MISSOURI CONSOLIDATED HEALTH CARE PLAN
BOARD MEETING
OCTOBER 27, 2016

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

Absent: Representative Caleb Rowden

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; Bruce Lowe, Chief Information Officer; Jennifer Stilabower, General Counsel; Julie Watson, Chief Population Health Officer; and visitors.

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

Senator Sater made a motion to approve the open session minutes of the September 22, 2016, regular MCHCP Board of Trustees meeting. Ms. Schaefer seconded. Motion passed unanimously.

Dr. John Davren reviewed the UMR Plan Performance Analytic Review (PPAR) presentation. The report covers calendar year (CY) 2015. There is a claims run out period of three months thereafter for claims paid through March 31, 2016. The report compares 2015 to 2014 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.

The Norm benchmark is UMR's Book of Business (BOB) of 1,923 groups representing 2.4 million members. Norms that include pharmacy are restricted to groups whose pharmacy vendors provide UMR with detailed pharmacy data.

Total membership decreased slightly from 2014 to 2015, and age and gender composition was relatively stable. Members age 45+ are well more than

the Norm. This population typically drives frequency and severity of chronic conditions. There was a 14.3 percent variance from the Norm.

Dr. Davren reviewed the key indicators of the PPAR presentation. The paid per member per month (PMPM) expenditures increased 6.4 percent and is 9.7 percent above the Norm. Over the last couple of years, both number of admits per 1,000 and admit days per 1,000 have trended downward; however, both are unfavorable compared to Norm. The rate of readmissions is more than the Norm; readmits include scheduled services such as chemo therapy and reconstructive surgery, as examples. Emergency room visits per 1,000 have trended upward over the last couple of years and are substantially more than the Norm and peer groups. Office visits, lab services and radiology utilization metrics are all far above the Norms.

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

Dr. Davren reviewed the HCC summary for members with medical and pharmacy expenditures more than the $50,000 threshold. The top HCC conditions include cancer, NICU/newborns and gastrointestinal.

The risk distribution overview shows the healthiest 37.5 percent of members account for 2.6 percent of costs while the sickest 4.1 percent of members account for 40.3 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 increased for all conditions. Cancer rates are all down. 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 lower back disorders and colon cancer, but all conditions cost less than UMR Norm.

Representative Kendrick joined the meeting.

In regard to notable chronic conditions per patient — overall, prevalence is mostly down but significantly higher than UMR Norms across all condition types. Cost per patient went up for five of the nine conditions, but most conditions cost less than UMR Norm. Overweight/obesity is notable as prevalence is up 15.9 percent and the increase is due to more providers now reporting the condition. A

lot of the clinical conditions are high but costs can be kept down when individuals are treated.

The top conditions that are potentially influenced by lifestyle factors include: Osteoarthritis; Coronary Artery Disease; Overweight/obesity; Cancer – breast; Cholecystitis/Cholelithiasis; Diabetes; Mental Health – depression; Mental Health – substance abuse; Cerebrovascular Disease; and Infections – respiratory, necrotizing enterocolitis (NEC).

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

Dr. Davren briefly reviewed the inpatient and emergency room utilization drivers. There are opportunities for some of the emergency room visits to be moved to a member's primary care provider. The primary care provider can share appropriate place to seek treatment.

The key takeaways from the PPAR Report include: the benefit plan and program changes made by MCHCP make a difference; unlike recent years, the 2015 data compared to 2014 shows the health status has degraded and claims risk of the population has increased; PMPM costs increased by 6.4 percent, as well as HCC by 12.9 percent; risk distribution shows an increase in the At Risk (0.3 percent), Struggling (1.5 percent), and In Crisis members (0.3 percent); prevalence of chronic conditions decreased in five of the nine conditions, however all exceed the UMR Norms; and lifestyle-related conditions accounted for 18.9 percent of total paid claims or $73,359,367 versus $69,521,356 in 2014. Overweight/obesity had the highest variance from the UMR Norm in 2015 and 2014.

Ms. Muck presented the 2017 state and public entity emergency and proposed rules that will be filed with the Joint Committee on Administrative Rules (JCAR) and the Secretary of State's (SOS) office so that they will be in effect on Jan. 1, 2017. Ms. Muck did not review every change but only those that have more substantive impact. She began with Chapter 2. Emergency rules will each have an emergency statement. Each emergency rule will have a corresponding proposed amendment.

22 CSR 10-2.010 Definitions — MCHCP is removing the definitions of behavior health coaching, disease management and non-formulary as they are no longer terms that are used in the Plan. MCHCP has added definitions for excluded drug and health education quiz. In addition, MCHCP is modifying the terms of essential benefits, formulary, out-of-pocket maximum and specialty

medications. The modifications are clarifications and/or corrections to the terms and are not substantive.

22 CSR 10-2.020 General Membership Provisions — MCHCP is clarifying requirements for members with Medicare and clarifies requirements for members with other health coverage. MCHCP is removing language in section (12) as that language belongs in a different rule for the PPO 300 Plan and PPO 600 Plan. MCHCP will be adding new language in those sections. MCHCP has also modified section (13) regarding disclosure to the plan administrator that rather than a member having to disclose each year with dependent claims potentially being denied if they fail to do so to requiring a disclosure and not having to repeat each year. This does not remove the requirement that they still have to report other insurance.

22 CSR 10.2.025 Participating Higher Education Entity (PHEE) — This is a brand new rule. MCHCP is not proposing to file as emergency. In section (1) the rule is stated that the PHEE must notify the board by August for coverage beginning January 1. In Section (2) we clarify that it is the PHEE that is responsible for determining eligibility of employees and retirees to be enrolled in MCHCP. Once determined eligible, the PHEE employees and or retirees are included in the term state employee and/or state retiree used throughout the chapter. Initial enrollment of PHEE eligible employees and/or retires shall take place during the next OE. Otherwise enrollment is as described in Chapter 2. Then the rule clarifies the role of the Board of Trustees and that the PHEE is responsible for submitting the full premium. And what happens in the event of non-payment. The rule also speaks to when MCHCP evaluates whether the PHEE enrollment is substantially different to the plan's detriment and what amount the PHEE will be charged. Finally, the rules speaks to how withdrawal from MCHCP shall be handled.

MCHCP had an inquiry from Lincoln University. We believe Lincoln is still considering whether they want to join MCHCP in its membership.

22 CSR 10-2.030 Contributions — MCHCP is clarifying the MCHCP contribution toward the retiree and survivor premium for members enrolled in the Medicare Prescription Drug Only Plan. This language is updated each year as the percentage is reflective of the total premium set by the actuary.

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges — MCHCP is adding diabetes education visits to the services paid at 100 percent when provided at a network provider and adds requirements for members with Medicare.

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges — MCHCP is adding diabetes education visits to the services paid at

100 percent when provided at a network provider and adds requirements for members with Medicare.

22 CSR 10-2.053 Health Savings Account (HSA) Plan Benefit Provisions and Covered Charges — MCHCP is adding diabetes education visits to the services paid at 100 percent after deductible when provided at a network provider and clarifies that a subscriber does not qualify for the HSA Plan if they are enrolled in Medicare, unless Medicare is secondary coverage to MCHCP and clarifies requirements for members who become ineligible for the HSA Plan during the Plan Year.

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges — MCHCP is clarifying the benefits for applied behavior analysis for autism, diabetes education, eye glasses, office visits and preventive services. MCHCP is removing the age requirement for Applied Behavior Analysis (ABA) for Autism in light of the new federal antidiscrimination rules. Age discrimination is one that was addressed in the rules. These apply to MCHCP because we are in receipt of federal funds. MCHCP is amending preventive services to add coverage to 3-D mammography as we have discussed at previous board meetings and we are clarifying that there is no age limit on colorectal screenings.

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and Health Savings Account Plan Limitations — MCHCP is removing the limitations upon gender reassignment services and associated expenses and self-inflicted injuries. We are removing this limitation in light of the new federal regulations on antidiscrimination. MCHCP is subject to these regulations because we receive federal funds. Gender reassignment will become subject to the same medical necessity determinations as all other services and the other limitations found in this section would also apply – for example, cosmetic procedures and experimental/investigational, and unproven. They will be subject to prior authorization (PA) to the same extent that the same service for other conditions is subject to preauthorization. MCHCP is removing the limitation on self-inflicted injuries as we did cover them if related to a mental diagnosis. Given that coverage, we did not want to imply if you accidently hurt yourself that MCHCP would not cover your treatment.

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members — MCHCP is revising the threshold in the initial coverage stage, coverage gap state and catastrophic stages, and clarifies terminology prescription coverage at 100 percent. Neither of these are substantive changes.

22 CSR 10-2.090 Pharmacy Benefit Summary — MCHCP is clarifying copayment and coinsurance tiers, adds diabetic drug copayments/coinsurance and test strips, lancets and glucometer as voted on by the board, and revises claim filing instructions for non-network services and clarifies language regarding the formulary.

22 CSR 10-2.110 General Foster Parent Membership Provisions — MCHCP is clarifying requirements for members with Medicare and clarifies requirements for members with other health coverage. These changes echo the changes made to 22 CSR 10-2.020 General Membership Provisions.

22 CSR 10-2.150 Disease Management Services Provisions and Limitations — MCHCP is rescinding this rule to reflect the board's previous votes to the plan design for 2017.

This concludes the rule changes in Chapter 2. The next is changes to Chapter 3 for Public Entities. Ms. Muck did not review the rule changes in Chapter 3 as they align with the changes in Chapter 2.

Director Lyskowski made a motion to authorize the Executive Director to finalize the rules applicable for the 2017 plan year, make technical corrections and file all necessary documents relating to the proposed and emergency rules based on the evidence presented and emergency statements with the Secretary of State and the Joint Committee on Administrative Rules (JCAR) to ensure they are in effect prior to Jan. 1, 2017. Representative Kendrick seconded. Motion passed unanimously.

Ms. Muck provided an Open Enrollment (OE) update of where we stand as of Oct. 23, 2016. She explained that the number of meetings and webinars were under reported and provided the board with the updated numbers as she presented.

There were actually a total of 36 active and non-Medicare retiree meetings not 17, and 29 Medicare retiree meetings instead of 12 for a total of 65 OE group meetings held throughout the state with 1,710 attendees. That is roughly 3 percent of our total subscribers. MCHCP reduced the number of group meetings this year based on analysis of last year's attendance and that there are not any major changes from last year. MCHCP held 121 group meetings last year with 1,729 attendees. MCHCP is actively exploring more e-Learning opportunities for 2018 so that we may further reduce the number of group meetings next year without giving up education opportunities. We are especially considering that move for active employees as retirees tend to rely on those group meetings and not e-Learning.

This year MCHCP also did 22 not 8 question and answer tables with an estimated 44 people stopping by after the group meeting to get general questions answered. These were not well attended.

MCHCP held 8 live webinars not 2 with 543 registered attendees. Recorded webinars were available on the MCHCP website.

So far MCHCP has received almost 7,000 phone calls and 600 walk-ins to the office. There have also been about 900 secure messages answered. As always this last week of OE is one of the busiest as employees tend to wait until the last moment to enroll.

The enrollment provided to the board is for those that have made an active choice. While that number will grow this week, MCHCP is not expecting much change as we have passive enrollment. Non-Medicare subscribers in the PPO 300 Plan will be placed in the PPO 600 Plan if they fail to make an active choice, otherwise all others stay in the 2016 plan choice. MCHCP has approximately 53,000 subscribers and 96,500 members today.

There has been a significant drop in the myPlan Advisor tool usage. Only about 3,900 users as of October 20, compared to a total of 17,399 users for the month of October last year. We'll be evaluating the usefulness of this tool for next year. It may be a product of not having much changes from 2016 to 2017 driving the lower usage.

MCHCP has a little more than 16,000 subscribers who have completed the Health Assessment and Health Education Quiz for the Partnership Incentive. That is on target from last year. Remember, members can sign up for the Partnership Incentive throughout the year. However, they need to complete it by November 30 to have the incentive begin January 1. Otherwise they will have a gap.

MCHCP has a way to go with the Tobacco-Free Incentive. Last year for the month of October there were a little more than 31,000 subscribers that completed the Tobacco–Free Promise, and 1,800 that completed the quit tobacco promise. Forty-three hundred spouses completed the tobacco free promise and 100 completed the quit tobacco promise. Again, members can complete the promise throughout the year, but they need to complete it by November 30 to have the incentive begin January 1.

Ms. Muck also shared a few stats on website visits, which clearly show that members are viewing for OE.

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

Monthly state contributions from the employer of $32,929,681 and member contributions of $9,194,945 represent contributions from 53,300 subscribers and total 95,645 covered lives.

MCHCP received $5,776,766 in pharmacy rebates. Of these rebates, $4,091,165 is related to commercial (active and early retirees) and $1,685,601 is

associated with our Medicare retirees through our Employer Group Waiver Plan (EGWP).

Next in our investment section, the Other Post-Employment Benefits (OPEB) Trust returned .36 percent for September net of fees with a concentration mix of 39 percent equities, 60 percent fixed income and 1 percent in cash and cash equivalents. Since inception, total fund return is 7.47 percent; a full 1 percent more than the benchmark of 6.43 percent. Comments from our investment manager as it relates to our performance strategy include: Update returns for September 2016 were generally flat. Large Cap stocks were unchanged, while Small Caps and Global stocks were both up about 1 percent. Markets spent a good part of the month listening to both sides of the Federal Open Market Committee (FOMC) interest rate argument. Rates weren't raised, but merely delayed until likely December. The election campaign may likely be keeping markets and economic activity at bay for now. Our equity position is nearing our maximum allocation. In the bond portfolio, we are maintaining a five year duration which should insulate from too much market value decline if interest rates were to move significantly higher, the manager views this as having small probability.

In our expense section, self-funded medical claims for September posted at $31,268,042. Ms. Fischer mentioned that we are often asked, how do actual MCHCP medical claims interact or measure with our early actuarial projections for a particular CY once the year progresses? Ms. Fischer reviewed the pre-2016 projections and compared those early estimates to our actual medical spend for January 2016 through Sept. 30, 2016. MCHCP's actual spend through September 2016 is within 3.1 percent of those early projections. This range sits exceptionally well within industry accepted actuarial margin. Happy to bring this information to you as we move into the fourth quarter, which traditionally is the heaviest claims period of the CY. September pharmacy expense was $15,314,396 and reflects two billed units of $8.9 and $6.2 million to comprise September's activity.

There are no changes to the current Incurred But Not Report (IBNR) levels from the recent August 2016 report. The next update will occur after third quarter claim levels are available in the Truven warehouse.

Turning to 2017, the Plan conservatively has maintained the fiscal year (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. Also, no changes to IBNR from our August report have occurred.

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. No changes to IBNR from our August report. In 2018, as conservatively projected with no new revenue stream over our current FY 2017 levels. 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.

Chairperson Nelson asked how MCHCP performed in relation to actuarial analysis. Ms. Fischer responded that for January through September actual spend was within approximately 3 percent and early estimates are well within margin.

Senator Sifton left the meeting.

Representative Kendrick 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 Haug, Ms. Hayes, Director Huff, Representative Kendrick, Mr. Langworthy, Ms. Luebbering, Director Lyskowski, Senator Sater and Ms. Schaefer in favor.

Upon return from closed executive session, Representative Kendrick made a motion to adjourn. Chairperson Nelson seconded. Motion passed unanimously. Meeting adjourned.