AGENDA

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

November 15th, 2019
10:00 a.m.

EBD Board Room – 501 Building, Suite 500

I.	*Call to Order*	*Susan Gardner, Chair*
II.	*Approval of October Minutes*	*Susan Gardner, Chair*
III.	*ASE-PSE October Financials*	*Bonnie Casey, EBD Comptroller*
IV.	*Health Risk Analysis Update*	*Elizabeth Montgomery & Mike Motley, ACHI*
V.	*Diabetic Plan Update*	*Eric Pohl & Krishna Rao, Kannact*
VI.	*Plan Update*	*Paul Sakhrani, & Courtney White, Milliman*
VII.	*Director's Report*	*Chris Howlett, EBD Director*
VIII.	*Adjournment*	*Susan Gardner, Chair*

Upcoming meetings:

December 13th, 2019, January 17th, 2020, February 14th, 2020

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.

BENEFITS MEETING MINUTES

The Benefits Sub-Committee of the State and Public School Life and Health Insurance Board (hereinafter called the Committee) met on November 15, 2019, at 10:00 a.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, Arkansas.

Date | *time* 11/15/2019 10:00 AM | *Meeting called to order by* Susan Gardner, Chair

In Attendance

Members Present	Members Absent
Susan Gardner – Chair	
Claudia Moran	
Stephanie Lilly-Palmer	
Carla Haugen- proxy – Cayce Raney	
Herb Scott	
Ronnie Kissire – Vice-chair	
Cindy Allen	
Chris Howlett, Employee Benefits Division (EBD) Director	

Others Present

Rhoda Classen, Shalada Toles, Sharon Parker, Bonnie Casey, EBD; Ronda Walthall, ARDOT; Elizabeth Montgomery, ACHI; Takisha Sanders, Jessica Akins, HA; Suzanne Woodall, Medimpact; Krishna Rao, Eric Pohl, Kannact; Courtney White, Scott Cohen, Milliman; Donna Morey, ARTA

Approval of Minutes by: Susan Gardner, Chair

MOTION by Scott:

Move to approve the October 18, 2019 minutes.

Lilly-Palmer seconded; all were in favor.

Minutes Approved.

Health Risk Analysis Update by: Elizabeth Montgomery, ACHI

Montgomery provided an update on health risk assessment (HRA) analyses and follow-up on questions from last meeting.

Discussion:

Gardner: You mentioned in the physical activity component that there were two, AHELP and what was the other one?

Montgomery: ACHI has been really involved in the Blue&You fitness challenge. This is something the BlueCross or their foundation does annually. Different employers' groups can sign up and the employees have different way to earn points through physical activity. It may be something we can push out to members and think about engagement around that.

Gardner: Is there ever any talk or discussion about state agencies having challenges with each other such as a step challenge.
Montgomery: I think that would be a great idea.
Lilly-Palmer: It really depends on the state agency director and if they are allowed to participate or not. It can be a healthy competition.

Diabetes Plan Update by: Krishna Rao & Eric Pohl, Kannact

Pohl and Rao provided a brief update on the Kannact plan and provided follow-up on questions asked in previous meetings.

Discussion:
Moran: Those that have been in the program for that long but are still not participating in anything; I know the coaches reach out to them, but is there anything else that goes on such as requirements to get their supplies?
Pohl: Typically, the way our program is structured, if participants don't engage for three consecutive months they are removed from the program. Usually, in any population you have a small group (5% or less) that do try to get away with minimal work. Here, it is more like 12%-13%, so it is higher than what we typically see.
Lilly-Palmer: The ones that you are talking about removing after the 3 months from having no activity at all, are you not having any re-enroll to simply get the products and supplies, and how are you coming to those numbers? Wouldn't they be going up and down?
Pohl: We are looking for a re-enrollment recommendation later on. We do see about 20 a month re-enroll. We would only recommend allowing them back on once to give people a chance to re-engage.
Lilly-Palmer: I have several employees participating in the program. If they aren't actually participating in the health coaching due to when the coach calls the participant, what happens? Is there not a time they are setting up with participants? Looking at your numbers, I am seeing 3,340 total active, but then I'm seeing 1,076 participants that are active, so I am just trying to figure out where those are coming from.
Pohl: The way the program typically works is the coaches schedule their health coaching calls on enrollment. They can choose their time preference and schedule their first call within the enrollment process. We have coaches staffed for a large range of hours. Essentially, once they get connected, they could schedule that call at whatever time they choose as well as going on the coach scheduling link and reschedule a call or adjust their time preference.
Moran: Is all of the coaching done by phone.
Pohl: Phone or secure message within our platform. Particularly with this population most of the communication is done by phone.
Gardner: Are there internal controls that monitor the coach's activity to ensure that they are doing what they are supposed to be doing as far as how many times they monitor or reach out to someone that is not engaged?
Pohl: Yes, essentially the minimum goal is one scheduled goal a month with any participant. Some of them do more and the coaches have enough flexibility in their calendars to schedule more than one call. When participants miss those calls, they follow a very clear reach out plan that is tracked and audited weekly. Essentially, if

someone disengages up front, they are supposed to reach out within 48 hours and then again, a week later and the third call is a month later. The first three happen quicker and then there is another three into the end of the 10 weeks totally to 6 calls. They try to adjust the phone calls, so they don't always call at the same time. In an 8-hour day they should have 5-6 hours of scheduled calls and then have time to review cases and reach out calling as well.

Allen: Is this just for people who are enrolled in the drug plan? I am thinking about our retired Medicare teachers.

Howlett: It was passed for the active membership at the time. We have some retires but I am not sure about the breakout on that. It is considered a medical benefit.

Pohl: The retirees are about 28%-30% of our current participants.

Kissire: I think option 3 (strict engagement) is the way to go. We set this up to try to help people and the coaching is not as effective if you're not turning in the readings. I don't want to pay for people to just do when they aren't turning in their readings. They are the easiest thing to do, because it goes right to your phone. When you test and pull it out, it automatically links to your phone so there is no difficulty there. I am in favor of either doing the whole program or don't do the program, because we are trying to help. Although, I don't know what supplies cost.

Howlett: EBD has been working with Kannact a lot this year to look at what the best path to take is. You don't always see an ROI on that from a tangible. I've charged the internal administrative staff and our EBRx partnership to look into where we can expand or where we could heighten some of the approach. We would like to come back and present to this committee as well as the Board with what we think would be the best approach going forward and be able to have data and commentary to support the decision. Looking at the information, something needs to be done to address member engagement.

Kissire: If we need to provide supplies then we need to see what that is really costing us and the plan.

Howlett: When the recommendation was passed by the subcommittee and went to the full Board and was approved, at that time, you had seen the 3-month nonengagement piece. Also, if they didn't enroll and participate in the program, they paid for their own supplies. I believe we have roughly 700 people that are paying for their own supplies. We want to look at that population and look at the cohort between the two.

Moran: As far as the user friendliness, I agree with Ronnie that if you're going to do then do it, but I also believe if there is a problem with submitting that it is something that can be addressed quickly.

Pohl: The coaches can see who is submitting or not and if there is a little more strictness around their need, essentially, the coach is their first level of trouble shooting if there actually having an issue. There are a couple other levels of tech support as well as another meter that doesn't go through the phone and instead through the 3G towers. That meter is a little bulkier but still an option. We should be hitting 98%-99% of people hitting their readings without the excuse of I can't.

Moran: How long are the phone calls for the health coaching?

Pohl: There are a few options, typically, 20 minutes is the most used option. For more severe cases or case where the coach knows they want to talk a little longer, they do have 30-minute options and then for follow-ups they may use a 10- or 20-minute option.

Moran: To be actively engaged you have to have at least a 20-minute call once a month. Is that kind of the criteria?

Pohl: Yes, that is the base level.

Lilly-Palmer: Out of the 419, you have 81 that are not receiving the coaching and are just reporting?

Pohl: Yes, the only thing they really talked to the coach about is supplies but not engaging in deeper health coaching conversations.

Lilly-Palmer: Out of all the programs that we offer to state and public school employees, everything we want to offer is for positive engagement for sure, and if we are able to get supplies at a lower cost, but we also need think about all other aspects. Looking back at ACHI's presentation and looking at obesity and high blood pressure as being one of the top 8 that we have, so you know that population of diabetic trends is going to go up. We have to encompass all of that. If these people aren't getting into coaching, we need to ensure that they are somewhere and if we set a 3-month mandatory if you don't enroll or actively participate then we need to stick to that.

Howlett: You have identified these individuals as a subset of a cohort, but I would like a list of these individuals for the plan to explore. This population and their claim spend overall, understanding that some are going to be at various levels. So, you can take a person who is ultra-compliant, someone who is middle of the road, and someone who does nothing at all and when you do that you will average middle of the road. In a group it will appear to be level set but out of the 419, I want to see that list of individuals so we can look at the deviation within each subgroup and compare that to claims.

Pohl: Yes, we can do that.

Plan Update by: Scott Cohen & Courtney White, Milliman

Cohen and White provided an update on high cost claimant and plan experience for ASE and PSE.

ASE

- Update projections show a slight reduction in net income of $1.0M in 2019 and reduction in net income of $4.2M in 2020. Changes are driven primarily by:
    - Reduction in budgeted headcounts
    - Lower medical claim cost
    - Lower than estimated pharmacy program savings
- 2019 plan experience
    - Estimated surplus of $12.1M
    - Estimated unallocated net assets at the end of 2019 is $6.6M
- 2020 plan experience
    - Allocated reserves for 2020 is $25.1M
    - Estimated surplus of $6.5M

- Estimated unallocated net assets at the end of 2020 is $13.1M
- No plan changes / 5% increase in employee contributions

PSE

- Update projections show a slight increase in net income of $2.1M in 2019 and $1.2M in 2020. Changes are driven primarily by:
  - Lower medical claim cost
  - Slightly higher pharmacy claim cost
  - Lower than estimated pharmacy program savings
  - Incorporated increase in PPE funding for 2020
- 2019 plan experience
  - Estimated deficit of $270K
  - Estimated unallocated net assets at the end of 2019 is $13.3M
- 2020 plan experience
  - Allocated reserves for 2020 is $25.2M
  - Estimated deficit of $4.6M
  - Estimated unallocated net assets at the end of 2020 is $8.8M
  - Allocated reserves for 2020 is 25.3M
  - No plan changes / 0% increase to employee contributions

Discussion:

ASE

Howlett: Are you saying the two averages averaged to a lower median point?

White: Yes, if you look at the 12 months between August ’18 and July ’19 versus the 12 months of September ’18 and August ’19, those numbers are slightly lower. You can see it’s mainly driven by one August going away and another one coming on. That is why they are changing every month.

Gardner: Of the graphs shown with the dotted line, the straighter the line the better projection or grain?

White: Consistency is the key. A flat line, the dotted line, would be a 0% trend so that is good too, but it may be misleading because you may be seeing high cost claims going down and regular claims going up and then next year if high cost claims also turn up, then it will go up more than you expect. Really, it’s consistency in the line that is most important to us, because we want to make sure there is consistency in what we are seeing historically and then we have more confidence.

Howlett: Part of the reason you will see the stability in the line with pharmacy is the overall management and how that is being done by EBRx and the partnership with the Plan. If we had what would be perceived on the medical side as a high cost claimant and the potential to have the increased cost intermittently. You would see the same deviation on the pharmacy if we didn’t manage drugs excluded until they are reviewed and just let every drug on the plan. The reason between the two, I would give more credit on the pharmacy side because of the stability of the management of the formulary and how we are able to still provide services and the pharmacological solutions to the membership but do it in a sensible and cost-effective way as well.

Director’s Report: Chris Howlett, EBD Director

Howlett provided an update on the wellness as listed below.

2020 discount:	2019, at this point:
81% Completed	80% With Discount
19% Without Completion	20% Without Discount

For catapult visits we are at 45,219, compared to last year we had 35,512 and the PCP forms are 25,230 of that we had a total 26,640 which leaves about 410 that were incomplete. Through ARBenefits we have the login portal for the members, and we were averaging about 420 logins an hour during the last week of open enrollment. On average, we had approximately 3,400 logins a day. I am very proud of the membership and definitely proud of the EBD team.

MOTION by Lilly-Palmer**:**

Move to adjourn the meeting.

Moran seconded. All in favor.

Meeting adjourned.

NOVEMBER 2019 BENEFITS PRESENTATION

Izzy Montgomery, MPA
Policy Analyst

11.15.2019

ACHI
INSPIRING HEALTHY ACTS

OBJECTIVES

- Address follow-up questions from last meeting
- Discuss upcoming update of Health Waste Calculator analysis

FOLLOW-UP QUESTION

- What is the age distribution of HRA respondents who self reported as being obese, physically inactive, or current smokers?

OBESITY AMONG HRA RESPONDENTS: AGE (2018)

Age Range	2018
18 to 24	260 (1%)
25 to 34	3,655 (19%)
35 to 44	4,409 (23%)
45 to 54	4,932 (26%)
55 to 64	5,096 (26%)
65 to 74	927 (5%)
Total	**19,278**

CURRENT SMOKING AMONG HRA RESPONDENTS: AGE (2018)

Age Range	2018
18 to 24	26 (1%)
25 to 34	451 (13%)
35 to 44	871 (25%)
45 to 54	964 (28%)
55 to 64	1,027 (30%)
65 to 74	109 (3%)
Total	**3,448**

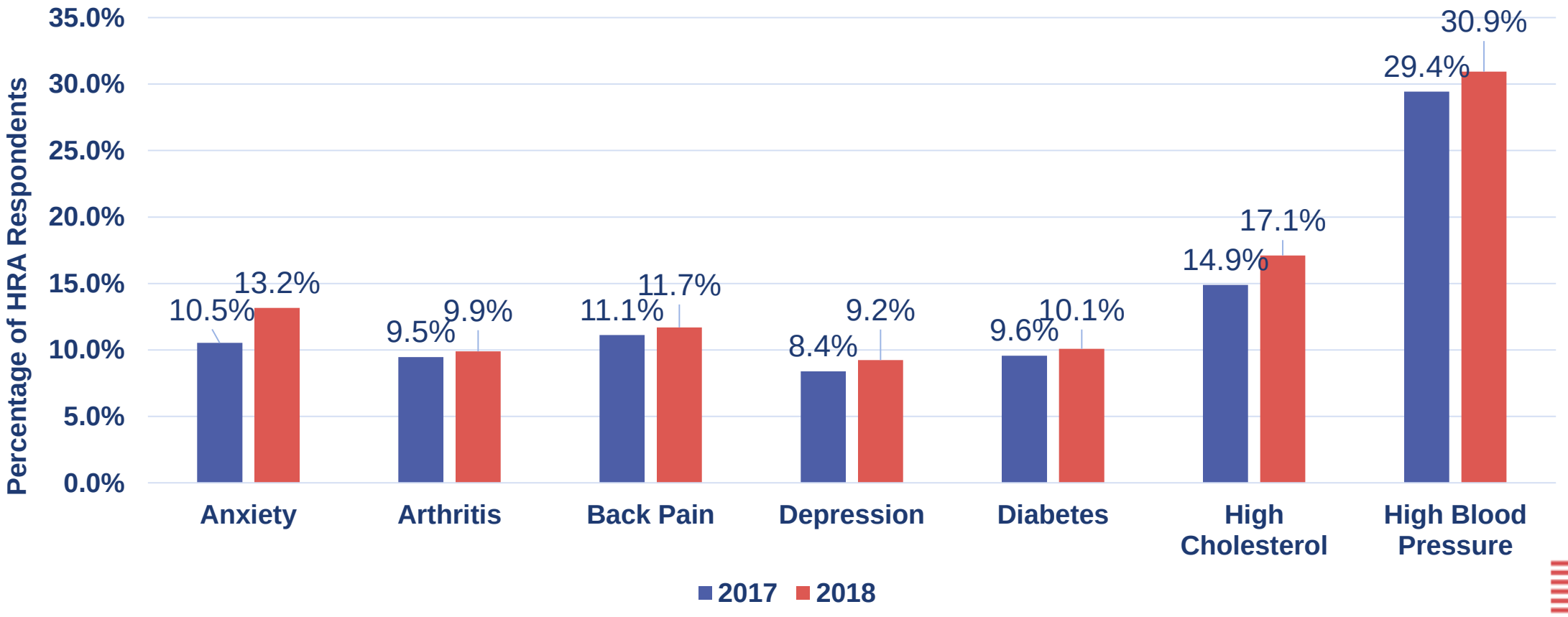
PHYSICAL INACTIVITY AMONG HRA RESPONDENTS: AGE (2018)

Age Range	2018
18 to 24	26 (1%)
25 to 34	470 (13%)
35 to 44	747 (20%)
45 to 54	1,073 (30%)
55 to 64	1,097 (31%)
65 to 74	183 (5%)
Total	**3,596**

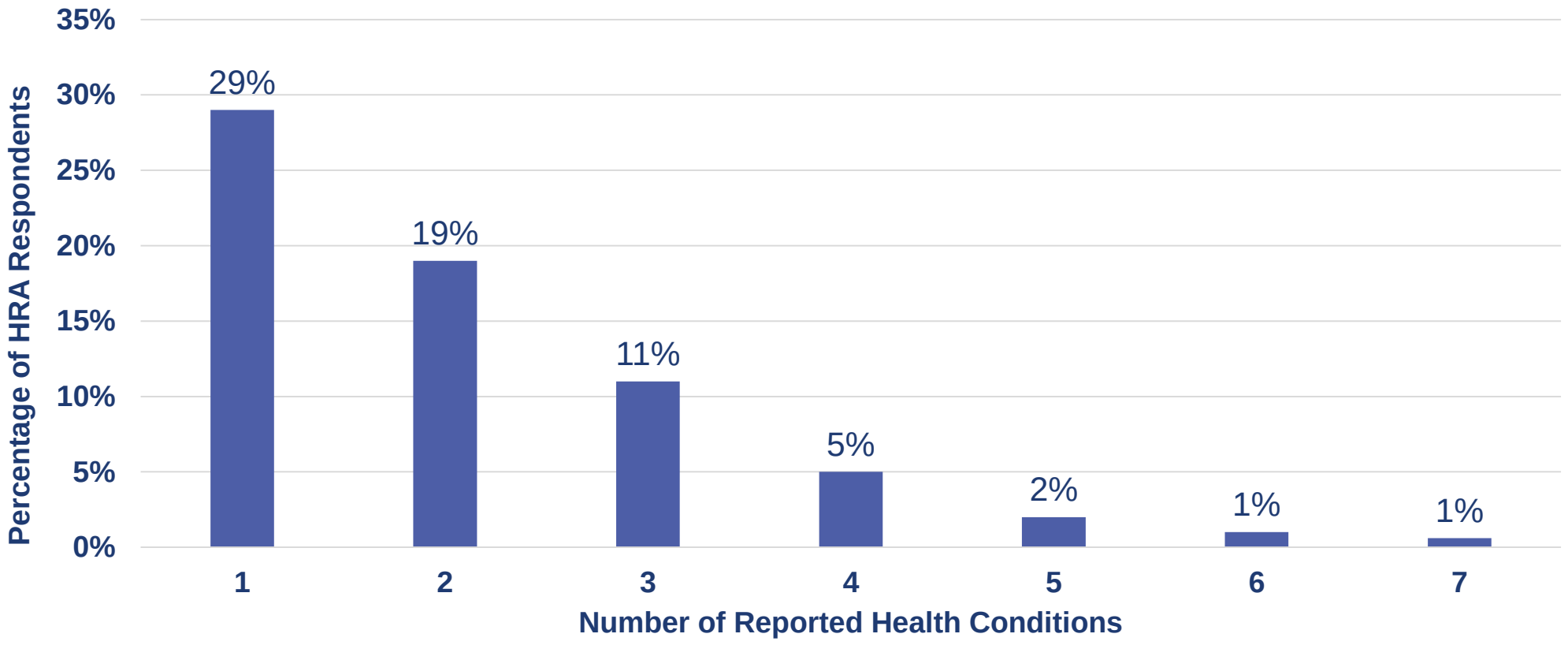
FOLLOW-UP QUESTION

- How many of the HRA respondents who reported having any of the current health conditions (listed in the survey) have more than 1 of those conditions?

MOST FREQUENT CURRENT HEALTH CONDITIONS AMONG RESPONDENTS (2017–18)



HRA RESPONDENTS REPORTING MULTIPLE CURRENT HEALTH CONDITIONS (2018)



FOLLOW-UP QUESTION

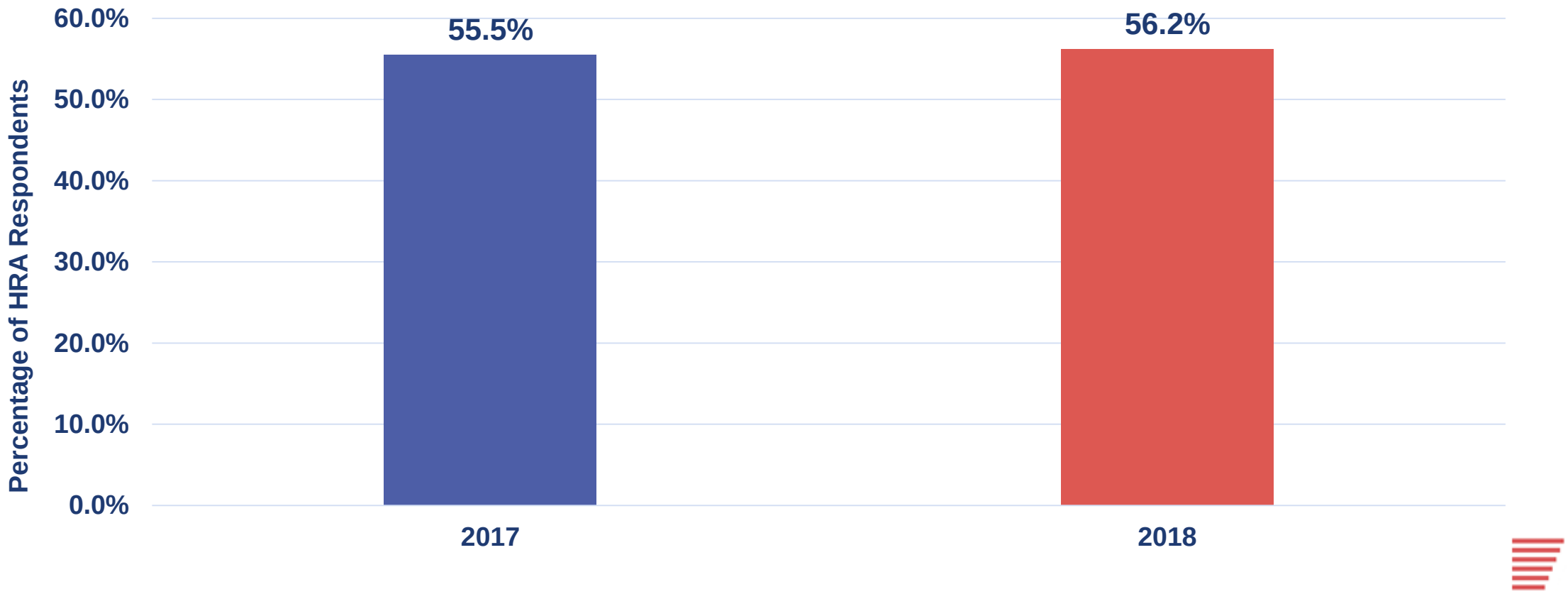
- What were the plan expenditures for those who did and did not have a flu shot?

BACKGROUND ON 2017–18 FLU SEASON

- According to the CDC, the 2017-18 flu season was a “high severity season”
- Overall effectiveness of the 2017-18 vaccine was estimated to be 40%

Source: *Centers for Disease Control and Prevention. Summary of the 2017-2018 Flu Season. Retrieved from https://www.cdc.gov/diabetes/data/statistics/statistics-report.html*

FLU SHOT RATES AMONG RESPONDENTS (2017–18)



FLU DIAGNOSES AMONG RESPONDENTS, 2018

- Of all HRA respondents, overall flu rate was 6.2%, based on flu diagnosis
- Of those reporting getting a flu shot, 6.6% had a flu diagnosis
- Of those reporting not getting a flu shot, 5.7% had a flu diagnosis

FLU EXPENDITURES

- For this analysis:
  - Episode defined as three weeks following flu diagnosis
  - Includes plan paid amount + member cost share
- Overall total episode costs were approximately $1,300,000
  - Plan paid episode costs were approximately $846,000
  - Member paid episode costs were approximately $454,000

FLU EXPENDITURES

- Total episode costs for respondents (1,384) who received a flu shot and had a flu diagnosis were approximately $800,000 (Average cost per member $578)
- Total episode costs for respondents (926) who did not receive a flu shot and had a flu diagnosis were approximately $500,000 (Average cost per member $539)

CONCLUSIONS

- Many respondents report having more than 1 current health conditions as asked in HRA
- There was very little difference in costs (following flu diagnosis) between those who did and those who did not receive a flu shot
- Other consequences related to flu such as absenteeism, severity of illness, spread of disease, etc. are not captured in analysis

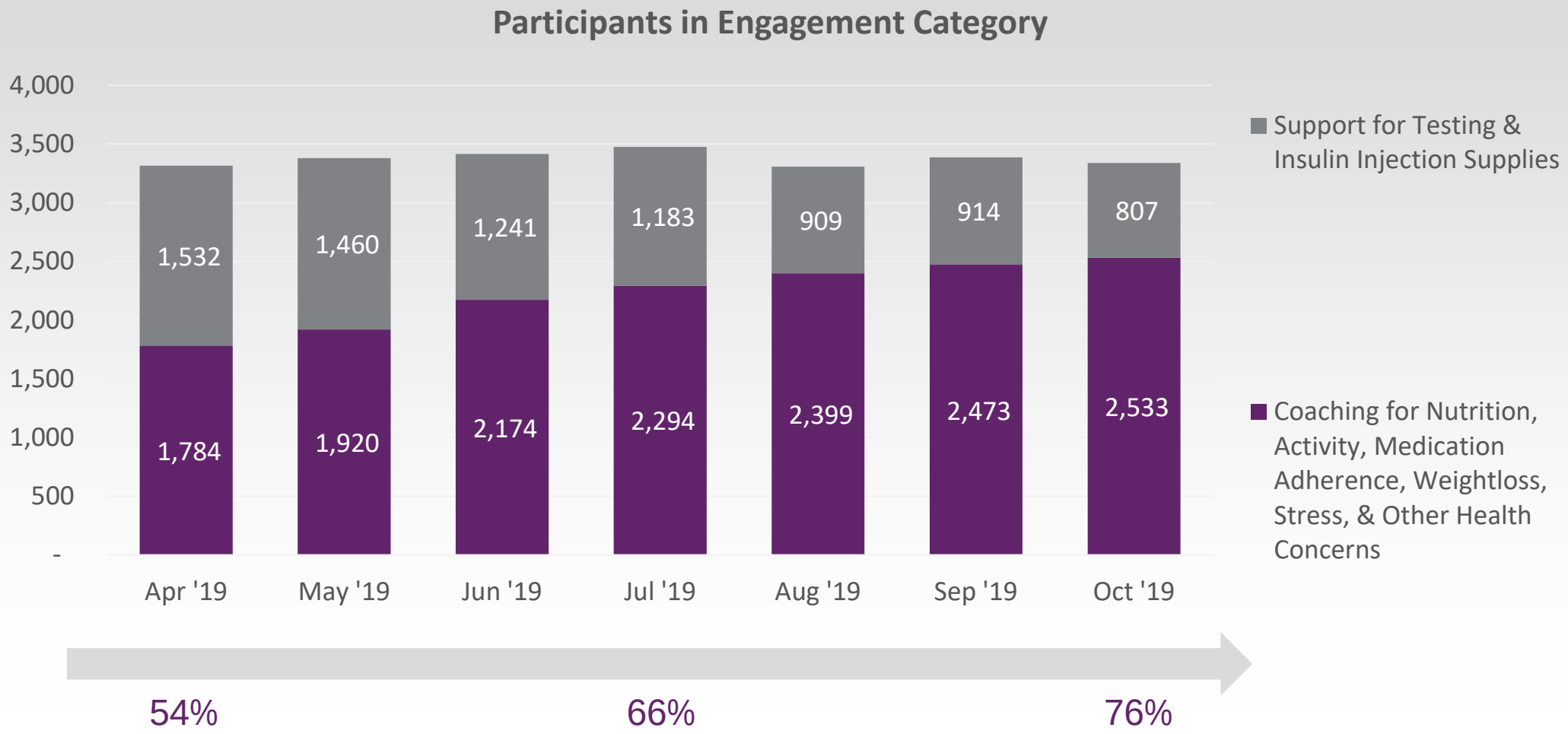
NEXT MONTH

- Will present updated Health Waste Calculator analyses
- Analyses will include first two quarters of 2019 and trends on top 8 wasteful services

Program Detail & Recommendations

The goal of the recommendation options is to increase the number of participants engaged in health coaching for behavior change and submitting blood glucose readings, while limiting costs to EBD for participants interested in Kannact only for testing and insulin injection supplies.

Health Coaching Engagement



Participant Breakdown

3,340
Total Active Participants

A breakdown of active participants includes the following four groups:

Group A
1,766 Participants

Engaged in health coaching for behavior change & submitting readings

Group B
767 Participants

Engaged in health coaching for behavior change & not submitting readings

Group C
340 Participants

Submitting readings & not engaged in health coaching for behavior change

Group D
467 Participants

Engaged only for supplies access

Group B Detail

767
Total Group B Participants

A breakdown of participants in Group B by active months includes:

Number of participants	Full months in the Kannact program
127	0 – 3 Months
107	4 – 6 Months
533	7+ Months

Participants in Group B have engaged in health coaching for behavior change but have not submitted readings to the platform. Kannact has seen improvement in this group, with more participants sharing readings each month.

Group C Detail

340
Total Group C Participants

A breakdown of participants in Group C by active months includes:

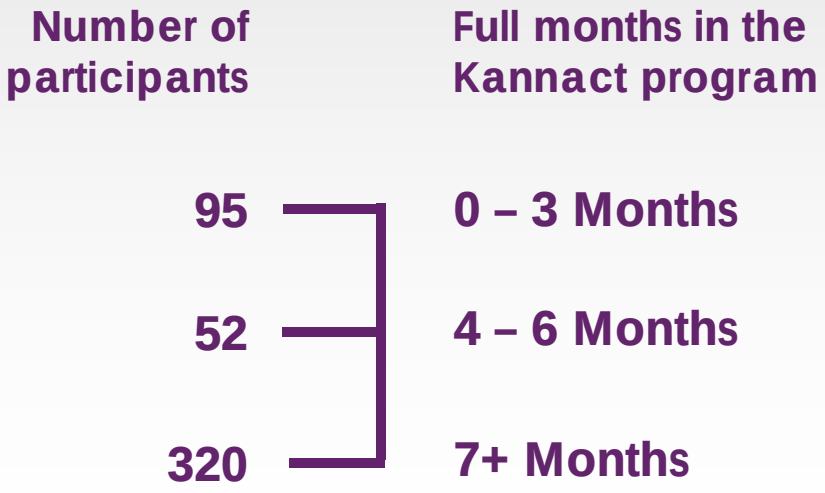
Number of participants	Full months in the Kannact program
25	0 – 3 Months
18	4 – 6 Months
297	7+ Months

Participants in Group C have engaged in support for supplies and have submitted readings. They have not shown an interest in engaging with the health coach to discuss behavior change. Kannact has seen improvement in this group, with more participants engaging in health coaching for behavior change each month.

Group D Detail

467
Total Group D Participants

A breakdown of participants in Group D by active months includes:



Participants in Group D have engaged in support for supplies only. They have not shown an interest in either engaging in coaching for behavior change or submitting readings. Kannact has seen a monthly decrease in the size of this group, with participants either dropping out of the program, or moving forward to an improved engagement category.

Option 1 Program Adjustments: Kannact Standard

All Enrollees: Participants who do not engage in submitting readings or health coaching for behavior change by the end of three (3) full months are removed from the program.

Group A: 1,776 participants engaging in both health coaching for behavior change and submitting blood glucose readings continue in the program.

Group B: 767 participants engaging in only coaching for behavior change to continue in the program, with continued program focus to increase number of participants submitting blood glucose readings.

Group C: 340 participants submitting blood glucose readings to continue in the program, with continued proactive coach outreach to increase number of participants engaging in health coaching for behavior change.

Group D: 467 participants engaging only for testing supplies offered until February 1, 2020 to submit blood glucose readings or engage in health coaching for behavior change, or be removed from the program.

Option 2 Program Adjustments: Health Coaching Focus

All Enrollees: Participants who do not engage in health coaching for behavior change by the end of three (3) full months are removed from the program. Participants who engage in health coaching but not submitting readings are moved to a coaching only program that does not provide no-cost testing supplies or insulin injection supplies.

Group A: 1,776 participants engaging in both health coaching for behavior change and submitting blood glucose readings continue in the program.

Group B: 767 participants engaging in only coaching for behavior change to continue in the program. Participants not submitting blood glucose readings are offered until February 1, 2020 to submit readings, or lose access to no-cost testing supplies and insulin injection supplies. Cost to EBD for participants moved to coaching only program would be $40 PPPM starting in February.

Group C: 340 participants submitting blood glucose readings offered until February 1, 2020 to engage in health coaching for behavior change, or be removed from the program.

Group D: 467 participants engaging only for testing supplies offered until February 1, 2020 to engage in health coaching for behavior change, or be removed from the program.

Option 3 Program Adjustments: Strict Engagement

All Enrollees: Participants who do not engage in both health coaching for behavior change and submitting blood glucose readings by the end of three (3) full months are removed from the program.

Group A: 1,776 participants engaging in both health coaching for behavior change and submitting blood glucose readings continue in the program.

Group B: 767 participants engaging in only health coaching for behavior change offered until February 1, 2020 to submit blood glucose readings, or be removed from the program.

Group C: 340 participants only submitting blood glucose readings offered until February 1, 2020 to engage in health coaching for behavior change, or be removed from the program.

Group D: 467 participants engaging only for testing supplies offered until February 1, 2020 to engage in both health coaching for behavior change and submitting blood glucose readings, or be removed from the program.

Enrollment of Previously Disenrolled Participants

Participants who are disenrolled from the program become ‘inactive’ on the Kannact platform. These participants will have one opportunity to reenroll. They will be required to engage within three (3) months of reenrollment, or will be removed from the program with no option to enroll a third time.

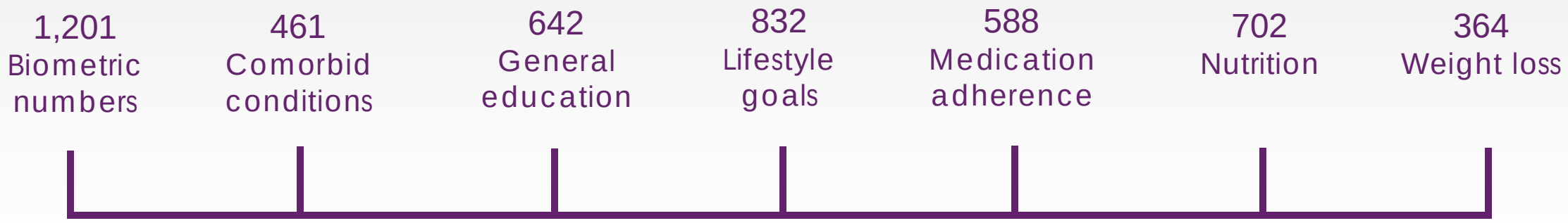
Appendix

Group A & B Coaching Topic Detail

2,533 (1,766+767)
Total participants in health coaching

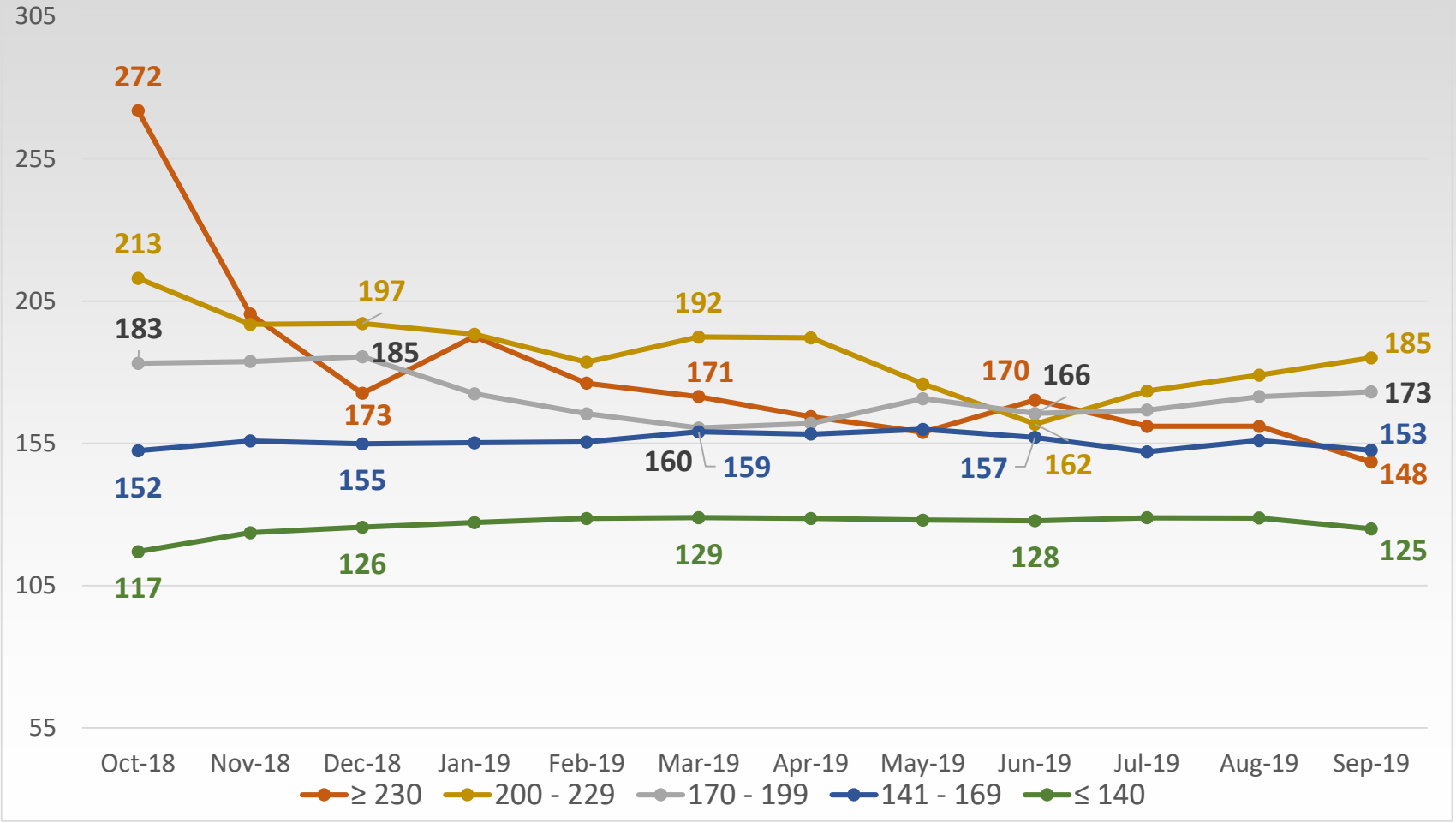
- 83% had successful engagement during October
- 17% did not have a successful engagement during October, coaches reach out after missed scheduled calls to re-engage

A breakdown of topics discussed during health coaching sessions includes:



Total health coaching topics
4,790

12-Month Trend Of 419 Participants who started in October 2018



348 of 419 are engaged in health coaching for behavior change

Requirements for Inclusion

- Began submitting blood glucose readings in October 2018
- Currently active in Kannact program

Participants placed in the following baseline groups based on October blood glucose average

Baseline Range	# of Participants
≥ 230	20
200 - 229	22
170 - 199	26
141 - 169	91
≤ 140	260

Thank You

State of Arkansas Employee Benefits Division

Interim Monitoring Report

Through October 31st

State and Public School Life and Health Insurance Benefit Subcommittee

Courtney White, FSA, MAAA
Scott Cohen, MPH

15 NOVEMBER 2019

Milliman

Agenda

- Education
  - High-Cost Claimants
- Arkansas State Employees (ASE)
  - Plan Experience
- Public School Employees (PSE)
  - Plan Experience
- Appendices
  A. Plan summary
  B. Assumptions / methodology
  C. Limitations & caveats

What is a High Cost Claimant (HCC)

Members who incur over a specified amount (e.g. $100,000) of medical and prescription drug claim costs over a specified period of time (usually a year)[1]

1. Finch, Kate, and Bruce Pyenson. *Benefit Designs for High Cost Medical Conditions*. Milliman, Inc., 2011, *Benefit Designs for High Cost Medical Conditions*, us.milliman.com/uploadedFiles/insight/research/health-rr/benefit-designs-high-cost.pdf.

Why HCC Matters?

- Can represent a significant portion of the plan sponsors liabilities
- Better understanding HCC may lead to better predictions
  - Are HCC acute or chronic?
  - What are the top conditions for HCC?
  - Are there programs to manage HCC?
  - How to reduce / mitigate HCC?

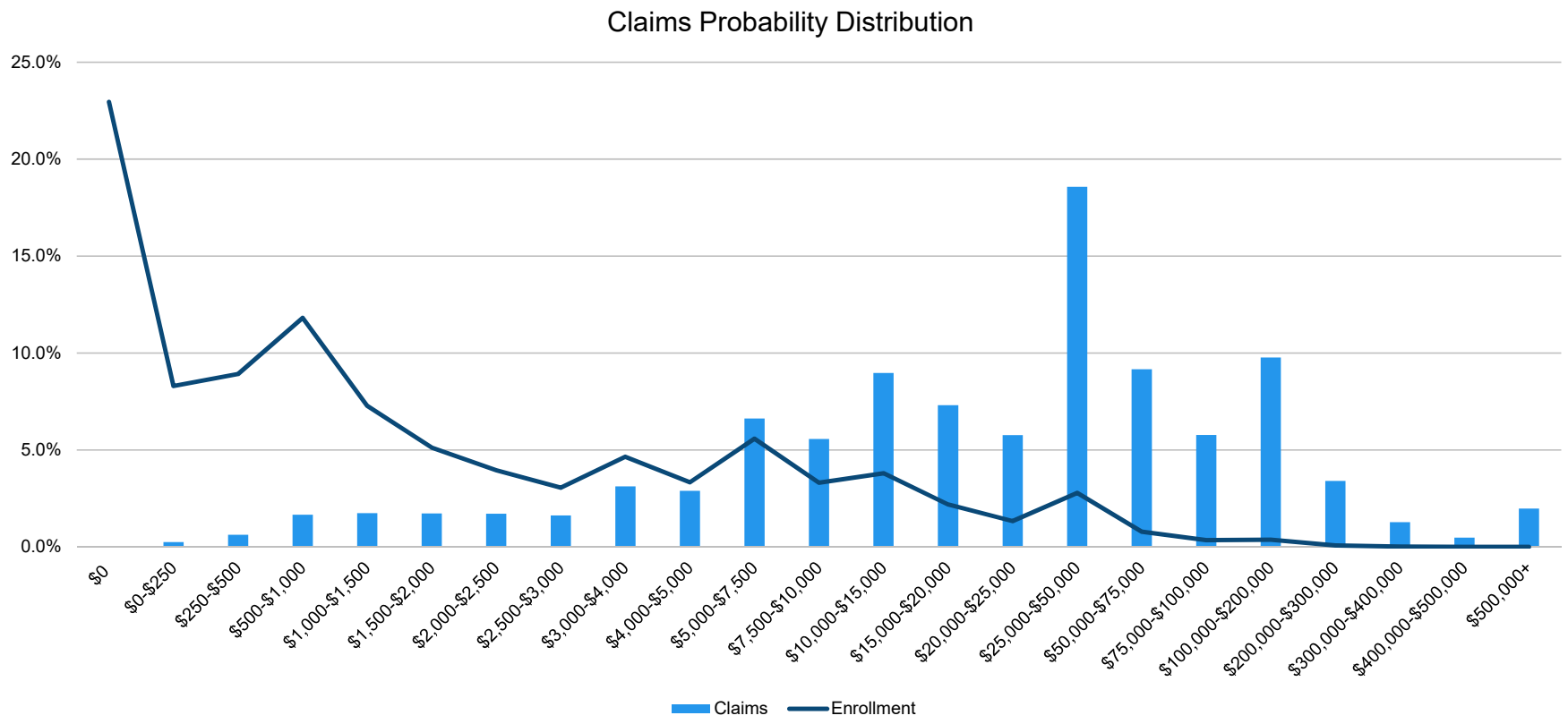
HCC Mitigation Strategy

Segment the population and develop plans to address each population's risk of incurring large claims totals. These are some potential segments:

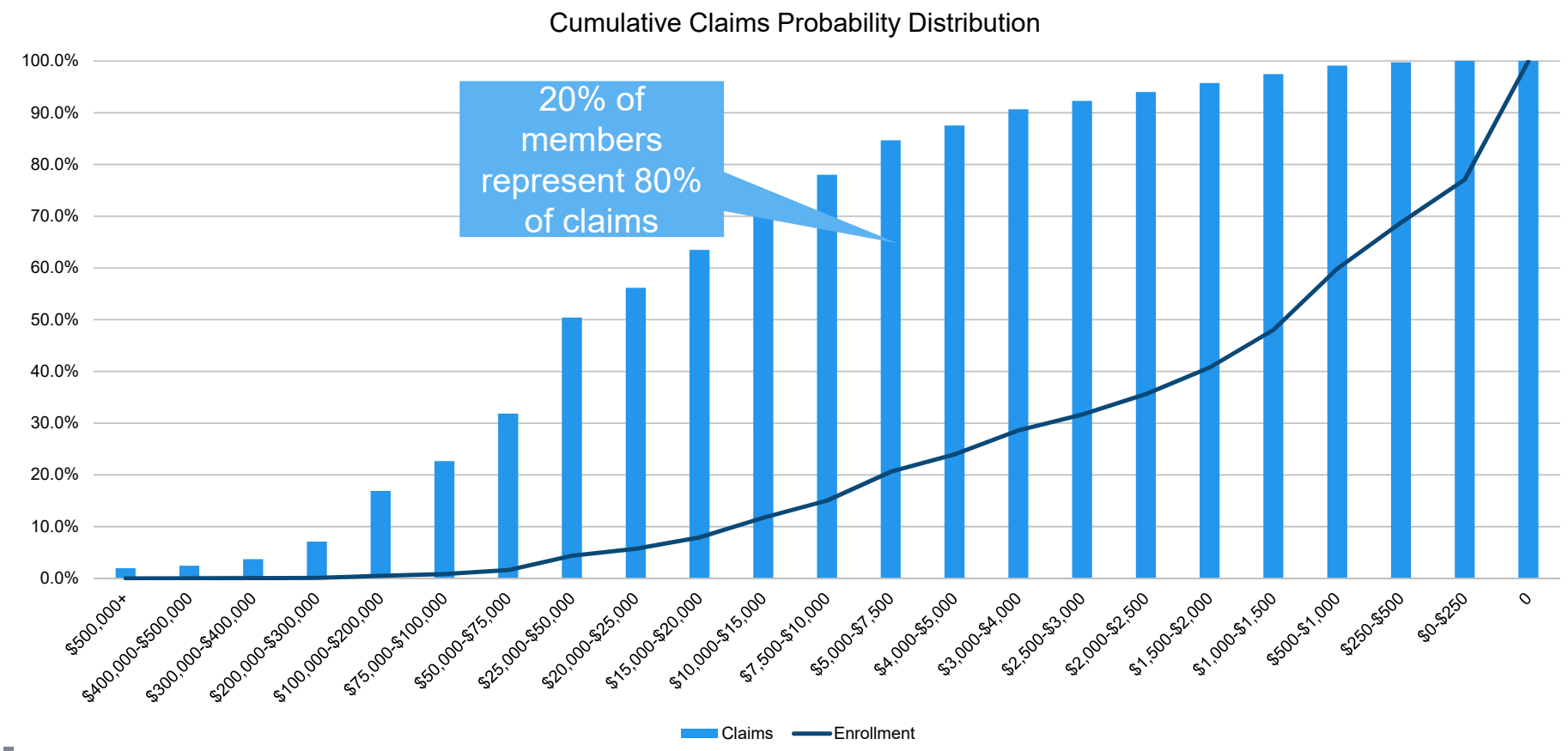
- Members with common chronic conditions – prevent complications
- Members on high-cost therapy – implement reasonable approval process and review process for ongoing approval. Negotiate better pricing.
- Complications during treatment – identifying and incenting use of high-quality providers, pre-surgical coaching to support optimal treatment choice and readiness for surgery and recovery if applicable
- Complications after treatment – case management

- Stop Loss Insurance
  - Passes liability from employer to insurer above a set threshold in return for premiums paid
  - Companies may chose to bare the risk of HCC themselves

Example – 2018 Claims & Enrollment



Example – 2018 Claims & Enrollment (cont.)



Arkansas State Employees (ASE)

Executive Summary

- Update projections show a slight reduction in net income of $1.0M in 2019 and reduction in net income of $4.2M in 2020. Changes are driven primarily by:
  - Reduction in budgeted headcounts
  - Lower medical claims costs
  - Lower than estimated pharmacy program savings
- 2019 plan experience
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- 2020 plan experience
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  - Estimated unallocated net assets at the end of 2020 is $13.1M
  - No plan changes / 5% increase in employee contributions

Total Plan Experience

Funding	2018	2019	2020
State Contribution	$ 174.70	$ 173.59	$ 172.26
Employee Contribution	96.70	97.49	102.94
Other	19.70	21.81	22.46
Total Income	$ 291.10	$ 292.89	$ 297.66
Medical Claims	$ (201.40)	$ (195.96)	$ (207.35)
Pharmacy Claims	(81.90)	(88.19)	(97.09)
Administration Fees[1]	(22.70)	(18.26)	(17.57)
Plan Administration	N/A	(2.93)	(2.95)
Total Expenses	$ (306.00)	$ (305.35)	$ (324.97)
Pharmacy Savings	$ -	$ 2.90	$ 8.75
Net Income / (Loss) Before Reserve Allocation	$ (14.90)	$ (9.56)	$ (18.56)
Allocation of Reserves	$ 18.00	$ 21.70	$ 25.10
Net Income / (Loss) After Reserve Allocation	$ 3.10	$ 12.15	$ 6.54

Average Membership			
Active Employees / Pre-65 Retirees	48,092	47,722	47,722
Post-65 Retirees	12,914	13,352	13,753
Total Enrolled	61,007	61,074	61,475

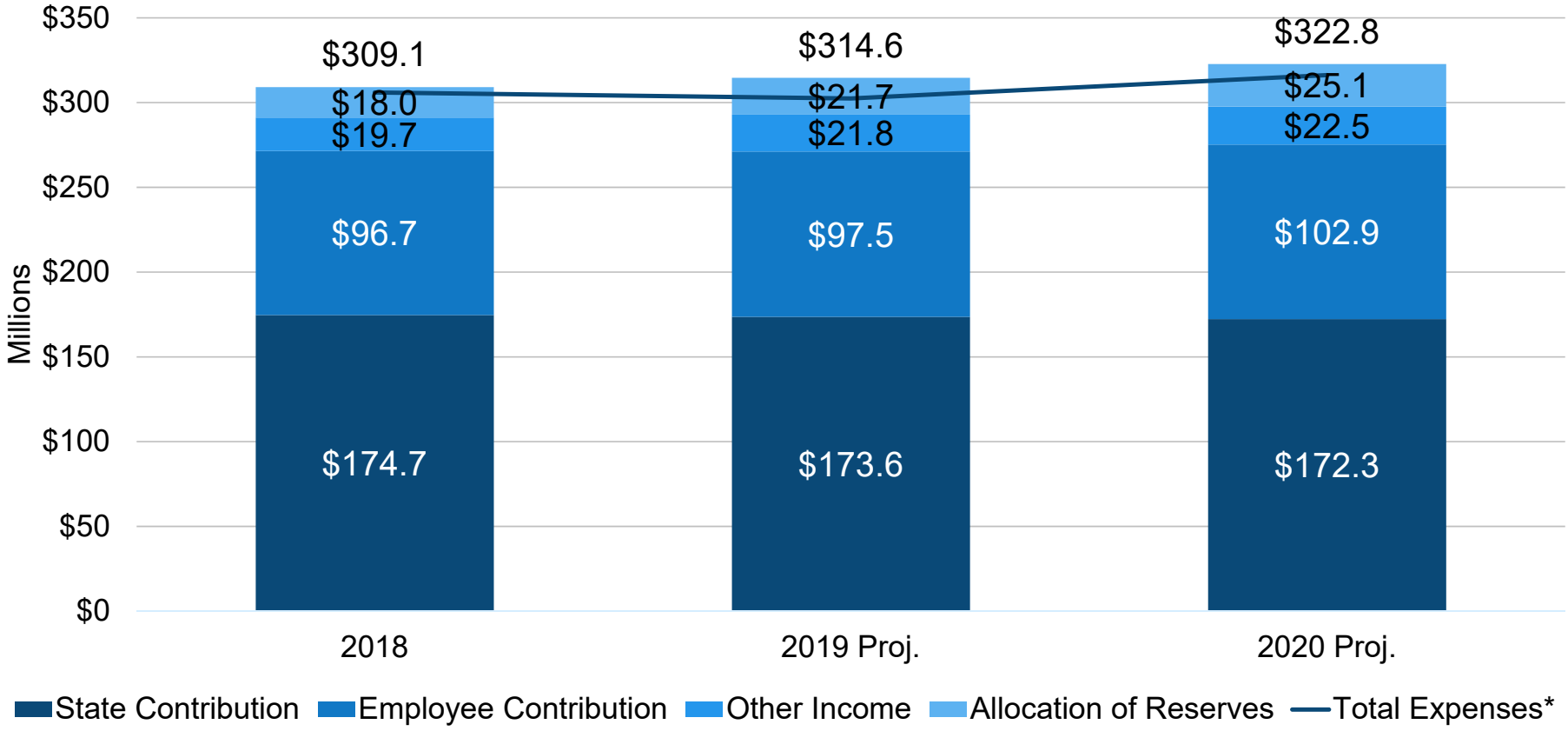
Total Income PMPM[2]	$ 422.22	$ 429.26	$ 437.53
Total Expenses PMPM[3]	$ (417.99)	$ (412.68)	$ (428.66)

[1] 2018 Administration Fees included Plan Administration

[2] Allocation of Reserves included in Total Income

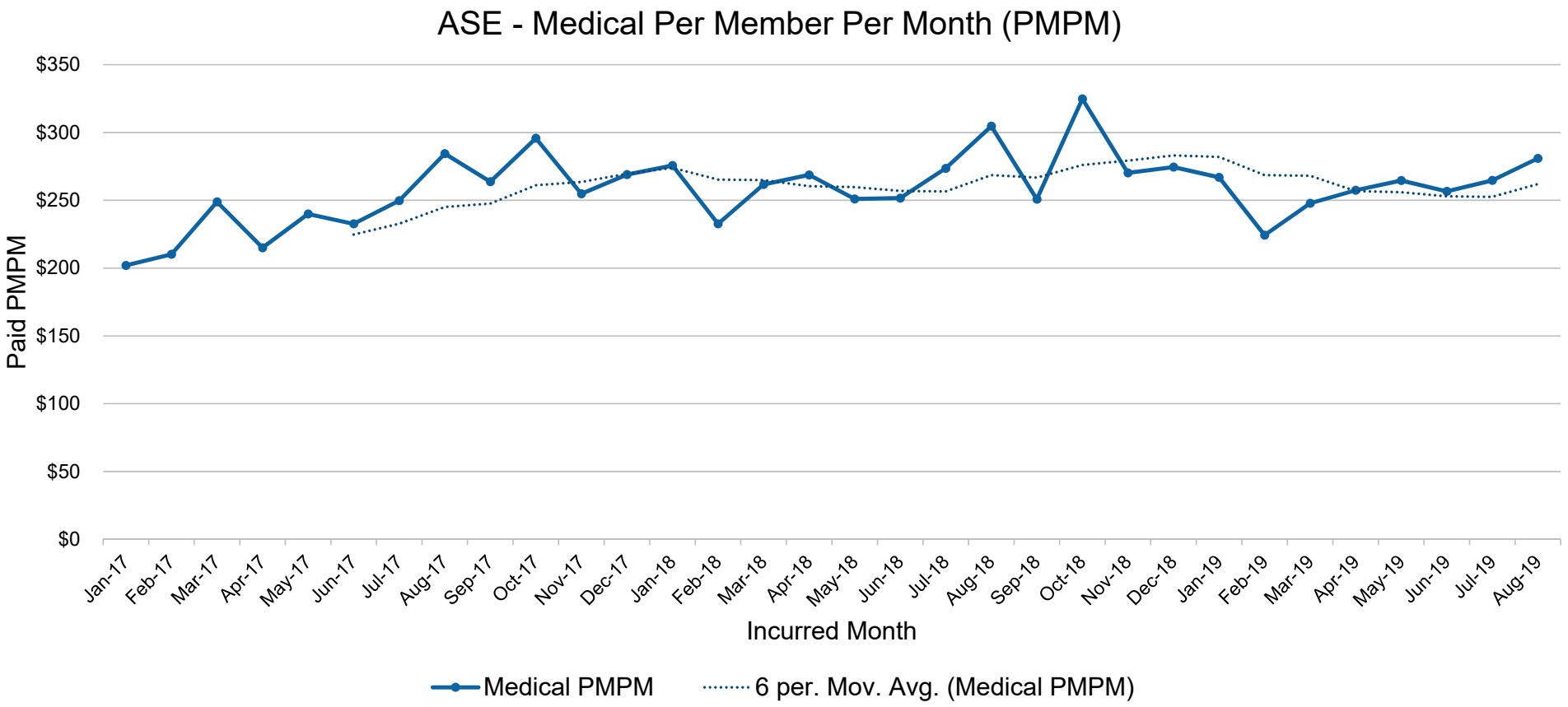
[3] Total Expenses offset by Pharmacy Savings

Income vs. Expenditure

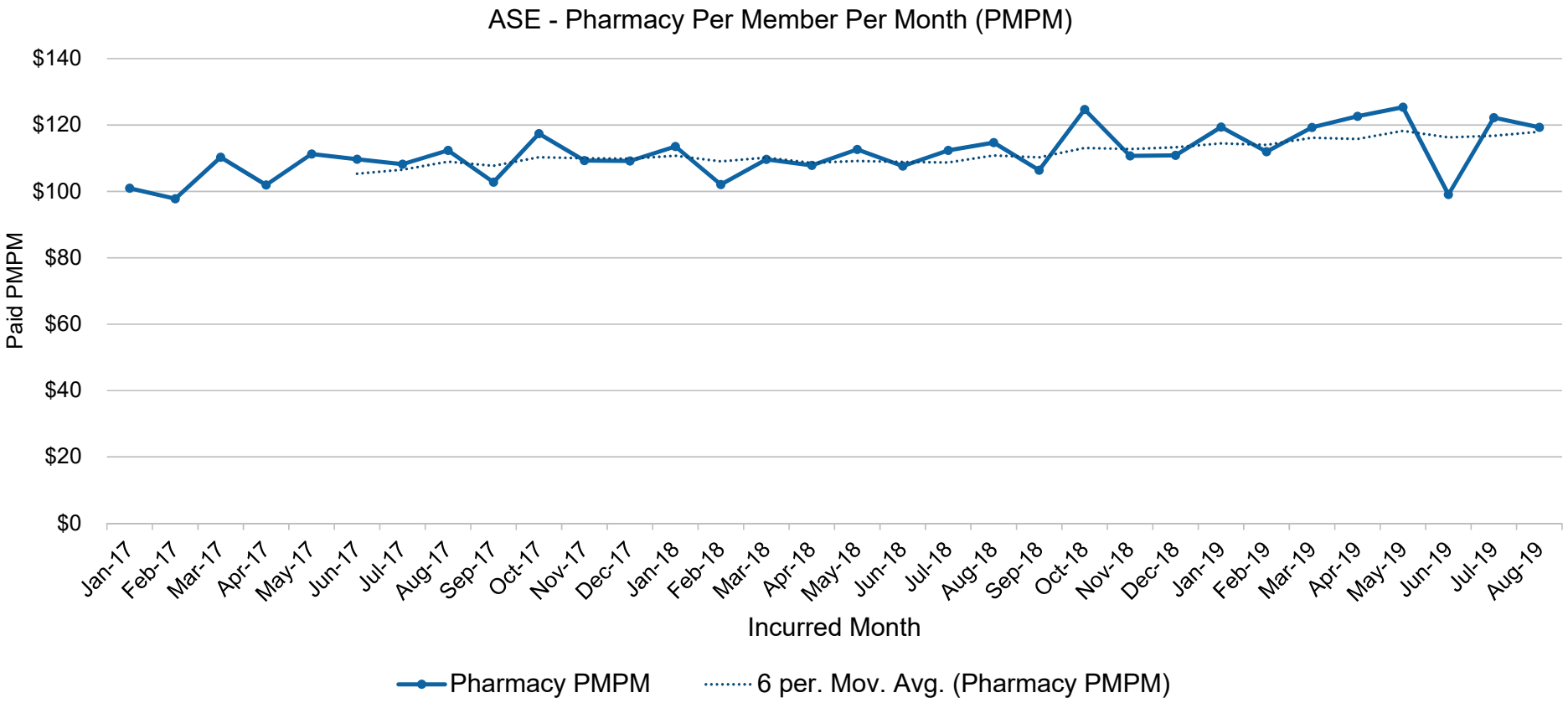


* Total Expenses offset by Pharmacy Savings

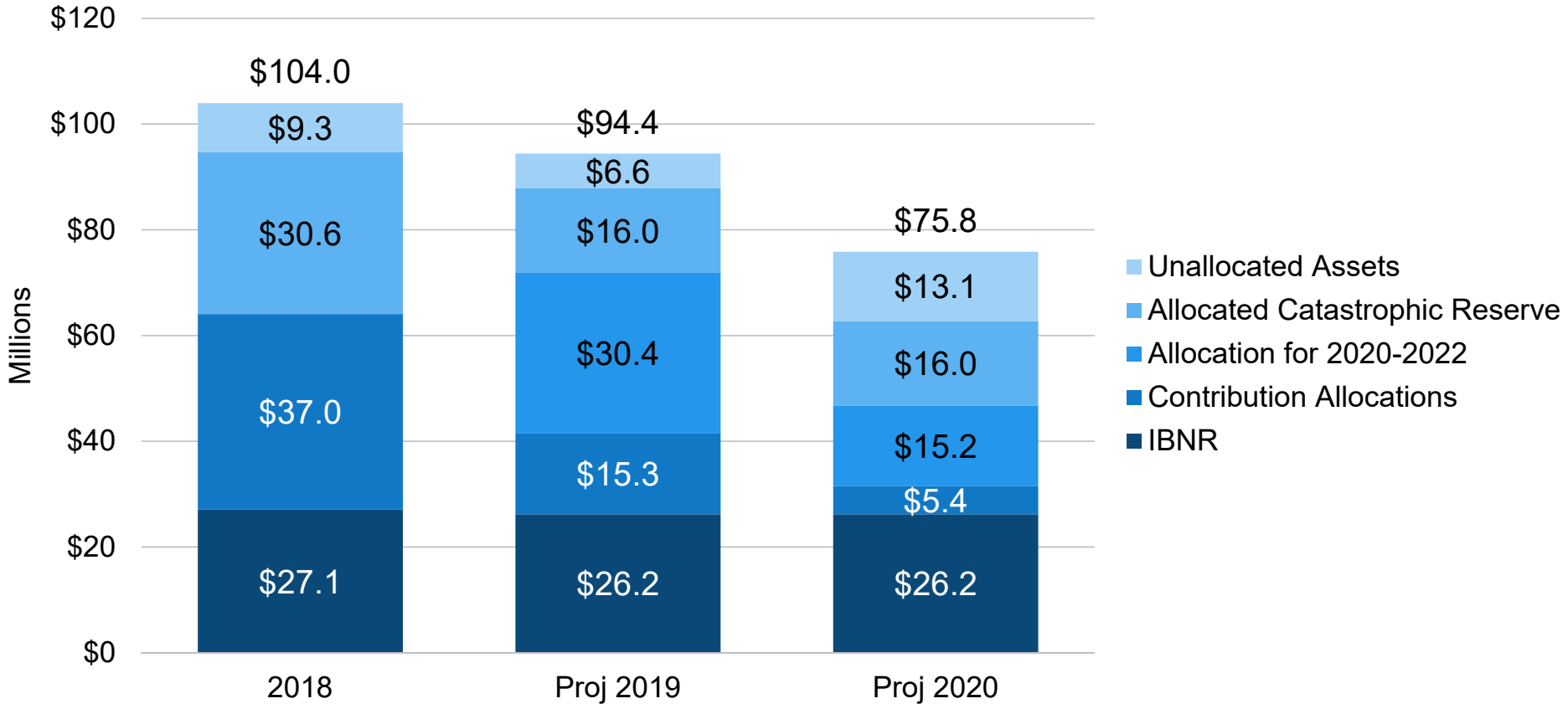
Trend Study – Medical



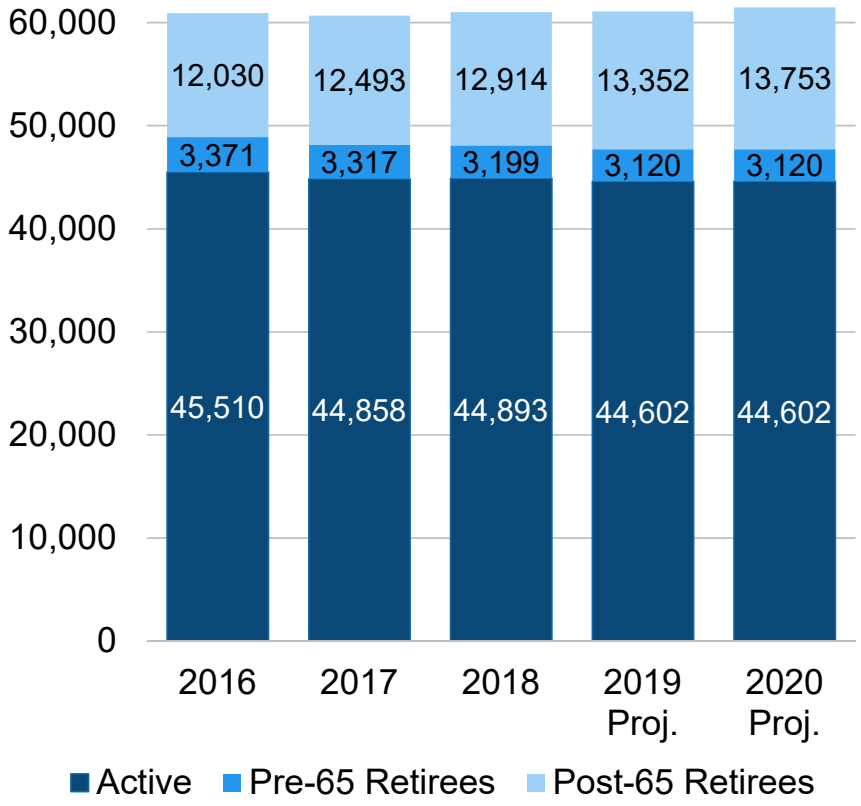
Trend Study – Pharmacy

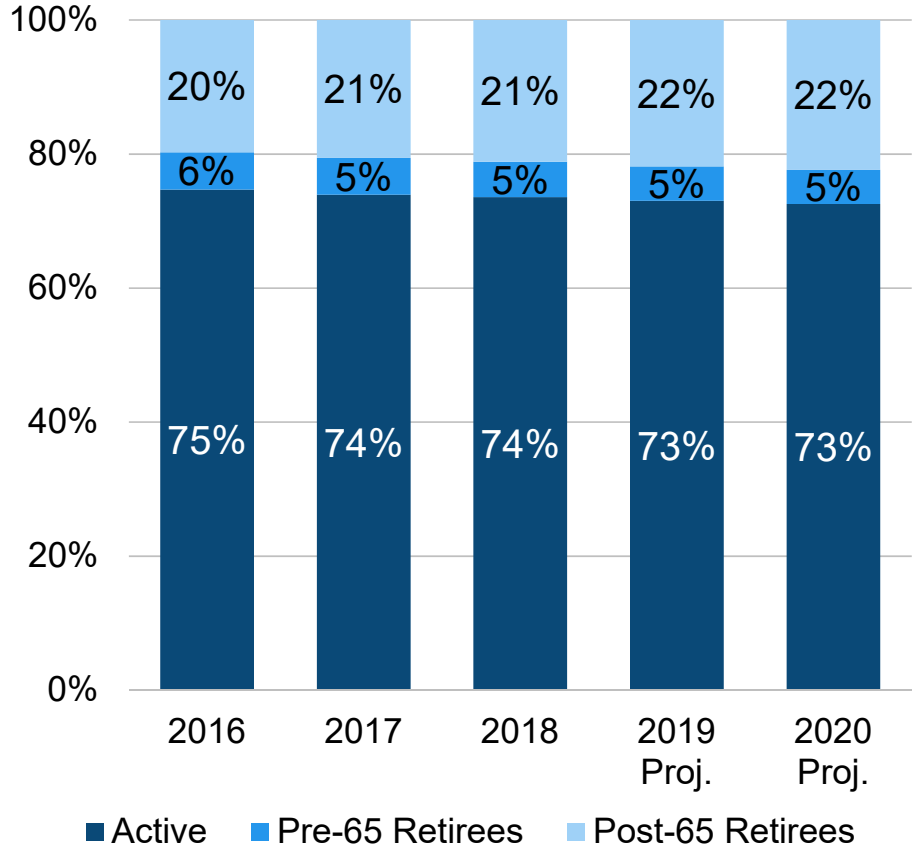


End of Year Assets



ASE - Average Membership by Status





Public School Employees (PSE)

Executive Summary

- Update projections show a slight increase in net income of $2.1M in 2019 and $1.2M in 2020. Changes are driven primarily by:
  - Lower medical claim cost
  - Slightly higher pharmacy claim cost
  - Lower than estimated pharmacy program savings
  - Incorporated increase in PPE funding for 2020
- 2019 plan experience
  - Estimated deficit of $270K
  - Estimated unallocated net assets at the end of 2019 is $13.3M
- 2020 plan experience
  - Allocated reserves for 2020 is $25.2M
  - Estimated deficit of $4.6M
  - Estimated unallocated net assets at the end of 2020 is $8.8M
  - No plan changes / 0% increase to employee contributions

Total Plan Experience

Funding	2018	2019	2020
PPE Funding	N/A	$ 102.40	$ 106.32
Employee Contribution[1]	217.40	121.09	125.11
Dept of Ed Funding	88.10	88.10	88.10
Other	13.80	15.16	15.79
Total Income	$ 319.30	$ 326.75	$ 335.33
Medical Claims	$ (235.20)	$ (248.13)	$ (271.32)
Pharmacy Claims	(56.80)	(62.47)	(69.38)
Administration Fees[2]	(30.90)	(28.62)	(28.10)
Plan Administration	N/A	(2.49)	(2.58)
Total Expenses	$ (322.90)	$ (341.71)	$ (371.37)
Pharmacy Savings	$ -	$ 2.04	$ 6.25
Net Income / (Loss) Before Reserve Allocation	$ (3.60)	$ (12.92)	$ (29.79)
Allocation of Reserves	$ 4.50	$ 12.66	$ 25.22
Net Income / (Loss) After Reserve Allocation	$ 0.90	$ (0.27)	$ (4.57)

Average Membership			
Active Employees / Pre-65 Retirees	79,949	82,296	84,648
Post-65 Retirees	13,536	14,287	15,144
Total Enrolled	93,485	96,582	99,792

Total Income PMPM[3]	$ 288.64	$ 292.85	$ 301.09
Total Expenses PMPM[4]	$ (287.84)	$ (293.08)	$ (304.90)

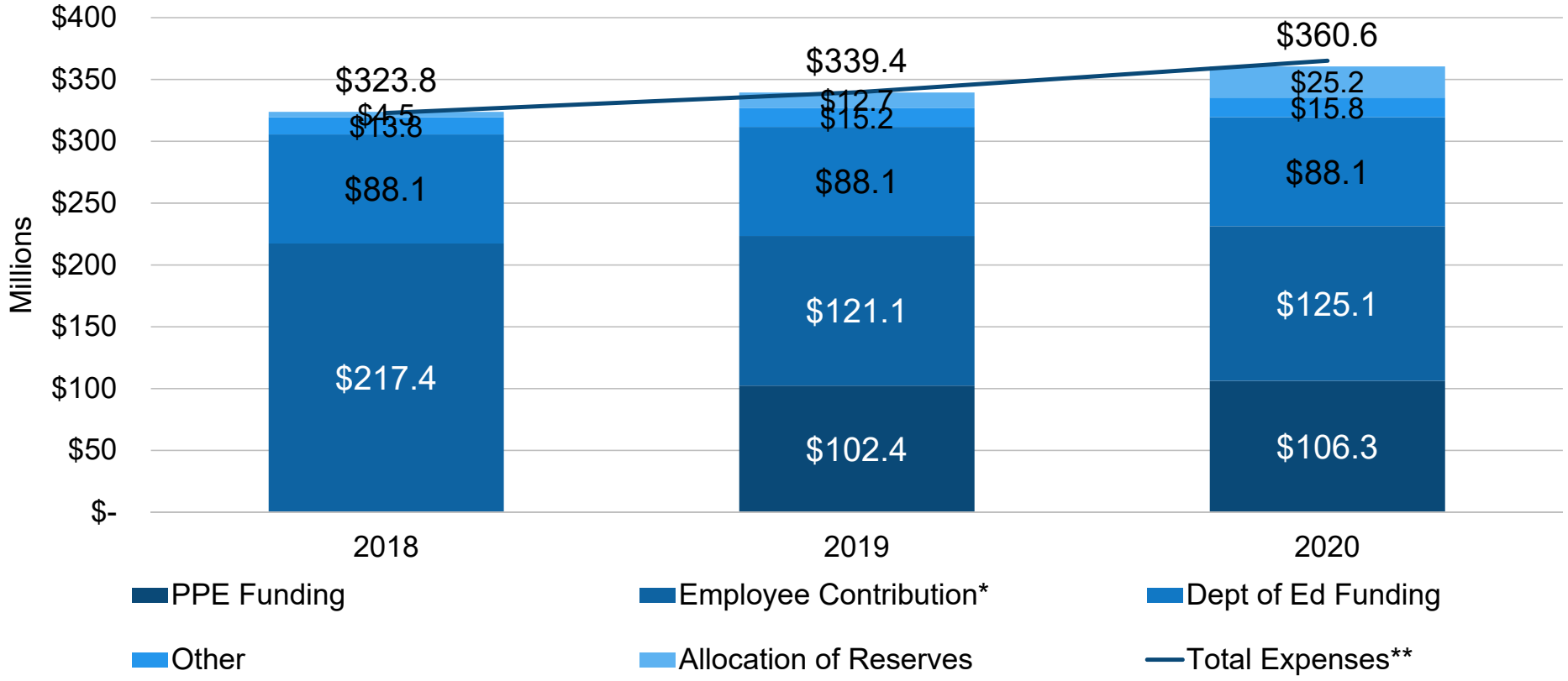
[1] 2018 Employee Contribution included PPE Funding and Allocation from Department of Education

[2] 2018 Administration Fees included Plan Administration

[3] Allocation of Reserves included in Total Income

[4] Total Expenses offset by Pharmacy Savings

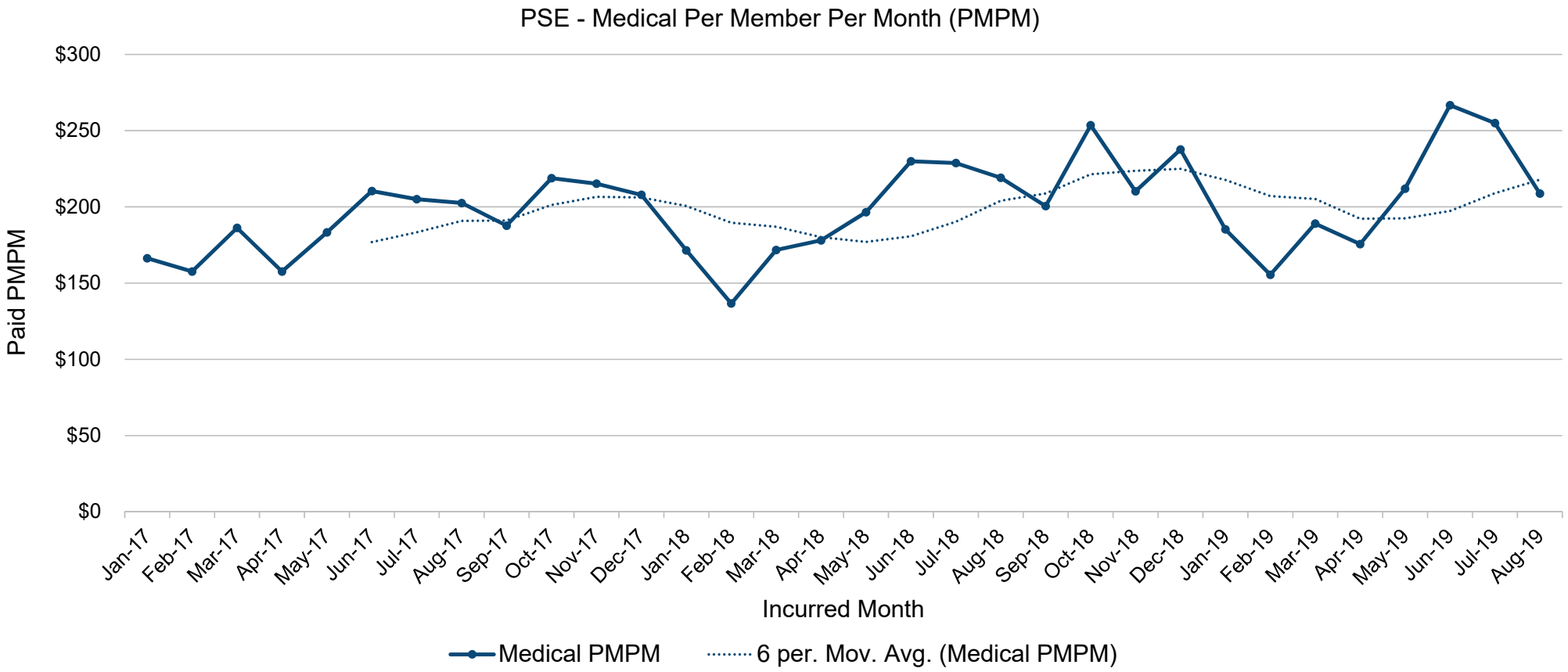
Income vs. Expenditure



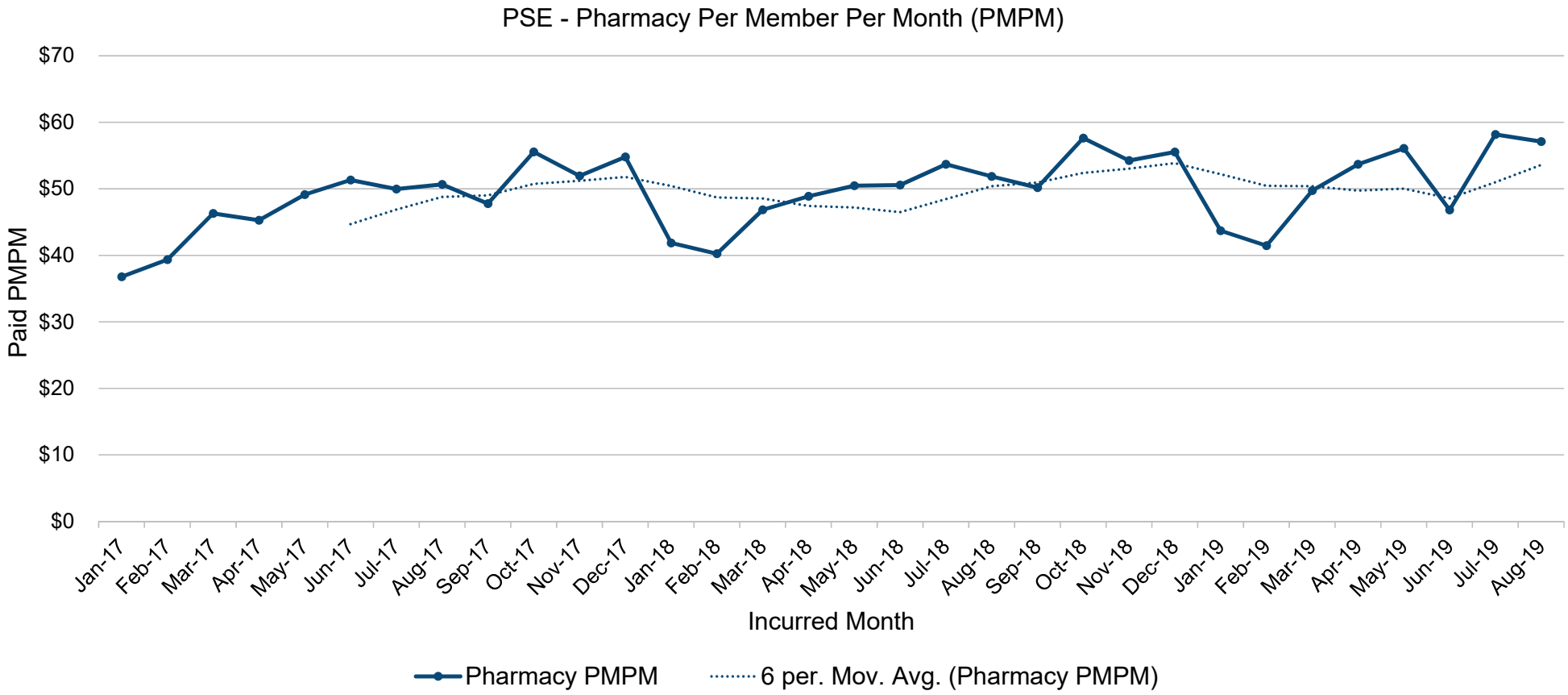
* 2018 Employee Contribution includes PPE Funding

** Total Expenses offset by Pharmacy Savings

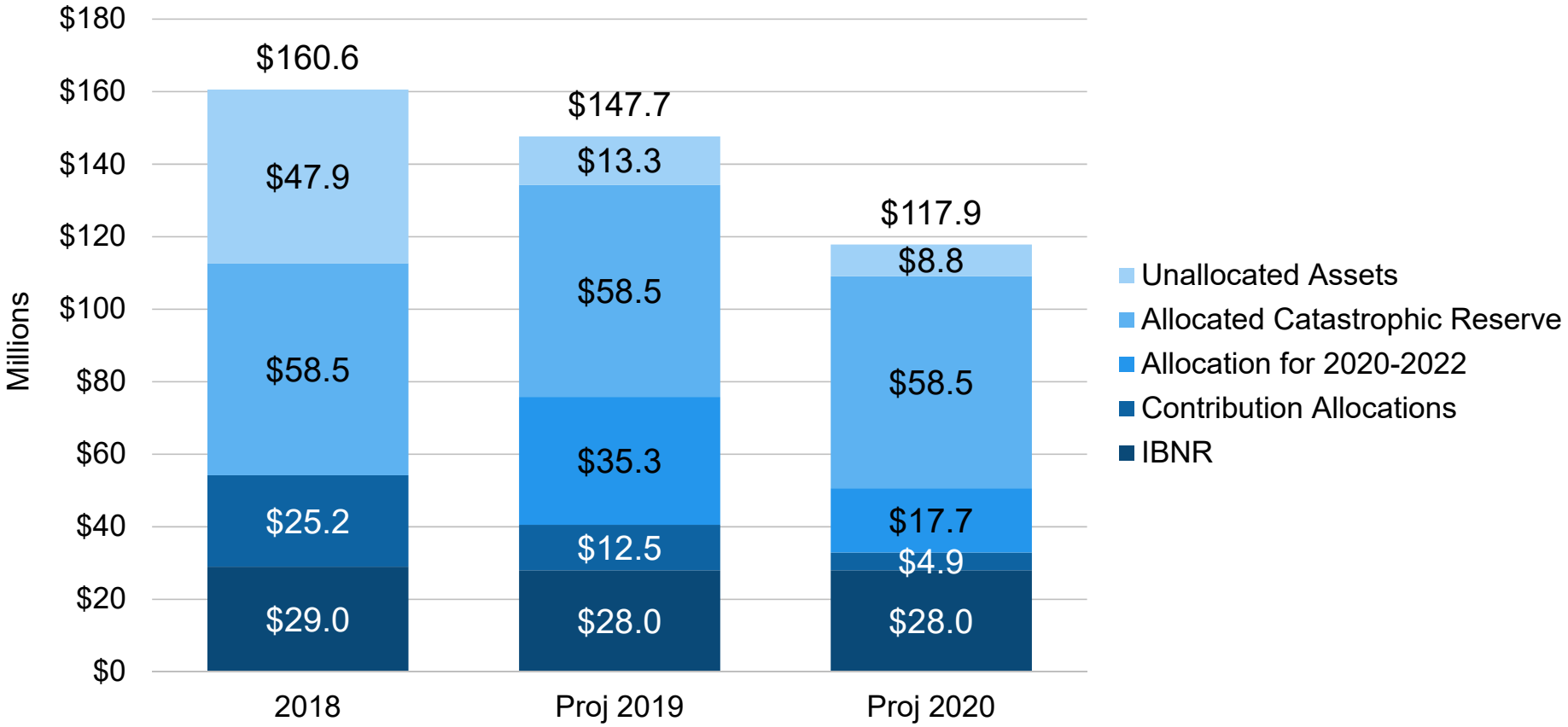
Trend Study – Medical



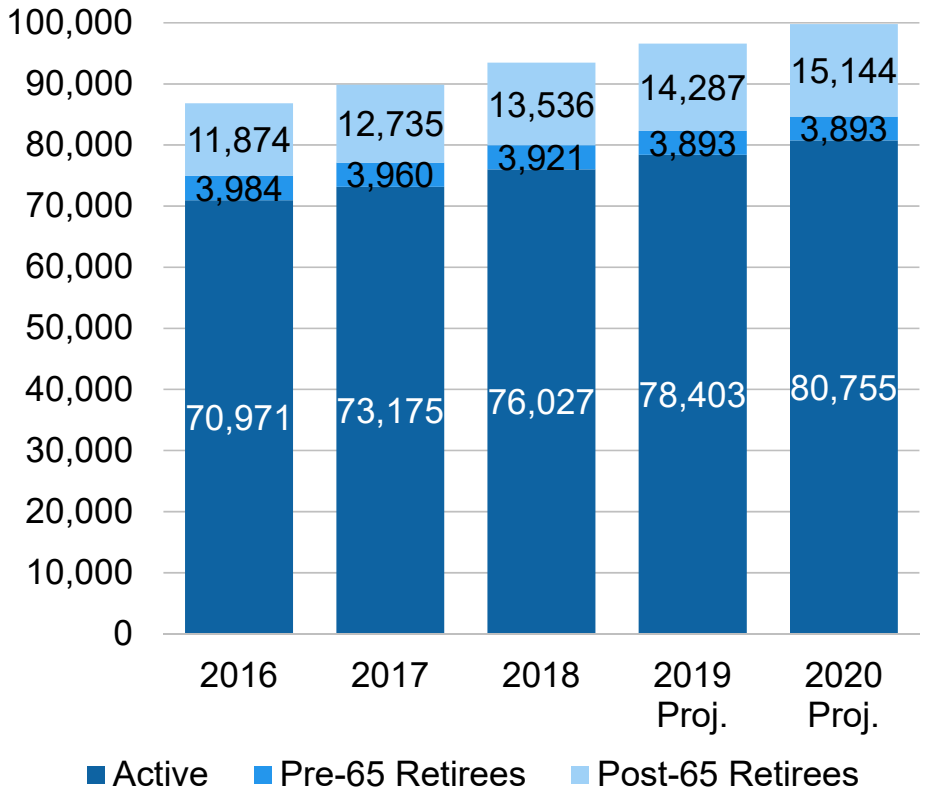
Trend Study – Pharmacy

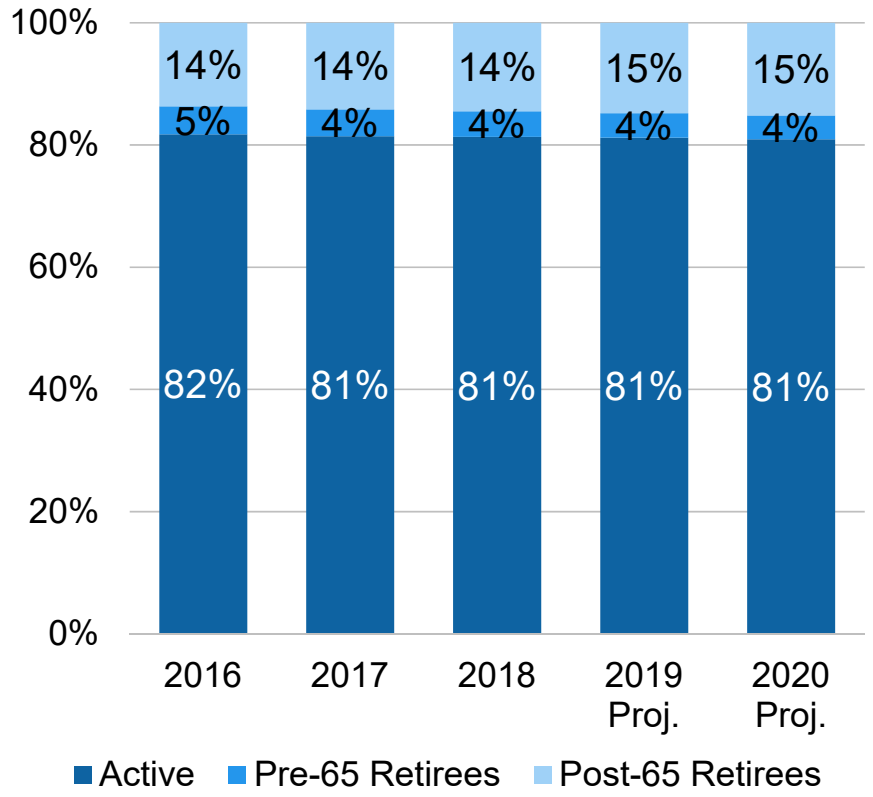


End of Year Assets



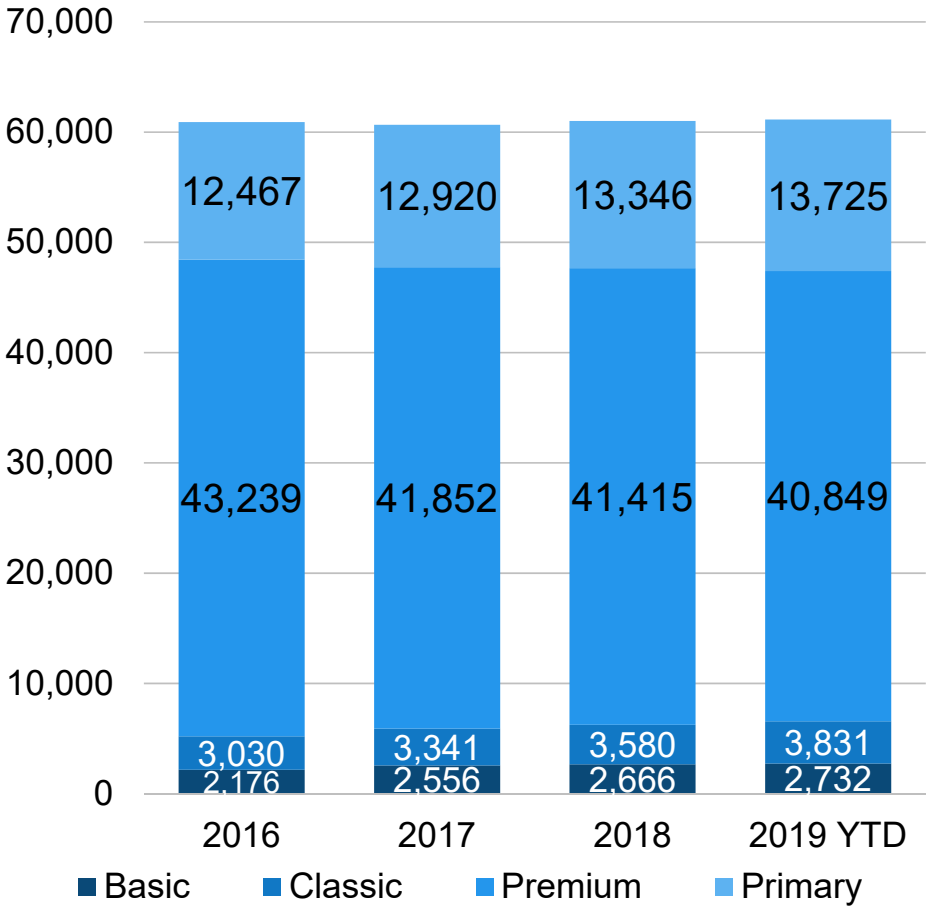
PSE - Average Membership by Status

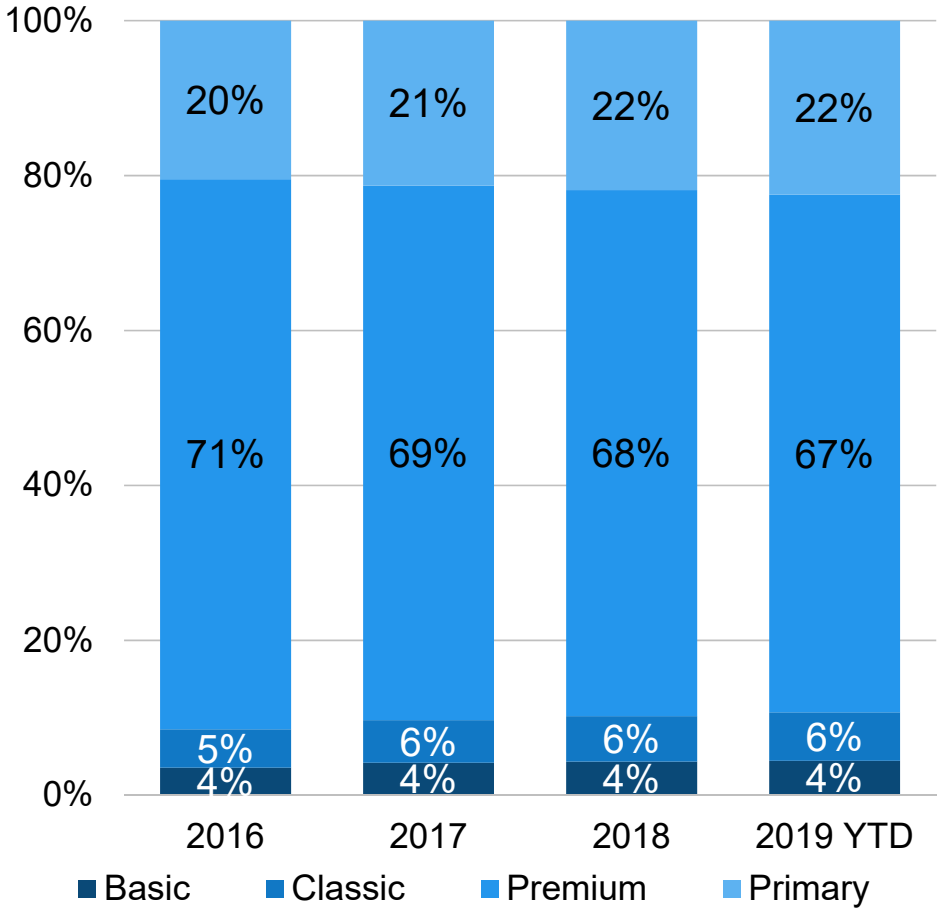




Appendix

Average Membership by Plan





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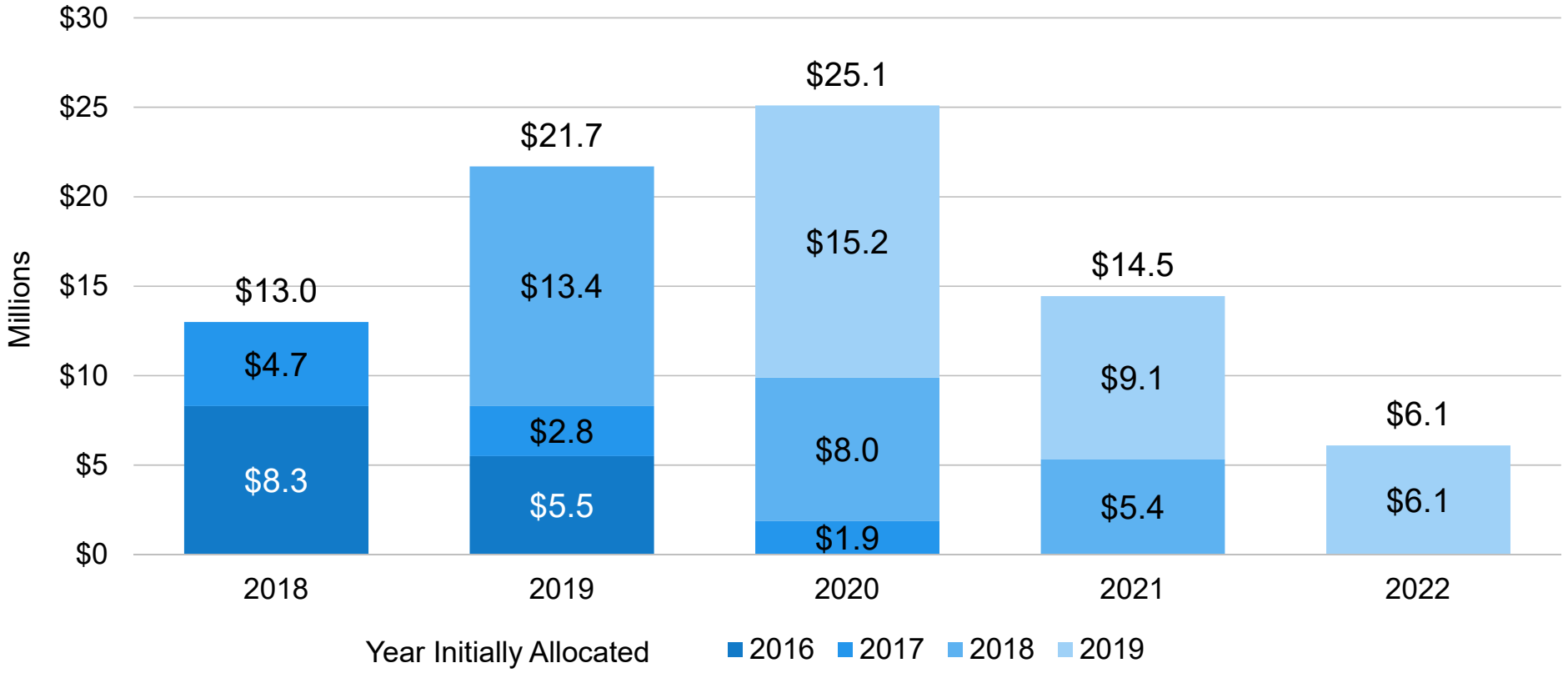
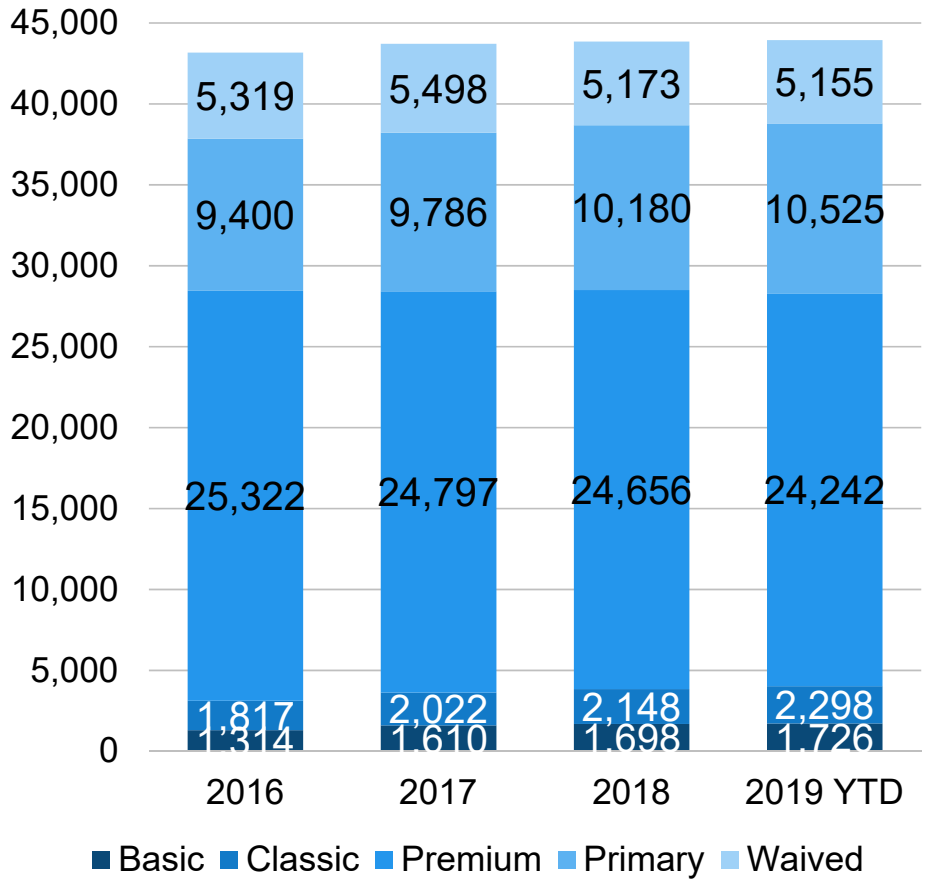
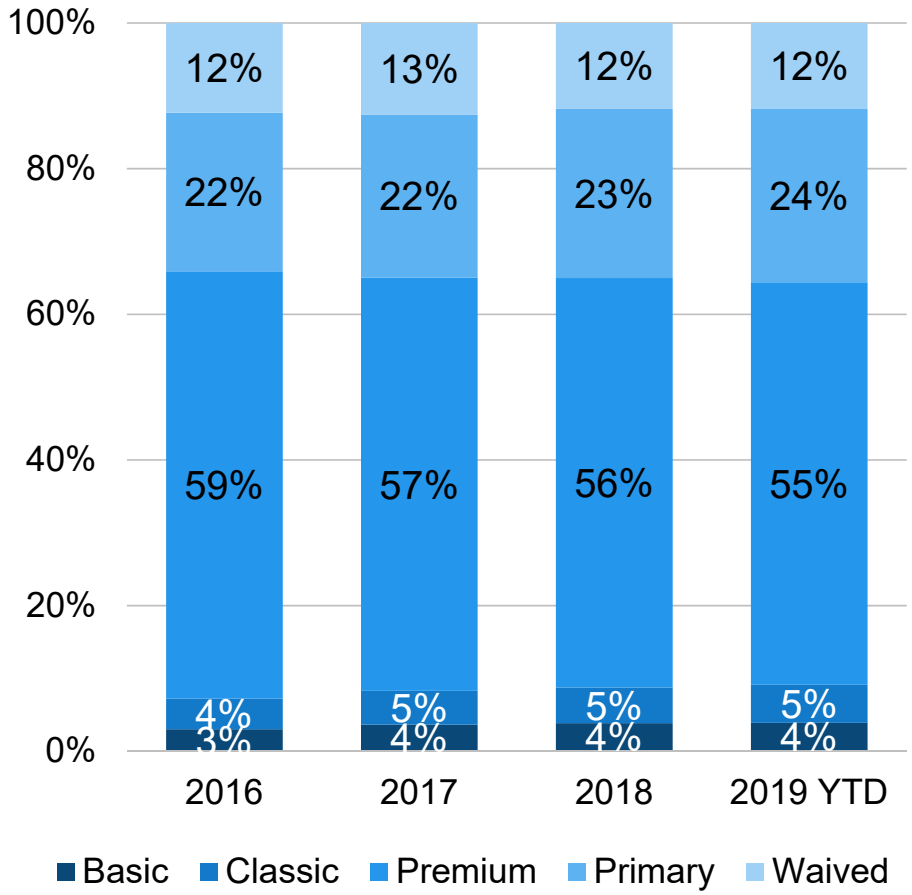
ASE - Reserves Allocation by Year

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



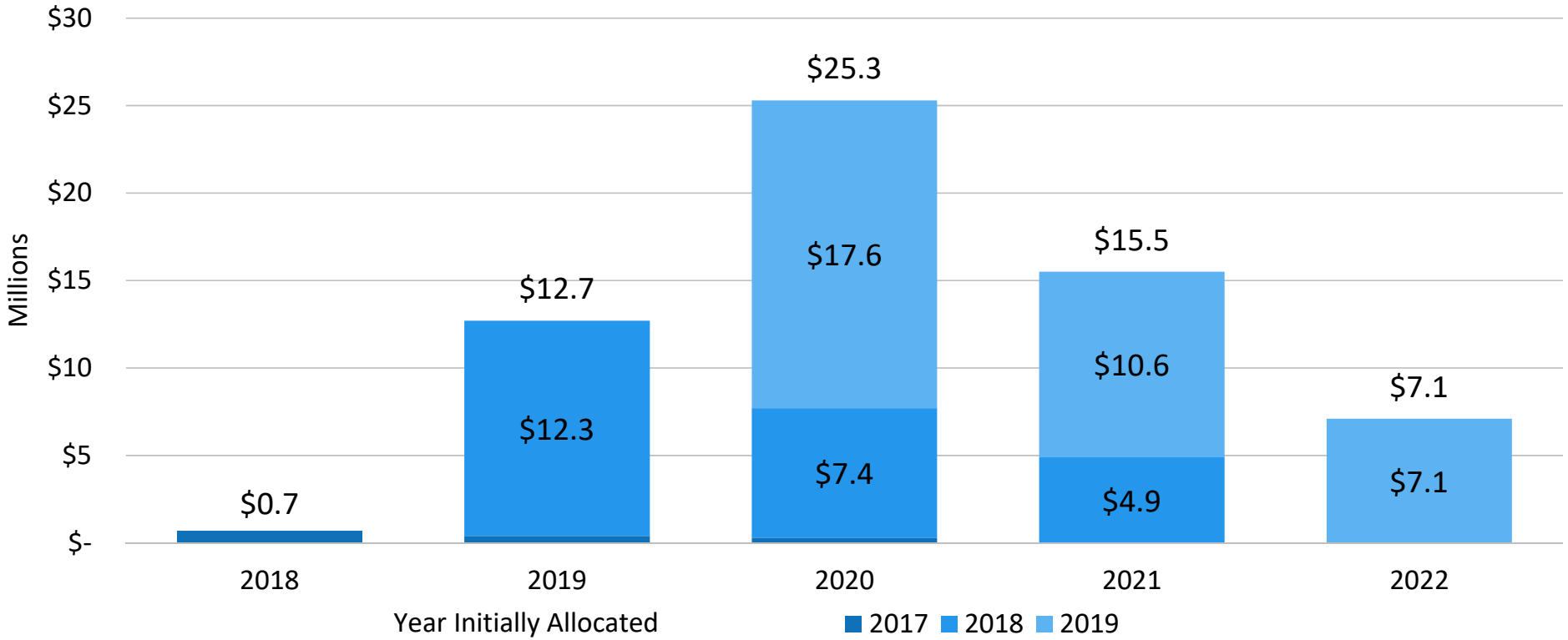
ASE - Average Enrollment (Subscribers) by Plan



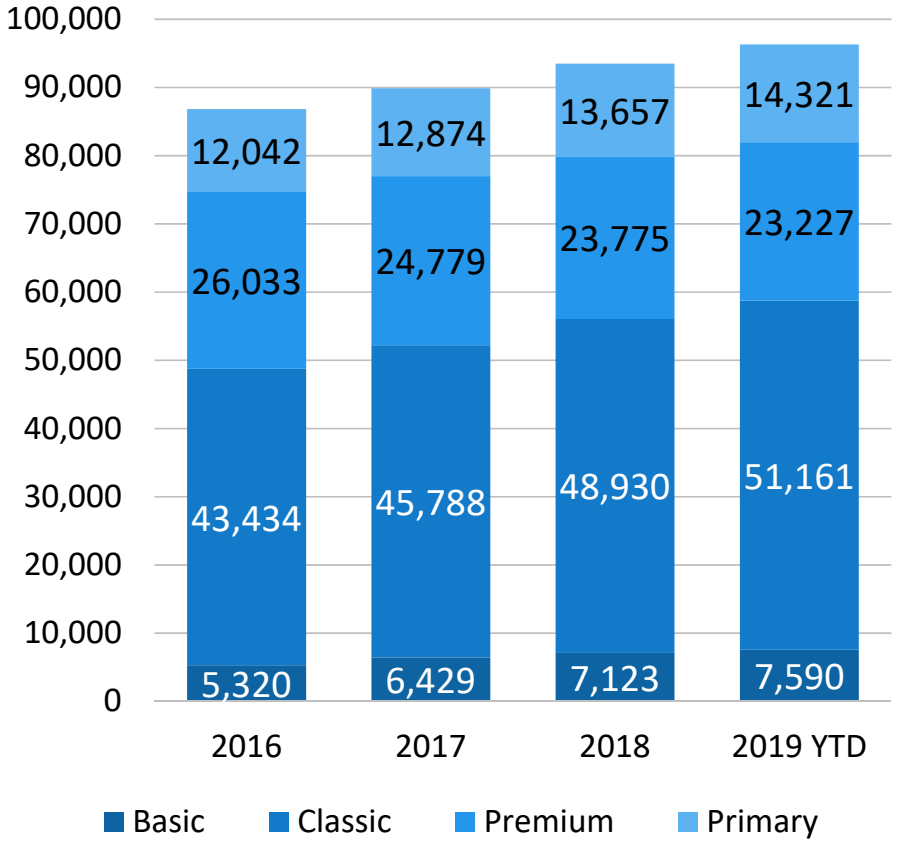


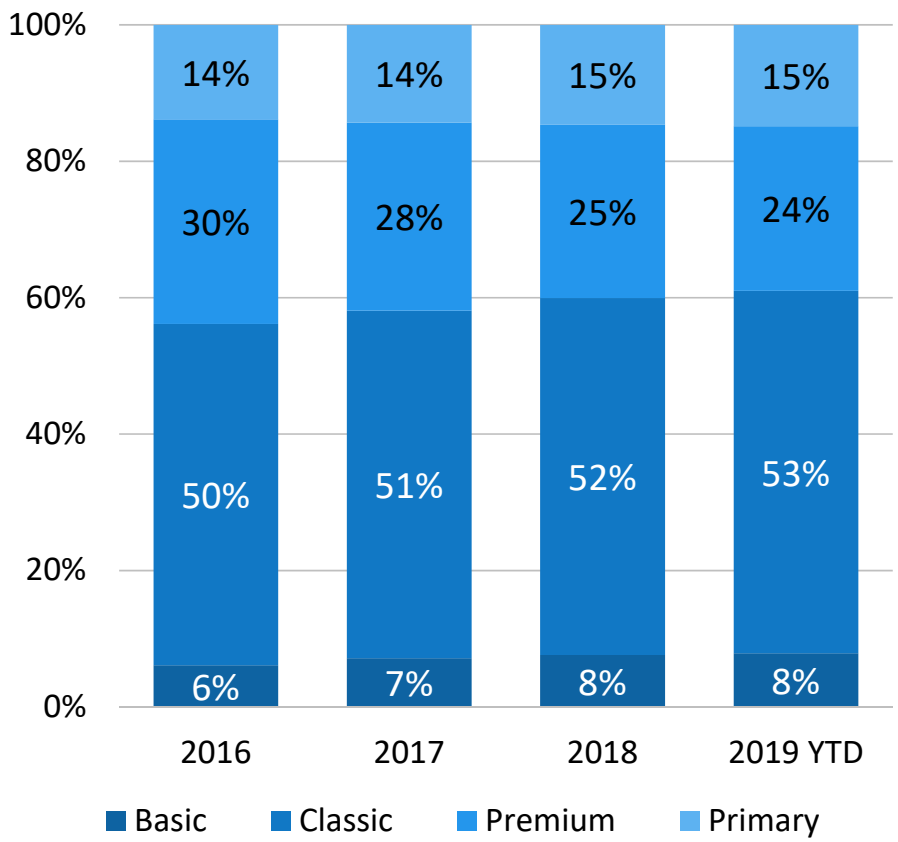
PSE - Reserves Allocation by Year

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

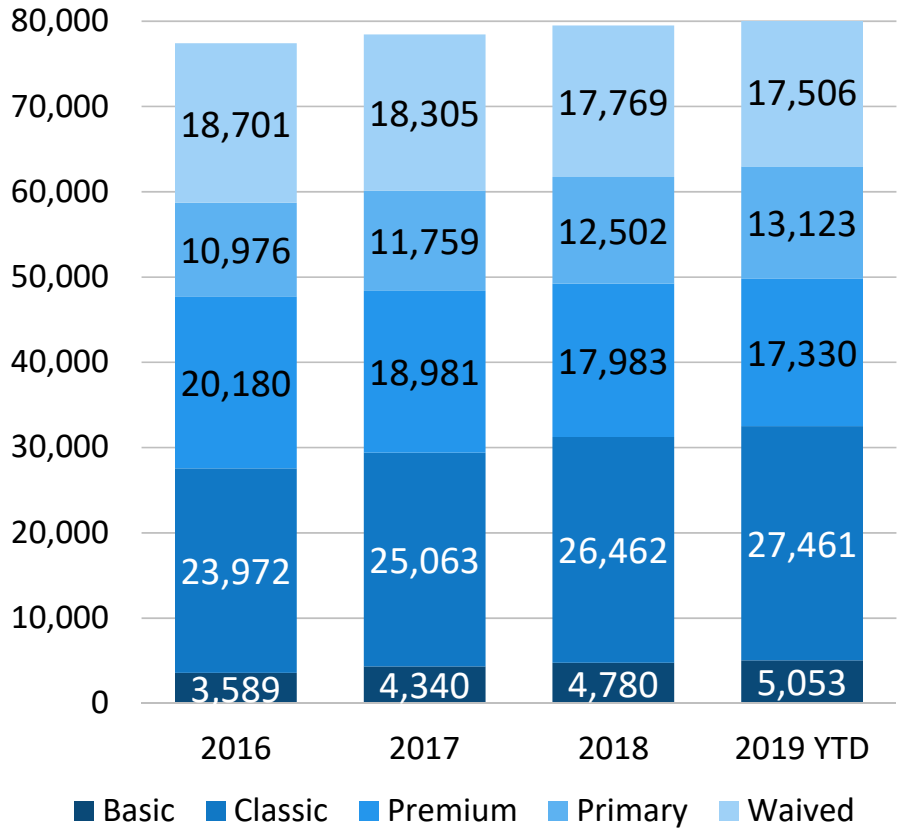


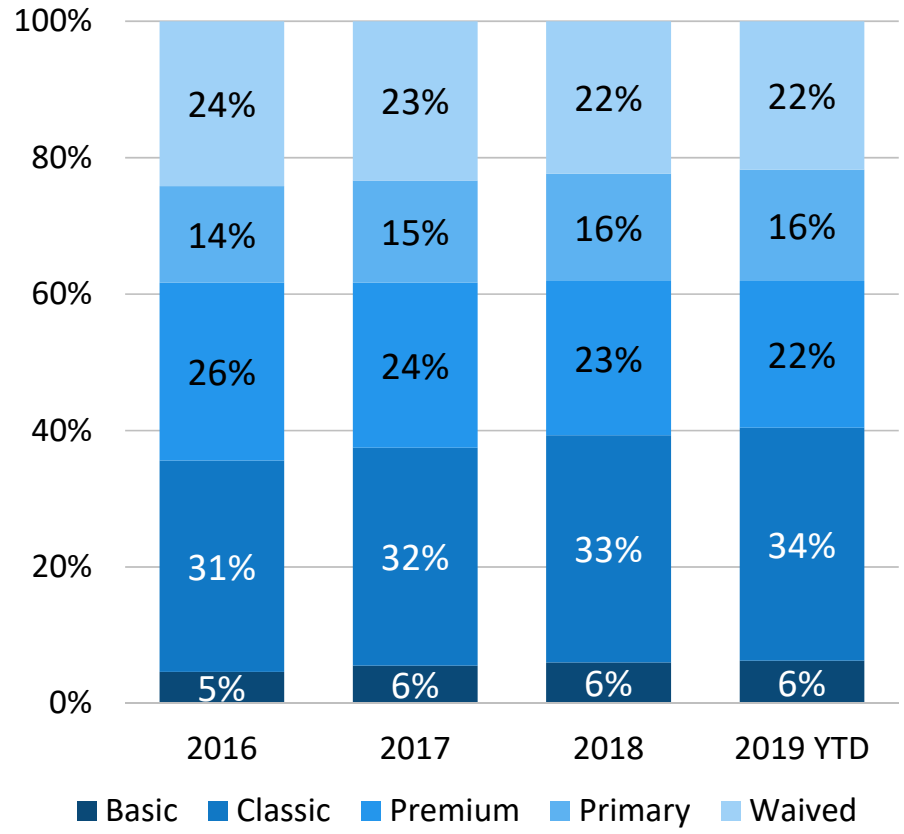
Average Membership by Plan





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	6.0% 5.0%	8.0% 8.0%

Assumptions & Methodology

Assumptions – Benefit Plan Changes (2018 to 2020)

- ASE
  - No significant plan cost changes for Active, Pre-65, and Post-65 benefit plans
- PSE
  - No changes for Post-65 benefit plan
  - Active and Pre-65 (2019 changes)
    - Premium
      - Deductible decrease from $1,000 to $750 (individual)
      - Out-of-Pocket Maximum (OOPM) decrease from $3,500 to $3,250 (individual)
      - Pharmacy OOPM increase from $3,100 to $3,350 (individual)
    - Classic
      - Deductible decrease from $2,000 to $1,750 (individual)
      - Medical coinsurance limit increase from $4,450 to $4,700 (individual)
    - Basic
      - Deductible decrease from$4,250 to $4,000 (individual)
      - Medical coinsurance limit increase from $2,200 to $2,450 (individual)

Assumptions & Methodology

Assumptions – Other

- Age/Gender
  - Age/Gender factor based on Milliman Health Cost Guidelines™
- Enrollment Projections
  - Actual enrollment utilized for January 2019 through September 2019
  - Projected October – December 2019 based on historical seasonality pattern
  - Projected 2020 based on historical trend rates
- Pharmacy Savings
  - $1.25 million in savings per month beginning in September 2019. Allocated between ASE / PSE based on pharmacy claims expense.
  - Pharmacy claims starting to reflect savings beginning in June 2019
- QualChoice Run-out Administration Fees
  - Actual run-out fees through August 2019
- Plan Administration Expense
  - ASE - $4.00 PMPM for CY2019 ($4.00 PMPM for CY2020)
  - PSE - $2.15 PMPM for CY2019 ($2.16 PMPM for CY2020)

Assumptions & Methodology

Methodology

1. Summarized fee-for-service (FFS) medical and pharmacy claims incurred from September 1, 2018 to August 31, 2019 and paid from September 1, 2018 to October 31, 2019. Medical claims include withholds starting January 2019.
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 September 1, 2018 to August 31, 2019.
4. Divided the summarized incurred claims by the appropriate member months to calculate PMPMs.
5. 2019 Projection composed of actual claims experience from January 2019 – August 2019 along with projected claims experience from September 1, 2019 – December 31, 2019.
6. 2020 Projected the incurred claims PMPM from the midpoint of the experience period (March 1, 2019) to the midpoint of the projection period (July 1, 2020) .
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 is a Member 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 2019 and 2020 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, 2018 and 2019 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 CY2019 and CY2020. It may not be appropriate for other purposes. Milliman does not intend to benefit any third party from this analysis.

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Thank you

Courtney White, FSA, MAAA
Scott Cohen, MPH