MISSOURI CONSOLIDATED HEALTH CARE PLAN
BOARD MEETING
DECEMBER 8, 2016

Attending: Chairperson Doug Nelson
Director Dan Haug
Nila Hayes
Representative Kip Kendrick
Linda Luebbering
Director Peter Lyskowski
Viola Schaefer
Senator Scott Sifton (via conference call)

Absent: Director John Huff
Mark Langworthy
Representative Caleb Rowden
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; Jennifer Stilabower, General Counsel; Julie Watson, Chief Population Health Officer; Aaron Cooper, Brown Smith Wallace, LLC; Todd Goldenhersch, Brown Smith Wallace, LLC; Christian Tieman, Brown Smith Wallace, LLC; and visitors.

Chairperson Nelson called the meeting to order. There were no public comments.

Ms. Muck announced that Missouri Consolidated Health Care Plan (MCHCP) received the Certificate of Achievement for Excellence in Financial Reporting, which is awarded by the Government Finance Officers Association, for MCHCP's Comprehensive Annual Financial Report (CAFR) for fiscal year (FY) ended June 30, 2015. MCHCP has received this award for 21 consecutive years.

Ms. Luebbering made a motion to approve the open session minutes of the October 27, 2016, regular MCHCP Board of Trustees meeting. Ms. Hayes seconded. Motion passed unanimously.

Aaron Cooper, Todd Goldenhersch and Christian Tieman of Brown Smith Wallace, LLC were introduced and presented the results of the annual external audit. This is the fourth year Brown Smith Wallace, LLC has performed the independent external audit.

Brown Smith Wallace, LLC congratulated MCHCP on 21 consecutive years of receiving the Certificate of Achievement for Excellence in Financial Reporting.

The data presented in Brown Smith Wallace, LLC, presentation was compiled from the financial statements of MCHCP (the Plan), which were audited by Brown Smith Wallace, LLC, for the year ending June 30, 2016. The data should be read in conjunction with the Plan's financial statements and the auditor's report thereon.

Mr. Goldenhersch briefly highlighted the three main phases of the audit process which include: planning – determine nature, timing and extent of procedures; fieldwork; and concluding the audit. He then reviewed the auditor's responsibility under professional standards: ensure that you receive information regarding the scope and results of the audit that may assist you in overseeing the Plan's financial reporting and disclosure process for which management is responsible; and communicate to you the nature of assurance provided by the audit and level of responsibility we assume under auditing standards generally accepted in the United States of America. In this regard, an " … audit is designed to obtain reasonable assurance about whether the financial statements are free of material misstatement whether caused by error or fraud". The reporting accounting basis for the Plan's audited financial statements are U.S. General Accepted Accounting Principles (GAAP).

Mr. Goldenhersch reviewed the audit results in regard to management responsibilities, auditor's report being issued, and independence.

Mr. Goldenhersch also reviewed the required communication in regard to significant or unusual transactions, adoption of, or change in, accounting policies/principles, significant management judgments and accounting estimates, unrecorded misstatements, disagreements with management, consultations with other accounts, difficulties encountered in performing the audit, and internal control.

Mr. Tieman provided a brief overview of cash and invested assets of the Plan. The distribution of Internal Service Fund (ISF) cash and investment assets are comprised of 80 percent cash and cash equivalents, 1 percent bonds – U.S. Government Guaranteed Mortgages, 9 percent bonds – U.S. Treasury and 10 percent bonds – U.S. agencies. The distribution of the State Retiree Welfare Benefit Trust (SRWBT) is comprised of 34 percent bonds, 8 percent mutual funds, 6 percent common stock, and 52 percent cash and cash equivalents.

Mr. Tieman reviewed the operating expense as a percentage of revenues. ISF operating ratio is calculated as a sum of payroll, administrative services and professional services divided by operating revenues. SRWBT ratio is calculated

as a sum of administrative and other expenses divided by total additions excluding investment income. Revenue is staying relatively stable.

Overall operating expenses is two percent with medical claims and capitation fees at 98 percent. The operating expense is calculated as a sum of payroll, administrative services and professional services. Operating expenses and medical and capitation fees were divided by approximate total active and retired members as of FY end. There is an increase from 2015 to 2016 in the average cost per member which is identified in the CAFR. Mr. Cooper added that nationally there is an increase in health care costs and this increase is not specific to MCHCP.

Following discussion, Director Haug made a motion to accept the Brown Smith Wallace, LLC Audit Report and the 2016 Comprehensive Annual Financial Report for FY ending June 30, 2016, as presented. Ms. Luebbering seconded. Motion passed unanimously.

Ms. Fischer reviewed the FY 2018 appropriations request. Ms. Fischer focused her review on the lead executive summary sheet which is supported by additional documents. Ms. Fischer began by briefly overviewing the column headings: Column A — FY 2018 core request, Column B — preliminary FY 2018 request (prior to the results of Open Enrollment [OE]) Column C — Updated FY 2018 request and Column D — reflects the change between Column C and Column B. Our budget process brings a preliminary request to the board in September of each year and with your approval in September of that request, it was submitted to the Office of Administration for inclusion in the Employee Benefits section of the budget. As the September request in Column B does not include the results of the recently completed OE, we come back to the board in December of each year and provide you with an updated request post OE.

Office salaries of $3,250,179 represent 70 full-time employees (FTEs) with no change from the core total. The personnel advisory board (PAB) recommendations include a 2.7 percent general structure adjustment and a 1.7 percent within grade along with an additional 1.1 percent for those with seven plus years of service. These items are included in our department request, as MCHCP will not automatically receive this funding if approved. If not approved by the General Assembly and Governor, MCHCP will conform as recommended to the state wide pay plan. The fringe benefits reflect the associated benefit costs for 70 FTE; overtime and fringes projected reflect primarily overtime associated with OE. The subtotal for personal service items is $5,051,852.

Operations expense of $2,932,442 (not including third party administrator [TPA] fees); furniture, fixtures and equipment of $178,250; less $128,796 from estimated income related to administrative fees from public entities net to the subtotal for operating expenses including personal service allocations of $8,033,748.

Ms. Fischer reviewed the projected plan cost assumptions. These items encompass our self-insured medical and pharmacy plan costs. Medical payments for our preferred provider organization (PPO) and Health Savings Account (HSA) plans total $436,813,068 and pharmacy payments are projected at $120,712,236. For calendar year (CY) 2017, the following assumptions in the development of these plan costs were utilized: actual premium equivalents as determined by MCHCP's actuary were used in calculating first half FY 2018 costs; for CY 2018, the following trends were used: active medical claims 7.5 percent (last year was 5.5 percent); non-Medicare retiree medical claims 7.5 percent (last year was 5.5 percent); Medicare retiree medical claims 3.5 percent (last year was 5.0 percent; and pharmacy claims 12 percent (remaining consistent with last year). Additional enrollment assumptions include: enrollment for Jan. 1, 2017, of total subscribers of 53,668 and total lives of 96,079 members; enrollment reflects the results of the recently completed 2017 plan year OE; and MCHCP subsidies for active employees in CY 2017 are developed by tier of coverage. The subsidies are for the base PPO 600 Plan and range from employee only at 92.9 percent to employee and spouse at 82.9 percent. Wellness and tobacco-free incentives were developed based upon actual participation. MCHCP is following the current contribution policy for retirees in CY 2018 as in CY 2017, which is 2.5 percent of the PPO 600 Plan premium for each year of service the retiree has with a cap at 65 percent.

Employee Assistance Program payments represent enrollment times the contract price and are projected at $678,028. Transitional Reinsurance (Section 1341) is estimated at $383,344. These estimates represent the projected cash cost of the assessment to be paid during FY 2018. The patient-centered outcomes research fee (PCORI) is projected at $195,571 and represents the fee per average covered life imposed on plan sponsors of applicable self-insured health plans to fund the PCORI institute. The subtotal for claims and TPA expenses equal $558,782,247; less projected member contributions of $111,559,603 and contributions from interest offset of $1,130,624; result in a grand total FY2018 request of $454,125,768. An increase from the September request of $3,296,635. Ms. Fischer added that the increase is related to the addition of 675 active members (subscribers, spouses and children); 18 early retiree members, and 60 Medicare retiree members.

Ms. Luebbering questioned if the shift in enrollment from the PPO 300 Plan to the PPO 600 Plan was due to the online tool or education? Ms. Muck responded that the online tool was not utilized as much as it has been in the past and MCHCP defaults to the PPO 600 Plan. Ms. Muck plans to give a more in-depth analysis of OE in January after members have the opportunity to appeal.

Following discussion, Ms. Hayes made a motion to accept staff recommendation to adopt the updated FY 2018 appropriation request as presented. Ms. Luebbering seconded. Motion passed unanimously.

Ms. Muck presented the Final Orders of Rulemaking. MCHCP is ready to file the Final Orders of Rulemaking for rescinded and proposed rules 22 CSR 10-2.094 Tobacco-Free Incentive Provisions and Limitations and 22 CSR 10-2.120 Partnership Incentive Provisions and Limitations. The two rules were originally filed on Aug. 26, 2016, to implement the 2017 *Strive for Wellness*® incentives as voted on by the board. MCHCP did not receive any comments to either rule, and it is now time to file the Final Order of Rulemaking.

Representative Kendrick made a motion for the Executive Director to file the Final Orders of Rulemaking for 22 CSR 10-2.094 and 22 CSR 10-2.120 with the Secretary of State's office and Joint Committee on Administrative Rules as discussed. Director Lyskowski seconded. Motion passed unanimously.

Ms. Watson presented the 2017 Population Health Initiatives. She began by sharing information on some of the *Strive for Wellness*® accomplishments in 2016. The Registered Dietitians taught on-site weight management courses several times each year and boast a combined participant weight loss of more than 980 pounds and 218 inches in the 10 courses offered; and the Registered Nurses led quit tobacco courses in state office buildings with an average quit rate of 45 percent in eight courses.

MCHCP is currently conducting a return on investment (ROI) study for the *Strive for Wellness*® Health Center since it has been in operation for two years now. She hopes to share additional information on the ROI study in early 2017.

Since opening, the Health Center has had approximately 7,700 visits, averaging 260 visits per month and 65 visits per week. The goal is approximately 270 visits per month. Approximately 65 percent of the total visits are for acute illness. The Health Center visitors report overall satisfaction rating in excess of 98 percent, with 90 percent of total center visitors completing the exit survey. Twenty-five percent of those surveyed would have gone to Urgent Care, 2.6 percent would have gone to the emergency room, and 14.5 percent would not have sought treatment if the Health Center would not have been available to them.

The Wellness Department Clinical Staff provided health and wellness education and outreach on 22 different topics in 35 state agency building visits touching close to 2,000 state employees with their efforts. The Wellness Program Nurses took blood pressures of nearly 400 employees throughout the state, during these events.

The Wellness Department, in collaboration with IT and Communications, worked diligently to write and create the *Strive for Wellness*® Weight Management Course, *Strive for Wellness*® Quit Tobacco Roadmap, and *Strive for Wellness*® Health Assessment and Health Education Quiz.

The Employee Assistance Program (EAP) was re-branded to be the Strive Employee Life & Family (SELF) program. One of the reasons for re-branding this program is due to underutilization of resources available at no cost to state employees that can help them and members of their household reduce stress, improve health and enhance life balance. MCHCP hopes to improve the usage of this program in 2017.

Ms. Watson reviewed 2017 focus initiatives which include: member and employee health education; SELF program re-launch and market, implement the addition of behavioral health counseling services at the *Strive for Wellness*® Health Center; form provider and community resource partnerships for chronic condition management; and 2018 research and preparedness. These initiatives were outlined and shared with the board.

Member and employee health education initiatives include: continuing healthy moment videos in a 45-second way; developing e-Learning/interactive learning tools; creating four to six national health observance videos (public service announcement type promos);continuing approximately four health action campaigns (average one per quarter); continuing in-person health education events and exhibits in state office buildings; developing an online health education library on the MCHCP website; *Strive for Wellness*® Ambassador Program/mentoring/support; health and physical activity events; on-site weight management and quit tobacco courses; and Lunch-and-Learns as requested.

The SELF program re-launch and market initiatives include: re-launch, promote and communicate employee assistance program under the new SELF brand; and educate employees regarding all aspects of the SELF program. This will be on-going throughout the year.

Initiatives to implement the addition of behavioral health counseling services at the *Strive for Wellness*® Health Center include: beginning Feb. 1, 2017, the *Strive for Wellness*® Health Center will provide behavioral health counseling services on-site; periodically reminding eligible members about the service and availability; and combine reminders with health center services already in place.

Initiatives to form provider and community resource partnerships for chronic condition management include: exploring new conditions to add to value-based design (similar to diabetes support services); consider a multiple chronic conditions pilot program to integrate chronic condition management with the local provider community; exploring how to incorporate disease self-management into plan design for conditions other than diabetes; clinical team develop routing schedule for targeted top health care provider groups and entities; clinical team meet with health systems, clinics, community programs and other state agencies to determine how we can partner to drive members to resources already in place in the community to help manage conditions, weight, add physical activity, etc.;

and consider targeted chronic condition mailers (electronic or paper) to MCHCP members with a chronic condition.

Primary initiatives for 2018 research and preparedness include: advocacy; disease self-management program vendors; Centers of Excellence; integrative medicine; and incentive plan design and opportunities.

Ms. Watson then briefly reviewed the 2017 population health focus touchpoints.

Ms. Muck noted that MCHCP recently implemented two member advisory committees referred to as the myVoice Panel, one for active members and one for retirees. MCHCP inquired as to how members would prefer to receive communications. MCHCP has learned from the myVoice Panel members that they do not typically access newsletters, they do not access on-site learning such as utilizing our OE group meetings. The myVoice Panel members would rather MCHCP reach them electronically. The panel members over the age of 40 prefer emails and those under 40 prefer text messages. MCHCP is also learning about the variances of how men learn versus women. MCHCP will be tailoring our communications by age and gender. MCHCP will be outreaching to our early retirees as well.

Ms. Schaefer asked if the weight management courses were open to active employees only. Ms. Watson responded that at this time they are open to active employees only as the courses are taught in state office buildings. Ms. Muck stated that MCHCP is looking at doing some eLearning opportunities. Ms. Watson stated that MCHCP could look at doing an online course or live webinar. Chairperson Nelson asked if MCHCP could invite the early retirees to the state facilities or post information on the MCHCP website for them to join. With the Commissioner's permission, Ms. Watson will look into this further.

Director Lyskowski asked if the 45 percent quit rate for tobacco use was by using education and coaching without nicotine replacement therapy (NRT)? Ms. Watson responded that the course MCHCP offered had a 45 percent quit rate with multiple supports including NRT except for one person who quit without NRT. Director Lyskowski asked about the role of e-cigarettes as an alternative to help older members quit. Ms. Watson responded that at present, e-cigarettes are not regulated and therefore MCHCP does not have a recommendation.

Ms. Fischer presented the financial update. She reviewed October activity and referenced points of interest.

Monthly state contributions from the employer of $32,920,103 and member contributions of $9,154,054 represent contributions reflecting near static enrollment over September.

With relatively little change in other revenue categories, she moved next to our investment section. The Other Post-Employment Benefits (OPEB) Trust returned -1.27 percent for October net of fees with a concentration mix of 38 percent equities, 60 percent fixed income and approximately two percent in cash and equivalents. Since inception, total fund return is 7.21 percent; a full one percent over the benchmark of 6.14 percent. Comments from our investment manager as it relates to our performance strategy include: we are less than fully invested in the equity market – still believing that a two plus percent economy could generate mid-single digit equity returns. Our bond exposure duration remains at about five years. Given the outlook for small interest rate increases, we are comfortable with that duration. Should we be surprised by inflation and rates, we will shorten duration and look to reinvest at higher rates.

In our expense section, self-funded medical claims for October posted at $33,977,606. October gross pharmacy expense was $12,607,178.

Incurred But Not Reported (IBNR) estimates have been updated to reflect paid claims through Sept. 30, 2016, with projections rolled through the remaining months of 2016 and CYs 2017 and 2018.

Turning to 2017, the Plan conservatively has maintained the FY 2017 funding level from the state for the full CY at $394.6 million or $32.8 million monthly. Pharmacy reflects seasoning at the six-month CY interval to reflect current pharmacy trends. All other expenditure lines have also been updated to reflect current enrollment and contract pricing.

Briefly turning to 2018, the Plan again has conservatively maintained the FY 2017 funding from the state of $394.6 million. MCHCP has 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 trend net of rebates. In 2018, as conservatively projected with no new revenue stream over our current FY 2017 levels, and if you proceed to the after reservations position the Plan is projected in December 2017 to drop below a one month level of Plan total claims and operating expenses after reservations. Please appreciate that actual results may differ from these projections.

As we go through the financial analysis each month, and as we have presented the appropriation request for the Plan for 2018, I want to draw your attention to line 32 of the report. This line reflects the demarcation between revenues for the month and its net against expenditures of the Plan. You can see as we progress with the actuarial estimates of Plan expense against our current revenue stream of $394 million, the Plan each month without additional funding through the calendar months of 2017 and 2018 is spending in excess of the contributions made by the state and members to fund the medical, pharmacy and

operations expenses of the Plan. As the Plan remains appreciative of the contributions from the state and member, the Plan's revenues from these contributors since FY 2012 have increased 2 percent, while the Plan's corresponding medical claims and gross pharmacy expenditures have increased nearly 20 percent. During the most recent period, FY 2016, the Plan's expenditures exceeded revenues by nearly $17 million. Operationally, we will continue our discussions throughout the upcoming legislative process to continue to educate the decision makers on the importance of the FY 2018 appropriation request and new decision item.

Ms. Muck has asked Willis Towers Watson to look into the increases to determine what is driving these trends. Willis Towers Watson will be working on this in December and January. Once the analysis is complete, MCHCP can then decide if there is anything that can be done to influence these emerging trends. MCHCP does not believe we are in isolation with regard to the trend increases. MCHCP believes we will have to take some action whether it is in regard to wellness initiatives, new programs, changes in plan design or other areas. MCHCP is looking proactively at what we can do to mitigate some of the trend increases. The trend increases are concerning in combination with the relatively flat funding available and its impact on the overall financial health of the trust fund should these trends continue.

Director Haug stated that Medicaid pharmacy costs are beginning to flatten. Ms. Muck responded that while the trend is still there it is not increasing, but our exposure to the speciality drug trends are highlighting the financial impact. MCHCP worked with Express Scripts, Inc. (ESI) to take advantage of the programs they have in place to limit our exposure to increased pharmacy trend. MCHCP is seeing more in rebates and we have protections in place with ESI.

Director Lyskowski asked for a historical perspective on how the board approached the question of potentially raising premiums. Ms. Muck responded that since 2010 for 2011 there was a significant change in plan design in regard to utilization and limited funding available from general revenue funds to address some of the shortfall that was seen. This is when MCHCP chose to eliminate the copay plan except for the PPO 300 Plan and switched to the PPO Plans. This was the last time MCHCP did major plan design shifts. Since then MCHCP has done some tweaks but nothing material in nature. MCHCP has added incentives and wellness incentives. What advantaged the plan from not receiving the full actuarial recommended level of funding from the General Assembly was the Plan's use of available net assets. MCHCP's ability to continue to leverage limited net assets of the Plan in the future, with the current projected spend down will be comprised without additional funding from the State. MCHCP will be looking closely at the options or steps we can recommend to the board. This may include plan design changes in order to drive behavior, elimination of the PPO 300 Plan as the board has looked at previously, more tiered network with

different out-of-pocket amounts, etc. MCHCP anticipates bringing recommendations to the board in early 2017 for consideration.

Representative Kendrick asked for confirmation that if MCHCP does not receive new funds in FY 2018 by December we are below our one-month threshold. Ms. Muck responded that MCHCP believes we will have enough funds but we will have to look at what funds we receive and what we have left from the previous FY. MCHCP has never presumed that we would receive additional funding over the current FY 2017 levels, and the projections reflect that flattened level of funding and the impact shown reflects the spend through of assets without increasing the funding from the State. MCHCP will look at what the expected return will be if we were to remove a plan or make plan design changes.

Chairperson Nelson added that the board is going to have to make some difficult decisions. MCHCP has been able to keep premiums flat. The board may have to look at increasing the copay at the emergency room as usage has increased. In the past, the board has been reluctant to take the difficult steps necessary for change.

Ms. Luebbering added that as a Plan we have high costs. Ms. Muck responded that this has not changed. She added that there is a pilot program that MCHCP is implementing with UMR and Aetna to see if we can intervene with our members who highly utilize the emergency room. MCHCP will evaluate the success of this program to determine if it is working.

Ms. Muck stated that we will need to ask the board what its tolerance is before we take action. Unfortunately, we have to take actions on predictions. MCHCP will be monitoring the analysis and keeping the board informed.

Ms. Fischer added that we will continue the collaborative effort we have as well as discussing our projections over the 24-month outlook. Again, MCHCP is anticipating no new revenue stream over the current levels, but we want to remain transparent to provide effective data for analysis and decision making.

Ms. Muck shared the 2017 Board of Trustees calendar with the board members. As in 2016, there will be no meetings in February, April or November. This will be helpful with those who are busy during the legislative session. However, if the need arises we will schedule meetings in February and April.

Director Lyskowski made a motion to move into closed executive session pursuant to §610.021 RSMo (1), (5), and (14) of §621.021 to discuss confidential or privileged communications between the board and its attorney; health proceedings involving identifiable persons; and records protected from disclosure by law. Representative Kendrick seconded. A roll-call vote was taken, and the motion passed with Chairperson Nelson, Ms. Hayes, Representative Kendrick,

Ms. Luebbering, Director Lyskowski, Ms. Schaefer and Senator Sifton in favor. Director Haug had stepped out of the meeting during this vote.

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