Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
March 27, 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, March 27, 2014, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

Members Present:
Chair Janet Cowell
Tony Gurley (for Art Pope)
Paul Cunningham
V. Kim Hargett
Noah Huffstetler
Charles Johnson
Bill Medlin
Vice-Chair Genell Moore
David Rubin
Warren Newton, MD

State Health Plan Staff: Mona Moon, Lotta Crabtree, Mark Collins, Thomas Friedman, Beth Horner, Nidu Menon, Lorraine Munk, Caroline Smart, Tracy Stephenson

Department of State Treasurer Staff: Andrew Holton, Fran Lawrence, Joanne McDaniel, Tony Solari

Welcome
Treasurer Janet Cowell, Chair, welcomed Board members, State Health Plan and Department of State Treasurer staff to the meeting and introduced Mr. Tony Gurley, Chief Operating Officer at the Office of State Budget and Management. Mr. Gurley represented State Budget Director Art Pope, who was unable to attend the meeting.

Agenda Item - Conflict of Interest Statement
In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, Chair Cowell read the "Conflict of Interest Statement" requesting members who have either an actual or perceived conflict of interest to identify the conflict and refrain from discussion and voting in those matters as appropriate. Mr. Huffstetler stated that he would recuse himself from the first item of discussion in Executive Session and asked the Chair and board to consider modifying the agenda to accommodate his request to discuss the Lake lawsuit first. The board and Chair unanimously agreed to change the agenda.

Review of Minutes
Following a motion by Mr. Medlin and seconded by Ms. Moore, the board unanimously approved the minutes from the January 31, 2014, regular meeting and the March 12, 2014, teleconference.

Strategic Planning Progress Update
Presented by Tom Gualtieri-Reed, Strategic Planning Facilitator for Board of Trustees

Mr. Gualtieri-Reed stated that the board has made great progress on the environmental scan and that Plan staff was moving forward to refine the analytical pieces. The focus is to prioritize input from the board, staff and others to define the measures and thanked Ms. Moore and Ms. Hargett for their solicited feedback on the draft of Plan measures and priorities.

He noted that the challenge for staff continues to be balancing the normal Plan operational workload and priorities while developing the strategic goals and measures. The timing of moving forward with benefit decisions for 2015 before the strategic plan is completed remains a concern.

The four primary goals for the Plan to address over the next 5-10 years are financial, quality of care, member health and member experience. In answer to a question from the board, Ms. Moon stated that over the next few weeks, version 1 of the strategic plan will be developed with the framework that demonstrates ways in which to reach the goals. The first iteration will include the specifics of what has been accomplished to date and other ideas the board would like to consider. The intent is to bring the broader discussions over the past year into a balanced approach.

Organizational and Legislative Update
Presented by Mona Moon, Executive Administrator

Ms. Moon stated that in the past two weeks, the Plan's executive committee and clinical pharmacist have interviewed medical director candidates to replace Dr. Prentice who retired in January. The Plan is on track to have the position filled by the end of April. Ms. Moon expressed a desire for Dr. Newton and Dr. Cunningham to speak with the final candidate(s) via phone before an offer is made.

A position for the State Health Plan Global Benefits Communication Director will be posted soon. This position would have dual reporting to the Department's chief of staff and Plan's executive administrator. Responsibilities include the management of communications and community and member outreach for the Department.

The Plan will also recruit for a Director of Policy, Planning and Analysis, the position formerly titled Director of Product Development. This person will oversee the financial and health policy areas, coordinate the internal director-level work plans, build and foster external relationships, coordinate meeting requests from external vendors and work with the board and Plan in the ongoing development of the strategic plan. The financial analyst and legislative liaison/health policy analyst will report to this position. Ms. Moon anticipates posting the job in April.

The Plan currently has four temporary staff members in the Operations area assisting with fielding member calls. A project manager, through the Plan's contract with HTMS, has been onsite to assist with the implementation process. The Plan recently received approval from the N.C. Department of Purchase and Contract (P&C) to add four additional positions, a project manager and three business analysts, through HTMS to assist with the new benefit plans as they relate to contracts, customer service and vendor management.

Through a contract with the Department and the UNC School of Government, the Plan has asked for UNC staff to conduct an assessment of the data and analytics area, including staffing, systems and reporting. That analysis may generate staffing changes and/or new positions. Depending on the process timeline, an update may be provided to the board at the May meeting.

Mr. Gurley stated that because of the substantial financial shortfall within the Department of Health and Human Services, state agencies would be asked to reduce spending, including the hiring of new positions. Ms. Moon stated that the Plan would work with the Department's Financial Operations Division to determine the impact on Plan staffing.

Ms. Moon stated that the Plan has no formal legislative agenda for the short session but will monitor several pending bills, including autism coverage. The Plan will also consider coverage options for newly eligible employees under the Affordable Care Act. She noted that during the 2013-2014 long session, SL 2013-382 (HB834) directed the Plan to "establish a workgroup to examine the best way to provide teachers and State employees greater transparency in the costs of health services provided under the State Health Plan." The Transparency Workgroup met on March 21 and anticipates meeting approximately four or five times over the next several months. Annual reports will be provided to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Committee on Governmental Operations through 2016.

Other than autism coverage, the Plan is not currently considering other benefit changes in 2015. The Plan will continue to seek guidance from the board regarding autism coverage and the potential timing of implementation.

At this point in the meeting, Dr. Cunningham arrived and noted no conflict of interest.

Pharmacy Report
Presented by Tracy Stephenson, Director of Pharmacy Benefits

Non-Preferred Specialty Pharmacy Tier
In January 2013, the board approved the creation of a new non-preferred tier on the Preferred Drug List for the anticipation of Biosimilar medications. In July 2013, the Plan received board approval for member cost sharing for the new tier – 25% coinsurance up to $150 maximum for a 30-day supply, which was implemented in January 2014 for the Traditional and Enhanced plans. Both of these plans are grandfathered (GF) under the ACA and to maintain that status, the Plan determined that the $50 increase in coinsurance maximum was beyond the amount allowed to retain grandfather status for both plans. Plan staff recommended lowering the $150 coinsurance to $125, which would allow both plans to remain grandfathered. The estimated cost impact of lowering the member coinsurance maximum to $125 is approximately $236,000 to $360,000 less than projected over the next four years. Ms. Stephenson stated that if the board approves the change, impacted members would receive a refund.

Following a motion by Dr. Cunningham and seconded by Mr. Huffstetler, the board unanimously voted to approve lowering the coinsurance maximum from $150 to $125 for Tier 5 non-preferred specialty medications for the Traditional and Enhanced plans.

One board member asked if there might be other imminent threats to the Plan's grandfather status. Ms. Moon stated that the Plan doesn't anticipate losing grandfather status in the short term but that it may be harder to maintain that status over the long term. The Plan's current benefit design and overall financial trends will both contribute to the Plan's ability to maintain grandfather status.

Pharmacy and Therapeutics Committee Meeting Summary
The Pharmacy & Therapeutics (P&T) committee met on February 11, 2014, and Ms. Stephenson highlighted the updates for several utilization management programs, including the cost impact for some of the new and revised programs. She noted that the Plan would work with members to minimize the impact.

Several new drugs were presented to the Committee for formulary consideration. Three of the drugs determined to have no clinical advantage were placed on tier 3 and two of the drugs were added under tier 2.

Potential Autism Spectrum Disorder Benefit
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance

Ms. Crabtree stated that the Plan was working with Blue Cross and Blue Shield of North Carolina (BCBSNC) to evaluate the network and design an autism benefit which would include applied behavioral analysis (ABA) therapy. The Plan, at the board's request, also met with several local experts to better understand autism treatment and the roles of different service providers. She stated that the actuarial analysis for House Bill 498 projects annual costs to be $2.5 million - $5.1 million in 2014-15 and $6.1 million - $12.7 million within the next five to six years.

The goal is to provide members with a benefit that covers treatment for Autism Spectrum Disorder that will assist in maximizing independence and improve their quality of life. While there is no cure for autism, experts feel that ABA therapy is very beneficial.

The current draft of the Plan's proposed benefit design and the comparison to language in HB 498 were discussed. The components of the benefit include age requirements, utilization management, diagnosis of care, providers of treatment, board certified behavior analysts, therapeutic care and the annual benefit maximum. In response to discussions with autism treatment experts, some of the language under various components was broadened from that contained in HB 498.

A board member raised a concern regarding the accuracy of an autism diagnosis. There was agreement that even though therapy works to varying degrees, the diagnosis may not always be accurate. Another concern raised was the determination as to how many hours per week are needed for ABA treatment. Ms. Crabtree acknowledged that more research is needed regarding medical necessity and network access. She also stated that the Plan's proposed language would be shared with TEACCH, one of the groups with whom the Plan consulted.

The board concurred that some level of treatment should be covered by the Plan. They also felt that it was important to consider outcome measures and to ensure that access is regional and not limited to certain areas.

Communications Report
Presented by Caroline Smart, Director of Health Plan Operations

New Medicare Primary Outreach Program
The Plan will implement a new Medicare Primary Outreach Program to assist members, partners and HBRs in better understanding the Medicare Advantage plan options. A communications plan is being developed and will be shared with the Member Outreach workgroup, as well as with the Plan's Roundtable group who will be meeting in April.

During the open enrollment process and since it concluded, it became evident that there is no substitute for face to face meetings. Delivering the message in person, answering questions and assisting members with the enrollment process is a valuable service, both in the short and long term. The Plan has also determined the importance of training its partners, i.e. Seniors Health Insurance Information

Program (SHIIP) and the Retirement Division staff to ensure the message is consistent and that everyone has the same material.

Ms. Smart presented a map which demonstrated the highest concentration of members turning age 65 and stated that these are areas that will be included in the 40 outreach meetings that will take place in 2014. New retirees must have their retirement papers approved at least 60 days prior to the effective date of retiree health coverage. The effective date of coverage is one month following the effective date of retirement. Ms. Smart noted that the Plan sends information to members turning 65 ninety days prior to their 65th birthday.

In addition to member outreach meetings, the Plan will continue to communicate through newsletters and email alerts. HBR webinars will be conducted to assist members who will be turning 65 and they will also be invited to attend educational sessions.

The open enrollment process for 2015 will be presented at the May board meeting.

Financial Report

Due to time constraints, the board and Plan staff agreed to incorporate the Financial Report with the Financial Modeling presentation during the Friday session.

Executive Session

Following a motion by Dr. Rubin and seconded by Charles Johnson, the board voted unanimously to move into executive session.

Lake Lawsuit
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance

Ms. Crabtree stated that oral arguments were presented in March. A legal analysis of the argument and next steps were discussed. Ms. Crabtree will send the list of panel members to Mr. Huffstetler. A decision on the case is expected by the end of June. The parties have agreed to move forward with mediation.

Consultation with Legal Counsel – Contract Issue
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance

Due to a potential conflict of interest, Mr. Huffstetler recused himself from the discussion.

Ms. Crabtree distributed information to board members which the board discussed in detail.

Following a motion by Dr. Cunningham and seconded by Dr. Rubin, the board voted unanimously to move into open session.

The meeting was adjourned at 6:35 p.m.

Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
March 28, 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, March 28, 2014, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

Members Present:
Chair Janet Cowell
Tony Gurley (for Art Pope)
Paul Cunningham
V. Kim Hargett
Noah Huffstetler
Charles Johnson
Vice-Chair Genell Moore
David Rubin
Warren Newton, MD

Absent:
Art Pope
Bill Medlin

State Health Plan Staff: Mona Moon, Lotta Crabtree, Mark Collins, Thomas Friedman, Beth Horner, Nidu Menon, Lorraine Munk, Caroline Smart, Tracy Stephenson

Department of State Treasurer Staff: Andrew Holton, Fran Lawrence, Joanne McDaniel, Tony Solari

Welcome
Treasurer Janet Cowell, Chair, welcomed Board members, State Health Plan and Department of State Treasurer staff to the meeting.

Agenda Item - Conflict of Interest Statement
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Affordable Care Act

How ACA is Changing Employer Health Benefits and the Marketplace
Presented by Rick Johnson, Segal Consulting

Mr. Johnson gave an overview of the presentation to be given and stated that the purpose was to assist in understanding this complex law and talk about how the Affordable Care Act (ACA) is changing the marketplace and employer approaches to health benefits. Mr. Johnson presented the mandates and requirements under the ACA and stated that the goal is to extend health insurance coverage to all

American citizens. Individuals can have coverage with minimum essential benefits or pay a tax penalty. Employers must provide a minimum level of affordable coverage to all full-time employees or pay tax penalties. Fully insured policies must have no pre-existing conditions limitations and carriers must adhere to limits on profit margins.

The penalty for individuals in 2014 is $95 per adult or 1% of their income and $695 per adult or 2.5% of income in 2016. There will be no penalties if the cost of coverage is more than 8% of household income; if there are lapses in coverage three months or less; if income is less than the threshold for income tax filing; or for Native Americans.

Employer penalties apply to employers with more than 50 employees who work more than 30 hours per week. Employees must have access to at least one reasonably affordable plan of coverage for themselves and dependent children. If a full-time employee receives a federal subsidy, a penalty is assessed to the employer. If a large employer does not offer minimum essential coverage to at least 95% of its full-time employees, the penalty is $2,000 times the number of eligible employees minus the first 30 workers. If the employer offers coverage that is not reasonably affordable or not of minimum value and one full-time employee receives federal subsidized coverage, a penalty of $3,000 times the number of full-time employees getting a tax credit is assessed to the employer. Mr. Johnson noted that under a February 10, 2014, transition rule, large employers with 100 or more employees must offer coverage to at least 70% of employees in 2015 and 95% beginning in 2016.

Eligibility has been redefined when considering seasonal and part-time employees with multiple part-time positions and college adjunct faculty working full-time but previously not eligible for benefits. Special plans may need to be put in place for these employees as federal law requires a minimum benefit plan that is reasonably affordable.

The board discussed grandfather status and changes under the ACA. To retain GF status, plans cannot eliminate most or all benefits to diagnose and/or treat particular conditions. Health plans that increase deductibles and copays by an amount that exceeds the amount of medical inflation plus 15% will give up GF status. Mr. Johnson noted that only 20% of plans in place in March 2010 remain grandfathered today. A question was asked regarding the cost impact if the Plan gives up grandfather status. Ms. Moon stated that it would cost the Plan approximately $25 million-$30 million per year but that the Plan could be strategic about the timing of giving up that status.

Mr. Johnson addressed options for retiree coverage. Employers of retired employees will not be subject to the penalties. Retirees not eligible for Medicare can apply for coverage through the Exchange or Medicaid if their retirement pay is the only source of income. Employers could consider the carve-out of retirees to their own plans and trusts or pushing non-Medicare retirees to the Exchange. Private exchanges for Medicare retirees could be implemented similar to the public Exchange.

The total compensation philosophy was discussed. Limited budgets restrict plans on what they can subsidize and/or provide. Benefits play a role in attracting and retaining employees and with the definition of full-time benefit eligible employees changing, the workforce within an organization will also change. The tipping point between health plan costs and the state exchange policy has to be examined.

With large employer groups downsizing and transitioning to an increased number of part-time employees, the question was raised as to what state governments/public employers are doing. Mr. Johnson stated that nothing official was on record at this point. Concerns that many public employees work several part-time jobs which gives them full-time status have been discussed among the public sector. A question was asked regarding whether the Plan's data would show the number of members in

this category and whether a defined contribution structure could be implemented to maximize the benefits. Ms. Moon stated that the Plan doesn't have income information nor is there a way to determine if members have other employment. The board would like the Plan to be able to offer some type of option to these members.

Mr. Johnson presented information on Accountable Care Organizations (ACOs) which are formed by doctors, hospitals and other providers to receive incentives for coordinating the care of Medicare members and those with disabilities. There are approximately 360 approved ACOs nationwide with 14 in North Carolina. With the dramatic consolidation of hospitals and physicians in the past few years, there may be a difference in the contracting of services and that may force some changes in networks.

Medicaid expansion has been a topic of discussion at both the federal and state levels. Federal law states that Medicaid coverage could be expanded to 133% of the federal poverty level but it is left up to the states to determine whether or not to expand coverage. While putting more pressure on state budgets, expansion would also provide a way for states to bring in more Federal revenue. If states choose not to expand, it is likely that more people will be eligible for Medicaid benefits who never applied for Medicaid in the past. As of March 1, approximately 200,000 people had enrolled in the NC Exchange, the largest percent of any state in the country.

Mr. Johnson summarized by stating that the playing field has changed and states now have to work more closely with the Federal government to comply with health coverage regulations. The Exchanges have become a competitor for insurance companies, and public employers may have to make significant changes to plan eligibility and workforce composition. Employees are working longer and are less healthy, therefore costlier to cover.

The Plan can expect to have to provide coverage for newly eligible employees and will most likely lose grandfather status in the 80/20 and 70/30 plans at some point. There will be increased emphasis on Patient Centered Medical Homes (PCMH) and ACOs, as well as wellness based premiums. The Exchanges will become the norm by which plans are measured and the Plan may face pressure from incoming employees to remain on the Exchange rather than joining the Plan.

<u>Joint Study Committee on the ACA – March 18, 2014</u>
Presented by Mona Moon, Executive Administrator

Ms. Moon presented highlights of her presentation to the Joint Study Committee on the ACA. Under the ACA, the Plan received approximately $87 million in revenue from the Early Retiree Reinsurance Program. Increased expenditures due to the ACA are projected to be approximately $59 million through fiscal year 2015. The majority of the increase is attributed to the coverage of dependents up to age 26, reinsurance fees (payments to insurer with high risk pools) and the coverage of essential health benefits.

Grandfathering requirements were reviewed and discussed. Coverage of preventive medical services and prescription drugs covered at 100% were included in the requirements not applicable to grandfather plans. To maintain grandfather status in the 80/20 and 70/30 plans, the Plan had to limit certain benefit changes related to coinsurance, deductibles, copays and employer contributions. As of July 2011, waiting periods for pre-existing conditions were eliminated for members under age 19 and in January 2014 pre-existing conditions were excluded for all members under the ACA. In addition, retroactive disenrollment is not allowed except in the event of misrepresentation or fraud.

Ms. Moon also presented the potential impact of newly eligible employees. During the 2013 legislative session, the eligibility statute was modified, stating that in 2015, all employees working 30 or more hours per week would become eligible for Plan benefits. Permanent employees (as opposed to temporary employees) who work 30 hours were already eligible for annual leave and retirement benefits, as well as coverage under the Plan. Other states are trying to determine if there should be a differentiation between temporary and permanent employees and whether there should be a separate health plan benefit for temporary employees who are newly eligible under the ACA.

The university system and other employing units are interested in pursuing a less costly health benefit plan for employees that fall into this category, rather than offering the same options currently available to permanent full time employees. Approximately 8,000 University of North Carolina (UNC) employees fall into this group, along with another 7,000 to 8,000 employees in other state agencies, the public schools and community colleges. The Plan is working with the UNC system, Office of State Human Resources and Segal to develop a lower cost health benefit option for newly eligible employees. The Plan will continue to monitor federal ACA regulations and the potential impact on the Plan. An update on coverage for newly eligibles will be provided at the May board meeting. A statutory change may affect what type of coverage the Plan offers this group.

Follow-up – Provider Payment Methodologies & Strategies

Blue Cross and Blue Shield of North Carolina
Presented by Jack Kenley and Lisa Cade

With nearly 4 million members in the state, Blue Cross and Blue Shield of North Carolina (BCBSNC) has a strong network of providers but recognizes their responsibility to grow it. BCBSNC is moving away from Fee For Service (FFS) and productivity to value based quality outcomes and provider accountability.

BCBSNC actively supports the Patient Centered Medical Home (PCMH) concept and views primary care as a critical component to improving the health of members. The need for additional primary care providers in outlying areas around the state was emphasized.

BCBSNC has been a leader in the area of bundled payments and has adopted several options for members. There is a significant difference in the cost of bundled and unbundled payments. Ms. Cade provided the example of a knee replacement, stating that the bundled cost is approximately $24,000 vs. the unbundled cost of approximately $43,000. She added that consumers are learning more about bundled payment options and will begin to pressure employers to move in that direction. A question was asked where reference pricing, currently used in California, might fit in. BCBSNC will begin exploring that option later this year. One board member noted that the average Plan consumer doesn't know to ask about pricing or quality and emphasized the importance of the educational component.

BCBSNC is actively developing the Accountable Care Organization (ACO) model which will allow insurance companies and health care providers to integrate high quality affordable care. ACOs promote the relationship between the payer and provider to lower costs and improve the patient experience. The savings are distributed between the provider, payer and member.

Ms. Cade provided a state map demonstrating active initiatives and collaborations in 76 counties and noted that BCBSNC has network providers in all 100 counties. One of these initiatives is with FastMed Urgent Care which currently has 38 locations around the state. FastMed provides both urgent and primary care and has been very successful, especially in rural areas. A FastMed visit is approximately 90% less than an emergency room visit.

One board member asked about the strategy for encouraging Plan members to participate in the various options that might be available to them. Ms. Cade stated that it would depend on what could feasibly be implemented in each region and that further discussions and dialogue with providers, insurers and the Plan would be the first step. BCBSNC would also welcome further discussion regarding the support of outcomes in the regions without PCMHs.

Humana

Presented by Glen Champlin, Tim Moorhead, Anup Sharma and Keith Peele

Humana has made it a goal to improve the health of communities by 20% by the year 2020 based on measures developed with the Centers for Medicare and Medicaid Services (CMS). Humana has developed an accountable care continuum that rewards providers for quality outcomes. Humana believes that quality outcomes are about data management and that the Primary Care Provider (PCP) must take responsibility for managing the patient across the health care spectrum.

In the quality-only reward program, Humana members are assigned to a practice. The goal of the practice is to meet four of the six HEDIS measures at the CMS 5-star level in order to receive annual rewards payments. Practices can participate in one program at a time and measures can be adjusted based on CMS priorities. A critical component in rural areas is to find willing provider participants.

Humana's annual VAT survey, modeled after the CMS surveys and part of the Star Rewards measures, focuses on the member's experience with the provider. Areas on the survey include access to care, coordination of care and patient discussion. The results are provider driven and the annual satisfaction target rate is 80%.

The Model Practice Program includes HEDIS measures similar to the Star Rewards Program but also contains Humana's own quality clinical measures. The rewards are paid for meeting each individual measure achieved and are paid on a quarterly basis. A practice can participate in only one program at a time.

Mr. Champlin reviewed the accountable care continuum from paying for volume to paying for value. He stated that care management on the ground to provide member care coordination will produce immediate results. The shared savings components are 25-75% depending on the group.

The Medical Home concept targets higher functioning practices where the infrastructure is well defined and advanced technology is in place. The measures mirror those in the Model Practice concept with additional measures that focus on the full spectrum of patient care. The practice must meet targeted goals in order to be eligible for quarterly payments.

Humana's Physician Quality Rewards Program includes standard measures that have resulted in $60 million in rewards payments to practices throughout the country in 2013. Humana is driving attribution through product designs that require members participating in HMO products to select a PCP. Humana is aggressively pursuing risk arrangements and by 2017 50% of its HMO population will be in a risk arrangement and Humana will have its first risk partner in North Carolina as of January 1, 2015. Humana opined that Medicare Advantage Plans are the best tool CMS has to bend the cost curve.

UnitedHealthcare
Presented by John Rennick, MD, Garland Scott and Stephen Daniels

Mr. Daniels began by stating that in the past, members haven't been at the core of the health care delivery system and the success of changing that depends on the tools that are available to members and providers. He stated that UnitedHealthcare (UHC) has three areas of focus: ACOs, engagement and clinical programs. Physician FFS is transitioning to outcome-based payment models with UHC's products and network offerings.

Currently, $29 billion of UHC's reimbursements to hospitals, physicians and ancillary care are tied to value and performance based programs. Two million members are in accountable care and coordinated care models. By 2018, UHC's accountable care contracts are expected to total $65 billion.

Successful ACOs foster improved quality outcomes, reduce cost and provider better care. Consumers benefit from lower premiums and out-of-pocket expenses, as well as improved satisfaction. Providers see improved efficiency and payments are tied to value. The total cost of care for payers is reduced through increased provider efficiency. In North Carolina, UHC has 5 Medicare shared savings programs and a commercial ACO, as well as a Centers of Excellence network.

Developing ACOs is a very lengthy process and the organizational structure varies depending on the geographical location. As a part of the process, a detailed questionnaire must be completed by ACO candidates who are identified by local market and health plan leaders. The questionnaire contains both subjective and objective criteria.

Supporting providers in managing population risk requires a balance of information and tools for patient engagement from the provider and data and transparency tools from UHC. The practice must have physician leadership and the ability to coordinate care across all care settings. UHC must have a mechanism to administer incentive and innovative care management programs and member empowerment strategies.

UHC reiterated their commitment to value-based programs and stated that the accountable care platform can be customized according to the level of risk a provider is ready to assume. A broad network provides the ability for UHC to position itself in many markets with a variety of care providers. Comprehensive data and reporting is offered, as well as innovative mechanisms to distribute funds.

Dr. Rennick stated that the Premium Designation Program was implemented eight years ago. The program was established to evaluate physicians using evidence based guidelines and national industry standards. Claims information and other data sources are used to measure provider efficiency and cost of care.

Thirty-five percent of a provider's population is working to become healthy and 50% are deemed healthy. Members who are categorized as healthy have wellness tools and resources available to them including an online health portal, telephonic health coaching, publications and a pregnancy program. Patients who are trying to become healthy have access to urgent needs support, condition education, treatment decision support and holistic care management. Disease and case management services are provided to members living with one or more chronic conditions.

Integrated Health Management Report

Engaging Members in Worksite Wellness
Presented by Nidu Menon, Director of Integrated Health Management

Worksite wellness contributes to addressing the "triple aim," which is improving the health of populations, reducing the cost of health care and improving the patient experience. The worksite wellness initiatives can be integrated into the Plan's business model to promote healthy behaviors. They're offered to counter the growing rates of chronic disease and obesity, which result in rising medical costs and loss of work productivity. Eighty-five percent of large employers and 81% of small employers have implemented worksite wellness programs.

Even though people who participate find value in these programs, resistance remains among the majority of employees. Lack of interest, lack of trust in the employer's motivation, inconsistent messaging, lack of leadership and the perception from employees that it only benefits the employer are some of the reasons given for not participating. Effective marketing of a worksite wellness program is vital to its success. Keeping employees engaged once they begin is also important, as well as communicating the value of the service offered. A large and entertaining kick-off generates interest and excitement and helps to create the expectation that everyone will participate.

Rewarding or penalizing employees has become a popular approach to encourage participation. Some incentives for Plan members would require legislative action and others would require funding. In 2013, over half of the large employer groups offered incentives above $250 per employee, an increase of 49% from 2012. Only 12% of employer groups offered incentives of less than $50 per employee in 2013.

Ms. Menon presented components and measures of success for the wellness program offered to the State of Nebraska employees. She also highlighted the wellness programs at Dell, Inc. and SAS. Wellness initiatives offered through NC Health*Smart* were discussed, as well as several wellness pilot projects conducted by the Plan. The Plan found that participation in the pilots was generally low, consistent with national experience.

A breakdown of Plan membership by agency and associated costs per member per year was shared with the board. The data demonstrated that agencies are very diverse with different risk profiles. A map of the percentage of chronic conditions for members by county was also presented. The highest prevalence of the major chronic conditions was found in five counties in the eastern part of the state. Planning for worksite wellness and meeting the needs of Plan members will be challenging. However, longevity among state employees is high and investing in keeping them healthy is very important.

Emerging recommendations include the visible engagement of agency and state leaders, effective communication and marketing, strategic use of incentives, ease of access and evaluation of data. The Plan should continue to pursue and expand worksite wellness initiatives, partner with agencies that influence policy changes and continue support of initiatives that are valued by members.

Ms. Moon stated that limitations on incentives in the General Statutes present challenges and suggested that the Plan and the Office of State Human Resources work together to redefine incentives. The Plan could also share high level aggregate data with state agency leadership and showcase priorities for their membership.

Board members agreed that knowledge and attitude don't quickly change behavior and that incentives have to be part of a long term strategy. While cost savings may take a long time to measure, improving the health of members is important.

During the discussion, Ms. Menon was asked how she might spend or allocate a dollar available for worksite wellness vs. alternative payment strategies. Ms. Menon suggested a 50/50 split might be considered. At the end of the discussion, Ms. Moon offered another option for spending the dollar, asking the board to consider developing options for employing units to implement pilot programs that focus more on worksite wellness programs in the short term. The long term focus could be on the payment side. One board member suggested finding an initiative in which everyone could participate and garnering support from everyone involved.

Patient-Centered Medical Home

Presented by Nidu Menon, Director of Integrated Health Management, and Scott Money, ActiveHealth Management

Ms. Menon started the presentation on the Plan's program design and approach to PCMHs. At the January board meeting, discussion focused on payment models and strategies, which are part of the overall strategy to create a positive experience for the members and achieve healthy outcomes. If quality and member health improves, a decrease in costs will follow.

To build a PCMH, the foundation must include a personal provider, payment strategy and the medical practice. The providers must coordinate and integrate the member's care, achieve quality outcomes and improve access. The personal provider and payment are necessary for a higher level of care with a team of people engaged in the care of the member. The expected outcomes of a PCMH include access, quality, experience and health outcomes.

Members and providers have certain expectations in a PCMH. Members know who to contact for assistance and are comfortable interacting with the medical home team. They are confident in the coordination of their care and specialist referrals. Providers ensure that access to care is readily available to their patients and that effective communication helps members to understand treatment and allows them to voice concerns.

Mr. Money presented information on ActiveHealth Management's new PCMH practice support model launched in January 2014. This integrated, member-centric model was piloted to enhance provider engagement with Plan members across the state and improve the member experience and health outcomes and reduce costs. Various payment methodologies with different practices and care management workflows will be explored. AHM will receive pharmacy and lab data from the practices and data from the N.C. Hospital Association. The goal is to provide members who require the most assistance with informed decisions. Accurate eligibility data will be a key component in the partnership.

Criteria to identify participating practices included population demographics, which reviewed attributed members in the county/region and in the practice. Practice demographics criteria included National Committee for Quality Assurance (NCQA) PCMH recognition, connection to a health system and use of electronic medical records. Clinical demographics criteria took into consideration the percent of attributed members targeted for programs, top medical conditions, high cost utilizers and health care costs. The practices and locations selected for potential participation include several underserved areas around the state.

The payment models in the practices range from fee for service to an ACO. Sylva Medical Center was the first practice to go live in January 2014. A care manager was embedded into the practice as a support for members. The practice schedules weekly meetings to close care gaps and address quality measures. The Eat Smart, Move More, Weigh Less program will offer onsite courses for Sylva members.

AHM will begin to get data feeds from the N.C. Hospital Association in 2014. The data is real-time and will be transmitted to AHM on a daily basis. AHM is also looking to build relationships with the State Health Information Exchanges (HIEs) to receive data once connectivity between the HIEs and provider electronic medical records is established.

The evaluation methodology is modeled on the Agency for Healthcare Research and Quality (AHRQ) guidelines and will evaluate quality, cost and experience. Participating practices will be compared to similar non-participating practices. Potential measures include 2014 clinical measures, utilization measures, member and provider satisfaction and operational measures.

AHM is currently recruiting additional practices and will be able to provide program evaluation and lessons learned by the end of 2015. A board member raised the question as to why the two state medical schools were not selected. Ms. Menon stated that neither school indicated an interest in being included but that the Plan and AHM would be glad to enter into discussions with them.

The Plan would like the board to consider the member/provider relationship attributes and how the Plan could best assist the providers. Ms. Moon stated that the Plan is working with AHM to improve the PCMH concept and embed it more in the benefit design in 2016. Recommendations will be brought to the board.

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

In response to the board's request for an environmental scan of other state health plans as compared to the North Carolina Plan, Mr. Friedman presented a comparative analysis of state health plans. The Plan reviewed the other plans for richness, premium cost sharing, healthy lifestyle benefits and the number of coverage options. Key findings included: the Plan provides employees/retirees generous and affordable health benefits, however, coverage for dependents does not compare favorably; the Plan's wellness credits of $40/$50 a month are in the middle in terms of dollar amounts at stake and tobacco cessation benefits are the most popular among states utilizing wellness premiums; there is at least one significant difference between the Plan and all other states but the difference is not uniform.

Mr. Friedman reviewed the methods to address the triple aim and the cost of health benefits which include the following: benefit offerings and programs; program administration and contracting; provider network; and provider payment methods. Mr. Friedman focused on the value for members through benefit offerings and programs based on plan richness, premium sharing, health lifestyle benefits, and choice.

Some of the comparator states were selected based on their proximity to North Carolina and several were selected based on their population and other factors. The case studies included the financing of premiums in Illinois and Wisconsin, plan design in Tennessee and Kentucky, and healthy lifestyle benefits in Connecticut and Utah.

The out-of-pocket costs included the highest and lowest premium offerings in comparison states and benchmarked them against the Plan's 80/20 plan. The Plan's CDHP and 70/30 plans were also included in the analysis. Plan staff consulted with Segal on the out-of-pocket comparison analysis, which included deductibles, coinsurance, office visits, inpatient surgery and pharmacy. Mr. Johnson stated that the Plan is at the forefront in looking at ways to reduce copayments and premiums to remove barriers to care.

The relative value of plan benefits included all three Plan options available to non-Medicare members and compared the average person utilizing the benefit, based on multiple scenarios. Mr. Friedman noted that the higher value plans normally have lower deductibles, copays, coinsurance and out-of-pocket maximums. The Plan options fall in the lower half of states in terms of relative plan value, which doesn't include premium contributions. However, the Plan has the most premium free options available to the retiree population of any state used in the analysis.

The second step of the analysis incorporated member premiums to demonstrate the total cost exposure. Combining the premium paid by each state for each plan and the relative plan value determines the overall relative value of the health benefit. Mr. Friedman noted that the Plan pays 100% of the premiums for the 70/30 plan. When the analysis includes premium contributions, the Plan's offerings provide a higher level of value. Comparatively speaking, the CDHP is the most generous plan of the three options available to individual Plan members. The overall relative benefit value for family coverage for all three Plan options is near the bottom of the cost comparison.

Mr. Friedman noted that each state government finances member health coverage differently. Most states provide direct subsidies for dependent coverage. The contribution rates in North Carolina differ from most states and significant changes could impact long-term Plan costs and sustainability. Many states are beginning to incorporate healthy lifestyle benefits into their health benefit design. State strategies vary, with some including mandatory requirements to participate in a particular plan option.

More than 60% of the states in the analysis have multiple third party administrators for the active member population and an average of three offerings. Maryland offers eight and Ohio offers one plan. North Carolina offers three options to active members. In Illinois, individual premiums vary by employee salary. Wisconsin utilizes regional HMO offerings and one plan option that is available through the state. Plans are ranked by quality metrics and positioned in tiers. Tennessee and Kentucky offer wellness initiatives that must be completed by members who choose the more generous plan options.

Mr. Friedman provided emerging conclusions. In other states, individual premiums are higher and dependent coverage is more heavily subsidized. States are moving toward incorporating healthy lifestyle credits and offering higher deductible options. More generous benefits for Plan members would likely require a premium increase for members since the General Assembly may not provide additional funding for the Plan.

The average individual employee premium contribution under the current Plan structure is relatively low compared to other states. The average family out-of-pocket cost is approximately $317 per month. Assuming no changes within the annual subsidy from the General Assembly, member premiums should be lower this year.

Questions and next steps include determining where the Plan should be positioned in the next three to five years. Given the possibility of no additional funding from the General Assembly and current budget constraints, member cost sharing increases will need to be considered. Dependent coverage will also need to be further analyzed, as well as the impact of the ACA.

Multi-Year Financial Model
Presented by Mark Collins, Financial Analyst

The multi-year financial model will be used as a planning tool to support the development of the strategic plan goals. Mr. Collins stated that significant strategic planning has already been done and that the Plan anticipates saving approximately $840 million over the next six years as a result of the implementation of the 2014 benefit options and wellness initiatives. In addition, the Plan has a higher cash balance than projected and therefore has reduced estimated premium increases in the near-term. The estimated annual premium increases under the new multi-year financial model prepared for the presentation are 6.3% for 2016 and 2017 and 13.1% for 2018 and 2019.

The multi-year forecast prepared for the presentation includes 2013 open enrollment results and projects a cash balance of $687 million at the end of 2015. The projected PMPM spending is $449.49 in 2016-2017 and $519.56 in 2018-2019. One board member stated that the trend continues to be better than the forecasted amount and asked when the Plan might consider a trend adjustment. Mr. Collins stated that Plan staff intends to have another trend discussion with Segal soon but that the Plan wants to continue to be somewhat conservative in that area.

The multi-year financial model will guide the Plan and board in deciding whether or not financial goals should be established as a part of the strategic plan. If so, the primary financial goal and the intended beneficiary both need to be established. The Plan has member health and engagement priorities that will most likely impact finances but, to date, a specific financial goal has not been set as part of the strategic plan. Three additional scenarios that illustrate potential financial goals were developed for the presentation.

Scenario One stabilizes premium increases. An 8.4% increase at the beginning of each year in 2016-2019 would balance to the 9% Target Stabilization Reserve (TSR) by December 2019. Premium increases would be higher in the near term and lower in the long term. The increase in revenue in the short term would level off in the long term. Mr. Collins stated that the General Assembly would have to agree to fund the higher short-term request for this model to be implemented.

Scenario Two reduces the annual premium increases by 1%, similar to language the General Assembly included in the 2013-2015 budget. This increase would require the Plan to decrease PMPM spending or bring in additional revenue from sources not tied to base premium levels.

Scenario Three reduces the long-term trend from 8.5% to 7.5% in 2018 and to 7.0% in 2019. Annual required premium increases would decrease to 7.98%. To achieve a reduction in long-term trends, the Plan would need to implement programs that would result in reduced costs. Some of the Plan's current initiatives have longer term financial impacts, and savings may not be realized for several years.

Mr. Collins summarized key questions that need to be addressed and some potential strategies that could be used to achieve financial goals set by the Board. No decisions were made and the Plan will continue to review this information with the board.

Due to time constraints, Mr. Collins did not present the financial report.

Member and Public Input Period

State Employees Association of North Carolina
Presented by Chuck Stone

Mr. Stone reviewed several items on the list of benefit changes that were not presented at the November 2013 meeting.

The State Employees Association of North Carolina (SEANC) requested that the Plan consider: linking hospital reimbursement rates to 120% of Medicare rates; eliminating payment for hospital "never events" where hospital errors result in additional expense to the Plan and Plan members; strengthening Plan ethics by seeking legislation or adopting a policy requiring political disclosure by service providers; coordinating the State Health Plan Medicare retiree enrollment with Federal Medicare enrollment periods; providing publication and notices to Plan members of ratings of health insurance products offered by the Plan to increase awareness; establishing a rewards program for members for finding billing errors and overcharges; reimbursing members for overdraft fees and bank charges arising from payroll/enrollment/bank draft errors made by the Plan or its vendors; seeking support which would enable Plan dependents to qualify for tax credits and premium subsidies in the Health Benefit Exchanges or seeking funding from the State for an equivalent premium subsidy. Mr. Stone stated that SEANC supports the autism bill. He also requested the Plan and board consider amending the bylaws to adjust the time allotment for public comment.

N.C. Retired School Personnel
Presented by Lacy Presnell

Mr. Presnell thanked the staff and board for providing Medicare Advantage plans for Medicare members and asked the Plan to continue to keep out-of-pocket costs as low as possible.

Autism Speaks
Presented by Patrick Ballantine

Mr. Ballantine expressed appreciation to the Plan and board for considering a benefit change to add autism coverage. He stated that Autism Speaks is pleased with the Plan's draft proposal and discussed some of the proposed language changes.

Chair Cowell thanked each group for their comments.

The meeting was adjourned at 3:30 p.m.

Janet Cowell, Chair