MISSOURI CONSOLIDATED HEALTH CARE PLAN
BOARD MEETING
OCTOBER 26, 2017

Attending: Jim McAdams
Representative Kip Kendrick (via conference call)
Mark Langworthy
Director Chlora Lindley-Myers
Linda Luebbering (via conference call)
Daniel O'Neill (via conference call)
Senator John Rizzo (via conference call)
Senator David Sater
Viola Schaefer
Representative David Wood (via conference call)

Absent: Director Randall Williams

Others attending: Judith Muck, Executive Director; Denise Chapel, Director of Vendor Relations; Shelley Farris, Director of Benefit Administration; Stacia Fischer, Chief Financial Officer; Tammy Flaugher, Senior Administrative Specialist; Ryan Hobart, Multimedia Communication Manager; Bruce Lowe, Chief Information Officer, Jennifer Stilabower, General Counsel; Julie Watson, Chief Population Health Officer; and visitors.

Mr. McAdams called the meeting to order.

Mr. Langworthy made a motion to approve the open session minutes of the September 28, 2017, regular MCHCP Board of Trustees meeting. Director Lindley-Myers seconded. Motion passed unanimously.

Ms. Schaefer joined the meeting.

Dr. John Davren reviewed the UMR Plan Performance Analytic Review (PPAR) presentation. The report covers calendar year (CY) 2016. There is a claims run out period of three months thereafter for claims paid through March 31, 2017. The report compares 2016 to 2015 in a 12-month period. All data provided is for members under the age of 65. The results are for all plans and locations. Pharmacy data is from reporting files provided by Express Scripts, Inc. (ESI).

The Norm benchmark is UMR's Book of Business (BOB) of 2,087 groups representing 2.6 million members. Norms that include pharmacy are restricted to groups whose pharmacy vendors provide UMR with detailed pharmacy data.

Total membership decreased slightly from 2015 to 2016, and age and gender composition was relatively stable. Members age 45+ are well over the Norm. This population typically drives frequency and severity of chronic conditions. The average adult age is 1.7 years higher than the Norm.

Dr. Davren reviewed the key indicators of the PPAR presentation. The paid per member per month (PMPM) expenditures increased 9.7 percent and is significantly higher than both Norm and peer (+15.1 percent and +17.1 percent). Admits per 1,000 decreased slightly in 2015 but are up 6.5 percent over prior year. All years are unfavorable compared to Norm. Rate of readmissions is well over Norm (note that readmits include scheduled services so high rates are often driven by chemotherapy, et al). Emergency room visits per 1,000 have trended upward over the last couple of years and are notably more than both Norm and Peer. The Peer group set is UMR Groups with greater than 10,000 covered lives, which comprises 29 groups, representing approximately 959.9 thousand members.

In regard to cost trend (medical and pharmacy paid PMPM) over the past four years, cost PMPM has trended consistently upward, driven by both high cost claimants (HCC) and non-high cost claimants.

Dr. Davren reviewed the HCC summary for members with medical and pharmacy expenditures more than the $50,000 threshold. The top HCC conditions include renal failure, bursitis and Leukemia.

The risk distribution overview shows the healthiest 36.8 percent of members account for 2.4 percent of costs while the sickest 4.5 percent of members account for 42.4 percent of costs. The risk groups include Healthy, Stable, At Risk, Struggling and In Crisis.

Preventive screenings and well visits show that the well visit rates and preventive rates of adult screenings in many categories are above the UMR Norm.

Condition prevalence and cost was then reviewed for musculoskeletal, cancer and other. Musculoskeletal conditions; prevalence decreased a little for join disorders and lower back disorders, but all conditions are significantly higher than Norm. Cancer rates are all down except for colon cancer, but all rates are significantly higher than Norm. Prevalence far exceeds UMR Norms for all joint conditions and all types of cancer. Across all condition types, cost per patient went up except for prostate cancer, but other than joint disorders, all conditions cost less than Norm.

In regard to notable chronic conditions — overall, prevalence is down except for coronary artery disease (CAD) and renal function failure, but all conditions compare quite unfavorably to Norm. Cost per patient went up

substantially except for asthma and congestive heart failure (CHF), but other than chronic obstructive pulmonary disease (COPD) and overweight/obesity, all conditions cost much less than Norm. COPD is notable: prevalence is 100.2 percent more than Norm, while cost per patient is up 37 percent and is 28.2 percent worse than Norm – most COPD is smoking related. Overweight/obesity prevalence 70.4 percent over Norm, while cost per patient is up 25.4 percent and is 160 percent worse than Norm.

The top conditions that are potentially influenced by lifestyle factors include: osteoarthritis; coronary artery disease; overweight/obesity; cancer – breast; diabetes; cholecystitis/cholelithiasis; cerebrovascular disease; mental health – depression; mental health – substance abuse; and Infections – respiratory, necrotizing enterocolitis (NEC). $79,076,990 spent on conditions with a potential link to lifestyle is equal to 18.9 percent of total paid versus $73,359,364 in 2015 (18.9 percent).

The top 10 major diagnostic categories (MDC) were reviewed and include: musculoskeletal; circulatory; digestive; health status; nervous system; ear, nose, mouth and throat; kidney; neoplasms; skin, breast; and metabolic. Major cost factor for musculoskeletal is knee issues and per patient costs mostly went up except for skin/breast. Most MDCs compare unfavorably to Norm.

Dr. Davren briefly reviewed the inpatient and emergency room utilization drivers. Two of the top inpatient diagnoses were related to maternity/newborns. Non-specific pain was a driver for both admits and emergency room visits. There are opportunities for some of the emergency room visits to be redirected to a more appropriate place to seek treatment.

The key takeaways from the PPAR Report include: PMPM costs increased 10.5 percent, as well as HCC increasing 16.9 percent; risk distribution shows an increase in the At Risk (0.8 percent), Struggling (1.3 percent) and in crisis (0.4 percent) members; prevalence of chronic conditions decreased in seven of the nine conditions; however, with the exception of pregnancy all exceed the UMR Norms; lifestyle-related conditions accounted for 18.9 percent of total paid claims or $79,076,990 versus $73,359,364 in 2015, overweight/obesity (7.9 percent of 18.9 percent) following 2015 trend (7 percent of 18.9 percent) and continues to be the highest variance from the UMR norm (1.7 percent of the 18.9 percent); and for 2017 UMR is interested to see how incorporating the following Care Management programs have affected the clinical results: UMR Group Population Support (GPS) with HealtheNotes, HealtheNote Reminders, Treatment Decision Support and Readmission Prevention programs.

Ms. Muck presented the non-contraception benefit option. The Internal Revenue Service; United States Departments of Treasury, Labor, and Health and Human Services filed interim final rules, effective Oct. 6, 2017, that would allow MCHCP to offer a benefit package without contraception services to those who

object to such services based on a religious belief or moral conviction. In part, the new regulation found at 45 CFR 147.133(b) and CFR 147.132(b) states that nothing in the Affordable Care Act's (ACA's) contraceptive mandate guidelines may be construed to prevent a willing plan sponsor from offering a separate policy, group health plan or benefit package option to any individual who objects to coverage or payments for contraceptive services based on sincerely held religious beliefs or moral convictions. These new regulations give MCHCP the option to approve individual requests for contraceptive-free coverage without violating the ACA's contraceptive mandate. There is a caveat in that this only applies to the contraceptive services required under the ACA and would not alter requirements under other federal or state laws governing the coverage of such services.

Missouri Revised Statues under Section 191.724 would seem to require MCHCP to offer such a benefit package without contraception if such services are contrary to the employee's religious beliefs or moral convictions.

In light of this new federal regulation in conjunction with Missouri state law, MCHCP is prepared to offer MCHCP non-Medicare primary members a non-contraception benefit option. MCHCP is planning to give current members through Nov. 20, 2017, to elect this benefit option for coverage effective Jan. 1, 2018. New employees will be offered this option through their regular enrollment processes. With the board's approval, MCHCP will be sending out communication the week of October 30 to allow members an opportunity to elect this coverage option.

MCHCP is not able to offer non-contraception coverage to those members who have Medicare-primary coverage. The Medicare Part D Drug Plan offered through MCHCP is governed by the Centers for Medicare and Medicaid Services (CMS) under Medicare regulations found at 42 CFR 423.120. Those regulations broadly include contraceptives approved by the FDA and associated CMS formulary reference guides list several contraceptives to be included in Medicare Part D formularies. Therefore, MCHCP cannot alter Medicare covered services which do include contraception services. MCHCP will be able to offer covered family members who do not have Medicare-primary coverage a benefit option without contraception.

The board was provided with the actuarial determined rates without contraception services for approval. Generally rates for active employees were reduced by .5 percent and retirees without Medicare coverage were reduced by .1 percent as outlined. An example of the premiums active employees will pay for coverage without contraception was also provided to the board. The rate difference is generally between $1 and $2 depending on the rate tier. Differences in retiree premium will be driven by the formula used to derive the amount MCHCP will subsidize — 2.5 percent times year of service capped at 65 percent of the PPO 600 Plan.

The board was provided with a copy of the new emergency rule to allow MCHCP to offer this benefit package option to state employees and retirees. It is a new rule, 22 CSR 10-2.135, Benefit Package Option. MCHCP also shared a copy of the companion rule for Public Entities, 22 CSR 10-3.135. Once approved by the board, MCHCP will file the emergency and proposed rules with the Secretary of State and Joint Committee on Administrative Rules (JCAR).

MCHCP anticipates filing the new rules on October 27 should the board approve today.

Following a brief discussion, Ms. Schaefer made a motion to offer a Benefit Package Option that excludes contraception benefits with an effective date of Jan. 1, 2018, for those declaring a religious or moral conviction and to authorize the executive director to finalize the requisite rules, make technical corrections and then to file with the Secretary of State and JCAR all necessary documents relating to the proposed and emergency rules based on the evidence and emergency statements presented to the board. Mr. Langworthy seconded. Motion passed unanimously.

Ms. Muck presented the administrative emergency and proposed rules necessary to fully implement the 2018 Plan year. Since MCHCP is not altering plan design and benefits from 2017, there are only a few rules that need to be modified.

22 CSR 10-2.030 Contributions — In Section 22 CSR 10-2.030 (7)(B), this is changed every year as the percentage of the total premium that represents prescription drug coverage changes with that year's premium. This year it is 59 percent versus 58 percent last year. The next change is found in Section (8). MCHCP now allows debit and credit card transactions for members to pay their premium should payroll or retirement not be sufficient to cover the amount. Section (8)(D)1. makes it clear that if the premium is paid by debit or credit card, the subscriber is responsible for any associated bank service fees.

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members — MCHCP is amending Section (1)(F) of this rule to reflect CMS changes in the initial coverage stage to end once claims reach $3,750 from $3,700 in 2017. And to reflect the Coverage Gap stage to begin once claims exceed $3,750 from $3,700 in 2017 and remain below $5,000 from $4,900 in 2017. MCHCP is correcting (F)(3) to reflect $5,000 versus $4,900. In Section 4, the catastrophic coverage stage begins once claims reach $5,000 from $4,950 in 2017. The copayments in this section change to $3.35 for generics and $8.35 for all other drugs with all other copayment requirements remaining the same.

Ms. Schaefer made a motion to authorize the executive director to finalize the rules applicable for the 2018 plan year, make technical corrections and then

to file with the Secretary of State and JCAR all necessary documents relating to the proposed and emergency rules based on the evidence and emergency statements presented to the board. Senator Sater seconded. Motion passed unanimously.

Ms. Muck presented the Central Bank, Banking and Investment contract renewal. This is the last renewal option for this contract. MCHCP's current contract is with Central Bank.

The renewal offer maintains 2017 pricing with one improvement. Central Bank improved the investment management fee for Capital Markets portfolio from 20 basis points to 17.5 basis points that is estimated to save a little more than $9,000. It is staff's recommendation to renew the contract for this final year.

Senator Sater made a motion to renew the banking and investment contract with Central Bank for CY 2018 as presented. Ms. Schaefer seconded. Motion passed unanimously.

Ms. Muck presented the ESI Opioid Program update. As mentioned in previous meetings, ESI is offering a new Opioid Management program priced at approximately an additional $350,000 annually. MCHCP has looked closely at what the new program brings that is different from what MCHCP already has in place.

MCHCP has many aspects of this program in place today. Most notably MCHCP has a Pharmacy Lock-In program through ESI's fraud, waste and abuse program. We have access to specialist pharmacists for inbound calls. We have concurrent drug utilization review and Rational Med to alert physicians as it relates to opioid use. There are currently 14 alerts specific to opioid. We have unlimited access to ESI utilization management tools such as prior authorization.

What MCHCP will not be able to implement without purchasing this program is a new physician care alert program via their electronic medical record portal, if available. MCHCP will not be able to implement the Morphine Equivalent Dose Edit and first fill supply limit to seven days. MCHCP will miss a member education letter and an outbound call to a member (two tries to reach the member) from a specialist pharmacist. And MCHCP will not have access to opioid deactivation disposal bags. MCHCP staff are most interested in the two new edits but ESI declined to carve out these edits from the program.

We have more than 100 members who have been diagnosed with opioid addiction who cost about $1 million annually.

Given the additional cost of the program and taking into account the breadth of interventions that MCHCP has already in place through the contract with ESI, unless the board has specific concerns, MCHCP will not elect this

option right now. MCHCP will continue to monitor claims to determine if it would make sense in the future.

Senator Sater commented that the opioid problem continues to worsen and he plans to file legislation on the issue.

Ms. Muck provided an Open Enrollment (OE) update. She was pleased to announce that OE this year is going very well. As is usual for our active employees, they are waiting until the last few days to take action. Many members may not take a proactive enrollment choice since most roll over to their same plan in 2018. The exception to that is active employees in the PPO 300 Plan, if they do not take action they will be rolled into the PPO 600 Plan.

Ms. Muck provided a synopsis of our involvement this year. MCHCP did not conduct on-site meetings and did not receive negative feedback from the membership. The board was provided with the member contacts so far and it was noted that it will pick up as we end the month. Only about half of our members had made a choice as of Monday. Again, it will pick up as we near the end of the month, with many members opting to passively enroll. Only about 19 percent of members used myPlan advisor. It is not surprising since we have not changed plan design. We have some time for the Partnership Incentive and Tobacco-Free Incentives, as members have until November 30 to complete those incentives to have a reduced premium January 1. If members do not complete the incentives by November 30, they can still do the incentive later, it will just have a later start date.

Finally, we have had a lot of website activity as provided to the board. Ms. Muck is pleased with the educational videos and recorded webinars viewed by our members, primarily actives.

Ms. Fischer presented the financial update. She reviewed some September 2017 results.

Monthly state contributions for September from the employer of $33,561,846 and member contributions of $8,762,639 represent contributions from 53,339 subscribers and total 95,766 covered lives.

MCHCP received $661,240 in payments associated with our retiree – Employer Group Waiver Plan (EGWP). These payments reflect direct subsidy and prospective federal reinsurance payments to the Plan.

Ms. Fischer then moved to our investment section primarily associated with the Other Post-Employment Benefits (OPEB) Trust. The OPEB Trust total portfolio returned 1.30 percent for September net of fees with a concentration mix of 40 percent equities, 57 percent fixed income and approximately 3 percent in cash and equivalents. Since inception total fund return is 7.41 percent; nearly a 1

percent increase over the weighted benchmark of 6.52 percent. The Plan's historical OPEB returns are as follows: rolling 12 months (1 year), benchmark 7.417 percent, actual 6.385 percent; rolling 36 months (3 years), benchmark 5.631 percent, actual 4.064 percent; and rolling 60 months (5 years), benchmark 7.924 percent, actual 6.392 percent. Comments from our investment manager include as it relates to our performance strategy. As we near the end of 2017, we will have an optic to tax reform and how interest rates react. Currently we are at the top of our equity market exposure, although pared back slightly as markets realize new highs – requiring a watch toward risk. Bond cash flows are in the 5-7 year part of the curve to target at 2.5 percent or more. As the Federal Open Market Committee (FOMC) has significant control over short term rates, the investment team believes most of the rate moves will be in this category.

In our expense section, self-funded medical claims posted at $32,455,155 for September, this after August totals posted at a calendar high at $45,261,336 primarily the result of higher large claimant spend in August of $4.9 million, an additional 2.3 days of August processing days over the average attributing to an additional $3.5 million, and an additional $1.5 million associated with the third party administrator's (TPA's) effort to reduce Medicaid claim inventory. These contributed to an average claims cost in August of $310, while September's average claims costs posted at $253. Gross pharmacy expense for September was $9,838,121.

Next, Incurred But Not Reported (IBNR) remains unchanged. September claims data has just posted to our data warehouse and has been sent to Willis Tower Watson for an IBNR update which will be reported to the board in December.

Turning to 2018, the Plan conservatively has maintained the fiscal year (FY) 2018 funding level from the state for the full CY at $403.3 million or $33.6 million monthly. Medical and pharmacy projections reflect seasoning at intervals to reflect projected medical and pharmacy trends. All other expenditure lines have been updated to reflect current enrollment and existing contract pricing. In 2018, as conservatively projected with no new revenue stream over our current FY 2018 levels, if you look to the net position, the Plan is projected in July 2018 to drop below the Plan's ability to be able to fully fund its liability for IBNR claims costs by the projected $55 million in July 2018.

Briefly turning to 2019, the Plan again has conservatively maintained the FY 2018 funding from the state of $403.3 million. Again, not making a presumption of the level of funding that will occur of the $91 million new decision item we previously discussed. In member contributions, we have not assumed the ability to maintain flat premiums and have reflected the anticipated trend increases in member contributions. We have also included the actuarially projected medical and pharmacy spend based upon the Plan's historical performance and anticipated trends net of rebates. In CY 2019, as conservatively

projected with no new revenue stream over our current FY 2018 levels, the Plan, beginning in January 2019 and for the full CY will be unable to fund the Plan's actuarially projected liability for (IBNR), and portions of the remaining liabilities progressively as the calendar months of 2019 continue. We ask you to appreciate that actual results may differ from these projections.

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

Upon return from closed executive session, Director Lindley-Myers made a motion to adjourn. Mr. McAdams seconded. Motion passed unanimously. Meeting adjourned.