South Carolina
PUBLIC EMPLOYEE BENEFIT AUTHORITY

PEBA

South Carolina Public Employee Benefit Authority
Healthcare Policy Committee
Meeting Minutes (as adopted December 12, 2012)

Wednesday, November 21, 2012

2nd Floor Conference Room
202 Arbor Lake Drive
Columbia, South Carolina 29223

Board Members Present:

Ms. Cynthia Hartley, Chairman (in person)
Mr. Joe "Rocky" Pearce (in person)
Mr. Art Bjontegard, Ex-officio (in person)
Ms. Stacy Kubu (in person)
Mr. Audie Penn (via phone)

Others present for all or a portion of the meeting:
Bill Blume, Robbie Bell, Susan Brownlee, Lil Hayes, Justin Werner, Travis Turner, Laura Smoak, David Quiat, Frank Fusco from the South Carolina Public Employee Benefit Authority (PEBA); Brooks Goodman from BlueCross BlueShield of South Carolina; Wayne Pruitt and Wayne Bell from State Retirees' Association; Amy Cohen, Mike Madalena, Bill Hickman from GRS; Adam Beam from the State newspaper; Daniel Brennan from STO; Whitney Williams from Fred Allen and Associates; Mary Elizaveth Van Horn from Mullikin Law Firm.

I. CALL TO ORDER; ADOPTION OF PROPOSED AGENDA

Chairman Hartley called the meeting to order at 10:04 AM. Ms. Brownlee confirmed completion of oaths of office and statements of economic interest by the board members and meeting notice compliance with the Freedom of Information Act. Chairman Hartley asked everyone in the room to introduce themselves.

A. Adoption of Proposed Agenda

Art moved, Rocky seconded, unanimous approval

II. LONG TERM CARE PROGRAM UPDATE

Mr. Blume introduced David Quiat to talk about Long Term Care. Mr. Quiat talked about Prudential's contract for LTC and the fact that they are getting out of the business. The market has changed so that it's not financially beneficial for companies to be in the LTC business. PEBA put out a Request for Information to see if any companies were interested. The only response came from Transamerica. Historically, PEBA has had Long Term Care set up w/ guaranteed underwriting and a reserve transfer—moving funds paid in to one company to the new company. Transamerica does not do group LTC, would require medical underwriting, and would not accept a reserves transfer. PEBA also directly contacted MetLife, Unum, and Genworth. None was interested in providing group Long Term Care for the state. No other vendors offered to provide this service. The only way to find someone to provide any form of LTC is Transamerica, but because they would only do individual

policies. PEBA would not like to do individual LTC policies. Vendors indicated that when the market improves, they may get back into LTC. Mr. Blume noted that the statute does not require PEBA to offer LTC coverage, it simply allows it. With medical evidence, those who would be denied would likely blame PEBA. Mr. Bjontegard asked if there were any way we can get a better rate with an individual policy. Mr. Blume responded that it may be possible to obtain a multi-group plan with a discount. Mr. Quiat stated that Transamerica would do a "multi-life" policy with discounts, but they still would be individual policies. Vendors have stated they would like to deal with professors and Highly Compensated Employees, but not other, riskier parts of the group. Mr. Bjontegard asked how PEBA would communicate to employees that they could get an individual policy at a discount. Mr. Quiat reminded him that PEBA would have to go through a procurement process in order to do anything regarding LTC, including endorsement of any individual plans. If PEBA does a Request for Proposal, vendors were not likely to accept a reserve funds transfer; therefore those who are with Prudential would probably stay with them. Mr. Pearce suggested that PEBA could communicate the guaranteed issue of LTC for employees before June 30, 2013. Mr. Fusco added that employees can also sign up other individuals such as parents, grandparents, etc. Mr. Bell responded to Mr. Pearce's suggestion by noting that the State's current Long Term Care plan only offers a guaranteed issue within 31 days of an employee's date of hire. After that, the employee would have to provide medical evidence of good health and be approved. Mrs. Hartley requested a motion that PEBA no longer offer a Long Term Care plan. Mr. Pearce moved to stop offering Long Term Care. Mr. Penn requested clarification as to whether PEBA is dropping LTC because of the possibility of denial for pre-existing conditions. Mr. Blume confirmed that this is a primary reason. Mr. Penn asserted that this creates an employee relations issue either way. Mr. Bjontegard seconded the motion to discontinue Long Term Care. Discussion ensued in which Mr. Penn stated there should be extensive employee communication about this change. Mr. Bjontegard agreed. Mrs. Hartley clarified that the existing 11,000 or so members of the current Long Term Care plan will still have that coverage after June 30, 2013. Mr. Bell confirmed that new hires still can enroll within 31 days of their hire dates until June 30, 2013. Mr. Penn asked whether existing employees who do not currently have LTC would be prevented from enrolling because Prudential is no longer accepting medical evidence. Mr. Quiat confirmed they would not. Mr. Werner—PEBA staff counsel—suggested to Mrs. Hartley that Mr. Bjontegard cannot make a motion or second. Mr. Bjontegard withdrew his second. Chairman Hartley explained that only Mrs. Kubu, Mr. Penn, and Mr. Pearce can make motions, second, or vote in the Healthcare Policy Committee meetings. Chairman Hartley requested a vote on whether to take this issue to the full PEBA Board. A vote was taken and it was unanimously approved. Discussion ensued about Mr. Bjontegard's ability to vote. The issue was resolved to the satisfaction of the members and PEBA counsel that Mr. Bjontegard, as an ex-officio member of all committees, does have the ability to make motions, second motions, and vote.

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III. HEALTH INSURANCE:

A. MEDICAL AND PHARMACY BENEFITS OVERVIEW

Bill Hickman of GRS began a presentation about medical benefits funding and actuarial processes. Chairman Hartley asked Mr. Hickman to introduce himself and explain what he, Ms. Cohen and Mr. Madalena do. Mr. Hickman explained that they are actuarial consultants for the State Health Plan. Mr. Bjontegard asked whether SC is the only group that develops its own network. Mr. Hickman responded that SC is the only one they work with. They used to handle Texas' network too, but it proved more difficult to establish a provider pool than in SC, where the public plan covers a greater percentage of the population. Mr. Hickman explained that provider discounts help the plan to contain costs. Mr. Fusco inquired as to the nature of the costs savings—asking whether they are actual cost or "manufacturer suggested retail prices." Mr. Hickman responded that they are the bill charges, to

which the discounts are applied. Mr. Bjontegard asked whether the State Health Plan enjoys most-favored nation status. Mr. Hickman confirmed with Brooks Goodman that the SHP does not have most-favored nation status. Chairman Hartley asked whether if claims were run through the BlueCross BlueShield preferred provider network would the plan experience better discounts. Mr. Hickman responded that he would rather have Mr. Madelena respond to that question. Mr. Bjontegard stated that with the retirement systems, PEBA always gets the best rate going and they should get that for healthcare too.

Mr. Hickman went on to explain that the State does not own its pharmacy plan's provider network. Employer contributions were over one billion dollars in 2011. Mr. Penn asked what the employer/employee split is for these premiums. Mr. Hickman responded that subscriber contributions are figured based upon premiums and out-of-pocket costs. The total cost to subscribers is about 40% of the cost. Mr. Turner noted that the premium split is 28% employee and 72% employer. Mr. Hickman stated that 83% of the increases in costs to the plan between 2007 and 2011 are attributable to inflation, increased utilization, and decreasing diversity in the provider population. He also explained that the revenue model consists of investment income (trust funds), employer contributions, subscriber premiums, Pharmacy Benefit Manager rebates from manufacturers, and federal government subsidies. Mr. Penn asked whether the plan is leveraging all cost-containment controls available such as step-therapy, networks, and mail-order pharmacy benefits. Mr. Hickman confirmed that the State Health Plan has already been using these methods. Chairman Hartley asked what the generic penetration rate is. Mr. Madalena responded that it is about 71.2%, but that this constitutes only about 20% of total dollars spent, because generics are much cheaper than brand drugs. Mr. Bjontegard asked whether this number is good or bad. Mr. Madalena responded that it is a little on the low-side. Mr. Bjontegard noted that this is an area of opportunity. Mr. Hickman agreed. Mr. Fusco asked what options are available to people who are unable to use generic. Mr. Madalena confirmed with Laura Smoak that this circumstance is appealable. Mr. Penn stated that the Plan is not leveraging with Express Scripts to get the best costs by directing maintenance drugs through ES' pharmacies (mail-order).

B. DISCUSSION OF PREMIUMS AND PLAN DESIGN FOR 2014

Chairman Hartley asked Mr. Hickman whether, if the State Health Plan's claims were run through the BlueCross BlueShield network, would they cost more. Mr. Hickman affirmed that claims expenditures for the State Health Plan network are lower than for the general BlueCross BlueShield network. In response to a question by Chairman Hartley, Mr. Madalena explained that the State Health Plan is typically an open-access plan because of the implications of excluding certain providers. Mr. Bjontegard suggested that the committee consider the mathematics, not the politics. Mr. Penn noted that another consideration is the quality of the outcome. Mr. Madalena agreed, explaining that the State Health Plan has metrics with which it evaluates the quality of care—such as readmission rates, infection rates, etc. He also explained that there may be substantial savings in using a "high-performance" networks, which are basically a premium network setup where the benefit is higher when patients use those certain providers. About 15% of the SHP's members constitute about 90% of the cost to the plan. He then explained the budgeting process where projections are used to measure costs-to-date and expected expenditures, to determine the monetary needs for the future. He mentioned the proviso that requires the SHP to keep sufficient funds on hand to cover 45 days' worth of claims. This means the process goes backward from the assumption of ending the year with that 45 days' worth of claims on hand. Mr. Fusco asked whether the 45-day requirement is reasonable. Mr. Madalena explained it is higher than most. Many other employers arrange their premium structures at about 80% employer and 20% employee contribution. The SHP is not there yet, with a breakdown of about 72% employer and 28% employee contributions. He explained the

Retiree Drug Subsidy—a program by the Federal government to reimburse plans for maintaining prescription coverage for Medicare-eligible retirees. The Early Retirement Reinsurance Program is a program with which the Federal government was giving plans subsidies to offer coverage for retirees, but this money has now run out. He also explained that plan received good return through litigation—such as settlements with pharmaceutical companies. Mr. Fusco inquired as to what pending litigation exists. Mr. Madalena explained there are currently two. Mr. Fusco inquired whether the plan gets the money from the settlements. Mrs. Smoak explained that SC state Medicaid and PEBA are reimbursed proportionately according to their recorded expenses. Mr. Fusco asked whether there is a portion of the allocation of these settlements is taken separately from the PEAB and Medicaid allocations. Mr. Blume explained that PEBA has not tracked anything other than its allocations. Mr. Madalena explained that, by statute, any funds in reserve that exceed 140% of the Incurred But Not Reported (IBNR) claims expenses must be deposited into the OPEB trust by January 31. 2010 and 2011 were good years in terms of claims experience. The PBM contract was enhanced and more aggressive provider updates have been made. If the plan had not been able to spend down some reserves, the 4.6% premium increase for 2013 would have been considerably higher. Chairman Hartley inquired whether there is a statutorily required differential between employer and employee contributions of premiums. Mr. Blume answered no. Mr. Fusco inquired whether the 2013 design is calendar year. Mr. Madalena stated it is calendar year. Mr. Fusco inquired whether the IBNR is theoretical or known. Mr. Madalena explained it is a projection. Mr. Madalena explained the current per capita trends. He showed how the pharmacy benefit trends are increasing at a much faster rate than those of medical benefits. He explained the demand-drug environment brought about by prescription drug advertising and how this is not mirrored with medical services. He explained that the Average Wholesale Price of drugs is inflating much higher because of the ACA mandates that require the pharmaceutical companies to fund closing the Medicare Part D "doughnut hole" and other requirements. Mr. Penn asked what the increase was from 2010 to 2011 for the active population. Mr. Madalena said he would provide that information to the committee, though he didn't have it at the time. Mr. Penn asked whether Medicare is primary for retirees. Mr. Madalena responded that Medicare is primary and the state offers a Medicare Supplemental Plan. Under this setup, Medicare pays the lion's share of medical claims, but the state still pays its part for prescriptions—with some reimbursement from the RDS.

At 11:58A.M., Chairman Hartley proposed to take a short break to get lunch and return.

The committee meeting resumed at 12:16 P.M. Mr. Madalena continued his presentation by explaining some options for containing costs through plan design. He explained several options including Employer Group Waiver Plan (EGWP) for pharmacy benefits, restructuring the provider network to an exclusive network, and increasing cost-sharing for medical services and pharmacy benefits. He explained the implications of the Affordable Care Act. He explained that there are two lists of preventive services required by the ACA that would result in a 3.5% increase in projected *additional* funding required. He explained that if the plan remains grandfathered, it would result in a required funding increase of 13.3% but would restrict what changes could be made to the plan; whereas if the plan becomes ACA compliant, there would be more latitude in what changes are made to the plan. Mr. Fusco inquired whether the plan would have options to remain grandfathered again after 2013. Mr. Madalena responded that the plan can continue to choose to remain grandfathered in the future. Mr. Fusco asked what the committee is required to do at this time. Chairman Hartley explained they need to make a recommendation to the Board as to the budget need to meet plan costs. Chairman Hartley requested a motion to recommend to the PEBA Board that the estimated revenue requirement for 2014 be submitted as that presented by GRS. Mr. Penn made the motion to

propose a $238.5 million additional increase in funds with the existing plan design. Mr. Pearce seconded. With a vote this motion was unanimously approved.

IV. OVERVIEW OF BUDGET PROCESS

Lil Hayes explained the budgeting process. She explained that the funds for the plan come through General Fund appropriations, not directly to PEBA, but through the allocation of funds to employer groups to cover employer contributions. This goes to the governor. The governor forwards it to the House Ways and Means Committee. They forward it to the House to vote. After the House approves, it goes to the Senate Finance Committee. After that, it goes to the full Senate. After voting on the budget proposal, the Senate sends it back to the House—which can make more changes. After it survives the Senate and House, it goes to the Budget and Control Board for approval—which is statutorily required to occur by August 15. Mr. Pearce requested that the proposal letter that will be sent to the governor—generated by the staff—be forwarded to the Board members. Staff agreed. Chairman Hartley confirmed the committee's action is just the first step in a long process.

V. NEW BUSINESS

Mr. Pearce inquired whether consideration is being made to come up with other solutions, such as wellness initiatives. Mr. Madalena confirmed it is.

There being nothing further to discuss, Chairman Hartley requested a motion to adjourn. Mr. Pearce moved to adjourn and Mr. Penn seconded. It was unanimously voted to adjourn at 12:56P.M.