



Dale R. Folwell, CPA
State Treasurer of North Carolina
DALE R. FOLWELL, CPA

**Board of Trustees Meeting
State Health Plan for Teachers and State Employees
Department of State Treasurer
February 8, 2018**

The meeting of the Board of Trustees of the North Carolina State Health Plan (Plan) for Teachers and State Employees was called to order at 10:00 a.m. on Thursday, February 8, 2018.

Members

Dale R. Folwell, Chair
Ted Brinn
Peter Chauncey
Kim Hargett
Donald Martin
Aaron McKethan
Charles Perusse
Elizabeth Poole
Pete Robie, MD
Margaret Way

Welcome

Chair Folwell welcomed Board members and visitors to the meeting. He asked visitors to sign the Member and Public Comment sheet if they wished to address the Board.

Conflict of Interest

Presented by Dale R. Folwell, Chair

In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, Chair Folwell 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.

Introduction of New Board Members

Chair Folwell introduced and welcomed new Board member, Pete Robie, MD.

Resolution for Departing Board Member

Chair Folwell acknowledged Dr. David Rubin for his service to the Board and a resolution was included in the meeting information provided to the Board. The resolution will be signed and sent to Dr. Rubin and included with the approved meeting minutes.

Member and Public Comment Period

Ms. Beth Levine, State Health Plan member, asked the Board to reconsider offering the Consumer Directed Health Plan (CDHP) as a plan option. She felt the Board and Plan should have kept the CDHP for at least eight years before making a decision.

For Board Approval

Minutes – November 28, 2017, Meeting

Presented by Dale R. Folwell, Chair

Following a motion by Dr. Martin and a second by Ms. Hargett, the Board unanimously approved the November 28, 2017, meeting minutes, as written.

State Health Plan Updates

Leadership Updates

Presented by Dee Jones, Executive Administrator

Calendar Year 2017 Financials: Ms. Jones provided a summary of the State Health Plan financial report for calendar year 2017. The Plan's ending cash balance was \$1.011 billion, \$152 million over the budgeted amount and revenue was \$52 million more than projected. Total expenses were \$100 million less than forecasted. The Per Member Per Month (PMPM) net income at year end was \$17 over the budgeted amount.

Over the past four years, the Plan ended the year with a cash balance of approximately \$1 billion. Ms. Jones noted that, by law, the Plan is required to have enough cash on hand to cover at least three weeks of claims expenditures. Additional funds could be used to build up the reserves for unfunded liability.

The allocation of total expenditures in 2017 demonstrated a modest increase of 1.4% from 2016. Pharmacy claims decreased slightly and medical claims increased approximately 2% in 2017. Administrative fees in 2017 remained the same at 5.3% of total expenditures. Approximately 86% of the Plan's costs are paid to five vendors.

Calendar Year 2018 Projections: The overall forecast for 2018, compared to the actual financial report in 2017 indicates an increase in both Plan revenue and expenses. The net income and ending cash balance are forecasted to decrease by approximately \$90 million and \$41 million respectively. Ms. Jones noted that the report was based on the September forecast. The Plan is working with Segal to incorporate the January data and update the 2018 forecast. The Plan will provide the updated forecast at an upcoming Board meeting.

Responding to several questions regarding the financial report, Ms. Jones stated that the Plan would provide additional information at one of the next two meetings on the following:

1. A more detailed explanation for the increase in administrative expenses
2. Explanation for the decrease in Plan expenses, in particular as it relates to rate/volume
3. How pharmacy rebates offset claims expenditures

Data Analytics Update: Ms. Jones provided a brief history regarding the development of the data analytics section and stated that the future success of the Plan is, in part, going to hinge on reliable data driving business decisions and strategies. She highlighted the data team's key accomplishments, noting that the new data warehouse went live on January 31.

With access to the eligibility and claims data, staff will have the opportunity to perform a variety of analyses and build reports. Staff will continue to monitor the vendor data to determine if and where gaps exist. Future plans include moving toward visual analytics and predictive modeling. The Plan may also bring in provider and financial data from Plan vendors.

Chair Folwell stated that not being able to access the Plan's data would no longer going to be tolerated. He further stated that data is worthless unless it provides meaningful reports. The goal is to have access to all the data by the end of 2018. Ms. Jones stated that the annual operations and maintenance costs are projected to be in the range of \$300,000-\$400,000.

The Plan is also partnering with BCBSNC to develop clinical groupers. Individual claims for certain procedures will be categorized to allow Plan staff to analyze and benchmark medical utilization and costs by procedures, i.e. hip replacements, knee replacements, etc.

Dr. McKethan expressed enthusiasm for the progress made in the data analytics area and sees the end product as a very useful tool in addressing random questions by Board members and other entities. He asked if the Plan and Board could establish standard data priorities and questions to avoid random requests. He added that asking the right question is often more difficult than extracting the data. The suggestion was made to reserve time at each Board meeting to review data on pertinent issues such as opioid use, pharmacy and medical trends, etc.

Ms. Jones expressed support for that idea and stated that Plan staff would discuss the best approach. Dr. McKethan added that it was also important to consider if there was information that would be meaningful to share with Plan members.

Other Matters: Benefit Change Requests Policy and Process: During one Board meeting per year, individuals and groups may present proposed benefit changes to Board members. The Plan is working to develop a process that will clearly define the steps from beginning to end.

Once a request is received and presented to the Board, Plan staff conducts research and analyzes the proposed benefit in order to make an informed recommendation to the Board. The final step is to ensure that the requestor and members of the public are notified of the Board's decision.

In response to a question from Ms. Hargett regarding the length of time required to reach a conclusion, Ms. Jones stated that each request is different. Some are complex and require far more research and analysis than others. While the Plan would prefer to close the loop on requests as soon as possible, it's more important to exercise due diligence.

Ms. Jones concluded by referencing the Plan's current organizational structure included in the Board packet. She noted that the Plan has approximately 15 vacant positions, most of which have been posted.

Plan Integration Updates

Presented by Caroline Smart, Sr. Director, Plan Integration

Tobacco Usage Update: Based on Open Enrollment results, the percentage of self-reported smokers is significantly lower this year than in 2017 and also lower than the 2015 report from the Centers for Disease Control & Prevention (CDC). Ms. Smart stated that approximately 18,500 Plan subscribers did

not respond to the tobacco attestation. Assuming that a majority of them use tobacco, the Plan's percentage of Plan smokers would line up more closely with the CDC report. Members who enrolled in the QuitlineNC smoking cessation program, but took no action, had the \$50 premium credit removed.

Third Party Administrator (TPA) Implementation Status: The Plan, BCBSNC and key Department of State Treasurer (DST) staff have been working together to evaluate the clinical, operational and customer experience programs. To date, the clinical and operational evaluations have been completed. Staff is currently reviewing the possibility of integrating the customer service tools used by BCBSNC and other Plan vendors to ensure the best member experience.

A newly designed member ID card will be ready for release when ID cards are issued for the 2019 Open Enrollment period later this year. The Plan's logo on front of the card will serve as a reminder that the State pays for employee benefits. Treasurer Folwell has emphasized the importance of employees knowing that their medical and pharmacy benefits are offered through the State Health Plan. BCBSNC, the Plan's third party administrator, provides the provider network and processes medical claims for Plan members.

Chair Folwell stated that he was pleased with the development of the new ID card. He also stressed the importance of members understanding the cost and value of their Plan benefits and pushed for a revision of the Explanation of Benefits (EOB) form. The Plan is targeting the end of the second quarter for the release of the revised EOB and will share it with the Board at a future meeting. Ms. Hargett stated that she believes many Plan members would be willing to help cut costs if they're educated as to what they can do.

Ms. Smart reviewed several infrastructure changes underway, some of which have been challenging from an operational standpoint. Most of these changes will ultimately result in reducing the complexity for members and/or Health Benefit Representatives (HBRs).

Dependent Eligibility Verification Audit (DEVA): The project goals and a timeline of the audit was presented. To date, 99% of the covered dependents under age 75 have been verified and documents uploaded in the system attached to the dependent's electronic record. Since August 2017, Plan staff has developed tools and reports to begin additional DEVA auditing.

Open Enrollment Update (Actives and Retirees): Based on the February 2, 2018 enrollment report, the Plan has over 727,000 members. With the elimination of the Consumer Directed Health Plan (CDHP), non-Medicare Primary members selected either the 70/30 or 80/20 plan. Approximately 87% of the Medicare primary members chose one of the Medicare Advantage (MA) plans. Ms. Smart noted, however, that MA enrollment was not yet finalized as we were still in the MA disenrollment period and not all of the enrollments had been approved by the Centers for Medicare and Medicaid (CMS).

2019 Plan Design Discussion and Enrollment Strategy

Presented by Caroline Smart, Sr. Director, Plan Integration

Since the November Board meeting, staff has met with Treasurer Folwell to review the Plan's financial outlook, cost-saving opportunities and feedback from constituent groups. Through those discussions, the framework for a three-year benefit strategy was developed. Several Board members shared comments, including support for provider incentives, encouraging members to take more responsibility for their healthcare and reducing the out of pocket cost for members.

Chair Folwell commented that having two plans for non-Medicare members would reduce the complexity, especially if the basic structure remained intact from year to year. He stated that his first goal is to maintain the current financial status. The second goal is to attract younger, healthier members to the Plan.

Dr. McKethan emphasized the importance of clearly communicating to members how their money is being spent and what they can do to reduce costs. He encouraged the Plan and Board to develop a simple measurement strategy for members, including the quality and value in their communities. He suggested placing less emphasis on reimbursement rates.

Following a request for a vote from Chair Folwell, Mr. Chauncey made a motion to approve the proposed 2019 benefit changes. This would include simplifying the 80/20 plan by replacing the separate pharmacy and medical out-of-pockets (OOP) with a single, combined medical/pharmacy OOP. Dr. McKethan seconded the motion and the Board voted unanimously to approve the changes.

Ms. Smart provided a brief history of the enrollment strategies since the introduction of premium credits in 2014. The 2019 strategy includes two enrollment options. The first is to leave the subscriber in their current plan at the start of Open Enrollment. The second is to default subscribers to the 70/30 plan for the start of Open Enrollment. Ms. Jones stated that this is a simple but consistent three-year enrollment strategy. She added that the Plan staff agrees that members should be engaged with the Plan at least once a year.

Following a request for a vote from Chair Folwell, Ms. Hargett made a motion, which was seconded by Mr. Brinn. The Board voted unanimously to approve Option 2, defaulting subscribers to the 70/30 plan for the start of Open Enrollment.

2018 Communication Strategy

Presented by Beth Horner, Director, Customer Experience and Communication

Ms. Horner presented the communication strategy for 2018, beginning with the goals and objectives. Given the role of HBRs in educating active members on their health benefits, the Plan will continue with the current monthly webinars and quarterly onsite trainings and enhance the library of online training resources. The Plan will also launch "HBR University," a training resource solution which will enable the Plan to track and enforce regular HBR training.

Member outreach in 2018 will continue to include monthly active and retiree webinars. Plan staff will also partner with the Retirement System for additional outreach at their retirement planning conferences. The Plan will again offer onsite meetings for members getting ready to become Medicare eligible, which aims to assist them with understanding their health plan options.

RFPs Under Development

Presented by Ted Enarson, Sr. Director, Contracts and Compliance

Mr. Enarson reviewed the Request for Proposals (RFPs) currently under development. In response to a question by Dr. Robie as to why the medical and pharmacy RFPs were separated, Mr. Enarson stated that different vendors were selected during the last bidding process, but that a single vendor could bid on both and potentially be selected by the Plan. Mr. Enarson also explained that these RFPs are on different procurement timelines.

Pharmacy & Therapeutics Committee/Bylaws

Presented by Tracy Linton, Sr. Director, Plan Benefits

At the November Pharmacy & Therapeutics (P&T) meeting, the P&T Committee welcomed two new members, Mr. Tony Gurley and Dr. Pete Robie, who also serves on the Plan's Board of Trustees. The Committee reviewed and approved a charter at the meeting. The Plan will institute bylaws, prescribed in the charter, which will outline basic rules, operating standards and procedures.

Ms. Linton summarized several formulary changes discussed at the November P&T Committee meeting. One of the changes for 2018 will limit the quantity of specialty drug prescriptions, ensuring safety and appropriate use. The estimated savings associated with this change is approximately \$1.328 million. A specialty copay card program for members on the 70/30 plan is estimated to save the Plan approximately \$1.305 million.

The pharmacy team will continue to review the data to determine additional opportunities to promote safety and prevent misuse of medications.

Chair Folwell asked if members had additional comments or questions. Dr. Martin thanked the Plan for the information provided and Dr. Robie commented that the Plan staff he's met so far are top-notch and he looks forward to serving on the Board.

At the request of Chair Folwell, Dr. McKethan made a motion to adjourn and Mr. Chauncey seconded the motion. The Board voted unanimously to adjourn at approximately 1:00 pm.

Dale R. Folwell, Chair

