AGENDA

State and Public School Life and Health Insurance Board

December 16th, 2020

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I.	*Call to Order*	*Dr. John Kirtley, Vice-Chair*
II.	*Approval of November Minutes*	*Dr. John Kirtley, Vice-Chair*
III.	*Trend Experience*	*Paul Sakhrani & Courtney White, Milliman*
IV.	*Subcommittee Updates*	*Shalada Toles, EBD Deputy Director*
V.	*COVID Update*	*Elizabeth Montgomery & Mike Motley, ACHI*
VI.	*Director's Report*	*Shalada Toles, EBD Deputy Director*
VII.	*Adjournment*	*Dr. John Kirtley, Vice-Chair*

2021 Upcoming Meetings:

January 26th, February 23rd, March 23rd

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

208th meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on December 16th, 2020, at 1:00 PM

Date | *time* 12/16/2020 1:00 PM | *meeting called to order by Dr. John Kirtley, Vice-Chair*

Attendance

Members Present	Members Absent
Cindy Allen - Teleconference	Renee Mallory - Chair
Stephanie Lilly-Palmer	
Greg Rogers	
Dori Gutierrez	
Secretary Cindy Gillespie – proxy – Damian Hicks	
Dr. John Kirtley – Vice-Chair	
Melissa Moore	
Dr. Terry Fiddler	
Secretary Amy Fecher	
Dr. Lanita White	
Lisa Sherrill	
Herb Scott	
Cynthia Dunlap	
Shalada Toles, Employee Benefits Division Deputy Director	

OTHERS PRESENT:

Rhoda Classen, Theresa Huber, Laura Thompson, Stella Greene, Mary Massirer, EBD; Micah Bard, Dwight Davis, Sherry Bryant, Octavia DeYoung, UAMS EBRX; Jessica Akins, Takisha Sanders, Health Advantage; Elizabeth Montgomery, Mike Motley, ACHI; Courtney White, Paul Sakhrani, Scott Cohen, Milliman; Mitch Rouse, TSS; Sylvia Landers, Colonial Life

Approval of Minutes by Dr. John Kirtley, Vice-Chair

MOTION by Scott:

Motion to accept the November 18, 2020 minutes.

Lilly-Palmer seconded; all were in favor.

Minutes Approved.

Trend Experience by Courtney White, Milliman

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

ASE

- 2020 & 2021 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through November 2020 and pharmacy claims data incurred from October 2019 to September 2020 and paid through November 2020.
- 2020 projected Plan experience
    - Allocation of Prior Years' Surplus for 2020 is $25.1M
    - Estimated surplus of $500K (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2020: $8.9M
    - 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
    - Allocation of Prior Years' Surplus for 2021 is $14.5M
    - Projected deficit: -$4.8M (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2021: $4.1M
    - Reflected 2021 program initiatives
    - Increased membership based on historical patterns
    - Baseline trends (medical: 5%, pharmacy: 8%)
    - September 29, 2020 Board action

PSE

- 2020 & 2021 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through November 2020 and pharmacy claims data incurred from October 2019 to September 2020 and paid through November 2020.
- 2020 Plan experience
    - Allocation of Prior Years' Surplus for 2020 is $25.3M
    - Estimated deficit of -$3.5M (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2020: $2.1M
    - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
    - No Plan changes / 0% increase in employee contributions
- 2021 Plan experience
    - Allocation of Prior Years' Surplus for 2021 is $15.5M
    - Projected deficit: -$27.2M (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2021: -$25.1M
    - 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: How much money are we going to have if the projections are plain? How much money is in the checking account? How much money is able to be spent? If this is true, how much money are we going to have to ask for to get us to stay in the black? That's my bottom line.

White: At The end of next year, our checkbook is going to be $4.8 million in the hole. We have spent $5 million more than we received in income. Because of that, we need to use assets to pay for that and go into our savings account in order to make ourselves whole. That only leaves us with $4.1 million at the end of 2021 in terms of assets. We still have the catastrophic reserves and a really small reserve set aside for funding premiums, but those are earmarked for the Board, and unless you decide to change that, you can't touch that money.

Dr. Fiddler: It goes to hell in a hand basket; 2020 epitomizes that we as a Board have to say that we want to go into our catastrophic funds, or is this an automatic that we go into those?

Dr. Kirtley: In the past, when we have gone over, it goes into either the unallocated assets for the future, or if we ran through that, it would go into the catastrophic fund.

White: In 2020, we have $9 million dollars of free assets, so it covers the $4.8 million as you go into 2021. So, you wouldn't have to go into catastrophic in this circumstance.

Dr. Fiddler: If everything remains the same, we would not have to go into it.

Dr. Kirtley: Generally, we would have that money go 50% for 2021, 30% for 2022, and 20% for 2023 to help smooth those lines, but that's generally the first money we would pull from, which means we haven't pushed it forward to smooth it later. It can mean a rougher transition at a later date because you don't have that extra money already coming in, and that's before you get to your catastrophic reserves.

Dr. Fiddler: If things remain the same, do you foresee us having to go into the catastrophic?

White: Based on these numbers for 2021, we would not for ASE.

Dunlap: I want to understand the 50-30-20 allocation.

Dr. Kirtley: Any money that is left over at the end of the year is split up to be spread across the next three years: 50% of it in the following year, 30% in the year after, and 20% the year after that. So, this year we are seeing the 20% from three years ago, the 30% from two years ago, and 50% from last year of whatever those numbers are so that it helps to float the transitions instead of having sharper peaks.

Dunlap: In 2020, we're at the 20% reserve allocation, and we don't have other?

Dr. Kirtley: No, in 2020, this year, we should have 20% of what we had extra three years ago, 30% of two years ago, and 50% of one year ago. Those could be zero though.

Dunlap: So, if you're doing that every year, what's been allocated for 2021 and 2022 are already out there. Where does the allocation stop so that we don't have anymore?

Dr. Kirtley: Yes.

White: There is no money allocated after 2022.

Dunlap: All we have to allocate at the end of this year is $8.9 million?

White: No, it's the $500,000.

Dunlap: So, basically, that's nothing for three years.

White: Yes.

Dunlap: In 2021, we are in a deficit; there's nothing.

White: You will take the $8.9 million in free assets and spend $4.8 million of it, so you still have about $4.1 million left that is not allocated. Your end of the year losses reflects that. So, the $4.1 million shows that you lost money in 2021.

Dr. Kirtley: So, we have the money to cover 2021, but we don't have the extra money to smooth the transition in 2022 or 2023 afterwards.

Dunlap: You said this is net of the IBNR, the $26 million. How subject is that to change?

White: We look at that every month, but it's not reported every month because within the same calendar year, it doesn't really matter from a financial reporting standpoint as long as you get the number at the end of the year. If it goes up and down throughout the year, it just kind of washes itself out. It has changed a lot this year because the claims have been down due to the pandemic. Lower claims mean you have lower reserves, and we haven't necessarily reflected that yet, because we think that claims have come back up. October is probably a high month because there is a lot of incurred claims in October. November and December are lower because of the holidays.

Dunlap: So, if that number goes up, that reduces the reserve amount.

White: Correct.

Dr. Kirtley: Several years ago, when we had a catastrophic year, we were in a position where we did not necessarily have the money to pay all the bills for the IBNR. That was a major concern and why the Board pushed back towards having the catastrophic reserve and smoothing out those rough edges. So, 2012 compared to now, instead of saying we don't have enough money to potentially pay all the bills if we close up shop today. What he's telling us is if we had to close up shop today and get everything to net, we would end with an estimated $26.2 million at the end of 2021. So, it's a catastrophic reserve of $16.1 million, but it's an overall pool of $26.2 million. So, we would have an overall pool of 26 days' worth of business, just 6 of it is in catastrophic, and 16 of it is in other funds.

Dr. Kirtley: So, in the last three years, medical has gone from $200 to $300 per member per month on average?

White: Yes, in January 2017, it was $200, and then September of 2020 it was $300.

Dr. Kirtley: Well, September trends are a little higher anyway because of the time of year.

PSE

Dr. Fiddler: If we still have a $5.1 million negative, that more than likely will come out of the $58.5 million to bring us to at least even or more to give us more money in that fund, is that correct?

Dr. Kirtley: We could take it out of that to put us at even to pay all the bills. I think the overriding message on both plans is if we want to build our catastrophic reserve more for better stability. We don't have reinsurance because we have catastrophic reserves. So, if we do have catastrophic reserves, that is what it's for, like 2012. We're going to have to change benefit design or increase funding to increase money because you can look at these trends, and the expenses are growing. It's an exponential growth with any type of spend like that, but we have to look for ways to control the growth, reduce it, or increase the income, or we are dead in the water.

White: I don't think we would take more than the minimum amount out of the catastrophic fund than we would need to fund the loss.

Fecher: Can you explain the different types of reserves? We have different types of reserve funds because the catastrophic fund is for catastrophic payments of something that we didn't really budget for, those high dollar claims. We can dip into it when we need to. There is also a reserve fund that is just used to pay claims as they come in, correct?

White: The IBNR is kind of like that because it just keeps rolling over every month. So, you set it up one month, and then you replenish it the next month because you draw down on those claims. The catastrophic reserve, I think is both if you have a bunch of high-cost claims that probably contributed to having a bad year. So, I think using all that money to set yourself even would be how that would work.

Dr. Kirtley: When we designed it, the problem is that we had a handful of catastrophic cases. It was something like 4 catastrophic cases that added up to be $2.9 million just for those cases and then 10 that were $12 million or something like that. I don't think that we designated if we had a catastrophic high dollar claim that it would automatically come out of that fund, but because it stretched the whole budget over that was completely unexpected due to those catastrophic claims, we had it there as our reinsurance so to speak.

White: There are two kinds of reinsurance. There's a specific stop-loss, which is if there is a particular claim over $150,000, that's when the reinsurance kicks in. There's also what they call aggregate reinsurance, where if your total spend gets over $400,000 million, then it kicks in. I think it's more like the latter where you have this overall protection for a bad year to do whatever causes that overage.

Dr. Kirtley: It was discussed back then, but because we had had such a catastrophic year, the insurance costs were estimated to be astronomical at that point versus us trying to build a catastrophic reserve.

White: Usually, what happens on reinsurance is it will estimate what your claims are based on what they have seen in prior years looking at your claimants, and then they'll build in their administrative costs and their margins to set the premium rate. Usually, the margins are fairly high because its low frequency, high risk business, so it's highly leveraged. You might expect to get fifty to sixty cents on the dollar from a reinsurer. So, say you need $10 million in reinsurance, they would charge you $20 million. By setting it up yourself, especially a plan your size, you are actually saving money from the reinsurance market.

Dunlap: When is the catastrophic reserve used? Is there anything specifically that determines when it's used? Because it is sitting there in a reserve. If there is no definition of when to use it, then it will always be in the reserve. This is significantly ($58.5M) higher than ASE, so I would like to understand why this reserve is so high. Also, what is the average daily claim expense for PSE?

White: For 2021, I think it will be around $1.13 million, and for 2022, I think it's about $1.25 million. So, that $58.5 million is roughly 50 days versus a target of 60-90. I think there was more surplus back then, but Dr. Fiddler said they drew down on the PSE fund between 2018-2019 and took half of it away. So, it was short to begin with and made it even shorter by using the funds to help mitigate costs.

Dunlap: How do we determine when that catastrophic is actually used? We know it's not supposed to take up a deficit at the end of a fiscal year like this. If an event occurs throughout the year, is it defined that if an event is this much or a certain type of event occurs then you will use the catastrophic reserve and then replenish it?

Dr. Kirtley: The way that I recall, this a way that we identified that area of assets so that we don't spend it in our normal budgeting process. This is like the savings account that we go to when we don't have another option, is the way that I would put it. It comes down to when we run out of our other options, do we want to go ahead and spend the future allocated dollars, leave those there to smooth those transitions and dip into the catastrophic leave, or if we have a catastrophic year and we run through all the other money, that's our last option. We don't use that money to budget for rates in the future. It's termed catastrophic, but I think it's just because it's isolated and not another part of the budgetary process to set rates.

White: We could take that $58 million and build that into the rate-setting process, and the retirees and employees would probably get a decrease in what they needed to pay because that money would offset it. But that would put the plan highly at risk going forward because there is no backstop if things go bad.

Dr. Kirtley: Because we have our own fund in case of the terrible years, we don't have to garner additional money to cover our risks, because we have our own risk insurance planned behind us.

White: It is my understanding that if we didn't put that into a catastrophic bucket and it was still in free assets, then it may not be protected.

Dunlap: It's almost like you have money sitting in the bank that you never use if you don't know how and when you can use it.

Dr. Kirtley: That's why it's a savings account in case of a catastrophic year where we have to have a special legislative session.

Allen: If we've had a pandemic, and I was in the subcommittee meeting on Friday, and they had really big numbers of people that have been tested out of our program, people that have been hospitalized, and unfortunately, deaths. It's hard for me to understand how this is less than what we would have in a normal year. Is that really true? Our expenses are less this year with the pandemic than they would be in a normal year?

White: That's correct. If you look at the trends for medical, you can see in March, April, and even May of 2020 compared to March, April, and May of 2019, they would typically be above that. The dip in the trend has gone way down more than it has in prior years. The deferred and avoided care is greater than the cost of treating COVID and doing the testing.

Allen: I know they run behind on the expenses and have addressed that because we have to keep money, and obviously, not everything will be reported by December 31st for people that have had medical expenses during the month of November or December. Is there any chance with the numbers going up that we are going to see more expenses for those last two months than we have seen?

White: We had a sneak peek at October and maybe November, and they weren't materially higher than the previous months we've seen. They weren't materially higher than in

prior years. So, I don't think that's going to happen, and the second wave hit just before Thanksgiving. I think there is more focus on sheltering in place and social distancing and things like that. So, I wouldn't be surprised if things come in lower than we would expect.

Dr. Kirtley: Generally, on PSE, we almost always have peaks at the end of the year as people in the high deductible plans, which is a much larger percentage, run through all their out-of-pocket parts, and then the plan pays a higher percentage of the claims at the end of the year.

Subcommittee Updates by Shalada Toles, EBD Deputy Director

Toles provided a brief update on the December Benefits sub-committee meetings. She reported that the overall wellness numbers for 2021 were 78% that met the wellness requirements and 22% that did not. As a comparison, for 2020, we were at 85% that received the wellness discount and 15% that did not. This Board also allowed Medicare retiree members to opt-out of the ARBenefits drug plan, and we had 214 that have done that for next year. We expect that number to increase next year as members age onto Medicare and have that choice. One of the Benefits committee members asked about our readiness for the COVID vaccine. Medimpact, our pharmacy vendor, has shared their readiness plan with us. So, once the vaccine is available, more information will be coming out.

Topics Discussed:

- Approval of Minutes
- COVID Update by ACHI
- Trend Experience by Milliman
- Director's Report

Discussion:

Fecher: For the Board's knowledge on the Director's position, with only two applicants received, the subcommittee has recommended to post the position today and will be live on ARCareers.

Dr. Fiddler: That will come before us for the next meeting, or will it be more than one month. I am not sure how this works.

Fecher: It will depend on the work of the subcommittee and how quickly they send it to the full Board.

Dr. Kirtley: We are looking at listing it for five days to see if we get any additional applicants. With Christmas break and everything coming, the subcommittee has discussed picking this right back up after the break to go through applications and that process to get it to the Board.

Dr. Fiddler: When applicants come before this committee, did I not read that because of the particular level, SE02, that you don't normally advertise for that position?

Dr. Kirtley: It does not have to be advertised at that level.

Dr. Fiddler: How do these people know about it if you don't advertise it? You said you only had two people, and one of them didn't meet the qualifications, so now you're doing it again.

Dr. Kirtley: It initially was not listed, and because it is such a public facing position with so much attention and talk with articles in the newspaper and such, I think that people knew it was open but may not have seen how to apply. At this point, when we put it on

ARCareers that will open it up so that people can see it and see a very clear application window for it. The subcommittee will then have to evaluate applications to see if they even meet MQ's to determine potentials for interviews at subcommittee or Board level.

Dr. Fiddler: Normally when you have this level of position, there usually is enough applicants and that's why you don't have to advertise?

Dr. Kirtley: Yes, I believe so. We were trying to work on a contracted timeline, because of the situation that it puts us in approaching legislative session.

COVID Update by Mike Motley, ACHI

Motley presented analyses regarding COVID-19 impact on the plan.

Discussion:

Dr. Fiddler: Do you have a cost estimate, or do you know who would have that? If we had 64,235, what is the multiplier on that per test cost?

Motley: The test that we saw in claims in the most recent look was around $56-$60 per test that the plan paid for. That total number of members ever tested is estimated. There may have been more tests done among members, but that is a little hard to distinguish from the data that we have because of the way that negative tests are reported. There is limited identifying information on that because you have so many labs out in the state. We can pretty confidently say that this many people have had at least one test, and I'd say of those 64,000 we have seen, typically about one-fourth to one-third of those are paid for by the plan. So, the majority out there were either getting self-paid or some other format if you could let us come back to you with the number that has actually been paid for by the plan.

Dr. Fiddler: I would like to know that. I would also like to know if I took a test in June and another in August and December, am I still just one test, or is that three different tests? Because you said on that total number, it was per member.

Motley: That number you see there is just one test per unique individual in that count. It is actually an undercount of the total tests done among members. Under the example you gave, you would be counted once.

Dr. Fiddler: So, it could be a lot more than that.

Motley: Yes sir, but if the plan paid for them, we would see a claim for that. So, we can tell multiple tests in terms of claims experience and we will come back with an update on that.

Dr. Fiddler: Looking to the future, in my blog today from Chicago and the local Democrat Gazette, if the home tests do work and it looks like they do. At $32.75 a test versus $58 per test, it would seem to me that it would be a cost-effective thing for the plan to pay for someone to own one of those and to do that rather than going out to have the test taken. It is just a thought for the future.

Dunlap: Those test costs are included in the claims amount that Milliman reports on their financial report?

Dr. Kirtley: The ones that are charged to the plan should be, and I hear Courtney agreeing. There have been tests that have had federal grant funding or tests that people have just paid

out of pocket for that would not be included. The scope that we see would be included in our costs.

Director's Report by Shalada Toles, EBD Deputy Director

Toles provided the report previously in the subcommittee update.

MOTION by Lilly-Palmer:

I make a motion to adjourn the meeting.

Scott seconded. All were in favor.

Meeting Adjourned.

State of Arkansas Employee Benefits Division

Interim Monitoring Report

Through November 30th

State and Public School Life and Health Insurance Board of Directors

Courtney White, FSA, MAAA

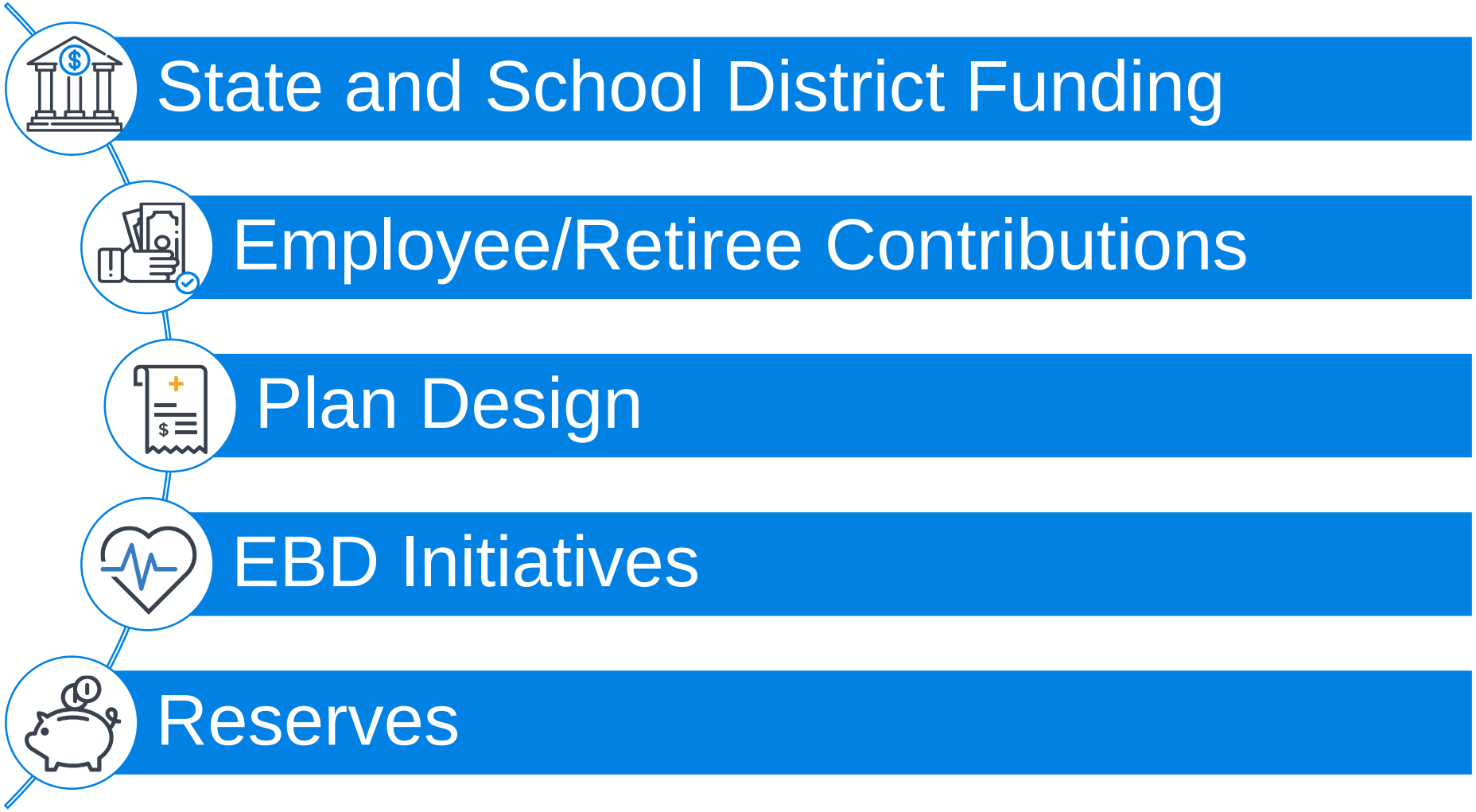
16 DECEMBER 2020

Milliman

Agenda

- Budget Levers
- Arkansas State Employees (ASE)
- Public School Employees (PSE)
- 2020 and Beyond Roadmap
- Assumptions and Methodology
- Appendices

Budget Levers



Arkansas State Employees (ASE)

Executive Summary

- 2020 & 2021 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through November 2020 and pharmacy claims data incurred from October 2019 to September 2020 and paid through November 2020
- 2020 projected plan experience
  - Allocation of Prior Years' Surplus for 2020: $25.1M
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  - End of Year Unallocated Assets for 2021: $4.1M
  - 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	99.01	110.02
Other	23.47	21.65	21.80
Total Income	$ 294.53	$ 292.91	$ 316.31
Medical Claims	$ (194.58)	$ (205.34)	$ (222.31)
Pharmacy Claims	(86.58)	(91.97)	(100.37)
Administration Fees	(18.30)	(17.42)	(17.53)
Plan Administration	(2.90)	(2.79)	(2.81)
Total Expenses	$ (302.36)	$ (317.52)	$ (343.02)
Program Savings	$ -	$ -	$ 7.50
Net Income / (Loss) Before Surplus Allocation	$ (7.84)	$ (24.61)	$ (19.22)
Allocation of Prior Years' Surplus	$ 21.70	$ 25.08	$ 14.46
Net Income / (Loss) After Surplus Allocation	$ 13.87	$ 0.47	$ (4.76)

Average Membership			
Active Employees / Pre-65 Retirees	47,751	46,611	46,611
Post-65 Retirees	13,343	13,748	14,161
Total Enrolled	61,094	60,359	60,772

Total Income PMPM[1]	$ 431.35	$ 439.03	$ 453.56
Total Expenses PMPM[2]	$ (412.43)	$ (438.38)	$ (460.08)

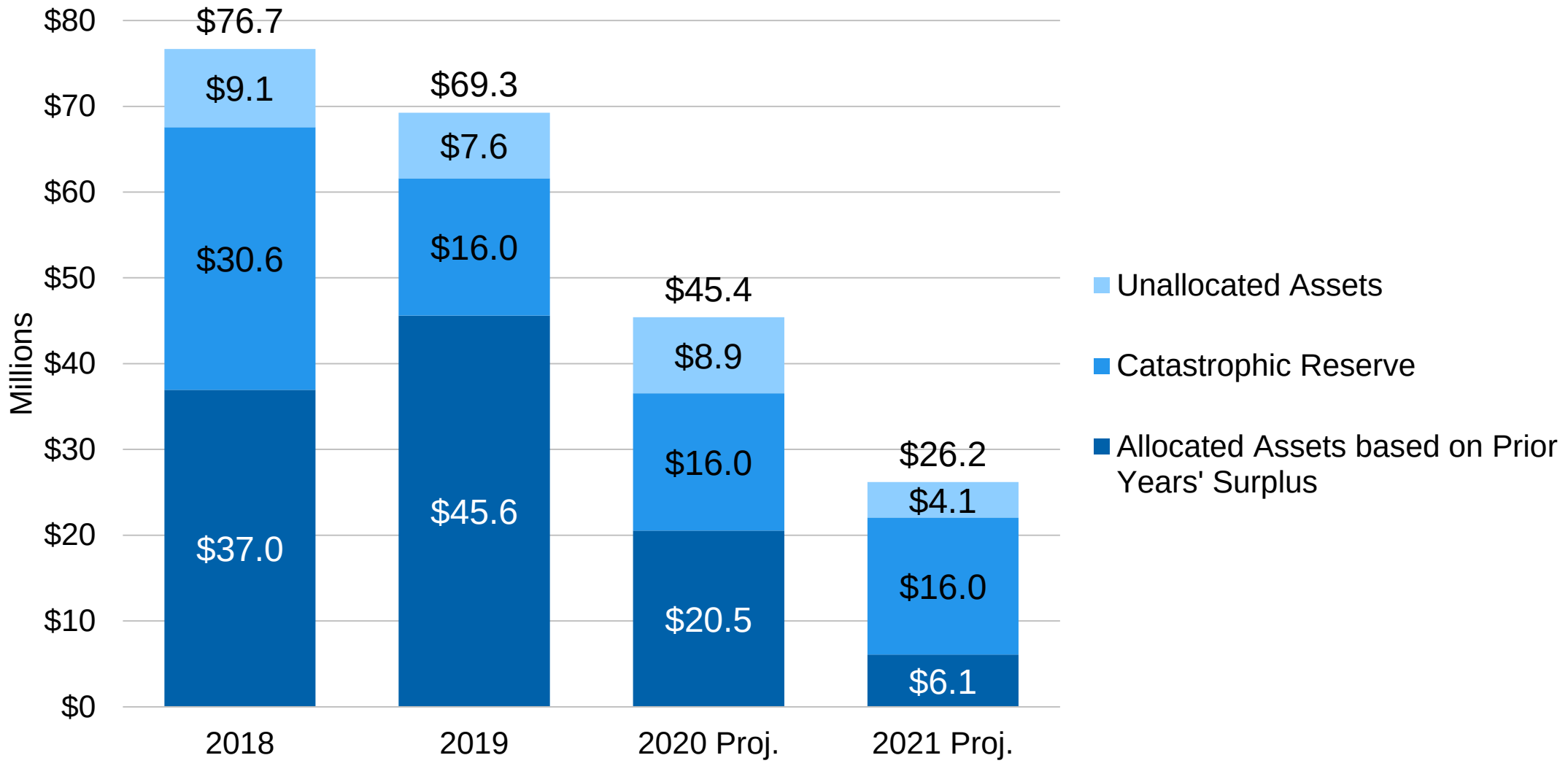
[1] Allocation of Prior Years' Surplus included in Total Income

[2] Total Expenses offset by Program Savings

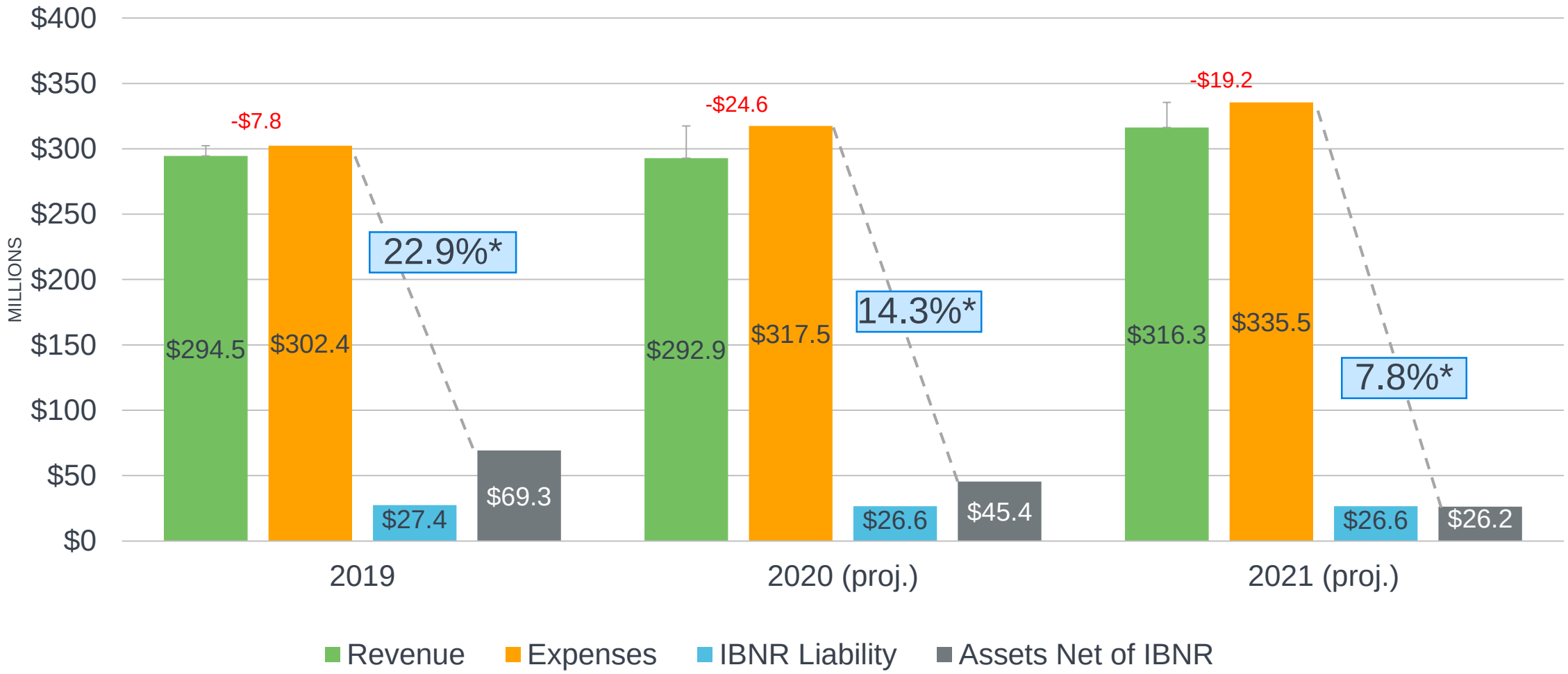
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
			Assets
(a)	2019	End-of-Year Gross Assets	$96.6
(b)	2020	Allocation of Prior Years' Surplus	($25.1)
(c)		Total Surplus / (Deficit)	$0.5
(d) = (a) + (b) + (c)		End-of-Year Gross Assets Available	$72.0
(e)		Incurred but not reported (IBNR)	($26.6)
(f) = (d) + (e)		End of Year Net Assets Available	$45.4
(g)	2021	Allocation of Prior Years' Surplus	($14.5)
(h)		Total Surplus / (Deficit)	($4.8)
(i) = (d) + (g) + (h)		End-of-Year Gross Assets Available	$52.8
(j)		Incurred but not reported (IBNR)	($26.6)
(k) = (i) + (j)		End of Year Net Assets Available	$26.2

End of Year Assets Net of IBNR



Change in Revenue, Expenses, and Assets



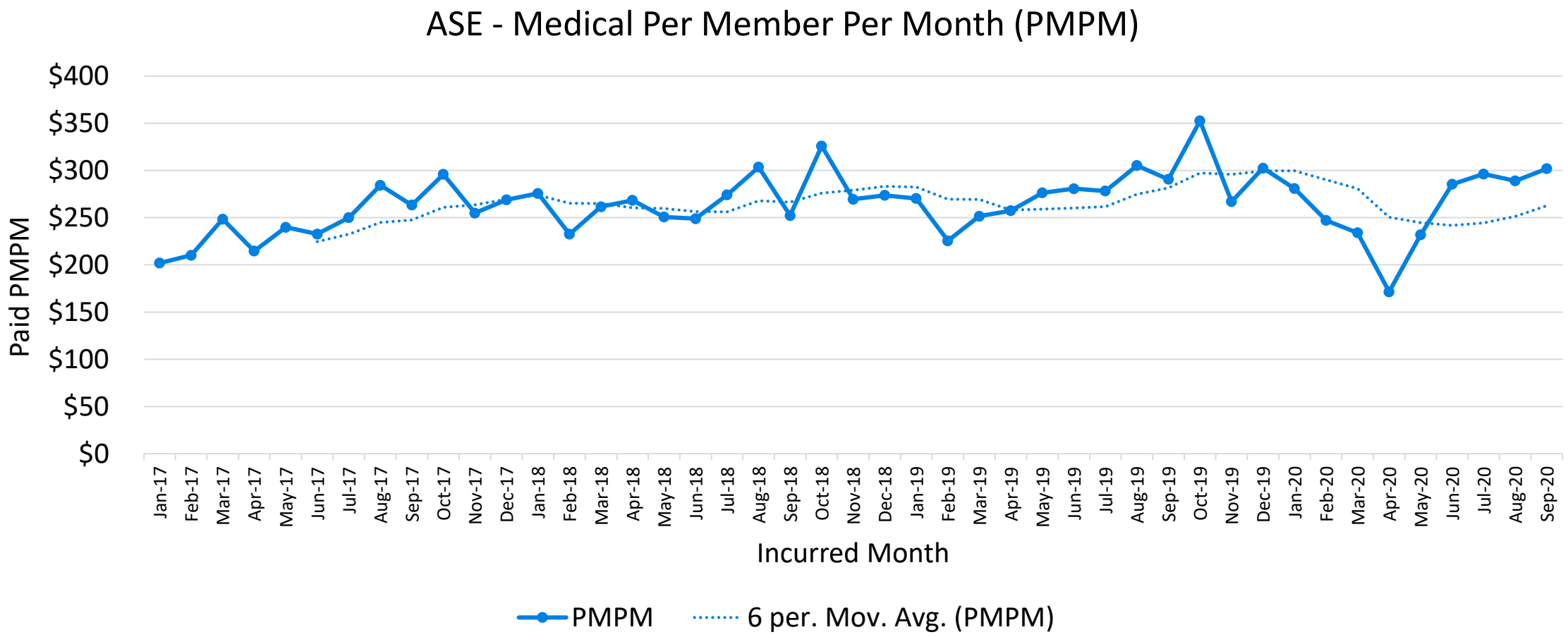
* Assets Net of IBNR as a portion of Expenses

Early 2022 Snapshot

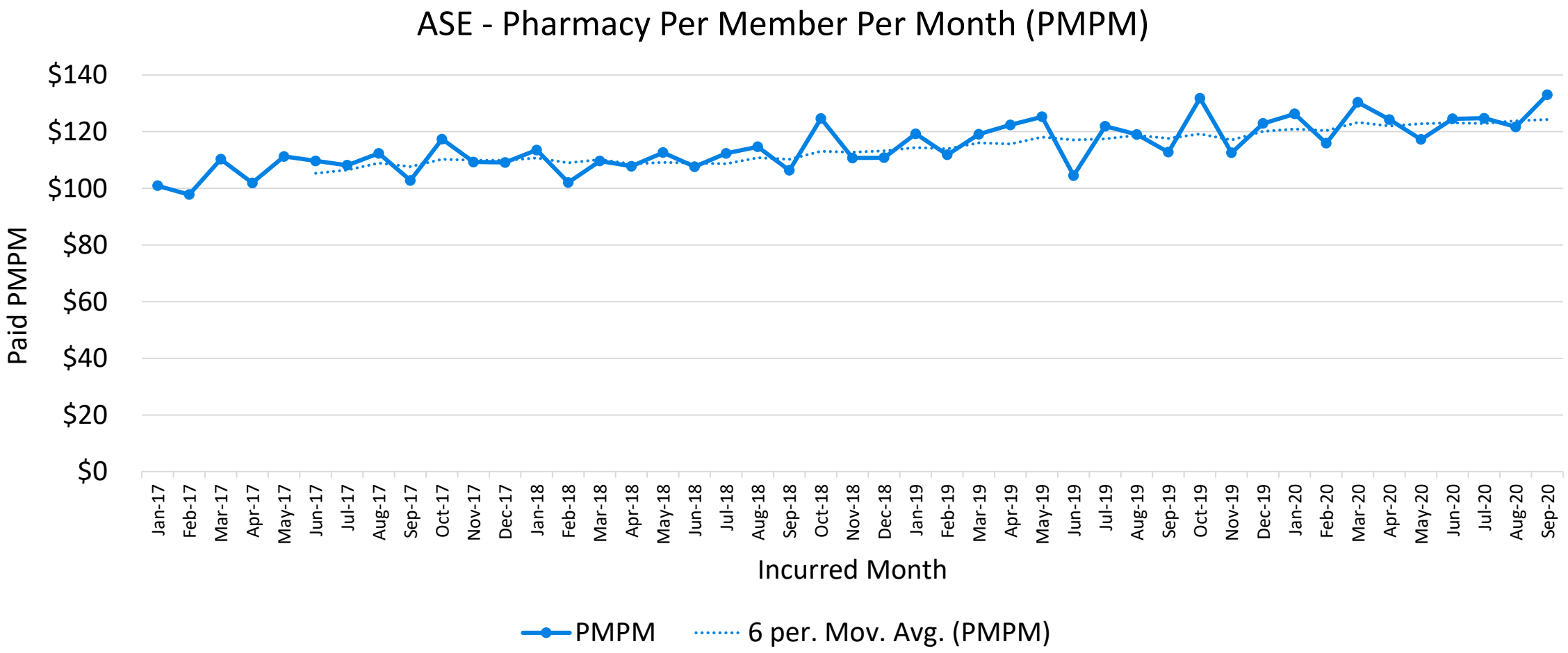
Funding	2022
State Contribution	$ 184.48
Employee Contribution	110.78
Other	21.80
Total Income	$ 317.06
Medical Claims	$ (235.02)
Pharmacy Claims	(109.14)
Administration Fees	(17.65)
Plan Administration	(2.91)
Total Expenses	$ (364.73)
Program Savings	$ 7.55
Net Income / (Loss) Before Surplus Allocation	$ (40.12)
Allocation of Prior Years' Surplus	$ 6.10
Net Income / (Loss) After Surplus Allocation	$ (34.02)

- 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%

Monthly Trend - Medical



Monthly Trend - Pharmacy



Public School Employees (PSE)

Executive Summary

- 2020 & 2021 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through November 2020 and pharmacy claims data incurred from October 2019 to September 2020 and paid through November 2020
- 2020 plan experience
  - Allocation of Prior Years' Surplus for 2020: $25.3M
  - Estimated deficit of -$3.5M (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2020: $2.1M
  - 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
  - Allocation of Prior Years' Surplus for 2021: $15.5M
  - Projected deficit: -$27.2M (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2021: -$25.1M
  - 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	$ 105.09	$ 108.59
Employee Contribution	121.12	123.87	137.97
Dept of Ed Funding	88.10	88.10	108.10
Other	15.02	14.88	15.38
Total Income	$ 326.64	$ 331.94	$ 370.03
Medical Claims	$ (247.11)	$ (261.74)	$ (312.59)
Pharmacy Claims	(60.87)	(68.35)	(73.89)
Administration Fees	(28.46)	(28.10)	(29.12)
Plan Administration	(2.61)	(2.54)	(2.63)
Total Expenses	$ (339.06)	$ (360.74)	$ (418.22)
Program Savings	$ -	$ -	$ 5.50
Net Income / (Loss) Before Surplus Allocation	$ (12.42)	$ (28.80)	$ (42.69)
Allocation of Prior Years' Surplus	$ 12.66	$ 25.25	$ 15.48
Net Income / (Loss) After Surplus Allocation	$ 0.24	$ (3.55)	$ (27.21)

Average Membership			
Active Employees / Pre-65 Retirees	82,388	84,191	86,597
Post-65 Retirees	14,277	15,009	15,909
Total Enrolled	96,664	99,200	102,507

Total Income PMPM[1]	$ 292.50	$ 300.06	$ 313.40
Total Expenses PMPM[2]	$ (292.30)	$ (303.04)	$ (335.52)

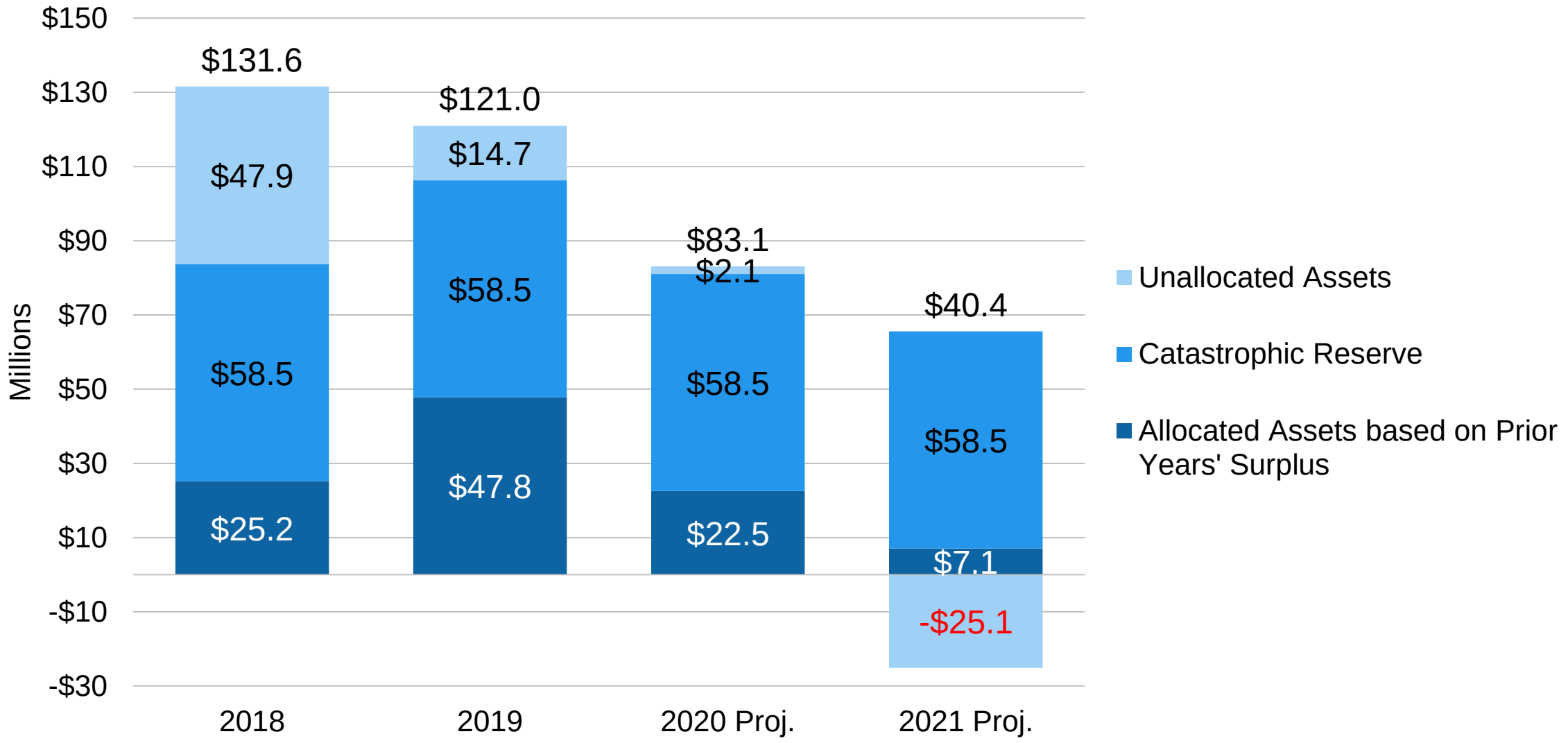
[1] Allocation of Prior Years' Surplus included in Total Income

[2] Total Expenses offset by Program Savings

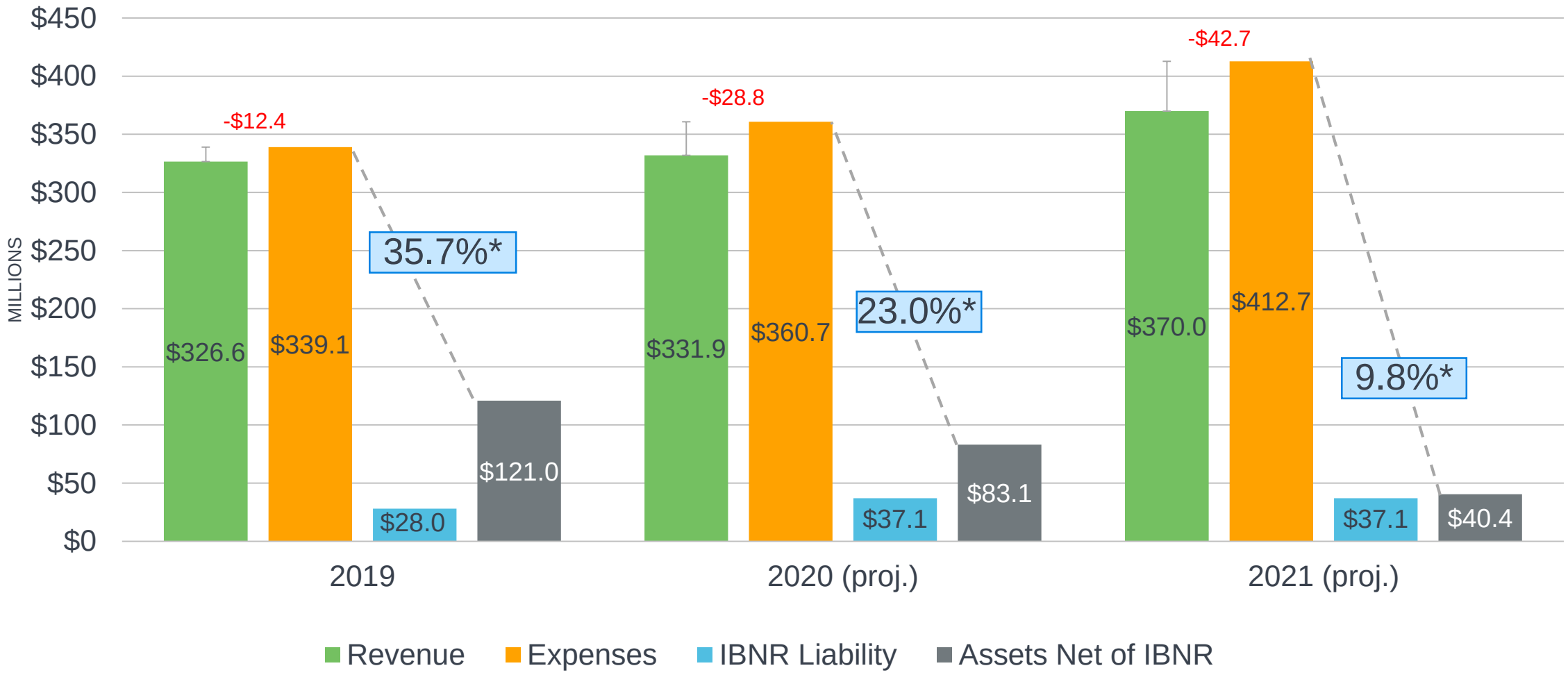
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
			Assets
(a)	2019	End-of-Year Gross Assets	$149.0
(b)	2020	Allocation of Prior Years' Surplus	($25.3)
(c)		Total Surplus / (Deficit)	($3.5)
(d) = (a) + (b) + (c)		End-of-Year Gross Assets Available	$120.2
(e)		Incurred but not reported (IBNR)	($37.1)
(f) = (d) + (e)		End of Year Net Assets Available	$83.1
(g)	2021	Allocation of Prior Years' Surplus	($15.5)
(h)		Total Surplus / (Deficit)	($27.2)
(i) = (d) + (g) + (h)		End-of-Year Gross Assets Available	$77.5
(j)		Incurred but not reported (IBNR)	($37.1)
(k) = (i) + (j)		End of Year Net Assets Available	$40.4

End of Year Assets Net of IBNR



Change in Revenue, Expenses, and Assets



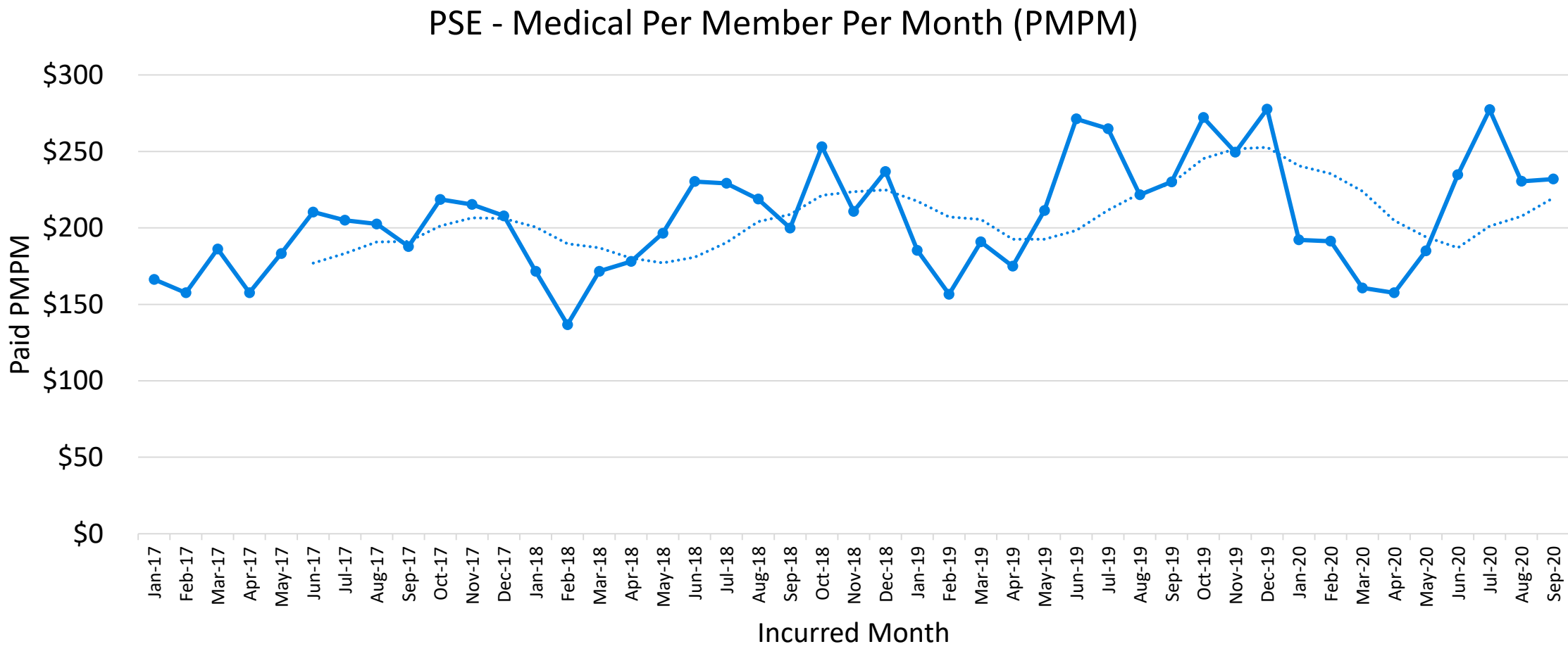
* Assets Net of IBNR as a portion of Expenses

Early 2022 Snapshot

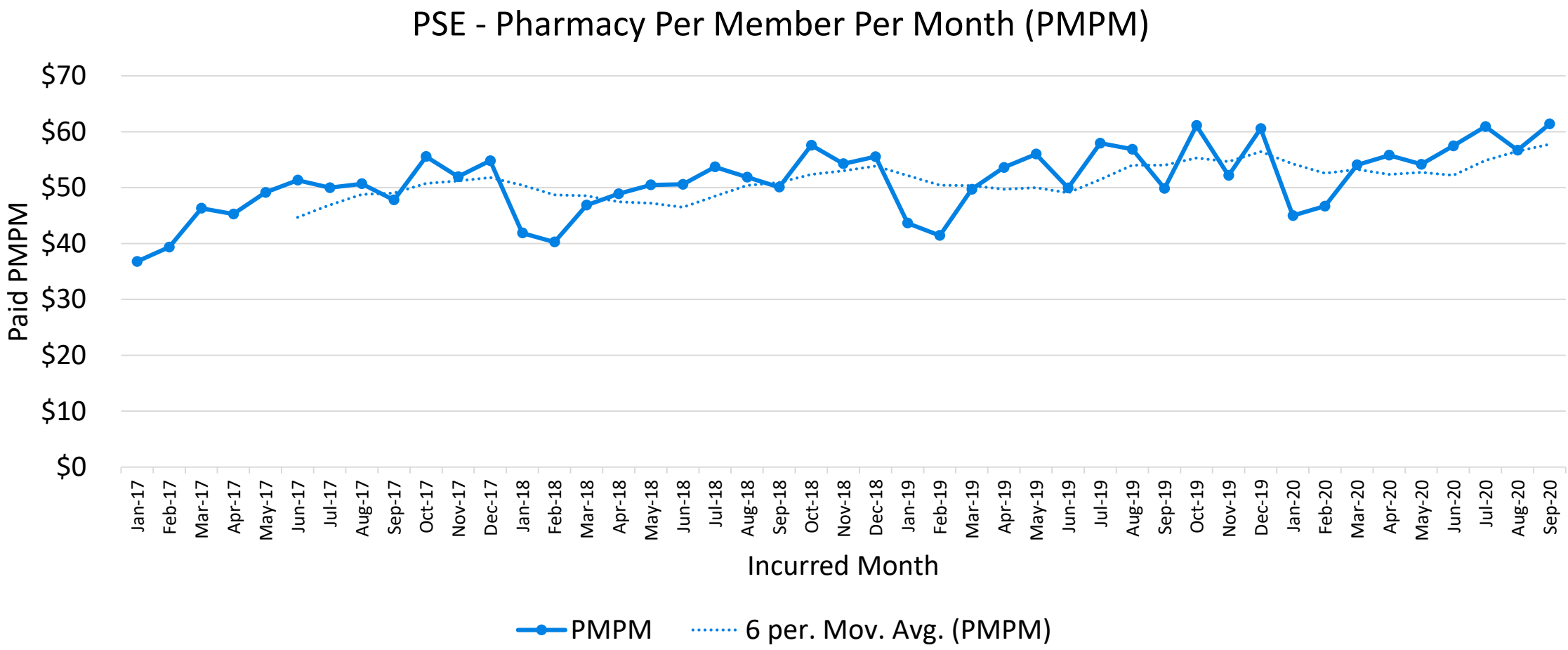
Funding		2022
PPE Funding	$	112.21
Employee Contribution		142.56
Dept of Ed Funding		108.10
Other		15.89
Total Income	$	378.77
Medical Claims	$	(345.62)
Pharmacy Claims		(82.46)
Administration Fees		(30.09)
Plan Administration		(2.80)
Total Expenses	$	(460.96)
Program Savings	$	5.68
Net Income / (Loss) Before Surplus Allocation	$	(76.51)
Allocation of Prior Years' Surplus	$	7.10
Net Income / (Loss) After Surplus Allocation	$	(69.41)

- 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%

Monthly Trend - Medical

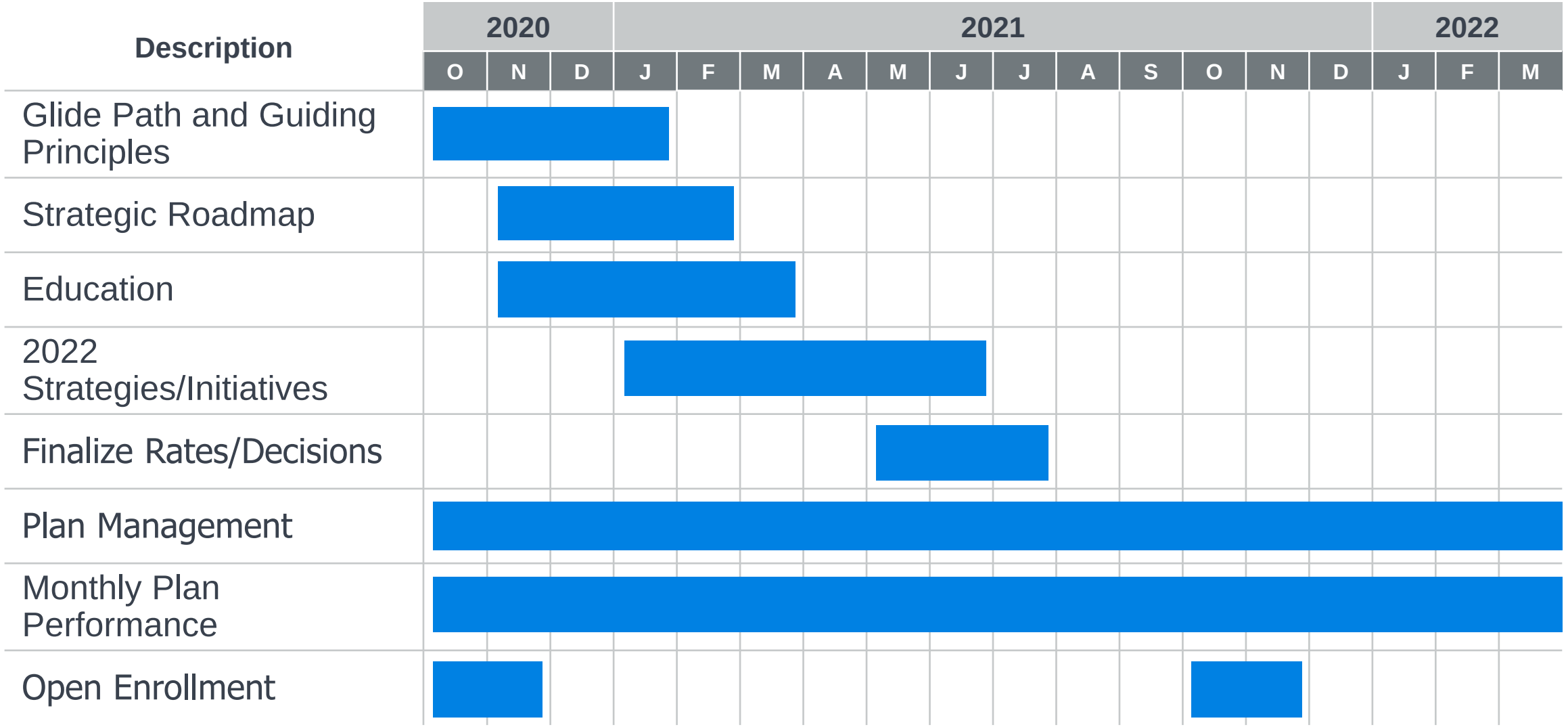


Monthly Trend - Pharmacy

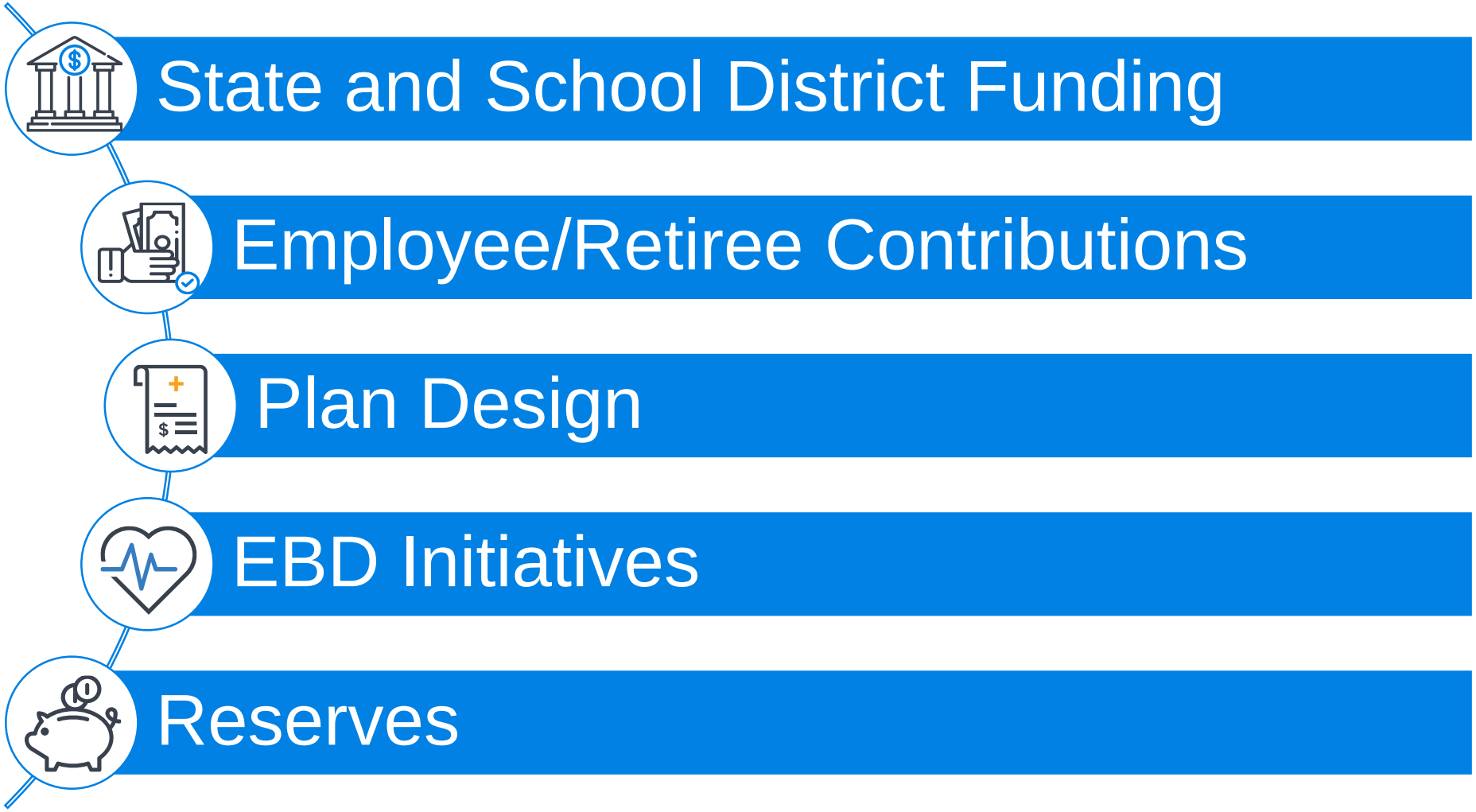


2020 and Beyond Roadmap

Timeline: Gantt chart

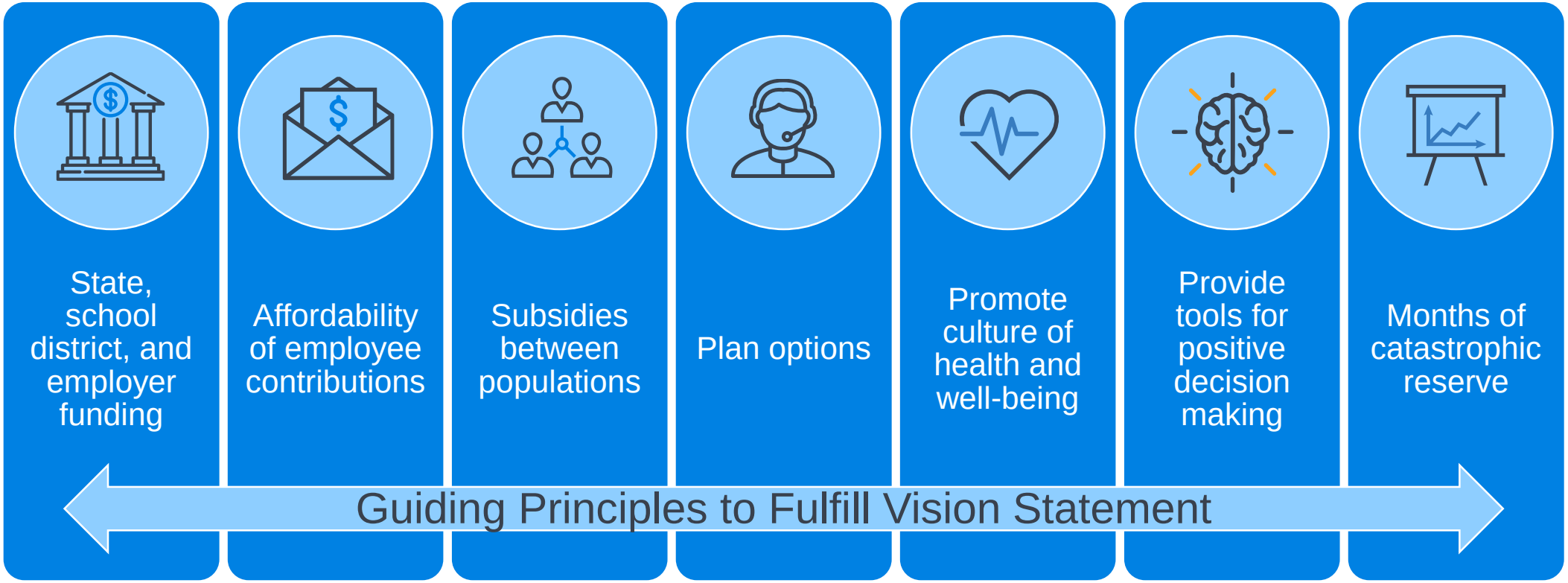


Budget Levers



Guiding Principles - *ILLUSTRATION*

Vision Statement:



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Thank you

Courtney White, FSA, MAAA

Assumptions & Methodology

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 October 2020
  - Projected November – December 2020 based on historical patterns
- Program Savings
  - 2021 program savings estimated to be $7.5 million for ASE and $5.5 million for PSE
- 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 claims incurred from March 1, 2019 to February 29, 2020 and paid from March 1, 2019 to November 30, 2020. Medical claims are gross of withholds. Reports reflects the timing of when EBD is expected to pay the withhold.
2. Summarized fee-for-service (FFS) pharmacy claims incurred from October 1, 2019 to September 30, 2020 and paid from October 1, 2019 to November 30, 2020.
3. Converted the paid and incurred claims to incurred claims using completion factors. This incorporates the incurred but not reported (IBNR) claim reserve.
4. Summarized member months for March 1, 2019 to February 29, 2020 (medical) and October 1, 2019 to September 30, 2020 (pharmacy).
5. Divided the summarized incurred claims by the appropriate member months to calculate PMPMs.
5. 2020 Projected the incurred claims for November 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 (December 1, 2020). Utilize actual claims for January 2020 to October 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 Fellows of the Society of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render actuarial 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 budgets relied on historical ASE and PSE medical and pharmacy claims from ABCBS and MedImpact, respectively; funding and plan administration from EBD; historical ASE and PSE members by benefit plan, age/gender, and by month from EBD; 2019, 2020, and 2021 ASE and PSE benefit plan summaries from EBD; 2020 and 2021 fees and administrative expenses from EBD: conversations with EBD regarding the program, and actuarial judgment.

While we reviewed the ABCBS, MedImpact, 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. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

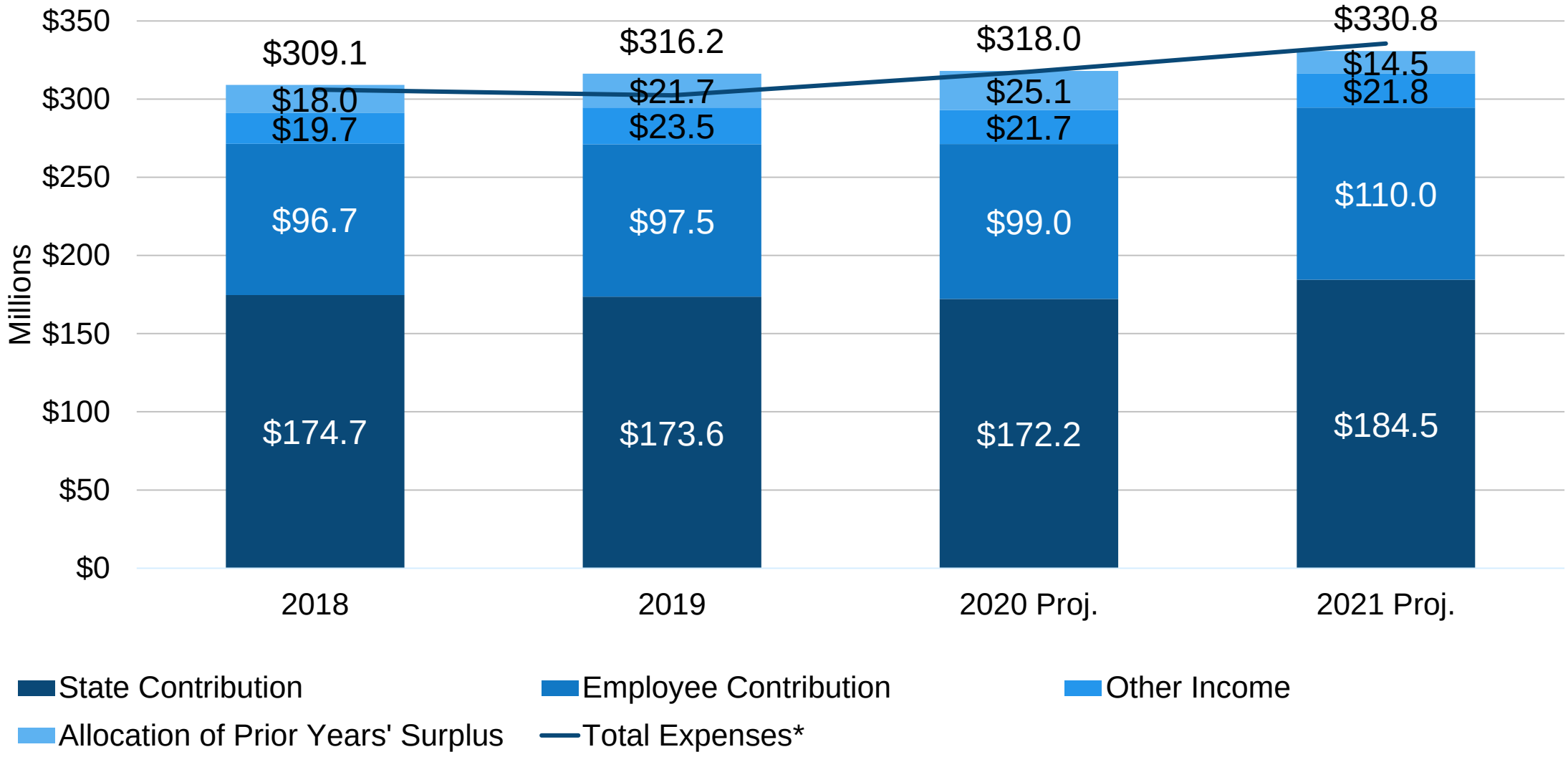
Any reader of this report should possess a certain level of expertise in areas relevant to this analysis to appreciate the significance of the assumptions and the impact of these assumptions on the illustrated results. The reader should also be advised by their own actuaries or other qualified professionals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

The terms of Milliman's Consulting Services Agreement as a subcontractor to Health Advantage, an affiliate of ABCBS, for the State of Arkansas dated October 29, 2019 apply to this email and its use.

This presentation has been provided for the internal use of the management of the State of Arkansas Employee Benefits Division for setting the ASE and PSE budget for CY2020 and CY2021. The information contained in this presentation is confidential and proprietary. This information may not be appropriate for other uses and should not be distributed to or relied on by any other parties without Milliman's prior written consent. We do not intend this information to benefit any third party even if we permit the distribution of our work product to such third party. If this analysis is distributed internally or to a third party, we request that it be distributed in its entirety.

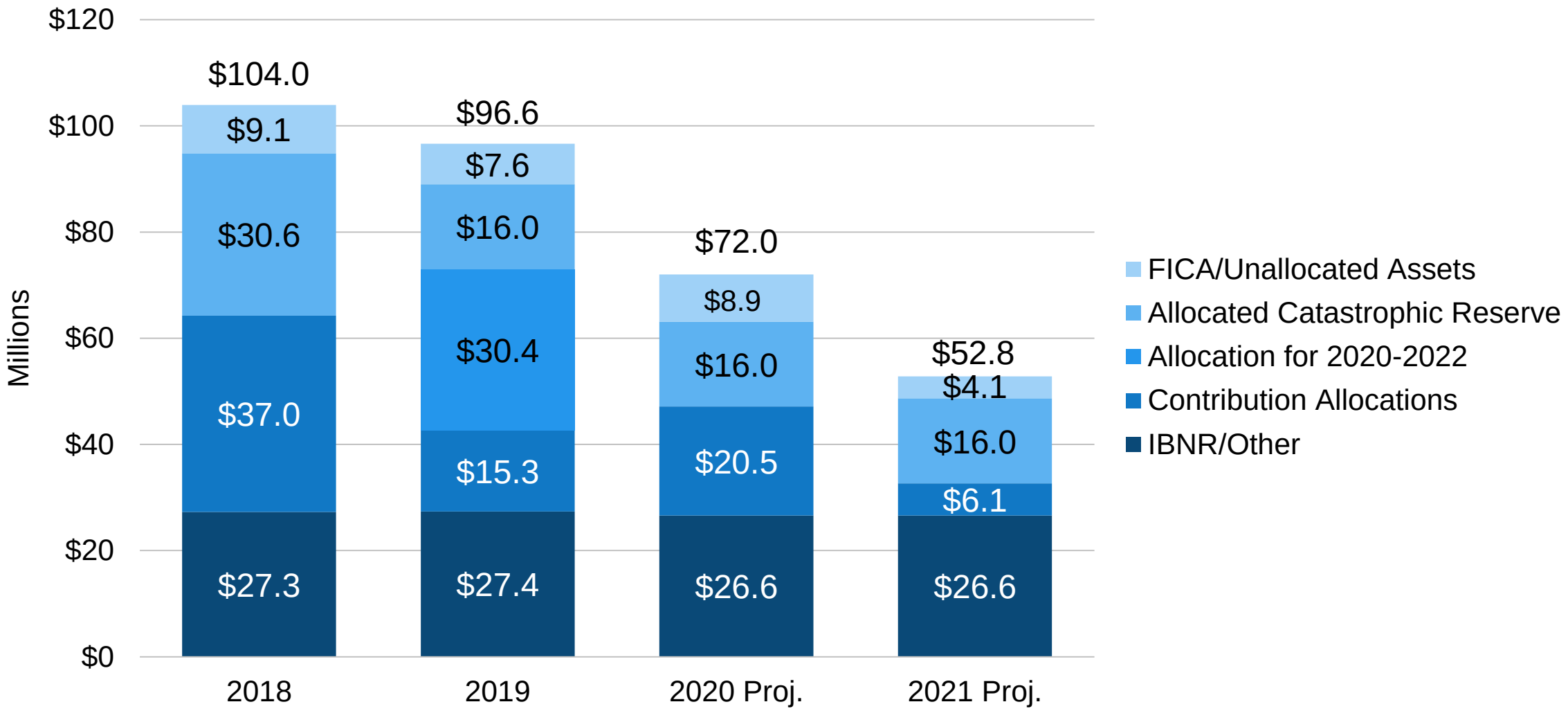
Appendix

ASE - Income vs. Expenditure



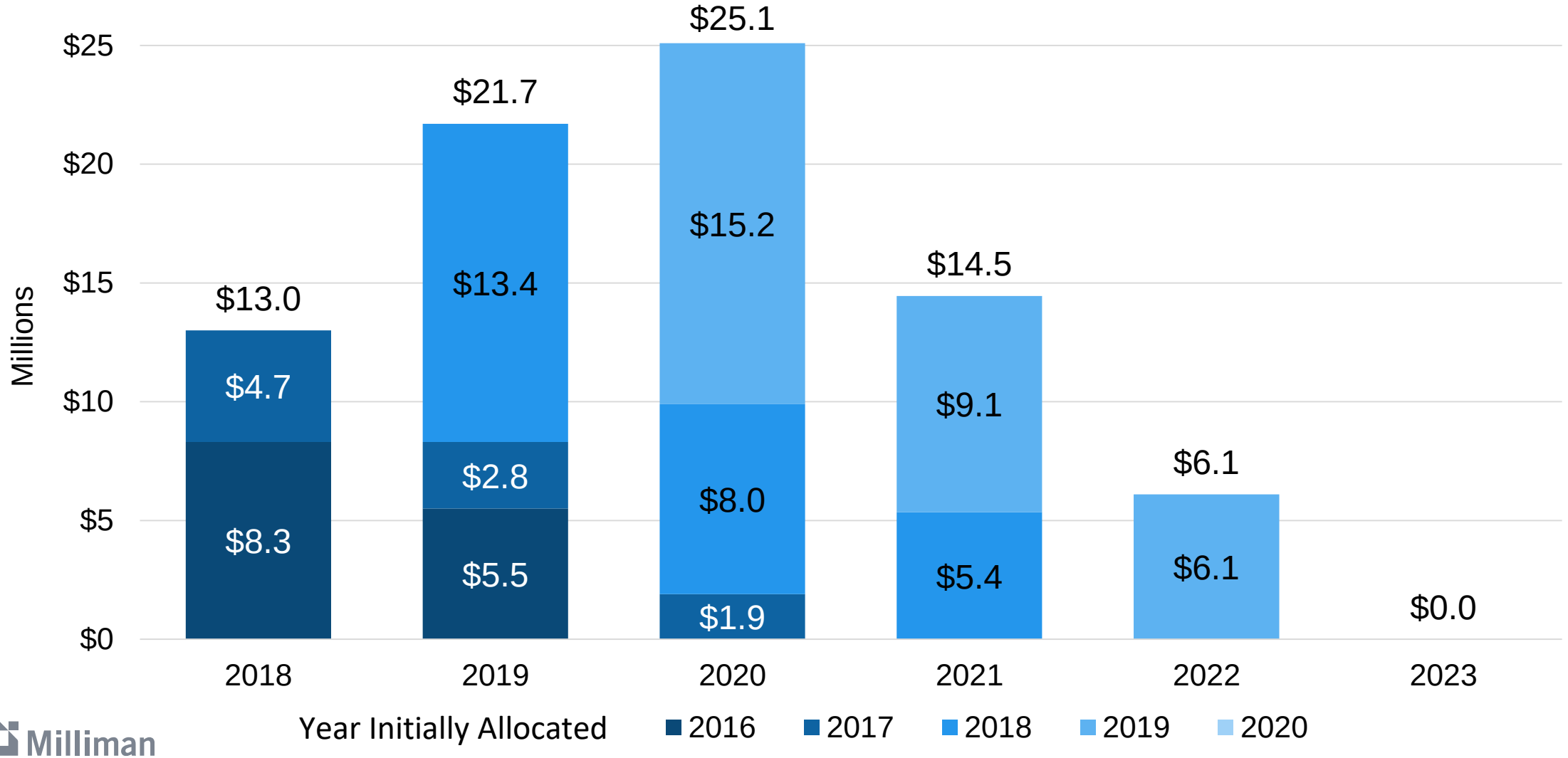
* Total Expenses offset by Program Savings

ASE - End of Year Assets

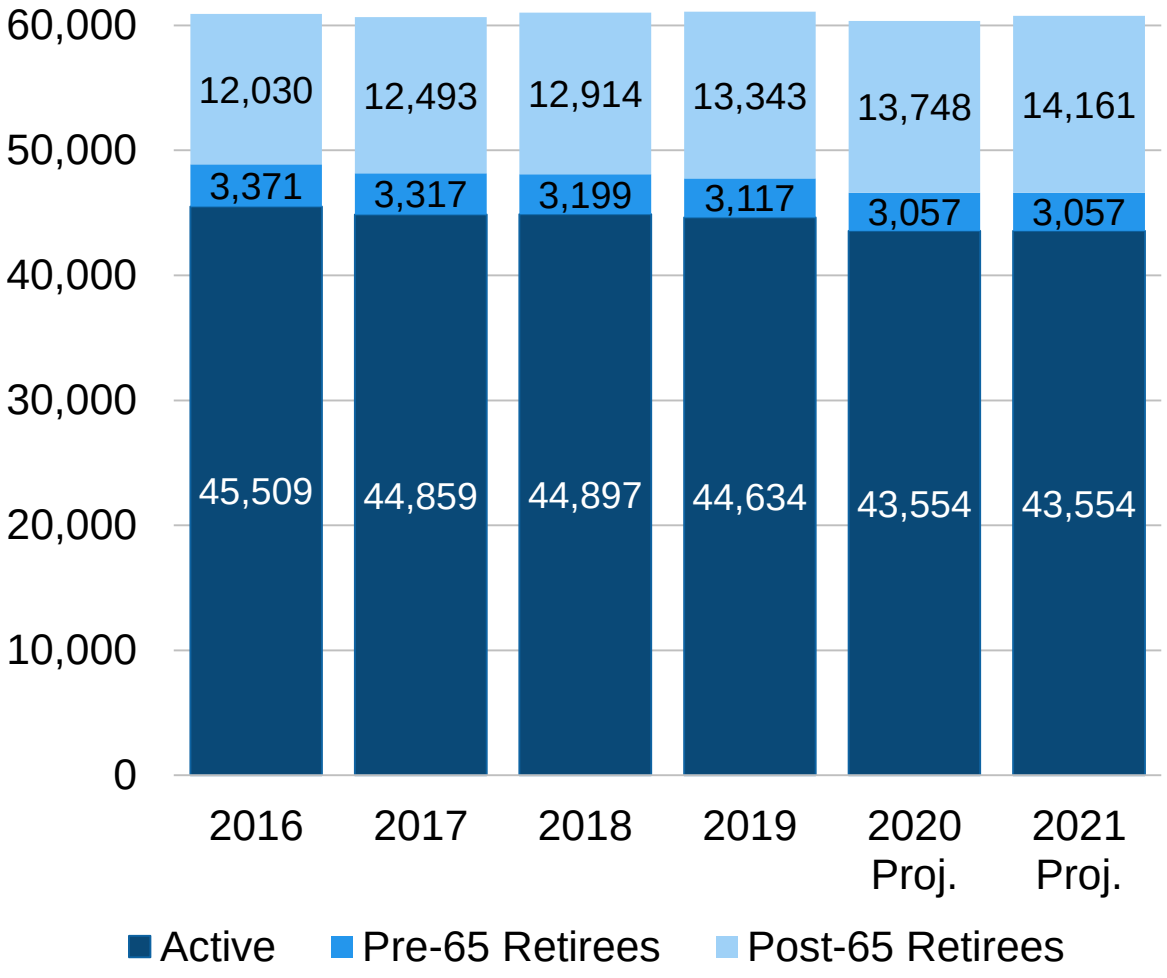


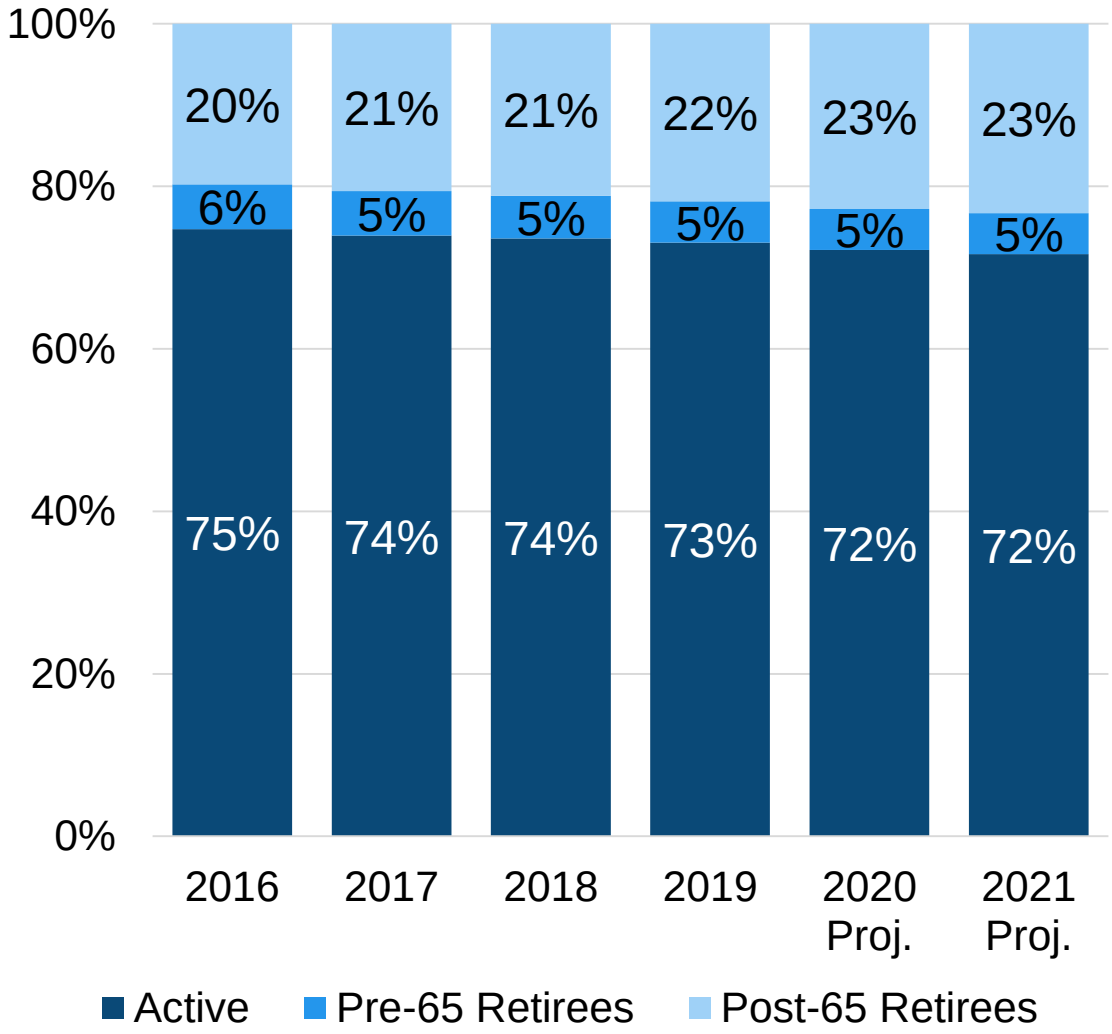
ASE - Surplus Allocation by Year

The chart represents the surplus amounts allocated each year (in millions), and how much prior years' surplus is available each year.

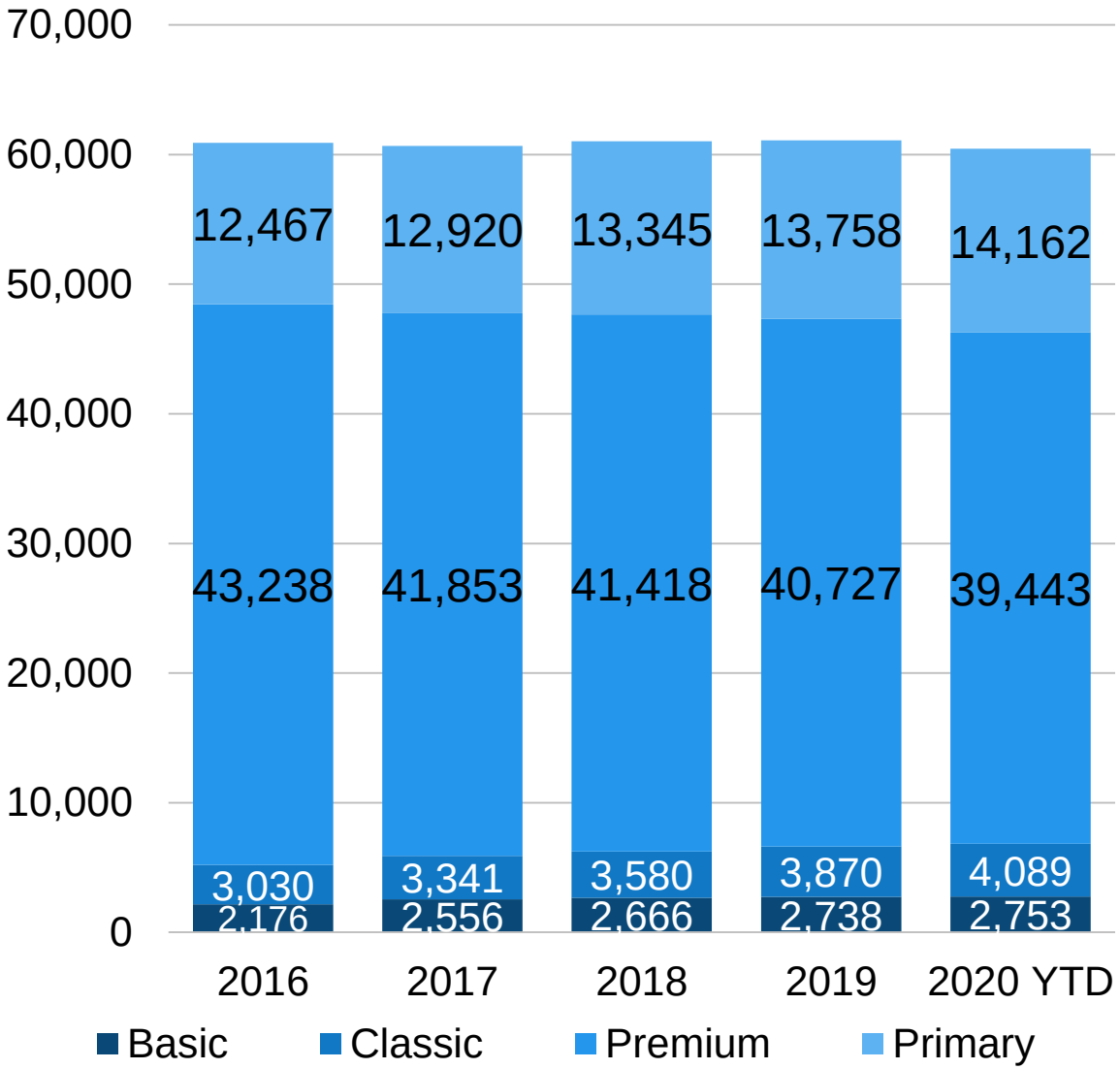


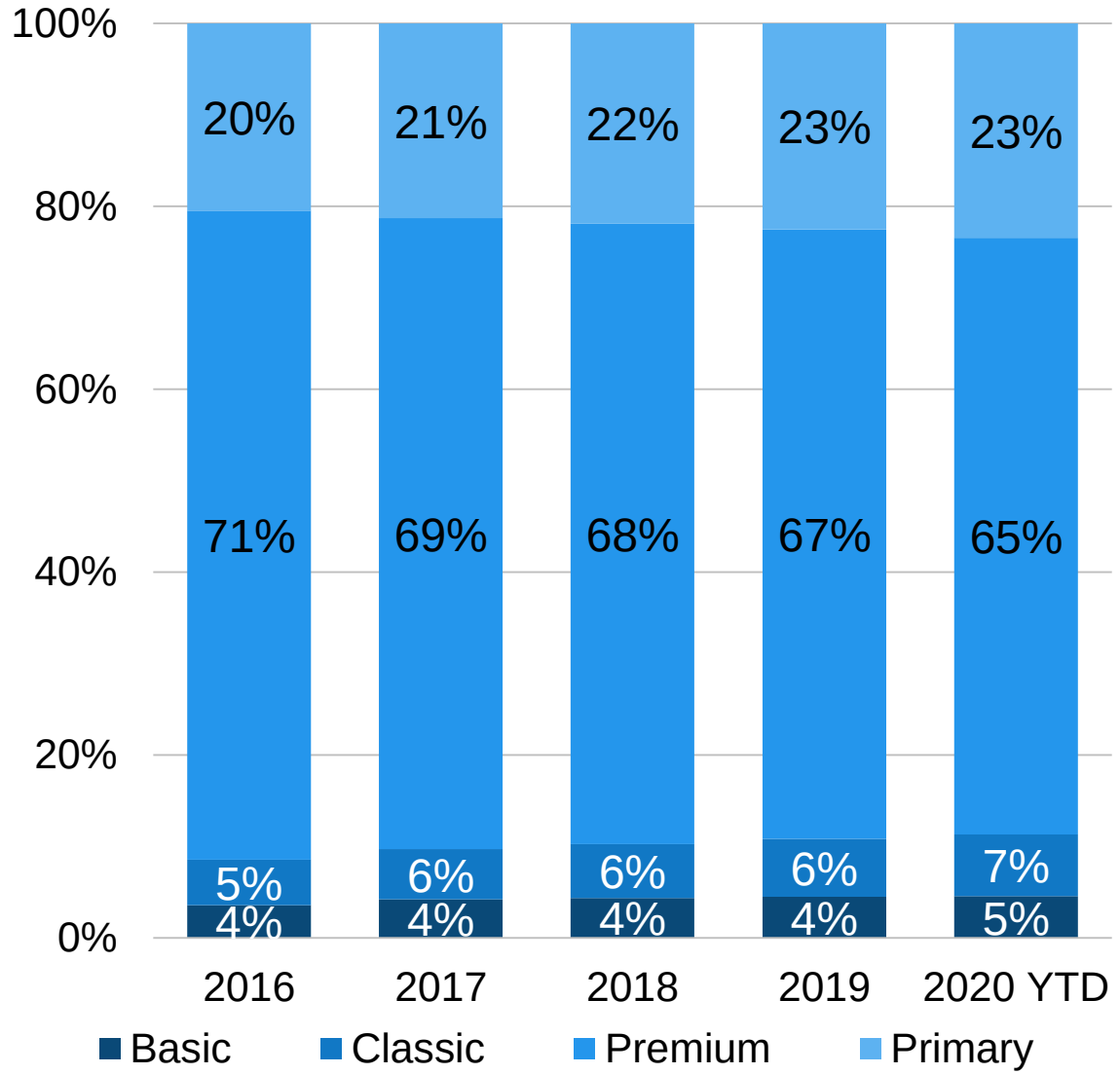
ASE - Average Membership by Status



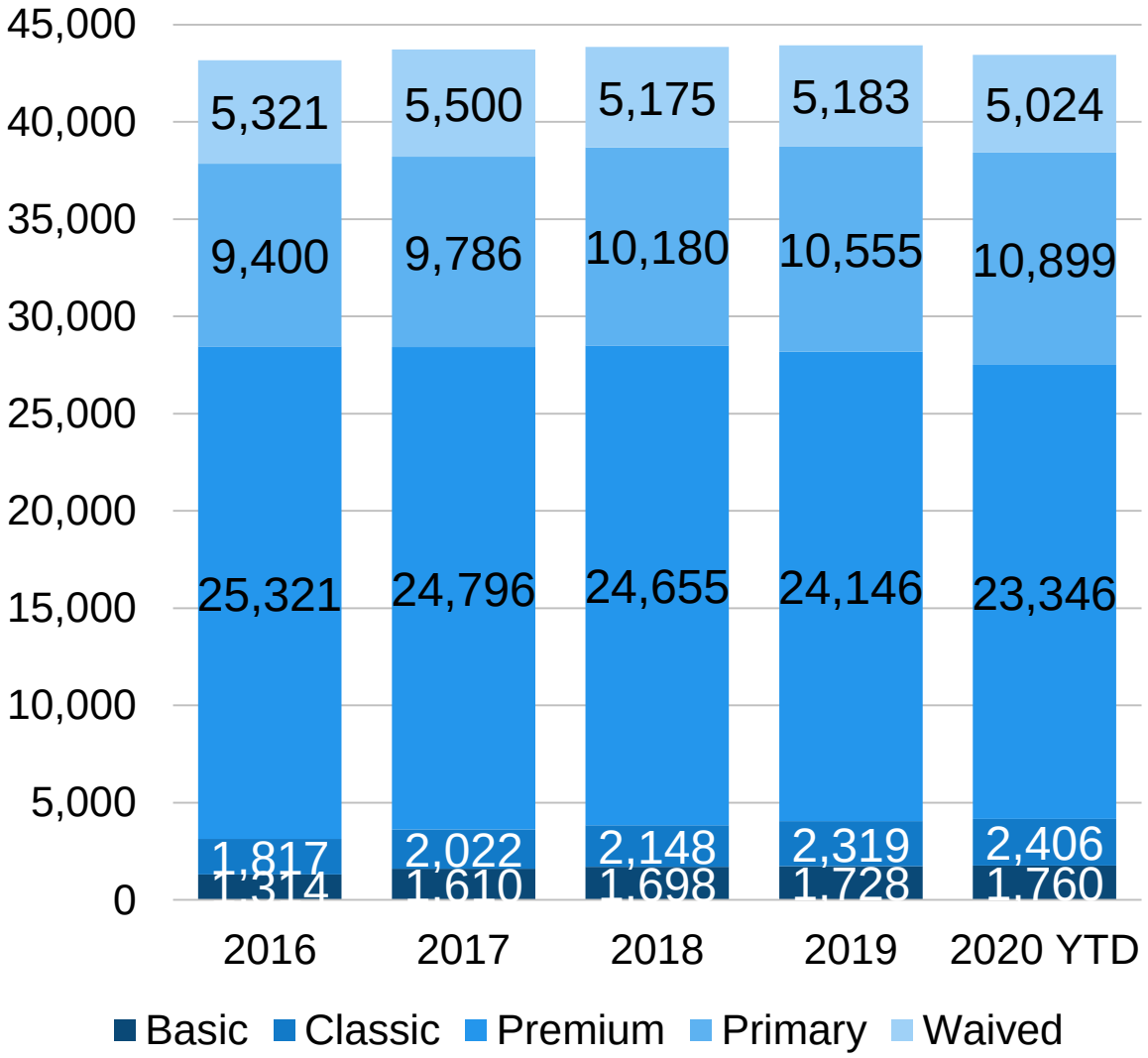


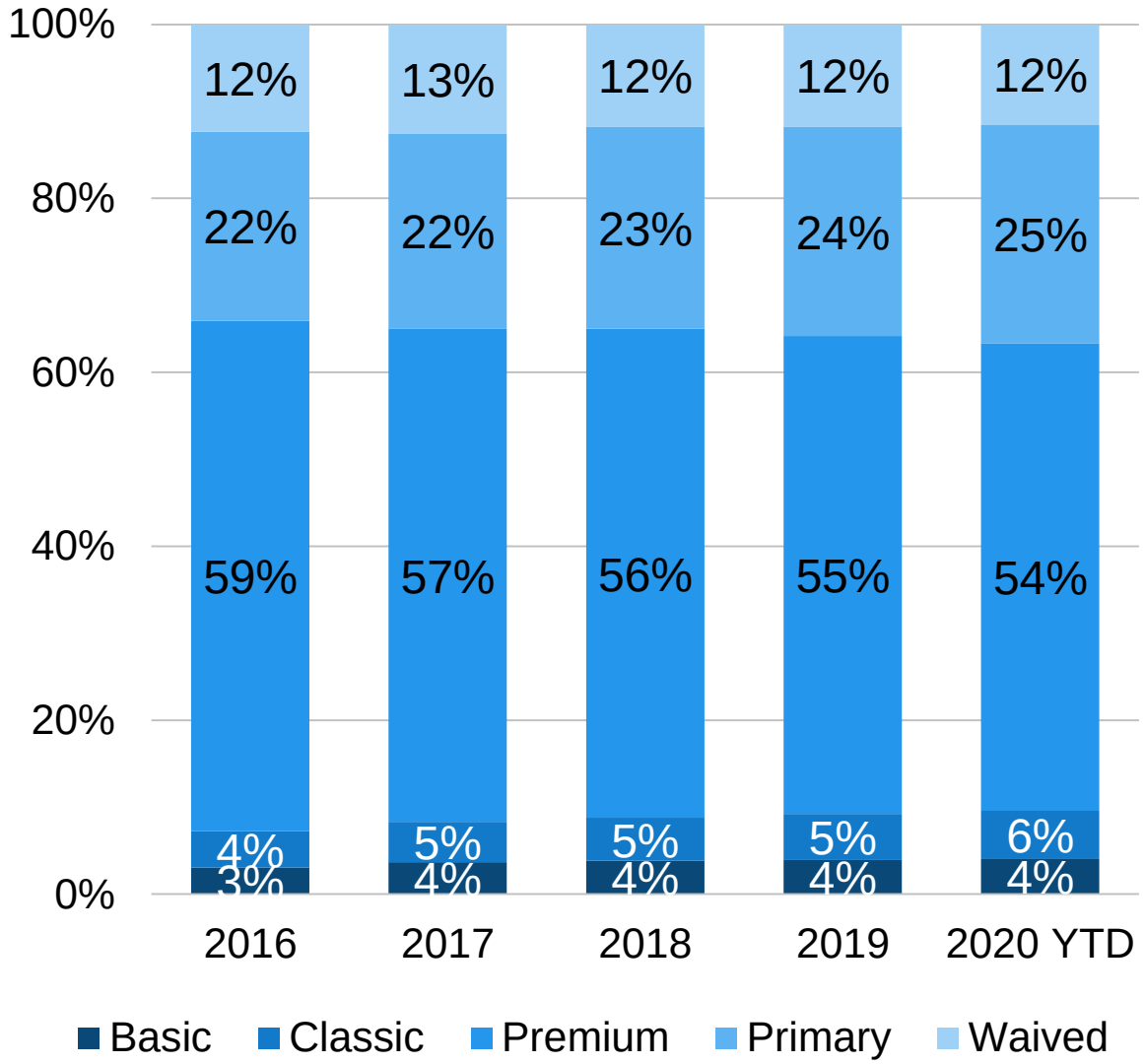
ASE - Average Membership by Plan





ASE - Average Enrollment (Subscribers) by Plan





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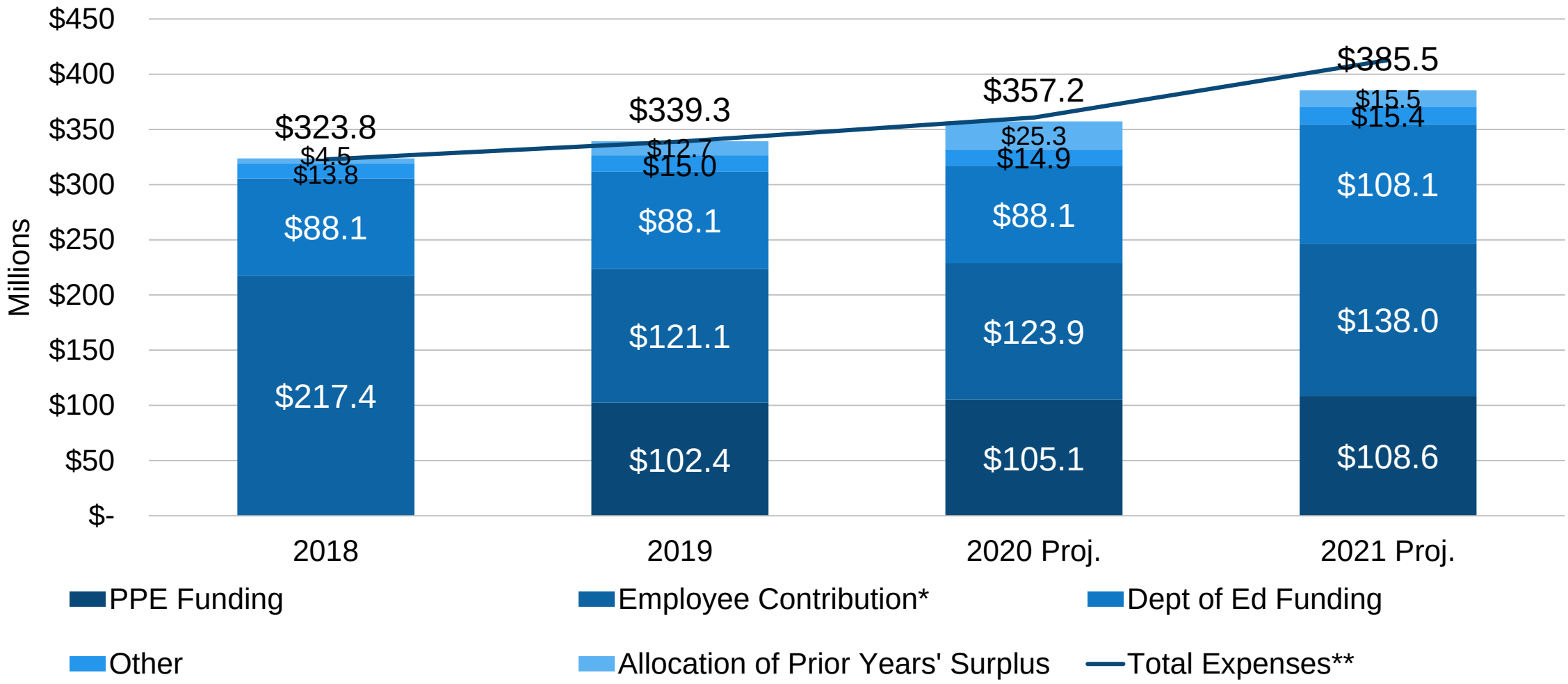
PSE - Income vs. Expenditure



* 2018 Employee Contribution includes PPE Funding

** Total Expenses offset by Program Savings

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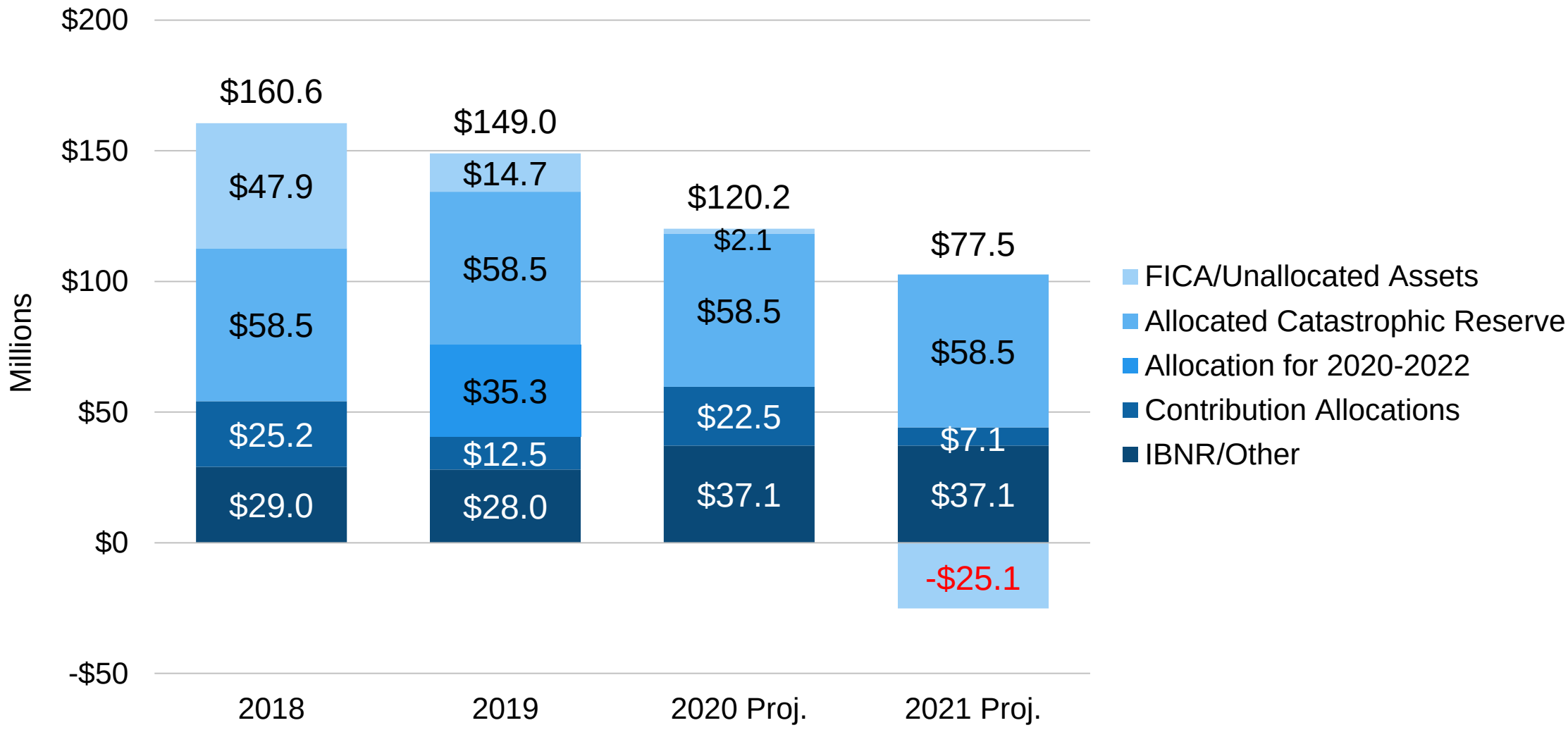
PSE - End of Year Assets



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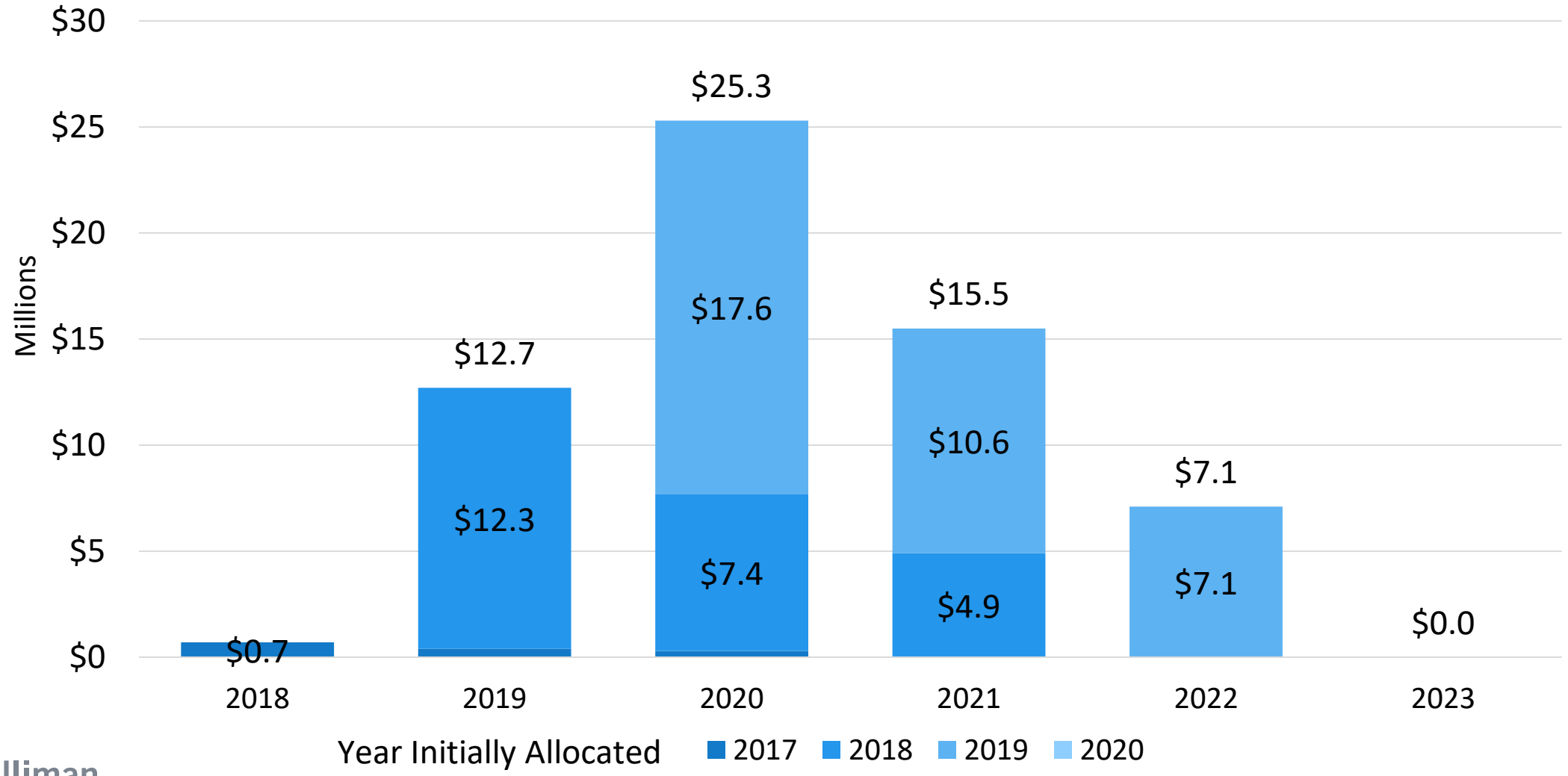
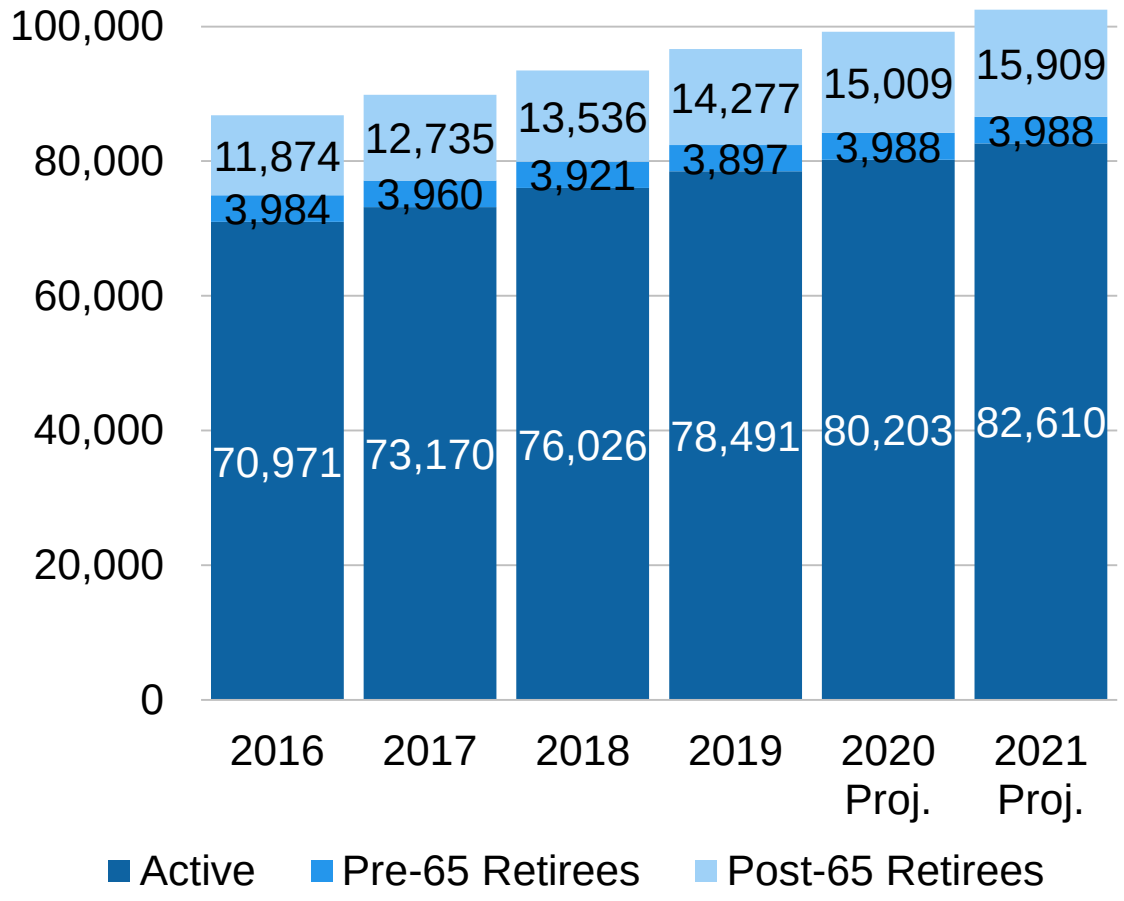
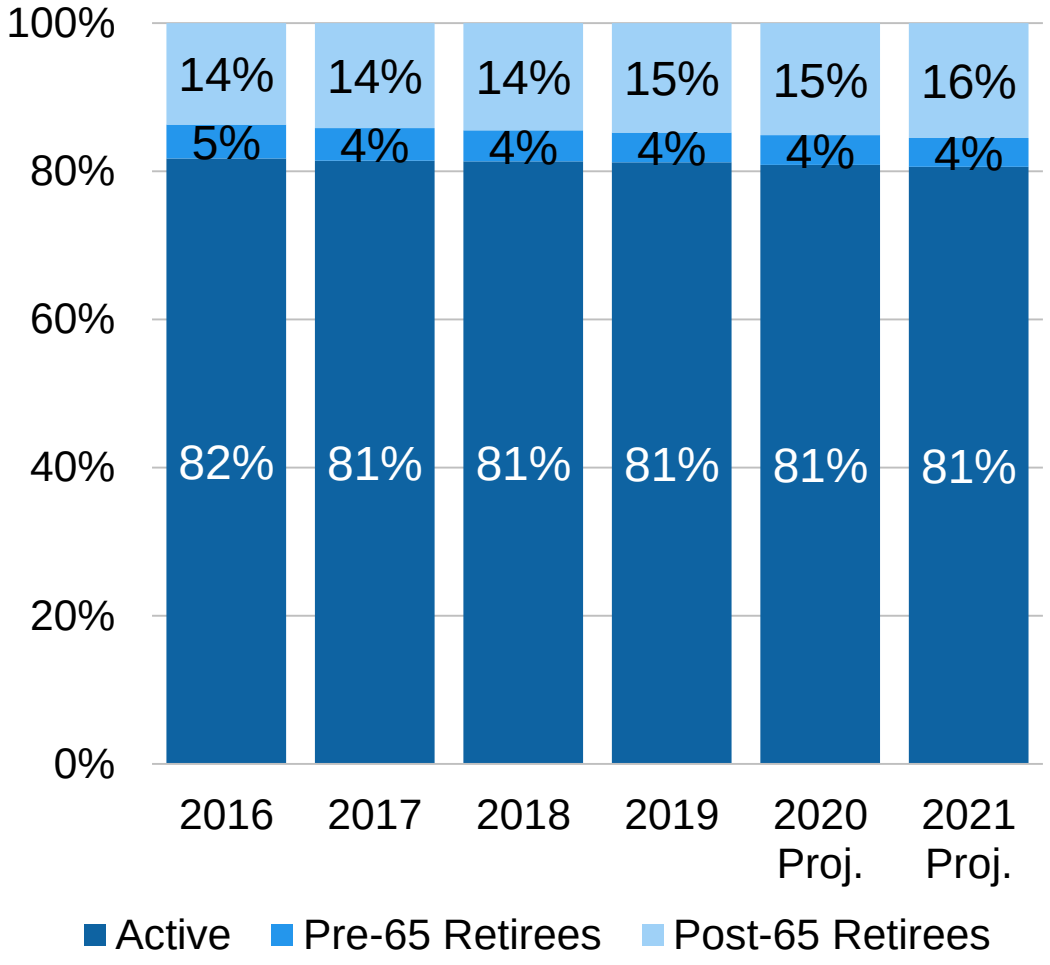
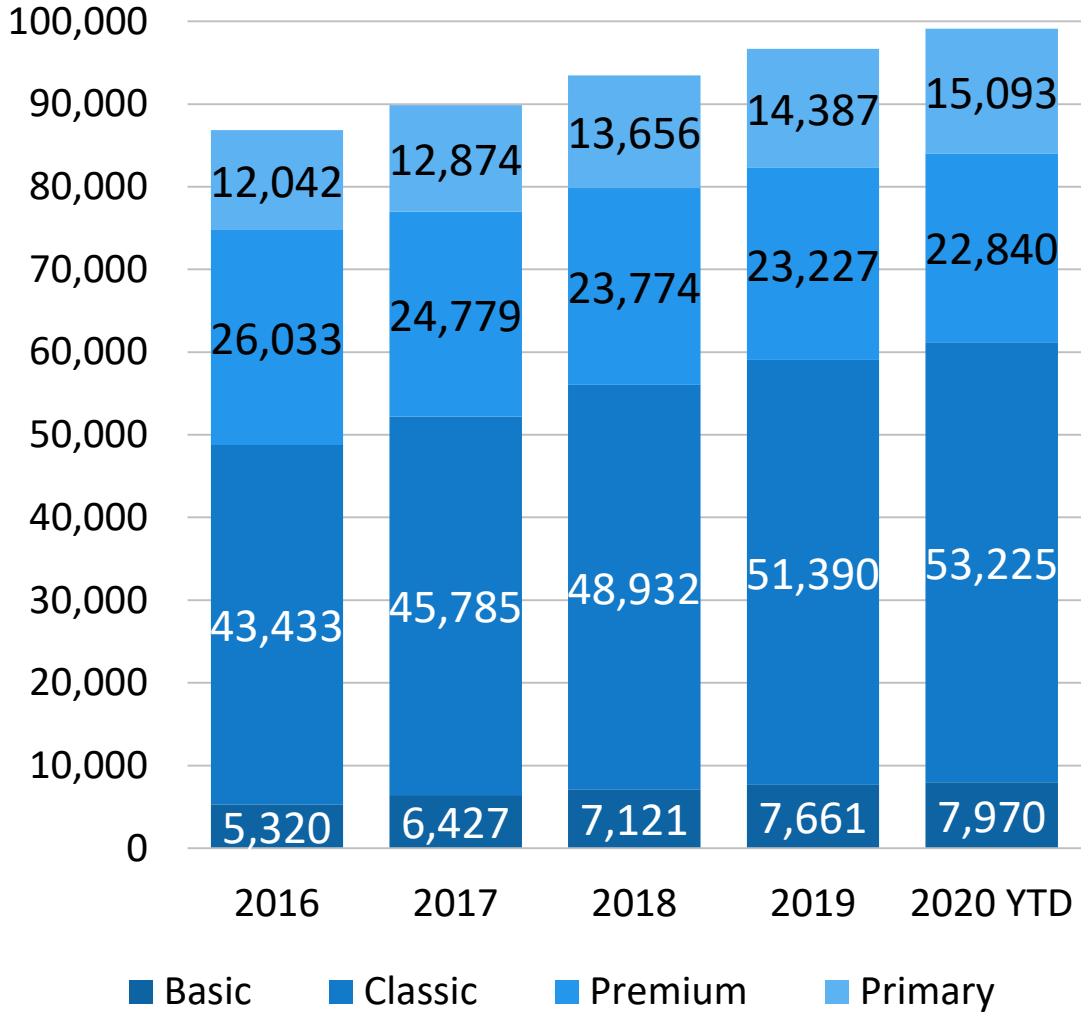


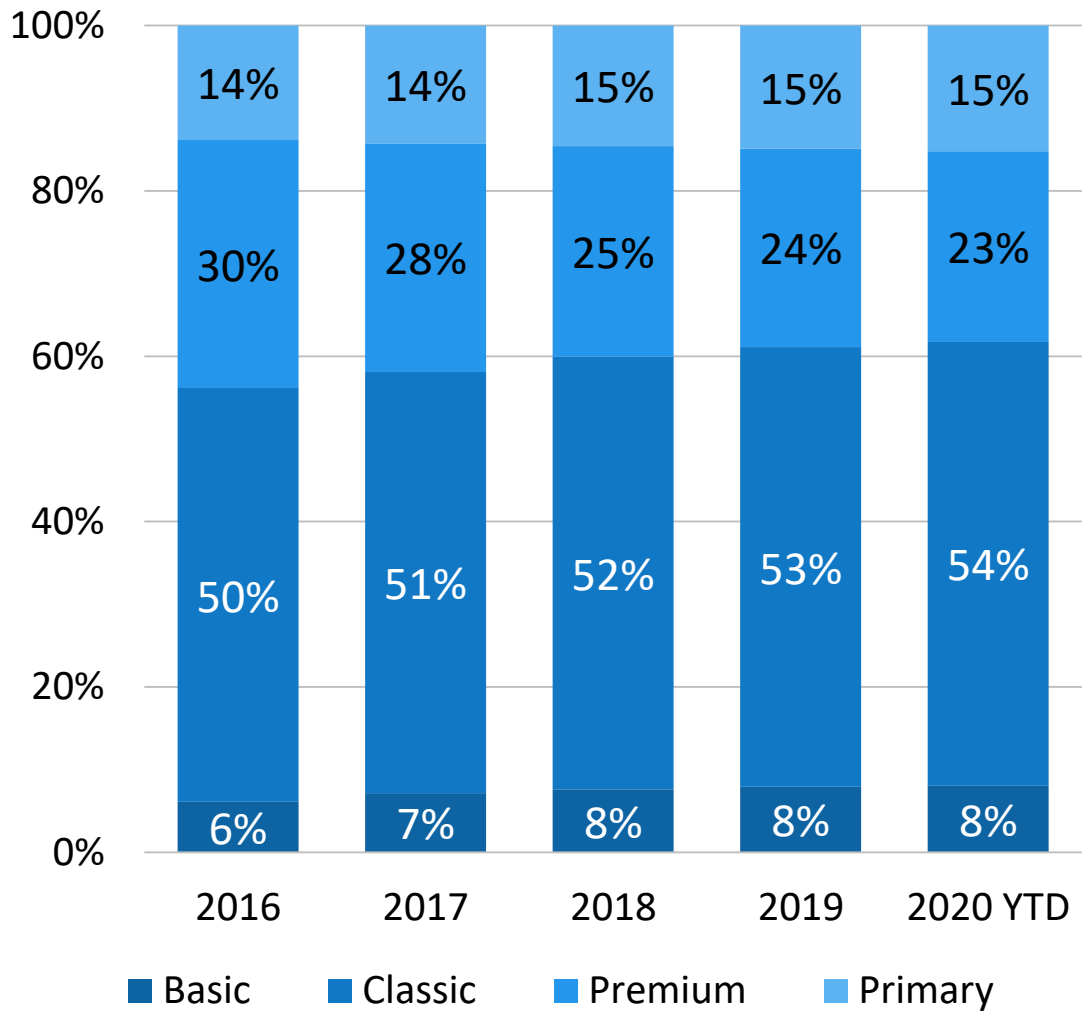
PSE - Average Membership by Status



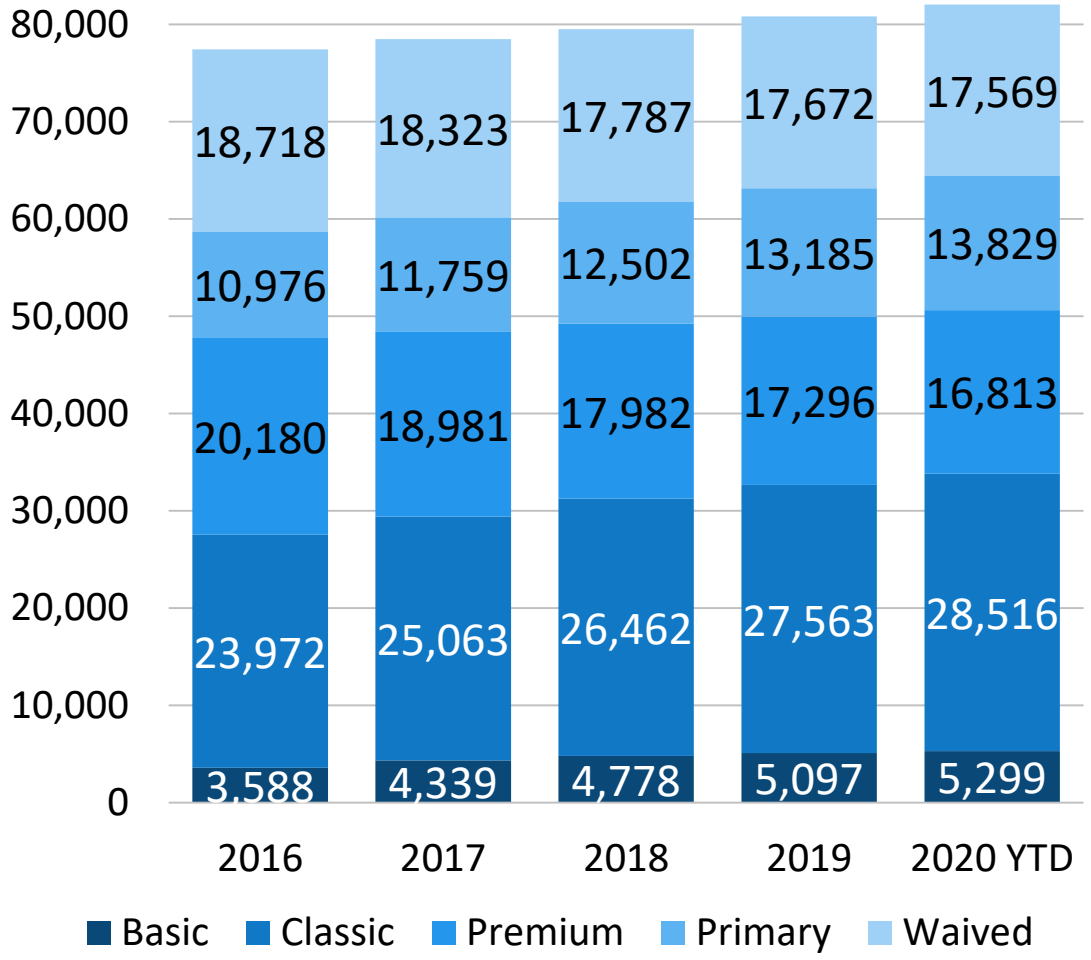


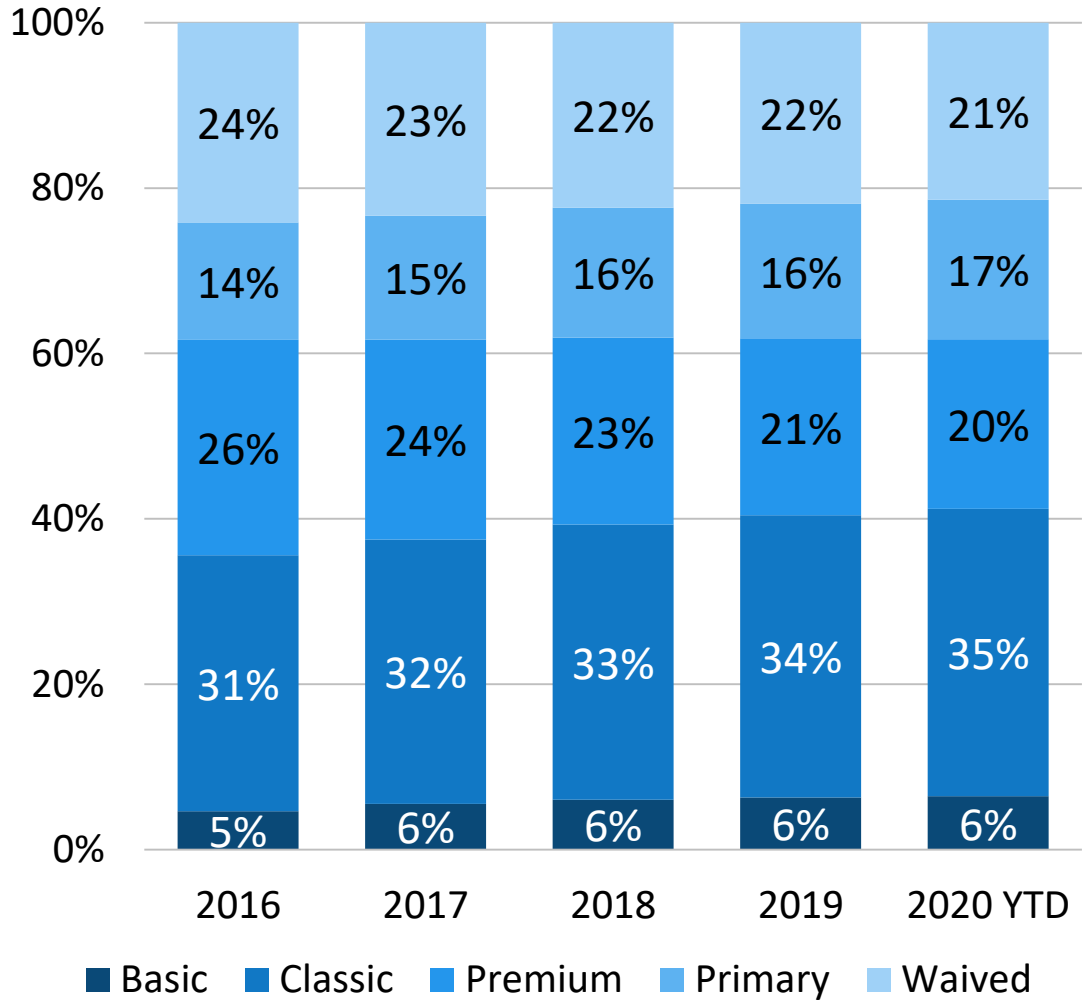
PSE - Average Membership by Plan





PSE - Average Enrollment (Subscribers) by Plan





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

The following report resulted from a meeting of the Benefits Sub-Committee. There was not a Quality of Care meeting for December.

Topics Discussed:
- Approval of Minutes
- Follow-up Analysis by ACHI
- Trend Experience by Milliman
- Director's Report

Follow-up Analysis: Elizabeth Montgomery & Mike Motley, ACHI
Montgomery and Motley presented analyses regarding COVID-19 impact on the plan and reviewed 2019-2020 influenza season impacts on the plan.

Plan Update: Paul Sakhrani and Courtney White, Milliman
White and Sakhrani provided an update on the Plan experience for ASE and PSE and presented a 2020 and beyond roadmap.

ASE

- 2020 & 2021 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through November 2020 and pharmacy claims data incurred from October 2019 to September 2020 and paid through November 2020.
- 2020 projected Plan experience
    - Allocated reserves for 2020 is $25.1M
    - Estimated surplus of $500K
    - End of Year Assets: $72.0M
    - 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: $4.8M
    - End of Year Assets: $52.8M
    - Reflected 2021 program initiatives
    - Increased membership based on historical patterns
    - Baseline trends (medical: 5%, pharmacy: 8%)
    - September 29, 2020 Board action

PSE

- 2020 & 2021 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through November 2020 and pharmacy claims data incurred from October 2019 to September 2020 and paid through November 2020.
- 2020 Plan experience
    - Allocated reserves for 2020 is $25.3M
    - Estimated deficit of $3.5M
    - End of Year Assets: $120.2M
    - 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: $27.2M
    - End of Year Assets: $77.5M
    - Reflected 2021 program initiatives
    - Increased membership based on historical patterns
    - Baseline trends (medical: 7%, pharmacy: 8%)
    - September 29, 2020 Board action

Director's Report: Shalada Toles, EBD Deputy Director

Toles provided a brief overview of how EBD is ending the year. We have about 78% of the membership who have met the wellness discount, with 22% who have not. In comparison, last year we had 85% who met the wellness requirements and 15% who did not. Based on the Board decisions to allow our Medicare retiree members to opt out of our drug coverage, the last count this morning was 212 members that have opted to do that. We allowed members to make that decision up to December 7th while the Medicare open enrollment was still going on.

DECEMBER 2020
EBD BOARD PRESENTATION

Mike Motley, MPH

Director, Analytics

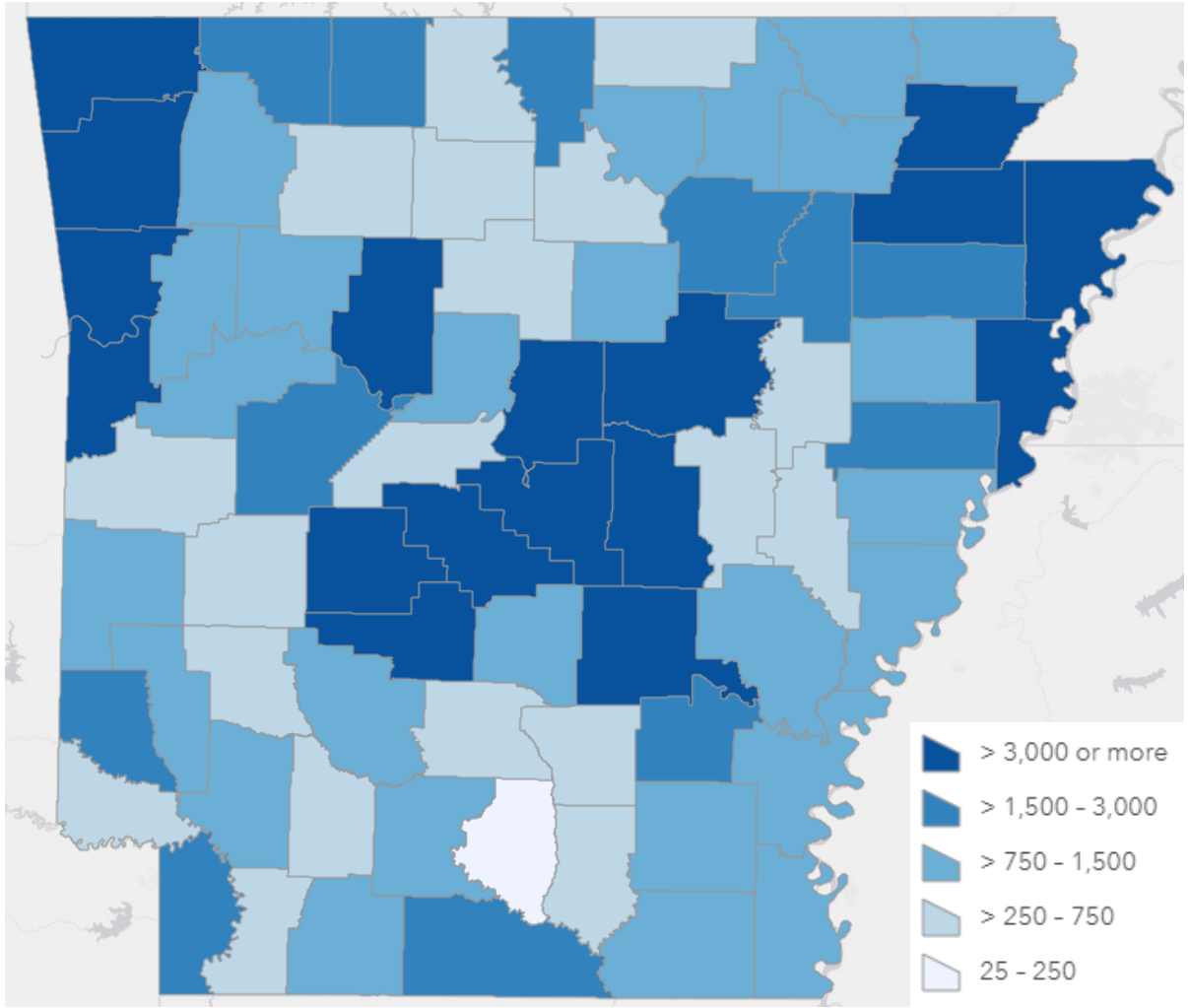
12.16.2020

ACHI
INSPIRING HEALTHY ACTS

OBJECTIVES

- Present updated analyses regarding COVID-19 impact on plan

COVID-19 IN ARKANSAS



Total Cases: 189,198

Total Active Cases: 20,690

Hospitalized: 1,070

On Ventilators: 190

Total Deaths: 3,016

Source: Arkansas Department of Health, as of Dec. 15

COVID-19 IN ARKANSAS: SINCE DEC. 1

- Hospitalizations
  - Dec. 2: Most currently hospitalized patients **(1,088)**
- New Cases
  - Dec. 4: Largest single-day increase **(2,827)**
- Deaths
  - Dec. 11: Most deaths reported in one day **(55)**
- Active Cases
  - Dec. 13: Highest active total since pandemic began **(21,489)**

Source: Arkansas Department of Health, as of Dec. 15

COVID-19 ANALYSES

- Data from March 16–November 23, 2020
- Estimated total members ever tested: 64,235
- Total with positive test: 7,240 (ASE=3,239; PSE=4,001)
- Total antigen or verbal positive probable infections: 1,726

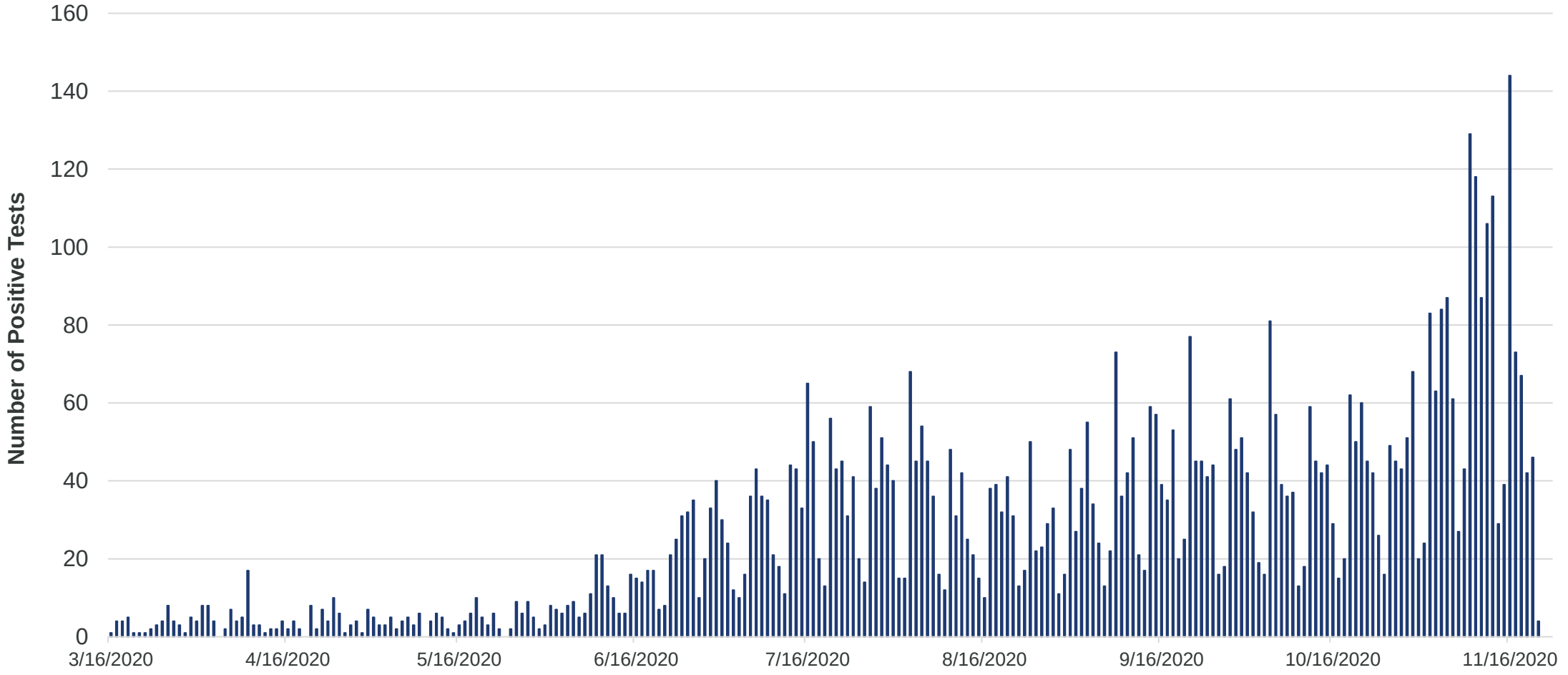
Source: Arkansas Center for Health Improvement based on data from the Arkansas Department of Health, as of Nov. 23

COVID-19 ANALYSES

- Total members ever hospitalized: 410 (ASE=193; PSE=217)
- Total members ever in ICU: 135 (1.9% of positive cases)
- Total members ever intubated: 58 (0.8% of positive cases)
- Deaths: 63

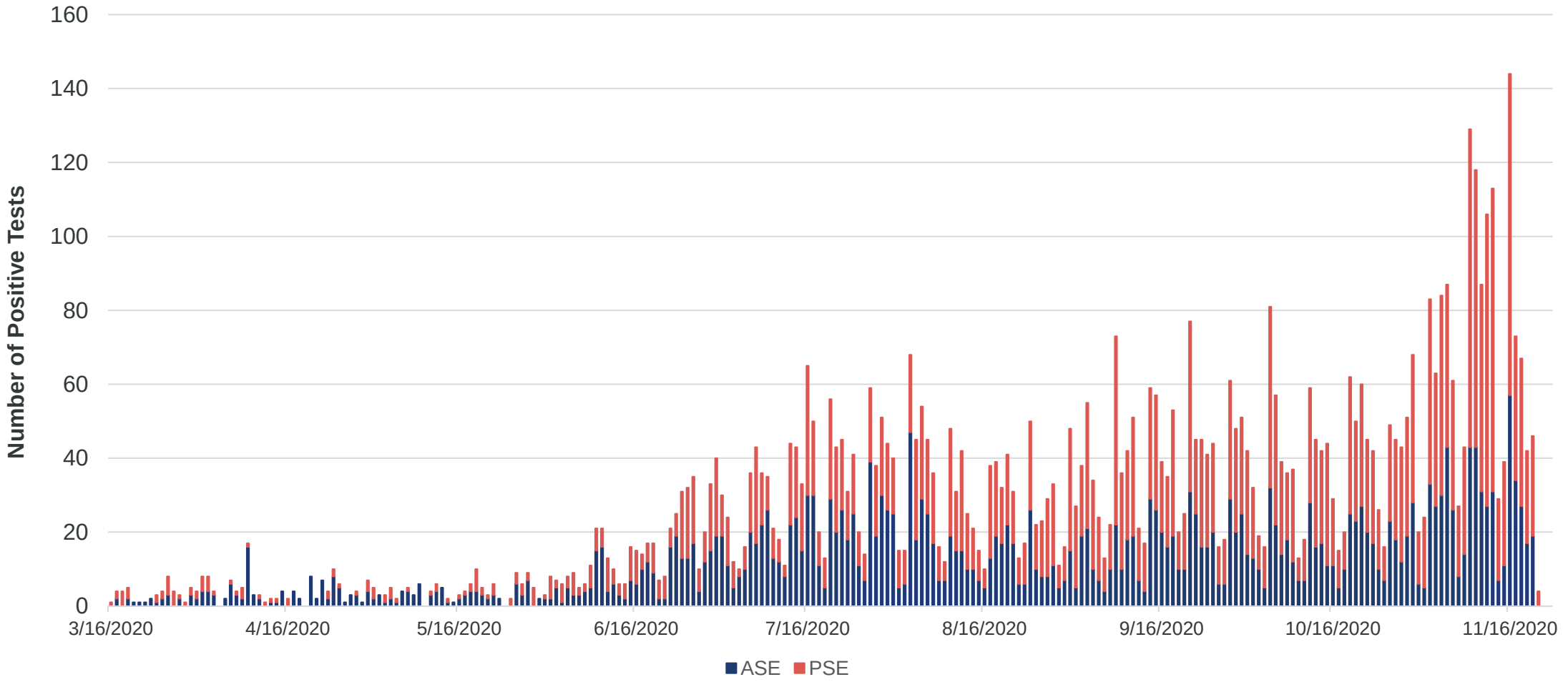
Source: Arkansas Center for Health Improvement based on data from the Arkansas Department of Health, as of Nov. 23

DAILY POSITIVE TEST COUNT — EBD MEMBERS



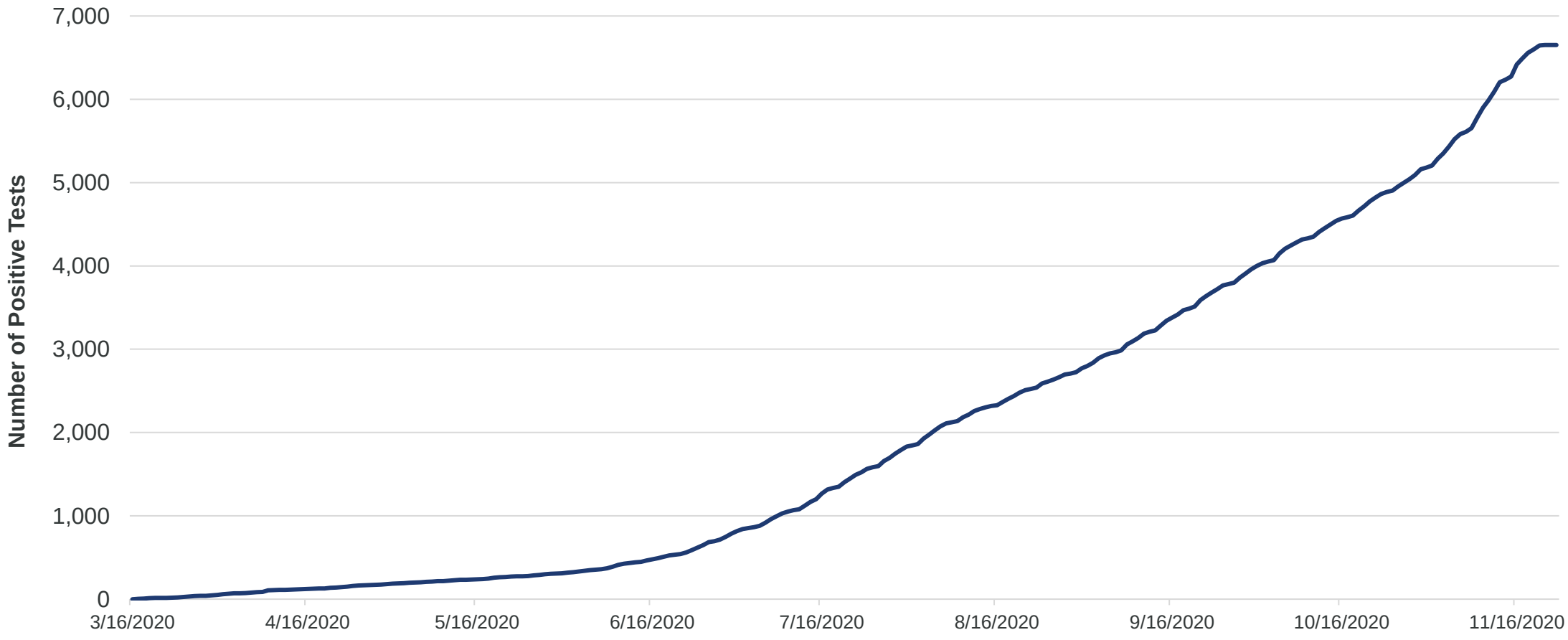
Source: Arkansas Center for Health Improvement based on data from the Arkansas Department of Health, as of Nov. 23

DAILY POSITIVE TEST COUNT BY ASE & PSE



Source: Arkansas Center for Health Improvement based on data from the Arkansas Department of Health, as of Nov. 23

CUMULATIVE POSITIVE TEST COUNT: EBD MEMBERS



Source: Arkansas Center for Health Improvement based on data from the Arkansas Department of Health, as of Nov. 23