AGENDA

State and Public School Life and Health Insurance Board

April 6th, 2021

1:00 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:

April 20th, May 25th, June 22nd

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 April 6th, 2021, at 1:00 PM

Date | *time* 4/6/2021 1:00 PM | *meeting called to order by Renee Mallory - Chair*

Attendance

Members Present

Stephanie Lilly-Palmer
Secretary Cindy Gillespie
Dr. Terry Fiddler
Secretary Amy Fecher
Renee Mallory – Chair
Dori Gutierrez
Herb Scott
Shalada Toles, Employee Benefits Division Deputy Director

Members Absent

Lisa Sherrill

Teleconference

Cindy Allen
Cynthia Dunlap
Dr. Lanita White
Dr. John Kirtley – Vice-Chair
Melissa Moore
Greg Rogers

OTHERS PRESENT:

Jennifer Goss, Megan Weick, Stella Greene, Drake Rodriguez, Laura Thompson, Mary Massirer, Janella DeVille, Jake Bleed, EBD; Micah Bard, Dwight Davis, Octavia DeYoung, Sherry Bryant, UAMS EBRX; Jessica Akins, Takisha Sanders, Jim Bailey, Health Advantage; Elizabeth Montgomery, ACHI; Courtney White, Paul Sakhrani, Greg Collins, Julia Weber, Milliman; Mitch Rouse, TSS; Sylvia Landers, Colonial Life; Kristie Banks, Mainstream; Brent Flaherty, Kristin Dolphy, MedImpact; Nicholas Poole, John Bridges, ASEA; Frances Bauman, Novo Nordisk; Stephen Carroll, AllCare Specialty; Erika Gee, WLJ; Robyn Keene, ASEA; Ronda Walthall, ARDOT; Pamela Mayo, Trisha Grantham, Ron Burch, BJ HendersonDianne Strickland, ASE Retiree; David Kizzia, AEA/NEA; Dwane Tankersley, NovaSys Health; Marissa Keith, BI; Jim Chapman, Abbvie ; Donna Morey, ARTA; John Robbins, DataPath; Nima Nabavi, Amgen

Review Options for Potential Plan Savings Discussion

White and Sakhrani provided an update on the Plan experience for ASE and PSE and presented the assumptions and methodology.

Discussion

Fecher: On the Post-65 retiree coordination of benefits, can you explain what that means?

White: The way Medicare works with the plan today, for PSE only, medical coverage is provided. Medicare is primary. When a Post-65 Retiree goes to the doctor, they know he is a Medicare retiree. So, Medicare would pay the claim first. In normal Medicare, there is cost-sharing that goes along with the visit, if you're just Medicare. There's an inpatient deductible and a physician deductible, but generally, the members pay about 20% on average. So, for anything that's covered by Medicare, Medicare pays first and then the plan picks up the Medicare copays and deductibles and coinsurance. So, Medicare might have 80% of the cost and EBD pays 20% of the cost. The member doesn't pay very much out of pocket. The member pays out of pocket when there is a service covered by EBD but not by Medicare, such as routine chiropractic visits. Today, Medicare pays the bulk of the cost, then EBD pays roughly 20% and the member picks up a very small portion for services they get that are not covered by Medicare. One thing that EBD asked Health Advantage to look at, and we are looking at it with them, is changing the way the Medicare costs are adjudicated. Going forward what we could say is when the member goes to the doctor, instead of EBD paying the 20%, it would be subject to the Premium plan deductible, coinsurance, and copays. It's like a benefit reduction for the Post-65 members. That's why we didn't show any premium increases for Post-65 members. We can talk about different approaches such as reducing the benefit and reduce the premium a little or just hold the premium flat and we can see some of the sensitivities around that.

Mallory: Do most insurances work like that? If a person has two insurances and one pays primary and there's a secondary. Doesn't a deductible have to be met before the secondary kicks in and pays 100%?

White: There are different methods and the employer can choose the method that they use to coordinate with.

Mallory: So, some private insurances work like that already, correct?

White: Yes. For example, if you went in and had a procedure for $1000 that is covered by Medicare, Medicare would pay $800, EBD would pay $200, and the member wouldn't pay anything. That is if it's a Medicare-covered service. Going forward, Medicare would still pay $800 but the $200 that the member sees, the member would now have to meet their plan deductible before it would be covered at a higher rate.

Mallory: A real-world example is that I have primary and secondary insurance. If I go in and my primary, state employee insurance, whatever it does not pay, my husband's plan kicks in and pays, but not until we have met his deductible.

Fecher: It's like Medicare has a deductible and EBD has a deductible. We have been covering the Medicare deductible for the members 65 plus 100%. The figure that was thrown out is around $203 as their deductible. We are saying they would have to pay their $203

deductible and then it would kick over to EBD and they would have to pay the EBD deductible. Is that different by plan or is it all $500, Shalada?

Toles: It's $500 for ASE and for PSE it's $750.

Fecher: They pay their $203 Medicare deductible and then they pay their $500 EBD deductible. Then everything would be covered at?

Toles: The plan benefits, whatever their plan benefits are, if there's a member cost-sharing, the member would be responsible for that.

White: The $203 is the Part B deductible. If you go into your doctor's office under Medicare on January the 1st, there is a part B $203 deductible. Today, EBD pays 100% of that. Going forward, that would count toward the members' EBD deductible of $500.

Fecher: It wouldn't be an additional, it would be included in the $500.

Toles: To further clarify, right now the ARBenefits plan functions as a bit of a supplement to Medicare. So, whatever Medicare leaves over, we pick up. This change would cause us to apply our plan benefits to whatever's left after Medicare pays. This is the way it currently functions for active employees.

Dr. Fiddler: I thought I had this down in my head. I have gone to the office to have a medical visit. My wife has also gone in for a medical visit. In order for me to keep my insurance, how much out-of-pocket for the two of us would it be before anything else kicks in. What would be the total cost at this point in time, real dollars for the members? That's what I want to see.

White: Under the current benefits, if it's a Medicare-covered service, you wouldn't pay anything. If it's a non-Medicare covered service, you would be subject to the deductible, copays, and coinsurance. Going forward, for PSE, when you went to the doctor you would have to pay the $750 out of pocket. Then, the Premium plan coinsurance and copays would work just like they do for the active employees until the maximum out-of-pocket was reached which I think is $3,200. Then you would have full coverage after that. You would be sharing in the copays and coinsurance, just like the actives and pre-65 members do. Most of the cost would still be covered by Medicare, that's what makes it confusing.

Toles: The Premium plan works a little bit differently. On the Premium plan, doctor visits are not subject to the ARBenefits deductible, there would be just a copay for that visit. It can get weedy with all of the scenarios. There would be a $25 copay for that visit because the deductible would not apply after the Medicare deductible has been met.

White: This deductible only applies to hospital services.

Dr. Fiddler: I'm trying to get it where the members can really understand what's going on. When Herb's people, when we get ready to vote, they need to understand where they are. We're sitting here and we've got a history of this and we're having a hard time. I'm just

fearful that these people are going to have a real hard time. From the beginning, it's the communication. We have got to get that understood.

Gutierrez: I have seen coworkers who are trying to retire, go to meetings, trying to figure out what kind of coverage they will get. I have a hard time making decisions that will affect the ones who are already there. They got the information and made their decisions whether to retire or not based on the information that they already got. So, making changes right now is hard for people who have already retired. It's hard for me to say yes we can make these changes knowing that they made a decision based on what information they already had.

Dunlap: Was there a projected increase to the retiree out of pocket cost? As Dori stated, that's a lot to put on someone who has already made their plans without seeing what that projected cost might be.

White: Health Advantage repriced every member so we have that impact based on their 2020 claims. We could summarize that for the Board so they can see how many people are in each bucket.

Toles: I would expect it would go to the out-of-pocket maximum. If that's $3,250 per individual on PSE, then that's what that would be.

White: That's the most that that would have. Some people are going to have a $100 impact and some will have a $3,000 impact.

Mallory: Do we have an average? Can we do it that way?

Fecher: I am trying to understand, as an active member you get open enrollment and you get to choose a plan every year. Do retirees get to do that or do they make the choice at retirement and that's it?

Toles: The Premium is the only plan offered to Medicare Primary retirees.

White: Because, historically, the Premium plan has been so much better for them, they don't pay much at all.

Lilly-Palmer: Just to clarify, we are saying ok you're going to retire and then you hit Medicare age. At that point, we are looking at a change of the coordination of benefits which means they would basically pay out-of-pocket post-tax, which is going to come out of their annuity and basically be based on the Premium plan for the deductible, for the individual is $750. Their out-of-pocket expense would be $3,250 for medical, which is if they go into the hospital or anything to that effect. Then they would pay the copay if they went to the physician. Is that kind of what we are looking at? We must get ready for the question, "so, we have to pay a premium, then we are going to function the way this plan functions instead of going Medicare Primary which pays Part A for the hospital and Part B for the physicians. I just want to make sure that's the direction we are talking about going.

Moore: I have a problem, too, when dealing with the Post-65 retirees who we're only offering the Premium plan to as their only option. Probably when they worked, we all know that a majority of the PSE folks were not on the Premium plan.

Fecher: That is currently the only plan they have now.

Moore: Yes, but prior to that, they were not on the Premium plan. I don't like doing it on the PSE side or the ASE side. Folks that are in retirement and on a fixed income and we start pulling the rug out from under them, so to speak. I understand we've got the deficit and we have to come up with ideas, but it seems to me that the least we can do to this population, the better I'm going to feel about it.

White: The thing is if they picked the classic or basic plan their out-of-pockets would be even more.

Dunlap: Is their premium the highest? The Premium plan has the highest monthly premium as well.

White: They still pay the retiree premium so it wouldn't change much today.

Fecher: I just want to say that we are talking about every option. We are not saying that this is what we are doing. We are just saying this is an option and how much it would net us to the plan should we chose to do that.

White: Their premiums wouldn't move to the active or the pre-65 contributions, they would still pay the $100.78 for retiree-only.

Mallory: So, their premiums wouldn't go up?

Toles: The only change would be during utilization.

Dr. Kirtley: Do we know what the actual cost for the plan is? Because I know we are paying more than we are bringing in on that.

Sakhrani: We looked at that a while ago and I want to say it was at 50% if I recall correctly.

Dr. Kirtley: Basically, we bring in about 50% of what it actually costs us.

White: Yes, the retiree pays 50% of the cost.

Dr. Kirtley: So, it would have the same function if we doubled the cost, which I know is a large number, then it would be self-sustaining.

White: Without the benefit change, yes.

Wellness Credit

Gillespie: What you are saying on wellness is, the non-wellness contribution of $25 a month would be for those who don't do a health risk assessment and tobacco cessation?

Fecher: It's for those that are not on the wellness plan now. So, those that have been participating in the wellness wouldn't take the whole brunt of that if they are losing $25 or $50 off their wellness credit. We're saying it's for those who have not formally been on the wellness credit program, they would see a $25 increase.

Gillespie: How would we do that, because it's for next year? So, it's kind of arrears if you didn't do something in the previous year.

Fecher: That's the number we have had to draw from, yes.

White: That would be for 2022, so they still have the rest of the year to get their wellness in for next year.

Sakhrani: So, essentially they would have to do their tobacco cessation program or be tobacco-free as well as their HRA. If we want to change any other requirements, it would just be removing the preventive screening requirements.

Gillespie: That's what I was asking. If you remove the preventive screening, the wellness is now doing the HRA and tobacco right? And that's the $25. That all I wanted to make sure I was right about.

Sakhrani: The $25 is tied to the wellness program, whatever the wellness program is, whether we keep the screening in place or not, that would be the impact. It's not so much changing the wellness program and if we leave the wellness program where it is today, we increase the non-wellness contribution by about $25. That would add about $3.1 million in revenue from those who are not getting the wellness benefit today.

Gutierrez: This is projecting for 2022. Some of us already had our wellness exam. We went in there; a lot of people went in their Catapult thinking they were going to get their $50 discount already.

Fecher: They are no charges for that though. If they have already visited catapult this year, there was no out-of-pocket expense for that. We just have some hard decisions to make.

Courtney: This is a little bit of a cleaner approach than trying to do some percentage of their current contributions. Everybody kind of pays $50 or just pays $25 more a month. There's not a 10% or 15% or 20%. It's a little bit more evenly felt by all employees.

Mallory: So, there's not a percentage increase in premiums, we're just taking the bottom line figure right there.

Fecher: If we can finish the explanation of changes to the plan that the board had, we will be finished with PSE. Then we can go through and get everyone's thoughts on what they could live with so far.

Mallory: So that includes the contract with Catapult? So, they don't charge us for those screenings?

Toles: They charge us, but they are a provider. There is not an administrative services contract.

Fecher: The reason you wouldn't save all of that money is because they still may be going to their doctor and getting a screening. We're not saying that we don't want people to get a screening and they would still have that option even if it was not required. There is a net saving of approximately $4.4 million.

Mallory: But we consider the ones that are getting two screenings, one from Catapult and one from their private provider.

Sakhrani: A lot of the $4.4 million may be from those duplicate services.

Fecher: I have written everything up on the board that has been modeled for us. We have the interactive spreadsheet. So, if you say you want to see what a 5% increase is across the board will get us, we can put that in there and get that number for you right now, or you want to see what a 10% on this group and 5% on that group. I think this is the time for discussion if you do feel very uncomfortable with one or another. Just to make your voice be known. Let's start with the wellness credit. Right now, for 2021, it's currently at $50 per member per month credit if they did the wellness and everything last year.

Gillespie: For me, it comes through fairly straightforward, if I'm understanding it. When we reduce the wellness credit on PSE by $25, it definitely will have an impact on the beneficiary but it also creates savings. I was trying to look at is if you were comparing some of that with a 5% contribution increase. There is such a range in its impact whereas everybody gets hit with the $50. If a person's income is lower $50 means more than someone's income who's higher. If you begin to look at the range of some cases it's a $1 or $2 impact up to $50 on the ASE side. When you move to the PSE side, it's up to $100 impact. If I am understanding that, if we could figure out a combination of those two then everybody might have a $25 impact but the percentage contribution impact would be more varied.

Mallory: That is a great point. I think the people who are making the lower wages are taking the basic insurance, which the premiums are lower. So, the percentage to a premium increase would be less. I think you are on the right track.

Gillespie: I'm trying to make it a little more balanced. I know we can't totally do because some of it is about the number of people in your family, etc.

Mallory: Is that not the case?

Toles: I would say the healthier people probably take Basic because they don't use it. Milliman do you have a real opinion?

Mallory: Is it the healthier people who pick the Basic as opposed to the people who can't afford the Premium insurance, but they may be sicker.

White: It's probably a combination of the two. We don't have salaries, so we don't know whose choosing what. Generally, people who pick those plans outside of the salary are going

to be the healthier ones who they know they can self insure under the deductible. Either they are healthy or they have the means to do it.

Fecher: Just a point of reference, the credit is off the plan they picked. So, if you go the $25 or the $50, you are going back to the cost of the plan that they have chosen.

Gillespie: It's still the same amount, it's $50. I was looking at it and thinking if we did half of the wellness credit and you did increase the non-wellness contribution for actives because that is totally within somebody's power as to whether or not they do or don't do it. So, you could still get that three, eliminate the wellness preventive screening requirement, do the 5% contribution increase, which gets you the $7 million, which would make up for not doing the full $50. It gives you some different variables coming up with about the same money. It seems like there should be some component of a contribution increase in some ways, just because we know going forward, while we hope to make some changes on the expense side, unless things change with medical trends, we will be having an annual contribution increase. So, having some component of that does seem to make some sense.

Fecher: How would we eliminate the wellness preventive screening if we still had a wellness credit?

Gillespie: I think what they were thinking is if you put these three together, you would just be doing the HRA and the tobacco.

White: You would still have the $50 gap. It's just that the wellness people would go up $25 and the non-wellness would go up $25, there's still a $50 gap. It's almost like there is a $25 wellness credit and a $25 wellness penalty.

Mallory: You would have to do the HRA and then you would have to go to your primary care physician to prove that you are smoke-free?

Sakhrani: What most employers do is an affidavit. They would require that an individual sign an affidavit saying that their tobacco-free.

Gillespie: It's usually part of your HRA. When filling out your HRA, part of it you say whether you do or don't smoke.

Moore: What is the benefit of keeping that? If we got rid of all of the wellness credit, why do we want to keep those two components?

Sakhrani: Most employers do have some sort of wellness program. So, it would put the state outside the norm. It's not something that we can't do, it's just that most do have some sort of wellness program.

Dr.Kirtley: One of the reasons we have this program in place is due to the fact that we, for years, had no idea what the overall health status was of the population. So, we went to having a risk-adjusted ASE side and have looked at doing a risk-adjusted which is basically covering the cost of what each subsection costs us, but we didn't even know what the population looked like. We've had a lot of discussion over the years about getting that

basic biometric data through the HRA. Then through the screening process, it really let us know what our obesity rates were, like what our overall rates of BMI would be for the population as well as nicotine use. I probably have a different view than some of nicotine, because nicotine replacement therapy to get you off of tobacco is not as harmful if it is even really much harm at all for like patches, gum, and lozenges. I'm not talking about vaping. That was data that helped us assess how healthy or unhealthy for some major markers, for example, Diabetes, hypertension, height, and weight comparisons of the population. I would also add that cotinine test, I cannot recall what it cost but it is not an inexpensive test and we are doing it every year. I would be interested to know if we canceled the cotinine test by itself how much money we are actually spending on that.

Toles: It's about $20 on Catapult. With an independent lab it about $80 -$100.

Dr.Kirtley: The number I remember hearing is it could be around $100. That's one reason we went with Catapult is it was so much less than that, but we all know that a lot of people are getting that through an independent lab and it's costing us a chunk of money every time.

Moore: It seems like if we are making some hard decisions, that might be something we need to look at.

Dr.Kirtley: I think it would be a real easy vote for me to say get rid of the cotinine test in itself and every person who got their wellness check, it was between $20 and $100.

Moore: Don't you think when we get our finances under control, I know this isn't what other states are doing, and we want to have wellness incentives because we want a healthy population, but given the situation we are in, we might have to temporaily suspend with the intentions of reinstating the wellness incentives once we get back where we would like to see them financially.

Dr.Kirtley: I would rather cut out parts of it instead of the whole thing, personally. I just remember how difficult it was to build a wellness program. If we don't see long-term value in continuing it, then I say let's get rid of it. Then at some point, it might come back, if we think there is value in having that biometric information. If I recall, we were criticized before for not having, then it's a weird and different argument. The other concerns that people are saying a percentage increase that hits everyone, say a 10% increase across the board, everyone knows exactly what that is. For a lot of people, $50 a month is a lot bigger hit than a 10% increase.

Mallory: I think that was the point Secretary Gillespie was trying to make.

Dr. Kirtley: I've heard that loud and clear. That's something that people are whispering in my ear, if not many of our ears.

Fecher: What would happen if we cut out components of the wellness visit. What if I go to my doctor that I have been going to for ten years and they do the same thing they have always done and they do whatever we've cut out, then as a member I am going to have to pay that correct?

Toles: No, wellness has no member cost-share.

Dr. Kirtley: I think what we can do is try to educate that it is no longer required, for example, the cotinine test. If you still get it, then it's going to be like any other lab test. We could change our wellness form because the wellness form shows them everything they need to fill out for us and one of them is that cotinine test. Secretary Fecher is completely right, some people are not going to see that and still get the test. So, it's not going to be a 100% thing, but if we could cut out 80%, that's got to be a chunk of money.

Gillespie: Part of what I was thinking is if we could restructure the wellness program. We keep it but restructure it so that it's still worth $50 but it's $25 instead that you get a credit, but you get the additional $25 attached on the other end. So, you get a $25 penalty if you don't do it. You get a $25 credit if you do it. In people's minds, it's still $50. Now, it's just if we do a contribution increase plus $25 if you don't do this.

Fecher: So, I'm hearing everyone say they might be comfortable with a $25 reduction and not a $50 reduction. Would that be a consensus of the board to put that number in and go with it for the moment? Not voting on it today, just saying that's what we are going to plug in.

Dunlap: The $25 wellness credit and then the $25 non-wellness increase, both of those together?

Fecher: Yes.

Dr. Fiddler: Just give me numbers on what that reduces in the savings if we do that for the plan.

Fecher: $11.7 million.

Dr. Fiddler: So, what is the impact to the plan? That's the number that I am looking for. If we don't do it, it comes out to $14.8 million correct?

Sakhrani: Yes, if we reduce the wellness by $25 and implement a $25 non-wellness increase.

White: That's no percentage increase.

Fecher: Retirees do not qualify for a wellness credit, so the initiative we are talking about right now would only affect active employees. It would not affect Post-65 or Pre-65 retirees. I just wanted to make that clear.

Gillespie: We don't know of the $4.4 million that's here for eliminating wellness preventive screening requirements, we don't know what doing away with the cotinine test as a component of that would save, do we?.

Toles: It's $20 for Catapult but not administered to those who admit that they use nicotine.

Mallory: The private providers also and that can be between $80 and $100 per test. So, we know there could be some cost savings there.

Dr.Kirtley: A simple guess would be $20 for every person who got a wellness check.

White: It would be three-quarters of a million.

Dr. Kirtley: It would seem like that would be the base, three-quarters of a million dollars. It could be double that depending on how many people got private labs.

Mallory: We could be talking a million more.

Fecher: We are not saying we will do this. We are just looking into this a little bit more as one of the options.

Pre-65 Retiree Contributions

Dunlap: What if we bundle all three with the same percentage and see what the impact is? What would it look like if we do 10% across the board?

Gillespie: It would be $15.1 million.

Mallory: So, 10% on all three is $15.1 million.

White: So, with this scenario, the actives will get $25 plus 10%.

Fecher: That will definitely affect the actives much more than the retirees. Both the wellness credit and the same increase across the board, the active employees will take the largest hit. It will increase their out-of-pocket significantly more than Post or Pre-65 retirees.

Allen: As we talked about earlier, the Post and pre-65 retirees are on more of a fixed budget and they may not know if they are deciding to retiree this year that this is going to happen. If we throw them 10%, it is going to be quite a bit. But if we do 10% across the board I think they will understand than if you say we are going to give none to the people that are active and then hit them with 10%. They don't have the wellness to think about, so they don't have a choice there. It would be pretty tough for them to understand if we didn't do anything to the active employees.

Fecher: Is there anyone objecting to 10% across the board for our modeling projection for today's purposes? Courtney or Paul if y'all could put that into the interactive spreadsheet and let us see what we are down to now that we are trying to dig out of.

Sakhrani: If everything is at 10% then we are at that $29.9 million so far and $42.3 million to go.

Deductible and Out-of-Pocket Expenses

Gillespie: In the discussion, we were having around the coordination of benefit changes, I know there were a lot of concerns being expressed around that. I may not have been understanding what was being explained, but it almost sounded like actives and Pre-65s basically have a deductible, but if you are a Post-65 retiree you don't have a deductible. So, when you start talking about doing an increase across all three, would that be bringing a deductible to play? We can't apply it to the retiree. Not saying we should I'm just asking the question.

White: This only applies to the actives and Pre-65 plans.

Gillespie: So, you can't apply it to the retirees? Not saying that we should, I am just asking the question.

Sakhrani: That would be the coordination of benefits change to bring in the deductible.

Gillespie: Do you just bring in the $250 or do you have to bring in the full $3,250?

Toles: That would be creating a different plan to have just a $250 deductible.

Courtney: We could do that, but it would only apply to the Medicare-eligible retirees.

Sakhrani: So an option is to create a whole new plan for the Post-65 population and change the coordination of benefits and apply whatever deductibles that we want to model.

Toles: You either take the coordination of benefits option, which is standalone or do the Pre-65 and active. I think those are two separate options.

Gillespie: It sounded like a coordination of benefits option is basically putting in for the retiree as $750 deductible?

Toles: Right. It would be making the plan benefits applicable for the retiree.

Lilly-Palmer: I think what Secretary Gillespie was asking is do they have to pay the full $750 deductible? Could it not be for the Post-65 retirees just the $250 deductible without completely doing a plan design change? In essence, that's not really changing the plan, that's just breaking it off at the 65 and over.

Gillespie: I was saying if everybody else was going up to $250 on their deductible, could they not pay that $250 earlier. Now, they don't pay it unless there comes a point where Medicare isn't covering them and they're over in strictly.

Lilly-Palmer: So if we were to go that option, is that considered a plan design change, since that's already the design of the Premium plan?

Toles: To be clear, Medicare retirees don't pay any deductibles in the current setting.

Gillespie: That may not be a good idea. I was just trying to look at it from a standpoint of a balance for everyone taking the same sort of hit.

Mallory: Could you offset the $250 for the Post-65 by a bigger increase in the premiums and make it more balanced? It seems like that's what we are talking about is making it even for all three groups.

White: So, a 10% increase on the Post-65, create a new plan design for the Post-65 Medicare eligible that might have a $250 deductible increase and still have some copays and things like that, but less out-of-pocket overall.

Mallory: If it's a plan design change and we are trying to keep from doing that, can you give a bigger increase on the premiums to maybe offset the extra that the other two groups are paying on the deductible?

White: I think it would be a big increase in the premiums. I don't think you'd want to do the COB (Coordination of Benefits) change and do the 10% premium increase because they're taking a fairly large benefit reduction and then also give them a premium increase.

Mallory: So, we are up to $35 million.

Fecher: Did we make a decision?

Mallory: I think we added the $250 deductibles.

Fecher: So, $250 deductible on actives and Pre-65 but we haven't decided on the Post-65?

Post-65 Retiree Coordination of Benefits

Gillespie: As someone who is not on the PSE side, part of the reason I was trying to think of an option is when you are on a fixed income, a deductible of $1,000, $2,000, etc, hitting all of a sudden. That is cash in hand that you have to come up with, which is different. I see the rationale to begin to shift that over time and no deductible, no out-of-pocket is usually not a principle you use in insurance. I do see that, but it seems like a very big leap to do the full all at once. That's why I was trying to think about an in-between, which doesn't work, I understand.

Toles: A deductible is utilization-based. If your first service is $100, then that's the amount you will pay. You don't get to the $750 or $1,000 until you accrue it and that's with Medicare paying some. It's a little different from an across-the-board premium increase because everybody pays it whether they use the insurance or not. This would only come about as its utilized.

Gillespie: It's a high utilizing group. You do want to make sure that people go to the doctor when they need to go.

Dr. Fiddler: Can somebody give me a number?

Fecher: $11 million. The Post-65 Retiree Coordination of Benefits change would net the plan $11 million.

Dr. Fiddler: So, what would that be if we turned that on and did what we were talking about here. We're going to have a change of impact. Your down to $25 million? We're looking at what-ifs so what if?

Fecher: $26.2 million

Dr. Fiddler: I agree with Secretary Gillespie, it's out-of-pocket money but maybe this is something we can figure from here. For the people on the Board who are retirees, we are looking at either losing something or increasing something, but we don't want to lose the whole

thing. If the benefit saves us $11 million and costs them a little bit more then that is something we can go with. If we see it's not going to work at that level, let's go back and punt before we go to the next level but at least we've got something.

Scott: Right. My group is very adamant. They don't want to lose their pharmacy coverage and they don't want to lose their medical. The things I have been getting is that they are willing to support an increase in their premium and that's both Pre-65 and Post-65 groups. What I haven't discussed is, how high is high?

Dr. Fiddler: We are drawing a line in the sand here on what we are going to do, but maybe we can put some sand back in so it won't be so deep. If we do the $11 million change in benefit, I think that is somewhere to start. It's like we are doing in all these 10% and 25%, it's just somewhere to start.

Courtney: If we put the retiree COB benefits change in, you would probably want to think about not increasing their premiums, because they are taking a significant benefit change.

Mallory: Because it is all or none right there. We have to do it, or we don't.

Fecher: What was the net to the plan with the 10% before you took that out?

Courtney: $2.2 million.

Dunlap: I understand the rationale behind the coordination of benefits, but that seems to me that it is still taking away a benefit that is costly to the retirees because it does mean additional monies out of pocket that they did not plan to have to pay for. Even if you go back and take away the premium increase, that's still not as much as this $3,250 per year. A $3,250 per year increase is a lot more than a 10% premium increase per year. What if we considered increasing their premium higher than the 10% to whatever the amount they could handle, like Herb was talking about. That may not cover the whole $11 million, but I just have a hard time with taking away a benefit at a cost to them that somebody is going to have to come up with money out of their pocket to cover because $3,250 a year is like $270 a month.

Fecher: Again, it is utilization-based. Some people will get zero of that and some people will get all of it, whereas the percentage on the rates would be across the board.

Dunlap: So, because you got an $11 million impact in savings means you got a lot of utilization there.

Dr.Kirtley: I think Secretary Fecher's trying to make the point that if it were across the board to everyone, it would be a higher number than that.

White: The average out-of-pocket increase would be around $900. Some would get zero and some would get $3,250.

Mallory: You could change the percentage increase to 15%, 20%, 25% and see how much it is going to go up for every person. I think that is the point being made is it's either based on utilization and people paying up to $3,250 or it's every single person paying

whatever that percentage increase is going to be. They have no control over that whereas with utilization they do somewhat have control.

Dunlap: It was just a thought for consideration for everybody to think about. I know that a percentage increase in premiums impacts everyone. This whole program is going to impact everyone somewhere. So, it's just a matter of how much other people are willing to take on some of the subsidies for the whole program. Somebody is going to pay for somebody. There is no way to be fair to everyone. There's going to be some that experience more than others. I know we've got the Department of Education annual funding increase in there. Do we know that that is certain?

Fecher: No, we have no certainty on that. What we are trying to get to is what the Board is comfortable with proposing and then go sit down and talk to the Governor and legislators about what the state can do. We need to show them in good faith what we are willing to do as a Board before we ask them for a particular amount of money.

Dr. Fiddler: Let's see what we are going to be. I like you turning that initiative on, the $11.7 million, then perhaps the premiums going up a little bit is better than not being there but at least we have a starting point. As you said, Secretary Fecher, we have got to have something to show good faith. I think if we give a number here trying to say that, then we are going to know what we are going to be able to do, eventually through the Governor, the Legislator, or the Department of Education and their funding. Right now, we have to come up with something. By adding that, I think we are down to a deficit of $26 million and now we are seeing what kind of monies we are going to have to come up with? There is a better chance for the Governor and the Legislator to know what's going to happen than the Department of Education because they are the ones that are going to be the recipients of that funding. That would be my suggestion. It's just a starting point.

Mallory: Just doing some quick calculations, it looks like if you tried to make up the $11 million that we are talking about for the retiree COB change on the Post-65, you are going to have to increase the premiums 60%. I don't know how you do that, we can't.

Moore: What would it look like if we turned the whole wellness reduction off. What kind of money would that be? I know we decreased it to $25. I'm curious to see what we would decrease it to if we turn that off. If we gave no wellness reduction at all.

Mallory: Do you still give the non-wellness increase?

Moore: No, we couldn't do anything there.

Mallory: Okay, they have put 10% on all the premiums, taken away the wellness reduction at $50, so that $43.6 million.

Dr.Fiddler: I know we have bantered this around but I thought that was going to possibly be the easiest thing to do. I thought we were going to turn those all off completely and see what we are getting.

Moore: Yes. No reduction. No incentive.

Mallory: The wellness reduction doesn't hit the retirees, so if you gave them 15% or 20% right there.

Fecher: Or do the $11.2 million COB change. I'm saying look at both.

Mallory: If you could go to zero on the premiums and then turn on the COB change.

Fecher: I'm not on the state employee plan or the teachers, but I do think we have to think about our active employees taking the brunt of it. I'm not saying that just because of myself. If I'm an active employee and I'm going to lose $75 and I'm getting a 10% increase, I'm going to expect that retirees take a bit of a hit themselves, as well. Whether that's increasing the percentage contribution, doing the COB change, or both.

Gutierrez: I'm not against going up on their premiums, I'm just afraid to make changes to their plan right now.

Mallory: You think we need to go up more on their premium?

Gutierrez: Instead of making a retiree change, yes.

Mallory: To get to that number, we are looking at 60%.

Fecher: Let's take COB off and put 20% on Post-65 and see what we get.

Dr.Kirtley: I think the most difficult thing that we've struggled with for years, especially on the retiree side is, every time we have tried to risk adjust it or anything else, it always looks like too big of a number. I think we have all known that sooner or later, it's got to be a big number, because of how the funding versus the spending of the retiree group is. Nothing else is building into the funding side of the retirees other than the retirees' contributions themselves.

Mallory: We are looking at $20 and $156 on a single retiree person and a retiree and spouse. What are we looking at on the actives for the increase? Would it be $70 plus the $75?

Sakhrani: The $70.58 is getting rid of the wellness credit and then the 10% increase. So, with the wellness, they'll see that $50 plus the 10%. Then without wellness, they will see roughly 10%. Most of the employees in the Premium plan will be paying an extra $70 per month.

Toles: It's also higher for those that have not met the wellness requirements over the past three years. People who have not met the wellness requirements will get a lower increase.

Gutierrez: I just don't think we can get rid of the wellness, because we have already started doing it. I would have never let them poke me if I knew I wasn't going to get the discount next year.

Moore: I understand that, but it does seem to make a large impact to the plan. To me, it is less painful than some of these other changes that we are talking about.

Mallory: So, we are at $50.9 million.

Fecher: We are still in the red $21.3 million. That does not include any state or department funding, so I think we need to get to a point soon with what we can take as a final to the Governor and the Legislature to look at. I will say that I've spent a lot of time discussing with our incoming director, and we feel very strongly that the board needs to look at a built-in increase based on the cost of the previous year so that we are not doing again in two or three years. It will be based on the last year's actual numbers to make sure we aren't staying flat, indefinitely.

Dr. Kirtley: That is a really good plan to get ahead of it. We can tell people; this is what it is this year, and we expect a 7% growth in the cost next year and therefore would expect a 7% increase in overall costs next year. You know, and I'm just throwing seven out, but if you take medicine and pharmacy, I think it needs to be a number that we have some confidence in being the actual number. If our performance is better and we back off on it, then that's just a bonus and we don't have to go as far as we might have planned. I just don't know that on health insurance that you can really plan for no cost increase years. I think they could happen, but they are going to be rare.

Fecher: I agree Dr. Kirtley, I think it also incentivizes the people to use the plan wisely and not go to the ER when a normal doctor's visit would do. If they keep their cost down, the overall costs are less, and the percentage will go up less.

Dr. Kirtley: We have tried to model our plans so they don't get adverse risk selection on specific parts of it but you are right, people don't use it wisely, then the costs go up for everyone.

Dr. Fiddler: Once we get all of this done, we are still looking at the Quality of Care subcommittee where we are still talking about low value, so we don't do these anymore. It will help us across the board. So, my question is, how do we do that? So that they know every year to sit down and budget their costs so that they are going to know that on the front end, and do we have the power as this Board to do that?

Fecher: We absolutely have the power because this Board has the power to set rates. So, the Board has the power to make that decision. I believe we would have to do it on past year's numbers. The problem comes in when you won't have the final numbers for the 2021 plan year until March or so.

Dr. Fiddler: Well it goes back to communication.

Fecher: We just have to do that. I think we just have to say, we're going up a percentage every year, the Board has decided that we will look at the past year's financial and how much was spent on the plan. Then we will have to go up accordingly to make sure that we're hitting the bottom line number we need.

Dr. Fiddler: Of those three groups that we are dealing with, we're just trying to be as fair as we can to all three groups. I think all you can do is try to be fair, we're not trying to hurt anybody, although it's hurting many people. But it's just the reality of the world of on medical.

Bleed: From a communication standpoint and an expectation standpoint, building into the plan from an employer and a beneficiary side, there will hopefully be a small increase on both sides annually, that everybody can anticipate. It could be part of our annually

scheduling or process that we would not get into this kind of kicking the can a little bit from one year to the next. The idea is how much would the increase be on the employee side and how much would it be on the employer side and how do we bridge the difference to whatever targeted numbers we need to get. Then if we hit our targets and exceed them if we have a better year than we anticipated, we'll be able to build up reserves and all that can be taken into consideration the next year going forward. The intent of all of that is to provide a lot more stability, communication, and expectation to the plan so that we don't have the kind of shocks that we're in right now.

Fecher: Is the board okay with using the 10% increase to active employees, a 15% to Pre-65, and a 20% to Post-65. Knowing the differences because the wellness credit would not affect any of the retirees.

Moore: Is there a reason we decided 15% for the Pre-65 and 20% for Post-65 since wellness didn't affect either of those categories?

Sakhrani: The Pre-65s are impacted by the plan changes though. If we do increase the deductibles by $250, both actives and the Pre-65s will be impacted.

Moore: They are impacted by the plan change and the Post-65s are not. We just need to be able to verbalize this and communicate this to people because, you know we've said we don't want to impact the Post-65 any more than we have to and then you're looking at a chart where if you don't understand everything else that goes with it, it looks like we're definitely doing what we say we didn't want to do.

Mallory: If you go back and look at the difference in what they're paying for the premiums, it's still substantial. There's a substantial difference between what the Post-65s are paying a month versus the increase that the actives are paying. That was the $50 difference. They are not as impacted as anywhere near what the actives will be.

Fecher: We haven't really discussed eliminating either plan. But, I think what they've shown us in the slideshow today is that does not have a positive effect on the plan. So, unless anyone wants to go any deeper into that, we'll just leave it where it is right now. Also, this would not be changing the retiree COB. It leaves us, right now, with a $21.3 million deficit. I need something to take on to the powers that be to say, this is where we are. I don't know if we want to vote on it today, I don't know if we want to think about it a week and vote on it next week. I guess my question is, is this something the Board is comfortable with? And if anyone's not, please feel free to speak up.

Allen: I think we need to think about this before we vote on it because this is going to start wheels turning. Maybe there are some things we haven't thought about. If we know that insurance is going up every year and the entire world knows insurance is going to go up, why can't we require the school districts to put in more for their teachers? I don't understand why we can't ever change that if insurance is going up for everybody? It's a legislative decision, why can we not go back to them and ask for an increase for the minimum that they contribute?

Bleed: This is something we are looking at closely and trying to find ways to make sure that when the state increases funding to public schools, and our funding formula statutorily

or constitutionally required to increase included in there an increase for salaries and benefits. So we're looking at working with the General Assembly to try to find ways to make sure those increases do trickle down to the benefits plan. I think it's a great point, though.

Rogers: Part of the problem is that we are trying to fix something in one year that has taken years to do. Right now, I'm not comfortable with this on the PSE side. If you look at what the basic plan is doing for what is probably going to be a new teacher probably making the minimum of $36,000 a year, you're going from a monthly contribution of $36 to $89. So, I just want everyone to understand what we're trying to fix is not just a one-year problem, it's a several-year problem that we're trying to fix in one year. I think without some change in the plan and just increasing their premiums needs to change. There has got to be a balance. I do think we need to dig deep because I don't mind going to the Governor and having those conversations, but we already went this year and that's why it's increasing the state. Everybody's taxpayer dollars have increased $20 million going forward for the PSE side. We have got to show that the Board really went dug and tried to do the hard work and make some changes that we think are going to make it sustainable. I just have a lot of concerns.

Dr. Fiddler: From 1998-2004 in Conway, we knew that in three years' time that it was going to hurt them the most the first year. By the third year, everyone was better prepared for it and it came to a balance.

Rogers: When we redid the foundation funding calculation, it goes back to the increase in the District contributions. It is set in law what the minimum contribution is now, and it only increases when the General Assembly increases the foundation funding amount and they have been increasing it each year. I think the minimum contribution right now that a district has to make is $164.44 per participant in the insurance program. So, I guess that some of what I was trying to say earlier is that we're trying to fix this whole thing on the backs of the participants and maybe general revenue. I don't know how to ask to buy a little time, maybe it's asking them for some of the American Recovery money that I keep asking about or something just to patch it over to give the General Assembly a chance to look at that. I just want to make sure that we are pulling all the levers that we can and that way when we go to the General Assembly because I think that is the discussion that we had to have with them. How do we build that lever in for the minimum contributions for districts as well? There hasn't been that built-in increase that districts have had to do that has kept up with the price of the plans.

Mallory: As far as the plan we have now, a teacher on the basic plan will have an increase of 148.9% on their premiums. That's what we need to think about as far as fairness.

Dunlap: A big part of that is because of taking away the wellness credit, right?

Mallory: $50 of it would be.

Gutierrez: We are talking about teachers but there are a lot of other workers at the schools and they're not making what a teacher makes either.

Fecher: I agree with everything everyone's saying. If we were able to get American Rescue plan money, the Stimulus money, the second batch that will be coming to the state, and the Department of Ed. This Board can vote to go forward with something so we can start working on that. So that we can start having those conversations. If it came back and we got more than the $21.3 million. We can always go back and say we don't have to do this and this. We could always change it for the better I think, without anyone getting upset with us. I don't think anyone is going to be happy with us if we go over there and say we need $80 million or $72.2 million.

Mallory: It seems that no one is comfortable with making a vote right now, so we can take some time to think about it and come back next week with a decision.

MOTION by Dr. Fiddler:

I make a motion to adjourn.
Dr. Kirtley seconded. All were in favor.
Meeting Adjourned

State of Arkansas Employee Benefits Division

CY2022 Planning

State and Public School Life and Health Insurance Board of Directors

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

6 APRIL 2021

Milliman

Agenda

- Public School Employees (PSE)
- Arkansas State Employees (ASE)
- Assumptions and Methodology
- Appendices

Public School Employees (PSE)

Recap of Projected Funds Needed for 2022

Additional Funding and/or Savings Needed to Fund 2022 Projected Expenses and at least 10% Reserve
$72.2M

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

	PSE
2022 Projected Revenue	$375.8
2022 Projected Expenses	($448.0)
2022 Projected Income / (Loss)	**($72.2)**
Projected Net Assets End of 2022	($2.0)
Target Net Assets (10% of Expenses)	$44.8
Needed Change in Net Assets	**$46.8**

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

Summary of Initiatives

- 2022 PSE target: ($72.2M) (estimated deficit + 10% catastrophic reserve minimum)

Initiative	2022 Estimated Savings	2022 Estimated Balance
Reduction in Wellness Credit from $50 to $0	$23.4M	($48.8M)
Eliminate Wellness Preventive Screening Requirement	$4.4M	($44.4M)
Increase Non-Wellness Contribution for Actives ($25 per month)	$3.1M	($41.3M)
10% Pre-65 Retiree Contribution Increase	$1.5M	($39.8M)
$250 Deductible & OOPM Increase for Actives/Pre-65 Retirees	$5.1M	($34.7M)
Post-65 Retiree Coordination of Benefit Change	$11.0M	($23.7M)
Department of Education Funding Increase from $108M to $133M	$25.0M	$1.3M
Total	$73.5M	

Summary of All Initiatives Modeled YTD

Initiative	2022 Estimated Savings
10% Contribution Increase for Actives, Pre-65 Retirees, and Post-65 Retirees	$15.1M
Reduction in Wellness Credit from $50 to $25[1]	$11.7M
Eliminate Wellness Preventive Screening Requirement	$4.4M
Increase Non-Wellness Contribution for Actives ($25 per month)	$3.1M
$250 Deductible & OOPM Increase for Actives/Pre-65 Retirees	$5.1M
Post-65 Retiree Coordination of Benefit Change	$11.0M
Department of Education Funding Increase from $108M to $138M	$30.0M
Eliminate Basic Plan for Actives/Pre-65 Retirees	($1.1M)
Introduce Hybrid Plan for Actives/Pre-65 Retirees	TBD

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

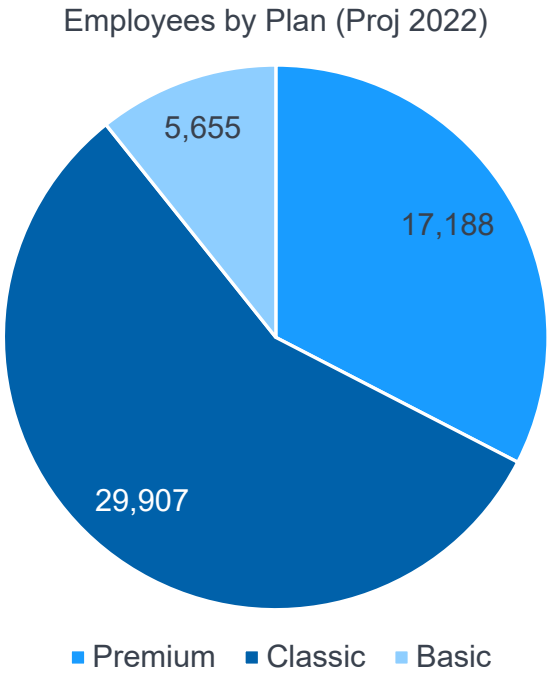
Elimination of Basic Plan

Background

- Actives and Non-Medicare Retirees currently have access to 3 medical plans
  - Premium (most rich), Classic, Basic (most lean)
  - Both Classic and Basic quality as High Deductible Health Plans (HDHP)
  - ~5,650 employees and retirees will need to elect either the Premium or Classic plan if they want to remain under EBD's group
  - Members will see a deductible ↓ from $4,000 to $1,750

Monthly Contributions

- Employee Only contributions will increase by $35 minimum
- Family contributions will increase by $83 minimum



Bottom Line: Estimated annual financial impact to EBD will be $1.1 Million in additional employer cost

PSE – Alternative Plan Design

	Premium Current	Classic Current	Basic Current	Hybrid Proposed
Individual / Family Deductible	$750 / $1,500	$1,750 / $2,850	$4,000 / $8,000	$2,250 / $4,500
Individual / Family MOOP[1]	$3,250 / $6,500	$6,450 / $9,675	$6,450 / $12,900	$6,450 / $12,900
Primary Care Physician / Specialist	$25 / $50	20% after ded.	20% after ded.	20% after ded.
ER	$250	20% after ded.	20% after ded.	20% after ded.
Inpatient	20% after ded.	20% after ded.	20% after ded.	20% after ded.
Outpatient	20% after ded.	20% after ded.	20% after ded.	20% after ded.
Generic Drug	$15	20% after ded.	20% after ded.	20% after ded.
Preferred Brand Drug	$40	20% after ded.	20% after ded.	20% after ded.
Non-Preferred Brand Drug	$80	20% after ded.	20% after ded.	20% after ded.
Specialty Drug	$100	20% after ded.	20% after ded.	20% after ded.
Actuarial Value (AV)	84.3%	74.4%	68.2%	72.4%
Proj. 2022 Enrollment[2]	17,188	29,907	5,655	35,562

[1] *Separate out-of-pocket maximum for pharmacy on Premium plan*
[2] *Represents Active and Pre-65 Retiree projected 2022 enrollment*

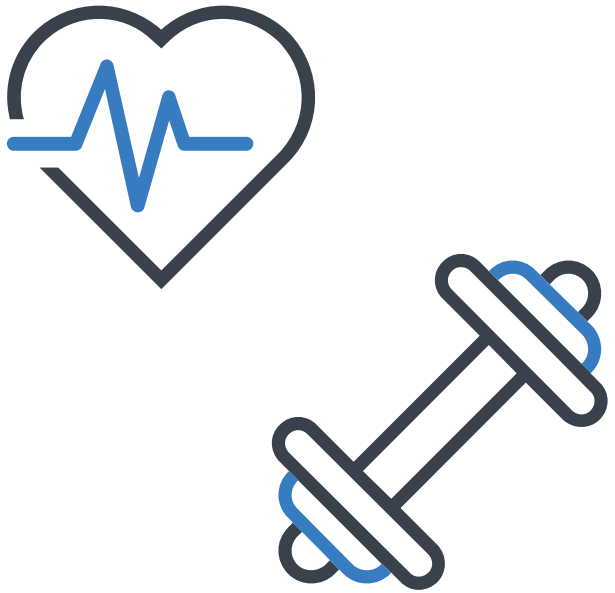
State of Arkansas' Wellness Program

Background

- Currently, employees can earn a $50 credit towards their monthly contribution
- Approximately 75-80% of enrolled employees satisfy the wellness requirements annually

Program requirements

- Biometric screening / wellness visit
- Health assessment
- Be a non-tobacco user or complete a tobacco cessation program



Bottom Line: Estimated program savings from removing the biometric screening / wellness visit requirement is $4.4M

Post-65 Retiree Coordination of Benefits (CoB)

Background

- Arkansas provides Post-65 retirees with medical benefit coverage
- Approximately 15,500 retirees are currently enrolled in the benefit
- Arkansas' Post-65 coverage coordinates with Medicare with Medicare being primary and Arkansas being secondary for medical services. There is no coordination for pharmacy.
- Currently, the Arkansas benefit program covers the Medicare deductible, inpatient/SNF copayment, and Part B deductible/coinsurance. Services not covered by Medicare are subject to Premium plan provisions.
- Arkansas could change the coordination of benefits such that the member would be subject to the Premium plan provisions on the Medicare deductible, inpatient/SNF copayment, and Part B deductible/coinsurance.

Bottom Line: Estimated program savings from changing the coordination of benefits process is $11.0M. This is a benefit change that increases the retiree out-of-pocket costs.

Arkansas State Employees (ASE)

Recap of Projected Funds Needed for 2022

Additional Funding and/or Savings Needed to Fund 2022 Projected Expenses and at least 10% Reserve
$33.0M

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

	ASE
2022 Projected Revenue	$314.2
2022 Projected Expenses	($347.2)
2022 Projected Income / (Loss)	**($33.0)**
Projected Net Assets End of 2022	$8.1
Target Net Assets (10% of Expenses)	$34.7
Needed Change in Net Assets	**$26.6**

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

Summary of Initiatives

- 2022 ASE target: ($33.0M) (estimated deficit + 10% catastrophic reserve minimum)

Initiative	2022 Estimated Savings	2022 Estimated Balance
Reduction in Wellness Credit from $50 to $0	$10.5M	($22.5M)
Eliminate Wellness Preventive Screening Requirement	$2.7M	($19.8M)
Increase Non-Wellness Contribution for Actives ($25 per month)	$1.7M	($18.1M)
5% Pre-65 Retiree Contribution Increase	$0.5M	($17.6M)
$250 Deductible & OOPM Increase for Actives/Pre-65 Retirees	$3.4M	($14.2M)
Post-65 Retiree Coordination of Benefit Change	$9.3M	($4.9M)
State Funding Increase from $450 to $475	$10.2M	$5.4M
Total	$38.4M	

Summary of All Initiatives Modeled YTD

Initiative	2022 Estimated Savings
5% Contribution Increase for Actives, Pre-65 Retirees, and Post-65 Retirees	$5.4M
Reduction in Wellness Credit from $50 to $25[1]	$5.2M
Eliminate Wellness Preventive Screening Requirement	$2.7M
Increase Non-Wellness Contribution for Actives ($25 per month)	$1.7M
$250 Deductible & OOPM Increase for Actives/Pre-65 Retirees	$3.4M
Post-65 Retiree Coordination of Benefit Change	$9.3M
State Funding Increase from $450 to $475	$10.2M
Eliminate Basic Plan for Actives/Pre-65 Retirees	$0.0M
Introduce Hybrid Plan for Actives/Pre-65 Retirees	TBD
Discontinue Medicare-Eligible Retiree Spouse Coverage[2]	$5.4M

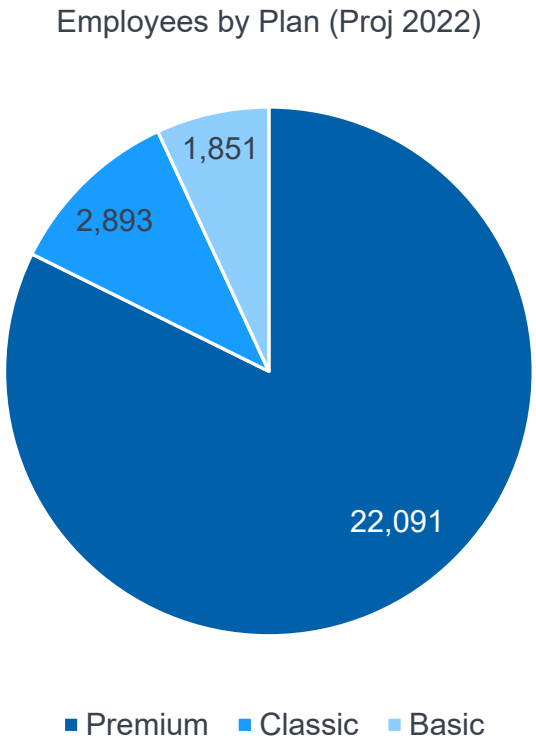
[1] Not recommending elimination of wellness program, showing value of change to credit

[2] Original estimate of $5.9M. However, if a 5% contribution increase is implemented across all plans and tiers, then the estimated savings drop from $5.9M to $5.4M

Elimination of Basic Plan

Background

- Actives and Non-Medicare Retirees currently have access to 3 medical plans
  - Premium (most rich), Classic, Basic (most lean)
  - Both Classic and Basic quality as High Deductible Health Plans (HDHP) and qualify for employer HSA contributions of $25/$50 per month for individuals/families
  - Currently, Employee Only coverage has a $0 employee premium contribution (~1,000 employees)
  - ~1,850 employees and retirees will need to elect either the Premium or Classic plan if they want to remain under EBD's group
  - Members will see a deductible ↓ from $6,450 to $2,500



Monthly Contributions

- Employee Only contributions will increase by $78 minimum
- Family contributions will increase by $165 minimum

Bottom Line: Estimated annual financial impact to EBD is cost neutral

ASE – Alternative Plan Design

	Premium Current	Classic Current	Basic Current	Hybrid Proposed
Individual / Family Deductible	$500 / $1,000	$2,500 / $5,000	$6,450 / $12,900	$4,000 / $8,000
Individual / Family MOOP[1]	$3,000 / $6,000	$6,450 / $12,900	$6,450 / $12,900	$6,450 / $12,900
Primary Care Physician / Specialist	$25 / $50	20% after ded.	0% after ded.	20% after ded.
ER	$250	20% after ded.	0% after ded.	20% after ded.
Inpatient	20% after ded.	20% after ded.	0% after ded.	20% after ded.
Outpatient	20% after ded.	20% after ded.	0% after ded.	20% after ded.
Generic Drug	$15	20% after ded.	0% after ded.	20% after ded.
Preferred Brand Drug	$40	20% after ded.	0% after ded.	20% after ded.
Non-Preferred Brand Drug	$80	20% after ded.	0% after ded.	20% after ded.
Specialty Drug	$100	20% after ded.	0% after ded.	20% after ded.
Actuarial Value (AV)	85.3%	75.5%	70.0%	71.5%
Proj. 2022 Enrollment[2]	22,091	2,893	1,851	4,744

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[1] Separate out-of-pocket maximum for pharmacy on Premium plan
[2] Represents Active and Pre-65 Retiree projected 2022 enrollment

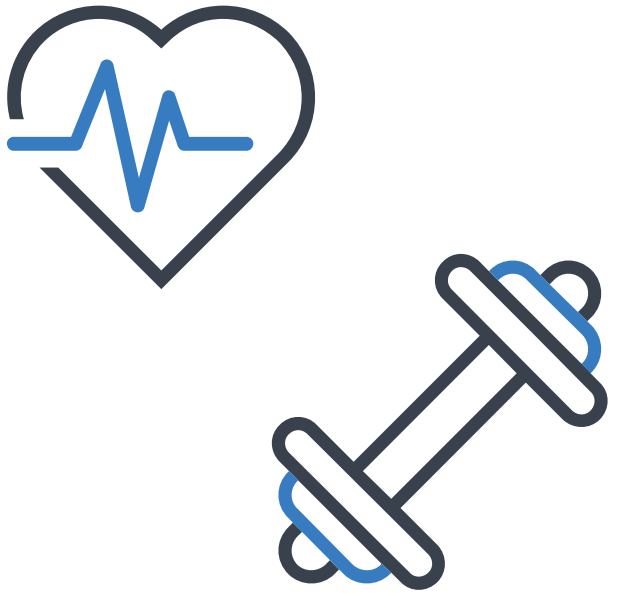
State of Arkansas' Wellness Program

Background

- Currently, employees can earn a $50 credit towards their monthly contribution
- Approximately 75-80% of enrolled employees satisfy the wellness requirements annually

Program requirements

- Biometric screening / wellness visit
- Health assessment
- Be a non-tobacco user or complete a tobacco cessation program



Bottom Line: Estimated program savings from removing the biometric screening / wellness visit requirement is $2.7M

Post-65 Retiree Coordination of Benefits (CoB)

Background

- Arkansas provides Post-65 retirees with medical and pharmacy benefit coverage
- Approximately 11,300 retirees are currently enrolled in the benefit
- Arkansas' Post-65 coverage coordinates with Medicare with Medicare being primary and Arkansas being secondary for medical services. There is no coordination for pharmacy.
- Currently, the Arkansas benefit program covers the Medicare deductible, inpatient/SNF copayment, and Part B deductible/coinsurance. Services not covered by Medicare are subject to Premium plan provisions.
- Arkansas could change the coordination of benefits such that the member would be subject to the Premium plan provisions on the Medicare deductible, inpatient/SNF copayment, and Part B deductible/coinsurance.

Bottom Line: Estimated program savings from changing the coordination of benefits process is $9.3M. This is a benefit change that increases the retiree out-of-pocket costs.

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Thank you

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

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 budgets relied on historical ASE and PSE medical and pharmacy claims from 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.

While we reviewed the ABCBS, MedImpact, 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. It is certain that actual experience will not conform exactly to the assumptions used in 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 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 setting the ASE and PSE budget for CY2020, CY2021, and CY2022. 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.

State of Arkansas Employee Benefits Division

Interim Monitoring Report

Through February 28th

State and Public School Life and Health Insurance Board of Directors

Courtney White, FSA, MAAA
Paul Sakhrani, FSA, MAAA
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Arkansas State Employees (ASE)

Executive Summary

- Updated 2020 income and expenses based on EBD financials
- 2021 & 2022 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through February 2021 and pharmacy claims data incurred from January 2020 to December 2020 and paid through February 2021
- 2021 projected plan experience
  - Allocation of Prior Years' Surplus for 2021: $14.5M
  - Projected deficit: -$3.4M (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2021: $15.5M
  - Reflects 2021 program initiatives and board decisions
  - Increased membership based on historical patterns
  - Baseline trends (medical: 5%, pharmacy: 8%)
- 2022 projected plan experience
  - Allocation of Prior Years' Surplus for 2022: $6.1M
  - Estimated deficit of -$26.9M (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2022: -$7.9M
  - Reflects baseline scenario
  - No plan design or contribution changes

Total Plan Experience

Funding	2020	2021	2022
State Contribution	$ 171.05	$ 184.48	$ 184.48
Employee Contribution	100.96	110.40	110.72
Other	17.43	17.94	19.03
Total Income	$ 289.44	$ 312.82	$ 314.24
Medical Claims	$ (201.46)	$ (219.17)	$ (227.16)
Pharmacy Claims	(90.53)	(98.01)	(106.46)
Administration Fees	(16.26)	(16.00)	(16.10)
Plan Administration	(2.55)	(2.51)	(2.52)
Life Insurance	(0.93)	(0.92)	(0.92)
Total Expenses	$ (311.74)	$ (336.60)	$ (353.16)
Program Savings	$ -	$ 5.89	$ 5.96
Net Income / (Loss) Before Reserve Allocation	$ (22.29)	$ (17.90)	$ (32.96)
Allocation of Reserves	$ 27.00	$ 14.46	$ 6.07
Net Income / (Loss) After Reserve Allocation	$ 4.71	$ (3.44)	$ (26.89)

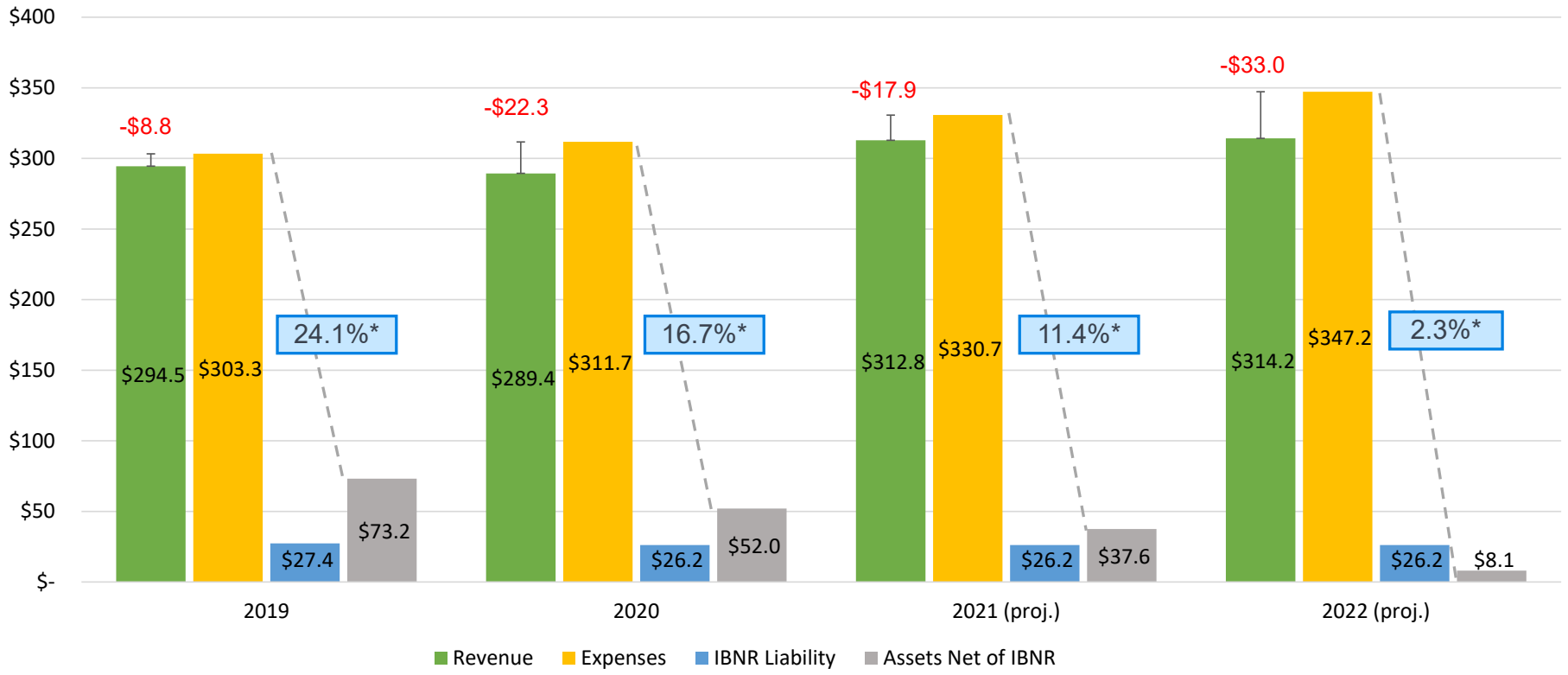
Average Membership			
Active Employees / Pre-65 Retirees	46,620	45,214	45,155
Post-65 Retirees	13,745	14,054	14,476
Total Enrolled	60,365	59,268	59,630

Total Income PMPM[1]	$ 436.85	$ 460.16	$ 447.63
Total Expenses PMPM[2]	$ (430.35)	$ (465.00)	$ (485.21)

[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Program Savings

Change in Revenue, Expenses, and Assets

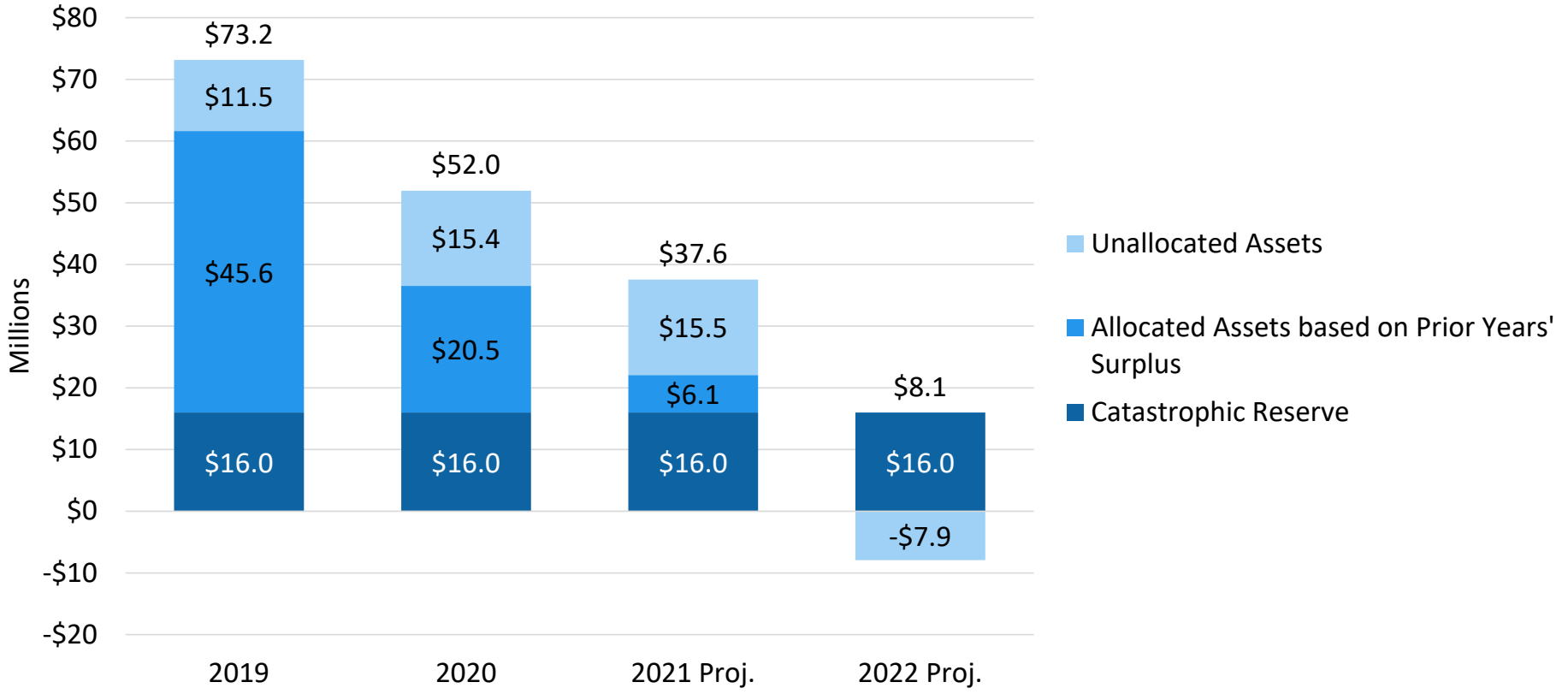


* Assets Net of IBNR as a portion of Expenses

Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
			Assets
(a)	2020	End-of-Year Gross Assets	$78.2
(b)	Proj 2021	Allocation of Prior Years' Surplus	($14.5)
(c)		Total Surplus / (Deficit)	($3.4)
(d)		FICA Funding	$3.5
(e) = (a) + (b) + (c) + (d)		End-of-Year Gross Assets Available	$63.8
(f)		Incurred but not reported (IBNR)	($26.2)
(g) = (e) + (f)		End of Year Net Assets Available	$37.6
(h)	Proj 2022	Allocation of Prior Years' Surplus	($6.1)
(i)		Total Surplus / (Deficit)	($26.9)
(j)		FICA Funding	$3.5
(k) = (e) + (h) + (i) + (j)		End-of-Year Gross Assets Available	$34.3
(l)		Incurred but not reported (IBNR)	($26.2)
(m) = (k) + (l)		End of Year Net Assets Available	$8.1

End of Year Assets Net of IBNR



Recommendations

For 2022

- Cover plan expense projection for 2022 + 10% reserve (minimum) using the levers of state funding and employee contributions or by reducing expense via reduction in plan value
- Complete a comprehensive plan performance review focused on utilization efficiency.

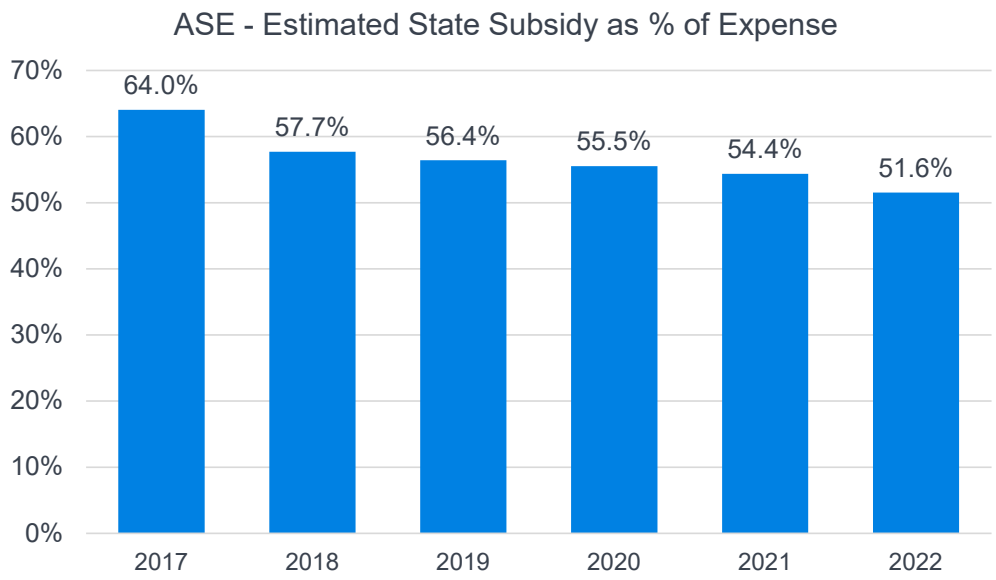
For 2023 and Subsequent Years

- Use benchmarking results to review and implement plan initiatives with best potential to reduce expense trend at an acceptable level of disruption to members and providers.
- Set revenue to match projected expenses each year (i.e., aim to maintain reserves at a reasonably consistent level).

ASE – Historical State Subsidy

2022 State Subsidy (PBPPM)	Additional Funding	% Increase	% of Expense
$450	$0	0%	51.6%
$475	$10.3M	6%	54.4%
$500	$20.5M	11%	57.3%
$530	$32.8M	18%	60.7%
$560	$45.1M	24%	64.2%

1. Assume no change in budgeted headcount



ASE State Subsidy was approximately 64% in 2017 and projected to be 51.6% in 2022 absent any changes

ASE – 2022 Alternative Contribution Scenarios

- Scenario 1: 5% increase in employee and retiree contribution
- Scenario 2: 10% increase in employee and retiree contribution
- Scenario 3: $25 reduction in wellness credit[2]
  - Impacts active only
- Scenario 4: 5% increase in employee and retiree contribution and $25 reduction in wellness credit[2]
  - 5% increase in employee and retiree contributions
  - $25 reduction in wellness credit to active employees

	2022 Estimated Impact[1]		
Scenario	Savings	EEs/Rets Impacted	Range of Change
Scenario 1	$5.4M	36,850	$2.85 - $50.04
Scenario 2	$10.7M	36,850	$5.70 - $100.08
Scenario 3	$5.2M	17,810	($25.00) - $25.00
Scenario 4	$10.6M	36,850	($25.00) - $53.75

[1]Maintain $0 contribution for Active Basic with wellness Employee Only for all scenarios

[2]Wellness credit changes impact the “with Wellness” rates, not the “without Wellness” rates

ASE – Active with Wellness

Tier	Employees	2021 Contribution	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Premium						
Employee	9,403	$143.99	$151.19 / $7.20	$158.39 / $14.40	$168.99 / $25.00	$176.19 / $32.20
Employee & Spouse	1,196	$455.48	$478.25 / $22.77	$501.03 / $45.55	$480.48 / $25.00	$503.25 / $47.77
Employee & Child(ren)	3,734	$263.52	$276.70 / $13.18	$289.87 / $26.35	$288.52 / $25.00	$301.70 / $38.18
Family	1,056	$575.01	$603.76 / $28.75	$632.51 / $57.50	$600.01 / $25.00	$628.76 / $53.75
Classic						
Employee	1,331	$77.79	$81.68 / $3.89	$85.57 / $7.78	$102.79 / $25.00	$106.68 / $28.89
Employee & Spouse	129	$300.98	$316.03 / $15.05	$331.08 / $30.10	$325.98 / $25.00	$341.03 / $40.05
Employee & Child(ren)	383	$149.30	$156.77 / $7.47	$164.23 / $14.93	$174.30 / $25.00	$181.77 / $32.47
Family	195	$372.49	$391.11 / $18.62	$409.74 / $37.25	$397.49 / $25.00	$416.11 / $43.62
Basic						
Employee	986	$0.00	$0.00 / $0.00	$0.00 / $0.00	$0.00 / $0.00	$0.00 / $0.00
Employee & Spouse	92	$175.44	$184.21 / $8.77	$192.98 / $17.54	$200.44 / $25.00	$209.21 / $33.77
Employee & Child(ren)	185	$56.98	$59.83 / $2.85	$62.68 / $5.70	$81.98 / $25.00	$84.83 / $27.85
Family	106	$207.43	$217.80 / $10.37	$228.17 / $20.74	$232.43 / $25.00	$242.80 / $35.37

$YYY / $Z represents the new monthly contribution rate and the change in monthly contribution

Scenario 1: 5% increase, Scenario 2: 10% increase, Scenario 3: $25 wellness reduction, Scenario 4: 5% increase & $25 wellness reduction

ASE – Active without Wellness

Tier	Employees	2021 Contribution	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Premium						
Employee	2,601	$193.99	$201.19 / $7.20	$208.39 / $14.40	$193.99 / $0.00	$201.19 / $7.20
Employee & Spouse	572	$505.48	$528.25 / $22.77	$551.03 / $45.55	$505.48 / $0.00	$528.25 / $22.77
Employee & Child(ren)	904	$313.52	$326.70 / $13.18	$339.87 / $26.35	$313.52 / $0.00	$326.70 / $13.18
Family	568	$625.01	$653.76 / $28.75	$682.51 / $57.50	$625.01 / $0.00	$653.76 / $28.75
Classic						
Employee	467	$127.79	$131.68 / $3.89	$135.57 / $7.78	$127.79 / $0.00	$131.68 / $3.89
Employee & Spouse	77	$350.98	$366.03 / $15.05	$381.08 / $30.10	$350.98 / $0.00	$366.03 / $15.05
Employee & Child(ren)	113	$199.30	$206.77 / $7.47	$214.23 / $14.93	$199.30 / $0.00	$206.77 / $7.47
Family	82	$422.49	$441.11 / $18.62	$459.74 / $37.25	$422.49 / $0.00	$441.11 / $18.62
Basic						
Employee	311	$50.00	$50.00 / $0.00	$50.00 / $0.00	$25.00 / ($25.00)	$25.00 / ($25.00)
Employee & Spouse	34	$225.44	$234.21 / $8.77	$242.98 / $17.54	$225.44 / $0.00	$234.21 / $8.77
Employee & Child(ren)	47	$106.98	$109.83 / $2.85	$112.68 / $5.70	$106.98 / $0.00	$109.83 / $2.85
Family	35	$257.43	$267.80 / $10.37	$278.17 / $20.74	$257.43 / $0.00	$267.80 / $10.37

$YYY / $Z represents the new monthly contribution rate and the change in monthly contribution

Scenario 1: 5% increase, Scenario 2: 10% increase, Scenario 3: $25 wellness reduction, Scenario 4: 5% increase & $25 wellness reduction

ASE – Pre-65 Retirees

Tier	Retirees	2021 Contribution	Scenario 1	Scenario 2
Premium				
Retiree	1,515	$293.71	$308.40 / $14.69	$323.08 / $29.37
Retiree & NME Spouse	240	$751.78	$789.37 / $37.59	$826.96 / $75.18
Retiree & Child(ren)	90	$542.75	$569.89 / $27.14	$597.03 / $54.28
Retiree & NME Spouse & Child(ren)	37	$1,000.80	$1,050.84 / $50.04	$1,100.88 / $100.08
Retiree & ME Spouse	164	$567.55	$595.93 / $28.38	$624.31 / $56.76
Retiree & ME Spouse & Child(ren)	11	$816.59	$857.42 / $40.83	$898.25 / $81.66
Classic				
Retiree	87	$227.51	$238.89 / $11.38	$250.26 / $22.75
Retiree & Spouse	16	$597.26	$627.12 / $29.86	$656.99 / $59.73
Retiree & Child(ren)	3	$428.53	$449.96 / $21.43	$471.38 / $42.85
Family	10	$798.27	$838.18 / $39.91	$878.10 / $79.83
Basic				
Retiree	41	$174.72	$183.46 / $8.74	$192.19 / $17.47
Retiree & Spouse	9	$471.74	$495.33 / $23.59	$518.91 / $47.17
Retiree & Child(ren)	2	$336.19	$353.00 / $16.81	$369.81 / $33.62
Family	3	$633.21	$664.87 / $31.66	$696.53 / $63.32

$YYY / $Z represents the new monthly contribution rate and the change in monthly contribution

Scenario 1: 5% increase, Scenario 2: 10% increase

ASE – Post-65 Retirees

Tier	Retirees	2021 Contribution	Scenario 1	Scenario 2
Primary				
Retiree	8,229	$183.92	$193.12 / $9.20	$202.31 / $18.39
Retiree & Non-Medicare Spouse	297	$641.99	$674.09 / $32.10	$706.19 / $64.20
Retiree & Child(ren)	59	$432.96	$454.61 / $21.65	$476.26 / $43.30
Retiree & Non-Medicare Spouse & Child(ren)	17	$891.01	$935.56 / $44.55	$980.11 / $89.10
Retiree & Medicare Spouse	2,677	$440.62	$462.65 / $22.03	$484.68 / $44.06
Retiree & Medicare Spouse & Child(ren)	33	$689.66	$724.14 / $34.48	$758.63 / $68.97

$YYY / $Z represents the new monthly contribution rate and the change in monthly contribution

Scenario 1: 5% increase, Scenario 2: 10% increase

ASE – Alternative Plan Design

	Premium		Classic		Basic	
	Current	Proposed	Current	Proposed	Current	Proposed
Individual / Family Deductible	$500 / $1,000	$750 / $1,500	$2,500 / $5,000	$2,750 / $5,500	$6,450 / $12,900	$6,700 / $13,400
Individual / Family MOOP[1]	$3,000 / $6,000	$3,250 / $6,500	$6,450 / $12,900	$6,700 / $13,400	$6,450 / $12,900	$6,700 / $13,400
Primary Care Physician / Specialist	$25 / $50	$25 / $50	20% after ded.	20% after ded.	0% after ded.	0% after ded.
ER	$250	$250	20% after ded.	20% after ded.	0% after ded.	0% after ded.
Inpatient	20% after ded.	20% after ded.	20% after ded.	20% after ded.	0% after ded.	0% after ded.
Outpatient	20% after ded.	20% after ded.	20% after ded.	20% after ded.	0% after ded.	0% after ded.
Generic Drug	$15	$15	20% after ded.	20% after ded.	0% after ded.	0% after ded.
Preferred Brand Drug	$40	$40	20% after ded.	20% after ded.	0% after ded.	0% after ded.
Non-Preferred Brand Drug	$80	$80	20% after ded.	20% after ded.	0% after ded.	0% after ded.
Specialty Drug	$100	$100	20% after ded.	20% after ded.	0% after ded.	0% after ded.
Actuarial Value (AV)	85.3%	84.3%	75.5%	74.5%	70.0%	69.4%
Proj. 2022 Enrollment[2]	22,091	22,091	2,893	2,893	1,851	1,851

Milliman

[1] Separate out-of-pocket maximum for pharmacy on Premium plan
[2] Represents Active and Pre-65 Retiree projected 2022 enrollment

Public School Employees (PSE)

Executive Summary

- Updated 2020 income and expenses based on EBD financials
- 2021 & 2022 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through February 2021 and pharmacy claims data incurred from January 2020 to December 2020 and paid through February 2021.
- 2021 projected plan experience
  - Allocation of Prior Years' Surplus for 2021: $15.5M
  - Additional $20M funding from the Department of Education
  - Projected deficit: -$800K (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2021: $4.7M
  - Reflected 2021 program initiatives and board decisions
  - Increased membership based on historical patterns
  - Baseline trends (medical: 7%, pharmacy: 8%)
- 2022 projected plan experience
  - Allocation of Prior Years' Surplus for 2022: $7.1M
  - Estimated deficit of -$65.2M (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2022: -$60.5M
  - Reflects baseline scenario
  - No plan design or contribution changes

Total Plan Experience

Funding	2020	2021	2022
PPE Funding	$ 102.23	$ 106.13	$ 109.77
Employee Contribution	124.15	137.08	142.16
Dept of Ed Funding	90.45	130.45	110.45
Other	13.41	12.90	13.40
Total Income	$ 330.24	$ 386.56	$ 375.79
Medical Claims	$ (253.50)	$ (303.06)	$ (339.40)
Pharmacy Claims	(67.04)	(73.74)	(81.69)
Administration Fees	(26.80)	(27.19)	(28.13)
Plan Administration	(3.16)	(3.13)	(3.22)
Total Expenses	$ (350.50)	$ (407.13)	$ (452.44)
Program Savings	$ -	$ 4.32	$ 4.45
Net Income / (Loss) Before Reserve Allocation	$ (20.26)	$ (16.25)	$ (72.20)
Allocation of Reserves	$ 22.00	$ 15.48	$ 7.05
Net Income / (Loss) After Reserve Allocation	$ 1.74	$ (0.77)	$ (65.15)

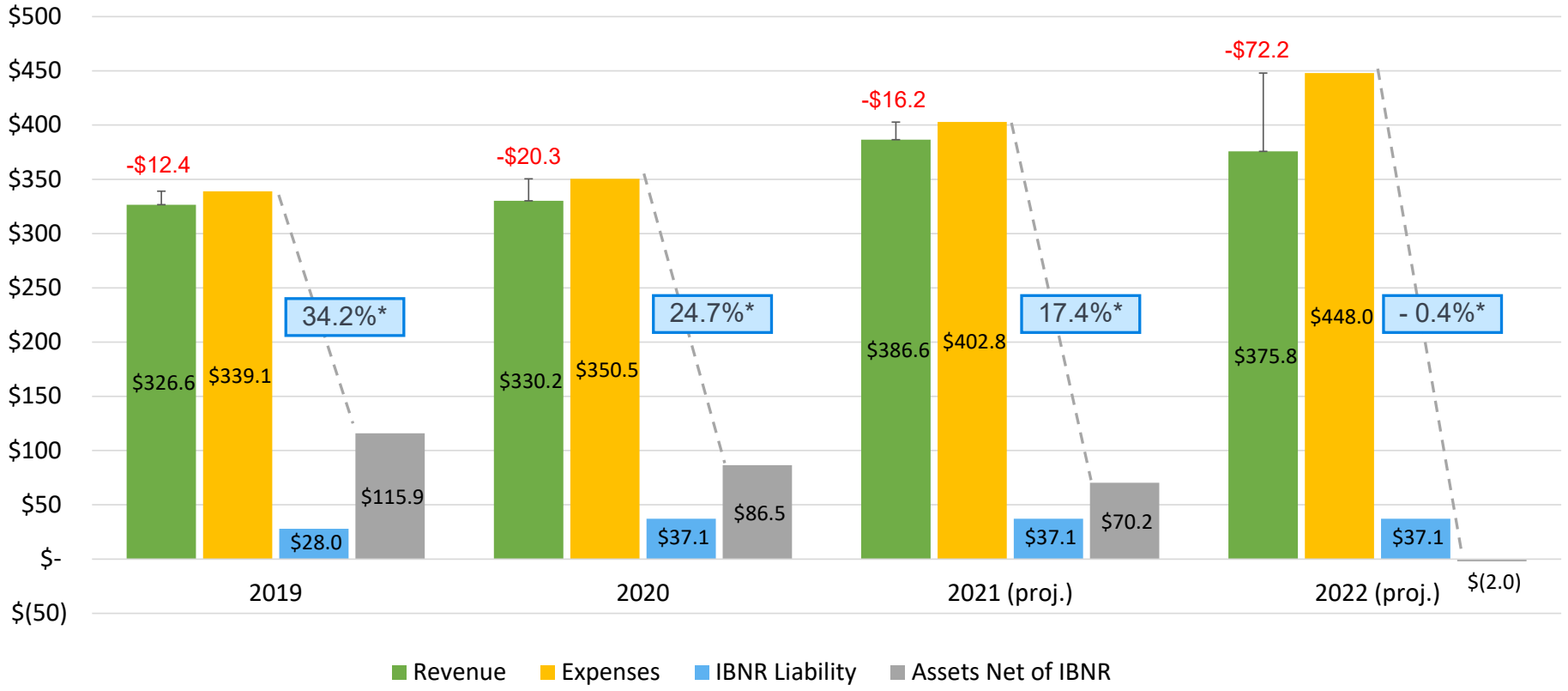
Average Membership			
Active Employees / Pre-65 Retirees	84,232	85,592	88,119
Post-65 Retirees	15,005	15,878	16,831
Total Enrolled	99,238	101,470	104,949

Total Income PMPM[1]	$ 295.79	$ 330.18	$ 303.99
Total Expenses PMPM[2]	$ (294.33)	$ (330.81)	$ (355.72)

[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Program Savings

Change in Revenue, Expenses, and Assets

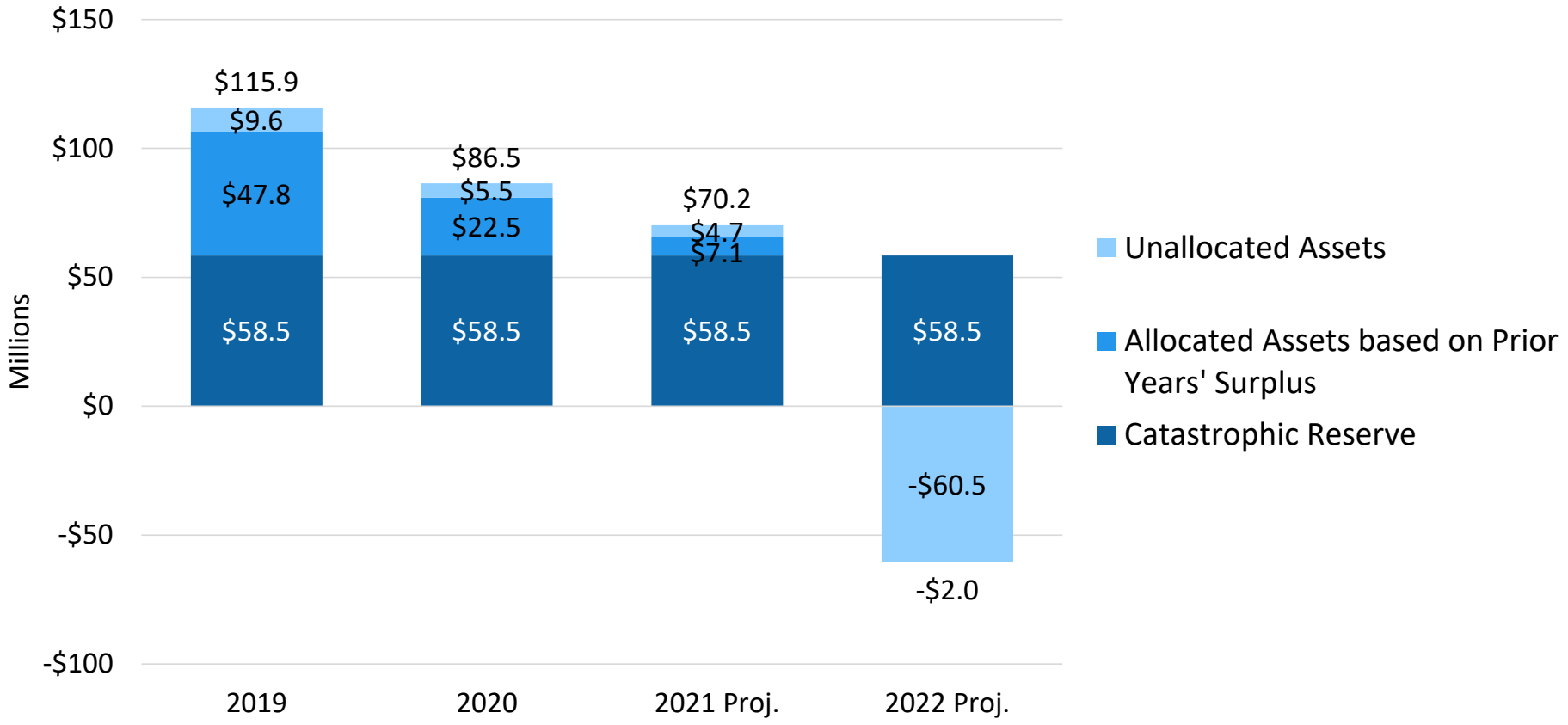


* Assets Net of IBNR as a portion of Expenses

Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
			Assets
(a)	2020	End-of-Year Gross Assets	$123.6
(b)	Proj 2021	Allocation of Prior Years' Surplus	($15.5)
(c)		Total Surplus / (Deficit)	($0.8)
(d) = (a) + (b) + (c)		End-of-Year Gross Assets Available	$107.4
(e)		Incurred but not reported (IBNR)	($37.1)
(f) = (d) + (e)		End of Year Net Assets Available	$70.2
(g)	Proj 2022	Allocation of Prior Years' Surplus	($7.1)
(h)		Total Surplus / (Deficit)	($65.2)
(i) = (d) + (g) + (h)		End-of-Year Gross Assets Available	$35.2
(j)		Incurred but not reported (IBNR)	($37.1)
(k) = (i) + (j)		End of Year Net Assets Available	($2.0)

End of Year Assets Net of IBNR



Recommendations

For 2022

- Cover plan expense projection for 2022 + 10% reserve (minimum) using the levers of state funding and employee contributions or by reducing expense via reduction in plan value
- Complete a comprehensive plan performance review focused on utilization efficiency.

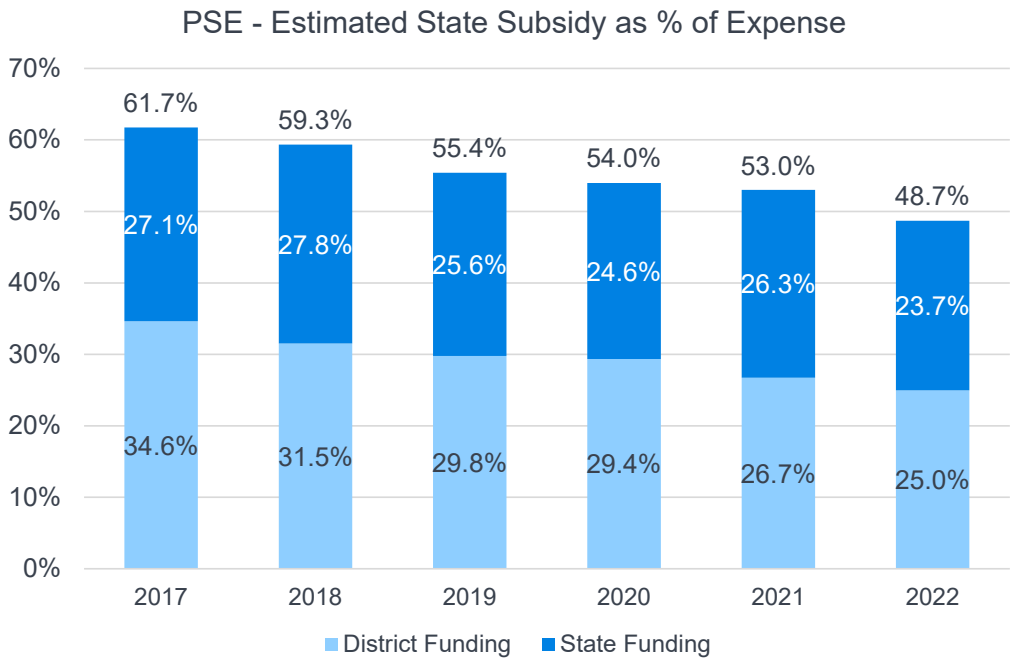
For 2023 and Subsequent Years

- Use benchmarking results to review and implement plan initiatives with best potential to reduce expense trend at an acceptable level of disruption to members and providers.
- Set revenue to match projected expenses each year (i.e., aim to maintain reserves at a reasonably consistent level).

PSE – Historical State Subsidy

2022 Dept of Education	Additional Funding	% Increase	% of Expense[1]
$108.1M	$0	0%	48.7%
$138.1M	$30M	28%	55.3%
$168.1M	$60M	55%	61.9%
$178.1M	$70M	65%	64.1%

1. Assume no change in district funding



Consider Funding on a Per Eligible Basis (i.e. like ASE / School District)

PSE State and School Subsidy was approximately 62% in 2017 and projected to be 49% in 2022 absent any changes

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PSE – 2022 Alternative Contribution Scenarios

- Scenario 1: 5% increase in employee and retiree contribution
- Scenario 2: 10% increase in employee and retiree contribution
- Scenario 3: $25 reduction in wellness credit[2]
  - Impacts active only
- Scenario 4: 10% increase in employee and retiree contribution and $25 reduction in wellness credit[2]
  - 10% increase in employee and retiree contributions
  - $25 reduction in wellness credit to active employees

	2022 Estimated Impact[1]		
Scenario	Savings	EEs/Rets Impacted	Range of Change
Scenario 1	$7.5M	68,226	$1.81 - $100.43
Scenario 2	$15.1M	68,226	$3.63 – $200.86
Scenario 3	$11.7M	39,050	$25.00
Scenario 4	$26.8M	68,226	$3.63 - $200.86

[1]May need to risk rate active and pre-65 retirees separately depending upon contribution strategy

[2]Wellness credit changes impact the “with Wellness” rates, not the “without Wellness” rates

PSE – Active with Wellness

Tier	Employees	2021 Contribution	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Premium						
Employee	10,706	$208.46	$218.88 / $10.42	$229.31 / $20.85	$233.46 / $25.00	$254.31 / $45.85
Employee & Spouse	170	$856.20	$899.01 / $42.81	$941.82 / $85.62	$881.20 / $25.00	$966.82 / $110.62
Employee & Child(ren)	1,861	$495.54	$520.32 / $24.78	$545.09 / $49.55	$520.54 / $25.00	$570.09 / $74.55
Family	335	$858.44	$901.36 / $42.92	$944.28 / $85.84	$883.44 / $25.00	$969.28 / $110.84
Classic						
Employee	12,571	$71.02	$74.57 / $3.55	$78.12 / $7.10	$96.02 / $25.00	$103.12 / $32.10
Employee & Spouse	1,280	$379.62	$398.60 / $18.98	$417.58 / $37.96	$404.62 / $25.00	$442.58 / $62.96
Employee & Child(ren)	5,642	$183.42	$192.59 / $9.17	$201.76 / $18.34	$208.42 / $25.00	$226.76 / $43.34
Family	2,627	$383.32	$402.49 / $19.17	$421.65 / $38.33	$408.32 / $25.00	$446.65 / $63.33
Basic						
Employee	2,902	$36.26	$38.07 / $1.81	$39.89 / $3.63	$61.26 / $25.00	$64.89 / $28.63
Employee & Spouse	194	$297.78	$312.67 / $14.89	$327.56 / $29.78	$322.78 / $25.00	$352.56 / $54.78
Employee & Child(ren)	485	$146.86	$154.20 / $7.34	$161.55 / $14.69	$171.86 / $25.00	$186.55 / $39.69
Family	277	$300.62	$315.65 / $15.03	$330.68 / $30.06	$325.62 / $25.00	$355.68 / $55.06

$YYY / $Z represents the new monthly contribution rate and the change in monthly contribution

Scenario 1: 5% increase, Scenario 2: 10% increase, Scenario 3: $25 wellness reduction, Scenario 4: 10% increase & $25 wellness reduction

PSE – Active without Wellness

Tier	Employees	2021 Contribution	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Premium						
Employee	2,922	$258.46	$268.88 / $10.42	$279.31 / $20.85	$258.46 / $0.00	$279.31 / $20.85
Employee & Spouse	83	$906.20	$949.01 / $42.81	$991.82 / $85.62	$906.20 / $0.00	$991.82 / $85.62
Employee & Child(ren)	451	$545.54	$570.32 / $24.78	$595.09 / $49.55	$545.54 / $0.00	$595.09 / $49.55
Family	188	$908.44	$951.36 / $42.92	$994.28 / $85.84	$908.44 / $0.00	$994.28 / $85.84
Classic						
Employee	2,744	$121.02	$124.57 / $3.55	$128.12 / $7.10	$121.02 / $0.00	$128.12 / $7.10
Employee & Spouse	441	$429.62	$448.60 / $18.98	$467.58 / $37.96	$429.62 / $0.00	$467.58 / $37.96
Employee & Child(ren)	1,013	$233.42	$242.59 / $9.17	$251.76 / $18.34	$233.42 / $0.00	$251.76 / $18.34
Family	1,153	$433.32	$452.49 / $19.17	$471.65 / $38.33	$433.32 / $0.00	$471.65 / $38.33
Basic						
Employee	881	$86.26	$88.07 / $1.81	$89.89 / $3.63	$86.26 / $0.00	$89.89 / $3.63
Employee & Spouse	91	$347.78	$362.67 / $14.89	$377.56 / $29.78	$347.78 / $0.00	$377.56 / $29.78
Employee & Child(ren)	128	$196.86	$204.20 / $7.34	$211.55 / $14.69	$196.86 / $0.00	$211.55 / $14.69
Family	162	$350.62	$365.65 / $15.03	$380.68 / $30.06	$350.62 / $0.00	$380.68 / $30.06

$YYY / $Z represents the new monthly contribution rate and the change in monthly contribution

Scenario 1: 5% increase, Scenario 2: 10% increase, Scenario 3: $25 wellness reduction, Scenario 4: 10% increase & $25 wellness reduction

PSE – Pre-65 Retirees

Tier	Retirees	2021 Contribution	Scenario 1	Scenario 2
Premium				
Retiree	390	$641.14	$673.20 / $32.06	$705.25 / $64.11
Retiree & NME Spouse	14	$1,457.18	$1,530.04 / $72.86	$1,602.90 / $145.72
Retiree & Child(ren)	7	$1,192.60	$1,252.23 / $59.63	$1,311.86 / $119.26
Retiree & NME Spouse & Child(ren)	2	$2,008.64	$2,109.07 / $100.43	$2,209.50 / $200.86
Retiree & ME Spouse	60	$795.12	$834.88 / $39.76	$874.63 / $79.51
Retiree & ME Spouse & Child(ren)	0	$1,346.58	$1,413.91 / $67.33	$1,481.24 / $134.66
Classic				
Retiree	2,017	$273.30	$286.97 / $13.67	$300.63 / $27.33
Retiree & Spouse	309	$565.78	$594.07 / $28.29	$622.36 / $56.58
Retiree & Child(ren)	70	$469.82	$493.31 / $23.49	$516.80 / $46.98
Family	41	$746.20	$783.51 / $37.31	$820.82 / $74.62
Basic				
Retiree	424	$148.50	$155.93 / $7.43	$163.35 / $14.85
Retiree & Spouse	66	$269.72	$283.21 / $13.49	$296.69 / $26.97
Retiree & Child(ren)	22	$238.52	$250.45 / $11.93	$262.37 / $23.85
Family	23	$335.72	$352.51 / $16.79	$369.29 / $33.57

$YYY / $Z represents the new monthly contribution rate and the change in monthly contribution

Scenario 1: 5% increase, Scenario 2: 10% increase

PSE – Post-65 Retirees

Tier	Retirees	2021 Contribution	Scenario 1	Scenario 2
Primary				
Retiree	14,135	$100.78	$105.82 / $5.04	$110.86 / $10.08
Retiree & Non-Medicare Spouse	92	$783.92	$823.12 / $39.20	$862.31 / $78.39
Retiree & Child(ren)	12	$757.10	$794.96 / $37.86	$832.81 / $75.71
Retiree & Non-Medicare Spouse & Child(ren)	7	$1,521.48	$1,597.55 / $76.07	$1,673.63 / $152.15
Retiree & Medicare Spouse	1,228	$263.04	$276.19 / $13.15	$289.34 / $26.30
Retiree & Medicare Spouse & Child(ren)	3	$888.58	$933.01 / $44.43	$977.44 / $88.86

$YYY / $Z represents the new monthly contribution rate and the change in monthly contribution

Scenario 1: 5% increase, Scenario 2: 10% increase

PSE – Alternative Plan Design

	Premium		Classic		Basic	
	Current	Proposed	Current	Proposed	Current	Proposed
Individual / Family Deductible	$750 / $1,500	$1,000 / $2,000	$1,750 / $2,850	$2,000 / $3,250	$4,000 / $8,000	$4,250 / $8,500
Individual / Family MOOP[1]	$3,250 / $6,500	$3,500 / $7,000	$6,450 / $9,675	$6,700 / $10,050	$6,450 / $12,900	$6,700 / $13,400
Primary Care Physician / Specialist	$25 / $50	$25 / $50	20% after ded.	20% after ded.	20% after ded.	20% after ded.
ER	$250	$250	20% after ded.	20% after ded.	20% after ded.	20% after ded.
Inpatient	20% after ded.	20% after ded.	20% after ded.	20% after ded.	20% after ded.	20% after ded.
Outpatient	20% after ded.	20% after ded.	20% after ded.	20% after ded.	20% after ded.	20% after ded.
Generic Drug	$15	$15	20% after ded.	20% after ded.	20% after ded.	20% after ded.
Preferred Brand Drug	$40	$40	20% after ded.	20% after ded.	20% after ded.	20% after ded.
Non-Preferred Brand Drug	$80	$80	20% after ded.	20% after ded.	20% after ded.	20% after ded.
Specialty Drug	$100	$100	20% after ded.	20% after ded.	20% after ded.	20% after ded.
Actuarial Value (AV)	84.3%	83.4%	74.4%	73.2%	68.2%	67.4%
Proj. 2022 Enrollment[2]	17,188	17,188	29,907	29,907	5,655	5,655

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[1] Separate out-of-pocket maximum for pharmacy on Premium plan
[2] Represents Active and Pre-65 Retiree projected 2022 enrollment

Appendix

Assumptions & Methodology

Assumptions & Methodology

Assumptions - Trend

Division	Group	Medical Trend	Pharmacy Trend
ASE	Active/Pre-65 Retirees Post-65 Retirees	5.0% 5.0%	8.0% 8.0%
PSE	Active/Pre-65 Retirees Post-65 Retirees	7.0% 7.0%	8.0% 8.0%

Assumptions & Methodology

Assumptions – Benefit Plan Changes (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

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

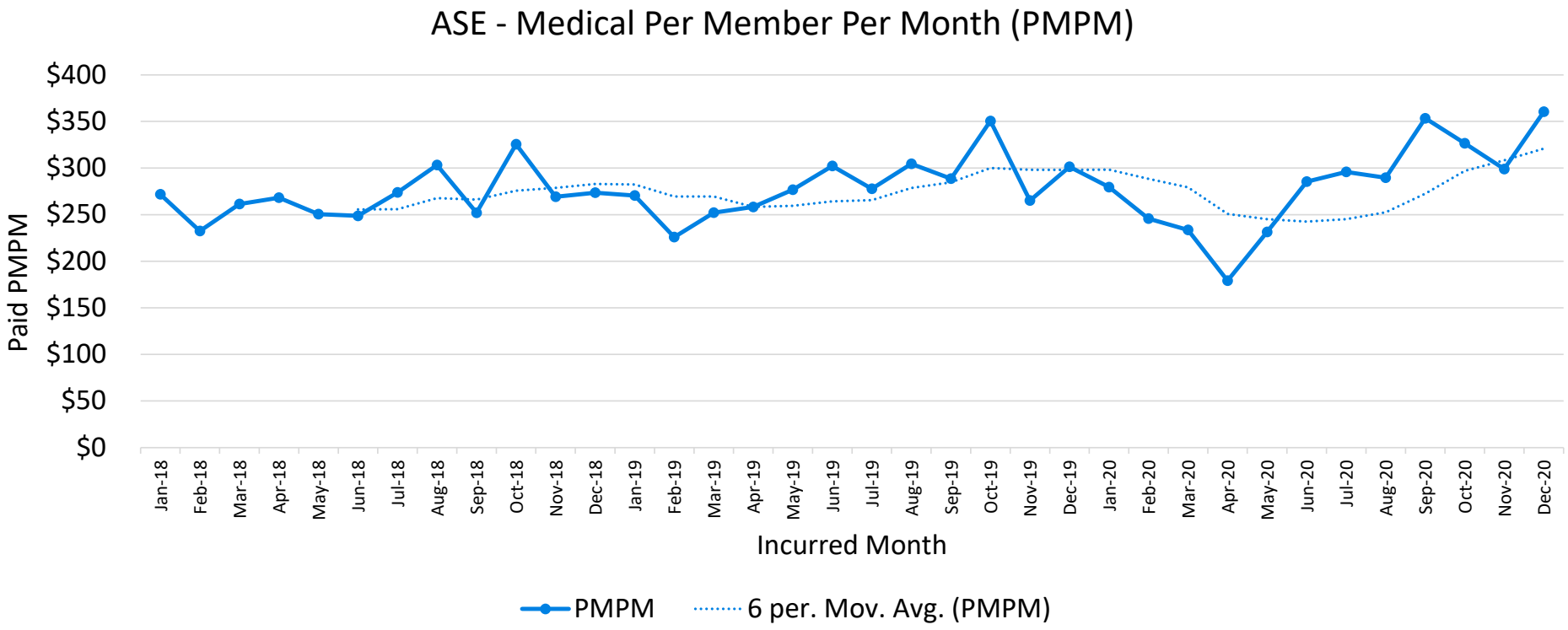
Methodology

1. Summarized fee-for-service (FFS) medical claims incurred from March 1, 2019 to February 29, 2020 and paid from March 1, 2019 to February 28, 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 December 31, 2020 and paid from January 1, 2020 to February 28, 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 January 2020 to December 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.

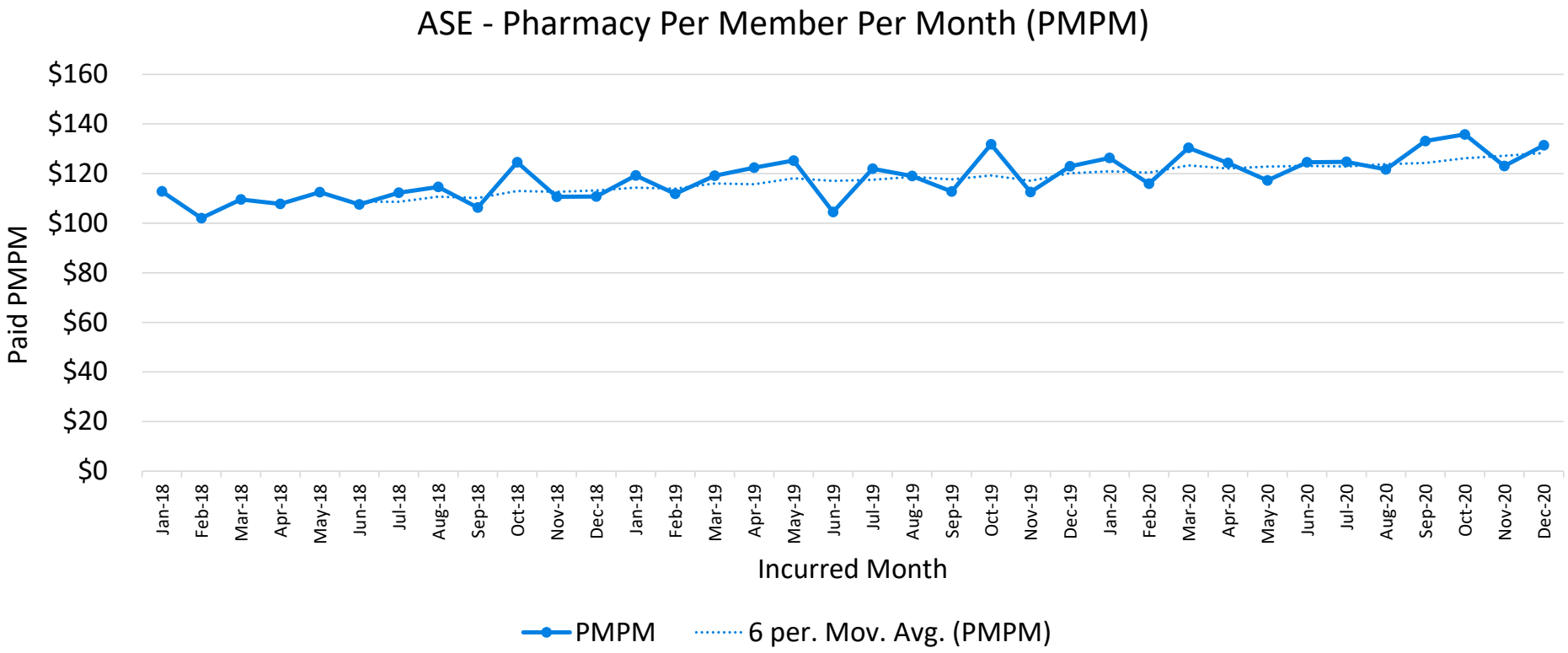
Appendix

ASE Supporting Exhibits

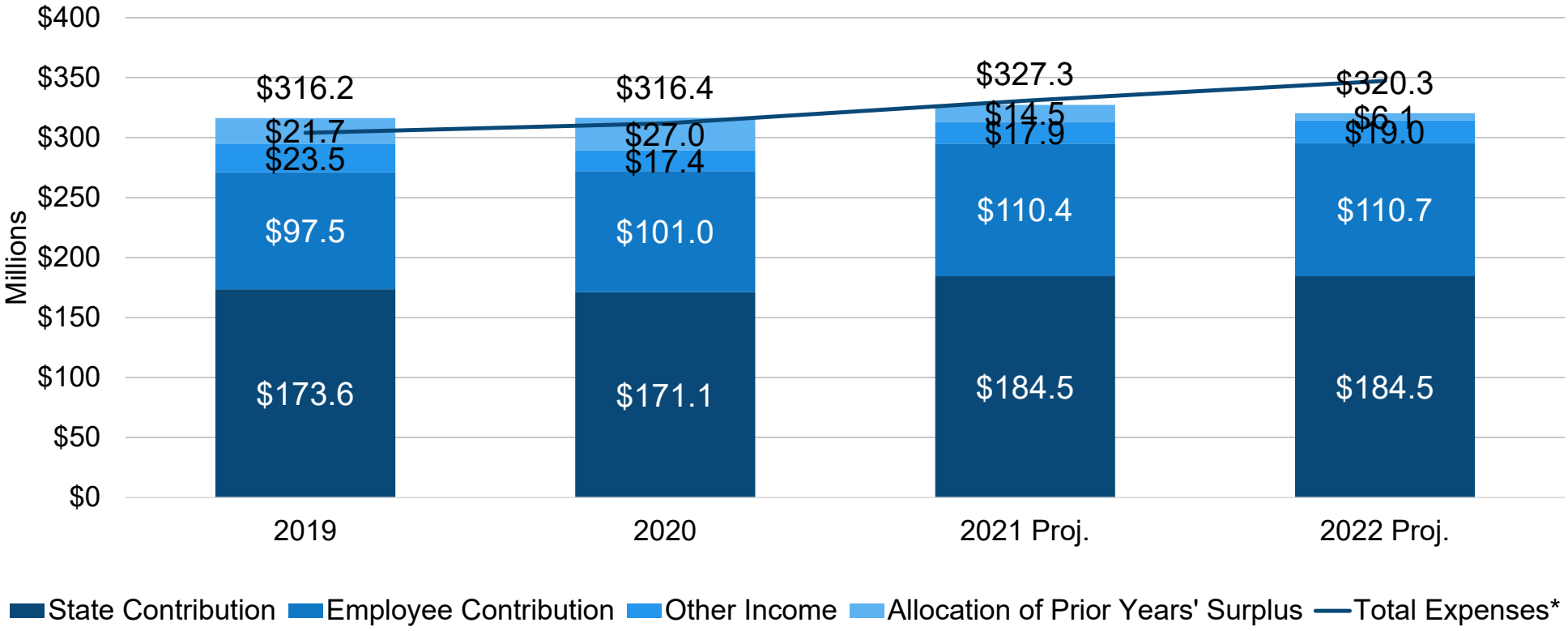
Monthly Trend - Medical



Monthly Trend - Pharmacy

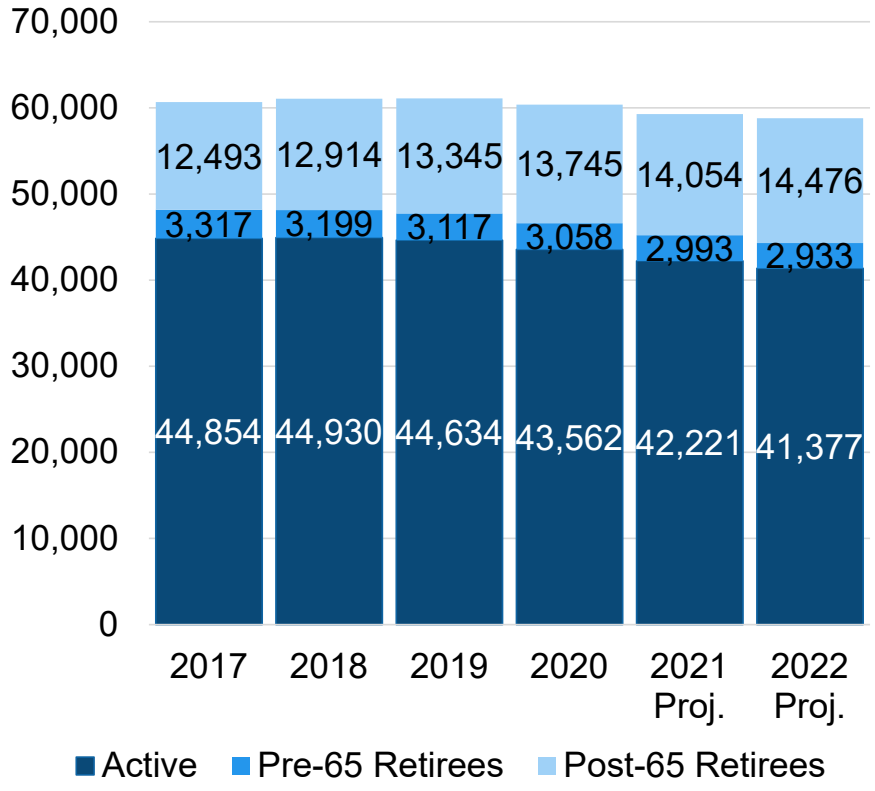


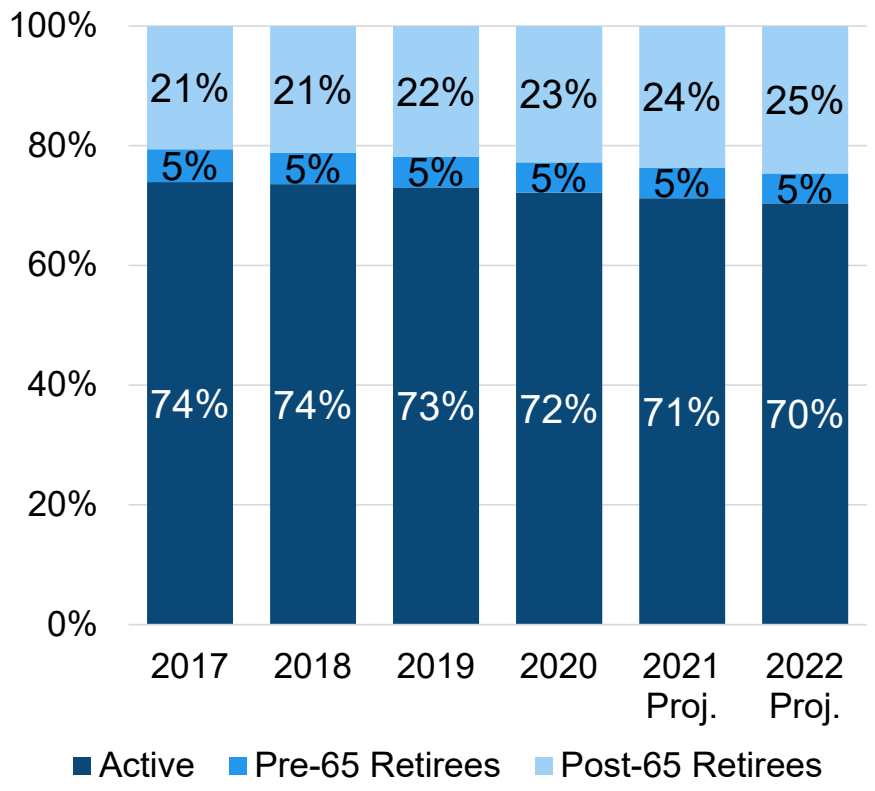
ASE - Income vs. Expenditure



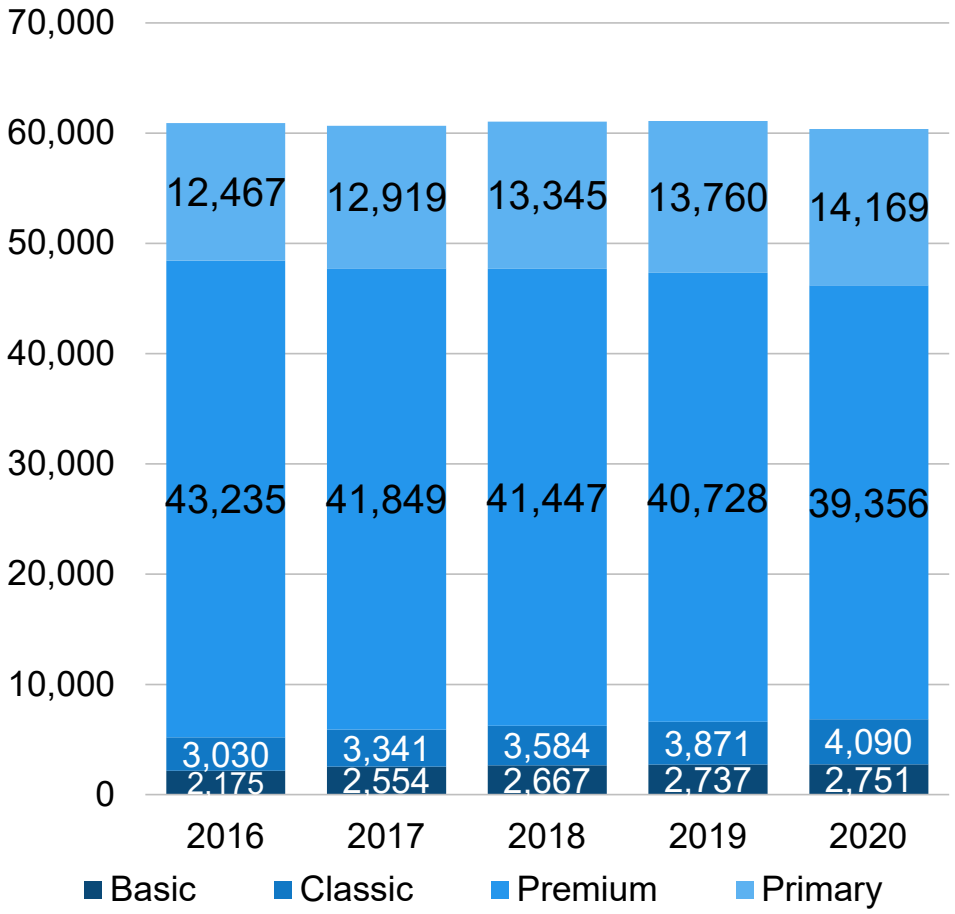
* Total Expenses offset by Program Savings

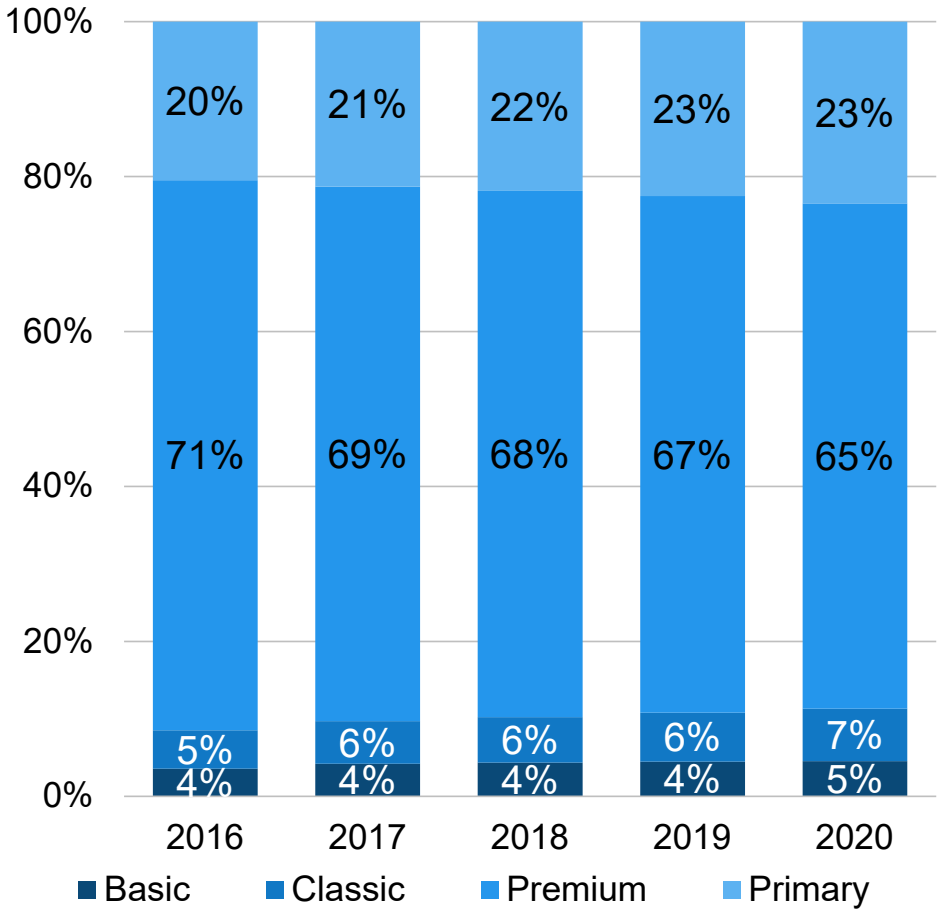
ASE - Average Membership by Status





ASE - Average Membership by Plan





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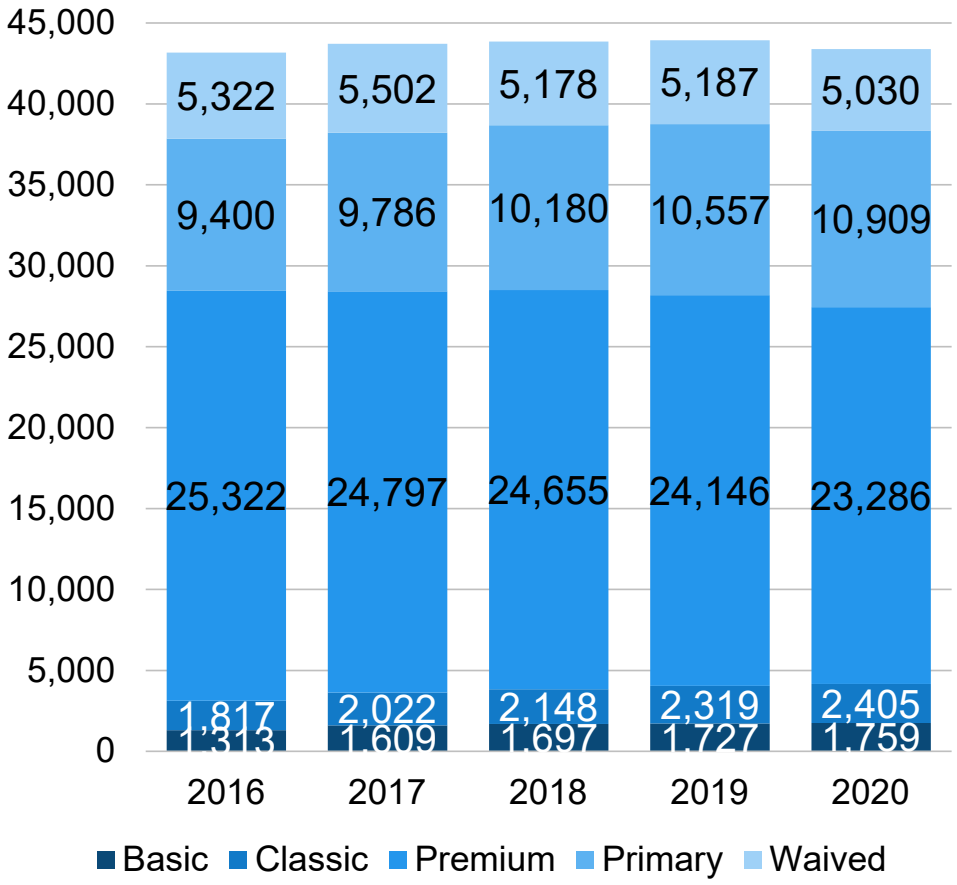
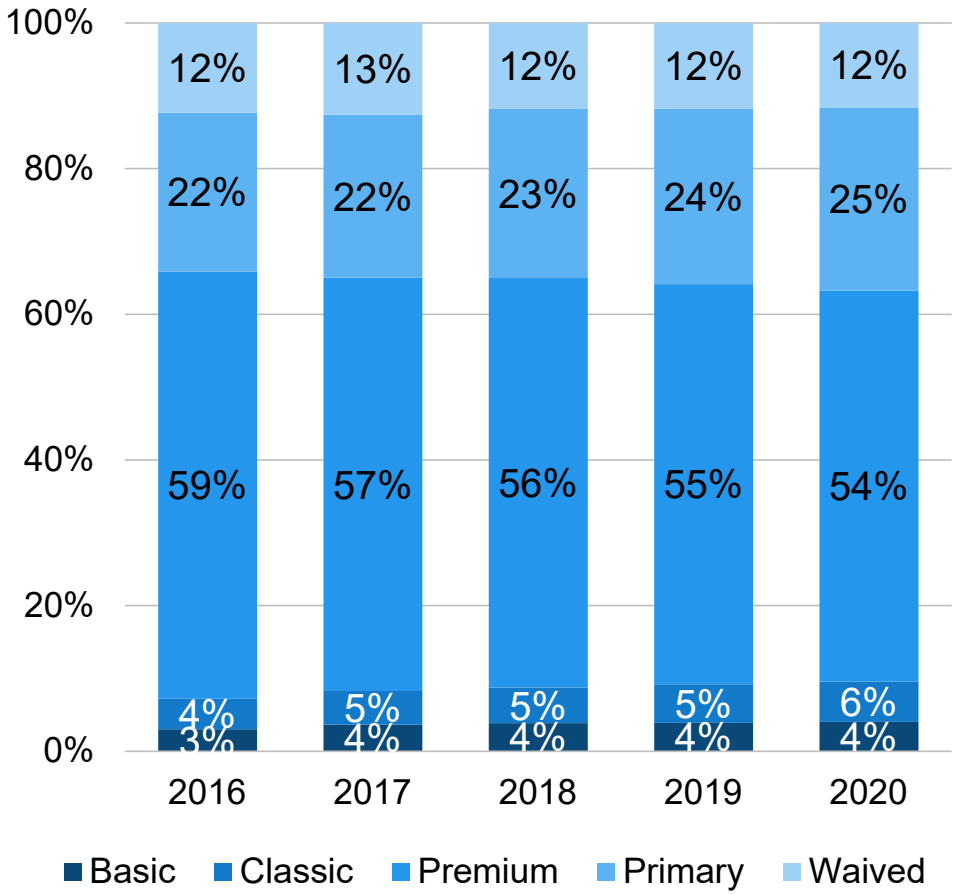
ASE - Average Enrollment (Subscribers) by Plan





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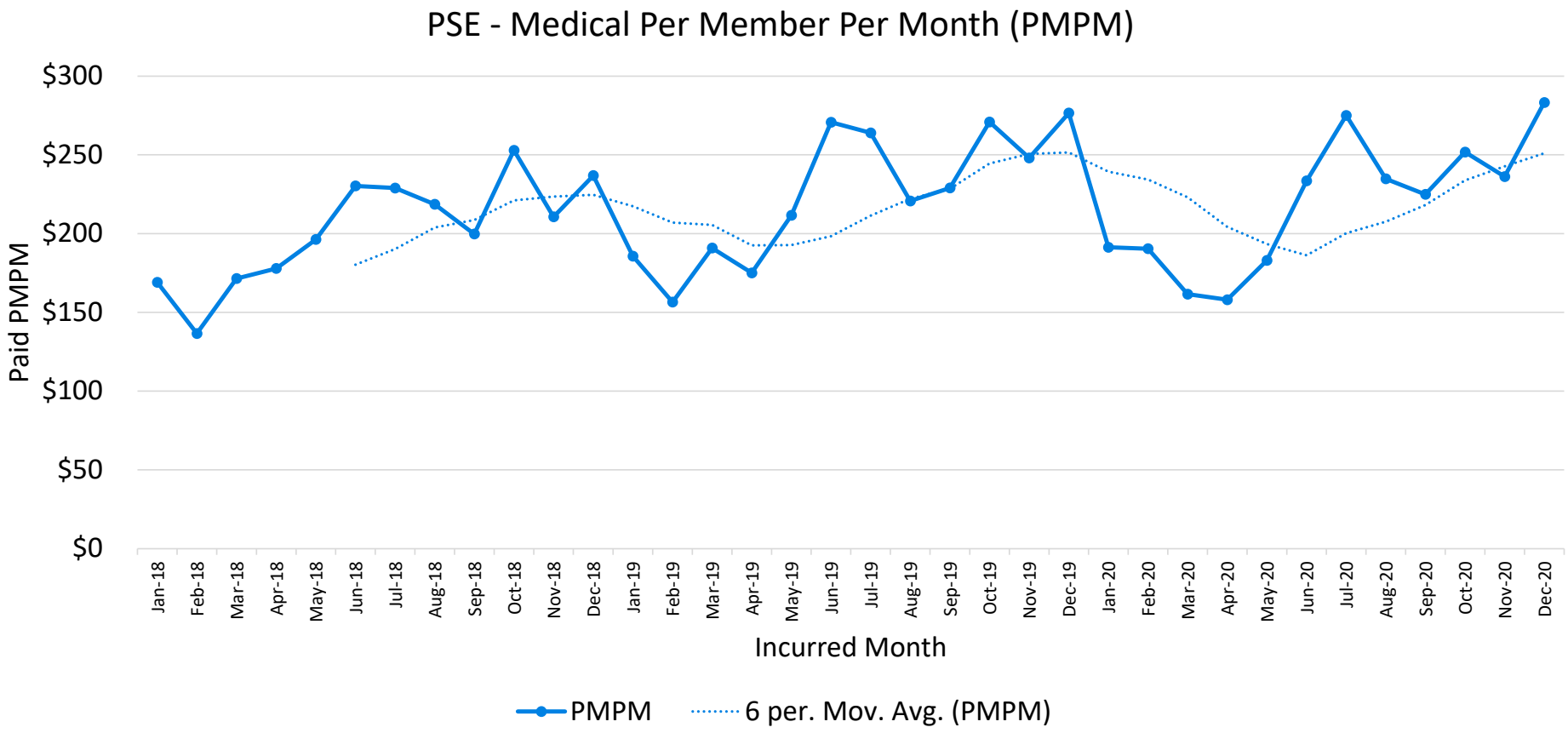
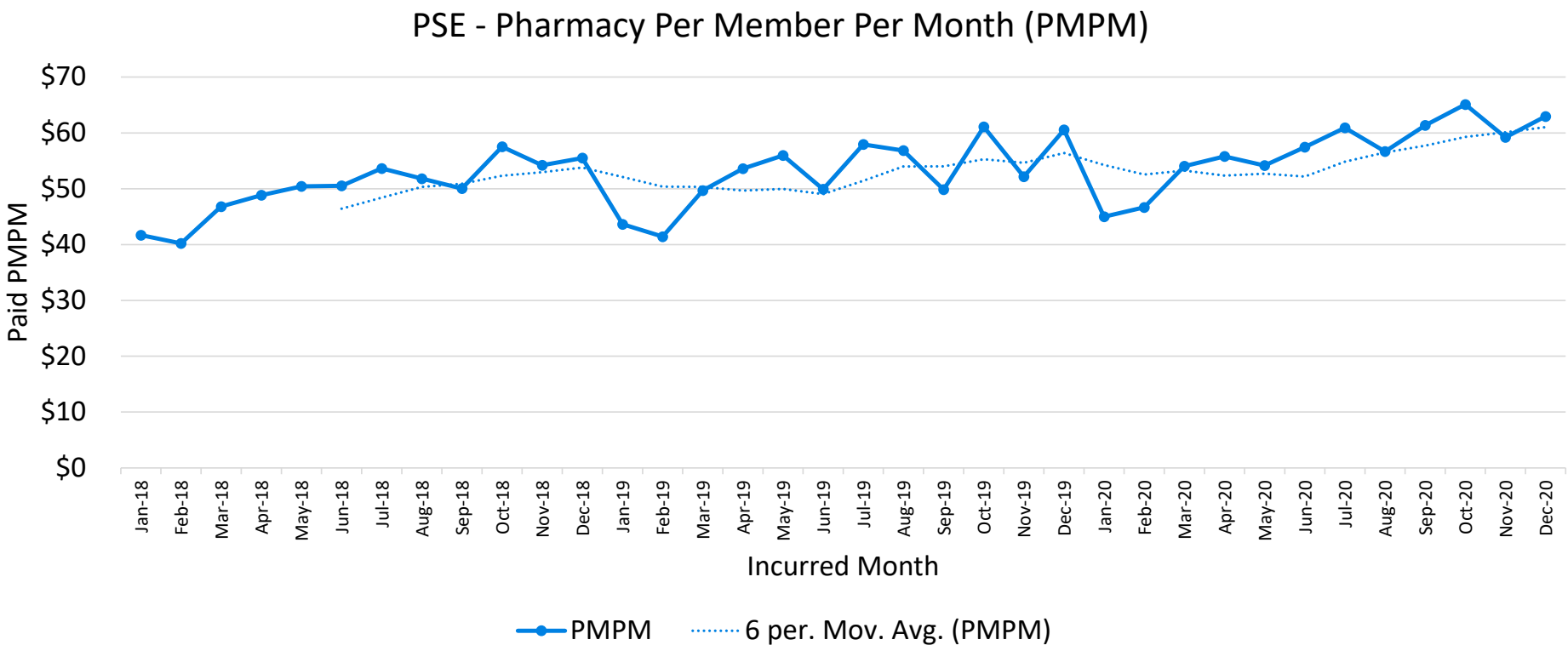
Appendix

PSE Supporting Exhibits

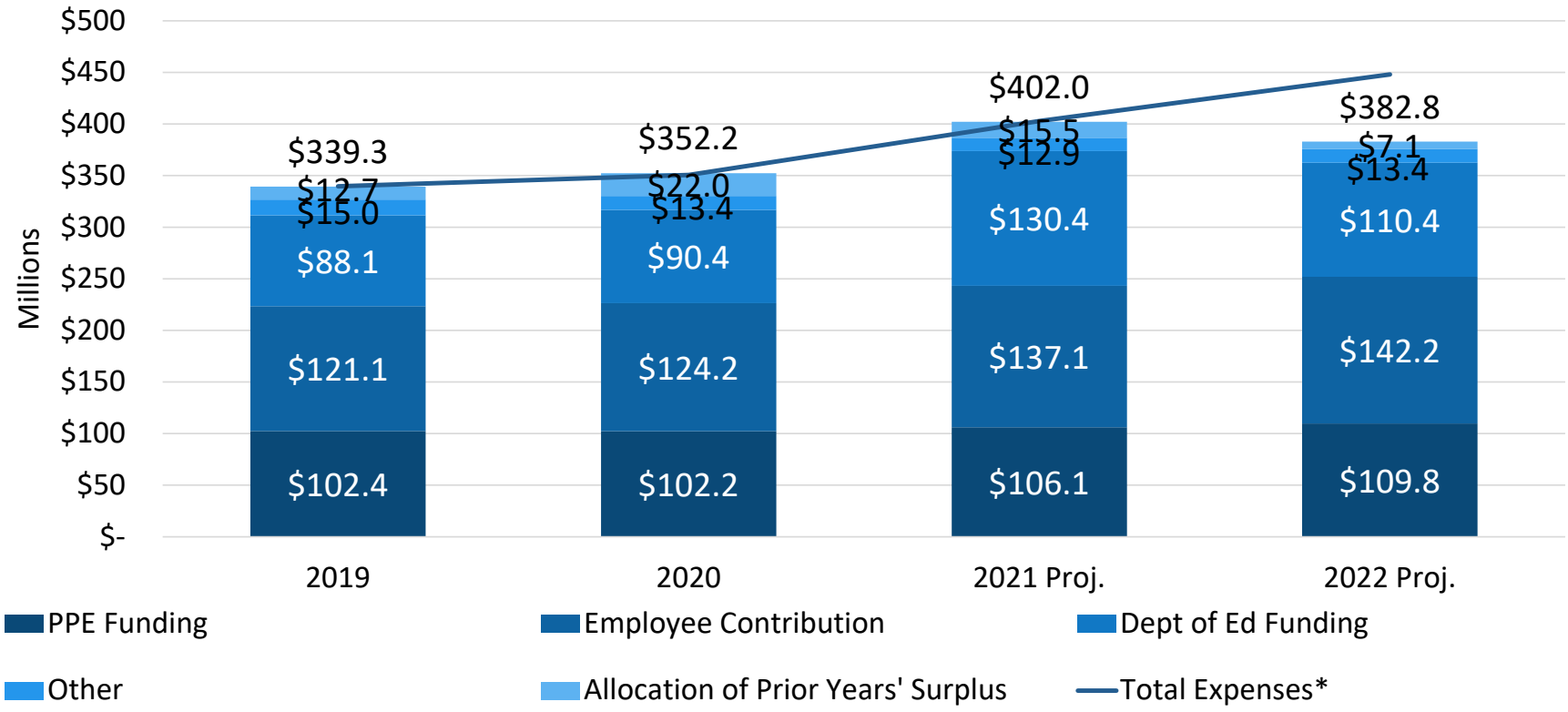
Monthly Trend - Medical



Monthly Trend - Pharmacy

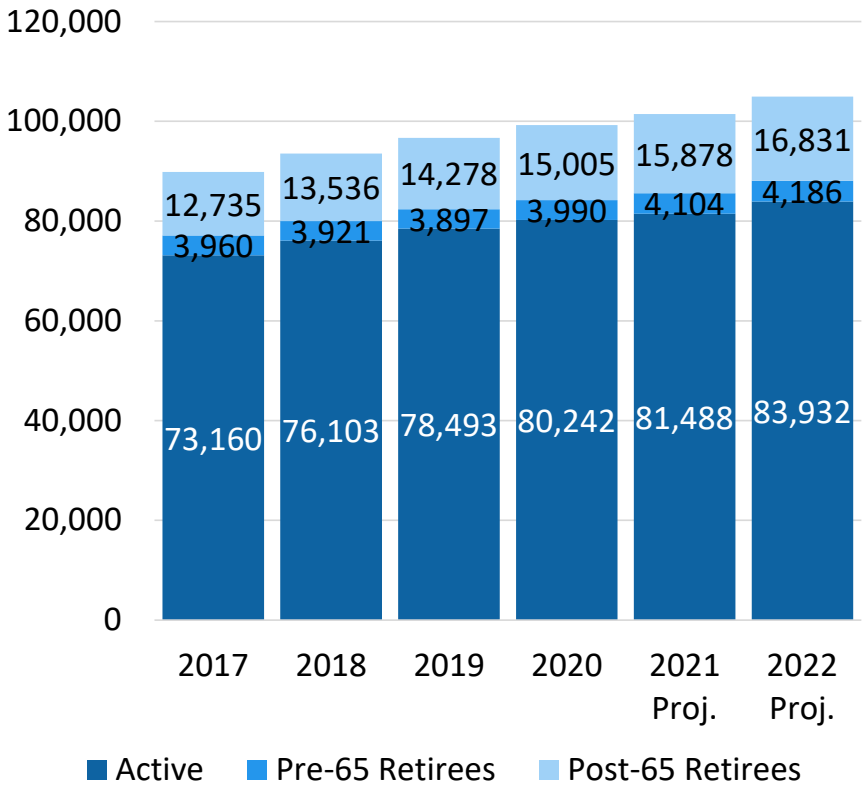


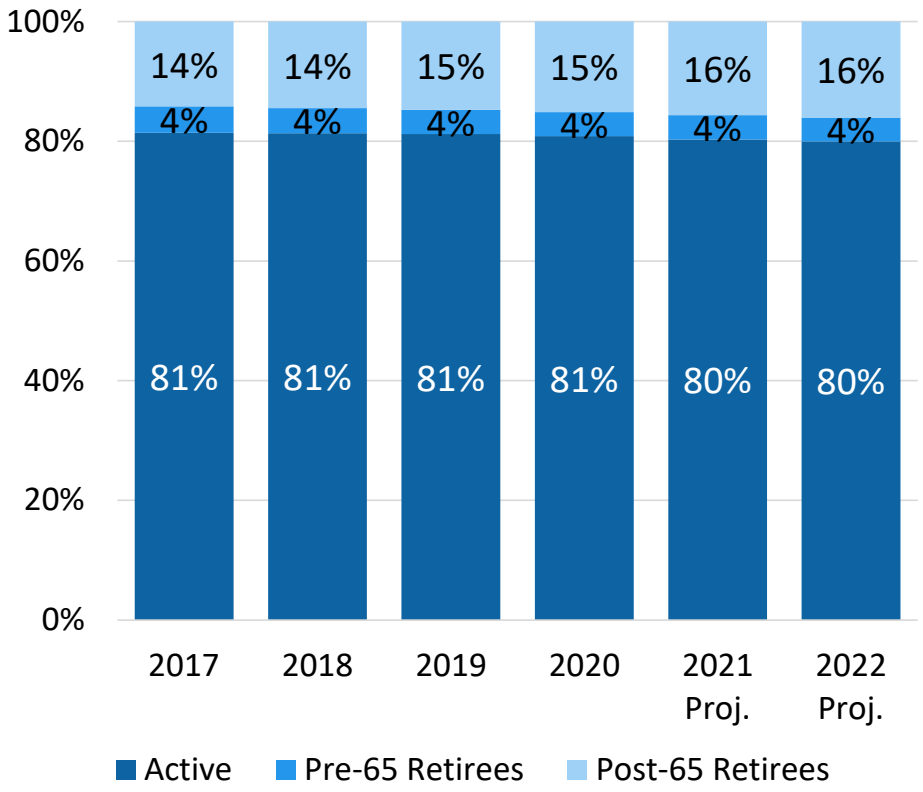
PSE - Income vs. Expenditure



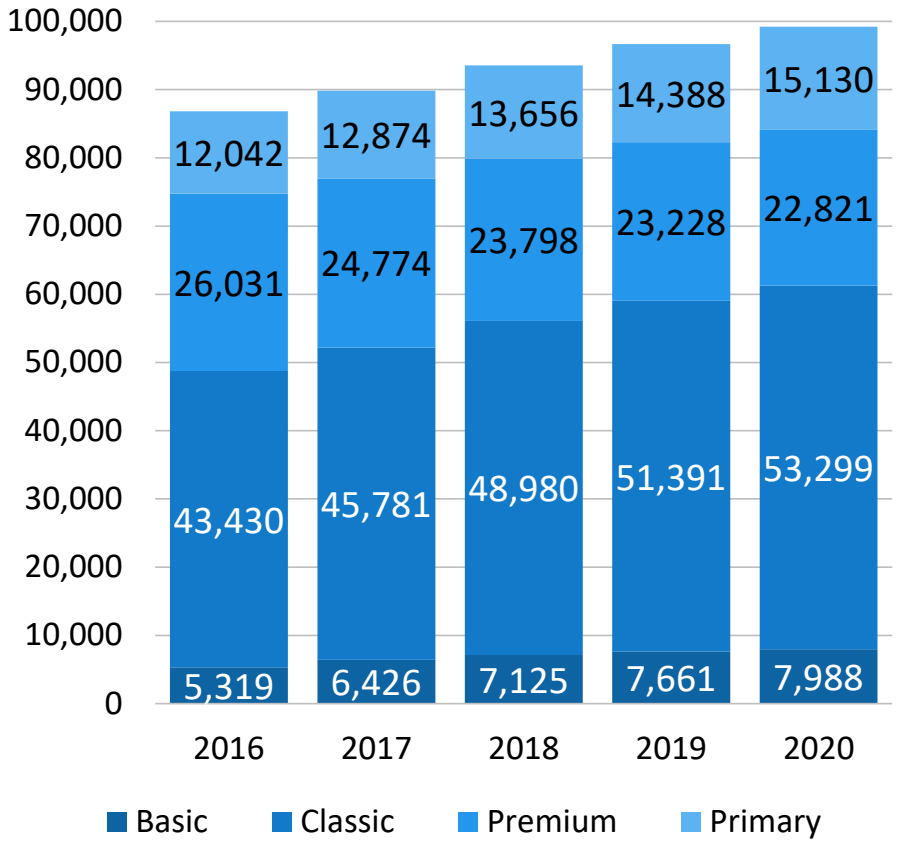
* Total Expenses offset by Program Savings

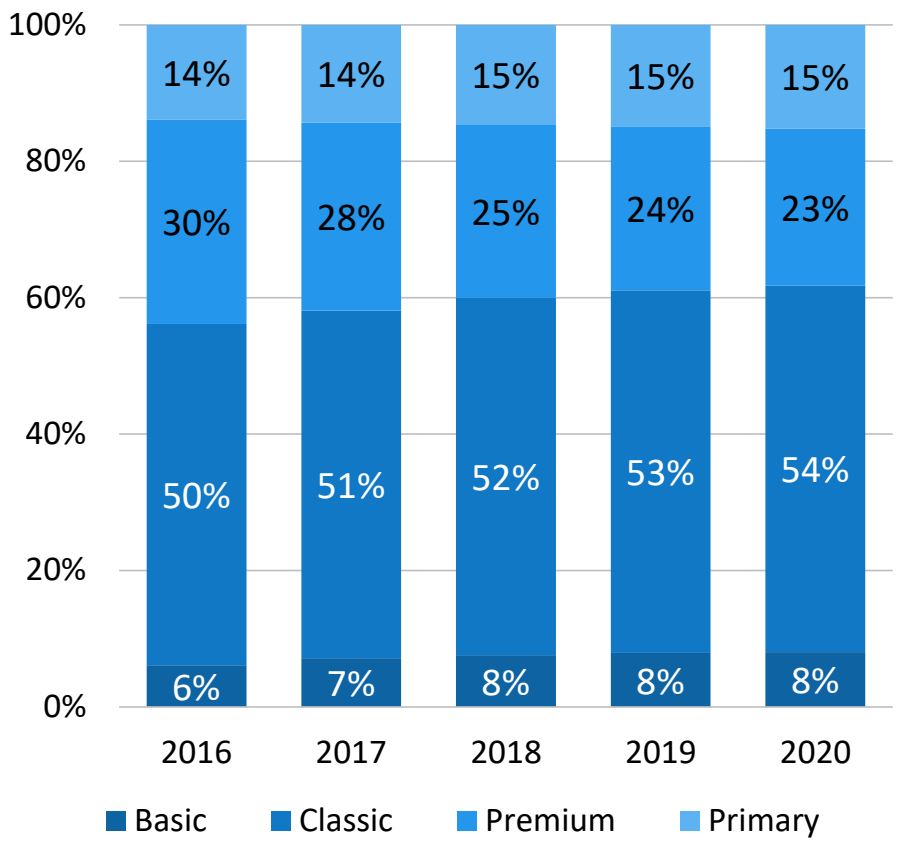
PSE - Average Membership by Status



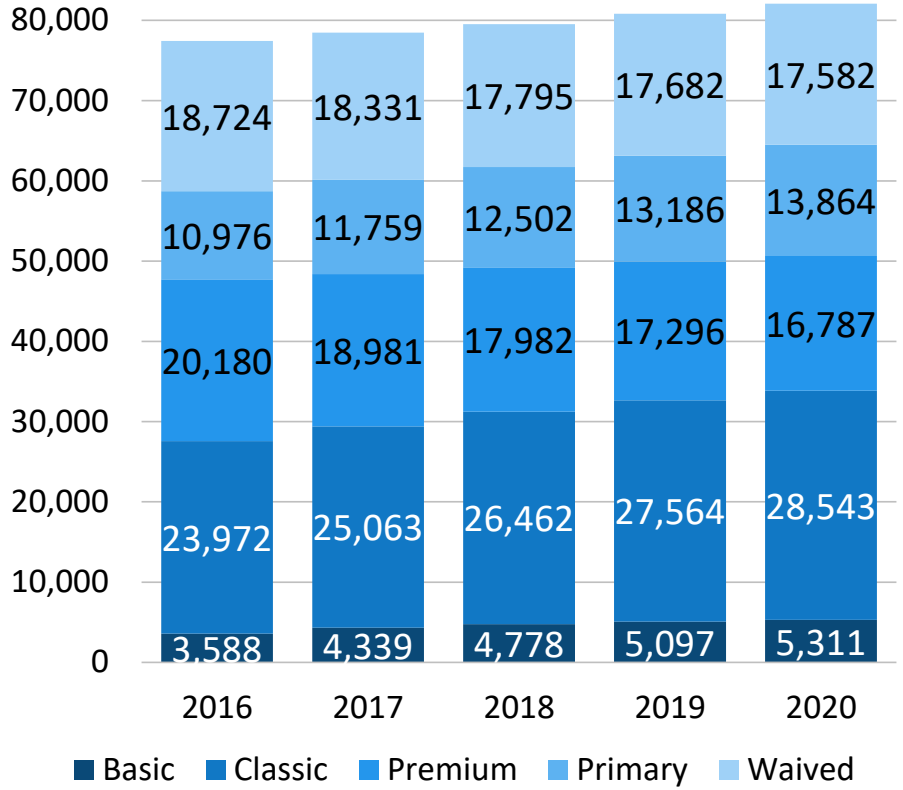


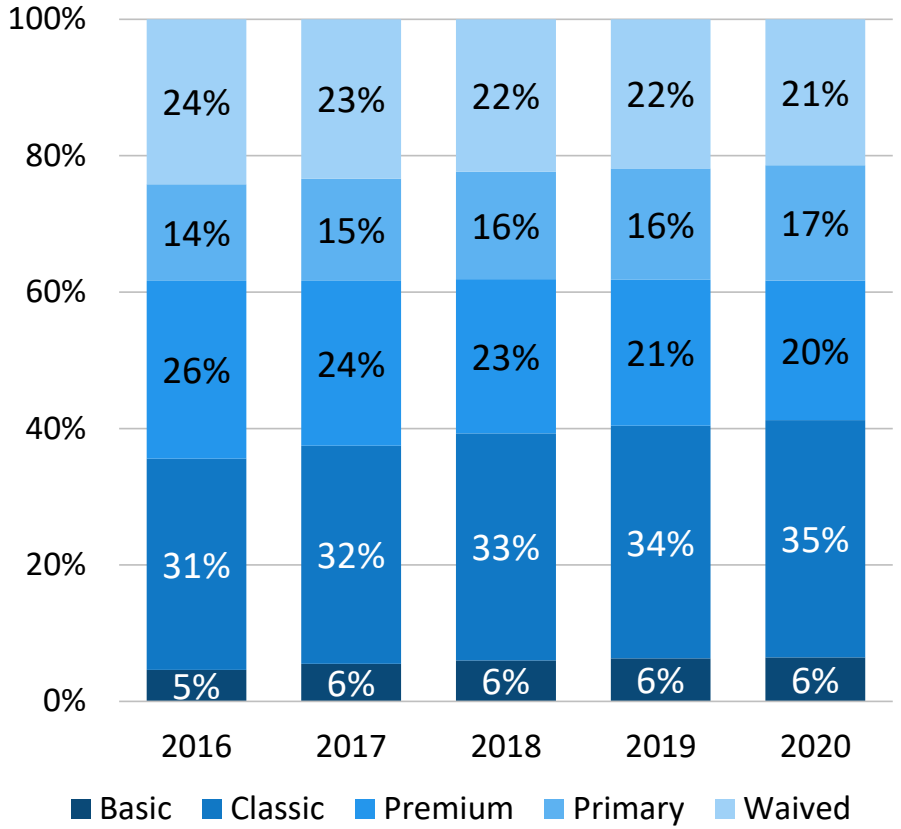
PSE - Average Membership by Plan





PSE - Average Enrollment (Subscribers) by Plan





Appendix

2021 Plan Design

Plan Design

	Premium		Classic		Basic	
	ASE	PSE	ASE	PSE	ASE	PSE
Individual / Family Deductible	$500 / $1,000	$750 / $1,500	$2,500 / $5,000	$1,750 / $2,850	$6,450 / $12,900	$4,000 / $8,000
Individual / Family MOOP[1]	$3,000 / $6,000	$3,250 / $6,500	$6,450 / $12,900	$6,450 / $9,675	$6,450 / $12,900	$6,450 / $12,900
Primary Care Physician / Specialist	$25 / $50	$25 / $50	20% after ded.	20% after ded.	0% after ded.	20% after ded.
ER	$250	$250	20% after ded.	20% after ded.	0% after ded.	20% after ded.
Inpatient	20% after ded.	20% after ded.	20% after ded.	20% after ded.	0% after ded.	20% after ded.
Outpatient	20% after ded.	20% after ded.	20% after ded.	20% after ded.	0% after ded.	20% after ded.
Generic Drug	$15	$15	20% after ded.	20% after ded.	0% after ded.	20% after ded.
Preferred Brand Drug	$40	$40	20% after ded.	20% after ded.	0% after ded.	20% after ded.
Non-Preferred Brand Drug	$80	$80	20% after ded.	20% after ded.	0% after ded.	20% after ded.
Specialty Drug	$100	$100	20% after ded.	20% after ded.	0% after ded.	20% after ded.
Actuarial Value (AV)	85.3%	84.3%	75.5%	74.4%	70.0%	68.2%
Proj. 2022 Enrollment[2]	22,091	17,188	2,893	29,907	1,851	5,655

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[1] Separate out-of-pocket maximum for pharmacy on Premium plan
[2] Represents Active and Pre-65 Retiree projected 2022 enrollment

Appendix

2021 Rates and Contributions

ASE – 2021 Active with Wellness Rates

Tier	Premium	State Contribution	Employee Contribution
Premium			
Employee	$552.28	$408.30	$143.99
Employee & Spouse	$1,243.01	$787.53	$455.48
Employee & Child(ren)	$927.68	$664.16	$263.52
Family	$1,618.38	$1,043.37	$575.01
Classic			
Employee	$480.14	$402.34	$77.79
Employee & Spouse	$1,070.98	$770.00	$300.98
Employee & Child(ren)	$801.25	$651.95	$149.30
Family	$1,392.07	$1,019.59	$372.49
Basic			
Employee	$423.77	$423.77	$0.00
Employee & Spouse	$936.82	$761.37	$175.44
Employee & Child(ren)	$702.61	$645.63	$56.98
Family	$1,215.66	$1,008.23	$207.43

ASE – 2021 Active without Wellness Rates

Tier	Premium	State Contribution	Employee Contribution
Premium			
Employee	$552.28	$358.30	$193.99
Employee & Spouse	$1,243.01	$737.53	$505.48
Employee & Child(ren)	$927.68	$614.16	$313.52
Family	$1,618.38	$993.37	$625.01
Classic			
Employee	$480.14	$352.34	$127.79
Employee & Spouse	$1,070.98	$720.00	$350.98
Employee & Child(ren)	$801.25	$601.95	$199.30
Family	$1,392.07	$969.59	$422.49
Basic			
Employee	$423.77	$373.77	$50.00
Employee & Spouse	$936.82	$711.37	$225.44
Employee & Child(ren)	$702.61	$595.63	$106.98
Family	$1,215.65	$958.23	$257.43

ASE – 2021 Pre-65 Retiree Rates

Tier	Premium	State Contribution	Retiree Contribution
Premium			
Retiree	$552.28	$258.58	$293.71
Retiree & NME Spouse	$1,243.01	$491.23	$751.78
Retiree & Child(ren)	$927.68	$384.93	$542.75
Retiree & NME Spouse & Child(ren)	$1,618.38	$617.59	$1,000.80
Retiree & ME Spouse	$1,041.48	$473.94	$567.55
Retiree & ME Spouse & Child(ren)	$1,416.88	$600.30	$816.59
Classic			
Retiree	$480.13	$252.62	$227.51
Retiree & Spouse	$1,070.98	$473.72	$597.26
Retiree & Child(ren)	$801.25	$372.72	$428.53
Family	$1,392.07	$593.80	$798.27
Basic			
Retiree	$423.77	$249.05	$174.72
Retiree & Spouse	$936.82	$465.07	$471.74
Retiree & Child(ren)	$702.61	$366.42	$336.19
Family	$1,215.65	$582.44	$633.21

ASE – 2021 Post-65 Retiree Rates

Tier	Premium	State Contribution	Retiree Contribution
Primary			
Retiree	$489.20	$305.28	$183.92
Retiree & NME Spouse	$1,191.83	$549.84	$641.99
Retiree & Child(ren)	$871.07	$438.11	$432.96
Retiree & NME Spouse & Child(ren)	$1,573.70	$682.69	$891.01
Retiree & ME Spouse	$978.39	$537.77	$440.62
Retiree & ME Spouse & Child(ren)	$1,360.26	$670.60	$689.66

PSE – 2021 Active with Wellness Rates

Tier	Premium	State Contribution	School Contribution	Employee Contribution
Premium				
Employee	$632.92	$259.80	$164.66	$208.46
Employee & Spouse	$1,533.81	$512.95	$164.66	$856.20
Employee & Child(ren)	$1,121.77	$461.57	$164.66	$495.54
Family	$1,810.56	$787.46	$164.66	$858.44
Classic				
Employee	$374.00	$138.32	$164.66	$71.02
Employee & Spouse	$849.95	$305.67	$164.66	$379.62
Employee & Child(ren)	$625.80	$277.72	$164.66	$183.42
Family	$1,091.70	$543.72	$164.66	$383.32
Basic				
Employee	$311.44	$110.52	$164.66	$36.26
Employee & Spouse	$690.19	$227.75	$164.66	$297.78
Employee & Child(ren)	$517.77	$206.25	$164.66	$146.86
Family	$853.38	$388.10	$164.66	$300.62

PSE – 2021 Active without Wellness Rates

Tier	Premium	State Contribution	School Contribution	Employee Contribution
Premium				
Employee	$632.92	$209.80	$164.66	$258.46
Employee & Spouse	$1,533.81	$462.95	$164.66	$906.20
Employee & Child(ren)	$1,121.77	$411.57	$164.66	$545.54
Family	$1,810.56	$737.46	$164.66	$908.44
Classic				
Employee	$374.00	$88.32	$164.66	$121.02
Employee & Spouse	$849.95	$255.67	$164.66	$429.62
Employee & Child(ren)	$625.80	$227.72	$164.66	$233.42
Family	$1,091.70	$493.72	$164.66	$433.32
Basic				
Employee	$311.44	$60.52	$164.66	$86.26
Employee & Spouse	$690.19	$177.75	$164.66	$347.78
Employee & Child(ren)	$517.77	$156.25	$164.66	$196.86
Family	$853.38	$338.10	$164.66	$350.62

PSE – 2021 Pre-65 Retiree Rates

Tier	Premium	State / School Contribution	Retiree Contribution
Premium			
Retiree	$641.14	$0.00	$641.14
Retiree & NME Spouse	$1,457.18	$0.00	$1,457.18
Retiree & Child(ren)	$1,192.60	$0.00	$1,192.60
Retiree & NME Spouse & Child(ren)	$2,008.64	$0.00	$2,008.64
Retiree & ME Spouse	$795.12	$0.00	$795.12
Retiree & ME Spouse & Child(ren)	$1,346.58	$0.00	$1,346.58
Classic			
Retiree	$273.30	$0.00	$273.30
Retiree & Spouse	$565.78	$0.00	$565.78
Retiree & Child(ren)	$469.82	$0.00	$469.82
Family	$746.20	$0.00	$746.20
Basic			
Retiree	$148.50	$0.00	$148.50
Retiree & Spouse	$269.72	$0.00	$269.72
Retiree & Child(ren)	$238.52	$0.00	$238.52
Family	$335.72	$0.00	$335.72

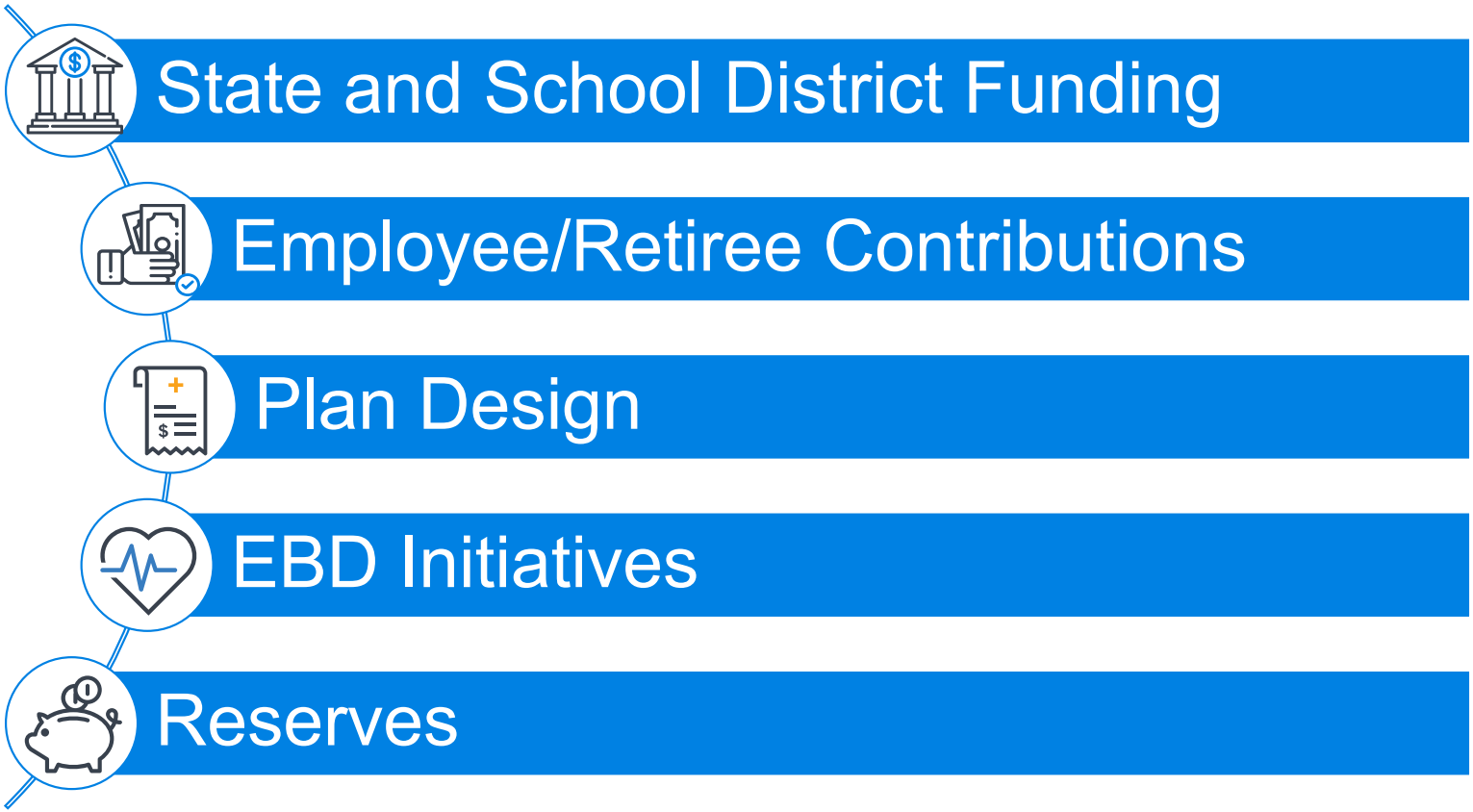
PSE – 2021 Post-65 Retiree Rates

Tier	Premium	State Contribution	School Contribution	Employee Contribution
Primary				
Retiree	$217.76	$116.98	$0.00	$100.78
Retiree & NME Spouse	$841.08	$57.16	$0.00	$783.92
Retiree & Child(ren)	$812.30	$55.20	$0.00	$757.10
Retiree & NME Spouse & Child(ren)	$1,632.41	$110.93	$0.00	$1,521.48
Retiree & ME Spouse	$397.68	$134.64	$0.00	$263.04
Retiree & ME Spouse & Child(ren)	$953.37	$64.79	$0.00	$888.58

Appendix

Miscellaneous

Budget Levers



Guiding Principles - *ILLUSTRATION*