AGENDA

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

April 10th, 2020
10:00 a.m.

EBD Board Room – 501 Building, Suite 500

I. Call to Order..... Susan Gardner, Chair

II. Approval of February Minutes..... Susan Gardner, Chair

III. Diabetic Supply/Options ..... Dwight Davis & Micah Bard, UAMS EBRx

IV. Plan Update.....Paul Sakhrani & Courtney White, Milliman

V. Director's Report .....Chris Howlett, EBD Director

VI. Adjournment..... Susan Gardner, Chair

2020 Upcoming Meetings:

May 15th, June 12th, July 17th

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 April 10, 2020, at 10:00 a.m. via teleconference

Date | *time* 4/10/2020 10:00 AM | *Meeting called to order by* Susan Gardner, Chair

In Attendance

Members Present

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

Members Absent

Others Present

Rhoda Classen, Shalada Toles, Laura Thompson, Stella Greene, Theresa Huber, Terri Freeman, EBD; Ronda Walthall, ARDOT; Elizabeth Montgomery, ACHI; Jessica Akins, HA; Paul Sakhrani, Courtney White, Scott Cohen, Milliman; Charles Hubbard, ASP; Robin Keene, AAEA; Kristie Banks, Mainstream; Donna Morey, ARTA; Frances Bauman, NovoNordisk; Gaelle Gravot, Cheiron; Alan Whitley; Mitch Rouse, TSS; Nima Nabavi, Amgen; Sidney Keisner, UAMS; Suzanne Woodall, Medimpact; Stephen Carroll, AllCare Specialty; Sean Seago, MERCK; Daniel Faulkner

Approval of Minutes by Susan Gardner, Chair

MOTION by Haugen:

Move to approve the February 14, 2020 minutes.

Moran seconded; all were in favor.

Minutes Approved.

Diabetic Supply/Options: Dr. Dwight Davis & Dr. Micah Bard, UAMS EBRx

Dr. Davis provided a presentation on the diabetic supply coverage policy evaluation.

Recommendations:

- Move coverage of all diabetes supplies (blood glucose test strips, lancets, syringes, pen needles) to the community pharmacies. (***Projected annual savings between $2,200,000 - $2,900,000***).
- Maintain monthly quantity limits on the blood glucose strips. (Currently, the quantity limit = 153 test strips/month)

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- Require a contingency edit on blood glucose test strips: 120-day lookback period to identify antidiabetic medications before the supplies will be reimbursed. Otherwise, a prior authorization request is needed.
- Move the Dexcom products out of the medical (DME) benefit into the pharmacy benefit. Prior authorization policy will govern access. (***Projected annual Plan savings between $64,000 - $315,000 – depending on the level of member copayment applied***)
- Apply a copay of $80/30-day supply for Dexcom sensors.
- The implementation date of July 1, 2020. (or at a reasonable future date given the current circumstances)

Discussion:

Lilly-Palmer: Back to the blood glucose meters on slide 7, one of the total numbers of claims is 2,472 and, then in option 1, you have 6,264. Where did you arrive at that number?

Dr. Davis: When we looked at the 2,472 based on the 522 people, the Dexcom is made up of three components. There's a sensor that you put on and then the transmitter which transmits data to a receiver. Those strips or sensors have to be purchased every month. The transmitter needs to be replaced four times a year. Lastly, the receiver could be used as your cell phone, so you may never need that. So, when we were looking at the sensors, just multiplying 522 times twelve months to try to get a ballpark, which is where we came up with the 6,264. We also received some information from the manufacturer that the patients tended to reuse these things if they were having trouble getting access to the product. We didn't want to encourage that.

Lilly-Palmer: I was curious on your first comparison, you said that members are opting out and they're buying their own supplies. So, in that option one, you're going off the assessment that all of the participants would be utilizing the plan, correct?

Dr. Davis: Yes.

Lilly-Palmer: The copay that you're recommending is that eighty dollars for a thirty-day supply? I'm not familiar with the diabetic supplies in that regard, but I don't know that that would be necessarily conducive at this time for the copay just due to the circumstances. That might be something we could consider at a later date.

Dr. Davis: This isn't a straightforward way to lay this out. On the traditional supplies that patients are getting today that they would typically get through their pharmacy like the diabetes test strips, the lancets, syringes, and the pin needles, we're not really recommending a copay on those because they're currently getting those without a copay at all. These particular members that we are talking about on slide 7 are those patients obtaining those continual blood glucose monitors through the plan on the medical side. Based on the numbers we're seeing in the medical claims, they're paying about $352 per claim, and so we're thinking that an $80 copay would still save them quite a bit of money. That was our logic on that.

Lilly-Palmer: You were looking at a savings standpoint for the member as well.

Dr. Davis: Yes ma'am. If you chose option two on slide 7 with a $80 copay, the membership would save over $300,000. For a $40 copay, they would save $600,000.

Allen: Does everyone have to enroll in this program, or did they have a choice if they enrolled or not? It sounded like they had a choice.

Dr. Davis: They always have a choice to enroll in the program, whether it is the current program Kannact or not, they do have a choice.

Allen: Okay, since I am a retired teacher on the Board, I'm concerned about what this would do to our 65+ people that are on Medicare and have this as their secondary insurance. From what you're saying, it would move from medical to pharmacy, is that true?

Dr. Davis: No, the retired teachers are not part of the pharmacy benefits.

Allen: That's what I mean if it moved from medical to pharmacy that would change their coverage.

Dr. Davis: No, they will stay where they are because they're not part of the pharmacy. They have their own, like Medicare Part D, from what I understand. So, it wouldn't affect them. These numbers did not include the retired teachers since they're not a part of our pharmacy program.

Allen: The other concern is the July date, not just because of the pandemic, but whenever we throw something out in the middle of the year, which has been done before, it's very confusing for people, because they think they're covered, and then they're not. They go in and all of a sudden, it's changed. I really have a problem with that being confusing for our participants because it's like surprise we're not covering that anymore or we've changed how we cover it. I've had it personally happen to me and that's very hard for people, especially with the uncertainty we have right now to throw things out and not have it on a yearly basis when they're choosing their coverage. I think that's something we need to consider.

Dr. Davis: One thing I'll mention is that we routinely try to keep changes at a minimum, but our Drug Utilization and Evaluation Committee meets every 60 days, and with the prescription drug market, it requires continual surveillance. So, our committee meets, and we'll take those recommendations to the Board for formulary changes. There are continual changes throughout the year on the prescription drug program, and honestly, we couldn't afford it if we didn't do it that way. We're very sensitive about patient's medications and change and disruption. We would love to avoid every bit of that, but unfortunately, we have to keep it affordable. The other piece is that the Board policy is that any change would require a sixty-day notice. What we're seeing on this, with our current situation we are in, we are not married to July 1st. We would want adequate notice and the ability of the member to make any switches. These particular strips that we are talking about are top of the line products. We wanted to offer the best in class to the members, but we also want to provide plenty of runway on communication.

Lilly-Palmer: I agree with Cindy on July 1st, I think that might be pushing it. Back to her question on the teachers being Medicare age and the ones that are not. I know in the past up until they were Medicare age, they were covered on the prescription plan. Are they still covered on that up to Medicare age? If they are, is that moving them from medical to pharmacy, because you said they weren't in those numbers at all.

Howlett: We have retirees that are Non-Medicare eligible, and then we have the Medicare eligible retirees. The population that Dr. Davis was alluding to previously and that Cindy's questions were directed towards was Medicare eligible retirees. They are not receiving pharmacy benefits from EBD. If they are a retiree but they're Non-Medicare age or aren't eligible, they would still be receiving the pharmacy benefit. So, there's a distinction there. Because there's a Part D plan for the Medicare eligible population, they're not inclusive in this data set. The plan, when applicable, would pay the 20% from a secondary standpoint or any portion thereof that Medicare has not picked up. One of the pieces here, there are two subsets to this. There's one with the supplies with the lancets, test strips, and all that, and there's also the Dexcom part. Those are two different components. One we have thousands of people utilizing which are test strips and supplies and then the Dexcom part, we only have 522 members that are doing that. They're both diabetic related, but they are two separate pieces. Traditionally, those in the first group that he spoke about would not be using the Dexcom meter. The other piece I would like to offer as a comment, traditionally what we see is when it comes to communication to members, I would advocate from a plan perspective to at least strongly consider if July 1st is not a date what that date might look like. Anytime we make a plan change, we try to do it with the least amount of member disruption. To put in into perspective, when we switched from our previous program to Kannact, that was in September 2018 of a year with a ramp-up period to the start of the beginning of 2019. What we have found is that we can take our current partner, Health Advantage, on the disease management side, and we can allow the coaching piece to be done through that partner as it is already included. There's no additional cost because it's already included and now, we have a situation where we can actually almost eliminate the total cost. Again, it's about $2.8-$3 million a year that we would be paying with Kannact. We could all but eliminate that with some of the options presented here today. As far as communication, we are going to letter and communicate with the affected members and give them those dates. The actual change in this process is instead of them calling Kannact to get their supplies billed monthly; they would be picking that up at their pharmacy. I understand during the current situation; we don't want to push that upon the population. From a fluid standpoint, we could look at those dates. But remember, inaction means we're still going to be paying and costing the plan money that by looking to adopt something here could be saving significant amounts of money in the meantime. As far as the members and how they would operate with our current partner, Kannact, they would still support that member through the date. They would also advise them and have all the literature and information to give them the proper communication piece if the member were to call in. Typically, we do give a 60-day notice, and we have generally been pretty open in doing 90 days when it comes to drugs. 60 days has been the standard for this Board and subcommittees and that includes the current situation. We looked at July 1st as a target, and that could still move. From a plan standpoint, we will see a situation where we might be needing money. So, what we have been working to for several months, on this piece alone, with diabetic supplies as well as

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Dexcom for those participants is, how can we increase the value to our membership and still save money?

Gardner: Is this presentation recommendations for action today or more of a presentation of intentions of where we want to be or want to consider being by July?

Howlett: From a plan perspective, our intent would be to put this before the subcommittee, and we would be asking for consideration and a vote all or in part.

Kissire: I agree with saving money. I would like to know if the meters will link to some type of app?

Dr. Bard: They are Bluetooth capable, so they could link to an app.

MOTION by Kissire:

I would like to make a recommendation to the Board to approve Part 1 Option 1 with no copay and Part 2 Option 2 with an $80 copay.

Kissire: I understand the change in the July date versus trying to push back to January, but I agree with the fact that we are losing money right now, and if we hold off another five or six months, we will lose half of our potential savings on this.

Seconded by Moran. All were in favor.

Motion Approved.

Lilly-Palmer: Do we need to include the implementation date in that motion to amend the motion?

Gardner: I think that's a very good idea.

Howlett: I think it might be wise and meet everyone's request by setting a target date of July 1st, but any affected member that runs into any issues with this we can handle through the EBRx team. We will work with them to minimize any effect to them. It will be a fluid date that we have a target date to switch over by, and if that's July 1st or whatever that might look like and we can work with that. We can work with any of the participants, one-on-one or otherwise, to make sure that that's as smooth as possible.

Amendment to motion by Lilly-Palmer

I motion to amend the previous motion to include a fluid implementation date of July 1, 2020 with an update by the EBD director as needed.

Kissire seconded. All were in favor.

Motion Approved.

Plan Update by Paul Sakhrani, Milliman

Sakhrani and White provided an educational piece on claims payment processing and an update on plan experience for ASE and PSE.

ASE

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

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- 2020 projected plan experience
    - Allocated reserves for 2020 is $25.1M
    - Estimated deficit of $14.4M
    - End of Year Assets: $57.2M
    - No plan changes / 5% increase in employee contributions
- 2021 plan experience
    - No additional funding ($14.5M allocated assets)
    - Projected deficit: $34.2M
    - End of Year Assets: $8.5M
    - No plan design or contribution changes
    - Increased membership based on historical patterns
    - Baseline trends (medical: 5%, pharmacy: 8%)

PSE

- Projections updated to incorporate claims data incurred from January 2019 to December 2019 and paid through March 2020

- 2020 plan experience
    - Allocated reserves for 2020 is $25.3M
    - Estimated deficit of $18.9M
    - End of Year Assets: $104.9M
    - No plan changes / 0% increase to employee contributions
- 2020 plan experience
    - Projected deficit: $58.3M
    - End of Year Assets: $31.1M
    - No plan design or contribution changes
    - Increased membership based on historical patterns
    - Baseline trends (medical: 7%, pharmacy: 8%)

Discussion:

Gardner: With the changes by the approval we did today and if it goes through, will you able to provide an example of how that affects what you're demonstrating today next month or the following month?

White: Yes, we can do that.

Director's Report by Chris Howlett, EBD Director

Howlett provided an update on some based on what the plan has done dealing with COVID-19. There have been three or four pieces that we have done from the health plan that would not necessarily increase the cost to the plan, but it would increase access to services and /or access to providers for our membership. The first one, dealing with pharmacy prior authorizations (PA's) – a prior authorization is a cost-saving measure that is in place to make sure certain levels of care that are being done to a patient that you've basically triaged it in a sense. We have taken PAs during this

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COVID-19 time that were due to expire and approved them or extended those until July. What this would do is decrease the presence in the doctor's office with patients during this time and also provide a more concentrated approach during the COVID treated patients versus someone trying to go in to get a PA approved. As far as cost to the plan, probably 99% of the PAs are generally extended on our plan anyhow due to the medical necessity for the patient. It's more of a smart thing that would be able to alleviate that pressure on our medical staff. Dealing with pharmacy early refill overrides, generally done on maintenance drugs. So, people that are inside of the 21-day refill are getting close to their time to refill, but they haven't hit the daily limit on that. What we have done is put that in place so that we could override them and allow them to fill the maintenance drug and not burden the system. From that standpoint, we have the EBRx team that handles our prior authorizations as well as any physician and pharmacy call back at their call center. The last piece dealing with pharmacy is the signature law that a lot of states have in place and Arkansas is one of those. In the statute, there is a provision that allows a health plan to relax requirements to allow the pharmacy where they are picking up their drugs, whether curbside or drive-thru, to decrease the amount of exposure. They can enter a code instead of signing for that. In that code, we can actually go back and track that code through the reports to compare the coding that was put in for that member. It is a check and balance for an audit if you will. The last piece is telemedicine. We have a process now with the COVID, as you are all aware that all elective procedures have been cancelled, and with that, we really don't have much happening in the facilities and doctor's offices. We wanted to make sure that we could help from a health plan. We have ramped up the telemedicine option for the health plan. We have always covered it, but in this case, we've ramped up a lot of the opportunities that the health plan can provide the membership to be able to get a standard of care through telephonic means. We are monitoring our weekly claims expenditures, and we're starting to see a little bit of a downturn in the claims experience at least from the money side.

Gardner: What month do we typically consider, if we're going to make changes to the health plan to next year's plan. What month do we need to get that done by?

Howlett: I would say typically we make decisions in June of a year. 2016 was the last time we broke that tradition, and the decision was made in July. Operationally speaking, we need the decision to be made by July.

MOTION by Moran:

I make a motion to adjourn the meeting.

Kissire seconded; all were in favor.

Meeting Adjourned

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Employee Benefits Division
Benefits Subcommittee

Diabetes Supply Coverage Policy Evaluation

April 10, 2020

Diabetes Test Supplies – Coverage Policy

- For members enrolled in EBD's "Diabetes Management Program", whether previously administered through Active Health Management or Kannact;
  - Type 1 or Type 2 diabetes diagnosis
  - Blood glucose strips, glucometer, lancets, syringes and pen needles covered with no copay
  - With prior program, all products were obtained through the member's pharmacy. With the Kannact program, all products are mailed directly to the member.
  - Both programs include some level of coaching.

- For members *not* enrolled in the program;
  - With the prior program, all products could be purchased at the pharmacy for a copay.
  - With the current model, only test strips can be purchased at the pharmacy for a copay. Other products (syringes, pen needles, and lancets) are excluded from coverage.

Plan Expenditures for Diabetes Supplies

- **Prior Program** -
  - In the last full 12-month dataset (CY 2018), the **total cost** of diabetes supplies (syringes, needles, lancets, test strips, glucometers) amounted to **$1,045,000** and involved approximately 1,100 members.
  - Of the total cost of $1,045,000, the total cost of test strips amounted to $487,445 with the EBD Plan paying $267,480 and members paying $220,000.
  - Prior program provided some level of coaching, but the fees associated with the coaching were included in the blended disease management charge.

- **Current Program** -
  - Through Kannact, all supplies are included in the monthly per-participant fee. EBD pays a monthly fee based on condition of member; $59.00, $69.00, or $79.00/month. Most participants are $79.00/month.
  - This cost includes supplies and coaching.
  - Currently 3,118 members enrolled with Kannact. Total current annual cost = $2,844,000 (~$76/participant/month)

Results of the Rebate Contract Bid Evaluation

Part One:

- Accu-Check Test Strips (Roche) chosen as the exclusive covered blood glucose strip. Blood glucose monitors are provided at no cost.
- TruePlus insulin syringes and pen needles chosen as the exclusive syringe/pen needle products.

Part Two:

- Dexcom brand chosen as the exclusive Continual Blood Glucose Monitoring (CGM) device.

Financial Impact to the Plan (rebate modeling) – Part One

Per-Utilizing-Member-Per-Month Cost for Diabetes Supplies			
Before		**After**	
Blood Glucose Test Strips	Blood Glucose Test Strips	Blood Glucose Test Strips w/free meter	Blood Glucose Test Strips w/free meter
Lancets	Lancets	Lancets	Lancets
Syringes	Pen Needles	Syringes	Pen Needles
$70.35	**$78.84**	**$16.53**	**$19.26**

The blended Total Cost per utilizing member ***before*** considering the rebate bid was approximately $78/month.

The blended Total Cost per utilizing member ***after*** considering the rebate bid is $19/month.

The net savings per utilizing member resulting from the rebate bid is $59/month.

Summary of Rebate Impact – Part One

Current Program - Kannact	
Number of participants	3,118
Total Annual Plan Cost (includes supplies & counseling and is based on $59, $69, or $79 per participant per month, depending on condition)	$2,844,000
Total Annual Member Cost	$0.00
Rebate / discount to Plan	$0.00
Net Annual Plan Cost	**$2,844,000**

Option #1 (Move supplies to local community pharmacy)	
Number of participants	3,118
Annual Supply Cost (assume $78 / utilizing member/month)	$2,918,000
Counseling Cost (through Health Advantage)	$0.00
Total Member Cost (no copay)	$0.00
Rebate / discount to Plan (Savings) Pre-rebate PMPM = $78 vs. Post-rebate PMPM = $19	$2,200,000
Net Annual Plan Cost	**$718,000**

Option #2 (Includes Option #1 PLUS)	
Add Co-pay for Supplies	Up to $15/Rx
Projected Annual Copay collected (Additional Savings)	$718,000
Net Annual Plan Cost	**$0.00**

Summary of Rebate Impact – Part Two

Current Coverage of Dexcom	
Number of utilizing members	522
Total # of Claims	2,472*
Total Plan Paid	$548,400 ($222/claim)
Total Member Paid	$869,000 ($352/claim)
Total Cost	**$1,417,400 ($574/claim)**

* Claims volume indicates extremely low compliance to sensor use

Note:

1. Dexcom is a wearable device classified as a continual blood glucose monitor (CGM).
2. Dexcom involves three (3) components; sensors, transmitter, and a receiver.
3. Dexcom is currently obtained through the medical benefit (durable medical equipment).

Option #1 – Move from Medical to Pharmacy Coverage	
Number of utilizing members	522
Total # of Claims	6,264*
Total *Projected* Plan Cost	$2,501,400
Total *Projected* Member Cost	$0.00
Net *Projected* Plan Cost (net of rebates)	**$1,604,000**

* Projected claims volume reflects 100% compliance to sensor use

Option #2 (Includes Option #1 PLUS)	
Add Co-pay of $40/30-day supply Net Plan Cost after co-pay	$250,500 **$1,354,500**
Add Co-pay of $80/30-day supply Net Plan Cost after co-pay	$501,100 **$1,103,000**
Total *Projected* Annual Member Savings	**$368,000 - $619,000**
Total *Projected* Annual Plan Savings (assuming a copayment is required)	**$64,000 - $315,000**

Recommendations:

- Move coverage of all diabetes supplies (blood glucose test strips, lancets, syringes, pen needles) to the community pharmacies. (***Projected annual savings between $2,200,000 - $2,900,000***).
- Maintain monthly quantity limits on the blood glucose strips. (Currently, the quantity limit = 153 test strips/month)
- Require a contingency edit on blood glucose test strips: 120-day lookback period to identify antidiabetic medications before the supplies will be reimbursed. Otherwise, a prior authorization request is needed.
- Move the Dexcom products out of the medical (DME) benefit into the pharmacy benefit. Prior authorization policy will govern access. (***Projected annual Plan savings between $64,000 - $315,000 – depending on level of member copayment applied***)
- Apply a copay of $80/30-day supply for Dexcom sensors.
- Implementation date of July 1, 2020 (*or at a reasonable future date given the current circumstances*)

Questions??

State of Arkansas Employee Benefits Division

Interim Monitoring Report

Through March 31st

State and Public School Life and Health Insurance Benefits Subcommittee

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

10 APRIL 2020

Milliman

Agenda

- Education – Claims Payment Process
- Arkansas State Employees (ASE)
  - Plan Experience
- Public School Employees (PSE)
  - Plan Experience
- Appendices
  A. Plan summary
  B. Assumptions / methodology
  C. Limitations & caveats

Claim Types

Incurred Claim

A claim for a procedure or service that has already occurred. Incurred claims are not always reported immediately.

Paid Claim

A claim that has been reported and paid.

Dollar Definitions

Billed Amount
- Amount charged by provider for care

Allowed Amount
- Maximum amount paid by insurer for care

Out-of-Pocket Cost
- Amount paid by insured for their care

Paid Amount
- Amount paid by insurer for care

Claims Processing

Incurred Claim

A person receives care from a provider and presents their insurance card.

Reported Claim

The provider bills the insurer for their services.

Paid Claim

The insurer pays the claim and bills the patient for any remaining balance.

Claim Payment – Example: Explanation of Benefits

Sally broke her foot and required surgery.

Her benefits:

- $1,000 deductible
- 20% coinsurance
- $6,000 out-of-pocket maximum

Description of Service	Billed	Contracted Rate	Deductible	Coinsurance / Copay	Total Patient Paid	Plan Paid
Surgical Center	$80,000	$20,000	$1,000	$3,800	$4,800	$15,200
Surgery	$10,000	$5,000	-	$1,000	$1,000	$4,000
Anesthesiologist	$2,000	$1,200	-	$200	$200	$1,000
Total	**$93,000**	**$26,200**	**$1,000**	**$5,000**	**$6,000**	**$20,200**

Claims Payment Processing - Considerations

Trend Analysis

Analyze trends using allowed / paid dollars on an incurred / paid basis

Cash Flow Projections

Determine future financial savings / costs using paid dollars

Plan Design Impact

Identify impact on benefits due to change in paid to allowed ratio

Incurred But Not Reported (IBNR)

Estimate future paid claims that have not been reported yet

Arkansas State Employees (ASE)

Executive Summary

- 2020 & 2021 projections updated to incorporate claims data incurred from February 2019 to January 2020 and paid through March 2020
- 2020 projected plan experience
  - Allocated reserves for 2020 is $25.1M
  - Estimated deficit of $14.4M
  - End of Year Assets: $57.2M
  - No plan changes / 5% increase in employee contributions
- 2021 projected plan experience
  - No additional funding ($14.5M allocated assets)
  - Projected deficit: $34.2M
  - End of Year Assets: $8.5M
  - No plan design or contribution changes
  - Increased membership based on historical patterns
  - Baseline trends (medical: 5%, pharmacy: 8%)

Total Plan Experience

Funding	2019	2020	2021
State Contribution	$ 173.61	$ 172.24	$ 172.24
Employee Contribution	97.45	99.63	100.31
Other	23.47	21.65	21.80
Total Income	$ 294.53	$ 293.52	$ 294.35
Medical Claims	$ (194.56)	$ (222.28)	$ (223.99)
Pharmacy Claims	(86.58)	(98.48)	(107.18)
Administration Fees	(18.30)	(17.52)	(17.63)
Plan Administration	(2.90)	(2.81)	(2.91)
Total Expenses	$ (302.34)	$ (341.08)	$ (351.71)
Pharmacy Program	$ -	$ 8.12	$ 8.69
Net Income / (Loss) Before Reserve Allocation	$ (7.82)	$ (39.43)	$ (48.67)
Allocation of Reserves	$ 21.70	$ 25.08	$ 14.46
Net Income / (Loss) After Reserve Allocation	$ 13.89	$ (14.35)	$ (34.21)

Average Membership			
Active Employees / Pre-65 Retirees	47,720	46,904	46,904
Post-65 Retirees	13,346	13,805	14,219
Total Enrolled	61,066	60,708	61,122

Total Income PMPM[1]	$ 431.54	$ 437.35	$ 421.02
Total Expenses PMPM[2]	$ (412.59)	$ (457.05)	$ (467.66)

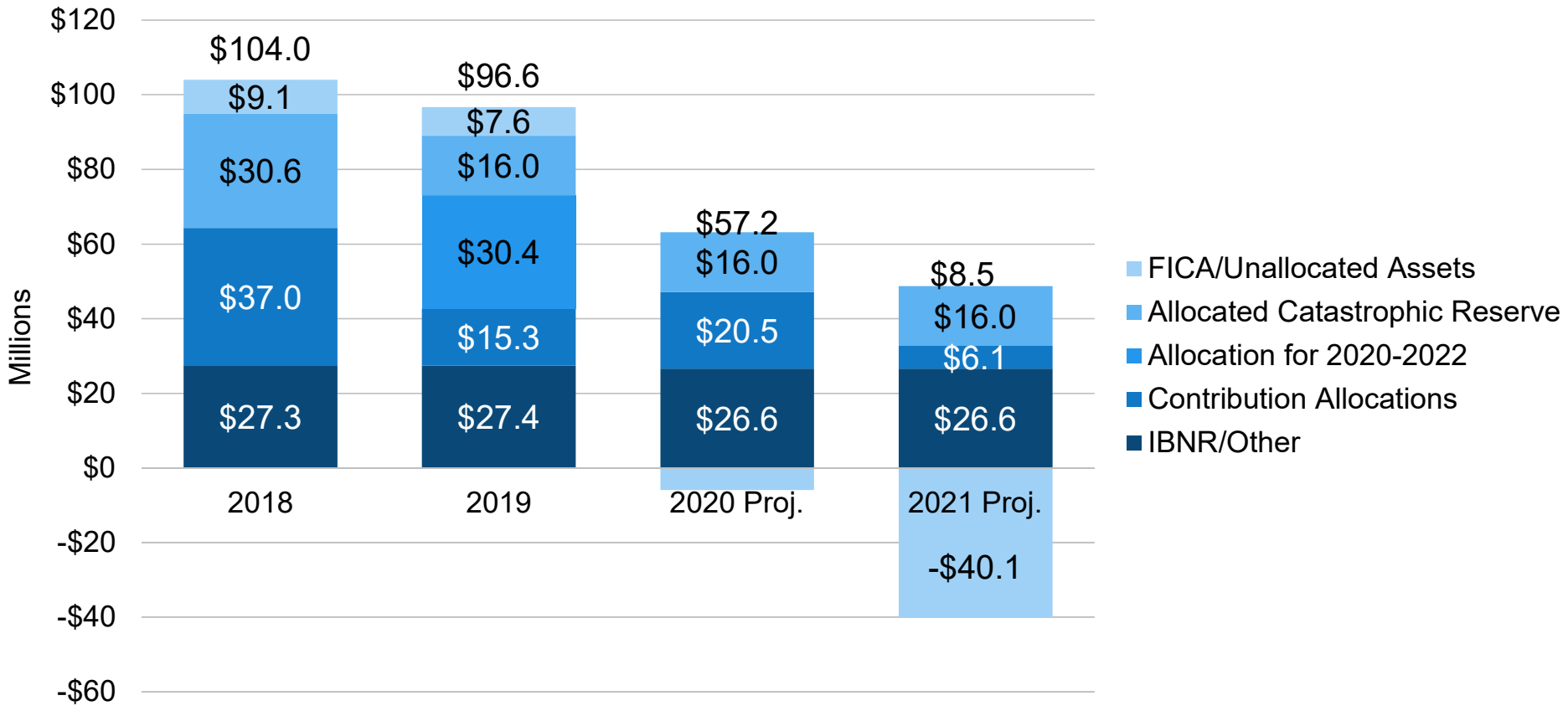
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Pharmacy Program

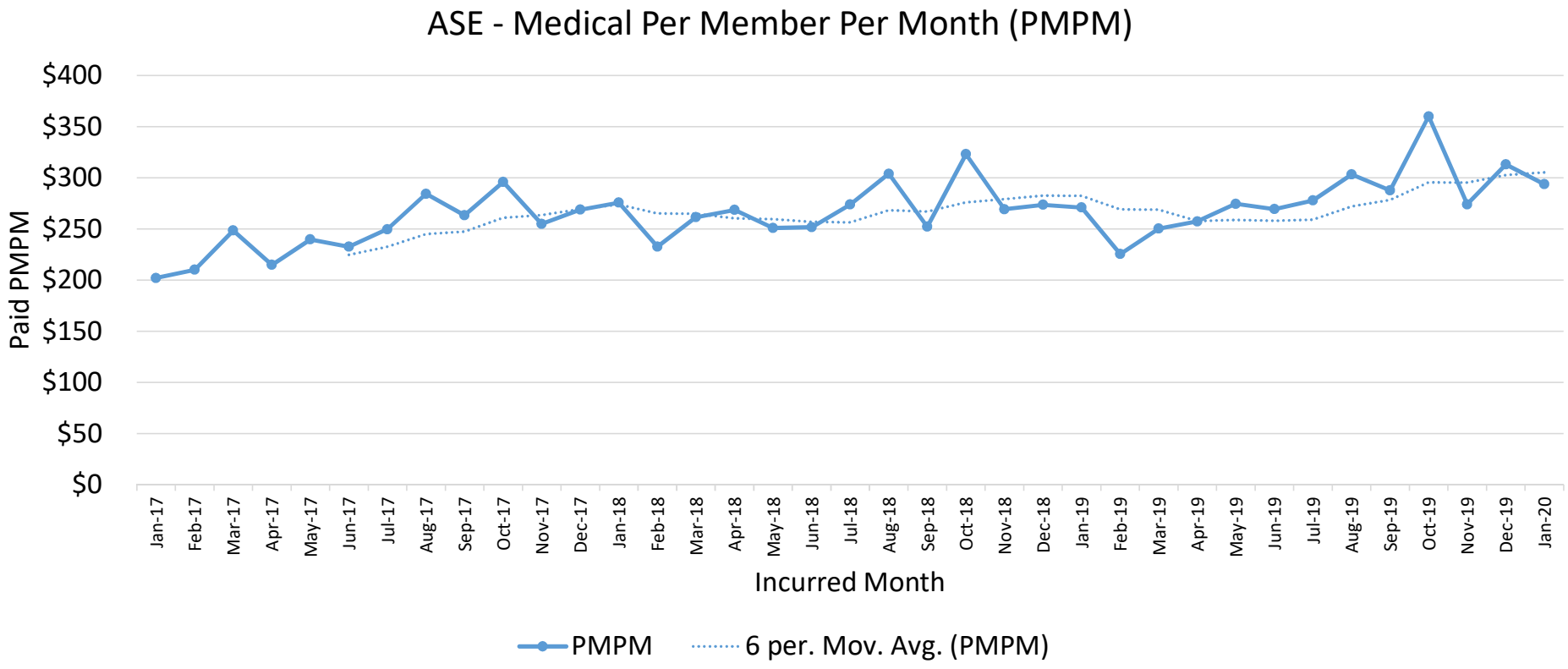
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets			
(a)	2019	End-of-Year Assets	$96.6
(b)	2020	Total Income	$293.5
(c)		Total Expenses	($333.0)
(d)		Allocated Assets	$25.1
(e) = (b) + (c) + (d)		Total Surplus / (Deficit)	($14.3)
(f) = (a) - (d) + (e)		End-of-Year Assets	$57.2
(g)	2021	Total Income	$294.3
(h)		Total Expenses	($343.0)
(i)		Allocated Assets	$14.5
(j) = (g) + (h) + (i)		Total Surplus / (Deficit)	($34.2)
(k) = (f) – (i) + (j)		End-of-Year Assets	$8.5

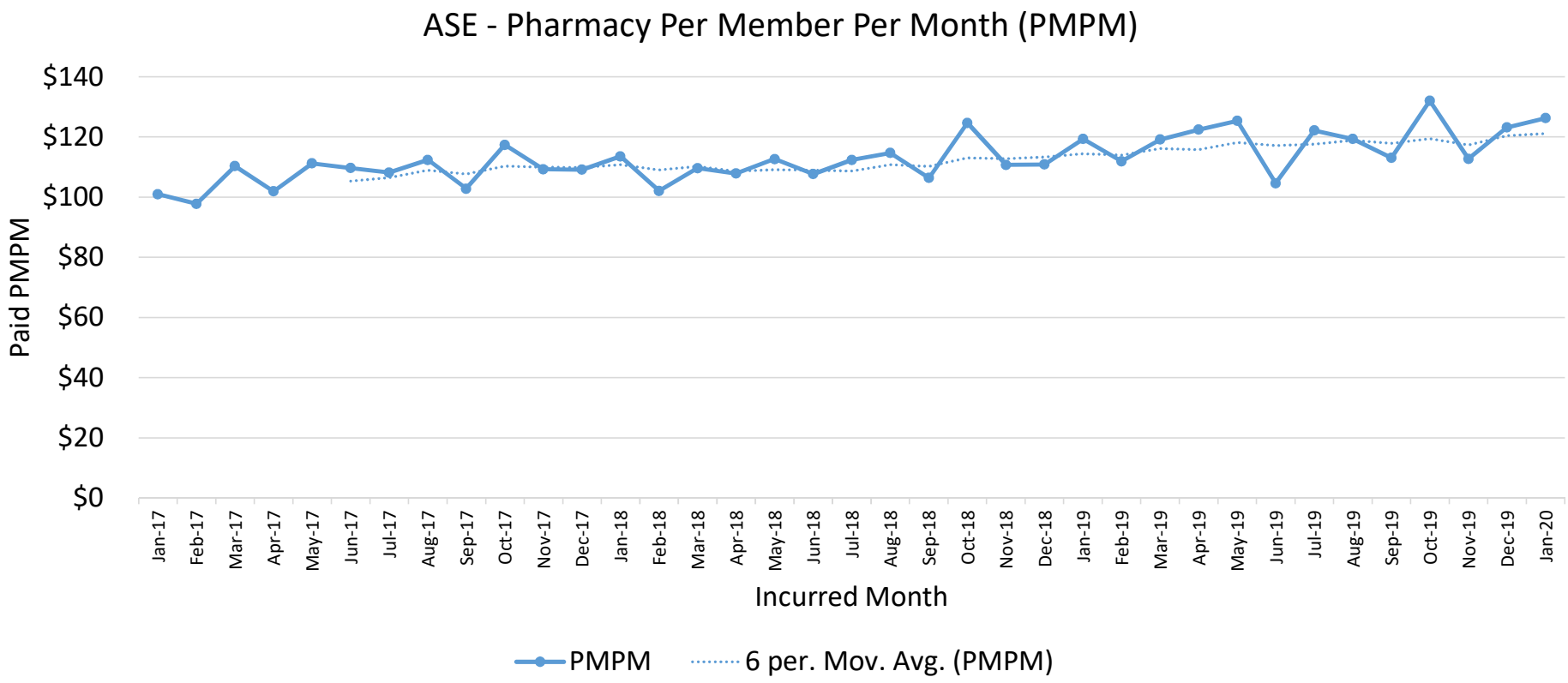
End of Year Assets



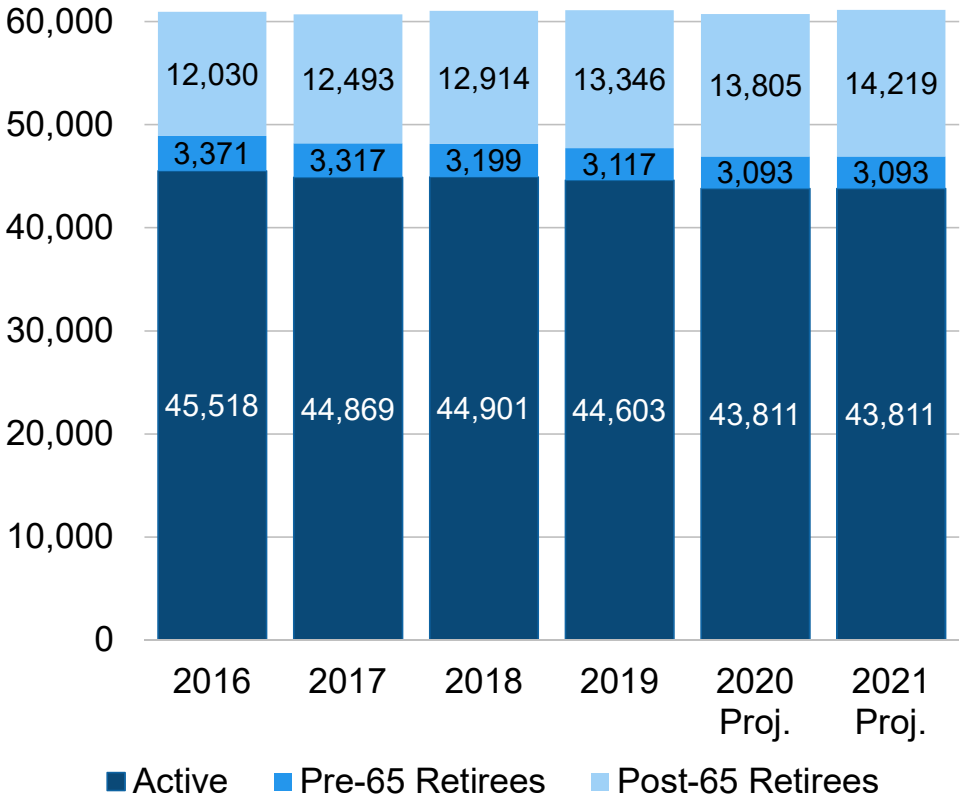
Monthly Trend - Medical

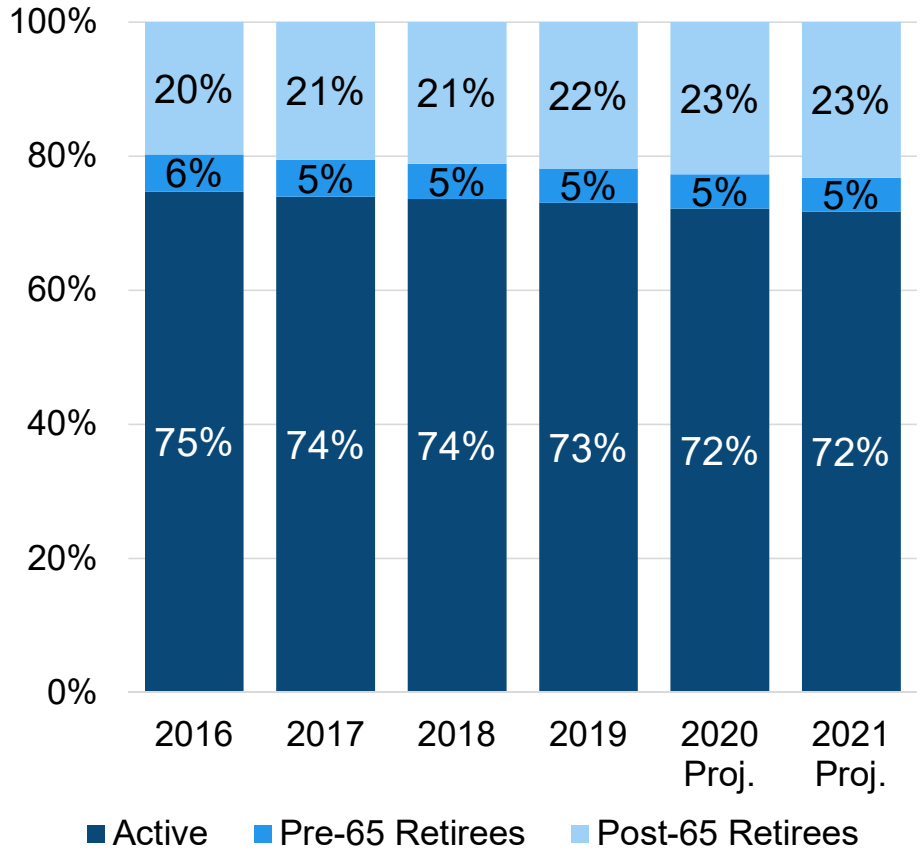


Monthly Trend - Pharmacy

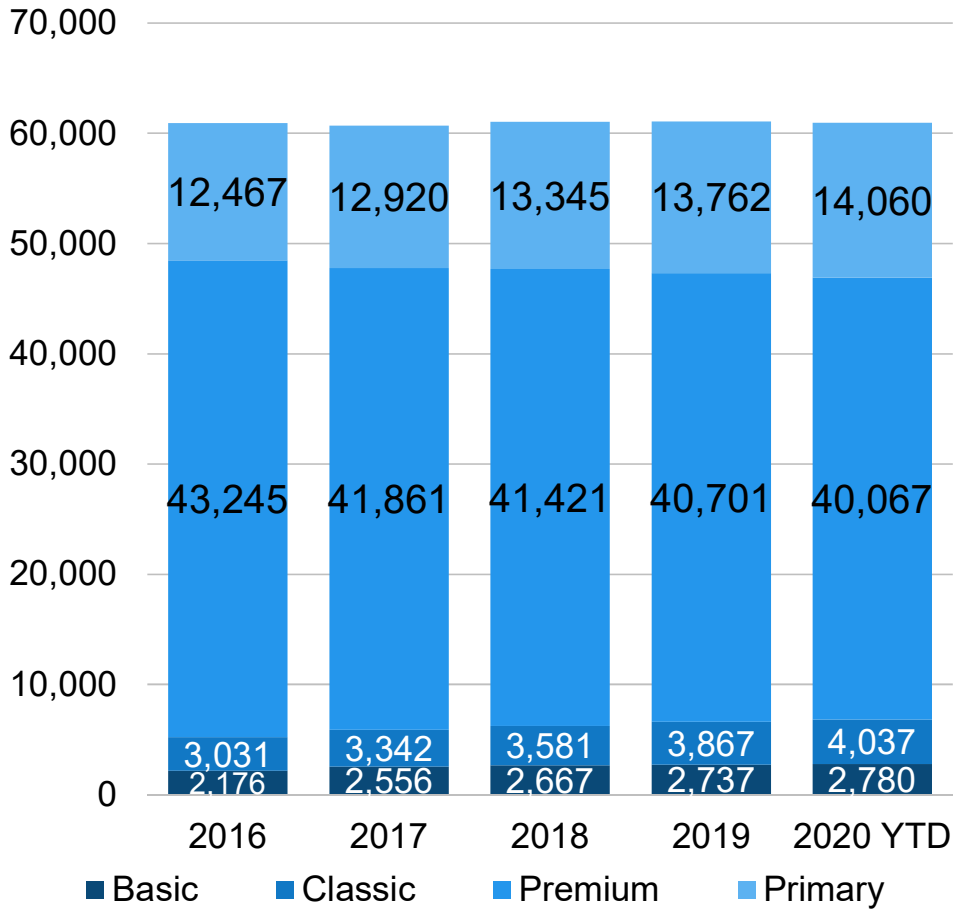


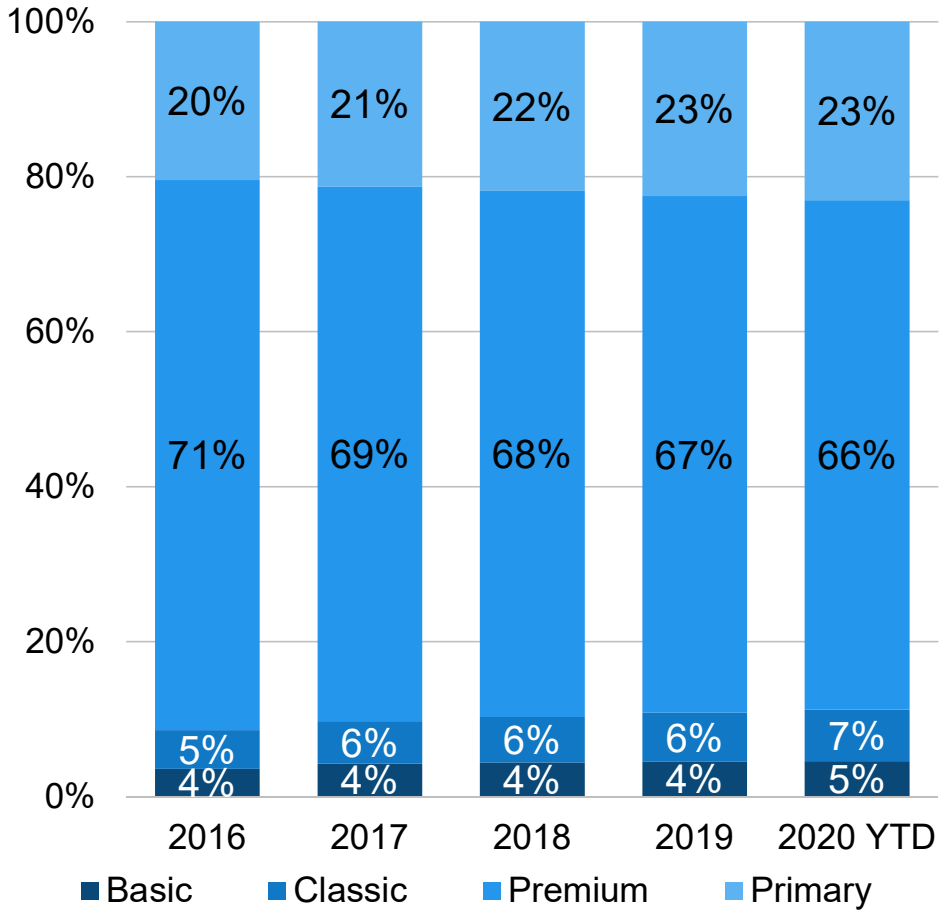
ASE - Average Membership by Status





ASE - Average Membership by Plan





Public School Employees (PSE)

Executive Summary

- Projections updated to incorporate claims data incurred from February 2019 to January 2020 and paid through March 2020
- 2020 plan experience
  - Allocated reserves for 2020 is $25.3M
  - Estimated deficit of $18.9M
  - End of Year Assets: $104.9M
  - No plan changes / 0% increase to employee contributions
- 2021 projected plan experience
  - Projected deficit: $58.3M
  - End of Year Assets: $31.1M
  - No plan design or contribution changes
  - Increased membership based on historical patterns
  - Baseline trends (medical: 7%, pharmacy: 8%)

Total Plan Experience

Funding	2019	2020	2021
PPE Funding	$ 102.39	$ 105.35	$ 108.87
Employee Contribution	121.12	124.18	128.32
Dept of Ed Funding	88.10	88.10	88.10
Other	15.02	14.88	15.38
Total Income	$ 326.64	$ 332.51	$ 340.67
Medical Claims	$ (247.12)	$ (281.30)	$ (311.14)
Pharmacy Claims	(60.87)	(70.56)	(77.79)
Administration Fees[2]	(28.46)	(28.16)	(29.17)
Plan Administration	(2.61)	(2.55)	(2.63)
Total Expenses	$ (339.06)	$ (382.57)	$ (420.74)
Pharmacy Program	$ -	$ 5.92	$ 6.31
Net Income / (Loss) Before Reserve Allocation	$ (12.42)	$ (44.14)	$ (73.76)
Allocation of Reserves	$ 12.66	$ 25.25	$ 15.48
Net Income / (Loss) After Reserve Allocation	$ 0.23	$ (18.88)	$ (58.29)

Average Membership			
Active Employees / Pre-65 Retirees	82,317	84,299	86,710
Post-65 Retirees	14,279	15,079	15,984
Total Enrolled	96,596	99,377	102,693

Total Income PMPM[1]	$ 292.71	$ 300.01	$ 289.00
Total Expenses PMPM[2]	$ (292.51)	$ (315.84)	$ (336.30)

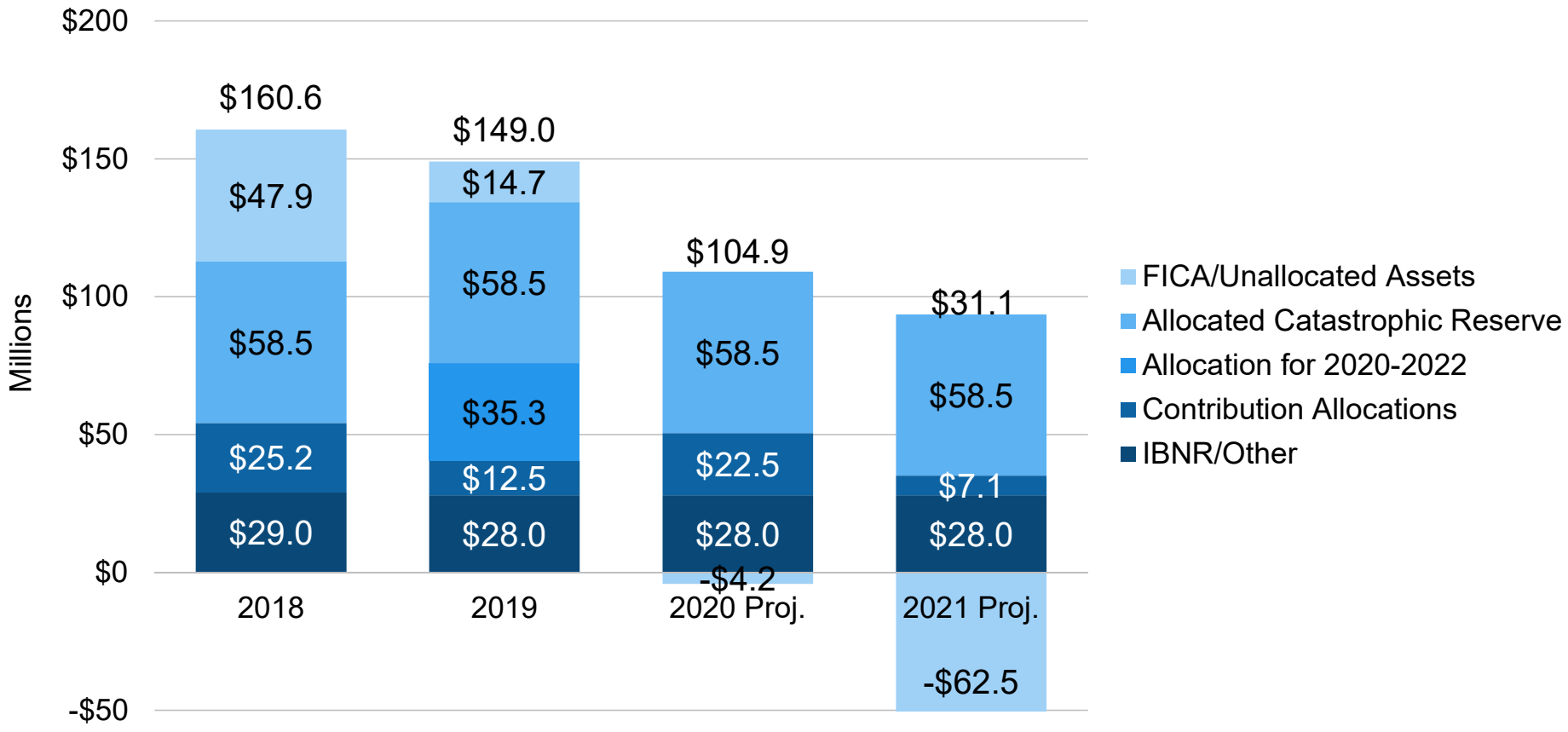
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Pharmacy Program

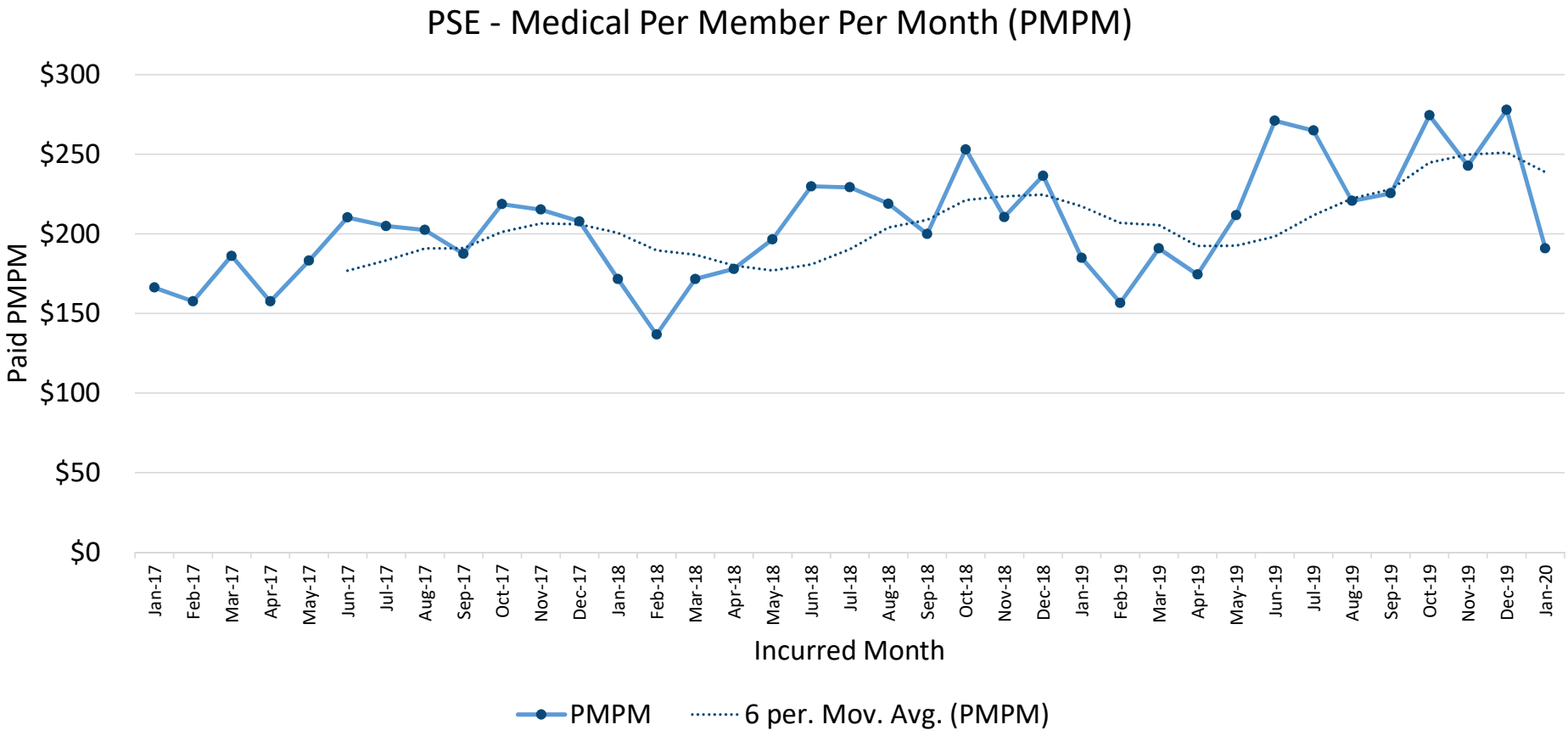
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets			
(a)	2019	End-of-Year Assets	$149.0
(b)	2020	Total Income	$332.5
(c)		Total Expenses	($376.7)
(d)		Allocated Assets	$25.3
(e) = (b) + (c) + (d)		Total Surplus / (Deficit)	($18.9)
(f) = (a) - (d) + (e)		End-of-Year Assets	$104.9
(g)	2021	Total Income	$340.7
(h)		Total Expenses	($414.4)
(i)		Allocated Assets	$15.5
(j) = (g) + (h) + (i)		Total Surplus / (Deficit)	($58.3)
(k) = (f) – (i) + (j)		End-of-Year Assets	$31.1

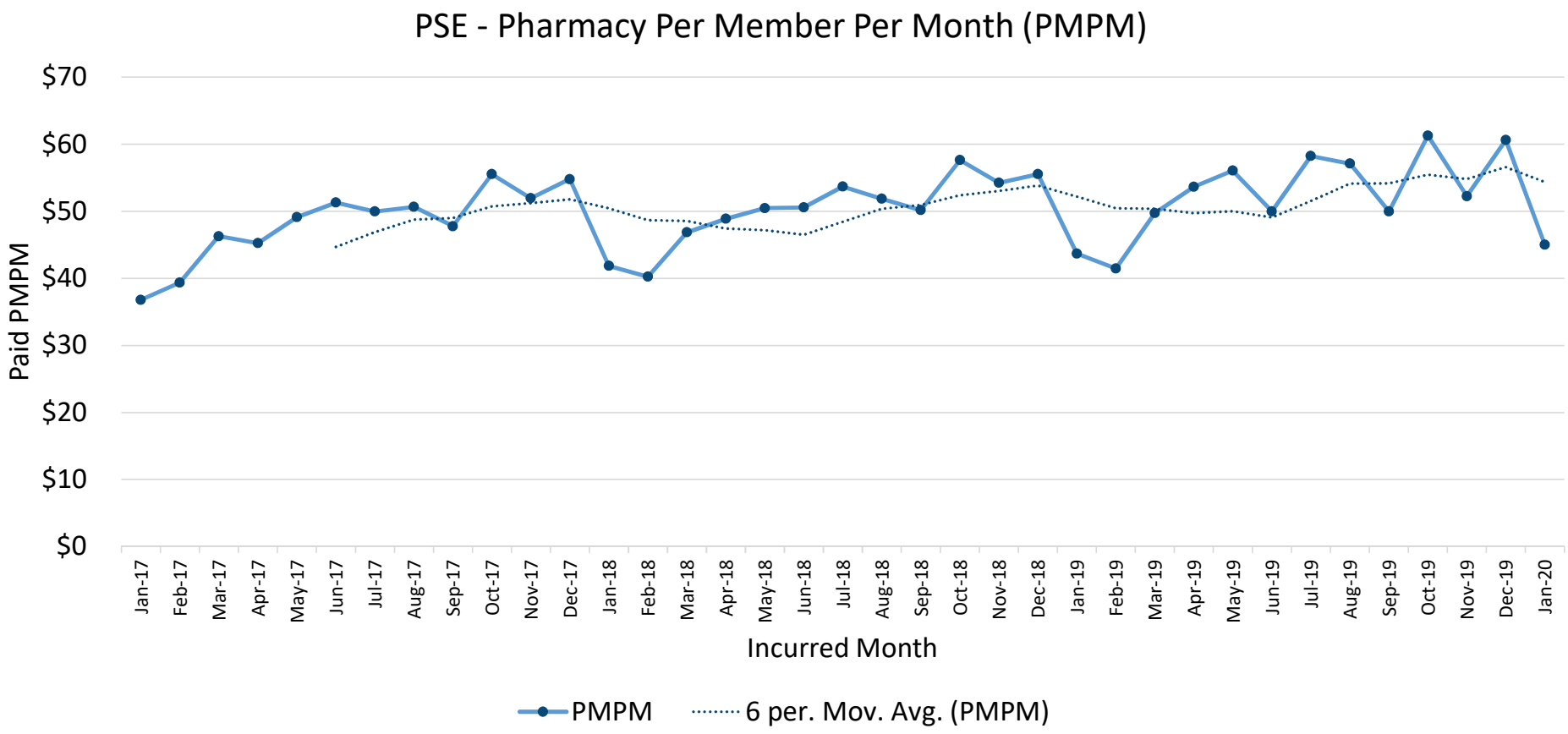
End of Year Assets



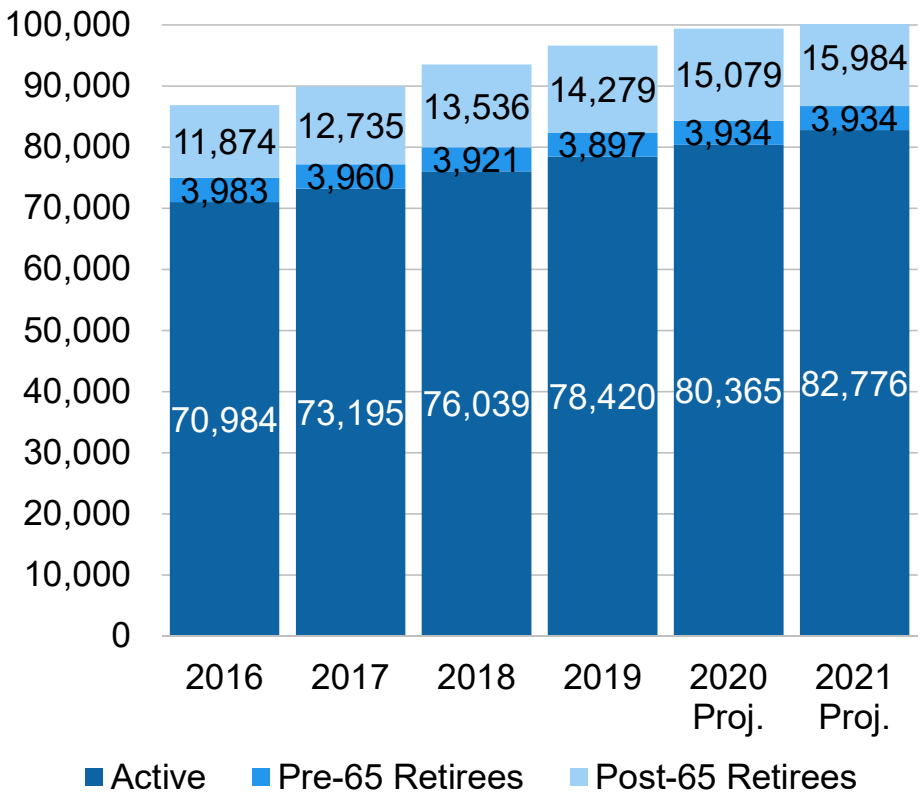
Monthly Trend - Medical

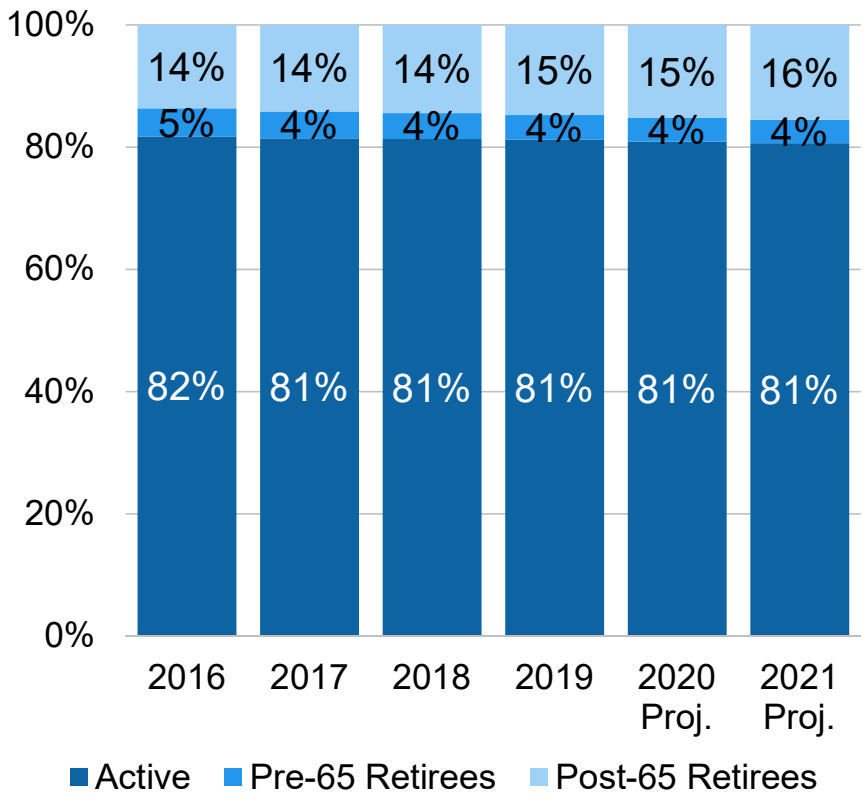


Monthly Trend - Pharmacy

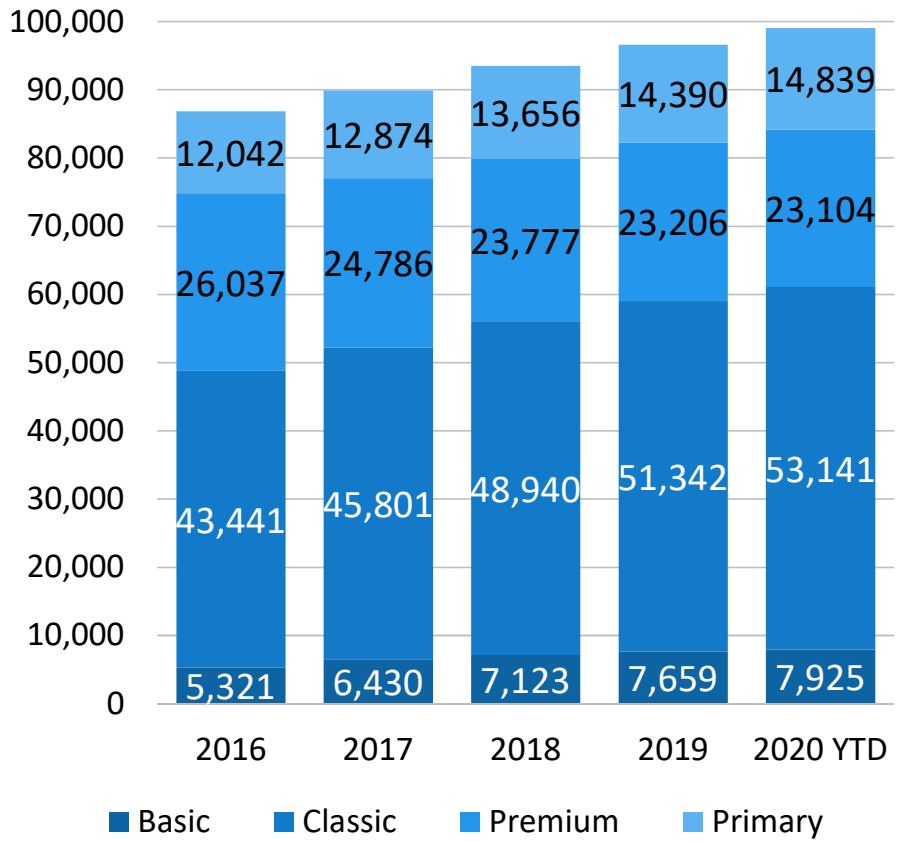


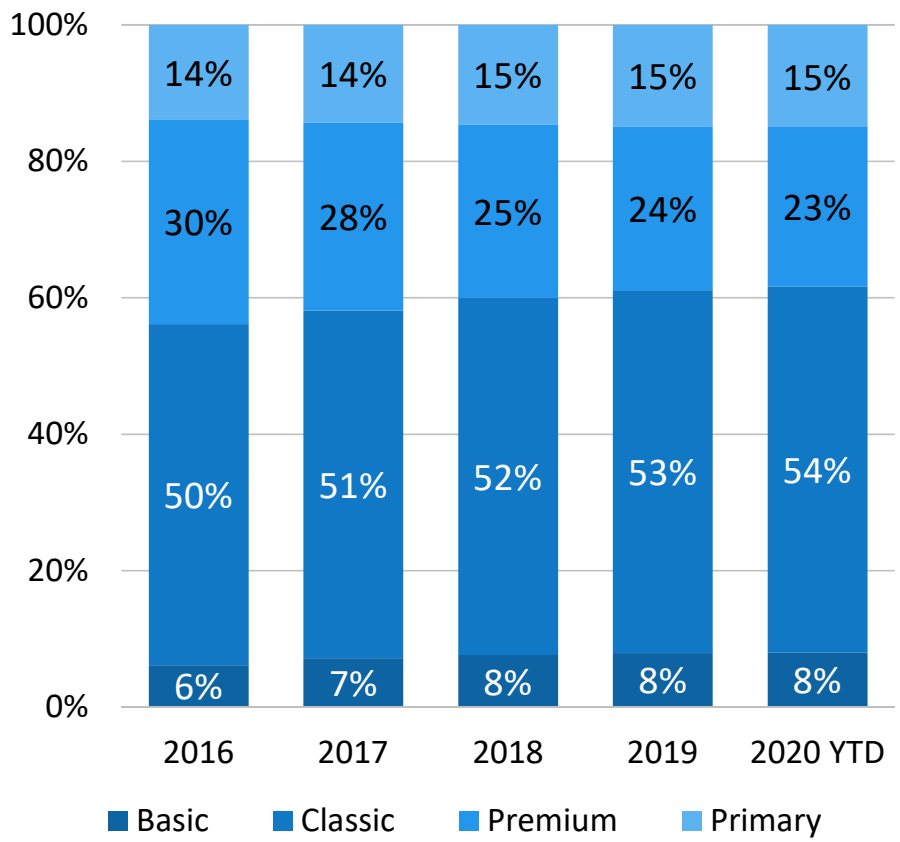
PSE - Average Membership by Status





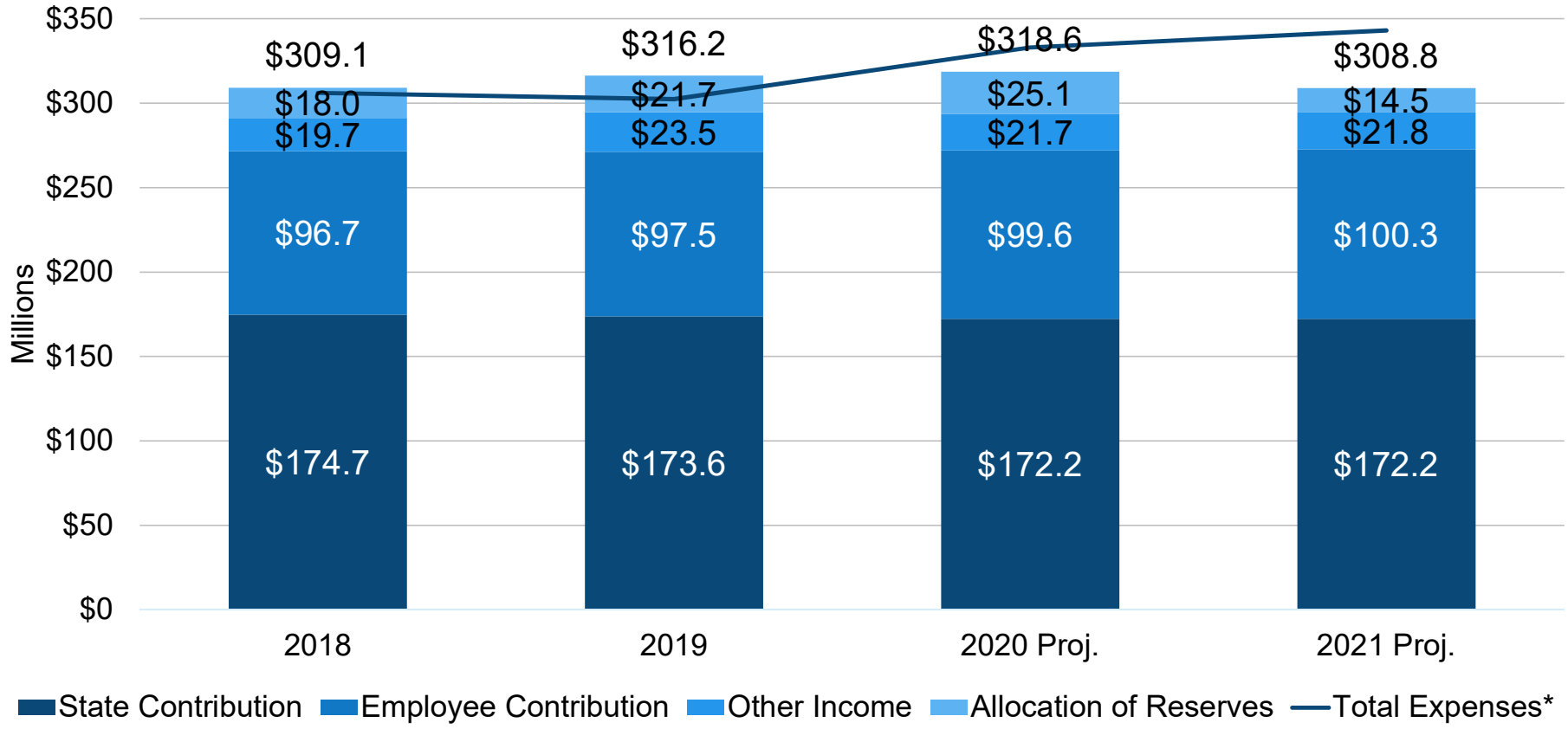
PSE - Average Membership by Plan





Appendix

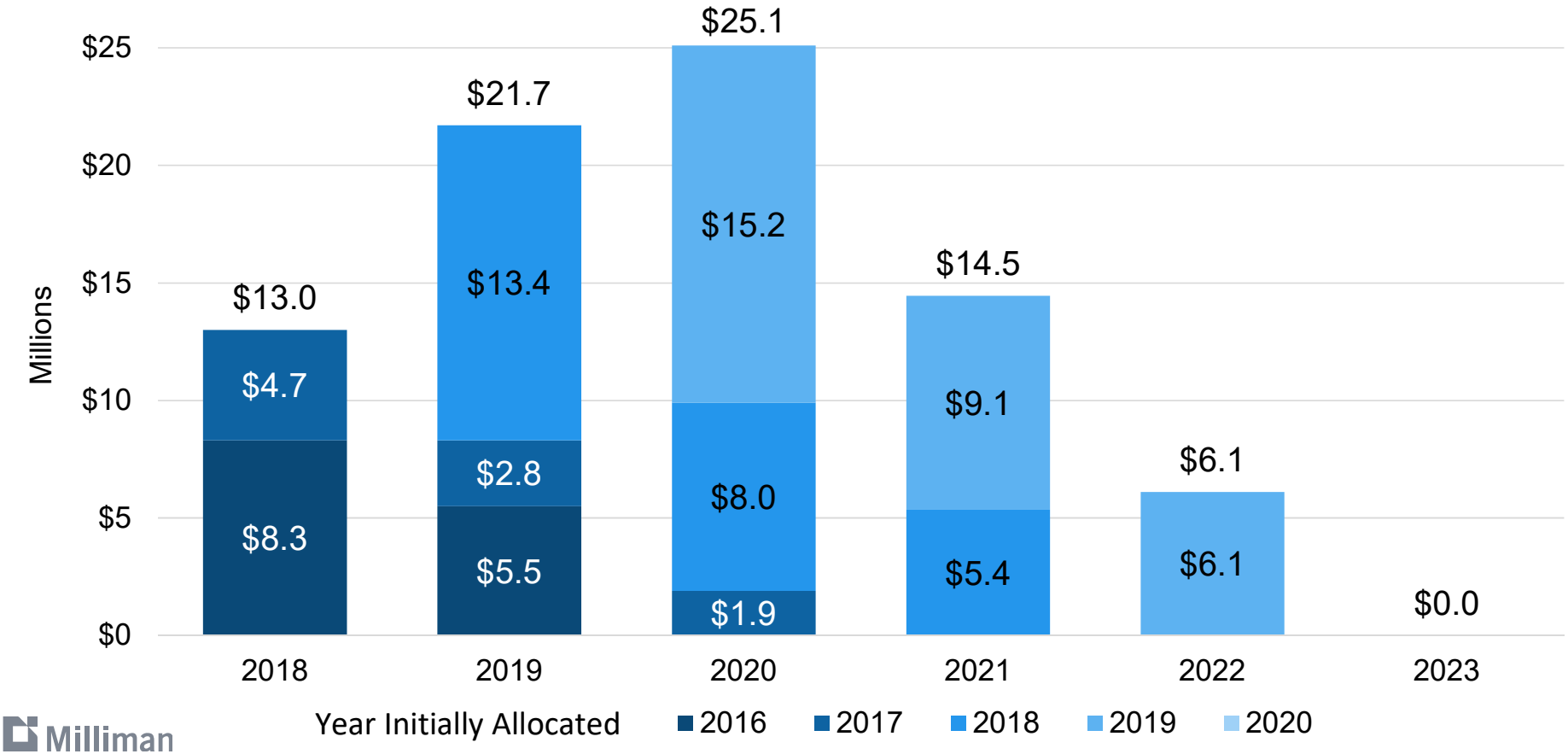
ASE - Income vs. Expenditure



* Total Expenses offset by Pharmacy Program

ASE - Reserves Allocation by Year

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



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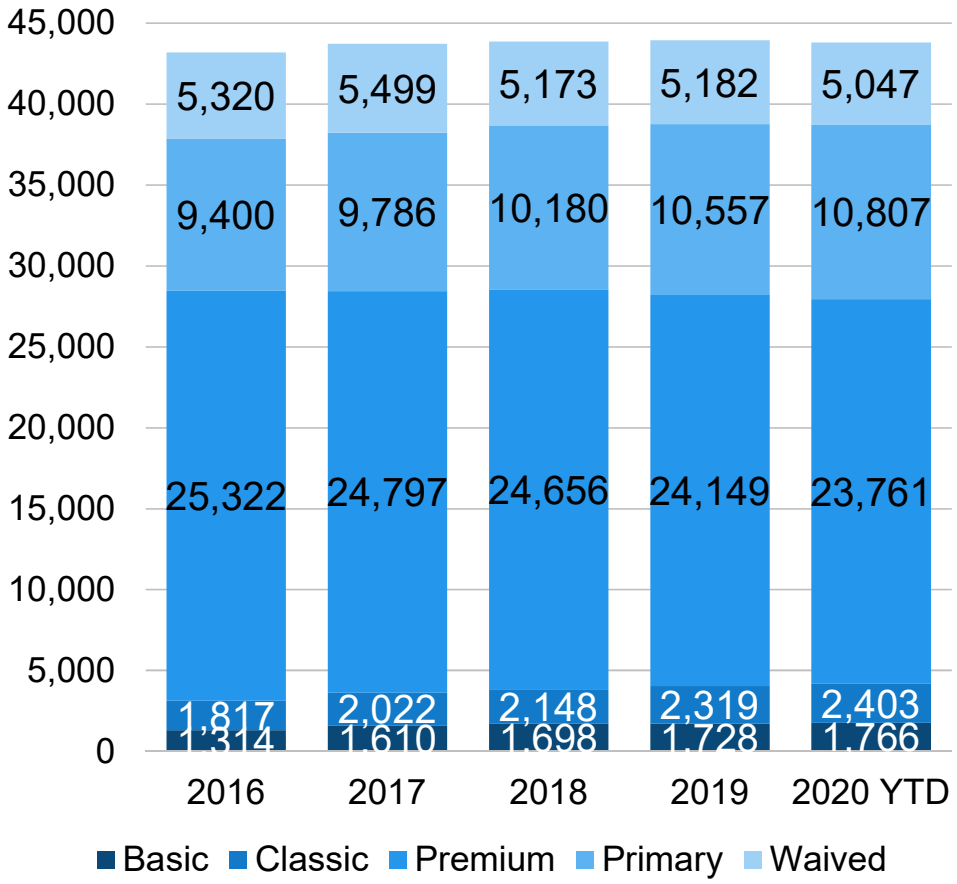
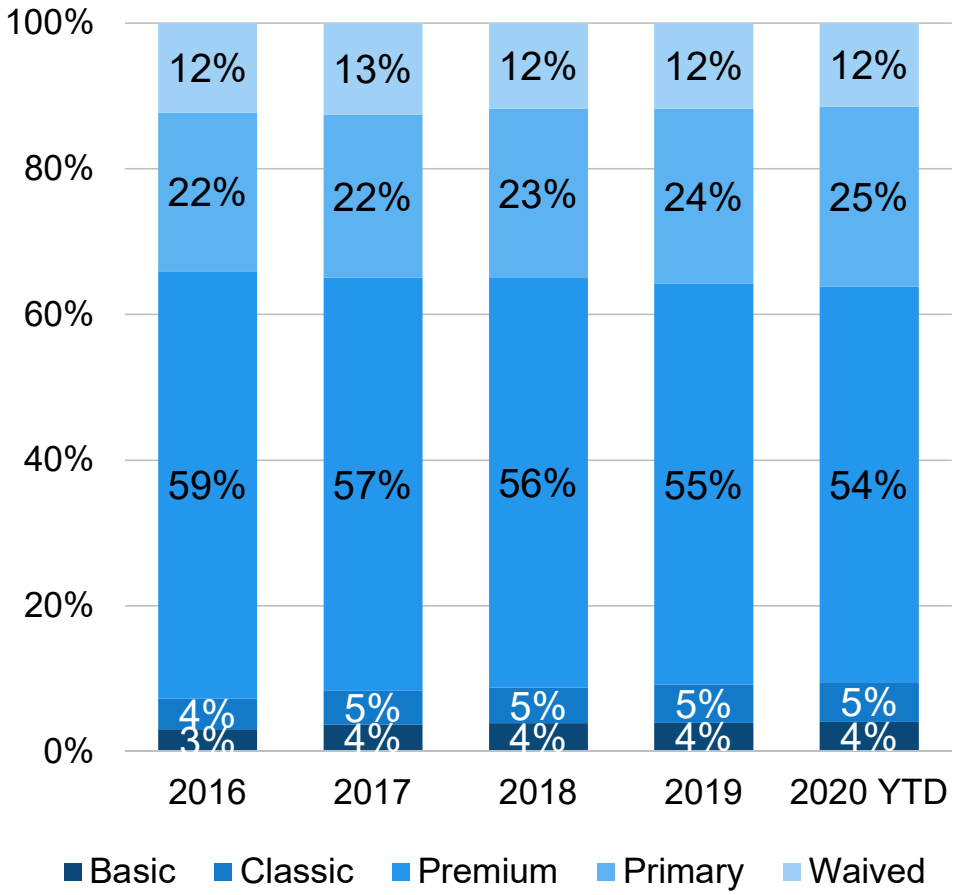
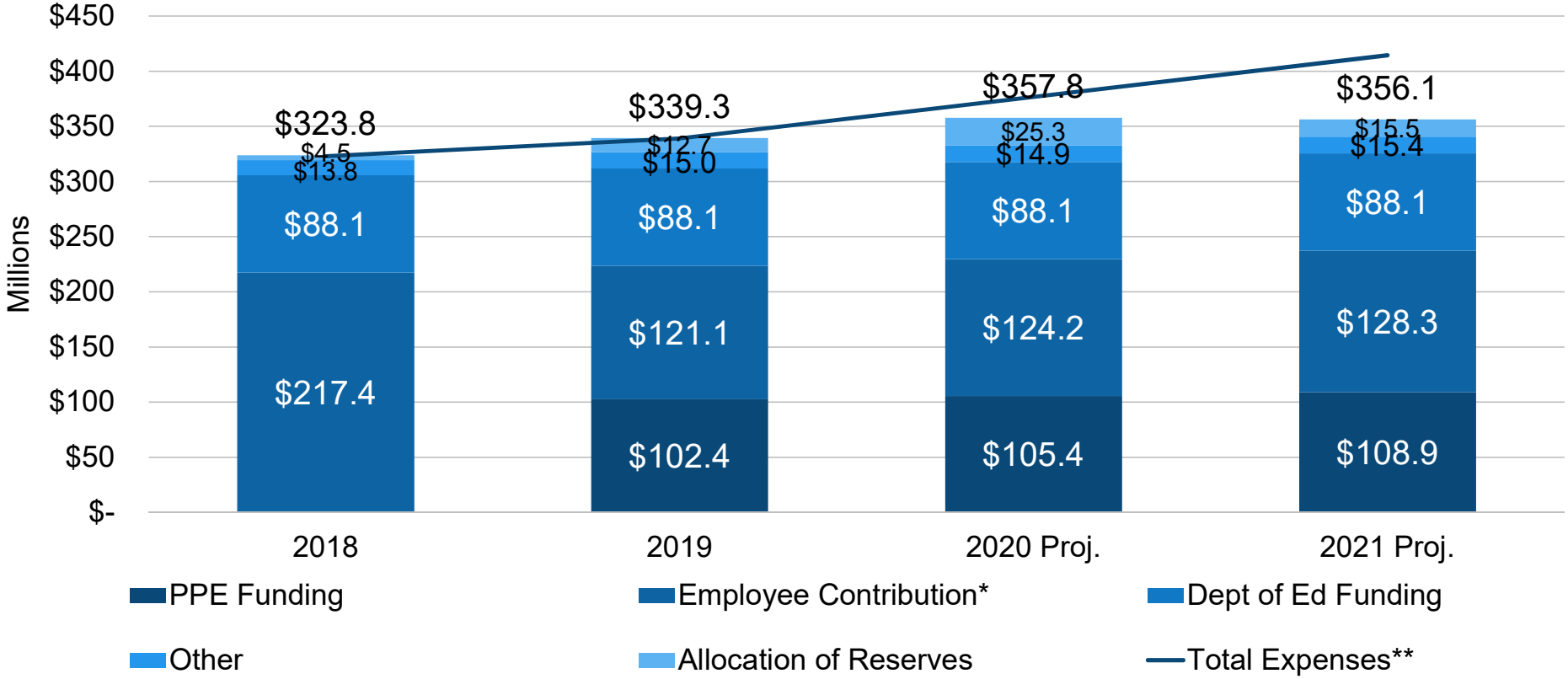
ASE - Average Enrollment (Subscribers) by Plan





PSE - Income vs. Expenditure

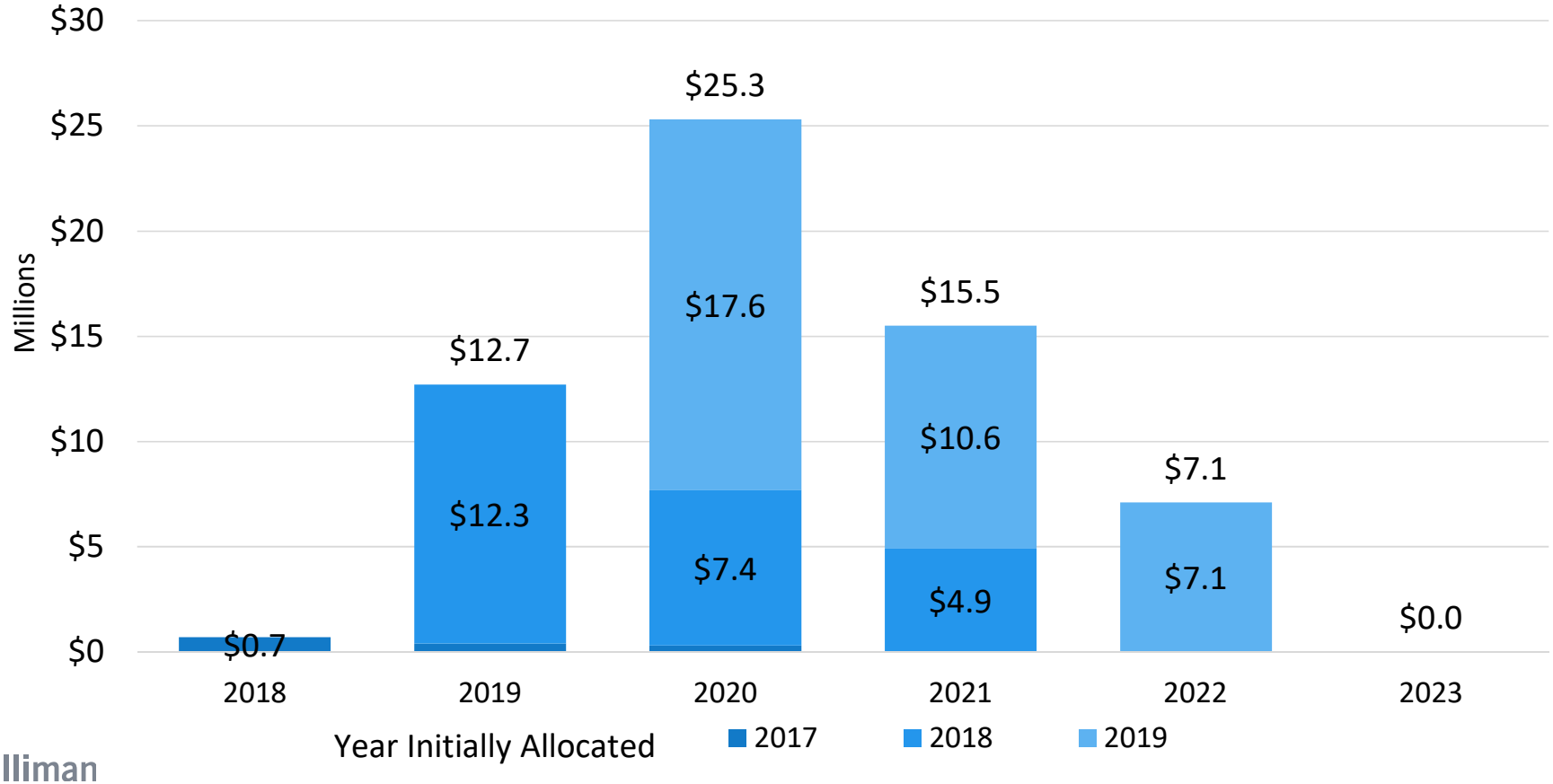


* 2018 Employee Contribution includes PPE Funding

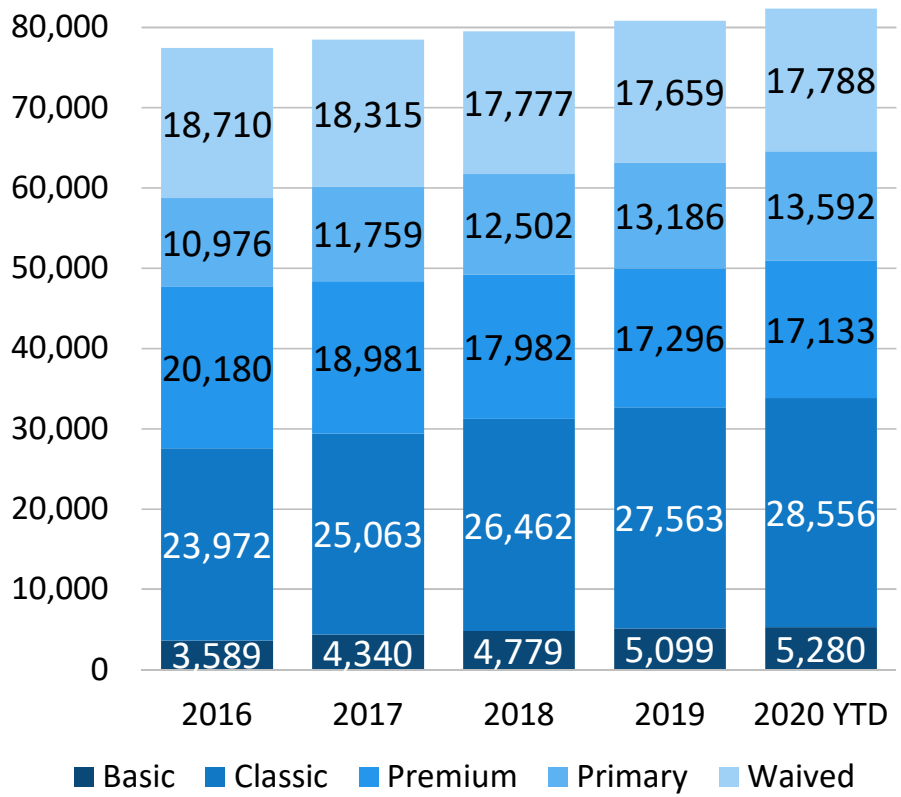
** Total Expenses offset by Pharmacy Program

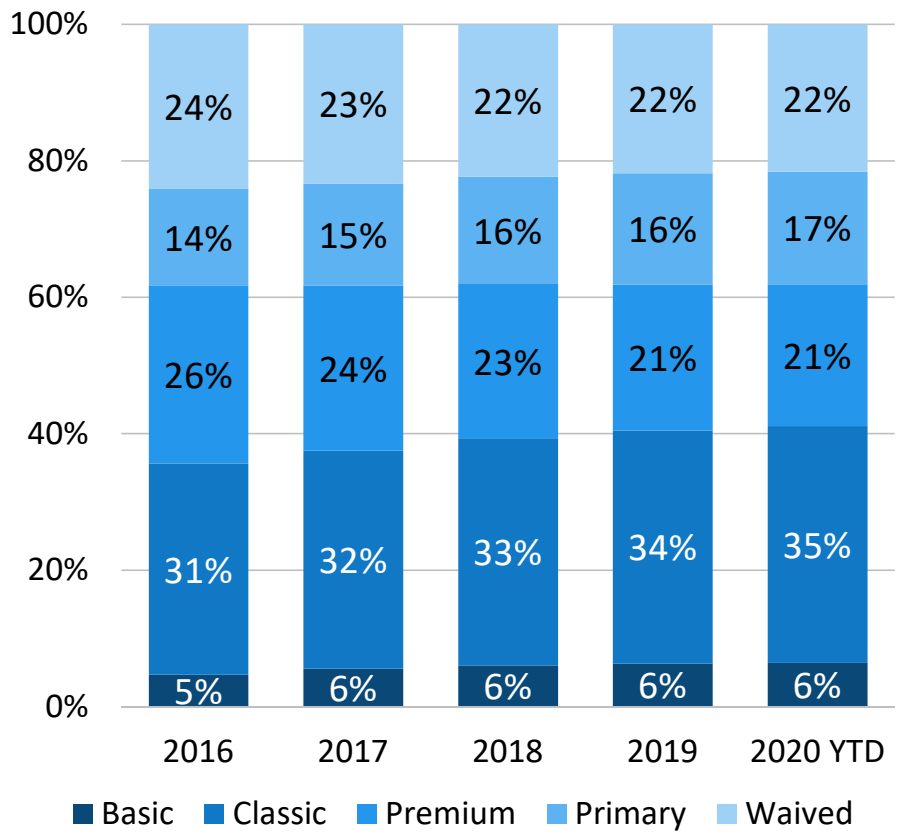
PSE - Reserves Allocation by Year

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



PSE - Average 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 January 2019 through February 2020
  - Projected March – December 2020 based on historical patterns
- Pharmacy Program
  - Projected program of $1.25 million per month for 2020, allocated between ASE / PSE based on pharmacy claims expense.
- Plan Administration Expense
  - ASE - $3.85 PMPM for CY2020 ($3.96 PMPM for CY2021)
  - PSE - $2.14 PMPM for CY2020 & CY2021
- Plan Administration Fees include PCORI charges for 2020 and 2021

Assumptions & Methodology

Methodology

1. Summarized fee-for-service (FFS) medical and pharmacy claims incurred from February 1, 2019 to January 31, 2020 and paid from February 1, 2019 to March 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 February 1, 2019 to January 31, 2020.
4. Divided the summarized incurred claims by the appropriate member months to calculate PMPMs.
5. 2020 Projected the incurred claims PMPM from the midpoint of the experience period (August 1, 2019) to the midpoint of the contract period (July 1, 2020).
6. 2021 Projected the incurred claims PMPM from the midpoint of the experience period (August 1, 2019) to the midpoint of the contract period (July 1, 2021).
7. Made adjustments for seasonality, benefit changes, and age/gender mix.
8. Accounted for rating period fees and administrative expenses.
9. Where applicable, converted incurred budget to paid budget based on historical payment patterns.

Limitations

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

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

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

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

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

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

Milliman

Thank you

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