AGENDA

State and Public School Life and Health Insurance Board

August 21, 2018

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I.	*Call to Order*	*Carla Haugen, Chair*
II.	*Approval of June 2018 Minutes*	*Carla Haugen, Chair*
III.	*ASE-PSE June Financials*	*Cheryl Reed, EBD Fiscal Officer*
IV.	*Benefits Sub-Committee Update*	*Chris Howlett, EBD Executive Director*
V.	*Quality of Care Updates*	*Margo Bushmaier, Q of C Chair*
VI.	*Diabetes/Plan Update*	*Allie Barker, EBD Registered Nurse*
VII.	*Kannact*	*Krishna Rao, Mike Pohl, Kannact*
VIII.	*Naturally Slim Update*	*Sandy Schenck, Naturally Slim*
IX.	*Director's Report*	*Chris Howlett, EBD Executive Director*

Upcoming Meetings

September 18, 2018, October 16, 2018, November 20, 2018

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

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

STATE AND PUBLIC SCHOOL LIFE AND HEALTH INSURANCE BOARD MEETING MINUTES

183rd meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on August 21, 2018 at 1:00 p.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock AR 72201.

Date | *time* 8/21/2018 1:00 PM | *Meeting called to order by Carla Haugen, Chair*

Attendance

Members Present	Members Absent
Dr. Terry Fiddler	
Stephanie Lilly-Palmer	
Renee Mallory- Vice-Chair	
Greg Rogers	
Dr. Lanita White	
Dr. John Kirtley	
Carla Haugen- Chair	
Rett Hatcher	
Dori Gutierrez	
Herb Scott	
Cindy Gillespie	
Melissa Moore	
Lisa Sherrill	
Chris Howlett, Employee Benefits Division Executive Director	

OTHERS PRESENT:

Eric Gallo, Rhoda Classen; Shalada Toles, Shay Burleson, Jamie Levinsky, Terri Freeman, Allie Barker, EBD; Sandra Wilson, Active Health; Ronda Walthall, Wayne Whitley, ARDOT; Suzanne Woodall, MedImpact; Karyn Langley, QualChoice; Marc Watts, ASEA; Dr. Dwight Davis, Dr. Micah Bard, UAMS EBRX; Jessica Akins, Health Advantage; Leah Swanson, Jackson Wimberly, Payton Snodgrass, UAMS; Sylvia Landers, Eileen Wider, Securian; Andy Davis, AR Democrat-Gazette; Jackie Baker, ASP; Tim Church, Sandy Schenck, Naturally Slim; Tabatha Wilson, BLR; Kristi Jackson, ComPsych; Bill Cleary, ARSEBA; Margo Bushmaier, QofC Sub-committee; Elizabeth Montgomery, Mike Motley, ACHI; Sean Seago, MERCK; Donna Morey, ARTA; Aaron Shaw, Brian Wensal BI; David Kren, AEA; Mike Pohl, Krishna Rao, Kannact; Marc Bagby, Lilly; Greg Jones, Mainstream; Frances Bauman, Novo Nordisk; Mark Adkison, Allcare; Marc Parker, Sunovion; Mary Ross, Sanofi; Bud McConkie, Allergen; Martha Hill, MW

Approval of Minutes by: Carla Haugen, Chair

MOTION by Scott

Motion to accept the June, 2018 minutes.

Dr. Kirtley seconded; all were in favor.

Minutes approved.

Financials by: Chris Howlett, EBD Executive Director

Howlett reported financials for June and July, 2018.

For PSE in the month of June, we paid 5 weeks of claims for both medical and pharmacy. The FICA savings received for the month was $522,608.58, and year-to-date savings of $3,145,119. We had a net loss of $7.6 million for the month and a net increase of $6.3 million year-to-date. Net assets available are $74.7 million.

For ASE in the month of June, we paid 5 weeks of claims for both medical and pharmacy. We had a net loss of $5.1 million for the month and $3.4 million year-to-date. Net assets available are $30.4 million.

The projected vs. actual claims and expenditures report shows the numbers from the current month, the year-to-date (YTD) and the differences. The monthly amounts are for June 2018 and YTD amounts are for January-June 2018.

For PSE in the month of July, we paid 4 weeks of claims for both medical and pharmacy. The FICA savings received for the month was $506,700.25, and year-to-date savings of $3,651,819.25. We had a net gain of $3.5 million for the month and a net increase of $9.8 million year-to-date. Net assets available are $75.8 million.

For ASE in the month of July, we paid 4 weeks of claims for both medical and pharmacy.We had a net gain of $3.6 million for the month and a net loss of $22 thousand year-to-date. Net assets available are $33.8 million.

The projected vs. actual claims and expenditures report shows the numbers from the current month, the year-to-date (YTD) and the differences. The monthly amounts are for July 2018 and YTD amounts are for January-July 2018.

Benefits Sub-Committee Report by: Chris Howlett, EBD Executive Director

The Benefits Sub-Committee met on August 10, 2018 and discussed the following:

- Approval of Minutes
- Choosing Wisely Update/Cost Drivers
- Naturally Slim Update
- Kannact
- Director's Report

There were two recommendations that came from the Benefits Sub-Committee with regards to Naturally Slim and Kannact.

Quality of Care Sub-Committee Report by: Margo Bushmaier, Chair of Benefits Sub-committee

The Quality of Care Sub-Committee met on August 14, 2018, and there was a presentation from ACHI regarding the 42 most common treatments deemed by providers to be overused, focusing on the eight most wasteful, low-value services. Montgomery and Motley plan to come back and focus on two of the top eight a month, and they plan to show dollar amounts as well. ACHI plans to present recommendations for these wasteful, low-value services, provide educations, review prior-authorization criteria or medical utilization management practices and review value-based payment models.

Diabetes/Plan Update by: Allie Barker, EBD Registered Nurse

Allie Barker, EBD RN, discussed a large subset of our population that are desperate for a more hands-on touch, long term management of chronic disease and conditions.

ACHI reported back in May that 11% of our member population has a diagnosis of Type 2 Diabetes, and these 15,000 members cost the plan $110 million in medical claims from 2016-2017. Our current UM provider is managing a group who receive free supplies to the member for participating in our voluntary diabetes management program. These costs add up to:

From January 1-July 31 of 2018

- $266,708.31 on test strips
- $184,172.89 on needles and pen tips
- $29,575.52 on syringes
- $15,162.68 on lancets

If we assume this trend to hold true, we are on track to spend near 1 million dollars on Diabetes supplies.

These are the facts and dollar amounts that lead our leadership team to request information on programs that can provide resources and tools to not only improve the health and overall well-being of our members but also to prevent unnecessary claims cost.

Kannact by: Krishna Rao, CEO & Mike Pohl, Dir of Marketing, Kannact

Kannact gave an overview of their patient centered model that is designed and proven to engage participants. They have behavior change programs for chronic and pre-chronic conditions. In this program, you coordinate with a dedicated coach to create a personalized care plan. They have easy online enrollment, supplies shipped directly to your home and you will have 24x7 support to communicate on your schedule. They focus on the time in between doctor visits by utilizing this coaching system available 24x7, and these coaches are AAED certified. Kannact also has a population reporting back to the health plan as early as month three, and they coordinate with other programs, like Naturally Slim. They provided a transition schedule of what to expect from the program setup, enrollment, engaging with the coach and ongoing monitoring, and the claims billing set-up details, and they also passed around a set up package that each member will have mailed once enrolled.

Discussion:

Dr. Fiddler	How many clients per coach do you have? How many coaches would you have for 10,000 participants?
Wilcox	It averages to 250 participants per coach, and it is also flexible relative to the risk level assigned to each participant. The higher risk level coaches will have less participants on their load than the lower needs.
Dr. Fiddler	If you started with a patient that had a very out of range A1-C level, would that person start automatically above the certified II level coach?
Wilcox	Yes, that is correct.
Dr. Fiddler	Would it go directly to a physician?
Wilcox	The physician will look at it, but the direct contact will be with the coach.
Dr. Fiddler	How long is between the time for a new participant with an above 7 (A1-C?), 70lbs overweight, and have a lot of things going on, will that person automatically go to the medical team for the physician to watch that person and how often will they be in contact with that person?
Wilcox	The coach will get on the phone immediately upon joining and go through the health and behavioral risk assessment as well as the data from the claims and the coach's assessment will be ran through the medical algorithm. We categorize each participant based on these factors. The medical team will look at each individual case, especially the 20% of really rising to the top, will get more specific. We categorize each participant based on these factors. It can be manually escalated up to the doctor.

Dr. Fiddler This is an eight-year-old study, the patient adherence surprises me. What if a someone is not taking their medication? Will we be able to see that on the PDMP (Prescription Drug Monitoring Program)?

Dr. Kirtley Since this is non-controlled, it would not be on the PDMP.

Dr. Fiddler There would be no way of knowing except by them saying, yes, I am taking it.

Dr. Kirtley Many electronic health records will show what prescriptions patients fill. PDMP is more comprehensive on over all control, but for prescribers if they have electronic health records they can see what all medications were picked up through pharmacy and what was billed through insurance.

Dr. Fiddler If they are with a coach and picking up their prescriptions, whether they are taking them or not, and they are getting worse they would need to be moved up the line to the medical team. But if they are not taking the medication, when does the team say we are going to cut you loose. When is the program allowed to cut the noncompliant person out and get someone else in there?

Dr. Kirtley It is just like any other program, it is a difficult thing if you're trying to get someone to manage their disease and to do better and have better outcomes. Ideally, we would much rather have someone do the program half way than not be in it at all and still hoping you have a better outcome than no care at all.

Dr. Fiddler We are looking at starting a new program. This would be the time to deal with this and decide what the best option is.

Howlett From a plan perspective, we run in to being bound between 'skin in the game'. Our population is not in certain situations because they are all participating as far as health. This board could decide what to do with noncompliance. When we started exploring this, we saw that we have a program that is incentivizing people to participate with no tracking that gives us anything tangible. We can't determine health improvement for anybody on the plan and are giving supplies for years. Historically, we have a 2011 board decision that grandfathered a group of the population in and there was no requirement to have them in a program. We have no proactive measurement that we have been able to entertain on this plan to try to come along side of or nudge participant to get them in a program doing what they say they are going to do and the plan be on the hook for paying for some of that. If we are going to deal with compliance the way that you have addressed it and steps to those that are not compliant to being kicked out of a program, we need to tread lightly to make sure we don't mess things up.

Dr. Fiddler If in 60 days, they are not doing the program, then can we put someone on the program off the waiting list?

Howlett If there is a waiting list, yes.

Dr. White We will save about a million dollars on supplies. How does that work?

Wilcox	There is a monthly per participant fee and supplies are rolled into the cost of the program. It is billed as a medical claim, $69 monthly fee, with unlimited supply refill for testing. We want to encourage more testing.
Dr. White	The number of strips are unlimited.
Wilcox	Yes, we will adhere to the doctor's prescription, but if the participant wants to test more, we will send an unlimited number. The coach will work with you on that.
Dr. White	Essentially, there is an unlimited amount of supplies with no change in cost?
Wilcox	Yes.
Dr. White	Did you say all the staff or coaches are trained as Diabetes Educators, CDE?
Wilcox	They are all level I and II educators, depending on the level of participant they are assigned to. They are going through the ADE curriculum and getting that certification.
Dr. White	On your graph, you show cost savings over the last three years drop. What is that contributed to?
Wilcox	Less hospitalization and hospital visits.
Dr. White	This is my specialty area, I ask that we do a nomenclature change. Instead of compliance, we need to use adherence. The other thing is every time we say Diabetic, it needs to be patients with Diabetes. We do not need to label them.
Howlett	The recommendation that came from the Benefits Sub-Committee is: All current active participants in the Diabetic program now will be transitioned to Kannact, any of the individuals that do not transition will be responsible for their own supplies, and any newly identified people will be offered an opportunity to go into the program.
Dr. Fiddler	Do we know how many people are currently enrolled in a Diabetes program to try to help their situation.
Howlett	We currently are around 6,500 participants. The issue that we run into is that we have people that were paying for supplies that were never bound to a program. We are having trouble, even in the claims research, to be able to track how those people are paying for their supplies. Whether the plan is paying, waving a copay, or out of pocket.
Dr. Fiddler	Say we do move to this program. It will be self-limiting for those who were not adhering. I'm looking for a time period that, as a Board, there is a report that is going to say "this is what it was going in, this is how much money we have seen to reduce the cost of the program."
Howlett	To get the tangible data for comparison, it would be about 6 months.

Wilcox	To start seeing the trends and outcomes, we start looking at the data at 6 months, because it is a longer-term condition change. Changes in blood sugar and the short term may not really tell you the story of what is really happening. We like to at it with a little bit more of a rear view to understand that the trend is sticking.
Dr. Fiddler	Could we get a report in 30 days from those individuals to see how many decided to move to this program.
Howlett	I believe what was discussed about the operational transition, we could move about 1,500 a month. It would take some time to get that, but we could have a monthly update of the 1,500 and how many participated.
Dr. Fiddler	I would really like that so that we can see if our money is being well spent or not.
Howlett	The other piece, supply base or not, there are other positive consequences. We are more adherent for patients with Diabetes, as we do that we should see other claims cost associated with that.
Gillespie	Did you say that we will only be charged for those patients that go into the program and are active? If part of the 1,500 don't transition, we won't be paying for them?
Wilcox	Yes, that is correct.
Haugen	How are you going to communicate all of this?
Howlett	It would be through the communication efforts that are worked out between us and Kannact. We would also go out our normal channels, EBD alerts and email blasts. The alerts go out to all the HIRs, agencies, and districts. We will post it on our media pages.
Wilcox	We will provide all the content for that with EBD's customization and approval on any material that goes out.
Gillespie	Will we have a check to make sure that people are not in both programs?
Howlett	We will have a cut date to cut those.
Gutierrez	For those members who will be dropped after 60 days of being inactive, can they come back?
Wilcox	Typically yes, we allow them to come back on and reengage.
Gutierrez	How long will they have to transition to the program?
Howlett	I don't know if we would have a limitation per say, but to look at the group on that respective time period of a month before we report back. I don't know that we should ever stop trying to educate them to incentivize them to come on to program for their own health.

Gutierrez	How will they know? Will we send a letter to let them know ahead of time? If they don't move onto this program, they will be responsible for their own supplies, so how long will they have to make the transition. Are they going to know ahead of time?
Kirtley	It would need to be a notification that their current program is ending and you can either sign up for this new program or you will be responsible for the complete cost.
Howlett	Could we scale and do a 6,500 at one time?
Rao	It would take a couple of months.
Howlett	With the boards permission, we could do a 1/1 transition where everything stops at 12/31. It will give them to the end of the year to meet the commitment. New starts would bleed over since they aren't receiving the free supplies. We can do an email blast instead of sending a letter due to the cost and it not being a good rate of return for the dollars spent.
Recap of Motion	All current active participants in the patients with Diabetes program now will be transitioned to Kannact, any of the individuals that do not transition will be responsible for their own supplies, and any newly identified people will be offered an opportunity to go into the program. Amended that this population will transition by 1/1/19 and the old program will die. It will allow the individuals receiving the benefits to transition to the new program. All newly identified individuals will have the opportunity to go into the program with no term date, but until they do so they will be responsible for their own supplies. We will have the normal communications and information going out to the HIRs and agencies as well as email blasts.
Dr. Fiddler	So if we make this motion, it will be four months before this program is going to start?
Howlett	The request was how long should we give them to get enrolled. It will start as soon as they enroll. We can do a hard stop on October 31st but what are we doing for those who are thinking about it.
Gillespie	When does Kannact start? With people rolling in and the current program doesn't end until 12/31, how does that work?
Howlett	We will start drafting it upon approval today. We could start with communications on September 1st.

MOTION by Kirtley

I motion to adopt Kannact to allow enrollment to begin as soon as notification can go out; to offer to any new people that would be able to enroll upon eligibility; to stop the old program on 12/31.

Dr. Fiddler seconded. All were in favor.

Motion Approved.

Naturally Slim Update by: Sandy Schenck and Dr. Tim Church, Naturally Slim

Schenck and Dr. Church gave an overview of Naturally Slim, the digital behavioral based program that has proved to prevent Diabetes and reverse Metabolic Syndrome for the last 12 years. The pilot program launched for ASE/PSE with a total of 2,400 in the program, and 243 never started the program. Additionally, he discussed what was next for Naturally Slim with Phase II, III, IV and V, as well as testimonials from members.

Howlett The Recommendation from the Benefits Sub-Committee is:

Roll out Phase II, limiting 3,000 PSE and 3,000 ASE and include non-Medicare eligible retirees to have the option of enrolling and start in September.

Even though we are starting a Phase II, Phase I, as we are still progressing, will still be monitored and have them as a subset. Phase II will be a second subset to the original pilot and look for outcomes based reporting on that. There were 804 for ASE and 1,200 on PSE that were on the waiting list. The recommendation, to further that, would be to start with the waiting list population and add to it up to the 3,000 for each side. We would run those programs concurrently at different stages and monitor for the outcomes and report back.

MOTION by Lilly-Palmer

The motion is to bring in the waitlist on ASE and PSE from the pilot and start Phase II. We will up the numbers to 3,000 on both ASE and PSE. We will also include the non-Medicare retirees to have the option of enrolling and start in September.

Mallory seconded. All were in favor.

Motion Approved.

Director's Report by: Chris Howlett, EBD Executive Director

Howlett provided an update. Currently we have 26,322 people that have completed the check-up as of 8/20. There are 203 remaining confirmed clinics through the end of October, with 2,702 open appointments available. There are still 17 pending clinics. They are still estimating that we will be in the mid-30,000s for the first year. Our HSA/FSA vendor RFP has been awarded and were moving towards implementation with that. Additionally, our Carrier Contract has been marked reviewed and we will be implementing that very soon. Both of those will have a 1/1 rollover date.

MOTION by Kirtley

Motion to adjourn.

Scott seconded. All in favor.

Meeting Adjourned.

Arkansas State Employees (ASE) Financials - January 1, 2018 through June 30, 2018

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	1652	50		1702		2599	68		2667
CLASSIC	2075	66		2141		3483	89		3572
PREMIUM	22538	2101		24639		38605	2629		41234
PRIMARY		210	10010	10220			438	12870	13308
TOTAL	26265	2427	10010	38702		44687	3224	12870	60781

REVENUES & EXPENDITURES

		Current Month	Year to Date (6 Month)
	Funding		
1	State Contribution	$ 14,536,564	$ 87,230,612
2	Employee Contribution	$ 8,069,735	$ 48,476,660
3	Other	$ 1,122,544	$ 6,853,828
4	Allocation of Reserves	$ 1,501,000	$ 9,006,000
	Total Funding	$ 25,229,843	$ 151,567,100
	Expenses		
	Medical Expenses		
5	Claims Expense	$ 20,891,763	$ 102,088,963
6	Claims IBNR	$ -	$ -
7	Medical Administration Fees	$ 1,006,714	$ 7,355,973
8	Refunds	$ -	$ -
9	Employee Assistance Program (EAP)	$ 108,732	$ 327,632
	Life Insurance	$ 78,298	$ 473,093
	Pharmacy Expenses		$ -
11	RX Claims	$ 7,759,679	$ 41,241,278
12	RX IBNR	$ -	$ 600,000
13	RX Administration	$ 124,619	$ 738,177
14	Plan Administration	$ 420,515	$ 2,228,827
	Total Expenses	$ 30,390,318	$ 155,053,942
15	**Net Income/(Loss)**	$ (5,160,475)	$ (3,486,842)

BALANCE SHEET

	Assets	
16	Bank Account	$ 4,137,685
17	State Treasury	$ 97,580,092
18	Due from Cafeteria Plan	$ 5,561,503
19	Due from PSE	
20	Receivable from Provider	
21	Accounts Receivable	$ 277,998
	Total Assets	$ 107,557,278
	Liabilities	
22	Accounts Payable	$ 803
23	Deferred Revenues	$ 6,726
24	Due to Cafeteria	$ 1,000
25	Due to PSE	$ 187,679
26	Due to Federal Government ($27 fee)	
27	Health IBNR	$ 25,700,000
28	RX IBNR	$ 1,400,000
	Total Liabilities	$ 27,296,207
	Net Assets	$ 80,261,071
	Less Reserves Allocated	
29	Premiums for Plan Year 1/1/18 - 12/31/18 ($5,040,000 + $8,262,000 + $4,710,000)	$ (9,006,000)
30	Premiums for Plan Year 1/1/19 - 12/31/19 ($5,508,000 + $2,826,000)	$ (8,334,000)
31	Premiums for Plan Year 1/1/20 - 12/31/20 ($1,884,000)	$ (1,884,000)
32	Catastrophic Reserve (2017 $20,600,000)	$ (30,600,000)
33	**Net Assets Available**	$ 30,437,071

34 5th week claims $5,655,905.26

35

Arkansas State Employees (ASE) Financials - January 1, 2017 through June 30, 2017

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	1585	44		1629	2519	61		2580
CLASSIC	1946	73		2019	3227	98		3325
PREMIUM	22587	2172		24759	38940	2761		41701
PRIMARY		208	9625	9833		432	12545	12977
TOTAL	26118	2497	9625	38240	44686	3352	12545	60583

REVENUES & EXPENDITURES

		Current Month	Year to Date (6 Months)
	Funding		
1	State Contribution	$ 14,654,304	$ 87,931,060
2	Employee Contribution	$ 8,086,882	$ 48,670,597
3	Other	$ 6,642,167	$ 9,959,058
4	Allocation of Reserves	$ 1,777,500	$ 10,665,000
	Total Funding	$ 31,160,852	$ 157,225,715
	Expenses		
	Medical Expenses		
5	Claims Expense	$ 20,153,673	$ 84,167,710
6	Claims IBNR	$ -	$ (2,300,000)
7	Medical Administration Fees	$ 1,343,627	$ 6,805,640
8	Refunds	$ 2,213	$ 3,435
9	Employee Assistance Program (EAP)	$ 55,201	$ 329,364
	Life Insurance	$ 79,538	$ 474,278
	Pharmacy Expenses		
11	RX Claims	$ 8,806,662	$ 39,607,467
12	RX IBNR	$ -	$ 300,000
13	RX Administration	$ 121,655	$ 689,023
14	Plan Administration	$ 682,363	$ 2,278,441
	Total Expenses	$ 31,244,931	$ 132,355,358
15	**Net Income/(Loss)**	$ (84,079)	$ 24,870,357

BALANCE SHEET

	Assets	
16	Bank Account	$ 14,699,055
17	State Treasury	$ 96,058,820
18	Due from Cafeteria Plan	$ 5,561,503
19	Due from PSE	$ -
20	Receivable from Provider	$ 575,989
21	Accounts Receivable	$ 1,262,550
	Total Assets	$ 118,157,918
	Liabilities	
22	Accounts Payable	$ 4,884,072
23	Deferred Revenues	$ 42,488
24	Due to Cafeteria	$ 10,596
25	Due to PSE	$ 8,122
26	Due to Federal Government ($27 fee)	$ -
27	Health IBNR	$ 25,700,000
28	RX IBNR	$ 2,000,000
	Total Liabilities	$ 32,645,278
	Net Assets	$ 85,512,639
	Less Reserves Allocated	
29	Premiums for Plan Year 1/1/17 - 12/31/17 ($7,560,000 +13,770,000)	$ (10,665,000)
30	Premiums for Plan Year 1/1/18 - 12/31/18 ($5,040,000 + 8,262,000)	$ (13,302,000)
31	Premiums for Plan Year 1/1/19 - 12/31/19 ($5,508,000)	$ (5,508,000)
32	Catastrophic Reserve (2017 $20,600,000)	$ (20,600,000)
33	**Net Assets Available**	$ 35,437,639

34 Fifth Week of Claims $5,245,484.55 Sixth Week of Claims $4,789,535.92

Public School Employees (PSE) Financials - January 1, 2018 through June 30, 2018

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	4135	486		4621		6269	632		6901
CLASSIC	23490	2255		25745		44970	2677		47647
PREMIUM	16947	604		17551		22558	650		23208
PRIMARY		59	12499	12558			120	13599	13719
TOTAL	44572	3404	12499	60675		73797	4079	13599	91475

REVENUES & EXPENDITURES

		Current Month	Year to Date (6 Month)
	Funding		
1	Per Participating Employee Funding (PPE Funding)	$ 8,352,345	$ 50,287,265
2	Employee Contribution	$ 9,708,311	$ 58,581,809
3	Department of Education $35,000,000 & $15,000,000 & Other Funding	$ 4,583,333	$ 53,100,000
4	Other	$ 1,398,177	$ 6,939,512
5	Allocation of Reserves	$ 1,883,333	$ 11,299,998
	Total Funding	$ 25,925,499	$ 180,208,584
	Expenses		
	Medical Expenses		
6	Claims Expense	$ 25,297,409	$ 111,503,457
7	Claims IBNR	$ -	$ 2,300,000
8	Medical Administration Fees	$ 1,995,462	$ 11,317,951
9	Refunds	$ -	
10	Employee Assistance Program (EAP)	$ 159,653	$ 479,826
	Pharmacy Expenses		
11	RX Claims	$ 5,448,889	$ 26,937,538
12	RX IBNR	$ -	$ (400,000)
13	RX Administration	$ 190,247	$ 1,143,840
14	Plan Administration	$ 435,800	$ 2,447,753
	Total Expenses	$ 33,527,460	$ 155,730,365
15	Less DOE Allocation		$ (18,100,000)
16	**Net Income/(Loss)**	$ (7,601,961)	$ 6,378,218

BALANCE SHEET

	Assets	
17	Bank Account	$ 33,803,380
18	State Treasury	$ 141,415,947
19	Receivable from Provider	$ -
20	Accounts Receivable	$ 1,959,078
21	Due from ASE	$ 187,679
	Total Assets	$ 177,366,084
	Liabilities	
22	Accounts Payable	
23	Due to ASE	
24	Deferred Revenues	$ 17,016
25	Due to Federal Government ($27 fee)	
26	Health IBNR	$ 28,000,000
27	RX IBNR	$ 1,000,000
	Total Liabilities	$ 29,017,016
28	**Net Assets**	$ 148,349,067
	Less Reserves Allocated	
29		
30	Premiums for Plan Year 1/1/18 - 12/31/18 ($3,840,000 + $660,000+18,100,000 DOE)	$ (11,300,002)
31	Premiums for Plan Year 1/1/19 - 12/31/19 ($396,000)	$ (396,000)
32	Premiums for Plan Year 1/1/20 - 12/31/20 ($264,000)	$ (264,000)
33	Premium Assistance (FICA Savings)	$ (3,145,119)
34	Catastrophic Reserve (2017 $58,500,000)	$ (58,500,000)
35	**Net Assets Available**	$ 74,743,946

36 5th week claims $6,062,652.45

Public School Employees (PSE) Financials - January 1, 2017 through June 30, 2017

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	3763	419		**4182**	5685	533		**6218**
CLASSIC	22277	2171		**24448**	42160	2609		**44769**
PREMIUM	17857	787		**18644**	23470	847		**24317**
PRIMARY		66	11783	**11849**		132	12845	**12977**
TOTAL	**43897**	**3443**	**11783**	**59123**	**71315**	**4121**	**12845**	**88281**

REVENUES & EXPENDITURES

		Current Month	Year to Date (6 Months)
	Funding		
1	Per Participating Employee Funding (PPE Funding)	$ 8,211,746	$ 49,356,923
2	Employee Contribution	$ 9,612,811	$ 57,981,509
3	Department of Education $35,000,000 & $15,000,000 & Other Funding	$ -	$ 41,509,091
4	Other	$ 1,144,869	$ 4,701,350
5	Allocation of Reserves	$ 3,792,121	$ 21,107,273
	Total Funding	$ 22,761,547	$ 174,656,146
	Expenses		
	Medical Expenses		
6	Claims Expense	$ 25,126,816	$ 96,421,570
7	Claims IBNR	$ -	$ (4,300,000)
8	Medical Administration Fees	$ 1,982,412	$ 10,310,156
9	Refunds	$ -	$ -
10	Employee Assistance Program (EAP)	$ 78,442	$ 471,333
	Pharmacy Expenses		
11	RX Claims	$ 6,239,604	$ 25,134,459
12	RX IBNR	$ -	$ 300,000
13	RX Administration	$ 184,566	$ 1,044,379
14	Plan Administration	$ 679,769	$ 2,502,964
	Total Expenses	$ 34,291,609	$ 131,884,861
15	Less DOE Allocation		$ (18,100,000)
16	**Net Income/(Loss)**	$ (11,530,062)	$ 24,671,285

BALANCE SHEET

	Assets	
17	Bank Account	$ 17,867,473
18	State Treasury	$ 139,211,276
19	Receivable from Provider	$ 304,167
20	Accounts Receivable	$ 1,912,523
21	Due from ASE	$ 8,122
	Total Assets	$ 159,303,561
	Liabilities	
22	Accounts Payable	$ 5,295,586
23	Due to ASE	$ -
24	Deferred Revenues	$ 16,859
25	Due to Federal Government ($27 fee)	$ -
26	Health IBNR	$ 25,700,000
27	RX IBNR	$ 1,400,000
	Total Liabilities	$ 32,412,445
28	**Net Assets**	$ 126,891,116
	Less Reserves Allocated	
29	Premiums for Plan Year 1/1/17 - 12/31/17 ($5,760,000+$20,000,000 + $18,100,000 DOE)	$ (22,752,727)
30	Premiums for Plan Year 1/1/18 - 12/31/18 ($3,840,000)	$ (3,840,000)
31	Premium Assistance (FICA Savings)	$ (3,101,215)
32	Catastrophic Reserve (2017 $40,500,000)	$ (40,500,000)
33	**Net Assets Available**	$ 56,697,174

34 Fifth Week of Claims $5,624,790.53 Sixth Week of Claims $5,255,791.62

PROJECTED PAID CLAIMS AND EXPENSES BY MONTH

PSE

2018 June

Medical Claims

PROJECTED Monthly Amount	ACTUAL Monthly Amount	DIFFERENCE Monthly Amount	PROJECTED YTD Total	ACTUAL YTD Total	DIFFERENCE YTD Total
26,850,000	25,297,409	(1,552,591)	105,760,000	113,803,457	8,043,457

Note: IBNR increased for Medical by $2,300,000

Pharmacy Claims

PROJECTED Monthly Amount	ACTUAL Monthly Amount	DIFFERENCE Monthly Amount	PROJECTED YTD Total	ACTUAL YTD Total	DIFFERENCE YTD Total
7,240,000	5,448,889	(1,791,111)	28,130,000	26,537,538	(1,592,462)

Note: IBNR decreased for Pharmacy by $400,000

Expenses/Other

PROJECTED Monthly Amount	ACTUAL Monthly Amount	DIFFERENCE Monthly Amount	PROJECTED YTD Total	ACTUAL YTD Total	DIFFERENCE YTD Total
2,730,000	2,781,162	51,162	16,410,000	15,389,370	(1,020,630)

ASE

2018 June

Medical Claims

PROJECTED Monthly Amount	ACTUAL Monthly Amount	DIFFERENCE Monthly Amount	PROJECTED YTD Total	ACTUAL YTD Total	DIFFERENCE YTD Total
22,240,000	20,891,763	(1,348,237)	96,160,000	102,088,963	5,928,963

Note: IBNR no change

Pharmacy Claims

PROJECTED Monthly Amount	ACTUAL Monthly Amount	DIFFERENCE Monthly Amount	PROJECTED YTD Total	ACTUAL YTD Total	DIFFERENCE YTD Total
10,210,000	8,110,828	(2,099,172)	44,390,000	41,592,427	(2,797,573)

Note: IBNR decreased pharmacy $600,000

Expenses/Other

PROJECTED Monthly Amount	ACTUAL Monthly Amount	DIFFERENCE Monthly Amount	PROJECTED YTD Total	ACTUAL YTD Total	DIFFERENCE YTD Total
2,170,000	1,680,368	(489,632)	13,070,000	10,772,553	(2,297,447)

Arkansas State Employees (ASE) Financials - January 1, 2018 through July 31, 2018

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	1648	49		1697	2602	67		2669
CLASSIC	2087	66		2153	3494	89		3583
PREMIUM	22460	2097		24557	38520	2623		41143
PRIMARY		207	10046	10253		434	12967	13401
TOTAL	26195	2419	10046	38660	44616	3213	12967	60796

REVENUES & EXPENDITURES

		Current Month	Year to Date (7 Month)
	Funding		
1	State Contribution	$ 14,592,564	$ 101,823,176
2	Employee Contribution	$ 8,080,124	$ 56,556,784
3	Other	$ 1,849,623	$ 8,703,450
4	Allocation of Reserves	$ 1,501,000	$ 10,507,000
	Total Funding	$ 26,023,310	$ 177,590,410
	4 weeks claims		
	Expenses		
	Medical Expenses		
5	Claims Expense	$ 14,172,661	$ 116,261,624
6	Claims IBNR	$ -	
7	Medical Administration Fees	$ 1,182,582	$ 8,538,554
8	Refunds	$ -	
9	Employee Assistance Program (EAP)	$ 54,172	$ 381,804
	Life Insurance	$ 78,033	$ 551,125
	Pharmacy Expenses		
11	RX Claims	$ 5,721,878	$ 47,314,305
12	RX IBNR	$ -	$ 600,000
13	RX Administration	$ 245,006	$ 858,565
14	Plan Administration	$ 878,218	$ 3,107,045
	Total Expenses	$ 22,332,549	$ 177,613,022
15	**Net Income/(Loss)**	$ 3,690,761	$ (22,611)

BALANCE SHEET

	Assets	
16	Bank Account	$ 6,004,727
17	State Treasury	$ 97,773,059
18	Due from Cafeteria Plan	$ 5,561,503
19	Due from PSE	$ -
20	Receivable from Provider	$ -
21	Accounts Receivable	$ 176,324
	Total Assets	$ 109,515,613
	Liabilities	
22	Accounts Payable	$ 803
23	Deferred Revenues	$ 3,780
24	Due to Cafeteria	$ 1,050
25	Due to PSE	$ 187,679
26	Due to Federal Government ($27 fee)	$ -
27	Health IBNR	$ 25,700,000
28	RX IBNR	$ 1,400,000
	Total Liabilities	$ 27,293,311
	Net Assets	$ 82,222,302
	Less Reserves Allocated	
29	Premiums for Plan Year 1/1/18 - 12/31/18 ($5,040,000 + $8,262,000 + $4,710,000)	$ (7,505,000)
30	Premiums for Plan Year 1/1/19 - 12/31/19 ($5,508,000 + $2,826,000)	$ (8,334,000)
31	Premiums for Plan Year 1/1/20 - 12/31/20 ($1,884,000)	$ (1,884,000)
32	Catastrophic Reserve (2017 $20,600,000)	$ (30,600,000)
33	**Net Assets Available**	$ 33,899,302
34		
35		

Arkansas State Employees (ASE) Financials - January 1, 2017 through July 31, 2017

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	1574	44		**1618**	2492	61		**2553**
CLASSIC	1969	72		**2041**	3251	95		**3346**
PREMIUM	22528	2168		**24696**	38819	2739		**41558**
PRIMARY		212	9674	**9886**		441	12606	**13047**
TOTAL	**26071**	**2496**	**9674**	**38241**	**44562**	**3336**	**12606**	**60504**

REVENUES & EXPENDITURES

		Current Month	Year to Date (7 Months)
	Funding		
1	State Contribution	$ 14,568,288	$ 102,499,348
2	Employee Contribution	$ 8,089,927	$ 56,760,523
3	Other	$ 176,113	$ 10,135,172
4	Allocation of Reserves	$ 1,777,500	$ 12,442,500
	Total Funding	$ 24,611,828	$ 181,837,543
	Expenses		
	Medical Expenses		
5	Claims Expense	$ 7,867,476	$ 92,035,186
6	Claims IBNR	$ -	$ (2,300,000)
7	Medical Administration Fees	$ 1,049,256	$ 7,854,895
8	Refunds	$ -	$ 3,435
9	Employee Assistance Program (EAP)	$ 54,863	$ 384,228
	Life Insurance	$ 79,063	$ 553,340
	Pharmacy Expenses		
11	RX Claims	$ 4,599,562	$ 44,207,029
12	RX IBNR	$ -	$ 300,000
13	RX Administration	$ 121,420	$ 810,443
14	Plan Administration	$ 636,898	$ 2,915,339
	Total Expenses	$ 14,408,538	$ 146,763,896
15	**Net Income/(Loss)**	$ 10,203,290	$ 35,073,648

BALANCE SHEET

	Assets	
16	Bank Account	$ 17,372,081
17	State Treasury	$ 96,177,336
18	Due from Cafeteria Plan	$ 5,561,503
19	Due from PSE	$ -
20	Receivable from Provider	$ -
21	Accounts Receivable	$ 2,535,109
	Total Assets	$ 121,646,029
	Liabilities	
22	Accounts Payable	$ 3,143
23	Deferred Revenues	$ 3,780
24	Due to Cafeteria	$ 181
25	Due to PSE	$ 496
26	Due to Federal Government ($27 fee)	$ -
27	Health IBNR	$ 25,700,000
28	RX IBNR	$ 2,000,000
	Total Liabilities	$ 27,707,600
	Net Assets	$ 93,938,429
	Less Reserves Allocated	
29	Premiums for Plan Year 1/1/17 - 12/31/17 ($7,560,000 + $13,770,000)	$ (8,887,500)
30	Premiums for Plan Year 1/1/18 - 12/31/18 ($5,040,000 + $8,262,000 + $4,710,000)	$ (18,012,000)
31	Premiums for Plan Year 1/1/19 - 12/31/19 ($5,508,000 + $2,826,000)	$ (8,334,000)
32	Premiums for Plan Year 1/1/20 - 12/31/20 ($1,884,000)	$ (1,884,000)
33	Catastrophic Reserve (2017 $20,600,000)	$ (20,600,000)
34	**Net Assets Available**	$ 36,220,929

35 Fifth Week of Claims $

Public School Employees (PSE) Financials - January 1, 2018 through July 31, 2018

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	4078	498		4576		6190	652		6842
CLASSIC	23334	2319		25653		44681	2751		47432
PREMIUM	16581	598		17179		22143	644		22787
PRIMARY		65	12604	12669			132	13706	13838
TOTAL	43993	3480	12604	60077		73014	4179	13706	90899

REVENUES & EXPENDITURES

		Current Month	Year to Date (7 Month)
	Funding		
1	Per Participating Employee Funding (PPE Funding)	$ 8,067,520	$ 58,354,784
2	Employee Contribution	$ 9,708,339	$ 68,290,148
3	Department of Education $35,000,000 & $15,000,000 & Other Funding	$ 8,333,333	$ 61,433,333
4	Other	$ 912,829	$ 7,852,341
5	Allocation of Reserves	$ 1,883,333	$ 13,183,331
	Total Funding	$ 28,905,354	$ 209,113,938
	Expenses		
	Medical Expenses		
6	Claims Expense	$ 18,054,892	$ 129,558,350
7	Claims IBNR	$ -	$ 2,300,000
8	Medical Administration Fees	$ 1,821,097	$ 13,139,048
9	Refunds	$ -	
10	Employee Assistance Program (EAP)	$ 77,110	$ 556,935
	Pharmacy Expenses		
11	RX Claims	$ 4,367,244	$ 31,304,783
12	RX IBNR	$ -	$ (400,000)
13	RX Administration	$ 187,396	$ 1,331,236
14	Plan Administration	$ 887,257	$ 3,335,009
	Total Expenses	$ 25,394,996	$ 181,125,362
15	Less DOE Allocation		$ (18,100,000)
16	**Net Income/(Loss)**	$ 3,510,357	$ 9,888,576

BALANCE SHEET

	Assets	
17	Bank Account	$ 33,577,155
18	State Treasury	$ 141,695,600
19	Receivable from Provider	$ -
20	Accounts Receivable	$ 3,515,655
21	Due from ASE	$ 187,679
	Total Assets	$ 178,976,088
	Liabilities	
22	Accounts Payable	
23	Due to ASE	
24	Deferred Revenues	
25	Due to Federal Government ($27 fee)	
26	Health IBNR	$ 28,000,000
27	RX IBNR	$ 1,000,000
	Total Liabilities	$ 29,000,000
28	**Net Assets**	$ 149,976,088
	Less Reserves Allocated	
29		
30	Premiums for Plan Year 1/1/18 - 12/31/18 ($3,840,000 + $660,000+18,100,000 DOE)	$ (11,300,002)
31	Premiums for Plan Year 1/1/19 - 12/31/19 ($396,000)	$ (396,000)
32	Premiums for Plan Year 1/1/20 - 12/31/20 ($264,000)	$ (264,000)
33	Premium Assistance (FICA Savings)	$ (3,651,819)
34	Catastrophic Reserve (2017 $58,500,000)	$ (58,500,000)
35	**Net Assets Available**	$ 75,864,267
36		

Public School Employees (PSE) Financials - January 1, 2017 through July 31, 2017

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	3726	441		**4167**	5623	573		**6196**
CLASSIC	22101	2232		**24333**	41903	2681		**44584**
PREMIUM	17486	784		**18270**	23057	842		**23899**
PRIMARY		68	11883	**11951**		137	12953	**13090**
TOTAL	**43313**	**3525**	**11883**	**58721**	**70583**	**4233**	**12953**	**87769**

REVENUES & EXPENDITURES

		Current Month	Year to Date (7 Months)
	Funding		
1	Per Participating Employee Funding (PPE Funding)	$ 7,905,754	$ 57,262,677
2	Employee Contribution	$ 9,622,605	$ 67,604,114
3	Department of Education $35,000,000 & $15,000,000 & Other Funding	$ 8,333,333	$ 49,842,424
4	Other	$ 677,692	$ 5,379,043
5	Allocation of Reserves	$ 3,792,121	$ 24,899,394
	Total Funding	$ 30,331,506	$ 204,987,651
	Expenses		
	Medical Expenses		
6	Claims Expense	$ 10,632,795	$ 107,054,365
7	Claims IBNR	$ -	$ (4,300,000)
8	Medical Administration Fees	$ 1,638,815	$ 11,948,971
9	Refunds	$ -	$ -
10	Employee Assistance Program (EAP)	$ 75,942	$ 547,275
	Pharmacy Expenses		
11	RX Claims	$ 3,123,136	$ 28,257,595
12	RX IBNR	$ -	$ 300,000
13	RX Administration	$ 182,001	$ 1,226,381
14	Plan Administration	$ 717,216	$ 3,220,180
	Total Expenses	$ 16,369,906	$ 148,254,767
15	Less DOE Allocation		$ (18,100,000)
16	**Net Income/(Loss)**	$ 13,961,600	$ 38,632,885

BALANCE SHEET

	Assets	
17	Bank Account	$ 19,971,839
18	State Treasury	$ 139,383,032
19	Receivable from Provider	$ -
20	Accounts Receivable	$ 4,806,426
21	Due from ASE	$ 496
	Total Assets	$ 164,161,794
	Liabilities	
22	Accounts Payable	$ 1,199
23	Due to ASE	$ -
24	Deferred Revenues	$ -
25	Due to Federal Government ($27 fee)	$ -
26	Health IBNR	$ 25,700,000
27	RX IBNR	$ 1,400,000
	Total Liabilities	$ 27,101,199
28	**Net Assets**	$ 137,060,595
	Less Reserves Allocated	
29	Premiums for Plan Year 1/1/17 - 12/31/17 ($5,760,000+$20,000,000 + $18,100,000 DOE)	$ (18,960,606)
30	Premiums for Plan Year 1/1/18 - 12/31/18 ($3,840,000 + $660,000)	$ (4,500,000)
31	Premiums for Plan Year 1/1/19 - 12/31/19 ($396,000)	$ (396,000)
32	Premiums for Plan Year 1/1/20 - 12/31/20 ($264,000)	$ (264,000)
33	Premium Assistance (FICA Savings)	$ (3,602,283)
34	Catastrophic Reserve (2017 $40,500,000)	$ (40,500,000)
35	**Net Assets Available**	$ 68,837,706
36	Fifth Week of Claims $	

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

The following report resulted from a meeting of the Benefits Sub-Committee on August 10, 2018, with Claudia Moran presiding.

Topics Discussed:

- Approval of Minutes
- Choosing Wisely Update/Cost Drivers
- Naturally Slim Update
- Kannact
- Director's Report

Choosing Wisely Update/Cost Drivers: Izzy Montgomery &Mike Motley, ACHI
Montgomery and Motley presented preliminary results presented, including some of the most common wasteful, low-value services, and when looking at the EBD members enrolled in 2016, 65,135 had at least one of these low value services. Motley explained that over the next few months, they would like to break down these services maybe two at a time.

Naturally Slim: Austin Wilcox, VP of Business/Product Development
Wilcox gave an overview of Naturally Slim, the digital behavioral based program that has proved to prevent Diabetes and reverse Metabolic Syndrome for the last 12 years. The pilot program launched for ASE/PSE with a total of 2,400 in the program, and 243 never started the program. Additionally, he discussed what was next for Naturally Slim with Phase II, III, IV and V, as well as testimonials from members.

MOTION by Altemus

> The motion is to roll out Phase II, limiting 3,000 PSE and 3,000 ASE and include non-Medicare retirees to have the option of enrolling and start in September.

Kissire seconded. All in favor.

Motion approved.

Kannact: Krishna Rao, CEO & Mike Pohl, Dir of Marketing

Allie Barker, EBD RN, gave a brief introduction for Kannact, and she went over numbers for the EBD Diabetes population. Kannact gave an overview of their patient centered model that is designed and proven to engage participants. They have behavior change programs for chronic and pre-chronic conditions. In this program, you coordinate with a dedicated coach to create a personalized care plan.

MOTION

All current active participants in the diabetic program now will be transitioned to Kannact, any of the individuals that do not transition will be responsible for their own supplies, and any newly identified people will be offered an opportunity to go into the program.

All were in favor of this recommendation to the Board.

Motion Approved.

Director's Report: Chris Howlett, EBD Executive Director

EBD Director Chris Howlett reported that he will have new Catapult information next month. We will have more information for you on telemedicine. We will also have new contract information for you next month.

Summary of ACHI Presentation to EBD Quality of Care Subcommittee August 14, 2018 Meeting

The following items were discussed during last Tuesday's Quality of Care Subcommittee meeting:

- Mike Motley and Izzy Montgomery from the Arkansas Center for Health Improvement (ACHI) provided report on Choosing Wisely Initiative/framework, preliminary analysis of the eight most common low-value healthcare services provided to EBD members, and discussed next steps for further assessment of low-value services/opportunities for improvement within plan
- Background on Choosing Wisely:
    - Aims to promote conversations between clinicians and patients by helping patients choose care that is:
        - Supported by evidence
        - Not duplicative of other tests or procedures already received
        - Free from harm
        - Truly necessary
    - Recommendations come from provider specialty societies; Since 2012, over 80 specialty societies have published over 550 recommendations
- Analyses:
    - ACHI utilized a tool which leverages Choosing Wisely recommendations, US Preventive Services Task Force recommendations, etc. to identify low-value services and spending on claims data
    - For EBD, we examined 42 common treatments deemed by providers to be overused
    - Other states have also used this tool (Washington and Virginia)
- Findings within EBD Plan 2016:
    - Of the 42 measures assessed, 8 measures account for 82% of low-value service volume
    - These 8 measures represent at least 50% of the cost of low-value services
    - Among all EBD members enrolled in 2016, approximately 65,135 had at least one of these low-value services

8 Most Costly Low-Value Services by Volume (2016):

Low-Value Service	Number of Distinct Members with a Low-Value Service	Number of Low-Value Services
Don't prescribe oral antibiotics for members with upper URI or ear infection (acute sinusitis, URI, viral respiratory illness or acute otitis externa)	22,230	29,144
Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal	11,122	18,292
Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.	10,149	11,235
Don't order unnecessary cervical cancer screening (Pap smear and HPV test) in all women who have had adequate prior screening and are not otherwise at high risk for cervical cancer	10,130	10,238
Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease.	9,172	15,265
Don't obtain EKG, chest X rays or Pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery	3,428	6,372
Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.	2,201	2,343
Don't perform coronary angiography in patients without cardiac symptoms unless high-risk markers present.	1,023	1,093

- Next steps:
    - Over next few months, further assessment of each of these services will be presented and discussed in Quality of Care Subcommittee meetings
    - Will discuss possible recommendations, which may include the following:
        - Tailored member education
        - Provider-level education
        - Review of prior authorization criteria or medical utilization management practices
        - Provider-level assessment of variation
        - Review of value-based payment models

1. **Introduction**

2. **Naturally Slim & Kannact**

We've heard impressive results from Naturally Slim and how the program helped to decrease the risk of developing metabolic syndrome. A preventative program like NS, if approved by the board, will continue to improve the overall health of our members by working to decrease the mentioned risk factors.. There is certainly an ROI that could be shown to evaluate plan savings by preventing the progression or development of metabolic syndrome in members. However, there is still a large subset of our population that are desperate for a more high touch/ hands on, long term management of chronic disease and conditions.

3. **ACHI** reported back in May that 11% of our member population has a diagnosis of Type 2 Diabetes. (+23% who are unaware/undiagnosed which would total to an additional 30,000 members affected by T2DM)

- 8,295 T2DM without complications
- 6,695 T2DM with complications

These 15,000 members cost the plan $110 million in medical claims from 2016-2017

**in addition to these costs; our current UM provider is managing a group who receive free supplies to the member for participating in our voluntary diabetes management program. These costs add up to:

From January 1-July 31 of 2018

- $266,708.31 on test strips
- $184,172.89 on needles and pen tips
- $29,575.52 on syringes
- $15,162.68 on lancets

If we assume this trend to hold true, we are on track to spend near 1 million dollars on Diabetic supplies.

These are the facts and dollar amounts that lead our leadership team to request information on programs that can provide resources and tools to not only improve the health and overall well being of our members but also to prevent unnecessary claims cost. After using a very specific set of criteria in our search, Kannact stood out in many aspects. To mention a few, they are the only company that can provide raw, Clinical data to the member, provider and EBD in real time. They use a team of MD's, pharmacists, dietitians, psychologists, and nurse coaches to provide a holistic care approach to bridge the gap for these members between physician visits & they provide all of the supplies mentioned above to the members at no additional cost to the plan.

Should the plan choose to transition these members from our current program to Kannact, we could see initial cost savings of $495,617 on 6 months / $1 million annually for supplies alone. As time passes, EBD should begin to see a decrease in costs related to multiple provider visits, ER costs, dialysis, inpatient hospitalizations, and other complications/ effects of an un-managed disease state. Kannact also has a targeted approach to identify and engage pre-diabetics which works to de-escalate or prevent the occurrence of T2DM.

I hope this information serves as adequate detail on the instant cost savings a company like Kannact would bring to our plan while providing a proactive program to this underserved population.

Introduction: CEO Krishna Rao & Director of Marketing, Mike Pohl

Patient Centered Care –
Designed and Proven to ***Engage*** *Participants*

Behavior Change *Programs for Chronic and Pre-Chronic Conditions*

Key Elements Of Kannact Patient Centered Care

Convenient access

Focus on wellness and disease prevention

Performance Improvement

Coordinated care with dedicated coach

Personalized care plans

Support and resources for self-care

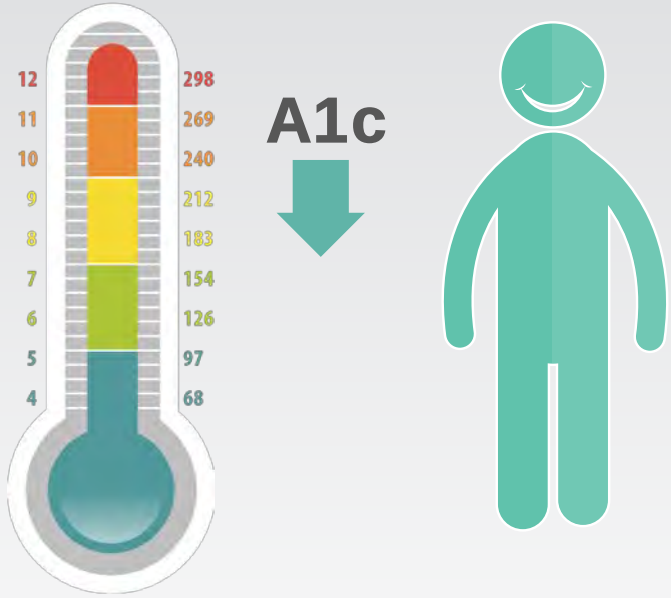
Long Term Results Prove Kannact Patient Centered Method Works

Client Description

Self-Insured Employer:

- **Large City in Texas**
- **Business with 10K employees**
- **80%** were engaged and adherent
- Significantly reduced blood glucose in **90%** of the population!

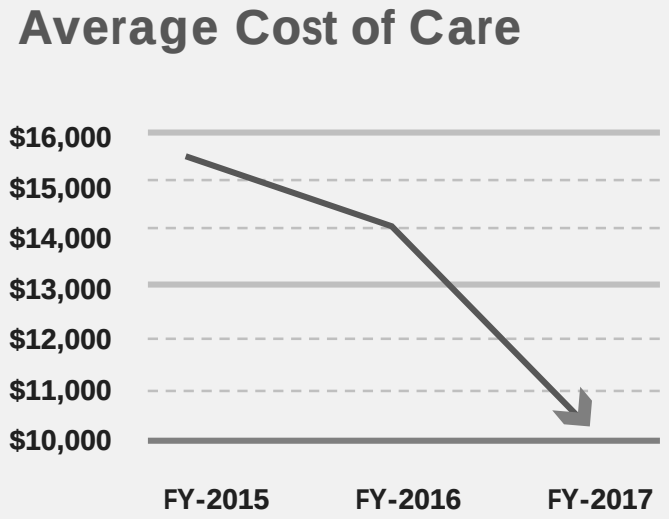
Participants Experience



Outcomes for Diabetes patients **improved 37%**

Glucose levels dropped 35 mg/dl or **HbA1c improved by 1 point**

Impressive Client Results



Cost dropped $15.2K to $10.3K **(32%)**

Convenient Access

Easy Online Enrollment

- Customized State of Arkansas landing page
- Enroll in under 5 minutes
- Support staff available on email and phone
- Engaging content, videos and emails to introduce the program

Supplies Shipped Directly to Home

- Tracked and delivered automatically as needed
- Unlimited supply
- No cost to participant

Communicate on your schedule

- 24 x 7 Support
- Multiple different methods (secure text, phone, email)
- System and coaches in English and Spanish
- Access all program data on smartphone

Focus On Wellness & Disease Prevention

- Diagnosis/Procedure Codes
- Hospitalization/ER visits

MEDICAL CLAIMS HISTORY

- Medication Possession Ratio
- Medication Compliance

PHARMACY CLAIMS DATA

- Weight/Height (BMI)
- Blood Pressure
- Blood Glucose

HEALTH DATA

- Nutrition Management
- Appropriate Activity
- Family & Support System
- Level of Disease Knowledge
- Level of Sleep & Stress

BEHAVIORAL ASSESSMENT DATA

Data

- Medical Claims
- Rx Claims
- Biometrics
- Health and Behavior Risk Assessment

PARTICPANT

Profile

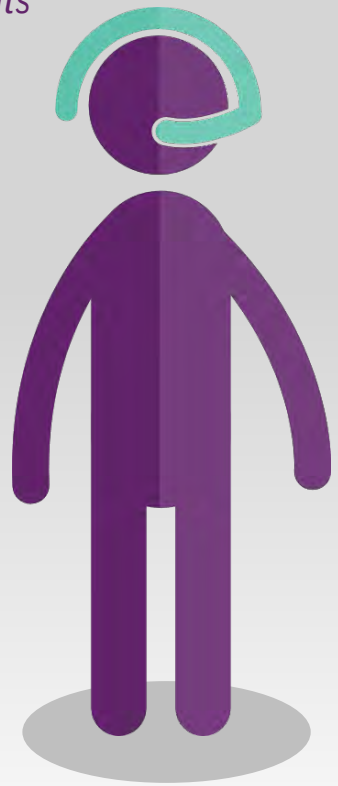
- DIABETES | HYPERTENSION
- 85% adherent to oral diabetic | +6 Months non-adherence to hypertension Rx
- A1C 7.5 | BMI 34 | BP 138/93
- High-stress work environment | Average sleep 6 hours/night

PERSONALIZED CARE PLANS

Personalized plan that fits the individual's circumstances created with achievable goals

Plan and goals are monitored on the platform, and updated between the coach and participant

Specific alert ranges and schedule for biometric testing and medication compliance



Guided by the coach and medical team

Support & Resources for Self Care

Ability to take measurements anytime anywhere – automatically logs, charts, and reports data

Participants learn how the biometric data is tied to their behaviors and habits

Accurate data allows the coaching team to adjust guidance in real time

Platform tracks wearable activity data from any device

Learning modules are adaptable to the participant's style of learning, and current knowledge level

Coordinated Care with Dedicated Coach

Coach conducts Health and Behavior Risk Assessment and is guided by pharmacists and clinicians

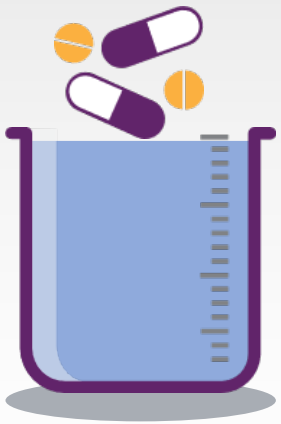
Personal coach creates relationship, accountability *and helps build* ***new skills*** *in dealing with* ***:***

- **Disease knowledge**
- **Lifestyle management**
- **Home biometric testing**
- **Managing personal plan & goals**

Coordinated Care – Medication Compliance

Medical and Pharmacy claims provide history, and pharmacists guide coach to provide medication compliance support

For every 100 Prescriptions written

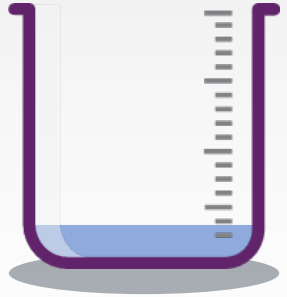


50-70
Go to a pharmacy

48-66
Come out of the pharmacy

25-30
Are taken properly

15-20
Are refilled As prescribed



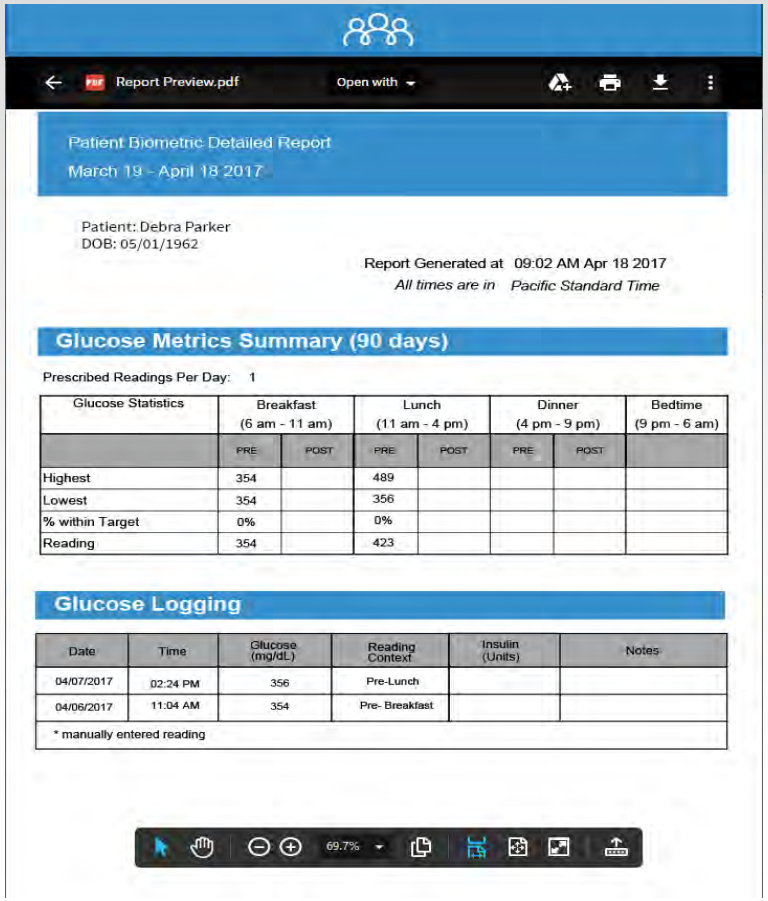
Source: National Association of Chain Drug Stores, Pharmacies. Improving Health, Reducing Costs, July 2010. Based on IMS Health data

Coordinated Care – Family & Social Support

Participants can share portal access to the friends and family that will help them stay on track by receiving health related alerts & notifications

Performance Improvement

On-Demand Detailed and Summary Reports to Physicians



Report Preview.pdf Open with

Patient Biometric Detailed Report
March 19 - April 18 2017

Patient: Debra Parker
DOB: 05/01/1962

Report Generated at 09:02 AM Apr 18 2017
All times are in Pacific Standard Time

Glucose Metrics Summary (90 days)

Prescribed Readings Per Day: 1

Glucose Statistics	Breakfast (6 am - 11 am)		Lunch (11 am - 4 pm)		Dinner (4 pm - 9 pm)		Bedtime (9 pm - 6 am)
	PRE	POST	PRE	POST	PRE	POST	
Highest	354		489				
Lowest	354		356				
% within Target	0%		0%				
Reading	354		423				

Glucose Logging

Date	Time	Glucose (mg/dL)	Reading Context	Insulin (Units)	Notes
04/07/2017	02:24 PM	356	Pre-Lunch		
04/06/2017	11:04 AM	354	Pre- Breakfast		

* manually entered reading

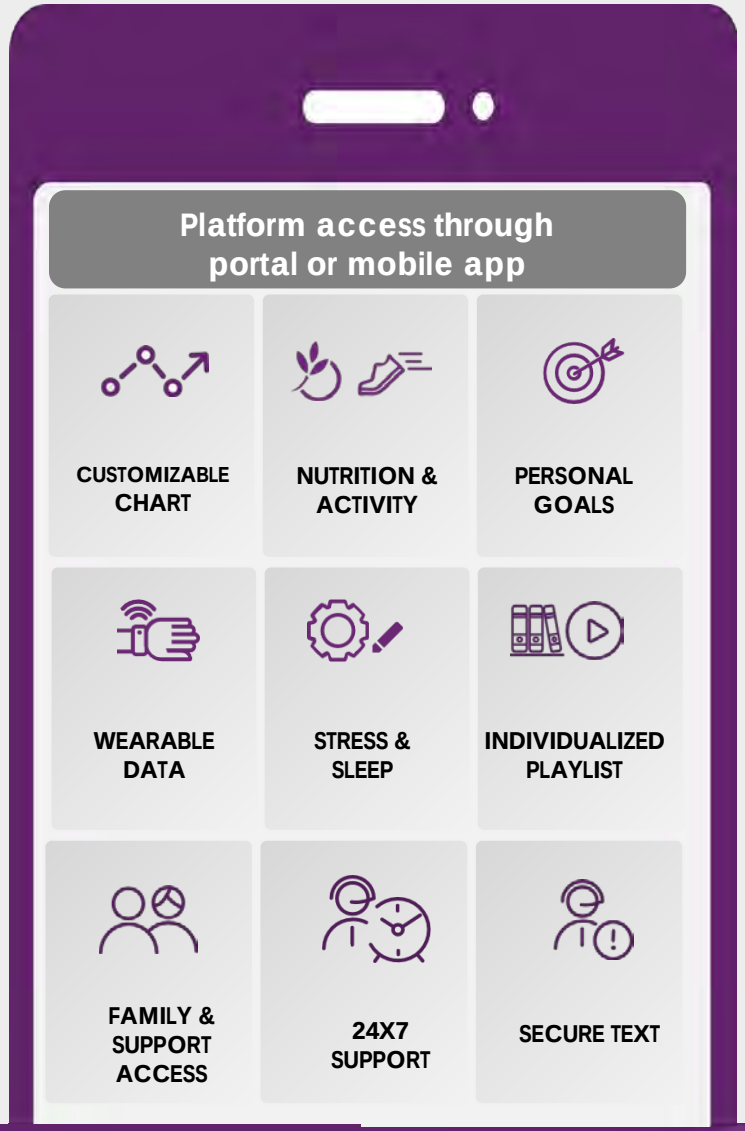
69.7%

Population Reporting Back to the Health Plan

- Initial Enrollment
- Month 3 – Early Program Engagement
- Month 6 – Phase 1 Review
  - Engagement
  - Testimonials and satisfaction
  - Early outcomes and trends
- Month 9 and ongoing quarterly
  - Health outcomes

PRE-CHRONIC PROGRAM

- **People with Pre-Diabetes** are at higher risk for diabetes, cardiovascular diseases, and other chronic conditions
- Members are identified using a combination of **claims data, wellness data, and HRA**
- Lifestyle change with an emphasis on activity and nutrition
- Self-monitoring to create self-awareness about how behaviors are directly effecting health scores



Coordinate With Other Programs

*The Kannact platform **complements other programs** with a holistic approach to chronic care. Our focus will be coordinating in these areas with other State-implemented programs. The Kannact coach works directly with each individual to identify barriers and motivate change.*

Mental Health

Wellness

Nutrition management

Kannact™

A BETTER WAY TO CARE

Transformational. Personal.

Over **80%** Engagement

Family/Friends Social Circle Support

Medical/Pharmacy/Data review and guidance

Outcome reporting

1 full point drop in A1C

UNLIMITED SUPPLIES FOR DIABETES & CARDIO

Customizable For client needs

Mobile platform is scalable & easy to use

$90 cost savings PPPM over 2 years

MEDICAL CLAIM In network billing

ZERO Implementation fees

Tailored Marketing Enrollment Campaign

Dedicated personal COACH

Implementation

Transition Schedule

Week 1

Program Setup

- In-Network Billing
- List of Members
- Claims data
- Communication materials

Enrollment

- Phone call and online enrollment

Weeks 2 - 4

Engage with coach

- Claims Data Analysis
- Assess risk category
- Create individual plan
- Ship supplies

Ongoing

Monitor and adjust for success

- Biometric monitoring
- Continually evaluate
- Intervene as appropriate

Customized Marketing and Communication

Claims Billing set-up Details

The following is the detailed information that we provide to the Claims Administrator (CA) to set up the In-network billing. We provide backup codes and modifiers as needed for each CA's specific system needs.

- CPT code for Chronic Care Program is S0317
  - There are 3 levels of service - each would use a different modifier according to the price of service.
    - Diabetes and Cardiovascular $79
    - Diabetes $69
    - Cardiovascular $59
- CPT code for Pre-Diabetes program is 0488T
  - No modifier – billed at $49
- Benefit level: pay at 100% with NO employee deductible/copay/co-share
- Benefit plan year max is 12 claims
- ICD10 / Diagnosis codes –
  - E13.00 – Diabetes
  - I99.9- Cardiovascular
  - R73.00 – Pre-Diabetes

Thank You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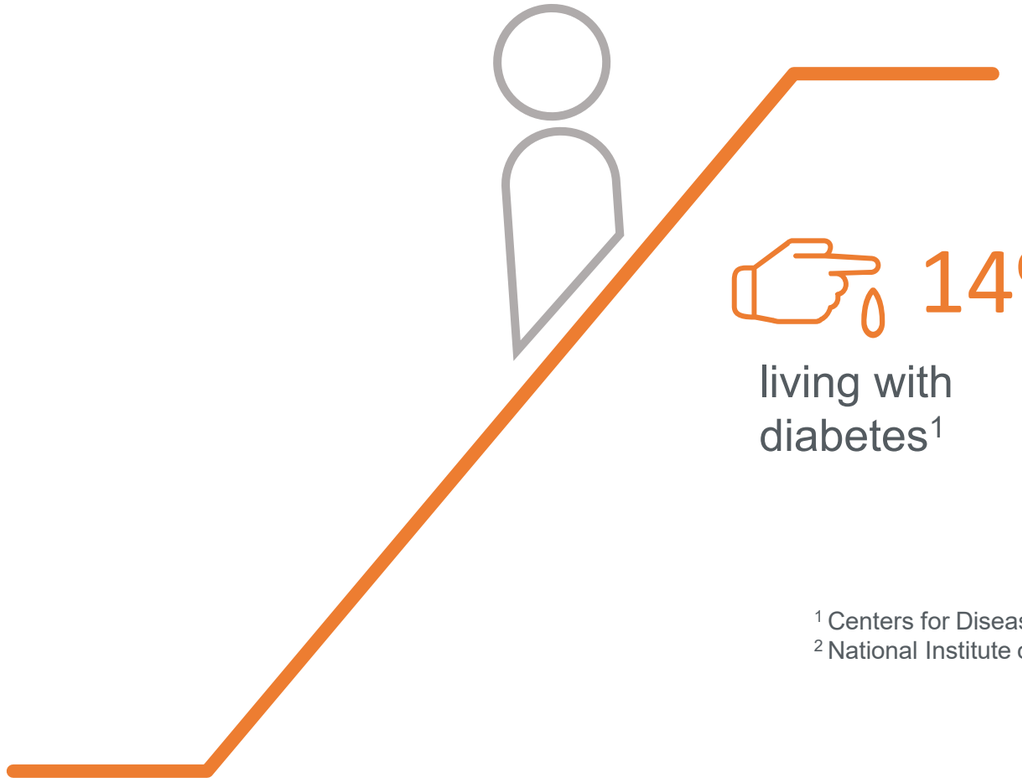
offered by acaphealth
Measurably slowing the production of disease
for ARBenefits.

Arkansas's Metabolic Escalator™



14%
living with diabetes[1]

37%
living with pre-diabetes[1]

70%
of adults overweight or obese[2]

[1] Centers for Disease Control and Prevention
[2] National Institute of Health

... weight loss of as little as 3% to 5% is likely to result in clinically meaningful reductions in [metabolic disease risk]...[1]

JAMA
The Journal of the American Medical Association

Percentage of body weight loss

3-5%	5-7%	7-9%	≥9%
41.2%	49.8%	59.2%	70.0%

Metabolic syndrome reversal rate

NATURALLY SLIM®

Foundations® Report

Outcomes as of 8/7/18

State of Arkansas
ARBenefits PSE & ASE

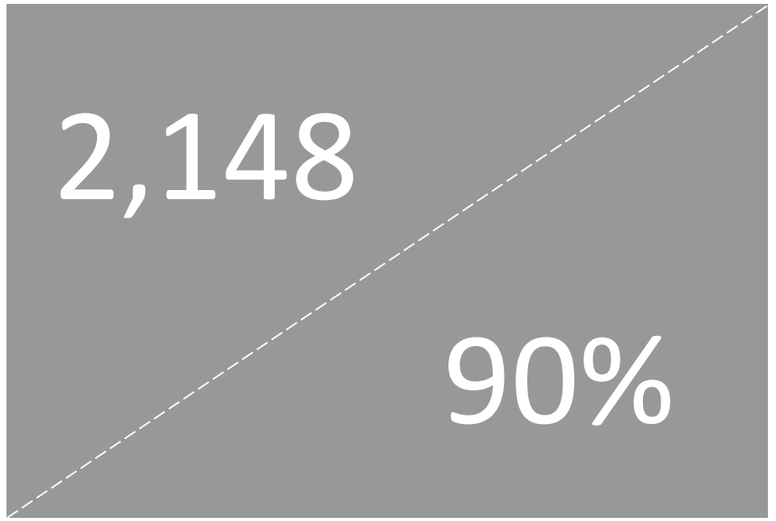
Program Start Date
05/28/2018

PARTICIPATION

Participation Overview

2,400

243



Accepted

Number of individuals that applied and were accepted.

Never Started

Number of individuals that were accepted but never started.

Started

Number of individuals that were accepted and started Week 1 of program.

Started
Demographic Highlights

48

35.7

91%
Women

9%
Men

Average Age

The average age of the U.S. Workforce is 41

Average BMI

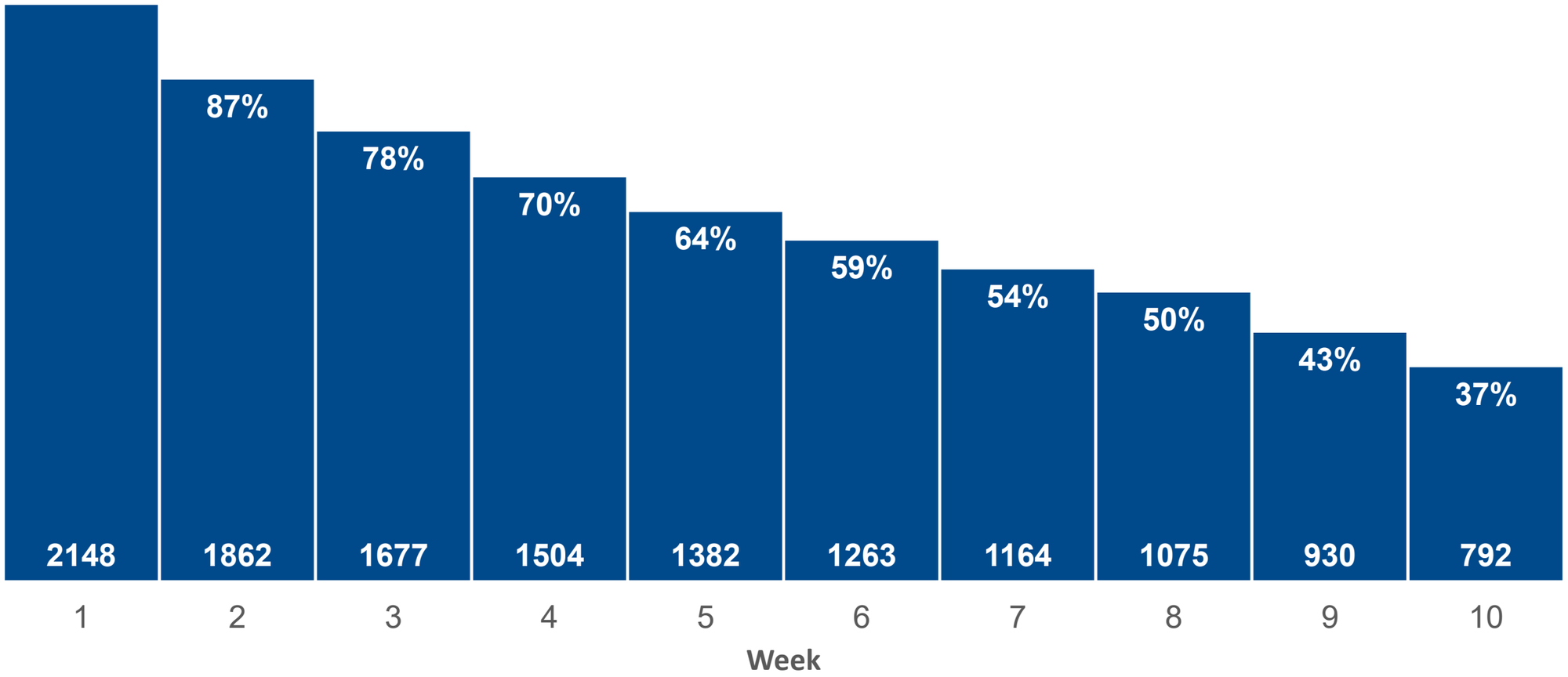
Normal: BMI 18.5 to < 25.0
Overweight: BMI 25.0 to < 30.0
Obese: BMI ≥ 30.0

Participants

On average, male participants lose more weight than female participants.

Participation Report

Participation in a Specific Week

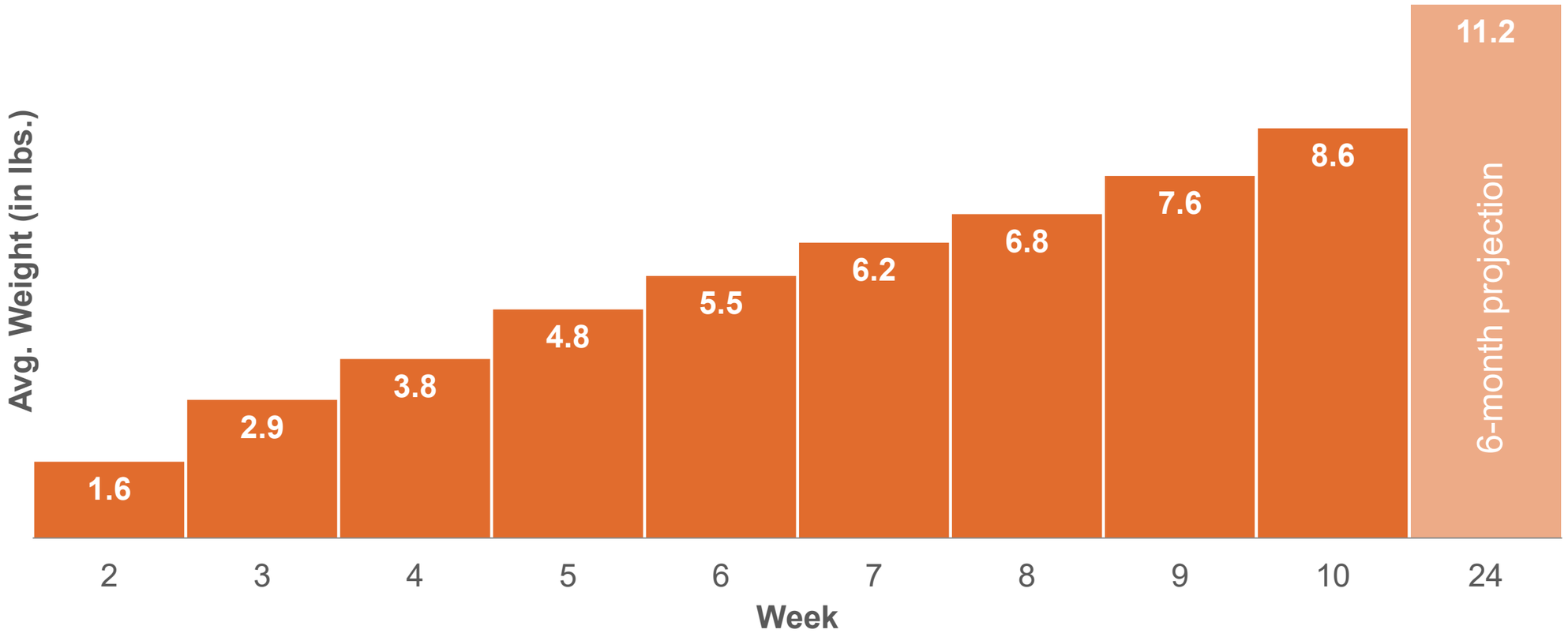


WEIGHT LOSS

Weight Loss by Week

For active participants

Total Weight Loss Greater Than 11,000 lbs.



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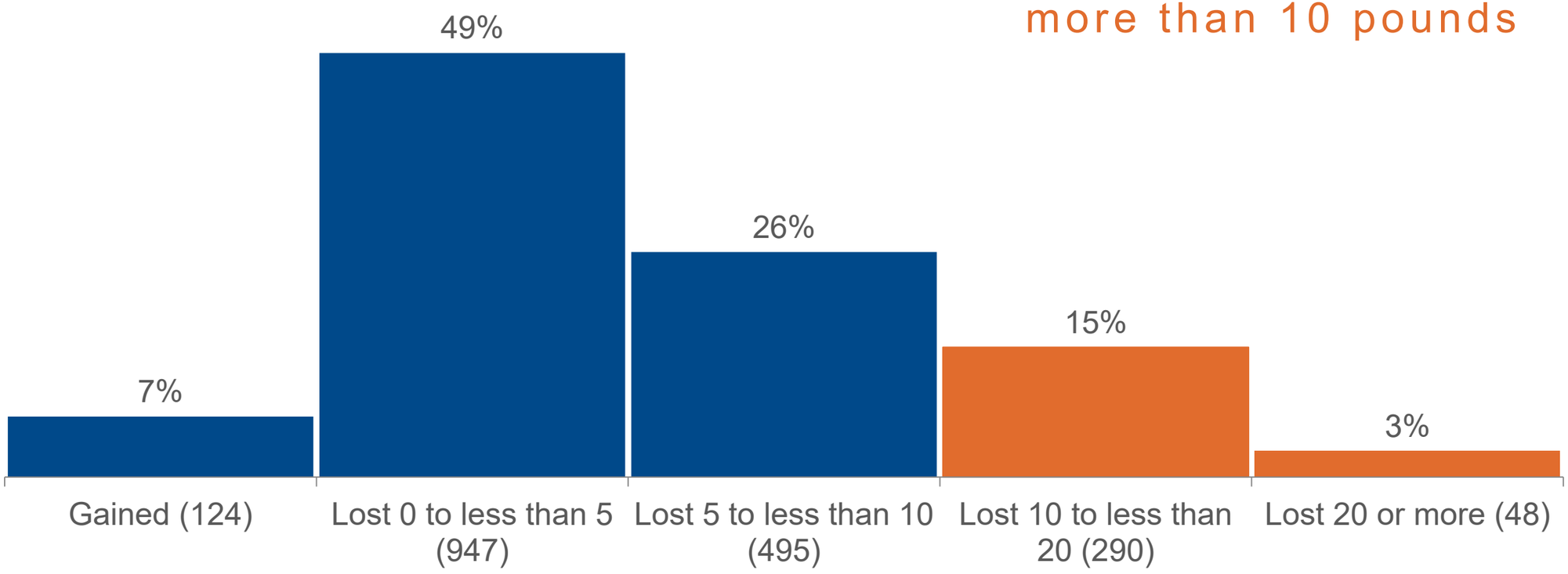
Weight Loss in Pounds

Percentage of total population with more than one weigh in

18% of individuals lost more than 10 pounds



N=1904

37% of individuals lowered their Diabetes risk.

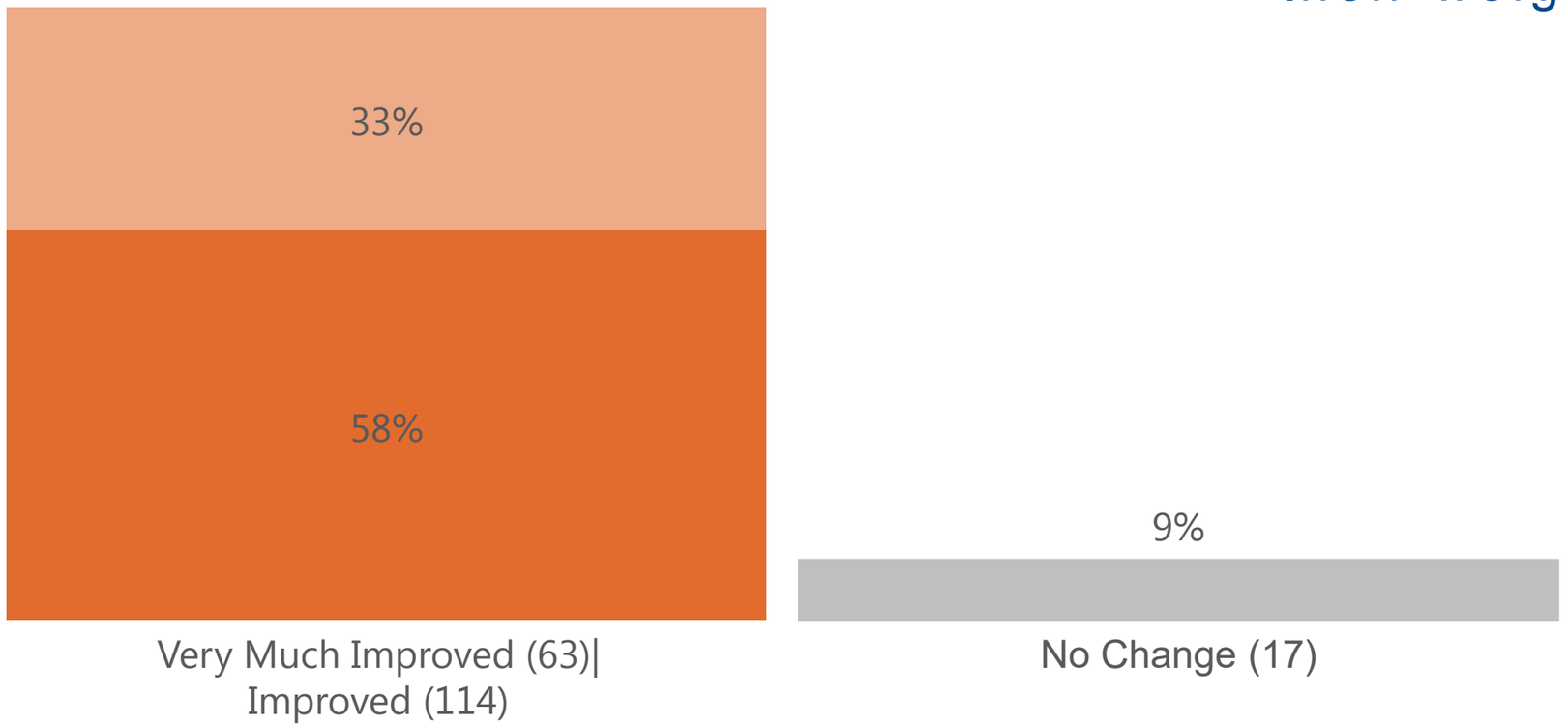
* Refer to “Federal Treatment Guidelines: How much weight loss is clinically significant?” slide in the glossary for further explanation

Post Foundations™ Quality of Life Survey

Feeling Weight is Out of Control

How has your feeling that your weight is “out of control” changed compared to before starting the Naturally Slim program?

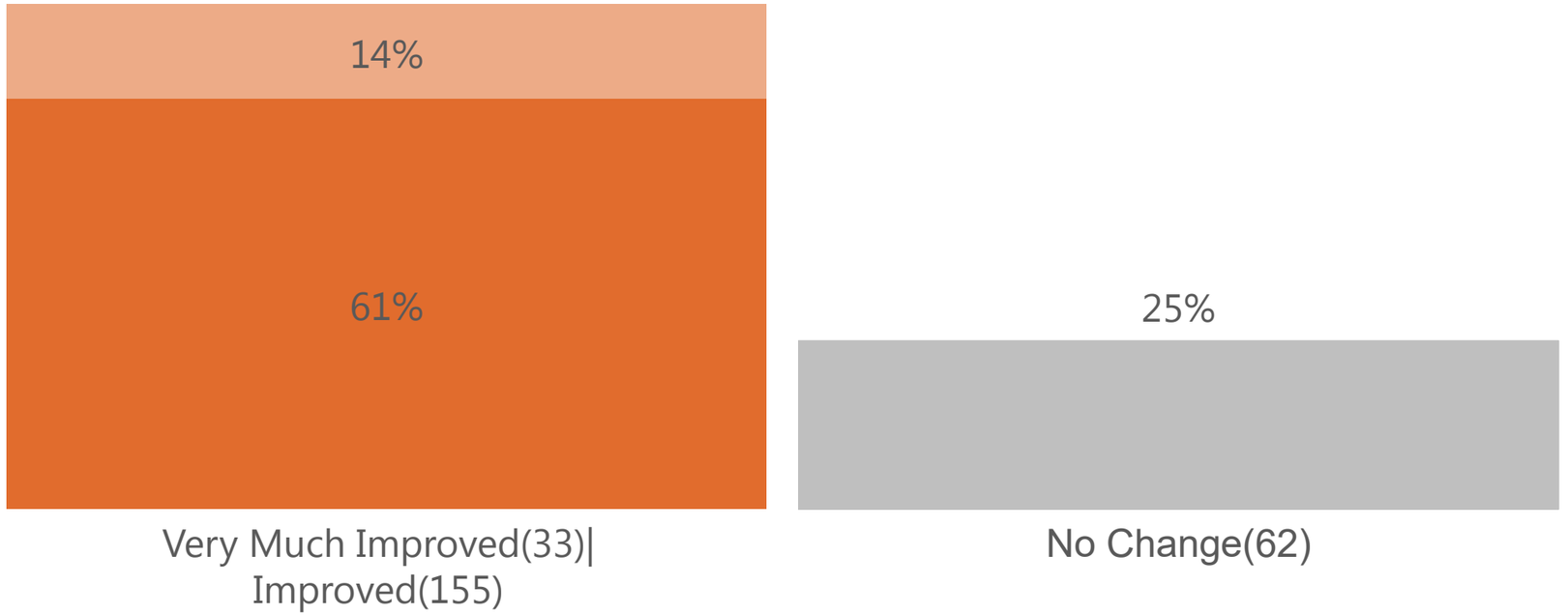
91% of individuals felt more in Control of their weight



Energy Level

How has your energy level changed compared to before starting the Naturally Slim program?

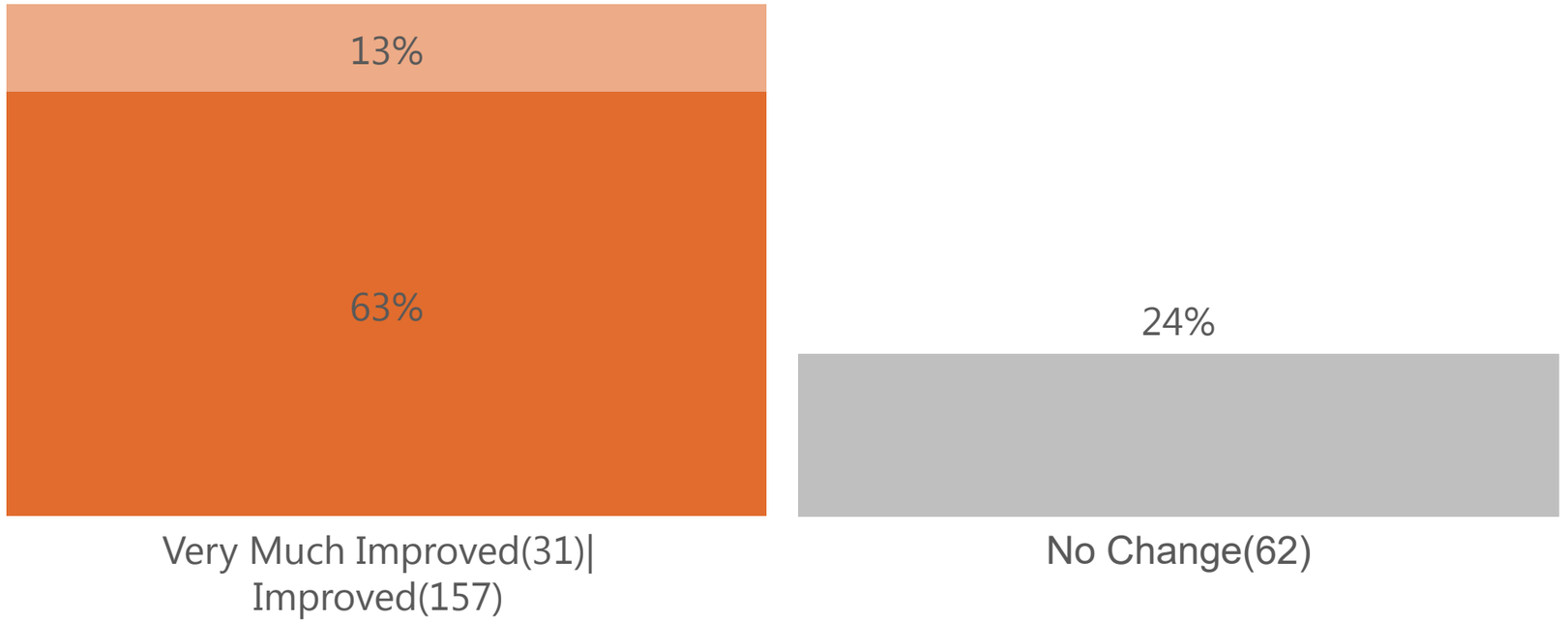
75% of individuals experienced a newfound burst of energy.



Self-Confidence

How has your self-confidence changed compared to before starting the Naturally Slim program?

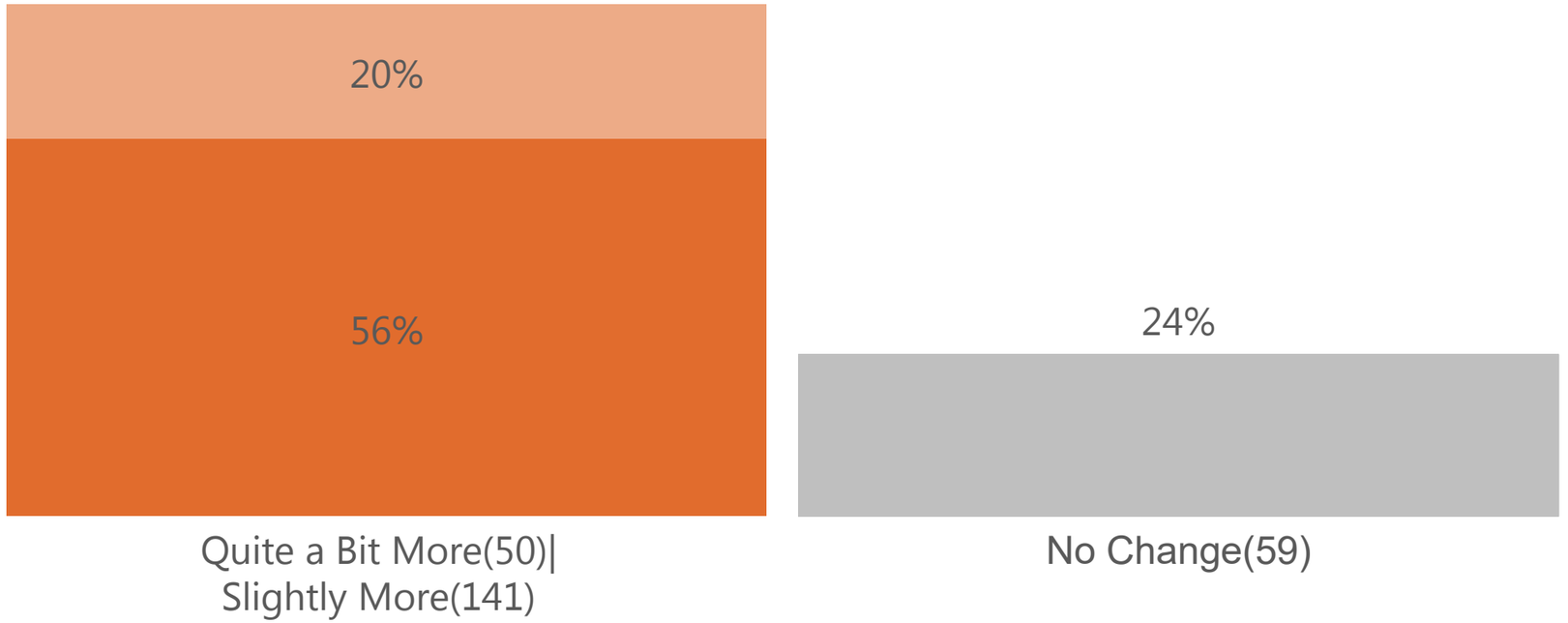
76% of individuals experienced a boost in confidence.



Physical Activity

How has your level of physical activity changed compared to before starting the Naturally Slim program?

76% of individuals increased their level of physical activity.



TESTIMONIALS

Thank you so much for all you do. This has been a life-changing experience and has given me skills for life! I'm so grateful. I'll never be the same!

-ARBenefits Participant

due to change in high blood pressure medication ringing in ears has decreased

-ARBenefits Participant

I think my Diabetes is better. I love this program and will continue to use it!

-ARBenefits Participant

I’m on cholesterol meds, but, at my recent insurance/employer health, it was so much lower I may ask my doctor if I can come off the meds.

-ARBenefits Participant

This was one of the best things I've been offered. I feel it has literally changed my life. I'm not where I want to be yet, but I met my initial goal and feel this is very sustainable. I would probably never have heard of the program had it not been for my employer.
-ARBenefits Participant

This is a great opportunity. I feel blessed that it was offered by my employer. I hope they offer it to more people who did not get the change to take advantage of it this time.

-ARBenefits Participant

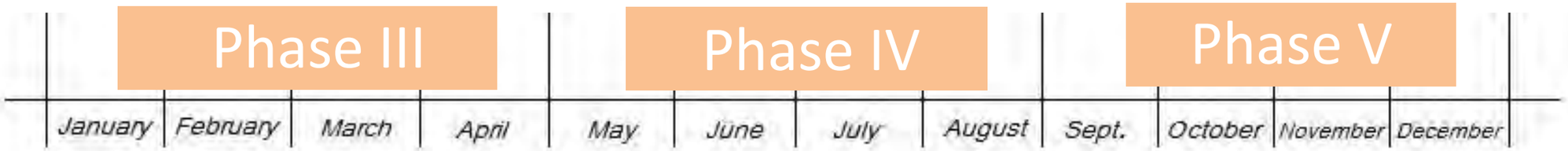
NEXT STEPS

What's next for ARBenefits?

With an estimated 70%+ of ARBenefits adults pre-diabetic, obese, and/or overweight, leveraging the momentum of the pilot success will be important in engaging those that need our help.

2018

2019

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