



AGENDA

State and Public School Life and Health Insurance Board

April 19, 2016

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. *Call to Order Carla Haugen, Chair*
- II. *Approval of March 22, 2016 Minutes..... Carla Haugen, Chair*
- III. *ASE-PSE Financials March, 2016..... Marla Wallace, EBD Fiscal Officer*
- IV. *Benefits Sub-committee Report Shelby McCook, Benefits Committee Member*
- V. *Quality of Care Sub-committee Report..... Margo Bushmiaer, Chair*
- VI. *DUEC Sub-committee Report..... Dr. Hank Simmons, Chair,
..... Dr. Geri Bemberg, UAMS*
- VII. *Trend Experience/2017 Preliminary Rates John Colberg,
..... Gaele Gravot, Cheiron, Inc.*
- VIII. *Director's Report..... Janis Harrison, Interim EBD Director*

Upcoming Meetings

May 17, June 21, July 19, 2016

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
April 19, 2016**

The 158th meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on April 19, 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
Dr. Tony Thurman
Lori Freno-Engman
Dan Honey – Vice Chairman
Dr. Joseph Thompson
Dr. Andrew Kumpuris
Angela Avery

MEMBERS ABSENT

Renee Mallory
Katrina Burnett

Janis Harrison, Interim Director, Employee Benefits Division

OTHERS PRESENT:

Jill Johnson, Sherry Bryant, Dr. Richard Smith, UAMS; Ethel Whittaker, Marla Wallace, Stella Green, Andrew Carle, Cecilia Walker, Lori Eden, Janna Keathley, Cecilia Walker, Eric Gallo, Terri Freeman, EBD; Dr. Hank Simmons, EBRX; Kristi Jackson, Jennifer Vaughn, ComPsych; Pam Lawrence, AHH; Sylvia Landers, Eileen Wider, Minnesota Life; Drew Crawford, Sebco; Mike Boyd, Ronda Walthall, AR Highway & Transportation Dept; Jessica Akins, Takisha Sanders, Health Advantage; Susan Walker, DataPath; Dr. John Vinson, APA; Martha Hill, Mitchell Williams; Bill Clary, H&H; Jackie Baker, ASP; Sean Seago, Merck; Karyn Langley, Qual Choice; Leah Raminez, ACHI; Jim Chapman, Abbie; Stephen Carroll, Mark Adkison, Allcare; Andy Davis, Arkansas Democrat-Gazette; Marti Morrison; Quinten Whiteside, WLJ; Allison Drennon; Insurance Advantage; Raina Porchay, Optum Rx; David Stover, Drug Room; John Powell, Sav-Mart Pharmacy; Hayda, LaGrone Drug Inc.

CALL TO ORDER:

Meeting was called to order by Carla Haugen, Chairman

I. APPROVAL OF MINUTES: *by Carla Haugen, Chairman*

The request was made by Haugen to approve the March 22, 2016 minutes.

Honey made the motion to adopt the minutes with Dr. Thompson's modifications; Avery seconded; all were in favor.

Minutes approved.

II. FINANCIALS: *by Marla Wallace, EBD Fiscal Officer*

Wallace reported financials for March 2016. For March PSE, five (5) weeks of medical and pharmacy claims were paid. There was a gain of \$1.042 million for the month, and \$13.2 year-to-date. The FICA savings are \$490,000. The Net Assets available are \$46.7 million.

For ASE the month of March, five (5) weeks of medical and pharmacy claims were paid. The fifth week of claims was \$4.879 million. There was a loss of \$803,000 for the month, and the year-to-date gain is \$7.53 million.

Dr. Thompson requested data regarding the pharmaceutical, financial growth trend of current brand-named drugs. Dr. Bemberg, EBD Pharmacist, will provide the information at the next Board meeting.

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

McCook reported the Benefits Sub-committee met on April 8, 2016. The committee discussed the following topics:

- ASE/PSE March Financials
- 2017 Preliminary Projections
- Director's Report

McCook motioned to adopt the report. Dr. Thompson seconded; all were in favor.

Motion approved.

IV. QUALITY OF CARE COMMITTEE REPORT: *By: Margo Bushmiaer, Chair*

Bushmiaer reported the committee met on April 12, 2016. The topics of discussion were: (1) Continued Review of Anesthesia for Screening Colonoscopies, (2) 2017 ARBenefits Wellness Program, (3) Overview of Medical Utilization and Evaluation Group.

Keathley and Walker completed an outline of the 2017 ARBenefitsWell program. The recommendations are as follows:

- No changes to the wellness program at this time
- Increase numbers for members meeting wellness requirements
- Reduce complaints of wellness program
- Continued Research
- Fees
- Allow time for programming

McCook has concerns with the value of the wellness discount as well as the benefits. Dr. Thurman also has concerns if the plan is receiving the full benefits of the discount. Dr. Thurman also believes there is a requirement to design measuring tools that will compute the value of the benefit or address the potential non-productive issues of the program. Dr. Kirtley reported the Board must set guidelines for metrics to measure and calculate the value of the wellness discount.

Dr. Smith reported on the debate between the current benefit coverage of conscious sedation for screening colonoscopies and whether anesthesia should or should not be a covered benefit for screening colonoscopies.

The committee recommended to the Board for consideration: cover anesthesia for screening colonoscopies, with a requirement of no added cost to the patient by physician or facility. Cost: \$2.77 per member/per year to \$8.12 per member/per year.

Boyd motioned to adopt the recommendation to cover anesthesia for screening colonoscopies effective June 1, 2016. Dr. Thompson seconded; all were in favor.

Motion approved.

Dr. Thompson motioned; Part I. Encourage the third party administrators through their episode around screening colonoscopies to incorporate financial incentives to discourage routine use of anesthesia and encourage routine use of conscious sedation. Part II. In one year provide an update regarding the outcome of the utilization rates of colonoscopies. McCook seconded; all were in favor.

Motion approved.

Dr. Smith presented and discussed the workflow of the Medical Utilization and Evaluation Workgroup with the Quality of Care Subcommittee and the Board to include:

- Evaluate topics of concern
- Provide literature reviews
- Address standards of care
- Develop options
- Estimate impacts

Dr. Thompson motioned formally to request a recommendation from the Quality of Care Committee regarding the strategy for the wellness and prevention benefit structure. McCook seconded; all were in favor.

Motion approved.

V. **DUEC REPORT:** *by Dr. Hank Simmons, Dr. Geri Bemberg, UAMS*

The attached report resulted from a special meeting of the DUEC on April 4, 2016, with Dr. Hank Simmons presiding.

I. Recommended Changes to Current Coverage

A. Delivery Coordination Workgroup Report: *by Dr. Geri Bemberg, UAMS*

Drugs used in the treatment of cancers and non-cancer drugs were reviewed by the DCWG and a report made to the DUEC on April 4th. Recommendations from this report are outlined below.

	Current Coverage	Proposed Coverage
Pulmonary Hypertension		
Selexipag (Uptravi)	Excluded (New Drug)	T4-PA, OL 2/1
Tadalafil (Adcirca)	Excluded	T4-PA
<u>Multiple Myeloma</u>		
Carfilzomib (Kyprolis)	Covered, no utilizers	Exclude pharmacy & medical
<u>Basal Cell Carcinoma</u>		
Vismodegib (Erivedge)	Exclude	Exclude
<u>ALK +Non-Small Cell Lung Cancer</u>		
Crizotinib (Xalkori)	Exclude	T4-PA
Alectinib (Alecensa)	Exclude (New Drug)	Exclude

Dr. Thompson motioned to adopt Section A. McCook seconded; all were in

favor. Motion approved.

B. 2nd Review of Drugs by Drs. Geri Bemberg, Jill Johnson, UAMS

1) Oral Mesalamine Products:

Brand	Strength/Formula	Cost/Month (UC Maint)	Current 4/4/16 Coverage	Proposed Coverage
Apriso	0.375mg ER Capsule 24 hour Therapy Pack	\$500.40	Excluded	Tier 4
Pentasa	250mg, 500mg Controlled Release Capsule	\$674.40/\$1348.80	Excluded	Tier 4
Delzicol	400mg	\$427.20	Tier 2	Tier 4
Asacol HD	800mg EC Tablet	\$776.70/\$1553.40	Excluded	Excluded
Lialda	1.2g EC Tablet	\$567.26	Excluded	Tier 3

McCook motioned to adopt Section B-1. Dr. Thompson seconded; all were in favor. Motion approved.

2) Rifaximin (Xifaxan) – Miscellaneous Antibiotic; FDA Labeled Indications: Traveler’s diarrhea, Irritable bowel syndrome with diarrhea, and Hepatic encephalopathy.

The committee recommended; PA all indications of Xifaxan, and move to T4. Currently, T3 with 59 utilizers in Q42015. All 59 were using 550mg. PA for IBS-D would include: 1) Dx of IBS-D 2) At least 18 years if age 3) Tried and failed 60 days (each) of: dietary modifications (FODMAP diet), loperamide, bile acid sequestrants, antispasmodics (hyoscyamine, dicyclomine), and tricyclic antidepressants. PA would be good for #126/365 days.

- a) “Modified grandfathering” – grandfather everyone using Xifaxan for six months.
- b) “Indication-specific grandfathering” – grandfather those getting qty #42 for 90 days, and those getting qty #60 for six months – 1 year.

3) Pioglitazone (Actos) – Currently, there is a PA on pioglitazone. For type 2 diabetes.

The committee recommended removing the PA requirement due to; 1) The MC, DB trial that randomized 3876 patients who had had recent ischemic stroke or TIA to either pioglitazone or placebo. 2) Eligible pts did not have diabetes but did have insulin resistance on the basis of a score of more than three on the homeostasis model assessment of insulin resistance index.

4) Afatinib (Gilotrif) – Current coverage includes; Erlotinib is currently covered with a PA for EGFR mutations. Afatinib and gefitinib are currently excluded.

The committee recommended; 1) Add afatinib to coverage for the full labeled indication. 2) Continue exclusion of gefitinib.

Dr. Thompson motioned to adopt 2, 3, & 4 of section B. Dr. Kirtley seconded; all were in favor. Motion approved.

II. NEW DRUGS

Johnson reported on new drugs. The review covered products released October 12, 2015 – January 4, 2016. The Committee’s recommendations follow:

A. Recommended Additions

1. Nonspecialty medications-proposed additions

2.Specialty medications-proposed additions					
BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON	DUEC VOTE

				FORMULARY/AWP	
Uptravi tabs	Selexipag tabs	\$17,400/60-1600mcg tabs	Treatment of pulmonary hypertension to delay disease progression and reduce the risk of hospitalization.		Cover, PA, QL
Zepatier tab 50-100mg	Elbasvir-grazoprevir tab 50-100mg	\$780/tab	Chronic Hepatitis C	All other Hep C treatments T4PA	Cover, PA

B. Recommended Exclusions

1. Nonspecialty Medications-proposed exclusion

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY/AWP	EXCLUSION CODE
Enstilar Aerosol	Calcipotriene/betamethasone dipropionate foam 0.005%/0.064%	\$997.16/60g (foam)	Psoriasis	Tier1-betamethasone dipropionate cream 0.05% \$81/45gm. Calcipotriene cream 0.005%/\$840/120gm	Exclude, use each product separately
Dyanavel XR	Amphetamine extended release suspension 2.5mg/ml	\$1094.998/454 ml (\$2,35991/ml)	ADHD	Extended release amphetamine products tiered for children, Reference prices to \$2.50/unit	Exclude code 13
Quillichew ER	Methylphenidate HCl Chew Tab Extended Release 20mg, 30mg, 40mg	\$10.80/tablet	ADHD	Extended release amphetamine products tiered for children. Reference priced to \$2.50/unit	Excluded, code 13

2. Specialty Medications-proposed exclusions

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY/AWP	EXCLUSION CODE
Viberzi Tabs	Eluxadine	\$1,152/60-100mg tabs. Dose=200mg/day	Treatment of irritable bowel syndrome wit diarrhea		Exclude code 13

McCook motioned to adopt the recommendations for non-specialty exclusions, specialty additions, and exclusions. Honey seconded; all were in favor. Motion approved.

III. Insulin Class Review for Rebate Contracting: *By Dr. Rachael McCaleb, UAMS*

Dr. McCaleb reported Insulin products are Food and Drug Administration (FDA) approved to improve glycemic control in patients with diabetes mellitus (DM) type 1 and 2. Available insulin products are summarized in the attached report.

Dr. McCaleb recommended:

- Maintain Humulin or Novolin as preferred but move to T1 copay
 - o Coverage for vials and pens
- Include one rapid-acting and one long-acting insulin analogue as preferred as a T2 copay
 - o Coverage for vials and pens
 - o Remaining rapid-acting and one long-acting insulin analogues will be excluded from plan
 - o All current members on an excluded analogue will NOT be grandfathered and will be given a 90 day grace period following the implementation of the contract to switch to a preferred analogue
- Required price protection for the life of the contract

Dr. Thompson motioned to adopt the Insulin recommendations. Dr. Kirtley

seconded; all were in favor. Motion approved.

Dr. Simmons reported an update regarding Desi drugs. The committee provided a list of Desi Drugs to the Board for review. The FDA reported the drugs in question were less than effective. The recommendation is to exclude all Desi Drugs. The members would receive a 90-day notification.

Dr. Thompson motioned to adopt the DUEC recommendations. Dr. Kirtley seconded; all were in favor.

Motion approved.

Dr. Simmons introduced Mike Boyd as a potential new DUEC committee member. Boyd would replace Larry Dickerson from the Highway Department, who recently resigned. Boyd is also an employee of the Arkansas Highway Department.

Dr. Thompson requested additional background data regarding Mike Boyd's expertise. Dr. Simmons will provide the data at the next Board meeting.

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

Colberg reported on the following topics:

- Pharmacy reimbursement decision
- Trend experience
- Updated 2016 projections
- Preliminary 2017 projections
- Next step

The Board adopted MedImpact proposed rates for the large majority of pharmacies. The expected savings of \$16 million is allocated \$8 million to members and \$8 million to the plan. The savings could be higher if usual and customary prices remain below AWP – 15.65% for non-MAC generic drugs. For projections, reduction in 2017 plan costs of approximately 8% for ASE and 4% for PSE.

The following table outlines the updated projections for 12/31/2016:

(In Millions \$)	PSE	PSE	ASE	ASE
As of	12/31/2015	Updated Projection 12/31/2016	12/31/2015	Updated Projection 12/31/2016
Net Assets before IBNR	\$132.1	\$136.3	\$93.9	\$89.6
IBNR Reserve	\$(29.4)	\$(29.4)	\$(26.5)	\$(26.5)
Reserve for Curr/Future Prem.	\$(57.3)	\$(47.7)	\$(28.8)	\$(12.6)
Catastrophic Reserve	\$(10.9)	\$(10.5)	\$(10.4)	\$(10.7)
Net Assets Available	\$34.5	\$48.7	\$28.2	\$39.8

McCook reported eliminating positions that are budgeted could have an impact on the employees retained and the level. Haugen reported a vast majority of the positions to be eliminated could be non-budgeted positions.

Colberg reported effective July 1, 2016, several budgeted positions could be removed. Colberg discussed the loss of 2000 budgeted positions could result in a loss of \$5 million. Any position receiving funds is considered a budgeted position, no matter the funding source. The plan receives funds for budgeted positions even if the positions are vacant.

Dr. Thompson reported, per the financials, there are 38,000 active state employees enrolled in the health plan. The plan could lose 2000 units of payments and still have 38,000 units of expense remaining.

McCook requested data on medical claims information to review the outcome for six months to one year for a possible pricing change, to mirror Medicaid claims. Also, what would it cost to implement such a project?

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

There is not a Director's report for this meeting.

VIII. AUDIENCE DISCUSSION: *by John Powell, Owner Sav-Mart Pharmacy, McGehee, AR and David Stover, Owner the Drug Room, Pine Bluff, AR*

Powell and Stover both stated the new pharmacy rates recently set by the Board will have a significant impact on the smaller pharmacy; it could as much as eliminate some smaller pharmacies. Powell and Stover would like the Board to reconsider the pharmacy rate decision.

IX. EXECUTIVE SESSION:

McCook motioned for the Board to exit for Executive Session; the hiring committee will review information with the Board. Honey seconded; all were in favor.

Motion approved.

McCook motioned for the Board to return to regular session. Dr. Thurman seconded; all were in favor.

Motion approved.

McCook motioned that the Board approve the action taken in Executive Session. The Board voted to provide recommendations for the EBD Director position to the DFA Director for review. Dr. Thurman seconded; all were in favor.

Motion Approved.

Haugen called for an effective date regarding the approval of anesthesia for screening colonoscopies.

Dr. Thompson motioned to modify the benefit for programming the vendors to approve anesthesia for screening colonoscopies effective June 1, 2016. Dr. Thurman seconded; all were in favor.

Motion approved.

Meeting adjourned.

Arkansas State Employees (ASE) Financials - January 1, 2015 through March 31, 2015

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	886	14		900		1568	28		1596
CLASSIC	1822	55		1877		3134	85		3219
PREMIUM	24704	2151		26855		43209	2784		45993
PRIMARY		229	8667	8896			469	11454	11923
TOTAL	27412	2449	8667	38528		47911	3366	11454	62731

REVENUES & EXPENDITURES

<u>Funding</u>	Current Month	Year to Date (3 Months)
State Contribution	\$ 14,362,878	\$ 43,069,364
Employee Contribution	\$ 8,047,498	\$ 24,200,978
Other	\$ 711,116	\$ 1,787,942
Allocation for Actives - Plan Year 2015	\$ 971,667	\$ 2,915,000
Total Funding	\$ 24,093,159	\$ 71,973,285
Expenses		
Medical Expenses		
Claims Expense	\$ 10,873,595	\$ 34,943,496
Claims IBNR	\$ -	\$ -
Medical Administration Fees	\$ 1,151,541	\$ 3,195,108
Refunds	\$ (1,248)	\$ (26,459)
Employee Assistance Program (EAP)	\$ 56,559	\$ 169,561
Life Insurance	\$ 55,141	\$ 165,294
Pharmacy Expenses		
RX Claims	\$ 4,144,230	\$ 15,049,230
RX IBNR	\$ -	\$ -
RX Administration	\$ 212,858	\$ 637,604
Plan Administration	\$ 288,301	\$ 1,000,085
Total Expenses	\$ 16,780,977	\$ 55,133,920
Net Income/(Loss)	\$ 7,312,182	\$ 16,839,365

BALANCE SHEET

Assets	
Bank Account	\$ 20,375,436
State Treasury	\$ 71,145,590
Due from Cafeteria Plan	\$ 709,521
Due from PSE	\$ -
Receivable from Provider	\$ -
Accounts Receivable	\$ 147,014
Total Assets	\$ 92,377,560
Liabilities	
Accounts Payable	\$ 4,014
Deferred Revenues	\$ -
Due to Cafeteria	\$ 57
Due to PSE	\$ 344,690
Due to Federal Government (\$44 fee)	\$ -
Health IBNR	\$ 24,700,000
RX IBNR	\$ 1,800,000
Total Liabilities	\$ 26,848,761
Net Assets	\$ 65,528,800
Less Reserves Allocated	
Premiums for Plan Year 1/1/15 - 12/31/15 (\$6,260,000 + \$5,400,000)	\$ (8,745,000)
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	\$ 42,783,800

Fifth Week of Claims \$

Arkansas State Employees (ASE) Financials - January 1, 2016 through March 31, 2016

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	1247	27		1274	2077	41		2118
CLASSIC	1694	64		1758	2839	87		2926
PREMIUM	23523	2167		25690	41025	2785		43810
PRIMARY		215	9110	9325		438	11928	12366
TOTAL	26464	2473	9110	38047	45941	3351	11928	61220

REVENUES & EXPENDITURES

	Current Month	Year to Date (3 Months)
Funding		
1 State Contribution	\$ 14,694,092	\$ 44,080,848
2 Employee Contribution	\$ 7,976,701	\$ 23,986,330
3 Other	\$ 874,050	\$ 2,047,953
4 Allocation of Reserves	\$ 1,350,000	\$ 4,050,000
Total Funding	\$ 24,894,843	\$ 74,165,131
Expenses		
Medical Expenses		
5 Claims Expense	\$ 16,376,663	\$ 41,659,170
6 Claims IBNR	\$ -	\$ -
7 Medical Administration Fees	\$ 1,114,779	\$ 3,298,963
8 Refunds	\$ -	\$ -
9 Employee Assistance Program (EAP)	\$ 55,379	\$ 166,139
10 Life Insurance	\$ 79,490	\$ 238,458
Pharmacy Expenses		
11 RX Claims	\$ 7,568,151	\$ 19,650,121
12 RX IBNR	\$ -	\$ -
13 RX Administration	\$ 214,855	\$ 639,034
14 Plan Administration	\$ 289,418	\$ 975,530
Total Expenses	\$ 25,698,735	\$ 66,627,414
15 Net Income/(Loss)	\$ (803,892)	\$ 7,537,717

BALANCE SHEET

Assets	
16 Bank Account	\$ 5,786,779
17 State Treasury	\$ 86,364,280
18 Due from Cafeteria Plan	\$ 5,195,886
19 Due from PSE	\$ -
20 Receivable from Provider	\$ -
21 Accounts Receivable	\$ 398,711
Total Assets	\$ 97,745,656
Liabilities	
22 Accounts Payable	\$ 654
23 Deferred Revenues	\$ -
24 Due to Cafeteria	\$ 2,063
25 Due to PSE	\$ 355,749
26 Due to Federal Government (\$44 fee)	\$ -
27 Health IBNR	\$ 24,700,000
28 RX IBNR	\$ 1,800,000
Total Liabilities	\$ 26,858,466
Net Assets	\$ 70,887,190
Less Reserves Allocated	
29 Premiums for Plan Year 1/1/16 - 12/31/16 (\$3,600,000 + \$12,600,000)	\$ (12,150,000)
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	\$ 35,437,190

34 Fifth Week of Claims \$4,879,419.53

Public School Employees (PSE) Financials - January 1, 2015 through March 31, 2015

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	2383	125		2508	3529	150		3679
CLASSIC	21524	1578		23102	39456	1921		41377
PREMIUM	20881	1298		22179	26785	1398		28183
PRIMARY		111	9893	10004		224	10822	11046
TOTAL	44788	3112	9893	57793	69770	3693	10822	84285

REVENUES & EXPENDITURES

	Current Month	Year to Date (3 Months)
Funding		
Per Participating Employee Funding (PPE Funding)	\$ 8,257,199	\$ 24,754,572
Employee Contribution	\$ 9,121,748	\$ 27,561,833
Department of Education \$35,000,000 & \$15,000,000	\$ 19,475,771	\$ 29,589,408
Other	\$ 829,072	\$ 1,801,416
Allocation for Actives	\$ 1,666,667	\$ 5,000,000
Total Funding	\$ 39,350,457	\$ 88,707,229
Expenses		
Medical Expenses		
Claims Expense	\$ 10,388,602	\$ 36,703,663
Claims IBNR	\$ -	\$ -
Medical Administration Fees	\$ 1,569,656	\$ 4,640,545
Refunds	\$ -	\$ (3,153)
Employee Assistance Program (EAP)	\$ 77,462	\$ 232,531
Pharmacy Expenses		
RX Claims	\$ 2,411,685	\$ 9,199,339
RX IBNR	\$ -	\$ -
RX Administration	\$ 293,859	\$ 872,975
Plan Administration	\$ 371,566	\$ 1,167,459
Total Expenses	\$ 15,112,831	\$ 52,813,359
Net Income/(Loss)	\$ 24,237,626	\$ 35,893,870

BALANCE SHEET

Assets	
Bank Account	\$ 23,084,895
State Treasury	\$ 78,532,994
Receivable from Provider	\$ -
Accounts Receivable	\$ 4,669,983
Due to ASE	\$ -
Total Assets	\$ 106,287,872
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	\$ 76,886,997
Less Reserves Allocated	
Premiums for Plan Year 1/1/15 - 12/31/15 (\$20,000,000 rec'd from Dept. of Education)	\$ (15,000,000)
Premium Assistance (FICA Savings)	\$ (1,421,023)
Catastrophic Reserve (2015 \$10,900,000)	\$ (10,900,000)
Net Assets Available	\$ 49,565,974

Public School Employees (PSE) Financials - January 1, 2016 through March 31, 2016

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	3196	231		3427		4798	291		5089
CLASSIC	21990	1850		23840		40840	2245		43085
PREMIUM	19633	1009		20642		25336	1087		26423
PRIMARY		86	10675	10761			172	11649	11821
TOTAL	44819	3176	10675	58670		70974	3795	11649	86418

REVENUES & EXPENDITURES

	Current Month	Year to Date (3 Months)
Funding		
1 Per Participating Employee Funding (PPE Funding)	\$ 8,195,088	\$ 24,572,576
2 Employee Contribution	\$ 9,304,661	\$ 27,997,620
3 Department of Education \$35,000,000 & \$15,000,000 & Other Funding	\$ 3,181,818	\$ 13,295,455
4 Other	\$ 925,809	\$ 1,937,231
5 Allocation of Reserves	\$ 3,975,000	\$ 11,925,000
Total Funding	<u>\$ 25,582,376</u>	<u>\$ 79,727,882</u>
Expenses		
Medical Expenses		
6 Claims Expense	\$ 17,306,177	\$ 47,122,413
7 Claims IBNR	\$ -	\$ -
8 Medical Administration Fees	\$ 1,679,696	\$ 4,967,174
9 Refunds	\$ -	\$ -
10 Employee Assistance Program (EAP)	\$ 77,601	\$ 232,856
Pharmacy Expenses		
11 RX Claims	\$ 4,716,812	\$ 11,774,313
12 RX IBNR	\$ -	\$ -
13 RX Administration	\$ 310,585	\$ 922,444
14 Plan Administration	\$ 448,980	\$ 1,441,963
Total Expenses	<u>\$ 24,539,852</u>	<u>\$ 66,461,164</u>
16 Net Income/(Loss)	\$ 1,042,524	\$ 13,266,718

BALANCE SHEET

Assets	
17 Bank Account	\$ 19,947,123
18 State Treasury	\$ 108,869,320
19 Receivable from Provider	\$ -
20 Accounts Receivable	\$ 4,276,530
21 Due from ASE	\$ 355,749
Total Assets	<u>\$ 133,448,722</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	\$ 104,048,343
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)	\$ (35,775,000)
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)	\$ (1,471,149)
32 Catastrophic Reserve (2016 \$10,500,000)	\$ (10,500,000)
34 Net Assets Available	<u>\$ 46,702,194</u>

35 Fifth Week of Claims \$4,149,635.63



**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 April 8, 2016, with Jeff Altemus presiding.

Topics Discussed:

- ASE/PSE March Financials
- 2017 Preliminary Projections
- Director's Report

ASE/PSE Financials for March: Marla Wallace, EBD Fiscal Officer

Wallace reported financial information for the month of March, 2016. Please see the attached ASE/PSE financial information.

2017 Preliminary Projections: John Colberg, Cheiron, Inc.

Colberg reported on the Pharmacy Reimbursement Decision, Trend Experience, Updated 2016 Projections, and Preliminary 2017 Projections.

The Board adopted MedImpact's proposed rates for the large majority of pharmacies.

- AWP – 15.65% for brand (13.65% for certain rural pharmacies)
- Dispensing fee of \$1.50
- New MAC pricing

The projected savings of \$16 million is as follows:

- \$8 million to members
- \$8 million to the plan
 - o Assuming a reduction of over 8% for ASE and over 4% for PSE
- Savings could be higher if usual and customary prices remain below the AWP of 15.65% for non-MAC generic drugs.

Based on actual March 2016 enrollment and calendar year 2015 claims paid through February 2016 assumed trends of:

- 6% medical for actives and Non-Medicare retirees (to allow for resuming to position trend environment plus leveraging)
- 10% pharmacy (national average projection plus leveraging)
- 5% medical for Medicare Eligible retirees

Director's Report, Janis Harrison, EBD Interim Director

WageWorks has completed the bulk transfer of assets from DataPath to WageWorks on HSA accounts. Harrison reported the final approximately 200 accounts are still in the bulk transfer process. On March 23, 2016 the Health Insurance Representatives were notified going forward if an employee wishes to transfer their funds, a request form must be submitted. Only accounts with a balance exceeding \$100.00 will qualify for transfer in order to limit the plan transfer expenses of \$25 per account. Those accounts with a balance of \$100.00 or less will remain with DataPath. There are approximately 6,300 accounts already transferred.

McCook requested additional data regarding the 1571 State Employees who have an HSA account; what is the ratio of those supporting their accounts financially?

Altemus requested additional data regarding Public School Employees: of the 6300 employees who have an HSA account, what is the average contribution amount? Baggett, EBD Operations Manager, reported the report will not provide the amount, however it will provide if the employee is participating. Baggett reported the data will be provided at the next Benefits meeting.



**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 April 12, 2016, with Margo Bushmiaer presiding.

Topics Discussed:

- 2017 ARBenefits Well Program
- Continued Review of Anesthesia for Colonoscopies
- Overview of Medical Utilization and Evaluation Group

2017 ARBenefits Well Program - Janna Keathley, EBD Quality Assurance Officer and Cecilia Walker, EBD RN

Keathley and Walker provided an update of the Program that included:

- Qualification statistics
- Agency reporting statistics
- Summary of findings provided by Guidance Resources from the Health Assessments completed in 2015

- Additional organizational comparison information
- Recommendation for no change to existing Program for 2017, but look at changes for 2018

Please see the attached Wellness Report and Health Assessment Chart.

Continued Review of Anesthesia for Colonoscopies –Dr. Jill Johnson and Dr. Richard Smith, UAMS

Dr. Johnson reported on the use of propofol versus conscious sedation for colonoscopies:

- Dr. Johnson's conclusion is: it appears the use of propofol instead of a traditional agent (benzo) during colonoscopy results in a shorter recovery. Pain control favored the traditional agents. In a population of EGD patients (may not apply to colonoscopy patients), 12-13% more patients achieved deep sedation with propofol than with midazolam. The literature states sedation deeper than intended is more frequently associated with a higher rate of complications. In one trial, more patients on propofol than on midazolam experienced mild transient hypoxemia for >30 seconds after the jaw thrust maneuver. However, there was no serious complication in either group. Although endoscopists may process more patients per day with propofol, there were no data in the literature to assess the cost-effectiveness of propofol from a plan's perspective (or from any perspective).

Dr. Smith reported on the debate between the current benefit coverage of conscious sedation for screening colonoscopies and whether anesthesia should or should not be a covered benefit for screening colonoscopies:

- For decades, conscious sedation has been used routinely with screening colonoscopies. Anesthesia is an alternative to conscious sedation.
- Screening colonoscopies are recommended by the U.S. Preventative Services Task Force every ten years for those 50-75 years old.
- ACA requires most plans to cover screening colonoscopies at no charge to the patient.

- Best interest of the patient and the plan's financial interest.
- Trend moving to use of anesthesia, but patient does not realize the out of pocket costs.
- Evidenced base for anesthesia versus conscious sedation.
- Ancillary/anecdotal information.
- Plan experience.
- Options and impacts.
- Recommendation

**The committee recommended option 2 be presented to the Board for consideration: cover anesthesia for screening colonoscopies, with requirement of no added cost to patient by physician or facility.
Cost: \$2.77 per member/per year to \$8.12 per member/per year.**

Dr. Smith stated the increased cost of the anesthesia could potentially be offset if the change in coverage resulted in more employees receiving colonoscopies and cases of colon cancer are caught or prevented.

Please see the attached Report

Overview of the Medical Utilization and Evaluation Workgroup – Dr. Richard Smith, UAMS

Dr. Smith presented and discussed the workflow of the Medical Utilization and Evaluation Workgroup with the Quality of Care Subcommittee and the Board to include:

- **Evaluate topics of concern**
- **Provide literature reviews**
- **Discuss standards of care**
- **Develop options**

- **Estimate impacts**
- Please see the attached **Workflow Proposal**



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

The following report resulted from a meeting of the DUEC on April 4, 2016 with Dr. Hank Simmons presiding.

I. Recommended Changes to Current Coverage

A. Delivery Coordination Workgroup Report: *by Dr. Geri Bemberg, UAMS*

Drugs used in the treatment of cancers and non-cancer drugs were reviewed by the DCWG and a report made to the DUEC on April 4th. Recommendations from this report are outlined below.

Pulmonary Hypertension	Current Coverage	Proposed Coverage
Selexipag (Uptravi)	Excluded (New Drug)	T4-PA, OL 2/1
Tadalafil (Adcirca)	Excluded	T4-PA
<u>Multiple Myeloma</u> Carfilzomib (Kyprolis)	Covered, no utilizers	Exclude pharmacy & medical
<u>Basal Cell Carcinoma</u> Vismodegib (Erivedge)	Exclude	Exclude
<u>ALK +Non-Small Cell Lung Cancer</u> Crizotinib (Xalkori) Alectinib (Alecensa)	Exclude Exclude (New Drug)	T4-PA Exclude

The Committee recommends the proposed coverage for Section A.

B. 2nd Review of Drugs *by Drs. Geri Bemberg, Jill Johnson, UAMS*

1) Oral Mesalamine Products:

Brand	Strength/Formula	Cost/Month (UC Maint)	Current 4/4/16 Coverage	Proposed Coverage
Apriso	0.375mg ER Capsule 24 hour Therapy Pack	\$500.40	Excluded	Tier 4
Pentasa	250mg, 500mg Controlled Release Capsule	\$674.40/\$1348.80	Excluded	Tier 4
Delzicol	400mg	\$427.20	Tier 2	Tier 4
Asacol HD	800mg EC Tablet	\$776.70/\$1553.40	Excluded	Excluded
Lialda	1.2g EC Tablet	\$567.26	Excluded	Tier 3

The committee recommended the proposed modified coverage for section B, 1.

- 2) Rifaximin (Xifaxan) – Miscellaneous Antibiotic; FDA Labeled Indications: Traveler’s diarrhea, Irritable bowel syndrome with diarrhea, and Hepatic encephalopathy.
The committee recommended; PA all indications of Xifaxan, and move to T4. Currently, T3 with 59 utilizers in Q42015. All 59 were using 550mg. PA for IBS-D would include: 1) Dx of IBS-D 2) At least 18 years if age 3 3) Tried and failed 60 days (each) of: dietary modifications (FODMAP diet), loperamide, bile acid sequestrants, antispasmodics (hyoscyamine, dicyclomine), and tricyclic antidepressants. PA would be good for #126/365 days.
- a) “Modified grandfathering” – grandfather everyone using Xifaxan for 6 months.
 - b) “Indication-specific grandfathering” – grandfather those getting qty #42 for 90 days, and those getting qty #60 for 6 months – 1 year.
- 3) Pioglitazone (Actos) – Currently, there is a PA on pioglitazone. For type 2 diabetes.
The committee recommended remove the PA requirement due to; 1) The MC, DB trial that randomized 3876 patients who had had recent ischemic stroke or TIA to either pioglitazone or placebo. 2) Eligible pts did not have diabetes but did have insulin resistance on the basis of a score of more than 3 on the homeostasis model assessment of insulin resistance index.
- 4) Afatinib (Gilotrif) – Current coverage includes; Erlotinib is currently covered with a PA for EGFR mutations. Afatinib and gefitinib are currently excluded.
The committee recommended; 1) Add afatinib to coverage for the full labeled indication. 2) Continue exclusion of gefitinib.

II. NEW DRUGS

Johnson reported on new drugs. The review covered products released October 12, 2015 – January 4, 2016. The Committee’s recommendations follow:

A. Recommended Additions

1. Nonspecialty medications-proposed additions

2.Specialty medications-proposed additions					
BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY/AWP	DUEC VOTE
Upravi tabs	Selexipag tabs	\$17,400/60-1600mcg tabs	Treatment of pulmonary hypertension to delay disease progression and reduce risk of hospitalization.		Cover, PA, QL
Zepatier tab 50-100mg	Elbasvir-grazoprevir tab 50-100mg	\$780/tab	Chronic Hepatitis C	All other Hep C treatments T4PA	Cover, PA

B. Recommended Exclusions

1. Nonspecialty Medications-proposed exclusion

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY/AWP	EXCLUSION CODE
Enstilar Aerosol	Calcipotriene/betamethasone dipropionate foam 0.005%/0.064%	\$997.16/60g (foam)	Psoriasis	Tier1-betamethasone dipropionate cream 0.05% \$81/45gm. Calcipotriene cream 0.005%/\$840/120gm	Exclude, use each product separately
Dyanavel XR	Amphetamine extended release suspension 2.5mg/ml	\$1094.998/45 4ml (\$2,35991/ml)	ADHD	Extended release amphetamine products tiered for children, Reference prices to \$2.50/unit	Exclude code 13
Quillichew ER	Methylphenidate HCl Chew Tab Extended Release 20mg, 30mg, 40mg	\$10.80/tablet	ADHD	Extended release amphetamine products tiered for children. Reference priced to \$2.50/unit	Excluded, code 13

2. Specialty Medications-proposed exclusions

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY/AWP	EXCLUSION CODE
Viberzi Tabs	Eluxadine	\$1,152/60-100mg tabs. Dose=200mg/day	Treatment of irritable bowel syndrome wit diarrhea		Exclude code 13

The committee recommended the proposed coverage for Non-specialty exclusions, Specialty additions and exclusions.

III. Insulin Class Review for Rebate Contracting: *By Dr. Rachael McCaleb, UAMS*

Dr. McCaleb reported Insulin products are Food and Drug Administration (FDA) approved to improve glycemic control in patients with diabetes mellitus (DM) type 1 and 2. Available insulin products are summarized below.

Generic Name	Trade Name/Manufacturer	Vial	Prefilled Disposable Pen
Rapid-acting insulins			
Insulin lispro	HumaLOG/Lilly	Yes	Yes
Insulin aspart	NovoLOG/ Novo Nordisk Inc	Yes	Yes
Insulin glulisine	Apidra/Sanoi Avnetis US	Yes	Yes
Short-acting insulin			
Insulin regular	NovoLIN/ Novo Nordisk Inc HumuLIN/Lilly	Yes	No
Intermediate-acting insulin			
Insulin NPH (isophane suspension)	NovoLIN/ Novo Nordisk Inc HumuLIN/Lilly	Yes	Yes
Long-acting insulins			

Insulin glargine	Lantus/Sanoi Avnetis US Toujeo/Sanoi Avnetis US	Yes No	Yes Yes
Insulin detemir	Levemir/Novo Nordisk Inc	Yes	Yes
Insulin degludec	Tresiba/Novo Nordisk Inc	No	Yes
Combination Products			
Insulin degludec/insulin aspart	Ryzodeg 70/30 Novo Nordisk Inc	No	Yes
Insulin aspart protamine suspension/insulin aspart	NovoLOG Mix 70/30 Novo Nordisk Inc	Yes	Yes
Insulin lispro protamine/insulin lispro	HumaLOG Mix 75/25/Lilly HumaLOG Mix 50/50/Lilly	Yes	Yes
Insulin NPH suspension/insulin regular solution	NovoLIN 70/30 Novo Nordisk Inc HumuLIN 70/30/Lilly	Yes	Yes (HumuLIN only)

Dr. McCaleb recommended:

- Maintain Humulin or Novolin as preferred but move to T1 copay
 - o Coverage for vials and pens
- Include one rapid-acting and one long-acting insulin analogue as preferred as a T2 copay
 - o Coverage for vials and pens
 - o Remaining rapid-acting and one long-acting insulin analogues will be excluded from plan
 - o All current members on an excluded analogue will NOT be grandfathered and will be given a 90 day grace period following the implementation of the contract to switch to a preferred analogue
- Required price protection for the life of the contract

The committee recommended Dr. McCaleb’s proposed coverage for the Therapeutic Class Insulins.

***New Drug Code Key:**

1	Lacks meaningful clinical endpoint data; has shown efficacy for surrogate endpoints only.
2	Drug’s best support is from single arm trial data
3	No information in recognized information sources (PubMed or Drug Facts & Comparisons or Lexicomp)
4	Convenience Kit Policy - As new drugs are released to the market through Medispan, those drugs described as “kits will not be considered for inclusion in the plan and will therefore be excluded products unless the product is available solely as a kit. Kits typically contain, in addition to a pre-packaged quantity of the featured drug(s), items that may be associated with the administration of the drug (rubber gloves, sponges, etc.) and/or additional convenience items (lotion, skin cleanser, etc.). In most cases, the cost of the “kit” is greater than the individual items purchased separately.
5	Medical Food Policy - Medical foods will be excluded from the plan unless two sources of peer-reviewed, published medical literature supports the use in reducing a medically necessary clinical endpoint. A medical food is defined below: A medical food, as defined in section 5(b)(3) of the Orphan Drug Act (21 U.S.C. 360ee(b)(3)), is “a food which is formulated to be consumed or administered eternally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive

	nutritional requirements, based on recognized scientific principles, are established by medical evaluation.” FDA considers the statutory definition of medical foods to narrowly constrain the types of products that fit within this category of food. Medical foods are distinguished from the broader category of foods for special dietary use and from foods that make health claims by the requirement that medical foods be intended to meet distinctive nutritional requirements of a disease or condition, used under medical supervision, and intended for the specific dietary management of a disease or condition. Medical foods are not those simply recommended by a physician as part of an overall diet to manage the symptoms or reduce the risk of a disease or condition, and all foods fed to sick patients are not medical foods. Instead, medical foods are foods that are specially formulated and processed (as opposed to a naturally occurring foodstuff used in a natural state) for a patient who is seriously ill or who requires use of the product as a major component of a disease or condition’s specific dietary management.
6	Cough & Cold Policy - As new cough and cold products enter the market, they are often simply re-formulations or new combinations of existing products already in the marketplace. Many of these existing products are available in generic form and are relatively inexpensive. The new cough and cold products are branded products and are generally considerably more expensive than existing products. The policy of the ASE/PSE prescription drug program will be to default all new cough and cold products to “excluded” unless the DUEC determines the product offers a distinct advantage over existing products. If so determined, the product will be reviewed at the next regularly scheduled DUEC meeting.
7	Multivitamin Policy - As new vitamin products enter the market, they are often simply re-formulations or new combinations of vitamins/multivitamins in similar amounts already in the marketplace. Many of these existing products are available in generic form and are relatively inexpensive. The new vitamins are branded products and are generally considerably more expensive than existing products. The policy of the ASE/PSE prescription drug program will be to default all new vitamin/multivitamin products to “excluded” unless the DUEC determines the product offers a distinct advantage over existing products. If so determined, the product will be reviewed at the next regularly scheduled DUEC meeting.
8	Drug has limited medical benefit &/or lack of overall survival data or has overall survival data showing minimal benefit
9	Not medically necessary
10	Peer -reviewed, published cost effectiveness studies support the drug lacks value to the plan.
11	Oral Contraceptives Policy - OCs which are new to the market may be covered by the plan with a zero dollar, tier 1, 2, or 3 copay, or may be excluded. If a new-to-market OC provides an alternative product not similarly achieved by other OCs currently covered by the plan, the DUEC will consider it as a new drug. IF the drug does not offer a novel alternative or offers only the advantage of convenience, it may not be considered for inclusion in the plan.
12	Other
13	Insufficient clinical benefit OR alternative agent(s) available

IV. EBD REPORT: *by Dr. Geri Bemberg, UAMS*

Dr. Bemberg requested from the committee new drugs for possible rebates. Dr. Bemberg reported the plan is currently working with Hepatitis C drugs and insulins are now in the rebate category. Dr. Kirtley recommended inhalers for rebate.

Dr. Bemberg reported the new pharmacy vendor; MedImpact will begin July 1, 2016. Members will have minimum disruption and new cards will not be issued. The mail order members will be notified and assistance will be provided for the transfer process. There are less than 50 members affected by this change.

Currently, some members are using Briova Rx. Those members will have the option to switch to a new pharmacy. No more than a month supply for specialty drugs and mail order drugs will be issued. There are 600 members affected by this change.

Bennett recommended communicating with those Pharmacies that are in the plan's network regarding the new Pharmacy Benefit Manager.

Respectfully submitted,

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

DESI Drugs

Recommendation from DUEC: Exclude all DESI drugs with a value of “5” from formulary.

DESI Drugs			
Aero Otic HC	Cortane-B Otic	Guaifenesin DAC	Pramosone
Alcortin A	Cortic	Hydrocortisone Acetate	Pramosone E
Analpram E	Covaryx	Hydrocortisone Acetate/Pramoxine	Proctocort
Analpram-HC	Covaryx HS	Hydrocortisone/Iodoquinol	Prodrin
Analpram-HC Singles	Dermazene	Isometheptene/Caffeine/ Acetaminophen	Rectacort-HC
Anucort-HC	Donnatal	Isometheptene/APAP/ Dichloralphenazone	Revina
Anusol-HC	EEMT	Librax	Trimo-San
Chlordiazepoxide HCl/ Clidinium bromide	EEMT HS	Nodolor	Vasolex
Cortane-B	Esterified estrogens/ Methyltestosterone	Novacort	Vytone
Cortane-B Aqueous	GRX Hicort 25	Oto-End 10	Xenaderm

From Dr. Keisner’s February DUEC Handout:

Drug Efficacy Study Implementation (DESI):

Classifies all pre- 1962 drugs as effective, ineffective, or needing further study. Due to Kefauver-Harris Drug Control Act requiring all drugs to be efficacious in addition to being safe.

DESI RxClaim Classification:

2= Non DESI, 3= DESI under review, 4=LTE for some indications, 5=LTE for all indications, 6=LTE withdrawn from market (LTE=Less than effective)

EBD Coverage:

T1 no restrictions

Other Coverage policies:

-Excluded from Arkansas Medicaid

-“A DESI drug is one that the FDA has determined to be safe, but not effective. DESI drugs are not covered by any Medicare Part D plan” -CMS

EBD DESI claims 1/1/15 to 6/30/15:

Number of Claims: 3,335 (all with a value of 5)
 Total Plan Cost: \$346,470
 Total Drugs: 43
 Total Members: 1393

Top Drugs:

Anucort HC (hydrocortisone sup) - 543 Claims, \$88,428
 EEMT (esterified estrogens/methyl testosterone): 1276 claims \$98,880
 Covaryx/Covaryx HS (branded EEMT)- 252 claims \$17,237
 Librax (chlordiazepoxide/clidinium)- 532 claims \$33,641
 Donnatal- 32 claims \$10,331
 Midrin/Nodolor (Isometheptene/Dichloralphenazone/APAP)- 221 claims \$28,543

Rectal Steroids			
DESI Drug	Avg plan cost per Rx	Alternatives	Avg cost per Rx
Anucort HC suppository 25mg	\$186.87	proctozone cream 2.5%	\$33.43
Hydrocortisone 25mg sup (Anucort)	\$109.38	proctosol HC cream 2.5%	\$21.84
Hydrocortisone 30mg sup (Proctocort)	\$268.22	Procto-PAK cream 1%	\$27.18
		proctofoam	\$41.44
		Hydrocortisone ENE	\$76.88

Other Rectal Steroid related products: Hydrocortisone-pramoxine, Anusol HC, Pramosone, Rectacort-HC (Discontinued), GRx Hicort

Hemorrhoids:

“Topical steroids have not been well evaluated for effectiveness in treating thrombosed hemorrhoids. If used, some experts suggest applying cream rather than using suppositories” - *UpToDate*

Colitis:

“For people who do not respond to oral forms of the drugs, it may be necessary to administer corticosteroids through other routes. These include: Rectally as enemas (hydrocortisone, methylprednisone, Cortenema®), foams (hydrocortisone acetate, ProctoFoam-HC®, UCERIS®Rectal Foam), and suppositories.” - *Crohn’s and Colitis Foundation of America*

Estrogens			
DESI Drug	Avg plan cost per Rx	Alternatives	Avg cost per Rx
EEMT (brand & generic)	\$81.23	Menest (esterified estrogens)	\$30.36
Covaryx	\$80.22	premarin tab (conjugated estrogens)	\$88.89

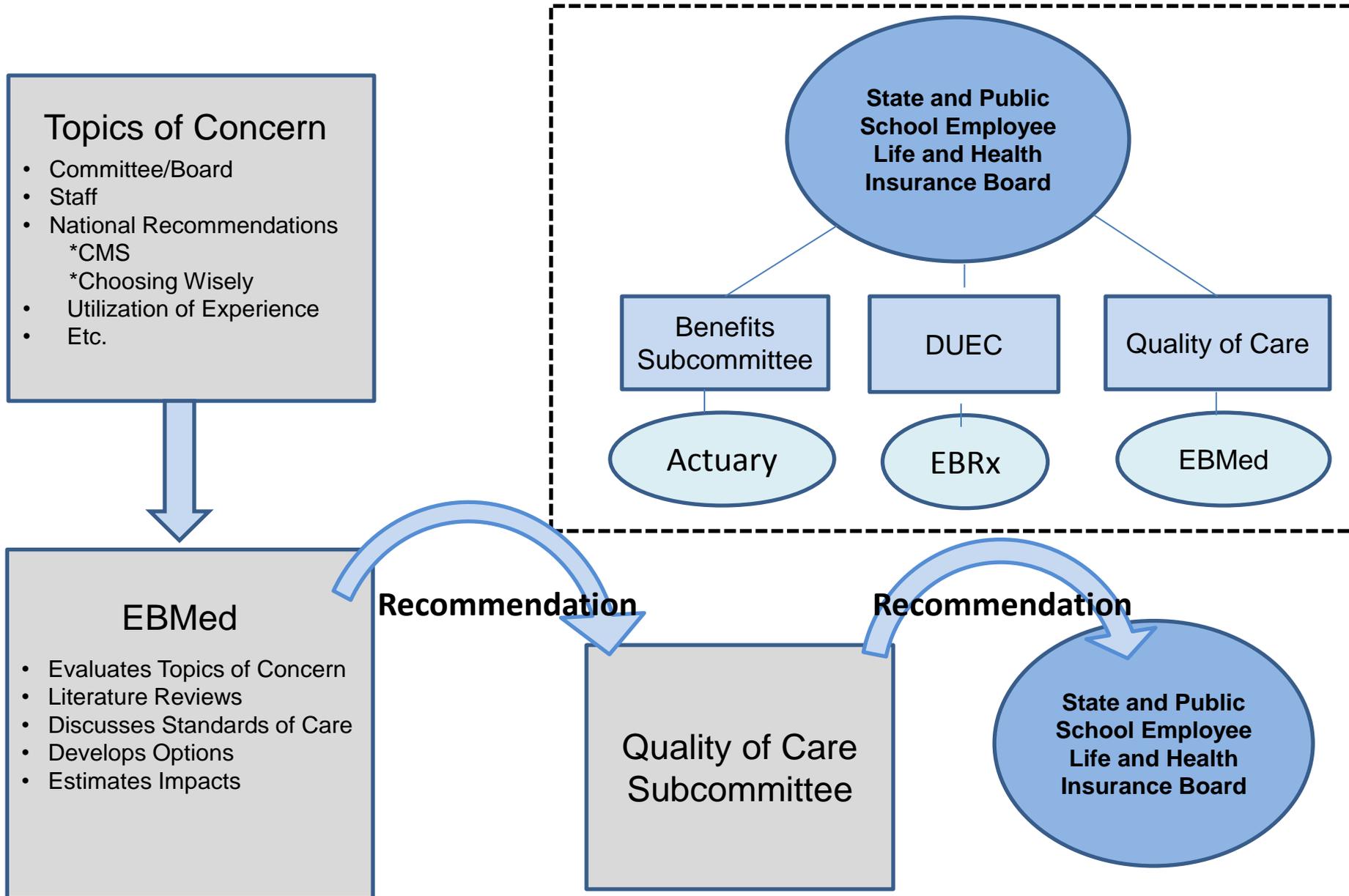
Other estrogen-related products included: Covaryx H.S.

“Clinical trials of exogenous testosterone replacement suggest benefits of testosterone therapy in some postmenopausal women. However, there are potential risks associated with androgen replacement. Until the beneficial effects of androgen replacement are better established, it cannot be routinely recommended to postmenopausal women” – UpToDate

Irritable Bowel Syndrome			
DESI Drug	Avg plan cost per Rx	Alternatives	Avg cost per Rx
Librax (chlordiazepoxide/clidinium)	\$66.68	dicylomine	\$0.31
Donnatal (phenobarbital/hyoscyamine/atropine/scopolamine)	\$338.96	hyoscyamine	\$35.19

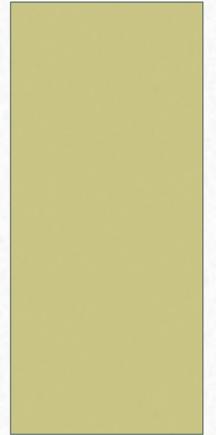
Other Drugs and Indications			
DESI Drug	Indication	Avg plan cost per Rx	Alternative
Nodolor (isometheptene/ dichloralphenazone/acetaminophen)	Migraine Headache	\$142	Sumatriptan (Imitrex), Naratriptan (Amerge), Rizatriptan (Maxalt), Zolmitriptan (Zomig)
Prodrin (acetaminophen/ caffeine/isometheptene)	Migraine Headache	\$0	
Cortane-B Otic, Aero-Otic, Cortic, & Oto-End 10 (hydrocortisone/ pramoxine/chloroxylonol)	Swimmer’s Ear (otitis externa)	\$3	Antibiotic ear drops
Dermazene, Alcortin A & Vytone (iodoquinol/hydrocortisone)	Dermatoses	\$28.69 Alcortin - \$4,959.46	Multiple creams
Guaifenesin DAC (Guaifenesin/ pseudoephedrine/codeine)	Cough/nasal Congestion	\$5.09	Cheratussin AC, multiple cough syrups
Xenaderm, Revina & Vasolex (discontinued) (trypsin/balsam peru/castor oil)	Dermatologic conditions	\$0	Multiple creams
Trimo-San (oxyquinolone) gel	Vaginal health	\$0	Multiple products

EBD Medical Utilization and Evaluation Workflow Proposal



EBMed

COLONOSCOPY SCREENING ANESTHESIA



QUESTION

Should the plan routinely cover anesthesia for screening colonoscopies? Anesthesia is currently not covered as a benefit and is routinely denied. It may be paid on appeal due to medical necessity. (283 paid/1,529 billed)

CONTEXT

1. The decision only involves screening colonoscopies.
 - In contrast to diagnostic and/or therapeutic colonoscopies.
 - For decades, conscious sedation has been used routinely with screening colonoscopies. Anesthesia is an alternative to conscious sedation.
2. Screening colonoscopies are recommended by the U.S. Preventative Services Task force every 10 years for those 50-75 years old.

CONTEXT

3. The Affordable Care Act requires most plans and all Marketplace plans to cover screening colonoscopies at no charge to the patient, even co-pays and deductibles.
4. It is in the patient's best interest and the plan's best financial interest for patients to receive routine screening colonoscopies because:
 - Patient morbidity is reduced.
 - The plan savings from avoiding colon cancer treatment presumably outweigh the cost of screening.

CONTEXT

5. Currently, medical practice appears to be incorporating anesthesia and many doctors and health facilities are asking patients if they want “anesthesia” with their screening colonoscopy. Our understanding is that patients often understandably say “yes” not knowing the difference between anesthesia and conscious sedation. Thus, resulting in a denied anesthesia claim and fee that is the patient’s responsibility.

EVIDENCED BASE FOR CONSCIOUS SEDATION VERSUS ANESTHESIA (PROPOFOL) FOR SCREENING COLONOSCOPIES

1. Recovery and discharge time shorter (better) for anesthesia.
2. Patient satisfaction slightly better with anesthesia.
3. Procedure duration is not different between anesthesia and sedation.
4. Generally, no difference in complications between anesthesia and sedation.
5. Amnesia and sedation are greater with anesthesia.

ANCILLARY/ ANECDOTAL INFORMATION

1. Physicians are being trained to use both conscious sedation and anesthesia.
2. Some physicians believe that they can obtain a more thorough exam with anesthesia.
3. Some members complain when billed for what they thought was a no cost service.
4. BC/BS covers anesthesia for screening colonoscopy for other lines of business.

ANCILLARY/ANECDOTAL INFORMATION

5. Medicare is changing to a higher reimbursement rate that it will pay regardless of whether anesthesia is used or not.
6. Efficiency of procedure with anesthesia has financial incentives for providers.

PLAN EXPERIENCE

10/1/2014 – 9/30/2015 Colonoscopy Data for ASE & PSE Service Volume for Screening Colonoscopies

	# of Members w/ GI Doctors - Paid	# of Members w/ Anesthesia
With Anesthesia	1,529	283 allowed-paid (1,246 not paid by plan)
W/O Anesthesia	1,562	0

Payment Amount \$ for Screening Colonoscopies

	A+B Total Amt. Pd.	(A) Total Amt. Pd. for Colonoscopy	(B) Total Amt. paid for Anesthesia	(C) Total Amt. of patient responsibility
1,529 with Anesthesia	\$1,614,443.	1,521,247.	93,195.	129,229.
1,562 w/o Anesthesia	1,453,352.	1,453,352.	0	126,560.
Total	3,067,795.	2,974,599.	93,195.	255,789.

Average Unit Cost (Amount paid)

Average Screening Colonoscopy cost with conscious sedation	\$962
Average cost of Anesthesia for screening colonoscopy when paid	\$329
Average total plan cost for screening colonoscopy with anesthesia	\$1,291

OPTIONS FOR FUTURE AND PROBABLE IMPACTS TO PLAN

1. No coverage change
 - a. Increase member education
 - b. Continued negative member reaction to unexpected out of pocket costs
 - c. Limited immediate increased costs to plan

OPTIONS FOR FUTURE AND PROBABLE IMPACTS TO PLAN

2. Cover anesthesia for screening colonoscopies with requirement of no added out of pocket costs to patient by physician or facility
 - a. Increase patient satisfaction and decrease recovery and discharge time
 - b. Eliminate negative member reaction
 - c. Initial additional plan costs will be $1,246 \times \$329 = \$410,000$ (\$2.77 per member, per year*) but would likely rise to $2,808 \times \$329 = \$924,000$ (\$6.25 per member, per year*) and probably increase to \$1.2M (\$8.12 per member, per year*) as number of screenings increase.

*Based on 147,829 members

OPTIONS FOR FUTURE AND PROBABLE IMPACTS TO PLAN

3. Increase reimbursement for screening colonoscopies with or without anesthesia at an intermediate rate (Medicare approach)
 - a. Increase patient satisfaction and decrease recovery and discharge time
 - b. Eliminate negative member reaction
 - c. Additional yearly costs of $\$200 \times 3091 = \$618,000 - \$800,000$ as number of screenings increase
4. Restrict network providers to those who primarily use conscious sedation not anesthesia.

WORKGROUP RECOMMENDATION

Cover anesthesia for screening colonoscopies with requirement of no added cost to patient by physician or facility. Cost: \$2.77 per member/per year to \$8.12 per member/per year.

Arkansas State Employees & Public School Employees Health Benefits Program



Preliminary 2017 Projections

April 19, 2016
Board Meeting

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

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- Board adopted MedImpact proposed rates for the large majority of pharmacies
 - AWP -15.65% for brand (-13.65% for certain rural pharmacies)
 - Dispensing fee of \$1.50
 - New MAC pricing
- Expected savings of \$16 million (2015)
 - \$8 million to members
 - \$8 million to plan
 - For projections, reduction in 2017 plan costs of approximately 8% for ASE and 4% for PSE
 - Savings could be higher if usual & customary prices remain below AWP – 15.65% for non-MAC generic drugs.



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	-1.2%	-0.1%
- 2014 to 2015	1.3%	-2.7%
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	-1.6%	-4.0%
AVERAGE	3.2%	3.3%

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

2014 to 2015 Trends are based on claims paid through February 29, 2016, 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.



- 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 reflect separately
 - New strategies implemented, including changes to PBM contract

Updated Projections for 12/31/2016



(In Millions \$)	As of	PSE		ASE	
		12/31/2015	Updated Projection 12/31/2016	12/31/2015	Updated Projection 12/31/2016
Net Assets before IBNR		\$ 132.1	\$ 136.3	\$ 93.9	\$ 89.6
IBNR Reserve		(29.4)	(29.4)	(26.5)	(26.5)
Reserve for Current and Future Premiums		(57.3)	(47.7)	(28.8)	(12.6)
Catastrophic Reserve		(10.9)	(10.5)	(10.4)	(10.7)
Net Assets Available		\$ 34.5	\$ 48.7	\$ 28.2	\$ 39.8

Preliminary 2017 Projections



- Based on actual March 2016 enrollment and calendar year 2015 claims paid through February 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 reflect potential impact from changes in pharmacy contracting
- Assumes no changes to State and minimum District contributions
 - For ASE, considering 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 as more complete experience emerges

Preliminary 2017 Rate Change: 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	\$259.5	\$93.7	\$82.0	(\$4.6)	\$88.5	\$88.5	\$0.0	0%	44,217
Non-Medicare Eligible Retirees	\$18.2	\$0.0	\$0.0	(\$0.8)	\$19.0	\$19.0	\$0.0	0%	3,697
Medicare Eligible Retirees	\$25.2	\$6.4	\$0.0	\$3.0	\$15.7	\$15.7	\$0.0	0%	11,086
Total	\$302.9	\$100.1	\$82.0	(\$2.4)	\$123.2	\$123.2	\$0.0	0%	59,000

2017 stable population, \$200,000 new reserve allocated; same State & District contributions, HSA contributions of \$25/\$50 for Actives in Classic or Basic

Actives	\$271.6	\$93.7	\$82.0	\$7.5	\$88.5	\$88.5	\$0.0	0%	44,217
Non-Medicare Eligible Retirees	\$18.2	\$0.0	\$0.0	(\$0.8)	\$19.0	\$19.0	\$0.0	0%	3,697
Medicare Eligible Retirees	\$25.2	\$6.4	\$0.0	\$3.0	\$15.7	\$15.7	\$0.0	0%	11,086
Total	\$315.0	\$100.1	\$82.0	\$9.7	\$123.2	\$123.2	\$0.0	0%	59,000

The above scenario assumes no change in enrollment as a result of the HSA contributions. Additional analysis would need to be performed to evaluate migration and additional enrollment impact.

Preliminary 2017 Rate Change: 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 \$8.2 million new allocated reserves

Actives	\$208.4	\$141.3	\$13.2	\$54.0	\$54.0	\$0.0 0%	26,202
Non-Medicare Eligible Retirees	\$19.2	\$7.5	\$0.7	\$11.0	\$11.0	\$0.0 0%	2,518
Medicare Eligible Retirees	\$60.7	\$30.2	\$2.8	\$27.8	\$27.8	\$0.0 0%	9,588
Total	\$288.4	\$178.9	\$16.7	\$92.8	\$92.8	\$0.0 0%	38,308

2017 above; \$5 million less state contribution: need \$18.2 new allocated reserves

Actives	\$208.4	\$136.3	\$18.2	\$54.0	\$54.0	\$0.0 0%	26,202
Non-Medicare Eligible Retirees	\$19.2	\$7.5	\$0.7	\$11.0	\$11.0	\$0.0 0%	2,518
Medicare Eligible Retirees	\$60.7	\$30.2	\$2.8	\$27.8	\$27.8	\$0.0 0%	9,588
Total	\$288.4	\$173.9	\$21.7	\$92.8	\$92.8	\$0.0 0%	38,308

2017 above; \$10 million less state contribution: need \$28.2 new allocated reserves

Actives	\$208.4	\$131.3	\$23.2	\$54.0	\$54.0	\$0.0 0%	26,202
Non-Medicare Eligible Retirees	\$19.2	\$7.5	\$0.7	\$11.0	\$11.0	\$0.0 0%	2,518
Medicare Eligible Retirees	\$60.7	\$30.2	\$2.8	\$27.8	\$27.8	\$0.0 0%	9,588
Total	\$288.4	\$168.9	\$26.7	\$92.8	\$92.8	\$0.0 0%	38,308



- Additional trend information
 - Dollars/PMPMs as well as percentages
- Multi-year projections considering scenarios with variations in
 - Trends
 - Enrollment
 - For PSE,
 - Plan Funding of HSA accounts
 - Benefit improvements

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



Yellow highlight means the coverage is changed

	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
In-Network:						
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				
Out-of-Network:						
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



- Projections are based on Calendar Year 2015 claim experience, paid through February 2016, adjusted for demographic, benefits, and network changes. Additional details about assumptions and methods will be provided in follow-up documentation.
- 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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