



AGENDA

State and Public School Life and Health Insurance Board

March 15th, 2021

3:00 p.m.

EBD Board Room – Rockefeller Building, Suite 500

- I. Call to Order.....Renee Mallory, Chair*
- II. Review Options for Potential Plan Savings Discussion*
- III. Adjournment.....Renee Mallory, Chair*

2021 Upcoming Meetings:

March 23rd, April 20th, May 25th

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

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

State of Arkansas Employee Benefits Division

State and Public School Life and Health Insurance Board of Directors

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

15 MARCH 2021



Agenda

- Summary of Findings for Analyses To Date
- Guiding Principles and Budget Levers
- 2022 Budget Target
- State Funding – Budget Lever
- Employee Funding – Budget Lever
- Appendices

Summary of Findings

Trend - Expenses vs. Revenue

- 2017 – 2022 – ASE - Plan expenses are growing at an annualized rate of 5.6% per member compared to state funding of 1% and employee funding of 2.6%
- 2017 – 2022 – PSE - Plan expenses are growing at an annualized rate of about 6.6% per member compared to flat district funding, 3.8% for Department of Education, and less than 1% for employee contributions

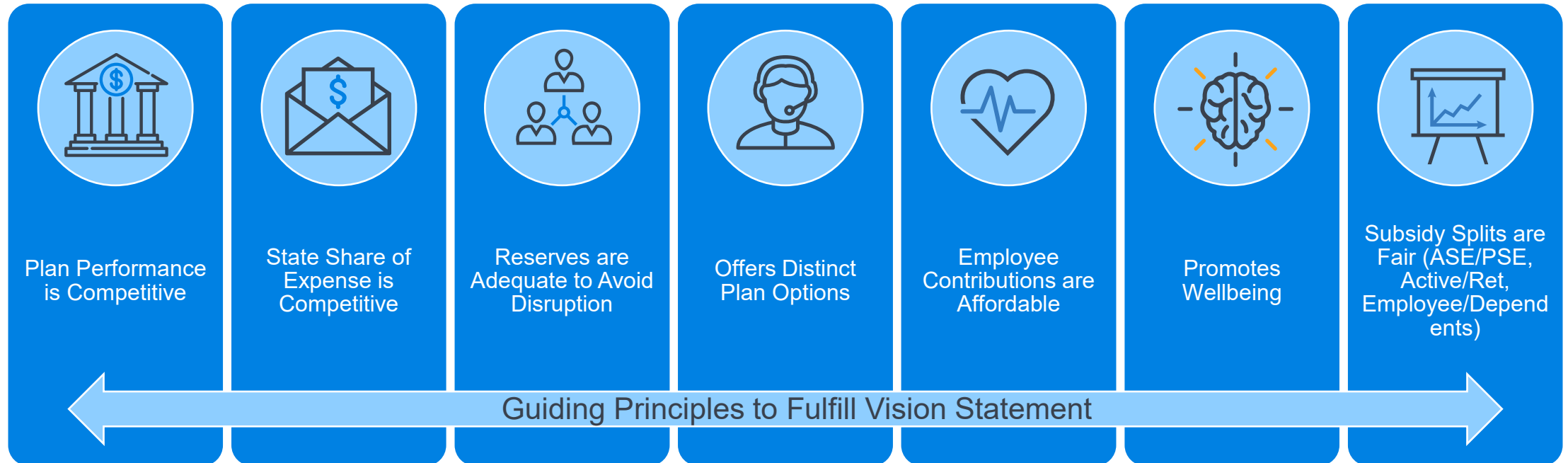
Benchmarking

- Funding – State funding for ASE was lower than all but one surrounding state while employee contributions were higher than all but one surrounding state
- Price Efficiency (normalized to Medicare fee schedule) – State of Arkansas was about 15% lower than the average of all Arkansas employers in IBM MarketScan data set
- Utilization Efficiency – in progress

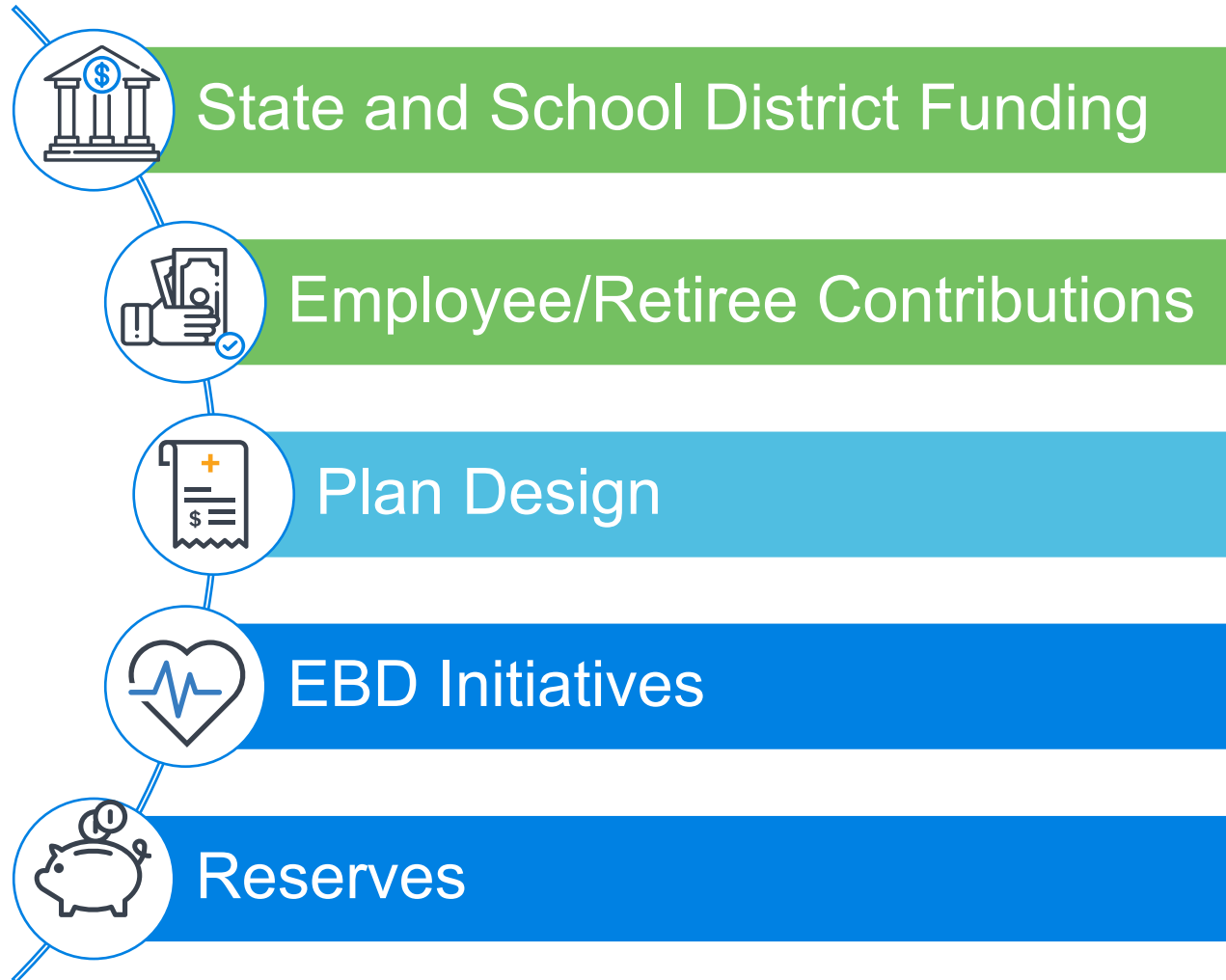
Guiding Principles

Draft Vision Statement:

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



Budget Levers



- Today's focus is on options to raise revenue to match projected expense and 10% reserve for 2022
- Plan design options will also be explored
- New EBD initiatives will be recommended after completion of detailed utilization benchmarking analysis – implementation for start of 2022 is not practical

Recap of Projected Funds Needed for 2022

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

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

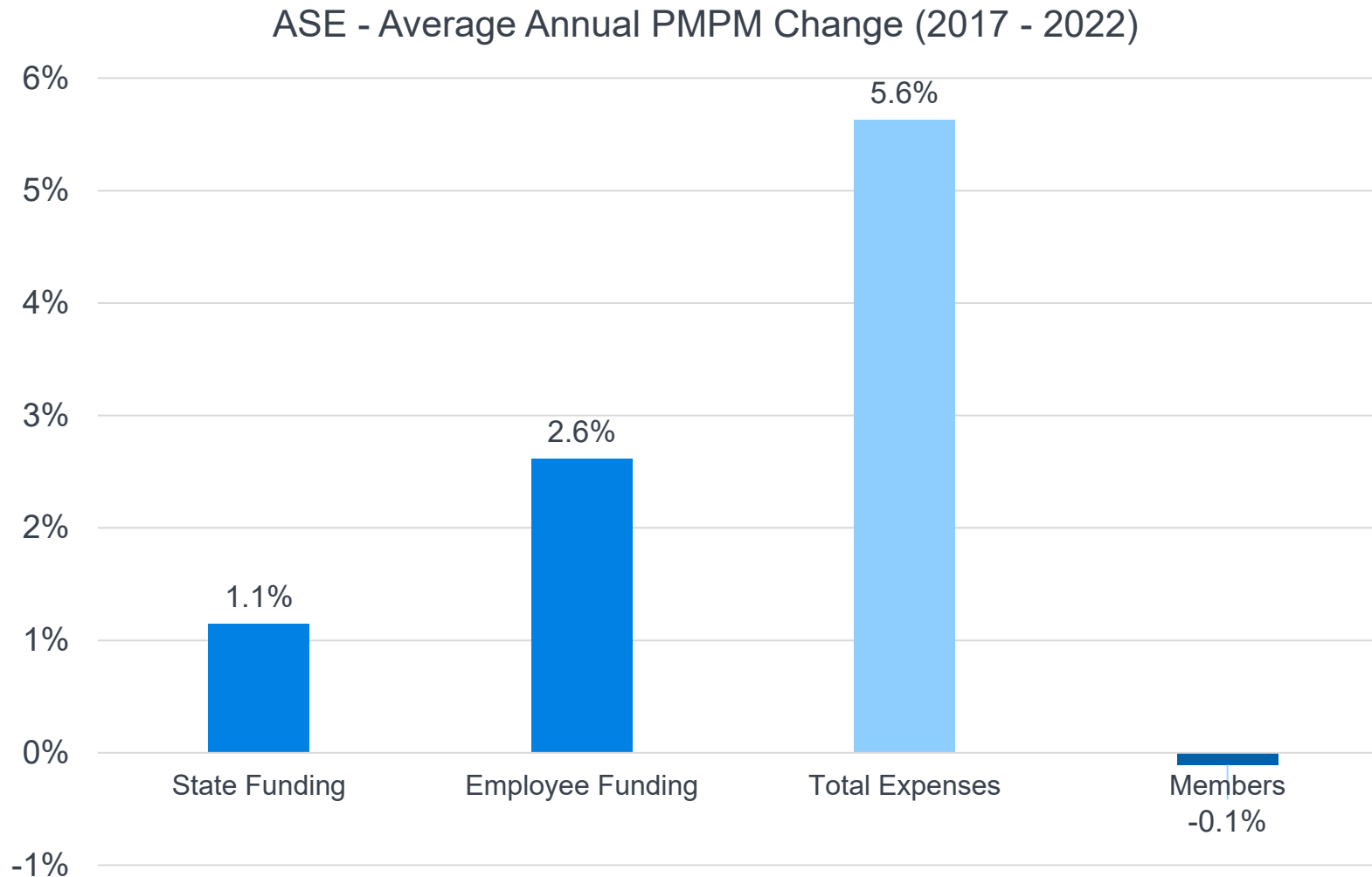
	02/23/2021 Board Report	
	ASE	PSE
2022 Projected Revenue	\$316.0	\$379.9
2022 Projected Expenses	(\$351.3)	(\$450.6)
2022 Projected Income / (Loss)	(\$35.3)	(\$70.7)
Projected Net Assets End of 2021 ¹	(\$4.9)	(\$18.8)
Target Net Assets (10% of Expenses)	\$35.1	\$45.1
Needed Change in Net Assets	\$40.0	\$63.8

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

1. Does not reflect changes to 2020 FICA or 2021 Department of Education Funding as of 3/12/2021

State Funding

ASE – Average Annual PMPM Change from 2017 - 2022

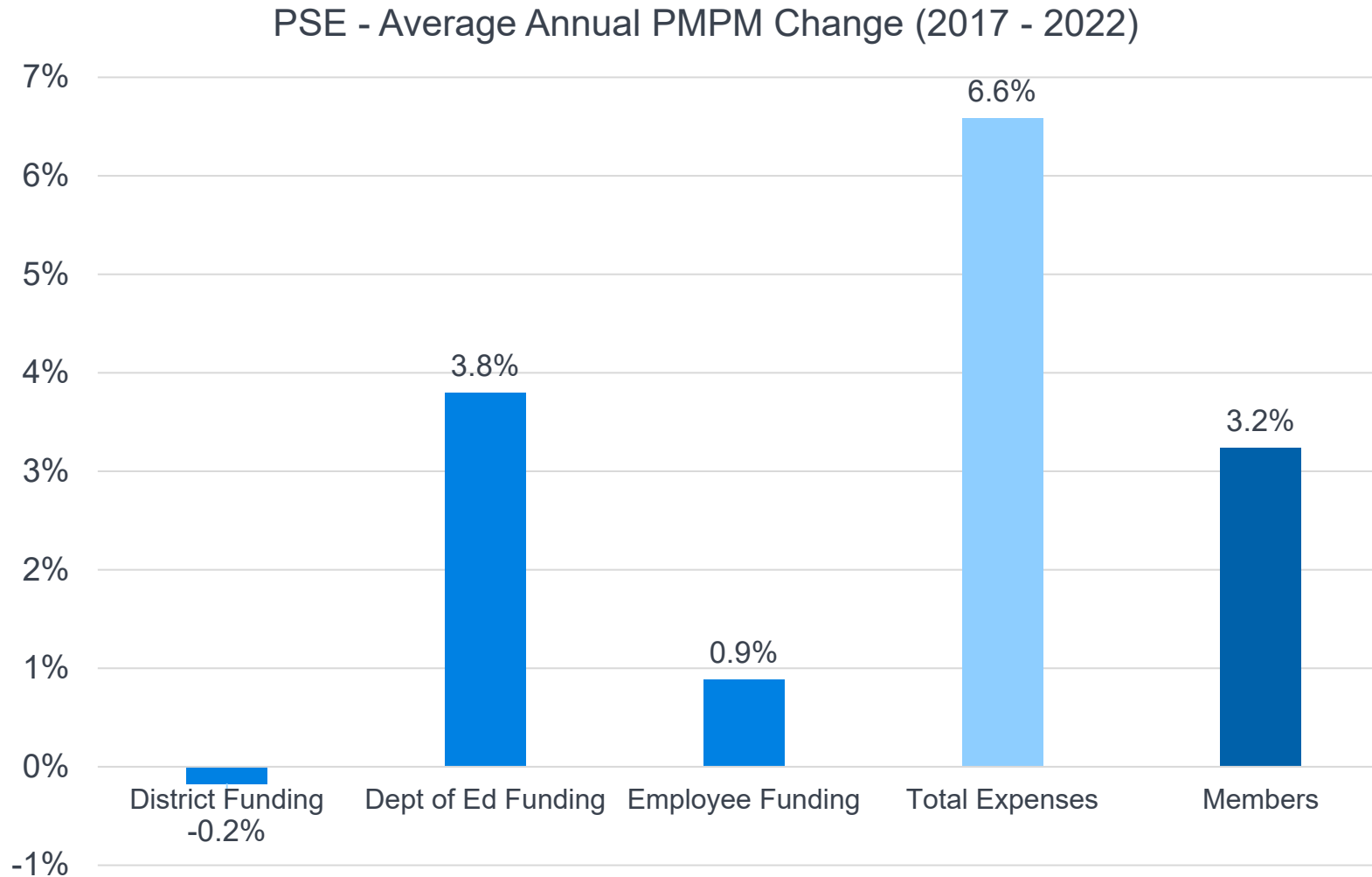


- ◆ Expenses expected to increase on average 5.6% from 2017 - 2022

- ◆ State Funding and Employee Funding expected to increase 1.1% and 2.6% per year respectively absent any changes

- ◆ Funding increasing at a much slower rate than expense, which require the use of asset / catastrophic reserve

PSE – Average Annual PMPM Change from 2017 - 2022



- ◆ Expenses expected to increased on average 6.6% from 2017 - 2022

- ◆ District funding increases each year on a PPE, however, when spread across all eligible (active + retiree) it is actually flat or slightly negative

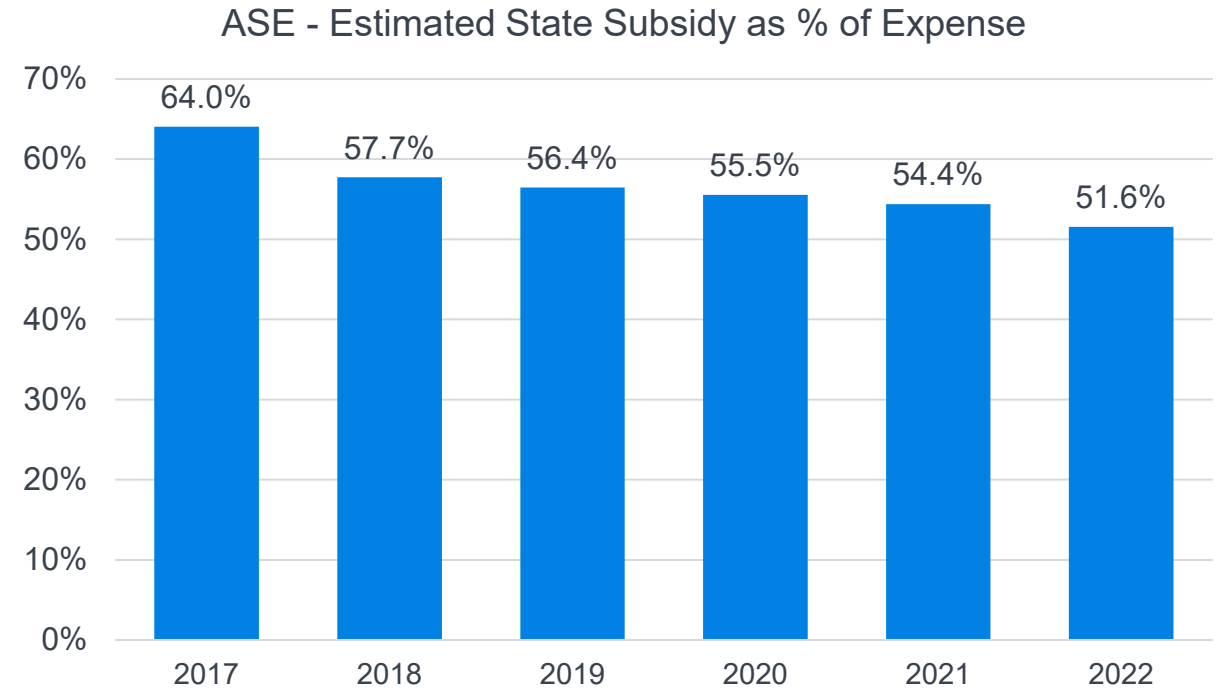
- ◆ Funding increasing at a much slower rate than expense, which require the use of asset / catastrophic reserve

- ◆ PSE membership growing around 3% per year

ASE – Historical State Subsidy

2022 State Subsidy (PBPPM)	Additional Funding	% Increase	% of Expense
\$450	\$0	0%	51.6%
\$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

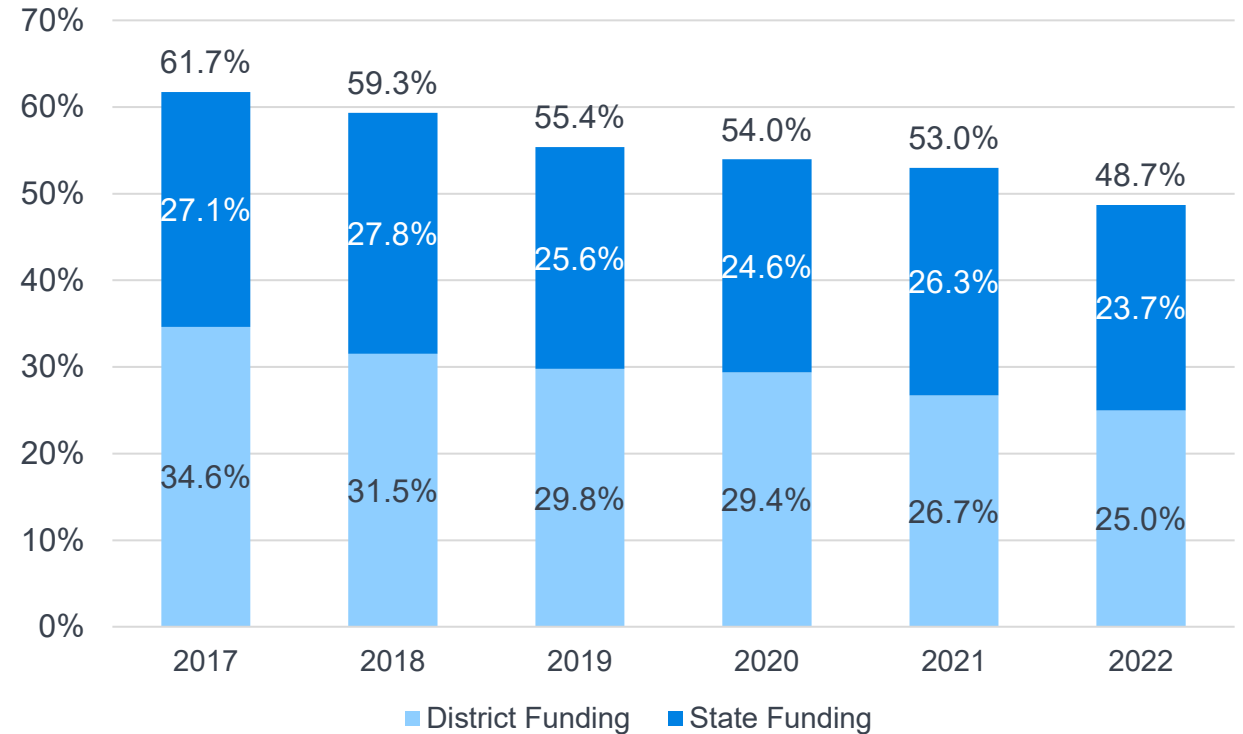
PSE – Historical State Subsidy

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 - Estimated State Subsidy as % of Expense



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

Employee Funding

Summary of Initiatives – Illustration

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

Initiative	2022 Estimated Impact			
	ASE		PSE	
	Savings	Balance	Savings	Balance
5% Contribution Increase	\$5.4M	(\$34.6M)	\$7.6M	(\$63.1M)
Reduction in Wellness Credit from \$50 to \$25 ¹	\$5.7M	(\$28.9M)	\$11.8M	(\$51.3M)
\$250 Deductible & OOPM Increase	<u>\$3.4M</u>	(\$25.5M)	<u>\$5.1M</u>	(\$46.2M)
Total	\$14.5M		\$24.5M	

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

Recommendations

For 2022

- Raise enough revenue to meet plan expense projection for 2022 +10% reserve using the levers of state funding and employee contributions or by reducing expense via reductions 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).



Thank you

Courtney White, FSA, MAAA

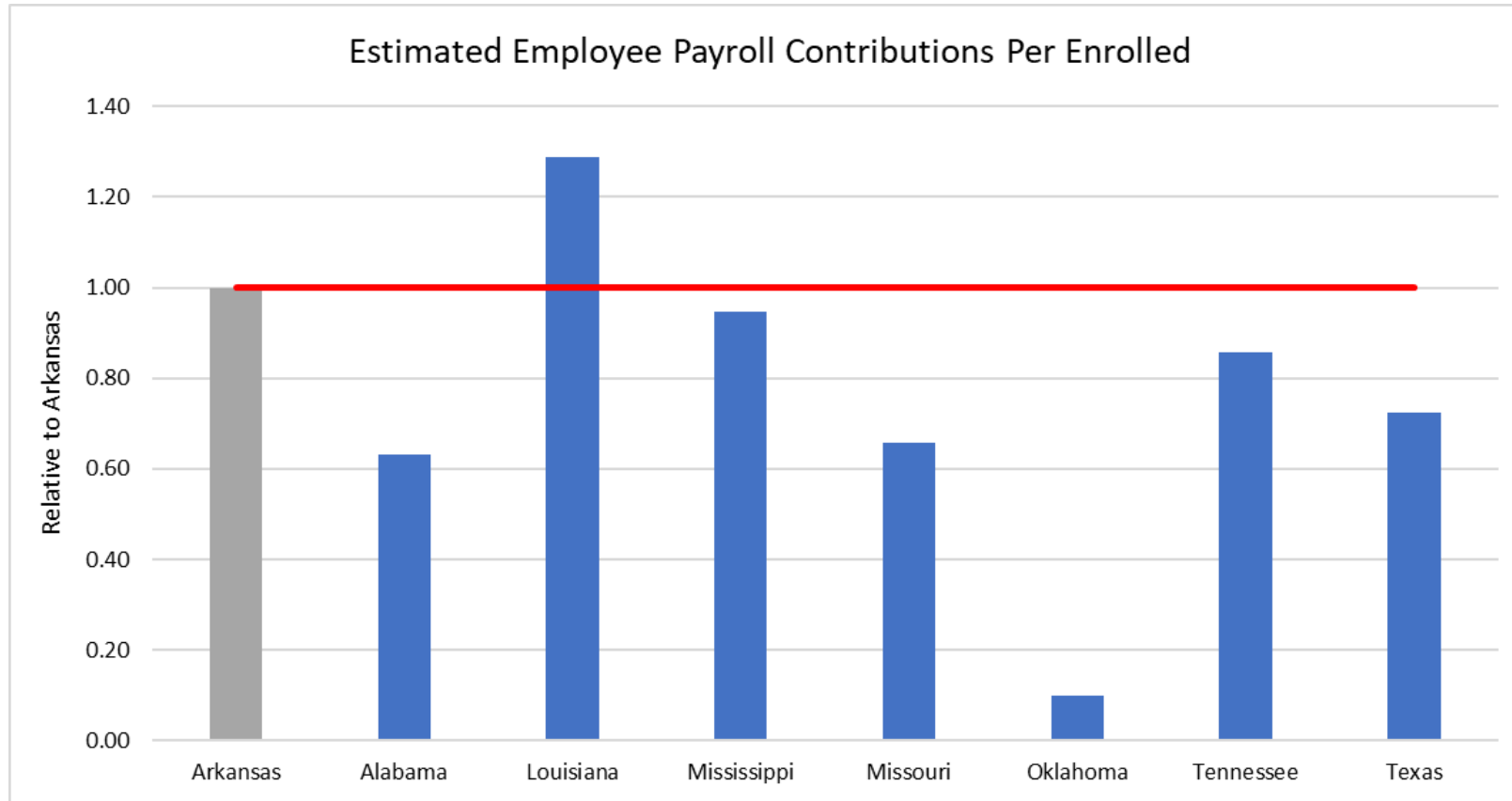
Paul Sakhrani, FSA, MAAA

Scott Cohen, MPH

Appendix State Benchmark

ASE – Benchmark Study (Active Employees)

Estimated* Employee Contributions per Enrolled



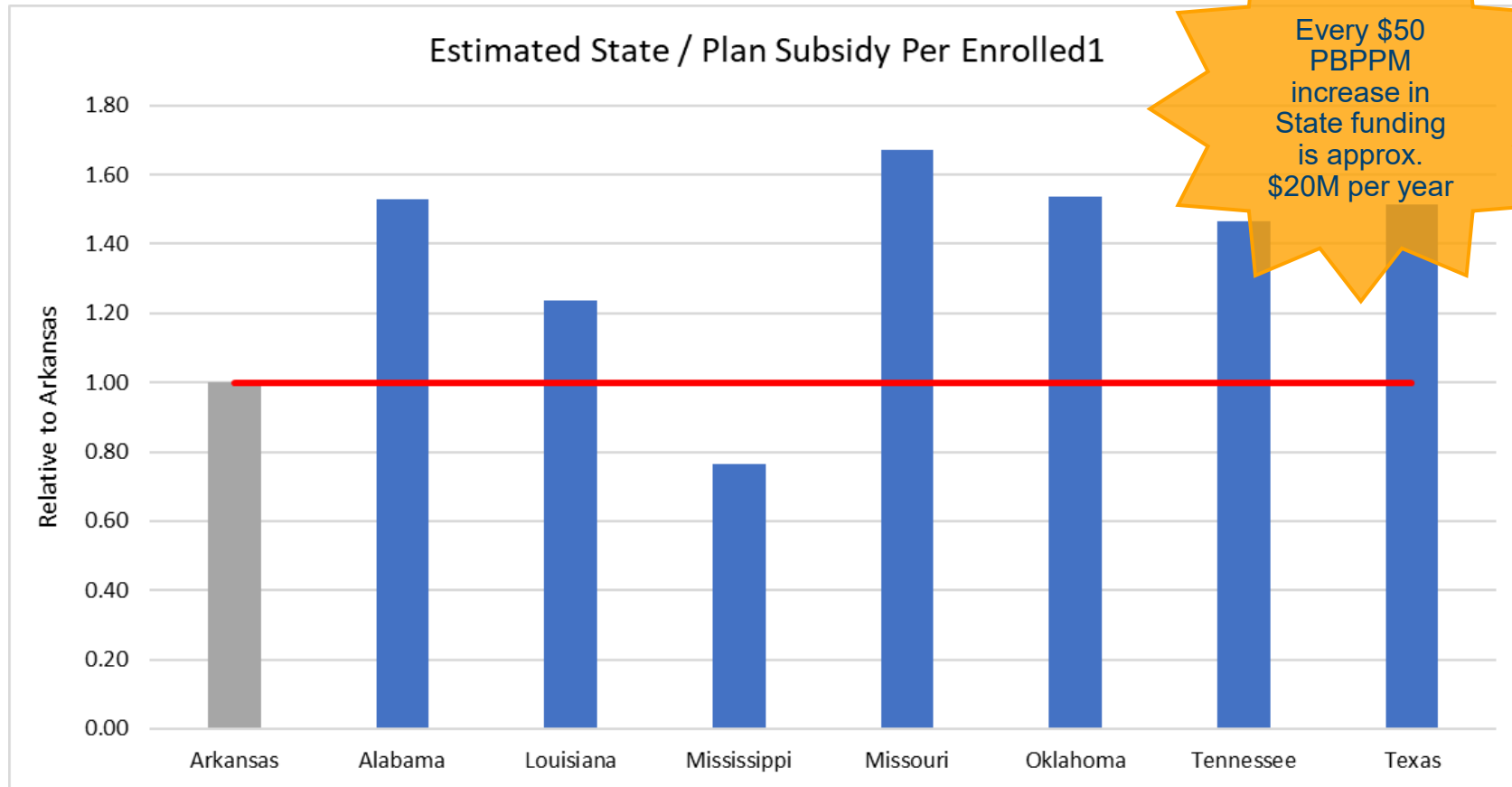
*See Assumptions and Methodology at the end of this report

- ◆ Arkansas employee payroll contribution ranks 7 (higher the rank, higher the employee contributions)

- ◆ A few states provide a fix subsidy level by tier (e.g. MS, OK, TN, and TX)

ASE – Benchmark Study (Active Employees)

Estimated* State/Plan Subsidy



- ◆ Arkansas State / Plan Subsidy ranks 2 (lower the rank, lower the subsidy)

- ◆ Each year plan sponsors reassess their subsidy levels (typically increase subsidy annually to keep pace with healthcare inflation)

- ◆ Alabama expresses their subsidy similarly to Arkansas (i.e. FY2020: \$930 per active employee per month)

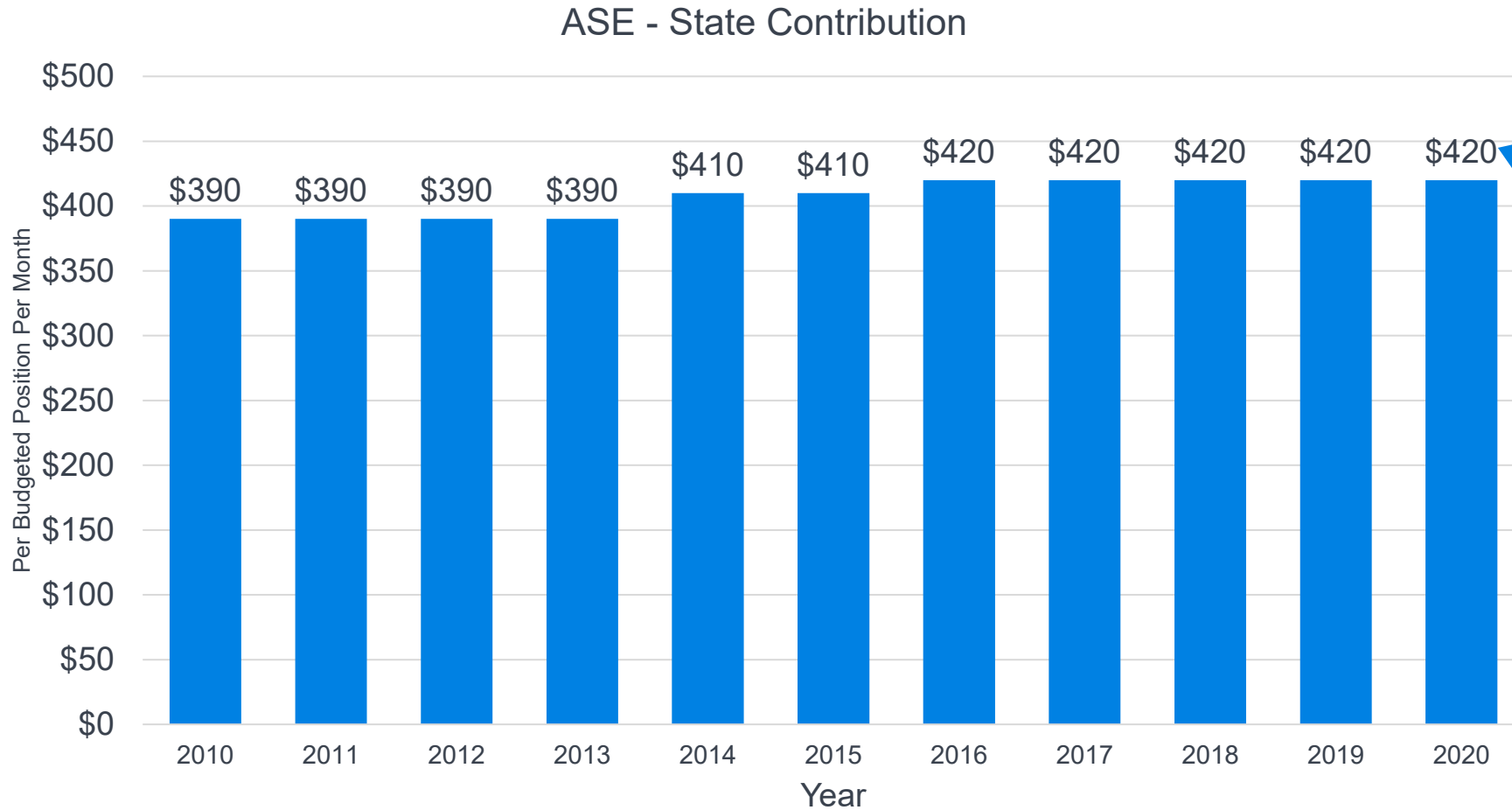
- ◆ Arkansas would need a subsidy of about \$690 per budgeted position per month (PBPPM) in 2020 to be approximately equivalent to Alabama (without reducing the number of budgeted positions)

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

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

Appendix Historical State Benchmark

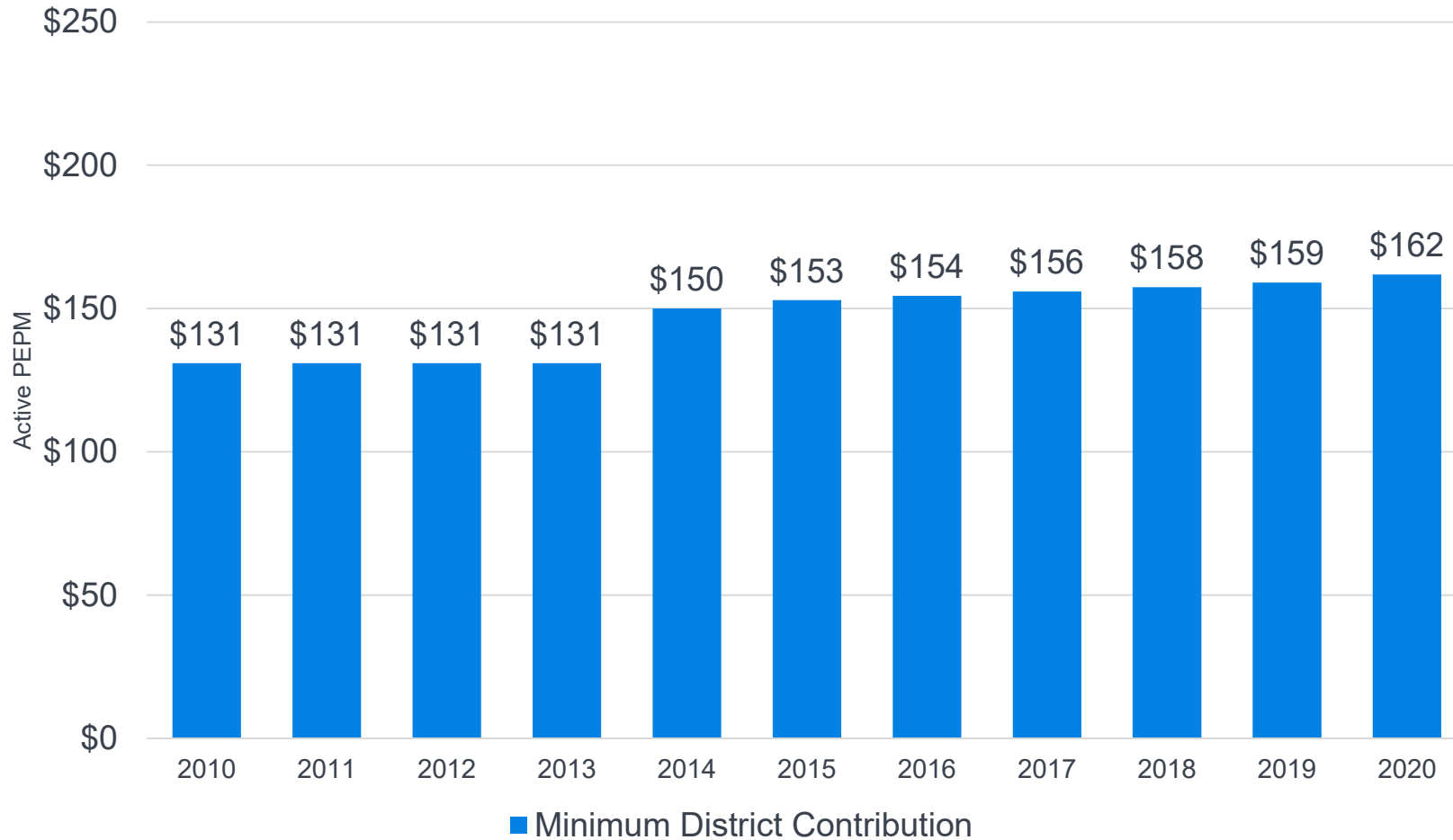
ASE – Historical State Funding



Over the past ten years ASE State Funding has increased from \$390 per budgeted position per month to \$420 (approx. \$0.7% per year).

PSE – Historical School District Funding

PSE – Minimum School District Contribution



Minimum District Funding has increased from \$131 per eligible per month to \$162 (approx. 2.1% per year) over the past 10 years.

Appendix Assumptions & Methodology

Assumptions & Methodology – Monthly Projections

Assumptions - Trend

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

Assumptions & Methodology – Monthly Projections

Assumptions – Benefit Plan Changes (2020 to 2022)

- ASE
 - No significant plan cost changes for Active, Pre-65, and Post-65 benefit plans
- PSE
 - No significant plan cost changes for Active, Pre-65, and Post-65 benefit plans

Assumptions & Methodology – Monthly Projections

Assumptions – Other

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

Assumptions & Methodology – Monthly Projections

Methodology

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

Assumptions & Methodology – Benchmarking

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

Assumptions & Methodology – Benchmarking

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

Limitations

Courtney White and Paul Sakhrani are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render actuarial opinion contained herein. To the best of our knowledge and belief, this analysis is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The assumptions used in the development of the 2020, 2021, and 2022 monthly projections relied on historical ASE and PSE medical and pharmacy claims from Arkansas Blue Cross and Blue Shield (ABCBS) and MedImpact, respectively; funding and plan administration from EBD; historical ASE and PSE members by benefit plan, age/gender, and by month from EBD; 2019, 2020, and 2021 ASE and PSE benefit plan summaries from EBD; 2020, 2021, and 2022 fees and administrative expenses from EBD; conversations with EBD regarding the program, and actuarial judgment.

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

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

While we reviewed the ABCBS, MedImpact, EBD, and state website information for reasonableness, we have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

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

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

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

STATE AND PUBLIC SCHOOL LIFE AND HEALTH INSURANCE BOARD – WORKING SESSION MEETING MINUTES

The State and Public School Life and Health Insurance Board (hereinafter called the Board), met on March 15th, 2021, at 3:00 PM

Date | time 3/15/2021 3:00 PM | meeting called to order by Renee Mallory, Chair

Attendance

Members Present

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

Members Absent

Teleconference

Cindy Allen
Cynthia Dunlap
Dr. Lanita White
Dr. John Kirtley
Greg Rogers
Melissa Moore
Lisa Sherrill
Dori Gutierrez
Herb Scott

OTHERS PRESENT:

Rhoda Classen, Laura Thompson, Jennifer Goss, Drake Rodriguez, Janella DeVille, EBD; Micah Bard, Dwight Davis, Octavia DeYoung, UAMS EBRX; Jessica Akins, Takisha Sanders, Jim Bailey, Health Advantage; Courtney White, Paul Sakhrani, Scott Cohen, Greg Collins, Julia Weber, Milliman; Mitch Rouse, Ryan Fischer, TSS; Jake Bleed, DFA; Sylvia Landers, Colonial Life; Judith Paslaski, MedImpact; Nicholas Poole, ASEA; Frances Bauman, Novo Nordisk; Erika Gee, WLJ; Ronda Walthall, ARDOT; Dwane Tankersley, NovaSys Health; Elizabeth Montgomery, ACHI;

Review Options for Potential Plan Savings Discussion

Milliman provided a presentation to educate the Board on guiding principles of the budget levers, 2022 budget target, and state funding and employee funding budget levers.

Discussion:

Fecher: I just wanted to talk to the Board based on our conversations at the last meeting. We have invited Blue Cross Blue Shield (BCBS), who will update us on some of the questions we all were asking last time. We have to look at this two-fold, we have to look at the long term and see what we can do, but we also have to look at the short term and what we can do right now, and what we are going to do for 2022. So, I think that is where our focus needs to be, and we can keep our eye on the long-term fixes, but some of the things we spent a long time talking about at our last board meeting are going to take a lot longer than 2022 to get in place. Right now, with the shape of the plan, we are going to have to do something to address the now, and I just wanted to bring that to everyone's attention. Do you have any questions?

Dr. Fiddler: It's taken us five years to get 15% lower than the average of all Arkansas employers, is that correct?

Cohen: No, I wouldn't say that. We did this analysis based on 2020 data. So, you could have been more efficient from a price being paid for medical services for all of those years. We didn't model every single year. Those numbers don't usually change very quickly. So, you may have had that advantage for all five of these years. We aren't sure; we just benchmarked it on 2020.

Dr. Fiddler: I'm just trying to understand with just a couple of years history on the Board. I'm trying to figure out how we got here, and we don't want to do it again. It states here that from 2017-2022, we are basically 3% each year for five years. So, in 2018 we knew we were 3% behind, and in 2019, we knew we were 6% behind. In 2020 we knew we were 9%. If I'm understanding these bench markings and the price efficiency that you were talking about, we had five years that we saw every year we were getting a little bit farther behind. Is that a correct statement?

Cohen: No, I think I have caused you to mix up two different concepts. So, in that top set, we are just comparing plan expenses to revenue. That price efficiency is the actual price of the services that the plan is paying. So going for an office visit, let's say it costs a hundred dollars. We would also look at what that same visit would have been if Medicare was reimbursing us, and then we just do that for all of the services. Then we do that for EBD as a whole, and we say, on average, what is the plan paying for compared to what Medicare would pay, and we get a rate. Then we do the same thing for a benchmark data set made up of all the employers in Arkansas for the IBM market scan data set. So, that is focused only on the price of services. What we are trying to say is that your carrier, Arkansas BCBS, is competitive compared to all employers in Arkansas. If you were paying the average price for all the services the members are getting, you would be

paying about 15% more for those services. So, you are getting a price advantage because of the contract discount that BCBS plan in the Arkansas market.

Bailey: They have laid out (Milliman) a very nice summary of what's taken place, but there are some people who have not been on the board long enough, as Dr. Fiddler referenced. I want to remind the Board that in 2013 the plan found itself in a similar place. At the time, Governor Beebe had to step in and infuse \$36 million into the plan. So, we got that funding, and things began to turn around a little bit. Because of some things we knew we needed to do, we didn't do anything around potential plan design or contributions. Terry, to try to answer your question, I think that is how we have found ourselves in the situation we are in today.

Dr. Fiddler: Thank you for answering my question. Obviously, we can't address it all right now, and we are going to have to address just where we are to get to 2022. What we are trying to do in two parts is in 2021, we have got to do something to get through this year, but also at this same time, we have to do something to implement the initiative so that we don't go from 2017-2022 and this catches up with us. So, we are trying to stay ahead of this from now on. Is that a correct statement?

Fecher: Partially, yes, we are still working on the numbers for the next regular Board meeting for this month. I believe we will come out okay for 2021; if not, we will be very close. We need to focus on 2022. We have a huge deficit in 2022, where we are sitting now. We have to make those decisions very quickly to get them rolling so they can roll out on January 1, 2022. I believe because of some things that are moving around, and the numbers are always moving, we will squeak by in 2021, but in 2022 is when the bottom is going to fall out.

Dr. Fiddler: So, with 2022 coming about, are we going to get options later in this presentation of what those initiatives will be?

Fecher: No, those are things that EBD is doing.

Dr. Fiddler: Mike Beebe, as Jim stated, in 2013, had to come up with a suggestion, which was a large amount of money. Increasing our cost to our ASE and PSE members or cutting services are basically our options to stay ahead after 2022.

Fecher: Yes, and we are going to talk about some options if we complete this presentation. They're going to give us several different things we can go through. I think they are going to make this clear as we go on, and that's the decision the Board is going to make. Milliman is never going to come in here and say do this, this, and this, and you will be okay. They are going to say you can adjust the rates, you can adjust the deductible, you can adjust this, and then we as a board will have to make those decisions of what we are going to do. I've spent a lot of time talking to a lot of legislators and what I'm hearing is that they do not want to

just completely bail us out in 2022. I think we are going to have to make some hard decisions for 2022.

Bailey: As it relates to the PSE program, the affordability of that program today, for Milliman, for a single-family ratio is sitting at about 1.3. So, the idea that we need to raise \$70 million to which you are covering employees for the most part only in this program. That's an incredible amount of premium you would have to generate from the employee pool. We do have a couple of large districts that, because of their agreement with the local school boards, fund up to a certain amount to cover almost the employee costs, but many of the districts do not. So, we are basically at a very kind of inflection point in terms of what happens to this PSE program in its current state.

Fecher: For those of you who don't know, Mr. Bailey is with BCBS and he is going to speak after this presentation

Bailey: In recent years, ASE/PSE has done a good job on the EBRx side in terms of securing manufacturer rebates on drugs. My assumption is the rebate money is baked in here. So, the situation could be even worse had those numbers not improved in the last couple of years.

White: For PSE, keep in mind that the benefits are made richer, so the deductibles were lowered, I think in 2019 or 2018. Their benefits are richer than ASE's, so this would bring them back up to where they were before.

Gillespie: Just for a frame of reference, a 5% contribution increase, how much would that be for an employee?

White: It is going to vary by what kind of benefit plan they have and by what kind of family structure they have. Keep in mind, too, that on ASE most of the employees are in the premium plan, and for PSE, the majority are in the classic and basic plan, with most in the classic plan.

Dunlap: The last few times we have gotten together, we have talked about these three areas of potential increases: the percentages, the wellness credit, and the deductible. It was mentioned earlier if we double each one and went from five to ten and from \$250 deductible to \$500 deductible, you get twice the amount. But doubling these impacts here only gets you \$14.5 million. We still need \$25.5, which still puts us in a deficit. What other areas are we looking at that we have possibilities to raise these funds. I know we talked about the drug plan initially, but there hasn't been much discussion about what part of that would be considered. Is there something that could be modified to what we did back in August to could help with this? This presentation here, even if you double it, doesn't even get us where we need to be. What other options are we looking at?

White: One thing this doesn't take into account is the state funding changes for ASE. One thing we have looked at was the elimination of spouse coverage for Medicare retirees.

Dunlap: Do we have a dollar impact on that?

White: Yes.

Fecher: That is something we get to at the end as well, where we can play with the numbers on all of the different scenarios. I think, Dr. Fiddler, that is the point you were trying to make is that the Board at that time went through a fix several years ago, but no inflation was built in to keep up with the rising medical cost, so now we are in a deficit again. So, that is part of the plan going forward that we should present. I was going to have Blue Cross Blue Shield go first to kind of address some of the things. I think it may be good if they could do their brief presentation before we get into the numbers, just so the Board has that information with them as well.

Bailey: My name is Jim Bailey. I'm Senior Vice President of Marketing, and I've been our Chief Marketing Officer. I work with our very large commercial clients such as Walmart, Tyson, JB Hunt, Windstream, and others. What we've seen with the covid-19 pandemic in the utilization patterns with this particular group is different than what we saw in our commercial population. We contract separately with each medical facility. We look at scale, and we look at volume in terms of what we have with these particular facilities. Obviously, Medicare has always been a good barometer in terms of its relationship to Medicare. We are somewhat sensitive to critical access hospitals because they are at a very difficult time right now. We look at them in a different light because we need to have affordable access. We do have a statewide fee schedule for all professional related services. So, whether a physician is in Eldorado, Arkansas, or Bentonville, Arkansas, the fee schedule is the same. We look at that every year in terms of making any particular adjustments to it. We have an outpatient ambulatory surgery fee schedule as well as an outpatient hospital fee schedule. So, all those things are in place that we target and manage to somewhat; it's kind of benchmarking. One of the attributes we have is our medical coverage policy. Everything we do at Arkansas BCBS has to be evidence-based. So, when we are presented with challenges around things that might be experimental, we have to take them into consideration but we have to demonstrate there is actually efficacy and what that particular procedure or service is going to provide. In terms of oversight for ASE/PSE, we have eleven dedicated case managers that interact with the members on a basis of what their needs are. We have two dedicated maternity case managers and a dietitian. We have also added, in the last couple of years, because of behavioral health moving to front and center, thirteen social workers that are somewhat spread out and have them engaged in overseeing the management of both ASE and PSE. My comment would be that

the Milliman report is spot on. They have laid it out very well. One of the things that our commercial population is targeting and looking at is sculpted or nested networks that are structured around quality and value. When we are looking at our commercial population, which is a problem for ASE/PSE, it is sculpted or nested networks that are structured around quality and value. We are looking for ways to effectively measure and would take out unnecessary medical costs or inappropriate medical costs. That's a challenge for ASE/PSE because of the state. You have to adhere to state mandates, even though you finance your plan in a self-funded mode. State mandates are applicable and can become a political hot potato in your particular case. Maybe another thing we need to look at is what those state mandates represent in terms of impact. The other thing, because of our state, we have what is called any willing provider legislation. Any provider that meets the credentialing standards and protocols is in the network. You cannot dislodge a provider unless they have violated certain practice standards that we adhere to. This is where things are and it's been a dilemma in terms of how the state can present or head down the path of value without encountering some political situations that would present a real challenge.

Mallory: So, what you're saying on the quality networks is that in a commercial plan, they can guide people toward those networks, but we are unable to do that. Is that what you are saying, or did I misunderstand that?

Bailey: No, you didn't misunderstand it. We can redirect populations to people whom we have done quality analysis on, but I think it becomes a political hot potato if we publicly announce that. Our largest client today already has this model in place for their corporate people in northwest Arkansas and we have some providers who did not meet the criteria, and it raised a storm, but they have worked through it. I think it would present a different type of challenge for ASE/PSE.

Mallory: With diagnostic procedures, do you negotiate those rates as you do for an inpatient facility? How are those rates done? For example, a CT, ultrasound, or an MRI.

Bailey: Yes, we do negotiate those, and they will move based on the changes coming out of Medicare. We will make adjustments every year. There may be a small adjustment in one category, and the other categories may be a large adjustment. For example, CMS, the plan was to reduce the reimbursement in several subspecialty categories, but they increased the reimbursement for primary care services to the tune of about 3%. So, we kind of track along with that in terms of making those adjustments. The challenge for large employers right now is they believe that about 30% of healthcare delivered in this country today is either deemed medically inappropriate or medically unnecessary. So, our large commercial clients are saying you guys have to attach that portion of the healthcare expense because if you make a dent in that, that is going to be far

greater than we would be able to accomplish in terms of just the unit price. This can't be just a unit price decision.

Dr. Fiddler: One of the things the EBD board has been dealing with for both ASE and PSE are low-value procedures, which is basically the 30% you are talking about. So, if the EBD board chooses, if we get to these low-value procedures and we say we just can't do these, this saves us so much money. When you see this, do the blues (BCBS) go in and say we are going to negotiate what's left of those procedures and try to get that cost of the procedure down for the membership of ASE and PSE? Is that a fair statement?

Bailey: It is a fair statement. We have been transitioning away from fee for service for the past four and a half to five years. It has been a stress for the provider community to shift away from that fee for service because for many of them, that's what they live by. We have been trying for a long time, Terry, to move to a value-based structure. From the provider's side, it becomes a real challenge. We're focused on it, and we're going to get there.

Scott continues Milliman presentation.

Gillespie: I thought the chart you showed a minute ago showed that the contribution was \$420, but now you are stating that it's at \$450?

Fecher: It went up to \$450 on January 1st, 2021. But now I think they are looking to see if it went up to \$500.

Gillespie: You think net assets are about to come in, and instead of being \$5 million short, we're going to be about zero.

Fecher: The numbers start over every calendar year, so even if we break even this year, those numbers (the 40 and 70) will still hold true for 2022.

White: If it's zero, maybe we only need \$35 million, just because we only want to break even. If we get to \$35 million in 2022, break-even, then that \$35 million ends up flowing into assets. So, that gets you to your reserve if we're at zero for 2021. Things are gonna move around a little bit over the next three or four months as the 2021 experience starts to emerge and then we see what happens with the COVID impact in the first quarter of 2021.

Gillespie: Are you still seeing it trend lower?

White: It's lower than what we would have expected based on pre-COVID plus trend.

Mallory: When you're talking about the increase, would we also have to add the \$25 on top of that?

White: So, if we reduce the wellness credit, that is in addition to that. What happens when you reduce the wellness credit, the people up here just get the 5% increase because they're already at the higher level. So, they're reducing the gap between wellness and non-wellness by increasing the wellness people's rates because we're reducing the credit. So, the non-wellness premiums actually go up less than the people with wellness.

Mallory: Okay, I just want to make sure that everybody is clear on that.

Fecher: I know Dr. Fiddler was asking about different menus of what we can do. So, some of the things we could do for 2022 is increase the member share. That could be, as mentioned, the same across the board, or we could look at actives and retirees. We could look at spouses and dependents having different rates, so it doesn't have to be across the board. Then we have the state share and the school district funding. I don't know how easy it would be to change the school district funding, but we could look at the state's portion. We could change the deductible and raise it in some way. Again, anytime we could do it differently between the different classes. We could look at the number of plans as we are currently offering three plans. Some states offer two or one. Then, as I said, we could look at spouses and dependents and if we want them to cover a higher percentage of that rather than the state. And then, of course, the wellness credit. Are there other levers that the board has in mind that we could possibly pull? I'm not saying we do all these. I'm not giving, you know, any kind of suggestion; I'm just saying these are our options of things that we could do quickly.

White: One thing we haven't talked about is prescription drug copays. I know we want to get input from Dr. Davis, but that's another lever that we could pull. I think it's a \$15 generic copay, \$40 preferred brand, \$80 nonpreferred brand, and \$100 for specialty drugs. I don't think those have been changed in quite some time. You know, a lot of times the generic drugs cost less than \$15. So, the members are probably paying a lot for that, but I've definitely seen a large increase in specialty drug cost over the years. So, some plans have coinsurance there so that there's a greater share of the cost being shared with the member. Also, EBRx has put in place some coupon programs with the manufacturers to help offset some of that employee cost as well.

Lilly-Palmer: So, I kind of want to piggyback on what Secretary Fisher is saying. We do have some levers that we can pull. One of the things that I do want to point out, though, with the plans that we have operational and functional now for the actives is the fact that we have already, and I was not on the board at that time, but for the state employees, if their spouse is offered coverage at a different place of employment, they have to sign the affidavit saying they are not eligible. That may be something because of the way it functions right now; if their state and school, we may be able to look at that. I don't know what that would do to numbers when it comes to state contribution and school subsidy. I know it was

mentioned earlier, in regards to the retirees when they carry over and carrying their spouses are not. One of the other things is that I would like to see it because what I hear from the employees from our side is the contribution, and they're just looking at the bottom line. So, I would kind of like to see if it's even worth the funding to possibly eliminate the basic plan and see where that takes us in regards to the money, but allow that option for the high deductible plan but not get rid of the point of service plan. Whatever we do, the educational piece right here is so important to the employees because even just going up 5%, they don't see what we see. They don't see that it really only equals \$7 pre-tax. So, if they can see that breakdown after whatever decisions we make and possibly provide an educational piece or summary of how we had to come to this decision, that would also be helpful to them as well. Then, if we do look at increasing the deductible, maybe we look at increasing a deductible alone instead of out-of-pocket max. It's one of the things I think employees also get a little confused about, and that's because they don't do it every day. The plans and the prescription plans are two different copay or coinsurance limits. So I think that there's a shock factor there. So, if we could look at what Courtney was saying in regards to the \$40 and the \$80; there are a lot of prescriptions out there that are not the \$15. They are \$7 or \$4, so that might be something that might benefit us to look at those programs that are offered.

Gillespie: Last August, we looked at moving the Medicare retiree population's drugs over. Where is that in this, because as the time we said we would do it a year later.

Fecher: That was something we voted on to extend for a year. I did not have that as an option, but it is an option if the board wanted to choose that.

Gillespie: We will need to be reminded of what the cost impact of that was.

Allen: If we leave the three plans, which I know some teachers cannot afford more than the basic plan with what they make, because we have some areas that are very low income and their teachers are not paid well. If you look at the difference in the premiums between PSE and ASE, you'll see there's quite a difference there. And if they have a family, it's very difficult for them. But what I'm saying is, if we leave three plans, there's going to be some people, and we saw this before that are going to move down a plan, because they can't afford the premium anymore or they have to go to basic because they can't afford classic anymore. So we do need to take that into consideration because last time, we didn't have as much savings as we thought because people did move down on plans, whether it's ASE or PSE. It doesn't mean they'll stick with their plan if their premiums go up.

Scott: I certainly hope that to be a real slow, slow slope that we will go down. I know we pretty much had agreed to the year extension. I really hope we can be cautiously optimistic and making that the very, very last recommendation, if possible. I certainly don't want to be surprised. I mean, we had a virtual volcano last year; I

think that volcano would just double this year. So I hope that'll just be a slope that we will just cautiously go down if we go that route.

Fecher: At some point, we have to get into the brass tacks of what we want to do and how that will affect the bottom line. I don't know if that's this meeting or a different meeting, but that's what we're trying to get to. A plan that we can say the board votes on and approves to take us into 2022.

Lilly-Palmer: Is it possible, Courtney, that maybe we could have a breakdown of what it would look like if we eliminated, for example, the basic plan. To Secretary Gillespie's point earlier, would it be possible to have an exhibit per se or an appendix that would even demonstrate that for us so we could see that? With the wellness going down to the \$50? And then potentially going down to the 25? To see those scenarios in play

White: We can do that for the next Board meeting.

Mallory: Instead of having the total can we break it out, you know in the past, we would get a table when we had recommendations like this that would actually show what individual beneficiaries are paying depending on which plan they're on whether their individual, individual and spouse or individual and family and what the increase would be dollar-wise. So, if we could look at something like that, maybe 5% or maybe 10%, and have those in front of us. Then, the total for some of the other bigger stuff might help too.

Scott: Whatever you do, I would certainly like to see the advantage or disadvantage for some of the retirees.

White: Any plan design changes wouldn't really affect the Medicare retirees because the plan pays secondary to Medicare. So, Medicare pays first, and then the plan changes, then most of the time, I think retirees pay very little for medical.

Dunlap: One of the disadvantages I have is that I don't have state employee insurance. So, I am not familiar with the deductibles and the amount of the premiums for the different categories. It's kind of difficult to visualize what some of these changes would mean to each one of the categories. So, where can I find that summary that will show the difference between the deductible for each one of the categories?

Toles: We can provide that to you. We can send you what the current rates and deductibles are.

Gillespie: I think you mentioned potentially relooking at what we do in terms of drug copays across different populations since that is an area that other employers update almost yearly. Is that something that it would be appropriate for you to bring us some thoughts on what other employers have been doing around the drug side?

White: Yes, we can do that too.

Mallory: Secretary Gillespie, does Medicaid charge a copay for drugs?

Gillespie: We do for different populations. Some populations, no we don't, but we do for other populations. Basically, CMS allows for Medicaid in general; it has a cap on the amount. In general, there is an overall cap of 5% of your income, then there's a specific amount, like a doctor's visit is capped at \$4.90 and drug at \$9.40. So, they do allow around Medicaid if your income is zero 5% percent of zero is still zero, right. But yes, we do have drug co-pays on some of the Medicaid population here, including the children.

Toles: In regards to the drug copays, we have recently learned that we have a 92% utilization of generics on our plan. So, I don't imagine that changing drug copays is the way that our pharmacy is set up; we'll have that big of an impact. So, we might find something but just kind of want to prepare you.

Dr. Kirtley: Yeah, I think our drug side is 18%, which is almost an aberration in most plans that the medical side is spending money. I think that including the plan cost sheet that we used to religiously have in every meeting. We're discussing how those changes are; I think that'll be a great thing, especially for our newer Board members to see; here's what each specific one calls because we will have to make micro-adjustments to smooth the numbers on that when we pick our numbers.

Dr. Fiddler: I have never been an ASE employee, a PSE employee, or a retiree of either fund, so I'll just know what I hear from the others. Those people who we're addressing are on the low end of this totem pole. Now I grant you, they have to have skin in the game. It's their individual; it's their family. But I think we also have to know what the Blues (BCBS) are going to do, what the legislature is going to do, and what the governor is going to do, just to see where this is going to end up costing out of our memberships pocket. It just seems like the last time when it blew up that it all went on the member immediately, and then we had to go a different direction to help the member. I don't want to get there this time. I think we need to know what, and I've been listening and watching the live screening of the legislature. I understand where they're coming from here. But, I also understand the bottom line has got to be that the members are taken care of. You would say, well, of course, they are, but I don't see that happening. I don't understand the politics or the flow of it. We come up with a number, and this is what's gonna cost us. The membership says we can't afford this and there becomes a blowup. Then we go back and say, well, let's do this then. So I think everybody has to know what everybody's willing to give before we set a rate for a particular member for a particular group. The teachers are the lowest-paid, underappreciated group in the world. They can't afford certain things already. So, you put more burden on them. Retirees, you're putting more burden on them. I think we need to know a little bit more, even if you're holding back a little bit to find out what everybody is willing to do, so that we know how much it's going to

actually cost our members as we approach this, not only for 2021. We're taking care of them because of catastrophic funding, but we don't have that anymore. So, I think we need to lay all the cards on the table and see what everybody else is willing to do before we're asking so much of our members.

Gillespie: To Milliman's point earlier, none of us like the reality of what's going on with the medical trend. I do agree with all of you that we really need to focus on what is 2022. How do we do some more longer-term, such as bigger initiatives and things? But I also do think it's important that, unfortunately, we all recognize that unless something changes in the macro world around medical trends, we will be having annual increases. Just as you talked about, back in 2017, inflation, that medical trend was not built-in on the state funding side. It also was not built-in on the employee side. Alright, so I do think we are doing a disservice to our members to let them believe that we will be the one type of plan that somehow bucks medical trend growth and that they won't have increases year over year over year. We need to start, I think, being honest about that and educating on it while we take actions to hopefully keep it from becoming out of control, right. But it isn't realistic that healthcare costs don't go up every year. So whether it's for the members or what kind of dialogue we have around the state side. But I also think it's fair to put an expectation on us that we really do have some longer-term initiatives and figure out how to put some teeth in them. I had not realized until you all said it today that even something simple, like low value, the things we've been looking at from ACHI. It's always been let's educate, let's just educate. Instead, let's say we're putting in place tougher steps so that those don't occur. I'll be interested in exploring why we actually can't do that when other employers can do it, or even Medicaid can do it. So, why can't we do that kind of thing here? And no, those will never be popular. But those are the kinds of steps others are taking.

Allen: I do want to agree with Secretary Gillespie because I do happen to be a Medicare person, and it's gone up every year since I've been on it. I haven't been in it that long, but it's going up every year. My supplement goes up every year. So, it's a fact of life; it shouldn't be a tremendous surprise. I just think we need to, as I think it has been pointed out today, to keep it on a level so that it's not a shocking surprise to them that we're going to go up in some tremendous amount all of a sudden because I'm still having trouble understanding how the PSE got so far in the hole so fast, especially after we've done basically nothing for three years, at least the time that I've been on the Board. I told the teachers group the other day that everybody's going to realize it's going to go up next year; just accept it. It's not going to go down, and it's not going to stay the same; it's going up. So I think we do have to educate them on that.

Dunlap: Secretary Fecher, to Dr. Kirtley's point before about what other players are putting in the game. Where are we on the state funding? If we know the legislation was to go up to \$500. If that's the maximum and we go up to that \$500

the first year, then we have nothing left to use for state funding. Is there any other possibility of any other legislative support that anyone's looking at right now?

Fecher: That was part of the presentation that Milliman gave at the last meeting. They did a comparison on the surrounding states from Arkansas and through Alabama as well. For example, Alabama is putting in \$900 and something per member per month. So, we are one of the lowest states on the state side of those that they compared to, but we can get that and send it back out with the information that Shalada is going to send out. I believe you're going to see a change in that number in the legislation to \$600 before the session is over. I'm not saying we will go up to \$600; I'm just saying that would be the cap statutorily that we could go up to.

Moore: Are we seeing anything in the legislature for the PSE side?

Fecher: Greg may be able to address more of what we can and can't do. I don't think we are able to do anything on the school district side; the legislature could. I'm not aware of anything they're writing on the PSE side at this point.

Rogers: Secretary Fecher is right. We can't change anything on the PSE as far as it goes with school districts unless we were to have something changed in the code because it is a formulary code of how the school district size is calculated.

Fecher: A few minutes before this meeting, a press release went out that we have a new director of the Employee Benefits Division, Mr. Jake Bleed. He will be starting the transition over after the conclusion of the legislative session. So, he will stay as the budget director through the session and then transition over. Congratulations Jake.

MOTION by Lilly-Palmer:

I make a motion to adjourn the meeting.

Gillespie seconded. All were in favor.

Meeting Adjourned.