D

State of Arkansas

BLR Review

Recommendations

September 2021

Segal

Recommendations

Plans and Contributions

Reserves and Funding Strategy

MAPD

Medical and Pharmacy

Clinical

Communications

Additional Items

Plans and Contributions

Background

- The EBD plan designs have competitive actuarial values when compared in our benchmarking analysis:

Plan	ASE AV	PSE AV
Premium	85%	84%
Classic	78%	78%
Basic	72%	71%

- Logical spread between the three options and offer at least one HSA eligible high deductible plan
- Cost sharing is properly staggered — incentivizing members of Premium Plan to receive services at most cost efficient modality

Plan Designs

Recommendation

- 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 in order 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 in tact

Employee Contribution

Background

- The plans utilize the most common tier structure (4-tier)
- Significant EE contribution increases for 2022 means EBD now higher than benchmarks
- Similar subsidy across all plans protects program from migration risk
- Employee Only and Employee + Children lower contribution as a percentage of total premium than Spouse and Family coverage
  - Thus, EE only makes up the greatest proportion of total contracts
- PSE contribution vary with district contribution
- ASE contribution defined

Employee Contribution

Recommendation

- 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.

Reserves and Future Funding

Background

- Historical financial issues stem from stagnant State funding and short term planning causing reactionary decision making
- Changes in 2022 mitigated short term financial issues, but long term strategy required
- Status-quo projection indicates assets nearing zero at the end of 2024
- The vast majority of states have reserve policy in place at varying degrees of risk tolerance
  - Most set a % for IBNR and adverse claims
- Segal model calculates appropriate claims fluctuation reserve of 8% given size of and structure of EBD
- Other states range from 3%–10%

Reserve and Future Funding

Recommendation

- 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

Medicare Advantage Prescription Drug

MAPD

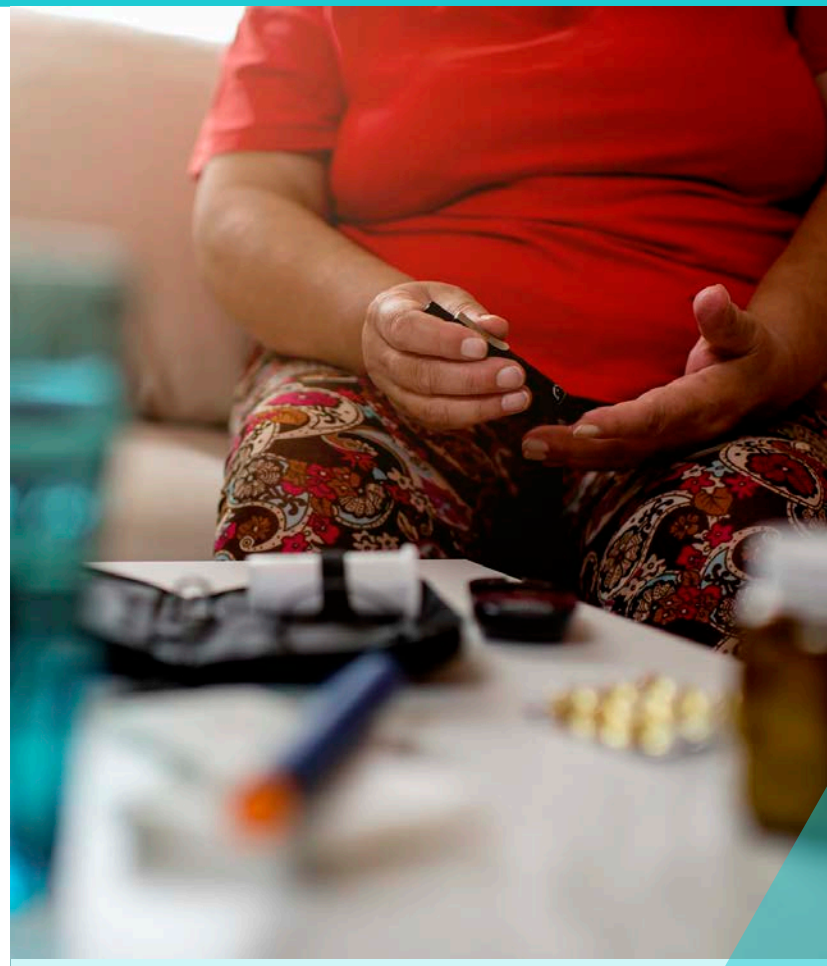
Background

- Group MAPD's are fully insured plan offered by Private Carriers
  - Combines Traditional Medicare (Parts A & B), Wrap Benefits and Part D
  - Carriers receive capitated payments from CMS to subsidize the cost of coverage
- Passive PPO network allows all members to receive care from any provider accepting Medicare
- Segal presented the benefits of this program at the July & August meetings
- Majority of states have moved to Medicare Advantage

MAPD

Background

- Arkansas is 1 of 2 states relying solely on RDS for ASE
  - No Rx coverage currently provided for PSE
- Segal has implemented this program for several state clients achieving substantial savings
  - Savings on a cash and OPEB liability basis
- Market analysis conducted where conservative rates (full replacement) were provided from the 2 largest carriers
  - MAPD rate roughly 50% of current cost
  - $45M reduction in total premium for ASE
  - $5M additional premium for PSE, which includes adding Rx coverage back into the design under the ASE



MAPD

Recommendation

- 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

MAPD

Recommendation

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

Medical and Pharmacy

Medical

Background

- Currently using BCBS to administer medical plan
- Segal prepared discount database analysis to compare the four major carriers
  - Results indicate BCBS leader in aggregate discount based on actual membership footprint
  - Two other vendors within a reasonable range
  - Other carriers have adequate access
- An analysis of ASO fees show the current amount of $20.55 PMPM is competitive for the group's size
- Fees include most core services but missing some programs to help reduce costs

Medical

Recommendation

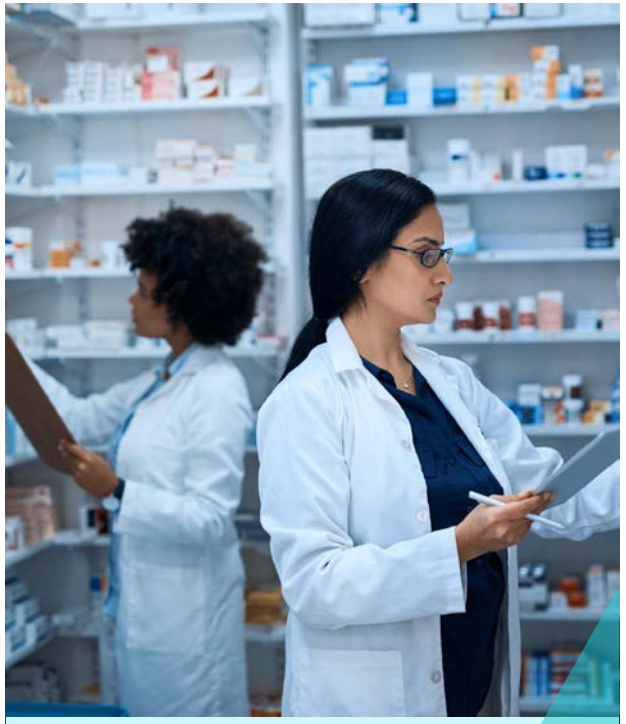
Release RFP and allow for plenty of time for analysis and potential transition

- 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

Pharmacy

Background

- Arkansas is currently using EBRx to manage formulary, clinical review and manufacturer rebates and using MedImpact to process claims, customer service, manage retail network, etc.
- The plan has performed above market with a generic dispensing rate (GDR) of 93%.
- However, generic drugs represent 15% of plan paid while specialty drugs represent 53% of plan paid and continue to grow



Segal 19

Pharmacy Market

Factors driving increased pharmacy spend:

- **Specialty Drugs**
  - High cost, used to treat complex, chronic conditions
  - Require special oversight and distribution
  - Growing limitations on which pharmacies can dispense select drugs
  - Account for over 50% of drug spend
- **Utilization or number of prescriptions dispensed**
  - Covid-19 may have helped keep overall utilization trends down.
  - Avoided doctor visits during Covid-19 may lead to spike in utilization going forward.
  - Increased use of specialty drugs and diagnosis of chronic conditions like diabetes and obesity.
- **New and Novel brand name drug therapies coming to the market faster**
  - Higher list price at launch
  - Rare conditions with no competing therapies

Cost Reduction and Risk Mitigation Strategies

Plan sponsors are looking for lowest net cost and have generally employed the following strategies:

- Formulary Management
  - Includes generic focused, brand exclusion and closed formularies
- Utilization Management and Clinical Rules
  - Prior Authorizations, Quantity Limits and Step Therapy
- Limited Networks
  - Retail, Mail and Specialty Pharmacies
- Plan Design
  - Incentivize use of lowest cost drugs through member copays or co-insurance
- Maximizing Manufacturer Rebates
  - Using formulary options to maximize value in therapeutic categories
  - Minimum guarantees for the plan
- Specialty coupon programs

Other Items of Importance to State Plans

- Promote and protect local community pharmacies
  - May have special pricing/reimbursement
  - Plan design may not have mail order pharmacy option
- Transparency
  - Pharmacy reimbursement
  - Manufacturer rebate revenue
  - Formulary Design
- Formulary flexibility and control
  - Customization of Utilization Management and Clinical Rules
  - Ability to manage individual drugs
- Financial guarantees on discounts and rebates

Opportunities for Arkansas: Rebates

- Rebates are an important component of drug prices in the US
  - Drug manufacturers use rebates to increase market share.
  - The larger the PBM or rebate aggregator the larger the rebate.
- Segal reviewed Arkansas data in detail and compared to several 2021 state bid guarantee proposals. Rebates in Arkansas compared to other states:
  - Current rebates are approximately 11-12% of gross discounted cost
  - Other state level plans are receiving 25-35% of gross discounted cost
  - Potential increase in rebates = $25-$50M annually ($200M annual discounted cost)
- Top Current Therapeutic Categories of Spend
  - $40.0M Inflammatory Drugs (market rebates ~ 50%)
  - $15.0M Cancer Drugs (market rebates ~ 5%)
  - $11.5M Insulin Drugs (market rebates ~ 50%)
  - $ 8.8M Anticoagulent Drugs (market rebates ~ 50%)
  - $ 8.3M Non-Insulin Diabetic Drugs (market rebates ~ 50%)
  - Based on these top 5 categories, rebates could be in the range of $35M annually, $13M more than the $22M the state is currently receiving

Opportunities for Arkansas: Specialty Pharmacy

- Specialty drugs are currently negotiated with local specialty pharmacies and some other arrangements for limited distribution drugs.
  - Current specialty discounts realized are at least 30% lower than other state minimum guarantees
- Other States compared to Arkansas
  - Generally employ an exclusive arrangement with one primary specialty pharmacy
  - Partner with larger specialty pharmacies to maximize volume and access to other care services such as 24 hour, 7 day a week access to pharmacists and nurses
  - Have extensive service guarantees and pricing guarantees including discounts, rebates and manufacturer assistance programs.
- Potential Plan Concerns
  - Loss of local specialty pharmacy access
    - Some states have negotiated a semi-open network with a specialty pharmacy and a local specialty pharmacy or hospital.

Opportunities for Arkansas: Contract Guarantees

- Contract Guarantees in Arkansas compared to other states
  - Currently no minimum guarantees on discounts or rebates which means the Plan is taking on 100% of the risk with no ability to have PBM take a portion of the risk.
  - Other state level plans have minimum guarantees on overall discounts and rebates by distribution channel with 100% pass through to the plan.
  - This structure allows for maximum payments with no limits on upside while putting downside risk on the PBM who has negotiating power with the manufacturers, retail network and specialty pharmacies
- Potential Plan Concerns
  - Pressure on retail pharmacy reimbursement
  - May lose some control on formulary and utilization management decisions with rebate guarantees

Opportunities for Arkansas: Optimizing Plan Design

- Plan design in Arkansas compared to other states
  - Currently using a reference based pricing (RBP) program that sets the amount the plan will reimburse for a drug category based on the cheapest drug in the category. Members pay the difference for anything above the plan reimbursement amount.
  - Other state level plans have generally used generic tier strategies to have low cost and high cost generic copays or have selectively excluded brands and in some cases generics to drive to lowest net cost alternatives.
  - The potential concerns with the current strategy:
    - Shifting cost to members without their knowledge of alternatives, creates confusion potentially on drug coverage and cost.
    - How is reference based price monitored and adjusted?
- Potential Plan Concerns
  - Removing RBP may increase plan cost
- Potential Plan Barriers
  - Current structure precludes the large PBMs from bidding
  - Plan design with reference based pricing creates operational and pricing discount barriers for many PBMs

Recommendations

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

Recommendation

Repeal Act 1104, Insulin

- 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.

Clinical

Clinical - Wellness Program

Background

Currently providing information and resources

- Currently using Catapult to administer wellness program
  - Biometric Screening
  - Nicotine Screening
  - Health Assessment
- For completion members receive a $50 monthly contribution credit
- BCBS has diverted staff to focus on telephonic engagement attempts based on biometric results

Clinical - Wellness Program

Recommendation

Shift the wellness program from self-serve to results based to drive sustained behavior change

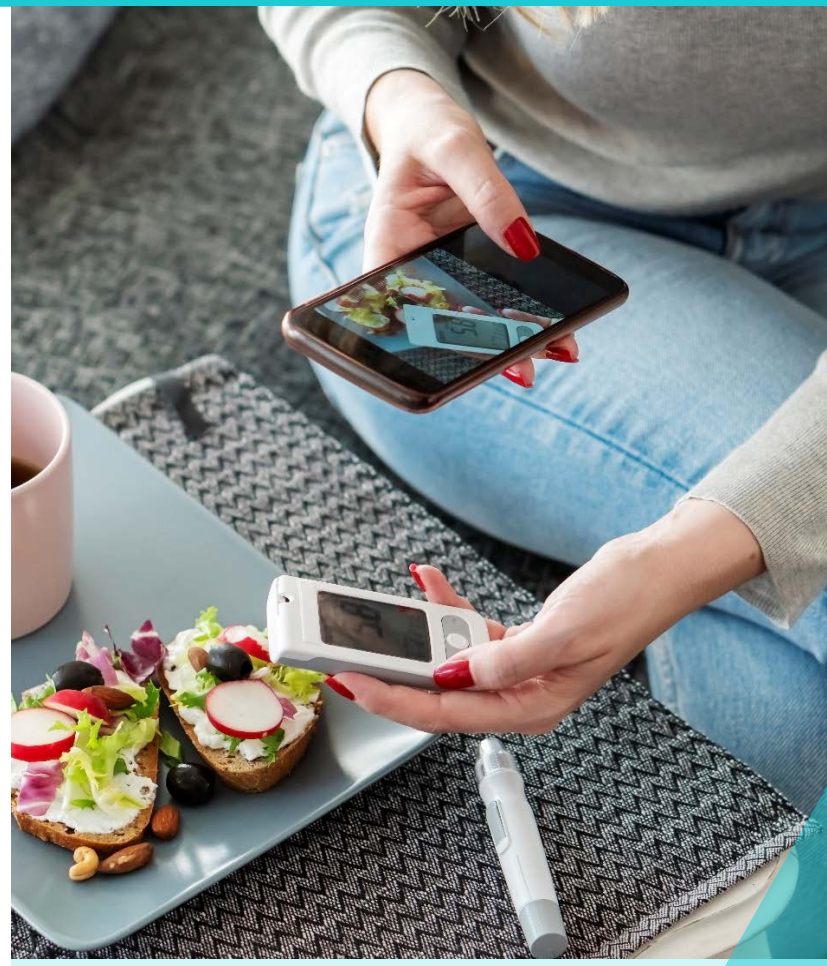
- Results-focused for broad population
  - Negotiate Performance Guarantees with vendors tied to improvement in the overall population health
  - Incentivize age and gender specific health screenings (i.e. primary care visit, flu shot, OBGYN screening, dental screening, cancer screenings, etc.)
- Results-focused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

Clinical – Comprehensive Diabetes Strategy

Recommendations

Comprehensive Diabetes management strategy should include a focus on prevention, management, and lifestyle improvement

- 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**



Clinical - Oncology

Recommendations

The pandemic reduced access to preventive care screenings and many rural communities lack access to high quality oncology care

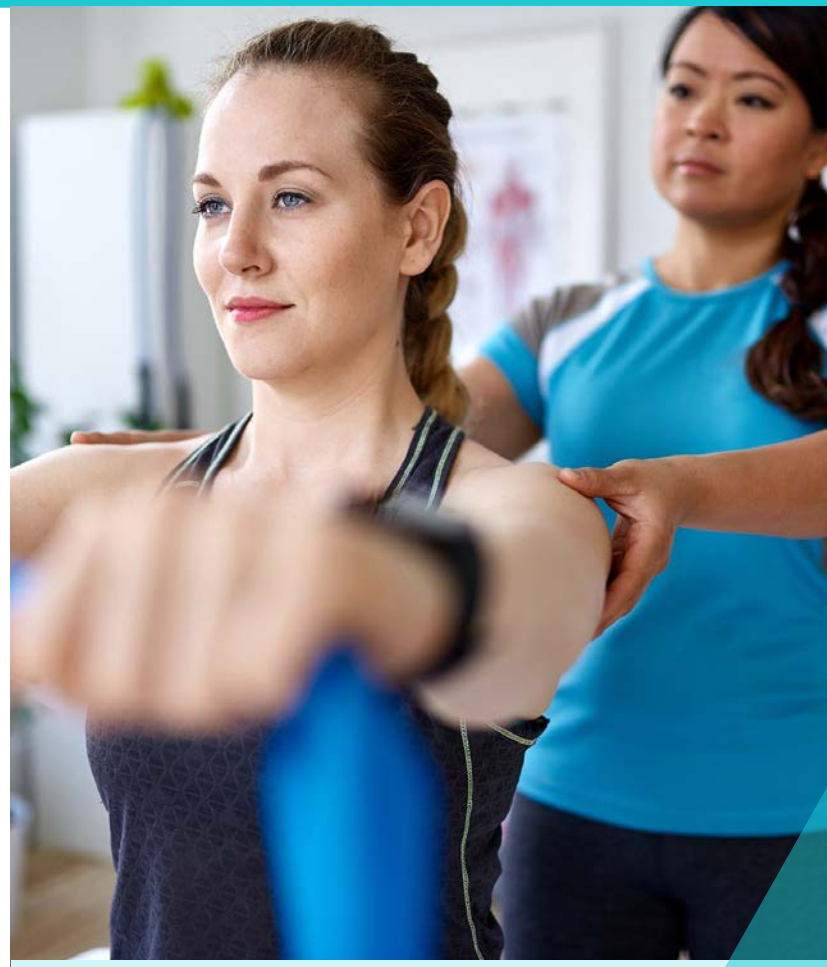
- Communicate and incentivize age/gender specific cancer screenings
- Enhance utilization management programs that require adherence to national standards of oncology care (NCCN Guidelines and appropriate genetic testing)
- Connect oncology patients to nationally recognized Oncology Centers of Excellence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

Clinical - Musculoskeletal

Long Term Recommendations

Comprehensive musculoskeletal program includes site of service steerage and virtual access to care

- 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



“Onsite” Clinic

Long Term Recommendations

Onsite clinics and other models can reduce inappropriate medical spending and can reduce the burden of medically underserved communities and high social deprivation index

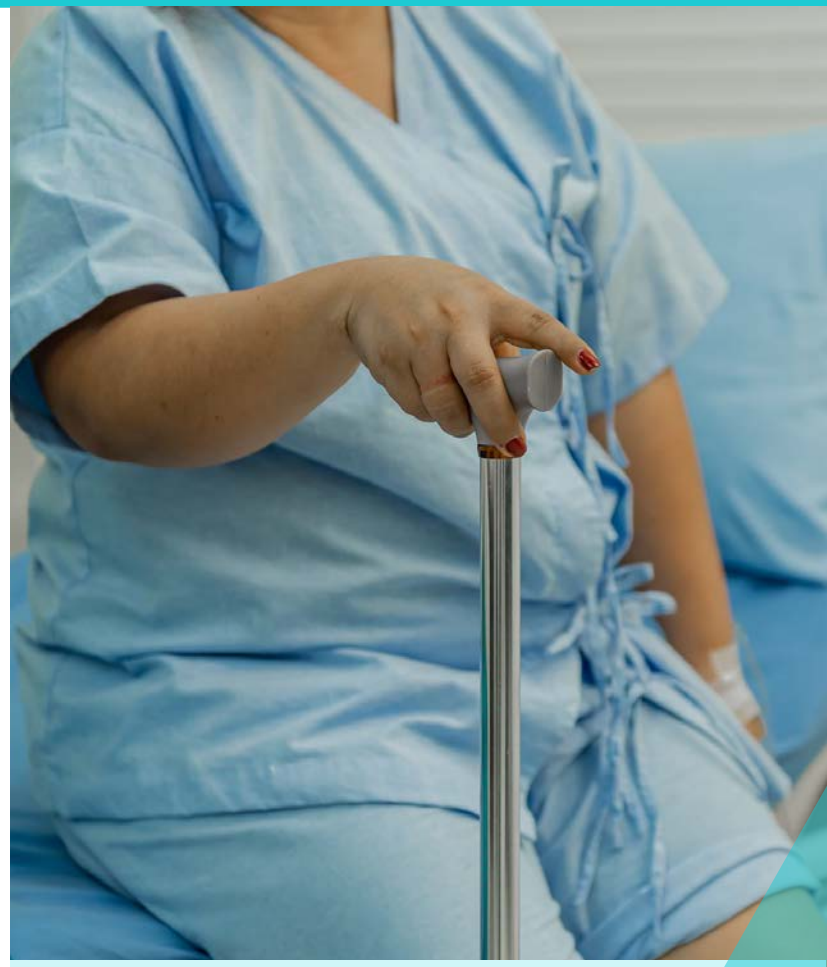
Options to consider:

- 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

Recommendation

ACT 927, Bariatric Program

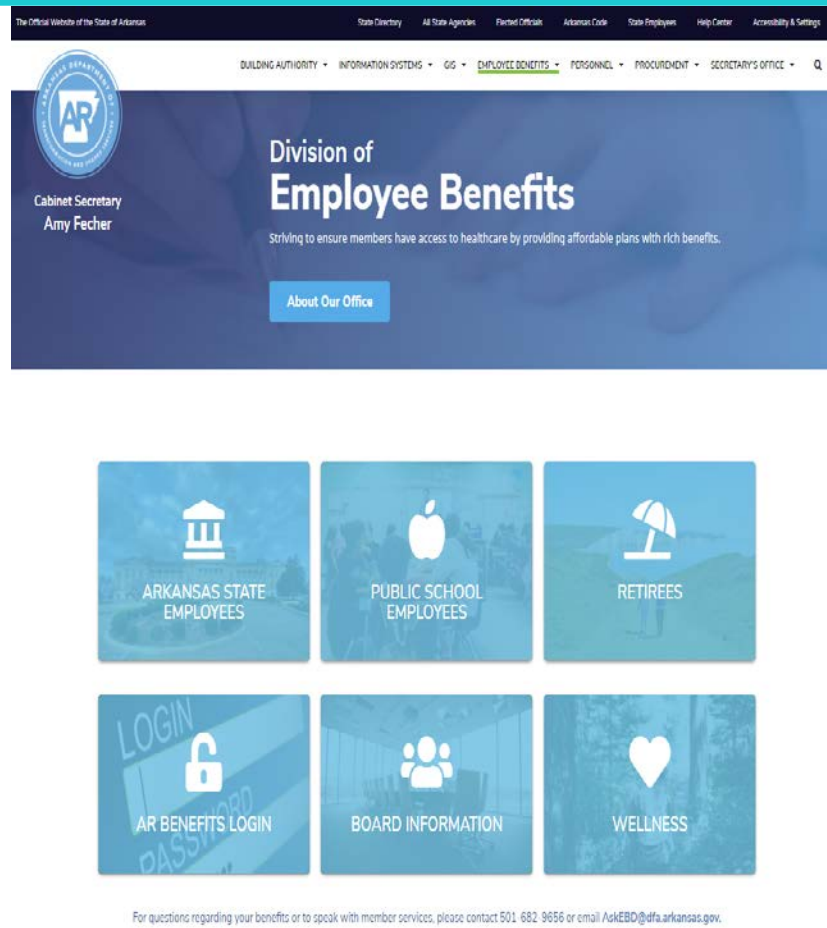
- Market data and BLR specific analysis both support the continued funding and promotion of the current bariatric program.
- Keep current $3M cap in place to mitigate risk, although history indicates a low likelihood of surpassing.



Communications

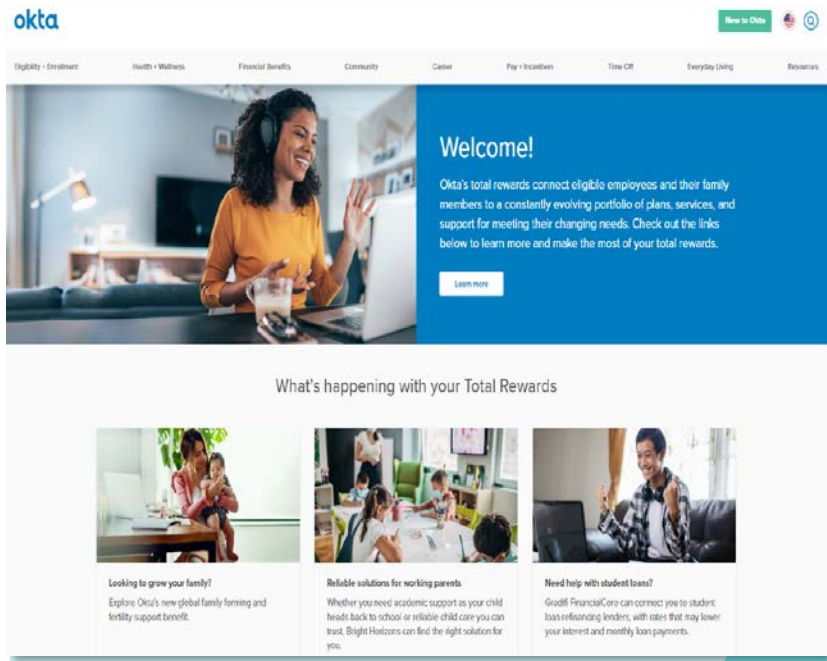
transform.ar.gov Benefits Websites Review

- **transform.ar.gov** has 2 similar benefits information website subsections:
  - State employees
  - Public School employees
- Segal took a brief look at the sites, analyzing them at a high level to help determine sites' value to current and prospective employees. We looked at:
  - Usability
  - Design
  - Content accessibility, hierarchy, and organization
  - Navigation
  - Naming and information linking conventions

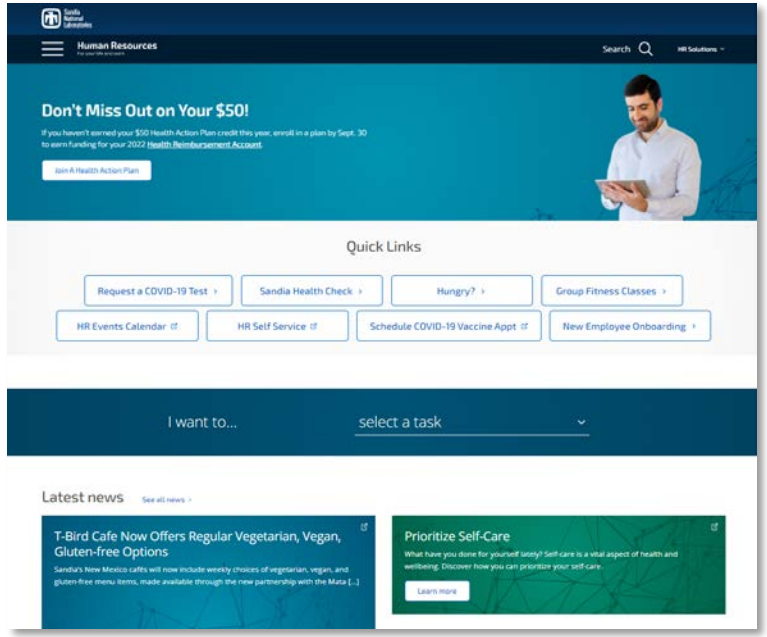


Recommendations and Best Practices

- Highlight home page content using “tiles”
- Direct “call-to-action” buttons to featured information
- Spell out all acronyms
- Have design elements properly anchor page text
- Include HTML (web-specific) text that’s descriptive \ provides links to details
- Use consistent and descriptive terminology
- Configure search engine to return relevant results
- Use primary navigation to separate topics clearly and intuitively
- Optimize for mobile viewing / use
- Organize content around employees’ goals and priorities (not HR / Benefits organization silos)
- Promote as the go-to source for all benefits information
- Keep content and design fresh by updating consistently
- Review and act on site analytics regularly



Sample Client Sites



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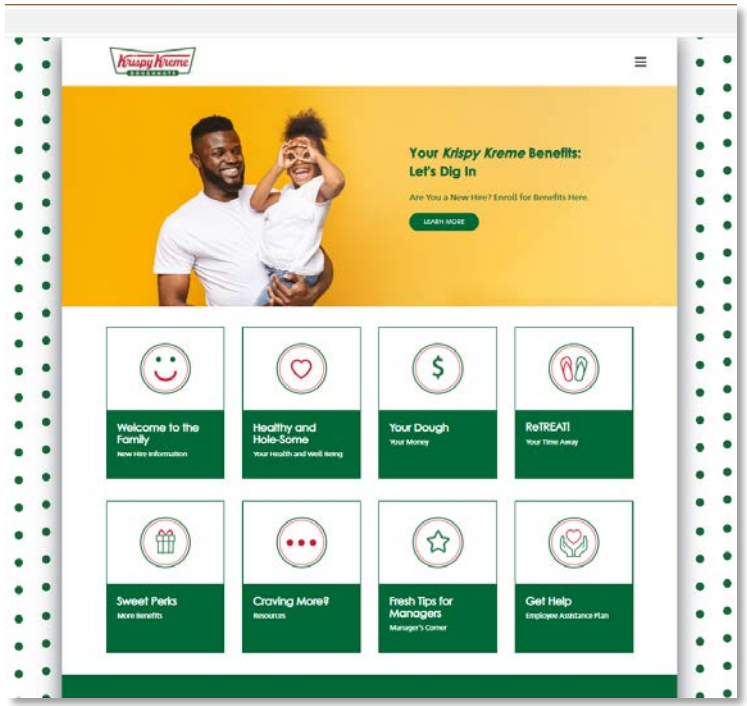

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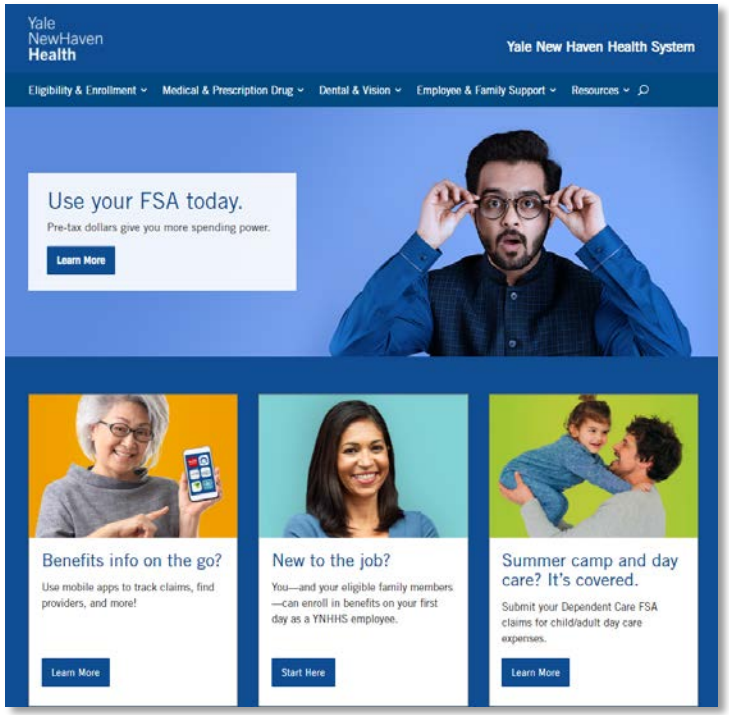

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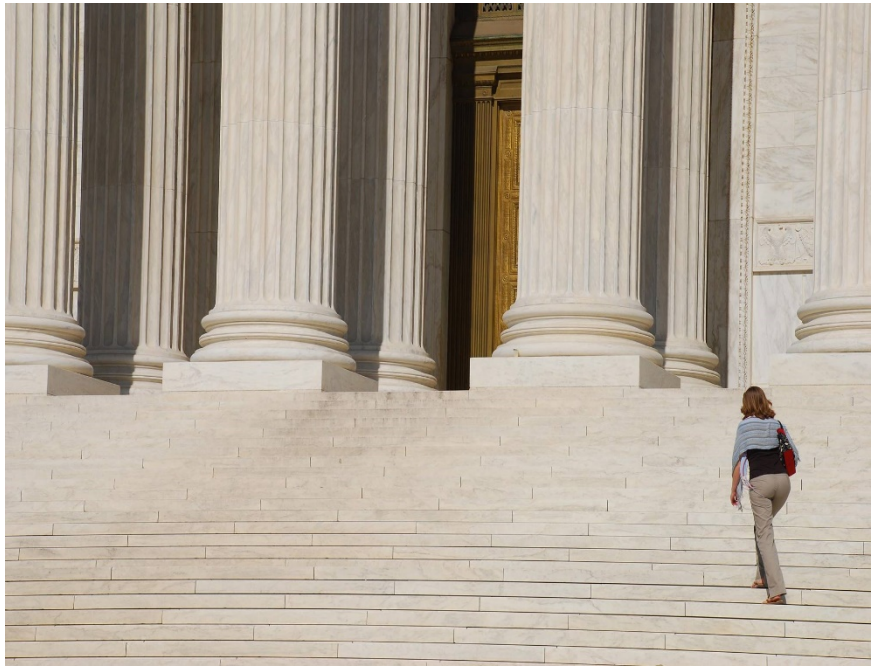
Additional Items

Additional Items

Recommendation

- 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.



Thank You!