1. **What role does the Board play in governance of the State Health Plan?**

   The Board plays a significant role in governance of the Plan and has the following statutory responsibilities:

   (1) Approve benefit programs, as provided in G.S. 135-48.30(2).
   (2) Approve premium rates, co-pays, deductibles, and coinsurance maximums for the Plan, as provided in G.S. 135-48.30(2).
   (3) Approve contracts in excess of $500,000, as provided in G.S. 135-48.33(a).
   (4) Consult with and advise the State Treasurer as required by the Article and as requested by the State Treasurer.
   (5) Develop and maintain a strategic plan for Plan.

   The following additional responsibilities are also set forth in statute:

   (1) **Assist in the evaluation of the Executive Administrator.** As prescribed by G.S. 135-48.23, the State Treasurer shall consult with the Board before removing the Executive Administrator.
   (2) **Report to the General Assembly.** The Board shall report to the General Assembly as requested by the President Pro Tempore of the Senate and the Speaker of the House of Representatives. G.S. 135-48.27.
   (3) **Consultation.** As prescribed by Article 3B of G.S 135, the Board must provide consultation to the State Treasurer on the following matters: adoption and implementation of rules; adoption and implementation of utilization review and internal grievance procedures; establishment and implementation of medical procedures that require prior approval and as otherwise requested by the State Treasurer.
   (4) **Delegation of powers.** The Board will be required to carry those powers and duties delegated to it by the State Treasurer.
   (5) **Guidelines.** The Board in concert with the State Treasurer is required to examine the issue of moving to a calendar year, including the costs and mechanics of doing so; find savings through wellness programs, Medicare Advantage plans, alternative plan designs, or other resources and use those savings to offer a premium-free plan option no later than July 1, 2013; and strive to keep premiums low by finding savings through wellness programs, Medicare Advantage plans, alternative plan designs, or other resources.

2. **What was the process for determining the criteria for the RFP since it has not been out for bid in recent years?**

   A. **RFP Reviews** – Plan requested copies of other states’ RFPs. In addition to giving us insight into their process, it provided specifics details about possible criteria.
   
   B. **Vendor Engagement** – Plan began engaging vendors in February 2011
1. **Request For Information (RFI)** – Issued a RFI that was open to all interested vendors. The RFI gave the Plan an opportunity to learn what the market had to offer, and potential bidders to understand some of the Plan requirements.

2. **Vendor Meetings** – Through the RFI, we learned that not all TPAs offered enrollment services or COBRA and Individual Billing services, so we expanded our outreach to those vendors as well. Between WebX and on site meetings, we spoke to more than a dozen vendors gathering more market information.

3. **Terms and Conditions (T&Cs) Comment Period** - We provided the Plan’s proposed T&Cs to all interested vendors for their feedback. While we had some contract terms that could not be changed, we wanted to ensure that our T&Cs did not preclude vendors from bidding.

   The result of the vendor engagement process was a decision to structure the RFP into four components:

   - Eligibility and Enrollment Services
   - COBRA and Individual Billing
   - Third Party Claims Administration
   - Medicare Advantage

C. **Consultants** – The Plan engaged Aon Hewitt to review the RFP sections and provide feedback. Aon also assisted in evaluating the claims pricing and administrative fees.

D. **Legal Review** – In addition to a review by the Attorney General’s office, the Plan engaged outside counsel to review and provide feedback, which was incorporated.

3. **Why was BCBSNC selected to administer the State Health Plan over other providers?**

   While four vendors responded to the first phase, called the minimum requirements, only two vendors chose to submit a final bid for consideration (All four vendors met the minimum requirements and were eligible to submit a final bid.) Both the technical responses and the cost proposal of each bidder was evaluated and scored. Based on the results, BCBSNC was awarded the contract.

4. **What is being done to reduce the existing premiums for employees/family coverage?**

   Effective Jan. 1, 2013, the Plan will implement a new Medicare Part D Prescription Plan for Medicare-eligible retirees and their dependents called the Express Scripts Medicare™ Prescription Drug Plan (PDP) (note: this plan was formerly referred to as “EGWP”- employer group waiver plan). All Medicare-eligible retirees and their dependents will be automatically enrolled in the plan and the current dependent premium rates will be reduced by $50 per month. The overall pharmacy benefit will remain similar to current pharmacy coverage, as the PDP Plan is comparable to the Plan’s Traditional Pharmacy Plan and offers better coverage than a standard Medicare Part D Plan.
The Plan recently awarded contracts to two vendors, United Healthcare and Humana, to offer a Medicare Advantage plan to Medicare eligible members beginning in January 2014. The details and premium rates won’t be finalized until next summer, but based on the bids; the Plan expects to realize savings, and as result to reduce the premium rates for Medicare-eligible dependents that enroll in the Medicare Advantage plan.

In addition to the two plan offerings for Medicare-eligible members, the Plan has experienced lower than projected claims costs over the last two years. These positive financial results are expected to reduce the amount of the required premium increase over the next two years, although final rates have yet to be determined and will be based on the benefit design(s) approved by the Board of Trustees and State funding provided by the General Assembly.

5. **Will there be consideration for premiums based on family size (ex: employee/spouse/1 child vs employee/spouse/3 children)?**

As the Plan considers new benefit designs and products, the premium structure will be evaluated as well to ensure it aligns with the plan offerings. In the future there may be changes in the rates, similar to the upcoming dependent rate reduction for eligible Medicare-primary dependents (effective Jan 2013, see #4).

The Plan currently offers employee-spouse, employee-child(ren), and employee-family premium tiers for dependent coverage. As a group health benefit, the Plan seeks to balance the premium rates across all tiers, whereas premiums for individual policies are typically based on the number of individuals covered under the policy. If the Plan’s tiers are changed to reflect the number of dependents in each tier, some employees/retirees would see a reduction in their dependent premiums, while others would see an increase.

6. **What are the differences between our current plan and the proposed plan?**

Proposed changes to the general benefit design (i.e. 80/20 and 70/30 PPO plans) have not been finalized, but potential scenarios presented at the September Board meeting included discussion of the following changes:

- Conversion of the plan benefit year from the state fiscal year to the calendar year effective Jan 2014
- Offering Medicare Advantage plan to Medicare-eligible members effective Jan 2014
- Offering enhanced coverage for preventive benefits under the 80/20 plan effective Jan 2014 (i.e. 1st dollar or 100% coverage for preventive benefits). Co-payments, deductibles and out of pocket maximums would remain at the current level.

Incorporating incentives and wellness programs as part of the plan design and the possibility of offering health savings accounts (HSA) or health reimbursement accounts (HRAs) was also discussed. As a result the Board requested the Plan conduct focus groups to identify other potential changes for consideration. Meetings with member focus groups are currently underway.
7. **How will administrative savings be passed down to the plan members?**

   The projected administrative savings associated with the recent award for third party administrative services, COBRA and billing services, and eligibility and enrollment services will be incorporated in the Plan’s overall budget forecast for the next two years and will help reduce the required premium increases.

8. **Will the new plan require a BMI or non-smoking requirement in order to receive a special, preferred rate (80/20 vs 70/30)?**

   The Plan is evaluating various options around benefit design at this time. No decisions have been made to date. The Plan is interested in a benefit design that will engage members in their health and wellness, but we will need to evaluate and compare the costs associated with any proposed wellness programs and incentives to engage members with the potential program benefits and consider the likely delay in a return on that investment. It may be several years before we see improvement in health status and/or reduced costs.

9. **Will there be any changes to deductibles, co-pays, and premiums?**

   Proposed changes to the general benefit design (i.e. 80/20 and 70/30 PPO plans) have not been finalized, but potential changes presented at the September Board meeting included a scenario in which co-payments, deductibles, and out of pocket maximums would be held at the current level for the next two years and preventive benefits would be enhanced under the 80/20 plan (e.g. coverage would no longer be subject to co-payments and other cost sharing). Premium rates will be based on the final plan design.

10. **Will there be any wellness benefits?**

    See response to #8.

11. **Could there be any incentives to use ECU Physicians (or other state physicians) vs. physicians in private practice?**

    Consideration may be given to a tiered network approach if there’s potential for better outcomes and lower costs.

12. **Will the new plan affect retirees the same as active state employees?**

    Historically plan offerings for retirees and active employees have been similar. The application of plan design differs for Medicare retirees, and the Plan is working to implement a new prescription drug benefit for Medicare retirees in January 2013 and offer Medicare Advantage plans for Medicare retirees in January 2014.

    In addition, State law requires the Plan to offer retirees a premium-free option. Legislation enacted in 2011 also directed the Board/Plan to “strive to offer” a premium free option to active employees. The 70/30 plan is currently offered to active employees on a premium free basis and while proposed changes to the benefit design have not been finalized, the Plan expects to continue offering the 70/30 plan to active employees on a premium free basis.
13. Has there been consideration to split plans for active employees vs. retirees? (Mona, Caroline)

The Plan’s actuary recently completed a study that looked at differences in contribution rates and claims experience of active employees, non-Medicare retirees, Medicare retirees, and their dependents. The cost to cover non-Medicare retirees and dependents is greater than the premium contributions received on their behalf. Splitting the plans would likely require significant increases in the premiums rates for non-Medicare retirees and dependents. The Plan is evaluating whether changes in the contribution structure would benefit the plan as a whole.

14. At a 70/30 plan, why is it less expensive to cover a spouse through BCBSNC directly? (Mona, Caroline)

As a group health benefit, the Plan seeks to balance the premium rates across all tiers to accommodate a very wide variance in age and health status, whereas premiums for individual policies are typically based on the number of individuals covered under the policy and the age and health status of those individuals. Not every spouse enrolled in the 70/30 plan can get individual coverage at a lesser cost.

15. Will vision and/or dental benefits ever be added?

This can be considered, but will require a premium increase.

16. What are the chances that a 90/10 plan would be reoffered to state employees?

This can be considered, but the premium rate would be significantly higher than when the 90/10 option was originally offered.