MISSOURI CONSOLIDATED HEALTH CARE PLAN
BOARD MEETING
JANUARY 25, 2018

Attending: Jim McAdams
Representative Kip Kendrick
Mark Langworthy
Director Chlora Lindley-Myers
Linda Luebbering (via conference call)
Daniel O'Neill
Senator John Rizzo (via conference call)
Senator David Sater (via conference call)
Viola Schaefer
Director Randall Williams
Representative David Wood

Others attending: Judith Muck, Executive Director; Kim Backes, Research Coordinator; Denise Chapel, Director of Vendor Relations (via conference call); Shelley Farris, Director of Benefit Administration; Stacia Fischer, Chief Financial Officer; Tammy Flaugher, Senior Administrative Specialist; Bethany Goodin, Member Services Manager; Ryan Hobart, Multimedia Communication Manager; Garry Kornrumpf, Internal Auditor; Bruce Lowe, Chief Information Officer; Jennifer Stilabower, General Counsel; Julie Watson, Chief Population Health Officer; and visitors.

Mr. McAdams called the meeting to order.

Dennis Morrissey addressed the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees. Mr. Morrissey would like the board to consider a change to their published Code of State Regulations (CSR) because it does not allow members to have a Health Savings Account (HSA) during the year they turn 65.

22 CSR 10-2.053 (18) states: If a retiree subscriber and/or his/her dependent(s) becomes eligible for Medicare in the upcoming plan year then s/he may not enroll in the HSA Plan during open enrollment.

Mr. Morrissey discussed the additional premium costs associated with the period prior to an individual reaching the age of 65 and the lost tax benefit of being able to participate in the HSA for those months. He mentioned that with his example the additional premiums and loss of the tax benefits associated with an HSA could cost approximately $1,500. Mr. Morrissey also gave an example of an individual whose birthday is in December and what those additional costs could be.

Again, Mr. Morrissey requested that the board consider changing the rule.

The board briefly discussed the time needed to review and consider a rule change. It was noted that any rule change would require board action and could take up to six months to make a change. The board agreed to take Mr. Morrissey's request under consideration and ask staff to look into this further.

No further public comments were offered.

Representative Kendrick joined the meeting.

Representative Wood made a motion to approve the open session minutes of the December 14, 2017, regular MCHCP Board of Trustees meeting. Director Williams seconded. Motion passed unanimously.

Dave Meyer, Mike McCoy, Don Perdue and Dave Roehl of Central Bank were introduced and presented the investment update.

Mr. Meyer provided a brief introduction. For more than 100 years Central Bank has focused on personal service, investment management and leading product innovation. Central Bank is part of a 13-bank holding company with more than $13 billion in assets and more than $1.7 billion in capital. Central Bank is financially strong, a trusted partner and committed to Missouri. Central Bank has been a long term partner of MCHCP and their commitment to Missouri includes more than $6 million in taxes paid to Missouri in 2016.

Mr. Meyer discussed the Central Capital Markets and Retiree Welfare Benefit Trust. He also reviewed MCHCP's historical cash balance. MCHCP's cash position is monitored on a daily basis by the Central Bank team of advisors.

Mr. McCoy reviewed various graphs and charts associated with the Capital Markets Portfolio. He then reviewed the Capital Markets comments: allowing this account to run off to supplement low cash operating balances in the Operating account of $13 million in 2018; fast rise in short-term rates has flattened the yield curve, they continue to manage the portfolio with no fee; and since inception (2006), incremental earnings of $4 million.

Mr. McCoy then reviewed various graphs and charts associated with the Retirement Benefit Trust Portfolio. Then he reviewed the Retiree Welfare Benefit Trust comments: conservative/moderate allocation allowed the allocation to remain at the high end (~40 percent); since inception (2009), account has grown from the initial investment of $66 million to $115 million (7.43 percent annualized); Central Bank is monitoring how the equity markets ultimately handle increasing short-term rates; inflation seems to be picking up - closer to 2 percent

than 1.5 percent - they are watching the United States dollar; and tax reform/cuts should continue to be a nice tail wind for equity markets.

Given our current policy, Ms. Muck asked if Central Bank believes it is serving MCHCP well or are there any adjustments we need to make? Mr. McCoy responded that in hindsight there existed some opportunity to be more aggressive; although returns were consistent within the existing policy. Given how much the equity markets run he would be hesitant at this point to push up the risk. However, this is probably an ongoing conversation MCHCP and Central Bank should consider having. Ms. Muck will be monitoring closely as we move forward. With reductions in operating cash over time, what is the impact to overnight spend? Mr. McCoy responded that the overnight today is earning 165 versus a year ago earnings of 65.

Ms. Muck presented the Final Orders of Rulemaking for the board's approval and filing with the Joint Committee on Administrative Rules (JCAR) and the Secretary of State's (SOS) office.

In December, MCHCP's proposed rules for the 2018 plan year were published in the Missouri Register. Comments were not received and no changes have been made to the proposed rules. It is now time to file the Final Orders of Rulemaking for the following rules: 22 CSR 10-2.030 Contributions; 22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members; 22 CSR 10-2.135 Benefit Package Option; 22 CSR 10-3.090 Pharmacy Benefit Summary; and 22 CSR 10-3.135 Benefit Package Option.

Mr. Langworthy 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 SOS office. Director Williams seconded. Motion passed unanimously.

Ms. Fischer and Ms. Muck presented the financial update and future planning.

Prior to discussing the monthly financial results, Ms. Fischer began with updates on the MCHCP fiscal year (FY) 2019 budget as recently recommended by the governor. MCHCP resides in the Office of Administration's budget within employee benefits in House Bill (HB) 5. The governor has recommended a core budget of $403,133,360 with an "E"; comprised of $246,643,832 or approximately 61 percent in general revenue (GR). The Board approved a cost to continue decision item for the actuarially determined costs of the Plan not covered by the core appropriation in September and we updated those results to the board in December increasing the cost to continue from $91,706,809 to $94,189,689 due to increases in the enrolled population in the Plan. Of this amount, the governor recommended $61,210,968 with an "E."; comprised of $37,889,589 in GR. Also

recommended was $1,622,947 for new personal service additions throughout statewide department budgets for FY 2019 making the governor's total recommendation for MCHCP's FY 2019 budget at $465,967,275. HB 5 before the House Budget Committee began yesterday and will resume on Monday for MCHCP. In addition, MCHCP appeared before the Senate for a FY 2018 Supplemental Request of $4,000,000 on Tuesday. This request was not to increase the FY 2018 appropriation to MCHCP, but rather to allow GR to cover transfers through the end of the FY as the "E" had been removed from this appropriation in FY 2018.

Ms. Fischer presented the financial update. She reviewed some of the December 2017 results.

Monthly state contributions for December from the employer of $33,740,537 and member contributions of $9,106,857 represent contributions from 53,261 subscribers and total 95,561 covered lives.

MCHCP received $8,590,071 for second quarter commercial and Employer Group Waiver Plan (EGWP) pharmacy rebates. These rebates encompass both our active and retiree group receipts. MCHCP also received $7,397,391 comprised primarily of the 2016 Centers for Medicare and Medicaid Services (CMS) annual reconciliation payment of $6,738,288.

Ms. Fischer then moved to our investment section primarily associated with the Other Post-Employment Benefits (OPEB) Trust. The OPEB total portfolio returned .34 percent for December net of fees with a concentration mix of 40 percent equities, 56 percent fixed income and 4 percent in cash and equivalents. Since inception total fund return is 7.43 percent; nearly a 1 percent increase over the weighted benchmark of 6.57 percent. Through year end 2017: The one-year portfolio return was 8.03 percent with the 3-year at 5.19 percent and the 5-year at 7.18 percent. Comments from our investment manager as it relates to our performance strategy include: We are nearly fully invested in the equity market, but watching for signs to begin to pare exposure; and the Federal Reserve is expected to increase interest rates two to three times in 2018 and we expect to pare back to below five years to limit market erosion.

In our expense section, self-funded medical claims posted at $32,794,387 for December. For the 2017 calendar year (CY) just concluded, self-funded claims expense on a paid basis of $408.8 million was within 2.4 percent of the actuarial projection; extremely well situated within actuarial margin for such projections. Gross pharmacy expense for December was $16,452,517. Additionally, for the 12 recently completed months of CY 2017, net pharmacy expense (adjusted for the period rebate receipt) is trending at $10.1 million per month; essentially equaling what had been actuarially projected for the period. Ms. Fischer expressed the importance and significance of how the actuarial accuracy is to the Plan's forecasting.

Next, Incurred But Not Reported (IBNR) was evaluated in November 2017 by Willis Towers Watson based upon claims activity through Sept. 30, 2017, and projected through CY 2019. As a result of the mature claims data through June 30, 2017, IBNR reservations for the second six months of 2017 have been increased by a range of .7 percent to 3.8 percent through Dec. 31, 2019. Finally, the Plan projects after reservations a position at approximately $18 million.

Turning to 2018, the Plan has included the FY 2019 governor's recommended funding level from the state beginning in July 2018 at $465 million or $38.8 million monthly and this will be updated as we move through the legislative process. Medical and pharmacy projections reflect seasoning at intervals to reflect projected medical and pharmacy trends, but we are anticipating that Willis Towers Watson will perform an experience study in 2018 to reevaluate. All other expenditures have been updated to reflect current enrollment and existing contract pricing. In 2018, as projected with the governor's recommended level of funding, if you look to the net position the Plan is projected in September to drop below the Plan's ability to be able to fully fund its liability for IBNR claims costs. It was noted that the July and August figures of 2018 should be reflected in the black instead of red text as provided to the board.

Briefly turning to 2019 and with an understanding that these projections reflect the current plan design today and do not incorporate design decisions before you today, the Plan has again inserted the FY 2019 governor's recommended funding level from the state of $465 million, and for member contributions, we have 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 trends net of rebates. In CY 2019, the Plan beginning in January 2019 and for the full CY will be unable to fund the Plan actuarially projected liability for IBNR claims, and portions of the remaining liabilities progressively as the calendar months of 2019 continue. We ask you to appreciate that actual results may differ from these projections.

Ms. Muck discussed future planning. As Ms. Fischer just presented, the governor's recommended $61.2 million to fund our original October request of $91.7 million which was updated to $94.2 million in December. MCHCP is looking at options to close the approximate $30 million difference. For reference, MCHCP spends approximately $1.7 million per day/365 days a year. Therefore, we are looking for savings of approximately 18-days of claims spend.

Ms. Muck began early discussions on potential changes that MCHCP has modeled. This includes a combination of plan changes and other opportunities to bridge the gap. The board will not be asked to vote on these potential changes as they are not final and there will be a lot of details to work out. Today, Ms. Muck is seeking the board's feedback.

The current designs include the Preferred Provider Organization (PPO) 300 Plan, PPO 600 Plan and Health Savings Account (HSA) Plan. The board was provided with these plan's actuarial value. The actuarial value is the value of what the Plan covers in expenses for members. The actuarial value of the PPO 300 Plan is 90.4 percent, the PPO 600 Plan is 89.2 percent and the HSA Plan is 83.9 percent. Our legal liability or minimum that we can go down to is 60 percent.

One potential plan to address the funding gap is to eliminate the PPO 300 Plan and PPO 600 Plan and replace those with a PPO 750 Plan and PPO 1000 Plan. We currently offer a PPO 1000 Plan to Public Entities (PE) with approximately 55 percent of PE members enrolled in this plan. We would offer office visit copayments with the PPO 1000 Plan. Members appreciate the certainty around the cost of an office visit. The PPO 750 Plan would not have copayments as some members do not want a copayment. They realize the copayment is not applied to the deductible and prefer the office visit cost be applied toward their deductible.

For both of the proposed PPO plans we are considering instituting an inpatient copayment of $200 plus deductible and coinsurance and an emergency copayment increase from $100 to $200 plus deductible and coinsurance. Inpatient and emergency room rates are above the Norm (public sector). Forty-six percent of emergency room visits are not emergent.

Another area that MCHCP is interested in exploring is an opportunity to expand access to telemedicine.

MCHCP is also looking at our copayments for pharmacy. Currently, the pharmacy costs are $8 for generic, $35 preferred brand, $100 non-preferred and $35 specialty copayment. We are considering changing the generic to $10, preferred brand to $40 and specialty copayment to $75 with no change to non-preferred.

MCHCP is also considering a change to the out-of-pocket (OOP) max formula. Today, the PPO 300 Plan and PPO 600 Plan have the same OOP max which is 2.5 times the PPO 600 Plan deductible. The HSA Plan is two times the deductible. We are proposing to make each plan have the same formula and increase it to three times the deductible. The industry mean is approximately four times the deductible. Eight percent of active individual employees meet their OOP max with four percent of active families meeting their OOP max. Fourteen percent of early retiree individuals meet their OOP max while three percent of early retiree families meet their OOP max.

With these proposed changes, the actuarial value of the PPO 750 Plan would be 86.8 percent, the PPO 1000 Plan would be 85.3 percent and the HSA

Plan would be 80.5 percent. These percentages are still more than the legal minimum of 60 percent.

According to a 2017 Willis Towers Watson Health Care Financial Benchmarks Survey the median PPO plan has an actuarial value of 84.9 percent. The median High Deductible Health Plan (HDHP) has an actuarial value of 81.7 percent.

The proposed changes will result in approximately $9 million in savings to the Plan with minimal expected impact to premiums.

In our discovery phase, we did model if we kept current designs and just increased premium. At the time, we did not have governor recommendations, so we used $45 million as a proxy of the amount we would need from additional premium. In one model, active contributions would have to increase by 130 percent on average, while non-Medicare and Medicare retiree contributions would increase by an average of 28 percent and 21 percent respectively. We also looked at increasing everyone by the same percentage and that would require an 80 percent increase in premium overall to all groups.

In 2017, 35 percent of active individual-only employees met their deductible and 38 percent active families meet their deductible. There were 52 percent of individual early retirees who met their deductible and 31 percent of retiree families meeting their deductible. It was noted that most of the early retirees are in the PPO 300 Plan.

MCHCP is also looking at other opportunities to meet the $9 million gap. Our vendor partners brought us the idea of moving to a Medicare Advantage Plan for our Medicare-primary members. We already moved to a Medicare Part D Drug Plan for this population, this would bring medical services into the arena. Looking at current plan design, we estimate that it could save MCHCP $4 million in FY 2019. MCHCP would like to put out for a request for information (RFI) to solicit ideas on plan designs for this population and once we have gathered more information, then we can go out to bid having a more informed bid. At the same time we do the RFI, we believe it would be interesting to include a request for any ideas of what solutions there may be for the pre-Medicare retiree population. We will be issuing the RFI fairly soon so that we can issue a request for proposal (RFP) for the board to consider award.

We have several other ideas. Based on self-disclosure information on Health Assessment (HA), 78 percent of those that completed the HA are overweight or obese. Given our high rates of diabetes, cardiovascular disease and musculoskeletal conditions, we would like to solicit bids from companies that have proven scalable online weight control programs so we can reach those that would qualify wherever they reside. We will be looking for programs with evidenced-based content and a high degree of medical oversight. In addition, the

online visits must be billable as claims so that they qualify as preventive services so all members who will qualify may have access with 100 percent coverage including those in our HSA Plan. We know our vendor partners have current relationships with firms in this space – UMR through United HealthCare has a relationship with Real Appeal and Aetna has a relationship with ACAP Health – Naturally Slim. So MCHCP will be seeking bids that members can access regardless of what health plan they have chosen.

Musculoskeletal remains our most expensive major diagnostic category, reflecting almost 19 percent of our spend in FY 2017, or about $76 million dollars. MCHCP has been looking at solutions that could enhance utilization management of musculoskeletal procedures such as joint replacement surgeries and spinal fusion with site of care optimization as a component. We would also like to see if we can develop a solution that would provide member incentive to choose a less expensive place of care that would meet their needs. There are firms that specialize in this arena achieving immediate cost savings to their customers. So we are planning to bid this out and integrate with our current vendor partners to maximize our success.

Health literacy is a major driver of how wisely patients interact with the health system and we know that most Americans have very low health literacy. There is a firm that has had some really good success driving savings using a very unique model. They work with both the provider and the patient to educate the member about their health condition and reward both for using their online educational course. This type of intervention is called information therapy to achieve knowledge-adherence response by delivering information at the right time to enable a patient to make informed choices. The studies we have seen have had an impressive outcome. We are exploring the potential of conducting a pilot to determine if the results seen by other plans can be replicated with our population. MCHCP is not ready to issue an RFP, there are numerous issues to resolve before we take that next step, including determining our financing mechanism. But we did want you to be aware we are seeking innovations as part of our due diligence. MCHCP would potentially seek a bid later this summer.

Finally, we are also looking at pharmacy cost transparency to help drive member behavior change. There are some innovating firms out there that can layer over what our pharmacy benefit manager (PBM) is doing to help patients choose the lowest cost retail drug. We know of several states that are starting to put this type of product in place for their members. This will also come later in the year as we complete some of the other bids that are in queue for this year.

Following discussion, there was board concurrence to move forward with Medicare Advantage and the other items discussed.

Ms. Muck presented the 2018 contract and RFP overview. She briefly reviewed the upcoming contracts that will be brought to the board for approval

and award. The new RFPs that were previously discussed will be added. There will be numerous contracts and renewals brought before the board in the coming months.

Mr. Langworthy made a motion to move into closed executive session pursuant to §610.021 RSMo (1), (5), (14) and (17) of §621.021 to discuss confidential or privileged communications between the board and its attorney; health proceedings involving identifiable persons; records protected from disclosure by law; and confidential or privileged communications between a public governmental body and its auditor, including all auditor work product; however, all final audit reports issued by the auditor are to be considered open records pursuant to this chapter. Mr. O'Neill seconded. A roll-call vote was taken, and the motion passed with Mr. McAdams, Representative Kendrick, Mr. Langworthy, Director Lindley-Myers, Ms. Luebbering, Mr. O'Neill, Senator Rizzo, Senator Sater, Ms. Schaefer, Director Williams and Representative Wood in favor.

Upon return from closed executive session, Directory Lindley-Myers made a motion to adjourn. Representative Kendrick seconded. Motion passed unanimously. Meeting adjourned.