State and Public School Life and Health Insurance Board Benefits Sub-Committee Minutes January 14, 2011

The Benefits Sub-Committee of the State and Public School Life and Health Insurance Board (hereinafter called the Committee) met on Friday, January 14, 2011 at 9:00 a.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, Arkansas.

Members Present	**Members Absent**
Jeff Altemus	
Janis Harrison	
Shelby McCook	
Becky Walker	
Lloyd Black	
Gwen Wiggins	
Bob Alexander	

Jason Lee, Executive Director, Employee Benefits Division (EBD).

Others Present:
George Platt, Leigh Ann Chrouch, Michelle Hazelette, Amy Tustison, Doug Shackelford, Latryce Taylor, Stella Greene, Florence Marvin, Lori Eden, Sherri Saxby, Paige Harrington, Cathy Harris, EBD; Rhonda Hill, ACHI-EBD; Barbara Melugin, Kathy Ryan, David Bridges, Ron Dewberry, AR BC/BS Health Advantage; Bryan Meldrum, NovaSys; Marc Watts, AR State Employee Association; Wayne Whitley, Rhonda Walthall, Sarah Sanders, AR Highway & Transportation Dept;Jon Foose, Qualchoice; Warren Tayes, MERCK; John Greer, Ann Jones, Bob Walt, Humana; Bridget Johnson, Cindy Bemis, Pfizer;

Call to Order
The meeting was called to order by Janis Harrison, Acting Chairman.

Approval of Minutes
A request was made by Harrison to approve the October 8, 2010 minutes. Walker made the motion to approve. Harrison seconded. All were in favor. Minutes approved.

PSE 2010 PLAN YEAR REVIEW *by Jason Lee*
Lee provided an overview of the 2010 PSE plan year.

Lee explained the 2010 plan year incorporated only a few changes from 2009; hearing exams, hearing aids, and vision exams were added to the standard schedule of benefits. Enrollment remained stable with just under 75% of eligible employee selecting to join the plan. HDPPO participation increased significantly to more than 10% of the active public school employees. Claims utilization on a per contract per month basis increased above 2009 level; however pharmacy claims, mental health premiums, and administration expenses fell. Trust fund account balance is stable after reserve allocations for 2011, 2012, and 2013.

STRATEGIC PLANNING WORKGROUP REPORT *by Jason Lee*
Lee presented a side by side comparison of the current health plan arrangement for ARHealth active employees and Medicare primary members vs. the Medicare Advantage plan.

Platt reported the BSPW meet on January 11th. Humana representatives talked to the workgroup about Medicare Advantage.

Recommendation from the BSPW: The BSPW recommends the Benefits committee review and consider the Medicare Advantage option as a possibility for out Medicare Retiree population.

The Benefits committee requested further in depth investigation by the BSPW in conjunction with the plan's actuarial firm to look into financial data on what we are doing compared to Medicare Advantage Plan without restriction and evaluates the same advantages of an employer group waiver plan.

Meeting adjourned.

The following pages
were made available to
attendees of the meeting

AGENDA

State and Public School Life and Health Insurance Board

Benefits Sub-Committee

EBD Board Room - 501 Building - 5th Floor

January 14, 2011 9:00 a.m.

1. **Call to Order** .... *Jeff Altemus, Chairman*
2. **Approval of Minutes** .... *Jeff Altemus, Chairman*
3. **PSE 2010 Plan Year Review** .... *Jason Lee, Executive Director*
4. **Strategic Planning Workgroup Report** .. *George Platt, Deputy Director*
   a. **Medicare Advantage – Post Healthcare Reform Discussion**
5. **Director's Report** .... *Jason Lee, Executive Director*

Next Meeting
February 4th, 2011

2010 PSE - Plan Year Review

The 2010 Plan Year incorporated only a few changes from 2009; hearing exams, hearing aids, and vision exams were added to the standard schedule of benefits. Enrollment remained stable with just under 75% of eligible employees electing to join the plan. HD PPO participation increased significantly to more than 10% of the active public school employees. Claims utilization on a per contract per month basis increased above 2009 level however pharmacy claims, mental health premiums, and administration expenses fell. Trust fund account balance is stable after reserve allocations for 2011, 2012, and 2013

	Total	Per Contract Per Month (PCPM)	Percent of Total Spend
Medical Claims Expense	$192,676,020.00	$308.77	73%
Pharmacy Claims Expense	$49,683,757.00	$79.62	19%
Behavioral Health Expense	$3,411,508.00	$5.47	1%
Administration Expense	$19,682,587.00	$31.54	7%
Total *	**$265,453,872.00**		

Percent of Enrollment	Jan-10	Oct-10
ARHealth	94.40%	89.90%
ARHealth HD PPO	5.60%	10.10%

2010 Contract Months *624,005*

	2007	**2008**	**2009**	**2010**
Medical Claims - PCPM	$ 279.94	$ 284.82	$ 298.97	$308.77
Pharmacy Claims - PCPM	$ 81.18	$ 77.85	$ 81.78	$79.62
Behavioral Health - PCPM	$ 5.32	$ 6.14	$ 6.02	$5.47
Administration - PCPM	$ 36.67	$ 30.10	$ 33.68	$31.54
	$ 403.11	$ 398.91	$ 420.45	$ 425.40

	2007	**2008**	**2009**	**2010**
Medical Claims - PCPM	69%	71%	71%	73%
Pharmacy Claims - PCPM	20%	20%	19%	19%
Behavioral Health - PCPM	1%	2%	1%	1%
Administration - PCPM	9%	8%	8%	7%

* Actual financial statement reflects IBNR and Refunds not reflected here

Information taken from September 2010 financial report and ARBenefits.org enrollment data

Contract defined as primary employee member or retiree member - count does not include dependents

Medicare Advantage: A Strategic Solution

State of Arkansas

State and Public School Life and Health Insurance Board

Benefit Strategic Planning Workgroup

January 11, 2011

Today's Discussion

- Medicare Advantage (MA)
  - What is it?
  - What is the impact of Healthcare Reform on MA?
  - Is MA a sustainable solution for the Employee Benefits Division and Medicare Primary retirees/spouses?
- Discussion of recent case studies
- Strategic solution for your consideration
- Q & A

What is Medicare Advantage?

Traditional Medicare Program

- National health insurance program for elderly and disabled
- First beneficiaries enrolled in 1966
- Covers 45 million beneficiaries today (11.9M in MA)
- Plan design features deductibles, coinsurance with no out-of-pocket limits
- Consists of four parts:

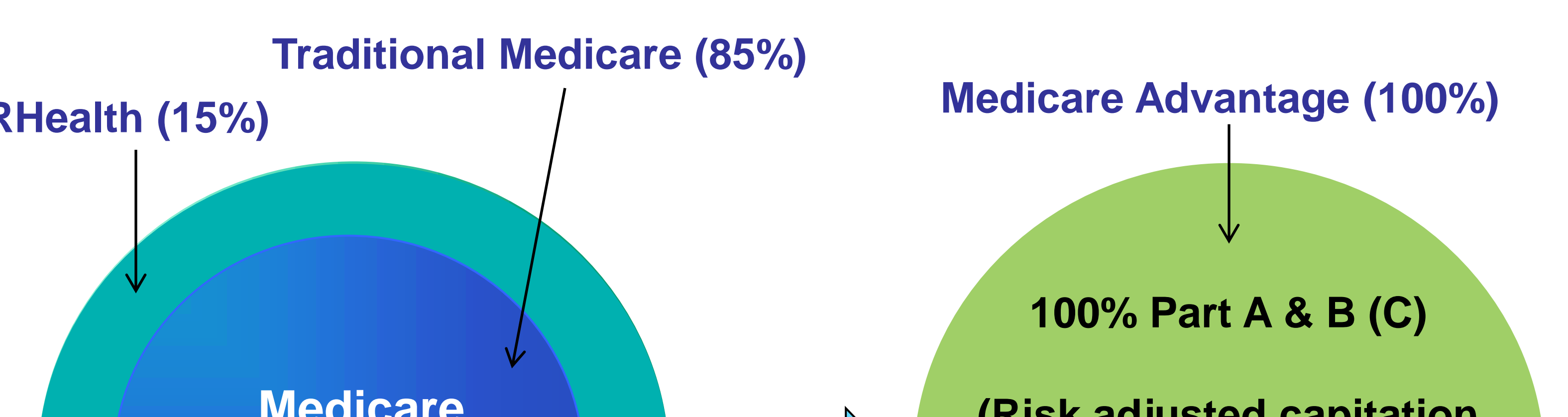
Part	Covered Services
A – Hospital Ins	IP Hospital, SNF
B – Supplemental Ins	Physician, OP Hospital
C – Private Plan Options (**Medicare Advantage**) *	Parts A & B plus benefit enhancements
D – Prescription Drug Ins **	Pharmacy

Notes:

* CMS pays private plans risk -adjusted monthly capitation payments at the county level based on a rate book developed from traditional Medicare cost in each county, with a range of subsidies and the potential for an additional quality bonuses

** CMS pays private plans risk adjusted monthly capitation payments based upon regional benchmarks and plan bids. Plans receive additional payments for catastrophic claims and beneficiaries qualifying for Low Income Subsidies

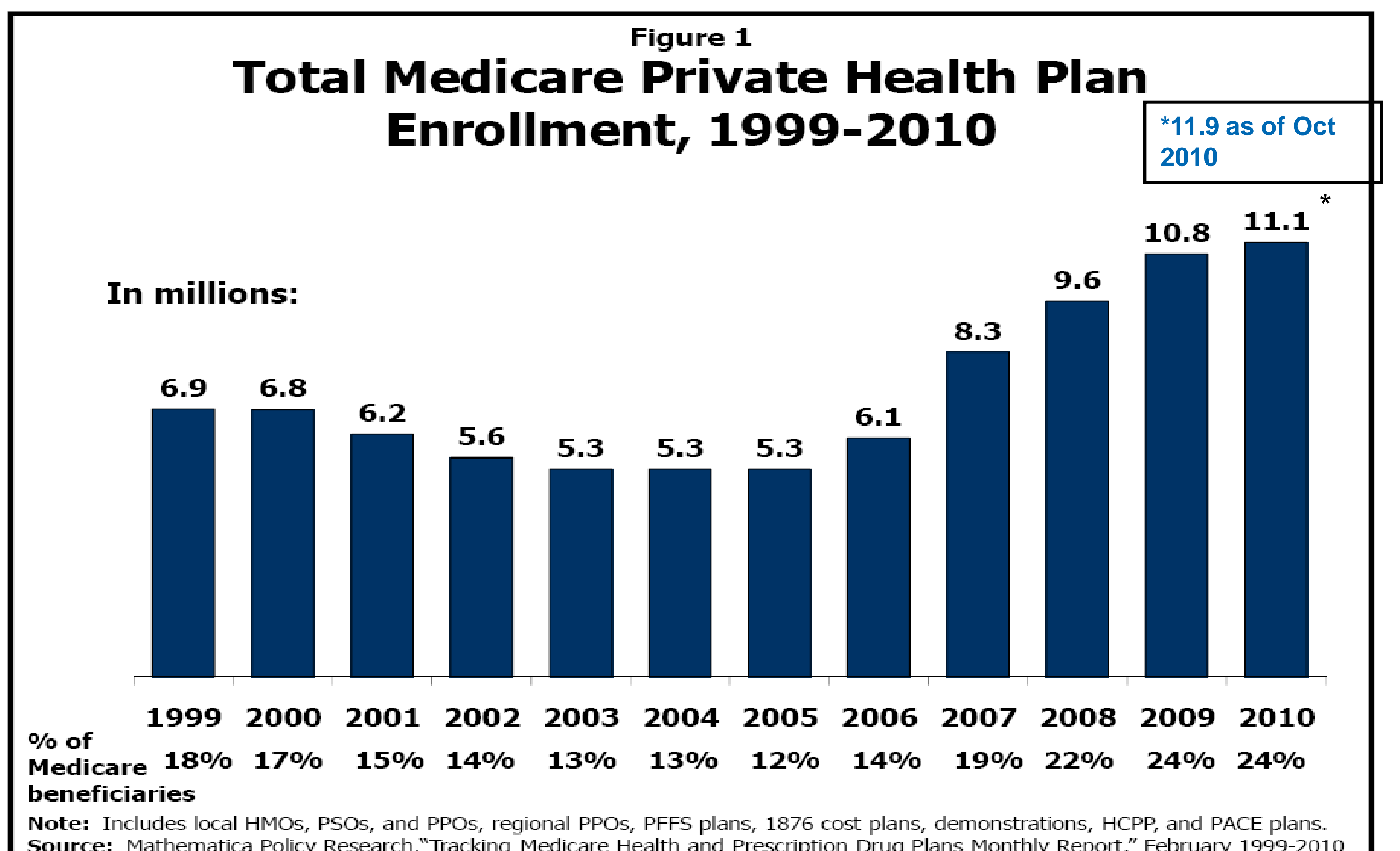
Medicare + ARHealth Medicare Primary Plan vs. Medicare Advantage Plan



Examples of Medicare Advantage enhancements include:

- Wellness/physical fitness
- Integrated behavioral health/medical programs (e.g. LifeSynch)
- Full spectrum of senior-focused care management
- Focus on "whole person" that improves quality and lowers cost

National Enrollment in Medicare Advantage



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Impact of Healthcare Reform (i.e. Affordable Care Act) on MA – Base Payments

- MA county benchmarks; no change in 2011 (update for 2012)
- Restructure MA payments to align with new county benchmarks set at different percentages of traditional Medicare Fee For Service costs (FFS)
  - Counties across the country DC ranked by FFS costs
  - MA county benchmark percentage linked to one of four FFS cost quartiles

FFS County Cost Quartile	*MA County Benchmark %*
Highest	*95%*
Second Highest	*100%*
Third Highest	*107.5%*
Lowest	*115%*

- Phased-in over two, four or six years depending upon the amount of county benchmark reduction when comparing current (2010) law benchmark to sum of ½ current and ½ new county benchmark (including quality bonus)

County Benchmark Monthly Reduction	*Phase in Period*
$50 or more	*2012-2017*
$30-$49	*2012-2015*
Les than $30	*2012-2013*

- New county benchmarks capped (not to exceed) current benchmarks under current law

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County Benchmark Quartile Map

- Quartile 1 = 95%
- Quartile 2 = 100%
- Quartile 3 = 107.5%
- Quartile 4 = 115%

Note – County quartile assignment is based on interpretation. Future guidance provided by CMS may result in different quartile than shown.

Impact of Healthcare Reform (i.e. Affordable Care Act) on MA – Quality Bonus

Affordable Care Act

- Pay quality bonuses to MA Plans beginning in 2012
  - Based on CMS's Five-Star Quality Rating System
  - Driven by HEDIS, CAHPS, HOS and other scores
  - Qualifying plans must have a 4-Star rating
  - Benchmarks increased for qualifying plans by 1.5% in 2012, 3% in 2013, and 5% in 2014 and after
  - Double bonus provision for certain urban area counties

2012 Three-year Demonstration Program

- Change in focus that rewards progress
- Beginning in 2012:
  - Five-star plans receive 5% bonus
  - Four-and-a-half star plans receive 4.5% bonus
  - Four-star plans receive 4% bonus
  - Three-and-a half star plans receive 3.5% bonus
  - Three-star plans receive 3% bonus

MA Funding: Pulaski County/ Statewide

Arkansas							
Forecasted Medicare Advantage Revenue Flow							
Post-Health Care Reform							
County	Medicare Eligibles Residing in Service Area	2010 MA LPPO/HMO County Bench-marks	2010 MA RPPO County Bench-marks	2010 MA CMS Funding Ratio RPPO	Post HCR County Bench-mark Quartile	Post HCR Phase-in Period (years)	Ultimate Funding Ratio w/ Bonus
Pulaski	59,449	814.42	779.44	105.5%	2	4	105.0%
State Weighted Average		772.03	779.44	115.8%	3	3	111.1%

Sustainability: Keys to a Viable Medicare Advantage Solution

- Revenue maximization – Risk adjustment expertise
- Integrated clinical (medical and pharmacy claims) and risk adjustment processes
  - Align provider contracting methodology with risk adjustment, clinical and STAR rating objectives
- CMS STAR ratings management and revenue maximization
- Patient-Centered and coordinated clinical programs to include preventive care, behavioral health and wellness
- Efficient and effective provider networks
- Collaborative relationship with providers
- Innovative performance-driven provider reimbursement
- Focus on “whole person” which eliminates fragmentation and duplication while improving quality and reducing cost
- Dedicated Medicare Advantage claims and customer service
- High member satisfaction and retention

***and…** the technology, business processes, human capital and infrastructure to support all of the above*

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Sustainability: 15% Solution

Our holistic approach, together with the scale needed to execute in a post-reform environment, positions us well to deal with wasteful spending in the health system that has been estimated at more than half of all health spending.*

1% to 2%

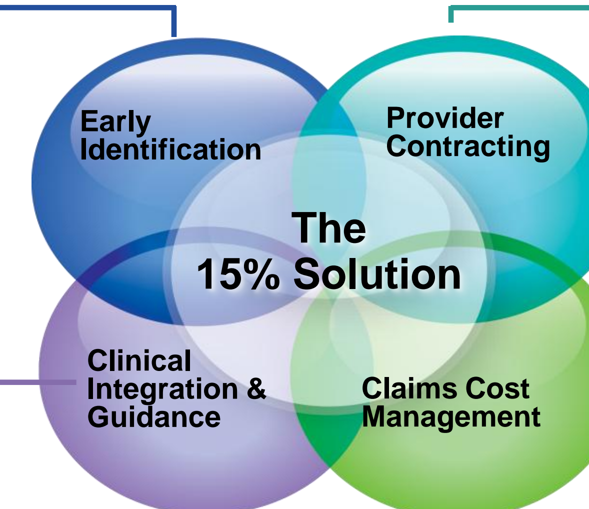
Early Identification

- Humana Health Assessment
- Predictive modeling

7% to 10%

Provider Contracting

- Efficient physician networks
- Efficient hospital contracting
- Discounts for free-standing facilities and ancillary services



3% to 4%

Clinical Integration & Guidance

- Provider guidance
- Clinician-based support
- Wellness and productivity
- Pharmacy solutions

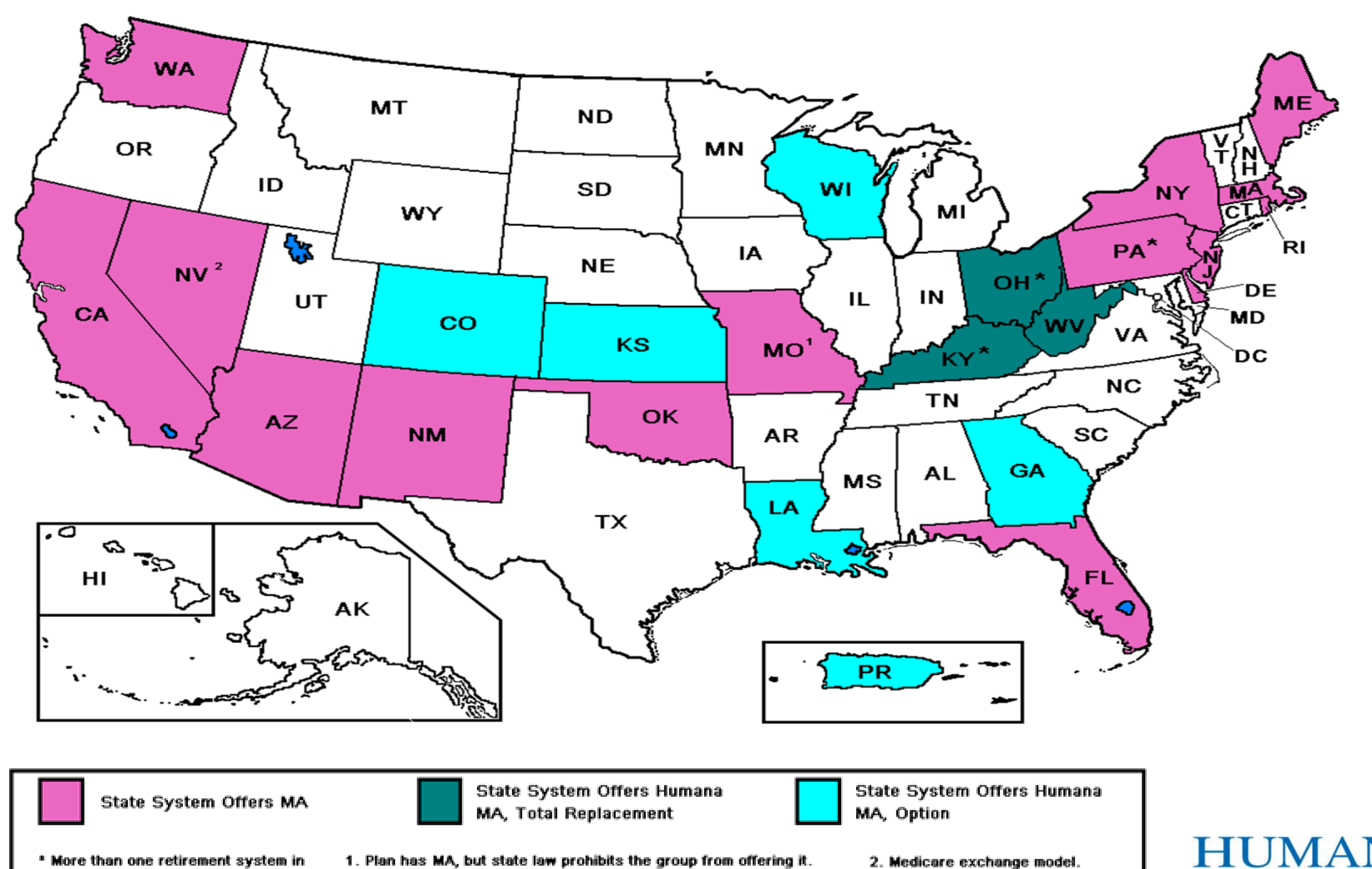
1% to 2%

Claims Cost Management

- Consistent application of Medicare-published local coverage determinations
- Timely DRG audits and recoveries
- Specialized physician billing review software
- Observation status review
- Fraud detection

** PricewaterhouseCoopers' Health Research Institute, 2008*

States Where At Least One Retirement System Offers Medicare Advantage



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Guidance when you need it most

Strategic Solution for Consideration

- Initiate a Medicare Advantage Procurement in 1Q 2011 for a Jan 2012 effective date
  - Provide detailed demographic and claims (medical and pharmacy)data
  - Ask questions that address key MA Plan initiatives to ensure sustainability, stability and member satisfaction with improved well-being
- Evaluate Non-Medicare eligible and Medicare eligible (Medicare primary) carrier solutions separately
- Keep the respective pre- and post-65 retiree risk pools in tact through an enrollment strategy that maximizes MA enrollment (e.g., MA Total Replacement or MA Default Plan Option)