MISSOURI CONSOLIDATED HEALTH CARE PLAN
BOARD MEETING
MAY 26, 2016

Attending: Chairperson Doug Nelson
Director John Huff (via conference call)
Representative Kip Kendrick (via conference call)
Mark Langworthy (via conference call)
Linda Luebbering
Director Peter Lyskowski
Senator David Sater
Senator Scott Sifton (via conference call)

Absent: Representative Caleb Rowden
Viola Schaefer
Michael Warrick

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; Bruce Lowe, Chief Information Officer; Mia Platz, Communication and Publication Manager; Jennifer Stilabower, General Counsel; Julie Watson, Chief Population Health Officer; and visitors.

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

Director Lyskowski made a motion to approve the open session minutes of the April 28, 2016, regular MCHCP Board of Trustees meeting. Senator Sater seconded. Motion passed unanimously.

Ms. Muck presented the Dashboard Report. This report compares calendar year (CY) 2015 to CY 2014.

Ms. Muck took a few minutes to talk about revenue versus medical and pharmacy claims experience. The report is on a per member per month (PMPM) basis for the entire population.

Members pay approximately $98 PMPM while MCHCP picks up $349 PMPM, for a total of $447 PMPM. Most of MCHCP's share of the premium comes from the state appropriation — about $332 PMPM, which is a difference of $17 PMPM.

When looking at the total net paid amount of approximately $440 PMPM, MCHCP is about $10 PMPM from the amount of revenue collected from member premium and state appropriation short to cover claims expenses. This equates to approximately $11.5 million coming from the Trust Fund for CY 2015 to meet claims expense. This is expected from our previous discussion on the level of state appropriation.

As we will learn when Ms. Fischer presents our financials, we expect to continue to draw from our Trust Fund assets in 2016 due to the expected funding levels from state appropriations.

MCHCP enrollment remains relatively flat. The average member count by relationship: 53,000 subscribers, 12,000 spouses, and 30,000 children.

Musculoskeletal continues to be a high cost driver for MCHCP. It accounts for approximately 19 percent of our medical expenditures.

MCHCP's high cost claimants continue to grow. MCHCP has about 10 percent more high cost claimants in 2015 than 2014. The 1,649 high cost claimants accounted for approximately 35 percent of MCHCP expenditures, costing on average $111,000 per high cost claimant per year compared to $2,800 for non-high cost claimant per year.

The risk band profiles have changed very little. MCHCP continues to spend a lot of our resources on those members who are struggling or are in crisis. The healthy and stable risk categories remain relatively unchanged.

MCHCP reviewed active members meeting their deductible and out-of-pocket (OOP) maximum. Overall for those enrolled in the Preferred Provider Organization (PPO) 600 Plan, in CY 2015 approximately 22 percent of those with individual coverage met their deductible and approximately 36 percent of those with family coverage met their deductible. Approximately 5 percent of those with individual coverage and 3 percent with family coverage met their OOP maximum. At that point, MCHCP began paying 100 percent of their claims.

Mr. Langworthy joined the meeting via conference call.

Humira continues to be our number one drug with spend at $6.6 million for 223 patients. Humira is losing patent protection this year and a generic version has become available, however, MCHCP will not see savings until additional manufacturers enter the market. MCHCP believes we should see savings in a few months.

Approximately two-thirds of our members use the pharmacy benefit with only about 3 percent using specialty drugs. Most of those users have more than

four maintenance medications. Many of them have more than 10 maintenance medications. The average cost per script is $52 for non-specialty and $3,500 for specialty drugs.

The board briefly discussed the topic of biologics and how these could offer more competition and potentially lower pharmacy costs to MCHCP and its members.

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

Monthly state contributions from the employer of $32,531,582 and member contributions of $9,380,680 represent contributions from 53,609 subscribers and 96,324 covered lives for April.

MCHCP received subsidies related to our Employer Group Waiver Plan (EGWP) program for retirees in the amount of $1,674,330. This is comprised of $1,349,521 from coverage gap and $324,809 in direct subsidies.

Next in our investment section, most notably associated with our Other Post-Employment Benefits (OPEB) Trust for April, the total fund returned .61 percent net of fees with a portfolio equity concentration of 39 percent equities; fixed income of 54 percent and cash and cash equivalents of 7 percent. Total funds since inception have returned 7.41 percent; which reflects a full 1 percent over the weighted benchmark of 6.32 percent total fund.

Regarding yield strategy from the investment manager, equity exposure has been pared back slightly. And, we are currently utilizing a larger allocation of dividend-yielding stocks as the investment manager believes that overall returns will be subdued.

In our expense section, self-funded claims for April reported at $30,823,155. The actuary last month re-projected this line item through December 2017 after receipt of 2015 claims data from Truven Health Analytics, our data warehouse. With the newly projected results, April’s actual results benchmarked at approximately 1.5 percent below revised projections for the current month.

Pharmacy expense for March was $8,431,805; moderating some from first quarter results.

Next, Incurred But Not Reported (IBNR) paid claims through December 2015 were evaluated by the actuary for remaining quarterly CY 2016 and CY 2017 projections and were incorporated in the results. IBNR projections have increased for the future periods. They were presented in a range of 1.7 to 2.1

percent per individual calendar month based upon historical claims patterns and mature 2015 medical claims results.

Turning to CY 2017, no calendar change updates. Net position for December 2017 is projected at $23.4 million after reservations with the increase most notably reflected due to lowered pharmacy expense for April 2016. As always, actual results may vary from these projections.

Senator Sater requested a summarization regarding the pharmacy increase for CY 2017. Ms. Fischer responded that there was a projected overall increase of approximately 12 percent for the CY. Line 24 of the financial report reflects net spend, net of rebates in the projected months. Rebates are posted to the income section and actual gross pharmacy results reflect gross spend with anticipation by calendar year end that the net of rebate income and gross RX cost for the twelve month period will mirror the previously netted projections.

Senator Sater also inquired as to how MCHCP is keeping the pharmacy cost under control. Ms. Muck responded that the formulary that MCHCP has with Express Scripts, Inc. (ESI) excludes some drugs, requires step therapy or prior authorization for certain medications, has quanity level limits, etc. to assist in controlling unnecessary spending. However, even with those excluded medications MCHCP still offers a pathway for coverage at a higher copay. Another notable item is that MCHCP's high generic fill rate is almost at the maximum. MCHCP also moved to ESI's National Preferred Formulary to take advantage of greater rebates.

Director Lyskowski asked if there was anything going on or that could go on that could address the problem of Opioid use? Ms. Muck responded that she does not believe that ESI offers a specific Opioid use program. However, MCHCP looks at this from a fraud, waste and abuse programmatic perspective. MCHCP has an active program through ESI to lock the member into a pharmacy so that ESI may monitor these type of prescriptions coming through for the member from a single source.

Ms. Luebbering 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. Director Lyskowski seconded. A roll-call vote was taken, and the motion passed with Chairperson Nelson, Director Huff, Representative Kendrick, Mr. Langworthy, Ms. Luebbering, Director Lyskowski, Senator Sater, and Senator Sifton in favor.

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