AGENDA

State and Public School Life and Health Insurance Board

September 22nd, 2020

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

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

2020 Upcoming Meetings:

October 20th, November 18th, December 16th

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

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

STATE AND PUBLIC-SCHOOL LIFE AND HEALTH INSURANCE BOARD MEETING MINUTES

204th meeting of the State and Public-School Life and Health Insurance Board (hereinafter called the Board), met on September 22nd, 2020, at 1:00 PM

Date | *time* 9/22/2020 1:00 PM | *meeting called to order by Renee Mallory, Chair*

Attendance

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

OTHERS PRESENT:

Rhoda Classen, Theresa Huber, Laura Thompson, Stella Greene, Shalada Toles, Mary Massirer, EBD; Micah Bard, Sherry Bryant, Octawia DeYoung, 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; Kristie Banks, Mainstream; Ronda Walthall, ARDOT; Mary Grace Smith, Sheila Weddington, ASE Retiree; Geoffery Becker, Medtronics; Jim Musick, Sanofi; Stephen Carroll, AllCare Specialty; John Vinson, APA; Bill Clary, ARSEBA; Ann Purvis, Alex Johnston, Mitch Rouse, TSS; Charles Hubbard, ASP; Julia Weber; Jacquelyn Ross; Amy Walker; William Rains; Lesheia Swift; Luke Daniel; Tony Glenn; Treva Phillips; Glenda Martin; Brenda McCrady; Jim Chapman; Steve Vermette, Jessica Reece, Sylvia Landers, Colonial Life; Erika Gee; Jake Bleed; Daniel Faulkner; Kim Hammer, State Senator; Mike Wickline, Democrat Gazette;

Approval of Minutes by Renee Mallory, Chair

MOTION by Lilly-Palmer:

Motion to accept the August 5th, 2020 minutes.

Hicks 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, September 14th, 2020 with Dr. Hank Simmons presiding.

I. Old Business

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

Levonorgestrel Intrauterine Devices (IUDs)

- All products can be removed at any time. Most patients have return of fertility within one year of removal.
- ACOG guidelines do not provide guidance for when to choose one product over another
- In practice, devices with a smaller size (Kyleena and Skyla) may be preferred for nulliparous women.

Consider possible rebate opportunities.

No recommendation; No vote.

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

Generic	Brand	Recommendation
(1) IMATINIB	GLEEVEC	Remove PA requirement
(2) AVELUMAB	BAVENCIO	Cover with PA
(3) ELETRIPTAN	RELPAX	Remove reference pricing from generic; cover T1
(4) TEPROTUMUMAB-TRBW	TEPEZZA	Cover with PA
(5) SC IMMUNE GLOBULINS	MULTIPLE BRAND NAMES	Seek rebates
(6) RAVULIZUMAB	ULTOMIRIS	Remove PA requirement and edit eculizumab PA to prefer ravulizumab over eculizumab for PNH.

The DUEC voted to adopt the recommendations as presented.

II. New Business

A. New Drugs: *Dr. Sidney Keisner, UAMS*

Brand	Generic	Recommendation
Non-Specialty Drugs		
(1) NEXLIZET	BEMPEDOIC ACID/EZETIMIBE	Exclude, Code 1 and 13
(2) ORIAHNN	ELAGOLIX/ESTRADIOL/NORETHINDRN	Cover with PA
(3) PHEXXI	LACTIC ACID/CITRIC/POTASSIUM	Exclude, Code 13
(4) LYUMJEV	INSULIN LISPRO-AABC	Exclude, Code 13
(5) HELIDAC	BISMUTH SSAL/METRONID/TETRACYC	Exclude, Code 4 and 13
(6) ORTIKOS	BUDESONIDE	Exclude, Code 13
(7) DURYSTA	BIMATOPROST IMPLANT	Exclude, Code 13
Specialty Drugs		
(1) AVSOLA	INFLIXIMAB-AXXQ	Exclude, Code 13
(2) ZEPOSIA	OZANIMOD HYDROCHLORIDE	Exclude, Code 13
(3) KYNMOBI	APOMORPHINE HCL	Cover; QL 5/day
(4) ZEPZELCA	LURBINECTEDIN	Exclude, Code 1 and 13
(5) UPLIZNA	INEBILIZUMAB-CDON	N/A Medical
(6) PHESGO	PERTUZUMAB-TRASTUZUMAB-HY-ZZXF	Exclude, Code 13
(7) FINTEPLA	FENFLURAMINE HCL	Cover with PA
(8) RUKOBIA	FOSTEMSAVIR TROMETHAMINE	Cover
(9) BYNFEZIA	OCTREOTIDE ACETATE	Exclude, Code 13
(10) FENSOLVI	LEUPROLIDE	Exclude, Code 13
(11) DARZALEX FASPRO	DARATUMUMAB/ HYALURONIDASE	Exclude, Code 13

The DUEC voted to adopt the recommendations as presented.

Discussion:

Dr. Fiddler: Where it says seeking rebates under immune globulins, don't you do that on anything if you have an opportunity where there is a rebate out there? Don't you generally try to cut down the costs on things for people?

Dr. Simmons: I don't know that the plan seeks rebates on all drugs. There are actually people that are better qualified to answer that than I am.

Dr. Fiddler: I know in the past, if there was anything that could be done to help the patient, we're going to do it.

Dr. Simmons: What the rebate process does, as I understand it, is anytime that there multiple alternatives for a given drug and there are multiple competitors who are producing the drug, then what we would certainly do is with your permission, we would make an effort basically to see the best option for the plan without compromising actual care or quality of the drug.

Dr. Bard: I just wanted to add that we seek permission every time we go out for a rebate bid. What we do is we make sure that all the drugs are clinically equivalent, and there won't be any difference between them first. Then, we come to the DUEC committee, followed by the Board, to seek permission to go out for rebate.

Dr. Simmons: Each one of the candidates has been studied in some detail by the various folks that assess these things on the basis of peer reviewed literature before we ever make a recommendation about the potential of searching our rebate offers.

MOTION by Dr. Kirtley:

Motion to accept the recommendation as presented.

Dr. White seconded; all were in favor.

Motion Approved.

Subcommittee Updates by Chris Howlett, EBD Director

Howlett provided a brief update on the September sub-committee meetings. He stated that there was an update provided and acknowledged Secretary Fecher to provide an update to their fellow peers on the Board.

Fecher: I just want to give the Board an update on some of the things that the division has done and that we have worked together since our August 5th Board meeting. So, as far as the sixty-five plus retiree pharmacy benefit goes, we have sent out emails, and we've sent out hard copy letters through the Postal Service to all retirees. We've also engaged with a call center through U.S. Hub to call all of the members and to let them know about this change as well as refer them to the SHIIP program at the Insurance department that can help counsel them. They have partners all over the state that do this kind of work. So, they're trying to refer them to their local partners to get help for counseling for which Medicare plan will be better for them when they're able to sign up, and we're letting them know about the exact enrollment dates. Then the call center will be attempting to call them all back once open enrollment goes live on October 15th, and they'll try to reach them again before it closes on December 7th. We have also spoken to two committee meetings. Chris and I went on September 9th to the Public Health committee, and then last week, we were at the PEER committee on the 15th, and we are scheduled to speak to the Insurance and Commerce on Monday of next week on the 28th. So, we're getting a lot of questions, receiving a lot of calls, emails, and letters, at my home and at work and trying to respond to all of those as well as a lot of suggestions that are coming in. So, we're taking each one of those suggestions, and we have an ongoing spreadsheet that we're sending them to Milliman and asking them, "If we did this suggestion, what would it net the state and what would it cost the member?" So, we are trying to have all of that ready. We know that we'll get a lot of the same questions. I sent an email to both the Senate Pro Tempore and the Speaker of the House, and they will send it out to their entire membership, asking them for any input or suggestions. So, we

could have that information when we're there next week and kind of go through because there is a numbers part of it, but also, we want to make sure that we are looking at everything we can because we promised the legislature. They outright asked us at the PEER meeting last week if they come up with a suggested alternative approach if we would bring it back to the board, and we said we would. So, if there is something that comes out of the hearing next week, we could possibly be calling a special board meeting to look at those and consider those. We're also trying to engage some of the retirees. Mr. Herb Scott is part of the group. We're putting together a small focus group of the sixty-five plus retirees to try to address some of these concerns. We're getting several of the same suggestions over and over. So, we're going through that with them. Unfortunately, because of COVID, we're unable to have a huge town hall or public setting, but we are getting a few, I think it's about eight retirees to come in, and I've called them all personally, they are very encouraged about coming in and speaking with us. We are going to do that on Thursday and just kind of go through some of these suggestions and also show them the numbers and what it would mean for them or for the state. So. we're working through that, and we will be bringing you back more information as it goes along. But I'm happy to take any questions or Chris can assist as well on those because he's been involved every step of the way.

Dr. Fiddler: First, when we were talking about this last time and this vote that we took the first week of August. What I'm hearing then is that this vote is not necessarily etched in stone. The vote itself was, but the changes are a possibility, which is why you are calling for a possible special Board meeting if monies come up or if different approaches occur. Is that fair?

Fecher: Correct, as of today, it is a vote of the Board, and that is why we are continuing to go forward with the outreach knowing that the timing of the open enrollment. So, we are continuing full speed ahead on that. However, with the legislative ask, we did say that if there was an alternative plan and that the numbers would work that we would bring it back to the Board, and it would take a Board vote to change it So, if the Board votes not to change it, then the current plan will stand. If there is a proposal, yes. It is all very if right now.

Dr. Fiddler: Well, I look around at the board members here, and I'm not going to speak for a single one of them because they'd let me know if I misspoke, I'm sure. But there was not a single board member here that didn't vote in favor of doing that without wringing our hands, nobody wanted that, but that's where we were and that's where this decision came to be. I'm like you, I've had a few discussions and the point that I would make is that we're only here to help, we're not here to hurt. If it has hurt people, which obviously it has, or they would not have contacted us, it was simply because we had no other way to go financially except what we were doing. Would that be a fair statement?

Fecher: I would agree with you, Dr. Fiddler, and also what I've been very clear with members and with the legislature is, if there is an alternative plan that is brought forward and that this Board votes to approve that, it will be a one year fix. It will not fix the plan for years to come. So, were going to have to continue to take measures if there is an alternative plan approved by the Board.

Dr. Fiddler: But if the COVID is one of the "reasons" we are having problems, hopefully within the next 90 to 120 days, there is going to be a solution or at least a marked decrease in the amount of infections that are out there. So, if that is the reason and it is a "one-year fix,"

that vote could have possibly been a different thing had we not had the situation which we are in. Would that also be a fair statement?

Fecher: It could be yes, but I would say what Chris has given me information on is that this is not just a result of COVID currently and that since 2018 we have seen the premiums rising and our costs rising. I mean, isn't it 11% year over year, Chris? It's been happening long before COVID, and we still don't know the impact that COVID will have today. I think we will have that by the time we are getting ready to set rates again next year, but I do not think that it is just a result of COVID.

Dr. Fiddler: But it didn't help. If I said something to any of the Board members that you would disagree with on what I thought your attitude is about, please forgive me and correct that, but I mean why would any of us sit here and want to take away from somebody. It just doesn't make any sense and it just happened because of the financial situation.

Scott: I've got a lot of calls. I didn't get a few. I got all the calls to the point where I thought I was going to have to hire a temp service to answer my phone while I'm responding to text messages, emails, and phone calls. I think I spoke on the 5th when we voted that you can get ready because the retirees are not going to lay down. I understand what you are saying about us not intentionally hurting, and I don't think people are looking at that. I think people are more upset with did this just happen. How long has the Board known about running into situations here? To come back and then just vote to put everybody off has not set well. The big question that I get more than anything else is what other recommendations did Milliman come to discuss with the Board? Was this the only one that they settled on and was there no other alternatives. I couldn't answer that because I wasn't in those meetings and I don't know what was discussed and decided. I got a text message yesterday saying, "I have Crohn's disease, and my husband has colon cancer. I need coverage, and for you to just make that decision, that's wrong. I had no input, and you don't know what my situation is financially what I'm faced with, and this is the decision you made." I guess I tend to have a little compassion with people like that because we are not promised anything, and you could have a disease tomorrow that would totally wipe out your savings and everything else. I've seen that happen to people. So, I don't think anybody thinks we intentionally hurt anybody, but on the other hand, I think people are saying why didn't we go ask for more and ask the people that you're expecting; get our side of the story and let them talk a little bit. That's kind of what I've been dealing with on it. I've lost a couple nights of sleep on this decision because people don't understand it. I can talk all day long about how the teachers lost theirs in 2007, and they no longer have it and blah, blah, blah. They want to know if now they are going to be paired now with the teachers. Are our rates going to be the same since now we don't have the (Part D) plan? People have questions that they just want answers to, and we can't just vote and say that's it, and we wash our hands of it. I had the same issue last year with the 5% increase voting. The only difference was, I had enough time to get with my constituents and say this is what we have, this is where we are, and this is some of the alternatives. People said they would be more than happy to do the 5% increase as long as you don't touch the benefits on it. It's like they are saying they don't even trust the Board now and is there an oversight committee. If not, I think we need to start getting with the legislators and say that the Board needs oversight. People are past mad. They want to know why we don't have a public comment period. I would not be surprised if you find a push for a public comment period next time on this. I was really just taken aback so shocked, and to be honest we

had a voice vote and if you really want to know the truth, I didn't vote either way, yes or no. I just felt like I can't believe we are even doing this. So, I appreciate the Secretary for at least trying to come up with some resolutions. That certainly helps me sleep a little bit because I'm getting the calls and people think I should be the one to overrules the Board. I have one vote, and there are thirteen or fourteen people on this Board. So, if everybody but Herb votes no, then Herb is outvoted. I do have one more question for Dr. Kirtley. Have you notified the pharmacies of all these decisions and letting them know that people may be coming to them? Let me tell you why, and this is my own personal experience. I went to my pharmacist Saturday just to see, and I asked the young lady and told her the situation and stated that I just need some help with these plans. These plans are difficult, and I just don't understand it, and I understand that I can come to you and set up a meeting and you or someone can walk me through what I need to do. Her comments were, well I can't select a plan for you, and I told her I didn't need her to do that. I asked you to explain to me and advise. I'm asking that since you have a profile of my medications and you can look at that and possibly tell me. She said she can't do that, but what you need to do is go out on Medicare.gov and list your prescriptions, and probably a hundred plans are going to come up. That's not going to help me; I just need one plan.

Dr. Kirtley: Herb, first of all, you remind me why I like you so much, in all honesty, because you went out and asked that. So. I've talked several times to our association, to the exec, and one thing that is weird right now is the plans are trying to finalize what their rates are and what the offerings are going to be. There's even a brand-new plan that's based here in Arkansas for that. Most of our pharmacy colleagues are there taking care of their patients and saying, let me pull this up, and they literally can generate it in that system, and it will show you; here are the five plans that look like they cover most of your stuff. But I think, and I'm going to back up, and part of what you're saying is a hundred percent right. In the anger that we see is out of the fear that we see and I think that most of the messages that we're really hearing, and I know this what the legislators are getting hit on is people on fixed incomes that have a budgetary plan that they felt like they could plan really well with the known of their health insurance. When you look at these plans out, and once again, I'll tell you, you can get better customization when you have multiple options, but when you start looking at some of the specifics of people that are on chemotherapeutic agents or that are on insulins and things like that, their fear is the donut holed trough that they fall in and their fear is that they don't know if it's just going to cost him four hundred and thirty five dollars for the plan plus copays or if they're going to have a three or four thousand dollar donut hole spend in that. Now, I would add to that we are being presented with scenarios from individuals that may or may not represent the whole on the average, because what we can really pull data on is the average, and there are going to be outliers where it's going to be cheaper for them and outliers where it's going to be more expensive for them. One thing I would suggest for any of the board members that have not seen it is for you to go back and watch the committee meetings that have already happened because you'll get to hear what the legislators are saying and they're not, in my perspective, saying absolutely we're going to bail you out but, you know, Secretary Fecher has to go again on the 29th and I'm going to be sure, I may not be able to watch it right then, because of another meeting, but I'm going to watch it that night or the next day. The messages that they we're hearing, even from them, if they have heard the anger due to the fear from the people

and I think they have a desire to try and help with that. There are a lot of questions about how this came to be, but I also think our legislators are looking at how they can help with that. I don't think we knew that this was necessarily a straightforward option when we made this decision. So, I would advise you to go watch the other two meetings, and it's going to take a few hours at least and watch the 29th because they are about to stick these two guys with it.

Fecher: John, it changed to the 28th. It was originally the 29th.

Dr. Kirtley: I've got meetings both those days, but I'll try to watch it by the 29th. They're going to hit these guys with questions that are the same things that we're all going to get here if we haven't already from the calls and emails that we are all getting.

Dr. White: Dr. Kirtley, correct me if I'm wrong, but I believe the Medicare plans are not published until October 1st. So, we can't really even see the 2021 plans yet. We're in a weird place where it's going to be really hard for people to understand what their true options are because they aren't published until October 1st.

Dr. Kirtley: That is a very different troubling thing, because the advice I could give you today would be if you became Medicare eligible today, I can tell you what the 2020 plan is. It's very difficult for me to show you what the 2021 plans are going to be until October 1st.

Fecher: One thing I just wanted to share with the Board; two of the questions that we keep getting a lot from both legislators and from members is if they kept their pharmacy benefit plan, how much would their rates go up? The answer to that is 116% is what Milliman tells us. Correct Chris?

Howlett: Yes ma'am. 2.26 times, but yes.

Dr. Kirtley: And that is if we fully risk adjusted to make the same money as canceling, correct? So, if we cancel it, it's a thirty-eight-million-dollar difference. We lose ten million for Medicare, but we save forty-eight million, so it's a thirty-eight million net difference. To make up the thirty-eight million would be 2.26 times. We're not fully risk adjusted, though.

Howlett: Yes, we are on ASE.

Dr. Kirtley: Well, if we are fully risk adjusted, then how are we behind thirty-eight million dollars? It couldn't be fully risk adjusted last year and it being overrun.

Howlett: Our claim spend on the health plan year over year, total volume of claims on the medical, I need to verify for medical combined is over 11%, so we're spending four hundred twenty-four to four hundred and thirty million. So, that's forty-two million above year over year. So, it's factored in; you're just burning through reserves. We're not premiumed for that higher component.

Dr. Kirtley: We're not risk adjusted straight to premium. We are charging less for the plan than is has cost.

Howlett: Yes, so by doing very small incremental or no rate increases, we have used reserves or other means to offset that. That would be correct.

Dr. Kirtley: We've been very fortunate, and the years where our claims data was better than expected, it has smoothed the transitions. So, we haven't had to fully, down to the principle amount we charge, risk adjusted. I mean, it's the same thing on the PSE side, we already know it's not risk adjusted anyway, but even with the adjustments we made and the hope of what we have coming, it's still going be ten million short. So, unless we find another stop gap for that, we are going into catastrophic reserve on ten million dollars for that.

Fecher: The second question that I was going to get to is, we are asked if we took the amount for the pharmacy benefit plans for the sixty-five plus members and spread it out over all state employees what the increase would be. What was that percentage, Chris?

Howlett: It would be 40% without the other initiatives, and with the other initiatives, it would be 35%

Fecher: I just wanted to share those answers, but when we get all of our questions answered, we will send those out to the Board as well.

Dr. White: I have a quick question, Secretary, going back to the focus group that you talked about. What's the composition of that focus group, and how did you choose those members? I think that we're probably all getting emails, calls, etc., possibly from a lot of our outliers, and I want to make sure their voices are heard, and those that feel like or have shown that they'll be the most adversely affected. I think it's very important to hear from them. Medicare recipients like my mom to me, don't count. She's on two medications, so she's not a person that would cringe at this. But we have a lot of our members that I've gotten information from, and I'm sure that guys have too, and it's heartbreaking to read. So, is that segment represented in this focus group? So, my question to you is, what is the composition? How are they chosen, and what's the plan for this focus group? Is it just a one-time meeting, or is it an ongoing meeting? Are they going to turn into an advisory council for this Board? What are we going to do with those people?

Fecher: I do not want to give out specific names, because I haven't asked them if I have their permission to do that

Dr. White: I'm wanting segments of people so, kind of general.

Fecher: Yes, I will say that I tried to choose the ones that have been the most vocal, and that they are most opposed to this. There are people that have a long term, debilitating diseases to represent those that we're hearing the worst of the worst about. I took Herb's recommendation on a couple of people that he has heard from over and over. So, we're trying to take different segments and make sure that it's all representative, but if there's anyone, because of social distancing, we would love to keep the group small. Right now, we have eight people. If there's someone you feel strongly should be there, please, let me know that, because we don't want to be exclusive, but we just want to be mindful that we are in a pandemic and keep everyone as safe as possible.

Dr. White: Great. Is that group also balanced as far as gender and race and ethnicity? I want to make sure we don't have a white male focus group, or a white female focus group. I want to make sure we have some minority members there to represent all segments of Arkansas.

Fecher: I'll find out. I don't know the gender on any except a couple.

Dr. Kirtley: Also, their financial abilities.

Dr. White: Absolutely. So, I think we just need to make sure we're balanced so that we are getting a good a representation of members. Thank you.

Dr. Fiddler: It will take you too long to explain it to me between you guys because you all understand numbers that I don't understand. I'll be the first one to admit it when you start talking about percentages and net, I lose you. You probably all have been doing this long enough that you're not lost. So, I would like to have you send us something about your discussion that you just had showing the thirty-eight million dollars? Why is it this? You made the comment on some part about it not applying to ASE or PSE. There are some of those things that I just don't understand. The bottom line is that I understand that people are upset, and I understand that very well. When I'm told by a

person that if you were just going to raise it 8%, why didn't you just go there? I said, hey if it was just going to be 8% percent, we wouldn't be having this discussion. There's so much misinformation out there and it's not because of Chris's fault or because of Secretary Fecher's. It just that there is misinformation out there, and if we can just give honest information from your focus group, you're talking about. If you can just hear it and you may disagree with it, you might not like it, but at least you heard it and can make some kind of judgment call from that.

Howlett: I would say that the one differing piece that was mentioned today was basically the risk rating. What he is referencing is a liability or the cost of the claims associated with it. Other than that, everything else has been presented in the Milliman presentation and on that list of initiatives. So, basically, what Dr. Kirtley stated, my interpretation of what he's asking or saying is to offset that dollar amount what would it take to make up that difference? We've asked Milliman to model that for us, and that's where I got the 116%, because it did come out of some of the conversations that have happened. I respect everyone's role and position, and I'm like you; we're getting direct communication from members. We've had a few come in to visit as well as phone and emails and you guys providing information to us. But, yes, I'll try to put something together. I think if we take the information and the models that Secretary Fecher was mentioning and we give that to you guys, you'll have that same information. So, I believe we'll be able to comply with that request.

Allen: The only comment I'll make, and I'm speaking from the teacher's point of view and the public education side. I'm wondering how many of you all have ever looked at the two plans. You keep saying that we need to make it more equitable to what the Medicare teachers pay, but obviously it's much less because we've not had a drug plan since 2007, as I understand. But have you ever looked at the rest of it? You can't say a thing about equitable if you don't look at the rest of it, and when you look at the rest of it, you'll see it's impossible. It's way, way, way more for public education people in almost every case. This is the one exception. I guarantee you I was pre-Medicare with it and paying it so I can guarantee you it's a lot more for those people that are retired Pre-Medicare. You're going to have to tell them, I'm sorry, but there is a difference in how much we pay and most of the time, all except this one, it's been on public education, because we're funded different ways. I've learned that since I've been on the board and I think that's something a lot of them don't understand, is that it's not the same, but this is the only area that it's different, and it was because they had the drug plan. So, I just want to state that in case some of the board members, especially if you're ASE and do not realize how different it is.

Scott: I think that is the crux of the matter. Dr. Fiddler just said it; I think it is just a lack of information. I think people just don't understand, and if there's some kind of way that we can do a better job.

Mallory: Something we can show them.

Scott: Even in the future, before we come to these points, my biggest concern is with the information educational thing last meeting. That's why I was so afraid that we wouldn't be detailed enough to where people would understand what we're doing. It's the lack of information that I think we're having our trouble. You know, people think they understand, and I'm glad Mrs. Allen said what she just said, I need to go back and look. I mean, she's put something on with me that I just didn't know. So, I think that's where

we are. We are just floating with a lot of information, misinformation, and misunderstandings. We just have to do a better job in communicating.

Lilly-Palmer: To piggyback on what Herb is saying, one of the biggest things is the simplistic communication. What they are seeing is one rate versus another rate, and this coverage is going away, and that's why I am looking at a parity. It's even been said to me by several retirees, if this is going to go this way, I would like to just get that money back to help pay for this Part D plan. They are looking at serious donut holes and serious medical conditions, but they're also just looking at the overall concept. They're seeing a number, and it's not balancing. For the SHIIP program at the Insurance Department, it is a great program, and they have really stepped up their game over the past three to four years, and their outreach is phenomenal. The outreach for this, if this is the direction that we are going, we really need to be on our game with that. My first state job was state and public-school retirees, so they are very special to me. They're in the heart. So, we need to do everything we can for informational purposes.

Dr. Fiddler: I'd like to make a statement from the minutes of the last Board meeting, a person said on the Part D market, "as far as the retirees we have to do everything we can to educate those 13,800 retirees. What can we do to ease their pain and helped him in any way that we can?" I think that Secretary Gillespie and Mr. Scott both concurred with that thought. This is just a follow up from the last time that we get all the information that we possibly can.

Mallory: In a way that can be understood.

Fecher: If the Board has any further suggestions to add to what we are doing, that's why I wanted to update you on the things that we've done so far, we are happy to take those and try to run with them. We're really trying to think of everything we can do. I agree if we could get it in a more digestible format that is easier to understand, and we can work on that. But if there are other suggestions, please let us know.

Dr. Kirtley: Yeah, I think there are some good graphs even in our Milliman reports that if you look at the PMPM (per member per month), the ASE side has much more funding going into it to help pay for it. The ASE side is funded better, so it looks like it has less cost for the employees, but we apparently are much higher utilizers of it in both the active employee and the retiree side. So, you're trying to explain to someone the reason why we have a legislative mandate to strive for parity, and what has been said several times is that it is almost a parody because of the fact that the funding models are so different and the utilization is as well. It's not apples and apples, but more like apples and tomatoes, because when you get down to it, it's saying, well, why don't we get that same rate? We strive really hard to be risk adjusted for what it actually costs. It appears as though the cost for the retirees is undervalued to me because it looks like the medical costs would be what the total cost is and the pharmacy was another thirty-eight million dollars, which is a very difficult concept. But it's the per member per month that is higher on ASE.

Dunlap: One question, Secretary, you mentioned that you were working on some different models to bring to the board for us to consider. How soon would we be able to see some of that information before we had to come to the meeting? I think I'm the newest person here being the least amount of time so, it would take it take me a little longer to look over that information and understand what it means to come in here and be prepared to ask questions and understand questions. Could we get some of that information before the meeting?

Fecher: What we're trying to do is to wrap everything up on the questions that have been submitted this far by the end of the week, because we have that meeting on Monday. We really want to get them by Thursday, if possible, as we meet with the focus group to show them the outcome of each suggestion. We can go ahead and send those to the Board. Not that it will be a plan, that it will be all of the suggestions that have come in and what it will cost the member and what it would benefit the plan if we implemented those. But then, secondly, if there is a suggestion that comes out of the focus group, or out of the legislature, we could send you those as, as they come forth just to review.

Topics Discussed:

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

COVID Update by Elizabeth Montgomery & Mike Motley, ACHI

Montgomery and Motley presented analyses regarding COVID-19 impact on the plan, reviewed COVID-19 test utilization and related costs, assessed updated output on COVID-19-related telemedicine utilization within the plan and service utilization by diagnoses, and presented school district and ZIP code-level statewide data.

Discussion:

Mallory: How does the telemedicine consult or visit compare to an in person visit?

Howlett: With the president declaring the national emergency and partnering with the public health emergency for our state, we are following some of the CARES Act provisions. We, as a plan, would be paying the member share as well as the standard visit. We are paying a little higher for the telehealth than we would the office visit. I believe about $56 for an office setting and about $90-$93 for the telehealth, and that includes the cost share for the member.

Mallory: Okay, that is significant. Looking at the mental health conditions, are these mostly new diagnoses or preexisting, or do we know the answer to that?

Howlett: I do not, but Mike and Izzy might. Is there a modifier for continued treatment or if it is an initial case or identification?

Motley: That is not something that we have looked at yet, but that is something that we can identify.

Mallory: That would just be interesting to know to see if we have people seeking care now that might not have before because the telemedicine is available.

Howlett: As far as New Directions, our EAP for the plan, with that group, we are up about 40% with COVID.

Lilly-Palmer: Something I just want to add to that 40%; there is a fear and anxiety that comes with that. So, the question that you're asking about the numbers, I would be curious to see that too, but one of the things that we have pushed out is letting the employees know that EAP is there and letting them know what the resources are because the EAP

actually has a link to just COVID information for the employees and it's a free service. So, I think the utilization on that may be an extraordinary number for this year, but I would be curious to see that as well.

Howlett: Mike and Izzy, we could probably go back and correlate that from when EBD, under TSS, has put the notifications out and the flyer. We first started that back this spring when that was done with correlation and utilization. There is a distinct difference between EAP as a visit and someone billing the health plan for continued therapy. One is an initial triage, if you will, for it and then handing off to the coverage benefits.

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

Vermette provided a brief presentation on the Colonial Life Group Term Life renewal for the plan. He covered the financial summaries of our group and requested an increase in the existing rates that are subject to our approval in accordance with our partnership agreement. They modified their request to push it out until 1/1/2022.

Discussion:

Lilly-Palmer: So, what you're proposing is that the increase would not take place until 2022. Does that come with the caveat that potentially by mid next year, you might have a different view of that? There might be different numbers.

Vermette: Yeah, we could actually keep you updated around the loss ratios so that you could look at that in the middle of next year. Absolutely.

Dr. Fiddler: So, my understanding is through the chair that no changes in premiums this coming year.

Vermette: Yes sir, that's correct.

Dr. Fiddler: Can we do that? Are we allowed by law to do that? I know we can write them a contract, but I guess if it's their rates and their rules, we can say yes, but that guarantees that they're going to have business through the next two years. Can we do that?

Howlett: As far as the authority given by statute, that's given to this Board. At the present moment, any one of our contracts have a term clause. We have a thirty day out term clause on all the contracts, and it's mutual upon both parties or for cause. So, we could do that, but our issue is the member disruptions that would cause. So, if we gave them thirty days' notice, we'd be in a vacuum. So, there's lead time to it. See, let me back up to make sure I understood his proposal. You're stating that your intent was to come here asking for what you had modeled on the screen for those three or four groups and to put them into place 1/1/21. However, if I heard you correctly, based on what you've heard here for the Board and our membership, you want to get approval for that to go into place 1/1/2022 and/or sooner if that ratio changes.

Vermette: We could look at that at the middle of next year, yes.

Howlett: It can be done. There's nothing as far as outside of the authority.

Dr. Fiddler: I mean, I know common sense, but I don't know law.

Fecher: Since it is a new plan, starting on January of this year, you set the rates. What do you think, in your projections, has made it so out of balance? Was it the number of claims paid, or was it the paid loss ratios by group? What has going it out of queue?

Vermette: I would say it's a combination of the number of claims, and the incidents is a little higher. That's probably the biggest driver. The rates have been stable for a long time, over a decade. So, that's probably part of it, to be honest with you, but no aberrations. I mean, we don't know yet the effects of COVID. It's just too early to tell.

Mallory: So, are we being asked for a vote today for 2022?

Howlett: That is what he is offering. What I see as being the potential would be as proposed for 1/1/2021. The caveat that was thrown in there is to try to work with the plan, evidently, to not impose it for 1/1/2021, but to look at it 1/1/2022, and they have to come back and tell us.

Rogers: Does this contract have to be renewed ever, July 1st? Is this a contract that we have agreed to? I know that contracts can't go past the fiscal year.

Howlett: This contract, I believe, started January 1st of this year, so it would be on an annual. We view everything as renewable on the yearly.

Rogers: Do you have to go back to review each year?

Howlett: No, it was reviewed initially. Colonial Life has two components. They put the $10,000 state sponsored, that is paid by EBD as a condition of employment for all currently active employees, and they have the ability to buy supplemental or buy up in that as well as in our relationship with ARSEBA they have other life products that are worked through ARSEBA, which is our voluntary products vendor.

Mallory: Is a vote required today, or do we have a choice of whether or not to take a vote?

Howlett: From a procedural standpoint, if the changes should take effect 1/1/2021, then, yes, we would have to have that made prior to open enrollment this fall because that's going to be notified to the membership. If there's further discussion on their caveat as to push it to 2022, we would probably need to have some more discussion.

Dr. Fiddler: Here's my point, when I first came on the Board, we voted on something, and about halfway through my first term, we had to go back and reread what this had said because it didn't make sense. Let's etch it in stone here what we are going to say or do, so that we don't have to come back before January 2022 like you said on a yearly basis.

Howlett: The Minnesota Life from 2018, this Board voted on a second rate increase for them, but they are no longer part of the team. So, that was done then, but I offered the clarification of what the motion was; there's not an official motion. They've (Colonial Life) made an offer. It's really what the will of the Board wants to do with the caveat and/or the initial request.

Rogers: I don't see why we need a vote right now if nothing is changing. So, if they agreed to what Stephanie just said, to come back later on in the year, if something does change, I would say that then we'd have to vote on something. If we agree with them right now, to hold them steady and that nothing's changing, then there's nothing to vote on, but if they come back, mid-year like they said they would and said, "hey something's changed. We need to talk." I think that's when we would have to vote. So, for right now, I don't see why we have to.

Mallory: I think that's what I'm trying to get to what happens if we don't vote on it today?

Howlett: If the initial request was for FY21 and they're pushing it to 2022. Steve, from an operational standpoint or otherwise, if the Board were not to vote today for a start of 1/1/2021, and they're willing to take you up on the positional thing of looking at 1/1/2022, would you do that in the spring?

Vermette: If the Board doesn't vote, what assurances do we have that we will get the increase on 1/1/2022?

Howlett: If we look at rates, we would look at them yearly or as needed. We could bring it up in the spring of 2021 to go into effect mid-year or at the beginning of 2022 if you want to update the Board at that time.

Vermette: I guess where I'm coming from is how we could get some concurrence that you like option B better than option A. That's what it boils down to because it was either a 2021 increase of 5% across the classes that we showed you, retiree classes, or no increase until 1/1/2022. It was one or the other so, we're trying to get to a decision.

Dr. Fiddler: This is business. If you had not offered us this 5% rate increase in 2021 and put it off until 2022, we wouldn't be having this discussion.

Howlett: We would have it for 2021.

Dr. Fiddler: That's right, and it would just be that discussion. So, his side is saying we're giving you some leeway, but they're asking for this difference. On our side, we're saying, why can't we just put this off. He's saying that's not a good business decision for us. His proposal is that they could come back and say, "okay, we're not going to give you a break, and we're just going to go with our original proposal of 1/1/2021." So, my suggestion is if this is what this, then we can save our membership money for one year, go ahead and vote this thing in, and that gives them something for 2022. I don't know this guy from Adam or her from Eve. But I'm just saying that you know, that's a good business decision. What we're trying to do on the medical end that we just got through having this discussion about. We're having to look at this and keep looking at and try to help save our people some money. Well, here it's being saved for one year. If we don't do this vote, we don't have insurance for these folks through this company. We will have to go back and relook at rebidding, I would assume.

Fecher: Colonial Life is through ARSEBA, correct?

Howlett: They are the state contracted to offer the State benefits and the supplemental. These are the supplemental. They are tied to the same relationship with ARSEBA.

Fecher: Going back to Greg's question, as I understand it, the ARSEBA contract is renewable every year on July 1st.

Howlett: This was handled through a procurement and a cooperative. This was done separately from anything ARSEBA related, and this is our first year in that relationship. So, it's still renewable, but if you were to treat it like a normal contract you would treat it like we are in the seven years.

Rogers: That gets back to where I was going, that it is renewable. So, it does have to go and still be requested to be renewed.

Howlett: I would need to go back and look at if we did the first three years or seven ones. I don't remember that off the top of my head.

Rogers: That would push me against obligating the state anything past a fiscal year at a time. That's a big no-no. That's why I am asking if it was renewable and then back to Stephanie's question that they would come back if something changed. So, it may be that the 5% that they're talking about is not enough and maybe it's too much, but that's what I understood. I mean, I know we're negotiating. I just don't think that if the contract has to be renewed annually, but it still has to go to review and still has to be accepted annually. The Board has the authorization to obligate the State to pay anything past the fiscal year, and that's beyond our control.

Dr. White: Just to make sure I'm thinking about this correctly, and I think it was a good question. What assurances do they have that we would continue this? I guess I'm thinking, what assurances do we have that this will go the way we're saying. So, no increase in 2021 and a 5% increase in 2022, but if I'm not mistaken, we said we don't know the impact of COVID-19, which would change all of the numbers drastically. So, what's to say that we're not in a ten or fifteen percent increase or even a seven or eight percent increase and 2022 based on the impact that we saw in 2020, and we offset that. We didn't raise rates in 2021, but now in 2022, we have to make up for it. So, that's what gives me a little bit of a pause, and I'm sensitive to Dr. Fiddler's point that they're trying to make a good business decision, but I mean, we're kind of doing the same thing. So, I would hesitate to give assurances for 2021 when we don't know the impact of 2020 yet. Am I thinking about that wrong? I mean, is that a reasonable thought process?

Gutierrez: I agree with you.

Dr. White: Trying to forecast is almost impossible, and so it puts us in an impossible situation that we would be stuck with after 2021.

Gutierrez: If we did the 5% now and then, later on, we see the impact of 2020, and we have to go back up again, that would actually make us increase again.

Scott: I think Mrs. Dunlap pointed out, I thought very clearly, that this is exactly what we are talking about. We get these figures at the Board meeting that you want to vote on, and we don't really understand it, and I don't know what to ask. Is there any way that we can change this process to where we can get this information/data a little earlier or a few weeks ahead where we can have some time to digest and know what questions to ask. If we had to vote right now, I'll be honest, I'm just going to vote present.

Howlett: This wasn't in on the plate relative to setting rates, which are more pressing. Steve, can we digest this more? Would your request be the 1/1/2021 for the affected groups? With those groups, can that go to the next Board meeting for consideration?

Vermette: Absolutely.

Reece: You want us to report at the next Board meeting, is that correct? The biggest thing to consider is that we're trying to discuss rates for 2021 and 2022. So, there is a time and element there to be sensitive to. I hope that everyone sees that we're trying to be good business partners here and present kind of what's going on with the current state, and we are open to representing at the next Board meeting.

Howlett: If we end up with a Board meeting between now and the regular scheduled board meeting in October, especially if that happens between now and the thirtieth of September, is that doable from your side?

Reece: I think that we could discuss it again in October because kind of what the proposal is doing is it's talking more about the population with the impact. And so, you know, it sounds like we can move forward with the active rates knowing that we need to kind of revisit the retiree rates. Is that a fair assessment?

Howlett: I think that would be fair, and I think that if we end up with another special Board meeting, we can look to entertain the notion of this motion or item for consideration then; if not we can push it to the October meeting.

Mallory: Well, we can at least answer the question of whether we the contract has to be reviewed or not.

MOTION by Fecher:

I make a motion to table this discussion until meeting.
Scott seconded. All were in favor.
Motion Approved.

Howlett: If there's anything that I can offer or work with Colonial or give them insight to offer that will better equip or help you understand, please get that to me, and I'll be able to make sure that they present that in appropriate fashion. Thank you.

Trend Experience 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 August 2020
- 2020 projected plan experience
    - Allocated reserves for 2020 is $25.1M
    - Estimated deficit of $7.8M
    - End of Year Assets: $63.8M
    - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
    - No plan changes / 5% increase in employee contributions
- 2021 plan experience
    - Allocated reserves for 2021 is $14.5M
    - Projected deficit: $29.8M
    - End of Year Assets: $79.1M
    - Reflected 2021 program initiatives
    - Increased membership based on historical patterns
    - Baseline trends (medical: 5%, pharmacy: 8%)
    - August 5, 2020 Board action

PSE

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

- 2020 plan experience
    - Allocated reserves for 2020 is $25.3M
    - Estimated deficit of $15.4M
    - End of Year Assets: $108.3M
    - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
    - No plan changes / 0% increase to employee contributions
- 2021 plan experience
    - Allocated reserves for 2021 is $15.5M
    - Projected deficit: $27.5M
    - End of Year Assets: $65.3M
    - Reflected 2021 program initiatives
    - Increased membership based on historical patterns
    - Baseline trends (medical: 7%, pharmacy: 8%)
    - August 5, 2020 Board action

Discussion

ASE

Howlett: We've come forward another month and a half, and we're seeing the actual incurred claims. We're just really demonstrating some of the volatility in the experience, but last year we did a five percent rate increase on ASE and used about the sixteen million dollars of catastrophic reserves. what this is demonstrating is that the trend has changed to be a little bit more favorable to where our numbers have rebounded enough that we picked up what we lost in the catastrophic or spent out of catastrophic, plus a little bit more to boot.

White: I think the catastrophic fund happened from 2018 to 2019, and we spent fourteen million there. I think when we showed this last month, this point six of an unallocated assets was actually a negative number there. There was less money available than you needed or that the fund was allocated to. I think the favorable experience from COVID in May and June has showed the rebound here. So, this number, I think it was -9 to -11 last time we presented, and so now we're showing a little favorability due to the COVID savings. It's starting to come through the data, and so because that loss is less now. It takes less assets to help fund that loss because it doesn't need to be funded out of reserves anymore.

Howlett: Our deficit is smaller that we're working out of basically.

White: Yes, and as we continue to monitor that number continues to go goes down, that'll put money into the bank account for 2020, which also flows into 2021.

Fecher: I just want to make a couple of comments and make sure that the Board is aware of this. Milliman said at the beginning that there were five things you can do to adjust,

which are change benefits, change deductibles, adjust rates, take from the reserve fund, and cost share.

White: So, there's state funding, there are benefits where our deductibles, copays, and maximum out of pockets, which is one by itself, employee contributions, initiatives, and then reserves.

Fecher: Okay, so when people say, “have you considered, you know, we keep getting the question, “have you considered alternative actions?” There are only five things you can do to change it, and that's something that we need to be mindful of. The other thing I want to let the Board know is that in both of the legislative committee meetings that we've spoken in so far, Senator Hickey has brought up that he's very concerned about the public school employee having a deficit and why are we not addressing that.

Director’s Report by Chris Howlett, EBD Director

Howlett believes it's been discussed by various individuals, as far as modeling or information to the Board, we will be providing that information as requested, and if there's anything that has come to mind, or that comes to mind on your thinking process related to the Board and your duties here, we'll be glad to model any of those scenarios and be able to provide that information back to you. I appreciate each and every one of you and your diligence to the Board.

MOTION by Dr. Fiddler:

I make a motion to adjourn the meeting.

Scott 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, September 14th, 2020 with Dr. Hank Simmons presiding.

I. **Old Business**

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

Levonorgestrel Intrauterine Devices (IUDs)

- All products can be removed at any time. Most patients have return of fertility within one year of removal.
- ACOG guidelines do not provide guidance for when to choose one product over another
- In practice, devices with a smaller size (Kyleena and Skyla) may be preferred for nulliparous women.

Consider possible rebate opportunities.

No recommendation; No vote.

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

Generic	Brand	Recommendation
(1) IMATINIB	GLEEVEC	Remove PA requirement
(2) AVELUMAB	BAVENCIO	Cover with PA
(3) ELETRIPTAN	RELPAX	Remove reference pricing from generic; cover T1
(4) TEPROTUMUMAB-TRBW	TEPEZZA	Cover with PA
(5) SC IMMUNE GLOBULINS	MULTIPLE BRAND NAMES	Seek rebates
(6) RAVULIZUMAB	ULTOMIRIS	Remove PA requirement and edit eculizumab PA to prefer ravulizumab over eculizumab for PNH.

The DUEC voted to adopt the recommendations as presented.

II. New Business

A. New Drugs: *Dr. Sidney Keisner, UAMS*

Brand	Generic	Recommendation
Non-Specialty Drugs		
(1) NEXLIZET	BEMPEDOIC ACID/EZETIMIBE	Exclude, Code 1 and 13
(2) ORIAHNN	ELAGOLIX/ESTRADIOL/NORETHINDRN	Cover with PA
(3) PHEXXI	LACTIC ACID/CITRIC/POTASSIUM	Exclude, Code 13
(4) LYUMJEV	INSULIN LISPRO-AABC	Exclude, Code 13
(5) HELIDAC	BISMUTH SSAL/METRONID/TETRACYC	Exclude, Code 4 and 13
(6) ORTIKOS	BUDESONIDE	Exclude, Code 13
(7) DURYSTA	BIMATOPROST IMPLANT	Exclude, Code 13
Specialty Drugs		
(1) AVSOLA	INFLIXIMAB-AXXQ	Exclude, Code 13
(2) ZEPOSIA	OZANIMOD HYDROCHLORIDE	Exclude, Code 13
(3) KYNMOBI	APOMORPHINE HCL	Cover; QL 5/day
(4) ZEPZELCA	LURBINECTEDIN	Exclude, Code 1 and 13
(5) UPLIZNA	INEBILIZUMAB-CDON	N/A Medical
(6) PHESGO	PERTUZUMAB-TRASTUZUMAB-HY-ZZXF	Exclude, Code 13
(7) FINTEPLA	FENFLURAMINE HCL	Cover with PA
(8) RUKOBIA	FOSTEMSAVIR TROMETHAMINE	Cover
(9) BYNFEZIA	OCTREOTIDE ACETATE	Exclude, Code 13
(10) FENSOLVI	LEUPROLIDE	Exclude, Code 13
(11) DARZALEX FASPRO	DARATUMUMAB/ HYALURONIDASE	Exclude, Code 13

The DUEC voted to adopt the recommendations as presented.

Meeting Adjourned.

Respectfully submitted,

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

***New Drug Code Key:**

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

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

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

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

COVID Update: Elizabeth Montgomery & Mike Motley, ACHI

Montgomery and Motley presented analyses regarding COVID-19 impact on the plan, reviewed COVID-19 test utilization and related costs, assessed updated output on COVID-19-related telemedicine utilization within the plan and service utilization by diagnoses, and presented school district and ZIP code-level statewide data.

Plan Update: Paul Sakhrani and Courtney White, 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 August 2020
- 2020 projected plan experience
    - Allocated reserves for 2020 is $25.1M
    - Estimated deficit of $7.8M
    - End of Year Assets: $63.8M
    - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
    - No plan changes / 5% increase in employee contributions
- 2021 plan experience
    - Allocated reserves for 2021 is $14.5M
    - Projected deficit: $29.8M
    - End of Year Assets: $79.1M
    - Reflected 2021 program initiatives
    - Increased membership based on historical patterns
    - Baseline trends (medical: 5%, pharmacy: 8%)
    - August 5, 2020 Board action

PSE

- Projections updated to incorporate claims data incurred from March 2019 to February 2019 and paid through August 2020
- 2020 plan experience
    - Allocated reserves for 2020 is $25.3M
    - Estimated deficit of $15.4M
    - End of Year Assets: $108.3M
    - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
    - No plan changes / 0% increase to employee contributions
- 2021 plan experience
    - Allocated reserves for 2021 is $15.5M
    - Projected deficit: $27.5M
    - End of Year Assets: $65.3M
    - Reflected 2021 program initiatives
    - Increased membership based on historical patterns
    - Baseline trends (medical: 7%, pharmacy: 8%)
    - August 5, 2020 Board action

Director's Report: Chris Howlett, EBD Director

Howlett reported that we welcome any of the options that you would like to have modeled and we can give EBD and Milliman a chance to work through those. We will continue to work with ACHI on the COVID-19 experience relative to the state population.

SEPTEMBER 2020
EBD BOARD PRESENTATION

Mike Motley, MPH
Director of Analytics

Izzy Montgomery, MPA
Policy Analyst

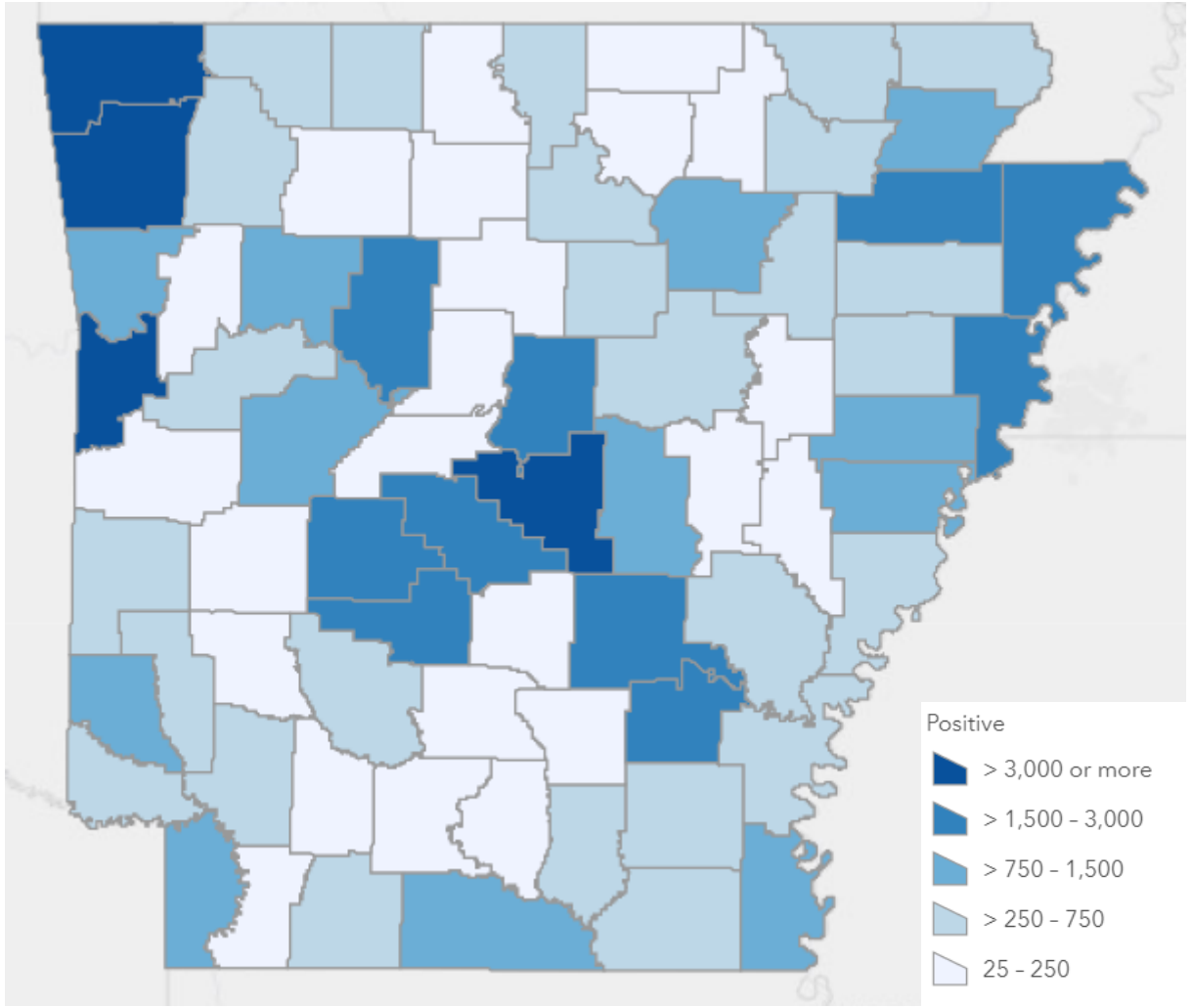
9.22.2020

ACHI
INSPIRING HEALTHY ACTS

OBJECTIVES

- Present analyses regarding COVID-19 impact on plan
- Review COVID-19 test utilization and related costs
- Assess updated output on COVID-19-related telemedicine utilization within plan, including related costs and service utilization by diagnoses
- Present school district and ZIP code-level statewide data

COVID-19 IN ARKANSAS



Cumulative Cases:
73,690 (6,256 active)

Hospitalized: 412

On Ventilator: 85

Deaths: 1,033

Source: Arkansas Department of Health, as of Sept. 20

COVID-19 ANALYSES

- Data from March 17–September 7, 2020
- Estimated total of members ever tested: 41,053
- Tests paid for by EBD (April—June 26, 2020): 6,509
- Total with positive test: 3,153 (ASE=1,650, PSE=1,503)

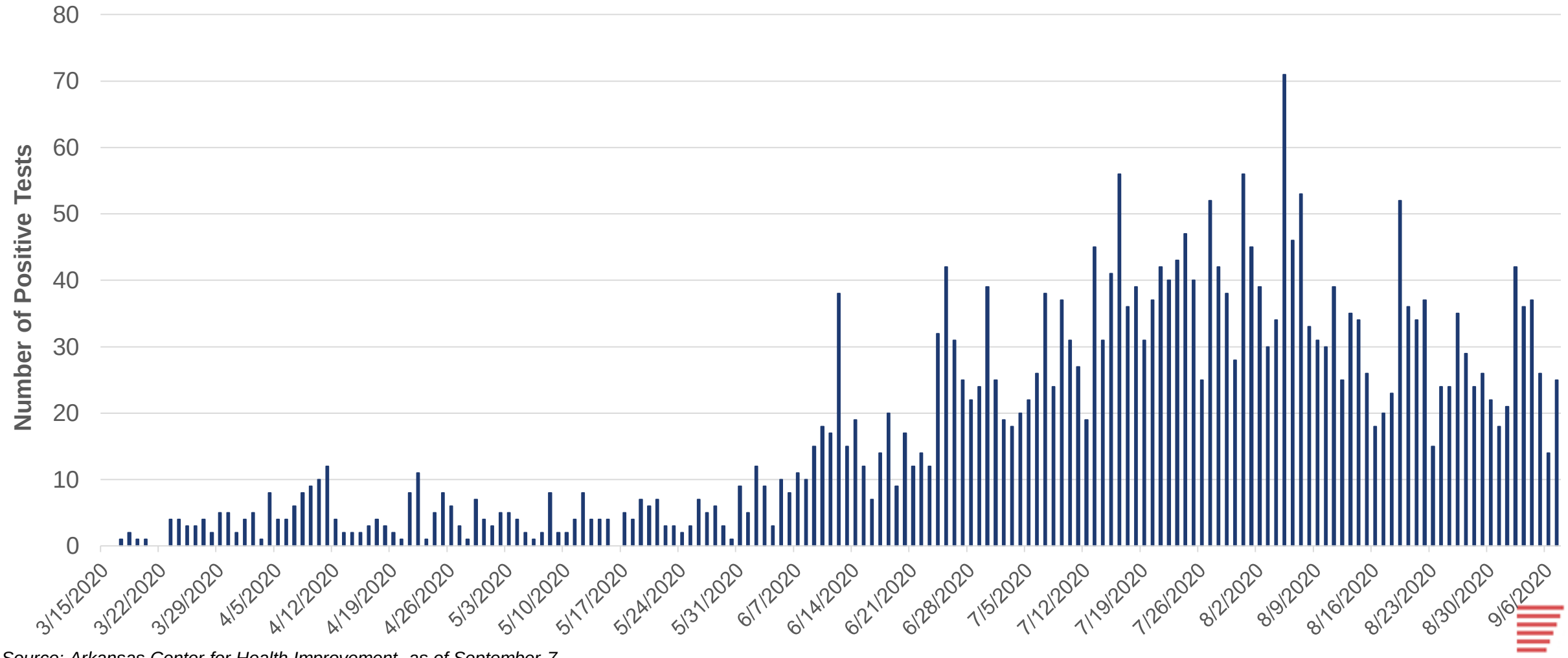
Source: Arkansas Center for Health Improvement, as of September 7

COVID-19 ANALYSES

- Total members ever hospitalized: 206 (ASE=110, PSE=96)
- Total members ever in ICU: 74
- Total members ever intubated: 27
- Deaths: 21

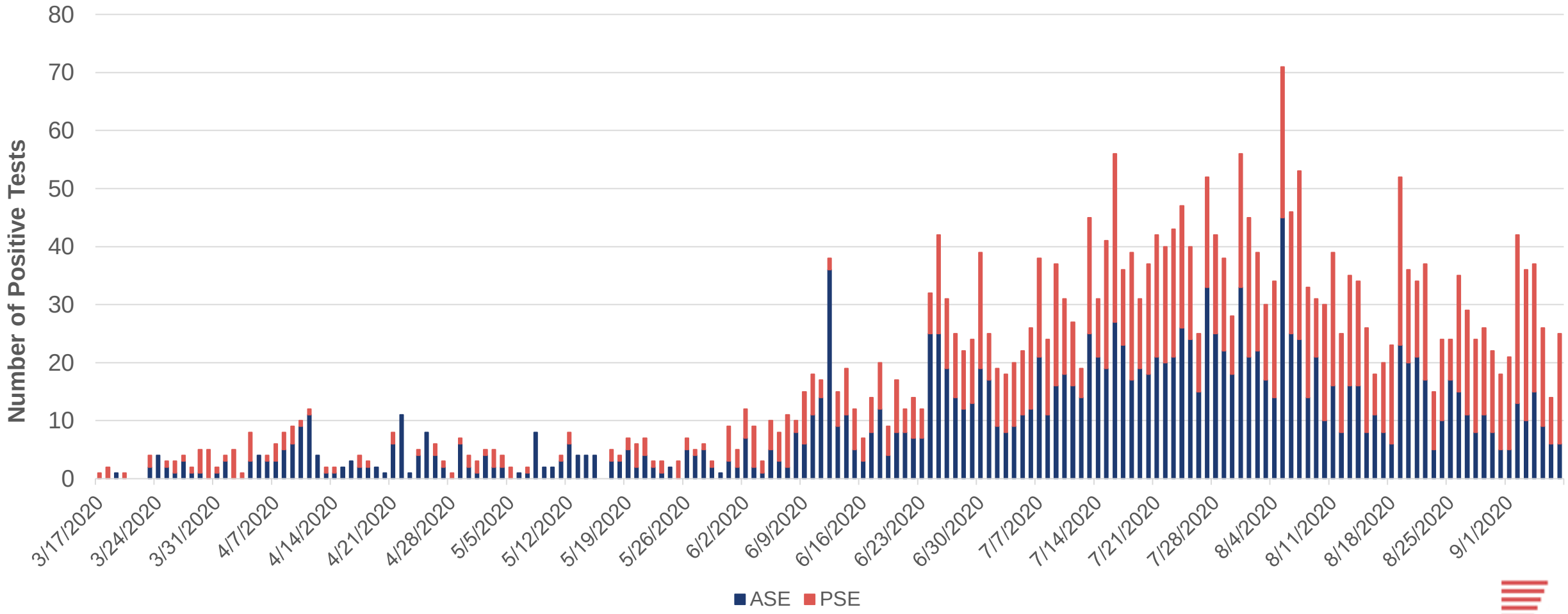
Source: Arkansas Center for Health Improvement, as of September 7

DAILY POSITIVE TEST COUNT — EBD MEMBERS



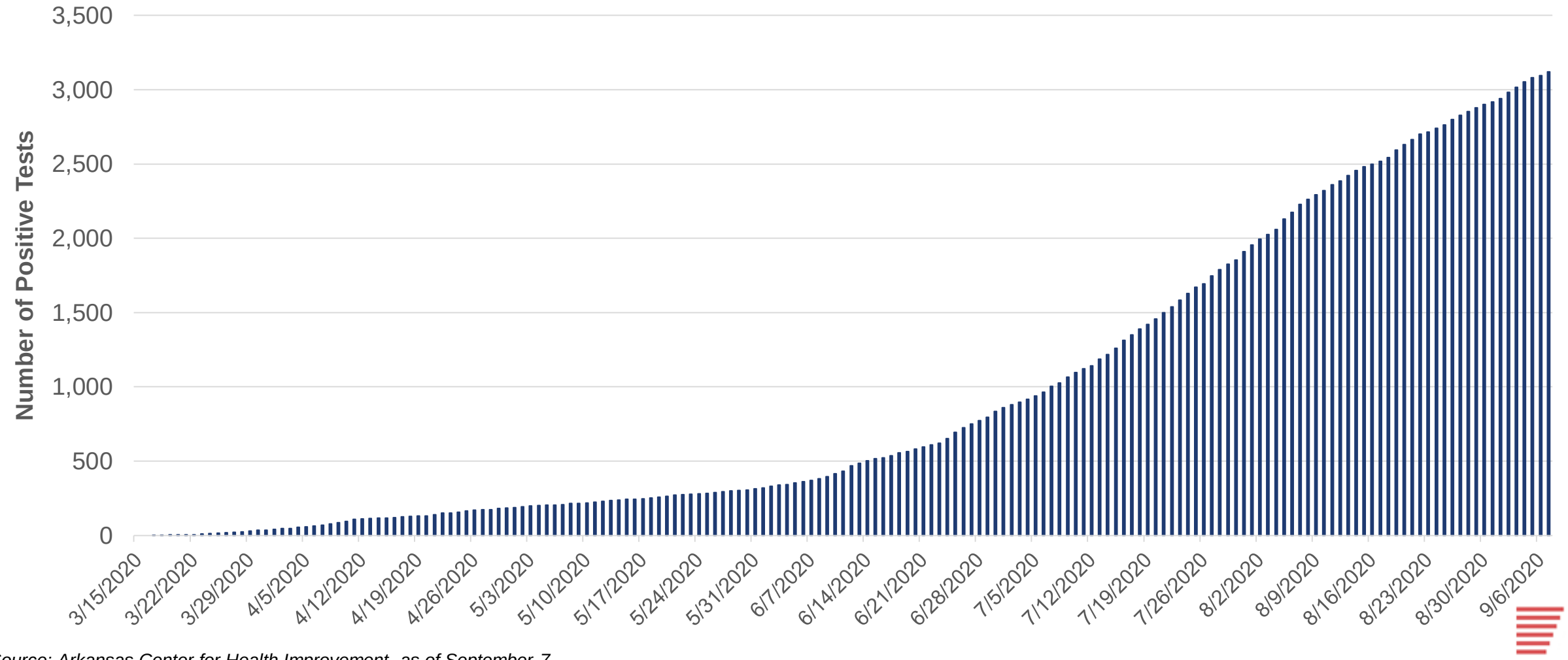
Source: Arkansas Center for Health Improvement, as of September 7

DAILY POSITIVE TEST COUNT BY ASE & PSE



Source: Arkansas Center for Health Improvement, as of September 7

TOTAL POSITIVE TEST COUNT — EBD MEMBERS



Source: Arkansas Center for Health Improvement, as of September 7

STATEWIDE ADJUSTED RELATIVE RISK OF SEVERE OUTCOMES FOR SELECTED CONDITIONS

	Hospitalization	ICU admission	Intubation	Death
Kidney Failure	**+60%**	**+80%**	**+140%**	**+100%**
Immunocompromised	**+80%**	**+90%**	**+160%**	**+70%**
Diabetes	**+60%**	**+60%**	**+60%**	**+70%**
CHF	**+50%**	**+70%**	+40%	**+60%**
Dementia	-10%	-10%	-50%	**+50%**
COPD	**+40%**	**+50%**	-10%	+20%
Asthma	**+30%**	+30%	+20%	+20%
CHD	**+30%**	**+20%**	+30%	0%
Other Heart Diseases	**+20%**	+20%	-10%	-10%
Mental and Behavioral Disorders	**+10%**	-10%	-20%	+10%
Essential Hypertension	0%	+10%	0%	-30%

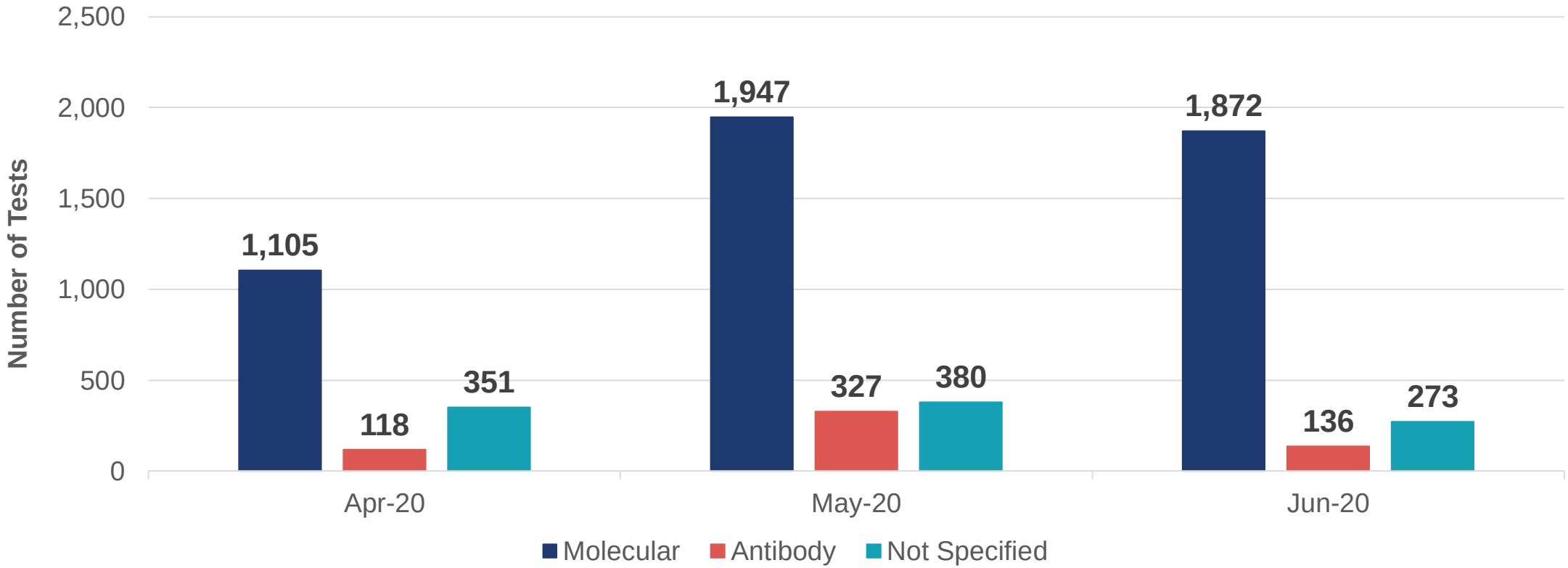
Note: Sample size more than 17,000 COVID-19 patients, chosen based upon data availability.

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

	ASE	PSE
Kidney Failure	*824 (1.7%)*	*866 (1.0%)*
Immunocompromised	*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%)*

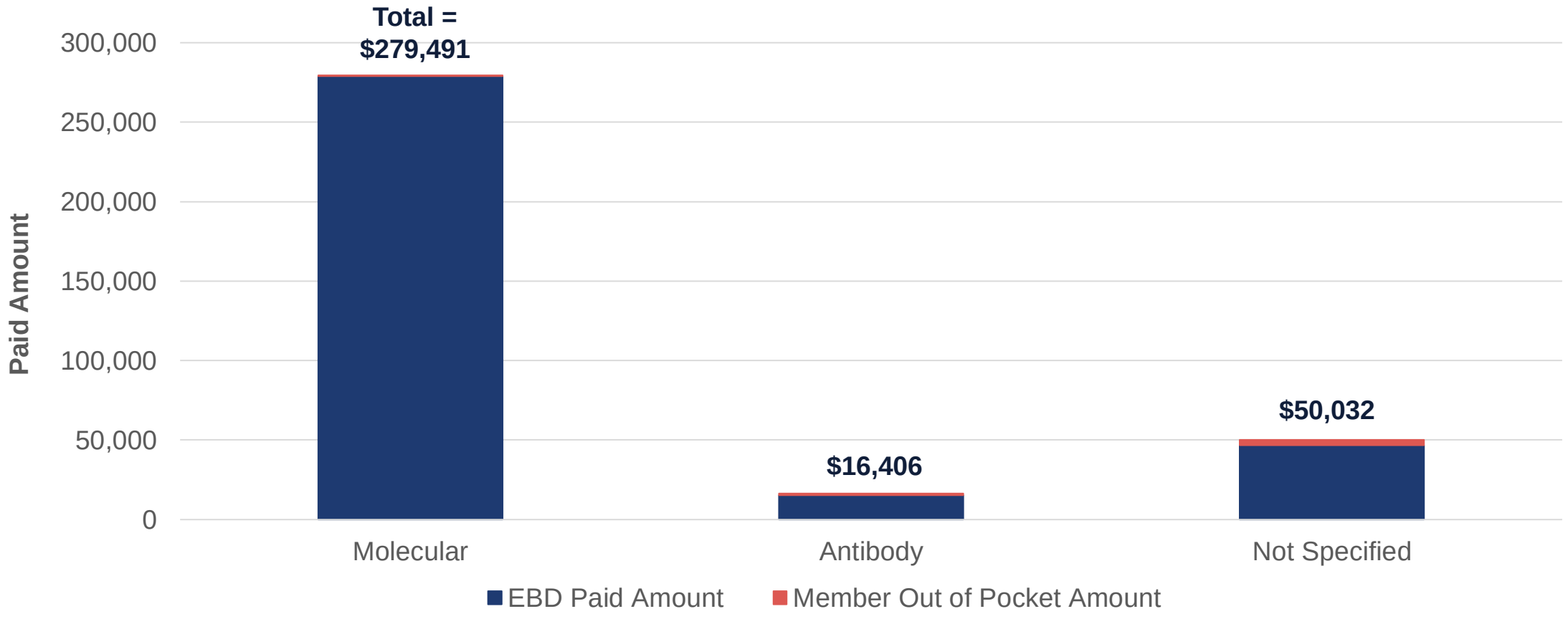
Source: Arkansas Center for Health Improvement

COVID-19 TEST VOLUME BY TYPE WITHIN PLAN (APRIL—JUNE 26, 2020)



Source: Arkansas Center for Health Improvement

EBD PLAN PAID AMT. & MEMBER OUT-OF-POCKET AMT. FOR COVID-19 TESTS, APRIL–JUNE 26, 2020

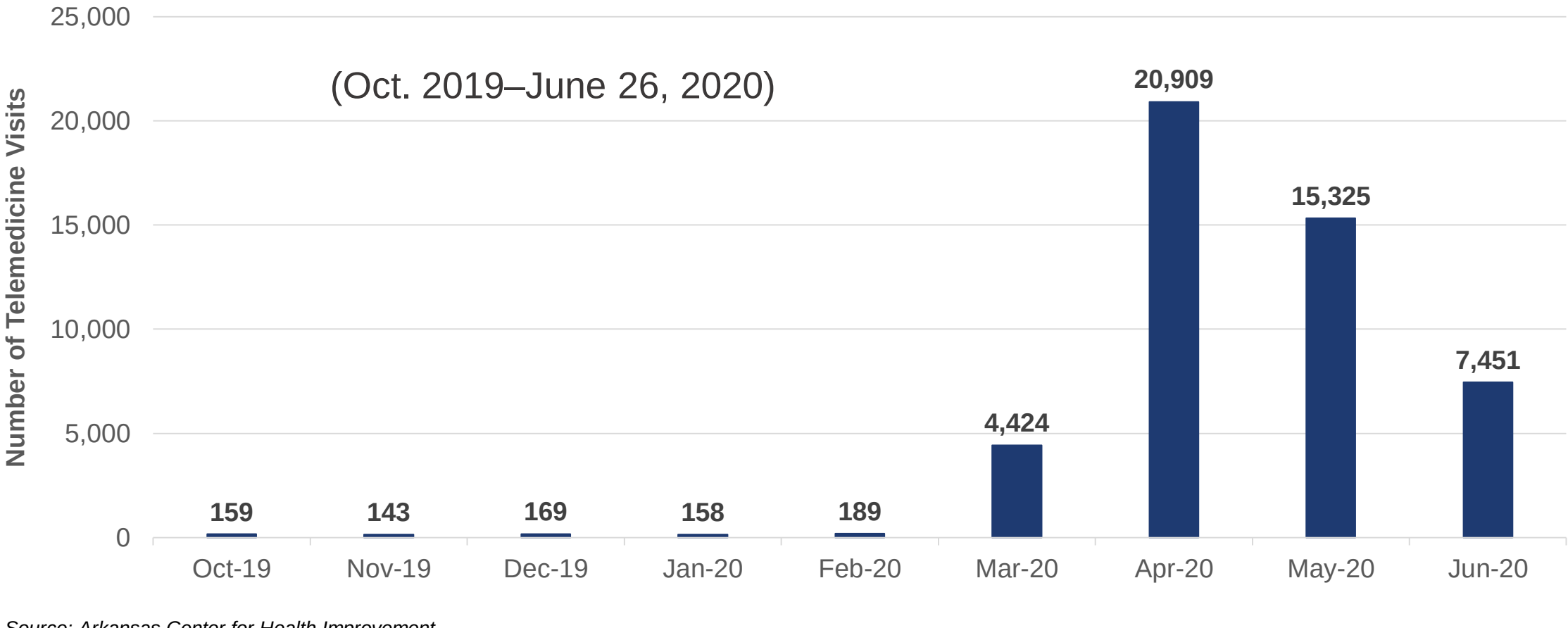


Source: Arkansas Center for Health Improvement

COVID-19 TESTING & OTHER COVID-RELATED COSTS WITHIN PLAN (APRIL—JUNE 26, 2020)

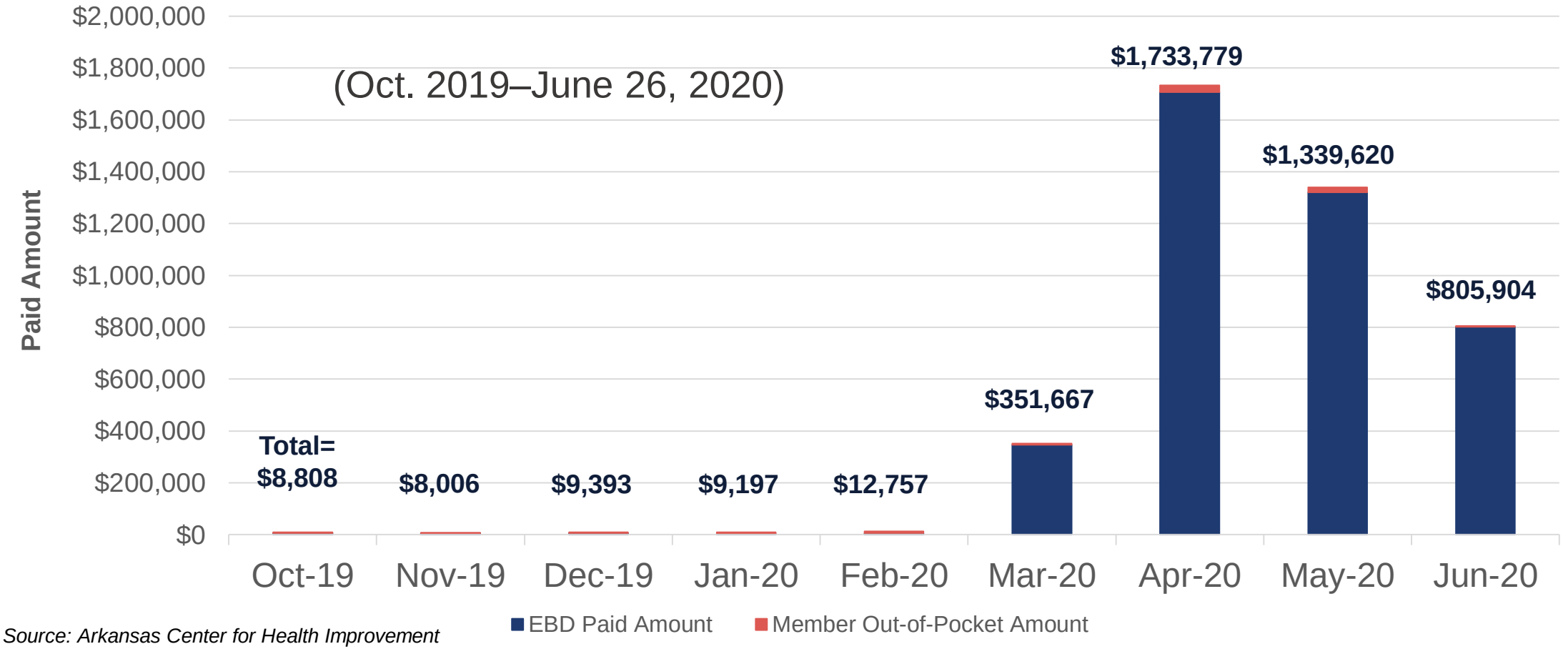
- Total costs for all COVID-19 tests = $340,619 (average of $52 per test)
- Outpatient (OP) or emergency department (ED) visits were associated with 2,919 of 6,509 tests (44.8%)
- Additional costs for associated OP or ED visits = $146,170
- Total amount paid by the plan for testing and associated OP or ED visits = $486,789

TELEMEDICINE SERVICE UTILIZATION WITH PLAN



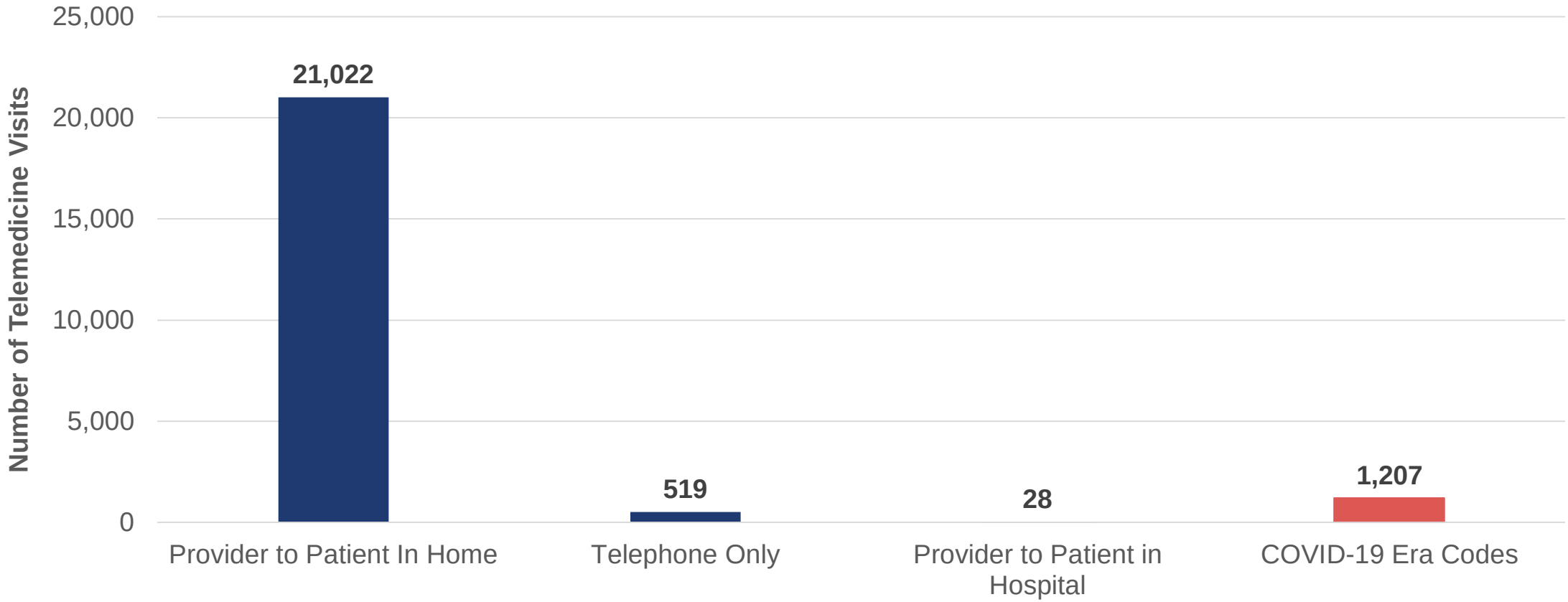
Source: Arkansas Center for Health Improvement

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



Source: Arkansas Center for Health Improvement

TELEMEDICINE SERVICE UTILIZATION BY TYPE WITHIN PLAN (MAY & JUNE 2020)

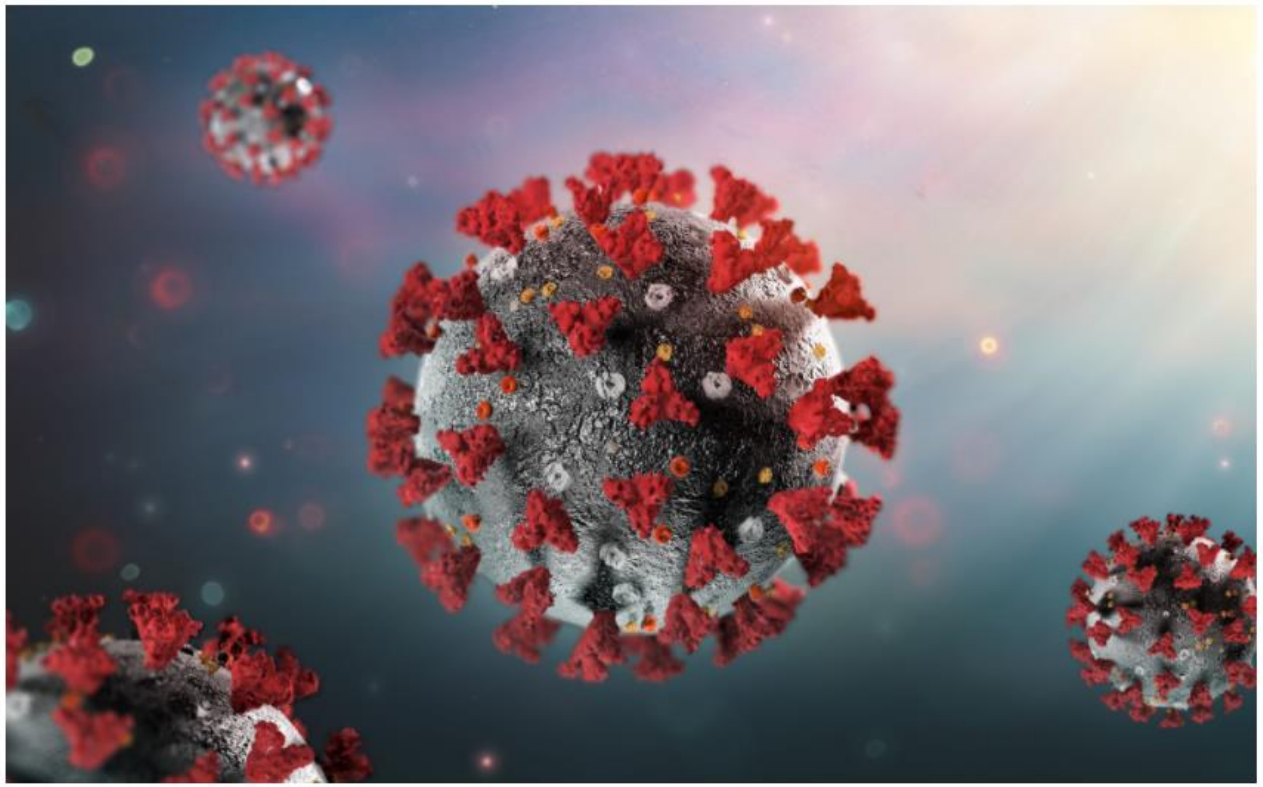


Source: Arkansas Center for Health Improvement

TELEMEDICINE SERVICE UTILIZATION BY DIAGNOSES (MAY & JUNE 2020)

Diagnosis	Number of Diagnoses
Mental health conditions	9,133
Musculoskeletal conditions	7,709
Specific developmental disorders of speech and language	1,186
Essential (primary) hypertension	1,132
Lack of expected normal physiological development in children and adults	717
Type 2 diabetes mellitus	661
Pervasive developmental disorders	333

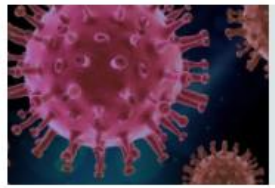
Source: Arkansas Center for Health Improvement



COVID-19 in Arkansas

The COVID-19 pandemic is affecting people around the world, including Arkansans. ACHI will provide updates and insights on this evolving public health crisis including tables with cumulative and active positive COVID-19 cases in communities across the state.

CLICK HERE FOR THE LATEST COVID-19 UPDATES



BLOG

COVID-19 Cases By ZIP Code Available

Read More

BLOG

Trend Information Added To School District-Level COVID-19 Data

Read More

BLOG

Defining COVID-19 Terms: Antigen Test

Read More

IN THE NEWS

ACHI Announces Addition of Active Case Numbers to Community-Level COVID-19 Data

Read More

achi.net/covid19

COVID-19: A LOCAL VIEW

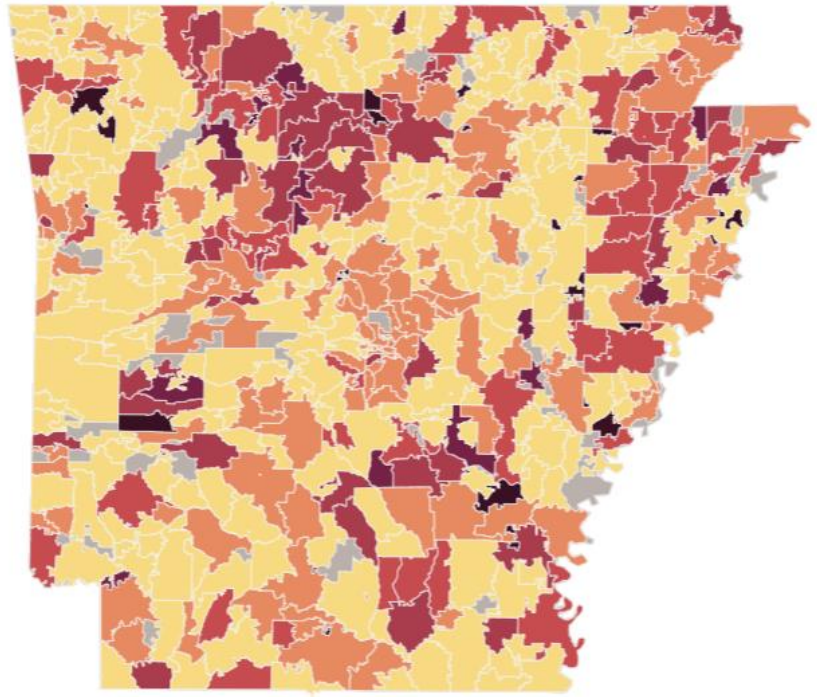
achi.net/covid19

The map illustrates new rates and the table shows cumulative and new numbers and rates of positive COVID-19 cases in Arkansas communities as of September 7. Some ZIP codes have missing rates because rates based on case counts of fewer than 10 are not displayed. *Use the dropdown menu above to select between map and table views.*

Find a ZIP Code

Rates of New Cases for 14-Day Period per 10K Residents

0 - 9	20 - 29	50 - 99
10 - 19	30 - 49	100 or more



COVID-19: A LOCAL VIEW

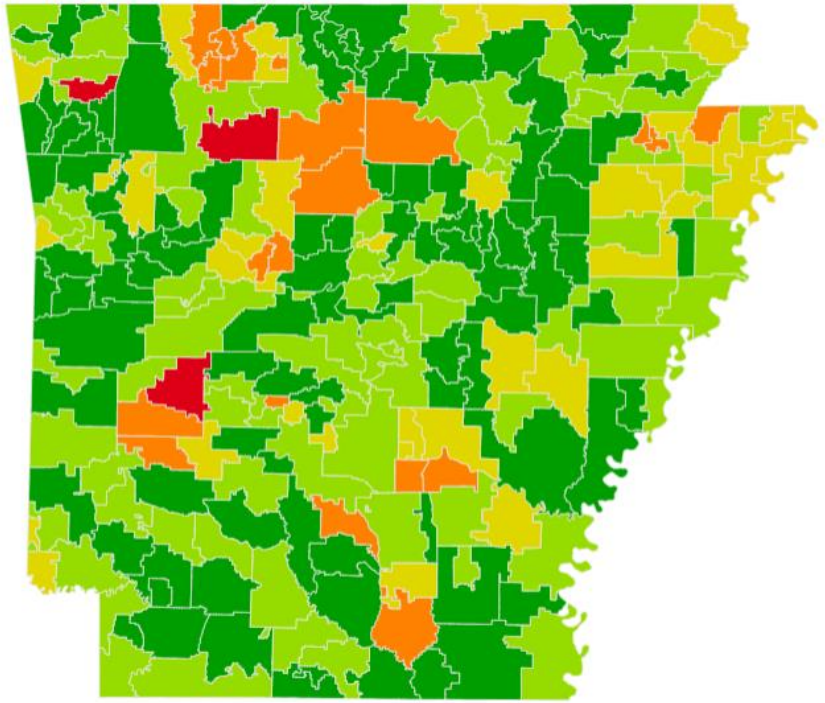
achi.net/covid19

These maps and tables show the counts and trends for new positive COVID-19 cases for school districts as of September 7. School district data consists of all residents in each school district. Some districts have missing rates because rates based on case counts of fewer than 10 are not displayed. *Use the dropdown menu above to select between map and table views.*

Find a School District

Rates of New Cases for 14-Day Period per 10K Residents in the Community by School District

- 0 - 9
- 10 - 19
- 20 - 29
- 30 - 49
- 50 or more



COVID-19: A LOCAL VIEW

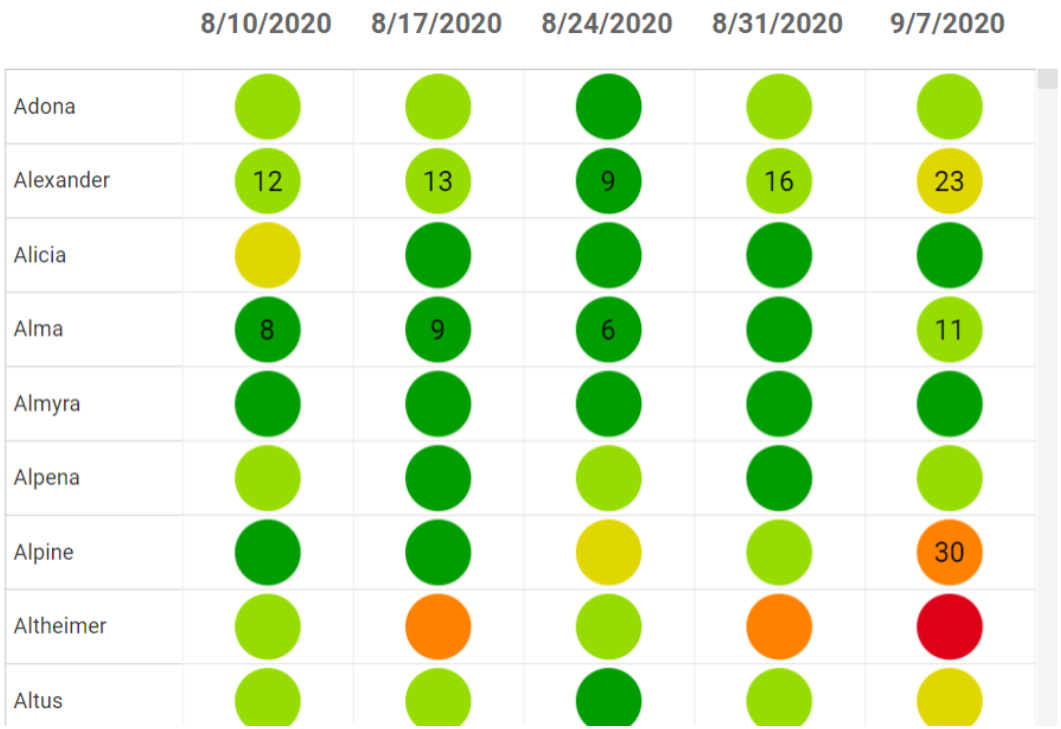
achi.net/covid19

These tables show the counts and trends for new positive COVID-19 cases for communities as of September 7. Some communities have missing rates because rates based on case counts of fewer than 10 are not displayed. *Use the dropdown menu above to select between table views.*

Find a Community

Rates of New Cases for 14-Day Period per 10K Residents

- 0 - 9
- 10 - 19
- 20 - 29
- 30 - 49
- 50 or more



NEXT STEPS

- Updates on estimated number of members tested, number of positive tests, and number of hospitalizations
- Updates on COVID-19 tests and related costs
- Updates on telemedicine utilization and related costs
- Assessments of financial impact of COVID-19 on plan

State of Arkansas

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

September 22, 2020

Steve Vermette – Large Public Sector Employer Specialist

Deborah Vandeventer – AVP, Underwriting

Jessica Reece – Senior Client Manager

Colonial Life®

Group Term Life

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

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

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

Group Term Life

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

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

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

Number of Claims Paid by Group

AUGUST 2020 YTD

ACTIVE COVERAGE	NUMBER OF CLAIMS
Basic	77
Expanded Basic	23
Supplemental	17
Spouse	21
Child	3
ACTIVE TOTAL	**141**

RETIREE COVERAGE	NUMBER OF CLAIMS
Basic	189
Expanded Basic	11
Supplemental	122
Spouse	36
Child	0
RETIREE TOTAL	**358**

COMBINED TOTAL	**499**

Paid Loss Ratios by Group

AUGUST 2020 YTD

ACTIVE COVERAGE	EST. PREMIUM*	PAID CLAIMS	PAID LOSS RATIO
Basic	1,393,428	736,800	52.9%
Expanded Basic	963,737	776,014	80.5%
Supplemental	1,901,050	1,448,586	76.2%
Spouse	486,869	192,993	39.6%
Child	123,817	110,000	88.8%
ACTIVE TOTAL	**4,868,901**	**3,264,393**	**67.0%**

RETIREE COVERAGE	EST. PREMIUM*	PAID CLAIMS	PAID LOSS RATIO
Basic	378,801	812,755	214.6%
Expanded Basic	235,822	180,013	76.3%
Supplemental	1,780,884	1,489,827	83.7%
Spouse	109,090	160,058	146.7%
Child	3,271	0	0.0%
RETIREE TOTAL	**2,507,868**	**2,642,654**	**105.4%**

COMBINED TOTAL	**7,376,769**	**5,907,046**	**80.1%**

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

Proposed Monthly Cost Changes To Retiree Groups with Averages

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

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

Colonial Life.com

State of Arkansas Employee Benefits Division

Interim Monitoring Report

Through August 31st

State and Public School Life and Health Insurance Board of Directors

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

22 SEPTEMBER 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 August 2020.
- 2020 projected plan experience
  - Allocated reserves for 2020 is $25.1M
  - Estimated deficit of $7.8M
  - End of Year Assets: $63.8M
  - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
  - No plan changes / 5% increase in employee contributions
- 2021 projected plan experience
  - Allocated reserves for 2021 is $14.5M
  - Projected surplus: $29.8M
  - End of Year Assets: $79.1M
  - Reflected 2021 program initiatives
  - Increased membership based on historical patterns
  - Baseline trends (medical: 5%, pharmacy: 8%)
  - August 5, 2020 Board action (next slide)

Board Action – August 5, 2020

- Increased employee contribution for the Active employees and Pre-65 retirees by 5%
  - No change to Post-65 retirees contributions
- Changed wellness credit from $75 per month to $50 per month for Active employees
  - Maintained $0 employee contribution for Basic Plan with Wellness for Employee Only contracts
- Increased State funding from $420 per eligible per month to $450 per eligible per month
- Medicare Retiree to obtain pharmacy coverage through Medicare Part D market
- No benefit or cost sharing changes

Total Plan Experience

Funding	2019	2020	2021
State Contribution	$ 173.61	$ 172.24	$ 184.48
Employee Contribution	97.45	99.27	108.66
Other	23.47	21.65	15.87
Total Income	$ 294.53	$ 293.16	$ 309.01
Medical Claims	$ (194.56)	$ (213.33)	$ (221.57)
Pharmacy Claims	(86.58)	(96.91)	(60.58)
Administration Fees	(18.30)	(17.46)	(17.58)
Plan Administration	(2.90)	(2.80)	(2.90)
Total Expenses	$ (302.34)	$ (330.49)	$ (302.62)
Program Savings	$ -	$ 4.45	$ 8.96
Net Income / (Loss) Before Reserve Allocation	$ (7.81)	$ (32.87)	$ 15.35
Allocation of Reserves	$ 21.70	$ 25.08	$ 14.46
Net Income / (Loss) After Reserve Allocation	$ 13.89	$ (7.79)	$ 29.81

Average Membership			
Active Employees / Pre-65 Retirees	47,755	46,730	46,730
Post-65 Retirees	13,344	13,791	14,204
Total Enrolled	61,099	60,521	60,935

Total Income PMPM[1]	$ 431.31	$ 438.20	$ 442.37
Total Expenses PMPM[2]	$ (412.37)	$ (448.93)	$ (401.60)

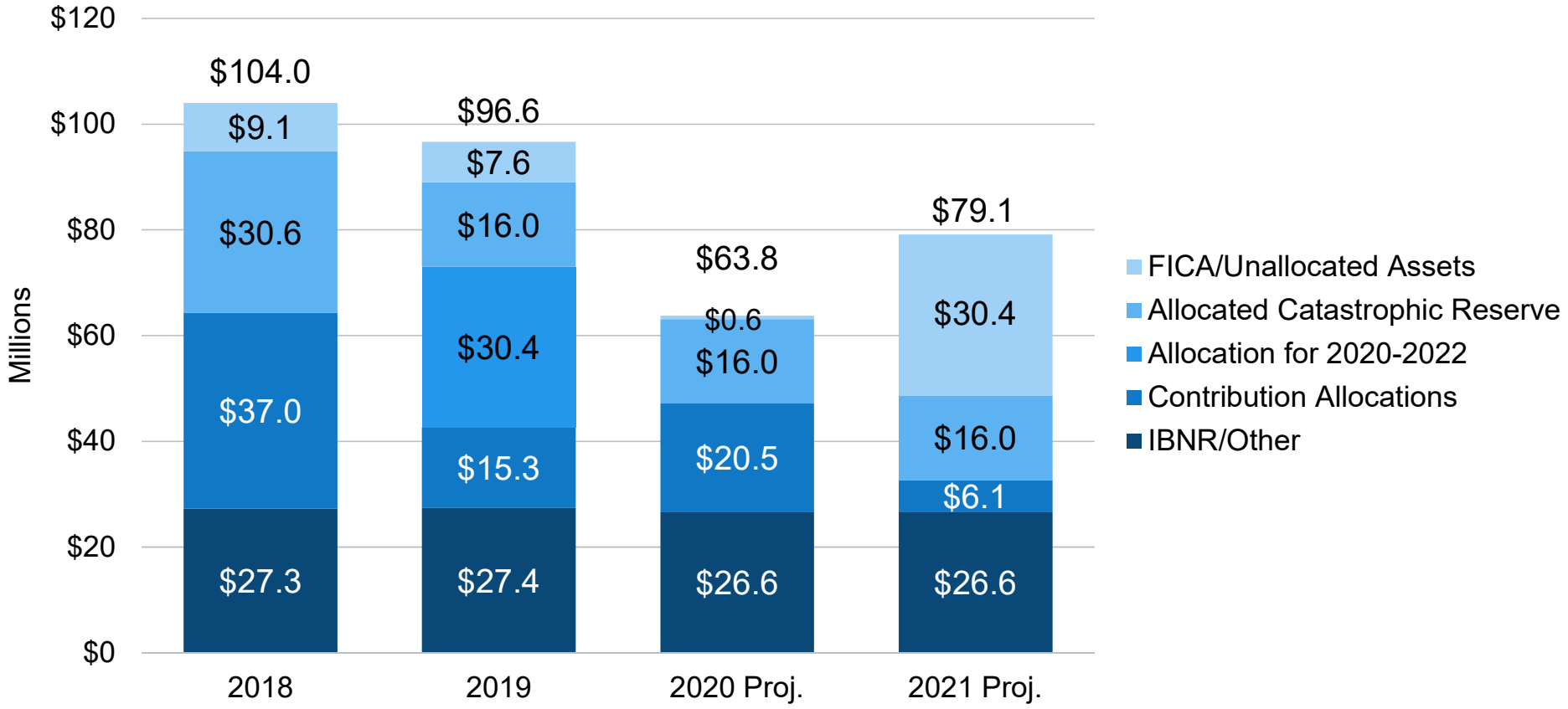
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Program Savings

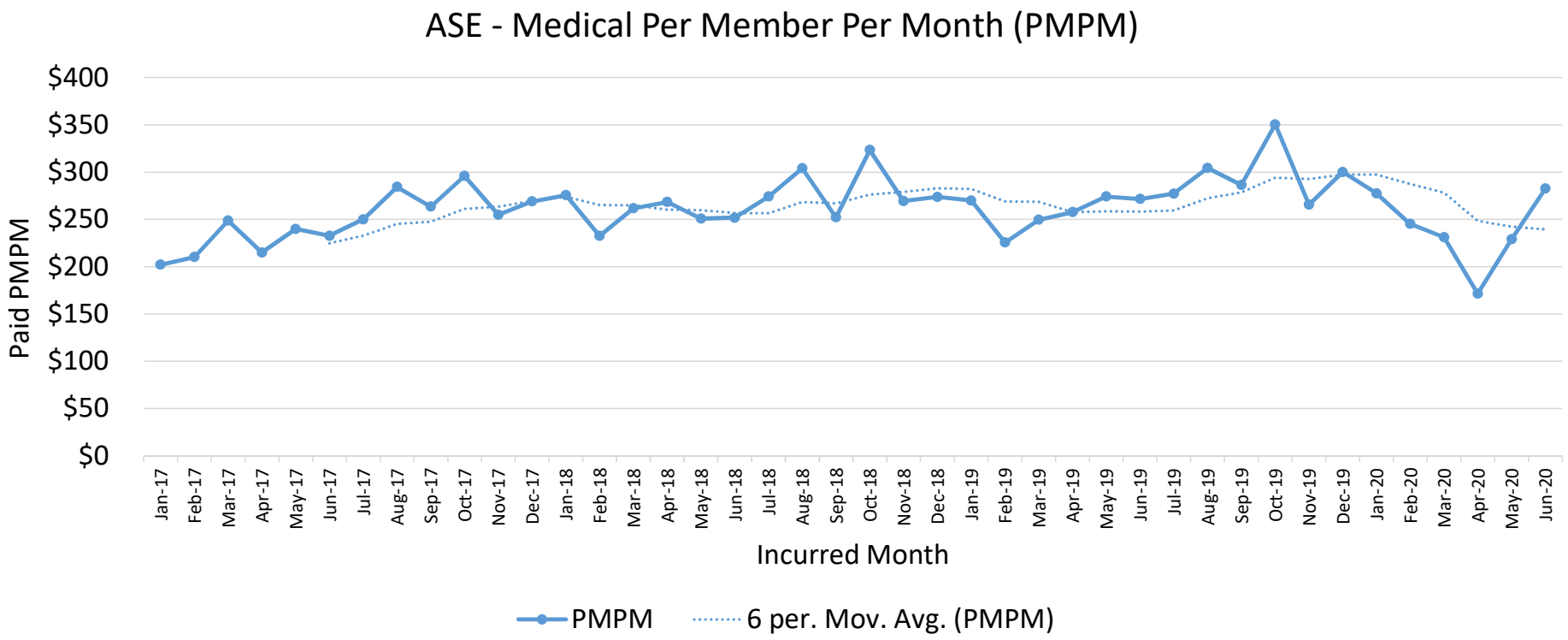
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
(a)	2019	End-of-Year Assets	$96.6
(b)	2020	Total Income	$293.2
(c)		Total Expenses	($326.0)
(d)		Allocated Assets	$25.1
(e) = (b) + (c) + (d)		Total Surplus / (Deficit)	($7.8)
(f) = (a) - (d) + (e)		End-of-Year Assets	$63.8
(g)	2021	Total Income	$309.0
(h)		Total Expenses	($293.7)
(i)		Allocated Assets	$14.5
(j) = (g) + (h) + (i)		Total Surplus / (Deficit)	$29.8
(k) = (f) – (i) + (j)		End-of-Year Assets	$79.1

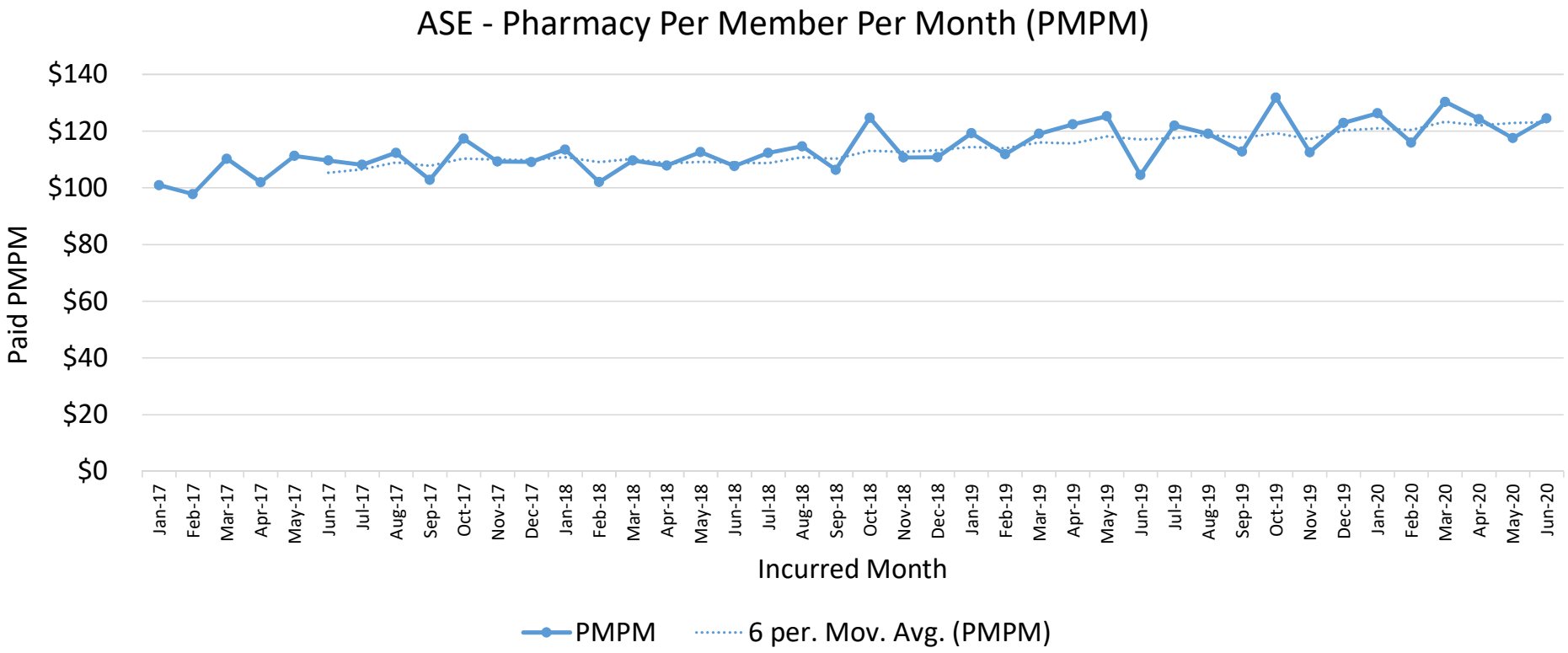
End of Year Assets



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 August 2020.
- 2020 plan experience
  - Allocated reserves for 2020 is $25.3M
  - Estimated deficit of $15.4M
  - End of Year Assets: $108.3M
  - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
  - No plan changes / 0% increase to employee contributions
- 2021 projected plan experience
  - Allocated reserves for 2021 is $15.5M
  - Projected deficit: $27.5M
  - End of Year Assets: $65.3M
  - Reflected 2021 program initiatives
  - Increased membership based on historical patterns
  - Baseline trends (medical: 7%, pharmacy: 8%)
  - August 5, 2020 Board action (next slide)

Board Action – August 5, 2020

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

Total Plan Experience

Funding	2019	2020	2021
PPE Funding	$ 102.39	$ 105.38	$ 108.89
Employee Contribution	121.12	124.21	138.60
Dept of Ed Funding	88.10	88.10	108.10
Other	15.02	14.88	15.38
Total Income	$ 326.64	$ 332.57	$ 370.96
Medical Claims	$ (247.12)	$ (275.18)	$ (314.77)
Pharmacy Claims	(60.87)	(70.82)	(79.14)
Administration Fees	(28.46)	(28.18)	(29.20)
Plan Administration	(2.61)	(2.55)	(2.63)
Total Expenses	$ (339.06)	$ (376.74)	$ (425.74)
Program Savings	$ -	$ 3.47	$ 11.77
Net Income / (Loss) Before Reserve Allocation	$ (12.42)	$ (40.70)	$ (43.00)
Allocation of Reserves	$ 12.66	$ 25.25	$ 15.48
Net Income / (Loss) After Reserve Allocation	$ 0.23	$ (15.45)	$ (27.52)

Average Membership			
Active Employees / Pre-65 Retirees	82,391	84,475	86,891
Post-65 Retirees	14,279	15,003	15,903
Total Enrolled	96,670	99,479	102,794

Total Income PMPM[1]	$ 292.48	$ 299.75	$ 313.28
Total Expenses PMPM[2]	$ (292.28)	$ (312.69)	$ (335.60)

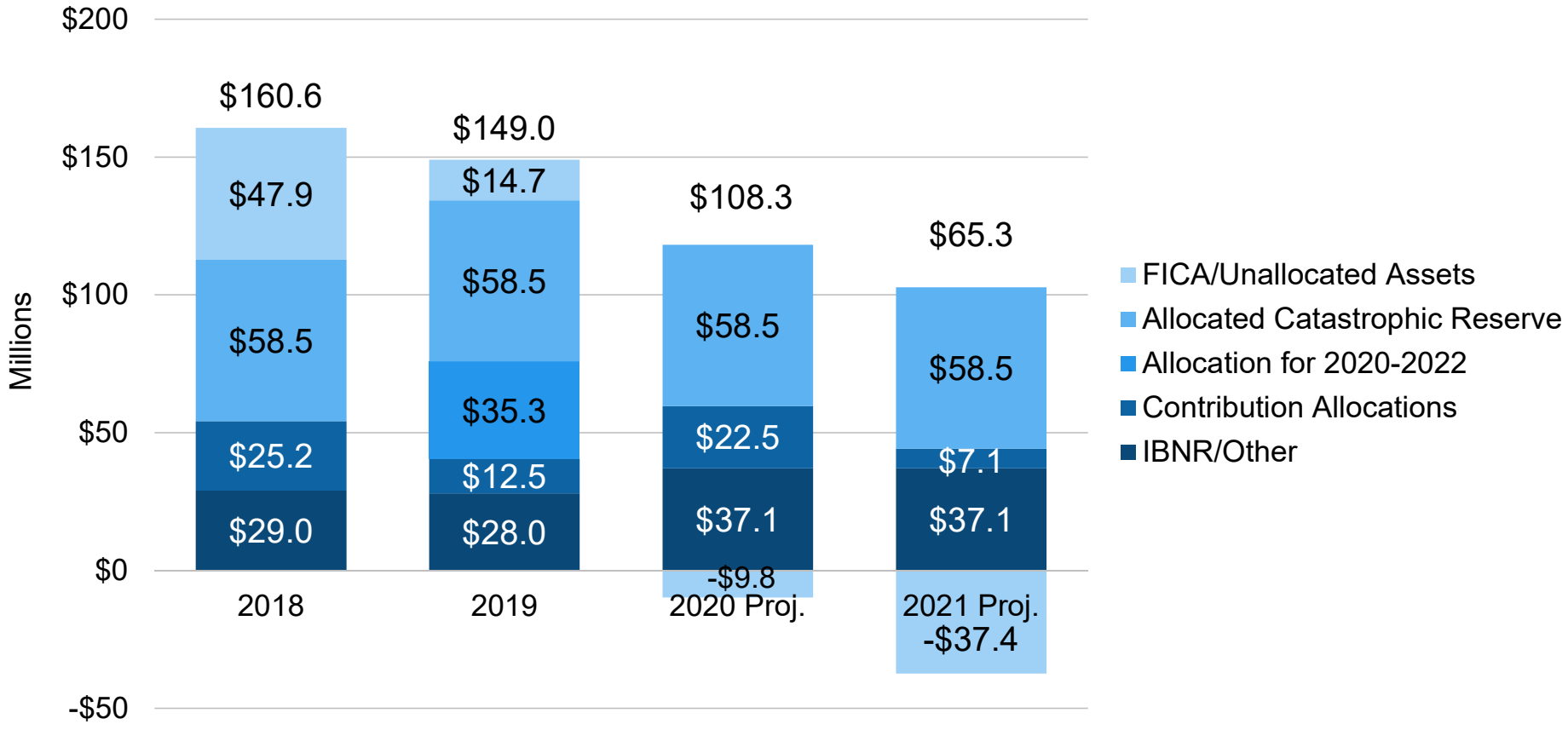
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Program Savings

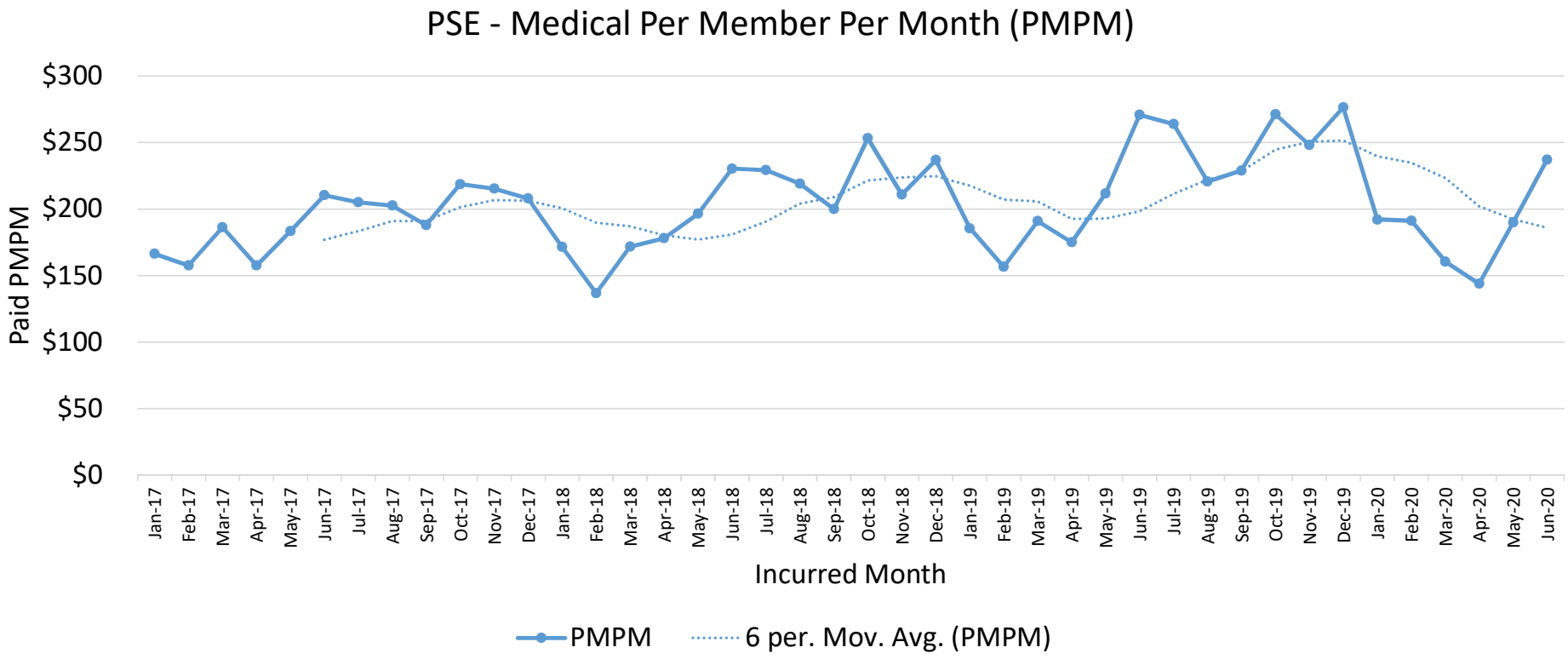
Projected Assets: 2019 – 2021

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	($373.3)
(d)		Allocated Assets	$25.3
(e) = (b) + (c) + (d)		Total Surplus / (Deficit)	($15.4)
(f) = (a) - (d) + (e)		End-of-Year Assets	$108.3
(g)	2021	Total Income	$371.0
(h)		Total Expenses	($414.0)
(i)		Allocated Assets	$15.5
(j) = (g) + (h) + (i)		Total Surplus / (Deficit)	($27.5)
(k) = (f) – (i) + (j)		End-of-Year Assets	$65.3

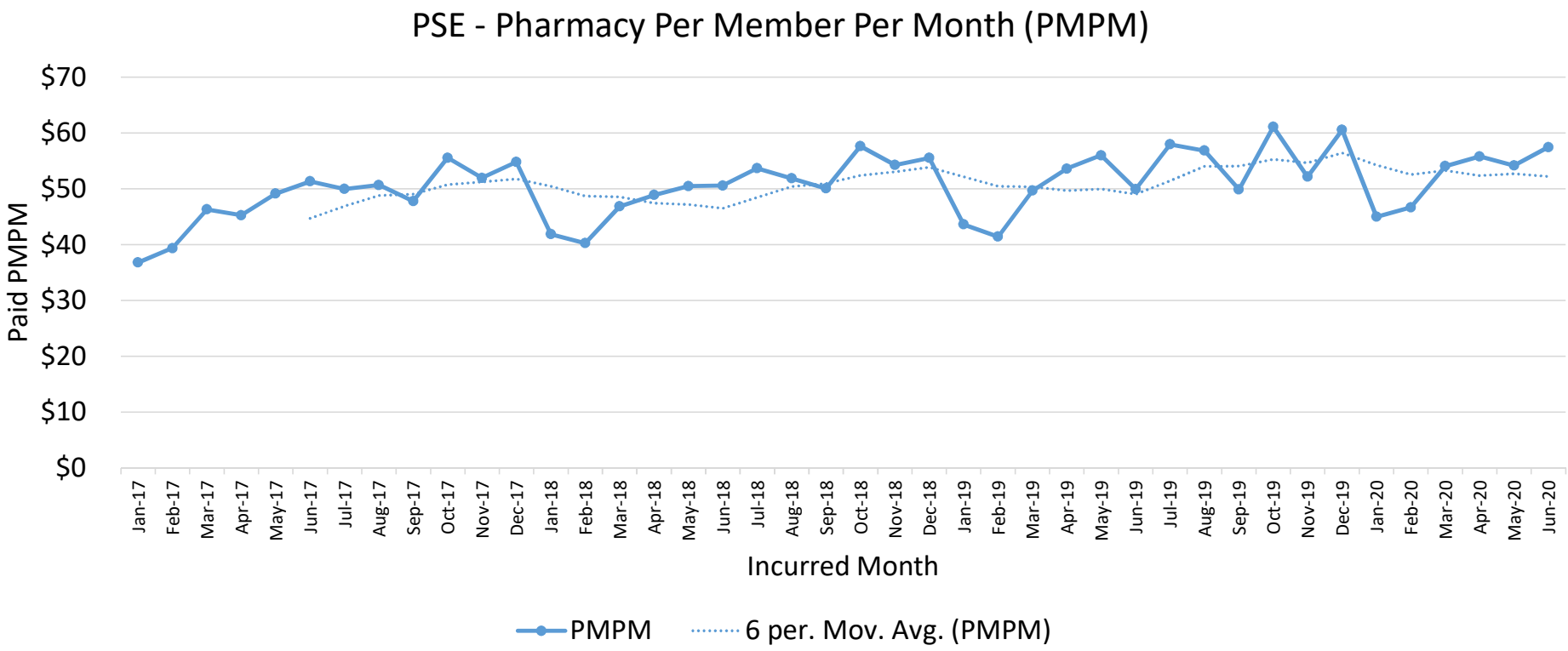
End of Year Assets



Monthly Trend - Medical

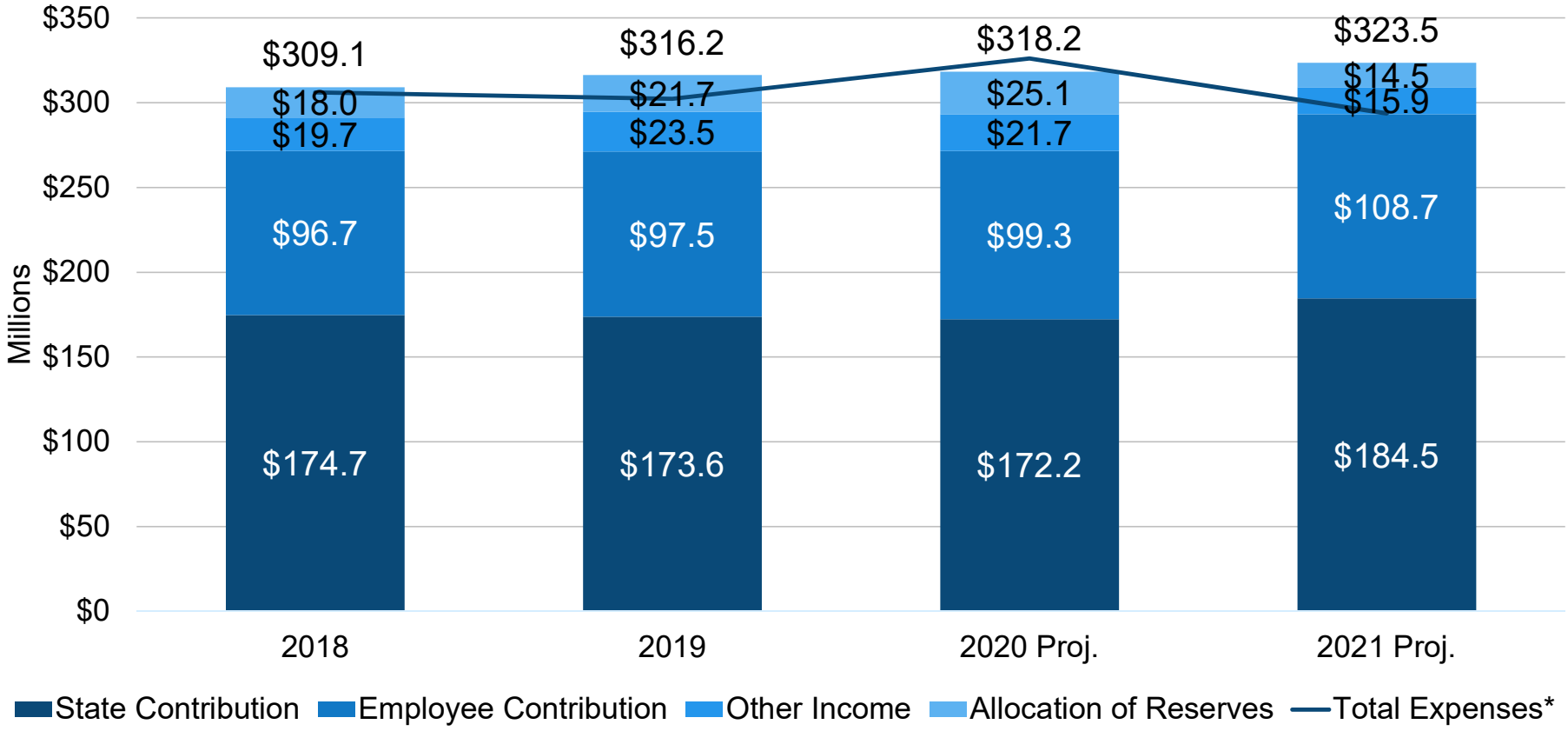


Monthly Trend - Pharmacy



Appendix

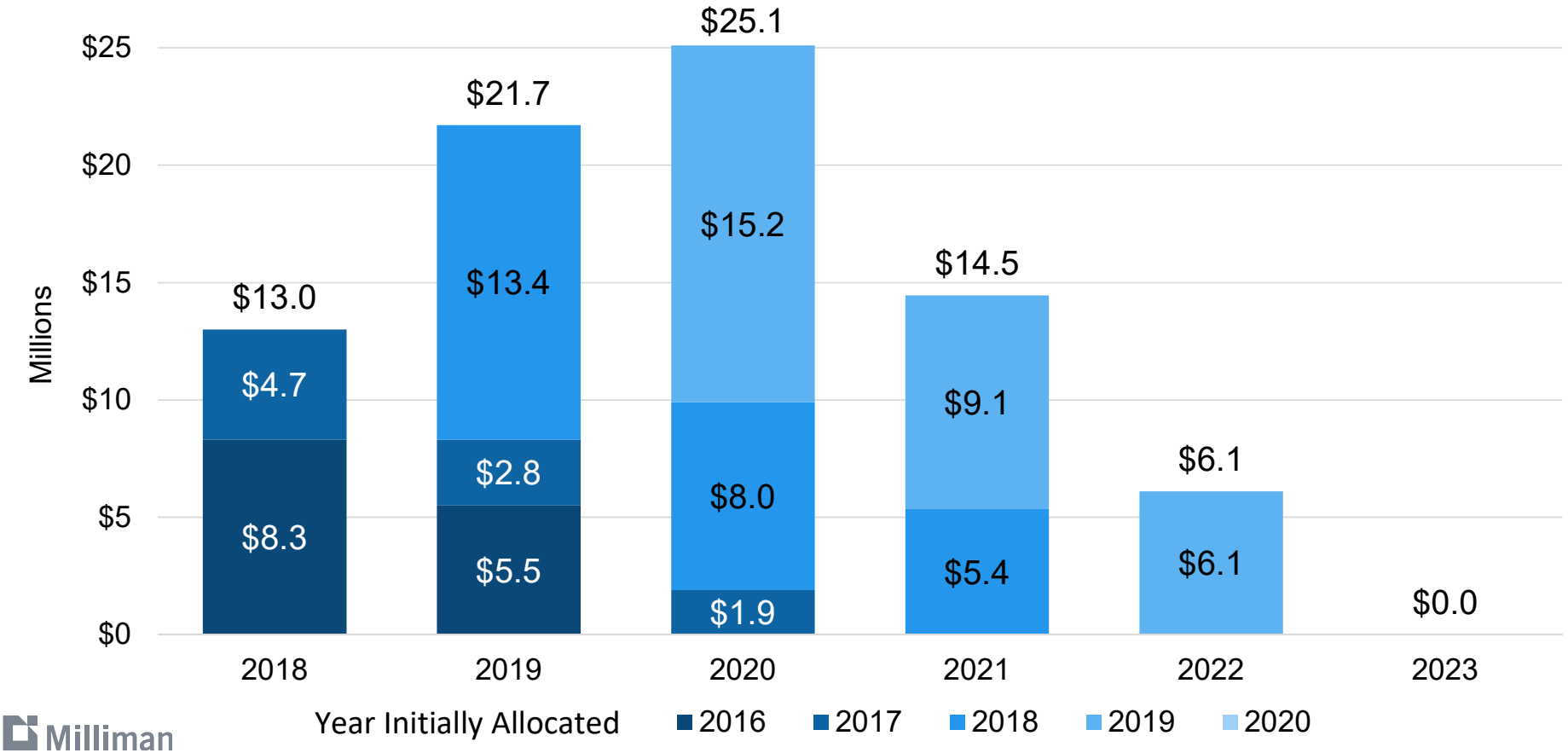
ASE - Income vs. Expenditure



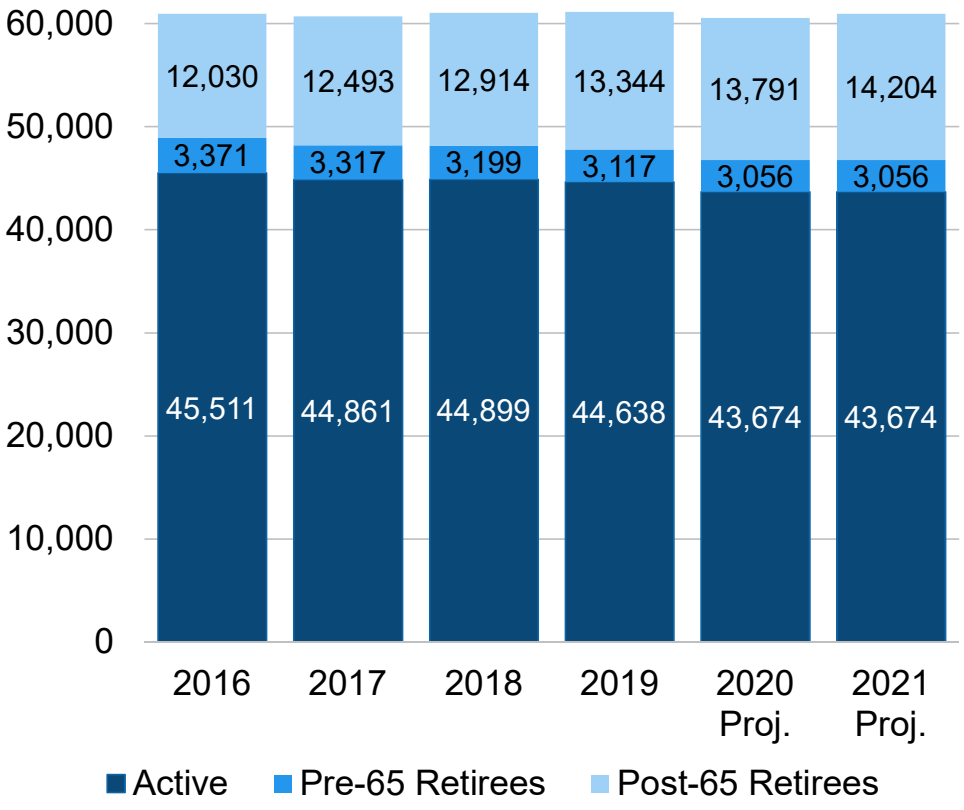
* Total Expenses offset by Program Savings

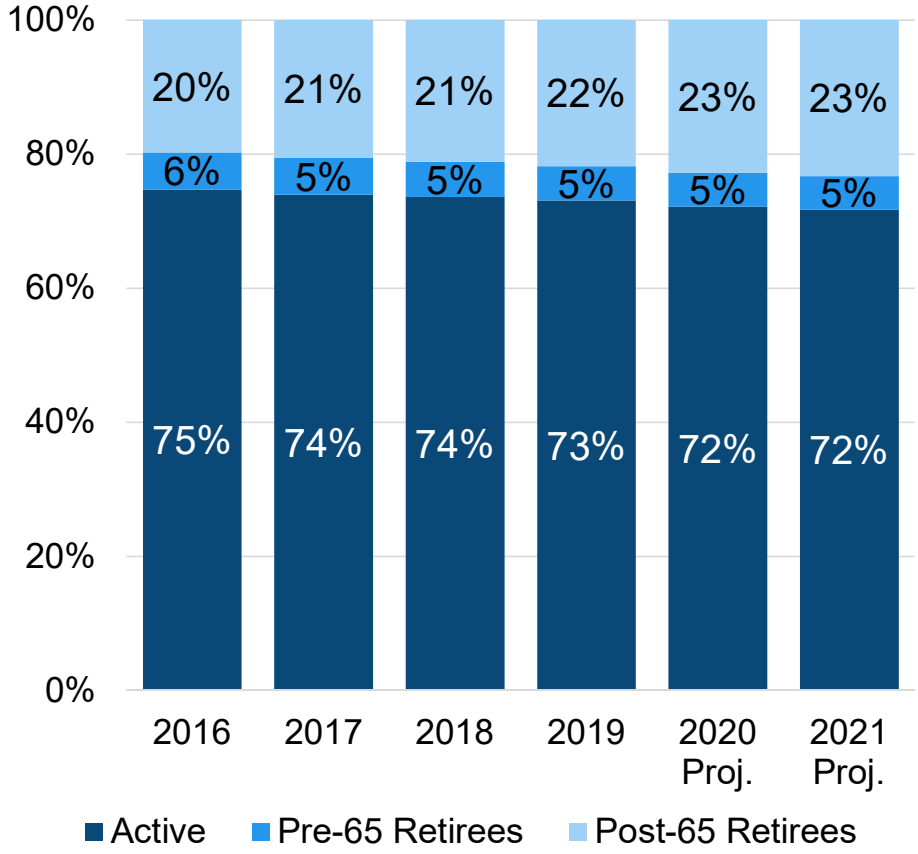
ASE - Reserves Allocation by Year

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

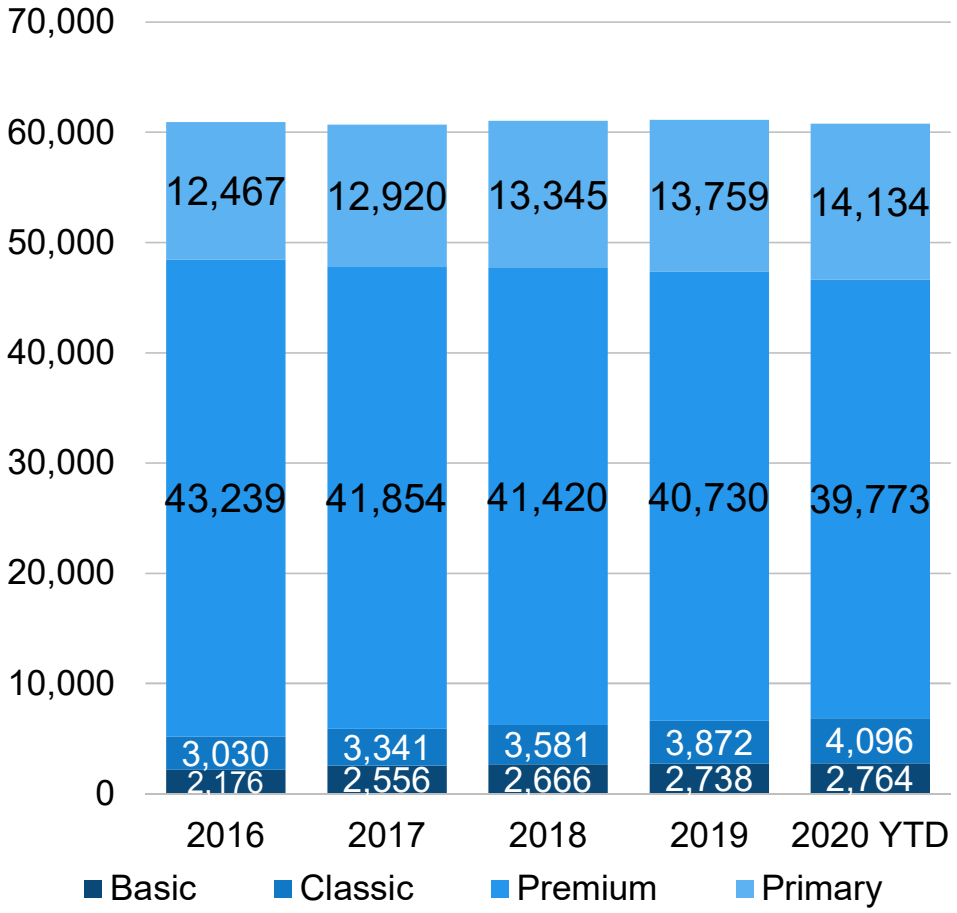


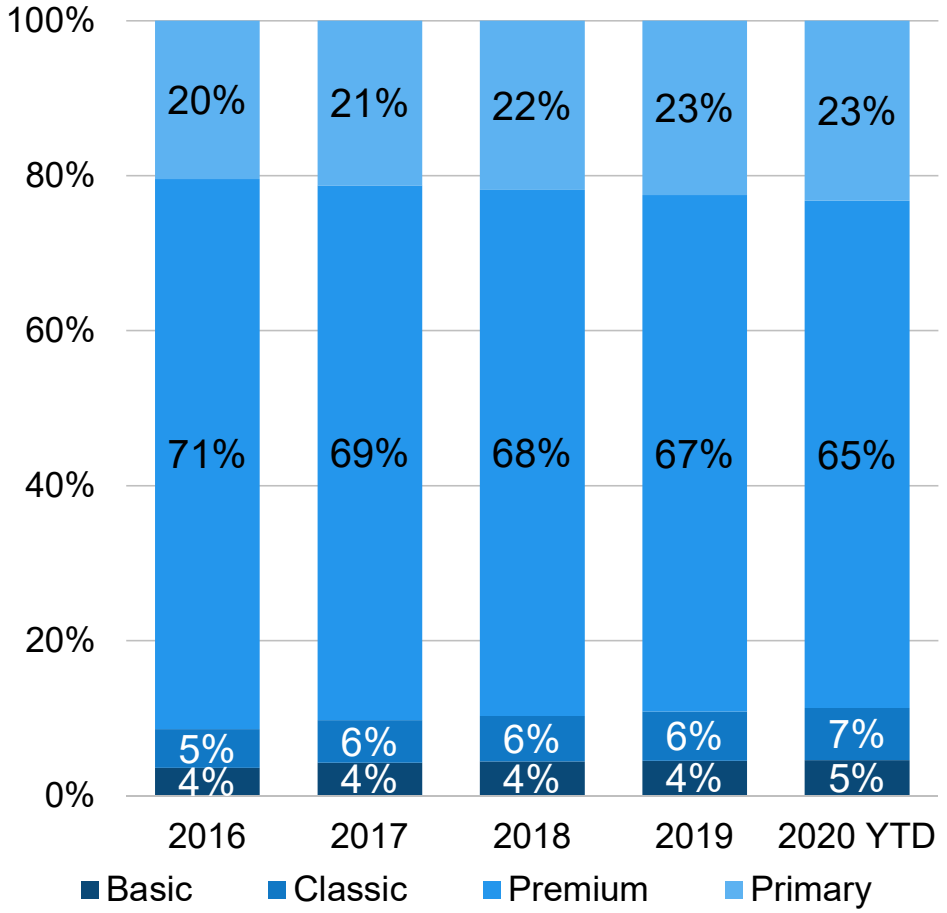
ASE - Average Membership by Status





ASE - Average Membership by Plan





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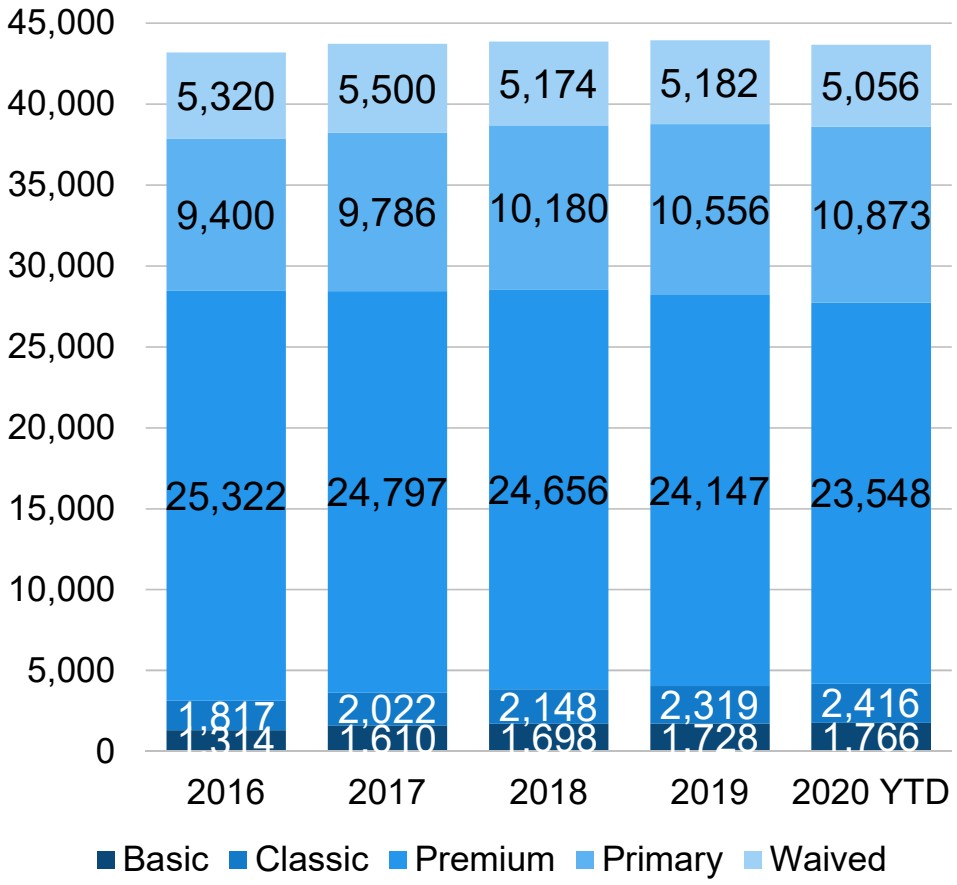
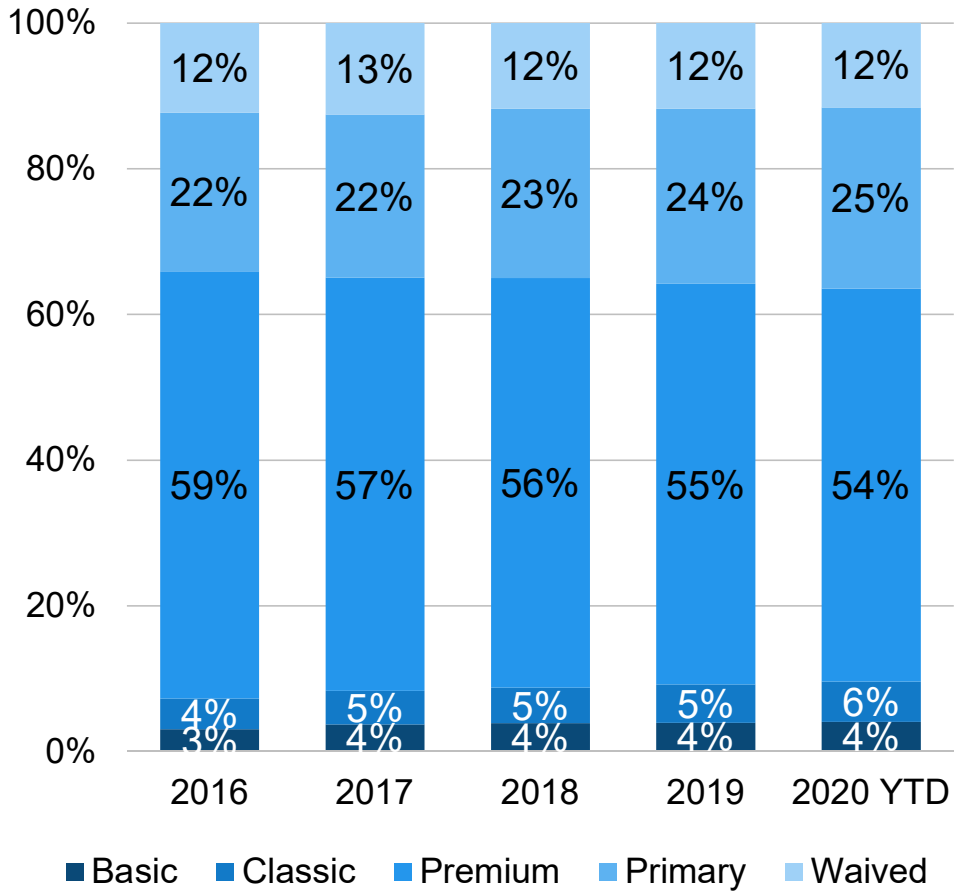
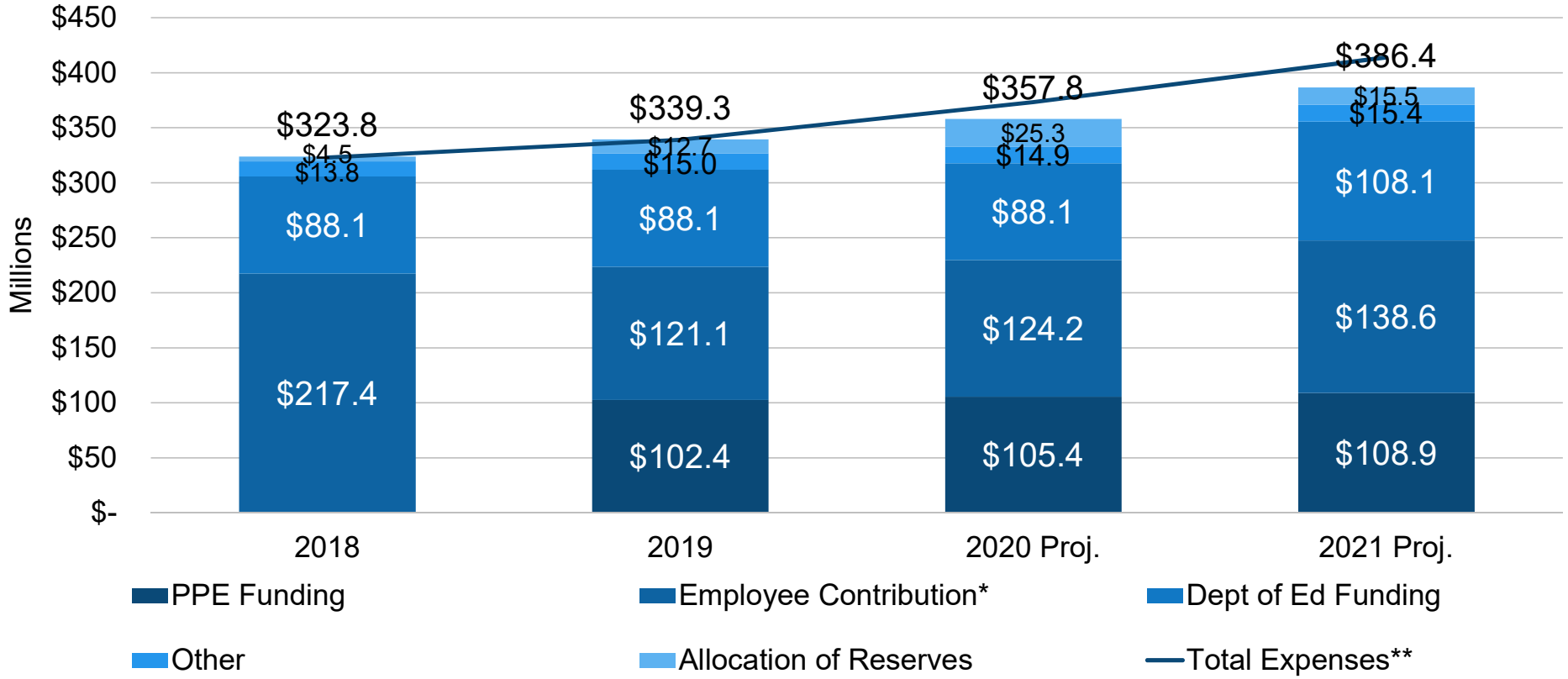
ASE - Average Enrollment (Subscribers) by Plan





PSE - Income vs. Expenditure

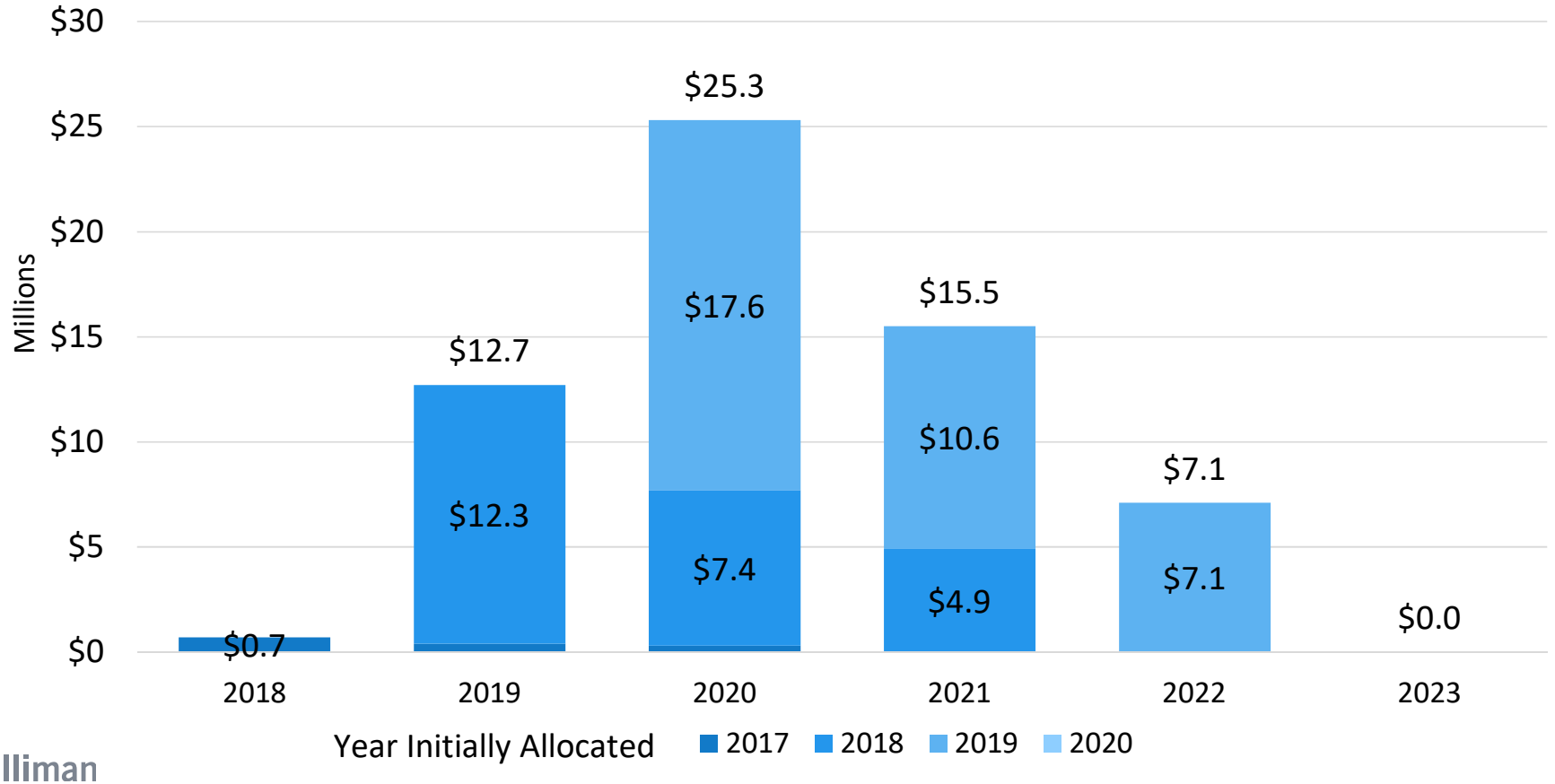


* 2018 Employee Contribution includes PPE Funding

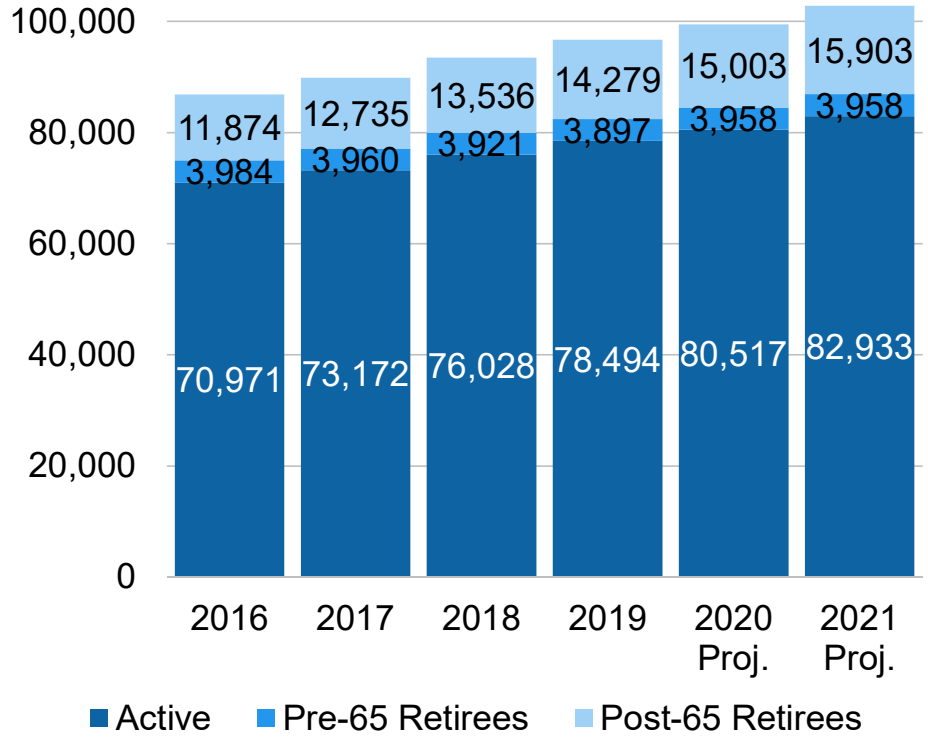
** Total Expenses offset by Program Savings

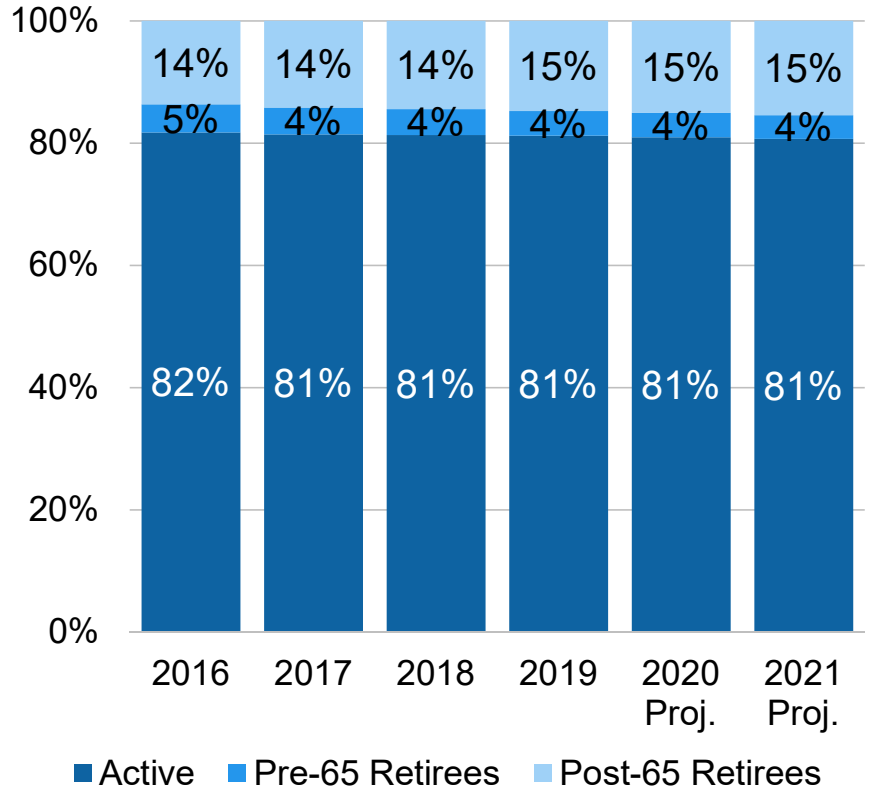
PSE - Reserves Allocation by Year

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

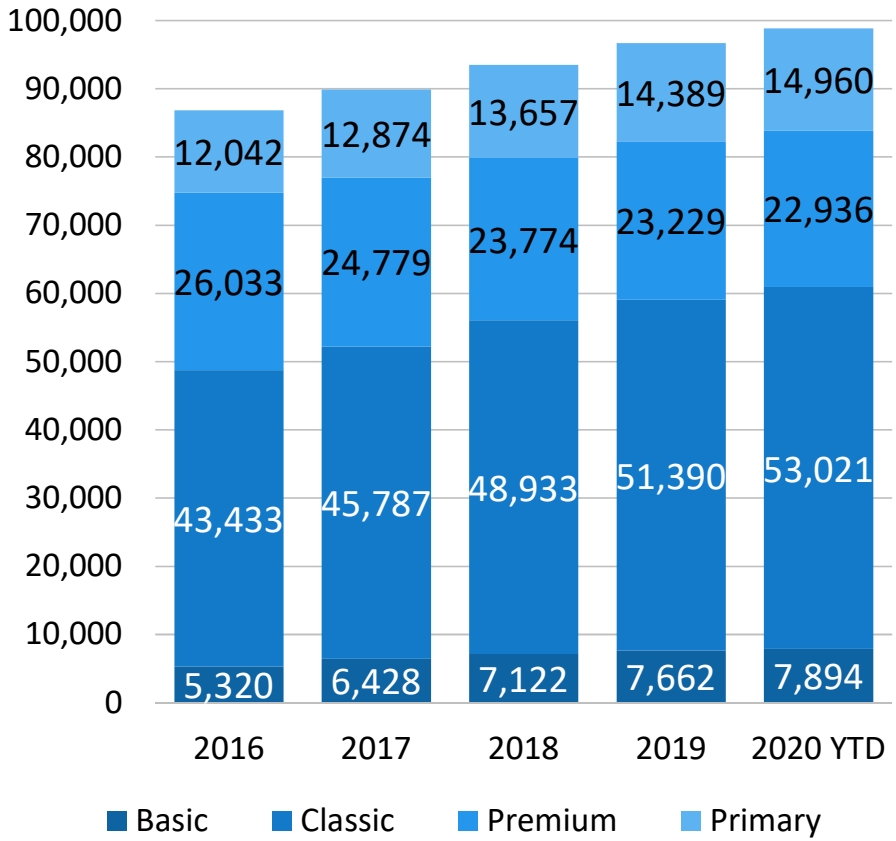


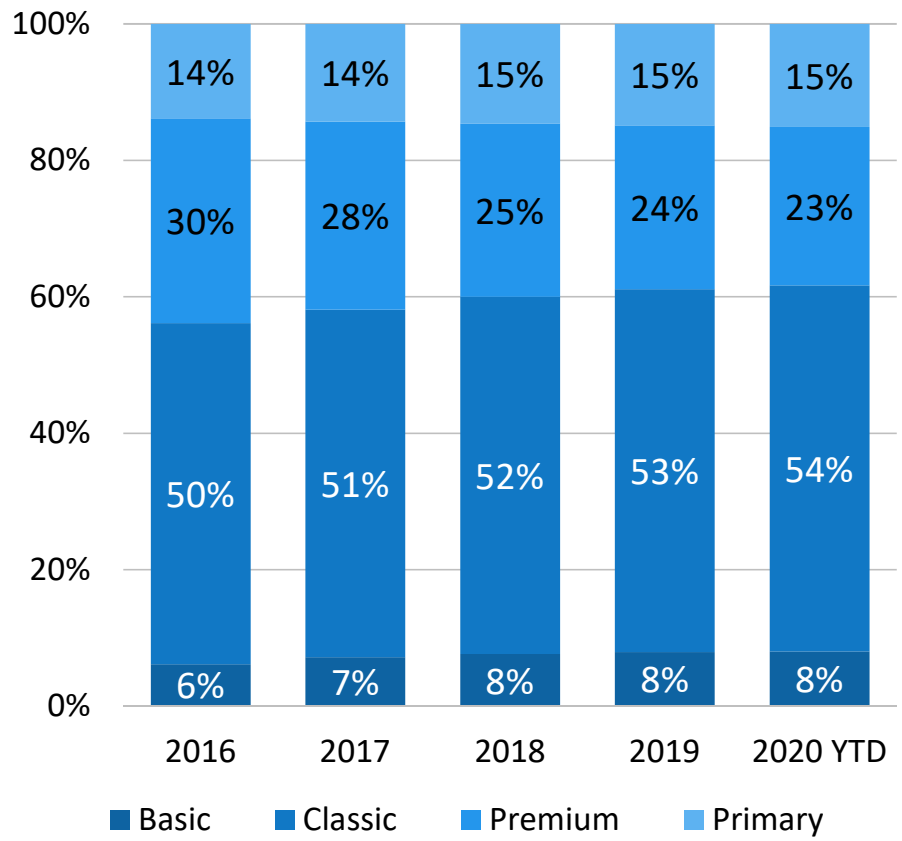
PSE - Average Membership by Status



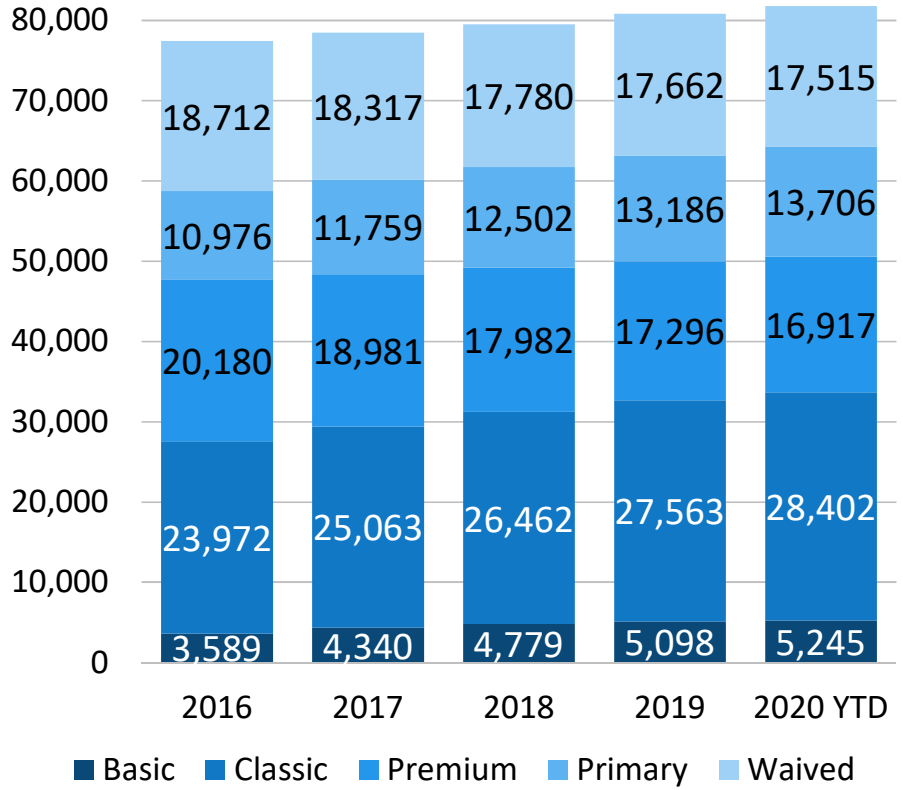


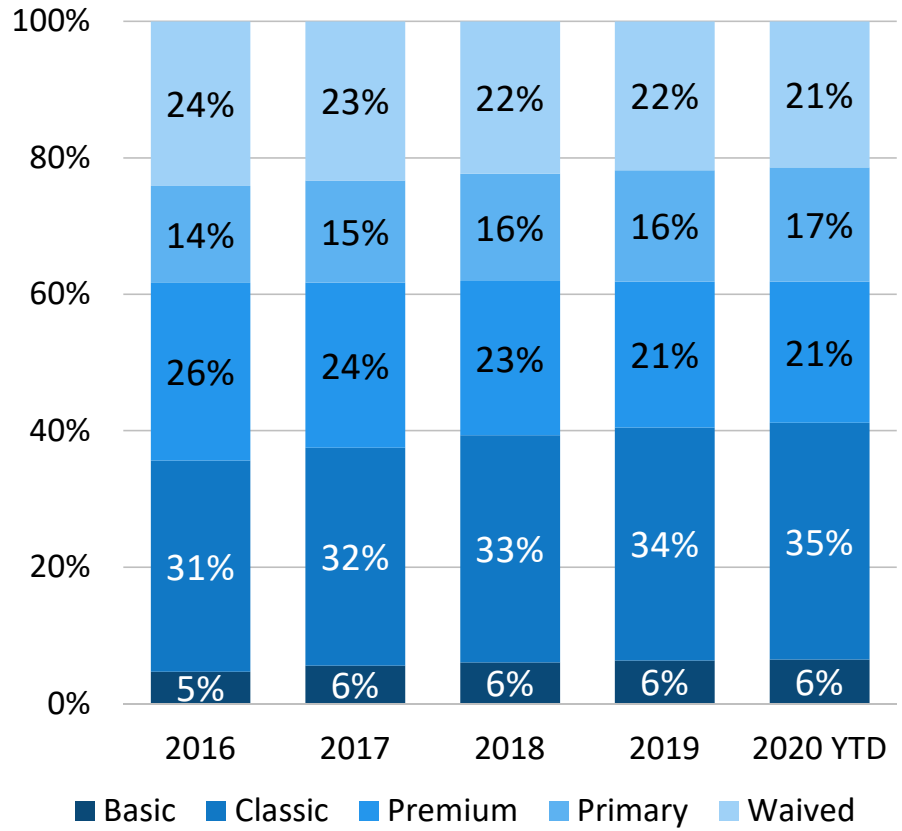
PSE - Average Membership by Plan





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 July 2020
  - Projected August – 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 August 31, 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 July 2020 to December 2020 based on the PMPM from the midpoint of the experience period (September 1, 2019) to the midpoint of the projection period (October 1, 2020). Utilize actual claims for January 2020 to June 2020 with completion.
6. 2021 Projected the incurred claims PMPM from the midpoint of the experience period (September 1, 2019) to the midpoint of the contract period (July 1, 2021).
7. Made adjustments for seasonality, benefit changes, and age/gender mix.
8. Accounted for rating period fees and administrative expenses.
9. Where applicable, converted incurred budget to paid budget based on historical payment patterns.

Limitations

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

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

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

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

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

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

Milliman

Thank you

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Paul Sakhrani, FSA, MAAA