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 Meeting
In-Person/Webinar/Recorded
January 25, 2024
Minutes

Convene Meeting

Welcome

The meeting of the North Carolina State Health Plan for Teachers and State Employees (Plan) Board of Trustees was called to order by Chair Dale R. Folwell, CPA, at 1:30 p.m. on Thursday, January 25, 2024.

Roll Call for Attendance

Present: Dale R. Folwell, Kristin Walker, Melanie Bush, Russell "Rusty" Duke, Wayne Fish, Peter Robie, M.D., Mike Stevenson, Cyrus Vernon, Kerry Willis, M.D. (via phone)

Conflict of Interest

No conflicts of interest were noted. During a board meeting, members should notify the board chair if a conflict arises.

Reading of SEI Statements into Minutes Pursuant to the Ethics Act § 138A-15(c)

No Statements of Economic Interest (SEI) were read into the minutes.

Introduction of New State Health Plan Staff Member

Dr. Emma Turner joined the Plan in November 2023 as the Plan's Chief Economist. Prior to joining the Plan, Dr. Turner served in the same role at the NC General Assembly. She has a PhD in Economics from NC State University and her role at the Plan will focus on cost-saving strategies, as well as various projects with the legal team.

Consent Agenda *(Requires Vote)*

- Minutes – October 26, 2023, Meeting

  Board Vote*:* Motion by Dr. Robie; second by Mr. Stevenson; roll call vote was taken; unanimous vote by Board to approve the minutes from the October 26, 2023, board meeting.

Acupuncture

Michael Harding, NC licensed practitioner of Acupuncture and Chinese Herbal Medicine and Dr. Rose Mulhearn, founder and owner of Acupuncture Therapeutics of Wake Forest, NC, provided a summary on the science behind acupuncture and the types of diseases, conditions and symptoms it can be used to treat. Most acupuncture practitioners have a masters level degree or doctorate and a license to practice acupuncture.

Mr. Harding and Dr. Mulhearn stated that one of the primary benefits of acupuncture for many people is pain relief. According to their presentation, statistics show a 45% reduction in opioid prescriptions for patients who use acupuncture to treat certain types of pain. In addition, Mr. Harding and Dr. Mulhearn

referenced studies indicating a reduction of approximately $900 in hospital care and stated that acupuncture improves the quality of life and health. One of the best benefits of acupuncture is that it can be used to treat a condition up front before a patient seeks primary care treatment.

Board Comments and Questions Addressed:

Are there instances in which acupuncture treatment of a certain condition was stopped because it didn't work? Dr. Mulhearn responded that acupuncture isn't used for emergency treatment and that certain techniques, if they were painful, are not used.

Acupuncture works for many, but not all, patients. Patient compliance also plays a role in successful outcomes.

In some cases, acupuncture treatment was effective for certain COVID-19 symptoms in patients who didn't receive vaccination.

A board member asked for the history of the Veteran's Administration (VA) use of acupuncture treatment. Dr. Mulhearn stated that she would provide that information to board members.

How is dry needling different from acupuncture? Acupuncture is based on ancient Chinese medicine with the idea of balance and restoring the proper flow of energy throughout the body. It's used to treat various conditions. Dry needling is relatively new and based on modern Western medicine. Needles are inserted into trigger points to treat cases of chronic and acute pain.

Do commercial plans in NC cover acupuncture? Both UnitedHealthcare and Blue Cross North Carolina cover acupuncture, but it's not a universally covered benefit.

Public Comments

A Plan member discussed her experience with weight loss drugs and asked the Board not to exclude such drugs.

Ms. Ardis Watkins, Executive Director, State Employees Association of North Carolina, stated that if the State Health Plan were to cover the high cost of weight loss drugs, additional money will have to come from somewhere to help offset the cost to the Plan. She added that, since it most likely won't come from the General Assembly, Plan members will have to absorb the cost in some way. She noted the high price for these drugs in the U.S. compared to other countries, stating that some of these drugs are produced in nearby cities, Durham and Clayton.

Blake Thomas, General Counsel, Office of State Human Resources (OSHR), noted that the NC Flex program is on the board agenda and offered to answer any questions the board or others may have. He stated that OSHR is reviewing the possibility of changing the way members sign up for Flex benefits. If that occurs, he committed for OSHR that it would be no sooner than the middle of 2025. He added that the change would occur only if there was certainty that it would save NC Flex members money and provide good customer service.

Operational Report

Sam Watts, Executive Administrator, began by stating that during his first year at the Plan, his focus centered on fiduciary responsibility. He noted that the cost of weight loss drugs, and the information uncovered through extensive research, has been somewhat shocking. The guiding principle in the Plan's and Board's decision regarding coverage of these drugs is what will do the greatest good for the highest number of Plan members within financial realities. He added that the Plan certainly doesn't want to double member premiums.

State Health Plan Annual Report

Plan staff are in the process of producing an annual report which will be shared with the Board upon completion.

NC Flex Transition

Mr. Watts stated that the decision by the Office of State Human Resources (OSHR) to transition NCFlex enrollment from Benefitfocus to Empyrean will not occur until 2025. He noted that the full exchange of correspondence between the Plan and OSHR was included in the Board book under the Appendix tab.

Third-Party Administrator (TPA) Audit

The Plan will engage in the procurement process to choose a vendor to provide an exit audit for the current Third-Party Administrator (TPA) claims. The scope of work will include a review of all claims and fees. The Plan will bring the information to the Board for a vote at the April 2024 board meeting.

Other

Mr. Watts stated that a new state law allows the University of North Carolina (UNC) and East Carolina University (ECU) hospital systems to create a retirement system for employees, making them ineligible for the state pension plan. Apparently, employees at UNC have been enrolled on the new plan; however, UNC has not directly communicated that information to the Department of State Treasurer.

Board Comments and Questions Addressed:

As to whether UNC is offering the State Health Plan to employees, it's not clear. UNC wouldn't be allowed to offer the State Health Plan to retirees but could to active employees. The Plan hasn't been made aware if UNC is giving active employees a choice. In response to a follow-up question regarding the legality of UNC decisions, Mr. Watts stated that UNC hasn't communicated any information to the Plan.

Chair Folwell added that he no confidence that UNC or ECU healthcare employees are aware of the situation and that approximately 91% of them, making up to $20 per hour, are in the State's pension system. New hires will no longer be eligible for the pension plan. He added that with UNC and ECU no longer paying into the Retirement System, other state agencies will have to allocate additional funds to make up for the loss.

Financial Report

Calendar and Fiscal Year-to-Date Financials through November

Mr. Rish provided a financial summary of information provided at the October meeting. The projections indicate significant operating losses over the next 4 calendar years. The budgeted funds were $240 million less than the Plan requested for fiscal years 2023-2025.

The calendar year report through November for the actual vs. budgeted numbers showed unfavorable results in revenue, total Plan expenses and the ending cash balance. The Target Stabilization Reserve (TSR) is 9% of the total claims payments and represents approximately one month of claims payments. Mr. Rish reminded the board that the TSR of $359.9 million is included in the ending cash balance of $645 million and not a separate fund elsewhere.

The Calendar Year to Date report, comparing 2023 to 2022, showed that the Plan's net claims payments in 2023 were $275 million higher than in 2022. Medical claims were 5% higher in 2023, which falls within the normal yearly increase of 4-6%. Pharmacy claims increased 19% in 2023 which is significantly higher than the average yearly increase of 9-11%.

Through November in Fiscal Year (FY) 23-24, the Plan experienced a $97 million operating loss compared to a budgeted loss of $80 million.

Board Comments and Questions Addressed:

It seems that the current financial projections could be significantly impacted by the actions of UNC and ECU health systems.

Wilmington Health

Mr. Watts commended staff for a remarkable job on a pilot project with Wilmington Health for Plan members in New Hanover and Brunswick counties. He added that staff from Wilmington Health have been invited to share the pilot program's financial results at the April 2024 board meeting.

The purpose of the project was to model a capitated care-type product. Initially, the Plan was reviewing various options to drive quality outcomes and reduce costs, out of which the Clear Pricing Project was implemented. When that didn't work, as planned, Wilmington Health met with Plan staff to present what they already had in place.

Wilmington Health has managed the care for approximately 28,000 Plan members. The relationship between the member and the primary provider and care team is a priority. The providers assist members in navigating the health care system, providing them with health guides and directing them to appropriate sites of care.

Providers engage members using technology, via phone or virtual visits, as well as an app that members can access. Providers follow up with members to ensure they're going to office visits, appropriately taking medications and answering any questions members may have.

Board Comments and Questions Addressed:

Does the Board approve pilot programs? This pilot was within the Plan's authority and didn't require Board approval.

Will the Plan expand this model in other locations around the State? The Plan's initial idea was to have that conversation, depending on the results of the pilot.

If the financial results are positive and the program was expanded, how long would it take to overcome the Plan's financial shortfall? Mr. Rish stated that it would take a long time, given the operational effort required to expand to other areas. He noted that a financial analysis on the Wilmington Health project will be available in April.

What can be done to overcome the current financial deficit, given that the General Assembly is unlikely to appropriate more money to the Plan? Mr. Watts stated that, until staff has a chance to determine how well the Wilmington Health project has performed, other cost-saving options will be reviewed.

If the Plan decides to move in this direction, a review of the NC Medicaid system would be appropriate since they're on a capitated system.

Gender Dysphoria Facility Analysis

Mr. Rish provided a summary of the gender dysphoria related expenditures for the last half of 2022 through November 2023.

Financial Forecast

A summary of the financial projections as of 3rd quarter 2023 for Calendar Years (CY) 2024-2026 was provided. Mr. Rish noted that a data refresh would occur after the Plan receives the 2023 4th quarter projections sometime in February 2024.

Glucagon-Like Peptide-1 (GLP-1s) (Weight Loss Drugs)

Mr. Watts began by reviewing the actions taken by the Board at the October 2023 meeting. In that prior meeting, the Board voted to exclude coverage of GLP-1, GIP-GLP-1 agonists and other similar new molecular entities, when used for the purpose of weight loss, for members who had not previously filled a prescription, effective January 1, 2024. At that meeting, the Board requested Plan staff to research options or alternatives for utilization management opportunities.

Since then, Plan staff have met several times, in person and virtually, with representatives from the drug manufacturing companies, as well as with CVS Caremark, the Plan's Pharmacy Benefit Manager (PBM). Mr. Watts stated that the Plan has been very transparent regarding the frustration in attempting to find a solution to contain the cost for weight loss drugs. He added that the manufacturer's contract with the PBM prevents the Plan from providing access to the medication, for the members who need it most, due to the financial barrier.

In reviewing the cost and utilization increases of GLP-1 drugs over the past year, Mr. Watts stated that there are three things to consider for coverage of GLP-1 drugs for weight loss: 1) lowering the price of the medications to where it's cost-effective and the Plan is able pay for them, 2) increasing rebates to the point where the drugs are affordable, or 3) giving Plan staff the flexibility to manage utilization. He added that the Plan is in the second year of the PBM contract and to their credit, CVS Caremark has been willing to meet and discuss options with the Plan, but there hasn't yet been a viable solution.

Dr. Emma Turner, Chief Economist, Dr. Jenny Vogel, Sr. Clinical Pharmacist and Ms. Sonya Dunn, Plan Integration Manager, presented additional information on GLP-1s. Dr. Turner reported that approximately 2,000 members received new prescriptions for GLP-1s between October 26, 2023 and January 1, 2024. Approximately 24,000 Plan members, who have prescriptions for GLP-1s, account for 10% of the Plan's 2023 pharmacy spend, which is approximately $1 billion.

Ms. Dunn stated that the PBM helps the Plan administer the pharmacy benefits and passes 100% of the rebates to the Plan. Excluding GLP-1 drugs for weight loss and changing the prior authorization process would result in the loss of rebates for all GLP-1 drugs for weight loss. Mr. Watts added that, as of October 26, 2023, the Plan is paying the full list price of $1,349 for grandfathered members, whereas prior to that, the cost was $880.

The total cost of Wegovy, Saxenda and Zepbound in 2023, before rebates, was $170 million. The net cost was approximately $102.2 million. Without the rebates, the projected cost of 24,749 grandfathered participants in 2024 is approximately $139 million. In modeling the cost of grandfathered members, Dr. Turner stated that historical data and a probability model indicated that members who have taken GLP-1s for a year are likely to continue. Adherence to the newer medications, such as Wegovy, appears to be higher.

Board Comments and Questions Addressed:

Is there a way to negotiate rebates for grandfathered members? Mr. Watts responded that the Plan is in active discussions with the manufacturers of the GLP-1 medications, encouraging them to work with the PBM to help solve the problem. The Plan wants to provide the medications for those who need it most. Chair Folwell added the manufacturers pushed back when the Plan requested that protocols include limiting the number of months providers can prescribe the GLP-1s at one time and to require more frequent follow-up visits with the providers to ensure members are reaching their goals.

The financial report showed a projected shortfall in 2024 of $195 million whereas the GLP-1 presentation shortfall is $139 million. It would appear that the shortfall improved by $31 million. Dr. Turner responded that assumptions over time may have changed and that it will be important to closely review the 4th quarter data to get a more accurate analysis.

Is the Plan ensuring that the Food and Drug Administration (FDA) clinical indications for the GLP-1 drugs are being met? Dr. Vogel responded that in 2023, the utilization management program didn't require documentation for certain indicators. For example, a provider could chart that a member's Body Mass Index (BMI) was over 27, but the actual number wasn't required. That documentation is now required. She added that telehealth visits present a problem because the BMI test can't be administered.

Plan staff reviewed the top 25 prescribers of GLP-1 medications and found that they account for 8% of the Plan's cost for GLP-1s. On average, they prescribed to 80 Plan members. In addition, 64% of these prescribers had more than half of their patients on GLP-1 medications and nine providers had over 75% of GLP-1s. The 25 providers, which equates to less than .5% of all Plan providers, were responsible for 8% of the Plan's pharmacy costs for GLP-1 medications.

Many of the top 25 prescribers also saw members via telehealth visits. Several providers didn't submit medical claims associated with the prescriptions, indicating there wasn't a medical reason for the visit.

Dr. Vogel referred to a Reuters article that highlighted some pertinent facts. Over a 10-year period, Novo Nordisk paid U.S. providers approximately $25.8 million in fees and other expenses related to Saxenda and Wegovy, i.e., speaker fees and money for food and beverages. Fifty-seven providers received payments over $100,000.

Novo Nordisk also provided grants to fund obesity medicine certifications for prescribers. Providers who profit from the manufacturers are highly influential. They represent prescribers who work in teaching hospitals and write obesity medicine treatment guidelines, which then shapes prescribing practices. They contribute to writing the standards of care, which is a reference guide for primary care physicians.

In summary, the article noted that Novo Nordisk has been recruiting and paying obesity medicine specialists millions of dollars related to GLP-1 medications.

Dr. Vogel highlighted several utilization management options that the Plan presented to CVS Caremark following the October board meeting. These ideas represented appropriate use of the medications and targeted members who would benefit the most. The result for each option presented was 100% loss of rebates. Mr. Watts noted that after numerous discussions, it became apparent that something in the contract between the manufacturer and the PBM was driving the rebate impact.

Ms. Dunn provided a list of several utilization management programs that Plan staff reviewed, along with the associated cost and rebate impact. The Plan would incur a cost with each of the programs and the CVS program would be in conjunction with a GLP-1 medication. All but the CVS Weight Loss Program would result in the loss of rebates.

In response to a Board question at the October 2023 board meeting, Mr. Watts introduced a 2023 study in the New England Journal of Medicine titled *"Semaglutide and Cardiovascular Outcomes in Obesity without Diabetes."* This study, funded by the manufacturers, shows how the drug is most efficacious for a very small group of people. Mr. Watts noted his frustration in not being able to use it for that group of Plan members unless the Plan covers it for everyone without restrictions.

Dr. Vogel stated that following the October board meeting, a Novo Nordisk representative approached Board members telling them that the study would be released soon. They were asked to review the study to determine how it might apply to Plan members.

Popular media highlights included a 20% risk reduction in major adverse cardiovascular events in patients over 45, who had heart disease, were overweight, but who did not have diabetes. In reviewing the full details of the study, Plan staff reported that there was a 1.5% absolute risk reduction where 8% of patients treated with a placebo had a major cardiac event, vs 6.5% of those taking semaglutide. Mr. Watts noted that more than ¾ of the study participants had previously experienced a heart attack. In addition, a high percentage of the participants were receiving lipid-lowering medications or beta-blockers and 72% were obese, with a BMI over 30. Approximately 66% met the criteria for pre-diabetes. While the study results are positive, similar results can be found with statin medications, which are 98% less expensive.

Ultimately, this study did not apply to the State Health Plan. The average Plan member on a GLP-1 medication is age 47, and only 2.5% had a medical claim indicating a heart attack or stroke. Novo Nordisk essentially wanted to expand the use of GLP-1s for prevention of secondary cardiac events in this targeted group of patients. Even if the Plan wanted to use this trial, it doesn't have the utilization management flexibility to target this group of members without the loss of rebates.

Board Comments and Questions Addressed:

Understanding that the clinical trial used very sick people, the 20% risk reduction might seem to imply that with less sick people, the risk reduction might increase. If the medication were used by healthier people as a preventative measure, as opposed to its use as a secondary treatment for a cardiac event, it might result in Plan savings. Dr. Vogel responded that without a clinical trial, it would be hard to prove. A board member added that the number one risk for a secondary heart attack was a prior heart attack. Mr. Watts stated that the Plan would be happy to review the available data further.

Mr. Watts reviewed the four options for the Board to consider, three of which would require a motion by the board.

1. Enact a full exclusion, end grandfathering that was approved at the October 26, 2023 Board meeting, and take no further action.
2. Enact a full exclusion, end grandfathering, and direct Plan staff to continue exploring options with the PBM and the manufacturers.
3. Maintain status quo and direct Plan staff to continue exploring options with the PBM and the manufacturers.

4. Maintain status quo and give the Plan staff no further direction. This option would not require a vote.

Board Comments and Questions Addressed:

It's a hard decision that affect people's lives. While the Plan is paying astronomical prices for these drugs, advocating for the members who truly need these medications is important.

Has the Plan researched what other states are doing to see if there are ideas that may work in North Carolina? Chair Folwell responded that Plan staff have done a great job researching what other states and health plans are doing. He added that he believes the two major manufacturers of these medications have no interest in competing against each other.

Each board member is a fiduciary for the State Health Plan and are here to protect the interest of the members.

Semaglutide is an effective drug and probably helps to prevent heart disease. Approximately 28-33% of people who start taking the drug stop taking it after the first year. There's also a concern with the side effects and muscle loss associated with GLP-1 drugs. The underlying issue is the cost of the drugs in the United States. The manufacturers could decrease the cost of these drugs as they've done with others. The board member supports moving the GLP-1 drugs to a pharmacy tier that is more affordable for the Plan.

Another choice would be the Eli Lilly product, Zepbound, which is approximately 40% less expensive. What would the impact be for the Plan to sole source Zepbound? Dr. Turner responded that it would be approximately 20% less and it's not clear if the Plan would receive rebates.

It appears the manufacturers and the PBM want to maintain the price at a high level. Mr. Watts responded that the most disturbing comments from one of the manufacturers is that "we're not interested in supplanting our competitor." The Board member added that if the contract between the PBM and the Plan isn't working, it doesn't seem like the relationship should continue.

Is there legislative action that could be taken to address the problem? Chair Folwell stated that the lobbying efforts of the pharmaceutical industry are very strong, and he isn't hopeful that any legislative action would be taken at either the state or federal level.

One Board member expressed appreciation to Plan staff for all their efforts in trying to solve this problem and stated that the actions of the PBM and Novo Nordisk are unconscionable. However, the Plan members shouldn't suffer for their actions. These are lifesaving, not cosmetic, medications and denying coverage shouldn't be an option. Doing the most good for the most people doesn't make logical sense. In the long term, the cost benefits will become evident when current employees retire.

Board Motion: Judge Duke stated that the Board has a fiduciary responsibility to protect the Plan and made the following motion to be effective April 1, 2024; seconded by Dr. Robie:

"To protect the fiscal solvency of the Plan for current and future members and safeguard the goal of lowering member and family premiums, I move that the Plan exclude all benefits coverage for, and end the grandfathering of, GLP-1, GIP-GLP-1 agonists, and other similar new molecular entities when used for the purposes of weight loss, effective April 1, 2024."

Board Comments and Questions Addressed:

While understanding the fiduciary responsibility, concern was expressed that this decision would cut off the ability to further negotiate with the drug companies. Plan staff were encouraged to continue the rebate discussions with the PBM and manufacturers and not end coverage for Plan members.

Making this decision may end putting the Plan in a better position to negotiate.

Could the vote be delayed until after the board meeting on April 25? Plan staff indicated that, operationally, a mid-quarter change would be possible.

Could the Pharmacy & Therapeutics (P&T) Committee tier the GLP-1 medications at their meeting in February? Caroline Smart, Sr. Director of Plan Integration, stated that the P&T Committee could recommend tier changes, but since that change would affect the member's cost share, Board approval would be required.

Board Motion to Amend Judge Duke's Motion: Mr. Stevenson made the following motion to amend Judge Duke's motion, extending the date to April 30, 2024; second by Mr. Vernon; roll call vote taken; amendment failed 5-2:

"To protect the fiscal solvency of the Plan for current and future members and safeguard the goal of lowering member and family premiums, I move that the Plan exclude all benefits coverage for, and end the grandfathering of, GLP-1, GIP-GLP-1 agonists, and other similar new molecular entities when used for the purposes of weight loss, effective April 30, 2024."

Board Comments and Questions Addressed:

Following the October 2023 meeting, the Board voted to end coverage for new GLP-1 prescriptions for weight loss effective January 1, 2024. Members who were already taking these medications were excluded from the moratorium. The current vote to end coverage of GLP-1 drugs for weight loss for everyone has greater consequences. A proposal for consideration was made: 1) ask the P&T Committee to make Zepbound the sole formulary drug and ask Plan staff to do the modeling to determine if it would be cost-effective and provide savings; 2) expeditiously explore using a third party to administer specialty medications for the Plan; and 3) seek to end the current contract with the PBM as quickly as possible switch to a new PBM; if nothing else, use the lessons learned when negotiating the next contract.

Judge Duke stated this motion is outside the motion on the floor and called the question.

Board Vote on Judge Duke's Motion: Motion by Judge Duke; second by Mr. Stevenson; roll call vote was taken; motion passed 4-3.

Mr. Watts stated that the Plan would ask the P&T Committee, with their clinical expertise, to review Zepbound as a sole formulary drug. He added that Plan staff would review the request of having a third party administer specialty drugs. The Plan will also report PBM contract options at the next board meeting.

Director Walker stated that the Plan projects a shortfall in 2024 of $195 million and that the motion by the board at this meeting to end coverage of GLP-1 medications for weight loss is projected to save approximately $100 million. She requested Plan staff to review cost-saving options for the remaining $95 million and provide them to the board at the April meeting. Dr. Robie requested Plan staff to also take into account for the potential loss of income with the recent decisions by UNC and ECU.

Adjournment

Chair Folwell called for a motion to adjourn.

Board Vote: Motion by Mr. Fish; second by Ms. Bush; vote was taken; unanimous vote by Board to adjourn.

The meeting was adjourned at 4:30 p.m.

Minutes submitted by: Joel Heimbach, Secretary

Approved by: _____

Dale R. Folwell, CPA, Chair