Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
November 22, 2013

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, November 22, 2013, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

Members Present:
Chair Janet Cowell
Art Pope
V. Kim Hargett
Noah Huffstetler (arrived at 10:00)
Charles Johnson
Bill Medlin
Vice-Chair Genell Moore
David Rubin
Warren Newton, MD

Members Absent:
Paul Cunningham, MD

State Health Plan Staff: Mona Moon, Lotta Crabtree, Mark Collins, Thomas Friedman, Beth Horner, Nidu Menon, Lorraine Munk, Derek Prentice, MD, Tracy Stephenson

Department of State Treasurer Staff: Andrew Holton, Melissa Waller, Joan Fontes, Joanne McDaniel, Tony Solari

Guests: Richard Lomax, Kyong Shina, Tom Gualtieri-Reed, Jessica Brower, Andy Howell, Mary O'Neill, John Thompson, Lacy Presnell, Charlotte Craver, Charla Katz, John Sparrow, Carla Whatley, Christa Klein, Jonathan Owens, Chuck Stone, David Vanderweide, Jack Kenley, Tom Bennett, Wadida Murib-Holmes, Steve Daly, Ed Regan, John Burress, Lorri Unumb, Ardis Watkins, Thomas Ayrd, Buck Lattimore, Joe Siragusa, Toni Davis, Jimmy Broughton

Welcome
Treasurer Janet Cowell, Chair, welcomed Board members, 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 read the "Conflict of Interest Statement" requesting members who have either an actual or perceived conflict of interest to identify the conflict and refrain from discussion and voting in those matters as appropriate. Dr. Newton disclosed his association with the North Carolina Area Health Education Centers (AHEC) program. Following his arrival, Mr. Huffstetler disclosed his association with several North Carolina medical providers and hospitals.

Agenda Item – Review of Minutes – September 27, 2013 (Attachment 1)
Presented by Janet Cowell, Chair

A change to the September 27, 2013, minutes was noted in the last sentence of paragraph 3 on page 10 under the Segal Dashboard report. The board will provide a regular review of priorities instead of once a year. Following a motion by Bill Medlin and seconded by Genell Moore, the Board voted unanimously to approve the amended minutes.

Agenda Item – Review and Approve Revised Bylaws (Attachment 2)
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance

The bylaws were revised to include the process of granting groups and individuals the opportunity to present proposed benefit changes. Changes to the policy and request form can be made if needed as the process evolves.

Following a motion by Warren Newton and seconded by Kim Hargett, the board voted unanimously to approve the revised bylaws.

Agenda Item – Wayne Memorial Hospital Update (Attachment 3)
Presented by Caroline Smart, Director of Health Plan Operations, and Jack Kenley, Blue Cross and Blue Shield of North Carolina

Mr. Kenley stated that Blue Cross and Blue Shield of North Carolina (BCBSNC) received a proposal from Wayne Memorial Hospital on November 13 and sent their best and final offer to the hospital on November 21. The deadline for a final agreement is December 2.

BCBSNC issued a press release regarding negotiations on October 28 and the Plan sent letters regarding continuity of care to members in the Goldsboro area on November 1. Approximately 4,400 members received care at Wayne Memorial in fiscal year 2012-13. Mr. Tony Solari, Director of Government Relations for the Department of State Treasurer, stated that discussions with legislators from that area and BCBSNC lobbyists have occurred on a regular basis throughout the negotiation process.

Agenda Item – 2014 Benefits – Implementation Update (Attachment 4)
Presented by Caroline Smart, Director of Health Plan Operations, and Mona Moon, Executive Administrator

<u>Open Enrollment Update</u>
Ms. Smart introduced Plan staff who conducted educational sessions on benefit changes for members around the state from July to October 2013. Medicare Primary outreach events were also conducted in Florida, South Carolina and Virginia. Approximately 19,000 miles were traveled and 12 webinars were offered. As a result of the premium incentives, over 200,000 health assessments were completed.

Approximately two-thirds of the Medicare Primary members who completed a survey indicated that they heard about open enrollment via email or online. The surveys also indicated that 75% agreed they had a better understanding of Plan options after attending an outreach event. Sixty-seven percent also

agreed/strongly agreed that they are pleased the Plan is offering more choices. The outbound call campaign, similar to a robo-call structure, didn't materialize due to the high call volume and insufficient vendor staffing.

The weekly Call Volume by Vendor report indicated a high abandonment rate at Benefitfocus in week one and continued to steadily increase throughout the open enrollment process with the exception of one week. BEACON, which has a very small call center, also experienced a high number of abandoned calls. The board expressed great concern with members not being able to reach someone to receive assistance. Ms. Smart stated that the Plan addressed the issue on numerous occasions with Benefitfocus, in particular. The Plan also undertook several member mailings due to the inability of the vendor to complete that task.

Enrollment numbers, to date, indicated that 395,355 active and non-Medicare retiree subscribers completed enrollment, with 9,131 choosing the Consumer-Directed Health Plan (CDHP) option and 190,042 choosing the 80/20 plan. Due to the complexity of the CDHP and the fact that it's a new option, the Plan will continue to educate and promote the CDHP.

Approximately 100,000 Medicare Primary retiree subsribers enrolled in one of the Medicare Advantage (MA) plans. Approximately 35,500 members chose Humana, 63,500 chose UnitedHealthcare and 32,700 elected to remain in the 70/30 plan. An updated membership report will be presented at the January meeting, but the official enrollment numbers will not be available until February.

Ms. Smart stated call activity is expected to increase over the next few weeks as member ID cards are mailed and inaccurate data is listed on the card. Several issues with the data file transfer between Benefitfocus and the vendors occurred and will need to be resolved as quickly as possible.

In answer to a question from a board member regarding adding additional MA vendors, Ms. Moon stated that it would be a part of the procurement process. The Plan has some flexibility to make changes but will review the MA data over the next three years.

Ms. Moon summarized by stating that the complexity in offering more choices was a challenge for both the Plan and members. The outreach events were successful but it was acknowledged that improvements can be made. Benefitfocus did not appear to be adequately staffed and there were concerns about how well they were trained to answer member inquires. The Plan will review those issues and potential solutions moving forward. Sending confirmation statements to members who enrolled telephonically is a high priority for the Plan. The integrity of the enrollment files is also very important and issues will be addressed over the next two months.

It was emphasized that member eligibility issues on either the medical or pharmacy side will be escalated and that members will not go without care or prescriptions. An updated membership report will be presented at the January meeting, but the official enrollment numbers may not be available until February.

Mr. Andy Howell, Chief Operation Officer for Benefitfocus, addressed the board and stated that the benefit options required a significant amount of software development and coding. He stated that Benefitfocus was pleased with the performance of the website from the beginning and the response time from users. He acknowledged their disappointment with the call volume results and stated that the changes and complexity, especially for Medicare retirees, contributed to the significant wait time for

members. Due to the high volume of calls, system surges occurred and calls were dropped. In response to a question from a board member regarding the ability to leave a message after a designated wait time, Mr. Howell stated that Benefitfocus was working to make that available. He also indicated that the current system does not have the capability of providing the approximate wait time to members at the beginning of the call and that the anticipated number of calls received was significantly higher than expected. Ms. Smart stated that the number of phone calls is unprecedented and that Plan staff returned calls to hundreds of members over the past few weeks.

Benefitfocus, Plan operations and BCBSNC have multiple teleconferences each day and will continue to do so, as needed.

Agenda Item – Requests for Benefit Changes (Attachment 5)

Autism Speaks
Presented by Lorri Unumb, Vice President, State Government Affairs

Autism Speaks would like the State Health Plan to consider coverage of autism spectrum disorders. Ms. Unumb provided background information on autism developmental disorders and the progression of applied behavior analysis (ABA) as the standard of care. ABA treatment teaches new skills and adaption to new environments and situations. The average child requires approximately 2 years of intensive therapy and further treatment depends on how well the child responds to ABA therapy.

The Centers for Disease Control and Prevention states that the prevalence for autism is nearly 1 in 88 children. Many providers and institutions are beginning to recommend intensive ABA therapy with the goal of autistic children leading a reasonably normal life. Forty-seven percent of children with autism who received early ABA therapy went into 1st grade as normal with no support. Without appropriate treatment, the estimated lifetime cost per child is approximately $3.2 million, which most people cannot afford. The estimated lifetime savings of providing appropriate treatment is approximately $1 million per child. Because of this, many states have moved or are moving toward insurance coverage of autism treatment.

North Carolina House Bill 498, Autism Health Insurance Coverage, passed the House during the 2013 Long Session and was referred by the Senate to the Insurance Committee at the end of the Session.

North Carolina Chiropractic Association
Presented by Dr. Joe Siragusa, D.C., M.Ed., Executive Director

The North Carolina Chiropractic Association requested the board to consider a reduction in copays for chiropractic visits equal to a primary care visit.

Included in Dr. Siragusa's presentation were technical reports that incorporated Plan claims data from 2000-2009 on headaches and complicated and uncomplicated low back pain and neck pain. He also presented average costs savings for each area comparing chiropractic vs. medical treatment. The medical treatment costs were higher in each area and the disparity is greater with complicated low back pain and uncomplicated neck pain. He stated that the current copay of $64 is a disincentive to seek chiropractic care as the first choice for certain problems. He also emphasized that he was not advocating that chiropractors be seen as primary care providers for other illnesses but would like to remove the financial barrier for members to choose chiropractic care.

In 2006 legislation for lower copays was passed by the N.C. General Assembly but was repealed a year later. During that year, costs to the Plan for selected conditions dropped significantly but rose after the repeal of the legislation. The typical course of chiropractic treatment is non-surgical, non-invasive and doesn't involve the use of prescription drugs.

N.C. Retired Governmental Employees' Association
Presented by Ed Regan, Executive Director

Mr. Ed Regan began by expressing appreciation to the board for expanding options for Medicare retirees in 2014. The N.C. Retired Governmental Employees' Association (NCRGEA) requested that the board consider the addition of a self-insured Medicare Supplement plan with Medicare Part D prescription drug plan equivalent to the EGWP plan offered by the Plan in 2012-13. This plan would provide members with good coverage at a lower employer cost than the 70/30 plan and produce savings for the state.

One of the board members requested clarification as to whether NCRGEA was asking the board to consider specific self-insured plans or one developed by the State Health Plan. Mr. Regan stated that they would welcome consideration of existing plans or a self-insured plan with reasonable rates.

State Employees Association of North Carolina
Presented by Ardis Watkins, Director of Legislative Affairs

On behalf of the State Employees Association of North Carolina (SEANC), Ms. Ardis Watkins presented several benefit changes for the board to consider. Treasurer Cowell requested that Ms. Watkins limit her presentation to items that pertain to benefit changes. Ms. Watkins expressed concern about how the Plan is viewed and that health benefits are not a gift. She stated that only one state spends less per member per month than the Plan and that cost shifting to employees has averaged approximately $1,300 per year. SEANC would like the board to consider re-establishing the premium free 80/20 option.

Ms. Watkins stated that SEANC had been notified that several items on their list for consideration did not fall under the definition of benefit changes and requested that the information should not be presented to the Board. She noted that SEANC strongly disagreed that those items do not meet the benefit change criteria. She stated that SEANC was formally requesting that they be allowed to present these items to the board at another meeting.

In response to a question from a board member regarding the current process for member benefit exceptions, Ms. Crabtree stated that active members go through their Health Benefit Representative and that retiree members are currently being handled by Plan staff.

Agenda Item – Financial Report (Attachment 6)
Presented by Mark Collins, Financial Analyst

September 2013 Financial Report
Plan revenue through September was $749.4 million, an increase of approximately $13 million over the certified budget amount. Total claims costs for the Plan were $23.1 million more than budgeted. Mr. Collins noted that the Plan continues to maintain a strong cash position despite higher than expected claims costs, with a cash balance of $732.8 million at the end of September, $22.5 million more than budgeted.

The per member per month (PMPM) net claims payments on the adjusted variance analysis were $8.53 over the certified budget amount, and administrative expenses were $2.01 less than budgeted. The net loss for the first three months of the short plan year was $28.80 PMPM, $6.37 more than the loss projected in the certified budget.

Through September, professional payments account for approximately 29% of claims expenditures and pharmacy 26%. Outpatient facility payments total 24% of claims expenditures.

Analysis of Paid Claims Report

In past meetings, the board expressed interest in comparing the actual vs. budgeted amount of the medical and pharmacy weekly paid claims on a PMPM basis. The report reviewed by Mr. Collins covered claims paid from July 2013 to October 2013. The medical claims pattern over the past year varied but has been much closer to the budgeted amounts in the first quarter of the current fiscal year, compared with last year when claims were often well below the budgeted amounts. Pharmacy payments in the current fiscal year have been higher than the budgeted amount. Several board members expressed concern about the cost of specialty drugs and would like to see future reports include a breakout of pharmacy expenditures. Ms. Moon noted that actual expenses could be split between specialty and non-specialty drug costs, but the budget and the Plan's actuarial projections do not separate specialty and non-specialty cost estimates.

The Plan and Member Shares of Paid Medical Claims page compares Plan costs to member copays, coinsurance and deductibles for medical expenses. Plan expenses slightly increased from the first quarter of FY 2011-12 to the first quarter of 2012-13, and increased more rapidly during the first quarter of 2013-14, due in part to the short plan year. The biggest decline in member cost share was in the deductible.

The first quarter Plan and member shares of paid pharmacy claim comparisons for FYs 2011-12, 2012-13 and 2013-14 demonstrated an increase in Plan costs from last fiscal year to the current fiscal year and decreasing member copays. Total pharmacy claims sharply increased in the current fiscal year, due in part to the EGWP accounting process. The Plan will continue to closely monitor pharmacy spending.

In summary, medical claims are slightly above the budgeted amount through the first quarter and pharmacy claims have been higher than budgeted in every month since February 2013. The Plan will review medical utilization in greater detail to determine if higher claims costs are the result of increased utilization.

1st Quarter Actuarial Forecast Update

Mr. Collins stated that the most recent forecast update did not significantly change from the previous forecast. The net income was close to what was projected, and the projected cash balance for December 31, 2013, was approximately $29 million over the budged amount. The forecast comparison of combined medical and pharmacy claims for the short plan year and FY 2013-14 were both close to the certified budget. One board member suggested that an increase in pharmacy utilization might lower medical costs due to a decrease in hospitalizations. Mr. Collins stated that it might be worth analyzing the data to determine if a correlation exists. Ms. Moon stated that the Plan wants to expand the financial presentations, including a quarterly utilization report.

The projected cash balances for the upcoming biennium were higher than anticipated in the certified budget, remaining approximately $30 million above the budgeted amount until the final six month period when the difference increases to $50 million. The forecasted premium increase for the 2015-17 Fiscal Biennium is slightly lower than originally anticipated.

Actuarial Valuation of Retired Employees' Health Benefits

Mr. Collins presented information on the financial reporting required by the Governmental Accounting Standards Board (GASB), specifically related to the State's liability associated with retiree health benefits. The presentation was based on a report by Segal to the State's Committee on Actuarial Valuation of Retired Employees' Health Benefits. The full report is available on the Board's website.

Mr. Collins reported that the unfunded liability dropped $6.5 billion from 2011 to 2012. The substantial drop was due to assumption and Plan changes that offset an increase in actuarial experience. The annual required contribution (ARC) of the retiree health benefits liability is determined by the amortization of the unfunded liability plus the liability of future benefits earned in the current year. The 2012 ARC and percent of payroll it represents were the lowest numbers seen in the last five years. The future benefits numbers include newly vested people in the Plan and not new staff coming in.

The benefit changes approved by the Board reduced the ARC by $331 million this past year. Treasurer Cowell stated that the unfunded liability in 2008 was one of the worst aspects of North Carolina's financial health and that the dramatic lowering of numbers in 2012 should be underscored. Ms. Moon thanked the Board for taking important steps to impact the unfunded liability.

Agenda Item – Strategic Planning

Presented by Strategic Planning Workgroup

Mr. Tom Gualtieri-Reed, Strategic Planning Facilitator, reported on his discussions with the board members, individually and as a group. He presented a number of questions and solicited the board's feedback.

Question 1: Member Experience – what do we want and need?

- Cost of coverage for dependents and spouse
- Member survey regarding care - if a member calls the provider's office, do they get an appointment? Do members with chronic disease appropriately take their medications? Do they take care of themselves?

Note: The survey taken this year could vary greatly from one taken next year given all the recent benefit changes

- Wellness initiatives are not seen as incentives by many members. The Plan needs to be affordable while still maintaining its fiduciary responsibility.
- Empower members to improve quality of life.
- Tools at the members' disposal need to be easy to use and well understood

Question 2: Value and Affordability

- Members can't invest and plan for the future when a large percentage of their salary goes toward health care

- The Plan cannot rely on the General Assembly to appropriate funds. The board is responsible for ensuring that members receive the best value. Improve transparency by making hospital charges and negotiated rates available to members.
- Determine successfulness in emphasizing and communicating the wellness aspect of the benefit options. Was the Consumer-Directed Health Plan information well communicated and understood by members? Knowing this will assist the board in strategizing next year.
- Board members agree with the comments on affordability but understand that fiduciary responsibility has to be maintained. Wellness initiatives shouldn't be seen as a burden and were designed to promote a healthy lifestyle. Ongoing education is critical for trust in the Plan and not just from a financial perspective.

Question 3: How is Plan perceived?

- If the Plan is perceived by members as an adversary, the reason needs to be determined. It may be that the Plan is perceived in this light due to the fact that more burden is put on the employees and less on the General Assembly for funding.
- The perception of the Plan is different depending on type of employee and place of employment.
- Determine the percent of members who feel Plan is perceived in a negative way through an employee survey.
- The belief is that an overwhelming number of employees cannot afford the Plan health benefit options.

Discussion: Determine the timeline for a survey and what to include. The Plan needs to ensure it has appropriate input from the board in order to design a comprehensive survey. A portion of future meetings could be used for further discussion on the survey development.

Question 4: What do we want and need to know about payment and reimbursement models for health services?

- Providers are being paid for volume rather than value. Consider different ways of reimbursement, i.e., bundled payments, patient-centered medical home, etc. The board would find it helpful for Plan staff to develop payment options for them to consider.
- The State is looking at Medicaid managed care, which could have impact on the health delivery system. Is capitated care a model the Plan could adopt?
- Provide the board with talking points to address how the Plan has continued to ask a lot from state employees.

The board discussed various areas to address in moving forward with the strategic plan development:

- Identify whether the full board is in agreement with moving in this direction. Do board members outside the strategic planning workgroup agree with this focus?
- Gather the information needed and determine the primary objectives for the strategic plan.
- Identify objectives and relate that information to the quality of care, affordability and provider engagement.
- Determine the perspective on the provider side and how they might better engage with the Plan.
- Determine ways in which the primary care provider/member relationship can be improved.
- Determine what the Plan can do to adequately support the strategic plan development.
- Expand the dashboard report and understand how everything works together.

Mr. Gualtieri-Reed will continue to work with Plan staff and the board on the development of the strategic plan and provide a preliminary report at the January board meeting.

Following a motion by Dr. Newton and seconded by Ms. Moore, the Board voted unanimously to move into executive session pursuant to G.S. 143-318.11 and G.S. 132.1.2.

Executive Session

Medical Claims Audit Services RFP (5B NCAC .0103)

A status on the medical claims audit services Request for Proposal (RFP) was provided. The procurement process was approved by the Division of Purchase and Contract (P&C) and the all bids were reviewed by the Plan and P&C. The recommendation to award the contract was presented to the board. Following a motion by Dr. Newton and seconded by Ms. Moore, the board voted unanimously to approve the recommended vendor. It was noted that approval by the Office of State Auditor is also required before the contract can be executed.

Lake Lawsuit (I. Beverly Lake et al. v. State Health Plan for Teachers and State Employees, et al.)
(G.S. *§143.318.11(a)(3))*
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance

The motion to dismiss the case was denied and mediation between the parties was scheduled. The Plan will continue to update the board on any developments in the case.

Consultation with Legal Counsel – Contract Issue (G.S. *§143.318.11(a)(3))*

Information on the enrollment process and issues with the enrollment vendor regarding meeting contractual requirements was discussed. The Plan presented a recommendation to address the issues. Following a motion by Mr. Huffstetler and seconded by Dr. Newton, the board voted unanimously to uphold the Plan's recommendation. The Plan will continue to update the board on the enrollment process.

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

Agenda Item – Wrap Up

Following a motion by Ms. Hargett and seconded by Mr. Medlin, the board voted unanimously to adjourn the meeting at approximately 2:25 p.m.

Janet Cowell, Chair