Department of Transformation and Shared Services
Governor Asa Hutchinson
Secretary Amy Fecher
Director Jake Bleed

September 14, 2021

The Honorable Terry Rice, Co-Chair
The Honorable Jeff Wardlaw, Co-Chair
Arkansas Legislative Council
Room 315, State Capitol Building
Little Rock, AR 72201

RE: Response of the Employee Benefits Division to the recommendations of the Segal Group, Inc.

Dear Sirs,

The following is in response to a request from the chairs of the Arkansas Legislative Council regarding the recommendations of the Segal Group, Inc., and potential changes to the Employee Benefits Division of the Department of Transformation and Share Services.

Recommendation: **Plan Designs (Slide 5)**

- *Lower Urgent Care copay ($75) to further incentivize lower ER utilization*
- *Leave current designs intact while monitoring emerging plan specific experience and migration patterns*
  - *Tweak designs accordingly and index Classic per individual deductible for family coverage to maintain "qualified" status*
  - *Consider simplifying plan designs by eliminating PSE offerings*
    - *Would cost an additional 0.9% of PSE spend to move to ASE designs, or $3-$4M in 2021 if enrollment spread remained intact*

EBD Response: The division supports recommendations regarding Urgent Care and can suggest additional actions related to a potential reduction in the utilization of ER services. However, we do not support a shift in PSE plan designs to mirror those of the ASE. A move such as this would have an adverse effect on the PSE members. We recommend a longer-term comprehensive redesign of both plans.

Recommendation: **Employee Contribution (Slide 7)**

- *Maintain same contribution structure*
- *When necessary, implement systematic annual increases*
- *State funding increase needs to outpace future employee increases to re-align with benchmarks*
  - *ASE contribution cost share of total rate is currently ~30% for Premium Plan (EE only) compared to 15% benchmark*
- *Keep ASE and PSE contribution structure separate due to current complexity of PSE.*

EBD Response: The division supports these recommendations and can provide additional proposals regarding the establishment of stable, ongoing funding for the operations of EBD.

Recommendation: **Reserve and Future Funding (Slide 10)**

- *Remove $500 cap on funding for ASE to allow for flexibility*
- *Institute a multi-year projection model (current year + 3 years)*
- *Establish a reserve target range of (12%–16% of claims)*
  - *8% for IBNR ; 4%–8% range for claims fluctuation*
- *Keep ASE and PSE funds separate due to dissimilar funding methods*
- *Solve for annual funding increase needed to meet midpoint of reserve target (14%) at end of projection period*
  - *ASE Status Quo: 5.4% increase for State & employee rates for 2023-2025*
  - *Long term approach offers smoother changes*
- *If fund balance is projected to fall beneath target reserve range at a given point, execute a trigger*
  - *Short term bump to funding so min. target reserve range is maintained*
  - *If State doesn't comply with trigger, funding must come from employees*

EBD Response: The division agrees that the state should adopt a strategic, multi-year approach to funding built around certain targeted reserves. However, based on actuarial recommendations, we believe reserves should be higher than recommended and sufficient to support plan operations for two months, or about 16% to 20% of claim costs.

Recommendation: **MAPD (Slides 14 & 15)**

- *Conduct a formal procurement as soon as possible. Recommend approval by year-end to meet 1/1/2023 effective date*
- *Construct RFP to provide flexibly and maximize contract provisions:*
  - *Plan options*
  - *Rate guarantees*
  - *Medical loss ratio guarantees*
- *Make plan design equivalent to current*
  - *Give consideration to lower Rx coverage for PSE, since not currently provided*
- *Full replacement will maximize savings, but initially keeping MAPD as an option along with current plan easier to communicate*

Recommend a side-by-side approach

- *Set the same State contribution percentage for MAPD plan to create buy-down effect incentivizing members to select MAPD*
- *Auto enroll into MAPD plan*
- *Estimated savings of $20.9M for plan and $12.6M for retiree at 75% enrollment assumption for MAPD*
- *Same approach for PSE costs plan $2.1M and $1.8M for retirees, however they now receive an exceedingly rich prescription drug plan*
- *Recommend reducing the value of the PSE drug plan to yield shared savings*

EBD Response: The division agrees that the cost-savings and potential improvements in coverage offered by Medicare Advantage plans must be considered. These changes should be accompanied by expanded communication, outreach, and support for those affected by the change.

Recommendation: **Medical (Slide 18)**

Release RFP and allow for plenty of time for analysis and potential transition

- *Have bidders re-price actual claims to give a more accurate discount comparison*
- *Ensure the ASO fee includes wellness related programs that can reduce cost*
- *Evaluate from a "total cost of care" approach, rather than just discounts and fees*
- *Request potential ACO/narrow network options*

- *Establish quantifiable performance guarantees tied to members health*

EBD Response: The division strongly supports regular, open, and competitive procurements for all contracts. The current contract in place with Health Advantage, dba HMO Partners, Inc., has some advantages and disadvantages which should be addressed in a future RFP. Specifically, the division could consider "unbundling" certain services in the future, which could then be bidout separately. The adoption of wellness or "total cost of care" approaches should be considered only after confirmation that these approaches will result in lower claims costs.

Recommendations: **Pharmaceutical (Slide 19)**

Release RFP and allow for plenty of time for analysis and potential transition

- *Prepare an RFP that describes the flexibilities desired in the program including for example custom formulary, custom clinical rules and role of independent pharmacies*
- *Have bidders provide proposals with minimum discount and rebate guarantees for each year of the contract*
- *Clearly define all terms so that you receive 100% pass through of manufacturer rebates including inflation protection and manufacturer admin fees*
- *May request trend guarantees for certain therapeutic classes to share risk with the PBM*
- *Have bidders propose rates with independent pharmacies guaranteed separately from all others*
  - *This will allow the Plan to have control over pricing terms for the independents*
- *Have bidders propose exclusive specialty pharmacy network (may include in-state presence)*
- *Remove requirement for RBP so that you do not limit potential bidders*
  - *Savings from other programs will outweigh increased cost*

EBD Response: The division believes its current operations regarding the regulation of pharmaceutical costs are the best available option for both public employees and taxpayers. The division would oppose measures which shift drug purchasing policies toward traditional Pharmacy Benefits Manager.

Recommendation: **Repeal Act 1104, Insulin (Slide 28)**

- *The way the law is currently written means that a plan sponsor has lost all ability to negotiate with a manufacturer of insulin and there is no requirement that the manufacturer offer any concession on their price to patients. Plan sponsors and their PBMs have been restricted in using their size and scale to negotiate with drug manufacturers.*
- *A more appropriate solution to limit member cost share is to write into law a cap on member cost share as many other states have done so that insulin cannot exceed a certain dollar amount per month.*
- *The most common caps are $25 and $100 per month depending on the State. This would take away the burden of cost share on the member and still allow the plan sponsor to effective negotiate price, rebates, discounts, etc to lower their cost.*

EBD Response: The division supports this recommendation.

Recommendation: **Shift the wellness program from self-serve to results based to drive sustained behavior change (Slide 31)**

- Results-focused for broad population
  - Negotiate Performance Guarantees with vendors tied to improvement in the overall population health
  - Incentivize age and gender specific health screenings (i.e., primary care visit, flu shot, OBGYN screening, dental screening, cancer screenings, etc.)

- Results-focused for targeted population
  - Negotiate clinical Performance Guarantees that are condition specific
  - Incentivize condition specific program engagement and milestone achievement
- Carriers can offer incentive platforms, or this can be bid independently

EBD Response: The division supports the adoption of policies and programs which provide verifiable and quantifiable benefits to the plan and its members. These benefits should specifically include a calculable cost savings. The division does not support the investment of taxpayer dollars in programs whose benefits cannot be independently verified and tracked. In addition, any consideration of wellness or condition-specific incentives should be mindful of discrimination claims and emerging EEOC rulings.
Recommendation**: Comprehensive Diabetes management strategy should include a focus on prevention, management, and lifestyle improvement (Slide 32)**

- Diabetes Prevention
  - Add a CDC approved Diabetes Prevention Program (DPP) through a digital platform
  - Incentive enrollment and key millstones
- Diabetes Management
  - Add a digital management program that reduces the out-of-pocket cost to the member and increases compliance with prescribed treatment
- Risk Reduction
  - Add a digital diabetes program that focuses on dose optimization with lifestyle changes reducing independence on high-cost injectable insulin
- Establish quantifiable performance guarantees tied to individual health outcomes
  - A pilot can be focused on the highest cost diabetics
- With 20% engagement of diabetics and pre-diabetics, we estimate that the State could achieve **savings of 1.3% - 1.9%, or $10M - $14M**

EBD Response: As noted above, the division supports the adoption of policies and programs which provide verifiable and quantifiable benefits to the plan and its members. In support of this goal, the division suggests, reviewing and verifying pilot projects on a disciplined and uniform basis within the new governance structure.

Recommendation: **The pandemic reduced access to preventive care screenings and many rural communities lack access to high quality oncology care (Slide 33)**

- *Communicate and incentivize age/gender specific cancer screenings*
- *Enhance utilization management programs that require adherence to national standards of oncology care (NCCN Guidelines and appropriate genetic testing)*
- *Connect oncology patients to nationally recognized Oncology Centers of Excellence (COE) virtually*
- *Established vendor partnerships exist within different carriers and independent cancer care centers can offer virtual consultation*

EBD Response: The division supports the extension of oncology care to all communities within the state.

Recommendation: **Comprehensive musculoskeletal program includes site of service steerage and virtual access to care (Slide 34)**

- Consider a prevention program related to early interventions for physical therapy and weight loss
- Direct contracting through bundled payments can be established independent of a carriers network for high volume high cost procedures
- Established vendor partnerships exist within different carriers and independent vendors can offer virtual physical therapy or a separate network

EBD Response: The division supports the adoption of programs whose benefits can be verifiably calculated and measured. This could certainly include programs similar to those described here.

Recommendation: **Onsite clinics and other models can reduce inappropriate medical spending and can reduce the burden of medically underserved communities and high social deprivation index (Slide 35)**

Options to consider:

- Onsite clinic vendor with satellite kiosks and nursing care
- Strategic health system partnerships
- Retail partnerships for onsite, virtual, and in home care
- These will require a full bid and analysis based on geographic alignment

EBD Response: As noted above, the division supports the adoption of programs whose benefits can be verifiably calculated and measured. However, the division would likely oppose plans to establish permanent or brick-and-mortar healthcare onsite at state and public-school facilities.

Recommendation: **ACT 927, Bariatric Program (Slide 36)**

- Market data and BLR specific analysis both support the continued funding and promotion of the current bariatric program.
- Keep current $3M cap in place to mitigate risk, although history indicates a low likelihood of surpassing.

EBD Response: The division supports this recommendation and is currently exploring incentives which are likely to result in significant cost savings for the plan.

Recommendation: **Website design and improvements (Slide 39)**

EBD Response: The division supports this recommendation and we have already begun the process to revamp and modernize the online resources, including offering expanded online enrollment opportunities.

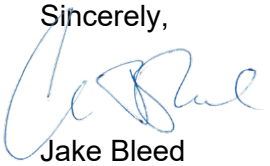
Recommendation: **Additional Items (Slide 42)**

- Several other states require actuarial notes to accompany bills to help voters understand the potential financial impact of said bill.
- Segal recommends a bill filing deadline and requirement for an actuarial statement for each bill impacting either the ASE or PSE plans, similar to the requirements in place for legislation filed affecting the state retirement systems.

EBD Response: The division supports this recommendation and would recommend consideration of an approach to EBD-specific bills which is similar to those dealing with state retirement programs.

Thank you for your consideration of the issues confronting the division and seeking our response to these recommendations.

Sincerely,



Jake Bleed