Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
January 22, 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, January 22, 2015, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

Members Present:
Janet Cowell, Chair
Lee Roberts
V. Kim Hargett
Noah Huffstetler
Charles Johnson – via phone
Bill Medlin
Genell Moore
David Rubin

Absent:
Paul Cunningham
Warren Newton, MD

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, Caroline Smart, Andrew Holton, Tony Solari

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

Agenda Item – Conflict of Interest Statement
In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, Chair Cowell requested that members who have either an actual or perceived conflict of interest identify the conflict and refrain from discussion and voting in those matters as appropriate. No conflicts were noted.

Agenda Item – Review of Minutes – November 20-21, 2014 (Attachment 1)
Presented by Janet Cowell, Chair

Following a motion by Mr. Medlin and seconded by Ms. Hargett, the Board unanimously approved the minutes from the November 20-21, 2014, meeting.

Agenda Item – Financial Report, Forecasting and Monitoring (Attachment 2)
Presented by Mark Collins, Financial Analyst

November 2014 Financial Report
The November financial report continued the pattern demonstrated since the first quarter of the calendar year. The State Health Plan's finances have been relatively close to budgeted figures following low spending in the first quarter of the year. Plan Revenue was $2.7 billion and total Plan expenses were approximately $90 million less than the certified budget. Net income was $183.7 million and the ending cash balance was $1.02 billion. The adjusted variance report demonstrated similar results. Plan

revenue was slightly less than the budgeted amount on both the per member per month (PMPM) and adjusted PMPM reports. Total plan expenses were 5% less than budgeted. The expenditure trend report demonstrated the closing gap between actual and budgeted numbers over the course of the year but suggested that expenses for the calendar year will still be $15-$20 PMPM below budget by the end of December.

CY 2014 3rd Quarter Actuarial Forecast Update

Mr. Collins presented the updated forecast which included updated membership numbers and claims experience and changes in anticipated costs or revenues. He noted that the current report included a chart demonstrating the premium increases required if plan options and the benefit design remained the same.

Several changes not included in the certified budget were a 7% medical trend assumption, the premium freeze for 2015, benefit enhancement costs and projections extended to calendar years 2018 and 2019. The forecast also included 100% coverage of preventive services and medications in the 70/30 Plan effective January 1, 2016. Pharmacy claims projections reflected new contracted discounts negotiated with Express Scripts, Inc. (ESI).

Mr. Collins presented several forecast models which provided quarterly comparisons of Plan financials, premium increases/decreases, pharmacy and medical claims and ending cash balances. In summary, the 3rd quarter update projected lower medical claims and higher pharmacy claims than the certified budget. The forecast ending cash balance is higher than the certified budget projection and exceeds the stabilization target reserve by $688 million. If no benefit changes are made from the 2013 plan design, a 5.05% premium increase would be needed in 2016 and 2017.

Several Board members expressed concern about a premium increase considering the Plan's healthy cash balance. Ms. Moon stated that the current 7% trend appears to be moving closer to projections and that the 5.05% increase assumes that the Plan will spend down the surplus. She also noted that the increased pharmacy spend would most likely contribute to a decrease in the cash balance. Mr. Roberts stated that the Office of State Budget and Management has been preparing a budget based on an assumption of a required state contribution of approximately $35 million in the first year of the biennium and $105 million in the second year. A 5.05% premium increase would require larger increases in state funding. It was noted that final premium increases will be determined by Board decisions and the final budget passed by the General Assembly.

Mr. Roberts requested a copy of the entire forecast document.

Agenda Item – Contracting and Vendor Partnerships (Attachment 3)

Aon Hewitt Implementation Update

Presented by Caroline Smart, Director of Health Plan Operations

Ms. Smart presented information regarding the transition from Benefitfocus to Aon Hewitt, effective June 1, 2015. All members will be on the same platform and enrollment system which should be seamless to members. A communication campaign will be launched and Health Benefit Representative (HBR) trainings will be held across the state. The Annual Enrollment period will end October 31, 2015.

Ms. Smart provided a detailed review of the member enrollment process. The enrollment workflow on the Aon Hewitt platform is similar to the Benefitfocus platform, but unlike the Benefitfocus platform, the Aon Hewitt platform saves the enrollment as the member goes along. On the Benefitfocus platform,

the subscriber has to confirm the enrollment at the very end for it to save. Many members stopped before the last confirmation page; therefore, their enrollments were not saved. We believe the Aon Hewitt "save feature" will benefit members. The Board did ask if a final confirmation page could be added as well, but Aon Hewitt is unable to support this request. .

In response to a request from all of the Plan's stakeholder groups, a benefits calculator comparing each of the Plan design options will be available to members to assist them in making informed decisions. It was noted that the system would include a disclaimer regarding the tool's use and that it would be legally vetted. Plan staff is working with Aon regarding the validation of emails provided by members, as well as the placement of the smoking attestation question.

Agenda Item – Other Updates (Attachment 4)

Legislative Agenda & Update

Presented by Lotta Crabtree, Deputy Executive Administrator, and Tom Friedman, Legislative Liaison and Policy Planning and Healthcare Policy Analyst

Ms. Crabtree reviewed several statutory changes identified by the Plan to clarify eligibility and enrollment requirements and facilitate the administration of benefits:

- Retiree Disenrollment without Qualifying Event
- Cancellation of Coverage
- Reduction in Force Clarification
- Affordable Care Act
- Banking Requirements

A portion of the Joint Legislative Education Oversight Committee report was provided to the Board. The information provided pertained to the legislation for the Plan's High Deductible Health Plan (HDHP) which is offered to non-permanent, full-time employees who are not eligible for coverage under the Plan. Under current law retirees returning to work as non-permanent full-time employees lose their retirement coverage under the Plan as long as they are working. With the HDHP being less attractive to retirees, many retirees are leaving their positions so as not to lose their retiree coverage. The greatest impact has been felt by public schools, which recommended a statute change to allow retirees to keep their traditional/regular Plan coverage. The Plan will monitor legislative action.

Mr. Friedman also presented a draft of a bill to transfer Medicaid to a Board-managed Health Benefits Authority within the Department of Health and Human Services (DHHS). This Board would have the autonomy to independently oversee Medicaid and create and monitor the budgets. The Plan will follow the progress of this proposal and provide updates to the Plan Board.

Pharmacy & Therapeutics Committee Meeting Summary

Presented by Glenda Adams, Clinical Pharmacist

Dr. Adams presented a number of utilization management (UM) programs discussed at the last Pharmacy & Therapeutics Committee meeting. She also discussed three new UM programs, one with a step therapy component and two that will require prior authorization, as well as a number of new drugs for formulary consideration.

Agenda Item – Wrap-Up

The meeting was adjourned at 5:35 p.m.

Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
January 23, 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, January 23, 2015, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

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

Absent:
Warren Newton, MD

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Glenda Adams, David Boerner, Mark Collins, Kathryn Keogh, Nidu Menon, Lorraine Munk, Jessica Pyjas, Andrew Holton, Malinda Peters, Melissa Waller

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

Agenda Item – Conflict of Interest Statement
In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, Chair Cowell requested that members who have either an actual or perceived conflict of interest identify the conflict and refrain from discussion and voting in those matters as appropriate. No conflicts were noted.

Agenda Item – Benefit Design, Plan Options and Premiums (Attachment 5)

Value-Based Insurance Design Recommendations
Presented by Mark Fendrick, MD, and David Edman, VBID Health

Dr. Fendrick reviewed the Plan's mission statement and guiding principles. He noted that the motivation for Value-Based Insurance Design (V-BID) focuses on the clinical value and appropriate services for members rather than the cost. He stated that in many instances, members pay for certain treatment(s) with no clinical value. Consequently, member cost-sharing increases and consequently, many people, especially those with lower incomes, aren't able to seek essential treatment.

V-BID has a growing role in other state benefit plans and broad stakeholder support among private and public payers. The State of Connecticut implemented the most comprehensive V-BID plan and will soon have year one financial results available.

The Consumer-Directed Health Plan (CDHP) already contains V-BID elements and Dr. Fendrick recommended that the Plan and Board consider a progressive enhancement of V-BID in the CDHP over the next three years. He noted that out of the three options offered by the Plan, the CDHP is the most valuable from an actuarial standpoint but only a small percentage of the membership are in that plan. He stated that the Plan has good data available and that it could be better used to optimize member outreach, plan choices and services.

Board members discussed ways in which to better educate both members and providers on the CDHP. It was suggested that expanding member utilization examples to convey a comparison of the three plan options might be the best educational method. Several Board members felt that the majority of members don't understand the CDHP and how it could work for them. The Board discussed the importance of providers and stakeholder groups understanding and promoting the CDHP but understand that member education should be the primary focus.

Proposed 2016 Benefit Design Changes

Presented by Mona M. Moon, Executive Administrator, Tom Friedman, Legislative Liaison and Healthcare Policy Analyst, Nidu Menon, Director of Integrated Health Management, Mark Collins, Financial Analyst, and Lotta Crabtree, Deputy Executive Administrator

Ms. Moon reminded the Board that a public comment period would be held before the Board discussion of the proposed benefit changes. She stated that members of the public would each have 5 minutes to speak.

The proposed 2016 benefit design changes were presented to seven stakeholder groups prior to the January Board meeting. Their comments, concerns and questions were a valuable part of the process. The presentation was also shared with the Plan's vendor partners. Ms. Moon stated that the Plan would present final recommendations to the Board on February 11, 2015, and request formal approval for the 2016 benefit design. She noted that the final presentation would be shared, via email, with the Board and stakeholders prior to the February meeting.

The majority of the changes apply to active and non-Medicare retirees. Changes in the 70/30 Plan, however, will impact the Medicare retirees who choose that option. It was noted that Medicare Advantage rates will not be available until May or June, at which time the Plan will present that information to the board.

The current wellness premium credits and incentives for calendar years 2014 and 2015 and proposed changes for calendar years 2016 and 2017 were presented and discussed. The Plan's focus has changed from member cost share and plan design to population health management and member engagement. Provider engagement and reimbursement will also be considered in the overall health benefit strategy.

Ms. Moon stated that the focus of the past decade has been on developing new plan options (PPO and CDHP). The Plan recognizes that the tools necessary to market the Plan haven't been available. Staff will now begin to focus on moving from communication to marketing strategies to improve the member experience.

Mr. Friedman provided a summary of proposed benefit changes and the rationale for the recommendations under each plan option. He noted that each change under the CDHP, 80/20 and 70/30 plans addressed an element in the strategic plan. The proposed changes will provide greater differentiation between each option.

Dr. Menon stated the health engagement program for 2016 and 2017 will be available to all members enrolled in the CDHP. The program will include milestone credits for both healthy members and those with certain chronic conditions. Member engagement incentives will increase each year, encouraging members to become aware of and understand their health status. The Plan is working with Active Health Management (AHM) and Blue Cross and Blue Shield of NC (BCBSNC) to operationalize some of the proposed incentives.

Mr. Collins presented the financial impact on the actuarial forecast. With the Board-approved 2013 benefit design, projected premium increases would be 5.05% in 2016 and 2017. Approximately $203 million would be needed from the General Fund over the biennium. Based on current proposed changes to the current plan options, the premium increase in 2016 and 2017 would be 4.53% and the General Funds needed would be approximately $180 million.

The cost and savings drivers associated with the proposed benefit changes and assumed member migration between plan options was presented. Savings would be generated by increased member cost sharing in the 70/30 Plan and movement by Medicare eligible members to one of the Medicare Advantage plans. Increased premium receipts would be generated from members who choose not to engage in health activities. Better educated and engaged members would purchase more value-based services.

Mr. Collins concluded his presentation by presenting additional information on premium increases and member and employer contributions, through 2019. He also shared the financial details of the wellness premium credits under each plan option through 2017.

In response to several questions regarding migration to the CDHP and increased member cost-sharing in the other two plan options, Plan staff reiterated the value of the CDHP. As proposed, the CDHP would be the only plan for active where the premium can be earned down to $0. The premium strategy is to help members understand that the CDHP is a better choice in most cases. The Plan wants members to save money by engaging in healthy activities and to understand the financial impact of their choices.

Several Board members expressed concerns regarding first dollar pharmacy expenses under the CDHP for many Plan members and the proposed premium on the 70/30 Plan. It was noted that a pharmacy debit card was discussed in the stakeholder meetings and that Plan staff is looking into that option. One Board member requested that Plan staff provide an actuarial analysis on postponing the premium on the 70/30 Plan for one year. The Board also focused on the importance of education, stating that if the CDHP is a better option, members need to understand how it works.

Ms. Crabtree provided several different scenarios to illustrate the member cost sharing under each plan option. In most instances, the CDHP proved to be the better financial choice for members.

<u>Public Comment on Proposed Benefit Changes</u>

Mark Jewell presented remarks on behalf of the North Carolina Association of Educators. He stated that North Carolina is losing good teachers to other school systems because of better pay, benefits and health care coverage. While acknowledging the importance of healthy living initiatives and that the Plan must be fiscally strong and financially sustainable, he encouraged the Board to consider the following:

- Maintain the 70/30 Plan as a free option or, if need be, allow employees to earn it down to $0 with a premium credit
- Provide a prescription debit card for members in the CDHP

- Develop a comprehensive educational plan for members
- Address affordable dependent coverage

Chuck Stone provided comments on behalf of the State Employees Association of North Carolina:

- Maintain a premium-free PPO option for members
- Eliminate or reduce premium surcharges
- Reduce copays for generic prescriptions
- Encourage voluntary member engagement rather than make it a coercive, involuntary type of engagement
- Request the General Assembly to appropriate funds to subsidize at least 50% of dependent premiums
- Request that board go on record supporting a change to the Affordable Care Act to allow dependents to qualify for premium tax credits

The current benefit proposal fails to address:

- Underfunding and cost of dependent premiums – Plan spends less per member per month than other states and employees pay 52% of total premium cost
- Member cost sharing which currently outpaces pay raises
- Impact and issues of CDHP
- Viable choices for members

Bill Medlin read comments on behalf of the Professional Educators of North Carolina

- Lower cost and/or employee no-premium option – make Plan affordable for employees and dependents
- Design or provide a navigation/choice tool to assist employees in choosing plan option

Pam Deardorff spoke on behalf of the North Carolina Retired School Personnel

- Eliminate premium and other cost sharing increases for Medicare retirees in 70/30 Plan
- Provide in-person education and communication to retirees regarding all the changes similar to what was provided for the Medicare Advantage plans
- Provide member scenarios for Medicare Advantage plans
- Consider calling the CDHP the 85/15 plan since members don't understand this option

She also expressed a strong concern that Medicare members won't know the benefit changes for the Medicare Advantage plans until May or June.

Discussion

Mr. Roberts stated that a large portion of dollars in the State budget goes toward the State Health Plan, retiree benefits, Medicaid and salaries for State personnel. If the Plan faces a shortfall, money that is otherwise allocated for salaries and other personnel-related costs is used to provide funding unless premiums and member cost sharing are increased. There isn't a separate fund set aside for the Plan.

The premium increases through 2019 were established assuming the Plan will spend down the cash balance but the timing of how quickly that happens is difficult to predict. If the spend down is slower, the premium increases will be less. The Plan's current medical trend is 7% and staff will continue to work towards reducing the overall long term trend. Several Board members applauded the work that has

been accomplished in the past few years to reduce the trend and implement benefit changes that promote healthier members.

Board members supported the premium increase on the 80/20 Plan but stated they would like for members to be able to earn the premium on the 70/30 Plan down to $0 for 2016. The Plan will provide revised forecast information to the Board prior to the vote on February 11, 2015.

Agenda Item – Provider Engagement Initiatives (Attachment 6)
Presented by Nidu Menon, Director of Integrated Health Management

Dr. Menon presented strategies to engage providers, hoping that the value of these strategies will ultimately benefit members. Currently, Plan vendors such as BCBSNC, Active Health Management (AHM), Humana and UnitedHealthcare assume the responsibility for provider engagement. Examples of the Plan strategies include the Patient Centered Medical Home (PCMH), provider pilot programs, and Accountable Care Organizations (ACOs).

The PCMH two-year pilot would engage providers across the state in four practices with a total of approximately 13,500 Plan members. Providers would engage in the care of these members through alternative payment strategies and data driven member support to promote better health outcomes. The pilot will be implemented on April 1, 2015, and will provide the plan with an opportunity to interact and develop a relationship with medical practices.

"Wellness Wins," a proposed two-year pilot program in three counties in Eastern NC, will utilize a multi-pronged approach. The Plan will engage and support providers in delivering high-level care to Plan members and also connect local leadership and resources to state agencies to promote worksite wellness.

The Advanced Primary Care Practice Demonstration began as a federal project in seven rural NC counties to evaluate health outcomes in a PCMH model in 2013 and2014. When the federal program ended, the Plan decided to continue the initiative in 2015 and will contract with Community Care of NC (CCNC).

Agenda Item – ACO Update and Move to Value (Attachment 7)
Presented by Susan Weaver, MD, Chief Medical Officer, and Susan Jackson, VP, Health Delivery Redesign, Blue Cross and Blue Shield of North Carolina

Dr. Weaver and Ms. Jackson provided the Board with an overview of ACOs and value-based partners. BCBSNC has aggressively moved on the development of the ACO model and other partnerships over the past several years, which has provided insight on the partnership of providers and payers. ACOs and value-based incentive facilities, as well as several bundled payment pilot programs, are spread across the state in seven different areas.

The ACO quality measures focus on health outcomes and BCBSNC works with the National Committee for Quality Assurance (NCQA) to get the metrics. Not all measures are included in every ACO as some practices may already be strong in a particular area. Metrics are chosen based upon where the most improvement is needed.

Ms. Jackson presented information on the Wake Med Key Community Care (WKCC), with whom BCBSNC is partnering. BCBSNC and WKCC are collaborating to provide high quality and affordable care to

members and patients and enhance their experience. The goal is to close the gaps in care and prevent duplicate services. This allows members to better understand all aspects of the health care system. The development of PCMHs around the state is supported by BCBSNC. Many of the primary practice groups participate in the Blue Quality Physician Program through BCBSNC. These practices have a different level of distinction and enhanced fee schedules.

BCBSNC has bundled payments for knee replacement surgery, which includes the pre-operative visit, anesthesia, hospital fee, and post-operative follow-up care. Outcomes have proven to be superior and readmissions have decreased. BCBSNC is currently reviewing other episodes of care for which bundled payments could apply.

BCBNSC developed a transparency tool and launched a web portal for members. A public transparency tool for non-members is also available which will allow members to better engage with their providers. The goal is for members to receive better care at a lower cost. As new models of care are developed, provider partnerships are critical to their success.

Agenda Item – Wrap-Up

Following a motion by Ms. Hargett and seconded by Mr. Johnson, the Board voted unanimously to adjourn the meeting at 2:45 p.m.

Janet Cowell, Chair