Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
May 24, 2013

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, May 24, 2013, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

Members Present:
Chair Janet Cowell
V. Kim Hargett
Noah Huffstetler
Bill Medlin
Vice-Chair Genell Moore
Warren Newton, MD
David Rubin
Michele Shaw

Members Absent:
Paul Cunningham, MD
Art Pope

State Health Plan Staff: Mona Moon, Glenda Adams, Mark Collins, Lotta Crabtree, Thomas Friedman, Beth Horner, Sally Morton, Lorraine Munk, Derek Prentice, MD, Kenisha Riley, Caroline Smart, Tracy Stephenson

Department of State Treasurer Staff: Joan Fontes, Joanne McDaniel, Tony Solari, Heather Strickland

Department of Justice Staff (for Executive Session Only): Marc Bernstein, Heather Freeman, Robert Curran

Guests: Suzanne Beasley, Janelle Cain, Charlotte Craver, Steve Daly, Pam Deardorff, Viki Fox, Wadida Murib-Holmes, Charla Katz, Jack Kenley, Christa Klein, Rich Lomax, Lanier McRee, Lacey Presnell, Ed Regan, Bill Stockard, Chuck Stone, Bill Sucic, John Thompson, Michelle Tietz, David Vanderweide

Welcome
Treasurer Janet Cowell, Chair, welcomed Board members, State Health Plan, Department of State Treasurer and Department of Justice 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, 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 represents a number of providers and will disclose that information if those providers become a part of the discussion. No other disclosures were made and no conflicts identified.

Executive Session

Following a motion by Dr. Newton and seconded by Ms. Moore, the Board voted unanimously to move into executive session pursuant to G.S. 143-318.11 and G.S. 132.1.2.

Lake Lawsuit Update
Presented by Marc Bernstein, Assistant Attorney General and Lead Counsel on Lake Lawsuit

Mr. Bernstein reviewed the background and discussed the current status of the Lake lawsuit. He stated that the motion to dismiss had been denied by the judge. The pros and cons of several options, moving forward, were discussed. The Board unanimously agreed to take the advice of lead counsel pertaining to next steps.

Medical Claims Audit and Third Party Liability Recovery Services RFP
Presented by Caroline Smart, Director of Health Plan Operations

Ms. Smart discussed the status of the Medical Claims Audit and Third Party Liability Recovery Services RFP and stated that an update would be shared at the July meeting.

Following a motion by Dr. Newton and seconded by Ms. Shaw, the Board voted unanimously to move into open session.

Agenda Item – Review of Minutes – March 22, 2013 (Attachment 1)
Presented by Janet Cowell, Chair

Following a motion by Dr. Newton and seconded by Mr. Medlin, the Board voted unanimously to approve the minutes, as written.

Agenda Item – Legislative Update (Attachment 2)
Presented by Tom Friedman, Health Policy Analyst and Legislative Liaison

Update on Legislative Budget

The Senate's proposed budget provides appropriations sufficient to cover the biennium; however, the increased funds are linked to the general consumer price index (CPI), not health care CPI. A long term funding philosophy based on CPI could create health plan funding issues in the future.

State Health Plan Related Legislation – Update on Bills
Mr. Friedman discussed several health care related bills that could impact the Plan. SB 98 (S.L. 2013-45), which is the only bill to become law at this time, expands the newborn screening program, and is projected to have a negligible fiscal impact.

The Plan's bill, HB 232, originally included language that gave the Treasurer the authority to adopt, implement and administer wellness and disease management programs. That language was later removed by the House Rules Committee. The bill has passed the House and has been referred to the Senate Committee on Pensions & Retirement and Aging. The fiscal impact is negligible.

The Board unanimously agreed that daily operations of the Plan should be managed by Plan staff and the Treasurer, not the Board. Mr. Huffstetler presented a draft of a letter to the Committee, which emphasized that point and requested that the original language be reinstated. Board members reviewed and signed the final version of the letter. Mr. Friedman stated that he would deliver the letter to the Committee Chair.

HB 498, which would mandate coverage for behavioral treatment of autism for members age 23 and under, would have a projected fiscal impact of $4.1 million to $9.7 million. The bill passed the house and has been referred to the Senate Insurance Committee. The Plan will ask Segal to review the fiscal impact and determine if the age should be changed to alleviate potential administrative issues given that most age associated benefits are 18, 21 or 26.

Although the coverage of autism would be a very positive benefit for members, the Board expressed concern that behavioral benefit coverage might set a precedent for consideration of coverage for other behavioral/social problems. Also discussed was a concern from the Board that the General Assembly is making benefit decisions on a case by case basis and that it might be appropriate for House and Senate leadership to determine if those decisions should be made at the legislative level. It was suggested that benefit changes should be evidence-based and that the Board and Plan should consider how to best communicate that to the legislature.

HB 675, Amend Pharmacy Laws, changes when and how the Plan would recoup money identified in audit findings and the amount that could be recouped. The projected fiscal impact would be $3.2 million to $3.4 million in lost revenue over the biennium. The bill passed the House and has been referred to the Senate Committee on Rules.

SB 477, Non-Covered Vision Services, would eliminate the 30% discount for certain vision services that Plan members currently receive through the vision discounts available through Blue Cross Blue Shield of NC (BCBSNC). The bill passed the Senate and has been referred to the Senate Committee on Insurance. There is no projected fiscal impact to the Plan.

SB 473, Health Care Cost Reduction and Transparency, would list the total payments by the Plan for inpatient stays for each of the top 100 Diagnostic Related Groups (DRGs), effective March 2014. The same information for the twenty most common surgery and imaging procedures for outpatient stays would be effective June 2014. The bill passed the Senate and has been referred to the House Committee on Health and Human Services. There is no projected fiscal impact to the Plan. This is the first step in determining the amount the Plan is paying for different types of service.

SB 336 and HB 459 require the Division of Medical Assistance (DMA), the Division of Public Health (DPH) and the Department of State Treasurer (DST) to identify goals and benchmarks to reduce chronic conditions and associated costs and improve care. SB 336, which addresses chronic conditions broadly, passed the Senate and HB 459, which specifically addresses diabetes, passed the House. The fiscal impact to the Plan of each bill is negligible.

Follow-up March BOT Meeting

Due to time constraints, Mr. Friedman did not present information on the follow-up items from the March meeting.

Agenda Item – Financial Report (Attachment 3)

Presented by Mark Collins, Financial Analyst

March 2013 Financial Report

Mr. Collins stated that the Plan continues to see consistent patterns in the financial reports and is continuing to run under budget. Specifically, claims expenditures were $88.5 million less than projected through March and administrative expenses were $28.3 million less than budgeted. The Plan's ending cash balance for March was $739.6 million. Year to date allocation of claims expenditures through March were as follows: Pharmacy 27%; Inpatient facility 18%; Outpatient facility 22%; Professional 30%; and other 3%.

Analysis of Incurred Claims Trend and Provider Payments

The report reviewed trends in incurred claims paid through March 31, 2013, and Plan provider rates compared to Medicare, as well as a comparison of Medicare and Medicaid provider rates. Comparing fiscal years 2010-2011 to 2011-12, Per Member Per Month (PMPM) claims costs were down 1.4%. A decrease in PMPM medical claims of 1.2% was partially offset by a 1.3% increase in pharmacy claims. Comparing the quarterly claims trend for the past two fiscal years demonstrated a mostly negative trend over the eighteen month period. The total claims cost trends per service were mostly negative, with the exception of pharmacy and outpatient facility services.

Provider rates for the Plan and Medicare demonstrated that the Plan pays 130% of Medicare rates for professional services. The same comparison for hospital services found that the Plan pays 164% of Medicare rates. In total, the Plan pays approximately 148% of Medicare rates for medical services. An analysis of NC Medicare and Medicaid provider rates indicated that, in general, Medicare pays more than Medicaid. Mr. Collins stated that, although an analysis comparing provider rates paid by other states relative to Medicare and Medicaid is not readily available, the Plan's actuaries have generally concluded that the Plan's provider rates are consistent with their expectations.

One Board member noted that with more provider practices moving into hospitals and merging with larger groups, the trend may change in the next few years. With less competition, health care costs will most likely increase. Ms. Moon stated that the Plan will ask Segal if they can provide payments as a percentage of Medicare for primary care practices only as well as an analysis of potential impact of practice consolidation.

Follow-up March BOT Meeting: Financial Impact of the Enhanced Blood Glucose Test Strip Benefit

At the March meeting, the Board approved an increase for blood glucose strips for Plan members with diabetes. The initial estimate for additional strips was $3.9 million for insulin dependent members and $2.1 million for non-insulin dependent members, based on a scenario in which all members taking insulin increase their usage to the new limits. Plan staff worked with Segal and Express Scripts, Inc. (ESI) to refine the analysis to estimate the impact of the benefit enhancement.

The refined analysis concluded that no more than 10-15% of affected members were at or above 80% of the previous limit for test strips allowed, suggesting that many members will not reach the new limit. Segal's analysis concluded that the new limit for test strips will result in additional costs of $500,000 to $1.5 million, with the higher number to be used in Plan projections.

Proposed Premium Rate Structure for 2014

The proposed premium rate structure for 2014 features lower premium options for dependents for the Consumer-Directed Health Plan and Medicare Advantage with Prescription Drug Plans; allows for split contracts; keeps rates within family tiers the same or less than they would be under current plans; and includes wellness surcharges and credits. The structure proposed is designed to offer flexibility and ability to save money for the member. The proposed rate structure is on page 6 of the presentation. A motion to approve by Dr. Newton and seconded by Ms. Moore was approved unanimously by the Board.

Dr. Rubin raised a concern that Medicare primary members may be at a disadvantage by no longer having the 80/20 plan as an option due to additional fees imposed by Medicare for higher income retirees. Ms. Moon pointed out that the strategy of offering base and buy-up Medicare Advantage plans in lieu of the 80/20 plan is intended to provide better value for both the Plan and members and that if the 80/20 Plan had continued to be offered the recommendation would not have been to continue the premium at the current cost of approximately $10 but to set it higher than the Medicare Advantage buy-up option.

Agenda Item – Implementation Update (Attachment 4)
Presented by Caroline Smart, Director of Health Plan Operations

2014 Final Plan Design Details

Medicare Advantage Plan Design Details There are four Medicare Advantage plan designs; a base and buy-up plan from both vendors. The premiums for the base plans will be the same for both vendors as will the buy-up plans from both vendors. The benefits in the base plan are the same for both carriers, but there are differences in the buy-up plans which include enhanced services such as eye exams, some dental coverage and hearing aid coverage. The best value for Plan members will come from having a pharmacy copay less than what they are currently paying under the Plan.

Following a motion by Ms. Hargett and seconded by Mr. Medlin, the Board voted unanimously to approve the Medicare Advantage plan design.

Consumer-Directed Health Plan (CDHP) with Health Reimbursement Account (HRA) Plan Features
The Consumer-Directed Health Plan has two primary features which are a High Deductible Health Plan (HDHP) and a Health Reimbursement Account (HRA). The HDHP has a high front-end deductible instead of copays. Once members meet the deductible they will pay 15% coinsurance on in-network medical and pharmacy benefits. Preventive care is covered at 100%. The pharmacy plan is integrated into the CDHP and can reach the deductible using either pharmacy or medical benefits. Preventive drugs under the Affordable Care Act (ACA) will be covered at 100%. For other preventive medications approved by the Plan the deductible will be waived meaning the member can obtain those prescriptions subject only to coinsurance. BCBSNC and ESI are working to integrate the claims data in order to synchronize accumulation of member deductibles and out of pocket expenses.

The starting value of the HRA is based on the subscriber's family size - $500 for the subscriber only account, $1000 for a subscriber with one dependent and $1500 for the subscriber with two dependents. All members are eligible to earn incentive reward HRA contributions and unused balances in the member's HRA may be rolled over for use in the next year.

Ms. Smart provided details of examples as to how the CDHP would work for office visits and inpatient admissions. She stated that members will have to obtain HRA balance information online since the Explanation of Benefits (EOB) for services rendered will not include that information. Future enhancements to the website and a smart phone application for determining account information are being discussed.

The Board emphasized the importance of a good communication plan for both members and providers.

Following a motion by Ms. Shaw and seconded by Ms. Hargett, the Board voted unanimously to approve the Consumer-Directed Health Plan designs.

Tiered Network Incentive Rewards
Mr. Huffstetler, Ms. Moore and Dr. Newton recused themselves from participating in the discussion and the vote on tiered networks.

Ms. Smart reviewed the incentive rewards for members accessing care from a designated Blue Options specialist or inpatient facility. The intent is to reward members for choosing high quality providers and facilities by reducing copays or adding money to the HRA for those members who choose the CDHP. Specialists

in the areas of General Surgery, OB/GYN, Gastroenterology, Orthopedics, Cardiology and Neurology are included and Blue Select facilities are chosen based on quality outcomes, cost efficiency and accessibility criteria.

The Board encouraged BCBSNC to expand the networks, if possible, to close the gap in areas that have fewer providers and facilities in the network.

Following a motion by Bill Medlin and seconded by Ms. Hargett, the Blue Options Designated incentives were approved unanimously by those voting.

Preview of the Enrollment Workflow of the Benefitfocus Platform

The Plan and vendors are currently engaged in the integration of premium incentives into the enrollment workflow. These incentives include the election of a primary care provider, the completion of the health assessment and the smoking attestation. Premium credits will be applied.

Ms. Smart reviewed the incentive workflow and screens that members will use for online enrollment. A comparison of health plan options will be available and members will also have the opportunity to enroll in Medicare. Hyperlinks will provide further descriptions of benefits and terms used.

The language for the smoking attestation is similar to the language under the Comprehensive Wellness Initiatives: *I understand that making a false statement, representation or attestation to the Plan could result in my termination from the Plan and that by attesting to my tobacco status I am also agreeing to cooperate with the Plan in any efforts to verify that status.* The Board suggested removing the word "any" to make the attestation more member-friendly. It was also suggested that the smoking attestation language be simplified to a yes or no.

Ms. Smart noted that managing split contracts, where one family member is eligible for Medicare and others are eligible for SHP primary benefits, has presented some challenges. When retirees and dependents are split between Medicare Primary and Plan primary, the Medicare eligible retiree will only be offered Medicare primary options and the non-Medicare eligible dependent will be offered the Plan primary options. The one exception is when the Centers for Medicare and Medicaid Services (CMS) disenrolls a Medicare primary family member. That member will then be enrolled in the Plan's traditional 70/30 plan.

Ms. Smart stated that the development of informational material is well under way and multiple workgroups are currently meeting. Systems testing is also in progress and Plan staff are preparing for presentations across the state in July, September and October.

Communications Update

The Health Benefit Representatives (HBRs) will play a key role in communicating plan options to members. The plan will conduct HBR training sessions across the state beginning July 8. A dedicated toll free phone number for HBRs to call the Plan with concerns and questions will be available July through December 2013.

Plan staff will continue to meet with the retiree groups to ensure adequate communication with retiree members. Meetings with the NC Medical Society, Senior Health Insurance Information Program and retiree employee associations began in April and are ongoing. It was suggested that the Plan also consider including the pharmacy associations in the communication meetings.

Member video production and mailings will be finalized in June. The four videos will include an overview of the Plan by Treasurer Cowell, a comparison of plans, the CDHP and the enrollment process. The Plan will also

conduct webinars and member information sessions in September and October. At the request of the Board, the Plan will explore the option of emailing the videos to members.

United Healthcare has secured at least 138 locations in North and South Carolina, Virginia and Florida to conduct member outreach meetings for Medicare retirees. Humana will set up a toll free number for Medicare retirees to respond to the invitation to participate at one of these meetings. Materials will be finalized in June.

Pharmacy Report (Attachment 5)
Presented by Sally Morton, PharmD, Clinical Pharmacist

Specialty Pharmacy Management
At the March meeting, the Board requested the Plan to provide additional detail regarding the specialty pharmacy costs and the management of these drugs. Specialty drug trend is at 17% and that is expected to increase to 22% by 2014. Specialty drugs may be billed under the pharmacy and medical benefit and at multiple places of service under the medical benefit. Under the current benefit design, the medication copay may be avoided by members utilizing the medical benefit rather than the pharmacy benefit.

Total specialty pharmacy costs under the pharmacy benefit increased $12.4 million during the first nine months of FY 2013 compared to the same period in FY 2012, which equates to a PMPM increase in specialty costs of $2.08. The average cost of a specialty drug increased $1000 in one year to an average monthly cost of approximately $4000 for a thirty day supply. The FDA is currently in the process of trying to define a biosimilar. In preparation for the release of biosimilars the Board previously approved a higher specialty copay tier for non-preferred specialty medications.

The top five therapy classes under the medical benefit are cancer, inflammatory conditions, blood cell deficiency, immune deficiency and multiple sclerosis. The pharmacy staff suspects the numbers on the Medical Specialty Claims report are low due to the difficulty in identifying medical specialty claims, and they are working with BCBSNC and the specialty medication vendor, Accredo, to obtain more accurate data.

Various management strategies have been implemented over the last seven years to address the specialty trend increase. Several effective strategies have included utilization management implementing a specialty pharmacy vendor to provide therapy management for Plan members.

In reviewing management strategies through 2015 and beyond, the Plan believes that focusing on medical specialty management including site of care management, reimbursement methods, oncology management and benefit design would provide the greatest impact. The Plan will partner with BCBSNC and Accredo to develop a medical management strategy.

The pharmacy staff will present further detail regarding specialty management strategies at the July Board meeting.

Pharmacy & Therapeutics Committee Meeting Summary
Dr. Morton referred the Board to the Pharmacy & Therapeutics Committee meeting summary included in the Board book and stated that Board members should contact her if they have questions or comments.

Integrated Health Management Report (Attachment 6)
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Kenisha Riley, Health Promotion and Wellness Manager

Stork Rewards Year One Outcomes
The Stork Rewards program was initiated as a result of the preterm labor and infant immortality rates in North Carolina, both of which are higher than the national average. In an average week in North Carolina, approximately 300 babies are born prematurely. The cost of preterm labor and low birth weight newborns to the Plan was $61,373 in 2010-2011.

The Stork Rewards program has assisted pregnant members to achieve full-term deliveries by offering incentives to promote engagement with a maternity case manager, especially in the first trimester, and maintain a healthy lifestyle. Member engagement increased to 96% with the program and the average number of members engaged per quarter increased 400% post incentive.

The Stork Rewards program data on preterm births for Plan members is not yet statistically significant, but the Plan would like to continue the program through 2014 to fully assess the impact. It was noted that members who choose the CDHP won't have a copay and, therefore, the Plan will have to determine another means by which to incent them to engage in the management of their care.

Tobacco Cessation Support through NC Quitline
Ms. Riley provided a summary of the current QuitlineNC supports and medical and pharmacy benefits and stated that the Plan's executive staff requested the IHM team to discuss support expansion with its external vendors.

The Plan currently offers the patch to smokers but would like to include nicotine gum as a single use nicotine replacement therapy (NRT) option since there are those members who experience issues with the patch. This change would be effective July 1, 2013. Another option is to offer a combination of the patch and gum to those who smoke nine or more cigarettes per day. All NRT options would remain free for the member. In addition, eligible members could re-enroll in a program to receive up to two 8-week NRT courses per plan year.

The cost in 2014 per member per year for the patches through QuitlineNC will be $193. The addition of nicotine gum would increase the per member per year cost to $214. A question was asked by the Board about how overall spend is affected by people who quit smoking and what percentage of Plan members smoke? The rate for plan members who smoke is 15%, which is lower than the rate for NC overall, which is 22%. Mark Collins responded that our actuaries have estimated that we spend about $3000 more per year per smoker and that when a person quits that amount decreases gradually.

Worksite Wellness Pilot Changes
A summary of the Charlotte-Mecklenburg Schools (CMS) pilot was provided. The number of participants in year one was 1,123 and 951 in year two. Members received biometric screenings at the worksite, completed health risk assessments and received follow up screenings from their primary care provider.

To align with the 2014 benefit changes, the program will end 12/31/2013 instead of March 31, 2014. Participants will receive a refund check representing the $15 copay reduction for each primary care provider visit from January 1, 2014, to March 31, 2014. The change will be communicated to members in August 2013.

Agenda Item - Process Discussion
Presented by Lotta Crabtree, Interim Deputy Executive Administrator

Occasionally, individuals or groups may request an opportunity to address the Board. Ms. Crabtree asked for the Board's feedback as to how they would like to handle these requests. Members agreed that Plan staff should be the first line of contact for people who request to speak at a Board meeting. They also indicated that a formal procedure for addressing the board should be established by the Plan.

The Plan will draft a policy and bring the recommendation to the Board for approval at a future meeting.

Agenda Item - Strategic Planning Update
Presented by Strategic Planning Workgroup

The Strategic Planning workgroup met via phone and in person several times since the March Board meeting. Their focus has centered on obtaining meaningful data to better assist the board in decisions related to benefits, medical and pharmacy management, incentives, program development, etc. Segal has developed a dashboard report that could provide a starting point.

The group has also explored the option of hiring an outside facilitator to guide the Board in strategic planning discussions. Mr. Holton has contacted several organizations and discussed the position with several people and will provide a status report at the July meeting.

Another area the workgroup has discussed focused on member satisfaction. Several recent completed surveys centered more on specific programs or the enrollment process rather than actual experience and satisfaction with the Plan. The group would like the Plan to consider conducting a member satisfaction survey and present results to the Board. As new plan options and design changes are implemented, the Board would like the Plan to develop a method by which to measure member satisfaction and conduct follow up surveys every 2-3 years.

The Plan will ask Segal to present their dashboard report at the July meeting.

Agenda Item – Wrap Up

Upon a recommendation by Mr. Medlin and seconded by Dr. Newton, the Board voted unanimously to adjourn the meeting.

The meeting was adjourned at approximately 2:40 p.m.

Janet Cowell

Janet Cowell, Chair