



AGENDA

State and Public School Life and Health Insurance Board

August 5th, 2020

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. Call to Order.....Renee Mallory, Chair*
- II. Approval of July Minutes.....Renee Mallory, Chair*
- III. Plan Update.....Paul Sakhrani, & Courtney White, Milliman*
- IV. Director’s Report.....Chris Howlett, EBD Director*
- V. Adjournment.....Renee Mallory, Chair*

2020 Upcoming Meetings:

August 19th, September 22nd, October 20th

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

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

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

203rd meeting of the State and Public-School Life and Health Insurance Board (hereinafter called the Board), met on August 5th, 2020, at 1:00 PM

Date | time 8/5/2020 1:00 PM | meeting called to order by Renee Mallory, Chair

Attendance

Members Present

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

Members Absent

OTHERS PRESENT:

Rhoda Classen, Theresa Huber, Terri Freeman, Laura Thompson, Stella Greene, 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; Nima Nabavi, Amgen; Kristie Banks, Mainstream; Alan Whitley; Ronda Walthall, ARDOT; Donna Morey, ARTA; Mary Grace Smith, Sheila Weddington, ASE Retiree; Geoffery Becker, Medtronics; Jim Musick, Sanofi; Robin Keene, AAEA; Marissa Keith, BI; Suzanne Woodall, Brent Flaherty, Kristin Dolphy, Medimpact; Stephen Carroll, AllCare Specialty; Judith Paslaski; Mark Adkison; John Vinson, APA; Karen Henson; Sam Smothers; Bill Clary, ARSEBA; Ann Purvis, Alex Johnston, Mitch Rouse, TSS; Jim Maxson; Jeff Altemus, PSE Retiree; Mary Hughes; John Bridges, ASEA; Charles Hubbard, ASP; Julia Weber; Melissa Riffle; Shauna Carpenter

Approval of Minutes by Renee Mallory, Chair

MOTION by Scott:

Motion to accept the July 21, 2020 minutes.

Dr. Kirtley seconded; all were in favor.

Minutes Approved.

Plan Update by Courtney White & Paul Sakhrani, Milliman

Sakhrani and White provided an update on plan performance and initiatives for ASE and PSE.

ASE

- 2020 & 2021 projections updated to incorporate claims data incurred from March 2019 to February 2020 and paid through June 2020
- 2020 projected plan experience
 - Allocated reserves for 2020 is \$25.1M
 - Estimated deficit of \$11.1M
 - End of Year Assets: \$60.4M
 - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
 - No plan changes / 5% increase in employee contributions
- 2021 plan experience
 - No additional funding (\$14.5M allocated assets)
 - Projected deficit: \$49.8M (\$35.4M with allocated assets)
 - End of Year Assets: \$10.6M
 - No plan design or contribution changes
 - Increased membership based on historical patterns
 - Baseline trends (medical: 5%, pharmacy: 8%)

PSE

- Projections updated to incorporate claims data incurred from March 2019 to February 2019 and paid through June 2020
- 2020 plan experience
 - Allocated reserves for 2020 is \$25.3M
 - Estimated deficit of \$20.1M
 - End of Year Assets: \$102.7M
 - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
 - No plan changes / 0% increase to employee contributions
- 2021 plan experience
 - No additional funding (\$15.5M allocated assets)
 - Projected deficit: \$82.5M (\$67.0M with allocated assets)
 - End of Year Assets: \$20.2M
 - No plan design or contribution changes
 - Increased membership based on historical patterns

- Baseline trends (medical: 7%, pharmacy: 8%)

Discussion

ASE

Dr. Fiddler: Is it 66,000 actual participants for ASE?

Howlett: As far as the health plan, we have just shy of 100,000 members total. There are about 66,000 on the school side and roughly 34,000 on the State side.

Dr. Fiddler: Out of the total number that is getting the 5% increase, how many people are actually getting the wellness credit? I am trying to figure out how many people this would affect,

Howlett: For this plan year, we had 14% of the members who didn't complete the wellness.

Lilly-Palmer: If we are looking at this for the ASE retirees like the PSE, are we going to look at doing a parity? ASE retirees that are Medicare primary, their rates are \$175.16, and the rates for PSE for Medicare primary are \$100.78 and they elect Part D on their own. Are we going to look at making that a parity in the future?

Howlett: Yes ma'am, we will continue to look for the initiative to have parity or quality between the two plans.

Dr. Kirtley: That is also why, a few years ago, we started trying to look closer to having it risk adjusted, so that it wasn't just how the numbers worked out, but that it's worked out for the cost and value of the plan. If you don't risk adjust it even when you look at parity, you would be looking at the adverse selection.

Dunlap: On the Medicare retiree pharmacy, so with this proposal, it means that all Medicare eligible employees would lose this benefit; there is no grandfathering in?

White: So, there are a few Medicare retirees that have non-Medicare spouses and children and they would continue to get pharmacy coverage through the premium plan. That's the plan they are in today, but that's a really small, like one and a half percent of all costs.

Dunlap: Are there any numbers that tell the difference between their benefit for the state using the Medicare retirees versus the Part D markets?

White: Yes, it's a different benefit design overall, and anytime you change from one program to the next, there's going to be winners and losers. There's going to be a whole continuum of people who are going to win/lose. It'll probably change some behavior too because the PDPs have different formularies with different copays by brand versus generic. So, they really try to encourage generic utilization and really see higher generic utilization in those PDPs. I think there are 27 options in the market, and premiums are \$25-\$50 per month. There's even a combination option if you want to do medical and dark drugs together. There's also a bunch of zero premium options out there.

- Dr. Kirtley: I can speak to watching two parents that were teacher retirees and a grandmother that was on it; the fascinating thing about the Part D side is that you can annually choose which Part D plan they were going to have for the next year, which gave them a lot more flexibility than if they were having to have continued increases on their other plan with PSE after they retired. It can offer you a lot better coverage for the needs that you have. Our pharmacists throughout the state routinely try to help our Part D population review their medications to the plan that is best for them. Many people want a customized plan, and Medicare Part D can be your customized plan.
- Howlett: In doing the research over the last several months, we found that for our population that this would affect that the overall net cost would be less for that population given the fact that there are some zero dollar options and the way that the copay structures work with those plans. As far as what our approach would be, we have several approaches that we have tailored things to, which include going out and meeting people where they are, a community outreach piece if you will. We can't take on full responsibility because we aren't licensed to sell product, but as Courtney addresses, there are about 27 different players in the state, and in our approach, we have contacted a few of those, and they're willing to partner with the plan and show up at some of these fairs to be able to educate them. The CMS website does a very good job if you have your current medication list and you search those out, it can help you pick the best plan for you and your need.
- White: Also, for anybody that's a low-income retiree, there are significant subsidies in terms of cost sharing and premiums. There's a sliding scale that helps them with that affordability as well.
- Fecher: Wasn't this something that was taken away from the public-school employees some time back?
- Howlett: They have a myriad. When that changed in 2007, they were moved to the Part D. At the time, BlueCross was a player, I believe United and several other of the larger pharmacies. We lost the ability to track that when it goes out private.
- Scott: My only concern is, I think we're going to get some feedback from this community. Last year or year before, when we agreed to do the 5% across the board, I think that was one of the trade-offs, we didn't mind doing the 5% increase if we didn't lose the pharmacy piece. We come back a year later, and we are talking about losing that piece. I think we are going to get some feedback from this group. Second, in terms of the educational piece that you talk about, when would that happen? That is one of my concerns; will we have some type of educational piece where people could understand. We get used to one thing, and someone comes in and says we can save 50%, and we switch over all of a sudden. I think you are going to have some people that are pretty irate because they accepted that 5% across the board. Well, when we did that with the caveat, understanding that we would not touch this pharmacy piece and now we are coming back and changing. At what point do you keep this information pieced in so that

people can understand. You know, sometimes shopping for plans is not as easy as people want to make it seem.

Howlett: Our approach would be with the respective carriers as we can't partner with all 27 of them. We would at least put out communication to them about our population. The other would be looking at pieces that would establish a connection between several participating entities with our population. Our other approach would be talking to the retired state employees and their association to partner with them since they have another outreach potential to be able to communicate with the membership. As far as education, it would start at the middle to late of this month. Open enrollment starts October 1st and runs through, I believe, the 15th of November. That would be our focus from a business plan perspective to address that with members and partner with those that would come in and help facilitate that for the Part D program.

Dr. White: I think you make a good point, it is hard to shop around these plans, but on the other hand of that, part of that education would be letting our members know that there is an entire profession that this is their specialty. Each of these members are already going to a pharmacy, and they need to partner with their pharmacist to help work through this. It is not easy, I can acknowledge that, but it can be done because you have someone whose expertise is in this area that can help you figure out the best way to do this. If we are going to make this change, I think it is incumbent upon us to direct our members where they can get information; absolutely sending out what Director Howlett is talking about, but also directing them to local people that they know and have worked with them navigate through this.

Fecher: Did I hear you say that the retirees that are eligible for Medicare will not get the 5% increase?

White: Correct, their rates will stay flat. Just to clarify, there are 11 PDPs that offer 27 plans in 2020, so we would expect something similar for next year. They can only offer up to three plans, so it doesn't confuse the market too much. So, it's all the big carriers.

Dr. Kirtley: Has it been three years since we have had a price increase?

Howlett: In ASE, as far as price for the premium, there was a 5% increase for this year, and in 2016 the 3% was passed for 2017 plan year, so three.

Dr. Fiddler: How many people are we talking about that this would be affecting?

Howlett: There are 13,865 retirees.

Summary

Dr. White: If we didn't take the recommendations, what happens? What is the worst-case scenario?

White: We do not have enough money to pay claims for our employees or retirees. Right now, we are expected to have \$10 million dollars at the end of 2021. So, if claims are higher

than expected, utilizations are higher than expected, COVID-19 is worse than we think, and this really blows up next year, we won't have enough money to pay claims.

Dr. White: I wanted to make sure I was thinking of it right. This is pretty serious right now, and if we don't do something, next year is going to be catastrophic, right?

Dr. Kirtley: It feels like 2012 again, which was the PSE side, but it is still worrisome. Having watched this for a decade, my theory is COVID may have slowed us down for about five weeks, but especially with the high deductible plan, they pay out much, much more at the end of the year. If the end of this year gets even worse than expected, that \$30 million could be way more than that. I hope it's not and that these are accurate conservative numbers and that maybe we will be looking at \$20 million. It's just like the risk pool and Part D, the pharmacy risk pool is a large amount of money on that population just in utilization.

Dunlap: I see we have estimated an income of \$28.7 million for ASE, but PSE is still a deficit. What happens to PSE, and how do we handle that deficit? Is there a projected income that we are trying to get to, or are we just trying to get to the black any way we can?

White: Ideally, you want to fully fund each year. Both ASE and PSE have a catastrophic reserve that is set aside to help fund catastrophic events. So, if you have a really bad year, it helps to fund that, but as you eat into that, it really puts you at further risk for future years if you don't replenish it. There is money to cover part of that through the catastrophic fund, but I think it's best to not use that if you don't have to.

Dunlap: That accountant in me just sees the negative bottom line, so I was wondering how do you handle that?

White: I think the net assets at the end of the school year are projected to be \$20 million dollars, and that is before getting the \$50 million dollars in initiatives that we just looked at. So, that number would be \$70 million dollars in assets, and you would have money to cover the \$30 million dollar loss. There are other things we have to pay for, like the claims that have been incurred but not recorded, and some of the money is set aside for next year's funding. So, not all of those assets are just out there to be used and drawn upon.

Howlett: We also have several initiatives, and we want to make sure that it is truly obtained before we can actually report it, but we see some significant gains, maybe up to two-thirds of that deficit in the coming six to nine months. We anticipate that we will be able to retain that. We are working with several of our vendor partners to achieve that.

Gillespie: First of all, thank you for the recommendations that are being brought forward. I know that all of us are working with unforeseen fiscal impact across all that we're working on, and the responsible thing to do is to not be rosy and hope our obligation, in my mind, is to book long term and ensure the solvency of this long program long term. So, there are not easy decisions to be made in the climate we are in. I think we are all seeing and feeling that. I know a lot of the work I have been doing, what I thought was looking

ahead and developing scenarios that were extremely conservative. It has turned out that I'm having to go back and look again and be even more conservative with it because we are in somewhat uncharted territory with what we are dealing with. If we move forward today with this set of recommendations, can we look again in two months and see where we are and then two months after that and so on? I don't view this as a one-time meeting as we are in the midst of change, and I think it's important as boards that we be ready to deal with the change as it moves along.

Howlett: From a plan perspective, as far as setting the actual rates and coverages for next year, we have to do that from a concrete standpoint to be able to meet legal requirements and get those published and such. But, yes, I wouldn't say we're doing every two months. I would say our goal would be every month to look at the status of the program and to be able to report that back to this body.

Gillespie: And against the program initiatives you have here that could potentially offset some of the increases and see if those are producing what we thought.

Howlett: That's where my caution is. I want to make sure that it's producing from that standpoint. The other approach we have done from a plan perspective is to, in the current situation and to address COVID, for the last several years, we have built up catastrophic funds to be able to be left alone. It's kind of like our own reinsurance to not fall into 2012 again, where there are legislative intervention and a lot of other things. To prevent that, we are trying to look at it from a reinsurance standpoint to say we can operate this many months or this dollar amount with these funds. What our approach has been since the spring is to focus on COVID related items to kind of fall in that catastrophic bucket. Then we can isolate the information that we have. COVID is one and then standard operating planned dynamics if you will, and how do we forecast that with the trends and try to find similar trends to give us some stability in this tumultuous time. So, this estimate and the recommendation that we are putting out from a plan admin perspective today is the recommendation going forward. Then dealing with any COVID related items would be dealt with from a catastrophic nature out of those funds. We feel that is the best way to do that from a solvency standpoint.

Dr. Kirtley: Anything that we have been fortunate enough to have over into the black in previous years, we are paying down our future rates. So, the good news is that helps us to smooth the bumps, and then we get to numbers like this, and we have to make a drastic change. Every time we do this, we get hate mail over this, because the pharmacy community isn't going to like parts of it. People aren't going to be happy, but the alternative I have explained over the years here is, "you like having health insurance, right?" I mean, this is with 5% medical growth and 8% pharmacy, and we have nailed pharmacy to the floor. I get an ear full of it every time I go to a meeting, reimbursement wise, and we have had several discussions around the table of reevaluating medical reimbursements and doing a real review of where we are in that. It's different than pharmacy because we just don't understand it the same.

- Moore: Are part of the things that we have in the works, speaking about the PSE side, is that the reason we haven't asked for a 5% increase on that since we are trying to move the two plans more in the same direction and there's still ending up with a negative, in the red balance. I just want to be clear about if that's your recommendation that we go with what is being recommended.
- Howlett: We are presenting the plan's recommendation, yes ma'am.
- Rogers: So, on the PSE side, we are already making a request in the biannual to increase it by \$20 million. What we are prepared to do going into the fiscal set into the regular session is add to a supplemental for this year and right now we're looking at putting \$10 million; so I can take \$10 million out of the reserves that we have and put \$10 million towards that, and if it's still holding at this \$30 million in the session, then we can do \$20 million, and that way we drop that down to \$10.62 million and I think some of the other initiatives talked about would take care of that. We are planning on going in and asking the general assembly for a \$10 million dollar supplement right now but can do \$20 million if it continues looking like this.
- Dr. Fiddler: There's a lot of things in our lives that we have all had to do, but this is where we are. 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 the pain and help them in any way that we can? What you think of is a disaster could become a worse disaster, and nobody likes it or wants it, but I don't see any other way to do what we need to do.
- Gillespie: I would echo what Dr. Fiddler said and if we need to make an official recommendation, we can do that. When you retire at 65, you know what's coming, and you learn what to do, right? If you're already retired at 82, this is a big change, and someone needs to hold your hand through the change. I think Dr. Fiddler makes an excellent point. We do have the resources to help people make that change and hold their hand through this, particularly those who have been out for a while and have higher pharmacy claims.
- Dr. Fiddler: There is no reason for anyone to slip through the cracks.
- Howlett: I will report back from a plan admin monthly. We would normally have a reprieve in July once rates are set, but it would probably be this August for us to go ahead and do that. We will report back to the committee and subcommittees in September, and we will be able to lay out that plan.
- Scott: I do understand the seriousness of what we are looking at. Thank you for your point, Dr. Fiddler, we'll take them. I just think it is going to be very crucial to get that educational piece out there as soon as possible. I have looked at various plans, and they are not as easy to wade through as you think they are. I would hate for someone to try to jump out there without any type of educational piece and trying to select something and end up being burned, because once you select, you are locked in for a period of time. I hope that when we talk about this educational piece that we will go forward with exactly what we say we will do.

Dr. Fiddler: There is true fear out there right now with COVID, and for someone who is elderly, they may be afraid to ask the question if you will. We have got to answer their question before it's asked so that they don't have to worry about it.

Howlett: Our desire is that they ask for help. We can't assume, so we are going to put it out there in front of them, and we are going to try. It will be put out there, and we will check with that population.

MOTION by Rogers:

I make a motion that we accept the recommendations presented today for the ASE to increase employee contribution for the active and pre-65 population by 5%, change the wellness credit from \$75 per month to \$50 per month, increase 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, and for PSE to change wellness credit from \$75 per month to \$50 per month, and increase Department of Education funding from \$88.1M to \$108.1M

Fecher seconded. All are in favor.

Motion Approved.

Director's Report by Chris Howlett, EBD Director

Howlett stated we will get started on this and report at subsequent meetings. We have already kind of started from a floating it out to understand it more, but as far as the work towards this, it will start in the morning.

Discussion

Dr. White: One thing that I have been saying for a long time now is that we spend a lot of time looking at pharmacy benefits and how we save money and reduce costs to pharmacy. It is time for us to start talking about medical benefits, and Dr. Kirtley eluded to that. We have got to look at medical benefits at some point soon.

MOTION by Dr. White

I would like to propose a motion to look at medical benefits before the end of 2020.

Dr. White: We have to get serious on that and look at what where we are spending. We know what we are doing with pharmacy, and I think we have bled that turnip dry. So, I think we need to really take a serious look at medical benefits and to it in a systematic, data-driven, evidence-based way.

Howlett: We have started that within the last 45 days with our partners on all sides, realizing that you can only tap one side of the well so much. At some point, you lose the ability to keep getting initiatives and savings there, so we have started that. Our goal is to roll it

out this fall, and you all will be made aware from a Board and subcommittee standpoint in the next coming months.

Dr. White: Is that Quality of Care who will be doing that or who?

Howlett: It will be Quality of Care, Benefits subcommittee, and the Board. All the committees will hear about it minus DUEC. I will be providing an update on what the program looks like and how we are doing it.

Dr. White: When?

Howlett: It will be in September.

Dr. White: Okay, I withdraw my motion.

Dr. Kirtley: To Dr. White's point, we have done huge multi-million-dollar, multiple time cuts in one-third of the plan through pharmacy.

Meeting Adjourned.

State of Arkansas Employee Benefits Division

Initiative Impact Report

Through June 30th

State and Public School Life and Health Insurance Board of Directors

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

5 AUGUST 2020



Agenda

- Arkansas State Employees (ASE)
 - Plan Performance
 - Initiatives
- Public School Employees (PSE)
 - Plan Performance
 - Initiatives
- Appendix

Definitions

- **Employee/Retiree Contribution** – Cost paid by the employee or retiree typically through payroll deductions
- **Wellness Credit** – Monthly premium credit to active employees who complete wellness requirements
- **State Contribution** – Funded by State of Arkansas as employer contributions
- **Minimum District Contribution** – The minimum amount funded by the school district as employer contributions
- **Department of Education (DoE) Contribution** – Funded by Department of Education as employer contributions

Arkansas State Employees (ASE)

Executive Summary - ASE

- 2020 & 2021 projections updated to incorporate claims data incurred from March 2019 to February 2020 and paid through June 2020.
- 2020 projected plan experience
 - Allocated reserves for 2020 is \$25.1M
 - Estimated deficit of \$11.1M
 - End of Year Assets: \$60.4M
 - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
 - No plan changes / 5% increase in employee contributions
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 - No additional funding (\$14.5M allocated assets)
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 - End of Year Assets: \$10.6M
 - No plan design or contribution changes
 - Increased membership based on historical patterns
 - Baseline trends (medical: 5%, pharmacy: 8%)

Summary of Initiatives - ASE

- Current Deficit for 2021 - \$49.8M (\$35.4M with allocated assets)

Initiative	Decision	Value of Initiative	Estimated Net Income / Loss
Starting Deficit			- \$49.84 M
Allocated Assets		\$14.45M	- \$35.39M
Program Initiatives	Current	\$4.18M	- \$31.21M
Employee Contribution*	5% incr.	\$3.26M	- \$27.95M
Wellness credit	Reduce to \$50	\$5.90M	- \$22.05M
State Contribution	\$450 PEPM	\$12.24M	- \$9.81M
Medicare Retiree Rx**	Part D market	\$38.53M	\$28.72M
Estimated Net Income / Loss			\$28.72M

* Must maintain affordability. Historical migration. No increase for Post-65 retirees.

** Reduced cost and program initiatives, lost rebates, and cap contributions at cost

Public School Employees (PSE)

Executive Summary - PSE

- 2020 & 2021 projections updated to incorporate claims data incurred from March 2019 to February 2020 and paid through June 2020.
- 2020 plan experience
 - Allocated reserves for 2020 is \$25.3M
 - Estimated deficit of \$21.1M
 - End of Year Assets: \$102.7M
 - Incorporate estimated impact of COVID from deferred services, pent-up demand, and treatment / testing costs
 - No plan changes / 0% increase to employee contributions
- 2021 projected plan experience
 - No additional funding (\$15.5M allocated assets)
 - Projected deficit: \$82.5M (\$67.0M with allocated assets)
 - End of Year Assets: \$20.2M
 - No plan design or contribution changes
 - Increased membership based on historical patterns
 - Baseline trends (medical: 7%, pharmacy: 8%)

Summary of Initiatives - PSE

- Current Deficit for 2021 - \$82.5M (\$67.0M with allocated assets)

Initiative	Decision	Value of Initiative	Estimated Net Income / Loss
Starting Deficit			- \$82.50M
Allocated Assets		\$15.48M	- \$67.02M
Program Initiatives	Current	\$5.50M	- \$61.52M
Wellness Credit	Reduce to \$50	\$10.90M	- \$50.62M
DoE Contribution	Increase \$20M	\$20.00M	- \$30.62M
Estimated Net Income / Loss			- \$30.62M

* Must maintain affordability. Assumes no migration.

Summary of Initiatives

Initiative	Decision	Value of Initiative	ASE		PSE	
			Estimated Net Income / Loss	Value of Initiative	Estimated Net Income / Loss	
Baseline			- \$49.84M		- \$82.50M	
Allocated Assets		\$14.45M	- \$35.39M	\$15.48M	- \$67.02M	
Program Initiatives	Current	\$4.18M	- \$31.21M	\$5.50M	- \$61.52M	
Employee Contribution	5% incr.	\$3.26M	- \$27.95M	\$0.00M	- \$61.52M	
Wellness credit	Reduce to \$50	\$5.90M	- \$22.05M	\$10.90M	- \$50.62M	
State Contribution	\$450 PEPM	\$12.24M	- \$9.81M	\$0.00M	- \$50.62M	
DOE Funding		\$0.00M	- \$9.81M	\$20.00M	- \$30.62M	
Medicare Retiree Rx	Part D market	\$38.53M	\$28.72M	\$0.00M	- \$30.62M	
Estimated Net Income / Loss			\$28.72M		- \$30.62M	

Summary of Initiatives

- ASE
 - Increase employee contribution for the Active and Pre-65 population by 5%
 - Change Wellness Credit from \$75 per month to \$50 per month
 - Increase 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
- PSE
 - Change Wellness Credit from \$75 per month to \$50 per month
 - Increase Department of Education funding from \$88.1M to \$108.1M

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 projections are based on the methodology and assumptions outlined in our July 20, 2020 presentation to the Board.

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.

Appendix

Assumptions Underlying Initiatives - ASE

- 5% increase in active and pre-65 retiree contributions – the increase applies to the wellness component of the contribution for active employees.
 - We maintained the \$0 cost Basic plan for employees that meet the wellness requirements.
 - No change to post-65 retiree contributions.
 - Migrate 2% of the Premium plan actives and pre-65 retirees to the Classic plan.
- Reduce wellness credit from \$75/month to \$50/month.
 - This results in a higher than 5% increase for active employees that meet the wellness requirements.
 - A decrease of \$25/month for the Basic plan employee only contract type without wellness, which will now be \$50/month instead of \$75/month since we did not increase the employee only contribution from \$0/month to \$25/month for employees meeting the wellness requirements.
- Increase state funding from \$420/month to \$450/month per budgeted headcount (34,163).
- Post-65 retiree pharmacy coverage moves to Medicare Part D market.
 - We adjusted the premium rates by contract type to reflect the removal of post-65 retiree pharmacy coverage. We also did this for the pre-65 retiree Premium plan retirees for the contract types with post-65 retiree spouses.
 - Coverage remains for non-Medicare dependents of post-65 retirees in the Premium plan.
 - Program initiatives were reduced to reflect less overall pharmacy coverage.

Assumptions Underlying Initiatives - PSE

- Reduce wellness credit from \$75/month to \$50/month.
 - This results in a higher than 5% increase for active employees that meet the wellness requirements.
- Increase Department of Education funding from \$88.1M to \$108.1M.

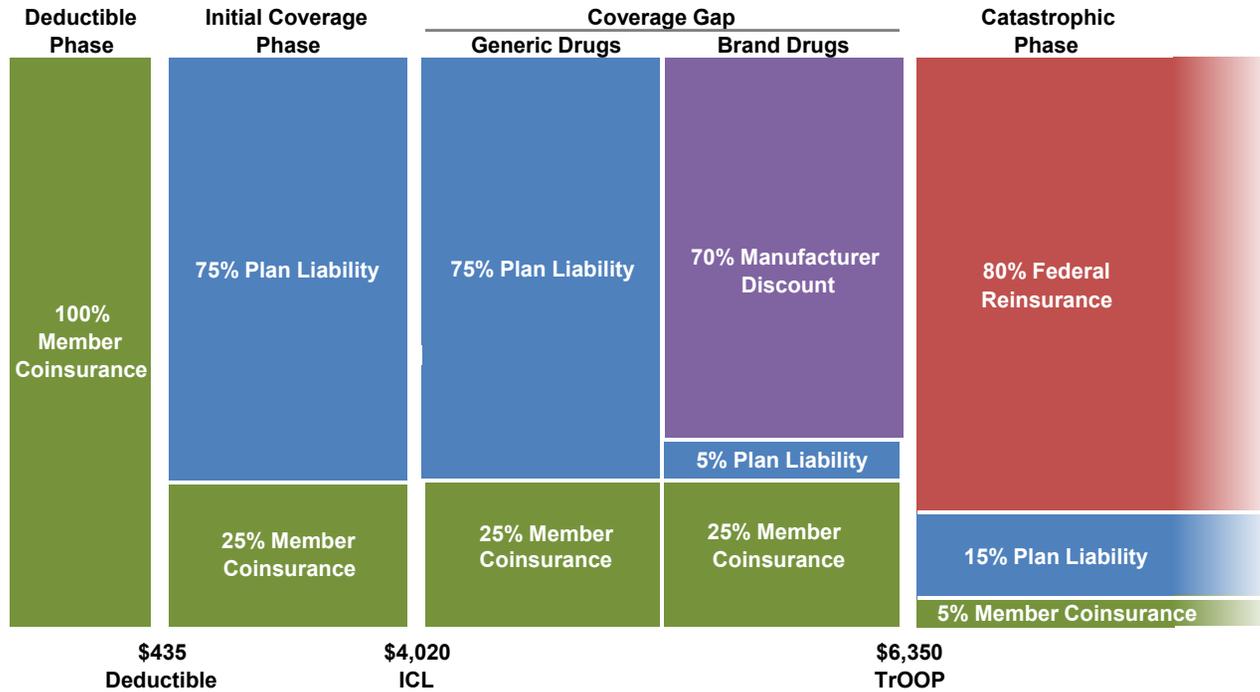
Medicare Advantage Prescription Drug Plans (PDP)

- Insurance carriers file bids with the Centers for Medicare and Medicaid Services (CMS)
 - Proposed benefits, formulary, and premium – reviewed and approved by CMS
- Arkansas – Region 19
 - About 275k members in PDPs
 - Major Carriers

Aetna	Delaware Life	Mutual of Omaha	USABLE
CIGNA	Express Scripts	Rite Aid	WellCare
CVS	Humana	UnitedHealth	

- 27 plans available in 2020
- Coverage types - PDP
 - Standard Part D - deductible plus 25% coinsurance
 - Actuarial or Basic Equivalent – can have lower deductible, exchange coinsurance for copays → equivalent to Standard Part D
 - Enhanced – can have lower deductible, exchange coinsurance for copays, additional coverage → better than Standard Part D
- Medicare Advantage Prescription Drug Plans (MAPD)
 - Combination of medical and pharmacy coverage (network plans), would replace state coverage completely
 - Options vary by county – many have \$0 premium

Standard Part D - 2020



Note

Both member and manufacturer liability accumulate toward TrOOP

Deductible and ICL are based on allowed costs. TrOOP is based on accumulated cost sharing.

Low income members are not eligible for manufacturer discount or ACA cost sharing reductions in the gap.

Cost sharing reductions instead provided through Low Income Cost Sharing (LICS) subsidies.

PDP Options for ASE Retirees – 2020 Range of Plans

Description ¹	Current	Basic ²	Enhanced ²
Premium	In contrib	\$22 to \$63	\$13 to \$138
Deductible ³	\$0	\$380 to \$435	\$0 to \$435
Pre-ICL Preferred Generic	\$15 copay	\$0 to \$3	\$0 to \$5
Pre-ICL Generic	\$15 copay	\$1 to \$6	\$2 to \$10
Pre-ICL Preferred Brands	\$40 copay	\$30 to \$47 ⁴	\$25 to \$47 ⁴
Pre-ICL Non-Preferred Drugs	\$80 copay	33% to 48%	32% to 50%
Pre-ICL Specialty	\$100 copay	25%	25% to 33% ⁵
Coverage Gap	Pre-ICL	25% ⁶	
Catastrophic	Pre-ICL	Max[\$3.60 (G)/\$8.95 (B),5%]	

¹ Tier structure can vary by carrier, PDPs tend to use Preferred Generic, Generic, Preferred Brand, Non-Preferred Drugs, and Specialty

² Retail preferred network; cost sharing at non-preferred pharmacies is higher; 90 day retail and mail order available

³ Some deductibles do not apply to all tiers; generally not applicable on tiers 1 and 2 on Enhanced plans

⁴ Some carriers have coinsurance from 15% to 25%

⁵ Generally 25% with deductible and 33% when no deductible

⁶ A few Enhanced plans have tier 1 and tier 2 coverage at Pre-ICL copays



Thank you

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