Board of Trustees Meeting
In-Person/Webinar/Recorded
April 27, 2023
Minutes

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 1:00 p.m. on Thursday, April 27, 2023.

Board Members Present: Dale R. Folwell (virtual participation), Wayne Fish, Kim Hargett, Peter Robie, M.D., Mike Stevenson, Cyrus Vernon

Absent: Cherie Dunphy, M.D., Russell "Rusty" Duke, Kristen Walker (Anca Grozav, Chief Deputy, Office of State Budget and Management, attended on behalf of Ms. Walker)

Welcome
Chair Folwell welcomed the Board and members of the public to the meeting.

Conflict of Interest
No conflicts of interest were noted.

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.

Board Approval

Minutes – February 22, 2023, Meeting

> ***Board Vote:*** Motion by Dr. Robie; second by Mr. Stevenson; roll call vote was taken; unanimous vote by Board to approve the February 22, 2023, meeting minutes.

What the Health Update

Medical Debt De-Weaponization Act

Frank Lester, Deputy Treasurer, Communications & Government Affairs, stated that Senate Bill 321, the Medical Debt De-Weaponization Act, has seen movement through several committees this year and was scheduled to be heard by the full Senate on May 1, 2023. The bipartisan legislation emphasizes limiting the ability of large medical facilities to charge unreasonable interest rates, employ unfair debt collection tactics, and charge facility fees. For patients, medical debt has become a leading cause of bankruptcy. Among other things, this bill seeks to require large health care facilities to post price information on their websites.

Sam Watts, Interim Executive Administrator, stated that discussions surrounding these issues started in February 2022 and eventually evolved into a legislative bill. As Treasurer Folwell traveled around the state hearing people's stories regarding the inability to pay medical bills, many members joined in the effort to try and force changes in the hospital systems. Some explored debt relief/forgiveness programs.

Operations Updates

Legislative Update

Mr. Watts stated that the House version of the Appropriations bill included adequate funding for the Plan, following some negotiations on the level and timing of reserves. He added that the letter from the Board to the Senate and House leaders, regarding required funding, was very effective.

Mr. Watts introduced Jenny Vogel, Plan Pharmacist, and stated that CVS Health, the Plan's Pharmacy Benefit Manager, would provide a comprehensive presentation to the board at the July meeting.

Pharmacy & Therapeutics Committee Overview

Caroline Smart, Senior Manager, Plan Integration, provided an overview of the Pharmacy & Therapeutics (P&T) Committee. In 2017, the Plan introduced a closed formulary, which means that not all available medications are on the list of covered drugs. By statute, Plan staff is required to develop the formulary, in consultation with, and approval by, the P&T Committee. Ms. Smart noted that the Plan has an exception policy for drugs for members who require a drug that is not included on the formulary.

The Committee, which includes physicians licensed to practice in North Carolina, meets quarterly. All formulary changes must be approved by the Committee, including any utilization management programs. These recommendations are then presented to the Plan for adoption, subject to approval by the Executive Administrator.

Ms. Smart provided a list of P&T members and a summary of discussion items at a typical meeting. She also presented a list of the formulary tier structure and the member copays for each tier for the Enhanced PPO Plan (80/20) and Base PPO Plan (70/30). She noted the intersection between the P&T Committee and Board of Trustees, as the Board approves the member cost share amounts. The P&T Committee then recommends the tier in which the drugs belong.

Board Comments and Questions Addressed:

Question: When a drug or product is changed to a different tier or is no longer covered, what is the member impact? Ms. Smart responded that a letter is sent to affected members six weeks before a drug is removed from the formulary. Additionally, if a member is currently on a prescription medication that is to be excluded from the formulary, they can submit an exception to remain on the medication at a higher tier. The exception process is similar to the prior authorization process.

Dr. Robie, who is also a member of the P&T Committee, added that the Committee is currently reviewing and discussing generic vs. brand name drugs. In some cases, brand name drugs are underpricing generic drugs and the question is whether the terms brand and generic are beginning to lose their meaning. Ms. Vogel agreed there are cases where the brand drug is cheaper than the generic, and the Plan wants to do its part in passing on those savings to members. She added that CVS has done a great job of recommending the drugs and products that fall into that category. The Plan, in turn, informs the Committee and recommends that the brand name drug be moved to a lower tier in order for members to take advantage of the savings.

Enrollment Discussion

Beth Horner, Director of Customer Experience and Communications, provided a Medicare Advantage (MA) enrollment update. She reminded the board that the Plan saves $4,700 per member per year for each MA member. As of April 1, 2023, 86.4% of the Plan's Medicare retiree members were in the

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Medicare Advantage Plan, compared to 81.7% at the same time last year. With the increase of approximately 10,000 members in the MA plan, the Plan saved $47 million.

Ms. Horner stated that the Plan provides numerous educational opportunities for Plan members getting ready to retire. The Plan targets members 2-3 years prior to them turning age 65, inviting them to take advantage of the educational sessions. This helps them to understand the options they have available to them when they become Medicare-eligible.

She noted that some members choose the Base PPO Plan (70/30) over the MA plan for specific reasons. The challenge for the Plan is that members aren't required to provide the reason. There may be cases where members are better off in the Base PPO Plan (70/30).

Mr. Watts added that one of the Plan's goals is to try to identify more of these members and determine if the Plan can provide another option for them. Depending on the member's situation, it will also prevent them from being auto-enrolled in the MA plan.

Chair Folwell stated that there could be an environment where the percentage of members in the MA plans remains steady, while the enrollment increases. This is due to the increase in the number of members who are, or will become, eligible to retire. He added his support for Plan staff trying to identify members who aren't eligible for the MA plans and those who are better served in the PPO Base Plan (70/30). He concluded by stating that raising the percentage of members in the MA plans increases Plan savings, thereby increasing the possibility of lowering family premiums at some point.

Board Comments and Questions Addressed:

One board member expressed appreciation for the Plan's Customer Experience and Communications staff for the member outreach and education, both in person and webinars. She added that page 5 of the presentation demonstrates the Plan's transparency in acknowledging why there are instances where the PPO Base Plan (70/30) may be better for some members.

State Fiscal Year End & Calendar Year-To-Date Financials

Charles Sceiford, Health and Benefits Actuary, provided the financial update for Matthew Rish, who was unable to attend the meeting. He noted that the beginning cash balance on the Fiscal Year to Date report was due to the infusion of COVID-19 reimbursements the Plan received in March and April 2022. Plan revenues increased slightly, mostly due to the board's approval of the increase of the 2022 employer premiums. Net claims payments were unfavorable, largely because of claims processing issues by Blue Cross North Carolina (BCNC) at the beginning of Calendar Year 2022. He added that pharmacy claims increased significantly over the past months. Even with higher rebates, pharmacy claims increased approximately 10%.

The Calendar Year to Date (CYTD) basis report demonstrated that the Plan is starting off in a better place in 2023, compared to 2022, due to the significant number of COVID-19 claims that were paid at the end of 2021. Plan revenue was slightly unfavorable, mostly due to a timing issue of premium payments that should have come in in January, but which were processed in December 2022. 2023 Claims payments were considerably higher than 2022 due to the BCNC processing issues experienced in 2022. There were some administrative invoice processing delays at the end of 2022 causing some Administrative Expenses to be processed in 2023 which resulted in unfavorable experience compared to 2022. The ending cash balance was higher compared to the same time in 2022.

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Mr. Sceiford presented the 2020-2022 report of COVID-19 expenditures, noting that costs in 2021 were significantly higher. He added that the high number of testing and vaccine claims may have resulted in lower treatment costs. Through March 2023, the Plan has paid approximately $465 million for COVID-19 related claims and received $215 million from federal pandemic relief funds allocated to North Carolina. Mr. Watts reminded the board that any remaining federal funds could still be allocated to the Plan from the Office of State Budget and Management (OSBM).

Board Comments and Questions Addressed:

In response to a question as to whether the Plan's relationship with BCNC has changed since the Aetna contract with the Plan was announced, Mr. Watts replied that the Plan has not experienced a decline at the service level. He added that the Plan continues to have a strong working relationship with the BCNC team.

Other Information

In the spirit of transparency, Mr. Watts reported on two contract disputes between insurance carriers and health care facilities. The first involved letters from BCNC to members served by AdventHealth in Hendersonville, NC, stating that they would be considered out-of-network. However, by the time the letters were sent, the contract issue was resolved. The second one also involves out-of-network communication between Humana and members with ECU Physicians in Greenville, NC. However, this does not affect the Humana MA network and, and therefore, State Health Plan MA members.

Public Comment

No requests to address the Board were submitted.

Executive Session

Board Vote to Move into Executive Session: Motion by Ms. Hargett; second by Mr. Vernon; roll call vote was taken; unanimous approval by Board to move into executive session pursuant to G.S 143-318.11(a)(1) and (a)(3) and Chapter 132 to consult with legal counsel regarding the matters of *Blue Cross and Blue Shield of North Carolina v. State Health Plan and Lake v. State Health Plan.*

The Board met in executive session with Plan Interim Executive Administrator Sam Watts, Department General Counsel Ben Garner, Assistant General Counsel Aaron Vodicka, and Assistant General Counsel Joel Heimbach. Mr. Garner, Mr. Vodicka, and Mr. Heimbach discussed with the Board the contested case titled *Blue Cross and Blue Shield of North Carolina v. State Health Plan* in the Office of Administrative Hearings and the case titled *Lake v. State Health* Plan in Gaston County Superior Court.

Return to Open Session

Board Vote: Motion by Mr. Fish; second by Ms. Hargett; roll call vote was taken; unanimous approval by Board to return to open session.

Adjournment

Mr. Watts called for a motion to adjourn.

Board Vote: Motion by Dr. Robie; second by Mr. Stevenson; vote was taken; unanimous vote by Board to adjourn.

The meeting was adjourned at 2:35 p.m.

Minutes submitted by: Joel Heimbach, Secretary

Approved by: _____
Dale R. Folwell, CPA, Chair

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