AGENDA

State and Public School Life and Health Insurance Board

October 20th, 2020

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I.	*Call to Order*	*Renee Mallory, Chair*
II.	*Approval of September 22nd & 29th Minutes*	*Renee Mallory, Chair*
III.	*DUEC Report*	*Dr. Hank Simmons, DUEC Chair*
IV.	*Subcommittee Updates*	*Chris Howlett, EBD Director*
V.	*Life Insurance Rates*	*Colonial Life*
VI.	*COVID Update*	*Elizabeth Montgomery & Mike Motley, ACHI*
VII.	*Trend Experience*	*Paul Sakhrani & Courtney White, Milliman*
VIII.	*Director's Report*	*Chris Howlett, EBD Director*
IX.	*Adjournment*	*Renee Mallory, Chair*

2020 Upcoming Meetings:

November 18th, December 16th

NOTE: All material for this meeting will be available by electronic means only

Notice: Silence your cell phones. Keep your personal conversations to a minimum.

STATE AND PUBLIC SCHOOL LIFE AND HEALTH INSURANCE BOARD MEETING MINUTES

206th meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on October 20th, 2020, at 1:00 PM

Date | *time* 10/20/2020 1:00 PM | *meeting called to order by Renee Mallory, Chair*

Attendance

Members Present

Cindy Allen
Stephanie Lilly-Palmer - Teleconference
Greg Rogers
Dori Gutierrez
Cindy Gillespie
Dr. Terry Fiddler
Melissa Moore
Renee Mallory - Chair
Secretary Amy Fecher
Dr. Lanita White
Lisa Sherrill - Teleconference
Herb Scott
Cynthia Dunlap
Chris Howlett, Employee Benefits Division Director

Members Absent

Dr. John Kirtley – Vice-Chair

OTHERS PRESENT:

Rhoda Classen, Theresa Huber, Laura Thompson, Stella Greene, Shalada Toles, Mary Massirer, EBD; Micah Bard, Dwight Davis, Sherry Bryant, Octawia DeYoung, UAMS EBRX; Jessica Akins, Takisha Sanders, Health Advantage; Elizabeth Montgomery, Mike Motley, ACHI; Courtney White, Paul Sakhrani, Scott Cohen, Milliman; Sean Seago, MERCK; Sidney Keisner, UAMS; Ronda Walthall, ARDOT; Mary Grace Smith, William Rains, Robert McQuade, Patricia Colford, ASE Retiree; Mark Adkison, Stephen Carroll, AllCare Specialty; Bill Clary, ARSEBA; Mitch Rouse, Brooke Hollowoa, TSS; Sylvia Landers, Jessica Reece, Steve Vermette, Colonial Life; Erika Gee; Daniel Faulkner; Nima Nabavi, Amgen; Donna Morey, ARTA; Suzanne Woodall, MedImpact; Treg Long, ACS; David Kizzia, AEA; Tony Glenn; Stephen D Sullivan; Jim Musick, GSK; Sam Smothers, Endo Pharmaceuticals; Kristie Banks, Mainstream; Jack Hopkins

Approval of Minutes by Renee Mallory, Chair

MOTION by Lilly-Palmer:

Motion to accept the September 22nd and September 29th, 2020 minutes.

Scott seconded; all were in favor.

Minutes Approved.

DUEC Report by Dr. Hank Simmons, DUEC Chair

The following report pertains to the DUEC meeting at 1:00 p.m. on Thursday, October 15th, 2020 with Dr. Hank Simmons presiding.

I. Old Business

A. Second Review of Drugs: *Dr. Jill Johnson, Dr. Micah Bard, UAMS*

Brand	Generic	Recommendation
(1) LYUMJEV	INSULIN LISPRO-AABC	Cover

The DUEC voted to adopt the recommendation as presented.

II. New Business

A. New Drugs: *Dr. Jill Johnson, Dr. Dwight Davis, UAMS*

Brand	Generic	Recommendation
(1) BREZTRI AEROSPHERE	BUDESONIDE, GLYCOPYRROLATE, FORMOTEROL	Cover
(2) SEMGLEE	INSULIN GLARGINE,HUM.REC.ANLOG	Cover

The DUEC voted to adopt the recommendations as presented.

MOTION by Scott:

Motion to accept the recommendations as presented.

Dr. Fiddler seconded; all were in favor.

Motion Approved.

Subcommittee Updates by Chris Howlett, EBD Director

Howlett provided a brief update on the October sub-committee meetings.

Topics Discussed:
- Approval of Minutes
- COVID Update
- Trend Experience *Benefits only
- Director's Report

Life Insurance Rates by Steve Vermette, Jessica Reece, & Deborah Vandeventer, Colonial Life

Vermette and Reece provided a brief presentation on the Colonial Life Group Term Life renewal for the plan. They covered the financial summaries of our group and requested an increase in the existing rates that are subject to our approval in accordance with our partnership agreement.

Discussion:

Dr. Fiddler: The point that you made that this group is being targeted (used loosely) because they have had higher incidents of use. Has this been a normal group that has had a higher incidence of use, or had this just happened this time?

Vermette: Historically, this has been the case where you've seen the retiree class running higher than normal and the active class running closer to normal. We saw the same thing with the prior carrier, Securian, and when they had rate increases, and Chris probably knows this better than I do, but those rate increases were targeted and applied to the retiree class. So, really it has not a recent phenomenon; it has been somewhat historical.

Dr. Fiddler: Have you suggested this in the past?

Howlett: For Colonial, no sir. With Securian, there was two rate increases that I'm familiar with. There was one in 2018 and then one previous to that. The Board did not seem to pass certain requests from Securian. In a 7-year engagement, Securian ended up losing money in large part due to the lack of the adjustments being allowed or afforded to them.

Dr. Fiddler: That makes sense. Would you just sum again what your options were and where we are?

Vermette: Yes. So, there are two options on the table. Option 1, which only applies to the retiree classes, would be to spread the rate increase across those segments where the experience is running poorly. So, for example, the basic current monthly cost is $4.20 and would go to $6.32. So, an average difference of $2.12 for each individual that's in that class. So that's option 1. Option 2 would simply be taking that 5% increase and spreading it across all of the class occasions, except for child. So, what you're doing is you're spreading it across a broader group of payers, and it mitigates the average increase to some extent. In either case, we would prefer option 1 because it's truer in terms of how it's targeting the increase, but whichever option you decide, we're willing to hold those rates through 2022. That would be 2 years: for the full year of 2021 and the full year of 2022 all the way to 1/1/2023. Does that help?

Gillespie: Could you remind us what the rates are for the active group?

Reece: Sure. Do you want to look at a certain population of the active, like expanded basic, supplemental, etc.?

Gillespie: Let's just start with basic.

Allen: While we are waiting for this, is this for both Arkansas state employees and public-school employees?

Howlett: Actually, it is both, but probably about 98% will be one ASE, as far as state employees and retirees. There are some districts that participate, but the way the law stipulates, districts can go out and procure those on their own. They can also take part in the state procured benefits that EBD offers.

Allen: The reason I asked was that back in September of 2018, we did have an increase for retired teachers on Minnesota Life. Is that something different?

Howlett: Securian is Minnesota Life, yes ma'am.

Allen: There was an increase at that time. It was my first meeting, and I remember because they said, "what do you think?" I said that I am the retired person, and of course, I don't want the rates to go up, but they did.

Howlett: So, if I'm reading this correctly, under the employee piece shows the dollars and cents per 1000 of coverage.

Gillespie: So, the $0.25 above that for basic is equivalent to the $4.20 that we see on the other for retirees. Is that correct?

Colonial Life: The $4.20 on the presentation is like an average monthly premium for an average size policy whereas the $0.25 is a rate for 1000, which would be applied to how many thousands that you have. The retirees are charged the same way as the actives. We were just trying to show a comparison of the rate increase current to proposed.

Vermette: So, your average retiree is paying $4.20 a month for basic coverage. This 5% increase would result in a $2.12% increase to that specific group.

Mallory: So, to compare apples to apples, how much is that per 1000?

Gillespie: Apple to apples for basic would be $0.25 to $0.89, right?

Reece: Yes, you got it. So, ASE expanded basic is $0.25 per 1000, and a retiree basic and expanded basic is $0.89 per 1000. That would be your apples to apples comparison. Does that help?

Gillespie: So, 5% would be about $0.45. It would go from $0.89 per 1000 to $0.90.

Colonial Life: It's not 5% on retiree rate; it's per case premium.

Vermette: The 5% overall increases the overall premium on the case by 5%. What we're doing is taking that increase and spreading it across those retiree classes, which is resulting in an average of $2.12 for a month for the basic class, $8.23 for another, and $2.90 for the spouse.

Colonial Life: I think what they're looking for though, is that a 5% increase on the case is either option one is 50% on those coverages or option two is 15% on those coverages. The retirees are like a third-ish of the total. Does that make sense?

Vermette: So, what we're saying is the 5% increase on the group is approximately $400,000-$500,000, which is being spread only across the retiree classes. These are the 2 options, not the active population whatsoever, because this is where the experiences have been running poor, generally, over time.

Dunlap: When I looked at the schedule earlier, and I heard you say 5%, but what I see here is that your average cost is $4.20, and the average goes up by $2.12, which is a 50% increase. I wasn't understanding how a 5% increase results in the average going up by 50% as well as the 15%, and I don't understand the $15.37 number that looks like it should be a total. Your current monthly costs are $4.20, $16.30, and if you throughout the $51.30, it's still not $15.37. So, what makes up the $15.37, $17.61, and $2.24? How do we go from a 5% increase in premiums across the board to a 50% average increase?

Vermette: When we say a 5% increase, we are talking about a 5% increase on the entire group in order to make it just. So, close to $11M in annualized premiums times 5% is going to run around half a million dollars. That's the increase that we need in order to true the plan up. Now, you could take that 5% and literally spread it across the entire group, all levels of coverage, but what made sense to us was to just target the segment that's hurting the group rather than penalize everybody. So, the answer to your question, it's

not a 5% increase for the retirees; it's more like a 50% increase for just those classes we're increasing, which results in a 5% increase to the overall state of Arkansas.

Dr. Fiddler: If I am a retiree with basic with a spouse, what would the normal premium cost per month for the two of us? Then I want to know what it would be by you raising the cost of that. What would be my true cost?

Vermette: We would need to know how much insurance coverage you have.

Dr. Fiddler: We're talking $50,000.

Reece: For a retiree, more of an average for basic and expanded basic would be $5000. So, you have the $5000 times $0.89, which is $4.45 a month. Then, for the retiree supplemental, also $5000, which would be $5.05. If you put those two together, it would give them a monthly rate of $9.50, and then you would multiply that by yearly. So, it looks like that would be $114 if I did my numbers right.

Vermette: Then, you would multiply that by 1.5 if it goes up. So, the $9.50 which you are currently spending for you and your spouse now would become $14.25 because it's a 50% increase to that specific class.

Dr. Fiddler: What I want as an individual member of this Board, and the rest of the Board can decide what they want as individual members, is a scenario that we can send out to our people on these people on the ASE and PSE, and say if you want this for yourself and this for your spouse and you want X amount for supplemental, this is what it's going to cost you a month. All these percentages that we are talking about as a Board means nothing to me as a John Q that's retired. I just want to know what the dollar amount is. That's what got us in trouble last time on something else.

Vermette: Yeah, that is a good point. We can do that. The reason we showed it to you the way we did was because we were trying to show you the average across those three classes because there are thousands of people with different levels of coverage.

Reece: So, you're looking for some live comparisons, is that correct?

Dr. Fiddler: If I'm sitting in my home and I get something in the mail that says it's gone up 5%. We've just gone through all these questions. What does a 5% mean? I just want to know what it's going to cost out of my pocket.

Gillespie: Just to make sure I'm clear on something, you're saying that you're recommending a 5% increase on the group and when you say that, you mean the full group, active and retiree?

Vermette: That 5% is applied to the entire group, yes.

Gillespie: So, not just 5% on the retiree group, which is the area running over.

Vermette: We're taking 5% of the aggregate group, which represents roughly half a million dollars, and just applying it to specific segments within the retiree class. We showed you averages, and we can certainly show you what that would mean. Option one is a 50% increase in those rates, and then option two is about 15% on that group.

Gillespie: I'm new to life insurance. If this is structured into two groups and one group is running at 64%, which is well under, and the other group is running at 108%, which is well over, why are we looking at an increase across the entire group? Is it somewhere in the margins that are supposed to be there or something? Our current premiums that we get from the actives total $5.4M, is that correct?

Reece: Yes.

Gillespie: Then the retiree group is roughly half of that, $2.4M?

Vermette: It's $2.8M, which totals $8.3M

Gillespie: So, they are roughly half of that so, our area that's running over is in that smaller premium group?

Vermette: Yes, you have a lot more claims just due to the average age, etc.

Gillespie: Which is not surprising. I'm not understanding what's supposed to be in a margin, and margin may not even be the correct term. I'm seeing a 1/3 with an overage, and 2/3 not with an overage and I'm wondering why we need to.

Vermette: One of the things that we try to do is to get as much participation in the younger healthy population as possible, and that allows the group to run optimally. The way you do that is to keep your rates as absolutely low and affordable as possible, which is why we were doing it this way, to be honest with you. As you can see, the majority of the premium is in the active working class, and the claims there are running well. One option would be to reduce rates on the active, and you increase rates on the retiree to make the plan run optimally, but it's a bigger hit to the retiree when that happens. We're only 9 months into this, and usually, it's about 18 months before we actually know how things are going, but what we are seeing here is the same scenario that the prior carrier, Minnesota Life/Securian, saw as well. So, rather than increase the rates on the active class, the rates are increased on the retiree class in hopes of stabilizing the plan.

Reece: I would also add that the goal is to spread out kind of good risk. So, one of the things that we're doing right now is we've offered a second time guaranteed issue offering, and we are in open enrollment right now for the active population. To help, from our perspective, not only offer a guaranteed issue offering but help kind of spread that risk to make the overall pool perform better.

Vermette: So, the prior carrier, would in the first year, you could get your coverage guaranteed, but beyond that, you had to provide evidence of insurability every year if you wanted more coverage. We are offering a guarantee issue again in the second year with a limit, but we are still doing it in an effort to get more people into the plan and just make it run better and just in recognition of COVID.

Reece: We did also have a short open enrollment window last year. We wanted to sync up and get in line with the health insurance and offer another opportunity for that guaranteed issue offering during their normal open enrollment period.

Vandeventer: We've heard a lot from customers that life insurance is important always, but even more important now and with that kind of on people's minds and wanting to make sure it was open and available for them. I think that does hopefully help us as we're looking at how do we improve the health of the case, and having more people definitely impacts that.

Fecher: On option two, is that if you would spread it over the entire group and not just the retirees

Vandeventer: So, both of those options are just adjusting the retirees. It just does it in two different ways. We actually don't have an option up there listed where it adjusts it across the whole population just because we were thinking we're steering the increase to the people who were impacted, or the rates were more needed there.

Fecher: Along with Dr. Fiddler, I'd like to request that we have the numbers on if it were spread out over the entire population. I'm just curious, have you all been watching the news about what's going on with retirees and their healthcare benefits, specifically pharmacy benefits?

Vermette: Yes ma'am.

Fecher: Okay, so I think this is a really, really bad time to go up on retirees only, and I cannot be supportive of that. Personally, everyone on the board has to vote their conscious, but

there is no way because I'm tired of sitting down at the table and answering the questions from legislators. I cannot support this. If you give me some numbers that show it spread over the entire population, then that maybe something I could vote for.

Colonial Life: Okay, sure, we can do that.

Dunlap: I just have one request. I agree with Secretary Fecher because my understanding was that this was not going to be applied to any other group except the retirees. The 5% was just the impact over the whole plan, but the retirees were the only ones getting the rate increase. Can you take those proposed rates to increase by category and do a similar table like you just showed us and say okay, the basic rate is $0.89, and if we increase it by 15%, if goes to this amount, and you apply that same percentage down the board, and then you can create this scenario that Dr. Fiddler was talking about? Somebody can say, “if my insurance is $5000 with this new rate increase, this is the premium that it would be.” It would be easy to calculate that amount if you take that percentage and just spread it all the way across the whole schedule, and then we can see the actual numbers. I can see that it goes from $0.89 to $0.95.

Vermette: Okay, we can do that. We can show you the existing rate, and we can show you the new rate across the whole population. We will have to give you a couple of options, but we can do that. We just didn’t think that it was an option, but again, the situation has changed, so were definitely cognizant and empathic of that.

Lilly-Palmer: I would like that ask the question of throw a scenario out there. For the actives, they start off with the $10,000 that you’re talking about going to the $5000, that’s the $0.89 that comes from the $0.25. Listed on that sheet, if everybody has an opportunity to go look at the ARBenefits website and look at the retiree and active difference. All of the coverages that retirees have, except for the supplemental dependent, is reduced by 50%. So, in the retiring of all the employees that I’ve done over all the years, one of the things that were in effect, I don’t remember the year, but that has been in effect for just a little bit, not this whole time. So, you take somebody who’s got $10,000 as an active employee that has no cost to that. Then you take the expanded basic, which is different than your supplemental, and that is a flat rate to them. Typically, it's been, I think, running $10 per month, because they had a special open enrollment to do up to $40,000. If you take the 10, that’s going down to 5, and you take their 40, that’s going down to the 20, that’s making their premiums $17.80. Then, if they have $50,000 in supplemental, and that’s automatically going to drop to 25, and their rate was $56.50 as an active, it’s going to drop to $28.25 if they retire at 60. So, the way this is said, it cuts in half (50%) at the time of retirement, and then it’ll cut in half at age 75. Is that something that can be looked at if these rates are going to have to change?

Reece: I think that’s a great point and a great observation. So, what I will say about how it’s currently set up from a retiree reduction and face amount perspective is consistent with the prior carrier. It is consistent with the contractual agreement that we have in place. We’re certainly happy to kind of explore that further, but I will indicate that that isn’t a change from the prior carrier, and we did follow suit with them.

Vandeventer: We’d be happy to put those examples in place just to showcase that so you can see the reduction. The claims reduction was factored into when the actuarial team looked at the rates just because the claims are paid out, like Jessica said, according to how they were before it was set up with the specific age reductions and how they hit.

Lilly-Palmer: I understand that, and the way Minnesota Life was set up, and I know what it carried over. I just know in retiring people, one of the things that they are concerned about, in a

lot of cases, the only life insurance they have is through their employer, is the phenomenal expense that they're looking at. So, when I figured all this up, just in looking at a 5% overall in the scenario, it made a $2.52 difference. However, you do have those employees that they simply can't afford that higher premium at the time that they retire. So, I'm just curious if that's something that can be looked at instead of that 50% cutting in half at the time of retirement. That might be something that can be changed if we do have to look at increasing the rates. I understand the 75, but if that's something that might be a weighing factor that might help.

Reece: Sure, we can absolutely look at it. There are some contractual things, and there are some implementation things that we need to look at, but we're open to looking at it for you. The last thing I would kind of say on that is, I mean, you picked up on it, the basic, and the expanded basic rate is a composite rate. So, it's just a flat rate per 1000 versus the supplemental rate is an age banded rate. So, that can kind of very what a person sees dependent upon what they had as an active employee and what they decided to continue as a retiree.

Lilly-Palmer: If that's a scenario that we are going to look at, I also think it's important that we also do some outreach on that and let the employees know when they go into retirement that they do have the option to reduce that a little bit, specifically on the form when they retire, it does give them an option to cancel , reduce, or keep their amount. That might be something that needs to be a part of the outreach, as well.

Reece: I think with a retiree population, it's not unusual for them to be on a more fixed income. It's not unusual for them to kind of recalculate what type of life insurance they may need to continue and, we have seen some retirees not continue certain pieces of life insurance and continue others. Even in talking to some of them, you know, it's just basically; I just need this for burial. I don't need as much insurance as I had when I was an active employee. So, they are, in my experience, seem that they're being intentional about what they want to keep and what they don't want to keep.

Fecher: I would also like to make a suggestion to the Board; what I have heard over and over and over throughout the committee hearings is that legislator is saying, "why didn't we know about this before you did it?" So, it might be good if we could get a letter explaining the reason from Colonial Life that they need to make an increase 9 months in so that we could present that to the Insurance and Commerce Committee chairs so they could be in the know before we vote and take action on that. I think that would be a much safer path to go down.

Vermette: That's fair, thank you.

Scott: I was just wondering about the time frame and how much time we have to get this together? Does it have to be done before the 31st of October? How does it work?

Howlett: Typically, rates and other things are set as late as July, and before we go into an open enrollment session, these rates are set in August and maybe as late as September depending on different events. This year with everything that has culminated in response to the rates and the Board decision, this has not been on the agenda to take precedence for that. In a typical year, all this is wrapped up before we exit summer.

Scott: What about now. I mean, do we have until January?

Howlett: What you're up against are the notification and the outreach. Technically speaking, you can actually get to the beginning of the plan year that you're dealing with, you can do a rate increase, but we like to, typically, give a lot of notice before you're going into open enrollment to make this as part of one of the selections for the active employees or

those that are choosing to retire. So, we still have latitude to do that, but the gap is narrowing.

Scott: The reason I'm asking is because I would like to move that we table this, but I don't want to table this too far out, and I'd like to be as fluid as possible.

Howlett: Under statute, EBD has the ability to do a special open enrollment period and do that with a simple declaration. Colonial, Jessica, and Steve, if you were to have a drop-dead date, so to speak, would that be at the end of November? What would that look like?

Reece: Well, I would say, just to clarify, the active population is already enrolling. So, I don't know if it would be necessarily the best outcome to review looking to add something to the active rate for folks that are already enrolling. To directly answer your question about how much time we have left, I would say; ideally, we'd like to get some information back to you all within the next week. I'd like to have kind of where we go from here wrapped up by the end of the month if at all possible, if that's fair. I know we owe you all some materials to kind of review and get comfortable and answer the questions that either you or others may be having.

Vermette: I think it would be difficult to change any of the active rates right now because they've already been published, and we're already in the middle of the enrollment. I don't think it would bring us any goodwill to do that, to be honest with you. I don't think we'd be able to do it this year, and retirees, even at this point, are stretched. We are running out of time, but we will give you what you want to see. We would just need to work relatively quickly with your help, if that's possible.

Reece: It goes back to exactly what Chris was saying about the notification timeframe. If you look at doing an implementation for 1/1, you need to back up some of that notification time to make people aware of what's changing and how that impacts them for planning purposes.

Dr. Fiddler: We just had an us against them moment, and we don't need that anymore. I think we need to say that we're all in this together: the provider, the Board, and the employee. We can't do that at all until, as Secretary Fecher has said, we've got to go to the Insurance and Commerce and look at this. They need to say, "okay, you guys are doing it right this time." So, whatever needs to make this happen, I would encourage the Board, Mr. Howlett, Secretary Fecher, and everybody that's on this thing to do that. I don't want to have a special Board meeting if we don't have to, but if we have to wait a month, then we wait a month. I'm just trying to figure a timeline.

Howlett: How about we start with the requests that have been mentioned. EBD will work with Colonial Life to turn this information around very quickly and then be able to get the information once we have it to be able to focus on a little path to get it to the Board and the respective committees and go that route.

Dr. Fiddler: I know you will do the right thing; I just want to make sure that it gets into our employee's hands and retirees' hands in a very understandable way because we didn't have it the last time. So, we need it this time.

Dunlap: Related to the timing, what happens, because the active rates can't be changed now and not wanting to necessarily change just the retiree rates, what happens if you do nothing between now and the beginning of 2021? What are our options, and what can we do if you're not going to change the active rates because active enrollment has already started? What is the next window that you'd be able to make that changes?

Vermette: Let us get back to you on what our options would be regarding the different timing options if that's permissible.

Vandeventer: We definitely understand that the active piece is important to you, and we will include that as part of the option as well.

Scott: Chris, I just think it would be easier on the members of the Board, that when we have these types of presentations, you just request that they do bottom line dollar amounts so we can actually see if you do this, this will happen, and this is your cost. I think that Cynthia brought this up at the last meeting when you start throwing these figures at us and then you expect a vote right then and there. It's almost, and I won't say impossible, but it's very difficult to try to decipher and then take a vote. So, just give us some bottom-line numbers.

Howlett: I can agree with that, and I think as we all trade shoes on this, when this was brought up last time, I execute the decisions of the Board, and I can only do my role based on the feedback that I have from all players. So, for that, what has become problematic for me is when I don't get any communication back as to what we would like to see. As we move forward, I covet any feedback I can get back to help educate and make individuals more part of the process. I will work with Colonial, and we will take that information back and try to get it back with you in hopefully a week. By doing that, we will be able to get some of their options and their pieces together and be able to come back with a successful timeline for the body.

COVID Update by Elizabeth Montgomery & Mike Motley, ACHI

Montgomery and Motley presented analyses regarding COVID-19 impact on the plan, reviewed COVID-19 test utilization and related costs, assessed updated output on COVID-19-related telemedicine utilization within the plan, including related costs and service utilization by diagnoses, and upcoming analyses on bariatric surgery and influenza vaccination.

Discussion:

Dr. Fiddler: Slide 5 says that your tests paid for EBD are 15,875, and slide 7 said we paid $780,000, and you said we paid most of the costs. On slide 5 again, it shows the total number ever tested, and that's through October 5th, but your charts just show through July 24th. So, between July 24th and October 5th, you're going to pay for a lot more because if you tested 47,000 and you only paid for 16,000. So, you still have to account for another 30,000?

Montgomery: Part of that, Dr. Fiddler, is that not all of the tests are billed to EBD. As you've pointed out, this is a more narrow window in terms of looking at the paid claims versus the total volume of all the members that have been tested. So, in other data where we see those types of tests come through. So, I do think with the additional claims experience, we will see a higher volume of tests paid for by the plan and we'll be able to break that out by different testing categories.

Motley: I would just add to that, Dr. Fiddler, that it won't be a delta of 30,000 additional paid tests. We have seen about 2 to1 with the plan paying for one and then two more being done somewhere where the plan didn't pay for them. So, there will be additional ones added on, but not the complete gap of 30,000 more.

Dr. Fiddler: Is there a difference between asynchronous and synchronous telemedicine? In other fields there is a difference in the rate that the insurance pays out. Is there a difference in

your rates or our rates that we pay between patient to doctor and patients' video to doctor?

Motley: We have not looked at that yet, but that could be a next step for us. I'm not sure if someone from the plan has additional feedback on that, but we've not looked at that specifically.

Dr. Fiddler: They have been, generally, paying more for a 1-on-1 than they have been with a middle step. I'd kind of like to know because that's what's coming up at the federal level and what they are going to pay in 2021. I would like to know what we will be doing here in Arkansas.

Howlett: Based on the current requirements with the CARES act and things that we're required to pay like zero cost-share related to COVID, we're paying on average around $93 for a telehealth visit when brick and mortars are averaging about $56, but a lot of it is going to be codependent on the codes that are being billed by the physician in both settings. So, your one significant difference is in your place of service settings, office versus the telehealth or telemed. With that $30 cost member share added into that $93, it tips it over. It's about a 45-55 spread without the member cost-share

2021 Rates/Benefits Discussion by Courtney White, Paul Sakhrani, & Scott Cohen, Milliman

White, Sakhrani, and Cohen provided an update on the Plan experience for ASE and PSE.

ASE

- 2020 & 2021 projections updated to incorporate claims data incurred from March 2019 to February 2020 and paid through September 2020
- 2020 projected Plan experience
    - Allocated reserves for 2020 is $25.1M
    - Estimated deficit of $4.1M
    - End of Year Assets: $67.4M
    - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
    - No Plan changes / 5% increase in employee contributions
- 2021 Plan experience
    - Allocated reserves for 2021 is $14.5M
    - Projected deficit: $3.6M
    - End of Year Assets: $49.4M
    - Reflected 2021 program initiatives
    - Increased membership based on historical patterns
    - Baseline trends (medical: 5%, pharmacy: 8%)
    - September 29, 2020 Board action

PSE

- Projections updated to incorporate claims data incurred from March 2019 to February 2019 and paid through September 2020

- 2020 Plan experience
    - Allocated reserves for 2020 is $25.3M
    - Estimated deficit of $11.6M
    - End of Year Assets: $112.1M
    - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
    - No Plan changes / 0% increase to employee contributions
- 2021 Plan experience
    - Allocated reserves for 2021 is $15.5M
    - Projected deficit: $25.2M
    - End of Year Assets: $71.5M
    - Reflected 2021 program initiatives
    - Increased membership based on historical patterns
    - Baseline trends (medical: 7%, pharmacy: 8%)
    - September 29, 2020 Board action

Discussion:

ASE

Dr. Fiddler: Is the $184.4M a solid, or is that what they're projecting it to be?

Fecher: I believe that's a projection, Dr. Fiddler, because we won't know exactly how many employees we have. They take a snapshot. Chris, do you know what time of year it is, March or April of each year?

Howlett: Typically, it's done in the springtime.

Fecher: It will be based on the number of active employees at that time.

Dr. Fiddler: So anytime we see this later on, I won't have to ask the question. It is all being an assumption of what happens at that time.

Howlett: Office of Budget will set those around April or May, and they put those in and that when we receive it from the insurance perspective. Those numbers are those that are put out by the Office of Budget for those respective agencies on the state side.

White: That is a budgeted headcount and not the number of people that are actually enrolled. So, whether you had one person in the health plan or 30,000, you would still get the $185M, right?

Howlett: Correct, yes sir.

Gillespie: When talking about projecting a 5% increase in medical trend, what are you now using as your base? Things have obviously changed quite a bit, so what are you using as your base for that 5%?

White: We are using March 2019 through February 2020 as our 12-month base to do the second half of 2020 and for 2021 projections. So, we are applying 5% on an annual basis over those time periods from that 12-month period and all the way to 2022.

Gillespie: What increase was that over that period, because we do have that dive as you say that hit? What does that average out to now? Originally, we thought the trend was going to be more, and then it wasn't. So, I was just wondering if we looked back over the two years you've now said for this period of March 2019 through April of 2020

White: It’s February 2020.

Gillespie: February 2020 is what you’re using as the base, and you’re growing 5% off of that per year. Are you assuming a 5% from there for the rest of this year, calendar year, or you’re just working out the job for 2021?

White: Our actual data is through July of 2020. So, January through July of 2020 is based on the actual claims paid by EBD to their vendors for both medical and pharmacy. For August through December of 2020, we're using the timeframe shown here, March 2019 to February 2020, projected to the second half of the year. Then there's also seasonality that comes into play because a lot of people have met their deductibles or out of pocket maxes by the time they get to this time of the year. So, there's an uptick in claims due to EBD paying more out of a particular claim. So, there's kind of there's a combination of trend plus a seasonality adjustment to project that second half of the year.

Gillespie: Okay, then looking at 2021 and 2022, you’re looking at a 5% growth and then 5% on top of that for 2022?

White: Correct, and those are all per capita numbers. So, the numbers that you’re seeing in those tables are the actual expected number of total payouts in millions. So, we do everything on a per capita basis and then multiply it by the number of covered lives. So, if the headcount changes a lot, then your claims would go up. You don’t see that as much on ASE as you do PSE. I think on ASE, it’s less than a 1% overall increase in headcount, but on PSE, it’s closer to 3%. So, you see a 5% trend plus 3% increase in headcount because you’re covering more people.

2020 and Beyond Roadmap

Fecher: Is this something that we’re going to have as part of our meeting every month where we are going to work through this timeline and a strategic roadmap and set these priorities? Is the Board going to all do it together?

Howlett: Yes ma’am. Part of this was in response to Secretary Gillespie and Mrs. Dunlap’s question on the things we have identified and how we are going to arrive there. So, that’s going back to that timeline that chart is kind of how we're going to progress there. I've worked with Milliman on several pieces, and they are going to put together small snippet videos and different things that each board member would have made available to them to go out on a portal to go out and view in their own time and in their own fashion to be able to basically learn at your own speed. They are not very lengthy, maybe 15-20 minutes. If you have questions you can always come back to me or even to Courtney, Paul, and the team there. A lot of those are going to be kind of like, prerequisites as we roll into the next Board meeting. I have worked on other pieces with the TSS secretary staff to see about looking at opportunities that we can increase our knowledge base to additional trainings and different things. So, there’s more to come on that as well. My goal would be to make it as expeditiously as possible to occur, knowing what we have before us in the next six months.

Fecher: Thank you. I definitely support that. I just think we need to budget our time for the meetings accordingly because when I’ve done strategic planning before to have the rich discussion, we will need; it will be time consuming.

Gillespie: When we are doing the education piece, I think an area, I know I do at least, need more understanding is what our population looks like that we serve here. I would like to understand what they look like and utilization. Also, if there was a way for us to look at whether or not some of the bigger issues. For example, there are areas where,

unfortunately, our state as a whole continues to look very badly. Those areas where the state as a whole is having problems and seeing if we are having those same problems within our employee ranks. If so, that would be an area I would hope we could also look at. A simple example is maternal mortality, maternal health, and infant mortality. I would hope our employees are not having a lot of low birth weight babies or babies in NICUs. Arkansas ranks 49th or 50th, depending in that area, so I'd like to know if that is happening, and there are also huge expenses associated with that for the plan not just at the birth but throughout the life of the child. So, looking at some of those areas that we need to be addressing and I'd like to see if our population is a carve out exception or should we be looking at those as real strategic areas that can be addressed working with an employee group.

Howlett: Specific to the maternity section, I don't know that that was discussed in our piece. In the bigger picture, we looked at the high-end classifications, and some of the most common are obesity, diabetes, and those things, but yes, I will definitely make that a part of that. As we roll into this timeline, part of that is to understand more of the mechanics of the plan and more of those pieces. Once you understand those foundations, then we can come back and apply the experience of the plan to those things, and then we know the triggers and the levers that are there, and that's the ultimate goal.

Director's Report by Chris Howlett, EBD Director

Howlett reported the wellness statistics for the plan. The end of October is the end of the wellness discount timeframe. Right now, we are at about 60% with the discount of our population and 40% without the discount. That is about 72,500 people that would qualify on that. Catapult visits, as of today, are 42,592 and about 14,487 on the PCP visits, which total 57,000. We've been made aware of the CARES act extension. The extension is now; it was to subside on the 23rd of October, through January, 21st of 2021. Really, everything else has been extended, and under that, there is a piece that we're reviewing, and we'll probably have to get with our plan legal counsel to make sure that we're in compliance with some of the statutes around timely filing changes. I think they're trying to put a moratorium on that for the March through present or through the duration of the national health emergency. On the Part D numbers, as you're well aware, there those that have the choice to be able to opt out. We have run that report and we've finished the configuration and tested all that. Right now, there are 21 individuals that would fall in that bucket. The breakout would be a subscriber or the retiree member only; there are 16, the subscriber/member and spouse, 3, and the subscriber/retiree and family, 2. That is a total of 21 that have opted out.

MOTION by Dr. White:

I make a motion to adjourn the meeting.

Dr. Kirtley seconded. All were in favor.

Meeting Adjourned.

State and Public-School Life and Health Insurance Board
Drug Utilization and Evaluation Committee Report

The following report pertains to the DUEC meeting at 1:00 p.m. on Thursday, October 15th, 2020 with Dr. Hank Simmons presiding.

I. **Old Business**

A. Second Review of Drugs: *Dr. Jill Johnson, Dr. Micah Bard, UAMS*

Brand	Generic	Recommendation
(1) LYUMJEV	INSULIN LISPRO-AABC	Cover

The DUEC voted to adopt the recommendation as presented.

II. New Business

A. New Drugs: *Dr. Jill Johnson, Dr. Dwight Davis, UAMS*

Brand	Generic	Recommendation
(1) BREZTRI AEROSPHERE	BUDESONIDE, GLYCOPYRROLATE, FORMOTEROL	Cover
(2) SEMGLEE	INSULIN GLARGINE,HUM.REC.ANLOG	Cover

The DUEC voted to adopt the recommendations as presented.

Meeting Adjourned.

Respectfully submitted,

Henry F. Simmons, Jr., MD
Chair, DUEC

***New Drug Code Key:**

1	Lacks meaningful clinical endpoint data; has shown efficacy for surrogate endpoints only.
2	Drug's best support is from single arm trial data
3	No information in recognized information sources (PubMed or Drug Facts & Comparisons or Lexicomp)
4	**Convenience Kit Policy** - As new drugs are released to the market through Medispan, those drugs described as "kits will not be considered for inclusion in the plan and will therefore be excluded products unless the product is available solely as a kit. Kits typically contain, in addition to a pre-packaged quantity of the featured drug(s), items that may be associated with the administration of the drug (rubber gloves, sponges, etc.) and/or additional convenience items (lotion, skin cleanser, etc.). In most cases, the cost of the "kit" is greater than the individual items purchased separately.
5	**Medical Food Policy** - Medical foods will be excluded from the plan unless two sources of peer-reviewed, published medical literature supports the use in reducing a medically necessary clinical endpoint. A medical food is defined below: A medical food, as defined in section 5(b)(3) of the Orphan Drug Act (21 U.S.C. 360ee(b)(3)), is "a food which is formulated to be consumed or administered eternally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." FDA considers the statutory definition of medical foods to narrowly constrain the types of products that fit within this category of food. Medical foods are distinguished from the broader category of foods for special dietary use and from foods that make health claims by the requirement that medical foods be intended to meet distinctive nutritional requirements of a disease or condition, used under medical supervision, and intended for the specific dietary management of a disease or condition. Medical foods are not those simply recommended by a physician as part of an overall diet to manage the symptoms or reduce the risk of a disease or condition, and all foods fed to sick patients are not medical foods. Instead, medical foods are foods that are specially formulated and processed (as opposed to a naturally occurring foodstuff used in a natural state) for a patient who is seriously ill or who requires use of the product as a major component of a disease or condition's specific dietary management.
6	**Cough & Cold Policy** - As new cough and cold products enter the market, they are often simply re-formulations or new combinations of existing products already in the marketplace. Many of these existing products are available in generic form and are relatively inexpensive. The new cough and cold products are branded products and are generally considerably more expensive than existing products. The policy of the ASE/PSE prescription drug program will be to default all new cough and cold products to "excluded" unless the DUEC determines the product offers a distinct advantage over existing products. If so determined, the product will be reviewed at the next regularly scheduled DUEC meeting.
7	**Multivitamin Policy** - As new vitamin products enter the market, they are often simply re-formulations or new combinations of vitamins/multivitamins in similar amounts already in the marketplace. Many of these existing products are available in generic form and are relatively inexpensive. The new vitamins are branded products and are generally considerably more expensive than existing products. The policy of the ASE/PSE prescription drug program will be to default all new vitamin/multivitamin products to "excluded" unless the DUEC determines the product offers a distinct advantage over existing products. If so determined, the product will be reviewed at the next regularly scheduled DUEC meeting.
8	Drug has limited medical benefit &/or lack of overall survival data or has overall survival data showing minimal benefit
9	Not medically necessary
10	Peer -reviewed, published cost effectiveness studies support the drug lacks value to the plan.
11	**Oral Contraceptives Policy** - OCs which are new to the market may be covered by the plan with a zero dollar, tier 1, 2, or 3 copay, or may be excluded. If a new-to-market OC provides an alternative product not similarly achieved by other OCs currently covered by the plan, the DUEC will consider it as a new drug. IF the drug does not offer a novel alternative or offers only the advantage of convenience, it may not be considered for inclusion in the plan.
12	Other
13	Insufficient clinical benefit OR alternative agent(s) available

The State and Public School Life and Health Insurance Board
Benefits Sub-Committee and Quality of Care Summary Report

The following report resulted from a meeting of the Benefits Sub-Committee and Quality of Care meeting.

Topics Discussed:
- Approval of Minutes
- COVID Update
- Trend Experience *Benefits only
- Director's Report

COVID Update: Elizabeth Montgomery & Mike Motley, ACHI
Montgomery and Motley presented analyses regarding COVID-19 impact on the plan, reviewed COVID-19 test utilization and related costs, assessed updated output on COVID-19-related telemedicine utilization within the plan, including related costs and service utilization by diagnoses, and upcoming analyses on bariatric surgery and influenza vaccination.

Plan Update: Paul Sakhrani and Courtney White, Milliman
White provided an update on the Plan experience for ASE and PSE.

ASE

- 2020 & 2021 projections updated to incorporate claims data incurred from March 2019 to February 2020 and paid through September 2020
- 2020 projected Plan experience
    - Allocated reserves for 2020 is $25.1M
    - Estimated deficit of $4.1M
    - End of Year Assets: $67.4M
    - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
    - No Plan changes / 5% increase in employee contributions
- 2021 Plan experience
    - Allocated reserves for 2021 is $14.5M
    - Projected deficit: $3.6M
    - End of Year Assets: $49.4M
    - Reflected 2021 program initiatives
    - Increased membership based on historical patterns
    - Baseline trends (medical: 5%, pharmacy: 8%)
    - September 29, 2020 Board action

PSE

- Projections updated to incorporate claims data incurred from March 2019 to February 2019 and paid through September 2020
- 2020 Plan experience
    - Allocated reserves for 2020 is $25.3M
    - Estimated deficit of $11.6M
    - End of Year Assets: $112.1M
    - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
    - No Plan changes / 0% increase to employee contributions
- 2021 Plan experience
    - Allocated reserves for 2021 is $15.5M
    - Projected deficit: $25.2M
    - End of Year Assets: $71.5M
    - Reflected 2021 program initiatives
    - Increased membership based on historical patterns
    - Baseline trends (medical: 7%, pharmacy: 8%)
    - September 29, 2020 Board action

Director's Report: Chris Howlett, EBD Director

Quality of Care

Howlett stated that if you had any further questions that we can have presented or modeled or anything like that just feel free to reach out and send them to us.

Benefits Subcommittee

Toles reported that EBD did send out 13,800 letters last Friday to the over 65 retirees to update them of the board decision from September 29th. So far, we are about halfway through open enrollment and we have had about 9 members opt out of ARBenefits drug coverage for 2021.

State of Arkansas

Colonial Life Group Term Life Renewal
State and Public School Life and
Health Insurance Board

October 20, 2020

Steve Vermette – Large Public Sector Employer Specialist

Deborah Vandeventer – AVP, Underwriting

Jessica Reece – Senior Client Manager

Colonial Life®

Group Term Life

- Thank you for choosing Colonial Life to be your partner for Group Term Life insurance starting in 2019 (effective January 1 ,2020). We are so pleased to be your new partner to help in protecting you and your employees.

- Thank you also for putting us on the agenda today.

- We will be covering the financial summaries of your group and the resulting requested increase in the existing rates that are subject to your approval in accordance with our partnership agreement.

Group Term Life

- ✓ To sustain the plan for the benefit of your employees we would like to show you how the plan has performed thus far in 2020.

- ✓ Due to the number of entities insured (i.e. Over 200 schools, state employees, and multiple retirement groups, overall premium was not established until mid-year).

- ✓ The three exhibits we will show you are:
  - Number of claims paid by group
  - Paid loss ratios by group
  - Proposed monthly cost changes to retiree groups with averages

Number of Claims Paid by Group

SEPTEMBER 2020 YTD

ACTIVE COVERAGE	NUMBER OF CLAIMS
Basic	87
Expanded Basic	25
Supplemental	19
Spouse	24
Child	4
ACTIVE TOTAL	**159**

RETIREE COVERAGE	NUMBER OF CLAIMS
Basic	211
Expanded Basic	14
Supplemental	135
Spouse	46
Child	0
RETIREE TOTAL	**406**

COMBINED TOTAL	**565**

Paid Loss Ratios by Group

SEPTEMBER 2020 YTD

ACTIVE COVERAGE	EST. PREMIUM*	PAID CLAIMS	PAID LOSS RATIO
Basic	1,567,606	836,800	53.4%
Expanded Basic	1,084,204	856,014	79.0%
Supplemental	2,138,681	1,488,586	69.6%
Spouse	547,728	210,993	38.5%
Child	139,294	130,000	93.3%
ACTIVE TOTAL	**5,477,513**	**3,522,393**	**64.3%**

RETIREE COVERAGE	EST. PREMIUM*	PAID CLAIMS	PAID LOSS RATIO
Basic	426,152	898,254	210.8%
Expanded Basic	265,299	220,013	82.9%
Supplemental	2,003,495	1,746,211	87.2%
Spouse	122,726	207,709	169.2%
Child	3,680	0	0.0%
RETIREE TOTAL	**2,821,352**	**3,072,187**	**108.9%**
COMBINED TOTAL	**8,298,865**	**6,594,580**	**79.5%**

*Estimated premium: Assumes full nine months of premium is received and applied; variance expected

Proposed Monthly Cost Changes to Retiree Groups with Averages

OPTION ONE	CURRENT MONTHLY COST	PROPOSED MONTHLY COST	AVG. DIFFERENCE
Basic	4.20	**6.32**	2.12
Expanded Basic	16.30	**24.53**	8.23
Supplemental	51.30	**No Change**	-
Spouse	5.75	**8.65**	2.90
Child	0.68	**No Change**	-
	15.37	**17.61**	**2.24**

OPTION TWO	CURRENT MONTHLY COST	PROPOSED MONTHLY COST	AVG. DIFFERENCE
Basic	4.20	**4.83**	0.63
Expanded Basic	16.30	**18.75**	2.45
Supplemental	51.30	**59.00**	7.70
Spouse	5.75	**6.61**	0.86
Child	0.68	**No Change**	-
	15.37	**17.67**	**2.30**

Colonial Life.com

OCTOBER 2020
EBD BOARD PRESENTATION

Mike Motley, MPH
Director, Analytics

Izzy Montgomery, MPA
Policy Analyst

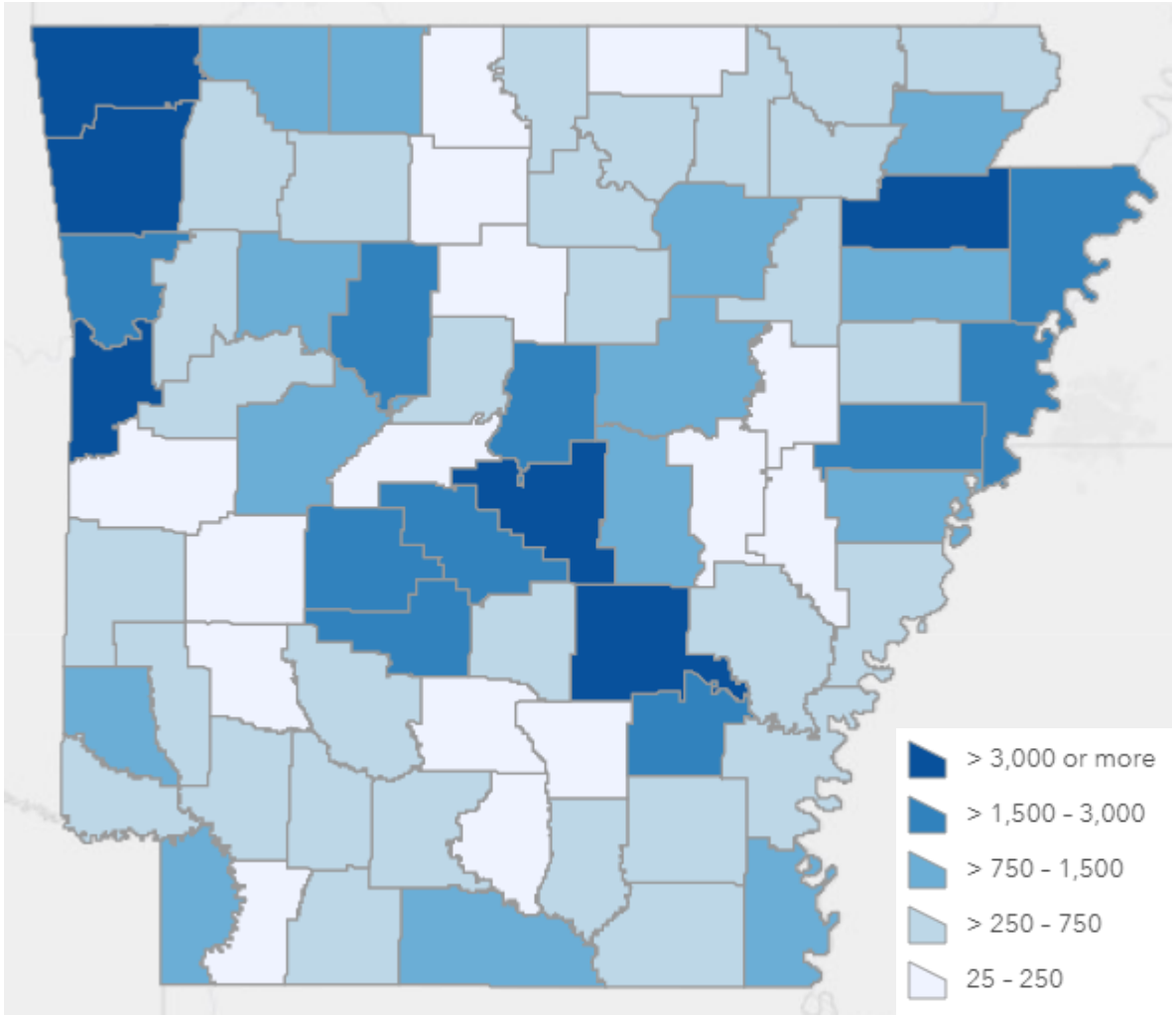
10.20.2020

ACHI
INSPIRING HEALTHY ACTS

OBJECTIVES

- Present analyses regarding COVID-19 impact on plan
- Review COVID-19 test utilization and related costs
- Assess updated output on COVID-19-related telemedicine utilization within plan, including related costs and service utilization by diagnoses
- Upcoming analyses on bariatric surgery and influenza vaccination

COVID-19 IN ARKANSAS



Total COVID-19 Cases

99,597

Confirmed Cases

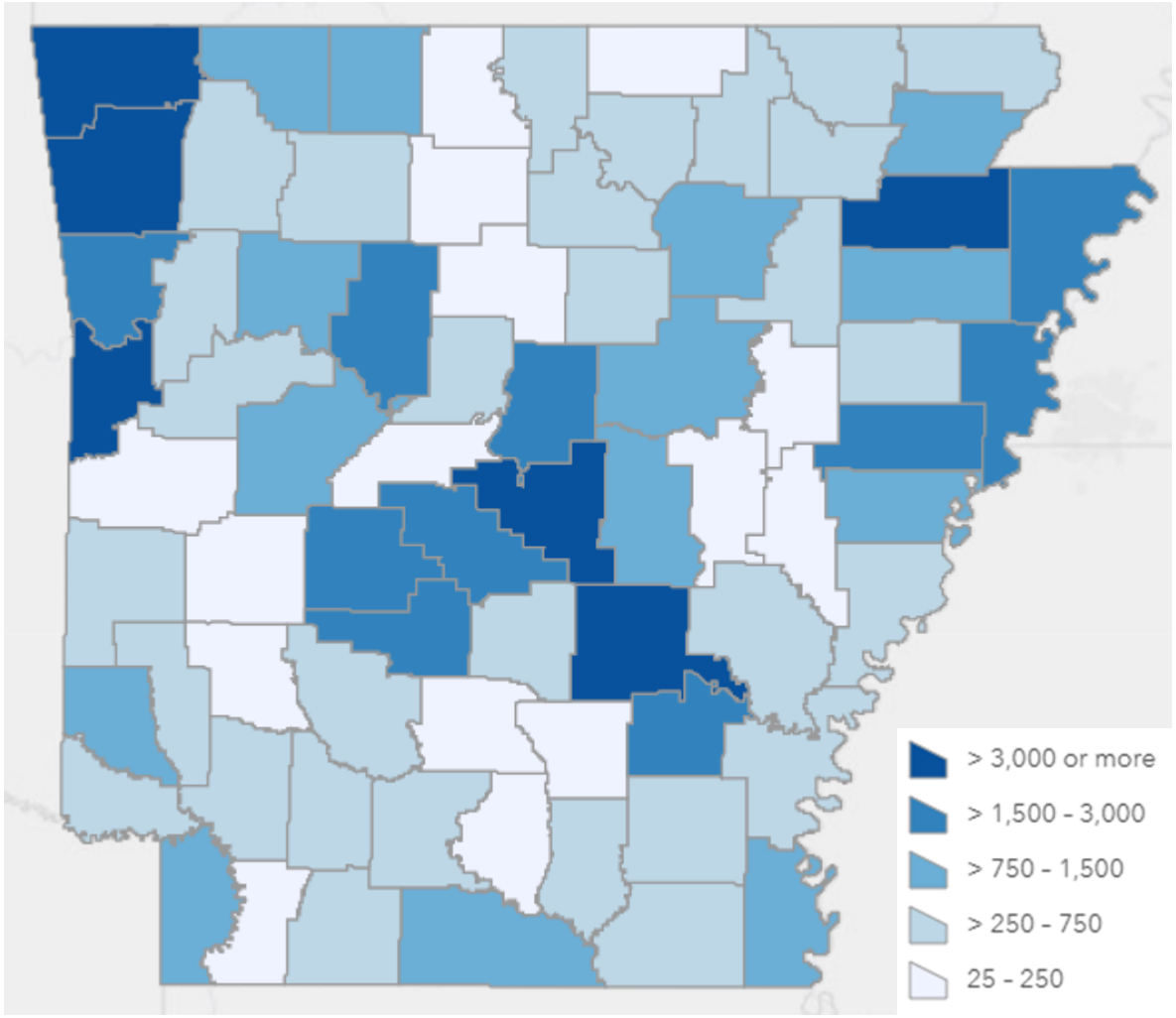
93,790

Probable Cases

5,807

Source: Arkansas Department of Health, as of Oct. 19

COVID-19 IN ARKANSAS



Hospitalized: 613

On Ventilators: 99

Confirmed Deaths: 1,562

Probable Deaths: 152

Source: Arkansas Department of Health, as of Oct. 19

COVID-19 ANALYSES

- Data from March 16–October 5, 2020
- Estimated total members ever tested: 47,231
- Total with positive test: 4,361 (ASE=2,145, PSE=2,216)
- Total Antigen or verbal positive probable infections: 390
- Tests paid for by EBD (April–July 24, 2020): 15,875

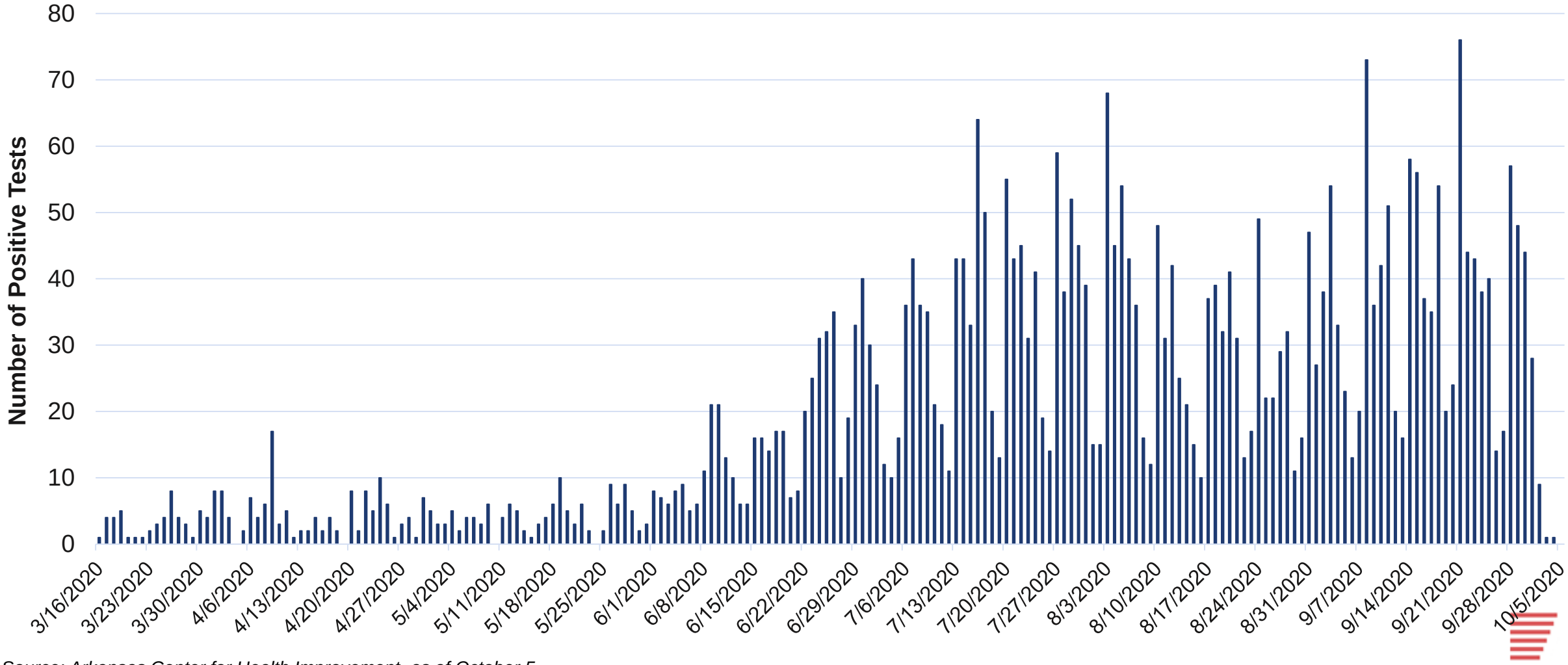
Source: Arkansas Center for Health Improvement, as of October 5

COVID-19 ANALYSES

- Total members ever hospitalized: 268 (ASE=137, PSE=131)
- Total members ever in ICU: 91 (2.1% of positive cases)
- Total members ever intubated: 40 (0.9% of positive cases)
- Deaths: 37

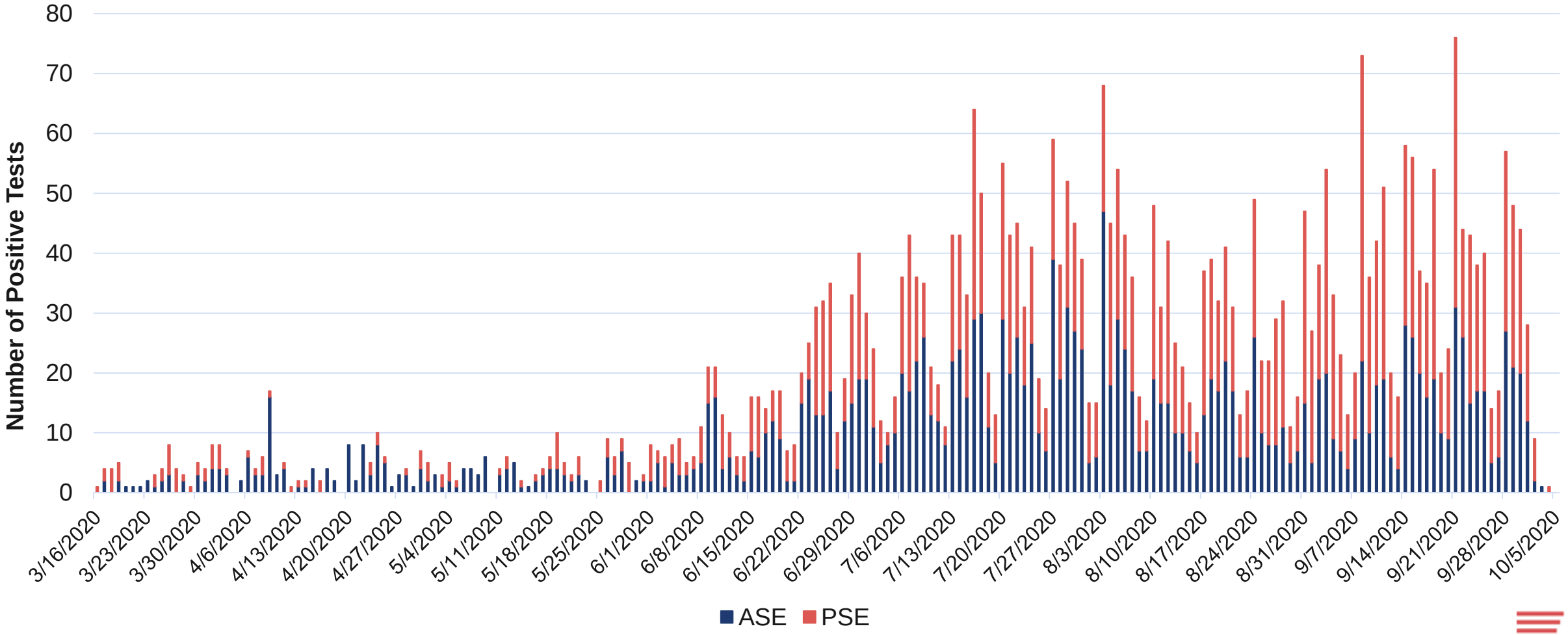
Source: Arkansas Center for Health Improvement, as of October 5

DAILY POSITIVE TEST COUNT — EBD MEMBERS



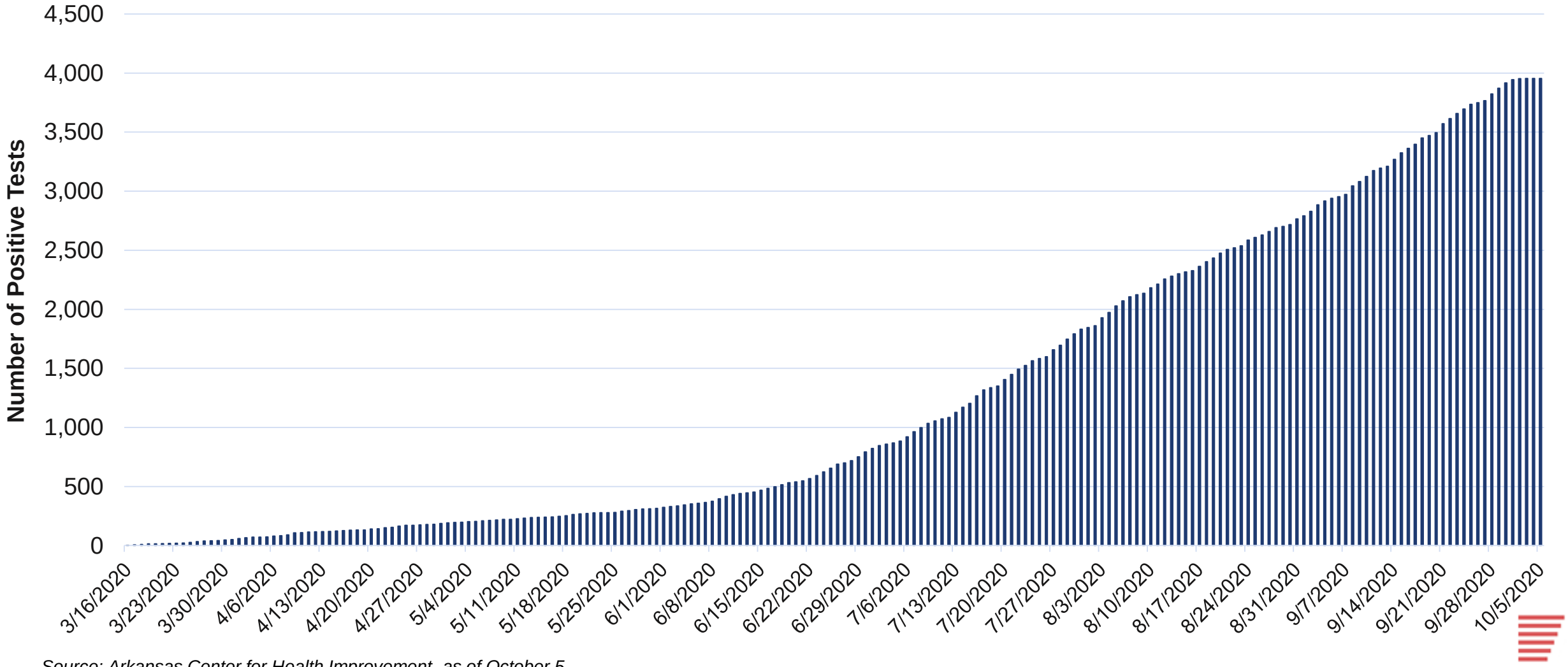
Source: Arkansas Center for Health Improvement, as of October 5

DAILY POSITIVE TEST COUNT BY ASE & PSE



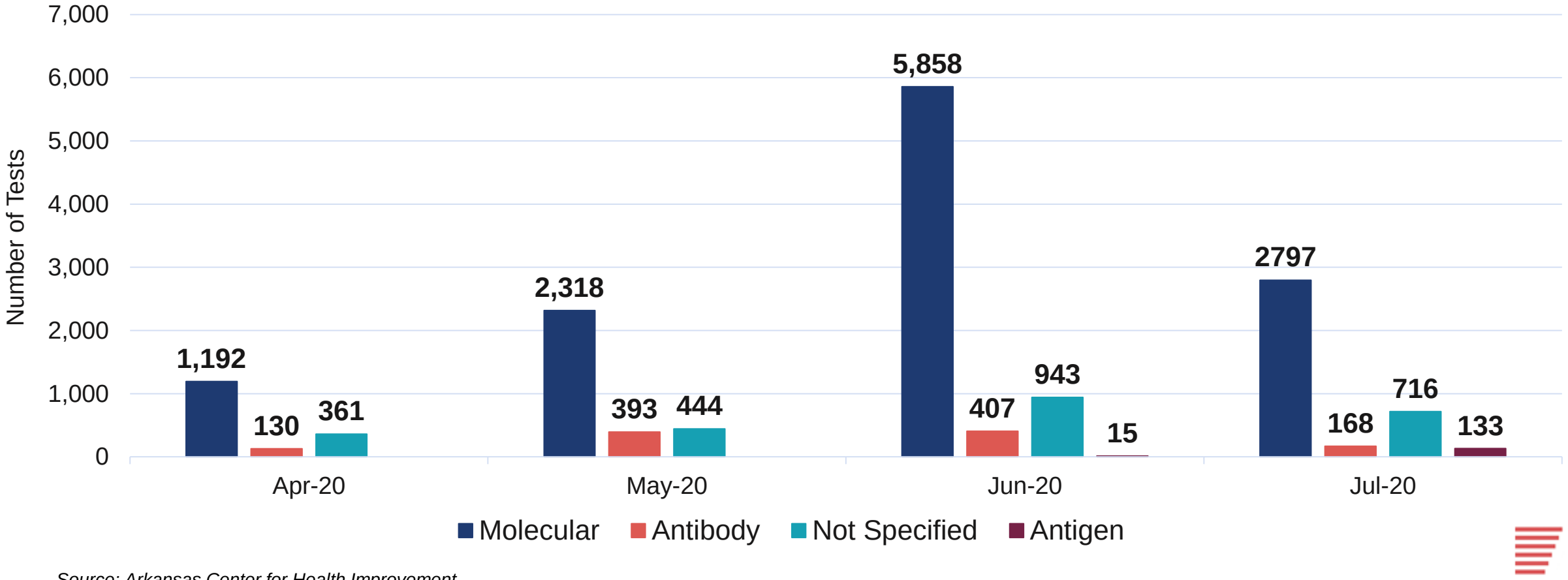
Source: Arkansas Center for Health Improvement, as of October 5

TOTAL POSITIVE TEST COUNT — EBD MEMBERS



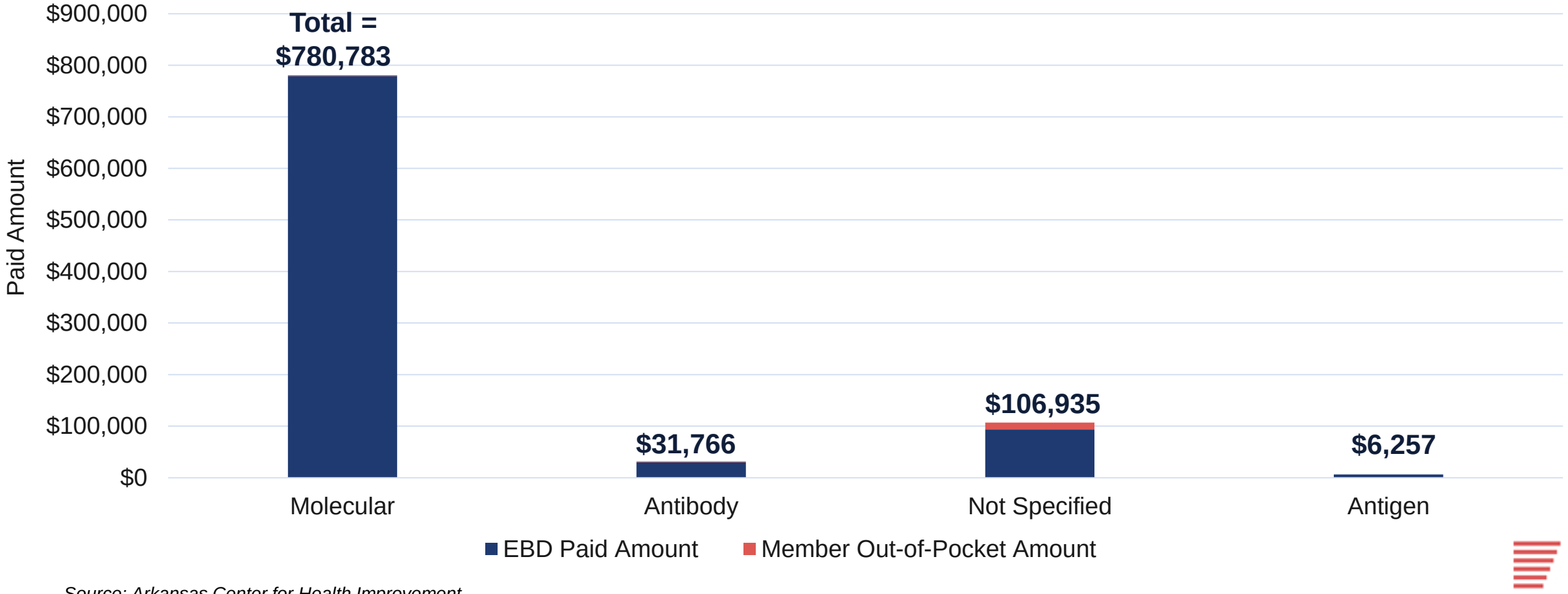
Source: Arkansas Center for Health Improvement, as of October 5

COVID-19 TEST VOLUME BY TYPE WITHIN PLAN (APRIL—JULY 24, 2020)



Source: Arkansas Center for Health Improvement

EBD PLAN PAID AMT. & MEMBER OUT-OF-POCKET AMT. FOR COVID-19 TESTS, APRIL–JULY 24, 2020



Source: Arkansas Center for Health Improvement

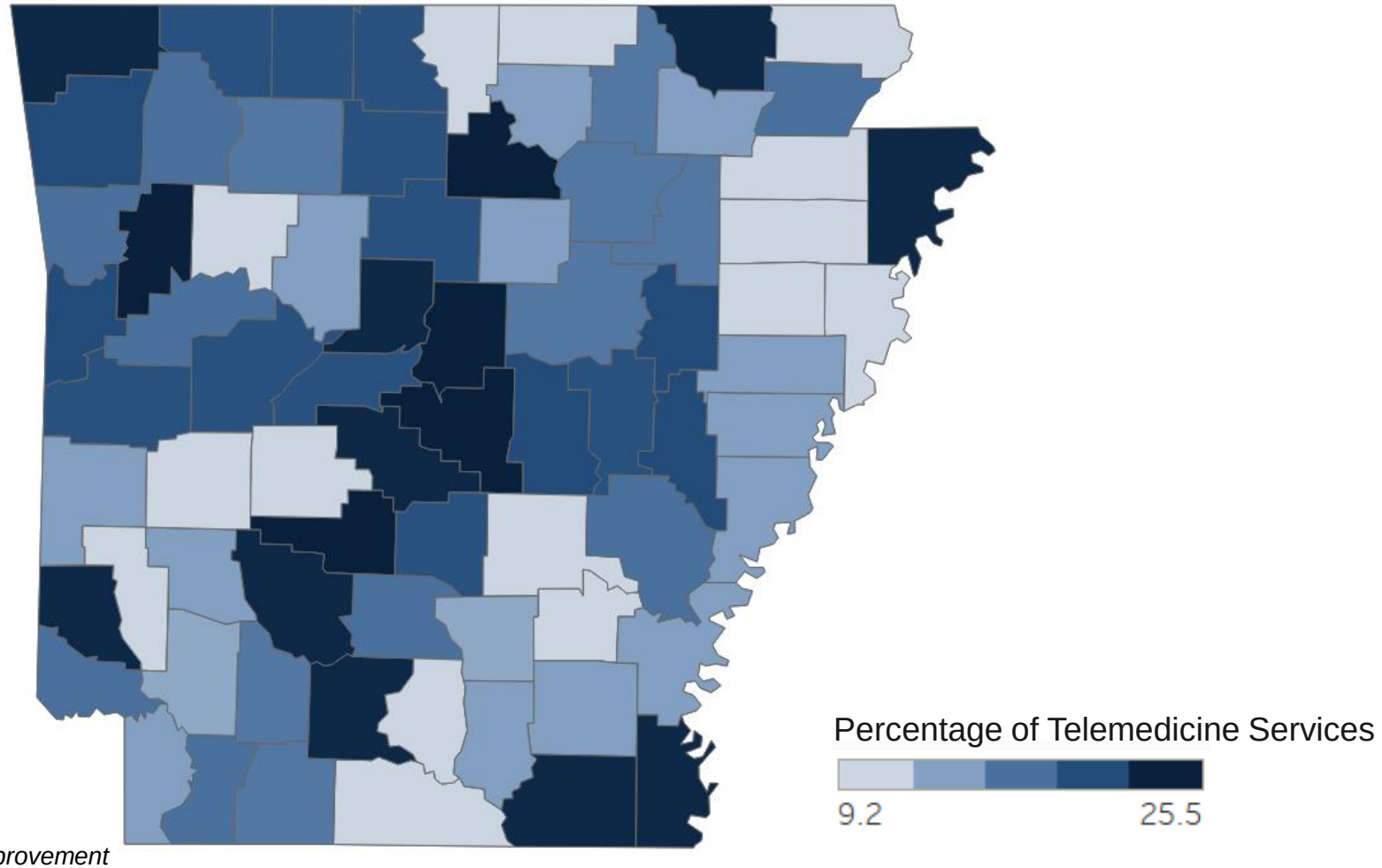
COVID-19 TESTING & OTHER COVID-19-RELATED COSTS WITHIN PLAN (APRIL—JULY 24, 2020)

- Total costs for all COVID-19 tests = $908,877 (average of $57 per test)
- Outpatient (OP) or emergency department (ED) visits were associated with 6,058 of 15,875 tests (38.2%)
- Additional costs for associated OP or ED visits = $323,553
- Total amount paid by the plan for testing and associated OP or ED visits = $1,232,430

NEW TELEMEDICINE SERVICE UTILIZATION AMONG MEMBERS, APRIL—JULY 24, 2020

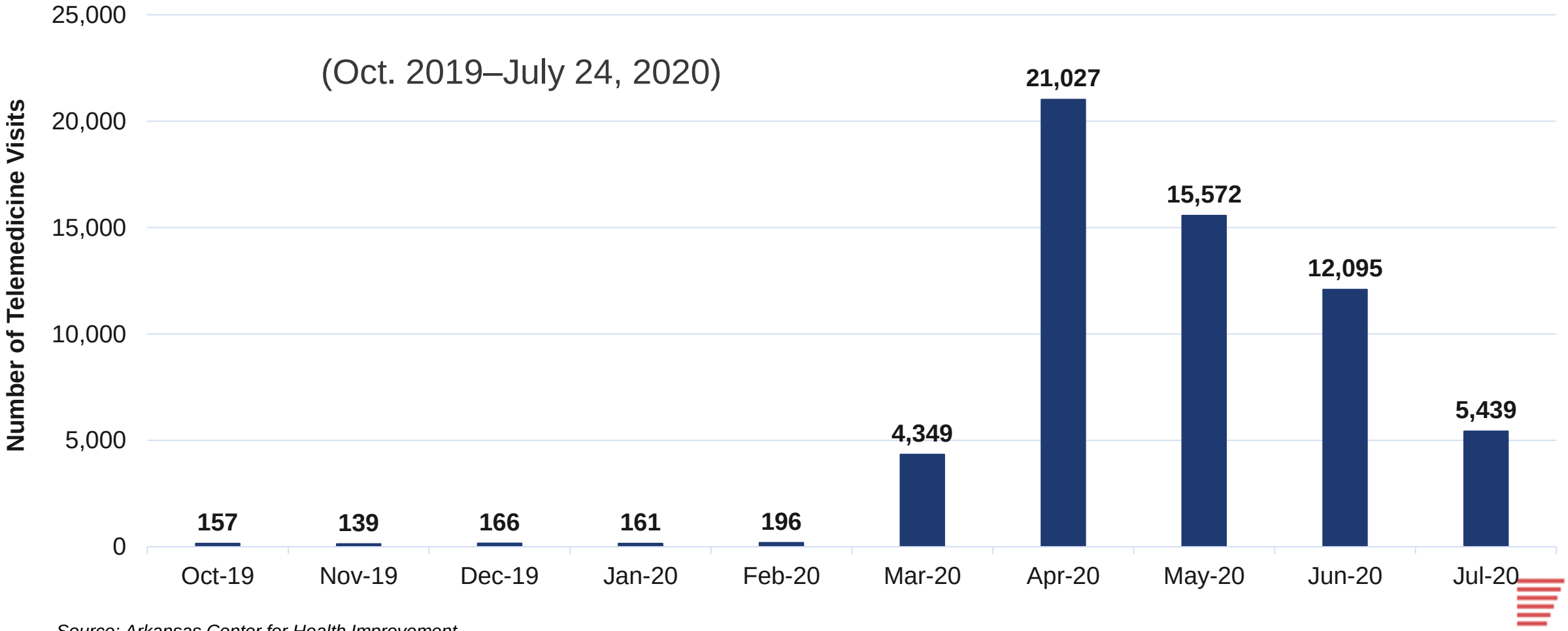
- Members utilizing telemedicine services: 25,836
- Members utilizing telemedicine services who did not in the previous six months (Oct. 2019-March 2020): 23,643
- Percent of first time telemedicine users (April-July 24, 2020) who did not use telemedicine in the previous six months: 92%

PROPORTION OF PRIMARY CARE AND MENTAL HEALTH VISITS DONE BY TELEMEDICINE, BY COUNTY, APRIL—JULY 24, 2020



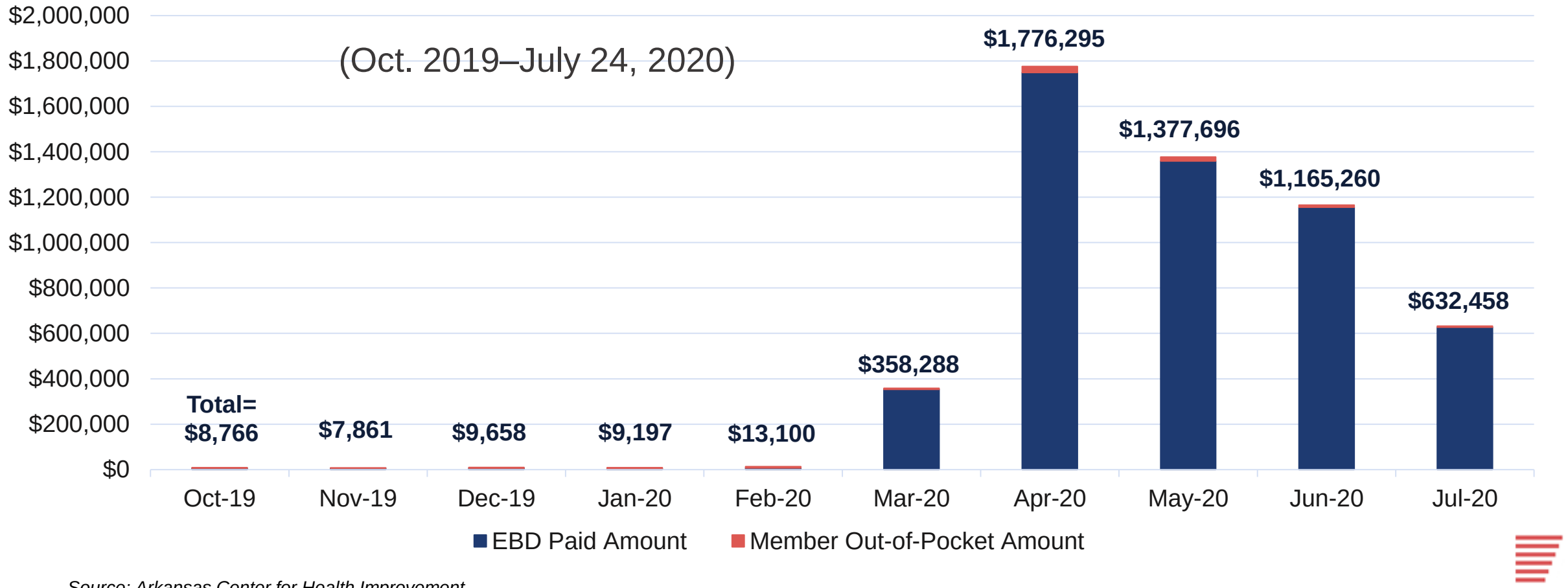
Source: Arkansas Center for Health Improvement

TELEMEDICINE SERVICE UTILIZATION WITH PLAN



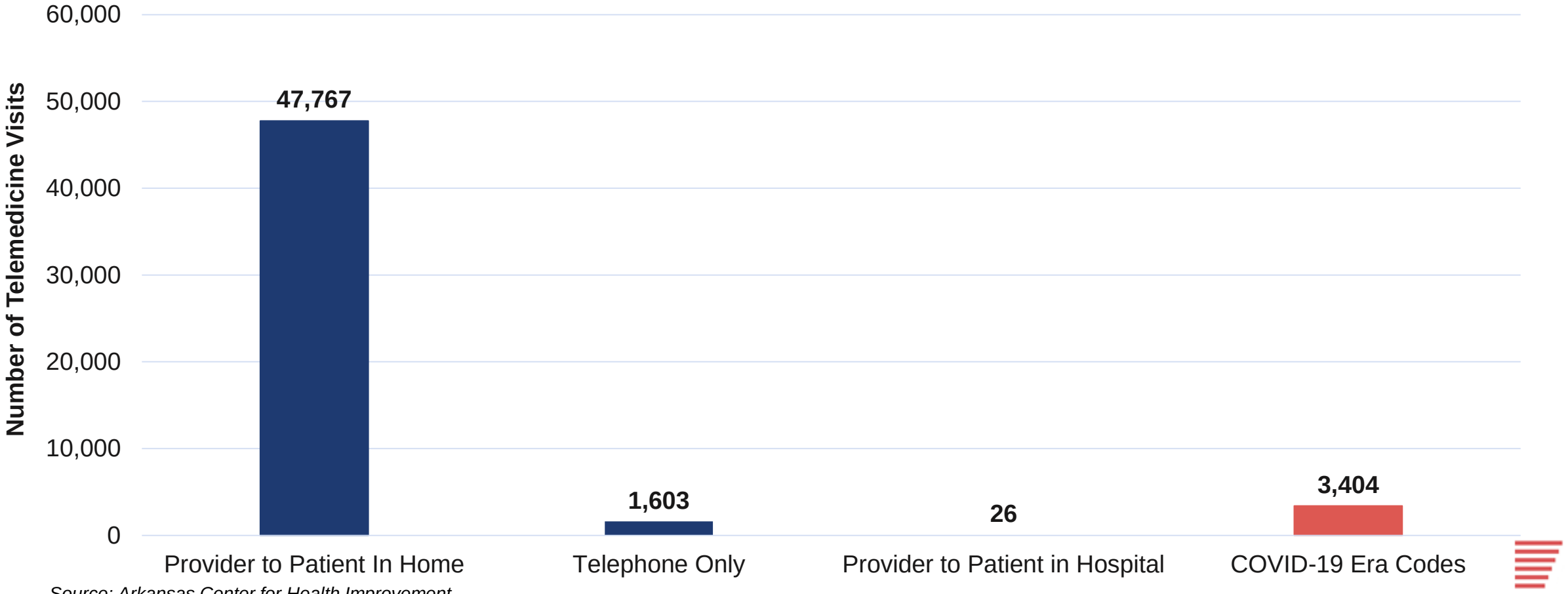
Source: Arkansas Center for Health Improvement

TELEMEDICINE SERVICES: EBD PLAN PAID AMOUNT & MEMBER OUT-OF-POCKET AMOUNT



Source: Arkansas Center for Health Improvement

TELEMEDICINE SERVICE UTILIZATION BY TYPE WITHIN PLAN (MAY—JULY 24, 2020)



Source: Arkansas Center for Health Improvement

TELEMEDICINE SERVICE UTILIZATION BY DIAGNOSES (MAY–JULY 24, 2020)

Diagnosis	Number of Diagnoses
Mental health conditions	13,983
Essential (primary) hypertension	1,569
Type 2 diabetes mellitus	950
Musculoskeletal conditions	742
Contact with and (suspected) exposure to communicable diseases	474
Disorders of lipoprotein metabolism and other lipidemias	352
Specific developmental disorders of speech and language	352
Chronic ischemic heart disease	292
Hypothyroidism	285
Vasomotor and allergic rhinitis	285

Source: Arkansas Center for Health Improvement

UPCOMING ANALYSES: BARIATRIC SURGERY PROGRAM ASSESSMENT

- At the request of EBD leadership ACHI will update evaluation of bariatric surgery pilot program
- Assessment will include number of procedures (and type of surgery), associated costs, and updated review of bariatric surgery literature and evidence

UPCOMING ANALYSES: INFLUENZA IMPACT

- At the request of EBD leadership, ACHI will provide updated analysis of the impact of flu in the 2019–2020 season
- Assessment will include flu diagnoses, flu shot rates, and associated costs

NEXT STEPS

- Continue updates on impact of COVID-19 on plan
- Discuss framework/anticipated analyses for bariatric surgery program evaluation
- Revisit wellness program discussion, including flu vaccination
- Discuss 2019 health risk assessment analyses

State of Arkansas Employee Benefits Division

Interim Monitoring Report

Through September 30th

State and Public School Life and Health Insurance Board of Directors

Courtney White, FSA, MAAA
Paul Sakhrani, FSA, MAAA
Scott Cohen, MPH

20 OCTOBER 2020

Milliman

Agenda

- Arkansas State Employees (ASE)
  - Plan Experience
- Public School Employees (PSE)
  - Plan Experience
- 2020 and Beyond Roadmap
- Appendices
  A. Plan summary
  B. Assumptions / methodology
  C. Limitations & caveats

Arkansas State Employees (ASE)

Executive Summary

- 2020 & 2021 projections updated to incorporate claims data incurred from March 2019 to February 2020 and paid through September 2020.
- 2020 projected plan experience
  - Allocated reserves for 2020 is $25.1M
  - Estimated deficit of $4.1M
  - End of Year Assets: $67.4M
  - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
  - No plan changes / 5% increase in employee contributions
- 2021 projected plan experience
  - Allocated reserves for 2021 is $14.5M
  - Projected deficit: $3.6M
  - End of Year Assets: $49.4M
  - Reflected 2021 program initiatives
  - Increased membership based on historical patterns
  - Baseline trends (medical: 5%, pharmacy: 8%)
  - September 29, 2020 Board action (next slide)

Board Action – September 29, 2020

- Increased employee contribution for the Active employees, Pre-65 retirees, and Post-65 retirees by 5%
- $25 per month stipend for Post-65 retirees opting out of pharmacy coverage
- Changed wellness credit from $75 per month to $50 per month for Active employees
  - Maintained $0 employee contribution for Basic Plan with Wellness for Employee Only contracts
- Increased State funding from $420 per eligible per month to $450 per eligible per month
- No plan design changes

Total Plan Experience

Funding	2019	2020	2021
State Contribution	$ 173.61	$ 172.24	$ 184.48
Employee Contribution	97.45	99.07	110.11
Other	23.47	21.65	21.80
Total Income	$ 294.53	$ 292.96	$ 316.39
Medical Claims	$ (194.58)	$ (209.76)	$ (221.48)
Pharmacy Claims	(86.58)	(95.91)	(108.75)
Administration Fees	(18.30)	(17.43)	(17.54)
Plan Administration	(2.90)	(2.79)	(2.81)
Total Expenses	$ (302.37)	$ (325.88)	$ (350.58)
Program Savings	$ -	$ 3.73	$ 16.17
Net Income / (Loss) Before Reserve Allocation	$ (7.84)	$ (29.19)	$ (18.01)
Allocation of Reserves	$ 21.70	$ 25.08	$ 14.46
Net Income / (Loss) After Reserve Allocation	$ 13.86	$ (4.11)	$ (3.56)

Average Membership			
Active Employees / Pre-65 Retirees	47,754	46,628	46,628
Post-65 Retirees	13,344	13,769	14,182
Total Enrolled	61,098	60,397	60,810

Total Income PMPM[1]	$ 431.32	$ 438.83	$ 453.39
Total Expenses PMPM[2]	$ (412.41)	$ (444.50)	$ (458.27)

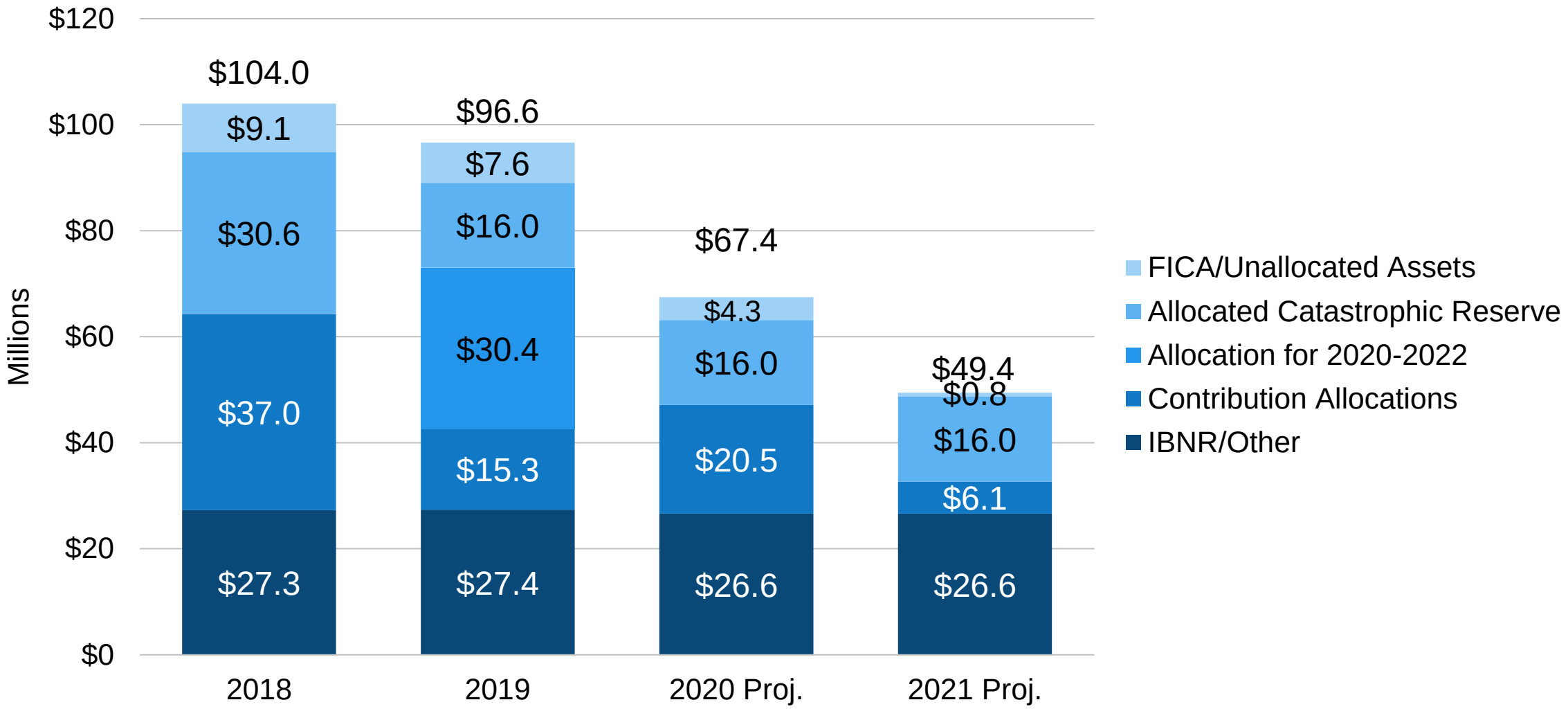
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Program Savings

Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
(a)	2019	End-of-Year Assets	$96.6
(b)	2020	Allocated Assets	($25.1)
(c)		Total Surplus / (Deficit)	($4.1)
(d) = (a) + (b) + (c)		End-of-Year Assets	$67.4
(e)	2021	Allocated Assets	($14.5)
(f)		Total Surplus / (Deficit)	($3.6)
(g) = (d) + (e) + (f)		End-of-Year Assets	$49.4

End of Year Assets

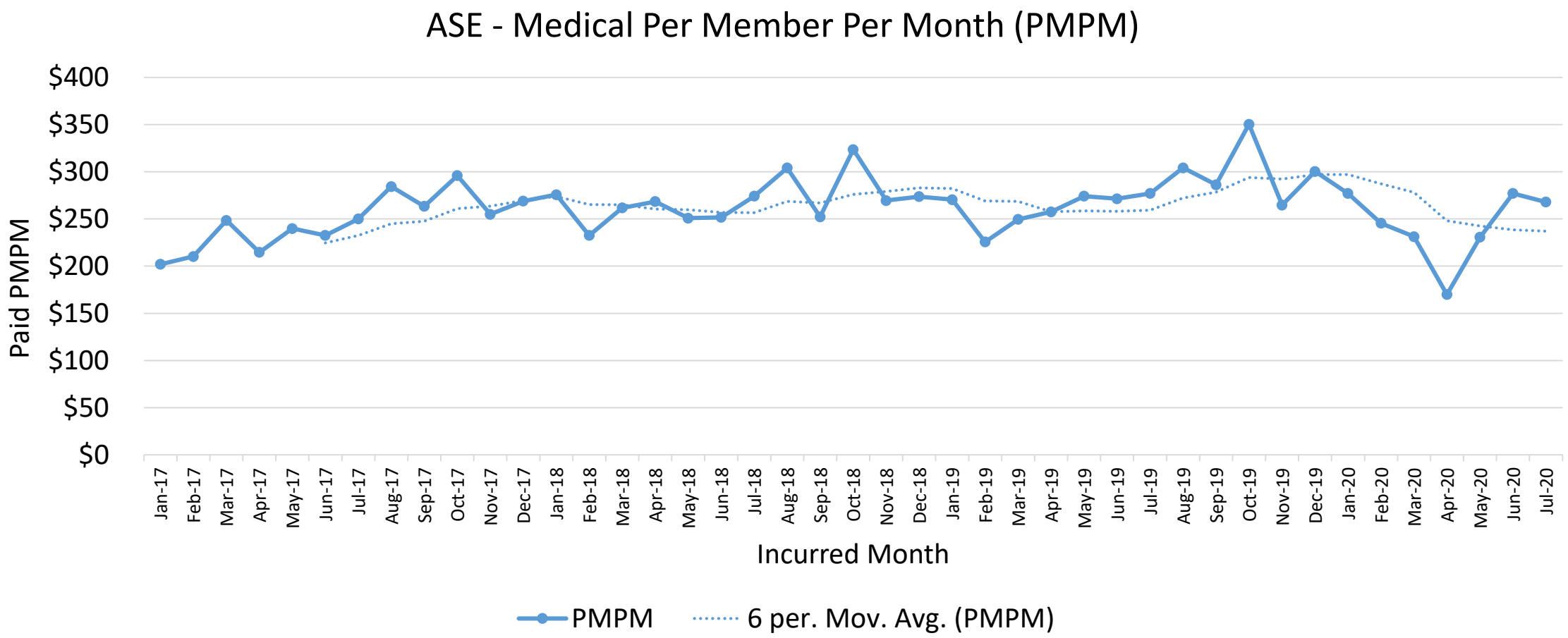


Early 2022 Snapshot

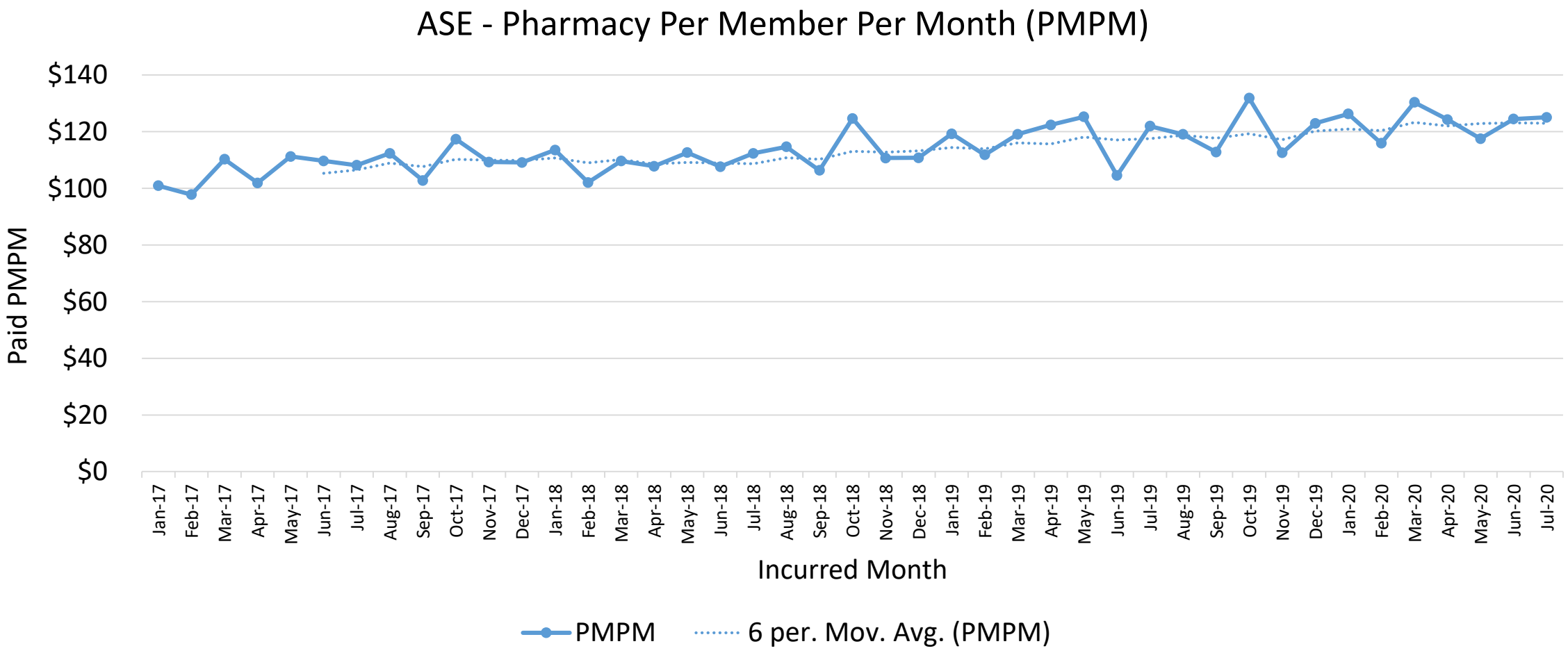
Funding		2022
State Contribution	$	184.48
Employee Contribution	$	110.86
Other	$	21.80
Total Income	$	317.14
Medical Claims	$	(234.15)
Pharmacy Claims	$	(118.25)
Administration Fees	$	(17.66)
Plan Administration	$	(2.92)
Total Expenses	$	(372.97)
Program Savings	$	16.28
Net Income / (Loss) Before Reserve Allocation	$	(39.54)
Allocation of Reserves	$	6.10
Net Income / (Loss) After Reserve Allocation	$	(33.44)

- Key Assumptions
  - 2021 state contributions - $450 per budget employee per month
  - No changes to Employee Contributions or Other
  - Headcount
    - Active/Pre-65: 0%
    - Post-65: +3%
  - Trends
    - Medical: +5%
    - Pharmacy: +8%
    - Admin: +0%
    - Plan Admin: +3%
  - Allocation of reserves based on 2019 surpluses

Monthly Trend - Medical



Monthly Trend - Pharmacy



Public School Employees (PSE)

Executive Summary

- 2020 & 2021 projections updated to incorporate claims data incurred from March 2019 to February 2020 and paid through September 2020.
- 2020 plan experience
  - Allocated reserves for 2020 is $25.3M
  - Estimated deficit of $11.6M
  - End of Year Assets: $112.1M
  - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
  - No plan changes / 0% increase to employee contributions
- 2021 projected plan experience
  - Allocated reserves for 2021 is $15.5M
  - Projected deficit: $25.2M
  - End of Year Assets: $71.5M
  - Reflected 2021 program initiatives
  - Increased membership based on historical patterns
  - Baseline trends (medical: 7%, pharmacy: 8%)
  - September 29, 2020 Board action (next slide)

Board Action – September 29, 2020

- Changed wellness credit from $75 per month to $50 per month for Active employees
- Increased Department of Education funding from $88.1M to $108.1M
- No changes to Active employee, Pre-65 retiree, and Post-65 retiree contributions
- No plan design changes

Total Plan Experience

Funding	2019	2020	2021
PPE Funding	$ 102.39	$ 105.05	$ 108.56
Employee Contribution	121.12	123.83	138.04
Dept of Ed Funding	88.10	88.10	108.10
Other	15.02	14.88	15.38
Total Income	$ 326.64	$ 331.87	$ 370.08
Medical Claims	$ (247.11)	$ (270.84)	$ (312.37)
Pharmacy Claims	(60.87)	(70.16)	(78.38)
Administration Fees	(28.46)	(28.09)	(29.11)
Plan Administration	(2.61)	(2.54)	(2.63)
Total Expenses	$ (339.06)	$ (371.63)	$ (422.49)
Program Savings	$ -	$ 2.91	$ 11.76
Net Income / (Loss) Before Reserve Allocation	$ (12.42)	$ (36.85)	$ (40.66)
Allocation of Reserves	$ 12.66	$ 25.25	$ 15.48
Net Income / (Loss) After Reserve Allocation	$ 0.23	$ (11.60)	$ (25.18)

Average Membership			
Active Employees / Pre-65 Retirees	82,388	84,152	86,557
Post-65 Retirees	14,279	15,019	15,920
Total Enrolled	96,666	99,170	102,477

Total Income PMPM[1]	$ 292.50	$ 300.09	$ 313.53
Total Expenses PMPM[2]	$ (292.29)	$ (309.84)	$ (334.00)

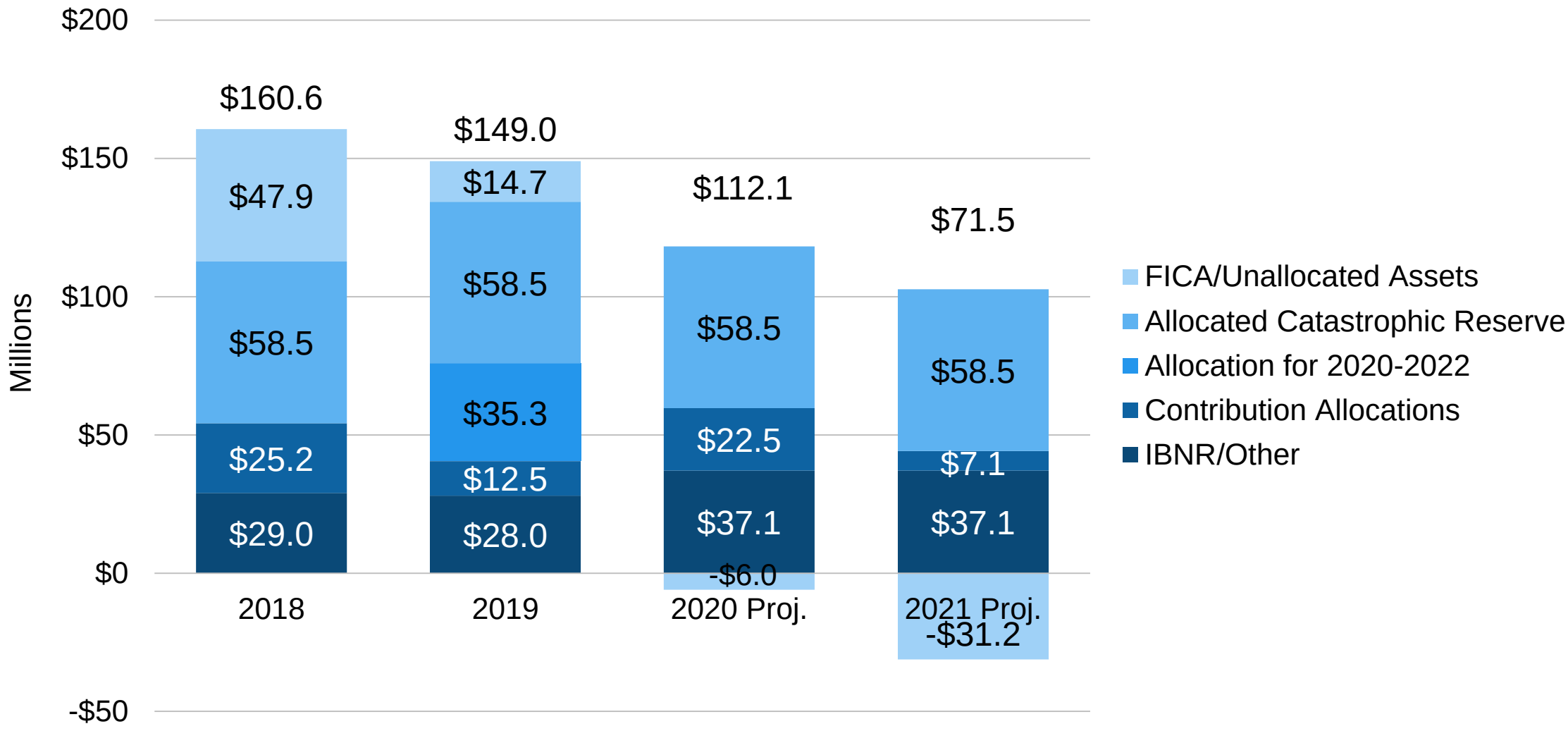
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Program Savings

Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
(a)	2019	End-of-Year Assets	$149.0
(b)	2020	Total Income	($25.3)
(c)		Total Expenses	($11.6)
(d) = (a) + (b) + (c)		Allocated Assets	$112.1
(e)	2021	Total Income	($15.5)
(f)		Total Expenses	($25.2)
(g) = (d) + (e) + (f)		Allocated Assets	$71.5

End of Year Assets

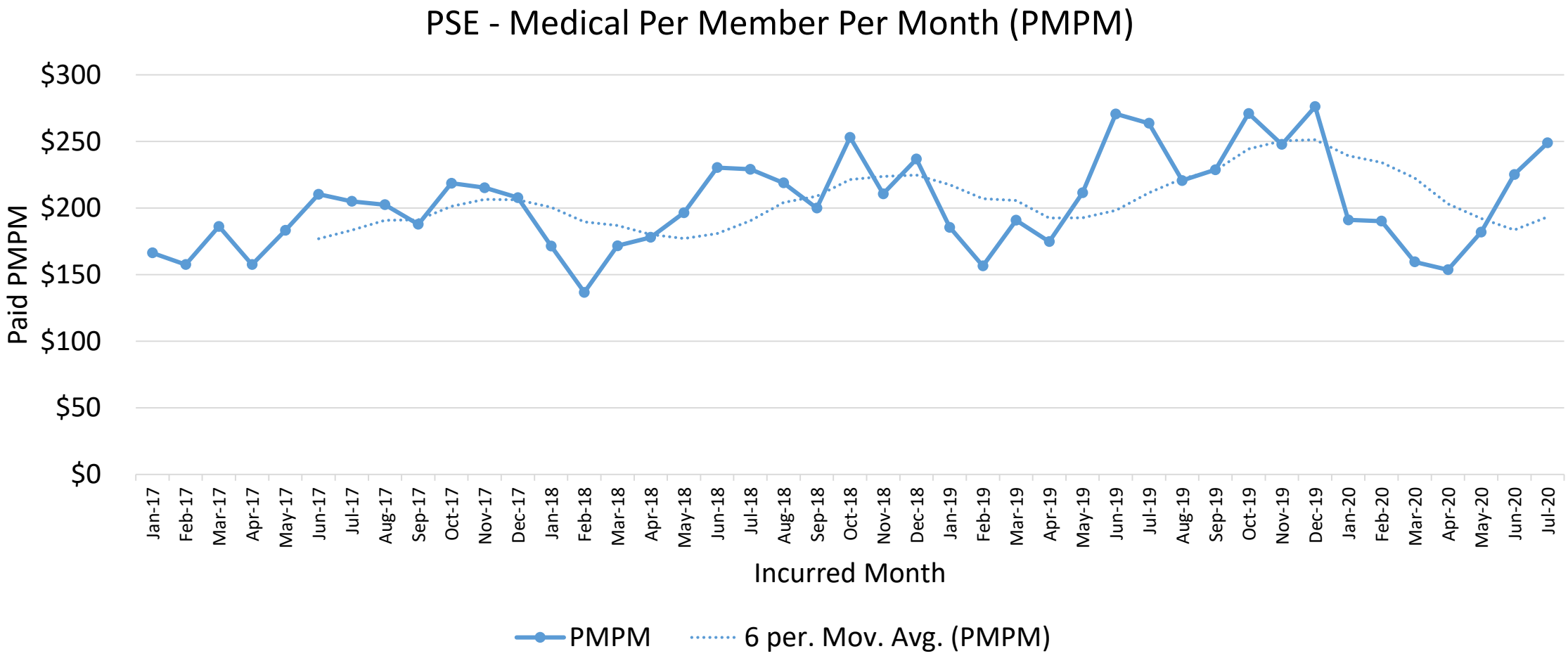


Early 2022 Snapshot

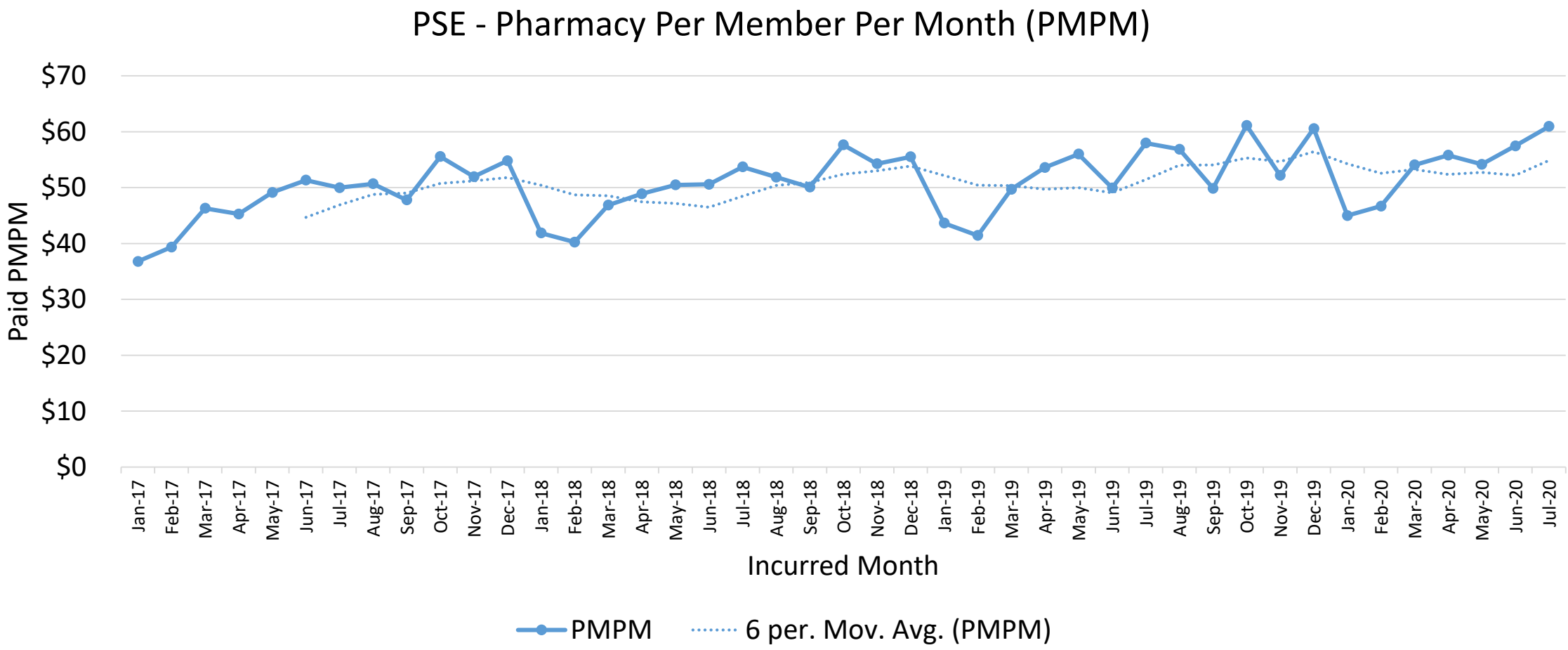
Funding		2022
PPE Funding	$	112.18
Employee Contribution		142.64
Dept of Ed Funding		108.10
Other		15.38
Total Income	$	378.30
Medical Claims	$	(345.38)
Pharmacy Claims		(87.47)
Administration Fees		(30.08)
Plan Administration		(2.80)
Total Expenses	$	(465.73)
Program Savings	$	12.15
Net Income / (Loss) Before Reserve Allocation	$	(75.28)
Allocation of Reserves	$	7.10
Net Income / (Loss) After Reserve Allocation	$	(68.18)

- Key Assumptions
  - No changes to PPE, DOE, Employee Contributions or Other
  - Headcount
    - Active/Pre-65: +3%
    - Post-65: +6%
  - Trends
    - Medical: +7%
    - Pharmacy: +8%
    - Admin: +0%
    - Plan Admin: +3%
  - Allocation of reserves based on 2019 surpluses

Monthly Trend - Medical

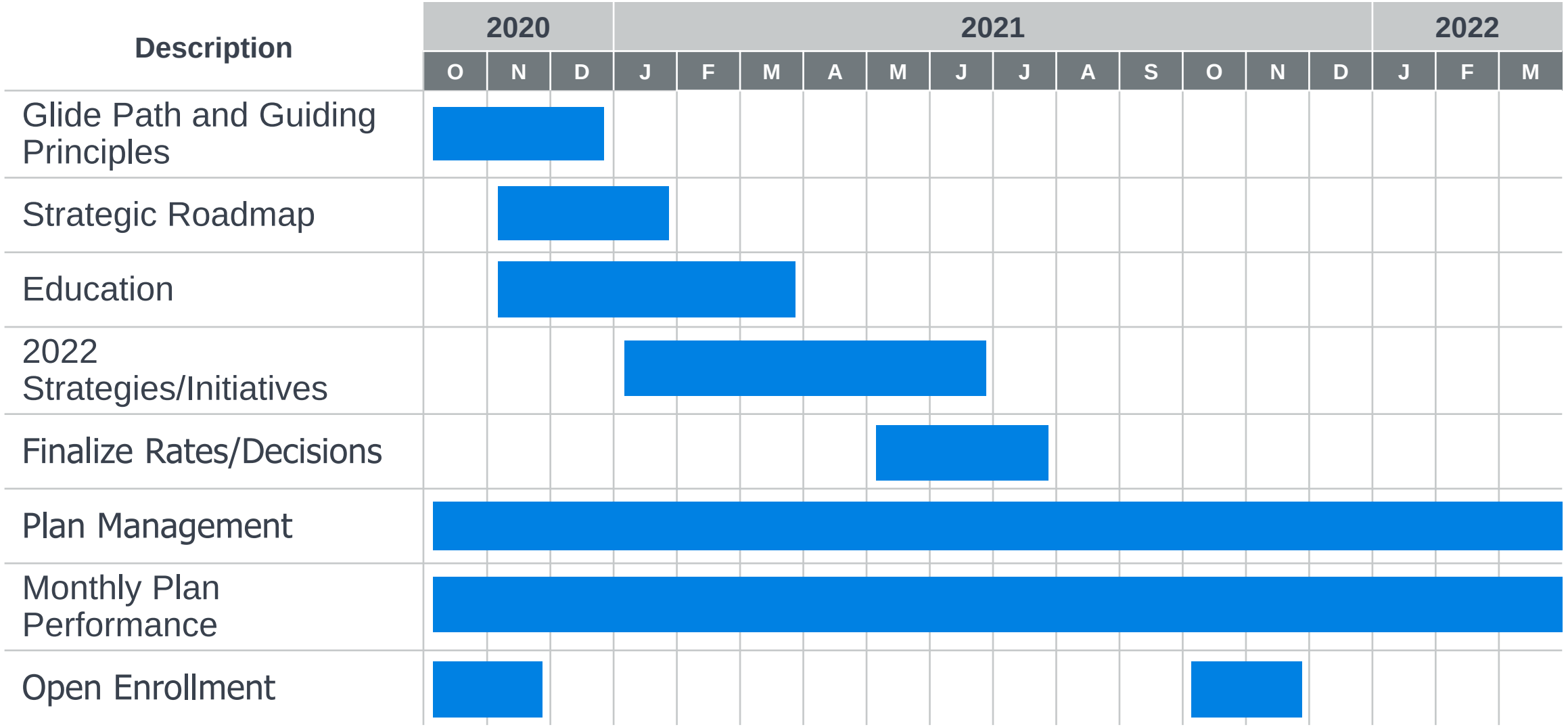


Monthly Trend - Pharmacy



2020 and Beyond Roadmap

Timeline: Gantt chart

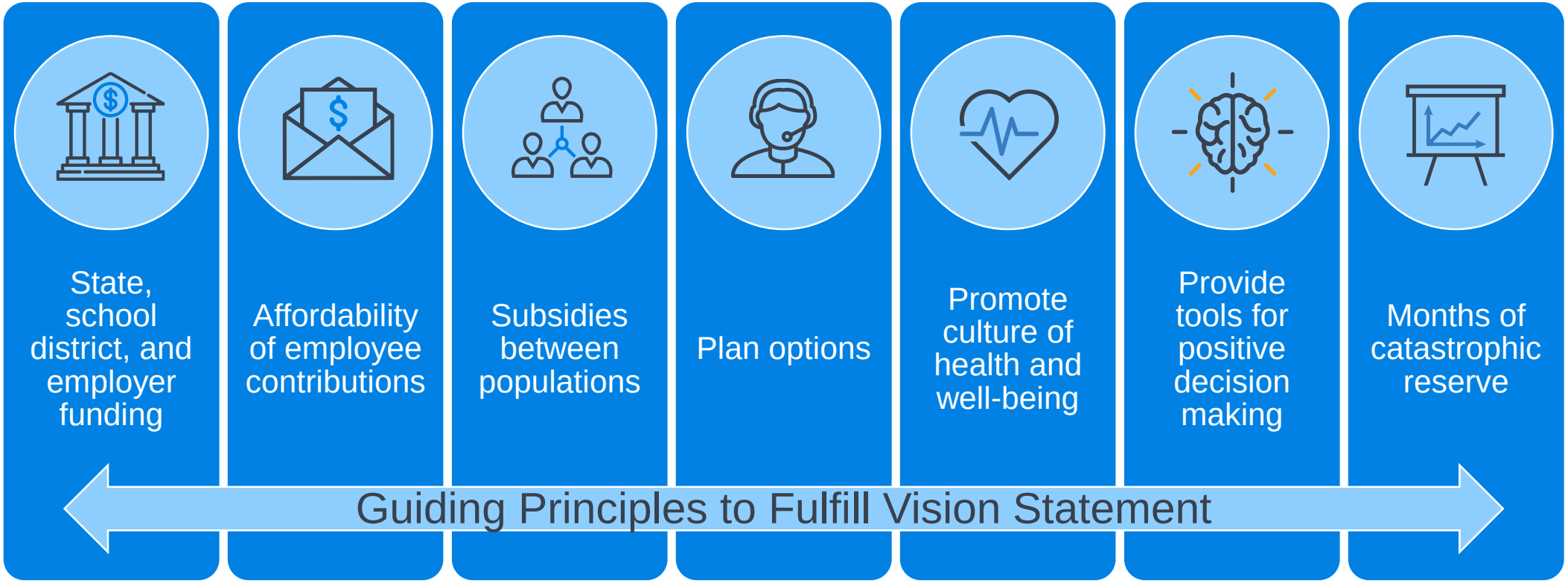


Strategic Glide Path

- Develop a shared understanding of mission, vision, and values for plan administration
- Guide and teach
- Use benchmarking to identify opportunities to improve plan performance
- Collaborate with Employee Benefits Division to review and assess the strategy and roadmap
- Support strategy process with data/analytic tools
- Address all facets of a strategic plan (substantive, tactical, political, financial, etc.)

Guiding Principles

Vision Statement:

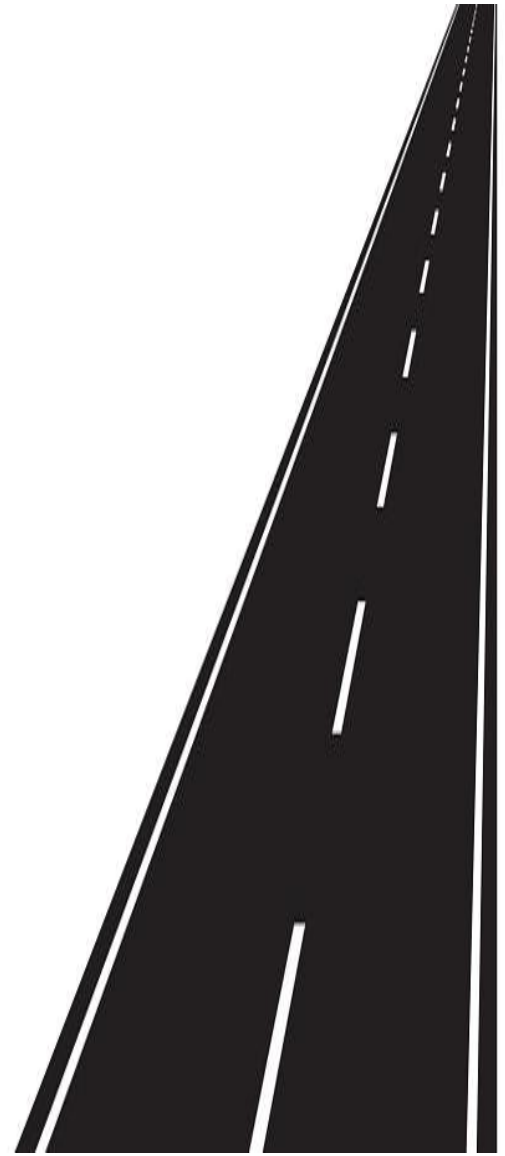


Road Map Looking Forward

2021

2022

2023



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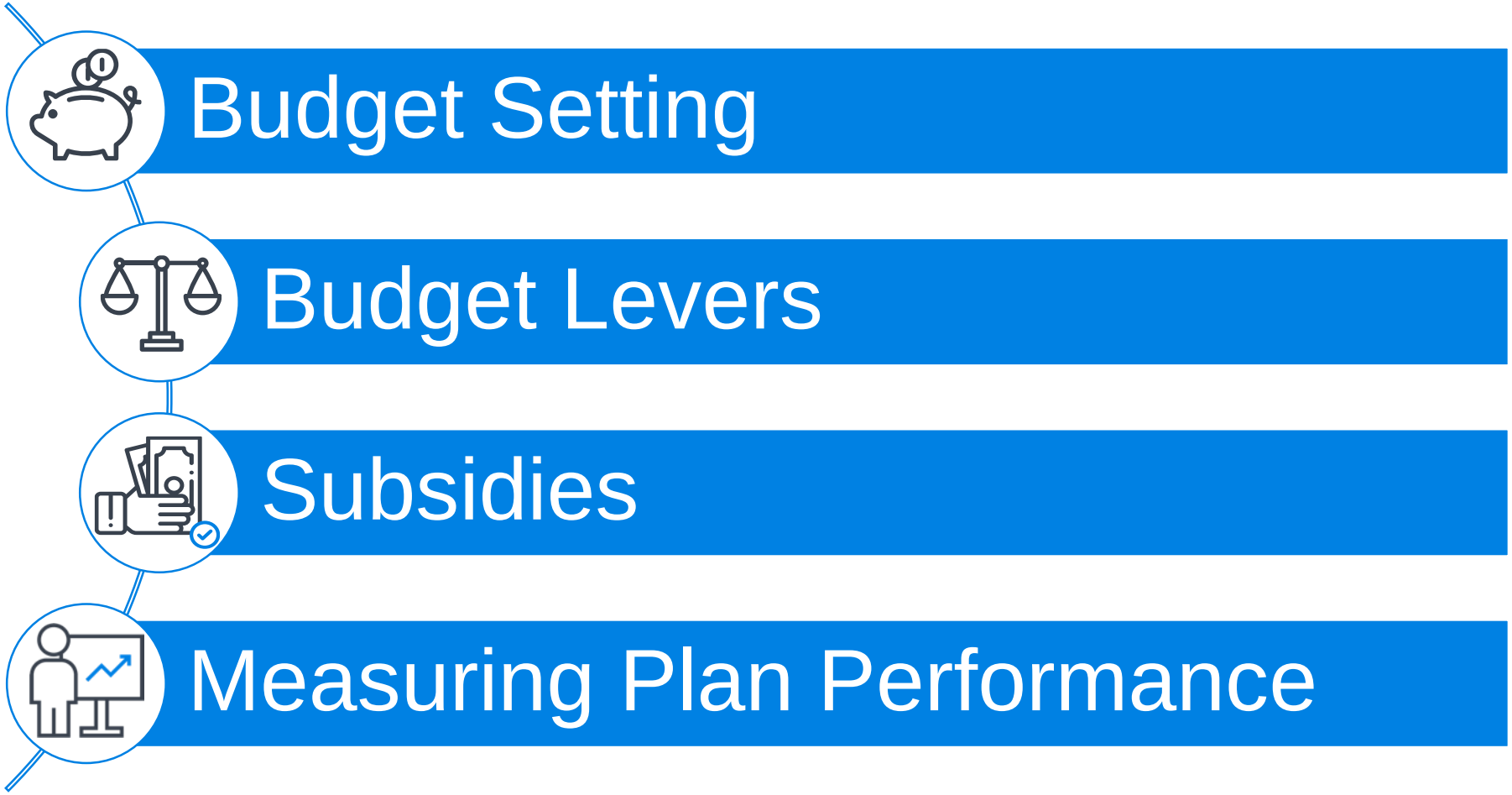
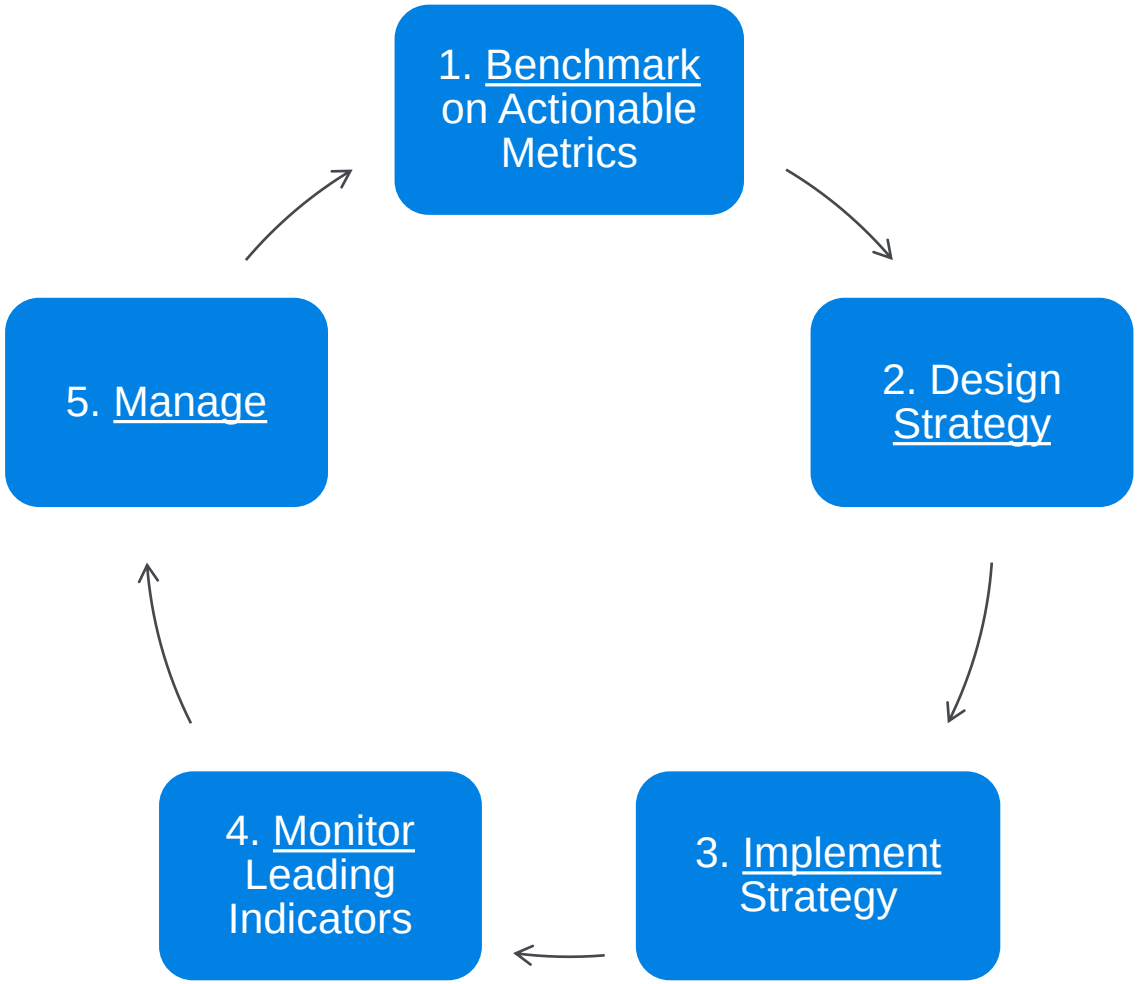
Education


Budget Setting
Budget Levers
Subsidies
Measuring Plan Performance

Performance Improvement Cycle and Strategy Development



Strategic Themes

- Plan Subsidization – transparent, fair, predictable with value to all parties
- Chronic Conditions – improve identification of members with care gaps to minimize complications
- Value of Care Received – reduce low-value services, drive to right setting and right providers
- Population Health

Hierarchy of Benchmarking Metrics

Risk-Adj Allowed PMPM

(Spending per Member Stratified for Condition Risk)

Utilization Efficiency

Risk-Adjusted RVUs/PMPM

(Relative Value of Utilization (RVU) Stratified by Top Condition)

- Preference Sensitive Conditions
- Chronic Conditions
- Optimal Site of Service for Non-Emergent Conditions
- Surgical Complication Rates
- Low-Value Services

Price Efficiency

Allowed Per RVU

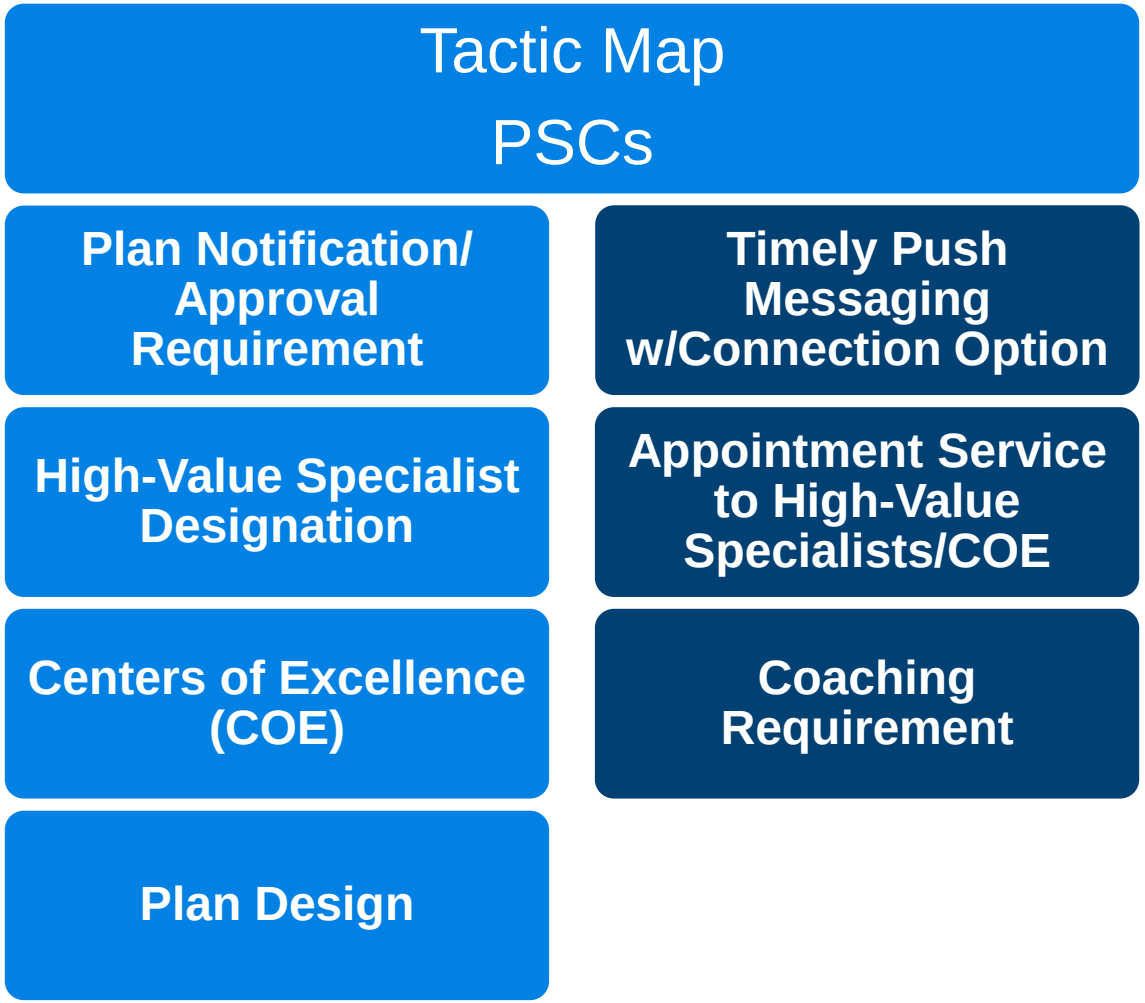
- Drilldown to Detailed Service Category
- Price Variation Analyses

Preference Sensitive Conditions (PSC)

Conditions often treated with surgery that have alternatives that may be preferred by patient

Outcome Metrics: Preference Sensitive Conditions
RVU per PSC episode type (e.g., low back pain)
% of PSCs with surgical intervention
% of PSCs with low value tests

Leading Indicators (as % of PSC Episodes)
Plan notifications
Timely push notification of treatment options (via text or phone call)
Coaching delivered (live conversation or chat)



Common Tactics for Controlling Cost

Cost = **Utilization** x **Price**

Utilization	Utilization Management	Formulary Management	Prior Authorization	Treatment Decision	Plan Benefits	Concurrent Review
Price	Telemedicine / Onsite	Network Evaluation	Adjust R&C Levels	Reference Based Pricing	Center of Excellence	ACOs / Narrow Network	Direct Contracting
Health Status	Wellness Program	Disease Management	Chronic Management	Biometric Screenings	Gym Membership	Healthy Lifestyle

Employee Impact

Plan Design / Administration	Claims Audit	Incentivize Behavior	Three-Tier Design		Plan Reduction	Eliminate / Change Plan Options
Contribution	Increase Tobacco Surcharge	Reduce Wellness Credit	Working Spouse / Part-Time Surcharge	Increase Employee Cost Share	Salary Band Contributions	Per Unit Contribution
Eligibility	Dependent Audit	Steer COBRA Participants to ACA Market	Working Spouse Must Enroll in Own Plan First	Eliminate Coverage for PT	Offer Retiree EGWP / PDP on Open Market	Exchange Offering (Active/Retiree)

Monthly Plan Performance and Rate Development

Funding	2019	2020
PPE Funding	$ 102.39	$ 105.05
Employee Contribution	121.12	123.83
Dept of Ed Funding	88.10	88.10
Other		
Total Income		
Medical Claims		
Pharmacy Claims		
Administration Fees		
Plan Administration		
Total Expenses		
Program Savings		
Net Income / (Loss) Before Res		
Allocation of Reserves		
Net Income / (Loss) After Reser		

Funding	2019	2020
State Contribution	$ 173.61	$ 172.24
Employee Contribution		
Other		
Total Income	$ 2	
Medical Claims	$ (1	
Pharmacy Claims	(	
Administration Fees	(	
Plan Administration		
Total Expenses	$ (3	
Program Savings	$	
Net Income / (Loss) Before Res	$	
Allocation of Reserves	$	
Net Income / (Loss) After Reser	$	

AR BENEFITS

ARKANSAS STATE ACTIVE EMPLOYEES MONTHLY PREMIUMS

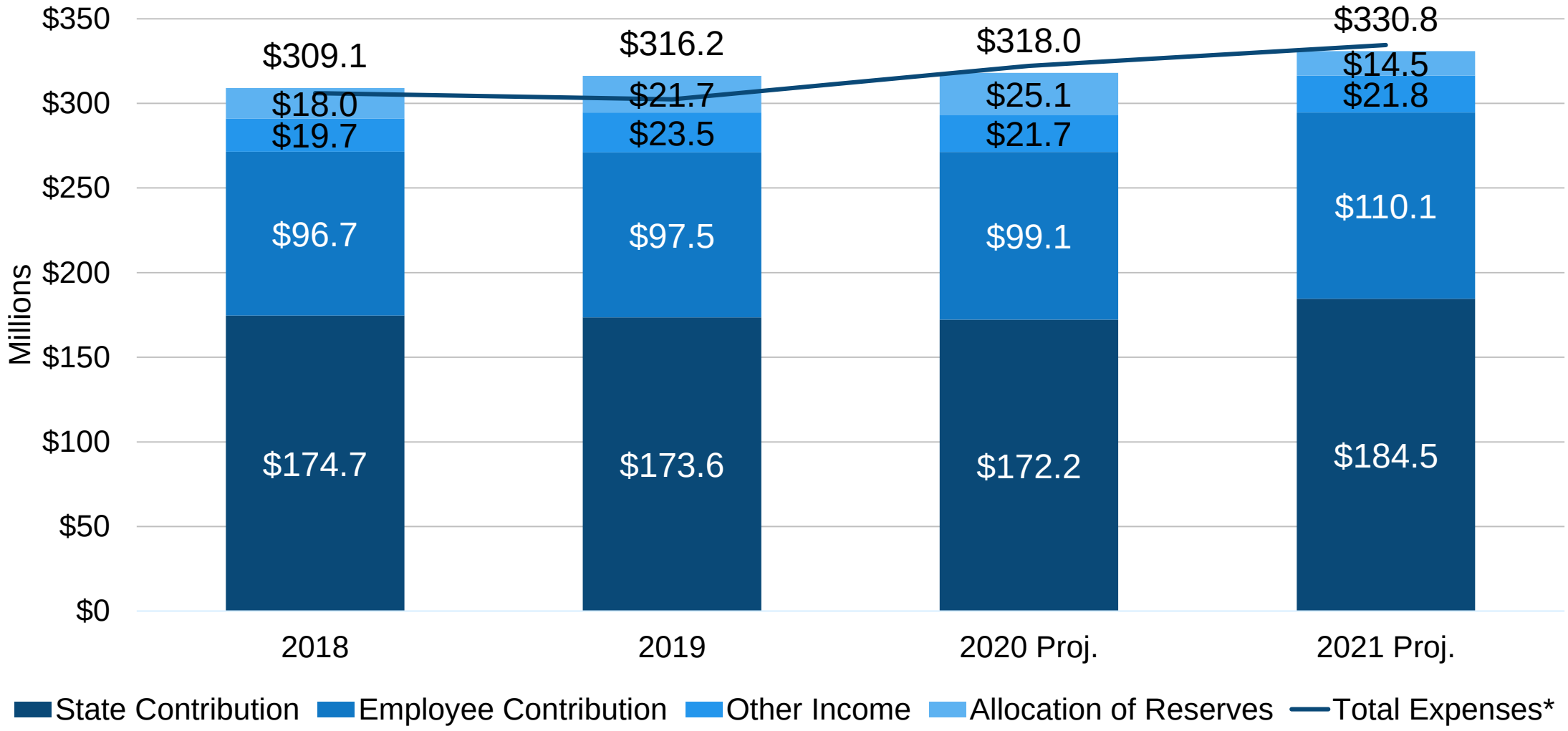
WITH WELLNESS

2021 Plan Year Rates - Effective January 1, 2021 - December 31, 2021

	Base Monthly Premium	State & Plan Contribution	Total Monthly Employee Cost	Per-Payroll Deduction (24 payroll)
Premium				
Employee Only	$552.28	$408.30	$143.99	**$71.99**
Employee & Spouse	$1,243.01	$787.53	$455.48	**$227.74**
Employee & Child(ren)	$927.68	$664.16	$263.52	**$131.76**
Employee & Family	$1,618.38	$1,043.37	$575.01	**$287.51**
Classic				
Employee Only	$480.14	$402.34	$77.79	**$38.90**
Employee & Spouse	$1,070.98	$770.00	$300.98	**$150.49**
Employee & Child(ren)	$801.25	$651.95	$149.30	**$74.65**
Employee & Family	$1,392.07	$1,019.59	$372.49	**$186.24**
Basic				
Employee Only	$423.77	$423.77	$0.00	**$0.00**
Employee & Spouse	$936.82	$761.37	$175.44	**$87.72**
Employee & Child(ren)	$702.61	$645.63	$56.98	**$28.49**
Employee & Family	$1,215.65	$1,008.23	$207.43	**$103.71**
The Basic plan meets the minimum essential coverage required under A.C.A.				

Appendix

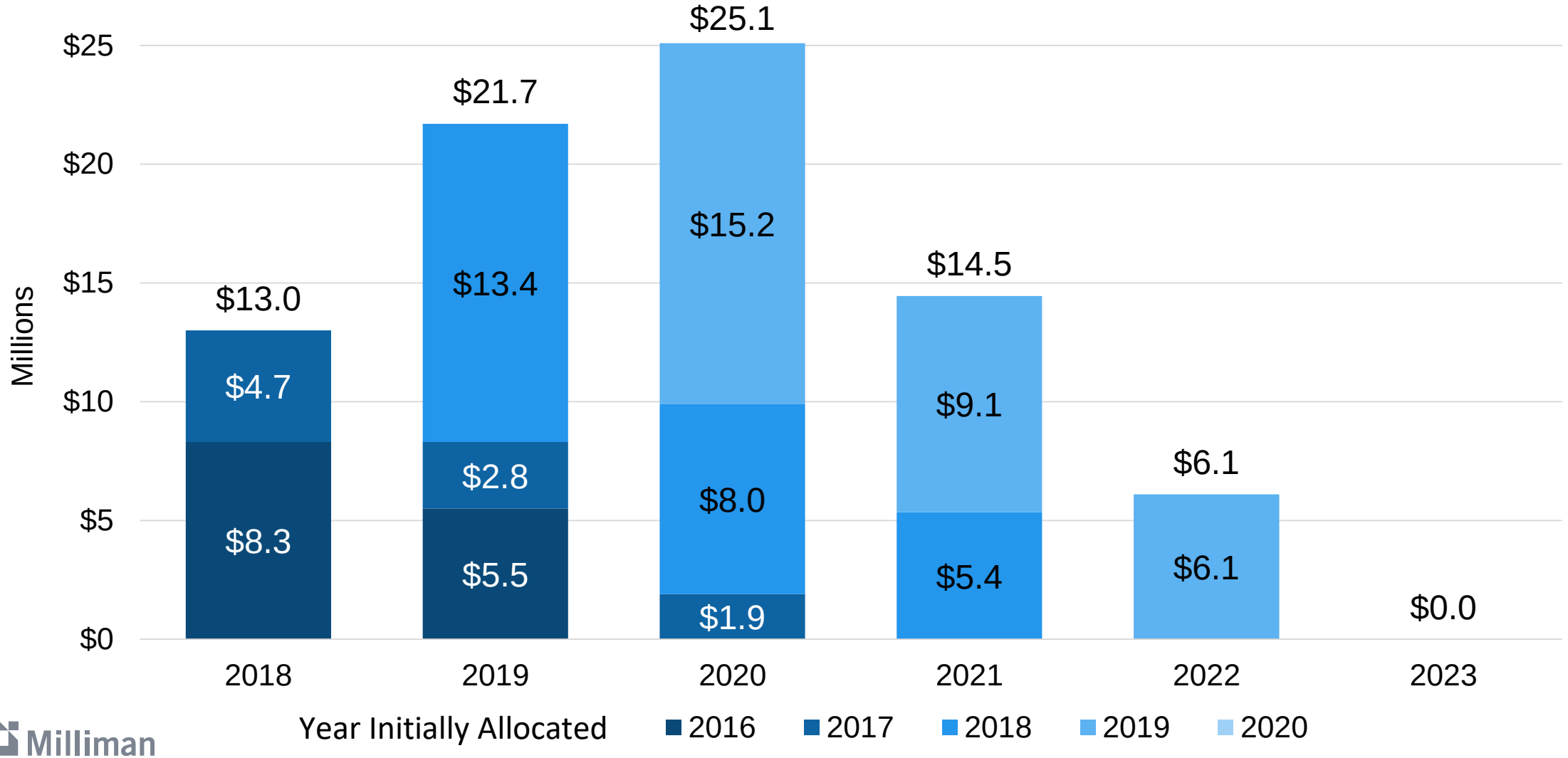
ASE - Income vs. Expenditure



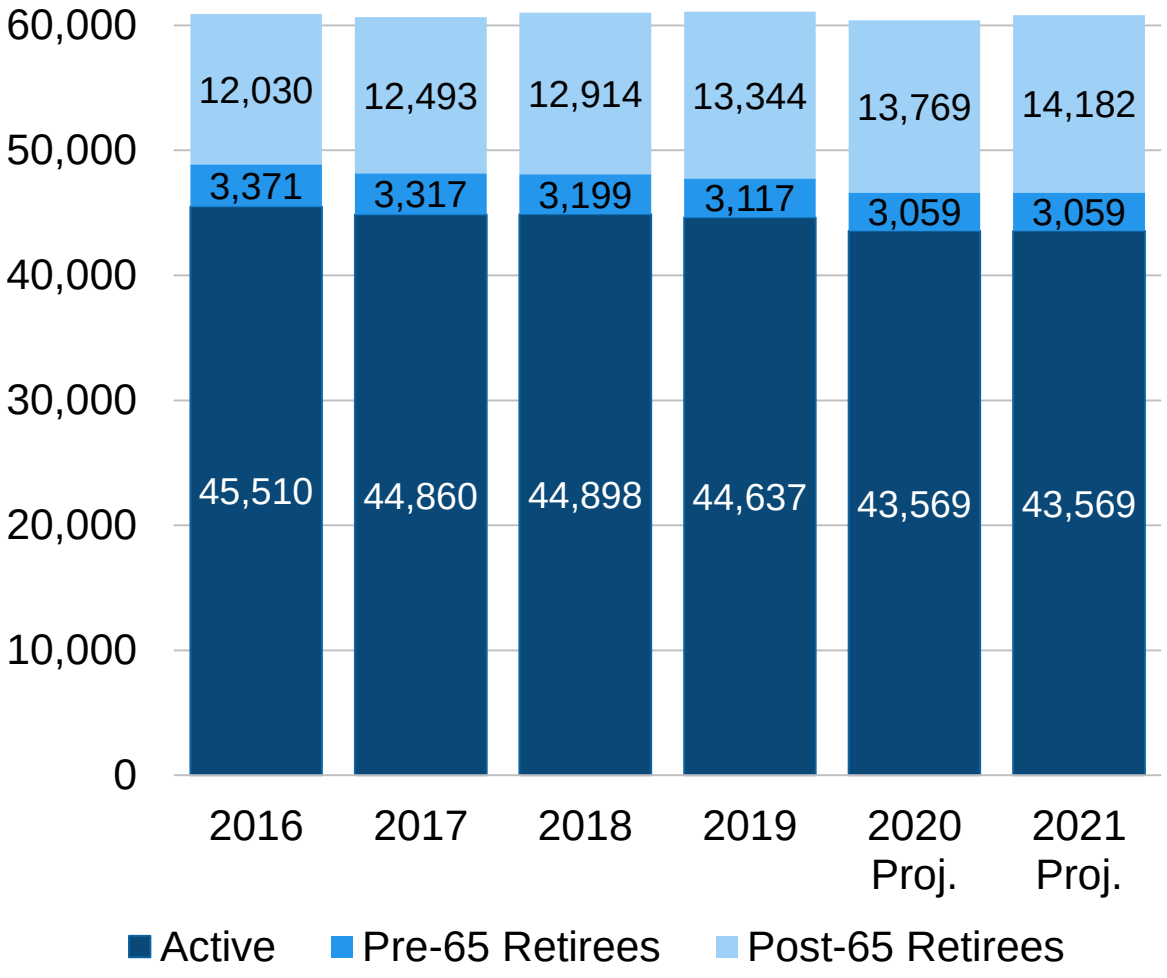
* Total Expenses offset by Program Savings

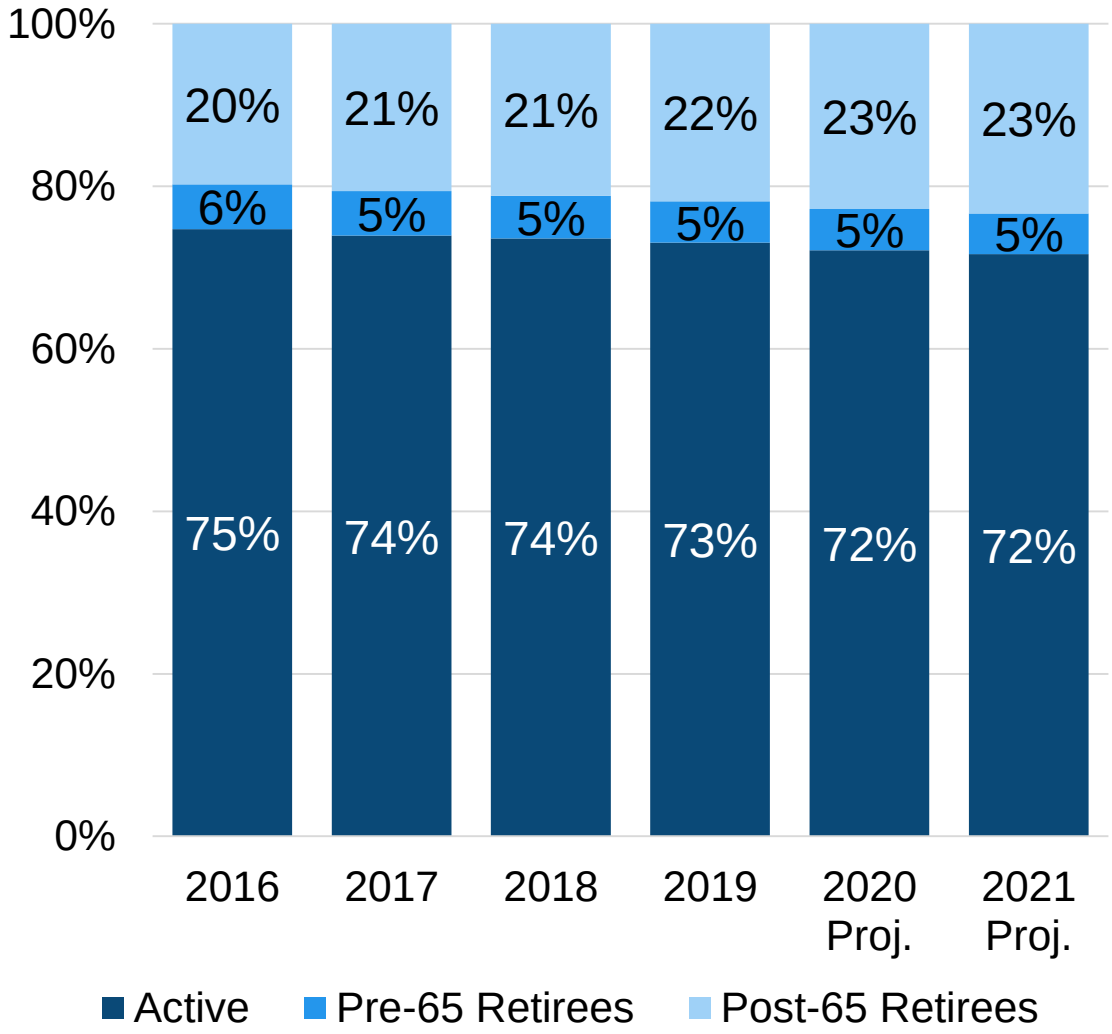
ASE - Reserves Allocation by Year

The chart represents the reserves amounts allocated each year (in millions), and how much reserves are available each year.

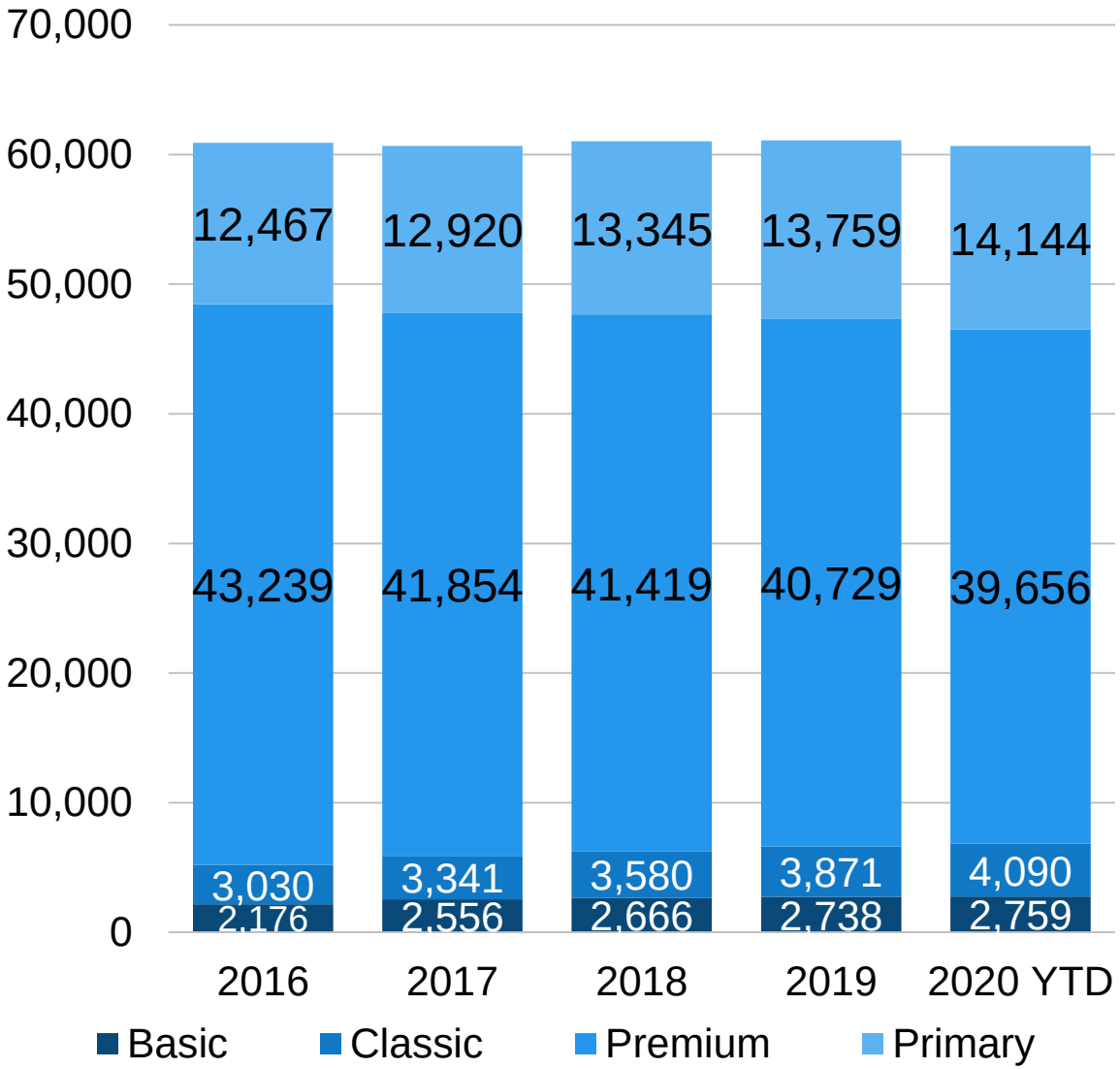


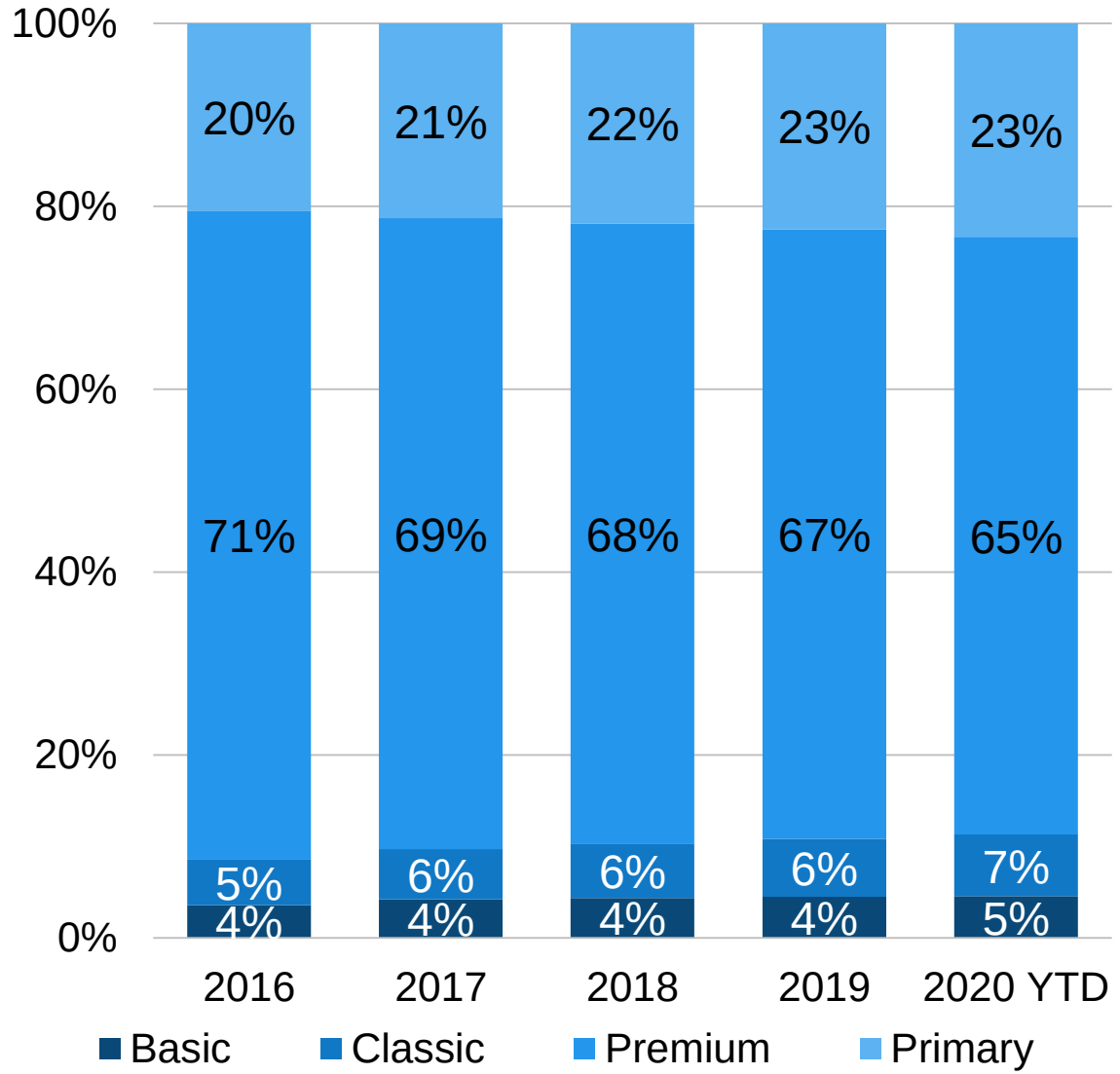
ASE - Average Membership by Status





ASE - Average Membership by Plan





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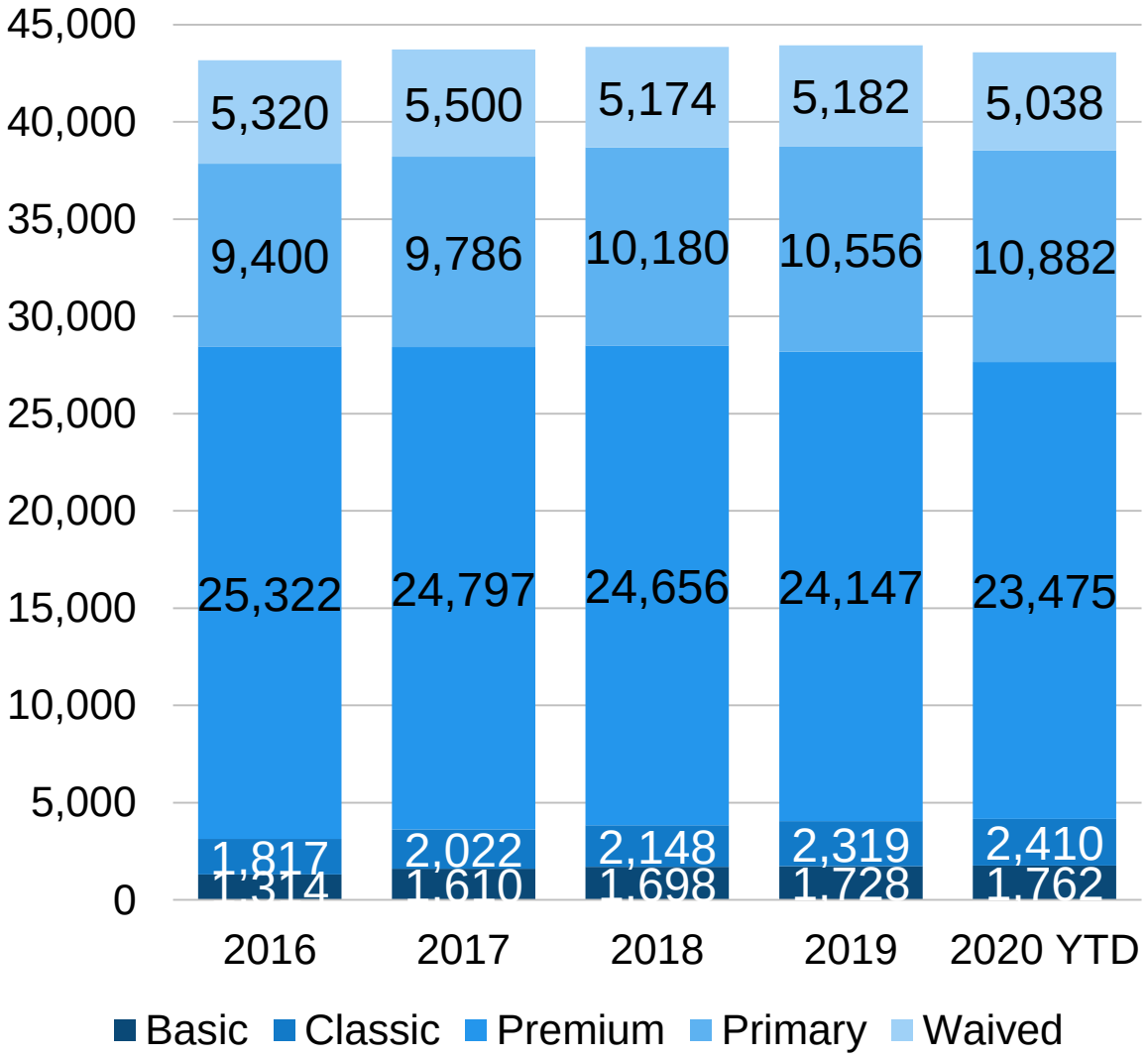
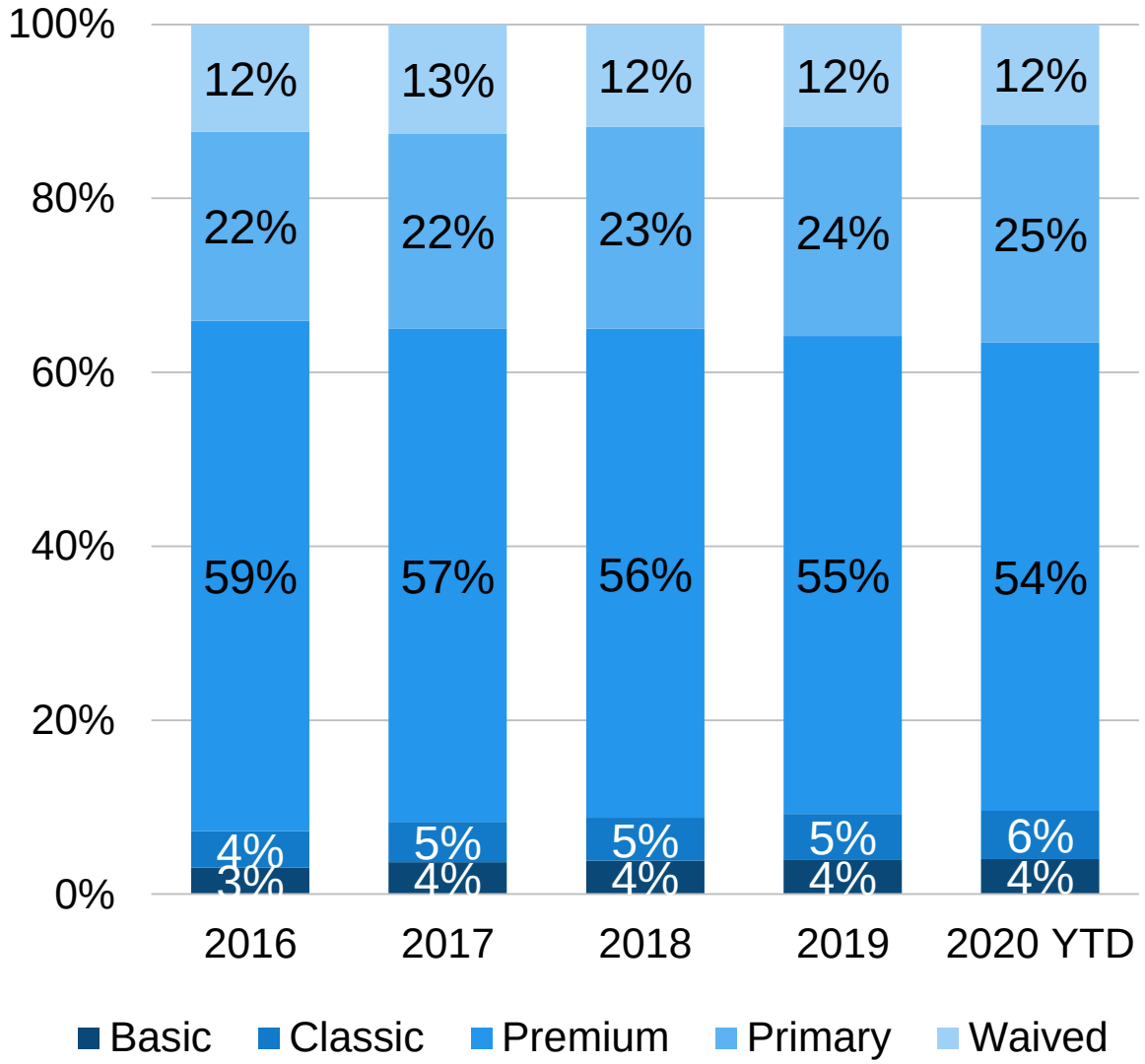
ASE - Average Enrollment (Subscribers) by Plan





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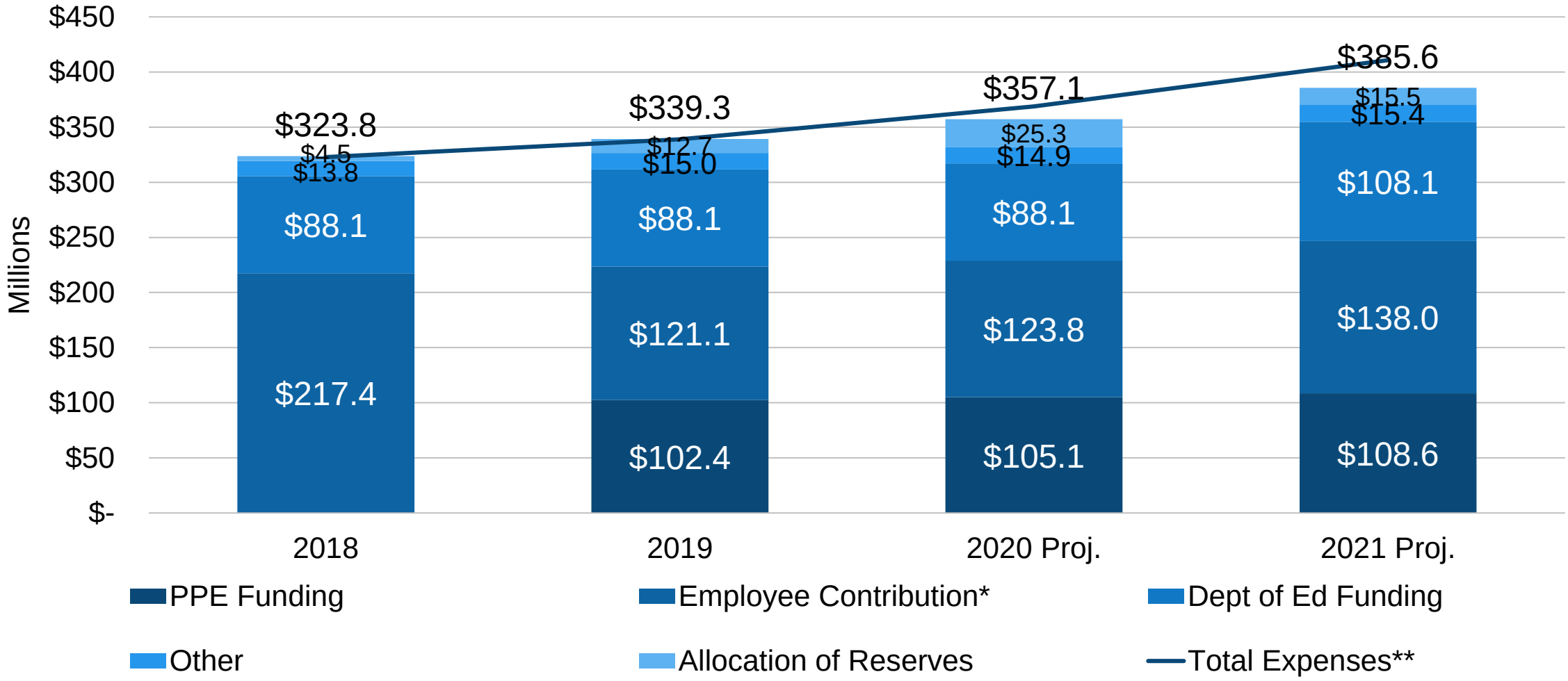
PSE - Income vs. Expenditure



* 2018 Employee Contribution includes PPE Funding

** Total Expenses offset by Program Savings

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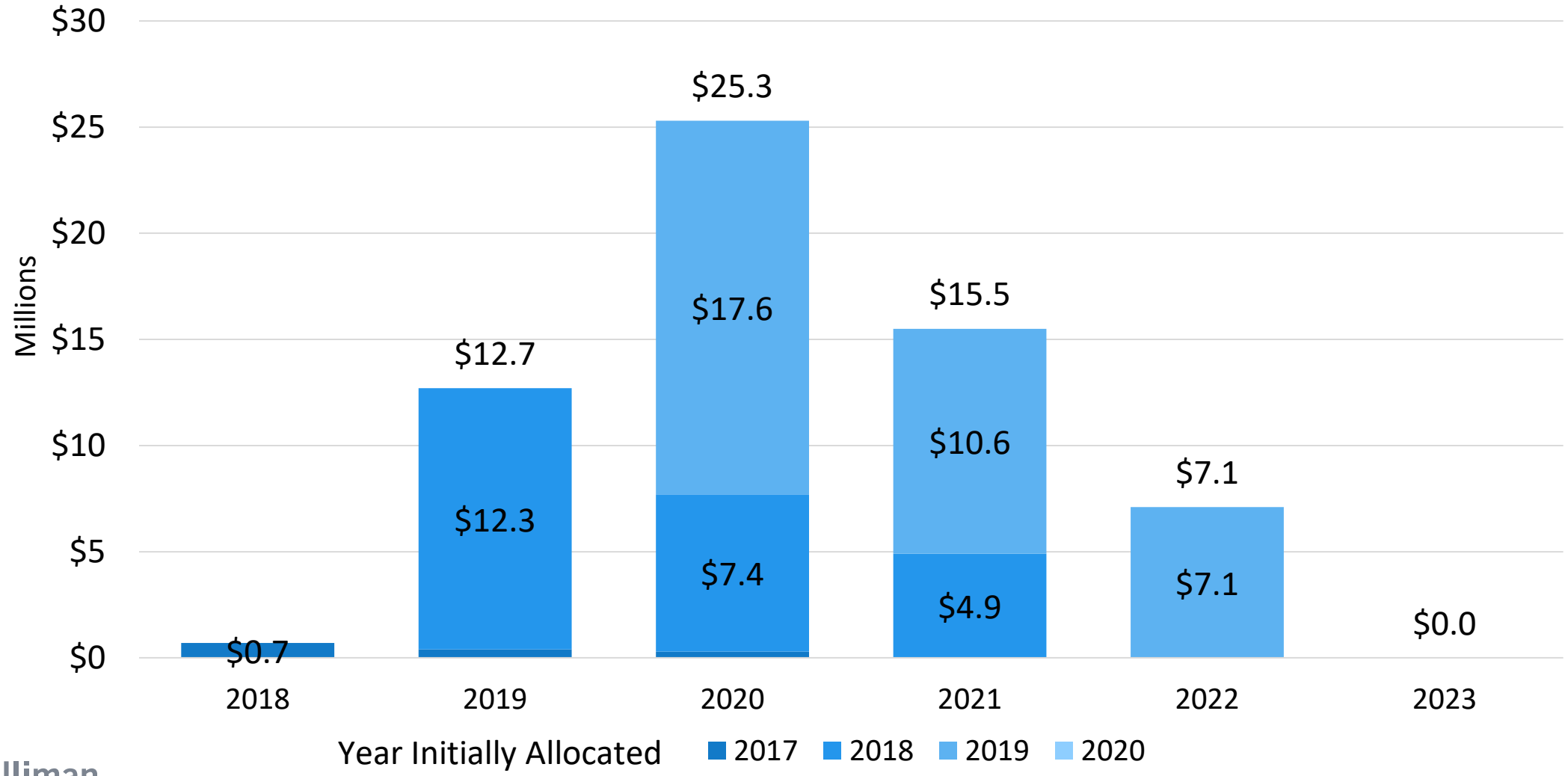
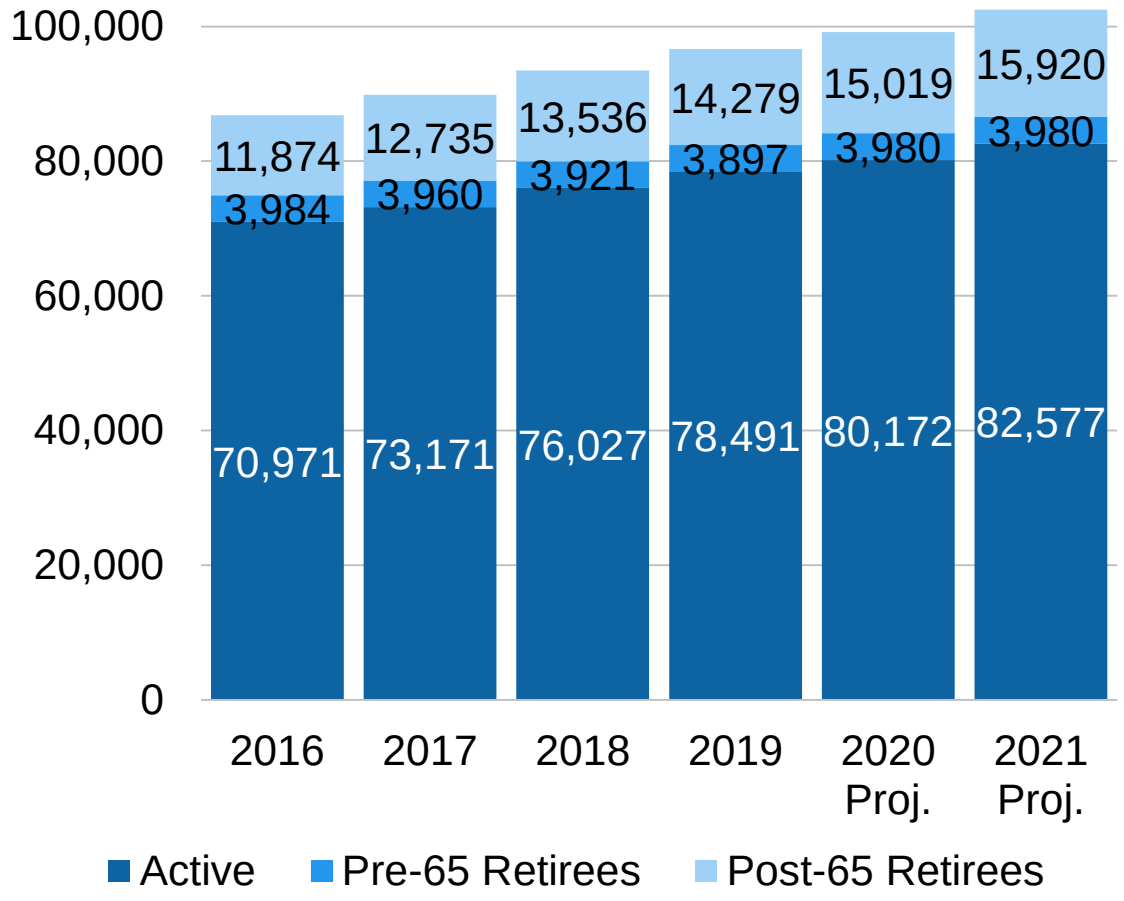
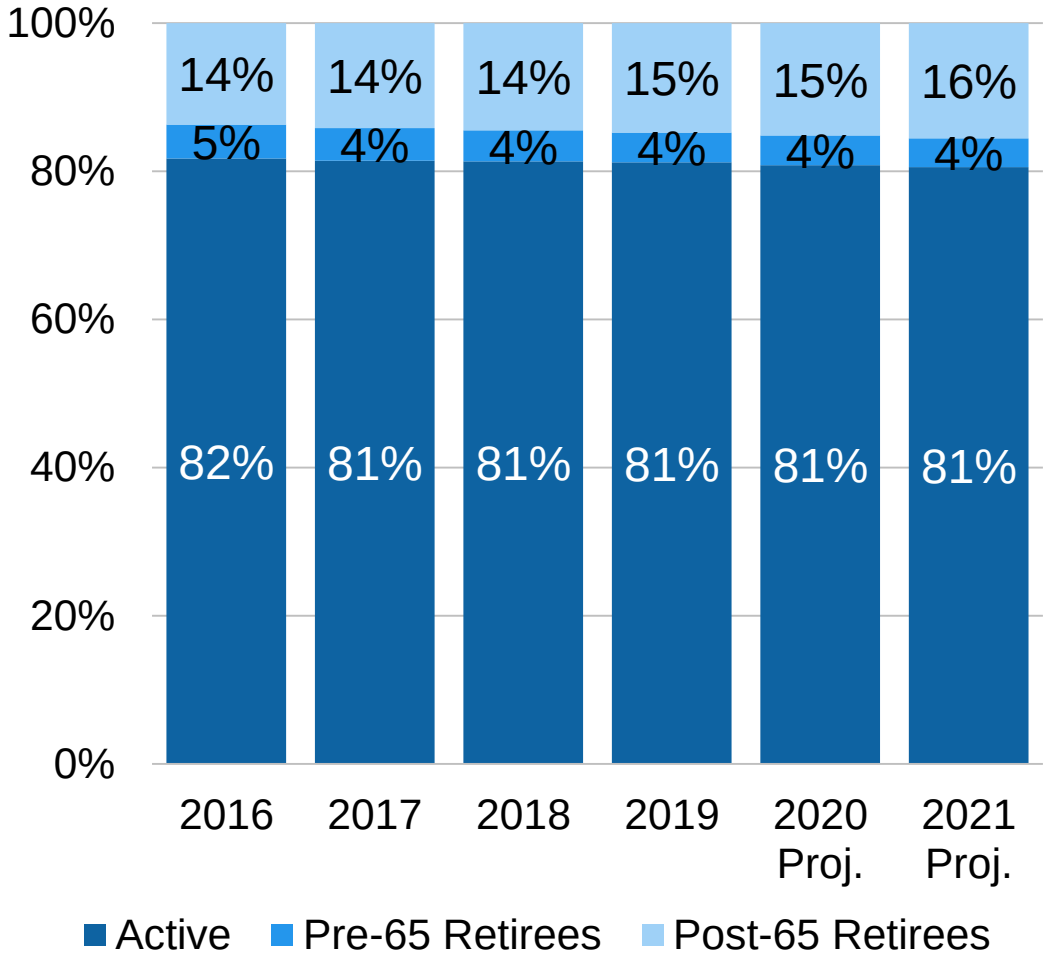
PSE - Reserves Allocation by Year

The chart represents the reserves amounts allocated each year (in millions), and how much reserves are available each year.

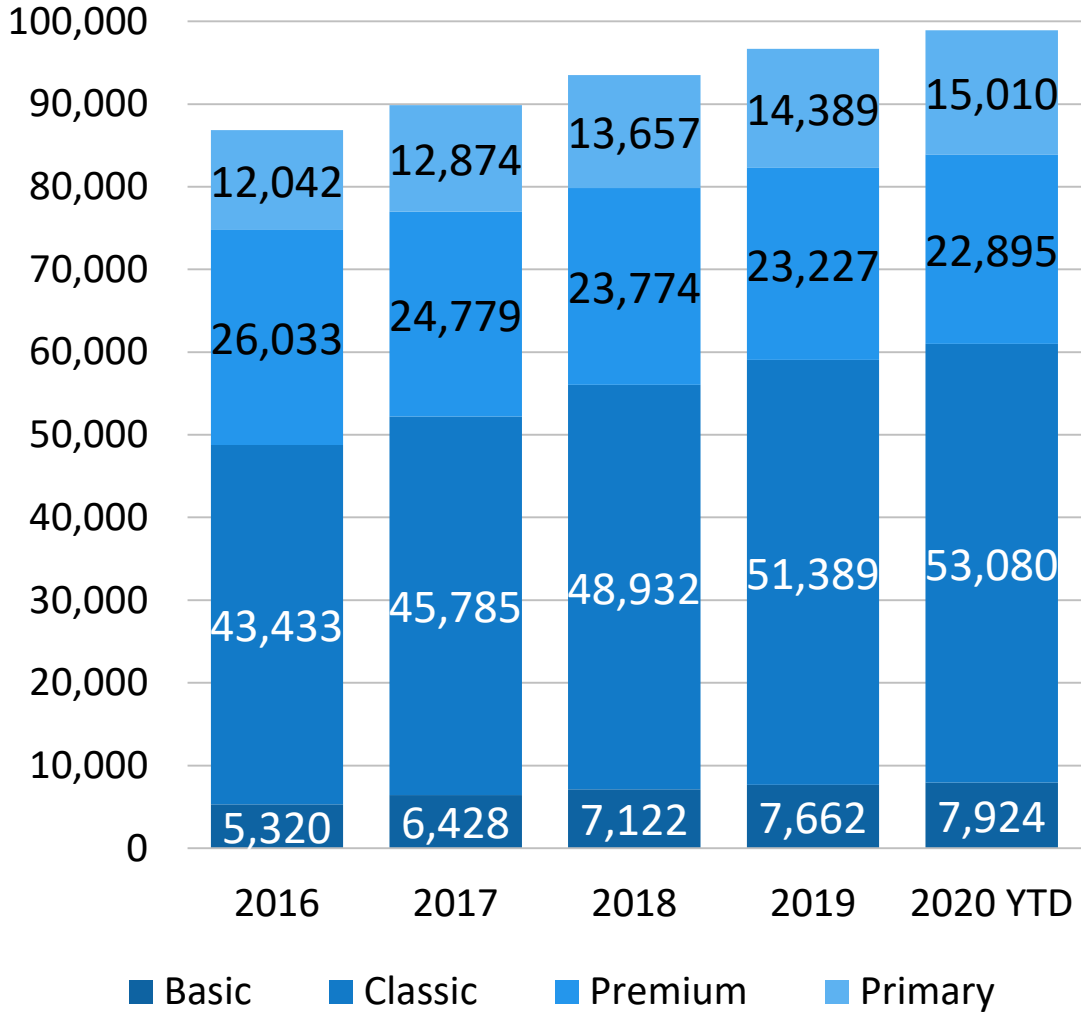


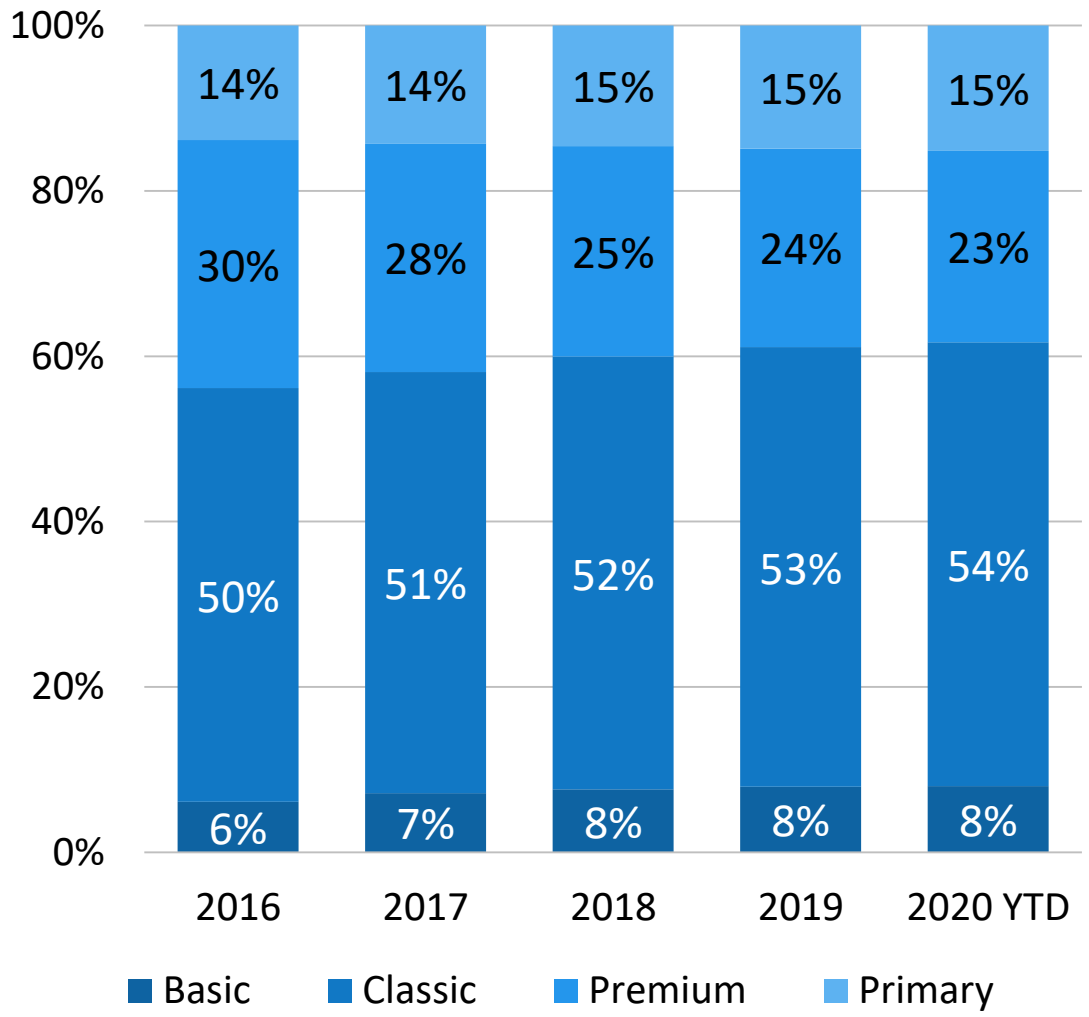
PSE - Average Membership by Status



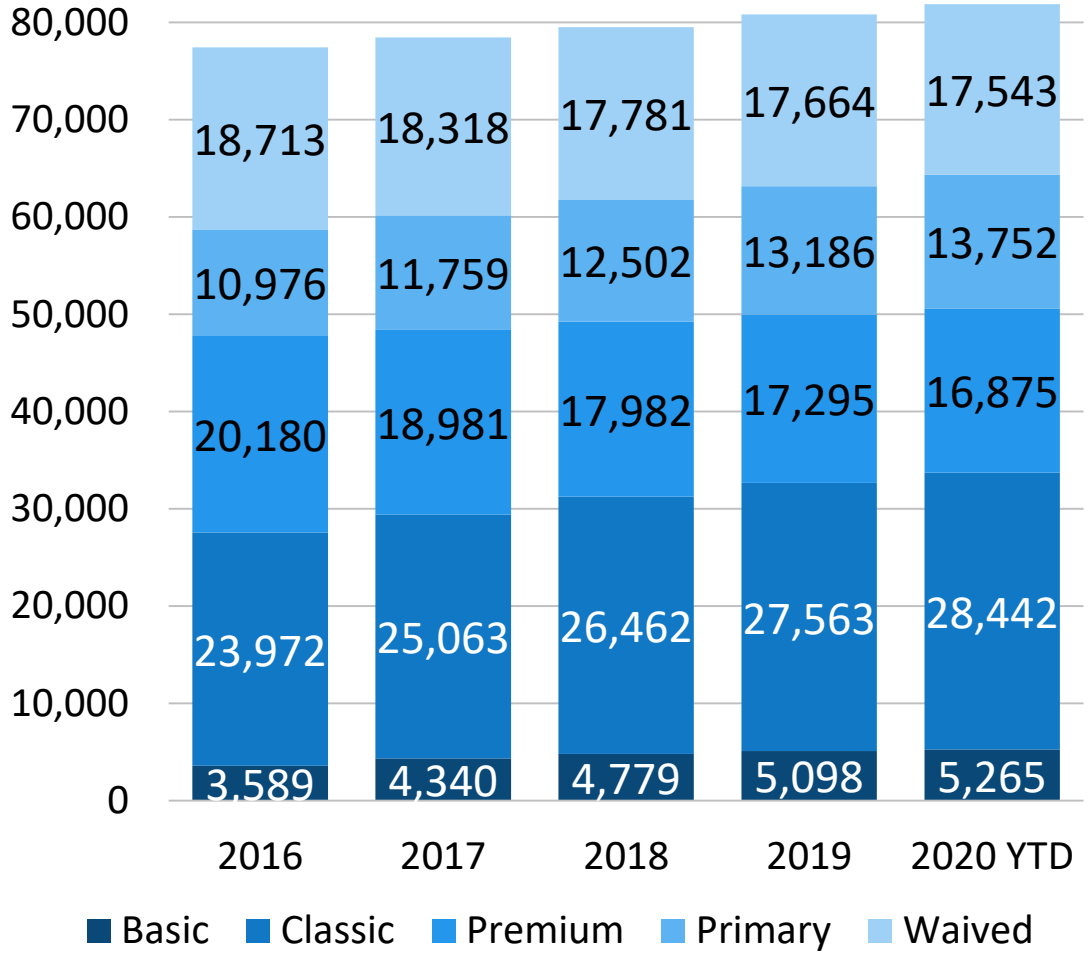


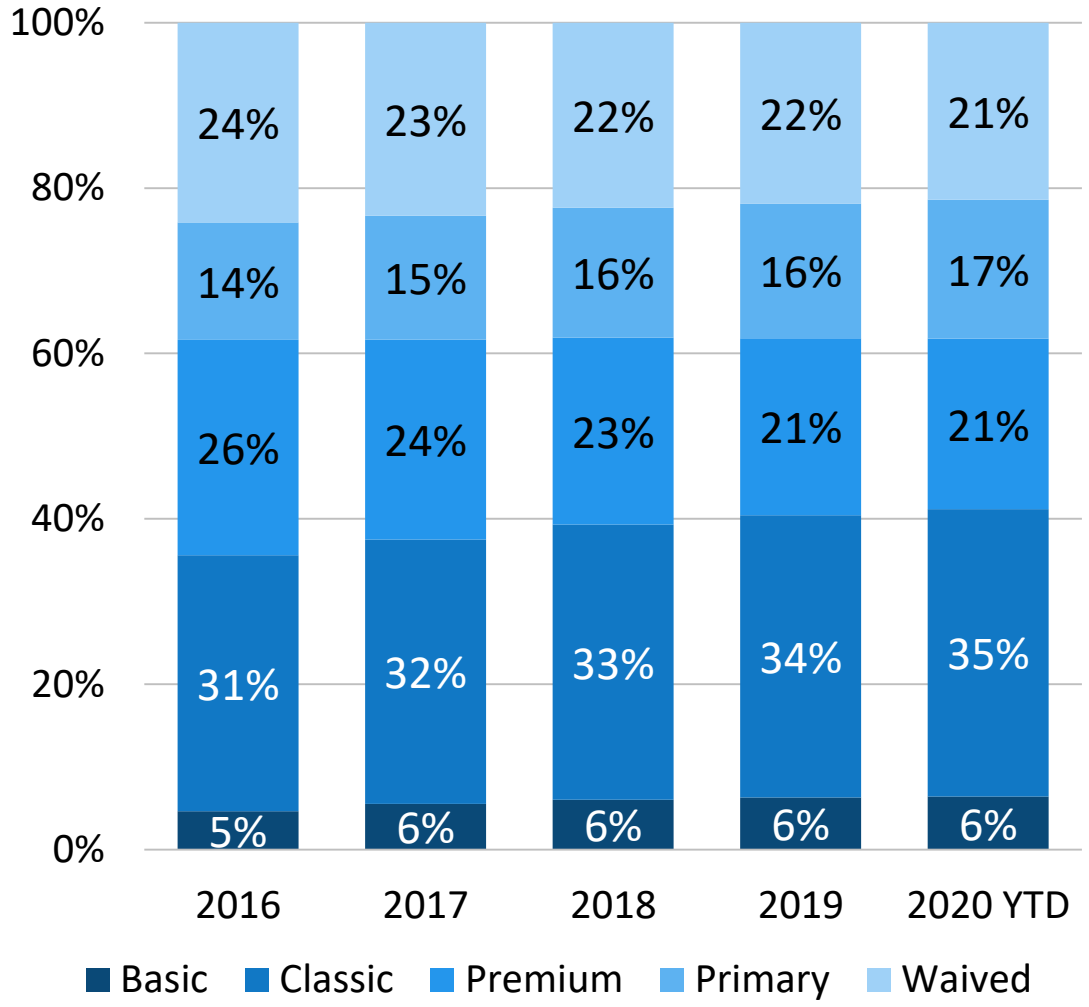
PSE - Average Membership by Plan





PSE - Average Enrollment (Subscribers) by Plan





Assumptions & Methodology

Assumptions - Trend

Division	Group	Medical Trend	Pharmacy Trend
ASE	Active/Pre-65 Retirees Post-65 Retirees	5.0% 5.0%	8.0% 8.0%
PSE	Active/Pre-65 Retirees Post-65 Retirees	7.0% 7.0%	8.0% 8.0%

Assumptions & Methodology

Assumptions – Benefit Plan Changes (2019 to 2021)

- ASE
  - No significant plan cost changes for Active, Pre-65, and Post-65 benefit plans
- PSE
  - No significant plan cost changes for Active, Pre-65, and Post-65 benefit plans

Assumptions & Methodology

Assumptions – Other

- Age/Gender
  - Age/Gender factor based on Milliman Health Cost Guidelines™
- Enrollment Projections
  - Actual enrollment utilized for March 2019 through August 2020
  - Projected September – December 2020 based on historical patterns
- Program Savings
  - Projected program of $1.25 million per month for 2020, allocated between ASE / PSE based on pharmacy claims expense.
- Plan Administration Expense
  - ASE - $3.85 PMPM for CY2020 and CY 2021
  - PSE - $2.14 PMPM for CY2020 and CY 2021
- Plan Administration Fees include PCORI charges for 2020 and 2021
- Percentage of Population earning wellness incentive
  - ASE – 82%
  - PSE – 82%

Assumptions & Methodology

Methodology

1. Summarized fee-for-service (FFS) medical and pharmacy claims incurred from March 1, 2019 to February 29, 2020 and paid from March 1, 2019 to September 30, 2020. Medical claims are gross of withholds. Reports reflects the timing of when EBD is expected to pay the withhold.
2. Converted the paid and incurred claims to incurred claims using completion factors. This incorporates the incurred but not reported (IBNR) claim reserve.
3. Summarized member months for March 1, 2019 to February 29, 2020.
4. Divided the summarized incurred claims by the appropriate member months to calculate PMPMs.
5. 2020 Projected the incurred claims for August 2020 to December 2020 based on the PMPM from the midpoint of the experience period (September 1, 2019) to the midpoint of the projection period (October 15, 2020). Utilize actual claims for January 2020 to July 2020 with completion.
6. 2021 Projected the incurred claims PMPM from the midpoint of the experience period (September 1, 2019) to the midpoint of the contract period (July 1, 2021).
7. Made adjustments for seasonality, benefit changes, and age/gender mix.
8. Accounted for rating period fees and administrative expenses.
9. Where applicable, converted incurred budget to paid budget based on historical payment patterns.

Limitations

Courtney White and Paul Sakhrani are Members of the American Academy of Actuaries and a Fellow of the Society of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to render opinion contained herein. To the best of our knowledge and belief, this analysis is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The assumptions used in the development of the 2020 and 2021 budget are based on historical ASE and PSE claims, funding, and plan administration, historical ASE and PSE members by benefit plan, age/gender, and by month, 2019 and 2020 ASE and PSE benefit plan summaries, 2020 fees and administrative expenses, conversations with EBD regarding the program, and actuarial judgment.

While we reviewed the ABCBS and EBD information for reasonableness, we have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Expected outcomes are sensitive to the underlying assumptions used. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Any reader of this report should possess a certain level of expertise in areas relevant to this analysis to appreciate the significance of the assumptions and the impact of these assumptions on the illustrated results. The reader should be advised by their own actuaries or other qualified professionals competent in the subject matter of this report, so as to properly interpret the material.

This presentation has been prepared for the sole use of the management of the State of Arkansas Employee Benefits Division for setting the ASE and PSE budget for CY2020 and CY2021. It may not be appropriate for other purposes. Milliman does not intend to benefit any third party from this analysis.

Milliman

Thank you

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