Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
August 4, 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, August 4, 2016, at the Department of State Treasurer, 3200 Atlantic Avenue, Raleigh, NC 27604.

Members
Janet Cowell, Chair
Neal Alexander
Paul Cunningham, MD
Bill Medlin
Warren Newton, MD
Elizabeth Poole
David Rubin
John Sparrow for Andrew Heath

Participated via Phone
Aaron McKethan

Absent:
Charles Johnson
Andrew Heath

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Caroline Smart, Nidu Menon, Tom Friedman, Lauren Wides, Lucy Barreto, Mark Collins, Matthew Grabowski, Beth Horner, Lorraine Munk, Lisa Alnutt, Melinda Peters, Laura Rowe, Tony Solari, Blake Thomas, 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.

Agenda Item – Conflict of Interest
Presented by Janet Cowell, Chair

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 Bill Medlin and seconded by Warren Newton, the Board unanimously approved the June 2-3, 2016, minutes, as written.

Agenda Item – Introduction of New Staff
Presented by Mona M. Moon, Executive Administrator

Ms. Moon introduced Jamilah Brunson, Clinical Pharmacist Manager.

Agenda Item – Requests for Benefit Changes (Attachment 2)

P. Korey Newton, State Health Plan Member – Mr. Newton and his wife recently underwent bariatric bypass surgery, which has resulted in the need for nutritional supplements and monitoring for life. He asked the Board to consider providing coverage for over-the-counter vitamin supplements. In addition, he requested increased coverage for blood tests, which are not considered preventive and therefore not covered at 100%.

Beth Levin, State Health Plan Member – Ms. Levin, a preschool teacher, requested the Board to consider additional coverage for chiropractic visits. She is covered under the Consumer-Directed Health Plan (CDHP85/15) and currently sees a chiropractor one to three times per week. The current benefit under the CDHP 85/15provides a combined 30 visit limit physical therapy, occupational therapy, and chiropractic benefits. Ms. Levin indicated the limitation impacts members with chronic back pain, spinal cord injuries, and other conditions.

Ardis Watkins, State Employees Association of North Carolina – On behalf of SEANC, Ms. Watkins requested the Board to consider the following: Provide a Medicare supplement/Medigap policy or cash benefit for Medicare retirees OR allow them to choose the 80/20 plan option; provide active employees with the option to select retiree health coverage or free dependent coverage equal in value to the current retiree health coverage; provide a combined medical and pharmacy out-of-pocket maximum not to exceed $5,000 per covered member under the PPO options; reduce generic prescription copays not to exceed $10; provide a premium free option equal to the 80/20 plan and eliminate premium credits under the new 80/20 plan; provide coverage for acupuncture; provide member credits for phone/tablet apps and/or technology devices to help members monitor and improve their health.

Agenda Item – Legislative Update (Attachment 3)
Presented by Matthew Grabowski, *Health Policy Analyst/Legislative Liaison*

Mr. Grabowski provided an overview of the final State budget and reviewed key legislation relevant to the Plan. He stated that the budget did not call for the immediate release of funds which have been held in reserve for the employer share of 2017 premium increases. Furthermore, the Treasurer and Board are directed to adopt cost-saving measures for calendar years 2017 - 2019 to limit employer contribution increases. The Director of the Budget can release the funds if the projected employer contribution increase is 4% or less in CYs 2018 and 2019. The Plan received notification from the Office of State Budget and Management (OSBM) on August 1, 2016 that conditions for release of the funds have been met.

The cap for local government participation was increased to 13,500 through June 30, 2017, and 16,000 members through January 31, 2018. The Plan has begun the process of accepting participation requests from interested local units of government.

Agenda Item – Financial Report, Forecast and Monitoring (Attachment 4)
Provided by Mark Collins, Financial Analyst

2015-16 Fiscal Year-End Report
Mr. Collins provided highlights of the Plan's fiscal year-end report. He noted that medical claims expenses spiked in April and were lower than projected in June. Overall, the net claims payments are running close to projections.

The year-end cash balance, less than $1 billion, verified expectations that the Plan would begin to spend down the excess cash balance at some point. Mr. Collins stated that with the membership higher than expected, revenue was approximately $50 million higher than projected. Administrative expenses were lower than the forecasted amount. The adjusted variance report followed a similar pattern.

A comparison of claims expenditures from the past two fiscal years demonstrated that pharmacy expenses continue to grow at a faster rate and represent approximately 28% of Plan expenses. Inpatient claims were slightly lower as a percentage of claims expenses this past fiscal year and outpatient claims were slightly higher.

In response to a question regarding the amount members spend out-of-pocket (OOP), Mr. Collins stated that over the past several years, the average amount was approximately $90 for members in the copay based plan options or about 18-19% of cost. Ms. Moon stated that the Plan would update that information and provide it to the board at the next meeting.

June 2016 Financial Report
Mr. Collins reiterated that the increase in membership accounted for the increase in revenue. The June report followed a pattern similar to prior reports. He stated that the forecast takes seasonal expenses into account.

The June report demonstrated the steady increase in pharmacy expenditures the Plan has seen over the past several years. Total calendar year 2016 expenses through June were approximately $1.6 billion. Plan staff will continue to monitor pharmacy expenditures.

CY 2016 1st Quarter Actuarial Forecast Update
Mr. Collins reviewed the State Budget language regarding the directive to sufficiently reduce projected employer premium increases in 2018 and 2019. The updated forecast projects increases of 3.74% for those two years. He noted that on August 1, 2016, the Office of State Budget and Management notified the Plan that the funds held in reserve would be reallocated to employing units January 1, 2017.

The forecast assumptions maintained in the updated forecast were reviewed, as well as those which were changed and/or revised. In response to a question regarding when the Plan might need to increase the pharmacy trend, Mr. Collins stated that pharmacy rebates coming in consistently stronger has allowed the trend to remain at 8.5%. He noted, however, that the Plan would review pharmacy expenditures sometime in the near future to determine if the trend should be revised.

In response to a question regarding an aggregate calculation of savings as a result of Board approved benefit decisions since 2011, Ms. Moon stated that Plan staff will provide that information to the Board. Mr. Collins provided quarterly forecast comparisons for claims and ending cash balance in CY 2015-16 and the projected ending cash balance in June 2017. He noted that the projected cash balance at the end of June 2017 wouldn't fall below the floor set in the State Budget of 12% of projected expenses.

Agenda Item – Strategic Plan Update (Attachment 5)
Presented by Tom Friedman, Director of Policy, Planning and Analysis

2016 Strategic Plan Update
Mr. Friedman acknowledged Board members for taking the time to meet with him individually and stated that the discussions were valuable to the Plan. A copy of the revised Strategic Plan was distributed to Board members.

Review of Changes
Mr. Friedman reviewed the key proposed changes to the Strategic Plan and roadmap. He noted that when the Strategic Plan was developed, the industry was moving toward a patient centered medical home (PCMH) model. Since that time, the methods of care delivery have expanded and the Strategic Plan was revised to reflect the changes.

Language was updated to incorporate a communication strategy. Initiatives were added to address the high utilizers of emergency room and inpatient care. Plan staff would also like to discuss options to address the growing problem of opiate addiction.

Revisions to the roadmap were presented and Mr. Friedman noted that most of the strategic initiatives are ongoing and the program and projects within the initiatives would frequently change.
Following a discussion of the proposed language revision on page 12 of the Strategic Plan, Ms. Crabtree stated that the word "obligations" would be changed to "actions."

Following a motion by Dr. Newton and seconded by Mr. Alexander, the Board voted unanimously to approve the Strategic Plan with the language revision.

Scorecard – Measuring Success
Mr. Friedman briefly reviewed the executive summary, approved metrics and a timeline of events. He noted several areas where the scores fell below the threshold or benchmarks. Of particular concern to the Board was the low percentage of members with diabetes meeting the clinical standards of care.

The modifications to improve the metrics were presented and discussed. Mr. Friedman reviewed the next steps, which include upcoming meetings with workgroups to discuss and finalize 2017 goals and identify areas of focus to achieve the strategic goals.

One board member expressed concern about the member satisfaction score and requested that the Board focus on that and develop a strategy for improvement. Ms. Moon stated that she appreciated the request and suggested that the Provider Network, Quality and Access workgroup would be a good starting point for this discussion.

Agenda Item - Adjourn
Presented by Janet Cowell, Chair

The meeting was adjourned at 5:55 p.m.

Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
August 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 9:00 a.m. on Friday, August 5, 2016, at the Department of State Treasurer, 3200 Atlantic Avenue, Raleigh, NC 27604.

Members
Janet Cowell, Chair
Neal Alexander
Paul Cunningham, MD
Aaron McKethan
Bill Medlin
Warren Newton, MD
Elizabeth Poole
David Rubin
John Sparrow for Andrew Heath

Absent:
Charles Johnson
Andrew Heath

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Caroline Smart, Nidu Menon, Tom Friedman, Lauren Wides, Mark Collins, Matthew Grabowski, Beth Horner, Lorraine Munk, Lucy Barreto, Fran Lawrence, Blake Thomas, Lisa Alnutt, Laura Rowe, Brad Young, Kathryn Keogh, Natasha Davis

Welcome

Janet Cowell, 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 Janet Cowell, Chair

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 – Benefit Design, Plan Options and Premiums (Attachment 1)

<u>2017 Premium Contribution Rates</u>
Presented by Mark Collins, Financial Analyst

Mr. Collins stated that the overall premium structure contained no dramatic changes from the previous meeting presentation. UnitedHealthcare proposed renewal rates, which resulted in lower premiums in the Medicare Advantage plan. Mr. Collins provided a summary of the staff recommendations for each

plan option, noting that the largest premium increase would be for active employees in the 70/30 Plan who use tobacco and are not willing to enroll in QuitlineNC.

One board member noted that employees tend to focus on the 3.4% increase rather than the dollar amount. In addition, employees focus on the 1.5% salary increase and compare that to a 3.4% premium increase. The importance of communicating the information in a positive way was emphasized, especially in the case of members in the 80/20 Plan where the increase computes to 84 cents. Ms. Moon agreed and stated that Plan staff recognize the importance of the communication strategy.

In response to a question regarding whether the Plan has experienced the effect of the ACA with respect to dependent coverage, Mr. Collins stated that there may be a slight increase in membership, especially in the CDHP. A follow-up question was asked regarding how many Medicare retirees have multiple Medicare dependents. Mr. Collins stated that in most cases there was one dependent. Ms. Moon noted that the Medicare Advantage plans offer significant savings for dependents.

In response to a request for an age banding report for dependent coverage, Ms. Moon stated that the Plan would provide that information to the Board.

In response to a question as to how soon the Plan would reach the Cadillac plan level, Ms. Moon stated that it would possibly be 2028 or 2029 for family coverage, but could be sooner for individual coverage depending on several variables. The Plan will continue to update the Board and staff as more information is received. She noted that the Plan is working with Segal to determine which plan option would most likely reach the Cadillac level first. The Cadillac Tax is a reference to a provision in the Affordable Care that incorporates a 40% excise tax on health plans above the annual total premium cost level. The implementation of the tax and the penalty threshold have been pushed back and modified since they were introduced.

Following a motion by Dr. Newton and seconded by Mr. Alexander, the Board voted unanimously to approve the 2017 premium rates outlined in the presentation.

<u>2017 Out-of-Pocket Cost Savings Changes</u>
Presented by Caroline Smart, Chief Operating Officer

Ms. Smart reviewed changes the Board approved for the Enhanced 80/20 plan at the May 2016 meeting. She stated that Plan vendors are unable to track one of the approved changes, which is the total medical and pharmacy out-of-pocket maximum. A system fix was offered by the vendors which requires Board approval for separate pharmacy and medical family out-of-pocket maximums.
In addition, a mistake was made on the Board approved non-network family deductible for the 70/30 option. Ms. Smart stated that Board approval for the correction is required.

Following a motion by Mr. Alexander and seconded by Dr. Newton, the Board unanimously approved the changes for the 80/20 Plan and the technical correction for the 70/30 Plan as outlined in the presentation.

One Board member noted that it would be beneficial for the Plan to focus on vendor system capabilities prior to the decision-making process.

2017 Health Engagement Program
Presented by Kathryn Keogh, Health Systems Clinical Coordinator

Ms. Keogh presented information on the current Health Engagement Program (HEP) and proposed enhancements for 2017.

Following a motion by Dr. Cunningham and seconded by Mr. Medlin, the Board voted unanimously to approve the changes to the Health Engagement Program for 2017 as outlined in the presentation. Following the vote, several members asked if making the program harder will discourage members from engaging, if the Plan has a target number of members who need to engage in order to make a financial impact, and how success is measured. Although a mathematical computation hasn't been done, Ms. Keogh stated that 50% would be a good starting number. She also stated that the program enhancements offer an "a la carte" rather than an "all or nothing" approach and that the intent was not to make it harder.

Ms. Moon stated that more detail on the HEP would be provided in the afternoon session. She further commented that the Plan is looking for a way to make a real difference in the member's long-term health. Setting the bar where it needs to be will also help healthy members stay healthy.
In response to a contract question, Ms. Moon stated that the plan pays for each member enrolled in the healthy lifestyles program.

In response to a question as to whether the Plan is paying members for activities they're already doing or a profile is available of the members the HEP is reaching, Ms. Keogh stated that members are self-reporting activities through the Health Assessment. The Plan will work with Active Health Management and present baseline data and a summary profile of the HEP over the past three years.

Member Experience and Communication Update (Attachment 2)

Benefitfocus Phase III and Open Enrollment Readiness Update
Presented by Caroline Smart, Chief Operating Officer

Ms. Smart reviewed the plan established in September 2015 to transition from Aon Hewitt to Benefitfocus. She reviewed several challenges the Plan is currently experiencing in the last phase of the implementation process. In addition to the requirements in the final implementation phase, system changes to support the 2017 Open Enrollment were also required.

Ms. Smart addressed the current Benefitfocus readiness status for the upcoming Open Enrollment. While several system enhancements are behind schedule, all items related to Open Enrollment (OE) are still on target for completion prior to OE. Additionally, Benefitfocus customer service is stable and they are exceeding their service metrics. The deliverables that are behind schedule primarily impact the two largest payroll systems. The Plan is working with those entities to provide resources where needed. Staff anticipates that all of the phase three items will be completed by early 2017.

Ms. Smart presented the online enrollment process for both the BEACON and non-BEACON groups. Ms. Smart pointed out the member workflow enhancements that had been made to eEnroll as well as the additional messaging encouraging members to save their enrollment. Ms. Moon noted that a large number of exception requests during the past Open Enrollment were due to the fact that members were not aware they had to hit save in order for their enrollment to process. The Plan put steps in place this year to address that issue.

Mr. Alexander followed up with questions as to why the Plan allows single-sign-on from BEACON or other employing units. He suggested that the Plan should dictate a single process for enrollment. Ms. Smart explained that the Plan has allowed these workflows in an effort to support these other groups' preferences for their employees. She also acknowledged that it made it more challenging to communicate a single starting point for enrollment.

Ms. Moon agreed and stated that another issue is that members aren't always aware of which enrollment system to choose. The Plan is attempting to solve the issue through messaging on the Plan's web site and in enrollment materials.

Ms. Smart followed up with another concern that only applies to members enrolling through a single-sign-on from BEACON to Benefitfocus. New hires will be required to have an NCID to complete enrollment. Historically, NCIDs have not always been provided to new hires until sometime after their hire date. The Plan is working with the State Controller's Office and the Office of State Human Resources to develop an employing unit and new hire communication plan advising employing units of the importance of providing the NCID early in the onboarding process. The eligibility and enrollment telephone number should also be provided so that new members who cannot access the online portal can enroll in the Plan via phone.

Open Enrollment Communication and Outreach
Presented by Beth Horner, Customer Experience Manager

Before the presentation, Ms. Moon stated that the Plan received the Jim Long Outstanding Seniors' Health Insurance Information Program (SHIIP) award at the SHIIP Coordinator Conference on August 3, 2016. The award was given in recognition of the Plan's efforts and support of SHIIP, which is a part of the Department of Insurance. In addition, Roberta Hamby, Healthcare Product Manager at the Plan, received the Jim Long Outstanding SHIIP award for her work and efforts in supporting SHIIP.

The Plan also won an APEX Award of Excellence in the "Campaigns, Programs & Plans – Employee & Benefit Communications" category for the "Consumer-Directed Health Plan: Separating Myth from Fact" video. Segal entered the video into the competition.

Ms. Horner stated that the Membership Satisfaction survey is under way and will end on August 31, 2016. The survey is open to all members online and as of August 3, approximately 3,000 members completed the survey. The results will be presented to the Board at the December meeting.

The communications strategy and information regarding the HBR training sessions were presented. Additional training will take place in September leading up to Open Enrollment. Ms. Horner reviewed the various member communication and outreach methods and stated that the Plan will again conduct several telephone town hall meetings in September, as well as in-person meetings across the state. The Plan will also telephonically register Medicare members to attend one of the more than 50 outreach meetings scheduled and has hired three temporary staff members to assist with those calls.

Pharmacy Formulary Exclusions Exception Process
Presented by Natasha Davis, Pharmacy Benefit Program Manager

Following approval of a custom, closed drug formulary, Board members requested information regarding the formulary exclusion exception process when members are advised by their providers to remain taking an excluded drug.

Ms. Davis reviewed a draft of the exception coverage criteria and process, stating that the Plan is currently working with CVS Caremark to finalize the criteria and process.

In response to a question regarding urgent requests, a representative from CVS, Robby Wallace, stated that providers would have 24/7 access to CVS customer care.

Salary-Based Benefit Options (Attachment 3)
Presented by Tom Friedman, Director of Policy, Planning and Analysis

Mr. Friedman presented information on several ways in which salary based premium options could be administered. However, there would be challenges with each option given that employing units use different payroll systems.

Following Mr. Friedman's initial comments regarding the implementation requirements, several Board members stated they didn't feel that salary-based premiums options was a benefit change the Plan should pursue at this time.

Chair Cowell acknowledged the comments from Board members and requested that Mr. Friedman complete the remainder of the presentation at a high level.

One board member stated he felt it was incumbent on the Board to review and discuss a long-term premium strategy for low-income employees.

2018 Benefit Development (Attachment 4)

<u>Premium Strategy</u>
Presented by Tom Friedman, Director of Policy, Planning and Development

Mr. Friedman discussed the future of wellness premium credits and presented the potential healthy activities and premium credits for 2018. He stated that if the Plan moved to one wellness credit, the premium structure would need to be revised.

A base premium on all plans is another option to consider. However, Mr. Friedman noted that a premium-free option would continue to be available for retirees. Approximately 75% of Plan members currently pay less than $15 per month. Base premiums for individual coverage could be a way to offset the growth of dependent premiums. Most states provide a higher subsidy for dependent coverage and require an employee-only premium.

Following a summary of two potential scenarios for a monthly base premium on each benefit option, Mr. Friedman reviewed the list of questions to consider and solicited feedback from Board members.

Ms. Moon stated that a premium across all plans is one way to address the funding issue for reducing dependent premiums and that the Plan cannot expect funding from the General Assembly. She asked for specific guidance from the Board regarding the percentage the Plan should use as a starting point for premiums on each plan option.

As the Plan and Board go through the process, Ms. Moon reminded them to keep in mind that the employer contribution must not exceed 4% for 2018 and 2019.

As for moving to two plan options, members would certainly disagree on which option to eliminate. The Plan might experience adverse financial results if the lowest value plan (70/30) was eliminated. One board member commented that member education on plan options and a voluntary move would be important.

Potential Cost Sharing Changes
Presented by Tom Friedman, Director of Policy, Planning and Development

Mr. Friedman reviewed the Board's cost-saving strategies to date and considerations for 2018. The presentation focused primarily on the 70/30 Plan, which has essentially remained the same between 2011 and 2016. It has continued to provide members with a premium-free option. However, the cost-sharing for members in that plan increased for 2016 and 2017. Mr. Friedman asked Board members to consider the approach the Plan should take and the long-term vision for the 70/30 Plan.

Members on expensive specialty medications may benefit from the 70/30 Plan due to lower copays. The challenge for the Plan and Board is to determine how to deal with the high cost of those medications if significant changes are made to that plan. One Board member suggested marketing the 70/30 Plan in a different way and develop a strategy that targets the group of people who truly benefit from that plan. Ms. Moon noted that the Plan can't specifically market and send members to a particular plan.

Another Board member suggested renaming the plan options to move away from the traditional names that mean certain things to certain people. Marketing them in a different way might encourage movement to an option that better serves the member.

Other comments from Board members included the fact that, as a part of the culture, members do not want to think about which plan option to choose because insurance is hard to understand. Also, members trust the Plan to take care of and protect them.

The discussion will continue in workgroup meetings in September and October and at the Board meeting in December.

Health Engagement Program Considerations
Presented by Kathryn Keogh, Health Systems Clinical Coordinator, and Nidu Menon, Director of Integrated Health Management

Ms. Keogh reviewed the HEP for 2016 and 2017 and the expansion considerations for 2018. The Healthy Lifestyles and Positive Pursuits programs are currently offered to members in the CDHP. She provided the rationale and intent for each item under consideration, noting that expanding the HEP to members on the 80/20 Plan would impact approximately 50% of Plan membership.

In response to a question regarding how the clinical goals under Consideration 3 would be measured, Ms. Keogh stated that technology products such as Fitbits could transmit information to providers or the tests could be done in-office. Ms. Moon added that the Plan wants to move toward outcome-based incentives and not just award participation without improvement. She noted that all of these options come with administrative challenges.

Considerations for the Healthy Lifestyles program were reviewed, including incentives for physical activity and nutrition goals and completing age/gender appropriate preventive screenings, exams and immunizations. Ms. Moon noted that even though preventive screenings are free, it has not incented

people enough to engage. She added that the Plan still needs to determine the actual incentives for each consideration.

Next steps include feedback from Board members and stakeholders and staff research on ways to operationalize some of the considerations. A cost analysis will also need to be completed.

Following a motion by Mr. Medlin and seconded by Mr. Alexander, the Board voted unanimously to move into executive session.

Pursuant to G.S. 143.318.11 (a)(1), G.S. 132-1.1 and 132-1.9, Ms. Crabtree provided information on a legal issue under the Affordable Care Act.

Following a motion by Mr. Alexander and seconded by Mr. Medlin, the Board voted unanimously to return to open session.

Ms. Moon announced that two new Board members were appointed to replace Mr. Medlin and Mr. Johnson and thanked them for service. Mr. Medlin expressed his pleasure serving on the Board and working with Plan staff. Ms. Moon will share more information on the new members as it becomes available.

Following a motion by Mr. Medlin and seconded by Mr. Alexander, the Board voted unanimously to adjourn at approximately 3:00 p.m.

Janet Cowell

Janet Cowell, Chair