Arkansas Bureau of Legislative Research

Observations and Recommendations Draft Report

October 12, 2021

Table of Contents

Executive Summary 1
- Project Overview 1
- Recommendations 2
- Plan Designs and Contributions 7
  - Plan Designs 7
  - Contributions 9
- Medical 12
  - Discounts 12
  - ASO Fees 12
- Pharmacy 14
  - Benchmarking 15
  - Opportunities 17
- Medicare Retiree Coverage 21
  - Current Retiree Coverage 21
  - Medicare Advantage with Prescription Drug 23
  - Market Analysis 27
  - *MAPD Recommendation* 29
- Clinical Review 31
  - Wellness Program 31
- Diabetes Management Strategy 34
  - Impact of Diabetes 34
  - Communications 36
  - Oncology 37
  - Musculoskeletal 38
  - Clinic Model Evaluation 39
  - Bariatric Program 42
- Other Recommendations 44
  - Actuarial Statements 44
  - Communications 44
- Reserve and Funding 45
  - Reserve Policy 45
  - Funding Strategy 46
  - Going Forward *Without Recommended Changes* 48
  - Going Forward *With Recommended Changes* 49
  - Combining ASE and PSE Funds 51
- Funding Policy Recommendation 52
- Financial Projection – Including All Recommended Changes and Funding: 53

Executive Summary

Project Overview

The Bureau of Legislative Research (BLR) released Request for Proposals ("RFP") "BLR-210011" to provide Employee Health Benefits Consulting Services for the Executive Subcommittee of the Legislative Council. The Subcommittee issued this RFP with the clear intent to develop and implement a strategic plan and legislative framework for the State and Public School Life and Health Insurance Program (collectively referred to herein as the "Plans" or specifically as the "ASE Plan" for State employees and retirees and the "PSE Plan" for Public School employees and retirees) that will allow the Plans to operate on an actuarially-sound basis while offering high-quality and reasonably-priced insurance options for active employees and retirees of both the State of Arkansas and various public school districts

It is the objective of the Subcommittee, by entering into a contract for consultant services, to provide to the members of the Arkansas Legislative Council detailed and accurate information concerning a multi-year strategic path forward for the Plans in such areas that include, but are not limited to, legislative-initiated funding, employer subsidy, plan design consideration, and network operations.

The final work product shall constitute a spectrum of options with reasonable assumptions as to the economic, logistic, legal, and political ramifications of the various options. Every effort should be made to provide the options in a politically-neutral and option-agnostic approach so that the Subcommittee is presented actionable and reasonable data, likely outcomes, and anticipated costs for the Subcommittee to fully analyze, debate, and act upon as they elect to do so. The final work product shall address all aspects of operations of the Plans, such as Provider Network Reimbursement, Employer contribution strategy, administration expenses, plan design comparisons, market-based benchmarks, quality initiatives, and the over-arching systemic goals regarding the Plans.

Segal was awarded the contract on May 21, 2021. The end goal was to provide information in a timely manner to the Subcommittee in order to assist the Subcommittee in compiling its report due to the Legislative Council at its October 15, 2021 meeting. Given the robust scope of services and tight timeline, Segal began work immediately.

Initial Observations

Segal requested numerous data elements to help review the current program and its history. It is clear the Plans have dealt with financial stress in the past. Historically, these issues have been mitigated through one-time deposits of revenue into the plan without a long-term strategy to prevent future problems. For Plan Year 2022, the state continued this approach, having one-time deposits to fund the program. Over time this will continue to cause funding "emergencies" and create continued financial volatility.

We project that at the end of Plan Year 2024 the ASE plan will have $8M in assets, well below a recommend reserve level. PSE faces a bigger challenge, as we project the assets will drop to ($35M), a cash flow deficiency. These projections assume no changes to the program or increases to funding.

In addition to the financial history, we investigated multiple aspects of the ASE and PSE Plans. Our primary goal was to uncover savings opportunities that would not adversely affect members. Reducing plan designs and increasing employee contributions are two common tactics that save money for a plan sponsor, but these savings are generated by shifting cost to the members and not true program savings. From the onset, we identified three areas of opportunity for the program that looked to be "low hanging fruit". There are very few opportunities like this that can save the state and members significant dollars – a true "win-win". These included:

- Maximizing pharmacy vendor contract
- Utilizing additional federal subsidies for Medicare eligible members – most likely through a Medicare Advantage with Prescription Drug contract
- Diabetes management

Through our review and analysis, we confirmed these opportunities and uncovered additional considerations for BLR. Our recommendation are included in the presentations, subsequent sections of this report, and briefly summarized below.

Recommendations

Segal has completed our review and developed strategic recommendations for consideration, with some initiatives having a possible implementation in 2023 and other longer-term initiatives after 2023. This section provides a high level review and summary, with subsequent sections having detailed background and reasoning for each.

Plan Designs & Contributions

As part of the initial phase of work, Segal reviewed plans and contributions and benchmarked various elements against neighboring states, Segal's College and University Benefits Survey (CUBS), and overall market trends. From a plan design perspective, the State plans are generally middle of the pack, though employer contributions are low relative to these benchmarks. The State offers plans with a good actuarial value spread, and contribution

converge tiers in line with the prevailing 4-tier structure in the market. Based on this review, the main areas to consider updating are as follows:

- Reduce the Urgent Care copay to $75 on Premium Plan to better align incentives.
- Maintain current employee contribution structure – as a percentage of premium.
- **Align ASE & PSE plan designs to simplify offerings and introduce more consistency between programs – $4M cost in exchange for richer benefits for PSE members.**

Medical

Using Segal's Uniform Data Submission (UDS) discount database, Segal reviewed the overall discounts provided by BCBS in comparison to other carriers in the Arkansas market. Further, Segal reviewed administrative fees against comparator states and market numbers. Based on this review BCBS discounts appear to be best in class, and fees are in line with market. As a result, we would recommend that the State:

- Continue to review opportunities to improve the administrative terms
- On normal contract cycle, conduct an RFP, encouraging competition. The financial advantage to BCBS has narrowed over time and some vendors have become more competitive in your market. In the future, a procurement could generate more competition and potentially subsequent savings.
- Evaluate from a "total cost of care" approach, rather than just discounts and fees, incorporating consideration of medical management practices, including clinical measures available from other carriers.
- Consider carving out components of the contract and implementing more point solutions from specialty vendors, who could address particular issues in your population- i.e. diabetes, MSK,etc.

Pharmacy

The pharmacy arrangement used by EBD is somewhat unique compared to the market. EBD has split the operational function of a traditional Pharmacy Benefit Manager (PBM), relying on EBRx and Medimpact to work in tandem to manage the program. Note that Medimpact is as a PBM, but EBRx is primarily running the plan by performing formulary management, rebate contracting, and clinical criteria development and review. This are typically functions that the PBM performs in conjunction with a P&T Committee.

The aggressive formulary management with reference based pricing has been successful in some aspects – such as obtaining a high generic dispensing rate and use of lower cost drugs, but has not been successful in others – with overall benchmark costs higher than the market and members bearing a significant cost share.

A major piece impacting the net cost of the program are the rebates paid by the drug manufacturers. Benchmarks show these to be 25%-35% of gross costs, while your program is generating 11-12% for the same drugs purchased. We are recommending that EBD:

- Prepare an RFP that describes the flexibilities desired in the program, including, for example, custom formulary, custom clinical rules and role of independent pharmacies.

- Require bidders to provide proposals with minimum discount and rebate guarantees for each year of the contract.
- Clearly define all terms so that the Plans receive 100% pass through of manufacturer rebates, including inflation protection and manufacturer admin fees.
- Potentially request trend guarantees for certain therapeutic classes, to share risk with the PBM.
- Require bidders to propose guaranteed rates with independent pharmacies separately from others. This will allow the Plan to have control over pricing terms for the independent pharmacies.
- Make the Referenced Based Pricing program an optional program so that you do not limit potential bidders.

A competitive procurement should generate savings of $25M-$50M annually through greater rebates – assumes the same plan design and formulary.

Additionally, we recommend a repeal and replace of Act 1104 (Insulin) to avoid an estimated $7M annual cost starting in 2022 (effective January 1, 2022).

Medicare Retiree Coverage

As part of the benchmark analysis, Segal also reviewed the Medicare retiree plans and compared to our state plan benchmarks. It was determined that the majority of states have moved to Medicare Advantage programs, and all but one other state has moved away from traditional RDS coverage for prescription drugs. From our experience with other state plans, we estimated the savings that could be achieved. After the initial presentation, Segal was directed to reach out to the market for quotes relating to Medicare Advantage for both ASE and PSE employees, including prescription drug coverage. These quotes were for plans that match current plan designs and are projected to produce significant savings on both a cash and actuarial liability basis. As a result, Segal recommends the State:

- Prepare an RFP for a group Medicare Advantage Prescription Drug (MAPD) vendor.
- Introduce MAPD in 2023 for ASE & PSE. Keep current retiree option so retirees have choices.
- Auto enroll participants in MAPD to maximize enrollment, but allow for opt-out back into the current plan.
- Set ASE MAPD plan deign so benefits are at least equivalent to current.
- Set PSE MAPD medical plan design so benefits are at least equivalent to current. Reinstate Rx coverage for PSE that was cut in 2018, with a design identical to ASE.
- Structure contributions to incentivize the MAPD. The lower premium of the MAPD yields shared savings for both the State and the retiree.
- Create a communication strategy to maximize success.
- **ASE – Based on initial rates provided by major MAPD carriers, expected savings of at least $34M - $41M. We would expect these number to grow during a competitive bid.**

- **PSE – Reinstate Rx coverage. Because the baseline is medical only, MAPD savings from medical are used to subsidize the new Rx coverage. This is currently a small cost but will likely be cost neutral during a competitive bid.**

Clinical

The health of the country's population continues to decline. Arkansas is no different. In fact, Arkansas ranks at the low end of many metrics that gauge health and well-being. Thus, there are opportunities to make improvements though programs and strategies. Our clinicians met with BCBS and reviewed the protocols in place for a number of programs. From a high level, we reviewed clinical conditions related to: the current wellness program, musculoskeletal (MSK), bariatric surgery, diabetes, oncology, centers of excellence, BCBS medical management and others. Managing your clinical programs is a long-term approach that requires continued state commitments. Investments in long-term approaches are prudent in a population where you expect to retain members throughout their active careers and retirement. Below are Segal's recommendations:

- Shift wellness plan from self-serve to results-based, in order to drive behavior change.
- Roll out a comprehensive diabetes management strategy.
- Increase communication about oncology with a focus on centers of excellence ("COE") and incentivizing age/gender-specific cancer screenings.
- Introduce musculoskeletal program that includes site-of-service steerage and virtual access to care.
- Conduct feasibility study, or other related model, for onsite clinic.
- Maintain bariatric program, but eliminate the cap on the number of participants.

We estimate initial savings of $10M - $14M driven by engagement of diabetics and pre-diabetics. Some of the other recommendations are longer term, where successes may be better connected to clinical metrics.

Reserve & Funding Strategy

As Segal reviewed the overall state of the State's health plan finances, it was determined that many of the funding shortfalls were the result of short term planning. The State has historically budgeted only one year in advance, which does not allow the State to prepare for changes that may be required in order to keep the program funded. As a result, the State has been required to infuse large amounts of money into the program as a reactive measure to avoid going into a deficit. This annual "short-term" approach often requires pulling from other sources in order to fill these gaps.

Segal recommends budgeting for multiple years, in order to have a longer term view of any issues that may be on the horizon, and allow for more moderate budgeting increases from year to year. Further, it is best practice to increase funding annually to account for market trends, while tracking against a reserve target, including both IBNR and claims fluctuation. Based on Segal's experience, we would recommend the following:

- Build a multiyear projection model (current year + 3 additional years)
- Establish a reserve target range of 12%-16% of claims (8% IBNR; 4%-8% claims fluctuation)

- Set the annual State future funding increases to correspond with an appropriate healthcare index - healthcare CPI, for example. The Employee Benefits Division (EBD) would be responsible for managing plan expenses so that the fund balance is projected to be equal to the mid-point reserve target of 14% by the end of the projection period.
- Use low and high end of target reserve range as guardrails. If the projected reserve falls beneath 12%, a funding “trigger” should be executed to stay within range. Conversely, if the projected reserve is above 16%, the Plans may elect to increase funding at a rate below the prescribed index.
- Consider increasing employee contributions at a slower rate than State contributions in the near-term. This would effectively change the percentage of total premium paid by your members, bringing them closer to the benchmarks.
- Combine ASE and PSE funds to maximize stability and provide consistency between programs. In the near term, this approach also minimizes future increases and requires lower funding needs.

Other

- Segal recommends adding a requirement of an actuarial note or fiscal impact statement for proposed legislation that impacts either the ASE or PSE Plan. This would be similar to the requirement in place for legislation filed affecting the State Retirement Systems. By doing this, legislators and bill sponsors will fully understand the financial impact of proposed changes.
- Create an updated website that achieves best practices. Possibly outsource to communications expert.

Results

The recommendations above produce estimated annual savings of **$70M**. The savings are created by maximizing what is currently available in the healthcare market, rather than increasing participant contributions or reducing plan designs, both of which negatively impact the employees and retirees of the EBD program. Moreover, while many of the recommendations listed have no direct or immediate financial impact, they do offer long-term value to EBD from a budgeting and population health perspective (e.g., reserving policy, clinical enhancements).

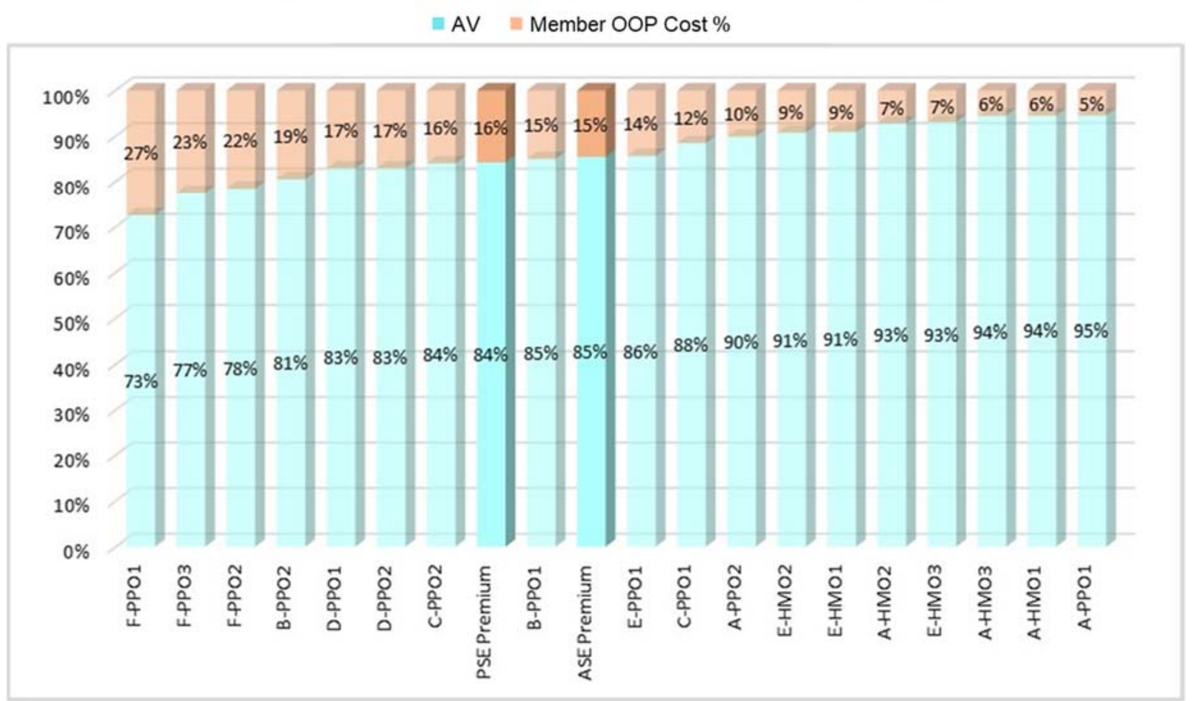
Incorporating the recommended reserve structure for the combined ASE and PSE funds, and making the changes above to capture savings will provide EBD financial stability into the future. We project assets at the end of 2025 to be $234M, well above the established reserve target. Thus allowing the Plan to increase funding at a rate lower than the target Medical CPI and keeping employee contribution relatively stable.

Plan Designs and Contributions

Plan Designs

Segal reviewed the benefit options available to the Non-Medicare population, as well as the cost of those benefits.   We have presented a benchmark study in July that provided rational for recommendations.   Currently, EBD offers the “Premium Plan”, “Classic Plan”, and “Basic Plan” to the ASE and PSE groups. However, the plans for each group are slightly different even though they have the same name.

In 2021, the EBD “Premium Plan” provides a competitive benefit value on a weighted enrollment basis of 85% ASE and 84% PSE, compared to other non-HDHP state employee health benefit programs reviewed in our benchmarking report. Note that “benefit value” or “actuarial value” is the projected percentage of claims paid by the benefit plan overall. The higher this value, the greater the benefit to the member, resulting in higher costs to the employer. The range of plan values in the benchmark were from 95% to 73%.

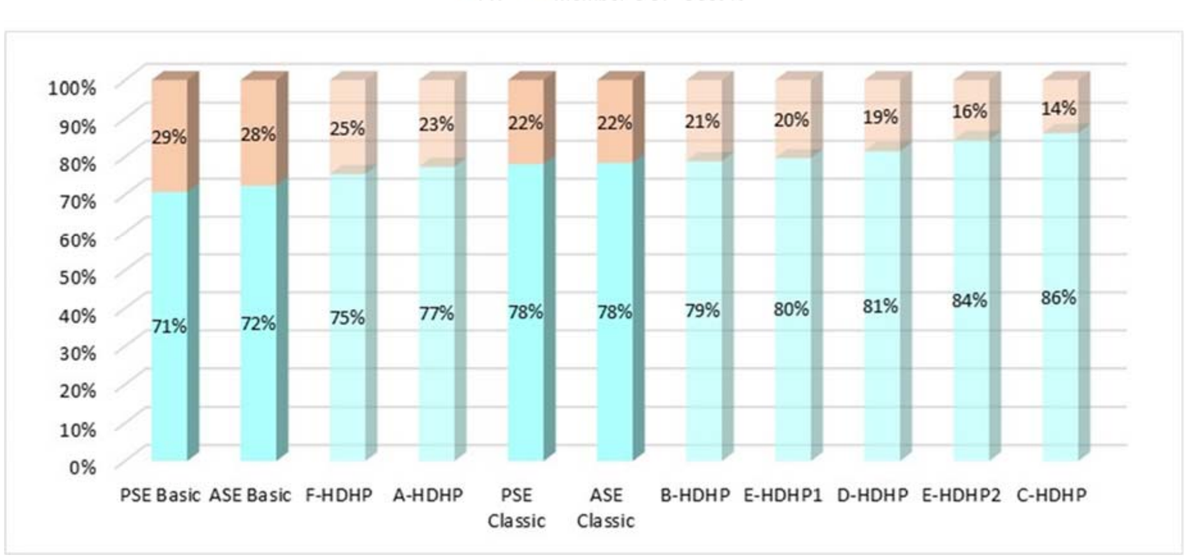


The Premium Plan offers members copays for routine services, such as office visits with physicians and specialists, as well as urgent care visits. **The urgent care visit copay of $100 is relatively expensive. Segal recommends decreasing this to $75 with the anticipation of reduced emergency room utilization.**

The Premium plan is the overwhelmingly most popular plan for the ASE group and second most popular for the PSE group.

The “Classic Plan” and “Basic Plan” are qualified high deductible health plans (HDHP) that allow the EBD member to contribute to a Health Savings Account (HSA). High deductible health

plans are lower-value plans by nature and cheaper on a monthly basis. The philosophy is that members use the savings from the lower premiums to fund the HSA and become consumers of their healthcare as they pay claims costs in full or at a percentage (coinsurance) until an out-of-pocket (OOP) maximum is hit.



As shown in the table above, the Classic Plan's actuarial value is competitive, relative to the benchmark's HDHP plans. The Basic Plan is at the bottom of the range, but this is by design. The Basic Plan is attractive to low utilizers who want an inexpensive alternative with limited coverage. This plan is free for the ASE employee-only tier, as long as the employee earns the wellness credit.

Looking at the offerings in whole, the designs provide a diverse range of benefit options. This allows the member to select a plan that fits their individual needs – balancing contribution costs and coverage.

The ASE group's version of the three plans are faintly richer than the PSE group's version and have different benefit-design elements. These differences have materialized over time. **Segal recommends the designs be realigned so that the PSE group receives the current ASE offerings. This will be a benefit enhancement to the PSE and cost approximately $4M on a weighted average basis. $4M is** a small cost to pay for the synergy created and confusion avoided for members who see plans with the same name, but a different schedule of benefits.

Plan	ASE AV	PSE AV
Premium	85%	84%
Classic	78%	78%
Basic	72%	71%

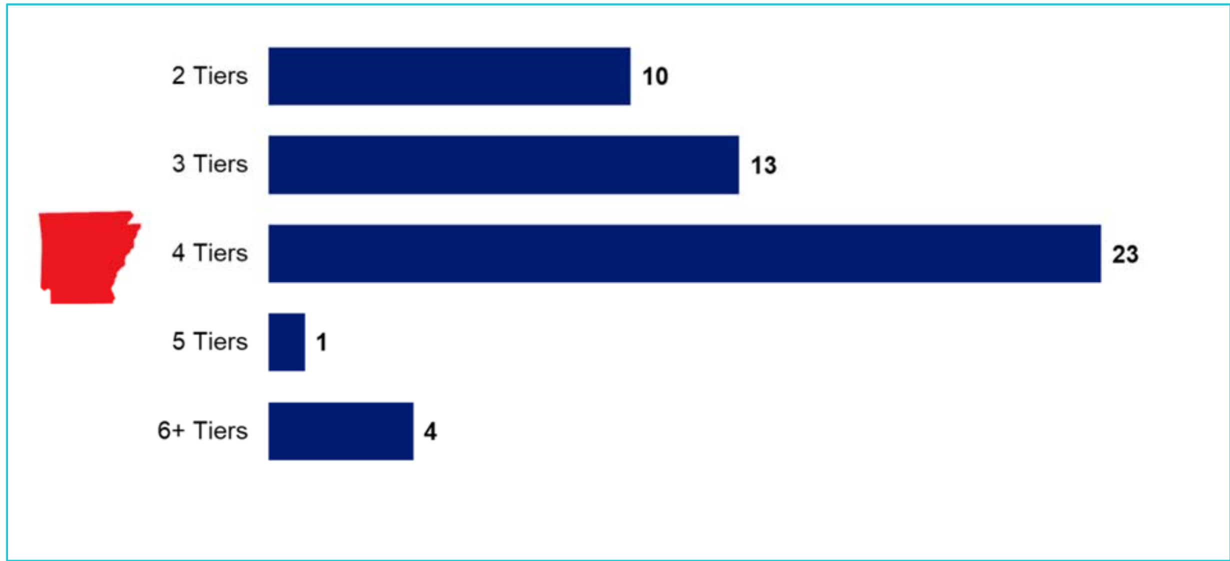
Contributions

Employee contributions were held close to flat between 2015 and 2019. However, looming financial challenges have triggered increases in 2020, 2021, and 2022. The benchmark study relied on the 2021 contribution – the most recent at the time of analysis. The study compared EBD rates to neighboring states, as well as national, state, and college and university (CUBS) averages. Note that the ASE and PSE plans have distinguished differences in the mechanics of the rate contribution. ASE is straightforward, as members have a defined contribution. Conversely, PSE contributions vary by district. There is a minimum district contribution that is defined, so we used that assumption for consistency in the benchmarking exercise.

Tier Structure

Plans have the choice to offer any number of tiers that define a subscriber and their dependents. EBD utilizes the 4-tier system below:

- Employee Only
- Employee & Spouse
- Employee & Child(ren)
- Employee & Family



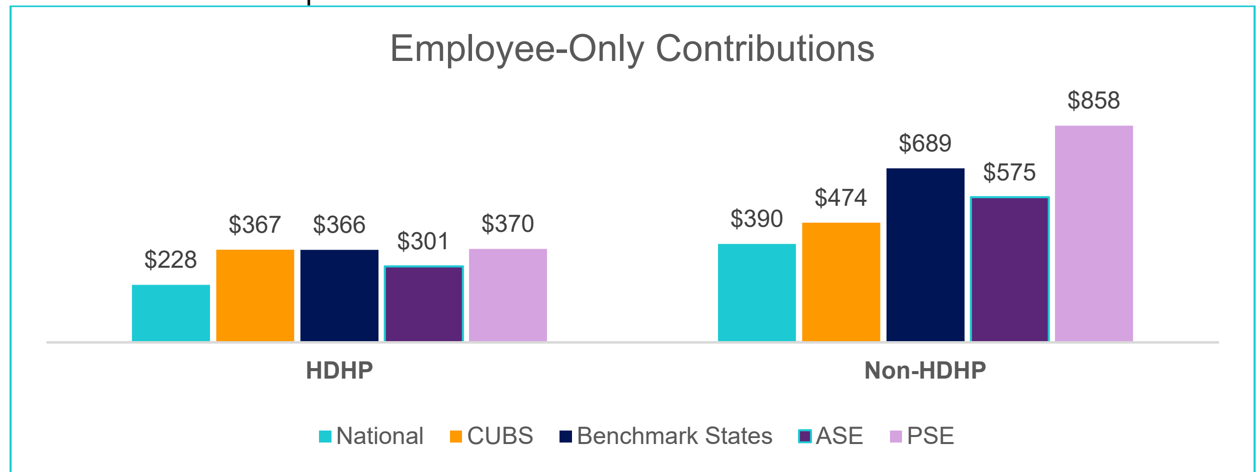
The table above shows the approach used by other states. The majority (23 states) use four tiers, and we recommend EBD continue using this tier system, going forward.

Employee Premiums

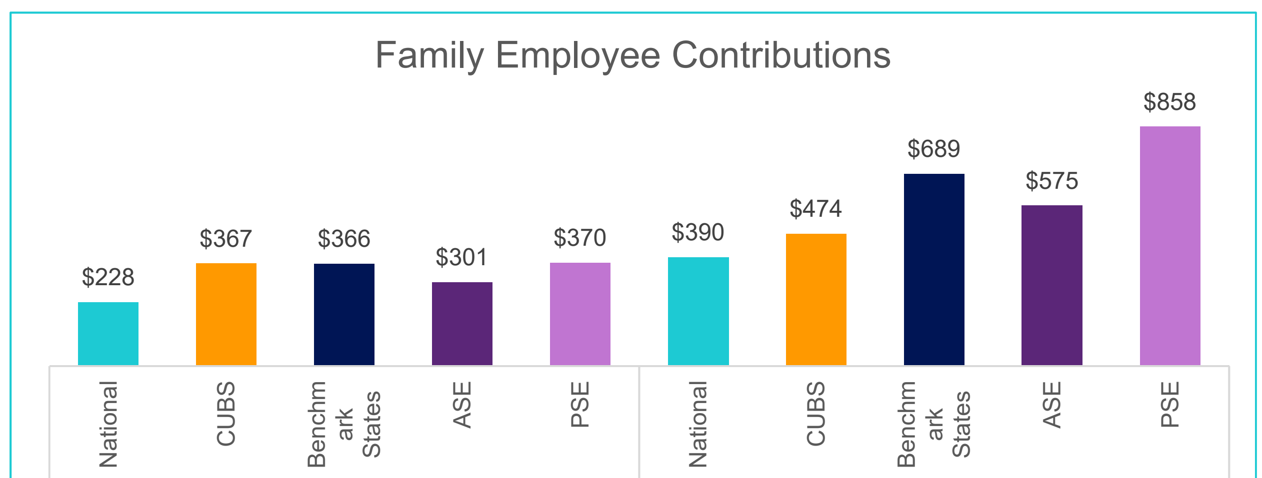
Employee premiums are the amounts the member pays for insurance coverage. Employers have discretion on what this amount is. Typically the employee premium is only a portion of the total cost of coverage. The remainder is called the employer subsidy.

The employee premium may vary for each plan and coverage tier. To avoid potential adverse selection, we advise the premiums align with the total cost. The EBD program has tailored their contribution strategy in this manner.

Similar to the plan designs section, the benchmarking report is core tool used in the analysis. The first comparison is the gross contribution to benchmark. This comparison disregards the value of the plan associated with the contribution, but is still useful to review. Note that the wellness rates are reflected in the information below because the majority of employees receive this rate. The 2021 employee-only contribution illustration below shows the Basic and Classic contributions are comparable to the HDHP benchmark averages however the Premium plan contribution is at the top of the Non-HDHP benchmark.



The same analysis holds true for the family contributions.



Percentage of Total Premium

Another more complex approach is to compare plans' contributions as a percentage of the total premiums. This added layer helps incorporate the quality of coverage associated with the contribution price tag.

The pie charts above demonstrates that employees in the Premium Plan are paying a higher share of the premium than the benchmark groups in the left-hand column. The Classic Plan is in line with the benchmarks. This is based on 2021 employee contribution levels; however these amounts are scheduled to increase in 2022 so it's reasonable to say EBD is trailing the other states and universities in this metric.

Recommendation

Segal recommends that EBD maintain the same general contribution structure. We do not advise combining the ASE and PSE contribution amounts because of the unique, district-specific funding that yields variable contribution amounts for PSE. Furthermore, this would create financial losers depending on their current plan election.

Healthcare costs inevitably increase, and increase at a rate higher than standard cost of living. Employee contributions are a necessary element of funding the plan sufficiently. Segal recommends strategically increasing the employee contributions to meet the reserve target requirements. However, in the short-term, the State contribution changes should supersede employee contribution increases until EBD aligns with the benchmarks.

Medical

EBD currently contracts with BCBS to administer medical benefits. EBD is self-insured and are therefore at risk from the plan's claims. In this arrangement, the vendor is responsible for managing the network and processing claims, among other tasks. The vendor is compensated by the Plan through an administrative services only (ASO) fee – a nominal cost to the Plan relative to the total spend.

Medical vendors are evaluated largely based on the discounts they can negotiate with providers within their network. This has a material impact on the net claims paid by the Plan. The ASO fee, and the services received for this fee, is also a differentiator.

Discounts

The right health care solution depends on where employees are located since network discounts vary by provider. To aid in the selection of solutions, we conducted a preliminary evaluation of the availability of health plan networks in Arkansas.

Segal has access to the Discount Database that houses provider discount information on a national basis.

We participate in the Uniform Data Specification (UDS) task that has devised a common methodology, accepted by most carriers, of evaluating provider discounts. Data is updated twice annually and can be used for client-specific discount analyses to evaluate the competitiveness of provider networks.

For the analysis, we used the EBD census and mapped members by 3-digit zip to the discount database. The four vendors we evaluated were BCBS, Cigna, Aetna, and UHC. BCBS had the best discount, overall. UHC and Cigna had comparable discounts, but their discounts were still lower than those of BCBS. Cigna did have the best discount in the Little Rock area but were less competitive in the rural areas of the state.

ASO Fees

The current ASO fee charged by BCBS is $20.55 PMPM. This covers claims administration, network administration, medical management, etc. Segal reviewed this fee against other state clients and utilized the Sherlock Benchmark Study. Our conclusion is the fee is competitive compared to the marketplace, considering the size of the population and the services included. As a comparison point, Sherlock published the median ASO fee was $26.95 PMPM.

Recommendation

Segal recommends that EBD conduct an RFP in conjunction with the current contract's termination date. Because the Plan is already utilizing a best-in-class discount and has competitive fees, at this time, we do not anticipate material savings. However, the market is

dynamic so the Plan should be diligent in checking to ensure they are maximizing discounts. The following steps should be considered:

- Have bidders re-price actual claims to give a more accurate discount comparison
- Ensure the ASO fee includes wellness related programs that can reduce cost
- Evaluate from a “total cost of care” approach, rather than just discounts and fees
- Request potential ACO/narrow network options
- Establish quantifiable performance guarantees tied to members health

Pharmacy

As part of our analysis, Segal was asked to review the pharmacy program and look for potential opportunities for operational improvement and financial savings. In this section we will briefly discuss the process we undertook, preliminary results, findings and recommendations. All of these components were presented to the ALC Executive Subcommittee in great detail.

At the start of the engagement, Segal met with EBRx and Medimpact individually to understand the following key program attributes:

- Formulary development process and implementation of changes
- Clinical program development, implementation and ongoing review
- Customer Service / Client service provided by each
- Ongoing program management
- Plan financials

Segal requested and eventually received a number of items for our analysis: financial reporting, copy of contracts with EBRx and Medimpact, administrative fee reporting, a copy of the formulary, plan documents (SPD), annual review reporting from Medimpact and potential plan savings solutions offered by Medimpact.

From our conversations and research, we recognize that the structure of the pharmacy program is somewhat unique in design, splitting management functions between different parties. Most organizations have one entity manage the entire program, being accountable for all aspects. In general:

- EBRx: Manages a custom process specific to the state that includes:
  - Creation and ongoing maintenance of a custom formulary
  - Management of rebate contracting through a process that has not been made available for evaluation
  - Creation and management of clinical reviews and appeals
  - In conjunction with Medimpact, management of a custom MAC price list
  - Negotiation of specialty pharmacy with local specialty pharmacies
  - Management of a Specialty Coupon program
  - Management of a Reference Based Pricing program for 12 therapeutic categories

- Medimpact: works with EBRx and provides the following:
  - Claims processing
  - Retail network contracting
  - Customer service and Account management include Arkansas based/onsite staff
  - Specialty pharmacy wrap program (Limited Distribution/Exclusive Distribution drugs)
  - Opioid Management program

Segal also requested and received a detailed claims file, with 3 years of pharmacy claims information. From that file, we extracted a file representing the most recent 12 months and conducted a thorough analysis of claims accounting for brand drugs, generic drugs, specialty

drugs, over the counter drugs and vaccines. Analysis included a review of the drugs subjected to the reference based pricing program and corresponding impact to member cost share.

The claims extract, including approximately 2.4 million claims, was loaded into a financial analysis tool and several pricing benchmarks were selected representing current client experience and available pricing from recent public sector procurements. A validation process was included to ensure total pharmacy claims where in sync with Medimpact annual reporting.

Benchmarking

From the prior benchmarking, the overall actuarial values of the program were found to be comparable to other state programs that we reviewed. However, when breaking out the pharmacy component from the overall benefits, the Rx plan designs are somewhat lower than our norms, resulting in more cost sharing for members. The premium plan, utilizing a standard copay design, is comparable to benchmarks, but the Classic and Basic plans have much greater cost sharing, consistent with high deductible programs.

The plans uses a highly managed custom formulary created by EBRx that:

- Eliminates high cost low clinical value drugs
- Excludes high cost brand medications when generic alternatives with similar clinical efficacy are available
- Excludes brand medications in many categories to optimize rebate opportunity
- Uses extensive prior authorization criteria to pre-screen patients for access to drugs to ensure right drug, right patient, and right condition

This highly managed plan approach has resulted in a generic dispensing rate in the 93% range for several years which is at the top end of the market range for generic dispensing. While a high generic dispensing rate is desirable, it leads to a situation that limits the opportunity for plan cost savings by further promotion of generic drug use.

Additionally, all plans use a reference based pricing (RBP) program that sets the amount the plan will reimburse for a drug category based on the cheapest drug in the category. Members pay the difference for anything above the plan reimbursement amount, resulting in increased member cost sharing.

An initial benchmark analysis was completed in July, utilizing a sampling of Segal clients in our National Data Warehouse. This preliminary benchmark represented a broad sampling of clients with different utilization patterns, formulary designs, plan designs and utilization of clinical programs from several different PBMs.

Due to delays in receiving detailed data, we used the original EBD plan paid amounts per member per month (PMPM) as reported in MedImpact's Business Financial Review 2020. Based upon comments of the benchmark comparison during the ALC Executive Subcommittee meeting, particularly around whether coupon amounts were included in the numbers, Segal performed additional review.

We confirmed that coupon amounts are netted out of the plan paid amounts in EBD’s numbers; however, they are not included in Segal’s data warehouse benchmarks. Also upon further review, we noticed that eligible members were overstated by 15,000 in the PMPM calculated by

MedImpact, creating a lower PMPM than actual in their published reports. It appeared that the PMPM amounts were calculated based on total members in ASE and PSE including actives, early retirees and Medicare retirees, although PSE Medicare retirees do not have pharmacy coverage (this was confirmed by EBD and these reports are being re-issued with the correct member counts).

With the corrected PMPMs, Segal refreshed this benchmark in our presentation to the ALC Executive Subcommittee in September. We utilized an average membership of 144,319.

	EBD	Benchmark	Vs. BM
Total Cost	$119.32	$113.04	5.6%
Member Cost Sharing	$19.70	$9.04	117.8%
Other Paid (Coupon)	$8.06	$8.06	
Plan Paid	$91.56	$95.94	-4.6%
Rebate %	13%	25%	-48.0%
Net Plan Paid	$79.66	$71.95	10.7%
PMPM Difference		$(7.71)	
Total Difference		$(13,345,679)	

In the chart above, the Total Cost represent the discounted ingredient costs and dispensing fees that are paid to pharmacies. EBD pays 5.6% more to pharmacist than our benchmark. The next two lines represent amounts that a member would pay either through plan design or coupon assistance programs. What remains after the cost sharing, would be the Plan Paid amounts, which is lower than for EBD because member cost sharing is more than double the benchmark. Outside of what is paid at the pharmacy, EBD receives manufacturer rebates to offset the cost. As you can see, the rebates are much lower than the benchmark, resulting in a Net Plan Paid of 10.7% more expense or $13.3M.

As mentioned earlier, the benchmarking above was based on a broad sampling of clients and meant to be a high-level review of the program performance. After we received claim line detailed data, we were able to conduct a thorough claims analysis. We refined our benchmarks to represent recent procurements for state level plans located in the southeastern region of the country. More specifically, the benchmark included:

- Plans that **do not** offer mail pharmacy benefits
- Plans that utilized a custom formulary and custom clinical rules
- Plans that had similar utilization patterns in therapeutic categories such as Inflammatory Conditions, Diabetes, Cancer and Blood clotting
- Plans that utilized one specialty pharmacy and / or a network of specialty pharmacies
- Plans that incorporated fully transparent pricing models and plans that utilized a spread pricing model
- Plans with any willing provider laws
- Plans that have defined reimbursement policies / rates for in-state independent pharmacies
- Plans that have specialty drug utilization that represents approximately 50% or more of total plan cost, high generic dispensing rates (> 88%) and comparable use of retail independent pharmacies and chain pharmacies

- Plans that have incorporated programs to control high cost low value drugs and to leverage manufacturer copay assistance coupon programs

We have utilized these benchmarks to estimate the savings from the following opportunities.

Opportunities

Rebates

Like it or not, rebates are an important component of drug prices in the US. Drug manufacturers use rebates to increase market share, and the larger the PBM (or rebate aggregator) the larger the rebate. It is imperative that EBD achieves the maximum rebate for the drugs being utilized under your current formulary. Segal reviewed Arkansas data in detail and compared to several 2021 state bid "guarantee" proposals.

Current rebates are approximately 11-12% of gross discounted cost and well below industry averages. Other states receive rebates of at least 25% of discounted drug cost, with many achieving over 35%.

Using our benchmark state rebate percentages, we estimate savings of $25M-$50M could be achieved annually through greater rebates. Note that this assumes the same plan designs and EBD's custom formulary.

	EBD	25% Rebates	35% Rebates
Total Cost	$119.32	$119.32	$119.32
Member Cost Sharing	$19.70	$19.70	$19.70
Other Paid (Coupon)	$8.06	$8.06	$8.06
Plan Paid	$91.56	$91.56	$91.56
Rebate % of Total Cost	13.0%	25%	35%
Rebate $	$(15.51)	$(29.83)	$(41.76)
Net Plan Paid	$76.05	$61.73	$49.80
PMPM Difference		$(14.32)	$(26.25)
Total Difference		$(24,797,705)	$(45,462,459)

Rebates are directly related to utilization of drugs and our estimates are based on actual claims experience compared to market benchmarks. The top categories for plan spend include drugs for inflammatory conditions and diabetes, which are brand name medications known to have very high rebate payments from manufacturers. These categories have limited to no opportunity to move to lower cost generic drugs; therefore, for some drug classes, it is important to maximize the rebate opportunity. This does not mean high cost drugs with low clinical value should be incorporated to "chase" rebates.

Contract Guarantees

All the States utilized in our benchmark have contract guarantees. EBD currently has no minimum guarantees on discounts or rebates, which means the Plan is taking on 100% of the risk with no ability to have a PBM take a portion of the risk.

Other State level plans have minimum guarantees on overall discounts and rebates by distribution channel, with 100% pass through to the plan. The guarantees are fully transparent and auditable.

This structure allows for maximum payments with no limits on upside while putting downside risk on the PBM who has negotiating power with the manufacturers, retail network and specialty pharmacies.

We have not estimated any savings from network contracting, which assumes overall pharmacy reimbursement would be maintained. The savings accounted for in the prior section are from increased rebates alone.

Specialty Drugs

Specialty drug utilization and cost continues to rise and now represents more than 50% of plan cost. Plan sponsors are utilizing preferred pharmacies and limited networks of pharmacies who can dispense specialty medications due to the complexity of the medications and requirements around patient education and administration training for these medications. Additionally, pharmacies who exclusively dispense specialty drugs are often able to offer lower cost, enhanced care and expanded service offerings including nursing service and payment assistance.

Specialty drugs are currently negotiated with local specialty pharmacies and some other arrangements for limited distribution drugs. Current specialty discounts realized are at least 30% lower than other state minimum guarantees.

Other States compared to Arkansas

- Generally employ an exclusive arrangement with one primary specialty pharmacy
- Partner with larger specialty pharmacies to maximize volume and access to other care services such as 24 hour, 7 day a week access to pharmacists and nurses
- Have extensive service guarantees and pricing guarantees including discounts, rebates and manufacturer assistance programs

In order to avoid losing local specialty pharmacy access, some states have negotiated a semi-open network with a specialty pharmacy and a local specialty pharmacy or hospital.

Medimpact reported that their specialty solution and changes in reimbursement rates on specialty medications could save approximately $3 million per year. We believe during a competitive procurement, there could be opportunities for additional savings.

Repeal Act 1104 (Insulin)

The way the law is currently written means that a plan sponsor has lost all ability to negotiate with a manufacturer of insulin, and there is no requirement that the manufacturer offer any concession on their price to patients. Plan sponsors and their PBMs have been restricted in using their size and scale to negotiate with drug manufacturers. We were told the estimated cost is approximately $7M annually in 2022. This has not been validated by Segal, but appears reasonable based on the data we have received.

A more appropriate solution to limit member cost share is to write into law a cap on member cost share as many other states have done so that insulin cannot exceed a certain dollar amount per month.

Continue Cost Reduction and Risk Minimization Strategies

Plan sponsors are looking for lowest net cost and have generally employed the following strategies:

- Formulary Management
  - Includes generic focused, brand exclusion and closed formularies
- Utilization Management and Clinical Rules
  - Prior Authorizations, Quantity Limits and Step Therapy
- Limited Networks
  - Retail, Mail and Specialty Pharmacies
- Plan Design
  - Incentivize use of lowest cost drugs through member copays or co-insurance
- Maximizing Manufacturer Rebates
  - Using formulary options to maximize value in therapeutic categories
  - Minimum guarantees for the plan
- Specialty coupon programs

We recommend continuation and expansion of these programs, noting that when successfully preformed, they help control overall trends and minimize the cost of the program, including what you members would pay.

Overall Recommendation – Market Program

In general there is no harm in evaluating what is available in the Market. All recommendations included in this section would be integrated into the RFP requirements.

Release "Best-in-Class" RFP and allow for plenty of time for analysis and potential transition.

- Prepare an RFP that describes the flexibilities desired in the program including, for example, custom formulary, custom clinical rules and role of Independent pharmacies

- The State's current formulary, formulary review process and clinical protocols can be accommodated in a RFP

- Have bidders provide proposals with minimum discount and rebate guarantees for each year of the contract
- Clearly define all terms so that you receive 100% pass through of manufacturer rebates including inflation protection and manufacturer admin fees
- Require 100% transparency for: pharmacy reimbursement, manufacturer rebate revenue and formulary design
- May request trend guarantees for certain therapeutic classes to share risk with the PBM
- Require annual market checks for pricing adjustment
- Have bidders propose rates with independent pharmacies guaranteed separately from all others. This will allow the Plan to have control over pricing terms for the independents. It will also help to promote and protect local community pharmacies.
- Have bidders propose exclusive specialty pharmacy network (may include in-state presence)
- Make the Referenced Based Pricing program an option program so that so that you do not limit potential bidders
  - Savings from other programs will outweigh potential increased cost

We would recommend a diverse group to provide feedback on RFP development and evaluation. All PBMs and PBM combinations would be evaluated to determine what is in the best interest of the state.

We would expect savings of $25M-$50M annually, primarily from greater rebates. Additional savings from specialty may apply as discussed in that section.

Medicare Retiree Coverage

Segal reviewed the current benefit options available to Medicare eligible retirees, as well as the cost of those benefits. Evident in the results from the benchmarking, Segal believes a Medicare Advantage with Part D (MAPD) program would be a tremendous opportunity for both the retirees and EBD. We developed two detailed presentations on this topic and presented both to the ALC Executive Subcommittee. The first presentation in July was a discussion of what Medicare plans are currently being offered, an education of Medicare Advantage plans available in the group market, and a preliminary estimate of the financial savings available to retirees and the State. Our second presentation in August focused on the market assessment we performed and further quantified the opportunity. Final recommendations were presented to the ALC Executive Subcommittee in September.

This report will summarize the main points of our presentations and focus on the recommendations and next steps.

Current Medicare Retiree Coverage

Your current program offers medical benefits that coordinate with Medicare. Medicare is the primary payor, and the ASE/PSE plans provide supplemental benefits for what is not paid by Medicare.

There are three main ways that plans coordinate with Medicare:

- Full Coordination of Benefits (Full COB): The health plan pays the difference between total eligible charges and the Medicare reimbursement amount, or the amount it would have paid in the absence of Medicare, if less
- Exclusion: The health plan applies its normal reimbursement formula to the amount remaining after Medicare reimbursements have been deducted from total eligible charges.
- Carve-Out: The health plan applies its normal reimbursement formula to the total eligible charges, and then subtracts the amount of Medicare reimbursement.

ASE/PSE both have Full COB, which is the most generous to retirees and the costliest for the State.

The coverage for prescription drugs is much different, where there is no coordination of benefits. In 2006, Medicare Part D drug coverage was introduced (via the Medicare Modernization Act of 2003) and the Retiree Drug Subsidy (RDS) Program was established. The purpose of RDS was to provide reimbursement to group plans who already had pharmacy coverage for Medicare eligible members, encouraging employers to maintain coverage. RDS was initially designed to be cost neutral to the federal government. In general, your program looks similar in design to the active program, but the RDS reimbursement is used to offset a portion of the program costs.

ASE retirees have pharmacy benefits, but PSE retirees do not. Due to budget constraints resulting in underfunding, the pharmacy benefits for PSE were eliminated in 2018.

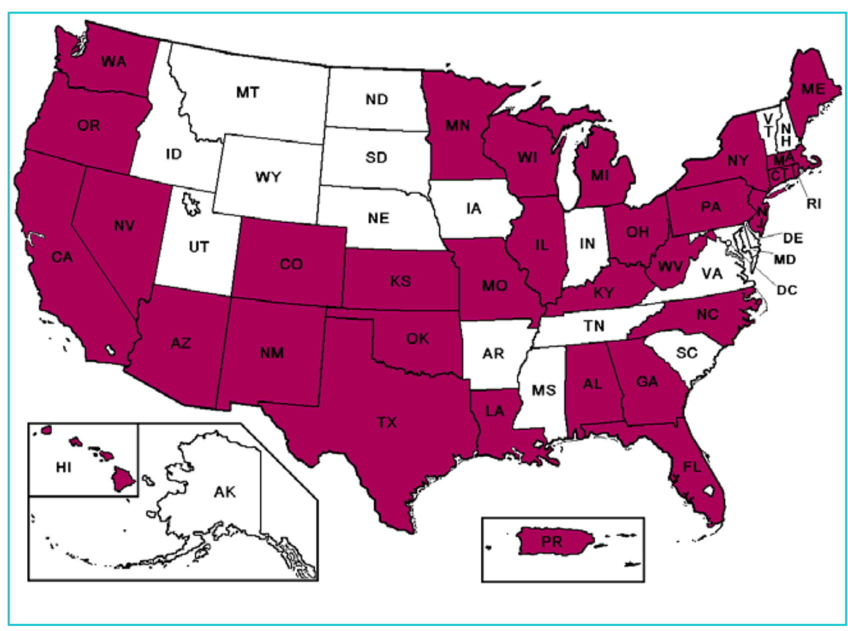
For 2022, we are projecting the total cost of medical and pharmacy coverage for ASE retirees (14,400) will be \$89M, \$55M paid by state and \$34M paid by retirees. The total premium is

more than $500 PMPM. This amount is more than twice the cost of other states with MAPD programs.

Similarly, the 2022 medical only total cost for PSE retirees (15,500) is projected to be $43M, $23M paid by state and $20M paid by retirees. The total medical only premium is more than $200 PMPM, again more than twice the costs of other state with an MA only program.

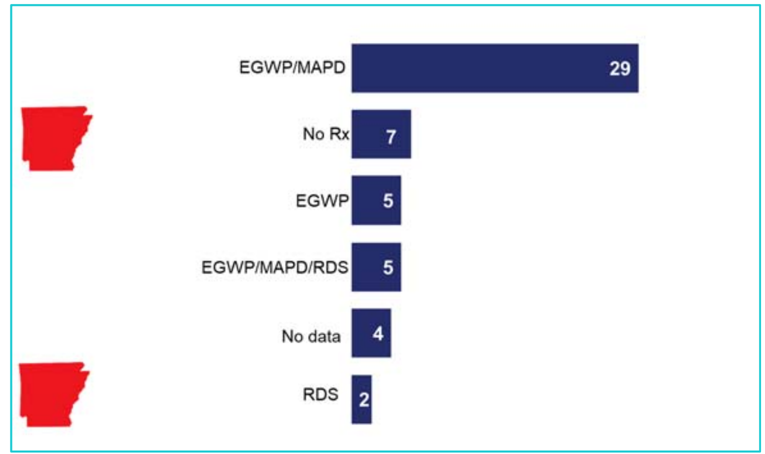
Benchmarking

A review of what other states offer provides insight into what makes sense in the current environment. On the medical side, it is very common for state health plans to offer a Group Medicare Advantage plan. Below is a map identifying states that have a MA offering:



Thirty (30) state systems offer Medicare Advantage as an option, an opt-out, or total replacement. Nearly every state around Arkansas has implemented a Group MA plan. Only Mississippi and Tennessee remain in COB type plans, due to legislation of no pharmacy coverage, eliminating the MA option.

For the pharmacy benefit, nearly all states have an Employer Group Waiver Plan instead of RDS.



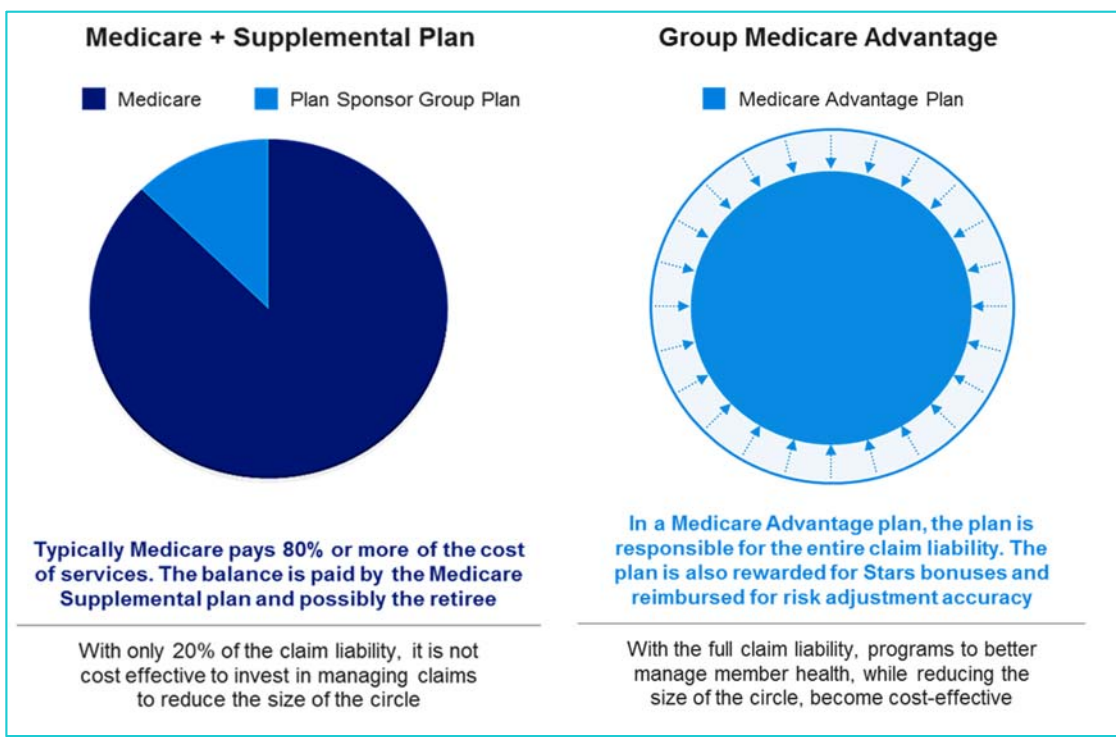
There are 7 states that do not offer pharmacy coverage to retirees, similar to PSE. Only one other state offers pharmacy benefits with RDS, like ASE. The vast majority of states offer pharmacy benefits through an Employer Group Waiver Plan, primarily in conjunction with an MAPD program.

Medicare Advantage with Prescription Drug

Medical Medicare Advantage Overview

- A Medicare Advantage (MA) Plan is offered by Private Carriers
- MA combines all benefits into one plan including:
  - Traditional Medicare (Parts A&B)
  - Wrap Benefits
  - Pharmacy (Part D) may be included in the same plan, but can be separate
- MA carriers receive capitated payments from the Centers for Medicare & Medicaid Services (CMS) that subsidize the cost of coverage
- CMS provides payment based on:
  - **Benchmark Rates – fixed monthly payments based on county of residence**
  - **Risk-adjustment – reflects illness burden of each member**
- Fully insured premiums from Plan Sponsors to MA carriers cover the cost of benefits and enhancements above CMS payment
- MA carriers manage all claims, risk adjustment, clinical programs, care management and customer service

A group Medicare Advantage Plan is more cost effective because it is responsible for the entire claim.



Because the employer premiums are highly leveraged, small savings on the entire cost can cause large reductions in employer cost.

It is important to understand that we are recommending a Group Medicare Advantage PPO program. These programs are completely different than an Individual Medicare Advantage plan that are available in the market. Group Medicare Advantage plans are offered exclusively to employer/union group health plan sponsors and are customized for each specific group, typically designed to mirror their current benefit design. Below are some key differences:

	Individual Medicare Advantage	Historical Group Medicare Advantage	Group Medicare Advantage PPO
Geographic availability	Limited to areas with viable contracted networks		National service area including all U.S. counties
Plan type	Primarily HMO		Non-differential "Passive" PPO
Provider access	Contracted providers only		All willing Medicare providers
Financial value proposition	Typically higher retiree out of pocket costs	Actuarial equivalent benefits at lower cost	Actuarial equivalent benefits at lower cost
Sustainability	Significant market disruption followed Balance Budget Act of 1998		Nearly a decade of price stability and significant plan sponsor savings

Group Medicare Advantage PPOs have a number of advantages:

- Quantifiable savings and no financial risk with all-inclusive fully insured rate
- Maintain current benefit levels
- Nationwide provider access
- Simplified administration - all medical benefits covered under one plan
- All Medicare retirees can enroll regardless of where in the U.S. they live and obtain care
- Maintains single national plan design and rate consistency
- Ability to manage long-term risk with improved clinical and wellness programs

CMS allows Employer Group Plans to provide coverage to members anywhere in the country as long as they meet the network adequacy requirements for at least **51%** of a particular employer or union group's beneficiaries. This is what enables plans to offer a "passive" PPO.

What is a passive PPO?

- Retirees pay the same cost share for services received both In-Network and Out-of-Network
- Carriers pay in-network providers according to their contracts
- Carriers pay out-of-network providers according to the Medicare fee schedule
- All Medicare accepting providers are provided with easy to use tools and resources to submit claims directly to the Carrier

- If the provider will not bill the Carrier, the member can pay the provider and submit a claim for reimbursement
- No PCP selection required, no referrals required to see a specialist

A passive PPO is what the vast majority of states offer and the program we are recommending for ASE/PSE.

Pharmacy Employer Group Waiver Plan Overview

An Employer Group Waiver Plan (EGWP) is a group sponsored Medicare Part D prescription drug plan with an enhanced benefit beyond the Standard Part D benefit. Some key points are:

- EGWP's are true Medicare Part D plans, largely regulated by CMS. However, CMS is required to grant waivers to encourage use of plans by employers. For example, employers can have custom enrollment periods and custom communications.
- An EGWP plan design is customizable to mirror current plan design as long as the plan is as good or better than the standard Part D benefit level.
- The Medicare Part D Coverage Gap Discount Program is available to EGWPs.
- An EGWP also provides for catastrophic reinsurance (for costs beyond coverage gap)
- Low-income subsidies are available for eligible participants

An EGWP Standard Plan Design will typically include enhancements designed to match the existing plan offering.

Part D benefit stage†	Rx drug costs	Standard Part D plan	EGWP plan design available enhancements
1 Deductible	$0 – $445	Retiree pays 100% of the network discounted cost.	• Eliminate the deductible
2 Initial coverage	$445 – $4,130	The retiree is considered "in-benefit" and pays the applicable 25% coinsurance.	• Modify copay/coinsurance to equal current plan design
3 Coverage gap	$4,130 – **$6,550 TrOOP***	Coverage Gap Discount Program (70% discount on brands). The retiree pays 25% coinsurance.	• Modify copay/coinsurance to equal current plan design
4 Catastrophic coverage	**$6,550+ TrOOP**	The retiree pays 5% coinsurance.	• Plan can cap coinsurance but cannot exceed CMS mandated coinsurance

The RDS program has not changed since its initial creation in 2006, the same time the EGWP was created. Initially, subsidies through the RDS program were designed to be financially neutral to subsidies available through a Part D program, incentivizing plan sponsors to continue offering group coverage. Over time though, the EGWP became more financially advantageous, as the Part D program changed. For example, in 2011, with the Patient Protection and Affordable Care Act changes, Part D benefits were enhanced to close the "doughnut hole", requiring manufactures to pay a portion of the claims. As these were changed, the EGWP subsidies grew, while the RDS subsidies remained consistent, not getting any lift from the

changes. With similar types of changes occurring over time, a large financial gap between the options was created.

Savings Provided by Additional EGWP subsidies are listed in the table on the following page.

	RDS	EGWP
Description	Employer-sponsored programs that are actuarially equivalent or better than the standard Part-D drug benefit are eligible for the RDS subsidy.	PDP contracts directly with CMS. Plan design is actuarially equivalent or better than the Standard Part-D plan design.
RDS Subsidy	Maximum RDS Subsidy is capped at 28%* (Cost Treshold - Cost Limit)	Not Applicable to EGWP plans
Coverage Gap Discount Program Subsidy	Not Applicable to the RDS program	Plan sponsor receives a 70% discount on brand drugs in the coverage gap hole. This counts toward the retirees' TROOP and pushes through the coverage gap faster.
Catastrophic Reinsurance Subsidy	Not Applicable to the RDS program	80% of Cost over the catastrophic threshold less applicable rebates.
Part-D Direct Subsidy	Not Applicable to the RDS program	Risk Adjusted Payment made by CMS directly to PDP for each Part-D participant.
Low Income Subsidy (LIS)	Not Applicable to the RDS program	LIS participants experience no coverage gap and no cost sharing above Part-D OOP threshold. The LIS mitigates the cost of the plan sponsor of covering these beneficiaries.

Further, under current Government Accounting Standards Board (GASB) requirements, public plan sponsors are not able to offset projected RDS subsidies from their actuarial liability for their retiree programs. By shifting to an EGWP, public plan sponsors are able to realize these future savings as an offset to their liability, which results in a significant reduction in what they are required to book for the cost of the program.

Given the above, it is understandable why there is only one other state who has not adopted an EGWP. Like the recommendation on Medicare Advantage, it is recommended that ASE (and PSE if pharmacy benefit return) adopt the EGWP for pharmacy benefits. We also recommend the medical and pharmacy benefits are combined into a MAPD offering.

We noted in our July presentation that there were some challenges for Public School Medicare Retirees as follows:

- Currently have no plan sponsored benefits for pharmacy
- Members cannot be enrolled in an EGWP plan and an individual plan simultaneously
- CMS will automatically remove a member from existing coverage when enrolled in another plan

Based on the above challenges, the only option for PSE to consider would be a MAPD program, adding back in pharmacy coverage. The goal would be to reduce PSE cost of medical coverage enough to cover the additional cost of adding pharmacy benefits., making it budget neutral.

Market Analysis

After our initial presentation in July, Segal was directed to get further information from the market. The goal was to access the feasibility of an MAPD. To do this:

- Segal reached out to the 2 largest carriers in the MAPD market
- We requested 2022 rates that would illustrate the savings available for ASE and PSE if the plan were to move to either an MA only plan or MAPD
- Carriers were provided with ASE and PSE enrollment and claims data at a level of detail that would allow the carriers to provide estimates with a fairly quick turnaround
- Carriers modeled medical and pharmacy plan designs to provide comprehensive benefits to be equivalent to current benefits
  - including all non-Medicare covered benefits
  - taking into account the coordination of benefits methodology in place today
  - providing additional MA group benefits
- Pricing for PSE pharmacy benefits and plan designs were based on ASE
- Rates received are assumed to be conservative based on the following factors:
  - not a formal procurement, therefore illustrative look at ability to produce savings
  - would have more detail and time for analysis in a formal procurement for actual pricing

ASE Full Replacement MAPD:

Segal provided an original conservative estimate that a MAPD would save the State $11M to $29M. The market analysis resulted in total savings of $45M, with the State share at $28M. As stated earlier, we believe these number will be even greater during a competitive procurement.

ASE	Current Enrollment	Premium Equivalent	State Contribution	Retiree Contribution	State Contribution %
2022					
Medical - BCBS PMPM	287	$250.15	$83.29	$166.87	33%
Medical + EB Rx PMPM	14,083	$521.00	$325.12	$195.87	62%
Total Baseline	14,370	$88,906,801	$55,230,196	$33,676,605	
MA & MAPD					
MA PMPM	287	$125.00	$63.75	$61.25	51%
MAPD PMPM	14,083	$257.00	$160.38	$96.62	62%
Total Scenario	14,370	$43,861,838	$27,322,346	$16,539,492	
Change from Baseline					
Medical PMPM	-	($125)	($20)	($106)	
Medical + Rx PMPM	-	($264)	($165)	($99)	
Total Change	-	($45,044,963)	($27,907,850)	($17,137,113)	

Note, that for the analysis:

- State contribution is required to be greater than 50% - changed from 33% to 51%
- Group MA is not allowed for retirees with an individual Part D plan; however MAPD contribution is approximately $100 lower than current plan contribution

We believe a full replacement option may be challenging, so Segal put together a number of scenarios. A side-by-side offering with an auto-enrollment would likely get close to 75% participation and is the scenario utilized in our financial recommendations (Scenario 4).

ASE		Estimated Savings TOTAL	Estimated Savings STATE	Estimated Savings RETIREES
Scenario 1	Full Replacement MAPD	($45,044,963)	($27,907,850)	($17,137,113)
Scenario 2	Full Replacement MA with EB Rx	($21,581,211)	($13,265,548)	($8,315,663)
Scenario 3	Retiree Option with 50% MAPD Enrollment	($22,306,669)	($13,920,237)	($8,386,432)
Scenario 4	Retiree Option with 75% MAPD Enrollment	($33,460,004)	($20,880,356)	($12,579,648)

PSE Full Replacement MAPD (with Rx benefits)

As we discussed earlier, the only feasible option for a group MA plan would be to add back the pharmacy benefit for these retirees. The goal was to have a total premium that would cover the additional expense of the pharmacy benefit. With the current rates proposed, we estimate the additional cost to be $5.2M, $2.8 from the State and $2.4M from retirees. Note that while this appears to represent a visible cost to retirees, it would be offset by the elimination of individual market prescription drug premiums they are currently paying, as well as reduced out of pocket costs since the quoted plan is vastly richer than what is available in the individual market. As mentioned above, we would expect more aggressive rates could eliminate this cost during a formal procurement.

PSE	Current Enrollment	Premium Equivalent	State Contribution	Retiree Contribution	State Contribution %
2022					
Medical - BCBS PMPM	15,459	$228.65	$122.83	$105.82	54%
Total Baseline	15,459	$42,416,033	$22,785,762	$19,630,271	54%
2022					
MAPD PMPM	15,459	$257.00	$138.06	$118.94	54%
Total Scenario	15,459	$47,675,556	$25,611,162	$22,064,394	54%
Change					
MAPD PMPM	-	$28	$15	$13	
Total Change	-	$5,259,523	$2,825,399	$2,434,123	

Note, that for the analysis:

- Group MA is not allowed for retirees with an individual Part D plan; therefore, the plan would have to include pharmacy coverage
- Rx plan design is assumed to be equal to ASE plan design for this illustration but could be vetted further in a formal procurement

Like the option for ASE, we ran similar scenarios for PSE. Scenario 5 is identical to ASE Scenario 4 and what we would recommend using.

PSE		Estimated Cost TOTAL	Estimated Cost STATE	Estimated Cost RETIREES
Scenario 1	Full Replacement MAPD with ASE Plan	$5,259,523	$2,825,399	$2,434,123
Scenario 2	Full Replacement MAPD with Lower State Contribution	$5,259,523	$1,528,771	$3,730,751
Scenario 3	Full Replacement MAPD with Lower Rx Plan Benefit	$0	$0	$0
Scenario 4	Retiree Option with 50% MAPD Enrollment	$2,629,761	$1,412,700	$1,217,062
Scenario 5	Retiree Option with 75% MAPD Enrollment	$3,944,642	$2,119,050	$1,825,593

Overall Summary

A market analysis conducted, where conservative rates (full replacement) were provided from the 2 largest carriers:

- MAPD rate roughly 50% of current cost
- $45M reduction in total premium for ASE
- $5M additional premium for PSE, which includes adding Rx coverage back into the design under the ASE

This is an incredible opportunity, where any scenario saves the state and retirees – a rate win-win.

MAPD Recommendation

Conduct a formal procurement as soon as possible. Recommend approval by year-end to meet a 1/1/2023 effective date

The procurement should:

- Ask for multiple scenarios to assess your options including things such as:
  - MA versus MAPD
  - Full replacement versus optional pricing

- Any other flexibilities you want to explore including drug lists or other unique components of the plan

- Ask for guaranteed rates for at least 2 years and a not-to-exceed rate cap for future years
- Ask for medical loss ratio guarantees since it is a fully-insured product
- Make plan design equivalent to current – re-instating the pharmacy benefit for PSE retirees
- Ask for all reporting and data you want to capture including CMS reports specific to your members
  - for your own information; and
  - for future procurement purposes

We have gathered many of these initial assessments over the years and do expect the savings to be greater than those presented in this report when provided in a formal procurement.

Initially, we recommend a side-by-side approach, offering the MAPD plan next to the current plans. Best practice would:

- Set the same State contribution percentage for MAPD plan to create buy-down effect incentivizing members to select MAPD
- Auto enroll into MAPD plan
- Estimated ASE total savings of $33.5M, $20.9M for the State and $12.6M for retirees at 75% enrollment assumption for MAPD
- Same approach for PSE costs the plan $2.1M and $1.8M for retirees, primarily because they would have prescription drug benefits reinstated with the same plan design as ASE. We also believe a procurement could eliminate this cost through more aggressive bid pricing and negotiations.

The complete process would take 6 months to complete the procurement, leaving 3-6 months for implementation. It is imperative that the RFP is conducted by those with expertise in the market so the contract is comprehensive and savings are maximized. Lastly, the chosen vendor must have a robust communication campaign, traveling across the state to educate retirees.

Clinical Review

Wellness Program

The State is currently using Catapult to administer the wellness program. To complete the wellness program, a members must receive one of the following:

- Biometric screening
- Nicotine screening
- Health assessment

For completion of the wellness program, members receive a $50 monthly contribution credit.

This is a self-serve, information-gathering approach that lacks a focus on impactful, sustainable behavior change.

Well-being Strategy

Historically, a well-being strategy's core concept is to reduce health care costs while improving the quality of life for individual members and their families. A major shortcoming of traditional well-being programs has been low engagement, resulting in a minimal impact on overall quality of life and total health plan cost. Health technology applications, devices and companies have emerged in the marketplace, and COVID-19 has increased the visibility of these solutions. While engagement with digital health platforms has increased, quality can differ considerably and cause reliability concerns for members.

Meaningful engagement hinges on the individuals being well informed on the program's existence, identifying a perceived benefit for participation, and overall satisfaction and convenience with the program. With rigorous vendor selection and oversight, a targeted communications strategy and proper incentives, a creditable enrollment rate may be achieved.

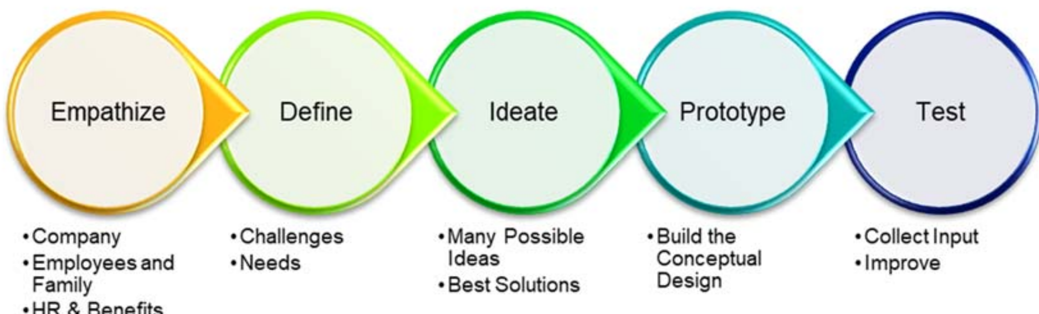
Formation

Vision, mission, business strategy, operating plan and human capital strategies all define the boundaries within which human well-being strategies should be developed. After having some sense of these boundaries, Segal recommends formation of:

- A well-being strategy development workgroup: Its charter is to recommend to the Committee a formal, well-being program by drafting a mission statement, vision statement, conceptual program design and three-year operating plan. Their work product highlights objectives, constraints, program content, incentive structure, budget, and resource requirements.
- A well-being advisory group: The advisory group provides input to the workgroup, monitors their progress and serves as a sounding board.

Facilitation

Segal recommends developing a protocol for working with these groups. Each group will need to be oriented to the subject matter and what knowledge-sharing should take place. Design Based Thinking is the recommended model for developing well-being strategies. It is a non-linear process, but the ingredients and flow appear below:



Evidence-based Well-being Philosophy

Segal recommends evolution of the current wellness plan to a philosophy grounded in the belief that members can attain optimal results when they are encouraged to achieve sustained behavior change. It's not enough to offer a variety of programs, or even engage a large number of participants in information-based biometric activities, if members are not improving their psychological, physical, financial, work and social well-being – in a sustained manner. Indeed, only through sustained behavior change can members realize the full potential of a robust well-being program, including demonstrable cost savings and risk reduction of the membership.

How do successful organizations help members achieve sustained behavior change? Most individuals would prefer well-being over poor health, yet people often lack the means to achieve optimal health. Hence, well-being programs are most successful when they tap into members' intrinsic desire to enjoy improved psychological, physical, financial, work and social well-being.

Rather than over-relying on a single component of knowledge/motivation/resources (for example, pouring more money into incentives, in the hope that extrinsic motivation alone will make employees more healthy), we believe a more balanced approach is necessary. By providing members the appropriate combination of knowledge/motivation/resources, members are able to generate more ROI on their wellness investments.

Ultimately, well-being programs are most successful when they focus on results-focused outcomes. Higher ROI is often achieved when results-based programs are focused on the highest risk population. Additionally, best-in-class wellness programs raise awareness, drive intentions, prompt specific actions and, most importantly, help members create sustainable healthy habits.

Recommendation

Segal recommends establishing a well-being strategy development workgroup that will define the vision, mission, business strategy, operating plan and human capital strategies.

Segal recommends shifting the wellness program from self-serve to results-based to drive sustained behavior change.

- Results-focused for broad population
  - Negotiate performance guarantees with vendors tied to improvement in the overall population health
  - Request participation in health improvement activities to earn the $50 credit
  - Incentivize age and gender-specific health screenings
    - Yearly primary care visit
    - Flu vaccination
    - OBGYN screening
    - Dental screening
    - Cancer screenings

- Results-focused for targeted population
  - Negotiate clinical performance guarantees that are condition-specific
  - Incentivize condition-specific program engagement and milestone achievement
    - Diabetes Prevention Program – Provide an initial credit upon enrollment, and to maintain the credit the member must achieve the program milestones
    - Diabetes Management – Provide an initial credit upon enrollment and require ongoing engagement to maintain the credit

Diabetes Management Strategy

Impact of Diabetes

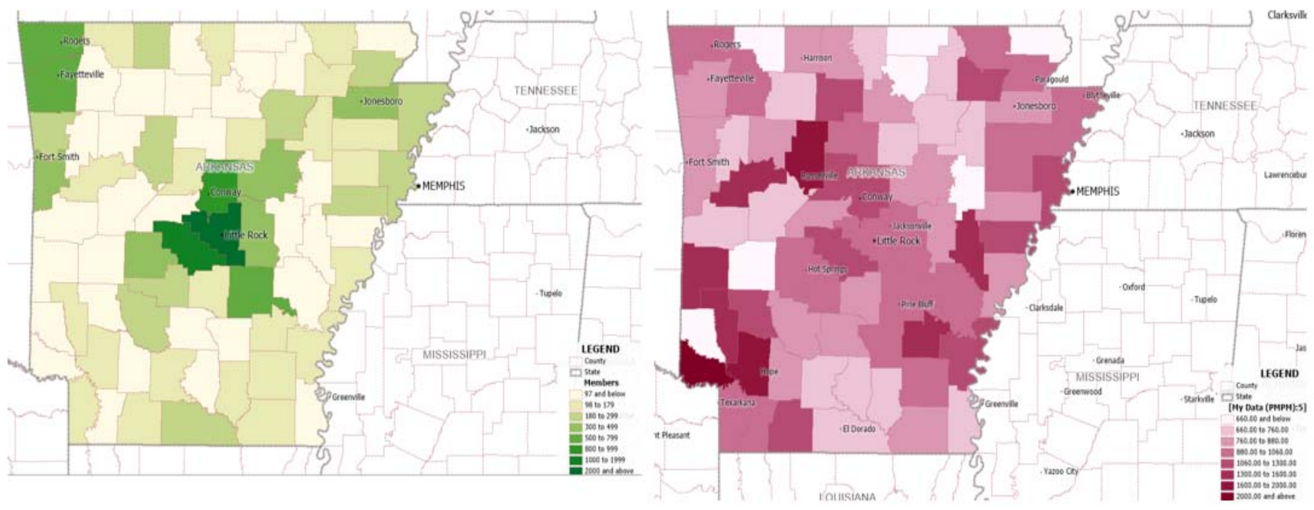
The diabetes epidemic has both an associated fiscal and societal impact. EBD's diabetic prevalence is higher than the national average, at 9.1%, and represents 23.4% of total plan spend.

Chronic Condition	January 2020 – December 2020							% Change	
	Members	% of all Members	Norm[1]	Medical & Rx Cost	% of Total Cost	Medical & Rx PMPM	PMPM Relative Cost[2]	Members	PMPM
Diabetes	16,239	9.1%	6.5%	$182,405,414	23.4%	$949	2.6x	2.3%	35%

Type of Diabetes	Diabetes Breakdown						% Change	
	Diabetics	% of all Diabetics	Medical & Rx Cost	% of Total Diabetics Cost	Medical & Rx PMPM	PMPM Relative Cost[3]	Diabetics	PMPM
Type I	1,592	10%	$32,231,241	18%	$1,704	1.8x	7.1%	24%
Type II	13,164	81%	$136,874,370	75%	$876	0.9x	19.8%	28%
Unspecified	1,483	9%	$13,299,803	7%	$780	0.8x	-56.4%	71%

With diminishing capacity to address and properly manage chronic illness, there may be an increase in diabetes-related complications, such as heart disease, stroke, kidney damage, etc.

Medically underserved communities have a lower prevalence of diagnosed diabetics but a higher PMPM.



The top left map illustrates the distribution of diabetics by county. The darker green indicates counties with large numbers of diabetic people. The top right map reflects the average cost (PMPM) of diabetics by county. The darker red indicates counties with higher diabetic PMPM cost. Diabetics residing in fully underserved counties have a total PMPM that is 3% higher than diabetics residing in partially underserved counties. This variance is entirely driven by medical PMPM. Total PMPM cost for pre-diabetics members is 1.6 times the PMPM of those without the condition, while total PMPM cost for diabetic members is 2.6 times the PMPM cost for non-diabetic members. EBD's prevalence of high-risk diabetics taking injectable insulin is higher than the national average.

Pre-diabetes

Pre-diabetes is a condition in which an individual's blood sugar is higher than normal but has not hit the threshold to be considered a diabetic. Unfortunately, many do not know they have pre-diabetes and claims analysis often will not show the true prevalence within the population. EBD showed 1% of the total population as having claims associated with a diagnosis of pre-diabetes. The National Institute of Diabetes and Digestive and Kidney Disease (NIH) estimated that more than 37% of the population has pre-diabetes and around 20% are unaware.

Recognizing the concern of a growing public health crisis, in 2018, the Center for Disease Control (CDC) gave approval for the National Diabetes Prevention Program (DPP) to be considered a preventive care service. Focusing interventions on lifestyle modification to prevent or delay the onset of type 2 diabetes.

Diabetes

In 2019 the American Diabetic Association (ADA) recognized that, through lifestyle modification and Medical Nutrition Therapy (MNT), patients with type 2 diabetes can go into remission. Simultaneously, the ADA advocated for medical nutritional therapy to be considered front line therapy for pre-diabetes and type 2 diabetes.

Currently, EBD has a structured disease management program through BCBS. Traditional disease management programs have had difficulty demonstrating sustainable change while reducing both overall trend and disease prevalence. Traditional programs have focused on a behavior-driven, telephonic coaching model, but, due to the costly nature of staffing, a high variability in the ROI modeling, and minimal engagement, many programs have fallen short in achieving savings.

Due to these compounding factors, numerous vendors have emerged in the market, offering digital diabetes solutions and free diabetic supplies. However, many still focus on medication adherence instead of true attainable and sustainable lifestyle modification. Engagement credit has shifted to self-driven models without evidenced-based clinical benchmarks. Some vendors have worked to embed themselves into the carrier suite of products as a buy-up option. Currently, BCBS works with Onduo as a third party vendor solution.

Recommendation

Segal recommends creating a comprehensive approach to diabetes. EBD can partner with BCBS or perform an independent RFP.

The comprehensive diabetes disease management strategy should include a focus on prevention, management, and lifestyle improvement.

- Diabetes Prevention
  - Add a CDC-approved Diabetes Prevention Program (DPP) through a digital platform or partner with local DPP programs
  - Incentivize enrollment and key millstones

- Diabetes Management
  - Add a digital management program that reduces the out-of-pocket cost to the member and increases compliance with prescribed treatment

- Risk Reduction
  - Add a digital diabetes program that focuses on dose optimization with lifestyle changes, reducing dependence on high-cost, injectable insulin

- Establish quantifiable performance guarantees tied to individual health outcomes that are clinically relevant and disease specific
  - A pilot can be focused on the highest-cost diabetics

With 20% engagement of diabetics and pre-diabetics, we estimate that the State could achieve **savings of 1.3% - 1.9%, or $10M - $14M**

Communications

Focus on Communicating for Behavior Change

Thoughtful, strategic, and creative communication can be an effective and powerful tool to encourage behavior change. This is especially true (and important) when it comes to improving employee engagement with the State's wellness and disease/condition management programs and improving employee and covered-dependent health outcomes.
Segal recommends that, following the State's decisions about how its wellness and disease / condition management programs will look in the future, the State develop a strategic wellness and disease/condition management program communication plan. Areas to explore that would be key to creating the plan would be:

- Developing a refreshed brand identity and campaign theme for the State's wellness and disease/condition management programs. A brand identity is meant to convey the value of the programs and would be expressed using a logo, imagery, colors, fonts, and tone of voice
- Understanding the State's employee/dependent audiences and their unique and related communication needs
- Setting objective, measurable employee/dependent behavior goals for program engagement
- Developing key messages for each targeted audience
- Identifying critical program information to be conveyed
- Detailing media available to convey key messages and content
- Specifying timing for the delivery of media
- Understanding and reviewing the collateral communication that the State's programs' vendors may have available, and how those elements or their content can be incorporated into the communication strategy

There is a wide range of media elements that could be developed as part of the communication strategy. They include (but aren't limited to):

- Video (e.g., messaging from State leadership, program information/education, promotional/marketing shorts)
- Program talking points for managers and supervisors to use at department/group meetings
- Email and home-mailed postcard campaigns

- Workplace signage (e.g., floor/wall/stairs stick-on/take-off graphics, posters, and tent cards)
- Brief, printed, online program overviews
- Self-directed, online presentations with professional voice-over narration
- Live webinars
- Podcasts
- Call-in “Town Hall” events
- Content for the State’s benefits website pages

Oncology

Treatment Plan Management

Certain types of cancers can be difficult to diagnose and there is a risk that the pathologist’s opinion may be inaccurate. Studies have shown between 25 and 30 percent of patients that receive a second opinion will have their diagnosis and/or treatment plan changed. Inaccurate diagnosis can lead to over or under treatment, inferior outcomes, and increased cost. The National Comprehensive Cancer Care Network (NCCN) supports and recommends a second opinion. The current cancer program identifies members after they start treatment and manages through the acute phase while focusing engagement on the high stage malignancies. Layering a second opinion that targets engagement with members before a treatment plan is decided can reduce the rate of diagnostic errors, increase access to latest technologies, and ensure members are receiving the highest standards of care. Requiring a review of treatment plan against NCCN guidelines can improve access to best–in-class treatment while reducing unnecessary cost.

Acute care case management is focused on members with high-stage malignancies. BCBS clinical program provides support to address social determinants of health, behavioral health support, care management, palliative or hospice support, and survivorship resources. Nutritional support is an essential part of a complete treatment plan. According to the National Cancer Institute (NCI), up to 80% of patients undergoing cancer treatment will experience malnutrition, which can lead to higher rate of mortality. BCBS should consider adding a Registered Dietitian (RD), who would consult with members to reduce negative side effects, mitigate nutritional losses, and maximize treatment.

Focusing care management on members with the highest-stage malignancies reduces impact to the overall population. An opportunity exists to consider a low-touch and/or virtual model for lower-stage, uncomplicated cases with a focus on the social and behavioral health needs of this population.

Recommendation

Many carriers do not have the clinical expertise in house to provide treatment plan recomemendations, access to the latest clinical research, and recommendations on alternative care. Segal recommends working with your carrier to identify opportunities

develop a parnternship with comprehensive cancer treatment guidelines, enhance access to genetic testing and counseling, and viable second opinion options.

Musculoskeletal

Centers of Excellence

Select Type of Surgery	Oncology Breakdown				
	Patients	Surgeries	Total Cost	Cost per Surgery	ALOS
Hip Replacement/Revision	223	240	$2,232,244	$9,301	2.4
Knee Replacement/Revision	391	421	$3,925,564	$9,324	3.4
Spine Fusion	117	120	$3,282,622	$27,355	4.1

When evaluating centers of excellence (COE), it is important to consider both the quality and cost. Further, providers in certain regions will inherently have lower costs due to the market pressures within the region. Due to the relatively close proximity of members, there may be opportunities for savings from establishing regional centers of excellence in lower-cost regions and implementing cost-sharing incentives to encourage members to use these providers. This strategy is particularly popular with expensive musculoskeletal surgeries, such as surgeries involving the hips, knees, spine, and shoulder.

Digital Therapeutics

Physical therapy (PT) involves treatment focused on the prevention and management of injuries. This can help relieve pain and prevent overuse of opioid medications. The goals of PT are to promote healing and restore function and movement. In-person physical therapy typically has low adherence rates and often requires time away from work and family. Increasing out-of-pocket cost can deter members from attending all sessions. Sustained coaching and adherence to the recommended treatment is required to return to a normal level of function. To break down barriers to treatment, new technology exists where members can access PT in the comfort of their home. Through sensor technology, members can achieve the same results as those from in-person therapy. Many of these programs are achieving higher engagement rates by breaking down barriers to access.

Recommendation

Segal recommends evaluating options for centers of excellence focused on high cost conditions. Work with carrier to identify digital physical therapy options.

Clinic Model Evaluation

Feasibility Study

Segal's evaluation illustrated higher PMPM cost in counties that are medically underserved.

Recommendation

Segal recommends evaluating the feasibility of a clinic model to meet the unique needs of the population. A pre-clinic feasibility study should be conducted and include procuring, staffing, conducting ROI studies and strategizing ways to maximize ROI. A consulting firm should be engaged and be able to provide services regarding operations, staffing, costs, and return on investment for all onsite employee health service clinics.

Clinic Model

In addition to knowing how much money a clinic can save, it is important to know why a clinic can save money. One reason clinics can save money, is that they provide an environment that allows for increased patient participation and compliance with treatment. Because of the proximity of the clinic, travel is not a barrier to visit a doctor when needed. Removing this travel barrier can be instrumental in closing social determinants of health gaps. The barrier of not being able to secure an appointment with the doctor's office is also eliminated as the clinic can accommodate walk-in patients. Further, closing a key barrier to care in medically underserved communities. Clinics can be designed to be open on weekends, and before or after work-hours, making clinics more available than most doctors' offices. The ability to visit a clinic during a wider range timeframe may incentivize members to visit a clinic instead of an emergency room in some non-emergent situations, thereby eliminating some emergency room visits

Additional benefits are realized from the clinic staff knowing the benefit plan of the patients, giving them personal attention, and getting them to engage in wellness and disease management programs. Also, proximity and a well-thought-out clinic design that provides all the necessary services under one (nearby) roof makes it more likely that patients will comply with the treatment regimens. Especially for chronic conditions, increased patient participation and compliance leads to, over time, decreased specialist referrals and visits, emergency room visits, and inpatient hospitalizations. Members are also directed to more efficient service providers and facilities, so the cost per unit of service is less. Additionally, clinics can be designed to restrict service to treatments that research has proven effective.

Newer clinic models are combining virtual access to care while utilization acuity-specific staffing, further optimizing access to the most appropriate level of care. Consideration can be given to "clinic-like" models that forgo brick-and- mortar and rely on a telemedicine platform with in-home support and evaluation.

Finally, consideration should be given to including pharmacy service in the clinic. Significant savings can be generated by dispensing generic drugs, obtaining a lower price than is available from retail providers, and better monitoring drug utilization and compliance.

A clinician-trusted model of wellness and primary care delivery hinges on:

- Having the right staff, employer engagement and employee buy-in,
- Providing guidance around the appropriate scope and scale of the clinic services,

- Providing analysis on beginning and future returns on investment, and
- Developing measures for its impact on employee health and behavior.

In evaluating the feasibility of a clinic, the following topics should be given significant consideration:

- Who is eligible to use the clinic, for example, members, dependents, retirees, etc.?
- What costs are currently targeted through the use of an onsite clinic?
- Are the services at the clinic free to the user or is there a charge? Should there be a charge and, if so, how much should the charge be?
- How should the clinic pricing be positioned, compared to the cost of obtaining medical services through the existing health benefit plan?
- Given the healthcare services provided at the clinic, what staffing is appropriate?
- What are the desired benefits of the clinic and how should these be measured?
- Does it make sense to contract with a nearby existing retail clinic or a virtual hybrid?
- Does it make sense to invite other employers/group health plans in the vicinity to participate in the clinic, and hence share the costs?
- What services should be offered by the clinic and what are the costs/benefits of each?

Recommendation

Segal recommends developing an overall consulting and actuarial project plan.

Data Integration and Management

No program is complete without knowing, monitoring and measuring its success. Data analysis is the most critical element for knowing how well the program is working. Typically the savings associated with on-site clinics are generated by the elements below and it is critical to be able to collect this data and set up reporting so that these are tracked over time and compared year-over-year.

A performance measurement scorecard should include the following metrics:

- Reduced Utilization – patient compliance and program participation, over time, leads to decreased:
  - Specialist referrals and visits
  - Discretionary ER visits
  - Inpatient hospitalizations – due to increased compliance with medications and treatment
  - Pharmacy costs (longer term, through generic, OTC and appropriate prescribing. Initial increase is possible and desirable.)
- Increased medication compliance
- Improved compliance with preventive screenings
- Increased compliance with evidence-based medicine
- Increased participation in disease management programs

- Increased participation in wellness programs, health promotion programs, and health coaching programs
- Network replacement savings and savings from steerage to high-quality/high-efficiency health care professionals and facilities
- Productivity savings from reduced lost time for doctor visits, pharmacy, lab and other medical needs
- Decreased absenteeism and increased presentism

Performance Measurement

Depending on the data available, performance measures should report on the impact of onsite clinics.

The list may include the following:

- Specialist referrals and visits
- Discretionary ER visits
- Inpatient hospitalizations
- Pharmacy costs
- Medication compliance
- Compliance with preventive screenings
- Compliance with evidence-based medicine
- Participation in disease management programs
- Participation in wellness programs, health promotion programs, and health coaching programs
- Absenteeism rate

Recommendation

Segal recommends:

1. Conducting a feasibility analysis using claims data

2. Issuing an RFP for vendor procurement to establish an on-site/near-site clinic or alternative clinic model

3. Implementing and project management support

4. Seeking consultation related to optimal benefit plan design and incentives to maximize clinic utilization

5. Conducting an ROI analysis after a clinic has been in place for 3 years

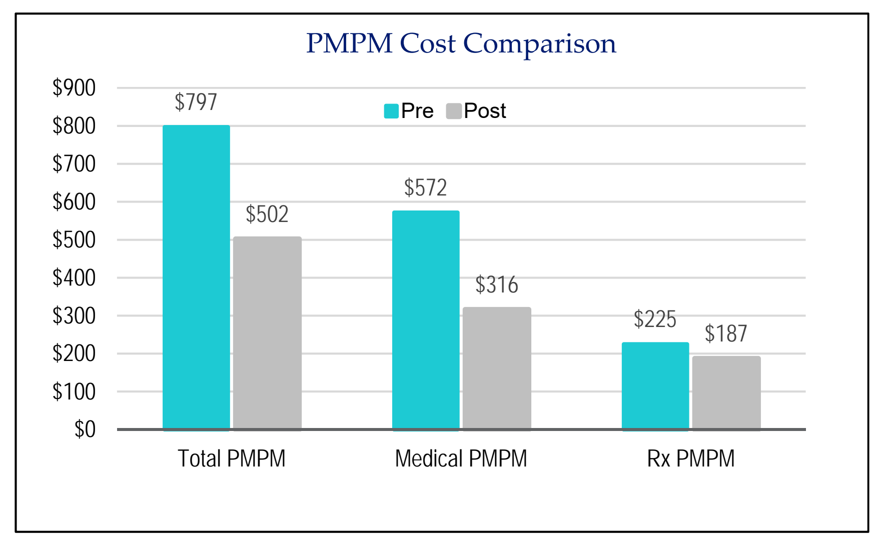
Bariatric Program

ACT 927

A dollar limit was set at 3 million per plan per year, totaling 6 million for cost of bariatric surgery. There is client-specific criteria for the member to meet in order for the procedure to be approved for coverage. BCBS has a specific, clinical coaching program to assist members in completing the required pre-operative activities. EBD and BCBS capped the program at 300 people with the logic that this would be equivalent to $3m.

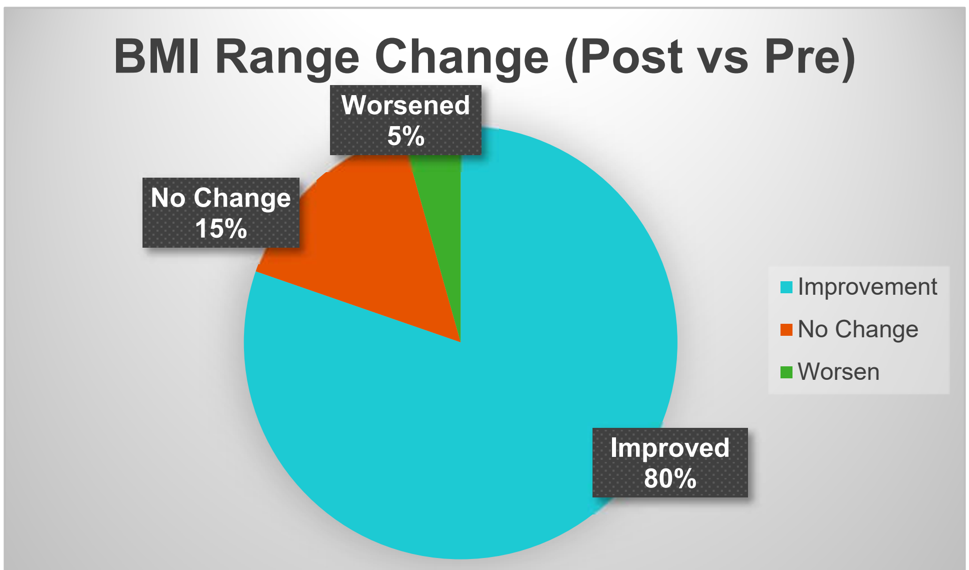
Segal analyzed the claims related to bariatric surgery to determine success.

Data Metrics (n=244)	12mo Prior to Surgery ("Pre")	12mo Post Surgery ("Post")	Variance (Post vs Pre)
Claims Experience (PMPM)			
Medical	$572	$316	-45%
Rx	$225	$187	-17%
Total	**$797**	**$502**	**-37%**
Key Utilization (Services per 1,000)			
Inpatient Admissions	57	74	29%
ER Visits	258	160	-38%
Urgent Care Visits	12	20	67%
Rx Scripts	33,291	25,926	-22%



The charts above identify bariatric surgeries performed in calendar year ("CY") 2019 and then compare the financial and key utilization variances of those members 12-months prior to their surgery and 12-months after their surgery. In CY 2019, 265 members had bariatric surgeries with an average cost per surgery of about $12k. Of those 265 members, 244 had 12-months of claims experience pre- and post-surgeries. The cost impact, on a PMPM basis, is very

favorable for members post-surgery. Total PMPM cost decreased 37% for those members, largely driven by a reduction of 45% in medical PMPM cost. Key utilization metrics also look favorable with ER visits and Rx scripts down 38% and 22%, respectively. We note that the increase in hospital inpatient admissions could be due to co-morbid conditions of the affected members.



Of the 244 members with bariatric surgeries, 137 had BMI ranges recorded through diagnosis codes. Of the 137 identified members, 80% saw improvement in their BMI range post-surgery, 15% saw no change, and 5% saw their BMI range worsen.

Segal confirmed similar findings with BCBS's analysis.

Recommendation

Segal recommends lifting the current restrictions on the program and adopting the standard carrier coverage policy. There is a clear, clinical and financial benefit to reducing the burden of chronic disease. Eliminating barriers to access to care will improve member satisfaction and reduce the overall disease burden to the Plan. Remove the yearly legistated finaical cap of $3 million/$3 million.

The client specific criteria requires participants to enroll in 3 months of nurse coaching with Health Advocate. Bariactric's centers have phsycian led nutritional, weight loss, and behavioral modification counseling. The coaching program has a participant cap both due demand and capacity of staffing the coaching program. In addition, the client specific clinical criteria to meet medical necessity is restrictive and does not align with the current literature and clinical recommendations. Segal recommends changing the coaching program to voluntary and adopting the standard carrier's policy for medical necessity.

Other Recommendations

Actuarial Statements

Segal understands that legislative bills are currently passed without a full understanding of the financial impact to the EBD Plans. Most states require legislative changes to be accompanied by an actuarial note or fiscal impact statement. This allows bill sponsors and legislators to understand the full impact of the bill before they vote. Sometime these go to a subcommittee to flush out some of the nuances of the bill and potentially fix any unanticipated bill costs.

Recommendation

Segal recommends adding a requirement of an actuarial note or fiscal impact statement for proposed legislation that impacts either the ASE or PSE Plan. This would be similar to the requirement in place for legislation filed affecting the State Retirement Systems. By doing this, legislators and bill sponsors will fully understand the financial impact of proposed changes.

Communications

Segal's communication practice reviewed the website EBD uses to communicate benefit information to its members. Specially, reviewing the following attributes:

- Usability
- Design
- Content accessibility, hierarchy, and organization
- Navigation
- Naming and information lining conventions

Recommendation

The current website does not incorporate best practices. We understand EBD was previously aware of this and were actively looking for solutions. Below are a few of the key takeaways, more details can be found in the prior presentation.

- Highlight home page content using "tiles"
- Direct "call-to-action" buttons to featured information
- Spell out acronyms
- Optimize for mobile viewing/use
- Configure search engine to return relevant results
- Include HTML (web-specific) text that's descriptive/provides links to details
- Use primary navigation to separate topics clearly and intuitively
- Review and act on site analytics regularly

Reserve and Funding

Reserve Policy

As part of responsible budgeting and plan management, it is important for self-insured plan sponsors to establish reserve policies, in order to shoulder year-to-year fluctuation in claims experience, as well as budget for outstanding claims that have not yet been paid. Typically, plan sponsors will hold two types of reserves as part of their budgeting strategy:

1. Incurred but not reported (IBNR) reserves: IBNR reserves represent reserves for claims that have been incurred (i.e., procedures provided, treatments received) that have not yet been paid. These reserves occur due to lags in payments resulting from claims reviews, and billing processes. For states similar to Arkansas, as well as other large plan sponsors of similar size, a reserve of this type is typically in the range of 7% - 9% of claims.
2. Claims fluctuation reserves (CFR): CFR are established in addition to IBNR in order to ensure plan solvency in the event of adverse claims experience. These reserves provide protection for the plan if claims exceed budgeted targets for a specific month and/or year. For groups of Arkansas' size, Segal's proprietary models would recommend a CFR of 7.9%, which is calculated based on group size and stop loss coverage. Other states vary widely in their policies, with CFR reserves ranging from 3% to 10% of projected claims.

We reviewed reserve policies established by other states across the country. The following summarizes the various procedures in place for these states:

- Alaska: Total reserve of 150% to 250% of IBNR
- Arizona: Total reserve of 200% of total unpaid liability
- Colorado: Minimum target reserve of 12%
- Kansas: 5.5% solvency reserve in addition to IBNR
- Mississippi: CFR of ½ of monthly projected incurred claims, approximately 4%
- Nebraska: 7.8% solvency reserve in addition to IBNR, and a $5M daily operating reserve.
- New Hampshire: 3% solvency reserve (considered a floor)
- North Carolina: Reserve set at 9% of anticipated claims
- South Dakota: Solvency reserve equal to IBNR, approximately 8%
- Tennessee: Reserve set at 10% of anticipated claims
- West Virginia: Target reserve of 14% of plan expenses
- Wisconsin: Target reserve of 8-10% of medical self-insured claims and 3-5% of fully-insured premiums

Recommendation

Based on Arkansas' size, Segal's modeling, and established practices of other states in the country, Segal recommends that Arkansas establish a reserve policy of 12% - 16% of projected expenses in a given plan year. We feel that this will sufficiently fund the IBNR reserve as well as provide adequate protection against adverse claims experience.

Funding Strategy

In addition to the establishment of targeted reserves, it is a best practice to establish a funding strategy over a multi-year period managing plan design decisions and funding strategies against these established reserves. A good, long-term budgeting policy and funding strategy allows the plan sponsor to be prepared.

History

In reviewing the past policies, Arkansas's plan management has been reactive to budget shortfalls, reviewing claims on a short-term basis, requiring the need for ad hoc funding for both State employees and Public School employees. The following tables represent the historical funding of the program:

Arkansas State Employees:

	2012	2013	2014	2015	2016	2017	2018	2019	2020
State Funding	$162	$167	$172	$174	$176	$175	$175	$174	$171
Employee Funding	86	87	91	95	95	97	97	97	101
Other Income	11	10	11	12	12	16	20	23	17
Total Income	**$259**	**$264**	**$274**	**$281**	**$283**	**$288**	**$292**	**$294**	**$289**
Medical Claims / Expenses	$190	$204	$197	$183	$195	$184	$218	$211	$218
Rx Claims / Expenses	78	84	72	77	78	78	83	88	91
Plan Administration	4	4	7	7	6	4	5	3	3
Total Expenses	**$272**	**$292**	**$276**	**$267**	**$279**	**$266**	**$306**	**$302**	**$312**
Net Income / (Loss)	**($13)**	**($28)**	**($2)**	**$14**	**$4**	**$22**	**($14)**	**($8)**	**($23)**

Public School Employees:

	2012	2013	2014	2015	2016	2017	2018	2019	2020
District Contribution	$94	$97	$100	$98	$97	$98	$100	$102	$102
Employee Funding	130	131	120	109	112	116	117	121	124
Dept of Education	50	50	50	104	70	77	88	88	90
Other Income	2	53	22	8	8	11	14	15	13
Total Income	**$276**	**$331**	**$292**	**$319**	**$287**	**$302**	**$319**	**$326**	**$329**
Medical Claims / Expenses	$233	$237	$225	$201	$223	$215	$259	$271	$279
Rx Claims / Expenses	64	68	53	52	54	53	59	63	68
Plan Administration	5	4	9	9	8	5	5	3	3
Total Expenses	**$302**	**$309**	**$287**	**$262**	**$285**	**$273**	**$323**	**$337**	**$350**
Net Income / (Loss)	**($26)**	**$22**	**$5**	**$57**	**$2**	**$29**	**($4)**	**($11)**	**($21)**

Over the years, there have been periods of flat funding (i.e., no increases), followed by the need for large influxes of dollars into the program and/or significant changes to the plan designs (e.g., elimination of Medicare Rx program for PSE retirees, large increases to employee contributions for 2022). This can be seen in the tables above, with the largest variation in short-term funding being additional ad hoc Department of Education funding for Public School Employees. These changes are the result of short-term planning, with the legislature reacting to funding holes, rather than planning for them on a long-term basis.

Going Forward *Without Recommended Changes*

On a projected basis, these funding shortfalls are expected to perpetuate and increase. The following tables detail our projections for the health of the program through 2025:

Arkansas State Employees

	2021	2022	2023	2024	2025
State Funding	$192	$204	$204	$204	$204
Employee Funding	111	123	123	123	123
Other Income	18	20	21	23	25
Total Income	**$321**	**$347**	**$348**	**350**	**$352**
Medical Claims / Expenses	$230	$242	$253	$266	$279
Rx Claims / Expenses	97	105	113	122	132
Plan Administration	2	2	2	2	2
Total Expenses	**$329**	**$349**	**$368**	**$390**	**$413**
Net Income / (Loss)	**($8)**	**($2)**	**($20)**	**($40)**	**($61)**
Total Assets	**$70**	**$68**	**$48**	**$8**	**($61)**
Reserve Target (14%)	**$46**	**$49**	**$52**	**$55**	**$58**

Public School Employees:

	2021	2022	2023	2024	2025
District Contribution	$94	$97	$97	$97	$97
Employee Funding	149	165	165	165	165
Dept of Education Funding	130	165	110	110	110
Rebates	13	19	21	22	24
Total Income	**$386**	**$446**	**$393**	**$394**	**$396**
Medical Claims / Expenses	$326	$347	$371	$396	$422
Rx Claims / Expenses	73	78	84	91	98
Plan Administration	3	3	3	4	4
Total Expenses	**$402**	**$428**	**$458**	**$491**	**$524**
Net Income / (Loss)	**($16)**	**$18**	**($65)**	**($97)**	**($128)**
Total Assets	**$109**	**$127**	**$62**	**($35)**	**($163)**
Reserve Target (14%)	**$56**	**$60**	**$64**	**$69**	**$73**

The above projections account for projected, additional funding from recent changes enacted during the 2021 legislative session, including changes to wellness contributions, employee contributions, additional one-time funding from the State, and ongoing increases to funding from the Department of Education.

For both the State Employees and Public School Employees, net income is projected to be negative for the majority of the projection, and without additional funding or changes to the program, assets are projected to run out during 2025 and 2023, respectively. Further, both programs are projected to fall below a reserve target of 14% in 2023. This report details a number of potential plan changes that would increase plan income and reduce medical/Rx expenses with little to no impact on participants, but even with these changes, it is likely that additional funding will be required. Without any changes to the plan, the ASE program would require an additional $20 million in funding in 2023 to break even, and the PSE program would need an additional $65 million. These annual deficits are projected to increase, as medical and pharmacy expenses increase and funding is projected to remain flat.

Going Forward *With Recommended Changes*

If the State were to implement all of the changes recommended in this report, the funding shortfall is less significant but does still exist.

Arkansas State Employees:

	2021	2022	2023	2024	2025
State Funding	$192	$204	$204	$204	$204
Employee Funding	111	123	110	110	110
Other Income	18	20	42	36	39
Total Income	**$321**	**$347**	**$348**	**$350**	**$353**
Medical Claims / Expenses	$230	$242	$238	$251	$264
Rx Claims / Expenses	97	105	83	92	102
Plan Administration	2	2	2	2	2
Total Expenses	**$329**	**$349**	**$323**	**$345**	**$368**
Net Income / (Loss)	**($8)**	**($2)**	**$33**	**$5**	**($15)**
Total Assets	**$70**	**$68**	**$101**	**$106**	**$91**
Reserve Target (14%)	**$46**	**$49**	**$45**	**$48**	**$52**

Public School Employees:

	2021	2022	2023	2024	2025
District Contribution	$94	$97	$97	$97	$97
Employee Funding	149	165	165	165	165
Dept of Education Funding	130	165	110	110	110
Rebates	13	19	37	40	43
Total Income	**$386**	**$446**	**$409**	**$412**	**$415**
Medical Claims / Expenses	$326	$347	$375	$400	$427
Rx Claims / Expenses	73	78	79	86	93
Plan Administration	3	3	3	4	4
Total Expenses	**$402**	**$428**	**$457**	**$490**	**$524**
Net Income / (Loss)	**($16)**	**$18**	**($48)**	**($78)**	**($109)**
Total Assets	**$109**	**$127**	**$79**	**$1**	**($108)**
Reserve Target (14%)	**$56**	**$60**	**$64**	**$69**	**$73**

The changes incorporated above include a move to Medicare Advantage, with assumed migration of 75%, recognition of additional rebates due to pharmacy contract updates, the implementation of recommended diabetes management programs, and a change in the PSE benefits designs to match that of the ASE employees. All changes are assumed to be implemented as of January 1, 2023.

As shown above, the shortfall is reduced, particularly for the ASE program, by implementing the changes but a gap still exists. Before any funding strategy is incorporated, it will be important for the State to increase funding of the program, particularly for the PSE program. In order to close the $48M gap in 2023, we estimate that the current Department of Education funding requirement will need to be increased. A one-time payment into the fund only act as a band aid rather than fixing the problem. However, the EBD collects $168.52 per *enrolled* teacher in the districts. If this were increased in 2023 to $278 per *enrolled* teacher, or alternatively, $194 per *eligible* teacher, the funding gap would be eliminated as this funding source is reoccurring each year.

Combining ASE and PSE Funds

To further stabilize the fund balances and reserve process, the State should consider combining the two funds from a revenue and expense perspective. Since employee contributions are highly variable from district to district within the PSE program, we would not recommend harmonizing the employee contribution strategy, just combine the funds from a budgeting perspective. The tables below represent the impact that this would have and fund balances and reserve requirements, assuming no changes, as well as incorporating all of the recommended changes in this report.

Combined Funding Without Recommended Changes:

	2021	2022	2023	2024	2025
State Funding	$192	$204	$204	$204	$204
Employee Funding	260	288	288	288	288
District Contribution	94	97	97	97	97
Dept of Education Funding	130	165	110	110	110
Other Income	31	39	42	45	49
Total Income	**$707**	**$793**	**$741**	**$744**	**$748**
Medical Claims / Expenses	$556	$589	$624	$662	$701
Rx Claims / Expenses	170	183	197	213	230
Plan Administration	5	5	5	6	6
Total Expenses	**$731**	**$777**	**$826**	**$881**	**$937**
Net Income / (Loss)	**($24)**	**$16**	**($85)**	**($137)**	**($189)**
Total Assets	**$179**	**$195**	**$110**	**($27)**	**($216)**
Reserve Target (14%)	**$102**	**$109**	**$116**	**$123**	**$131**

With no changes, combining funds would still result in shortfalls over the five-year projection period. However, if recommended changes are incorporated, the overall funding requirements for the program are less significant, as the ASE program would help to support the shortfalls of the PSE program (see chart below):

Combined Funding With Recommended Changes:

	2021	2022	2023	2024	2025
State Funding	$192	$204	$204	$204	$204
Employee Funding	260	288	288	288	288
District Contribution	94	97	97	97	97
Dept of Education Funding	130	165	110	110	110
Other Income	31	39	79	76	82
Total Income	**$707**	**$793**	**$765**	**$762**	**$768**
Medical Claims / Expenses	$556	$589	$613	$651	$691
Rx Claims / Expenses	170	183	162	178	195
Plan Administration	5	5	5	6	6
Total Expenses	**$731**	**$777**	**$780**	**$835**	**$892**
Net Income / (Loss)	**($24)**	**$16**	**($15)**	**($73)**	**($124)**
Total Assets	**$179**	**$195**	**$180**	**$107**	**($17)**
Reserve Target (14%)	**$102**	**$109**	**$116**	**$123**	**$131**

Although additional funding would still be required in order to stabilize the program in the long-term, the combination of the two funds would reduce the additional funding required to hit reserve targets. As a result, additional funding should be incorporated into the PSE program, before combining these two funds. If the income shortfall is not addressed, the State will be in a similar situation in the coming years.

Funding Policy Recommendation

Regardless of the changes that are adopted for the program, we feel that it is imperative for the State to incorporate a longer term funding policy for the program, in order to stay ahead of projected shortfalls or cost increases. Going forward, the State should review actuarial projections for cost and expenses over the period of at least two biennium. These projections should include annual funding increases for the program, as well as an understanding of whether plan assets will remain above reserve targets. For the projection period, the following provisions should apply:

- Reserve target should be defined as a percentage of projected plan expenses. Based on the review noted above, we would recommend a reserve target of 14%.
- The Plans should establish a range around the reserve target to serve as a corridor to account for potential adverse experience. With a 14% target, we would recommend a 12% - 16% reserve target range.
- State funding should be projected to increase annually, based on an appropriate inflation figure (e.g., CPI-Medical Care)

- After accounting for projected funding increases over the period, should assets fall below the reserve target corridor, a financial "trigger" should be established. This would result in the need for additional funding in excess of the chosen inflation figure in order to ensure that assets remain within the target reserve corridor.
- If the Plan fails to act in this manner, the increase required to satisfy the funding need should come directly from employee contributions or changes to the plan design.
- If projected assets exceed the reserve corridor at the end of the projection period (i.e., above 16%), the Plan may elect to increase funding at a level below the selected inflation rate.

These actuarial projections should be provided on an annual (at least) basis and presented to the legislature. Since actuarial projections are reliant on assumptions, it may also be appropriate to have these calculations approved by a separate, independent actuary to ensure that the assumptions are reasonable and in line with standard actuarial practices.

Financial Projection – Including All Recommended Changes and Funding:

The main source of additional required funding is related to the shortfall in the PSE program. Currently, we project a funding shortfall of $48 million in 2023 for that program on its own, assuming the recommended changes are implemented. As noted, the funding will need to be increased as a baseline, and then further increased on an annual basis by some appropriate inflationary factor. The following table represents the funding levels if the program were to increase PSE funding by $48 million in 2023 to eliminate their annual shortfall, and increases further funding amounts by an assumed medical CPI of 4.5%.

	2021	2022	2023	2024	2025
State Funding	$192	$204	$213	$223	$233
Employee Funding	260	288	275	275	275
District Contribution	94	97	145	152	158
Dept of Education Funding	130	165	115	120	126
Other Income	31	39	79	76	82
Total Income	**$707**	**$793**	**$827**	**$845**	**$874**
Medical Claims / Expenses	$556	$589	$613	$651	$691
Rx Claims / Expenses	170	183	162	178	195
Plan Administration	5	5	5	6	6
Total Expenses	**$731**	**$777**	**$780**	**$835**	**$892**
Net Income / (Loss)	**($24)**	**$16**	**$47**	**$10**	**($18)**
Total Assets	**$179**	**$195**	**$242**	**$253**	**$234**
Reserve Target (14%)	**$102**	**$109**	**$116**	**$123**	**$131**

Although the income levels are projected to remain negative in 2025, with the additional funding, the program remains well above target reserve amounts for the duration of the five-year projection with these increased funding levels. Finally, since the Assets are expected to be above the high end of the Target Reserve Range, the State may elect to increase funding below Medical CPI and still remain financially sound.