Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
May 29, 2014

The meeting of the Board of Trustees of the North Carolina State Health Plan for Teachers and State Employees was called to order at approximately 4:00 p.m. on Thursday, May 29, 2014, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

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

Absent:
Paul Cunningham

State Health Plan and Department of State Treasurer Staff: Mona Moon, Lotta Crabtree, Glenda Adams, David Boerner, Mark Collins, Thomas Friedman, Beth Horner, Nidu Menon, Sally Morton, Lorraine Munk, Caroline Smart, Tracy Stephenson, Andrew Holton

Welcome
Treasurer 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 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. No conflicts were noted.

Strategic Planning
Presented by Tom Gualtieri-Reed, Strategic Planning Facilitator

Ms. Moon opened the discussion by stating that a series of discussions and meetings, several of which were facilitated by Mr. Gualtieri-Reed, occurred over the past two months. From these discussions, a draft of the strategic plan guiding principles and strategic priorities was developed, as well as a proposed vision statement. Between the May and July board meetings, Plan staff will work on the "road map" including the 2016 benefit changes, a contract timeline, metrics and the method by which to meet the priorities and initiatives.

Mr. Gualtieri-Reed began by acknowledging the leadership of Ms. Moon and thanked Plan staff for the work that has been accomplished on the development of the strategic plan while attending to the daily operations of the Plan. He stated that the focus of discussion for the May meeting would be the "why" and "what" and the July meeting would address the "how" and "when."

Board members responded to various aspects of the guiding principles.

> #4 - The board doesn't have the control to ensure that every member has a positive patient experience. It was suggested that the word "improve" be incorporated into this principle.
>
> #5 - The board has frequently discussed the importance of reaching all members across the state (i.e. geographic access to quality care). Equally important is addressing the affordability of medications for everyone and appointment availability.
>
> #10 - In addition to focusing on the membership, the board should also consider their fiduciary responsibility and do everything possible to explicitly recognize that. Mr. Gualtieri-Reed noted that the guiding principle is all-inclusive but separating this item to address fiduciary responsibility could be considered.

Mr. Gualtieri-Reed invited the board to share additional comments via email or phone.

The board discussed the proposed vision statement and agreed that quality access to care and transparent partnerships are important to include in the vision. When reviewing future benefit changes, the board will review best practices and determine how proposed changes fit into the vision. The board also discussed adding or recognizing certain "values" as part of the strategic plan to further guide the work of the board and Plan staff.

Mr. Gualtieri-Reed presented the strategic priorities. Managing the health of the population includes aspects of engaging health care providers to improve the health of Plan members and determining how to do that through multiple channels. Following discussion, the board agreed that the first priority should be changed to "improve the health of the members." It's important to create a benefit plan that can be used to recruit young, healthy members. It was also noted that a portion of our members have healthy dependents who don't choose the plan because of the cost. Ms. Moon stated that dependent premiums were somewhat addressed with the addition of the CDHP but that it hasn't affected the Plan's risk pool. She also noted that the Plan's benefits are comparable to the Gold Plus tier on the Marketplace Exchange.

Improving member's experience includes the member's interaction with both the Plan and providers.

The third priority is to ensure a financially stable Plan by continuing to offer benefits and access to quality health care. Within that, medical costs and predictability, managing utilization and working with the General Assembly for funding will be addressed. The board urged caution regarding wording that ensures action will be taken to avoid "the diminishment of benefits." The board recognizes that utilization and the cost and value of specific benefits must be addressed in order to keep the Plan sustainable but cannot guarantee a certain level of benefit. It was also suggested that the reference to a reserve balance equal to "16 weeks of projected Plan spending" be clarified to provide context. As written it is not clear if 16 weeks is sufficient.

The board next discussed the 10 initiatives within the 3 priorities. It was suggested that 'assist' replace 'engage in the 2nd initiative. One member noted that while the emphasis is on the management of chronic disease, it's irrelevant if members can't get access to care.

Mr. Gualtieri-Reed stated that there are various components related to communication and that it's continuous. It's important for members to understand their benefits and also the value. The message has to be tailored to the audience and the way they receive information. The enrollment experience is a

foundational component. Ms. Moon acknowledged that the Plan hasn't done a lot from a marketing perspective and that use of the term "marketing" was purposeful in that the Plan has to move beyond just providing information. It was suggested that a video on the Plan and benefit options might be helpful and a way to establish an identity. It was suggested that "demonstrate and promote the value of SHP offerings" replace "influence the perception of the value of SHP offerings."

It was suggested that improving the member enrollment experience could be expanded to include the patient experience with the health care system, i.e. being able to get appointments, reaching appropriate people by phone after hours, cost barriers to taking medications. It could also include educating members on insurance choices. The Plan's benefit design offers fewer choices than many companies and lends itself to a great educational opportunity.

The promotion of health literacy provides members with the opportunity to understand their choices and to engage more in where to go for quality, affordable care. It's broader than the benefit selection itself. If a particular benefit is of interest to a member, they can determine what plan works best for them if they have the knowledge. This initiative provides the Plan with a great opportunity to promote the CDHP. As members learn about how it works, others are becoming more interested and requesting additional CDHP educational sessions.

Mr. Gualtieri-Reed noted that the three initiatives under financial stability included short and long term goals. It was suggested that acute services and "never" events be added to hospital and specialist medical expenses.

One board member suggested another dimension to consider, in addition to reducing costs, is ensuring that adequate funding is there. Maintaining confidence in and support for the Plan is important. Ms. Moon stated that engaging the General Assembly was a part of earlier discussions and that the Plan will revisit that to create a topic of cost and funding. Another board member expressed support for this and asked the Plan to also consider adding the development of a scorecard to determine how the Plan is perceived among all of its stakeholders. Ms. Moon stated that these suggestions would fall under the partnership area and noted that to "collaborate with the General Assembly..." was listed in the strategic priorities section.

The question arose as to whether organizational development should be added as a goal. In order to move forward, it's important to have a process including orientation. Ms. Moon stated that in addition to organizational development, there were lengthy discussions regarding data and analytics. In the end, it was decided that these items fell more under organizational operations that strategic planning. She also stated that Plan staff have discussed board orientation and the best process given that member turnover can occur every two years.

Ms. Moon and Mr. Gualtieri-Reed will review the changes and present a draft to the board, as well as measures and a roadmap at the July meeting.

Wrap Up

At the request of Chair Cowell, a motion was made by Mr. Medlin and seconded by Dr. Newton to move into executive session pursuant to GS §143-318.11(a)(6) and GS §143-318.11(a)(1) in relation to GS §126-24.

Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
May 30, 2014

The meeting of the Board of Trustees of the North Carolina State Health Plan for Teachers and State Employees was called to order at approximately 9:00 a.m. on Friday, May 30, 2014, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

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

Absent:
Paul Cunningham

State Health Plan Staff: Mona Moon, Lotta Crabtree, Glenda Adams, David Boerner, Mark Collins, Thomas Friedman, Beth Horner, Nidu Menon, Sally Morton, Lorraine Munk, Caroline Smart, Tracy Stephenson

Department of State Treasurer Staff: Andrew Holton, Fran Lawrence, Tony Solari

Welcome
Treasurer 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
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Review of Minutes
Following a motion by Mr. Medlin and seconded by Ms. Moore, the board unanimously approved the minutes from the March 27-28, 2014 meeting.

Executive Administrator Update
Presented by Mona Moon, Executive Administrator

Public Comment Period: Ms. Moon stated that a public comment period would be added to the agenda at the end of the day. Anyone wishing to speak was asked to see Ms. Munk or Ms. Horner during one of the breaks to add their name to the sign-up sheet.

Board Onboarding Process: The Department is in the process of establishing a best practice onboarding process for the seven boards the State Treasurer currently chairs. The Plan is revising the current orientation materials for new board members which include a history of the Plan, term information and a summary of Plan operations. Current Plan board members are appointed by the Governor, General Assembly and the State Treasurer. Board members can serve no more than three consecutive two-year terms. Members that are not reappointed can continue to serve until a new appointment is made. Ms. Moon requested that current members contact Mr. Holton if they no longer wish to serve on the board.

Plan Staffing: Interviews for the Global Communications Director will begin shortly. If the position is filled within the next two months, the new director will be introduced to the board at the July meeting. The Plan will soon post the Director of Policy Planning and Analysis position and anticipates hiring someone by the September or November meeting.

Legislative Update
Presented By Tom Friedman, Legislative Liaison and Health Policy Analyst

Following consultation with the board, Treasurer Cowell made a recommendation to the General Assembly to forgo premium increases for both employers and employees in 2015. This will save approximately $22 million in General Fund and $1 million in Highway Fund appropriations. Mr. Friedman presented a breakdown of funds in the Governor's recommended budget and the proposed budgets from the Senate and House. He also highlighted the reallocation of funds in the Governor's budget originally appropriated for the 2015 premium increase.

The proposed Senate budget includes a $12.8 million increase in the Plan's administrative budget and alternative health benefit coverage for newly eligible employees to comply with the Affordable Care Act (ACA). The budget language also directs the Treasurer and the Plan board to determine essential minimum coverage and contributions for these members no greater than the "Bronze" level in the ACA. The University of North Carolina system is also allowed the discretion to provide their own coverage to newly eligible employees within their system.

House Bill 498 requires the Plan to provide annual coverage of $36,000 for autism behavioral treatment benefits. This bill has been referred to the Senate Committee on Insurance. Based on the legislative actuarial note, the estimated annual impact for 2014-15 is approximately $3-5 million and the long term estimated impact is $6-13 million. (Note: The board agenda included a related item and recommendation from Plan staff to establish a benefit for applied behavior analysis (ABA) for autism spectrum disorder. See the section on *Benefit Design and Plan Options* for details).

Senate Bill 783 establishes chiropractor copay parity and is similar to SB 561 introduced in the 2013 long session. The fiscal impact to the Plan is estimated to increase costs by approximately $1-1.5 million in the first year and $2.6-$4 million in the second year based on the 2013 actuarial note.

The Plan will continue to track Plan related legislation and communicate the Plan's position to legislators. An update on the revised budget will be presented at the July board meeting.

Financial Report, Forecasting and Monitoring
Presented by Mark Collins, Financial Analyst

March 2014 Financial Report
The Plan experienced good financial results in the first quarter of calendar year 2014 with revenue slightly higher than budgeted and claims payments substantially lower. Medicare Advantage premiums

were $3.1 million less than the budgeted amount and administrative expenses were 18% below forecast. Medicare Advantage premiums totaled approximately $40 million. The Plan's ending cash balance was $922 million, $232 million over the Certified Budget amount.

Revenue on the PMPM (Per Member Per Month) Adjusted Variance Report was very close to the forecast. The administrative expenses and net claims payments were both less than the budgeted amount and the net income was $48.13 PMPM, which was $50.43 better than the forecast.

The board discussed the fact that administrative expenses are consistently below budget and asked for a breakdown on the allocation of expenses. Ms. Moon and Mr. Collins responded that approximately 60% of administrative expenses are attributed to Third Party Administrator (TPA) costs, which, as expected, have decreased somewhat with the addition of new vendors. Approximately 30% are related to the Pharmacy Benefit Manager (PBM) and ActiveHealth Management and the remaining 4% to6% is attributed to other contracts and Plan (agency staff) operations. In response to a question as to whether Plan staffing is adequate, Ms. Moon stated that the Plan's executive committee is reviewing the organizational structure and that additional staff will be brought onboard over the next few months. She stated that the Plan reviews the contracted rates at the beginning of the biennium and is typically very conservative in the forecast assumptions; hence the reason actual expenditures are less than budgeted. It was also noted that the General Assembly is considering a request for an additional $13 million for administrative expenses in the budget for FY 2014-15.

In response to a question from the board, the Plan will provide follow up information on administrative expenses for the State's Medicaid.

CY 2014 1st Quarter Actuarial Forecast Update- Baseline Scenario

Mr. Collins provided a comparison of the Certified Budget with the CY 2014 1st quarter forecast update. There was a slight increase in projected administrative expenses for 2014 but total expenses for 2014 were approximately $107 million less in the 1st quarter update. The projected net income increased by $131.6 million and the ending cash balance for the year was estimated at $994.7 million, an increase of $275 million over the Certified Budget estimate. The projected annual premium increases for 2016 and 2017 were 4.47% and 16.11% for 2018 and 2019.

The CY 2014 forecast comparisons show a steady reduction in projected medical claims as forecasts are updated and an increase in pharmacy claims over the Certified Budget amount. The ending cash balance forecast comparison continues to demonstrate higher projected balances in more recent forecasts due to higher revenue projections and lower expense estimates. The cash balance is expected to exceed the 9% target reserve amount by approximately $750 million at the end of the 2013-15 Fiscal Biennium, equal to more than fifteen weeks of projected operating expenses in 2015-16. Mr. Collins noted that the 1st quarter update projects a 4.47% premium increase on January 1 of each year through 2017 assuming no benefit changes. The Certified Budget premium increase projection was 8.22%.

CY 2014 1st Quarter Actuarial Forecast Update- Modified Trend Scenario

Plan staff and Segal have had discussions regarding the Plan's trend assumption for forecasting purposes. Plan results for 2009 through 2013 demonstrated that the trends assumed in the budget were well above the actual results. Trend factors reviewed by the Board showed a 4% drop in utilization in two overlapping measurement periods. The paid claims trends were below the 8.5% trend assumption in the time periods reviewed. Board members requested data on out-of-pocket costs for Plan members outside of premiums. Ms. Moon stated that the Plan has some information on out-of-pocket expenditures and that it would be shared with the board.

The FY 2013-2014 trend experience through December 2013 suggests higher trends in allowed and paid claims for the current fiscal year. The Plan has taken on a greater share of overall costs, and member out-of-pocket costs have likely decreased. The short plan year may be affecting more recent trend rates. Trends in PMPM allowed claims increased in the first half of the current fiscal year but are still less than 8.5%. Despite some risks, recent data supports reducing the trend assumption to 7%. Board members expressed concern about lowering the trend to 7% given unpredictable factors and projected higher pharmacy costs.

Mr. Collins presented a comparison of forecast models using a 7% trend. For the 7% model, Plan expenses for CY 2014 are projected to be $2.80 billion, $22.5 million less than the 8.5% trend forecast and $130 million less than the Certified Budget. The ending cash balance is projected to be $1.017 billion, an increase of approximately $300 million compared to the Certified Budget. Assuming no increase in premiums for 2015, the 7% trend forecast projects a 1.99% premium increase for 2016 and 2017. Ms. Moon expressed appreciation to the board for their conservative approach related to lowering the trend and stated that the Plan will continue to have discussions with Segal and update the board at future meetings.

Due to time constraints, Ms. Moon recommended moving to the next agenda item. Mr. Collins suggested that board members review the proposed 2015 premium freeze on page 11 of the presentation and the effects of moving to a 7% trend.

Member Migration Analysis: FY 2012-13 to CY 2014

In FY 2012-13, among the active employees and non-Medicare retirees, 58% were in the Standard (80/20) plan and 42% were in the Basic (70/30) plan. In CY 2014, 75% of the members in the 80/20 plan remained in the Enhanced 80/20 plan and 81% of those in the 70/30 plan remained in the Traditional 70/30 plan. Approximately 3% of those in the 80/20 plan selected the Consumer-Directed Health Plan (CDHP) while 4% of those in the 70/30 plan chose the CDHP. Plan selections among new members indicated that 43% chose the Enhanced plan, 51% chose the Traditional plan and 6% selected the CDHP. In comparing the forecasted and actual numbers, fewer active employees and non-Medicare retirees selected the CDHP than anticipated.

Among Medicare primary members, 79% of members who had been in the Standard 80/20 plan selected one of the Medicare Advantage plans. Seventy-two percent of Medicare members in the Basic 70/30 plan chose one of the Medicare Advantage Plans. Among newly eligible Medicare members, 51% selected the Traditional plan and 49% chose one of the Medicare Advantage plans. It was noted, however, that Segal has not been provided with a reliable eligibility data file from the Plan's enrollment vendor. The Plan will continue to review the enrollment numbers and revise the reports as needed.

A question was asked regarding whether the Plan could break the data down by gender, race, income, age, geography, etc. Ms. Smart stated that the Plan doesn't have access to income but that the other data is available once the Plan receives the eligibility file from Benefitfocus. The Plan will provide a demographic breakdown to the board at a future meeting.

Due to time constraints, Mr. Collins ended his presentation.

Benefit Design and Plan Options

Coverage for Applied Behavior Analysis

Presented by Lotta Crabtree, Interim Deputy Executive Administrator, Director of Contracting and Legal Compliance and Legal Counsel

In response to a request from Autism Speaks and a directive from the board, Plan staff explored coverage options for Applied Behavior Analysis (ABA). As a part of the process, staff met with various community groups, reviewed the law as it relates to the provision of ABA, and reviewed the credentialing and clinical criteria provided by ValueOptions. A proposed benefit was drafted and an actuarial analysis of the financial impact was completed. Ms. Crabtree stated that representatives from three groups would speak at the conclusion of the presentation after which a recommendation to cover ABA will be brought to the board for a vote.

One in 68 children was identified with autism spectrum disorder (ASD) in 2010, a 30% increase from the estimate in 2008. There are no medications that can cure or treat ASD and evidence suggests that early intervention is beneficial for children with autism. Thirty-seven states now cover ABA through legislation. The Plan's current coverage includes speech therapy, occupational therapy, medical evaluation and treatment and mental health evaluation and treatment.

ABA is a structured strategy that addresses challenging behavior in individuals with ASD. Social activities can be limited and access to ordinary community and educational facilities can be denied. ABA is a system that relies on principles to modify behavior. The two components of ABA are analysis and intervention. Typically, ABA is provided by psychologists and licensed psychology associates or temporary licensees. Board certified Behavior Analysts and Assistant Behavior Analysts are not licensed or authorized to provide ABA in North Carolina.

The proposed benefit design for ABA would include treatment for members under age 26, diagnosed with ASD by a licensed physician (MD or DO) or a licensed doctoral level clinical psychologist (PsyD or PhD). Coverage would be limited to a maximum of $36,000 per benefit year and would available only in-network. Coverage would be subject to copays, deductibles and coinsurance depending on the ABA component and place of service.

Treatment for members with medical conditions or impairments that would prevent beneficial utilization of services or members requiring 24-hour care in a hospital setting would be excluded from ABA coverage. ABA would not be certified for speech, occupational, recreational, dolphin, equine or hippo therapy, service animals, supportive respite care, vocational rehabilitation, orientation and mobility or other educational services.

Criteria for coverage would include a verified diagnosis of ASD, display of severe challenging behavior that presents a safety or health risk or interferes with socially acceptable activities, verification that less intensive treatment has not reduced interfering behavior or other appropriate treatment would not be beneficial, a reasonable expectation from the provider that ABA therapy will improve behavior and parental or caregiver training and support. The treatment plan would be individualized for the child and would target specific behaviors, include quantifiable progress measures, describe detailed behavioral interventions and coordinate ancillary services and a transition plan.

The continuing treatment criteria would include documentation on the child's condition, a reasonable expectation that continued therapy would be beneficial and that the treatment plan is realistic with specific goals noted and that services and treatment interventions would be structured to achieve optimum results. The criteria would also include documentation of progress for specific symptoms and impairments, a transition plan, coordination of care when appropriate and family involvement in the treatment.

Discharge criteria would include documentation that the child has achieved stabilization in his/her challenging behavior and meets criteria for less intensive services. ABA discharge would also apply to

children who are getting persistently worse from the treatment or when the child is not making progress toward treatment goals.

The Plan recommends that coverage be available in-network only. Blue Cross and Blue Shield of NC (BCBSNC) will work on developing the network of providers which will include credentialing and contracting, as well as amending current provider contracts to include ABA billing codes. Ms. Crabtree noted that temporary codes will be utilized until the billing codes are finalized by the American Medical Association. She also stated the Plan will lose mental health parity and will exercise the opt-out under federal law.

The projected calendar year cost impact for the coverage of ABA benefit is $4 million in 2015, $5.2 million in 2017 and $5.8 million in 2019. The benefit effective date would be January 1, 2015.

Board members expressed some concern about the Plan losing mental health parity and whether there would be consequences to the Plan or members. Ms. Crabtree answered that there would be no consequences and that members would be notified. She stated that the Plan weighed the decision to opt out vs. providing ABA coverage for members and felt that offering the benefit for Plan members was more important.

In response to a question about how often the benefit and cost would be reviewed, Ms. Crabtree stated that it would be up to the board. One board member asked who would be responsible to perform quality oversight for all the measures that would be in place for accountability. Ms. Crabtree responded that the Plan and its third party administrator will monitor the benefit.

A board member had questions regarding the supervision of ancillary staff by providers and whether the definition should be clarified within the statutes. Ms. Crabtree stated that legislation to clarify who can provide services was put forth by the NC Psychological Association but that legislative language had not changed. She noted that if the Plan were to take a position, she would recommend that it support that non-licensed providers of ABA be supervised by psychologists or have their own board and licensure requirements. A question was asked regarding whether it would cost more for visits to licensed psychologists. Ms. Crabtree answered that going to certified, non-licensed providers might be less expensive but this was more about the quality of service.

Several board members felt that legislative language defining providers should be changed. Dr. Laura Klinger, TEACCH Autism Program, stated that social workers who can make the diagnosis of autism by law would not be recognized to make the diagnosis for the purposes of this benefit. One board member noted that diagnosis vs. treatment was an important distinction.

<u>Comment on Proposed ABA Benefit</u>

Autism Speaks - Presented by Lorri Unumb, Vice President, State Government Affairs
Ms. Unumb complimented Plan staff for thoughtful communication and a good benefit design. She stated that the trend in the country to cover ABA is growing. She stated that Autism Speaks would prefer that legislation would be created to allow behavioral analysts to provider ABA treatment. She noted that several self-funded companies are closely following the Plan's benefit design and the board's decision.

Ms. Unumb stated that the greatest impact for the Plan's ABA benefit would be recognizing Board Certified Applied Behavior Analysts as network providers

TEACH Autism Program – Presented by Dr. Laura Klinger, Executive Director
Dr. Klinger stated that the TEACCH, a UNC Autism program, has 7 outpatient clinics and that the data supports the board making a decision to cover ABA. She stated that the earlier ASD is diagnosed, the better the outcome. Children who begin intensive behavioral treatment before age 5 can save approximately $3 million per child in the long run. She commended the Plan's decision to provide ABA therapy for members up to age 26.

She acknowledged that most issues were addressed in the proposed language. She did, however, raise the point that TEACCH feels additional providers will be needed to treat Plan members and supports the inclusion of board certified behavioral analysts and other mental health professionals. The intensity and hours needed each week is important in order to make a significant impact. TEACCH recommends 25 hours per week per child.

North Carolina Psychological Association – Presented by Dr. Vickie Shea, Past President
Dr. Shea expressed strong support for the ABA benefit and that the proposal correlates with the law with respect to providers. She commended Plan staff for including different groups to collaborate on the benefit development and would be happy to continue to collaborate if needed.

In response to a question by a board member, Ms. Crabtree stated that parents/caregivers receive training but do not receive financial compensation.

SHP Member Addressed the Board - The member's son is profoundly affected by autism but with ABA therapy he was able to go from taking 5 medications to 1 medication per day. She emphasized the power of the board to transform lives by voting to cover ABA and asked that they please help.

Following a motion by Mr. Johnson and seconded by Dr. Rubin, the board voted unanimously to cover ABA for the treatment of Autism Spectrum Disorder.

<u>2015 Enrollment Rules & Medicare Advantage Plan Renewals</u>
Presented by Caroline Smart, Director of Health Plan Operations

Ms. Smart presented the proposed 2015 enrollment rules on premium credits, annual enrollment and the Affordable Care Act (ACA) new hire automatic enrollment. In order to receive the premium credits in 2014, members had to complete the smoking attestation and elect a PCP during annual enrollment and complete the Health Assessment (HA) by the end of the annual enrollment periods.

During the 2015 annual enrollment, the Plan proposes that subscribers and their spouses, if applicable, re-attest to not smoking or participating in a smoking cessation program in order to receive the premium credit. In response to a question, Ms. Smart stated that the smoking attestation does not apply to e-cigarettes but that the Plan is looking into what other health insurance companies are doing.

Following a motion by Dr. Newton and seconded by Mr. Huffstetler, the board voted unanimously to approve re-attestation for the smoking premium credit.

The Plan also recommended that subscribers/family members who selected a PCP in 2014 do not need to change or update their PCP in order to receive the premium credit. In response to a request by the board, Ms. Smart stated that the Plan will provide data on the number of members who selected a PCP when the Plan receives reliable eligibility files.

Following a motion by Dr. Rubin and seconded by Mr. Medlin, the board voted unanimously to approve that members who selected a PCP in 2014 do not need to change or update the PCP selection.

Plan staff recommended that subscribers who updated or completed the HA for the first time between November 2013 and the end of the 2015 annual enrollment period will receive the HA credit.

Following a motion by Dr. Newton and seconded by Ms. Hargett, the board voted unanimously to approve that members who completed the HA between November 2013 and the end of the 2015 annual enrollment period will receive the premium credit.

Plan staff recommended a passive enrollment for existing active and non-Medicare primary retiree members. If no changes are made during annual enrollment, the member will remain in the plan option they chose in 2014.

Following a motion by Ms. Hargett and seconded by Mr. Medlin, the board voted unanimously to approve a passive enrollment for active and non-Medicare primary retiree members.

Plan staff prefers a passive enrollment for existing Medicare Primary retiree members. However, the Plan is currently negotiating renewal pricing with the Medicare Advantage vendors. Depending on the results, staff may recommend changes to the auto enrollment and contribution strategies and present a final recommendation to the board at a later date.

Ms. Smart also reminded the board that if the ACA implements new enrollment requirements related to new hires for January 2015, the Plan recommends enrolling those members in the 70/30 Plan if no selection was made by the end of their 30-day initial enrollment period. In that case, they would not have the opportunity to make a new selection until the next annual enrollment period.

Following a motion by Dr. Newton and seconded by Ms. Hargett, the board voted unanimously to enroll new hires in the 70/30 Plan if a selection is not made at the end of their 30-day initial enrollment period.

Potential Benefit Option for Newly Eligibles
Presented by Mona Moon, Executive Administrator

The Affordable Care Act updated federal definitions of full-time employees and the requirements to determine which employees must be offered employer-sponsored health care in order to avoid tax penalties. Full time employees are reasonably expected to work 30 hours a week but employers have the flexibility to determine eligibility. This includes all non-permanent full-time employees, who are currently not offered coverage through the Plan.

To avoid penalties, employers must offer full-time employees access to a plan that provides minimum essential coverage. This is defined as a plan with a value of at least 60% of the cost of services at the bronze level on the Marketplace Exchange. In addition, the cost to an employee must be no more than 9.5% of gross taxable wages for employee only coverage.

Based on a December survey of employing units, the Plan determined that approximately 24,000 people could become eligible under the 2015 rule. However, several state entities indicated a potential change in HR policies to reduce the number of newly eligible employees. Under current state law, newly eligible members will be eligible to enroll in the Plan's benefit options. Various employing units have expressed interest in creating a lower cost option for newly eligible members that would include a member premium. Plan staff has been exploring options for an alternate plan for these members.

The UNC system has expressed interest in creating its own plan to reduce costs for UNC. This would increase the cost to the remainder of the employing units covered by the Plan. Segal developed and priced benefit options with and without UNC's participation and two levels of benefits. Both offerings would provide significant savings to employing units when compared to current Plan offerings. Savings would be reduced by both offering a more generous benefit and by excluding UNC.

In response to a question, Ms. Moon stated that legislative action is required for UNC to offer its own plan and that it's currently included in the Senate budget. The board expressed some concern at the precedent it might set for employing agencies to create their own plans. Ms. Moon stated that the Plan shares that concern, especially since UNC's potential newly eligible employees are significantly younger and healthier than the average of other employing units and would adversely impact the remaining risk pool covered by the Plan.

In response to a question from Chair Cowell regarding whether there was a role the board could play, Ms. Moon stated that board members could reach out to members of the legislature and other decision makers. The board unanimously agreed that there are significant concerns regarding this proposal and asked that the Department legislative liaisons express those concerns to House and Senate leadership.

After further discussion, the board asked Mr. Holton and Mr. Collins to draft a letter to the legislature for the board to sign by the end of the meeting.

Member Experience and Communications

Medicare Primary and Open Enrollment Outreach
Presented by Caroline Smart, Director of Health Plan Operations

Both Humana and UnithedHealthcare have conducted outreach events statewide to educate Medicare and members on their benefits and highlight the SilverSneakers program. Additional meetings and other outreach efforts are scheduled for June and July. Statewide sessions for pre-65 members have also been scheduled and will continue through the summer.

The Plan will also try to accommodate requests for CDHP educational sessions.

2014 Member Satisfaction Survey
Presented by Caroline Smart, Director of Health Plan Operations

Prior surveys focused on member communication, customer service and plan design with the purpose of soliciting member feedback to support customer experience improvements, plan changes and new offerings. Members received a postcard invitation to participate in an online survey. Approximately 4,800 members responded to the survey in 2011 and 10,500 in 2012.

Plan staff, in conversations with the board, is researching two ways to solicit feedback from members in the 2014 survey. An all member survey would focus on customer experience and overall satisfaction. The verbiage for this survey has been reviewed by Plan staff, the board's communication workgroup, and the Department's communication team and should be ready to implement during the summer. A draft of the survey was included in the board packet and members were asked to review and send comments to Caroline by June 6. Survey results will be presented to the board upon completion of the survey.

A patient experience survey would focus on the patient centered medical home and payment reforms. The survey would be longer and more involved and is still in the discovery phase. The Plan anticipates implementing the survey during the first quarter of 2015.

Member Contact Information Contest
Presented by Nidu Menon, Director of Integrated Health Management

One of the Plan's challenges is obtaining and keeping correct contact information for members. Over half of the identified members who could benefit from population health management services are unable to be reached. Correct information would allow the Plan to increase engagement with disease and case management services and keep members informed about wellness resources.

In an effort to improve the number of members with correct contact information, the Plan is conducting a member contact contest for active members between May 12 and June 27, 2014. The contest will be promoted in the member newsletter and HBR Updates and posted on the Plan's website and Facebook page. The incentive for members to update their contact information in BEACON or eEnroll is a chance to win wellness kits, Fitbits and iPads.

Four employing sectors would compete against each other (state agencies/others; public and charter schools; universities and state hospitals; community colleges). Participants from the groups with the highest percentage of participation would be entered into a drawing for the prizes. HBR and Wellness leaders from the first place worksite from each sector will be placed in a drawing to win a Visa gift card. The winners will be announced on July 11 and the results will be presented at the July board meeting.

Contracting and Vendor Partnerships

Eligibility and Enrollment Services (EES) Contract
Presented by Mona Moon, Executive Director, and Caroline Smart, Director of Health Plan Operations

The Plan has been exploring EES vendor options over the past several months. Staff met with several eligible companies and conducted detailed requirements review sessions. Various Plan partners including BCBSNC, UHC and Humana and several state agencies were invited to participate in sessions with the vendor whom the Plan would like to select.

The Plan confirmed its authority to sole source the contract with the AG's office. A letter of intent will be executed with Aon Hewitt as the selected EES vendor. Aon Hewitt has expertise in Medicare services and the ability to handle the size of the Plan's population. One additional project managers and three business analysts (consultants) will be brought onboard to assist with on-going EES services as well as the transition from Benefitfocus to Aon Hewitt. Ms. Smart noted that the 2015 annual enrollment will be conducted on the Benefitfocus platform and stated that the goal is to complete the transition to AonHewitt by July 2015.

Chair Cowell extended her appreciation to Plan staff and vendors.

ADT Data from NC Hospital Association

Dr. Menon stated that the Plan has been working with the North Carolina Hospital Association over the past several months to facilitate providing real time admissions, discharge and transfer information (ADT) to the Plan's population health management vendor. NC Hospital Enterprises participates in the administration and can facilitate the sharing of ADT feeds with the Plan. Sixty-one hospitals currently

have the technology which will cover approximately 70% of hospital admissions for Plan members. Medicaid currently uses this data to manage its population.

This data can potentially reduce avoidable hospitalizations, admissions and emergency department utilization. It will also provide useful information to assist with transition of care and address medication management and adherence. The Plan will work with ActiveHealth Management (AHM) to develop criteria for high priority members who could benefit from care transition. AHM would also be responsible to deliver care transition services and evaluate the financial impact.

The estimated timeline for executing the contract is August 2014. ActiveHealth Management should complete system changes in October and the Hospital Association will be responsible for executing hospital agreements through December 2014. The full implementation is expected to be complete in 2015.

In response to a comment by a board member, Ms. Moon stated that the Plan is interested in working with different entities to obtain data and noted that the Government Data Analytics Center (GDAC) is where the Plan's SAS data is currently housed. She also stated that data security is covered in agreements and contracts and that the authorization for the release of data is a primary focus for the Plan in its relationships with various entities. Internal audits for HIPAA compliance are also conducted.

Dr. Menon stated that she anticipated bringing the contract before the board in July for approval.

Pharmacy & Therapeutics Committee Meeting Summary
Presented by Sally Morton, PharmD, Clinical Pharmacist

Dr. Morton presented several updates to current utilization management (UM) programs discussed at the May 13, 2014, Pharmacy & Therapeutics (P&T) Committee meeting. She also provided three new UM programs which were reviewed by the P&T Committee. One of the programs is for Hetlioz, a sleep disorder medication for people who are totally blind. The cost of the medication is approximately $8,400 per month and the Plan is working with ESI on prior authorization criteria. None of our members are currently using this medication. The target implementation date is July 2014.

The two additional programs reviewed, step therapy and quantity limits, were for long-acting brand and generic opioids to treat pain. Even though the Committee was supportive, they emphasized that the Plan should consider a comprehensive pain management program which should include disease and case management. The targeted implementation date is November 2014.

The board briefly discussed the option of a closed drug formulary to control utilization which would require more discussion. An appeals process would have to be implemented which might present operational challenges for Plan staff.

On June 1, 2014, Nexium 24HR will be available over-the-counter (OTC) for a $5 copay for a 42-day supply for members in the 70/30 and 80/20 plans. CDHP members are responsible for their deductible and 15% coinsurance. Members will have to obtain a prescription in order to receive prescription coverage. Members in the 70/30 and 80/20 plans who switch to the OTC product will save over $700 per year. Letters notifying of the available benefit coverage will be sent to members currently using prescription Nexium.

Strategic Plan

Presented by Tom Gualtieri-Reed, Strategic Plan Facilitator for Board of Trustees

Mr. Gualtieri-Reed stated that the next step in the development of the strategic plan is to add proposed measures and deliverable dates. He reminded the board that the prioritization of the initiatives was not discussed during the Thursday session and that Plan staff would determine the timing. He asked the board for comments on the process of the strategic plan, as well as their thoughts regarding content.

> The transition and maturity of the board has been exciting to see and a lot of that had to do with strategic planning. Directional guidance was important.
>
> The board has come a long way since the first meeting. It's important to have a coherent strategic plan as new board members join the board. The document was kept at a strategic rather than a tactical level.
>
> The strategic plan is evidence of the work and direction and consensus was a key factor. It was good to work with Plan staff.
>
> Other groups, partnerships and alliances have already solved some of the issues the board and Plan are discussing and those resources can be used.
>
> The whole process was interesting with a lot of viewpoints and expertise. The process was positive and the content is very good.
>
> It's strategically important to manage a good product with cost affordability.

The board discussed outcomes vs. activity measures and the fact that outcome based metrics should be used whenever possible. Long and short term outcomes are necessary and it was suggested that a session for the board to review progress could be useful. Member dissatisfaction was used as an example to determine if a measure has moved. Other items, such as the communication strategy and branding, are not measurable or quantitative but should be reviewed on a regular basis.

Member outreach has been greatly enhanced and the interaction between the Plan and members has changed and hopefully improved. The communication part of the strategic plan has made an impact in a short amount of time. It was suggested that perhaps fictionalized characters could be used to make some of the metrics more relatable.

Mr. Gualtieri-Reed asked board members to email additional comments to him and/or Ms. Moon and stated that the board will discuss the revised strategic plan at the July board meeting.

The meeting was adjourned at 2:30 p.m.

Janet Cowell, Chair