Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
February 5, 2016

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 3:00 p.m. on Friday, February 5, 2016, at the Department of State Treasurer, 3200 Atlantic Avenue, Raleigh, NC 27604.

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

Participating by Phone:
Aaron McKethan
Warren Newton, MD

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Lucy Barreto, Mark Collins, Beth Horner, Julie McManus, Lorraine Munk, Nidu Menon, Caroline Smart, Lauren Wides, Sandy Wolf, Joan Fontes, Schorr Johnson, Brad Young

Welcome

Janet Cowell, Chair, welcomed Board members, staff from the State Health Plan and Department of State Treasurer and visitors to the meeting. She set the stage for the meeting and noted that possible termination of spousal coverage was off the table and would not be a part of the proposed benefit change discussion.

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 – Transition Specialty Medications from Medical to Pharmacy Benefit (Attachment 1)
Presented by Sandy Wolf, Director of Pharmacy Benefits

Ms. Wolf stated that the transition of specialty drugs, excluding cancer drugs, from the medical to the pharmacy benefit will occur in three stages. She noted that the transition will help to manage adherence and the pharmacy costs and increase medical stability.

The management strategy and projected savings in each phase were reviewed. One Board member asked whether the transition could occur more quickly, given the fiscal pressures elsewhere and also how soon oncology could be included. Ms. Wolf stated that the implementation of phase 2 could

possibly occur sooner than January 1, 2017, and if so, Plan staff will notify the Board. The inclusion of cancer drugs under the current pharmacy contract isn't possible, but the Plan is reviewing that option for the future.

Following a motion by Dr. Newton and seconded by Dr. Cunningham, the Board voted unanimously to approve moving specialty drugs identified for Phases 1 and 2 from the medical benefit to the pharmacy benefit effective June 1, 2016, and January 1, 2017, respectively. Board approval for phase 3 will be requested at a later date.

Agenda Item – Coverage for Clinical Trials (Attachment 2)
Presented by Lotta Crabtree, Deputy Executive Administrator and Legal Counsel

Ms. Crabtree reviewed the current coverage of clinical trials under the Affordable Care Act (ACA), which includes a phase I, II, III or IV trial conducted in relation to the prevention, detection or treatment of life-threatening diseases or conditions, and is a federally funded or approved trial, a trial conducted under an FDA investigational new drug application or a drug trial that is exempt from the requirement of an FDA investigational new drug application.

Ms. Crabtree summarized Plan coverage of clinical trials and stated that current coverage under the grandfathered 70/30 and 80/20 plans excludes phase I. The projected cost of expanding coverage to include phase I trials is approximately $1 million annually. The coverage of phase I trials is not a mandate for the Plan's grandfathered benefit plans.

Following a motion by Dr. Cunningham and seconded by Ms. Hargett, the Board voted unanimously to approve the coverage of approved clinical trials consistent with ACA requirements for grandfathered 70/30 and 80/20 plans, effective January 1, 2016.

Agenda Item - Provider Reimbursement Strategies & Opportunities (Attachment 3)
Presented by Mona Moon, Executive Administrator, and Lotta Crabtree, Deputy Executive Administrator and Legal Counsel

Ms. Moon reminded the Board that one of the strategic priorities in the strategic plan is to achieve financial stability. She stated that the Plan, under the leadership of Treasurer Cowell and the Board, has accomplished a great deal over the past few years by implementing benefit enhancements. A number of challenges remain and future benefit decisions should be made based on the strategic plan. If the Board decides to move in a different direction, the strategic plan should be revised to reflect that course of action.

Under the Comprehensive Major Medical Plan, Plan staff initiated and maintained provider contracts, including reimbursement. The model changed in 2006 when the Preferred Provider Organization (PPO) plans options were implemented. The Plan is no longer responsible for provider contracting but does manage costs in some areas and is able to establish clear financial incentives.

In January 2014, the Plan presented information on payment methodologies to the Board. Ms. Moon reviewed key findings included in that presentation and stated that the goal of alternative payment arrangements is to shift some or all of the risk to providers and to establish a balance of access and choice, with affordability and quality of care. She also reviewed the spectrum of potential payment methodologies and a summary of findings. It was noted that the size of the Plan's population offers opportunities for alternative payment methodologies and arrangements, although the geographical distribution of members presents challenges.

Ms. Moon discussed next steps and recommendations, keeping in mind the goal of ensuring a financially stable Plan.

One Board member noted that with the membership numbers, the Plan should be able to obtain better buying power in order for the member's money to go further and could do better in areas with higher membership. Another member noted that the Plan loses buying power with the membership spread across the state and because not all providers, including hospitals, are under contract with the third party administrator.

In response to a question regarding why the Plan doesn't look at the prison system model, Ms. Moon stated that the population health management component isn't a part of what they offer. Care in the prison system is also incident-based rather than managed to promote member engagement and healthy outcomes. Ms. Moon noted that the Plan is reviewing potential pilot programs in Charlotte and the Triad area to compare rates if members receive care from certain providers.

The Plan's payments under Fee for Service (FFS) were reviewed by Segal, who compared the Plan's average reimbursements in 2012 to Medicare rates. The conclusion was that the Plan pays providers at approximately 148% of Medicare rates, which is consistent with Segal's expectations.

Ms. Moon briefly reviewed the networks, reimbursement and discount rates for the Plan's Third Party Administrator (TPA) and Pharmacy Benefit Manager (PBM) contracts. She noted that a regional model approach with multiple TPAs will be contemplated in the next TPA Request for Proposal (RFP). A market analysis of the PBM contract concluded that pricing in the comparison plans was somewhat better than the Plan's contract. Those findings were used to renegotiate the contract terms with the Plan's PBM.

Next steps and decision points were presented and discussed. Ms. Moon pointed out that with the TPA contract development under way, the Plan needs strategic direction from the Board.

Agenda Item – Proposed Benefit Design Changes for 2017 (Attachment 4)
Presented by Mona Moon, Executive Administrator, Lotta Crabtree, Deputy Executive Administrator and Legal Counsel, and Mark Collins, Financial Analyst

Ms. Crabtree discussed the long-term outlook and provided a summary of recent legislative actions. Projected premium increases of 14.8% in 2018-19 caused concern among members of the General Assembly, the Board and Plan stakeholders. As a result, the 2015 Appropriations Act included a provision that required the Treasure and the Board to take "sufficient measures" to reduce the projected increase in employer contributions for the 2017-19 biennium. It also required that the Plan maintain a cash reserve equal to 20% of annual expenses through June 2017.

Over the course of the past year, Plan staff had numerous conversations with members of the General Assembly asking them to define "sufficient measures" but no clear answers were provided. The Plan worked with its actuarial consulting firm to model two scenarios that would require a savings between $402 million-$459 million by the end of 2019. She noted that if the Legislature determines the savings aren't sufficient, member premiums would need to increase by 37% to maintain the 20% reserve requirement.

Ms. Crabtree reviewed the proposed benefit changes presented at the January 2016 meeting. She noted that as a result of feedback from the Legislature, Plan members and stakeholders and the Board, Plan staff recommended delaying a decision on the long-term benefit strategy.

Ms. Moon presented the Plan's recommended benefit design for calendar year 2017. The changes would result in a savings of approximately $100 million, which is 22-25% of the assumed amount needed by CY 2019 to meet the "sufficient measures" requirement by the General Assembly.

Ms. Moon reviewed the current employee premium structure, noting that approximately one-third of active employees don't pay a premium for health coverage. Approximately one-quarter of active members pay dependent premiums. She reiterated that if the Board doesn't approve the proposed premium increases and the General Assembly doesn't provide funding for the 2nd year of the biennium to meet the required reserve amount, the premium increase for members will be 37%.

The proposed 2017 healthy activities and premium credits were presented. Members in the 70/30 plan would receive a premium credit of $40 for non-tobacco use or enrolling in the QuitlineNC program. Allowed credits for smoking attestation, primary care provider selection and the health assessment completion in the Consumer-Directed Health Plan (CDHP) would be $80 and $90 in the Enhanced 80/20 plan.

A detailed outline of the proposed benefit design in all three plan options was included in the presentation. No changes are recommended for the CDHP. Out-of-pocket costs would increase in the 80/20 and 70/30 plans, as well as proposed increases within the pharmacy tiers. Generic versions of several specialty drugs are due to be released in 2016. To incent members to utilize these medications, the Plan recommended adding a new tier for low cost/generic specialty pharmacy drugs.

Mr. Collins presented the financial impact of the proposed design changes. He noted that the new staff recommendation generates both short- and long-term changes. He provided a value comparison of the plan options, noting that the CDHP still remains a good value in comparison to the 80/20 and 70/30 plans.

Ms. Crabtree reviewed the plan options for retirees, noting that the Plan would continue to offer a premium-free option for retirees. The Medicare Advantage rates are contingent on action by CMS and will be presented to the Board for approval at a later date.

The long-term benefit strategy will include further discussions with the Board and Plan stakeholders. Consideration will be given to an enhanced engagement model, moving from three plan options to two plans. Plan staff will continue to investigate alternative strategies to achieve cost savings. Future benefit and premium changes should be driven by the strategic plan.

Board members provided feedback they received from members following the January Board meeting. Affordability and out-of-pocket costs were a common theme. It was also apparent that many members don't understand the plan options, particularly the CDHP, despite communication efforts. Members were very vocal in their desire to keep the 80/20 plan.

Staff recommendations for 2017 benefit design changes included: Changes to base premium rates outlined in presentation; healthy activities and premium credits outlined in presentation; changes to member cost-sharing in the Traditional 70/30 and Enhanced 80/20 plans outlined in presentation; changes to the pharmacy tiers in the Traditional 70/20 and Enhanced 80/20 plans outlined in presentation.

Agenda Item - Proposed Open Enrollment Strategy for 2017 (Attachment 5)
Presented by Caroline Smart, Chief Operating Officer

Ms. Smart reviewed the open enrollment strategy in 2014-2016 and the proposed strategy for 2017. Based on the experience of the past three years, the Plan recommended moving all non-Medicare primary subscribers to the 70/30 plan as a starting point and requiring them to take action to elect the plan of their choice.

The recommended enrollment process would also require subscribers to complete all three activities to receive the premium credits. Previous primary care provider selection and health assessment answers would be removed. Only the active subscribers in the Traditional 70/30 plan would be required to complete the tobacco attestation to receive the premium credit.

Plan staff recommended a passive enrollment for existing Medicare primary retirees, dependents and surviving dependents who have already made a Medicare primary selection. Pricing information will not be available until later in the year.

One Board member suggested listing the primary care provider selected in the 2016 enrollment period and asking members if they want to keep that selection. Ms. Smart responded that the Plan would discuss that programming enhancement and related costs. Another Board member suggested a system change to clearly inform members that their wellness premium credits have been accepted and saved.

Agenda Item – Member and Public Comment Period

Mr. Angaza Laughinhouse, UE Local 150, NC Public Service Workers Union, discussed the financial impact on lower wage workers. He stated that many of these members work in dangerous jobs that pose health risks and they need a decent health plan with decent rates. He noted that this is a critical stakeholder group that would benefit from regional public hearings in order for them to have a voice.

Mr. Matt Brody, University of North Carolina, stated that he received many emails and phone calls following the January Board meeting and applauded the Plan's decision to defer some of the proposals. He expressed appreciation to the Plan for taking the time to meet with stakeholders during a very busy week. He noted the importance of a good benefit plan relative to staff recruitment and would like to continue the opportunity to provide input for future changes.

Ms. Marge Foreman, North Carolina Association of Educators, read a letter to the Board from Mr. Rodney Ellis, NCAE President. The letter was provided to Chair Cowell and will be included with the minutes.

Mr. Chuck Stone, State Employees Association of NC, stated that it was heartening to hear the presentation on alternative payment methodologies but said that it has taken the Plan four years to do so. He stated that the wellness surcharges represent a 300% increase for employees. He stated that raising member premiums is always the first option the Plan presents to save money and that it violates the Board's bylaws and fiduciary responsibility to provide a Plan "solely for the members' benefit." He encouraged the further negotiation of reimbursement rates with the General Assembly and asked the Board not to vote on the proposed changes at this meeting.

Ms. Pam Deardorff, NC Retired School Personnel, voiced appreciation to Plan staff for the stakeholder meetings and the hard work involved. She stated that sometime the retirees are a forgotten group of people. She expressed appreciation for a premium-free option for retirees but not for the costs

associated with the 80/20 plan. The cost-of-living increase last year was less than the $750 one-time bonus that active employees received and places a significant burden on retirees. She encouraged the Plan and Board to keep that in mind when setting benefits. It's also difficult for members to make decisions when Medicare Advantage information isn't available until later in the year. She expressed opposition to the potential elimination of spousal coverage and appreciation that that it wouldn't be included in the Board vote.

Representative Darren Jackson, North Carolina General Assembly, stated that he represents Eastern Wake County where the concentration of Plan members is perhaps the highest in the State. He noted that there were a lot of references during the presentations regarding the meeting "last month" when it was really only 10 days ago. He wasn't aware of the proposed changes until he started receiving emails and phone calls from members. He asked that the Board delay the vote on the benefit design and requested that Plan staff come and meet with members of the General Assembly in order for them to explore other options. He stated that the numbers presented at the meeting were different than what he was providing to his constituents. He acknowledged that some of the emails may have been exaggerated but delaying the vote would provide the General Assembly with a chance to come up with something different.

Letters to the Board from the Professional Educators of NC and the NC Retired Governmental Employees' Association were also provided to the Chair and will be included with the minutes.

Board Discussion and Vote

Benefit Design Changes for 2017

A Board member asked the Plan for the latest date they would need a decision if the vote were to be delayed. Ms. Moon encouraged them not to delay the vote since the Plan needs sufficient time to prepare, implement and communicate. She added that some of the Plan vendors require more lead time to make system changes.

Another Board member expressed appreciation to the group of legislators present at the meeting but also expressed concern that "sufficient measures" had never been clearly defined by anyone in the General Assembly. He stated that a delay in the vote would allow time for conversation with legislative members.

Mr. Johnson made a motion to defer a vote on all items until a discussion with legislators occurs.

Ms. Moon stated that a vote on premium increases can't, in good conscience, be delayed but that it was the Board's prerogative to do so. She asked the Board to consider voting on the premium credits if nothing more.

A friendly amendment was made to Mr. Johnson's original to delay a Board vote on all four recommendations: Delay a vote on Item 1 (Changes to base premium rates outlined on slides 11, 28 and 29 of the presentation) and Item 3 (Changes to member cost-sharing in the Traditional 70/30 and Enhanced 80/20 plans outlined on slides 17 and 18 of the presentation).

Dr. Cunningham seconded the amended motion. Vote was taken and the amended motion was approved. Dr. Newton and Mr. McKethan were opposed to the motion. Dr. Rubin expressed concern about delaying the vote, given the consequences, and moved for a reversal of the previous motion. Given that the majority members approved the original motion, the Chair stated that the vote would stand.

Open Enrollment Strategy for 2017

Following a motion by Dr. Cunningham and seconded by Ms. Hargett, the Board voted unanimously to approve the following staff recommendations:

1. All non-Medicare primary subscribers be defaulted to the Traditional 70/30 Plan and required to take action to select either the Enhanced 80/20 Plan or CDHP for the 2017 benefit year if they do not want coverage under the Traditional 70/30 Plan
2. Non-Medicare primary subscribers be required to **re-select a valid PCP for each family member during the Open Enrollment period** to receive the PCP selection credit for 2017**.**
3. Non-Medicare primary subscribers be required to **complete a new Health Assessment by the end of the Open Enrollment period** to receive the HA credit for 2017. The HA will be available for completion beginning March 1, 2016
4. Non-Medicare primary subscribers be required to **attest to being a non-tobacco user or to enrolling in the QuitlineNC cessation program during the Open Enrollment period** to receive the tobacco premium credit for 2017.

Agenda Item – Adjourn

Following a motion by Charles Johnson and seconded by Kim Hargett, the Board voted unanimously to adjourn the meeting at 5:30 p.m.

Janet Cowell

Janet Cowell, Chair