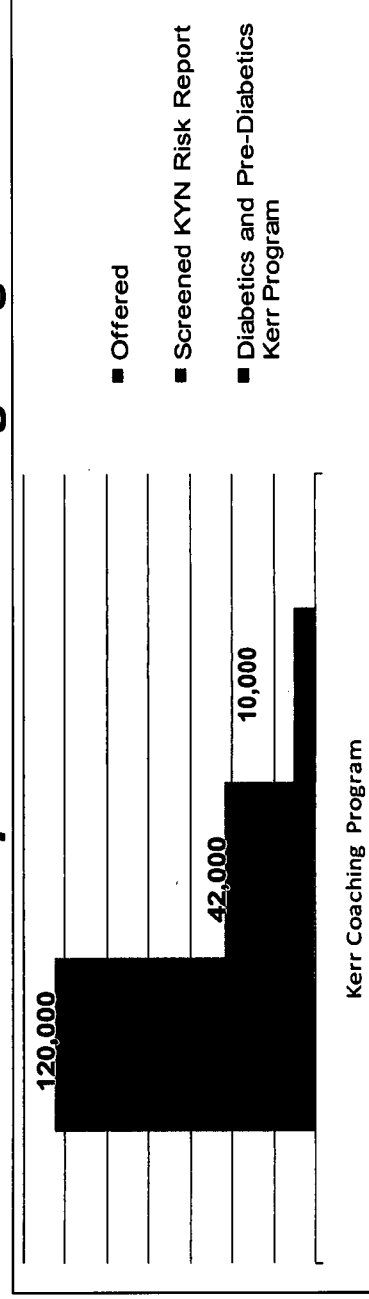
*Provide long-term funding to support a comprehensive
disease prevention program for state employees that
includes disease risk assessment, biometric screening and
wellness coaching components*



What BioSignia is Proposing:

- A unique 5-year program that offers a proven health coaching program “Asheville Project” focused on diabetes management, co-morbidities, and disease prevention screening. Aligns with national focus on disease prevention versus “just treating the sick”
- Health screening will be offered to the 300,000 employee members twice during 5-year period and will touch and impact 70% of the estimated 70,000+ diabetic and pre-diabetic State Health Plan employee members with education programs
- Complimentary to the health plan obesity and smoking initiatives
- 5-year ROI goal is 3.5 to 1 and will save \$124 million in health costs (screening, Know Your Number and health coaching costs \$36 million)

Overview of Year 1 Screening Program



Subscriber / husband / ①
no children

Guilford County Schools

School No.	379	School Name	GATEWAY EDUC CENTER						
Date	03/15/10	Check No.	435893	Amount	\$\$\$575.67				
EMPLOYEE INFORMATION									
Enrolled in Retirement	YES	Installment Pay	N	Direct Deposit	Budget Position	Tax Information	Withholding Status	Exemptions	Additional Withholdings
						Federal	M	00	0.00
						State	M	00	0.00
JOB INFORMATION									
Budget Code	Description	Salary	Dock Amt.	Grade	Step	% Emp.	Days Emp.	Days Paid	Hrs Paid
1-5210-027-142-379-000-00	ASST-TCHR EC PRE K	1,943.00	0.00	5410	11	100.00	21.50	21.50	0.00

Exceptional Needs Teacher Assistant
in her 12th year -

Covers her husband: only -
80/20 Plan

502.74
+ 100.55
\$603.29 per month
x 10 months

WAGES							
	Earnings	Federal Tax	State Tax	Social Security Tax	Retirement	Misc Ded.	Net
Current	1,943.00	.00	42.00	97.76	116.58	1110.99	575.67
Y-T-D	5,829.00	.00	126.00	293.28	349.74	3,332.97	1,727.01
MISCELLANEOUS DEDUCTIONS							
Code	Description	Current	Y-T-D	Code	Description	Current	Y-T-D
IO5	LIFE-EMP 50,000	8.25	24.75	IO5T	LIFE-ESCROW	1.65	4.95
IS3	LIFE-SPOUSE 30,0	12.00	36.00	IS3T	LIFE-ESCROW	2.40	7.20
IC1	LIFE-CHILD 10,000	2.00	6.00	IC1T	LIFE-ESCROW	.40	1.20
DIF	GCS DENTAL-FAMIL	38.60	115.80	DIFX	GCS-DENTAL-ESCROW	7.72	23.16
NCCU	STATE EMP CREDIT	200.00	600.00	403B	403-B DEDUCTIONS	210.00	630.00
403A	403B - ADMIN FEE	1.50	4.50	HCS	PPO CHOICE-SPOUS	502.74	1508.22
HCST	PPO CHOICE-ESCRO	100.55	301.65	CBVM	CAFE BEN-VISION MAT	23.18	69.54

In 2010-2011, the same coverage will cost her \$656.98 a month.

Leave	Current Period			Year-to-Date				
	Earned	Used	Beg. Bal	Earned	Used	Adj.	Transferred	Ending Balance
SICK LEAVE	1.000	.000	52.500	7.000	2.000	.000	.000	57.500
PERSONAL LEAVE	.000	.000	.000	.000	.000	.000	.000	.000
ANNUAL LEAVE	1.650	.000	24.200	11.050	6.000	.000	.000	29.250
EXTENDED LEAVE	.000	.000	.000	.000	.000	.000	.000	.000
MISC LEAVE	.000	.000	9.830	.000	.000	.000	.000	9.830



GUILFORD COUNTY SCHOOLS ADMINISTRATIVE UNIT
GREENSBORO, NORTH CAROLINA
DIRECT DEPOSIT VOUCHER

NO. 435893

DATE
03/15/10

DEPOSITED EXACTLY ***575 DOLLARS AND 67 CENTS

IN
THE
ACCOUNT
OF



DIRECT DEPOSIT ADVICE
NON-NEGOTIABLE

\$\$\$575.67 net

DEPOSIT ADVICE ONLY - THIS IS NOT A CHECK

2010-2011 net ≈ \$522.00 a month

Subscriber / husband / 3 children (2)

Guilford County Schools

School No. 379		School Name GATEWAY EDUC CENTER						
Date 02/26/10	Check No. 428003	Amount \$*2,388.66						
EMPLOYEE INFORMATION								
Enrolled in Retirement YES	Instalment Pay N	Direct Deposit []	Budget Position []	Tax Information	Withholding Status	Exemptions	Additional Withholdings	
				Federal State	M M	04 04	0.00 0.00	
JOB INFORMATION				Step	% Emp.	Days Emp.	Days Paid	Hrs Paid
Budget Code	Description	Salary	Dock Amt.	Grade				
1-5210-032-121-379-000-00	TCHR-EC TR AC	3,264.00	50.00	AE	04	100.00	21.50	21.50 0.00
2-5210-032-181-379-000-00	TCHR-EC TR AC	506.00	0.00	AE	04	100.00	21.50	21.50 0.00

Exceptional Needs Teacher
in her 5th year
of teaching-

#450.26
+ 90.05

\$540.31 per month x 10 months

WAGES							
	Earnings	Federal Tax	State Tax	Social Security Tax	Retirement	Misc. Ded.	Net
Current	3,720.00	54.75	119.00	239.71	223.20	694.68	2,388.66
Y-T-D	7,490.00	97.50	241.00	483.24	449.40	1,388.36	4,829.50
MISCELLANEOUS DEDUCTIONS							
Code	Description	Current	Y-T-D	Code	Description	Current	Y-T-D
IOA	LIFE-EMP ONLY 10	16.50	33.00	IOAT	LIFE-ESCROW	3.30	6.60
IS3	LIFE-SPOUSE 30,0	12.00	24.00	IS3T	LIFE-ESCROW	2.40	4.80
IC0	LIFE-CHILD	1.00	2.00	IC0T	LIFE-ESCROW	.20	.40
DIF	GCS DENTAL-FAMIL	38.60	77.20	DIFT	GCS-DENTAL-ESCROW	7.72	15.44
HBF	PPO BASIC-FAMILY	450.26	900.52	HBFT	PPO BASIC-ESCROW	90.05	180.10
MU01	ORG DUES-NCAE	53.75	107.50	CBPL	CAFE BEN-PREPAID	18.90	37.80

70/30

husband + 3 children

Leave	Current Period			Year-to-Date				
	Earned	Used	Beg. Bal	Earned	Used	Adj.	Transferred	Ending Balance
SICK LEAVE	1.000	.000	7.400	7.800	4.000	.000	.000	11.200
PERSONAL LEAVE	.200	1.000	5.000	1.400	1.000	.000	.000	5.400
ANNUAL LEAVE	1.150	.000	4.370	8.970	6.000	.000	.000	7.340
EXTENDED LEAVE	.000	.000	.000	.000	.000	.000	.000	.000
MISC LEAVE	.000	.000	.000	.000	.000	.000	.000	.000



Guilford
County Schools

GUILFORD COUNTY SCHOOLS ADMINISTRATIVE UNIT
GREENSBORO, NORTH CAROLINA
DIRECT DEPOSIT VOUCHER

NO. 428003

DATE
02/26/10

DEPOSITED EXACTLY *2,388 DOLLARS AND 66 CENTS

\$*2,388.66

IN
THE
ACCOUNT
OF

DIRECT DEPOSIT ADVICE
NON-NEGOTIABLE

DEPOSIT ADVICE ONLY - THIS IS NOT A CHECK

single mom / 1 child

3

Guilford County Schools

School No. 379 School Name GATEWAY EDUC CENTER
Date 03/15/10 Check No. 435887 Amount \$*1,327.69

EMPLOYEE INFORMATION									
	Enrolled in Retirement	Installment Pay	Direct Deposit	Budget Position	Tax Information	Withholding Status	Exemptions	Additional Withholdings	
	YES	N			Federal State	S H	05 02	0.00 0.00	
JOB INFORMATION									
Budget Code	Description	Salary	Dock Amt.	Grade	Step	% Emp.	Days Emp.	Days Paid	Hrs Paid
2-5210-519-142-379-000-00	ASST-TCHR EC INF/TODD	1,943.00	0.00	5410	11	100.00	21.50	21.50	0.00

Exceptional Needs Teacher Assistant
in her 12th year - Single mom -

Has a healthy 13-year old son -
was on BCBS Health Choice -
This year, the son is on Medicaid.

The mom/teacher assistant said
"I can't afford the state health plan premium
for my son."

WAGES							
	Earnings	Federal Tax	State Tax	Social Security Tax	Retirement	Misc Ded	Net
Current	1,943.00	.00	56.00	142.11	116.58	300.62	1,327.69
Y-T-D	5,829.00	.00	168.00	426.33	349.74	902.05	3,982.88
MISCELLANEOUS DEDUCTIONS							
Code	Description	Current	Y-T-D	Code	Description	Current	Y-T-D
IOO	LIFE-EMP 5,000	.00	.00	DAO	AMERITAS-DENTAL EMP	31.55	94.65
DAOT	AMERITAS-DENTAL	6.31	18.93	M005	ORG DUES-NCAE	30.56	91.68
ETC-A	EIC ADVANCE REBATE-	118.82	356.27	HCO	PEO CHOICE-EMPLO	.00	.00
HCOT	PEO CHOICE-ESCRO	.00	.00	403B	403-B DEDUCTIONS	25.00	75.00
LOOT	LIFE-ESCROW	.00	.00	NCCU	STATE EMP CREDIT	250.00	750.00
03A	403B - ADMIN FEE	1.50	4.50	CBMR	CAFE BEN-MED REI	25.00	75.00
CBHI	CAFE BEN-HOSP IN	22.52	67.56	CBSD	CAFE BEN-SUPP. DISA	27.00	81.00

09-10 - The cost for her son on Basic (70/30) would be \$196.89 per month
(10 month employee).

10-11 - The cost for her son on Basic (70/30) would be \$214.42 per month.

Current Period				Year-to-Date				
Leave	Earned	Used	Beg. Bal	Earned	Used	Adj.	Transferred	Ending Balance
SICK LEAVE	1.000	3.000	6.500	7.000	7.500	.000	.000	6.000
PERSONAL LEAVE	.000	.000	.000	.000	.000	.000	.000	.000
ANNUAL LEAVE	1.400	.000	12.800	9.800	6.000	.000	.000	16.600
EXTENDED LEAVE	.000	.000	.000	.000	.000	.000	.000	.000
MISC LEAVE	.000	.000	4.170	.000	.000	.000	.000	4.170



Guilford
County Schools

GUILFORD COUNTY SCHOOLS ADMINISTRATIVE UNIT
GREENSBORO, NORTH CAROLINA
DIRECT DEPOSIT VOUCHER

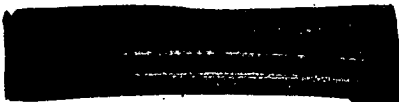
NO. 435887

DATE
03/15/10

DEPOSITED EXACTLY *1,327 DOLLARS AND 69 CENTS

\$*1,327.69

IN
THE
ACCOUNT
OF



DIRECT DEPOSIT ADVICE
NON-NEGOTIABLE

DEPOSIT ADVICE ONLY - THIS IS NOT A CHECK

NCAE Daily Political Briefing

Provided by the NCAE Government Relations Department



November 24, 2009

State Health Plan Blue Ribbon Task Force Begins Work

Vicki Simmons was appointed to the Blue Ribbon Task Force on the State Health Plan by NC Speaker of the House Joe Hackney this year. Simmons, a proud NCAE member, is a Physical Education Teacher (NBCT) at Gateway Education Center in Greensboro.

When the Blue Ribbon Task Force on the State Health Plan for Teachers & State Employees convened last week for its inaugural meeting, committee member Vicki Simmons said she understood that she was at the table on behalf of public school employees, including 65,000 NCAE members, who are depending on her.

She said she hears her colleagues' concerns about a State Health Plan that has gotten more expensive, punitive, and less accountable to those it insures. While Simmons concedes she doesn't have all the answers to the State Health Plan's problems, she knows the current structure needs to be redesigned and it needs to maintain its promise of being a 100% employer-paid health care plan.

Reform Is Needed

"We have to bring younger, healthier people into the State Health Plan," said Simmons. "To do that, we must lower the monthly contribution rate for spouses, children, and families."

Simmons says lower premiums not only enhance the quality of life and benefits package for educators and state employees, it lowers health care costs to the taxpayer. "We need more people, not less, paying premiums into the State Health Plan," she explained. "Most young people are healthy, use less health care, and therefore subsidize employees who need more care."

It is universally accepted at the General Assembly that the State Health Plan is largely comprised of state employees and their less healthy dependents. Healthy dependents are likely to buy coverage outside the more costly State Health Plan at a fraction of the cost, mainly through Blue Cross Blue Shield's Blue Advantage program. Consequently, Blue Cross Blue Shield's management of the State Health Plan has raised the eyebrows of many educators.

5

"Under the current system, healthy spouses and children of public school employees are usually covered elsewhere," said Simmons. "But if a chronic diagnosis is made, those dependents are often enrolled on the State Health Plan during the enrollment period. It's become a plan of last resort and it's costing the taxpayers millions."

This past legislative session, the General Assembly committed over \$944 million to stabilize the State Health Plan over the biennium.

Concerns About Comprehensive Wellness Initiative

This out-of-balance State Health Plan membership led the General Assembly to begin a Comprehensive Wellness Initiative, a controversial program that pushes smokers and those with a body mass index of 40 points or more to the State Health Plan's 70/30 program (as opposed to the 80/20). Simmons says she supports programs that reward good health, but she is concerned that CWI is a punitive program and should be redesigned to be an incentive program.

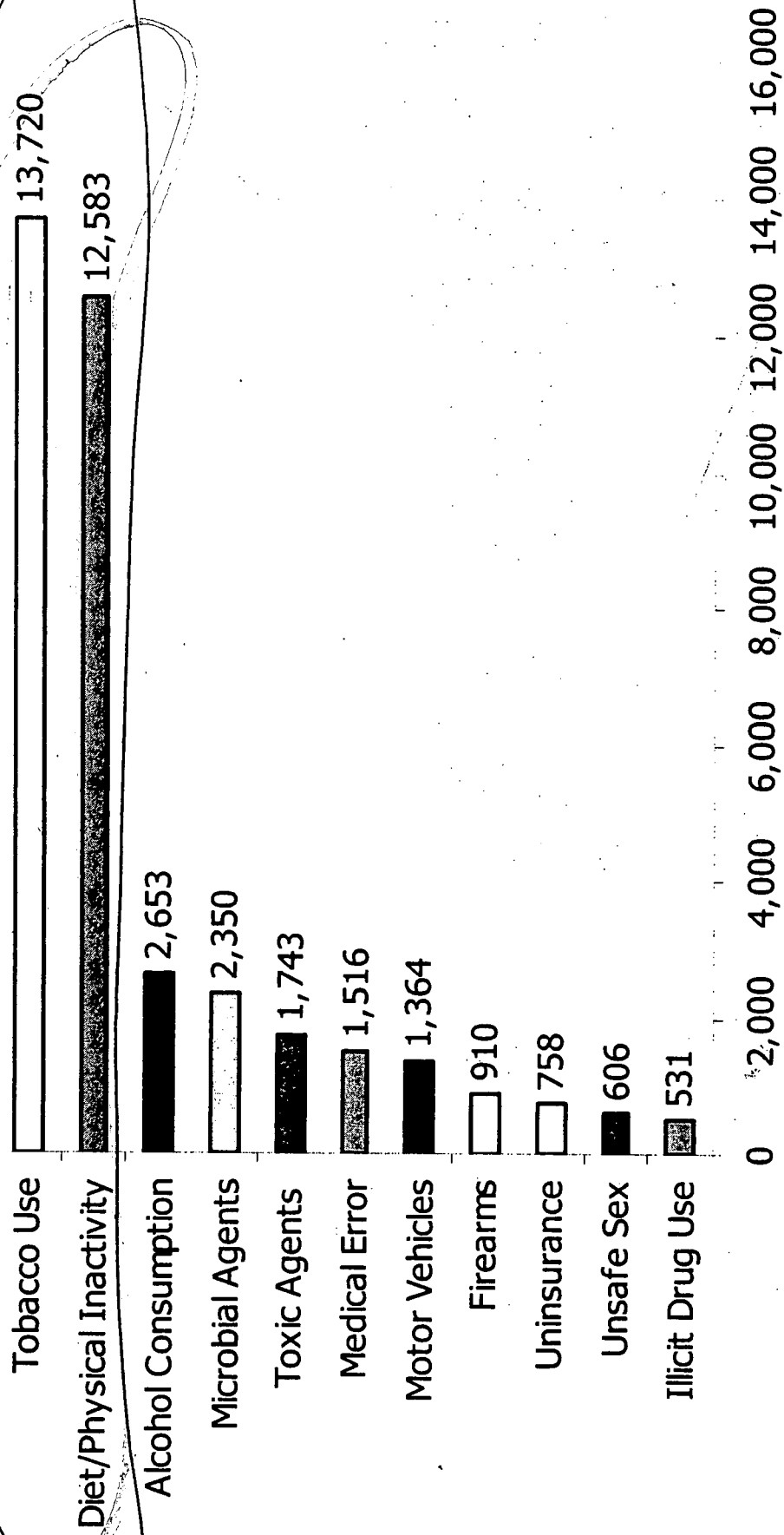
NCAE Government Relations Research Specialist/Lobbyist Marge Foreman, who takes the lead on State Health Plan matters for NCAE, is working with Simmons as she learns the intricacies of the State Health Plan, its complex contractual relationships, and those who oversee it. Foreman, who has known Simmons for all of her 25 years at NCAE, says that the Guilford special education teacher is the perfect NCAE member to help the state reform its State Health Plan.

"Vicki understands that the current system is unsustainable under its current model," Foreman said. "She will give this committee a teacher, teacher assistant, and custodian perspective that will translate into positive change for State Health Plan members."

The Blue Ribbon Task Force is scheduled to meet again on December 2 at 9 a.m. in room 1228 at the Legislative Building in Raleigh.

Brian Lewis, Lobbyist/Government Relations Specialist brian.lewis@ncae.org
North Carolina Association of Educators 700 South Salisbury Street
Raleigh, North Carolina 27601
(919) 832-3000 or (800) 662-7924 extension 256 or (919) 413-2580 mobile

Preventable Causes of Death in North Carolina (2007)



Estimated Number of deaths

Weight Management begins 10/11 → BMI less than 40 kg/m² to enroll in 80/20.

		Normal										Overweight										Obese										Extreme Obesity									
		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54				
BMI		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54				
Height (inches)		Body Weight (pounds)																																							
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258					
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267					
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276					
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285					
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295					
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	276	282	287	293	299	304					
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314					
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324					
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334					
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344					
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354					
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365					
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376					
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386					
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397					
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408					
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420					
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431					
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443					

to enroll in 80/20.

beginning July 1, 2012

BMI less than 35 Kg/m²

to enroll in 80/20.

Option: to claim exempt from (see www.shipnc.org)

Beginning 10/12 BMI less than 35 kg/m² to enroll in 80/20.

Option: to claim exemption (see www.shpnc.org)

Memo: State Employee Health Care Plans.

26 states operate on Fiscal Year basis.

24 states operate on Calendar Year basis.

STATE	TYPE		
Alabama	Fiscal		
Alaska	Fiscal		
Arizona	Fiscal		
Arkansas	Calendar *		
California	Calendar *		
Colorado	Fiscal		
Connecticut	Fiscal		
Delaware	Fiscal		
Florida	Fiscal		
Georgia	Calendar *		
Hawaii	Fiscal		
Idaho	Fiscal	South Carolina	Calendar *
Illinois	Fiscal	South Dakota	Fiscal
Indiana	Calendar *	Tennessee	Calendar *
Iowa	Calendar *	Texas	Fiscal
Kansas	Calendar *	Utah	Fiscal
Kentucky	Calendar *	Vermont	Calendar *
Louisiana	Fiscal	Virginia	Fiscal
Maine	Fiscal	Washington	Calendar *
Maryland	Fiscal	West Virginia	Fiscal
Massachusetts	Fiscal	Wisconsin	Calendar *
Michigan	Fiscal	Wyoming	Calendar *
Minnesota	Calendar *		
Mississippi	Fiscal		
Missouri	Calendar *		
Montana	Calendar *		
Nebraska	Fiscal (beginning '09-'10)		
Nevada	Calendar *		
New Hampshire	Calendar *		
New Jersey	Calendar *		
New Mexico	Fiscal		
New York	Calendar *		
North Carolina	Fiscal		
North Dakota	Calendar *		
Ohio	Fiscal		
Oklahoma	Calendar *		
Oregon	Calendar *		
Pennsylvania	Calendar *		
Rhode Island	Fiscal		

House Bill 438: State Health Plan/Change to Calendar Year
Sponsors: Representatives Folwell, Holliman, Blackwell, Blue

The following individuals /organizations have endorsed House Bill 438:

- 1. North Carolina Association of Educators**
- 2. State Employees Association of North Carolina**
- 3. North Carolina Retired Governmental Employees Association**
- 4. North Carolina Retired School Personnel Association**

Carol Bowers (Rep. Holliman)

Subject: FW: Blue Ribbon Task Force on the State Health Plan meeting



NORTH CAROLINA GENERAL ASSEMBLY

16 West Jones Street
LEGISLATIVE BUILDING
RALEIGH NC 27601

April 7, 2010

MEMORANDUM

TO: Members, Blue Ribbon Task Force on the State Health Plan

FROM: Rep. Hugh Holliman, Co-Chair
Sen. Dan Blue, Co-Chair

SUBJECT: Committee Meeting Notice

The Blue Ribbon Task Force on the State Health Plan will meet on the following date:

DAY: Thursday
DATE: April 22, 2010
TIME: 10:00 am
LOCATION: Room 1228 Legislative Building

If you have any questions concerning this meeting or you cannot attend, please contact Carol Bowers, Committee Clerk at 919-715-0873 or Hollimanla@ncleg.net.

04/13/2010

Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

Thursday, April 22, 2010
10:00 a.m.
Legislative Building, Room 1228/1327

I. Welcome, Introductions, and Remarks

Representative Hugh Holliman, Co-Chair
Senator Dan Blue, Co-Chair

II. Approval of Minutes - *motion* *2nd* *Myers - Stone*

III. Federal Health Care Reform: State Health Plan Impact

Jack Walker, Executive Administrator
State Health Plan

IV. Draft Interim Task Force Report *Theresa Matula presented* *Feezor - Stone - adopted*

V. Closing Remarks & Adjournment

meet;

HOUSE PAGES

BLUE RIBBON TASK FORCE

STATE HEALTH PLAN

NAME OF COMMITTEE _____

DATE 4-22-10

1. Name: _____

County: _____

Sponsor: _____

2. Name: _____

County: _____

Sponsor: _____

3. Name: _____

County: _____

Sponsor: _____

4. Name: _____

County: _____

Sponsor: _____

5. Name: _____

County: _____

Sponsor: _____

HOUSE

SGT-AT-ARM

SENATE

1. Name: MARTHA PARRISH STAN JOHNSON

2. Name: DUSTY RHODES JOHN FITCHETT

3. Name: JOHN BRANSON CURTIS DOWD

4. Name: _____

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Abby Emanuelson

NMSS- NC

Lynn Patterson

RBNC

Julia Adams Leggett

The Arc of NC

Chris Minard

NC State Bd of Ed

Dir B of

Civilian

Bill STOCKARD

STATE BUDGET

Andy Ellen

NCRMA

ANN LORE

DUKE

Evin Schattelpely

UNC

Mark Fleming

BC/BS

DANIEL BAUER

TROUTMAN SANDERS

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Bill Rustin	ACP
Robert Trank	WCAAC
Ed Lurlington	Brooks Pierce
Jeff Moyer	UHQ
Alexandra O'Connor	NMSS
Robert G. Lho	R. Lho & Assoc.
Peter Hans	Nelson Mullins

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Gene Cauby	NCSCA
Jim Stegall	UCPS.
Katherine Gage	NCASA
Chris Shuffner	Citizen
Teri Gutierrez	Citizen
JOHN SUTTER	Citizen
Mary Foreman	NCAE
Ed Regan	NCRGEA
Ray Presnell	NCRSP
Matt Farrell	TPG
Bo Heath	MWC

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Ronnie Conduy	NC DOI
John Bowditch	Astra Zeneca
Paul Bone	Bone & Bone
Mickey Mouse	Disney
Cam Cove	BPM & L
Shunt Harmon	WCPSS
Ally My	NM
Jonathan Kotel	Health Care for All NC
Rose Williams	NC DOI
Toni Davis	SEANC
Suzanne Brasley	SEANC

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Ruth Barlow

OSP

Carl Dean

DSP

MINUTES

BLUE RIBBON TASK FORCE ON THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

Thursday, April 22, 2010

10:00 AM

Room 1228/1327 Legislative Building.

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees met Thursday, April 22, 2010 at 10 a.m. Co-Chair Representative Holliman presided. On motion of Dr. Myers and second by Mr. Stone, the minutes for the March 25 meeting were approved.

Presentation

Co-Chair Holliman introduced Dr. Jack Walker, Executive Administrator of the State Health Plan for a review of recent federal health care reform vis a vis the State Health Plan. (*SEE ATTACHMENT: 2010 Federal Health Care Reform.*) Dr. Walker said that the presentation would be available on the SHP website on April 23, 2010. He pointed out that the comments refer to the State Health Plan without dealing with Medicaid or Medicare, or the effect on the provider community. He also cautioned that the examination of the effect on the SHP required that this be a work in progress since many rules had not been formalized.

Dr. Walker said the first key to his assessment was that health insurance would be "extended" to 95% of Americans, but that it does not require you to buy health insurance, but you will be taxed if you don't. He believes that younger, healthier people will pay more for insurance and by 2014 the State Health Plan may look more attractive. This would be a reverse of the recent trend for the Plan. He said it is possible that with the new eligibility requirements for Medicaid, some lower paid state employees may qualify for Medicaid coverage. Changes to the Medicare Part D provisions may cause the SHP to examine the coverage for state employment retirees.

In the current assessments of the federal health plan, there are time lines that affect the SHP. In June 2010, there will be re-insurance available for a narrow age group of early retirees. (Age 55-64). This could bring some revenue to the plan, but the rules have not been written.

As of January 1, 1011 employers will be required to provide IRS information for the value of the health benefits. This will be on W-2 forms. Dr. Walker stressed that the term employer did not refer to the SHP, but to the actual entity paying the employee, i.e. The Charlotte-Mecklenburg School System, the N. C. Department of Correction, etc. This information will be added by the accounting system of the agencies and will increase administrative costs. There are other potential administrative costs possible for payroll deductions for long-term care insurance.

In July of 2011, a provision begins which requires coverage on parental plans for any dependent who is "not eligible for other group coverage" until age 26. This could cost the SHP between \$11 million and 27 million per year.

Starting in July of 2012, there will be a tax on Plan enrollment for "Quality Research". The first year the tax is \$1/member, \$2/member the second year. The tax sunsets in 2019.

In July, 2013 employers of more than 200 employees must disclose all options to all employees and automatic enrollment starts for new employees.

Dr. Walker said the big changes come in 2014. The employers with more than 50 workers will offer coverage or pay a penalty. There is also a system to cover employees who make less than 400% of the poverty level. It is in this time frame that the Health Insurance Exchange is established. (The HIE is a market for health insurance for people who are not able to afford of other insurance coverage. It is also a method for small businesses to purchase insurance for employees.) A chart tracking the earning qualifications for a family of four is contained on page 9 of the attachment.

Dr. Walker said he could see as much as half of the SHP enrollment shifting to the HIE because the coverage will be cheaper. Then there is the potential for these people to shift back to the Plan as retirees and the per member/ per month cost will go up.

The state may offer large group coverage through a Health Insurance Exchange beginning in 2017.

In summary, Dr. Walker expects higher administrative costs for employers; in the case of state employees, the agencies, school districts, universities etc. Determining the family income levels will be one of those costs. Another new cost is the value of insurance coverage which must be shown on employee W-2s. Since the reform affects employers, Dr. Walker pointed out that a number of payroll/accounting systems in state government will be involved.

Due to exemptions as a "grandfathered plan" the SHP will not be affected by such provisions as prevention services, limits on cost sharing etc.

Co-Chair Representative Holliman asked who would run the HIEs. Rose Williams from the Department of Insurance said that decision was left up to the states to decide how to operate an HIE. The federal government could operate the HIE in some instances and there could be regional HIEs, too. If the state does not create a qualifying HIE, then the federal government will take over the responsibility.

He said that health care providers will be receiving lower Medicare payments, but there will be a higher demand. He also said there is a question of how employers will react to mandatory health insurance coverage.

During the discussion, Representative Braxton asked if the coverage for the SHP and the federal plan relating to lower income members would be cost neutral. Dr. Walker said that was the case, but there was actually a gain for the employer.

Co-Chair Holliman asked the most costly age range for the Plan, those between 55 and 64. Dr. Walker said the average cost per member in the range is about nine thousand dollars per year. Thus the other insurance is cheaper for the younger people, who cost the Plan less so; they leave the Plan and then come back to the Plan at a later age, when the cost to the Plan is higher.

Dr. Walker said there is no information about how fast someone might be able to switch into one plan from another, or then move back.

Representative Braxton asked if Dr. Walker thought states might eliminate the premium plans, such as 90/10, or 80/20 in order to push covered members to move to the federal plans. Dr. Walker said he had not heard of this happening, but there were still a lot of variables to be considered. He said he could foresee some small employers giving workers a raise and telling them to use it to buy insurance from the HIE.

Mr. Feezor said that he had been with some CEOs of North Carolina companies who had indeed decided to pay the \$2,000 per work tax, and provide the extra pay to purchase the HIE coverage.

In response to a question from Representative Folwell, Dr. Walker guessed HIEs would operate on a calendar year.

In another question, Representative Folwell asked how the federal reform impacted the state's GASB obligation. Dr. Walker said it did not reduce that obligation, but it did give employers incentives to stop offering retired employee coverage.

In further discussion relating to an earlier meeting, Representative Folwell inquired about projected costs to the Plan. Dr. Walker had projected that between 2012 and 2015 the projected increase is \$1.8 billion and Dr. Walker reiterated that this was additional cost to the plan. As Representative Folwell said the additional was \$500 million per year. The current cost for the Plan is approximately \$1.7 billion per year.

At this point, Co-Chair Holliman recognized the pending retirement of Gann Watson, Staff Attorney in Bill Drafting. The Co-Chair praised and thanked her for service to the Task Force.

Theresa Matula, Legislative Research Analyst presented the Task Force final report. (SEE **ATTACHMENT: Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees.**) The findings note that reports are expected on Consumer Directed Health Care, Medicate Product and Strategy, Dependent Subsidy, including Salary Based Premium Structure and an Audit of the State Health Plane.

The Task Force recommends that the General Assembly continue to deal with issues concerning the Plan during the short session, beginning May 12, 2010 and that the Task Force resume work after that Session and develop a report to the 2011 General Assembly.

Mr. Stone asked if discussion on dependent coverage was precluded based on the report. Mr. Mark Trogon, of the Fiscal Research staff noted that currently dependents are covered by the Plan up to age 26, if they maintain student status. He said members can make additional recommendations, and said the dependent coverage issue is being studied by both the Plan and the Legislative staff. He said the cost of such coverage is unknown, but one reason the staff is studying the issue was the possibility that a member of the General Assembly would introduce a bill dealing with the calendar year issue in the upcoming Session.

Mr. Stone raised the issue of calendar year conversion of the plan. Mr. Trogon said that issue will be studied as part of the report on Consumer Directed Health Care. He

did say it could be addressed separately, too. He also said that costs could be different based on the yet-to-be formed rules of the HIEs.

Mr. Feezor moved adoption of the report and Representative Braxton seconded the motion. The motion carried.

Representative Folwell asked if Dr. Walker felt the federal health reform plan was good for the employees of North Carolina. Dr. Walker said it was too early to tell.

Representative Folwell asked if Dr. Walker felt the federal health reform plan was good for the taxpayers. Again, Dr. Walker said it was too early to tell. He said the rules and regulations were yet to be written.

Representative Folwell asked Dr. Walker if he supported the federal health plan bill, based on what Dr. Walker knew now. Dr. Walker said he had no comment.

Representative Folwell said a disappointment for him in the Task Force was there had not been enough time figuring how to cut costs; how to come up with the future additional \$500 million per year appropriations. Further, he asked if a member of the health plan, who received a bill, could have the bill "scrubbed." He said, in the interest of cutting costs, could the member who considered errors in a bill check to see if the bill is correct. Dr. Walker said the member could call the SHP. The caller would have to be either the member, or authorized to speak for the member and the information would be provided.

In terms of cutting costs, Dr. Walker said the best way was to have people stay healthy. He said the percentage of people who are active has dropped and these people have picked up chronic diseases---due more to life style than age. Representative Folwell said he did not find those mutually exclusive: that you either focus on wellness and people's lifestyle or you focus on cutting costs. He asked what one suggestion Dr. Walker had for the committee that could substantially cut costs in the SHP. Dr. Walker said promote wellness and promote prevention. He said if he went to providers and asked them to cut their costs, the provider network would shrink. He said he felt that coverage was being bought about as cheap as it could be bought. He said he did not think provider costs could be cut any more; the federal government already does that. Representative Folwell said he had not said that. Co-Chair Holliman said that as far as costs were concerned, the Task Force would continue to study that.

Representative Folwell asked Dr. Walker if he felt the federal health reform would exacerbate the adverse selection of the SHP. Dr. Walker said would make it better, "it certainly won't make it worse," he said.

Representative Folwell asked if Dr. Walker favored conversion of the SHP to a calendar year. Dr. Walker said that was a legislative decision. Co-Chair Holliman said he believed the consensus of the Task Force was to make that conversion.

Ms. Simmons said Guilford County schools served tossed salads, but did not have salad bars. She had found the answer: the Health Department regulations prevented the salad bars, since food had to be destroyed at the end of the day etc. She said the Guilford County system said the food served met all state and federal guidelines for fat content etc.

The meeting adjourned at 11:15 a.m.



Representative Hugh Holliman, Co-Chair
Presiding



Carol Bowers, Committee Clerk



Senator Dan Blue, Co-Chair



Minutes by Ted Harrison

2010 Federal Health Care Reform

The following comments are a work-in-progress. Many details about the administration of these laws have yet to be written.

Key Focus Areas of Health Care Reform

Insurance Reform

- Extends insurance coverage to 95% of Americans (an additional 31-36 million Americans) over the next 10 years
- Establishes national high risk pool until 2014
- Establishes individual mandate and employer mandates to employers w/ >50 employees, with certain exceptions
- Creates regional/statewide insurance exchanges
- Offers reinsurance for employers covering pre-Medicare retirees ages 55-64
- Eliminates pre-existing condition exclusions
- Eliminates annual and lifetime limits
- Provides free preventive care
- Extends dependent age to 26 with no student requirement

Medicaid Expansion

- Expands eligibility to 133% of FPL
- Demonstration projects to improve care delivery

Medicare

- Medicare Advantage rate cuts
- Allows for providers in Accountable Care Organizations to “share” savings with CMS
- Medicare Part D changes

Quality Improvements

- Establishes an Innovation Center to reduce expenditures and improve quality
- Various provisions to establish comparative effective and quality research

Timeline for Federal Health Care Reform

Timeline as it Impacts the NC State Health Plan

Date	Change	State Health Plan Cost
June 23, 2010	Temporary re-insurance program for early retirees	Possible revenue to Plan; It is a temporary opportunity but regulations for use are not written
January 1, 2011	Employers required to disclose value of health benefits on W-2 IRS forms for calendar year 2011 Large group plans must spend at least 85% of premiums on medical claims or provide a rebate. This provision may only apply to "insured" plans. Class Act: Will require a payroll deduction line for long term care insurance	Programming and administrative costs are uncertain. The value definition is uncertain. Not applicable Administrative costs uncertain; consider rescinding SHP requirement to offer Long Term Care
July 1, 2011	Bans pre-existing conditions exclusions for dependents under age 19 Prohibits lifetime maximums Mandates that dependents who are "not eligible for other group coverage" can stay on or join parents' policies up to age 26 Note: An employer is NOT required to offer dependent coverage	Negligible None An early estimate indicates that dependent premiums would need to be increased to recover added net claims exposure of \$11-27 million per year. The cost of this coverage is free of federal tax but is a question for states.

*See "Background" on page 9

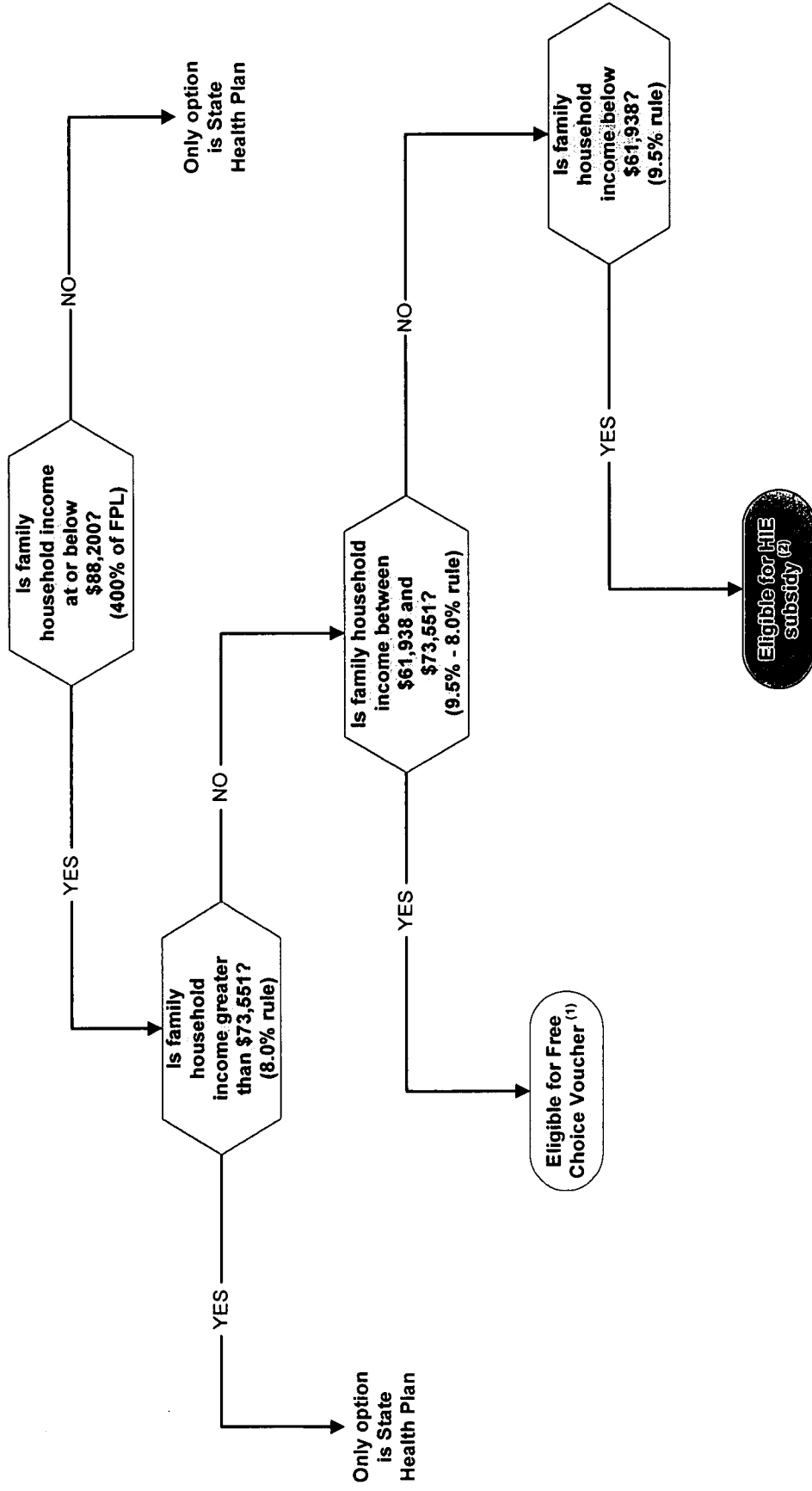
Date	Change	State Health Plan Cost
March 23, 2012	New standards for the description of covered benefits to become effective	Administrative cost uncertain
July 1, 2012	There is a tax on all Plan enrollment for "Quality Research"	The tax is \$1/yr/member for FY 2013 and then \$2/yr/member. This tax sunsets in 2019. The Plan currently has 661,000 members.
January 1, 2013	Caps contribution to Flexible Spending Account (FSA) at \$2,500 a year	None
July 1, 2013	Employers of 200 or more employees must provide disclosure of all options to all employees and make enrollment for new employees only automatic.	Administrative cost uncertain
July 1, 2014	<u>Requirements to Provide Coverage</u> • Employers of 50 or more will be required to offer coverage to employees or pay a penalty. In addition, employers will either be required to pay a penalty per affected employee if certain affordability criteria are not met, or provide a "free choice voucher." (see below) <u>\$3,000 Penalty</u> • The law requires an employer who offers coverage to pay a penalty on behalf of employees whose family income is no more than 400% of the Federal Poverty Level (FPL) and 1) employee premium contributions exceed 9.5% of family income, or 2) the plan's actuarial value is less than 60%. • If the above affordability test is not met, then the employee can go to the Health Insurance Exchange (HIE), be qualified and receive a premium subsidy. The employer then pays 1/12 of \$3,000 every month for every full-time employee who is receiving a subsidy. The legislation defines a "full-time employee" as one working 30 hours per week. (Employers need to look carefully at their seasonal and contracting employees; there may be an impact).	Uncertain

Date	Change	State Health Plan Cost
January 1, 2014 Or July 1, 2014, cont.	<i>Note: The employer may compare the difference between paying the monthly 1/12 of \$3,000 penalty for all affected employees, or paying 1/12 of \$750 for every full-time employee, and pay whichever is less.</i> - As of today, both State Health Plan offerings exceed 60% of the actuarial value. Free Choice Voucher - The law requires an employer who offers coverage to provide employees whose family income is no more than 400% of poverty level a "free choice voucher" if <u>both</u> of the following conditions apply: - Employee premium contributions are between 8% and 9.5%¹ of family income, and - Plan coverage is greater than or equal to 60% of the actuarial value - A "free choice voucher" must be equal to the contribution the employer would have paid on behalf of the employee for the employer plan in effect. - The employee uses the "free choice voucher" to purchase coverage in the HIE. It appears any amount in excess of the premium amount for the plan purchased at the Health Insurance Exchange is given back to the employee as wage income. Bans pre-existing conditions exclusions for all individuals Bans waiting periods greater than 90 days Members of Congress and staff have coverage only through plans offered through an HIE	Uncertain Negligible None (the existing period for the State Health Plan is less than 90 days) None

¹ The law uses 9.8%, but it is expected that the percentage will be reduced to 9.5%.

Date	Change	State Health Plan Cost
January 1, 2014 Or July 1, 2014, cont.	The age 26 rule will drop the requirement for "grandfathered" plans of eligibility for other group plans. Employers permitted to offer employees penalties/rewards up to 30 % of the cost of the healthcare program for participation in health programs (current law: 20%) Establishes state-based Insurance Exchanges Requires individuals to obtain health care coverage	Negligible and effective 7/1/2014 for State Health Plan None None None
January 1, 2017	States are allowed to offer large group coverage through the HIE.	Uncertain
January 1, 2018 or July 1, 2018	Imposes a 40% excise tax on high cost health plans that exceed \$10,200 for individual and \$27,500 for family coverage	None (Plan costs are projected to be below these limits)

Health Care Reform
Employee – Family of Four (4)
2010 Data



(1) Employer pays HIE \$410.80 for each month for each employee enrolled in HIE

(2) Employer pays HIE 1/12 of \$3,000 for each month for each employee enrolled in HIE

Background

- Health Care Reform was passed through a combination of the Senate Bill (H.R. 3590), entitled “Patient Protection and Affordable Care Act,” and the Reconciliation Bill (H.R. 4872), entitled, “Health Care and Education Affordability Act of 2010.”
- Generally speaking, health care reform is not effective until 2014. However, there are a number of reforms effective plan years beginning on or after six months following enactment of the laws. For the State Health Plan, those requirements will become effective no later than July 1, 2011.
- The State Health Plan is exempt as a “grandfathered plan” from many of the legislative requirements. Some examples of requirements not applicable to grandfathered plans include:
 - Prevention services
 - Limits on cost sharing
 - Appeals process
 - Selection of doctors and referral requirements
 - Coverage of routine costs of clinical trials for qualified individual
- According to the legislation, group renewal, initiation of benefit changes, and adding new subscribers or dependents does not result in a plan losing its grandfather status. New types of plans would probably be subject to all requirements and not be given “grandfather status.”

Individual Mandate

- Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance.
 - Hardship waiver if health insurance is unaffordable
 - If one doesn't enroll, then one pays a tax penalty
 - ✓ Must pay the greater of: \$95/person or 1% taxable income (2014); \$325 or 2% (2015); or \$695 or 2.5% (2016), increased by cost-of-living adjustment;
- For example, if household income is \$50,000 the penalty would be: \$500 (2014); \$1,000 (2015) and \$1,250 (2016) subject to the number of uninsured in the household and other limitations.*
 - Required to report health insurance coverage to the IRS
- Exemption/Affordability defined:
 - Some of the exemptions include individuals who are not required to file taxes and those for whom the lowest cost plan exceeds 8% of an individual's income.
- Individuals not required to change coverage under group plan or individual policy that person enrolled in as of March 23, 2010.
- Individuals can enroll in qualified health plans in or outside the Health Insurance Exchange (HIE)
- Individuals with income between 100% and 400% of the FPL will be eligible for premium assistance tax credits in the HIE

Health Insurance Exchange

- States may:
 - Contract with state Medicaid agencies to determine eligibility for subsidy.
 - Allow agents or brokers to enroll people into plans and assist people in qualifying for subsidy.
- If states do not create qualifying HIE, then federal government will assume these responsibilities.

Coverage Penalty and Other Considerations

Coverage Penalty

\$2,000/EE penalty for not offering coverage. Many expect this penalty to increase over time.

Other Considerations

The Plan will have reinsurance for 80% of the cost of claims between \$15,000 and \$90,000 per year for retirees 55 to <65 without Medicare coverage. *(Note: The Plan has retirees below age 55 whose claims expenditure will not apply to this reinsurance.)* State Health Plan needs to apply on or about June 23 and get a Plan Sponsor ID; funding is limited to \$5 billion; no rules created to manage this benefit; also unclear is how a plan can use the money; may need to create an age-specific non-Medicare retiree tier.

It is anticipated that the Medicare Part D (pharmacy benefit) donut hole will be closed by 2020. The State Health Plan may see its subsidy (\$50 million/yr decrease over time. As such, it is looking at other options such as an EGWP plan.

- EGWP Actuarial Equivalence is easier to meet
- EGWPs may offer the ability to take advantage of the 50% discount on brands in the gap from Pharma
- EGWP subsidy will increase over time

Employers will have little federal assistance to lower health costs.

Prevention and Wellness

- Worksite Wellness initiatives:
 - CDC to provide technical assistance
 - Employers can have wellness programs that include requirements that enrollees satisfy health status factors (i.e. tobacco cessation or weight) if the financial consequences (reward or penalty) do not exceed 30% of the cost of employee-only coverage (or 30% of family coverage if dependents participate).

Other Factors

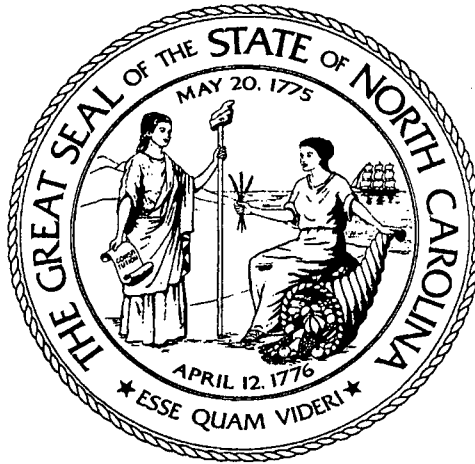
How will providers react to lower Medicare reimbursement and higher demand for services because of expanded coverage (Medicaid and Health Exchanges)?

How will employers react to mandatory employee health insurance coverage (smaller employers may revise coverage for dependents and retirees)?

What will be the impact to the State Health Plan of the 12 year patent protection for biologics; the tax of medical devices and the 50% brand discount for Medicare beneficiaries in the “donut” hole?

DRAFT

NORTH CAROLINA GENERAL ASSEMBLY



**BLUE RIBBON TASK FORCE ON THE STATE
HEALTH PLAN FOR TEACHERS AND STATE
EMPLOYEES**

**REPORT TO THE
2010 SESSION
of the
2009 GENERAL ASSEMBLY**

APRIL, 2010

DRAFT

TRANSMITTAL LETTER

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees was established by S.L. 2009-16, Part Seven, as amended by S.L. 2009-571. The Task Force respectfully submits the following report.

Representative Lindsey Hugh Holliman
Co-Chair

Senator Daniel T. Blue, Jr.
Co-Chair

TASK FORCE MEMBERSHIP

Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

Co-Chairs

Rep. Lindsey Hugh Holliman (Co-Chair)
Sen. Daniel T. Blue, Jr. (Co-Chair)

House Appointment
Senate Appointment

Legislative Members

Rep. R. Van Braxton
Rep. Dale R. Folwell
Sen. Thomas M. Apodaca
Sen. Linda Dew Garrou

House Appointment
House Appointment
Senate Appointment
Senate Appointment

Ex Officio Members

Hon. George Wayne Goodwin
Mr. Andrew M. Perkins, Jr.

Ex Officio
Ex Officio

Public Members

Ms. Gale Brown Adcock, RN
Mr. Allen Feezor
Dr. William C. Harrison
Dr. Dan A. Myers, MD
Ms. Sharnese Ransome
Ms. Victoria Leigh Simmons
Mr. Charles Stone

Governor's Appointment
House Appointment
Senate Appointment
Senate Appointment
Senate Appointment
House Appointment
House Appointment

TASK FORCE PROCEEDINGS

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees met six times from November 11, 2009 until April 22, 2010. The Task Force heard from the individuals listed below during the specified meeting dates. Detailed minutes and copies of handouts from each meeting are on file in the Legislative Library.

November 18, 2009

- Gann Watson, staff attorney, presented to the Task Force a summary of Session Law 2009-16 (SB 287), which made significant changes to the laws governing the operation of the State Health Plan for Teachers and State Employees (State Health Plan). Ms. Watson's presentation covered the key components of the enacted legislation including additional funding appropriated to the State Health Plan, annual premium increases authorized over the 2009-11 biennium, benefit changes affecting out-of-pocket requirements for Plan members, the establishment of a Comprehensive Wellness Initiative, a directive for an operational audit of the State Health Plan's medical and drug claims processing vendors, and the authorizing language for the Blue Ribbon Task Force on the State Health Plan.
- Mark Trogdon, staff fiscal analyst, made a presentation to the Task Force entitled "Overview of the State Health Plan." Mr. Trogdon's presentation covered the State Health Plan's statutory authorization and creation, its size based on enrollment, total claims, and total revenues, benefit design, funding basis, administrative structure, Plan member eligibility guidelines, enrollment demographics, etc. His presentation also provided a financial summary of the State Health Plan including the financial impact of Session Law 2009-16, a historical summary of the State Health Plan's claims growth over time, and the State Health Plan's per capita medical costs by age bands and the percent of Plan members in each of those bands.

December 2, 2009

- Theresa Matula, staff legislative analyst, presented a document listing priorities developed from input provided by Task Force members during the November 18, 2009 meeting.
- Dr. Jack Walker, Executive Administrator, State Health Plan, presented an overview of the State Health Plan and the Comprehensive Wellness Initiative. The presentation included demographic data on Plan membership, statistics concerning the rationale for choosing tobacco use and body mass index (BMI) as targets for the Wellness Initiative, and information on the Comprehensive Wellness Initiative. Comprehensive Wellness Initiative information covered the following topics: employee privacy, employee benefits and support, and desired outcomes for the State Health Plan.

January 21, 2010

- Ann Rogers, Director of Integrated Health Management, State Health Plan, provided information on tobacco use testing for Plan members. Her presentation included information on the development of the Request for Proposal for a vendor to administer off-site tobacco use testing to members and to verify members' enrollment in smoking cessation programs. Ms. Rogers also reviewed the testing process, explained how members' attestation to tobacco use status will drive initial State Health Plan qualifications, and reviewed member consequences for falsifying tobacco use status.
- Dr. Jack Walker, Executive Administrator, State Health Plan, reviewed the financial requirements for the State Health Plan for the next five years. He presented information on current and projected State Health Plan revenues, member cost-sharing, projected annual increases in health costs and utilization, and State Health Plan efforts to detect and prevent fraudulent claims. Dr. Walker's presentation emphasized the importance of improving the health status of active Plan members through behavior management, case management, and disease management, in order to achieve savings and lower the cost trend.
- Lacey Barnes, Deputy Executive Administrator, State Health Plan, provided follow-up information on select inquiries by Task Force Members which included the reduction in cost savings if individual members, rather than entire family units, are moved to the 70/30 State Health Plan; and reasons Plan members are electing to terminate dependent coverage under the State Health Plan.
- Carol Durrell, Director of Product Development, State Health Plan, provided an outline, timeline, and costs for planned actuarial studies to be performed by Aon Consulting in 2010 to address Task Force requests, responses to questions from the Legislative Oversight Committee and constituents, and State Health Plan requirements. Ms. Durrell discussed the Cost Comparison study of State Health Plan benefit options in Georgia, Virginia and Tennessee (which should be available in mid February) and the study concerning Other Post-Employment Benefits like retiree benefits.

February 25, 2010

- Carol Durrell, Director of Product Development, State Health Plan, presented details of our State Health Plan in comparison to the state health plans of Georgia, Virginia, and Tennessee. Ms. Durrell highlighted differences and similarities in state health plan benefits, premium costs, subsidization of dependent care premiums, and other aspects of operations.
- Ann Rogers, Director of Integrated Health Management, State Health Plan, discussed the extension of a nutritional visit benefit to all Plan members (previously available only to Plan members with diabetes). She noted that for provision of this benefit the State Health Plan has contracted for participation in the Eat Smart, Move More, Weigh Less program.
- Dr. Derek Prentice, Consulting Medical Director, State Health Plan, discussed a range of issues related to medications prescribed to members participating in State Health Plan weight loss programs.

March 25, 2010

- Chris Schoffner, Managing Partner, White Bear Group, an employee benefit consulting firm, discussed methods of changing member behavior to create savings for the State Health Plan. Mr. Schoffner presented information on the success of the Ashville Project. In the Ashville Project, diabetic employees received support and guidance from counselors, physicians, and pharmacists all working together, and employees received preventive care without any out-of-pocket costs. Mr. Schoffner recommended the following main steps:
 1. Identify employees with needs via Health Fairs.
 2. Engage beyond the chronically ill; remove barriers to treatment.
 3. Educate through face to face coaching.
 4. Communicate at all steps to allow all to get information.
- Mark Ruby, Vice President for Business Development, BioSignia, a healthcare risk assessment company located in Research Triangle Park., presented information on BioSignia's "Know You Number" product. BioSignia uses data analysis of large populations and individual test results to help participants better understand their personal health risks. According to Mr. Ruby, the State Health Plan could save \$124 million over five years by screening 300,000 Plan members twice a year for five years.
- Victoria Simmons, Task Force member, provided copies of pay slips for several Guilford County School employees and discussed the importance of the "promise" of affordable health care from the State to its employees. The Task Force discussed the "promise" of health care at no cost and whether employees would be willing to pay a member contribution based on a percentage of their salaries.
- Representative Folwell, Task Force member, advocated the use of a calendar year, rather than State's fiscal year, for the State Health Plan. He cited broad support for the change among various State employee organizations and the use of a calendar year by 24 other states. Although there would be a one-time cost of \$25 millions and a six month moratorium on rate increases, Rep. Folwell requested that the Task Force endorse the idea in order to facilitate health insurance planning by families with non-State Health Plan options.

April 22, 2010

- Jack Walker, Executive Administrator, State Health Plan, presented information concerning the impact on the State Health Plan of the following federal health reform Acts: Patient Protection and Affordable Care Act (HR 3590), and the Health Care and Education Affordability Act of 2010 (HR 4872).
- The Task Force received a draft report to be presented to the 2010 General Assembly, the Governor, and the Committee on Employee Hospital and Medical Benefits and took action on the report.

FINDINGS AND RECOMMENDATIONS

FINDINGS:

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees met six times prior to the convening of the 2010 short session. During these meetings Task Force members received an overview of the State Health Plan, the State Health Plan's Comprehensive Wellness Initiative, and information on issues that will impact the State Health Plan in the future. Members were also apprised of the study issues identified in the legislation creating the Task Force and prioritized the study of these issues. The Task Force explored a number of concerns regarding the State Health Plan and found there is a good bit of information that, although not immediately available, will be forthcoming during the tenure of the Task Force and following adjournment of the 2010 short session. In the coming months, the Task Force anticipates receiving the following reports: Consumer Directed Health Care, Medicare Products and Strategy, Dependent Subsidy including Salary Based Premium Structure, and an Audit of the State Health Plan.

RECOMMENDATION:

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees recommends that the General Assembly continue addressing State Health Plan issues during the 2010 Session and that the Task Force resume its work after adjournment of the 2010 Session and develop a report to the 2011 General Assembly.



NORTH CAROLINA GENERAL ASSEMBLY

16 West Jones Street
LEGISLATIVE BUILDING
RALEIGH NC 27601

July 20, 2010

MEMORANDUM

TO: Members, State Health Plan Blue Ribbon Task Force

FROM: Rep. Hugh Holliman, Co-Chair
Sen. Dan Blue, Co-Chair

SUBJECT: Committee Meeting Notice

The State Health Plan Blue Ribbon Task Force Committee will meet on the following date:

DAY: Thursday
DATE: August 12, 2010
TIME: 10:00 am
LOCATION: Room 1228 Legislative Building

If you have any questions concerning this meeting or you cannot attend, please contact Carol Bowers, Committee Clerk at 919-715-0873 or Hollimanla@ncleg.net.

MINUTES

BLUE RIBBON TASK FORCE STATE HEALTH PLAN

Thursday, August 12, 2010

10:00 a.m.

Room 1227 State Legislative Building

The Blue Ribbon Task Force on the State Health Plan met August 12, 2010, at 10:00 a.m. in Room 1227 of the Building. Co-Chair, Representative Hugh Holliman presided. (*SEE ATTACHMENT: Members and Guests Present.*) On motion of Insurance Commissioner, Wayne Goodwin and second by Ms. Adcock the last meeting's minutes were approved.

PRESENTATIONS

Navigant Report Recommendations

Paula Douglass, Director of Navigant Consulting, the project coordinator for the audit on SHP Performance and Efficiency said the Governance issue was part of the overall performance audit which was presented to the Oversight Committee in May. The Governance issue is one of 12 areas of the SHP which were reviewed. Ms. Douglass introduced Celina Knippling, Senior Associate of MGT of America who was responsible for the audit area of Governance review. (*SEE ATTACHMENT: Navigant Consulting Audit.*) The first finding was that North Carolina's governance structure was unique. The SHP is an independent agency responsible to the General Assembly. The management on the day to day basis comes from the Executive Administrator. Plan oversight includes a legislative committee: Committee on Employee Hospital and Medical Benefits, the Board of Trustees of the SHP and the SHP Administrative Commission.

Ms. Knippling said that in the 16 states that were reviewed, the health plan was responsible to an independent governing board or an executive branch department or agency. None of the other plans came under administration by the legislative branch. All 16 states had boards of some type, either governing or advisory. Most were governing boards.

The report said that the North Carolina Legislative Committee lacked the capacity to manage the Plan, while the Board of Trustees lacks the authority of govern the Plan. Further, the reports notes little oversight is provided by other state agencies.

The report recommends:

- The SHP should be an independent agency reporting to a governing board attached to the Governor's Office
- Elimination of the current of Board of Trustees in favor of a new governing board with authority to manage the SHP operations.
- Parameters be set up for balance on the Governing Board.

In the discussion, Representative Folwell asked who had the authority to hire or fire the executive director of the North Carolina SHP. The response was that the SHP Administrative Commission held such authority. Ultimately that responsibility lies with the Co-Chairs of the Task Force. *(SEE PAGE 6 Re: The Commission.)*

In response to questions from Representative Braxton concerning the make up of other boards, Ms. Knippling said some of the boards were appointed others were elected and there was a variety throughout the systems. She said there was not a strong indication of qualifications for membership. Navigant's proposal would create a 9-member board with knowledge and experience of the mission of the Plan and would represent segments of the membership: state employees, teachers and retirees. Those guidelines would be followed by the Governor's three appointees, plus the addition six members appointed by the Senate President Pro Tem and the Speaker of the House, according to the Navigant recommendation.

In response to questions from Ms. Adcock, Ms Knippling said that those states which elect the members of the governing board , some elections are done by members of the plan others are votes cast in general elections. She said California elects the members of its board in a general election and that there have been charges of conflict of interest on the part of some members of that board. Drawing on his experience in California, Mr. Feezor said the election of board members for CALPERS cost about a million and a half dollars.

Mr. Feezor said it should be determined if North Carolina's SHP was a multiple employer plan or a single employer plan. Ms Knippling said the audit took the position that it was a single employer plan, even though the various constituent groups: state employees, teachers, state employees, etc might not have the same interests. He asked who held the fiduciary responsibility in the SHP and was told that comes under the role of the executive administrator. Mr. Feezor said such responsibility in the hands of one person seemed to lack enough checks and balances, no matter who the person might be.

Responding to questions from Dr. Myers, Ms. Knippling did not have specifics about how many of the 16 plans examined were set up as separate agencies or fell under an executive agency. She promised to follow up with that information.

Mr. Stone asked for clarification and verification that the Administrative Commission mentioned above was in line with the General Statutes. Ms Knippling responded to another question from Mr. Stone saying that some of the other boards did include members of the legislature. Further she said the Navigant proposal would appoint people other than legislators to allow for experience and expertise and to save further draws on legislators' time. Concerning any change in roles caused by the new federal health plan, she said the attention to oversight did recognize that Medicaid was administered by the Department of Health and Human Services. She said, "You wouldn't want the legislative branch overseeing an executive branch function such as the health plan." At the same time the recommendations did not take the legislature out of the process since the 9-member board proposal used 3 members appointed by the House and 3 by the Senate. The legislature has the final oversight in the form of the budget. The day to day operation of the plan would be the function of the governing board in the Navigant recommendation.

In discussion with Dr. Myers, Ms. Knippling said there would need to be new legislation to set up qualifications for board members. She said some boards, not necessarily health plan boards require testing of knowledge of the particular field being governed and some included oral interviews with members of the legislative bodies.

In answer to questions from Mr. Feezor on relationship of a board to the broader benefits offered by a state, Ms. Knippling the governance area focused on who is making the decisions and their qualifications and experience more than how such benefits would tie-in with other parts of an employee's overall benefit package.

Board of Trustees' Recommendations

Dr. John Hammond, member of the SHP Board of Trustees provided Task Force Members with the idea from a sub-committee of that Board. *(SEE ATTACHMENT: Report on SHP Governance Structure. Adopted, May19, 2009 by the Board. The presentation began with page 11 of the report.)*

The report found several approaches to Health Plan Governance in other states:

- 25 states have the Health Plan in an executive agency
- 15 states have the Plan in an executive agency with a governing board.
- 8 states have independent agencies with governing boards.
- 2 states did not have an identifiable structure.

The Trustees alternatives included:

- Administer the SHP within an executive agency adding responsibilities to the board, such as:
 1. The executive agency would have day to day responsibility for the Plan
 2. The board would help with health plan policies
 3. The agency would have decision and rule-making authority
 4. The secretary of agency would be responsible for hiring and evaluating the performance of the Executive Administrator

The Trustees favored this alternative noting that the executive agency would have the fiscal responsibility for the Health Plan.

The second alternative from the Trustees would maintain the SHP independence, but vest the Trustees with true fiduciary and oversight responsibility. Thus the Trustees would set plans and policies and evaluation of the Executive Administrator. Trustees believe this would take more than a volunteer board and would require members with the needed business skills to oversee the operation. Those Board members would need to be compensated appropriately.

The Trustees third alternative would maintain the status quo, but remove "fiduciary" from the statutes and reduce Trustee input to the more critical areas facing the SHP. Mr. Hammond said, "We hope you don't do this."

Co-Chair Blue noted that the third alternative was really not an alternative and Mr. Hammond agreed. He asked if the Board of Trustees would still do final agency reviews if the first alternative was followed. Mr. Hammond agreed, but added the Board did not have the expertise to figure the responsibilities of the Board vis a vis the agency where the Plan might be housed. Noting that he felt the co-pays were "out of whack", he

said he would like to see the Board of Trustees taken seriously. Senator Blue asked if the Advisory Board outlined in the Navigant Report given a set amount of money could wrestle with co-pays etc., but did not bind ultimately the Plan, could that work be done by outside experts. Mr. Hammond agreed this could be done. He said if a board consisted of people who were knowledgeable in health insurance, health care, hospital administration and the like could provide insight into such issues as co-pays. Thus specialist co-pays would not be so high that members did not seek that care and later became patients who needed the higher price specialist care, when earlier intervention might have kept the management within the scope of a generalist. Mr. Hammond said that if the future board should have the responsibility of hiring an executive director, then members of that board should be a part of any search committee formed for such hiring.

Ms. Ransome asked where such health plans were located in the study that Mr. Hammond did. He said most of them were in the Department of Human Resources, but there were variations. Ms. Knippling said some plans were in the financing agency, and others were in the department of insurance. Ms. Ransome said she felt that a board with the kind of knowledge and expertise being mentioned would need to be a full time board, and if so how would this board be paid. Ms. Knippling said some boards were fulltime and budgeted for that, others were paid a stipend for meetings. She said there was some indication that full-time boards could bring saving benefits to offset the cost of the board.

Mr. Stone asked how the new federal health insurance appeal process to the Department of Insurance might fit with an appeal process to the Board of Trustees. Representative Holliman said that had yet to be decided. Mr. Feezor said he understood that the appeal process dealt with new plans that came into existence. Commissioner Goodwin said members of his staff were meeting with other state insurance departments to create an operating system.

Representative Folwell asked how much the Navigant audit cost. Mark Trogon from fiscal research put that figure at \$1.2 million. The SHP had submitted a request for bids and awarded the contract on that basis. Representative Folwell followed by asking about the enrollment audit to determine fraud and did that include fraud investigation. Mr. Hammond said that the operation was handled through Blue Cross Blue Shield. Executive Administrator Jack Walker said there was a division within BCBS to deal with provider fraud. He said he believed that the State Retirement System would handle removing the names of deceased members from the roles. The enrollment is handled by each agency. In answer to another question from the Representative, Dr. Walker said he did not know of any cases of provider fraud in the millions of transactions handled by the SHP.

Ms. Simmons asked about the existence of any fraud hotlines. She was told there was such a hotline in both the State Auditor and Commissioner of Insurance offices. She said those should be publicized better.

Representative Braxton asked if there were new innovative ideas to make the administration of a health plan better coming from the boards that were surveyed. Neither Mr. Hammond nor Ms. Knippling knew of any such innovations. She noted that the Navigant report dealt with governance rather than operations.

Representative Folwell said that most of the members had heard of cases of fraudulent practices and that there should be better knowledge about how such cases can

be reported. Commissioner Goodwin agreed every tool should be used. He noted there were direct links on the DOI website to make such reports. He said DOI had seen an increase in fraud cases in the current economic situation, but he said most of those cases dealt with embezzlement and the like and he did not see that many cases involving the SHP. Mr. Feezor said that DHHS had been working to deal with both provider and member fraud and that Governor Perdue had made such work a priority.

Governance Discussion

Ms. Ransome asked if the process would proceed with the Task Force making recommendations that would need to be worked into new legislation. Co-Chairman Holliman said that was the process and would also include input from the Governor's office on the issue.

Representative Braxton said he felt the Task Force could handle various issues that would face aboard, except perhaps accountability. He suggested that this group could deal with various issues such as HRAs, HSAs and could look for good ideas on all matters including costs and make recommendations to the General Assembly.

Dr. Myers said he could see an impendent agency located in an executive branch department headed by a person with specific expertise and experience. He said a board should also have a level of expertise in the various issues, but it should not be a full-time board. Dr. Myers said speaking as a two-term member of the Board of Trustees that what ever evolves from this Task Force would be based on the resolution of the governance issue.

Mr. Stone said he felt that presentations should be made to the Task Force on the pros and cons of placement of the health plan. Co-Chair Holliman asked staff to set up such presentations.

Mr. Feezor said returned to the issue of whether the SHP is a single employer plan or a multiple employer plan, given the various pay structures for the elements of the Plan beneficiaries: teachers, National Guard members, etc. with the various salary structures. He said the health plan should also be considered with other benefits such as retirement. Based on his experience with in California with CALPERS, he said a voluntary board would be preferable with sufficient staff to gather the various good ideas. The board should be paid a stipend and the executive director should report to that board and there should be transparency. He likened such a board to the Unities Commission. The board would need representation of the various constituencies, knowledge of the health of the population and performance of providers.

Representative Folwell said he had sponsored a bill that would provide employee benefit statements that would show state employees the value in real dollars. He said that bill had not been implemented. He said employees had not been made aware of the value of the Plan or of the situation the Plan faces.

Commissioner Goodwin said locating such an agency within the Department of Insurance would be a conflict of interest since the Department is charged with regulating the insurance industry.

Ms. Adcock agreed with Dr. Myers that the board should have the expertise and broad representation for issues and constituencies. She said the board should have autonomy and responsibility for decisions to be made.

Co-Chair Blue said that given the benefits of a state employee lie in three areas: state personnel regarding salary, retirement in the Treasurer's office and the SHP with the Legislature, shouldn't these all be in the same place. He addressed the question to Mr. Feezor. Mr. Feezor said they did not need to be tied into the same place. He said he was concerned about replacing the 40% of the state work force that was due to retire in the next 5 years. The health plan and the pension had been attractive to various employees. He said that there should be the ability to look at the total workforce and what the future would hold. Co-Chair Blue said there were no bargaining units, but the responsibility needs to be placed in someone who reports directly to the Governor.

He said the aim was to come up with a SHP that was:

- Affordable
- Efficient
- Provide the best care to employees for the money

Ms. Simmons wanted to know how conflict of interest matters would figure for board members. Co-Chair Holliman said that depends on the way the Task Force defines the board.

Representative Folwell asked Dr. Walker who was he accountable to. Dr. Walker said the ultimate responsibility lies with the Co-Chairs of the Task Force. The administrative commission would make recommendations to the two co-chairs. Representative Folwell also asked about a new position in the SHP as director of state plans and operations. Dr. Walker said the person would oversee the contracts that come under the SHP, but there was not time enough at the meeting to explain the entire rationale for this position. He said that would be provided.

Co-Chair Blue asked Representative Folwell if it was his position that there was gross mismanagement going on at this time in the SHP. Representative Folwell said it was his opinion that "no one really knows what is going on in the SHP."

Mr. Stone noted that there were two bills introduced in the past session on governance, but neither had passed. He asked about how new legislation might proceed. Co-Chair Holliman said the recommendations from the Task Force would be presented in a bill.

Commissioner Goodwin said that drafts that had been seen vested the Office of the Commissioner of Insurance with certain responsibilities, but that those had been ended as of 2008.

Co-Chair Holliman said the House appointments to the Administrative Commission were Lewis Pate and Martha Adams. The Senate appointee's name was not available, but would be provided. The first term of the Commission provided two members appointed by the House and one by the Senate. The next term there would be two appointed by the Senate and one by the House.

Review of Task Force Work Plan

Ben Popkin of the Research Staff provided members with a handout covering the Work Plan as previously identified by the Task Force. (*SEE ATTACHMENT: Prioritizing the Work etc.*) He said this is the product of earlier meetings and the priorities set by the Task Force.

Mr. Stone said the Office of State Personnel had not provided information about the role of the SHP in the overall benefits package. He felt that was an important issue to be considered in recruiting and retaining the work force for the State. He also said he had not heard any presentations about charging premiums to state employees. He asked how much money was provided by the federal government for benefits to state employees. Mark Trogdon from Fiscal Research said that about 16% of the cost comes from other sources: federal funds, receipt-paid agencies and the highway fund.

Ms. Adcock said she did not see cost-sharing on the work plan. Co-Chair Holliman said the Task Force had mentioned that and it would be considered.

Prior to adjournment, Co-Chair Holliman reminded staff about presentations on the pros and cons of placing health plan governance within various places in state government.

The meeting adjourned at 11:45 a.m.

Representative Hugh Holliman,
Co-Chair Presiding.

Carol Bowers
Committee Assistant

Senator Dan Blue, Co-Chair

Minutes by Ted Harrison

Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

**Thursday, August 12, 2010
10:00 a.m.**

Legislative Building, Room 1228/1327

I. Welcome

*Representative Hugh Holliman, Co-Chair
Senator Dan Blue, Co-Chair*

II. Governance Issues

- **Navigant Report Recommendations**
Paula Douglass, Director, Navigant Consulting
Celina Knippling, Senior Associate, MGT of America, Inc
- **Board of Trustees Recommendations**
John Hammond, Board Member

III. Task Force Discussion: Governance

IV. Task Force Discussion: Review of the Task Force Work Plan

North Carolina State Health Plan for Teachers and State Employees

Performance/Efficiency Audit
Governance Structure

Presentation to
North Carolina Blue Ribbon Task Force on the State
Health Plan for Teachers and State Employees
August 12, 2010



NAVIGANT
CONSULTING

Overview of Presentation

- Performance and Efficiency Audit Background
- Governance Structure Background
- Audit Tasks
- Findings
- Recommendations

Performance and Efficiency Audit Background

- Reason for Audit: Concerns raised by State Legislature and others regarding SHP's performance and operation
- Review Areas:
 - SHP's Governance
 - SHP's Administrative Services Agreement with BCBSNC, the administrative services contractor for the SHP's medical benefits
 - Performance in 9 functional areas by BCBSNC
 - Performance by Medco, the SHP's pharmacy benefit management contractor
- Audit Period: state fiscal years (FYs) 2006, 2007 and 2008

Functional Areas Reviewed

Provider Relations and Delivery

Systems

Membership Accounting

Utilization Management

Other Health and Management

Properties

Customer Services

Claims and Reimbursement

Information Technology and

Health Reporting

Finance

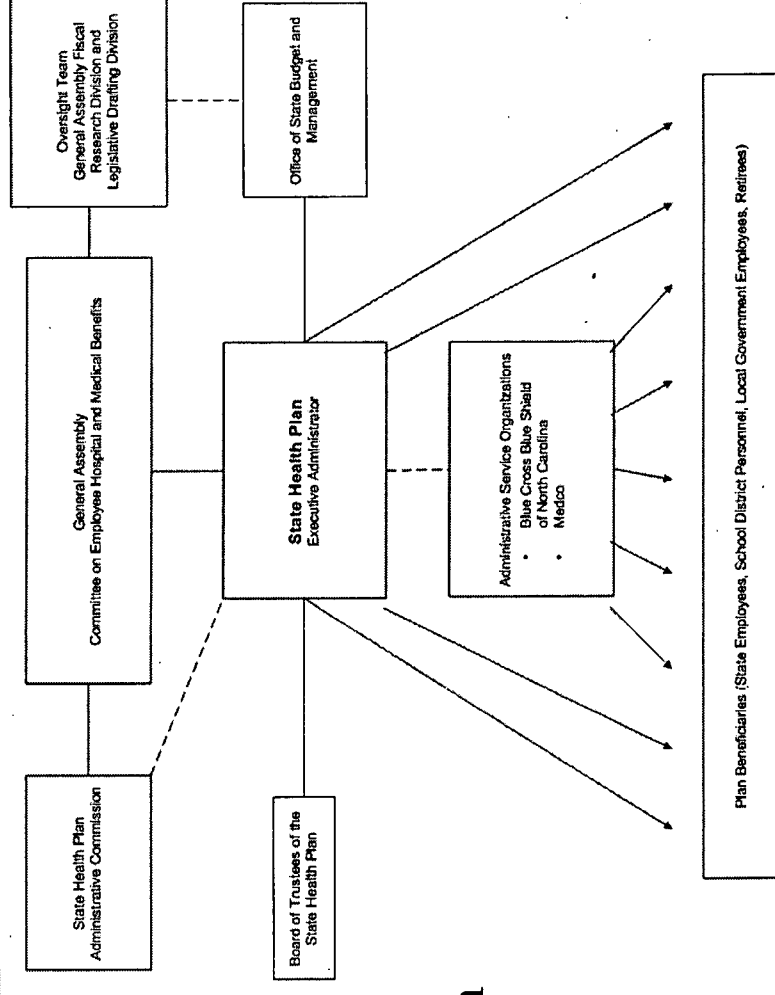
Governance Area Audit Tasks

- Evaluate the SHP's governance and oversight structure.
- Compare the SHP's reporting and governance structure with peer organizations.
- Identify governance and oversight elements that should be strengthened, changed, or eliminated.
- Follow-up on issues identified by the October 2008 and April 2009 State Auditor's reports.
- Evaluate the SHP's Board's recommendations for modifying the governance structure and oversight.
- Assess the impacts of limitations related to communication and confidentiality of information and contracts.
- Determine the appropriate placement of the SHP in state government.
- Develop recommendations to ensure prompt reporting of claims data and trends to actuaries.

North Carolina SHP's Current Governance Structure

Background

- The SHP operates as an independent agency under the jurisdiction of the Legislative branch of state government
- Day-to-day management is assigned to the SHP's Executive Administrator
- Several entities are involved in Plan oversight
 - General Assembly – Committee on Employee Hospital and Medical Benefits
 - Board of Trustees of the SHP
 - SHP Administrative Commission



NC SHP's Governance Structure is Unique

Findings

- Our review of other state health plans' oversight and governance did not identify other states or programs with a structure similar to that used in North Carolina
- Oversight for other state plans generally is performed by an independent governing board or an executive branch department or agency (in 12 of the 16 states reviewed)
 - No other state had a plan under legislative branch administration
- All 16 states had oversight boards
 - 13 of the 16 states had "governing" boards; 3 of the 16 states had "advisory" boards

The Current Governance Structure is Not Adequate

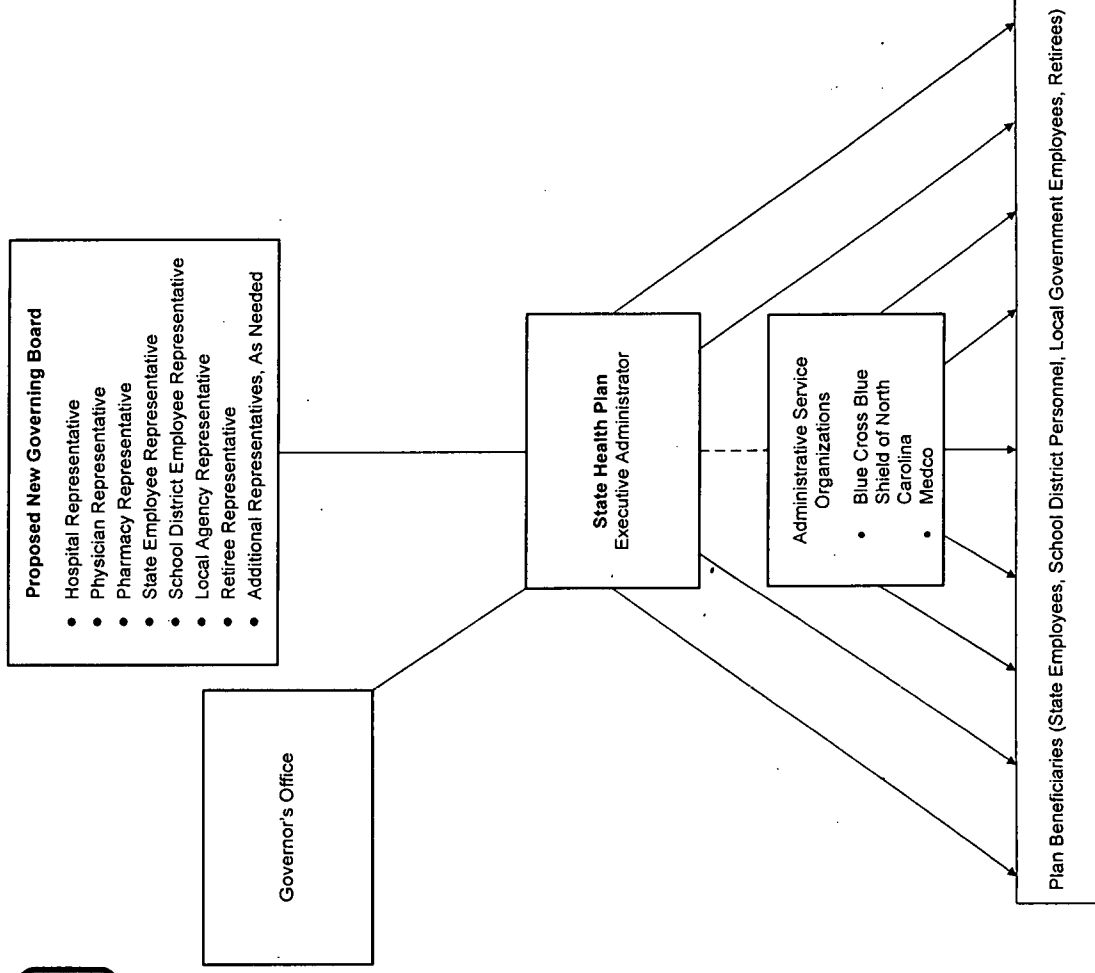
Findings

- The current governance structure does not ensure adequate oversight and monitoring of the SHP
 - The Oversight Committee lacks the capacity to manage the plan.
 - The Board of Trustees lacks the authority to govern the plan.
 - Other State agencies have provided little oversight of the Plan.
- Previous audits and reviews dating back to 1994 have raised concerns about the SHP's governance structure

Governance Recommendations

Recommendations

- The State should make the SHP an independent agency that reports functionally to an independent governing board and organizationally to the Governor's Office
- The State should discontinue the operations of the current Board of Trustees and establish a new governing board, tasked with the direct authority to manage the SHP's operations
- The State should develop parameters to allow for an appropriate balance of representation on the Governing Board



Governance Recommendations

Recommendations

- The new governing board should establish a formal charter and a set of guiding principles, including definition of:
 - Mission
 - Goals and objectives
 - Board responsibilities
 - Board positions and organization
 - Board protocol
 - Frequency, timing and format of meetings

Governing Board Recommendations

Recommendations

- The State should develop a formal selection process to ensure an appropriate level of competence among governing board members
- The Governing Board should work with the SHP Executive Administrator to establish a formal reporting and communications structure to allow for effective oversight
- The SHP should develop a formal communications strategy for periodically communicating its financial and operational status with the General Assembly and Governor's Office

HOUSE PAGES

Blue Ribbon Task Force
NAME OF COMMITTEE State Health Plan DATE 8-12-10

1. Name: _____

County: _____

Sponsor: _____

2. Name: _____

County: _____

Sponsor: _____

3. Name: _____

County: _____

Sponsor: _____

4. Name: _____

County: _____

Sponsor: _____

5. Name: _____

County: _____

Sponsor: _____

SGT-AT-ARM

1. Name: Reggie Sills

2. Name: Judy TURNER

3. Name: ERNE SHERRELL

4. Name: RONALD SPANIN

VISITOR REGISTRATION SHEET

Blue Ribbon Task Force on SHP

August 12, 2010

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
ANN Loke	DVLE
K. Wight	ReBSN
Julia Adams	The Arc of NC
Suzanne Beasley	Seane
Mitch Leonard	Seane
Bruce Mildner	WKA
Erica Baldwin	SEANC
Cam Cree	BPMHL
Jennifer Sasser	Williams Miller
Anne Rogers	State Health Plan
Jack W Walker	SHP

VISITOR REGISTRATION SHEET

Blue Ribbon Task Force on SHP

August 12, 2010

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

John Bowditch	Astrazeneca
Elizabeth Robinson	NORCIS
CHARLES WINKLER	STATE HEALTH PLAN
LINDA MCCRUDDEN	STATE HEALTH PLAN
Beverly Harris	State Health Plan
Lorraine Munk	State Health Plan
Sally Morton	State Health Plan
Mona Moon	SH P
Pam Deardorff	NC Retired School Personnel
Jinda Bunker	NCAE
Chris Shoffner	Citizen

VISITOR REGISTRATION SHEET

Blue Ribbon Task Force on SHP

August 12, 2010

Name of Committee

Date

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NAME

FIRM OR AGENCY AND ADDRESS

DANIEL BAUM	TROUTMAN SANDERS
Jimmy Jackson	Catalyst ~~PK~~
Andy Elk	NRN
Gary Robertson	AP
Carl Dean	OSP
Ruth Barlow	OSP
Brian Balfr	Civitas
Ed Regan	NCRGEA
Ronnie Landrey	DOI

VISITOR REGISTRATION SHEET

Blue Ribbon Task Force on SHP

Name of Committee

August 12, 2010

Date

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NAME _____

FIRM OR AGENCY AND ADDRESS

Wanda Tross

NCAU

Anthony S. Lee

Q. Und answer.

Bill P. Brown

Asa

Louise Hawthorne

ETERN

VISITOR REGISTRATION SHEET

Blue Ribbon Task Force on SHP

August 12, 2010

Name of Committee

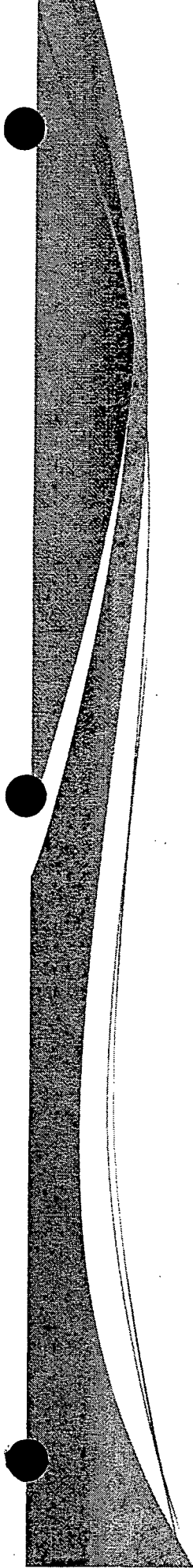
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Roger Olson	OSA
Eric Tharion	OSA
Andre Bel	FA
Schwartz	FA
A O'Lonnor	NMSS
Jim Stegall	UCPS.
Amey Whitel	NM8
Dennis Wickpa	NM25
Joey Nichols	Cap. Results
Mark Flenny	work for Joey
Adam Linker	NCTC



Report on State Health Plan Governance Structure

By

The Subcommittee of the Board of Trustees
on the Oversight of the State Health Plan

Pam Silberman*

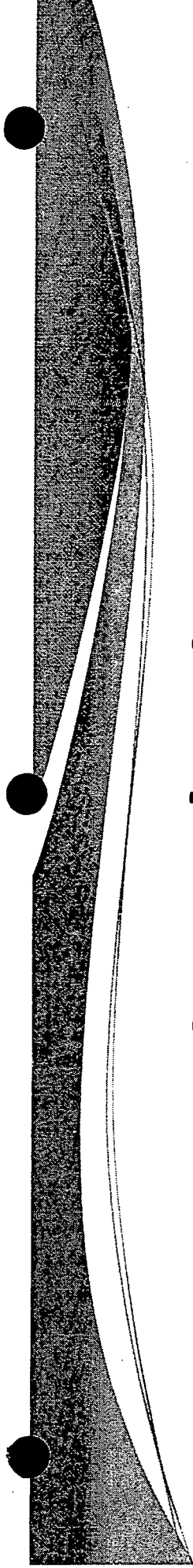
John Hammond

Neppie Stevens*

Linda Sutton*

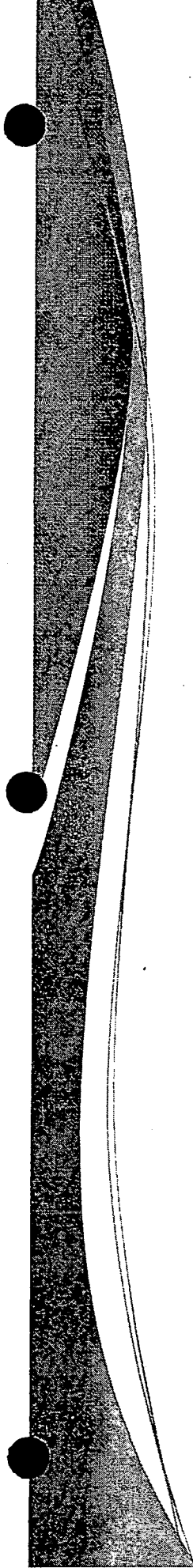
Adopted by the Board of Trustees on May 19, 2009

*Past Board Members



Introduction

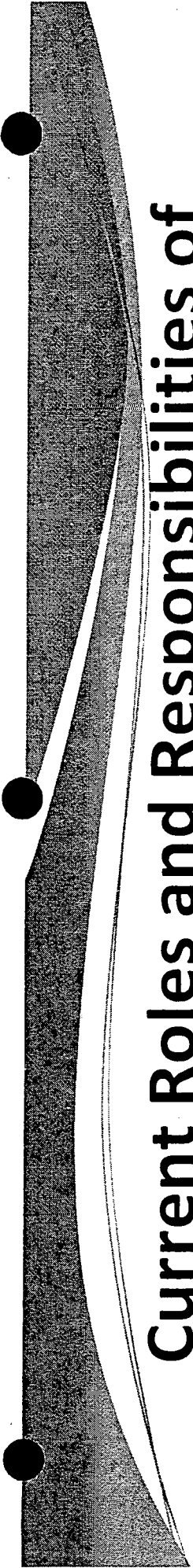
- In 2008, the Board of Trustees (BOT) began to reexamine their oversight role in relation to the State Health Plan.
- In 2009, the BOT appointed a subcommittee to study the Plan's governance and structure and to make recommendations for improvement.
- The subcommittee studied the current oversight structure, reviewed the structure of health plan boards in other states and made recommendations for improvement.
- The Board adopted the report on May 19, 2009.



Study Process

This presentation highlights the information in the full Board Report, including:

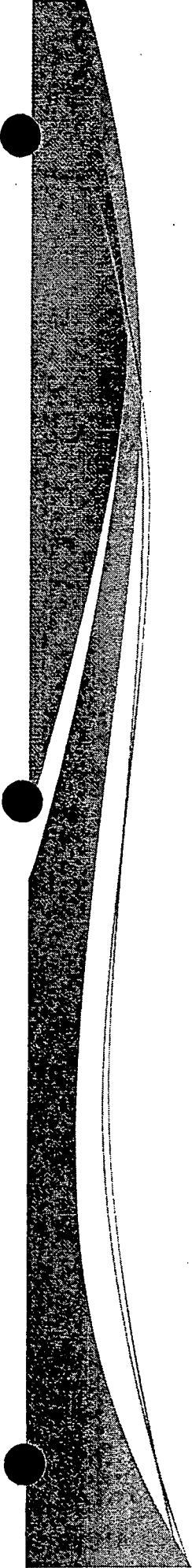
- A review of the current roles and responsibilities of the Executive Administrator and Board of Trustees.
- A summary of the current oversight structure.
- A discussion of “Fiduciary” as it applies to Health Plans.
- A summary of the 2008 and 2009 State Auditor’s Performance Report findings and recommendations regarding oversight.
- Options for improving oversight of the State Health Plan.
- Next steps.



Current Roles and Responsibilities of Executive Administrator and Board of Trustees

NCGS § 135-45

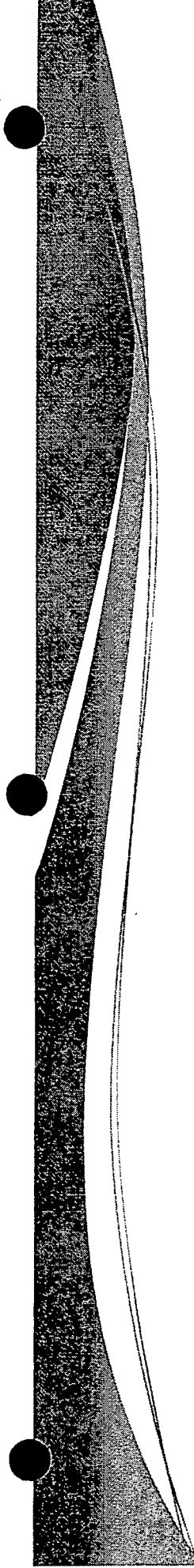
- The Board generally has joint, but limited, responsibilities with the EA to administer the Plan.
- The EA has the power, duty, right and responsibility to act after consulting with the Board.
- The EA consulting with the Board does not mean that the Board must approve or otherwise agree with the EA actions. The EA only has the duty to consult.
- The Board has exclusive responsibility for:
 - Electing officers.
 - Making final agency decisions on Administrative Appeals.



Oversight by Legislative Bodies

Committee on Employee Hospital and Medical Benefits (Legislative Oversight Committee)

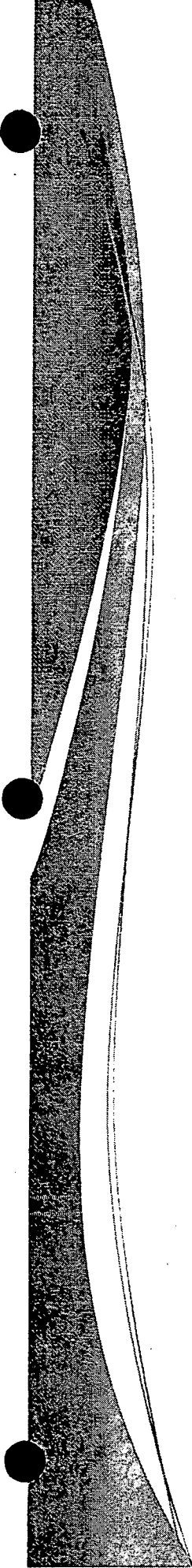
- Has the broadest responsibility.
- Must meet at least quarterly to review actions of the EA and the Board.
- The EA and Board are accountable to the Legislative Oversight Committee and shall report to the General Assembly when and in such manner as the Legislative Oversight Committee designates.



Oversight by Legislative Bodies

Oversight Team

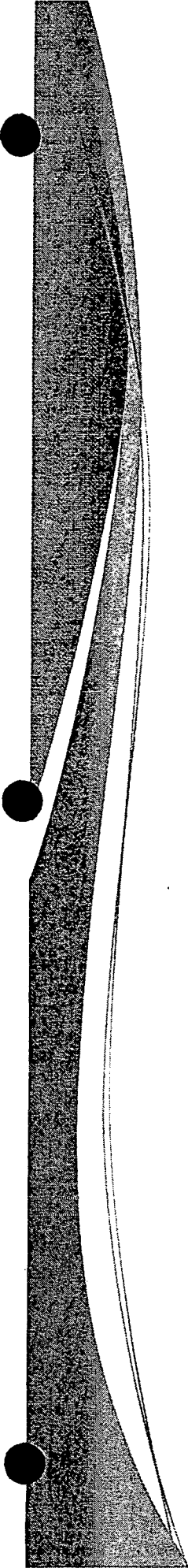
- Comprised of employees of the Legislative Services Office and Office of State Budget and Management.
- Purpose is to assist the Oversight Committee in monitoring the EA and Board.
- Entitled to have access to all records of the Plan and to attend Board Meetings.
- The EA and Board are accountable to the Oversight Team.



Oversight by Legislative Bodies

The Committee on Actuarial Valuation of Retired Employees' Health Benefits

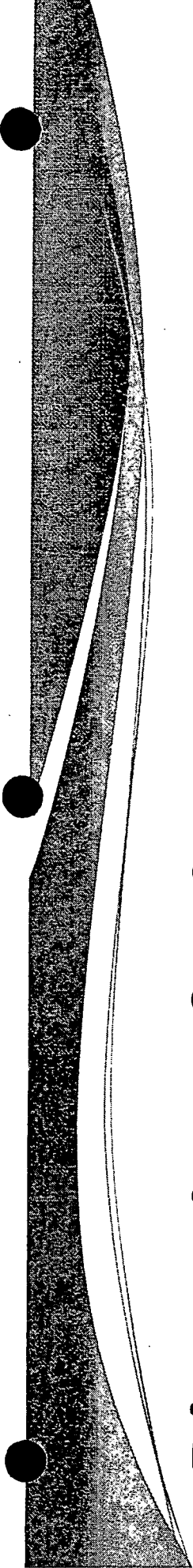
- Charged with collecting data and reviewing assumptions for the “sole purpose of conducting required actuarial valuation of the State supported retired employees’ health benefits.”
- Provides an annual calendar-year actuarial valuation of retired employees health benefits.
- The EA is a member of this Committee



Oversight by Legislative Bodies

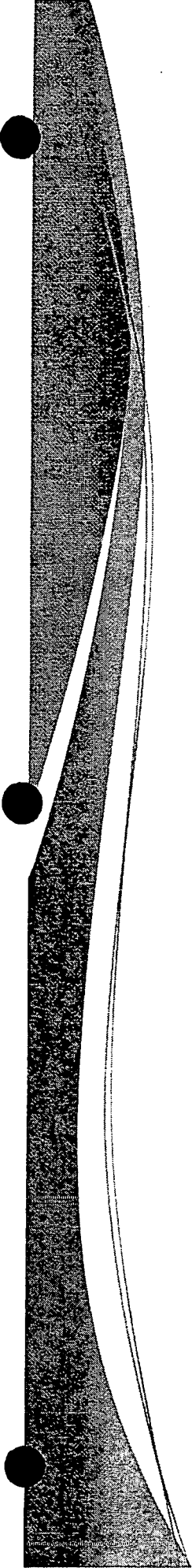
State Health Plan Administrative Commission

- Administratively exercises all of its duties independent of the Commissioner of Insurance who serves as the Commission Secretary.
- Upon the advice of an executive committee of the Legislative Oversight Committee, the three member Commission is responsible for appointing, setting the salary of, and removing the EA.
- Some members of this Commission have been appointed, but the Commission has never met.
- Created after the termination of the previous EA.



Discussion of Fiduciary Responsibility

- The General Statute requires the Board and EA to carry out their duties and responsibilities as fiduciaries for the Plan.
- “Fiduciary responsibilities” is a heightened standard of care that must be employed while carrying out the fiduciary’s duties.
- To be a fiduciary, one must be vested with discretionary authority or responsibility in the administration of a health plan.
- An example of such fiduciary duty would be the ability to hire and fire the EA, which clearly is **not** a responsibility of the Board by the General Statute.
- The Board believes that it does not have fiduciary authority and the term “fiduciary” should be removed from the General Statute.

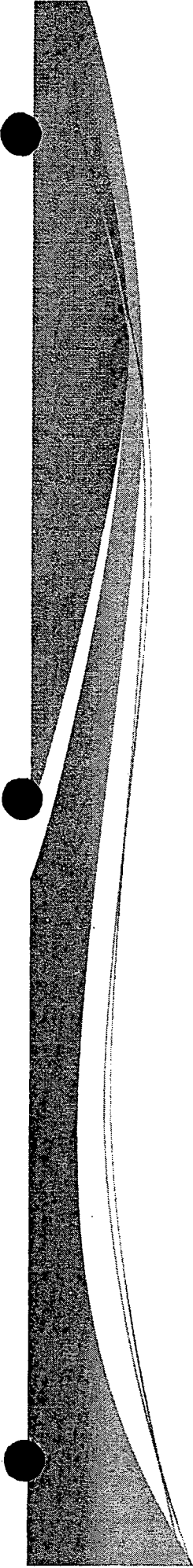


Plan Accountability and the Auditor's Reports

The State Auditor has periodically reviewed performance of the Plan generally when a crisis involving the SHP has occurred. In numerous audits, the Auditor has found:

- Oversight of the SHP was “inadequate and ineffective.”
- The lack of authority of the Board limits the Board’s ability to provide effective oversight of the Plan’s administration.
- The Plan does not function as a traditional state agency with clear, direct and ongoing accountability.
- The auditor has recommended that “the General Assembly should consider legislation to place the SHP under authority of an executive branch agency to ensure proper operational and financial oversight.”

The Board of Trustees agrees with the State Auditor’s assessment.

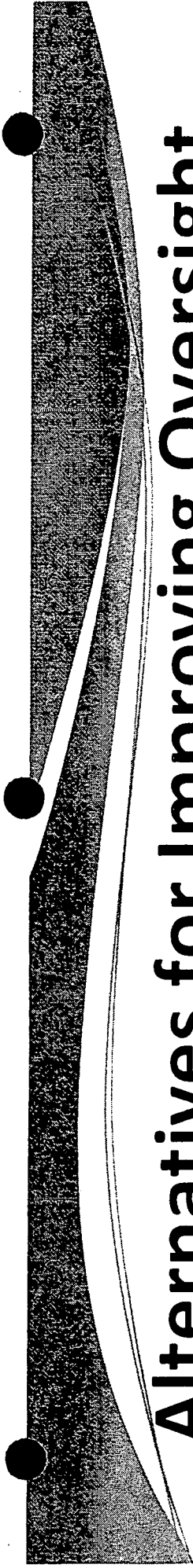


Other States and NC State Agencies

Other states approach to SHP organization

- In 25 states, the SHP is placed within an executive agency.
- In 15 states, the SHP is within an executive agency and has governing advisory board.
- In 8 states, there are independent agencies with their governing boards; CALPERS is the largest.
- In 2 states, we could not determine their approach to managing a SHP.

In other NC State Agencies there is no direct parallel of the administrative arrangement of the SHP.

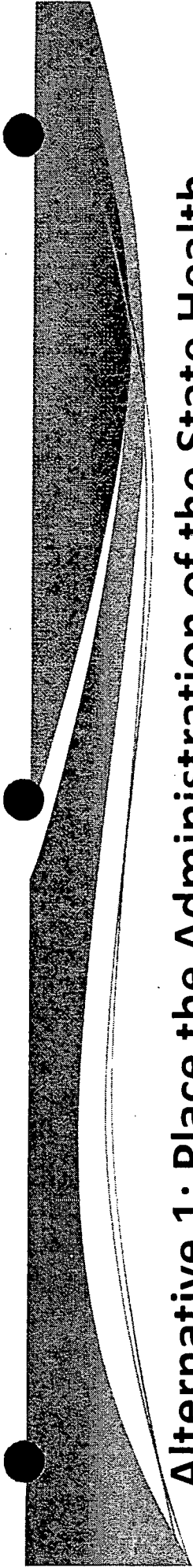


Alternatives for Improving Oversight of the State Health Plan

Alternative 1: Place the administration of the State Health Plan within an executive agency; invest the Board with additional responsibilities.

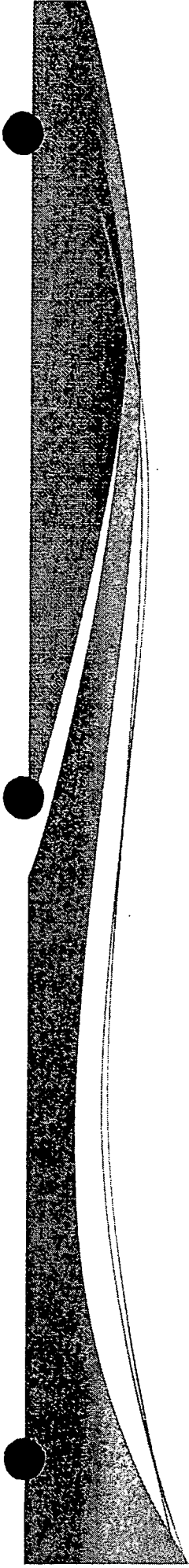
Alternative 2: Maintain the independence of the SHP but invest the Board with real fiduciary and oversight responsibilities.

Alternative 3: Maintain the status quo in terms of oversight, remove “fiduciary” from the statute and pare down the areas of Board oversight and advice to the areas where Board input is most critical.



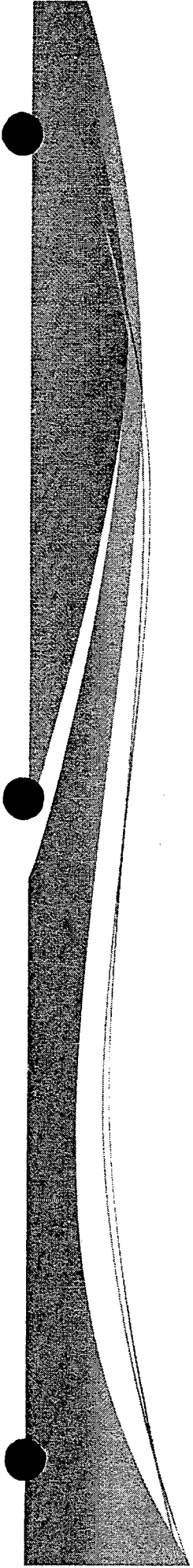
Alternative 1: Place the Administration of the State Health Plan within another executive agency; invest the Board with additional responsibilities (Recommended by Board)

- Under this scenario, the executive agency, reporting to the Governor would be ultimately responsible for the day-to-day performance of the SHP.
- The Board would help shape health plan policies.
- Continue final agency decision and rule making.
- The Secretary of the executive agency would be responsible for hiring, reviewing the performance of and firing the Executive Administrator.
- The major strength of this approach is that the executive agency would have ultimate responsibility for the fiscal oversight of the SHP.

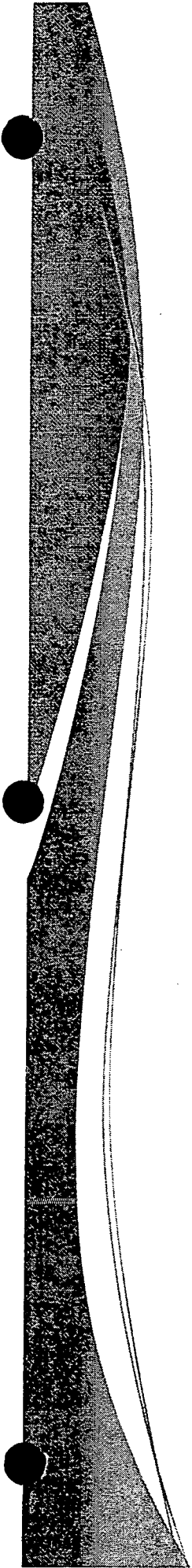


Alternative 2: Maintain the Independence of the SHP but invest the Board with Real Fiduciary and Oversight Responsibilities.

- The Board would have the responsibility for ongoing oversight of the Plan's finances and contracts, set plan policies, make final agency decisions and oversight of the EA, including hiring and termination.
- Total replacement of the volunteer Board would be required.
- Board composition would change to individuals with appropriate business skills to oversee such an organization.
- Board member would need to be compensated at fair market value for the responsibilities that they assume as a Board member.

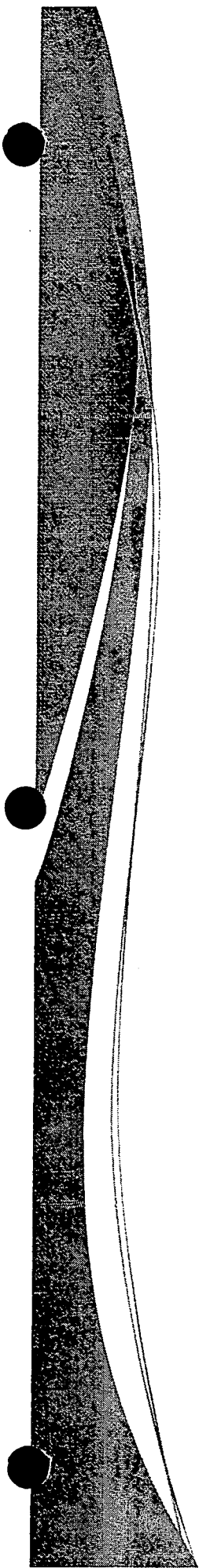


Alternative 3: Maintain the status quo in terms of oversight, remove “fiduciary” from the statute and pare down the areas of Board oversight and advice to the areas where Board input is most critical.



SHP Board Recommendation

- At the time of the Subcommittee's work on restructuring the governance of the SHP the consensus was to move the SHP into an executive agency.
- At the present time the Board membership has changed substantially but I believe that recommendation one remains the best option and has been supported numerous times by the State Auditor and a recent Navigant study.
- Option 3 which is remaining the same without the term "fiduciary" will generate the same oversight problems that we have experienced in the past.
- The Board believes it is time to fix the organizational structure of the SHP.



Thank you for your time and
consideration.

Questions???

NORTH CAROLINA GENERAL ASSEMBLY

Raleigh, North Carolina 27601

August 20, 2010

MEMORANDUM

TO: Members, State Health Plan Blue Ribbon Task Force
FROM: Rep. Hugh Holliman and Sen. Dan Blue
SUBJECT: Meeting Notice

DAY	DATE	TIME	ROOM
Tuesday	September 21, 2010	10:00 am	1228

Parking for non-legislative members of the committee/commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. You can view a map of downtown by visiting <http://www.ncleg.net/graphics/downtownmap.pdf>.

If you are unable to attend or have any questions concerning this meeting, please contact Carol Bowers at 919-715-0873 or hollimanla@ncleg.net

cc: Committee Record ☒
Interested Parties ☒

**Blue Ribbon Task Force
on the State Health Plan
for Teachers and State Employees**

**Wednesday, September 21, 2010
10:00 a.m.**

Legislative Building, Room 1228/1327

I. Welcome

*Representative Hugh Holliman, Co-Chair
Senator Dan Blue, Co-Chair*

II. Continued Discussion of State Health Plan Governance Options

III. Adjournment

MINUTES

BLUE RIBBON TASK FORCE ON THE STATE HEALTH PLAN

Tuesday, September 21, 2010

10:00 a.m.

Legislative Building, Room 1228/1327

The Blue Ribbon Task Force on the State Health Plan met Tuesday, September 21, 2010 in Room 1228/1327 of the Legislative Building. Co-Chair Senator Dan Blue Presided. (*SEE ATTACHMENT: Members and Guests Present.*)

Co-Chair Blue informed the Members that the meeting would be devoted to the Governance Issue for the State Health Plan. The minutes of the August 12, 2010 meeting were approved as written.

Governance Discussion

Co-Chair Blue invited Mark Trogdon of the Fiscal Research Division to provide an overview of the outline of the various parts of the issue of changing the governance of a State Agency. (*SEE ATTACHMENT: Governance Discussion.*) The document was prepared by the staff at the direction of the Co-Chairs of the Task Force. Mr. Trogdon said that Navigant Consulting, which had recommended the SHP be moved under the Governor's Office had provided a supporting material that cites the various reasons Navigant believes the SHP would not fit within any other North Carolina agency. (*SEE ATTACHMENT: Follow-up to Presentation.*)

Locating the SHP in the Executive Branch of Government could be handled in several ways, Mr. Trogdon pointed out. The location under the Governor's Office directly could be something such as the Office of Management and Budget. Cabinet Office could make the SHP part of some existing Cabinet Office. Under the placement of the SHP within a Council of State department, the Plan would fall under the direction of an elected officer, such as Department of Labor, etc. The SHP Board of Trustees recommended the Plan be placed under an executive branch office, but there was no specific idea that this be a Cabinet or Council of State office. In the fourth option, the SHP would be set up in some other arrangement. Mr. Trogdon pointed out that the N. C. Constitution limits the number of state agencies and that number is complete, so if the SHP were declared a state agency, another existing agency would have to be shifted in some other manner.

In terms of the Appointment/ Removal of the Plan's Executive Administrator, the power there depends on how the SHP is located. In the Governor's Office or as a part of a Cabinet agency or Council of State program the action is again reasonably straightforward. In other instances, there could be an appointed governing board with such power, or a shared responsibility: i.e. Governor's appointment with advice and consent of a governing board.

The List of duties presented in the Third Part of the document is a broad summary of the key elements of the structure and does not attempt to cover specific points that would be required in the legislation that would carry out the governance move. Mr. Trogon said the powers and duties would have to be vested with the administrator or with a governing board that would delegate the actual duties for the day-to-day operation. If the governance were placed with a Cabinet agency, the Cabinet Secretary to whom executive administrator of the Plan reports would delegate the powers, the same if the governance fell within the province of a Council of State department. In another scenario, a governing board would assign the powers and duties. He said the Governor was not specifically mentioned in this section, since the Governor would be the ultimate power in an agency in the executive branch. However, he noted that it would not be feasible for the Governor to attempt to manage the Plan on a day-to-day basis, thus the power would have to be vested in another manner.

Discussion

Representative Braxton asked for a refresher on the governance of the SHP at this time. Mr. Trogon said it was established as a part of the Executive Branch, but it sits out by itself, not as a part of any other agency. The existing Board of Trustees has very little power or authority. The powers and duties were vested in the Executive Administrator. The Trustees major responsibility is to handle appeals on medical claims.

Co-Chair Blue then directed the Task Force to consider the pros and cons of the options. He noted that the Navigant recommendation to place the SHP in the Governor's office did not specify how that fit would be accomplished. Mr. Trogon said that the Navigant recommendation was because the SHP does not seem to fit in any other place. The additional information from Navigant did not cover all state agencies, but did give a rationale for those that might have a possible fit. The Co-Chair noted that Insurance Commission Goodwin had said the Department of Insurance would not be the proper place since the Department regulates the insurance companies, and thus there would be a conflict of interest.

Co-Chair Blue asked the Insurance Commissioner to serve as a proxy to speak for other Council of State members since he is the only COS member on the Task Force. The Commissioner reiterated that his office could not operate with insurance companies and then regulate them. He was reluctant to single out any specific Council of State office noting that wherever the SHP was place there would need to be additional staff with the expertise to operate the system. He said there were agencies that deal with the fiscal matters already, but the new Plan would be different. Shifting to Cabinet Offices, he mentioned the Department of Health and Human Services. Co-Chair Blue said there were no legislators on the Task Force who feel that the authority should remain within the General Assembly, which is the de facto authority placement at this time.

The Commissioner continued to note some places the Plan would not fit:

- Superintendent of Public Instruction
- Department of Agriculture

He pointed out that he had not consulted with the various offices: such as the Treasurer's Office, Attorney General's Office, Auditor's Office, and Dept. of Labor.

Co-Chair Blue said that excluding the Department of Insurance, the Commissioner felt that the SHP might fit in either:

- The Auditor's Office
- Department of Labor
- State Treasurer

The Co-Chair considered this a plausible argument, still considering the Health Plan as a stand-alone entity. In the end, the argument still favored putting the Plan under the Governor's Office in some fashion.

Mr. Stone said that the SHP had been located in the Treasurer's Office in the late 1970s. He asked how that might fit in today's environment of federal health insurance etc. Mr. Trogon said the Treasurer's Office had included the Retirement system, which meant there was an employee service group similar to that of the SHP. The retirement system administers a defined benefit that is not as volatile as the SHP. He also said there had been not discussion with the Treasurer's Office about any such governance issue. Mr. Trogon said moving the Plan into the Treasurer's Office would mean moving a \$2 ½ billion program with all its complexities into that Office. He said the administration of the SHP would be much more complex that the Retirment system. Co-Chair Blue asked Mr. Stone what had been the reason for the move out of the Treasurer's Office. Mr. Stone deferred to Mr. Feezor.

Mr. Feezor said the earlier governance with the SHP under the retirement system did bring with complexities as noted. He said that there seems to have been a feeling at that time that there was no an active management of the Health Plan in that placement and not a clear oversight. Further, he said there was the perception that the tilt was in favor of the retirees and not the full complement of employees.

Ms. Adcock asked what the downside would be to place the SHP in the Office of the Governor. Ms. Ransome said if the decision was made to place the Plan in the Governor's Office then there should be a strong board of trustees with the powers to keep the SHP from becoming a political animal. Co-Chair Blue asked if there was no one who felt the Plan should go to an existing Cabinet Office. He said the State Treasurer might use the same conflict of interest arguments once she (Janet Cowell, State Treasurer) learned of the discussion. Further, the Co-Chair asked for anyone who felt the Plan *should* go into a Cabinet agency. Ms. Adcock said the Governor's Office seemed to avoid any sort of "force-fit". She continued that the governing board should set the policy and the executive administrator should carry it out.

Using the example of the Office of Controller, Ms. Ransome suggested a mechanism of appointment with Legislative confirmation for the Executive Administrator. Co-Chair Blue said the Controller's term overlapped that of the Governor.

In summary, Co-Chair Blue said it seemed no one on the Task Force seemed inclined to put the SHP governance within a Cabinet Office. He said that did not rule out a Cabinet agency except for the purposes of discussion at this meeting, and to provide the Staff with a "boundary" to work with. Further, he said that without making a hard and fast decision, the Council of State offices of Auditor, Labor and Treasurer were still viable for discussion.

Representative Braxton said he felt that no agency would want the SHP to come under that agency's jurisdiction. He continued that this would be a new direction and the

need for staffing. He took issue with the position from the Insurance Department that there would be a conflict of interest, saying that the same argument might come from the Auditor or the Treasurer. He argued that making the SHP a stand-alone part of an agency would be of benefit. He maintained that the knowledge of the Department of Insurance made a good place for the Plan. He agreed that Treasurer's Office placement was a good consideration, but was not sanguine about the Auditor's office. The Representative said it would be too political to put the Plan in the Governor's office. His best support was for the Treasurer's Office because of the retirement plan being there, although he did think the Insurance Department should remain in consideration.

Co-Chair Blue asked Representative Braxton if he felt the Treasurer might be able to use SHP funds for short-term gains. The Representative said that was possible. He noted that several years ago, the General Assembly was preparing to adjourn and the rumor was the SHP would have a \$17 million dollar surplus, then the real picture showed the Plan had a \$250 million deficit and the Legislature adjourned without any action. He argued that the Treasurer's office would have had a better track of the money.

Representative Folwell said he could not imagine any state office wanting to turn aside the opportunity to administer the Plan in order to show how that office could perform. He said it was more an opportunity than a problem. He said he was neutral on placing the Plan in the Cabinet level office. He said that if the Plan was a stand-alone office it would be taken over by regulators based on financial practices. He said the governance issue was standing in the way of real reform in the SHP. Co-Chair Blue asked if Representative Folwell felt that the Blue Ribbon Task Force possessed the sufficient expertise to get control of the rates and the other "burning issues" in the Health Plan. Representative Folwell said, yes and categorized the people "in this room" as knowledgeable consumers and knowledgeable people to provide the transparency and accountability, and to take advantage of the size of the SHP to benefit taxpayers, members and retirees.

Insofar as the State Treasurer's office was concerned, Representative Folwell recalled he asked at an earlier meeting, "How does the SHP know when a member has died?" He said he thought the answer was the notification came from the pension plan. He said the Task Force could better handle the administration of the SHP.

Responding to Co-Chair Blue's question that governance was an important issue facing the Task Force, Representative Folwell said governance was not the most important issue. He said the rising cost of care was eating away at what he called the legacy costs of the future.

Mr. Feezor asked about the percentage of SHP beneficiaries, not dependents, who were state employees. Dr. Jack Walker said the largest percentage were teachers. Mr. Feezor said teachers were paid by the state, but employed by the schools. He continued saying the SHP was a multi-employer purchasing program. Then he wondered about the purpose of the SHP: retention of employees, fulfilling a legislative responsibility, or a prudent use of taxpayer money. He agreed with Representative Folwell said the governance was important, but that the long-range issues facing the Plan over the next four years would be the ability of handle approximately 35% of the health care expenditures in North Carolina.

Co-Chair Blue said that given Mr. Feezor's observations what would be his ideas on the governance issue. Mr. Feezor said he leaned toward locating the Plan somewhere within the Council of State, with the reservation that the Plan be able to avoid the political forces, since the difficult decision would have to be made within the framework of stability and predictability. He said there should be a purchasing council that is independent with the expertise to render the decisions. That governing board should be independent and able to make the decisions that benefit both the taxpayers and the members. Further, more, he said that state between now and 2014 (the effective date of the full-force of the federal health care reform.) the state should develop this purchasing council to address all the various health care issues and wellness issues. He said the state had the opportunity to move now.

In the dialog, the Co-Chair and Mr. Feezor did mention the TENN-CARE system, which is the Tennessee Medicaid Managed Care Model. Further, Co-Chair Blue asked the importance Mr. Feezor placed on Governance. Mr. Feezor said the governance issue was part of the need he sees to consider the long-term issues. Co-Chair Blue offered the opinion that in the end the least qualified people to make all these decisions would be the Legislature.

Mr. Stone said the regular member state employee would like to see the SHP out of the realm of politics. He said that since the Governor's budget proposals were the ideas the General Assembly worked with toward the final budget, that the Governor's position should be a major discussion point.

Representative Braxton said his current position favored the State Treasurer's office for the powers of administration. He continued saying the governing board should have varied experience and expertise to set the policy of the Plan. He said placement of the Plan administration in the Governor's office would put politics into play since the membership represented a huge block of voters. An autonomous board with policy power would be a key. Co-Chair Blue said the Governor's office was not clamoring to have the Plan within this jurisdiction. He said he agreed with the point from Representative Folwell that there was an opportunity for whoever took over the governance. He also noted that the SHP dollars was only about 10% of the total budget for which the Governor is responsible. He said that he did not want to give the impression that just because the Governor is elected that the Task Force felt the Governor would be insensitive to the needs of the Plan, in terms of employee benefits etc.

Ms Adcock asked where 40 or so other states housed their health plan. She continued saying that valid points had been raised, including the premise that in the private sector the Plan would be taken over by regulators. Commissioner Goodwin said that the Department of Insurance only became involved with an insurance company when that company was being liquidated. He said if the Plan was up and running with full funding the rates would not be lowered due to the high standards of the Department. He said he did not know of any other state where the health plan was located in the Department of Insurance.

To Ms. Adcock's point, Mr. Trogon referred to information provided with the Health Plan's Board of Trustees, which said 25 states placed the health plan in the Governor's office, 15 placed the plan in the governor's office with a strong policy board, and there was no information about eight states. He said New Jersey's plan was in the

treasurer's office, In Georgia the plan is in the Department of Community Health. He said there were a variety of locations, including Nevada and West Virginia where there are strong policy boards in place. He continued reminding the Task Force that most of the benefit dollars went to local school employees, community college employees etc.

Co-Chair Blue said the benefits, terms and conditions of employment, which are usually parts of a collective bargaining process. Since North Carolina is one of only a few states that do not allow such a bargaining agreement; thus, North Carolina's position was unique since the other states health plans could come about through bargaining. Mr. Trogdon said some states did indeed arrive at the benefits level through bargaining. He said Minnesota came to mind immediately.

Mr. Stone asked if Mr. Feezor could draw a link between the operation of a health plan system under the governor's office and the ways that might be constructed. Mr. Feezor said some states have a purchasing council, either combined and voluntary, or dealing with health care such as Florida and Washington. Speaking from previous experience dealing with the North Carolina Health Plan when it was located under the Department of Insurance, Mr. Feezor agreed with Commission Goodwin: that purchasing health benefits and regulating those who supply those benefits poses a direct conflict of interest.

Ms. Adcock asked if various Cabinet and Council of State Offices could come to the Task Force to present the pros and cons of citing the SHP in those offices. Mr. Stone said there is reluctance for agencies to take the SHP under their wing, but he said that the issue needed to move along. Co-Chair Blue assured the Task Force that come the 2011 Legislative Session there would be legislation that would lay out the "WHERE, HOW AND WHAT" of the State Health Plan. He said there would need to be budget plans developed, etc. Speaking as the Co-Chair, he said that wherever the SHP is located, the powers needed to be decided by late November or early December to allow for drafting.

Representative Braxton said he hoped the Task Force would go further and have recommendations on health care policy, how to hold the line on Plan costs, or find better ways to give better care within that framework. He said he would like to see the Task Force develop a plan that is a model for other states.

Representative Folwell expanded on his earlier remarks by saying he looked for the Task Force as a way to reward health and not health care. He said he felt there should be a focus on promoting healthy behavior. He said we have to start talking to taxpayers and participants about what has really been going on in the SHP.

Ms. Adcock said this would segue into the powers and duties discussion: will be the power of what the entity would be and the power to create health care policy. She said she considered the power of an independent, expert board was more important than the placement.

Mr. Feezor said the duties and powers should include the ability to work to engage the employing units and their representative parts in the active management of their own health care.

Mr. Trogdon said the outline the document was a broad picture, but that implementation in drafting legislation would be a very detailed and specific fit in existing and new legislation. He said that some powers were already in the statutes, but that others would be additional, and tailored to go to the place such powers should be assigned.

Co-Chair Blue asked if there were powers and duties in the document's outline that members felt a board or administrator should not have. Mr. Stone said the federal health care reform placed the adjudication of appeals within the various Departments of Insurance. Staff of the Department of Insurance said the SHP was covered in Chapter 58 of the General Statutes for external review. Dr. Walker pointed out that the process of appeal began in the SHP, but proceeded into other stages as necessary. Those stages could include the Office of Administrative Hearings, or to Superior Court.

Representative Folwell asked if there was anything to prevent an educational unit from withdrawing from the SHP. Mr. Trogdon said his first thought would be that the money that was appropriated from the state to that educational unit for health care would be for the purchase of health care through the SHP. Mr. Trogdon said there was a recent issue when the University system wanted to pull the active employees out of the SHP, but would leave the health coverage for retirees still in the SHP. Representative Folwell followed up by saying that someone within the system facing rising costs would seek to do that in the future. Rep. Braxton said that his District reflected the opposite: small towns etc. seeking to be covered by the SHP. He said that groups should be allowed to opt out of the SHP, but if they decided later to opt in, there would be no requirement that they be allowed to return to coverage. Mr. Feezor said the experience in California was that some groups could opt out, but that active and retired members would have to be part of the new offshoot. He suggested that the powers and duties be written to allow a range of contributions and coverage.

Mr. Trogdon said the first part of the list of powers and duties covered who would be granted those delegated powers. Since the early 1980s, he said the coverage portion of the Plan had been set by the General Assembly. The contributions and deductibles had fallen by default to the General Assembly. Usually gubernatorial budgets have been sent to the General Assembly without allowing enough money for the SHP's needs, thus the General Assembly had to set the co-pays, deductibles and co-insurance. The outline presented to the Task Force is leading to a Board that would set those limits based on the amount of money allocated to the SHP. The whole issue of governance was been set in the direction of removing the General Assembly from the role of setting those co-pays, deductibles and co-insurance levels.

Co-Chair Blue asked for any additional powers and duties that needed to be added. Mr. Feezor asked that the governing board be allowed to participate in other purchasing plans. Further, the Co-Chair took notice of Mr. Trogdon's point that the Task Force decision should be made on whether these powers would lie with an administrator or a governing board.

Ms. Adcock said she was not sure how specific the powers and duties needed to be and asked for comments from Mr. Trogdon. He said he wished to provide context for the Task Force to decide whether the powers and duties should be delegated to an administrator, a governing board, or a combination of the two. He said once that was decided then the discussions would come as how detailed the powers and duties should be. He said the placement of the Plan would then lead to the decision of who possesses the powers and duties and who carries those out.

Mr. Stone said there was a need to consider the plan as "health insurance" and not "sickness insurance." Ms Adcock said the move to create health policy would be a broad

step. Co-Chair Blue said such a policy would also cut across many departments and agencies in state government. He said the points he drew from Mr. Feezor's observations was consideration of taking various member bases: Medicare base, Medicaid base and SHP and combine that to provide purchasing strength. Mr. Feezor said the approach would be to create a way to have performance improvements, cost effectiveness and at this time, it is good to look at the greater opportunities of using the various component parts. Co-Chair Blue said he took the view that Mr. Feezor was pointing out the opportunity to look more broadly than just the SHP and include DHHS, the Industrial Commission and the like as part of the health care issue. Both agreed that some discussion and decisions needed to be made in the context of something more than just the SHP.

Ms. Adcock said the collaboration needed to be considered beyond purchasing, but to making employees healthier. She said she felt the governing board should have the power of decision-making and the administrator the person to carry out the decisions.

Co-Chair Blue then moved to discussing the appointment process and that the outline provided by the staff did not include legislative participation in the appointment process.

The discussion turned to a governing board that was a stand-alone entity with the ultimate responsibility to the General Assembly. Co-Chair Blue said a stand-alone board within the Governor's office could have gubernatorial appointments and co-appointment responsibility. He said the board could have certain points of view and expertise representative in the various members.

Mr. Stone said some independent boards are elected by the members themselves.

Mr. Feezor said he felt the appointment and removal of the executive administrator should be the responsibility of the independent governing board. He also said the credibility of the SHP and the eroded confidence in the SHP would not be fixed in a year's time and particularly in a year's time with limited resources. He said it would take time involving all parties to create a model plan.

Co-Chair Blue asked the Task Force to consider who should be ultimately responsible for the actions.

Ms. Simmons asked the SHP staff where they could see the Plan placement and responsibility. Dr. Walker said he favored placing the Plan under the governor, with the power of the governor behind it, headed by an independent board. He did not have an opinion on how the board should be picked. He said he did not see the Plan working under any particular agency.

Co-Chair Blue asked Mr. Trogdon for his sense of what the Task Force wanted. Mr. Trogdon summarized the Plan should have an independent board with power and teeth. He said there seemed to be no consensus on where the Plan should be located within state government. He said also, there was no clear view of the powers and duties and the appointment/removal of an administrator.

Co-Chair Blue said the location would fall into place after the governing board and accountability issues are established.

Co-Chair Blue said the next meeting would be likely the first or second week in November.

The meeting adjourned at 12:16.

Sen. Dan Blue, Co-Chair
Presiding.

Carol Bowers, Committee Asst.

Rep. Hugh Holliman, Co-Chair

Minutes, Ted Harrison

VISITOR REGISTRATION SHEET

STATE HEALTH PLAN
Name of Committee

9-21-10
Date

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Emelyn Shawcross	EBOR
Den Mettman	KMA
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Ch Degea	NCRGEA
Mr. E. Jones	DCB
Martha & Marcus	Carolines Healthcare
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Kathy Joyce	NASA
Ed Gurling	Brooks Price
LORI Ann Harris	LANTA

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STATE HEALTH PLAN

Name of Committee

9/21/10

Date

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Plunkett Strategies

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County: _____

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1. Name:

House
John Brandon

2. Name:

Don McLennan

3. Name:

4. Name:

Senate
Ernie Sherrell

Ronald Spann

Robert Young

Blue Ribbon Task Force on the State Health Plan
Governance Discussion
September 21, 2010

This document provides a high-level outline of the primary decision elements that would need to be addressed by the Task Force in order to formulate a recommendation to change the current organizational location and governance of the State Health Plan. The outline is divided into three parts that address the most basic elements of changing the governance of a State entity: the location of the Plan within the Executive Branch of State government; the appointment/removal of the Executive Administrator of the Plan; and the powers and duties of the Executive Administrator, governing board or presiding chief executive (e.g., the Governor) over the Executive Administrator.

Part I – Location within Executive Branch of State Government

Potential options for changing the organizational location of the State Health Plan within the Executive Branch of State government:

- Option 1:** Office of the Governor (Navigant Recommendation)
- Option 2:** Cabinet Agency¹
- Option 3:** Council of State Agency¹
- Option 4:** Other

¹ The Plan's Board of Trustees recommended to the Task Force to locate the Plan with in an "Executive Agency", but did define executive agency to be limited to either a Cabinet or Council of State agency.

Part II – Appointment/Removal of the Plan's Executive Administrator

List of potential authorities to appoint or remove the Executive Administrator of the State Plan:

- Option 1:** The Governor
- Option 2:** Appointed Cabinet Secretary or Elected Council of State Officer
- Option 3:** An Appointed Governing Board
- Option 4:** Shared Appointment/Removal Process

Part III – Powers and Duties

Powers and Duties provide the fundamental authority for individuals operating and/or overseeing an entity to perform key functions related to the entity's mission. Below is a list of high-level powers and duties required for the Plan to meet its charge to provide health benefit coverage to Teachers and State Employees. This list is a summary list for explanatory purposes and does not represent very specific powers and duties that are required in statute to implement these broad categories of authority.

High-level Powers and Duties (Summary List)

- Enhance or reduce benefits offered under the Plan
- Set co-pay, annual deductible and co-insurance maximum amounts
- Set annual premium contribution rates
- Negotiate and enter into contracts on behalf of the Plan
- Provision of independent rule-making authority
- Fiduciary responsibility
- Adjudication of plan member appeals
- Conduct strategic planning
- Create and implement Medical policy

Assignment of Powers and Duties

The assignment of powers and duties can be provided to a single officer, shared or distributed among different officers, shared with a governing board, or provided to a governing board. Powers and Duties also may be delegated as in the example of a governing board delegating certain functions to a managing executive officer. For the State Health Plan, depending on the decisions made in Part I, the potential officers and/or entity that may have all or part of the basic powers and duties to operate the Plan are as follows:

- 1) The Executive Administrator of the Plan
- 2) A Cabinet Secretary or Elected Council of State officer
- 3) A governing board

North Carolina State Health Plan for Teachers and State Employees
Follow-up to Presentation of Governance Structure Report of Performance/Efficiency Audit to
North Carolina Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

Assessment of Compatibility of Selected State Departments, Agencies and Entities with the State Health Plan (SHP)

State Department, Agency or Entity	Department, Agency or Entity Mission and/or Responsibilities	Review Team's Assessment about the Compatibility of this Department, Agency or Entity with the SHP	Move SHP to This Department, Agency or Entity?
Department of Administration	• Acts as the business manager for NC state government. • Currently oversees a variety of government operations, including procurement. • Tends to be the "catch-all" agency for offices or departments that don't fit in other agencies.	• Lacks specific knowledge of employee benefits or health insurance requirements. • Is already overseeing 23 offices and commissions with diverse functional areas. • Appears to lack resources to properly oversee the SHP.	No
Office of State Auditor	• Has skilled auditors and analysts who could conduct in-depth reviews and audits of the SHP.	• Office of the State Auditor cannot accept oversight of the SHP as it would lose its independence and ability to conduct audits of the SHP.	No
Department of Commerce	• Responsible for economic, community, and workforce development. • Provides data, statistics, information, and reports for state government and agencies that regulate commerce.	• Functional areas do not include oversight or data related to provision of health care, insurance services, or employee benefits.	No
Employment Security Commission	• Responsible for helping employers find staff they need to carry out their business and serves as a career resource center for workers at all skill levels and age groups.	• Functional areas do not include oversight or data related to provision of health care, insurance services, or employee benefits.	No

State Department, Agency or Entity	Department, Agency or Entity Mission and/or Responsibilities	Review Team's Assessment about the Compatibility of this Department, Agency or Entity with the SHP	Move SHP to This Department, Agency or Entity?
General Assembly	Currently has functional oversight over the SHP via the Committee on Employee Hospital and Medical Benefits.	- Committee does not meet frequently enough to provide adequate oversight. - Committee members are legislators with competing demands on their time. - Oversight process is too susceptible to lobbying efforts. - The oversight of an executive branch function is being conducted by the legislative branch.	No
Office of the Governor	Head of the Executive branch of state government.	- Has jurisdiction over state employees, retirees, and teachers. - Can provide an organizational reporting structure while allowing the SHP to report functionally to an independent governing board with decision making autonomy. - May still inject "politics" into the process by placing demands on the executive administrator or board to act (can be ameliorated through proper safeguards and controls).	Yes

State Department, Agency or Entity	Department, Agency or Entity Mission and/or Responsibilities	Review Team's Assessment about the Compatibility of this Department, Agency or Entity with the SHP	Move SHP to This Department, Agency or Entity?
Department of Health and Human Services	• Large agency that has oversight over Medicaid, Mental Health and other health and human services programs, administrative, and support functions. • Has already taken responsibility for the state Children's Health Insurance Program (CHIP). • Is implementing a large information technology system that could be used for billing providers and enrolling state employees.	• Would need significant increases in staff and resources to be able to oversee the SHP appropriately. • Department's new information management system can process provider claims and member enrollment, but would need additional functionality to handle SHP members. • Lacks the provider networks that an outside group (such as Blue Cross Blue Shield of North Carolina) can provide. • Has major role in state's health care reform implementation that requires significant management attention.	No
Department of Insurance	• Responsible for regulating the insurance industry, licensing insurance professionals, and educating consumer about insurance products.	• Having responsibility for administration and oversight of the SHP would represent a conflict of interest with the Department's role as regulator of the insurance industry.	No
Department of Justice – Managed Care Assistance Section	• Provides advocates for patients and offers advice to North Carolina health care consumers with health insurance questions.	• Functional area is in providing assistance to health plan enrollees with managed care programs rather than the current PPO model employed by the state. • Does not serve in an oversight functional role (serves an advisory role).	No

State Department, Agency or Entity	Department, Agency or Entity Mission and/or Responsibilities	Review Team's Assessment about the Compatibility of this Department, Agency or Entity with the SHP	Move SHP to This Department, Agency or Entity?
Department of Labor	Responsible for promoting the health, safety, and general well-being of the state's workforce.	Functional area revolves around overseeing labor laws rather than insurance or employee benefits.	No
Office of State Budget and Management	- Provides statewide budgetary, management, and information services. - Responsible for providing information to agencies and the Legislature to ensure the most effective use of public resources in compliance with laws and regulations.	- Does not have experience in operating an agency or providing services. - Serves more as an advisory body than as an oversight body.	No
Office of State Personnel	Provides human resources services for state agencies and universities.	- Lacks jurisdiction over segments of the SHP's membership, e.g., county workers and retirees. - Is not currently responsible for overseeing benefits provided to state employees, such as health care or pension.	No
Department of Revenue	Responsible for administering the tax laws and collecting taxes due to the state.	Lacks experience with the provision or oversight of health insurance benefits.	No
Office of the State Controller	- Provides essential fiscal services to support and assist State agencies in complying with state and federal fiscal laws, rules, regulations, and generally accepted accounting principles. - Has staff with the knowledge and abilities to conduct detailed fiscal analyses.	Lacks experience with the provision or oversight of health insurance benefits.	No

State Department, Agency or Entity	Department, Agency or Entity Mission and/or Responsibilities	Review Team's Assessment about the Compatibility of this Department, Agency or Entity with the SFP	Move SFP to This Department, Agency or Entity?
Department of State Treasurer	• The Treasurer serves as the state's banker and chief investment officer. • Includes oversight of the state's retirement plan, including the teachers' and state employees' retirement system and the local governmental employees' retirement system.	• Lacks experience with the provision or oversight of health insurance benefits.	No
North Carolina Council of State	• Oversight would include members of several organizations that could provide resources or input into the process (including the Treasurer's office and the Insurance Commissioner).	• Similar to the General Assembly, members have competing demands on their time and attention. • Could cause a conflict of interest for the State Auditor and the Insurance Commissioner.	No

Carol Bowers (Rep. Holliman)

Subject: FW: State Health Plan Blue Ribbon Task Force meeting**NORTH CAROLINA GENERAL ASSEMBLY**

Raleigh, North Carolina 27601

November 8, 2010**MEMORANDUM****TO:** Members, State Health Plan Blue Ribbon Task Force**FROM:** Rep. Hugh Holliman and Sen. Dan Blue**SUBJECT:** Meeting Notice - *Agenda will be the Final Report*

DAY	DATE	TIME	ROOM
Tuesday	November 16, 2010	10:00 am	1228

Parking for non-legislative members of the committee/commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. You can view a map of downtown by visiting <http://www.ncleg.net/graphics/downtownmap.pdf>.

If you are unable to attend or have any questions concerning this meeting, please contact Carol Bowers at 919-715-0873 or hollimanla@ncleg.net

cc: Committee Record X
Interested Parties X

**Blue Ribbon Task Force
on the State Health Plan
for Teachers and State Employees**

**Tuesday, November 16, 2010
10:00 a.m.**

Legislative Building, Room 1228/1327

I. Welcome

*Representative Hugh Holliman, Co-Chair
Senator Dan Blue, Co-Chair*

II. Review of Final Task Force Recommendations

III. Adjournment

VISITOR REGISTRATION SHEET

Blue Ribbon Task Force State Health Plan 11/16/10
Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Peter Hans	Nelson Mullins
Art Britt	DC SOL
Jennifer Hargrove	DC SOL
Julia Adams	The Arc of NC
Joey Nichols	Capital Results
Wendy Zimm (Donnell)	Capital Results
W. Lynn Pugh	NCNA
NCDOI	Rose Williams
Bill Rustin	Acq
Mitch Leonard	SEANC
Caroline Denning	National MS Society

VISITOR REGISTRATION SHEET

HEALTH PLAN

11/16/10

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Ed Regan	NCRGEA
Pam Heardsyff	NCRSP
Tony Solari	DST
Marge Foreman	NCAE
Ardis Watkins	SEANS
Tori Davis	SEARC
X	
John Bowditch	AstraZeneca
Mark Flury	BCBSNL
Wesley Trank	NCAEC
Joel Maynard	GPM - ABSOL

VISITOR REGISTRATION SHEET

HEALTH PLAN

11/16/10

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

LINDA MCCRESTON	State Health Plan
Lacey Barnes	State Hlth. Plan
DAVID BAUM	TROUTMAN SAUNDERS
Cynthia Depew	AHIP
Karen Duquette	Civitas
Andrew Henson	" "
Ronnie Condrey	NC DOI
Cam Criss	BPMHL
Frank P. Pabon	NORWA
Elizabeth Lawrence	ETHR
Forrest William	Governor's Office

VISITOR REGISTRATION SHEET

Name of Committee

HEALTH PLAN

Date

11/16/10

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Kim Williams

American Lung Association of NC
1301 Pennsylvania Ave NW #801
Washington, DC 20004

Christine Wason

American Cancer Society

Betsy Tetter

American Heart Assn

Committee Sergeants at Arms

NAME OF COMMITTEE Blue Ribbon Task Force State Health Plan

DATE: 11/18/10 Room: 1228

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Martha Gadison
3. Name: Mike Martin
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

MINUTES

BLUE RIBBON TASK FORCE ON THE TEACHERS AND STATE EMPLOYEES HEALTH PLAN

Tuesday, November 16, 2010 10:00 a.m.
Room 1228, Legislative Building

The Blue Ribbon Task Force on the Teachers and State Employees Health Plan met November 16, 2010 in Room 1228 of the Legislative Building. Co-Chair Representative Hugh Holliman presided. (*SEE ATTACHMENTS: Agenda and Members and Guests.*)

Ryan Blackledge from Bill Drafting presented the draft of the Task Force report to the 2011 Session of the General Assembly. (*SEE ATTACHMENT: Draft Report.*) He said the Chairs of the Task Force had asked staff to review the meetings and summarize the discussions for the draft. Mr. Blackledge said a review of the meetings boiled down to the Task Force's belief that the Plan needed a stronger governing board with powers to carry out the Plan operation. The Board would have various responsibilities and would take over a number of decisions currently made by the General Assembly.

The findings reflected this consensus from the Task Force. The findings included the lack of a logical fit for the Plan within any existing state agencies. Indeed, the Task Force has received letters from agencies which reflected the same position (*SEE ATTACHMENTS: Letter from State Treasurer, Letter from Secretary of Labor.*) The findings provided an outline for composition of such a governing board. The governing board would have various responsibilities currently divided among several entities. The findings noted the complex nature of operating the SHP.

The ultimate recommendation was a strong, independent board with broad policy making authority and clarification of the power to hire and remove an executive administrator of the SHP.

Mr. Blackledge noted that Insurance Commissioner Goodwin, a member of the Task Force, had stated his objections to locating the SHP within that department on the belief that would be a conflict of interest. A similar position has been reflected by the State Auditor and a letter is expected to that effect. Commissioner Goodwin also offered to present his position in writing.

In the discussion, Mr. Stone said he was disturbed a copy of the draft had not been provided earlier. He said that political interference from the General Assembly is detrimental to the SHP and that operation of the Plan had to be moved to the Executive Branch. Furthermore, Mr. Stone said the recommendation should include placement of the Plan operation within the Executive Branch. He proceeded to enumerate other points, such as creating a governing board patterned after the health plan board for the Commonwealth of Pennsylvania. He said the board could be structured like the health exchange which Mr. Feezor chairs. Mr. Stone expressed the need to create a board which

would be consumer oriented. He said the report did not provide recommendations on issues such as obesity, tobacco use, etc.

Ms. Simmons provided the Task Force with charts taken from the SHP website concerning body mass index, including information from the Centers For Disease Control. (*SEE ATTACHMENT: Body Mass Index Table.*) She said that BMI should not be used as the only measure in considering weight and wellness.

Mr. Feezor thanked the Co-Chair for the work the Task Force had done. He termed the report as a big, important step. He agreed with Mr. Stone that the recommendation should be to locate the Plan within the Executive Branch and he moved to have that change made in the draft. In composition, the new governing board should include people with expertise in quality of health care prevention and promotion. He also asked that the draft reference to the federal health care laws, be broadened to include ALL federal laws. Co-Chair Holliman asked Mr. Feezor to confer with staff to make these suggestions into the form of a motion.

Dr. Myers, who has served on the Board of Trustees for the SHP said that same board had studied the governance issue and had recommended to the Task Force the Plan should reside in an existing branch of government. However, after further consideration he agreed that oversight by the Executive Branch would be preferable. He agreed with the changes suggested by Mr. Feezor. In the current financial situation facing health care, Dr. Myers said, what can be done for patients and what these patients need is more than the system can provide.

Ms. Adcock said the section concerning the makeup of the governing board has a permissive "may include", she suggested that be changed to "shall include". Ms. Adcock also said that the health benefits to state employees should be considered a part of the overall compensation package and as such should be a philosophy of the governing board. Ms. Adcock said she appreciated Ms. Simmons' comments about the body mass index, but that the purpose of the Task Force was not to "diddle" with the rules. She said the governing board could become involved in such matters.

Mr. Stone said that "may" should be replaced with "shall" in other places in the draft. Co-Chair Holliman noted that the purpose at hand was not to write the legislation, but to make recommendations. Mr. Stone said the decision on hiring and firing of the executive administrator should be done by either the new governing board or the Governor. Co-Chair Holliman said that issue should be left to the 2011 Legislature.

Responding to a question from Representative Folwell, it was noted that neither the SHP Executive Administrator nor any SHP staff members were present at the meeting. Further, Representative Folwell said he was disappointed that the recommendations did not include moving the SHP to a calendar year. Co-Chair Holliman said there was no objection to considering a motion to include that recommendation. Representative Folwell provided members with an evaluation of the State Retirement System by Aon Consulting. This evaluation, sent to the State Budget Director, said over \$3 billion dollars is necessary each year to fulfill health benefits for retiree medical benefits. (*SEE ATTACHMENTS: Aon Consulting to Charles Perusse.*)

Co-Chair Holliman asked Theresa Matula from the Research Division to review the recommendations made to that point. Representative Folwell and Mr. Blackledge agreed on a finding with reference to the calendar year recommendation. That finding per

Representative Folwell was that the SHP should reward members for focusing on their health, rather than their health care.

The various recommendations were combined into one amendment for consideration by the Task Force. Mr. Stone asked for explanation on several points. Dr. Myers was unclear about the section which referred to clarification of the role of the executive director. Co-Chair Holliman said the exact wording would come in the proposed legislation. Dr. Myers moved to amend the amendment to say that the appointment and removal of the executive board be a responsibility of the governing board. Ms. Matula worded the perfecting amendment. The motion passed with Representative Braxton dissenting.

Co-Chair Holliman then put the full amendment before the members. Mr. Stone continued to propose that the function of the Plan lie with the Executive Branch and that the report omit a negative reference to the General Assembly's role. He made that into a motion. Ms. Matula expressed the clarification that action is made by the governing board in conjunction with the Governor. Ms. Adcock said she felt the recommendation got the position Mr. Stone wanted, since one of the findings was that the General Assembly should not have broad oversight of the SHP. Mr. Stone moved that the section put the responsibility with the Executive Branch and the governing board. Commissioner Goodwin acknowledged the intent of the motion and asked about the funding role of the General Assembly, i.e. should that role be included. Mr. Stone said he had no objection to that wording. Co-Chair Holliman said the General Assembly would always have a role in the operation of the Plan. Mr. Feezor opposed the amendment saying the finding concerning the General Assembly's role was strong enough. A vote on the Stone amendment failed.

Then the motion to adopt the amended report passed, with Mr. Stone abstaining.
(SEE ATTACHMENT: Blue Ribbon Task Force report to the 2011 Session of the General Assembly.)

The Task Force adjourned at 10:45 a.m.

Representative Hugh Holliman,
Co-Chair Presiding

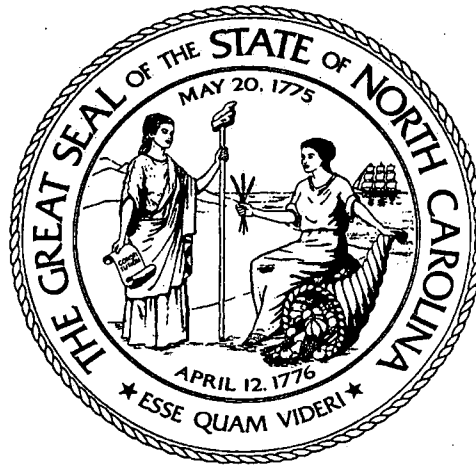
Carol Bowers, Clerk

Senator Dan Blue, Co-Chair

Ted Harrison, Minutes

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NORTH CAROLINA GENERAL ASSEMBLY



BLUE RIBBON TASK FORCE ON THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

REPORT TO THE
2011 SESSION
of the
GENERAL ASSEMBLY

NOVEMBER, 2010

TRANSMITTAL LETTER

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees was established by S.L. 2009-16, Part Seven, as amended by S.L. 2009-571. The Task Force respectfully submits the following report.

Representative Lindsey Hugh Holliman
Co-Chair

Senator Daniel T. Blue, Jr.
Co-Chair

TASK FORCE MEMBERSHIP

Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees

Co-Chairs

Rep. Lindsey Hugh Holliman (Co-Chair)

House Appointment

Sen. Daniel T. Blue, Jr. (Co-Chair)

Senate Appointment

Legislative Members

Rep. R. Van Braxton

House Appointment

Rep. Dale R. Folwell

House Appointment

Sen. Thomas M. Apodaca

Senate Appointment

Sen. Linda Dew Garrou

Senate Appointment

Ex Officio Members

Hon. George Wayne Goodwin

Ex Officio

Mr. Andrew M. Perkins, Jr.

Ex Officio

Public Members

Ms. Gale Brown Adcock, RN

Governor's Appointment

Mr. Allen Feezor

House Appointment

Dr. William C. Harrison

Senate Appointment

Dr. Dan A. Myers, MD

Senate Appointment

Ms. Sharnese Ransome

Senate Appointment

Ms. Victoria Leigh Simmons

House Appointment

Mr. Charles Stone

House Appointment

TASK FORCE PROCEEDINGS

The Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees met three times from August 12, 2010 until November 16, 2010. The information below provides an overview of presentations received and issues discussed by the Task Force. Detailed minutes and copies of handouts from each meeting are on file in the Legislative Library or are available for a period of time at the Task Force website: <http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=114>.

August 12, 2010

The Task Force was presented recommendations on changing the governance of the State Health Plan by two separate entities with a relationship to the Plan.

First, Navigant Consulting, a consulting firm to the State Health Plan, presented recommendations regarding the State Health Plan's governance arrangement. Navigant evaluated the Plan's governance and claims processing function under a General Assembly mandated audit. Representatives for Navigant Consulting recommended that the Plan be organizationally located under the Governor, but functionally responsible to an independent board. This independent board should be tasked with the direct authority to manage the Plan's operations. Representatives of Navigant Consulting noted that in most states, an independent board or executive branch agency or department houses the function of a public employer health benefit plan.

The second recommendation was from the State Health Plan's Board of Trustees. Dr. John Hammond, a member of the State Health Plan's current Board of Trustees, presented a recommendation to require that oversight of the Plan's day-to-day operations and appointment of the Plan's Executive Administrator fall under the responsibility of an executive agency with a reporting relationship to the Governor. The Board of Trustees also recommended that the Plan's Board of Trustees be given the responsibility to formulate policies implemented by the Plan, to conduct rule-making, and to make final agency decisions.

The balance of the meeting was devoted to discussion about the information presented to Task Force members regarding State Health Plan governance changes and ways to move forward with developing a Task Force recommendation.

September 21, 2010

At the request of the co-chairs in an effort to guide the Task Force discussion on governance options, Mark Trogon, staff fiscal analyst, presented a broad overview of issues related to governance of the State Health Plan. Mr. Trogon mentioned the following three primary areas the Task Force might wish to consider as they discuss governance options: organizational location within an Executive Branch of State

Government; the authority to appoint and remove the Plan's Executive Administrator; and the distribution of powers and duties relative to the Plan.

Mr. Trogon reviewed the following location options for organizational placement of the State Health Plan: Office of the Governor, Cabinet agency, Council of State agency, or other location. Mr. Trogon pointed out that Navigant Consulting, Inc. had provided the Task Force an *Assessment of Compatibility of Selected State Departments, Agencies and Entities with the State Health Plan* which recommended placement of the State Health Plan in the Office of the Governor. Mr. Trogon also reminded the Task Force that during their prior meeting they received a report from the Board of Trustees recommending placement of the State Health Plan in an executive agency, but not specifying whether it should be a Cabinet or Council of State agency.

Next Mr. Trogon reviewed a list of potential authorities to appoint or remove the Executive Administrator of the State Health Plan. The list of authorities included: the Governor; an appointed Cabinet Secretary or elected Council of State Officer; an appointed governing board; or a shared appointment/removal process.

The third area suggested for consideration by the Task Force was the powers and duties that provide the fundamental authority for operation and oversight. This summary list included the authority to: enhance or reduce benefit options; set co-pay, annual deductible and co-insurance maximum amounts; set premiums and contribution rates; negotiate and enter into contracts; fiduciary responsibility; and other broad elements key to the Plan's mission of providing health benefits to State employees and teachers. Mr. Trogon pointed out that to operate the Plan on a daily basis, the assignment of those powers and duties must be given directly to an executive administrator, to an agency head that carries out the power and duties or delegates them, or to a governing board or authority that carries out the power and duties or delegates them.

The Task Force asked for a reminder of the State Health Plan's current organizational placement. Mr. Trogon explained that the State Health Plan is currently placed under the executive branch but operates as an independent entity. The Plan does have a Board of Trustees vested with some powers and duties and limited governing authority. Currently, most of the powers and duties are assigned to the Plan's Executive Administrator.

Upon request, Mr. Trogon reported that research for prior reports received by the Task Force noted that 25 states place the health plan within an executive agency, 15 states place the health plan within an executive agency with a governing advisory board, there are 8 states where the health plan operates as an independent agency with a governing board, and a couple of states where they were not able to determine placement. It was noted that a decision on organizational placement of North Carolina's State Health Plan is complex because the Plan covers employees of both Cabinet and Council of State agency employees, legislative and judicial branch employees, employees of local school systems, employees of community colleges, and

university employees. Since the Task Force had heard from the Commissioner of Insurance, the Task Force suggested that the Auditor, Commissioner of Labor, and Treasurer be asked to comment on organizational placement of the State Health Plan under their agency.

The balance of the meeting was devoted to Task Force discussion of the organizational location of the State Health Plan within an Executive Branch of State Government; the authority to appoint and remove the Plan's Executive Administrator; and the distribution of powers and duties relative to the Plan.

November 16, 2010

The Task Force was presented a draft report to the 2011 Session of the North Carolina General Assembly.

DRAFT

FINDINGS AND RECOMMENDATIONS

FINDINGS:

During the 2010 Interim, the Blue Ribbon Task Force on the State Health Plan for Teachers and State Employees examined issues related to governance of the State Health Plan. Discussions of the Task Force yielded the observations below.

- Responsibility for broad oversight of the State Health Plan should not primarily reside with the General Assembly.
- Compatibility with the mission of existing State agencies and the range of employees covered by the State Health Plan present challenges in finding a logical organizational fit of the State Health Plan within an existing State agency.
- A strong governing board may be a logical entity to provide oversight of the State Health Plan. Membership of a strong governing board may include persons with experience in, but not limited to: health benefit financing, managing large group employer-sponsored health benefits plans, and utilization management. The governing board may also include representation from employee and retiree groups.
- The operation of the State Health Plan includes the following:
 - Authority to enhance or reduce benefits
 - Authority to set co-pays, deductibles, and co-insurance maximums
 - Authority to set premiums
 - Authority to negotiate and execute contracts
 - Authority to act as fiduciaries to the Plan
 - Authority to create rules
 - Authority to adjudicate members' appeals
 - Authority to conduct strategic planning
 - Authority to create and implement Medical policy
- The current appointment and removal process for the Plan's Executive Administrator is unclear.

The Task Force acknowledges that oversight of the State Health Plan is complex because coverage includes: executive, judicial, and legislative branch employees; local school system employees; community college employees; and university employees. Additionally, similar to most health insurance providers, the State Health Plan must respond to the challenges of an older and less physically active population, increasing health care costs, and compliance with Federal health care law. The Task Force finds that governance of the State Health Plan is a serious and substantial undertaking and must be clarified in order to effectively meet current challenges.

RECOMMENDATION:

The Task Force recommends that oversight of the State Health Plan be provided by a strong and independent governing board with broad policy making authority and also recommends that appointment and removal of the Executive Administrator be clarified.





Cherie K. Berry
Commissioner

November 12, 2010

The Honorable Dan Blue, Member
N.C. Senate
Room 314, Legislative Office Building
Raleigh, N.C. 27603

The Honorable Hugh Holliman, Member
N.C. House of Representatives
Room 2301, Legislative Building
Raleigh, N.C. 27601

Chairmen of the Blue Ribbon Task Force on the State Health Plan,

My office was recently contacted by Theresa Matula, Staff to the Blue Ribbon Task Force on the State Health Plan. She asked that I respond to you in writing regarding a proposal that the operation of the State Health Plan be shifted to the N.C. Department of Labor.

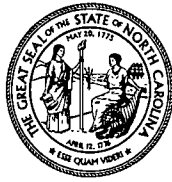
I do not believe that it would be appropriate to situate the State Health Plan within this agency. The core mission of the N.C. Department of Labor is to promote the health, safety, and general well-being of the state's workforce. Taking on the responsibility of the State Health Plan would be a significant departure from this mission and would not represent the best use of our manpower and resources. Furthermore, according to an August 25, 2010 report by Navigant Consulting, Inc. and MGT of America, Inc., this agency is not a reasonable location for the State Health Plan because our "functional area revolves around overseeing labor laws rather than insurance or employee benefits." I agree with that assessment and I hope that it is seriously considered as discussions about the placement of the State Health Plan continue.

Thank you for the opportunity to respond to this suggestion.

Respectfully,

Cherie K. Berry
Commissioner

cc: Theresa Matula, Staff to the Blue Ribbon Task Force on the State Health Plan



NORTH CAROLINA

OFFICE OF THE TREASURER

JANET COWELL, TREASURER

November 15, 2010

The Honorable L. Hugh Holliman
Representative – 81st District
2301 Legislative Building
Raleigh, NC 27601

Dear Representative Holliman:

We recently received an email from Ms. Theresa Matula of the General Assembly's Research Division inquiring whether the Department of State Treasurer has an interest to oversee the operations of the State Health Plan.

Although we appreciate the confidence you have expressed in our office, we do not believe it makes sense for the Department of State Treasurer to run the State Health Plan. First, the Treasurer's Office has no experience in running a health plan on a day-to-day basis. Second, the Department of State Treasurer has little expertise in either health care or insurance issues,

However, the State Treasurer can play a role as a member of an oversight board for the State Health Plan because the unfunded liability of the plan can impact our bond rating. (The State Treasurer is one of the primary contacts for the rating agencies, along with the budget director and state controller.) Additionally, State health care policy can impact pension fund liability, since decisions on the pension fund often include calculations on health care availability and cost.

As you are aware, the Department currently has the responsibility for managing the State's pension system, investing over \$70 billion in State funds, conducting the State's daily banking operations, issuing and overseeing State debt, assisting local government units through the State and Local Government Finance Commission and operating and overseeing the Escheats Fund. The Department of State Treasurer has focused its last two years to improve both the quality of services we deliver to North Carolina's citizens and the effectiveness and efficiency of our operations. At this point, it would be unwise for this office to take on a new and equally complex and demanding program.

I applaud the Blue Ribbon Task Force for its hard work on this important issue and am confident the Task Force will ultimately find a good home for the State Health Plan.

Best wishes,

A handwritten signature in cursive script that reads "Janet Cowell".

Janet Cowell

www.shpnc.org

July 1, 2011 -
less than
35 kg/m²

July 1, 2011 -
← BMI less than 40 kg/m²

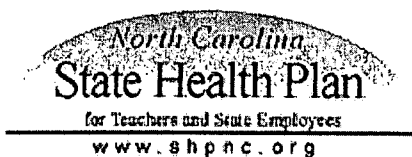
Body Mass Index Table

Normal										Overweight										Obese										Extreme Obesity									
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54			
Height (inches)	Body Weight (pounds)																																						
	58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258		
	59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267		
	60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276		
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Source: Adapted from Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.

<http://www.nhlbi.nih.gov/guidelines/obesity/bmi-tbl.pdf>

P-1



Questioning the Validity
the BMI as the
Single Measure to
Determine 70/30 or
80/20 :

(p.2)

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Comprehensive Wellness Initiative -- Weight Management Component

Weight Management Component Begins July 1, 2011

Members will continue to follow the tobacco cessation guidelines and as of July 2011, will also enroll based on the weight management guidelines. Subscribers will be eligible to enroll in the 80/20 Standard Plan if they declare on the Attestation Form that the subscriber and their covered dependent(s) do not use tobacco products, **AND**

- the subscriber and their covered dependent(s) have a Body Mass Index (BMI) less than 40 kg/m² **OR**
- the subscriber and their covered dependent(s) qualify for exemption due to participation in a weight management and/or tobacco cessation program **OR** have a physician-certified medical condition that prevents the attainment of the required BMI. (See "Exemptions" below for details.)

To calculate Body Mass Index, [click here](#)

enclosed →

Verification of Weight Management Status

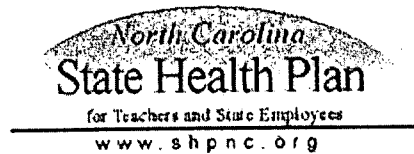
1. Subscribers who attest that they and their covered dependents meet the weight and tobacco use requirements for the 80/20 Standard Plan will also be attesting that they understand they may be randomly selected to participate in a tobacco use/weight management verification test at their worksite. Height and weight measurements will be collected to determine BMI status. Members must have a BMI less than 40 kg/m² to pass the test.
2. The Physician Certification Form will permit members to claim an exemption for member participation in a weight management program **and/or** for a medical condition that prevents members from attaining the required BMI, in addition to the tobacco cessation program exemption. If applicable, both the weight management related exemptions and the tobacco cessation exemption information must be included for enrollment in the 80/20 Standard Plan.
3. Beginning on July 1, 2012, members must have a BMI of less than 35 kg/m² to enroll in the 80/20 Standard Plan. **All** other program requirements and processes will remain the same.

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[Weight Management Support](#)

[Exemptions](#)

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Frequently Asked Questions: Verification Testing for the Comprehensive Wellness Initiative

1. [How will the Plan verify tobacco use and BMI?](#)
2. [Who will be tested for tobacco use?](#)
3. [Will members be made aware of testing for tobacco use ahead of time?](#)
4. [Will the Plan only be testing for tobacco? What confirmation or assurances will members have that other tests will not be conducted?](#)
5. [What happens if a member chooses not to participate in verification testing?](#)

1.) How will the Plan verify tobacco use and BMI?

A third party vendor, not yet selected by the Plan, will conduct the tobacco use validation tests on a sample of members who are enrolled in the 80/20 plan. Tobacco use will be verified using a saliva test that is non-invasive, accurate and provides the results at the time of testing.

The process around BMI verification has not been determined at this time.

2.) Who will be tested for tobacco use?

Initially, active employees will be selected for testing. However, the Plan reserves the right to test any non-Medicare primary Plan member who is eligible for the Comprehensive Wellness Initiative and enrolled in the 80/20 plan.

3.) Will members be made aware of testing for tobacco use ahead of time?

The Plan has not yet determined the details of the testing process for tobacco use. Once a testing vendor has been confirmed – and prior to annual enrollment in spring 2010 -- additional information will be provided regarding the testing process.

4.) Will the Plan only be testing for tobacco? What confirmation or assurances will members have that other tests will not be conducted?

The Plan will arrange for verification testing to address tobacco use during the first year of the Comprehensive Wellness Initiative. Members will not be tested for substances other than cotinine, a derivation of nicotine in the body. The testing vendor will adhere to all state and federal laws around testing, privacy and confidentiality.

5.) What happens if a member chooses not to participate in verification testing?

Members who are offered the verification testing, and refuse to take the tobacco verification



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About BMI for Adults

On this page:

- [What is BMI? \(#Definition\)](#)
- [How is BMI used? \(#Used\)](#)
- [Why does CDC use BMI to measure overweight and obesity? \(#Why\)](#)
- [What are some of the other ways to measure obesity? Why doesn't CDC use those to determine overweight and obesity among the general public? \(#Other Ways\)](#)
- [How is BMI calculated and interpreted? \(#Interpreted\)](#)
- [How reliable is BMI as an indicator of body fatness? \(#Reliable\)](#)
- [If an athlete or other person with a lot of muscle has a BMI over 25, is that person still considered to be overweight? \(#Athlete\)](#)
- [What are the health consequences of overweight and obesity for adults? \(#Consequences\)](#)
- [Is BMI interpreted the same way for children and teens as it is for adults? \(#Children\)](#)



[Adult BMI Calculator](#)

([english bmi calculator/bmi_calculator.html](#))

Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI is a fairly reliable indicator of body fatness for most people. BMI does not measure body fat directly, but research has shown that BMI correlates to direct measures of body fat, such as underwater weighing and dual energy x-ray absorptiometry (DXA).^{1,2} BMI can be considered an alternative for direct measures of body fat. Additionally, BMI is an inexpensive and easy-to-perform method of screening for weight categories that may lead to health problems.

BMI is used as a screening tool to identify possible weight problems for adults. However, BMI is not a diagnostic tool. For example, a person may have a high BMI. However, to determine if excess weight is a health risk, a healthcare provider would need to perform further assessments. These assessments might include skinfold thickness measurements, evaluations of diet, physical activity, family history, and other appropriate health screenings.

Calculating BMI is one of the best methods for population assessment of overweight and obesity. Because calculation requires only height and weight, it is inexpensive and easy to use for clinicians and for the general public. The use of BMI allows people to compare their own weight status to that of the general population.

To see the formula based on either kilograms and meters or pounds and inches, visit [How is BMI calculated and interpreted \(#Interpreted\)?](#)

Other methods to measure body fatness include skinfold thickness measurements (with calipers), underwater weighing, bioelectrical impedance, dual-energy x-ray absorptiometry (DXA), and isotope dilution. However, these methods are not always readily available, and they are either expensive or need highly trained personnel. Furthermore, many of these methods can be difficult to standardize across observers or machines, complicating comparisons across studies and time periods.

Calculation of BMI

BMI is calculated the same way for both adults and children. The calculation is based on the following formulas:

Measurement Units	Formula and Calculation
Kilograms and meters (or centimeters)	Formula: $\text{weight (kg)} / [\text{height (m)}]^2$ With the metric system, the formula for BMI is weight in kilograms divided by height in meters squared. Since height is commonly measured in centimeters, divide height in centimeters by 100 to obtain height in meters. Example: Weight = 68 kg, Height = 165 cm (1.65 m) Calculation: $68 \div (1.65)^2 = 24.98$
Pounds and inches	Formula: $\text{weight (lb)} / [\text{height (in)}]^2 \times 703$ Calculate BMI by dividing weight in pounds (lbs) by height in inches (in) squared and multiplying by a conversion factor of 703. Example: Weight = 150 lbs, Height = 5'5" (65") Calculation: $[150 \div (65)^2] \times 703 = 24.96$

Link from State Health Plan website:

http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html 11/15/2010

Interpretation of BMI for adults

For adults 20 years old and older, BMI is interpreted using standard weight status categories that are the same for all ages and for both men and women. For children and teens, on the other hand, the interpretation of BMI is both age- and sex-specific. For more information about interpretation for children and teens, visit [Child and Teen BMI Calculator \(http://apps.nccd.cdc.gov/dnpabmi\)](http://apps.nccd.cdc.gov/dnpabmi).

The standard weight status categories associated with BMI ranges for adults are shown in the following table.

BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal
25.0 – 29.9	Overweight
30.0 and Above	Obese

For example, here are the weight ranges, the corresponding BMI ranges, and the weight status categories for a sample height.

Height	Weight Range	BMI	Weight Status
5' 9"	124 lbs or less	Below 18.5	Underweight
	125 lbs to 168 lbs	18.5 to 24.9	Normal
	169 lbs to 202 lbs	25.0 to 29.9	Overweight
	203 lbs or more	30 or higher	Obese

The correlation between the BMI number and body fatness is fairly strong; however, the correlation varies by sex, race, and age. These variations include the following examples:^{3,4}

- At the same BMI, women tend to have more body fat than men.
- At the same BMI, older people, on average, tend to have more body fat than younger adults.
- Highly trained athletes may have a high BMI because of increased muscularity rather than increased body fatness.

It is also important to remember that BMI is only one factor related to risk for disease. For assessing someone's likelihood of developing overweight- or obesity-related diseases, the National Heart, Lung, and Blood Institute guidelines recommend looking at two other predictors:

- The individual's waist circumference (because abdominal fat is a predictor of risk for obesity-related diseases).
- Other risk factors the individual has for diseases and conditions associated with obesity (for example, high blood pressure or physical inactivity).

For more information about the assessment of health risk for developing overweight- and obesity-related diseases, visit the following Web pages from the National Heart, Lung, and Blood Institute:

- [Assessing Your Risk \(http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/risk.htm\)](http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/risk.htm)
- [Body Mass Index Table \(http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm\)](http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm) - enclosed
- [Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults \(http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm\)](http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm) - practical guide pages enclosed

According to the BMI weight status categories, anyone with a BMI over 25 would be classified as overweight and anyone with a BMI over 30 would be classified as obese.

It is important to remember, however, that BMI is not a direct measure of body fatness and that BMI is calculated from an individual's weight which includes both muscle and fat. As a result, some individuals may have a high BMI but not have a high percentage of body fat. For example, highly trained athletes may have a high BMI because of increased muscularity rather than increased body fatness. Although some people with a BMI in the overweight range (from 25.0 to 29.9) may not have excess body fatness, most people with a BMI in the obese range (equal to or greater than 30) will have increased levels of body fatness.

It is also important to remember that weight is only one factor related to risk for disease. If you have questions or concerns about the appropriateness of your weight, you should discuss them with your healthcare provider.

The BMI ranges are based on the relationship between body weight and disease and death.⁵ Overweight and obese individuals are at increased risk for many diseases and health conditions, including the following:⁶

- Hypertension
- Dyslipidemia (for example, high LDL cholesterol, low HDL cholesterol, or high levels of triglycerides)
- Type 2 diabetes
- Coronary heart disease
- Stroke
- Gallbladder disease
- Osteoarthritis
- Sleep apnea and respiratory problems
- Some cancers (endometrial, breast, and colon)

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For more information about these and other health problems associated with overweight and obesity, visit [Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults](http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm) (http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm).

Although the BMI number is calculated the same way for children and adults, the criteria used to interpret the meaning of the BMI number for children and teens are different from those used for adults. For children and teens, BMI age- and sex-specific percentiles are used for two reasons:

- The amount of body fat changes with age.
- The amount of body fat differs between girls and boys.

Because of these factors, the interpretation of BMI is both age- and sex-specific for children and teens. The CDC BMI-for-age growth charts take into account these differences and allow translation of a BMI number into a percentile for a child's sex and age.

For adults, on the other hand, BMI is interpreted through categories that are not dependent on sex or age.

¹Mei Z, Grummer-Strawn LM, Pietrobelli A, Goulding A, Goran MI, Dietz WH. Validity of body mass index compared with other body-composition screening indexes for the assessment of body fatness in children and adolescents. *American Journal of Clinical Nutrition* 2002;75:97–985.

²Garrow JS and Webster J. Quetelet's index (W/H²) as a measure of fatness. *International Journal of Obesity* 1985;9:147–153.

³Prentice AM and Jebb SA. Beyond Body Mass Index. *Obesity Reviews*. 2001 August; 2(3): 141–7.

⁴Gallagher D, et al. How useful is BMI for comparison of body fatness across age, sex and ethnic groups? *American Journal of Epidemiology* 1996;143:228–239.

⁵World Health Organization. Physical status: The use and interpretation of anthropometry. Geneva, Switzerland: World Health Organization 1995. WHO Technical Report Series.

⁶[Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults](http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm) (http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm).

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Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day - cdcinfo@cdc.gov

<http://www.nhlbi.nih.gov/guidelines/obesity/prctgd-c.pdf>

**The Practical
Guide**
Identification,
Evaluation,
and Treatment
of Overweight and
Obesity in Adults

Wast Circumference

Management
Overweight



Ten Steps to Treating Overweight and Obesity in the Primary Care Setting

1 **Measure height and weight** so that you can estimate your patient's BMI from the table in Appendix A. *see p. 18 (over)*

Measure waist circumference as described on page 9.

Assess comorbidities as described on pages 11–12 in the section on “Assessment of Risk Status.”

4 **Should your patient be treated?** Take the information you have gathered above and use Figure 4, the Treatment Algorithm, on pages 16–17 to decide. Pay particular attention to Box 7 and the accompanying explanatory text. If the answer is “yes” to treatment, decide which treatment is best using Table 3 on page 25.

Is the patient ready and motivated to lose weight? Evaluation of readiness should include the following: (1) reasons and motivation for weight loss, (2) previous attempts at weight loss, (3) support expected from family and friends, (4) understanding of risks and benefits, (5) attitudes toward physical activity, (6) time availability, and (7) potential barriers to the patient's adoption of change.

Which diet should you recommend?

In general, diets containing 1,000 to 1,200 kcal/day should be selected for most women; a diet between 1,200 kcal/day and 1,600 kcal/day should be chosen for men and may be appropriate for women who weigh 165 pounds or more, or who exercise regularly. If

the patient can stick with the 1,600 kcal/day diet but does not lose weight you may want to try the 1,200 kcal/day diet. If a patient on either diet is hungry, you may want to increase the calories by 100 to 200 per day. Included in Appendix D are samples of both a 1,200 and 1,600 calorie diet.

7 **Discuss a physical activity goal** with the patient using the Guide to Physical Activity (see Appendix H). Emphasize the importance of physical activity for weight maintenance and risk reduction.

8 **Review the Weekly Food and Activity Diary** (see Appendix K) with the patient. Remind the patient that record-keeping has been shown to be one of the most successful behavioral techniques for weight loss and maintenance. Write down the diet, physical activity, and behavioral goals you have agreed on at the bottom.

9 **Give the patient copies of the dietary information** (see Appendices B–G), the Guide to Physical Activity (see Appendix H), the Guide to Behavior Change (see Appendix I), and the Weekly Food and Activity Diary (see Appendix K).

10 **Enter the patient's information** and the goals you have agreed on in the Weight and Goal Record (see Appendix J). It is important to keep track of the goals you have set and to ask the patient about them at the next visit to maximize compliance. Have the patient schedule an appointment to see you or your staff for followup in 2 to 4 weeks.

Each step (designated by a box) in the treatment algorithm is reviewed in this section and expanded upon in subsequent sections.

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1 Patient encounter

Any interaction between a health care practitioner (generally a physician, nurse practitioner, or physician's assistant) and a patient that provides the opportunity to assess a patient's weight status and provide advice, counseling, or treatment.

2 History of overweight or recorded BMI ≥ 25

Seek to determine whether the patient has ever been overweight. A simple question such as "Have you ever been overweight?" may accomplish this goal. Questions directed toward weight history, dietary habits, physical activities, and medications may provide useful information about the origins of obesity in particular patients.

3 BMI measured in past 2 years

For those who have not been overweight, a 2-year interval is appropriate for the reassessment of BMI. Although this timespan is not evidence-based, it is a reasonable compromise between the need to identify weight gain at an early stage and the need to limit the time, effort, and cost of repeated measurements.

4 Measure weight, height, waist circumference; calculate BMI

Weight must be measured so BMI can be calculated. Most charts are based on weights obtained with the patient wearing undergarments and no shoes.

5 BMI ≥ 25 OR waist circumference > 35 in (88 cm) (women) or > 40 in (102 cm) (men)

These cutoff values divide overweight from normal weight and are consistent with other national and international guidelines. The relationship between weight and mortality is J-shaped, and evidence suggests that the right side of the "J" begins to rise at a BMI of 25. Waist circumference is incorporated as an "or" factor because some patients with a BMI lower than 25 will have a disproportionate amount of abdominal fat, which increases their cardiovascular risk despite their low BMI (see pages 9–10). These abdominal circumference values are not necessary for patients with a BMI ≥ 35 kg/m².

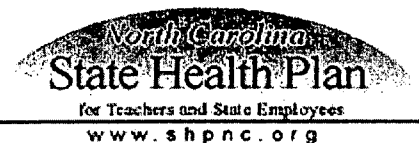
6 Assess risk factors

Risk assessment for CVD and diabetes in a person with evident obesity will include special considerations for the medical history, physical examination, and laboratory examination. Detection of existing CVD or end-organ

damage presents the greatest urgency. Because the major risk of obesity is indirect (obesity elicits or aggravates hypertension, dyslipidemias, and type 2 diabetes; each of these leads to cardiovascular complications), the management of obesity should be implemented in the context of these other risk factors. Although there is no direct evidence that addressing risk factors increases weight loss, treating the risk factors through weight loss is a recommended strategy. The risk factors that should be considered are provided on pages 11–13. A nutrition assessment will also help to assess the diet and physical activity habits of overweight patients.

7 BMI ≥ 30 OR ([BMI 25 to 29.9 OR waist circumference > 35 in (88 cm) (women) or > 40 in (102 cm) (men)]) AND ≥ 2 risk factors)

The panel recommends that all patients who meet these criteria should attempt to lose weight. However, it is important to ask the patient whether or not he or she wants to lose weight. Those with a BMI between 25 and 29.9 kg/m² and who have one or no risk factors should work on maintaining their current weight rather than embark on a weight reduction program. The panel recognizes that the decision to lose weight must be made in the context of other risk factors (e.g., quitting smoking is more important than losing weight) and patient preferences.

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At A Glance

Who's Covered?

The State Health Plan provides health care coverage to more than 665,000 ¹ teachers, ² state employees, ³ retirees, ⁴ current and former lawmakers, ⁵ state university and community college personnel, ⁶ state hospital staff and their dependents. A breakdown of that total includes:

⁸ - other?

- More than 483,000 active employees and dependents. (Dependents include spouses and unmarried children under age 19-or under age 26 if full-time students.)
- More than 3,900 COBRA participants and their dependents.
- More than 178,000 retirees and their dependents.

State Health Plan Options

The State Health Plan offers two PPO plans, using the Blue OptionsSM network.

Click to compare [plans](#).

Funding and Compliance

The State Health Plan is self-insured and exempt from ERISA as a government-sponsored plan.

North Carolina HealthSmart

North Carolina HealthSmart is a healthy living initiative that aims to:

- empower healthy members to stay healthy
- help those with chronic disease or disease risk factors better manage their health
- offer integrated, cutting-edge resources and programs to members at work, at home, and through their health care providers

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Enroll in the State Health Plan

Who is eligible to enroll in a benefit plan with the State Health Plan?

1. State employees with permanent employment working at least 30 hours per week for nine or more months per calendar year. For these employees, the state pays 100% of the cost of the coverage.
2. Permanent state employees working 20 or more hours but less than 30 per week. These employees may enroll, but they must pay the full cost of coverage.
3. Retired state employees and teachers.
4. Dependents' coverage, paid by the employee alone, is available at group rates. Dependents that are eligible for coverage include the following:
 - Legal spouse;
 - Unmarried children under age 19, including natural, legally adopted, or foster children of the employee or employee's spouse, as long as the employee is legally responsible for such child's maintenance and support;
 - Unmarried stepchildren of the employee when the employee is married to the stepchildren's natural parent and the stepchildren's primary residence is with the employee;
 - Unmarried children, from age 19 to 26, who are full-time students at a school or college accredited by the state of jurisdiction; and
 - Unmarried children who are physically or mentally incapacitated, to the extent that they are incapable of earning a living, and such handicap developed or began to develop before the dependent's 19th birthday (or 26th birthday, if a full-time student).

5 - other?

New employees who enroll themselves and dependents within 30 days of employment are not subject to a waiting period for pre-existing conditions.

To enroll in a plan, follow these simple steps:

1. Verify with your Health Benefit Representative/benefits office, if your enrollment is done through an electronic enrollment system or by completing a paper application.

- Employees that enroll through the BEACON system, [click here](#) for instructions.
- Employees that enroll through eBenefitsNow, [click here](#) for instructions.
- Retirees, [click here](#) for instructions on enrolling through eBenefitsNow.
- To enroll by paper, Enrollment Applications can be obtained from your New Employee Enrollment Kit, your Health Benefit Representative/benefits office or you can download the Enrollment Application below and follow the instructions included on the application.

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- [Enrollment Application](#) (PDF, 95KB)
- [Enrollment Application](#) (PDF, 75KB)
[For National Guard, Fire Department, Rescue Squad and Emergency Medical Services Members.](#)

2. Complete any necessary forms for your dependents

- [Certification of Dependent Eligibility](#) (PDF, 117KB)
If you have a child whose last name is different from yours, you will need to complete this form.
- [Coverage Request for Incapacitated Dependent](#) (PDF, 62.65KB)
If you have a child over age 19 who is eligible as a mentally or physically incapacitated dependent, complete this form.

3. Indicate if you were covered under a previous plan

- [Prior Health Coverage Information](#) (PDF, 183KB)
If you had coverage under a previous plan, you can apply to receive credit against the waiting period for pre-existing conditions.

Please print out the appropriate forms above and give the completed forms to your Health Benefits Representative/benefits office for processing.

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