Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
August 1, 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, August 1, 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
Bill Medlin
Vice-Chair Genell Moore
David Rubin
Warren Newton, MD

Absent:
Noah Huffstetler
Charles Johnson

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, David Boerner, Mark Collins, Thomas Friedman, Beth Horner, Nidu Menon, Sally Morton, Lorraine Munk, Tracy Stephenson, Andrew Holton, Joan Fontes, Tony Solari

Welcome
Treasurer Janet Cowell, 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, Chair Cowell 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. No conflicts were noted.

Agenda Item - Review of Minutes – May 28-29, 2014
Presented by Janet Cowell, Chair

Following a motion by Mr. Medlin and seconded by Dr. Newton, the board unanimously approved the minutes from the May 28-29, 2014, meeting.

Agenda Item - Executive Administrator Update
Presented by Mona Moon, Executive Administrator

Ms. Moon reported on the status of the Global Benefits and Communication Director position. The second round of interviews has been completed and the final two candidates will meet with Treasurer Cowell. This position will have dual reporting to Ms. Waller, Chief of Staff, and Ms. Moon. The Plan anticipates having the person in place or being able to announce the candidate's name by the September board meeting.

The Department has also posted the Director of Policy, Planning and Analysis position which closes August 11. This person will report to the Plan's Executive Administrator. Some of the key responsibilities include coordinating the Plan's strategic planning process, directing the monitoring and analysis of claims, financial data and actuarial reports and building and maintaining relationships with external health policy and health care organizations, various stakeholders and associations and members of the General Assembly, as well as national organizations and government bodies.

The first phase of the data analytics analysis has been completed. The recommendation was made to conduct strategic planning sessions with Plan staff by late August or early September. Staffing and resource needs for the data analytics area will be shared with the board at the September meeting or shortly thereafter.

The Plan's Operations area requested additional staffing and Ms. Moon will provide an update on approved positions at the September board meeting.

Ms. Moon stated that the board will need to meet in August to seek approval for the eligibility and enrollment services contract in order to meet the August 31, 2014, deadline. She also noted that if a plan design for newly eligible members was ready, it would also be presented to the board at this meeting. The Plan will host the meeting but board members may also participate via phone. Ms. Munk will send potential meeting dates to the board.

Agenda Item - Legislative Update
Presented By Tom Friedman, Legislative Liaison and Health Policy Analyst

The Senate voted to pass the proposed joint conference committee report on the budget shortly after midnight on August 1 and the House was scheduled to vote later in the day. Some of the highlights related to the Plan included approval of the recommendation to forgo the premium increase in 2015 which will save $22 million in General Fund and $1.5 million in Highway fund appropriations. A $12.8 million increase in the Plan's administrative budget for revised estimates of contract and agency administrative costs was also included in the conference report.

The budget also includes a provision for the Treasurer and the board to create an alternative benefit plan for nonpermanent full-time state employees. Mr. Friedman noted that the University of North Carolina did not receive authorization to provide their own plan for this group of employees. He stated that the letter opposing this option was instrumental in the legislature's decision to remove it from the budget. The Plan will closely monitor the potential for other entities to request establishing their own benefit plans which could destabilize the Plan's risk pool if only active members are included.

HB 498, Autism Health Insurance Coverage, requires the Plan to provide annual coverage of $36,000 for behavioral treatment for members 23 and under. The bill also allows board certified behavioral analysts to treat patients as long as they don't represent themselves as psychologists. The bill passed the House and was referred to the Senate Committee on Insurance. The Plan will closely monitor the bill's movement and seek exemption if legislation is enacted since the board approved benefit differs in certain areas.

SB 493 requires health plans to provide coverage for autism spectrum disorders but excludes the Plan. It establishes a licensure board for behavioral analysts and includes other health provisions not related to the Plan. This bill passed the House and was sent to the Senate Committee on Ways & Means. Parts of this bill may be considered in other legislation.

SB 105 allows active employees of Matthews and Elizabethtown and their dependents to enroll in the Plan but excludes retirees. The question was asked as to whether it's advantageous from an actuarial perspective to include municipalities under the Plan. Ms. Moon explained that the Plan doesn't receive enough information on these members at enrollment to make that determination. She noted that it's assumed by some that the Plan is getting adverse selection with these groups but that hasn't necessarily been the case. The Plan hasn't experienced a significant impact on its risk pool and stated that the Plan doesn't have the data, at this point, to exclude municipalities and other groups from Plan coverage.

As for including retirees, Mr. Friedman stated that the new accounting standards wouldn't want to take on the liability of these groups and that members of the legislature have indicated that they wouldn't vote for any bill that included retirees. Ms. Moon also stated that local government bills introduced over the years limited certain plan options but that the Plan didn't have the capability, operationally, to offer different options to these groups.

Mr. Chuck Stone, State Employees Association of North Carolina, strongly urged the Plan to develop a written policy to provide guidance on how groups requesting Plan coverage should be allowed to participate.

SB 376 allows Montgomery County employees and dependents to enroll in the Plan. The fiscal impact is projected to be approximately $443,000 to $675,000 over the next several years. The bill has been ratified and presented to the Governor.

Senate Bill 783, which would establish chiropractor copay parity, has been referred to the Senate Committee on Insurance. The fiscal impact to the plan is projected to increase Plan costs by $.8 million to $3.9 million over the next two years.

Mr. Friedman stated that any movement on these bills would be shared with the board via email. He also noted that the legislature may call for a special session in August if the budget isn't signed by the Governor and again in November to discuss Medicaid issues. Mr. Solari emphasized the importance of the board's support and the role they've played in moving Plan related bills through the legislature. He also expressed appreciation to the retired personnel associations and to Mr. Friedman for his contributions to the legislative process.

Agenda Item - Financial Report, Forecasting and Monitoring
Presented by Mark Collins, Financial Analyst

June 2014 Financial Report
The first six months of the calendar year demonstrated a net income of $120 million which was $98.3 million over the certified budget amount. Total Plan expenses were $102 million less than projected. Plan revenue on the Per Member Per Month (PMPM) adjusted variance report was very close to the forecast. Net claims and administrative expenses were lower than forecasted and the net income was $41.65, which was $35.93 better than the forecast. There was a large gap in the overall trend during the first three months of the calendar year but the 2nd quarter numbers were closer to the budget.

One board member requested a breakdown of the claims volume and the amount of claims, stating that the unit costs are more important than the volume. Mr. Collins stated that when the Plan begins to receive more reliable enrollment data, the dashboard report will be updated and routinely include this information. He also noted that reports from previous meetings indicated that utilization decreased approximately 4% and that the price inflation was in the range of 6-7%.

Looking at calendar year to date claims, the Plan is seeing a slightly different pattern on the allocation of claims expenditures. The report demonstrates a slight decrease in percent of spend for Pharmacy among the Blue Cross and Blue Shield of North Carolina (BCBSNC) population due to the move of a large share of the Medicare retirees to fully insured Medicare Advantage plans. Mr. Collins noted that the cost for Medicare Advantage members can now be seen in the premiums paid to carriers, not in the claims expenses.

2013-14 State Fiscal Year Financial Report

Plan revenue for fiscal year 2013-14 was $60 million over the budgeted amount and expenses were $154 million less than projected. Medicare Advantage premiums totaled $78.5 million which was $8.3 million less than forecasted. The net income was $175.1 million, $214 million over the budgeted amount. The ending cash balance was $958.6 million.

Mr. Collins pointed out that the year-to-date (YTD) actual expenses on the PMPM expenditure trend report were higher than the YTD budgeted expenses for the first several months of the 2013-14 fiscal year (FY). However, the Plan ended the year spending $352.30 PMPM, approximately $23 better than anticipated. Ms. Moon noted that PMPM spending in the first six months of calendar year 2014 have been about $335, roughly the same as PMPM spending in Fiscal Year 2012-13. Based on results from the first six months of the current plan year, it's not anticipated that actual expenses will go above $352 in the current plan year, but the Plan continues to closely monitor the trends.

Also reviewed were recent historical financial results for revenues and expenses. Revenues have been higher than expenses the past four years, with very little trend on the expense side. In Fiscal Year 2013-14, the Plan saw a 6.2% increase in expenses, due in part to membership growth and the short plan year. For the fourth straight year, the Plan has experienced an upward trend in net income.

Administrative expenses in FY 2013-14 were approximately $13 million lower than in FY 2012-13. That is due, in part, to the change in the BCBSNC contract which accounts for about two-thirds of the administrative budget. A question from the board focused on whether the Plan is in line or below where they should be regarding administrative expenditure. Ms. Moon stated that with the Medicare Advantage (MA) plans and the new BCBSNC and other TPA contracts, the Plan's total administrative expenses have decreased. Even with the potential increase in staffing and resources, Ms. Moon noted that it wouldn't have a great effect on the total administrative budget. The Plan will review administrative expenses of other states and provide follow-up information in the future.

In response to a question as to how much control, if any, the board has regarding staffing, Ms. Moon stated that the Plan's executive administrator has the authority to hire and create exempt positions which has historically afforded the Plan the opportunity to hire more competitively relative to salaries. However, the Plan does have to work with the Office of State Budget and Management and the Office of State Human Resources to add new positions.

Mr. Collins summarized the financial report by stating that the fiscal year ended on a positive note and outperformed the budget in both net income and PMPM spending. Given the slight increase in expenses during the past year, the Plan will continue to closely monitor this area.

Agenda Item - Benefit Design, Plan Options and Premiums

2015 Enrollment Rules – Medicare Retirees
Presented by Beth Horner, Customer Experience Manager

Renewal pricing for the Medicare Advantage vendors was finalized and the Plan recommended a passive enrollment for Medicare primary retirees and their dependents. New Medicare retirees would be assigned to an MA PDP base plan with an opportunity to elect any of the Medicare primary options if they wanted to make a change. In response to a question from the board, Ms. Moon stated that premiums for the MA plans increased 6% but wouldn't be passed on to the members or employing institutions.

The board expressed some concern about a passive enrollment and whether members would understand they could choose a different plan. Ms. Moon acknowledged that the Plan has faced challenges in conveying benefit information to this group of members but that giving them a choice was important. One board member asked if the Plan has considered providing more choices for retirees. Ms. Moon stated that plan designs for 2016 would be discussed at the next two board meetings and that the board would be asked to make some decisions at the January 2015 meeting. It was noted that the new Global Benefits Communication director would play a critical role in the educational process.

Following a motion by Ms. Hargett and seconded by Dr. Newton, the board voted unanimously to approve a passive enrollment for Medicare retiree members and their dependents.

ACA Preventive Medications & Services
Presented by Sally Morton, Clinical Pharmacist, and
Nidu Menon, Director of Integrated Health Management

The Affordable Care Act (ACA) preventive care updates were presented. Dr. Morton stated that a board vote would be required to approve coverage of these medications and services for the 80/20 and CDHP plans. Medications for risk reduction of primary breast cancer would be offered to women at risk for breast cancer and at low risk for side effects. Non-grandfathered plans will be required to cover these medications at no cost to the member effective January 2015. Secondly, several federal agencies jointly provided additional guidance in understanding, implementing and complying with the US Preventive Services Task Force (USPSTF) recommendations to provide preventive coverage of smoking and tobacco cessation therapies.

The Consumer Directed Health Plan (CDHP), as a non-grandfathered plan, must comply with all ACA preventive services requirements at no cost to the member. The 80/20 and 70/30 PPO options are grandfathered plans and therefore are not required to comply with these requirements. Dr. Morton noted that the board previously approved coverage of ACA preventive services at no cost to the member for the 80/20 plan.

The ACA preventive medication list, effective January 2014, was reviewed. All medications on the list require a prescription, even those that can be purchased over the counter, for the member to have no cost share. Smoking cessation products, including patches and gum, as well as women's contraception products, are included on the list.

Coverage for the proposed list of breast cancer preventive medications would be subject to specific age and gender recommendations and would also require a prescription. Providers would be required to request a copay review process and meet specific criteria for coverage of these medications at $0 cost

share similar to a prior authorization process. These drugs can be used to treat other problems and the review process would ensure that the medication was being prescribed for the prevention of breast cancer. Dr. Morton stated that the review process shouldn't take more than two days. The approval for $0 coverage would be for one year. The financial impact is estimated to be approximately $.03-.04 per member per month.

Following a motion by Dr. Cunningham and seconded by Ms. Moore, the board voted unanimously to approve adding primary breast cancer preventive medication coverage for the CDHP and 80/20 benefit options.

Following the vote, one board member asked the Plan and board to consider what happens when reviews come under question. Credible organizations in North Carolina may be asked to provide their opinions. Ms. Moon stated that the ACA currently relies on information provided by the USPSTF and that the Plan has to comply with the ACA mandates for preventive service coverage for the CDHP. She noted that the board could discuss what they want to do for non-grandfathered plans in the future.

The USPSTF guidance for tobacco cessation considers a plan to be in compliance if the plan screens for tobacco use and provides two cessation attempts per year for members who use tobacco products. The attempts would cover four counseling sessions at least 10 minutes in length and FDA-approved tobacco cessations medications including both prescription and over-the-counter (OTC) for a 90-day treatment regimen. The Plan currently provides coverage for OTC patches and gum and cessation programs that include four counseling sessions two times per year, per member. The medication treatment is for a 60-day supply opposed to the 90 days recommended by the UPSPTF. The Plan does not currently cover OTC lozenges.

The Plan's proposed changes for QuitlineNC tobacco cessation services would extend treatment to two 90 days of therapy and counseling and add lozenges to the nicotine replacement therapy for the CDHP, 80/20 and 70/30 plans. Coverage of a 6-month supply in 12 months of Chantix and generic sustained-release bupropion would be added at no cost to the member and limited to members 18 and older in the CDHP and 80/20 plans. Dr. Menon noted that Chantix is a high cost drug and has associated risks.

The board discussed the effectiveness of a 10 minute counseling session and also whether members under 18 should be eligible for smoking cessation medications. Dr. Menon stated that the Quitline program has the support of the Centers for Disease Control and Prevention (CDC) and that there is data to support behavior therapy for that amount of time. Dr. Morton stated that the Plan will cover medications for teens but not at $0 member cost share. The Plan also doesn't fund QuitlineNC for members under age 18 and that the FDA-approved drugs under CDC guidelines are for members over age 18.

The fiscal impact to add lozenges to the QuitlineNC offering is estimated to cost approximately $17,000 per year. Coverage of generic bupropion is estimated to cost the Plan less than $.01 PMPM and $.10 PMPM for Chantix. The Plan's actuary estimated that the additional ACA preventive medications for breast cancer and smoking cessation would cost the Plan approximately $692,000 in CY2015 to $1.462 million in CY2018.

Following a recommendation by Dr. Newton and seconded by Dr. Cunningham, the board voted unanimously to expand preventive tobacco cessation coverage effective January 1, 2015.

Update on Potential Benefit Option for Newly Eligibles
Presented by Mona Moon, Executive Administrator

Prior to Ms. Moon's presentation, she stated that the September board agenda would include a public comment period.

In order to comply with the ACA, non-permanent full-time employees will be eligible for health insurance coverage. The Plan formed a workgroup, including staff representing several state agencies, university and community colleges and state school systems to review potential benefit options and make a recommendation for these newly eligible members.

The workgroup discussed three potential options for the rate structure. An income based approach would have members placed into one of four pay bands with predetermined employee and employee premium amounts. The second option would be a single rate plan with employer and employee shares defined. All employees would pay the same premium rate. The third option would be a single total premium rate with each employer determining the rate to charge the employee. This option would allow the employer to minimize their contribution which was of interest to the workgroup. However, Ms. Moon stated that the Plan does not have the capability to operationalize that option. The Plan could charge the employing unit the full fee and they could collect the employee premium. The workgroup chose the single rate option with employer and employee shares defined.

Billing and premium collection options were also addressed by the workgroup. Employees in the newly eligible group are traditionally non-permanent and there tends to be more movement among these staff members. They may be paid on a different schedule and some would have checks that would not be large enough for a premium deduction. Direct billing would involve sending a monthly bill to the member which would be remitted on time to avoid termination. Under the group billing option, employers would receive a monthly statement for the total premium of the employer/employee amount and bill the member for their share of the premium. Late or retroactive terminations for delinquent accounts would not be accepted by the Plan. The workgroup chose the direct billing option, which the Plan is prepared to handle.

The board recognized the complexity of the newly eligible plan option and expressed concern about the Plan having the resources to handle billing statements and termination letters. Ms. Moon stated that it was the most viable option and that the Plan's direct billing vendor, COBRAGuard, would be used to handle the billing. She acknowledged that communication to members, agencies and the vendor would be a critical component. The number of members who might enroll is not clear

The workgroup's feedback on the Plan's recommended minimum value plan was shared with the board. They were supportive of a 50/50 coinsurance for individual and family coverage with preventive medical and pharmacy care under the ACA covered at 100%. The individual deductible would be $5,000 and the out-of-pocket maximum would be $6,450. The deductible for family coverage would be $10,000 and the out-of-pocket maximum would be $12,900. The plan would also be eligible for a health savings account which would help the employee pay for medical expenses. Ms. Moon stated a detailed plan would be presented to the board and a vote to approve the benefit design and premium rates would be required.

Agenda Item - Member Experience and Communications

Segmentation Pilot
Presented by Nidu Menon, Director of Integrated Health Management, and
Kim Wiese, Senior VP, Product Marketing and Strategy, ActiveHealth Management

The Plan conveys a large amount of information to members regarding benefits, available resources, services, etc. Most of the communication materials promote the NC Health*Smart* services offered by the Plan. Approximately 250,000 members currently subscribe to the online member newsletter but only 17% actually access it. Only 43% of the 1,705 Health Benefit Representatives (HBRs) who subscribe to the newsletter access the information. Board members expressed concern regarding the HBR percentage given their responsibility to disseminate information to members. Ms. Horner acknowledged that it's a challenge Plan staff has discussed and stated that being the health benefits representative is only a part of the HBR responsibilities.

The board discussed various ideas that could help to resolve this issue and stated that focusing on this part of the communication process is critical. Ms. Horner stated that the Plan conducted an HBR focus group in the past year to obtain their feedback on the barriers that exist and what works for them. Dr. Menon noted that HBRs are not remunerated for taking on the role of HBR.

Dr. Menon stated that the Plan has an opportunity to pilot a segmentation and communication initiative through AHM for active and non-Medicare retiree members. This pilot could assist the Plan in developing a communication and marketing strategy to better engage Plan members in active life coaching, as well as disease and case management.

Ms. Wiese stated that the importance of breaking the entire membership into smaller and more relevant segments improves the communication and helps to promote behavior changes. It provides a deeper understanding of members and allows for more appropriate resources to improve member health. The first aspect of segmentation is consumer and clinical analytics – evidence based rules that assist in looking at the entire population. The second is care management and the third is consumer or member engagement – understanding and implementing meaningful programs and services to engage members. She noted that an external company was hired to assist AHM in the legal and regulatory review of the program.

The process segmented AHM's population into groups based on behaviors, attitudes and lifestyles. The internal data gathered included health and risk assessments, health attitudes, interaction data, etc. External data included non-specific information about household behaviors and lifestyles. The combined data determined health attitudes, behaviors and lifestyles. The statistical analysis produced 8 segments for which specific products and services were developed. Four of the 8 segments had health conditions and 4 did not. Ms. Wiese emphasized the importance of engaging the healthy population to keep them healthy and to determine why unhealthy members are not engaging in the services available to them.

The successful segmentation test for another client included 187,000 employees across the country. The group included both union and non-union staff. The pilot initiative in this instance, achieved an 87% increase in engagement rates compared to the control communications during the test phase. Based on the success of this program, AHM will continue to test and roll out segmentation and a new communication engine later this year.

AHM is interested in doing a segmentation pilot for the Plan and developing a more personalized experience for members. AHM built an in-house creative team who are trained in communication and motivational interviewing. The two-phase pilot approach would begin with channel and message testing on the four segments of the population with conditions. Most people in the 4 segments have at least 2 conditions and some as many as 9. The second phase would involve drilling down into the segment messaging.

Ms. Wiese provided two sample letters for the board to review, the first being a standard letter and the second one more segment specific. AHM expressed interest in working with the Plan on more personalized outreach. One board member stated that the data is compelling and that an important dynamic is the Plan's number of members with chronic conditions who don't feel the need to engage in healthy behavior. Ms. Wiese noted that the trends are better now and that AHM would continue to do testing while rolling out the pilot.

Another board member expressed some concern that the pilot would potentially get into areas of communication that target specific diseases with certain messages. Ms. Wiese stated that AHM would only review data that's publically available and not send information based on individual data, i.e., what the member buys at a particular store, what movies they see, if they own a home, etc. The economic scores might indicate the best way to market to that individual, i.e., cell phone, mail, email, etc. The board cautioned that members might still have a reaction to receiving something that might appear member-specific.

<u>Multipronged Pilot Initiative to Improve Member Health</u>
Presented by Nidu Menon, Director of Integrated Health Management

The Plan is proposing a two-year pilot for three eastern NC counties for the purpose of looking for the best way to engage and support providers in delivering a higher level of care to Plan members. This initiative would also develop and strengthen wellness networks and worksite wellness programs and connect with local leadership and resources.

In analyzing data for major chronic conditions by county, the Plan determined a high prevalence and severity in Greene, Jones and Lenoir counties. Approximately 8,000 state employees work in 34 sites in this area. Provider turnover is prevalent which creates a lack of available appointments. The state is the largest employer in these three counties.

The Plan's role is to create a patient centered medical home (PCMH) approach to care to close gaps in care and promote better communication among providers and members. The goal is to find community resources and empower members to use them. Coordinating collaboration between worksites and community leaders is also an important aspect of this pilot. The Plan would also like to facilitate a partnership with Continuing Medical Education sessions for providers and inform them on NC Health*Smart*. The four-phase pilot includes an environmental assessment, engagement with area wellness leaders and HBRs, wellness leader training to deliver NC Health*Smart* presentations, biometric screenings, engaging members in care of chronic conditions and a follow-up screening in 2016.

Chair Cowell spent a lot of time with leaders in that area and stated that it would be helpful to reconnect with those same people. She also noted that Dr. Cunningham would be a great resource as the Plan and others engage people in these counties.

One board member noted that communication is a key component to the success of the program. People are not always aware of the resources available to them. Another board member stated the importance of creating pilot measures and sustainability. Plan staff was encouraged to think beyond the end of the two years and determine ways in which to build a long-lasting program. Dr. Menon stated that the Plan's role is to develop worksite wellness programs that will provide long-term support for members. The Plan also needs to determine what providers need in terms of communication, assessment tools, etc.

Ms. Moon acknowledged the importance of sustainability but noted that certain pilots in the past were implemented with the idea of gathering information to assist with benefit design. The purpose of the current pilot is to determine how the Plan should address the high prevalence of chronic conditions in certain areas and create worksite wellness programs that truly engage employees. With no plan for a long-term funding mechanism, the Plan will need to determine if and how it can continue to provide assistance. The preliminary expectation is to develop and strengthen worksite wellness and engage providers in order to have a robust plan in place by 2015. Utilization metrics will be used to evaluate the pilot.

Annual Enrollment Outreach Plan
Presented by Beth Horner, Customer Experience Manager

The Plan is heavily involved with material development and onsite Annual Enrollment education and webinars for HBRs to outline benefits for active and non-Medicare retirees. The Plan will begin outreach meetings and webinars for members in August. Seventy-two Medicare outreach meetings are currently scheduled in 42 counties. The Plan, BCBSNC, UnitedHealthcare and Humana will be present at each meeting, as well as SilverSneakers representatives. In response to a question as to whether segmentation would be used for Annual Enrollment, Ms. Moon stated that it wouldn't be used this year but possibly in 2015.

Aon Hewitt will be supplementing the Benefitfocus call center by handling retiree enrollment calls during Annual Enrollment. Benefitfocus will continue to take calls after Annual Enrollment ends.

Other Member Outreach Initiatives
Presented by Beth Horner, Customer Experience Manager

In May, the Plan began a pre-65 member outreach campaign for members turning age 65 in the upcoming year. Meetings were scheduled around the state and educational materials were created to assist members in understanding their health plan options. The HBRs were also invited to meetings and were very helpful in assisting members. One thousand out of 10,000 invited members attended 41 meetings in 16 counties. A survey was sent to members to gauge the success of the campaign and indicate where improvements could be made.

The Plan is conducting a member satisfaction survey from July 14 to August 29, 2014. Postcards were sent to members inviting them to participate. Approximately 9,000 members participated in the survey 2 years ago and the Plan anticipates a better response this year.

Agenda Item - Contracting and Vendor Partnerships

<u>Contract with NC Hospital Foundation for ADT Data</u>
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance, and Nidu Menon, Director of Integrated Health Management

At the May board meeting, Dr. Menon presented information on the possibility of entering into a contract with the NC Hospital Foundation (Foundation). At that time, the Plan wasn't prepared to present the contract for approval but is requesting approval today.

The Foundation contract with the Division of Public Health and subcontract with Truven Health Care Analytics captures real-time clinical data from approximately 50% (61) of the North Carolina hospital information systems.

As a result, the Foundation is positioned to provide the Plan with admission, discharge and transfer (ADT) data three times per day. A secure file transfer protocol will be used to transmit data. The Foundation will notify the Plan if data integrity or accuracy issues occur. The data will be used by AHM to develop a care coordination program, identify high priority members who could benefit from care management and deliver care transition services to members. This contract fits into the board's strategic plan under the goal of reducing avoidable hospital utilization. The cost of the contract over five years is $719,020 and should be fully implemented in 2015.

The Plan holds the right to a copy of the data received but the hospital owns the original data. Use of the data is limited to use for the purposes of care coordination and population health management. In addition, the Plan is prohibited from sharing the data with the TPA. Approximately 70% of Plan members reside in the areas where the 61 participating hospitals are located. She added that the goal is to engage all 61 hospitals to share ADT data with the Plan. The Foundation will contract directly with the hospital to release data to the Plan. In response to a concern from a board member regarding the Plan's five year commitment, Ms. Crabtree stated that this is the only opportunity available to the Plan at the present time. If that changes in the next five years, the Plan will consider its options.

Following a motion by Ms. Moore and seconded by Ms. Hargett, the board voted unanimously to approve the contract with the NC Hospital Foundation.

In response to a question from Ms. Craver from ValueOptions, Dr. Menon stated that behavioral health data will be included and that ValueOptions and the Plan will follow up with AHM.

Agenda Item - Strategic Planning
Presented by Tom Gualtieri-Reed, Strategic Plan Facilitator for Board of Trustees

Ms. Moon stated that the latest version of the strategic plan now includes the metrics and roadmap. Decision points and targeted launch dates, reviewed by Treasurer Cowell and the strategic planning workgroup, are depicted on the roadmap.

Before reviewing the details, Mr. Gualtieri-Reed Tom thanked the board for their input during the strategic planning process and asked that additional comments be sent to him and/or Lotta.

The document outlines the strategic plan through 2018. The board discussed the timeframe and the fact that the environment changes quickly. Ms. Moon stated that the five year plan is very doable and suggested that the board review the strategic priorities on an annual basis and the roadmap and

initiatives at every board meeting. The Plan will report on the decision points and seek guidance from the board. Board members agreed that the strategic plan is a working document that will most likely require revisions over the next few years.

No changes were made to the mission statement and minor edits discussed at the last meeting were incorporated into the final draft. The values align with the Department of State Treasurer values.

Mr. Gualtieri-Reed asked board members to provide feedback on the guiding principles. Members assuming accountability for their health is important in improving their health. Communication with members is found in various initiatives and a new initiative focused on communication with providers, legislators, governor, etc., was added. Sorting out the measurements involved a great deal of time, as there are many ways to measure progress. Ms. Moon noted that the metrics might change as the patient centered medical home is implemented.

Board members commented that the document provides them a quick view of upcoming procurement and decision points. Ms. Moon noted that some of the contract items are not listed separately on the strategic plan but are embedded throughout if the board is not required to make a decision, i.e., contract amendments.

Board members provided summary comments on the document and strategic planning process, in general. Most agreed that the document incorporated a lot of different ideas and expressed appreciation to the staff for their guidance. Many agreed that the document is much more than a "to do" list with deadlines.

Mr. Gualtieri-Reed again expressed appreciation for board member and staff contributions and stated that he would be meeting with Ms. Moon, Ms. Crabtree and Mr. Holton within the next two weeks to discuss whether the strategic plan could be incorporated into the Clearpoint project management reporting system currently used by the Department.

Ms. Moon stated that the board will need to use the September and November meetings to discuss benefit changes and prepare for the legislative long session. The September meeting will also include a presentation on a value-based benefit design.

The strategic plan will be revised and presented to the board for their approval in September. Once approved, the document will be signed by the Chair and posted on the Plan's website along with the bylaws.

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.

Executive Session

Lake Lawsuit (I. Beverly Lake et al. v. State Health Plan for Teachers and State Employees; et al.)
(G.S. §143.318.11(a)(3))
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance, and Mark Bernstein, Attorney General's Office

Mr. Bernstein presented the latest developments in the Lake lawsuit and probable next steps.

Consultation with Legal Counsel – Contract Issue (G.S. §143.318.11(a)(3)) and G.S. §132-1.2)

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

The board discussed a potential vendor contract which will require board approval prior to the September meeting.

Following a motion by Dr. Newton and seconded by Dr. Rubin, the Board voted unanimously to return to open session.

Agenda Item – Wrap Up

Following a motion by Dr. Newton and seconded by Mr. Medlin, the board voted unanimously to adjourn the meeting at approximately 3:20 p.m.

Janet Cowell, Chair