North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

State Treasurer of North Carolina
DALE R. FOLWELL, CPA

Board of Trustees Teleconference Minutes
December 10, 2019

The meeting of the NC State Health Plan for Teachers and State Employees (the Plan) Board of Trustees was called to order at approximately 10:00 a.m. on December 10, 2019.

Board Members Participating: Dale R. Folwell, Chair, Charles Perusse (via phone), Ted Brinn, Larry Chewning, Wayne Fish, Kim Hargett, Lisa Grimes, Donald Martin, Peter Robie, Margaret Way

Welcome

Chair Folwell welcomed Board members to the meeting. Dee Jones, Executive Director, stated that Ted Enarson would be acting Secretary for the Board in Andrew Norton's absence.

Conflict of Interest

No conflicts of interest were noted.

Public Comment

There were no requests from members of the public to address the Board.

Board Approval

Minutes – August 27 and September 12, 2019

Board Vote: Motion by Dr. Robie; second by Dr. Martin; unanimous approval by Board.

Operations Updates

Financial Update – 2019 CYTD and 19/20 FYTD

Dee Jones, Executive Director, presented the financial status through the third quarter, noting a favorable outcome in revenue, expenses and the ending cash balance. Chair Folwell reminded the Board that the report was positive, given that the State budget funded the Plan at a lower rate than staff requested. He added that a recent report from Blue Cross Blue Shield of North Carolina (BCBSNC) indicated that member out-of-pocket costs are lower but cautioned that the trend could change.

Plan Design 2021

Caroline Smart, Sr. Director of Plan Integration, presented proposed plan design changes for 2021. She stated that the Plan took a more targeted approach for 2021, adding that more options for opioid treatment and diabetes may be introduced. The Plan also wants to offer incentives for the Clear Pricing Project (CPP) providers.

Board Comments and Questions Addressed: The distribution of CPP dividers across the state includes many primary care providers and therapists but not enough to treat all Plan members. The network also needs additional specialty providers.

Physical therapy and acupuncture may be promoted for pain management and opioid treatment for members covered under the CPP or Blue Options network. Acupuncturists would be required to go through a credentialing process. Diabetic supplies have been a member concern for many years and the Plan would like to reduce the price of insulin by potentially moving it to a lower prescription tier. Before implementing these changes, Plan staff would need to analyze the financial impact.

Studies have shown that the prescription drug, Jardiance, can delay the need for insulin and should be made more affordable for members, along with insulin, if possible.

Follow-up: Determine the percentage of members with diabetes who are prescribed Jardiance and the cost impact of changing it to a lower cost tier. The Plan will request a Board vote on the 2021 plan design changes at the February 2020 meeting.

Open Enrollment Update

Beth Horner, Director of Customer Experience and Communications, provided an update on Open Enrollment (OE) which ended on November 19. The Plan's enrollment vendor, Benefitfocus, added new locations and extended hours to their call centers that support the Plan. In addition, and for the first time, Sunday hours were made available to Plan members, although many members still waited until the last two days of the shortened enrollment period to take action. Ms. Jones stated that the Plan anticipates OE occurring in October next year, but not for a full month as in past years.

Members enrolled in a Medicare Advantage Plan can make enrollment changes from January 1 – March 31, 2020, which is the Medicare Enrollment Period. Final enrollment results for Medicare members will be shared with the Board.

Board Comments and Questions Addressed: The importance of Health Benefit Representatives (HBRs) in the OE process in school systems was discussed. For some, the HBR role is a task that is lower on the list of their responsibilities. If an OE session or video was mandatory for employees, the percentage of members taking action might be higher. The Plan has worked with the Department of Public Instruction in the past to improve the OE process, but many decisions are made at the county level. Plan staff will continue to discuss ways in which to improve the OE participation rate and engagement with HBRs.

Concern was expressed that one of the call centers Benefitfocus used during OE was outside the United States. The potential risk for data breaches, where U.S. privacy laws do not apply, was discussed. Plan staff responded that all the privacy and security measures required by the Plan, for its primary vendors, are the same for subcontractors. The Plan's contracted vendors are required to seek approval from the Plan if a subcontractor is not listed in their contract. If an issue with a subcontractor is reported, the primary vendor is responsible, and the Plan may seek legal recourse against the primary vendor. Ms. Jones added that the calls routed to this center were level one calls, i.e. password resets, address changes, etc. She also noted that customer satisfaction at this office received the highest ranking.

Pharmacy/Health Care Support Program Update

Tracy Linton, Sr. Director of Plan Benefits, provided updates on the pharmacy benefit and Health Care Support program. She stated that 100% of all pharmacy rebates are passed on to the Plan and can significantly impact the pharmacy trend, as was the case in 2019. Specialty drugs continue as the highest cost driver related to pharmacy expenses. Plan and BCBSNC staff meet once per quarter to collaboratively review pharmacy costs and trends. Chair Folwell added that the Plan expects to receive approximately $280-290 million in rebates this year.

The BCBSNC Health Care Support Program, through claims data, specifically targets Plan members who have been diagnosed with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), diabetes and/or asthma and who have had an inpatient or catastrophic event. This program primarily focuses on members who need assistance managing their care. The program began in 2019 and it will be April (12/31/19 plus 90-day claims run out) before final year end results are available from which an ROI can be calculated.

> ***Board Comments and Questions Addressed:*** The pharmacy team, Plan staff and Pharmacy & Therapeutics Committee are to be commended for taking advantage of incentives and rebates and to ensure that our members get the highest quality drugs for the best price. With all the information regarding pharmacy coming from various outlets around the country, Ms. Jones encouraged Board members to contact the Plan if they have questions. There are instances where reported information doesn't apply to Plan members. For questions regarding generic drugs, members should first contact their provider, and then CVS. If questions still exist, members may call the Plan's pharmacy staff.

The Plan schedules in-person quarterly meetings with CVS to discuss and resolve existing issues.

Health Care Data Model

Frank DeVita, Program Director, stated that the Plan has completed the process of bringing the medical and pharmacy claims, BCBSNC provider, and benefit coverage data into the Plan's data warehouse. This will enable the data team to analyze membership, provider, utilization, and claims financial data to provide meaningful and reliable reports. The Plan will be able to provide reporting on financial claims, medical conditions, membership, and provider analyses for both in and out-of-network claims. Defined DataMarts are being developed for each of these four areas.

> ***Board Comments and Questions Addressed:*** Plan staff is currently creating initial user DataMarts which are targeted for completion by mid-2020. These initial DataMarts will use 2018 to current data. Future releases may also include data from 2014 through 2017. There is a limitation around how the data comes to the Plan, e.g. pharmacy costs, associated with an inpatient stay, are bundled. Therefore, total transparency may be difficult to achieve. In addition, the data from the hospital billing systems varies.
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> The Plan is not "reinventing the wheel" in the way data is analyzed and reported. Industry standard information such as CPT codes, Diagnostic Related Groups (DRG) codes, ICD-10 codes, etc. will be used to produce reports. Customized dashboards will be developed for users. The Data and Plan

Integration teams frequently collaborate to perform data quality checks as data entry errors frequently occur.

The Data Warehouse data is stored in the NC Government Data Analytics Center (GDAC) which is part of the NC Department of Information Technology (DIT).

Chair Folwell stated that it's important for people to know the Plan is not the hub for the Health Information Exchange (HIE) data.

A suggestion was made to invite the hospitals into the discussion regarding the need for transparency. Chair Folwell stated that hospital systems and the hospital association have been invited and brought into discussions.

Executive Director Updates

Dee Jones, Executive Director, provided Plan updates. She invited Board members to make suggestions for improvements or changes to the monthly Plan newsletter.

Health Information Exchange: One of the challenges with the HIE was unrealistic timelines. The latest challenge is provider compliance. While North Carolina has a mandate for provider participation, other states have not taken that approach, so adoption compliance is not an issue. Members want data to "travel" with them in order for any provider to have access where care is provided.

Clear Pricing Project Update: The Plan currently has over 26,000 providers in the network and is focused on offering incentives and programs for these providers. The goal is to design and possibly implement one or more pilot programs in 2020, to include expanding the use of bundled payments. A workgroup, which will report to a newly developed advisory committee, will develop and design these programs. The advisory committee will report to the State Health Plan Board. More information will be provided at future Board meetings.

Update Subsequent to the Board Meeting: Originally the thought was to have an Advisory Committee and Working Groups but as the Plan started to plan, it became clear that the best approach would be to only use Working Groups to develop and design these programs. The Working Groups will report out to the State Health Plan staff.

Rules Updates: The General Statutes allow the Plan to adopt and streamline rules whereas other agencies are subject to the Administrative Procedure Act (APA). The Plan recently amended the Rulemaking Policy and Procedure to outline the rules process. Ms. Jones noted that balance billing and surprise billing could potentially warrant a rule in the future.

Board Comments and Questions Addressed: A suggestion was made to develop resolutions around federal mandates. It was also suggested that maybe the Plan could provide background information on why a particular rule is created.

Chair Folwell emphasized the great working relationship with the State Employees Association of NC, Professional Educators of NC and others. He cautioned that comments made can be used in the wrong way. The ultimate goal is to reduce costs and provide care for Plan members. In 2020, the goal is to determine the true costs of medical care and foster good working relationships.

Board Vote to Move into Executive Session: Motion by Dr. Martin; second by Ms. Grimes; unanimous approval by Board

Executive Session

Consultation with Board Regarding Vendor Contract

Ted Enarson, Sr. Director, Contracting and Compliance, presented information regarding the Plan's current contract for pharmacy auditing services. The contract has two components, one of which was projected to cost over $500,000 and which the Board approved in 2018. After the contract became active, an amendment was made to the second component to implement reopenings of previous Retiree Drug Subsidy reconciliations filed with the Centers for Medicare & Medicaid Services (CMS) in 2014-2018. The Plan agreed to compensate the vendor with 30% of any additional subsidy generated from the reopenings. The results greatly exceeded the Plan's expectations, and consequently, the work completed by the vendor exceeded the $500,000 threshold. As a result, Board approval of this component of the contract was needed before the vendor could be paid.

Board Comments and Questions Addressed: Chair Folwell requested that the Plan amend the contract to require the vendor to reimburse the Plan an amount equal to the portion of its reopening compensation that is based upon any overpayment that the Plan must later return to CMS. He recommended that the Board's approval be contingent on the vendor's agreement to this language.

Board Vote to Approve Contract with Contingency: Motion by Mr. Chewning; second by Dr. Martin; unanimous approval by Board.

Board Vote to Move into Open Session: Motion by Mr. Brinn; second by Ms. Grimes; unanimous approval by Board

Adjournment

The meeting was adjourned at 1:00 p.m.

Minutes submitted by: Ted Enarson, Acting Secretary

Approved by: _____

Dale R. Folwell, Chair