Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
August 27, 2015

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, August 27, 2015, at the Department of State Treasurer, 3200 Atlantic Avenue, Raleigh, NC 27604.

Members Present:
Janet Cowell, Chair
Paul Cunningham, MD
V. Kim Hargett
Charles Johnson
Bill Medlin
Genell Moore
David Rubin

Participating by Phone:
Warren Newton, MD

Absent:
Lee Roberts

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Glenda Adams, David Boerner, Mark Collins, Tom Friedman, Beth Horner, Nidu Menon, Lorraine Munk, Adam Root, Caroline Smart, Sandy Wolf, Lisa Allnutt, Andrew Holton, Schorr Johnson, Fran Lawrence, Marni Schribman, Tony Solari

Welcome
Janet Cowell, Chair, welcomed Board members and staff from the State Health Plan and Department of State Treasurer 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 (Attachment 1)
Presented by Janet Cowell, Chair

Following a motion by Warren Newton and seconded by Bill Medlin, the Board unanimously approved the May 22, 2015, and July 8, 2015, minutes.

Agenda Item – Requests for Benefit Changes – Pursuant to Article IV, Section 2 and Article V, Section 10 of the Bylaws of the State Health Plan Board of Trustees (Attachment 2)

Ms. Moon reviewed the adoption of the policy that dedicates one meeting a year to listening to requests from members and member groups to change benefits available under the Plan. She reminded everyone that this not a forum for vendors or product manufacturers.

UNC Hospitals, Bone Marrow Transplant Program
Presented by Susan Elizabeth Sharf, Program Director and State Health Plan Member

Ms. Sharf presented background information on bone marrow transplants which are used to treat leukemia, myelodysplastic syndromes and aplastic anemia, among other diseases. She discussed the current benefit for State Health Plan members and noted that the $10,000 maximum for donor search coverage can easily be exceeded. Strategies to stay within that amount were presented which could financially protect the member, but could also cause a delay in securing a suitable donor. Ms. Sharf requested that Board members consider increasing the donor coverage benefit to $50,000.

NC Association of Acupuncture and Oriental Medicine
Presented by Chris Helmstetter, L.Ac., Director of Government Affairs

Due to a conflict of interest, Dr. Newton recused himself from the discussion.

Mr. Helmstetter stated that acupuncture is an effective treatment for a variety of conditions with almost no side effects. The number of visits rose 32% between 2002 and 2007 and approximately 40% of Americans have used Complementary and Alternative Medicine (CAM) within the past 12 months. In answer to a question by a Board member, Mr. Helmstetter stated that every county in North Carolina has at least one licensed acupuncturist. The cost effectiveness of acupuncture was shared with the Board, as well as a review of the number of states that provide coverage of acupuncture for state employees.

Mr. Helmstetter asked the Board to consider acupuncture as a covered benefit for State Health Plan members.

State Employees Association of North Carolina
Presented by Chuck Stone, Director of Operations

Mr. Stone began by stating that the State Employees Association of North Carolina (SEANC) supports increasing the donor coverage benefit and acupuncture coverage, only if medically and therapeutically indicated.

Several other requests for consideration included other plan options for Medicare retirees, an option for active employees to select retiree health insurance coverage or free dependent coverage equal in value to the current retiree health care coverage, a combined medical and pharmacy maximum out-of-pocket limit not to exceed $5,000 annually for the PPO options, a reduction in generic drug copays not to exceed $10 per script and a premium-free plan option equivalent to the 80/20 plan with no wellness premium surcharges.

Agenda Item – Program Updates (Attachment 3)

Pharmacy & Therapeutics Committee Meeting Summary
Presented by Glenda Adams, Clinical Pharmacist

Ms. Adams provided updates to the Plan's utilization management programs reviewed by the Pharmacy & Therapeutics Committee at their May and August meetings. Several new drugs for formulary consideration were also discussed by the Committee.

Ms. Adams also noted that as of September 15, the Plan will no longer cover certain pain patches and compound kits. The Plan communicated the change to impacted members August 1, 2015. In response to a Board Member question, Ms. Adams reviewed the recommendations that the committee makes for the new drugs that they review which includes "may add" or "must add." The committee and Plan look at efficacy and rebate opportunities.

Wellness Wins Pilot Update
Presented by Christine Allison, Health Promotion and Wellness Coordinator

Ms. Allison reviewed the goals and objectives of the two-year Wellness Wins pilot program and provided an update of the milestones that have occurred in the past year. She also presented worksite wellness program strategies and resources which are available to assist in sustaining a program.

Next steps in 2015 include the recruitment of participating worksites and introductory meetings, training sessions and financial stability web training. In 2016, the Plan will sponsor a worksite wellness networking meeting and diabetes/heart/asthma/COPD prevention, awareness and management campaigns.

Intended outcomes for the member, worksite and provider were presented and discussed. Each site will be able to establish a program that works best for them. The goal is to develop a wellness culture that will be sustainable long-term. Plan partners will track specific pieces to determine improvement although Ms. Allison acknowledged that it may be difficult to see significant change in two years.

Patient Centered Medical Home Pilot Update
Provided by David Boerner, Medical Director

Dr. Boerner stated that much progress has been made in the Patient Centered Medical Home (PCMH) pilot. The Plan has contracts with 4 provider groups around the state with a combined 21,000 attributed Plan members. Three of the 4 groups have established baseline and target metrics.

Next steps include finalizing the metrics for the remaining group and scheduling a first quarter stakeholder meeting at each practice to review operations, accomplishments and performance results.

The meeting was adjourned at 5:30 p.m.

Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
August 28, 2015

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 28, 2015, at the Department of State Treasurer, 3200 Atlantic Avenue, Raleigh, NC 27604.

Members Present:
Janet Cowell, Chair
Paul Cunningham, MD
V. Kim Hargett
Charles Johnson
Bill Medlin
Genell Moore
Warren Newton
David Rubin

Absent:
Lee Roberts

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Glenda Adams, David Boerner, Mark Collins, Tom Friedman, Beth Horner, Nidu Menon, Lorraine Munk, Adam Root, Caroline Smart, Sandy Wolf, Lisa Allnutt, Andrew Holton, Schorr Johnson, Fran Lawrence, Marni Schribman, Tony Solari

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

Following a motion by Ms. Hargett and seconded by Dr. Newton, the board voted unanimously to move into executive session pursuant to G.S. 143-318.11 and G.S. 132-1.2.

Agenda Item – Executive Session

Consultation with Legal Counsel
Presented by Lotta Crabtree, Deputy Executive Administrator and Legal Counsel

Ms. Crabtree presented information regarding a contract issue with Aon Hewitt to Board members.

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

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 – Executive Administrator Report (Attachment 1)
Presented by Mona Moon, Executive Administrator

Ms. Moon stated that Mr. Huffstetler did not seek reappointment at the end of his first term on the Board of Trustees. She informed the Board that Ms. Moore was also not seeking reappointment but would continue as a member until the Governor names a replacement. Ms. Moore spoke briefly regarding her decision and members of the Board responded with well wishes and appreciation for her service.

Introduction of New Staff

Ms. Moon introduced the Plan's new Director of Pharmacy Benefits, Sandra Wolf. Ms. Wolf's professional background includes experience in pharmacy benefits, Medicare Part D, compliance and the prevention of fraud, waste and abuse.

Contracting and Vendor Partnerships

Eligibility & Enrollment Services (EES) – Due to issues with the transfer of data files by Aon Hewitt, the Plan is recommending a return to Benefitfocus for eligibility and enrollment services. Ms. Moon noted that the priority from day one has been the member experience. Members who have encountered issues enrolling in the Plan may contact Blue Cross and Blue Shield of North Carolina (BCBSNC) to ensure that medical and pharmacy services can be received. Plan staff will notify its agency partners about the transition plan pending board approval of the contract change and Ms. Moon acknowledged all entities involved for their support.

Ms. Crabtree provided the estimated cost of the three-year contract and background information regarding the procurement of eligibility and enrollment services for both the Plan and NCFlex benefits. She also cited the statutes that authorize the Executive Administrator to negotiate and execute this contract, which is exempt from the Department of Administration's Purchase and Contract rules.

EES Services Transition Plan

Ms. Smart reviewed the three phases of the transition plan and noted that the most difficult part of the transition is the data conversion for Plan and non-Beacon/NCFlex enrollment. Information will be manually loaded into the Benefitfocus system, using Plan, Retirement System and Blue Cross and Blue Shield of North Carolina (BCBSNC) resources. She stated that due to time constraints, the automated transfer of data isn't possible.

Active members will have access to the Benefitfocus platform for 30 days beginning September 15 and retirees, COBRA and other non-active members for 14 days beginning September 30. During these times, members will be able to review the system for accuracy and make changes. Annual Enrollment will begin on October 15 rather than October 1.

Members in the BEACON system will be encouraged to re-enroll to ensure accuracy of personal information and health care choices. The Plan is addressing issues which were experienced under the first contract with Benefitfocus. Board members emphasized the importance of a good communication plan to members. In addition to written materials and in person educational meetings, the Plan will host six live, interactive telephone town hall sessions in September and October. This will allow the Plan to reach thousands of members during each session.

EES Contract Approval

Ms. Crabtree reviewed the contract provisions and administrative fees. Following a motion by Dr. Newton and seconded by Dr. Cunningham, the Board voted unanimously to approve the contract with Benefitfocus for eligibility and enrollment services effective September 15, 2015.

Agenda Item – Legislative Update (Attachment 2)

Presented by Tom Friedman, Director of Policy, Planning and Analysis

State Budget

Mr. Friedman stated that the final budget has not been released and that he's working with legislators regarding Plan funding. He presented information on the recommended employer contributions in the Governor's Senate and House budget proposals. He reviewed various scenarios for premium increases based upon the Plan fully funding the employer contributions. A special provision in the House budget would make FY 2016-17 (i.e the second year of the biennium) funding for employer contributions available to the Plan provided that the State Treasurer and Board adopt sufficient measures to limit projected employer contribution increases during the 2017-2019 fiscal biennium.

The Senate budget doesn't include an increase for the employer contribution in 2016 but fully funds the Plan's administrative budget request (as does the House budget). It also requires the Plan to retain at least 20% of its cash reserve for annual expenses during the current biennium. If at any time the Plan projects the reserve to fall below the 20%, the Department will be required to submit a plan of action to maintain the reserve to the Joint Legislative Commission on Governmental Operations. The Senate budget also eliminates retiree health coverage effective January 1, 2016. Plan staff is working with members of the legislature to address concerns over these special provisions.

Given the current significant cash balance, the General Assembly may be expecting the Plan to spend it down and forgo providing an increase to employer contributions. However, depletion of excess cash reserves is already accounted for in the forecast, and conversely requiring the Plan to hold a higher percentage of reserves may result in higher member premiums and employer contributions in the next biennium.

Mr. Friedman summarized enacted legislation relative to the Plan.

State Health Plan Related Legislation

Mr. Friedman reviewed several pending bills related to the Plan. He will continue to monitor the budget development and track Plan related legislation, provisions and board appointments. The Plan will convey pertinent information to the Board.

Local Government Participation in the State Health Plan

Session Law 2015-112 allows local government units to join the Plan. Up to 10,000 total members will be accepted and the Plan currently has approximately 3,500 local government members. Government units with more than 1,000 employees will not be eligible for coverage. Local government units may not enroll retirees. Segal has determined that the fiscal impact is approximately $3.39 million based on various bills and legislation proposing to include specific local governments. However, since government units coming in under the enacted legislation are not named nor required to provide data, the fiscal impact is difficult to quantify.

Mr. Friedman reviewed the requirements, under the law, for governmental units to join the Plan and acknowledged Plan staff member, Rita Sandoval, for her contribution in working with all the local government units and employees over the past several years.

In response to a question from a Board member regarding the potential for adverse selection, Mr. Friedman stated that the Plan hasn't found evidence of that being the case – on average the claims experience of local governments is similar to that of the Plan as a whole.

Joint Legislative Program Evaluation Oversight Committee – Report Number 2015-05, Retiree Health, July 27, 2015

Mr. Friedman provided an overview of the Program Evaluation Division (PED), a commission that oversees government functions. Requests for program evaluations are generated from a member of the General Assembly. The PED work plan for 2013-15 included a study on the funding of the retiree health benefit fund and how the state should address the $25.5 billion unfunded liability. Both Department and Plan staff were interviewed by the PED and their report was presented to the legislative oversight committee in July. Mr. Friedman noted that the PED did not interview Treasurer Cowell.

Mr. Friedman presented the report findings to the Board, including the options that could and should be considered to reduce the unfunded liability, including requiring eligible retirees to be on a Medicare Advantage (MA) plan. According to the report, that would generate an annual savings up to $64 million although that amount has not been substantiated by the Plan's actuarial consultant. The PED requested a response to the findings from the Plan, but Ms. Moon stated that she wanted feedback from the Treasurer and Board members before providing a statement.

Several Board members expressed some concern that if MA plans were mandated, that two carriers may not provide a sufficient number of choices for members. Ms. Moon stated that Plan staff had also discussed that concern but hadn't determined the best strategy if the Plan were to move in that direction.

Mr. Friedman stated that a vote on the report by the legislative oversight committee is scheduled for the week of August 31.

Agenda Item – Financial Report, Forecasting and Monitoring (Attachment 3)

Presented by Mark Collins, Financial Analyst, and Tom Friedman, Director of Policy, Planning and Analysis

Actuarial Valuation of Retired Employees' Health Benefits – Other Postemployment Benefits (OPEB) as of December 31, 2014

Mr. Collins provided background information on the Governmental Accounting Standards Board (GASB), which requires government entities to disclose information on liabilities associated with Other Postemployment Benefits (OPEB), primarily the liability for retiree health benefits. He also reviewed the components used to determine the results of the actuarial valuation.

At the end of December 2014, approximately 570,000 employees and retirees were eligible for retiree health benefits. The unfunded liability increased approximately $1.1 billion (4%) during 2014, which was $0.54 billion less than projected. Mr. Collins noted that the current unfunded liability of $26.6 billion is significantly less than it was in 2009 and 2010. Positive claims experience over the past two years and the implementation of the Medicare Advantage plans have contributed to the decrease in the unfunded liability amount.

2014-15 State Fiscal Year End Report

Before reviewing the fiscal year-end report, Mr. Collins reviewed high-level financial results for the Plan from the April to June quarter. He estimated that the current medical claims trend is between 5.5 and 6

percent, slightly below the assumed 7 percent trend, while pharmacy spending continues to be above the assumed 8.5 percent trend, probably running in the 10 to 15 percent range. Mr. Collins also noted that the timing of pharmacy rebates will be mentioned in several of the subsequent presentations.

For the fiscal year that ended June 30, 2015, total expenses were $25.5 million above the authorized fiscal year budget, and the net income was $57.7 million more than the budgeted amount. The ending cash balance was $1.024 billion.

June 2015 Financial Report

Plan revenue was $5 million over the authorized budget amount, and total expenses were $28.8 million less than projected. The ending cash balance was slightly over $1 billion. The adjusted variance report demonstrated a larger difference between the actual and budgeted numbers due to the inclusion of anticipated pharmacy rebates that were not received by the end of June. The allocation of claims expenditures report more clearly defined the large increases in pharmacy expenses through June 2015 (27.1 percent of claims expenditures) compared to CY2014 (25.7 percent).

CY 2015 2nd Quarter Actuarial Forecast Update

Mr. Collins presented the actuarial forecast schedule and reviewed the assumptions which were maintained and those which were revised in the CY15 2nd Quarter update. Revisions included premium changes for the Medicare Advantage plans, the impact of local governments joining the Plan and the timing of pharmacy rebate payments to the Plan in 2014 and 2015. He noted that the Plan didn't receive rebate true-up payments during the first six months of the year. Since July 1, 2015, approximately $43 million has been paid. He stated that even without the $43 million, the Plan's cash balance at the end of the fiscal year was higher than projected.

The CY 2015 2nd quarter forecast update demonstrated that Plan revenue was $6.3 million higher compared CY 2015 authorized budget. Total plan expenses were down approximately $74 million and the ending cash balance was $80.5 million over the budgeted amount. Based on the current forecast, premium increases in 2016 and 2017 are projected to be 2.83% rather than 3.43%. However, Mr. Collins noted that premium increases in 2018 and 2019 are projected to be significantly higher. The forecasted ending cash balance as of December 31, 2015, is higher than any of the previous projections.

In summary, the forecast projects lower medical claims, higher pharmacy rebates in 2015 and higher long-term pharmacy costs. The required premium increase for 2016 and 2017 is lower than the increase identified by the authorized budget.

Agenda Item – Benefit Design, Plan Options and Premiums (Attachment 4)

Delay Tobacco Attestation Requirements for 70/30 Plan

Presented by Mona Moon, Executive Administrator

Ms. Moon provided a summary of the 2016-2017 benefits and cost-sharing changes for the 70/30 plan approved by the Board and reviewed the anticipated progression for CY2018 and 2019. She noted that the approved changes resulted in a richer benefit for members in the 80/20 plan and Consumer-Directed Health Plan (CDHP).

Due to the timing of the transition of enrollment and eligibility services (EES) back to Benefitfocus, the Plan is reconsidering the tobacco attestation requirement for active members in the 70/30 plan in 2016. Payroll and other systems for several agency partners would need to be reconfigured to allow for the attestation premium credit. Giving the timing and resources required for the EES transition, the Plan

asked for the Board to consider delaying the smoking attestation premium credit in the 70/30 plan until 2017. A delay would not have a significant financial impact.

Board members discussed various reactions and ideas, including the message it sends regarding smoking, perhaps implementing the credit mid-2016 rather than waiting a year and the actual impact of the premium credit on smoking cessation.

Ms. Moon stated that system changes are typically made at the beginning of the enrollment period and not in the middle. Members also choose a particular plan for a one-year period and implementing a premium credit in the middle of the year might encourage members to choose another plan. Both changes could destabilize the system.

The tobacco premium credit across all plan options will better assist the Plan in determining the impact of smoking cessation for the total membership. The Plan can currently provide data to the Board regarding the number of members who earned the credit. Dr. Menon stated that the percentage of smokers is generally higher than in other states but the overall trend of smokers is decreasing.

Following a motion by Dr. Newton and seconded by Ms. Hargett, the Board voted unanimously to delay the creation of the $40 wellness premium and corresponding tobacco attestation credit on the Traditional 70/30 plan until January 1, 2017.

2016 Premium Contribution Rates

Presented by Tom Friedman, Director of Policy, Planning and Analysis, and Mark Collins, Financial Analyst

Mr. Friedman presented the 2015 state and national trends in premium increases and projected trends for 2016. He stated that premiums for North Carolina employers increased 37% since 2008 which equates to approximately 5% annually. The BCBSNC premium increase for the NC Exchange was approximately 30% in 2015.

Mr. Friedman reviewed the Plan's traditional approach to premium increases and stated that because the State's budget has not yet been finalized, the Plan had to consider a different approach. In order to adequately prepare for Annual Enrollment and allow time for system changes, the staff proposed that the Board approve the premium increases without a commitment from the General Assembly to increase employer contributions.

The proposed rates for the CDHP, 80/20, 70/30 and MA plans were presented and discussed. It was noted that the 2015 premium increase by the MA carriers for dependent coverage wasn't passed on to the Plan members. It was also noted that for active and non-Medicare retiree members who choose **not** to engage in wellness activities, the employee premium increase in the 80/20 plan and the dependent tiers across all plans become much higher than 2.83%.

Proposed premium increases for other member groups in the Plan, including COBRA, National Guard, firefighters and emergency medical personnel, were also presented. Mr. Collins noted that COBRA and 100% and 50% contributory members in any MA plan will not pay more than the premium associated with the MA plan, plus the Plan's administrative fee.

The proposed rate increase for members in the High Deductible Health Plan (HDHP) is 2.83%. The required increase for the employer contribution is 4.4%. The Plan doesn't recommend adjusting the rates based on actual HDHP claims, as that would result in a significantly larger increase due to the small

number of enrolled members. The overall objective is to limit the employer contribution for non-permanent employees.

Mr. Friedman presented the 2016 premium contribution rate recommendations to the Board for their consideration.

Several Board members expressed concern about establishing rate increases without a passed budget. Ms. Moon acknowledged their concern and stated that the Plan wants the General Assembly to fund the Plan as they have in the past and has conveyed that message to them.

Mr. Friedman reviewed various scenarios and resulting implications with the Board based on the current House and Senate budgets. If the General Assembly follows the traditional funding model or provides for some increase in the employer contribution for 2016, the required premium increases in 2017 would be smaller than without an increase in the employer contribution.

Ms. Moon expressed concern that the General Assembly will assume the Plan doesn't need funding, given the current cash balance. Using the latest forecast has been the Plan's best approach to determine a reasonable premium increase given that a budget hasn't been passed. One board member asked if a 2.83% increase is adequate to maintain the Target Stabilization Reserve. Ms. Moon responded that increasing the premium amount beyond 2.83% would penalize members and isn't an option the Plan wants to consider, if possible. She also stated the Plan's desire to implement long-term changes beyond premiums and cost-sharing. However, the message conveyed by the General Assembly has forced the Plan to provide a short-term funding resolution.

A lengthy discussion followed with Board members expressing concerns about imposing a premium increase without a budget in place and the impact on Plan members.

Following a motion by Dr. Newton and seconded by Ms. Hargett, the vote was 5-2 in favor of approving the Plan staff 2016 premium contribution rate recommendations outlined on page 18 of the presentation. Charles Johnson and Bill Medlin voted "no."

Following the vote, the Board requested that Plan staff draft a letter from the Board to the General Assembly, urging the General Assembly to pass the budget. Mr. Friedman and Mr. Solari agreed to draft a letter for the Board to review and sign prior to adjournment.

Mr. Medlin stated that his vote against the recommendations was regrettable but that it was a matter of conscience.

<u>Out-of-Network Lab Benefit</u>

Presented by Caroline Smart, Chief Operating Officer

The Plan has followed BCBSNC's policy of paying out-of-network (OON) labs ordered by an in-network provider as in-network. These claims were paid at 100% of billed charges. On July 15, 2015, BCBSNC implemented a new OON fee schedule which applies to all BCBSNC commercial business as well as the Plan. The estimated savings for the Plan from the new fee schedule is $13,418,181. On January 1, 2016, BCBSNC will make additional changes that will bring OON independent lab claims in line with industry payment policies. If approved by the BOT, the claims will no longer be paid as in-network but will be paid at the appropriate OON coinsurance.

Following a motion by Dr. Newton and seconded by Dr. Rubin, the Board voted unanimously to approve that out-of-network lab services be paid at out-of-network cost share effective January 1, 2016.

Health Engagement Program

Presented by Nidu Menon, Director of Integrated Health Management, and Angie Wester, Disease and Case Management Coordinator

Ms. Wester reviewed the Board-approved 2016 Health Engagement Program (HEP) for Consumer-Directed Health Plan members over age 18 and all CDHP members with a chronic health condition. Healthy lifestyle activities include interaction with a lifestyle coach, physical activity and nutrition tracking. Numerous health apps and devices can be used to track fitness and nutrition activities. Members will have the ability to earn $125 per year in their health reimbursement account by participating and meeting the criteria in the HEP.

Members with chronic condition(s) will be able to earn incentives through interaction with health coaches, Primary Care Provider visits, lab work, recommended treatment and education for their condition(s). Incentives that can be earned in this program range from $50-$335.

To answer a question from a board member regarding how well incentives work, Dr. Menon stated that with this program, evaluating the success and member progress will be much improved. After the two-year evaluation is completed, the Plan should be able to determine how well the incentives are working and the direction in which to take incentive programs. The actual evaluation criteria have not yet been developed. Ms. Moon added that this program provides the Board with an opportunity to determine what they'd like to evaluate in line with the strategic plan.

The Plan anticipated implementing the HEP on January 1, 2016, but may delay the effective date until April 1, 2015. A robust communication plan will be developed for members and providers.

Following a motion by Ms. Hargett and seconded by Dr. Cunningham, the Board voted unanimously to approve the healthy lifestyle program component for all CDHP members, including the requirements, activities and amounts and frequency of incentives.

Following a motion by Mr. Johnson and seconded by Dr. Newton, the Board voted unanimously to approve the chronic conditions component for eligible CDHP members, including the requirements, activities and amounts and frequency of incentives.

The Health Engagement Program may be delayed until the 2nd quarter of 2016.

Diabetes Primary Prevention Program

Presented by Nidu Menon, Director of Integrated Health Management

Dr. Menon presented statistics on the Plan members with diabetes and those who are pre-diabetic. She added that many people aren't aware they're pre-diabetic or have diabetes and the prevention program would target those in the pre-diabetic category. Eight states currently offer diabetes prevention programs as a covered benefit.

The Plan is proposing a one-year lifestyle change program effective March 2016 that would include 16 weekly sessions with a lifestyle coach. Following the weekly sessions, the coach would follow up with the members one time per month for 6 months. The Plan would have a contract with the NC Agricultural Foundation, NC State University to deliver the program. Dr. Menon noted that the Plan currently has a contract with the NC Agriculture Foundation for the Eat Smart, Move More, Weigh Less program which is offered to all Plan members.

Dr. Menon reviewed the administrative details of the program including the responsibilities of each vendor and subcontractor, invoicing and accounting, analysis and reporting. The start-up cost will be approximately $50,000 and the total budget will be $394,487.50 assuming a total enrollment of 750 Plan members. Members will pay $25 which will hopefully incent a commitment to the program.

The communication and engagement strategy will include a pre-diabetes awareness campaign among Plan members, as well as for providers.

In answer to a question regarding the coordination of care with the member's Primary Care Provider, Dr. Menon stated that the Plan is still developing the details of the way in which information will be communicated to providers. It was suggested that primary providers should be encouraged to refer members to the program. It was also noted that the Plan has a contract with Buck Consulting, Inc. to assist with member messaging.

Agenda Item – Member Experience and Communications Update (Attachment 4)
Presented by Beth Horner, Customer Experience Manager

The member satisfaction survey opened in July and will end August 31. To date, approximately 5,000 people have responded.

The one-year prescription home delivery pilot program is available to members with established long-term medications. A letter was mailed to qualifying members in early August and interested participants will have 30 days to enroll in the program.

Buck Consulting, Inc. was awarded the Communications and Marketing Services contract in May. The vendor will be utilized to assist the Plan and the Department of State Treasurer (DST) with messaging and strategy in the EES transition.

The 2016 Annual Enrollment communication and outreach is under way. The Plan faced several challenges when information on the Medicare Advantage plans and rates was unknown and when issues with the EES vendor became evident in July. In addition, some of the communication materials were discontinued or had to be changed at the last minute. Ms. Horner stated that member outreach meetings across the state will begin in September. Medicare retiree mailers encouraged members to attend one of the meetings in their area.

Six telephone town hall meetings are scheduled for September and October. This will allow the Plan to reach thousands of members in a single session and provide members with the opportunity to ask questions during the session.

The Plan has continued to communicate information regarding the EES transition to health benefit representatives and employing units. Information has also been posted on the website instructing members on who to call if there are access-to-care issues.

Following a motion by Ms. Moore and seconded by Mr. Medlin, the Board voted unanimously to move into executive session pursuant to G.S. 143-318.11 and G.S. 132-1.2.

Agenda Item – Executive Session

Lake Lawsuit
Presented by Lotta Crabtree, Deputy Executive Administrator

Ms. Crabtree provided settlement information from the Plaintiffs to the Board.

Communications and Market Services RFP Recommendation
Presented by Beth Horner, Customer Experience Manager

Ms. Horner discussed the RFP process and provided the scope of work built around the comprehensive communications and marketing campaign. The vendor recommendation was presented to the Board. Following a motion by Mr. Medlin and seconded by Ms. Hargett, the Board voted unanimously to approve the vendor recommendation.

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

Agenda Item - Adjourn

Following a recommendation by Dr. Newton and seconded by Dr. Cunningham, the board voted unanimously to adjourn at 2:40 p.m.

Janet Cowell, Chair