Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
November 20, 2014

The meeting of the Board of Trustees of the North Carolina State Health Plan for Teachers and State Employees was called to order at approximately 4:00 p.m. on Thursday, November 20, 2014, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

Members Present:
Vice-Chair Genell Moore
Lee Roberts
V. Kim Hargett
Noah Huffstetler
Charles Johnson
Bill Medlin
David Rubin
Warren Newton, MD

Absent:
Janet Cowell, Chair
Paul Cunningham

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, David Boerner, Mark Collins, Kathryn Keogh, Nidu Menon, Sally Morton, Lorraine Munk, Dorothy Brown Smith, Tracy Stephenson, Andrew Holton, Tony Solari

Welcome
Genell Moore, Vice-Chair, welcomed Board members and State Health Plan and Department of State Treasurer staff to the meeting.

Agenda Item – Conflict of Interest Statement
In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, Vice-Chair Moore requested that members who have either an actual or perceived conflict of interest identify the conflict and refrain from discussion and voting in those matters as appropriate. Mr. Huffstetler noted that his law firm has accepted some representation from Blue Cross and Blue Shield of North Carolina (BCBSNC).

Agenda Item – Review of Minutes – September 19, 2014
Presented by Genell Moore, Vice-Chair

Following a motion by Dr. Rubin and seconded by Dr. Newton, the board unanimously approved the minutes from the September 19, 2014, meeting.

Agenda Item – Member Experience and Communications
Presented by Caroline Smart, Director of Health Plan Operations

<u>2014 Member Satisfaction Survey Results</u>

Postcards were mailed to subscribers inviting them to participate in the member satisfaction survey which was posted on the Plan's website. The response rate was approximately 2%. Ms. Smart provided

a summary of the survey results. The cost of monthly premiums was the top reason for why members chose a particular plan. Approximately one-third of active members indicated they delayed care or didn't receive care in the past 12 months due to financial reasons but 85% indicated they had a primary care visit with the provider listed on their ID card. Approximately 85% of Medicare primary members had a visit with the primary care provider (PCP) listed on their ID card.

Satisfaction with care and service is fairly good among Medicare primary retirees while the satisfaction rate for active and non-Medicare retiree members is lower. Approximately 60% of active and non-Medicare retirees gave the highest rating for customer service when they call for assistance. Fifty-seven percent gave the highest rating for the prescription benefits. Eighty-seven percent of Medicare primary members take their medications as prescribed compared to 72% of active/non-Medicare retiree members. In response to a question from a board member, Ms. Smart stated that a second member satisfaction survey regarding patient care and the provider experience would be conducted in 2015.

The survey results demonstrated that Plan members are not fully engaged in trying to determine the costs of health care services or equipment needed. The Plan will focus on providing more education in this area as transparency tools are reviewed and implemented.

Medicare retirees rank communication between the PCP and specialists higher than active/non-Medicare retiree members. They also ranked the resources provided by the PCP higher, as well as the PCP assisting them with understanding and managing their care. Medicare retirees still prefer to have printed material mailed to them rather than email communication. This presents a challenge given that the Plan would prefer to use email as the primary avenue of communication.

The 2014 survey results were similar to the results in 2012. The Plan would like to see overall member satisfaction higher than 50%.

One board member stated that he experienced a lot of questions and some distrust from members regarding the enrollment process. The Plan is aware that face-to-face enrollment meetings are important and should continue in some capacity, but increasing member engagement is a challenge. It was suggested by a board member that members and health benefit representatives (HBRs) could be incented to attend enrollment meetings. Two board members mentioned that attendance at supplemental insurance presentations is mandatory in some schools and state agencies. The board agreed that having other insurance companies answer questions regarding Plan benefits undermines what the Plan and board are doing and feel the issue should be addressed.

Ms. Moon acknowledged that the Plan has discussed increasing the educational meetings across the state but that staffing becomes an issue. Mr. Alexander, Director of the Office of State Human Resources, stated his support for a call center to field questions from all state employees as opposed to in-person enrollment meetings. Health plan benefits are only a small part of what HBRs do within their employing units and a call center would staff properly trained representatives to answer member questions.

Ms. Moore requested that Plan staff come back to the board with a recommendation regarding the best way to disseminate health benefit information to Plan members and address the issue of other insurance companies presenting information about the Plan.

<u>Annual Enrollment Results (CDHP, 80/20, 70/30, MAPDP)</u>
Member outreach included HBR trainings, videos, a direct mail campaign, webinars and Medicare primary in-person events across the State. The trainings also included a brief survey. Almost 100% of

the 405 participants indicated that the trainings were helpful and easy to understand. Medicare primary members were also invited to complete a survey and approximately 97% of the attendees who responded were pleased that the Plan provides health plan choices for them. A high percentage also indicated that the information presented was helpful and easy to understand.

Initial enrollment results for active/non-Medicare retiree subscribers demonstrate that membership increased in the Enhanced 80/20 Plan and decreased in the Traditional 70/30 Plan. Approximately 3% of the subscribers chose the Consumer-Directed Health Plan (CDHP). Medicare primary retiree subscriber membership demonstrated a decrease in the 70/30 plan, as well. Final membership results will be available in early February 2015.

One board member noted a system issue with the timing of Medigap policies and State Health Plan enrollment. If a member is accepted into a Medigap plan after October 31, enrollment in the Plan can't be canceled. Ms. Smart and Ms. Moon both stated that the Plan was aware of the issue and will continue to discuss a possible solution.

The premium wellness credits approved at the May 2014 board meeting included a mandatory smoking attestation during the Annual Enrollment period in order to receive the $20 premium credit. Members could elect a new PCP during Annual Enrollment and were required to complete a health assessment if their last one was completed before November 1, 2013. Ms. Smart noted that random browser compatibility issues were brought to the Plan's attention by members who had trouble completing the health assessment. Active Health's call center was available to assist members on the phone and workaround instructions were posted on the website. The number of health assessments completed prior to the start of annual enrollment increased approximately 45% this year. Overall, about 19,000 more members successfully completed the health assessment by the end of the 2015 annual enrollment period.

Approximately 51,000 members did not receive the non-smoker credit during the 2015 enrollment period. The Plan received feedback from members who forgot to do it or stated they were unaware they had to complete the attestation. However, many members indicated they thought by completing the tobacco related questions in the health assessment that they had completed the attestation. Ms. Smart noted that 163,000 members did complete the attestation and have received the credit. Several board members agreed that the enrollment process could be improved. Plan staff acknowledged enrollment issues and stated that internal discussions to address the problems and determine ways to better engage members will occur in early 2015.

The board questioned how the Plan would address the issue of 51,000 members who didn't complete the smoking attestation. Ms. Moon again reiterated that some of the members in this group didn't attempt to complete the attestation. The Annual Enrollment material included a bolded statement that directed members to complete the attestation during the Annual Enrollment period, even if they completed it last year, in order to get the premium credit. Following additional discussion, the board requested that Plan staff determine and implement a feasible solution.

<u>Communication and Open Enrollment Update (HDHP)</u>
New legislation in 2014 required the Plan to offer a new health benefit option for full-time employees not covered by the Plan to comply with the Affordable Care Act (ACA). Plan staff worked with a group of representatives from state agencies, universities and employee associations to define the plan structure. The statute requires that the Plan offer coverage that provides minimum essential benefits at no greater than the ACA Bronze level and which minimizes the employer contribution.

Particular concern from various groups and members has focused on the impact to retired employees who return to work. Legislation effective January 1, 2015, requires employing units to cover re-hired employees if they meet the definition of full-time employees. Consequently, members who choose coverage under the High Deductible Health Plan (HDHP) are not eligible for their retiree health benefit coverage under the State Retirement Systems as required by state law and the Plan terminates the retiree from the retiree group coverage. The Plan has communicated information to the HBRs and letters have been sent to affected retirees notifying them of the terminated coverage.

Ms. Smart noted re-hired retirees/employees who are no longer eligible for the HDHP will be able to re-enroll in their State Health Plan coverage under the Retirement Systems within 30 days of losing the HDHP eligibility. If the employee fails to re-enroll within that time period, they will be unable to come back on the Plan until the next enrollment period. Ms. Moon noted that the Board doesn't have the authority to change the eligibility or coverage requirements.

The Plan continues to address questions and issues from numerous groups impacted by this legislation. Staff has been invited to attend various statewide meetings to present additional information on the HDHP and to clarify coverage requirements.

Same-Sex Marriage Qualifying Event Update

The federal court overturned 4th Circuit law (North Carolina is in the 4th Circuit) prohibiting same-sex marriage on October 10, 2014. NC courts have applied the 4th Circuit law to NC cases pending before the courts. These rulings make same-sex spouses of Plan subscribers eligible for Plan coverage. To date, the Plan enrolled 54 same-sex spouses who were eligible for coverage effective November 1, 2014.

Communication Update – Health Literacy

Blue Cross Blue Shield of North Carolina (BCBSNC) will roll out an enhanced member website, Blue Connect, in January 2015. The member portal will provide more clarity, choice and control for State Health Plan benefits.

Bundled knee replacement surgery at OrthoCarolina and Triangle Orthapaedics is also coming soon and the Plan is working on an educational campaign for these services.

Agenda Item – Financial Report, Forecasting and Monitoring

September 2014 Financial Report

Presented by Mark Collins, Financial Analyst

The September financial report demonstrates the same pattern presented at the past two board meetings and the actual numbers are running close to the certified budget. Plan revenue was $2.24 billion and total expenses were $2.11 billion. The net income was $105 million over the budgeted amount.

In the past six months, the Plan has averaged $1 million over budget each month, due in part to a higher membership than projected. The per member per month (PMPM) report in the first three months of 2014 demonstrated a big difference between the budgeted amounts and actual expenses. As the Plan moved through the calendar year, the actual and budgeted amounts have moved closer together. The PMPM difference between the budgeted and spending amounts at the end of September was approximately $20 and could be close to $15 by the end of the year if recent patterns continue.

Actuarial Valuation of Retired Employees' Health Benefits – Other Post-Employment Benefits (OPEB) as of December 31, 2013
Presented by Mark Collins, Financial Analyst

Mr. Collins reviewed background information for the Other Post-Employment Benefits (OPEB) report and the makeup of the Committee on Actuarial of Retired Employees' Health Benefits. He reminded the board that the OPEB report is the measure of liability in today's dollars for retiree health benefits. The unfunded actuarial accrued liability (UAAL) increased $2.4 billion from 2012 to 2013 but is still below the unfunded liability in 2008 to 2011.

Mr. Collins reviewed future changes for OPEB reporting that could require the Board to examine potential changes in retiree health benefits depending on how bond rating agencies react to the new reporting. NC is currently one of about 10 states that have an AAA bond rating from all three rating agencies. In the future, all states will have to list OPEB liabilities as a line item on the balance sheet rather than a note.

The full OPEB report can be accessed on the Plan's website.

Summary of Audit Results

Caroline Smart, Director of Health Plan Operations, presented the medical claims audit results. This quarterly audit is conducted by Thomas & Gibbs CPAs, PLLC, and determines if claims are processed and paid by BCBSNC according to the terms of the contract. The Plan's quality team performs additional process quality checks throughout the year.

The results for 2013-14 exceeded the performance guarantees in the Plan's contract with BCBSNC.

Mark Collins, Financial Analyst, presented the BCBSNC administrative costs audit results. This audit has been conducted by Thomas & Gibbs CPAs, PLLC, to determine the validity of BCBSNC's administrative charges under the Cost Plus contract that ended June 30, 2013, and ensure the Plan doesn't reimburse BCBSNC for unallowed costs. The most recent audit also included a review of charges to ensure the Plan wasn't billed for implementation costs associated with the new BCBSNC contract effective July 1, 2013.

The audit found that administrative costs of $108.3 million were less than administrative costs in the prior year and less than the overall cost plus cap established for the fiscal year.

Tracy Stephenson, Director of Pharmacy Benefits, presented the pharmacy audit results. The quarterly financial audit is conducted by The Segal Company to verify that the Pharmacy Benefit Manager (PBM) has adjudicated pharmacy claims consistent with the pricing terms in the contract and to determine if the PBM met the financial performance guarantees. The audit components consist of invoice reconciliation, claims average wholesale price (AWP) audit, dispensing fees audit, discount guarantees audit and duplicate claims identification. No issues were noted in the invoice reconciliation, AWP, specialty drug discount or duplicate claims areas. Shortfalls were noted in the dispensing fees and the aggregate achieved discount areas and the PBM was required to pay the Plan $4.5 million.

The quarterly pharmacy claims audit is conducted by Thomas & Gibbs CPAs, PLLC, to determine if claims are processed and paid by the PBM according to the terms of the contract and to determine whether the PBM met the claims accuracy performance guarantee. The audit found that the PBM met the performance guarantees in each area.

The annual pharmacy rebate audit is conducted by The Segal Company for the purpose of verifying that contractual requirements between the Plan and PBM have been met and that payments provided under the Plan's rebate payment agreement validate rebate history. The Plan received rebate payments as contracted for the top eight manufacturers audited.

Caroline Smart, Director of Health Plan Operations, presented the Early Retiree Reinsurance Program (ERRP) audit results. The audit was conducted by the Centers for Medicare and Medicaid Services (CMS). The Plan received $87 million in ERRP reimbursements for early retirees with incurred claims between $15,000 and $90,000 in June 2010 to December 2011. The program requirements portion was completed in 2012 and the claims audit for medical and pharmacy was conducted in February 2014. Audit findings determined that the Plan was overpaid by $1,949.29 and payment was promptly reimbursed by the Plan.

Agenda Item – Legislative Update
Presented by Nidu Menon, Director of Integrated Health Management, and Sally Morton, Clinical Pharmacist

Diabetes and Chronic Disease Legislative Reports
Session Law 2013-192 (Senate Bill 336) required the Divisions of Medical Assistance and Public Health and the State Health Plan to coordinate the diabetes programs which are administered by each division. Session Law 2013-207 (House Bill 459) required the same divisions to collaborate to reduce chronic diseases and improve care coordination within NC. Reports are due to the Legislature on or before January 1, 2015, and on January 1 of each odd-numbered year thereafter.

Dr. Menon and Dr. Morton reviewed the required report components and the current coordination for diabetes prevention and control. Action items developed by the divisions were also presented and include the development of a combined campaign to increase awareness of pre-diabetes and diabetes; evaluation and enhancement of the Plan's benefit design and DMA's covered plans; the promotion of third party coverage of Diabetes Prevention Lifestyle Change Programs for people with pre-diabetes; support for a statewide network of DSME providers; and establishment of common quality metrics.

The current coordination of chronic disease management includes tobacco prevention and control, weight loss, heart disease and stroke prevention, asthma management and all diabetes related coordination. Action items include the continuance of QuitlineNC management for tobacco users who want to quit smoking; promotion of QuitlineNC to ensure people are aware of the services available; the support of the development and dissemination of a comprehensive "Know your Numbers" campaign; promotion and delivery of evidence-based weight management programs; expansion of the current transition of care programs to address hospital and emergency admission and re-admission rates; and continued exploration of opportunities for pharmacists to work with providers to manage chronic conditions.

The State Health Plan is responsible for the value-based benefit design review, medication therapy management vendor resource evaluation and the financial analysis of services identified by the Plan as essential for offering transitional care support and the patient centered medical home (PCMH) coordination. The Plan will also evaluate and propose a reimbursement methodology to pay pharmacists and/or vendors based on clinical outcomes and performance.

Expected outcomes include early detection and screening of breast and cervical cancer, cardiovascular disease risk factors and renal disease; increased cost savings from reduced hospital utilization; improved medication adherence; increased referrals to and participation in smoking cessation programs; and

expanded transitional care programs to reduce inpatient and emergency department re-admissions for high-priority Plan members.

Agenda Item – Wrap-Up
Presented by Genell Moore, Vice-Chair

Ms. Moore stated that the Friday session would focus on 2016 benefit changes.

Mr. Huffstetler requested a summary of board membership terms which will be provided to the board by Andrew Holton via email.

The meeting was adjourned at 6:20 p.m.

Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
November 21, 2014

The meeting of the Board of Trustees of the North Carolina State Health Plan for Teachers and State Employees was called to order at approximately 9:00 a.m. on Friday, November 21, 2014, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

Members Present:
Vice-Chair Genell Moore
Lee Roberts
V. Kim Hargett
Noah Huffstetler
Charles Johnson
Bill Medlin
David Rubin
Warren Newton, MD

Absent:
Janet Cowell, Chair
Paul Cunningham

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Glenda Adams, David Boerner, Mark Collins, Kathryn Keogh, Nidu Menon, Meaghan O'Neal, Sally Morton, Lorraine Munk, Dorothy Brown Smith, Tracy Stephenson, Andrew Holton, Tony Solari

Welcome
Genell Moore, Vice-Chair, welcomed Board members and State Health Plan and Department of State Treasurer staff to the meeting.

Agenda Item – Conflict of Interest Statement
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Agenda Item – Benefit Design, Plan Options and Premiums

2016 Benefit Planning

Comparative Analysis of State Health Plans
Presented by Thomas Friedman, Legislative Liaison and Policy Analyst

A comparative analysis of other state health plans was initially presented to the board, at their request, in March 2014. That presentation was updated to include an analysis by Segal of plan richness and premium cost sharing, healthy lifestyle benefits and the number of choices other plans provide.

Strategies to improve member health, member experience and affordability (Triple Aim) in other states were presented. Benefit offerings and program initiatives and the administration of those programs, provider networks and payment methods to reduce costs were discussed. States included in the comparative analysis included Georgia, Kentucky, Tennessee, South Carolina, Virginia, Arizona, Maryland, Michigan, Ohio, Wisconsin, Connecticut, Minnesota, Oregon and West Virginia. Some were used to compare to North Carolina based on proximity, others based on population size and several others who have incorporated value based initiatives into their plan option(s).

Plan richness included a review of the out-of-pocket (OOP) costs a member pays, including deductibles, coinsurance, premiums and copays. The highest and lowest premium offerings available in other states were benchmarked against the Plan's 80/20 option. The relative value of NC's plan designs has increased as some states are offering less rich options and plan designs. The CDHP offers a relatively rich benefit but only 3% of Plan members have chosen that option. Mr. Friedman noted that few dependents are covered by the Plan and that number might change if dependent premiums were lower.

Based on individual coverage, the Plan's CDHP is the 2nd most generous plan included in the comparative analysis. The 70/30 plan is slightly higher in value based on the fact that it's premium-free. A question for the board to consider is whether the Plan should have two plan options so close together in value, i.e., the Enhanced 80/20 and Traditional 70/30 Plans. Looking at the overall plan value based on dependent coverage, the three NC plan options rank at the low end of the comparative analysis. Mr. Friedman noted that the State contributes between 39% and 47% of the cost of family premiums through the State's employer contribution.

Several board members agreed that members might choose a different plan if that option included a narrow provider network that was more affordable. One board member noted that Plan members want choice but might require guidance, such as a flowchart, to assist them in choosing the option that would work best for them. Mr. Friedman noted that some states have online "classes" to assist members in choosing their health care plan.

More state plans continue to incorporate lifestyle benefits into their plan options with the intent of reducing health care costs and to increase member engagement and accountability. The comparative analysis indicated that 80% of the states have at least one healthy living benefit in place. Some require healthy action steps in order to enroll in the richer benefit options. States that utilize health assessments increased from last year. In answer to a question from a board member, Mr. Friedman stated that cost savings related to healthy lifestyle initiatives are difficult to analyze. However, in completing the state comparative analysis, it was clear that other states intend to continue wellness programs.

Meaningful member choice will most likely continue to be a topic of discussion for states as they design plan options. Approaches include the number of vendors, premium rates, number of plan offerings and the scope of differentiation between each plan option. The number of plan offerings in the state analysis varied from 1 to 7.

Plan staff examined three states that have incorporated different components of value-based insurance design in their benefit offerings. Results of the review indicated that there are several ways to incent value within a plan option and that there doesn't appear to be a consistent model for implementing a value-based design. Components in this type of model include tiered networks/benefits by network, enrollment tied to participation in programs, reducing/removing copays, focus on a PCMH and end of life care.

Mr. Friedman presented different value-based incentives and requirements implemented in Connecticut, Oregon, Minnesota and West Virginia. He also noted that innovative plan design solutions in Tennessee and Kentucky are attempting to bend the health care curve in different ways. Members in both states are required to complete health assessments in order to enroll in the lowest premium option or the most generous plan offerings. Tennessee also requires biometric screenings to enroll in the lowest premium plan and Kentucky requires that members keep contact information current and complete healthy activities in order to enroll in the generous plan offerings.

Mr. Friedman summarized the comparative analysis by stating that states have not determined a consistent plan that works best. The State Health Plan benefit options are now more generous than in 2012 and the Plan is near the front of the curve in integrating value-based. Most states are developing programs that provide choice and are implementing incentives to promote healthy behavior and member engagement. The trend of utilizing multiple third party administrator and other vendors is increasing in some states.

Next steps and questions for the board to consider include determining plan options for 2016, reviewing potential opportunities in the market, demonstrating differentiation within the plan offerings and changing vendor arrangements to afford the opportunity for greater flexibility.

ACA Impact of Benefit Planning
Presented by Richard Johnson, Sr. Vice-President, The Segal Company

Mr. Johnson reviewed the timeline of future ACA requirements for employers and health plans. The temporary reinsurance program fee of $63 for covered lives in 2014 does affect the Plan and the required paperwork is under way. The Plan will begin reporting 2015 coverage offered to full-time employees in 2016.

The most significant ACA requirement is the 40% excise tax on high cost health plans. The cost threshold in 2018 of $10,200 for individuals and $27,500 for families is based on the total cost of coverage – employee + employer contribution. The thresholds are slightly higher for retirees and those in high risk professions. No regional adjustments are made for the cost of medical care. Thresholds will increase if the actual cost of health care in the U.S. between 2010 and 2018 exceeds the projected growth. To avoid reaching the threshold, the value of the plan itself must be lowered. Shifting premium cost sharing to members does not lower the value of the plan; the benefits have to be reduced.

Based on very basic, non-actuarial numbers, Segal predicts that the 80/20 plan would hit the individual threshold by 2024. This projection assumes a 7.5% trend increase in overall plan cost. Mr. Johnson stated that Congress is strongly pushing for all health plans to be taxed because of it being a rather

significant funding source. In response to a question by a board member, Mr. Johnson stated that Segal hasn't developed a projected model of the financial impact but could do so at the Plan's request. He also suggested that since the majority of health benefits will be taxable if the law stands, the board should consider ways to minimize spending and keep costs down as the 2016 benefit plan design changes are discussed.

Various strategies for avoiding the excise tax were presented and discussed. The calculation strategy would include a review of all pre-tax benefits available to members and which would apply to the excise tax. The most important question is which plan would take precedence in the event of an excise tax issue. Cost control strategies, where possible, would include vendor, health and plan design management. Some states are moving to multiple third party administrators. Another area in which to control costs and which the Plan and board have discussed at length is member engagement and accountability.

The Plan could also consider a carve-out plan for retirees. In doing this, plan options could be designed to meet the specific needs of both active and retired employees. Many ACA requirements would be avoided for retirees if no active members were included in the retiree plans. Carving out the membership in this way might provide better insight regarding actual costs for both groups. The total cost for active employees would most likely be lower.

The last excise tax implication to consider is Medicaid and the impact on the Plan. North Carolina was one of 21 states that chose not to move forward with Medicaid expansion to 133% of the Federal poverty level. That would have increased the number of citizens eligible for Medicaid, putting pressure on the State budget. It would force discussions on how Medicaid care is delivered.

Even if North Carolina doesn't move forward to expand Medicaid, more citizens will most likely become eligible for Medicaid benefits and Medicaid enrollment will grow. Lower paid employees and their dependents in the Plan may meet the Medicaid eligibility requirements. As employers trim benefits to avoid the excise tax, more of the lower paid employees may find Medicaid coverage a better option. The Plan doesn't currently have the percent of Plan-eligible employees who meet the poverty level or the percent of members eligible for subsidies through the Exchange. Mr. Alexander, Director of the Office of State Human Resources, stated that it may be close to 800 and that without the Plan's wellness incentives to reduce the premiums, it would be hard for many employees to afford the premium.

Ms. Moon stated that the purpose of this presentation was to provide the board with information to consider for future benefit design changes and not recommendations from either the Plan or Segal.

Benefit Design Options for Achieving Strategic Priorities
Presented by Mona Moon, Executive Administrator, Nidu Menon, Director of Integrated Management, Tracy Stephenson, Director of Pharmacy Benefits, and Thomas Friedman, Legislative Liaison and Policy Analyst

The Plan will need direction from the board in several areas in order to develop a strategy for 2016-17 and provide the Office of State Budget and Management (OSBM) with appropriate budget numbers. Plan staff reviewed the strategic plan's guiding principles and key initiatives to determine priorities for the next biennium and beyond.

Members have significant opportunities around primary care provider (PCP) visits and healthy behavior. It depends on whether the member is engaged and chooses to participate in all the wellness activities and use their designated PCP or if the member is non-engaged. The question for the board to consider

is whether or not to create more differentiation in the plan options. The difference between the engaged members in the richest CDHP and the least rich 70/30 plan is 16% in terms of relative value. The difference is even greater between the engaged CDHP and the non-engaged 80/20 plan. However, the relative value difference between the 70/30 plan and the non-engaged 80/20 plan is only 5%. The engaged CDHP is an unusual example of a plan which has rich benefits for less money.

On the family side, engaged members could receive the richest overall benefit plan. The relative value for the engaged employees and their dependents in the CDHP is 36% higher than in the non-engaged enhanced 80/20 family plan. One option for the board to consider is to further enhance the Enhanced 80/20 plan for engaged members who prefer the copay model.

Ms. Moon and Mr. Friedman discussed the value comparison points and asked the board to consider several questions. Those included whether the Plan offers members meaningful choices, if and how the current plan designs address the strategic plan, if and how much the benefit value should be modified and whether to have a plan option that does not incent engagement and if so, how that plan should be priced.

In response to a question regarding comparative pricing, Ms. Moon stated that the out-of-pocket expense for members varies dramatically. In the long term, a high utilizer would most likely come out ahead in the CDHP. Some members, however, prefer the 70/30 plan because of the pharmacy benefit and that there's not premium for employee only coverage. Several board members agreed that the educational aspect of the CDHP is important. Many members see the up-front costs and don't take the long-term picture into account. Furthermore, many members don't take the $500 HRA into account.

One of the goals in the wellness design is to reward engaged members in order to help them improve their health. The enhanced 80/20 and CDHP are the two plans that currently have that option. The original intent was to add incentives to the 70/30 plan and increase wellness premium credits and other healthy activities over time. The current financial forecast includes those assumptions and, ideally, the board will approve wellness activities and premium credit amounts through 2017. The question is whether the Plan should include an option for people who don't want to engage.

Dr. Menon presented the healthy activities and premium credits under consideration for 2016 through 2018. Some of the ideas included for 2016 were to add a spouse credit for tobacco attestation, self-reported biometric screening and member contact information. In 2017, the health assessment could include reporting biometrics by a lab or PCP, a PCMH selection, health literacy learning module and a health engagement program. Credits in 2018 could include completion of a tobacco cessation program, replacement of a PCP choice with a certified PCMH and preventive screenings for low and high risk members.

In summary, the Plan would like to strategically encourage members to become healthier and better consumers of health care through education and incentives. This multi-year process would allow members time to engage and allow the Plan time to accurately operationalize and administer the benefits. Several board members noted that Plan members are skeptical and want to see value in the direction the Plan is going. Education and communication for the motives behind decisions and goals along the way is a key component of success for both the Plan and members.

The board was asked to share their thoughts and consider the multi-year approach for healthy activities and premium credits, if the activities support the strategic plan, the appropriate number of activities that can be effectively communicated and if there are other ideas the Plan should consider implementing.

The board discussed the reasons for biometric screening and the possibility of tobacco attestation testing. Dr. Menon stated that completion of the health risk assessment and biometric screening, together, are necessary to determine the overall health status of the member. For instance, members with pre-diabetes could be identified and encouraged to make lifestyle changes and participate in programs to prevent further health problems. In response to a question from the board, Ms. Crabtree stated that the Plan had reviewed HIPAA laws and legal ramifications of targeting members in this way.

Ms. Moon stated that the Plan does not intend to implement testing for tobacco use. Testing was discussed in the past when the Comprehensive Wellness Initiative (CWI) was created but it was highly unpopular among many groups and members and potentially costly to the Plan. Ultimately the Plan did not implement testing as enrollment in the 70/30 plan was in line with expectations based on the number of estimated tobacco users.

One member noted that incentives for flu shots and immunization programs could be considered. Another member expressed support for the progression of incentives and that it is important for members to be aware of their biometric information. Another suggestion was to include a provider engagement strategy and requested staff to provide a strategy for that. Several board members agreed that the Plan should keep the incentives as simple and concise as possible.

The Plan also proposes a chronic disease engagement program for non-Medicare primary members focused on the treatment of diabetes, cardiovascular disease and asthma/COPD, all of which are prevalent among Plan members. Members would be able to earn reduced office visit and pharmacy copays by visiting their PCP or engaging in health coaching or testing. This value-based program would apply to members in the Enhanced 80/20 and CDHP beginning in 2016 and build on engagement in 2017 and 2018.

In summary, the Plan would like to build a culture of wellness by incenting and engaging both low and high risk members and provide a foundation for future plan enhancements. Different design incentives and programs will be required for low risk and high risk members.

Mr. Friedman presented various options for plan design differentiation, with focus on proposed changes in the 70/30 plan to provide a greater variance between that and the 80/20 plan. Deductibles and copays would increase in the 70/30 plan option. There would also be proposed pharmacy changes with increases in each of the tiers in the 70/30 plan and a decrease in Tier 1 of the 80/20 plan. There would be no proposed changes in the CDHP.

Mr. Friedman stated that if the Plan can keep members healthy by making the Plan more affordable, the cost trend will remain lower which should fit in well with some of the proposed changes. The Plan had to make some decisions around modeling the various scenarios to determine the trend assumption. One of the questions for the board to consider is whether the Plan is doing enough to reasonably lower the cost trend. The Plan will continue discussions with Segal regarding lowering premiums and financial modeling.

Other design considerations that require further discussion include the possibility of a salary-based premium schedule, retiree plan options, such as Medigap, specialty pharmacy management, maternity coverage for dependents and Telehealth.

Following a motion by Warren Newton and seconded Mr. Medlin, the board voted unanimously to move into executive session, pursuant to G.S. 143-318.11 and G.S. 132-1.2. A legal question was raised regarding whether the lawsuit filed by the Governor against members of the General Assembly and the

Coal Ash Commission could have an impact on the Plan's board. Legal Counsel will review that issue for the Board.

Agenda Item – Executive Session

Pharmacy Benefit Management Core Audit Services Contract
Presented by Tracy Stephenson, Director of Pharmacy Benefits

Ms. Stephenson presented the procurement of the Pharmacy Benefit Management audit services. In response to a question by a board member, Ms. Stephenson responded that bidders who weren't awarded the contract could appeal the decision.

Two board members felt it would be helpful to have a list of vendors with whom the Plan has a contract in order for board members to avoid conflicts of interest. Ms. Crabtree stated that a list would be made available to board members.

Board members also requested that members of the audience be recognized by the Chair and identify themselves and the organization they represent when requesting to speak during board meetings.

Following a motion by Dr. Newton and seconded by Mr. Huffstetler, the board voted unanimously to return to open session.

Agenda Item – Benefit Design, Plan Options and Premiums, con't.

Final Benefit Approvals for 2015
Presented by Lotta Crabtree

ACA Preventive Services – The CDHP is a non-grandfathered plan that must comply with ACA preventive requirements. The board previously approved coverage for ACA preventive services at $0 for members in the grandfathered Enhanced 80/20 plan that does not have to comply with all of the ACA preventive service requirements.

In August, the board approved several breast cancer preventive medications under the CDHP and 80/20 plans as well as several interventions for tobacco cessation. Federal preventive care updates include recommended screening for Hepatitis C Virus (HCV) and 100% coverage for breast cancer assessment and genetic counseling. Annual lung cancer screening for members age 55-80 who have a 30 year history of smoking, and currently smoke, or who have quit within the past 15 years is also recommended under federal preventive care guidelines. Other federal recommendations include oral fluoride supplements for preschool children over 6 months of age and the provision of tobacco interventions for school age children and adolescents over 5 years of age.

One board member expressed concern regarding the potential costs involved with Hepatitis C virus and lung cancer screenings depending on the number of at-risk members who might get multiple screenings. The total financial impact analysis from Segal to cover all the preventive services at 100% is approximately $622,000 for 2015 but the board felt that number could be significantly higher. Ms. Moon stated that the Plan would continue internal discussions regarding Hepatitis C Virus and lung cancer screenings and provide more information at the next board meeting.

Ms. Crabtree noted that the Plan would incur penalties for members on the CDHP at a cost of $100 per member per day for non-coverage of ACA preventive service requirements. The effective date of coverage would be January 1, 2015.

Following a motion by Mr. Medlin and seconded by Ms. Hargett, the board voted unanimously to approve coverage for preventive services described in the presentation under the CDHP and Enhanced 80/20 plans.

High Deductible Health Plan – At the August meeting, the board approved an alternative benefit option to comply with General Statute 135-48.40(e). Ms. Crabtree provided an overview of coverage, benefits and exclusions in the high deductible health plan (HDHP). She noted that the HDHP has fewer utilization management (UM) programs but does provide ACA preventive services covered at 100%. There are a few circumstances where coverage for certain services differs from what has traditionally been covered under other plans and Plan staff is seeking approval for those differences.

Plan staff recommended coverage for the replacement of teeth lost as a result of chemotherapy or radiation and bariatric surgery subject to UM. In addition, the exclusion of applied behavior analysis (ABA) was also recommended. Finally, neutral benefit coverage for emergency services, emergency medical transportation, urgent care, skilled nursing care, durable medical equipment, hospice services and home health care was recommended by Plan staff.

Following a motion by Mr. Huffstetler and seconded by Dr. Rubin, the board voted unanimously to approve coverage under the HDHP as described in the Benefits Booklet, effective January 1, 2015.

Implementation of Applied Behavior Analysis (ABA) Benefit

The board approved applied behavior analysis coverage with certain limitations at the May 2014 board meeting. The Plan is working with BCBSNC to implement the benefit on January 1, 2015. Customer service training, for both member and provider representatives, has been completed. Benefit information has been posted on the BCBSNC provider portal and promotional information was emailed to all in-network providers at the end of October.

Non-network providers who call BCBSNC will receive information about the benefit through the interactive voice response system. A transfer protocol from customer service to BCBSNC Network Management has been set up if non-network providers want additional information about network requirements, credentialing or joining the network.

Agenda Item – Strategic Planning

Strategic Plan Scorecard – Measuring Success

Presented by Thomas Friedman, Policy Analyst and Legislative Liaison

The strategic plan includes metrics to evaluate Plan progress in achieving goals set forth in the strategic plan. The metrics and targets were established to address the needs of Plan members and stakeholders. Several metrics will require collaboration with Plan vendors to measure results.

Mr. Friedman reviewed the approved metrics for the strategic priorities – improving members' health and experience and ensuring a financially stable Plan. The metrics for improving members' health are aimed at meeting the goals of healthier, more engaged members and better managed chronic diseases. Measurements for improving the members' experience will hopefully lead to increased engagement and

a higher level of member trust. Meeting the goals for a financially stable Plan will lead to reduced member costs, fraud, waste and abuse, appropriate care delivery and payment for quality and value.

Mr. Friedman summarized the proposed methodology for strategic measurements. The benchmark periods will be FY 2012-13 and CY 2014 to reflect two full plan years. Success will be measured by meeting at least two of three priority groupings. The summary scorecard will be a high level summary of the detailed analysis. A scorecard for each strategic priority will provide the metrics detail for each description.

Next steps will include a review of CY 2014 results, establishing 2015 threshold/targets/stretch goals and a discussion of how the CY 2016 plan options might impact the areas of focus. At the request of the board, the Plan will develop a simple one page summary outlining the goals and whether or not the targets were met.

The Plan will continue to work on the tracking process and present the information to the board at the January or May board meeting.

Workgroups and Next Steps
Presented by Mona Moon, Executive Administrator

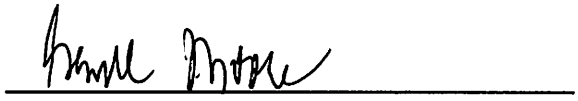
The Plan proposes a restructure of the workgroups by creating operational and strategic groups to address the different aspects of the approved strategic plan. Regular board meetings will be scheduled quarterly rather than bi-monthly and additional meetings will be scheduled, as necessary, to address Plan business. Ms. Moon stated that an additional 3-hour meeting in late January or early February will be required for 2016 benefits approval. The board was asked to respond to the proposed meeting dates before the end of November.

The Plan proposes workgroup meetings once every 2-3 weeks between regular board meetings. These meetings could be conducted via conference call or WebEx rather than in person. Ms. Moon noted that workgroup meetings would be scheduled in December and January to discuss value-based insurance design (V-BID) and would include Dr. Fendrick and David Edman, V-BID consultants. The original strategic planning workgroup will also meet, via phone, during the week of December 2 as schedules permit. The Plan will meet with stakeholder groups before the January regular board meeting to provide feedback on proposed benefit changes.

In response to a question from a board member regarding the Plan's legislative agenda, Ms. Moon stated that the Plan will have a short list of statutory changes and will discuss those items with the Member and Legislative Outreach workgroup.

Agenda Item – Wrap-Up
Presented by Genell Moore, Vice-Chair

Following a motion by Mr. Johnson and seconded by Ms. Hargett, the board voted unanimously to adjourn the meeting at 2:30 p.m.



Genell Moore, Vice-Chair