Board of Trustees
State Health Plan for Teachers and State Employees
Department of State Treasurer
January 31, 2014

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, January 31, 2014, at the State Health Plan, 4901 Glenwood Avenue, Suite 300, Raleigh, NC 27612.

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

State Health Plan Staff: Mona Moon, Lotta Crabtree, Glenda Adams, Mark Collins, Thomas Friedman, Beverly Harris, Beth Horner, Nidu Menon, Sally Morton, Lorraine Munk, Caroline Smart, Tracy Stephenson

Department of State Treasurer Staff: Andrew Holton, Fran Lawrence, Tony Solari

Guests: Mike Laraway, Nate Lewey, Christa Klein, Janelle Cain, Michelle Tallman, Charlotte Craver, Neal Alexander, Chuck Stone, Andy Howell, David Vanderweide, Pam Deardorff, Toni Davis, Suzanne Beasley, Ann Marie Hubbard, Ed Regan, Steve Daly, Wadida Murib-Holmes, Jeff Scott, Heather Freeman, Rick Johnson, Bill Sucic, John Sparrow, Sherri Harmon-Butts, Jack Kenley, Lacey Presnell, Tom Gualtieri-Reed, Charla Katz, Mary O'Neill, Kim Turk, Marge Foreman

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.

Agenda Item – Review of Minutes – November 22, 2014 (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 – 2014 Benefits – Implementation Update (Attachment 2)
Presented by Caroline Smart, Director of Health Plan Operations

Open Enrollment Final Results

Based on total Plan membership, approximately 15% of all members chose one of the Medicare Advantage Plans and 5% chose the Traditional 70/30 plan for Medicare members. Thirty-nine percent of members chose the Enhanced 80/20 plan and 3% chose the Consumer-Directed Health Plan (CDHP). The remaining 38% of members chose the Traditional 70/30 plan for non-Medicare members. Of the 127,147 total Medicare subscribers, 76% chose one of the Medicare Advantage plans and 24% chose the Traditional 70/30 plan.

Approximately 306,500 members selected a primary care provider (PCP) with 73 selecting an "unknown" PCP. Blue Cross and Blue Shield of North Carolina (BCBSNC) is researching the "unknown" PCPs. Regarding whether members are actually seeing the providers they chose, the Integrated Health Management (IHM) team will be following up on the claims information from BCBSNC. Overall visits to selected PCPs appeared to be rather low and Ms. Smart pointed out that the reporting period was July through October 2013 when many members had not yet selected a PCP. The Plan would like to see less visits to urgent care centers with the goal of members visiting and establishing relationships with their designated PCP and will continue to track this information.

A question was asked as to whether visits to another physician in the office of a selected PCP could be captured. Ms. Smart will see if that information is available.

As of December 31, 2013, approximately 214,500 health assessments were completed. A question was asked regarding the number of members who selected a plan but didn't choose to participate in the incentive options. Ms. Smart will provide that information.

Open Enrollment Exceptions

Active employees who want to submit exceptions must do so through their agency health benefit representative (HBR). The exceptions process has been communicated to HBRs and is also posted on the Plan's website. It was noted that members are held harmless in the event of an HBR mistake. Retiree exception requests are submitted directly to the Plan and, in the past, retirees could enroll in a plan or drop coverage without a qualifying event. As of January 1, 2014, election changes are subject to qualifying events as defined by federal law.

On average, the Plan receives approximately 40 exception requests per week and they are generally resolved within three business days. However, from November 18, 2013, to January 14, 2014, the plan received more than 2,600 exception requests. Each exception request was then reviewed by the Director of Health Plan Operations. Approximately 90% of the 2,600 exceptions were approved.

A question was asked regarding how the Plan is handling the increase in calls. Ms. Smart stated that four temporary assistants were hired in the fall to assist with open enrollment and have been retained to assist with member calls. In addition, numerous Plan staff fielded overflow calls during the past two months. Ms. Moon stated that the Plan continues to work with its vendors to identify and resolve issues in order to meet member needs. She also noted that educational sessions will be ongoing, especially for the retiree population. An update on educational outreach will be provided at the March meeting.

Agenda Item – Hearing Aid Benefit (Attachment 3)
Presented by Caroline Smart, Director of Health Plan Operations, and Jack Kenley, Blue Cross and Blue Shield of North Carolina

Follow-up on ACA Essential Health Benefits Discussion

At the July 2013 board meeting, Plan staff discussed Essential Health Benefit requirements under the Affordable Care Act. To bring benefits into compliance, Plan staff recommended removing dollar limits on essential health benefits. The board voiced concerns about the ability to control costs especially around hearing aids if dollar limits were removed. At the September 2013 board meeting, 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 could be limited to the usual, customary and reasonable (UCR) amounts with the balance billed to members. BCBSNC is now concerned that UCR is not the best way to limit costs and is proposing a fee schedule instead.

Reimbursement Methodology

BCBSNC analyzed claims data to develop a pricing schedule to support the Plan and all other lines of BCBSNC business. It was determined that a fee schedule was the best way to address provider reimbursement for costs associated with hearing aids. This solution serves the purpose of addressing costs and better supports the reimbursement aspect. BCBSNC plans to implement the schedule April 1, 2014, and will communicate the change to providers. Over the past 3 years the Plan has had 400 claims and paid out approximately $400,000.

BCBSNC will provide the relative value schedule and the timeline of how often the fee schedule is reviewed.

Agenda Item – Pharmacy & Therapeutics Committee Meeting Summary (Attachment 4)
Presented by Dr. Sally Morton, Clinical Pharmacist

Dr. Morton stated that the Pharmacy & Therapeutics (P&T) committee meeting summaries are included in the board books to provide an overview of the P&T committee recommendations, including medication tier placement for the 70/30 and 80/20 plans, prior authorization and step therapy programs, quantity limits on medications, etc. The committee is composed of NC pharmacists and other health care providers who see and treat Plan members. North Carolina is one of the few state health plans that has its own P&T committee.

The pharmacy benefit tier structure was reviewed and Dr. Morton noted that some new higher cost generic drugs are now in Tier 2. ACA preventive medications must be covered at 100% on the 80/20 and CDHP plans but not on the 70/30. Some of the ACA preventive medications previously were in Tier 1 (for example, generic oral contraceptives) and the cost of coverage for those drugs could probably be determined after three months of claims data is collected. All drugs on the ACA list require a prescription in order to be covered at 100%.

In the CDHP, members pay 15% of the cost of the drug after the deductible is met. For certain preventive medications used to prevent and manage chronic conditions, the Plan waives the deductible and the member pays the 15% coinsurance. The member's health reimbursement account can be used to pay for these medications.

It was noted that many Plan members who take advantage of the low cost generic drug plans at various pharmacies may not show their insurance cards. While it isn't required and doesn't save the member any money, it would provide valuable information to the Plan including pharmacy utilization and medication adherence data. The Plan will include information on the importance of members using their insurance cards when obtaining all prescriptions in upcoming member communications.

The board raised a question about why the Plan doesn't have an overall $4 generic copay. The Plan can review the cost impact of changing the $12 generic prescription amount to $4; however, per Ms. Moon, a $2 reduction in copay would cost the Plan approximately $12 million so a drop to $4 would be very significant and the Plan would have to make up that loss. The Plan needs to look at the Tier 1 copay in terms of a broader pharmacy strategy where generic medications for chronic diseases may be incentivized with lower copays possibly if members participate in disease and case management.

The board suggested including a question about generic prescriptions and insurance card usage on the member survey. It was also suggested that the Plan consider the possibility of educating pharmacies to ask members for their cards.

The formulary management process begins with the Pharmacy Benefit Manager (PBM) providing manufacturer contracting and clinical reviews to the Plan. The P&T committee reviews the clinical information and makes recommendations for tier placement and utilization management programs. The Plan implements the tier placement and utilization management programs based on the P&T committee recommendations and cost analysis.

Dr. Morton reviewed updates to the current utilization management programs presented at the November P&T meeting and the cost impact and timing of several new program recommendations. New program recommendations are always posted to the Plan's website at least 60 days in advance as a way for providers to offer comments. The Plan is working on a communication plan for the preferred insulin step therapy program which will be implemented in July. Approximately 7,000 members will be affected and the projected Plan savings is $6 million.

The P&T committee constantly reviews new drugs on the market quarterly and several of these drugs and their tier placement were discussed at the November P&T committee meeting. The Plan will continue to include P&T committee meeting summaries in the board packet and post to the Plan's website.

Agenda Item – Follow-Up – Benefit Change Requests (Attachment 5)
Presented by Mona Moon, Executive Administrator; Tom Friedman, Legislative Liaison/Health Policy Analyst; Mark Collins, Financial Analyst

At the November 22, 2013, meeting, several groups presented benefit change requests to the board. Two of these requests were coverage for autism spectrum disorders and reduced copays for chiropractic services. House Bill 498, which addresses autism coverage, passed the House in the long session and was referred to the Senate Committee on Insurance. As the Plan works to develop a benefit for the coverage of autism to present to the board, staff will be meeting with two groups who have expertise in the treatment of autism, as well as BCBSNC and ValueOptions. The General Assembly could move forward with an autism benefit in the short session and the Plan may consider language revisions based on the language in the bill.

The board asked for the number of Plan members who would be covered and Ms. Moon stated that the Plan will get that data. She noted that not all claims list autism as a diagnosis and thought the number might be well less than 10,000 and possibly less than 1,000. The financial impact projects plan costs to be approximately $3-5 million in 2014-15 and $6-13 million annually in the long term.

The board agreed that the Plan should move forward with the development of benefit language rather than wait for the General Assembly to pass a bill. Ms. Moon stated that if benefit coverage would be effective in 2015, it was important to move quickly to ensure that operational details could be worked out. The Plan will provide a draft of the language at the March meeting.

The Chiropractic Association requested that the board consider reducing copays for chiropractic care to the primary care copay level. They stated that the Plan could see a reduction in overall costs if copays were reduced based on an earlier study of Plan data. Senate Bill 561 was referred to the Senate Committee on Insurance.

Following the presentation at the November meeting, the Plan requested that Segal review the data to determine the cost impact and potential long term savings. They could not definitely conclude that savings would exist with the copay change. Plan staff also consulted with clinicians and researchers in Chapel Hill to validate the data and following that meeting, questions still remain regarding the study results and conclusions.

A question was asked regarding whether or not there was the possibility of a "diagnosis dependent" copay reduction. For certain conditions, it might be appropriate to seek chiropractic care. Mr. Collins stated that the Plan had not researched that option and that risk factors would have to be considered. The coordination of care function of the primary care physician was also mentioned as a concern.

Ms. Moon stated that it's difficult to make a recommendation for chiropractic care without outcome information. Chair Cowell asked the board if they want to pursue reducing the copay in light of the number of questions that remain. The board agreed that more data from external groups is required before an informed decision can be made.

Agenda Item – Financial Report (Attachment 6)
Presented by Mark Collins, Financial Analyst

<u>December 2013 Financial Report</u>
Plan revenue through December was $1.540 billion, $64 million over the certified budget amount. Total claims costs for the Plan were $30 million less than budgeted. Mr. Collins noted that the Plan continues to maintain a strong cash position with a balance of $838.5 million at the end of December, $143.5 million more than budgeted.

However, he also stated that the adjusted variance report may provide a more complete picture of Plan finances due to several factors that impacted December finances. First, a large amount of January premium revenue was received in December. On the expenditure side, the monthly administrative payment to BCBSNC was paid in early January rather than in December. The Plan also anticipated paying three pharmacy invoices in December and the last one was instead paid in early January. As adjusted, net claims payments were slightly higher than projected and the ending cash balance was approximately $51 million more than budgeted. Overall, the Plan financials still remained favorable related to projections.

The per member per month (PMPM) net claims payments on the adjusted variance analysis were $1.29 more than the certified budget amount, and administrative expenses were $3.36 PMPM less than budgeted. The net loss for the short plan year was ($9.98) PMPM, $4.93 less than the loss projected in the certified budget.

Through December, professional payments accounted for approximately 28% of claims expenditures and pharmacy 29%. Outpatient facility payments totaled 23% of claims expenditures.

One board member asked about the acceptable industry budgeting variable and how the Plan could improve on moving closer to the budgeted amounts. Ms. Moon stated that based on discussions with the Aon and Segal actuaries over the past number of years, the Plan wants to see no more than a 2-3% variance. The pharmacy numbers have been close to or higher than the trend assumption and the medical numbers have been lower. She stated that the Plan now updates the forecast more frequently and attempts to keep the variance as low as possible.

Mr. Collins compared the short plan year administrative expenses with the FY 2012-13 plan year. The administrative expenses percent was lower for BCBSNC in the short plan year due to the missed December payment, the new contract with BCBSNC and the addition of a billing vendor and an enrollment and eligibility vendor. The Plan had a higher than normal cost for communication materials due to the benefit changes. Pharmacy administrative fees grew from 11% of FY 2012-13 administrative costs to 14% in the short plan year.

The financial performance highlights were presented by Mr. Collins, who stated that Plan expenses were substantially less than projections. He emphasized that when timing adjustments were factored in, the numbers were much closer to the budgeted amounts.

Analysis of Incurred Claims Trend and Loss Ratios

Segal analyzed the annual claims trends over the past four years, using incurred claims paid through October 2013. The data demonstrated more variations on the pharmacy side while the medical side has remained fairly stable. The PMPM costs increased 1.7% from FY 2011-12 to 2012-13 including a 4.8% increase in PMPM pharmacy costs. The pharmacy trend in the past three quarters has been significant compared to the prior five quarters. The Plan has reviewed a breakdown on each component of the pharmacy trend and believes that the overall trend might be due more to inflation utilization. Mr. Collins reminded the board that a quarterly variance is understandable and that one adverse outcome can affect the trend.

The annual PMPM trend in allowed charges reflects the total claims amounts paid by Medicare, members and the Plan. The annual trends in allowed charges are consistent with the overall trend in paid claims. The Plan reviewed the allowed charges trend in comparison to the Consumer Price Index (CPI) for medical care and found the trend to be fairly consistent with the CPI over the past four years. Paid claims for inpatient admissions decreased in both of the last two fiscal years, while claims for outpatient visits increased which may be a good trend if care is being moved from inpatient settings to outpatient settings.

Loss ratios relate member costs to the funding received and are defined in percentages. A loss ratio of 120% for a subgroup of members means that for every $1 in collected premiums, the Plan paid $1.20 in expenses. A 90% loss ratio means that for every $1 in collected premiums, the Plan paid $.90 in expenses

for that particular subgroup. Differences are driven by the claims experience in each subgroup. It was noted that ACA legislation regarding loss ratios doesn't apply to the Plan.

The loss ratio analysis for subscribers and dependents indicates that the overall dependent loss ratio was greater than 100%. The non-Medicare group had the highest loss ratio among both the subscribers and dependents. It was noted that dependent costs are subsidized by State-paid subscriber premiums.

The loss ratio by family tier among non-Medicare members demonstrated a loss ratio among non-Medicare retirees of over 100% in all tiers. The employee-spouse tier likewise had loss ratios greater than 100% in the active and non-Medicare retiree groups. The loss ratio numbers for the total non-Medicare population and active employees were similar across each tier.

The analysis by Plan option indicated that the non-Medicare members in the 80/20 Standard Plan had the highest loss ratio at 106%. Members in the Standard Plan, with the exception of the Medicare retirees, had higher loss ratios than in the 70/30 Basic Plan.

In summary, 90% of collected premiums in 2012-13 were spent to support claims and Plan administration. Mr. Collins stated that the premiums collected for some member subgroups did not cover associated costs. The most notable loss ratio of 137% was for the non-Medicare retiree members which equated to a $117.1 million loss.

Agenda Item – Health Plan Dashboard (Attachment 7)
Presented by Tom Friedman, Legislative Liaison/Health Policy Analyst; Mark Collins, Financial Analyst

Update on Dashboard Development & Process
The Plan will take a more active role in developing the quarterly dashboard reports and present the information to the board. Presentations will include an annual review of the entire dashboard with quarterly updates, highlighting trends and topics of interest. The key areas of focus will be on keeping healthy members healthy and help members to manage chronic conditions.

Segal will continue to provide data for the dashboard report and discuss trends and key points with Plan staff. The quarterly "spotlight" reports will address key challenges identified by both Segal and Plan staff with Segal providing the data analysis. As the strategic plan evolves, the dashboard revisions will include appropriate metrics to evaluate Plan initiatives and determine progress. Examples would include drilling further into the data on members with chronic conditions and a review of data on hospital readmissions and copay waivers and medication adherence, among other things.

Clinical quality measures will be compared to CY 2013 results to track progress on member health. Benchmarks will include more diverse groupings depending on the measure. Available data systems, i.e. Segal's Book of Business and Truven, will be used to provide additional viewpoints.

A comprehensive dashboard report will be presented to the board on an annual basis. The report will be updated on a quarterly basis and discussed with the board as needed. The quarterly presentations will focus on the "spotlight" reports which highlight measures that support the strategic plan objectives. The dashboard development process may lead to a more focused view on provider and member engagement and financial sustainability and affordability.

The first proposed area of focus is to keep healthy members healthy. The Clinical Risk Grouper (CRG) report from Segal indicated that 48% of Plan members are healthy. The goal is to keep these members healthy. The second proposed area of focus is to help members manage their chronic conditions. The CRG report categorized 51% of Plan members as having at least one or more chronic conditions and accounted for 78% of FY 2012 claims expenses. Potential metrics for both areas of focus include preventive care utilization, medication adherence, PCP utilization and the CRG report, the latter of which will be reviewed in two years.

One board member suggested tracking member engagement around the health portal. Another board member suggested drilling further in the category of members who have one or more chronic diseases given the high cost associated with their care. The board also discussed the management of those members with multiple diseases. Many times, population management groups focus on one disease group.

Ms. Moon stated that the two areas of focus include 99% of our population who account for 90% of Plan claims costs. She acknowledged that the metrics are not all-inclusive but hopefully provide the board with ideas of where to begin the process.

Following input from the board on the approach and areas of focus, Plan staff will finalize the benchmarks, update the reporting format, determine possible "spotlight" topics for 2014 and monitor results and contemplate 2016 wellness programs.

Dashboard Report, Period Ending October 31, 2013

Mr. Collins presented an outline of the Healthcare Dashboard for November 2012 through October 2013 and noted that the Appendix would change very little from quarter to quarter. The board discussed the eight panels, alerts, observations and recommendations contained in the dashboard report.

Panel 2, Paid Claims Summary: Total Plan paid claims increased 5.2% from prior year, due more to pharmacy expenditures than medical expenditures.

Panel 3, Key Performance Metrics: Plan staff will monitor the dashboard and seek board input if utilization trends change.

Panel 4, Major Conditions: The number of identified members in this panel is growing and associated claims costs are rising within this group.

Panel 5, High Risk, High Cost: A high cost claim definition is $25,000 and above. It was suggested that the Plan spotlight the top 1% of high cost members or those members whose claims totals are close to the $25,000. The Plan could drill further into this group of members to determine the highest disease prevalence and focus on those members. It was noted that some of these diseases group together and when members have three or four chronic conditions, it becomes extremely difficult to manage their care.

Panel 6, Clinical Quality Measures: The Plan is actively monitoring clinical quality performance and will continue to work with ActiveHealth Management to increase provider engagement and care delivery.

Panels 7, Rx Summary and 8, Rx Top Ten: Specialty pharmacy utilization and costs continue to increase and are driving the trend. Review and discussion continued to page 11 of the presentation at which point the presentation ended due to time constraints.

Agenda Item – Provider Payment Methodologies & Strategies (Attachment 8)
Presented by Tom Friedman, Legislative Liaison/Health Policy Analyst

In the development of the strategic plan, the board requested that the Plan review alternative payment strategies that focus on quality of care, cost and member experience. The current Plan model places all the risk on the Plan and pays providers for volume rather than quality outcomes. Provider payment strategies focus on health care payers sharing the risk with providers. The goal of an alternative payment arrangement is to shift more risk to the providers and incent them to increase quality and lower costs by keeping members healthy.

The Plan's 2014 service model consists of a third party administrator (BCBSNC) and two Medicare carriers who provide a broad access of care to Plan members in all 100 NC counties. In this model, the Plan assumes the financial risk for BCBSNC members. The Plan pays the Medicare vendors a fixed amount and they assume the risk. The Plan benefits from these vendor partnerships and the large membership in the negotiation of provider rates.

The Plan's membership is spread across North Carolina with more than 50% living in counties outside the three largest metropolitan areas. However, many counties have less than 1,000 members. With more than 670,000 members, the Plan accounted for only 27% of BCBSNC's total membership in 2013 and that percentage may drop as more than 100,000 members choose one of the Medicare Advantage plans.

Ms. Moon stated the distribution of the Plan's population is important as the board considers payment strategies. Partnering with other vendors increases the Plan's buying power. As expected, Segal's analysis of the professional and hospital rates demonstrated that the Plan pays providers approximately 148% of Medicare rates. The board will have to determine if they want to go in the direction of trying to decrease that rate and, if so, how to do it. The board discussed ways in which to work with the provider community to get closer to or match the Medicare rates, while working within the political constraints.

Mr. Friedman discussed the spectrum of potential payment methods with the goal of paying for quality and outcomes rather than productivity and procedures. New payment models would include coordination of care, enhanced focus on primary care, incentives for positive outcomes and payment withheld for lower quality of care.

The capitated model features include monthly fixed per member payments to the provider to provide care regardless of whether or not the member seeks care. The network is tightly managed and the provider assumes full financial risk. This model doesn't account for complex care need and significantly limits member choice. Accountable Care Organizations (ACOs) features include fixed capitated payments but with the flexibility to adjust the amounts to address acuity. Member care is coordinated to ensure quality outcomes and providers receive bonuses and withholds depending on outcomes. Some ACOs provide primary care and some provide acute or post-acute care and are currently emerging in North Carolina.

Bundled payment arrangements are very slowly emerging in North Carolina. Providers and payers agree on a bundled rate of payments for conditions or procedures. A single payment is made to two or more providers in a group and they are responsible for disbursing payments among themselves. Providers are not compensated

if quality care is not provided. This type of arrangement promotes members taking some accountability for their care and lends itself to a positive member experience at a lower cost. The Plan currently makes Diagnostic Related Group (DRG) payments to several NC hospitals for inpatient care.

The pay for performance and value-based contracting arrangement where risk is shared provides bonus payments to providers if they exceed quality or performance measures. Financial withholds are imposed on providers who fail to meet the quality standards and measures.

The PCMH arrangement exists in a fee for service model. Community Care of North Carolina (CCNC) is a national leader in this approach where providers receive enhanced fees or PMPM payments to coordinate member care. This is a patient-centric model that may also include outcome-based bonuses.

In summary, Mr. Friedman stated that the board and Plan may need to consider multiple payment strategies depending on the geographic area. Achieving the right balance between cost and quality is important for members, providers and other payers. Board members agreed that the infrastructure has to support changes and that many of these methodologies are still being developed. One board member suggested starting small with a test market and expanding from there.

Ms. Moon stated that in thinking about alternative payment strategies, vendor relationships become very important. In terms of implementing different payment methods to providers, the Plan will need to coordinate that aspect, possibly through pilot plans. The operational issues of implementing pilot plans would have to be considered, as well as determining how they would interface with all the benefit options the plan offers.

The next step is for Plan staff to follow up with each of its vendor partners to determine what they're learning about payment methodologies in the marketplace. Those ideas can then be applied to the Plan's population and strategies can be developed and presented to the board. The Plan will present an update to the board at the March meeting and will also provide a report on what other states are doing. The board also requested that data on the bundled knee replacement program with BCBSNC and CaroMont Health be provided at the March meeting.

Agenda Item – Strategic Planning (Attachment 9)
Presented by Tom Gualtieri-Reed, Strategic Planning Facilitator

Phase I Discovery Report
Mr. Gualtieri-Reed provided an update on the development of the strategic plan. The Phase I Discovery report was distributed and included key findings, guiding principles and recommendations. The document is intended to capture what the board will use as a guide for strategic planning. The discussion that took place regarding alternative payment methods is strategic planning and evidence that the Board is beginning to live the principles included in the report.

Phase II Updates, Discussion & Next Steps
During phase II, the Plan will develop a work plan to manage the development of the strategic plan analyses and board discussion topics. The workgroups may be restructured and key areas of focus will be determined. Plan staff is currently working on several things including payment models and strategies, the dashboard report, the evaluation of other state offerings and payment structures, member engagement and worksite wellness opportunities.

The Chair commented that the board will also review the governance structure, operating model and member communication as well as look more closely at what should be done by Plan vendors versus by the Plan itself.

The board also asked the Plan to consider the staffing structure and whether the appropriate numbers of people are in place to complete the work ahead. It was also suggested that a yearly calendar be developed to review the course of business including onboarding of new members.

Ms. Moon stated that in the short term the Plan must leverage the structure already in place and that the Plan needs to determine where to focus its time and efforts and adjust staffing needs accordingly. The current number of staff members has impacted the Plan's ability to move forward in several areas. If the Plan's business model should change at the board's direction, staffing and the organizational structure will certainly be topics of discussion.

It was suggested by Chair Cowell that it would be relevant for the strategic planning facilitators and Plan staff to work in concert with the Office of State Human Resources staff regarding benefits, total compensation and supplemental insurance options.

Following a motion by Dr. Newton and seconded by Dr. Rubin, the Board voted unanimously to move into executive session pursuant to G.S. 143-318.11 and G.S. 132.1.2.

Executive Session

Consultation with Legal Counsel – Contract Issue (G.S. 143-318.11(a)(3))

Mr. Huffstetler requested that he be recused from the discussion.

Updated information on performance issues by the enrollment vendor and their ability to meet contractual requirements was discussed. The board requested a legal opinion from the Attorney General's office. The Plan agreed to the request and will continue to provide updates to the board.

Following a motion by Dr. Newton and seconded by Dr. Rubin, the Board voted unanimously to return to open session.

Agenda Item – Wrap Up

Following a motion by Ms. Hargett and seconded by Dr. Rubin, the board voted unanimously to adjourn the meeting at approximately 3:00 p.m.

Janet Cowell, Chair