Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
May 12, 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 4:00 p.m. on Thursday, May 12, 2016, at the Department of State Treasurer, 3200 Atlantic Avenue, Raleigh, NC 27604.

Members
Andrew Holton, Chair
Neal Alexander
Paul Cunningham, MD
Aaron McKethan
Bill Medlin
Warren Newton, MD
Elizabeth Poole
David Rubin

Absent:
Janet Cowell, Chair
Andrew Heath

Participated via Phone
Charles Johnson

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Caroline Smart, Nidu Menon, Mike Santos, David Boerner, Mark Collins, Matthew Grabowski, Beth Horner, Kathryn Keogh, Christine Allison, Lorraine Munk, Andrew Holton

Welcome

Andrew Holton, Chair, welcomed Board members, staff from the State Health Plan and Department of State Treasurer and visitors to the meeting. He also welcomed Neal Alexander, Director of the Office of State Human Resources, to his first meeting as a member of the Board of Trustees.

Mr. Holton asked Board members to review the agenda for approval. Following a motion by Dr. Newton and seconded by Mr. Medlin, the Board unanimously approved the meeting agenda.

Agenda Item – Conflict of Interest
Presented by Andrew Holton, Chair

In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, Chair Holton 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. Dr. Newton notified Chair Holton and the Board that he is a part-time employee of the Department of Health and Human Services.

Agenda Item – Review of Minutes (Attachment 1)
Presented by Andrew Holton, Chair

Mr. Medlin noted a typographical error in the April 27, 2016, minutes on page 4, paragraph 2 under the section for Proposed Benefit Design Changes: 70/20 should read 70/30. Following a motion by Dr. Rubin and seconded by Mr. Medlin, the Board unanimously approved the January 26, 2016, February 5, 2016, March 10, 2016, and April 27, 2016, minutes with the noted correction.

Agenda Item – Clinical & Wellness Programs and Operations (Attachment 2)

Patient Centered Medical Home Practice Pilot

Dr. Nidu Menon, Director of Integrated Health Management, provided a review of the pilot program, stating that the initiative was designed to engage physicians in the care of Plan members. The goal of the pilot is to improve the member experience and outcomes, ultimately impacting health care costs. The second year began on May 1, 2016.

Dr. Menon introduced the four practices who participated in the program and their staff who were present at the meeting to share their experience over the past year.

Eagle Physicians & Associates: Dr. Jim Osborne and Ms. Vickie Gregory presented information for Eagle Physicians & Associates, which has 58 providers in Greensboro and Guilford County. During year 1, the practice saw improvement in several clinical quality metrics and patient satisfaction and member engagement was high. Due to the success of some of the processes developed for the pilot program, similar processes have been applied to other population groups within the practice.

The group looks forward to working with the Plan and ActiveHealth Management (AHM) in year 2 and has determined that value, not volume, is the future of primary care medicine. Building on the lessons learned is important, as well as expanding practice/provider incentives to promote population health management.

In response to a question regarding the readmission rate, Dr. Osborne stated that sending their Patient Advocate to the hospital to develop a relationship with the patient has been very important. The patient is provided with a list of follow-up questions to ask their provider and transition of care phone calls are made to the member after discharge.

In response to a question from Dr. Newton regarding the percent of total spend that went to primary care, Dr. Menon stated that she would research the answer and report back to Dr. Newton.

CaroMont Medical Group: Ms. Lynda Hoyt and Ms. Heather McConnell presented information for CaroMont Medical Group, which has 250 physicians in the Gastonia area. Process changes during the past year occurred in workflow, patient tracking, scheduling and member outreach. With six years of experience as a patient centered medical home, the practice was able to integrate the pilot program within a large system already in place.

Several programs within the practice to promote patient engagement and a healthier lifestyle were presented. Processes and programs to improve patient and physician satisfaction were also discussed. Future opportunities in the pilot program include motivating and incenting member engagement and self-management.

In response to a question by Dr. Newton regarding the role of Medical Assistants, Ms. McConnell stated that they work with AHM, call members to schedule mammograms and other appointments and call in orders for patients.

New Hanover Medical Group: Mr. John Wheeler, Ms. Marian Proctor, Ms. Deborah Musselwhite and Ms. Diana Amedy presented information for New Hanover Medical Group, which is located in the Wilmington area. The motivation for participating in the pilot was to manage the patient population through a collaborative relationship and to pave the way for future efforts in managing patient populations.

The implementation costs, internal processes and staffing changes were discussed, as well as physician engagement and leadership. Care management staffing was expanded and enhancements were made to the electronic medical records system. It was noted that the practice physicians were very involved throughout the entire process. Much of the pilot program success was credited to strong practice leadership.

In response to a question regarding the role of AHM, it was stated that prior to the pilot program, the practice didn't have a patient risk stratification method. AHM assisted staff to put that in place. The practice has also had a lot of interaction with AHM, initially meeting with them weekly.

Novant Medical Group, Inc.: Ms. Marimartha Matthews and Ms. Rea Buie presented information for Novant Medical Group, Inc., which has an attributed population of 12,000 patients between Winston-Salem and north Mecklenburg County. Novant has committed staff to the pilot program including RNs who work with referrals, transition of care, and quality measures. A pharmacist monitors medication alerts and a value-based performance coordinator is responsible for the success of the contract.

Novant staff reviewed program successes and presented quality improvement challenges. Their recommendations include working with AHM to streamline the identification and risk stratification of members, improving the integration of current processes to address patient needs and identifying opportunities to improve care gap closure and increase member engagement using the electronic health record platform.

In response to a question regarding attribution and what has been learned, Novant staff stated that the name and date of birth doesn't always work and it takes a data analytics team and eligibility information from the Plan to match up patients. The practice receives some data on a daily basis and other data on a weekly basis.

In response to a general question, Dr. Menon stated that the Plan would have preferred a more regional spread regarding practice participation. Provider size and type of system were used to determine eligible practices, as well as a willingness and desire by the practices themselves to enter into a pilot program.

RivalHealth Wellness Program (Attachment 3)
Presented by Christine Allison, Health Promotion and Wellness Coordinator, and Pete Durand, RivalHealth

Ms. Allison stated that the Plan recently expanded NC Health*Smart* services to include the RivalHealth program, which is made available through the Plan's contract with Blue Cross and Blue Shield of NC. The program is designed to enhance opportunities for members to implement health behaviors and to incentivize organizations to support employee health.

Mr. Pete Durand stated that RivalHealth is a fitness-based wellness platform that engages members with daily exercise and nutrition activities. He provided information on member engagement and how RivalHealth assists participants in setting and reaching their goals. He noted that one solution does not fit all.

Ms. Allison stated that RivalHealth was made available to the Consumer-Directed Health Plan (CDHP) subscribers and their spouses, local education agencies, school districts and Wellness Champions who meet identified criteria effective April 1, 2016. She reviewed the criteria for Wellness Champions participation and stated that two webinars were provided for them to learn more about RivalHealth.

There are currently 107 CDHP members enrolled with a weight loss goal of 2,542 pounds. A Board member asked if and when retirees would be able to participate in the program. Ms. Moon stated that RivalHealth is currently available to retirees on the CDHP, a roll-out plan will be developed and future benefit design changes might include the Health Engagement Program.

In response to a question as to how RivalHealth identifies individuals at risk, Mr. Durand stated that they work with other State Health Plan vendors and strive to assist members in understanding programs and benefits that could help them most. He also noted that RivalHealth has trained staff who, when working with clients, recognize issues that require additional attention. He noted that modified exercise movements are based on the individual physiology and capability.

Mr. Alexander stated that the Office of State Human Resources (OSHR) has a wellness program with an established infrastructure and would like to discuss how that might be integrated into the Wellness Champions Program. Ms. Allison will pursue scheduling a meeting with OSHR.

Adjourn

The meeting adjourned at approximately 6:00 p.m.

Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
May 13, 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 9:00 a.m. on Friday, May 13, 2016, at the Department of State Treasurer, 3200 Atlantic Avenue, Raleigh, NC 27604.

Members
Andrew Holton, Chair
Andrew Heath
Neal Alexander
Paul Cunningham, MD
Charles Johnson
Aaron McKethan
Bill Medlin
Warren Newton, MD
Elizabeth Poole
David Rubin

Absent:
Janet Cowell, Chair

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Caroline Smart, Nidu Menon, Mike Santos, David Boerner, Mark Collins, Matthew Grabowski, Beth Horner, Lorraine Munk, Greg Moore, Natasha Davis, Lucy Barreto, Andrew Holton, Fran Lawrence, Lisa Alnutt, Schorr Johnson, Brad Young, Tony Solari,

Welcome

Andrew Holton, Chair, welcomed Board members, staff from the State Health Plan and Department of State Treasurer and visitors to the meeting.

Agenda Item – Conflict of Interest
Presented by Andrew Holton, Chair

In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, Chair Holton 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 – Financial Report, Forecasting and Monitoring (Attachment 1)
Presented by Mark Collins, Financial Analyst

Calendar Year 2015
Mr. Collins reviewed the financial results for calendar year 2015. He noted that the net claims payments represent approximately 85-90% of Plan expenses, with Medicare Advantage premiums and administrative expenses making up the remainder. Administrative expenses include staff salaries, vendor administrative fees, actuarial consulting fees, legal expenses, etc.

The net income and ending cash balance for CY 2015 were both higher than projected. However, from the adjusted variance report perspective, the results were not as good as the actual vs. budgeted report demonstrated.

The revenue on the per member per month (PMPM) report was higher than forecasted and expenses weren't as high as anticipated. One Board member noted the unpredictability of membership and the health status of members who join the Plan. Mr. Collins stated that the CY 2015 expenses were more stable than in 2014. In response to a question regarding future claims projections, Mr. Collins stated that year-over-year reports demonstrate a rise in claims expenses. Ms. Moon noted that the trend used in the actuarial forecasts was 9.5% several years ago and it's currently closer to 7%.

The pharmacy trend continues to run higher than the medical trend. Mr. Collins stated that the Plan hasn't seen a significant increase in utilization and that drug pricing is driving up the cost. The Plan closely monitors both medical and pharmacy trends and staff has asked Segal to provide a trend analysis on the 2015 plan year.

March 2016 Financial Report

Mr. Collins noted that the actual claims payments for CY 2016 through March are very close to the forecasted amount. Revenue was approximately $20 million higher than budgeted and the ending cash balance was also higher than projected in the certified budget.

In summary, Mr. Collins stated that with respect to the current cash balance, the Plan is doing well. However, claims expenses are approximately 90% of the Plan's total expenses and are close to the forecasted amount. He cautioned that 2018-19 could see significant premium increases without action by the Board to address the projected increases. The Plan's budget is more aggressive than in the past and brings some added risk.

Agenda Item – Legislative Update (Attachment 2)

Presented by Matt Grabowski, Health Policy Analyst/Legislative Liaison

Since the last Board meeting, Plan staff had several meetings with members of the legislature, including the House Appropriation chairs. Even though the Plan didn't receive a lot of feedback in that meeting, the House leadership did recommend that the Board approve the proposed benefit changes. Staff will also seek to schedule a meeting with the Senate Appropriation leadership in the next few weeks. The Plan will provide relevant updates to the Board during the legislative session.

Mr. Grabowski reviewed current bills filed in the House and Senate on behalf of the Plan. Plan and Department staff will continue to monitor the development of the House and Senate Budgets and track Plan-related legislation.

Agenda Item – Benefit Design, Plan Options and Premiums (Attachment 3)

2017 Benefit Design Changes

Presented by Mona Moon, Executive Administrator

Following an overview of the presentation, Ms. Moon stated that approximately 75% of the Plan's membership would be impacted by the proposed benefit changes discussed in the meeting. She reminded the Board that discussion regarding the Medicare Advantage plans would occur in executive session at the end of the meeting.

Ms. Moon presented the proposed changes for the Consumer Directed Health Plan (CDHP), Enhanced 80/20 and Traditional 70/30 plans. The only recommended change to the CDHP is the inclusion of the deductible in the out-of-pocket maximum. Due to its popularity, the Plan recommended keeping the 80/20 plan but with some changes driven, in part, by the legislative mandate. Both the 80/20 and 70/30 plans contain value based design elements. The 70/30 plan will remain free to employees in 2017.

The impact on the actuarial forecast through 2021 was presented. Various scenarios Ms. Moon discussed included benefit changes with an open or closed formulary under the new pharmacy benefit manager contract. The scenarios also demonstrated the length of time it would take to meet the legislative savings mandate. The release of funds from the General Assembly is a high priority in order to keep premium increases down in 2018 and 2019.

Based on a discussion at the April 27, 2016, Board meeting, Ms. Moon presented a chart demonstrating the plan share of total costs for 2014 and 2015 and the actuarial values for 2016 and the staff recommended 2017 benefit design. She noted the challenge in breaking out the engaged and non-engaged and asked Board members to let her know if they would prefer percentages that blend the two.

In response to a question regarding increasing funds in the HRA to incent members to use RivalHealth, Ms. Moon stated that it was considered. However, due to timing issues, the Plan elected to focus on the Wellness Champions program. The Plan will continue to discuss that option, as well as health engagement options in the 80/20 plan.

At the suggestion of a Board member at the February 2016 meeting, Ms. Moon provided various scenarios for the purpose of determining which plan option would be best for the member. She noted that aggregated claims data was used in the scenarios but that members use other factors when choosing a plan option.

The Plan is increasing the communication efforts for the CDHP but there are members for whom no amount of communication will convince them or influence their decision. Plan staff would prefer not to default members to a certain plan and require them to move if they choose another option. Finding the right balance is a challenge.

Modify Coverage of Specialty Medications
Presented by Caroline Smart, Chief Operating Officer

The transition of specialty drugs from the medical benefit to the pharmacy approved by the Board at the February 2016 meeting was to occur in three phases. However, with the transition to a new Pharmacy Benefit Manager, Ms. Smart presented several issues that have surfaced which could impact the implementation timeline.

The Plan recommends that the Board rescind its February action authorizing the transition of specialty medications from the medical to pharmacy benefit. The Plan will present a revised transition timeline to the Board at the August 2016 meeting.

Pharmacy Benefit Management Implementation
Presented by Caroline Smart, Chief Operating Officer

Ms. Smart presented information on two programs that complemented the formulary and copay structures in place at that time – Medication Adherence Program (MAP) available to retirees and "Member Pay the Difference" program. Several plan design changes since 2011 have lessened the need

for the MAP and the Plan has other similar programs in place which are available to all members. In addition, the proposed value based plan design for members in the 80/20 plan reduces the member cost share for Tier 1 and 2 drugs.

The Plan proposes discontinuing the MAP effective January 1, 2017, and considering options for value added programs after the evaluation of the CVS 90-day Network is complete.

The "Member Pay the Difference" program was implemented when the tier structure was more restrictive and generic drugs were always the lowest cost drugs. Moving to more value based benefits will result in the Plan's drug tiers becoming more blended. The Plan recommends discontinuing the "Member Pay the Difference" program.

Additional information will be presented to the Board at the June 2017 meeting.

Ms. Smart presented information on the possibility of adopting a closed formulary. The Plan staff has completed an initial evaluation of the CVS closed formulary and recommends that the traditional plans move toward a closed, custom formulary. By doing so, the Plan will benefit from cost savings and support the move to more value based benefits. The Plan will continue to evaluate the best option for the CDHP.

Medicare Advantage Update
Presented by Caroline Smart, Chief Operating Officer

The Plan is in the third year of its contracts with the two Medicare Advantage vendors and needs to determine if extensions will be given. The Plan will meet with the retiree stakeholder groups later in May and present a recommendation to the Board and request approval at the June 2016 meeting. Ms. Smart stated that additional information would be presented to the Board during the executive session.

Member and Public Comment on Proposed Changes
Mr. Mark Jewel, NC Association of Educators (NCAE), stated that health benefits are a big decision for teachers as to what they can afford. North Carolina ranks 10 out of 12 pay-wise in the Southeast. Retention is a big concern for administrators and low pay with minimal raises makes it hard to keep good teachers. Many of them have to work two or more jobs in order to make ends meet. He encouraged Plan staff to better educate members as to how the CDHP works if that's the direction we want them to go. NCAE wants to continue working with the Plan to make the benefits affordable. He asked the Board to delay a vote on the benefit design until the budget is released.

Ms. Ardis Watkins and Mr. Chuck Stone, State Employees Association of NC (SEANC): Ms. Watkins echoed Mr. Jewell's statements and voiced appreciation to the Plan staff for getting the stakeholders' input prior to the Board meetings. She stated that in February, the Plan attempted to shove through benefit design options that the Board, in their wisdom, did not adopt. The Plan still doesn't have an answer as to what "sufficient" measures mean and Ms. Watkins stated that the Plan should have acted earlier in asking the legislature to define that.

Mr. Stone stated that as a former Board member, he questioned whether the current Board members understood what the out-of-pocket increases would mean to Plan members and suggested that the materials did not provide insight. He stated that he thought members would refute the Plan's assertion that the benefits improved and they're not paying more money. With no recent pay increases, the percent of their net income today is more than they've ever paid in the history of state government. He

urged the Board to demand answers and not vote for the proposed benefit changes. He further stated that members are not being properly educated on the CDHP and encouraged the Plan and Board to eliminate that option and keep the 80/20 and 70/30 plans.

A letter from Matt Brody, University of NC General Administration, was distributed to the Board.

Board Action on Proposed Benefit Design Changes & Specialty Transition

Prior to the vote, Board members discussed various aspects of the proposed benefit changes and requested clarification on several pages of the presentation. One Board member stated that the Plan is doing a good job explaining the plan options but members are not getting the individual scenarios included in the presentation. Including the scenarios in member outreach meetings or online might be a way to better educate them on the CDHP.

Board members recognized the dilemma of members not receiving raises and needing to make decisions about what they can afford. It was noted, also, that while the Plan and Board have no control over salaries, they do have a fiduciary responsibility to keep the Plan sustainable. One Board member asked how much the Plan would save if the CDHP were eliminated. Ms. Moon stated that it would depend which Plan the CDHP members chose.

The Board discussed the increase on out-of-pocket expenses and how that approach "taxes" the sickest members. The question over the long-term is how to balance the out-of-pocket costs among all members. Ms. Moon stated that it was the philosophical decision before the Board – whether to raise premiums or increase medical and pharmacy out-of-pocket costs.

After additional discussion and affirmation from several members that the Board should not delay a vote on the 2017 benefit design, Chair Holton called for a vote on the two items. On the Coverage of Specialty Medications, Chair Holton suggested changing the word "rescind" to "reverse."

Following a motion by Dr. Cunningham and seconded by Dr. Newton, the Board vote to approve the recommendation by the Plan that the Board revoke its February 5, 2016, action authorizing transition of specialty medications from the medical to the pharmacy benefit.

Following a motion by Dr. Cunningham and seconded by Dr. Rubin to approve the benefit designs and cost sharing changes outlined on slides 5-7 as well as the corresponding changes to family out-of-pocket maximums and out-of-network cost sharing outlined on slides 42-51 of the 2017 Benefit Design Changes presentation, effective January 1, 2017, the vote was 7-1 with Mr. Johnson voting no.

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

Communications & Marketing Strategy
Ms. Horner provided information on two deliverables outlined in the contract with Buck Consulting. The communications audit results found that the Plan had an effective communications strategy but areas of improvement were noted.

The second deliverable, a comprehensive communications and marketing strategy, has the goal of encouraging member engagement with the Plan to maximize their benefits and improve their health. The Plan received high marks for their website, which has 50,000-70,000 visitors per month.

The Plan increased the Health Benefit Representative (HBR) communication with voluntary monthly webinars and quarterly onsite training. Plan staff offer seminars across the state between March and August for members who are turning age 65.

Diabetes Prevention Program

The diabetes prevention program is a new benefit for at-risk members. The 12-month class covers a variety of subjects and is offered onsite or online. The cost to members is $25, a $400 savings. A diabetes resource center was developed on the Plan's website to educate members and assist them in managing diabetes.

Online Enrollment Experience

Benefitfocus conducted informal group conversations focused on the online enrollment member experience. The purpose was to identify user attitudes and behaviors, as well as identify key issues. The second phase of their research was one-on-one interviews to assess usability, with a focus on the wellness credits tasks in eEnroll.

Several changes were made to the enrollment screen within eEnroll and Benefitfocus will extend hours during Open Enrollment in October.

2017 Open Enrollment Experience

Ms. Horner reviewed the training and outreach opportunities for HBRs and the communication plan for members. In response to a question regarding the possibility of on-demand health care webinars that could be used for teacher CEU credits, Ms. Horner stated that she would research the idea. The Plan would look into working with the Department of Public Instruction to determine how the credits could be applied.

Agenda Item – Contracting and Vendor Partnerships (Attachment 5)

Third Party Liability Recovery Service RFP

Presented by Greg Moore, Quality Program Manager

Mr. Moore reviewed the statute regarding subrogation and stated that the Plan currently contracts with a third party liability vendor, HMS. The current contract was extended through August 31, 2016. The total subrogation recoveries and fees paid from 2012-2015 were presented to the Board. The average number of claims submitted is 500 per month.

The Request for Proposal for the third party liability recovery services closed on April 22, 2016, and is currently being evaluated. The Plan will have a recommendation for the Board at the June 2016 meeting.

Auditing Services Results

Medical Claims
Presented by Greg Moore, Quality Program Manager

Mr. Moore provided a general overview of the auditing process and the results of the medical claims audit findings and follow-up for the Plan's Third Party Administrator (TPA). In a random sampling of all medical claims processed from July 2014 to December 2015, the TPA met all of the performance guarantees outlined in the contract.

Pharmacy Claims & Financial Terms
Presented by Natasha Davis, Pharmacy Benefit Program Manager

Ms. Davis provided an overview of the pharmacy financial audit and the 2013-2015 results. In 2014, the Plan's Pharmacy Benefit Manager, ESI, had dispensing fees and discount guarantee shortfalls. As a result, ESI paid the Plan $3.3 million.

In 2015, the preliminary audit report finds that ESI owes the Plan approximately $8.6 million for dispensing fees and discount guarantee shortfalls.

The auditor listed no findings for the pharmacy claims audit findings.

The auditor found several variances on exclusions in the pharmacy plan design accuracy audit review. No other issues were noted.

In response to a question regarding benchmarks, Ms. Smart stated that the Plan looks to the auditors to help determine them. She noted that the Plan's benchmarks are higher than many and the Plan reviews the contract to determine if the benchmark should change.

Agenda Item – Clinical & Wellness Programs and Operations (Attachment 6)

Pharmacy & Therapeutics Committee February Meeting
Presented by David Boerner, MD, Medical Director

Dr. Boerner provided updates to the utilization management programs for a number of drugs. He also presented several drugs which the Committee reviewed. The Committee looked at these and made decisions on tier placement.

Chair Holton reminded the Board of the special meeting June 2-3 and the regular meeting August 4-5.

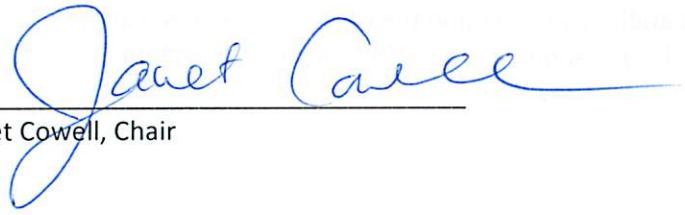
Following a motion by Ms. Poole and seconded by Mr. Johnson, the Board voted unanimously to move into executive session, pursuant to G.S. 143-318.11 and G.S. 132-1.2.

Executive Session
Pursuant to G.S. 143.318.11(a)(1)), Ms. Crabtree discussed renewal information for the Medicare Advantage plans.

Following a motion by Ms. Poole and seconded by Mr. Johnson, the Board voted unanimously to return to open session.

Adjourn

Following a motion by Dr. Cunningham and seconded by Mr. Johnson, the Board voted unanimously to adjourn at 3:25 p.m.



Janet Cowell, Chair