AGENDA

State and Public School Life and Health Insurance Board

July 21st, 2020

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I.	*Call to Order*	*Dr. John Kirtley, Vice-Chair*
II.	*Approval of June Minutes*	*Dr. John Kirtley, Vice-Chair*
III.	*DUEC Report*	*Dr. Hank Simmons, DUEC Chair*
IV.	*Quality of Care/Benefits Subcommittee Report*	*Chris Howlett, EBD Director*
V.	*COVID Update*	*Elizabeth Montgomery & Mike Motley, ACHI*
VI.	*Plan Update*	*Paul Sakhrani, & Courtney White, Milliman*
VII.	*Director's Report*	*Chris Howlett, EBD Director*
VIII.	*Adjournment*	*Dr. John Kirtley, Vice-Chair*

2020 Upcoming Meetings:

August 19th, September 22nd, October 20th

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

202nd meeting of the State and Public-School Life and Health Insurance Board (hereinafter called the Board), met on July 21st, 2020, at 1:00 PM via teleconference

Date | *time* 7/21/2020 1:00 PM | *meeting called to order by Dr. John Kirtley, Vice-Chair*

Attendance

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

OTHERS PRESENT:

Rhoda Classen, Theresa Huber, Terri Freeman, Mary Massirer, EBD; Micah Bard, Sherry Bryant, UAMS EBRX; Jessica Akins, Takisha Sanders, Health Advantage; Elizabeth Montgomery, Mike Motley, ACHI; Courtney White, Paul Sakhrani, Scott Cohen, Milliman; Frances Bauman, Novo Nordisk; Sean Seago, MERCK; Sidney Keisner, Jill Johnson, UAMS; Nima Nabavi, Amgen; Kristie Banks, Mainstream; Alan Whitley; Treg Long, ACS; Sylvia Landers, Colonial Life; Ronda Walthall, ARDOT; David Kizzia, AEA; Donna Morey, ARTA; Mary Grace Smith, Sheila Weddington, ASE Retiree; Geoffery Becker, Medtronics; Jim Musick, Sanofi; Robin Keene, AAEA; Marissa Keith, BI; Suzanne Woodall, Brent Flaherty, Kristin Dolphy, Medimpact; Leann Perkins, ASU; Stephen Carroll, AllCare Specialty; Judith Paslaski; Tyler Tollett

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

MOTION by Lilly-Palmer:

Motion to accept the June 17, 2020 minutes.

Dr. Fiddler 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 Monday, July 6th, 2020 with Dr. Hank Simmons presiding.

I. Old Business

A. DCWG Update: *Dr. Sidney Keisner, UAMS*

Drugs for Relapsed/Refractory T cell lymphoma

Brand	Generic	Current Coverage	Recommendations
Romidepsin	Istodax/generic	Medical PA	**Exclude from pharmacy and medical benefit**
Bexarotene	Targretin/ generic	T4PA	**Exclude from pharmacy benefit**

The DUEC voted to adopt the recommendation as presented.

B. Second Review of Drugs: *Dr. Jill Johnson, Dr. Sidney Keisner, UAMS*

1. **Amlodipine benzoate (Katerzia®) 1mg/1mL suspension**
   Due to the commercial availability of Katerzia, generic liquid formulations are no longer available through compounding at pharmacies.
   Recommendation: Allow coverage of this medication for members under the age of 4.

2. **Etoposide oral capsule (Vepesid/generic)**
   FDA approved indication: Small cell lung cancer
   Recommendation: Cover

The DUEC voted to adopt the recommendations as presented.

II. New Business

A. New Drugs: *Dr. Jill Johnson and Dr. Sidney Keisner, UAMS*

Brand	Generic	Recommendation
Non-Specialty Drugs		
(1) DAYVIGO	LEMBOREXANT	Exclude, Code 13
Specialty Drugs		
(1) ONTRUZANT	TRASTUZUMAB-DTTB	Exclude
(2) KOSELUGO	SELUMETINIB/VITAMIN E TPGS	Cover (PA REQUIRED)
(3) ISTURISA	OSILODROSTAT	Cover (PA REQUIRED)
(4) PEMAZYRE	PEMIGATINIB	Exclude, Code 1, 13
(5) TUKYSA	TUCATINIB	Cover (PA REQUIRED)
(6) TRODELVY	SACITUZUMAB	Exclude, Code 1, 13
(7) RETEVMO	SELPERCATINIB	Exclude, Code 1, 13
(8) TABRECTA	CAPMATINIB	Exclude, Code 1, 13
(9) QINLOCK	RIPRETINIB	Cover (PA REQUIRED)

The DUEC voted to adopt the recommendations as presented.

MOTION by Dr. Fiddler:

I make a motion to accept the recommendations as presented above.

Lilly-Palmer seconded; all were in favor.

Motion Approved.

Quality of Care/Benefits Subcommittee Report by Chris Howlett, EBD Director

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

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

COVID Update by Elizabeth Montgomery & Mike Motley, ACHI

Montgomery and Motley presented ongoing analyses regarding COVID-19 impact on the plan, reviewed preliminary output on COVID-19 drug treatment utilization within the plan, assessed preliminary output on COVID-19-related telemedicine utilization within the plan, and presented analyses regarding COVID-19 financial impact on the plan.

Discussion

Dr. Fiddler: Where it shows all of the chances of death or percentages of it happening, do you have a chart or slide that shows how many it really happened to or how many actually died from COVID with kidney failure?

Motley: We don't have that prepared for today, but we can bring that back to you.

Dr. Fiddler: I would like to know how many of our membership had these conditions and died.

Motley: There have been deaths among the plan, but that number is less than 10. So, we are not reporting that yet.

Dr. Fiddler: What is the total number of members as far as ASE and PSE if we are talking about less than 10 deaths?

Howlett: The total population as far as subscribers are about 66,000 for PSE and 32,000 on ASE, totaling 158,500.

Dr. Fiddler: Out of the 160,000 members, we have less than 10 deaths? Is this correct?

Motley: To our knowledge, according to the health department, that is correct as of July 7th.

Plan Update by Courtney White & Paul Sakhrani, Milliman

Sakhrani and White provided an update on 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 June 2020
- 2020 projected plan experience
    - Allocated reserves for 2020 is $25.1M
    - Estimated deficit of $11.1M
    - End of Year Assets: $60.4M
    - 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
    - No additional funding ($14.5M allocated assets)
    - Projected deficit: $35.4M
    - End of Year Assets: $10.6M
    - No plan design or contribution changes
    - Increased membership based on historical patterns
    - Baseline trends (medical: 5%, pharmacy: 8%)

PSE

- Projections updated to incorporate claims data incurred from March 2019 to February 2019 and paid through June 2020
- 2020 plan experience
    - Allocated reserves for 2020 is $25.3M
    - Estimated deficit of $20.1M

    - End of Year Assets: $102.7M
    - 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
    - No additional funding ($15.5M allocated assets)
    - Projected deficit: $67.0M
    - End of Year Assets: $20.2M
    - No plan design or contribution changes
    - Increased membership based on historical patterns
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Director's Report by Chris Howlett, EBD Director

Howlett stated that we will take any questions that any of the members need answers to or have for us from the plan administrative side and provide responses back to you. Anything that you would like to see or want us to demonstrate in the presentations with Milliman or anything, we will be glad to take those as well. We will continue to work with Mike and Izzy on the COVID related information for the state as a whole, but mainly for the health plan and what potential risk would be there. You will be getting an email for a special Board meeting to further discuss rates in the upcoming week.

MOTION by Scott:

I motion to adjourn the meeting.

Lilly-Palmer 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 Monday, July 6th, 2020 with Dr. Hank Simmons presiding.

I. **Old Business**

A. DCWG Update: *Dr. Sidney Keisner, UAMS*

Drugs for Relapsed/Refractory T cell lymphoma

Brand	Generic	Current Coverage	Recommendations
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The DUEC voted to adopt the recommendation as presented.

B. Second Review of Drugs: *Dr. Jill Johnson, Dr. Sidney Keisner, UAMS*

1. **Amlodipine benzoate (Katerzia®) 1mg/1mL suspension**
   Due to the commercial availability of Katerzia, generic liquid formulations are no longer available through compounding at pharmacies.
   Recommendation: Allow coverage of this medication for members under the age of 4.

2. **Etoposide oral capsule (Vepesid/generic)**
   FDA approved indication: Small cell lung cancer

   Recommendation: Cover

The DUEC voted to adopt the recommendations as presented.

II. New Business

A. New Drugs: *Dr. Jill Johnson and Dr. Sidney Keisner, UAMS*

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(8) TABRECTA	CAPMATINIB	Exclude, Code 1, 13
(9) QINLOCK	RIPRETINIB	Cover (PA REQUIRED)

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
- Plan Update *Benefits only
- Director's Report

COVID Update: Elizabeth Montgomery & Mike Motley, ACHI

Montgomery and Motley presented ongoing analyses regarding COVID-19 impact on the plan, reviewed preliminary output on COVID-19 drug treatment utilization within the plan, assessed preliminary output on COVID-19-related telemedicine utilization within the plan, and presented analyses regarding COVID-19 financial impact on the plan.

Plan Update: Paul Sakhrani and Courtney White, Milliman

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    - Increased membership based on historical patterns
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Director's Report: Chris Howlett, EBD Director

Quality of Care

Howlett provided a brief update on operational pieces relative to COVID and the normal plan admin role as far as the claim to judication membership and getting ready for open enrollment in the fall.

Benefits Subcommittee

Howlett stated that the biggest thing is that we are monitoring the COVID scenario and the impact to the plan. We are also looking at different scenarios to bring forward to the committee and board regarding rates. Respective to ongoing, we are trying to get more real time data to be able to get that in front of you so that you can see the impact. As far as the rates, we'll have some more information that we're working with Milliman on to be able to provide some options for consideration.

JULY 2020 EBD BOARD PRESENTATION

Mike Motley, MPH
Director, Analytics

Izzy Montgomery, MPA
Policy Analyst

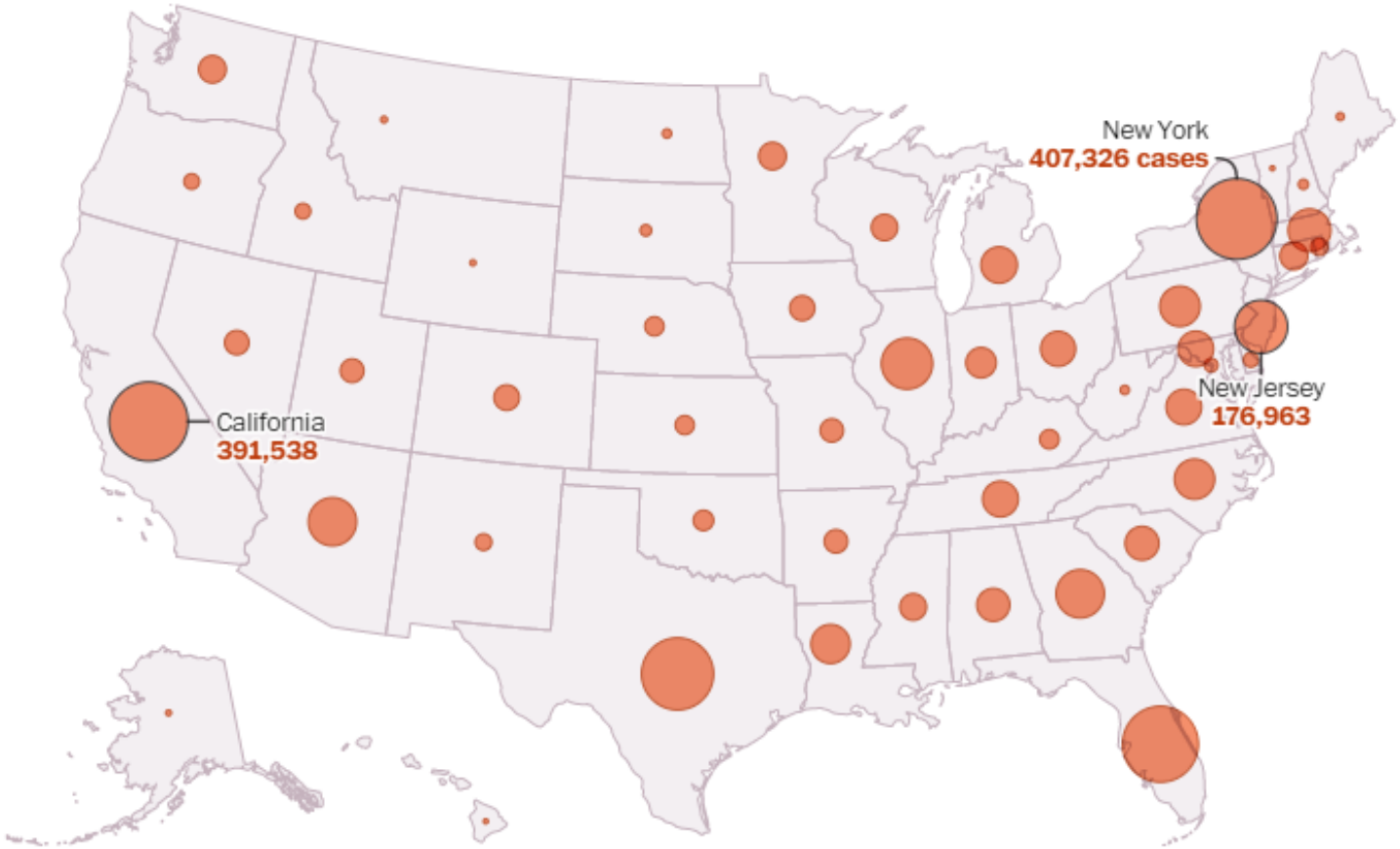
7.21.2020

ACHI
INSPIRING HEALTHY ACTS

OBJECTIVES

- Present ongoing analyses regarding COVID-19 impact on plan
- Review preliminary output on COVID-19 drug treatment utilization within plan
- Assess preliminary output on COVID-19-related telemedicine utilization within plan
- Present analyses regarding COVID-19 financial impact on plan

COVID-19: CONFIRMED CASES & DEATHS IN U.S.

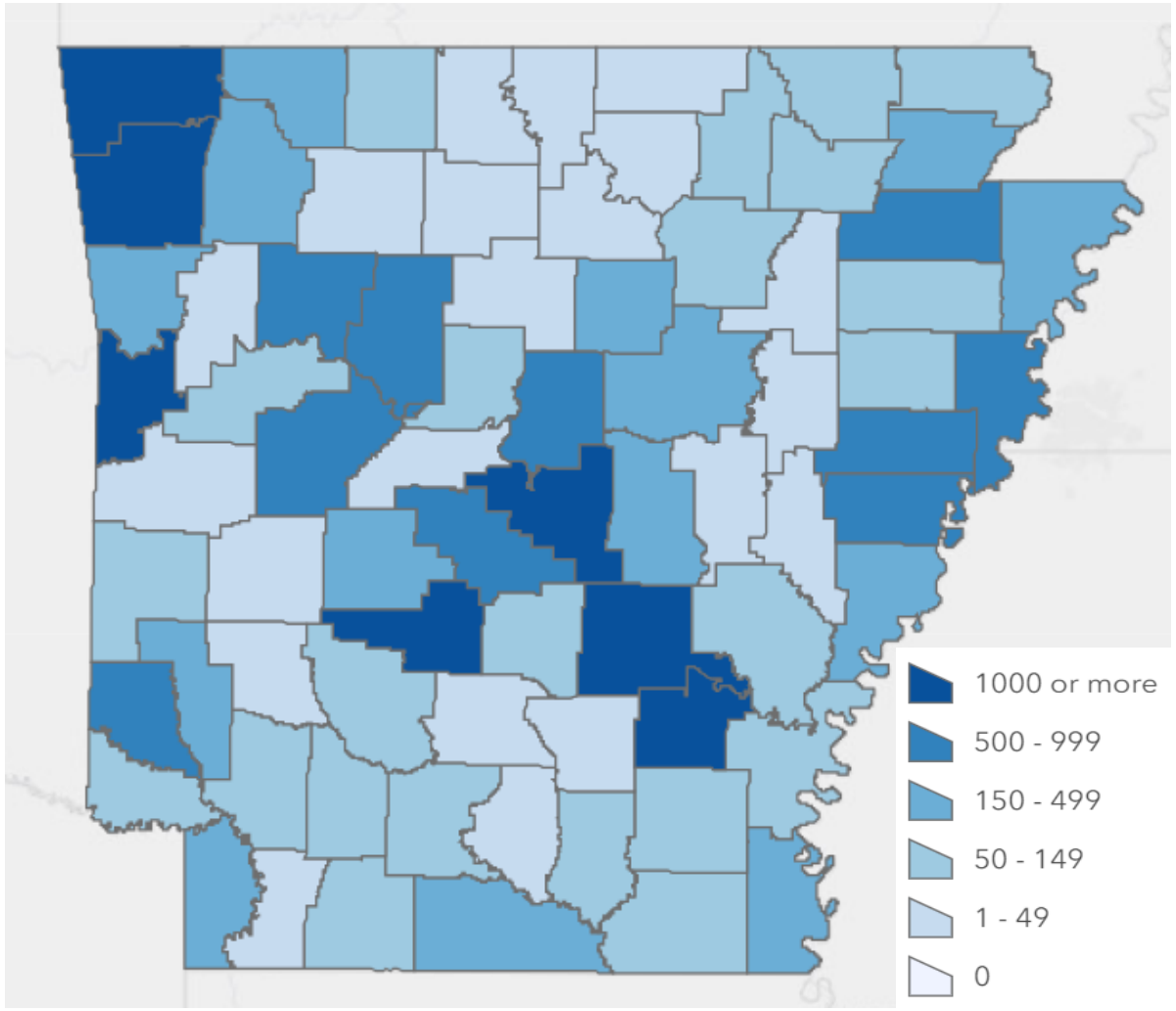


At least
3,810,000
confirmed cases

At least
138,000
reported deaths

Sources: Washington Post and Johns Hopkins University, as of July 21

COVID-19: CONFIRMED CASES BY AR COUNTY



Cumulative Cases:
33,927 (7,167 active)

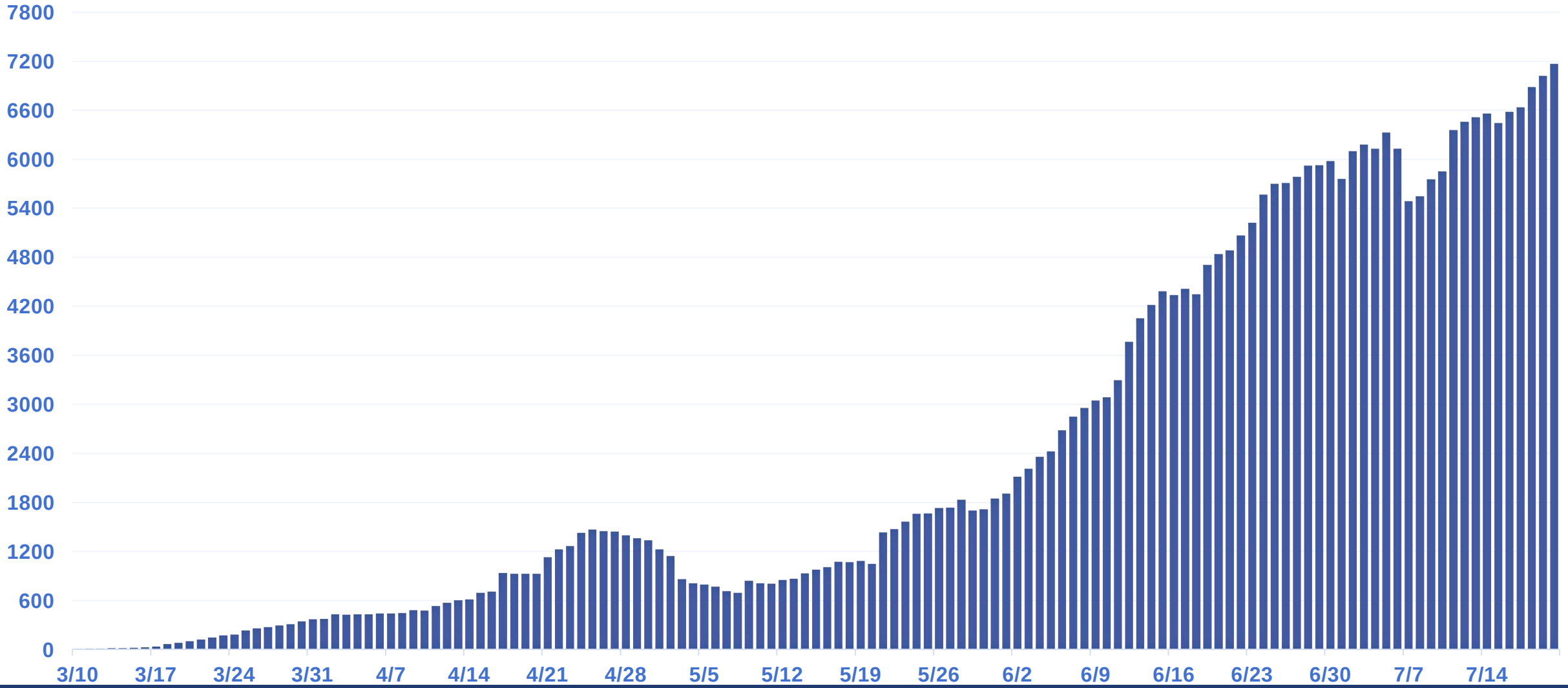
Source: Arkansas Department of Health, as of July 21

ADDITIONAL COVID-19 STATEWIDE STATISTICS

- Hospitalized: 471
- On Ventilator: 111
- Deaths: 363

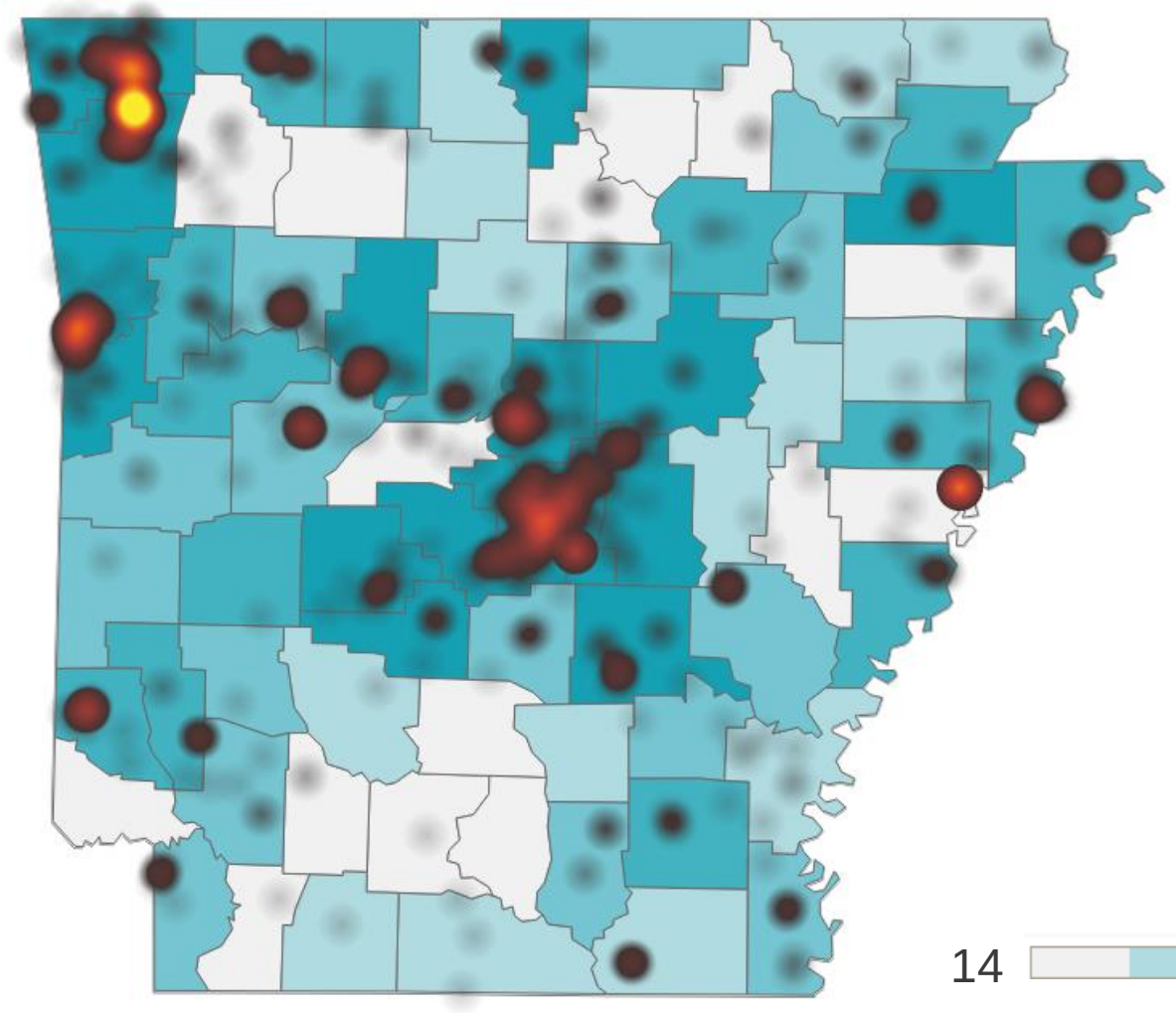
Source: Arkansas Department of Health, as of July 21

DAILY ACTIVE COVID-19 CASES



Source: Arkansas Department of Health

WEEK 26: POSITIVE CASES AND NUMBER OF TESTS



14 3,122

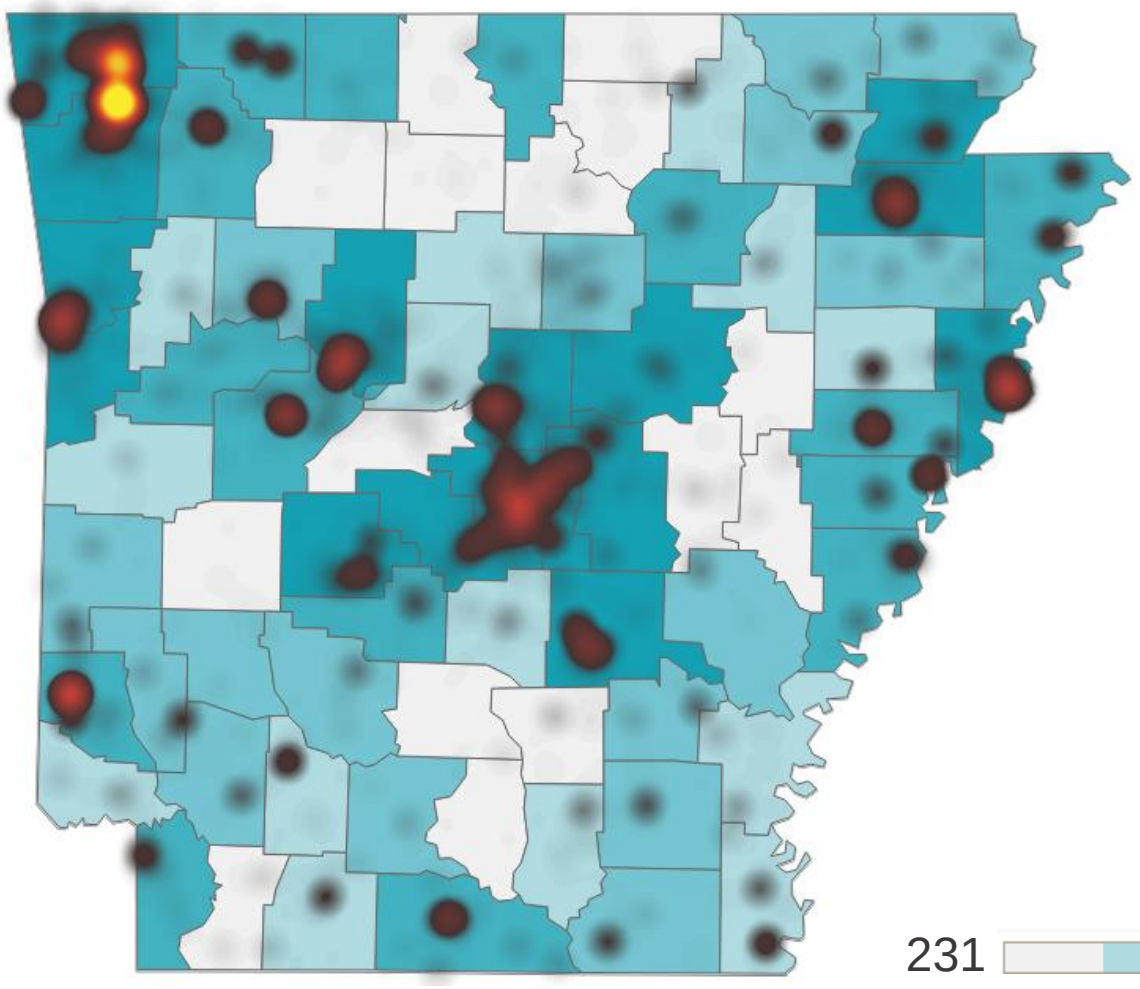
Week beginning:

June 28, 2020

Notes: Excludes jail, not cumulative

Partial week

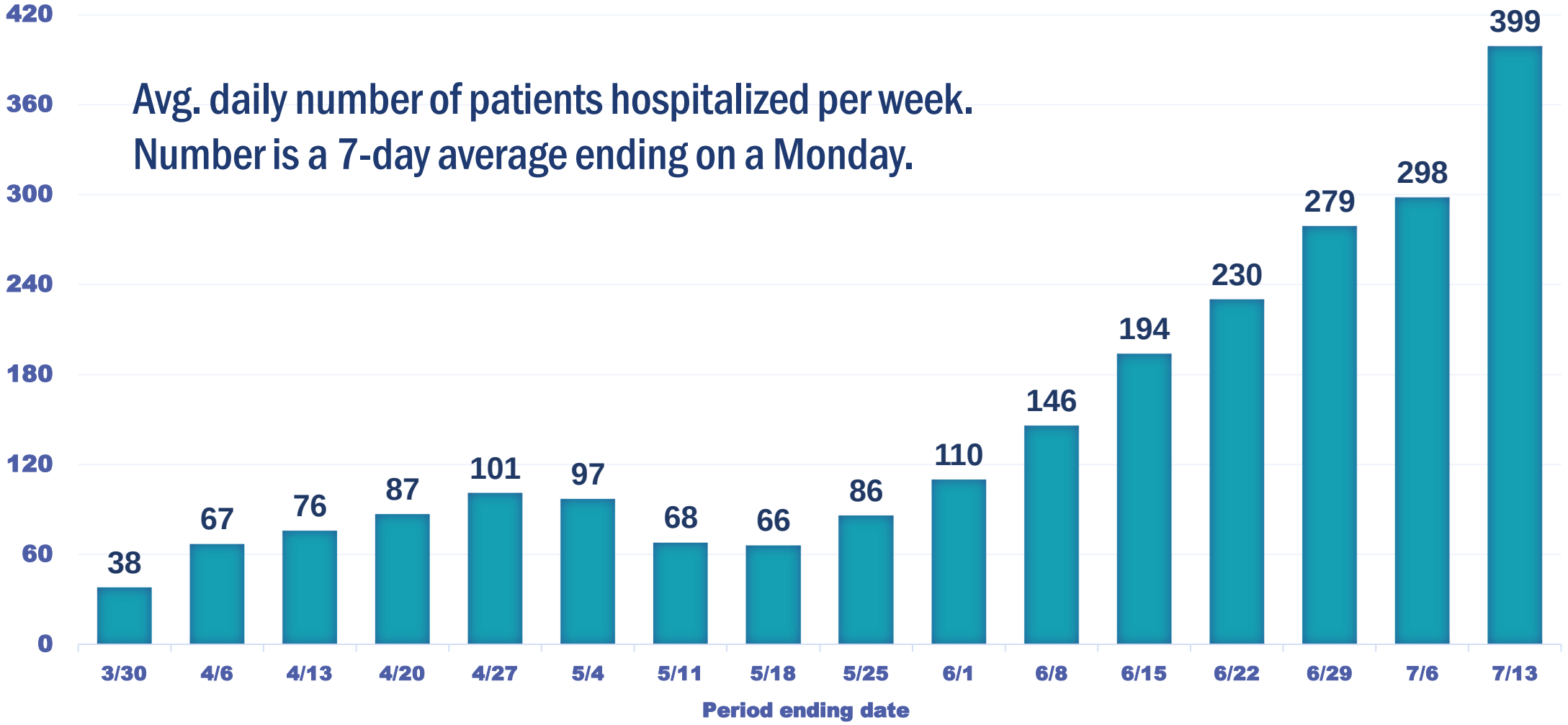
ALL: POSITIVE CASES AND NUMBER OF TEST



Cumulative

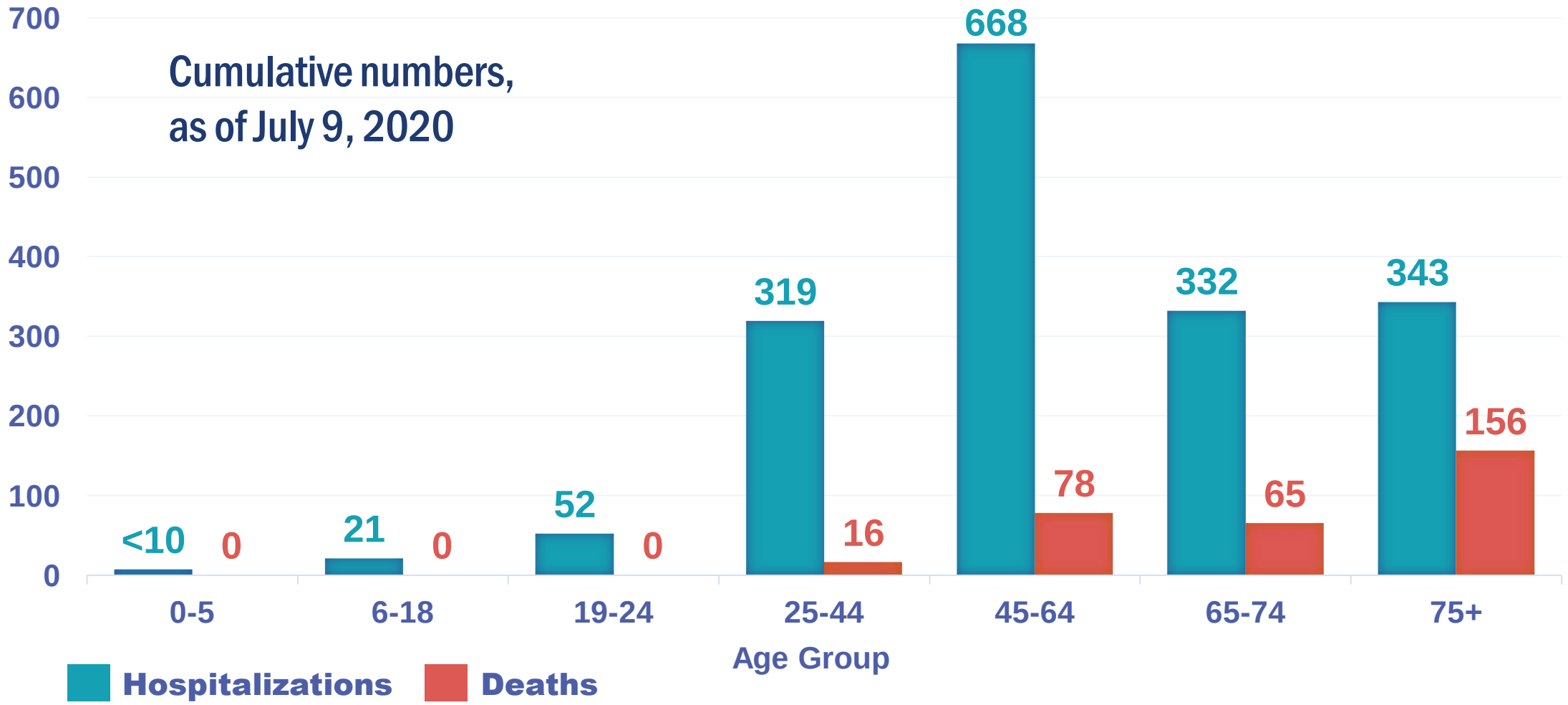
Notes: Excludes jail

COVID-19 HOSPITALIZATIONS IN ARKANSAS



Source: Average of daily numbers reported by Arkansas Department of Health

ARKANSAS HOSPITALIZATIONS & DEATHS BY AGE

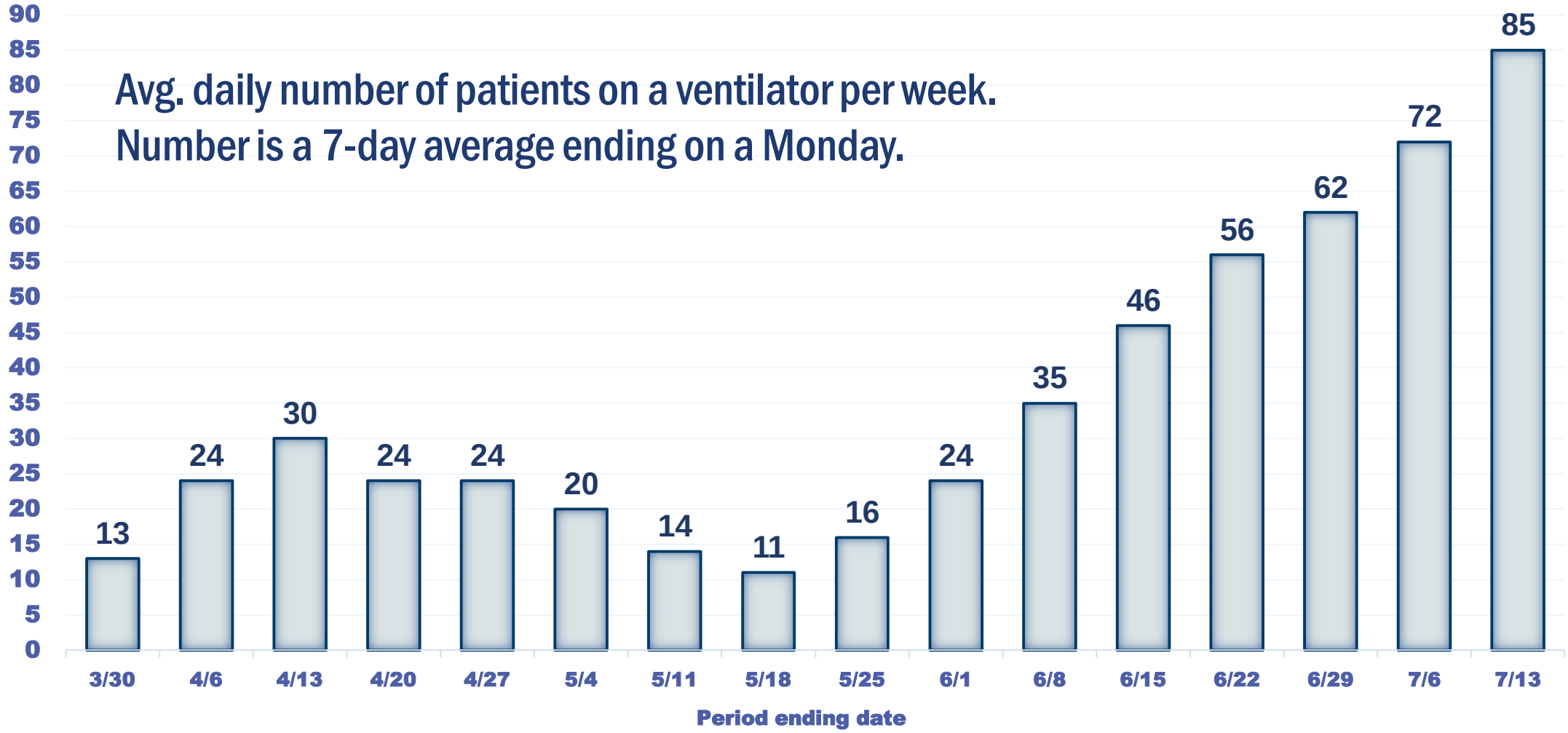


Source: ACHI Analyses of Arkansas Department of Health data.

ADH ANALYSIS OF ARKANSANS HOSPITALIZED WITH COVID-19

- Information presented at July 1 press conference
- Of the 1,300 ever hospitalized (at that time):
  - 860 were discharged (66.2%)
  - 263 were still hospitalized (20.2%)
  - 177 died (13.6%)

COVID-19 PATIENTS ON A VENTILATOR IN ARKANSAS



Source: Average of daily numbers reported by Arkansas Department of Health

ADH ANALYSIS OF ARKANSANS ON VENTILATORS WITH COVID-19

- Information presented at July 1 press conference
- Of the 203 ever on a ventilator (at that time):
  - 94 died (46.3%)
  - 57 were taken off a ventilator (28.1%)
  - 52 were still on a ventilator (25.6%)

COVID-19 PLAN IMPACT

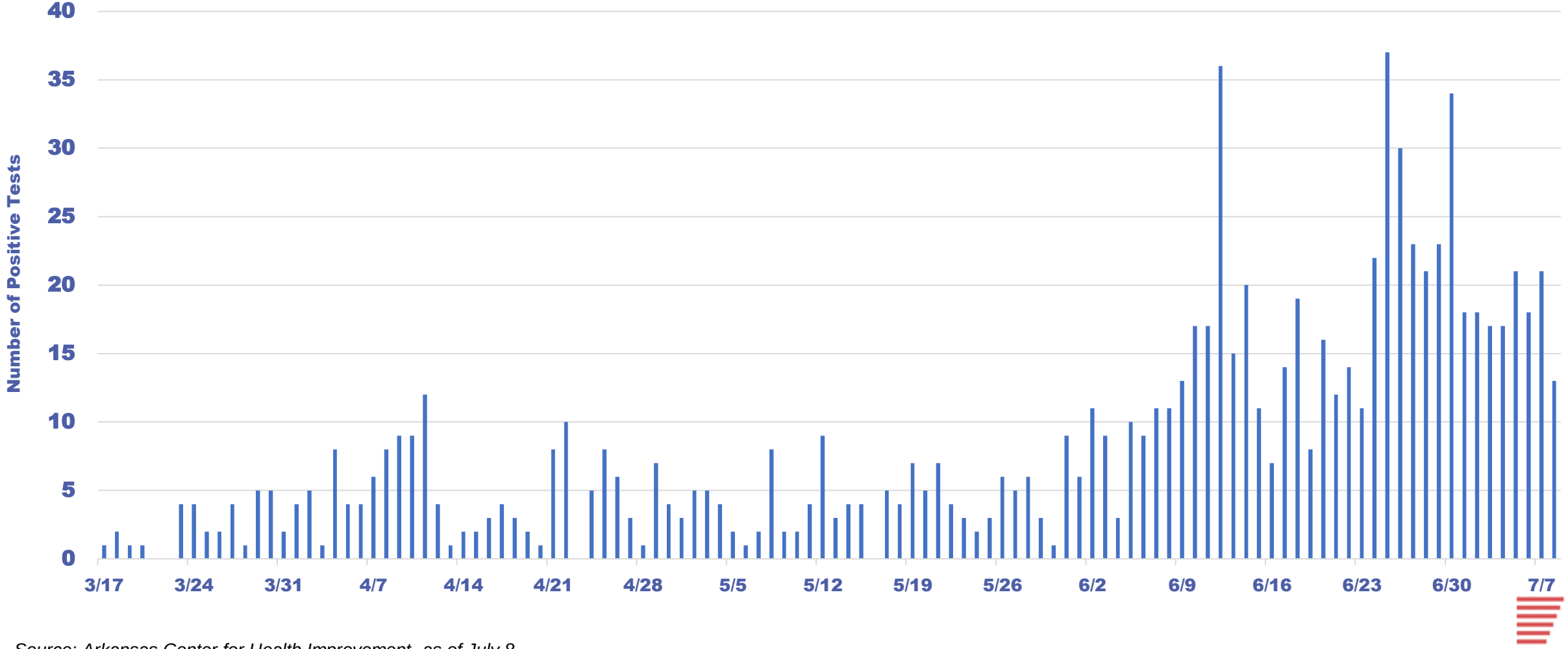
- ACHI has worked with Arkansas Department of Health to obtain COVID-19 data
- Developing analyses to determine ongoing impact of COVID-19
- Analyses today include updates on estimated number of members tested, number of positive tests, and number of hospitalizations

COVID-19 ANALYSES

- Data from March 17 through July 8, 2020
- Estimated total number of members ever tested: 19,100
- Total number of members with positive test: 942 (ASE=562, PSE=380)
- Total number of members ever hospitalized: 66
- Total numbers of members ever in ICU: 28
- Total number of members ever intubated: 10

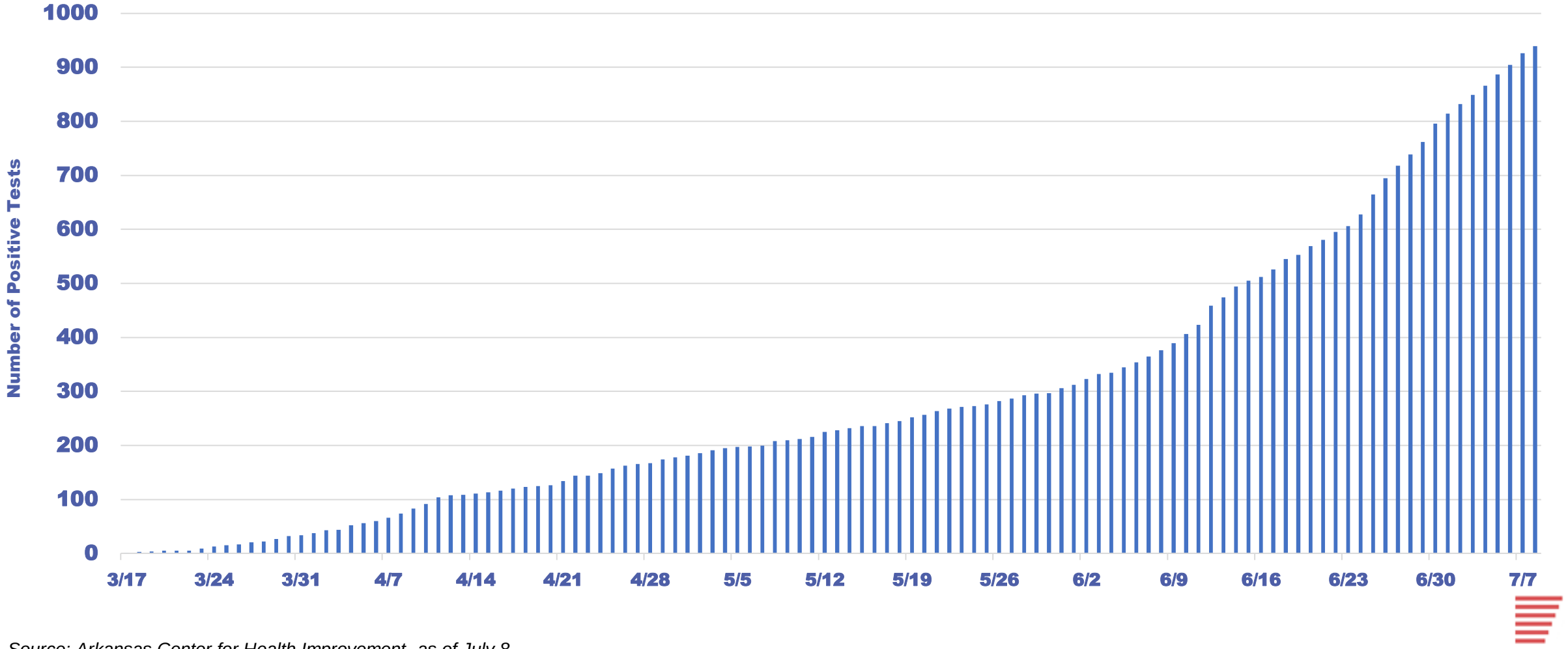
Source: Arkansas Center for Health Improvement, as of July 8

DAILY POSITIVE TEST COUNT AMONG EBD MEMBERS



Source: Arkansas Center for Health Improvement, as of July 8

CUMULATIVE POSITIVE TEST COUNT AMONG EBD MEMBERS



Source: Arkansas Center for Health Improvement, as of July 8

STATEWIDE RESULTS FOR ADJUSTED RELATIVE RISK OF SEVERE COVID-19 OUTCOMES FOR SELECTED CONDITIONS

	Hospitalization	ICU Admission	Intubation	Death
Kidney Failure	*+80%*	*+100%*	*+103%*	*+70%*
Immuno-compromised	*+60%*	*+90%*	*+210%*	*+80%*
Diabetes	*+40%*	*+30%*	*+30%*	*+60%*
COPD	*+30%*	*+50%*	*-40%*	*-10%*
Coronary Heart Disease	*+30%*	*+20%*	*+40%*	*+20%*

Kidney failure and immunocompromised states were associated with a higher rate of hospitalization, ICU admission, intubation and death; Diabetes mellitus was associated with a higher rate of hospitalization, ICU admission, and death; COPD was associated with a higher rate of hospitalization and ICU admission. Coronary heart disease, other heart disease, all at the significance level of 0.05.

Sources: Arkansas Department of Health Redcap Data and the Arkansas APCD.

COUNTS (PREVALENCE) OF ASE/PSE PRIMARY MEMBERS WITH SELECTED CONDITIONS

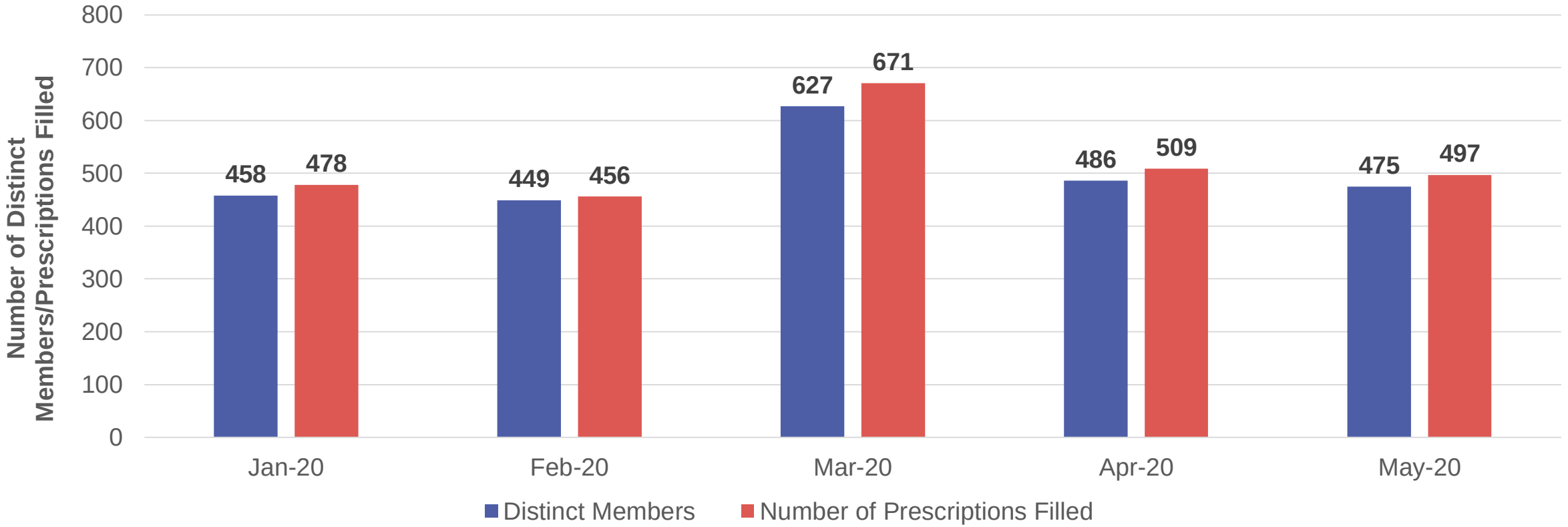
	ASE	PSE
Kidney Failure	*824 (1.7%)*	*866 (1.0%)*
Immuno-Compromised	*536 (1.1%)*	*695 (0.8%)*
Diabetes	*4,968 (10.4%)*	*5,519 (6.4%)*
COPD	*731 (1.5%)*	*559 (0.7%)*
Coronary Heart Disease	*1,959 (4.1%)*	*1,860 (2.2%)*

Source: Arkansas Center for Health Improvement

COVID-19 TREATMENT UPDATES

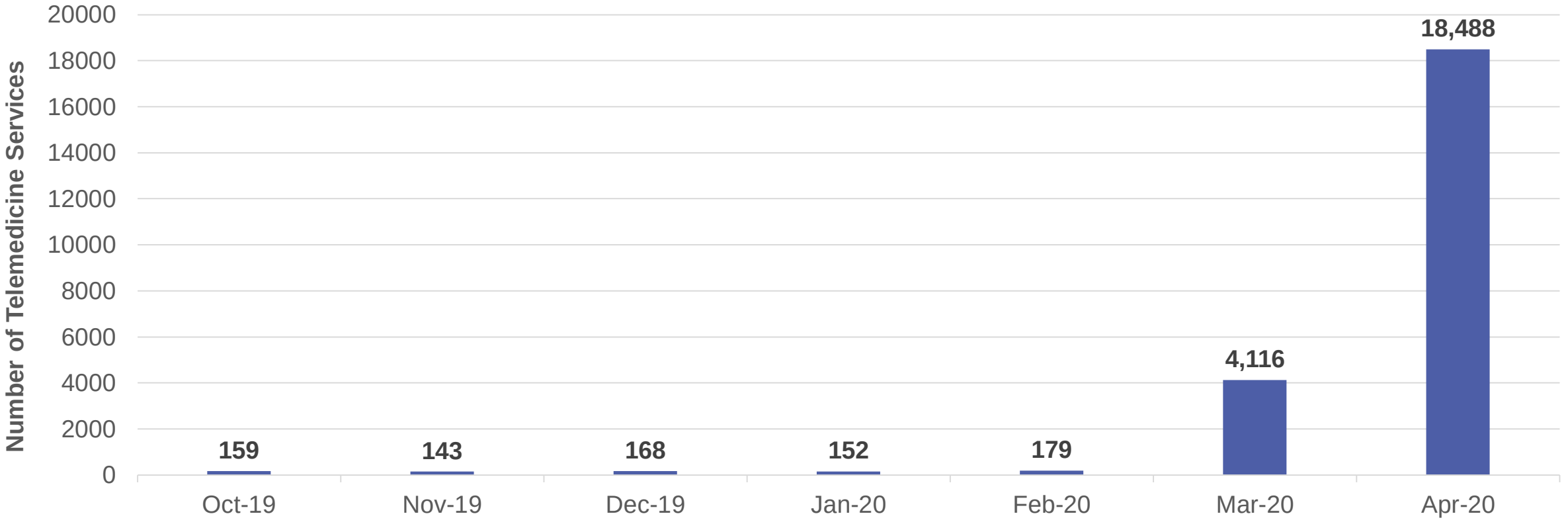
- Convalescent plasma
- Remdesivir
  - Update: U.S. insurers will pay $3,120 for 5-day course
- ~~Hydroxychloroquine~~
- Dexamethasone

HYDROXYCHLOROQUINE UTILIZATION WITHIN PLAN (JAN. 2020 – MAY 2020)



Source: Arkansas Center for Health Improvement

TELEMEDICINE SERVICE UTILIZATION WITH PLAN (OCT. 2019–APR. 2020)



Source: Arkansas Center for Health Improvement

EBD PLAN PAID AMOUNT FOR TELEMEDICINE SERVICES (OCT. 2019– APR. 2020)

Source: Arkansas Center for Health Improvement

COVID-19 FINANCIAL IMPACT ASSESSMENT

In addition to tracking COVID-19 positive tests, hospitalizations, and number of members tested, ACHI is also assessing financial impacts to plan:

- Costs of COVID-19 related hospitalizations
- Related costs for all members with a positive test result
- Costs to the plan for testing and related assessments
- Additional costs related to expanded telemedicine utilization

COVID-19 FINANCIAL IMPACT ASSESSMENT

- To assess financial impact, ACHI is linking claims data to ADH COVID-19 data
- Current plan claims data available to ACHI is as current as May 20, 2020
- Current analyses includes total costs for members with a positive test and for members with a related hospitalization
- Analyses also include costs of testing (molecular) and related assessment visits

COVID-19 HOSPITALIZATION COSTS

- Due to 6-month timely filing requirements and necessary claims run-out periods, costs analyses specific to all hospital stays are not available at this time
- ACHI will update hospitalization-specific cost analyses as more claims experience becomes available

COSTS RELATED TO TESTING AND ASSESSMENTS

- Through May 21, claims for tests = 1,624
- Costs for tests = $125,504 (average of $77 per test)
- Outpatient or emergency department (ED) visits were associated with 1,003 of 1,624 tests (62%)
- Additional costs for associated OP or ED visits = $48,537
- Total amount paid by the plan for testing and associated OP or ED visits = $174,041

COSTS FOR MEMBERS WITH A HOSPITALIZATION

- As of June 4, 32 members were identified as having a hospitalization related to COVID-19
- 24 members deemed as having been hospitalized had claims experience within one week prior to their COVID positive test date through May 21
- Total amount paid by the plan across those claims = $197,468 (average of $8,228 per member)
- Future claims experience will provide a more complete picture of hospital costs

COSTS FOR MEMBERS WITH A POSITIVE TEST

- 121 members had claims within one week prior to their positive test date through May 21
- Total amount paid by the plan (including those with a hospitalization) = $237,825 (average of $1,965 per member)

NEXT STEPS

- ACHI will continue to provide updates on estimated number of members tested, number of positive tests, and number of hospitalizations
- Will continue providing updates on drug therapy utilization
- Will continue providing updates on telemedicine utilization and plan spend, including an update May 2020 experience
- Will continue assessing financial impact of COVID-19 on plan

State of Arkansas Employee Benefits Division

Interim Monitoring Report

Through June 30th

State and Public School Life and Health Insurance Board of Directors

Courtney White, FSA, MAAA
Paul Sakhrani, FSA, MAAA

21 JULY 2020

Milliman

Agenda

- Arkansas State Employees (ASE)
  - Plan Experience
- Public School Employees (PSE)
  - Plan Experience
- 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 June 2020.
- 2020 projected plan experience
  - Allocated reserves for 2020 is $25.1M
  - Estimated deficit of $11.1M
  - End of Year Assets: $60.4M
  - 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
  - No additional funding ($14.5M allocated assets)
  - Projected deficit: $35.4M
  - End of Year Assets: $10.6M
  - No plan design or contribution changes
  - Increased membership based on historical patterns
  - Baseline trends (medical: 5%, pharmacy: 8%)

Total Plan Experience

Funding	2019	2020	2021
State Contribution	$ 173.61	$ 172.24	$ 172.24
Employee Contribution	97.45	99.56	100.24
Other	23.47	21.65	21.80
Total Income	$ 294.53	$ 293.46	$ 294.28
Medical Claims	$ (194.59)	$ (216.03)	$ (222.99)
Pharmacy Claims	(86.58)	(99.15)	(109.26)
Administration Fees	(18.30)	(17.51)	(17.63)
Plan Administration	(2.90)	(2.81)	(2.90)
Total Expenses	$ (302.37)	$ (335.50)	$ (352.78)
Program Savings	$ -	$ 5.85	$ 8.66
Net Income / (Loss) Before Reserve Allocation	$ (7.84)	$ (36.19)	$ (49.84)
Allocation of Reserves	$ 21.70	$ 25.08	$ 14.46
Net Income / (Loss) After Reserve Allocation	$ 13.86	$ (11.10)	$ (35.38)

Average Membership			
Active Employees / Pre-65 Retirees	47,752	46,885	46,885
Post-65 Retirees	13,345	13,815	14,229
Total Enrolled	61,098	60,700	61,114

Total Income PMPM[1]	$ 431.32	$ 437.32	$ 420.99
Total Expenses PMPM[2]	$ (412.41)	$ (452.56)	$ (469.23)

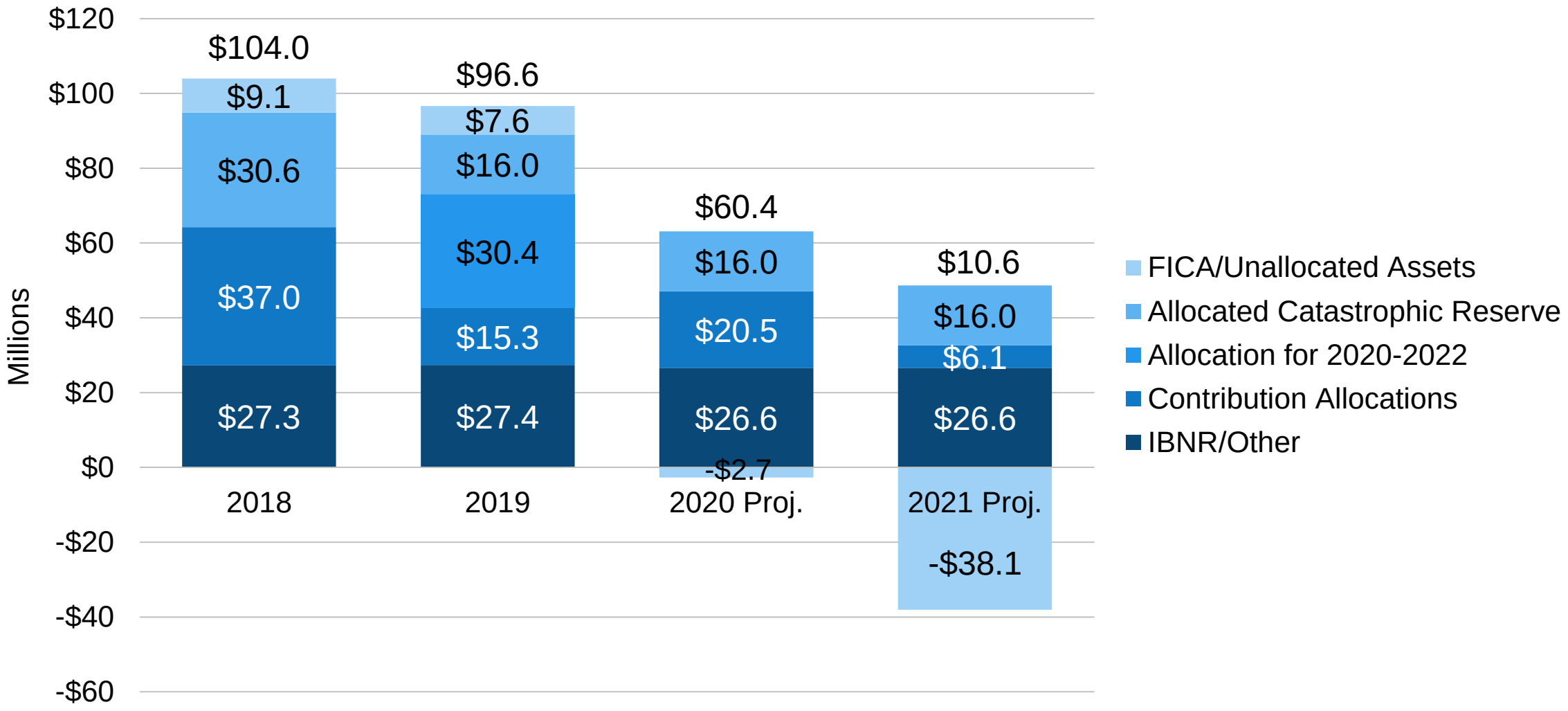
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Program Savings

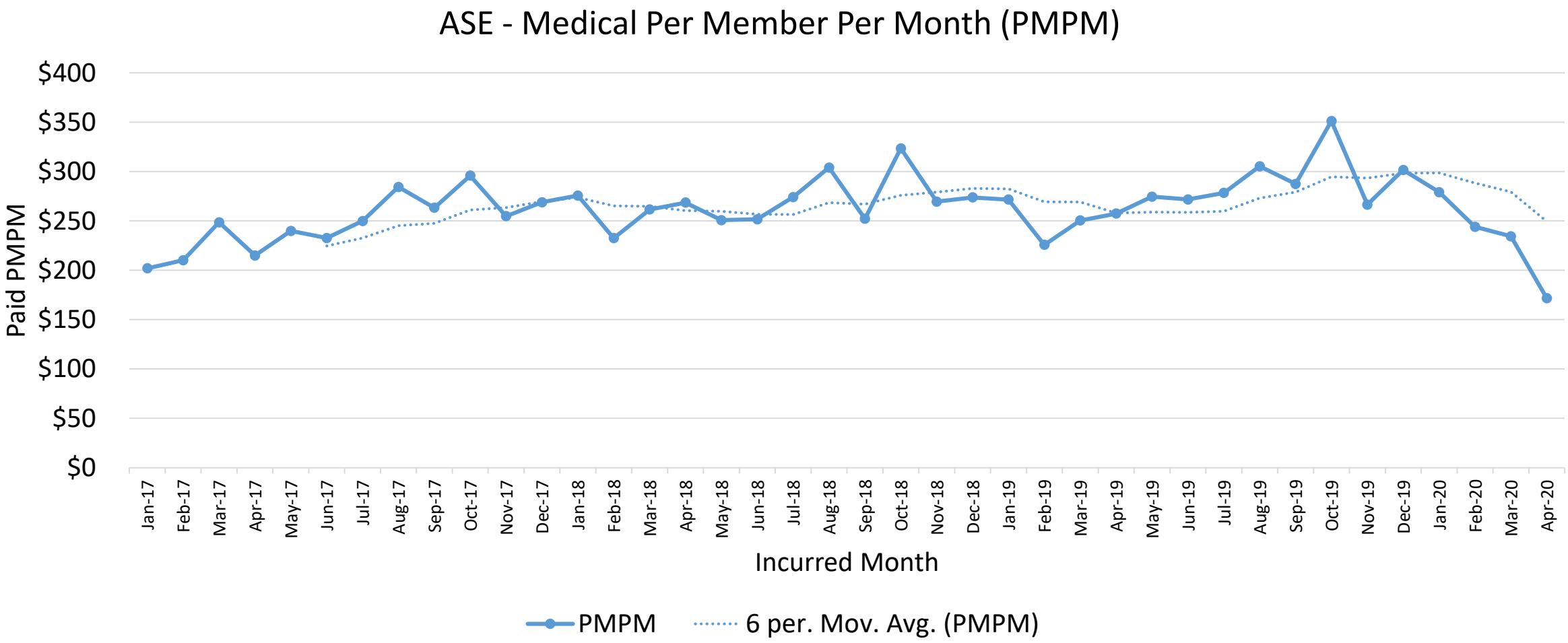
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
(a)	2019	End-of-Year Assets	$96.6
(b)	2020	Total Income	$293.5
(c)		Total Expenses	($329.6)
(d)		Allocated Assets	$25.1
(e) = (b) + (c) + (d)		Total Surplus / (Deficit)	($11.1)
(f) = (a) - (d) + (e)		End-of-Year Assets	$60.4
(g)	2021	Total Income	$294.3
(h)		Total Expenses	($344.1)
(i)		Allocated Assets	$14.5
(j) = (g) + (h) + (i)		Total Surplus / (Deficit)	($35.4)
(k) = (f) – (i) + (j)		End-of-Year Assets	$10.6

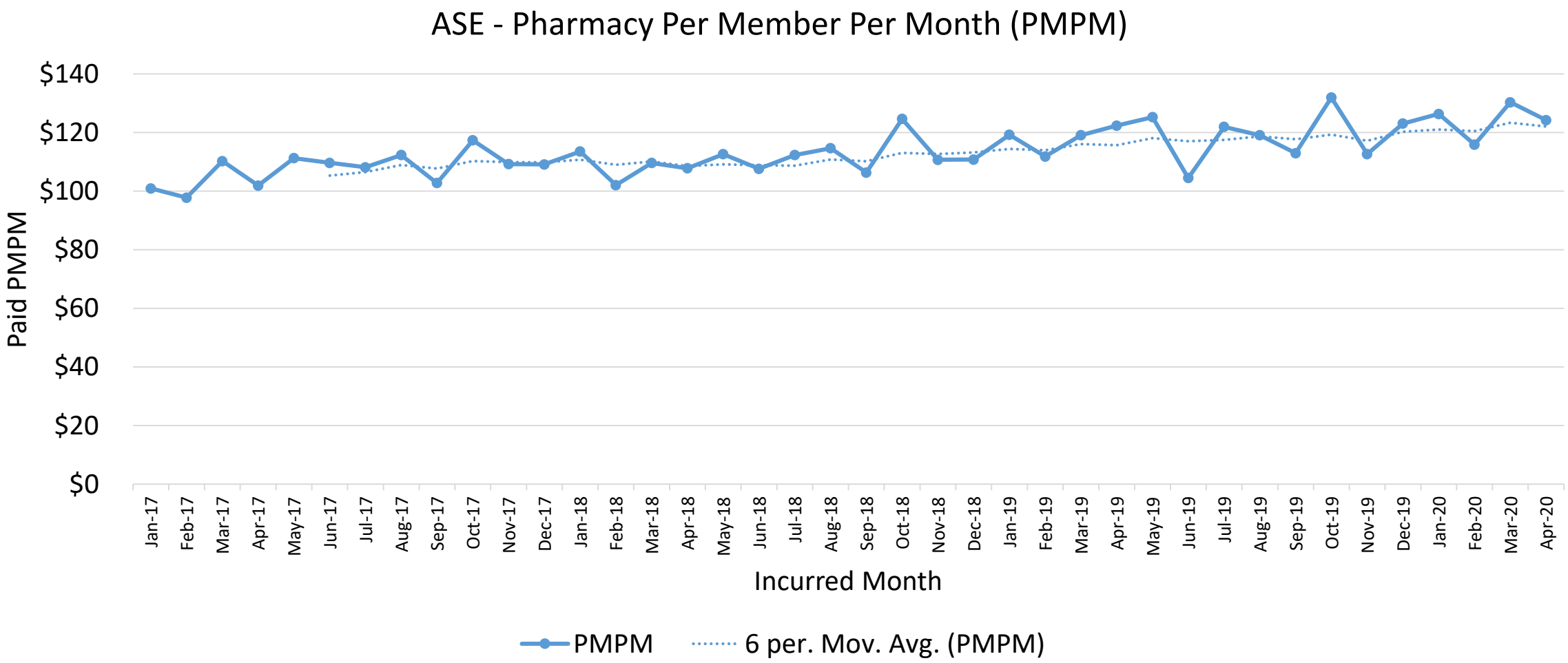
End of Year Assets



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 June 2020.
- 2020 plan experience
  - Allocated reserves for 2020 is $25.3M
  - Estimated deficit of $21.1M
  - End of Year Assets: $102.7M
  - 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
  - No additional funding ($15.5M allocated assets)
  - Projected deficit: $67.0M
  - End of Year Assets: $20.2M
  - No plan design or contribution changes
  - Increased membership based on historical patterns
  - Baseline trends (medical: 7%, pharmacy: 8%)

Total Plan Experience

Funding	2019	2020	2021
PPE Funding	$ 102.39	$ 105.38	$ 108.89
Employee Contribution	121.12	124.21	128.35
Dept of Ed Funding	88.10	88.10	88.10
Other	15.02	14.88	15.38
Total Income	$ 326.64	$ 332.56	$ 340.72
Medical Claims	$ (247.12)	$ (280.49)	$ (317.69)
Pharmacy Claims	(60.87)	(72.20)	(80.03)
Administration Fees	(28.46)	(28.18)	(29.20)
Plan Administration	(2.61)	(2.55)	(2.63)
Total Expenses	$ (339.06)	$ (383.42)	$ (429.56)
Program Savings	$ -	$ 4.55	$ 6.34
Net Income / (Loss) Before Reserve Allocation	$ (12.42)	$ (46.31)	$ (82.50)
Allocation of Reserves	$ 12.66	$ 25.25	$ 15.48
Net Income / (Loss) After Reserve Allocation	$ 0.23	$ (21.05)	$ (67.02)

Average Membership			
Active Employees / Pre-65 Retirees	82,391	84,441	86,856
Post-65 Retirees	14,279	15,038	15,940
Total Enrolled	96,669	99,478	102,795

Total Income PMPM[1]	$ 292.49	$ 299.75	$ 288.76
Total Expenses PMPM[2]	$ (292.28)	$ (317.38)	$ (343.09)

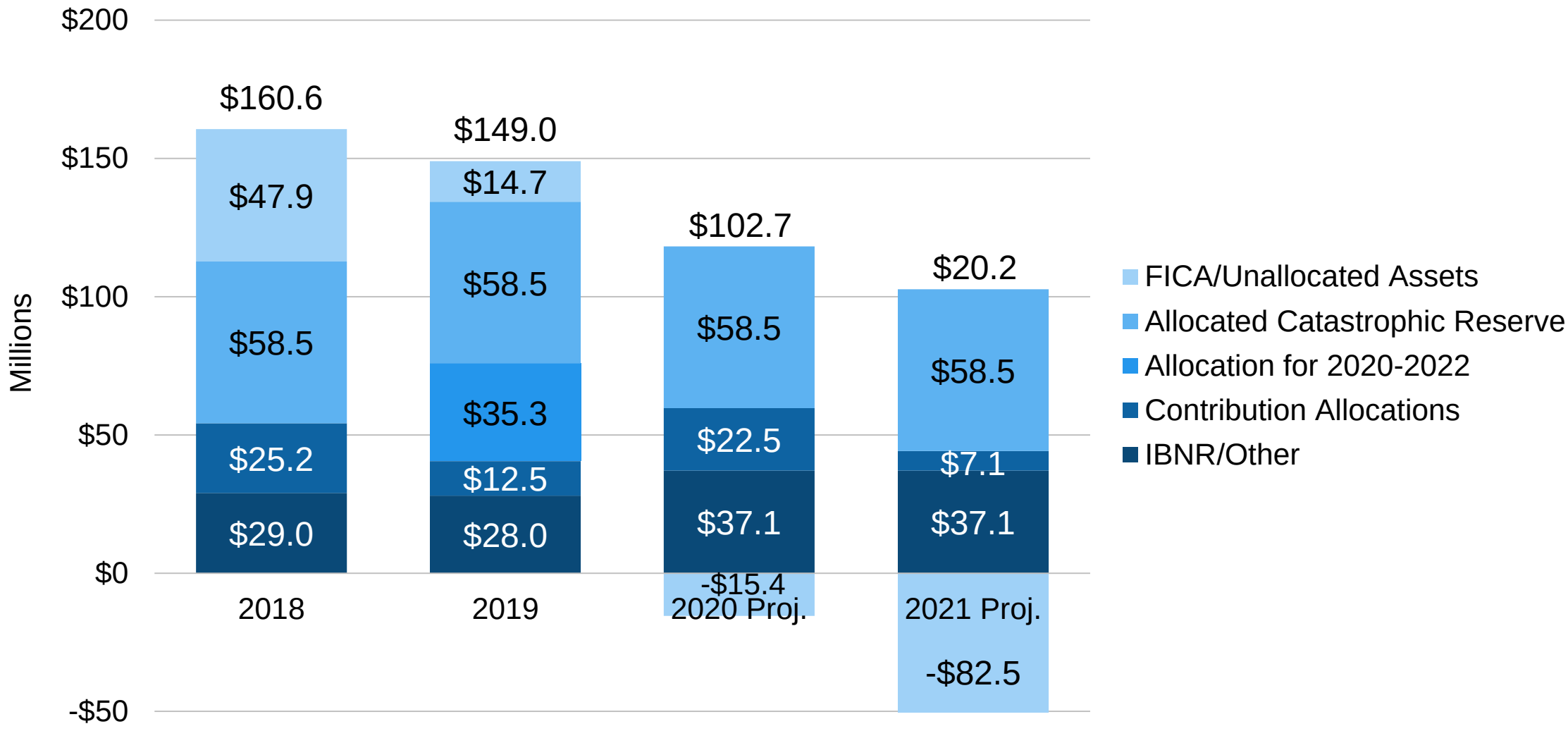
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Program Savings

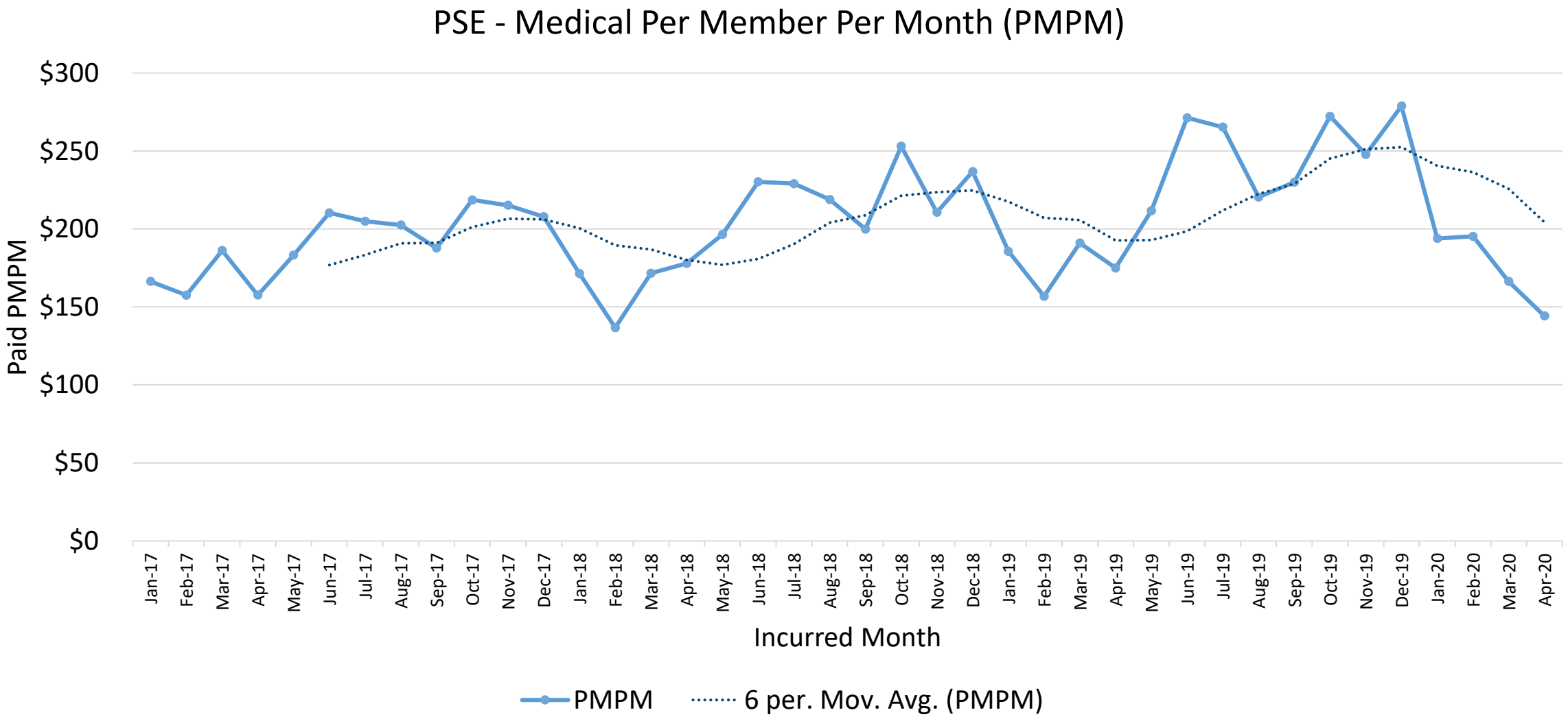
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
(a)	2019	End-of-Year Assets	$149.0
(b)	2020	Total Income	$332.6
(c)		Total Expenses	($378.9)
(d)		Allocated Assets	$25.3
(e) = (b) + (c) + (d)		Total Surplus / (Deficit)	($21.1)
(f) = (a) - (d) + (e)		End-of-Year Assets	$102.7
(g)	2021	Total Income	$340.7
(h)		Total Expenses	($423.2)
(i)		Allocated Assets	$15.5
(j) = (g) + (h) + (i)		Total Surplus / (Deficit)	($67.0)
(k) = (f) – (i) + (j)		End-of-Year Assets	$20.2

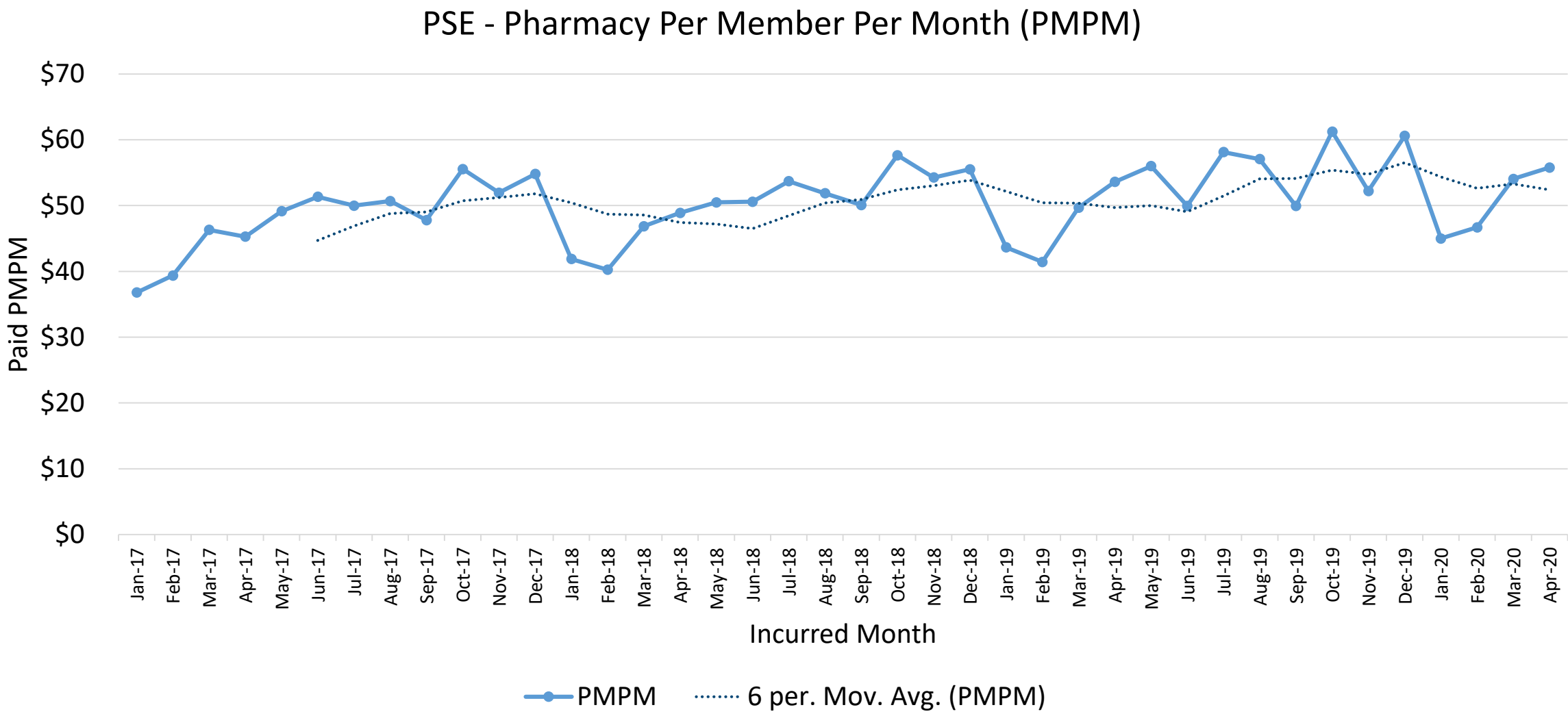
End of Year Assets



Monthly Trend - Medical

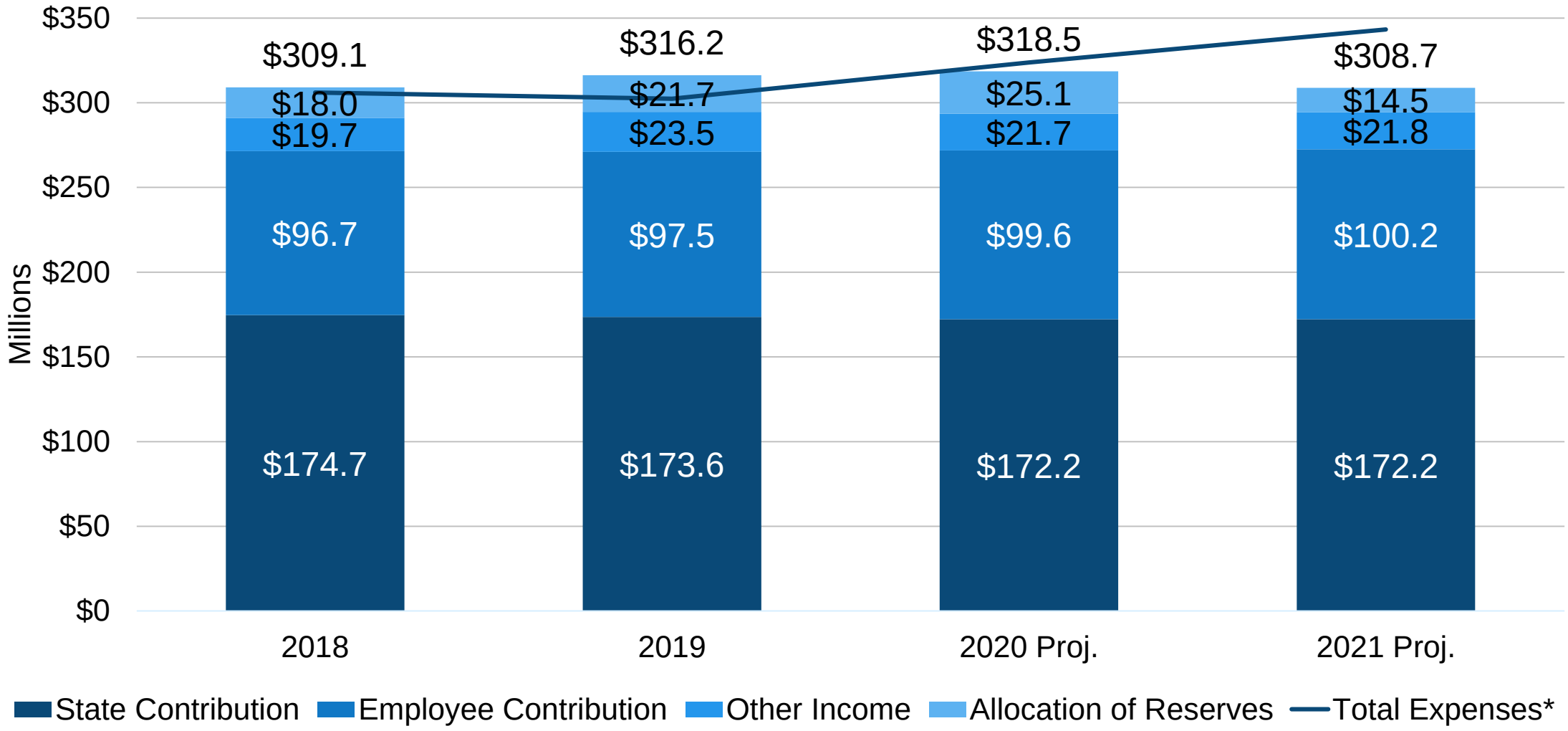


Monthly Trend - Pharmacy



Appendix

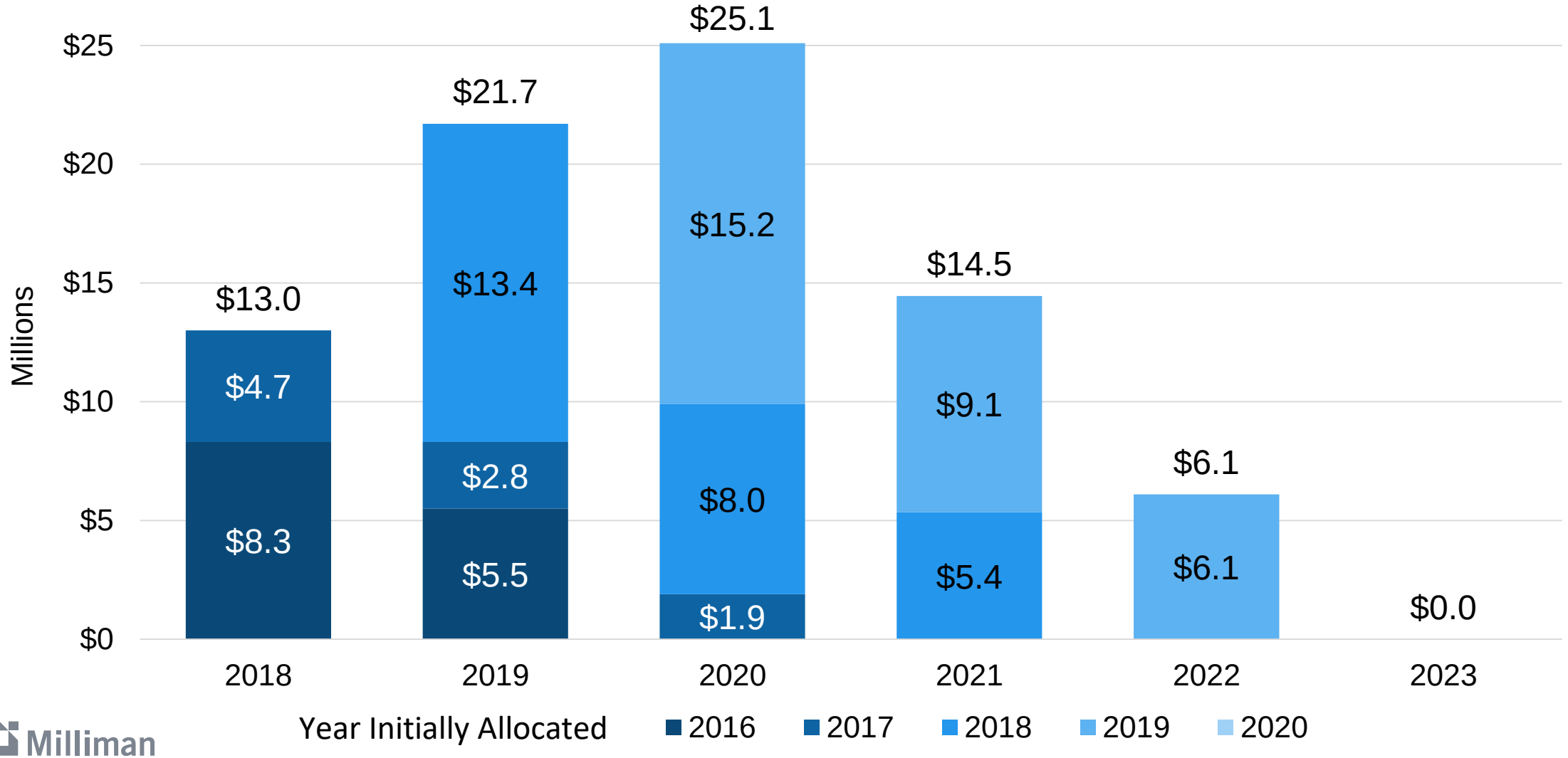
ASE - Income vs. Expenditure



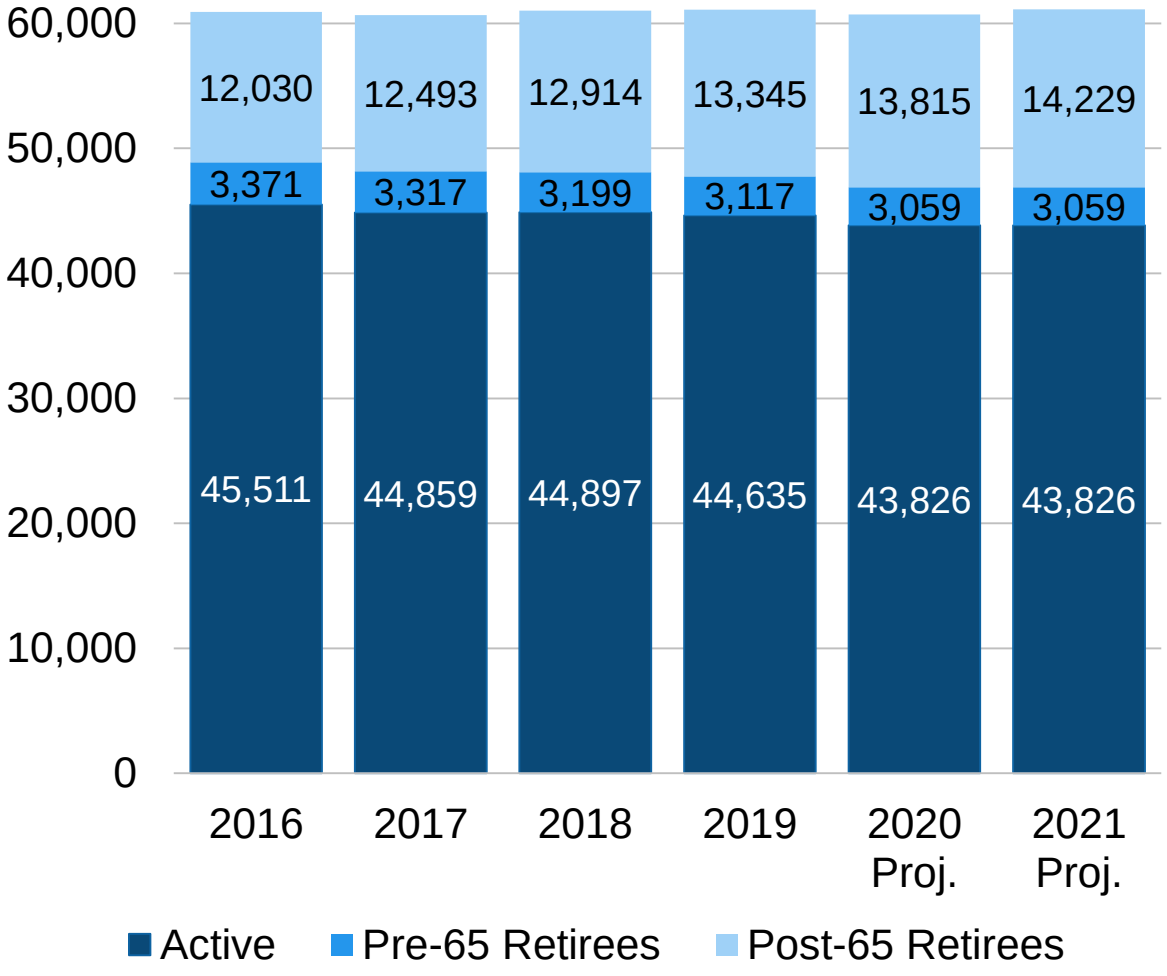
* Total Expenses offset by Program Savings

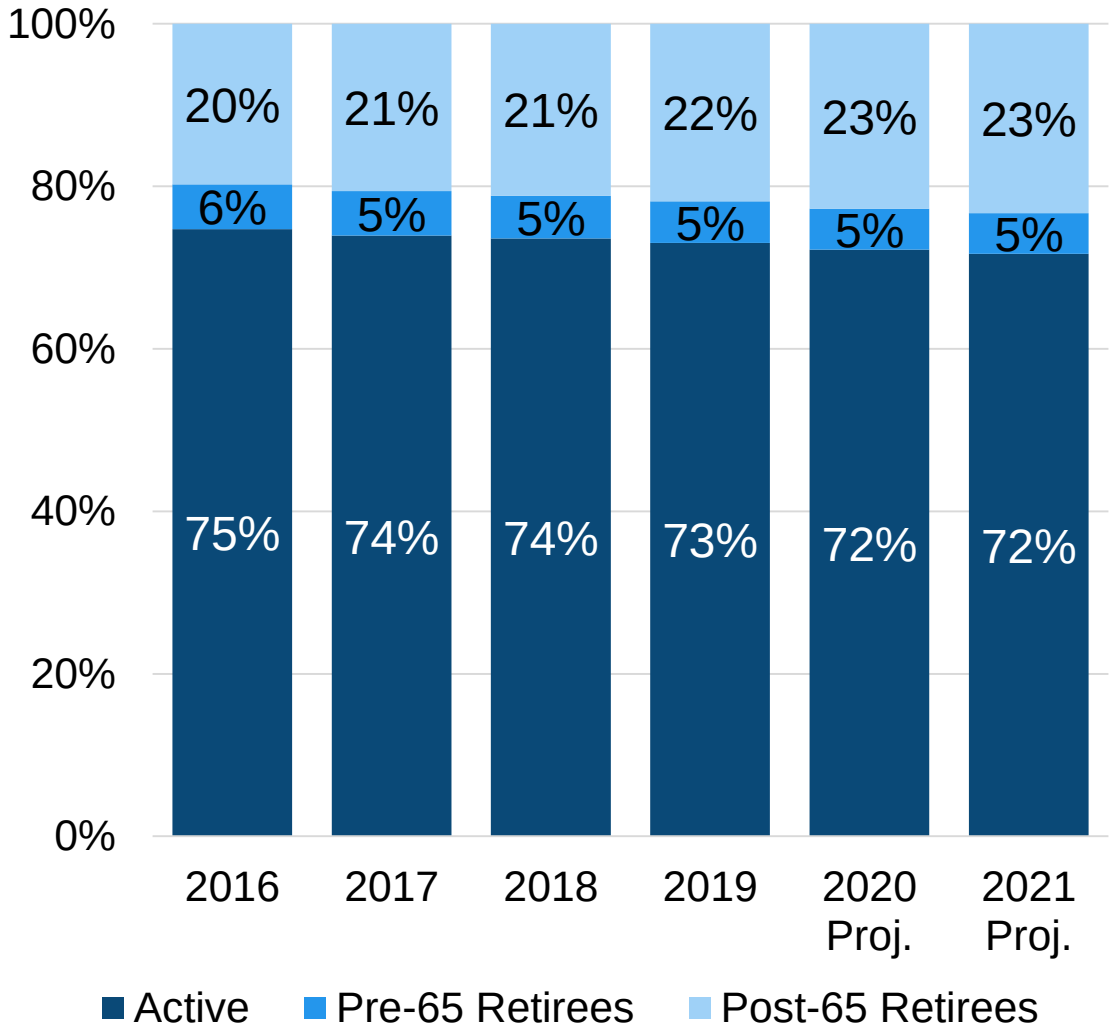
ASE - Reserves Allocation by Year

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

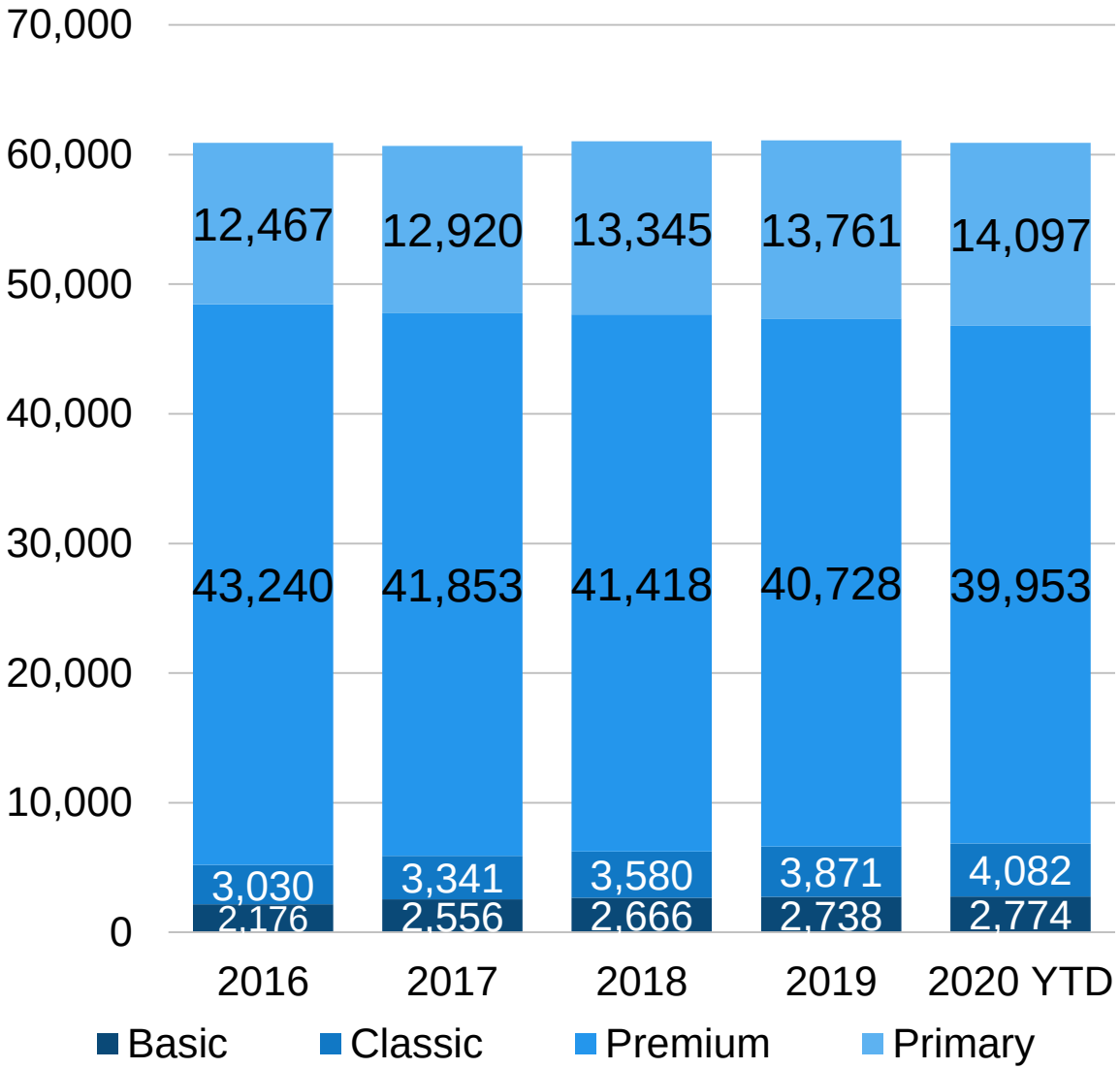


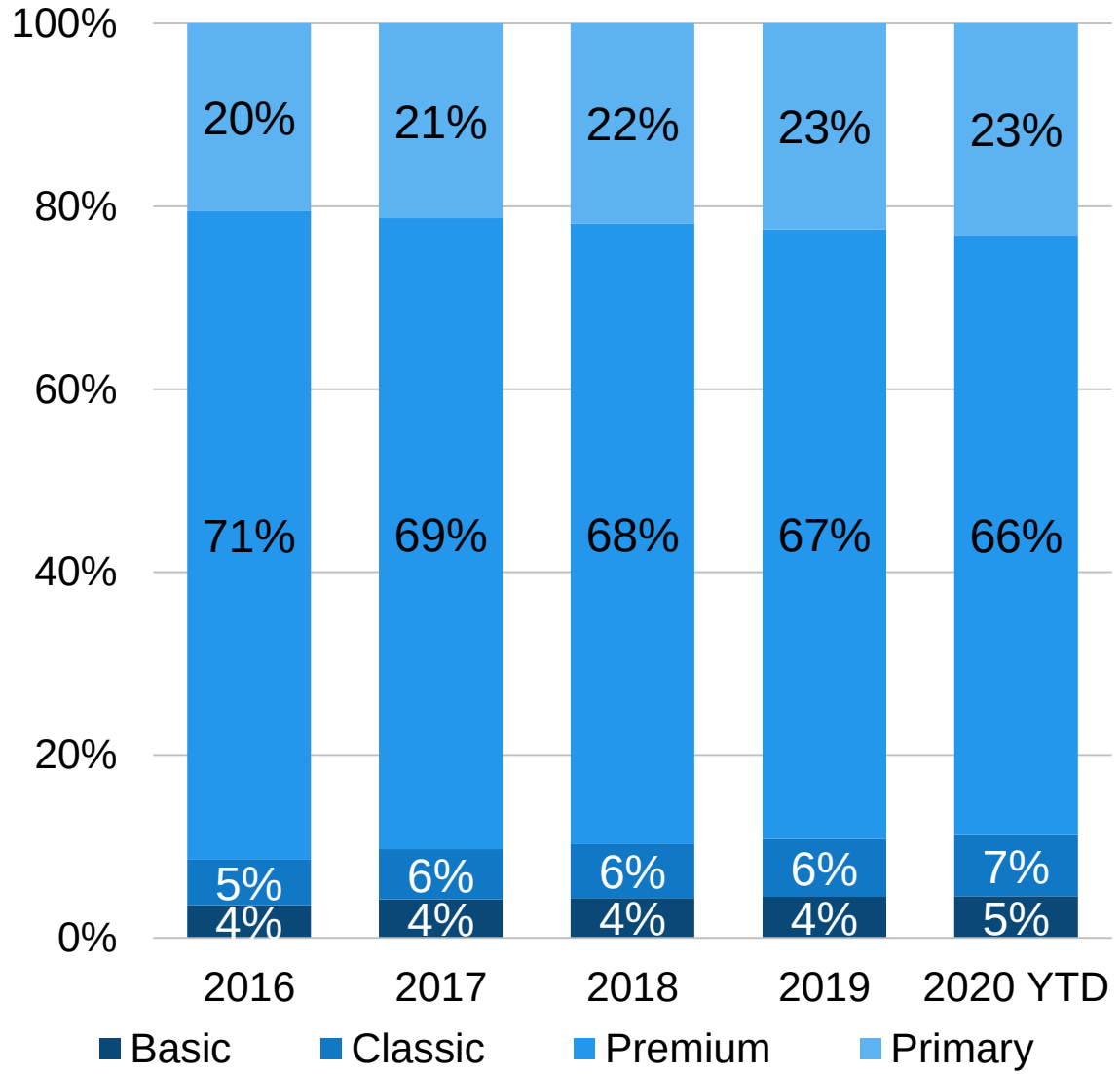
ASE - Average Membership by Status





ASE - Average Membership by Plan





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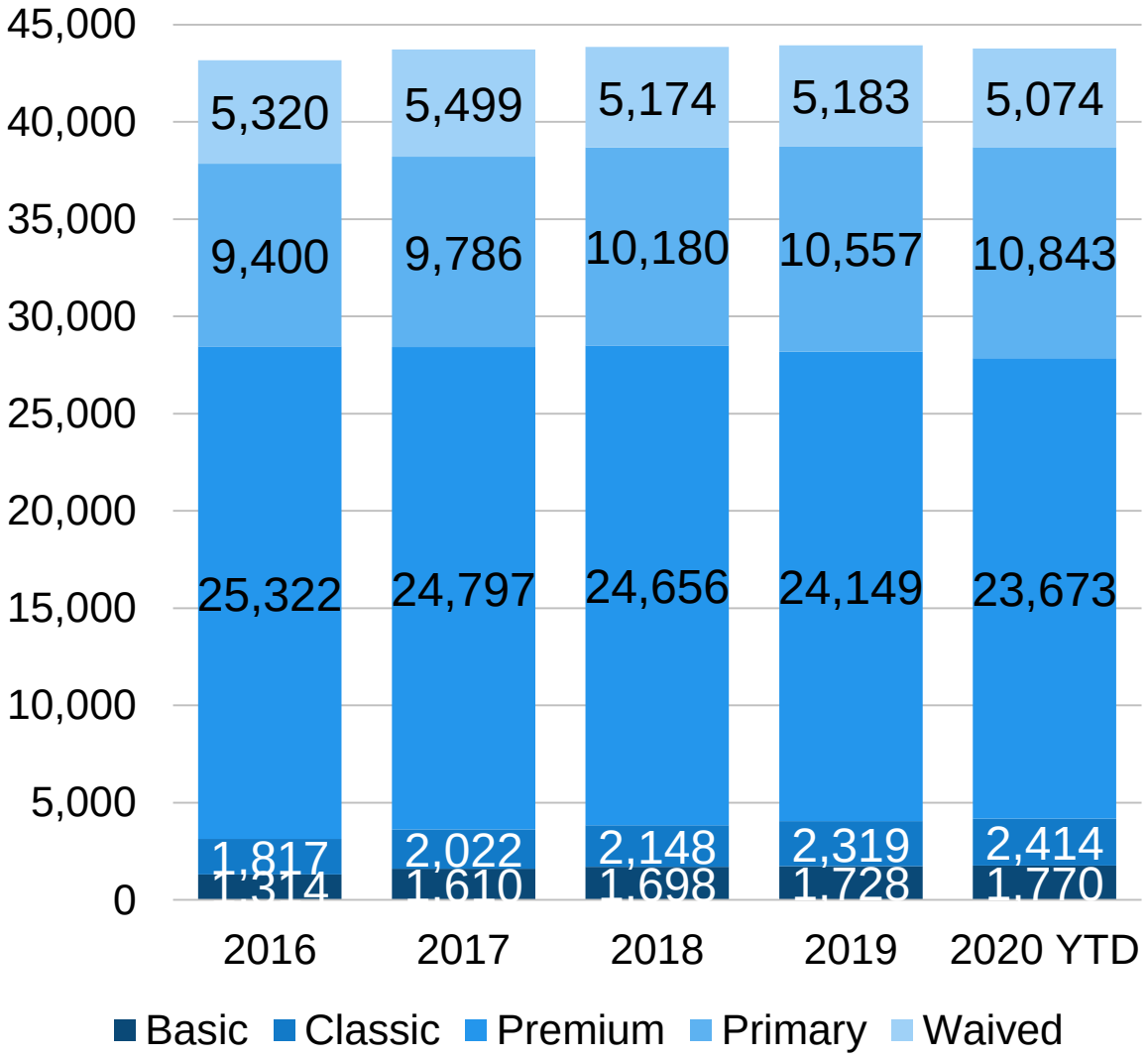
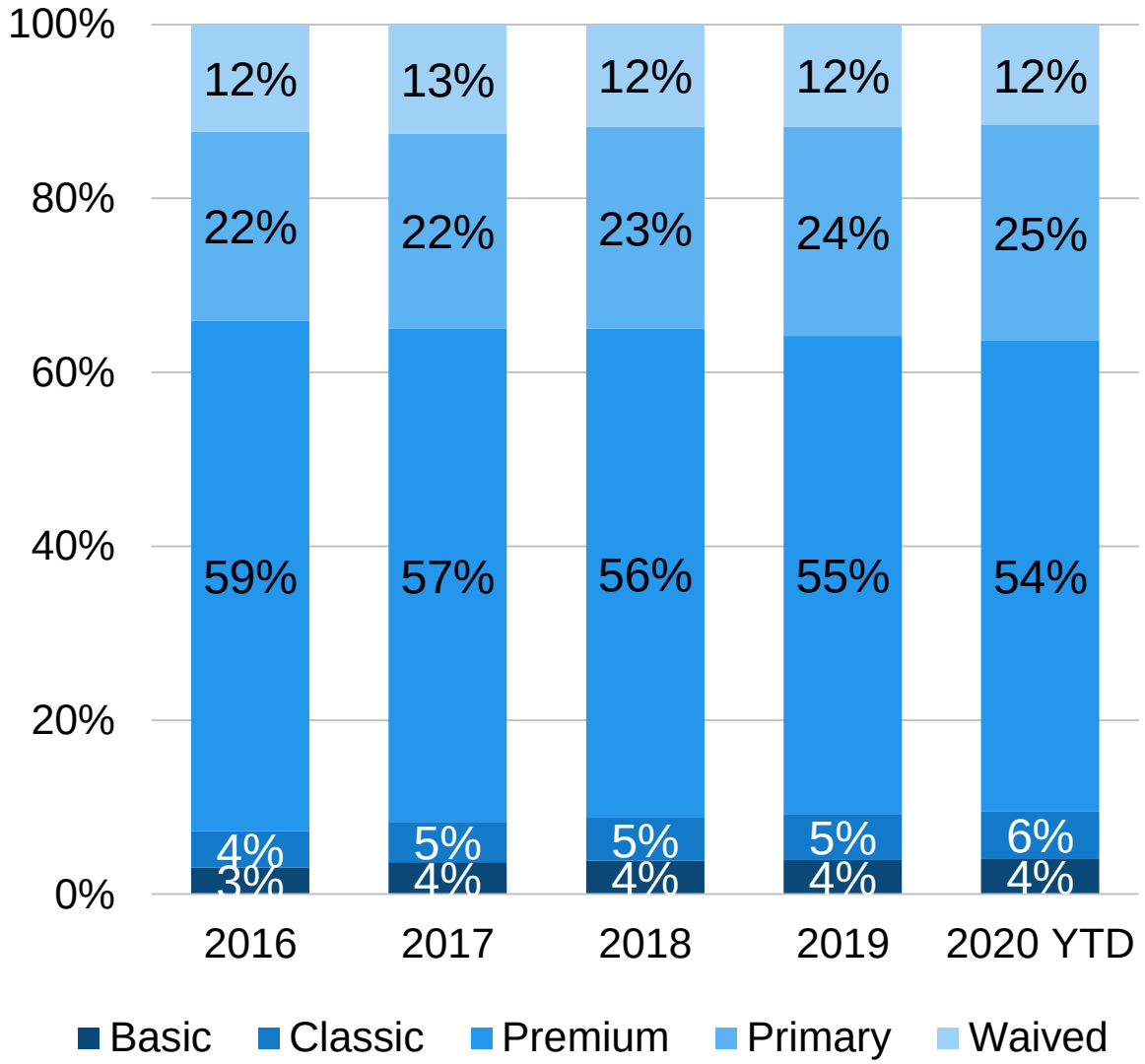
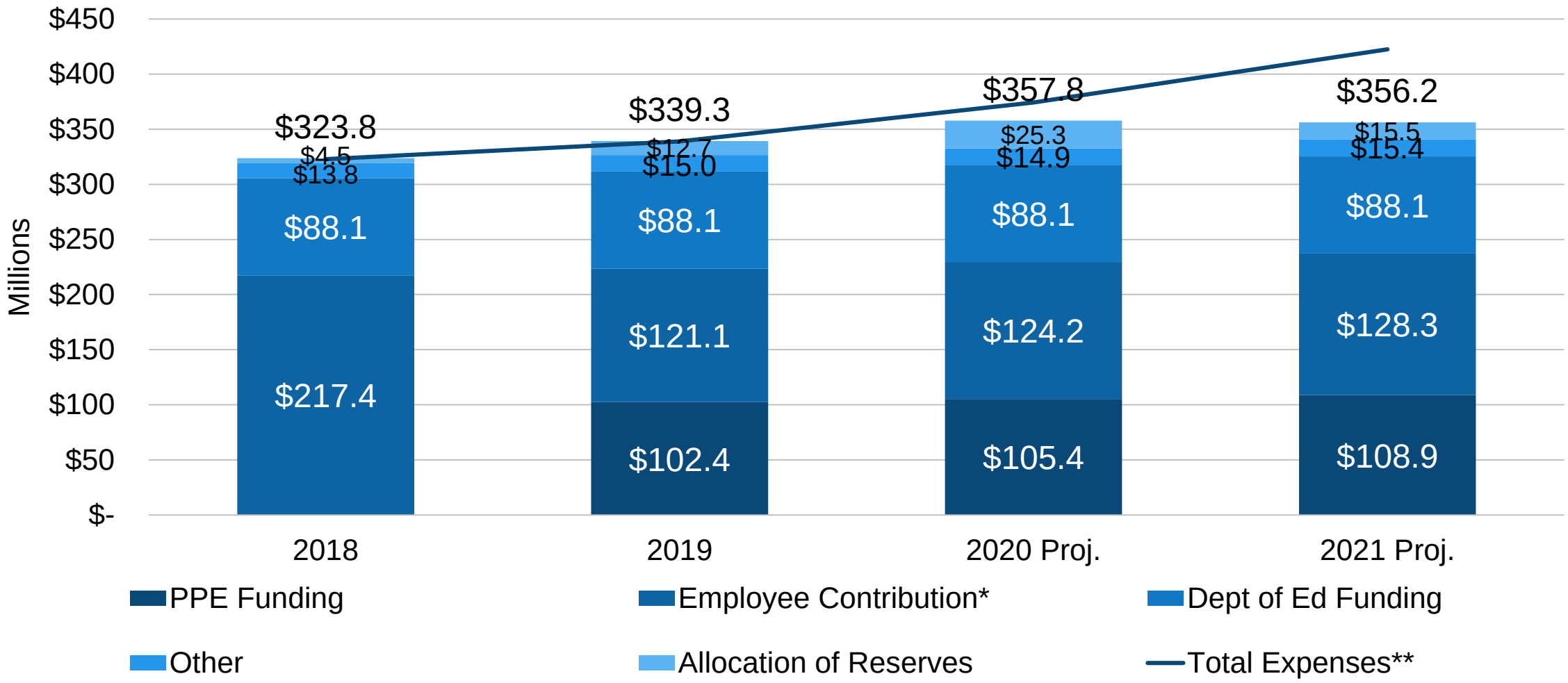
ASE - Average Enrollment (Subscribers) by Plan





PSE - Income vs. Expenditure



* 2018 Employee Contribution includes PPE Funding

** Total Expenses offset by Program Savings

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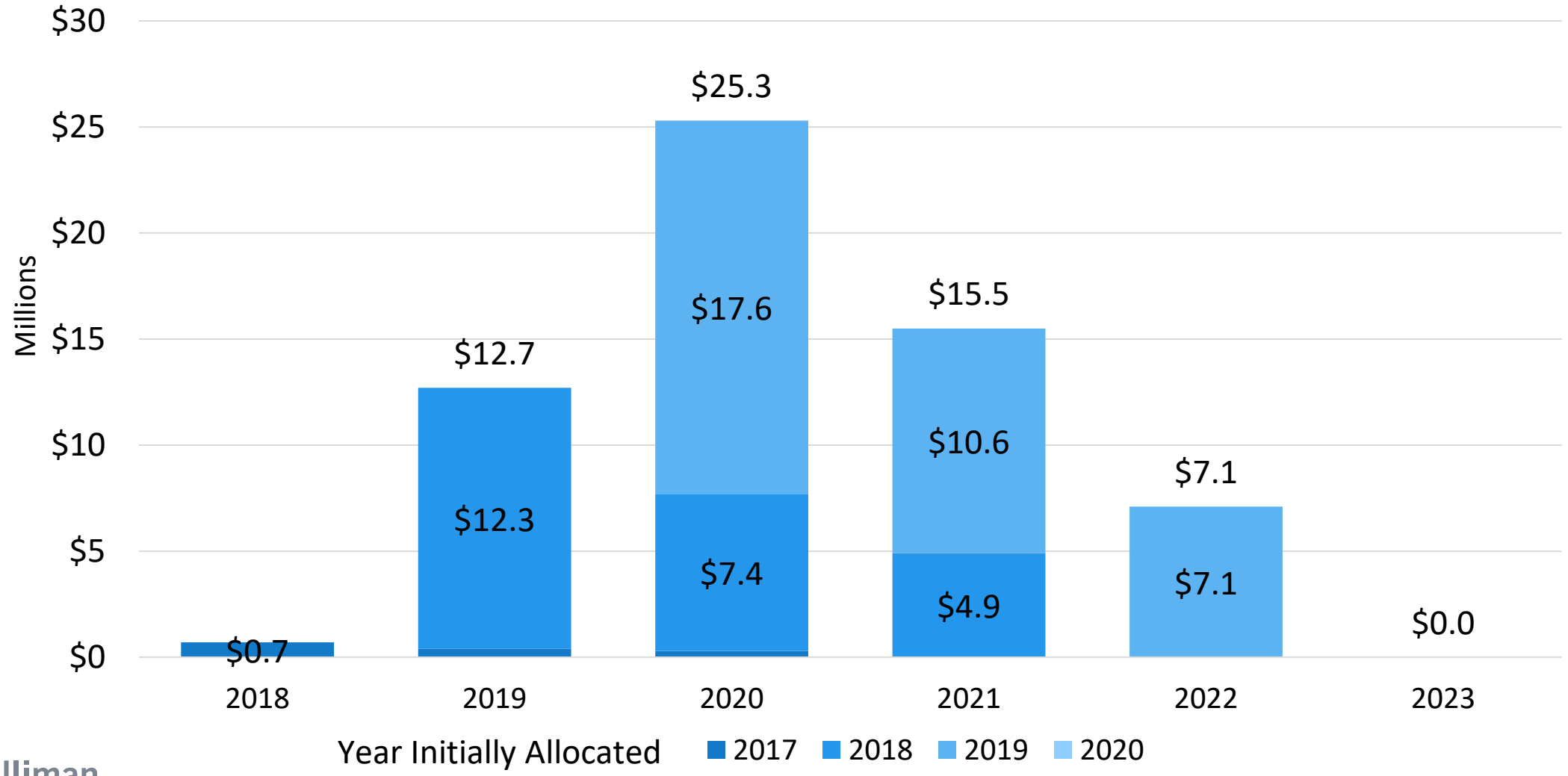
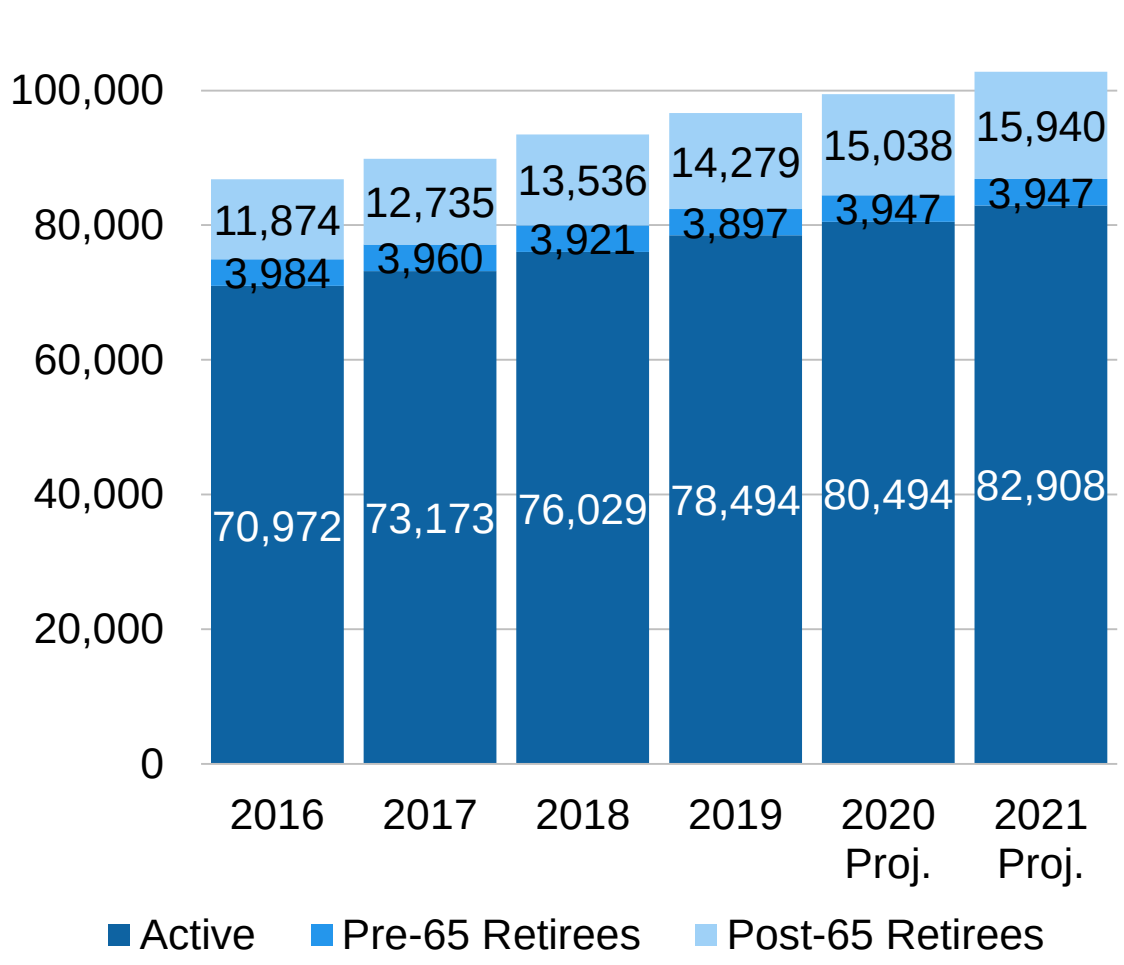
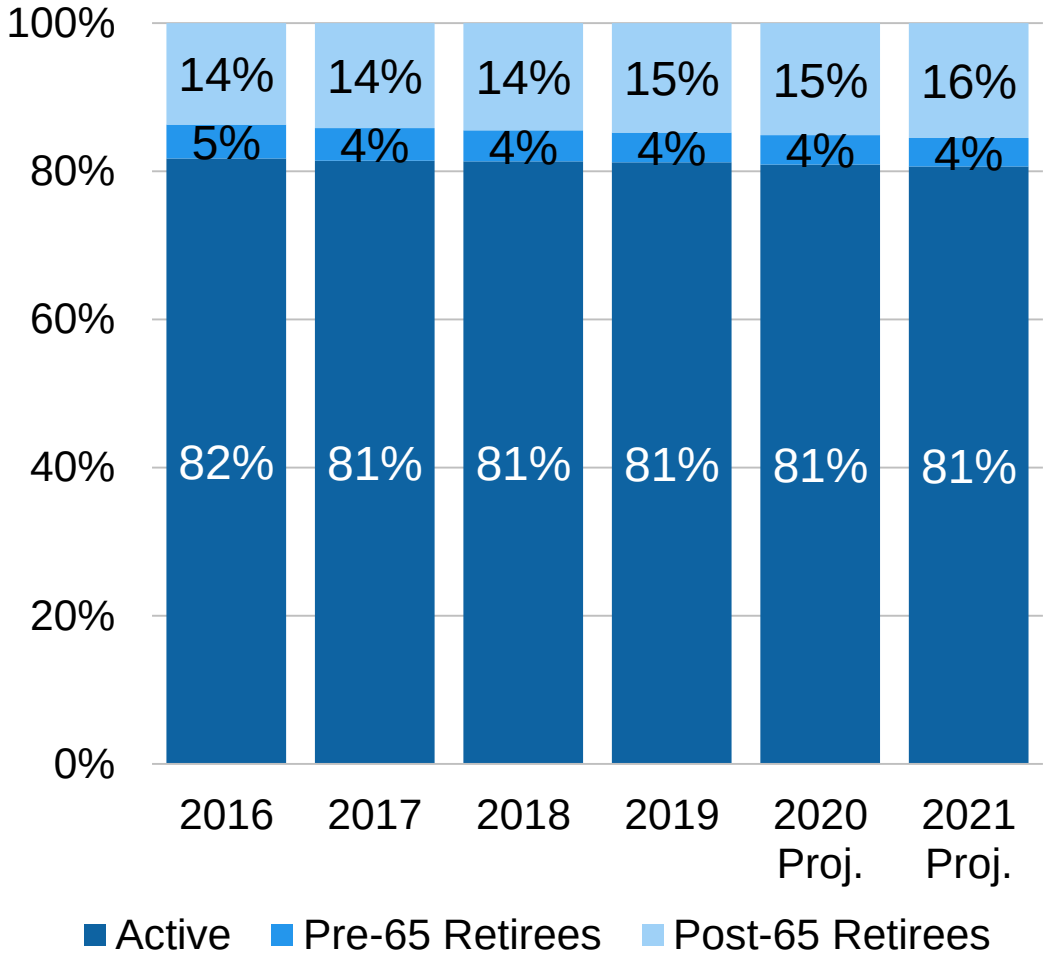
PSE - Reserves Allocation by Year

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

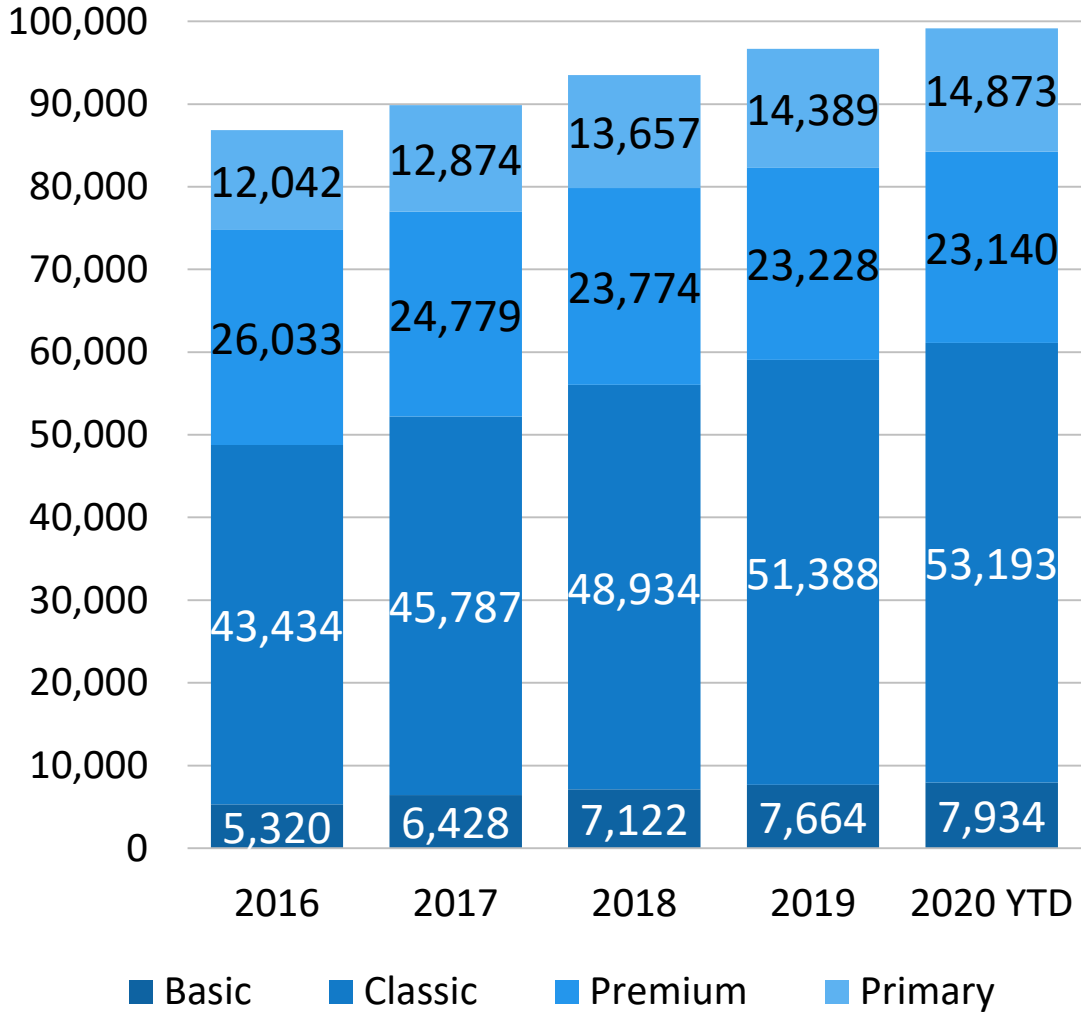


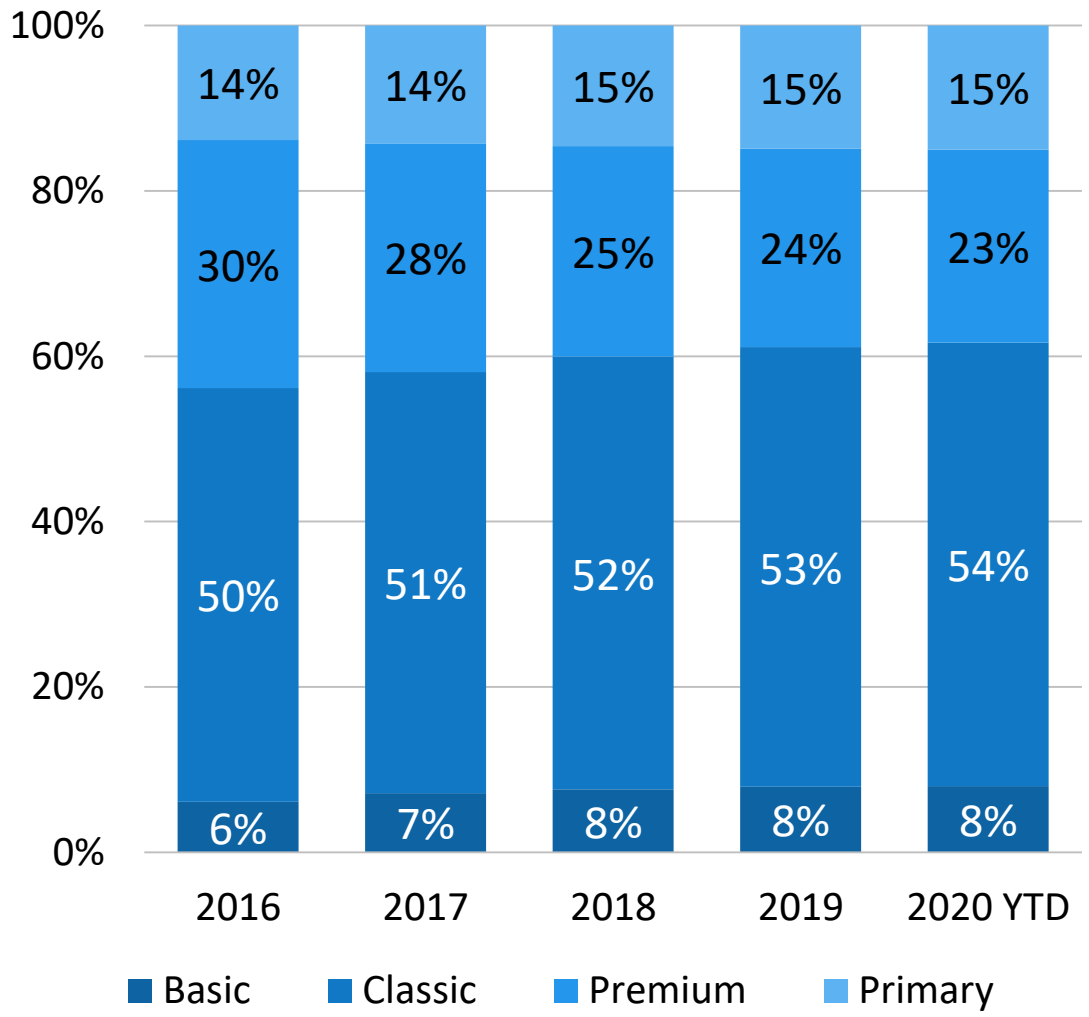
PSE - Average Membership by Status



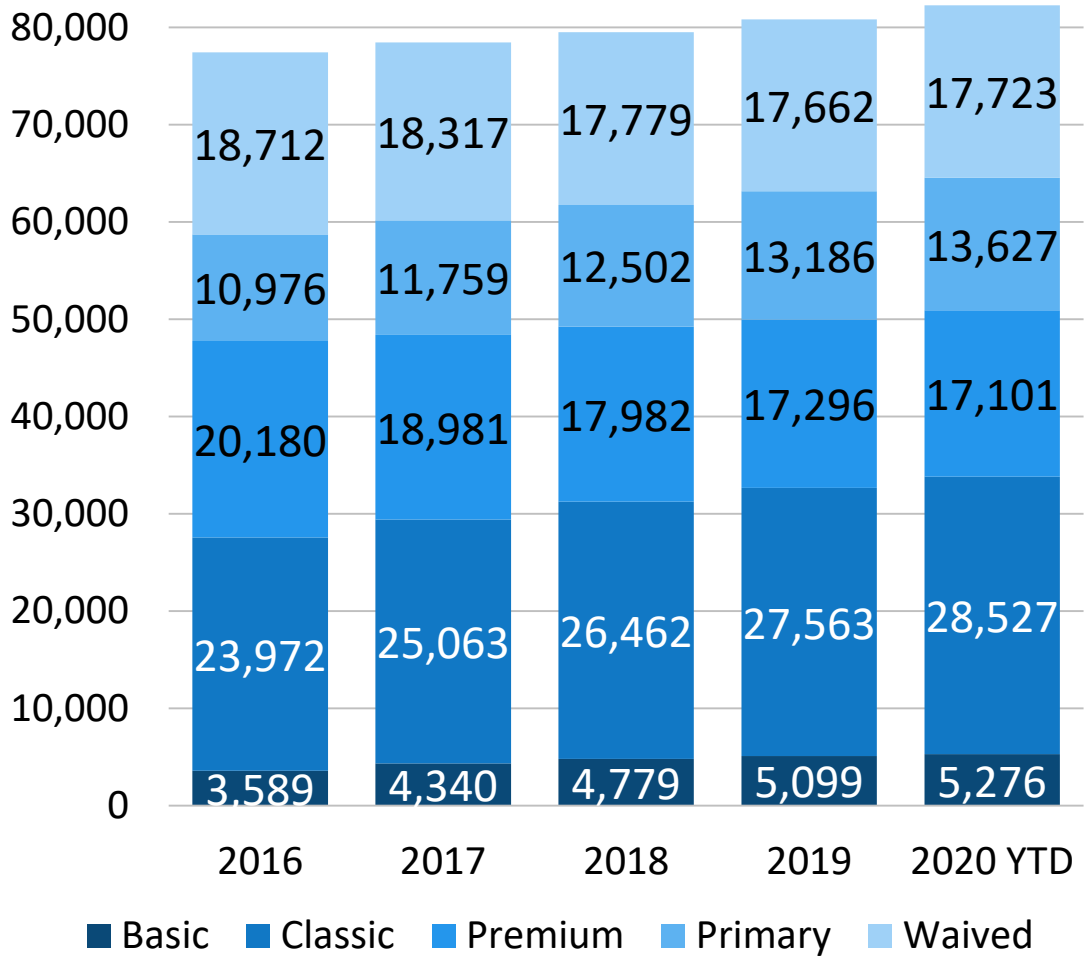


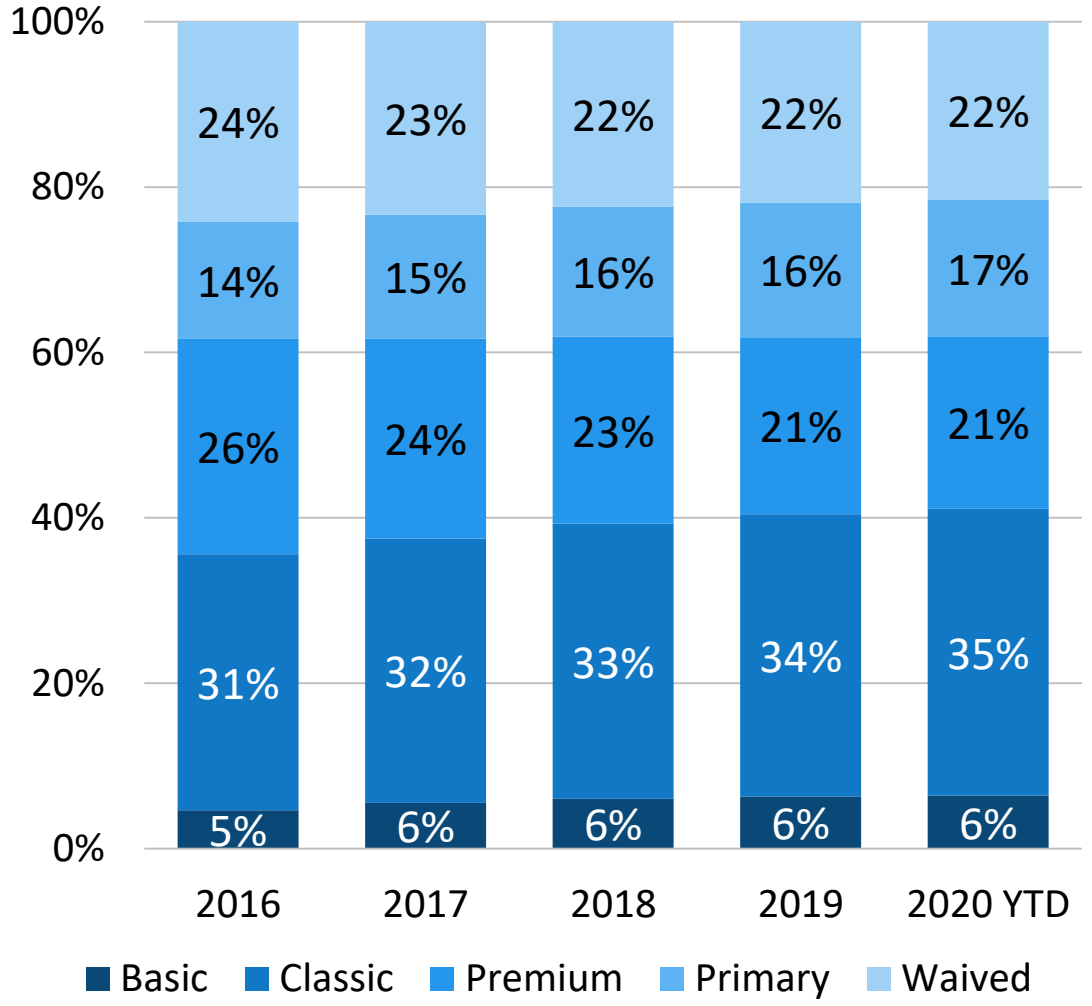
PSE - Average Membership by Plan





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 May 2020
  - Projected June – 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 ($3.96 PMPM for CY2021)
  - PSE - $2.14 PMPM for CY2020 ($2.14 PMPM for CY2021)
- 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 June 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 May 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 (September 1, 2020). Utilize actual claims for January 2020 to April 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.

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Thank you

Courtney White, FSA, MAAA
Paul Sakhrani, FSA, MAAA