MISSOURI CONSOLIDATED HEALTH CARE PLAN
BOARD MEETING
JULY 26, 2018

Attending: Jim McAdams
Representative Kip Kendrick
Director Chlora Lindley-Myers (via conference call)
Linda Luebbering (via conference call)
Senator John Rizzo (via conference call)
Viola Schaefer
Director Randall Williams
Representative David Wood

Absent: Mark Langworthy
Daniel O'Neill
Senator David Sater

Others attending: Judith Muck, Executive Director; Kim Backes, Research Coordinator; Denise Chapel, Director of Vendor Relations; Shelley Farris, Director of Benefit Administration; Stacia Fischer, Chief Financial Officer; Tammy Flaugher, Senior Administrative Specialist; Bethany Goodin, Members Services Manager; Ryan Hobart, Multimedia Communications Manager; Garry Kornrumpf, Internal Auditor; Bruce Lowe, Chief Information Officer; Jennifer Stilabower, General Counsel; Julie Watson, Chief Population Health Officer; John Stahl, Willis Towers Watson; and visitors.

Mr. McAdams called the meeting to order.

There were no public comments.

Representative Wood made a motion to approve the open session minutes of the June 28, 2018, regular MCHCP Board of Trustees meeting. Representative Kendrick seconded. Motion passed unanimously.

Ms. Muck along with John Stahl, Senior Consulting Actuary with Willis Towers Watson (WTW) reviewed the 2019 plan design and premiums.

Mr. Stahl began with a thorough review of the pricing memorandum and described the assumptions and methodology WTW used to develop the 2019 preliminary premium equivalent rates. For the most part this method is very similar to what has been used in previous years. The primary difference is in plan design.

Mr. Stahl discussed MCHCP's medical and prescription drug claims including claim experience, adjustment for Incurred But Not Reported (IBNR) claims and assumptions for experience weighting and migration adjustment. Enrollment by month was provided by MCHCP and used to arrive at per capita historical claims cost.

The annual trend rates used to develop the 2019 preliminary rates include: actives at 6.5 percent, non-Medicare retirees at 6.5 percent, and prescription drugs (for all groups) at 13 percent.

Historical experience was adjusted to reflect any changes in plan design and vendor arrangements from the historical periods (CY 2016 and CY 2017) to the projection period (CY 2019). This included the prescription drug and medical changes as described in the memorandum. The pharmacy rebate and Employer Group Waiver Plan (EGWP) subsidies were also reviewed and appropriately reflected in the estimations. Rebate assumptions will be updated pending the final results from an ongoing pharmacy contract market check.

WTW developed premium equivalent rates for two options offered to State employees for 2019. Option 1 for active and non-Medicare retirees offer the PPO 750 Plan, PPO 1250 Plan and high deductible health plan (HDHP). Option 2 for active and non-Medicare retirees offer the PPO 1000 Plan, PPO 1250 Plan and HDHP. Medicare retirees will be offered the prescription drug only plan for both options.

Mr. Stahl briefly discussed the 2019 changes as outlined in the memorandum.

Mr. Stahl then reviewed the 2019 premium equivalent rate spreadsheet for Option 1 and Option 2. He briefly discussed the projected 2019 enrollment and tier ratio. Enrollment is weighted to the most recent experience. It is anticipated that individuals in the current PPO 300 Plan will migrate to the PPO 750 Plan, 40 percent of individuals in the current PPO 600 Plan will move to the PPO 750 Plan and 60 percent will migrate to the PPO 1250 Plan. It is also anticipated that individuals enrolled in the current HSA Plan will remain in that plan.

Director Williams joined the meeting.

Ms. Muck reviewed the impact to the member's portion of the premiums. The subsidy levels are based on the subsidy amount today for the PPO 600 Plan. HSA Plan would receive the same subsidy amount as they would today.

She first looked at Option 1 with the HSA Plan, PPO 1250 Plan and PPO 750 Plan. Using the same subsidy percentages as MCHCP uses today and applying them to the rates just presented, the monthly active employee contribution will go up slightly. More for the PPO 750 Plan than for the PPO 1250

Plan and HSA Plan. The examples assume full participation in the Partnership and Tobacco-Free Incentives.

Then Ms. Muck reviewed Option 2 with the HSA Plan, PPO 1250 Plan and PPO 1000 Plan. Again, using the same subsidy percentages as used today and applying them to the rates, the monthly active employee contribution will go up slightly as well. The amount of change in premium between 2018 and this scenario is very small. The examples again assume full participation in the Partnership and Tobacco-Free Incentives.

Ms. Muck then reviewed the change to retiree premiums. The example given is for a retiree with 26 or more years of service and receives the maximum subsidy. It also assumes the retiree takes advantage of all Partnership and Tobacco-Free Incentives. It also assumed the contribution strategy currently found in regulation. In summary, the retiree contribution strategy is as follows:

Years of creditable service times 2.5 percent. The resulting product is capped at 65 percent. That percentage is then used to calculate the amount of MCHCP subsidy by applying it today to the retiree-only PPO 600 Plan total premium with all incentives applied. For today, we will use the PPO 1250 Plan as the base plan and use the retiree-only PP0 1250 Plan total premium times the years of creditable service calculated percentage. The resulting product is what MCHCP will contribute toward the plan chosen by the retiree. The retiree will then pay the difference.

For dependent coverage, MCHCP uses a similar process for each rate tier selected by the retiree. However, the regulation caps the amount of retiree dependent contribution to the dollar amount MCHCP contributes for dependent portion of the premium for active employees.

It was noted that there was a slight error in the “Summary of Change in Retiree Contributions (Preliminary) FY19 Plan Scenarios – HSA Plan, PPO 1250 and PPO 750 or PPO 1000” document. The Retiree/Spouse with Medicare rates in 2018 for the PPO 600 Plan and PPO 300 Plan were transposed on both options shown with the PPO 750 Plan option and the PPO 1000 Plan options. The current 2018 rate for Retiree/Spouse with Medicare for the PPO 600 Plan is $526 instead of $484 and the PPO 300 Plan is $484 instead of $526. Therefore, the change in premium from 2018 to 2019 for the PPO 1250 Plan will actually drop by $50 as compared to the PPO 600 Plan and the PPO 750 Plan will drop by $27 as compared to the PPO 300 Plan.

Ms. Muck then looked at what the monthly change in premium will be to retirees under both scenarios using the rates calculated by WTW.

Ms. Muck reviewed the FY 2019 budget projections for Option 1 (HSA Plan, PPO 1250 Plan and PPO 750 Plan), with no changes to current plan

design, we were projecting a $94 million shortfall. The actuary has updated the shortfall incorporating changed plan design. Plan design changed the shortfall from $94 million to $74 million. If we deduct the $62.6 million in new funding from the State and estimated saving of $5.6 million from the pharmacy benefit manager (PBM) market check we have reduced the shortfall to approximately $6.6 million shortfall or approximately four days of claims.

She also reviewed the FY 2019 budget projections for Option 2 (HSA Plan, PPO 1250 Plan and PPO 1000 Plan) which left a final preliminary shortfall of approximately $3.9 million.

Ms. Muck has had communications with the Office of Administration, Budget and Planning office and they will support MCHCP should we have a need for a supplemental budget request to address a shortfall under either scenario if needed. This is dependent upon actual claim charges.

Ms. Muck then returned to plan design and reminded the board that the myVoice Panel groups (active and retiree) recommended the PPO 750 Plan as their desired plan choice over the PPO 1000 Plan. Whichever is chosen will also be offered to our Public Entity (PE) members.

Following discussion, the board then looked at the Medicare Advantage Plan options for State Medicare-primary retirees and Medicare-primary dependents of retirees. Active members/dependents with Medicare will not be eligible for Medicare Advantage as MCHCP is primary over Medicare nor will PE members be eligible. There are a very small number of active employee members who become Medicare-primary due to their End Stage Renal Disease diagnosis, but they will remain in the active category.

The Medicare Advantage Plan offered by UnitedHealthcare (UHC) is at $0 premium for all three design options. There is a PPO 250 Plan PPO 500 Plan and PPO 400 Plan. Ms. Muck reminded the board that this is very different from our Medicare coverage today. The plans here combine coverage of Medicare claims and MCHCP claims for the retiree – so for medical coverage they will only have coverage through UHC. She also highlighted some additional benefits that our Medicare members do not have today, that they will have under the UHC MA Plan. They will have copays on most services rather than a deductible. They will have care management services, SilverSneakers Fitness benefit, Nurse Line, and video doctor visits similar to what we will be offering to our non-Medicare members.

Each covered member is treated as an individual so there is not family coverage offered. A retiree could not purchase a plan like this on the private market. UHC has guaranteed all three options for three years at a $0 premium. At year four, there is not guaranteed pricing in place, so the premium would be negotiated at that time. MCHCP is recommending the board look at offering the

PPO 400 plan. The reason for this rather than the PPO 250 plan is that at the end of the three years, there could be a bigger cliff if there is a premium for coverage than with the PPO 400 Plan. A lower deductible generally encourages more utilization creating a larger premium for coverage as we have seen today in our coverage discussion for non-Medicare members. So while it would seem to make no difference in price to offer a lower deductible, it may create a problem in three years that would have been softened if we had gone for a higher deductible. Remember most services are not subject to deductible and coinsurance and are instead charged a copayment. The PPO 500 is also an option, but because the 400 and 500 are so close, we are recommending the PPO 400 Plan.

In addition, we are recommending we do not offer the Prescription Drug Only Plan in 2019. It was offered so members could find another alternative on the individual market, but with a $0 premium the Medicare Advantage plan that would not be available on the individual market and only 41 retiree members who are enrolled in this Prescription Drug Only Plan, there is no need to include this type of plan in the retiree offerings.

Non-Medicare retirees will also be allowed to enroll in the HSA Plan even if they will turn 65 in the Plan year. Since when they turn 65 they will move to the Medicare Advantage Plan there is no reason for them to not have the opportunity to enroll in the HSA Plan until that time. In addition, if they have non-Medicare dependents, we will allow the non-Medicare dependent to enroll in the HSA Plan as well.

Following discussion, Representative Wood made a motion to offer the PPO 750 Plan and PPO 1250 Plan for plan design and the PPO 400 Plan for Medicare Advantage Plan. Director Williams seconded. Motion passed unanimously.

The board then moved onto the subsidy amount to be offered. The board reviewed the 2019 premium equivalent rates for self-insured plans as presented by WTW, MCHCP will provide the subsidy using the subsidy percentage as used in 2018 as follows: the HSA Plan will have the 2018 HSA Plan subsidy, the PPO 1250 Plan will have the PPO 600 Plan subsidy and the PPO 750 Plan will have the PPO 300 Plan subsidy. For state Medicare-retirees the UHC Medicare Advantage PPO 400 Plan will be offered in conjunction with the ESI EGWP prescription drug plan. Retiree subsidies will follow the current MCHCP's state regulation except the PPO 600 Plan will be replaced with the PPO 1250 Plan as applicable.

The subsidy percentages for actives, non-Medicare retirees and Medicare retirees are rated separately based on their own experience.

Representative Wood made a motion to approve the subsidy percentages as presented. Director Williams seconded. Motion passed unanimously.

Director Lindley-Myers joined the meeting via phone.

Ms. Muck asked for board consensus to offer the 2019 incentives with no changes, they will remain the same as 2018. The board agreed.

Ms. Fischer presented the financial update. Before beginning she provided some general logistical comments. For the 2018 calendar year (CY), the projections before the board present preliminary financial activity through June 2018 and beginning in July 2018, reflect the FY 2019 appropriation level of $465,967,275 or $38,830,606 per month. The CY 2019 projections reflect the FY 2019 appropriation level and continue through the first six-months of FY 2020 beginning in July 2019. As decisions you will consider today regarding plan design for 2019 will materially impact the CY 2019 of the report, I will defer discussions related to CY 2019 to a future meeting once actuarial modeling regarding your decisions can be reflected for the report. With those considerations, we'll discuss June activity.

Monthly state contributions for June from the employer of $33,601,888 and member contributions of $9,171,358 represent contributions from 53,260 subscribers and total 95,829 covered lives.

MCHCP received pharmacy rebate payments of $9,389,563 comprised primarily from commercial rebates of $6.8 million and Employer Group Waiver Plan (EGWP) payments of $2.5 million related to pharmacy activity for the period through Dec. 31, 2017.

Ms. Fischer then moved to discussions regarding the investment section primarily associated with the Other Post-Employment Benefits (OPEB) Trust. The OPEB portfolio returned .69 percent for June net of fees with a concentration mix of 38 percent equities, 56 percent fixed income and 6 percent in cash and equivalents. Since inception total fund return is 7.05 percent; outperforming the weighted benchmark of 6.25 percent. For our rolling returns, the one-year portfolio return was 5.62 percent with the three-year at 4.66 percent and the five-year at 6.68 percent. Comments from our investment manager include as it relates to our strategies: We look to continue to pare some exposure in the equity markets with some potential for slowing domestic markets. A belief exists that the Federal Reserve will continue to raise short term interest rates impacting the US dollar and domestic corporate earnings may be unlikely to continue at 20 percent plus increases which should lower pricing. Proceeds from equity sales are holding in short term agency bonds allowing us to move cash when equities are favorable.

In our expense section, self-funded medical claims posted at $33,059,552 for June. Gross pharmacy expense for June was $18,126,082. Net of rebates through June 2018, pharmacy is trending at $11.1 million per month; and very comparable to our projected net expense of $11.273 million shown for July through December 2018.

Next, Incurred But Not Reported (IBNR) presents no change over the updates from last month reflecting paid claims through March 31, 2018, projected by the actuary for the remainder of CY 2018 and through Dec. 31, 2019. The IBNR projections have been influenced by an increase in both claims and an increase in trend for actives and non-Medicare retirees. For the period June 30, 2018 through Dec. 31, 2019, the increases in IBNR represent a range of 4 to 7 percent increases over the last report for claims paid through Dec. 31, 2017. With these updates, at Dec. 31, 2018, MCHCP's position would allow for the funding of only approximately $4.5 million of the $70.6 million in IBNR at Dec. 31, 2018. We ask you to appreciate that actual results may differ from these projections.

Ms. Muck noted that now that we have the plan design, WTW will develop rates for those who choose not to have contraceptive coverge. The board's approval was requested to move forward as MCHCP has to go to print with our Open Enrollment materials very soon. The board agreed.

Director Williams made a motion to move into closed executive session pursuant to §610.021 RSMo (1), (11), (12) and (14) of §621.021 to discuss confidential or privileged communications between the board and its attorney; specifications for competitive bidding; sealed bids and related documents; and records protected from disclosure by law. Representative Kendrick seconded. A roll-call vote was taken, and the motion passed with Mr. McAdams, Representative Kendrick, Director Lindley-Myers, Ms. Luebbering, Senator Rizzo, Ms. Schaefer, Director Williams and Representative Wood in favor.

Senator Rizzo left the meeting just after the motion to move into closed executive session was made.

Upon return from closed executive session, Representative Wood made a motion to adjourn. Director Williams seconded. Motion passed unanimously. Meeting adjourned.