SC PUBLIC EMPLOYEE BENEFIT AUTHORITY
BOARD OF DIRECTORS

Monday, August 5, 2013 – 1:00 p.m.
202 Arbor Lake Drive, Columbia SC, Main Conference Room 2nd Floor
MINUTES [as approved 8/21/13]

Board Members Present:

Mr. Art Bjontegard, Chairman (by telephone)
Ms. Peggy Boykin (by telephone)
Mr. Frank Fusco (by telephone)
Ms. Stacy Kubu (by telephone)
Mr. Steve Matthews (by telephone)
Mr. Joe "Rocky" Pearce (by telephone)
Mr. Audie Penn (by telephone)
Mr. Steve Heisler (by telephone)
Mr. John Sowards (by telephone)

Others present for all or a portion of the meeting:

David Avant, Lil Hayes, Stephen Van Camp, Justin Werner, Laura Smoak, and Virginia Wetzel from the South Carolina Public Employee Benefit Authority (PEBA); Donald Tudor with the State Retirees Association; Betts Ellis, Karyn Rae, and Dr. Mark Lyles from MUSC (by telephone); Daniel Brennan with the SC State Treasurer's Office; Adam Beam with the State Newspaper; and William Kinney with Mullikin Law Firm.

I. Call to order

Chairman Bjontegard called the meeting to order at 1:00 p.m., and gave the invocation. Ms. Hayes confirmed meeting notice compliance with the Freedom of Information Act. Mr. Heisler moved to adopt the agenda. Mr. Penn seconded. The agenda was unanimously approved.

II. MUSC Pilot Program

Chairman Bjontegard introduced Dr. Mark Lyles with MUSC who presented an overview of the MUSC PCMH Pilot Program [In notebook materials. MUSC's Proposed PCMH Pilot Program].

Health Care Policy Committee Chairman Rocky Pearce opened the floor for Board member questions for MUSC.

Mr. Penn noted that additional quality metrics for health and cost were added. However, there were no targeted values for each metric. Specifically, Quality Metric Number Sixteen, Fifteen, and Fourteen and Cost Metrics One through Four. Dr. Lyles explained that values will be identified once the health assessments have been completed during the initial year of the pilot.

Ms. Kubu wanted to insure that MUSC's educational/communication campaign target all levels of employees. Dr. Lyles is confident that MUSC has a wide variety of communication tools to reach their entire workforce.

Ms. Boykin also wanted to insure that the MUSC communication campaign expressly state that subscribers will continue to have the option of participating in the Standard Health Plan (SHP) or the new PCMH Pilot. Dr. Lyles confirmed they will disclose this information.

Mr. Penn questioned if there will be a targeted participation rate required to allow the continuation of the MUSC Pilot Plan. Mr. Avant confirmed that the anticipated target enrollment rate would be 70%. Currently, approximately 50% of MUSC employees utilize MUSC providers. He also explained that the PEBA Board will annually approve the continuation of this plan. Mr. Bjontegard requested the percentage of subscribers who live out of state (predominantly dependents). Dr. Lyles indicated it is a small percentage of the subscriber population and that the SHP out-of-state benefit components would apply to this population.

Mr. Fusco asked if there was a point at which enrollment levels would not meet a targeted participation rate for continuation of the pilot program. He questioned if MUSC anticipated the 50% of those currently utilizing MUSC providers to enroll into the pilot program. Dr. Lyles indicated that 70% is the anticipated enrollment rate and MUSC was hopeful that the benefit incentives would drive plan commitment.

Mr. Penn and Mr. Fusco requested clarification on the enrollment process for the MUSC pilot plan. Mr. Avant indicated that enrollment status (Pilot program vs. SHP) will be determined by the subscriber's utilization of a particular provider (MUSC providers vs. SHP in or out of network providers). Therefore benefits would be determined by virtue of the type of provider chosen by the subscriber. At any point during the calendar year, subscriber benefits would change based upon the utilization of a MUSC provider or SHP provider (In or out of network). Based on enrollment structure and the fact that subscribers will not be definitely committed to the pilot plan, Mr. Penn and Mr. Fusco expressed concern about the management of the pilot's metric outcomes and measurement of pilot success or failure. Dr. Lyles explained that during the first year of the pilot program participation will be voluntary but it is their hope that the benefit incentives will drive and maintain participation.

Mr. Fusco asked PEBA staff if there will be a formal written document outlining the MUSC pilot plan. Ms. Kubu also requested confirmation that the MUSC pilot plan would include reporting requirements and guidelines which must be approved in advance by the Board. Mr. Van Camp indicated that a memorialized Plan Document will be completed by September or October of the 2013 Calendar Year.

Mr. Heisler also indicated concern that the enrollment structure of the pilot program may result in poor pilot measurement. Mr. Avant explained given the parameters of Section 1-11-710 of the Code of Laws and Proviso 105.7 of the FY 2013/2014 Appropriation Act this was the best plan option considering the overall pilot plan goals.

Mr. Fusco questioned if the actuarial assumptions would be more defined if subscribers were required to enroll into a specific plan and be committed to that plan for an entire plan year. Mr. Avant indicated that it would probably make a difference in the actuarial assumptions.

Mr. Lyles stated that this new plan would provide three sets of benefits with three sets of coordinating providers.

Mr. Pearce indicated that it is his understanding that the Board is in support of developing PCMH pilot programs to enhance the health of all South Carolinians if not during the current 2013/2014 plan year, definitely for the 2014/2015 plan year. Mr. Penn requested confirmation from MUSC that their Pilot Program may consists of three benefit sources, however, all

subscribers utilizing all three benefits will be monitored for quality metric data accumulation and managed health care. MUSC confirmed yes. Mr. Heisler explained that it may be most beneficial to identify the following 3 populations for measurement: PCMH Subscribers Only; PCMH/ SHP Subscribers; SHP Subscribers Only.

Mr. Fusco expressed his support of a PCMH plan based upon the following features: Incent health prevention; the opportunity of a shared system to allow for measurement of health outcomes and satisfaction; and to reduce long term health care costs. He recommended that language be included in the memorialized MUSC Pilot plan document requiring frequent plan reporting to include data collection and measurement outcomes to the PEBA Health Care Policy Committee.

Motion:
Mr. Pearce asked for a motion to approve the proposed MUSC PCMH Pilot Health Plan. The proposal is as follows:

1. MUSC has proposed a Health Plan Pilot to study the cost-effectiveness and quality impact of a health plan based on a Patient Centered Medical Home model.
2. The participants in the Pilot will be MUSC employees and their dependents.
3. Those MUSC employees who have currently elected to participate in the Savings Plan or Blue Choice will be able to opt out of the Pilot program.
4. The PCMH Pilot is designed to be revenue neutral to PEBA.
5. The Pilot Plan has the same premiums as the SHP Standard Plan.
6. Pilot Plan participants may receive treatment at MUSC or with MUSC-affiliated physicians under the terms of the PCMH or may receive treatment from other providers participating in the SHP under the normal terms and conditions of the SHP.
7. The Pilot Plan is a non-grandfathered health plan under the ACA and includes all required features for a non-grandfathered plan, such as first dollar coverage of preventive care.

Mr. Heisler seconded this motion.

Chairman Bjontegard asked for any amendments to the motion to approve the MUSC PCMH Pilot Program.

Amendments:

Chairman Bjontegard offered the following amendment:
There must be a formal memorialized MUSC Pilot Plan agreement presented to the PEBA Board by the end of September 2013.

Mr. Penn offered the following amendment:
The memorialized MUSC Pilot Plan agreement must include the validation of initial target metrics.

Mr. Fusco offered the following amendment:

The memorialized MUSC Pilot Plan agreement must include the requirement of continuous monitoring of metrics by the PEBA Health Care Policy Committee through continuous reporting by MUSC.

Mr. Heisler offered the following amendment:
The memorialized MUSC Pilot Plan agreement must include an annual approval process by the PEBA Board to include guidelines for plan continuation based upon the comparison of expressly stated baseline target metrics, actual target metrics, and expressly stated required target metrics.

Action:
Chairman Bjontegard asked for a motion to approve the consolidated amendment to the MUSC PCMH Pilot Program. Due to the telephonic nature of the meeting the following roll call vote was taken:

Chairman Bjontegard:	AYE
Mr. Heisler:	AYE
Mr. Matthews:	AYE
Mr. Sowards:	AYE
Mr. Pearce:	AYE
Mr. Fusco:	AYE
Ms. Boykin:	AYE
Mr. Penn:	AYE
Ms. Kubu:	AYE

By a roll call vote of nine to zero the amendment was approved.

Action:
Chairman Bjontegard asked for a motion to approve the MUSC Pilot Program as amended. Due to the telephonic nature of the meeting the following roll call vote was taken.

Chairman Bjontegard:	AYE
Mr. Heisler:	AYE
Mr. Sowards:	AYE
Mr. Pearce:	AYE
Mr. Fusco:	AYE
Ms. Boykin:	AYE
Mr. Penn:	AYE
Ms. Kubu:	AYE

By a roll call vote of eight to zero the MUSC Pilot Program as amendment was approved.

III. Round Table Discussion

Chairman Bjontegard announced the dates of the upcoming meetings:

- PEBA Board Meeting: August 21, 2013, 1:00 p.m.
- FAAC Meeting: August 16, 2013, 2:00 p.m.
- Retirement Policy Committee Meeting: September 4, 2013, 2:00 p.m.

Chairman Bjontegard encouraged all Board members to attend any PEBA committee meetings.

IV. Adjournment

There being nothing further to discuss, Chairman Bjontegard requested a motion to adjourn. Mr. Heisler moved to adjourn and Mr. Penn seconded. The Board unanimously voted to adjourn at 2:00 p.m.

SC Public Employee Benefit Authority
Board of Directors Meeting

202 Arbor Lake Drive, Columbia SC, 29223 ♦Main Conference Room

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Monday, August 5, 2013 – 1:00 P.M.

AGENDA

1. **Adoption of Proposed Agenda**
2. **MUSC Pilot Program**

NOTICE OF PUBLIC MEETING

This notice is given to meet the requirements of the S.C. Freedom of Information Act and the Americans with Disabilities Act. Furthermore, this facility is accessible to individuals with disabilities, and special accommodations will be provided if requested in advance.

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
PEBA Board

Monday, August 5, 2013 **Agenda 1**

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1. Subject: Medical University of South Carolina – Health Plan Pilot

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2. Summary:

Background Information:

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3. What is Board asked to do? The Board is being asked to receive as information and possibly approve details of the MUSC Health Pilot for the 2014 Plan Year.

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4. Supporting Documents:

(a) Attached:
1. Plan Details
2. §1-11-710 and Proviso 105.7

MUSC's Proposed PCMH Pilot Program

	MUSC Pilot Participant utilizing		
Feature	**PCMH and Provider Panel**	**SHP Network Provider (Same as Std. Plan)**	**Out-of-Network Provider (Same as Std. Plan)**
Deductible	385/770 (PCMH and panel specific)	420/840 (SHP and Out-of-Network specific)	420/840 (SHP and Out-of-Network specific)
Coinsurance Rate	80%	80%	60%
Coinsurance Maximum	2200/4400	2400/4800	4800/9600
Preventative Benefits (List A/B)	No cost	Current SHP preventative benefits and cost share	Current SHP preventative benefits and cost share
Primary Care Office Visit	**20.00+ Copay	12.00 Per Occurrence Deductible and Deductible and Coinsurance	12.00 Per Occurrence Deductible and Deductible and Coinsurance
Specialist Office Visit – Coordinated By PCP	35.00 Copay	12.00 Per Occurrence Deductible and Deductible and Coinsurance	12.00 Per Occurrence Deductible and Deductible and Coinsurance
Specialist Office Visit – Not Coordinated By PCP	**50.00+ Copay	12.00 Per Occurrence Deductible and Deductible and Coinsurance	12.00 Per Occurrence Deductible and Deductible and Coinsurance
Emergency Room	150.00 per occurrence deductible plus coinsurance / deductible (per occurrence deductible waived if admitted)	150.00 per occurrence deductible plus coinsurance / deductible (per occurrence deductible waived if admitted)	150.00 per occurrence deductible plus coinsurance / deductible (per occurrence deductible waived if admitted)
Outpatient Hospital	Preventative – No cost PCP – 20.00 Specialist / Coordinated – 35.00 **Specialist / Non Coordinated – 50.00+ **Surgical – 250.00+ Radiology – **50.00+ (with reimbursement limited to SHP professional / free standing fee schedule)	90.00 per occurrence deductible plus coinsurance / deductible	90.00 per occurrence deductible plus coinsurance / deductible

	Pathology – 50.00		
***Inpatient Hospital Facility**	No cost	Deductible / Coinsurance	Deductible / Coinsurance
Inpatient Hospital Professional	Deductible / Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance
High End Radiology (MRI, CT, CAT, PET)	75.00 Copay with reimbursement limited to SHP professional / free standing fee schedule	75.00 per occurrence Deductible / Coinsurance	75.00 per occurrence Deductible / Coinsurance
Prescription Drugs	SHP Benefits	SHP Benefits	Not covered

Other reimbursement to PCMH:

1) 64.43 fee paid to PCMH for each member that completes a baseline health assessment / risk appraisal. Data gathered for the assessment will be shared with EIP for the purpose of program evaluation.
2) 10.00 / 4.00 monthly management fee paid to PCMH based upon patient risk and complexity. The fee will be paid per member per month and payment for a member will commence upon completion of the baseline health assessment / risk appraisal.

* Inpatient hospital facility services have allowances set at 80% of SHP contractual allowances

**To maintain revenue neutrality, these copays to be adjusted upward to increase total revenue by 7%.

Premiums

Both subscriber and employer premiums for the MUSC PCMH Pilot will be the same as the SHP premiums.

Outcomes Measurement

Outcomes will be determined based on the following:

<u>Quality Metrics</u>

1. Diabetic care – Hba1c
2. Diabetic care – LDLc
3. Diabetic care – eye exam
4. Breast cancer screening
5. Cervical cancer screening
6. Colorectal cancer screening
7. Proper user of asthma medications
8. ER utilization for asthma
9. Readmission rate
10. Emergency room utilization rate

11. Well child visits
12. Immunizations for two year olds
13. Immunizations for adolescents
14. Reductions in the evolution of population's biometric trends (i.e. metabolic risk factors, metabolic syndrome)
15. Population's compliance to "basic care requirements" for chronic conditions (i.e. Compliance target of XX%, all conditions or the top X)
16. Population's participation in health assessments and biometrics (XX% participation)

Cost Metrics

Outcome will also be determined by the total savings to the plan based on the results of the PCMH compared to expected results for the MUSC population. Any savings will be shared equally between the SHP and MUSC. All costs (administrative, claims, health assessment, and management fees) are considered in the shared savings calculation. Such metrics include:

1. XX% reduction in top medical spend such as Musculoskeletal Disease costs
2. XX% reduction in medical leave of absence days
3. XX% reduction in occasional sickness absence days
4. XX% reduction in the year-on-year cost per employee trend

Beneficiary Satisfaction Metrics

Metrics from the CAHPS Patient-Centered Medical Home Item Set will be used. This survey tool is attached and also may be found on the web as the fourth item on the following webpage:

https://www.cahps.ahrq.gov/clinician_group/

This survey tool includes question such as:
In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?

1. When you talked about starting or stopping a prescription medicine, how much did this provider talk about the reasons you might want to take a medicine?
2. In the last 12 months, how many days did you usually have to wait for an appointment when you needed care right away?
3. In the last 12 months, how often did the provider (named in an earlier question) seem informed and up-to-date about the care you got from specialists?
4. Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?

SECTION 1-11-710. Board to make insurance available to active and retired employees; Insurance Reserve Fund to provide reinsurance; cost to be paid out of appropriated and other funds.

(A) The board shall:

(1) make available to active and retired employees of this State and its public school districts and their eligible dependents group health, dental, life, accidental death and dismemberment, and disability insurance plans and benefits in an equitable manner and of maximum benefit to those covered within the available resources;

(2) approve by August fifteenth of each year a plan of benefits, eligibility, and employer, employee, retiree, and dependent contributions for the next calendar year. The board shall devise a plan for the method and schedule of payment for the employer and employee share of contributions and by July first of the current fiscal year, develop and implement a plan increasing the employer contribution rates of the State Retirement Systems to a level adequate to cover the employer's share for the current fiscal year's cost of providing health and dental insurance to retired state and school district employees. The state health and dental plans must include a method for the distribution of the funds appropriated as provided by law which are designated for retiree insurance and also must include a method for allocating to school districts, excluding EIA funding, sufficient general fund monies to offset the additional cost incurred by these entities in their federal and other fund activities as a result of this employer contribution charge. The funds collected through increasing the employer contribution rates for the State Retirement Systems under this section must be deposited in the SCRHI Trust Fund established pursuant to Section 1-11-705. The amounts appropriated in this section shall constitute the State's pro rata contributions to these programs except the State shall pay its pro rata share of health and dental insurance premiums for retired state and public school employees for the current fiscal year;

(3) adjust the plan, benefits, or contributions, at any time to insure the fiscal stability of the system;

(4) set aside in separate continuing accounts in the State Treasury, appropriately identified, all funds, state-appropriated and other, received for actual health and dental insurance premiums due. Funds credited to these accounts may be used to pay the costs of administering the state health and dental plans and may not be used for purposes of other than providing insurance benefits for employees and retirees. A reserve equal to not less than one and one-half months' claims must be maintained in the accounts.

(B) The board may authorize the Insurance Reserve Fund to provide reinsurance, in an approved format with actuarially developed rates, for the operation of the group health insurance or cafeteria plan program, as authorized by Section 9-1-60, for active and retired employees of the State, and its public school districts and their eligible dependents. Premiums for reinsurance provided pursuant to this subsection must be paid out of state appropriated and other funds received for actual health insurance or cafeteria plan premiums due.

(C) Notwithstanding Sections 1-23-310 and 1-23-320 or any other provision of law, claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board, which shall constitute the exclusive remedy for these claims, subject only to appellate judicial review consistent with the standards provided in Section 1-23-380.

(D) The General Assembly intends to authorize funding for the SCRHI Trust Fund in order to make progress toward reaching or maintaining the minimum annual required contribution under Governmental Accounting Standards Board Statement No. 45. The board shall determine the minimum annual required contribution pursuant to Section 1-11-705(H).

HISTORY: 1992 Act No. 364, Section 1; 1995 Act No. 145, Part II, Section 19; 1996 Act No. 312, Section 1; 2001 Act No. 62, Sections 1, 2; 2008 Act No. 195, Section 4, eff May 1, 2008; 2012 Act No. 278, Pt IV, Subpt 2, Section 32, eff July 1, 2012.

FY 2013/2014 Appropriations Act

PROVISO 105.7. (PEBA: FY 2014 State Health Plan) Of the funds authorized for the State Health Plan in Plan Year 2014 pursuant to Section 1-11-710(A)(2) of the 1976 Code, an employer premium increase of 6.8% and a subscriber premium increase of 0% for each tier (subscriber, subscriber/spouse, subscriber/children, full family) will result for the standard State Health Plan in Plan Year 2014. Co-payment increases for participants of the State Health Plan in Plan Year 2014 shall not exceed 20%. Notwithstanding the foregoing, pursuant to Section 1-11-710(A)(3), the Public Employee Benefit Authority may adjust the plan, benefits, or contributions of the State Health Plan during Plan Year 2014 to ensure the fiscal stability of the Plan.