North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Dale R. Folwell, CPA
State Treasurer of North Carolina
DALE R. FOLWELL, CPA

Board of Trustees Meeting
In-Person/Webinar/Recorded
April 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, April 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. Chair Folwell indicated that a quorum was present.

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.

Consent Agenda *(Requires Vote)*

Minutes – January 25, 2024, Meeting

> **Board Vote***:* Motion by Mr. Vernon; second by Mr. Stevenson; roll call vote was taken; unanimous vote by Board to approve the minutes from the January 25, 2024, Board meeting.

Public Comments

Mr. Kirk Montgomery, President, State Employees Association of North Carolina (SEANC), stated that while he advocates for members getting the medicines they need, the high cost of these drugs needs to be addressed. When the manufacturers charge 400 times more in the United States than they do in other countries, something has to be done to offset the cost for both members and the State Health Plan. The estimated 40% rebate that the manufacturers deduct from the list prices doesn't adequately address the problem. Making a profit is understandable and fine, but this is a matter of corporate greed. SEANC is actively pursuing legislative changes to make these drugs more affordable.

Introduction of Jessi Stout, PharmD

Dr. Jenny Vogel, Plan Sr. Clinical Pharmacist, introduced Jessi Stout, PharmD, and owner of Table Rock Pharmacy in Morganton, NC.

Independent Pharmacy Presentation

Dr. Jessi Stout provided an overview of Table Rock Pharmacy and a summary of the services they provide to the community. Dr. Stout discussed the history of pharmacy benefit managers (PBMs) in the United States.

Dr. Stout noted some of the major issues independent pharmacies experience, especially reimbursement rates below drug costs. Dr. Stout provided a sampling of claims from independent pharmacies to demonstrate the inadequate reimbursement rates. Dr. Stout presented a list of items for the Plan to review and investigate.

Judge Duke requested permission to put a motion on the floor for a Board vote. Chair Folwell stated that he would entertain a motion.

A Board member requested clarification on Direct and Indirect Remuneration (DIR) Increase, referenced in the presentation.

Board Motion and Substitute Motion: Request that Plan staff review and investigate each item on the list presented by Dr. Stout, plus the additional item, and put the questions to CVSCaremarkPCS Health, L.L.C. (CVSCaremark) in writing.

- Investigate why CVSCaremark reimburses pharmacies at different rates.
- Ask CVSCaremark why they often reimburse below medication acquisition cost.
- Ask CVSCaremark how they can contract with GoodRx/other PBMs to adjust prices (the contract is with CVSCaremark, not other PBMs) and to review the language in the contract.
- Review the PBM bid process – are rebate dollars submitted in the bid?
- Utilize a 3rd party advisor to investigate CVSCaremark's claims (spread pricing, fair reimbursement, maximum allowable cost [MAC] appeal success rate, rebate pass-through, etc.).
- Investigate DIR fees imposed by CVSCaremark.

Board Vote*:* Motion by Judge Duke; second by Dr. Robie; roll call vote was taken; unanimous approval by Board.

Aetna Transition

Beth Horner, Director of Customer Experience & Communications, provided information on the communication planning regarding the transition from Blue Cross NC to Aetna, effective January 1, 2025. This includes written material mailed and emailed to Plan members and stakeholders, information posted to the Plan website, in-person meetings, telephone town hall meetings and webinars.

Ms. Horner noted that members should begin to receive mailed information in early August, with the Decision Guide mailed closer to the Open Enrollment date. Members will receive new ID cards in early December.

Wilmington Coordinated Care Pilot Project Update

Wilmington Coordinated Care staff members Jeff James, Chief Executive Officer, and Melissa Odom, Chief Operating Officer, provided the history and background information on Wilmington Coordinated Care. Mr. James introduced Apree Health staff members Donald Trigg, Chief Executive Officer, and Carly Hamann, Regional Vice President.

Mr. James provided background on Wilmington Health and their efforts to improve transparency and reduce costs for health care payers. Mr. James discussed Wilmington Health's partnership with Apree Health to communicate with pilot project members. A review of the pilot project performance for 2023 was provided.

Mr. James summarized the pilot by stating that he believes there's space for other groups to form an Accountable Care Organization (ACO), as well as an opportunity to engage other primary care providers and groups. He also stated that he believes the Wilmington Health model would help to shift some of the risk from the State Health Plan to provider groups willing to accept that accountability.

In response to a question on member participation in the pilot, Mr. James stated any non-retiree Plan member from four surrounding counties had the option to participate.

A Board member asked whether selection bias might be indicated in the way the pilot was set up. Mr. James noted that data regarding health outcomes and patient satisfaction for participating members was included in the pilot. All of the normal Healthcare Effectiveness Data and Information Set (HEDIS) measurers are tracked.

> **Board Request:** Provide a comparative analysis for participating vs. non-participating members. Wilmington Health can provide the data for participants but doesn't have access to the data for non-participating members.

Financial Report

Financial Update

Dr. Emma Turner, Chief Economist, stated that the Plan received $240 million less than the amount requested from the General Assembly last year. That funding request didn't account for the full extent of the growth of GLP-1 drugs. Although recent actions taken by the Board in October 2023 and January 2024 helped to improve the Plan's financial status, they didn't fully resolve the funding shortfall.

Financial Projections

Dr. Turner reviewed the Fiscal Year (FY) 2023-2024 financial projections, noting the increase in both medical and pharmacy claims. The difference between expenses and revenue is expected to be slightly higher compared to last year, with a loss of $84.2 million. Administrative expenses increased, mostly due to high legal costs incurred by the Plan. The calendar year ending cash balance is projected to be $658 million.

The Plan anticipates 3.5% increase in revenue in FY 2024-2025, but that won't cover the 7.3% projected increase in expenses. The projected decrease in pharmacy claims is due to the change in coverage for GLP-1 drugs. Dr. Turner emphasized that the Plan's projected ending cash balance of $410.6 million at the end of 2025 is very concerning to Plan staff. That's approximately $15 million above what the Plan believes is the minimum amount required to operate the Plan. If this line item was to be projected several months forward, the Plan would be well below what is needed to continue operating the Plan.

Dr. Turner informed the Board that recent developments, regarding the Plan's Medicare Advantage contract with Humana, resulted in significantly higher rates than anticipated. As indicated on the 2024-25 biennium projections, Medicare Advantage payments are expected to increase 203%. To date, Humana hadn't yet provided a reason to the Plan for the excessive increase. No decisions have been made regarding next steps. However, based on the current information, procurement could be a part of the conversation.

Charles Sceiford, Health & Benefits Actuary, provided background information on establishing a Target Stabilization Reserve (TSR) and its necessity. The TSR, adopted by a former Plan Board, is a guideline for conservative fiscal management and the minimum acceptable cash reserve at the end of the year. Mr. Sceiford reviewed several graphs, demonstrating the fluctuation in cash on hand throughout a given month.

Dr. Turner provided a brief historical review of the financial results by Plan year, noting that in 2008, the cash balance dropped to a point where the Plan had to delay vendor payments. At that time, the General Assembly convened to provide emergency funding to the Plan.

Over time, the Plan was able to build up the reserves, reaching $1.4 billion in 2019. At that time, the Plan transferred some of its reserves to the Retiree Health Benefit Trust Fund, which was significantly underfunded. That action, along with pandemic costs, reduced the Plan's reserves. The Plan incurred over $515 million in COVID-19 costs and has been reimbursed $215 million. The Plan has not yet received the remaining $300 million from federal funds the State received for COVID-19 related expenses.

Dr. Turner continued with the financial projections for the calendar year 2025-2027. She highlighted that the Plan's financials are monitored quarterly to incorporate actual financial results, enrollment data, claims experience, policy changes, and other anticipated costs or revenue changes. This careful monitoring allows the Plan to identify and adjust to any deviations from expected revenue and expenditures promptly. She explained that the cumulative funding gap over the next 3 years is $1.5 billion.

Dr. Turner presented the updated financial projections, showing that without the Board's recent actions, the Plan's cash balance would have fallen below the target reserve by the end of CY 2024. The exclusion of weight-loss GLP-1 drugs from coverage significantly improved the projections, reducing the funding gap for calendar year 2025 from $500 million to $89 million. However, the unexpected increase in Medicare Advantage premiums further impacted the projections, increasing the funding gap for 2025 to $155 million.

She continued with a projection showing the Plan's cash balance just above the Target Stabilization Reserve (TSR) for 2025, assuming the recommended adjustments are implemented. These recommendations include increasing the Retirement System contribution and increasing premiums for dependents and contributory retirees who elect Medicare Advantage plans. This ensures the Plan maintains sufficient reserves to manage cash flow variations and avoid dipping below the necessary reserve levels.

Looking towards the future, Dr. Turner outlined several strategic actions to address the ongoing financial challenges. These include requesting increased employer contribution rates from the General Assembly during the FY 2025-2027 biennium, seeking additional reimbursements for COVID-related costs, and potentially procuring new Medicare Advantage plans. Other strategies involve collaborating with the third-party administrator (TPA) to achieve medical cost savings, seeking pharmacy cost savings, and reviewing benefit design and cost-sharing mechanisms.

Dr. Turner concluded by emphasizing the importance of these measures to ensure the financial stability and sustainability of the Plan.

2025 Premiums

Chair Folwell stated that he wasn't ready to call for a vote on the premiums, given the uncertainty with the Humana contract. He requested a special meeting in June to vote on premiums.

Mr. Sceiford provided a summary on the 2025 proposed premiums. Mr. Sceiford discussed the proposed rates for the Medicare Advantage Plan, Retirement System contributions and Employer contributions. Presently, the Plan isn't recommending changes to current employee premiums.

Executive Administrator Report

Glucagon-Like Peptide-1 (GLP-1s) Options

Sam Watts, Executive Administrator, announced that the Plan issued a Request for Information (RFI) on Friday, April 19, 2024, following attempts to negotiate better pricing for this class of drugs from the Plan's PBM and drug manufacturers.

Executive Session Report

The Board unanimously voted to award the Medical Claims Full Population Audit Service to 4C Digital Health.

Blue Cross NC Error Correction

Blue Cross NC discovered and took full responsibility for an error in the claims system. This error pertained to the incorrect calculation of Plan member's out-of-pocket spending amount. The members were held harmless.

Federal Trade Commission v. Novant Health, Inc., and Community Health Systems, Inc.

Included in the Board material was a brief filed by Treasurer Folwell, on behalf of the State Health Plan, supporting the Federal Trade Commission's opposition to the merger of two hospitals in Lake Norman, NC. The brief explains the concept of how consolidation in the health industry directly increases costs for the Plan.

Conflict of Interest Concern

Dr. Robie, as a member of the Plan's Pharmacy & Therapeutics Committee (P&T), discussed an issue that came up at a recent P&T meeting, of which he's a member. He stated that CVSCaremark, who participates in the meetings, made a recommendation to add a particular drug to the Plan's formulary. The conflict of interest concern was that CVSCaremark owns a part of the manufacturing company that produces the drug and failed to disclose that to Committee members. The Plan sent a letter to CVSCaremark regarding the concern.

Adjournment

Chair Folwell called for a motion to adjourn.

> ***Board Vote:*** Motion by Dr. Robie; second by Dr. Wills; vote was taken; unanimous vote by Board to adjourn.

The meeting was adjourned at 4:45 p.m.

Minutes submitted by: Joel Heimbach, Secretary

Approved by: Dale R. Folwell CPA

Dale R. Folwell, CPA, Chair

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