

**Board of Trustees
State Health Plan for Teachers and State Employees
North Carolina State University, Centennial Campus
February 17, 2009**

The North Carolina State Health Plan for Teachers and State Employees began its scheduled meeting at 9:32 a.m. on Tuesday, February 17, 2009.

Members Participating:

Steve Beam, Chairman
John Hammond
Charles Hayek, M.D.
Dan Myers, M.D.
Andrew Perkins
Neppie Stevens

State Health Plan Staff Participating:

Jack W. Walker
Lacey Barnes
Linda Forsberg
Josie Grasse
Wendy Greene
Linda McCrudden
Mona Moon
Lorraine Munk
Derek Prentice, M.D.
Anne Rogers
Tracy Stephenson
Marci Wilding

BCBSNC Staff Attending:

Sally Morton, PharmD
Carol Sutton

Welcome

Mr. Beam welcomed Board members, State Health Plan staff and guests to the meeting which began at 9:32 a.m at North Carolina State University, Centennial Campus.

Conflict of Interest Statement

Mr. Beam read the Conflict of Interest statement to Board members. Any member who has an affiliation or conducts business with a vendor associated with the State Health Plan must refrain from discussion and voting in matters pertaining to that vendor.

Dr. Walker stated that if the Plan develops a Medicare Advantage product in the future, he will recuse himself from discussions with United due to the fact that a family member holds a management position with United.

Mr. Beam also informed the group that Marion Sullivan resigned from the Board due to her new position in the Governor's office. A replacement for Ms. Sullivan will not be appointed until the end of the long session.

State Health Plan Medical Director Announcement

Dr. Walker introduced Derek Prentice, M.D. as the Plan's new Medical Director. Dr. Prentice will work part-time and will focus on utilization management and other projects within the Integrated Health Management department.

Dr. Walker also informed the Board that Lacey Barnes has been promoted to Deputy Executive Administrator for the Plan.

Approval of Minutes

Following a review of the minutes, Mr. Perkins moved to approve them and Dr. Hammond seconded the motion. The Board members voted unanimously to approve the minutes as written.

Follow-up Items from Previous Board Meeting

BCBSNC Contracting Process

Ms. Barnes provided some background regarding the Plan's contracting process with BCBSNC. The Claims Processing Contract (CPC) was last put out for bid in 1996 with BCBSNC being the sole bidder. The Request for Proposal and the response from BCBSNC is maintained by the Plan and available for the Board's review.

In 2005, the Plan discussed an optional plan (PPO) option with the legislative Oversight Committee. Senator Rand, Oversight Co-Chair, stated that, according to General Statute 135-39.5(b) pertaining to optional plan language, the Plan would not be required to go through the bidding process. The Plan also consulted with the Joint Legislative Oversight Committee at a meeting in November 2005 where an optional plan option was discussed.

In February 2006, the PPO contract, with BCBSNC as the claims processor, was approved by the Plan's Board of Trustees. The current contract with BCBSNC expires on June 30, 2013. Dr. Walker stated that the Plan will begin the RFP process for the claims processing contract sometime during the summer of 2010.

Amendment #18 to Claims Processing Contractor Contract

An amendment to the Claims Processing Contractor contract is created any time a revision is made to current contract. The General Assembly voted to move the administration of NC Health Choice from the Plan to the Department of Medical Assistance. Amendment 18 was developed to facilitate that change.

Employees by State Report Update

Mississippi and Louisiana have been added to the report the Board received at the November 2008 Board meeting. Six of the eight states surveyed are on a calendar plan year. Three states have a tobacco surcharge, one of whom is Georgia, who also charges employees \$30 for choosing the state health plan if another plan is available through employment elsewhere.

Alabama will be instituting a wellness initiative in 2010 whereby members earn a \$25 monthly discount for participating in the wellness program.

The Board requested that the Plan clarify whether premium increases in other states are on an annual or biennial basis. Ms. Forsberg will provide that clarification as well as revised copies of the report.

Dependent Eligibility Audit Update

The Plan is in the process of reviewing Request for Proposals (RFP) for the dependent eligibility audit and is currently in the “silent period.” The Plan will conclude the review by February 20 after which a conference call with the Board will be scheduled to solicit approval for the recommended vendor.

The Plan anticipates beginning the audit process in April to coincide with annual enrollment.

Electronic Enrollment

Phase one of the electronic enrollment kick off will begin during the week of February 23. Four public schools with a total of 45,000 members – Charlotte, Guilford, Wake and New Hanover – will go live in April.

The Plan will continue to phase in agencies with the university and community college systems a part of phase two.

Cholesterol Lowering Medication Adherence

Implementation of this pilot program is scheduled for April 1, 2009 as approved by the Board at the November 2008 meeting. Plan pharmacy and communication staff are working closely together to ensure that all affected members and providers are aware of

the program. Since the last Board meeting, a revision has been made to the program to allow generic coverage for a three month supply for \$10 in addition to the \$4 monthly prescription charge.

The Plan anticipates that members currently taking generic drugs and who continue to participate in this program will save \$80 per year if prescriptions are filled correctly. Members who switch from a brand to a generic alternative can save \$320 to \$560 annually.

The Plan will monitor and review adherence data for this program over an 18 month period.

Warfarin Pilot Program Update

Seventy-seven out of 316 eligible members accepted this program, but only forty-nine providers. Twenty-four members have received completed testing results, 15 have results pending and 10 did not pursue testing which will likely end in February. Medco and the Mayo Clinic plan to publish results of the study upon completion.

The purpose of the program was to offer warfarin sensitivity information to providers in order to optimize warfarin dosing and increase safety by preventing hospitalizations.

Tobacco Settlement Follow-up

The state received funds through the Tobacco Master Settlement Agreement allocated to the Golden Leaf Foundation and the Settlement Reserve Fund. The Plan is reviewing opportunities it might have in the settlement monies, particularly through the Health and Wellness Trust Fund which received half of the money allocated to the Settlement Reserve Fund. This organization addresses health and wellness issues in North Carolina.

Hospital Data Report

When Medicare data is excluded, hospital admissions vary but overall the PPO and Indemnity data are very similar. Analysis also indicated that the inpatient Indemnity and PPO discounts were nearly identical.

BOT Subcommittee Report

The subcommittee reviewed the current structure and developed several options for the Board to consider.

The Plan receives oversight from a committee of the General Assembly. The General Assembly meets from one-fourth to one-half of the year every year. The Oversight Committee is supposed to meet quarterly to receive reports from the Plan Administrator. One of the Subcommittee's suggested recommendations is for the Plan to report to an

agency which has a direct reporting relationship to the Governor in order to allow more effective, continuous oversight of the Plan.

Another recommendation is that the Plan maintain its current structure with a Board that has greater responsibility. The third recommendation is to maintain the current oversight structure for both the Plan and Board, but remove reference to “fiduciary” responsibility from the Board’s duties and pare down the Board’s responsibilities to areas where input is more critical. The Board acknowledged that the current list of duties and responsibilities is not practical for a part-time board. The Board suggested that the document, in its entirety, be sent to the Oversight Committee Co-Chairs for their review. Members agreed that a decision during the current session is not likely.

At the request of Mr. Beam, Mr. Perkins made a recommendation to further refine the document and continue the discussion at the May 2009 meeting. The motion was seconded by Dr. Myers and unanimously passed by the Board.

In order to aid in the discussion, Ms. Greene will prepare a table depicting the roles and responsibilities of other state boards.

Clinic Project

The Plan is reviewing the possibility of two employee wellness clinics in areas with a large concentration of members. This would allow members to see providers during the day who are in close proximity to worksites. The clinic providers would not replace primary care physicians but would provide members the opportunity to get blood pressure checks and other biometric screenings, as well as receive support for lifestyle changes. Clinic providers could make referrals to primary providers or secure those services as needed.

A Request for Proposal is in process with the goal of implementing the model during the first quarter of 2010.

Disease Management ROI

After a chronic disease trend report showed a decline in the percent of healthy members, the HealthSmart program was implemented in 2005. The program targets chronic diseases and uses health coaches to assist members who have diabetes, hypertension, coronary artery disease, etc.

The 2008 trend report, which will be mailed to Board members, indicates that the disease management programs are making a positive difference for that population. The Plan realized a 2:1 return on investment and a savings of approximately \$18 million in 2007.

A healthy person costs the Plan around \$1200 a year whereas the costs for members with chronic illness is approximately \$7000. As the Plan addresses the issues around chronic disease management, there will be a need to refocus on the NC HealthSmart program

goal of ensuring that healthy members continue to remain healthy. There are tools in place to promote healthy lifestyles but those tools need to be refined to reduce the trend in movement to higher levels of chronic disease states.

Pharmacy Initiatives – First Quarter 2009

Fifty-four percent of Plan members have a chronic condition and almost 98% of the annual pharmacy spend is attributed to those members. The Plan continues in its efforts to improve its financial status by identifying clinically appropriate, cost-effective pharmacy programs.

On February 2, 2009, additional heartburn medications were added to the existing step therapy program to encourage generic, over-the-counter and certain brand name medications as first-line therapy. This program revision has a projected savings of \$1.1 million with 1200 members impacted.

On May 1, 2009, the Plan will implement another step therapy program for migraine management with several medications moving to the highest copay tier. The projected savings are over \$2 million and impact approximately 14,000 members. Those members who switch to the generic Imitrex product could save \$240 annually in copays. The Plan will implement a quantity limit on antiemetic medications, effective May 1, 2009, to allow for coverage of seven treatment days in a thirty day period. In 2008, the cost for these medications was \$4.4 million with an average ingredient cost of \$670 per prescription. A quantity limit will ensure appropriate utilization of these drugs. Estimated savings to the Plan is around \$1.5 million and will impact around 2,100 members.

The Enhanced Refill Too Soon program will be implemented on March 2, 2009. The program will enhance the Plan's system to comply with pharmacy practice standards and regulatory requirements as they apply to the utilization of prescription medications. The system currently looks back thirty days to determine if a prescription can be filled. The enhanced system will allow a pharmacist to review drug history for a member for the prior 180 days. Within the 180 days, a member can receive a refill once 75% of the current medication on hand is used. No more than a seven day supply should be on hand when requesting a refill for a 30 day supply

The projected annual savings to the Plan for these programs is approximately \$5 million. An extensive member and provider education program has been developed to accompany these changes.

BCBS Billing Correction

An incident occurred on January 16, 2009 where 262 state agencies did not receive premium invoices. The Plan learned about the error on January 26. BCBSNC printed the bills and sent them to agencies via overnight mail. While the hardcopy billing was delayed, many of the agencies received their electronic statements, as usual. That fact,

combined with BCBSNC's interventions, minimized the impact on our cashflow. As of February 16, two agencies were delinquent in premium payment. No claims payments were delayed as a result of this incident.

The BCBSNC business process reengineering team has identified the problem and implemented steps to ensure this doesn't occur in the future. In addition, electronic billing will replace paper billing for about 60% of state agencies mid-year to coincide with electronic enrollment.

Financial Reports

December financials and Quarterly Report

The actual revenue was higher in December due to early premium payments for January from several agencies. January receipts were significantly less than projected due to the higher December revenue. The Plan continues to track cash flow closely.

Plan expenses, year-to-date, were \$1.27 billion compared to a projection of \$1.3 billion. The pharmacy programs appear to be contributing to a decrease in expenditures, as well as the rescheduling of administrative payments to the Plan's top vendors.

The January financial statement will be sent to Board members by the end of the week. The revenue appears to be around \$40 million less than projected, again due to several January payments made in December.

The Plan has sufficient cash to pay claims through the end of February but may experience cash flow problems in March. The General Assembly has indicated that money from the rainy day fund will most likely be allocated to the Plan but not until after April 1. With five weeks of claims payments and three pharmacy payments to Medco due in March, the Plan may need to delay payments to providers and hospitals the last week in March.

Performance and Financial State Auditor Report Status

The financial audit revealed routine findings, one being the delay of payments in June 2008. A significant finding was that several administrative expense items were identified as claims expenses. Steps were taken to correct this issue.

The state auditor will complete phase two of the performance audit and present findings to the Plan. No timeline for completion of that report has been provided but the Plan will present findings to the Board at a future meeting.

Premium Tiers

The Executive Administrator and Board of Trustees have the authority to create different tiers and establish rates for those groupings. Analysis indicates that the average age of

Plan members is around 46 with a very small percentage of subscribers under age 30. Data for the employee/spouse tier also shows that for every dollar currently collected, the Plan pays \$1.27 in claims, making it the most costly tier.

If the Board were to approve setting new tiers, the mechanics to implement the new structure would take close to a year. The Board requested that more detailed information be presented at the May meeting and that discussion continue regarding ways to attract younger members to the Plan.

Medical Policies

The following modifications of current NC Health Choice medical policies were presented to the Board for their approval: AD0660, AD0220, RA0203, AD0528, SU0160, AH0750 and AD0225.

The following NC Health Choice policies due for routine review were also presented to the Board for their review and approval: SU0300, ME0005, AD0660 and AD0350.

Dr Meyers moved to approve all medical policies and Dr. Hayek seconded the motion. The Board voted unanimously to approve the medical policies presented.

Dr. Meyers informed the Board that he would recuse himself from discussing or voting on any policies regarding lithotripsy.

Next Board of Trustees' Meeting

The next Board meeting will be scheduled on May 19, 2009 in Greensboro.

A teleconference will also be scheduled for the week of February 23 to discuss and approve the vendor for the dependent eligibility audit. Ms. Munk will email Board members once the date and time is determined.

Rulemaking Policy

The Executive Administrator and Board of Trustees may adopt rules in the administration of the Plan. The Rulemaking policy establishes a formal procedure the Plan will use to adopt rules to implement statutes. Once a rule is developed, it must be vetted at the Plan and presented to the Board for approval. The rule is then posted on the Plan's website during which time people have the opportunity to send the Plan comments on the proposed rule. After receiving comments and integrating them as necessary, the rule must then be presented a final time to the Board for approval depending on the comments and suggestions received from the public. The rule will be adopted following the Board and Executive Administrator approval.

The Board felt that in order to protect the Plan and for purposes of transparency, there should be an opportunity for the public to comment to the Board about the proposed rules. The procedure and public section of the Rulemaking Policy document will be amended to include public comment as a part of the process.

Mr. Perkins made a motion to approve the Rulemaking Policy, as amended, and Dr. Myers seconded the motion. The Board agreed unanimously to adopt the Rulemaking Policy, as amended.

Legislative Update

The 2009 long session is currently underway and committees are being organized. The Plan's Oversight Committee has two new members, Senator Tom Apodaca and Representative Joe Tolson.

Dr. Walker and Plan staff will meet with the Oversight Committee on February 19 to discuss proposed benefit changes and provide information on the current financial situation. The Board requested that a summary of the meeting be provided to them.

Among benefit changes in the Plan's legislative bill, the Plan will also seek to change Board meeting quorums to a majority as opposed to the current language which states that six members constitute a quorum.

At the request of Mr. Beam, Mr. Perkins made a motion to move into executive session and Dr. Hayek seconded the motion. The Board voted unanimously to move into executive session.

Executive Session

Benefit Modeling and Financial Forecast

The Plan presented several benefit modeling options, primarily in the pharmacy and comprehensive wellness areas.

Members of the legislature have indicated their desire to keep family premium increases below ten percent annually. Premium increases will most likely occur on July 1, 2009 as opposed to October 1, 2009 and the Plan will not be required to pay back the \$250 million dollar loan it requires to remain viable.

OAH Cases

Board rulings in OAH case 08INS 0846 and OAH Case 08 INS 1039 can be found on Attachment A.

Following a motion by Dr. Hayek to return to open session and seconded by Dr. Myers, the Board voted unanimously to return to open session. Mr. Beam then called for a

motion to ratify the matters considered in Executive Session. The motion was made by Dr. Hammond and seconded by Dr. Hayek. The Board members voted unanimously to ratify the items discussed in Executive Session.

Dr. Hammond requested permission to revisit the Subcommittee Report. The subcommittee requested the full Board to consider transmitting the information to the Oversight Committee Co-Chairs prior to the May Board meeting. The Board agreed and requested that the Subcommittee reconvene over the next few weeks to revise the current document and communicate changes to the full Board via email. The subcommittee will attempt to schedule a meeting with the Oversight Co-Chairs prior to the May 19 Board meeting.

There being no further business and at the request of Mr. Beam, Mr. Perkins made a motion to adjourn the meeting and Dr. Hayek seconded the motion. The Board voted unanimously to adjourn the meeting at 2:00 p.m.