MISSOURI CONSOLIDATED HEALTH CARE PLAN
BOARD MEETING
JUNE 23, 2016

Attending: Chairperson Doug Nelson
Representative Kip Kendrick
Linda Luebbering (via conference call)
Viola Schaefer
Senator Scott Sifton (via conference call)
Michael Warrick

Absent: Director John Huff
Mark Langworthy
Director Peter Lyskowski
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; Bethany Goodin, Member Services Manager; Garry Kornrumpf, Director of Plan Integrity and Cost Recovery; Mia Platz, Communication and Publication Manager; Jennifer Stilabower, General Counsel; John Stahl, Willis Towers Watson (via conference call); Connie Perry, Willis Towers Watson (via conference call); Don Sanford, Willis Towers Watson; Beth Grellner, Willis Towers Watson; and visitors.

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

Representative Kendrick made a motion to approve the open session minutes of the May 26, 2016, regular MCHCP Board of Trustees meeting. Mr. Warrick seconded. Motion passed unanimously.

Ms. Muck and Mr. Stahl, Willis Towers Watson, presented a preliminary look at the 2017 plan year.

This year MCHCP comes to the board with the least number of changes since Ms. Muck has been with MCHCP. With minor adjustments, Ms. Muck is proposing that the plan design for 2017 mirror 2016. The board was asked to consider the changes and will not be asked to vote on these changes until the July meeting.

MCHCP has a few tweaks to the services offered at 100 percent coverage. The no-cost glucometer, diabetic test strips and lancets, and visits with a certified diabetes educator were offered as described in 2016; however, they were only offered to those in Disease Management (DM). For this disease, in particular, given the high incidence rate and the fact that MCHCP will not be recommending DM in 2017, this value-based plan design will encourage education and adherence to glucose testing — a foundation to ensuring good blood glucose control.

The deductible and coinsurance and copayments are not recommended to be changed except for two tweaks. Similar to the discussion above, coinsurance and copayments for diabetic drugs were .5 times the applicable coinsurance or copayment. Again this was offered only to those in DM and MCHCP will expand to the entire population for the reasons stated.

The network out-of-pocket (OOP) maximum is not changing for either medical or pharmacy coverage.

The non-network plan design is not changing from 2016 except for the prescription drug coverage at 100 percent for diabetic test strips and lancets as well as .5 times the applicable coinsurance/copayments for diabetic drugs as described. The remaining factors remain the same as 2016.

Ms. Muck then reviewed the *Strive for Wellness®* Incentives. For both Partnership and Tobacco-Free Incentives, the eligibility requirements and incentive amounts remain the same as 2016.

Partnership Incentive — MCHCP is continuing the requirement to complete the online health assessment and in addition to complete a health quiz at the same time. This will help MCHCP more fully assess the health literacy of our population and where we need to focus our educational activities.

Tobacco-Free Incentive — MCHCP is proposing that we send a quit tobacco kit that staff are developing, to those who sign the Quit Tobacco Promise. The board briefly discussed what the kit would consist of.

All other elements remain the same as 2016.

MCHCP is not proposing any changes to the dental or vision plans. They will remain just as it is designed for 2016.

And while Ms. Muck has not presented the Public Entity (PE) design as a handout, MCHCP is not proposing changes to the designs currently offered to PE in 2016 except as necessary to conform with changes to the state offerings so the two are comparable.

MCHCP will not propose continuing the DM program or lifestyle coaching. Rather, MCHCP will focus on public health education campaigns. MCHCP staff will meet with members through health fairs, blood pressure checks, etc. through our own initiatives. Return on investment was not seen to continue the health coaching.

So as MCHCP considered the same plan design as 2016, our attention turned to rates. MCHCP asked Willis Towers Watson (WTW) to do two things — look at the last three years of trend and compare what was assumed to actual. This analysis will provide some transparency as we look at preliminary rates for 2017. Ms. Muck then asked Mr. Stahl to go over the trend analysis and preliminary rates.

Mr. Stahl began by reviewing the purpose, methodology and key assumptions.

The purpose of this analysis is to compare MCHCP's actual historic medical and prescription drug trends to the trend assumptions used in setting the premium equivalent rates over the study period for actives, non-Medicare and Medicare. Incurred and paid claims were provided by MCHCP, showing claims by month from Jan. 1, 2012, through Dec. 31, 2015. Four separate years of data was collected. Enrollment by month was provided by MCHCP for the same time period. WTW used average monthly enrollment during their analysis.

In WTW's methodology, historical claims and enrollment were grouped into four calendar year (CY) experience periods. Claims were separated by medical and prescription drug as well as by plan and status. Prescription drug rebates were not reflected in the trend rates; these are accounted for separately in the premium rate development process, following the results of the annual market check.

Each year of claims was adjusted by a relative value to account for plan migration over time.

Additional adjustments were made for aging of the population and historical plan design changes. These adjustments were made to remove the effects of both aging and plan design changes. Adjustments were made for each individual plan. Adjusted claims embody what experience would have looked like without any improvements to the medical and prescription drug programs to develop relative comparability.

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

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

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

While medical trend has been historically low over the last three years, the analysis presents that the historical projection assumptions are well within established actuarial methodologies and WTW is comfortable with the variability. The assumptions used are in line with market place trends at the time premium equivalent rates were calculated, and it would be outside established actuarial modeling in the market place to set medical trends for pricing purposes as low as those actually experienced by MCHCP over the period.

Medical and pharmacy trends used in historical pricing projections were provided to the board. The prescription drug trends used in pricing projections align well with MCHCP experience. The trend rates are consistent with industry trend.

Mr. Stahl reviewed the June 17, 2016, memorandum regarding assumptions and methodology for 2017 preliminary premium equivalent rates.

Mr. Stahl then briefly reviewed the 2017 preliminary rates for active employees, retiree/survivor without Medicare, and retiree/survivor with Medicare. Active employee rates show a slight increase of 2.3 percent, retiree/survivor without Medicare show a -0.3 percent decrease, and retiree/survivor with Medicare show a -3.2 percent decrease when compared to 2016 rates. The preliminary rates could improve before they become final. The board will make a decision at the next meeting as to whether the contribution level will be elevated.

Connie Perry of WTW joined the meeting via conference call.

Ms. Muck reminded the board that these are preliminary benefits and rates and will be voted on next month.

Mr. Stahl (via conference call) left the meeting.

Ms. Muck presented the contract renewals for UMR, Aetna, Delta Dental, and National Vision Administrators (NVA). The board agreed that Ms. Muck would review all of the contract renewals and vote for all in one vote instead of separately.

First is UMR who provides Third Party Administrative (TPA) services statewide. The contract allows for no increase in administrative fees for 2017.

The fee is $21.44 per employee per month which is approximately $14 million per year. In addition they continue to offer $150,000 in discretionary funds that MCHCP uses for small projects throughout the year not covered by the fee. UMR offers another $100,000 of discretionary funds that MCHCP uses for health and wellness initiatives. MCHCP staff recommends that the board renew the contract with UMR for 2017. This renewal is the third year of up to a five year contract.

Second is Aetna who provides TPA services in the Southwest/South Central regions. The contract allows for a 3.9 percent increase in fees for 2017. Moving it from $32.76 to $34.04 per employee per month which is approximately $1.3 million per year. Aetna provides for $10,000 communication allowance and $10,000 wellness allowance each year as well. MCHCP staff recommends that the board renew the contract with Aetna for 2017. This renewal is the third year of up to a five year contract.

Chairperson Nelson asked if there was any reason for Aetna's increase. Ms. Muck responded that Aetna has a small population so their fixed costs are increasing, there is more variance, and this is the offer that was brought to MCHCP. Ms. Luebbering asked why their fixed costs would raise since they have been with MCHCP for a while now. Ms. Muck responded that Coventry has moved to an Aetna platform.

Chairperson Nelson asked what the options were if the board does not approve the renewal. Ms. Muck responded that she was not sure that MCHCP could do a rebid for that year. Chairperson Nelson added that since this was year three of a five year renewal option MCHCP could go out to bid next year. Ms. Muck will continue to look at what MCHCP can do for next year and see if Aetna can improve their financial offering.

Third is Delta Dental. Delta Dental provides fully-insured dental benefits to about 41,000 state subscribers (77,000 members). This is a negotiated contract year and Delta Dental is offering the state population a no premium increase for 2017 and a slight premium decrease to PE members. These premiums are paid entirely by the member. There is no MCHCP contribution for this benefit. This is the fourth year of a five year contract.

Finally, the board discussed NVA. NVA provides fully-insured vision benefits to about 34,000 state subscribers (65,000 members). This is a negotiated contract year and NVA is offering no premium increase for 2017. Again, these premiums are paid entirely by the member. There is no MCHCP contribution for this benefit. This is the fourth of a five year contract.

Representative Kendrick made a motion to renew the following contracts as recommended by staff for 2017: UMR, Aetna, Delta Dental and National Vision Administrators. Ms. Schaefer seconded. Motion passed unanimously.

Ms. Muck briefly reviewed Senate Bill (SB) 997 which has a provision impacting MCHCP.

SB 997 removes state-sponsored institutions of higher learning from the definition of PE. Rather such institutions may join MCHCP as part of the state pool. The board must accept the institution if it decides to join the plan. The institution must remain with MCHCP for at least five years and give a minimum of six months' notice to withdraw from the plan. The institution may have to pay a first year adjustment if the population is different from the current state plan. MCHCP did not have a fiscal impact to this change, as the premium will be covered by the institution of higher learning and their employee/retiree.

The bill was signed by the governor and this provision becomes effective the end of August. MCHCP is in the midst of evaluating what regulatory changes are necessary to implement these provisions. For example, the timing of notice necessary from a state institution of higher learning prior to a start of a plan year, rules on contribution strategy, eligibility requirements, how to treat retirees, and other provisions. The latest these rules will come to the board will be in October along with the 2017 plan year amendments.

Oversight's fiscal note assumed the soonest an institution of higher learning could be effective is the Jan. 1, 2018, plan year and we concur. We are already well into 2017 planning and upon the bill's effective date would have essentially 30 days prior to Open Enrollment beginning to prepare for a new group.

Ms. Luebbering questioned whether MCHCP could deny an institutions request to come on in 2017 since there is no times listed in the legislation. Ms. Stilabower responded that the rules are needed to accept the universities and they could not be filed until the law was in effect. Ms. Muck stated that MCHCP will look into this further. She also added that MCHCP will meet with an organization next month. There are a lot of details that would have to be in place before MCHCP could move forward.

Another update on SB 997 will be provided at a future meeting.

Ms. Fischer presented the financial update. She highlighted the areas of interest for May 2016.

Monthly state contributions from the employer of $32,465,708 and member contributions of $9,262,737 represents contributions from 53,455 subscribers and 96,036 covered lives for May 2016.

Next in our investment section, most notably associated with our Other Post-Employment Benefits (OPEB) Trust for May, the total fund returned .46 percent net of fees with a portfolio equity concentration of 39 percent equities;

fixed income of 57 percent and cash and cash equivalents of 4 percent. Total funds since inception have returned 7.39 percent; which reflects a full 1 percent over the weighted benchmark of 6.32 percent total fund.

Regarding yield strategy from the investment manager, it is hard to see a significant increase in the equity markets so we will likely look for opportunities to pare back equity exposure. We continue to keep Bond duration at approximately five years. The next big issue facing the markets will be the FOMC and their plan for interest rates as they could continue to pursue some rate normalization.

In our expense section, self-funded claims for May reported at $29,237,714 pacing with the updated actuarial projections for claims expense going forward.

Pharmacy expense for May was $17,350,280. This spend reflects three billed May cycles versus the average of two billed cycles. Cycles were $5.5 million, $6 million and the final cycle on May 31 of $5.9 million. Analyzing pharmacy spend net of rebates through May, pharmacy net costs are trending at $9.2 million for the first five months of the 2016 CY.

Next, Incurred But Not Reported (IBNR) in June, paid claims through March 2016 were evaluated by the actuary for remaining quarterly CY 2016 and CY 2017 projections and have been incorporated in the results. IBNR projections have increased for the future periods presented in a range of 7.9 percent to 8.8 percent per individual calendar month based upon historical claims patterns and updated medical claims results. Increases are reflective of enrollment fluctuations, an increasing lag in claims payment patterns and may also be attributable to some large claims activity. Future quarters will be evaluated to determine the consistency of the large claim activity impact.

Turning to CY 2017, no calendar change updates. Net position for December 2017 is projected at $15.9 million after reservations with the decrease from the prior month most notably the result of increases in actuarial IBNR projections. As always, actual results may vary from these projections.

Mr. Warrick 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 Chairperson Nelson, Representative Kendrick, Ms. Luebbering, Ms. Schaefer, Senator Sifton, and Mr. Warrick in favor.

Upon return from closed executive session, Mr. Warrick made a motion to adjourn. Ms. Schaefer seconded. Motion passed unanimously. Meeting adjourned.