Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
July 26, 2013

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, July 26, 2013, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

Members Present:
Chair Janet Cowell
Paul Cunningham, MD
V. Kim Hargett
Noah Huffstetler
Bill Medlin
Vice-Chair Genell Moore
Warren Newton, MD

Members Absent:
Art Pope
David Rubin
Michele Shaw

State Health Plan Staff: Mona Moon, Glenda Adams, Mark Collins, Lotta Crabtree, Thomas Friedman, Beth Horner, Sally Morton, Lorraine Munk, Derek Prentice, MD, Tracy Stephenson

Department of State Treasurer Staff: Andrew Holton, Joan Fontes

Guests: Ginger Austin, Janelle Cain, Charlotte Craver, Steve Daly, Pam Deardorff, Larry Earle, Bob Fronius, Wadida Murib-Holmes, Ann Marie Hubbal, Rick Johnson, Charla Katz, Jack Kenley, Chris Mathews, Scott Money, Lacey Presnell, Ed Regan, Jonathan Rubins, Bill Stockard, Chuck Stone, John Thompson, Michelle Tietz, David Vanderweide, Ken Vieira, John York

Welcome
Treasurer Janet Cowell, Chair, welcomed Board members, 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 read the "Conflict of Interest Statement" requesting members who have either an actual or perceived conflict of interest to identify the conflict and refrain from discussion and voting in those matters as appropriate. No disclosures were made and no conflicts identified.

Agenda Item – Review of Minutes – May 24, 2013 (Attachment 1)
Presented by Janet Cowell, Chair

Following a motion by Dr. Newton and seconded by Mr. Medlin, the Board voted unanimously to approve the minutes as written.

Agenda Item – Premium Rates for 2014 (Attachment 2)

3rd Quarter Forecast Update
Presented by Mark Collins, Financial Analyst

Mr. Collins presented the revised forecast in light of the approved State budget, including a comparison of approved benefit design projections. The forecast includes the most recent financial results, membership data, claims experience and changes in anticipated costs and/or revenues.

The forecast's overall trend assumption is 8.5% with a membership trend that includes an annual 1% decrease in active member enrollment and a 1% increase in retiree membership. The forecast includes the Board approved benefit designs which will be effective January 1, 2014. Mr. Collins noted that the final pricing on Medicare Advantage products was substantially lower than the projected amounts that had been used in previous updates, reducing projected costs in the 3rd quarter update relative to prior forecasts.

A summary of the plan designs, approved by the Board in February 2013, includes: the conversion to a calendar year, the offering of Medicare Advantage plans with Prescription Drug Programs (MA-PDP), a Consumer-Directed Health Plan (CDHP), wellness initiatives for the 80/20 and CDHP plans, and a traditional free 70/30 plan option. In addition, the Board approved a gradual increase of the Target Stabilization Reserve (TSR) from 7.5% to 9% of claims cost by December 2015. The Plan's actuary incorporated the design changes and associated assumptions in the revised forecast and will continue to refine the assumptions as membership data and claims experience change.

For FY 2012-13 a comparison of the Authorized Budget and the 3rd quarter forecast demonstrated a decrease of $147.8 million in total Plan expenses and an increase in net income and ending cash balance. Plan revenue also increased approximately $22 million. Medical and pharmacy claims have maintained the same pattern throughout the 2012-13 fiscal year, with projected medical claims costs consistently revised downward while estimated pharmacy claims have remained in line with projections. The forecasted ending cash balance increased steadily in the quarterly forecast comparisons and the Plan ended the year with approximately $780 million compared to the forecasted amount in March of $755.8 million.

The estimated premium increases in the initial projection of the Board-approved benefit design (from February 2013) was 4.7% for the 2013-15 biennium and 10.4% in for the 2015-17 biennium. With the 3rd quarter update, the projected premium increase for January 2014 and 2015 decreased by 4.6% and increased in the 2015-17 biennium by the same amount. With the reduced premium for 2013-15, the employer contribution and General Fund amounts also decreased relative to the initial projection in February.

The growth in the premium increase in the 2015-17 fiscal biennium (from 10.4% to 15.0% is due to the Plan's large cash balance and traditional forecasting methodology. Under the current methodology for setting rates, the cash amount above the TSR (approximately $500 million) is budgeted for use over the 2½ years. Therefore, the need to increase the premium in 2014 and 2015 is reduced but higher increases in 2016 and 2017 are needed to make up for the lower premiums collected in the previous years. In summary, the cumulative premium increases for the period 2014-2017 in the revised forecast are lower than the cumulative premiums suggested by the initial forecast.

When comparing the May 2013 baseline forecast (i.e. which assumes no changes in benefits) vs. the Board approved plan design, the premium increase was 1.6% higher for the 2013-15 biennium and 3.9% lower for the 2015-17 biennium. In the short term, the design changes require more money but the long term savings over the next four years are significant. The State could realize savings of approximately $377 million, including $300 million in General Fund spending. Employees and retirees could save $241 million in premium contributions.

Projected expenses are expected to decrease approximately $889 million over the next four years. Even with the decreased revenue of $322 million from the Employer Group Waiver Plan (EGWP), the Plan's net savings are approximately $567 million.

State Budget Update

Presented by Thomas Friedman, Health Policy Analyst and Legislative Liaison

Mr. Friedman presented a comparison of the Governor's, House and Senate budgets, as well as a four year budget outlook and a comparison of the Plan's 3rd quarter forecast to the State budget. The proposed funding in the Governor's budget includes a 4.7% premium increase, while the Senate and House both proposed slightly lower increases.

The House budget and Conference Report include a special provision requiring the Plan to adopt new plan changes beyond those approved as of June 1, 2013, in order to reduce the employer premium increases over the next four years by at least 1%. This could be achieved by changing out-of-pocket requirements, changes to employee and retiree premiums, new plan options, changes in the services and products covered, changes to the provider network structure, changes to provider rates or payment methodology, incentives for members to choose and maintain healthy behavior, incentives to control utilization, integrated health management programs, fraud detection, utilization management or changes in plan administration.

The Conference Report approved by both the House and Senate includes increased funding for employer contributions of $33.5 million for FY 2013-14 and $89.0 million for FY 2014-15. If the autism and pharmacy audit bills become law, the budget also includes reserve funding for these bills. The Report also approved a total increase of $122.5 million in general fund appropriations in the 2013-15 biennium and the equivalent of a 3.5% premium increase in FY 2014 and a 2.14% increase in FY 2015.

Board Discussion

Next steps include Board approval of premium rates effective January 1, 2014, evaluation of new benefit options and impact on the forecast model and strategies to address the provisions required to reduce the average premium increase over the next four years.

Plan staff will continue to closely monitor both medical and pharmacy claims utilization and update the forecast periodically to ensure the Plan is on target financially. The plan design changes present a challenge in forecasting due to the uncertainty of which option members might choose. Although we will have information on plan selection after open enrollment, we will not have much information on claims utilization until we get through the 2nd quarter of 2014 (i.e. the end of the 2013-14 fiscal year). The 2nd Quarter Forecast Update for FY 2013-14 will reflect the actual plan selection, however, the financial impact of the wellness and behavioral changes will not be known for some time.

The Board encouraged the Plan to provide a six-year forecast if possible. They also understand that reducing premiums by up to 1% can translate into a lot of money and that actual dollars, as well as the percentage, should be included in future reports. Board members also felt it would be helpful to review the annual compensation of an average state employee and the percentage that is deducted for premiums. That information could be used as a benchmark for future benefit considerations.

The General Assembly supports the current benefit changes and member involvement and accountability for their health care but wants the Plan to aggressively pursue options to further reduce costs.

Premium Rates for 2014
Presented by Mark Collins, Financial Analyst

The 2014 rate structure, approved by the Board at the May 2013 meeting, includes new plan options, split contracts and wellness surcharges and credits. The state budget bill set the maximum employer contribution for each fiscal year. In the past, the percentage increases for the employer contribution have been the same as the employee/retiree premium. The equivalent of a January 1, 2014, premium increase of 3.57% for all coverage tiers was included in the bill. Premiums for dependents in the Medicare Advantage plans will be equal to the premium charged by the plans ($112 per month) plus an additional monthly $2.50 administrative fee.

The 2014 employee/non-Medicare retiree premium in the 80/20 (Enhanced) plan will be $13.56 – $63.56 depending on the member's participation in the wellness activities. The employer share will be $448.11 in both the 80/20 and 70/30 (Traditional) plans. The employee/retiree share in the Medicare Advantage – Prescription Drug Plan (MA-PDP) will be $0 - $33.00 per month depending on the base or buy-up plan and the employer share will be $348.25. The premiums for employees/non-Medicare retirees in the Consumer-Directed Health Plan will range from $0 - $40, again depending on the member's participation in the wellness activities. The dependent premiums depend upon the plan chosen and number of dependents.

Mr. Collins presented a detailed premium rate structure for each plan, based upon family status and participation in the wellness activities. The Traditional plan is less complex given that the wellness activity incentives do not apply to this option.

In addition to the applicable member-paid premium rates, COBRA members will also be required to pay the employer contribution and a 2% fee or an additional 50% fee for disability subscribers. The exception is for MA-PDP subscribers who will not pay more than the fully insured premium costs charged by the MA-PDP vendors (plus the $2.50 monthly administrative cost). The National Guard, firefighters and emergency medical personnel will also pay the employer premium and an additional 20% to protect against adverse selection.

Plan staff recommended that the Board approve the 3.57% rate increase effective January 1, 2014, and to authorize the Executive Administrator to alter rate increases to match the percentage increase in the maximum employer contribution should that rate be revised in 2013-14.

Ms. Moon stated that the Plan engaged Segal to develop a rate calculator to assist members in determining which plan would be best for them. Since the CDHP is a new option for consideration, the Plan recognizes the challenge in educating members. She also mentioned that the Plan may review a

different staff model and hire additional employees to meet the needs of administering the new options and that it would be shared with the Board at the appropriate time.

Mr. Chuck Stone, from SEANC, requested permission to address the Board. He stated that the past 1% increase in salaries has not been adequate for employees and that the General Assembly's message is to reduce costs over the next biennium. Cost shifting to employees has occurred most years in the past and the current plan design will be a hardship on many state workers. Many will pay more out-of-pocket which may or may not be offset with the wellness activity incentives. He shared concerns about implementing the CDHP and the fact that medical expenses are the leading cause of personal bankruptcy. He asked the Board to consider the impact of the premium increase and benefit changes on state employees.

Following a motion by Ms. Hargett and seconded by Ms. Moore, the Board voted unanimously to approve the 2014 premium rates.

Agenda Item – Additional 2014 Coverage Changes (Attachment 3)
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance

Ms. Crabtree stated that a compliance review by the Plan's vendors and legal counsel identified two areas of concern: Essential Health Benefits (EHB) and federal mental health parity. She indicated that future coverage changes may need to be reviewed depending on regulations under the Affordable Care Act (ACA).

The issues identified under Essential Health Benefits (EHB) are the $600 lifetime limit for cranial bands, the hearing aid limit of $2,500 per ear, per three year period up to age 22 and the $5,000 lifetime limit for infertility and sexual dysfunction treatments. Identified concerns under the Federal Mental Health Parity Act are that prior authorization is required for mental health and substance abuse visits beyond the 26th visit, one psychiatric review per provider per benefit period and a limit of 6 preventive counseling visits per benefit year.

Ten categories of service comprise Essential Health Benefits under the ACA. These categories were established to ensure that health plans in the individual and small group markets offer a comprehensive benefit package. For 2014 and 2015, EHB has been defined as a "benchmark plan" that each state selects. North Carolina's benchmark is the Blue Options PPO under Blue Cross and Blue Shield of North Carolina (BCBSNC). As a large employer plan, the State Health Plan is not required to cover EHB, but for any EHB covered, annual or lifetime dollar limits cannot be imposed.

The Plan proposed the following: a quantity limit of one cranial band per lifetime; a quantity limit of one hearing aid per ear every three years up to age 22; removal of the lifetime dollar amount for infertility with the establishment of a lifetime quantity limit of three ovulation induction cycles and associated services; and retain the $5,000 limit for sexual dysfunction. The total estimated cost for all the changes is approximately $2.6 million.

Ms. Crabtree stated that the Plan could also consider maintaining the current coverage which would result in non-compliance, eliminate the dollar amounts on EHB or drop the current coverage altogether resulting in loss of grandfather status. None of these options are recommended by the Plan.

Several Board members expressed concern about eliminating dollar limits on hearing aids and the wide range of devices that are available.

The Mental Health Parity Act requires that financial requirements and limitations on treatment cannot be more restrictive for mental health and substance abuse than it is for medical and surgical benefits. Previously, the Board approved mental health copays on par with primary care visits in order to meet parity requirements but did not address the treatment limitations.

The Plan could remove the quantity limit on visits to comply with the Mental Health Parity Act. The annual cost would be approximately $1.3 million. The Plan could also opt of out compliance as it has done in the past.

Board members discussed the financial impact of eliminating the number of visits and also providing appropriate coverage for members seeking mental health care.

Following a motion by Dr. Cunningham and seconded by Mr. Huffstetler, the Board voted unanimously to approve the recommended coverage changes for mental health parity.

Following the vote, Dr. Newton requested a break-out of the financial impact of eliminating the quantity limit of visits for each item listed under the current coverage.

The vote regarding Essential Health Benefits was deferred and the Board requested that the Plan explore utilization management options for the proposed benefits.

At this point, Treasurer Cowell turned the meeting over to Vice-Chair Moore.

Agenda Item - Specialty Pharmacy Management (Attachment 4)
Presented by Sally Morton, Pharm D, Clinical Pharmacist

Coinsurance Maximum for Non-preferred Specialty Pharmacy Formulary Tier
Dr. Morton provided a history of the specialty pharmacy management progression and reiterated the changes approved by the Board at the January 2013 meeting. One of the changes was to split the specialty tier to establish preferred and non-preferred specialty tiers under the pharmacy benefit. The Plan would like to implement a non-preferred specialty tier in January 2014 to coincide with other benefit changes. Staff recommended a non-preferred specialty pharmacy coinsurance of 25% up to $150 maximum for a 30-day supply.

The financial analysis for projected savings of this benefit change performed by Express Scripts and Segal assumed a 15% annual trend for specialty pharmacy. It was noted that the recommended changes would apply only to the Enhanced 80/20 and Traditional 70/30 PPO plans. The current member cost share based on the average specialty medication cost of approximately $4,000 is 2.5%. With the new coinsurance maximum, the member cost share would increase to 3.75%. The estimated annual Plan savings is between $490,000 in 2014 to $746,000 in 2017 which does not account for the expected release of Biosimilars. Dr. Morton noted that increasing the coinsurance maximum in the non-preferred specialty tier more than the recommended $150 could potentially impact medication adherence.

There are currently approximately 263 members taking medications on the non-preferred list and they will be notified about the coinsurance increase prior to January 1.

Following a motion by Mr. Medlin and seconded by Dr. Cunningham, the Board voted unanimously to approve the recommended coinsurance maximum for medications in the non-preferred specialty tier to be implemented January 1, 2014.

Specialty Pharmacy Utilization Management Opportunities

The Plan processed approximately 80 pharmacy claims in the first six months of 2013 for seven specialty medications for rare diseases that have exceeded $1 million. The average monthly cost of these medications is approximately $7,000 or above. To ensure they are appropriately prescribed, the Plan recommends adding prior authorization requirements for these new, high cost specialty medications. The Pharmacy & Therapeutics committee will review the authorization criteria at the August meeting.

Over the next six months, the Plan will focus on medical specialty benefit management and work with BCBSNC and Accredo to develop a medical benefit management work plan. The focus areas will include reimbursement management, site of care management, plan design and clinical management. Details will be shared with the Board within the next few months.

Agenda Item – May 2013 Financial Report (Attachment 5)

Presented by Mark Collins, Financial Analyst

Mr. Collins stated that the Plan continues to run under budget. Revenue was $31 million above the budgeted amount and claims expenditures were $142.6 million less than projected through May. Administrative expenses were $25.1 million less than budgeted. The Plan's ending cash balance for May was $783.8 million. Year to date allocation of claims expenditures through May were as follows: Pharmacy 29%; Inpatient facility 17%; Outpatient facility 22%; Professional 29%; and other 3%.

The Board emphasized that with pharmacy expenses expected to increase each fiscal year, this is the area in which the Plan might find savings in order to lower premium increases as per the directive from the General Assembly. Mr. Collins stated that the Plan may have opportunities for savings in specialty medications and noted that the Plan's actuaries used a 15% trend assumption to project the savings for a new specialty medication tier approved by the Board.

Legislative Update (Attachment 6)

Presented by Thomas Friedman, Health Policy Analyst and Legislative Liaison

Mr. Friedman presented bills signed by the Governor which impact the Plan either directly or indirectly.

HB 232, the State Health Plan/Statutory Changes/Agency Bill, redefines and broadens eligibility rules based on the Affordable Care Act, clarifies the period in which retirees can enroll and repeals the requirement to collect certain penalties and interest.

HB 459, Chronic Care Coordination Act, requires the Department of the Treasurer and divisions within the Department of Health and Human Services (DHHS), to identify goals and benchmarks, reduce the incidence of chronic conditions and improve coordination of care in the State. Annual progress reports are to be provided to the legislature. The fiscal impact is negligible.

SB 98, Require Pulse Oximetry Newborn Screening, adds this screening for all newborns and requires follow-up protocols for newborns with congenital heart defects. The fiscal impact is negligible.

SB 248, Choice of Hearing Aid Specialist, is an act to ensure that patients have the right to choose their hearing aid specialist and to authorize the State Hearing Aid Dealers and Fitters Board to increase certain fees. Mr. Friedman noted that providers have to be within network to receive the Plan's rate of cost sharing. The fiscal impact is negligible.

SB 336, Collaboration Among State Diabetes Programs, requires certain DHHS divisions and the Department of State Treasurer to work together to develop plans and establish goals to reduce the incidence of diabetes, improve diabetes care and control diabetes related complications. Progress reports are to be provided to the legislature every other year. The financial impact is negligible.

Ratified bills sent to the Governor for signature were presented.

HB 675, Amend Pharmacy Laws, restricts the right to recoup, as well as the amount that may be recouped from pharmacists in the event of audit findings. The projected biennium fiscal impact may be revised but currently amounts to a revenue loss of $3.2 million-$3.4 million. Mr. Friedman noted that in the case of fraud or misrepresentation, the Plan would recoup all the money.

HB 473, Health Care Cost Reduction and Transparency, as it relates to the Plan, states that each hospital will report the combined range of payments and average payment for the top five insurers and the Plan for both inpatient and outpatient centers. The top 100 DRGs would be included in the inpatient report due at the end of June 2014. The top 20 most common surgery and imaging procedures for outpatient and ambulatory surgery centers would be included in the report due at the end of September 2014.

The bill requires the Plan to establish a workgroup to examine the best way to provide pricing transparency and provide the first report of findings by December 31, 2013. This bill would ultimately allow members to know what they pay for services. Ms. Moon stated that BCBSNC already has a transparency tool which the Plan is evaluating, along with other vendor transparency tools. The Plan may need to develop its own tool to meet the specific need relative to Plan members.

A summary of key crossed-over legislation eligible for consideration in the 2014 short session was presented.

HB 498, Autism Health Insurance Coverage, requires the Plan to provide annual coverage of $36,000 for autism behavioral treatment for members up to age 23. The bill passed the House and was referred to the Senate Committee on Insurance. The projected biennium fiscal impact on expenses is $2.9 million-$6 million.

SB 477, No Set Fee/Non-covered Vision Services, prohibits insurers and health benefit plans from limiting or fixing the fees an optometrist may charge for services and/or materials unless they are covered by reimbursement under the Plan or insurer contract with the optometrist. The bill would require optometrists to provide a written disclosure to patients.

BCBSNC currently provides various vision discounts through their discount program, which is available to Plan members. This bill would restrict Plan members from taking advantage of those discounts. The bill passed the Senate and has been referred to the House Committee on Insurance. There is no fiscal impact to the Plan.

At the close of session, the Plan will provide an update to the Board if any changes to pertinent bills occur.

Agenda Item – Benefits Implementation Update (Attachment 7)

Communications Update
Presented by Beth Horner, Customer Experience Manager

Ms. Horner presented the communications strategy for the new plan design. To date, 47 training sessions for Health Benefit Representatives (HBRs) have taken place in 37 counties. Eighty-five percent of the training participants agreed or strongly agreed that the information provided in the 2-hour session was adequate and provided a better understanding of the new plan options. The remaining 15% thought additional training would be helpful. Ms. Horner noted that training sessions were strategically placed at locations in less populated areas.

Plan staff is preparing member materials and conducting frequent meetings with key stakeholders to educate and keep them informed of key decisions. The Plan also has meetings scheduled with the Medical Society and Hospital Association. Member mailings will occur over the next couple of weeks and the Plan's website will be updated to include the new benefit information and rate calculator tool. HBR feedback has been very valuable and incorporated into Plan material.

The Board stressed the importance of consistent messaging to ensure that members understand the different plan options in order to make informed decisions. The question was raised as to if and how the Plan can measure its success in educating and training members. That may ultimately be determined by the number of questions members raise following the enrollment process. The Plan will also conduct a member satisfaction survey during the next year.

The Board suggested that including information on member feedback on future agendas might be helpful to the Board as they continue to make benefit decisions.

Medicare Plan Design Comparison: 2014 Options vs. Former 80/20 PPO
Presented by Mona Moon, Executive Administrator

As a follow-up from the May Board meeting, Ms. Moon provided a Medicare Plan Design Comparison of 2014 Options vs. the Former 80/20 PPO. This information will not be included in the communication materials since the standard 80/20 option will not be available in 2014.

Dr. Newton noted that ER visits were not included. Ms. Moon noted that it was an oversight and that the document will be revised. The corrected version will be posted on the Plan's website.

Update on Medical Claims Audit RFP
Presented by Mona Moon, Executive Administrator

Ms. Moon also provided a brief update on the Medical Claims Audit Request for Proposal (RFP). The Division of Purchase and Contracts granted the Plan's request to cancel the third party liability recovery services component of the RFP. The Plan has extended its contract with the current vendor, HMS, and will go out to bid again for services during the fall of 2013.

Bids on the Medical Claims Audit component for the RFP have been rejected and the Plan is in the process of negotiations with potential vendors.

In response to a question by a Board member, Ms. Moon stated that a Dependent Eligibility Verification audit was completed in 2012 and that the results could be provided to the Board. She noted that the Plan did not actively go through the process of recouping claims costs for those members who were deemed ineligible.

Agenda Item – ActiveHealth Management – 2012 Annual Report (Attachment 8)
Presented by Wadida Murib-Holmes, ActiveHealth Management

A video testimonial from a member who has actively engaged with a case manager was shared with the Board.

AHM reported the results of their Return on Investment (ROI) calculation for 2012. AHM estimated their impact on trend was -8.0% and the estimated ROI was 7.53:1, yielding savings of approximately $187 million. More than 178,000 gaps in care were identified and 77,000 of those gaps were closed. The total care consideration compliance was 43.4% compared to the 35.7% for book of business compliance. The top three conditions that generated care considerations were diabetes, cardiovascular disease, and lipid disorders. The Plan's consulting actuary, The Segal Company, worked with AHM to agree on the methodology for calculating ROI and certain underlying assumptions. Segal is in the process of validating AHM's ROI calculation.

AHM also reviewed changes in risk factors and found reductions in blood pressure, cholesterol, weight and smoking. Member numbers improved in the areas of their perception of health, physical activities and seatbelt use. One Board member mentioned that smoking cessation programs have not been successful in his part of the State. Ms. Murib-Holmes stated that AHM would work with the Plan to determine if there are more opportunities to promote smoking cessation programs and/or incentives.

A member satisfaction survey demonstrated that 93% of engaged members in the program were very or mostly satisfied with the program and 93% were also very or mostly satisfied with their nurse coach interaction. The percent of eligible Plan members who were engaged in the program increased from 4.59% to 5.4%. Member engagement for those in the program was above the performance guarantee target of 75%. The only targets not met in the performance guarantees outlined in the contract were two clinical measures: diabetes LDL monitoring and diabetes nephropathy.

Copies of the annual report were distributed to Board members and Ms. Murib-Holmes stated that AHM and the Plan are reviewing innovative ways to move to the next level.

Agenda Item - Clinical Risk Grouper Report (Attachment 9)
Presented by Chris Mathews, The Segal Company

Mr. Mathews discussed the financial opportunities for managing the Plan's population, behavioral aspects that drive health care costs and reviewed the findings of the Clinical Risk Grouper (CRG) analysis. A U.S. study in 2012 showed that $939 billion of the $2.6 trillion spent on medical care was avoidable, with $493 billion attributed to patient behavior such as obesity, smoking, non-adherence to medications and alcohol abuse.

In 2013, the projected medical costs for the Plan are over $1.8 billion and projected pharmacy costs are approximately $678 million. The potentially avoidable medical cost savings from member behavioral changes are approximately $480 million. Potential savings from clinical and operational efficiencies are $431 million for a total of approximately $911 million.

By categorizing members into risk categories, health risks can be identified within the Plan's population and provide opportunities to control costs and improve member health. Nine CRG categories within the Plan range from healthy to catastrophic. This information was obtained from the two most recent years of claims experience. The population profiles were categorized by non-Medicare, actives, retirees and groups, systems and departments. The information contained in the Board packet was limited to the non-Medicare population. A full report is available to the Board.

Over 51% of the Plan's population is considered to be chronic with either single or multiple conditions. That number equates to $2.1 billion, or 77.7% of total claims, spent in fiscal year 2012. A chronic member costs an average of $7,764 per year or more than six times that of a healthy/acute member. Focusing on members in the lower risk levels to prevent them from moving to unhealthy categories is key. These members are easily identified but engaging them is the challenge. A suggestion was made to provide incentives for members to get yearly physicals. Several board members suggested that the gap could be closed by communication and educational opportunities in the communities in which they live and places they frequent.

The ten-year estimate shows that the number of healthy/acute members is projected to decrease 2.8% and the overall risk factor for the Plan's population will increase from 1.00 to 1.09. However, it was also noted that the trend three years ago was much higher.

Next steps include defining the metrics the Plan will use to measure improvements in the health risk profiles and set targets for each metric to monitor the progress. Segal staff stated that within the next year, they will compare 2012 and 2013 data to determine the area with the greatest movement.

Agenda Item – Dashboard Report (Attachment 10)
Presented by Chris Mathews, The Segal Company

Mr. Mathews provided an overview of Segal's Healthcare Dashboard report. He also outlined strategic opportunities for the Plan to increase member awareness of their health status and to improve their health through programs, medication adherence and treatment compliance and to impact positive trends in utilization management.

The Dashboard report provides a mechanism to track claims, trends, compare utilization metrics with benchmarks and targets, and the population's health status. The information in the report is derived from the medical and pharmacy claims experience and benchmark data is provided on a regional basis. The strategic planning work group has discussed this type of report as a way to monitor the Plan on an ongoing basis. One board member stated that it would be valuable to drill down into the data further to determine if there's a correlation between completing one of the wellness activities and associated costs, i.e. choosing a primary provider and ER utilization.

The Board also discussed the quality of care being provided to Plan members and reviewing and comparing the clinical performance and data within the state, as well as to other states. It was also suggested that the report include gaps in care and in order to compare numbers in the future. Dr. Newton is concerned with quality by region and stated that a report on quality would be released soon and that he would follow up by providing copies to the Board.

The Board agreed that the Dashboard report was very useful and that discussions regarding content should continue.

Agenda Item - Board Process Discussion Follow-up (Attachment 11)
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance

At the May meeting, the Board discussed the Plan developing a process allowing individuals and groups to address the Board regarding changes in benefit coverage. Staff proposed a process that would require groups to complete a Request Form and submit it to the Plan and Board. Plan staff would review the request and provide it to the subcommittee members for their review. The Chair of the subcommittee would make a recommendation to the Board Chair and the Board agenda would be set according to the Chair's decision.

If the Board agreed with the process outlined, the next steps would include identifying a subcommittee and Chair, identifying the frequency of subcommittee meetings, drafting a resolution, charter and policy and vote on these steps at the next Board meeting. The frequency of subcommittee meetings would be determined by the number of requests received to address the Board. Currently the Chiropractic and Autism groups have initiated informal requests. The current statute states that the Treasurer has the authority to set benefits and that no one can be assured they will be able to address the Board.

There was concern by the Board that this would create an opportunity for these groups to take Board decisions to the Office of Administrative Hearings. There was also a question as to whether or not criteria should be established regarding which benefit requests would be considered. Time commitment for the process was also a concern. Mr. Holton suggested that Plan staff develop appropriate timing and frequency of when individuals and/or groups can be included on the Board agenda. Mr. Holton and Ms. Crabtree will take the Board comments and concerns into consideration and amend the current proposal. The revised document will be emailed to the Board.

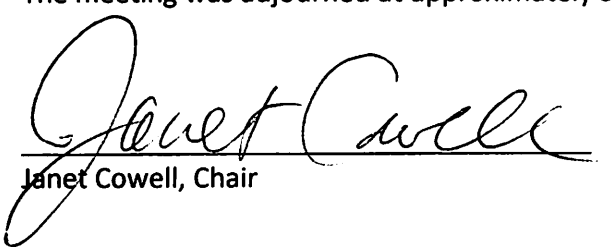
Agenda Item - Strategic Planning
Presented by Strategic Planning Workgroup

The Board will continue to discuss the strategic plan beginning with the environmental scan and whether the Plan really has a fiscal cliff. The Board must consider whether there is an artifact to the current surplus and the impact of the 8.5% trend assumption. In addition, the Board must consider the impact of the ACA on the Plan.

Agenda Item – Wrap Up

Upon a recommendation by Dr. Cunningham and seconded by Ms. Hargett, the Board voted unanimously to adjourn the meeting.

The meeting was adjourned at approximately 3:15 p.m.



Janet Cowell, Chair