AGENDA

State and Public School Life and Health Insurance Board

May 19th, 2020

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I. *Call to Order ..... Carla Haugen, Chair*

II. *Approval of April Minutes ..... Carla Haugen, Chair*

III. *DUEC Report ..... Dr. Hank Simmons, DUEC Chair*

IV. *Quality of Care/Benefits Subcommittee Report ..... Chris Howlett, EBD Director*

V. *Plan Analysis ..... Elizabeth Montgomery & Mike Motley, ACHI*

VI. *Plan Update ..... Paul Sakhrani, & Courtney White, Milliman*

VII. *Director's Report ..... Chris Howlett, EBD Director*

VIII. *Adjournment ..... Carla Haugen, Chair*

2020 Upcoming Meetings:

June 17th, July 21st, August 19th

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

200th meeting of the State and Public-School Life and Health Insurance Board (hereinafter called the Board), met on May 19, 2020, at 1:00 PM via teleconference

Date | *time* 5/19/2020 1:00 PM | *meeting called to order by Carla Haugen, Chair*

Attendance

Members Present

Cindy Allen
Stephanie Lilly-Palmer
Greg Rogers
Dori Gutierrez
Cindy Gillespie – proxy – Damian Hicks
Dr. Terry Fiddler
Melissa Moore
Carla Haugen – Chair
Amy Fecher
Dr. John Kirtley
Dr. Lanita White
Lisa Sherrill
Herb Scott
Cynthia Dunlap
Chris Howlett, Employee Benefits Division Director

Members Absent

Renee Mallory - Vice-Chair

OTHERS PRESENT:

Rhoda Classen, Theresa Huber, Stella Greene, Shalada Toles, Laura Thompson, Mary Massirer, EBD; Micah Bard, Dwight Davis, Octawia DeYoung, Sherry Bryant, UAMS EBRX; Jessica Akins, Health Advantage; Elizabeth Montgomery, Mike Motley, ACHI; Courtney White, Paul Sakhrani, Scott Cohen, Milliman; Frances Bauman, Novo Nordisk; Sean Seago, MERCK; Sidney Keisner, UAMS; Jim Chapman, Abbvie; Nima Nabavi, Amgen; Charles Hubbard, ASP; Mitch Rouse, TSS; John Colberg, Cheiron; Kristie Banks, Mainstream; Alan Whitley; Treg Long, ACS; Sylvia Landers, Colonial Life; Ronda Walthall, ARDOT

Approval of Minutes by Carla Haugen, Chair

MOTION by Scott:

Motion to accept the April 14, 2020 minutes.

Lilly-Palmer 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, May 4th, 2020 with Dr. Hank Simmons presiding.

I. Old Business

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

Parenteral Iron Products

Brand	Generic	Plan Paid/Claim	Current Coverage	Proposed Coverage
Injectafer	Ferric Carboxymaltose	$765.54	N/A Medical*	Exclude
Feraheme	Ferumoxytol	$252.67	N/A Medical*	Exclude
Monoferric	Ferric Derisomaltese	N/A	New product not yet available	Exclude
Infed	Iron Dextran Complex	$137.40	N/A Medical*	N/A Medical*
Venofer	Iron Sucrose	$24.88	N/A Medical*	N/A Medical*
Ferrlecit	Ferric Gluconate	$7.80	N/A Medical*	N/A Medical*
Triferic	Ferric Pyrophosphate Citrate	N/A	N/A Medical*	Exclude

*N/A Medical means that EBD does not have a specific coverage policy; however, coverage is determined through Health Advantage policy.

Recommendation:

-Exclude Feraheme, Injectafer, and Triferic. Exclude Monoferric when launched.
-Potential savings (assuming Injectafer/Feraheme shift to iron dextran): $126,932/year

The DUEC voted to adopt the recommendation as presented.

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

1. Ophthalmic Antihistamines

Recommendation: Exclude drugs per the table below. Several OTC alternatives are available for much less cost.

	Brand	Generic	Strength	Proposal
OTC	Pataday	Olopatadine	0.1% & 0.2%	Exclude
RX	Pazeo	Olopatadine	0.7%	Exclude

OTC	Generic	Olopatadine	0.1% & 0.2%	Exclude
OTC	Generic	Azelastine	0.05%	Exclude
OTC	Zaditor, Alaway, Caritin Eye, Refresh Eye Itch Relief, Zyrtec Itchy Eye	Ketotifen	0.035%	Exclude
OTC	Visine-A	Naphazoline 0.25%/pheniramine 0.3%	0.3%	Exclude
OTC	Generic Equate	Ketotifen	0.035%	Exclude
OTC	Naphcon A	Pheniramine/naphazoline		Exclude
OTC	Vasocon-A	Antazoline/naphazoline		Exclude
OTC	Opcon-A	Pheniramine/naphazoline		Exclude
RX	Lastacaft	Alcaftadine	0.25%	Exclude
RX	Bepreve	Bepotastine	1.5%	Exclude
RX	Generic	Epinastine	0.05%	Exclude

2. <u>Provenge® (sipuleucel-T)</u>
Recommendation: Cover with medical PA

Provenge is indicated for a subset of metastatic prostate cancer. Provenge has been reviewed multiple times and is currently excluded. There is no consistent data that support coverage for patients with minimal symptoms and who are in the early phases of their disease course.

3. <u>Reblozyl® (luspatercept-aamt)</u>
Recommendation: Cover with medical PA

Reblozyl is currently excluded due to limited medical benefits. It recently received a new indication for anemia caused by lower-risk myelodysplastic syndrome. Compared to placebo, there was a significant increase in the percentage of patients who became transfusion independent (requiring no RBC transfusions at all). The patients included in the study and the FDA approval were those who already failed or were not candidates for erythropoietin.

<u>The DUEC voted to adopt the recommendations as presented.</u>

II. New Business

A. <u>New Drugs: *Dr. Jill Johnson and Dr. Sidney Keisner, UAMS*</u>

Brand	Generic	Recommendation
Non-Specialty Drugs		
(1) REYVOW	LASMIDITAN SUCCINATE	Exclude, Code 10
(2) VYEPTI	EPTINEZUMAB-JJMR	Exclude, Code 13
(3) NEXLETOL	BEMPEDOIC ACID	Exclude, Code 1 & 13
(4) NURTEC ODT	RIMEGEPANT SULFATE	T4PA; Pending Rebates vs. Ubrelvy

(5) TRIJARDY XR	EMPAGLIFLOZ/LINAGLIP/METFORMIN	Exclude, Code 1
(6) PENTACEL	DTAP-IPV	Cover, No copay
(7) XCOPRI	CENOBAMATE	Cover, T3 with QL of 2/day
Specialty Drugs		
(1) RUXIENCE	RITUXIMAB-PVVR	N/A Medical; Exclude pharmacy
(2) TAZVERIK	TAZEMETOSTAT HYDROBROMIDE	Exclude, Code 1
(3) PALFORZIA	PEANUT ALLERGEN POWDER-DFNP	Exclude, Code 1, 8, & 10
(4) TRAZIMERA	TRASTUZUMAB-QYYP	N/A Medical; Exclude pharmacy
(5) ADAKVEO	CRIZANLIZUMAB-TMCA	Exclude, Code 10
(6) ASCENIV	IMMUNE GLOBULIN, GAMMA(IGG)SLRA	Exclude, Code 13
(7) SARCLISA	ISATUXIMAB-IRFC	Exclude, code 8
(8) SCENESSE	Add coma fter side	Exclude, code 1 and 9 (medical and pharmacy)
(9) HERZUMA	TRASTUZUMAB-PKRB	N/A Medical; Exclude pharmacy

The DUEC voted to adopt the recommendations as presented.

III. Other Considerations: *Dr. Dwight Davis, UAMS*

Dr. Davis, with EBRx, asked for the opportunity to pursue rebate contracts for biosimilars such as Rituximab and Herceptin and also for the immune globulin products.

The DUEC voted to allow EBRx to pursue rebate opportunities.

Discussion

MOTION by Dr. Kirtley:

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

Dr. White seconded

Dr. Fiddler: On this rebate portion, have you had luck with this in the past? Do we get 100% that we ask or do the prorate this on what they actually return to us?

Dr. Davis: In some of these categories, as you know, we have several biosimilar opportunities, and these are actually three categories that we felt were pretty significant. These drugs are actually administered on the medical side, where we now have access to the data on the medical side. We have gone down this pathway with a couple of infusible drugs before and have been very successful. The drug manufacturers are very willing to contract these drugs as long as you can control the market share. EBD has a closed formulary, which is very effective in controlling the specific drug used. That is very attractive to them, and we have been very successful in driving those rebates, and 100% of those rebates paid by the manufacturer flow right back to this plan.

Restated **MOTION** by Dr. Kirtley:

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

Dr. White seconded

All were in favor.

Approved.

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

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

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

Plan Analysis by Elizabeth Montgomery & Mike Motley, ACHI

Montgomery and Motley presented new analyses regarding COVID-19 impact on the plan and review options for additional related analyses.

Discussion

Dr. Fiddler: I'm with the ADA and I am over five states with the COVID-19. All of these numbers that we are seeing now, I think Arkansas is reality, but they're about to change or stop if you will, some of these reported deaths. There are so many states that are being counted for deaths even though a patient died of something else, but because they were in a COVID situation, they were named a COVID death. Colorado is a prime example, and they have dropped theirs by a third because their listing of deaths was not necessarily due to COVID.

Howlett: Just to give a little landscape and backstory here, ACHI was partnered with the Department of Health on their request to provide COVID-19 analysis for the state. Once we became aware of that from a plan perspective, and as a department, that is where this analysis and brief update has come from. We are going to try to take what they are doing for the overall state and partner with ACHI in our current partnership and provide the analysis for COVID-19 for EBD. There are things that you might want to see, and if we are able to show them, we will be glad to do that. But we are trying to do a little insight into what the EBD health plan is experiencing compared to the state.

Plan Update by Courtney White & Paul Sakhrani, Milliman

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

ASE

- 2020 & 2021 projections updated to incorporate claims data incurred from March 2019 to February 2020 and paid through April 2020

- 2020 projected plan experience
    - Allocated reserves for 2020 is $25.1M
    - Estimated deficit of $16.2M
    - End of Year Assets: $55.4M
    - No plan changes / 5% increase in employee contributions
- 2021 plan experience
    - No additional funding ($14.5M allocated assets)
    - Projected deficit: $36.6M
    - End of Year Assets: $4.3M
    - 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 April 2020

- 2020 plan experience
    - Allocated reserves for 2020 is $25.3M
    - Estimated deficit of $23.9M
    - End of Year Assets: $99.9M
    - No plan changes / 0% increase to employee contributions
- 2021 plan experience
    - No additional funding ($15.5M allocated assets)
    - Projected deficit: $63.5M
    - End of Year Assets: $20.9M
    - No plan design or contribution changes
    - Increased membership based on historical patterns
    - Baseline trends (medical: 7%, pharmacy: 8%)

Discussion

Dr. Fiddler: If there is some way that there could be a summation of this or some type of impact statement or whatever on a little more succinct gathering, that would be helpful. I don't mean to belittle because I appreciate all this, but this is just more than I can take.

Scott: We will do a summary at the end, where we show a scenario that pulls one scenario of all of these things together. That will probably be helpful.

Dr. Fiddler: This is the best case scenario that I'm looking at here, but we have a current deficit of $36.5 million and $51 million without allocated assets. Let's just say we don't have the

initiatives and the increased state funding, and this throws us into the $25 to $30 million-dollar deficit. What do we do?

Howlett: The mechanisms for the health plan being self-funded would be through premiums or employer contributions. The plan's administrative piece would be to help control the inflation of the cost of that, and the members' role is either reduced claims. There are only a few mechanisms in the equation. You have employer contribution, premiums, and then those are driven by claims and utilization. We have to find some method to bring that down within reason. That's where the plan initiatives, the program initiatives, and the administrative side of the plans come in. The other piece is going to be through premiums, employer contributions, or benefit changes to help reduce the overall liability risk for the plan.

Dr. Fiddler: That's what I thought, and I see three options here. You reduce the amount of procedures that are allowed by the insurance company so that, therefore you reduce the amount of cost to the plan; that is an option. That is what you're saying?

Howlett: In option three, when you're dealing with deductibles or out-of-pocket, that is a mechanism in the plan design. That is a cost shift, which means the plan pays less on that, and the member picks up more.

Scott: There are also benefits that are required to be provided that you could eliminate, but usually those are benefits that are small in the effect of a meaningful population.

Haugen: In the past, benefits changes are about the only thing that makes any real dollar changes that overall deductible amount other than premiums.

Dunlap: On the employer contribution, you mentioned that you don't know how that would be approved or when. When do you know whether you can increase the employer contribution? When do we have to put these changes in place, because if you don't know the employer contribution piece, that's going to impact the overall impact of what you get from the other changes?

Howlett: As far as the decisions being made between now and July, those decisions would take effect on 1/1/2021. As we are vetting all of these components out, before decisions are made, we would look at all of the different mechanisms or what levers we would want to deploy to help deal with this situation. As far as how the contribution rates would be viewed, recommendations from the Board that were approved would be taken by the EBD director to the chief fiscal officer of the state, Secretary Walther. That would be considered against the resources of the state for that time period.

Dunlap: Okay, any increase in the employee contribution rate will not go into effect until July 2021.

Howlett: As far as the health plan, we are on a twelve-month calendar year. Secretary Walther would have to look at available resources to consider the Board's recommendation for the employer contribution increase. Even though the FY21 budget is set, it would be

against that, meaning we would have to look at the current budget and find the resources to address the recommendation.

Dunlap: Where would the difference come from. If the employers for FY21 are only going to pay $420 and you recommend the increase for $425, where does the five-dollar difference come from until the next year when it can be passed on to the employers?

Howlett: That would go to the chief fiscal officer, and they would have to determine where those proceeds or funds would come from.

Haugen: Greg, what is the likelihood of any kind of additional funding on the public school fund, and I'm not committing you, I'm just kind of the same thing with the budget crunch even on the state employee side seeing that increase paid by the state might be a hard thing to swallow with the current budget and all the kids.

Rogers: That would be hard for me to say with where we are right now with what it would be on the public side.

Haugen: Of course, we are making cuts all over. We just need to know with all the current budget cuts going on, we have to be cognitive that the decision of any additional funding from the public-school fund or the state.

Moore: I would like to see what it would be if we raised the rates on all three plans, including the premium plan. I'm more looking at raising the rates equally if that has to happen rather than choosing just the middle tier or the lower tier.

Haugen: You're saying kind of like we have done before, just an overall rate increase in total.

Lilly-Palmer: I agree with Melissa. I would like to see what the rate changes would be across the board so that it would give us a better view. I also think that next month we are going to have some new numbers. I just think that the employees are more apt to pay a little more pre-tax than they are going to want to increase other things.

Haugen: That is a really good point.

Howlett: So, aside from what Missy and Stephanie had mentioned, would a better approach to help the Board members be to chunk the whole situation up into different pieces or how would you like to see it? If I hear it correctly, we are less inclined towards any of the deductibles and out-of-pockets being changed, maybe considering some benefit changes, but primarily, we want to look at the rate and the flow of the dollars.

Moore: Yes, just look at maybe some different scenarios where we raise the rates on the different levels and see what that would look like.

Sherill: For what it's worth, at least with the rate increase, there's at least a small possible tax break if they're having that pre-tax taken out, whereas when you're having to pay out-of-pocket, you're not going to see that. It may not be much, but it may help.

Allen: One of the things we also have to keep in mind is what we saw last year with ASE, if we go up across the board, we may see a lot of people go to a lower plan. We need to think about what that might do on how much we are going to be able to save on our deficit if they all start to go to a lower plan, which could happen if we change across the board. That is something else to consider too.

Howlett: As far as risk aversion from members going from premium to classic or classic to basic, yes. What I have as far as future information will be all around rates, from pre-tax. As far as the rate breakdown, as we were to increase the rate, revenue generated back towards the plan increases. One of the other components as we go into May, if needed, we can have two meetings in June to be able to present you with enough information to be able to give you a solid footing in making a decision, and likewise with July. From an administrative standpoint, our decision, a drop-dead date, would be right there at the end of July for us to make any configuration changes or things for the health plan to be able to put in place for the open enrollment. We can deal with that and talk about that more as we go into the next meeting.

Haugen: It goes through Benefits, so for those not on the Benefits, it might help listening in on those because you would get the first round of it being presented, and then when it comes back at Board it might shorten the hashing out.

Howlett: We will send out the Benefits subcommittee information out to the Board members as well.

Director's Report by Chris Howlett, EBD Director

Howlett stated that we will turn this information around and have that before the Benefits. The next Board meeting is set for June 17th, about the middle of the month. You will have an update next month with a little more focused agenda. As far as what passed last month with the diabetic supplies and the movement of that population, we are pleased to announce that we have communicated with all the members. There have been a few questions and comments and a few people that were misinformed, and we were there to help. It was requested that I provide updates on that, and we have set a tentative soft date of July 1st,and we will continue to work with the members that have some bleed over past July 1st.

MOTION by Lilly-Palmer:

I motion to adjourn the meeting.

Dr. Kirtley seconded. All were in favor.

Meeting Adjourned.

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

The following report pertains to the DUEC meeting at 1:00 p.m. on Monday, May 4th, 2020 with Dr. Hank Simmons presiding.

I. Old Business

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

Parenteral Iron Products

Brand	Generic	Plan Paid/Claim	Current Coverage	Proposed Coverage
Injectafer	Ferric Carboxymaltose	$765.54	N/A Medical*	Exclude
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Infed	Iron Dextran Complex	$137.40	N/A Medical*	N/A Medical*
Venofer	Iron Sucrose	$24.88	N/A Medical*	N/A Medical*
Ferrlecit	Ferric Gluconate	$7.80	N/A Medical*	N/A Medical*
Triferic	Ferric Pyrophosphate Citrate	N/A	N/A Medical*	Exclude

*N/A Medical means that EBD does not have a specific coverage policy, however, coverage is determined through Health Advantage policy.

Recommendation:

-Exclude Feraheme, Injectafer, and Triferic. Exclude Monoferric when launched.
-Potential savings (assuming Injectafer/Feraheme shift to iron dextran): $126,932/year

The DUEC voted to adopt the recommendation as presented.

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

1. Ophthalmic Antihistamines

Recommendation: Exclude drugs per the table below. Several OTC alternatives available for much less cost.

	Brand	Generic	Strength	Proposal
OTC	Pataday	Olopatadine	0.1% & 0.2%	Exclude
RX	Pazeo	Olopatadine	0.7%	Exclude
OTC	Generic	Olopatadine	0.1% & 0.2%	Exclude
OTC	Generic	Azelastine	0.05%	Exclude
OTC	Zaditor, Alaway, Caritin Eye, Refresh Eye Itch Relief, Zyrtec Itchy Eye	Ketotifen	0.035%	Exclude
OTC	Visine-A	Naphazoline 0.25%/pheniramine 0.3%	0.3%	Exclude
OTC	Generic Equate	Ketotifen	0.035%	Exclude
OTC	Naphcon A	Pheniramine/naphazoline		Exclude
OTC	Vasocon-A	Antazoline/naphazoline		Exclude
OTC	Opcon-A	Pheniramine/naphazoline		Exclude
RX	Lastacaft	Alcaftadine	0.25%	Exclude
RX	Bepreve	Bepotastine	1.5%	Exclude
RX	Generic	Epinastine	0.05%	Exclude

2. Provenge® (sipuleucel-T)

Recommendation: Cover with medical PA

Provenge is indicated for a subset of metastatic prostate cancer. Provenge has been reviewed multiple times and is currently excluded. There is now consistent data that support coverage for patients with minimal symptoms and who are in the early phases of their disease course.

3. Reblozyl® (luspatercept-aamt)

Recommendation: Cover with medical PA

Reblozyl is currently excluded due to limited medical benefit. It recently received a new indication for anemia caused by lower risk myelodysplastic syndrome. Compared to placebo, there was a significant increase in the percentage of patients who became transfusion independent (requiring no RBC transfusions at all). The patients included in the study and the FDA approval were those who already failed or were not candidates for erythropoietin.

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) REYVOW	LASMIDITAN SUCCINATE	Exclude, Code 10
(2) VYEPTI	EPTINEZUMAB-JJMR	Exclude, Code 13
(3) NEXLETOL	BEMPEDOIC ACID	Exclude, Code 1 & 13
(4) NURTEC ODT	RIMEGEPANT SULFATE	T4PA; Pending Rebates vs. Ubrelvy
(5) TRIJARDY XR	EMPAGLIFLOZ/LINAGLIP/METFORMIN	Exclude, Code 1
(6) PENTACEL	DTAP-IPV	Cover, No copay
(7) XCOPRI	CENOBAMATE	Cover, T3 with QL of 2/day
Specialty Drugs		
(1) RUXIENCE	RITUXIMAB-PVVR	N/A Medical; Exclude pharmacy
(2) TAZVERIK	TAZEMETOSTAT HYDROBROMIDE	Exclude, Code 1
(3) PALFORZIA	PEANUT ALLERGEN POWDER-DFNP	Exclude, Code 1, 8, & 10
(4) TRAZIMERA	TRASTUZUMAB-QYYP	N/A Medical; Exclude pharmacy
(5) ADAKVEO	CRIZANLIZUMAB-TMCA	Exclude, Code 10
(6) ASCENIV	IMMUNE GLOBULIN, GAMMA(IGG)SLRA	Exclude, Code 13
(7) SARCLISA	ISATUXIMAB-IRFC	Exclude, code 8
(8) SCENESSE	AFAMELANOTIDE ACETATE	Exclude, code 1 and 9 (medical and pharmacy)
(9) HERZUMA	TRASTUZUMAB-PKRB	N/A Medical; Exclude pharmacy

The DUEC voted to adopt the recommendations as presented.

III. Other Considerations: *Dr. Dwight Davis, UAMS*

Dr. Davis with EBRx asked for the opportunity to pursue rebate contracts for biosimilars such as Rituximab and Herceptin and also for the immune globulin products.

The DUEC voted to allow EBRx to pursue rebate opportunities.

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

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
- Plan Follow-up Analysis
- Plan Update *Benefits only
- Director's Report

Plan Follow-up Analysis: Elizabeth Montgomery & Mike Motley, ACHI
Montgomery and Motley presented new analyses regarding COVID-19 impact on the plan and addressed follow-up questions from the previous meeting.

Plan Update: Paul Sakhrani and Courtney White, Milliman
Sakhrani and White provided an educational piece on trend and 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 April 2020

- 2020 projected plan experience
  - Allocated reserves for 2020 is $25.1M
  - Estimated deficit of $16.2M
  - End of Year Assets: $55.4M
  - No plan changes / 5% increase in employee contributions
- 2021 plan experience
  - No additional funding ($14.5M allocated assets)
  - Projected deficit: $36.6M
  - End of Year Assets: $4.3M
  - 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 April 2020

- 2020 plan experience
    - Allocated reserves for 2020 is $25.3M
    - Estimated deficit of $23.9M
    - End of Year Assets: $99.9M
    - No plan changes / 0% increase to employee contributions
- 2021 plan experience
    - No additional funding ($15.5M allocated assets)
    - Projected deficit: $63.5M
    - End of Year Assets: $20.9M
    - No plan design or contribution changes
    - Increased membership based on historical patterns
    - Baseline trends (medical: 7%, pharmacy: 8%)

Director's Report: Chris Howlett, EBD Director

Quality of Care

Howlett stated that with ACHI partnering with the Health Department, we will continue to provide updates as they become available.

Benefits Subcommittee

Howlett provided an update on the recommendation made to the Board in regard to the diabetic changes. All members have been lettered with a soft start date of July 1st. More updates will be provided as information comes available.

MAY 2020 EBD BOARD PRESENTATION

Mike Motley, MPH
Director, Analytics

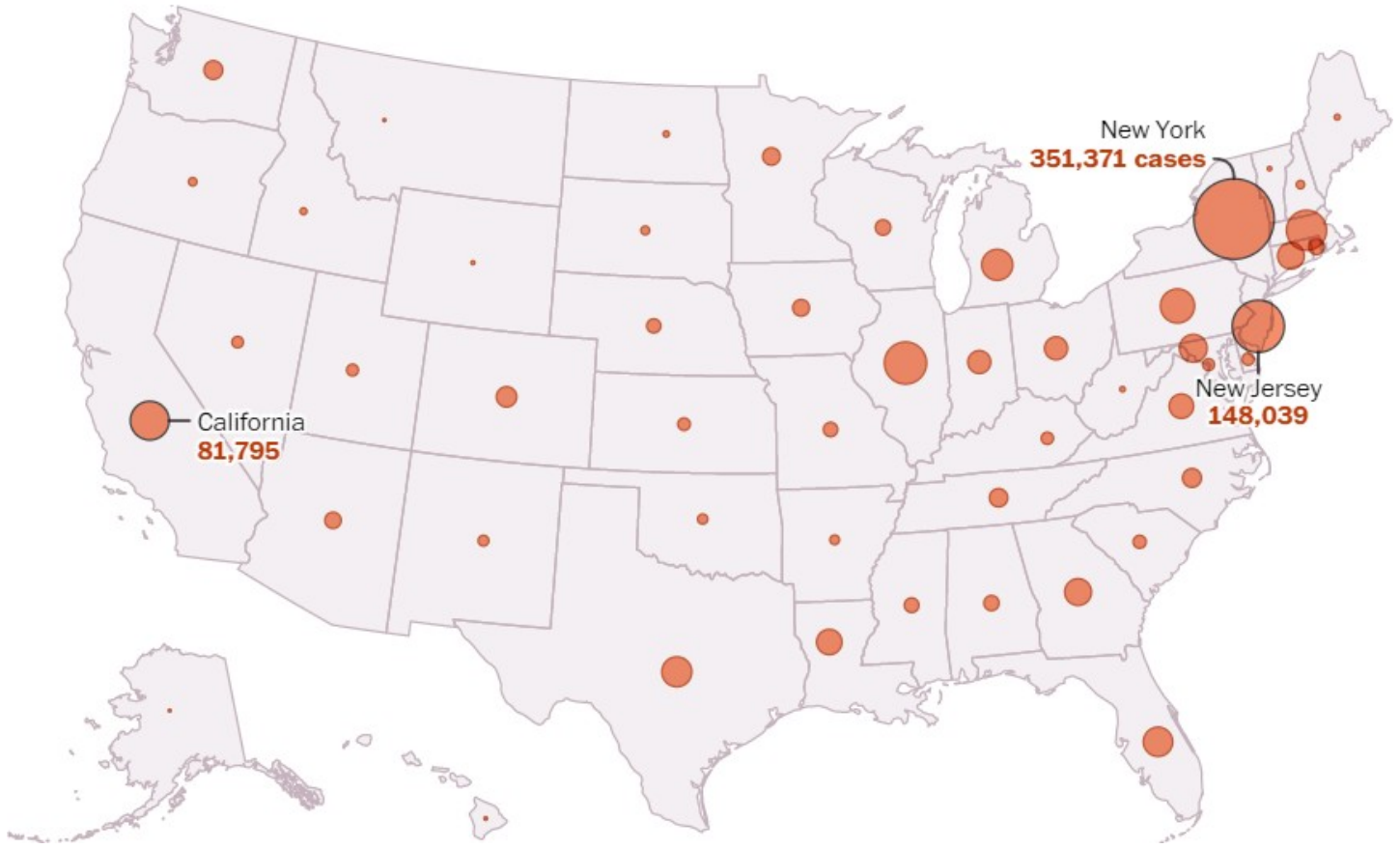
Izzy Montgomery, MPA
Policy Analyst

5.19.2020

OBJECTIVES

- Present new analyses regarding COVID-19 impact on plan
- Review options for additional related analyses

COVID-19: CONFIRMED CASES IN THE U.S.



Source: Washington Post

Confirmed Cases

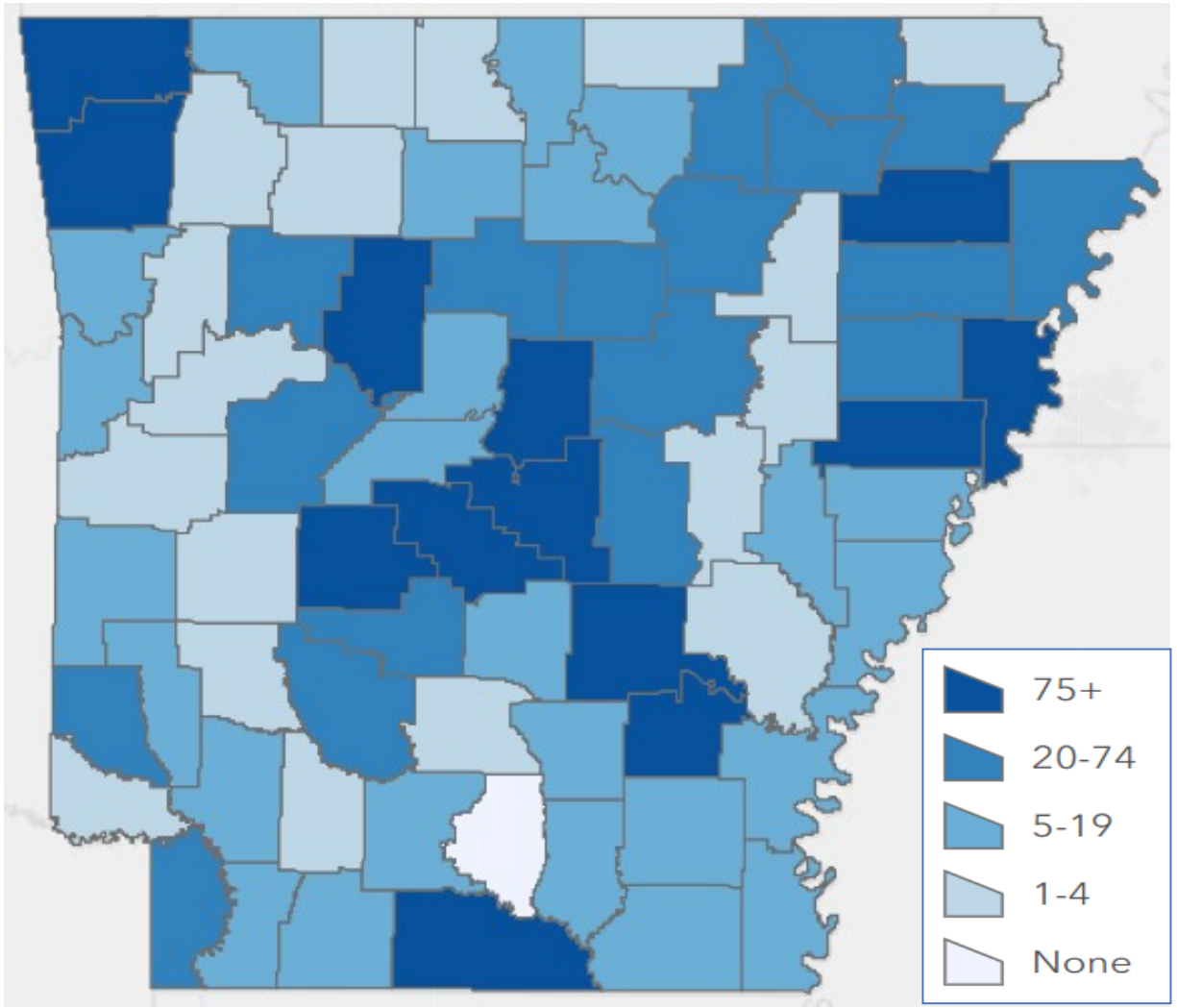
1,507,162

Reported Deaths

89,377

As of May 19
10:00 a.m.

COVID-19: CONFIRMED CASES BY AR COUNTY



Cumulative Cases:
4,813

Hospitalized: 77

On Ventilator: 12

Deaths: 100

Recoveries: 3,645

As of May 19
10:00 a.m.

Source: Arkansas Department of Health

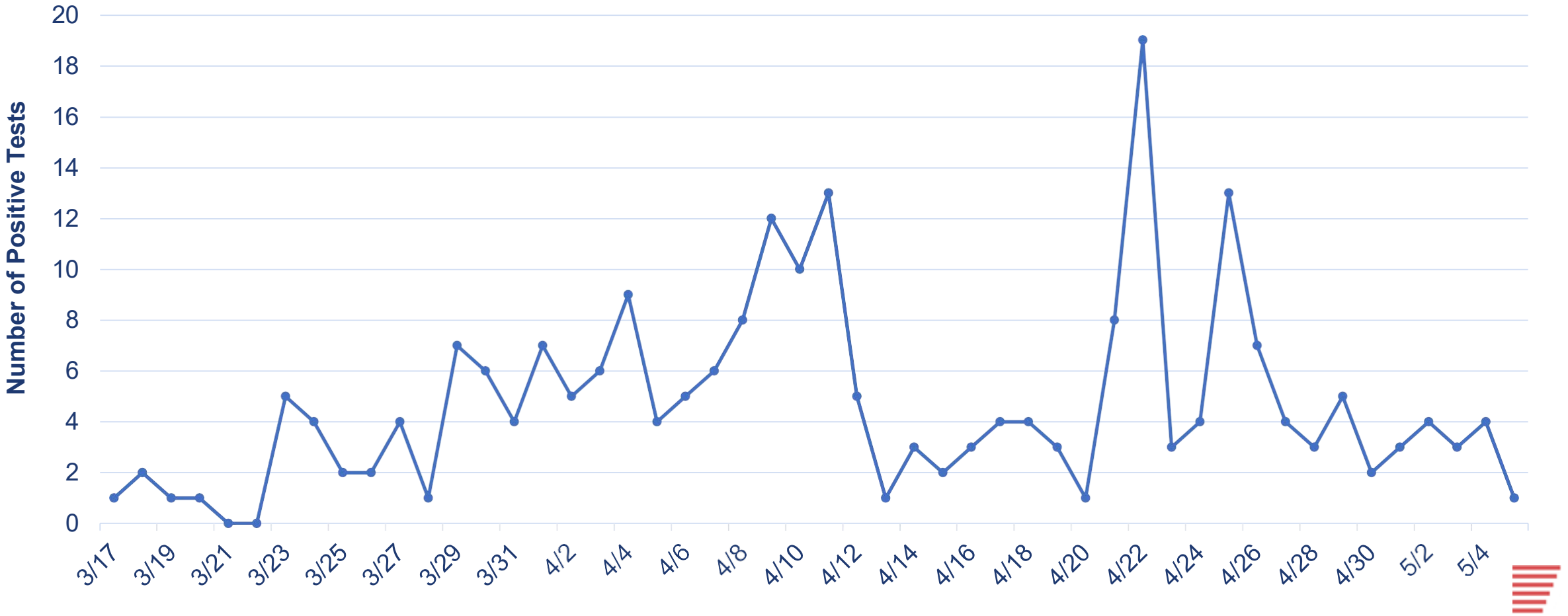
COVID-19 PLAN IMPACT

- ACHI has worked with Arkansas Department of Health to obtain COVID-19 data
- Developing analyses to determine ongoing impact of COVID-19
- Preliminary analyses today on number of positive cases and hospitalizations

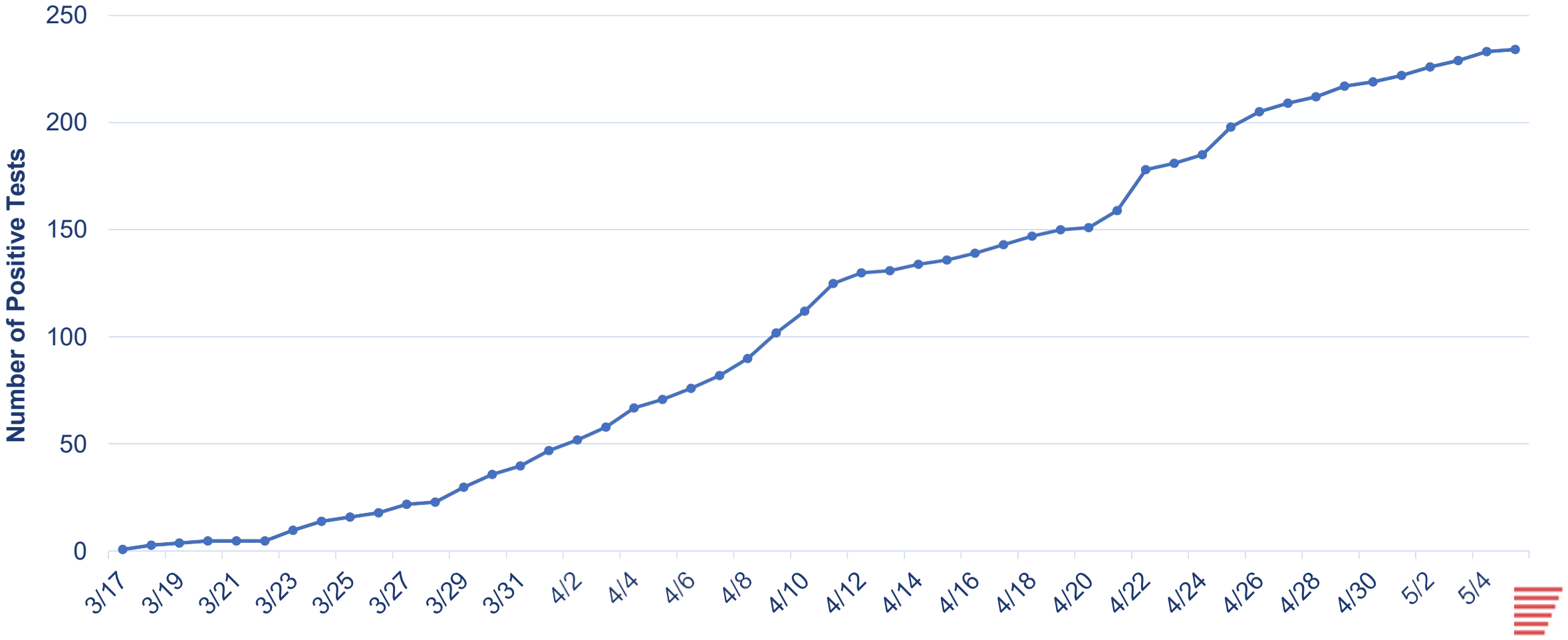
COVID-19 ANALYSES

- Data from March 17 through May 5, 2020
- Total number of members with positive test: 239
- Total number of members hospitalized: 26

DAILY POSITIVE TEST COUNT



CUMULATIVE POSITIVE TEST COUNT



POTENTIAL COVID-19 ANALYSES

- Ongoing updates of positive cases
- Assessment of geographic “hot spots” of positive cases
- Assessment of number of members tested
- Hospitalization-related cost impact
- Comorbid condition impact
- Increase in telemedicine utilization
- Variation in elective procedure utilization

State of Arkansas Employee Benefits Division

Interim Monitoring Report

Through April 30th

State and Public School Life and Health Insurance Board of Directors

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

19 MAY 2020

Milliman

Agenda

- Arkansas State Employees (ASE)
  - Plan Experience
- Public School Employees (PSE)
  - Plan Experience
- Reducing the Plan Deficit
  - Plan Funding
  - Employee Contribution
  - Plan Design
  - Program initiatives
- 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 April 2020
- 2020 projected plan experience
  - Allocated reserves for 2020 is $25.1M
  - Estimated deficit of $16.2M
  - End of Year Assets: $55.4M
  - No plan changes / 5% increase in employee contributions
- 2021 projected plan experience
  - No additional funding ($14.5M allocated assets)
  - Projected deficit: $36.6M
  - End of Year Assets: $4.3M
  - 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	99.66	100.34
Other	23.47	21.65	21.80
Total Income	$ 294.53	$ 293.55	$ 294.37
Medical Claims	$ (194.56)	$ (222.07)	$ (224.20)
Pharmacy Claims	(86.58)	(99.82)	(109.32)
Administration Fees	(18.30)	(17.52)	(17.64)
Plan Administration	(2.90)	(2.81)	(2.91)
Total Expenses	$ (302.34)	$ (342.21)	$ (354.06)
Program Savings	$ -	$ 7.40	$ 8.67
Net Income / (Loss) Before Reserve Allocation	$ (7.82)	$ (41.26)	$ (51.02)
Allocation of Reserves	$ 21.70	$ 25.08	$ 14.46
Net Income / (Loss) After Reserve Allocation	$ 13.89	$ (16.18)	$ (36.56)

Average Membership			
Active Employees / Pre-65 Retirees	47,719	46,911	46,911
Post-65 Retirees	13,346	13,813	14,228
Total Enrolled	61,065	60,724	61,138

Total Income PMPM[1]	$ 431.55	$ 437.27	$ 420.95
Total Expenses PMPM[2]	$ (412.59)	$ (459.47)	$ (470.78)

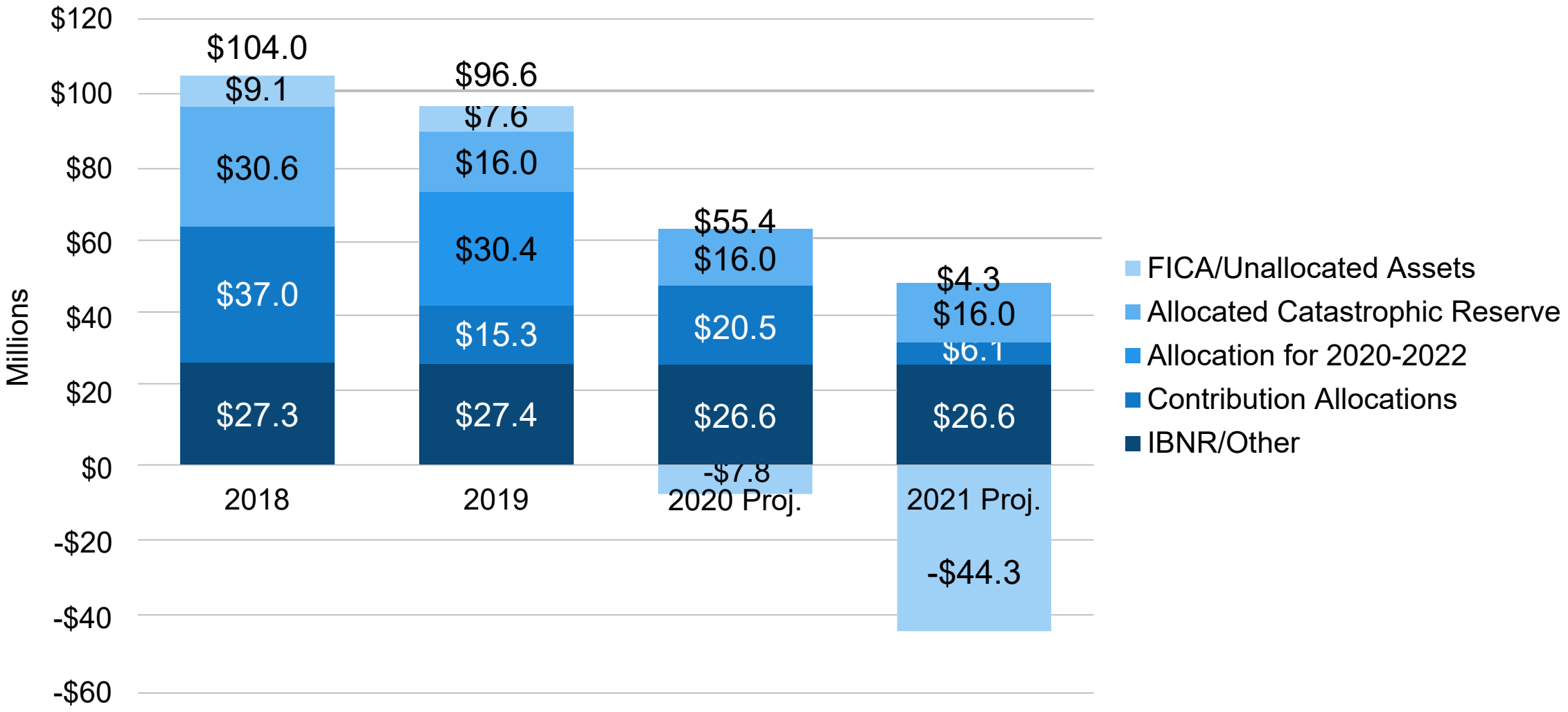
1Allocation of Reserves included in Total Income

2Total Expenses offset by Program Savings

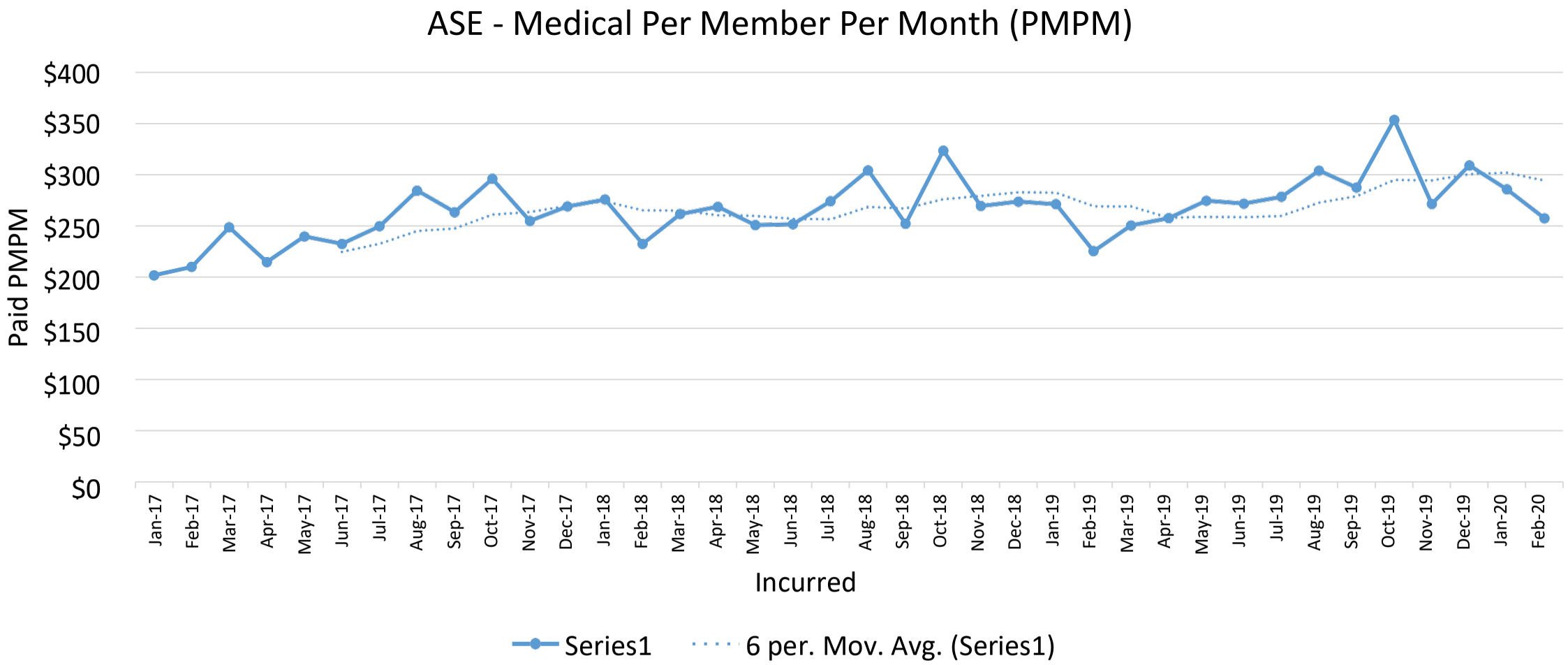
Projected Assets: 2019 – 2021

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	($334.8)
(d)		Allocated Assets	$25.1
(e) = (b) + (c) + (d)		Total Surplus / (Deficit)	($16.2)
(f) = (a) - (d) + (e)		End-of-Year Assets	$55.4
(g)	2021	Total Income	$294.4
(h)		Total Expenses	($345.4)
(i)		Allocated Assets	$14.5
(j) = (g) + (h) + (i)		Total Surplus / (Deficit)	($36.6)
(k) = (f) – (i) + (j)		End-of-Year Assets	$4.3

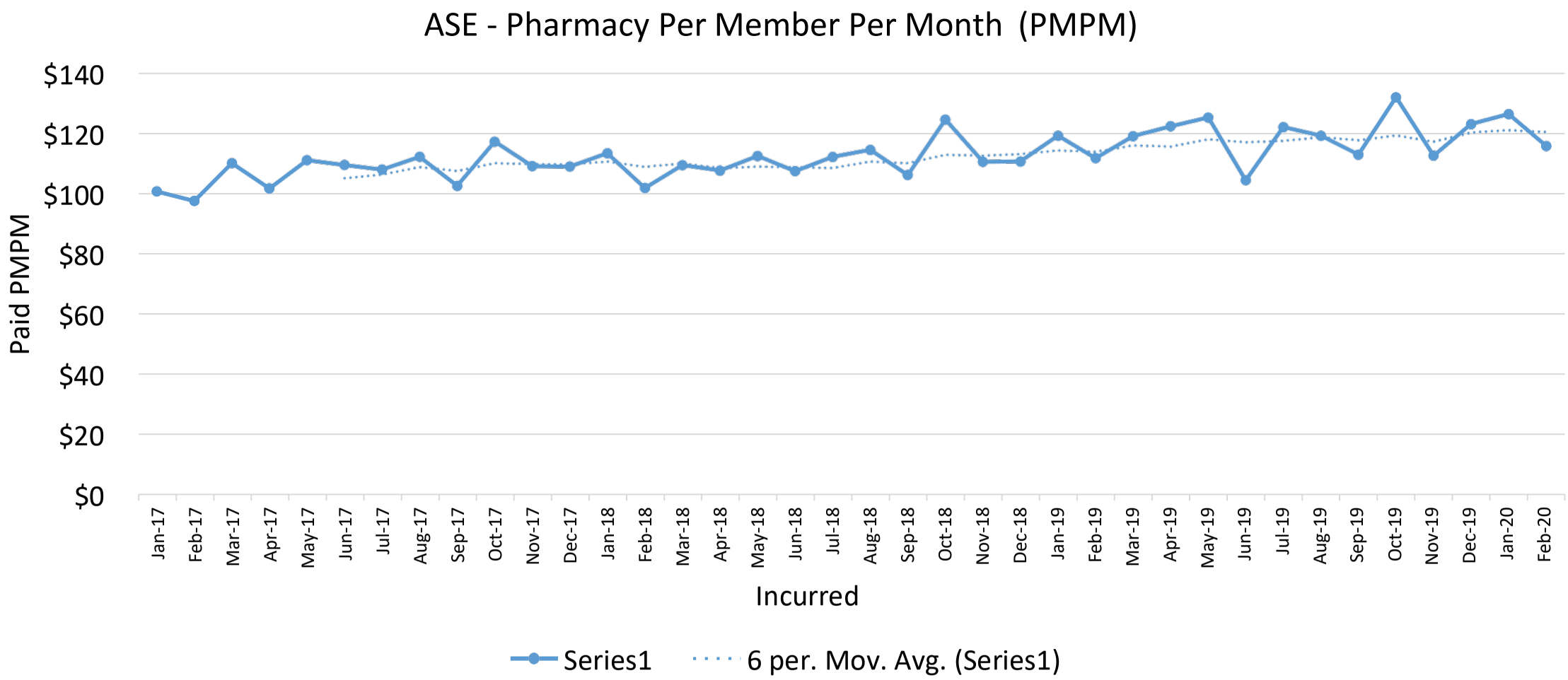
End of Year Assets



Monthly Trend - Medical



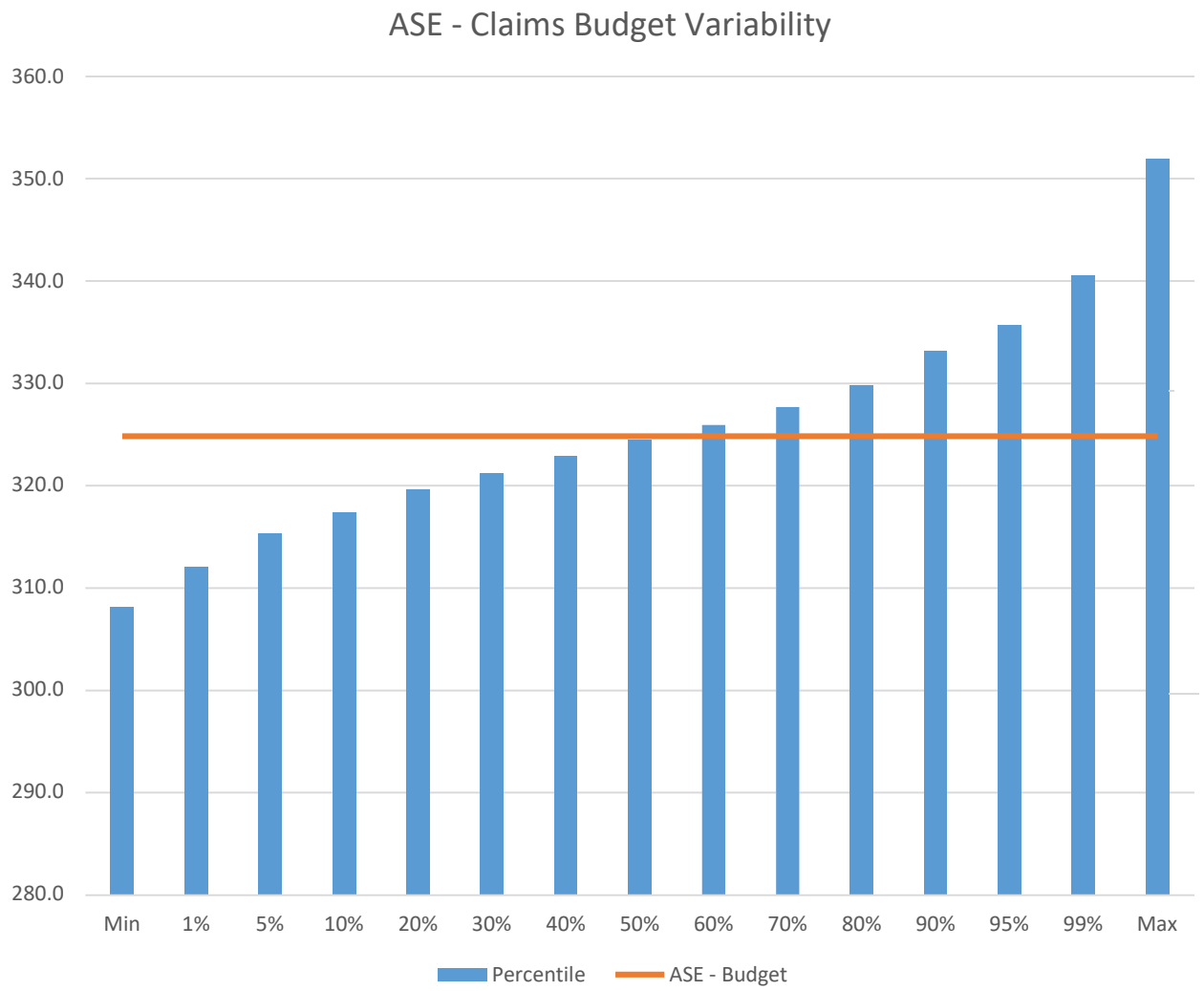
Monthly Trend - Pharmacy

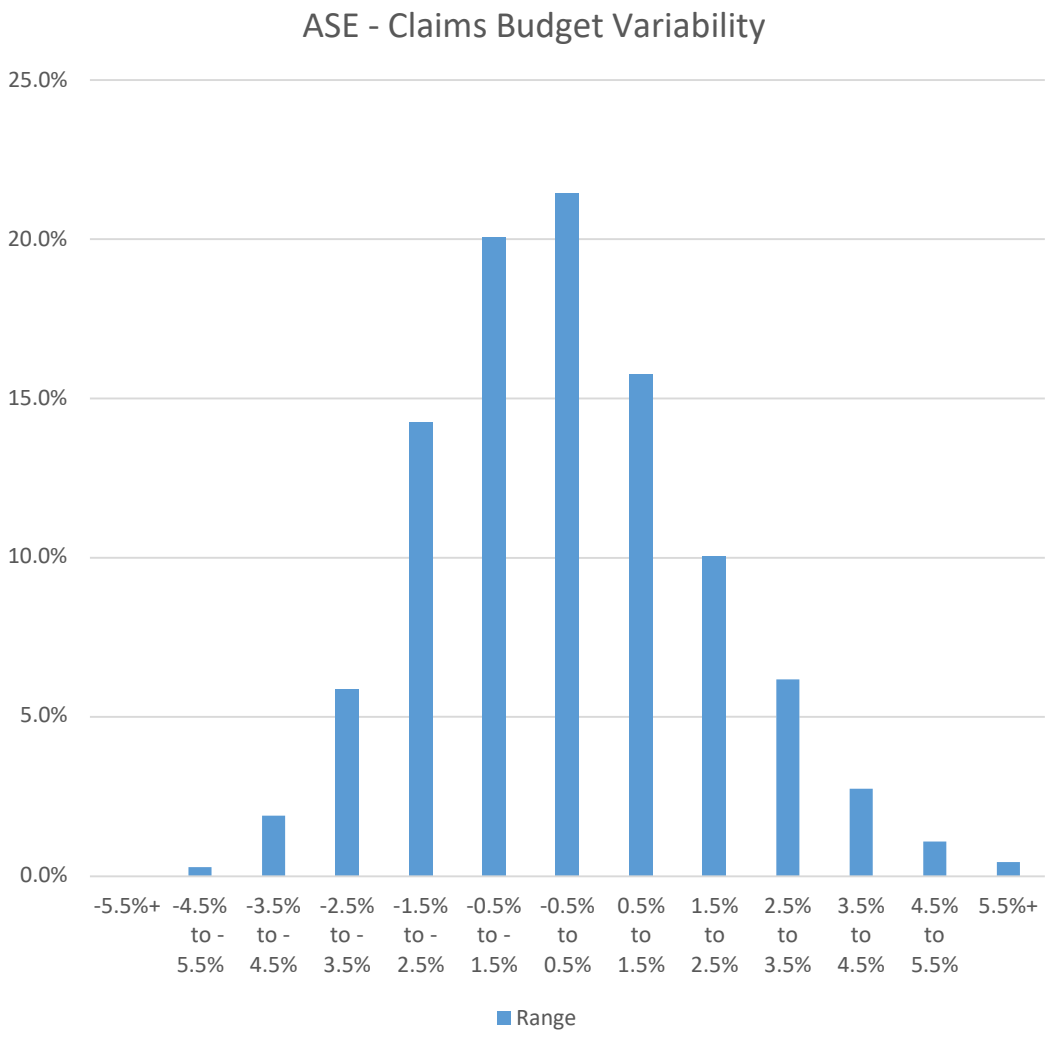


Sensitivity Testing - Trends

Trend Scenario	2021 - ASE Impact	2021 - PSE Impact
+/- 1% medical	+$3.7M/-$3.7M	+$5.1M/-$5.1M
+/- 2% medical	+$7.5M/-$7.4M	+$10.2M/-$10.1M
+/- 3 % medical	+$11.2M/-$11.0M	+$15.4M/-$15.1M
+/- 1% pharmacy	+$1.9M/-$1.8M	+$1.4M/-$1.3M
+/- 2% pharmacy	+$3.7M/-$3.7M	+$2.7M/-$2.7M
+/- 3 % pharmacy	+$5.6M/-$5.5M	+$4.1M/-$4.0M

Monte Carlo – Claims Variability Noise





Public School Employees (PSE)

Executive Summary

- Projections updated to incorporate claims data incurred from March 2019 to February 2020 and paid through April 2020
- 2020 plan experience
  - Allocated reserves for 2020 is $25.3M
  - Estimated deficit of $23.9M
  - End of Year Assets: $99.9M
  - No plan changes / 0% increase to employee contributions
- 2021 projected plan experience
  - No additional funding ($15.5M allocated assets)
  - Projected deficit: $63.5M
  - End of Year Assets: $20.9M
  - 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	$ 105.34	$ 108.86
Employee Contribution	121.12	124.17	128.31
Dept of Ed Funding	88.10	88.10	88.10
Other	15.02	14.88	15.38
Total Income	$ 326.64	$ 332.50	$ 340.65
Medical Claims	$ (247.12)	$ (284.18)	$ (314.37)
Pharmacy Claims	(60.87)	(72.28)	(79.80)
Administration Fees	(28.46)	(28.16)	(29.17)
Plan Administration	(2.61)	(2.55)	(2.63)
Total Expenses	$ (339.06)	$ (387.17)	$ (425.98)
Program Savings	$ -	$ 5.53	$ 6.33
Net Income / (Loss) Before Reserve Allocation	$ (12.42)	$ (49.14)	$ (79.00)
Allocation of Reserves	$ 12.66	$ 25.25	$ 15.48
Net Income / (Loss) After Reserve Allocation	$ 0.23	$ (23.88)	$ (63.53)

Average Membership			
Active Employees / Pre-65 Retirees	82,317	84,312	86,723
Post-65 Retirees	14,279	15,061	15,964
Total Enrolled	96,595	99,373	102,688

Total Income PMPM[1]	$ 292.71	$ 300.01	$ 289.00
Total Expenses PMPM[2]	$ (292.51)	$ (320.03)	$ (340.56)

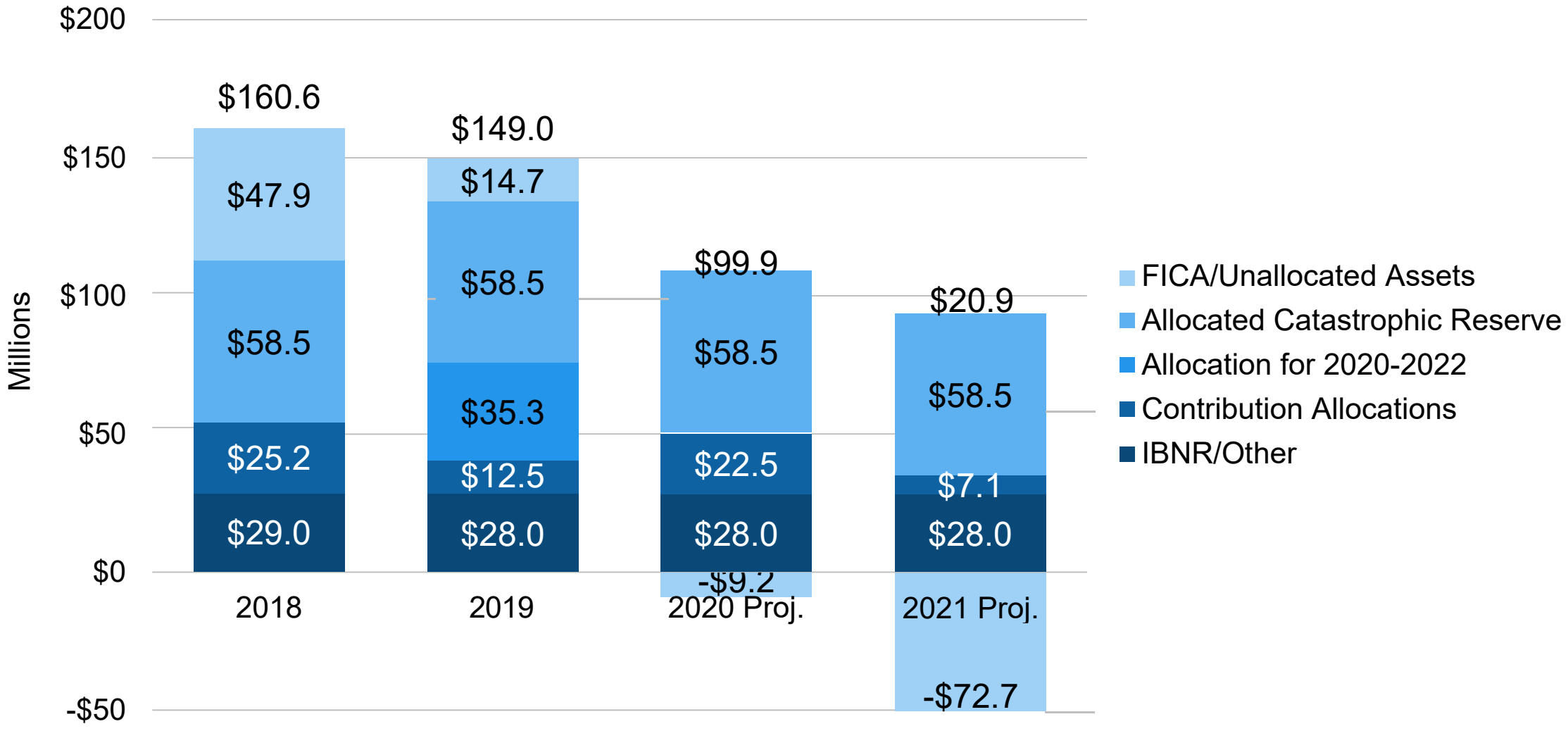
1Allocation of Reserves included in Total Income

2Total Expenses offset by Program Savings

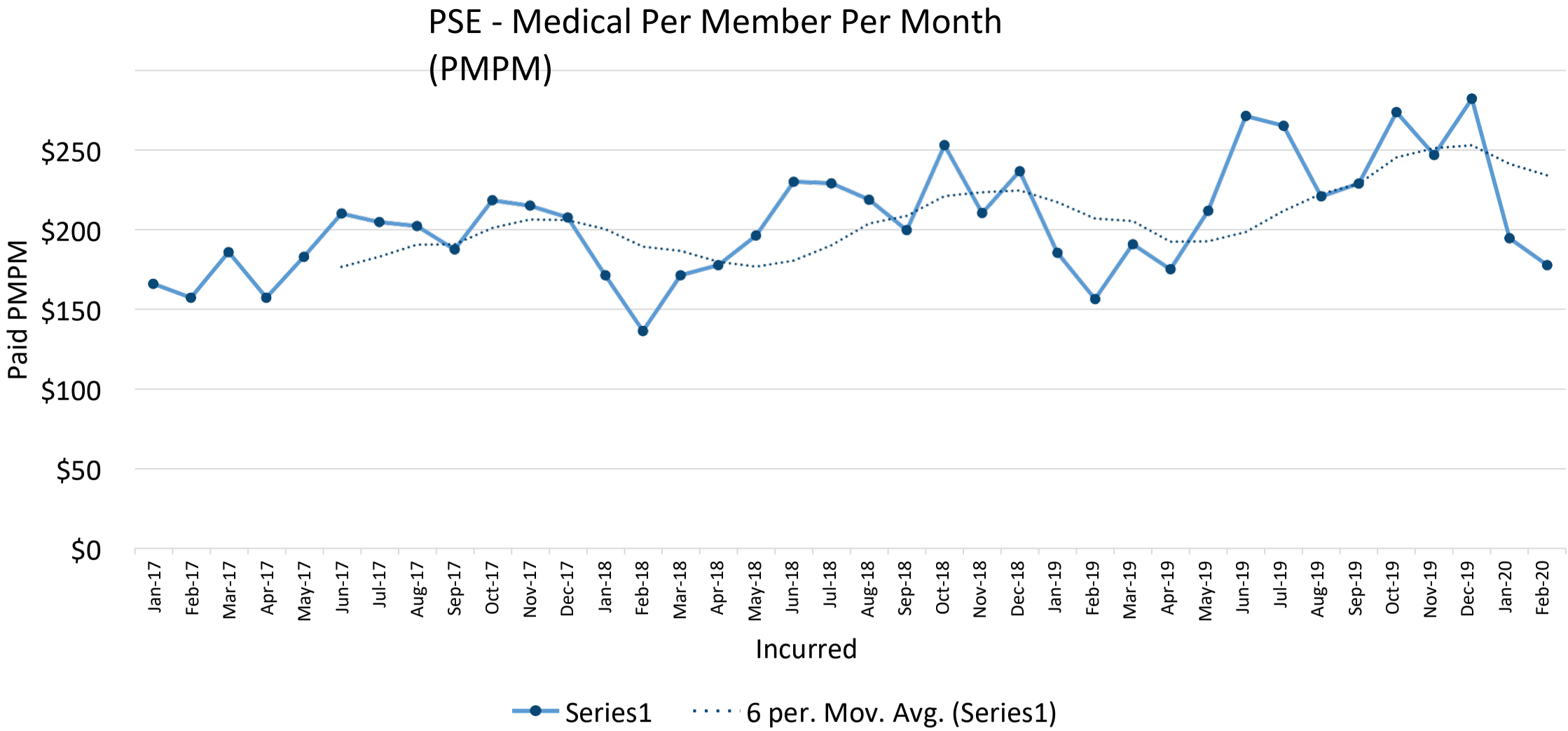
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
(a)	2019	End-of-Year Assets	$149.0
(b)	2020	Total Income	$332.5
(c)		Total Expenses	($381.6)
(d)		Allocated Assets	$25.3
(e) = (b) + (c) + (d)		Total Surplus / (Deficit)	($23.9)
(f) = (a) - (d) + (e)		End-of-Year Assets	$99.9
(g)	2021	Total Income	$340.6
(h)		Total Expenses	($419.7)
(i)		Allocated Assets	$15.5
(j) = (g) + (h) + (i)		Total Surplus / (Deficit)	($63.5)
(k) = (f) – (i) + (j)		End-of-Year Assets	$20.9

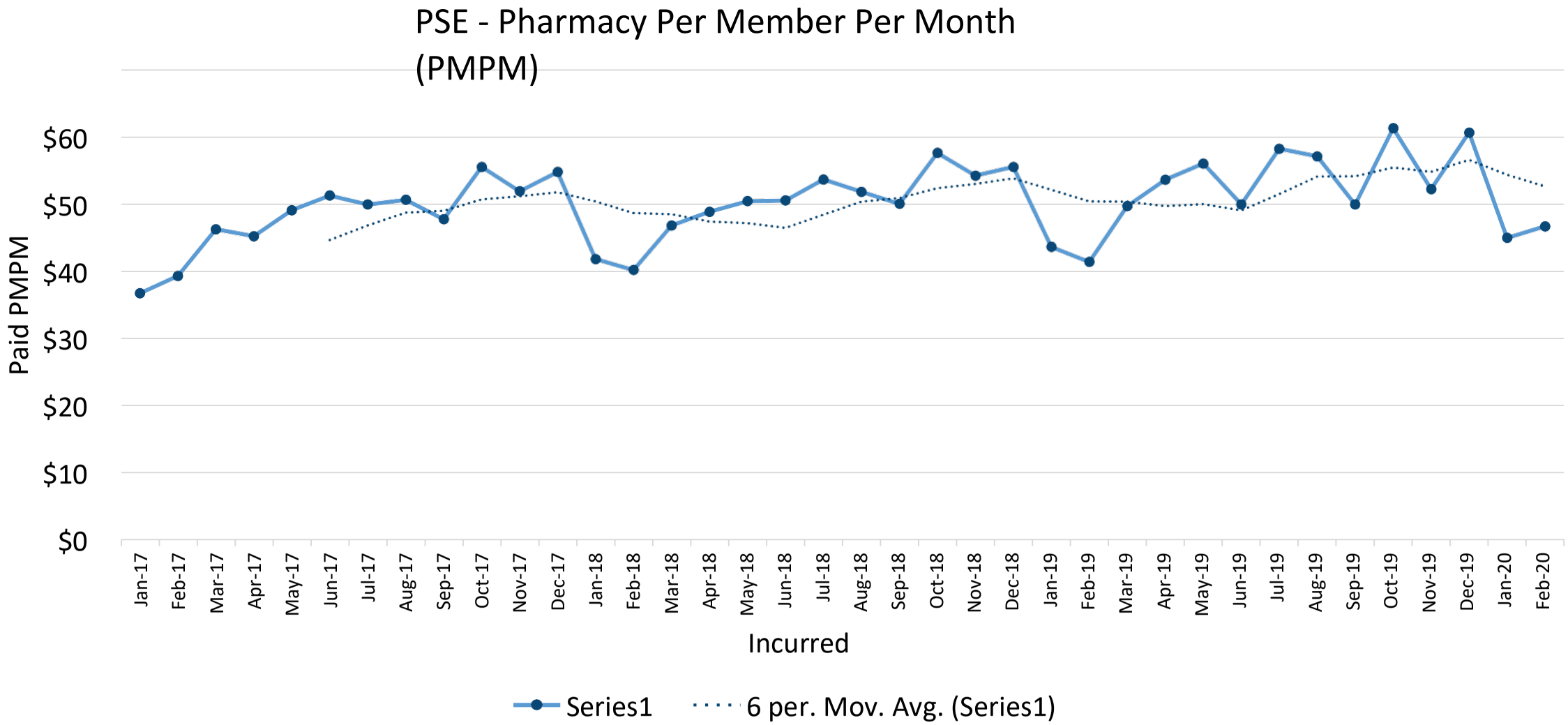
End of Year Assets



Monthly Trend - Medical



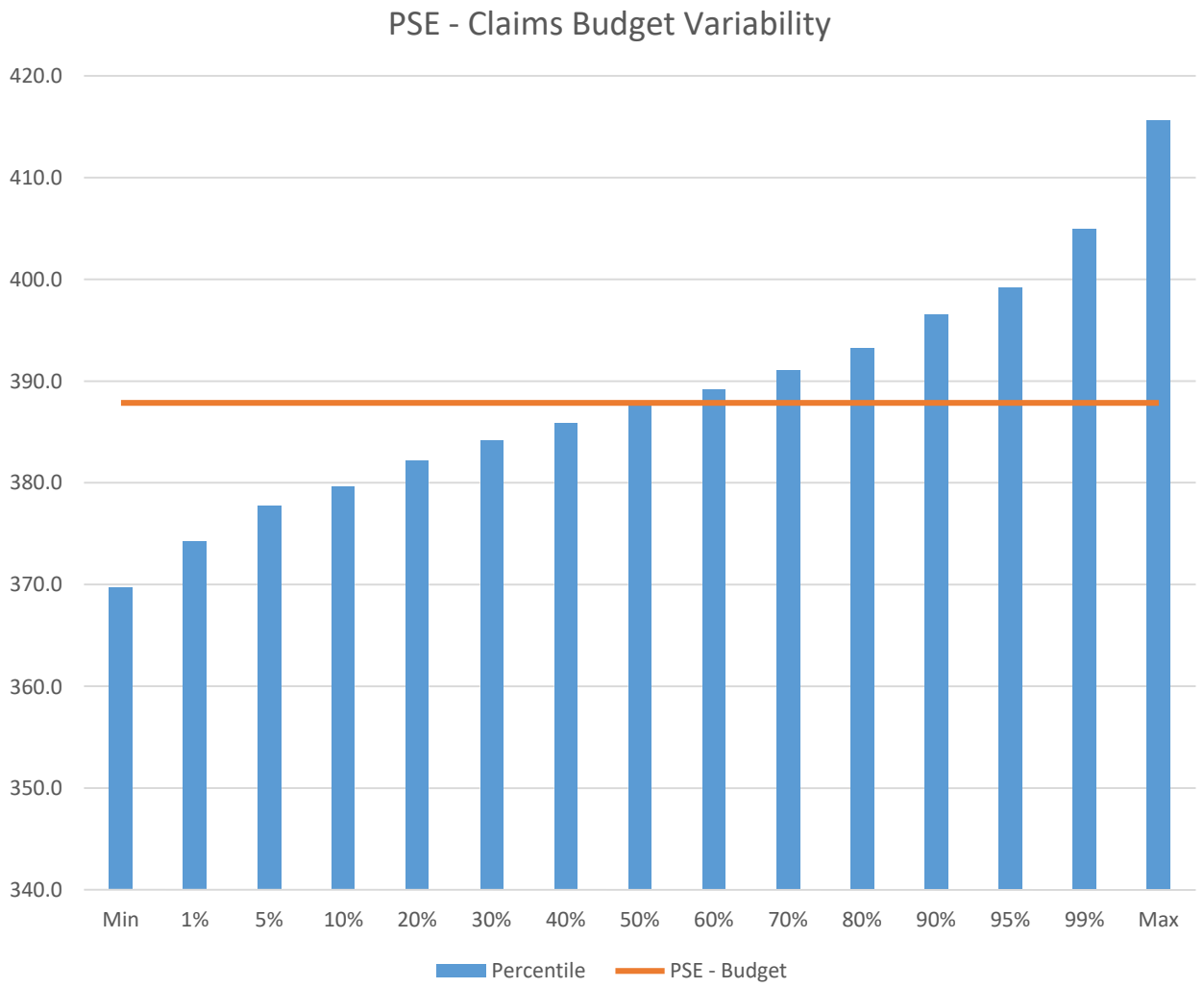
Monthly Trend - Pharmacy

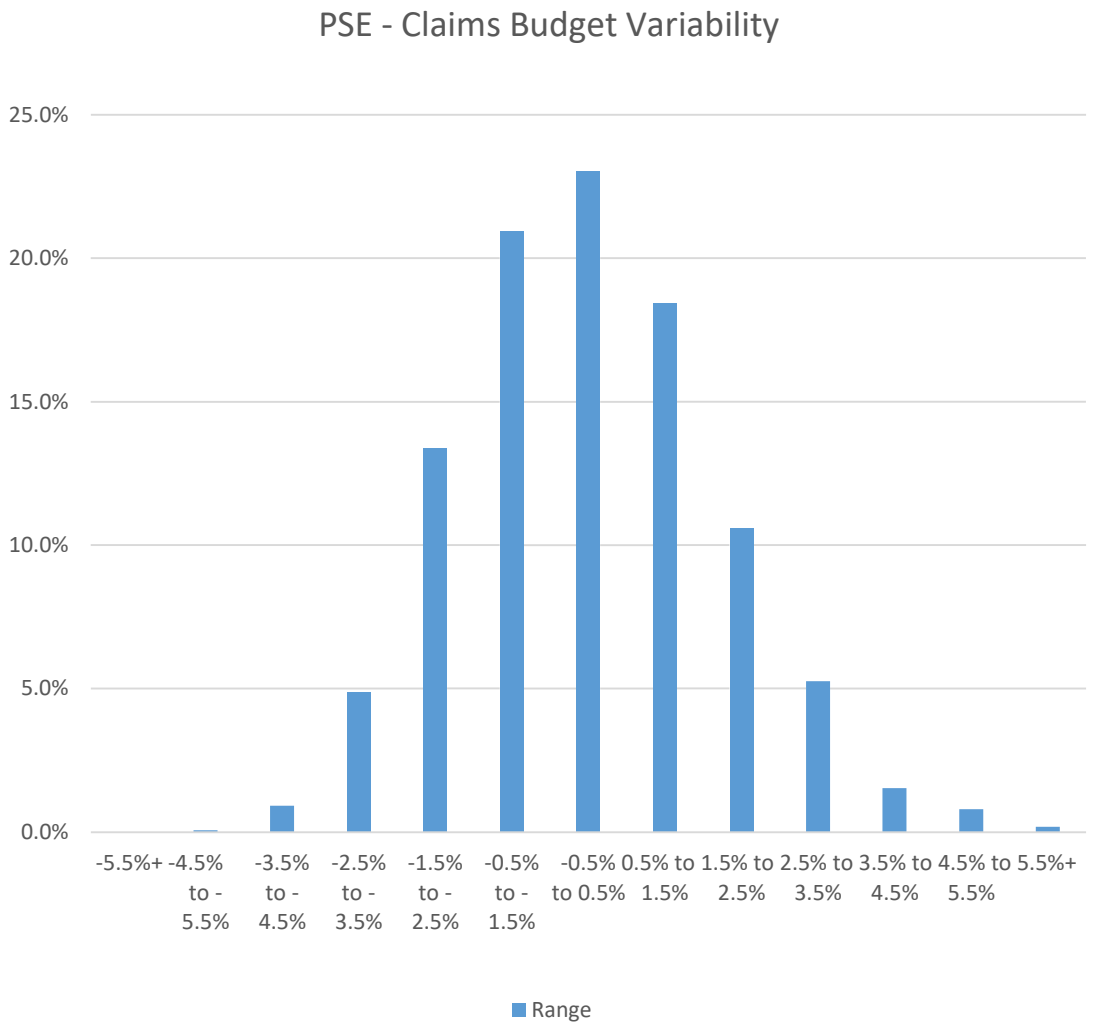


Sensitivity Testing - Trends

Trend Scenario	2021 - ASE Impact	2021 - PSE Impact
+/- 1% medical	+$3.7M/-$3.7M	+$5.1M/-$5.1M
+/- 2% medical	+$7.5M/-$7.4M	+$10.2M/-$10.1M
+/- 3 % medical	+$11.2M/-$11.0M	+$15.4M/-$15.1M
+/- 1% pharmacy	+$1.9M/-$1.8M	+$1.4M/-$1.3M
+/- 2% pharmacy	+$3.7M/-$3.7M	+$2.7M/-$2.7M
+/- 3 % pharmacy	+$5.6M/-$5.5M	+$4.1M/-$4.0M

Monte Carlo – Claims Variability Noise





Reducing the Plan Deficit

Leveraging

- If employee benefits remain fixed, then the plan paid cost will increase at a higher rate to absorb the impact on employees
- Plan Design Example:
  - Emergency Room Visit: $1,000 dollars in 2020. Member cost share: $500 deductible
  - Trend 5% to 2021. Deductible remains flat at $500

2020 Cost Breakdown			2021 Cost Breakdown	
$1,000	Emergency Room visit	Trend	$1,050	Emergency Room Visit
- $500	Deductible		- $500	Deductible
$500	Plan Paid		$550	Plan Paid

Plan cost goes from $500 to $550 an increase of 10%

Summary of Initiatives

- Current Deficit for 2021
  - ASE: $36.5M ($51M without allocated assets)
  - PSE: $63.5M ($79M without allocated asset)
- Funding
  - State Funding
  - District Funding
- Employee Contributions
  - Active / Pre-65 / Post-65
  - Employee / Spouse / Child
- Plan Design
  - Premium / Classic / Basic
- Program initiatives

Sensitivity Testing – State Funding (ASE)

- State Funding
  - Current funding is $420 per budgeted position per month
  - $1 dollar increase in state funding increasing total funding by approximately $400K
- Current projected 2021 deficit for ASE $36.5M ($51M without allocation ofreserve)

Additional Funding[1]	2021 Impact – ASE	2021 Budget – Impact[2]
$1 PEPM	$400K	1.1%
$2 PEPM	$800K	2.2%
$3 PEPM	$1.2M	3.3%
$4 PEPM	$1.6M	4.4%
$5 PEPM	$2.0M	5.5%

1. Per budgeted position per month increase
2. Impact on budget = Savings / Deficit (example: $1PEPM: $400K / $36.5M = 1.1%)

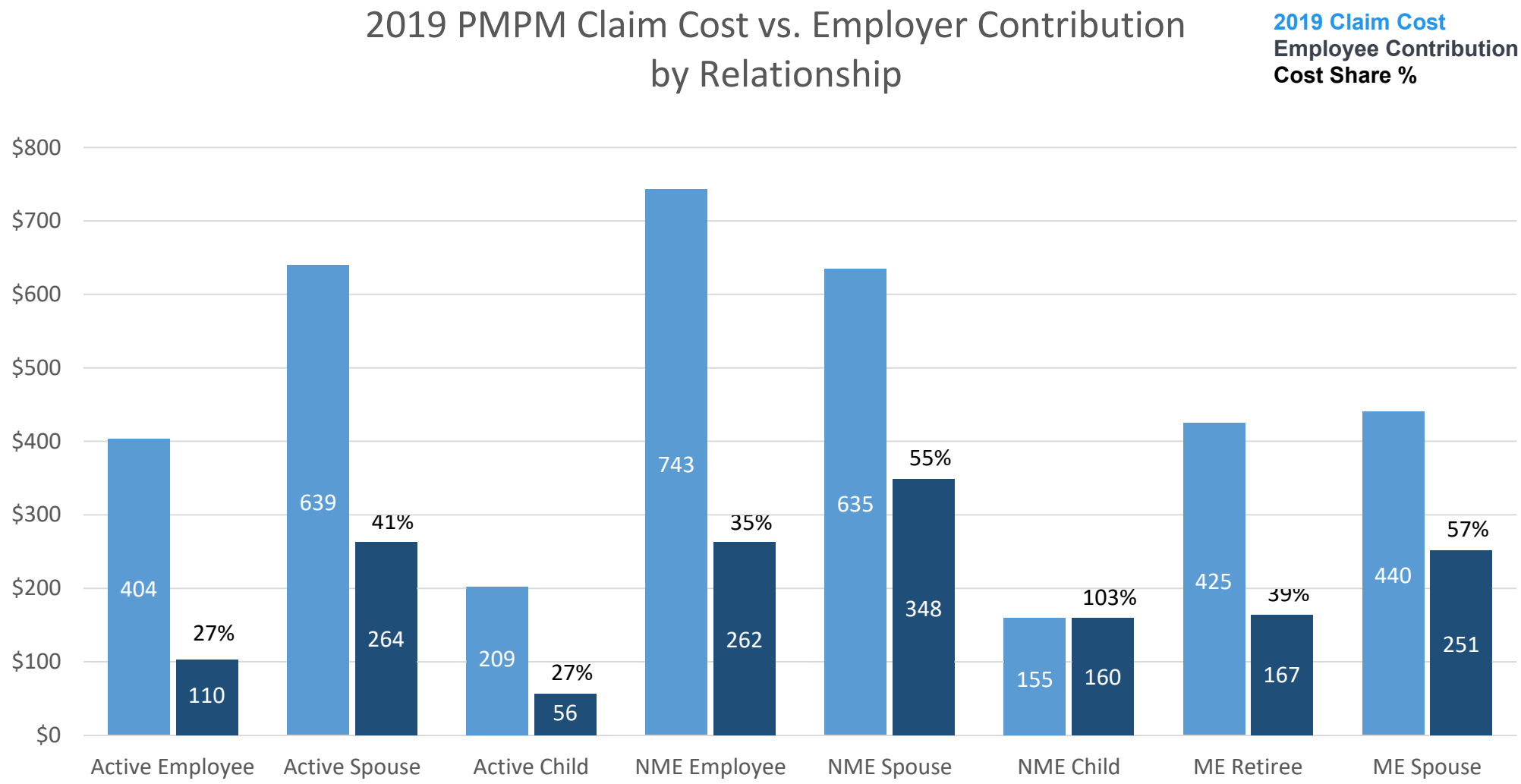
Sensitivity Testing – District Funding (PSE)

- District Funding
  - Current minimum funding in 2020 is $161.87 per employee per month
  - Approximately 317 school districts
- Current projected 2021 deficit of $63.5M ($79M without allocation of reserve)

Additional Funding	2021 Impact – PSE[1]	2021 Budget – Impact[1]	# of Schools Districts Impacted[2]
$2.50 PEPM	$700K	1.1%	220
$5.00 PEPM	$1.5M	2.4%	237
$7.50 PEPM	$2.4M	3.8%	247
$10.00 PEPM	$3.3M	5.2%	253

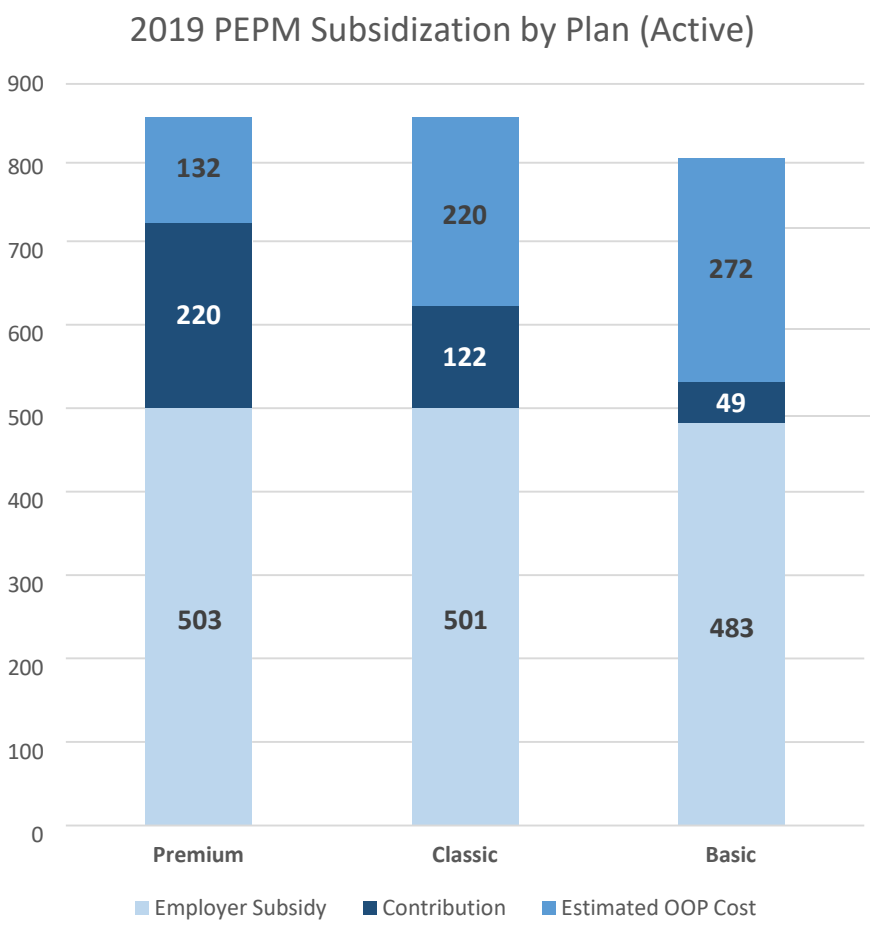
1. Impact on budget = Savings / Deficit (example: $2.50 PEPM: $700K / $63.5M = 1.1%)
2. Assumes districts above the minimum contributions do not decrease their funding

ASE Cost vs. EE Contribution – By Relationship



Categorization is based on the subscriber's benefit election.

ASE Subsidy – By Plan Option



Plan Option	Premium	Employee Contribution[1]	Plan Subsidy
Premium Plan			
Employee Only	$510.48	$122.17	$388.31
Employee + Spouse	$1,138.22	$404.71	$733.51
Employee + Child	$851.64	$230.59	$621.05
Family	$1,479.40	$513.13	$966.27
Classic Plan			
Employee Only	$446.18	$62.13	$384.05
Employee + Spouse	$987.56	$264.57	$722.99
Employee + Child	$740.42	$126.99	$613.43
Family	$1,281.80	$329.43	$952.37
Basic Plan			
Employee Only	$394.52	$14.25	$380.27
Employee + Spouse	$864.62	$150.71	$713.91
Employee + Child	$650.00	$43.25	$606.75
Family	$1,120.10	$179.71	$940.39

Based on 2019 information – For illustrative purposes only

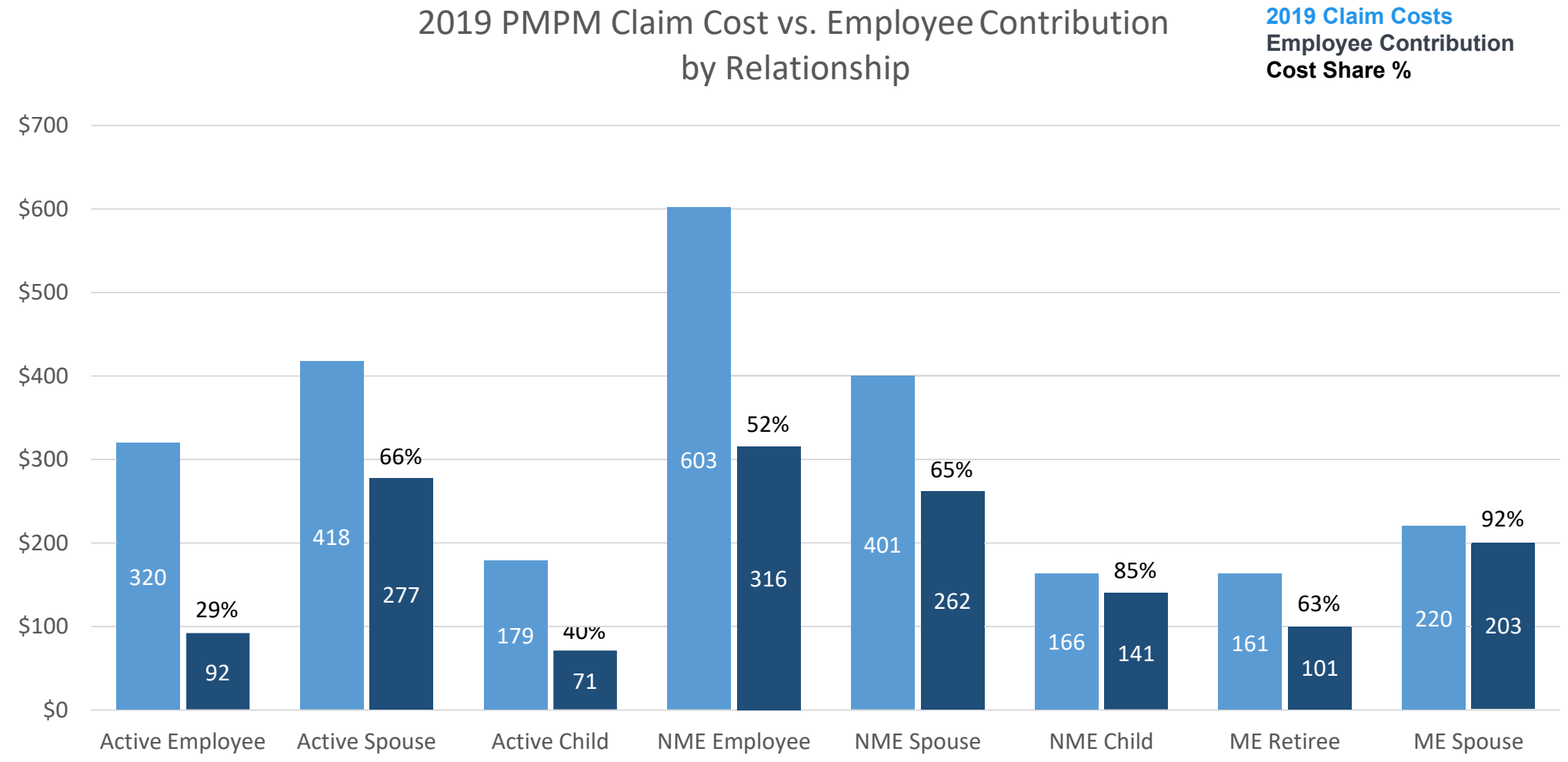
1. Contribution based on 81/19 wellness credit / non-wellness credit blend

Contribution Scenario (ASE)

- Employee contributions
  - Increase contributions by employee status (Active / Pre / Post)
  - Increase contribution by tier (EE only, EE + Sp, EE + Ch, EE + Family)
- Should maintain level subsidy by plan (i.e. keep contribution increases consistent among plan options)

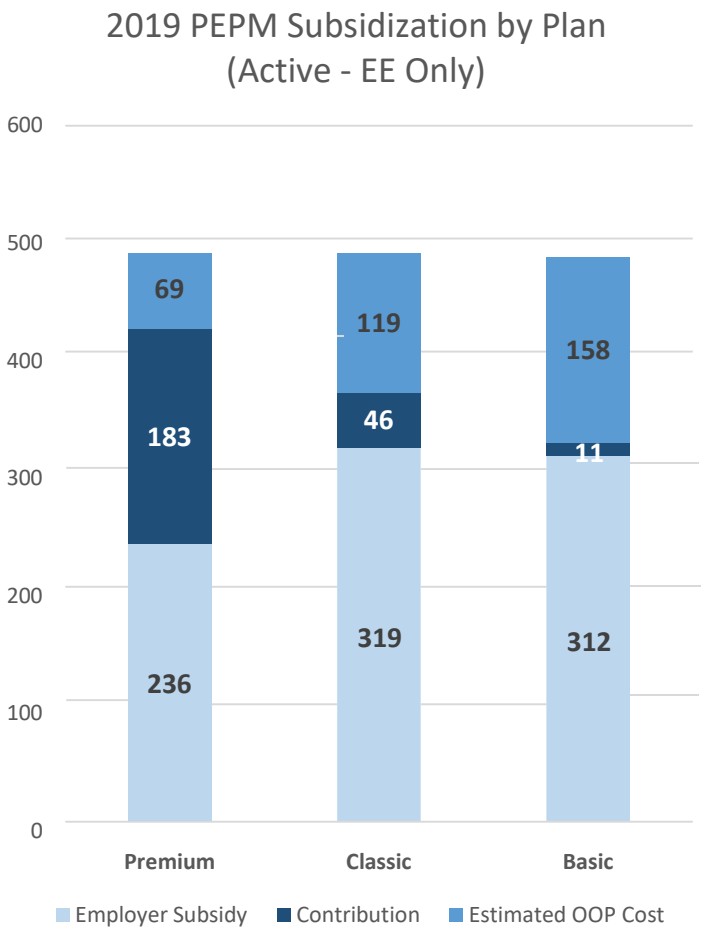
Contribution Scenario	2021 Impact – ASE	Employee Impact Range	Number of employees Impact
Increase Active contributions (1%)	$549k	$0.00 - $5.24	25.6k
Increase Pre-65 contributions (1%)	$104k	$1.66 - $9.53	2.3k
Increase Post-65 contributions (1%)	$332k	$1.75 - $8.49	11.1k
Increase Active EE + SP / EE + Fam (1%)	$221k	$1.43 - $5.24	4.3k
Increase Pre-65 EE + SP / EE + Fam (1%)	$44k	$4.49 - $9.53	0.5k
Increase Post-65 EE + SP / EE + Fam (1%)	$161k	$4.20 - $8.49	3.0k

PSE Cost vs. EE Contribution – By Relationship



Categorization is based on the subscriber's benefit election.

PSE subsidy based on reallocated premium – By Plan Option



Plan Option	Premium (current)	Premium[1] (reallocated)	Employee Contribution[2]	Plan Subsidy[3]
Premium Plan				
Employee Only	$555.99	$419.50	$183.46	$236.04
Employee + Spouse	$1,328.58	$935.36	$831.20	$104.16
Employee + Child	$967.92	$699.86	$470.54	$229.32
Family	$1,555.82	$1,215.73	$833.44	$382.29
Classic Plan				
Employee Only	$313.40	$365.43	$46.02	$319.41
Employee + Spouse	$717.00	$814.79	$354.62	$460.17
Employee + Child	$520.80	$609.65	$158.42	$451.23
Family	$900.70	$1,059.03	$358.32	$700.71
Basic Plan				
Employee Only	$251.64	$322.80	$11.26	$311.54
Employee + Spouse	$535.16	$719.75	$272.78	$446.97
Employee + Child	$384.24	$538.54	$121.86	$416.68
Family	$603.00	$935.50	$275.62	$659.88

1. Premiums reallocated based on value of the plan option
2. Contributions based on wellness credit
3. Plan subsidy is based on the reallocated premium

Based on 2019 information – Illustrative purposes only

Contribution Scenario (PSE)

- Employee contributions
  - Increase contributions by employee status (Active / Pre / Post)
  - Increase contribution by tier (EE only, EE + Sp, EE + Ch, EE + Family)
- May consider contribution changes by plan (to reduce migration / selection risk)

Contribution Scenario[1]	2021 Impact – ASE	Employee Impact Range	Number of employees Impact
Increase Active contributions (1%)	$475k	$0.11 - $3.58	32.0k
Increase Pre-65 contributions (1%)	$106K	$1.49 - $7.46	3.3K
Increase Post-65 contributions (1%)	$210k	$1.01 - $15.21	14.7k
Increase Active EE + SP / EE + Fam (1%)	$255k	$2.73 - $3.58	6.1k
Increase Pre-65 EE + SP / EE + Fam (1%)	$33K	$2.70 - $7.46	0.5K
Increase Post-65 EE + SP / EE + Fam (1%)	$47k	$2.63 - $15.21	1.3k

1. Assume Premium Plan remains unchanged for the Active population (e.g. Active scenarios are based on changes to the Basic and Classic Plan.)

Contribution and Deductible/OOP Max Benchmarking

Benefit	ASE – Premium	ASE – Classic	ASE – Basic	Benchmark
Individual/Family Deductible	$500/$1,000	$2,500/$5,000	$6,450/$12,900	$500/$1,000
Individual/Family MOOP*	$3,000/$6,000	$6,450/$12,900	$6,450/$12,900	$3,608/$6,000
Coinsurance	80%	80%	100%	80%
PCP / Spec Office Visit	$25/$50	Ded./Coins.	Ded./Coins.	$25/$40
Emergency Room	$250	Ded./Coins.	Ded./Coins.	$150
Benefit	**PSE – Premium**	**PSE – Classic**	**PSE – Basic**	**Benchmark**
Individual/Family Deductible	$750/$1,500	$1,750/$2,850	$4,000/$8,000	$500/$1,000
Individual/Family MOOP*	$3,250/$6,500	$6,450/$9,675	$6,450/$12,900	$3,608/$6,000
Coinsurance	80%	80%	80%	80%
PCP / Spec Office Visit	$25/$50	Ded./Coins.	Ded./Coins.	$25/$40
Emergency Room	$250	Ded./Coins.	Ded./Coins.	$150

* MOOP is based on the medical out-of-pocket. The Premium plan has a separate pharmacy MOOP.

Plan Design Impact (ASE)

- Plan Design
  - 85% of employees currently in the Premium Plan
  - Two key levers for plan design are deductible and maximum out-of-pocket (MOOP)
- Scenarios assume changes to the active and pre-65 retiree plan options

Plan Design Scenario[1,2]	2021 Estimated Savings	Impact on Deficit
Deductible: increase $250 all plans MOOP: no change	$2.1M	5.6%
Deductible: increase $500 all plans MOOP: increase $250 all plans	$4.8M	13.1%
Deductible: increase $500 all plans MOOP: increase $500 all plans	$5.6M	15.4%

1. Maximum out of pocket increase for the Basic plan to be at the same level of the deductible
2. Plan designs must maintain minimum value and stay compliant as a qualified high deductible health plan

Plan Design Impact (PSE)

- Plan Design
  - Active and Pre-65 retirees enrollment distribution:
    - Premium / Classic / Basic Plan (28% / 63% / 9%)
  - Two key levers for plan design are deductible and maximum out-of-pocket (MOOP)
- Scenarios assume changes to the active and pre-65 retiree plan options

Plan Design Scenario[1]	2021 Estimated Savings	Impact on Deficit
Deductible: increase $250 all plans MOOP: no change	$4.5M	7.1%
Deductible: increase $500 all plans MOOP: increase $250 all plans	$9.7M	15.2%
Deductible: increase $500 all plans MOOP: increase $500 all plans	$10.7M	16.9%

1. Plan designs must maintain minimum value and stay compliant as a qualified high deductible health plan

Summary of Initiatives (ASE)

- Current Deficit for 2021 - $36.5M ($51M without allocated assets)

Initiative	Decision	Savings	Deficit
Starting Deficit			- $51.0 M
Program Initiatives	Current	$7.5M	- $43.5M
Increase State Funding[1]	$5 PEPM	$2M	- $41.5M
Employee Contributions[2]	5% incr.	$4.9M	- $36.6M
Plan Design Changes[3]	Scenario 3	$5.6M	- $31.0M
Remaining Deficit			- $31.0 M
Allocated Assets		$14.5M	- $16.5M
Total Remaining Deficit			**- $16.5M**

1. Increase in stated funding per budgeted position
2. Must maintain affordability
3. Must maintain minimal essential coverage

Summary of Initiatives (PSE)

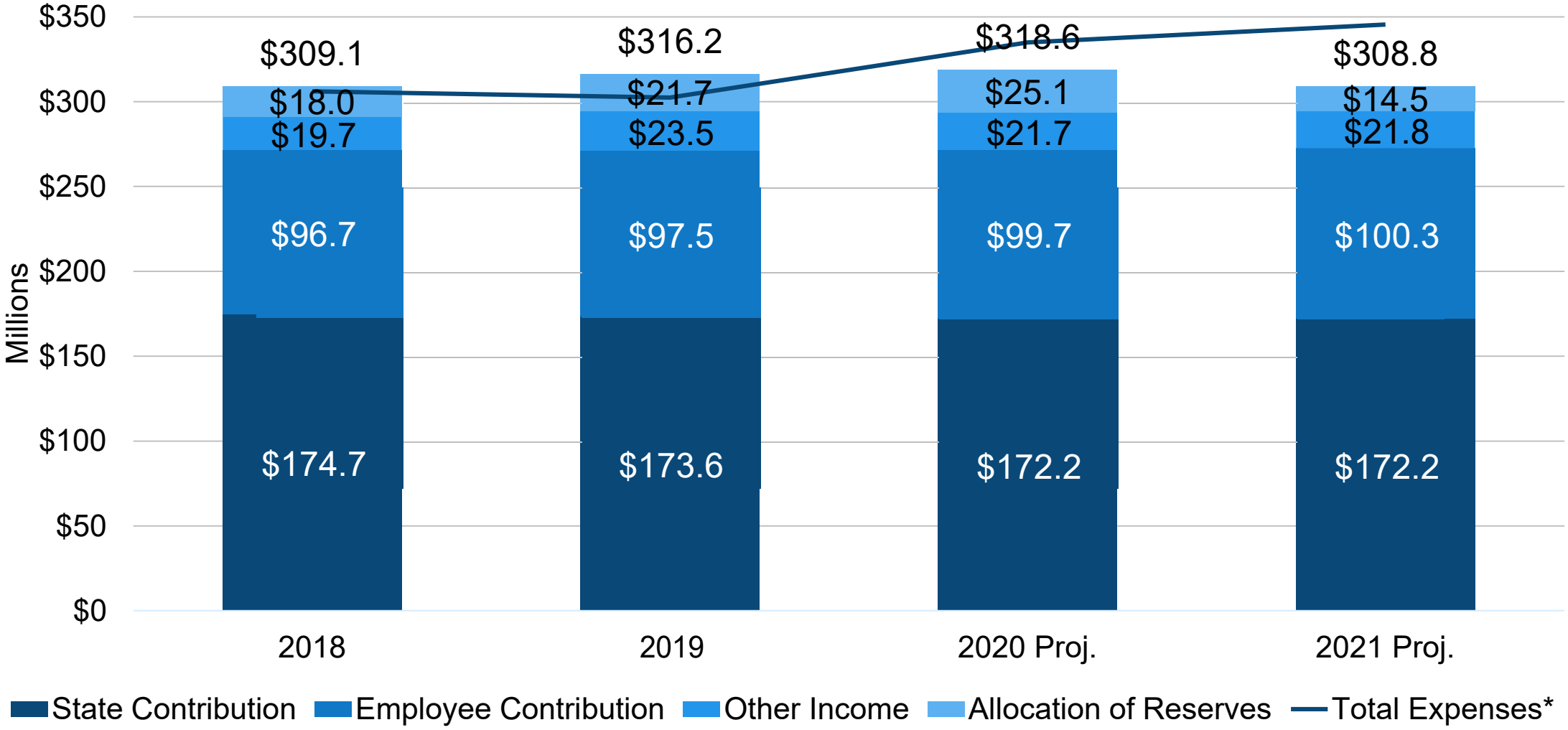
- Current Deficit for 2021 - $63.5M ($79M without allocated assets)

Initiative	Decision	Savings	Deficit
Starting Deficit			- $79.0 M
Program Initiatives	Current	$5.5M	- $73.5M
Increase District Funding	$10 PEPM	$3.3M	- $70.2M
Employee Contributions[1]	5% incr.	$4.0M	- $66.2M
Plan Design Changes[2]	Scenario 3	$10.7M	- $55.5M
Remaining Deficit			- $55.5M
Allocated Assets		$15.5M	- $40.0M
Total Remaining Deficit			**- $40.0M**

1. Must maintain affordability
2. Must maintain minimal essential coverage

Appendix

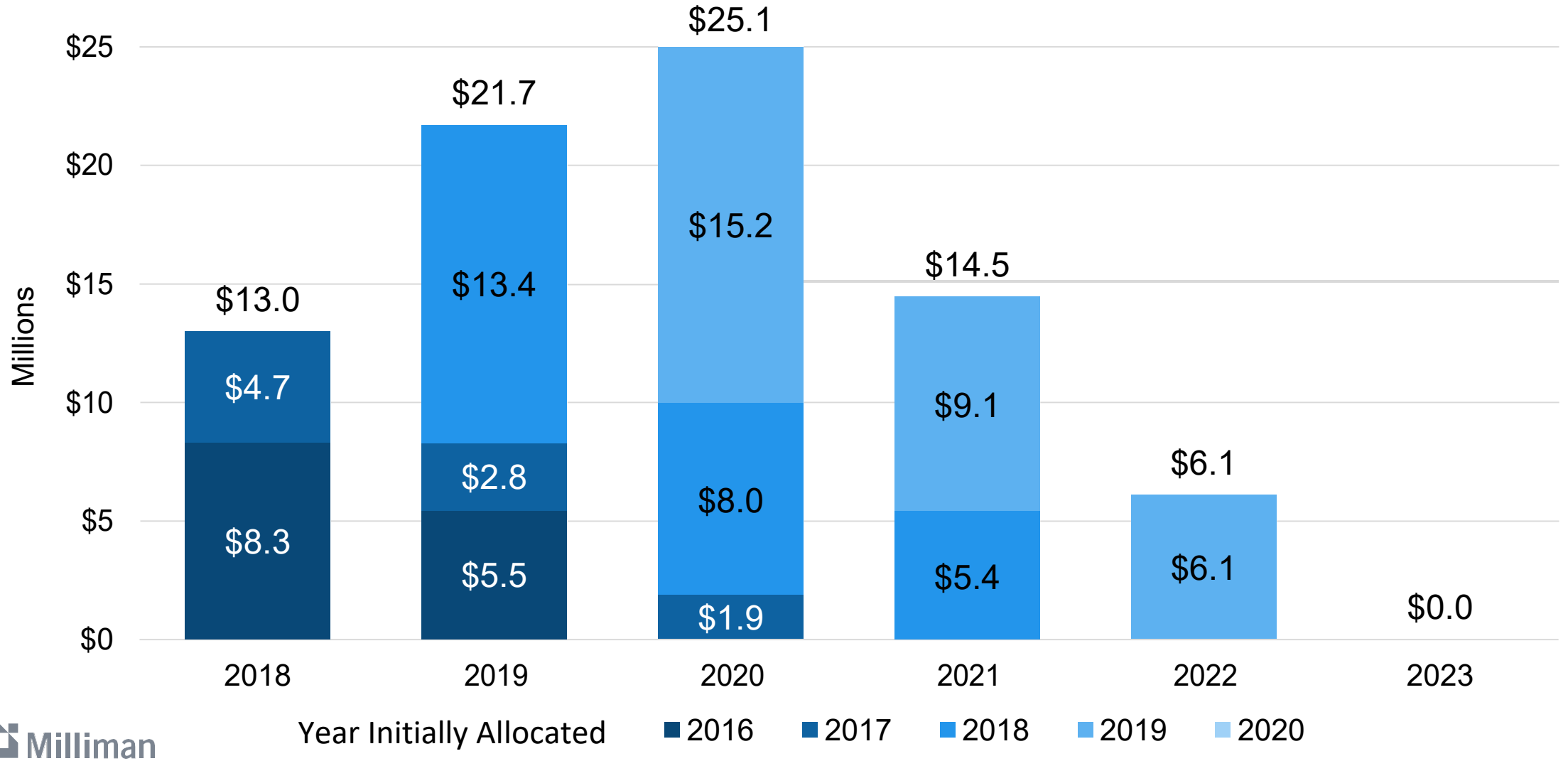
ASE - Income vs. Expenditure



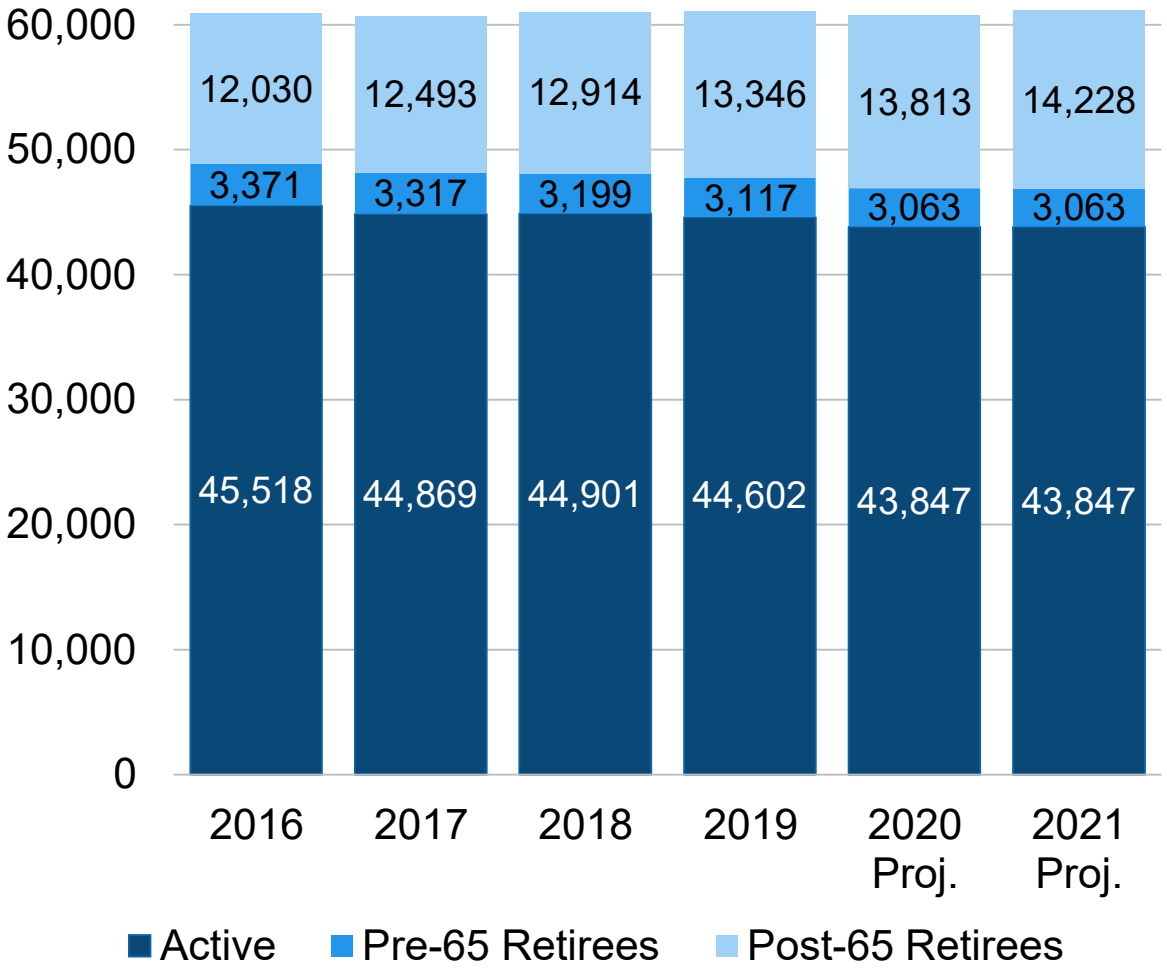
* Total Expenses offset by Program Savings

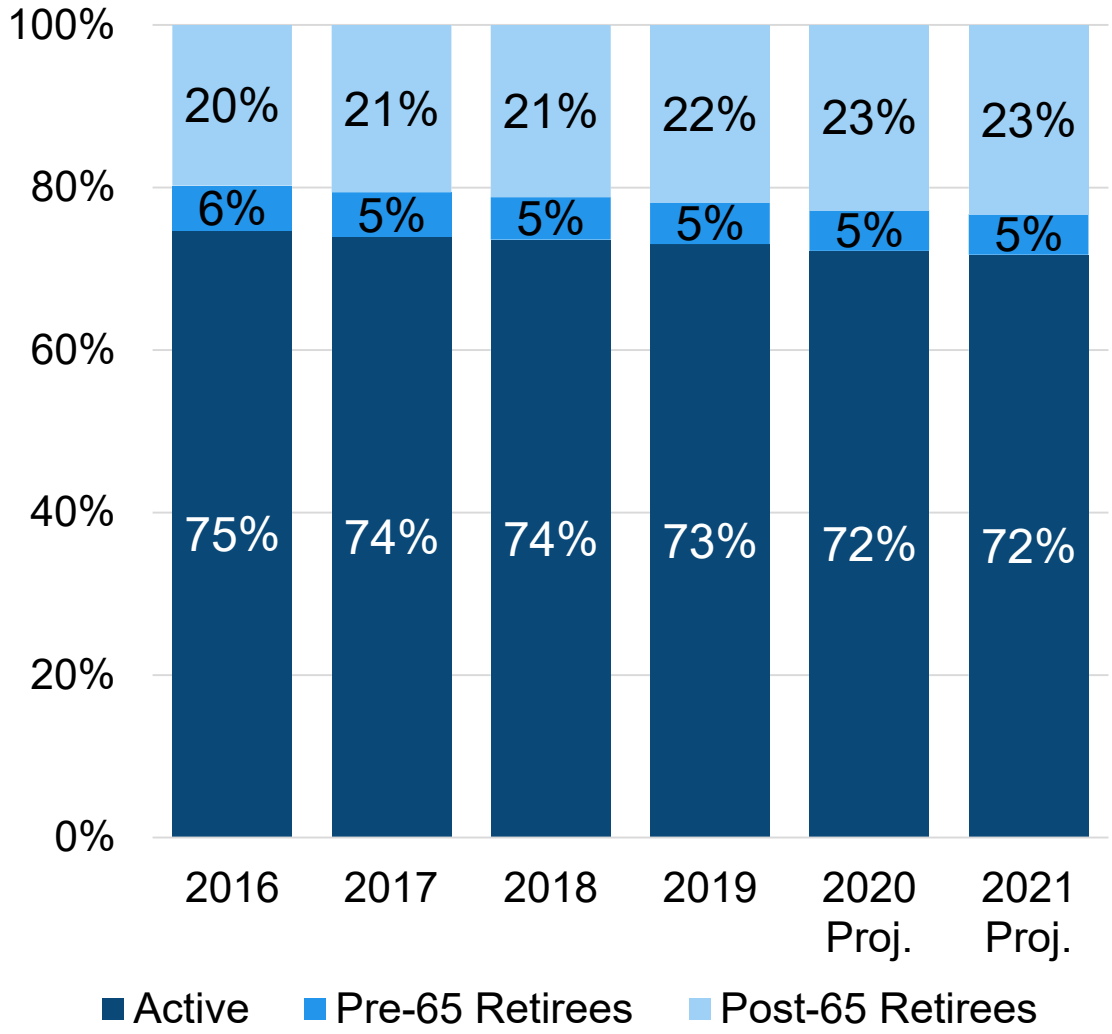
ASE - Reserves Allocation by Year

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

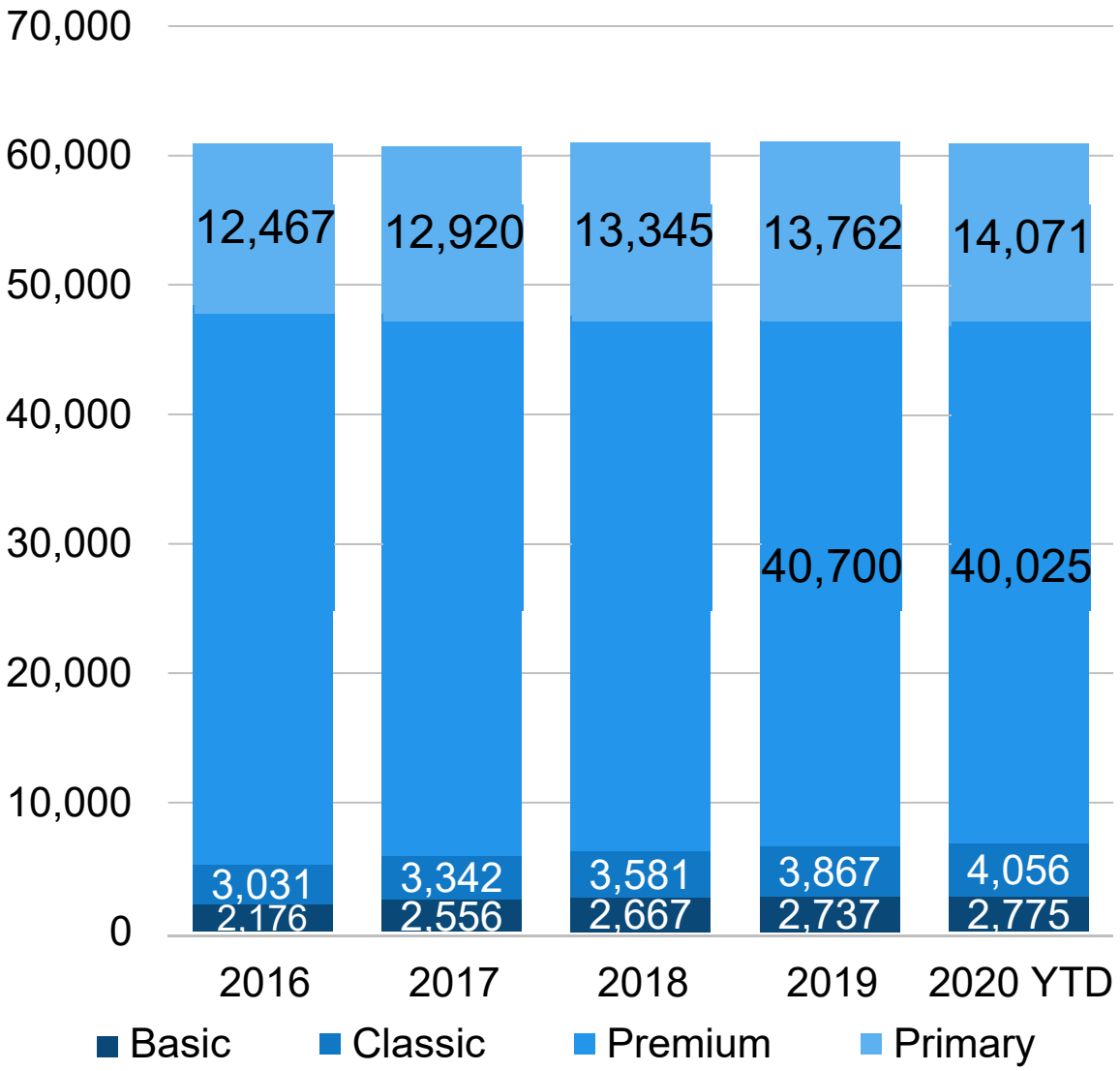


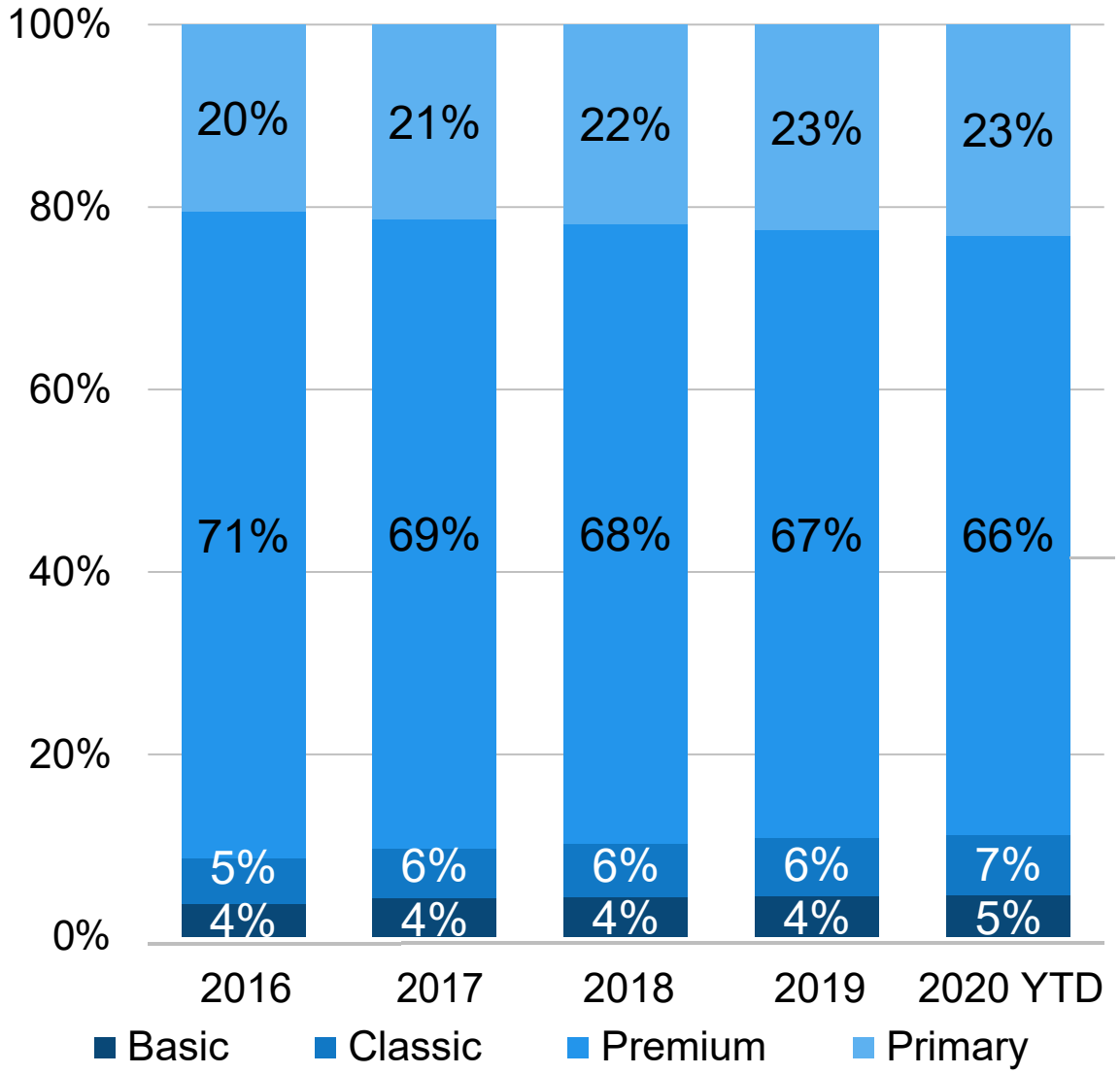
ASE - Average Membership by Status



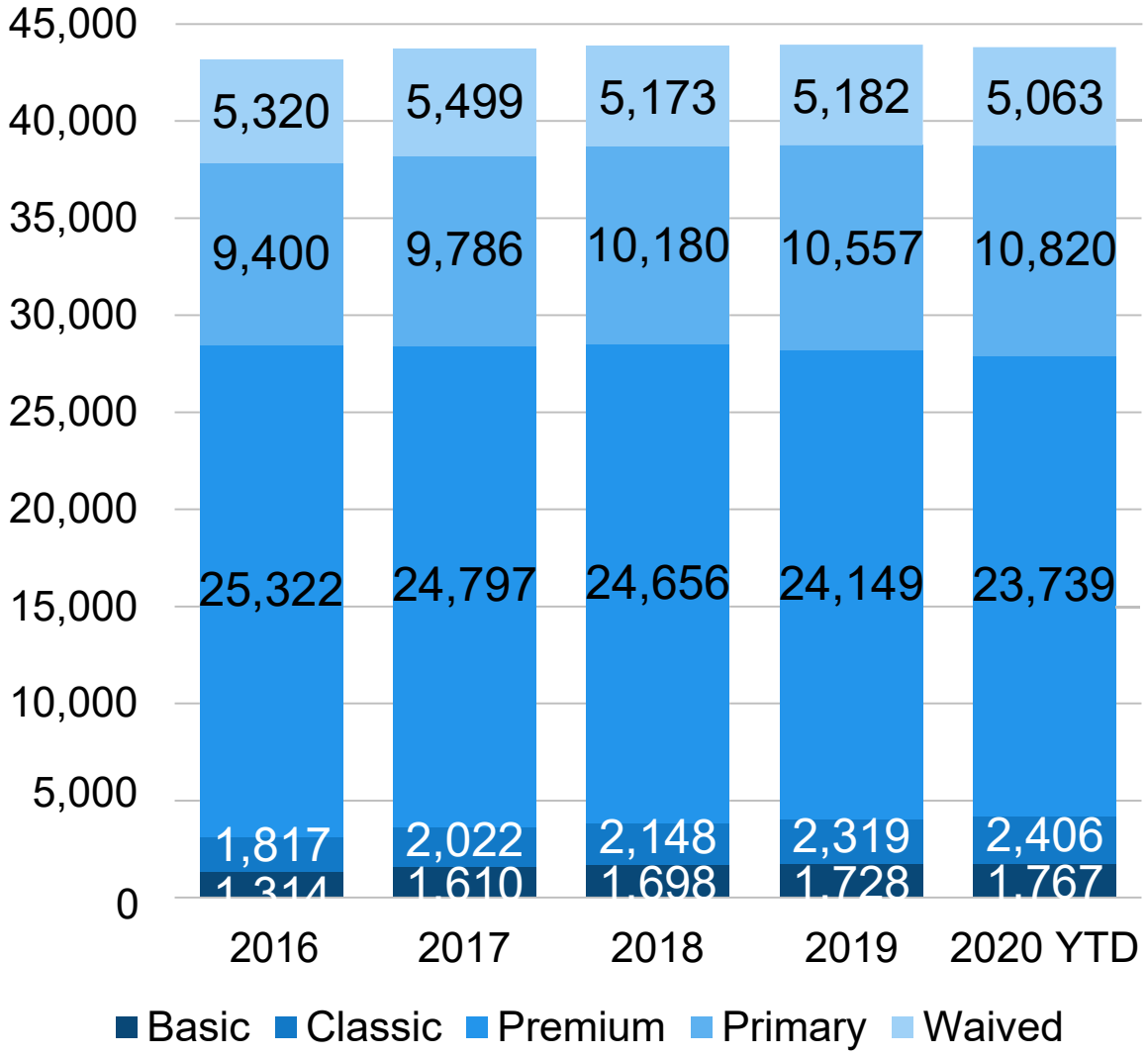


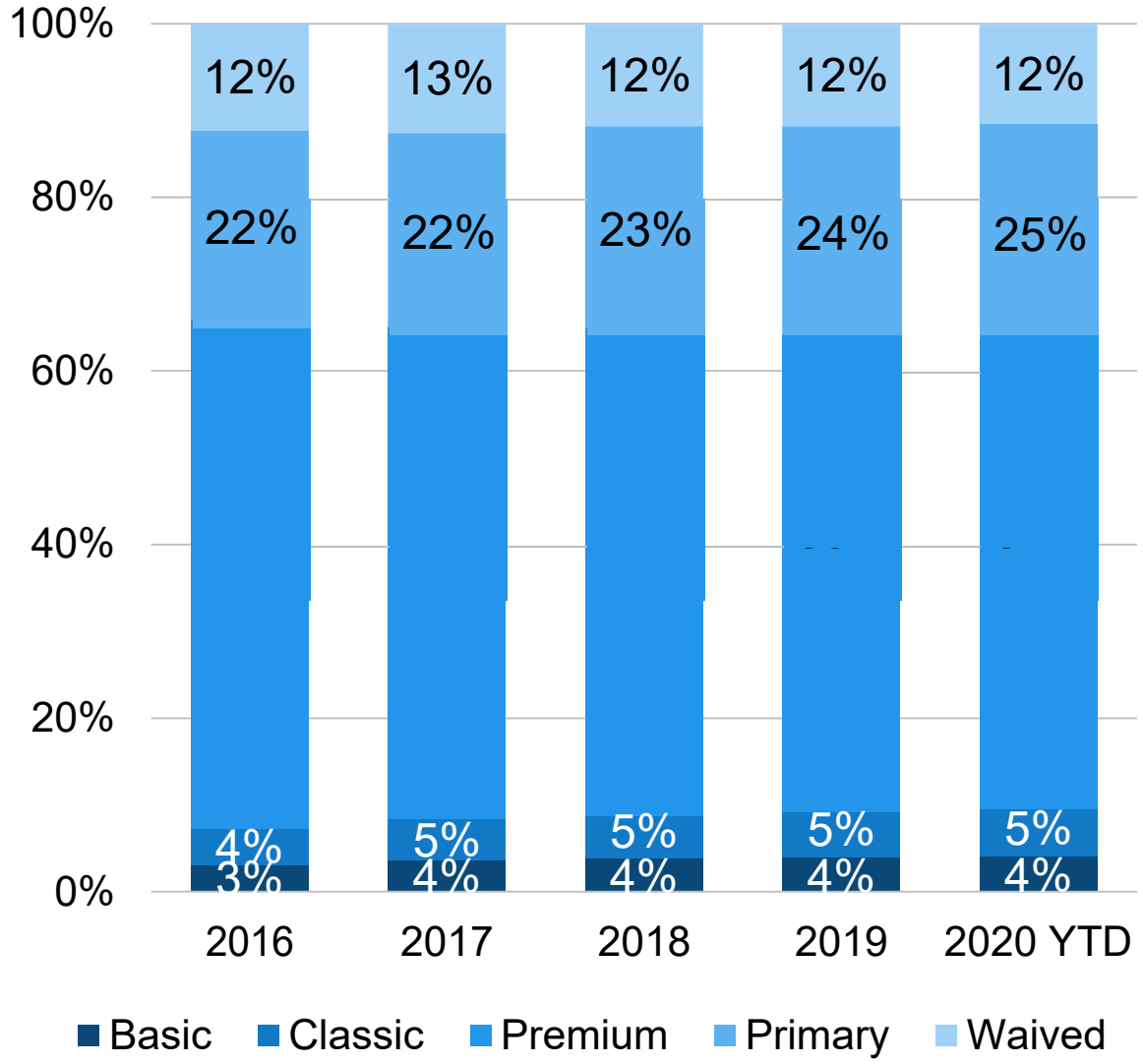
ASE - Average Membership by Plan



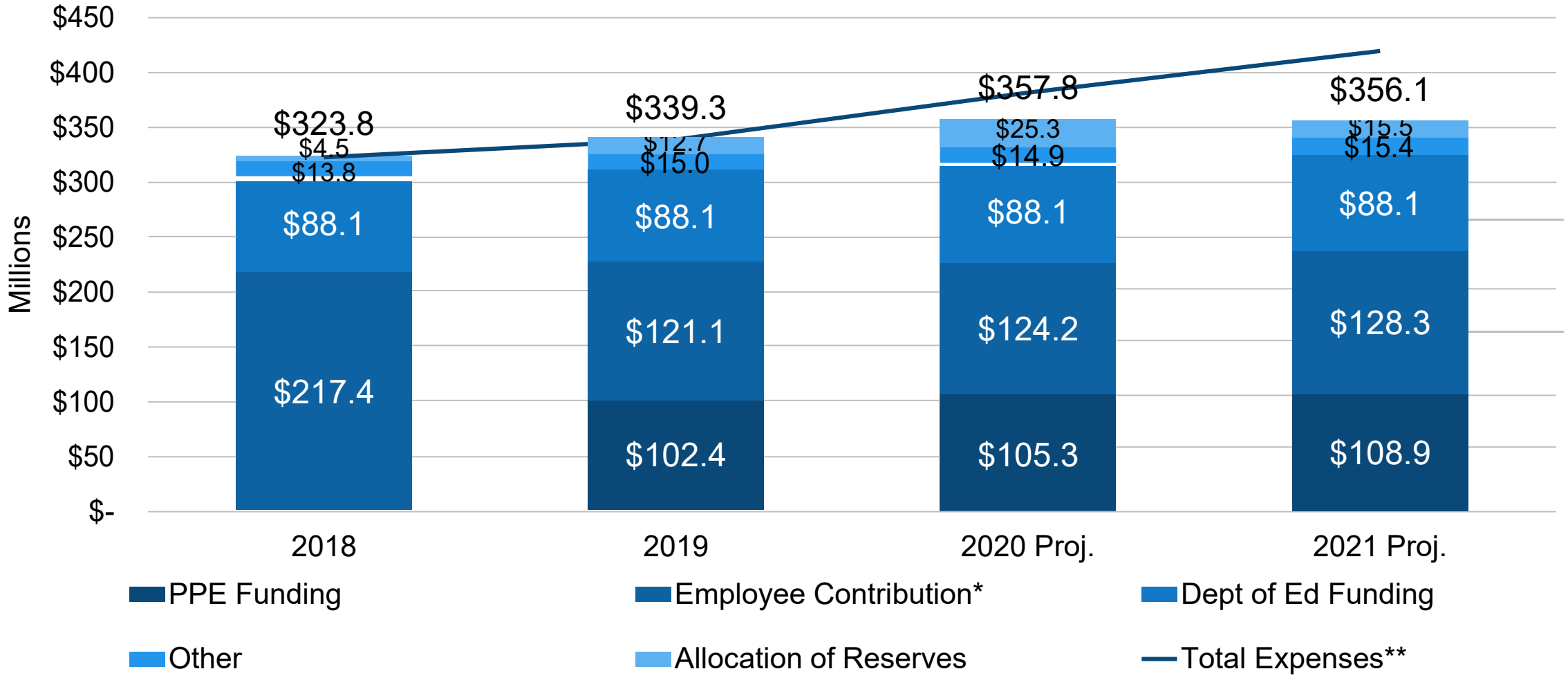


ASE - Average Enrollment (Subscribers) by Plan





PSE - Income vs. Expenditure

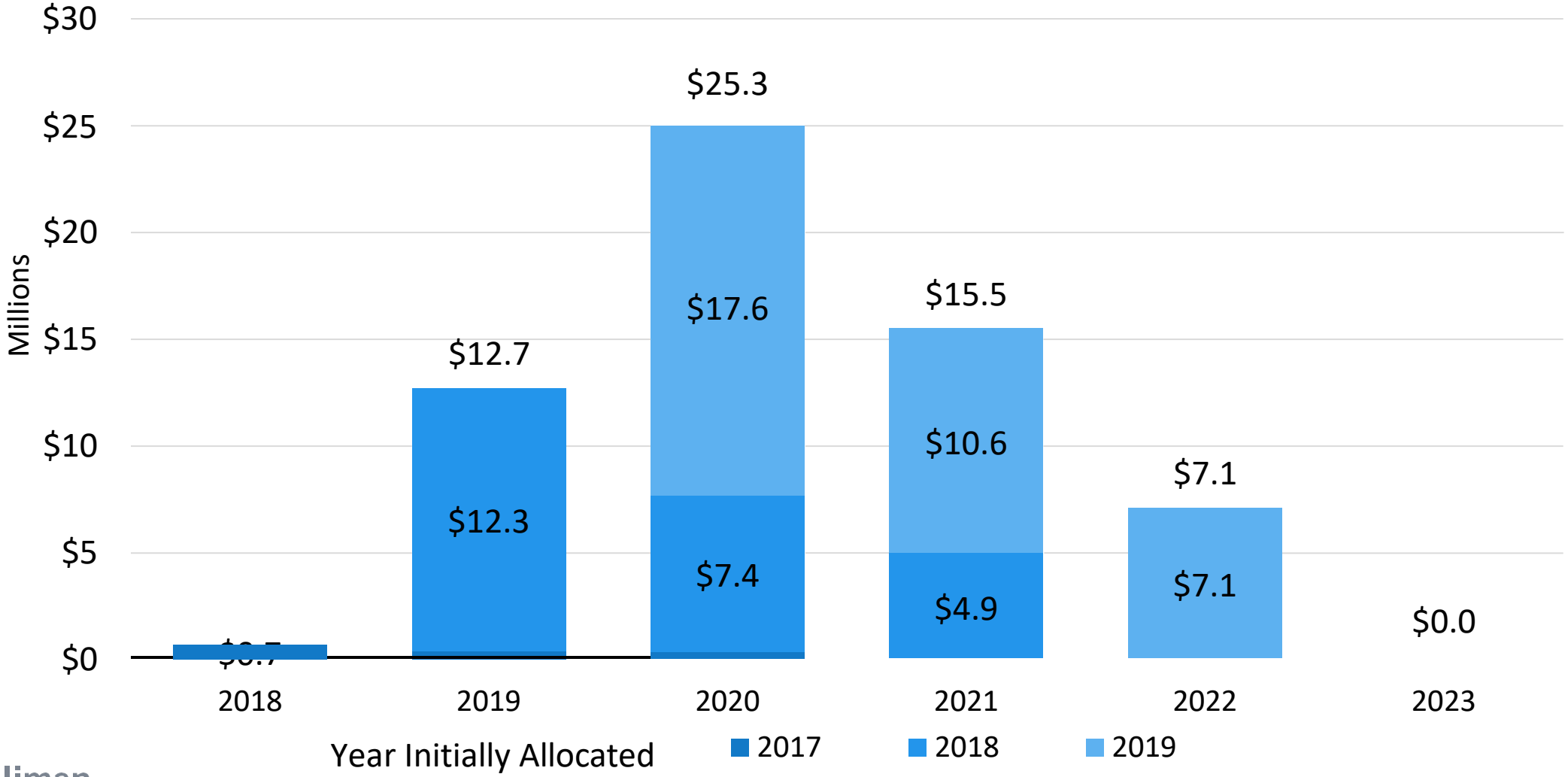


* 2018 Employee Contribution includes PPE Funding

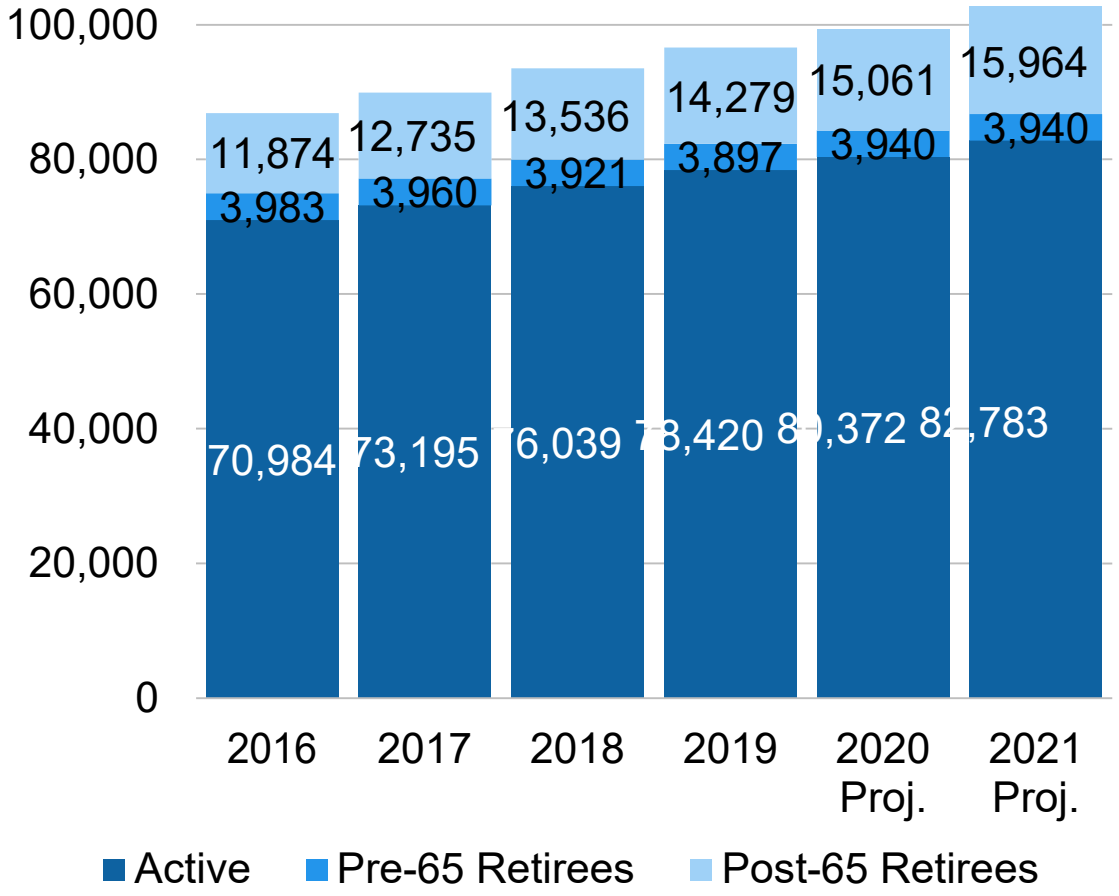
** Total Expenses offset by Program Savings

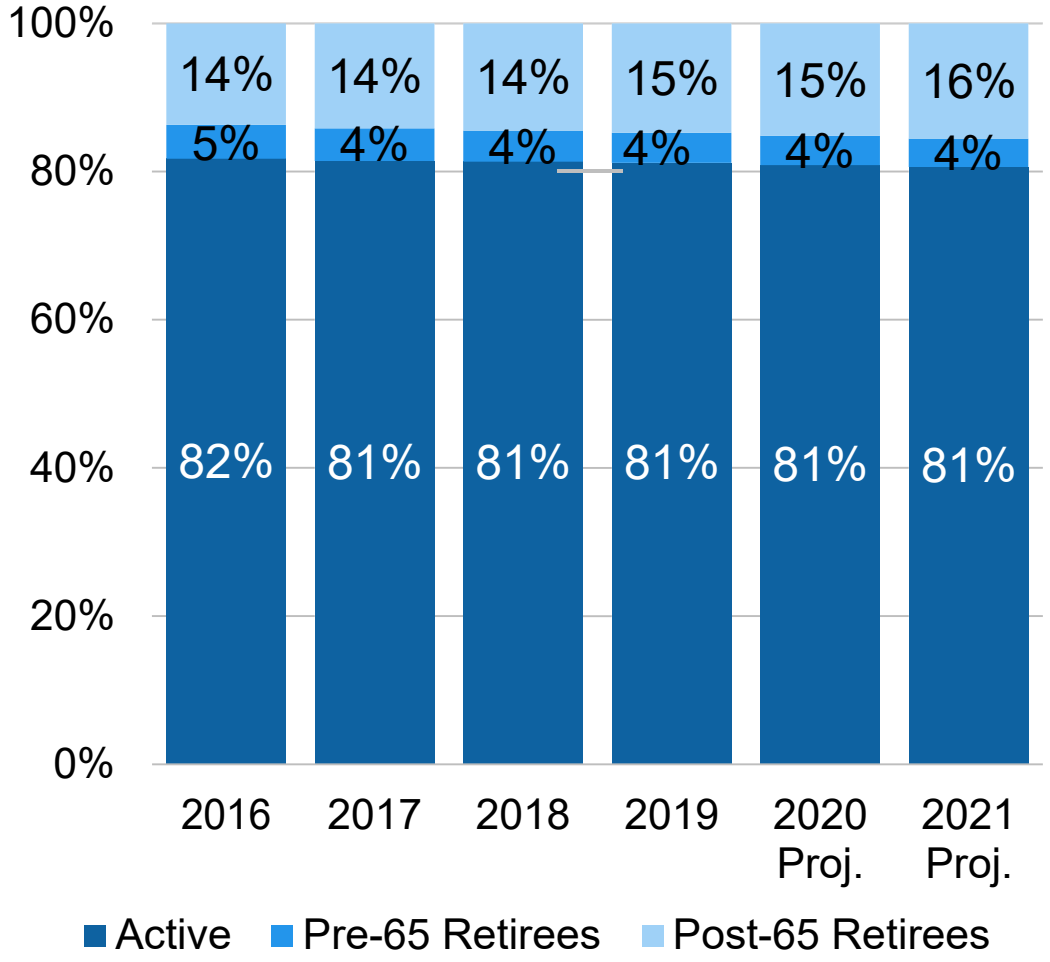
PSE - Reserves Allocation by Year

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

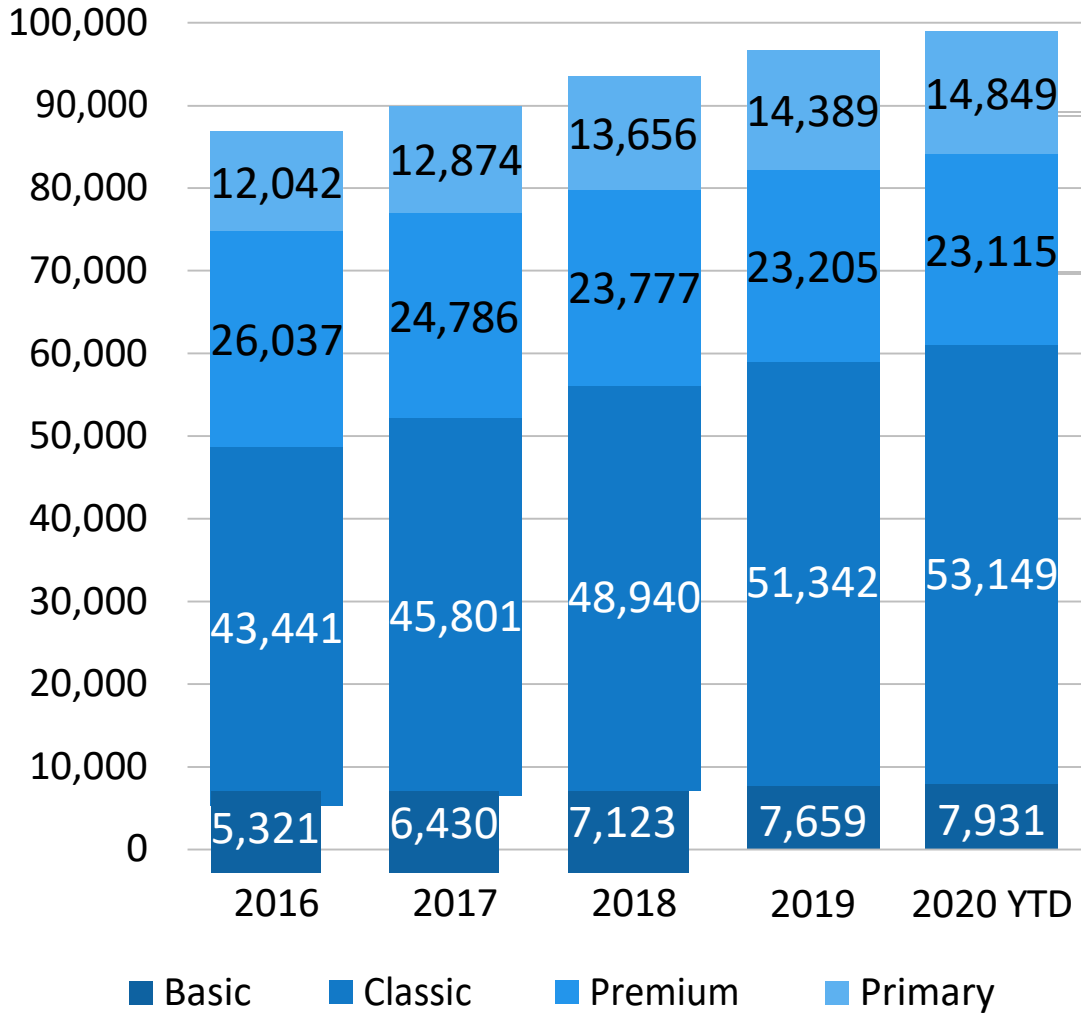


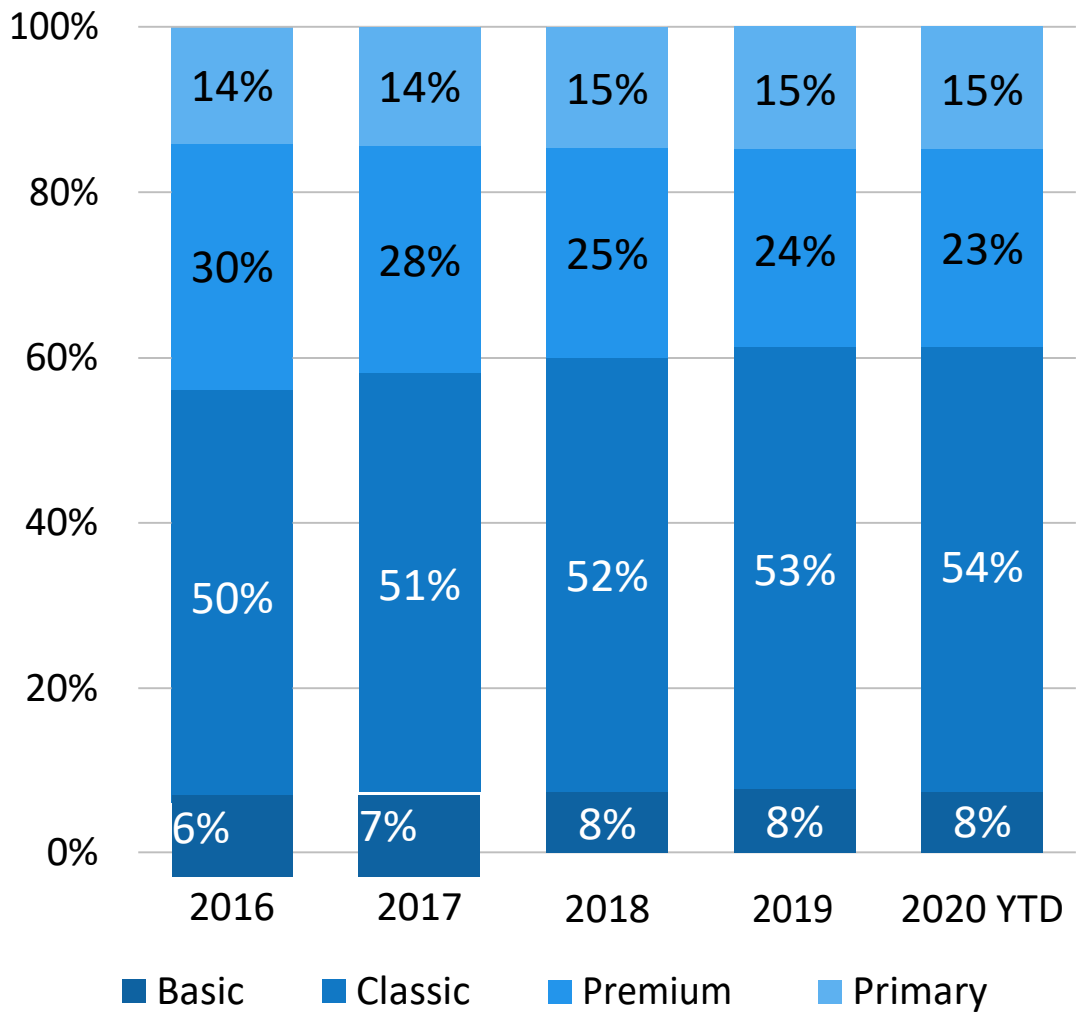
PSE - Average Membership by Status



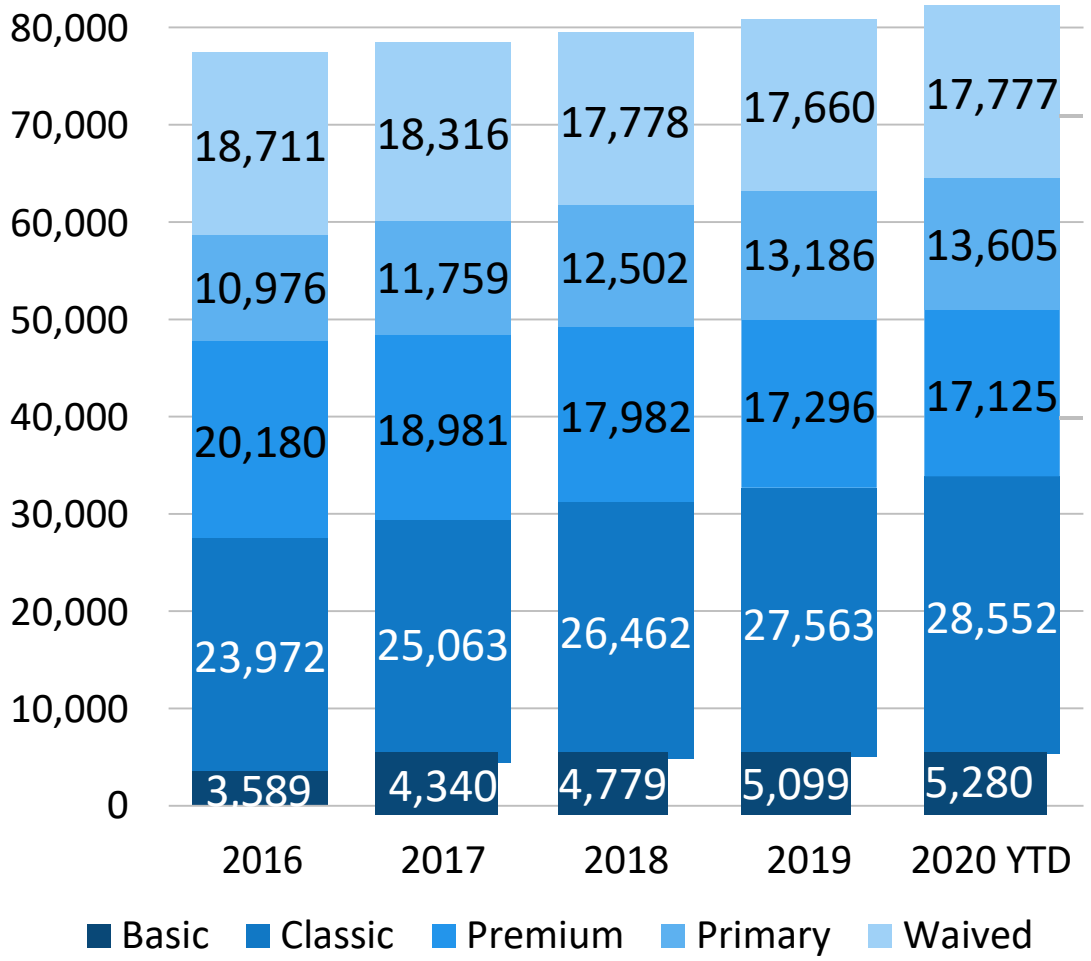


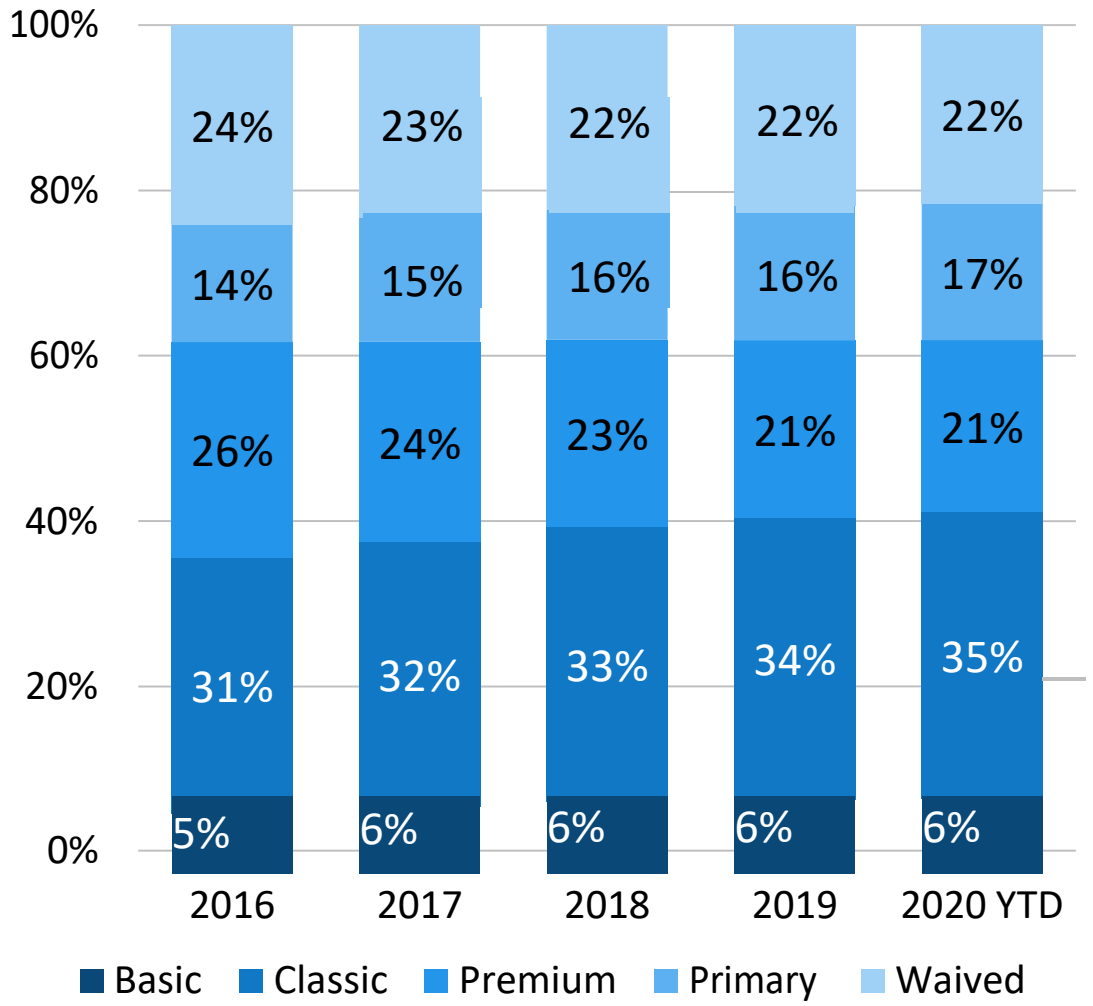
PSE - Average Membership by Plan



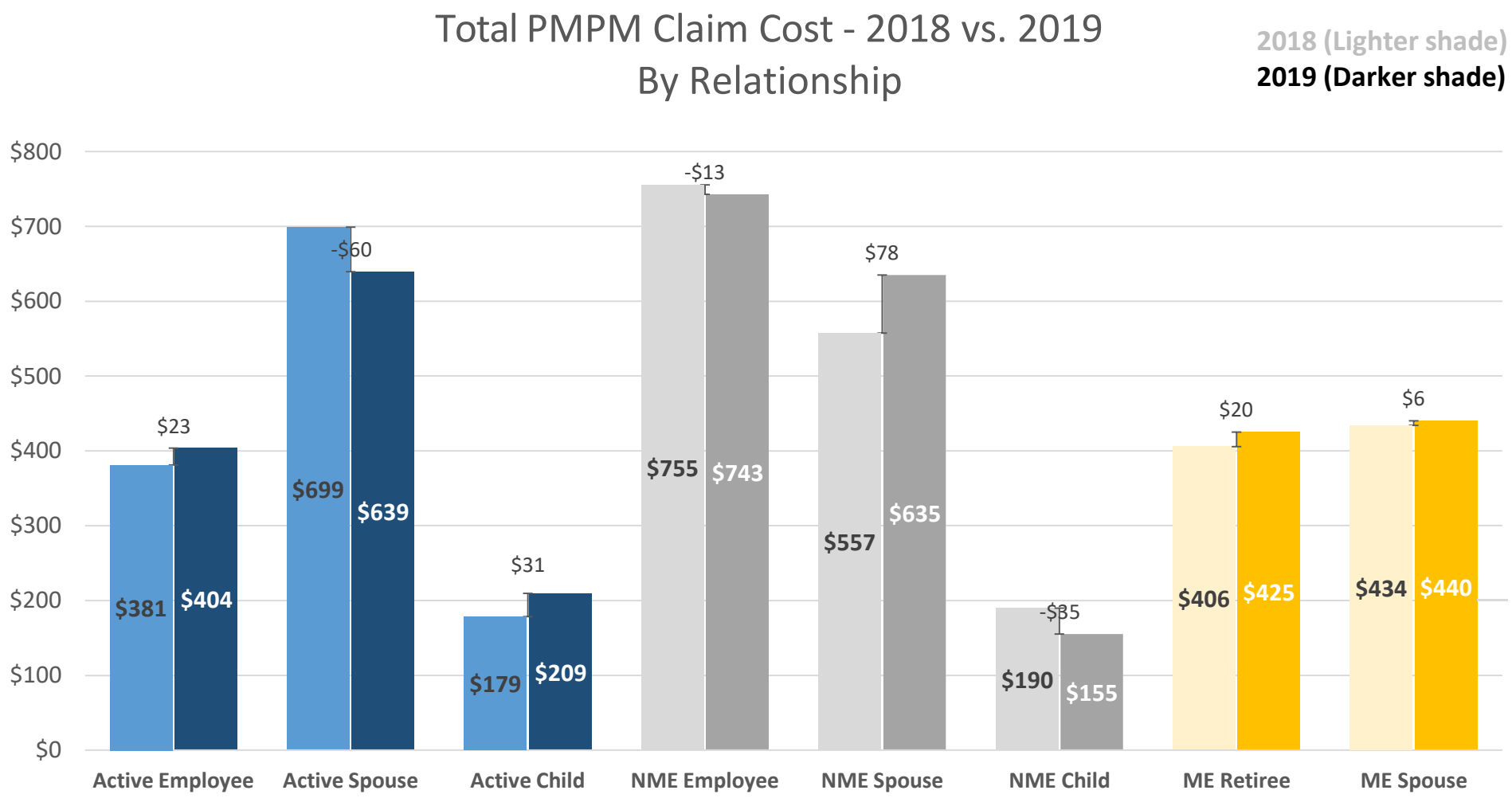


PSE - Average Enrollment (Subscribers) by Plan



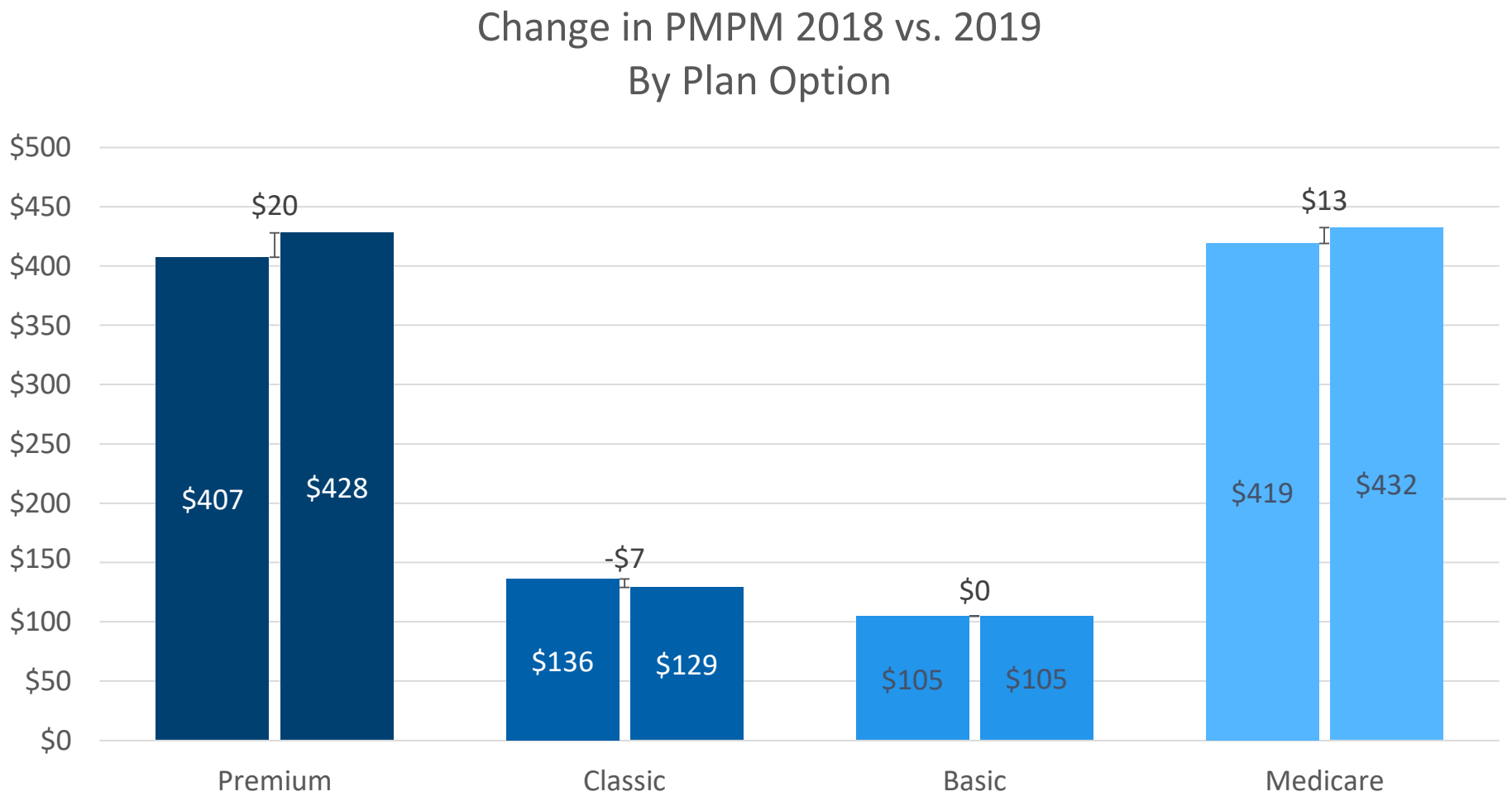


ASE Plan Performance – YoY (By Relationship)



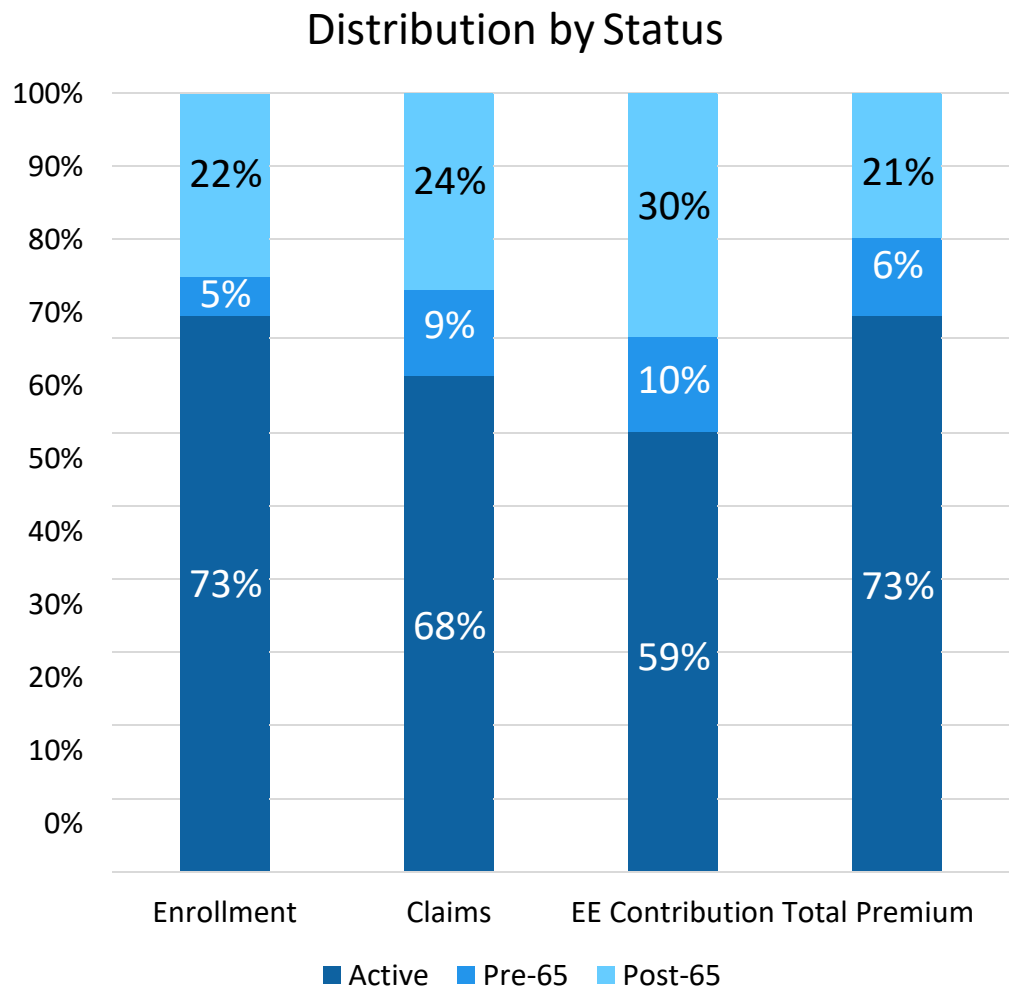
Categorization is based on the subscriber's benefit election.

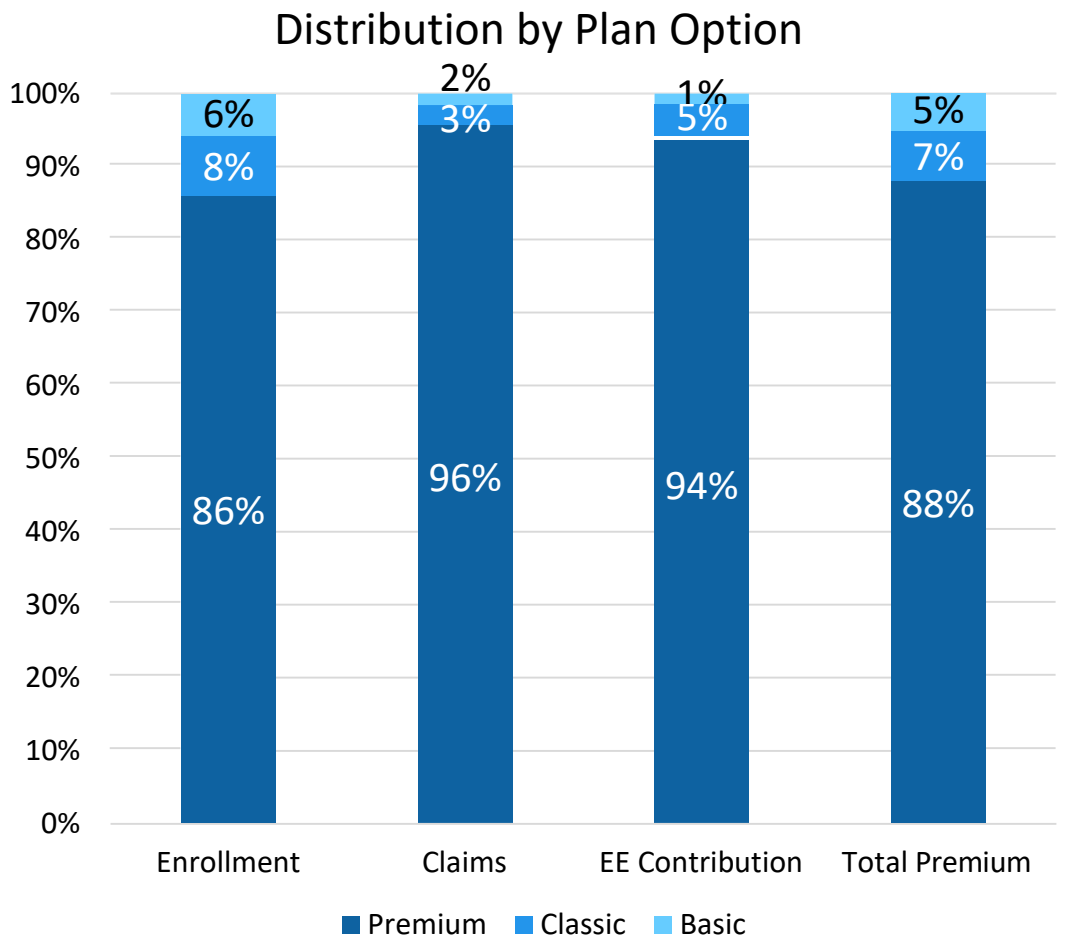
ASE Plan Performance – YoY (By Plan Option)



Categorization is based on the subscriber's benefit election.

ASE Breakdown – Employment Status and Plan Option



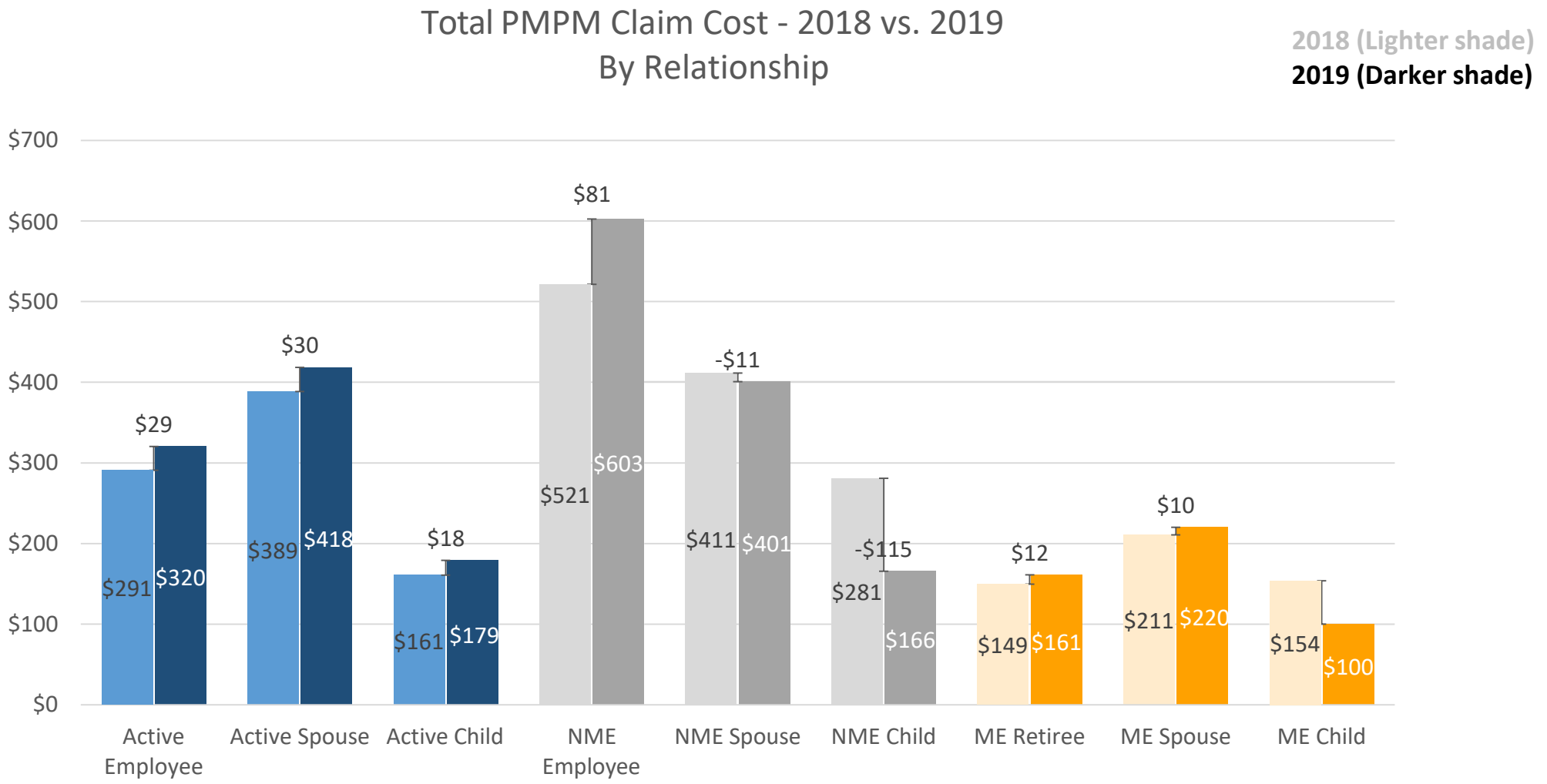


Enrollment based on membership.

Based on 2019 information
Categorization is based on the subscriber's benefit election.

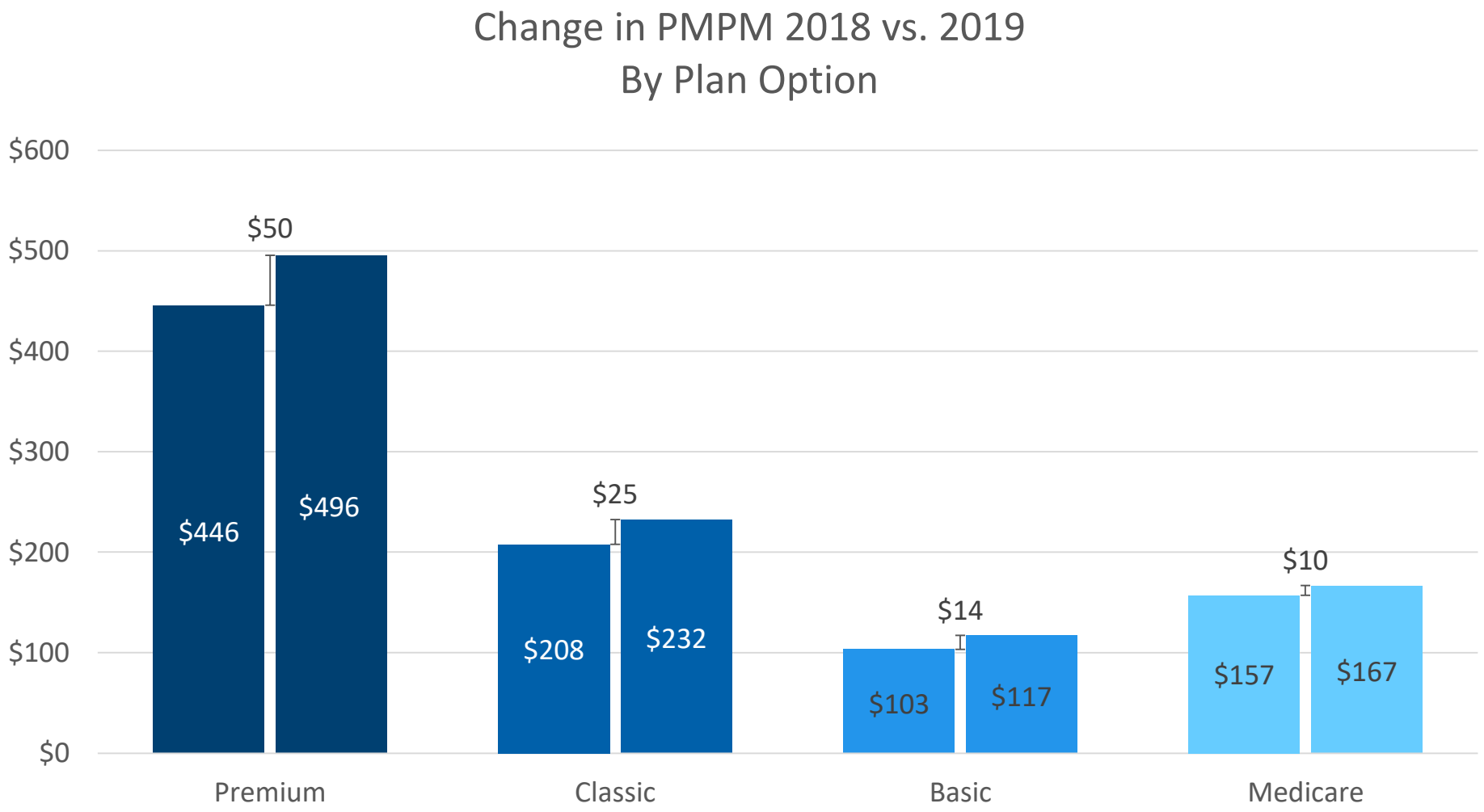
ASE Breakdown – Employment Status and Plan Option

PSE Plan Performance – YoY (By Relationship)



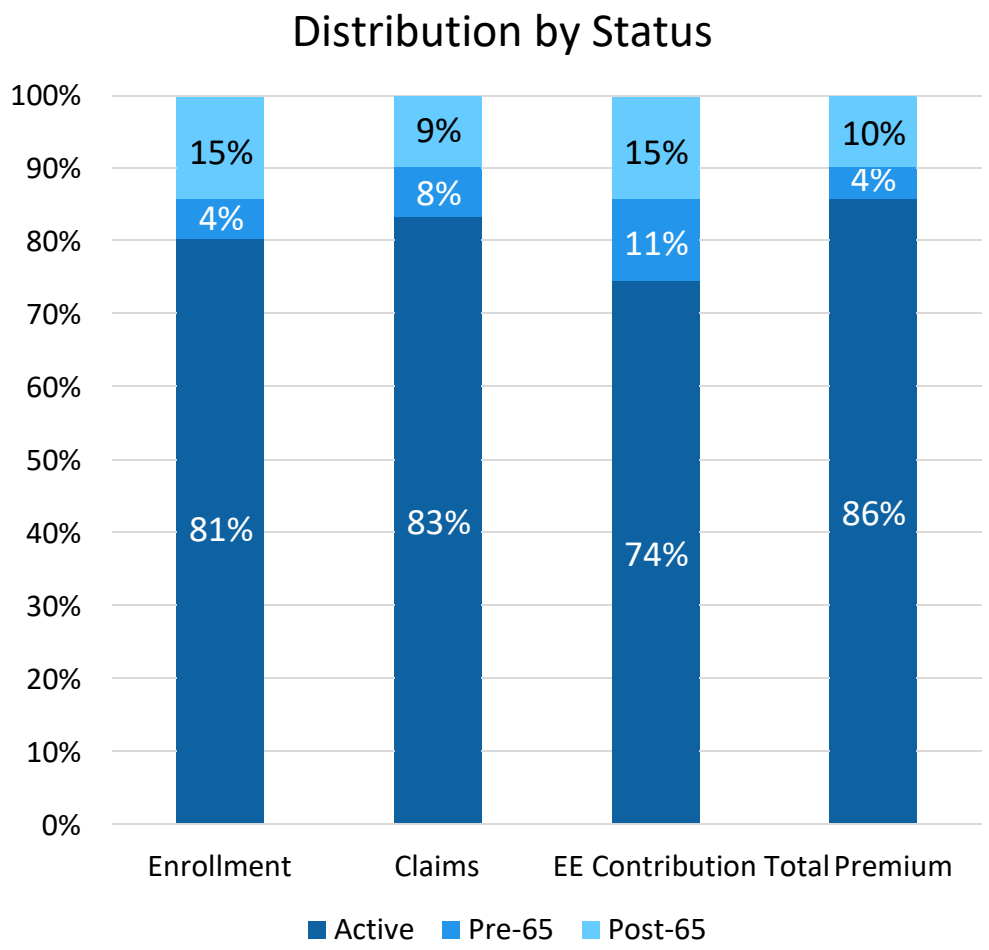
Categorization is based on the subscriber's benefit election.

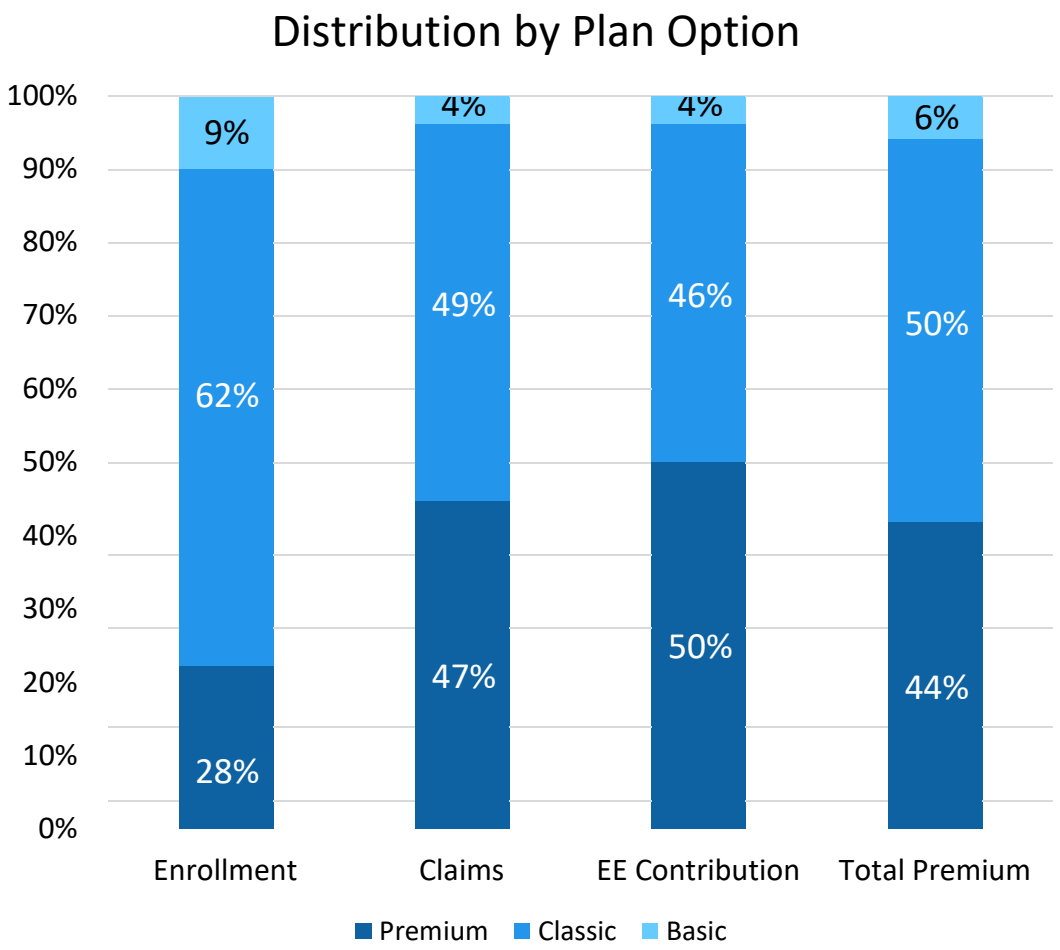
PSE Plan Performance – YoY (By Plan Option)



Categorization is based on the subscriber's benefit election.

PSE Breakdown – Employment Status and Plan Option





Enrollment based on membership.
Based on 2019 information
Categorization is based on the subscriber's benefit election.

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 February 2019 through March 2020
  - Projected April – 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 & CY2021
- Plan Administration Fees include PCORI charges for 2020 and 2021

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 April 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 PMPM from the midpoint of the experience period (September 1, 2019) to the midpoint of the contract period (July 1, 2020).
6. 2021 Projected the incurred claims PMPM from the midpoint of the experience period (September 1, 2019) to the midpoint of the contract period (July 1, 2021).
7. Made adjustments for seasonality, benefit changes, and age/gender mix.
8. Accounted for rating period fees and administrative expenses.
9. Where applicable, converted incurred budget to paid budget based on historical payment patterns.

Limitations

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

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

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

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

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

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

Milliman

Thank you

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