MISSOURI CONSOLIDATED HEALTH CARE PLAN
BOARD MEETING
MAY 24, 2018

Attending: Jim McAdams
Representative Kip Kendrick (via conference call)
Mark Langworthy
Linda Luebbering (via conference call)
Daniel O'Neill
Viola Schaefer (via conference call)
Representative David Wood

Absent: Director Chlora Lindley-Myers
Senator John Rizzo
Senator David Sater
Director Randall Williams

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 Communication 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.

Representative Wood made a motion to approve the open session minutes of the April 26, 2018, regular Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees meeting. Mr. O'Neill seconded. Motion passed unanimously.

Ms. Muck presented the employee assistance program (EAP) contract renewal with ComPsych.

MCHCP contracts with ComPsych to administer the Strive Employee Life & Family (SELF) program to active state employees and public entity employees that have elected to provide the benefit to its employees. Missouri Department of Transportation, the Highway Patrol and Missouri Department of Conservation also participate in this contract.

In accordance with the contract, ComPsych has submitted 2019 renewal rates that are equal to the 2018 contract rates, as negotiated at the time the contract was first awarded. There will be no rate increase for 2019.

It is MCHCP staff's recommendation that the board renew the contract with ComPsych for 2019. This renewal is the third year of up to a five-year contract.

Mr. O'Neill made a motion to approve MCHCP staff recommendation to renew the employee assistance program contract with ComPsych for 2019. Representative Wood seconded. Motion passed unanimously.

Prior to discussing some monthly financial results, Ms. Fischer began with an update on the completed MCHCP fiscal year (FY) 2019 legislative budget process. MCHCP resides in the Office of Administration's budget within employee benefits in House Bill 2005. MCHCP's last budget action was to be presented before the joint conference committee and the bill position was returned to the original governor's position after House and Senate deliberations. The truly agreed and finally passed (TAFP) conference committee substitute is comprised of total funds of $465,967,275 without an (E). Of the $465,967,275; the bill total is comprised of $285,856,087 or approximately 61 percent in general revenue.

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 financial activity through April 2018 and beginning in July 2018, reflect the TAFP conference committee substitute level of funding just mentioned. The 2019 projections reflect the TAFP conference committee substitute appropriation level and continue through the first six months of FY 2020 beginning in July 2019. As decisions before the board today are being considered regarding Plan design for 2019 that will materially impact the CY 2019 section of the report, discussions related to CY 2019 will be deferred to a future meeting once actuarial modeling regarding the decisions can be reflected in the report. With these considerations, she began discussion regarding April activity.

Monthly state contributions for April from the employer of $33,541,276 and member contributions of $9,224,268 represent contributions from 53,494 subscribers and total covered lives of 96,172.

MCHCP received subsidy payments of $2,718,213 comprised of fourth quarter 2017 financial reconciliation payments for the Coverage Gap Discount Program of $2,031,588 and direct subsidy Employer Group Waiver Plan (EGWP) payments of $686,625.

Ms. Fischer then moved to discussions regarding the investment section primarily associated with the Other Post-Employment Benefits (OPEB) Trust. The OPEB total portfolio returned a negative .14 percent for April net of fees with a concentration mix of 41 percent equities, 55 percent fixed income and 4 percent in cash and equivalents. Since inception total fund return is 7.01 percent; outperforming the weighted benchmark of 6.19 percent. For our rolling returns, the one-year portfolio return was 4.451 percent with the three-year at 5.492 percent and the five-year at 4.932 percent. Comments from our investment manager include as it relates to our performance strategy: In the fixed income portfolio, we are largely reinvesting cash in the 3-5 year range. While those investments will likely suffer some devaluation in the tightening cycle, that should give us funds to reinvest at higher rates later. We continue to trim the equity exposure ever so slightly. Earnings are strong, as is the economy, so we are not ready yet to shrink the equity exposure.

In our expense section, self-funded medical claims posted at $37,343,644 for April. Gross pharmacy expense for April was $21,930,668. The $21 million in pharmacy expense represents three billed cycles for the month versus the normal two cycles.

Next, Incurred But Not Reported (IBNR) has been updated to reflect paid claims through March 31, 2018, and has been projected by the actuary for the remainder of CY 2018 and forward through Dec. 31, 2019. The updated 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 four to seven 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 $6.2 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.

John Stahl with Willis Towers Watson (WTW) presented the MCHCP trend analysis. He began by reviewing the purpose, methodology and key assumptions.

The purpose of this analysis is to compare MCHCP's actual historic medical and prescription drug trends to the trend assumptions used in setting the premium equivalent rates over the study period

The data collection for incurred and paid claims were provided by MCHCP, showing claims by month through Dec. 31, 2017, and starting Jan. 1, 2017. Enrollment by month was provided by MCHCP for the same time period. WTW used average monthly enrollment during their analysis.

In WTW's methodology, historical claims and enrollment were grouped into six CY experience periods, 2012 through 2017. Claims were separated by

medical and prescription drug as well as by plan and status. Prescription drug rebates were not reflected in the trend rates; these are accounted for separately in the premium rate development process, following the results of the annual market check.

Claims data by plan was adjusted by plan relative value to remove the impact on trend of plan migration.

Additional adjustments were made for demographics of the population and historical plan design changes. These adjustments were made to remove the effects of both demographics and plan design changes. Adjustments were made for each individual plan. Adjusted claims reflect our best estimate of what experience would have looked like without any plan changes or pricing improvements to the medical and prescription drug programs.

Claims by plan were combined into separate medical and prescription drug totals, then converted into a per adult equivalent per month (PAEPM) for each CY.

The CY PAEPMs were then compared to calculate “raw” trend. Annual trend was also calculated prior to aging and plan design adjustments to develop actual experience trend.

Trend analysis was provided to the board. Trend was provided after adjustment for plan migration, demographics and pharmacy pricing improvement and also for trend after adjustment for plan migration only.

Medical and prescription drug experience trend rates have been unusually high over the most recent three-year period, with the exception of medical trend for Medicare retirees. As a result, WTW recommends increasing the trend assumption used for pricing purposes.

Medical and pharmacy trends used in the historical projections along with suggested assumptions for 2019 rate development was provided to the board. This would include a 1 percent increase for active/non-Medicare retiree medical, a 1.5 percent decrease for Medicare retiree medical and a 1 percent increase for prescription drugs as compared to 2018.

MCHCP’s trend compared to other employers that WTW serves tend to be below average. When comparing per employee per year (PEPY), MCHCP is approximately 5 percent below average for all employers and 11 percent below average for those in your industry. While MCHCP’s trend is higher, costs are within the norm for the peer groups.

Ms. Muck expressed her appreciation to the Office of Administration budget staff, the House budget chair and staff and the Senate budget chair and

staff for their attention to the MCHCP during this budget process. There was a commitment from all that MCHCP was an important priority. Discussions during the legislative budget hearings were for MCHCP to have minimal impact on premium rates while recognizing that MCHCP will have to change plan design.

Ms. Muck reviewed the 2019 plan design. She hopes to have a robust discussion as the board makes their decisions on the 2019 plan design options. After the discussions on MCHCP financials and on trend, changing plan design is necessary to stabilize the financial position of the plan. The first step for the board is to choose a design so MCHCP can have WTW begin the necessary work on premiums. MCHCP is still exploring ideas and recommendations on benefits that will be presented at a future board meeting. The discussion today will be around the structure of the plan design.

Ms. Muck reviewed four designs with the board, picking no more than three to move forward. She then went over how these designs address the budgetary shortfall. Finally, WTW has prepared an overview of four other large employers current plan designs so you can compare that to what is being proposed for MCHCP. The employers are large and have a presence in Missouri and are blinded for today's purpose.

The options to be discussed for 2019 are a Preferred Provider Organization (PPO) 750 Plan, PPO 1000 Plan, PPO 1250 Plan and a Health Savings Account (HSA) Plan. A high deductible health plan is required by state statute to be offered. RSMO 103.080 which reads in part "… the board shall offer to all qualified state employees and retirees, in addition to the plans currently offered including but not limited to health maintenance organization plans, preferred provider organization plans, copay plans, and participating public entities the option of receiving health care coverage through a high deductible health plan and the establishment of a health savings account."

Ms. Muck began by discussing the network plan design. While not on the chart provided to the board, it is worth mentioning that preventive care is covered at 100 percent for all plan designs.

The first impactful change for the PPO plans is the increase in both single and family deductibles. There is not a change proposed in the deductibles for the HSA Plan. Ms. Muck highlighted the following changes:

- Currently, there is a $300 difference for single coverage between the PPO 300 Plan and the PPO 600 Plan and a difference of $600 for family coverage.
- The gap between the new plan designs has been narrowed to $250 for single coverage and $500 for family coverage. This change recognizes that the deductibles are increasing.
- We have maintained the design to have the family deductible be two times the single deductible.

- Overall, for actives in 2017, about 35 percent of individuals met their deductible and 39 percent of families. While there are slight differences between the PPO 600 Plan and PPO 300 Plan, the HSA Plan had about 18 percent of individuals and about the same percent of families meeting their deductible as did the PPO plans. This has not changed much when compared to 2016. Based upon historical data, there exists the likelihood, that a little more than 60 percent of all actives will not be impacted by the increase in plan deductibles.

The second change is to the medical out-of-pocket (OOP) maximums. This change affects all plan design options including the HSA Plan. Ms. Muck highlighted the following changes:

- Currently the PPO 300 Plan and PPO 600 Plan medical OOP amounts are the same and are set at 2.5 times the PPO 600 Plan single and family deductibles. For the PPO 300 Plan that equates to five times the deductible for single and family coverage.
- Currently, the HSA Plan is two times the single/family deductibles.
- We are proposing to change the formula since it is different between the plans offered today, and set the medical OOP maximum to three times the single/family deductibles for each plan proposed.
- There is a nuance for that change that would impact HSA Plan members. The federal limit for an individual OOP is $6,750 and family is $13,500. With the family OOP maximum set at $13,500, which means that for family coverage, once the first family member reaches $6,750 then we must begin paying 100 percent of that individuals charges. The other family members will have to reach the remaining $3,150 before we begin paying 100 percent on their charges.
- For actives, in 2017, overall about 8 percent of individuals met the out of pocket maximum and 4 percent of families. This has not changed much when compared to 2016. The increase in OOP maximum is estimated not to impact 92 percent of the active population based upon historical data.

The third change to consider is the amount of coinsurance a member will pay once the deductible is met. Ms. Muck highlighted the following changes:

- Currently, PPO Plan members pay 10 percent of the allowed amount and the plan pays 90 percent. HSA Plan members pay 20 percent of the allowed amount and the plan pays 80 percent.
- We are asking the board to consider increasing the coinsurance amount of a PPO Plan member would pay to 20 percent, with no change to the HSA plan coinsurance.

The fourth change to consider is in regard to office visit and urgent care copayments in the PPO plans. Ms. Muck highlighted the following changes:

- Today, the PPO 300 Plan has office and urgent care copayments. While not included on the chart, we offer the PPO 1000 Plan to Public

Entities (PE) and it has the same copayments as the PPO 300 Plan does today. The PPO 1000 Plan has the greatest PE enrollment.

- We would not suggest putting copayments into the PPO 750 Plan since it is still under $1,000 and only $150 more than the current PPO 600 Plan.
- We would suggest putting office visit and urgent copayments into the PPO 1000 Plan and PPO 1250 Plan to be the same as is offered to today in the PPO 300 Plan and PE PPO 1000 Plan. As we increase the deductible, an office visit and urgent care copayment would help member's access office visits and urgent care at a set price before the deductible is met.
- Office visit and urgent care copayments do not apply to deductible but do apply to OOP maximums. Copayments also do not cover ancillary services like lab and x-ray. Those remain subject to deductible and coinsurance.

The fifth change is to consider adding an inpatient copayment to PPO plans in addition to deductible and coinsurance for that service. Ms. Muck highlighted the following changes:

- We do not include this feature in our plans today.
- According to UMR's recent presentation to the board in October, admits per 1,000 (70 per 1,000) for MCHCP's population was 38 percent higher than their data base's Peer Norm and 41 percent higher than their overall book-of-business (BOB). The Peer Norm is UMR groups with greater than 10,000 covered lives which represents almost one million lives.
- Inpatient stays are a significant cost to the plan.
- This copayment would not apply to the deductible but would apply to the OOP maximum.

The sixth change is to increase the PPO Plan Emergency Room (ER) copayment. Ms. Muck highlighted the following changes:

- Currently members in the PPO plans pay $100 plus deductible plus coinsurance. The ER copayment is waived if the member is admitted or the third party administrator (TPA) considers the visit a true emergency.
- We recommend increasing the ER copayment to $200 plus deductible plus coinsurance. And waiving only if admitted at which time, they would be charged the inpatient copayment.
- According to UMR's recent presentation to the board in October, ER visits per 1,000 (317 per 1,000) for MCHCP's population was 55 percent higher than their data base's Per Norm and 48 percent higher than their BOB. Other analysis that we have done suggest that the majority of ER visits are not for emergent conditions.

The seventh change is to change the PPO plans' pharmacy copayment amounts.

- Currently PPO Plan members pay $8 for generics; $35 for preferred brands and $100 for non-preferred prescriptions.
- We suggest increasing those generics and preferred brand to $10 and $40 respectively.
- We suggest adding a $75 copayment for preferred specialty brands.
- No change to the $100 for non-preferred prescriptions.
- In 2017, almost 78 percent of members utilized non-specialty pharmacy and 5 percent utilize specialty. The plan cost per script of non-specialty was almost $57 and a little more than $2,800 for specialty. About 43,000 members took four or more drugs.

The eighth change will be to the PPO plans' pharmacy OOP maximum. Today it is $5,100 for individual and $10,200 for family coverage. We set the amount the same for both the PPO 300 Plan and PPO 600 Plan. You will notice that under the PPO 750 Plan, PPO 1000 Plan and PPO 1250 Plan, there are differing amounts. This is because if you add the medical OOP maximum to the pharmacy OOP maximum, it will equal the maximum amount that can be charged under the federal limits. We suggest, once the board chooses the PPO plans it wants to offer in 2019, we choose the lowest amount of the ones offered and make it the same for each plan offered. So if the board chooses the PPO 1250 Plan, you would take that amount and apply it to the other PPO plan offered. The reason to eliminate variance is the pharmacy plan is the same under each PPO plan.

At the end of the table, the actuarial value of the plans offered today and for the proposed plans are presented. By law, the actuarial value may not be lower than 60 percent. With the proposed changes, MCHCP does not go below 80 percent for any plan that would be offered.

Ms. Muck then briefly reviewed the changes to non-network plan design:

- The formula today for the non-network deductible is two times the network deductible for both individual and family coverage. We are not proposing any changes to that formula. So the non-network deductible is increased relative to the increase in network deductible.
- We propose the medical OOP maximum for non-network be the same formula as the proposed new network formula at three times the deductible. There is no legal requirement that we have a medical OOP maximum for non-network services.
- We suggest the board consider increasing the PPO non-network coinsurance from 30 percent to 40 percent, which is the same under the HSA Plan.
- We are also suggesting we change the maximum amount the plan will pay to non-network providers. Today, if there is not a contractual discount (we look to see if the provider is participating in another

secondary network like multi-plan or First Health), the plan will pay no more than 80 percent of usual, customary and reasonable (UCR) rates. We are suggesting we change the amount to 110 percent of Medicare.

- We would apply the $200 inpatient copayment plus non-network deductible plus non-network coinsurance to non-network providers.
- We are not suggesting any other changes to non-network plan design.
- Members are protected against non-network providers in a few ways, Urgent Care and ER services are considered a network benefit. Services provided by non-network providers in a network facility – such as radiologists and anesthesiologists - are treated like network. And if there is not a network provider within 100 miles, then a provider would be allowed within that radius and services treated like a network.
- About 3 percent of claims are from non-network providers.

The board briefly discussed the reasoning behind changing the office visit and specialty copayment to the higher PPO plan than the lower PPO plan. When changing to a PPO plan with a deductible of more than $1,000, the unintentional consequence that we do not want to occur is for members to delay care and wait for care when it's in an emergent state. By adding the copayment members can receive an office visit or specialty at a set price and not delay needed services.

Once the suggested changes were reviewed, Ms. Muck discussed the FY 2019 budget. The board was provided with a simplified spreadsheet that estimates the impact of the changes with WTW assistance.

- In the top column, you can see after receiving $61.2 million for TAFP cost-to-continue MCHCP has a shortfall of approximately $33 million of what was requested from the board in December.
- MCHCP used the maximum amount of savings available from the options we discussed to illustrate that choosing the PPO 1000 Plan, PPO 1250 Plan and HSA Plan at three times the OOP maximum and increase coinsurance, we will save nearly $20 million and another $1 million for the change in non-network maximum payment.
- That will leave approximately $12 million that is still to be resolved. MCHCP will be coming to the board with potential changes in benefits and, hopefully, savings from the group Medicare Advantage Plan to help offset that shortfall.
- Any other combination will increase the shortfall amount to be resolved in other ways.

Finally, MCHCP has asked WTW to benchmark our plan designs against other large employers in Missouri. They chose four which have been blinded and the results are in the Alternate Plan Design Benchmarking.

- With the PPO plans, the individual deductible will be higher than the four compared except for the $750, but the family deductible is more comparable.

- The medical OOP maximum at three times the deductible is generally comparable or lower than those offered by the other employers.
- Office visit copays, when offered, are comparable.
- Coinsurance is generally at 20 percent.
- $200 inpatient copayment is comparable.
- Urgent Care copayment is comparable.
- ER copayment, when offered, is comparable.
- Increased pharmacy copayments are within the range.
- Non-preferred is within the range.
- Pharmacy maximum is on the high end of the range.

Results for the high deductible health plan (HDHP) are as follow.

- Our HSA Plan deductible is on the low end of the range.
- Our proposed OOP maximum would be on the highest with a couple plans very close.
- Other plan design features are well within norms.

In summary, we have a significant plan shortfall projected and we have attempted to give you a range of options that are within norms of what other large employers offer their employees. After reviewing the options, Ms. Muck returned to the 2019 options of the PPO 750 Plan, PPO 1000 Plan, PPO 1250 Plan and HSA Plan.

Ms. Muck began by discussing the formula to three times the deductible for all plans offered. She asked for the board's consensus on this option. Following a thorough discussion on this option the board agreed to move forward with three times the deductible.

Ms. Muck then discussed increasing the PPO plans coinsurance from 10 percent to 20 percent for network and 30 percent to 40 percent for non-network. She asked the board for their consensus on this option. The board agreed to move forward with the increase of 20 percent coinsurance for network and 40 percent for non-network.

Ms. Muck then reviewed the office visit/urgent care copayments for the PPO 1000 Plan or PPO 1250 Plan as discussed. There would be a $25 copayment for an office visit, $40 copayment for specialty care visit, and $50 copayment for urgent care. She then asked the board for their consensus on this option. The board agreed to move forward with this change as modeled.

Ms. Muck then discussed the inpatient copayment and increasing the ER copayment to both be $200 plus deductible and coinsurance with the ER copayment waived if admitted. She then asked the board for their consensus on this option. Following discussion, the board agreed to $250 ER copayment plus deductible and coinsurance waived on admission and for true emergencies as

determined by the third party administrators. The inpatient copayment will be $200 plus deductible and coinsurance.

Next, Ms. Muck discussed raising the copayments for the prescription drug plan offered with the PPO plans. This would be an increase from $8/$35 to $10/$40 for generic/preferred formulary and creating a new tier for specialty at $75. There would be no change to the non-preferred formulary copayment. She then asked the board for their consensus on this option. The board agreed to the increase for copayments.

Ms. Muck then moved to non-network to determine if there is consensus on changing the maximum plan payment to 110 percent of Medicare from 80 percent of UCR. The board briefly discussed the impact and agreed to move forward with this change.

Now that the board has discussed all the universal issues, MCHCP has three different PPO plan options for consideration. It was recommended that we offer no more than two of the three plans. Of the PPO 750 Plan, PPO 1000 Plan and PPO 1250 Plan is there one that the board can agree to eliminate? Mr. McAdams proposed elimination of the PPO 1000 Plan. The reason for this is so that members can have a closer comparison between what they have and what they can get. The PPO 750 Plan is closest to double the current PPO 300 Plan and the PPO 1250 Plan is closest to double the current PPO 600 Plan. Representative Wood agreed, however members may have an increased premium if the board chooses to go with the PPO 750 Plan as an option. Mr. O'Neill agreed with concern over increased premium for members. Ms. Luebbering is curious to see what the premium would like with the PPO 750 Plan. Representative Kendrick agrees that eliminating the PPO 750 Plan is necessary. To recap, the board has a proposal to eliminate the PPO 1000 Plan and another proposal to eliminate the PPO 750 Plan. Ms. Muck offered to work with WTW on rates for a combination of the PPO 750 Plan and PPO 1250 Plan and rates for a combination of the PPO 1000 Plan and PPO 1250 Plan. The board agreed that they would like to see what the actual premium increase will be before making the final decision on which PPO plan combination will be chosen.

Ms. Muck did a final review of the board decisions:

- MCHCP will develop one set of rates based on the combination of the PPO 750 Plan and PPO 1250 Plan and a second set of rates based on the combination of the PPO 1000 Plan and PPO 1250 Plan.
- MCHCP will offer the HSA Plan.
- MCHCP will move to three times the deductible for medical OOP maximum.
- MCHCP will increase the PPO plans to 20 percent coinsurance for network and 40 percent for non-network.

- MCHCP will initiate the PPO office visit/urgent care copayments on the PPO 1000 Plan and PPO 1250 Plan as discussed.
- MCHCP will have a $200 inpatient copayment. MCHCP will have a $250 ER copayment that is waived upon admission or determined a true emergency.
- MCHCP will increase prescription drug copayments as discussed.
- MCHCP will implement the pharmacy OOP maximum will be $4,150 for single and $8,300 for family for all PPO plans offered.

Mr. McAdams made a motion to move forward with the 2019 plan design as was reviewed. Representative Wood seconded. Motion passed unanimously.

Mr. Langworthy made a motion to move into closed executive session pursuant to §610.021 RSMo (1), (5), (11), (12), (14) and (17) of §621.021 to discuss confidential or privileged communications between the board and its attorney; health proceedings involving identifiable persons; specifications for competitive bidding; sealed bids and related documents; and records protected from disclosure by law. Representative Wood seconded. A roll-call vote was taken, and the motion passed with Mr. McAdams, Representative Kendrick, Mr. Langworthy, Ms. Luebbering, Mr. O'Neill, Ms. Schaefer and Representative Wood in favor.

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