MISSOURI CONSOLIDATED HEALTH CARE PLAN
BOARD MEETING
JUNE 28, 2018

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

Absent: Mark Langworthy
Senator David Sater

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

Mr. McAdams called the meeting to order.

Mark Reading addressed the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees. Mr. Reading is President of the Association of Active and Retired Missouri State Employees (ARMSE). He was a state employee for 31 years.

Mr. Reading began by saying that ARMSE monitors what is happening with benefits as they relate to state retirees and provides members with updates on what is transpiring. He stated that within the last week, Missouri State Employees' Retirement System (MOSERS) and Missouri Department of Transportation (MoDOT) had held board meetings.

As of yesterday, general revenue collections were up for the year 5.2 percent. The budget was based on the assumption there would be collections of 1.9 percent this year. $300 million were paid last year for refunds in June 2017. This year they have been paid on time. There may be $250 million or more coming in than expected. Revenue collections year-to-date as of yesterday were basically at the same number that is projected for the end of next budget year,

fiscal year (FY) 2019. With the tax cuts that have been passed the revenues may only slightly rise or stay flat. Basically the collections brought in this year should be used for one-time purposes. In the past few years, the state has had to borrow from MCHCP's reserve. MCHCP might consider asking that those amounts be repaid.

Mr. Reading indicated that MOSERS has discussed several changes in assumptions that are large. They have discussed requesting a sizable budget increase of even more than MCHCP asked for in FY 2019. One of MOSERS assumptions relates to automation. They believe this will allow for the elimination of 9,000 state workers over the next few years. Depending upon which trend line they choose this could require getting rid of 500-750 employees each year. The trend line they are working on is behind schedule. Mr. Reading wonders if MCHCP had considered these in our assumptions. The affected positions will likely be account clerks, accountants, data entry, etc. and will primarily be females. This will likely change MCHCP's pool. Representative Fitzpatrick implored that the pay plan should not be considered to increase more than 1.75 percent. The concerns ARMSE has is if state workers can only get 1.5 percent pay raise this eliminates any hope from any automation effort that occurs.

Mr. Reading said that ARMSE believed the 2011 retirement changes and the decisions the MOSERS board had made had solved long-term changes. However, it seems MOSERS is preparing to ask for a large increase for a problem that doesn't need to be resolved immediately and MCHCP is not asking for money for a more immediate need.

MoDOT met yesterday and their consultant told them they do not need to make any changes. They could keep their PPO 600 Plan with no premium increase. The health care plan board decided to go with a 2 percent increase. The MoDOT Commission will decide if they will participate to that 2 percent increase. The health care board itself was left with the impression that MoDOT was going to pick up some, if not all, of the 2 percent increase.

Mr. Reading concluded by saying that ARMSE has written a letter to the governor and to Representative Fitzpatrick regarding their concerns for state employees who are looking at changes in the PPO plans and premium increases.

There were no further public comments.

Representative Wood made a motion to approve the open session minutes of the May 24, 2018, regular MCHCP Board of Trustees meeting. Director Williams seconded. Motion passed unanimously.

Ms. Muck reviewed the 2019 plan design. Today, there are more issues/decisions for the board to make for 2019 coverage. Ms. Muck included an

overview of the plan designs that were discussed in May. At the May meeting, the board indicated that they wanted to look at the difference in rates between a PPO 750 Plan combined with the PPO 1250 Plan and Health Savings Account (HSA) Plan versus a PPO 1000 Plan combined with the PPO 1250 Plan and HSA Plan. Rates will not be available until the July meeting.

MCHCP met with our myVoice Panel (MVP) groups on June 6 – one for actives and one for retirees. MVP is MCHCP's focus group that we use to solicit opinions and advice from our membership. MCHCP went over the options presented to the board in May. Overwhelmingly, both groups would like to see the PPO 750 Plan combined with the PPO 1250 Plan and HSA Plan as plan designs for 2019. They liked the distinct difference in PPO Plan deductible amounts and with the PPO 750 Plan closer to what members are used to in the PPO 600 Plan and an option without copayments included. They didn't believe the difference between the PPO 1000 Plan and PPO 1250 Plan was substantial enough to make a distinction between the two plan design options.

MCHCP has also compared these offerings to what is offered in 2018 among other public groups in our area. We do not have their 2019 offerings as a comparison point.

MoDOT offers a PPO 600 Plan at an employee cost of $94 for employee-only coverage and a $1700 High Deductible Plan at an employee cost of $47 for employee-only coverage. Those are the only plans offered.

Conservation offers a PPO 1000 Plan at an employee cost of $174.70 for employee-only coverage and a $2500 High Deductible plan at an employee cost of $174.70 for employee-only coverage. Those are the only plans offered.

University of Missouri offers a PPO 500 Plan at an employee cost of $163 for employee-only coverage if they take advantage of their tobacco-free incentive and a $1500 High Deductible Plan at an employee cost of $38 for employee-only coverage.

Jefferson City Public schools has a PPO 500 Plan and a PPO 1000 Plan at a cost of $70 and $25 respectively for employee-only coverage and a $1500 High Deductible Plan at a $0 cost with wellness incentives.

City of Jefferson has a PPO 500 Plan at an employee cost of $35 for employee-only coverage and a $2700 High Deductible Plan with an employee cost of $35.00.

Columbia Public Schools has a PPO 750 Plan at a $0 employee cost for employee-only and a $2000 High Deductible Plan also at a $0 employee cost.

Many of the local public employer plans charge a much higher percentage of premium for dependent coverage than MCHCP does.

These public group offerings are simply informational to provide a lens to what other groups are offering.

Next, Ms. Muck discussed some benefit changes that we are proposing to tighten controls of the plan and generate savings.

The first change would be to infusion therapy benefits. Infusion therapy involves the administration of medication through a needle or catheter that is inserted into a vein and secured. Many infusion therapies can be administered in an outpatient center or even in the home. Examples of types of infusion therapy includes medications for blood factor disorders, dialysis and chemotherapy. The network cost of the infused drug is generally much more advantageous than what is charged by non-network providers. For example, in our analysis we had one patient receiving non-network treatment at a cost of $432,815. The same treatment was received through a network provider at an average cost of $45,158. In fact, all seven patients receiving services by network providers cost less in total than the one patient receiving the treatment from a non-network provider. Staff is recommending we eliminate non-network coverage of infusion therapy except if the service is not available within 100 miles of the member's home. This change will impact fewer than 100 members and is estimated to save $1 million annually.

Staff are also recommending that we implement a preauthorization on both dialysis and chemotherapy services to identify patients to care management early in their treatment protocol. There are about 500 members annually that receive chemotherapy at an annual cost of $10.5 million and fewer than 100 members receive dialysis at an annual cost of $4 million.

Next, we took a look at non-mandated MCHCP benefits that MCHCP offers that are not otherwise required by federal or state statutes or regulations. We identified five benefits with spending of more than $100,000 annually. There were three additional benefits with less than $100,000 that were not reflected given the low spending level for those benefits. MCHCP did this review as part of our due diligence in ensuring the board has a full understanding of the area of coverage under its discretion.

Ms. Muck reviewed the five benefits in further detail. She reviewed them in order of their annual spend from highest to lowest.

First is bariatric surgery. MCHCP has most recently covered this service since 2012. It was eliminated in 2011 as a cost savings measure but reinstated the following year. During 2011, public comments were received from physicians with the University of Missouri and Washington University School of Medicine

and from bariatric patients. We also received public comment from Johnson and Johnson. All public comments were requesting reinstatement of the benefit. The benefit was restored for 2012. MCHCP believed there would be a return on investment (ROI) within three years based on the analysis completed at that time. The cost to implement in 2012 was estimated to be $0.5 million. The board approved the reinstatement of the benefit.

Currently, approximately 100 members receive this surgery annually. The medical literature supports positive clinical outcomes with some caveats. ROI for bariatric surgery can now take up to seven years to realize. Patients will regain 20 to 25 percent of the weight lost. And 20 to 23 percent do not have a successful weight outcome. Substance use disorders are increased by six percent of patients following surgery – particularly alcohol abuse. MCHCP claims data that were adjusted for trend indicates that patient's claims data is higher for the three years after the surgery than the year before surgery. The annual cost of the surgery is approximately $3 million.

According to our third party administrator (TPA), self-insured plans generally do not cover bariatric surgery.

Director Williams had questions regarding inpatient versus outpatient bariatric surgeries, where the surgeries are being done geographically and length of stay for those inpatient surgeries. Ms. Watson agreed to discuss further with Director Williams and he agreed to provide information surrounding this topic with regard to Medicaid patients.

Second is non-essential drugs. MCHCP staff reviewed 11 of the most common non-essential drugs. The most utilized of these drugs are those for erectile dysfunction (ED). Some of the other non-essential drugs reviewed had little or no utilization. Most self-insured clients do cover ED drugs. MCHCP has both a preauthorization and quantity level limit for coverage. MCHCP had nearly a 12 percent decrease over the previous 12 months as Viagra went generic in December 2017 and Cialis is going generic later this year. All but a small portion of drug costs is for ED use. The annual cost of these drugs is $1.9 million.

Third is coverage of hearing aids. MCHCP covers hearing aids every two years with a dollar limit. Approximately 585 members access this benefit annually. Most self-funded plans do not choose to cover hearing aids. The annual cost is $1.9 million. This does not include cochlear implants which is about $80,000 per year.

Fourth is coverage of allergy testing and immunotherapy for members with allergic symptoms. Approximately 72 members get tested annually and almost 3,000 are on immunotherapy. The annual cost is $750,000 for this coverage.

Fifth is an annual vision exam that includes refraction covered under the medical benefit. Approximately 8,500 members take advantage of this benefit at an annual cost of $580,000. This service is also separately covered as part of the vision plan.

Following the overview of services, Ms. Muck asked if the board had any changes to coverage of the non-mandated services or questions. The board briefly discussed coverage of non-essential drugs and routine vision exams.

Director Williams made a motion for the 2019 benefit to approve to eliminate the non-network benefit for infusion therapy and add a preauthorization requirement for dialysis and chemotherapy. Mr. McAdams seconded. Motion passed unanimously.

Ms. Muck presented the Aetna, UMR and Stinson Leonard Street contract renewals.

She began with the Aetna renewal. This is the final renewal option for the five-year contract with Aetna. Aetna provides TPA services to MCHCP in the Southwest and South Central regions. Aetna has agreed to keep the administrative base fee at $34.04 per employee per month (PEPM). This fee remains the same regardless of what the board decides on with Medicare Advantage. The total estimated annual cost of this contract is $1 to $1.2 million.

The other fee of note is the fee for Teladoc services. This is telephone or online video consultation with a physician for routine common illnesses. Consultations are available twenty-four hours/seven days a week (24/7). Aetna has offered two different fees that we can elect for Teladoc. For general medicine there is a $0.95 PEPM. With this option, MCHCP can customize the plan design and have a different structure than the underlying plan design for primary care or we can have a $0.25 PMPM and a $3 per consult fee. This option has the claims following the existing plan designs. Each consult fee is $40 for general medicine. Dermatology is included in the general medicine rates and has a $75 consult fee. Finally they also offered two different options for behavioral health. $0.15 PEPM or $.07 PMPM and $3 consult administration fee. The claim for behavioral health is a $160 initial diagnostic; $90 for psychiatrists and $80 for non-psychiatric services.

Aetna also includes a $10,000 communication allowance and a $10,000 wellness allowance we can use for related costs.

It is MCHCP’s staff’s recommendation to renew the Aetna contract at the fees quoted.

Once the board approves the renewal, MCHCP will return at the July board meeting with our recommendation on Teladoc services and which fee structure is preferred.

Next is the UMR renewal. This is also the final renewal option for the contract with UMR. UMR provides TPA services statewide for both state and public entity (PE) members. UMR has kept the administrative base fee at the same level as 2018. They have not increased their fees throughout the term of the contract. The rate would be $21.44 PEPM that translates to an estimated $12.9 million annually. If we move to a group Medicare Advantage Plan, then the fee will increase to $22.49 PEPM because of the decrease in the number of subscribers. This would lower the annual estimated cost to $10.6 million.

UMR also has contracted with Teladoc. The estimated PEPM fee is $0.97 with a $45 encounter fee, dermatology is included in the general medicine PEPM rate with a $75 encounter fee. Behavioral health is a $.30 PEPM fee with $200 for the initial evaluation; $95 for psychiatrist and $85 for non-psychiatric services. The initial evaluation is only associated with the first psychiatric visit. Once the board approves the renewal, MCHCP will return at the July board meeting with our recommendation on Teladoc services.

MCHCP's staff recommends renewal of this contract. UMR continues to offer a $150 annual maintenance allowance and $100,000 discretionary funds.

The final contract renewal to review is for Stinson Leonard Street. This is the second renewal option of up to four renewals. The contract was awarded beginning in fiscal year (FY) 2017; renewed for FY 2018 and now before the board for FY 2019. Stinson has offered a renewal with a 5 percent increase rather than the 7 percent as allowed by their contract. A chart included in the renewal provides the hourly rates for each type of service which was provided to the board. It is staff's recommendation to renew the contract for FY 2019.

Director Lindley-Myers made a motion to approve the contract renewals for Aetna, UMR and Stinson Leonard Street as presented. Representative Wood seconded. Motion passed unanimously.

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

regarding your decisions can be reflected for the report. With those considerations, we'll discuss May activity.

Monthly state contributions for May from the employer of $33,467,420 and member contributions of $9,196,557 represent contributions from 53,460 subscribers and total covered lives of 96,114.

MCHCP received payments of $683,557 comprised of direct subsidy Employer Group Waiver Plan (EGWP) payments.

Ms. Fischer then moved to discussions regarding the investment section primarily associated with the Other Post-Employment Benefits (OPEB) Trust. The OPEB portfolio returned .79 percent for May net of fees with a concentration mix of 41 percent equities, 54 percent fixed income and 5 percent in cash and equivalents. Since inception total fund return is 7.06 percent; outperforming the weighted benchmark of 6.22 percent. For our rolling returns, the one-year portfolio return was at 4.92 percent with the three-year at 3.99 percent and the five-year at 6.21 percent. Comments from our investment manager include as it relates to our performance strategy: Plan to cut equities by 5 percent over the next month or so as a prudent step toward protecting existing equity gains. Anticipate shortening the bond duration slightly to target four versus five years. Believe interest rates will have a future downturn and that will allow for reinvesting cash flow at more attractive rates.

In our expense section, self-funded medical claims posted at $35,185,183 for May. Gross pharmacy expense for May was $14,540,325.

Next, Incurred But Not Reported (IBNR) presents no change over the updates from last month reflecting paid claims through March 31, 2018, projected by the actuary for the remainder of CY 2018 and through December 31, 2019. The updated IBNR projections have been influenced by an increase in both claims and an increase in trend for actives and non-Medicare retirees. For the period June 30, 2018, through Dec. 31, 2019, the increases in IBNR represent a range of 4 to 7 percent increases over the last report for claims paid through Dec. 31, 2017. With these updates, at Dec. 31, 2018, MCHCP's position would allow for the funding of only approximately $1 million of the $70.6 million in IBNR at Dec. 31, 2018. We ask you to appreciate that actual results may differ from these projections.

Ms. Muck presented a legislative update regarding Senate Bill (SB) 843. She brought the board's attention to the Truly Agreed to and Finally Passed (TAFP) Conference Committee Substitute for House Committee Substitute for Senate Substitute for Senate Committee Substitute for Senate Bill 843. The language was provided to the board members. This bill was signed into law by the Governor on June 1, 2018. The bill modifies the compositions, duties or repeals outright certain administrative boards, commissions and councils. On

page 11 of the bill, there was modification to section 103.008 of MCHCP's statutory section. It modified the eligibility requirements of the three members of the board who represent plan members.

MCHCP put a fiscal note for conducting a board election to be $60,000 to $100,000 based on the costs that MOSERS experience for its board elections.

Currently, the statutory requirement is that the governor appoints three members of the plan with advice and consent of the Senate. The bill changes the requirement for these three members to two members who shall be current employees elected by a plurality of employee members and one shall be a retiree elected by a plurality of retired members. The governor will continue to appoint three members who are not members of the plan but who are familiar with medical issues with advice and consent of the Senate.

MCHCP has MOSERS process for its board elections and we have its Request for Proposal (RFP) and contract with the vendor it uses for board elections. We are actively working on developing a rule for the board's consideration that will be modeled after MOSERS' processes with some modifications. As we go into our discovery mode, we are exploring the cost savings if we have an online board election process developed by our Information Technology (IT) department. Paper ballots will be available to those members that need an accommodation.

MOSERS requires active members to seek signature nominations from 100 active members and retiree members to seek signature nominations from 25 retiree members. They contract with a firm to conduct the election process and allow votes by paper, phone and online.

The requirement goes into effect August 28, 2018. A rule cannot be filed earlier than that date. We will bring the board a draft rule at the August board meeting so that we may file with the Secretary of State and Joint Committee on Administrative Rules (JCAR). We anticipate this will be an emergency rule.

MCHCP anticipates that if we can conduct the election process in concert with OE it could save money. Since it is already June, the requirement goes into effect in August, we will not have a rule in place to allow enough time for members to get their signature nominations made in order to be listed as a candidate for the position during this year's OE timeframe. It will most likely be November or soon thereafter.

MCHCP also anticipates that developing the board election process by our IT department will be less expensive to implement. Ms. Muck asked for the board's perspective of pursuing the online versus paper vote which could save up to $100,000. The board agreed to move forward with MCHCP's IT department

development of an online election process. MCHCP would have terminals available in our building for member to use who may not have computer access.

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

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