



AGENDA

State and Public School Life and Health Insurance Board

September 20, 2016

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. Call to OrderCarla Haugen, Chairman*
- II. Approval of August 16, 2016 MinutesCarla Haugen, Chairman*
- III. ASE-PSE Financials August, 2016 Marla Wallace, EBD Fiscal Officer*
- IV. Benefits Sub-Committee Report ... Shelby McCook, Board & Benefits Comm. Mbr.*
- V. EBD Wellness/AR Works PCP Visit Req. Dr. Joseph Thompson, Director ACHI*
- VI. DUEC Discussion of Nasal Steroids Dr. Geri Bemberg, UAMS*
- VII. Cost Effectiveness Dr. Bradley C. Martin, Pharm D.*
- VIII. Director's Report..... Chris Howlett, EBD Executive Director*

Upcoming Meetings

October 18, 2016; November 15, 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 September 20, 2016

The 163rd meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on September 20, 2016, at 1:00 p.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, AR 72201.

MEMBERS PRESENT

Carla Haugen - Chairman
Katrina Burnett
Shelby McCook
Lori Freno-Engman
Dr. Andrew Kumpuris
Dan Honey – Vice-Chairman
Dr. Joseph Thompson
Angela Avery - Teleconference
Dr. Tony Thurman

MEMBERS ABSENT

Robert Boyd
Janis Harrison
Dr. John Kirtley
Renee Mallory

Lori Eden, EBD Deputy Director, Employee Benefits Division

OTHERS PRESENT:

Geri Bemberg, Dwight Davis, Brad Martin, UAMS; Ethel Whittaker, Matt Turner, Marla Wallace, Cecilia Walker, Lori Eden, Janna Keathley, Terri Freeman, Sherry Bryant, EBD; Kristi Jackson, Jennifer Vaughn, ComPsych; Pam Lawrence, AHH; Sylvia Landers, Minnesota Life; Drew Crawford, Sebco; Marc Watts, ASEA; Ronda Walthall, Wayne Whitley, AR Highway & Transportation Dept; Jessica Akins, Takisha Sanders, Health Advantage; Martha Hill, Mitchell Williams; Karyn Langley, Qual Choice; Mark Adkison, Stephen Carroll, Allcare; Andy Davis, Arkansas Democrat-Gazette; Allison Drennon; Insurance Advantage; Liz Tullos, WageWorks; Steve Althoff, Greg Jones, MTI; Sam Smothers, Astra Zeneca; Scott McRae, APSRC; David Kissia, AEA; Sean Seago, Merck; Martha Carlson, ABCBS; Elizabeth Whittington, Mike Motley, ACHI; Robyn Keene, AAEA; Randy Loggings, ACHI

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 August 16, 2016, minutes.

McCook made the motion to adopt the minutes. Freno-Engman seconded; all were in favor.

Minutes approved.

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

Wallace reported financials for August 2016. For August PSE, four (4) weeks of medical and pharmacy claims were paid. The FICA savings for the month is \$468,971. There was a net gain of \$2.09 million for the month, and \$25.2 million year-to-date. Net assets available are \$56.3 million.

For ASE for the month of August, four (4) weeks of medical and pharmacy claims were paid. The net gain was \$2.09 million. The year-to-date net gain is \$17.06 million. Net assets available are \$17.4 million.

III. Benefits Sub-Committee Meeting: *by Shelby McCook, Benefits Committee Member*

Topics Discussed:

- August Financials
- EBD Wellness/Arkansas Works PCP Requirements

IV. EBD Wellness/Arkansas Works PCP Requirements: *by Dr. Joseph Thompson, Director, ACHI*

Language from the Arkansas Works Legislation on Wellness Visit Requirements is to promote health, wellness, and healthcare education about appropriate healthcare-seeking behaviors. In the legislation, 23-61-1005, as it was passed there are requirements for increased personal responsibility for individuals in the program to take steps to improve their health.

The legislation requires those above the federal poverty level have premiums to pay, and all persons will need to have a wellness visit with their primary care provider to receive additional benefits beyond the standard essential health benefit.

Dr. Thompson reported the Board has discussed over the past three (3) years, developing financial incentives to have individuals take more responsibility and seek preventive and wellness care to reduce their future health risk and the cost of the plan.

In the navigation of the Legislation process for continuation of the Medicaid expansion converting from the health-care independence program to the Arkansas Works Program; the legislation would possibly provide lower-income Arkansans with an incentive for themselves to have a wellness visit and preventive care. As a result, there is the potential to receive additional benefits. The legislation discussed the possibility of dental coverage as an added benefit.

Dr. Thompson reported a group of health-care professionals recently met to review the best possible strategies for the wellness programs. There were several options discussed.

The Board is in review for the 2018 plan year to decide if the premium differential would be continued or not, and what would be necessary to get a bonus incentive for taking the responsibility to improve your health.

To provide the best possible solution for the member's the following strategies were discussed:

- In addition to the on-line health risk appraisal, any contact with a clinical provider would serve as a wellness visit. The member would receive a premium discount. (EBD)
- Restrict the visit to only a primary care provider.
- Contact with the Attributing Primary Care Provider, which is selected by the Third Party Administrator.
- Require the member to provide a signed document from the physician that a wellness assessment was performed. This scenario could provide the most accurate result. However, administratively the most difficult to administer.
- There are a set of codes under the Affordable Care Act where co-pays are not assessed for a wellness visit.
- Biometric Screening (UALR)
- Establish new claims codes (Medicare)
- Create a new code for wellness only (South Carolina)
- Financial Incentives for additional benefits (Medicaid)

McCook has concerns regarding developing a new contract with a third-party administrator to manage the wellness plan.

Dr. Thurman reported the plan is not incentivizing for the wellness exam and members are penalized for not participating. Dr. Thurman also has concerns that members are waiting several days for responses to inquiries.

ARBenefits Plan Goals for Wellness Program/Visit Requirement

- Purpose:
 - "Created to reduce ever-increasing claims costs and encourage participants of the ARBenefits Plan to actively engage in their health and well-being."
- Background:
 - Wellness program was implemented in 2014
 - Members eligible for monthly premium incentive with completion of online health risk assessment and wellness visit
 - In 2015, only member was required to complete wellness requirements; As of 2016, covered spouses also must complete requirements
 - \$75 monthly premium incentive was in place for 2015 and 2016 plan years; Board determines amount of wellness discount annually

V. **DUEC UPDATES:** *by Dr. Geri Bemberg, UAMS*

HIV Medications:

Dr. Bemberg reported previously two HIV medications Edurant and Complera, were not discussed at the last Board meeting. Dr. Bemberg recommended to continue coverage but remove the PA requirement. Dr. Kumpuris motioned to approve. Freno-Engman seconded; after discussion, all were in favor.

Motion approved.

Nasal Steroids:

Dr. Bemberg reported there are currently three nasal steroids available over the counter, with only one available for purchase on this plan. The previous proposal presented to DUEC recommended excluding all nasal steroids and azelastine from the formulary, resulting in a savings of \$80,000/quarter or \$320,000 per year. However, after conversations concerning azelastine, the recommendation was amended to continue covering azelastine products at Tier 1, resulting in a cost savings of \$40,000/quarter. This was not passed by DUEC.

Based on current information, the recommendation is being amended again. Our new proposal is to continue coverage of this class and revisit in 6 months. Concerns include a large amount of member disruption with little savings, as well as the potential to shift members to a higher cost medication. The committee will reevaluate the class of medications in 6 months.

VI. **Cost-effectiveness of Healthcare Interventions:** *by Dr. Bradley C. Martin, Pharm D.*

DOES COST EFFECTIVENESS REALLY MATTER?

- | |
|--|
| - Guideline Developers Considering Cost Effectiveness |
|--|

- ACC/AHA Task Force on Practice Guidelines
- AMCP Dossier
- Includes Cost Effectiveness Evidence
- Surveys indicate 40-75% of plans use or plan to use cost-effectiveness in aiding decisions (Garber 2004, Bryan, 2009)
- National Institute for Clinical Effectiveness (NICE) in UK
 - They do not pay for drugs that cost more than £20,000-£30,000
- Canada and many other European countries consider cost effectiveness
- Medicare and PCORI are prohibited from using cost/QALY

USING COST EFFECTIVENESS DATA

Option 1. Establish a willingness to pay threshold or thresholds, which, if exceed would warrant lack of coverage of a medical intervention

Option 2. Allow reported and evaluated cost-effectiveness data to be presented, alongside clinical data, for coverage determination.

- Weigh ICER information more for high budgetary impact medications

Option 3. Ignore cost-effectiveness considerations in decision-making

WHAT IS A GOOD VALUE?

- Technologies that DOMINATE others are CLEAR WINNERS
- Always choose LOWER COST and HIGHER EFFECT Technologies

- Most often a NEW Technology is MORE EXPENSIVE and MORE efficient

- Interpret the Incremental Cost Effectiveness Ratio (ICER)
 - a. Very High Value
 - b. \$50k – 100 k/QALY
 - c. High Value
 - d. \$50k – 150k/QALY
 - e. Low Value
 - f. >\$150,000/QALY

- Who suggest three times the GDP per capita (~\$150,000 per QALY in U.S.)

McCook has concerns that opiates could be over prescribed and contributing to new drug addictions. McCook questions should the Board have concerns and is there an action that needs to be applied? Dr. Thompson will provide legislative information relating to the issue at the next Quality of Care meeting.

Dr. Bemberg reported agencies are reviewing how you can limit the number of pills prescribed. Dr. Bemberg will provide additional information at the next Quality of Care meeting.

VII. DIRECTOR'S REPORT: *by Lori Eden, EBD Deputy Director*

Medical Management is in review at the legislative level. Active Health is the new vendor.

Open enrollment for State Employees concluded September 15, 2016. The division processed 2,280 enrollment forms, 4,600 phone calls, and assisted 88 walk-ins.

Public Schools open enrollment will kick-off October 1st and go through October 15th.

The Director continues to review options for the 2018 plan design and will provide an update at a future meeting.

Dr. Thurman questioned how many employees were available to process 4,600 calls? Eden reported there are twelve (12) call-center employees. In addition, employees of the accounting department assisted members who paid premiums.

Dr. Thompson motioned to adjourn. Haugen seconded; all were in favor.

Meeting adjourn.

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

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	985	21		1006	1698	37		1735
CLASSIC	1806	68		1874	3082	99		3181
PREMIUM	23809	2218		26027	41578	2878		44456
PRIMARY		216	8880	9096		443	11673	12116
TOTAL	26600	2523	8880	38003	46358	3457	11673	61488

REVENUES & EXPENDITURES

	Current Month	Year to Date (8 Months)
Funding		
State Contribution	\$ 14,693,616	\$ 115,542,980
Employee Contribution	\$ 7,911,884	\$ 63,849,719
Other	\$ 584,466	\$ 9,724,740
Allocation for Actives - Plan Year 2015	\$ 971,667	\$ 7,773,333
Total Funding	\$ 24,161,632	\$ 196,890,772
Expenses		
Medical Expenses		
Claims Expense	\$ 12,640,165	\$ 103,138,894
Claims IBNR	\$ -	\$ -
Medical Administration Fees	\$ 1,075,952	\$ 8,609,392
Refunds	\$ -	\$ (89,076)
Employee Assistance Program (EAP)	\$ 55,580	\$ 449,753
Life Insurance	\$ 54,233	\$ 438,646
Pharmacy Expenses		
RX Claims	\$ 5,881,230	\$ 47,404,015
RX IBNR	\$ -	\$ -
RX Administration	\$ 171,673	\$ 1,654,671
Plan Administration	\$ 341,330	\$ 4,135,506
Total Expenses	\$ 20,220,163	\$ 165,741,801
Net Income/(Loss)	\$ 3,941,469	\$ 31,148,971

BALANCE SHEET

Assets	
Bank Account	\$ 17,130,179
State Treasury	\$ 81,282,008
Due from Cafeteria Plan	\$ 5,195,886
Due from PSE	\$ 99
Receivable from Provider	\$ -
Accounts Receivable	\$ (1,001,297)
Total Assets	\$ 102,606,875
Liabilities	
Accounts Payable	\$ 7,040
Deferred Revenues	\$ -
Due to Cafeteria	\$ 50
Due to PSE	\$ -
Due to Federal Government (\$44 fee)	\$ 1,119,712
Health IBNR	\$ 24,700,000
RX IBNR	\$ 1,800,000
Total Liabilities	\$ 27,626,802
Net Assets	\$ 74,980,072
Less Reserves Allocated	
Premiums for Plan Year 1/1/15 - 12/31/15 (\$6,260,000 + \$5,400,000)	\$ (3,886,667)
Premiums for Plan Year 1/1/16 - 12/31/16 (\$3,600,000 + \$12,600,000)	\$ (16,200,000)
Premiums for Plan Year 1/1/17 - 12/31/17 (\$7,560,000))	\$ (7,560,000)
Premiums for Plan Year 1/1/18 - 12/31/18 (\$5,040,000)	\$ (5,040,000)
Catastrophic Reserve (2015 \$10,400,000)	\$ (10,400,000)
Net Assets Available	\$ 31,893,406

Fifth Week of Claims \$0

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

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	1302	39		1341		2147	54		2201
CLASSIC	1779	69		1848		2989	92		3081
PREMIUM	22740	2174		24914		39638	2799		42437
PRIMARY		213	9315	9528			435	12174	12609
TOTAL	25821	2495	9315	37631		44774	3380	12174	60328

REVENUES & EXPENDITURES

Funding	Current Month	Year to Date (8 Months)
1 State Contribution	\$ 14,702,184	\$ 117,561,304
2 Employee Contribution	\$ 7,880,195	\$ 63,639,252
3 Other	\$ 142,367	\$ 9,194,272
4 Allocation of Reserves	\$ 1,350,000	\$ 10,800,000
Total Funding	\$ 24,074,746	\$ 201,194,828
Expenses		
5 Medical Expenses		
Claims Expense	\$ 14,757,836	\$ 115,496,288
6 Claims IBNR	\$ -	\$ 3,300,000
7 Medical Administration Fees	\$ 1,021,588	\$ 8,694,702
8 Refunds	\$ -	\$ 265
9 Employee Assistance Program (EAP)	\$ 54,313	\$ 441,157
Life Insurance	\$ 78,180	\$ 634,178
Pharmacy Expenses		
11 RX Claims	\$ 5,496,320	\$ 50,123,760
12 RX IBNR	\$ -	\$ (100,000)
13 RX Administration	\$ 184,306	\$ 1,510,593
14 Plan Administration	\$ 391,453	\$ 4,030,751
Total Expenses	\$ 21,983,997	\$ 184,131,693
15 Net Income/(Loss)	\$ 2,090,750	\$ 17,063,135

BALANCE SHEET

Assets		
16 Bank Account		\$ 8,358,214
17 State Treasury		\$ 91,037,313
18 Due from Cafeteria Plan		\$ 5,018,599
19 Due from PSE		\$ 177,363
20 Receivable from Provider		\$ -
21 Accounts Receivable		\$ (563,221)
Total Assets		\$ 104,028,267
Liabilities		
22 Accounts Payable		\$ 1,253
23 Deferred Revenues		\$ -
24 Due to Cafeteria		\$ 28
25 Due to PSE		\$ 84
26 Due to Federal Government (\$27 fee)		\$ 664,295
27 Health IBNR		\$ 28,000,000
28 RX IBNR		\$ 1,700,000
Total Liabilities		\$ 30,365,660
Net Assets		\$ 73,662,608
Less Reserves Allocated		
29 Premiums for Plan Year 1/1/16 - 12/31/16 (\$3,600,000 + \$12,600,000)		\$ (5,400,000)
30 Premiums for Plan Year 1/1/17 - 12/31/17 (\$7,560,000 + \$13,770,000)		\$ (21,330,000)
31 Premiums for Plan Year 1/1/18 - 12/31/18 (\$5,040,000 + \$8,262,000)		\$ (13,302,000)
Premiums for Plan Year 1/1/19 - 12/31/19 (\$5,508,000)		\$ (5,508,000)
32 Catastrophic Reserve (2016 \$10,700,000)		\$ (10,700,000)
33 Net Assets Available		\$ 17,422,608

34 Fifth Week of Claims \$0

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

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	2571	233		2804	3780	291		4071
CLASSIC	20994	1965		22959	38626	2401		41027
PREMIUM	19680	1245		20925	25323	1337		26660
PRIMARY		102	10369	10471		206	11324	11530
TOTAL	43245	3545	10369	57159	67729	4235	11324	83288

REVENUES & EXPENDITURES

	Current Month	Year to Date (8 Months)
Funding		
Per Participating Employee Funding (PPE Funding)	\$ 7,841,011	\$ 65,231,790
Employee Contribution	\$ 8,984,535	\$ 72,883,745
Department of Education \$35,000,000 & \$15,000,000	\$ 3,181,818	\$ 49,816,680
Other	\$ 507,421	\$ 4,833,043
Allocation for Actives	\$ 1,666,667	\$ 13,333,333
Total Funding	<u>\$ 22,181,451</u>	<u>\$ 206,098,591</u>
Expenses		
Medical Expenses		
Claims Expense	\$ 15,552,738	\$ 111,358,983
Claims IBNR	\$ -	\$ -
Medical Administration Fees	\$ 1,496,529	\$ 12,453,683
Refunds	\$ -	\$ (66,503)
Employee Assistance Program (EAP)	\$ 73,388	\$ 612,835
Pharmacy Expenses		
RX Claims	\$ 3,819,840	\$ 30,320,007
RX IBNR	\$ -	\$ -
RX Administration	\$ 230,370	\$ 2,273,777
Plan Administration	\$ 339,664	\$ 5,510,519
Total Expenses	<u>\$ 21,512,530</u>	<u>\$ 162,463,301</u>
Net Income/(Loss)	\$ 668,921	\$ 43,635,290

BALANCE SHEET

Assets	
Bank Account	\$ 10,286,315
State Treasury	\$ 88,679,540
Receivable from Provider	\$ -
Accounts Receivable	\$ 8,344,102
Due from ASE	\$ -
Total Assets	<u>\$ 107,309,958</u>
Liabilities	
Accounts Payable	\$ 983
Due to ASE	\$ 99
Deferred Revenues	\$ 577
Due to Federal Government (\$44 fee)	\$ 1,613,216
Health IBNR	\$ 28,000,000
RX IBNR	\$ 1,400,000
Total Liabilities	<u>\$ 31,014,874</u>
Net Assets	\$ 76,295,083
Less Reserves Allocated	
Premiums for Plan Year 1/1/15 - 12/31/15 (\$20,000,000 rec'd from Dept. of Education)	\$ (6,666,667)
Premiums for Plan Year 1/1/16 - 12/31/16 (\$9,600,000)	\$ (9,600,000)
Premiums for Plan Year 1/1/17 - 12/31/17 (\$5,760,000)	\$ (5,760,000)
Premiums for Plan Year 1/1/18 - 12/31/18 (\$3,840,000)	\$ (3,840,000)
Premium Assistance (FICA Savings)	\$ (3,747,244)
Catastrophic Reserve (2015 \$10,900,000)	\$ (10,900,000)
Net Assets Available	<u>\$ 35,781,172</u>

Fifth Week of Claims \$0

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

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	3392	337		3729		5066	416		5482
CLASSIC	21931	2139		24070		40845	2594		43439
PREMIUM	18644	1008		19652		24382	1075		25457
PRIMARY		83	11163	11246			166	12164	12330
TOTAL	43967	3567	11163	58697		70293	4251	12164	86708

REVENUES & EXPENDITURES

	Current Month	Year to Date (8 Months)
Funding		
1 Per Participating Employee Funding (PPE Funding)	\$ 7,815,057	\$ 64,782,914
2 Employee Contribution	\$ 9,222,257	\$ 74,262,507
3 Department of Education \$35,000,000 & \$15,000,000 & Other Funding	\$ 3,181,818	\$ 33,522,727
4 Other	\$ 592,338	\$ 5,091,514
5 Allocation of Reserves	\$ 3,975,000	\$ 31,800,000
Total Funding	<u>\$ 24,786,470</u>	<u>\$ 209,459,663</u>
Expenses		
Medical Expenses		
6 Claims Expense	\$ 16,689,049	\$ 128,873,475
7 Claims IBNR	\$ -	\$ 2,000,000
8 Medical Administration Fees	\$ 1,585,694	\$ 13,111,411
9 Refunds	\$ -	\$ -
10 Employee Assistance Program (EAP)	\$ 73,828	\$ 613,970
Pharmacy Expenses		
11 RX Claims	\$ 3,700,481	\$ 32,525,296
12 RX IBNR	\$ -	\$ (300,000)
13 RX Administration	\$ 257,927	\$ 2,179,252
14 Plan Administration	\$ 390,828	\$ 5,228,958
Total Expenses	<u>\$ 22,697,807</u>	<u>\$ 184,232,362</u>
16 Net Income/(Loss)	\$ 2,088,664	\$ 25,227,301

BALANCE SHEET

Assets	
17 Bank Account	\$ 15,392,607
18 State Treasury	\$ 109,089,802
19 Receivable from Provider	\$ -
20 Accounts Receivable	\$ 3,942,815
21 Due from ASE	\$ 84
Total Assets	<u>\$ 128,425,308</u>
Liabilities	
22 Accounts Payable	\$ 2,889
23 Due to ASE	\$ 177,363
24 Deferred Revenues	\$ 303
25 Due to Federal Government (\$27 fee)	\$ 1,010,826
26 Health IBNR	\$ 30,000,000
27 RX IBNR	\$ 1,100,000
Total Liabilities	<u>\$ 32,291,381</u>
28 Net Assets	\$ 96,133,927
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)	\$ (15,900,000)
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)	\$ (3,881,786)
32 Catastrophic Reserve (2016 \$10,500,000)	\$ (10,500,000)
34 Net Assets Available	<u>\$ 56,252,140</u>
35 Fifth Week of Claims	\$ 0

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Arkansas Works Wellness Visit Requirements

Language from Arkansas Works Legislation

<http://www.arkleg.state.ar.us/assembly/2015/2016S2/Acts/Act1.pdf>

23-61-1005. Requirements for eligible individuals.

(a)(1) To promote health, wellness, and healthcare education about appropriate healthcare-seeking behaviors, an eligible individual shall receive a wellness visit from a primary care provider within:

(A) The first year of enrollment in health insurance coverage for an eligible individual who is not a program participant and is enrolled in employer health insurance coverage; and

(B) The first year of, and thereafter annually:

(i) Enrollment in an individual qualified health insurance plan or employer health insurance coverage for a program participant; or

(ii) Notice of eligibility determination for an eligible individual who is not a program participant and is not enrolled in 23 employer health insurance coverage.

(2) Failure to meet the requirement in subdivision (a)(1) of this section shall result in the loss of incentive benefits for a period of up to one (1) year, as incentive benefits are defined by the Department of 27 Human Services in consultation with the State Insurance Department.

Language from Arkansas 1115 Waiver Extension Application

<https://www.medicaid.state.ar.us/Download/general/comment/ARWorksAppFinal.pdf>

Incentivizing Timely Premium Payment and Completion of Healthy Behaviors

Arkansas seeks to encourage personal responsibility and further the objectives of the State's Healthy, Active Arkansas initiative. Under Arkansas Works, Arkansas will create a new incentive benefit (e.g., dental services) for the new adult population. This benefit will only be available to enrollees who make timely premium payments (if required) and achieve healthy behavior standards.

- **Arkansas Works enrollees with incomes above 100% FPL.** Arkansas Works enrollees with incomes above 100% FPL who make three consecutive months of timely premium payments (i.e., within a 90-day grace period) will be eligible to receive an incentive benefit. To retain this incentive benefit, these enrollees must pay all premiums timely and must visit a primary care provider (PCP) during each calendar year (assuming at least six months of enrollment in Arkansas Works during that calendar year). For individuals covered through QHP premium assistance, carriers will monitor whether enrollees are paying premiums timely and whether individuals have visited a PCP. In the event that an individual enrolled in QHP coverage has failed to pay premiums timely or failed to see a PCP, carriers will inform Arkansas Medicaid. For individuals covered through ESI premium assistance, premiums will be paid through a paycheck

EBD Wellness Program Background

ARBenefits Plan Goals for Wellness Program/Visit Requirement

- Purpose:
 - “Created in an effort to reduce ever-increasing claims costs and encourage participants of the ARBenefits Plan to actively engage in their own health and well-being.” (From EBD Website)
- Background:
 - Wellness program was implemented in 2014
 - Members eligible for monthly premium incentive with completion of online health risk assessment and wellness visit
 - In 2015, only member was required to complete wellness requirements; As of 2016, covered spouses also must complete requirements
 - \$75 dollar monthly premium incentive was in place for 2015 and 2016 plan years; Board determines amount of wellness discount annually

ARBenefitsWell Program Components (EBD)

Wellness Visit Requirements	Eligible Screening Providers	Timeframe for Completion	Member Incentive	If Requirements Not Completed	Additional Benefits
<p>-An visit with PCP or specialist and completion of online health assessment); Must be conducted in office setting</p> <p>-If an employee and covered spouse had an office visit between November 1, 2015—October 31, 2016 this counts as their wellness visit for 2017</p>	<p>-PCPs can include specialists, APNs, PA's, and other providers if they are in-network for the plan</p>	<p>-Each wellness plan year is November 1 through October 31 for Jan. 1 effective date</p> <p>-Enrollment = Within 60 days hire or during open enrollment begins in September</p> <p>- New hires (those employed after July 1, 2016) automatically receive premium discount for 2017</p> <p>-Rate setting takes place by July of each year (for next calendar year)</p>	<p>-Monthly premium incentive (\$75)</p>	<p>-No monthly premium incentive (both wellness visit and health assessment criteria must be met)</p>	<p>-Health management program opportunities (American Health = Case Management Vendor, ComPsych = EAP/Wellness Coaching Vendor)</p> <p>-Referrals to these programs determined based on claims data and</p>



Home

Preventative Wellness Services

It is the intent of the ARBenefitsWell program to encourage members to be actively engaged with their health care and specifically preventive services. The preventive services recommended by the United States Preventive Services Task Force are specific to age, gender, and certain risk factors such as tobacco use and sexual activity. Appropriate recommended preventive services are covered by ARBenefits at no cost to members (no deductible, co-pay, or co-insurance). Please use the widget below to find the services recommended to you and bring the list of "A" and "B" recommendations to your primary care physician. We also suggest bringing a copy of the results page from your Health Assessment provided by GuidanceResources®, and a list of medications currently prescribed to you.

AHRQ ePSS

Find screening, counseling, and preventive medication services specific to a patient's risk factors.

Age: Years

Sex: Female Male

Pregnant:

Tobacco User: Yes No

Sexually Active: Yes No

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DFA

ARBenefits is provided by the Employee Benefit Division of the Department of Finance & Administration

Find us on...



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Private Option Interim Report Graph

Figure 9. Proportion of Medicaid and QHP Enrollees with a First Outpatient Care Visit, by Day

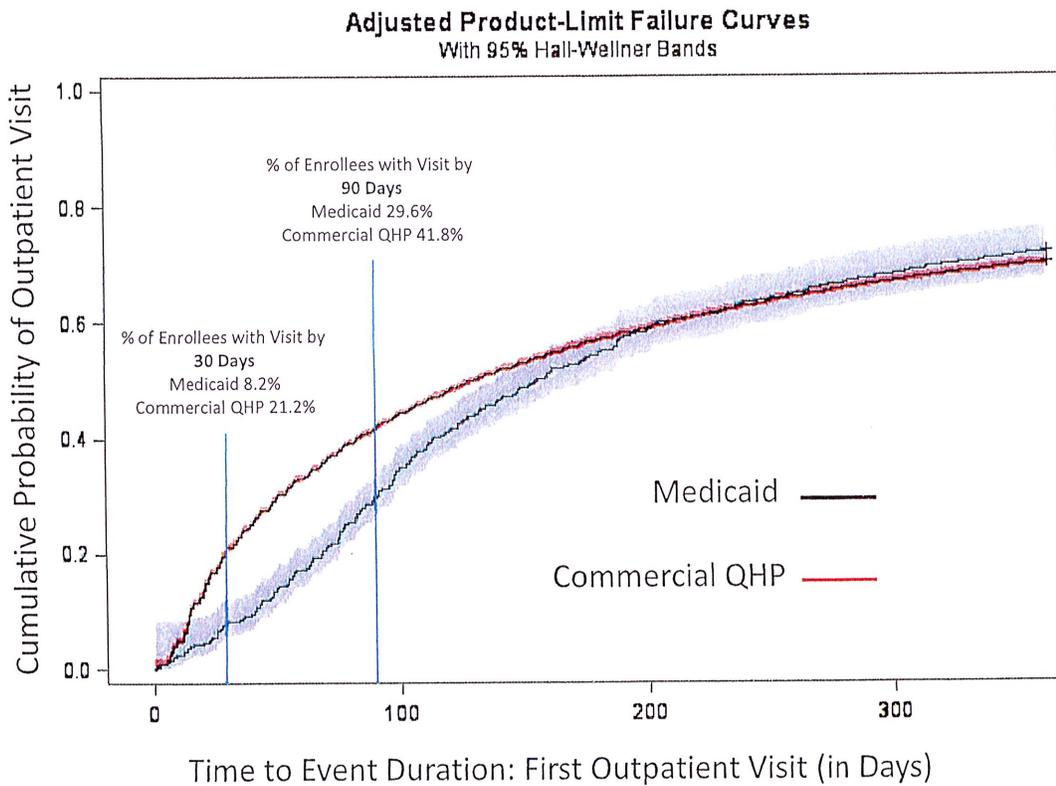


Table 4 compares utilization of ER measures for Medicaid and QHP enrollees in both the General Population and the Higher Needs population. Emergent and non-emergent ER visits were compiled using a commonly used New York University (NYU) algorithm.^{31,32} Unassigned ER visits include visits that the algorithm did not assign as emergent or non-emergent (including ER visits for psychiatric, alcohol and substance abuse, etc.).

On three of the four ER measures, a lower proportion of visits were made by QHP enrollees in the General Population and Higher Needs population compared to Medicaid enrollees. These include total ER visits (13.2 percent lower in the General Population and 50.8 percent lower in the Higher Needs population), non-emergent emergency room visits (58.1 percent lower in the General Population and 63.6 percent lower in the Higher Needs population), and unassigned ER visits (9.4 percent lower in the General Population and 67.0 percent lower in the Higher Needs population). For emergent ER visits, QHP enrollees had a higher proportion of use than Medicaid enrollees (122.1 percent higher in the General Population and 51.9 percent higher in the Higher Needs population).

PCMH Attribution Methodology

AR BCBS Patient Panel Attribution Methodology

From the PCMH Provider Manual 2016:

http://www.arkansasbluecross.com/doclib/forms/providers/abcbs%20pcmh%20provider%20manual%202016%20v3_8.pdf

2c. Attribution of Patients (Patient Panel) Fully insured members will be assigned to a physician based on an attribution methodology that will include but not be limited to factors such as claims containing specific evaluation and management CPT codes (99201-99499), assignment through recent dates of service, the total allowed amount of the paid claims and a member PCP selection process.

If a member cannot be assigned based on paid claims or the member declines to select a PCP that member may be assigned to a participating clinic based on geographic proximity to the participating clinic. Members assigned to participating clinics but who have not established care at that clinic (no paid claims for E&M codes 99201-99499) will not be included in the patient panel of attributed members until the participating clinic is paid for an eligible E&M service code (99201 – 99499). For those members, care coordination payments will not begin until the member has established care and the participating clinic has been paid for an eligible E&M service code (99201-99499).

Self-insured employers will independently choose to participate or not participate in the PCMH program. They will also choose the Care Coordination Payment amount for their members.

CMS Medicare FFS Patient Attribution Methodology

From CPC+ Request for Practice Applications: <https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf>

Appendix E: Attribution Methodology

Beneficiaries will be aligned with the practice that either billed for the plurality of their primary care allowed charges, or that billed the most recent claim (if that claim was for CCM services) during the most recently available 24-month period. If a beneficiary has an equal number of qualifying visits to more than one practice, the beneficiary will be aligned to the practice with the most recent visit.

To be eligible for this initiative and aligned with a practice, beneficiaries must:

- Have both Medicare Parts A and B;
- Have Medicare as their primary payer;
- Not have end stage renal disease (ESRD) or be enrolled in hospice;
- Not be covered under a Medicare Advantage or other Medicare health plan;
- Not be institutionalized;
- Not be incarcerated;
- Not be enrolled in any other program or model that includes a shared savings opportunity with Medicare FFS initiative;
- Reside in one of the regions selected for this model;

For all beneficiaries who meet the criteria above, claims with the following qualifying CPT codes will be selected for the look-back period (the most recent 24 months) when the physician or practitioner specialty is internal medicine, general medicine, geriatric medicine, family medicine:

Service	Code
Office/Outpatient Visit E&M	99201-99205 99211-99215
Complex Chronic Care Coordination Services	99487-99489
Transitional Care Management Services	99495-99496
Home Care	99341-99350
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439

Draft-Subject To Change

Service	Code
Chronic Care Management Services	99490

The following information will be needed to conduct beneficiary alignment.

For a practice:

- Practice name;
- Practice Address (street, city, state, zip);
- Group Provider Transaction Provider Number (PTAN) (Group Provider Identification Number (PIN));
- Group National Provider Identifier (NPI) (If the practice is a solo practitioner, relevant Billing P-Tan or Individual Billing P-Tan/PIN information would be needed);
- Tax ID.

For each individual practitioner:

- Practice affiliation;
- Practice name;
- Individual NPI;
- Effective start date of participation;
- Effective termination date of participation.

CMS will provide each practice with a list of its claims-based aligned patients prior to the start of the initiative and each performance year. In addition, the beneficiary assignment algorithm will be run every three months with reports provided to the practice within 15 business days of the end of the look back period and applicable to payments starting 30 days after the end of the look back period.

Practices will be required to inform their patients in writing of their involvement in this initiative, and the changes their practice has made or is undertaking to provide comprehensive primary care and better serve their needs. Patients may opt out of data sharing.

At all times during the initiative, though Medicare beneficiaries will be attributed to a practice, they will remain free to select the providers and services of their choice and will continue to be responsible for all applicable beneficiary cost-sharing. CPC+ does not include any restrictions on or changes to Medicare FFS benefits, nor does it include provisions for beneficiaries to opt out of alignment with a participating practice for purposes of expenditure calculations and quality performance measurement.

Medicare Annual Wellness Visit Codes

Lung Cancer Screening Counseling and Annual Screening for Lung Cancer with Low Dose Computed Tomography

Effective February 5, 2015, Medicare began covering lung cancer screening counseling and a shared decision making visit, and for appropriate beneficiaries, annual screening for lung cancer with low dose computed tomography (LDCT). For more information, visit <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAid=274> on the CMS website.

Coding, Diagnosis, and Billing

Coding

Use the following Healthcare Common Procedure Coding System (HCPCS) codes when filing claims for AWWs.

AWW HCPCS Codes and Descriptors

AWW HCPCS Codes	Billing Code Descriptors
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit
G0439	Annual wellness visit; includes a personalized prevention plan of service (PPPS), subsequent visit

Diagnosis

Since CMS does not require a specific diagnosis code for the AWW, you may choose any appropriate diagnosis code. You must report a diagnosis code.

Billing

Medicare Part B covers AWW if performed by a:

- Physician (a doctor of medicine or osteopathy);
- Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist); or
- Medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of such medical professionals who are working under the direct supervision of a physician (doctor of medicine or osteopathy).

When you provide a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service in addition to the AWW, Medicare may pay for the additional service. Report the Current Procedural Terminology (CPT) code with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary's illness or injury or to improve the functioning of a malformed body member.

Who Can Get the AWW?

Medicare covers an AWW for all beneficiaries who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not gotten either an IPPE or an AWW within the past 12 months (that is, at least 11 months have passed following the month in which the IPPE or the last AWW was performed). Medicare pays for only one **first** AWW per beneficiary per lifetime and pays for one **subsequent** AWW per year thereafter.

Frequently Asked Questions (FAQs)

Is the AWW the same as a beneficiary's yearly physical?

No. The AWW is not a "routine physical checkup" that some seniors may get every year or so from their physician or other qualified non-physician practitioner. Medicare does not cover routine physical examinations.

Are clinical laboratory tests part of the AWW?

No. The AWW does not include any clinical laboratory tests, but you may make referrals for such tests as part of the AWW, if appropriate.

Do deductible or coinsurance/copayment apply for the AWW?

No. Medicare waives both the coinsurance or copayment and the Medicare Part B deductible for the AWW.

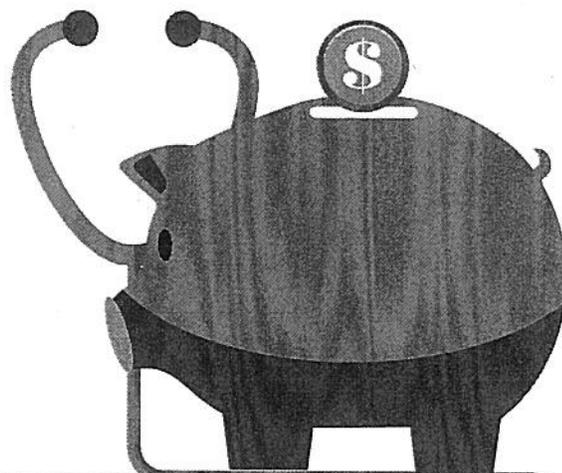
Can I bill an electrocardiogram (EKG) and the AWW on the same date of service?

Generally, you may provide other medically necessary services on the same date of service as an AWW. The deductible and coinsurance/copayment apply for these other medically necessary services.

2016 Preventive Screening Voucher



Employees, retirees, COBRA subscribers and their covered spouses, whose primary coverage is the State Health Plan, are eligible for one free preventive screening in 2016. If you are unable to attend a worksite or regional screening event, take this voucher and your State Health Plan ID card to a participating provider. For a list of providers, visit www.PEBAperks.com.



Present this voucher along with your State Health Plan insurance card to one of the participating providers and ask for the preventive screening. In addition to measuring your height, weight and blood pressure, the screening will also include a lipid panel (total cholesterol, HDL, LDL, triglycerides); chemistry profile (BUN and creatinine, glucose and electrolytes); and hemogram (red and white blood cell, hemoglobin and hematocrit). There will be no cost to you and test results will be mailed to your home within 14 business days.

Note to Provider: This screening is covered in full without member cost share for employees, retirees and spouses whose primary insurance is the State Health Plan. Please bill code 99420. If you have any questions, please contact BlueCross BlueShield of South Carolina at 800.444.4311.

EXPIRES DECEMBER 31, 2016



www.PEBAperks.com

Draft-Subject To Change

Potential Options

1. Any outpatient contact with NCQA code or
2. Restrict only to primary care providers with NCQA code
3. Qualified health plans must attribute relationships and assess assigned provider/site
4. Only allow CPC/PCMH sites to be eligible; any visit would count towards requirement
5. Determine new wellness code to be used across both programs
6. From 9/16 meeting with Medicaid, QHPs, EBD and other stakeholders: Utilize ACA mandated preventive service codes (covered at no-cost to beneficiaries) as requirement for wellness visit.

COST EFFECTIVENESS OF HEALTHCARE INTERVENTIONS

BRADLEY C MARTIN, PHARM.D., PH.D.



DOES COST EFFECTIVENESS REALLY MATTER?

- Guideline Developers Considering Cost Effectiveness
 - **ACC/AHA Task Force On Practice Guidelines**
- AMCP Dossier
 - Includes Cost Effectiveness Evidence
 - Surveys indicate 40-75% of plans use or plan to use cost effectiveness in aiding decisions (Garber 2004, Bryan, 2009)
- National Institute of Clinical Effectiveness (NICE) in UK
 - They do not pay for drugs that cost more than £20,000 - £30,000 per QALY
- Canada and many other European countries consider cost effectiveness
- Medicare and PCORI are prohibited from using cost/QALY



TYPES PHARMACOECONOMIC AND HEALTH CARE TECHNOLOGY ASSESSMENT (HTA) STUDIES

- **Budget Impact**
 - Estimate plan or population expenditures with adoption of new technology
- **Cost Effectiveness (CEA)**
 - Cost Utility Analysis (CUA)
- **Cost Minimization (CMA)**
- **Cost Benefit Analysis (CBA)**

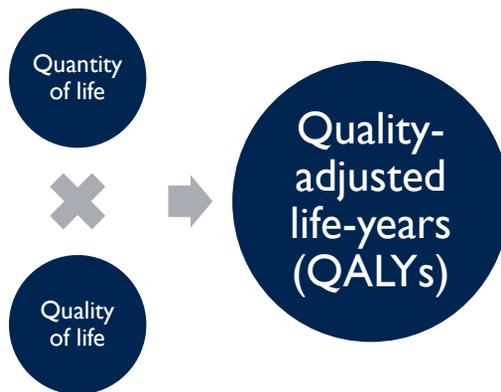


COST EFFECTIVENESS ANALYSIS

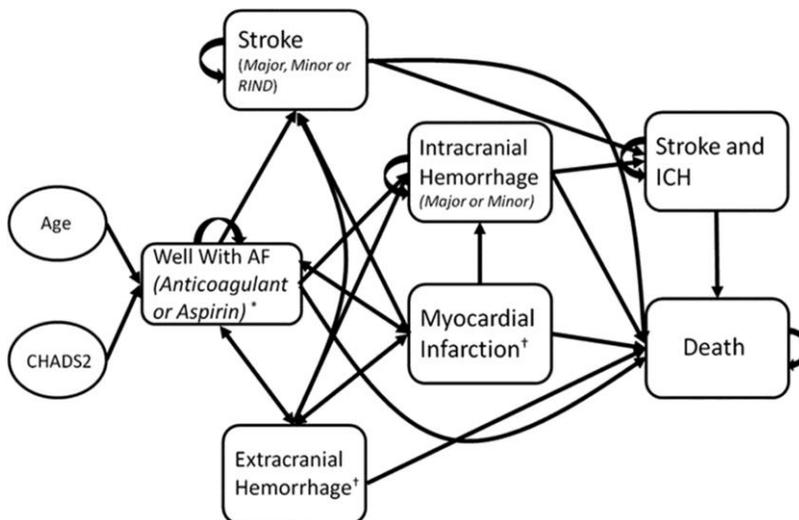
- Study Comparing the Costs and Effects of at Least Two Alternatives
- Important Considerations
 - Measure of Effectiveness
 - Perspective
 - Who's Costs Do We Consider?
 - Payer or Society
 - Time Frame
 - Lifetime, Year(s), Episode such as a hospitalization
 - Study Methodology
 - Modeled Estimates Projected from Clinical Trials
 - Cost Effectiveness Alongside Clinical Trials



QUALITY-ADJUSTED LIFE-YEAR (QALY) OFFERS A COMMON CURRENCY IN ASSESSMENT OF HEALTH GAIN



Cost Effectiveness Models



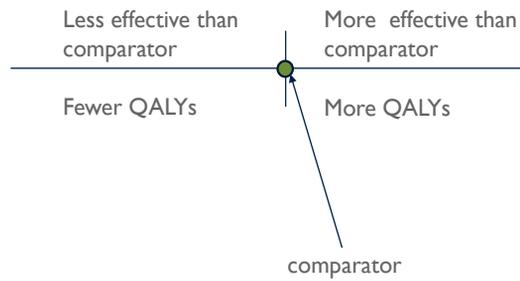
Anuj Shah et al. Stroke. 2016;47:1555-1561



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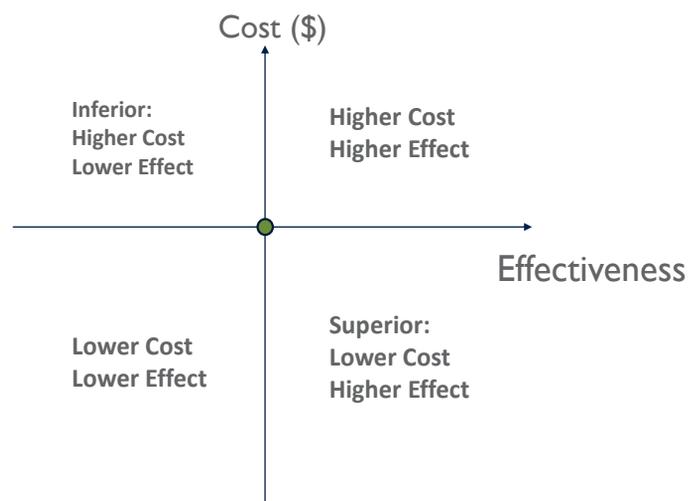
Interpreting Effectiveness:

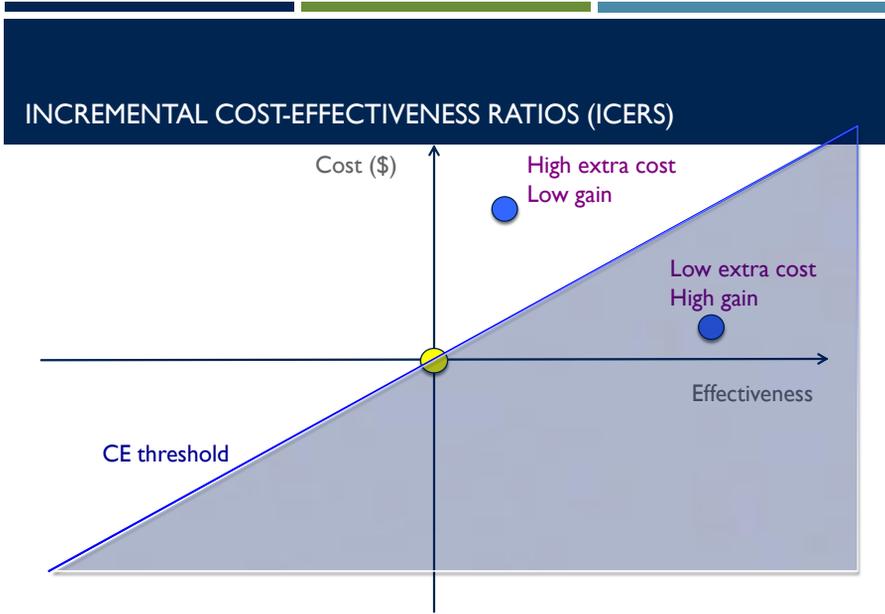
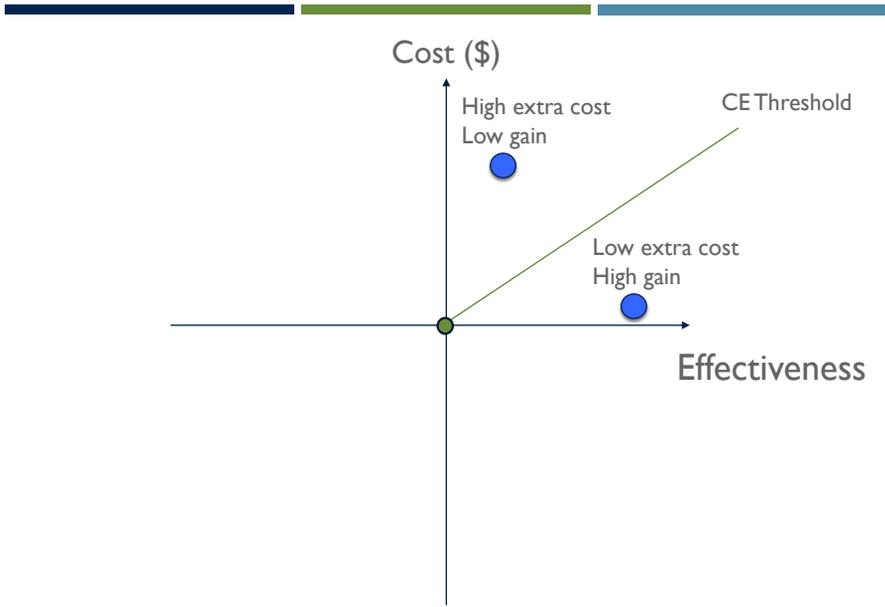
Considering **clinical efficacy**, **safety** and **tolerability**, estimate effectiveness (**QALYs**)



EBM: Does a new technology improve relevant patient outcomes?

Now Consider Costs





WHAT IS A GOOD VALUE?

- Technologies that **DOMINATE** others are **Clear Winners**
 - Always Choose **Lower Cost** and **Higher Effect** Technologies
- Most Often a NEW Technology is **More Expensive** and **More Effective**
 - Interpret the Incremental Cost Effectiveness Ratio (ICER)
 - Very High Value
 - <\$50,000/QALY
 - High Value
 - \$50K-100K/QALY
 - Moderate Value
 - \$100K-\$150K/QALY
 - Low Value
 - >\$150,000/QALY
- WHO suggests 3 times the GDP per capita (~\$150,000 per QALY in U.S.)

**COST
EFFECTIVE**

INTERPRETING COST EFFECTIVENESS RESULTS

Table 2. Base Case Costs, Quality-Adjusted Survival, NMB, and ICERs

Strategy	Therapies in the Order of Cost				Warfarin as the Common Reference
	Cost (95% CI)	QALY (95% CI)	ICER	NMB (95% CI)	ICER
Adjusted dose warfarin	\$46 241 (44 499–47 874)	9.02 (8.90–9.12)	0	\$856 092 (844 556–866 594)	0
Edoxaban	\$54 159 (52 670–55 702)	9.31 (9.16–9.40)	Ext dom	\$876 817 (863 807–886 194)	\$27 643
Apixaban	\$55 455 (54 138–56 493)	9.38 (9.24–9.48)	\$25 816	\$882 567 (870 327–892 217)	\$25 816
Dabigatran	\$56 425 (55 203–57 749)	9.35 (9.23–9.45)	Abs dom	\$878 304 (867 159–887 641)	\$31 435
Rivaroxaban	\$58 889 (57 467–60 444)	9.24 (9.11–9.35)	Abs dom	\$865 465 (853 044–875 853)	\$57 434

Abs dom indicates absolutely dominated; Ext dom, extendedly dominated; ICER, incremental cost effectiveness ratio; NMB, net monetary benefits; and QALY, quality-adjusted life years.

CAUTIONS

CAUTION
WATCH YOUR
STEP

- Most Cost Effectiveness Studies Use Models
 - Often take trial results of 6 months to a couple years and simulate lifetime costs and effects
 - Very few models are externally validated
 - Most models are a simplified representation of reality
 - Assumptions!!!
 - Models are only as good as the data they are based on
- Uncertainty
 - Sensitivity Analyses
- Be mindful of comparator(s)
- Proprietary driven studies and publication bias

USING COST EFFECTIVENESS DATA

Option 1: Establish a willingness to pay threshold or thresholds, which, if exceed, would warrant lack of coverage of a medical intervention

Option 2: Allow cost effectiveness data to be presented, alongside clinical data, for coverage determination.

Weigh ICER information more for high budgetary impact medications

Option 3: Ignore cost effectiveness considerations in decision making

Nasal Steroids

Current Coverage		
Product	Current Tier Placement	Proposed Tier Placement
Veramyst (fluticasone)	Excluded	No change
Fluticasone	Tier 1	No change
Flonase Allergy Relief	RBP	No change
Triamcinolone Nasal	Excluded	Continue Exclusion
Nasacort Allergy 24Hr	Excluded	Continue Exclusion
Nasacort Allergy 24 Hr Children	Excluded	Continue Exclusion
Rhinocort Allergy	Excluded	Continue Exclusion
Budesonide Nasal	Excluded	Continue Exclusion
Astepro 0.15%	BPC	No change
Azelastine 0.1%	Tier 1	No change
Azelastine 0.15%	Tier 1	No change
Flunisolide	Tier 1	No change
QNasl	RBP	No change
QNasl Childrens	Excluded	Continue Exclusion
Beconase AQ	RBP	No change
Nasonex	RBP	No change
Mometasone	RBP	No change

Histamine Antagonist		
Product	Current Tier Placement	Proposed Tier Placement
Astepro 0.15%	BPC	No change
Azelastine 0.1%	Tier 1	No change
Azelastine 0.15%	Tier 1	No change

Cost Comparison		
Product	Rx Cost	OTC Cost w/o RBP
Veramyst (fluticasone)	AWP: \$226.38	
Fluticasone	\$15 AWP: \$84.32	
Flonase Allergy Relief		\$22.47 (#120 sprays)
Triamcinolone Nasal	AWP: \$122.53	
Nasacort Allergy 24Hr		\$17.96 (#120 sprays)
Nasacort Allergy 24 Hr Children	Excluded	\$12.94 (#60 sprays)
Rhinocort Allergy		\$18.64 (#120 sprays)
Budesonide Nasal		\$14.99 (#120 sprays)
Astepro 0.15%	AWP: \$185.64	
Azelastine 0.1%	\$15	

	Plan: \$21.81	
Azelastine 0.15%	\$15 Plan: \$103.94	
Flunisolide	\$15 Plan: \$44.49	
QNasl	\$154.14 Plan: \$26	
QNasl Childrens	Excluded	
Beconase AQ	\$234.94 Plan: \$26	
Nasonex	\$215.66 Plan: \$26	
Mometasone	\$180.13 Plan: \$26	

Revised Proposal: There are currently 3 nasal steroids available over the counter, with only one available for purchase on this plan. The previous proposal presented to DUEC recommended excluding all nasal steroids and azelastine from the formulary, resulting in a savings of \$80,000/quarter or \$320,000 per year. However, after conversations concerning azelastine, the recommendation was amended to continue covering azelastine products at Tier 1, resulting in a cost savings of \$40,000/quarter. This was not passed by the DUEC.

Based on current information, the recommendation is being amended again. Our new proposal is to continue coverage of this class, and revisit in 6 months. Concerns include a large amount of member disruption with little savings, as well as the potential to shift members to a higher cost medication.