Meeting Minutes | Board of Directors

Wednesday, July 15, 2015 | 1 p.m.
200 Arbor Lake Dr., Columbia, SC 29223 | Second Floor Conference Room

Minutes Approved August 19, 2015

Board Members Present: Chairman Art Bjontegard, Mr. Steve Matthews, and Mr. David Tigges

Board Members Present via Telephone: Mr. Frank Fusco, Mr. Steve Heisler, Ms. Stacy Kubu, Mr. Steve Osborne, Vice Chairman Joe "Rocky" Pearce, Mr. Audie Penn, and Mr. John Sowards

Board Members Absent: Sheriff Leon Lott

Others Present for All or a Portion of the Meeting: Peggy Boykin, Ariail Kirk, Heather Muller, John Page, Jacalin Shealy, Laura Smoak, Rob Tester, Stephen Van Camp and Heather Young from the South Carolina Public Employee Benefit Authority (PEBA); Brooks Goodman and Dr. Shawn Stinson from Blue Cross Blue Shield of South Carolina; Sam Griswold and Wayne Pruitt from the State Retirees Association of South Carolina; Carlton Washington from the South Carolina State Employees Association; Tylar Brannon from the South Carolina Office of the State Treasurer; Mary Elizabeth Van Horn from Milliken Law Firm; Brad Wright from the McNair Law Firm; and Bill Tomes from Public Management Leadership Development Services, LLC.

I. Call to Order

Chairman Art Bjontegard called the PEBA Board of Director's (Board) meeting to order at 1:00 p.m., and stated that the public meeting notice was posted in compliance with the Freedom of Information Act.

II. Adoption of Proposed Agenda

Mr. Steve Matthews made a motion, which was seconded by Mr. David Tigges, and approved unanimously, to adopt the proposed Board meeting agenda.

III. Approval of Meeting Minutes- June 17, 2015 and July 8, 2015

Mr. Tigges made a motion, which was seconded by Mr. Matthews, and approved unanimously, to adopt the June 17, 2015, meeting minutes as presented.

Mr. Matthews made a motion, which was seconded by Mr. Tigges, and approved unanimously, to adopt the July 8, 2015, meeting minutes as presented.

IV. Committee Chairman Appointments

Chairman Bjontegard stated that the Health Plan Policy Committee; The Retirement Policy Committee; and the Finance, Administration, Audit and Compliance (FAAC) Committee, all recommend retaining their current Committee chairmen. Chairman Bjontegard confirmed the Committee Chairmen reappointments.

V. 2016 State Health Plan Approval of Benefits and Contributions

Mr. Rocky Pearce, Health Care Policy Committee Chairman, discussed the proposed health plan program changes effective January 1, 2016 including:

A. <u>All Health Plans</u>

i. Employer contribution increase of 4.5 percent;
ii. No enrollee contribution increase;
iii. Composite contribution increase of 3.4 percent which is the amount funded in the fiscal 2016 Appropriations Act and detailed in Proviso 108.6 of the Act.

B. <u>State Health Plan</u>

i. Elimination of patient cost sharing for covered contraceptives (mandated in Proviso 108.13 of fiscal 2016 Appropriations Act); and
ii. Patient-Centered Medical Home incentive.

Mr. Pearce stated that patients obtaining services at practices participating in the Blue Cross Blue Shield of South Carolina PCMH program will receive a waiver of the $12 Physician Office deductible, and provision of Plan coinsurance at 90 percent (rather than 80 percent at other network providers).

iii. VBID services: The following services will be provided with no patient liability:
   a. Colonoscopies;
   b. Adult vaccinations;
   c. Tobacco cessation pharmaceuticals; and
   d. Diabetes education services.

C. <u>MUSC Health Plan</u>

i. Increase Specialist Copay to $45/visit (from $35/visit)

D. <u>Flexible Benefits (MoneyPlus)</u>

i. Eliminate the one-year waiting period for employee to establish a Medical Spending Account; and
ii. Establish a $1500 limit for 2016 on Dependent Care Accounts for highly-compensated employees.

Mr. Pearce stated that the Health Care Policy Committee recommends accepting the proposed health plan program changes effective January 1, 2016. Chairman Bjontegard stated that the motion presented is a Committee motion which does not require a second. Following further discussion, the motion passed unanimously.

VI. Committee Reports

A. Health Care Policy Committee

Mr. Pearce stated that the Health Care Policy Committee does not have any further business to report.

B. Retirement Policy Committee

Mr. Sowards stated that the Retirement Policy Committee does not have any business to report at this time.

C. Finance, Administration, Audit and Compliance (FAAC) Committee

Mr. Steve Matthews stated that the FAAC Committee met on June 30, 2015, for the purposes of electing a Committee Chairman.

VII. Old Business

A. Director's Report

Ms. Peggy Boykin, PEBA's Executive Director, provided the Director's Report, and stated that the Benefits at Work (BAW) Conference will be held at the Columbia Convention Center August 31-September 3, 2015, and reminded the Board that they are invited to attend. Ms. Boykin stated that the BAW conference is held annually for benefits administrators and other personnel across the state, to ensure that they understand any legislative or health care plan changes for the upcoming year. Ms. Boykin added that the BAW conference is also an opportunity for employers to express their feedback or concerns with PEBA's procedures.

Ms. Boykin stated that an update on the Strategic Action Plans will be presented at the September Quarterly Board meeting.

B. Roundtable Discussion

At the conclusion of the Director's Report, Chairman Bjontegard provided an opportunity for a roundtable discussion.

VIII. Executive Session Pursuant to S.C. Code of Laws § 30-4-70

At 1:20 p.m., Mr. Matthews made a motion, which was seconded by Mr. Tigges, and passed unanimously, to recede into executive session to receive legal advice concerning assessment of fiduciary compliance, and to discuss personnel matters, pursuant to S.C. Code Ann. § 30-4-70.

The Board reconvened in open session at 1:45 p.m. Chairman Bjontegard announced that no action was taken by the Board while in executive session.

Mr. Matthews made a motion, which was seconded by Mr. Tigges, and approved unanimously, to accept the fiscal year 2015-2016 Agency Head Planning Stage as recently submitted.

IX. Adjournment

There being no further business, and upon motion by Mr. Frank Fusco, which was seconded by Mr. Audie Penn, and approved unanimously, the Board meeting adjourned at 1:48 p.m.

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I. Call to Order

II. Adoption of Proposed Agenda

III. Approval of Meeting Minutes- June 17, 2015 and July 8, 2015

IV. Committee Chairman Appointments

V. 2016 State Health Plan Approval of Benefits and Contributions

VI. Committee Reports
1. Health Care Policy Committee
2. Retirement Policy Committee
3. Finance, Administration, Audit and Compliance (FAAC) Committee

VII. Old Business
1. Director's Report
2. Roundtable Discussion

VIII. Executive Session Pursuant to S.C. Code of Laws § 30-4-70
1. To Receive Legal Advice Concerning Assessment of Fiduciary Compliance
2. Personnel Matters

IX. Adjournment

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
BOARD MEETING

Meeting Date: July 15, 2015

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1. Subject: 2016 State Health Plan Approval of Benefits and Contributions

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2. Summary: 2016 State Health Plan Approval of Benefits and Contributions

Background Information:

3. What is the Board asked to do? Approve the 2016 State Health Plan

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4. Supporting Documents:

(a) List those attached:

1. Program Changes Effective January 1, 2016
2. Contribution Rates for 2016
3. Contraceptives Proviso
4. PCMH Write-up
5. PCMH Map
6. Value Benefits Write-up

Proposed Program Changes Effective January 1, 2016

All health plans

- Employer contribution increase of 4.5 percent
- No enrollee contribution increase
- Composite contribution increase of 3.4 percent
- Amount funded by General Assembly in fiscal 2016 Appropriations Act and memorialized in Proviso 108.6 of Act

State Health Plan

- Elimination of patient cost sharing for covered contraceptives (mandated in Proviso 108.13 of fiscal 2016 Appropriations Act)
- Patient-Centered Medical Home (PCMH) incentive:

  Patient incentives for services obtained at practices participating in BCBSSC PCMH program will be provided in the form of waiver of the $12 Physician Office per occurrence deductible, and provision of Plan coinsurance at 90 percent (rather than 80 percent at other network providers). (Coinsurance differential in Standard and Savings plans; waiver of office deductible in Standard plan only—no such provisions exists in Savings plan)

- VBID services: The following services will be provided with no patient liability (Standard and Savings Plans):
  - Colonoscopies: This procedure, including the consultation and associated anesthesia during the procedure, will be provided at no cost to the member at in-network providers for both diagnostic services and routine services within specified age ranges. (US Preventive Services Task Force A recommendation)
  - Adult vaccinations: Adult vaccinations within CDC-recommended intervals will be covered at no cost to the member (as is currently the case with childhood immunizations) at in-network providers.
  - Tobacco cessation pharmaceuticals: Prescription medication related to tobacco cessation (Chantix, generic Zyban (bupropion)) will be provided at no cost to the member.
  - Diabetes education: Diabetes education services will be provided at no cost to the member at in-network providers.

MUSC Health Plan

- Increase Specialist Copay to $45/visit (from $35/visit)

Flexible Benefits (MoneyPlus)

  - Eliminate one-year waiting period for employee to establish a Medical Spending Account.
  - Establish $1500 limit for 2016 on Dependent Care Account for highly-compensated employees in order to address passage of federal non-discrimination test.

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State Health Plan Monthly Contribution Rates by Level of Coverage

Effective January 1, 2016

4.5 percent increase for employers/no increase for enrollees

2016 Employer rates for all health plans

	2015	2016
Enrollee only	$344.58	$360.10
Enrollee/spouse	$682.54	$713.26
Enrollee/child	$528.88	$552.68
Full family	$854.58	$893.04

2016 Employee rates (no change from 2015)

Savings Plan

Enrollee only	$9.70
Enrollee/spouse	$77.40
Enrollee/child	$20.48
Full family	$113

Standard Plan/Medicare Supplement

Enrollee only	$97.68
Enrollee/spouse	$253.36
Enrollee/child	$143.86
Full family	$306.56

Tobacco users will pay a $40 (enrollee only) or $60 (enrollee plus coverage) per month surcharge in addition to health premiums.

2016 Proposed Program Changes: Covered Contraceptives

Fiscal Year 2015-16 General Appropriations Act

108.13. (PEBA: Covered Contraceptives) In its Plan of Benefits effective January 1, 2016, the State Health Plan shall not apply patient cost sharing provisions to covered contraceptives. This provision does not alter the current approved list of contraceptives and complies with the requirements of proviso 108.4.

2016 Proposed Program Changes: Patient-Centered Medical Homes

Chronic diseases and the behaviors that frequently cause them account for more than **3 in 4 dollars spent on health care in the United States**, according to the Centers for Disease Control and Prevention (CDC).[1]

Research shows that one of the best ways to reduce costs and improve health outcomes for patients with chronic conditions is to ensure that they receive coordinated care. Patients who have **convenient** access to a reliable "medical home" are less likely to seek care from providers outside that practice. This coordinated care helps them avoid duplicative services and extra costs. Multiple surveys show that patients are more satisfied and more willing to seek preventive care when a medical home team provides, coordinates and follows up on their care.

A patient-centered medical home (PCMH) model of care features a team of providers who meet all their patients' health care needs. Typically led by a physician, PCMH teams may include nutritionists, health educators, pharmacists and behavioral health specialists who share a patient's treatment information with one another. The team also makes appropriate referrals to other qualified health care providers as needed, sharing treatment information with those providers.

We assert that the PCMH model is currently the best avenue to pursue improving health outcomes and reducing costs. Among other benefits, PCMHs:

- Offer same-day appointments for both sick and well patients to help them avoid unnecessary use of the emergency room.
- Use evidence-based medicine and clinical decision support tools to guide decision-making.
- Give patients expanded access to health care practitioners through extended hours and online communication.
- Closely manage chronic illness.
- Improve patient compliance with care plans.
- Strengthen the physician-patient relationship through more frequent and consistent encounters over time.
- Reduce gaps in care.
- Reduce health disparities.
- Focus on coordinated preventive care rather than traditional (and more expensive) reactive care.

Studies have demonstrated that PCMHs save money. BCBSSC analyzed the treatment costs and utilization for State Health Plan members with diabetes and hypertension in 2014 and compared those who used PCMH practices with those who did not. Its findings included:

- PCMH patients treated for diabetes had 5 percent fewer emergency room services per 1,000 members and patients treated for hypertension had 12 percent fewer emergency room services per 1,000 members.
- PCMH patients with diabetes had 3 percent fewer hospital admissions per 1,000 members and patients treated for hypertension had 16 percent fewer hospital admissions per 1,000 members.
- There was a 12 percent savings on inpatient facility costs for State Health Plan members with diabetes and a 13 percent savings for members with hypertension in PCMH practices.

These savings take into account the care coordination fee BCBSSC pays each PCMH practice (in addition to the traditional fee for service). The care coordination fee is increased annually when the practice meets mutually determined quality metrics. BCBSSC also helps medical practices pursue the high standards required for national PCMH certification. In addition, practices are provided an industry-leading population health management and reporting tool fueled by claims and clinical data. The tool is used by practices to more effectively manage patient populations and continually improve quality and performance.

Analysis performed for PEBA by the S.C. Revenue and Fiscal Affairs Office (RFA) also indicated positive results for patients receiving care in a PCMH versus at a non-PCMH provider. This analysis was conducted on claims paid in 2014 for patients with and without chronic conditions receiving care at a PCMH compared with those at a non-PCMH. The following differences met tests of statistical significance at a 95 percent confidence level.

- Average amount paid for patients without a chronic condition in a PCMH was $3,920 versus $4,757 in a matched sample outside a PCMH setting
- Average amount paid for patients with a chronic condition this amount was $5,607 in a PCMH versus $6,595 in a matched sample outside a PCMH setting
- PCMH members without a chronic condition with at least one hospital stay was 2.8 percent versus 4.3 percent for those not in a PCMH
- PCMH members with a chronic condition with at least one hospital stay was 3.9 percent versus 5.8 percent for those not in a PCMH
- PCMH members without a chronic condition had a 9.8 percent lower rate of having at least one ER visit
- PCMH members with a chronic condition had a 19.3 percent lower rate of having at least one ER visit.

The supply of PCMHs in South Carolina is increasing, with the number of participating physicians more than tripling since 2012. There are not yet enough recognized PCMHs to serve every SHP member, nor are they evenly distributed geographically. But there is sufficient capacity to treat many additional patients struggling with chronic health conditions. *It is proposed that for services obtained at a PCMH in the BCBSSC program in 2016 that the $12 physician office visit per occurrence deductible be waived and that Plan coinsurance be paid at 90 percent.* The addition of an incentive for members who obtain services at a PCMH will encourage both member and provider participation in the program. This

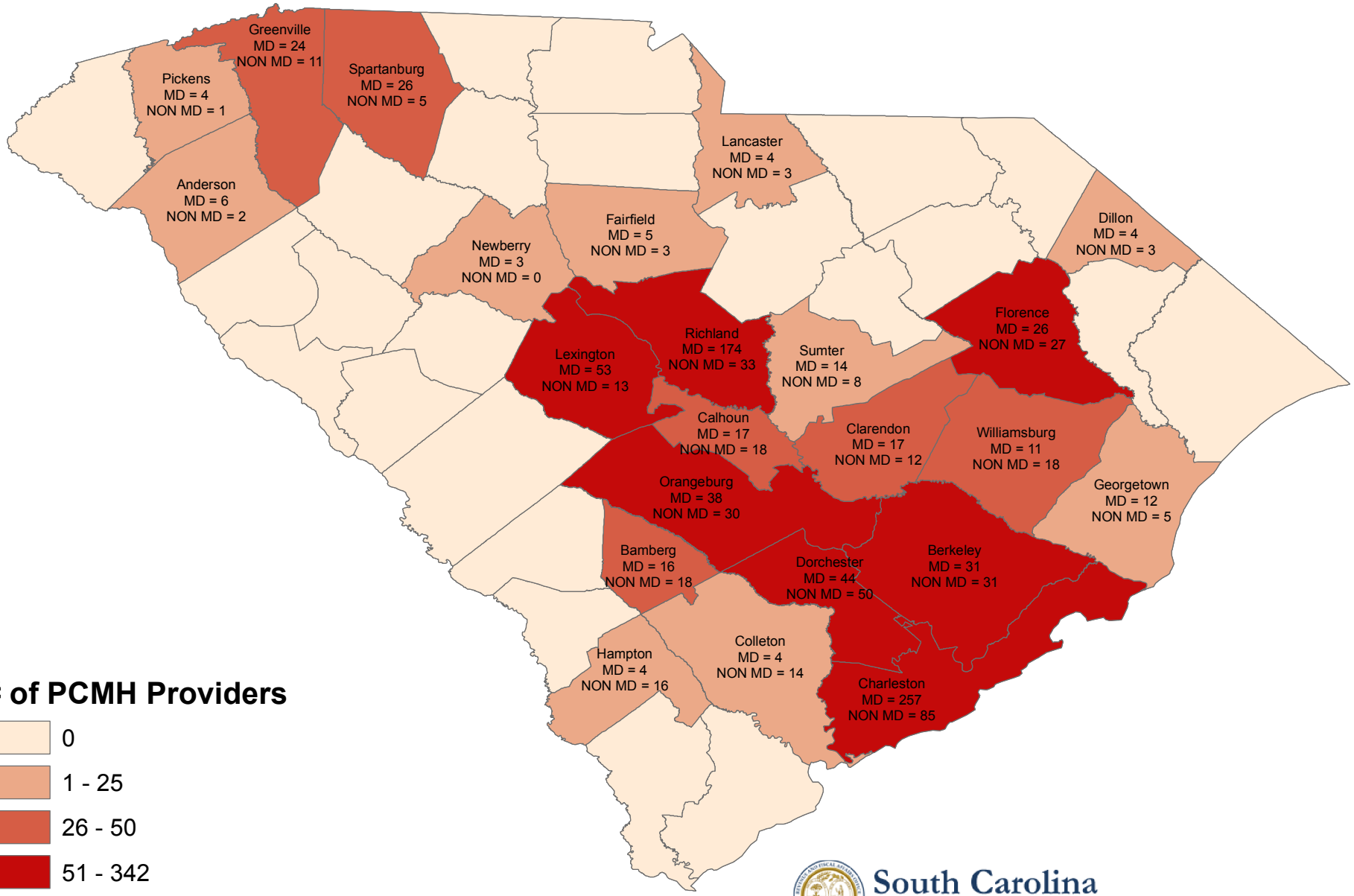
strategic investment will, we believe, put the SHP on track for significant cost savings and improvements in health outcomes among its members within a few short years.

It also will align PEBA's strategy with a best practice being utilized by many major health plans nationwide. For example, the Department of Defense is working to help its primary care practices become PCMHs. The Department of Health and Human Services is transforming community health centers into medical homes. Government and private sector initiatives in 38 states are helping practices transition to PCMHs. And more than 48,600 clinicians and 10,000 medical practices across the country have earned PCMH recognition.

There is a reason for this trend—patients, providers and health plans all benefit when PCMHs deliver more efficient, less costly, coordinated care.

[1] Centers for Disease Control and Prevention. Chronic Disease Overview: Costs of Chronic Disease. Centers for Disease Control and Prevention website. Available at http://www.cdc.gov/nccdphp/overview.htm. Accessed June 22, 2015.

PCMH Providers by County as of June 2015



South Carolina
Revenue and Fiscal Affairs Office

2016 Proposed Program Changes: New Value-Based Benefits

Colorectal cancer screening: colonoscopy

Colorectal cancer (CRC) is the second most common cause of cancer deaths among men and women in both the United States and in South Carolina. Early stage CRC does not have symptoms; however, this disease can be prevented as well as detected early through screening, saving both lives and money. Screening can identify polyps so they can be removed before they turn into cancer. Late stage CRC has poor survival rates and is very expensive to treat. Regrettably, more than 50 percent of CRC cases in the state are reportedly diagnosed at late stage. According to the South Carolina Cancer Alliance, CRC screening is the most cost effective cancer screening available. The U.S. Preventive Services Task Force has assigned an A rating to colorectal cancer screening for people ages 50 through 74 years. The A rating is defined as "high certainty that the net benefit is substantial."

The SHP currently covers colonoscopy subject to regular Plan deductible and coinsurance. Routine colonoscopies have been covered since 2006, again subject to deductible and coinsurance. According to the S.C. Cancer Alliance, a recent consumer survey identified affordability as the major barrier to CRC screening. While CRC screening rates among SHP members have increased since 2006, more than 30 percent of eligible members are not current with this preventive measure.

It is recommended that the SHP, effective in 2016, remove patient out-of-pocket cost for all diagnostic colonoscopy as well as routine screenings within recommended age parameters, including the pre-surgical consultation, prep kit, the procedure itself and associated anesthesia. This is in the same manner as required in an ACA-compliant plan. It is estimated that for every $1 spent on early detection of colon cancer, $3 is saved in treatment costs alone. By removing any remaining financial barriers to colonoscopy screening, we believe we can make a meaningful difference in the lives of our membership while saving millions of dollars in treatment costs.

Adult vaccinations

Vaccination is considered one of the most important public health achievements of the past century. Vaccines save lives and improve the quality of life by preventing serious infectious diseases and their consequences. However, adult vaccination rates remain low in the US, despite the widespread availability of safe and effective vaccines. The Centers for Disease Control (CDC) and its Advisory committee on Immunization Practices (ACIP) currently recommends 13 vaccines for adults to prevent a host of diseases. The SHP began coverage of childhood vaccinations at no cost to the member in 1996, but only began paying for routine adult vaccinations in part in 2015 with coverage of the Zoster (Shingles) vaccine and the Influenza vaccine beginning with the upcoming flu season.

It is recommended that the SHP in 2016 begin covering the remaining adult vaccinations within specified age parameters as recommended by the ACIP at no cost to the member. This coverage is in the same manner is that required by ACA-compliant plans.

The recommended schedule for vaccinations is provided below:

Centers for Disease Control (CDC) Adult Vaccination Schedule

	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥ 65 years
Influenza[*2]	←1 dose annually→					
Tetanus, diphtheria, pertussis (Td/Tdap)[*3]	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs					
Varicella[*4]	←2 doses→					
Human papillomavirus (HPV) Female[*5]	←3 doses→					
Human papillomavirus (HPV) Male[*5]	←3 doses→					
Zoster [6]					←1 dose→	
Measles, mumps, rubella (MMR)[*7]	←1 or 2 doses→					
Pneumococcal 13-valent conjugate (PCV13)[*8]	←1-time dose→					
Pneumococcal polysaccharide (PPSV23)[8]	←1 or 2 doses→					←1 dose→
Meningococcal[*9]	←1 or more doses→					
Hepatitis A[*10]	←2 doses→					
Hepatitis B[*11]	←3 doses→					
Haemophilus influenzae type b (Hib)[*12]	←1 or 3 doses→					

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle or other indication)

No recommendation

Tobacco cessation medication

The dangers of smoking are well documented, with smokers at significantly greater risk for heart disease, lung disease, and many types of cancers. It remains the leading preventable cause of death in the United States. Quitting smoking reduces these health risks within a relatively short period of time. The SHP provides its Quit-for-Life tobacco cessation program at no cost to the member. In addition, prescription medications associated with tobacco cessation have been covered with copays the same as any other covered pharmaceutical. For 2016, PEBA is planning to re-ignite its marketing efforts with respect to tobacco cessation to call attention to the tools provided by the SHP to aid its members in the difficult task of becoming tobacco free. In accord with this campaign, it is recommended that copayments for prescription medication used for tobacco cessation (Chantix, generic Zyban (bupropion)) be waived beginning in 2016. This is consistent with what is required for ACA-compliant plans.

Diabetes education

Diabetes education trains diabetics to manage their condition to avoid disease-related complications. Research has demonstrated that people who have received diabetes education are more likely to use primary care and preventive services, to take medications as prescribed, and to control their blood glucose, blood pressure and cholesterol levels. RFA has calculated that 10.6 percent of all SHP enrollees are diabetic, and that $102.2 M in recent annual claims expenditure was directly related to diabetes. All efforts at attempting to achieve better compliance with self-care protocols on the part of diabetics will, if even partially successful, bring about cost savings to the SHP and improve quality of life on the part of a sizable portion of its membership.