MISSOURI CONSOLIDATED HEALTH CARE PLAN
BOARD MEETING
JANUARY 26, 2017

Attending: Vice Chairperson Mark Langworthy
Acting Director Bret Fischer
Director Dan Haug (via conference call)
Nila Hayes
Director John Huff
Representative Kip Kendrick
Linda Luebbering
Senator John Rizzo
Senator David Sater
Viola Schaefer
Commissioner Sarah Steelman (via conference call)

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; Garry Kornrumpf, Internal Auditor; Bruce Lowe, Chief Information Officer; Jennifer Stilabower, General Counsel; Julie Watson, Chief Population Health Officer; Beth Grellner, Willis Towers Watson; and visitors.

Ms. Muck called the meeting to order. Ms. Muck led the meeting as the board is currently without a Chairperson.

Ms. Muck announced that we have three new board members. She welcomed Acting Director Bret Fischer, Senator John Rizzo and Commissioner Sarah Steelman to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees.

There were no public comments.

Election of Chairperson and Vice Chairperson. Chapter 103.012 states that the board elect a Chairperson and Vice Chairperson in January of each year. Ms. Muck recognizes that this is a different year as the board gains new members during an administration transition. Ms. Muck welcomed the board's thoughts on moving forward with the election of a 2017 Chairperson and Vice Chairperson.

Mr. Langworthy asked if the election could be tabled for this meeting. Ms. Muck stated that this would be one option as long as we have board

consensus to wait on the election(s) until we have a more firm board membership. The board agreed.

Ms. Luebbering made a motion to approve the open session minutes of the December 8, 2016, regular MCHCP Board of Trustees meeting. Representative Kendrick seconded. Motion passed unanimously.

Beth Grellner of Willis Towers Watson presented the Data Analytics evaluation. MCHCP requested that Willis Towers Watson conduct an analysis of the detailed claim information in order to determine the primary cause of the increase in claims over the last several months. Willis Towers Watson enlisted its Data Analytics team to obtain two years of medical and pharmacy data from the Truven data warehouse and conduct the review. This includes both medical health plans (UMR and Aetna) and pharmacy prescription (Express Scripts, Inc.) claims data.

Ms. Grellner then reviewed the high level overview. Allowed and plan paid per member per year (PMPY) costs have increased by 11 percent and 12 percent, respectively, from the 12-month period ending October 2015 to the 12-month period ending October 2016. The high trend is primarily driven by an increase in medical costs for high-cost claimants (HCC). HCC are defined here as claimants with more than $50,000 in annual medical and pharmacy spending.

Director Haug and Commissioner Steelman joined the meeting via conference call.

The allowed PMPY and plan paid PMPY have increased over the last two-year period. While there has been an increase in pharmacy claim costs, the primary increase is coming from the medical-only portion of the claims. This trend is being driven by the HCC and their higher medical costs.

The number of HCC increased by nearly 250 year-over-year despite a slight decrease of -1.5 percent in overall active membership. As a result, the percentage of members who are HCC and the share of total medical costs attributable to HCC increased substantially. The largest categories of increase in high cost claims spend are in myeloproliferative diseases (i.e. blood cancers) and circulatory conditions. The top diagnostic areas for HCC include: musculoskeletal, circulatory, cancer, nervous system and digestive.

Ms. Grellner reviewed the top 20 HCC and recurring claimants. Cancers and circulatory conditions were the two most prevalent HCC condition groups. Cancer, circulatory and newborns were the three most costly condition groups for the top 20 HCC.

Ms. Grellner reviewed outpatient spending and utilization. The volume of physician visits and emergency room visits is much higher than the best practice

norms, which is leading to much higher PMPY costs for these services. Costs and utilization increased for all outpatient services from the 12-month period ending October 2016 except for a slight decrease in the volume of laboratory visits.

The board briefly discussed the additional charges associated with facility fees. MCHCP does not have control over the facility charges as they are within the hospital systems charge structure. MCHCP is not involved with those negotiations.

Ms. Grellner reviewed inpatient spending and utilization. Spending and utilization increased substantially for inpatient mental health/substance abuse (MH/SA) services, with a 50 percent increase in both the paid amount PMPY and the admit rate per 1,000 members. Paid PMPY increased nearly 14 percent for surgery, while surgery utilization stayed fairly constant. This may be tied to the large increase in HCC activity. Maternity costs increased by 44 percent while utilization was unchanged; this is related to two of the top 10 HCC being newborns.

Ms. Grellner then reviewed the MH/SA utilization and spending for inpatient and outpatient. Total MH/SA spending increased by 7 percent, while utilization increased by 21 percent. PMPY costs increased the most for depression ($4.60), autism ($2.22), bipolar disorder ($2.21) and anxiety disorder ($2.14). PMPY costs decreased substantially for eating disorders (-$4.13) and psychoses (-$1.62).

Ms. Muck added that MCHCP will be adding behavioral health counseling services at the *Strive for Wellness*® Health Center in the near future.

Ms. Grellner discussed the common condition prevalence. Costs for the top five common conditions increased between 9 percent and 29 percent. Spending for cancer rose nearly $60 PMPY. Key diagnostic areas include: cancer, coronary artery disease, diabetes, major depression, and chronic renal failure.

Ms. Grellner then reviewed the five areas of key recommendations. These include HCC, emergency room, maternity, MH/SA, and specialty pharmacy management.

> HCC — Musculoskeletal, circulatory and cancer are the main high-cost claims drivers; opportunity to increase case management and/or utilization management participation to ensure MCHCP members are managed appropriately in these severe cases; and explore programs related to top categories to help prevent future HCC in these areas.

Emergency room — Emergency room utilization per 1,000 is extremely high, 74 percent above the norm and more than double the best practice benchmark (~185); opportunity to promote alternate sites of care for MCHCP (e.g., telemedicine/virtual visits); and increase communication about the importance of a primary care physician relationship.

Maternity — MCHCP's overall C-section rate is 32.8 percent; while largely driven by physician practices, Healthy People 2020 suggests an optimal target C-section rate of 23.9 percent; and opportunity to communicate risks of elective C-sections, as MCHCP's rate is high even for younger members.

MH/SA — Promote Employee Assistance Program (EAP) and consider tele-EAP/behavioral health options.

Specialty pharmacy management — Specialty pharmacy under the medical benefit has increased as a percentage of overall MCHCP pharmacy spend, nearing 19 percent of all pharmacy costs; and work with medical carriers and MCHCP's pharmacy benefit manager (PBM) to understand options to manage this spend.

Ms. Luebbering asked for an update on where MCHCP is with cost to member for emergency room visits. Ms. Muck responded that in the PPO plans, members are charged a $100 copayment in addition to the deductible and coinsurance. For a member only in the PPO 600 Plan the member is charged a $600 deductible, $100 copayment, and 10 percent after that for any remaining charges up to the out-of-pocket maximum. MCHCP has worked with UMR and are doing an emergency room pilot project to outreach to those members who frequently utilize the emergency room. MCHCP will be evaluating the effectiveness of this program as time goes on.

MCHCP will be looking at the need to raise the copayment level to discourage emergency room utilization. When MCHCP looked at emergency room utilization we found approximately 40 percent of the usage were not true emergencies and member care could have been seen in another setting.

The board briefly discussed the number of cancer claimants, the increase in autism and C-sections.

Following discussion, Ms. Muck presented Executive Order 17-02 and Executive Order 17-03. Ms. Muck brought these to the board's attention so they are aware of how MCHCP is adhering to these orders.

Executive Order 17–02 is to employees of the executive branch prohibiting soliciting or accepting gifts. MCHCP currently has an employee conduct policy that prohibits MCHCP employees from soliciting or accepting any gifts that is

consistent with this executive order. While MCHCP are not employees of the executive branch, we are complying with this order within our personnel policies.

Executive Order 17–03 requires state agencies as defined in Chapter 536.010 to suspend all rulemaking until Feb. 28, 2017. Any proposed regulation that is time-sensitive or required by law is to be submitted to the Office of the Governor prior to Feb. 28, 2017. MCHCP has worked with the Commissioner's office to submit the proposed Orders of Rulemaking to the Office of the Governor for the office's approval to proceed. Ms. Muck is pleased to report that the Governor's office has approved MCHCP's rules to be filed. Ms. Muck will review the proposed Orders of Rulemaking with the board for their vote to file.

MCHCP will also be undertaking a review of MCHCP's regulations in concert with the executive order and will report back to the board before we issue a report to the Office of the Governor as required by this executive order. As MCHCP reviews its regulations each year, Ms. Muck does not anticipate that this will be too burdensome to complete. MCHCP works closely with the Secretary of State (SOS) office and Joint Committee on Administrative Rules (JCAR).

Ms. Muck presented the Final Orders of Rulemaking for the board's approval and filing with the JCAR and SOS office. MCHCP is preparing to file the Final Orders of Rulemaking for all the rules MCHCP filed as emergency and proposed to reflect the 2017 MCHCP plan offerings as voted on previously by the Board of Trustees.

MCHCP received one comment from the Board for Certification of Nutrition Specialists located in La Grange, Illinois. The comment was provided to the board. This comment applied to several rules – 22 CSR 10-2.010, 22 CSR 10-2.051, 22 CSR 10-2.052, 22 CSR 10-2.053, 22 CSR 10-2.055 along with the corresponding rules in Chapter 3. The commenter asked MCHCP to consider not limiting diabetes education services to be delivered by a Certified Diabetes Educator. Rather, this board recommended language that would open diabetic education services to professionals who provide diabetes education services consistent with their education and training. MCHCP has not made changes as a result of this comment. MCHCP believes it very important that those delivering diabetes education be certified to deliver this service to ensure quality and effectiveness. The certification is based on the 10 guiding principles of the national standards for diabetes self-management education and is based on evidenced-based standards. This level of standard is not an entry level to the specialty, rather it is a practice-based certification requiring individuals to accrue professional practice experience. The overall objectives of diabetic education is to support informed decision making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life. There are a wide variety of health care disciplines that can achieve certification. The change as suggested would lower the level of service provided to MCHCP diabetic members. Because diabetes is

such a prevalent condition in our population it is critical that MCHCP maintain a high level of service to this population.

No other comments were received and no amendments have been made to the proposed rules.

Director Fischer made a motion to authorize the Executive Director to finalize and file the Final Orders of Rulemaking, make technical corrections and file all necessary documents relating to the Final Orders of Rulemaking, with JCAR and the Secretary of State's office. Ms. Hayes seconded. Motion passed unanimously.

Ms. Muck stated that with the success of our *Strive for Wellness*® Health Center located at the Truman Building, MCHCP is evaluating options for expansion where it may make sense. As reported last month, MCHCP is expanding services at the health center to include behavioral health counseling to meet a growing need for this type of service. That service will be available beginning Feb. 1, 2017.

Representative Justin Hill contacted Ms. Muck this past summer about considering a health center located near correctional facilities to help covered employees and their dependents have closer access to care. MCHCP looked at correctional facilities and chose two sites to look at that made the most sense. MCHCP looked at the Northeast Correctional Center and South Central Correctional Center locations. These would not be on-site health centers but near-site health centers since access to health care is not conducive directly on-site.

MCHCP engaged Willis Towers Watson to perform a feasibility study to determine if a health center would make sense to pursue as a means to deliver convenient care to our members in these areas.

Ms. Grellner of Willis Towers Watson presented the health center feasibility study. The analysis includes the impact of direct and indirect costs avoided, such as redirected primary care visits, avoided specialist and emergency room visits, and productivity savings. Enhanced access, convenience and affordability may well lead to significantly higher visit volume than modeled in the analysis.

Ms. Grellner reviewed the health center eligibility and utilization assumptions. Willis Towers Watson modeled two health center scenarios for MCHCP, Northeast Correctional Center and South Central Correctional Center locations. Both locations include the enrolled employees, enrolled non-Medicare retirees, and dependent populations. She also reviewed the health center utilization and average visit frequency and range.

Ms. Grellner then reviewed the return on investment (ROI). The feasibility analysis indicated the following preliminary ROI results: A satisfactory business case to implement a near-site clinic at the Northeast Correctional Center location as this indicates a five year ROI of 1.1 including start-up costs; and an unsatisfactory business case to implement a near-site clinic for the South Central Correctional Center location as this indicates a five year ROI of .06 including start-up costs.

The Northeast Correctional Center analysis projects better financial results for the following reasons: larger eligibility population; greater historical utilization of health care which factors into greater opportunity for cost avoidance (primary care, specialist visits, emergency room, inpatient, and labs); and higher historical community costs which factors into greater opportunity for cost avoidance (primary care, specialist visits, and emergency room).

There are additional benefits to implementing health centers that are not captured by these financial results; for example, increased employee satisfaction, retention and morale, improved presenteeism and reduced absenteeism. Employers view the addition of convenience, accessible, high-quality health centers as an important enhancement to the employment value proposition and a contributing factor in their positioning as an employer of choice.

Ms. Grellner discussed the quantitative feasibility results for a five-year financial impact. Over a five-year period, results indicate a positive ROI for the Northeast Correctional Center scenario and a sub-break even ROI for the South Central Correctional Center scenario. The total costs avoided (costs saved by the client) for the Northeast Correctional Center is estimated at $3.2 million and South Central Correctional Center was estimated at $1.7 million.

Ms. Grellner briefly reviewed the calculation of ROI, MarketScan medical information and health center staffing.

Representative Kendrick asked what MCHCP realized in the first year of the *Strive for Wellness*® Health Center located in the Truman Building. Ms. Grellner responded that MCHCP broke even in the first year which typically takes five years.

Senator Rizzo and Senator Sater left the meeting.

Ms. Grellner reviewed the other key assumptions including: implementation year (2017); hours of operation; management model; facility space; health center staff salaries; member cost share; member copayment; saved time away from work (productivity); and member salaries.

The board was provided with the detailed financial results for the Northeast Correctional Center and South Central Correctional Center.

Ms. Muck stated that MCHCP is looking at this opportunity seriously but may not be able to implement in 2017. The board briefly discussed the hours of operations. MCHCP will check the shift change schedules for Corrections so that we have the health center available when Corrections staff are changing shifts. Since we are considering a near-site health center, MCHCP could be open to early retirees, spouses and children utilizing the health center.

Ms. Luebbering left the meeting.

Ms. Muck added that this is an interesting study and MCHCP will be considering this as we plan for the future.

Ms. Fischer presented the financial update. She reviewed some December 2016 activity and referenced points of interest.

Monthly state contributions from the employer of $33,127,223 and member contributions of $9,010,447 represent contributions for 53,295 subscribers and 95,318 covered lives.

Next, pharmacy rebates for the second quarter of 2016 were $6.6 million. These are comprised of $4.4 million commercial rebates and $2.2 million related to our Employer Group Waiver Plan (EGWP).

With relatively little change in other revenue categories, she moved to our investment section. The Other Post-Employment Benefits (OPEB) Trust returned .64 percent for December net of fees with a concentration mix of 40 percent equities, 58 percent fixed income and approximately 2 percent in cash and equivalents. Since inception total fund return is 7.35 percent; a full 1 percent above the benchmark of 6.37 percent.

As it relates to our calendar year (CY) 2016 performance: Equities (small and large cap) returned 16.43 percent annualized year to date (YTD) while fixed income posted at 1.81 percent. Global stocks were at 1.64 percent reflecting the continued underperformance of the global markets to that of the United States. Going forward, we will maintain our allocation to equities and interest rates will be key to how Bond returns fare for 2017. The Bond portfolio is positioned in the five year duration curve expected to limit our exposure in the event rates rise faster than expected.

In our expense section, self-funded medical claims for December posted at $37,068,089. December gross pharmacy expense was $14,996,809.

Incurred But Not Reported (IBNR) estimates are unchanged from last month’s report and reflect paid claims through Sept. 30, 2016, with projections rolled through CYs 2017 and 2018. As CY Plan data for 2016 became available

to the data warehouse earlier this week, Willis Towers Watson is evaluating IBNR estimates utilizing paid claims data through Dec. 31, 2016, and we will update the projections in a future meeting.

Ms. Fischer then reviewed what we actuarially projected would occur by the end of CY 2016 versus what our actual results are showing. The Plan had actuarially projected in late 2015 that prior to the beginning of 2016 to end our CY 2016 position at $92.3 million. The Plan position is at $77.3 million after reservations. The decreased position is primarily the result of medical claims on a paid basis coming it at $8.6 million higher for CY 2016 ($401.3 million versus early projections of $392.7 million) and the resulting increase in the associated IBNR by over $6 million from early projections at Dec. 31, 2016.

Projecting for both CYs 2017 and 2018, the Plan conservatively has maintained the fiscal year (FY) 2017 funding level from the state for the full CY at $394.6 million or $32.9 million monthly. Pharmacy reflects seasoning at the six-month CY interval to reflect current pharmacy trends. All other expenditures have also been updated to reflect current enrollment and contract pricing and Willis Towers Watson, since our last report to you in early December, has updated medical claims and net pharmacy costs to reflect revised actuarial projections based upon historical performance and anticipated trends.

With conservatively projecting no new revenue stream over our current FY 2017 levels, if you proceed to the after reservations position the Plan is projected on the CY 2017 page that between July and August 2017 to drop below a one-month level of Plan total claims and operating expenses after reservations and on the CY 2018 page beginning in June 2018, to less than fully meet Plan reservations by $10 million. Please appreciate that actual results may differ from these projections.

Director Huff made a motion to adjourn. Representative Kendrick seconded. Motion passed unanimously. Meeting adjourned.