AGENDA

State and Public School Life and Health Insurance Board

March 23rd, 2021

1:00 p.m.

EBD Board Room – Rockefeller Building, Suite 500

I.	*Call to Order*	*Renee Mallory, Chair*
II.	*Approval of February 23 and March 8 Minutes*	*Renee Mallory, Chair*
III.	*DUEC Report*	*Dr. Hank Simmons, DUEC Chair*
IV.	*Trend Experience*	*Paul Sakhrani & Courtney White, Milliman*
V.	*Board Discussion on 2022 Funding*	
VI.	*Secretary's Report*	*Amy Fecher, TSS Secretary*
VII.	*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 MEETING MINUTES

211th meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on March 23, 2021, at 1:00 PM

Date | *time* 3/23/2021 1:00 PM | *meeting called to order by Renee Mallory, Chair*

Attendance

Members Present

Stephanie Lilly-Palmer

Greg Rogers

Secretary Cindy Gillespie – proxy – Keesa Smith

Dr. John Kirtley – Vice-Chair

Herb Scott

Dori Gutierrez

Secretary Amy Fecher

Cynthia Dunlap

Renee Mallory - Chair

Shalada Toles, Employee Benefits Division Deputy Director

Members Absent

Lisa Sherrill

Teleconference

Cindy Allen

Melissa Moore

Dr. Lanita White

Dr. Terry Fiddler

OTHERS PRESENT:

Rhoda Classen, Laura Thompson, Drake Rodriguez, Janella DeVille, Jake Bleed, EBD; Octavia DeYoung, Dwight Davis, Jessica Akins, Jim Bailey, Takisha Sanders, Health Advantage; Elizabeth Montgomery, ACHI; Courtney White, Paul Sakhrani, Scott Cohen, Julia Weber, Milliman; Alex Johnston, Mitch Rouse, TSS; Sylvia Landers, Colonial Life; Judith Paslaski, MedImpact; John Bridges, ASEA; Frances Bauman, Novo Nordisk; Stephen Carroll, AllCare Specialty; Charles Hubbard, ASP; Erika Gee, WLJ; Aaron Shaw, BI; Donna Morey, ARTA; Mary Grace Smith, Jess Wilson, Pamela Mayo, Robert McQuade, Zona Maness, Jeff Altemus, Kent Williams, ASE Retiree; John Robbins, DataPath; Dianne Strickland; Lauren Brakebill

Approval of Minutes by Renee Mallory, Chair

MOTION by Fecher:

Motion to accept the February 23 and March 8, 2021 minutes.

Gutierrez seconded; all were in favor.

Minutes Approved.

DUEC Report by Dr. Hank Simmons, DUEC Chair

The following report pertains to the DUEC meeting at 1:00 p.m. on Monday, March 8th, 2020 with Dr. Hank Simmons presiding.

I. Old Business

A. Second Review of Drugs: *Dr. Jill Johnson, UAMS*

Brand	Generic	Indication	Recommendation	Reasoning	Member Disruption
(1) ENHERTU	FAM-TRASTUZUMAB DERUXTECAN-NXKI	Gastric Cancer	Cover w /PA	New clinical data showing improvement in overall survival	Previously Excluded
(2) SINUVA	MOMETASONE FUROATE	Nasal Polyps	Cover (Medical)	New Clinical Data showing reduction in repeat surgery	Previously Excluded
(3) TIBSOVO	IVOSIDENIB	Acute Myeloid Leukemia	Cover w/ PA	New clinical data showing improvement in overall survival (relapsed/refractory)	Previously Excluded

The DUEC voted to adopt the recommendations as presented.

II. New Business

A. New Drugs*: by Dr. Jill Johnson, UAMS*

Brand	Generic	Recommendation	Additional Info
Non-Specialty Drugs			
(1) ALKINDI SPRINKLE	HYDROCORTISONE	Exclude, Code 13	Multiple generic alternatives available
(2) XARACOLL	BUPIVACAINE HCL	N/A Medical	Surgical Implant
(3) VAXELIS	DIP, PERT(A)TET/HEPB/POL/HIB/PF	N/A Medical	Expected to be given only

			through Medical benefit
(4) WINLEVI	CLASCOTERONE	Exclude, Code 13	No clinical benefit over plan alternatives
(5) KLISYRI	TIRBANIBULIN	Exclude, Code 13	No clinical benefit over plan alternatives
(6) ASTRAZENECA COVID19 VAC(UNAPP)	COVID-19 VAC, AZD1222(ASTRA)/PF	Cover (pending FDA approval)	Administration fee only ($40)
(7) JANSSEN COVID19 VACC	COVID-19 VAC, AD26(JANSSEN)/PF	Cover	Administration fee only ($40)
(8) GEMTESA	VIBEGRON	Cover (reference priced category)	
Specialty Drugs			
(1) DOJOLVI	TRIHEPTANOIN	Exclude, Code 13	No clinical benefit over OTC alternatives
(2) CYSTADROPS	CYSTEAMINE HCL	Cover w/PA	
(3) ORENITRAM ER	TREPROSTINIL DIOLAMINE	Exclude, Code 1 & 13	No clinical benefit over plan alternatives
(4) ZAVESCA	MIGLUSTAT	Cover w/PA	
(5) NYVEPRIA	PEGFILGRASTIM-APGF	Cover (subject to rebate contracts)	Current rebated category
(6) OXLUMO	LUMASIRAN SODIUM	Exclude, Code 1	
(7) DANYELZA	NAXITAMAB-GQGK	Exclude, Code 1 and 13	No clinical benefit over plan alternatives
(8) ORLADEYO	BEROTRALSTAT HYDROCHLORIDE	Exclude, Code 13	No clinical benefit over plan alternatives
(9) RIABNI	RITUXIMAB-ARRX	Cover (subject to rebate contracts)	Current rebated category
(10) IMCIVREE	SETMELANOTIDE ACETATE	Exclude, Code 1	
(11) ORGOVYX	RELUGOLIX	Exclude, Code 13	No clinical benefit over plan alternatives
(12) ZOKINVY	LONAFARNIB	Exclude, Code 12	Unable to confirm

			benefit of drug based on clinical trial data

The DUEC voted to adopt the recommendations as presented.

Fecher: For the increase on the administration fee, is it just for those two, or will it be across for all of the vaccines?

Dr. Simmons: I'm going to guess that going forward, it would surprise me greatly if CMS didn't make the same recommendation for all of them. We probably, with an absence from information, would probably recommend that you all accept that.

Fecher: Is that part of the fee covered by the federal government, or will that be picked up on the health plan?

Dr. Simmons: I will defer to Dr. Davis for that one.

Dr. Davis: I'm Dwight Davis, director of the evidence-based prescription drug program, and the answer to the question for CMS, the guidance that we got or received last week was $40 per injection, whether it's two series or one. So, it's $40 per shot. That's the piece that's picked up by the health plan. So that's a significant increase at a time when we're looking for every cost-saving avenue. The timing on this is not good.

Dr. Kirtley: When you look at some of the discussion behind it is since it is a paid-for vaccine. When it is paying and the struggle in trying to get that much of it out at that time, they increase it across the board. We were thinking they were just going to do the Johnson and Johnson, but they did it across the board on all of them because of the delivery problems they are having.

MOTION by Dr. Kirtley:
I make a motion to approve the DUEC recommendations as presented.
Lilly-Palmer seconded. All were in favor.
Motion Approved.

Trend Experience by Courtney White & Paul Sakhrani, Milliman

White and Sakhrani provided an update on the Plan experience for ASE and PSE and presented the 2021 roadmap.

ASE

- 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 is $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
    - Allocated of Prior Years' Surplus for 2022 is $6.1M
    - Estimated deficit: -$26.9M (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2021: -$7.9M
    - Reflected baseline scenario
    - No plan design or contribution changes

PSE

- 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
    - Allocated of Prior Years' Surplus for 2021 is $15.5M
    - 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
    - Allocated of Prior Years' Surplus for 2022 is $7.1M
    - Estimated deficit: -$65.2M (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2021: -$60.5M
    - Reflected baseline scenario
    - No plan design or contribution changes

Discussion:

ASE

Dr. Kirtley: What you're saying is that in 2022, we have enough predicted money to pay all the bills with $8.1 million at the end of the year. If we want to have a 10% reserve, we need to raise $27 million on ASE, correct?

White: Correct, but we are eating into the catastrophic reserve in order to do that by about half of it. That $8 million would all be catastrophic reserve if you decided to use that.

Dr. Kirtley: Yes, just to rebuild the catastrophic reserve without any prior year surplus allocation even included, we would need $27 million.

White: Correct.

Scott: Do you have figures showing multiple percentages, for instance, with the contribution increases or increases to the deductible. Do you have some variable figures? So, the 5% and the 250%?

White: Yes, after we get through the first two options, we show some of these in more detail where you can actually see the actual employee contributions by the different benefit plans and for a single versus family. We also have the benefit design on a little later.

Dunlap: For option one, you talked about discontinuing Medicare-eligible retiree spouse coverage. I don't know that I heard or saw in any of the presentations where that impact would be seen. Was it figured into any of those that you showed on the slides after that?

White: It is not; it is separate. The 2677 retirees that have spouses here and the 33 that have a Medicare-eligible spouse here would actually drop down, and they would get savings on their contributions because they now become a Medicare retiree only. They would no longer have to pay for their spouses, so their contribution would go from $440 to $183. For two Medicare eligible that has children, these 33 people would go down a category.

Dunlap: Where is the cost savings coming from?

White: There wouldn't be any claims for them; they would be gone. Those Medicare eligibles wouldn't have any claims because they wouldn't be covered anymore. Also, that would be offset slightly by the lower contributions for the people who are now not a couple, just the single retiree.

Mallory: That's where we save the $5.4 million.

Dunlap: So, it's not just drug coverage. You're taking away total medical coverage for spouses.

White: For this option, yes.

Sakhrani: There are about 2,700 spouses.

Scott: There lies the problem. We want to keep harping on this.

White: These are just demonstrated for you. We understand the sensitivity.

Fecher: These are just scenarios. We're not making a recommendation at this time. Milliman is just bringing us numbers so we can make a recommendation.

Scott: I realize that, but sometimes when you start seeing numbers, you get in your head, and you start making some prejudgment. I don't, you know, want to sit there and start this can of worms.

Lilly-Palmer: Courtney, one of the things that you had mentioned was the discontinuing of the Medicare-eligible retiree spouse coverage. That means the spouse stays on the coverage at the time of retirement if they were on the coverage at the time of retirement until they become Medicare primary. Is that correct? I'm asking for a reason because we already have it for the active employees. I think I had brought this up at the last meeting that the spouse cannot be on their coverage or their dependents if they have the option for other coverage. So, they do sign the spousal affidavit. The only way a spouse is even on the coverage for the state side is if they do not have group coverage somewhere else or do not have the option for another group plan. So, with that being

said, the retiree at the time they retire also has to have that spouse active on the plan while they're active, not put them on the plan at retirement. So that maybe that was saying a little too much, but to try to give a little history to what we're looking at. We already are in a position where the spouses are not on the plan unless they don't have the other option. So, to my original question, is that saying they can be covered through non-Medicare age, and once they hit Medicare age, then they come off the plan?

White: That's correct. Shalada can correct me if I'm wrong; on the active spouses, does that have to be a group health plan, or can that be individual coverage too?

Toles: It has to be a group health coverage.

Fecher: I'll just mention in case anyone missed it. When Courtney was giving it, the reason that scenario was on there is because we are meeting with legislators regularly, and they've asked for that information. So that's the reason we pulled it. Also, Stephanie, to your point, they're having to sign that affidavit once. But if that spouse gets a job three years later and they don't come back and tell us that, they're on it until they do.

Dr. Kirtley: That's exactly why we keep hearing that we have to continue doing audits of that specific issue.

Dunlap: So, what is different about this suggestion in this scenario than what's currently being done with Medicare-eligible retiree spouse coverage?

Lilly-Palmer: Well, at this time, the way I understand it, and maybe Shalada can help me out, but the way that it is done now if an active member is on the coverage and their spouse is on the coverage at the time of retirement, if I'm not mistaken, that's legislation and how it's written, they can carry that spouse over to retirement with him/her on the state plan. Right now, when the retiree becomes Medicare primary, or their spouse has Medicare primary, they're still carried over onto that plan. The scenario that we're putting out there is at the time the spouse becomes Medicare primary; they come off that retirement plan. That's the difference. As Secretary Fecher said, these are just scenarios. I realize that one of the things that employees do work towards are these benefits. They're working for these benefits. With this state contribution, these employees, dependent on whether they're contributory and non-contributory, they've contributed all these years. But I also would like to say, and I understand where we're at, we are looking at deficits that we have not seen in history. And so, in trying to find the best options not just for active employees but for the retirees, we have to look at all the options that are out there.

Dr. Kirtley: I was going to add one thing, Stephanie. The other thing that this shows us is that the specific risk pool of people (2,600) being on the plan are costing the plan $5.4 million a year more than what they are bringing in. So we're actually paying out that from the risk-based scenario, which historically, if you have a $10 million risk pool, you've got to bring $10 million in. Well, this one is taking out from the plan $5.4 million more than it's bringing in, or else it would have been a breakeven issue and not even worth looking at. So, we have a higher risk pool than the money that's being brought in.

Lilly-Palmer: I know we are trying to meet proactively to come up with scenarios. Herb, you may be able to speak better to this; the retirees may be willing to pay a little more cost of contributions to keep their spouses on the plan. I think that's a viable option, but we need to see the numbers because, again, we're at an unprecedented deficit that we have not had in historical years, at least not to my knowledge.

Scott: That's a good point, Stephanie. The calls that I've been receiving lately that have been exactly what has been said. You know, if we need to pay more, we're willing to pay more costs. Then I always get the questions, well what is more? So, that's why I keep asking the question to Courtney and them. What would it cost to be fairly close to help close that gap?

Dr. Kirtley: It would be $170 apiece a month. Courtney can verify that, but we've made the point before that some people would prefer a choice of either off the plan or what would it cost me to stay. At 2,677 people for $5.4 million in 12 months, it's $168 per person per month.

Scott: That's good to know. That's what I like to take back and just say, here it is. Now we just need to make a decision. But what I'm getting and what I'm hearing from people who talk with me, I'm willing to pay a little more for me to keep my coverage. But I can't just throw a number in there. I need to say it's going to cost you $170 more or $200 more.

Dr. Kirtley: That's looking back as what the estimate is now. If you add adverse selection to that, it's going to go up. You have to be prepared for the fact that if we did $170 and gave an option for adverse selection, it could be $250 the following year based on what the experience is, but in the al a carte menu style which has been discussed here before, that is what it would be on that.

White: A 10% increase is $44. So, $180 is a lot more than 10%

Lilly-Palmer: I'm not saying take the plans away and working with state employees on a daily basis; the plan design is important to them. What is the possibility and maybe all sides, this could help all parties. The basic plan, and I understand it has a $0 premium. That basic plan is just that it's a basic plan, it doesn't cover out-of-state coverage, it does not have any out-of-network benefits. There's also worldwide coverage on the premium and the classic that some people don't really know that it's there. What is the possibility if we were to look at those numbers and take out that basic plan because the classic and the basic are both high deductible plans? So, just go into a premium and classic? Does that give us an option to look at the percentage increase from 7% to 10%? for the employees on premium and classic? With that, does that have any cost savings that we might be able to push towards the retirees?

White: What's the 7% and 10%?

Lilly-Palmer: I was just throwing a scenario out there. If we took the basic away and we increase the employee premiums from 7% to 10% as active employees. Does that give us any

wiggle room to look at it across the board and allow us any room to look at what the retiree plans are doing?

White: When you say take the base plan away? Do you mean not have a zero contribution?

Lilly-Palmer: Correct. Because those are still budgeted positions for us. I'm just throwing scenarios.

Dr. Kirtley: You mean to have no zero copay but still have a high deductible plan.

Lilly-Palmer: The classic and the basic are both high deductible plans. The classic where it's 80/20, basic is you just pay that for individual only that $6450, and then it's going to pay out of pocket 100%. But the benefits to the classic high deductible, just from my experience, the employees prefer the plan design as opposed to just having that zero copay. So, I'm just trying to figure out cost savings for everybody.

Dr. Kirtley: So, basically cut out one high deductible plan where we're not managing three plans, but only managing two.

Dr. Fiddler: As Herb mentioned, we have to realize that if it is $160 or $170, whatever that figure will be per month for this scenario, as a starting point to have that discussion. If that is not palatable, I can't imagine what palatable would be for the 2023 year. If it goes from $2000 to $3000, as Courtney just suggested, other than the $170, if you had to go up to the$ 200 plus. So that has to be a conversation that once that can of worms is open, Herb, they have to understand that this is not the end-all to meet all, but that this could just be the start of it going up even more.

Scott: I concur. Of course, that's going to have to be decisions that people are going to have to make, Dr. Fiddler. Are they willing to pay that difference? What I'm getting is, I am willing to pay more for the spousal coverage than to be dropped. So, to your point, I think that's the conversation that I need to have with the people that I represent and say, you know, here's the starting figure. Now, as shown earlier, we're beginning to look at income versus expenditure scenarios for the future. And at some point, it is definitely going up.

Dr. Fiddler: When a person retires, do most people keep the insurance on the ASE plan and the same for PSE? Do they keep their insurance because they can't get anywhere else?

Toles: They definitely keep the insurance because it's good coverage.

Dr. Fiddler: So, if that's the best coverage they could get, then for a retiree's spouse, there wouldn't be any sense in them getting off of something if there's not any better.

Toles: There could be better coverage out there, but not for the premiums.

White: There are really two considerations. So, for a pre-65 retiree, their only choice is really to go to ACA, Affordable Care Act, market, and get an individual plan. A post 65 retiree has the Medicare Advantage market to go to or Medicare supplement.

Lilly-Palmer: I just want to say too, it's also written what you're talking about where they have the option to go to the marketplace, or they can get other prescription or Medicare. Once a retiree leaves the plan, they cannot come back on the plan. So I want to point that out for the actual retirees once they leave the plan, they can't come back. So if they have gone to those other plans, they cannot come back on the plan, and that was per legislation.

Fecher: Except for the 65 plus that went to the pharmacy if they want off. We gave them the option to come back this year, but only for pharmacy.

Dunlap: When they become 65, and they are Medicare, they have to go to Medicare. Does this now become supplemental?

Lilly-Palmer: This plan becomes supplemental when they go to Medicare.

Dunlap: Do the premiums change, or are they the same premiums?

Lilly-Palmer: The premiums do change when they go Medicare primary. For example, the state retiree monthly premiums on the premium plan retiree-only are $293 71. Within the same Medicare and pharmacy, the retiree-only Medicare eligible is $183 92. That's just the retiree. If they elected to do without the prescription and they have medical-only it is $158 92. One of the things that I hear and I think Herb does, the prescription drug coverage is extremely important to them. So this discussion that we're having, we are taking it seriously for those reasons, because we do hear them, and we're trying to make the best decisions possible with what we're working with.

White: Just to be clear, Medicare pays primary, but only for medical. The pharmacy pays primary for Medicare retirees; there is no coordination. But that's why the drug costs are actually more than the medical costs for the Medicare retirees.

Dr. Kirtley: I think the same per member per month breakdown on the pharmacy costs translated to something like $225 a month because it is actually a higher cost than the medical.

White: Correct, I think the medicals $200ish and the pharmacy are $225 to $250, somewhere in that range.

Scott: Secretary Gillespie and Stephanie had said in the last meeting, the communication piece and the educational piece are so critical. You just can't drop and say go to Part D. As I mentioned last year, those plans are complicated. You really need to have some educational piece to help people understand what those choices are. I'm hoping at some point; the EBD will take that step and do an educational, informational piece on those various plans to help people understand. It may not be as bad as we think if people understand what we're getting into. I think that's one of the missing links that we need to do. I want to point out, if the retirement board can go across this state and have informational seminars and meetings on retirement benefits, we as a board and EBD could do the same thing. We could start educating some of our people as to what it is we're running into. I think people know, especially for 2022, we got this deficit. But what

I'm hearing is don't blame it all on the retirees. It's not all retirees' fault because we run a deficit. I think Secretary Fecher said it very well in one of our meetings, all those good years, we probably should have had some increases, and we did not. Now here we are. It certainly shouldn't be looked at as a retiree problem, and that's what I'm getting. That's also what was pointed out last year when you ran the numbers. It wasn't necessarily the retirees that were creating the problem.

Fecher: Well, I'll make a couple of comments; if you don't mind Herb on your comments, I agree that we have to do a better job educating people whichever way we go. I do not think that the EBD Board can do consults on Medicare and give people all of their options. I don't think that is our role. But when we thought we were going to do away with the pharmacy coverage for the 65 Plus, we did send out information. For every county, there are people that can discuss that with them, and as you said, a pharmacist or something like that. I think we do need to educate them on what some of the options are. But again, we are under a time crunch. We're either going to have to do education very quickly, and to go on a roadshow around the state is going to be difficult. We could definitely do some webinars and sit there and say these are the things we're looking at and get input. But, I really wanted the board to make a decision in April on what we were going to do for 2022. So, if that's what the board wishes to do, it's going to have to be done quickly. So, then we can get the information out and say this is what's changing with your plans and give them an option because some people may rather go to a Medicare Part D coverage or something. They may, I'm not saying they have to, but if they put it to the pencil to the paper and the numbers come out better because I've had some state employees that have retired that have come to me and said Medicare Part D is so much cheaper than my coverage was through the state. And I've got better coverage. That's their opinion. I'm just saying, for some people, they really should sit down and value which is better for them.

Scott: Secretary Fecher, you are exactly right. I think at our last meeting, Shalada had indicated, I believe, it was 218 at the time had already dropped and gone to Part D.

Toles: That's correct.

Dr. Fiddler: Herb, you made that comment about the pharmacist. Well, knowing that, I went to my pharmacist knowing I wasn't even in that situation, and I asked that question. That person wore me out about information. They knew everything about what was going on and how it would, and not suggest, but they gave me all the things that I would want to do for me and my wife to make a choice. So, I'm not going to be critical of that pharmacist nor EBD. I'm with Secretary Fecher, that's not our job. But apparently, this particular pharmacist knew the information and gave guidance for it.

Herb: Sounds like I need to change pharmacists.

Dr. Kirtley: The other thing is it's a timing issue of when they can see what the benefits are going to look like the next year, whether it's you doing it individually, the pharmacist, or anyone else promoting one of the plans. It's weird, because to Secretary Fecher's point, we've

got to make a decision very quickly. Much of the information on things like Part D will not be effective until late fall. So, it's tough, but we're going have to make our decision independent of their timeline on that.

Dunlap: Stephanie made a suggestion about looking at some savings to the retirees by making some changes to the basic, the premium, and the classic plan. Is that going to be done and brought back so that it could be put into the pot as an option as well, for consideration as a way to help share the cost across the board, as opposed to some of the savings for the retirees by doing those changes?

White: We wouldn't have to wait until next month. We could do it later this week or early next week.

Fecher: I think we could do that and pull some information and send it out to the board and the board should come prepared with that information at hand as one of the options, so we can start from a level playing field in April and say these are what we think we should do.

Mallory: Well, and I think Herb can get with the retirees during that time, and kind of, you know, feel out from that perspective.

Scott: What was your plan option?

Lilly-Palmer: I am not sure, which is why I would want to see how it would work. My suggestion was to look at a scenario to potentially eliminate the basic plan as it stands now. The classic and the basic plans are both high deductible plans; the classic just covers a little more. The basic plan offers a zero premium for individuals only. So, my suggestion, and it might not work depending on how many people are on the plan, but to look at savings across the board, and looking at maybe 7% to 10% increase for the employees and seeing how that's going to affect the numbers across the board and if that will help eliminate some of the retiree Medicare primary and after. I don't know that that's even a solution. We may not have enough people on it, and it may not have any cost savings, but we can look at it.

White: A lot of this hinges on the state on how much you need to do versus how much they're going to do on the funding side. I don't understand how the state funding all works exactly. But if they increase that cap, and we don't have to go all the way to the top, that's better, because that leaves additional money for future years. So hopefully, there's some kind of medium ground there.

Fecher: There was some legislation filed this week to increase the statutory maximum that we could go up to $550. Not saying that we would automatically go up to that, but it gives us a little bit more wiggle room in there because right now, we are at the top of it at $450.

Dr. Fiddler: That would give us if the state funding does allow that kind of increase, that will give the EBD board the understanding that we can use up to that amount are any amounts in between?

Fecher: It would allow us to change it. Then we would have to go to the Department of Finance and Administration and see if it's available in the budget. So it's not saying it's there and if you want to use it, use it. It's us recommending to them that we go up, and then the state says yes, we can afford that. And we don't have that yes, yet.

Dr. Kirtley: It's a nibble at the apple approach, not just the whole thing at once. It's generally expected that that's to last for a number of years, and it's a financial issue in DFA for every step that that is.

Dr. Fiddler: I understand that. I'm getting down to, if that funding is available, with an additional instead of from 450 to 500, that you went from 450 to 550. I'm trying to zero out this balance; here is what I'm trying to do. Instead of being $3.1 million in the red, it would be an increase enough to zero out that balance. That's what I'm looking for.

Fecher: I would agree with you on that, and it can be done in some ways. It could be done with state funding or those other options.

Dr. Fiddler: Okay, that's just what I want to know. Because if we're going to have a drop-dead date in April to do this. I would like to know from the DFA if the money is available there just cause the legislature said so it doesn't make it so. But if it is available, rather than having those $10 increments or whatever. I wouldn't even mean $550; I don't care what it would be, but if it's something we could zero out and get our head above water to start for this 2023. That's what I'm looking at.

Fecher: Good news is our incoming director, the budget director currently, so we should be able to get some response on that.

Rogers: Don't forget that it's not as easy as increasing that per budgeted position amount because there's also other legislation out there that says that we got to cut any positions older than two years. So, once that dust settles, once you see what it is, we may be having to go to DFA and ask and just to increase from the $450 to the $460s or $465 just to hold our water where we are. So, it's an ongoing thing that we're going to have to keep looking at. Then as far as DFA saying yes, you can go to that $500; I've never once had a discussion with the DFA when they said they had additional money. So, that's something that we need to be looking at. It's a complicated issue when you're going in there.

Mallory: I think we also need to consider; we keep kicking this can down the road and not doing the hard part that we probably need to do, which is raising rates and actually looking at our plan. So, I think we need to really consider what we need to do as a Board. You know, with the reasons we're on the Board.

Fecher: We can't kick the can any farther, or none of us will have insurance.

Gutierrez: I'm not very familiar with how Medicare works. So, if they reach Medicare age, what exactly can they get from Medicare?

Toles: Once they reach age 65. they qualify for part A and Part B. Part A is inpatient hospital. Part B is professional doctors' offices, screening tests. Part D, which is drug prescription.

Gutierrez: So they get all that.

Toles: Yes, now they have to pay for it, but they do qualify for it at that point.

Gutierrez: So, someone mentioned $170. That seems to be more than what the actual premium is for. I was thinking that it was around $150, the premium that they pay. To me, going up to $170 seems a whole lot more than what they would actually have to pay if they didn't find another supplemental insurance, or I might not be understanding that right.

White: The way that Medicare works, on average, the member, when they go to the doctor, they pay roughly 20%. So, when you have a $1,000 doctor bill, you pay $200, Medicare pays $800. The way the plan works today is the plan picks up most of that $200. So they don't have anything. So, one of their choices is to go get a Medicare supplement. Medicare Supplement is basically you're trading premiums for those cost-sharing dollars, that 20% coinsurance. So I don't know how much a Medicare supplement plan in Arkansas is, say $150. They could pay $150 a month, and they wouldn't have to pay any cost-sharing when they go to their Medicare physician or hospital. They don't get Part D in that, so they'd have to buy a prescription drug plan or a PDP that, you know, those premiums range from $20 to probably $100. So, that's their option on doing a Medicare supplement and a PDP. The other choice is they can get a Medicare Advantage plan, which the medical side looks a lot like the premium plan, you know, you pay a hospital inpatient copay, you pay a PCP and a specialist copay. Sometimes there are some bells and whistles benefits. You might get vision hardware, you might get hearing aids, and then they usually attach a part D benefit to that that is integrated with the medical plan as part of the premium. Those you can get for no premium, the whole thing combined if you shop right. There's a lot of those available, and you can obviously buy up to better options depending on who the carrier is and what kind of benefits you want. The challenge with Part D is there's the doughnut hole. So, once you get to a certain level around, just over $4,000, you're on the hook for 25% of the cost in most cases.

PSE

Board Room experienced technical difficulties.

Allen: We never get to what we are doing about public-school education, and us public school people are a little worried.

Dr. Fiddler: Can I ask a question? It's probably inappropriate, which is typical of me, but since I've got many of the teachers of the line. Have you all ever considered having perhaps that

you would receive a stipend from the state, a fixed amount stipend so that you would know how much that you have? Because you're never going to make the income that comes from ASE in order to cover these particular functions. Has that ever been considered from the Teachers Association?

Allen: I am not sure. They are trying to get rid of the Teachers Association.

Meeting adjourned due to technical difficulties.

State and Public-School Life and Health Insurance Board
Drug Utilization and Evaluation Committee Report

The following report pertains to the DUEC meeting at 1:00 p.m. on Monday, March 8th, 2020 with Dr. Hank Simmons presiding.

I. Old Business

A. Second Review of Drugs: *Dr. Jill Johnson, UAMS*

Brand	Generic	Indication	Recommendation	Reasoning	Member Disruption
(1) ENHERTU	FAM-TRASTUZUMAB DERUXTECAN-NXKI	Gastric Cancer	Cover w /PA	New clinical data showing improvement in overall survival	Previously Excluded
(2) SINUVA	MOMETASONE FUROATE	Nasal Polyps	Cover (Medical)	New Clinical Data showing reduction in repeat surgery	Previously Excluded
(3) TIBSOVO	IVOSIDENIB	Acute Myeloid Leukemia	Cover w/ PA	New clinical data showing improvement in overall survival (relapsed/refractory)	Previously Excluded

The DUEC voted to adopt the recommendations as presented.

II. New Business

A. New Drugs*: by Dr. Jill Johnson, UAMS*

Brand	Generic	Recommendation	Additional Info
Non-Specialty Drugs			
(1) ALKINDI SPRINKLE	HYDROCORTISONE	Exclude, Code 13	Multiple generic alternatives

			available
(2) XARACOLL	BUPIVACAINE HCL	N/A Medical	Surgical Implant
(3) VAXELIS	DIP, PERT(A)TET/HEPB/POL/HIB/PF	N/A Medical	Expected to be given only through Medical benefit
(4) WINLEVI	CLASCOTERONE	Exclude, Code 13	No clinical benefit over plan alternatives
(5) KLISYRI	TIRBANIBULIN	Exclude, Code 13	No clinical benefit over plan alternatives
(6) ASTRAZENECA COVID19 VAC(UNAPP)	COVID-19 VAC, AZD1222(ASTRA)/PF	Cover (pending FDA approval)	Administration fee only ($40)
(7) JANSSEN COVID19 VACC	COVID-19 VAC, AD26(JANSSEN)/PF	Cover	Administration fee only ($40)
(8) GEMTESA	VIBEGRON	Cover (reference priced category)	
Specialty Drugs			
(1) DOJOLVI	TRIHEPTANOIN	Exclude, Code 13	No clinical benefit over OTC alternatives
(2) CYSTADROPS	CYSTEAMINE HCL	Cover w/PA	
(3) ORENITRAM ER	TREPROSTINIL DIOLAMINE	Exclude, Code 1 & 13	No clinical benefit over plan alternatives
(4) ZAVESCA	MIGLUSTAT	Cover w/PA	
(5) NYVEPRIA	PEGFILGRASTIM-APGF	Cover (subject to rebate contracts)	Current rebated category
(6) OXLUMO	LUMASIRAN SODIUM	Exclude, Code 1	
(7) DANYELZA	NAXITAMAB-GQGK	Exclude, Code 1 and 13	No clinical benefit over plan alternatives
(8) ORLADEYO	BEROTRALSTAT HYDROCHLORIDE	Exclude, Code 13	No clinical benefit over plan alternatives
(9) RIABNI	RITUXIMAB-ARRX	Cover (subject to rebate contracts)	Current rebated category
(10) IMCIVREE	SETMELANOTIDE ACETATE	Exclude, Code 1	
(11) ORGOVYX	RELUGOLIX	Exclude, Code 13	No clinical benefit over

			plan alternatives
(12) ZOKINVY	LONAFARNIB	Exclude, Code 12	Unable to confirm benefit of drug based on clinical trial data

The DUEC voted to adopt the recommendations as presented.

Meeting Adjourned.

Respectfully submitted,

Henry F. Simmons, Jr., MD
Chair, DUEC

***New Drug Code Key:**

1	Lacks meaningful clinical endpoint data; has shown efficacy for surrogate endpoints only.
2	Drug's best support is from single arm trial data
3	No information in recognized information sources (PubMed or Drug Facts & Comparisons or Lexicomp)
4	**Convenience Kit Policy** - As new drugs are released to the market through Medispan, those drugs described as "kits will not be considered for inclusion in the plan and will therefore be excluded products unless the product is available solely as a kit. Kits typically contain, in addition to a pre-packaged quantity of the featured drug(s), items that may be associated with the administration of the drug (rubber gloves, sponges, etc.) and/or additional convenience items (lotion, skin cleanser, etc.). In most cases, the cost of the "kit" is greater than the individual items purchased separately.
5	**Medical Food Policy** - Medical foods will be excluded from the plan unless two sources of peer-reviewed, published medical literature supports the use in reducing a medically necessary clinical endpoint. A medical food is defined below: A medical food, as defined in section 5(b)(3) of the Orphan Drug Act (21 U.S.C. 360ee(b)(3)), is "a food which is formulated to be consumed or administered eternally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." FDA considers the statutory definition of medical foods to narrowly constrain the types of products that fit within this category of food. Medical foods are distinguished from the broader category of foods for special dietary use and from foods that make health claims by the requirement that medical foods be intended to meet distinctive nutritional requirements of a disease or condition, used under medical supervision, and intended for the specific dietary management of a disease or condition. Medical foods are not those simply recommended by a physician as part of an overall diet to manage the symptoms or reduce the risk of a disease or condition, and all foods fed to sick patients are not medical foods. Instead, medical foods are foods that are specially formulated and processed (as opposed to a naturally occurring foodstuff used in a natural state) for a patient who is seriously ill or who requires use of the product as a major component of a disease or condition's specific dietary management.
6	**Cough & Cold Policy** - As new cough and cold products enter the market, they are often simply re-formulations or new combinations of existing products already in the marketplace. Many of these existing products are available in generic form and are relatively inexpensive. The new cough and cold products are branded products and are generally considerably more expensive than existing products. The policy of the ASE/PSE prescription drug program will be to default all new cough and cold products to "excluded" unless the DUEC determines the product offers a distinct advantage over existing products. If so determined, the product will be reviewed at the next regularly scheduled DUEC meeting.
7	**Multivitamin Policy** - As new vitamin products enter the market, they are often simply re-formulations or new combinations of vitamins/multivitamins in similar amounts already in the marketplace. Many of these existing products are available in generic form and are relatively inexpensive. The new vitamins are branded products and are generally considerably more expensive than existing products. The policy of the ASE/PSE prescription drug program will be to default all new vitamin/multivitamin products to "excluded" unless the DUEC determines the product offers a distinct advantage over existing products. If so determined, the product will be reviewed at the next regularly scheduled DUEC meeting.
8	Drug has limited medical benefit &/or lack of overall survival data or has overall survival data showing minimal benefit
9	Not medically necessary
10	Peer -reviewed, published cost effectiveness studies support the drug lacks value to the plan.
11	**Oral Contraceptives Policy** - OCs which are new to the market may be covered by the plan with a zero dollar, tier 1, 2, or 3 copay, or may be excluded. If a new-to-market OC provides an alternative product not similarly achieved by other OCs currently covered by the plan, the DUEC will consider it as a new drug. IF the drug does not offer a novel alternative or offers only the advantage of convenience, it may not be considered for inclusion in the plan.
12	Other
13	Insufficient clinical benefit OR alternative agent(s) available

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
Scott Cohen, MPH

23 MARCH 2020

Milliman

Agenda

- Arkansas State Employees (ASE)
- Public School Employees (PSE)
- 2021 Roadmap
- Assumptions and Methodology
- Appendices

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)

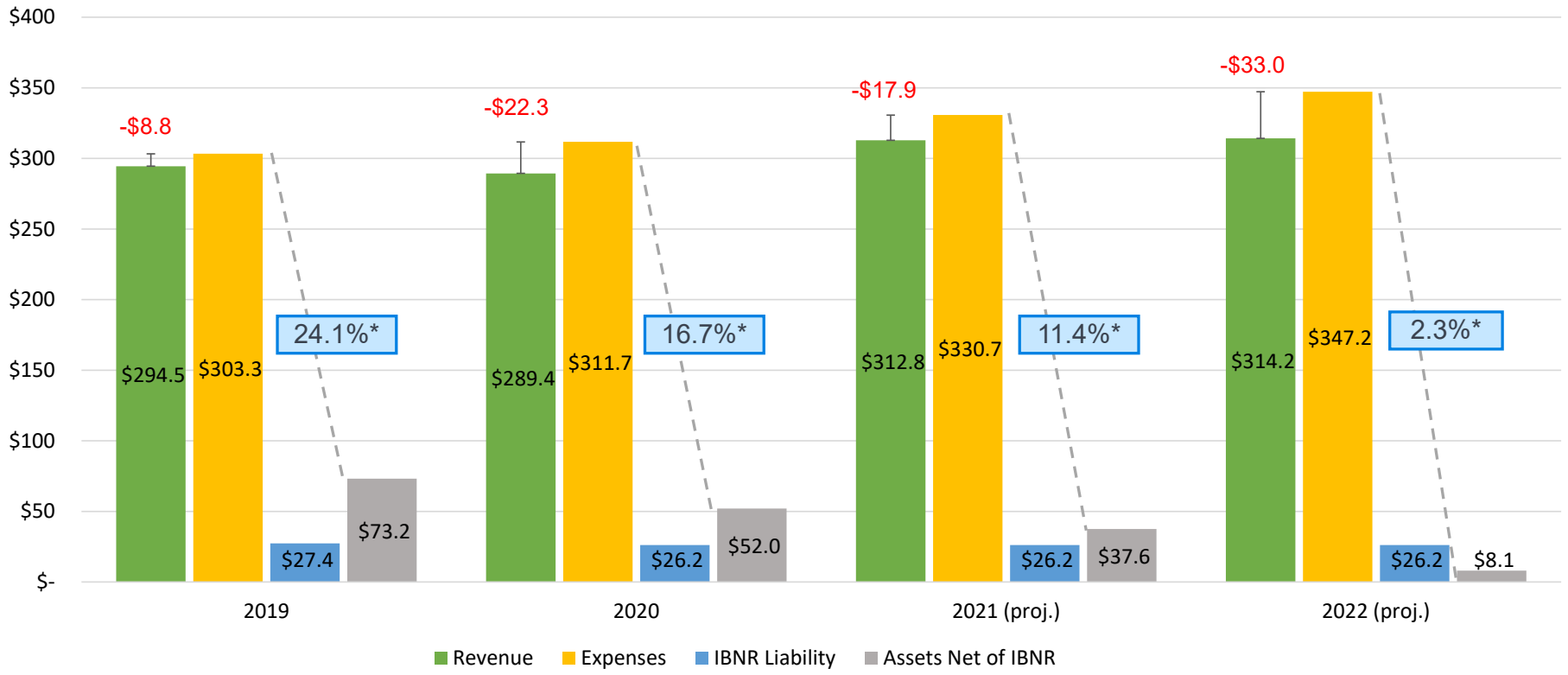
Average Membership			
Active Employees / Pre-65 Retirees	46,620	45,214	45,155
Post-65 Retirees	13,745	14,054	14,476
Total Enrolled	60,365	59,268	59,630

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

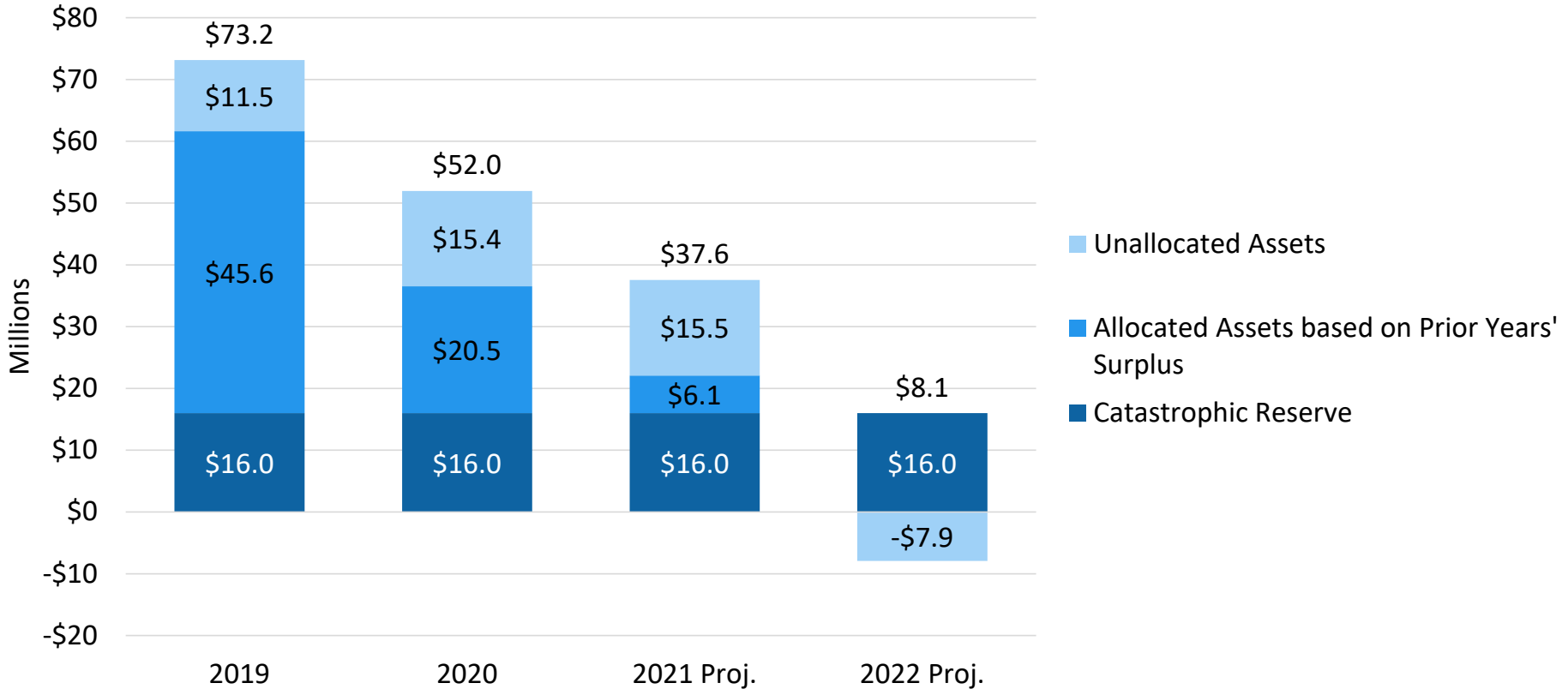


* Assets Net of IBNR as a portion of Expenses

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



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

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).

Summary of Initiatives – Option 1

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

Initiative	2022 Estimated Impact	
	Savings	Balance
State Funding Increase from $450 to $475	$10.3M	($22.7M)
5% Contribution Increase	$5.4M	($17.3M)
Reduction in Wellness Credit from $50 to $25[1]	$5.2M	($12.1M)
$250 Deductible & OOPM Increase	$3.4M	($8.7M)
Discontinue Medicare-Eligible Retiree Spouse Coverage[2]	$5.4M	($3.3M)
Total	$29.7M	

[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

Summary of Initiatives – Option 2

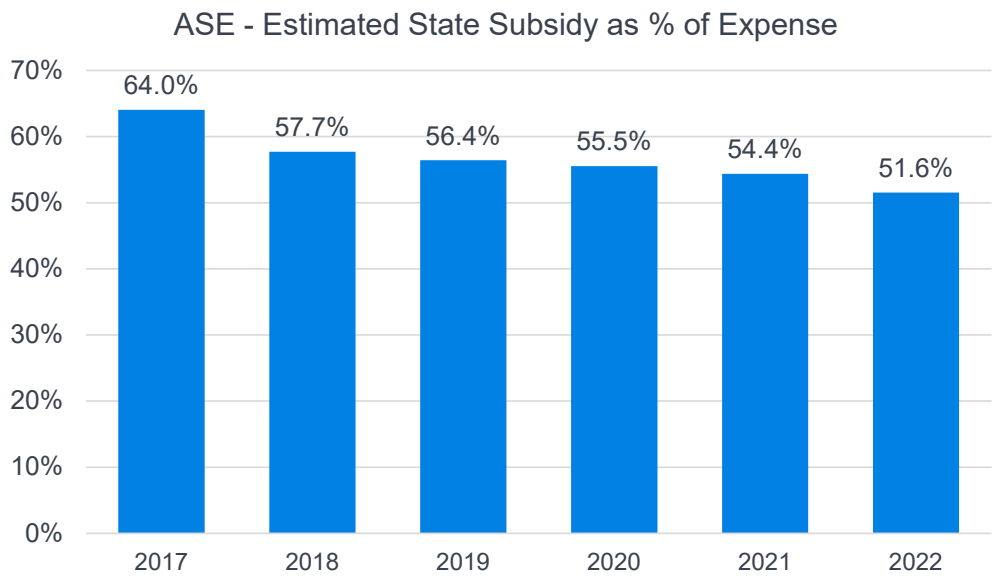
- 2022 ASE target: ($33.0M) (estimated deficit + 10% catastrophic reserve minimum)

Initiative	2022 Estimated Impact	
	Savings	Balance
State Funding Increase from $450 to $500	$20.5M	($12.5M)
5% Contribution Increase	$5.4M	($7.1M)
$250 Deductible & OOPM Increase	$3.4M	($3.7M)
Total	$29.3M	

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

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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

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)

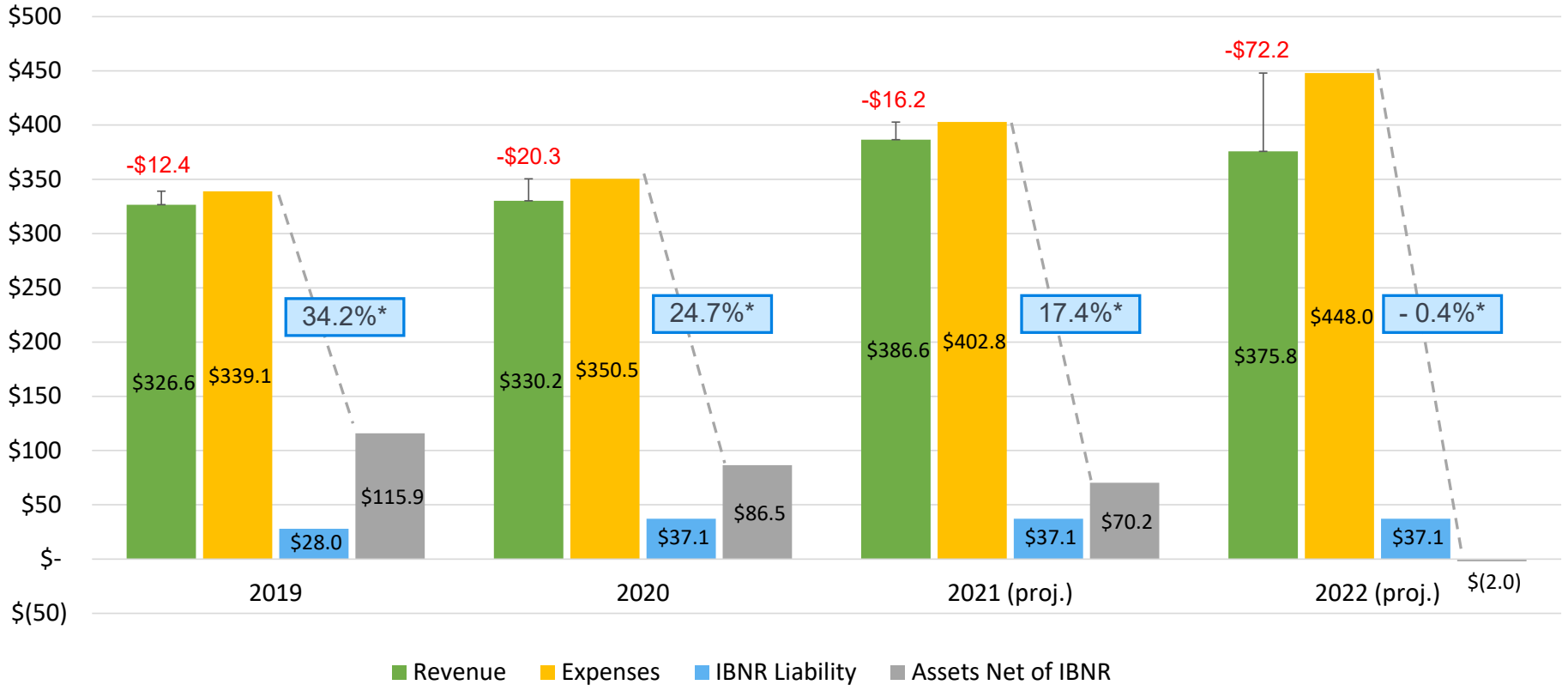
Average Membership			
Active Employees / Pre-65 Retirees	84,232	85,592	88,119
Post-65 Retirees	15,005	15,878	16,831
Total Enrolled	99,238	101,470	104,949

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

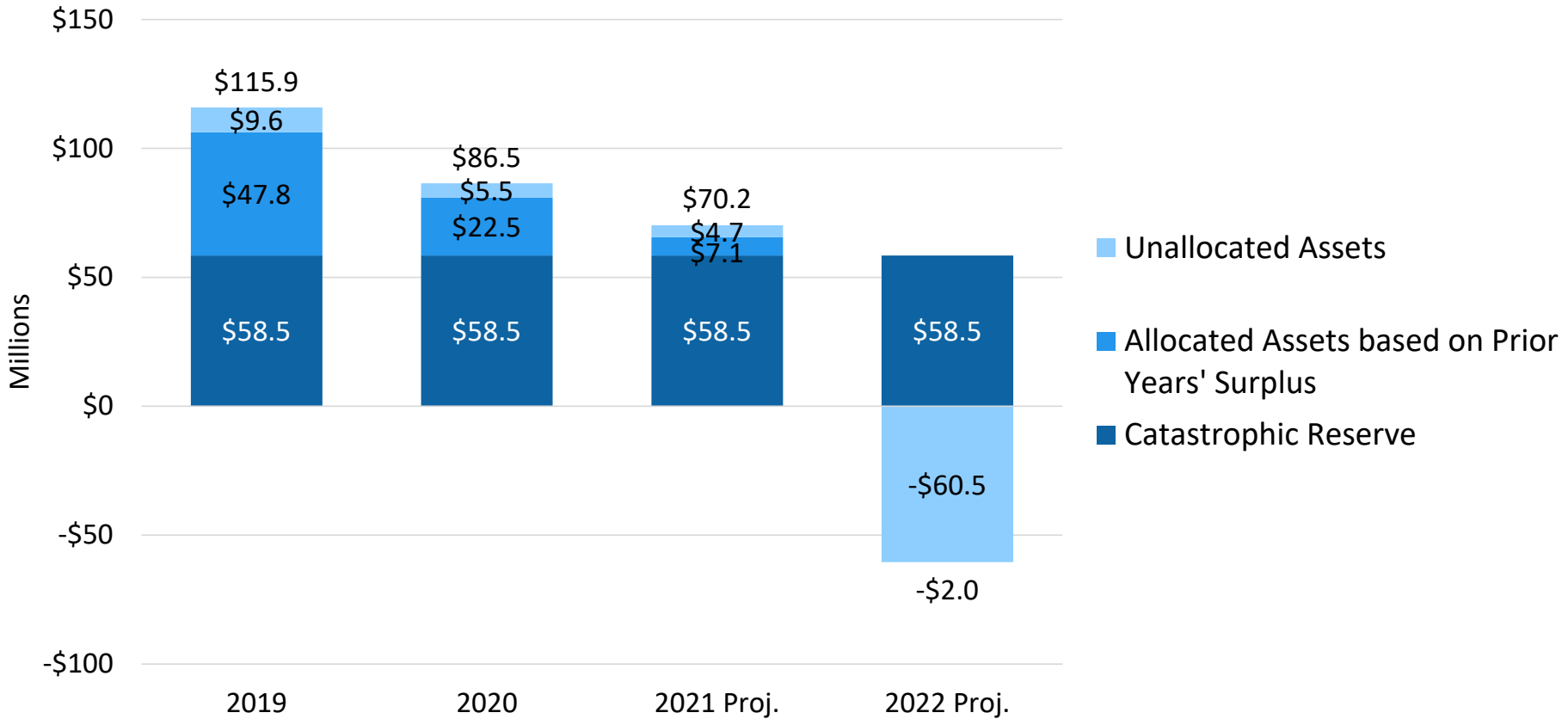


* Assets Net of IBNR as a portion of Expenses

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



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

	ASE
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

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).

Summary of Initiatives – Option 1

- 2022 PSE target: ($72.2M) (estimated deficit + maintain catastrophic reserve)

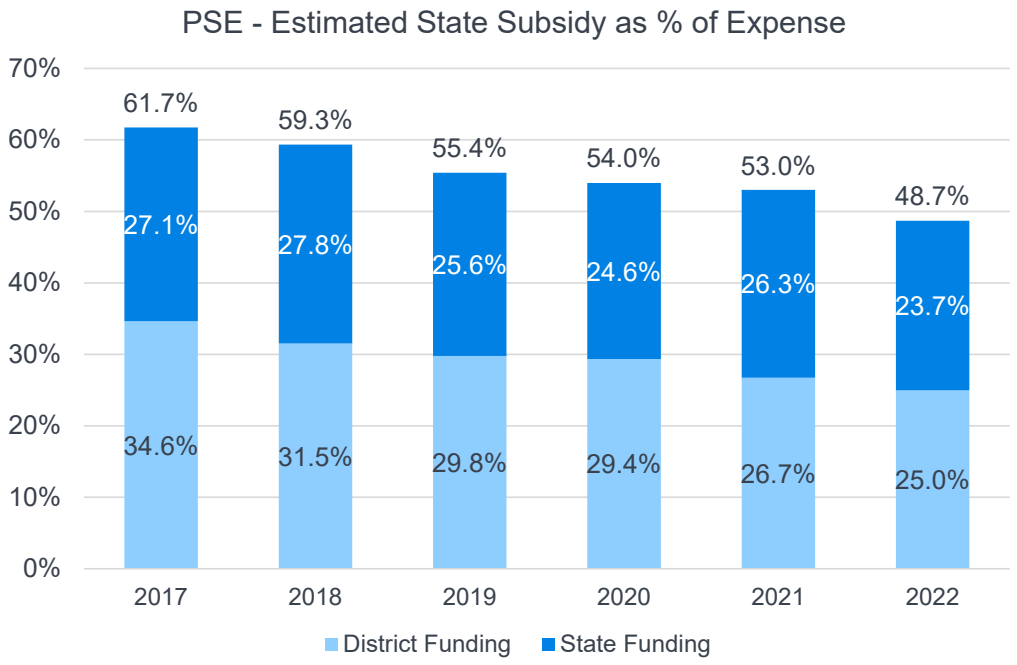
Initiative	2022 Estimated Impact	
	Savings	Balance
Department of Education Funding Increase from $108M to $138M	$30.0M	($42.2M)
10% Contribution Increase	$15.1M	($27.1M)
Reduction in Wellness Credit from $50 to $25[1]	$11.7M	($15.4M)
$250 Deductible & OOPM Increase	$5.1M	($10.3M)
Total	$61.9M	

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

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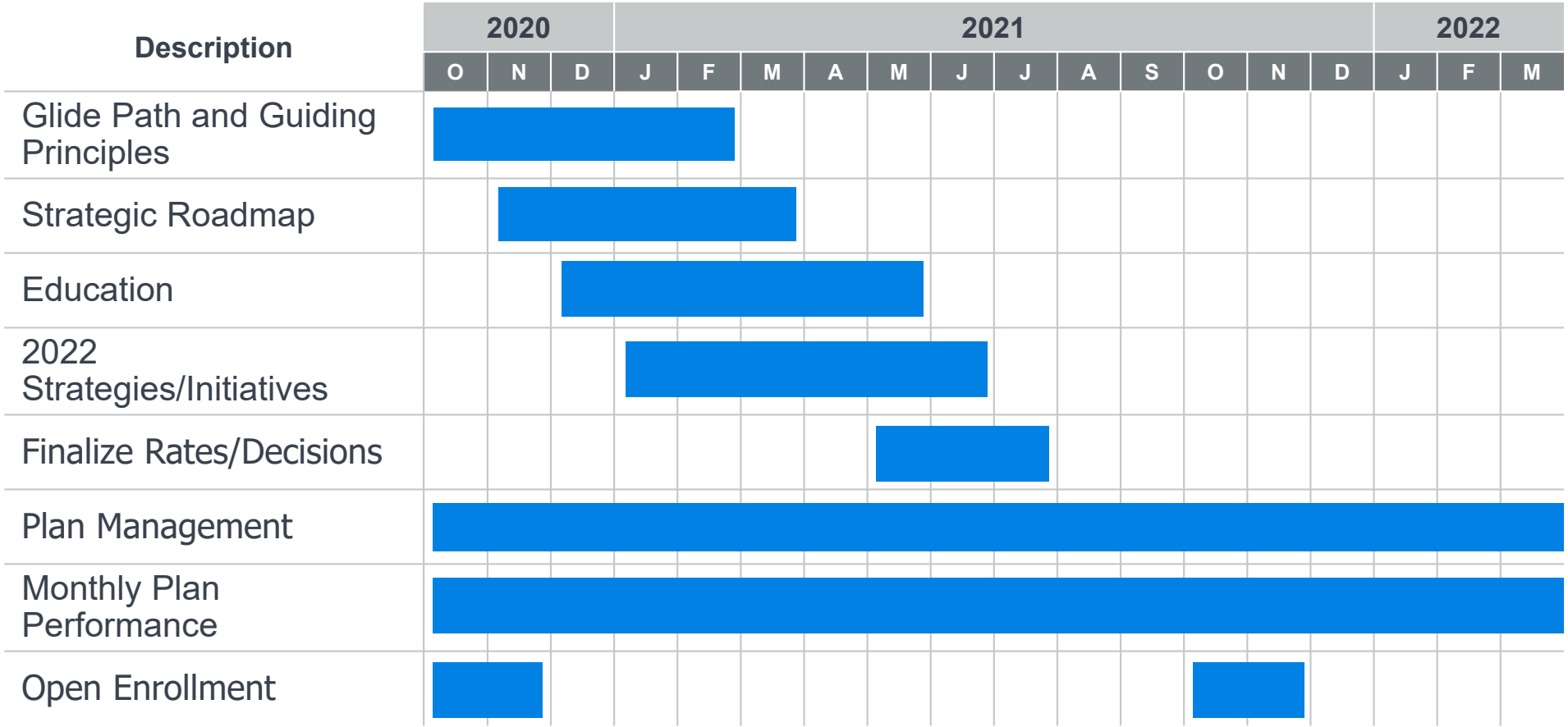
[1] *Separate out-of-pocket maximum for pharmacy on Premium plan*
[2] *Represents Active and Pre-65 Retiree projected 2022 enrollment*

2021 Roadmap

Timeline: Gantt chart



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Thank you

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

Appendices

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.

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.

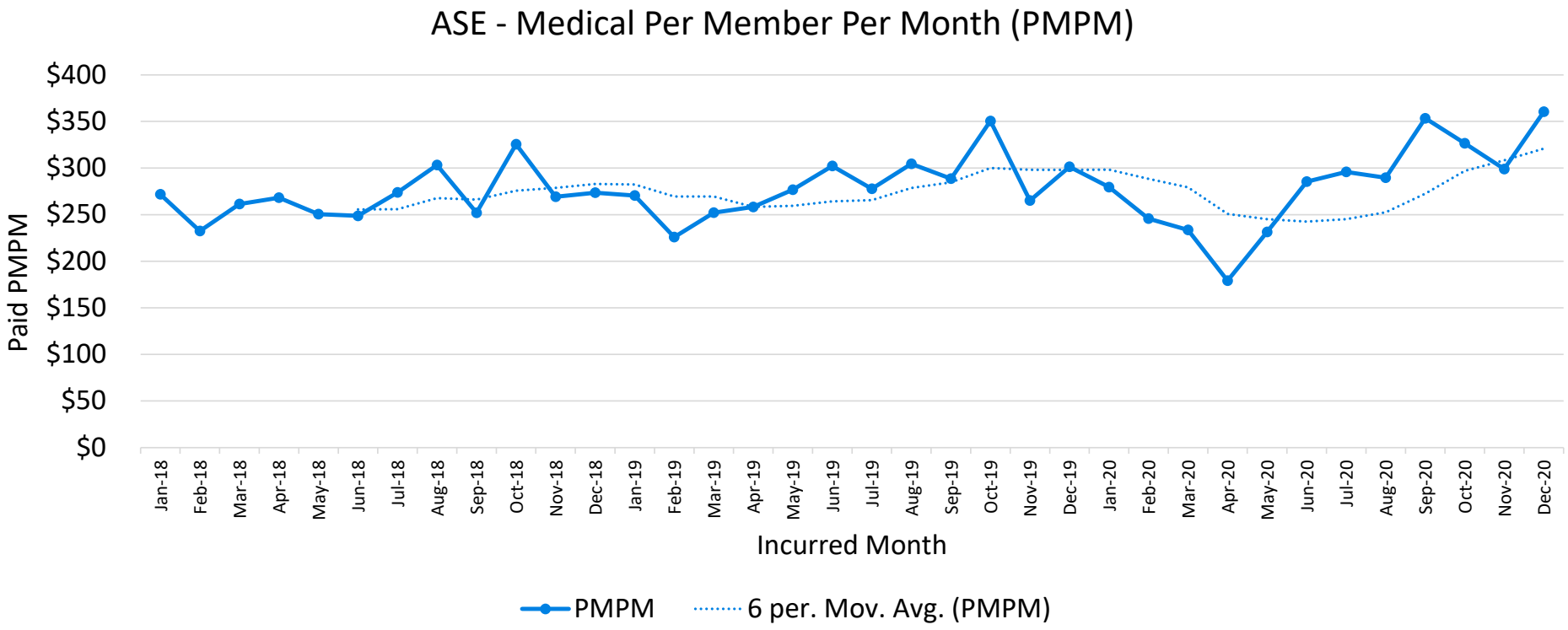
The terms of Milliman's Consulting Services Agreement as a subcontractor to Health Advantage, an affiliate of ABCBS, for the State of Arkansas dated October 29, 2019 apply to this email and its use.

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.

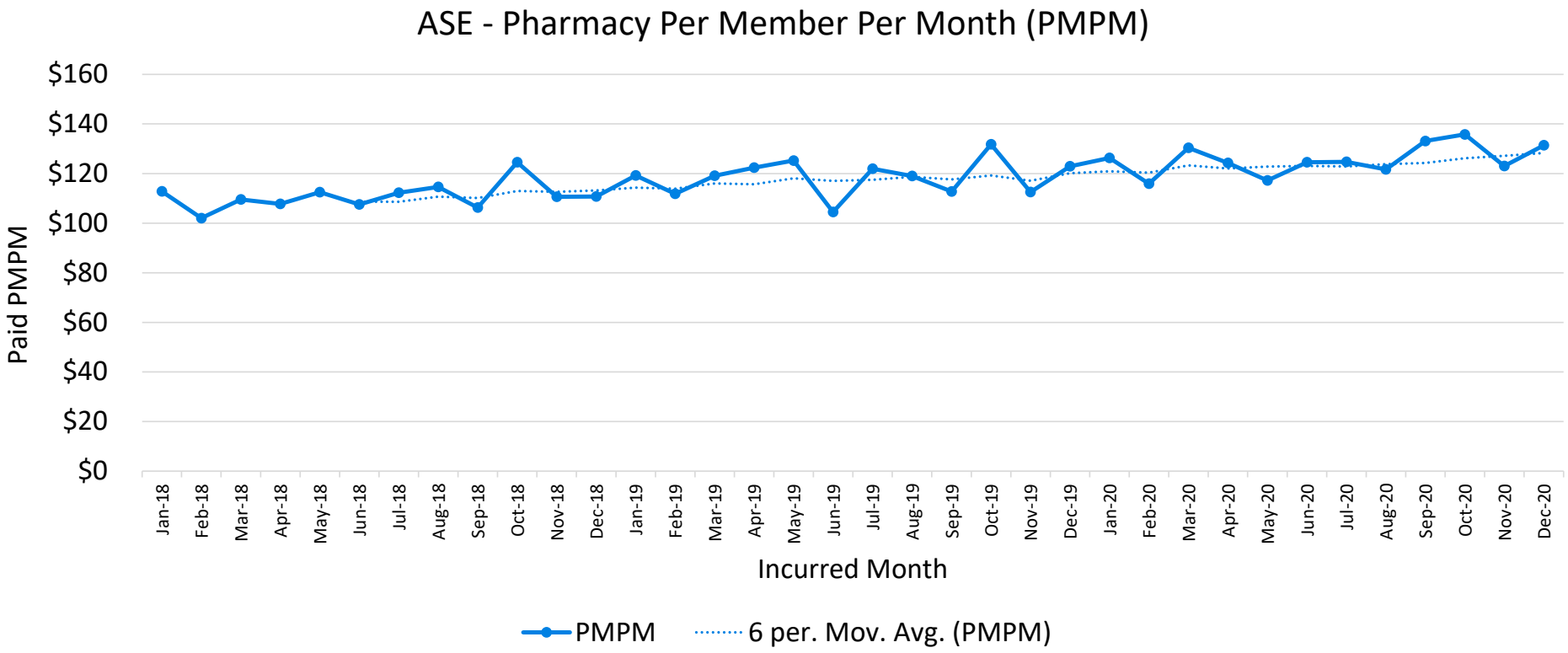
Appendix

ASE Supporting Exhibits

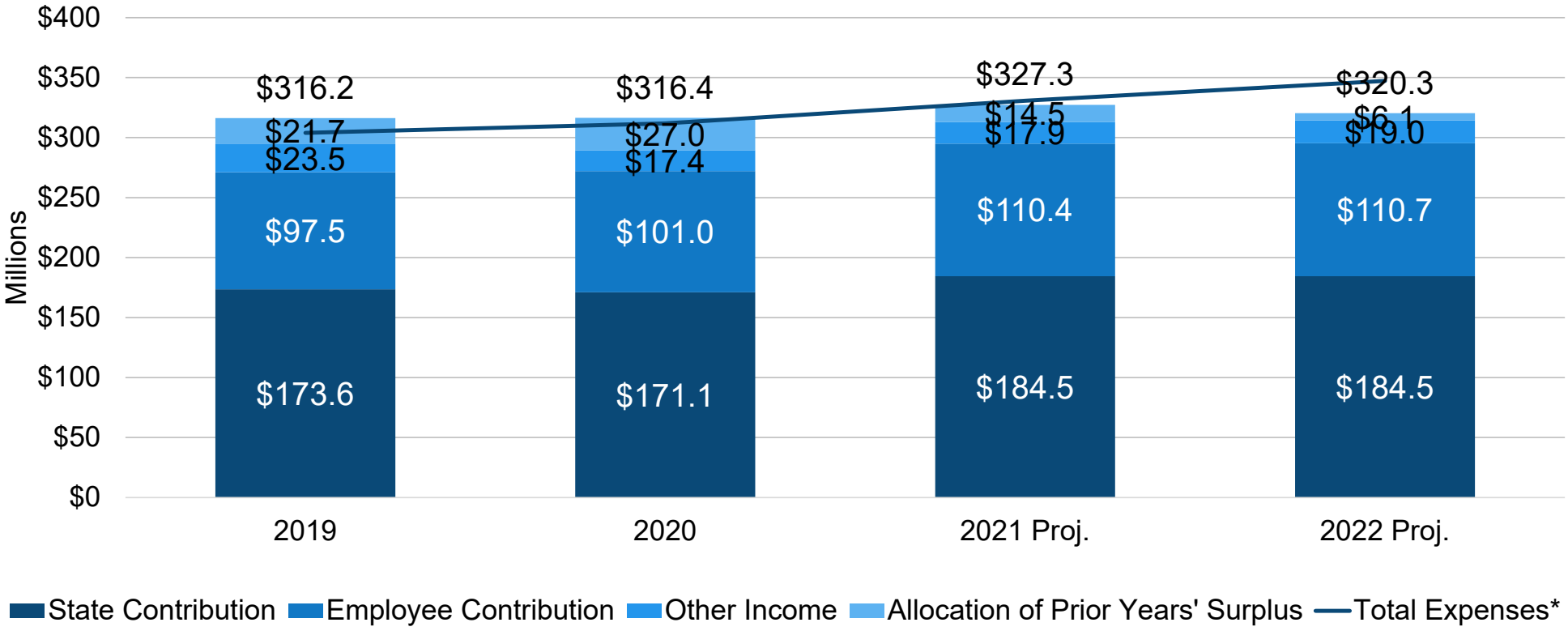
Monthly Trend - Medical



Monthly Trend - Pharmacy

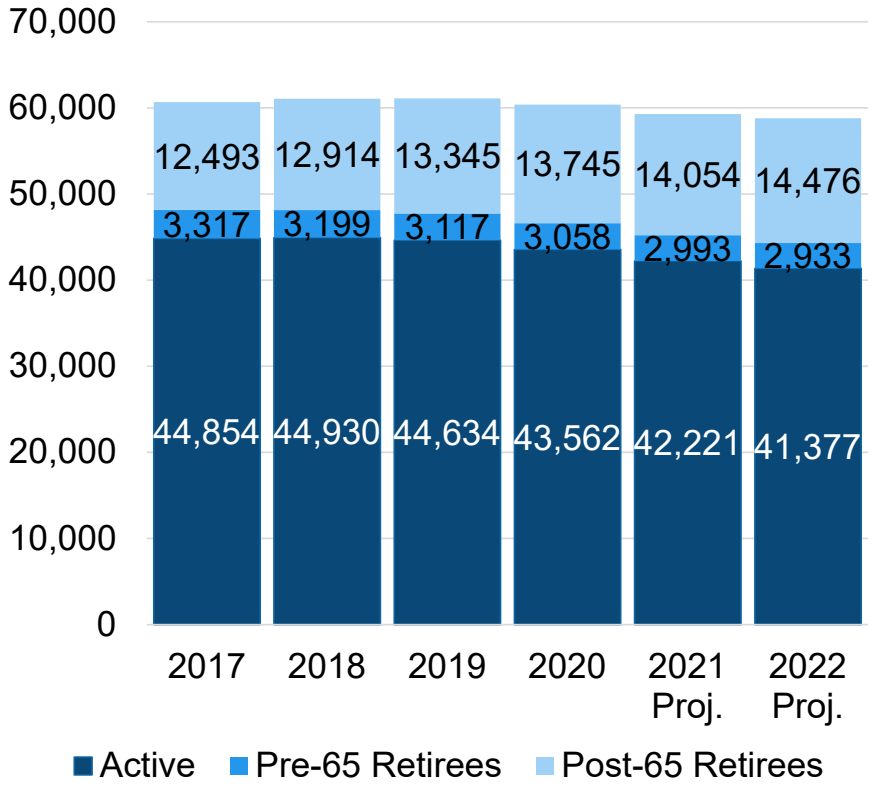


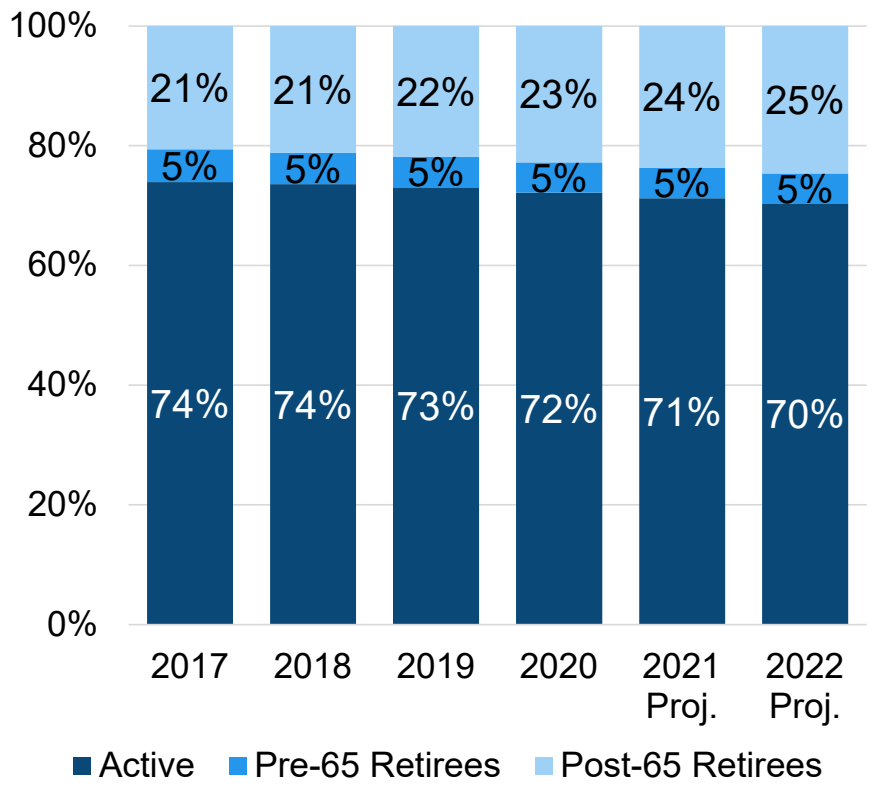
ASE - Income vs. Expenditure



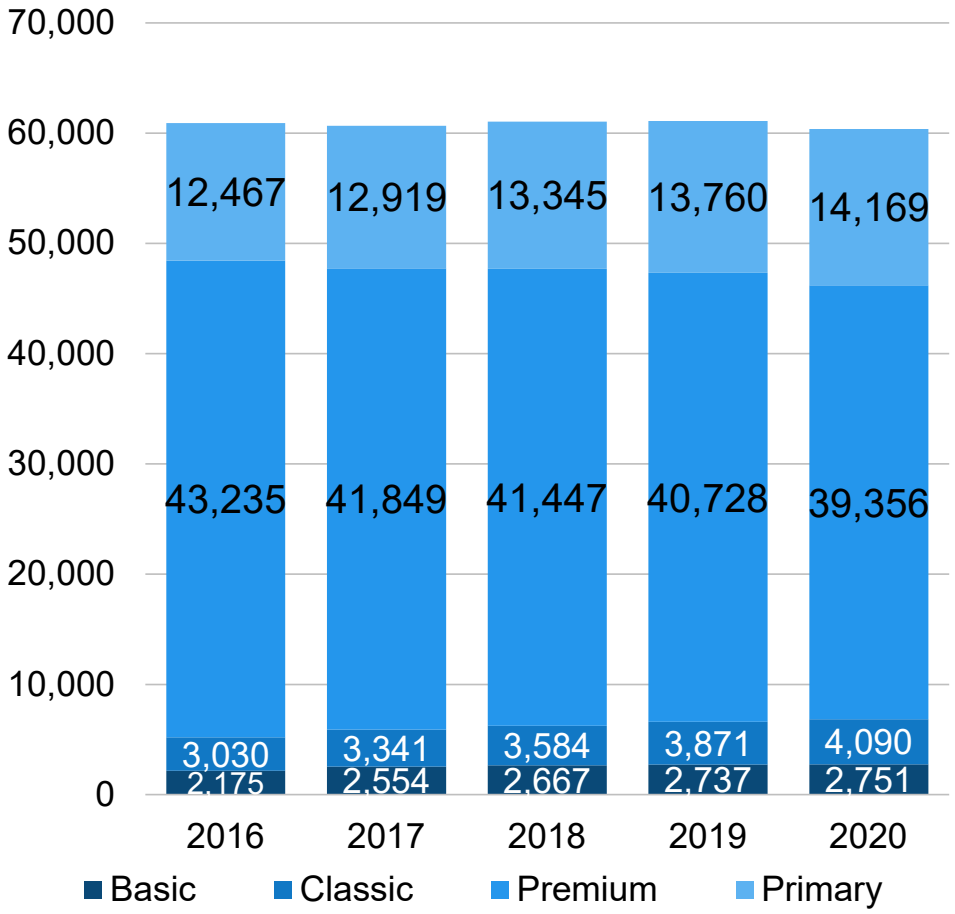
* Total Expenses offset by Program Savings

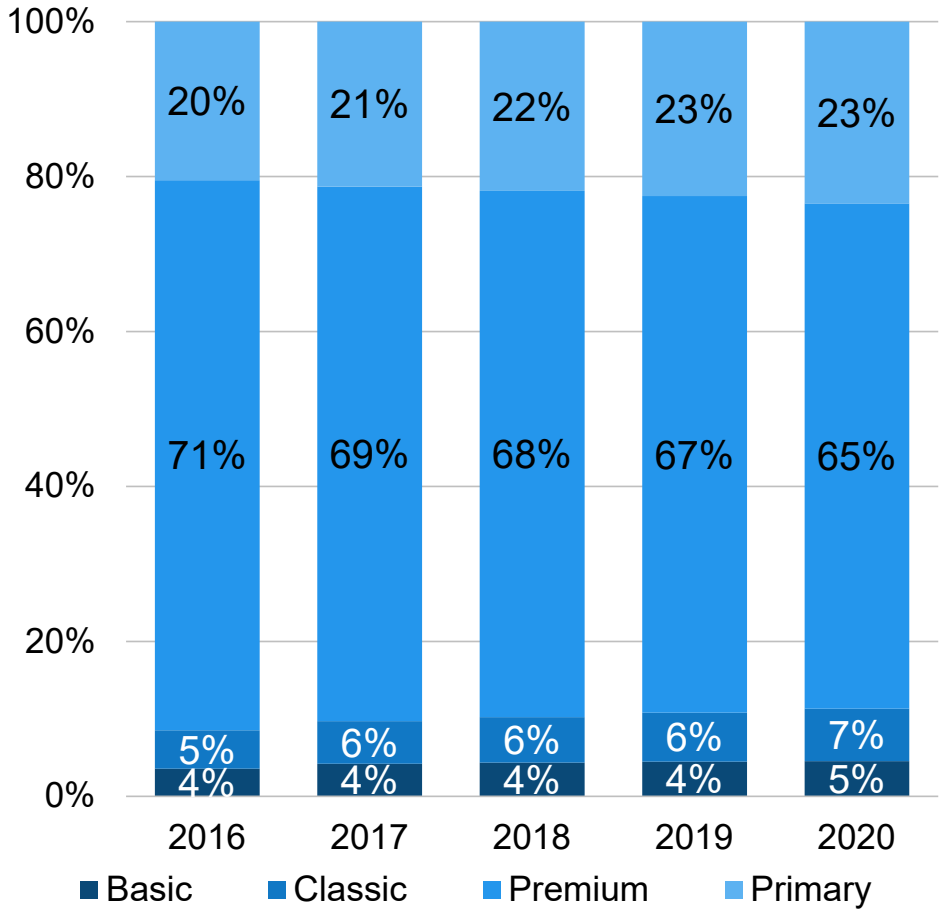
ASE - Average Membership by Status





ASE - Average Membership by Plan





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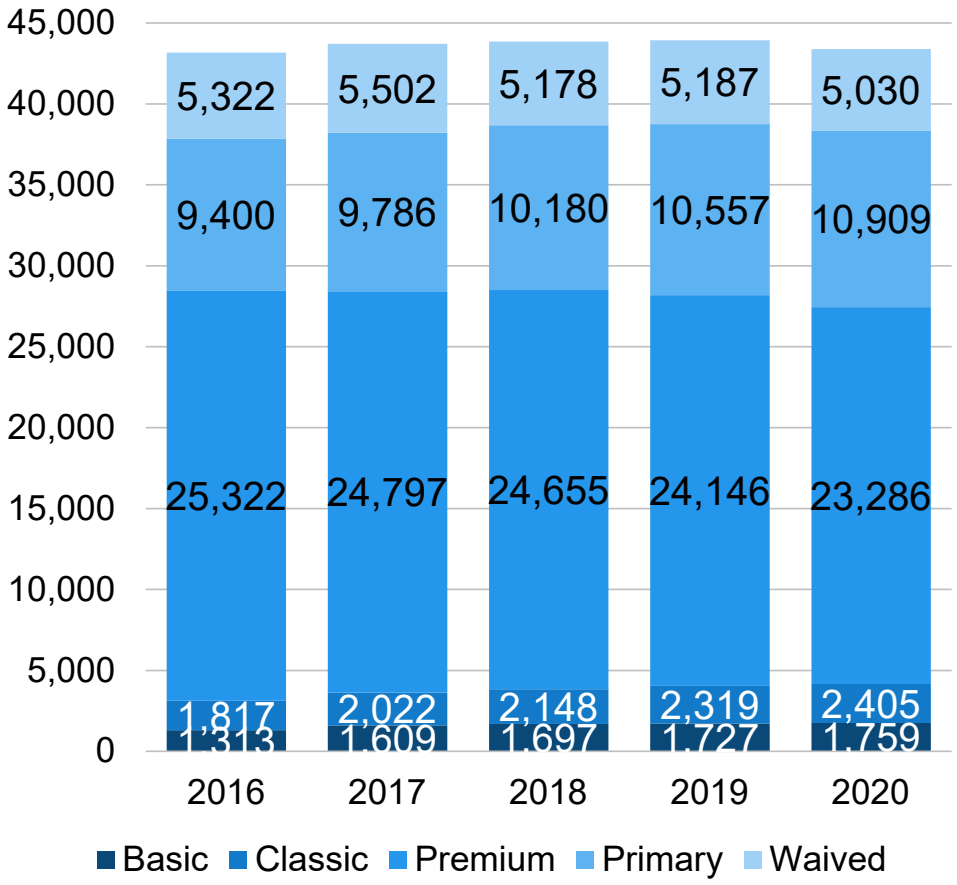
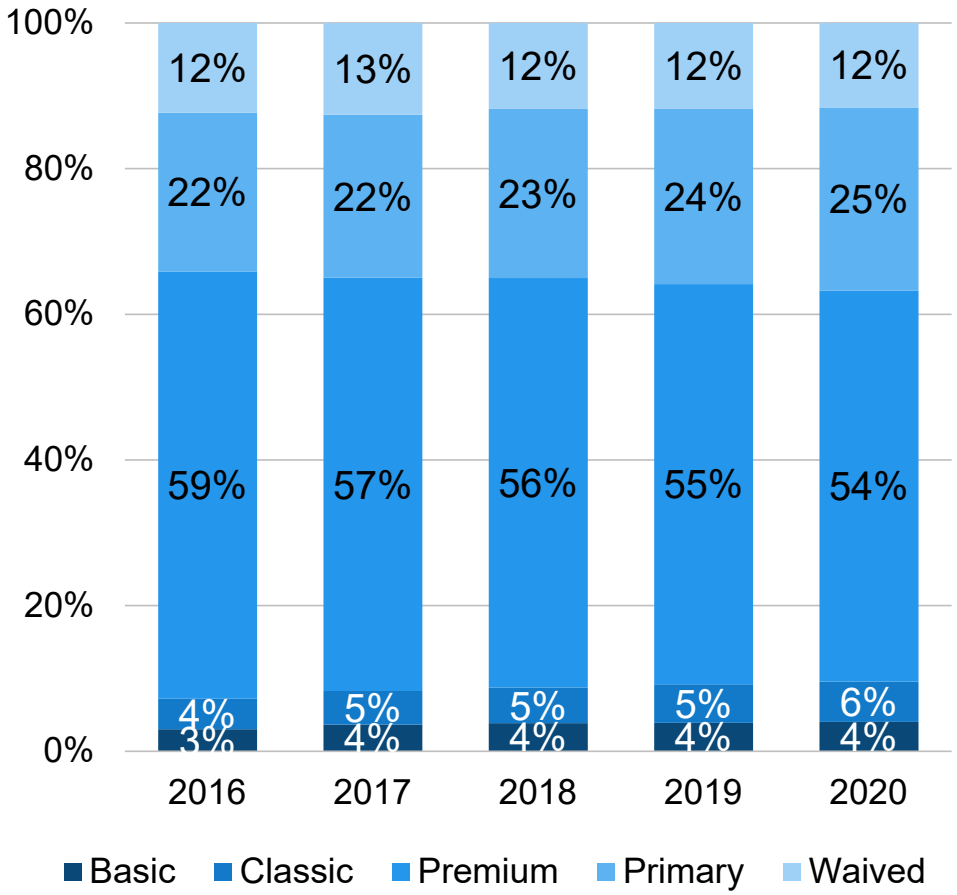
ASE - Average Enrollment (Subscribers) by Plan





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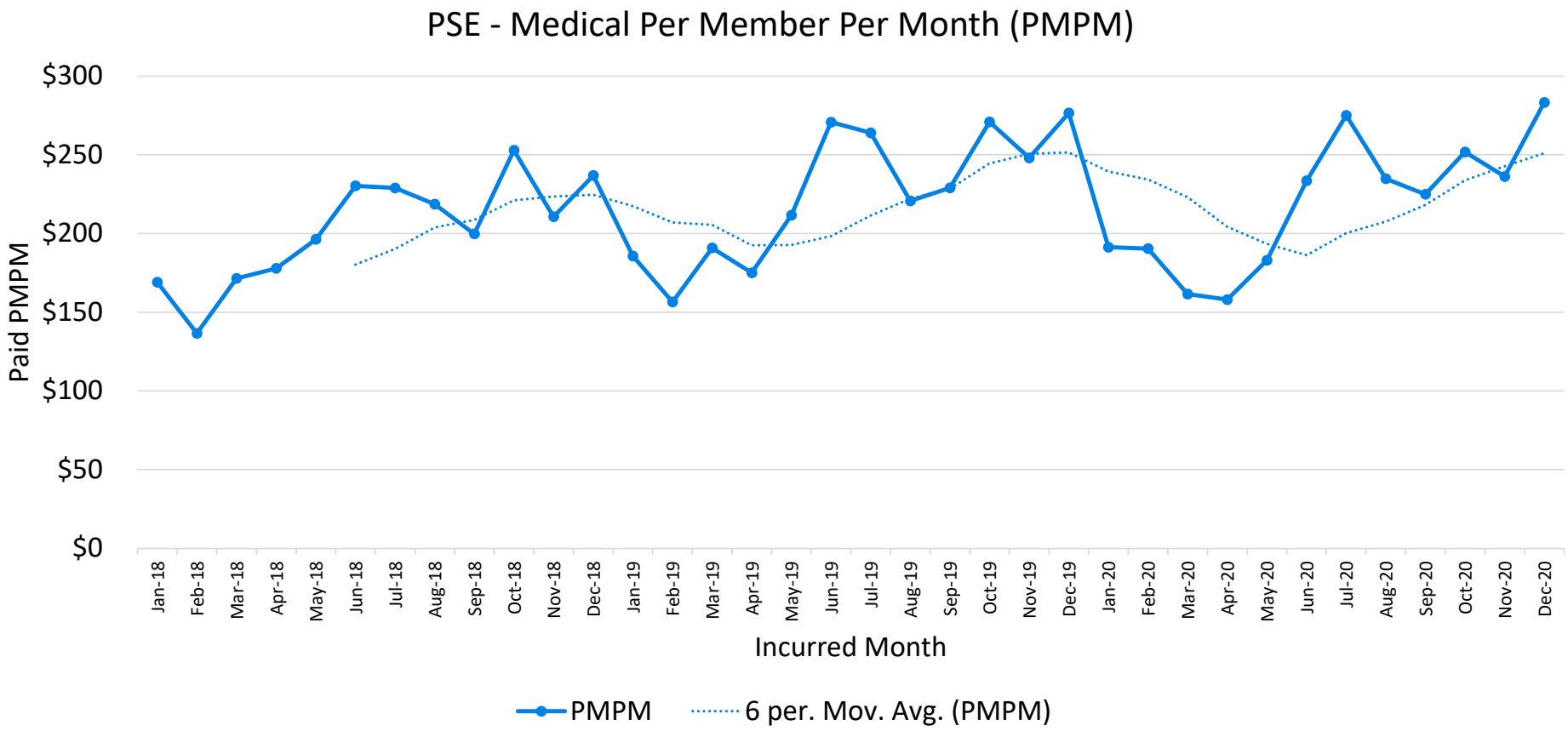
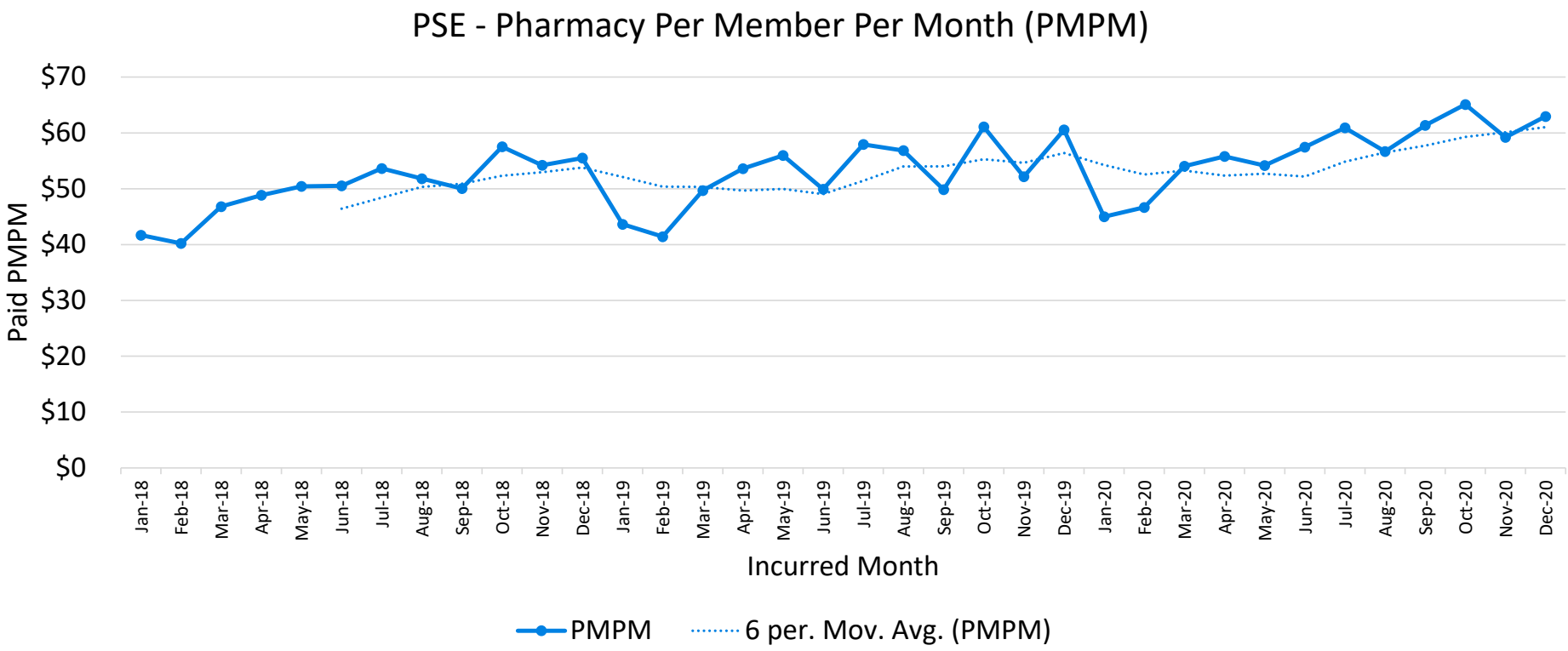
Appendix

PSE Supporting Exhibits

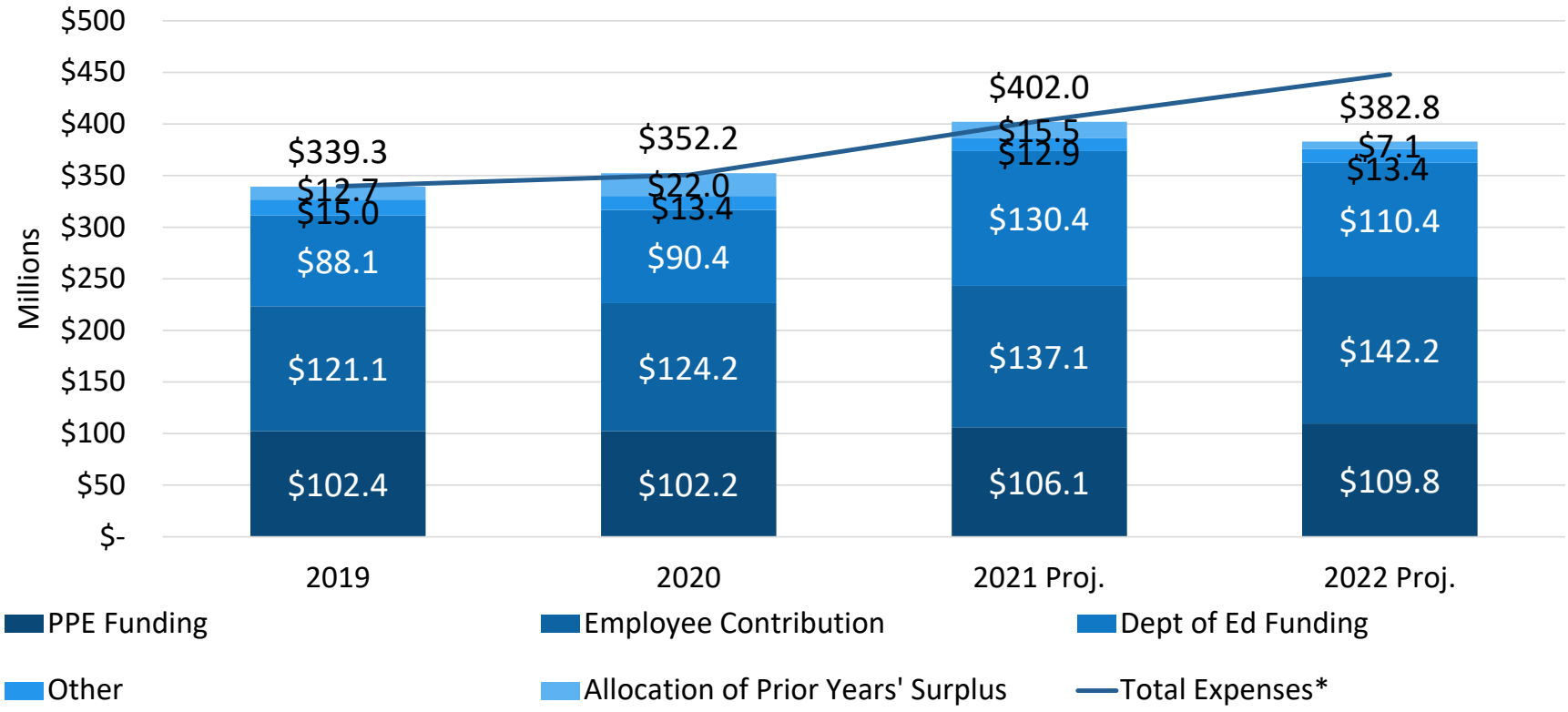
Monthly Trend - Medical



Monthly Trend - Pharmacy

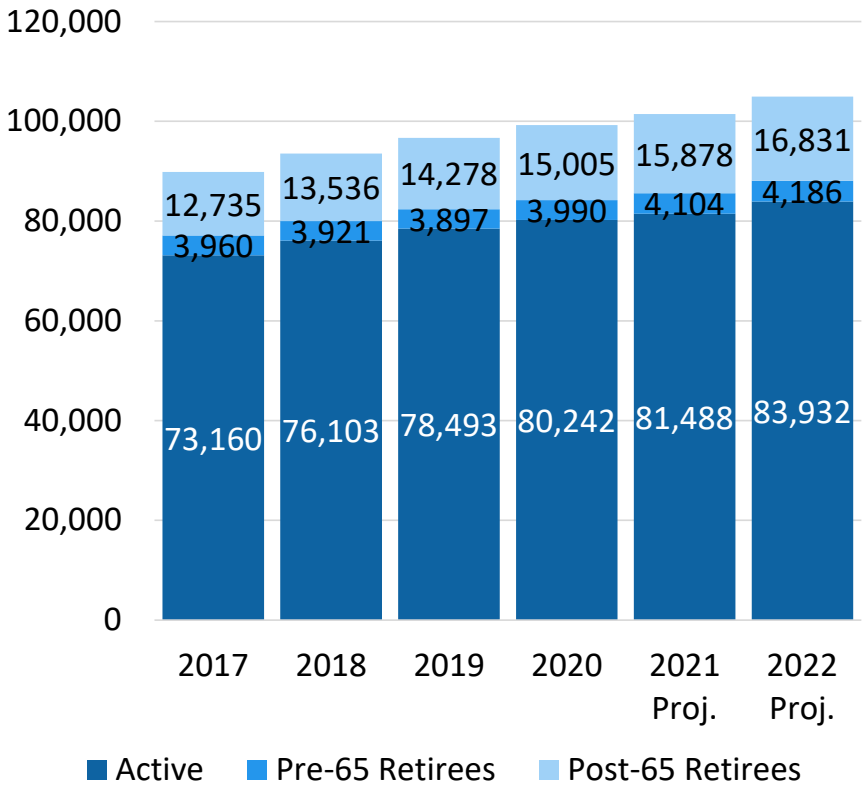


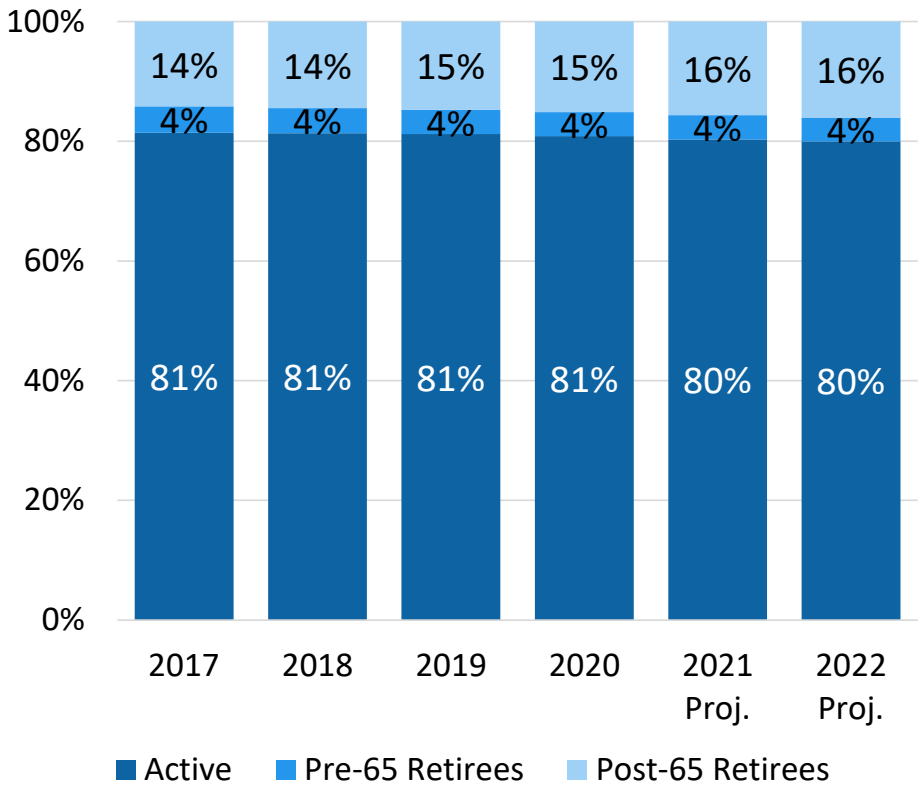
PSE - Income vs. Expenditure



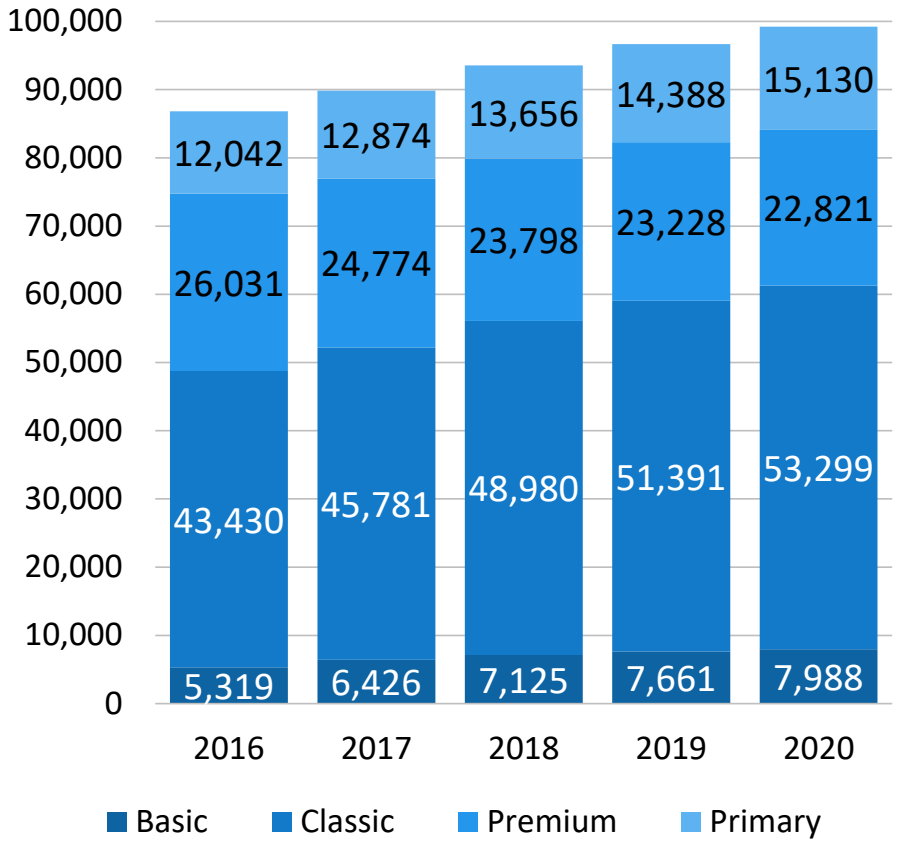
* Total Expenses offset by Program Savings

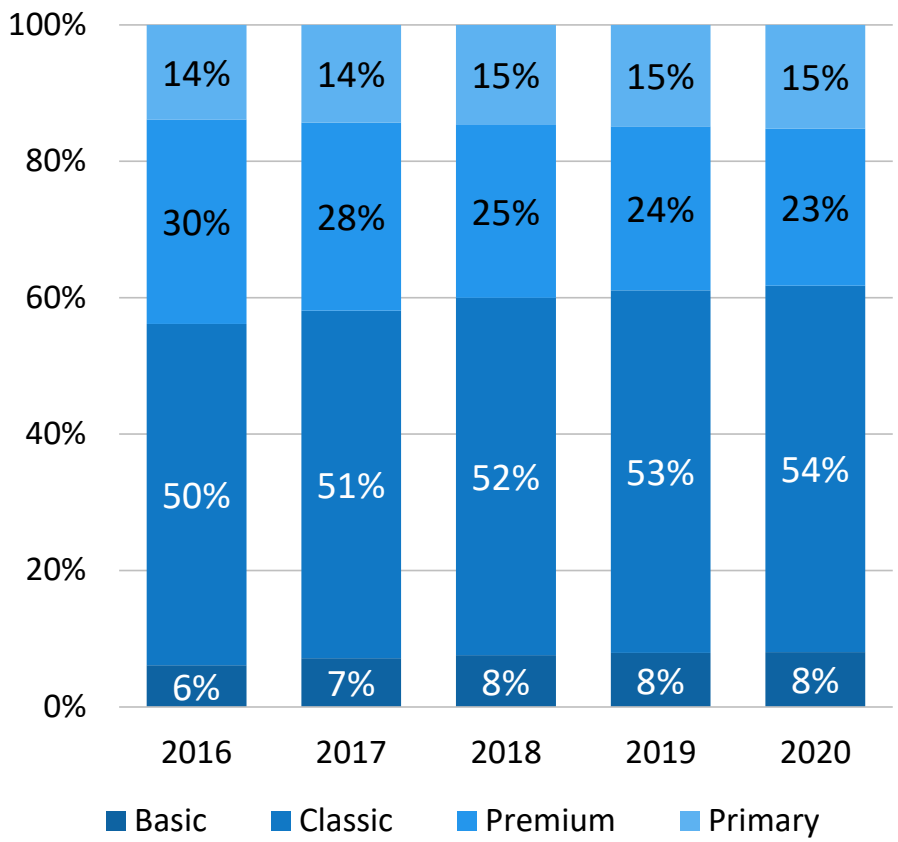
PSE - Average Membership by Status



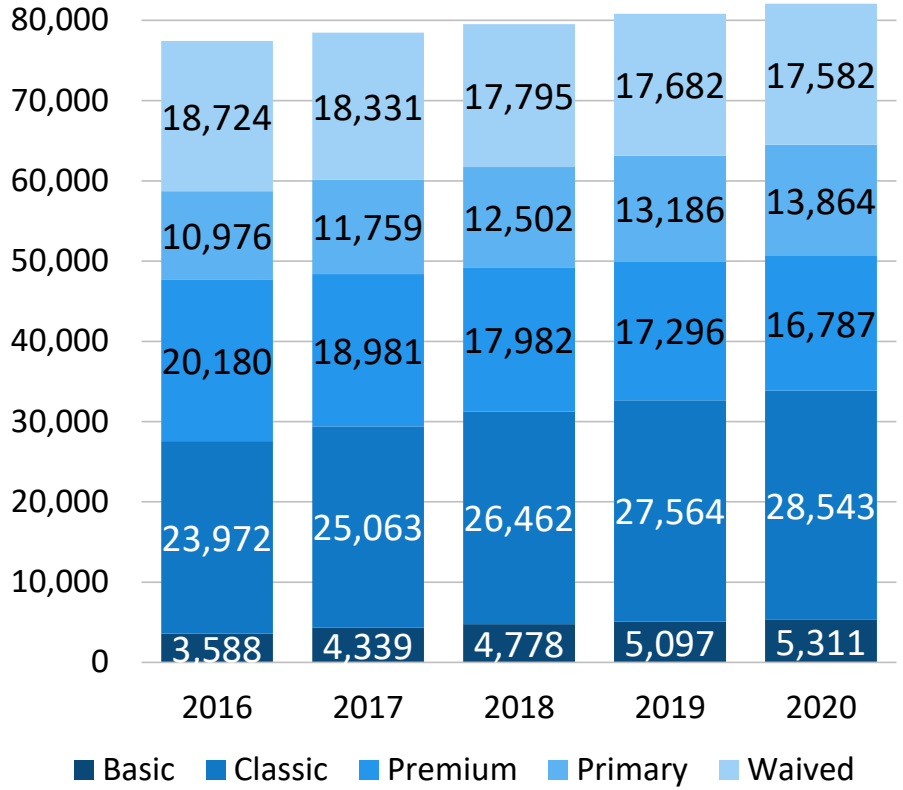


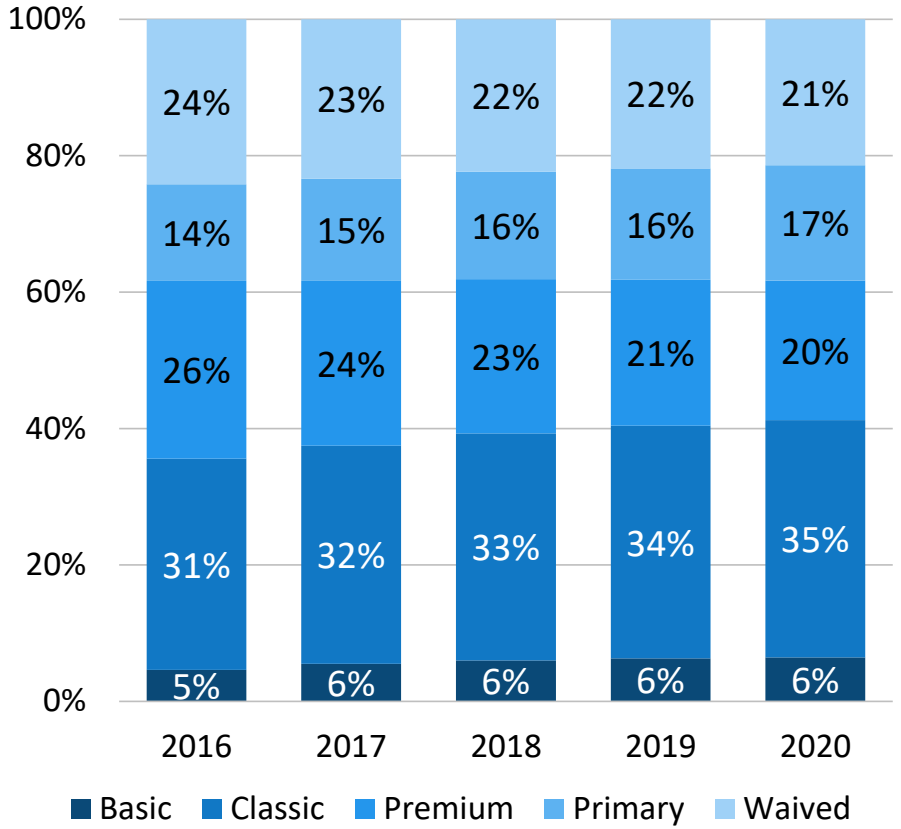
PSE - Average Membership by Plan





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

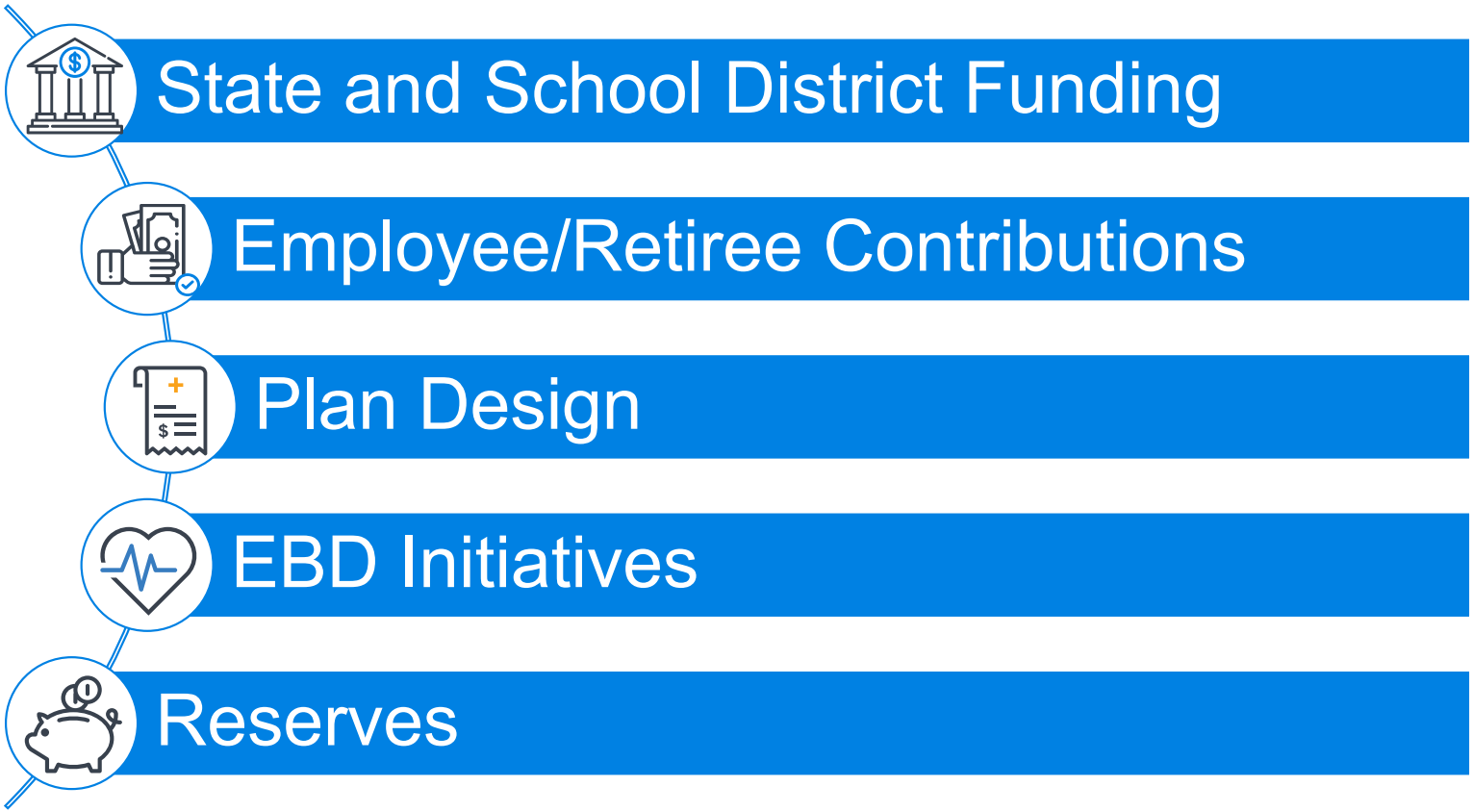
PSE – 2021 Post-65 Retiree Rates

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*