North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

State Health Plan Update

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Personnel Administrators of North Carolina
Fall 2016 Conference

Open Enrollment Dates: Oct. 1-31, 2016

A Division of the Department of State Treasurer

What We Will Cover Today

- Overview of changes
  - Auto enrollment in the Traditional 70/30 Plan
  - Tobacco Attestation for Traditional 70/30 Plan
  - Health Engagement Program changes
  - Medical benefit changes for Enhanced 80/20 and Traditional 70/30 plans
  - Prescription benefit plan changes
  - ACA Reporting update
  - New Plan Policies

Changes Ahead

Overview of Changes: Rationale

- In the 2015 Budget, the General Assembly required the State Health Plan to take steps to reduce the projected increase to the state contribution for the 2017-19 fiscal biennium while maintaining significant cash reserves.
- With this legislative directive in mind and in an effort to avoid double digit premium increases in the next few years, the State Health Plan's Board of Trustees approved benefit changes for 2017 that are value based designed to increase member engagement.
- Increasing member engagement is a priority for the Board as a way to reduce costs over time while providing benefits that are value based to Plan members.

Overview of Changes

- The State Health Plan will continue to offer three plan options to actives and non-Medicare retirees for 2017:

Consumer-Directed Health Plan 85/15 (CDHP)

Enhanced 80/20 Plan

Traditional 70/30 Plan

- The Plan will continue to offer the opportunity to earn **Wellness Premium Credits** to reduce employee-only premiums.
- These credits reduce premiums for the CDHP 85/15 and 80/20 Plan, and NEW this year, the 70/30 Plan.
- There is a NEW Wellness Premium Credit for the Traditional 70/30 Plan for active members – we will cover this in a moment.

Overview of Changes: Enrollment Process

- **New:** ALL members and eligible dependents have been moved to the Traditional 70/30 Plan –effective Jan. 1, 2017.
  - When members log in to eEnroll in October, they will see that they (and any currently covered dependents) have been enrolled in the 70/30 Plan for 2017.
  - If members want coverage under a different Plan, they MUST take action and enroll in their preferred Plan.
  - If members fail to take any action by Oct. 31, they will remain enrolled in the 70/30 Plan and pay an employee-only premium of $40 per month.

Why Is Active Enrollment Required for 2017?

- Members need to be actively engaged in managing their health and health care.
- It is good for members to periodically re-evaluate their options – is their current choice the best choice?
- This helps ensure that members are enrolled in the Plan that best fits their health care needs and financial situation.
- The State Health Plan continues to offer members an online Health Benefit Estimator tool to help them choose the best plan for their circumstances.

Wellness Premium Credit Opportunities

- Active members have three opportunities to earn Wellness Premium Credits if enrolled in the CDHP 85/15 and 80/20 Plans:

Attest to being tobacco-free OR enroll in QuitlineNC. (Subscribers only)

Confirm selected Primary Care Provider (PCP) for all covered members.

Take (or RETAKE) the Health Assessment if the member hasn't taken it SINCE MAY 1, 2016. (Subscribers only)

- For each of these actions, the member earns reductions on his or her premiums.
  - Wellness premium credits apply only to the employee-only premium.
  - Reminder: All Health Assessment data entered prior to May 1, 2016 was cleared. This credit can be completed prior to OE.
  - New hires must re-attest to being tobacco-free during Open Enrollment even though they might have just enrolled.
  - This tobacco-free attestation is separate from the tobacco question included in the Health Assessment. Doing the Health Assessment doesn't count as doing the attestation.

Wellness Premium Credit Amounts for 2017

	CDHP	80/20 Plan	70/30 Plan
Attest to being tobacco-free OR enroll in QuitlineNC	$40	$40	$40*
Choose/confirm a Primary Care Provider (PCP)	$20	$25	N/A
Complete the Health Assessment	$20	$25	N/A
TOTAL CREDITS AVAILABLE FOR 2017	**$80**	**$90**	**$40**
All CREDITS EARNED SUBSRIBER ONLY MONTHLY PREMIUM	**$0**	**$15.04**	**$0**

*New for 2017

Change Comparison Charts: CDHP 85/15 (No Change)

	2016 In-Network	2017 In-Network	2017 Out-of-Network
HRA Starting Balance	$600 Employee $1,200 Employee + 1 $1,800 Employee + 2 or more	$600 Employee $1,200 Employee + 1 $1,800 Employee + 2 or more	$600 Employee $1,200 Employee + 1 $1,800 Employee + 2 or more
Annual Deductible	$1,500 Individual $4,500 Family	$1,500 Individual $4,500 Family	$3,000 Individual $9,000 Family
Coinsurance	15% of eligible expenses after deductible	15% of eligible expenses after deductible	35% of eligible expenses after deductible and the difference between the allowed amount and the charge
Coinsurance Maximum	N/A	N/A	N/A
Out-of-Pocket Maximum (Combined Medical and Pharmacy) *Includes Deductible*	$3,500 Individual $10,500 Family	$3,500 Individual $10,500 Family	$7,000 Individual $21,000 Family
ACA Preventive Services	Covered at 100%	Covered at 100%	65% after deductible
<u>Office Visits</u> Selected PCP Non-selected PCP	15% after deductible+$25 HRA credit 15% after deductible	15% after deductible+$25 HRA credit 15% after deductible	35% after deductible

B.O.D. = Blue Options Designated Provider

Change Comparison Charts: CDHP 85/15 (No Change)

	2016 In-Network	2017 In-Network	2017 Out-of-Network
Office Visits B.O.D. Specialist Non-B.O.D. Specialist	15% after deductible+$20 HRA credit (for B.O.D.specialists. 15% after deductible	15% after deductible+$20 HRA credit (for B.O.D.specialists. 15% after deductible	35% after deductible
Urgent Care	15% after deductible	15% after deductible	15% after deductible
Emergency Room	15% after deductible	15% after deductible	15% after deductible
Outpatient Hospital	15% after deductible	15% after deductible	35% after deductible
Inpatient Hospital B.O.D. Non-B.O.D.	15% after deductible. + $200 HRA Credit for B.O.D. Hospitals 15% after deductible	15% after deductible. + $200 HRA Credit for B.O.D. Hospitals 15% after deductible	35% after deductible
Therapy Services (Chiro/PT/OT)	15% after deductible	15% after deductible	35% after deductible
Drugs	15% after deductible CDHP Maintenance Medications are deductible exempt	15% after deductible CDHP Maintenance Medications are deductible exempt	35% after deductible CDHP Maintenance Medications are deductible exempt

B.O.D. = Blue Options Designated Provider

Change Comparison Charts: Enhanced 80/20 Plan

	2016 In-Network	2017 In-Network	2017 Out-of-Network
Annual Deductible	$700 Individual $2,100 Family	**$1,250 Individual** **$3,750 Family**	**$2,500 Individual** **$7,500 Family**
Coinsurance	20% eligible expenses after deductible	20% eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge
Medical Coinsurance Max	$3,210 Individual/ $9,630 Family	N/A	N/A
Medical Out-of-Pocket Max	N/A	**$4,350 Individual** **$10,300 Family**	**$8,700 Individual** **$26,100 Family**
Pharmacy Out-of-Pocket Max	$2,500	$2,500 Individual **$4,000 Family**	$2,500 **4,000 Family**
Total Out-of-Pocket Max *(Includes Deductible)*	N/A	**$6,850 Individual** **$14,300 Family**	**$11,200 Individual** **$30,100 Family**
ACA Preventive Services	Covered at 100%	Covered at 100%	Dependent on Service
Office Visits Selected PCP Non-selected PCP	 $15 $30	 **$10** **$25**	40% after deductible
Office Visits B.O.D. Specialist. Non-B.O.D. Specialist	 $60 $70	 **$45** **$85**	40% after deductible

B.O.D. = Blue Options Designated Provider

Change Comparison Charts: Enhanced 80/20 Plan

	2016 In-Network	2017 In-Network	2017 Out-of-Network
Urgent Care	$87	**$70**	**$70**
Emergency Room *(Copay waived w/ admission or observation stay)*	$233, then 20% after deductible	**$300, then 20% after deductible**	**$300, then 20% after deductible**
Outpatient Hospital	20% after deductible	20% after deductible	40% after deductible
Inpatient Hospital B.O.D. Non-B.O.D.	$0, then 20% after deductible $233, then 20% after deductible	$0, then 20% after deductible **$450, then 20% after deductible**	**$450, then 40% after deductible**
Therapy Services (Chiro/PT/OT)	$52	$52	40% after deductible
Drugs Tier 1 (Generic) Tier 2 (Preferred Brand & High-cost Generic) Tier 3 (Non-preferred Brand) Tier 4 (Low-cost/Generic Specialty) Tier 5 (Preferred Specialty) Tier 6 (Non-preferred Specialty) Preferred Diabetic Supplies*	 $12 $40 $64 N/A 25% up to $100 25% up to $132	 **$5** **$30** **Deductible/Coinsurance** **$100** **$250** **Deductible/Coinsurance** **$5**	 **$5** **$30** **Deductible/Coinsurance** **$100** **$250** **Deductible/Coinsurance** **$5**

B.O.D. = Blue Options Designated Provider

**Non-preferred Diabetic Supplies will be priced at Tier 3.*

Change Comparison Charts: Traditional 70/30 Plan

	2016 In-Network	2017 In-Network	2017 Out-of-Network
Annual Deductible	$1,054 Individual $3,162 Family	**$1,080 Individual** **$3,240 Family**	**$2,160 Individual** **$6,480 Family**
Coinsurance	30% of eligible expenses after deductible	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Medical Coinsurance Max Pharmacy Max Out-of-Pocket Max *(Includes Deductible)*	$4,282 Individual/$12,845 Family $3,294 N/A	**$4,388 Individual/** **$13,164 Family** **$3,360** N/A	**$8,776 Individual/** **$26,328 Family** **$3,360** N/A
ACA Preventive Services	Cost-Sharing Applies ($39 for Primary Care/$92 for Specialists)	Cost-Sharing Applies **($40 for Primary Care** **$94 for Specialists)**	Only certain services are covered
Office Visits PCP Copay	$39	**$40**	50% after deductible
Office Visits Specialist Copay	$92	**$94**	50% after deductible

Change Comparison Charts: Traditional 70/30 Plan

	2016 In-Network	2017 In-Network	2017 Out-of-Network
Urgent Care	$98	**$100**	**$100**
ER *(Copay waived w/ admission or observation stay)*	$329, then 30% deductible	**$337, then 30% deductible**	**$337, then 30% deductible**
Outpatient Hospital	30% after deductible	30% after deductible	50% after deductible
Inpatient Hospital	$329, then 30% deductible	**$337, then deductible/30% coinsurance**	**$337, then deductible/50% coinsurance**
Therapy Services (Chiro/PT/OT)	$72 Copay	$72 Copay	50% after deductible
Drugs Tier 1 (Generic) Tier 2 (Preferred Brand & High-cost Generic) Tier 3 (Non-preferred Brand) Tier 4 (Low-cost/Generic Specialty) Tier 5 (Preferred Specialty) Tier 6 (Non-preferred Specialty) Preferred Diabetic Supplies*	 $15 $46 $72 N/A 25% up to $100 25% up to $132	 **$16** **$47** **$74** **10% up to $100** **25% up to $103** **25% up to $133** **$10**	 **$16** **$47** **$74** **10% up to $100** **25% up to $103** **25% up to $133** **$10**

**Non-preferred Diabetic Supplies will be priced at Tier 3.*

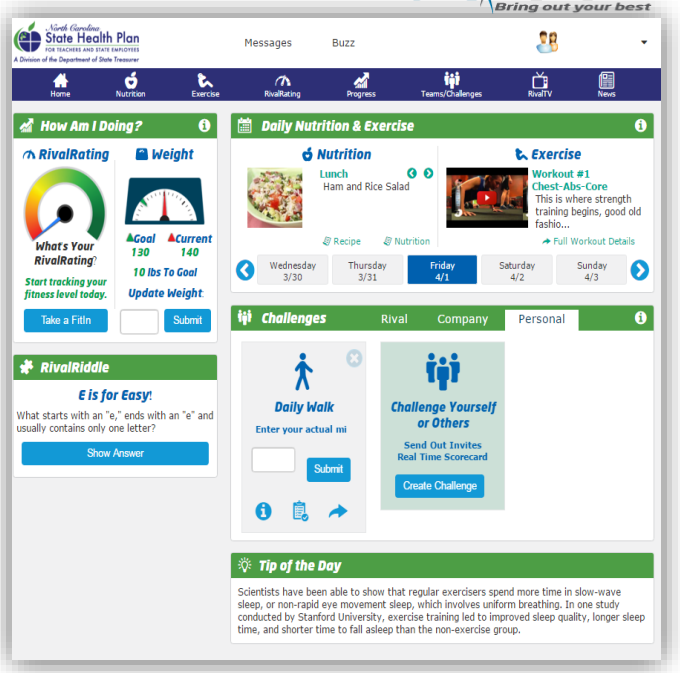
Health Engagement Program for CDHP Members

- The Health Engagement Program offers additional Health Reimbursement Account funds for CDHP members who engage to help offset their health care expenses. There are two components:
  - The **Healthy Lifestyles Program** is an incentive-based program designed to encourage all **CDHP** members to engage in healthy behaviors
  - **Positive Pursuits** offers **CDHP** members with certain conditions an opportunity to earn even more in the HRA for actively managing their condition

New for 2017!

Members will have more activities in which to earn incentives with RivalHealth! RivalHealth is a fitness-based wellness platform that engages members with daily exercise and nutrition activities as well as social interaction and challenges.

Currently it's available to CDHP members and qualifying Wellness Champions worksites. In 2017, CDHP members can earn HRA funds through completed activities.



New Pharmacy Benefit Manager Implementation

- As of January 1, 2017, the State Health Plan will be transitioning to a new Pharmacy Benefit Manager, CVS/caremark.
- ALL members will receive a new ID Card. The 2016 card WILL NOT work – members **MUST** use the new CVS/caremark card.
- Advantages of switching to CVS/caremark:
  - Members will have access to the CVS/caremark online drug lookup tool during Open Enrollment.
    - This tool enables members to look up and compare the costs of various drugs – especially useful for those enrolled in the CDHP 85/15.
- Members will begin to receive letters from CVS/caremark mid-October if they are currently on medications that will not be covered or include any utilization management criteria that requires any prior approval.

Formulary Change

- The State Health Plan will be moving to a Closed, Custom Formulary effective January 1, 2017.

Open Formulary – In an "open" formulary, all drugs are included, subject to any benefit exclusions. The Plan currently utilizes an "open" formulary for the Enhanced 80/20, Consumer-Directed Health Plan (CDHP) 85/15, and Traditional 70/30 Plans.

- **Closed Formulary** – In a "closed" formulary, certain drugs are not covered.
  - Formulary is posted to the Plan's website.
  - Members are encouraged to call CVS for specific questions about drug coverage.

- There will be an exception process available to providers who believe that, based on medical necessity, it is in the members' best interest to remain on the excluded drug(s).
- Impacted members and their providers will receive communication regarding any affected prescriptions.

New Pharmacy Tier for Diabetic Testing Supplies

- There will be a new tier added for Preferred Diabetic Supplies
  - Enhanced 80/20 Preferred Diabetic Tier copay will equal the Tier 1 copay
  - Traditional 70/30 Preferred Diabetic Tier copay will remain at $10 (Tier 1 is $16)

Drugs	Traditional 70/30 Plan	Enhanced 80/20 Plan	Consumer-Directed Health Plan 85/15
Tier 1 (Generic)	**$16**	**$5**	Preferred brands fall under CDHP Preventive List – deductible is waived
Tier 2 (Preferred Brand & High-cost Generic)	**$47**	**$30**	
Tier 3 (Non-preferred Brand)	**$74**	**Deductible/Coinsurance**	
Tier 4 (Low-cost/Generic Specialty)	**10% up to $100**	**$100**	
Tier 5 (Preferred Specialty)	**25% up to $103**	**$250**	
Tier 6 (Non-preferred Specialty)	**25% up to $133**	**Deductible/Coinsurance**	
Preferred Diabetic Supplies* (e.g. Test Strips, Lancets, Syringes, Needles)	**$10**	**$5**	

**Non-preferred Diabetic Supplies will be priced at Tier 3*

Important Reminders

Resources to Remember

- Visit State Health Plan website (shpnc.org) for tools to help you make the right choice during Open Enrollment:
  - Health Benefits Cost Estimator
  - Rate Calculator
  - Plan Comparisons
  - E-magazine
  - Enrollment Guides
  - Videos
    - What's New for 2017
    - Choosing a 2017 Health Plan
    - Consumer-Directed Health Plan: Myths and Facts
    - e-Enroll Navigation for Step-by-Step Guide

Medicare Retiree Plan Options for 2017

- Medicare retirees will have the following plan options for 2017:

UnitedHealthcare Medicare Advantage Base Plan

UnitedHealthcare Medicare Advantage Enhanced Plan

Traditional 70/30 Plan

- The Humana plan options will no longer be available in 2017. For that reason, auto-enrollment into the Humana Base Plan for newly eligible members has ceased.
- If a family member is already enrolled in Humana for 2016, the Plan will continue to auto-enroll any additional newly Medicare eligible family members to same plan for the remainder of 2016.
- **Members currently enrolled in a Humana Group Medicare Advantage Plan** will be automatically enrolled in the UHC Group Medicare Advantage Base Plan unless they choose another option during Open Enrollment.
- **Members currently enrolled in a UHC Group Medicare Advantage Plan (Base or Enhanced) or the Traditional 70/30 Plan**, only need to take action if they wish to make a change.

ACA Reporting

Timeline for Groups that Signed Up with Benefitfocus

- **Please note the upcoming tasks and Milestones on the timeline:**
  - **Sep 10th** Milestone Complete**:** Benefitfocus 2016 Autumn Release: Contains 1095-C Extract Changes
  - **Sep 12-Oct 14:** Employers fill out 1094-C form. This must be completed before you can upload 1095 data.
  - **Sep 12-Oct 14**: Employers run 1095 extracts, make updates to Jan-Sep codes and upload data.
  - **Sep 12-Oct 14:** Employers offering HDHP run 1095 extracts from CG site and upload data to BF.
  - **Oct 11th Milestone:** SHP Delivers COBRA data to employers for Jan-Oct – **On track!**
  - **Oct 14th Milestone:** 1094-C filled out by All Employers
  - **Oct 17-31**: Employers incorporate COBRA data into their ACA data for Jan-Oct

Questions can be sent to: ACA@nctreasurer.com

New Policies

Enrollment Exceptions and Appeals Policy and Procedure

- The purpose of this policy is to provide State Health Plan members with information on how to file exceptions and appeals for enrollment related activities, including enrollment, changes in benefit elections premiums and premium credits, and terminations.
- This policy does not change the process, but places a timeframe in which an exception can be submitted.
- To make an enrollment exception request, active employee members must contact their HBR and request that the HBR file an enrollment exception request with the Plan. Enrollment exception requests must be submitted to Plan within the following timeframe:
  - Within sixty (60) days of enrollment, termination or change in benefit election or within thirty (30) days of paycheck deduction or premium payment due date reflecting enrollment, termination, or change in benefit election, whichever is later.
- The State Health Plan will respond back to the HBR via secure email with a final disposition. The Plan's decision will be communicated within fifteen (15) State business days of receipt of the exception request.

Policy and Procedure on Arrears

- The purpose of this policy and procedure is to outline the arrears rules for the Plan when a member is in a category that requires the member to be responsible for paying the full premium or a portion of the premium directly to the employing unit or the Plan's billing vendor.
  - For example, the policy describes what happens when an employee is on an official leave of absence and does not pay their portion of the premium to the employing unit or billing vendor by the due date.
- Any member whose coverage is canceled for non-payment of premium will be eligible to enroll during the next Open Enrollment period.
- The employing unit is responsible for collecting the member's premium while the member is on a leave of absence (LOA), FMLA or Workers' Compensation. Employing Units are expected to pay the premiums for these members along with other active members by the invoice due date. If the employee does not pay the premium by the last day of the effective month, the employing unit should complete the cancellation by the end of the effective month by using the "loss of coverage due to non-payment" reason code in eEnroll.
- eEnroll will not permit cancellations after the grace period closes. If necessary, the employing unit is responsible for creating a retroactive cancellation exception to be submitted to the Plan, but in no circumstance will the Plan approve a cancellation for non-payment more than sixty (60) days in arrears. If the employing unit does not complete the termination for non-payment within the appropriate time frames, the employing unit is responsible for the members' premium.
- This policy and procedure for arrears is effective December 1, 2016 and applies to premiums due for coverage months beginning on or after January 1, 2017.

New Polices

- The Plan will be sending out additional information regarding both policies.
- Both policies will get posted to the Plan's website under the HBR tab.

Any Questions?

- During Open Enrollment, the **Eligibility and Enrollment Support Center** will have extended hours:
  - Monday – Friday, 8:00 a.m. – 10:00 p.m.
  - Saturday 8:00 a.m. – 3:00 p.m.
  - 855-859-0966
- **Blue Cross and Blue Shield of NC (benefit questions)**
  - 888-234-2416
- **CVS Caremark (2017 Rx questions)**
  - 888-321-3124
- **NCHealth*Smart* (Health Assessment)**
  - 800-817-7044

Thank You!

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