Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
September 27, 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, September 27, 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
Bill Medlin
Vice-Chair Genell Moore
Warren Newton, MD
Charles Johnson
Barbara Baldwin attending for Art Pope

Members Absent:
Noah Huffstetler
Art Pope

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

Department of State Treasurer Staff: Andrew Holton, Joan Fontes

Guests: Ginger Austin, Barbara Baldwin, Janelle Cain, Charlotte Craver, Pam Deardorff, Carol Durrell, Pam Deardorff, Larry Earle, Marge Foreman, Bob Fronius, Charla Katz, Jack Kenley, Mike Laraway, Rich Lomax, Jackie Matis, Lanier McRee, Tim Moorhead, Wadida Murib-Holmes, Keith Peele, Lacey Presnell, Tom Gualtieri-Reed, Ed Regan, Joe Sheehan, Lynn Spragens, Chuck Stone, John Thompson, Kim Turk, Mark Werner

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 – Introduction of New Staff

Ms. Moon introduced Nidu Menon, Ph.D., Director of Integrated Health Management. Dr. Menon joined the Plan on September 3, 2013.

Agenda Item – Review of Minutes – July 27 and September 5, 2013 (Attachment 1)
Presented by Janet Cowell, Chair

Following a motion by Warren Newton and seconded by Paul Cunningham, the Board voted unanimously to approve the July 27, 2013 regular meeting minutes as written.

Following a motion by Bill Medlin and seconded by Warren Newton, the Board voted unanimously to approve the September 5, 2013 teleconference meeting minutes with correction of typographical errors to page 2.

Agenda Item – Financial Report (Attachment 2)
Presented by Mark Collins, Financial Analyst

FY 2012-13 Final Financial Results
The year-end Plan revenue was $2.96 billion, an increase of approximately $24 million over the authorized budget amount. Total plan expenses were $173.6 million less than budgeted and the ending cash balance was $783.4 million, $197.3 million more than budgeted. The adjusted variance report results were similar, with revenue $29 million over the authorized budget amount and total Plan expenses $158.5 million under budget. With adjustments, the ending cash balance was $773.6 million, approximately $187 million more than budgeted.

The per member per month (PMPM) adjusted variance analysis demonstrated savings on the medical claims side, as well as for administrative expenses. The net income of $33.46 PMPM was significantly better than the budgeted amount of $10.35 PMPM. The year-to-date expenditure trend and the allocation of claims expenditures followed a similar pattern to what the Plan has experienced over the past year.

The financial performance highlights for Fiscal Year 2012-13 included Plan expenses that were 6.1% lower than the projected amount. The PMPM expenses were 6.8% less than projected. The year-end ending cash balance of $783.5 million equates to approximately 15 weeks of operating expenses and exceeds the 9% targeted reserve benchmark established by the Board. In comparison, the 2011-12 ending cash balance of $502.2 million equated to approximately 9 weeks of operating expenses. The net income and ending cash balance have both increased steadily since Fiscal Year 2009-10, when Plan expenses exceeded revenue for the year.

In response to a question by the Board regarding member cost sharing, Ms. Moon stated that the contribution rate from members has been between 15-18% on the premium side. The Plan can produce a report that provides a general idea of out of pocket member costs. She stated that in FY 2009, the Plan made no benefit changes and that $250 million was appropriated to the Plan from the General Assembly. The members did not bear the cost of the shortfall that year. However, there were significant changes to the benefit structure, including increases in member cost sharing and premiums in FY 2010 and again in FY 2012. The Plan will provide a report to the Board on the historical cost structure, including member cost sharing information.

In comparing the cost sharing of Plan members to other insurance companies, Ms. Moon stated that the Plan tended to be on the higher side several years ago but assumes that gap has closed over the past year or two given there have been no additional increases in copays, deductibles and coinsurance maximums since September 2011 and none are currently planned for this biennium . With the economy improving, members may be able to seek more care and Plan expenses may increase, although medical costs and member behavior are hard to accurately predict.

From a financial standpoint, the Plan is doing well and a healthy cash balance is important if utilization increases. From a healthcare outcomes perspective, however, the Plan is concerned that members are not using services and seeking appropriate care. For example, some members categorized as "healthy" have no claims experience and that could be a concern.

4th Quarter Forecast Update

For Fiscal Year 2012-13, pharmacy and medical claims expenditures were fairly close to the projections from the 3rd quarter actuarial forecast. Projections of the fiscal year ending cash balance have steadily increased over the past year of forecast updates, and the actual fiscal year ending cash balance was nearly $30 million higher than projected in the 3rd quarter update.

Many forecast assumptions were maintained from the 3rd quarter update to the 4th quarter update, including the trend and membership assumptions. Changes and revisions in the 4th quarter update included a rebasing of the pharmacy claims to use the past six months, rather than the past 12 months, due to an increase in the pharmacy trend in more recent months. The projected pharmacy rebate amounts also increased.

Mr. Collins provided a comparison of the 3rd and 4th quarter updates for the short plan year. Projections of revenue and claims expenses increased slightly in the 4th quarter update. The net income and ending cash balance remained the same between the forecasts. Relative to the 3rd quarter forecast, projected medical claims expenses for the short plan year decreased by about $12 million and projected pharmacy claims increased by about $12 million.

Looking at the 2013-15 Fiscal Biennium, the 4th quarter forecast projects that the cash balance will decrease during the short plan year, increase slightly in 2014 and decrease in the first half of 2015. Unlike recent years when revenues have exceeded expenses, the Plan would use cash on hand to pay a portion of Plan costs, reducing the cash balance over the biennium.

The 2015-17 Fiscal Biennium outlook projects a starting cash balance of approximately $689 million, which exceeds the 9% target reserve amount and equates to approximately 11 weeks of projected Fiscal Year 2015-16 operating expenses. The 4th quarter update projects 7.64% premium increases in January 2016 and 2017, which is lower than the previous projection of 8.22%.

July 2013 Financial Report

Mr. Collins stated that the 3rd quarter forecast update will be used as the certified budget. This decision, made in consultation with Fiscal Research, recognizes that the General Assembly had access to and used the 3rd quarter update when it made final funding decisions for the Plan in July 2013.

July revenue was $10 million above the budgeted amount and claims expenditures were $6.3 million more than projected through July. Administrative expenses were $0.2 million less than budgeted. The Plan's ending cash balance for July was $751.4 million. Year-to-date allocation of claims expenditures for July was as follows: Pharmacy 26%; Inpatient facility 17%; Outpatient facility 25%; Professional 29%; and other 3%.

Noting that claims expenses exceeded projections in July, Ms. Moon reminded the Board that the coinsurance maximum and deductibles were cut in half in the short plan year and members will reach those levels more quickly. Utilization patterns, therefore, could change during the short plan year. The Plan will continue to closely monitor pharmacy and medical claims to see if spending levels remain above projections.

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

Under the Affordable Care Act (ACA), individual and small group health plans are required to offer a comprehensive package of services – Essential Health Benefits (EHB). As a large employer plan, the State Health Plan is not required to cover EHB but if they do, annual or lifetime dollar limits cannot be imposed. Actuarially equivalent treatment or service limits, however, may be applied.

Each state selects a "benchmark plan" which in North Carolina is the Blue Cross Blue Shield Blue Options PPO plan. As a self-funded benefit plan, the Plan doesn't have to follow the NC benchmark plan and can choose another plan to follow.

In July, Plan staff recommended removing dollar limits on essential health benefits however the Board had concerns about the ability to control costs especially around hearing aids. Following discussions with BCBSNC, Plan staff recommended that the dollar limits be removed and replaced with the previously proposed quantity limits. In addition, reimbursement for hearing aids can be limited to the usual, customary and reasonable (UCR) amounts with the balance billed to members.

Plan staff continues to recommend removing the dollar limit on cranial bands and replacing it with a quantity limit of one per lifetime. In addition, the Plan recommended removing the combined lifetime dollar limit for infertility and sexual dysfunction and establishing an infertility lifetime quantity limit of three ovulation induction cycles and associated services; coverage for sexual dysfunction would be unlimited.

The total estimated annual cost for all proposed coverage changes would be approximately $2.7 million.

The options were to change the coverage on EHB as proposed, eliminate or drop current coverage (and risk losing Grandfather status for the 80/20 and 70/30 plans), or to choose a benchmark plan that does not include coverage of some or all of these services.

In response to a question about the low cost associated with the sexual dysfunction change, Ms. Crabtree stated that the Plan doesn't cover sexual dysfunction drugs.

The Plan recommends that the Board approve the proposed coverage changes to eliminate dollar limits on EHB, effective January 2014.

Following a motion by Paul Cunningham and seconded by Genell Moore, the Board voted unanimously to approve the proposed coverage changes.

Agenda Item - Board Process Discussion Follow-up – Requests to Consider Benefit changes (Attachment 4)
Presented by Lotta Crabtree, Interim Deputy Executive Administrator and Director of Contracting and Legal Compliance and Andrew Holton, Deputy Chief of Staff and Legal Counsel

At the July meeting, Board members discussed a process by which groups and individuals could address the Board to propose benefit coverage changes. The Board requested that Plan staff simplify Step 2 of the original process recommendation.

The requestor would complete a form including name, requested change, rationale, effective date, supporting documentation and contact information and send it via email to the Board/Plan. The Plan would provide the forms to the board as they are received. The November 2013 Board meeting will be used to review requested changes. It was suggested that beginning in 2014, requests would be reviewed annually at the July Board meetings.

Persons requesting to address the Board may be allowed to speak or present at the discretion of the Treasurer with input from Plan staff. The Treasurer could also invite persons requesting changes to speak at the annual meeting. Ms. Crabtree presented proposed additions to the bylaws.

The Plan also frequently receives requests from vendors to meet with Plan staff. An informal process is currently in place but a more formalized process could be instituted. Both processes could be added to the Plan's website.

Changes brought to the Board in November 2013 and July 2014 would not be effective until 2015 since the benefit structure is already set for the upcoming plan year.

Following a motion by Dr. Newton and seconded by Dr. Cunningham, the Board voted unanimously to approve the process for requests to consider benefit changes.

Following the vote, it was suggested that the word "individuals" replace "people" under the *Proposed Board of Trustees Policy* on page 2 of the presentation.

Agenda Item – Implementation Update (Attachment 5)

Communications Update
Presented by Caroline Smart, Director of Health Plan Operations

Health Benefit Representative (HBR) training sessions were completed this summer with over 1,500 participating in fifty-three counties and two webinars. Of those who attended more than 85% completed a survey and 80% either agreed or strongly agreed that the training was helpful.

Newsletters and Decision Guides were mailed to active and non-Medicare retiree members in August and mid-September. Approximately 20,000 health assessments have been completed, a 45% increase since July. Over 34,000 unique visitors clicked on the Open Enrollment web page and the first member video received more than 15,000 clicks. Forty-five information sessions and enrollment tours are scheduled across the state, in addition to 12 member webinars.

Decision guides and newsletters were also mailed to Medicare primary retirees and more than 7,000 attended outreach events. Twenty-eight percent of those attending completed a survey and comments indicate a positive response to the Medicare Advantage options being offered. Approximately 134 Medicare retiree outreach events are scheduled across the state and in Virginia, South Carolina and Florida during September and October.

A question was asked regarding a contingency plan for those members who miss the October 31 enrollment deadline. Ms. Smart responded that she wasn't prepared to address an exception process at this point but stated that a cut-off date would be established.

Member Questions Regarding Network Coverage
Presented by Caroline Smart, Director of Health Plan Operations

Two questions most consistently asked by members relate to network coverage and provider accessibility. Active and non-Medicare primary members have expressed concern regarding the lack of Blue Options designated facilities in the eastern part of the state and whether or not members can only use the designated facilities. Medicare primary member questions center around whether or not their provider is in the Humana or UnitedHealthcare network. They have also expressed concern about whether their provider will accept Medicare Advantage and file their claims.

Representatives from Blue Cross Blue Shield of NC, Humana and UnitedHealthcare addressed concerns.

Blue Options Designated Providers (Blue Cross Blue Shield of North Carolina
Presented by Jack Kenley, Vice President Sales and Marketing, State Health Plan Executive

Members in the Enhanced plan and CDHP can reduce their costs if they use a Blue Options designated provider. The criteria used to determine whether a hospital is designated are quality outcomes, cost efficiency and accessibility. Designated specialists are in the areas of general surgery, OB-GYN, gastroenterology, orthopedics, cardiology and neurology. Members are incented to use designated providers through reduced copays or health reimbursement account (HRA) credits. They may, however, choose to use non-designated providers but will not receive copay reductions or HRA credits.

Designated providers go through an annual review to determine if the measures are still being met. The Centers for Medicare and Medicaid Services (CMS) has eleven quality core measures and a hospital's quality score is based on these measures. If they are below the 66th percentile, they will not be chosen as a designated provider. Following the quality evaluation, BCBSNC reviews cost efficiency through claims data. Providers must score at or below 40%. A cluster analysis is also conducted that includes bed size, utilization volume, and diversity of services. There are 6 peer groups and they do not look just at region. Outside of the annual review, providers can request to meet with BCBSNC network staff to discuss opportunities to have their designation changed.

A question was asked regarding the accuracy of the specialty area of the providers on the designated list. BCBSNC stated that a provider may end up as designated when they're not in one of the six specialties and that they are working on a process to minimize those errors. In addition, some providers may be double boarded; when a misclassification is brought to BCBSNC's attention, it is corrected.

Humana Medicare Advantage Providers
Presented by Tim Moorhead, Market Vice President, North Carolina, Senior Products and Keith Peele, Director of Contracting, North Carolina

Humana continues to reach out to providers not in their network via telephone, onsite visits and through community forums throughout the state. Meetings with the major health systems have occurred and anticipated contracts with new hospital systems may be finalized soon. In person visits to interested providers are occurring to ensure that plan benefits are well understood and whether or not they are willing to accept Plan members. Humana is visiting offices of providers who processed member claims in the past year but who are not in the network.

Humana will be up and running on January 1 and have staff available to address potential issues. Staff will be on the ground in Greenville on January 2.

UnitedHealthcare Medicare Advantage Providers
Provided by John Thompson, Vice President, Client Development, UHC Retiree Solutions

In addition to attending retiree meetings, UnitedHealthcare (UHC) reviewed the last twelve months of claims data and reached out to providers who processed Plan member claims. UHC reached out to 117 hospitals and currently have contracts with 76 of them. They are conducting in-person meetings with providers and have eight offices in North Carolina. All provider representatives are located in the state and a customer service center is located in Greensboro.

UHC has focused on educating provider staff and members to the fact that the Plan members are in a group UHC product. To alleviate the burden on retirees, UHC is calling providers on their behalf and then reaching back out to the member regarding questions about the network.

Mr. Chuck Stone, State Employees Association of NC, stated that it would be helpful for the Medicare Advantage vendors to have a communication system in place between provider offices and the Plan to address urgent issues. Mr. Thompson responded that a dedicated team in the customer service center in Greensboro could address urgent issues and that they also have a tracking system for member satisfaction.

HBR Implementation Satisfaction Survey Results
Presented by Caroline Smart, Director of Health Plan Operations

The Plan conducted an HBR satisfaction survey and 50 out of 492 training participants responded. The majority (87.5%) found the implementation of the newsletter helpful while 48% answered "no" to the engagement of the Account Manager (Benefitfocus). The Plan is working to resolve some outstanding issues with NC Flex implementation and Ms. Smart will be at Benefitfocus during the first week of October to assist with calls and outstanding issues.

Communicating with retirees has been a primary focus since most of the questions are coming from that segment of the population. Reaching out to retirees to ensure they understand the process for enrolling and the need to make a choice has been a primary focus for the Plan. Suggestions for further communication with retirees including local newspapers, television and other news outlets were discussed.

Agenda Item – Express Scripts, Inc. FY 2012-13 Pharmacy Report (Attachment 6)
Presented by Tracy Stephenson, Director of Pharmacy Benefits and
Jeff Scott, Senior Director, Express Scripts, Inc.

Mr. Scott presented the historical performance of key metrics by quarter and stated that the PMPM costs have been stable over the past few years. The Plan's generic prescription fill rate is 80% and several new generics coming out in 2014 could increase the generic prescription rate. The Plan's generic fill rate is a value driver for the Plan; a 1-2% difference in generic fill rates drive savings. It was noted that a 1% change in the generic rate is equivalent to approximately $17 million and for every 1% increase, the savings are approximately 2.5% of total Plan cost. The member cost share would be reduced 6%.

The Plan PMPM cost trend on specialty drugs is 12.1% compared to a 2.5% trend on non-specialty drugs. Brand inflation is the largest cost driver of the PMPM costs and discounts are the largest cost saver of the Plan PMPM cost. The Plan achieved an additional $12.1 million in savings in pharmacy clinical programs over the previous fiscal year.

Future challenges include the management of specialty medications, inflation on brand drugs, high cost generics and coupon cards.

Agenda Item – State Health Plan Audits (Attachment 7)

Audit Process
Presented by Tracy Stephenson, Director of Pharmacy Benefits

The Plan conducts audits to ensure contractual compliance, identify pricing errors, assess vendors' internal controls, validate that the benefits are being administered correctly, validate vendor performance guarantees and comply with State laws and regulations. Ms. Stephenson discussed the audit workflow from the audit plan, including the scope and assessment of data needs to post audit follow up, which can include the monitoring of a correction plan and fund collection for miss performance guarantees.

Medical Claims
Presented by Caroline Smart, Director of Health Plan Operations

The objective of the medical claims audit is to ensure that claims are accurately processed and paid by the Third Party Administrator (TPA). Thomas & Gibbs, PLLC performs quarterly audits of random samples of medical claims and provides an annual report at the end of each year. In the 2012-13 fiscal year, no errors were noted in the first quarter and for the year, the financial accuracy rate was 99.8%. Most of the errors noted related to Medicare coordination of benefits claims. When errors are found, the Plan works with the TPA to develop a corrective action plan and performs several follow-up reviews throughout the year.

The quality management team's review of the TPA was redesigned and the following processes were reviewed during the past fiscal year: financial processing services - check deposit, appeals, debt set off, Medicare claims processing accuracy, and enrollment retro-termination processing. The most significant process improvement was the verification of Medicare primary members. The Plan is working with HBRs to assist in providing information on terminated members.

BCBSNC Administrative Costs
Presented by Mark Collins, Financial Analyst

The purpose of the annual audit is to determine the validity of BCBSNC's administrative charges and to ensure that the Plan hasn't been charged for unallowed costs.

In 2011-2012, the Plan's auditor reviewed 80 separate transactions totaling approximately $10 million in costs. BCBCNC's incurred costs exceeded the cost plus cap for 2011-12 and administrative fees charged by BCBSNC equaled the cap of $115.2 million.

Unallowed costs identified in the 2011-12 audit included a portion of BCBS lobbying activities that may have been charged to the Plan and sponsorship costs. BCBSNC modified the accounting process for unallowed items; however, there was no reimbursement to the Plan because BCBSNC administrative costs exceeded the cost cap under the contract. The final audit of the cost plus contract with BCBSNC, which ended June 30, 2013, will be conducted this fall.

ActiveHealth ROI Validation
Presented by Mark Collins, Financial Analyst

The purpose of the annual audit is to validate the return on investment (ROI). Actual claims costs are compared to projected costs and the difference is compared to ActiveHealth Management (AHM) fees to produce the ROI. The audit results for calendar year 2012 were submitted to the Plan in July 2013. The results indicated a savings of $142.7 million and the calculated ROI was 5.74:1, exceeding the targeted ROI of 3:1.

Pharmacy
Presented by Tracy Stephenson, Director of Pharmacy Benefits

Ms. Stephenson reported that there are three types of audits conducted on the PBM, the pharmacy financial audit, pharmacy rebate audit and the pharmacy claims audit.

The purpose of the pharmacy financial quarterly audit is to verify appropriate adjudication of pharmacy claims by the pharmacy benefit manager (PBM), ExpressScripts, Inc. (ESI) and to determine if financial performance guarantees are met. The Plan's actuarial consultant, Segal, performs a biweekly analysis of claims to determine the accuracy of pricing and invoicing. The Fiscal Year 4th quarter audit is due at the end of September. For previous quarters, there were no findings in three of the five audit components: invoice reconciliation, claims average wholesale price (AWP) and dispensing fees. ESI paid the Plan $2.5 million for a shortfall in financial discounts.

The purpose of the pharmacy rebate audit is to verify that the PBM has met its contractual requirements surrounding rebates. Segal will review the contracts between the PBM and major pharmaceutical manufacturers to ensure that 100% of the rebates are passed back to the Plan as required in the contract. The Plan is finalizing the contract with Segal and anticipates completing the rebate audit by early 2014.

The purpose Pharmacy claims audit is to determine if claims are appropriately processed and paid by the PBM and whether the claims processing error rate of no more than 1.5% is met. The audit is conducted by Thomas & Gibbs, CPAs, LLC. Approximately 200 claims are reviewed annually and no findings have been reported since 2002.

Early Retiree Reinsurance Program
Presented by Linda Forsberg, Program Manager

The Early Retiree Reinsurance Program (ERRP) was one of the components of health care reform. The Plan received approximately $87 million in reimbursement from the Federal government for early retirees with incurred claims of $15,000 or greater in 2010 and 2011. The Centers for Medicare and Medicaid Services (CMS) are conducting an audit to ensure that the Plan met the program requirements and received appropriate reimbursements.

The program requirements audit was completed in 2012 and the claims audit is scheduled to be conducted in October 2013. To date, no findings have been reported.

In response to a question regarding whether or not the Plan changes auditors on a regular basis, Ms. Moon stated that the current contract terminates at the end of 2014. Typically, this procurement area produces a low number of bidders.

Agenda Item - Strategic Planning (Attachment 8)

Facilitator Report
Presented by Lynn Spragens and Tom Gualtieri-Reed, Spragens & Associates

Ms. Spragens and Mr. Gualtieri-Reed met with members of the Board and Plan staff to begin the process of developing and implementing the strategic plan. The strategic plan should be sustainable through Board turnover and environmental changes. Board members recognize that strategic planning is ongoing and that principles, by which the strategic plan is developed, should be created.

Segal Dashboard
Presented by Mona Moon, Executive Administrator

The Healthcare Dashboard developed by Segal is nearly finalized and was been presented to Plan staff and the Board work groups to solicit feedback and suggestions. Eight panels within the report will be incorporated into the strategic plan. The goal is not to depend solely on the dashboard management report but to manage the data in-house. The Plan will develop a timeline and the frequency in which the Dashboard Report will be presented to the Board in the future. Ms. Moon stated that while the Board is working on its strategic plan, the Department of State Treasurer also has a strategic plan within which the Plan is working.

Board members commented that it's important to review Plan data and develop priorities to incorporate in the strategic plan. It was also mentioned that the primary focus has been on cost and that quality and member experience have been overlooked. The quality of care for members should be a priority.

The Dashboard report included a spotlight on asthma. Three years of claims data was used in the analysis. A steady increase in the incidence of newly diagnosed members is cause for concern. Patient medication compliance for members with asthma is well below the norm. They also use the emergency room at double the rate of the total population. Priorities will change over time and the Board suggested a regular review of the Dashboard report and focusing on one area each year where gaps in care occur.

Workgroup Discussion
Presented by the Strategic Planning Workgroup

The workgroup determined that priorities need to be established and the immediate focus should be on quality of care and member experience.

The Communications work group discussed some of the issues regarding the upcoming enrollment process. They also reviewed the satisfaction survey results and discussed whether or not the survey might provide an opportunity to establish a baseline of the information the Board wants to collect.

The Legislative committee did not meet in September.

The Forecasting and Financial workgroup discussed the frequency and content of audit report presentations to the Board. Ms. Moon stated that the Board should determine the level of detail they want and that it would ultimately be up to the Treasurer to determine what is brought to the Board. Several Board members stated that the summaries provided at the meeting were adequate and that more detail wasn't needed. The Plan will continue to provide summaries to the Board.

Agenda Item – Wrap Up

A resolution acknowledging Michele Shaw's participation on the Board was read. Upon a motion by Ms. Hargett and seconded by Mr. Medlin, the Board voted unanimously to approve the resolution.

Upon a motion by Ms. Hargett and seconded by Bill Medlin the Board voted unanimously to adjourn the meeting.

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

Janet Cowell, Chair