AGENDA

State and Public School Life and Health Insurance Board

March 8th, 2021

3:00 p.m.

EBD Board Room – Rockefeller Building, Suite 500

I. Call to Order.....Renee Mallory, Chair

II. Review Options for Potential Plan Savings Discussion

III. Adjournment.....Renee Mallory, Chair

2021 Upcoming Meetings:

March 23rd, April 20th, May 25th

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 – WORKING SESSION MEETING MINUTES

The State and Public School Life and Health Insurance Board (hereinafter called the Board), met on March 8th, 2021, at 3:00 PM

Date | *time* 3/8/2021 3:00 PM | *meeting called to order by Renee Mallory, Chair*

Attendance

Members Present

Stephanie Lilly-Palmer
Greg Rogers
Secretary Cindy Gillespie
Dr. John Kirtley – Vice-Chair
Dr. Terry Fiddler
Secretary Amy Fecher
Dr. Lanita White
Cynthia Dunlap
Renee Mallory - Chair
Shalada Toles, Employee Benefits Division Deputy Director

Members Absent

Teleconference

Cindy Allen
Melissa Moore
Lisa Sherrill
Dori Gutierrez
Herb Scott

OTHERS PRESENT:

Rhoda Classen, Theresa Huber, Laura Thompson, Jennifer Goss, Drake Rodriguez, Janella DeVille, EBD; Micah Bard, Dwight Davis, Octavia DeYoung, UAMS EBRX; Jessica Akins, Takisha Sanders, Health Advantage; Courtney White, Paul Sakhrani, Scott Cohen, Greg Collins, Julia Weber, Milliman; Mitch Rouse, Ryan Fischer, TSS; Sylvia Landers, Colonial Life; Jill Johnson, UAMS; Judith Paslaski, Suzanne Woodall, MedImpact; Nicholas Poole, ASEA; Frances Bauman, Novo Nordisk; Charles Hubbard, Phillip Warriner, ASP; Erika Gee, WLJ; Aaron Shaw, BI; Ronda Walthall, ARDOT; Robert McQuade, ASE Retiree; Melissa Riffle, AGFC; Dwane Tankersley, NovaSys Health; Charlotte Downs, AstraZeneca

Review Options for Potential Plan Savings Discussion

Milliman provided a presentation to educate the Board on guiding principles, benchmarking, plan performances, and initiatives.

Discussion:

Gillespie: What would be the increase in the out-of-pocket max in this scenario?

White: It would go up by $250. If your deductible is $500 and your out-of-pocket max is $1,500, it would be $750 and $1,750.

Dr. Kirtley: Can you remind us how many lives we are talking about on each plan, ASE versus PSE? I know there are two ways we look at the plans. It is belly buttons versus actual plans.

White: It's around 60,000 and 90,000 roughly. We can get those for you. One thing to keep in mind, the deductible and the out-of-pocket max increase don't apply to the post-65 retirees because they are secondary to Medicare, so they don't have the same kind of benefits provisions.

Dr. Kirtley: The high deductible plans aren't maxed out on that yet, correct?

White: That's correct.

Moore: When can we expect to have this kind of breakdown for the PSE side?

Sakhrani: In terms of the benchmarks, we are looking at the benchmark information to see how the PSE plan stacks up. We are still looking for some of that information as well, so I imagine it will be a week or two before we get to some of those PSE benchmarks.

White: That information is not as publicly available as the states are unless they are state employees.

Sakhrani: Similarly to what we saw with the state of Arkansas, we do know that other school districts may have their own employee funding or subsidize some of their employees. I don't think we are going to be able to capture that kind of information when we look at public school employees for other states with districts that do their own thing.

White: For PSE, there are about 81,600 active members, belly buttons, and there's a little over 4,000 pre-65, and about 15,500 post-65.

Fecher: I will point out the obvious for the Board, the pre-65 retirees are where we have the lowest numbers but the highest cost.

Dr. Fiddler: On slide 21, under strategic themes, reduce low-value services, and then on slide 22, that falls underutilization efficiency. This is what we have talked about month after month that we have been in here about where we can cut costs and how we were going to do this. Are you going to make a recommendation at the end of this concerning low-value services and what could be saved from reducing those, or is this just one of the things for us to look at?

Cohen: It's one of the things to look at, and we think that you need more information. You need that benchmarking information that we are working on.

Fecher: Courtney, I was wondering if you could explain to the Board like you were explaining on the weekly call with me about the difference in managing the pharmacy and the medical side and how that is a little bit harder on the medical side while trying to get information for Dr. White that she has been requesting. Can you go into that a little bit?

White: On the pharmacy side, generally, EBD contracts with an entity. MedImpact is the PBM, and that entity then has contracts with all downstream pharmacies, whether they are

independents or chains. On top of that, there are also relationships with the manufacturers for the rebates. EBRx helps with that as well, so there is a limited number of players. There are more levers on the pharmacy side that do not impact the member like they do on the medical side. For example, if Dr. Davis and his group are able to negotiate a better rebate with the manufacturer, the member doesn't see or feel that. It just creates savings to the plan. From a contracting standpoint, if they want to do something with how generics are reimbursed or the discounts for brand name drugs, they can just go to that one entity to make those changes. There's a limited number of people that you have to deal with to do this. On the medical side, Health Advantage is the TPA, and then under that TPA, there is almost every hospital and every physician in Arkansas. They all have individual contracts with Health Advantage, so there's an extra intricacy. Those contracts are on a three to five-year basis where they renegotiate those. Usually, when they negotiate a contract with a hospital, say it's X, and then there's usually inflationary increases year over year until the next contract renewal comes up, and then they will renegotiate again. Also, on the medical side, from a utilization management standpoint, there is usually a trade-off between the cost savings and then the impact on the member, whether there is any kind of delay in care or the appearance or perception of not providing care. It's easier to create savings on the pharmacy side because of those than it is on the medical side; even though the medical side is a much bigger piece of the pie, but there are opportunities that we are going to look at. There may be a potential for savings, and some of it is making sure that providers follow those administrative rules in providing the care, but also some of it may be if the member has to jump through some of those hoops to get their care.

Dr. Kirtley: I think what you just described is where we were in pharmacy a decade ago. A decade ago, we had a contract directly with the PBM, and they managed all other issues. The only thing that we managed at that point was the contract to the PBM, and then we had some input from time to time over what the overall reimbursement rate might be. But we removed all the rebate contracting, all the clinical management of which drugs were chosen for formulary to basically break up that pie. Our contract for this Board is with the TPA, so are you telling us that we do not have terms to dictate contractual prices directly to the TPA because they have decided to do it themselves previously?

White: No, I'm not saying that. I haven't seen the Health Advantage contract with you all, but generally, the way those work, I don't know if you can dictate prices to the downstream providers, hospitals, and physicians. I think there may be things that you can do on the medical management side, but that would require you to add FTE's and provide benefits for them and increase staff to do that. There may be ways to buy up a higher level of Medicare management from Health Advantage or other outside vendors to target certain populations like we did with Kannact that would focus on certain chronic conditions or certain other things that are easier to identify and isolate.

Dr. White: Thank you for your explanation of the difference and the complexities of the two, and while I appreciate that, I would still like to see what our approach is going to be to look at medical costs. While I get there is an extreme amount of work and could cause an increase in staff, FTE, etc., it's probably not going to add up to these millions of dollars

that we need to figure out where to find it. Just like we have a drug utilization review committee, I think from a Board perspective, we need to look at how we are managing, looking at, or processing reviewing medical use because as you just said, that is the largest part of our expenditures. Right now, it just seems to have no guard rails on it. While I understand it is actually complex, and it is a big huge gorilla to wrangle, we are going to end up in this position every couple of years if we don't get serious about doing something about it. I understand that we can't control it as tightly as we have pharmacy, but I think we have run out of most of the options on pharmacy or large savings from a pharmacy standpoint. We have got to get serious about looking at medical costs and how we look at that. You said you have some strategies you are going to look at. What are those? Can you give me an overview of those?

White: Right now, we are in the process of putting together a detailed benchmarking of your utilization and costs for a large number of categories. Some of them are by type of service, and some of them are by condition and looking at those verses other benchmarks for similar employers to see how they stack up and try to identify where there may be opportunities. Once we drill down on those, we may say there is definitely an opportunity here to reduce cost, or we may say no, you just have a sicker group here, and then maybe there is a way around that too. Maybe there are other ways to improve their health or help them better manage their health. We are definitely looking at the benchmarks. I'm not saying there is nothing we can do and throwing our hands up. We are looking at opportunities for potential savings, but as you said, they take a lot more effort and coordination because the care is so much more diverse on the medical side. You know when people take drugs, they tend to take them year over year over year and there are the chronic conditions that we need to focus on too, but then there are also these random treatments that take place. You know if you break a leg one year and someone else breaks theirs the next year. Probably less than half of the costs on medical are actually predictable. The rest of them are these random events that happen in people's lives. We are definitely going to dig into that benchmarking to try to come up with some key things to dig into deeper for you to consider that we may be able to take action on.

Dr. White: What is your timeline on that? Scott is working on that now, and I'm not sure where that is, but I know we are pulling the benchmark data and lining it up, so I think we are getting close. We can update you on that through Secretary Fecher or Shalada.

Dr. Fiddler: On your last point under additional notes, when you are talking about being conservative in savings estimates, is it a different percentage of savings to the conservative level per procedure, or is the overall amount of savings that you are looking at for the total surgical picture?

Cohen: Each intervention, looking at surgery, we would typically start with a benchmark against other employers to see what is average and then potentially what is possible. You might take everyone who has knee osteoarthritis match on age and then say on average X percent are getting a surgery. We will look at EBD's numbers and say, is it about in the ballpark, or is it much higher? If it is higher, we might think that there is more room for improvement there. Usually, what we think of is kind of a close the gap methodology

where you'd okay this is what is average and this is what is possible; how much would the savings be if we moved towards what is average or what is possible. That has to be done at a pretty granular level, and there is a lot of assumptions in there, and that's why we typically hedge in terms of how likely the savings are because there is a lot of things that have to happen. In comparison to the drugs, as a new medication comes up, it is sometimes one of 6, 7, 8, 9, or 10 alternatives. Those drugs would be considered almost direct substitutes to the members. By picking one drug, the member may not really feel like they got triaged or rationed care versus a member who is recommended a medical treatment or surgery by their physician and are told they need to try medical treatment first or just take pain relievers or physical therapy first. It's not an apples to apples comparison. On the drug side, you can say we're going to switch most people over to this, and on average, it's going to be $200 less per script. It's a pretty direct line of savings. On the medical side, we might try to shift more people to medical treatment instead of surgical, but maybe only a small percentage of them actually stick on the medical side and end up having surgery anyway. It's a long answer to why we're hedging, and it can be a pretty low percentage of the opportunity that's actually harvested.

Dr. Kirtley: So, this may be an overgeneralization, but what I am generally told on the medical side of billing is that the known entity and we are talking about two things. One is the medical management of when a patient gets access to specific care. That is some micromanagement of what types of approaches we would have on certain things. Then we are talking about the actual payment side, whether we reference priced the procedures or if we just take a different approach like we did with pharmacy on what the reimbursable rates are. The known in that has always been Medicare, or even Medicaid, reimbursement rates, and I don't think anybody at this table has any idea where we are to that specific benchmark. We know how we might compare to some other plans by your next slide, and the suggestion is not that we go parallel to Medicare. Every other plan I've ever dealt with or heard of use a benchmark of Medicare plus a percentage of whatever that percentage is because of the way Medicare has looked at all of these procedures and what they cost.

Mallory: I think that's where I was going to go. I mean, do we know based on different facilities for a knee surgery, what's the cost is at each facility? Is there a big difference in that for diagnostic procedures? Is there a big difference in the cost of a diagnostic procedure depending on where you have that done? I mean, I think that's where instead of the management part, I think that is the piece we need to start with.

Dr. Kirtley: That is exactly what we saw on colonoscopies that we have discussed and discussed and discussed at this table because there was such great variability, as well as how they did the procedure. Did they knock you out? Did they just put you in twilight basically, or whatever it would be, but you know, with the provider laws the way they are in Arkansas if a plan sets a rate that allows anyone to participate that is willing to take the rate. Now, you can get to where no one will participate. But we don't know where we are on that type of benchmark.

Mallory: And to that, eventually you would ask the question if it does cost more at one facility, are we getting better quality at that facility? So, you would have to put that in there too.

Fecher: I believe what Health Advantage Blue Cross Blue Shield is doing now is negotiating the rates with the providers, correct? We don't even have access to that information. We can request it from Blue Cross Blue Shield, but that's what they're currently doing. That is their role is to negotiate with providers.

White: We can see from the data how much procedures cost at different facilities. If we focus on a knee surgery, we can look at all the knee surgeries that were done by a provider and get an idea of high cost versus low cost. The quality side is really hard to measure. You see quality statistics out there about hospice, but they're very macro level about tests and readmissions and things like that. But this is kind of touching on the point of Scott mentioning the kind of Centers of Excellence are even referenced based pricing, but in a different way that says, all your knee surgeries have to go to this facility; this is the gold standard for knee procedures. If you want to go someplace else, you have to pay the difference in cost plus your normal cost sharing. So, this is more of a discussion as to how you're going to get those members to go get those services in those facilities. So, if you don't do something with the network to drive them there, then a lot of times they don't know where they're going to get sent because the doctor says you need to go to hospital A, and they say okay. They don't know if it's high cost or low cost. They just know that's where their doctor told him to go, so that's where they're going to go. That's certainly something we were touching on in terms of Scott's discussion about the reference base price in the Centers of Excellence.

Gillespie: There are several different methods you've talked about for us to do more medical management. And it would be good, for me at least, useful to see some of the different ones. Preauthorization, for example, I don't know that we fully use preauthorization as much as we could, and a preauthorization does not have to take forever to do. It can be set up to happen quickly. But in many cases, that preauthorization, if you look at our data for us, you should be able to see some trends where there's just sort of an automatic trajectory of you come in the door for this, and you move straight along and out. That might be where it makes some sense for us to look and see where we're off standard, put in a preauthorization, and begin to see does that begin to change what happens. Do people get diverted into a better type of treatment for them with where they are versus just through an automatic trajectory? I don't know how much we are using any sort of, to your point about quality as well as cost, any kind of value-based purchasing, or how much even bundling we're doing around some of this. So, I mean, there might be some elements to look at because I do think we've seen in a lot of places where there's been great success, saying to employees, we would recommend going here, this is where we get the best value. That's both quality as well as costs. If they do something else, it's pretty typical in a lot of plans for the beneficiary to pay the extra because they've chosen to go somewhere different, or they might have a very unique situation, and you can always have exceptions. I think there's a lot of opportunity. It's the question of how quickly can our Milliman team begin to pull a lot of this together so that we can begin to put together a way to actually work our way through it. But I guess

I'd be a little nervous about just going low cost because low cost could lead to poor quality.

Dr. White: I think the whole point is to do evidence base, like we have done on pharmacy, even on the medical side. To your point, there are many things that we can put in place and it is going to be a huge task. In the end, it can really produce some cost savings. So, I think the evidence-based piece of it is important because we have gone heavy on evidence on one side, and we seem to not necessarily be reviewing evidence on the other side.

Dr. Kirtley: I think that is what ACHI has brought us snippets of for years. I never thought I would spend the number of hours we have spent at this table talking about colonoscopies., but it was a couple million dollars' worth of difference between Plan A or Plan C on that as well, as you're looking at current guidelines of it wasn't indicated for everyone as fast as some were getting it. I think we're going to find that with knee surgeries, the grand example, because we know how expensive they are and how common they are.

White: A couple things; I think the pre-auth idea will definitely be something as part of our initiatives that if we find things that look like they are not in line with the benchmarks that could be put in place. The other comment was value-based care. So right now, Health Advantage has what they call a withhold program. So, what they do today is hold back a certain percentage of the amount paid to the providers, and this is primarily in Central Arkansas. They hold back, say up to 20% of the reimbursement. So, if a claim was $100, they'd pay them $80 and hold the $20 back. Then what we do is set overall medical targets for the active and the pre-65 populations. At the end of the year, we compare the actual claims to the targets, and if the claims are above the target, then EBD gets that money. If the claims are below the targets, then the money goes back to the provider. So, it's a little bit of a loosely aligned value-based care program, and really, it provides protection if things were to go much worse than expected. You don't get a lot of savings on a good year, but on a bad year, you get extra protection. For example, we got extra money in 2019 because of the withhold program. We had a conversation with Health Advantage last week or the week before about maybe changing that program to more of an ACL approach. You've probably heard the ACL terminology and what that tends to do is provide more up and downside risk sharing with the provider. So, you set a target and if they come in 10% below the target, then you would both share 50/50 in that savings because you're taking the risk, but they're also providing the care. So, there's some sharing there that goes on to give them the incentive to come in below target to get that extra amount. So, we're definitely having those conversations as well.

Toles: As it relates to prior authorizations, we do some prior authorizations; we do have a list that we can provide. So, there are prior authorizations going on all the time, but maybe that needs to be added to or taken and looked at.

White: But on prior authorizations, I think the trends were heavy. They were heavy early on, and then plans started pulling back on those because I think they looked back and said, yeah, we did 1000 pre-authorizations, and 900 of them got approved anyway and of those 100 that didn't get approved, the person ultimately got the surgery or procedure done for some other reason or after they did the stuff they were supposed to do. So, I think that's certainly something we can look at as we look at these benchmarks.

Dr. Kirtley: In a normal plan, what is the general split in spend between medical and pharmacy?

White: Pharmacy is usually 20%-25%.

Dr. Kirtley: What is ours? 18%?

White: I am not sure, but we can get that information for you.

Dr. Kirtley: I just know on a lot of them when I look at other plans, the number I usually hear is 25% to 30% of plan spend is pharmacy. I know we have really micromanaged pharmacy to get ours below 20%, which is fascinating when we see other health plans that people say, well, we manage this, or we manage that so we can help you. I go and look at the pharmacy spend, and their pharmacy spend is higher. So, they're doing a much better job on medical, or we're doing a really, really good job on pharmacy. It's difficult to tell which one it is, but I think it's we're doing a really good job on pharmacy.

White: The benefit design can affect that too. I think in the basic and classic plans doesn't the pharmacy benefits fall into the deductible, whereas under the premium plan its first dollar? On the ASE side, I would guess that pharmacy might be a little higher than it is on the PSE side because the PSE people are having to meet the deductible, and then they also have coinsurance instead of fixed copays.

Dr. Kirtley: But that's the way it is for most plans. I see a lot of high deductible plans that every dollar is out of pocket until you meet the deductible, whether it's pharmacy or medical, unless I've completely missed the boat on that.

Sakhrani: Yes, that's correct.

Dr. Kirtley: Are you saying that the EBD plan is based off of Medicare, 136% of Medicare on inpatient and 138% on outpatient and then the total or average is 135%?

White: That's the yield. They may not be paying that way, but that's the yield. So, they may be paying under other structures. They may have per diems in place, or they may have DRG's in place on inpatient. At the end of the day, it yields 136% of Medicare. Their contract may not say we pay Medicare plus 36%.

Dr. Kirtley: I understand. That's is just not how I had read the date reviewing this beforehand.

White: If you were to look at a hospital claim, and it was $10,000 for Medicare, EBD would be paying $13,600. Nationally, it's much higher.

Sakhrani: To add to that, there's still opportunity on price. So, we talked about one of the initiatives we'll probably look at is those high-cost procedures. So, whether it's knee replacement MRIs, we definitely do see price variations in some of those procedures. So, some of those high-cost procedures, maybe we do put in place a reference base price or something like that. So, there may be still opportunities on the price side. But generally, this is where we see where the yield was over the past year's data.

Fecher: I would just say that these are all some really good ideas, and I think we do have to follow up on some of them. I also think we're on a bit of a time crunch for the end of 2022. I think that we're not going to be able to fully vet everything because of the timeframe to roll everything out. By rate-setting time, we're going to have to have everything figured out and we saw last year when we tried to compress that timeline, how that went over. So, I have Ryan Fischer here that has an interactive spreadsheet that we use with some of the legislators just to show you in real time if you tinker with certain numbers, how much that nets the plan and Milliman gave us three examples

there. I think the board is really going to have to come to an understanding soon on what we're willing to do for 2022 to dig out of that $70 and $40 million hole.

Dr. Fiddler: Secretary Fecher, you stated that we have to get some plan for 2022. What is your timeline? When are we looking at as the drop-dead date that we've got to have something?

Fecher: Open enrollment is October. So, October is when we would have to have everything in place and approved by that time. We're going to have to have time to get the information out to the public as well. So really, I think we need it in the next couple of months.

Toles: No later than July.

Fecher: I think historically, you were setting rates in around June or July. It was a little later last year.

Fischer presents interactive spreadsheet

Fecher: There is a bill that would take the maximum amount the state funding could go up to $500, which we're now at $450. However, this board would have to vote to take it to that amount, all that bill would do is say that it could go up to that, and then you're going to have an issue of the balanced budget as well.

Dr. Kirtley: It's a weird tightrope on that. We've cut some budgeted positions in the state, but I don't think that was enough to have an appreciable effect on that number.

Fecher: I just have to say we're not saying we have to do these things. We're just showing you what we could do; you may want to change 5% to 10% or 7%. You may want to play with the deductible. These are some examples. This is not a recommendation of Milliman; it's not a recommendation of EBD; it is giving you data that you can help make those decisions.

Dr. Kirtley: This is the easy data to calculate. All the other stuff we have talked about is the long road to get a better answer. That's going to take more time than just next month.

Fischer: These are all just revenue drivers. The expenses are the long things that we can't really project; I can’t project. Milliman will have to be the ones to do that. I'm just recreating their numbers based on the data that they gave me.

Dr. White: So basically, no matter what scenario we do, as Secretary Fecher was saying, we could play with the numbers. We've got to do multiple things, is what I'm saying. We can't just do one thing. So, it's going to be a combination of several different things that we're going to have to do.

Fecher: Then Greg has to tell us what we can do on the PSE side.

Dr. Fiddler: Milliman made the comment earlier to be conservative in savings estimates. Are you thinking these are conservative numbers in order to get us to this number that we're talking about here?

Fischer: These are their (Milliman) numbers. I just took them and put them into a spreadsheet that we can play with. I don’t have their backup data.

Sakhrani: Most of these revenue numbers are hard no numbers. So, they're purely based off of headcounts and elections. So, they're pure revenue numbers; when it comes to these

numbers are not conservative; they're best estimates. When it comes to those longer-term plan initiatives, those are where we would say you would want to be conservative because those are a lot harder to measure.

Gillespie: Is there a difference between the percentage contribution an employee makes based on the type of plan they're in? So, in other words, those that are in the HSA, do they have a different percentage contribution versus those that are in the more premium plan?

Dr. Kirtley: As I recall, each type of plan has to have a percentage value. So, the dollar amounts are much less, but the plan has to pay a certain percentage to qualify as a premium plan or a basic plan. So, I don't recall what that percentage was. It seemed to me it was like a 60% versus a 90%, or 85% at one point, but it's not necessarily percentage-based. Like you could have a standalone employee with the basic coverage, and it could cost them nothing. So, their percentage that they have pay in is zero, but it's basically catastrophic insurance for that single person.

Gillespie: So, when we talk about a 5% increase, that means everyone gets a 5% increase on whatever their current percentage is, but we could vary that if we chose to.

Dr. Kirtley: That's the thing. At times we have smoothed the edges a little bit. In the past, this Board moved towards a risk basis allocation so that if you have a higher cost area that it could be a slightly different percentage when you get down into the micro-levels of it. Because saying we're going to increase, you know, $1 by 5%, it's $1.05. Well, that's not necessarily an incremental difference. It may be that that becomes a $10 cost or something. So, we do have to look at the specifics as well as the percentages, I think, to make sure it makes sense.

Gillespie: But if we were, I'm not saying we're doing this, but if we were wanting to really encourage people, particularly those who were at the earlier stage of their careers, to begin moving towards the HSA option, you might give them a one or 2% increase whereas if you really want to make it clear that if you're going for the premium, you're going to carry a heavier load, you might shift more of it that way.

Mallory: Which we have done.

Dr. Kirtley: We've seeded the HSAs in the past. Along the same lines trying to push your healthy population to that. But then it's catastrophic insurance, so if they use it, they use it big versus premium. So, we we've tried to smooth those edges for adverse selection over the years through advice of our actuaries as well.

Toles: I just want to add, it's not really based on a percentage. There is a premium amount for each class, and then when you go up 5%, it goes to 5% more of their premium. So, I don't know that we've ever looked at it as a percentage of the spend or anything like that. It's not true dollars associated with how much the actual spend is.

Courtney: One thing that Paul talked about was, some employers will say, for example, instead of paying 25% of every employee's cost, we want them to pay 25%. You could say we want them to pay 10% of their own costs, but every dependent is 50% of that person's cost. So, that way, the people with larger families aren't really getting a bigger benefit because they're paying a similar percentage of their costs. So, right now, an employee only contract in the premium plan, and an employee and family, may both pay 50% of the cost. You could structure it so that that employee only person actually pays less

percent because the other people are paying more before their dependents. Because right now, the dollar amounts are different, but the percentage allocations are similar.

Fecher: So, this has been a lot of information to take in, but as I said at our last meeting, I think it's going to take more than one session. I think this gives us a really good baseline, and the next time we come together, we can talk about options and things that we would want to tweak because we are going to have to make a decision soon.

Dr. Fiddler: It would help me immensely if we could do these by sections. This has just overwhelmed me. If we can just understand what we're going to do for our members. and we can do it piece by piece. This is so global to me I can't get specifics on how I want to vote on this.

Mallory: Well, I think what we're going to have to come up with is different scenarios and what we want to do for each category to get to the total that we need. So, we had to have this basic information. Like Secretary Fecher is saying, we've got to get a little bit more strategic in what our recommendations might need to be. I think we got into some discussion today about some things that we're going to need to do down the road. But yet, we don't have time to do those now. I mean, the things that we need to do now are a lot more specific in the recommendations that we need to come up with at this point.

MOTION by Lilly-Palmer:

I make a motion to adjourn the meeting.

Dr. Fiddler seconded. All were in favor.

Meeting Adjourned.

State of Arkansas Employee Benefits Division

State and Public School Life and Health Insurance Board of Directors

Courtney White, FSA, MAAA
Paul Sakhrani, FSA, MAAA
Scott Cohen, MPH

8 MARCH 2021

Milliman

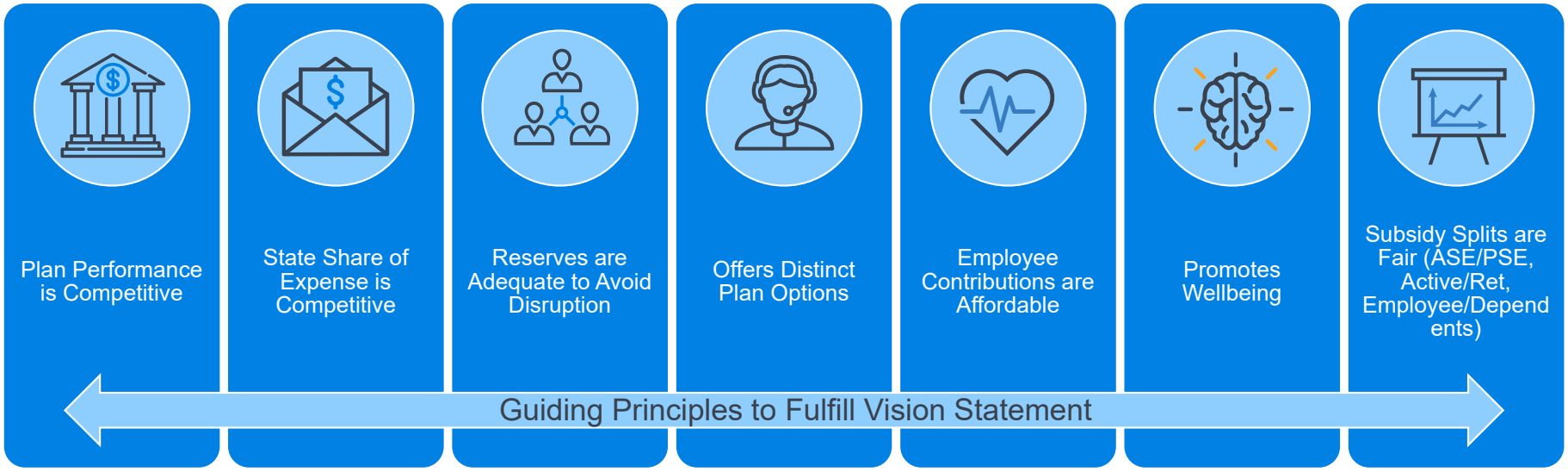
Agenda

- Guiding Principles and Budget Levers
- State and Employee Funding Benchmarking
- Population Subsidization
- Plan Design Benchmarking
- Plan Performance
- Initiatives
- Appendices

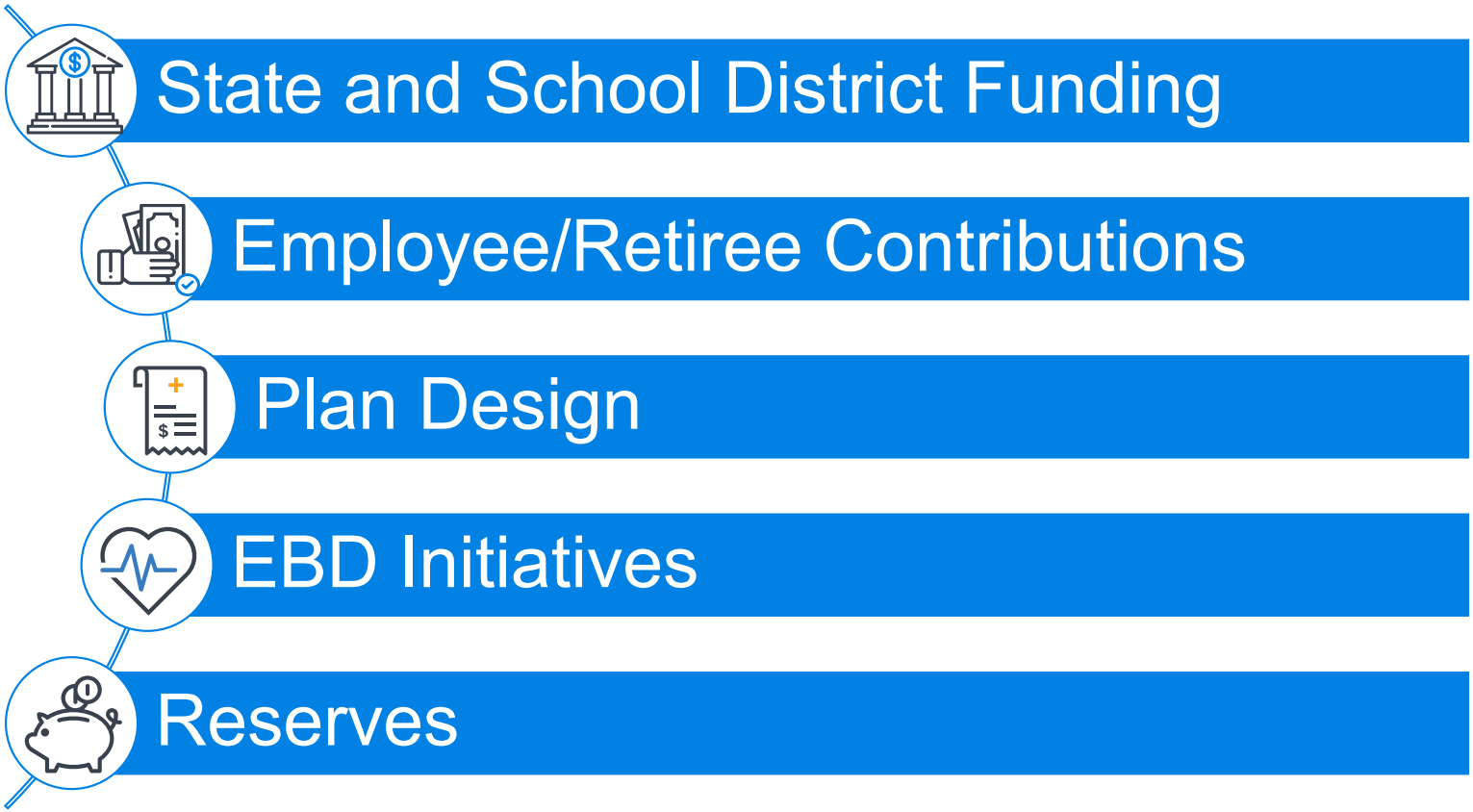
Guiding Principles

Draft Vision Statement:

The Board will offer plan options that provide competitive value and health promotion in comparison to other states and consistently ensure that the plan is fully funded to maximize value and remain solvent



Budget Levers



Recap of Projected Funds Needed for 2022

Additional Funding and/or Savings Needed to Fund 2022 Projected Expenses and at least 10% Reserve	
ASE	**PSE**
$40.0M	**$70.7M**

Total estimated funding needed / reduction in expenditure to cover 2022 expenses and achieve 10% reserve or maintain current reserve level (PSE)

	02/23/2021 Board Report	
	ASE	**PSE**
2022 Projected Revenue	$316.0	$379.9
2022 Projected Expenses	($351.3)	($450.6)
2022 Projected Income / (Loss)	**($35.3)**	**($70.7)**
Projected Net Assets End of 2021	($4.9)	($18.8)
Target Net Assets (10% of Expenses)	$35.1	$45.1
Needed Change in Net Assets	**$40.0**	**$63.8**

Once budget is balanced with targeted reserve, will need to increase funding each year to match projected expenses

Summary of Initiatives – Illustration

- 2022 ASE target: ($40.0M) (estimated deficit + 10% catastrophic reserve)
- 2022 PSE target: ($70.7M) (estimated deficit + maintain catastrophic reserve)

	ASE		PSE	
Initiative	Savings	Balance	Savings	Balance
5% Contribution Increase	$5.5M	($34.5M)	$8.0M	($62.7M)
$250 Deductible & OOPM Increase	$3.4M	($31.1M)	$5.1M	($57.6M)
Reduction in Wellness Credit from $50 to $25[1]	$5.4M	($25.7M)	$11.9M	($45.7M)

[1]Not recommending elimination of wellness program, showing value of change to credit

ASE – State and Employee Funding Benchmarking

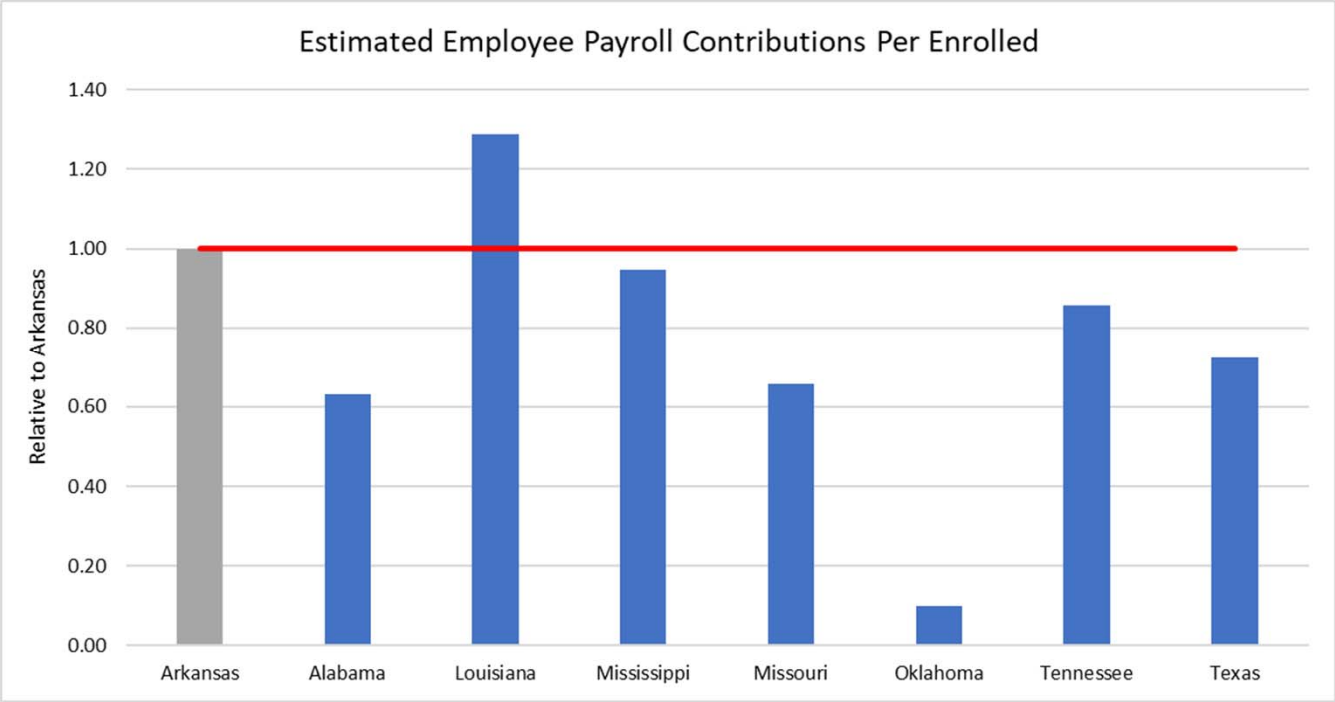
ASE – State and Employee Funding Benchmarks

- Reviewed healthcare benefits of 7 states surrounding Arkansas. States included are:
  - Alabama, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, Texas
- Mapped Arkansas employees to the closest matching plan option in alternative State
  - This assumes that enrollment distribution between plan, tier, and employment status is similar to Arkansas
- Relied upon the 2020 premiums and employee payroll contributions published on State websites for employee payroll contributions, total plan cost, and State subsidy
  - Actuarial judgement used when information was limited
- State of Arkansas 2020 premiums, employee payroll contributions and plan subsidy based on actual 2020 cost estimates
- Benchmarking results are primarily for directional purposes. Preliminary Findings:

Statistics	ASE (Rank) - Active
Employee Contributions	Rank: 7 of 8 (high employee contributions)
Estimated Plan Cost	Rank: 2 of 8 (low cost)
Plan / State Subsidy	Rank: 2 of 8 (low subsidization)

ASE – Benchmark Study (Active Employees)

Estimated Employee Contributions per Enrolled*

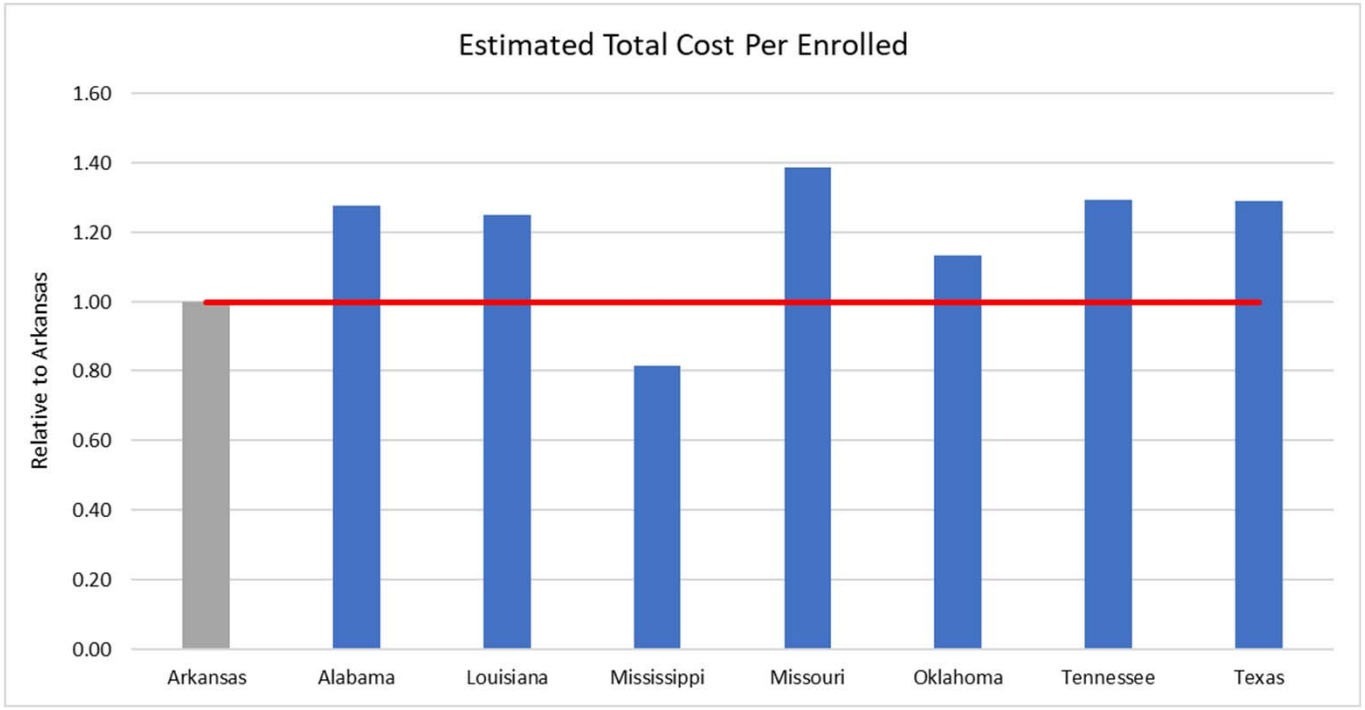


**See Assumptions and Methodology at the end of this report*

- Arkansas employee payroll contribution ranks 7 (higher the rank, higher the employee contributions)
- A few states provide a fix subsidy level by tier (e.g. MS,OK,TN, and TX)

ASE – Benchmark Study (Active Employees)

Estimated Total Cost per Enrolled*

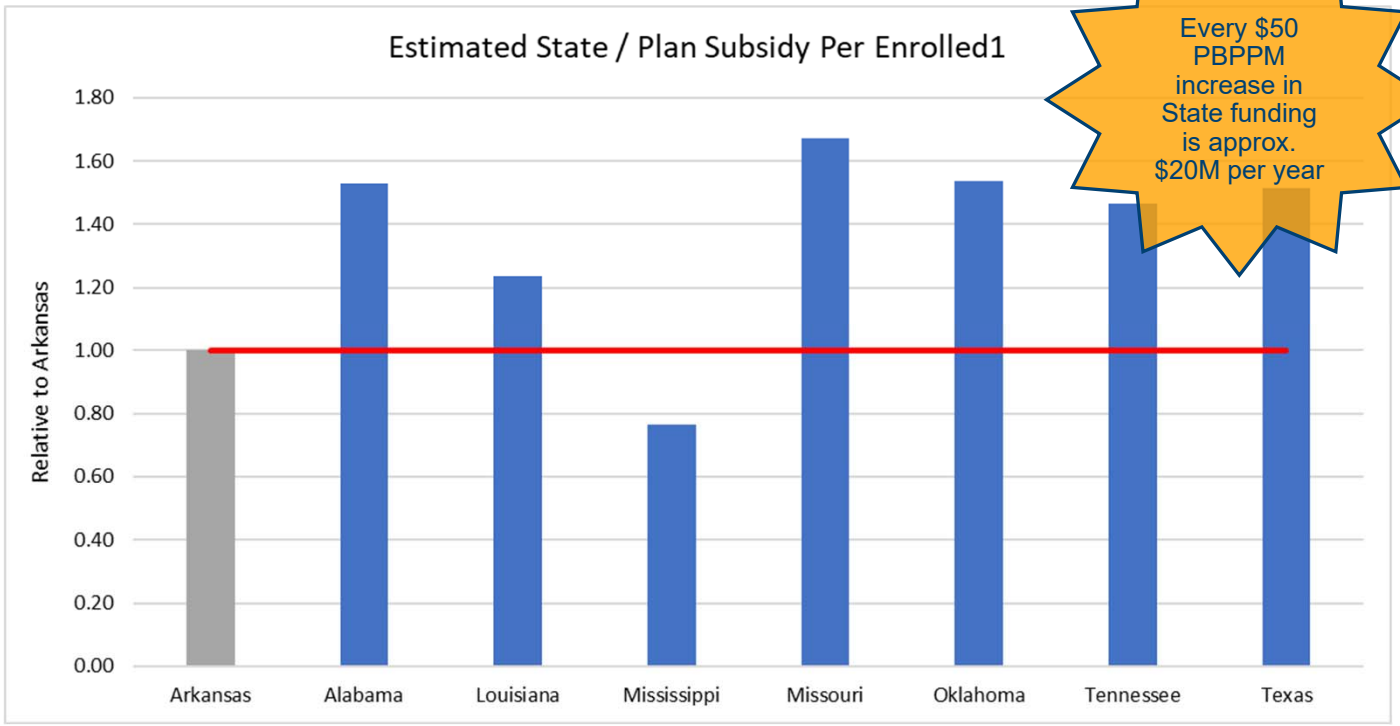


*See Assumptions and Methodology at the end of this report

- Arkansas total plan cost ranks 2, just behind of Mississippi (higher the rank, higher the plan costs)
- Arkansas low claim cost may be attributed to: cost of living, better plan management

ASE – Benchmark Study (Active Employees)

Estimated State/Plan Subsidy*



Every $50 PBPPM increase in State funding is approx. $20M per year

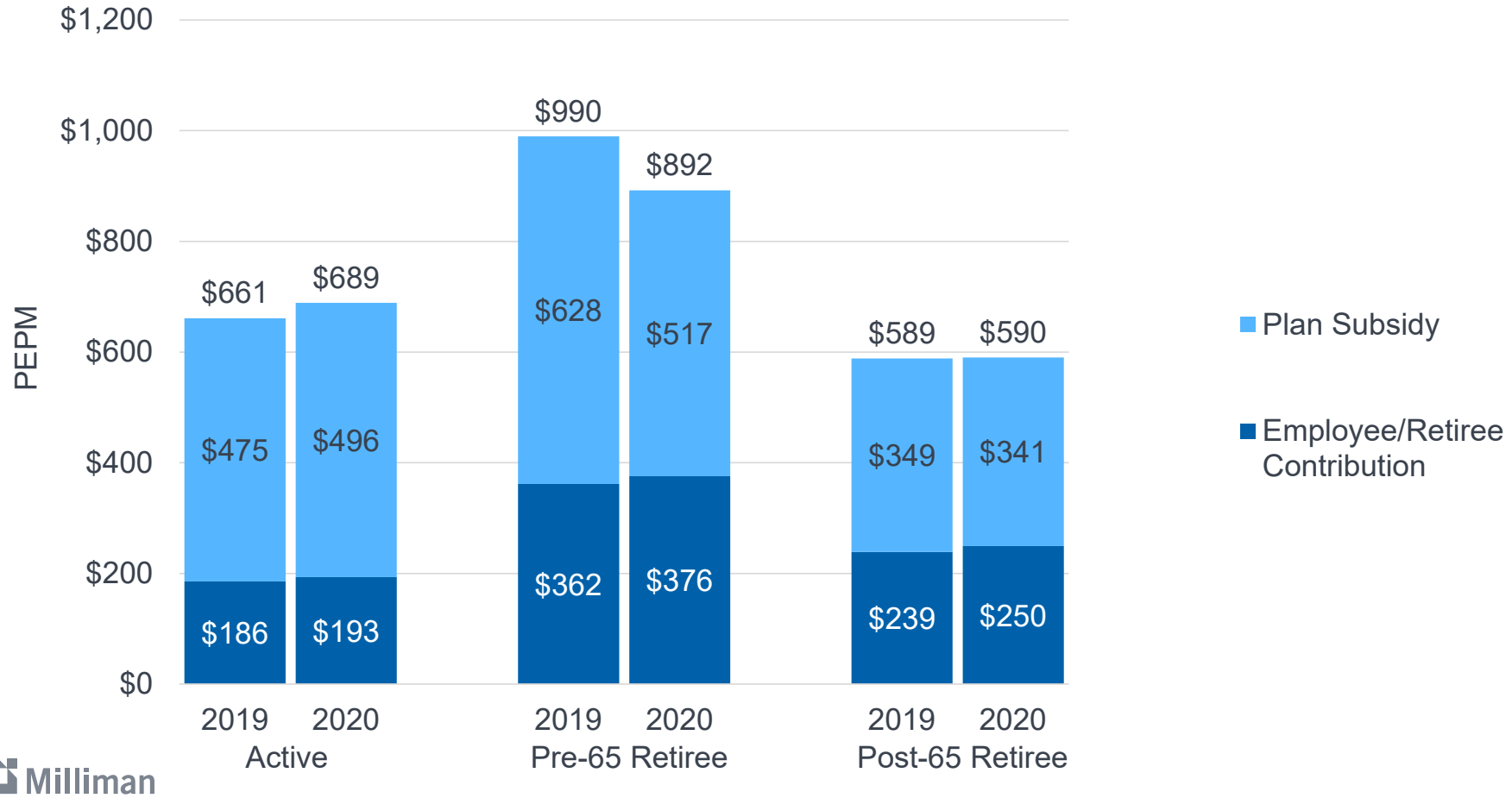
- Arkansas State / Plan Subsidy ranks 2 (lower the rank, lower the subsidy)
- Each year plan sponsors reassess their subsidy levels (typically increase subsidy annually to keep pace with healthcare inflation)
- Alabama expresses their subsidy similarly to Arkansas (i.e. FY2020: $930 per active employee per month)
- Arkansas would need a subsidy of about $690 per budgeted position per month (PBPPM) in 2020 to be approximately equivalent to Alabama (without reducing the number of budgeted positions)

1. Estimated State / Plan Subsidy = Average Premium Per Enrolled less Average Employee Payroll Contribution Per Enrolled

**Also see Assumptions and Methodology at the end of this report*

Population Subsidization

ASE - Premium Breakdown by Employment Status



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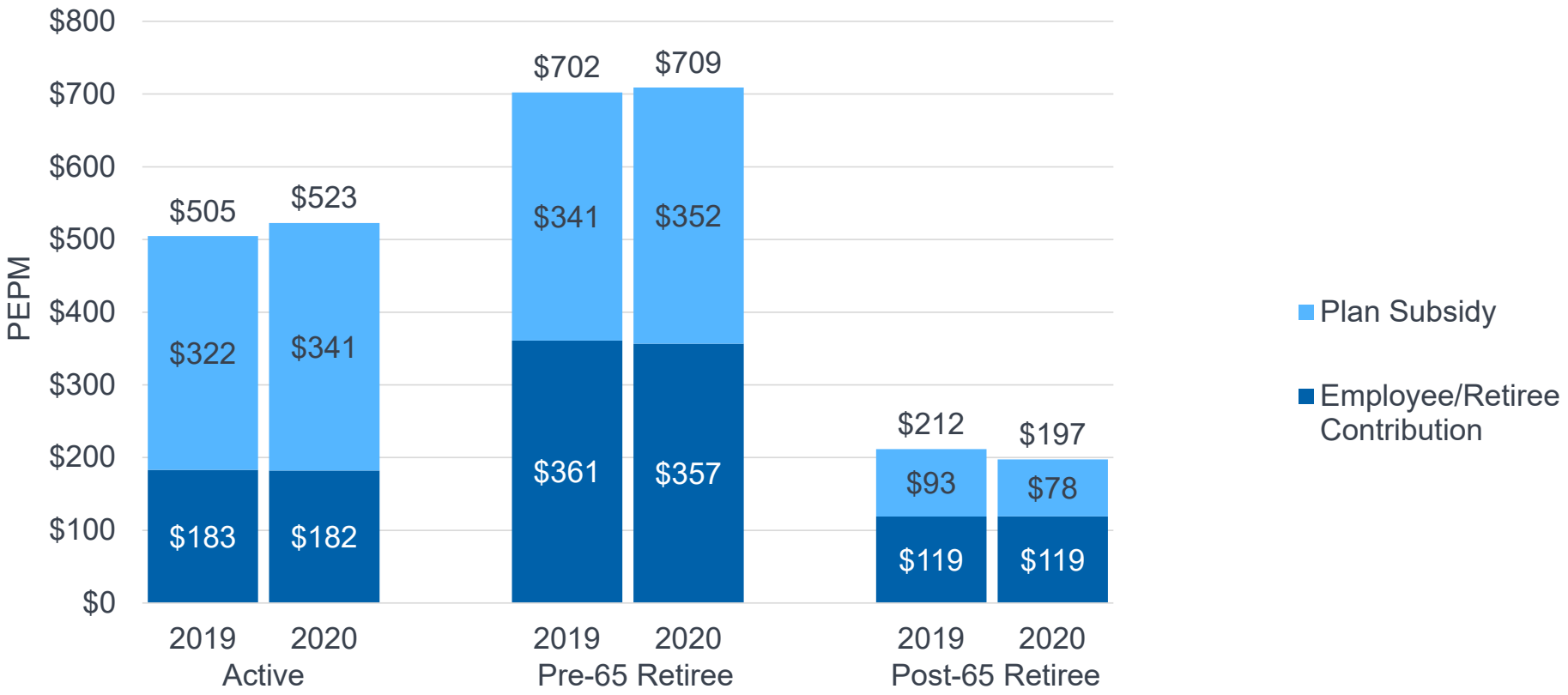
PSE - Premium Breakdown by Employment Status



ASE – Plan Design Benchmarking

ASE - Plan Design Benchmarking Findings

- On average, states offer between 2 to 3 plans
  - Alabama only offers 1 plan, which is comparable to the Premium plan design
- The average deductible for the most generous plan ranges from $300 to $1,000 (excluding Texas, which is a copay plan) for individuals
- The average deductible for the least generous plan ranges from $1,500 - $2,100 (excluding Alabama, which only offers one plan) for individuals
- Most states offer a qualified high deductible plan option
  - Louisiana, Missouri, Oklahoma, Tennessee, and Texas offer HSA plans
  - Most states that offer a qualified HDHP provide a HSA seed
- Louisiana, Oklahoma, and Texas offer local HMO solutions
- Plan design details by state in Appendix

Types of Plan Initiatives

Types of Plan Initiatives – Overview

- Plan initiatives can be broadly grouped into plan administration and plan management

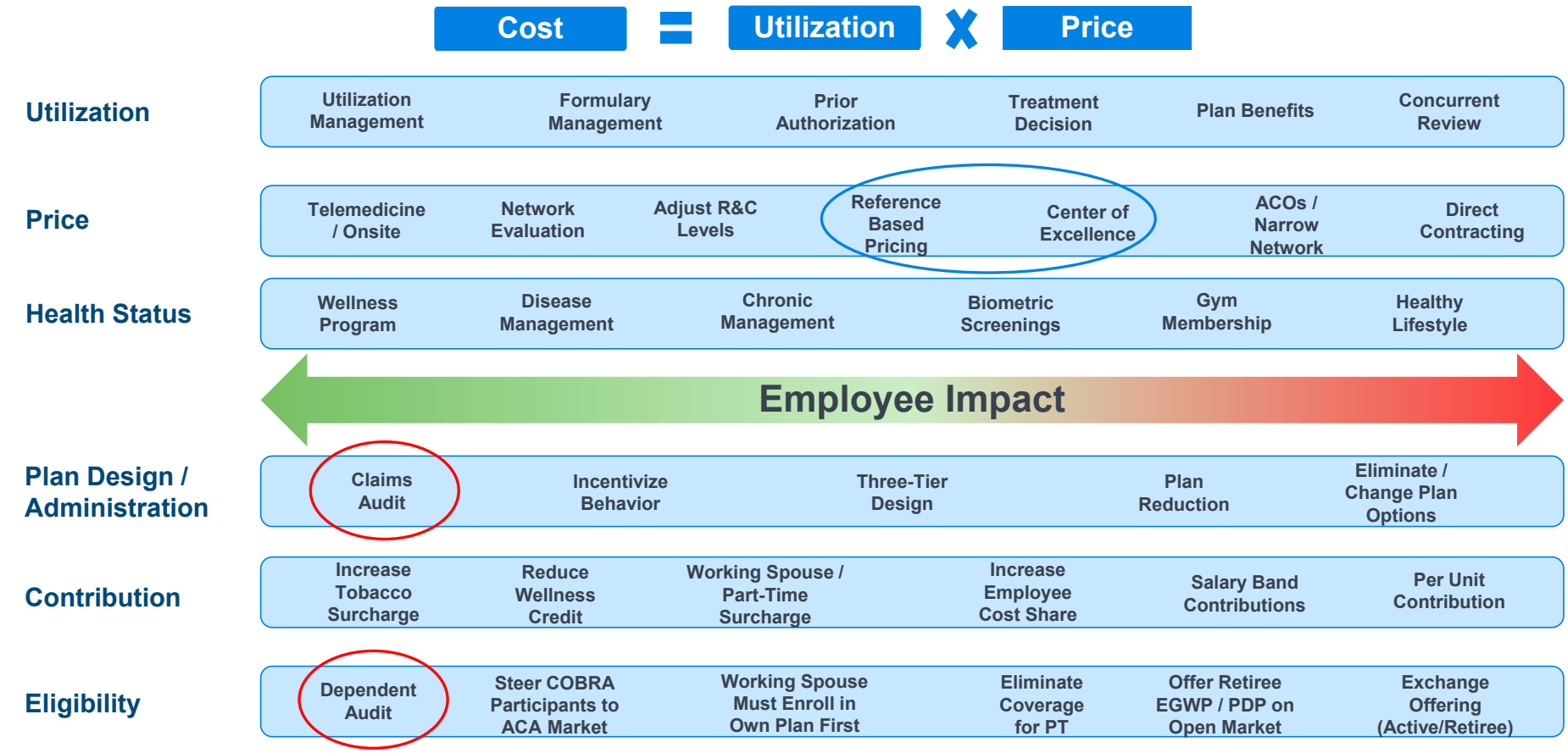
Plan Administration Macro Issues

- Who should be covered?
- How should subsidies be structured?
- Are claims being paid correctly?
- What types of plan options should be offered?
- What should be covered?

Plan Management Micro Issues

- What level of utilization management is appropriate?
- What coaching programs should be offered?

Common Tactics for Controlling Cost



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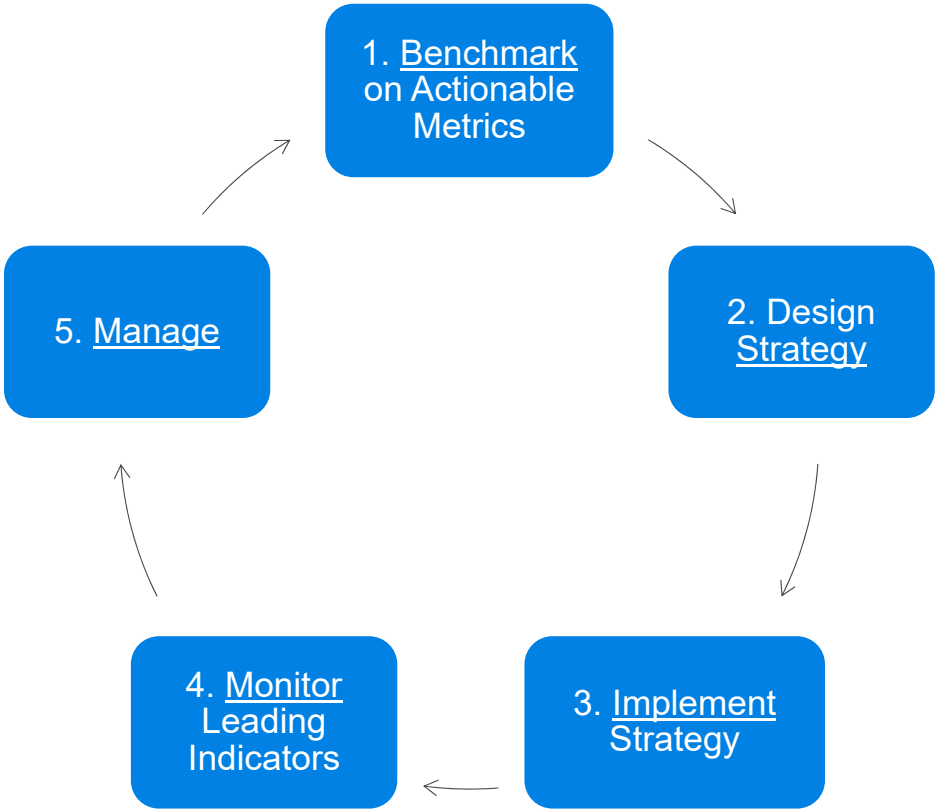
Framework for Considering Medical Management Plan Initiatives

Performance Improvement Cycle and Strategy Development



Strategic Themes

- Population Health – long-term investment, difficult to measure, difficult to improve
- Chronic Conditions – improve identification of members with care gaps to minimize complications
- Price of Services – Plan contracting has biggest impact, may be micro-opportunities
- Reduce Low-Value Services – high potential but may require intrusive medical management and/or large incentive differentials

Framework for Detailed Evaluation of Plan Performance

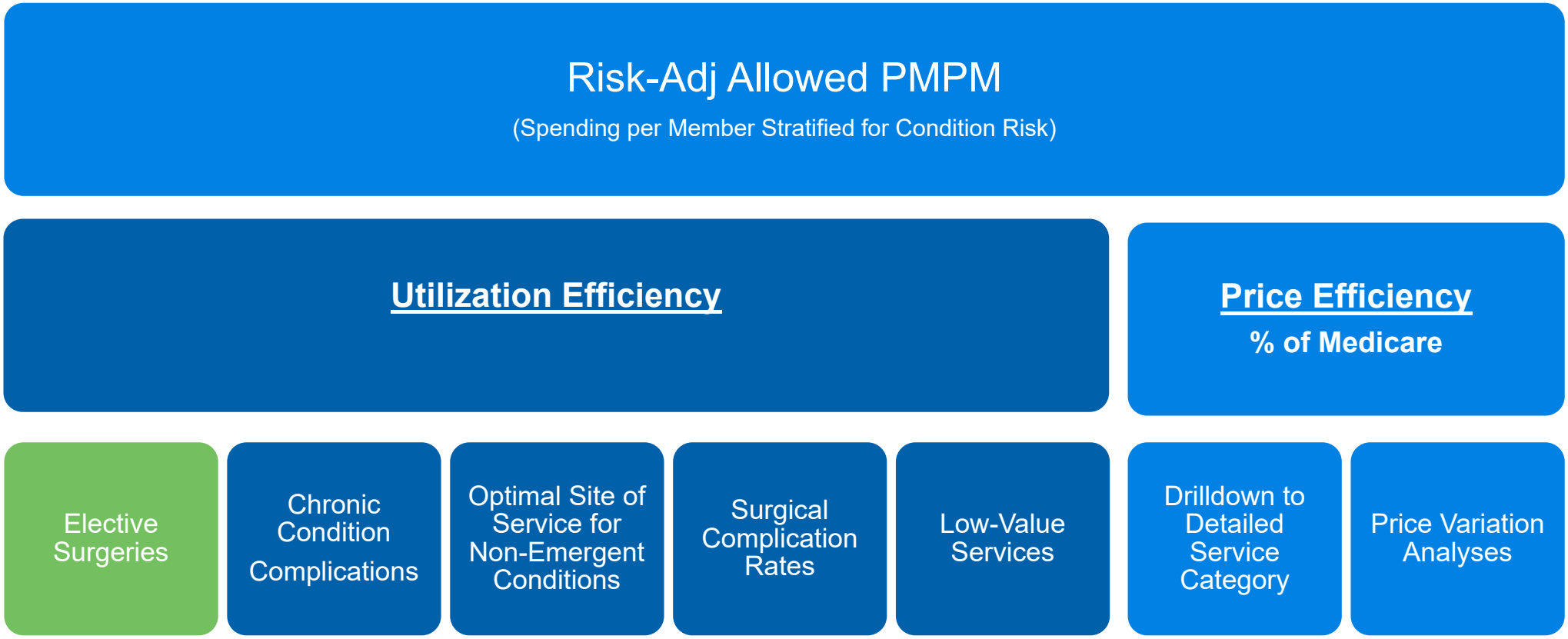
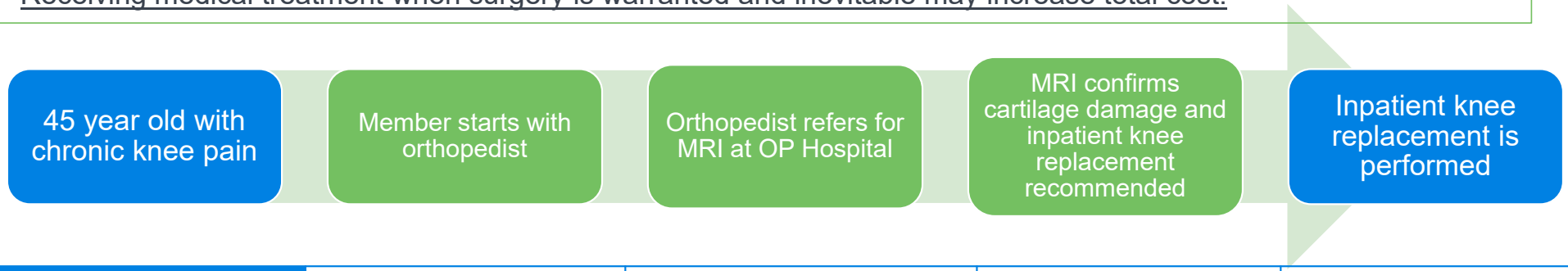


Illustration of Potential Medical Management Interventions
Treating Osteoarthritis of the Knee

- Knee replacements are a leading driver of plan cost for most plans, including EBD, and are an effective treatment for the problem of chronic knee pain due to osteoarthritis.
- Medical treatments may also be effective with accompanying lifestyle changes (e.g., lose weight, switch to lower impact exercise, etc.), but may be viewed by members as withholding care.
- Tighter medical management typically requires higher administrative fee.
- Receiving medical treatment when surgery is warranted and inevitable may increase total cost.



Potential Interventions	• COE for Knee Pain • High-value specialist • Start with PCP	• Pre-approval for MRI • Assist with finding low-cost MRI	• Pre-approval for knee replacement • Assist with finding high-value facility (including lower cost surgical center)	• Confirm readiness to return home before discharge • Check-in post discharge to identify complications

Additional Notes on the Potential for Medical Plan Management Initiatives

- Start with benchmarking results – this will help to frame the magnitude of the opportunity vs. the potential for member disruption and additional costs to pay for higher levels of medical management
- Medical management is likely to be viewed differently than pharmacy management because pharmacy management typically offer a substitute medication that is considered equivalent
- Be conservative in savings estimates – let savings flow into reserves rather than banking on savings

High-Level of Plan Performance

Entity	Utilization (1)	X	Price (2)	=	Total (3)
Arkansas – EBD[1]	In Progress	X	135%	=	In Progress
Arkansas – Benchmark	In Progress	X	160%	=	In Progress
Result: EBD Compared to Benchmark Below 1.0 is Favorable Variance	In Progress	X	0.84	=	In Progress

(1) Utilization – May be estimated as the residual of the Total

(2) Price – Calculates ratio of EBD allowed charges (before application of withhold) per adjusted utilization unit to what the same services would be priced on a Medicare fee schedule and compares to the state average ratio in the IBM MarketScan reference data set. The average for the reference of benchmark data set was 18% higher than EBD's result (see description in the Appendix)

(3) Total – Compares EBD's actual allowed PMPM to benchmark data adjusted for illness burden and matched on geography.

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Thank you

Courtney White, FSA, MAAA
Paul Sakhrani, FSA, MAAA
Scott Cohen, MPH

Appendix
Plan Design by State

Plan Design – Arkansas State Employees

	Premium	Classic	Basic
Individual / Family Deductible	$500 / $1,000	$2,500 / $5,000	$6,450 / $12,900
Individual / Family MOOP[1]	$3,000 / $6,000	$6,450 / $12,900	$6,450 / $12,900
Primary Care Physician / Specialist	$25 / $50	20% after ded.	0% after ded.
ER	$250	20% after ded.	0% after ded.
Inpatient	20% after ded.	20% after ded.	0% after ded.
Outpatient	20% after ded.	20% after ded.	0% after ded.
Generic Drug	$15	20% after ded.	0% after ded.
Preferred Brand Drug	$40	20% after ded.	0% after ded.
Non-Preferred Brand Drug	$80	20% after ded.	0% after ded.
Specialty Drug	$100	20% after ded.	0% after ded.

1.Separate out-of-pocket maximum for pharmacy on Premium plan

Plan Design – Alabama

	BlueCard PPO
Individual / Family Deductible	$300 / $900
Individual / Family MOOP	$8,150 / $16,300
Primary Care Physician / Specialist	$35
ER	$150
Inpatient	$200 per admin + $25 per day for days 2-5
Outpatient	$150
Generic Drug	$10
Preferred Brand Drug	20% (min 40, max 80)
Non-Preferred Brand Drug	50% up to $150
Specialty Drug	$150

Plan Design – Louisiana

	Magnolia Open Access	Magnolia Local Plus	Magnolia Local	Pelican HRA 1000[1]	Pelican HSA 775[2]
Individual / Family Deductible	$900 / $2,700	$400 / $1,200	$400 / $1,200	$2,000 / $4,000	$2,000 / $4,000
Individual / Family MOOP	$3,500 / $8,500	$3,500 / $8,500	$2,500 / $7,500	$5,000 / $10,000	$5,000 / $10,000
Primary Care Physician / Specialist	10% after ded.	$25 / $50	$25 / $50	20% after ded.	20% after ded.
ER	$150 + 10% after ded.	$200	$150	20% after ded.	20% after ded.
Inpatient	10% after ded.	$100 per day	$100 per day	20% after ded.	20% after ded.
Outpatient	10% after ded.	$100	$100	20% after ded.	20% after ded.
Generic Drug	50% up to $30	50% up to $30	50% up to $30	50% up to $30	$10 after ded.
Preferred Brand Drug	50% up to $55	50% up to $55	50% up to $55	50% up to $55	$25 after ded.
Non-Preferred Brand Drug	65% up to $80	65% up to $80	65% up to $80	65% up to $80	$50 after ded.
Specialty Drug	50% up to $80	50% up to $80	50% up to $80	50% up to $80	$50 after ded.

1.State contributes $1,000 into HRA.
2.State contributions up to $775 into HSA
3.Additional local HMOs are available

Plan Design – Mississippi

	Select	Base
Individual / Family Deductible	$1,000 / $2,000	$1,800 / $3,000
Individual / Family MOOP	$6,500 / $13,000	$6,500 / $13,000
Primary Care Physician / Specialist	$25 / 20%	$10 / 20%
ER	$50 first visit 200 + 20% after first visit	$50 first visit 200 + 20% after first visit
Inpatient	20% after ded.	20% after ded.
Outpatient	20% after ded.	20% after ded.
Generic Drug	$12	$12
Preferred Brand Drug	$45	$45
Non-Preferred Brand Drug	$100	$100
Specialty Drug	$100	$100

Plan Design – Missouri

	PPO 750	PPO 1250	HSA
Individual / Family Deductible	$750 / $1,500	$1,250 / $2,500	$1,650 / $3,300
Individual / Family MOOP	$2,250 / $4,500	$3,750 / $7,500	$4,950 / $9,900
Primary Care Physician / Specialist	20% after ded.	$25 / $40	20% after ded.
ER	$250 + 20% after ded.	$250 + 20% after ded.	20% after ded.
Inpatient	$200 + 20% after ded.	$200 + 20% after ded.	20% after ded.
Outpatient	20% after ded.	20% after ded.	20% after ded.
Generic Drug	$10	$10	10% up to $50 after ded.
Preferred Brand Drug	$40	$40	30% up to $100 after ded.
Non-Preferred Brand Drug	$100	$100	40% up to $200 after ded.
Specialty Drug	$75	$75	

1.Separate out-of-pocket maximum for pharmacy on PPO plans
2.State will contribute up to $600 into HSA

Plan Design – Oklahoma

	HealthChoice High	HealthChoice Basic	HealthChoice HDHP
Individual / Family Deductible[1]	$750 / $2,000	$1,000 / $1,500	$1,750 / $3,500
Individual / Family MOOP	$3,300 / $8,400	$4,000 / $9,000	$6,000 / $12,000
Primary Care Physician / Specialist	$30 / $50	50% after ded.	$30 / $50 after ded.
ER	$200 + 20%	50% after ded.	$200 + 20% after ded.
Inpatient	20% after ded.	50% after ded.	20% after ded.
Outpatient	20% after ded.	50% after ded.	20% after ded.
Generic Drug	$10	$10	$10 after ded.
Preferred Brand Drug	$45	$45	$45 after ded.
Non-Preferred Brand Drug	$75	$75	$75 after ded.
Specialty Drug	$10 / $100 / $200	$10 / $100 / $200	$10 / $100 / $200 after ded.

1.Basic Plan has $500 first dollar coverage paid by plan. Amount shown is after first dollar coverage.
2.Additional local HMOs and Alternative plans are available
3.Basic and High plan have a separate pharmacy deductible before copay applies

Plan Design – Tennessee

	Premier PPO	Standard PPO	CDHP / HSA
Individual / Family Deductible	$500 / $1,250	$1,000 / $2,500	$1,500 / $3,000
Individual / Family MOOP	$3,600 / $9,000	$4,000 / $10,000	$2,500 / $5,000
Primary Care Physician / Specialist	$25 / $45	$30 / $50	20% after ded.
ER	$150	$175	20% after ded.
Inpatient	10% after ded.	20% after ded.	20% after ded.
Outpatient	10% after ded.	20% after ded.	20% after ded.
Generic Drug	$7	$14	20% after ded.
Preferred Brand Drug	$40	$50	20% after ded.
Non-Preferred Brand Drug	$90	$100	20% after ded.
Specialty Drug	10% (min $50, max $100)	10% (min $50, max $100)	20% after ded.

1.State contributes up to $500 into HSA

Plan Design – Texas

	HealthSelect of Texas	Consumer Direct HealthSelect
Individual / Family Deductible	$0 / $0	$2,100 / $4,200
Individual / Family MOOP	$6,750 / $13,500	$6,750 / $13,500
Primary Care Physician / Specialist	$25 / $40	20% after ded.
ER	$150 + 20%	20% after ded.
Inpatient	$150 per day (max $750) + 20%	20% after ded.
Outpatient	$100 + 20%	20% after ded.
Generic Drug	$10	20% after ded.
Preferred Brand Drug	$35	20% after ded.
Non-Preferred Brand Drug	$60	20% after ded.
Specialty Drug	$35 / $60	20% after ded.

1.Additional local HMOs plans are available
2.State will contribute up to $1,080 into HSA for the Consumer Direct HealthSelect Plan
3.HealthSelect of Texas plan has a pharmacy deductible

Appendix
Medicare Repricing Summary

Percent of Medicare Benchmarks

State	Percent of Medicare			
	IP	OP	Prof	Total
Arkansas – Benchmark	178%	174%	141%	160%
Arkansas – EBD[1]	136%	138%	134%	135%
National – Benchmark	203%	265%	143%	193%

[1] Arkansas EBD – Claims incurred 1/2020 - 12/2020 (paid thru 1/2021). Excludes Medicare eligible retirees due to secondary nature of EBD benefits.

Appendix
Assumptions & Methodology

Assumptions & Methodology – Subsidies

Assumptions

- Administration expense
  - ASE
    - CY2019: $46.31 PEPM for Actives / Pre-65 Retirees, $43.63 PEPM for Post-65 Retirees
    - CY2020: $46.50 PEPM for Actives / Pre-65 Retirees, $37.16 PEPM for Post-65 Retirees
  - PSE
    - CY2019: $42.56 PEPM for Actives / Pre-65 Retirees, $35.11 PEPM for Post-65 Retirees
    - CY2020: $42.92 PEPM for Actives / Pre-65 Retirees, $27.41 PEPM for Post-65 Retirees
  - 2019 administration expense included fees for QualChoice
- Percentage of population earning wellness incentive
  - ASE – 81%
  - PSE – 81%
- Pharmacy claims do not include manufacturer rebates or retiree drug subsidy
- Medicare is primary for Post-65 medical claims

Assumptions & Methodology – Subsidies

Assumptions

- Average family size
  - ASE
    - Actives: 1.71
    - Pre-65 Retirees: 1.34
    - Post-65 Retirees: 1.29
  - PSE
    - Actives: 1.68
    - Pre-65 Retirees: 1.20
    - Post-65 Retirees: 1.09
- Employment status determined by subscriber status

Assumptions & Methodology – Subsidies

Methodology

1. Summarized fee-for-service (FFS) medical and pharmacy claims paid from January 1, 2019 to December 31, 2020. Medical claims are gross of withholds.
2. Summarized member and subscriber months for January 1, 2019 to December 31, 2020.
3. Divided the summarize incurred claims by the appropriate subscriber months to calculate PEPMs.
4. Admin includes ASO contract rates and estimated plan administration costs.
5. Employee contributions based on enrollment x employee payroll deductions. Actual contributions may differ if school districts contributed above the minimum.

Assumptions & Methodology – Initiatives

- None of the change in employee and retiree contributions reflect migration to lower cost plans
- Contribution increases apply to all actives, pre-65 retirees, and post-65 retirees
- Increase in deductible and OOPM applied to individual plan. Family deductible and OOPM increase based on current relationships.
- Reduction in wellness credit reflects change in contributions only. Does not reflect any reduction in costs (e.g. members still receive wellness visit from providers).
- For ASE, reduction in wellness credit will not affect $0 contribution for Employee Only for Basic Plan
- State funding increase per budgeted employee per month of 34,163
- Discontinuation of Medicare eligible retiree spouse coverage reflects elimination of medical and pharmacy costs offset by lower contributions (e.g. Retiree and Retiree Spouse is now Retiree Only contract), pharmacy rebates, RDS, and other income

Assumptions & Methodology – Monthly Projections

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 – Monthly Projections

Assumptions – Benefit Plan Changes (2020 to 2022)

- 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 – Monthly Projections

Assumptions – Other

- Age/Gender
  - Age/Gender factor based on Milliman Health Cost Guidelines™
- Enrollment Projections
  - Actual enrollment utilized for March 2019 through January 2021
  - Projected February 2021 – December 2022 based on historical patterns
- Program Savings
  - Estimated remaining 2021 program savings of $6.5 million for ASE and $4.7 million for PSE
  - Estimated remaining 2022 program savings of $6.6 million for ASE and $4.9 million for PSE
  - Program savings offset as initiatives are reflected in the claims experience and projected pharmacy claims cost
- Plan Administration Expense
  - ASE - $3.85 PMPM for CY 2021 ($3.97 PMPM for CY 2022)
  - PSE - $2.14 PMPM for CY 2021 ($2.20 PMPM for CY 2022)
  - Plan Administration Fees include PCORI charges for 2021 and 2022
- Percentage of Population earning wellness incentive
  - ASE – 76.4%
  - PSE – 79.2%
- Minimum District Funding: $161.87 in 2020 and $164.66 in 2021 and 2022

Assumptions & Methodology – Monthly Projections

Methodology

1. Summarized fee-for-service (FFS) medical claims incurred from March 1, 2019 to February 29, 2020 and paid from March 1, 2019 to January 31, 2021. Medical claims are gross of withholds. Reports reflects the timing of when EBD is expected to pay the withhold.
2. Summarized fee-for-service (FFS) pharmacy claims incurred from December 1, 2019 to November 30, 2020 and paid from December 1, 2019 to January 31, 2021.
3. Converted the paid and incurred claims to incurred claims using completion factors. This incorporates the incurred but not reported (IBNR) claim reserve.
4. Summarized member months for March 2019 to February 2020 (medical) and December 2019 to November 2020 (pharmacy).
5. Divided the summarized incurred claims by the appropriate member months to calculate PMPMs.
6. For 2020, utilized actual claims for January 2020 to December 2020.
7. 2021 and 2022 projected the incurred claims PMPM from the midpoint of the experience period (September 1, 2019) to the midpoint of the contract period (July 1, 2021 and July 1, 2022, respectively).
8. Made adjustments for seasonality, benefit changes, and age/gender mix.
9. Accounted for rating period fees and administrative expenses.
10. Where applicable, converted incurred budget to paid budget based on historical payment patterns.

Assumptions & Methodology – Benchmarking

- Reviewed healthcare benefits of 7 states surrounding Arkansas. States included are:
  - Alabama, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, Texas
- Mapped Arkansas employees to the closest matching plan option in alternative State
  - This assumes that enrollment distribution between plan, tier, and employment status is similar to Arkansas
- Relied upon the 2020 premiums and employee payroll contributions published on State websites for employee payroll contributions, total plan cost, and State subsidy
  - Actuarial judgement used when information was limited
  - Some Plans appear that the active & pre-65 retirees were underwritten together and have the same total premium rate
  - Blended child + child(ren) rate when applicable
- State of Arkansas 2020 premiums, employee payroll contributions and plan subsidy based on actual 2020 cost estimates
  - 2020 Plan Subsidy includes funding from the State agencies, reserves, and other revenue
- Compared healthcare benefits of each state using Arkansas as a 1.00 basis
  - For example, 1.10 indicates a 10% increase
- Alabama
  - Alabama subsidy is $930 per active employee (assumed this was per active enrolled)
  - Relied upon subsidy use case to estimate total premium
  - Assume all spouses get spousal waiver credit
  - All employees who currently get wellness credit would still get wellness credit

Assumptions & Methodology – Benchmarking

- Louisiana
  - Assumed employees who earn the wellness credit would continue to earn the $10 credit
- Mississippi
  - Based on Horizon rates (hired after 2006)
- Missouri
  - Employees earning wellness credit would get the partnership rate
  - Employees who do not earn wellness credit would get the standard rate without tobacco incentives
- Oklahoma
  - Employees who do not earn wellness credit would enroll in the HDHP
  - Employees earn a benefit allowance. Assume the benefit allowance goes entirely towards medical, however, the employee contributions would not go below zero
- Tennessee
  - Assume employees select BCBST as its vendor
- Texas
  - Employees earning wellness credit would receive the tobacco free rate, whereas employees not earning the wellness credit will have a tobacco surcharge

Assumptions & Methodology – % of Medicare Repricer

Percent of Medicare Comparisons

- The State of Arkansas ASE and PSE and IBM MarketScan® data commercial claim data was repriced using the *Milliman Medicare Repricer*. The following considerations apply to the results:
- Data Quality

- ASE/PSE data quality – the Milliman Medicare Repricer excludes claim records that have omissions or irregularities that impact the ability to accurately derive a Medicare price. Note that these issues do not mean that there is an error in the claim records but only that the Milliman's Repricing Tool did not assign a repriced amount. The Milliman Repricing Tool assigned a repriced amount for about 67% of billed charges. Some of the top exclusion reasons were as follows:

  - Invalid Medicare ID
  - Medicare Allowed Not Available
  - Low Billed Amount
  - Allowed Amount Higher than Billed Amount
  - Missing a HCPCS/CPT procedure code
  - Invalid Units

Assumptions & Methodology – % of Medicare Repricer - Continued

- IBM MarketScan® data is comprised of multiple contributors. Certain service categories are excluded for some contributors based on a review of the contributor coding by service category.

- Examples include:

  - Inpatient claims for contributors where the diagnosis (ICD-10) coding was not complete enough for Diagnosis Related Group (DRG) assignment.
  - Hospital and office injectable drugs claims where the unit coding was not sufficient to accurately reprice the results.
  - Professional results for a subset of contributors where HCPCS and Modifier were not reliably populated.
  - Inpatient maternity claims where the contract IDs were not populated consistently enough to reliably match delivery claims with baby claims.

Assumptions & Methodology – % of Medicare Repricer - Continued

Outlined below are the limitations of the *Milliman Medicare Repricer*:

- All repriced amounts reflect prospective amounts and do not reflect any settlements with the Centers for Medicare and Medicaid Services (CMS).
- No adjustments are made for sequestration.
- Repriced amounts are based on information released at the beginning of each year (Federal fiscal year for inpatient and calendar year for other types of services).
- No adjustment is made for providers that participate in Medicare's Bundled Payment for Care Improvement (BPCI) initiative.

Limitations

Courtney White and Paul Sakhrani are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render actuarial 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, 2021, and 2022 monthly projections relied on historical ASE and PSE medical and pharmacy claims from Arkansas Blue Cross and Blue Shield (ABCBS) and MedImpact, respectively; funding and plan administration from EBD; historical ASE and PSE members by benefit plan, age/gender, and by month from EBD; 2019, 2020, and 2021 ASE and PSE benefit plan summaries from EBD; 2020, 2021, and 2022 fees and administrative expenses from EBD: conversations with EBD regarding the program, and actuarial judgment.

The assumptions used in the development of the 2019 and 2020 Plan Subsidy relied on historical ASE and PSE medical and pharmacy claims from ABCBS and MedImpact, respectively; historical funding and plan administration from EBD; historical ASE and PSE members by benefit plan, conversations with EBD regarding the program, and actuarial judgment.

The assumptions used in the development of the benefit benchmark comparison relied on state websites, final 2020 ASE premium rates and employee contributions, and actuarial judgement.

While we reviewed the ABCBS, MedImpact, EBD, and state website 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.

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 also 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.

The terms of Milliman's Consulting Services Agreement as a subcontractor to Health Advantage, an affiliate of ABCBS, for the State of Arkansas dated October 29, 2019 apply to this email and its use.

This presentation has been provided for the internal use of the management of the State of Arkansas Employee Benefits Division for developing the CY2022 strategy. The information contained in this presentation is confidential and proprietary. This information may not be appropriate for other uses and should not be distributed to or relied on by any other parties without Milliman's prior written consent. We do not intend this information to benefit any third party even if we permit the distribution of our work product to such third party. If this analysis is distributed internally or to a third party, we request that it be distributed in its entirety.