Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
September 19, 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, September 19, 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, Christine Allison, David Boerner, Mark Collins, Beth Horner, Kathryn Keogh, Nidu Menon, Sally Morton, Lorraine Munk, Dorothy Brown Smith, Tracy Stephenson, Andrew Holton, Fran Lawrence, Tony Solari, Melissa Waller

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 requested that members who have either an actual or perceived conflict of interest identify the conflict and refrain from discussion and voting in those matters as appropriate. No conflicts were noted.

Agenda Item – Review of Minutes – August 1 and August 28, 2014
Presented by Janet Cowell, Chair

Following a motion by Dr. Newton and seconded by Bill Medlin, the board unanimously approved the minutes from the August 1 and August 28, 2014, meetings.

Agenda Item – Introduction of New Staff

Ms. Waller introduced Ms. Dorothy Brown Smith, Director of Global Benefits Communication. Ms. Brown Smith will be responsible for the Department of State Treasurer (Department) communications, with a strong emphasis on the State Health Plan. Her past experience includes

internal and external communications, developing communication strategies, public relations and managing numerous benefit communications to a variety of memberships. She will join the Department senior leadership team and the Plan's executive committee.

Dr. Menon introduced Dr. Kathryn Keogh, Health Promotion and Wellness Manager for the Plan. Dr. Keogh's experience includes implementing quality improvement initiatives to improve clinical efficiency and worksite and community health promotion and education. Her doctoral research focused on social and environmental influences on overweight and obese employees.

Chair Cowell announced that the Department will be moving to a new location sometime at the end of first quarter 2015. The new space will accommodate all the Department divisions, including the Plan.

Ms. Moon stated that a public comment period would be held at the end of the board meeting, if time allowed. She asked that interested parties sign up before the beginning of the afternoon session.

Agenda Item – Value-Based Insurance Design: Changing the Health Care Cost Discussion from How Much to How Well
Presented By A. Mark Fendrick, MD, University of Michigan Center for Value-Based Insurance Design, and David E. Edman, Managing Partner, Risk Management Partners, LLC

Following introductions, Dr. Fendrick began by stating that Value-Based Insurance Design (V-BID) focuses on improving care and "doing more with less" (or the same amount of funds) by turning attention from how much to how well health care dollars are spent, i.e., cost sharing should be set to encourage clinically appropriate use of health care services. A typical benefit design for over 95% of Americans provides the same coinsurance percentage for specialty drugs as regular drugs. The consumer needs to be more engaged and responsible and given better tools if health care costs are to decrease.

Engaging members is a challenge across the country. Due to a variety of reasons, many people aren't able to get the care and services they require. Dr. Fendrick stated that the cost impact of non-adherence to medications, which continues to increase, was his motivation in researching V-BID. The member cost-share on services that are unnecessary is also increasing. The fastest growing health plan doesn't cover an exam for people with diabetes until their deductible is met.

Research has found that members who saw their provider less often had increased visits to the hospital. The effects are systematically harming the health of the low income population and rising copays may worsen the disparities. Some companies are moving to a $0 copay for primary care visits to save costs. Earlier diagnoses and treatment from primary providers could potentially prevent emergency room and inpatient stays.

A new approach is moving away from a "one size fits all' system. Medical services differ in the value they produce. Not all provider office visits or medications are equal. Most people making medical decisions don't have the tools or the knowledge to appreciate the clinical nuance and the fact that services differ in the clinical benefit produced. The second part of the clinical nuance is that clinical benefits from a specific service depend on the person receiving the care, the provider and the facility. For example, a patient whose first degree relative has colon cancer should be paid to get a

colon screening due to the high risk factor. People over 50 should get a colonoscopy for free and those who have no risk factors or family history should be charged for colon screenings. This approach would allow payors to limit colon cancer screenings at certain facilities, providing the same quality at a lower cost.

The V-BID solution to put the clinical nuance into perspective is low cost sharing to encourage high value services and high cost sharing to discourage low value services.

One board member supported the concept but questioned whether the Plan is ready to implement something like this. Starting with a list of 10 diseases or drugs might be a more realistic approach to determine if the Plan would want to fully implement a value based design program. Dr. Fendrick noted that many companies start with one or two areas on which to focus.

The board discussed the relevance of disease management (DM) programs based on a 2014 Health Affairs evaluation of V-BID plans. Dr. Fendrick stated that V-BID and DM programs, alone, are better than nothing. DM programs incent many people to do certain things but silos remain, preventing members from properly managing their care. He acknowledged that V-BID is not the answer to quality gaps across the entire care system but stated that people in V-BID programs spend less money out-of-pocket. The evidence also demonstrates that V-BID programs improve medication adherence with no significant increase in total spending and reduce health care disparities.

The board noted the implementation challenges for public plans. Investment in technology and data is not easy. The problems have less to do with money than bureaucracy. Dr. Fendrick recommended that if the Plan decides to go in this direction, the focus could be on a stand-alone program for a certain group of members or it could work with the plans already in place. He reiterated that services should not be offered to members who don't need them.

Connecticut implemented V-BID for state employees. Those who participate receive lower premiums if they commit to yearly physicals, age-appropriate screenings and preventive care, as well as two free dental cleanings. Employees with five or more chronic conditions were required to participate in a DM program which included free office visits and lower drug copays. Ninety-nine percent of state employees enrolled in the V-BID program and were compliant. Early results have demonstrated a decrease in ER visits and specialty care and an increase in primary care visits.

Key initiatives for V-BID include applying the concept to specialty medications and incorporating it into HSA-qualified high deductible health plans. Dr. Fendrick noted that one of the barriers to the HSA plans is that the IRS excludes services or benefits meant to treat an existing illness, injury or condition under their definition of preventive care. Another barrier is the confusion of the services that can and cannot be covered outside of the deductible.

In summary, Dr. Fendrick stated that provider based initiatives, such as payment reform, tiered networks and health information technology, are being restructured. Consumers are now encouraged to engage in shared decision-making and literacy regarding their health care and treatment. Adding clinical nuance into payment reform and member engagement can improve the quality of care, contain costs and enhance the member's experience.

Some board members commented that the politics of implementing V-BID would be challenging but that the concept was interesting. One member stated that V-BID fits into the Plan's mission statement of being fiscally responsible and keeping members healthy. Most board members agreed with moving in the direction of a value based plan but that a lot more discussion would be needed.

Dr. Fendrick reviewed the Plan's current benefit options and noted that hospital visits were not included in the V-BID discussion. He also stated that some of the drugs used to treat some of the more common diseases aren't included on tier one of the prescription drug list. Mr. Edman noted that several V-BID concepts are already included in some of the Plan's current benefits and that it would be feasible to build on those options. One board member noted that emergency room (ER) visits were not listed in the presentation under the Plan options. Dr. Fendrick stated that ER visits were not included in the first round of V-BID and that ER over-use is far above the benefit design discussion but that it could be tied into other areas.

One board member noted that one of the board's challenges is addressing the high costs associated with specialty drugs and asked how V-BID would fit into the discussion. Dr. Fendrick stated that some of the more expensive specialty drugs aren't all that useful and that at least one state has instituted a multi-step process that has to be completed in order for a member to get these medications.

The board discussed the opportunities and potential barriers of implementing V-BID with the Consumer-Directed Health Plan. Plan staff stated that nothing in the state law would prohibit moving in that direction and that the board could develop the design.

Agenda Item – Benefit Design, Plan Options and Premiums
Presented by Mona M. Moon, Executive Administrator

2016 Benefit Design Planning
Ms. Moon presented the development process for the 2014 plan options by reviewing the overarching themes, goals and initiatives, including improving the health and wellness of Plan members, bending the cost curve, engaging members and providers, increasing choice and flexibility, increasing the reserve target and converting from a fiscal to a calendar year.

The 2014 wellness benefit design elements included 100% of coverage for preventive services and a premium strategy to encourage healthy lifestyles in two of the Plan's three benefit options for active employees and non-Medicare retirees. The tiered provider networks provided an incentive for members to use Blue Options designated hospitals and specialists. The Consumer-Directed Health Plan (CDHP) was implemented as an option for members to become more engaged in their health care services. Ms. Moon noted that the tiered network element could integrate well with the V-BID concept.

The features of the Enhanced 80/20, Traditional 70/30 and the CDHP plan options implemented for 2014-15 were briefly reviewed. The original intent for future changes was to incorporate additional steps toward improving member health and strengthen the wellness design and to offer the premium-free Traditional 70/30 plan to active employees only through 2015. The premium credits available in the 80/20 and CDHP would apply to the 70/30 plan for active employees beginning in 2016, meaning that a premium would be added to that plan.

A comparison of the relative plan value, excluding premium contributions, demonstrated that the Plan's options are similar to other state plans. The overall benefit value, including premium contributions, indicated that North Carolina (NC) plan options provide a higher level of value and a broad range of value propositions for individuals and less so for dependent coverage. The comparison of lifestyle benefits will be updated and presented at the November meeting.

With respect to relative value, the Plan's three options are very similar to each other. Emerging trends include more differentiation and steerage, a value-based design, modifying the pharmacy benefit, high deductible plans and possible regional offerings. Adding the wellness component to the 70/30 plan would make the plans even more similar and premiums for the three plans would continue to offer individuals greater choice but provide little for dependents. The ultimate goal is to align Plan offerings with the strategic plan.

A board member noted that current copays are higher than the Plan's peers and expressed concern that higher copays may be preventing members from getting prescriptions filled. Dr. Morton and Ms. Stephenson stated that the pharmacy strategic plan includes a review of copays related to medication adherence and the cost impact, if any, on hospital utilization.

Ms. Moon presented the elements for differentiating the Plan options in 2016. Payment methods have not been discussed as much as some of the other areas and could be integrated into a strategy for a different plan design and premium strategy if the board decides to move in that direction. If the board would like to see more differentiation in plan options, the current 70/30 plan could be significantly modified or even discontinued. A high deductible plan could also be offered.

A new provider network arrangement could include a limited network or managed care options or members could be further incented to use the Blue Options provider network. The medical and pharmacy benefit structure could include a wellness design, deductible and copay changes and a redesigned pharmacy structure. The wellness premium credits and activities could be differentiated across the plans, as well.

If the Plan were to continue with the previous vision for the 2016 benefit design, the member out-of-pocket cost for services could be modified and premiums for employees could be increased to subsidize for dependents. The wellness premium credits and activities could be differentiated somewhat across the plan options and additional healthy activities could be considered.

Ms. Moon stated that the Plan is currently exploring options for disease and case management services. The Plan is also reviewing health literacy and transparency tools from several vendors.

One board member suggested changing the premium structure, particularly for dependents, based on salary. Ms. Moon stated that the Plan considered that option in the past but doesn't have access to income information. If the board wanted to pursue that option, current laws regarding the sharing of information between agencies would have to be reviewed. Mr. Johnson from Segal noted that other states who are doing this don't offer a free plan option.

Over the next few weeks, Plan staff will conduct internal meetings, as well as pursue discussions with vendors and consultants and present options and recommendations to the board at the November meeting. A final plan design will be presented to the board in January for their approval and then presented to the budget office.

Agenda Item – Member Experience and Communications
Presented by Beth Horner, Customer Experience Manager

Member Experience Update
The Plan recently conducted educational meetings in 16 counties for members who will turn 65 in the next year. Following those meetings, a survey was emailed to everyone who registered for the meetings. Of the 280 who responded, 95% found the meeting helpful regarding their options for retiree health benefits and 84% felt the presentation was easy to understand. Approximately 180 respondents included comments.

The membership satisfaction survey concluded in late August and results of the survey will be presented at the November board meeting. Approximately 7, 700 members completed the survey, a relatively low percentage of the active population.

Webinar and onsite Annual Enrollment Health Benefit Representative (HBR) training sessions were held in August. Approximately 500 HBRs attended and 206 responded to a brief survey. Ninety-eight percent indicated the meeting was helpful regarding Annual Enrollment and 84% felt the presentation was easy to understand.

Annual Enrollment decision guides for active members and non-Medicare retirees will be mailed the week of September 22. Reminder postcards will be mailed in October. Onsite meetings around the state, as well as webinars, will be held throughout the month of October. Enrollment materials and informational videos will be available on the Plan's website. Invitations to meetings for Medicare members were mailed in August and decision guides will be sent the week of September 22. Information for Medicare retirees will also be available on the Plan's website.

To date, 72 meetings in 42 counties have been scheduled and approximately 2,000 members have registered to attend. For the 10 meetings already held, approximately 500 members have attended.

Agenda Item – Financial Report, Forecasting and Monitoring
Presented by Mark Collins, Financial Analyst

July 2014 Financial Report
The report demonstrated a net income of $147 million, which was $120.7 million over the certified budget amount. Total Plan expenses were $107.7 million less than projected. Plan revenue on the Per Member Per Month (PMPM) adjusted variance report was very close to the forecast. Net claims, Medicare Advantage premiums and administrative expenses were all lower than forecasted and the net income was $35.65, which was $29.74 better than the forecast. A larger-than-expected pharmacy rebate true-up payment contributed to a greater financial gain.

The expenditure trend report demonstrated a strong start in CY 2014 but has returned to numbers much closer to budget projections. Allocation of claims expenditures were somewhat evenly distributed and similar to the June report.

CY 2014 2nd Quarter Actuarial Forecast Update
The updated forecast takes into account the financial results, cash balance, claims data, membership, etc., and is revised every quarter and at the end of the calendar year. The forecast

assumptions maintained in the updated forecast include a 1% annual decrease in the active membership trend and a 1% increase in the retiree trend. The forecast reflected a pharmacy trend of 8.5% and a 3.57% premium increase in January 2014. The forecast also assumes that the wellness premium structure will be extended to the 70/30 plan beginning in 2016. Mr. Collins noted that the board had expressed concern about decreasing the trend assumption to 7% and that the Plan would stay with an 8.5% pharmacy trend assumption for now. The Plan is closely monitoring pharmacy utilization, especially with continued growth in specialty drug utilization.

Forecast revisions and changes included the actual June 2014 membership and claims expenses based on actual experience through June 2014. The forecast assumed 100% coverage of preventive services and medications for the Traditional 70/30 plan beginning in 2016. Projections have been extended to include CY 2018 and 2019.

New changes in the CY 2014 2nd quarter update included a reduced medical trend assumption of 7% and the premium freeze for 2015. The Medicare Advantage premium costs are projected to increase with 7% medical trend beginning in 2016. The forecast also included a $12.8 million increase in FY 2014-15 administrative costs approved by the General Assembly. Applied Behavior Analysis (ABA) projected costs were also added to the forecast, as well as the cost for 100% coverage for new Affordable Care Act (ACA) preventive medications for the Enhanced 80/20 and CDHP plans. Mr. Collins noted that the actuaries were better able to analyze the actual experience resulting from the 2014 benefit design and apply that experience to the forecast rather than making multiple adjustments to account for the impact of potential changes.

The ending cash balance is significantly ahead of the certified budget by $252.6 million. Premium increases for 2016-17 are 3.53% rather than 8.22%. Projected premium increases for 2018-19 continue to be high, 13.72% based on the forecast, but are a reflection of the break even forecasting model and will be determined by actual experience over the next two or more years. It's helpful for the Plan to look ahead and be more strategic about potential benefit changes and opportunities, but the numbers are likely to change as we approach the time frame. The Plan and actuaries will continue to closely monitor the trends, particularly in the pharmacy area.

The CY 2014 2nd quarter forecast update will be used as the authorized budget for the state fiscal year 2014-15 to benchmark against actual financial results.

State Health Plan Member Costs

Mr. Collins stated that much of the information contained in the presentation was covered in the V-BID and Benefit Design presentations. He provided background information on premium contributions for employees and retirees. In 2011, an employee/retiree contribution was added to the 80/20 plan and dependent premiums increased 5.3%. Since that time, premiums increased 5.3% in 2012 and 3.6% in January 2014. Premiums won't increase again until, at the earliest, January 2016.

In the Enhanced 80/20 plan, full participation in the wellness activities resulted in a 37.3% premium decrease in the employee/retiree only coverage tier when comparing 2011 to 2015. Members who chose not to participate in the wellness activities had a significant premium increase from $21.62 to $63.56 (194%). Approximately 92% of members in the 80/20 plan completed all three wellness activities in the 2013 enrollment period. Approximately 94% of members in the CDHP completed the three wellness activities.

In 2011, the last time there were major adjustments to member cost-sharing, deductibles increased from $800 to $933 in the 70/30 plan and from $600 to $700 in the 80/20 plan. Primary care copays increased $5, urgent care copays increased from $75 to $87, and generic drug copays increased from $10 to $12. Except for the addition of a 5th tier for specialty drugs, member cost-sharing figures have not increased since 2011. Benefit changes in 2014 reduced member cost sharing and provided incentives for members to seek preventive care. Comparing the first two quarters of plan years (excluding the short plan year), the Plan's share of medical costs increased from 76.6% in 2011-12 to 79.3% in CY 2014. The member cost share on the pharmacy side decreased from 25.6% in 2011-12 to 21.6% in the first five months of 2014.

In response to a question regarding how the Plan member cost share compares to other states, Mr. Collins stated that when looking at the actuarial value of the Plan, NC tended to be on the lower end but noted that the percentage very much depends on utilization patterns. With regard to the percentage of members who max out, Mr. Collins stated that the Plan could track that information.

Member cost sharing and potential changes to the wellness premium structure and activities will continue to be part of the discussion on the 2016 benefit design.

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

Approval of Strategic Plan
Ms. Moon presented the final version of the strategic plan for the board's approval. Prior to the vote, Chair Cowell thanked the staff and board members for their work on the strategic plan and stated that the process and format may be used by other divisions within the Department.

Following a motion by Mr. Medlin and seconded by Dr. Newton, the board voted unanimously to approve the strategic plan.

Next Steps
Mr. Tom Gualtieri-Reed, Ms. Moon and Ms. Crabtree will discuss next steps regarding the strategic plan governance and management. Plan leadership will seek more board input as they consider the existing structure and potential reorganization of the workgroups, Plan leadership staffing and the oversight and integration of the strategic plan. Conference calls between board meetings may be required as the legislative long session begins in 2015.

Metrics and baseline data will be established and discussed at the November board meeting. The Plan experienced some issues with the eligibility data over the past year but the goal is to build on the work of the dashboard report and create a balanced scorecard that will enable the board and Plan to organize measures and identify strategic priorities and areas of focus. It was suggested that the dashboard report be presented to the board and discussed on a quarterly basis.

Following a question from a board member regarding board membership terms, Ms. Moon requested that members contact Mr. Holton.

Agenda Item – Public Comment Period
Presented by Janet Cowell, Chair

Mr. Chuck Stone, State Employees Association of North Carolina (SEANC), thanked the board for the opportunity to speak and expressed support for the autism benefit approved by the board. He stated that SEANC would continue to work with Autism Speaks to extend that benefit to other groups.

He noted that with minimal pay increases for state employees, additional member cost sharing is not an option for employees. He stated that the Service Employees International Union (SEIU) supports value-based insurance design but noted that there may be push-back from members. If the board and Plan move in this direction, he encouraged the Plan to consider inviting stakeholders to work with staff to develop the benefit.

Mr. Stone expressed concern regarding charging a premium for the 70/30 plan benefit since the Plan has always offered a premium-free product.

He expressed appreciation to Plan staff for the work that has been accomplished over the past year. He asked the Chair to consider scheduling adequate time for the board to discuss benefit changes and to be able to study the issue of tax credit consequences related to automatic enrollment procedures.

Agenda Item – Wrap Up
Following a motion by Charles Johnson and seconded by Dr. Newton, the board voted unanimously to adjourn the meeting at approximately 2:40 p.m.

Janet Cowell, Chair