Board of Trustees Meeting
State Health Plan for Teachers and State Employees
Department of State Treasurer
September 19, 2017

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 9:00 a.m. on Tuesday, September 19, 2017.

Members
Dale R. Folwell, Chair
Peter Chauncey
Kim Hargett
Donald Martin
Aaron McKethan
Elizabeth Poole
David Rubin
Margaret Way

Absent
Paul Cunningham, MD

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 at the end of the public session. He stated that the Board would move into executive session and meet in a different conference room and then return to the first floor conference room to adjourn. He also stated that Board members and visitors were welcome to attend the press conference at 3:00 p.m. where the award of the Third Party Administration (TPA) Services contract would be announced.

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

Ms. Dee Jones, Executive Administrator, introduced and welcomed new Board members, Peter Chauncey and Kim Hargett.

Resolution for Departing Board Members

Chair Folwell acknowledged Neal Alexander and Warren Newton, MD for their service to the Board and a resolution for each former member was read. The resolutions will be signed and sent to Mr. Alexander and Dr. Newton and included with the approved meeting minutes.

For Board Approval

Minutes – July 24, 2017 Teleconference
Presented by Dale R. Folwell, Chair

Following a motion by Dr. Martin and seconded by Ms. Hargett, the Board unanimously approved the July 24, 2017, minutes, as written.

Requests for Benefit Changes

Mr. John Green, Plan member, requested that the Board consider a change to the policy on MRI-Guided Focused Ultrasound to allow for treatment of prostate cancer. He stated that the treatment has been FDA-approved and is no longer investigational as stated in the policy.

On behalf of her son, Joshua who has type 1 diabetes, Ms. Karen Johnston, Plan member, requested an exception on Humulin 70/30 Kwikpens. In addition, she requested that it be listed as a tier 2 drug. The current formulary preferred brand, Lilly, does not manufacture this insulin in pen form, only vials. She noted that the out-of-pocket cost for his first prescription is $886 on the 80/20 plan until he reaches his deductible.

Mr. Ames Simmons, Director of Transgender Policy, Equality North Carolina, requested that the Board consider maintaining transgender-related coverage, effective January 1, 2018. He stated that the Affordable Care Act (ACA) prohibits discrimination for health plans that receive federal financial assistance. He also noted that Blue Cross Blue Shield of North Carolina (BCBSNC) removed categorical exclusions for gender reassignment services. Letters of support from various state employees and healthcare providers were included in the Board books.

Mr. Chuck Stone, Director of Operations for the State Employees Association of North Carolina (SEANC), requested the Board to consider several benefit changes. He noted that SEANC represents approximately 55,000 state employees. The requests included the following provisions: a Medicare supplement/Medigap policy, an option for active/non-Medicare retirees to select their own retiree health insurance equivalent in value to the current coverage and a combined medical and pharmacy out-of-pocket limit not to exceed $5,000 annually per covered member. SEANC also requested the Board to consider reducing generic drug copays to a maximum of $10 per script, reducing the copay for chiropractic treatment where it has been proven to be medically therapeutic and to cover acupuncture benefits where it has been proven to have therapeutic medical value.

Operations Update

Financial Report
Presented by David Cozart, Sr. Director of Policy, Planning and Analysis

Mr. Cozart reported that the July 2017 ending cash balance of $882.8 million represents approximately 3 months of Plan operating expenses. The Plan revenue of $1.9 billion was approximately $25.8 million more than the authorized budget amount. The per member per month (PMPM) net loss of $17.29 was $4.90 less than the authorized budgeted amount.

The presentation included a detailed report of administrative expenses for the current calendar year through July. Approximately 80% of the administrative costs were attributed to the Plan's contracts with BCBSNC, ActiveHealth Management, Benefitfocus and to the Federal Government for ACA fees.

Open Enrollment Readiness and Communication

Presented by Caroline Smart, Sr. Director of Health Plan Benefits and Beth Horner, Director of Customer Service and Communications

The Plan's enrollment vendor, Benefitfocus, has made the necessary system changes to support 2018 Open Enrollment. The complexity of the online enrollment has been simplified and members will have far fewer clicks to complete their online health plan enrollment. There were no benefit changes this year with the exception of changes within the formulary (drug list). There is currently a formulary exception process. The process will be less liberal moving forward, which could ultimately increase the out-of-pocket expense for members.

A Board member suggested that a diagram of the enrollment process would be helpful in order to determine the complexity. Ms. Smart noted that the workflows had been shared at a previous board meetings and that they would be incorporated into any future discussions. She also offered to share an enrollment video with Board members if that would be of interest or helpful to further understand the online enrollment process.

System testing requires a great deal of time and staff to verify enrollment workflows and transactions prior to the first day of enrollment. The Plan anticipates resolving the few outstanding issues that remain before September 30.

The Open Enrollment communication strategy has been extensive with several member outreach meetings, Health Benefit Representative (HBR) training sessions, onsite collaborative meetings with NCFlex, webinars, telephone town halls and mailings. Many of these outreach efforts will continue through the end of the Open Enrollment period.

Ms. Horner stated that the Medicare Outreach meetings and telephone town halls target retiree members who don't have the benefit of human resources or an HBR to assist them. In response to a question from a Board member regarding webinars, Ms. Horner stated that current and archived webinars are available for both active and retiree members on the Plan's website.

Dependent Eligibility Verification Audit

Presented by Caroline Smart, Sr. Director of Health Plan Benefits and Beth Horner, Director of Customer Service and Communications

Ms. Smart presented background information on the Dependent Eligibility Verification audit which began in May of this year. She stated that even though the deadline for submitting documentation was July 31, staff will continue to collect information until February 2018 in anticipation of verifying the eligibility of all dependents on the Plan. Ineligible members will be terminated at that time.

In response to a question as to whether the Plan could review claims of those members with whom the Plan has not be able to communicate, Ms. Smart stated that it would not be feasible due to technical challenges. Ms. Horner addressed a question regarding HBR assistance in contacting these members, stating that the Plan has continued to reach out to HBRs throughout the process.

In response to a question regarding how the Plan would handle ineligible members for which claims had been paid, Ms. Smart stated that it was an issue for staff would need to address. She added that premiums paid for these dependents would also have to be taken into consideration in determining a resolution

Chair Folwell stated that the Plan and Board have a fiduciary responsibility to ensure that all Plan dependents are eligible. He added that similar issues have been discovered in the pension plan and that the same philosophy would be applied with these members, as well.

In response to a request for clarification, Ms. Smart stated that the Plan approved the local government groups who requested coverage under the Plan. Mr. David Vanderweide, a staff member with Fiscal Research, stated that the General Assembly approved Plan coverage for a few local governments under a legislative bill a number of years ago. Since that time, minimum requirements have been established which local government entities must meet in order to be covered under the Plan. The Plan currently has 89 groups and the Board has limited authority to approve local government groups who don't meet the minimum requirements.

Member and Public Comment Period

Joaquín Carcaño, University of North Carolina, stated that he is a research specialist and a transgender man. He wanted to share this part of his life and encouraged the Board to vote to continue medical coverage for gender dysphoria beginning in 2018.

Andy DeRoin, North Carolina State University, is the program coordinator for the Gay, Lesbian, Bisexual and Transgender Center. He is also a transgender, as well as a Plan member. He expressed gratitude to the Plan for providing medical coverage for transgender dysphoria during the past year and requested continued coverage in 2018.

Jeanne Duwve, Wake County teacher, stated that her son had transgender surgery as a result of the Board's decision to provide coverage in 2017. She noted that, as a result, his life has completely changed. Instead of feeling like a burden to society, he is now a payer into the system. The ability to have gender dysphoria coverage is a matter of life and death to some people. She asked the Board for their vote to approve and continue coverage in 2018.

Dano Parrish stated that he is the husband of a state employee and father of a transgender daughter. He and his wife are supportive parents but are not therapists. He shared that a trained therapist has helped their child through the gender identity process. He and his wife hope that transgender care will continue to be included in the 2018 benefit coverage for Plan members.

Ardis Watkins, SEANC, listed several items they would like the Board to consider: Link hospital reimbursement rates to a percentage of Medicare rates, such as 120% of Medicare rates; eliminate payment for hospital "never events" where hospital errors result in additional expense to the Plan and members; strengthen Plan ethics by seeking legislation or adopting a policy requiring political disclosure by contractors/vendors; establish a member self-audit rewards program to reimburse Plan members for finding billing errors and overcharges; provide annual publication and notice to Plan members of ratings on health insurance products offered by the Plan; seek congressional support for federal statutory or regulatory change which would enable Plan dependents to qualify for tax credits and premium subsidies in the Health Benefit Exchanges under the Affordable Care Act or seek funding from the State for an equivalent premium subsidy in the Plan for dependent coverage; reimburse Plan members for overdraft fees and bad check charges arising from enrollment/bank draft/payroll errors by the Plan or its vendors. In addition, Ms. Watkins stated that SEANC would appreciate and welcome more dialogue with the Plan Board of Trustees.

Frann Sarpolus acknowledged the life changes transgender people face. She doesn't believe the State should be responsible for the medical costs but supports coverage for more extensive therapy and counseling.

Patty Adams, a clinical social worker and therapist with Liberation Healing Arts, stated that she was trained to understand the comprehensive and inclusive health care picture of her clients and the support services that may be needed. She shared the State motto which is "to be rather than to seem" and stated that, to her, this includes treating all of her clients, including transgender people, with the dignity they deserve.

Chair Folwell thanked everyone for their comments and stated that a press conference would be held at 3:00 p.m. to announce the award of the TPA Services contract.

Following a motion by Dr. McKethan and a second by Dr. Martin, the Board voted unanimously to move into executive session, pursuant to G.S. 143-318.11 and G.S. 132-1.2.

Executive Session

RFP recommendation – Third Party Administration Services
Presented by Dee Jones, Executive Administrator, Ted Enarson, Sr. Director, Contracts and Compliance and Caroline Smart, Sr. Director, Health Plan Integration

Request of Board: Ms. Dee Jones, Executive Administrator, stated that the goal for the Executive Session was for the Board of Trustees to approve the recommendation for award of the Third Party Administrator (TPA) medical claims contract. Ms. Jones told the Board that the proposals received in the response to the Request for Proposals (RFP) that the Plan had posted were evaluated by a committee comprised of members of the Plan's Senior Leadership Team as well as subject matter experts. Ms. Jones introduced those in attendance from the Committee: Ms. Caroline Smart, Mr. David Cozart, Ms. Natasha Davis, Ms. Lucy Barreto, and Ms. Beth Horner in addition to Mr. Ted Enarson and Ms. Sharon Smith who oversaw the process. Ms. Jones also spoke to the soundness and integrity of the evaluation process. Ms. Jones also introduced others in attendance: Mr. Sam Hayes and Mr. Andrew Norton from the Department of State Treasurer and Mr. David Vanderweide from the Fiscal Research Division of the North Carolina General Assembly.

TPA Contract Recommendation:

Mr. Ted Enarson and Ms. Caroline Smart presented the Evaluation Committee's recommendation to the Board of Trustees. Mr. Enarson provided background on the RFP's development, how the evaluation process was performed, and the scoring methodology utilized by the committee. Plan staff started drafting the RFP in the summer of 2016. The Plan received Minimum Requirement responses from Aetna Life Insurance Company (Aetna), BlueCross BlueShield of North Carolina (BCBSNC), Medcost Benefit Services, LLC (Medcost), and UnitedHealthcare Services, Inc (UHC). Medcost failed to meet the minimum requirements and was eliminated from further consideration. The Evaluation Committee met between July 11-28, 2017 to score fifteen technical sections and one optional service (Population Health Management). Aetna was eliminated from consideration during this process for failing to meet mandatory minimum requirements in the Finance & Banking section of the RFP. Ms. Smart spoke more specifically to the technical aspects of the proposals from the two remaining bidders. Ms. Smart indicated that both remaining bidders had the technology, resources, and expertise to meet the core requirements. Ms. Smart then explained that where they differentiate themselves is in flexibility and transparency.

Mr. Enarson also presented the technical and cost proposal scores: The cost proposals, including two requests for Best and Final Offers, were independently evaluated by the Plan's actuary, Segal. The technical proposals were weighted 40% of the final score, while the costs proposals were weighted 60% of the final score. BCBSNC scored 2,204.77 out of a possible score of 3,200 on technical and 5,987.38 out of a possible 6,000 on cost for a total score of 8,192.15. UHC scored 2,083.17 out of a possible score of 3,200 on technical and 6,000 out of a possible 6,000 on cost for a total score of 8,083.17.

Mr. Enarson then informed the Board of Trustees that based upon the scoring, the Evaluation Committee's recommendation was to award the contract to BCBSNC. Ms. Smart spoke briefly about next steps for implementation if the contract award was approved by the Board.

Treasurer Folwell asked how the administrative costs in the BCBSNC proposal compared to what the Plan is currently paying. Mr. Cozart and Ms. Smart described the fee comparison.

Dr. McKethan asked whether the Plan would have better access to data under this new contract. Ms. Smart responded that the Plan is currently working with BCBSNC on data access and these efforts would continue under the new contract.

Mr. Chauncey asked about flexibility for plan designs in the new contract. Ms. Smart responded that this flexibility did exist and that these decisions would be made during the implementation of the contract.

Ms. Hargett then spoke about the virtues of the Consumer Directed Health Plan (CDHP) that is being eliminated at the conclusion of the 2017 plan year. Ms. Hargett indicated that she would like to keep the door open for plan designs other than the 70/30 and 80/20 in the future.

Treasurer Folwell responded that the Plan needs to be agnostic regarding members' choices of plan options. Treasurer Folwell stated that the Plan needs to achieve certainty and stability. Treasurer Folwell noted that the CDHP was too confusing for many members.

Dr. Martin asked whether BCBSNC has the necessary technology to meet the Plan's needs. Ms. Smart responded that BCBSNC is working to improve their technology and that the Plan will continue to push them along to get to where the Plan needs them to be.

Dr. McKethan praised the evaluation process. Dr. McKethan stated that he was excited about the possibility of tapping into consumerism and exploring shared savings possibilities.

Treasurer Folwell talked about the Plan's cost trend line and the need to stabilize costs. Treasurer Folwell indicated that this new contract would not be a renewing of vows with BCBSNC, but rather a resetting of the relationship.

Ms. Way spoke about Explanation of Benefit (EOB) statements. She indicated that most consumers of health care blame the insurance companies, drug companies, and doctors for high costs. She stated that an effort needs to be made to better educate members on costs.

Following a motion by Dr. Rubin and a second by Dr. Martin, the Board voted unanimously to award the TPA Medical Claims contract to BCBSNC.

Chair Folwell emphasized the importance of continuing the silent period until after the conclusion of the press conference at 3:00 pm.

Following a motion by Mr. Perusse and a second by Ms. Poole, the Board voted unanimously to return to open session.

The meeting adjourned at approximately 12:30 p.m.

Dale R. Folwell, Chair