PEBA
SC Retirement Systems and State Health Plan

South Carolina Public Employee Benefit Authority
Serving those who serve South Carolina

Meeting Agenda

|Health Care Policy Committee |Finance, Administration, Audit and Compliance Committee |Retirement Policy Committee| Board of Directors
Wednesday, October 23, 2024 | 202 Arbor Lake Drive., Columbia, SC 29223| 1st Floor Conference Room

Health Care Policy Committee |9:30 a.m.

I. Call to Order
II. Approval of Meeting Minutes – June 26, 2024
III. State Health Plan Budget Requirements Approval for 2026 with Contributing and Mitigating Factors
IV. Accessibility of Behavioral Health Services in the State Health Plan
V. Vice-Chairman Elections
VI. Old Business/Director's Report
VII. Adjournment

Notice of public meeting
This notice is given to meet the requirements of the S.C. Freedom of Information Act and the Americans with Disabilities Act. Furthermore, this facility is accessible to individuals with disabilities, and special accommodations will be provided if requested in advance.

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
HEALTH CARE POLICY COMMITTEE

Meeting Date: October 23, 2024

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1. Subject: State Health Plan Budget Requirements Approval for 2026 with Contributing and Mitigating Factors

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2. Summary: Rob Tester will present the Plan's estimated budget needs for the next fiscal year, which includes the projected rate increase for Plan Year 2026. He will preface these numbers with discussion as to the causes of budgetary stress, as well as matters that are helping to curb Plan spending. With the Board's approval, these requirements will be presented at the Governor's Budget Hearing next Wednesday, October 30, the kickoff to the upcoming year's budget season.

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3. What is Committee asked to do? Approve the 2026 State Health Plan budget requirements.

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4. Supporting Documents:

(a) Attached: 2026 State Health Plan Budget Information and Continuation Requirements

State Health Plan Budget Requirements for 2026

Contributing Factors

1. Continued High Expenditure Trends

Overall Medical and Pharmacy Trends through September

State Health Plan expenditure this year incurred and paid through September is up 5.8% over the same period in 2023. Medical expense (processed through Blue Cross of SC) is up 5.7%, while pharmacy expense (processed through Express Scripts) is up 6.0%.

- **Cost Drivers**
  - **Outpatient Hospital:** The most significant cost driver in the Plan year-to-date is the Outpatient Hospital sector. Year over year claims expenditure trend for 2024 in this service type or place of service, is 9.1%, and this category's growth accounts for over 40% of the total increase in Plan spend. Surgery and Emergency Room (ER) are the two most costly service types in the Outpatient Hospital setting, accounting for over 62% of the spend in this category. Both of these types are growing at a substantial rate: outpatient surgery spend is up 8.8%, while ER spend is up by an even more sizeable 15.9%. Volume is driving the ER growth, with encounters per person up 10.0%. Intensity (replacement of a lower-cost service with a higher-cost service) appears to be the main growth driver for outpatient surgery; the average payout per encounter is up 6.9%, well above this year's pricing update of 2.0%.
  - **Office:** Professional office expense has increased 9.2% per member year over year through September 2024. It accounts for a full quarter of the growth in Plan expenditure this year. The lion's share of this growth, 7 out of 8 of the new dollars, is attributable to "sick" visits (encounters with a diagnosis on the claims form). The remainder comes from increased spend on care coordination fees (associated with the Patient Centered Medical Home program) and well visits. Well adult visit expense has increased about 11% this year (the annual well woman exam with no patient cost share was added for 2024); however, it still accounts for just over 5% of the growth in the professional office setting. Well child visit spend is essentially flat.
  - **GLP-1s:** The GLP-1(Glucagon-like Peptide 1 agonists) class of medication continues in a second year as a major cost driver in the Plan. GLP-1s refer to a class of medication designed for treatment of type 2 diabetes. This class has been around for several years—the newest and now best-known GLP-1 products are Ozempic and Mounjaro. Widespread misuse facilitated by social media promotion of GLP-1s has led to increased use for weight loss. Weight loss coverage is a Plan exclusion, and neither of these products is FDA-approved for weight loss. Nonetheless, spend for GLP-1s continues to increase at an alarming pace. Following the 47.8% increase in per member spend in 2023, GLP-1 post-rebate expenditure in 2024 year-to-date has increased an estimated 44.2% per member ($14.82 to $21.37 per member per month). The number of GLP-1 patients over last year

continues to increase at an accelerating pace; however, these persons still only comprise just over 5% of Plan membership.

- **Other Observations**
  - **High Dollar Claims:** The effect of high-dollar claims on overall Plan expense continues to grow. In 2023, the less than 0.1% of Plan members with attributable medical spend for the year at $250,000 or more accounted for 11.1% of Plan expenditures on the medical side, up from 9.4% in 2022 and a mere 6.1% back in 2013. Expanding this pool to those claimants with at least $50,000 in 2023 expense, still only about 1% of membership, accounts for 37.2% of total medical spend—the highest percentage to date and well over the 31% this group accounted for in 2013. It is expected that high dollar claims will continue to have a disproportionate impact on Plan expense.
  - **Adverse Selection:** Our staff, consultants, and contractors have long thought the Plan is subject to adverse selection, whereby persons who are more likely to use health care resources seek out our coverage. With a history of stable insurance benefits and over 800 employers as access points, the Plan certainly has higher-than-usual exposure to this phenomenon. We'll describe two ways in which this is manifested. Anecdotally, we have been informed that our membership's incidence of rare diseases (defined as a condition that affects no more than 200,000 people in the United States), with their accompanying expensive treatment, is notably higher than that seen in a general population. And in our most recent high-dollar claimant analysis, five of the most expensive 10 adults in terms of claims expense in the past year joined the Plan relatively recently (in the past 5 years), as is the case for 12 of the top 25. There is no identifiable solution to the Plan's adverse selection exposure, given the Plan's program structure and federal prohibition of pre-existing condition limitations, but all should be aware of its effect of distorting the risk pool and creating a "non-normal" population to insure.

2. Inflation Reduction Act (IRA) changes to Medicare prescription drug plan

As reported at the June Committee meeting, the federal Inflation Reduction Act (IRA), enacted in 2022, is bringing about considerable change to the Medicare Part D prescription drug benefit. PEBA sponsors a group Part D plan, which now includes about 95,000 Medicare-eligible members. Two noteworthy changes regarding this program affecting the budget become effective with plan year 2025.

One, the Part D Standard Defined Benefit has been restructured. Beginning in 2025, a Part D beneficiary will have no out-of-pocket expense for prescriptions once the member cost share (known as TrOOP, or True Out-of-Pocket), reaches $2000 for the year. However, this amount is not what would be commonly understood as member cost share for a copay-based plan as is the State Health Plan. The Standard Defined Benefit for 2025 includes a $590 member deductible with the member paying 25% coinsurance in the Initial Coverage phase. PEBA Plan Part D members pay copays equal to that paid by non-Medicare members; however, for purposes of the Part D cost share accumulator, "phantom" cost share as embodied in the Standard Defined Benefit deductible and coinsurance count toward the TrOOP. Because of this methodology, PEBA Plan Part D members will pay copays only until the accumulator reaches the $2000 TrOOP, which is substantially lower than the current $8000 TrOOP. It is projected that around 28,000 Plan

Medicare Part D beneficiaries will reach the TrOOP limit next year and achieve zero cost share status. Our actuaries predict that having such a significant number of members with zero cost share for at least part of the year will have material cost impact on the Plan.

Two, the federal subsidy structure associated with the group Part D offering has been altered significantly. This is a material revenue source for the Plan accounting for almost 6% of overall income. Following the Part D restructuring, the Manufacturer Subsidy and Catastrophic Reinsurance elements of the program are expected to reduce greatly in value, and although the Direct Subsidy will increase substantially, it will not compensate completely for the loss from the other sources. As a result, Medicare Part D subsidy income to the Plan is expected to decline.

Together, the increase spend from reduced patient cost share on the part of Medicare retirees and the reduced Part D subsidy will bring about a $22.184 M/year negative impact on the Plan and will increase budget requirements by 0.6 percentage points.

3. Source of Funds—additional State appropriations to schools

The Executive Budget Office provides guidance to PEBA each year as to the share of State appropriations funding health insurance for each of the groups funded in at least some measure by the State: employees of State agencies (including colleges and universities), employees of school districts, and State-funded retirees (retired employees of State agencies, school districts, and the MUSC health system). This year, PEBA has been instructed by key state budget actors (Executive Budget Office, RFA, Governor's Office, legislative budget committee staff) to increase the State-funded share on behalf of school employees from 70% to 75%, on account of the formula in the new State Aid to Classrooms program. This adds about $1 M. to this year's budget requirements State appropriations total in a shift from local school funds to State funds.

Mitigating Factors

1. Board actions from this summer

- **GLP-1 management**

  The GLP-1(Glucagon-like Peptide 1 agonists) class of medication continues as a major cost driver in the State Health Plan, as noted above. The Board at its June meeting approved a staff recommendation to address this surging spend through two actions. One, limiting supply of GLP-1s to 30 days per fill, to reduce waste as there are a material number of users who prove not to tolerate the product. Two, placing a new prior approval process for GLP-1s to now require documentation that a patient's condition qualifies this individual to obtain the prescription under the terms of the Plan. This process will begin in November and be fully phased in by January 2025.

  These actions affect our Commercial (non-Medicare) plan only. Our pharmacy benefits contractor has informed us that federal CMS rules will not permit the 30-day fill limit for

Medicare beneficiaries for a single class of drug. Likewise, Medicare rules prohibit the type of prior authorization that will go into effect soon for the non-Medicare membership.

It is conservatively estimated that these rules will save the Plan $18 M/year, and as a result budget requirements are reduced by 0.5 percentage points.

- **Removal of PCMH preferential patient cost share**

  At the June meeting, the Board adopted a staff recommendation to remove the preferential patient cost share at Patient-Centered Medical Home (PCMH) practices effective January 2025. Services received at a PCMH will be subject to regular copays and coinsurance next year. We continue to collaborate with Blue Cross to improve the PCMH program and better align it with Plan objectives.

  This action will save the Plan around $14 M/year and will reduce Plan budget requirements by 0.4 percentage points.

- **Realign copays for diabetic supplies**

  At the June meeting, the Board adopted a staff recommendation to place high-cost diabetic supplies in the regular pharmacy copay structure. Beginning in January, high-cost supplies such as Continuous Glucose Monitors, Insulin Pumps, and their associated supplies will have applied the appropriate preferred or non-preferred brand copay. “Old school” supplies such as low-cost needles, syringes, lancets, and test strips will continue to have the generic copay in force.

  This action is estimated to save the Plan around $2 M/year in direct expenditure and will reduce budget requirements by 0.1 percentage point.

2. Movement to biosimilars

Although specialty pharmacy trend has moderated this year, it has historically been the most significant cost driver in the State Health Plan. Specialty accounts for over half of the Plan’s pharmacy expense, though only around 2% of Plan members use a specialty drug.

Payers have long anticipated biosimilars for relief from the accelerating expense associated with specialty pharmacy. Below is basic information from the US Food & Drug Administration (FDA) pertaining to biosimilars:

- A biosimilar is a biological product. FDA-approved biosimilars have been compared to an FDA-approved biologic, known as the reference product.
- A biosimilar is highly similar to a reference product. For approval, the structure and function of an approved biosimilar were compared to a reference product, looking at key characteristics such as purity, molecular structure, and bioactivity. The data from these comparisons must show that the biosimilar is highly similar to the reference product.
- A biosimilar has no clinically meaningful differences from a reference product. Studies were performed to show that biosimilars have no clinically meaningful differences in safety, purity, or potency compared to the reference product.

- A biosimilar is approved by the FDA after rigorous evaluation and testing by the applicant manufacturer. Prescribers and patients should have no concerns about using these medications instead of reference products because biosimilars meet the FDA's rigorous standards for approval, are manufactured in FDA-licensed facilities, and are tracked as part of post-market surveillance to ensure continued safety.

Specialty product Humira has long been the single most expensive item in the State Health Plan. There is now an interchangeable biosimilar for Humira on the market, and the Plan's pharmacy benefits contractor is removing Humira from the formulary effective the beginning of 2025. We calculate the difference in expense for a "patient year" of Humira (post-rebate) vs. the biosimilar to be around $65,700 to $13,000. These numbers bring about a conservative savings estimate of $20.5 M/year and reduce budget requirements by 0.6 percentage points.

There are additional biosimilar products on the horizon, and we will press forward to maximize replacement of reference specialty products with biosimilars where feasible.

10.18.2024

State Health Plan Budget Information and Continuation Requirements

Annual Base – Calendar Year 2025

Employer funds: $2,894.6 M.
Enrollee funds: $ 555.6 M.
Total: $3,450.1 M.

State-appropriated portion of Employer funds = $1,455.3 M.

Funds are spread throughout the budget in Employer Contributions lines of agencies and State Aid to Classrooms lines of the State Department of Education.

Current composite monthly contribution rate effective January 2025:

Employer rate: $791.07 (86.0% of regional State employee plan average)
Enrollee rate: $159.36 (76.0% of regional average)
Total: $950.43 (84.1% of regional average)

FY 2025-26 Budget Requirements for ongoing SHP operations in 2026

- **Annualization**: There is a 11.8% Employer Only rate increase going into effect January 2025. Funding in the amount of **$75.862 M.** was appropriated for the January-June 2025 period. A like amount will be required in the upcoming budget for the July-December 2025 period to make agencies and school districts whole for the rate increase.
- **Retiree Enrollment Growth**: Net retiree enrollment growth continues at a historically low level. It is estimated that **$1.579 M**. is required for the estimated net number of new retirees with State-funded insurance. This number is based on the recent experience of 0.3% net growth in retirees, compared to last year's 0.8% rate.
- **2026 Rate Increase:**
  - **3.9%** increase in total contribution rate.
  - This percentage equates to **$36.76**/subscriber/month.
  - Rate increase will become effective January 1, 2026.
  - If increase is distributed proportionately to the Employer and Enrollee, State-appropriated funding for rate increase equals **$ 29.166 M.** for January-June 2026 and average enrollee rate increase equals **$5.92**/month.
  - If increase is provided entirely through the Employer, State-appropriated funding for rate increase equals **$34.794 M.** for January-June 2026.
  - State-appropriated funding for 2026 rate increase will require annualization in fiscal 26-27 budget.

Summary (State funds):

Annualization of 2025 11.8% employer only increase	**$75.862 M.**		
2025-26 base Retiree Enrollment Growth	**$1.579 M.**		
2026 Employer Increase (w/ proportional enrollee increase)		**$29.166 M.**	
2026 Employer Increase (w/ no enrollee increase)(4.6% Employer Only)			**$ 34.794 M.**
TOTAL CONTINUATION OF CURRENT PLAN (3.9% INCREASE)		**$ 106.607 M.** w/EE increase	**$112.234 M.** no EE increase

10.18.2024

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
HEALTH CARE POLICY COMMITTEE

Meeting Date: October 23, 2024

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1. Subject: Accessibility of Behavioral Health Services in the State Health Plan

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2. Summary: There has been a general view in the nation, especially since the COVID lockdown, that society is in a sort of mental health crisis. That's why it is imperative that we do what we can in the State Health Plan to assure that quality behavioral health services are available to Plan membership. Dr. April Richardson of Blue Cross' Companion Benefit Alternatives, the Plan's behavioral health manager, will speak to the status of these services and to initiatives to fill in gaps and bring about better access to services.

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3. What is Committee asked to do? Receive as information

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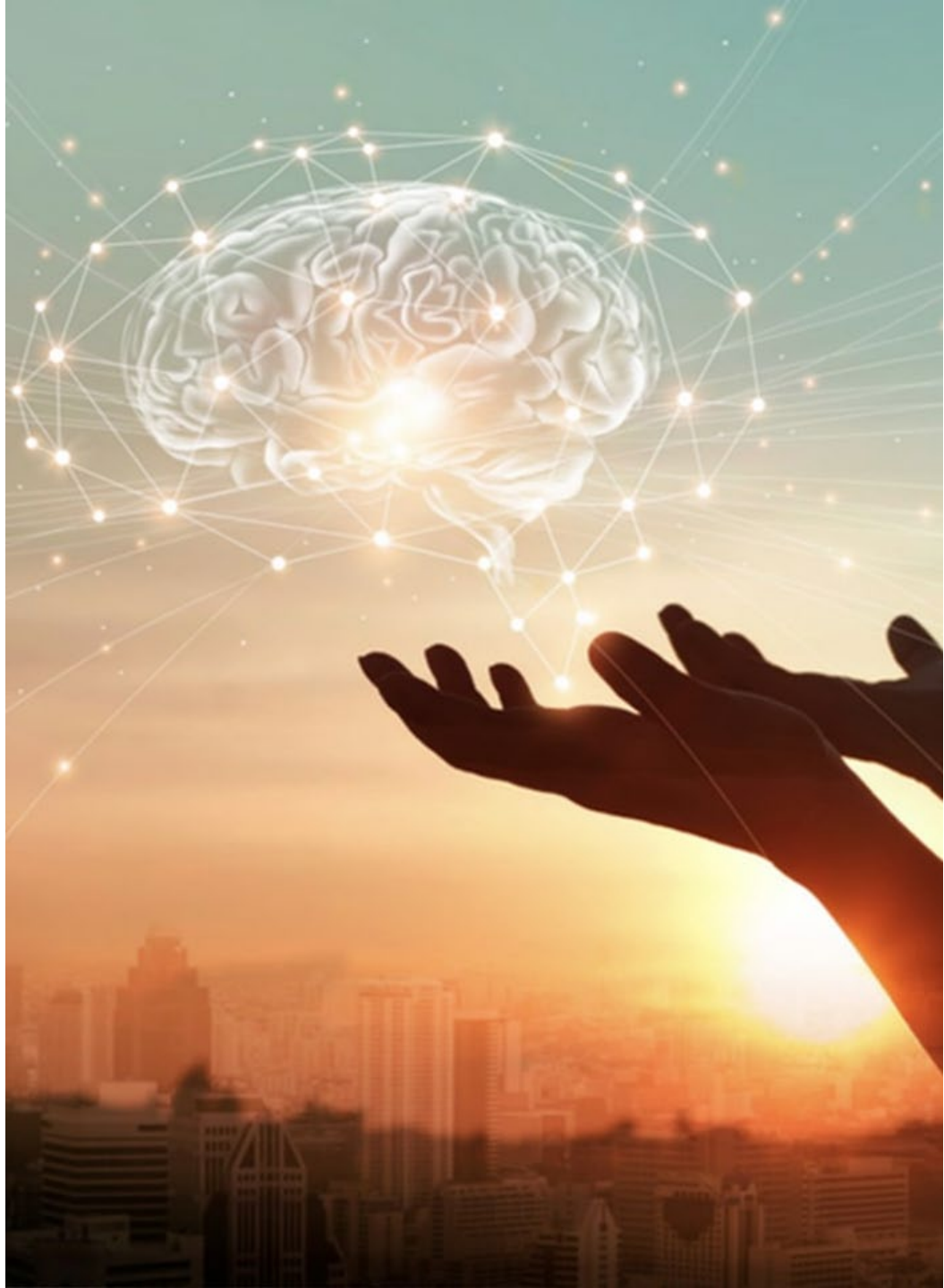
4. Supporting Documents:

Attached: Accessibility of Behavioral Health Services in the State Health Plan

Accessibility of Behavioral Health Services in the State Health Plan

April Richardson, M.D.
VP of Clinical Services, BCBSSC HII
COO, Companion Benefit Alternatives



Companion
BENEFIT ALTERNATIVES

Since 1992, Companion Benefit Alternatives (CBA) has provided behavioral health management for BlueCross BlueShield of South Carolina.

- 115 employees
- 2.3M members managed
- SHP behavioral health benefit manager since 2012
- SHP – mental health parity since 2002
- Commercial market – mental health parity since 2009

Behavioral Health Statistics- National

- Nearly 60 million Americans reported having a mental illness in 2022, according to The State of Mental Health in America study.
- The CDC reports over 1 in 5 of adults are experiencing a mental illness while 1 in 6 children have a diagnosable mental health condition.
- In 2022, half of young adults and one-third of all adults reported they felt anxious either always or often in the past year as outlined in the KFF/CNN Mental Health in America Survey.
- The KFF also found 90% of the public think there is a mental health crisis in the United States.

Behavioral Health Trends- COVID Impact

- In the first year after the pandemic, the global prevalence of anxiety and depression increased by 25%, according to the WHO.
- Rate of change of behavioral health conditions varies by condition, with eating disorders, anxiety, and alcohol/substance use being the top 3.
- According to data from the Kaiser Family Foundation, 47% of the U.S. population in 2022 was living in a mental health workforce shortage area.
- This highlights the need for increased access to mental health services.

Behavioral Health Statistics - SHP

- Inpatient utilization for behavioral health services has declined over the past 2 ½ years.
  - Admits are down to 3.0/1000 in 2024 (YTD through Q3) from 3.7/1000 in 2022
  - Days are down to 36.3/1000 in 2024 from 43.59 in 2022

- Residential treatment has also decreased for the SHP since 2022.
  - Reduction of 14.8% from 2022 to 2023
  - Reduction of 16% from 2023 to 2024

- Outpatient facility services are increased slightly in 2024 compared to 2022 and 2023 with Intensive Outpatient and fairly steady in Partial Hospital Program utilization across that same period.

CBA Network Access

- Recent studies across multiple states/insurers have shown that fewer than 20% of providers are accessible to members seeking new patient therapy appointments.
- BHI (Blue Health Intelligence) completed an analysis of 25 Blue Plans (including CBA) to look at how active or engaged therapists are in the network.
- Although CBA's therapist network engagement rate is similar to Blue's Plans nationally, we are below the benchmark on engaged therapist per 1000 members.
- Our members may face challenges finding an available therapist as the overall available number of therapists relative to our population size is less than ideal.

CBA Network Access

Current Network Composition

- 574 Psychiatrists
- 315 Psychologists
- 252 Psychiatric Nurses
- 1384 Masters Level
  - 959 Social Workers
  - 1836 Counselors
- 425 Autism Providers

Overall Network Adequacy of 99.9%

- Adequacy gaps include:
  - Psychiatric hospital locations in Allendale County (ave. distance of 55 miles) and Hampton County (ave. distance of 54 miles)
  - Psychologists in Allendale County (ave. distance of 50 miles)
  - Autism providers in Allendale County (ave. distance of 55 miles), Bamberg County (ave. distance of 51 miles), Barnwell County (ave. distance of 53 miles)

CBA Network Access

CBA Traditional Network Utilization

- 2022: 319,928 claims with 40% of services via telehealth
- 2023: 338,420 claims with 40.5% of services via telehealth
- 2024 YTD: 180,395 claims with 40% of services via telehealth

- Across above time periods slightly more therapy sessions occur via telehealth vs. MD E/M codes for BH providers

Improving Access Based on Our Data

CBA ANALYZED OUR UTILIZATION DATA TO BETTER UNDERSTAND PATTERNS AND TRENDS.

IDENTIFYING AREAS OF HIGH UTILIZATION ALLOWS ALLOCATION OF RESOURCES TO MEET THE NEEDS OF OUR MEMBERS.

Strategies to Access Care

Reduce Wait Times

By streamlining intake and increase contracting provider numbers, we can ensure that those who need care can receive it promptly

Leverage Telehealth

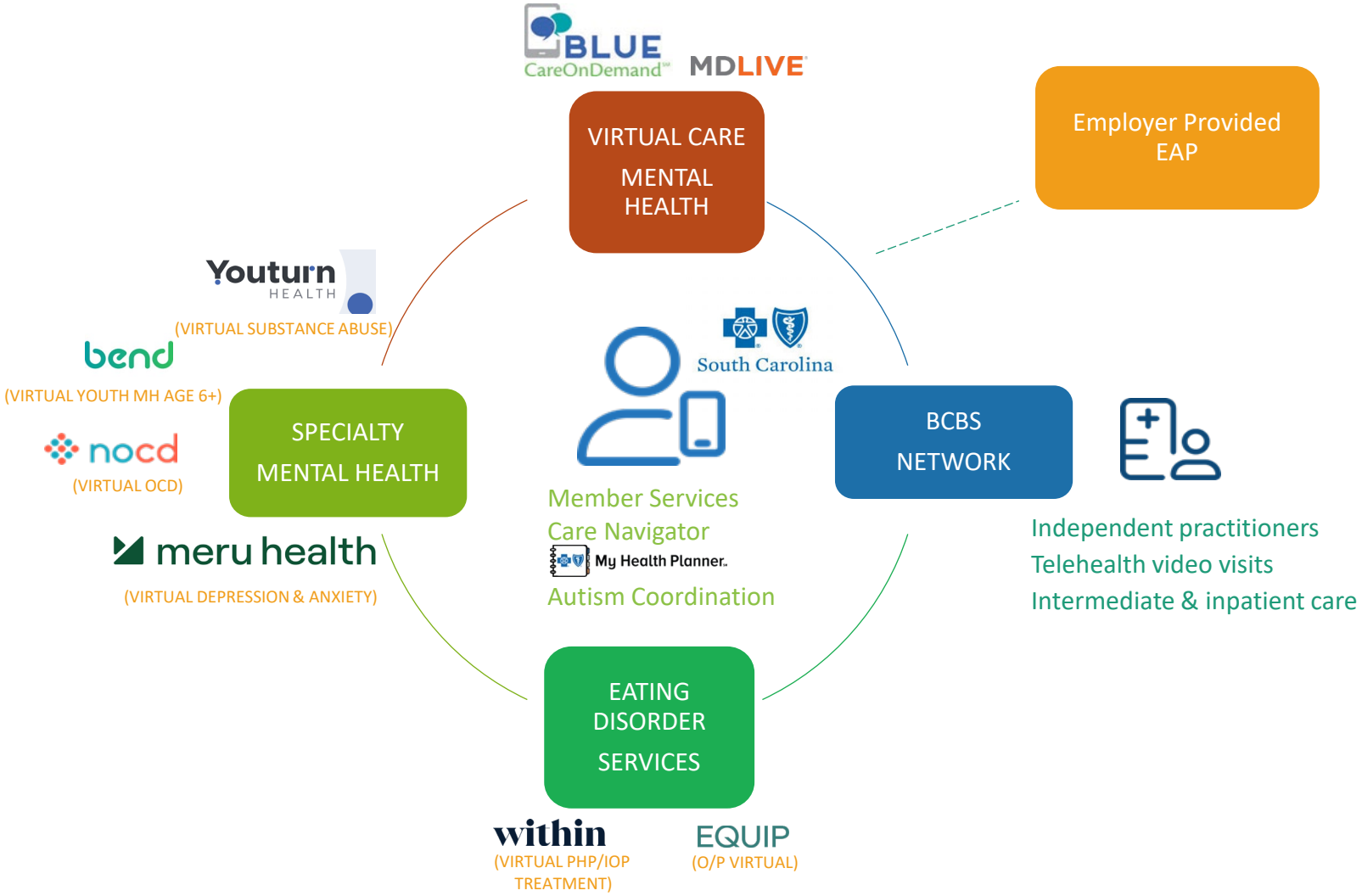
By prioritizing telehealth, we can increase access and reduce disparities

Address Affordability

Health plans can explore ways to look at benefit structure and enhanced benefits

Focusing on What the Members Need with Access and Accessibility

Behavioral Health focus on engagement and addressing support across the care continuum with optimal alignment



CBA In-network Virtual Providers

- Meru Health
- nocd
- Youturn Health
- Within
- Equip
- Bend

Specialty Mental Health

Meru Health

The New Standard of Mental Healthcare

- 12-week digital therapy program
- Enrollment appointment & intake call with a licensed therapist
- Daily lessons including topics such as psychotherapy, self-regulatory skills, lifestyle science, motivational interviewing
- Continuous and proactive support by a licensed therapist
- Peer support group
- Psychiatrist support and PCP collaboration

Specialty Mental Health

- OCD-specialty virtual provider that makes Exposure and Response Prevention (ERP) accessible
- Live virtual therapy sessions
- Unlimited messaging with a therapist from the NOCD network
- Between-session support including peer communities, emergency support, access to treatment data and educational content

Specialty Mental Health

- A virtual treatment program for substance misuse
- Matches individuals and their primary supports to certified peer support specialists
- All peers are state-certified, NAADAC-credentialed and specialty trained in Assertive Community Engagement (ACE) principles
- Includes a learning and assessment platform
- Family support with peers dedicated to family members
- Includes individual and group sessions through a virtual format
- 24/7/365 access

Specialty Mental Health

- Virtual in network care providing personalized eating disorder treatment at home.
- Remote, comprehensive treatment – access to a Clinical Care Team consisting of registered dietitians, therapists, nurses, physicians, and care partner.
- Intensive outpatient program or partial hospitalization program levels of care
- Weekly treatment schedule with different types of therapy, meal delivery, and after-hours support.

Specialty Mental Health

Equip

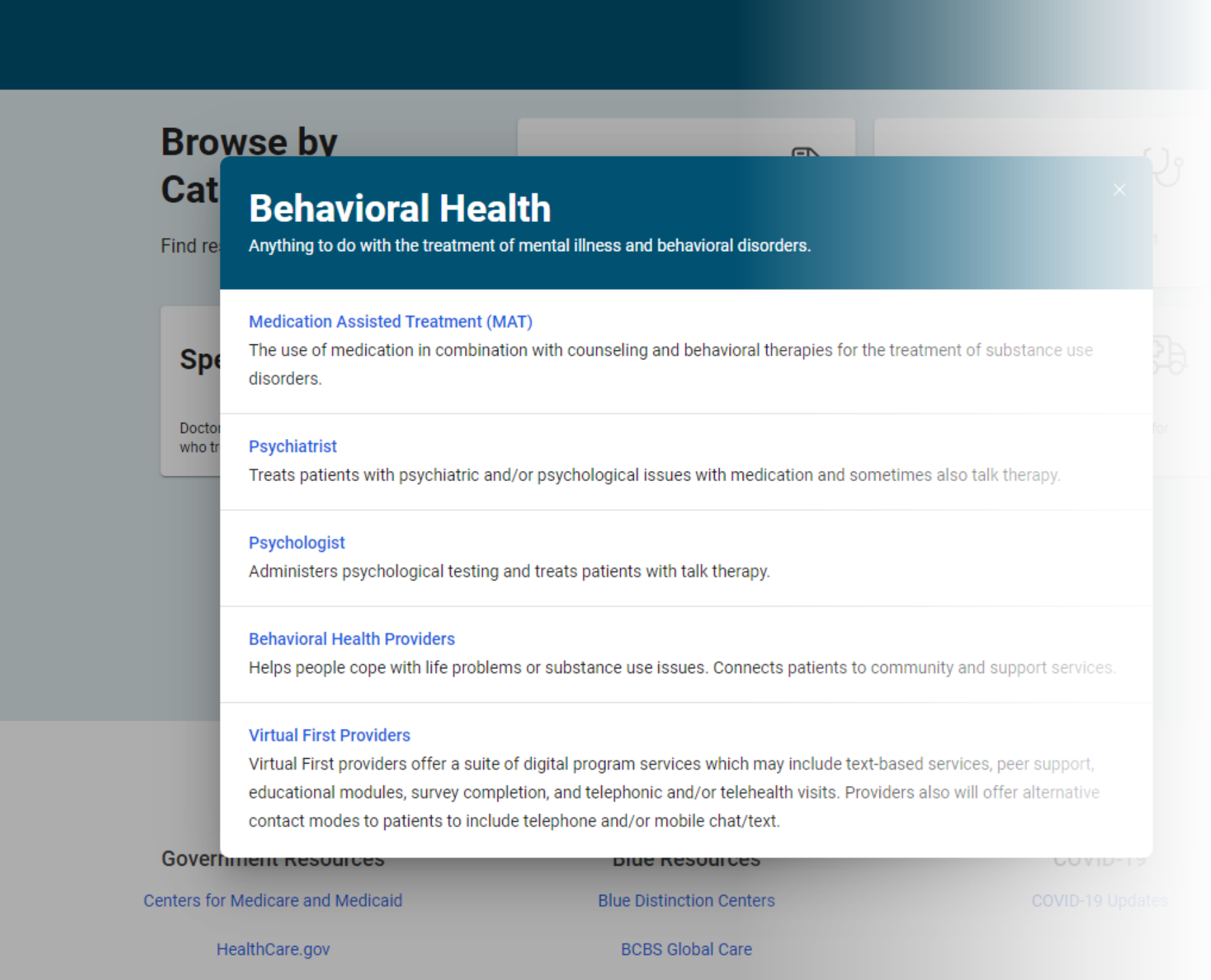
- Evidence-based, individualized, outpatient, virtual eating disorder treatment
- Multidisciplinary provider team providing wrap around care – psychiatrist, medical provider, therapist, dietician, peer mentor and family mentor
- Prevents higher level of care in 90% of patients
- No waitlist – improving access for members with eating disorders
- More comprehensive than traditional outpatient care
- Measurement based care – progress monitored using clinically validated surveys to ensure early response and inform care plans throughout treatment
- Ability to develop and utilize skills at home or school, with family support

Specialty Mental Health

- Outpatient virtual network provider for kids, teens, and young adults up to age 25
- Increase access for families - appointments available in days
- Comprehensive care with coaching, therapy, and medications (if needed)
- One-on-one live video session with coach and therapist with unlimited messaging with care team between sessions
- Collaboration with primary care physician
- Dedicated behavioral care manager
- Parent skill training plus kid and teen cognitive and behavioral techniques
- Access to learning resources to help build skills

SHP Utilization of Virtual First Providers

	CY 2021	CY 2022	CY 2023	YTD 2024
Meru	-	1138 visits; 360 members	2850 visits; 866 members	3419 visits; 1139 members
NOCD	155 visits; 13 members	534 visits; 27 members	629 visits; 43 members	47 visits; 61 members
Youturn	-		16 visits; 2 members	53 visits; 10 members
Within	-	4 visits; 1 member	117 visits; 4 members	603 visits; 7 members
Equip	-	-	-	-
Bend	-	-	-	-

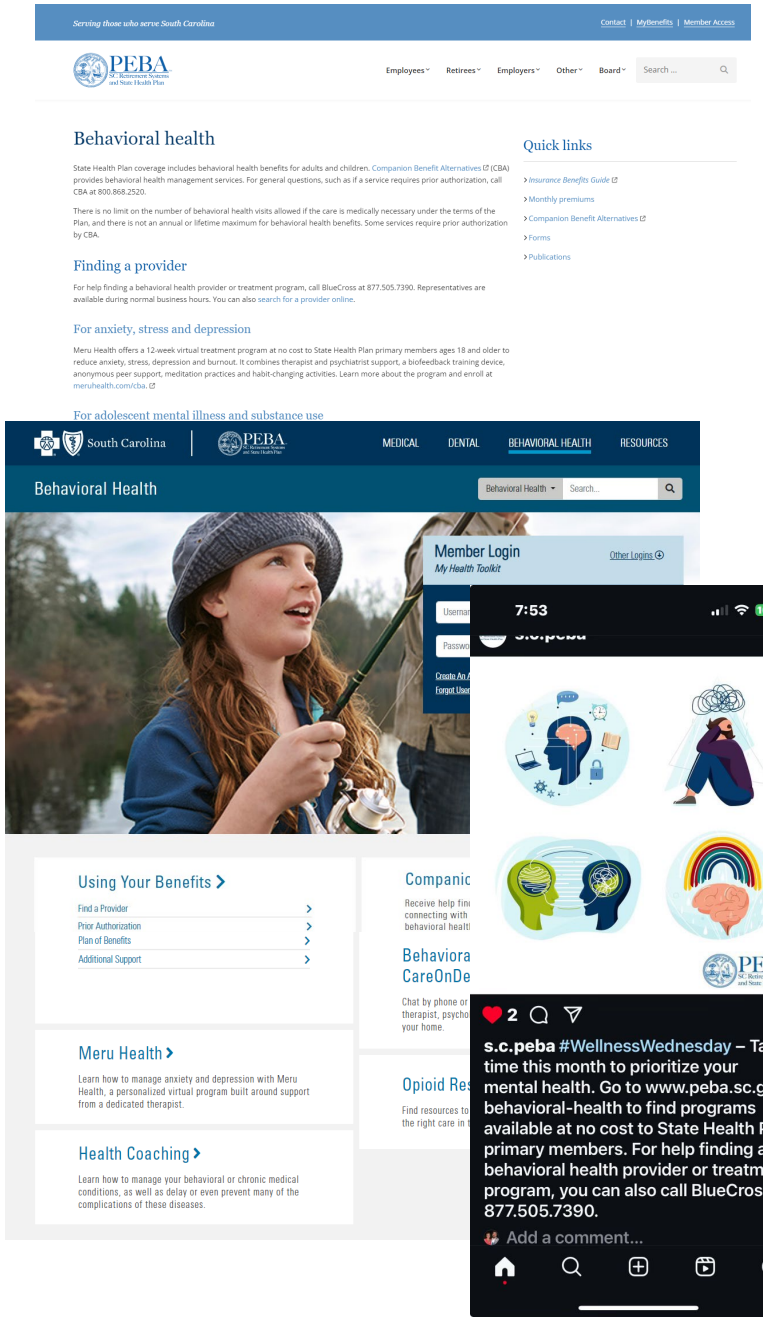


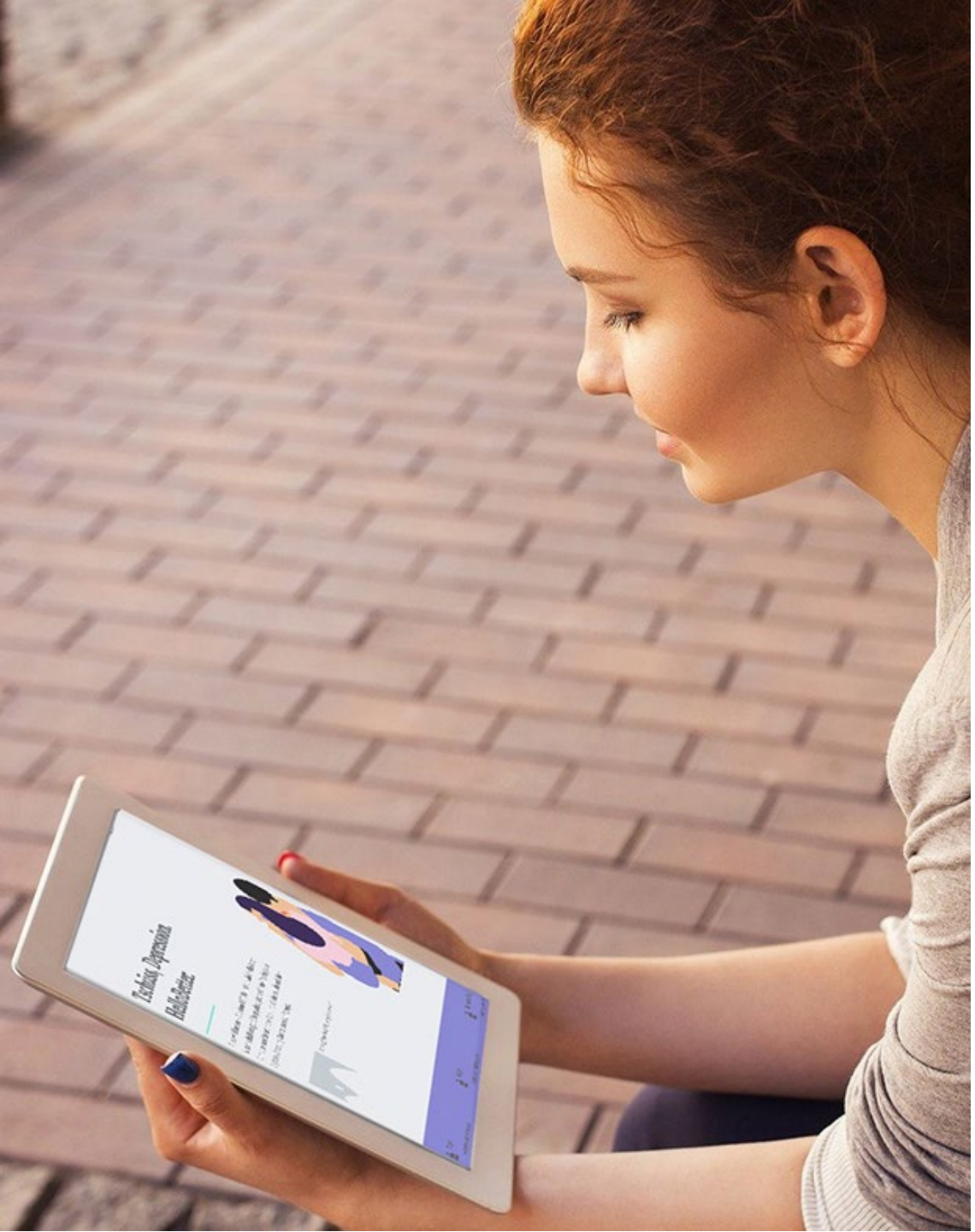
Navigating the Options

- As part of our network, these providers are accessible like any other in- network provider.
- Members can access care through a link from My Health Toolkit (MHTK) phone app or link to Meru Health through Strive.
- The providers can be found on the Virtual First Provider link on Finding Care.

Collaborative Communication of Benefits

- PEBA and BCBSSC have added Behavioral Health webpages
- Addition of dedicated phone line directly to live agent for members searching for care options
- Strategic promotion of Behavioral Health benefits throughout the year
  - Emails
  - Text messages
  - Social media posts
  - Communication to benefits administrators





Priority Areas of Future Expansion for Digital Behavioral Health

- Increase access to virtual Intensive Outpatient treatment for Adolescents
- Additional Substance Use Disorder treatment options
- Explore ways to streamline navigation of members to all BH options
- Increase access and timeliness to care with additional general BH providers by partnering with BH provider aggregators to add therapists and psychiatrists to our network

Thank You!

Questions:
April.Richardson
@BCBSSC.com

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
Health Care Policy Committee

Meeting Date: October 23, 2024

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1. Subject: Election of HCP Committee Vice-Chairman

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2. Summary*:* According to the PEBA Board Bylaws: At the first committee meeting after the Chairman's appointment of the standing committee members and chairmen each even-numbered year, each standing committee shall elect a vice-chairman to preside over the committee and oversee committee business in the absence of the committee chairman.

3. What is the Committee asked to do? Elect a Health Care Policy Committee Vice-Chairman

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4. Supporting Documents: