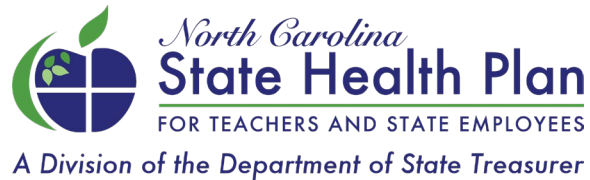




August 20, 2026

Medical Policy Advisory Committee

Benefit Limitations / Tier Changes
and Medical Conditions



North Carolina
State Health Plan

FOR TEACHERS AND STATE EMPLOYEES

A Division of the Department of State Treasurer



Agenda

1. Convene Meeting

- Welcome & Call to Order
- Conflict of Interest Statement

Dr. Brian Miller, Chair
Dr. Brian Miller, Chair

2. Old Business

- Approve Minutes from May 13, 2026 meeting

Dr. Brian Miller, Chair

3. State Health Plan: Important Updates

- Reference: [Full Press Release](#)

Dr. Brian Miller, Chair

4. Discussion Topics / Committee Feedback

Introduction of Speaker: Dr. Richard Bock

Varicose Vein Treatment Lifetime Limitation

Dr. Brian Miller, Chair

- Review of Benefit Booklet Limitations
- Histotripsy Overview
- Tier Changes and Medical Conditions

5. Committee Recommendations

6. Adjournment

Dr. Brian Miller, Chair

Welcome & Call to Order / Roll Call

Medical Policy Advisory Committee Members

- **Brian Miller, MD (Chair)**
- Joel Gallagher, MD
- Anna Edhegard, MD
- Caroline Wilds, MD
- Zari Cain-Akbar, MD
- Kathy Ricardson, MD
- Jugta Kahai, MD
- Prathana Jain, MD
- Jennifer Parker-Cote, MD
- Geoffrey Rose, MD
- Carl Gessner, MD
- Fabian Johnston, MD
- Justin Sullivan, MD
- Susan Moore, MD
- Steven Bokshan, MD

State Health Plan Staff

Tom Friedman, Executive Director

Beth Horner, Chief of Staff

Sonya Dunn, Integrated Health Management Director

Ethics Awareness & Conflict of Interest

In accordance with the [Recusal Guidelines for Public Servants](#), it is the duty of every member of the Medical Policy Advisory Committee, whether serving in a vote casting or advisory capacity, to avoid both conflicts of interest and appearances of conflict.

Members are asked to disclose any conflicts of interest, or the appearance thereof, regarding today's discussion. Should a conflict become apparent during the proceedings, please declare it and recuse yourself from the matter involved.

Does any Committee member have any known conflict of interest or the appearance of any conflict? If so, please state it at this time.

Approve Minutes from May 13, 2026

REVIEW:

- Copies of the minutes were distributed prior to the meeting for your review.
- Are there any additions or corrections to the minutes?

REQUEST MOTION / VOTE:

- Motion to approve the minutes? Second? All in Favor?

FINALIZE:

- Motion carries. The minutes stand approved.

State Health Plan: Important Updates

July 10th Board of Trustees Meeting

The State Health Plan (Plan) Board of Trustees took several landmark actions at making tangible improvements for the state's hardworking teachers, state employees and retirees. These steps are aimed at affordability, strengthening access to care and ensuring the long-term sustainability of the Plan for its nearly 750,000 members.

The Board of Trustees voted on the following:

- ✓ Approved the contract award for Third-Party Administrative (TPA) Services to Blue Cross NC, effective Jan. 1, 2028.
- ✓ Approved the contract award for Pharmacy Benefit Manager (PBM) for Blue Cross NC, effective Jan. 1, 2028.
- ✓ Approved Preferred Provider contracts with UNC Health and Novant Health effective Jan. 1, 2027.
- ✓ Approved 2027 premium rates for all members.
- ✓ Approved 2027 benefit changes, including some decreased copays associated with parts of the new tiered provider network.

Plan Limitation Discussion

Introduction of Speaker: Dr. Richard Bock

We are pleased to welcome board certified vascular surgeon, **Dr. Richard Bock**, Attending Physician and Medical Director at the Asheville Vein Center who will share his clinical perspective on the “**ONE LEG PER LIFETIME**” varicose vein exception.

Plan Limitation: Varicose Vein Treatment

Medically necessary varicose vein treatments are covered with lifetime limits:

1 endovenous procedure per limb per lifetime and 3 sclerotherapy procedures per limb per lifetime.

Richard Bock MD, Vascular Surgery

- Medical School: University of Virginia
- General surgery residency: University of Louisville (6 years)
- Vascular surgery fellowship: U.C.L.A (2 years)
- Asheville NC 1995: founded/chief Mission Health vascular surgery
- 3 years as chief of vascular surgery, Presbyterian (Charlotte, 2016-19)
- Vein subspecialty research & clinical: part-time since 2003
- **Full-time vein disease subspecialty in Asheville since 2019**
- Added second vascular surgeon in 2021

WNC: 18 counties
Western Tennessee
North Georgia



Vein problems: the *other* side of vascular disease

- Redheaded stepchild of vascular surgery
- Not exciting
- Our incisions are 2mm max
- Nobody dies

Major morbidity!

Please note, the upcoming slides contain graphic images that some viewers may find disturbing. If you prefer not to view graphic medical photos, feel free to look away or step outside for a moment.

CEAP Classification for CVD



Telangiectasia
or Reticular Veins



Varicose Veins



Edema



Pigmentation
or Eczema



Lipodermatosclerosis
or Atrophie Blanche



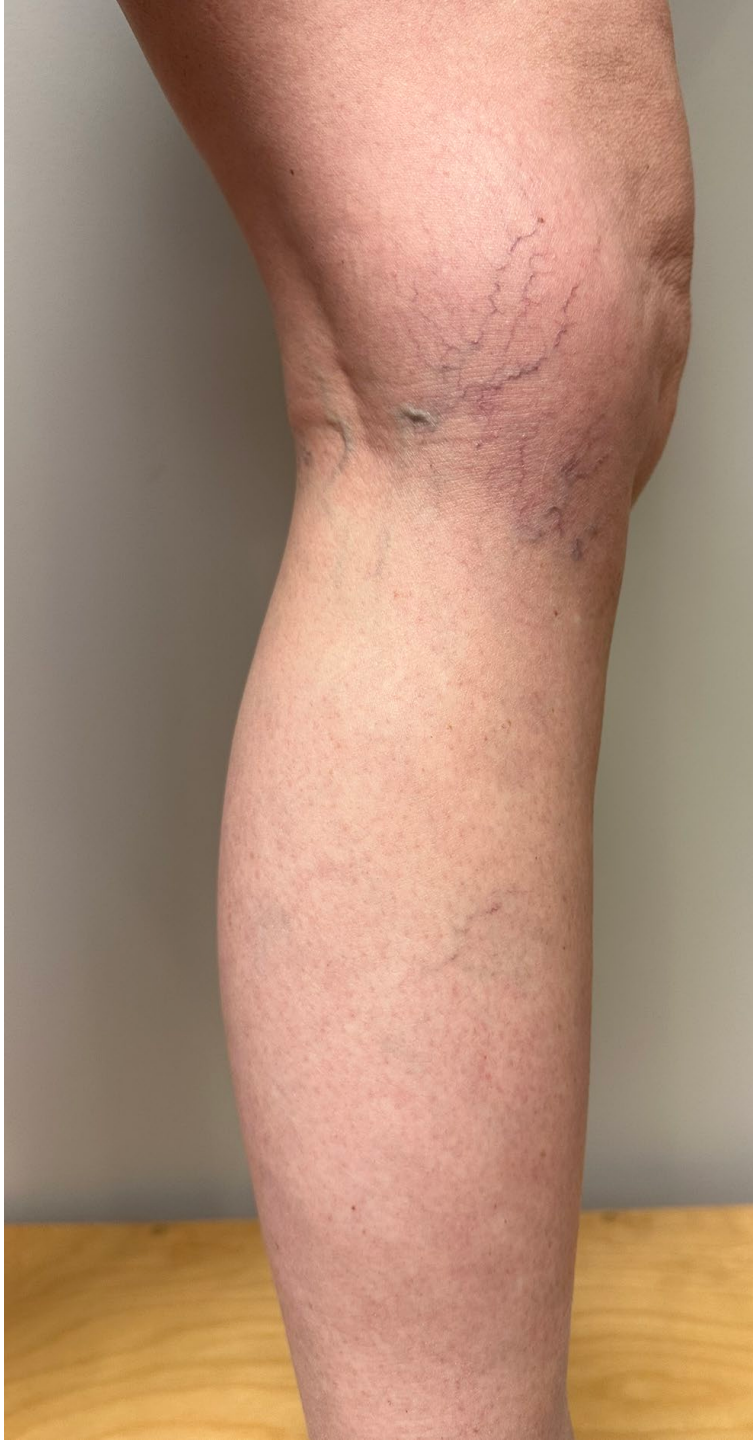
Corona
Phlebectatica



Healed
Venous Ulcer



Active Venous Ulcer





Chronic venous insufficiency: earlier symptoms

- Dull, aching, fatigue-like pain
- Swelling
- “My leg feels like a telephone pole by the end of a day of work”
- Worse at end of day
- Improved with exercise
- Improved with elevation

Chronic venous insufficiency: who gets it

- Occupational
 - Hairdressers
 - Cooks
 - Surgeons
 - Teachers
- Genetic
- Obesity
- Multiple pregnancies
- Or just bad luck

Chronic venous insufficiency: later symptoms & findings

- Worsening dull pain
- Edema
- Skin changes
- Superficial thrombophlebitis (SVT)
- Acute hemorrhage
- Deep vein thrombosis (DVT)
- Open venous stasis ulcer



Radiofrequency
ablation (RFA) with
microphlebectomy

Performed in the
office

Local anesthesia

Patients are up &
walking immediately

1-2 days off work

96-98% effective





Microphlebectomy





**Lidocaine + Epinephrine:
shrinks the vein
temporarily
by 90%**





Microphlebectomy











36-year-old



3 months postop



45-year-old



1 week postop



4 months postop

Spontaneous hemorrhage from varicose veins

- Painless
- Profuse
- "Spurting through the air"
- "Murder scene"





Protocol-based treatment of spontaneous hemorrhage from varicose veins prevents short- and long-term recurrence of bleeding

Richard Bock, MD • Danielle Fontenot, MD, RVPI • Spencer Bock, BA
Gwyn Eiler, RVT • Kristie Worley-Fry • John Blebea, MD MBA



UIP2023

Connecting the Continent... Welcoming the World





Case report

Unattended fatal haemorrhage due to spontaneous peripheral varicose vein rupture—Two case reports

E. Doberentz^{a,*}, L. Hagemeyer^a, C. Veit^b, B. Madea^a^a Institute of Forensic Medicine, University of Bonn, Stiftsplatz 12, 53111 Bonn, Germany^b Institute of Pathology, Johannes Wesling Klinikum Minden, Hans-Nolte-Str. 1, 32429 Minden, Germany

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Varicose veins

Varicosis

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Venous haemorrhage is a rare complication of varicose veins of the legs. Varicosis is found in 15–50% of the population. Haemorrhage from ruptured varicose veins of the legs can occur spontaneously or after a minor trauma. More frequent complications of varicosis include peripheral oedema of the ankles, skin pigmentation and skin ulcers. In case of venous haemorrhage simple possibilities of first aid can be applied, therefore fatal haemorrhage is a rarity. Two cases of fatal varicose vein rupture are presented. A 58-year-old man and a 76-year-old woman, both living alone, were found dead in the bathrooms of their apartments. Significant traces of blood were found in all rooms. Both corpses showed typical signs of death from exsanguination. No traumatic lesion was found. Cause of the haemorrhage was a small lesion of the skin of the lower legs of the victims with continuation to an underlying superficial varicose vein. Misinterpretation of life-threatening varicose haemorrhage, unconsciousness, alcohol or drug influence, old age and dementia can promote the death. In case of fatal haemorrhage the death scene can simulate crime due to massive traces of blood and may focus primarily on a non-natural death. However, police investigations and autopsy will disclose the rare cause of spontaneous natural death.

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1. Introduction

In case of fatal haemorrhage the death scene can simulate accidents, suicide or even crime due to massive traces of blood and may focus primarily on a non-natural death [2]. Varicose veins are found in 15–50% of the population in developed countries [13,15]. Fatal varicose bleeding as a sudden natural death is a very rare phenomenon and few cases of venous varicose haemorrhage in the literature have been reported (Table 1) with a wide difference of incidence. Byard et al. found in a period of 10 years 8 cases with fatal haemorrhage due to varicose vein rupture among 10,686 autopsies. Racette and Sauvageau reported only 9 cases in 30 years. Evan et al., however, reported on 23 cases of fatal haemorrhage in just 1 year (1971). In an investigation of about 30,000 autopsies 12 cases of fatal haemorrhage were found [18]. Weyrich reports of an incidence of 0.7 per mille cases.

Two cases of fatal varicose vein rupture are reported here with a review of literature.

2. Case reports

2.1. Case 1

A 78-year-old woman was found dead by her daughter lying in the bathroom of her apartment (Fig. 1). In the kitchen was a large pool of blood (Fig. 2). On the kitchen floor a long strip of plaster was found. Bloody footprints from victim's steps were found in the hall (Fig. 2). They indicated the way into the bathroom where the woman was lying. In the bathroom was blood on the floor, in and around the toilet bowl. On the left heel a blood-soaked plaster had been applied. According to the treating family physician, the woman had not taken any antithrombotic medication. High blood pressure, a slight depressive syndrome and also slight varicosity were known but therefore medical treatment was not indicated.

The external examination showed a body with a weight of 57.4 kg and a body length of 153 cm with sparsely developed livores and pale skin. The external examination revealed a small 1–2 mm lesion of the superficial skin on the left heel (Figs. 1 and 3) connected with a superficial varix (Fig. 4). Some visible varicose veins of the legs, particularly on the lower thigh, on the right and left dorsum of the foot and the left heel were found. No traumatic lesions were revealed.

The internal examination revealed bloodless organs, subendo-cardial haemorrhage, shock kidneys, pulmonary emphysema, fatty



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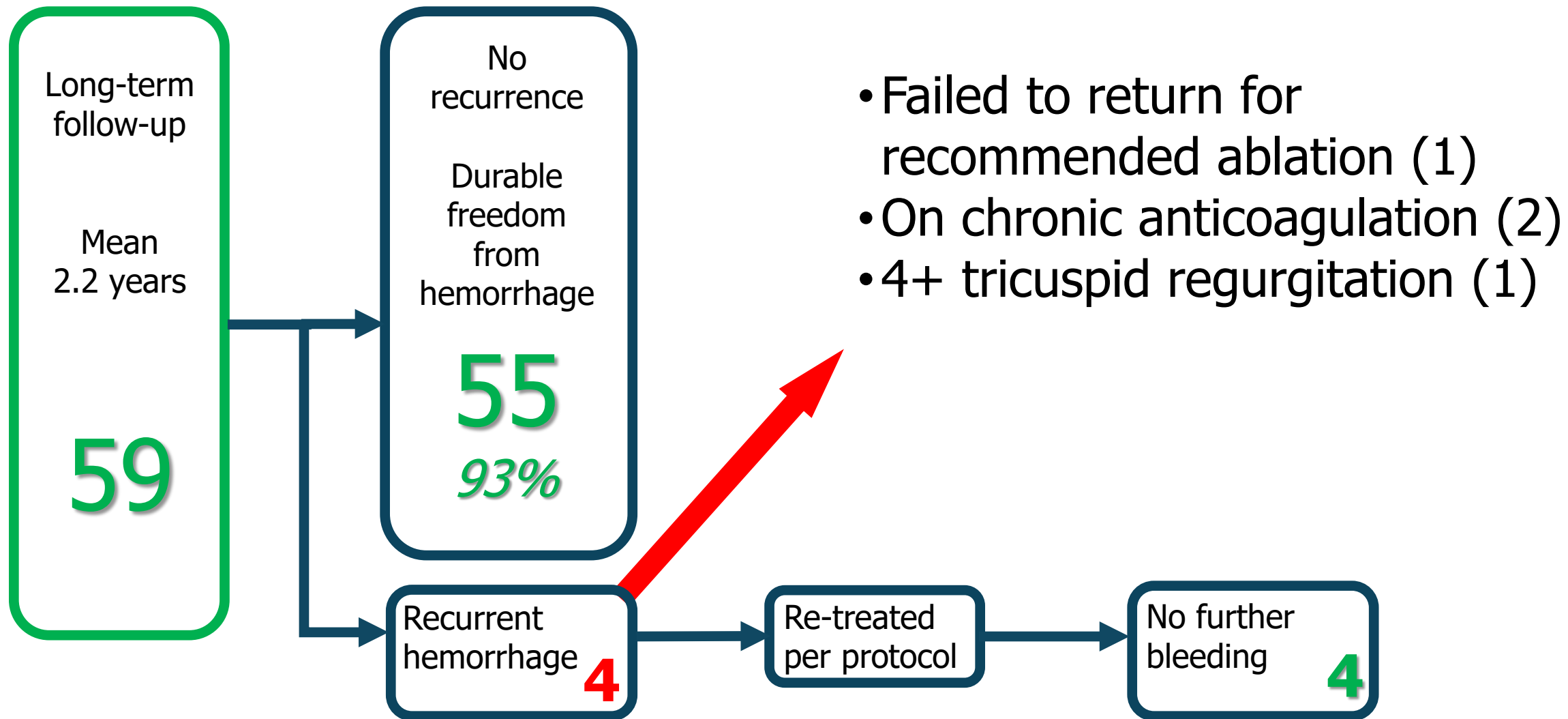
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Death from spontaneous hemorrhage of varicose veins

- Incidence estimated 1/2100 deaths
- 0.7 – 1.3/million population
- 245 to 500 deaths per year in the USA
- Many thousands of non-fatal bleeds





Richard Bock, MD • Danielle Fontenot, MD, RVPI • Spencer Bock, BA
Gwyn Eiler, RVT • Kristie Worley-Fry • John Blebea, MD MBA

"Patient X"

February 27, 2026

Teacher

No photographs

Endovenous ablation left great saphenous vein 2019 by a radiologist

Within 2 years developed huge nest bulging varicose veins left thigh

Deep dull aching pain left leg with skin changes

Prolonged standing in job

Risk thrombophlebitis (clot) DVT or SVT

Pain

Needed RFA saphenous vein with microphlebectomy

SHP Aetna *policy exclusion*

“One vein per leg per lifetime”

"Patient X"

April 7, 2026

Acute superficial thrombophlebitis

Unrelenting pain & inflammation

Risk of DVT/pulmonary embolism/death

Full anticoagulation – Eliquis

Pain medicine

Out of work

Now he **cannot have**
RFA saphenous vein with
microphlebectomy

Contraindicated: severe inflammation
and clot

Instead: pain medicine
Wait 6-12 months



"Patient X"

July 27, 2026

Clot slowly resolving

Pain improved

Skin ulcerating at ankle

Ultrasound: persistent
clot, so too soon for
intervention

Wait another 6 months

Aetna/SHP policy exclusion



“One vein per leg per lifetime” policy

- Plan *exclusion*: not subject to appeal
- Blue Cross – Blue Shield of NC since 2016
- The only such BCBS in the country
- The only such policy among *any* insurer in the country

“One vein per leg per lifetime” policy

- 2024: was carried over to the Aetna State Health Plan
- No other Aetna plan carries this exclusion
- 550,000 lives
- People like "Patient X"

Suggested policy change: Option 1

- **Use Aetna's national/N.C. policy**
 - Three months conservative management, then return visit
 - Allows prompt treatment in patients with:
 - Superficial thrombophlebitis
 - Hemorrhage
 - Ulceration
 - Pre-authorization process before treatment permitted
- **Downside:**
 - Needless delays in symptomatic teachers and other State employees
 - Not supported by medical literature
 - Wasteful (teacher downtime, pre-authorization process)

Suggested policy change: Option 2

- **Allow treatment only by board-certified specialists**
 - Vascular surgeons
 - Interventional cardiologists
 - Interventional radiologists
 - General surgeons
- Downside:
 - Pushback from vein clinics run by less-trained/non-certified physicians and NP's

Suggested policy change: Option 3

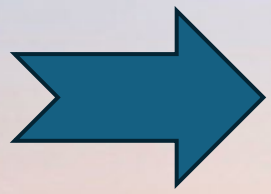
- **Adopt Medicare policy**
- CEAP class 2 - 3: three months of conservative management
 - Lifestyle changes
 - Trial of 20-30 mmHg medical grade compression stockings
- CEAP class 4 – 6: allow prompt treatment
 - End-organ damage (skin)
 - Hemosiderin deposition
 - Lipodermatosclerosis and/or corona phlebectatica
 - Ulcer
- Downside: none

Market trend





- 22% Commercial
- 78% Medicare, Medicaid, No-pay



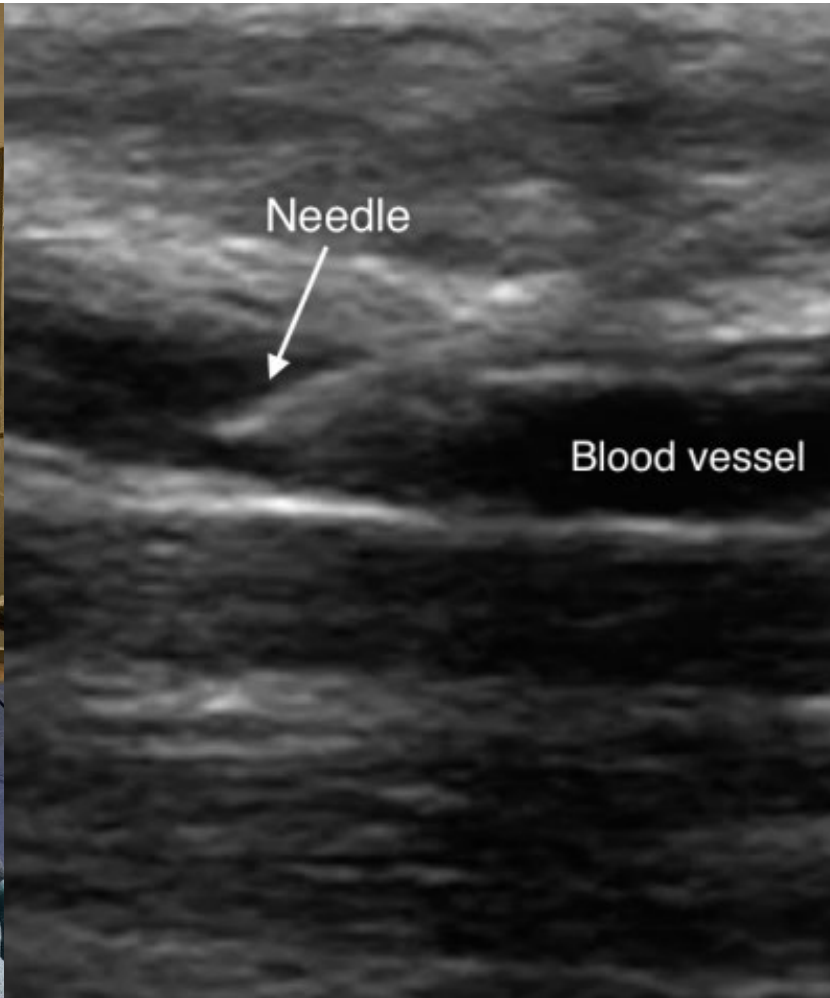
State Health Plan — 1VPLPL
Blue Cross — 1VPLPL

ASHEVILLE
VEIN
CENTER

WNC: 18 counties
Western Tennessee
North Georgia



Venclose small saphenous ablation for ulcer



ASHEVILLE
VEIN
CENTER



Committee Task: **Action Item**

Committee members were requested to complete the following actions:

- **Evaluate Plan Limitations:**

Review the current benefit limitations outlined in the 2026 BENEFITS BOOKLET and submit feedback.

- **Assess New Treatment Option:**

Evaluate internal research on histotripsy to determine its viability of State Health Plan coverage.

- **Identify Continuity of Care Risks:**

Pinpoint medical conditions where a transition between specialists would introduce clinical risk.

This assessment supports the implementation of new network tiers in January 2027, minimizing member disruption during cost-coverage alignment.

Committee Feedback: **Evaluate Plan Limitations**

Committee Comments:

“Plan limitations are reasonable & appropriate”

PLAN LIMITATION: SKILLED NURSING CARE

Limited to 100 visits per benefit period. Precertification/prior authorization is required.

- **Propose:** Expanding nursing benefit to 120-150 visits up to 4 hours a visit / per year.

PLAN LIMITATION: VARICOSE VEIN TREATMENT

Medically necessary varicose vein treatments are covered with lifetime limits:

1 endovenous procedure per limb per lifetime and 3 sclerotherapy procedures per limb per lifetime.

- **Propose:** Expanding coverage through the prior authorization process.

Committee Feedback: **Histotripsy**

Assess New Treatment Option:

Evaluate internal research on histotripsy to determine its viability of State Health Plan coverage.

- Histotripsy is a non-invasive interventional radiology procedure that utilizes focused ultrasound waves to destroy targeted soft tissue without the need for incisions, heat, or radiation.
- As this coverage expands across other plans, we are evaluating it for the State Health Plan.
- Committee members were requested to evaluate the compiled research and determine if the procedure should be recommended for subsequent coverage consideration.
- We would also like to share projected cost figures from Segal.

Histotripsy Procedure: **Segal Projected Cost**

HISTOTRIPSY

524,465	Non-Medicare Members	
\$ 18,000	Cost per treatment \$18,000	
	0.05 utilization per 1,000	*Emerging treatment. Only 200 treatments nationally as of June 2024. Assume low utilization with lack of data.
26.22	# of treatments	
\$ 500,000	Projected Allowed Cost (no cost share)	
\$ 400,000	Projected Plan Cost (assume 80% AV)	

* No shape data...could be used as substitute for more expensive surgeries to remove liver tumors.

New York-Presbyterian and Weill Cornell Medicine are participating in a study to collect data on all patients that receive histotripsy around the country to compare their results to other treatments. These patients will be followed for five years. So far, about 200 patients have been treated nationally with histotripsy.

Committee Feedback: **Histotripsy**

Committee Comments:

- In support of coverage within defined clinical criteria and FDA-cleared indications, aligning with standard health plan guidance. Access should target appropriate patients at experienced centers while long-term outcomes and cost-effectiveness data emerge.
- As an oncologist, I have had patients inquire about this procedure and request referrals. Suspect that indications will increase over time assuming the long-term data is positive. Given the reduced side effects associated with histotripsy, it would be wonderful to see this replace more invasive procedures. Recommend coverage with prior authorization based on standard criteria.
- Histotripsy is a safe alternative to reduce tumor burden. I would vote yes to coverage.
- Because better-tested, proven alternatives exist, use should currently be restricted to investigational purposes. Consequently, coverage for State Health Plan beneficiaries is not recommended.

Committee Feedback:

Identify Continuity of Care Risks

The Plan will implement new network tiers in January 2027, which may require some members to transition to different specialists to maintain optimal cost coverage. Please identify any specific medical conditions where a disruption or a switch in specialists—even within the same field—would place a member at clinical risk.

Committee Feedback:

Identify Continuity of Care Risks

Committee Comments:

- As an oncologist, I have a strong view that patients undergoing active treatment for a malignancy should be allowed to remain with their treating oncologist. Continuity of care for these patients is critical. Since the care of oncology patients is frequently multidisciplinary, would the continuity of coverage extend to other specialists involved in the patient's care within the same institution? Survivorship care can likely be shifted to a new physician.
- Not all neurologists provide specialized treatments like Botox for migraines or up-to-date epilepsy care. Furthermore, managing nuanced conditions like Parkinson's disease relies heavily on a stable patient-neurologist relationship, making forced changes in specialists highly disruptive to patients and the workforce.
- Ulcers of colitis and Crohn's disease would be conditions where disruption or switch-in specialist could place a member at clinical risk and allowances should be made. In my specialty, gastroenterology, it can be very difficult to get access to another gastroenterologist due to current demand. Chronic liver diseases are another area of concern, also. Requiring a change of hepatologist and the delay associated with obtaining an appointment with a new hepatologist could place a member at clinical risk, also.
- Concerned about patients with complex conditions where access to specialty care is limited. For example, complex hematologic, rheumatologic, gastrointestinal, endocrine or pulmonary disorders. At a minimum, there would need to be a long runway to transition care.

Committee Feedback:

Identify Continuity of Care Risks

Committee Comments:

- I am concerned that access to care in some geographies will be compromised due to potential large shifts in patient volumes. Resources and access that is already stretched could worsen. The other challenge is in geographies with no preferred option.
- **EXCEPTIONS** should be made for any **PATIENT CURRENTLY WITH** a **SCHEDULED SURGERY** or **PROCEDURE** on the books, oncology patients in a treatment plan, obstetrical patients.
- Recommend 6 to 12-month continuity-of-care exceptions to reduce clinical and travel risks for patients in complex or critical treatment, including:
 - Active cancer therapies
 - Organ transplant monitoring
 - High-risk pregnancies
 - Advanced heart failure
 - Severe mental illness
 - Complex pediatric conditions
 - Sub-specialist care for neurological diseases
 - Biologic treatments for autoimmune diseases

Next Steps: Plan Staff

Research trends, policies and financial impacts regarding:

- Expansion of varicose vein treatment thorough the prior authorization process.
- Coverage of histotripsy procedure thorough the prior authorization process for experienced clinical centers and FDA-cleared indications.
- Continuity of care exceptions - provide 6 to 12 months of extended coverage to reduce clinical and other risks for patients undergoing complex, critical, or specialized conditions and treatments such as:
 - Active cancer therapies
 - Organ transplant / monitoring
 - Pregnancy
 - Advanced heart failure
 - Severe mental illness
 - Complex adult / pediatric conditions (examples: complex hematologic, rheumatologic, gastrointestinal, endocrine or pulmonary disorders.
 - Sub-specialist care for neurological diseases
 - Biologic treatments for autoimmune diseases

Next Steps: Vote Recommendations

- MOTION
- SECOND
- ALL IN FAVOR

➤ ROLL CALL

➤ MOTION to ADJOURN / Second / All in Favor



Thank you!