Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
January 27, 2017

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 27, 2017, at the Department of State Treasurer (DST), 3200 Atlantic Avenue, Raleigh, NC 27604.

Members
Dale Folwell, Chair
Charles Perusse
Neal Alexander
Donald Martin
Aaron McKethan
Warren Newton, MD
Elizabeth Poole
David Rubin
Margaret Way

Absent:
Paul Cunningham, MD

State Health Plan Staff: Mona Moon, Lotta Crabtree, Caroline Smart, Nidu Menon, Carl Antolick, Lucy Barreto, Mark Collins, Matthew Grabowski, Beth Horner, Lorraine Munk, Jessica Pyjas

Welcome

Chair Folwell welcomed Board members and visitors to the meeting. He requested State Health Plan (Plan) staff and stakeholders to identify themselves by standing. Following an introduction of Board members, Chair Folwell stated that he expected meetings to start and end on time or earlier if possible. He stated that his priorities would include making family premiums more affordable and addressing and reducing the $32 billion retiree health liability.

Conflict of Interest
Presented by Dale Folwell, Chair

In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, Chair Folwell 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 of interest were noted.

For Board Approval (Attachment 1)

Review of Minutes
Presented by Dale Folwell, Chair

Following a motion by Donald Martin and seconded by Neal Alexander, the Board unanimously approved the December 20, 2016, minutes, as written.

Preparation for Future Board Action (Attachment 2)

Agenda Item – 2018 Benefits Planning
Presented by Mona M. Moon, Executive Administrator

Potential benefit changes for the 2018 benefit year were briefly discussed at the December Board meeting. The proposed 2018 benefit design will be brought before the Board for a vote at the February 10, 2017, meeting.

Ms. Moon reviewed the State Health Plan strategic plan's mission and strategic priorities, which are frequently referred to during the benefit design process. She stated that the financial goal is to ensure that, in accordance with the 2016 Appropriations Act, the employer contribution does not exceed 4% in 2018 and 2019.

The current baseline forecast indicates that a 3.15% across-the-board increase would be needed for both employers and employees, assuming the Plan maintains the current premium credit structure with assumed increases in the dollar amount of the premiums/credits. This assumption is based on the Board's strategy adopted in 2014. She reminded members that the 2016 budget language does not require a premium increase of 4% or less nor does it prohibit the General Assembly from appropriating funds greater or less than 4%, but suggested it be used a target.

Ms. Moon presented the details of the 2018 premium strategy, including wellness premiums and credits, subscriber base premiums and dependent premiums. She noted that, for the first time, the tobacco premium credit was added to the 70/30 plan option for active employees in 2017. Subscribers on the Traditional 70/30 Plan and Consumer-Directed Health Plan (CDHP) could reduce their premiums to $0 by completing the associated credits.

In response to a question about the number of tobacco users on the Plan, Ms. Moon stated that the total number of subscribers who attested to smoking, agreed to participate in QuitlineNC or did not respond to the attestation is approximately 13%, which is consistent with the literature on smoking. As for the number of smokers who have quit, Dr. Menon stated that a clear baseline has not yet been established.

Mr. Alexander suggested adding a surcharge to smokers rather than a premium credit and eliminate the other premium credits. In response to a question about the Primary Care Provider (PCP) credit, Dr. Menon stated that the Plan has seen a steady increase with members choosing, visiting and staying with their designated PCP.

Chair Folwell suggested that having an "I don't know" box for members to check on the health risk assessment doesn't encourage members to change their behavior. In response to a question regarding preventive services, Ms. Moon stated that under the Affordable Care Act (ACA), adult preventive care (routine exams) are covered at 100% for members in the Enhanced 80/20 Plan and CDHP 85/15. She noted that the Affordable Care Act (ACA) also has gender- and age-specific services covered at 100% under those plans. Members who don't take advantage of these preventive services covered by the Plan can end up costing the Plan in the long run. Chair Folwell stated that his instinct is to believe people are telling the truth and that he prefers to reward them for doing so and reduce their costs.

Ms. Moon presented information on the subscriber base premiums and stated that approximately one-third of active employees pay no premium for their coverage. Active employees who will be impacted the most by a 3.15% premium increase are the 25% who pay dependent premiums.

Establishing a base premium on all plans would spread the risk and is an option the Board has expressed a desire to consider. Ms. Moon provided several scenarios for each plan option based on the current premium credits and a tobacco attestation only credit. If the Plan maintains the current premium credit amounts, as opposed to increasing them as originally assumed, the premium increase would be 3.5%.

For the benefit of the stakeholders attending the meeting, Chair Folwell stated that the Board would not be voting on anything until February 10. He further stated that the stakeholders and members don't trust the Plan and that the Legislature puts things in the statutes that differ from the Board recommendations. As the Treasurer, he will not put something in place and explain it later. There has to be trust instilled around all of the topics discussed. He has a handle on the pension under the Retirement Division and understands where the money is going, but does not share that feeling about the State Health Plan.

In terms of a long-term premium strategy, Dr. McKethan commented that the Plan and Board need to consider cost-sharing to balance the risk, but also determine how to care for the sickest and most vulnerable members. Many of them choose the lowest premium plan which also has the higher deductibles, which prevents them from seeking needed care. Ms. Moon stated that this is the Plan's biggest challenge and that staff is relying on the Board to determine the overall needs of the Plan vs. an improved plan design. Dr. Newton agreed and stated that, as an example, inhalers can prevent hospitalizations, but members aren't filling their inhaler prescriptions due to the high cost.

The contribution strategy for dependent premiums differs from most states in that the employee-only coverage is highly subsidized by the state while dependent coverage is paid by the employee. Chair Folwell stated that because of the high cost of dependent premiums, young, healthy people are not choosing Plan coverage. As a result of the Plan's benefits, they're going elsewhere. With more than 700,000 members, the Plan should be able to leverage better prices.

Plan staff provided two options for consideration: freeze family premiums at the current rates (3.33%) and freeze all the dependent premiums at the current rates (3.67%)

Ms. Moon provided information on CY 2015 loss ratios by tier for non-Medicare members, stating that the Plan spends more than it collects for employee-children/spouse/family premiums. She noted that it would take a lot to change the ratios and that the high dependent premium rates have resulted in adverse selection. Freezing the dependent rates may increase membership but it wouldn't significalty change the underlying risk in the short term. Attracting younger, healthier members would require a multi-year strategy.

Mr. Alexander stated that with the loss ratio percentages, the Plan is driving away healthy members and attracting unhealthy people. Ms. Moon said the point is to change that, but it will require significant funding.

Chair Folwell stated that this sets the tone for the next four years. The premiums need to be more affordable to attract healthier families, where the loss ratio is the highest. He stated that if any Board member believes the $32 billion liability is not this Board's responsibility, they shouldn't be on the Board. He stated that this has become a very important issue due to the fact that money hasn't been put aside for the past thirty years

Dr. McKethan and Dr. Martin asked how to take the information presented today and prepare for a vote on February 10. Chair Folwell stated that it's his job to think about and determine what to present to the Board. Mr. Alexander asked if there was a reason why the Board needed to vote on February 10

rather than at the end of the February. Chair Folwell stated that this date was set last year and members have it on their calendars. Dr. Rubin asked how much further the date could be extended if the Board needed more time. Ms. Moon stated that the timeline is relatively tight, given the need for technical and programming changes and testing with multiple Plan vendors. Adequate time is also required to develop and implement a communication strategy. Ms. Moon also noted that the employer premium rates will most likely not be available from the General Assembly until August.

Chair Folwell stated that the General Assembly deserves some clarity of thought regarding funding requirements. Once that happens, the Board can determine how to reduce costs.

Mr. Perusse stated that the Office of State Budget and Management (OSBM) anticipates presenting the Governor's budget in the next month. He further stated that this Plan has been well managed under Ms. Moon's direction and premium increases aren't in the double digits, nor have they been in quite some time. He stated that he feels positive about what the Plan has presented and the numbers from which we're starting.

In the interest of time, Chair Folwell requested that staff move to the recommendations and entertain questions from the Board.

Dr. Menon provided the Stork Rewards program changes for consideration: to continue offering maternity coaching in 2018 but phase out the Stork Rewards incentive during 2017 and to discontinue enrollment in the Storks Rewards incentive program after March 31, 2017.

In response to a question from Dr. McKethan regarding the rationale for continuing maternity coaching, Dr. Menon stated that it provides a service for members without an additional cost to the Plan.

Mr. Collins briefly reviewed the 70/30 plan cost-sharing information shared at the December Board meeting. In 2016 and 2017, the member cost-sharing for the 70/30 plan was increased to the limits which allow it to retain grandfather status under the ACA. The increases provided greater differentiation between the 80/20 and CDHP 85/15 options and also met the Legislature's financial goals. Mr. Collins pointed out the pharmacy tier changes to the 70/30 and 80/20 plans and stated that if the Plan were to realign the pharmacy benefits in these plans, the 70/30 plan would lose grandfather status.

Mr. Alexander and Chair Folwell both stated they understood from the discussion at the December meeting that all of the plan options no longer had grandfather status and that it's been that way for some time. Ms. Moon stated that the 70/30 has always had grandfather status, as did the 80/20 plan until 2017, and apologized if that wasn't clearly communicated.

The 2018 proposed benefit changes for the 70/30 plan were presented to the Board for their consideration. Mr. Collins stated that the cost-sharing in the Traditional plan would be less advantageous for the members. In response to a question from Dr. Rubin as to whether cost-sharing improvements to the 80/20 plan were being considered to realign it with the 70/30 plan, Mr. Collins stated that the cost would result in a premium increase. Ms. Moon stated that Segal could model some options, but noted that the 2017 80/20 plan was designed to be a value-based plan by reducing costs for high-value services and increasing costs for lower value services and for non-engaged members. The Plan could then determine who would bear the cost.

In response to a question from Chair Folwell regarding who was responsible for the 70/30 Plan being out of compliance, Ms. Moon reiterated that the Plan is not out of compliance; the issue is around aligning the 70/30 and 80/20 benefits. Chair Folwell stated that from this point forward, the Plan needs to consider whether benefit changes would increase or decrease the $900 million Plan reserve amount.

The cost-sharing options for consideration were presented, which Ms. Moon stated were modeled without the premium credits for selecting a primary care physician and completing the Health Assessment. She stated that the baseline forecast assumed the Plan is spending down to the target reserve amount.

Chair Folwell stated that all proposals assume the Plan will spend down from $900 million to $300 million and noted that with the $32 billion liability, the appetite isn't there for spending down that amount of money.

Dr. Martin asked if the 7.5% trend was adequate and if the Plan was comfortable with that five years ago, why the reserve was built up at that time. Ms. Moon stated that the Plan was comfortable with the current trend and that five years ago, the trend was 9.5%. When Plan trends were clearly below 9.5%, the Board was comfortable decreasing the trend assumption to 7.5%.

Mr. Perusse noted that it was a good problem to have, and that Ms. Moon had categorized it right. He stated that the State is seeing the same trending in the Medicaid program. With the ACA, growth was not as high as expected. From a budget standpoint, he stated his support for the way in which the Plan has calculated the trend and forecast. Dr. Newton added that the trend has changed very little over the past number of years, including the period during the recession.

Following a question from Chair Folwell regarding the pharmacy trend, Mr. Collins stated that it is assumed to be 8.5% in the forecast, but the Plan has experienced double digit increases over the last couple of years. Chair Folwell noted that approximately one-third of the Plan expenses will increase from single to double digits.

He reiterated that trust in the Plan is very important. When premium increases are proposed, the Plan and Board need to be honest about the finances and trends. He further commented that the average member not familiar with the Plan's finances doesn't understand the need for a 4% increase.

Dr. Menon briefly summarized the key points of the current Health Engagement Program (HEP) available on the CDHP 85/15 and the proposed expansion for the 80/20 plan. Plan data demonstrates that approximately 53.3% of the non-Medicare membership was enrolled in the 80/20 plan, many with chronic health conditions. One member with diabetes who adheres to the clinical guidelines for the management of the condition could save the Plan nearly $10,800 per year. Approximately 22,851 members in the 80/20 plan have been diagnosed with diabetes.

The value-based diabetic pharmacy tier, approved by the Board in 2016, was added to the 70/30 and 80/20 plans for 2017. Diabetic supplies for members in the 80/20 plan are $5 and $10 for members in the 70/20 plan. As a next step, consideration could be given to expanding the diabetic tier or create a new tier for cost-preferred insulin to further reduce the cost barriers for some members. The annual cost of reducing the member cost-share for insulin in the two plans is expected to be approximately $10 million-$15 million.

Dr. McKethan stated that with the inflation on medications, the Plan might be able to leverage better costs given the size of the membership. He suggested that the Plan complete a breakdown of pharmacy spend and work with the Plan's pharmacy benefit manager, CVS Caremark, regarding the cost inflation. Ms. Moon stated that a Director of Pharmacy Benefits would join the Plan on 1/30/17 and that staff would present the suggestion to him.

Chair Folwell stated that a percentage of members who are prescribed medications either don't take them as prescribed or don't take them at all. He noted that many pharmacies incent customers to get prescriptions at a better price than what they might currently be paying at another pharmacy. For members who file insurance for their prescriptions, the actual cost of the drug appears at the top of their "explanation of benefits" form. He stated that most members don't see or look for that information and have no idea what the cost is to the Plan. He added that he would be reviewing the inflationary information as Dr. McKethan suggested.

Agenda Item – Options for Open Enrollment Strategy for 2018 Plan Year
This item was not presented due to time constraints.

Consultative Items (Attachment 3)

Agenda Item – BOT Self-Assessment – Proposed Action Plan
Presented by Mona M. Moon, Executive Administrator

Ms. Moon briefly reviewed the opportunities for improvement and the action items for Board education and development. To improve the meeting efficiencies, the Plan will solicit feedback from Board members on previous agenda topics and materials and provide a high-level agenda for the entire year. She noted that in response to the Board's request, the agenda format was changed to reflect action, consultative and oversight sections.

The Board currently meets on Thursday afternoon and Friday but the Thursday sessions may be used for other purposes, i.e., workgroup meetings, Plan stakeholder/Board interactions, individual Board member meetings with the Plan's executive administrator, etc.

Ms. Moon stated that there are high level agenda items that do drive meeting dates, but the Plan is open to considering changes based on the Treasurer's schedule.

Chair Folwell stated that he hoped future surveys could be conducted in-house. Ms. Moon stated that this particular survey was conducted through Segal, the Plan's actuary.

Chair Folwell asked about liability insurance for Board members and stated that he doesn't ever want personal assets jeopardized.

Agenda Item – 2017 Enrollment Exceptions
Presented by Caroline Smart, Chief Operating Officer

Ms. Smart stated that approximately 3,000 tobacco users who agreed to participate in the QuitlineNC program in order to get the $40 premium credit have not enrolled in the program. Members received a letter from the Plan in December advising them to enroll before December 31, 2016, or their premium credit would be removed. The Plan will send another letter to these members within the next few weeks to advise them that the premium credit for January, February and March will be deducted from their check.

In response to a question from Ms. Poole regarding whether the Plan would allow members another chance to enroll this year and enforce it next year, Ms. Smart stated that she was open to the Board's decision.

Chair Folwell stated that even though he had compassion for the members who didn't comply, he agrees that the Plan needs to properly manage the situation. The Board agreed that the credit should be removed since members received a reminder letter in December.

Agenda Item – Opioid Management Strategy
Presented by Dr. Nidu Menon

Dr. Menon provided highlights of the presentation, stating that 3,347 Plan members received and filled 12 or more 30-day opioid prescriptions in CY 2015. The total cost to the Plan for pharmacy and associated medical costs was $58 million. The per-member, per-year cost for these members was $17,428, compared to $4,958 for average Plan members.

Since March 2016, the Plan received 52 referrals regarding potential fraud, waste and abuse (FWA) from the Plan's previous pharmacy benefit manger. Out of 35 probable opioid misuse cases, 32 were associated with a single pharmacy and 5 to a single provider.

The Plan currently has no initiative or resources for members to address opioid abuse and overuse. Although the Plan does have access to an Enhanced Fraud, Waste and Abuse program through CVS, its Pharmacy Benefit Manager (PBM), Plan staff would like to propose an opioid case management program through the current population health management vendor. ActiveHealth Management would develop this program at a per-member, per-month rate of $.035 with an annual cost to the Plan of approximately $230,000.

Chair Folwell asked the CVS representative, Robbie Wallace, if the Plan could refuse to honor prescriptions at a certain pharmacy where overuse is suspected. Mr. Wallace stated that CVS would perform an audit of a pharmacy and take the necessary appropriate action. In response to a question from Chair Folwell regarding a member's grounds for termination, Ms. Crabtree stated that if criminal activity is suspected, the case would be referred to the SBI or local authorities.

Dr. Menon stated that the Plan is in the process of accessing mortality records for 2014-15 to determine the number of instances where intentional or unintentional overdose was listed as the cause of death. Responding to a question from Dr. Newton, she stated that the Plan is looking into the utilization of Naloxone, a medication used to prevent opioid overdose deaths.

Dr. McKethan reminded the Board that no one sets out to become an addict and that the member's problem should first be addressed before determining if there's an FWA issue. Dr. Menon stated that the Plan will partner with Blue Cross and Blue Shield of North Carolina (BCBSNC), Medicaid and other agencies to promote the new Centers for Disease Control and Prevention (CDC) guidelines for effective prescription among providers and to develop strategies to address opioid overuse in the State and among Plan members.

The 2017 proposed Plan actions were presented. Chair Folwell requested Plan staff to strengthen the review of fraud and termination of benefits and to ensure that that providers in the pension and health care system, as employees of the state, are not engaged in prescription fraud.

Agenda Item – 2017 Legislative Agenda
Presented by Matt Grabowski, Health Policy Analyst and Legislative Liaison

Mr. Grabowski presented the Plan's priorities for the Long Session. The primary request is full funding of the employer contribution based the benefits approved by the Board for 2018. Using the current baseline forecast projection, which requires a 3.15% increase, state funding would be approximately $80 million-$85 million in 2018 and $85 million-$90 million in 2019. The Plan will develop a formal request based on the Board's recommendations and final forecast.

The Plan will also ask for an amendment to the statute to allow termination of coverage in cases where members knowingly enroll ineligible individuals or provide false information during the enrollment process. Ms. Crabtree stated that the Plan conducted a dependent eligibility verification audit in 2010 where approximately 7,100 members were found to be ineligible for Plan coverage. The savings were estimated to be approximately $20 million.

Chair Folwell stated that he had requested this type of audit for many years. He added that if only one person was found to be ineligible, it demonstrates to people that the Plan is closely minding the finances. Ms. Poole stated that she fully supports this type of audit. Mr. Alexander added that if people are falsifying health insurance information, they are most likely doing the same type of thing in the workplace. He stated that he supports an audit, as well.

The Plan will also ask for an amendment to the statute requiring parents to take action to enroll their newborns within 30 days of birth. Ms. Smart clarified that a newborn isn't automatically enrolled in the Plan and coverage begins the first of the month in which the baby is born. The Plan currently has no way of knowing a baby is born unless the parents provide notification.

The Plan would also like to authorize the Treasurer, through legislation, to set aside a portion of excess cash reserves to offset the unfunded liability. Chair Folwell added that unfunded liability is a national issue and he would like for North Carolina to be at the forefront in setting up reserves for unfunded liabilities.

In response to a question from Dr. Rubin regarding the effect that might have on future premiums, Ms. Moon stated that there are two relevant funds. The Plan administers one for premium receipts and claims and other payments, and the second one resides in the Retirement division, the Retiree Health Benefit Fund (RHBF), which is used to pay health plan premiums on behalf of retirees. The RHBF is funded via an employer contribution that is set as a percentage of payroll. Chair Folwell stated that he wants to keep the Plan from going off of any budgetary cliff.

Another legislative request is to provide statutory protection to limit the personal civil liability for Board members to amounts available through insurance or other liability coverage. In response to a question from Dr. Rubin, Ms. Crabtree stated that the Board does have some liability coverage up to $1 million and excess coverage up to $10 million.

Oversight and Informational

Agenda Item – November 2016 Financial Report
Presented by Mark Collins, Financial Analyst

Mr. Collins provided a summary of the Plan financials for the month of November, and noted looking forward that there was a spike in medical claims during the month of December. Based on preliminary

results for the calendar year, however, Plan revenues exceeded the budget forecast and the cash balance was higher than projected. The net loss was less than anticipated. He stated that even though the forecast may project a loss of $660 million over the next couple of years, the Plan hopes to stay ahead of that and maintain a healthy cash balance.

Agenda Item – Contract and Benefit Implementation Update
Presented by Caroline Smart, Chief Operating Officer

Ms. Smart reviewed the list of new contracts and a highlight of associated issues. All ID cards were mailed to members and several issues with the prescription debit card were corrected. Issues still remain with the Medicare Coordination of Benefits (COB), but only a small number of members are affected.

The retiree billing process is the most complicated process the Plan is attempting to improve. The vendors continue to make progress and are reviewing options for a revised implementation schedule.

Agenda Item – Comparative Analysis of State Health Plan Benefits
Presented by Matthew Grabowski, Health Policy Analyst and Legislative Liaison

Mr. Grabowski presented the analysis which compares North Carolina to other states based on proximity and to others based on the membership size. The findings demonstrated that North Carolina is very competitive in the overall plan value. Arizona and Maryland have richer plans but higher premiums.

Following a question from Dr. Martin, Mr. Grabowski stated that the Plan's best performing plan option was compared to a similar plan in other states. As to whether other states had a similar outcome as North Carolina in high value/low value plans, Mr. Grabowski stated that a deeper analysis of the data would be necessary to determine the answer. The Plan would also need to further study the data to determine if a third option, such as the Plan offers, is the right strategy, value- and cost-wise. The analysis also didn't provide an answer as to whether more states are moving toward narrow networks. A request was made for the Plan to determine if any of the other states on the comparative analysis have an AAA bond rating and how the funding of pension and retiree health liabilities in those states works.

Agenda Item – December 2016 Pharmacy & Therapeutics Meeting Summary
Presented by Jamilah Brunson, Clinical Pharmacist Manager

Dr. Brunson stated that the primary focus of the Pharmacy & Therapeutics meeting was a review of the closed formulary and exception process. The committee members agreed that the final decision for exclusion or inclusion in the formulary would be made by the Plan's executive administrator.

Chair Folwell listed three items that are important to him: how the ACA impacts the cost, the current cash balance, and whether state and local government entities enrolled in the Plan are appropriately priced.

He also voiced his concern regarding facility fees when members see a provider in a practice that has been purchased by a hospital. Nothing has changed from the member's perspective except they now have an added fee. In addition, he noted that college infirmaries are not in the network and the student's parents receive a large bill.

He urged Plan staff and the Board to be very diligent regarding fraud, waste and abuse issues. He also stated that he wants to encourage members to understand the importance of their Explanation of Benefits form.

Adjourn

The meeting was adjourned at 1:40 p.m.

Dale R. Folwell ON ADVICE OF L. MUNK RE: JAN. 27. 2017 MEETING

Dale R. Folwell, Chair