AGENDA

State and Public School Life and Health Insurance Board

January 26th, 2021

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

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

II. *Approval of December Minutes.....Renee Mallory, Chair*

III. *Trend Experience .....Paul Sakhrani & Courtney White, Milliman*

IV. *DUEC Report..... Dr. Hank Simmons, DUEC Chair*

V. *Subcommittee Updates.....Shalada Toles, EBD Deputy Director*

VI. *COVID Update.....Elizabeth Montgomery & Mike Motley, ACHI*

   a. *COVID Update*

   b. *Bariatric Program Analysis*

VII. *Director's Report.....Shalada Toles, EBD Deputy Director*

VIII. *Adjournment.....Renee Mallory, Chair*

2021 Upcoming Meetings:

February 23rd, March 23rd, April 20th

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

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

STATE AND PUBLIC SCHOOL LIFE AND HEALTH INSURANCE BOARD MEETING MINUTES

209th meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on January 26th, 2021, at 1:00 PM

Date | *time* 1/26/2021 1:00 PM | *meeting called to order by Renee Mallory, Chair*

Attendance

Members Present	Members Absent
Cindy Allen - teleconference	
Stephanie Lilly-Palmer	
Greg Rogers	
Dori Gutierrez	
Secretary Cindy Gillespie – proxy – Damian Hicks - teleconference	
Dr. John Kirtley – Vice-Chair	
Melissa Moore	
Dr. Terry Fiddler - teleconference	
Secretary Amy Fecher - teleconference	
Dr. Lanita White	
Lisa Sherrill	
Herb Scott	
Cynthia Dunlap	
Renee Mallory - Chair	
Shalada Toles, Employee Benefits Division Deputy Director	

OTHERS PRESENT:

Rhoda Classen, Theresa Huber, Laura Thompson, Drake Rodriguez, Mary Massirer, EBD; Micah Bard, Dwight Davis, Sherry Bryant, Octavia DeYoung, UAMS EBRX; Dr. Hank Simmons, DUEC Chair; Jessica Akins, Takisha Sanders, Jason Treece, Health Advantage; Elizabeth Montgomery, Mike Motley, ACHI; Courtney White, Paul Sakhrani, Scott Cohen, Julia Weber, Milliman; Mitch Rouse, TSS; Sylvia Landers, Colonial Life; Kristie Banks, Mainstream; Sidney Keisner, Jill Johnson, UAMS; Brent Flaherty, Judith Paslaski, Medimpact; Jeff Altemus, Robert McQuade, ASE/PSE Retiree; Nicholas Poole, ASEA; Leo Hauser; Bi-Partisan Strategies; Frances Bauman, Novo Nordisk; Stephen Carroll, AllCare Specialty; Donna Morey, ARTA; Charles Hubbard, ASP; Julie Grogan, UCB; Erika Gee, WLJ; Dwane Tankersley, NovaSys Health; Stephanie Cyz; J. Daughty, DPAS; John Lee; Patrick Gurley

Approval of Minutes by Renee Mallory, Chair

MOTION by Dr. Kirtley:

Motion to accept the December 16, 2020 minutes.

Scott seconded; all were in favor.

Minutes 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 2020 and beyond roadmap.

ASE

- 2021 & 2022 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through December 2020 and pharmacy claims data incurred from November 2019 to October 2020 and paid through December 2020. 2020 reflects actual claims paid.

- 2020 projected plan experience
    - Allocation of Prior Years' Surplus for 2020 is $25.1M
    - Estimated surplus of $1.2M (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2020: $9.6M
    - No Plan changes / 5% increase in employee contributions
- 2021 Plan experience
    - Allocated of Prior Years' Surplus for 2021 is $14.5M
    - Projected deficit: -$400K (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2021: $9.2M
    - Reflected 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: -$32.8M (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2021: -$23.6M
    - Reflected baseline scenario
    - No plan design or contribution changes
    - Baseline trends (medical: 5%, pharmacy: 8%)

PSE

- 2021 & 2022 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through December 2020 and pharmacy claims data incurred from November 2019 to October 2020 and paid through December 2020. 2020 reflects actual claims paid.

- 2020 projected plan experience
    - Allocation of Prior Years' Surplus for 2020 is $25.3M
    - Estimated deficit of -$200K (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2020: $5.5M
    - No Plan changes / 0% increase in employee contributions

- 2021 Plan experience
  - Allocated of Prior Years' Surplus for 2021 is $15.5M
  - Projected deficit: -$22.7M (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2021: -$17.3M
  - 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: -$66.2M (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2021: -$83.5M
  - Reflected baseline scenario
  - No plan design or contribution changes
  - Baseline trends (medical: 7%, pharmacy: 8%)

Discussion:

ASE

Dunlap: Can you explain how the wellness percentage impacted the reserves.

White: The wellness percentage in 2020 was approximately 82%, and it dropped down to 76% for 2021. So, that means that there were 5% of people who didn't qualify for the wellness percentage and won't get the $50 credit on their contributions. So, they pay $50 more. For that 5% of people, the employee contributions went up by $50 a month.

Dr. Kirtley: On 2021 versus 2022, the IBNR on both is 26.6. Do we not expect to have a related growth in the IBNR to the related overall claims increase?

White: We look at the IBNR every month, and it has stayed pretty static. It hasn't gone up at the same levels. We will update that before we do the rate setting in the next month or two, so we get the most up to date picture of what the IBNR may be.

Dr. Kirtley: It would just seem like if we have a 5%-8% growth that the IBNR would grow accordingly, as well. I was just concerned we may be missing a couple million dollars.

White: No, we are looking at that every month to make sure that we aren't significantly over or under that and making sure that we are being as prudent as possible when setting the reserve.

PSE

Dr. Kirtley: The medical trends on the PSE side are traditionally seeing a 7% growth versus ASE. Any insight as to why that is?

Sakhrani: We do know that ASE's plan cost per participant is slightly higher than PSE. So, I think that the average cost per participant on PSE is about $314 and $450 for ASE. We do have a lower base as a starting point, so it is a little easier to trend a little higher when you are coming off a lower base. We could also see what is driving some of these trend differences between where they are coming from on the medical side as well as on the pharmacy side.

Dr. Kirtley: I figured it might be in part due to the higher selection of the high deductible plans because once they started paying, they pay and pay and pay once they hit those amounts.

Sakhrani: That is a good point as well. On ASE, I think 90% of the enrollment is on the Premium plan and on the PSE, it's about 50% on the Classic and 20% on the Basic. As they go into these lower costs options like the Classic and the Basic, there is a leveraging effect that pushes that trend up higher on the plan side.

DUEC Report by Dr. Hank Simmons, DUEC Report

The following report pertains to the DUEC meeting at 1:00 p.m. on Monday, January 11th, 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) TRODELVY	SACITUZUMAB GOVITECAN	Breast Cancer	Cover w/PA	New Clinical Data	Previously Excluded
(2) OXERVATE	CENEGERMIN	Neurotrophic Keratitis	Cover w/PA	New Clinical Data	Previously Excluded
(3) KESIMPTA	OFATUMUMAB	Leukemia; Multiple Sclerosis	Exclude	Alternatives with superior clinical data	No Current Utilizers

The DUEC voted to adopt the recommendations as presented.

B. Formulary Cleanup: Dr. Oktawia DeYoung, UAMS

Topical Anti-infective Agents: EBRX Fraud, Waste and Abuse Prevention Policy

ACTION: To prevent abuse of Plan resources, recommending Quantity Limit for topical anti-infective creams of 120 grams or 120 mL per 30 days. This allows for twice-daily dosing over 9% body surface area for acute treatment of infection, based on average American Academy of Dermatology (AAD) estimation. PA for amounts over proposed QL. There are no members currently filling more than the proposed quantity limit.

The DUEC voted to adopt the recommendation as presented.

II. New Business

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

Brand	Generic	Indication	Recommendation	Additional Info
Non-Specialty Drugs				
(1) SUTAB	SOD SULF/POT CHLORIDE/MAG SULF	Colon Cleansing	Exclude, Code 13	Multiple generic and OTC alternatives
(2) PFIZER COVID 19 VACCINE	COVID-19 VACC, MRNA(PFIZER)/PF	COVID-19	Cover	Administration fee only ($22.70)
(3) MODERNA COVID 19 VACCINE	COVID-19 VACC, MRNA(MODERNA)/PF	COVID-19	Cover	Administration fee only ($22.70)
(4) OLINVYK	OLICERIDINE FUMARATE	Acute Pain	Exclude from Pharmacy; Code 13; N/A Medical	Multiple generic alternatives available
Specialty Drugs				
(1) CASIRIVIMAB (REGN10933) (EUA)	CASIRIVIMAB (REGN10933)	COVID-19	N/A Medical; Cover pharmacy if applicable	These medications do not have a cost other than the cost to administer. Most likely to be given through medical benefit.
(2) IMDEVIMAB	IMDEVIMAB (REGN10987)	COVID-19	N/A Medical: Cover pharmacy if applicable	
(3) BAMLANIVIMAB (EUA)	BAMLANIVIMAB	COVID-19	N/A Medical: Cover pharmacy if applicable	

The DUEC voted to adopt the recommendations as presented.

MOTION by Dr. Kirtley:
I make a motion to accept the DUEC recommendations as presented.
Dr. White seconded. All were in favor.

Discussion:
Dr. Fiddler: What is the administrative cost of these drugs? I think that is more than what general pharmacies get or what administrations costs are in the public. Why is that more per dose?

Dr. Simmons: It was my understanding that it was an average. Let me deflect Dr. Fiddler's question to Dr. Bard, who is much more familiar with the calculations.

Dr. Bard: The rates were published by CMS as the recommended rates. There was a different rate for the first and second dose, and MedImpact was not able to program the different rates. So, we took the two and added them together, and then divided by two to come to that administration rate.

Dr. Fiddler: So, the second dosage is 60%-70% more than the first dose, so it averages out to the $22.

Dr. Bard: Yes, the first dose was recommended to be $16, and the second dose was recommended to be $28.

Motion Approved.

COVID Update by Mike Motley, ACHI

Montgomery and Motley presented updated analyses regarding COVID-19 impact on the plan and reviewed preliminary analyses of the bariatric surgery program.

Discussion:

Mallory: Is there a way to do a return on investment for the bariatric surgeries that we've done?

Motley: We have looked at that in the past, 2019 and 2017 as well. What we have found is that in terms of offset future expenditures, the ROI is not really there in terms of that in a near term sense, but the quality of life and health improvement for the members seems to be there in terms of average BMI point reduction and somewhat improves coexisting conditions. We looked at a number of prescriptions for diabetes and things like that, and we did see a reduction in those.

Subcommittee Updates by Shalada Toles, EBD Deputy Director

Toles provided a brief update on the subcommittees with one caveat. The Quality of Care subcommittee made a motion to recommend to the Board to remove one of the bullet points from the bariatric surgery program. On slide 21 of ACHI's presentation, the committee voted to remove the first part of the fourth bullet point.

Topics Discussed:

- Approval of Minutes
- COVID Update by ACHI
- Trend Experience by Milliman
- Director's Report

Discussion:

Mallory: Can you provide some discussion on that?

Toles: The discussion was that people qualify for this surgery because they have not been able to prove that they are able to lose weight or maintain a weight loss.

Mallory: So, just because they can't lose weight before the surgery is not an indicator of not being able to lose weight after the surgery.

Toles: Yes.

Dr. Fiddler: The discussion was basically that the whole bullet point was going to be taken out, but after going back and forth, it came down to just part of the bullet point being removed. It was not specific enough as to what, how, and when it would be accomplished during that time. There wasn't much argument over it other than saying it was redundant in the discussion.

Dunlap: So, are you taking away the whole bullet point or just changing part of it?

Toles: The motion by Dr. Kahn states, "I motion that we recommend to the Board that we remove the first half of the fourth bullet on the 2021 bariatric requirements." So, up until the semicolon on the fourth bullet point.

Dr. Kirtley: so, it would erase, "Records must document compliance with the program and must show progress of weight loss or no net weight gain." Historically, there used to be a whole psychiatric evaluation for this, but then we found that no one had ever failed the evaluation, so we removed that requirement.

MOTION by Dr. White:

I move to accept the committee's recommendation to remove the first part of bullet four under the requirements.

Dunlap seconded. All were in favor.

Motion Approved.

Director's Report by Shalada Toles, EBD Deputy Director

Toles stated that, as previously mentioned by Milliman, we will be following up with any of the Board members who have not had an opportunity to log into the Milliman training portal. Rhoda and I will be working with you to make sure you have that access. Each year the Board votes on the stipend and travel reimbursement policy. We did not do that for 2020. We need to do that for 2020 and 2021 today.

MOTION by Dr. Kirtley:

I make a motion to adopt the Board stipend and travel reimbursement policies for 2020 and 2021.

Scott seconded. All were in favor.

Motion Approved.

Hiring Process

Toles recognized Mitch Rouse, legal counsel for TSS, to discuss the hiring process.

Rouse stated that the Board will be going into Executive Session to conduct the interviews of the viable candidates that have been identified by the subcommittee. The subcommittee was formed by this Board and set parameters for the interview process. Initially, we thought that with it being a high-level position, it would not need to be advertised but we only received one or two. After the subcommittee decided to advertise the position through ARCareers and we received seven applications. Of those seven, the subcommittee determined that only three of those applicants were viable candidates. Of the three viable candidates, only two of them will be interviewing during the Executive Session because one of them withdrew their application. The Executive Session will be two 30-minute interviews and following with this Board discussing those candidates. The Executive Session will start with saying that you are entering the Executive Session and then going offline to

conduct the interviews. You will then rank the candidates once the interviews are completed. When you exit, you will go into another public session and vote on what you discussed. That ranking will then go to Secretary Fecher, and she will use that to decide on our next EBD Director.

Dr. Fiddler: We have seen in this last hour how involved this position requires, and our interim is doing a very good job. I have only been on this Board for three years, so I don't have a longevity standard by this at all. At first, we couldn't get anyone to apply, and as I have previously asked, why have we not done this in a public situation? As you just noted, it went to the Arkansas listing of positions and received seven. Now we are down to three, one of whom removed himself. My first question is, is the subcommittee obligated to make a choice, or can they make the decision that they need to reopen the position?

Rouse: Speaking for the subcommittee, I would say that the subcommittee has made the decision to proceed and made the decision of the viable candidates that were available to be interviewed by the Board. I am not sure that opening it back up will really change anything as far as moving forward. These are the candidates that have applied, met MQ's, and were viable. The purpose of the subcommittee was to make sure that the best candidates were presented to the Board as opposed to the Board having to go into several Executive Session to work through everything.

Dr. Fiddler: I am not faulting the subcommittee. My point is you have seen how much is necessary to be an EBD Director of this group. If those two people don't have the background or knowledge, and all you have to go on right now is their resume.

Mallory: That's the purpose of the Board actually doing the interviews, and then we will get in a room and discuss how we feel and what we think. After, we will come out and we may decide that we don't want either one of them. We can do that as the Board.

Dr. Fiddler: That was my first question as I begin this discussion.

Mallory: I think it was taken as whether or not we should go forward with these two candidates and the answer to that is yes. We need to finish this process.

Dr. Fiddler: So, once the process is finished does it necessitate that there has to be a selection of one these two people?

Lilly-Palmer: In this process, when you post a position, it is open for five days. Typically, with these positions you don't get a whole plethora of applicants anyway. The applicant pool was narrowed down due to the job description. When those applicants come in, they go through a minimum qualification process to make sure that the qualifications are met. We did only have seven, one of which did not meet the MQ's. As a subcommittee, we rank those applicants and decide who we will interview. After the interview, if we decide that they have not met the criteria we are looking for even though they met minimum qualifications, then we can go back to the drawing board. That is how all the job processes work in the state. This isn't just singular to this particular position.

Dr. Fiddler: Yes, I just wanted to make sure. I certainly go on the position of what our subcommittee thinks. My point was if they met minimum qualifications but didn't meet our requirements, was it an option to select neither. Right now, we seem to be making our way. This person that comes in has to know a whole lot more than I know, because I get lost in this every time we have a Board meeting. I need someone to be able to turn to, and that understands what we are going into as an EBD Board.

Mallory: That is what our questions are for, and hopefully, we will know what the capabilities are once we get done with those interviews, and we will be able to discuss that very thing.

Dr. Kirtley: I think that both the committee and the full Board are committed to not sending names to Secretary Fecher that we do not expect to be successful in this position. That would not serve EBD and/or Secretary Fecher any good if we were putting forth candidates that we did not feel were truly viable candidates that could accomplish this job.

Mallory: If it takes going back to the drawing board that is what we will do.

Secretary Update

Toles recognized Secretary Fecher.

Secretary Fecher provided a legislative update. The legislature is very interested in our financial situation in expecting deficit. They are having regular meetings with me on possibilities. Milliman has also been very involved in that, and the legislature has asked for specific requests from them, and we are providing that information. I do not have any indication of where that will go at this point. Hopefully, by the next Board meeting, we will know more and will be able to report that to you. On the previous discussion regarding our next EBD Director, while I do appreciate you saying that everything is going very well without a director in that seat and that is in great part to Shalada and the team at EBD, it has been very intensive, especially with the situation that we are in as well as legislative session. If there is a qualified viable candidate that the Board sees fit to move forward, I do believe we need a person in the director's seat that can dig in and lead this division and everything we will be going through this year. If there is not a viable candidate that you move forward, I would just encourage everyone with haste to try and find that candidate to move forward because it has become a big responsibility that we are working on. We want someone in there as soon as possible that can take those reigns and really lead the division as we go forward.

MOTION by Lilly-Palmer:

I make a motion to adjourn the meeting.

Dr. White seconded. All were in favor.

Meeting Adjourned.

State of Arkansas Employee Benefits Division

Interim Monitoring Report

Through December 31st

State and Public School Life and Health Insurance Board of Directors

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

26 JANUARY 2020

Milliman

Agenda

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

Arkansas State Employees (ASE)

Executive Summary

- 2021 & 2022 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through December 2020 and pharmacy claims data incurred from November 2019 to October 2020 and paid through December 2020. 2020 reflects actual claims paid.
- 2020 projected plan experience
  - Allocation of Prior Years' Surplus for 2020: $25.1M
  - Estimated surplus of $1.2M (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2020: $9.6M
  - No plan changes / 5% increase in employee contributions
- 2021 projected plan experience
  - Allocation of Prior Years' Surplus for 2021: $14.5M
  - Projected deficit: -$400K (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2021: $9.2M
  - Reflects 2021 program initiatives and board decisions
  - Increased membership based on historical patterns
  - Baseline trends (medical: 5%, pharmacy: 8%)

Executive Summary

- 2022 projected plan experience
  - Allocation of Prior Years' Surplus for 2022: $6.1M
  - Estimated deficit of -$32.8M (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2020: -$23.6M
  - Reflects baseline scenario
  - No plan design or contribution changes
  - Baseline trends (medical: 5%, pharmacy: 8%)

Total Plan Experience

Funding	2020	2021	2022
State Contribution	$ 172.24	$ 184.48	$ 184.48
Employee Contribution	99.01	111.29	111.81
Other	21.65	21.80	21.95
Total Income	$ 292.91	$ 317.57	$ 318.25
Medical Claims	$ (205.71)	$ (219.54)	$ (234.31)
Pharmacy Claims	(90.92)	(100.01)	(109.85)
Administration Fees	(17.42)	(17.53)	(17.66)
Plan Administration	(2.79)	(2.81)	(2.91)
Total Expenses	$ (316.83)	$ (339.89)	$ (364.73)
Program Savings	$ -	$ 7.50	$ 7.60
Net Income / (Loss) Before Reserve Allocation	$ (23.93)	$ (14.82)	$ (38.88)
Allocation of Reserves	$ 25.08	$ 14.46	$ 6.07
Net Income / (Loss) After Reserve Allocation	$ 1.16	$ (0.36)	$ (32.81)

Average Membership			
Active Employees / Pre-65 Retirees	46,614	46,614	46,614
Post-65 Retirees	13,746	14,158	14,583
Total Enrolled	60,360	60,772	61,197

Total Income PMPM[1]	$ 439.02	$ 455.29	$ 441.63
Total Expenses PMPM[2]	$ (437.43)	$ (455.79)	$ (486.31)

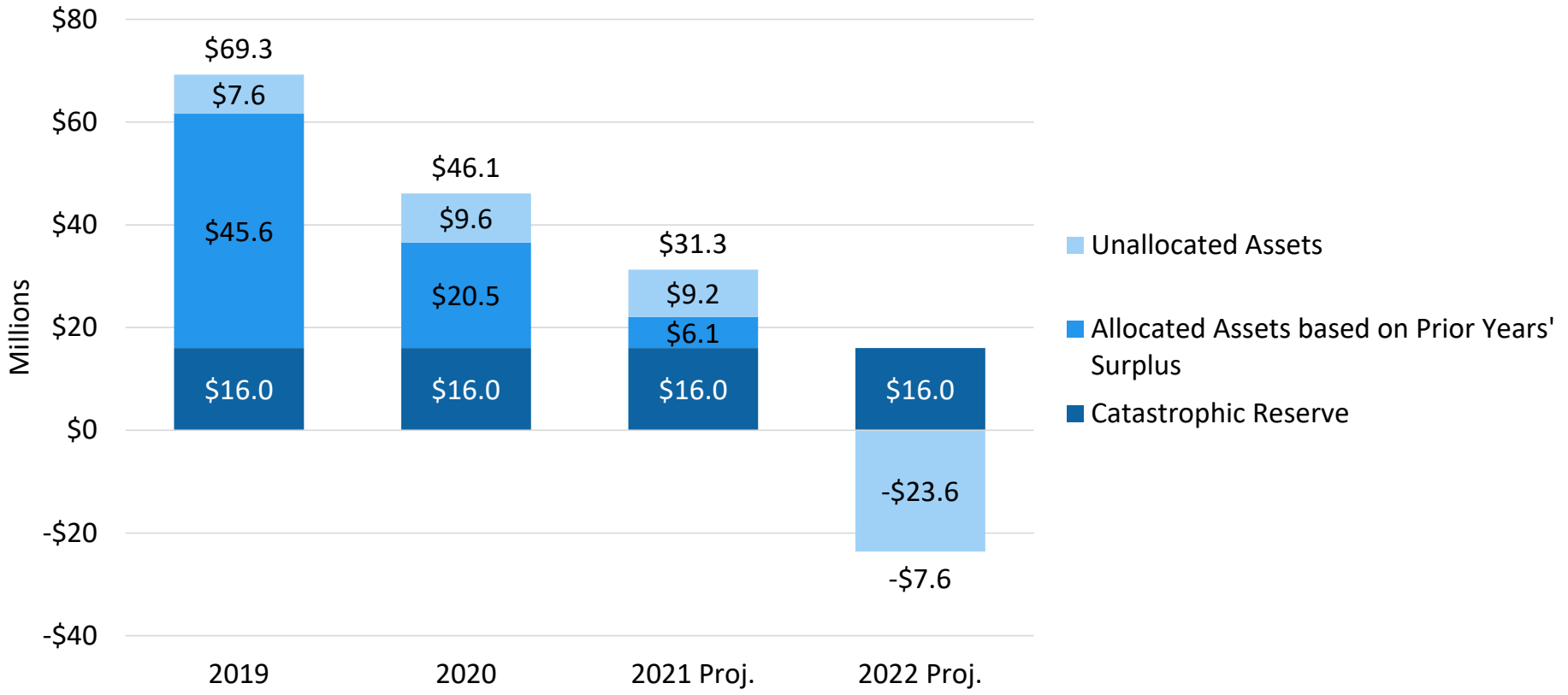
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Program Savings

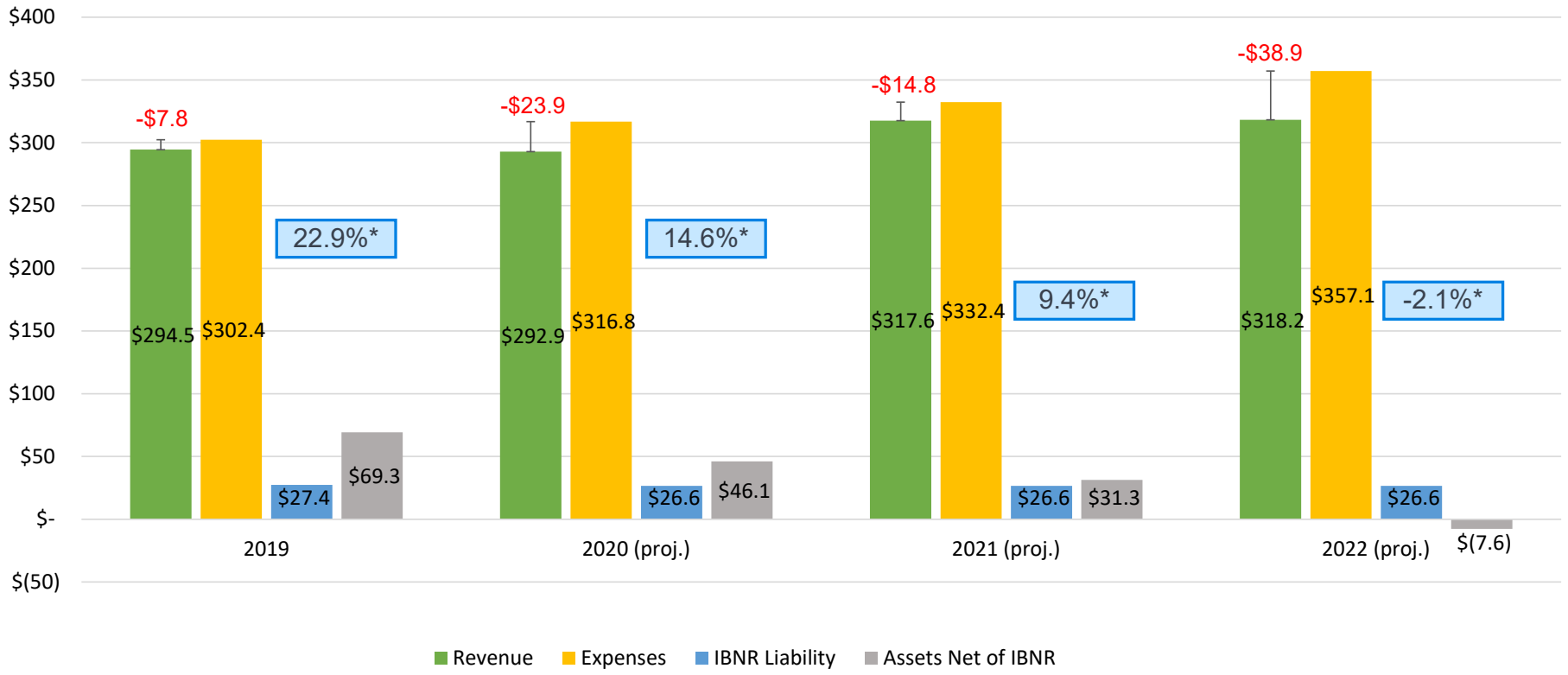
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
			Assets
(a)	Proj 2020	End-of-Year Gross Assets	$72.7
(b)	2021	Allocation of Prior Years' Surplus	($14.5)
(c)		Total Surplus / (Deficit)	($0.4)
(d) = (a) + (b) + (c)		End-of-Year Gross Assets Available	$57.9
(e)		Incurred but not reported (IBNR)	($26.6)
(f) = (d) + (e)		End of Year Net Assets Available	$31.3
(g)	2022	Allocation of Prior Years' Surplus	($6.1)
(h)		Total Surplus / (Deficit)	($32.8)
(i) = (d) + (g) + (h)		End-of-Year Gross Assets Available	$19.0
(j)		Incurred but not reported (IBNR)	($26.6)
(k) = (i) + (j)		End of Year Net Assets Available	($7.6)

End of Year Assets Net of IBNR

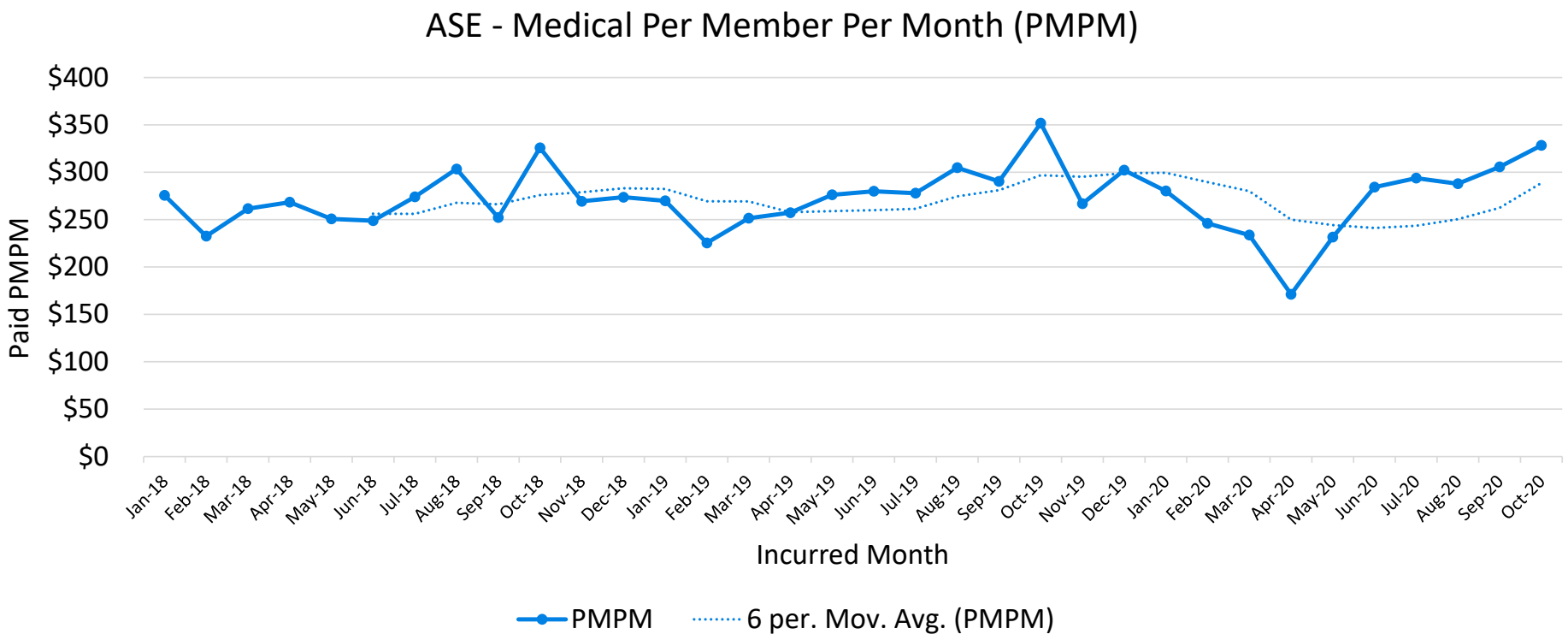


Change in Revenue, Expenses, and Assets

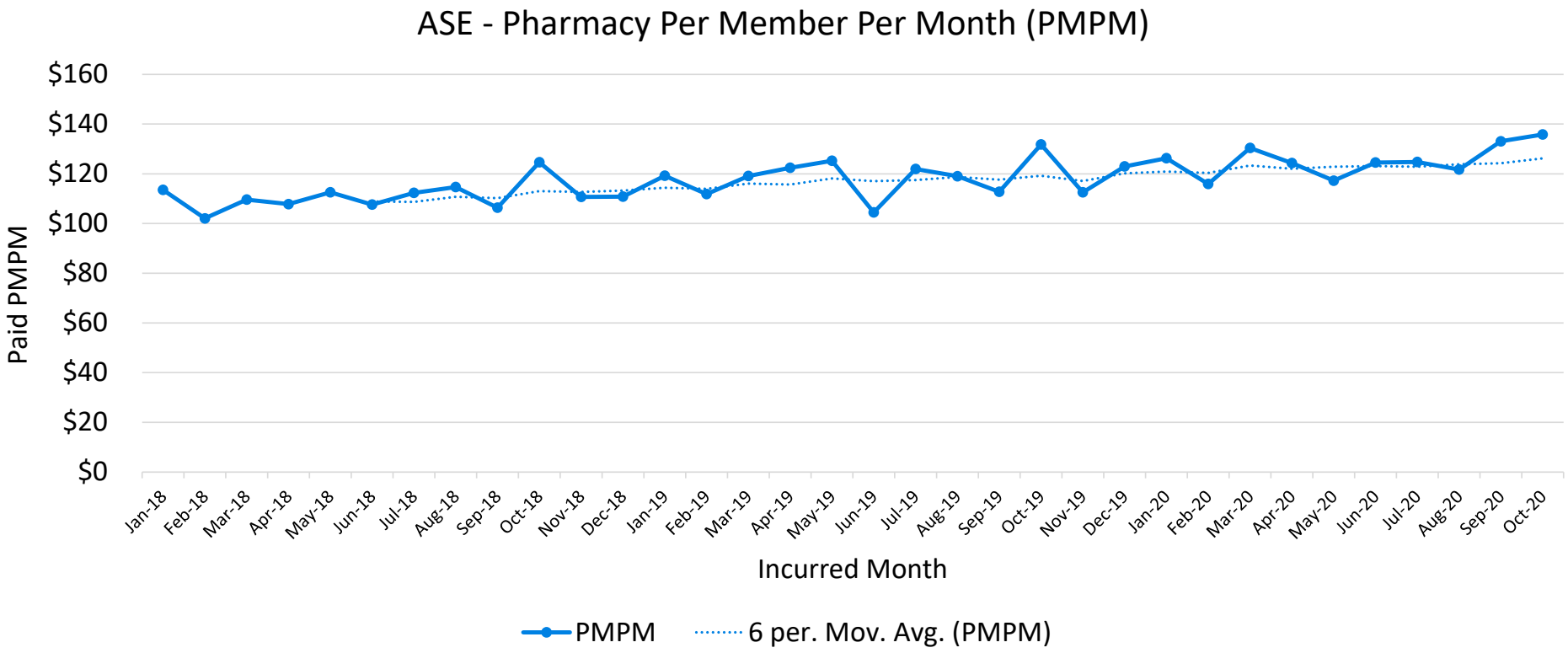


* Assets Net of IBNR as a portion of Expenses

Monthly Trend - Medical



Monthly Trend - Pharmacy



Public School Employees (PSE)

Executive Summary

- 2021 & 2022 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through December 2020 and pharmacy claims data incurred from November 2019 to October 2020 and paid through December 2020. 2020 reflects actual claims paid.
- 2020 plan experience
  - Allocation of Prior Years' Surplus for 2020: $25.3M
  - Estimated deficit of -$200K (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2020: $5.5M
  - No plan changes / 0% increase to employee contributions
- 2021 projected plan experience
  - Allocation of Prior Years' Surplus for 2021: $15.5M
  - Projected deficit: -$22.7M (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2021: -$17.3M
  - Reflected 2021 program initiatives and board decisions
  - Increased membership based on historical patterns
  - Baseline trends (medical: 7%, pharmacy: 8%)

Executive Summary

- 2022 projected plan experience
  - Allocation of Prior Years' Surplus for 2022: $7.1M
  - Estimated deficit of -$66.2M (after prior years' surplus allocation)
  - End of Year Unallocated Assets for 2020: -$83.5M
  - Reflects baseline scenario
  - No plan design or contribution changes
  - Baseline trends (medical: 7%, pharmacy: 8%)

Total Plan Experience

Funding	2020	2021	2022
PPE Funding	$ 105.10	$ 108.61	$ 112.24
Employee Contribution	123.89	138.68	143.03
Dept of Ed Funding	88.10	108.10	108.10
Other	14.88	15.38	15.89
Total Income	$ 331.98	$ 370.76	$ 379.27
Medical Claims	$ (259.30)	$ (308.71)	$ (343.25)
Pharmacy Claims	(67.43)	(74.02)	(82.07)
Administration Fees	(28.11)	(29.12)	(30.10)
Plan Administration	(2.54)	(2.63)	(2.80)
Total Expenses	$ (357.39)	$ (414.48)	$ (458.22)
Program Savings	$ -	$ 5.50	$ 5.66
Net Income / (Loss) Before Reserve Allocation	$ (25.41)	$ (38.22)	$ (73.29)
Allocation of Reserves	$ 25.25	$ 15.48	$ 7.05
Net Income / (Loss) After Reserve Allocation	$ (0.15)	$ (22.74)	$ (66.24)

Average Membership			
Active Employees / Pre-65 Retirees	84,211	86,618	89,097
Post-65 Retirees	15,006	15,907	16,861
Total Enrolled	99,217	102,524	105,957

Total Income PMPM[1]	$ 300.04	$ 313.94	$ 303.83
Total Expenses PMPM[2]	$ (300.17)	$ (332.43)	$ (355.93)

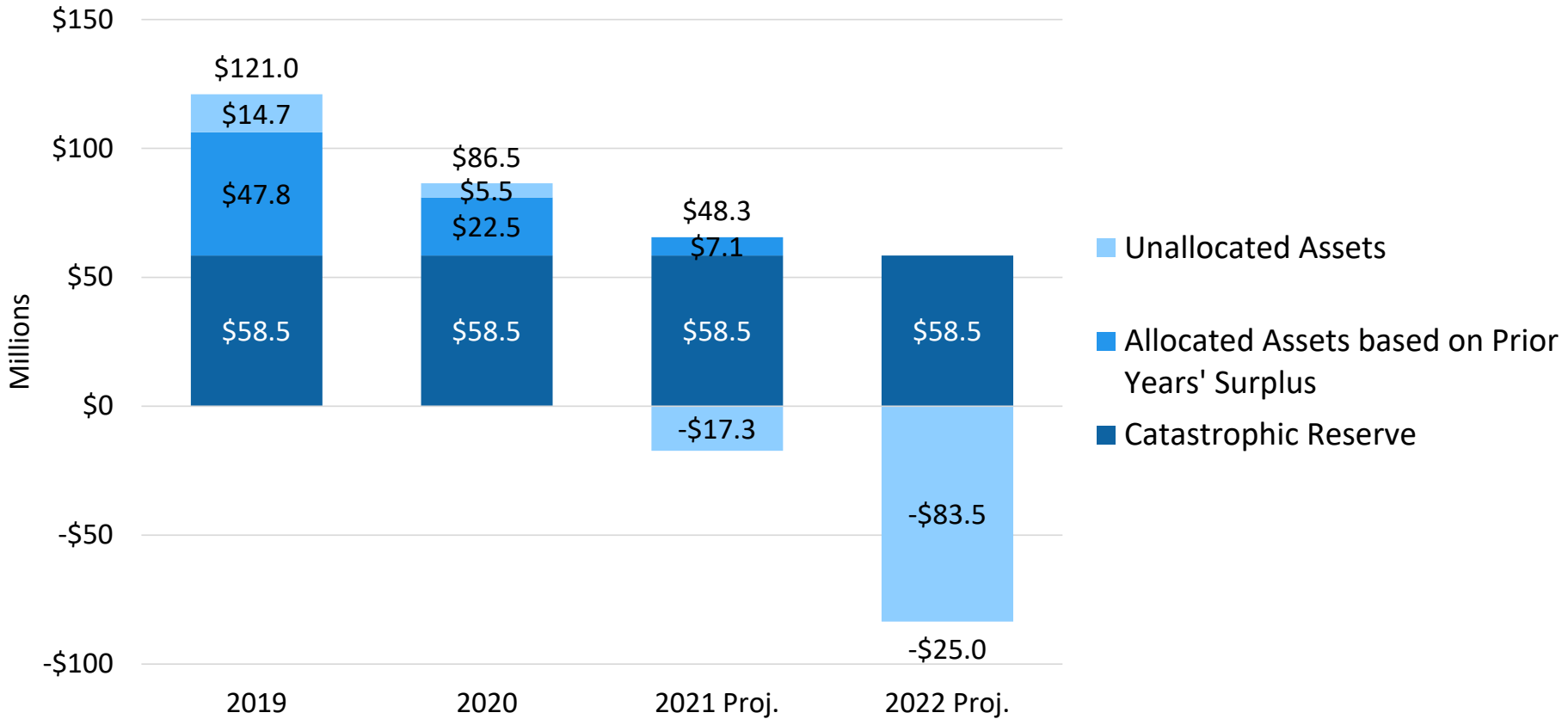
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Program Savings

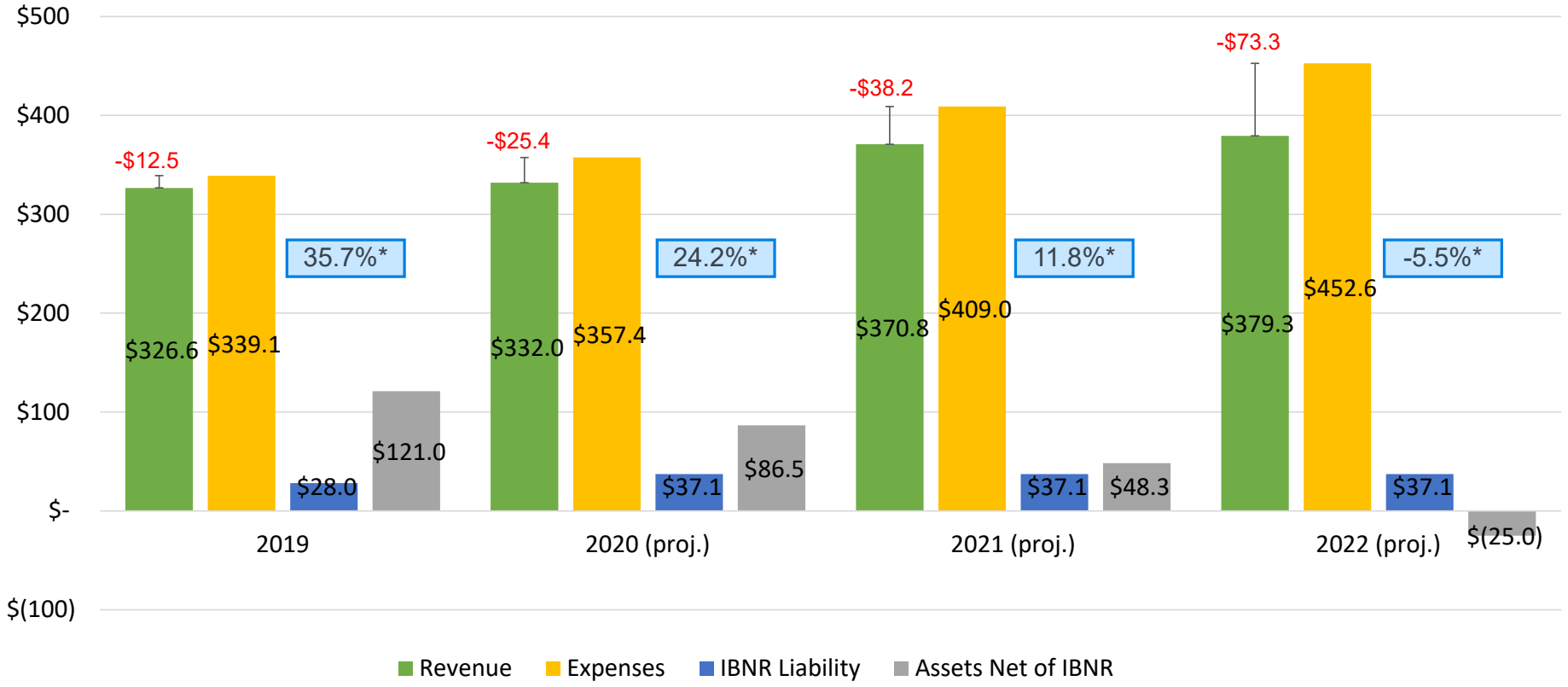
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets ($millions)			
			Assets
(a)	Proj 2020	End-of-Year Gross Assets	$123.6
(b)	2021	Allocation of Prior Years' Surplus	($15.5)
(c)		Total Surplus / (Deficit)	($22.7)
(d) = (a) + (b) + (c)		End-of-Year Gross Assets Available	$85.4
(e)		Incurred but not reported (IBNR)	($37.1)
(f) = (d) + (e)		End of Year Net Assets Available	$48.3
(g)	2022	Allocation of Prior Years' Surplus	($7.1)
(h)		Total Surplus / (Deficit)	($66.2)
(i) = (d) + (g) + (h)		End-of-Year Gross Assets Available	$12.1
(j)		Incurred but not reported (IBNR)	($37.1)
(k) = (i) + (j)		End of Year Net Assets Available	($25.0)

End of Year Assets Net of IBNR

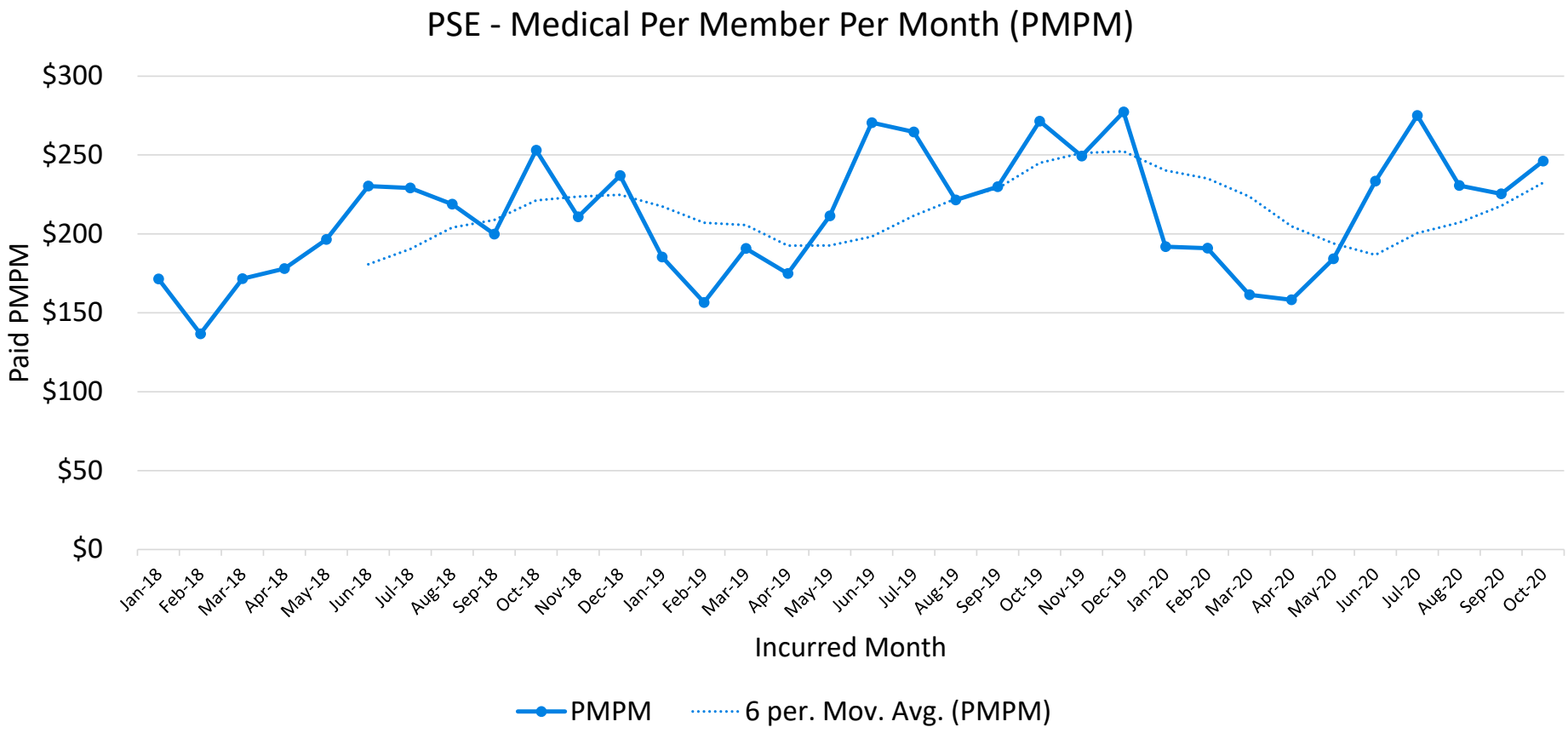


Change in Revenue, Expenses, and Assets

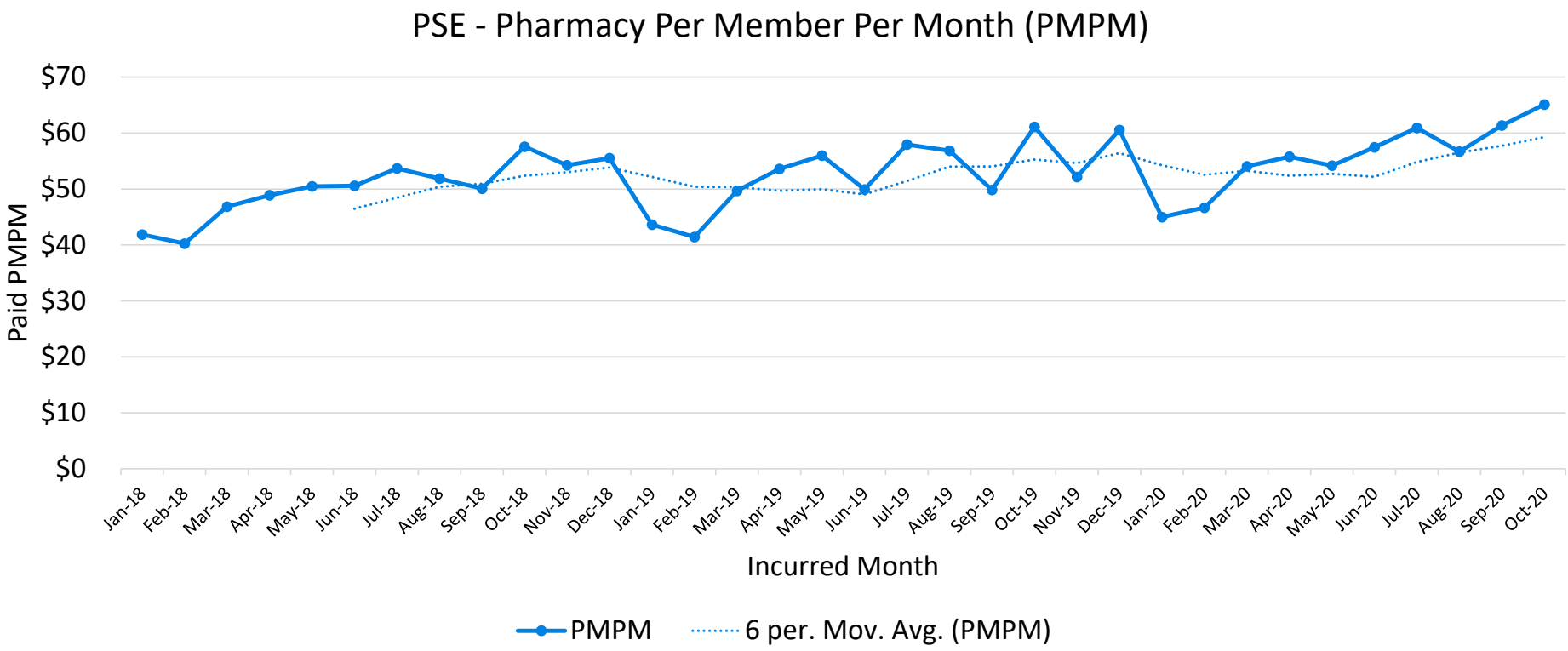


* Assets Net of IBNR as a portion of Expenses

Monthly Trend - Medical

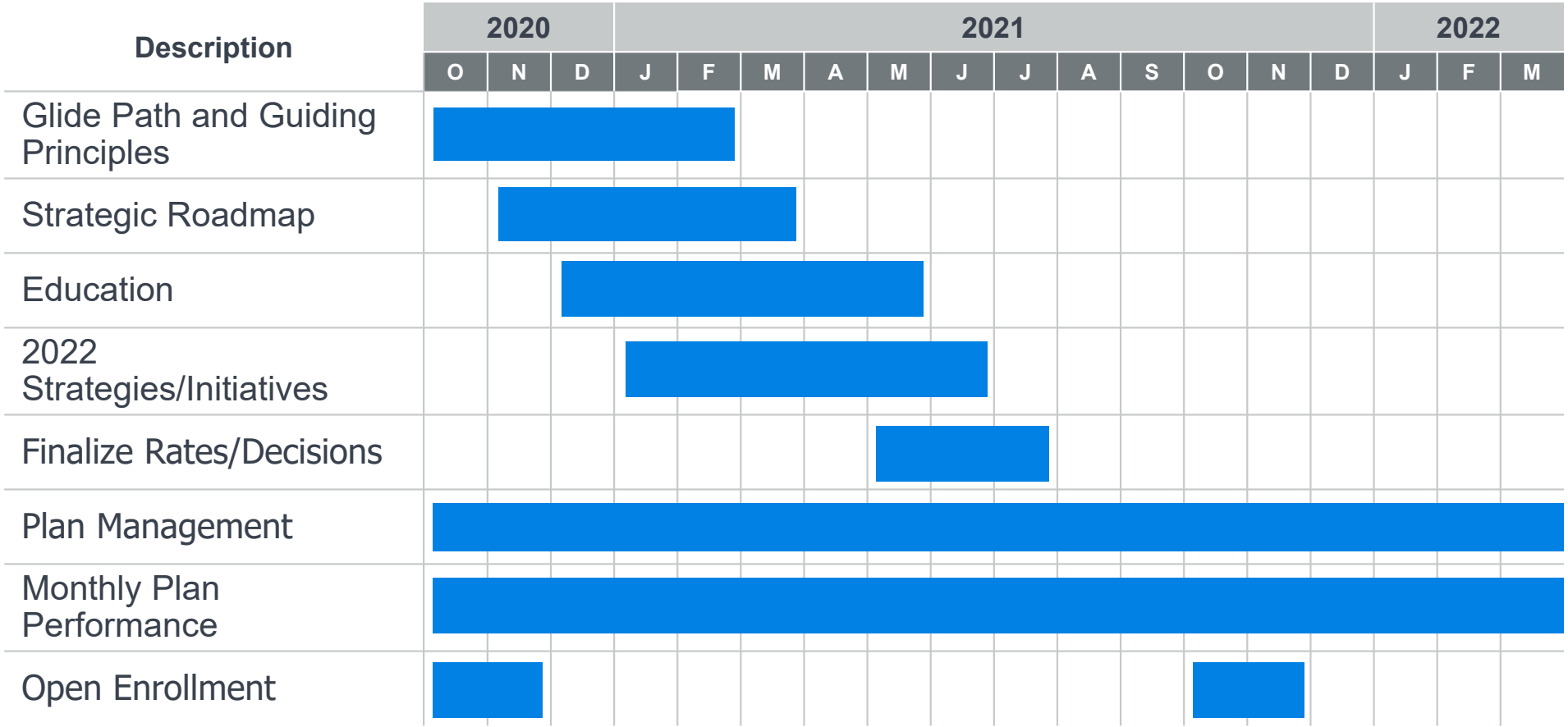


Monthly Trend - Pharmacy

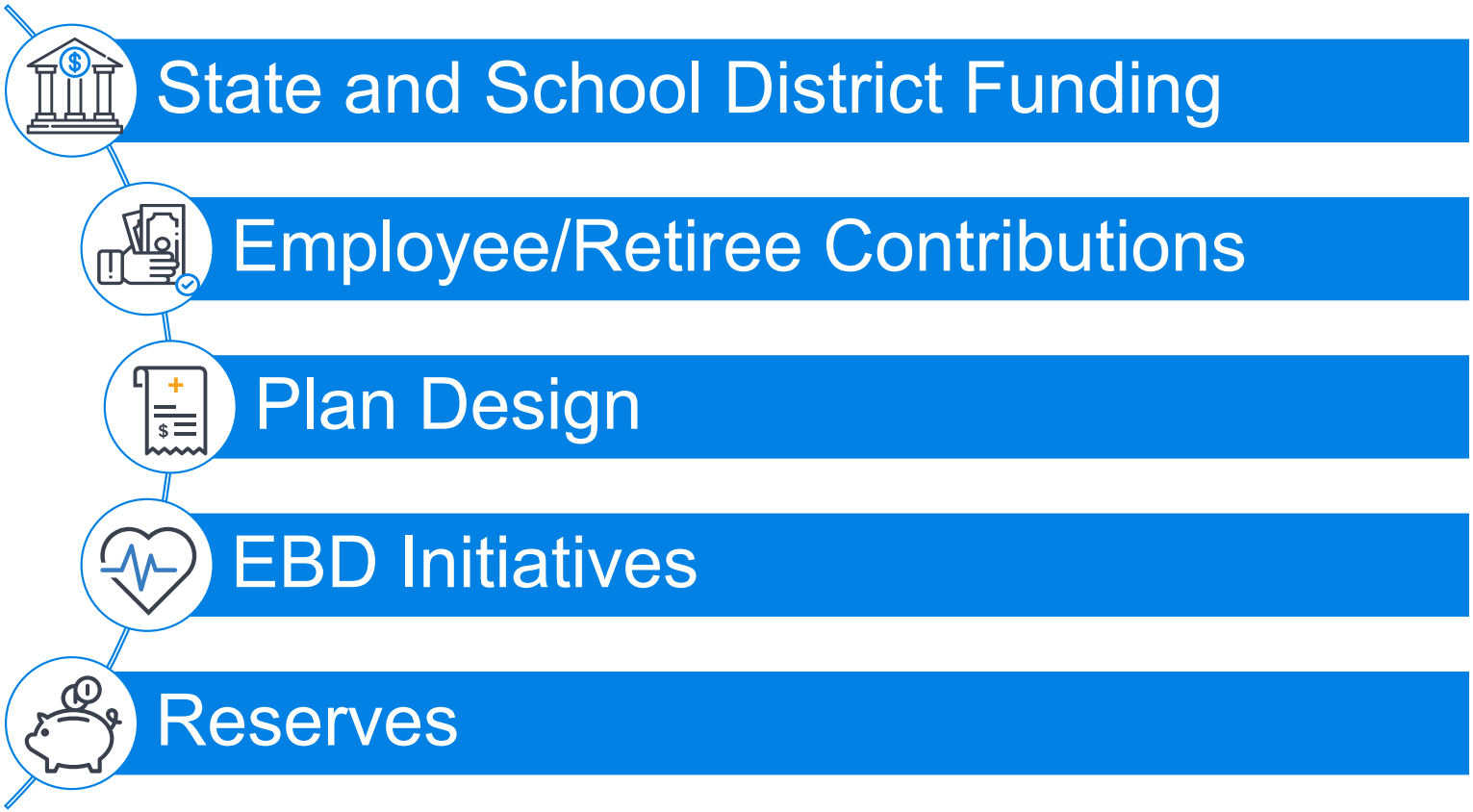


2021 Roadmap

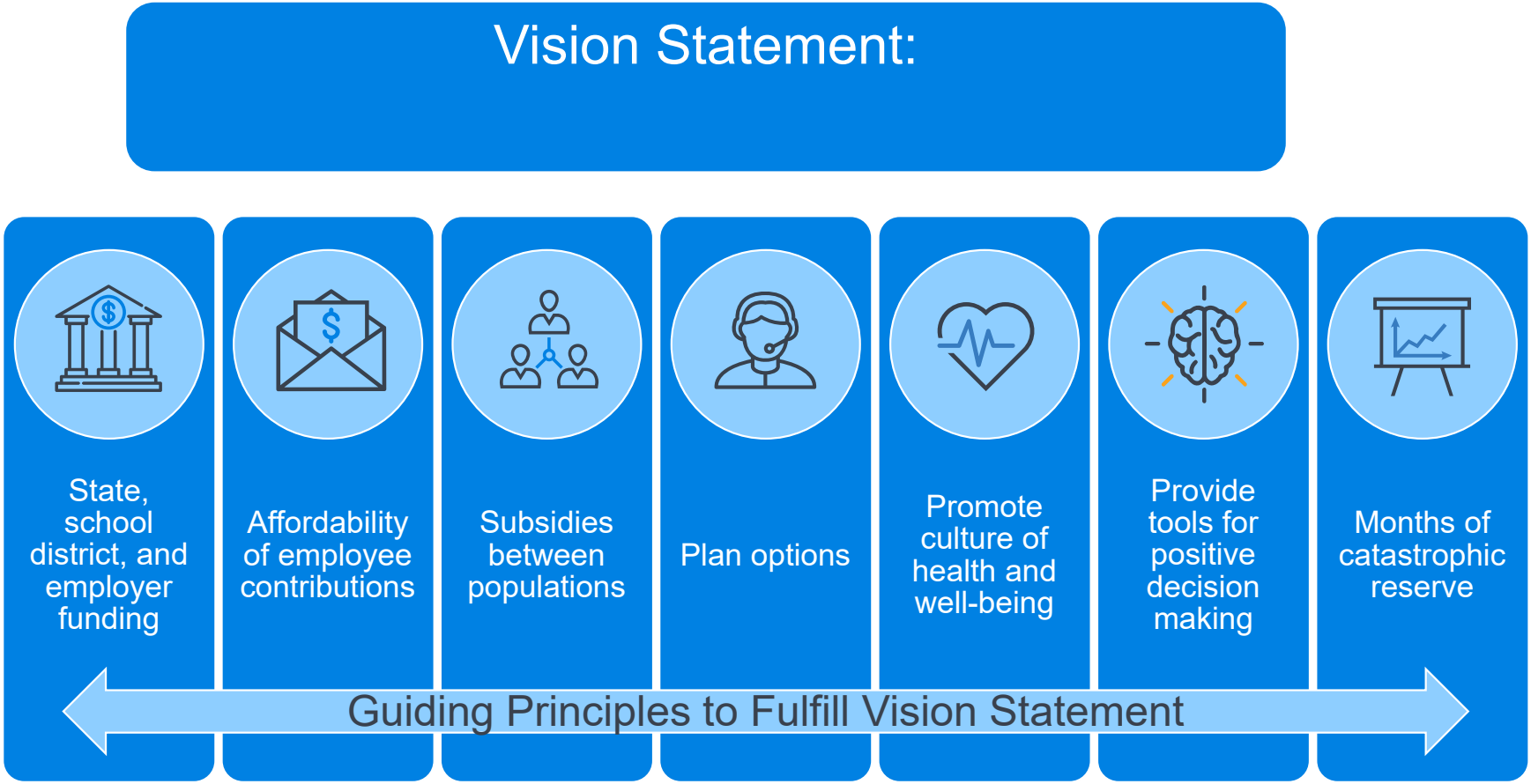
Timeline: Gantt chart



Budget Levers



Guiding Principles - *ILLUSTRATION*



Milliman

Thank you

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

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 December 2020
  - Projected January 2021 – December 2022 based on historical patterns
- Program Savings
  - 2021 program savings estimated to be $7.5 million for ASE and $5.5 million for PSE
  - 2022 program savings estimated to be $7.6 million for ASE and $5.7 million for PSE
- 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%

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 December 31, 2020. 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 November 1, 2019 to October 31, 2020 and paid from November 1, 2019 to December 31, 2020.
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 1, 2019 to February 29, 2020 (medical) and November 1, 2019 to October 31, 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.

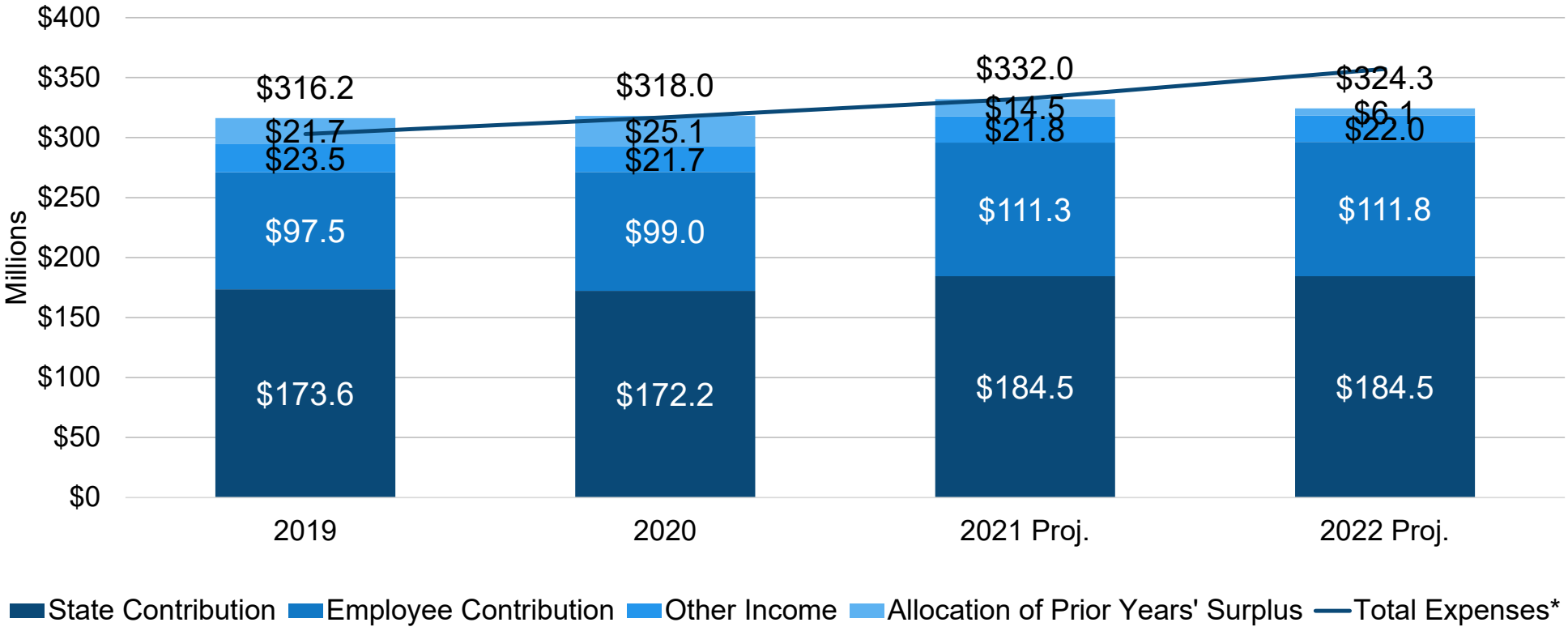
Any reader of this report should possess a certain level of expertise in areas relevant to this analysis to appreciate the significance of the assumptions and the impact of these assumptions on the illustrated results. The reader should also be advised by their own actuaries or other qualified professionals 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.

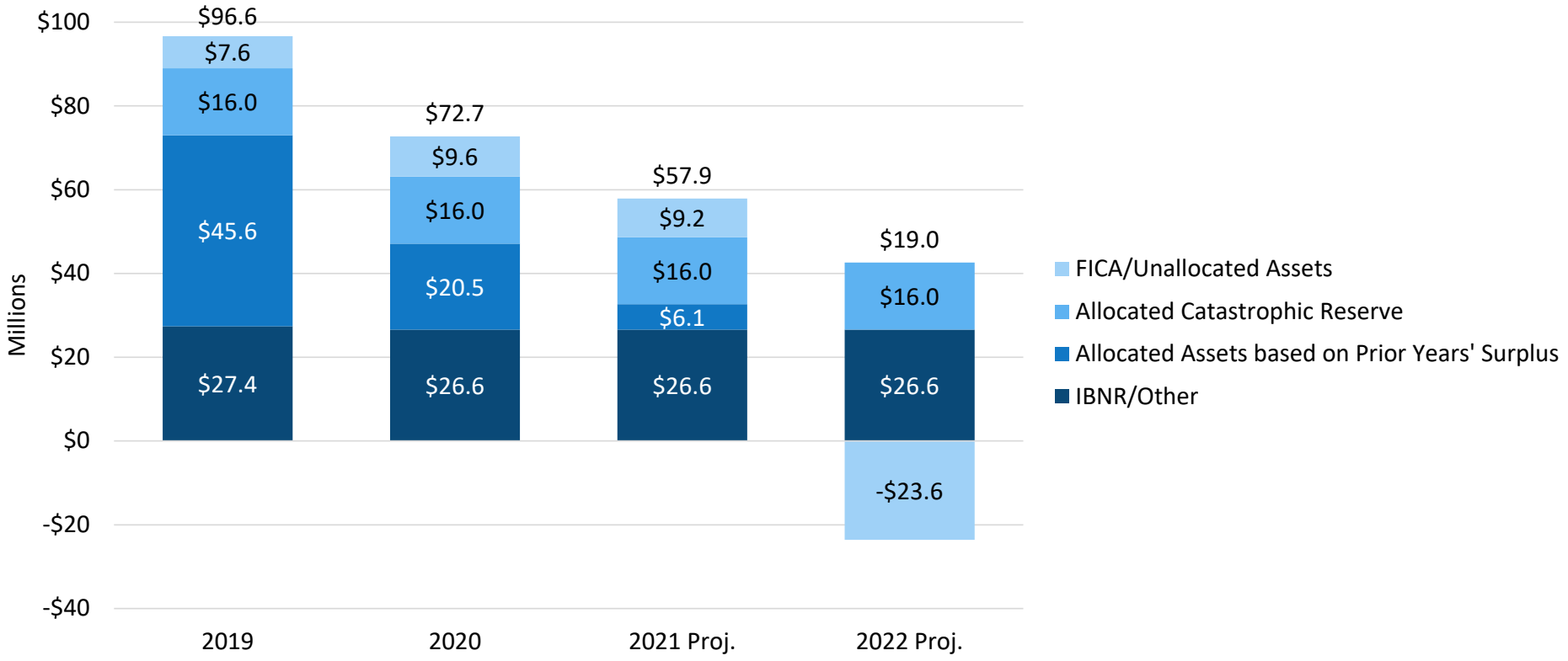
Appendix

ASE - Income vs. Expenditure

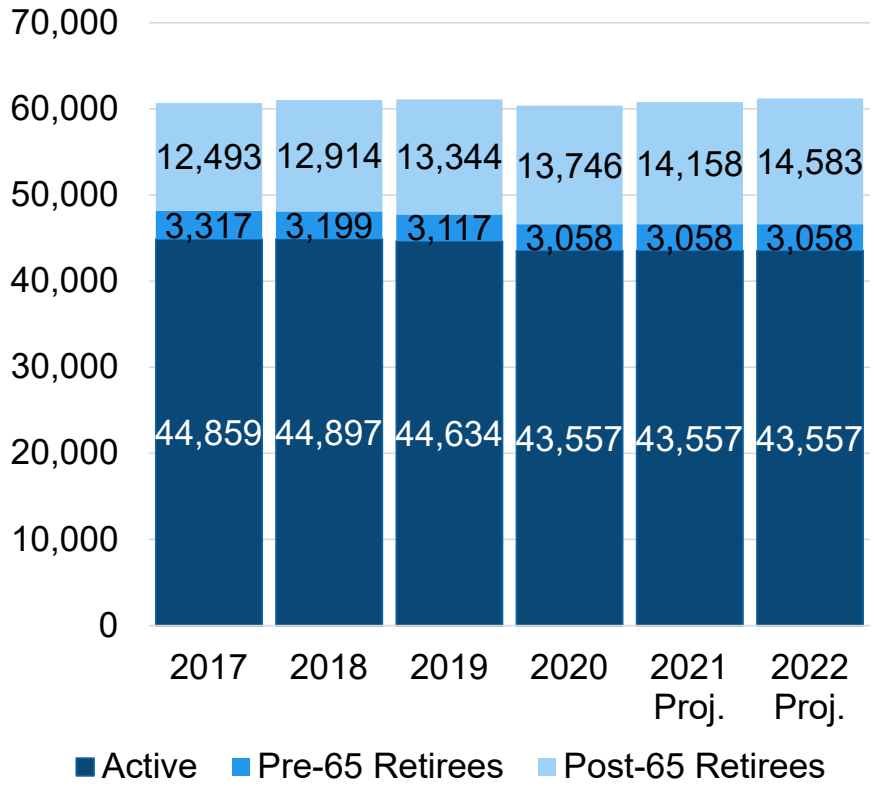


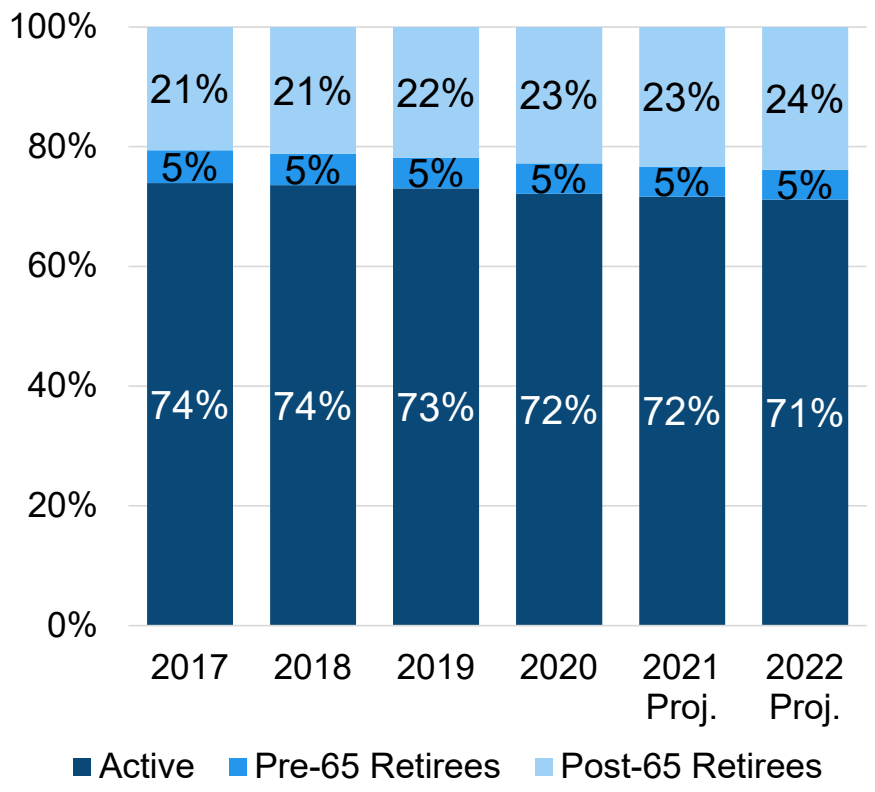
* Total Expenses offset by Program Savings

ASE - End of Year Assets

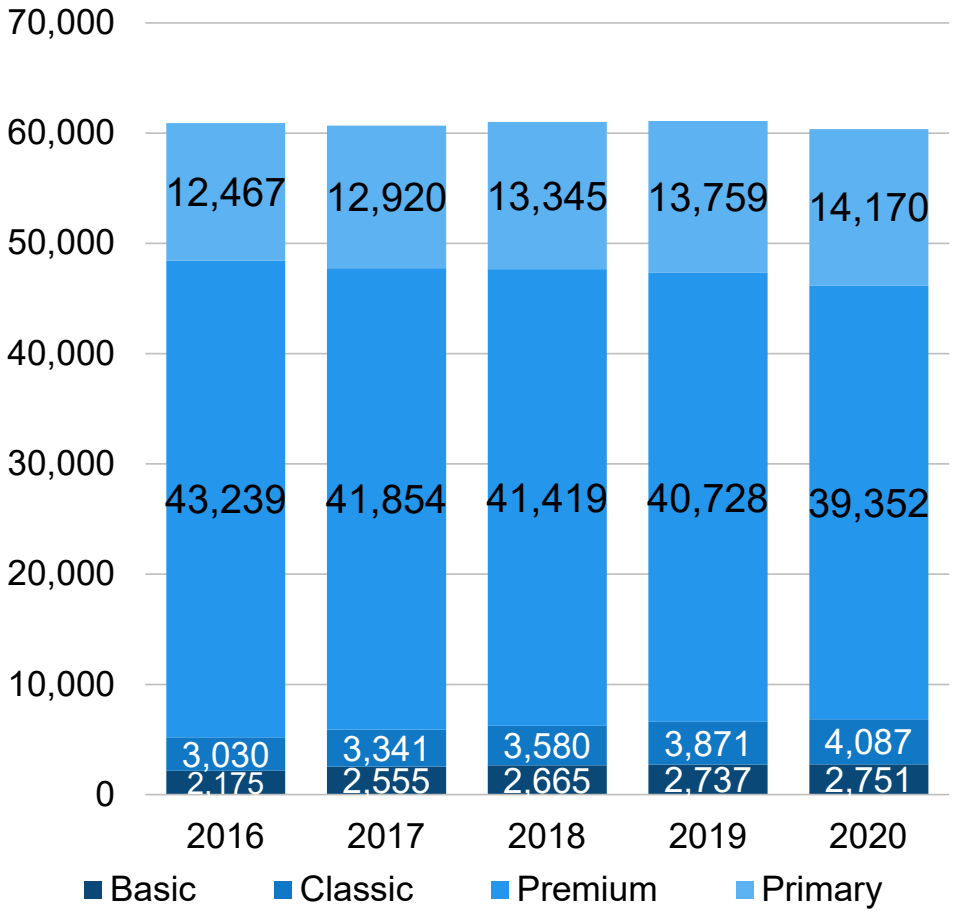


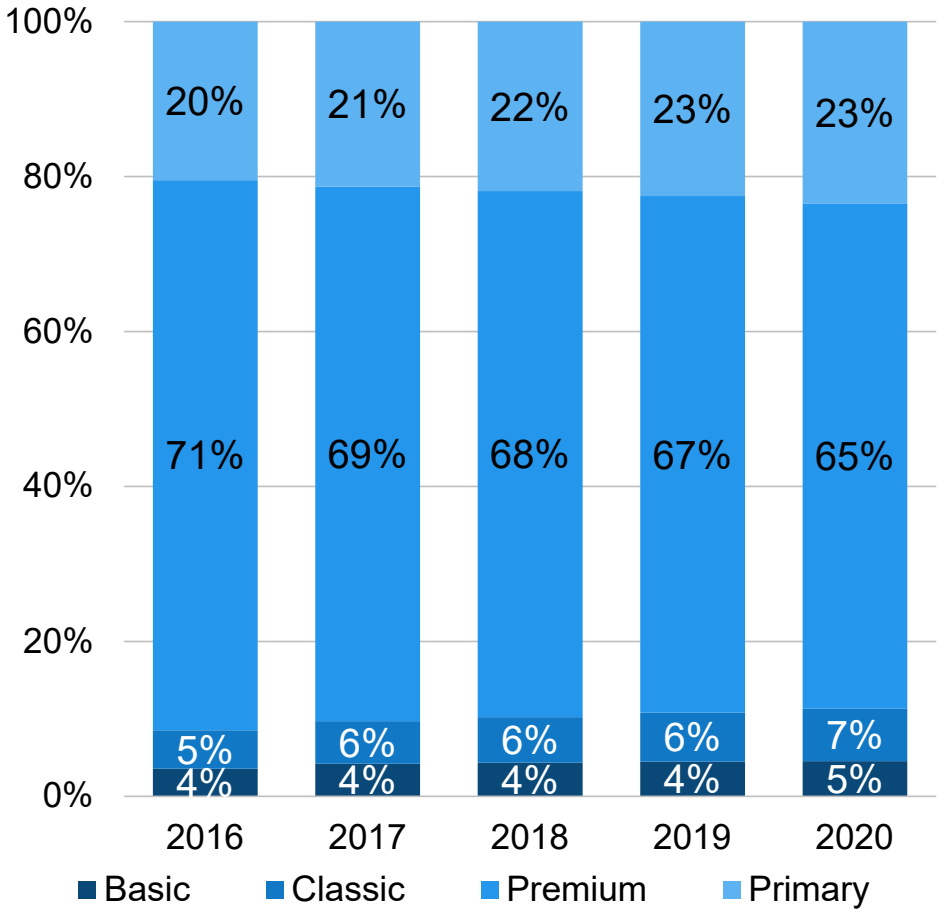
ASE - Average Membership by Status





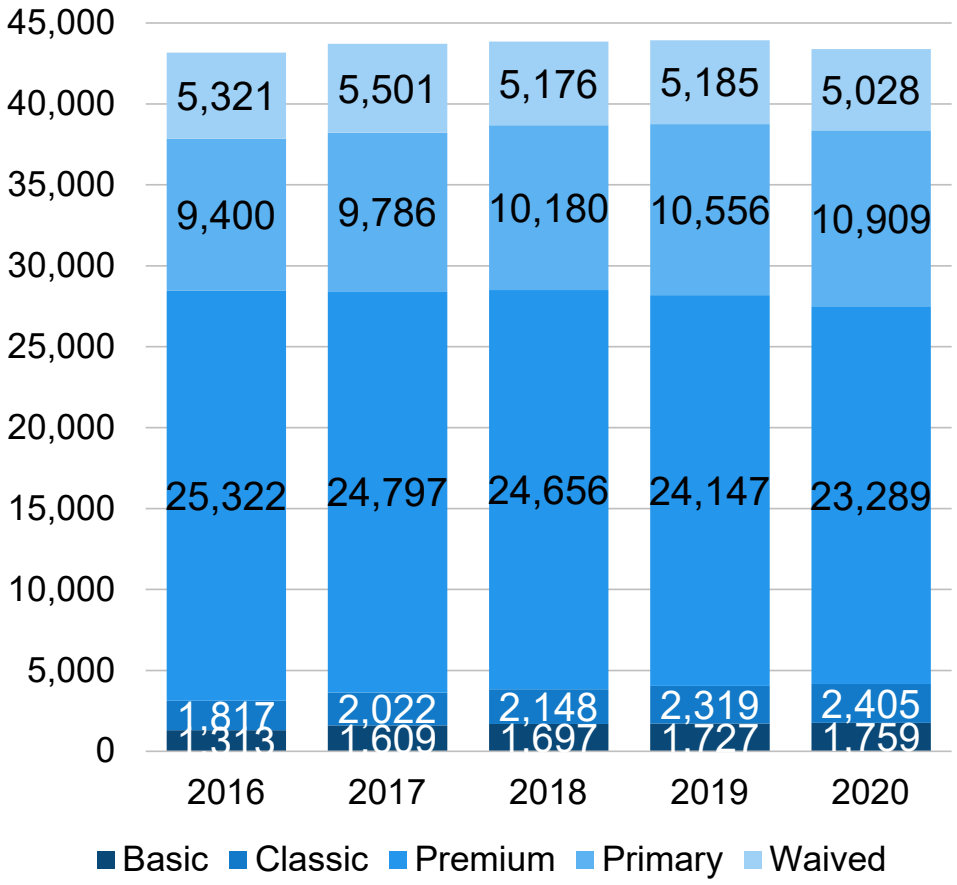
ASE - Average Membership by Plan

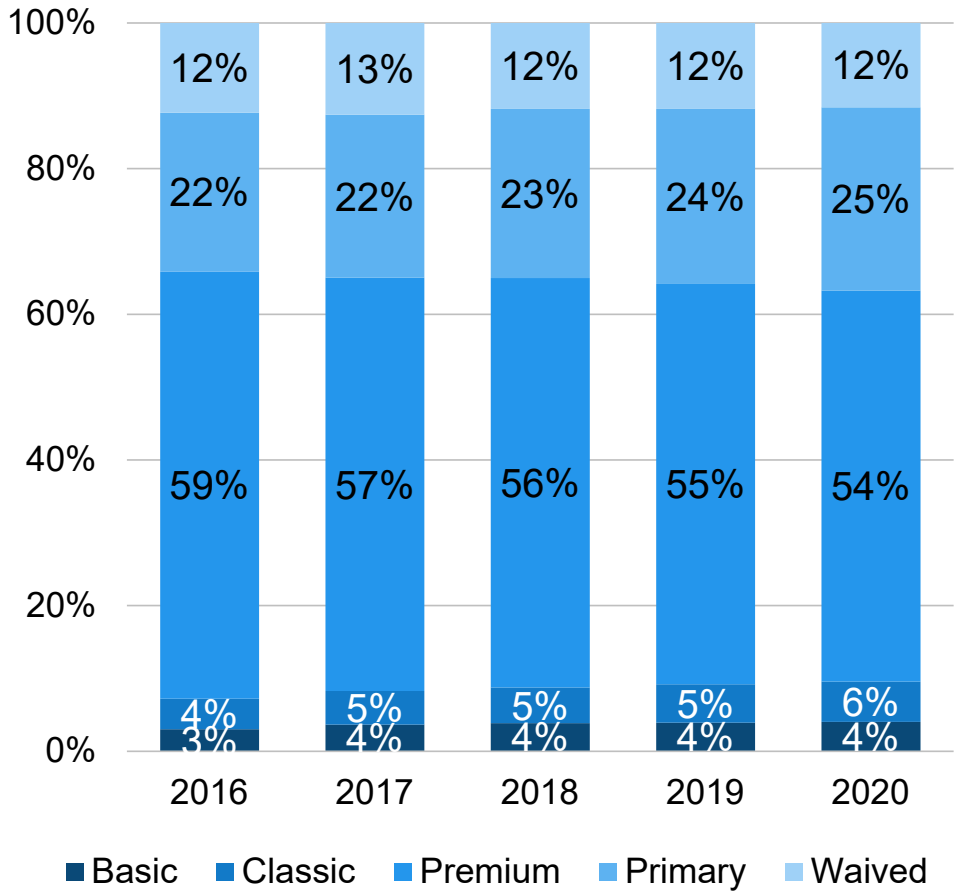




Milliman

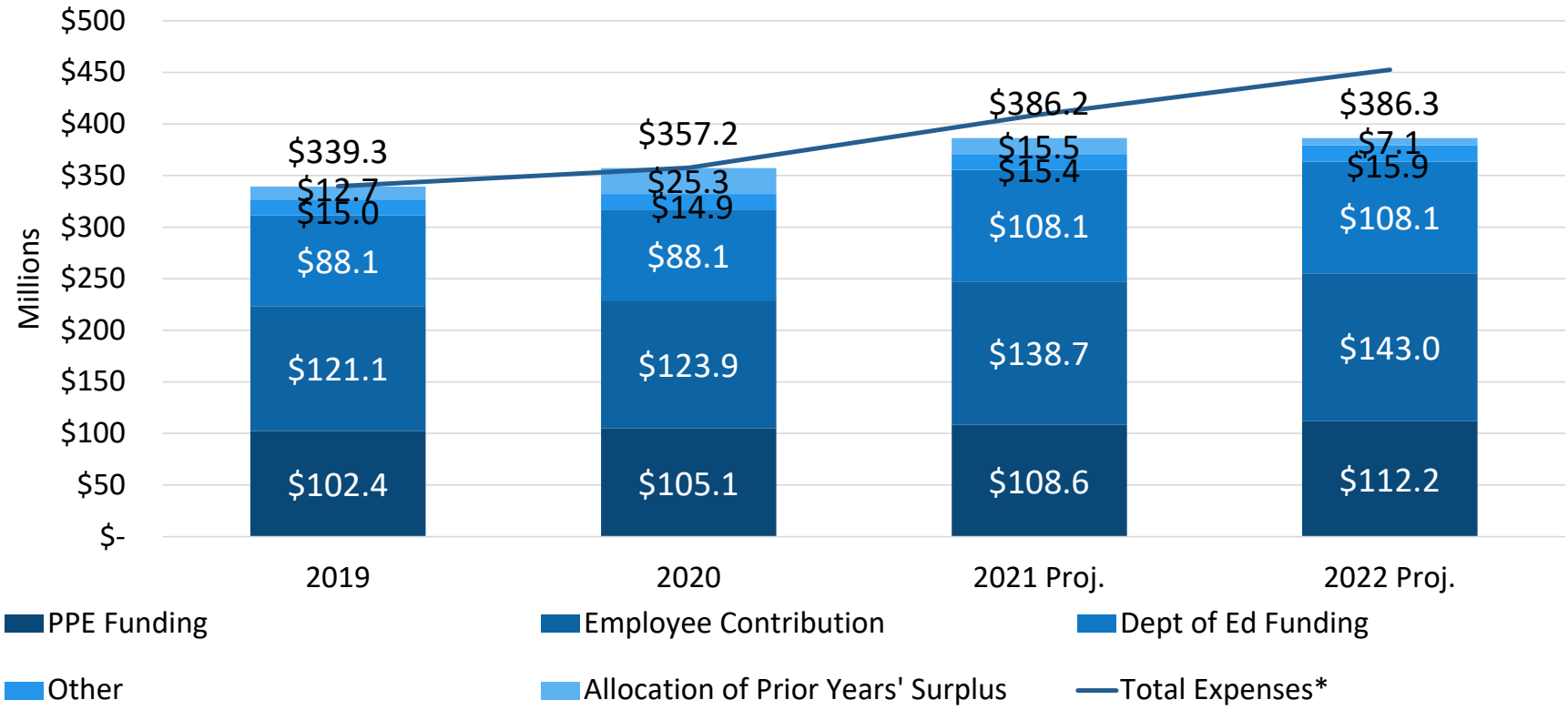
ASE - Average Enrollment (Subscribers) by Plan





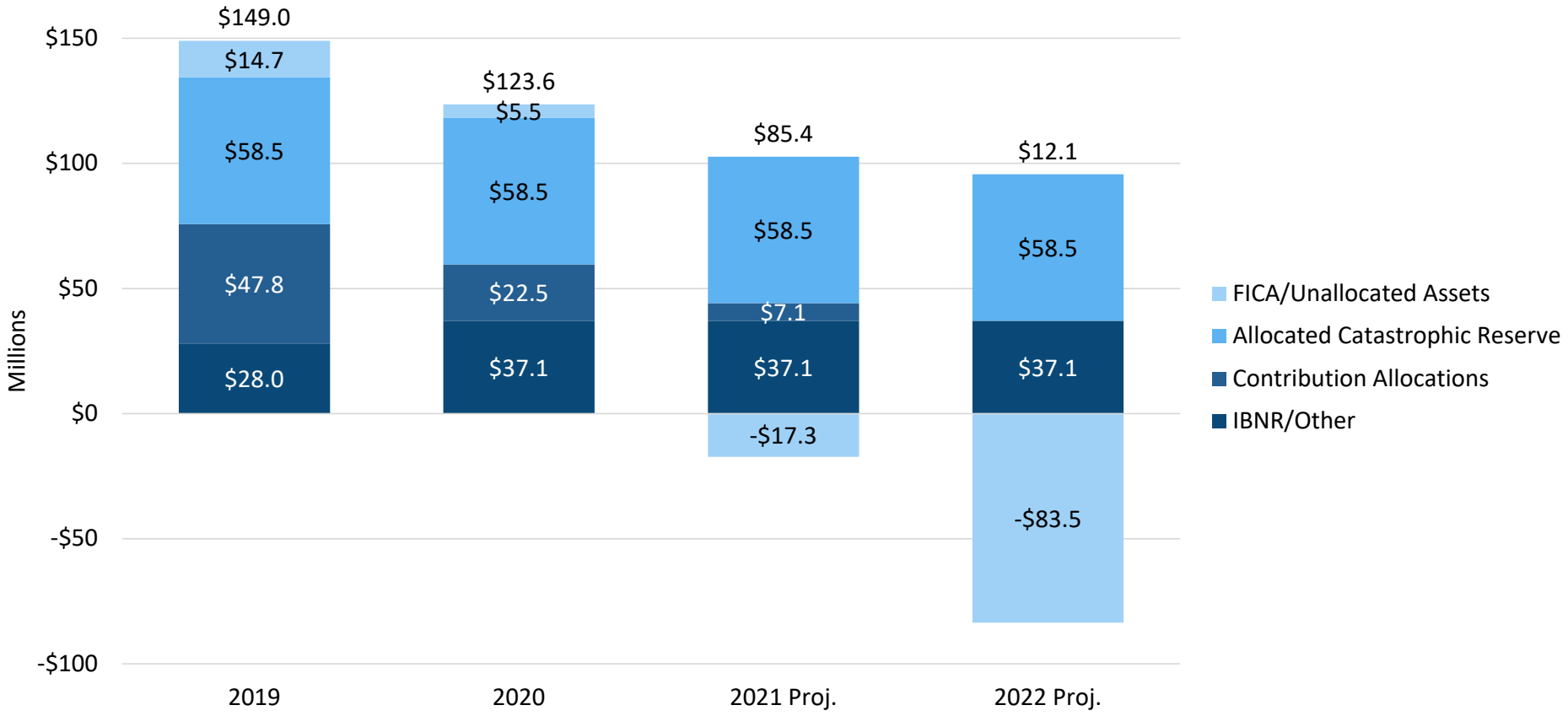
Milliman

PSE - Income vs. Expenditure

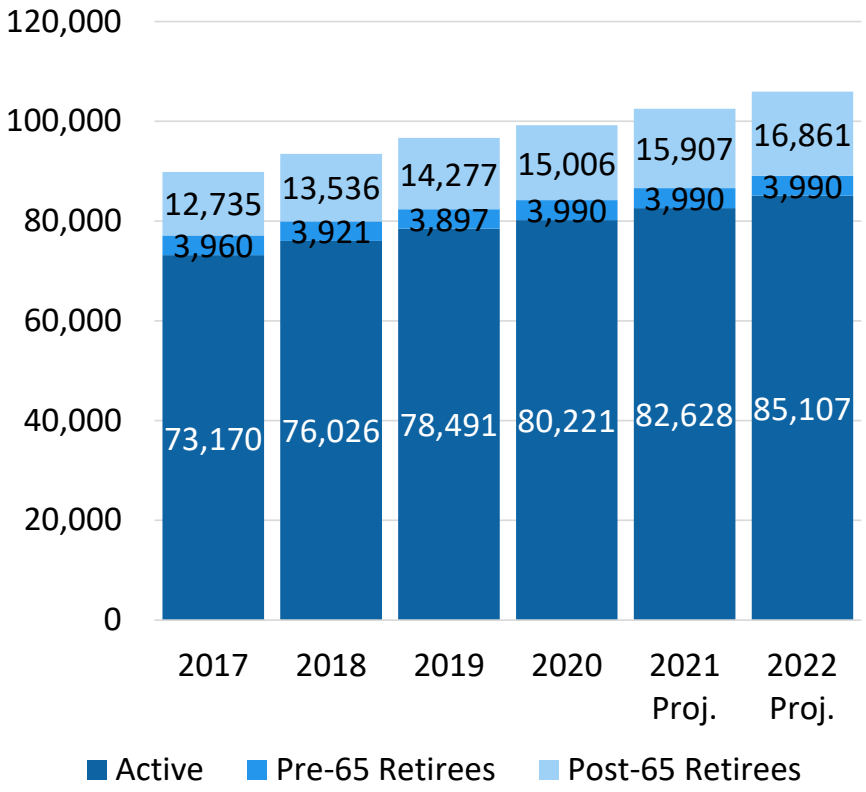


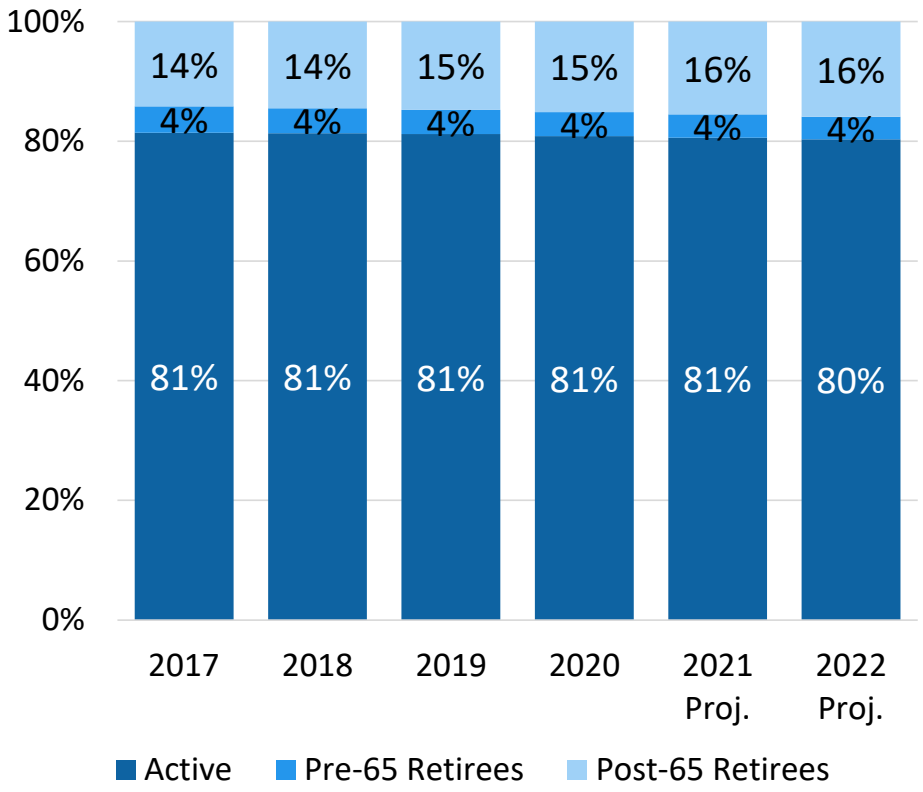
* Total Expenses offset by Program Savings

PSE - End of Year Assets

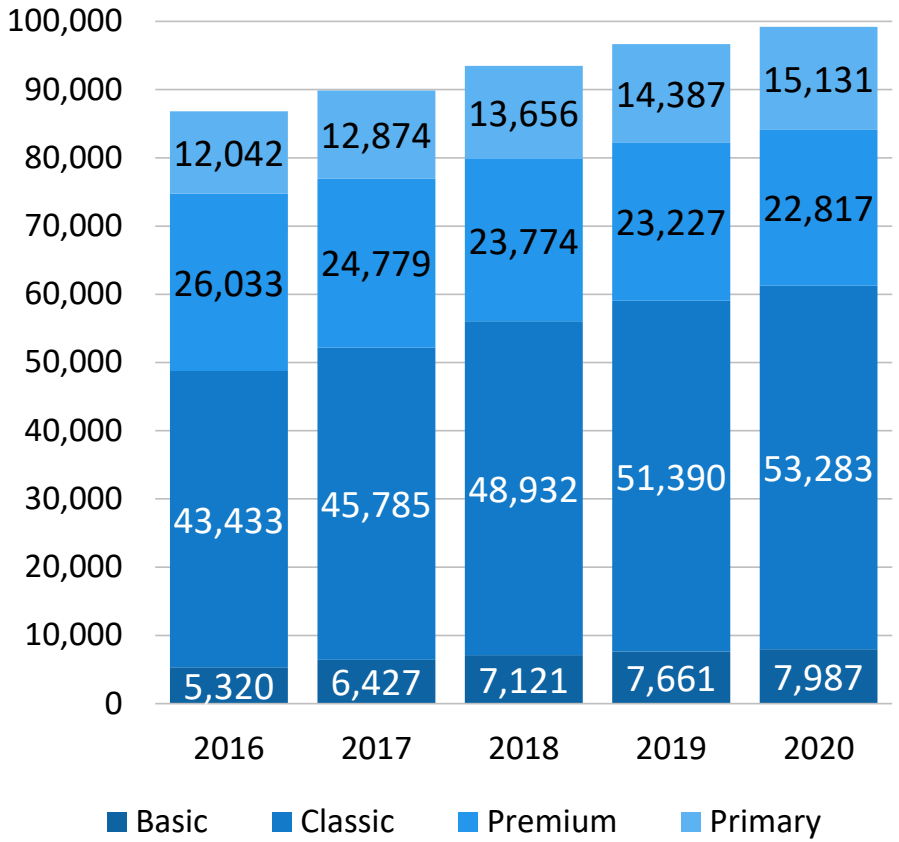


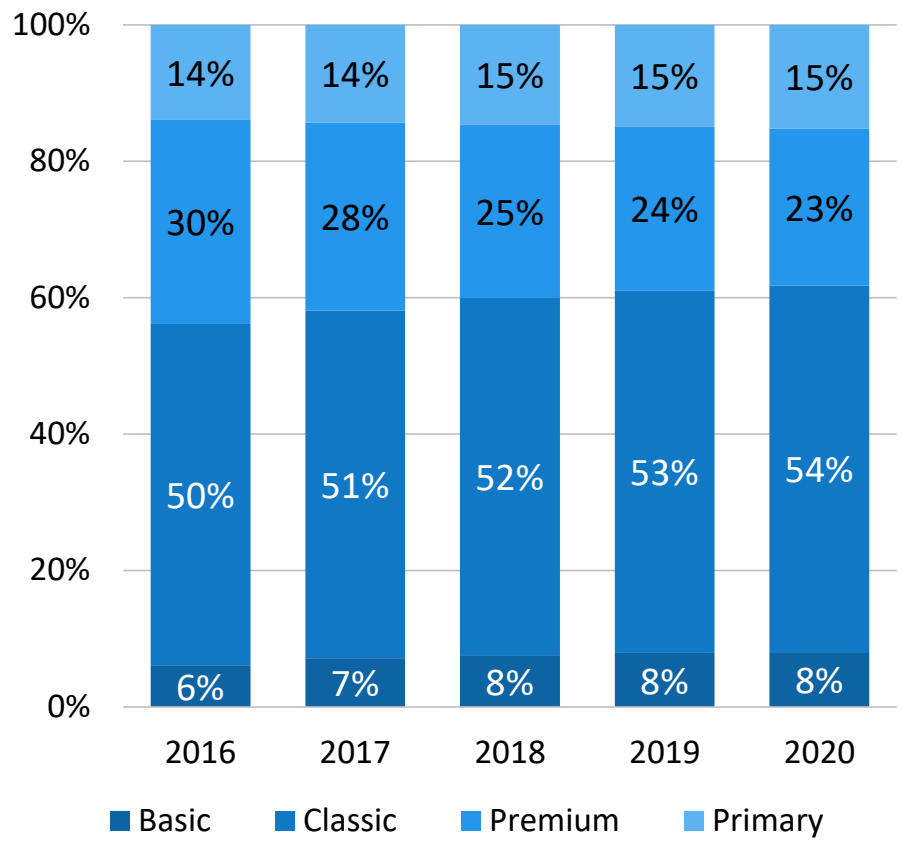
PSE - Average Membership by Status



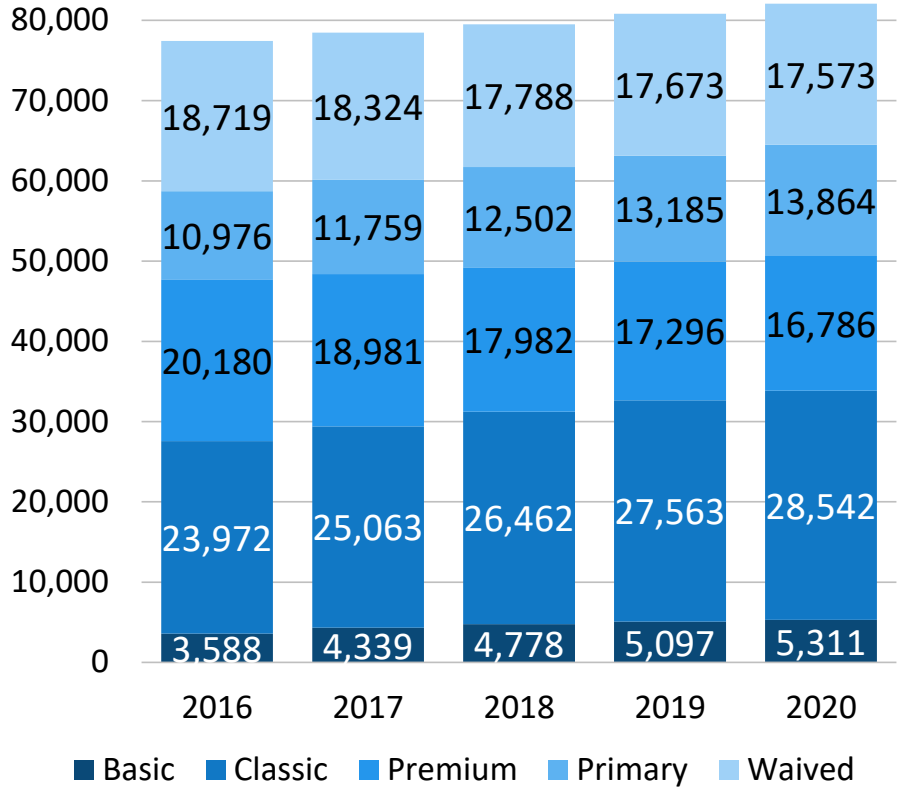


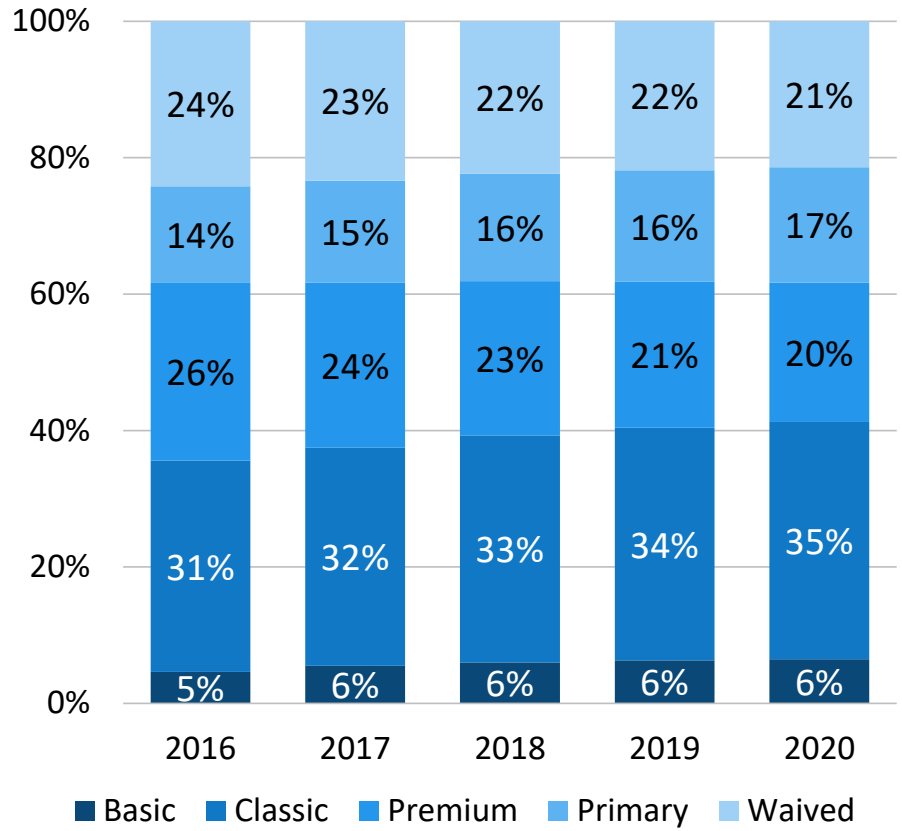
PSE - Average Membership by Plan





PSE - Average Enrollment (Subscribers) by Plan





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, January 11th, 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) TRODELVY	SACITUZUMAB GOVITECAN	Breast Cancer	Cover w/PA	New Clinical Data	Previously Excluded
(2) OXERVATE	CENEGERMIN	Neurotrophic Keratitis	Cover w/PA	New Clinical Data	Previously Excluded
(3) KESIMPTA	OFATUMUMAB	Leukemia; Multiple Sclerosis	Exclude	Alternatives with superior clinical data	No Current Utilizers

The DUEC voted to adopt the recommendations as presented.

B. Formulary Cleanup: Dr. Oktawia DeYoung, UAMS

Topical Anti-infective Agents: EBRX Fraud, Waste and Abuse Prevention Policy

ACTION: To prevent abuse of Plan resources, recommending Quantity Limit for topical anti-infective creams of 120 grams or 120 mL per 30 days. This allows for twice daily dosing over 9% body surface area for acute treatment of infection, based on average American Academy of Dermatology (AAD) estimation. PA for amounts over proposed QL. There are no members currently filling more than the proposed quantity limit.

The DUEC voted to adopt the recommendation as presented.

II. New Business

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

Brand	Generic	Indication	Recommendation	Additional Info
Non-Specialty Drugs				
(1) SUTAB	SOD SULF/POT CHLORIDE/MAG SULF	Colon Cleansing	Exclude, Code 13	Multiple generic and OTC alternatives
(2) PFIZER COVID 19 VACCINE	COVID-19 VACC, MRNA(PFIZER)/PF	COVID-19	Cover	Administration fee only ($22.70)
(3) MODERNA COVID 19 VACCINE	COVID-19 VACC,MRNA(MODERNA)/PF	COVID-19	Cover	Administration fee only ($22.70)
(4) OLINVYK	OLICERIDINE FUMARATE	Acute Pain	Exclude from Pharmacy; Code 13; N/A Medical	Multiple generic alternatives available
Specialty Drugs				
(1) CASIRIVIMAB (REGN10933) (EUA)	CASIRIVIMAB (REGN10933)	COVID-19	N/A Medical; Cover pharmacy if applicable	These medications do not have a cost other than the cost to administer. Most likely to be given through medical benefit.
(2) IMDEVIMAB	IMDEVIMAB (REGN10987)	COVID-19	N/A Medical: Cover pharmacy if applicable	
(3) BAMLANIVIMAB (EUA)	BAMLANIVIMAB	COVID-19	N/A Medical: Cover pharmacy if applicable	

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

The State and Public School Life and Health Insurance Board
Quality of Care and Benefits Sub-Committee Summary Report

The following report resulted from a meeting of the Quality of Care and Benefits Sub-Committee meetings.

Topics Discussed:
- Approval of Minutes
- Trend Experience by Milliman *Benefits only
- Follow-up Analysis by ACHI
- Director's Report

Plan Update: Paul Sakhrani and Courtney White, Milliman

White and Sakhrani provided an update on the Plan experience for ASE and PSE and presented the 2020 and beyond roadmap.

ASE

- 2021 & 2022 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through December 2020 and pharmacy claims data incurred from November 2019 to October 2020 and paid through December 2020. 2020 reflects actual claims paid.

- 2020 projected plan experience
    - Allocation of Prior Years' Surplus for 2020 is $25.1M
    - Estimated surplus of $1.2M (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2020: $9.6M
    - No Plan changes / 5% increase in employee contributions
- 2021 Plan experience
    - Allocated of Prior Years' Surplus for 2021 is $14.5M
    - Projected deficit: -$400K (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2021: $9.2M
    - Reflected 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: -$32.8M (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2021: -$23.6M
    - Reflected baseline scenario
    - No plan design or contribution changes
    - Baseline trends (medical: 5%, pharmacy: 8%)

PSE

- 2021 & 2022 projections updated to incorporate medical claims data incurred from March 2019 to February 2020 and paid through December 2020 and pharmacy claims data incurred from November 2019 to October 2020 and paid through December 2020. 2020 reflects actual claims paid.

- 2020 projected plan experience
    - Allocation of Prior Years' Surplus for 2020 is $25.3M
    - Estimated deficit of -$200K (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2020: $5.5M
    - No Plan changes / 0% increase in employee contributions
- 2021 Plan experience
    - Allocated of Prior Years' Surplus for 2021 is $15.5M
    - Projected deficit: -$22.7M (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2021: -$17.3M
    - 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: -$66.2M (after prior years' surplus allocation)
    - End of Year Unallocated Assets for 2021: -$83.5M
    - Reflected baseline scenario
    - No plan design or contribution changes
    - Baseline trends (medical: 7%, pharmacy: 8%)

ACHI Presentation: Elizabeth Montgomery & Mike Motley, ACHI

Montgomery and Motley presented updated analyses regarding COVID-19 impact on the plan and reviewed preliminary analyses of the bariatric surgery program.

Director's Report: Shalada Toles, EBD Deputy Director

Toles provided an update on the Milliman training to help build fundamentals and stated that EBD will also be working with you to get some training with EBRx to explain how the pharmacy part works.

JANUARY 2021
EBD BOARD PRESENTATION

Mike Motley, MPH
Director, Analytics

Izzy Montgomery, MPA
Policy Analyst

1.26.2021

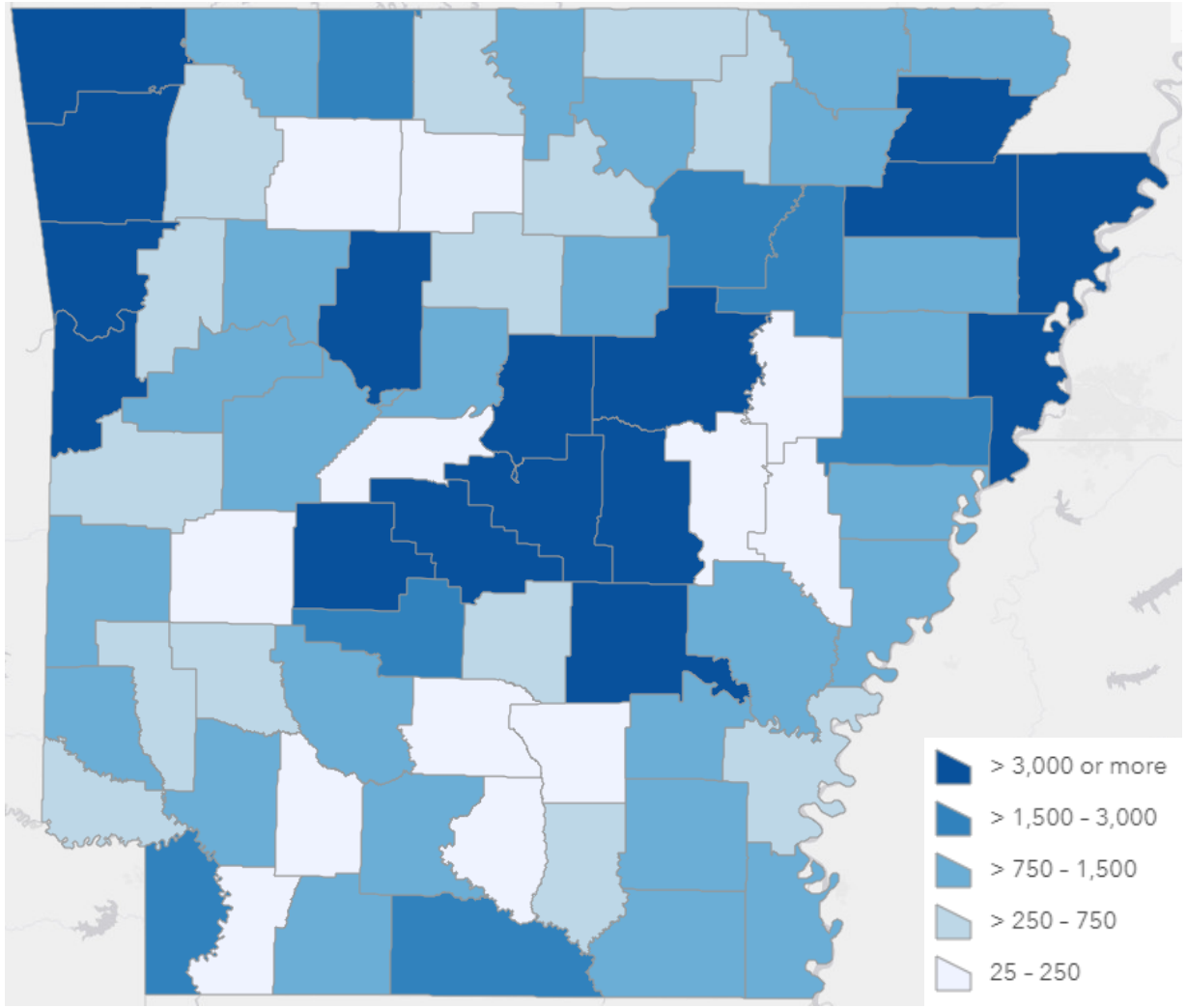
ACHI
INSPIRING HEALTHY ACTS

OBJECTIVES

- Present updated analyses regarding COVID-19 impact on plan
- Review preliminary analyses of bariatric surgery program

COVID-19 PLAN UPDATE

COVID-19 IN ARKANSAS



Total Cases: 284,066

Total Active Cases: 19,395

Hospitalized: 1,080

On Ventilators: 170

Total Deaths: 4,606

Source: Arkansas Department of Health, as of Jan. 24, 2021.

COVID-19 ANALYSES

- Data from March 16–December 21, 2020
- Estimated total members ever tested: 76,039
- Total with positive test: 10,088 (ASE=4,178; PSE=5,910)
- Total positive antigen tests plus total presumptive other: 3,038

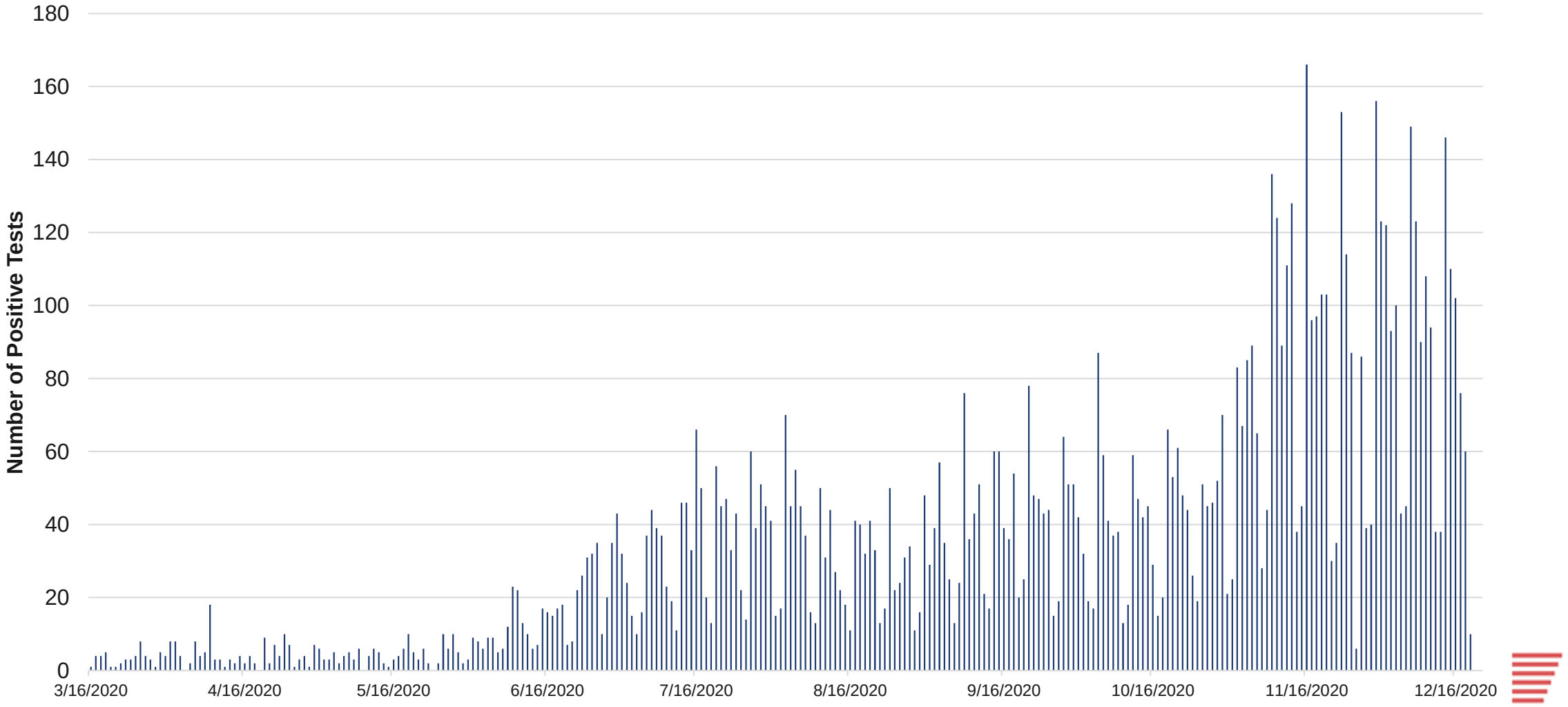
Source: Arkansas Center for Health Improvement based on data from the Arkansas Department of Health, as of December 21, 2020.

COVID-19 ANALYSES

- Total members ever hospitalized: 524
- Total members ever in ICU: 162 (1.6% of positive cases)
- Total members ever on a ventilator: 72 (0.7% of positive cases)
- Deaths: 89

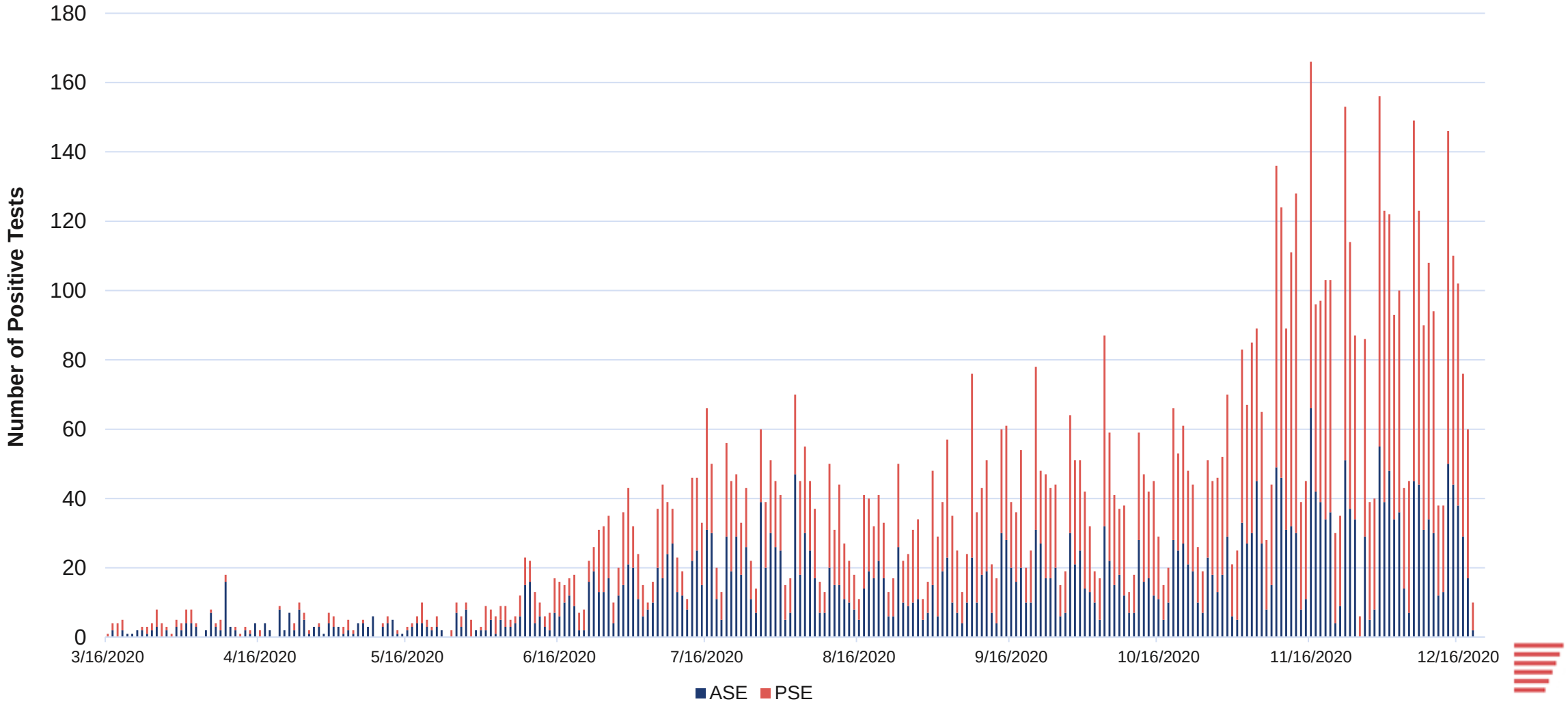
Source: Arkansas Center for Health Improvement based on data from the Arkansas Department of Health, as of December 21, 2020.

DAILY NEW POSITIVE TEST COUNT — EBD MEMBERS



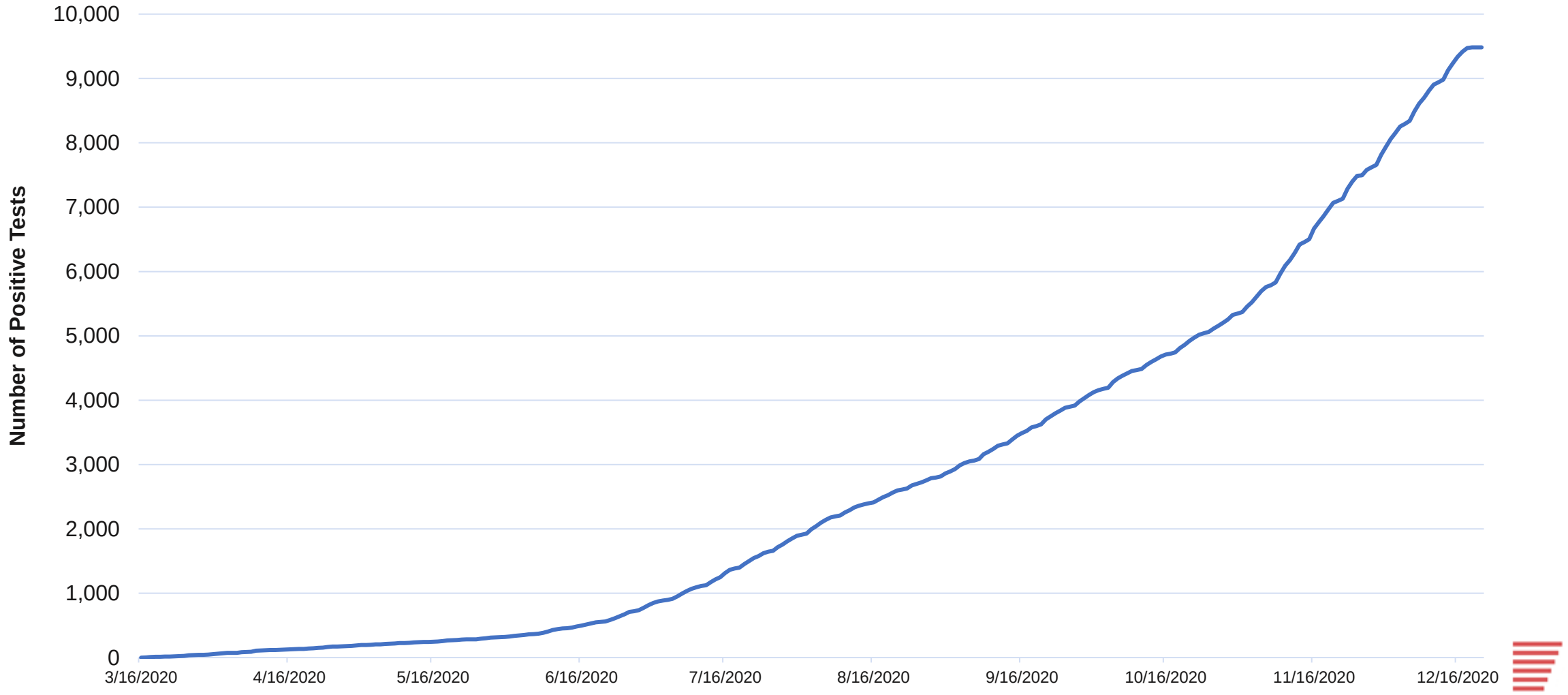
Source: Arkansas Center for Health Improvement based on data from the Arkansas Department of Health, as of December 21

DAILY NEW POSITIVE TEST COUNT BY ASE & PSE



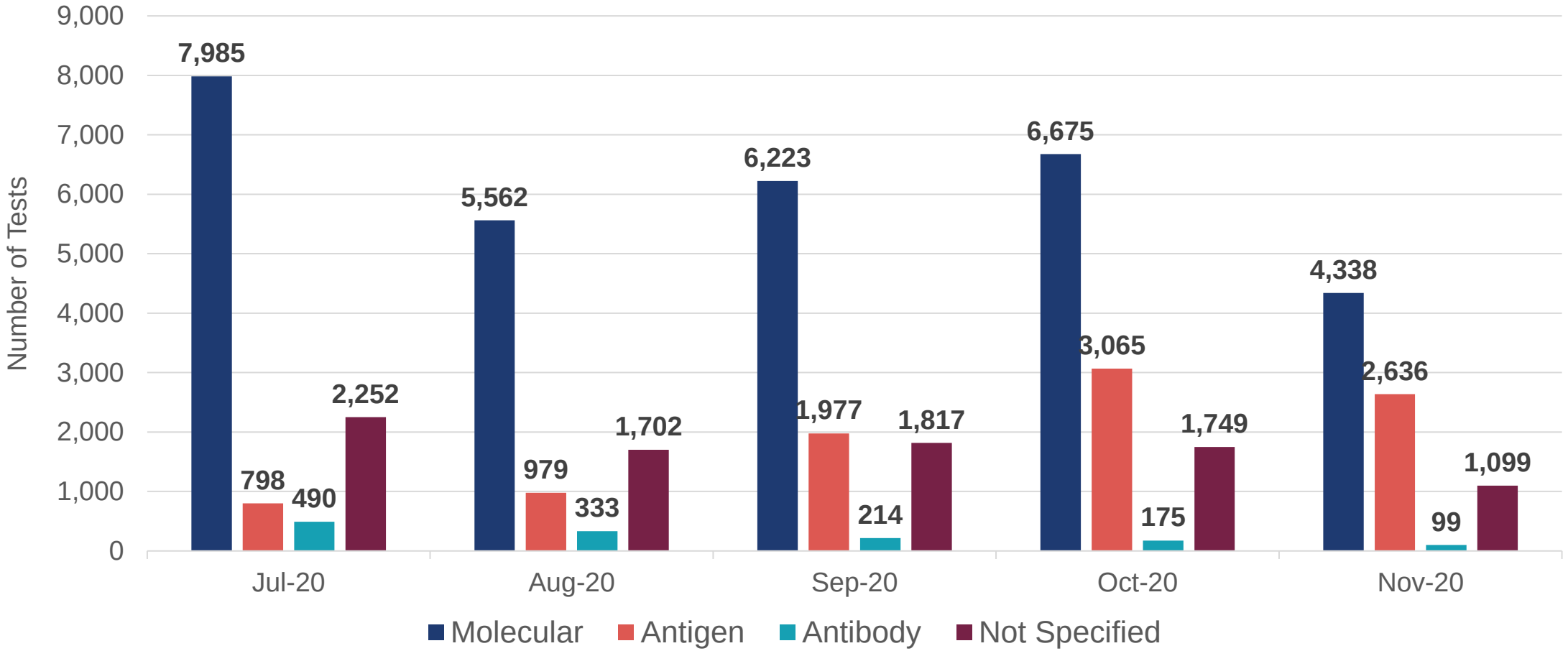
Source: Arkansas Center for Health Improvement based on data from the Arkansas Department of Health, as of December 21

CUMULATIVE POSITIVE TEST COUNT — EBD MEMBERS



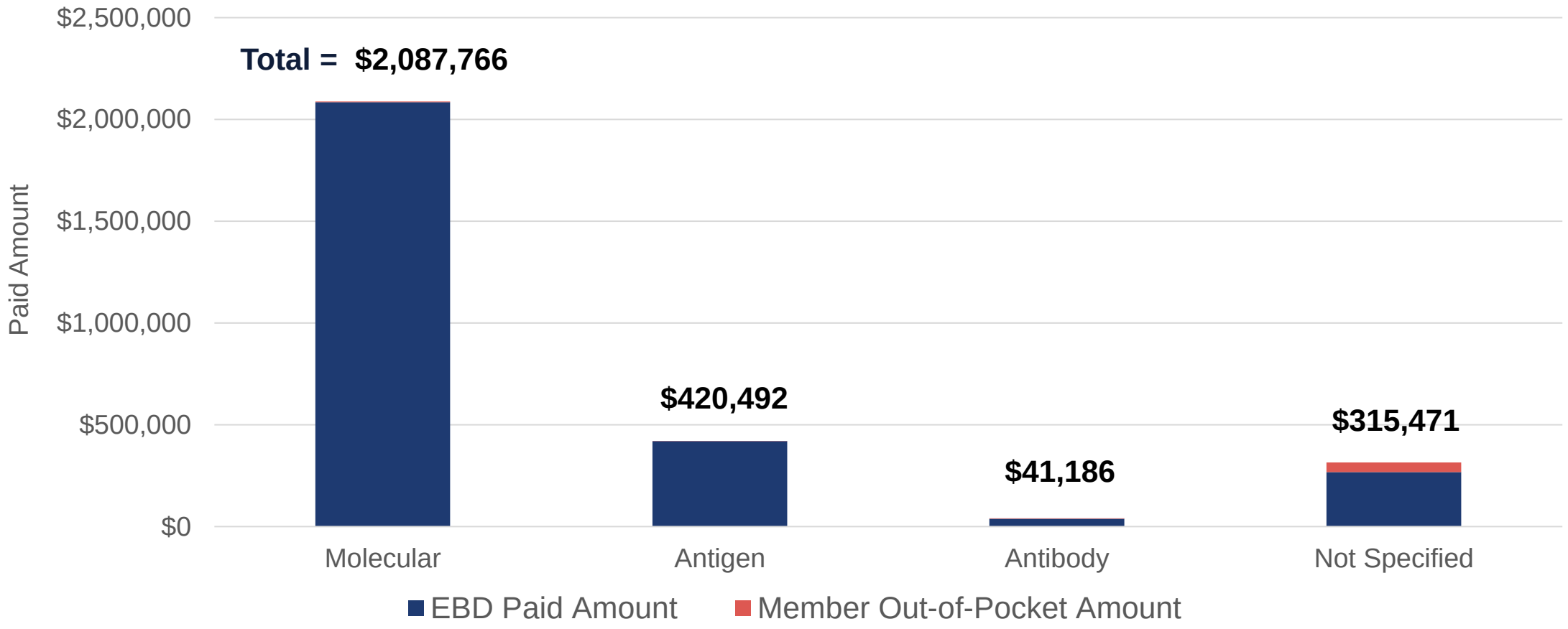
Source: Arkansas Center for Health Improvement based on data from the Arkansas Department of Health, as of December 21

COVID-19 TEST VOLUME BY TYPE FROM CLAIMS DATA (JULY 1–NOV. 25, 2020)



Source: Arkansas Center for Health Improvement

EBD PLAN PAID AMT. & MEMBER OUT-OF-POCKET AMT. FOR COVID-19 TESTS, JULY 1–NOV. 25, 2020



Source: Arkansas Center for Health Improvement

COVID-19 TESTING & OTHER COVID-19-RELATED COSTS WITHIN PLAN (JULY 1–NOV. 25, 2020)

- Total costs for all COVID-19 tests = $2,811,411 (average of $56 per test)
- Outpatient (OP) or emergency department (ED) visits were associated with 24,265 of 50,168 tests (48.4%)
- Additional costs for associated OP or ED visits = $1,559,247
- Total amount paid by the plan for testing and associated OP or ED visits = $4,370,658

BARIATRIC SURGERY PILOT PROGRAM ANALYSES

BARIATRIC SURGERY PILOT PROGRAM ENABLING LEGISLATION

- 2011 Legislation charged EBD to create a pilot program for bariatric surgery (*Act 855 of 2011*) ending on Dec. 31, 2017
- Enrollment began in 2011 with initial surgeries taking place in 2012

Source: Act 855 of the 2011 Regular Session.

BARIATRIC SURGERY PILOT PROGRAM LEGISLATIVE CHANGES

- 2012–2013 programmatic costs exceeded initially projected costs
- 2014 legislation required that costs for program should not exceed $3 million for ASE or $3 million for PSE

Source: Act 6 of the Second Extraordinary Session.

BARIATRIC SURGERY PILOT PROGRAM LEGISLATIVE CHANGES

- During 2017 session, pilot program was extended through Dec. 31, 2021 (*Act 927 of 2017*)
- Continued requirement that costs for the program not exceed $3 million for ASE or $3 million for PSE

Source: Act 927 of 2017.

EBD BOARD ACTION

- In 2017, the EBD Board passed the following motion related to pilot program requirements:
  - The Board conditionally cover up to $3M each for ASE and for PSE plans
  - Utilize Medicare requirements for surgery eligibility (BMI of 35+ with comorbidity or BMI of 40+ with no comorbidity, as well as unsuccessfully attempted medical weight loss treatment)

Source: EBD Board Meeting Minutes, April 2017.

EBD BOARD ACTION (CONTINUED)

- In 2017, the EBD Board passed the following motion related to pilot program requirements:
  - Require prior authorization for surgery and that it be performed at a Center of Excellence
  - Withhold 25% of provider and hospital pay with payment reconciliation contingent upon completion of all pre-surgery and all post-surgery follow up requirements
  - Program components to be specified by EBD prior to implementation

Source: EBD Board Meeting Minutes, April 2017.

2021 BARIATRIC SURGERY PROGRAM REQUIREMENTS

- Be policyholder on plan for at least 1 year as of Feb. 1, 2021
- BMI between 36-39 with a weight-related comorbidity or BMI between 40-59 without a comorbidity
- No previous bariatric surgery
- Be financially prepared to cover all member cost-share at or before the scheduled surgery date
- Participate in monthly case management phone calls M-F between 8 a.m.-4 p.m.

Source: ARBenefits Bariatric Pilot Program Requirements 2021

2021 BARIATRIC SURGERY PROGRAM REQUIREMENTS (CONTINUED)

- Be an active employee at the time of surgery
- Have surgery on or before Dec. 31, 2021
- Enroll in 3 months of coaching with Health Advantage nurse
- Telephone contact must be documented monthly, no less than 20 days nor more than 40 days between contacts
- Surgery must be completed within 1 year after enrollment

Source: ARBenefits Bariatric Pilot Program Requirements 2021

2021 BARIATRIC SURGERY PROGRAM REQUIREMENTS (CONTINUED)

- A 3-month physician-supervised nutrition & exercise program:
  - Low-calorie diet or diet program recommended for member by his/her physician (or surgeon)
  - Increased physical activity and behavior modification
  - Member's compliance with program must be documented in the medical record at least monthly
  - *Records must document compliance with the program and must show progress of weight loss or no net weight gain; Member's weight must be documented at each visit*

Source: *ARBenefits Bariatric Pilot Program Requirements 2021*

BARIATRIC SURGERY BACKGROUND

BARIATRIC SURGERY BACKGROUND

- More than 340,000 bariatric surgery procedures performed worldwide in 2011
- Demonstrated to be effective at achieving weight loss and improving coexisting conditions
- 3 most commonly performed bariatric procedures:
  - Gastric bypass
  - Gastric sleeve
  - Lap banding

Source: Schroeder, R., et. al., "Treatment of Adult Obesity with Bariatric Surgery." American Family Physician, January 2016, 93(1): 31-37.

ESSENTIAL COMPONETS FOR BARIATRIC SURGERY PROGRAM

- Intensive behavioral management before referral for surgery
- Multidisciplinary team approach (bariatric specialist, psychologist/psychiatrist, nutritionist, etc.)
- Post-surgery care, including ongoing weight monitoring, review of dietary changes, and assessment of coexisting conditions

Source: UptoDate, "Bariatric procedures for the management of severe obesity: Descriptions" & "Bariatric surgery: Postoperative and long-term management of uncomplicated patient." Accessed on April 2, 2019.

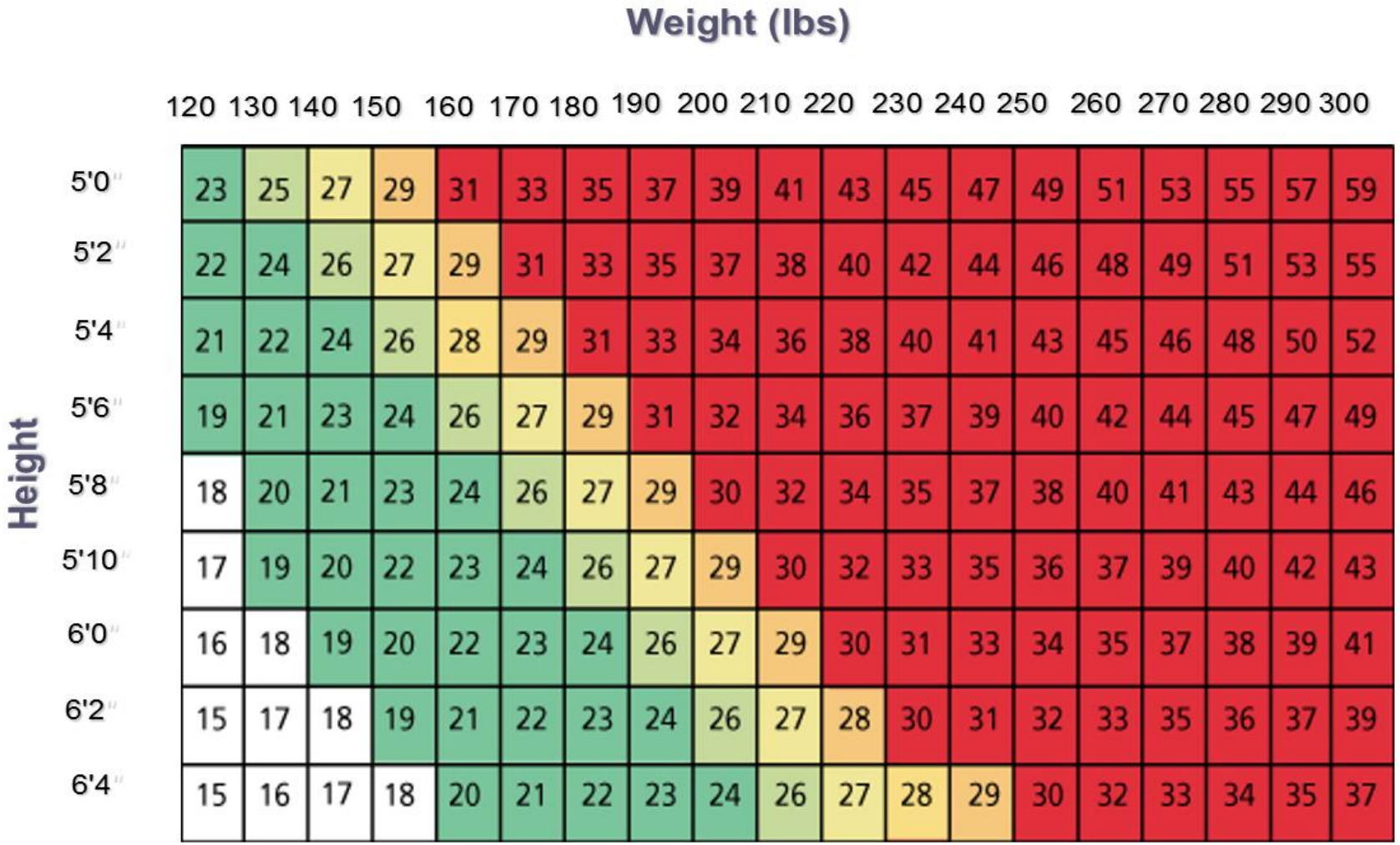
BODY MASS INDEX (BMI) EXAMPLES

Example: Individual with height measurement of 5’9”

Weight Range	BMI	Considered
124 lbs. or less	Below 18.5	Underweight
125–168 lbs.	18.5–24.9	Healthy weight
169–202 lbs.	25.0–29.9	Overweight
203 lbs. or more	30 or higher	Obese
271 lbs. or more	40 or higher	Class 3 Obese

Source: Centers for Disease and Control (CDC), “Defining Adult Overweight and Obesity.”

ADULT BMI CHART



UTILIZATION AND COST ANALYSES

BARIATRIC SURGERY RECIPIENT DEMOGRAPHICS, 2019 & 2020

Gender		
	2019	2020
Female	**301** (86%)	**58** (91%)
Male	**50** (14%)	**6** (9%)
Total	351	64

Plan Type		
	2019	2020
ASE	**171** (49%)	**27** (42%)
PSE	**180** (51%)	**37** (58%)
Total	351	64

Age Group		
	2019	2020
<=35	**48** (14%)	**6** (9%)
36-45	**119** (34%)	**20** (31%)
46-55	**113** (32%)	**17** (27%)
56-65	**55** (16%)	**11** (17%)
>66+	**16** (4%)	**10** (16%)
Total	351	64

Source: Arkansas Center for Health Improvement

BARIATRIC SURGERY BY TYPE OF PROCEDURE, 2019 & 2020

Surgery Type		
	2019	**2020**
Gastric Bypass	74	11
Sleeve Gastrectomy	277	53
Total	351	64

Source: Arkansas Center for Health Improvement

BARIATRIC SURGERY MEDIAN COSTS, 2017–2020

Median Surgery Costs*	
2017	$10,971
2018	$11,502
2019	$9,746
2020	$9,536

*Costs include amount paid by plan one day prior to surgery date through discharge date.

Source: Arkansas Center for Health Improvement

BARIATRIC SURGERY PROGRAM UTILIZATION & COST

Year	Bariatric Surgery Recipients	Plan Amount Paid for Surgery Admission
2012	189	$2,144,633
2013	298	$3,516,403
2014	181	$2,301,193
2015	48	$481,850
2016	59	$622,782
2017	123	$1,201,964
2018	253	$2,695,825
2019	351	$3,435,292
2020	64	$578,859
Total	**1,567**	**$16,978,801**

*Costs include amount paid by plan one day prior to surgery date through discharge date.

Source: Arkansas Center for Health Improvement