



AGENDA

State and Public School Life and Health Insurance Board
March 22, 2016
1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. Call to OrderCarla Haugen, Chairman**
- II. Approval of February 16, 2016 MinutesCarla Haugen, Chairman**
- III. ASE-PSE Financials February 2016 Marla Wallace, EBD Fiscal Officer**
- IV. Benefits Sub-committee Report.....Shelby McCook, Benefits Committee Member**
- V. Quality of Care Sub-committee Report.....Bob Boyd, Q of C Committee Member**
- VI. Rx Network Rate Presentation and Analysis.....John Colberg & Gaelle Gravot, Cheiron, Inc.**
- VII. Pharmacy Network Management Discussion.....Mary Mitchell, Sales Director, MedImpact**
- VIII. Arkansas Patient Centered Community Pharmacy Program Scott Pace, PharmD/JD, EVP & CEO, & John Vinson, PharmD, VP of Practice Innovation, Arkansas Pharmacists Association**
- IX. Trend Experience/2017 Preliminary RatesJohn Colberg & Gaelle Gravot, Cheiron, Inc.**
- X. Director's Report..... Janis Harrison, EBD Interim Director**

Upcoming Meetings

April 19, May 17, June 21, July 19, August 16

NOTE: All material for this meeting will be available by electronic means only ethel.whittaker@dfa.arkansas.gov...Notice: Silence your cell phones. Keep your personal conversations to a minimum. Observe restrictions designating areas as "Members and Staff only"

**State and Public School Life
And Health Insurance Board Meeting
Board Meeting Minutes
March 22, 2016**

The 157th meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on March 22, 2016 at 1:00 p.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, AR 72201.

MEMBERS PRESENT

Robert Boyd
Dr. John Kirtley
Shelby McCook
Carla Haugen- Chairman
Katrina Burnett
Renee Mallory
Dan Honey – Vice Chairman - Teleconference
Dr. Joseph Thompson
Dr. Andrew Kumpuris - Teleconference

MEMBERS ABSENT

Lori Freno-Engman
Dr. Tony Thurman
Angela Avery

Janis Harrison, Interim Director, Employee Benefits Division

OTHERS PRESENT:

David Keisner, Dwight Davis, Geri Bemberg, Jill Johnson, Sherry Bryant, UAMS; Ethel Whittaker, Marla Wallace, Stella Green, Andrew Carle, Cecilia Walker, Gretchen Baggett, Lori Eden, Janna Keathley, Arlene Chan-Mouton, EBD; Kristi Jackson, Jennifer Vaughn, ComPsych; Pam Lawrence, AHH; Sylvia Landers, Eileen Wider, Minnesota Life; Marc Watts, ASEA; Mike Boyd, Robyn Smith, Wayne Whitley, Ronda Walthall, AR Highway & Transportation Dept; Jessica Akins, Takisha Sanders, Health Advantage; Susan Walker, DataPath; Jennifer Smith, ASU; Steve Althoff, MTI; Charles Warren, FSPS; Dr. Scott Pace, Dr. John Vinson, APA; Martha Hill, Mitchell Williams; Bill Clary, H&H; Richard Ponder, J & J; Harmony Daniels, Jackie Baker, ASP; Karen Langley, B.J. Himes; QualChoice, Sean Seago, Merck; Erica Gee, Attorney; Michael Lindsey, Walmart; Leah Ramez, ACHI; Brian Strickland; Jim Chapman; Stephen Carroll, Mark Adkison, Allcare; Treg Long, ACS; Andy Davis, Arkansas Democrat Gazette; Scott McRae, APSRC; Susan Gardner, ADFA

CALL TO ORDER:

Meeting was called to order by Carla Haugen, Chairman

APPROVAL OF MINUTES: *by Carla Haugen, Chairman*

The request was made by Haugen to approve the February 16, 2016 minutes.

Dr. Kirtley made the motion to approve the minutes, Boyd seconded; all were in favor.

Minutes approved.

FINANCIALS: *by Marla Wallace, EBD Fiscal Officer*

Wallace reported financials for February 2016. For February PSE four (4) weeks of medical and pharmacy claims were paid. There was a gain of \$5.2 million for the month and \$12.2 year-to date. The FICA savings are \$490,000. The net assets available are \$46.1 million.

For ASE the month of January four (4) weeks of medical and pharmacy claims were paid. There was a gain of \$3.9 million for the month and \$8.3 million year-to-date. The net assets available are \$36 million.

BENEFITS SUB-COMMITTEE REPORT: *By: Shelby McCook, Benefits Committee Member*

McCook reported the Benefits Sub-committee met on March 11, 2016. The committee discussed the following topics:

- ASE/PSE January & February Financials
- Rx Network Rate Presentation
- Medical & Rx Trends/2017 Preliminary Rates/PSE HSA Allocation

Dr. Kirtley motioned to approve the report. Boyd seconded. All were in favor.

Motion approved.

QUALITY OF CARE SUB-COMMITTEE REPORT: *by Bob Boyd, VP, Windstream*

Bob Boyd reported the sub-committee met on March 8, 2016. The topics of discussion were: (1) Continued Review of Anesthesia for Screening Colonoscopies, (2) Wellness Programs Review, (3) Update of Primary Care Referral Recommendations, and (4) new business topics.

McCook motioned to approve the Quality of Care Committee Report. Dr. Thompson seconded. All were in favor.

Motion approved.

Rx NETWORK RATE PRESENTATION AND ANALYSIS: *by John Colberg, Galle Gravot, Cheiron Inc.*

Colberg reported on the Pharmacy Reimbursement Dispensing Rates. The current rates established by Catamaran versus the new rates established by MedImpact. There is the possibility of no rate increase for PSE, but there is a possibility of an increase for ASE, but based on the decision by the Board regarding the network rates and dispensing fees, the possibilities may change.

AWP Discount	Disp Fee Generic	Disp Fee Brand	Plan Savings	Member Savings	Total Savings
15.65%	\$1.50	\$1.50	\$8M	\$8M	\$16M
13%	\$1.50	\$1.50	\$6M	\$8M	\$14M
13%	\$3.50	\$3.50	\$4M	\$6M	\$10M
10%	\$1.50	\$1.50	\$4M	\$7M	\$11M
10%	\$2.50	\$3.50	\$3M	\$6M	\$9M
10%	\$3.50	\$3.50	\$2M	\$5M	\$7M
10%	\$4.50	\$3.50	\$1M	\$4M	\$5M

PHARMACY NETWORK MANAGEMENT DISCUSSION: *by Mary Mitchell, Sales Director, MedImpact & Brian Sweat, VP Financial Analytics, MedImpact*

Mitchell reported MedImpact was present to answer questions to assist the Board in making a decision regarding the pharmacy rates.

Dr. Kirtley inquired if the rates indicated on the first line are quoted by MedImpact? Mitchell replied the rates are those proposed by MedImpact. The rates are based on many factors including the contracts and the networks already in place.

Dr. Kirtley inquired if MedImpact was receiving 95% participation from pharmacies in Arkansas contracted at that rate? Mitchell reported MedImpact is receiving 95% participation.

Dr. Kirtley inquired if MedImpact is aware of one major pharmacy chain who states the above discussed rate does not exist? Sweat reported MedImpact was aware of the statements. However, MedImpact has evidence of the proposed rate or better.

McCook inquired if the Board makes a decision to select another option how much time is needed for MedImpact's process to make changes prior to the effective date? Sweat replied it could take 60-90 days.

McCook inquired if 95% of pharmacies are agreeing to the contract, of those, how many are smaller pharmacies? Sweat reported there are approximately sixteen pharmacies not contracted in Arkansas.

McCook reported he has concerns with the smaller pharmacies. In an effort to protect the small pharmacies in smaller communities, could the criteria be written to assist the smaller communities and pharmacies? Mitchell reported it's the Board's decision in terms of how to set the criteria.

Boyd motioned to adopt the MedImpact rates as proposed. McCook seconded.

Discussion:

Dr. Thompson inquired of MedImpact what evidence do you have that MedImpact is achieving the said rates with the pharmacies?

Sweat reported MedImpact operates a national network. There are contracts that support that pharmacies have accepted lower reimbursement rates than indicated.

McCook reported meeting with Harrison regarding a proposal with the potential to save the plan funds and service the members. McCook would like to postpone voting on the motion until after the Pharmacists Association presentation.

Dr. Thompson inquired if the rebates would be administered by MedImpact? Mitchell reported MedImpact is the claims processor. McCook reported the Board will have control of the rebates.

ARKANSAS PATIENT CENTERED COMMUNITY PHARMACY PROGRAM: *by Dr. Scott Pace, Dr. John Vinson, Arkansas Pharmacists Association*

Dr. Pace reported the difference in 87% utilization versus 90% utilization is \$12.7 million.

Dr. Pace reported the hope is that the plan savings could be reinvested in plans such as the Arkansas Patient-Centered Community Pharmacy Program.

Dr. Vinson reported the proposal is an enhanced network. The network would serve as platform for improving quality for the patient and the plan. There are nine (9) categories to the program. The plan would have the option to implement the categories of interest.

The Quadruple Aim Focused is: improved patient experience, improved population health, increased provider engagement and lower overall total medical cost. The program should be designed as comprehensive, coordinated, patient focused, accessible, and with high quality and safety.

After discussion McCook is in favor of offering more enhancements to the smaller pharmacies based on the criteria established. Boyd reported, in his opinion, more information is needed in order to determine the amount of subsidy to apply.

Dr. Thompson motioned that the Arkansas Patient-Centered Community Pharmacy Program be referred to the Quality of Care Committee for discussion of development for potential proposed additions to the benefits structure. Boyd seconded. All were in favor.

Motion approved.

Discussion:

McCook called for questions on the previous motion presented by Boyd. Dr. Pace and the APA recommended the AWP – 13.50% and \$2.50; this would reduce the amount of savings to the plans and employees from approximately \$16 million to \$12 million.

Dr. Thompson has concerns with the flexibility of the MedImpact contract. Concerns are: is the AWP - 15.65% in concrete or is there flexibility to modify the rate based on future Board decisions? What is the possibility of reducing the reimbursement fee?

Sweat reported if the Board modified the AWP amount, the new rate would need to be secured by the pharmacies. Sweat reported an executed contract could be modified to reimburse more than the contracted amount through notification. The change could be implemented in 60-90 days.

Haugen reported there is a motion and second for Boyd's previous motion.

Haugen reported Boyd's motion is to accept the proposed rates of AWP -15.65% by MedImpact. There was a second by McCook, however he voted no. The following also voted no; Dr. Andrew Kumpuris, Dan Honey, Dr. John Kirtley, Katrina Burnett, and Renee Mallory. Dr. Joseph Thompson and Robert Boyd both voted yes.

Motion failed.

McCook motioned to adopt AWP -15.65% + \$1.50 for all pharmacies except the smaller pharmacies, and set the criteria for the smaller pharmacies at \$2.00 dispensing fee along with AWP at AWP -13.50%. Honey seconded.

Discussion:

Boyd requested Colberg to discuss the possibility of how the change could affect employee premiums for 2017.

Colberg reported PSE, without any allocation from the reserve, would increase the premiums by 6%. PSE has reserve funds; therefore an allocation of \$15.6 million could eliminate an increase. The \$15.6 million could be allocated as \$7.8 million for 2017 and \$4.68 million for 2018, and \$3.12 million for 2019.

ASE would require a 20% increase without utilizing the \$28 million in reserves. If the reserves are used the rate increase could decrease to 6%.

McCook withdrew his previous motion as there is not enough information provided on smaller pharmacies.

Kirtley motioned AWP – 13.50% + \$2.50 dispensing fee on Brand, Generic, or MAC. McCook seconded.

McCook amended the previous motion to AWP -13.65% +\$1.50 dispensing fee. Honey seconded.

Discussion:

Boyd reported this could affect 2.5 million prescriptions.

Dr. Thompson reported supporting the clinical aspect of the local pharmacist. The plan pays pharmacies through dispensing fees. Implementing the changes in an effort to save the plan funds, offers the potential to provide additional services to the members, Dr. Thompson recommended to determine the amount of savings and then pay pharmacies \$.50 to \$1.00 per-member-per-month through the Patient-Centered Medical Homes, and to work with the local Primary Care Providers; pay them to provide the services versus a dispensing fee from an AWP discount that is unfamiliar.

Dr. Kirtley reported the AWP list is updated often. However, there are also regular changes.

Boyd reported 80% of savings from the original motion and the amended motion will benefit the larger pharmacies, and 20% of savings will be allocated for the smaller pharmacies. Therefore, since such a small percentage is allocated for the smaller pharmacies, and they are not aided as discussed, Boyd recommended his original motion.

Sweat reported the plan's population is 107,000 members in the rural areas. Of those 107,000 members 98% have access to a pharmacy within 15 miles of their location.

Dr. Kirtley reported an additional rule of the Board is if there is an area with more than 10 miles in any direction from a pharmacy, a pickup station can be established, if there's a medical clinic in the area with a prescriber available.

Haugen repeated the motion. Currently McCook's amended motion is AWP-13.65% + \$1.50 dispensing; Honey already seconded. McCook reported his motion is for Arkansas independent pharmacies where they are the only one in the area. The remaining pharmacies will be allocated AWP-15.65% + \$1.50 dispensing fee.

Honey questioned the possibility of postponing a decision until further information is received.

Harrison reported the plan is obligated to proceed with the implementation on July 1, 2016. If no decision is made by the Board, at the very least the MAC list would be implemented.

Dr. Thompson was not in agreement for considering a proposal where there was no written documentation available.

Dr. Thompson repeated McCook's motion to state: pharmacies in communities with a population of less than 5000, and only one pharmacy available, that the AWP discount will be -13.65%. The remaining pharmacies' AWP will be -15.65%. Honey seconded the motion. All members voted yes except Dr. John Kirtley and Robert Boyd.

Motion approved.

Dr. Kirtley withdrew his original motion.

Due to Dr. Kirtley withdrawing his original motion, McCook adopted a clearer motion to state; adopt MedImpact's schedule for every pharmacy in the State of Arkansas except smaller pharmacies in cities with a population of less than 5000, and where there's only one (1) Arkansas pharmacy and no other pharmacy within 20 miles of the city center, and that they are to be paid AWP -13.65% + \$1.50 dispensing fee. Burnett seconded. All members voted yes, except Dr. John Kirtley and Robert Boyd.

Motion approved.

TREND EXPERIENCE/2017 PRELIMINARY RATES: *by John Colberg, Gaelle Gravot, Cheiron, Inc.*

The presentation was rescheduled for the April Board meeting.

DIRECTOR'S REPORT: *by Janis Harrison, EBD Interim Director*

Harrison reported the Bariatric Program has 100 participants in ASE and 100 in PSE. Currently, enrollment into the program has been closed for 2016.

Harrison reported obtaining additional information from WageWorks regarding the fees. After the 722 accounts are transferred the total accounts transferred will be 6,237 records.

Harrison reported a letter was generated by BNY Mellon and sent to participants who had an HSA with WageWorks. The participants were advised effective April 1, 2016 there will be a \$2.00 monthly administration fee for accounts that have a balance of \$5000.00 or less on a daily basis. Effective October 1, 2016 there is a \$16.00 fee for participants who would like to transfer assets from WageWorks to another account. The third fee of \$3.95 is an additional administration fee for participants who resigned employment with the Public Schools or State Government, and wish to maintain their accounts with WageWorks.

Harrison reported that currently DFA's legal counsel is in the process of reviewing the information for the legality of the charges. The participants were notified they are not responsible for the additional charges. In the event the participants' accounts are assessed additional fees, their accounts will be reimbursed for the \$2.00 and \$16.00 fees. WageWorks has agreed verbally to pay the fees through 2016.

Meeting adjourned.

Arkansas State Employees (ASE) Financials - January 1, 2015 through February 28, 2015

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	858	12		870		1526	24		1550
CLASSIC	1802	58		1860		3114	92		3206
PREMIUM	24816	2170		26986		43454	2797		46251
PRIMARY		229	8651	8880			469	11432	11901
TOTAL	27476	2469	8651	38596		48094	3382	11432	62908

REVENUES & EXPENDITURES

	Current Month	Year to Date (2 Months)
Funding		
State Contribution	\$ 14,362,412	\$ 28,706,486
Employee Contribution	\$ 8,128,652	\$ 16,153,481
Other	\$ 630,706	\$ 1,076,826
Allocation for Actives - Plan Year 2015	\$ 971,667	\$ 1,943,333
Total Funding	\$ 24,093,437	\$ 47,880,126
Expenses		
Medical Expenses		
Claims Expense	\$ 17,372,607	\$ 24,069,901
Claims IBNR	\$ -	\$ -
Medical Administration Fees	\$ 983,128	\$ 2,043,568
Refunds	\$ (20,668)	\$ (25,211)
Employee Assistance Program (EAP)	\$ 56,550	\$ 113,002
Life Insurance	\$ 55,119	\$ 110,153
Pharmacy Expenses		
RX Claims	\$ 5,305,708	\$ 10,905,000
RX IBNR	\$ -	\$ -
RX Administration	\$ 212,329	\$ 424,746
Plan Administration	\$ 445,661	\$ 711,784
Total Expenses	\$ 24,410,434	\$ 38,352,943
Net Income/(Loss)	\$ (316,997)	\$ 9,527,183

BALANCE SHEET

Assets	
Bank Account	\$ 12,221,560
State Treasury	\$ 71,138,735
Due from Cafeteria Plan	\$ 709,521
Due from PSE	\$ -
Receivable from Provider	\$ 665,520
Accounts Receivable	\$ 961,217
Total Assets	\$ 85,696,552
Liabilities	
Accounts Payable	\$ 3,758
Deferred Revenues	\$ 4,510
Due to Cafeteria	\$ -
Due to PSE	\$ -
Due to Federal Government (\$44 fee)	\$ -
Health IBNR	\$ 24,700,000
RX IBNR	\$ 1,800,000
Total Liabilities	\$ 26,508,268
Net Assets	\$ 59,188,284
Less Reserves Allocated	
Premiums for Plan Year 1/1/15 - 12/31/15 (\$6,260,000 + \$5,400,000)	\$ (9,716,667)
Premiums for Plan Year 1/1/16 - 12/31/16 (\$3,600,000)	\$ (3,600,000)
Catastrophic Reserve (2015 \$10,400,000)	\$ (10,400,000)
Net Assets Available	\$ 35,471,618

Fifth Week of Claims \$

Arkansas State Employees (ASE) Financials - January 1, 2016 through February 29, 2016

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	1238	27		1265	2071	43		2114
CLASSIC	1691	65		1756	2851	88		2939
PREMIUM	23626	2164		25790	41157	2782		43939
PRIMARY		213	9111	9324		434	11932	12366
TOTAL	26555	2469	9111	38135	46079	3347	11932	61358

REVENUES & EXPENDITURES

	Current Month	Year to Date (2 Months)
Funding		
1 State Contribution	\$ 14,693,616	\$ 29,386,756
2 Employee Contribution	\$ 7,996,435	\$ 16,009,629
3 Other	\$ 731,667	\$ 1,173,903
4 Allocation of Reserves	\$ 1,350,000	\$ 2,700,000
Total Funding	<u>\$ 24,771,718</u>	<u>\$ 49,270,288</u>
Expenses		
Medical Expenses		
5 Claims Expense	\$ 13,010,126	\$ 25,282,507
6 Claims IBNR	\$ -	\$ -
7 Medical Administration Fees	\$ 1,096,500	\$ 2,184,184
8 Refunds	\$ -	\$ -
9 Employee Assistance Program (EAP)	\$ 55,466	\$ 110,760
10 Life Insurance	\$ 79,610	\$ 158,968
Pharmacy Expenses		
11 RX Claims	\$ 6,090,974	\$ 12,081,970
12 RX IBNR	\$ -	\$ -
13 RX Administration	\$ 215,022	\$ 424,178
14 Plan Administration	\$ 312,827	\$ 686,112
Total Expenses	<u>\$ 20,860,523</u>	<u>\$ 40,928,679</u>
15 Net Income/(Loss)	\$ 3,911,195	\$ 8,341,610

BALANCE SHEET

Assets		
16 Bank Account		\$ 7,916,205
17 State Treasury		\$ 86,352,747
18 Due from Cafeteria Plan		\$ 5,195,886
19 Due from PSE		\$ -
20 Receivable from Provider		\$ -
21 Accounts Receivable		\$ 78,425
Total Assets		<u>\$ 99,543,262</u>
Liabilities		
22 Accounts Payable		\$ 654
23 Deferred Revenues		\$ 1,260
24 Due to Cafeteria		\$ 266
25 Due to PSE		\$ -
26 Due to Federal Government (\$44 fee)		\$ -
27 Health IBNR		\$ 24,700,000
28 RX IBNR		\$ 1,800,000
Total Liabilities		<u>\$ 26,502,180</u>
Net Assets		\$ 73,041,082
Less Reserves Allocated		
29 Premiums for Plan Year 1/1/16 - 12/31/16 (\$3,600,000 + \$12,600,000)		\$ (13,500,000)
30 Premiums for Plan Year 1/1/17 - 12/31/17 (\$7,560,000)		\$ (7,560,000)
31 Premiums for Plan Year 1/1/18 - 12/31/18 (\$5,040,000)		\$ (5,040,000)
32 Catastrophic Reserve (2016 \$10,700,000)		\$ (10,700,000)
33 Net Assets Available		<u>\$ 36,241,082</u>
34 Fifth Week of Claims \$		

Public School Employees (PSE) Financials - January 1, 2015 through February 28, 2015

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	2359	127		2486		3498	152		3650
CLASSIC	21530	1601		23131		39461	1948		41409
PREMIUM	20910	1358		22268		26808	1464		28272
PRIMARY		112	9843	9955			226	10771	10997
TOTAL	44799	3198	9843	57840		69767	3790	10771	84328

REVENUES & EXPENDITURES

Funding	Current Month	Year to Date (2 Months)
Per Participating Employee Funding (PPE Funding)	\$ 8,244,350	\$ 16,497,373
Employee Contribution	\$ 9,190,984	\$ 18,440,085
Department of Education \$35,000,000 & \$15,000,000	\$ 3,181,818	\$ 10,113,636
Other	\$ 486,980	\$ 972,344
Allocation for Actives	\$ 1,666,667	\$ 3,333,333
Total Funding	\$ 22,770,798	\$ 49,356,772
Expenses		
Medical Expenses		
Claims Expense	\$ 17,530,880	\$ 26,315,061
Claims IBNR	\$ -	\$ -
Medical Administration Fees	\$ 1,525,300	\$ 3,070,889
Refunds	\$ -	\$ (3,153)
Employee Assistance Program (EAP)	\$ 77,457	\$ 155,069
Pharmacy Expenses		
RX Claims	\$ 3,347,935	\$ 6,787,654
RX IBNR	\$ -	\$ -
RX Administration	\$ 289,436	\$ 579,116
Plan Administration	\$ 395,763	\$ 795,893
Total Expenses	\$ 23,166,772	\$ 37,700,528
Net Income/(Loss)	\$ (395,973)	\$ 11,656,244

BALANCE SHEET

Assets	
Bank Account	\$ 10,456,671
State Treasury	\$ 62,233,044
Receivable from Provider	\$ -
Accounts Receivable	\$ 11,027,197
Due to ASE	\$ -
Total Assets	\$ 83,716,912
Liabilities	
Accounts Payable	\$ 875
Due to ASE	\$ -
Deferred Revenues	\$ -
Due to Federal Government (\$44 fee)	\$ -
Health IBNR	\$ 28,000,000
RX IBNR	\$ 1,400,000
Total Liabilities	\$ 29,400,875
Net Assets	\$ 54,316,038
Less Reserves Allocated	
Premiums for Plan Year 1/1/15 - 12/31/15 (\$20,000,000 rec'd from Dept. of Education)	\$ (16,666,667)
Premium Assistance (FICA Savings)	\$ (947,551)
Catastrophic Reserve (2015 \$10,900,000)	\$ (10,900,000)
Net Assets Available	\$ 25,801,820

Fifth Week of Claims \$

Public School Employees (PSE) Financials - January 1, 2016 through February 29, 2016

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	3200	233		3433		4800	296		5096
CLASSIC	21980	1882		23862		40752	2285		43037
PREMIUM	19676	1024		20700		25389	1101		26490
PRIMARY		86	10627	10713			172	11600	11772
TOTAL	44856	3225	10627	58708		70941	3854	11600	86395

REVENUES & EXPENDITURES

	Current Month	Year to Date (2 Months)
Funding		
1 Per Participating Employee Funding (PPE Funding)	\$ 8,194,827	\$ 16,377,488
2 Employee Contribution	\$ 9,346,722	\$ 18,692,959
3 Department of Education \$35,000,000 & \$15,000,000 & Other Funding	\$ 3,181,818	\$ 10,113,636
4 Other	\$ 505,839	\$ 1,011,422
5 Allocation of Reserves	\$ 3,975,000	\$ 7,950,000
Total Funding	<u>\$ 25,204,207</u>	<u>\$ 54,145,506</u>
Expenses		
Medical Expenses		
6 Claims Expense	\$ 13,987,933	\$ 29,816,236
7 Claims IBNR	\$ -	\$ -
8 Medical Administration Fees	\$ 1,651,800	\$ 3,287,478
9 Refunds	\$ -	\$ -
10 Employee Assistance Program (EAP)	\$ 77,672	\$ 155,255
Pharmacy Expenses		
11 RX Claims	\$ 3,527,084	\$ 7,057,501
12 RX IBNR	\$ -	\$ -
13 RX Administration	\$ 310,764	\$ 611,859
14 Plan Administration	\$ 430,159	\$ 992,983
Total Expenses	<u>\$ 19,985,412</u>	<u>\$ 41,921,312</u>
16 Net Income/(Loss)	\$ 5,218,795	\$ 12,224,194

BALANCE SHEET

Assets	
17 Bank Account	\$ 21,313,828
18 State Treasury	\$ 108,854,781
19 Receivable from Provider	\$ -
20 Accounts Receivable	\$ 6,212,589
21 Due from ASE	\$ -
Total Assets	<u>\$ 136,381,198</u>
Liabilities	
22 Accounts Payable	\$ 379
23 Due to ASE	\$ -
24 Deferred Revenues	\$ -
25 Due to Federal Government (\$44 fee)	\$ -
26 Health IBNR	\$ 28,000,000
27 RX IBNR	\$ 1,400,000
Total Liabilities	<u>\$ 29,400,379</u>
28 Net Assets	\$ 106,980,819
Less Reserves Allocated	
29 Premiums for Plan Year 1/1/16 - 12/31/16 (\$9,600,000 + \$20,000,000 DOE + 18,100,000 DOE)	\$ (39,750,000)
30 Premiums for Plan Year 1/1/17 - 12/31/17 (\$5,760,000)	\$ (5,760,000)
31 Premiums for Plan Year 1/1/18 - 12/31/18 (\$3,840,000)	\$ (3,840,000)
33 Premium Assistance (FICA Savings)	\$ (980,724)
32 Catastrophic Reserve (2016 \$10,500,000)	\$ (10,500,000)
34 Net Assets Available	<u>\$ 46,150,095</u>
35 Fifth Week of Claims \$	



**State and Public School Life and Health Insurance Board
Benefits Sub-Committee Summary Report**

The following report resulted from a meeting of the Benefits Sub-Committee on March 11, 2016, with Jeff Altemus presiding.

Topics Discussed:

- ASE/PSE January & February Financials
- Rx Network Rate Presentation
- Medical & Rx Trends/2017 Preliminary Rates/PSE HSA Allocation

ASE/PSE Financials for January & February – Marla Wallace, EBD Fiscal Officer

Wallace reported financial information for the months of January and February, 2016. Please see the attached ASE/PSE financial information.

Rx Network Rate Presentation – Dr. David Keisner, UAMS & Dr. Scott Pace, Arkansas Pharmacists Association

Dr. Keisner reported MedImpact, the new pharmacy vendor, is in the process of implementing the new Pharmacy Benefit Management (PBM) program; a decision regarding the rate and reimbursement structure is needed by the Board's March 22, 2016 meeting so the structure can be established, programmed, tested and implemented on July 1, 2016. The two main tasks of MedImpact will be (1) pharmacy claims processing, and (2) establishing and maintaining a comprehensive pharmacy network. Dr. Keisner presented the current pharmacy rate and reimbursement structure, MedImpact's proposed rate and reimbursement structure and the Pharmacy Benefit Management Institute's (PBMI) 2016 Report of averages for large employer pharmacy rate and reimbursement structure. Dr. Keisner reported the network rates will affect the members' out-of-pocket drug costs more than in previous years.

Dr. Pace and Dr. John Vinson, APA, presented information related to the Arkansas Patient Centered Community Pharmacy Program, an enhanced clinical services initiative that potentially could be provided by pharmacists.

After many failed motions, the Committee motioned for the Board to take all the pharmacy information into consideration, and make a decision on the pharmacy rates and reimbursements.

Medical & Rx Trends/2017 Preliminary Rates/PSE HSA Allocation, John Colberg, Cherion, Inc.

Colberg provided information regarding the 2015 Review, the Trend Experience, Preliminary 2017 Projections, and the Plan Funding of HSAs for PSE.

Colberg reported PSE assets increased significantly in 2015 primarily due to claims being well below the projection and income well above projection, finishing the year with almost \$35 million in net assets available.

Enrollment in 2015 was higher than projected for actives with fewer spouses than projected. Classic has the most enrollees; however, more participants enrolled in Premium than projected and fewer in basic. Fewer non-Medicare retirees enrolled than assumed, while the number of Medicare retirees was close to projection.

For ASE assets increased primarily due to enrollment changes.

Both medical and pharmacy claims in 2015 were below projected. However, after adjusting for changes in enrollment, both medical and pharmacy claims' experience was very close to, but still slightly below, projections.

Enrollment in 2015 was below projected for actives, and more spouses than projected dropped coverage. Retirees, in total, were above projection.

Generally, with the number of participants in the PSE HSA program, about \$11M would be required to fund PSE HSA accounts.

Director's Report, Janis Harrison, EBD Interim Director

Harrison reported that WageWorks/BNY Mellon sent letters to employees regarding additional fees not previously discussed for HSAs. Harrison reported the members should not be responsible for additional charges and the ASE and PSE plans will cover

the additional \$2.00 fee per month. There will be further discussion prior to October 1, 2016, regarding the \$16.00 transfer fee.



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

The following report resulted from a meeting of the Quality of Care Sub-Committee on March 8, 2016, with Margo Bushmiaer presiding.

Topics Discussed:

- Continued Review of Anesthesia For Screening Colonoscopies
- Wellness Programs Review
- Update of Primary Care Referral Recommendation

Continued Review of Anesthesia for Colonoscopies – Dr. Creshelle Nash, Medical Director, Blue Cross and Blue Shield

The American Society for Gastrointestinal Endoscopy states, “The routine assistance of an anesthesiologist for average risk patients undergoing standard upper and lower endoscopic procedures is not warranted”.

Dr. Nash reported updated information regarding the physician numbers by city and their respective amount and percentage of general anesthesia use for screening colonoscopies. After researching the claims data for screening colonoscopy in any claim field and associated services with exclusion, BCBS estimates that the anesthesia rate for screening colonoscopy by providers is 45%.

The Committee requested literature from UAMS regarding their training program. In addition, the committee would like data regarding conscious sedation versus propofol. The data will be presented at the next meeting.

Wellness Programs Review – Janna Keathley, EBD Quality Assurance Officer

Keathley reported information was collected from UAMS, AFMC, Nabholtz, Children’s Hospital, and Windstream regarding their wellness programs. There are differences and similarities with the wellness programs. The companies participating all have incentive programs to encourage employee participation.

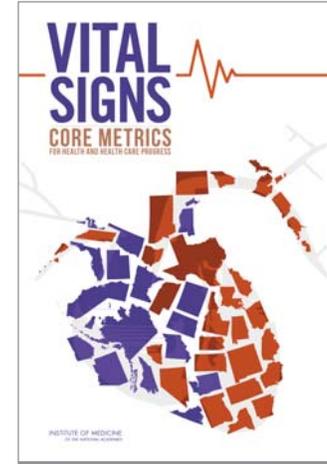
>Please see the attached report for detailed statistics.

Update of Primary Care Referral Recommendation – Janis Harrison, EBD Interim Director

Harrison reported the Board met February 16th and adopted the Primary Care Physician Program, previously recommended by the Quality of Care Committee. As a result, Health Advantage has begun the process by providing letters to EBD for review regarding the members and spouses. Upon EBD’s approval, the appropriate letter will be mailed to the members by Health Advantage.

Vital Signs

Core Metrics for Health and Health Care Progress



Thousands of measures are in use today to assess health and health care in the United States. Although many of these measures provide useful information, their sheer number, as well as their lack of focus, consistency, and organization, limits their overall effectiveness in improving performance of the health system. To achieve better health at lower cost, all stakeholders—including health professionals, payers, policy makers, and members of the public—must be alert to which measures matter most. What are the core measures that will yield the clearest understanding and focus on better health and well-being for Americans?

With support from the Blue Shield of California Foundation, the California Healthcare Foundation, and the Robert Wood Johnson Foundation, the Institute of Medicine (IOM) convened a committee to identify core measures for health and health care. In *Vital Signs: Core Metrics for Health and Health Care Progress*, the committee uses a four-domain framework—healthy people, care quality, lower cost, and engaged people—to propose a streamlined set of 15 standardized measures, with recommendations for their application at every level and across sectors. Ultimately, the committee concludes that this streamlined set of measures could provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas.

A streamlined set of measures could provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas.

The Measurement Landscape

Health measurements are requested or required by many organizations for many purposes, including efforts to track population, community, and individual health; assessments of health care quality and patient experience; transparency monitoring; public reporting and benchmarking; system or professional performance requirements; and funder reporting. Many of these measures are very similar, with only slight variations in terminology and methodology. However, their differences are often significant enough to prevent direct comparisons across states, institutions, and individuals. In addition, many measures focus on narrow or technical aspects of health care processes, rather than on overall health system perfor-

mance and health outcomes. According to the committee, the growing number of clinical measures, even those that provide valuable information, draws attention to narrow, specific elements and away from system capacity and effectiveness.

The necessity to collect, analyze, and store data for such a large number of measures also imposes a significant burden on providers, organizations, and the health care system as a whole. Preliminary research commissioned by the committee finds that the growth in measurement and reporting activities results in considerable expense and requires substantial time commitments—without a matching return on investment. The establishment of a core set of measures could improve efficiency and ensure a focus on the most important health outcomes.

The Core Measure Set

To select a core measure set, the committee first considers each candidate measure’s importance for health, likelihood to contribute to progress, understandability, technical integrity, potential to have broader system impact, and utility at multiple levels. Next, in considering how the measures should

operate as a set, the committee selects 15 measures that together have systemic reach, are outcomes-oriented, are meaningful at the personal level, are representative of concerns facing the U.S. health system, and have use at many levels. The core measures proposed by the committee are as follows:

- 1. Life expectancy:** Life expectancy is a validated, readily available, and easily understandable measure for a critical health concept. Because life expectancy depends on a full range of individual and community influences on health—from cancer to homicide—it represents an inclusive, high-level measure for health.
- 2. Well-being:** Well-being captures the subjective dimensions of health related to quality of life. Furthermore, levels of well-being often predict utilization of and satisfaction with health care. Self-reported well-being is a reliable indicator.
- 3. Overweight and obesity:** More than two-thirds of Americans are overweight or obese, a fact that has causes and consequences that extend beyond the health system—including socioeconomic, cultural, political, and lifestyle factors.

BOX Core Measure Set with Related Priority Measures

 <p>1. Life expectancy Infant mortality Maternal mortality Violence and injury mortality</p>	 <p>7. Preventive services Influenza immunization Colorectal cancer screening Breast cancer screening</p>	 <p>11. Care match with patient goals Patient experience Shared decision making End-of-life/advanced care planning</p>
 <p>2. Well-being Multiple chronic conditions Depression</p>	 <p>8. Care access Usual source of care Delay of needed care</p>	 <p>12. Personal spending burden Health care-related bankruptcies</p>
 <p>3. Overweight and obesity Activity levels Healthy eating patterns</p>	 <p>9. Patient safety Wrong-site surgery Pressure ulcers Medication reconciliation</p>	 <p>13. Population spending burden Total cost of care Health care spending growth</p>
 <p>4. Addictive behavior Tobacco use Drug dependence/illicit use Alcohol dependence/misuse</p>	 <p>10. Evidence-based care Cardiovascular risk reduction Hypertension control Diabetes control composite Heart attack therapy protocol Stroke therapy protocol Unnecessary care composite</p>	 <p>14. Individual engagement Involvement in health initiatives</p>
 <p>5. Unintended pregnancy Contraceptive use</p>		 <p>15. Community engagement Availability of healthy food Walkability Community health benefit agenda</p>
 <p>6. Healthy communities Childhood poverty rate Childhood asthma Air quality index Drinking water quality index</p>		

The necessity to collect, analyze, and store data for such a large number of measures imposes a significant burden on providers, organizations, and the health care system as a whole.

4. Addictive behavior: Addiction, including to nicotine, alcohol, and other drugs, is prevalent in the United States, representing a complex challenge for the health system, communities, and families. Every year, substance abuse and addiction cost the country more than \$500 billion.

5. Unintended pregnancy: Unintended pregnancy, a significant challenge for both individual and community health, is a measure that aggregates a variety of social, behavioral, cultural, and health factors—particularly women’s knowledge about and access to tools for family planning.

6. Healthy communities: Individual health is a function of a wide range of socioeconomic and community factors, from infrastructure to social connections. Community health includes critical elements of health that fall outside the care system, such as housing, employment, and environmental factors.

7. Preventive services: Preventive services (for example, screening for hearing loss or counseling for tobacco cessation) present a valuable opportunity for both improving health and reducing costs.

8. Care access: A person’s ability to access care when needed is a critical precondition for a high-quality health system. Factors that could hamper access to care include lack of health insurance, clinician shortages, lack of transportation, cultural and linguistic barriers, and physical limitations.

9. Patient safety: Avoiding harm is among the principal responsibilities of the health care system, yet adverse outcomes are common. Ensuring patient safety will require a culture that prioritizes and assesses safety through a reliable index of organizational results.

10. Evidence-based care: Ensuring that patients receive care supported by scientific evidence for appropriateness and effectiveness is a central challenge for the health care system. Currently, an estimated one-third of U.S. health care expenditures

do not contribute to improving health. Aggregating carefully selected and standardized clinical measures can provide a reliable composite index of system performance.

11. Care match with patient goals: Systematically assessing each patient’s individual goals and perspectives ensures that the health care system is focusing on the aspects of care that matter most to patients.

12. Personal spending burden: Care that is too expensive can limit access to care, lead people to avoid care, or prevent them from spending money in other areas of value to them—with far-reaching economic impacts.

13. Population spending burden: Health care spending consumes a large portion of the U.S. gross domestic product, dwarfing the health care spending of other nations. This burden can be measured at national, state, local, and institutional levels.

14. Individual engagement: Given the effects of personal choices on health, as well as the increasing use of personal health devices, it is critical for individuals to be aware of their options and responsibilities in caring for their own health and that of their families and communities.

15. Community engagement: Across the United States, communities have and utilize different levels of resources to support efforts to maintain and improve individual and family health—for example, addiction treatment programs, emergency medical facilities, and opportunities for social engagement.

The committee recognizes that these 15 measures will not be sufficient to meet every interest for each organization, nor are there established methods for measurement in each area. To begin to accommodate these challenges, the committee identifies 39 additional priority measures that can act as surrogates while refinement is under way (see Box).



Committee on Core Metrics for Better Health at Lower Cost

David Blumenthal (Chair)
The Commonwealth Fund

Julie Bynum
The Dartmouth Institute

Lori Coyner
Oregon Health Authority

Diana Dooley
California Health and Human Services

Timothy Ferris
Partners HealthCare

Sherry Glied
Robert F. Wagner Graduate School of Public Service, New York University

Larry Green
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George Isham
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Craig Jones
Vermont Blueprint for Health

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Study Sponsors

Blue Shield of California Foundation

California Healthcare Foundation

Robert Wood Johnson Foundation

Refinement of the measures and methodology will require leadership from stakeholders across sectors.

Implementation of the Core Measures

Successful implementation of the core measures will depend on their relevance, reliability, and utility to stakeholders. Implementation challenges include multiple competing priorities for stakeholders, the sizable degree of change proposed, and the slow pace of change overall in the health system. Progress can be accelerated by ensuring that the core measurement set is applied by, and adds value to, existing measurement activities. The committee stresses that leadership will be required at nearly every level of the health system. CEOs of health care organizations, payers and employers, standards organizations, and public health agencies will have important roles in the uptake, use, and maintenance of the core measures as practical tools. The committee recommends that the Secretary of the Department of Health and Human Services, with support from the Executive Office of the President, lead the effort to refine, standardize, and implement core measures throughout the nation.

Conclusion

The set of core measures proposed by the committee is a tool for enhancing the efficiency and effectiveness of measurement. Ultimately, widespread application of a limited set of standardized measures could not only reduce the burden of unnecessary measurement but also align the incentives and actions of multiple organizations at multiple levels. *Vital Signs* lays the groundwork for the adoption of core measures that, if systematically applied, could yield better health at lower cost for all Americans. 



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07-00-0010– THERAPEUTIC SUBSTITUTION (Arkansas State Board of Pharmacy Regulations)

Act: 274 of 2013: Authorizes pharmacists to substitute a therapeutically equivalent drug that is at a lower cost to the patient when given authorization in the prescription and after discussion with the patient:

A pharmacist may substitute a therapeutically equivalent drug that is at a lower cost to the patient only after the prescriber grants such authorization for each prescription. A prescriber may authorize a pharmacist to dispense a therapeutically equivalent drug product as part of a written prescription as defined to include a written, oral, faxed, or electronic prescription by indicating Therapeutic Substitution Allowed or May Therapeutically Substitute or abbreviating **“TSA” or “MTS”** as part of the prescription verbally, in writing or by utilizing a separate signature line to show such authorization.

(a) Therapeutic equivalence may be established with clinical publications comparing dosages of drugs in a therapeutic class.

(b) (1) Before dispensing, the pharmacist shall discuss verbally any suggested substitution with the patient and inform the patient that the patient has a right to refuse the substitution. This discussion shall include without limitation:

(A) Notification to the patient that the therapeutically equivalent drug does not contain the identical active ingredient present in the prescribed drug; and

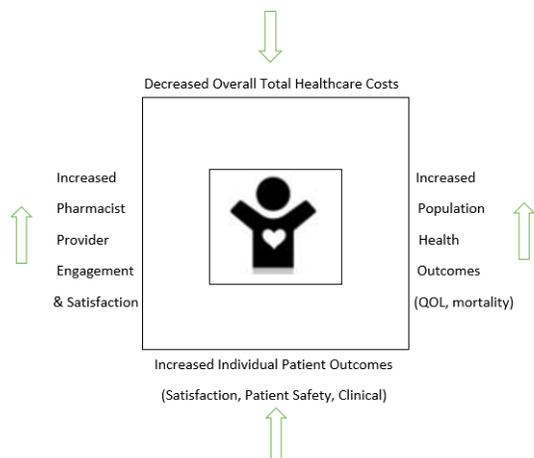
(B) All differences in dosage and frequency between the prescribed drug and the therapeutically equivalent drug.

(c) The pharmacist shall send notice of the substitution to the prescriber in writing or by electronic communication within twenty-four (24) hours after the drug is dispensed to the patient

3.18.2016

	AWP Discount	Disp Fee Generic	Disp Fee Brand	Plan Savings	Member Savings	Total Savings
MedImpact Proposed Rates	15.65%	\$1.50	\$1.50	\$8M	\$8M	\$16M
	13%	\$1.50	\$1.50	\$6M	\$8M	\$14M
	13%	\$3.50	\$3.50	\$4M	\$6M	\$10M
Catamaran Rates with no generic incentive	10%	\$1.50	\$1.50	\$4M	\$7M	\$11M
	10%	\$2.50	\$3.50	\$3M	\$6M	\$9M
	10%	\$3.50	\$3.50	\$2M	\$5M	\$7M
Current Catamaran Rates (still get MAC savings)	10%	\$4.50	\$3.50	\$1M	\$4M	\$5M

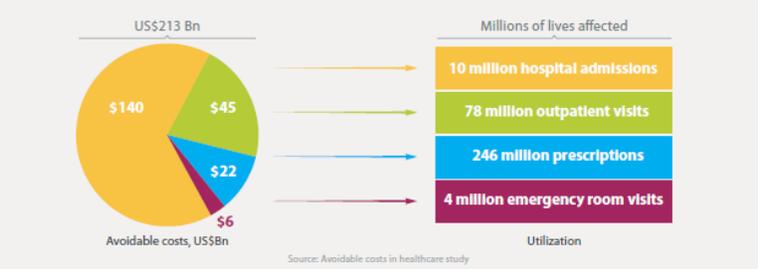
Arkansas Patient-Centered Community Pharmacy Program



- **Quadruple Aim Focused:** Improved patient experience, improved population health, Increased provider engagement and lower **overall total medical costs.**
- Design it as **comprehensive, coordinated, patient focused, accessible, high quality and safe**
- Multiple Phase Program Implemented **over 3-5 years**
 - Align the Incentives for Win-Wins

Phase 1 Pharmacist / Pharmacy Requirements – Enhanced Clinical Network (AR-PCCPP)

The Problem	IOM Value Metric	The Pharmacy Solution
-Arkansas pediatric vaccination rates are in bottom 5% (#50 in 2014) -U.S. adult vaccination rates are not meeting goals (Healthy People 2020) -Influenza and Pneumonia are the #8 cause of death in US and in AR (top 10 list of deaths)	1. Life Expectancy 6. Healthy Communities 7. Preventive Services 8. Care Access 10. Evidence Based Care 13. Population Spending \$ 14. Individual Engagement	1. Trained pharmacists that offer vaccinations.
-Pediatric / adolescent vaccinations are required to be reported to ADH Immunization Registry (WebIZ) -Adult vaccinations reporting to ADH registry is Optional in AR law - Use of a statewide vaccine registry improves vaccination delivery and decreases wasted \$ (avoid repeating vaccines that are not necessary)	1. Life Expectancy 6. Healthy Communities 7. Preventive Services 9. Patient Safety 13. Population Spending \$ 15. Community Engagement	2. Pharmacies offering vaccines will enter vaccines into the ADH WebIZ for both pediatric and adult populations
- Electronic prescriptions for DEA controlled substances are expected to combat fraud, waste and abuse - Electronic prescribed prescriptions for DEA controlled substances (pain, ADHD, anxiety, cough) is new technology. Electronically prescribed controlled substances availability is beginning to grow in Arkansas but implementation costs \$ and time.	4. Addictive Behavior 13. Population Spending \$	3. Pharmacies will have the ability to receive E-Rx (electronic prescriptions) and EPCS (electronically prescribed controlled substances)

The Problem	IOM Value Metric	The Pharmacy Solution
<p>- Opioid pain medications and benzodiazepine prescriptions have great potential for diversion, addiction and for death.</p> <p>- The CDC has called prescription drug abuse and opioid deaths an epidemic (40+ deaths a day in US in 2015, 20,000 to 25,000 deaths/yr).</p> <p>-The AR Prescription Drug Monitoring Program assists prescribers and pharmacists to prevent “doctor shopping” for DEA controlled substances for purposes of preventing abuse, diversion and likely death.</p> <p>-Pharmacist and prescriber use of the AR PDMP is optional in Arkansas.</p>	<ol style="list-style-type: none"> 1. Life Expectancy 4. Addictive Behavior 6. Healthy Communities 9. Patient Safety 13. Population Spending \$ 15. Community Engagement 	<p>4. Pharmacies and their pharmacists will have logins and lookup ability for Arkansas Prescription Drug Monitoring Program (PDMP).</p> <p>- Pharmacists and/or delegates will use the PDMP when needed.</p>
<p>Exhibit 2: \$213 billion includes unnecessary healthcare utilization and scripts and affects millions of people</p>  <p>Medication nonadherence and delayed evidence-based treatment practice are the key contributors to avoidable costs, accounting for 68% (\$144 billion) of the total.</p> <p><i>2013 IMS Institute's global report on the Responsible Use of Medicines</i></p> <p>Medication nonadherence. This occurs when patients do not take their medicines appropriately or at all. Nonadherence can result in costly complications that are often more expensive than the medicines and worsen health outcomes. The diseases assessed for nonadherence are hypercholesterolemia, hypertension, diabetes type 2, osteoporosis, HIV and congestive heart failure (CHF).</p> <p>Delayed evidenced-based treatment practice. This occurs when medicines are not delivered to patients at a time that would be most</p>	<ol style="list-style-type: none"> 1. Life Expectancy 2. Well Being 3. Overweight and Obesity 4. Addictive Behavior 5. Unintended Pregnancy 6. Healthy Communities 7. Preventive Services 8. Care Access 9. Patient Safety 10. Evidence Based Care 11. Care Match with Patient Goals 13. Population Spending \$ 14. Individual Engagement 	<p>5. Pharmacies will be contracted with Outcomes and Mirixa for face to face Medication Therapy Management (MTM) services</p> <hr/> <p>Program Design Examples:</p> <ul style="list-style-type: none"> - High total medical costs, ER/Hospital utilization - Transition of Care post hospital for medication reconciliation - prescription costs (>\$3,000), advanced age, + 5 or more prescription medications - Asthma with exacerbations - Insulin / diabetes - COPD with frequent exacerbations - Heart Failure with reduced ejection fraction / requiring use of diuretics (water pills) - Hypertension (blood pressure): heart disease or stroke prevention and management - Smoking cessation

<p>valuable in terms of health outcome and cost effectiveness. Screening and diagnostic capabilities could support timely medicine use for highly prevalent diseases and ensure that patients receive medicines to prevent or delay relatively costlier complications. The diseases assessed for delayed treatment are hepatitis C, diabetes type 2, atrial fibrillation, and coronary heart disease (CHD).</p> <p>Mismanaged polypharmacy. This occurs when healthcare professionals do not, or cannot, adequately oversee patients who take multiple medicines concurrently. The risk of costly and adverse events increases with age, particularly when patients are over 60 years old, and when patients take more than five medicines concurrently.</p> <p>- Medication Therapy Management (MTM): This is an opportunity for pharmacists to identify and to address prescription drug costs, need for vaccines, nonadherence, delayed evidence based treatment, mismanaged polypharmacy, misuse of drug therapy devices (inhalers / insulin)</p> <p>- MTM is a required service in Medicare part D plans and is optionally offered in a growing number of Medicaid and private third party insurance plans.</p>		
<p>The Problem</p>	<p>IOM Value Metric</p>	<p>The Pharmacy Solution</p>
<p>- Adherence: Nonadherence to chronic disease medications is estimated to be a \$104 billion waste and preventable cost in the health system (estimated by IMS).</p> <p>- Appointment-Based Medication Synchronization (ABMS) can improve medication persistence, adherence measured by proportion of days covered and prevent medication wastage by verifying patient need prior to each fill.</p> <p>- ABMS has been researched and tested in Arkansas community pharmacies across multiple insurance types. The study resulted in patients being 2.57 times more likely to be adherent across 9 drug classes compared to controls.</p> <p>- Face to face pharmacist adherence interventions in Pennsylvania resulted in a \$2.50 to \$1 ROI in The Pennsylvania Project.</p>	<ol style="list-style-type: none"> 1. Life Expectancy 2. Well Being 5. Unintended Pregnancy 6. Healthy Communities 7. Preventive Services 8. Care Access 9. Patient Safety 10. Evidence Based Care 11. Care Match with Patient Goals 13. Population Spending \$ 14. Individual Engagement 	<p>6. Offers Appointment Based Medication Synchronization for adherence (proportion of days covered).</p> <p>- Have access to EQiPP: An information management platform that makes benchmarked performance data available to both health plans and community pharmacies</p>

The Problem	IOM Value Metric	The Pharmacy Solution
<p>- High blood pressure: Heart Disease is the #1 cause of death in the United States and in Arkansas (1 in 4 of Americans and Arkansans / 1 in 3 die from stroke or heart disease). \$500 billion annual spend in U.S.</p> <p>- Prevention and treatment of heart disease includes exercise, nutrition, antiplatelet use (for select patients), blood pressure screening and control, cholesterol treatment with statin cholesterol medications (for select patients), and smoking cessation.</p> <p>- One of the most effective strategies to reduce spending and death from heart disease is to improve provide blood pressure control in adult patients from a national baseline of 46% to 65% (< 140/90 or < 150/90 for older adults)</p> <p>- Monitoring and screening for abnormal blood pressure is a smart and cost effective solution to prevent heart disease and complications. Pharmacists greatly improve access to patients to prevent and treat this important, costly and deadly disease.</p>	<ol style="list-style-type: none"> 1. Life Expectancy 2. Well Being 6. Healthy Communities 7. Preventive Services 8. Care Access 9. Patient Safety 10. Evidence Based Care 11. Care Match with Patient Goals 13. Population Spending \$ 14. Individual Engagement 	<p>7. Working blood pressure cuffs available in pharmacy</p> <p>- Pharmacist / staff are capable to screen for and monitor blood pressure for patients</p>
<p>Health Literacy: Patients with limited health literacy scores are more likely to skip preventive services (flu shots, etc.), are less likely to effectively manage their illnesses and medications, enter the healthcare system when they are sicker, have increased hospitalization rates and emergency rooms, and cost the healthcare system more dollars.</p>	<ol style="list-style-type: none"> 1. Life Expectancy 2. Well Being 5. Unintended Pregnancy 6. Healthy Communities 7. Preventive Services 8. Care Access 9. Patient Safety 10. Evidence Based Care 11. Care Match with Patient Goals 13. Population Spending \$ 14. Individual Engagement 	<p>8. Health literacy functions in pharmacy system and pharmacist workflows</p> <p>- Spanish labeling (and other languages as needed),</p> <p>- Offers alternative packaging for prescription medications as needed.</p>
<p>The Employee Benefits Division State and Public School pharmacy drug formulary program decisions have been both clinically evidence based but also aggressive in cost savings design. Incentivizing evidence based cost effective therapy is not always viewed as a win-win and may cause challenges to member satisfaction, prescriber satisfaction and pharmacist provider satisfaction. For example, reference based pricing and formulary preferences with brand drug exclusivity can produce significant cost savings but also produce stress and confusion for the patients and providers that these decisions impact.</p>	<ol style="list-style-type: none"> 8. Care Access 9. Patient Safety 10. Evidence Based Care 11. Care Match with Patient Goals 12. Personal Spending Burden 13. Population Spending \$ 14. Individual Engagement 	<p>9. Offer plan design education and communication to members by pharmacies as needed.</p> <p>- Pharmacists and pharmacy staff will be willing and able to provide patient education about formulary decisions and plan design in the state employee drug plan.</p>

Arkansas State Employees & Public School Employees Health Benefits Program



Pharmacy Reimbursement: Review of Trend Experience and Preliminary 2017 Projections

March 22, 2016
Board Meeting

John Colberg, FSA, MAAA
Gaelle Gravot, FSA, MAAA



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Pharmacy Reimbursement



	AWP Discount	Disp Fee Generic	Disp Fee Brand	Plan Savings	Member Savings	Total Savings
Medimpact proposed	15.65%	\$1.50	\$1.50	\$8M	\$8M	\$16M
	13%	\$1.50	\$1.50	\$6M	\$8M	\$14M
	13%	\$3.50	\$3.50	\$4M	\$6M	\$10M
	10%	\$1.50	\$1.50	\$4M	\$7M	\$11M
Current w/o generic incentive	10%	\$2.50	\$3.50	\$3M	\$6M	\$9M
	10%	\$3.50	\$3.50	\$2M	\$5M	\$7M
Current Rates	10%	\$4.50	\$3.50	\$1M	\$4M	\$5M

All figures assume new MAC pricing.



Underlying Trends (*)

	ASE	PSE
	PMPM	PMPM
Medical NME only		
- 2009 to 2010	5.8%	4.7%
- 2010 to 2011	2.5%	2.2%
- 2011 to 2012	7.7%	12.8%
- 2012 to 2013	4.2%	-1.8%
- 2013 to 2014	-1.1%	-0.1%
- 2014 to 2015	1.6%	-2.6%
AVERAGE	3.4%	2.4%

Medical ME Only		
- 2009 to 2010	9.0%	8.0%
- 2010 to 2011	0.0%	1.6%
- 2011 to 2012	8.0%	2.9%
- 2012 to 2013	-3.1%	-0.1%
- 2013 to 2014	7.6%	12.2%
- 2014 to 2015	0.8%	-1.6%
AVERAGE	3.6%	3.7%

* Underlying trends are adjusted for changes in benefits, geographic and demographic factors

2014 to 2015 Trends are based on claims paid through January 31, 2015, plus estimated runout. As actual runout claims become known, the percentages will likely change.

Pharmacy Trend: 2014 vs. 2013



	Unit Cost	Utilization	Total
<i>National Average*</i>			
Traditional	6.5%	-0.1%	6.4%
Specialty	25.2%	5.8%	30.9%
Total Overall	13.2%	-0.04%	13.1%
 <i>ASE&PSE</i>			
Brand	18.5%	-27.4%	-14.0%
Generic	-10.6%	1.0%	-9.7%
Traditional	-9.0%	-3.3%	-12.0%
Specialty	8.0%	-15.1%	-8.4%
Total Overall	-8.4%	-3.3%	-11.5%

*Per <http://lab.express-scripts.com/drug-trend-report>

The above figures are before changes in copays & other participant cost sharing.

Pharmacy Trend: 2015 vs. 2014



	Unit Cost	Utilization	Total
<i>National Average*</i>			
Traditional	-2.1%	1.9%	-0.1%
Specialty	11.0%	6.8%	17.7%
Total Overall	3.2%	2.0%	5.2%
 <i>ASE&PSE</i>			
Brand	26.5%	-13.6%	9.3%
Generic	3.0%	0.1%	3.2%
Traditional	7.9%	-1.4%	6.4%
Specialty	5.4%	-5.7%	-0.6%
Total Overall	6.8%	-1.4%	5.3%

*Per <http://lab.express-scripts.com/drug-trend-report>

The above figures are before changes in copays & other participant cost sharing.

Pharmacy Trend Considerations for 2017



- National forecast approximate 7% annually
- Generic utilization at 90.1%
 - Probably effectively higher since many generics less than copay
 - Unlikely to see much additional shift to generics
- Utilization trends
 - Last couple of years had negative utilization trends; unlikely to continue
 - Traditional therapies likely will see flat utilization
 - Specialty utilization likely to increase as drugs keep on entering the market
- Assuming an overall allowed trend of 7%
 - ...annual trend for the plan paid would likely be 10+%
 - Example: if a \$30 generic drug increases to \$32 (7%), the plan paid in the premium plan would increase from \$15 to \$17 (13%)
- Rates will consider
 - New strategies implemented, including changes to PBM contract

Preliminary 2017 Projections



- Based on actual January 2016 enrollment and calendar year 2015 claims paid through January 2016
- Assumed trends of
 - 6% medical for actives & NME retirees (to allow for resuming to positive trend environment plus leveraging)
 - 10% pharmacy (national average projection plus leveraging)
 - 5% medical for Medicare Eligible retirees
- Does not yet reflect potential impact from changes in pharmacy contracting
 - Terms not finalized before presentation
- Assumes no changes to State and minimum District contributions
 - For ASE, consider alternative scenarios of \$5 million and \$10 million lower State contributions due to potential loss of budgeted positions
- Assumes wellness participation is as assumed when setting 2016 rates
- Projections subject to change with as more complete experience emerges

Preliminary 2017 Projections: PSE



	Total Premium	Direct State Contrib + FICA (subsidy for ME)	School District Contrib.	Reserves Allocated / (Added)	Current Year Total EE/Ret Cost	Prior Year Total EE/Ret Cost	Change in EE/Ret Cost (\$/%)	Assumed Enrollment
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2017 stable population, no allocated reserves; same State & District contributions

Actives	\$274.2	\$92.7	\$81.8	\$3.8	\$95.9	\$89.6	\$6.3	7%	44,104
Non-Medicare Eligible Retirees	\$17.5	\$0.0	\$0.0	\$0.0	\$17.5	\$17.5	\$0.0	0%	3,304
Medicare Eligible Retirees	\$25.3	\$6.4	\$0.0	\$2.0	\$16.9	\$15.4	\$1.5	10%	10,953
Total	\$317.0	\$99.1	\$81.8	\$5.8	\$130.3	\$122.5	\$7.8	6%	58,361

2017 above with \$15.6 million allocated reserves (\$7.8 million used for 2017)

Actives	\$274.2	\$92.7	\$81.8	\$10.1	\$89.6	\$89.6	\$0.0	0%	44,104
Non-Medicare Eligible Retirees	\$17.5	\$0.0	\$0.0	\$0.0	\$17.5	\$17.5	\$0.0	0%	3,304
Medicare Eligible Retirees	\$25.3	\$6.4	\$0.0	\$3.5	\$15.4	\$15.4	\$0.0	0%	10,953
Total	\$317.0	\$99.1	\$81.8	\$13.6	\$122.5	\$122.5	\$0.0	0%	58,361

2017 above with 3% adverse experience; \$28 million allocated reserves (\$14 million used for 2017)

Actives	\$282.4	\$92.7	\$81.8	\$16.0	\$91.9	\$89.6	\$2.3	3%	44,104
Non-Medicare Eligible Retirees	\$18.0	\$0.0	\$0.0	\$0.0	\$18.0	\$17.5	\$0.5	3%	3,304
Medicare Eligible Retirees	\$26.1	\$6.4	\$0.0	\$3.8	\$15.9	\$15.4	\$0.5	3%	10,953
Total	\$326.5	\$99.1	\$81.8	\$19.8	\$125.8	\$122.5	\$3.3	3%	58,361

The Change in EE/Ret cost represents the change in dollars needed under the illustration. Actual rate changes could vary significantly from the amounts shown. Allocation of increases across Actives, NME Retirees, and ME Retirees is at Board's discretion.

Preliminary 2017 Projections: ASE



	Total Premium	State Contribution & FICA	Reserves Allocated / (Added)	Current Year Total EE/Ret Cost	Prior Year Total EE/Ret Cost	Change in EE/Ret Cost (\$/%)	Assumed Enrollment
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2017 - stable population and no new allocated reserves

Actives	\$219.2	\$146.6	\$6.0	\$66.7	\$55.3	\$11.4	21%	26,221
Non-Medicare Eligible Retirees	\$19.7	\$6.5	\$0.1	\$13.2	\$10.9	\$2.3	21%	2,504
Medicare Eligible Retirees	\$59.4	\$25.9	\$1.5	\$32.0	\$26.5	\$5.5	21%	9,229
Total	\$298.3	\$178.9	\$7.6	\$111.8	\$92.7	\$19.1	21%	37,954

2017 above with \$28 million new allocated reserves (additional \$14 million used for 2017)

Actives	\$219.2	\$146.6	\$14.3	\$58.4	\$55.3	\$3.0	6%	26,221
Non-Medicare Eligible Retirees	\$19.7	\$6.5	\$1.7	\$11.6	\$10.9	\$0.7	6%	2,504
Medicare Eligible Retirees	\$59.4	\$25.9	\$5.6	\$27.9	\$26.5	\$1.4	5%	9,229
Total	\$298.3	\$178.9	\$21.6	\$97.8	\$92.7	\$5.1	6%	37,954

2017 above with \$28 million new allocated; \$5 million less state contribution

Total	\$298.3	\$173.9	\$21.6	\$102.8	\$92.7	\$10.1	11%	37,954
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2017 above with \$28 million new allocated; \$10 million less state contribution

Total	\$298.3	\$168.9	\$21.6	\$107.8	\$92.7	\$15.1	16%	37,954
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The Change in EE/Ret cost represents the change in dollars needed under the illustration. Actual rate changes could vary significantly from the amounts shown. Allocation of increases across Actives, NME Retirees, and ME Retirees is at Board's discretion.



CHEIRON



Classic Values, Innovative Advice.

Cheiron (pronounced kī'ron), the immortal centaur from Greek mythology, broke away from the pack and was educated by the Gods. Cheiron became a mentor to classical Greek heroes, then sacrificed his immortality and was awarded in eternity as the constellation Sagittarius.

Appendix A – PSE Actives

2016 Final Rate Details



Actives	Unadjusted Total Rate	Direct State Contrib. & FICA	Reserve Used / (Added)	School District Contrib.	2016 Employee Cost with & without Wellness Visit		2015 Employee Cost	Change in EE Cost (\$/%) with & without Wellness Credit				Assumed Enrollment
					with	without*		with		without		
Premium												
Employee Only	\$590.40	\$236.11	\$20.43	\$154.48	\$179.38	\$254.38	\$179.38	\$0.00	0%	\$0.00	0%	17,627
Employee & Spouse	1,308.18	313.83	27.15	154.48	812.72	887.72	812.72	0.00	0%	0.00	0%	349
Employee & Child(ren)	1,077.80	426.35	36.89	154.48	460.08	535.08	460.08	0.00	0%	0.00	0%	2,131
Family	1,795.58	760.40	65.78	154.48	814.92	889.92	814.92	0.00	0%	0.00	0%	459
Est. Monthly Total (\$mil)	\$14.0	\$5.5	\$0.5	\$3.2	\$4.8	\$0.1	\$4.8	\$0.0	0%	\$0.0	0%	20,566
Classic												
Employee Only	\$270.02	\$64.92	\$5.62	\$154.48	\$45.00	\$120.00	\$45.00	\$0.00	0%	\$0.00	0%	12,885
Employee & Spouse	562.28	56.20	4.86	154.48	346.74	421.74	346.74	0.00	0%	0.00	0%	1,260
Employee & Child(ren)	468.48	146.43	12.67	154.48	154.90	229.90	154.90	0.00	0%	0.00	0%	4,403
Family	760.74	235.52	20.38	154.48	350.36	425.36	350.36	0.00	0%	0.00	0%	2,734
Est. Monthly Total (\$mil)	\$8.3	\$2.2	\$0.2	\$3.3	\$2.7	\$0.1	\$2.7	\$0.0	0%	\$0.0	0%	21,283
Basic												
Employee Only	\$133.02	\$0.00	(\$32.46)	\$154.48	\$11.00	\$86.00	\$11.00	\$0.00	0%	\$0.00	0%	1,839
Employee & Spouse	242.22	0.00	(178.98)	154.48	266.72	341.72	266.72	0.00	0%	0.00	0%	111
Employee & Child(ren)	207.18	0.00	(66.46)	154.48	119.16	194.16	119.16	0.00	0%	0.00	0%	213
Family	316.38	0.00	(107.60)	154.48	269.50	344.50	269.50	0.00	0%	0.00	0%	224
Est. Monthly Total (\$mil)	\$0.4	\$0.0	(\$0.1)	\$0.4	\$0.1	\$0.0	\$0.1	\$0.0	0%	\$0.0	0%	2,386
Total (Monthly) (\$ mil)	\$22.7	\$7.7	\$0.6	\$6.8	\$7.6	\$0.2	\$7.6	\$0.0/\$0.0		0%0%		44,235
Est Annual Total (\$ mil)	\$272.4	\$92.7	\$6.6	\$82.0	\$91.1	\$2.0	\$91.1	\$0.0/\$0.0		0%0%		
Total Active & Ret (\$ mil)	\$310.7	\$92.7	\$9.6	\$82.0	\$126.3	\$2.0	\$126.3	\$0.0	0%	\$2.0	2%	58,653

*Already subtracted from Total Rates

Appendix A – PSE Retirees

Non-Medicare Eligible 2016 Final Rate Details



NME Retirees	Unadjusted Total Rate	Direct State Contrib.	Reserve Used / (Added)	2016 Retiree Cost	2015 Total Retiree Cost	Change in Retiree Cost (\$/%)		Assumed Enrollment
Premium								
Retiree Only	\$590.40	\$0.00	(\$50.74)	\$641.14	\$641.14	\$0.00	0%	1,320
Retiree & NME SP	1,308.18	0.00	(149.00)	1,457.18	1,457.18	0.00	0%	72
Retiree & Child(ren)	1,077.80	0.00	(114.80)	1,192.60	1,192.60	0.00	0%	13
Retiree & NME SP&CH	1,795.58	0.00	(213.06)	2,008.64	2,008.64	0.00	0%	8
Retiree & ME SP	768.26	0.00	(26.86)	795.12	795.12	0.00	0%	120
Retiree & ME SP & CH	1,255.66	0.00	(90.92)	1,346.58	1,346.58	0.00	0%	1
Est. Monthly Total (\$mil)	\$1.0	\$0.0	(\$0.1)	\$1.1	\$1.1	\$0.0	0%	1,534
Classic								
Employee Only	\$270.02	\$0.00	\$2.08	\$267.94	\$267.94	\$0.00	0%	1,329
Employee & Spouse	562.28	0.00	7.60	554.68	554.68	0.00	0%	205
Employee & Child(ren)	468.48	0.00	(1.34)	469.82	469.82	0.00	0%	40
Family	760.74	0.00	29.18	731.56	731.56	0.00	0%	35
Est. Monthly Total (\$mil)	\$0.5	\$0.0	\$0.0	\$0.5	\$0.5	\$0.0	0%	1,610
Basic								
Employee Only	\$133.02	\$0.00	(\$15.48)	\$148.50	\$148.50	\$0.00	0%	117
Employee & Spouse	242.22	0.00	(27.50)	269.72	269.72	0.00	0%	15
Employee & Child(ren)	207.18	0.00	(31.34)	238.52	238.52	0.00	0%	1
Family	316.38	0.00	(18.36)	334.74	334.74	0.00	0%	3
Est. Monthly Total (\$mil)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	0%	136
Total (Monthly) (\$ mil)	\$1.5	\$0.0	(\$0.1)	\$1.6	\$1.6	\$0.0	0%	3,279
Est Annual Total (\$ mil)	\$18.4	\$0.0	(\$1.0)	\$19.4	\$19.4	\$0.0		

Appendix A – PSE Retirees

Medicare Eligible 2016 Final Rate Details



Medicare Eligible	Unadjusted Total Rate	Subsidy	Reserve Used / (Added)	2016 Retiree Cost	2015 Total Retiree Cost	Change in Retiree Cost (\$/%)		Assumed Enrollment
Retiree Only	\$177.86	\$50.66	\$28.40	\$98.80	\$98.80	\$0.00	0%	10,106
Retiree & NME SP	757.06	(26.86)	0.00	783.92	783.92	0.00	0%	85
Retiree & Child(ren)	718.76	(38.33)	0.00	757.10	757.10	0.00	0%	17
Retiree & NME SP&CH	1,383.03	(138.45)	0.00	1,521.48	1,521.48	0.00	0%	2
Retiree & ME SP	331.82	25.32	48.63	257.88	257.88	0.00	0%	928
Retiree & ME SP & CH	872.73	(15.84)	0.00	888.57	888.57	0.00	0%	0
Est. Monthly Total (\$mil)	\$2.2	\$0.5	\$0.3	\$1.3	\$1.3	\$0.0	0%	11,138
Total (Est. Annual)	\$26.2	\$6.4	\$4.0	\$15.9	\$15.9	\$0.0		

Appendix A – ASE Actives

2016 Final Rate Details



Actives	Risk Adjusted Total Rate	State Contrib. & FICA	Reserve Used / (Added)	2016 Employee Cost with & without Wellness Visit		2015 Employee Cost	Change in EE Cost (\$/%) with & without Wellness Credit				Assumed Enrollment	
				with	without*		with		without			
Premium												
Employee Only	\$459.96	\$325.41	\$29.77	\$104.78	\$179.78	\$104.78	\$0.00	0%	\$0.00	0%	14,489	
Employee & Spouse	1,024.48	591.31	54.09	379.08	454.08	379.08	0.00	0%	0.00	0%	2,371	
Employee & Child(ren)	766.76	510.06	46.66	210.04	285.04	210.04	0.00	0%	0.00	0%	5,506	
Family	1,331.28	775.96	70.98	484.34	559.34	484.34	0.00	0%	0.00	0%	2,157	
Est. Monthly Total (\$mil)	\$16.2	\$10.6	\$1.0	\$4.6	\$0.1	\$4.6	\$0.0	0%	\$0.0	0%	24,523	
Classic												
Employee Only	\$401.60	\$325.36	\$29.76	\$46.48	\$121.48	\$46.48	\$0.00	0%	\$0.00	0%	1,133	
Employee & Spouse	888.46	591.35	54.09	243.02	318.02	243.02	0.00	0%	0.00	0%	156	
Employee & Child(ren)	666.20	510.08	46.66	109.46	184.46	109.46	0.00	0%	0.00	0%	326	
Family	1,153.06	776.07	70.99	306.00	381.00	306.00	0.00	0%	0.00	0%	196	
Est. Monthly Total (\$mil)	\$1.0	\$0.8	\$0.1	\$0.2	\$0.0	\$0.2	\$0.0	0%	\$0.0	0%	1,811	
Basic												
Employee Only	\$355.16	\$325.39	\$29.77	\$0.00	\$75.00	\$0.00	\$0.00	n/a	\$0.00	0%	570	
Employee & Spouse	777.90	591.33	54.09	132.48	207.48	132.48	0.00	0%	0.00	0%	94	
Employee & Child(ren)	584.92	510.10	46.66	28.16	103.16	28.16	0.00	0%	0.00	0%	115	
Family	1,007.66	776.03	70.99	160.64	235.64	160.64	0.00	0%	0.00	0%	123	
Est. Monthly Total (\$mil)	\$0.5	\$0.4	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	0%	\$0.0	0%	902	
Total (Monthly) (\$ mil)	\$17.7	\$11.8	\$1.1	\$4.8	\$0.1	\$4.8	\$0.0/\$0.0		0%0%		27,236	
Est Annual Total (\$ mil)	\$212.3	\$141.3	\$12.9	\$58.1	\$1.2	\$58.1	\$0.0/\$0.0		0%0%			
Total Active & Ret (\$ mil)	\$288.7	\$176.8	\$16.2	\$95.7	\$1.2	\$95.7	\$0.0	0%	\$1.2	1%	38,915	

*Already subtracted from Total Rates

Appendix A – ASE Retirees: Non-Medicare Eligible 2016 Final Rate Details



NME Retirees	Risk Adjusted Total Rate	State Contrib.	Reserve Used / (Added)	2016 Retiree Cost	2015 Total Retiree Cost	Change in Retiree Cost (\$/%)		Assumed Enrollment
Premium								
Retiree Only	\$459.96	\$184.45	\$16.87	\$258.64	\$258.64	\$0.00	0%	1,649
Retiree & NME SP	1,024.48	332.08	30.38	662.02	662.02	0.00	0%	400
Retiree & Child(ren)	766.76	264.61	24.21	477.94	477.94	0.00	0%	99
Retiree & NME SP&CH	1,331.28	412.25	37.71	881.32	881.32	0.00	0%	38
Retiree & ME SP	861.74	331.62	30.34	499.78	499.78	0.00	0%	222
Retiree & ME SP & CH	1,168.54	411.79	37.67	719.08	719.08	0.00	0%	9
Est. Monthly Total (\$mil)	\$1.5	\$0.6	\$0.1	\$0.9	\$0.9	\$0.0	0%	2,417
Classic								
Employee Only	\$401.60	\$184.39	\$16.87	\$200.34	\$200.34	\$0.00	0%	36
Employee & Spouse	888.46	332.12	30.38	525.96	525.96	0.00	0%	16
Employee & Child(ren)	666.20	264.63	24.21	377.36	377.36	0.00	0%	3
Family	1,153.06	412.36	37.72	702.98	702.98	0.00	0%	5
Est. Monthly Total (\$mil)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	0%	60
Basic								
Employee Only	\$355.16	\$184.43	\$16.87	\$153.86	\$153.86	\$0.00	0%	10
Employee & Spouse	777.90	332.10	30.38	415.42	415.42	0.00	0%	5
Employee & Child(ren)	584.92	264.65	24.21	296.06	296.06	0.00	0%	0
Family	1,007.66	412.32	37.72	557.62	557.62	0.00	0%	4
Est. Monthly Total (\$mil)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	0%	20
Total (Monthly) (\$ mil)	\$1.5	\$0.6	\$0.1	\$0.9	\$0.9	\$0.0	0%	2,498
Est Annual Total (\$ mil)	\$18.6	\$6.9	\$0.6	\$11.0	\$11.0	\$0.0		

Appendix A – ASE Retirees: Medicare Eligible 2016 Final Rate Details



Medicare Eligible	Risk Adjusted Total Rate	State Contrib.	Reserve Used / (Added)	2016 Retiree Cost	2015 Total Retiree Cost	Change in Retiree Cost (\$/%)		Assumed Enrollment
Retiree Only	\$401.77	\$219.71	\$20.10	\$161.96	\$161.96	\$0.00	0%	6,326
Retiree & NME SP	861.73	271.55	24.84	565.34	565.34	0.00	0%	410
Retiree & Child(ren)	759.05	346.12	31.67	381.26	381.26	0.00	0%	77
Retiree & NME SP&CH	1,273.09	447.51	40.94	784.64	784.64	0.00	0%	29
Retiree & ME SP	779.65	358.81	32.82	388.02	388.02	0.00	0%	2,313
Retiree & ME SP & CH	1,136.93	485.22	44.39	607.32	607.32	0.00	0%	27
Est. Monthly Total (\$mil)	\$4.8	\$2.4	\$0.2	\$2.2	\$2.2	\$0.0	0%	9,181
Total (Est. Annual)	\$57.9	\$28.6	\$2.6	\$26.7	\$26.7	\$0.0		

Appendix B – 2016 Plan Design



<i>Yellow highlight means the coverage is changed</i>	ASE Premium	PSE Premium	ASE Classic	PSE Classic	ASE Basic	PSE Basic
Monthly Plan HSA Contribution (Ind./Family)	n/a	n/a	\$25/\$50	\$0	\$25/\$50	\$0
<i>In-Network:</i>						
Deductible - Individual	\$500	\$1,000	\$2,500	\$2,000	\$6,450	\$4,250
Co-Insurance Limit - Individual (after Deductible)	\$2,500	\$2,500	\$3,950	\$4,450	n/a	\$2,200
Med. Out-of-Pocket Max (Ded. + Co-Ins. + Med. Co-Pay) **	\$3,000	\$3,500	\$6,450	\$6,450	\$6,450	\$6,450
Deductible - Family	\$1,000	\$2,000	\$5,000	\$3,000	\$12,900	\$8,500
Co-Insurance Limit - Family (after Deductible)	\$5,000	\$5,000	\$7,900	\$6,675	n/a	\$4,400
Med. Out-of-Pocket Max (Ded. + Co-Ins. + Med. Co-Pay)	\$6,000	\$7,000	\$12,900	\$9,675	\$12,900	\$12,900
Coinsurance Rate	80%/20%	80%/20%	80%/20%	80%/20%	100%/0%	80%/20%
Physician Office Visit - Primary Care - Co-Pay	\$25	\$25				
Physician Office Visit - Specialist - Co-Pay	\$50	\$50				
Rx - Deductible	None	None	Incl. w/ Med.	Incl. w/ Med.	Incl. w/ Med.	Incl. w/ Med.
Rx - Tier 1 - Generic	\$15	\$15	**	**	**	**
Rx - Tier 2 - Preferred Brand	\$40	\$40	**	**	**	**
Rx - Tier 3 - Non-Preferred Brand	\$80	\$80	not covered	not covered	not covered	not covered
Rx - Specialty	\$100	\$100	**	**	**	**
Rx - Out of Pocket Maximum (Individual/Family)	\$3,600/\$7,200	\$3,100/\$6,200	n/a	n/a	n/a	n/a
Hospital / Facility - Inpatient & SNF - Co-Pay Per Admission*	\$0	\$0				
Hospital / Facility - Outpatient - Co-Pay*	\$0	\$0				
Urgent Care Visit	\$100	\$100				
Emergency Room Visit	\$250	\$250				
Emergency Transportation - Ambulance	\$50	\$50				
High Tech Radiology - Co-Pay (1st Procedure Only)*	\$0	\$0				
Rehab / Therapy - Outpatient - Physical/Speech/Occup	\$25	\$25				
Rehab / Therapy - Outpatient - Chiropractic - Co-Pay	\$25	\$25				
<i>Out-of-Network:</i>						
Deductible - Individual/Family	\$2,000/\$4,000	\$2,000/\$4,000	\$4,000/\$8,000	\$3,000/\$6,000	not covered	not covered
Co-Insurance	60%/40%	60%/40%	60%/40%	60%/40%	not covered	not covered
Co-Insurance Limit - Individual/Family (after Deductible)	None	None	None	None	not covered	not covered
Max. Out-of-Pocket (Deductible + Co-Insurance)	None	None	None	None	not covered	not covered

*Deductible & Co-Insurance also applies

** An embedded individual OOP Max is applied within the family OOP max



Appendix C – Use & Disclosures



- The assumptions and methods for updated projections are as described on our monitoring reports dated February 16, 2016. Projections do not reflect any updated claims experience since the rates were established in 2015. All projections for 2017 are illustrative and are not intended to convey any projected rate changes.
- Estimates of impact of pharmacy changes are intended to be conservative estimates. Our estimates assume the pharmacies' usual and customary rates will be above the discounted AWP or MAC charge, as applicable. Estimates rely on 2015 actual experience without trend and unadjusted for the Medicare Retiree Drug subsidy. Savings for classic and basic are allocated to members according to the member proportion of the original claim.
- In preparing the information in this presentation, we relied on information (some oral and some written) supplied by the EBD and the Plan's vendors. This information includes, but is not limited to, the plan provisions, employee eligibility data, financial information, and claims data. We performed an informal examination of the obvious characteristics of the data for reasonableness and consistency in accordance with Actuarial Standard of Practice No. 23. This presentation does not reflect future changes in benefits, penalties, taxes, or administrative costs that may be required as a result of the Patient Protection and Affordable Care Act of 2010, related legislation, or regulations.
- Cheiron's analysis was prepared exclusively for the Employee Benefits Division of the State of Arkansas for the specific purpose of providing projections and options to the Arkansas State and Public School Life and Health Insurance Board. Other users of this document are not intended users as defined in the Actuarial Standards of Practice, and Cheiron assumes no duty or liability to any other user.
- The figures in this presentation are preliminary and subject to change or modification as more detailed information is gathered and depending upon decisions made by the Board.

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