PEBA
SC Retirement Systems and State Health Plan

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Meeting Minutes | Health Care Policy Committee

Wednesday, March 3, 2021 | 10:30 a.m.
Via Zoom Conference

Minutes Approved July 28, 2021

Board Members Present: Mr. Calvin Elam, Mr. Joe "Rocky" Pearce, Chairman, and Mr. Alex Shissias

Others Present for All or a Portion of the Meeting Peggy Boykin, Robby Brown, Phyllis Buie, Sarah Corbett, Heather Muller, John Page, Laura Smoak, Rob Tester, Travis Turner, Stephen Van Camp, Angie Warren, Justin Werner, and Heather Young from the South Carolina Public Employee Benefit Authority (PEBA); Sarah Grace Bailey, Brooks Goodman, Joel Pierstorff, Matt Shaffer, and Carmen Wilson from BlueCross BlueShield of South Carolina; and Laura Crawn and Gary Kline from Express Scripts, Inc.

I. Call to Order

Chairman Rocky Pearce called the PEBA Health Care Policy Committee (Committee) meeting to order at 10:31 a.m., and stated that the public meeting notice was posted in compliance with the Freedom of Information Act.

II. Approval of Meeting Minutes – December 2, 2020

Mr. Calvin Elam made a motion, which was seconded by Mr. Alex Shissias, and passed unanimously, to approve the minutes from the December 2, 2020, Committee meeting.

III. Benchmark Review

Mr. Rob Tester, Insurance Policy Director, presented the State Health Plan (SHP) update and benchmarking review in which key SHP measures are compared with peer and national benchmarks. Mr. Tester reviewed the SHP enrollment as of February 2021; compared the SHP claims expenditure growth per member to national trends; and the SHP contribution rate increases versus the Consumer Price Index growth for medical care.

Mr. Tester also discussed the 2020 average monthly total premiums; the 2020 average annual deductible; the 2019 average annual gross plan cost per active employee; and the 2021 composite monthly premiums. Mr. Tester stated that the State Health Plan continues to compare very favorably to other public and private employers.

IV. New Federal Policies Affecting Health Plans

Mr. Tester introduced Ms. Laura Crawn and Mr. Gary Kline from Express Scripts, Inc., to discuss new federal policies regarding Medicare Part D rebate rules. Ms. Crawn explained that a pharmacy rebate is a price concession paid by a pharmaceutical manufacturer to the pharmacy benefit manager (PBM). The PBM negotiates with the manufacturer for the rebates and in return, the negotiated rate influences formulary tiers placement, or other utilization management criteria.

Ms. Crawn advised that currently, rebates are paid retrospectively and can be allocated as necessary to reduce premiums or cost sharing. In the future, the new Medicare rebate rule would require rebates to be paid at point of sale (POS), as an intention to reduce the member's cost share. Ms. Crawn cautioned that all stakeholders involved in paying claims receive a portion of the discount with the new rebate rule, so the State Health Plan would not receive the full value of the rebate to reduce net plan liability. Ms. Crawn advised that the Medicare rebate rule is only applicable to Medicare retirees, not other members of the State Health Plan.

Mr. Tester reiterated that rebates are an important element in funding the State Health Plan to reduce both the employee and employer premiums.

Mr. Kline reviewed the timeline of the removal of the Rebate Safe Harbor for drug manufacturer rebates paid to PBMs as of January 1, 2022. Mr. Kline stated that two additional Safe Harbors have been introduced to protect POS rebates, and protect fair market value service fees paid to PBMs by manufacturers, to be effective January 29, 2021. Mr. Kline advised that a court order delayed the elimination of drug manufacturer rebates to PBMs until January 1, 2023.

Ms. Crawn discussed the steps needed to prepare for the removal of the Rebate Safe Harbor in 2023, including a full formulary review and assessing ways to retain the full rebate value.

Mr. Tester introduced Mr. Joel Pierstorff, Director of Healthcare Regulation; from BlueCross BlueShield of South Carolina, to discuss additional federal polices related to surprise billing and transparency rules. Mr. Pierstorff stated that the Consolidated Appropriations Act (CAA) was enacted on December 27, 2020, and a major provision of the CAA impacting group health plans and individual coverages is the elimination of surprise billing effective January 1, 2022. Mr. Pierstorff addressed five major components of the provision including: coverage requirements; qualifying payment amounts; arbitration; balance billing; and air ambulance reporting. Mr. Pierstorff reviewed the surprise billing regulatory action timeline starting February 25, 2021, through January 1, 2022.

Mr. Pierstorff advised that plan transparency rules released October 29, 2020, requires health plans to make available personalized out-of-pocket cost information; the underlying negotiated rates for all covered items and services; and out-of-network allowed amounts through a self-service tool, and in paper form upon request, effective January 1, 2023. It also requires public disclosure of in-network negotiated rates effective Jan. 1, 2022; and insurers can include provisions that encourage consumers to shop for services from lower-cost, higher-value providers effective July 31, 2021.

Mr. Pierstorff concluded his presentation by reviewing hospital transparency rules effective January 1, 2021, which focuses on increasing price transparency of hospital standard charges.

V. Old Business/Director's Report

Ms. Peggy Boykin, Executive Director, stated that she would provide the Director's Report at the full Board meeting.

VI. Adjournment

There being no further business, the Committee meeting adjourned at 11:43 a.m.