

Board of Trustees
State Health Plan for Teachers and State Employees
State Health Plan Office
August 26, 2009

The North Carolina State Health Plan for Teachers and State Employees began its scheduled meeting at 9:30 a.m. on Wednesday, August 26, 2009.

Members Participating:

Steve Beam, Chairman
John Hammond
Charles Hayek, M.D.
Dan Myers, M.D.
Andrew Perkins
Pam Silberman
Neppie Stevens
Linda Sutton
Lyndo Tippett

State Health Plan Staff Participating:

Jack W. Walker
Lacey Barnes
Wendy Greene
Linda McCrudden
Mona Moon
Sally Morton, PharmD
Lorraine Munk
Derek Prentice, M.D.
Anne Rogers
Jane Schairer
Tracy Stephenson

Welcome

Mr. Beam welcomed Board members, State Health Plan staff and guests to the meeting which began at 9:35 a.m. at the North Carolina State Health Plan office.

He welcomed Mr. Lyndo Tippett, who joined the Board in August. Mr. Tippett is a partner in the firm of Tippett, Padrick, Bryan & Merritt, CPAs in Fayetteville and previously served as the Secretary of the North Carolina Department of Transportation. He currently serves on the Board of New Century Bank, and has held that Board position for the past seven years.

Ms. Lacey Barnes stated that several revisions were made to the agenda and distributed revised copies to Board members.

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.

Ethics Commission Letter

Ms. Greene stated that the State Ethics Commission recently evaluated the Plan Board and determined that members meet the coverage criteria under the State Government Ethics Act. After reviewing the criteria, the Plan sent a letter to the Commission stating that it disagreed with the determination based on the fact that the Board's duties are principally advisory.

The Ethics Commission responded that since the Board's duties are advisory, they would change their recommendation regarding coverage status at this time.

Approval of Minutes

Following a review of the minutes from the meeting on May 19, 2009, Ms. Sutton made a motion to approve the minutes and Dr. Hayek seconded the motion. The Board voted unanimously to approve the minutes as written.

Bridges to Excellence Report

Dr. Eugenie Komives, Vice-President and Senior Medical Director at Blue Cross Blue Shield of North Carolina, presented information on the Bridges to Excellence pilot program. The pilot, a joint venture with BCBSNC and the Plan, was developed and implemented in 2006 to recognize and reward physicians who achieved quality standards established by the National Committee for Quality Assurance (NCQA). The program focused on improving health for members, long-term medical cost savings and overall affordability. Two hundred fifty physicians provided care for around 40,000 members in the pilot. Future reports could separate the data for primary and specialty physicians.

During the pilot program, rewards were paid to practices where physicians obtained NCQA recognition in any of three quality improvement programs. The Physician Practice Connection enhanced the quality of care through the use of systems, processes and technology. The Diabetes and Cardiac Care Links were programs established to manage the overall care of patients with these diseases.

Randomly selected patients in the Diabetes and Heart/Stroke program were evaluated within six months after 12/31/2007. The program compared the percent of members compliant with the measure based on age and retrospective risk scores. The results demonstrated improvement in four out of six quality measures with one being statistically significant (blood pressure less than 130/80). Differences in costs between recognized and non-recognized physicians were not significant.

The Physician Office Link evaluation compared results for patients of recognized versus non-recognized physicians from July 2007 to June 2008. Utilization measures used were high-cost

radiology, admissions, bed days and specialty visits per 1000 members. Costs were evaluated for all episode groups for member months. Results demonstrated a twelve percent reduction in high tech imaging services, a thirty-four percent reduction in emergency room visits and a twenty-four percent reduction in specialist physician visits.

Clinical results indicate very good performance for NCQA recognized physicians. The Physician Practice Connection program was directly tied to utilization and appeared to produce costs savings due to overall improved management of patients.

Dr. Komives reported that BCBSNC will be implementing the Blue Quality Physician Program during the month of September. This program incorporates three of four areas of provider performance which are quality of care, administrative efficiency and patient experience. Primary Care Providers will receive fee schedules and must apply and qualify for the program.

BCBSNC also implemented E Business on June 1, 2009, whereby providers will now be reimbursed for e-visits provided they have the technology in their offices. Providers must adhere to the medical policies for those visits which can be viewed on the BCBSNC website by the public. Members are triaged and either treated over the phone or told to come in for an office visit.

IHM Update

Medical Home Concept

The Plan is reviewing the health delivery system to determine if there are ways to incent providers to improve quality of care. This would also afford the Plan an opportunity to impact care delivery, within and outside the medical office.

To maintain wellness, members are influenced by worksite wellness programs, wellness clinics and other direct supports. Health lifestyle behavior requires support at home and/or through the environment and public health efforts. The Collaborative Care model, practiced through the patient centered medical home, would provide support for both member and provider to determine the best course of treatment and coordination of care. It would also encourage and promote the sharing of information between providers and members.

CWI Implementation

Governor Perdue signed the State Health Plan Bill (Senate Bill 287) on April 23, 2009. Information on the Comprehensive Wellness Initiatives will be sent to members in September. Frequently Asked Questions (FAQs) are being developed and will be included in the packet sent to members and added to the Plan's website.

The Plan has partnered with the Agriculture Extension Foundation to support the weight loss aspect of the program. Weight loss classes began for members considering weight loss management in August in the five counties with the largest employee population including Wake, Orange and Mecklenburg. Four nutrition visits per plan year with a licensed dietitian with a primary care copay will be offered to all members and six nutrition visits will be offered to members with diabetes with no copay. FDA approved tobacco cessation and weight management drugs will be offered at the preferred copay rate and generic drugs will also be available to

encourage members interested in smoking cessation and weight management. The Plan is working on a contract with the NC Quitline for tobacco cessation counseling and over-the-counter nicotine replacement patches with no out-of-pocket cost to members.

DM/CM RFP

The current disease and case management contracts will be merged into one contract to avoid duplication of services. The contract will include a per member per month (pmpm) structure and requirements around return on investment, auditing components and clinic and outcome measures. The RFP is scheduled for release in mid to late September 2009. The Plan hopes to award the contract in late November or early December. This schedule is subject to change dependent upon the release date.

The Board encouraged the Plan to review conflicts of interest and proprietary information since the vendor chosen may subcontract with various groups to coordinate care.

Follow-up Items from Previous Board Meeting

Dependent Premiums

Original language in the General Statute 135-44.6 (a) stated that the Executive Administrator and Board of Trustees could “establish dependent premium rates for the Plan except as they may be established by the General Assembly.” In practice, this meant that the Executive Administrator and Board of Trustees could set dependent premium rates in the PPO.

Prior Plan administration set rates lower than projected costs, thus incurring additional losses for the dependent enrollment. Therefore, current Plan administration recommended that that legislature assume responsibility for all premium rates in the future. This recommendation was made part of Senate Bill 1274 and adopted by the legislature and signed by the Governor.

Contract Policy Update

The Plan’s contracts, over the past year, have generated considerable interest. The Plan has reviewed and revised the contract development and monitoring process given that Request for Proposals (RFPs), procurement and contract management comprise a large part of the Plan’s business. The current policy is extensive but the Plan has revised the process in two areas – terms and conditions and the external review process.

Certain items in every state contract are standard and additional items identified as unique to the Plan will become standard in all future contracts. Including standard items will aid staff in the timely development of RFPs and contracts and ensure compliance.

The internal review process was developed and implemented in the past two years and involves appropriate Plan staff. The external review process will continue to include the Department of Purchase and Contracts and the Board will be consulted on contracts with an annual financial impact greater than \$500,000. In addition, contracts greater than \$2.5 million will be reviewed by staff in the State Attorney General’s office. The Plan is also required to consult with the State Auditor’s office on services that may affect the annual accounting report.

Executive summaries on larger contracts will be provided to the Board and will include scope, the number of vendors who responded, oral presentation information by vendors, if applicable, criteria for choosing the vendor and the financial impact.

Ms. Barnes also informed the Board about an article that appeared in state newspapers regarding the Plan's Indemnity contracts and billing rates. It was reported that several hospitals did not report changes in outpatient rates to the Plan. A review of all hospital contracts is currently underway and may take from six months to a year to complete. The Plan has discussed a potential reconciliation process with the Attorney General's office in the event that money is owed to the Plan. Progress reports will be provided to the Board at future meetings.

Pilot Programs

Department of Correction

The Plan proposed a pilot program with Department of Correction (DOC) sites in Wake County to address the high prevalence of diabetes and hypertension within the agency. More than twelve percent of DOC Plan members have been identified with diabetes. The pilot will include pre, mid and post intervention biometric screenings and educational classes provided by Plan staff and contracted pharmacists. The Board suggested that a stress management component be included with the educational classes.

The Plan hopes to begin conducting medical screenings in late 2009 or early 2010 and offering interventions to those identified with diabetes and hypertension immediately following the screening process. The evaluation component of the program is still under review. Reports may be developed and processed in-house to reduce associated costs to the Plan.

Diabetes Adherence Pilot Program

The Plan is proposing a pilot program to increase medication adherence for diabetes and cardiovascular disease medications to start on 12/1/09. This program would be available to around 21,000 eligible retirees who are currently taking medications for these diseases. The pilot would offer members a financial incentive to utilize Medco's Therapeutic Resource Center by way of reduced copays for a 90-day supply of diabetes and cardiovascular prescriptions. Only 1.9% of retirees currently utilize mail order. The potential member savings if 10% participate in the mail order program is greater than \$936,000. Potential Plan savings would be around \$158,718.

The program would also include a comprehensive clinical communication strategy to assist members in using Medco's pharmacy. They would also receive personal announcement letters to address medication adherence issues and medication counseling would also be available from a specialist pharmacist.

The goal of the program is for members to become more compliant with taking prescribed medications and, consequently, significantly reduce medical costs.

State Health Plan Staffing and Dedicated Unit

Historically, the Plan has primarily relied on BCBSNC for data reporting and analysis. Although useful, that has not allowed the Plan the flexibility to quickly and effectively drill further into reports when additional information is required. In order to strengthen reporting capabilities, the Plan is in the process of recruiting a healthcare analyst. Board members concurred that internal data analyst services were a vital part of Plan business.

The Integrated Health Management and Pharmacy departments will also recruit for a Clinical Risk Manager and Pharmacy Analyst, respectively. In addition, Sally Morton will join the Plan effective September 1, 2009. The Plan, in the past, contracted with BCBSNC for her services.

The Plan and BCBSNC have been reviewing PPO and Indemnity Plan costs over the past few months. The Plan determined that, with the elimination of the Indemnity Plan, core services could be better managed with a dedicated unit at BCBSNC. This would not include network management services given that the Plan uses the PPO network at BCBSNC. The goal of a dedicated unit is to increase efficiency and potentially reduce Plan costs. BCBSNC is currently analyzing the financial impact.

Pharmacy Update

Pharmacy and Therapeutics Committee Report

The Pharmacy and Therapeutic (P&T) Committee met on August 18, 2009. The Plan constantly evaluates and updates its pharmacy programs to account for new drug indications.

Information on the generic lipid lowering medication program was presented to the Committee. The program, which began on April 1, 2009, offers low cost generic prescription options for members with high cholesterol. The generic dispensing rate increased from 41 to 44% since the program was implemented.

Smokers will have a less rich benefit option as of January 1, 2010 and in 2011, some obese members will be offered a reduced benefit option. The committee reviewed lowering copay rates for brand weight loss agents and removing the prior authorization requirements currently in place for these medications. Two smoking cessation brand medications were reviewed for movement to a lower copay, as well. The P&T committee concurred with the suggested options to remove financial and authorization barriers to weight loss and smoking cessation medications.

The next P&T Committee meeting is scheduled for November 2009.

Recap of UM/Clinical Management Pharmacy Programs

The Plan implemented 14 utilization Management and clinical pharmacy programs in a continuing effort to strengthen the financial health of the Plan. The total savings of these initiatives for FY 2008/2009 was estimated at 10.8 million. The report on estimated savings was provided by Medco and is currently being validated by Aon Consulting. The final report should be complete within the next two to three months. The Board requested that a projected savings column be added to the report and presented at the November meeting. Several additional pharmacy programs will also be presented at the next Board meeting.

Low Cost Generic Programs

Many pharmacies have introduced low cost generic programs within the past year. Medco has also developed a low cost generic program by mail that will be implemented in September 2009. More than 400 generic drugs on Medco's list will be available to Plan members for \$10 for a 90-day supply. The program is cost-neutral for the Plan.

A comprehensive communication plan will be implemented and the Plan will work with key stakeholders to promote awareness of all cost-saving pharmacy programs to Plan members.

Communications Update

Currently, 1700 Health Benefit Representatives (HBR) receive the Plan's HBR Update which provides pertinent benefit information and news for Plan members. The Plan also launched a monthly e-newsletter in August which includes updates on pharmacy and information on health issues. Members and other interested persons can subscribe to the newsletter by going to the Home Page on the Plan's website. Several of the Plan's stakeholder groups have promoted the e-newsletter in their member publications.

Since July 2008, 41 public records requests have been submitted to the Plan. The majority has come from media outlets and been in the areas of finance, contract, audits and correspondence.

Financial Reports

State Health Plan Quarterly and YTD Report

The fourth quarter membership numbers changed slightly. With the elimination of the Plus option under the PPO, there may be a greater membership change during the next quarter. The Plan will continue to track medical and pharmacy data on a PMPM basis and will provide that information on a quarterly rather than monthly basis and in a different format for fiscal year 2009-2010.

Plan revenue for June 2009 was \$347 million, \$153 million higher than projected, due to the receipt of the \$100 million remaining from the General Assembly appropriation. Member premium receipts also dramatically impacted the June financials due to the receipt of \$52 million in premiums prepaid by the Retirement System for July 2009 healthcare coverage.

Medical claims payments exceeded the projection by more than \$14 million due in part to membership numbers greater than projected. The Plan also paid almost \$15 million more than budgeted for administrative expenses during the month of June, as the Plan made the final catch-up payments associated with deferred administrative fees from earlier in the year.

At the request of the Board in a prior meeting, the financial report will no longer include the variance analysis of actual expenditures vs the original budget. It will also exclude the comparison of the original and recasted budgets.

The Plan summarized the financial comparison of actual FY 2008-2009 results and recasted budget information on a per member per month (PMPM) basis. Actual revenue was less than budgeted by \$1.65 PMPM and actual claims payments were \$1.79 PMPM less than budgeted.

Total plan expenditures were \$2.57 less than anticipated and the net loss for the fiscal year was almost \$1 less than anticipated on a PMPM basis.

July Financials

The financial comparison of actual vs. budgeted demonstrated \$16.6 million more in net claims payments than projected. Aon Consulting, the Plan's actuarial services firm, estimates that June incurred claims were \$30 to \$38 million higher than average. Payments for June services are spread over several months due to the timing of claims submission by providers. Most claims are paid within 90 days of the date of service. Only about one-third are paid within the month that the service occurs. The spike in June services will impact the 2009-2010 fiscal year financial results. The Plan will not know whether July claims' experience is in line with projections until late September.

The Plan will meet with Aon to discuss retrospective validation of data regarding savings generated from legislative changes to copayments, deductibles and benefits. The Plan will provide a financial impact report to the General Assembly during the next session, as required by statute.

In the future, the Consolidated Current Year vs. Prior Year report will replace the Original budget report. Comparison of actual financial results with the previous years' experience is also required by statute.

The Plan also presented a financial report for North Carolina Health Choice for Children. Responsibility for claims processing and other administrative activities for this program will transfer from the Plan to the Division of Medical Assistance by July 1, 2010 as required by State law. The Plan will provide a more detailed report of the transition at the November Board meeting.

The Board requested that the Plan continue to provide monthly financial reports to Board members via email.

Audit Status

Administrative Costs

Thomas & Gibbs (T&G), the Plan's auditing services vendor, is in the process of auditing administrative expenses and costs charged by BCBSNC under the PPO contract. The Plan should receive a draft report on this audit by the end of December. A final report will be issued thirty days after T&G Plan receives comments from BCBSNC on the draft report. The audit will provide information on whether or not there are issues with administrative costs charged by BCBSNC.

Claims

The claims audit for 2008/2009 is in the process of being completed. The information will be presented at the November Board meeting.

RFP Update

Efficiency

The Efficiency Audit Request for Proposal was posted on August 19 and information is available on the Purchase and Contracts website. Bidding is due to close on October 1. The Plan's preference is to contract with a single vendor but the longer posting period could allow vendors to collaborate with other vendors in order to cover the complex audit scope. Selected vendors will be invited to participate in oral presentations to the Plan October 12-16. The Plan will consult with the Board in a teleconference to be scheduled around October 19 regarding the vendor selected. The contract effective date will be November 1, 2009.

Board participation, as non-voting committee members, in the efficiency RFP review process would require 4 to 6 hours for three days and an additional 2-3 hours for vendor oral presentations. Dr. Hammond and Mr. Tippett volunteered to participate on the committee to review the RFP responses.

Dependent Eligibility

The Plan will post the Dependent Eligibility RFP by mid September 2009. Subscribers will be requested to submit information on dependents to determine if they are truly eligible to be covered under the Plan. The Plan sought authority and legislation from the General Assembly to prepare for this audit. Dr. Silberman will participate in the review of the RFPs. She requested a copy of the final version of the RFP upon its completion.

Pharmacy Program

The Pharmacy Benefit Manager (PBM) RFP will be posted mid to late October 2009. The Plan anticipates providing information to the Oversight Committee during the 2010 legislative session. Dr. Hammond will participate on the committee to review the PBM RFPs.

Board Participation

The Board requested that RFP timelines for major contracts be sent to members, along with a brief summary of the RFP. Members will then have the option of volunteering to participate in the review process. An executive summary will also be sent to members following the vendor selection process. The summary will include concise scope and purpose of the RFP, evaluation and grading tool, total number of respondents, evaluation criteria used to determine the vendors chosen for oral presentations and the evaluation expectations and tool used to grade the presentations.

Medical Policies

Some confusion exists around the State Health Plan and state mental hospitals which are not part of the BCBSNC network. The Plan is in the process of clarifying its relationship with these hospitals through medical policies. That information will be presented to the Board at a future meeting.

NC Health Choice medical policies which were presented for review were NHCAD0660, NHCAD0330, NCHCSU0025, NCHCME0075, NCHCSU0185, NHCAD0225, NHCIN0650, NHCAD0230, NCHCME0690, NHCAD0523, NCHCME0485, NCHCSU0650 and NHCAD0335.

Dr. Myers made a motion to adopt the medical policies and Ms. Sutton seconded the motion. The Board's vote was unanimous to adopt the medical policies

Future Board of Trustees' Meetings

The next meeting is scheduled for Wednesday, November 18 at the State Health Plan Office. At the request of Mr. Beam, Ms. Sutton 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

Follow-up from May 19, 2009 OAH Discussion

At the May 19, 2009 Board meeting, members requested that the dental benefit language be reviewed and revised, if necessary. The Plan consulted with the Attorney General's office and the Appeals Department at BCBSNC on the language revision.

Following a review of the proposed changes, Ms. Sutton made a motion to approve one of the suggested language revisions to better clarify language for members. Dr. Myers seconded the motion and the Board unanimously approved the revision which will be included in the new benefit booklet. However, the Board felt that further clarification was needed regarding dental coverage following trauma and asked the Plan to present further language revisions at the November meeting. Ms. Barnes will also consult with BCBSNC to determine dental coverage under their plans.

Long Term Care

Settlement negotiations continue and the Plan will continue to update the Board on the Long Term Care case.

OAH Cases

The summary of these cases is provided on Attachment A.

Upon a motion by Dr. Silberman and a second by Ms. Stevens to return to open session, the Board voted unanimously to return to open session.

At the request of Mr. Beam, Ms. Sutton made a motion to ratify the decisions made in Executive Session and Dr. Hayek seconded the motion. The vote by the Board was unanimous to ratify decisions made in Executive Session.

There being no further business, Ms. Sutton moved to adjourn and Dr. Hayek seconded the motion. The Board voted unanimously to adjourn.

The meeting was adjourned at 2:00 p.m.